§ 418.54 Condition of Participation: Initial and Comprehensive Assessment of the Patient

The Initial Assessment

- The registered nurse (RN) has 48 hours from the effective date of the hospice election statement to complete the initial assessment.
- The purpose of the initial assessment is ***not*** to determine the patient's eligibility for the hospice benefit, which is addressed in § 418.22 and § 418.24, or to orient the patient to the hospice benefit and obtain the election statement.
- **The initial assessment must be completed in the environment where the patient will receive hospice care.**
  - Initial assessments should not be completed in the hospital for a patient that will be discharged to home to receive hospice care.
- The RN must minimally be the first interdisciplinary team member to start the comprehensive assessment. Another team member can accompany the RN, but they cannot begin the comprehensive assessment process first.

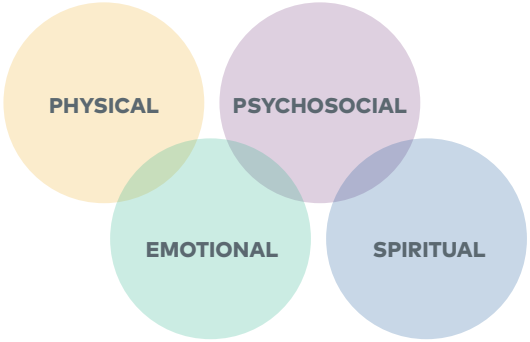
  The initial assessment serves to assess the patient/family immediate needs.

***Example:** A patient is discharged from the hospital at 4:00 p.m. and the RN arrives at 5:30 p.m. to complete the admission visit to hospice. The patient is tired and the family is overwhelmed. The RN decides to compete an initial assessment to identify and meet the patient's and family's most pressing needs for the rest of that day. She will return the next day to complete the rest of the assessment when the patient and family are more rested. She essentially provided enough coordination of care and education to get the patient and family through the night and start the patient's plan of care.*

- The initial assessment is essentially a short assessment process and can be formatted and utilized per the hospice provider's decision and the patient/family needs.
- If an RN can complete the entire nursing assessment at the first visit, then an initial assessment is not needed or required.

The Comprehensive Assessment

- The comprehensive assessment is not a single static document, a symptom and severity checklist, or a set of generic questions that all patients are asked. It is a process that needs to be documented in an accurate and consistent manner for all patients.
- The hospice interdisciplinary team (IDT) has **5 calendar days** from the effective date of the hospice election statement to complete the comprehensive assessment.
- CMS does not dictate how the comprehensive assessment is completed or what forms a hospice provider utilizes to document the comprehensive assessment.
- The comprehensive assessment must be patient-specific and identify the patient's need for hospice care and services in the following areas:



- The comprehensive assessment is more about assessing WHAT the patient needs versus WHO completes the assessment.
- While the optimal scenario is for each IDT member to complete their portion of the comprehensive assessment, that may not always be possible.

- IDT members may complete their portion of the comprehensive assessment via telephone if it is the patient's/family's request.
  - Routine completion of the comprehensive assessment via telephone is not recommended.
- The comprehensive assessment is completed by the IDT in consultation with the attending physician.

Content of the Comprehensive Assessment

- Physical, psychosocial, emotional, and spiritual needs related to the terminal illness and related conditions
  - Nature and condition causing admission
  - Complications and risk factors
  - Functional status
  - Imminence of death
  - Symptom severity
  - Drug profile
    - Identify all of the patient's current medications and prescribers. (including prescription, OTC, and herbals)
- Initial bereavement assessment of patient's family or caregiver
- Appropriate referrals

Update of the Comprehensive Assessment

- The comprehensive assessment is updated by the IDT as frequently as the patient's condition requires but at a minimum **every 15 days**.
- The purpose of updating the assessment is to ensure that the hospice IDT has the most recent accurate information about the patient in order to make accurate care planning decisions.
- The comprehensive assessment must be easily identifiable in the clinical record:
  - Hospices are free to choose the method that best suits their needs when documenting the update to the comprehensive assessment.
  - The IDT is required to update only those sections of the comprehensive assessment that require updating and if there were no changes in the assessment, then that must be documented. If there has been a change in the patient's condition/status, then the comprehensive assessment must be updated.

Electronic health records (EHR) and individualization of documentation

IDT members should use the free text area of every form in the EHR to write a short note that provides additional detail about the patient or family. This additional documentation serves to individualize the patient clinical record.

- Expand on "point and click" selections in a form.
  - Record observations about details the "drop down" does describe.
    - I.e.: state the number of feet a patient can ambulate.
- Document subjective comments from the patient and family to support continued eligibility.
    - I.e.: "I sat outside last week, but this week I just don't have the energy to go out".
    - I.e.: "He has been sleeping more during the day and is not interested in waking up to eat".

Patient Outcome Measures

- The comprehensive assessment must include data elements which are collected during the comprehensive assessment and subsequent updates that allow for measurement of outcomes.
- The hospice must measure and document data in the same way for all patients.
- The data elements must consider aspects of care related to hospice and palliation.

- The data elements:
  - Must be documented in a systematic and retrievable way for each patient.
  - Must be used in individual patient care planning and in the coordination of services.
  - Must be used in the aggregate for the hospice's quality assessment and performance improvement program.

Compliance Suggestions for Hospice Providers

- Review and revise current patient assessment policy/procedures at least annually.
- Use your assessment tools as tools; these forms are not just pieces of paper! A great deal of pertinent information is documented on the assessment form, which, in turn, drives the content of the patient's plan of care and is excellent data for measuring patient outcomes.
- The updated comprehensive assessment of the patient's/family's needs should be reflected in the interdisciplinary team notes as well.
- Remember - the IDT must update the parts of the patient's comprehensive assessment as frequently as the patient's condition requires, but at a minimum every 15 days.
- Choose patient level data that you can measure the same for every patient. Examples could include:
  - Pain scores
  - Severity of symptoms
  - Presence of advance directives
  - Family/caregiver confidence
  - Spiritual support
  - Initial bereavement risk assessment outcomes
- Incorporate education about the initial and comprehensive assessment requirements into your orientation program and continuing education.

Please note that hospice providers need to comply with the most stringent regulatory requirements (Federal or State).

Resources

- Medicare Benefit Policy Manual, Chapter 9 - Coverage of Hospice Services Under Hospital Insurance
- 1135 Waiver Page

References

- Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
  42 CFR Part 418 Medicare Hospice Care Regulations eCFR :: 42 CFR Part 418 -- Hospice Care