Mountain Valley
Hospice & PALLIATIVE CARE
mtnvalleyhospice.org

Documentation Standards

MOUNTAIN VALLEY HOSPICE & PALLIATIVE CARE

July 2020

Reviewed and Updated Annually

TABLE OF CONTENTS

HOSPICE 101 OVERVIEW

The Mountain Valley Way

CERTIFICATION OF TERMINAL ILLNESS & ELECTION PERIODS

An individual may elect hospice care during one or more of the following election periods:

- An initial 90-day period-Referring doctor and Hospice MD must certify that the patient is terminally ill with a life expectancy of 6 months or less.
- A subsequent 90-day period
- An unlimited number of subsequent 60-day periods

Each election period requires a physician narrative and signature to certify that the patient is terminally ill. Beginning in the third election period, the patient must have face-to-face encounter completed with a hospice physician or hospice nurse practitioner in order to continue hospice services.

LEVELS OF CARE

- **Routine Home Care** is the care that is provided in a patient's place of residence-home, nursing home, assisted living, etc. The standard of care is for every patient to have a Routine Home Visit at least every 7 days. Any visit that is pre-scheduled should be documented as a Routine Home Visit.
- **Respite Care** is providing a rest or break in the provision of care. Often caregivers experience exhaustion or may need to be away from the home. In those situations, the patient can utilize the IPU or contracted facility for a respite stay lasting a total of five days. While the provider does not visit daily, nurse and hospice aide services are provided around the clock. At the end of the five days, the patient returns home. Payment for respite level of care is covered 100% by Medicare, Medicaid, and most commercial insurances.
- **GIP (General In-Patient)** is when a patent's symptoms cannot be managed in the home, a short stay, usually about three days, at the IPU (In Patient Unit) or contracted facility is an excellent option. In the IPU patients receive daily provider visits in order to monitor symptom management and ensure the treatment plan is helping with patient comfort. Patients also receive around the clock nursing and hospice aide care. A social worker and chaplain are available to provide psychosocial and spiritual support. Hospice volunteers provide care and companionship when needed. A GIP stay at the IPU can be covered for symptom management needs even if symptom is not related to terminal diagnosis. When a patient chooses to go to the hospital for a need related to the hospice diagnosis, it would be considered GIP. Payment for general inpatient level of care is covered 100% by Medicare, Medicaid, and most commercial insurances.
- **Continuous Home Care** Continuous care is provided to the hospice patient during periods of medical crisis and only as necessary to maintain the patient at home. The **RN Case Manager** confirms the assessed need for level of care change to continuous care with the Director of Patient Services and obtain an order from the patient's attending physician. Only RNs, LPNs, and HAs are. Only RNs, LPNs and HAs are counted in the hours of care provided. Documentation includes individual visits as well as documentation of care at least hourly. The care does not need to be continuous but must total eight hours or more of care within the 24-hour period. Hospice aide services may be provided to supplement the nursing care. At least 50% of the total care provided must be by a nurse. Supportive services (MSW, Chaplain, and Volunteer) may be needed during time of crisis but may not be counted towards continuous care hours.

Interdisciplinary Team/Group (IDT/IDG)

The essential function of the interdisciplinary team or group is to work together as a cohesive unit to meet the physical, emotional, spiritual, and psychosocial needs of the patient and family. The IDT/IDG meeting is held every at least 14 days with the purpose of meeting Medicare requirements, reviewing patient eligibility, reviewing the plan of care and medications. The IDT/IDG consists of the MD, Skilled Nurse Case Manager, Medical Social worker, and Chaplain/Bereavement Coordinator. Optional members for meeting purposes include the Volunteer Coordinator, Home Hospice Aide, and Nurse Practitioner.

The Hospice Plan of Care

For hospice care to receive funding, in addition to the election of services and the written certification of terminal illness, a plan of care (POC) must be established. The POC is developed from the initial and comprehensive assessments and is a road map for care and services that are provided. The POC must include all services necessary for the palliation and management of the terminal illness, and related conditions. The POC must include individualized problems, interventions and goals. The POC must be established before services are provided and is continuously updated based on the patients every changing needs.

Recertification

In order for a patient to maintain the Medicare hospice benefit, they must be certified as terminally ill at time of admission and every 90 days twice and every 60 days ongoing. The recertification is a process via documentation that helps to verify that the patient remains hospice eligible.

Live Discharges

- **Medically ineligible**: Patient no longer meets terminally ill status requirement.
- **Revocation:** Beneficiary wishes to terminate hospice care.
- **Transfer:** Beneficiary wishes to transfer services to another Medicare-certified hospice.
- **Out of Service Area:** Hospice is no longer able to provide services as beneficiary is either out of service area or in a non-contracted facility.
- **Discharge for Cause:** Beneficiary is discharged from hospice services for a specific reason (i.e. staff safety, drug diversion, etc.).

Documentation Expectations

Documentation is the key to compliance efforts at Mountain Valley Hospice & Palliative Care. Our processes are outlined in this document which meet the requirements of State and Federal laws, as well as accreditation standards. We will update standards based on audits and system changes.

100% of Documentation is completed at the point of care and accurate. Every home care visit note is closed and completed within 24 hours and every IPU note is closed at the end of each shift. A closed visit note is your electronic signature and protects you from changes to your documentation.

Computers are synchronized at least every morning and every evening so that everyone has the latest information.

- All patient encounters (i.e. visits, phone calls, etc.) need to be recorded in the electronic medical record (EMR).
- Utilize this resource. Ask for help when needed from your preceptor or supervisor.

HealthWyse Mobile: Home Care Nurses

Nursing Workflows

Nursing Workflows			
Visit Reason	**Visit Type**	**Required Forms**	**Paper Forms**
Consult	Pre-Admit	Hospice Pre-Admit Narrative	
Hospice Admission ***(Includes Pediatrics)***	SN Hospice Admission	Integrated Assessment NHPCO Core Measures Narrative Hospice Item Set Hospice Pediatric (Peds only)	
Routine Visit	Routine Visit	Hospice Nurse Assessment Narrative Hospice Pediatric (Peds only) ***(Update Care Plans)***	
Routine Visit ***With Upcoming Recertification***	Routine Visit	Hospice Nurse Assessment Narrative Unipolicy 1st part Unipolicy disease specific (Update care plans)	
Routine Visit ***With Infection***	Routine Visit	Hospice Nurse Assessment Narrative Infection Report	
Routine Visit ***With Infection Follow-up***	Routine Visit	Hospice Nurse Assessment Narrative Infection Report (fill in follow up section)	
PRN Visit	PRN Visit	Hospice Nursing Visit Note Narrative	
Death Visit	Pronouncement	Pronouncement NHPCO Core Measures Med Disposal Hospice D/C - Died Narrative	**C#27** Funeral Home Communication
Live Discharge	Hospice Discharge	Agency D/C Summary Narrative ***Plus:*** If Live Discharge: Hospice D/C-Discharge	**C#22** Notice of Discharge **OMB#01** Notice of Medicare Non-Coverage **C#23** D/C Instructions **C#24** Request Change of Designated Hospice
Revocation Visit	PRN Visit	Hospice D/C Revocation Narrative	**C#26** Revocation
General Inpatient Visits (Outside Facilities)	Routine Visit minimum once per week; Daily Contact	Hospice Nurse Assessment Narrative ***(Update Care Plans)*** Quick Note	**C#10** Inpatient Education

CONSULTS

DOCUMENTATION REQUIRED FOR CONSULTS

- Under the Pre-admit Note, everything needs to be filled out.
    - Under the communication tab, you choose “Certification of Terminal Diagnosis” under the Medical Director and the Physician, insert the physician’s name. If the patient chooses MVH as their attending only the Medical Director is required.
- Narrative Note- copy and paste completed Navigator Consult Template

See Appendix for Eligibility Criteria (A) (on page 50) and Navigator Consult (B) (on page 48).

HOME CARE ADMISSION

PRIORITY LEVELS

This is completed under the ***Demographics*** tab of the patient’s chart in the ***Primary Info*** section.

1. Priority Level 1: (Highest need)
    - Patient is using electrical equipment for which the interruption of electrical service endangers life
    - Patient is maintained on Oxygen
    - Patient is receiving a medication or treatment that neither the patient nor caregiver can perform or administer
    - Missing the medication or treatment would create complications to the patient’s health status
    - Patient actively dying
    - Other conditions are present which would cause interruption of services to endanger life
2. Priority Level 2: (Moderate Need)
    - Patient lives alone
    - Interruption of services would not severely impact patient’s ability to meet basic physiological and safety needs without agency intervention
3. Priority Level 3: (Lowest Need)
    - Patient lives with caregiver
    - Caregiver or patient can meet basic physiological and safety needs without agency intervention
    - Patient resides in a skilled nursing facility or rest home

ALLERGIES

- Allergies need to include the type of reaction that patient has to the particular Drug/Food allergy.
- Use the free text box to include environmental and food allergies.

MEDICATIONS

- **add Refill x12 with the quantity per refill**
- **add Refill x5 with quantity per fill for sleep aids/anti-anxiety medications**

- **No refills added on opioids**
- Enter all meds (Rx and OTC), flushes, O2, Bi-PAP, C-PAP, tube feedings, finger sticks, creams, ointments, etc.
  - Order sets are available that include all Routine Standing Orders and Comfort Kit Order medications.
- If medication is not listed in the database or order sets, contact Flannery Heath ext. 1064. If unavailable, contact your supervisor.
- If on antibiotics, add number of days that they are to be on it and the stop date. Be specific as to why they are using this medication under *Indication*. You may free text the indication if needed.
- Call Delta Care Rx with all admission medications

ATTRIBUTES

- Category: Hospice
  - Attribute: Level of Care
  - Value: (fill in appropriate LOC)
  - Highlight this Attribute
- Category: Hospice
  - Attribute: Patient Location
  - Value: (fill in appropriate patient location)
  - Highlight this attribute
- Category: Care Team
  - Attribute: RN
  - Value: (select RN that will be assigned to patient)

If needed, add these:

- Category: Precautions
- Attribute: (select appropriate precaution)
- Value: Yes
- Category: Hospice
- Attribute: Comfort Kit Placed
- Value: Yes

INTEGRATED ASSESSMENT

- Each area needs to be addressed
- You must work down the list and across from left to right
- Social Work will complete the MSP section of the form. Select "No"
- ***You do not need to complete the Timed Up and Go (TUG)***
- Make sure to complete these sections in their entirety:
  - Past Medical & Surgical Histories
  - The Comprehensive Psychosocial, Bereavement, and Spiritual Assessment
  - Braden Scale under *Integumentary System*
  - Nutritional Assessment
  - MAHC 10 Fall Assessment under *Mobility*
  - Unipolicy 1st part
  - Unipolicy 2nd part (this will appear after you choose 1st part)
  - Unipolicy for Disease Specific Diagnosis
  - Edmonton Scale under *Clinical Findings*

HOSPICE ITEM SET (HIS)

- Complete this form in its entirety.
- If pain is an active problem, you need to be completing a Full Comprehensive Pain Assessment.
  - Active problem means:
    - They have pain now, or
    - They may not be in pain now, but they are on a medication prescribed for pain either routine or PRN. This includes Tylenol.
    - These 7 areas must be addressed:
      - Severity
      - Character
      - Location
      - Frequency
      - Duration
      - What makes the pain better or worse?
      - How does it affect the patient's quality of life?
- **PAIN SCALE**: You will need to use Mild 1-3, Moderate 4-6, & Severe 7-10
  - FLACC is only used on children 2 months to 7 years of age
  - PAINAD is used for nonverbal patients
- All patients are screened for **shortness of breath**
  - Active problem means:
    - They are short of breath now, require interventions, or ever have shortness of breath (talking, transfers, eating, etc.).
  - The way that HIS is designed is to find out if the patient has any treatments for their dyspnea. Since this is an admission visit, everything that is used to treat the dyspnea is "new". Whatever

may have been ordered for the dyspnea should be included here, whether they were using it before the admission or not.

