Hospice Care in the Nursing Home: The New Interpretive Guidelines for NF Surveyors

September 2017 Subscriber Webinar

The Plan

1. Brief Look: The Hospice – Nursing Home Partnership
2. Brief Look: The Nursing Home Survey Process
3. Deeper Look: The New Nursing Home Requirements for Participation - Interpretive Guidelines in Two Significant Areas
4. Critical Areas to Consider
5. Actions of the Prudent Hospice

Unless otherwise noted all regulatory language in this presentation is from the Advance Copy Appendix PP State Operations Manual Medicare Internet Only Manual System Effective 11/28/2017
The Relationship

• Started in the early 90s – neither side was really prepared
• No mention of hospice care in the NH in 1983 CoPS
• Discomfort from powerful quarters
  – CMS
  – MedPAC
  – HHS Office of the Inspector General

Originally Little Regulatory Guidance

“There is no indication in the statute that the term ‘home’ is to be limited for a hospice resident. A resident’s home is where he or she resides. The facility is considered to be the beneficiary’s place of residence (the same as a house or apartment), and the facility resident may elect the hospice benefit if he/she also meets the hospice eligibility criteria.”

» Section 2082, State Operations Manual (has been removed)
The Healthcare Regulatory Continuum

Nursing Homes

Hospices

Hospices at Start of Partnership

Loosely Regulated

Highly Regulated

The Survey Processes

<table>
<thead>
<tr>
<th></th>
<th>Nursing Homes</th>
<th>Hospices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>12 - 15 months</td>
<td>3 years</td>
</tr>
<tr>
<td>Financial Implications If Deficiencies</td>
<td>Yes</td>
<td>No*</td>
</tr>
<tr>
<td>Can Trigger Complaint Survey for Other Provider</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Regulations</td>
<td>42 CFR 483 Subpart B</td>
<td>42 CFR 418 Subparts C &amp; D</td>
</tr>
<tr>
<td>Surveys Guided By</td>
<td>State Operations Manual Appendix PP ~ 700 pages</td>
<td>State Operations Manual Appendix M 183 pages</td>
</tr>
</tbody>
</table>
**Scope & Severity**

Scope: How many residents are affected?

- Isolated
- Pattern
- Widespread

Severity: What is the potential or actual negative outcome?

- Level 1
- Level 2
- Level 3
- Level 4 (Immediate Jeopardy)

**Some Good News**

<table>
<thead>
<tr>
<th>Emphasis at start of partnership</th>
<th>Nursing Homes</th>
<th>Hospices</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Maintaining “highest practicable level of functioning”</td>
<td>Quality of life and patient's wishes</td>
</tr>
</tbody>
</table>

The gap between the two continues to decrease as NH regulations increasingly recognize resident/representative choice, quality of life and national focus on decreasing rehospitalization.
### The Saga: Nursing Home Residents Receiving Hospice Care

<table>
<thead>
<tr>
<th>Year</th>
<th>Provider</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>Hospice</td>
<td>New Conditions of Participation &amp; Interpretive Guidelines</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Included New Condition §418.113 Hospices that provide hospice care to residents of a SNF/NF or ICF/IID (Condition + 6 Standards)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Companion Regulatory Language for Residents Receiving Hospice Care Added to Requirements of Participation</td>
</tr>
<tr>
<td>2013</td>
<td>NH</td>
<td>§483.75 Administration (o) Hospice services. (effective date August 26, 2013)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No Accompanying Interpretive Guidelines Released</td>
</tr>
<tr>
<td>2016</td>
<td>NH</td>
<td>New Requirements of Participation</td>
</tr>
<tr>
<td>2017</td>
<td>NH</td>
<td>New Survey Process Commencing: Interpretive Guidelines for Surveyors Released and become effective 11/28/2017</td>
</tr>
</tbody>
</table>

