MDS Alert

Hospice Care: 4 Ways to Get With the Hospice Program and Avoid Survey Woes

Find out how to deal with this challenging juggling act.

When a nursing home patient elects hospice, you suddenly have a new partner in care, a new set of rules -- and a shift to palliative care. And you may have to explain unavoidable negative outcomes to surveyors who see the resident triggering on several QIs/QMs. If all this seems like a lot to balance while caring for a dying resident, these strategies can keep you a step ahead of the person's needs and the regulatory realities.

1. Be aware of new Medicare hospice conditions of participation (CoPs). The CoPs for hospices, which go into effect on Dec. 2, talk about nursing homes and hospice having one care plan for a resident, says long-time hospice nurse **Cherry Meier**, VP of public affairs for **VITAS Innovative Hospice Care** in Flat Rock, N.C. She's hoping, however, that the **Centers for Medicare & Medicaid Services**' interpretive guidelines for implementing the CoP requirements in nursing homes will clarify that the emphasis should be on coordinating the care plan rather than on the number of care plans.

Do the side-by-side test: Even before the guidance comes out, lay the nursing home and hospice care plans side by side to make sure they seem like the same patient. "Right now, that's not happening," says Meier.

Beware: Nursing home and hospice care plans that appear to be in conflict make it fairly easy for surveyors to write deficiencies, cautioned **Harold Bob, CMD, MD**, a nursing home and hospice medical director in a presentation on palliative care and survey regulations at the **2008 American Medical Directors Association** annual meeting. "When the care plans don't coincide, it probably leads to poor care," he said.

2. Get the facility and hospice on the same page with the MDS. The hospice staff should collaborate with the nursing department to provide their assessment information for the MDS, including pain, says **Gail Robison, RN, RAC-CT,** a consultant with **Boyer & Associates** in Brookfield, WI. The facility also needs a way for hospice staff to document or convey ADL assistance for coding Section G, she adds. "The hospice staff should also communicate to the nursing staff any changes they've observed in the resident," Robison says.

In turn, "the nursing home should communicate with the hospice about changes to the care plan and changes in the resident's condition," adds **Beth Carpenter**, president of **Beth Carpenter and Associates** in Lake Barrington, Ill.

Suggested collaborative model: Meier advises hospice nurses caring for patients in nursing homes to make the MDS coordinator their "very best friend."

And she advises the hospice nurse to review the MDS and the problems triggered for care planning. The hospice nurse can then compare those problems to the ones identified by the hospice assessment, and discuss these with the MDS coordinator. The "hospice nurse can help the MDS team with the care plan and work on finding palliative care solutions to the patient's problems."

3. Maintain a unified focus on palliative care. Nursing homes most often tend to differ from hospice in how they view and treat pain, pressure ulcers, and weight loss, in Meier's experience.

For example, "hospice uses PRNs to supplement scheduled medications," she points out. And if the patient needs too many PRNs for break-through pain, hospice will change the regularly scheduled pain medication to improve relief.

Reasoning: "When people get regularly scheduled pain medications, they actually require less in the long run," Meier says.

If you wait until the patient is in severe pain to give him the PRN, he will require a much bigger dose for relief, resulting in potential sedation, she adds.

Survey heads up: Maryland survey agency head nurse **William Vaughn, RN**, has seen nursing home patients on hospice -- usually nonverbal patients -- who get their PRN dose of pain medication only when the hospice nurse comes in. And when that happens, surveyors may take a look at what's going on, cautioned Vaughn, who co-presented with Bob in the AMDA session.

More potential conflicts: Nursing homes also get concerned when hospice wants to use Haldol, although it really eases terminal restlessness, Meier adds.

As part of end-of-life care, hospice may insert Foleys or provide anti-anxiety medications, both of which may trigger survey scrutiny.

4. Be prepared to explain a resident's unavoidable decline. Having the hospice designation and documentation can help allay surveyors' concerns, Meier notes.

But you also need documentation that shows your decision-making for care planning -- "and why you are treating pressure ulcers as you are or giving anti-anxiety medications or inserting a Foley," she says.

Also: The documentation trail should reflect your rationale for care as the patient's condition declines, Meier emphasizes.

Use this to your advantage: Some of the survey investigative protocols address end-of-life considerations -- for example, for weight loss, hydration, and pressure ulcers, Meier points out.

MDS risk management tip: The July 2008 RAI user's manual update encourages nursing facilities to do a significant change in status assessment (SCSA) when a resident elects hospice.

Doing an SCSA where you check that a patient is on hospice will exclude the resident from three of the quality indicators/measures: weight loss, the resident's ability to move in and about their room got worse, and ADL decline, Meier points out.