- Patients who are on an opioid need to be on a **bowel regimen**
  - There are exceptions for patients with these types of circumstances, but not limited to, tube feedings, bowel obstructions, actively dying, C-Diff, ostomies, etc.
  - If a patient is not on a bowel regimen, you must document the specific reason why it is not indicated.
- You must attempt discussion on **CPR, Life Sustaining Treatments, Hospitalizations, and Spiritual/Existential Concerns.**
  - You should never select "No" as an answer in the drop-down boxes.

NARRATIVE

Admission Narrative Note needs to incorporate:

- Patient Introduction, age, sex, hospice diagnosis and past history
- Exacerbations and decline
  - Why hospice ***and*** why now?
  - "Paint the Picture" of their decline.
  - What caused their decline?
  - Frequent hospitalizations, ER visits, exacerbations, etc.
- Symptom burden at baseline
- Functional status
- Intake and Output
- Equipment needed
- Medication review and changes
- Psychosocial and spiritual issues
- Individual and current goals of care
  - Family dynamics, personal information related to patient care
- ***Get as much detail as possible and elaborate by using the Hospice Eligibility Checklist (see appendix) on page 50.***

NURSING CLINICAL ORDERS (CARE PLANS)

- All patient care plans should be patient specific.
- Goals and Interventions should be tailored to meet the needs of the patient and families. Order Sets are available to use.
- All interventions should have a matching goal.
- Care plans need to be updated when patients condition changes. For example, when decline happens and the care plan no longer fits, d/c the care plan and add a new one.
- All care plans should have the following goals and interventions in addition to your patient specific goals and interventions:

CATEGORY	NURSING CARE PLANS
Goal	
General	(zz.G.1_____) Patient will remain as comfortable as possible within the confines of their disease process and wishes.
Medications	---_____ has the knowledge to safely administer medications per provider's orders
INTERVENTIONS	
Medications	Assess/teach safe administrations of scheduled and PRN medications. Medications to be administered by _____
Pain- Rest & Comfort (R&C)	Assess patient pain
Mobility	Allow client to complete activities independently as long as possible
General	Patient may have missed visit due to inclement weather, MD Appointments, holiday, and/or patient/family request.
ADLs- HCA Sup.	Supervise HCA every 14 days
General	Patient may receive tuck in calls from volunteers
General	Patient may receive respite care up to 5 days per stay for Caregiver relief/emergencies
General	Hazards identified; patient will receive education on _____.
General	Fire safety/escape plan developed and reviewed.
FACILITY PATIENTS NEED	
Hospice	Hospice is responsible for providing all services per hospice COP and management of care with frequency of 24 hrs./day.
Facility	Facility is responsible for serving as primary caregiver and medication administration with frequency of 24 hrs./day.
UNDER THE DISCHARGE TAB	
Discharge	Requires ongoing skilled intervention to support goal of comfortable death in setting of choice.

Hospice Aide Care Plans

Category	CNA Care Plans
Goal	
HCA	Pt's ADL status will be maintained
Interventions	
HCA	Assist patient with care per orders
HCA	Bed bath or shower: Patient/Caregiver is functionally and cognitively able to make the choice
Report	Was there constipation more than 3 days?
Report	Were there any new changes in condition?
Report	Was there new/increased pain?

- **If the patient requests a care that is not assigned to the aide, the aide must then call the nurse to get this added to the care plan.**
  - **Example:** Bed bath is on the care plan, but the patient requests a shower. The aide must call the nurse to have the order changed or added.
- **DO NOT ENTER PRN duties** for the Aide. Specify the task and when entering each clinical order, if task ordered is less than the VFO, please indicate how many days per week you would like the aide to perform this task.
- **More specific tasks should be added per patient needs and within scope of CNAs practice. Ex:** Shave patient with every bed bath.

Visit Frequency Orders (Home Care)

- The Mountain Valley Hospice expectation is to complete one routine visit weekly, at a minimum. Based on your nursing judgement, the patient may be scheduled to be seen more often. There may be rare occasions that a patient may be seen every 14 days, but this should be discussed with your supervisor and IDG team first.
- The patient's admission visits by a skilled nurse counts as 1 routine visit for the week. If the patient requires a follow up visit later that same week the Visit Frequency Order would be increased to 2x for that week.
- Example: Patient is admitted on a Monday, Routine Visit 2x week x 1 week; then 1x week 12 weeks.
- All patients are given PRN x4 for Exacerbation of Disease Process.
- **Please refer to Admission check list form AU#08 in Appendix on page 48 and review before signing off on your admission.**

Post Admission Follow-up

All Patients should receive a follow-up visit or phone call within 24-48 hours of admission. Patients who are admitted in pain, started on a new pain regimen or have changes in dosing related to pain should have follow-up documentation within 24 hours. Follow-up documentation is dependent on the situation and severity of pain. Follow-up may require a visit for assessment, further Plan of Care changes related to pain, and may need to occur much sooner than the 24 hour time frame.

New Admissions Follow-up Checklist

- ☐ Make initial visit or phone call within 24 hours of admission to get to know patient and introduce yourself. If the admission occurs on the weekend, the contact will be made on Monday. Go over Resource Guide with patient, family, and/or CG. Also make sure they have our phone numbers and they know when to call. (See appendix for script on pages 52 and 53.)
- ☐ Go over that MVHPC is now their insurance and we need to know when changes are made, if they go to the MD, ER, or having tests done. This will ensure continuity of care.
- ☐ Follow up on any pain issues, complete Pain Follow up within 24 hours if needed.
- ☐ Fax medication profile to facility pharmacy on facility patients. Make sure Pharmacy Benefit Manager has been notified of patient's admission.

Patients directly admitted to Hospice Care in IPU that are now being discharged home

These patients will need to include the following areas in the first home visit assessment:

- o Care Plan Review/Update for nurse and aide if applicable
- o Visit Frequency Orders for nurse and aide if applicable
- o Reconcile Medications, notify Delta Care (send pharmacy communication form if patient is at a facility)
- o Oxygen Safety Agreement
- o Environmental Safety & Fire Safety education needs to be addressed in teaching
- o Watchpoint form to be completed
- o Make sure patient has Reference Guide
- o If patient is a DNR make sure DNR order is in the home
- o Make sure blue reflector has been put out
- o Send form C#31 Routine Order to attending physician
- o Updated routine standing orders and comfort kit orders signed by new attending MD

Remember: Any discharge from GIP requires follow-up visit at time of discharge or within 24 hours.

ROUTINE VISIT

ROUTINE HOME CARE

Routine Home Care is the care that is provided in a patient's place of residence-home, nursing home, assisted living, etc. The standard of care is for every patient to have a Routine Home Visit with a full head to toe assessment at least every 7 days. Any visit that is pre-scheduled should be documented as a Routine Home Visit.

- Please be sure to review the highlighted Patient Notes and highlighted attributes.
- Pain Control should be addressed on every visit.
- All documentation should reflect the declining status of the patient.
- If patient receives hospice aide services, best practice is for RN to complete hospice aide supervisory every routine visit, but it must be completed at least every 14 days.
- If patient has had an LPN visit an LPN supervisory will need to be completed at next routine nurse visit by RN.
- If patient requires wound care, re-assessment (including measurements) should be documented at least weekly on the added Wound Care step of the workflow in the electronic medical record. Wounds should be measured at least every 7 days.
- New infections should be documented in the Infection Report, which is an added form in the electronic medical record. A follow up infection form should be completed upon completion of treatment, change in treatment or when infection is resolved.
- Responses to treatment and outcomes.
- Medication changes and care plan changes should be completed at this time.
- Patient/family participation or non-participation in the POC.
- Documentation of education, to include disease progression, medications, and utilization of IPUs.
- Ensure patient has enough supplies and medication refills

NARRATIVE

Narrative note needs to incorporate:

- Last medical visit? (i.e. ER visits, provider visits, our inpatient unit, specialists, hospital stays, etc.)
- What interventions have been completed? (i.e. labs, procedures, ABN needed, etc.)
- What is the outcome of treatment?
- Medication review, changes, refills
- Quantifiable evidence of disease progression and/or functional decline?
- Intake and Output
- Equipment needed
- Individual and current goals of care
- Family dynamics, personal information related to patient care

CLINICAL ORDERS (CARE PLANS)

- Documentation reflects the care plan's goals and interventions.
- Care plans need to be reviewed and updated weekly and more as needed.

INTERDISCIPLINARY GROUP MEETING

STANDARDS FOR IDG

- D. A. R. E. format is followed (Discharges, Admissions, Recertifications, Existing)
- Notes done prior to IDG
- Each discipline is represented- Important for Team Members to be present
- Discussion remains patient oriented
- Invite patient and their families (if you know ahead of time, they will be present, discuss them first)
- If a discussion was held and it is not included in the teams note, it wasn't discussed, add to note.
- If patient's primary diagnosis changes during IDG, Nurses must document "Patient's Primary Diagnosis changed to _____. And notify billing department of change.

IDG NOTE TEMPLATE

- Name, updated age, hospice dx and comorbidities
- Brief synopsis of what makes them hospice appropriate (disease burden on patient and family)
- PPS Score
- Fast Score
- Code Status
- Weights, MUAC, in descending order by date
- Changes in VFO for any team members and why
- Supportive services? PT/OT, CAP worker, private sitters
- Document toward the Care Plan
- What has happened in last two weeks?
- New s/s of decline
- Change of meds?
- Addition of meds or DME/Foley/Macy Cath for symptom management?
- Antibiotics/ infections?
- New or continued progression of wounds/interventions?
- Change of LOC? Moved to GIP? ER visit, hospitalization for something unrelated, respite stay?
- Falls or incidents/injuries?
- Change of Visit frequency orders, aide added or increased? SN visits increased or decreased, reason.
- Always document response to intervention
- What is planned for next two weeks?
- Any upcoming appointments or respite stays?
- Planned family meetings? Teaching needing to be completed
- Reassess intervention that were started in last two weeks, such as reassess pt after completion of abt.

- If there is nothing specific planned for next two weeks you can always put something like: “Plan over the next two weeks to assess for symptom management needs and apply interventions as ordered.”
- What are patient’s personal goals?
- End with, “POC and Medications reviewed with members of IDG including physician.”
- If in a facility note “Coordination of care continues with facility staff.”
- Add any changes or discussions held live during the meeting.
- Medical Records will fax IDT notes to the Attending to update them on the POC

RECERTIFICATION

- POC recertification needs to be started no more than 14 days prior to the start of the next certification period and must be completed by the next business day.
- ***Unipolicy 1st Part, Part 2, & Disease Specific*** should be done prior to recertification.
- Unipolicies may be added as forms to your routine visit or added as a documentation without visit.
- Part 2 is included with the 1st Part. It is not a separate form.
- POC recertification is audited for accuracy and individualization. Please be certain that you have looked over your care plans, DME, etc., and make sure that your clinical summary is detailed about the patient’s decline over the last certification period.
- Do not copy and paste your IDG summary or visit notes into your Clinical Summary. This is a red flag to CMS and is considered fraudulent.
- The recertification narrative should be a summary of the patient’s status and decline over the last 90 or 60 days depending on the certification period (not only the last visit or last two weeks).