### Implementation Grid*

<table>
<thead>
<tr>
<th>Implementation Date</th>
<th>Type of Change</th>
<th>Details of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1: November 28, 2016 (Implemented)</td>
<td>Nursing Home Requirements for Participation</td>
<td>New Regulatory Language was uploaded to the Automated Survey Processing Environment (ASPEN) under current F Tags</td>
</tr>
<tr>
<td>Phase 2: November 28, 2017</td>
<td>F Tag numbering Interpretive Guidance (IG) Implement new survey process</td>
<td>New F Tags. Updated IG Begin surveying with the new survey process</td>
</tr>
<tr>
<td>Phase 3: November 28, 2019</td>
<td>Requirements that need more time to implement</td>
<td>Requirements that need more time to implement</td>
</tr>
</tbody>
</table>

*From CMS New Long Term Survey Process Presentation May 15, 2017 Accessed 8/30/2017

https://www.cms.gov/Medicare/Provider‐Enrollment‐and‐Certification/GuidanceforLawsAndRegulations/Nursing‐Homes.html
Two Significant NH Interpretive Guideline Areas

Quality of Care
Hospice Services

NOTE: If NH Surveyor Notes Situations in Which

NH advised hospice of concerns and hospice failed to address and resolve issues related to
  – coordination of care plan
  – Implementation of appropriate services

Hospice failed to provide services in accordance with the coordinated plan of care

NH Surveyor Is to Refer Complaint to Hospice Survey Section

This guidance, or some variation there of, shows up several times in the two sections that we will be looking at today.
Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident’s comprehensive assessment and plan of care.

INTENT
To ensure facilities identify and provide needed care and services that are resident centered, in accordance with the resident’s preferences, goals for care and professional standards of practice that will meet each resident’s physical, mental, and psychosocial needs.

Definitions

**Highest practicable physical, mental, and psychosocial well-being** is defined as the highest possible level of functioning and well-being, limited by the individual’s recognized pathology and normal aging process. Highest practicable is determined through the comprehensive resident assessment and by recognizing and competently and thoroughly addressing the physical, mental or psychosocial needs of the individual.

**Hospice Care** means a comprehensive set of services...identified and coordinated by an interdisciplinary group (IDG) to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care. (42 CFR 418.3)

**Palliative care** means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice. (§418.3)

**Terminally ill** means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. (§418.3)
**Was Negative Outcome Avoidable?**

Did these 4 steps occur?

1. **Assessment**
   Conducted an accurate and comprehensive assessment including evaluating the resident’s clinical condition and risk factors for the concern being investigated;

2. **Development of Person Centered Plan**
   Based on information gathered through resident assessments, with resident/representative input, developed a person-centered care plan, defined and implemented interventions that are consistent with resident needs, goals, and recognized standards of practice.

3. **Implementation & Monitoring**
   Implemented the care plan, and monitored resident responses to the interventions; and

4. **Review & Revision**
   Provided ongoing review and revision of the care plan and interventions as necessary.
**F684 Quality of Care**

<table>
<thead>
<tr>
<th>Current</th>
<th>Review of a Resident Receiving Hospice Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mostly bullet-pointed recitation of regulations and mechanics of the partnership and provision of care</td>
<td></td>
</tr>
<tr>
<td>Length: 1 page</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>New</th>
<th>Review of a Resident at or Approaching End of Life and/or Receiving Hospice Care and Services Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognizes concept of appropriate care based on choice for all residents approaching end of life plus greatly expands on how hospice and NF will work together</td>
<td></td>
</tr>
<tr>
<td>Length: 10 pages</td>
<td></td>
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</table>

**F684 The NH Assessment**

The resident must receive a comprehensive assessment to provide direction for the development of the resident’s care plan to address the choices and preferences of the resident who is nearing the end of life. In addition, in order to promote the physical, mental, and psychosocial well being of a resident...the facility and the resident’s attending physician/practitioner, should, to the extent possible:

- Identify the resident’s prognosis and the basis for that prognosis; and
- Initiate discussions/considerations regarding advance care planning and resident choices to clarify goals and preferences regarding treatment including pain management and symptom control, treatment of acute illness, and choices regarding hospitalization.
### F684 The Expected Flow for All Residents

1. **Resident Assessment**
2. **Choices + Advance Directives**
3. **Care Planning**

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### Care Plan May Include, But Not Limited to

