Care Planning
The Road to Meeting Patients and Families Where They Are

Charlene Ross, MBA, MSN, RN
Consultant/Educator
R&C Healthcare Solutions & Hospice Fundamentals
602-740-0783
charlene@RCHealthcareSolutions.com

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Today's Session

- What the Medicare regulations require for care planning
- Establishing rules and standards for care planning
- Making a difference in patient / families hospice experience through effective care planning
- Connection between care planning and eligibility

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What do we promise people who are dying and those around them when we tell them about hospice care?

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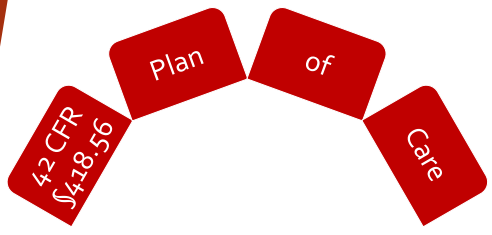
The OIG's Bridging Question

Did the plan of care exist and did it meet the specific requirements in 42 CFR §418.56?

The Bridge



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§418.200 Requirements for Coverage

To be covered, hospice services must meet the following requirements.

1. They must be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions.
2. The individual must elect hospice care in accordance with Sec. 418.24.
3. **A plan of care must be established and periodically reviewed by the attending physician, the medical director, and the interdisciplinary group of the hospice program as set forth in Sec. 418.56.**
4. **The plan of care must be established before hospice care is provided.**
5. **The services provided must be consistent with the plan of care.**
6. A certification that the individual is terminally ill must be completed as set forth in Sec. 418.22.

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What Do the CoPs Actually Say?

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The Condition and the 5 Standards

§418.56 IDG, Care Planning & Coordination of Services

- §418.56 (a) Approach to Service Delivery
- §418.56 (b) Plan of Care
- §418.56 (c) Content of the Plan of Care
- §418.56 (d) Review of the Plan of Care
- §418.56 (e) Coordination of Services

Problematic Care Plan Items

Order Cited	L Tag	Section	Regulation
2	L543	§418.56(b)	Standard: Plan of care
4	L545	§418.56(c)	Standard: Content of the plan of care
5	L547	§418.56(c)(2)	Standard: Content of the plan of care
8	L555	§418.56(e)(2)	Ensure that the care and services are provided in accordance with the plan of care
9	L552	§418.56(d)	Standard: Review of the plan of care

From CMS Top 10 Survey Deficiencies List 2015

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Think of the Plan of Care as a Road Map

Problem	Where do we want to go?
Measurable Goal	Who will we know when we get there?
Interventions	What route will we take to reach the destination
Evaluating	How will we know if we are still on the best route?
Updating of Goals	What if we decide to change the destination?
Coordination	How will we communicate along the way?

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Common Problems & Issues

	Quality	Survey	Payment
Not individualized	X	X	X
Not updated as care needs change	X	X	X
Not established at the right time	X	X	X
Not reviewed by IDT at appropriate intervals	X	X	X
Indicated interventions not provided during visit	X	X	X
Lack of involvement by entire IDT and attending	X	X	X
Goals not measurable, not patient centered	X	X	X
Eligibility disconnect from POC	X	X	X

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Contents of Plan of Care

A plan of care is a roadmap or GPS and includes

- Problems or needs
  - As identified in the initial and comprehensive assessments
- Measureable Goals
  - How hospice knows if the care is making a difference
- Interventions
  - What is going to occur
  - Who is going to provide the care
  - Frequency of services, visits
  - Medications, DME, supplies

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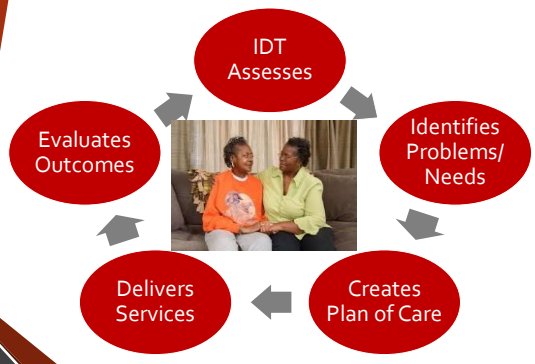
The Cycle of Care



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Plan of Care – Critical Elements

Established

- before services are provided
- by IDT in collaboration with attending physician
- based on patient specific assessments of needs including management of pain and symptoms

Is updated as frequently as patients condition requires but at least every 15 days

Notes progress or lack of progress towards the goals

Includes scope and frequency of services

Care and services must be consistent with plan of care

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Universal Care Planning Events

1. Opening or initiating a plan of care
2. Updating a plan of care
3. Closing a plan of care

But before you start…

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Before You Start…

How many goals are needed?

When do you care plan and when don't you?

Do you have to care plan Nursing 101 material?

How to assure that it is patient/family focused?

How will IDT communicate?

What are the components of your plan of care?