RECERT IN THE PATIENT’S CHART

- Open the patient’s ***Chart***
- Click on ***POC History***
  - In the drop-down box of certification periods, select the next certification period
  - Click ***Copy Forward***
  - A pop-up box will appear.
  - Clinical Orders
    - Check all of the clinical orders you wish to continue
  - Click on the Visit Frequency Orders tab
    - Check all of the visit frequency orders that you wish to continue – this includes all disciplines except the MD.
  - Click on the Locators tab
    - Check all of the locators that you wish to continue
  - Click on ***Copy*** in the top right corner
  - The next pop-up will show a list of all orders.
    - Make sure ***POT*** in the top left corner is selected

- Check the boxes next to Medications, Allergies, and Diagnoses
- Make sure the patient's attending is the provider selected
- In the Clinical Summary box at the bottom left complete a narrative about your patient's decline over the last recertification period. Begin documentation reflecting towards the terminal diagnoses.

o Once everything is completed, click on ***Sign & Submit*** in the top right corner.

GIP IN IPU

o When requesting a bed for GIP in the IPU, you need to speak with MD covering the IPU. If the MD is not available, please contact the Director, Assistant Director or IPU Admin On Call.

o Fax any medical records that are not in the electronic medical record.

o Enter the physician's order under the Care Plan for the level of care change in the patient's electronic medical record, "May advance level of care to In-Patient for symptom management of _____"

o Once you have obtained a bed and date that home care patient is going to IPU

o Communicate this information to the IDT and to the patient/family

o Give a thorough report to nurse accepting the patient at the IPU

o Let the patient/family know what they need to bring prior to traveling to IPU.

o Original DNR form must stay with the patient during transport

o Non-narcotic medications

o Bipap, Cpap, etc.

o Feeding pump and tube feeding formula.

o Pleurix chest tube drainage system and supplies.

o If your patient has DME, you must notify the DME company when patients are in GIP so that we will not be billed the daily rate.

o Commercial insurance patients in the IPU- Billing cannot get an authorization/approval started until the patient is physically in the building. To start the authorization, they need admitting clinical statistics, referring physician and diagnosis. So essentially, do what's best for your patient first and let billing know soon after or at the very latest upon arrival to IPU.

You do not have to complete daily contacts when your patient is in one of our IPUs.

o ***Best Practice:*** *Within 24 hours of discharge from a GIP level of care, a comprehensive assessment should be completed. The plan of care and visit frequency orders must be updated.*

WHEN YOUR PATIENT GOES TO IPU CHECKLIST

☐ Verify insurance type; all commercial insurances will need prior/pre-authorization before being transferred to IPU

☐ Notify IPU to check bed availability.

☐ Notify primary physician and obtain order to send

☐ Gather items needed to transfer to IPU - DNR, meds (do not send narcotics) clothes, cpap/bipap if used, any specialty supplies and any other comforts needed by the patient.

☐ Change in Level or Location of Care Order is completed by IPU.

- ☐ Complete Transfer Form (C#28)
- ☐ Notify DME that patient has gone to IPU. We are not charged daily rates for equipment in the home, if notification is completed.

GIP CARE IN THE HOSPITAL OR NURSING FACILITIES

- o A new order should be placed within the care plan to "May advance level of care to In-Patient for symptom management of _____."
- o When a patient is general inpatient (GIP) at any hospital or nursing facility, there should be a *weekly visit* made by a Registered Nurse. A nurse should do a daily contact to evaluate ongoing symptom management. It is the Case Manager's responsibility to make sure these contacts happen. D*ocumentation should reflect the reason why the patient needs the higher level of care, progress towards goals, and discharge planning.*
- o It is the responsibility of the nurse who sends the patient to the hospital to complete the **Transfer Form (C#28)** and ensure that the receiving facility has all the information related to the transfer: **Patient Clinical Summary, POC, In-Patient Education Sheet (C#10), and Transfer form (C#28)**.
- o ***Best Practice:*** *Within 24 hours of discharge from a GIP level of care, a comprehensive assessment should be completed. The plan of care must be updated.*

WHEN YOUR PATIENT GOES TO THE HOSPITAL CHECKLIST

- ☐ Notify primary physician
- ☐ Send Medication list and Patient Summary
- ☐ Complete Transfer form (C#28)
- ☐ Complete Change in Level or Location of Care Order in Attributes **should be completed as soon as you know if patient will be admitted to GIP. Or if they will be sent back home*
- ☐ Complete Inpatient Education sheet (C#10)
- ☐ Notify IDG members of patient level of care change
- ☐ Notify DME Company and Pharmacy Manager if patient not going to be returning home.
- ☐ If patient is admitted GIP, nurse will need to make a visit to ensure continuity of care.
- ☐ Daily contacts will need to be made by a member of the Hospice team.
- ☐ Remember to send email to After Hours to let them know when daily contacts will need to be made on weekends/holidays

WHEN YOUR PATIENT COMES HOME FROM THE HOSPITAL CHECKLIST

- ☐ Complete Change in Level or Location of Care Order in Attributes to show movement from the hospital to the home
- ☐ SNV within the first 24 hours post discharge to assess patient, review medications and make any changes and to give support to the patient and family. Ideally, the SNV should be made as soon as the patient gets home. New meds may have been ordered and teaching will need to be done, along with assisting patient/family in getting meds from the pharmacy.
- ☐ Complete Routine Orders (C#07) and update medication list (for MD to sign). (These will need to be faxed to the MD and the copy goes to Medical Records until the signed order returns.)
- ☐ Update the POC including care plans, medications, visit frequency orders, etc.

CONTINUOUS CARE

Nursing care may be covered on a continuous basis for as much as 24 hours a day during periods of crisis as necessary to maintain an individual at home. Either homemaker or home health aide (also known as Hospice Aide) services or both may be covered on a 24-hour continuous basis during periods of crisis but care during these periods must be predominantly nursing care. A period of crisis is a period in which the individual requires continuous care to achieve palliation and management of acute medical symptoms. (Refer to policy PC.L20)

- The **RN Case Manager** confirms the assessed need for level of care change to continuous care with the Director of Patient Services and obtains an order from the patient's attending physician.
- Place order in Care Plan: "May advance level of care to Continuous Care for symptom management of _____"
- Only RNs, LPNs and HAs are counted in the hours of care provided. The care does not need to be continuous but must total eight hours or more of care within the 24-hour period. Hospice aide services may be provided to supplement the nursing care. At least 50% of the total care provided must be by a nurse.
- Documentation includes individual visits as well as documentation of care at least hourly.

RESPITE CARE AT IN-PATIENT UNIT (IPU)

Contact the Director or Assistant Director for placement; not the IPU physician.

- Once you have obtained a bed and date that home care patient is going to IPU:
  - Communicate this information to the IDT and to the patient/family
  - Let the patient/family know what they need to bring prior to traveling to IPU
  - Original DNR form must stay with the patient during transport
  - Non-narcotic medications
  - Bipap, Cpap, etc.
  - Feeding pump and tube feeding formula
  - Pleurix chest tube drainage system and supplies
  - Arrange transport (contact MVHPC transport first to check for availability)
  - Provide a report to the IPU nurse
  - Complete Transfer Form (C#28)

RESPITE CARE AT HOSPITAL OR NURSING FACILITY

- A visit must occur at least once during the stay. Our best practice is to be there the first day to facilitate communication and make sure the patient has all needed medications and supplies.
- Any changes that occur during the respite stay would also require a visit.
- Respite Care Orders need to be signed by the patient's attending before the respite stay.
- Send a copy of patient's clinical summary, medical profile, original DNR, copy of advance directives, Comfort Kit orders, Routine Standing Orders, Respite Standing Orders (C#08), and Respite Education Sheet (C#09), Transfer Form (C#28).

- You do not have a new set of orders when the patient comes home from Respite. ***If however***, the patient's LOC were to change to inpatient during the respite stay because of acute changes, you would have to have a new set of orders.

Remember: When a patient is admitted to a facility, you must have a physician who has admitting privileges at that facility that will review your orders and sign them. There should be a telephone call documented daily when a visit is not done. Our HCA's Plan of Care should be continued as ordered and the need to increase VFO assessed during respite stay. HCA visits are not needed when patients are in our IPUs.

RESPITE CARE CHECKLIST

- ☐ Obtain orders from physician with admitting privileges to the hospital that patient is going to-orders not needed if patient is going to IPUs, attending there will sign.
- ☐ Arrange for bed, either at contracting hospital or IPUs. The following is a minimal listing of contracted hospitals (Check with your supervisor if hospital is not listed):
  - **Hospitals in NC**: Northern Hospital, Hugh Chatham, Lifebrite Community Hospital of Danbury, Novant - Forsyth, Wilkes Regional, Alleghany, Wake Forest Baptist Health and Ashe County Hospitals.
  - **Hospitals in VA**: Memorial Hospital of Martinsville, Pioneer Community, Pulaski, and Twin County Regional.
- ☐ Arrange for transportation (either by private vehicle or Non-Emergent Transport)
- ☐ Complete Respite Care Standing Orders Form C#08 (this form has orders already listed) and have physician sign.
- ☐ Complete Respite Care Education C#09
- ☐ Provide outside facility with copy of: CK, RSO, Medication List, Patient Summary, Respite Orders and Education
- ☐ Complete Transfer form (C#31)
- ☐ Educate family on what to expect with Respite care
- ☐ If at outside facility, daily phone call is needed (if no visit). Best practice of one in person visit during respite stay. *Continue to follow Plan of Care as if patient were home.*
- ☐ Continue HCA services if patient already has one in place, you may evaluate need to increase HCA to 5 days per week while in the hospital/outside facility for respite care.
- ☐ If patient does not have existing HCA, initiate HCA services for weekdays during time spent in respite, unless going to IPU.