<table>
<thead>
<tr>
<th>Care Areas</th>
<th>Verbiage Specifically Mentions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Care</td>
<td></td>
</tr>
<tr>
<td>Skin Integrity</td>
<td>Resident Choices</td>
</tr>
<tr>
<td>Medical Treatment / Diagnostic Testing</td>
<td>Resident Choices /Directives</td>
</tr>
<tr>
<td>Symptom Management</td>
<td>Resident Choices, Goals for Comfort, Dignity and Desired Level of Alertness</td>
</tr>
<tr>
<td>Nutrition and Hydration</td>
<td>Resident Choices /Directives, Disease Processes, Assessment</td>
</tr>
<tr>
<td>Activities / Psychosocial Needs</td>
<td>Resident Choices/Directives, Personal Beliefs, Interests, Ethnic/Cultural Practices and Spiritual Values</td>
</tr>
</tbody>
</table>
**Resident Care Policies**

Facility must develop and implement resident care policies that are consistent with current professional standards of practice for pain management and symptom control, assessing residents’ physical, intellectual, emotional, social, and spiritual needs as appropriate, and

**if a written agreement with a hospice,** ongoing collaboration and communication processes established by the nursing home and the hospice

F684

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**Coordinated Care Plan: NH Responsibilities**

- Furnish 24-hour R&B care  
- Meet resident’s personal care and nursing needs  
- Provide services consistent with the care plan  
- Offer these same services to residents receiving hospice care as those that are not

<table>
<thead>
<tr>
<th>Service</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive assessment</td>
<td>Monthly medication regimen review</td>
</tr>
<tr>
<td>Personal care</td>
<td>Support for ADLs</td>
</tr>
<tr>
<td>Activities</td>
<td>Social services as appropriate</td>
</tr>
<tr>
<td>Medication administration</td>
<td>Nutritional support and services</td>
</tr>
<tr>
<td>Required physician visits</td>
<td>Monitoring resident condition</td>
</tr>
</tbody>
</table>

F684
Coordinated Care Plan: NH Responsibilities

Resident / representative must be included in care plan development

To support communication on patient care between NH and hospice the NH must

- Designate staff member to participate in on-going communication
- Include resident representative in decision-making
- Provide name of the staff member/or designee to the resident/representative

F684

Coordinated Care Plan: Hospice Responsibilities

- Provision of hospice care and services
- Based on assessments, including but not limited to the following

  - Medical direction & management
  - Medical supplies & DME
  - Nursing (including assigning hospice aides as need to support resident’s ongoing care)
  - Drugs for palliation of pain and symptoms associated with the terminal illness and related conditions
  - Counseling (including spiritual, dietary and bereavement)
  - All other hospice services necessary for the care of the resident’s terminal illness and related conditions
  - Social work

F684
Is There a Care Provision Issue?

Next step is to review the written agreement

If there is an issue related to the provision of care by the hospice, the survey team may request the written agreement and review to see the steps the nursing home has taken to resolve the resident care issues. The written agreement should include how differences are resolved between the nursing home and the hospice, and the nursing home and hospice liaisons may need to be interviewed regarding the identified concerns. If there are concerns related to the provision of care based upon the failure of the implementation of the written agreement or the lack of a written agreement, refer to F849.

Structure, Location and Changes to the Care Plan

- May be divided into two portions, one established and maintained by hospice and one by NH
- Each partner must be aware of location and content
- Plan must be current and internally consistent
- Any changes must be discussed and approved by the NH, hospice staff, and, to the extent possible, the resident and/or representative
- Must identify which provider is responsible for performing each specific service/function

F684
Communication

NH must immediately inform the hospice of
- Significant changes in the resident’s status
- Clinical complications
- Emergent situations

Includes but not limited to
- Change in cognition
- Sudden unexpected decline
- Fall with suspected fracture
- Adverse consequences to a medication or therapy
- Other situations requiring a review or revision to the care plan

Does not relieve facility of responsibility of notifying resident’s attending and the family representative

Decision making must be consistent with resident’s wishes

F684

Communication

Prior to care plan or order changes, the hospice and the resident’s attending physician/practitioner may need to collaborate to address this change and to assure the resident’s immediate needs and treatment decisions are met, including situations which could require a potential transfer to an acute care setting. This decision making must be consistent with the resident’s wishes. (p 252)