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Individualized Plan of Care

- Patient/ family input & goals of care
- IDG comprehensive assessment
- Physician orders
- Medication Profile
- HA assignment
- Volunteer assignment
- IDG discussions

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Care Planning's Big Three

1. Identifying Problems
2. Setting Goals
3. Planning Interventions

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Patient/Family Problems/Needs

- Identified in initial and ongoing assessments
- Findings of all assessments are directly tied to the care planning process

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A Word About Goals

- Goals-patient and family directed
- Measurable
- Not static - must be flexible and will change as the situation requires or patient declines
- Should be reviewed any time there is a significant change in status

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What Do People Want?

1. Adequate pain/symptom control
2. Avoiding inappropriate prolongation of dying
3. Achieving sense of control
4. Relieving burden
5. Strengthening relationships with loved ones

Singer, et. al., *Quality End-of-Life Care - Patients' Perspectives*, JAMA, 1999; 281:163-168 (Jan 14)

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Establishing Patient Goals

What does the patient want?

Don't ask "what are your goals" since they may not know how to define goals

Instead ask

- "What is important to you now?"
- "What are your needs today?"
- "What would you like to get accomplished over the next couple weeks?"

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Goals of Care

- Hopes, goals, expectations change with illness
  - May be multiple goals that apply at the same time
  - Goals may be contradictory
  - Certain goals may take priority over other
- IDG's Role
  - Clarify goals, treatment plan keeping in mind what is important to patients and families
  - Be able to set limits on unreasonable goals
  - Incorporate goals into the plan of care

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The Interventions - Achieving the Goals

All services necessary for the palliation and management of the terminal illness and related conditions

- Scope, frequency and responsibility
- Assessments
- Visit frequencies
- Education
- Medications, supplies, DME
- Level of care

What about proactive interventions?

Define what functions you will perform during each visit and what you will document

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The Interventions - Achieving the Goals

The Goal: " I would like my hair done every Wednesday."

What interventions are necessary to meet the goal and which discipline will be responsible for each?

- Managing pain and symptoms
- Transportation to the beauty shop
- ADL support
- Safety needs
- What else?

How does the POC change when she can no longer leave the house?

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The Evaluation

How we know if the care is making a difference?

Is the POC working? If not, what are we going to do to correct this?

Have the problems been resolved?

Are there new problems/issues/needs that need to be care planned?

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The Evaluation

It's about the outcomes – the progress of lack of progress towards the goals

What are some indicators of your hospice's effectiveness of the care planning process?

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Back to the Universal Events

1. Opening or initiating a plan of care
2. Updating a plan of care
3. Closing a plan of care

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Opening/Initiating the Plan of Care

How does information from the initial and comprehensive assessments flow to the plan of care?

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Opening/Initiating the Plan of Care

Policy: Does policy incorporate requirements from §418.56?

Process

- Is the IDT involved in the development?
- How is it documented?
- Does POC identify care and services to address the immediate needs of the patient and family as identified in the initial assessment?
- How does collaboration with the attending physician (if there is one) occur?
- How many goals are expected?

Standards

- What are your hospice's expectations and standards?

Opening/Initiating the Plan of Care

Collaboration

- Attending physician involvement
- Burdensome process to show IDT collaboration at IDT meetings (sign in sheets, sign each POC)
- Collaboration in updates outside of IDT meeting

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Opening/Initiating the Plan of Care

Are the goals measurable? Patient centered?

- How can you make goals measurable?
- Is the measurement in the goal?
- Are the goals achievable? Realistic?

Are the interventions directly related to goal achievement?

How is care tied to making progress towards goals?

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Updating the Plan of Care

Are problems identified in the comprehensive assessment and updates care planned?

- What gets on the POC?
- Can you customize if canned problems do not clearly identify the problem?

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Updating the Plan of Care

Care and services consistent with the POC

- Do staff review plan of care before, during and after the visit?
- Is the plan of care guiding the visit – like a roadmap?
- Do you use the power of your EMR to match plans of care to visits made?
- Is each and every visit documented timely?
- Do you review POC during IDT?

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The EMR

Do you clearly understand how to use your EMR in care planning and visit documentation?

How much flexibility do you have in individualizing POC? Problems? Goals? Interventions?

What is the process for staff to learn how to individualize the POC?

Do you use set POC templates? How are they working? How can they be improved?

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Updating the Plan of Care

What is considered a significant change in patient's condition triggering a revision?

- How does this get communicated to the IDT?
- How is the IDT involvement get documented?

How does communication with the attending physician occur?

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Closing a Problem

Is the POC reviewed at IDT meetings and changes made at the review?

What triggers closing a problem on the plan of care? Goal achievement? What else?

How does it work in the EMR?

Who can close a problem on the plan of care?