Remember: A Respite patient is able to be changed to GIP status, but typically a GIP patient is unable to change into Respite Care level of care.*

LOCATION OR LEVEL OF CARE CHANGE

- It is the nurse's responsibility to make sure that the Level of Care & Location attributes reflect changes as they occur. This will ensure that all billing records are up to date and accurate.
- When a patient is requiring a change in their Level of Care, a Clinical Order (care plan) will need to be entered in HealthWyse Mobile. These Clinical Orders are found under the ***Hospice Level of Care category***.
  - GIP Level of Care: May Advance level of care to In-Patient for symptom management of _____
  - Routine Level of Care: May change level of care to Routine for family/caregiver support and symptoms management.
  - Respite Level of Care: May change level of care to Respite for family/caregiver support and relief as detailed in clinical record for up to 5 days.
  - Continuous Care Level of Care: May advance level of care to Continuous Care for symptom management of _____\

CHANGING LEVEL OF CARE & LOCATION IN HEALTHWYSE MOBILE

(IPU staff update attributes of LOC when patient is going or coming home from IPU)

ER Visits	
Patient	Attribute
Medicare or Medicaid Primary Related to Terminal Dx	LOC and Location Stays the same Add > Category is ER Visit > Attribute is ER Covered with date and time of visit. DC the visit at time of discharge or if patient admitted with correct date and time
Medicare or Medicaid Primary Unrelated to Terminal Dx Self Pay or Commercial Related or Unrelated to Terminal Dx	LOC and Location Stays the same Add > Category is ER Visit > Attribute is ER Non Covered with date and time of visit. DC the visit at time of Discharge or if patient admitted with correct date and time

INPATIENT OR GIP		
Patient	Location	Level of Care
Medicare or Medicaid Primary Related to Terminal Dx	Click on Attribute Click Edit Category=Hospice Attribute=Patient Location Effective Date = Admit date to Facility Value = (Name of Facility) Click SAVE	Click on Attribute Click Edit Category=Hospice Attribute=Level of Care Effective Date = Admit date to facility Value = Inpatient Click SAVE
Medicare or Medicaid Primary Unrelated to Terminal Dx Self Pay or Commercial (Not IPU) Related or Unrelated to Terminal Dx Notify Billing Of Self Pay/ Commercial Patient Movement	Click on Attribute Click Edit Category=Hospice Attribute=Patient Location Effective Date = Admit date to Facility Value = (Name of Facility) Click SAVE	From = Current Level of Care Stays Routine

Commercial Primary @ IPUs Related to Terminal Dx Prior Approval Required Notify Billing	Click on Attribute Click Edit Category=Hospice Attribute=Patient Location Effective Date = Admit Date to Facility Value = WHH/YHH Click SAVE	Click on Attribute Click Edit Category=Hospice Attribute=Level of Care Effective Date = Admit Date to Facility Value = Inpatient Click SAVE
RESPITE		
Medicare or Medicaid Primary	Click on Attribute Click Edit Category=Hospice Attribute=Patient Location Effective Date = Admit Date to Facility Value = Name of Facility Click SAVE	Click on Attribute Click Edit Category=Hospice Attribute=Level of Care Value = Inpatient Respite Effective Date = Admit Date to Facility Click Save
Self-Pay or Commercial Primary *Notify Billing of Patient Movement*	Should Never Occur; If Respite is required, this must be verified with insurance to see if it is a covered benefit. Should use IPU if approved/required.	

DEATH VISIT

- If a patient passes during your Routine/PRN visit:
  - Complete your documentation while the patient was alive, you will then end your visit like normal with the exception of your end time being one minute before the patient's time of death.
  - You will then open a new Pronouncement visit to complete documentation, and sign that visit.
- If a patient has passed before you have made a visit, start a Pronouncement visit documentation
  - You will finish your documentation, and sign your visit to lock it
  - Do not discharge the patient chart from the system within this visit.
- After ***ALL*** documentation for SN, HCA, MSW, Chaplain, etc. is completed, the **Case Manager** must discharge the patient's chart.

DISCHARGING THE PATIENT FROM THE SOFTWARE

- Click on patient card
- Click on GO
- ***Under Admit State***, click ***Change***, click ***Discharge***
  - Select ***Agency Discharge***
  - Select discharge reason – ***Died***
  - Change effective date to ***Date of Death***
  - Enter effective time as the ***Time of Death***
  - Optional - Check "*Send Message to care team*" to send a message through the software regarding patient's death
  - Click ***Ok***
  - This will open a discharge workflow.
  - A "B" for bereavement, and the patient's date of death will appear in red next to the patient's name in the upper left-hand corner.
  - In your workflow:
    1. Review: Verify patient
    2. Document: if there is any documentation that needs to be made further, you may add a form if needed.
    3. Complete: Sign & Complete.

WHEN THE PATIENT PASSES CHECKLIST

- ☐ Pronounce patient (TOD is **always** when the facility nurse or hospice nurse pronounces the patient)
- ☐ Assist with death care
- ☐ Contact the funeral home
- ☐ Complete Funeral Home Communication forms (C#27) and give to Funeral Home when they arrive.
- ☐ Document that you educated about wasting/Drop off locations, and or you witnessed family wasting meds. Medication disposal is a required element of the Death Summary

- ☐ Complete Death Summary under orders
- ☐ Notify primary physician, DME, Pharmacy, Pharmacy Benefit Manager, and any other resources including IDT/IDG members if they are not already aware. (If patient dies on weekend, CM should call resources, including physician ASAP Monday morning.)

LIVE DISCHARGE

An order from the Hospice physician is required on live discharges if patients is being discharged due to being medically ineligible, or for cause. For these two live discharges, the attending physician must be consulted with before discharge and documentation must reflect this consultation. This order needs to be placed in your care plan, on the day you give the notice of non-coverage. For example, “Order for discharge due to no longer meeting hospice criteria.” MD should be notified for other live Discharges such as transfer and revocation.

REVOCATION

- Form C#26 signed by patient or elected POA/CG
- Document patient’s choice of revocation and why
- Document education related to medications, what to do in the event that patient worsens, who to call after hospice is no longer involved, etc.
- Document notification of Delta Care and patient s pharmacy of the last day of service
- Document notification of DME co of the last day of service
- Notify physician/medical director
- When discharging patient out of system select Revocation

DISCHARGE: TRANSFER TO ANOTHER HOSPICE

- For C#24 Request for Change of Designated Hospice
- Document Reason for Transfer
- Discussion at most recent IDG prior to transfer if aware at that time
- Document referral to another hospice
- Document arrangements for medications, notify Delta Care, and notify patient’s pharmacy of the last day of service.
- Document arrangements for DME and notify DME Co of last day of service.
- Document notification of attending physician of plan to transfer
- Hospice discharge summary need to be sent to the receiving hospice. They may have the patient’s clinical record if they request it.
- When discharging from system:
    - If going to another hospice as a home patient choose: Transferred-Hospice home.
    - If going to a hospice inpatient unit: Transferred -hospice Med facility

DISCHARGE FOR CAUSE

- Forms C#23 and C#22
- Documentation of advising patient that a discharge for cause is being considered
- Make and document a serious effort to resolve the problem present by the patient’s behavior or situation, ex: narcotic contract, lock boxes, removal of weapons, etc..
- Notify MAC (Palmetto GBA), ACHC, and state (OLC for VA and DHHS for NC)

- Documentation leading up to a planned discharge must be present prior to notice of discharge, in most recent IDT note, **"*Care team will continue to monitor to ensure patient meets eligibility requirements and complete teaching/planning if patient is deemed no longer eligible".***
- When discharge has been deemed necessary, a notice of discharge will be issued to the patient/family and documented: ***5 day notice (VA only) or 2 day notice (NC only)***. **The day you give the notice is day "0", midnight starts day "1".**
- There should be clear ***documentation of teaching, referrals to other services, patient's disposition, reason for discharge, arrangements for medications, equipment and supplies, communication with facility staff (if applicable), communication with attending physician and medical director, discussion at IDG/IDT, patient and family understanding of reason for discharge and plan for care after discharge***. All this should be documented in your notes.
- Once the team determines discharge is necessary then each discipline should document accordingly, and everyone should be on the same page.
- After ***ALL*** documentation for SN, HCA, MSW, Chaplain, etc. is completed, the ***Case Manager*** must discharge the patient from the system.
- See Discharge Doors in Appendix page 51.

LIVE DISCHARGE FROM HOSPICE CHECKLIST

Complete Forms: Given at beginning of day 2 for NC and day 5 for VA, leave copy of all forms with patient

- ☐ Notice of Discharge (C#22)
- ☐ Discharge Instructions (C#23)
- ☐ Notice of Medicare Non-Coverage (OMB#01)
- ☐ Detailed explanation of Non-Coverage (OMB#03)
- ☐ Provide copy of Medication List

After discharge, Complete in chart:

- ☐ Discharge Planning Care Plan
- ☐ Narrative "*Summary of Care"*
- ☐ Live Discharge Summary

DISCHARGING PATIENT FROM THE SOFTWARE

- Click on patient name
- Click on GO
- ***Under Admit State***, click ***Change***, click ***Discharge***
  - Select ***Agency Discharge***
  - Select discharge reason ***Revocation, Transferred-hospice Home, Transferred Hospice Med Facility, Discharge for Cause, Beneficiary out of Service Area, or No Longer Meets Medicare Eligibility***
  - Change effective date to ***Date of Discharge***
  - Optional - Check Send Message to care team to send a message through the software regarding patient's discharge

- Click ***Ok***
- This will open a discharge workflow
- Under the Review section of your workflow, Verify patient
- Complete these forms: Agency D/C Summary, Hospice D/C Discharge, and Narrative
- If this is a Revocation, complete the form Hospice D/C Revocation instead of the Hospice D/C Discharge form
- Under the Complete section, Sign & Complete

HealthWyse Mobile in the Hospice In-Patient Units

Tips

- Hospice Home team desk secretaries completes all LOCs for patients transferred to and from IPU as well as any patients admitted to the facility. It is very important that you change the LOC and Patient Location attributes when it changes and the time that it changes.
- When a Virginia patient changes from GIP level of Care to Routine level of care, the patient must be discharged, and readmitted.
- Narrative documentation occurs every 4 hours. Each note needs to reflect why the patient is GIP appropriate.
  - Why does this patient require continued need for higher level of care?
  - What are we doing for the patient?
  - Medication changes required?
  - Focus on any uncontrolled symptoms, abnormalities, need for prn medications, signs/symptoms of decline, etc.
- **GIP Visit Count:** "GIP Visit Count means a visit to provide care that is reasonable and necessary for the palliation and management of the terminal illness and related conditions as described in the patient's plan of care"

Entering a New Admission

On dashboard, click *Start Shift,* find new patient and choose *Shift: Admission*. Make sure that start date and time are correct for the arrival of the patient.

Entering Emergency Profile

- Check patient's chart under demographics tab to ensure priority level is entered
- If it has not been entered, choose based on patient needs:
  - **Priority 1** (**Highest Need)** - Patient using electrical equipment for which the interruption of electrical service endangers life. Patient is maintained on Oxygen. Patient is receiving a medication or treatment that neither the patient nor caregiver is able to perform or administer. Missing the medication or treatment would create complications to the patient's health status. Patient is actively dying. Other conditions are present which would cause interruption of services to endanger life.
  - **Priority 2** (**Moderate Need)** – Patient lives alone and/or interruption of services would not severely impact patient's ability to meet basic physiological and safety needs without agency intervention.
  - **Priority 3 (Lowest Need)** – Patient lives with caregiver. Caregiver or patient is able to meet basic physiological and safety needs without agency intervention. Patient resides in a Skilled Nursing Facility or Rest Home.

Patient Tab

- Click box to verify patient and insurance information for accuracy

Diagnoses Tab

- Click box to verify diagnoses
- Do not add any diagnoses
- If asked to copy forward, select no

Alerts/Allergies Tab

- If there are no known allergies, click box to the left of the No Known Allergies
- If Allergies are known, click add:
- Use the search boxes to find the allergy
- If patient has allergy to Penicillin in general, use the search bar next to ***DRUG CATEGORY***.
- If you want to be more specific in which type of allergy, use the ***DRUG*** search bar
- Use the Free Text box for any other allergies that are not listed.

Medications Tab

- Click on Add Medication
- Begin Typing name of medication in the search box in the pop-up box, Click on the medication desired
- ***Choose either***: Existing Medication, New Medication (<30 days), Change in Rx (<60 days)
- ***Dosing:*** Choose appropriate Dosage, Units, Route, Frequency, Indication (what are they using this medication for)
- ***Prescriber:*** Make sure the appropriate prescriber is selected
- ***Payor:***
  - Financial: Who pays for this medication? Agency.
  - Pre-Pour: Who gets medication ready for patient? Facility.
  - Administer: Who gives medication to patient? Facility.
- ***Start date:*** Select correct date
- ***Duration:*** only used for medications with an end date, example: Antibiotic for 7 days
- ***Instruction:*** check continuous if the medication is continuous
- ***Notes:*** Enter any specific instructions about medication, when the medication is to be given
- Enter times to be given. Ex. 0800_____ 2000_____. This will notify you on the printed MAR what times medications are due.