If there is a conflict between the hospice and the resident’s attending physician/practitioner regarding the care plan, there must be communication between the hospice and the nursing home regarding the issue. This communication should be timely and include the hospice medical director and the nursing home medical director as well as other pertinent hospice and facility staff, as needed. (p 253)

F684
Communication

Must establish
– A communication process that functions 24/7
– A defined protocol how communication will be documented to reflect concerns and responses

Key Elements Of Noncompliance

To cite deficient practice at F684, the surveyor’s investigation will generally show that the facility failed to do any one of the following:

• Provide needed care or services resulting in an actual or potential decline in one or more residents’ physical, mental, and/or psychosocial well-being;
• Provide needed care or services (i.e., manage symptoms) resulting in one or more residents’ failure to improve and/or attain their highest practicable physical, mental, and/or psychosocial well-being;
• Recognize and/or assess risk factors placing the resident at risk for specific conditions and/or problems;
• Implement resident-directed care and treatment consistent with the resident’s comprehensive assessment and care plan, preferences, choices, rights, advance directives (if any, and if applicable, according to State law), goals, physician orders, and professional standards of practice, causing a negative outcome, or placing the resident at risk for specific conditions and/or problems;
• Monitor, evaluate the resident’s response to interventions, and/or revise the interventions as appropriate, causing a negative outcome, or placing the resident at risk for specific conditions and/or problems; and
• Inform and educate the resident who decides to decline care about risks/benefits of such declination; and offer alternative care options and take steps to minimize further decline, causing a negative outcome, or placing the resident at risk for specific conditions and/or problems.

F684
**Investigative Procedure**

- Review most recent NH comprehensive assessment, care plan and orders to identify if facility has recognized and assessed concerns or resident care needs under investigation.
- Make observations and conduct interviews to corroborate concerns.
- Note if care plan is evaluated and revised based on resident response to interventions.
- Interventions developed and implemented based on resident needs, goals for care and professional standards of practice.

**Deficiency Categorization Examples**

**Level 4**

*The facility failed to promptly identify and intervene for an acute change in a resident’s condition related to congestive heart failure (CHF), resulting in the family calling 911 to transport the resident to the hospital. The resident was admitted to the hospital with respiratory distress, pulmonary edema, and complications of CHF.*

(p 255)

F684
**Deficiency Categorization Examples**

**Level 3**

The facility failed to implement a resident’s hospice/nursing home coordinated care plan that specified the resident not being transferred to the hospital for treatment. The facility transferred the resident to the hospital for treatment related to a urinary tract infection even though the resident and the coordinated care plan indicated the resident did not wish to be hospitalized and preferred treatment at the facility. The facility did not contact the hospice prior to initiating the transfer to the hospital. The resident experienced increased pain during the transfer to the hospital and continued to express emotional distress (tearful/crying) over the transfer.

F684

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**F849 / §483.70 Hospice Services**

1. Provision of Hospice Services in a NH
2. NH Ensures Professional Standards and Timeliness of Services
3. Signed Written Agreement with Hospice Prior to Provision of Care
4. Hospice Plan of Care
5. Nursing Home Responsibilities
6. Communication Process between NH and Hospice
7. Notifying Hospice Regarding Clinical Changes
8. Hospice Determines Level of Hospice Services
9. NH Responsibilities for Personal Care and Nursing Needs in Coordination with Hospice
10. Delineation of Hospice Responsibilities
11. Nursing Home Responsibilities for Administration of Prescriber Therapies
12. Report to Hospice of Any Alleged Violations of Mistreatment
13. Responsibilities for Bereavement Services for NH Staff
14. NH Designee(s) Responsibilities
15. Provision of Current, Coordinated Plan of Care
2. NH Ensures Professional Standards and Timeliness of Services

Very emphatic language that the NH is responsible for ensuring that
• services provided by the hospice (including the individuals providing the services) meet professional standards and principles,
• meet the assessed needs of each resident, and
• the hospice is certified for participation in the Medicare program

NH & Hospice jointly must assure that all physician/practitioners meet State licensure requirements and are working within their scope of practice and professional State licensure requirements.