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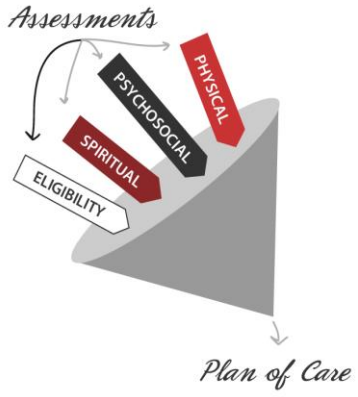

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Plans of Care

- Should change with decline
- Support eligibility
- Services provided according to plan of care
- Examples
  - Hospice aide increased from 3 times per week to daily as wife can no longer manage the increased physical requirements
  - Example: Hospice aide assignment changed to bed bath as too difficult to transfer patient into shower
  - Example: Oxygen order for 3 liters continuous from PRN

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General Decline

All should be addressed in the POC

- FAST, PPS
- Weight loss/decline in MAC/BMI
- Increasing dependence in ADLs
- Dysphagia
- Pocketing food
- Incontinence
- Skin breakdown
- Agitation
- Increased periods of sleeping
- Immobility
- Infections
- Medication changes

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Mr. Jones

- 78 year old admitted with ASHD. Depressed and anxious because of disease.
- Comprehensive assessment indicates
  - Pain – 6 /10 using verbal pain scale. Angina with exertion and occasionally at rest. Comprehensive pain assessment completed which indicates pain is more frequent and now greatly restricting any activities he found pleasure in doing.
  - Shortness of breath with any activity. Use of accessory muscles. Treatments consist of use of MS, oxygen and nebulizers, but he frequently takes off his oxygen.
  - On PRN opioid with bowel regimen started on admission.

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Mr. Jones

- Confirmed still does not have an Advance Directive, but considering it
- Ambivalent about future hospitalizations as he has always gotten better before
- Patient and caregiver refused to discuss any spiritual / existential concerns, but willing to see the spiritual counselor.

How does all this translate to a Plan of Care?

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Problems / Issues/ Needs: Pain management / Control

Goal: Patient's goal is pain to be controlled at a level of 3 or better

Interventions:

- Added Nitrates for symptom relief
- MS 5 – 10 mg q1h prn pain / dyspnea
- Education related to use of pain medications and side effects
- Assessment of pain level by all disciplines every visit using the verbal scale & CM notified if greater than 3
- SN frequency – 3 x week for 1st week then reevaluate

IDT update: Pain continues to be at a level of 5 – 6 as doesn't like feeling he gets with the MS. Nitro gives him a head. Educated on use of O2 with any activity. Changed to long acting MS for better pain management and control. SN frequency – 4x week until pain better managed to ensure using medications appropriately.

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Problems / Issues/ Needs: Dyspnea with activity

Goal: Patient's goal is dyspnea to be controlled to a mild level

Interventions:

- Increased O2 to 3 – 4 liters
- Evaluate effectiveness of nebulizers
- Encouraged to wear O2 at all times and especially with any activity
- Teach energy conservation techniques
- Assessment of dyspnea by all disciplines every visit using a verbal scale of mild, moderate, distressing & notify CM if greater than mild

IDT update: Dyspnea continues at a moderate level, especially with ADLs. Continue to encourage him to use O2. Has agreed to help and HA schedule 3 times/ week to assist with ADLs

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Problems/Issues/Needs: No advance directive but requests additional information. Not sure about future hospitalizations

Goal: Advance directive discussions and information will be provided by January 20th

Interventions:

- SW to educate and assist with advance directives
- SW to encourage family meeting to discuss advance directive
- SW explore the benefits of DNR status with patients and families and any future hospitalizations
- SW encourage execution of advance directives while patient is able
- SW frequencies – 1 x week until family decision made

IDT Update: Family meeting held on Jan 19th . Family in agreement with patient wishes. Advance directive being completed by patient. Pt express desire to not return to hospital. Will make a follow up visit by January 25 to obtain copy of completed advance directive. SW frequency changed to 2 x month

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Problems/Issues/Needs: Religious/Spiritual Struggle

Goal: Patient will report feeling less spiritual struggle during next 2 chaplain visits

Interventions

- Chaplain provide pastoral dialogue
- Chaplain provide reflective conversation
- Chaplain provide spiritual reflection
- Chaplain facilitate faith expressions
- Chaplain to provide dialogue to facilitate examination of beliefs
- Chaplain frequencies – 2x week

IDT Update: Patient seems less anxious partly as consequence to experiencing forgiveness. Continue with current interventions. Chaplain frequencies change to 1 x week.

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Meeting Patients Where They Are

Experts have concluded that if a patient is given an opportunity to speak without interruption for 2 minutes at the beginning of an encounter, the patient will provide the health professional with his or her issues and goals.

Talking with Patients (Vols 1 and 2), Cassell, E

IDG's Role

Clarify goals, treatment plan keeping in mind what is important to patients and families

Be able to set limits on unreasonable goals

Incorporate goals into the plan of care

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charlene@RCHealthcareSolutions.com

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