Schedule

- Click time box to select administration times for all scheduled medications
- This will alert the electronic MAR to notify you when the med is due
- Repeat the above steps to enter all medications

- If patient is on an antibiotic make sure to pull in *Infection Report* Form
- If you discontinue an antibiotic, pull *Infection Report* Form and complete follow up section
- Click on *Check/Resolve Interactions* to resolve interactions
- Click on *Print Medications* to print the medication list

ATTRIBUTES TAB

- Team Desk Secretary will enter the Level of Care, Location, and Suite # in the attributes
- Social Worker will add attributes like Advanced Directives, Military, Funeral Home, etc.
- If there are other attributes that are pertinent to this patient, please enter them
- Click *ADD*
- ***Category -*** Choose *Hospice*
- ***Attribute -*** Choose *Level of Care*
- ***Effective -*** Choose date and time of when change was made
- ***Value*** – Select appropriate level of care
- Click on ***Save***
- Click *ADD*
- ***Category -*** Choose *Hospice*
- ***Attribute -*** Choose *Patient Location*
- ***Effective -*** Choose date and time of when change was made
- ***Value -*** Choose correct location
- Click on ***Save***
- Click *ADD*
- ***Category -*** Choose *Hospice House*
- ***Attribute -*** Choose *Woltz Suite or Yadkin Suite*
- ***Effective –*** Choose date and time of when change was made
- ***Value -*** Choose the *room the patient is in*
- Click ***Save***
- Click *ADD*
- ***Category -*** Choose ***Directives***
- ***Attribute -*** make a selection
- ***Effective -*** Choose date and time of when it was determined
- Click ***Save***

IMMUNIZATIONS TAB

- Will only be completed if you administer an immunization. Otherwise verify and continue.

DOCUMENT TAB

Integrated Assessment Form

- Each area needs to be addressed
- Social Work will complete the MSP section of this form. Select "No"
- ***All*** Emergency preparedness evaluation sections need to be completed under "Emergency"
- Safety tab, answer no in IPU, this is a home safety evaluation
- You do not need to complete the Timed Up and Go (TUG)
- Make sure to complete these sections in their entirety:
  - Past Medical & Past Surgical Histories
  - The Comprehensive Psychosocial, Bereavement, and Spiritual Assessment
  - Braden Scale
  - Nutritional Assessment
  - MAHC 10 Fall Assessment
  - Unipolicy 1st part and 2nd part (this will appear after you do the 1st Part)
  - Unipolicy for Disease Specific diagnosis
  - Edmonton Scale

Hospice Item Set Form

- Complete this form in its entirety - all three tabs on the left hand side
- If pain is an active problem, you need to be completing a Full Comprehensive Pain Assessment.
- Active problem means:
  - They have pain now, or
  - They may not be in pain now, but they are on a medication prescribed for pain either routine or PRN. This includes Tylenol.
  - These 7 areas must be addressed:
    - Severity
    - Character
    - Location
    - Frequency
    - Duration
    - What makes the pain better or worse?
    - How does it affect the patient's quality of life?
- **PAIN SCALE**: You will need to use Mild 1-3, Moderate 4-6, & Severe 7-10
  - FLACC is only used on children 2 months to 7 years of age
  - PAINAD is used for nonverbal patients
- All patients are screened for shortness of breath
  - Active problem means:

- They are short of breath now, require interventions, or ever have shortness of breath (talking, transfers, eating, etc.).
- The way that HIS is designed is to find out if the patient has any treatments for their dyspnea. Since this is an admission visit, everything that is used to treat the dyspnea is "new". Whatever may have been ordered for the dyspnea should be included here, whether they were using it before the admission or not.

o Patients who are on an opioid need to be on a bowel regimen

o There are exceptions for patients with these types of circumstances, but not limited to, tube feedings, bowel obstructions, actively dying, C-Diff, ostomies, etc.

o You must attempt discussion on CPR, Life Sustaining Treatments, Hospitalizations, and Spiritual/Existential Concerns.

o You should never select "No" stating that you did not attempt the conversation as an answer in the drop-down boxes.

NHPCO Core Measures Form

o Complete Admission tab

Level of Care Form

o Complete appropriate tab based on the patient's level of care

Infection Report Form (if applicable)

o Click the Cogwheel to add Infection Report Form if needed

o This must be completed if the patient has an active infection that is or is not being treated OR if they have any antibiotics, antifungals, anti-infective, anti-virals, etc. ordered

o At the end of the course of the medications, you must fill this form out again, completing the follow up section

o Click add form and find the Infection Report Form. Once it is added it will show up under the Document tab. Navigate here to fill out the form.

o Type/Risk Factors

o Date of Infection must be selected. There should be a check mark in the box next to the date.

o Select type of infection from the list provided along the left hand side of the screen.

o Signs/Symptoms of Infection must be selected

o Follow up

o Physician notified, Med ordered, Lab Ordered?

LOCATORS TAB

o Complete all tabs down the left side based on the patient

o This helps compile the patient's initial plan of care

Flow Sheet Tab

Care Plan

- Go to patient chart and on the left-hand side find Care Plan. This is where you will add care plan goals and interventions for the nurse and the aide.
- Make sure that you add the required care plan goals and interventions and add **patient specific** goals and interventions based on their symptom management needs and specifics about them.
- After you have entered the care plan items go back to the visit you have open. Go to the Flow Sheet Tab and chart on each care plan item.
- You do not have to complete the head to toe assessment again or any other care plans that are duplicated (i.e. pain) on the care plan flow sheet as you have already completed these in the integrated assessment. Make sure to chart GIP counts in the flow sheet.

Category	Nursing Care Plans
Goal	
General	(zz.G.1_____) Patient will remain as comfortable as possible within the confines of their disease process and wishes.
Interventions	
Head to Toe	Assess head to toe
Vitals	Document vital signs
Visit Orders	24 hour care as eligible until the end of the certification period
Pain- Rest & Comfort	Assess patient pain
Mobility	Allow patient to complete activities independently as long as possible
ADLs- HCA	Supervise HCA every shift
Discharge	Requires ongoing skilled intervention to support goal of comfortable death in setting of choice

Hospice Aide

There should never be a PRN order for a HHA/CNA

Category	CNA Care Plans
Goal	
HCA	Pt's ADL status will be maintained
General	(zz.G.1_____) (Type in patient's code status)
Interventions	
HCA	Assist patient with care per orders
Visit Orders	24 Hour Care
Vitals	Document vital signs
Activity (Fac)	(Choose patient specific)
Alerts (Fac)	Call light within reach, bed in low position, side rails up for safety
Bath (Fac)	(Choose patient specific)
Elimination (Fac)	Record Bowel Movements
Elimination (Fac)	(Choose patient specific for voids)
Housekeeping (Fac)	(ZZ.1_____) Linen changed with bath and anytime they are soiled
Nourishment (Fac)	Diet as ordered:_____
Skin Care (Fac)	Turn patient every 2 hours if unable to turn self

Symptom or GIP Needed	Category	Intervention	Category
Foley Catheter			
Agitation, delirium, palliative sedation, safety	IPU Standing Orders	Foley Catheter 16 or 18 Fr 10 ml balloon for unmanageable incontinence or for skin breakdown with daily catheter care	Agitation/Delirium
Ascites, related respiratory distress		Catheter and drainage bag change based on clinical indication such as infection, obstruction, or when the closed system is compromised	Ascites
G Tube/J Tube			
Constipation, bowel regimen	Feeding	Feeding Tube Size: ____ fr, ____ cc balloon, Length: ____ cm	Bowel Elimination
Depression, suicidal	Feeding	Site Care: _____ and PRN for leakage/skin irritation	Depression
NG Tube			
C Diff or non C Diff diarrhea	Gastrointestinal	Insert/Re-Insert NG Tube as Ordered	Diarrhea
Bladder irrigation, urinary incontinence, urinary disease process	IPU Admission Orders	NG tube to: straight drain/intermittent low suction/continuous suction	GU Status
Ostomy			
NG tube, ostomy care, disimpaction	Gastrointestinal	ZZ.1_____ (Free text in specific orders related to ostomy care, frequency, etc.)	Gastrointestinal
SQ Site			
Edema/dyspnea related to heart failure	IPU Admission Orders	May place subcutaneous site. Flush with NS 0.5 ml post medication administration. Site and dressing change q 3 days unless otherwise indicated.	Heart Failure
Peripheral IV			
Altered mental status, altered level of consciousness	IPU Admission Orders	May place PIV site or maintain current PIV. Flush with NS 2 ml pre and post medication administration or every shift if not in use. Dressing and cap change q 72 hours. May leave in place until no longer able to use.	Mental/Neuro Status

Symptom or GIP Needed	Category	Intervention	Category
Port A Cath			
Nausea, vomiting, G tube to drain, GI bleed	IPU Admission Orders	Accessed Port A Cath: Flush with NS 5 ml pre and post medication administration. Dressing, Huber needle, and cap change completed weekly unless otherwise indicated.	Nausea or Vomiting
Dysphagia, lack of intake	IPU Admission Orders	Deaccessed Port A Cath: Access monthly with Huber needle and flush with NS 10 ml followed by Heparin (50 units/ml) 3 ml.	Nutrition/Hydration Status
Dyspnea, related anxiety, respiratory distress interventions	IPU Admission Orders	May use Port A Cath, PICC line, or Central line for blood draws. Flush line with NS 5 ml, withdraw 5 ml blood and discard. Obtain needed specimen. Flush line with NS 10ml.	Respiratory Distress
PICC Line			
Respiratory status, congestion, cough, sputum	IPU Admission Orders	PICC line: Flush each lumen with NS 5ml pre and post medication administration or daily if not in use. Dressing and cap change completed weekly. Measure mid upper arm circumference on admission and weekly.	Respiratory Status
Fatigue, energy utilization, sleeping habits		May use Port A Cath, PICC line, or Central line for blood draws. Flush line with NS 5 ml, withdraw 5 ml blood and discard. Obtain needed specimen. Flush line with NS 10ml.	Sleep/Rest Status
Central Line			
UTI, abnormal urinary function	IV Therapy	ZZ.1_____ (Free text type of line, site care, dressing/cap change order, frequency, and flush orders)	Urinary Elimination
	IPU Admission Orders	May use Port A Cath, PICC line, or Central line for blood draws. Flush line with NS 5 ml, withdraw 5 ml blood and discard. Obtain needed specimen. Flush line with NS 10ml.	
Trach			
	Trach	Patient uses Trach Type:___, Size: ___ cm	
	Trach	Trach Site Care: ___, Site Care: ___	
	Trach	Trach Suctioning utilizing ___ Fr. catheter. Depth of Suctioning: ___ cm, Frequency: ___ and PRN for thick secretions and if trach becomes obstructed	

Symptom or GIP Needed	Category	Intervention	Category
Oxygen			
	Respiratory Distress	Use of O2, positioning, opioids, steroids, pulse ox to determine need or response to tx	
	Respiratory Distress	Assess resp status each shift and monitor each contact	
BiPAP/CPAP			
	Respiratory Distress	Use of BIPAP, CPAP as ordered: Settings: _____	
	Respiratory Distress	Assess resp status each shift and monitor each contact	
Wounds			
	Click cogwheel, Click Add Wound, Fill out wound form and it will add an intervention	Make sure you put a general wound care protocol outlining the specifics on the dressing change, i.e. type of bandage, any treatments, type of tape, how often to change, etc.	