F849

2. NH Ensures Professional Standards and Timeliness of Services

The nursing home staff must monitor the delivery of care in order to assure that the hospice provides services to the resident in a way that meets his/her needs in a timely manner including:
• Observation of interactions and care provided by the hospice staff sufficient to assure that the hospice services meet the professional standards of care;
• Interviews with the resident/designated representative regarding hospice care and services; and
• Review of the resident’s record for pertinent documentation regarding the delivery of hospice care.

F849
4. Hospice Plan of Care

Reiterates that NH and hospice can define structure of care plan and that
- Individual portions be current and internally consistent
- Based on shared communication between the two partners that identifies
  - Diagnoses
  - Common problem list
  - Palliative interventions
  - Palliative goals and objectives
  - Responsible disciplines(s)
  - Responsible provider(s)
  - Resident/representative choices regarding care and goals

F849

4. Hospice Plan of Care

The nursing home must designate a member of the nursing home’s interdisciplinary team who is responsible for working with hospice to coordinate care for the resident. (See §483.70(o)(3)(i) below.) In addition, different nursing home staff, who are knowledgeable regarding the resident’s care, may also work with hospice staff in the development of the plan of care. The hospice coordinator must provide ongoing coordination and collaboration with the nursing home coordinator, the resident’s attending physician/practitioner and the resident/designated representative regarding changes to the resident’s plan(s) of care. (p 603)

F849
5. Nursing Home Responsibilities

Reiterates that resident receiving hospice services should receive same services from NH that non-hospice residents receive.

Also includes this passage: The nursing home must maintain an environment in which there are no inappropriate signs posted in residents’ rooms or in staff work areas visible by other residents and/or visitors that include confidential clinical or personal information, such as information about hospice services (p603)

6. Communication Process between NH and Hospice

Taking Orders
– Both hospice and NH staff may document physician orders in record
– No Federal regulations prohibiting facility staff from the hospice physician

Communication regarding Changes
– Any changes initiated by hospice should be communicated to attending in a timely manner
– NH must communicate changes made by attending to the hospice

Plan of Care Changes
– Resident’s NH attending and hospice physician may need to communicate on POC changes in emergent situations
– In any situation in which there is conflict between the orders, there MUST be communication between hospice and NH. Should include respective doctors.

F849
10. Delineation of Hospice Responsibilities

When the resident elects the hospice benefit, the resident may choose to specify his/her nursing home attending physician/practitioner as the hospice attending physician. If the resident does not choose his/her nursing home attending physician, he/she may select another physician/practitioner as the hospice attending physician. (p605)

Written agreement must specify the process to follow to reconcile disagreements between resident’s attending physician/practitioner and the hospice physician.

F849

13. Responsibilities for Bereavement Services for NH Staff

The written agreement should specify
1. when the nursing home should provide information to the hospice regarding nursing home staff that may benefit from bereavement services
2. how bereavement services will be coordinated and operationalized by the hospice provider for nursing home staff

The written agreement must include a description of the nursing home’s role in providing such services.

In the case of several hospices offering services in a nursing home, each hospice’s written agreement must include the provision regarding bereavement services for staff as noted above.

F849
14. NH Designee(s) Responsibilities

NH must designate in writing an employee responsible for collaborating and coordinating activities between NH and hospice; may delegate responsibilities if person not available

Requirements

– Clinical background and functioning within state scope of practice
– Ability to access resident or access to someone who does
– Familiar with hospice philosophy and practices
– System for the designated team member to obtain information

Provide name to resident/representative
If contracting with more than one hospice, may have a different person for each
Additional responsibility: assuring that orientation is provided to hospice staff of overall facility environment (policies, rights, record keeping and forms)
If multiple hospices may not be necessary for each hospice to provide info on hospice philosophy and principles of care if the NH has received this info and is aware

F849

Elements of Non-Compliance

To cite deficient practice at F849, the surveyor’s investigation will generally show that the facility failed to do any one of the following:

• Develop a written agreement with the Medicare-certified hospice prior to hospice services being provided to a resident; or
• Establish a communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day; or
• In accordance with the written agreement to immediately notify the hospice about a significant change in the resident’s condition, or the presence of clinical complications that suggest a need to alter the plan of care, or a need to transfer the resident from the facility or of the resident’s death; or