MAR

- Chart medications administered on MAR flow sheet
- Insert column for time of medication administration

Narrative

- Admission Narrative note needs to incorporate
- Patient Introduction and past history
- Exacerbations and decline
  - Why hospice now ***and*** why GIP level of care now?
  - What caused their decline?
  - What symptoms need managing?
- Symptom burden at baseline
- Functional status
- Medication review and changes
- Psychosocial and spiritual issues
- Individual and current goals of care
  - Family dynamics, personal information related to patient care
- ***Get as much detail as possible and elaborate!***
- Document here in four hour increments ex: 0700-1100 or 1900-2300, etc.
- Include everything that happens during that four hour period

Complete Tab

In this section you will check that your visit has ended, make sure that your start and stop times are correct, validate that all of your documentation has been completed, sign orders, and you will sign your visit to lock it.

Signing Orders

Make sure appropriate Provider is selected in the top right hand side of the screen. It needs to be the provided that gave you the orders/that is working in the IPU today. Not an outside attending physician.

Clinical Summary

Clinical Summary is where your Admission Narrative goes. You can copy and paste your Admission Narrative note to this section so that it will flow to the plan of treatment.

Shift Visit/Transfer in from Homecare for GIP, Routine, & Respite Level of Care

- Open a visit on ***all*** of your patients ***at the beginning of your shift***.
- If a transfer arrives, click *Start Shift,* select the patient, then select Shift: Standard. Change date/time to match arrival of patient.
- A complete head to toe assessment needs to be completed for:
    - GIP patients: once every 24 hours
    - Respite patients: on arrival to the IPU
    - Routine/Residential patients: once every 7 days
- If you are not completing the head to toe assessment on your shift, then you need to complete all parts of the review tab, all care plan items, supervisory, and narrative note

Review Tab

- Complete review/verify of all tabs down the left-hand side.
- If Medication changes are needed, you may complete this here.

Document Tab

- There will be nothing to complete under this tab unless you have to add an infection form.

Infection Report Form (if applicable)

- Click the Cogwheel to add Infection Report Form if needed
- This must be completed if the patient has an active infection that is or is not being treated OR if they have any antibiotics, antifungals, anti-infective, anti-virals, etc. ordered
- At the end of the course of the medications, you must fill this form out again, completing the follow up section
- Click add form and find the Infection Report Form. Once it is added it will show up under the Document tab. Navigate here to fill out the form.
- Type/Risk Factors

- Date of Infection must be selected. There should be a check mark in the box next to the date.
- Select type of infection from the list provided along the left hand side of the screen.
- Signs/Symptoms of Infection must be selected
- Follow up
- Physician notified, Med ordered, Lab Ordered?

Flow Sheet Tab

Care Plan

- Review SN and HCA care plan items each shift. If any do not apply to the patient, discontinue them.
- If new items or changes, add care plan items for SN and HCA.
- If patient is a transfer in
- Discontinue all VFOs in patient's chart
- Discontinue all SN and HCA care plan items that do not apply to the patient
- Discontinue all HCA care plan items that have a CW in the title
- Add new IPU specific care plan items for SN and HCA to document on
- Add new care plan items for symptom management needs

MAR

- Chart medications administered on MAR flow sheet
- Insert column for time of medication administration

Narrative Note

- Narrative note needs to incorporate

GIP

- Why GIP level of care?
- What symptoms need managing?
- What interventions have been completed?
- What is the outcome of treatment?
- Symptom burden at baseline
- Functional status
- Medication review and changes
- Individual and current goals of care
- Family dynamics, personal information related to patient care
- ***If patient is a transfer in, make sure to include interventions attempted/failed prior to coming in!***
- ***Get as much detail as possible and elaborate!***

Routine/Residential and Respite

- What interventions have been completed?
- What is the outcome of treatment?
- Symptom burden at baseline
- Functional status
- Medication review and changes
- Individual and current goals of care
- Family dynamics, personal information related to patient care
- Document here in four hour increments ex: 0700-1100 or 1900-2300, etc.
- Also, include everything that happens during that four hour period for that patient.

Post Tab

Complete HCA supervisory for the aide for that patient during your shift.

Complete Tab

In this section you will check that your visit has ended, make sure that your start and stop times are correct, validate that all of your documentation has been completed, sign orders, and you will sign your visit to lock it.

Signing Orders

Make sure appropriate Provider is selected in the top right hand side of the screen. It needs to be the provided that gave you the orders/that is working in the IPU today. Not an outside attending physician.

RN completing supervisory shift documentation

- LPN and HCA must be supervised every shift by an RN.
- Open visit on all of the patients that the LPN is caring for:
    - Under the review tab, you must check the you verify each of the tabs on the left-hand side
    - Under the post tab, you will find supervisory
    - Choose HCA supervision and fill in all areas
    - Choose Skilled supervision and fill in all areas
    - End shift when LPN stops caring for the patient

ENTERING IDG SUMMARIES

- In the Patient's Chart, click on ***Meetings*** on the left-hand side
  - Click on ***pending date for meeting***
  - Click Meeting Prep
  - Select the tab with your name on it
  - Click Add My Notes
  - Type your summary
  - Click ***Save*** when you are finished

INPATIENT UNIT IDG TEMPLATE

- ☐ Name, age, dx and comorbidities
- ☐ PPS Score
- ☐ Fast Score (If dementia)
- ☐ Code Status
- ☐ Brief synopsis of what makes them hospice appropriate
- ☐ What has happened during their stay in the IPU?
- ☐ New s/s of decline
- ☐ Change of meds?
- ☐ Addition of meds or DME/foley/macy cath for symptom management?
- ☐ Antibiotics/ infections?
- ☐ New or continued progression of wounds/interventions?
- ☐ Change of LOC? Moved from GIP to Respite? From Respite to GIP? From Respite/GIP to Residential
- ☐ Always document response to intervention
- ☐ What is planned for discharge?
- ☐ Going home? Being placed?
- ☐ Planned family meetings? Teaching needing to be completed?
- ☐ Reassess intervention that were started in the IPU, such as reassess pt. after completion of abt. Or change of any medications?
- ☐ What are patient and families' personal goals?
- ☐ End with, "POC and Medications reviewed with members of IDG including physician."

DEATH VISIT & DISCHARGE

Discharge patient due to death:

- If the patient passes during your shift, you will have to do it this way so that the correct date of death is entered:
- You do not need to end your current shift visit.
- On the census screen, click on your patient to display their chart overview on the right hand side of the screen.
    - Click on the Green ***GO*** in the upper right hand corner of the screen.
    - ***Under Admit State***, click ***Change***, click ***Discharge***
    - Select ***Agency Discharge***
    - Select discharge reason - ***Died***
    - Change effective date to ***Date of Death***
    - Enter effective time as the ***Time of Death***
        - Optional - Check *"Send Message to care team*" to send a message through the software regarding patient's death
    - Click ***Ok***
        - This will open a new workflow for discharge.
        - A "B" for bereavement, and the patient's date of death will appear in red next to the patient's name in the upper left hand corner.
- In your workflow:
    - Review: Verify patient
    - Document:
        - Pull in the required forms for a death and complete them.
        - ***Hospice D/C - Died***
            - Fill out each drop down box as it applies to patient's death.
        - ***NHPCO Core Measures***
            - Fill out the Discharge section on the left side as it applies to patient's death.
        - ***Pronouncement***
            - Fill out each drop down box as it applies to patient's death.
        - ***Narrative***
            - Complete documentation concerning the death of the patient.
        - **Complete**
            - Sign & Complete when all documentation is completed for all disciplines, including your own.

Your To-Do List will show both of your open workflows that will need to be signed. The one before the death, and the one after the death for discharge.

LIVE DISCHARGE

REVOCATION

- If a patient or family wishes for a revocation of hospice services, you will need to complete ***Form C #26***, and have the patient or caregiver sign this form.
- You will need to discharge the patient out of the system after every discipline has completed their documentation, including yourself.
- Discharge Patient due to Revocation
    - In the workflow, Complete these forms: ***Agency D/C Summary, Hospice D/C Revocation, and Narrative***
    - Click on the ***Gear*** (as you would to add a form)
    - Click on ***Discharge***
    - Select ***Agency Discharge***
    - Select discharge reason
    - Change effective date to ***Date of Discharge***
        - Optional - Check Send Message to care team to send a message through the software regarding patient's death
    - Click ***Ok***
    - Under the Complete section, Sign & Complete.

OTHER LIVE DISCHARGES

- This could occur if your patient is discharged to another hospice. Complete all required documentation up to the time that the patient was officially discharge.
- You do not need to end your current shift visit.
    - On the census screen, click on your patient to display their chart overview on the right hand side of the screen.
    - Click on the Green ***GO*** in the upper right hand corner of the screen.
        - ***Under Admit State***, click ***Change***, click ***Discharge***
        - Select ***Agency Discharge***
        - Select discharge reason – Select the appropriate discharge reason. (refer back to earlier section regarding the 5 different Live discharge reasons)
        - Enter effective date
            - Optional - Check *"Send Message to care team*" to send a message through the software regarding patient's death
        - Click ***Ok***
        - This will open a new workflow for discharge. Pull in the required forms
            - Agency D/C Summary, Narrative Note, and either Hospice D/C Discharge or Hospice D/C Transfer (depending on the type of discharge)

- In your workflow:
  - Review: Verify patient
  - Document: if there is any documentation that needs to be made further, you may add a form if needed.
  - Complete: Sign & Complete when all documentation is completed for all disciplines including your own.

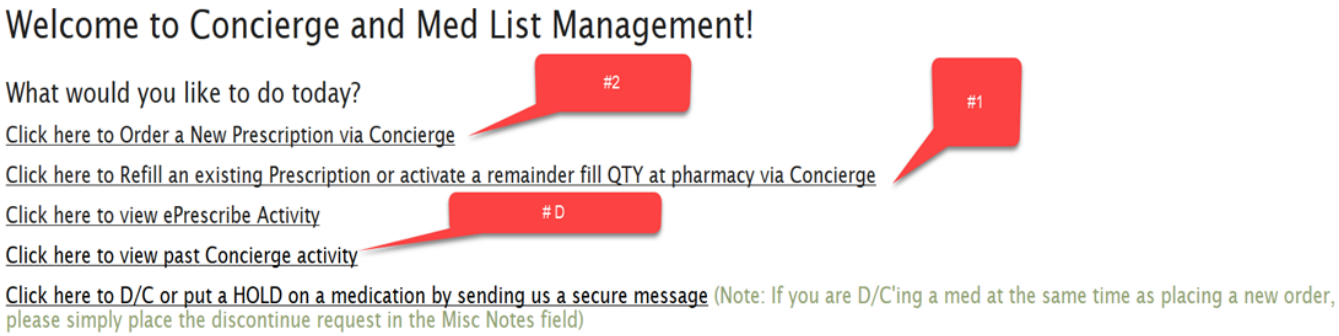
Your To-Do List will show both of your open workflows that will need to be signed. The one before the discharge, and the one for the discharge.