F849
Elements of Non-Compliance (2)

- To designate a member of the facility’s interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff; or

- Ensure that each resident’s written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident’s highest practicable physical, mental, and psychosocial wellbeing; or

- Delineate the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

No Coordinator
Care Plan Problems
No Responsibility
Delineation for NH Staff
Bereavement Services

Deficiency Categorization Examples

Level 4

- Resident has severe uncontrolled pain or acute respiratory distress and facility fails to contact and consult with the hospice for a change in condition as per the WA

- NH failed to establish a WA with a hospice that was allowed to provide services in the NH. Resident was administered medication for pain management by the hospice. Due to lack of coordination the NH, unaware that med had been given, also administered pain medication resulting in overdose of opioids followed by hospitalization for acute respiratory failure.
Deficiency Categorization Examples

Level 3

• Failure to assure that the resident received hospice care based on a WA. Resident experienced pain that compromised his/her function and ability to reach highest practicable well-being because NH failed to implement a pain management plan or to contact and consult with the hospice as per the WA.

• NH failed to establish a WA with a hospice that was allowed to provide services in the NH and then failed to contact the hospice when there were significant changes in the resident’s pain level that required changes to the plan of care. Facility failed to involve the hospice and failed to develop, implement, monitor or modify pain management interventions.

F849

Deficiency Categorization Examples

Level 2

• Facility failed to assure that the resident received hospice care and services based upon a written agreement with a Medicare-certified hospice. Resident was on a pain management program utilizing opioids. The resident was experiencing episodic minimal discomfort and the facility failed to consult with the hospice regarding the bowel management plan as identified in the coordinated plan of care.

• NH failed to assure that the written agreement met one or more of the regulatory specifications resulting in the potential for negative resident outcomes.

F849
Critical Area to Consider

F684 & F849

Critical Area: Written Agreement

Is there one in place?
Did individuals signing it have authority to do so?
Review against hospice and NH regulations and IGs
  – Are all areas covered?
  – Does it need to be expanded based on NH Interpretive Guidance?
Seek legal advice – no home cookin’
  – If provided with a new contract by the NH
  – If you want to update what you have in place now
Critical Area: Communication

• How is 24/7 communication assured?
• Is there a clear protocol that can be accessed and understood
  – by hospice IDG members?
  – by NH staff members?
• How, when and by whom are hospice contacts in resident chart updated?
• How does resident/representative know how and whom to contact on hospice team?
• How and where are hospice IFG visits documented in facility?

Critical Area: Coordinators

• How does hospice IDG know who the coordinator is for each facility?
• How is the coordinator updated on resident care issues on a regular basis?
• What type of information is communicated to the coordinator and by whom?
**Critical Area: Care Plans & Planning**

For each facility in which you work
- Where are NF care plans located?
- Where are hospice care plans located?
- What is protocol for updating (who, how and when)?
- Is the care plan current and internally consistent?
- When changes are discussed, where is conversation documented?
- How and by whom are representatives consulted and updated?
- How changes are made, how are they communicated?
- Where is that documented?
- Is it clear which provider is responsible for what and when action will occur?
- What is the protocol to resolve differences?
- Where, how and by whom are differences and outcome of resolution attempts documented?

**Critical Area: Resident Preferences**

- How do you communicate information regarding preferences to the NH?
- How do you review preferences that have been communicated to the NH before hospice care started?
- How are updated preferences / choices communicated to the NH and vice versa?
Actions of the Prudent Hospice™

• Review critical areas and take any necessary action
• Designate someone do follows and then take any actions necessary
  – Read IGs for F684 & F849
  – Review NH and Hospice companion rules
  – Read hospice 418.113 IGs
  – Review written agreement
• Check in with your facility partners to find out if the have specific areas of concern or would like assistance in reviewing
• If you are not aware of survey windows for each, find out now
• Retrain IDG members on existing and/or updated processes

To Contact Us

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The information enclosed was current at the time it was presented. This presentation is intended to serve as a tool to assist providers and is not intended to grant rights or impose obligations.

Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.