RECERTIFICATION

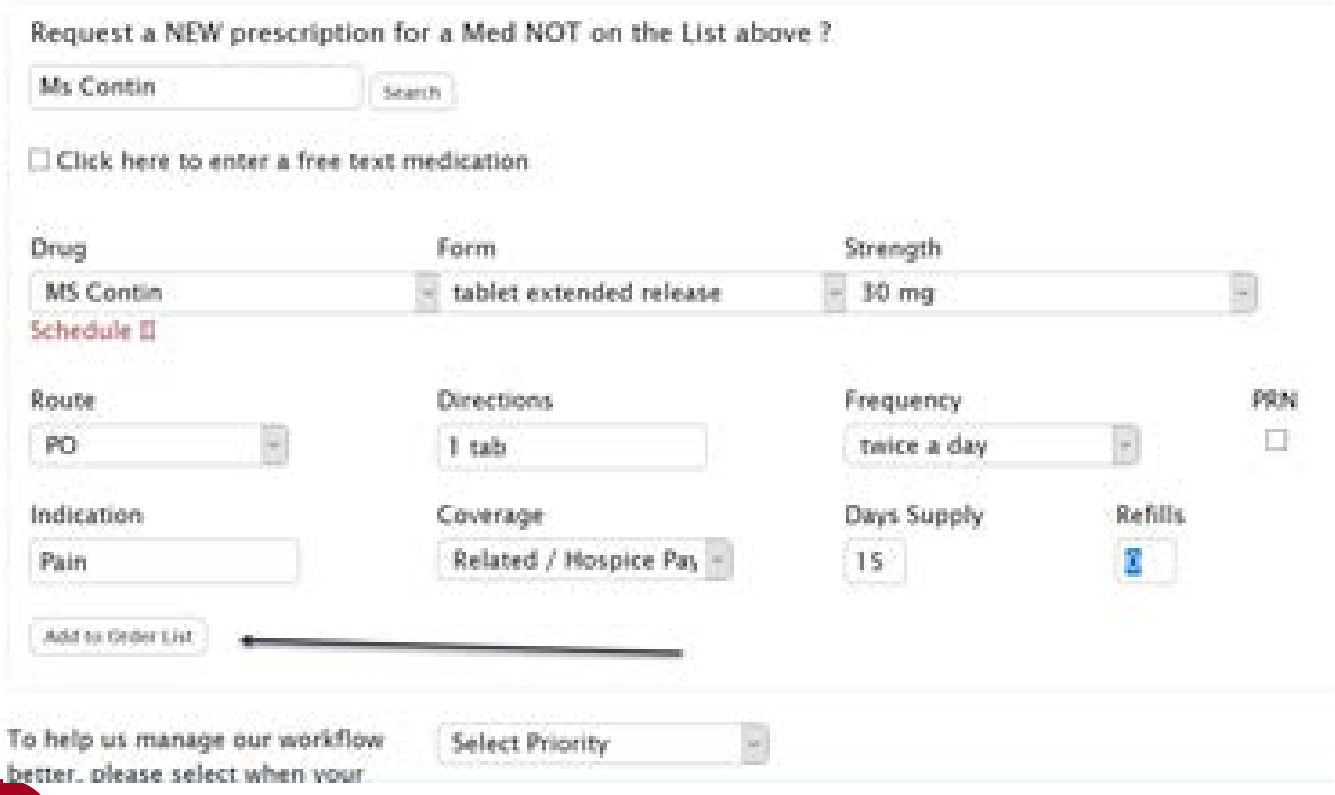
- POC recertification documentation can start 14 days prior to the start of the next certification period.
- ***During your shift you should add the following forms:***
  - Unipolicy 1st Part & Disease Specific Unipolicy
- ***In Patient's Chart***
  - Click on ***POC History***
    - In the drop-down box of certification periods, select the next certification period
  - Click ***Copy Forward***
    - Check all the clinical orders you wish to continue
    - Check all the visit frequency orders to continue – this includes all disciplines.
    - Check all locators to copy them forward and continue them
    - Click on ***Copy*** in the top right corner
    - The next pop-up will show a list of all orders
    - Make sure ***POT*** in the top left corner is selected
    - Check the boxes next to Medications, Allergies, and Diagnoses
    - Make sure the patient's attending is the provider selected
    - In the Clinical Summary box at the bottom left complete a narrative about your patient's decline over the last recertification period. Do not copy IDG note or a narrative note. This is a red flag to Medicare.
  - Once everything is completed, click on ***Sign & Submit*** in the top right corner.

INTEGRATIONS

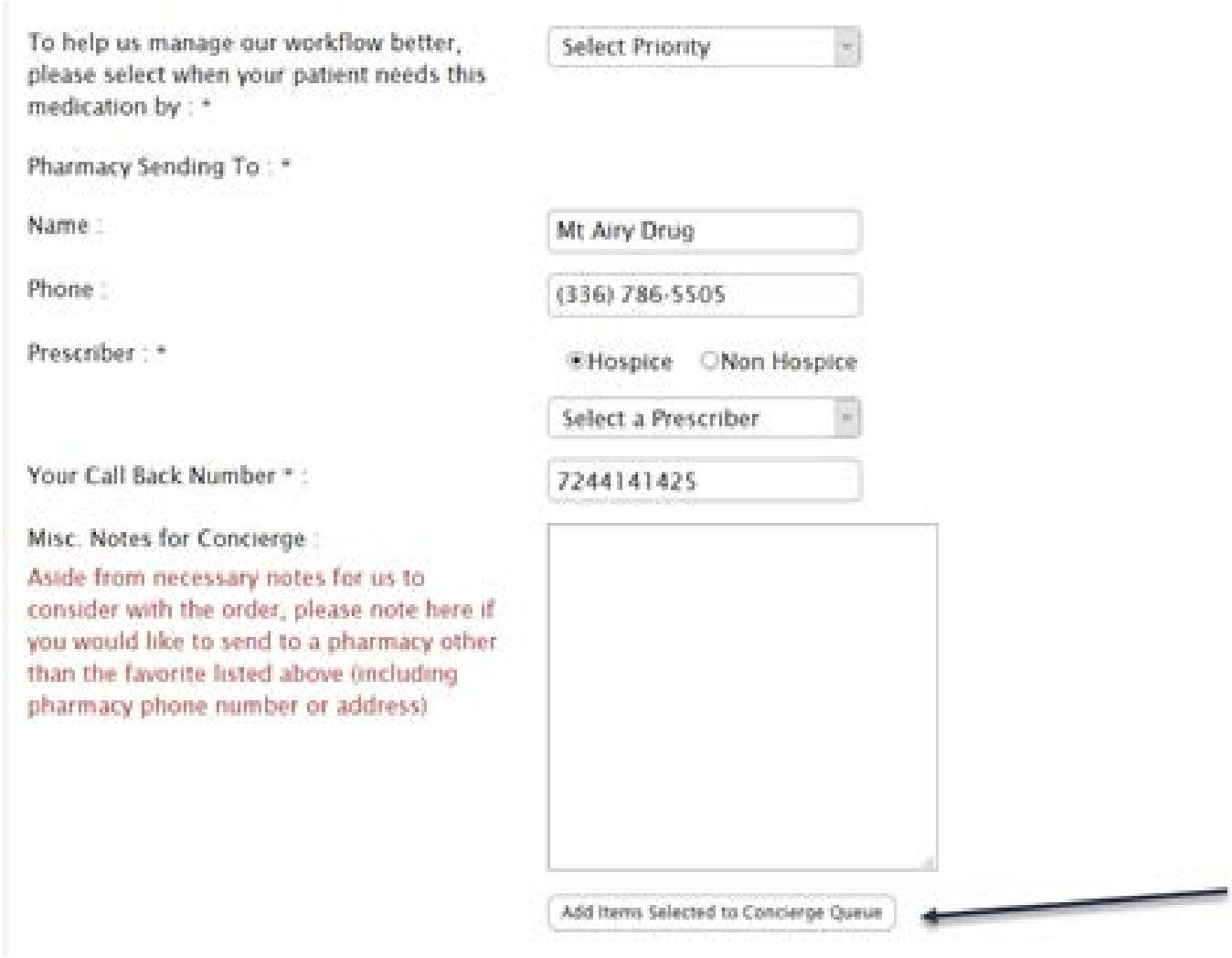
DELTA CARE



- For putting in refills (existing quantities on an existing RX): Click Med List/Concierge
  - Click here to Refill an existing Prescription or activate a remainder fill QTY at pharmacy via Concierge- this only will be needed if there is a remainder of a quantity already at the pharmacy.
- For New medications: (needing a new RX that needs signed by the MD)
  - Click here to Order a New Prescription via Concierge
    - Choose Medication (s) already profiled by clicking the box next to the medication and entering the day supply and refills.
    - **New medications not on the medication list**: Fill out name of drug, dosage, strength, coverage, supply and refills – **Then Click Add to Order List** –



– One orders are selected or entered if a new medication, you will need to complete the section below to send the order (s) to Delta Care and the last step is to click the add items selected to the Concierge Queue.



– After getting confirmation number in green on top of page, go under:
– ***Click here to view past Concierge activity***- you will be able to see what was sent to Delta to be completed

Other Programs

Palliative Care

Palliative Care is specialized medical care for people with a serious or advanced illness. The goal is to improve quality of life for both the patient and their family. Palliative Care specialists offer symptom management and support with goals of care and complex decision making. While receiving Palliative Care support, patients may continue with aggressive medical care with no limitations in their care or treatment plan. Co-existing services such as home care services, skilled nursing, physical therapy, etc. are not interrupted. Palliative Care is simply the addition of another medical specialty to offer support.

Kids Path

Kids Path is a consortium of hospice service providers who offer services to children and families who face serious illnesses or the loss of a loved one. The Kids Path interdisciplinary team joins with other medical and psychosocial professionals to provide families with the care they need.

It offers:

- Nursing services
- Counseling
- Spiritual support
- Grief support
- In-home support services
- Supportive care
- Health maintenance
- Hospice care
- Camp Kids Path
- In-School education/support
- Individual support

APPENDIX

NAVIGATOR CONSULT

SCREENING QUESTIONS

- Has anyone in the family traveled internationally within the last 14 days to countries or state with known COVID-19 (Coronavirus)?
- Do you or anyone in your family have signs or symptoms of a respiratory infection, such as a fever, cough, or sore throat?
- In the last 14 days, have you or anyone in your family had contact with someone with or under investigation for COVID-19 or ill with respiratory illness?
- Have you or anyone in your family been tested for COVID-19? If so, date and location of test.

Name:

Preferred Name:

Address:

Phone:

DOB:

Age:

Sex:

Race:

Marital Status:

Care Givers:

Current Primary Care Physician:

Code Status:

Advance Directive:

Allergies:

Medicare/Medicaid/Private Insurance:

SSN#:

Prior Hospice Services/F2F Needed:

Referred by:

Military:

Preliminary Terminal Diagnosis:

Discussed with Hospice Medical Director:

Verbal order to admit to hospice from Dr._____

Attending Physician: Verbal CTI

Hospice Medical Director: Verbal CTI

MCCM:

Faith:

PMH:

Preferred Pharmacy:

DME: Trilogy?

Home Health or other agencies involved:

Facility Patients: Inquire about Skilled Medicare Days for PT/OT/ST, Special Tiered Billing and COVID Skilled

Notified patient/family that ambulance transport not paid for by hospice if applicable

Ht: Wt:

PPS:

KPS-

FAST-

Labs-

Echo-

Isolation:

Goals of Care:

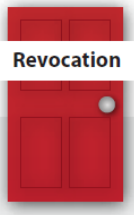
Navigator met with _____ to discuss hospice services. Discussed level of care needed for this patient

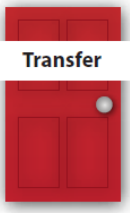
Narrative: Speak to “why hospice, why now”. Functional status. Use Laminated Green Sheet for guidance

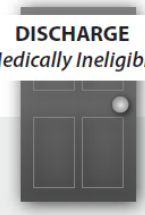
Hospice Eligibility Checklist

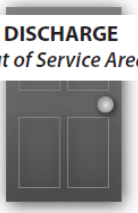
Alzheimer's and Related Conditions	Cancer
Accurate FAST score*	Evidence that pt **still has cancer***
Living situation*	Oncology records*
Mobility*	Biopsy (needed for death cert)
Dependence for ADLs*	Imaging*
Dysphagia/ aspiration	No more tx*
Recent albumin	Symptom burden*
Documented weight loss/ current weight*	Weight loss*
Incontinence*	Functional limitations*
Wounds	GOC: transfusions, CPR, intubation*
Contractures	
Infection hx	
Co-morbid conditions*	
GOC: PEG, CPR*	
Cardiopulmonary	**HIV Disease**
NYHA Class- ACC/ AHA stage*	Recent labs: CD4 count, viral load*
Oxygen/ steroid dependence*	Complications*
GOLD stage (COPD)	Functional decline*
Symptom burden **at baseline***	Weight loss*
Functional limitations*	Stopping treatment*
Weight loss*	
Echocardiogram	
Cardiac cath report	
CXR	
PFTs	
O2 sat	
Cardiology/ Pulmonology records	
Hospitalizations/ exacerbations/ infections*	
ABGs	
Liver Disease	**Neurological Conditions**
Symptom burden	Residual neurological deficits*
Recurrent ascites	Dysphagia
Refractory hepatic encephalopathy	Wounds
Portal HTN	Infections
Peritonitis	Imaging
Recent labs: LFTs, CBC, albumin, INR*	Dyspnea, O2, BiPAP, Trilogy
GI records	PFTs (FEV-1 < 30% of predicted for ALS)
EGD	ALSFRS score*
Imaging	Neurology records
Cachexia	Secondary/ co-morbid conditions*
Jaundice	GOC: PEG, CPR, intubation, tracheostomy*
Continued alcohol abuse	
GOC: EGD, TIPS, transplant, albumin, PEG, CPR*	
Renal Disease	
Recent BUN, Cr, **GFR,** K (while stable)*	
Secondary/ co-morbid conditions*	
Uremia	
Declining/ stopping dialysis*	

Live Discharges: Which Exit Door Is the Beneficiary Taking?









	Revocation	Transfer	DISCHARGE *Medically Ineligible*	DISCHARGE *Out of Service Area*	DISCHARGE *for Cause*
Initiated By	Beneficiary	Beneficiary	Hospice	Hospice	Hospice
Why	*Wishes to terminate hospice care and return to regular Medicare coverage*	*Wants to transfer to another Medicare-certified hospice*	*Patient no longer meets terminal status requirement*	*Hospice no longer able to provide services as beneficiary is a. out of service area or b. in a non-contracted facility*	*Based on hospice's policy that specifies reasons when hospice cannot deliver care appropriately - See language at §418.26 (a)(3)*
Hospice Physician Order Required	No	No	Yes	Yes	Yes
Attending Order Required	No	No	No but regs a §418.26 (b) note that physician should be consulted before discharge and his or her review and decision included in the discharge note		
Effective Date	Date revocation signed or later date as specified - May not be a date earlier	Date designated by patient on the transfer statement	Date selected by hospice	Date beneficiary leaves service area	Date selected by hospice
Notice of Medicare Non-Coverage Required	No	No	Yes; *deliver at least two calendar days before discharge.*	No	No
Impact on Benefit Period	Ends It	Maintains current period *(only one transfer per benefit period allowed)*	Ends It	Ends It	Ends It
Claim Coding	Occurrence Code 42	DC Status 50 or 51	No additional coding	Condition Code 52	Condition Code H2
		Submit final bill or NOTR within 5 days of all live discharges.			

visit **www.hospicefundamentals.com**

HOSPICE FUNDAMENTALS

NEXT DAY CALL SCRIPT FOR NEW HOME ADMISSIONS

(Be sure to call the person most involved with the patient's care)

INTRODUCTION

I am _____ (name and title of caller) from Mountain Valley Hospice. I am calling to follow up on some of the **training** that you may have received yesterday and answer any questions that you may have. I know your admitting nurse _____ (name of admitting nurse) may have provided you with a lot of new information, introduced you to the hospice team; and she asked me to check to make sure you feel comfortable and understand all of the **training and new information** you received.

REVIEW OF HOSPICE CARE TRAINING FROM REFERENCE GUIDE

o Review: when to call, who to call.

- As a reminder, if you have any issues with **pain, trouble breathing, constipation, anxiety, or training needs**, you can call us at _____. We are available 24/7 to address your needs.

o Review any documented Hospice Care Training (in patient admission note).

ASSESSMENT OF NEW NEEDS/PROBLEMS

Ask: **Any new questions or concerns?** Escalate or resolve as needed

o When talking to the patient:
- Do you have enough medicine or pills at home?
- Are you having any **trouble breathing**?
- Have your bowels moved recently?
- How is your **pain** today? Are you having any **side effects from your pain medication**?
- Are there any supplies that are needed before the next time a hospice team member visits on _____.

o When talking to the Caregiver:
- Are there enough medicine/pills for (Name of patient) at home?
- Is (Name of patient) having any **trouble breathing**?
- Is (Name of patient) having **constipation**?
- Is (Name of patient) experiencing any **pain**? Is he/she having any **side effects from pain medications**?
- Are there any supplies that are needed before the next time a **hospice team** member visits on _____.

UNDERSTANDING OF PLAN FOR NEXT VISIT

Verify the **hospice team** that has been assigned or will be assigned to work the patient and family. Next scheduled visit is planned for _____.

CLOSING

We appreciate you allowing MVH to participate in your (your loved one's) care. Our mission is to create the best experience for you or your loved one, please contact _____ (RN Case Manager) for any feedback, **support** or **training** you may need.

NEXT DAY CALL SCRIPT FOR NEW FACILITY ADMISSIONS

(Be sure to call the person most involved with the patient's care)

INTRODUCTION

I am _____ (name and title of caller) from Mountain Valley Hospice. I am calling to follow up on some of the **training** that you may have received yesterday and answer any questions that you may have. I know the admitting nurse may have provided you with a lot of new information, introduced you to the hospice team, and she asked me to check to make sure you feel comfortable and understand all of the **training and new information** you received.

REVIEW OF HOSPICE CARE TRAINING FROM REFERENCE GUIDE

- o Review: when to call, who to call.
  - As a reminder, you or the facility can call with any concerns, 24/7 to address your needs. We are able to work with the facility to address any symptoms your loved one might be experiencing like **pain, trouble breathing, constipation, or anxiety**. We are available 24/7 at _____.
- o Review any documented Hospice Care Training (in patient admission note).

ASSESSMENT OF NEW NEEDS/PROBLEMS

Ask: **Any new questions or concerns?** Escalate or resolve as needed

UNDERSTANDING OF PLAN FOR NEXT VISIT

Verify the team that has been assigned or will be assigned to work the patient and family. Next scheduled visit is planned for _____.

We want to ensure good communication regarding your loved one's care. What is the best way to communicate with you regarding routine visits? How often would you like updates regarding your loved one's care? ***Document in patient chart under Demographic Tab, patient note.***

CLOSING

We appreciate you allowing MVH to participate in your (your loved one's) care. Our mission is to create the best experience for you, please contact _____ (RN Case Manager) for any feedback, **support** or **training** you may need.

Special Circumstances

Veteran Patients

- **Protocol for patient with a primary VA benefit who may become candidate for GIP:**
  - Contact MVHPC billing so they can contact the VA right away. VA must be contacted prior to placing the patient and requires a prior approval.
  - MVHPC will not get paid (no exceptions) if prior approval is not given.
  - Billing has to send medical records to the VA and they will determine if the patient meets conditions to be placed in GIP.
  - The VA will decide what is "best" for the patient, which may involve moving the patient to Salisbury/Salem to their palliative care unit or allowing the veteran to stay in ours.
  - The process can take a couple of days, so please let billing know ahead of time if you think your VA patient may be declining and will be a possible candidate for GIP.
  - If social worker is not present on admission, Military History Checklist must be completed.

Traveling Patients

- Patients traveling outside our service area must have a **Traveling Patient Contract** secured prior to the patient leaving, otherwise hospice services will not be available for the patient while traveling and may not be billable.
- Patients who travel outside our service area are at risk of needing hospice services while away. If the Traveling Patient Contract is not completed, the patient could possibly end up at a non-contracted hospital and subsequently be responsible for a large hospital bill. Medicare will not pay when the patient is using their hospice Medicare benefit, unless the patient is discharged from hospice services. The patient/family is responsible for at least 20% of the bill, loses a benefit period and puts our organization at risk.
- All contract requests should be sent to Supervisor for approval.

Physical Therapy/Occupational Therapy/Speech Therapy Orders

- Review request for therapy with IDG including supervisor
- After patient has been evaluated by therapist and plan of care has been approved by IDG/supervisor place order in Care plan with goal and intervention per therapy care plan.
- Place Visit frequency order to match frequency of therapy visits. Ex: PT 2 x week for 6 weeks.
- Request therapy visit notes from Therapy Company and medical records specialist will scan in.
- Update progress with therapy in routine visit documentation and IDG notes.

ADMISSION CHECK LIST (SN) THINGS MOST COMMONLY MISSED

- ☐ Emergency preparedness assessment
- ☐ Comprehensive bereavement (CG name must be entered in contacts first or this will not flow over. Cannot free type)
- ☐ Comprehensive Spiritual assessment
  - ☐ Are there any spiritual concerns? (Covered by spiritual comprehensive assessment) Part of HIS
- ☐ Comprehensive psychosocial assessment
- ☐ Braden scale (Under Integumentary section)
- ☐ MACH 10 assessment (Under ADL section)
- ☐ Edmonton scale (Under Clinical Findings)
- ☐ HIS info:
  - ☐ End of life decisions, must document that discussion was held concerning, Code status, CPR, hospitalizations, feeding tube, IV fluids, antibiotics, ventilation
  - ☐ Short of breath? Now or anytime? Yes-what treatment are they using or are we starting? (if on morphine for pain are they using it for SOB too? If so add pain and SOB for indication.)
  - ☐ Pain?- Yes-need comprehensive assessment,(active problem? Meaning pain now or at any time and tx is required. Even if tx is just Tylenol) What are we tx it with?
    - ☐ Severity
    - ☐ Character
    - ☐ Location
    - ☐ Frequency
    - ☐ Duration
    - ☐ What makes it better and/or worse
    - ☐ Effect on quality of life?

This must be done even if pt is nonverbal. If family or CG of nonverbal pt is unable to describe the above assessments then you still must document that you attempted to assess these areas. If confused about how to document this for a nonverbal pt then don't hesitate to call Flannery or DPS for further clarification before closing chart. Must have all 7 components of pain documented!

- ☐ Are they on a bowel regimen (if on narcotic then bowel regimen must be added if not on one, if patient refuses then we must document why)
- ☐ On 02? Put on med list and care plan.
- ☐ Bi pap or C Pap? Put on med list with settings
- ☐ FSBS? Put on med list with frequency
- ☐ Infection? (including yeast or prophylactic) Pull over infection form.
- ☐ Port, PICC, IV, sub q site? Add to care plan including frequency of dressing and cap changes. If PICC line- measure line and arm circumference, document.

**** *Go over this check list prior to finishing admission* ****