Care Planning Primer

An NHPCO Clinical Resource

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NHPCO
Leading Person-Centered Care

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Care Planning Primer

NHPCO Quality and Regulatory Workgroup

SECTION ONE: Introduction

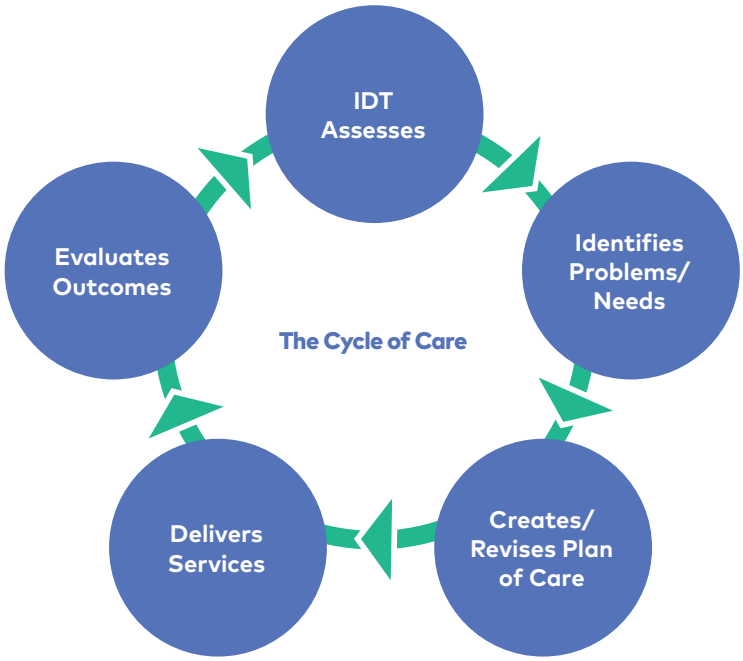
Care planning is essential to provide the right care and services that meet patients and families where they are in their end of life journey. Care planning and assessments are tied together. The top CMS survey deficiencies consistently include multiple care planning standards.

Understanding the cycle of care provides a framework for care planning (problems, goals and interventions). IDT/IDG assessments based on patient and family goals of care identity the problems and goals. Interventions are developed to achieve goals and care is delivered according to the interventions. Evaluations of progress or lack of progress towards the goals lets the IDT/IDG know if the care is working.

Citations:

- **418.54** Initial and comprehensive assessments
- **418.56** Interdisciplinary group, care planning and the coordination of care
- State Operations Manual Appendix M

The Cycle of Care



Stages

There are 3 stages in the plan of care (the plan of care is both a process and a living document):

1. **Opening or initiating a plan of care (POC)** at admission and when changes in the patient's condition requires. Services are delivered according to the plan of care (POC) based on the IDT/IDG assessments.
2. **Updating a plan of care** (when current problems, goal(s) or intervention(s) needs to change). The assessments by the IDT/IDG determine when the care plan needs updated through evaluating the progress or lack of progress towards the goals.
3. **Closing a plan of care** (problem has been resolved, goal has been achieved). The assessments by the IDT/IDG determine when.

SECTION TWO: Foundational Processes To Address At Your Hospice

These are foundational processes to develop and/or improve and decisions a hospice needs to make. Answering these questions is important and a good starting point as you work toward improvement.

1. How to assure that the POC is patient/family focused?
2. What are the components/what makes up the plan of care at your hospice? Is this supported by policy? These are some components to consider:
   - Plan of care (problems, goals and interventions)
   - IDT/IDG initial and comprehensive assessment
   - Physician orders
   - Medication Profile
   - Hospice Aide assignment
   - Volunteer assignment
   - IDT/IDG discussions/Care Coordination notes
3. What are problems, goals and interventions called in your electronic medical record (EMR) so you can translate?
4. How many goals are needed?
5. When do you care plan and when don't you?
6. Do you have to care plan basic assessment functions? Example; patient with cardiopulmonary disease, you will care plan respiratory and cardiac assessments, but do you care plan skin assessments when there is not a problem yet still assess skin? Do you have to care plan all nursing tasks? How does your policy support this?How might this be different for care in the nursing facility in order to coordinate care?
7. What about proactive interventions?
8. Depending on your EMR, do you address problems by systems or by symptoms? Or is this not applicable in your process?
9. How will IDT/IDG communicate regarding changes in assessment findings and need to update the POC outside of the IDT/IDG meetings?
10. If you are accredited, consider how your accrediting organization considers these areas.
11. How are the IDT/IDG members instructed (and held accountable) to review the care plan before or during every visit and to readily know what the goals are?
12. How will your organization document the involvement of the attending physician, hospice physician, and members of the IDT/IDG in establishing and updating the plan of care?

SECTION THREE: Problems, Goals And Interventions

Have a process/standard on eliciting and identifying problems and goals/outcomes. What does the patient/family need? Here are some questions you can use as conversation starters with patients and families.

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

Problems (Needs, Issues, Opportunities)

Problems are identified by the IDT/IDG during initial, comprehensive and ongoing assessments. Problems may include physical, spiritual, psychosocial. Findings of all assessments are directly tied to the care planning process. Keep in mind it is the patient's plan of care-whose problem/need is it anyway?

Examples of Problems:

- Pain
- Caregiver exhaustion
- Family not in agreement with goals of care
- Spiritual struggle
- Lack of funeral plans

Goals/Outcomes

Goals/outcomes should be patient and family directed. Measurable goals/outcomes allow the IDT/IDG to determine if the care and services (as identified in the plan of care) are making a difference. Consider if the plan of care is effective.

Goals are meant to be reviewed any time there is a significant change in status. Goals are not static (not set it and forget it), they are meant to be flexible and change as the situation requires or patient declines.

Examples of measurable goals include:

- Pain 3 or less
- Bowel movements at least every 3 days
- Advance directive discussed and completed by June 19
- Reports agitation is decreased to an acceptable level by the caregiver in 2 days
- Dyspnea at patient goal of mild
- Caregiver will administer medications according to orders in next 2 visits
- Family will report "I understand" regarding nutrition and the terminally ill in 2 weeks.
- Patient will receive sacrament of the sick within 3 days.

State Operations Manual / Tag L548
§418.56(c)(3) - Measurable outcomes anticipated from implementing and coordinating the plan of care.

Interpretive Guidelines §418.56(c)(3) The outcomes should be a measurable result of the implementation of the plan of care. The hospice should be using data elements as a part of the plan of care to see if they are meeting the goals of care.

Probes §418.56(c)(3) Are the outcomes documented and measurable? Look for movement towards the expected outcome(s) and revisions to the plan of care that have been made to achieve the outcomes.

Note: Accreditation standards may be more prescriptive in using time frames (days to weeks) as measurable in each goal. Check with your accrediting organization.

IDT/IDG Interventions

Interventions define what services, functions, and care the hospice team will perform during a visit and outside a visit for coordination. Interventions can be thought of as a "to do" list. Interventions should include all services necessary for the palliation and management of the terminal illness and related conditions. **This includes:**

1. Scope, frequency and responsibility (what, how often and who).
2. Visit frequencies
3. Evaluation/observation of effectiveness of interventions so the IDT/IDG knows if the care is making a difference; what are the outcomes, the progress or lack of progress towards the goals. Make sure to include assessments as part of the interventions.
4. Education to be provided
5. Medications, supplies, DME
6. Level of care (changes)

State Operations Manual / Tag L546
§418.56(c)(1) - Interventions to manage pain and symptoms.

Interpretive Guidelines §418.56(c)(1) The goal of effective pain and symptom management is quality of life. When the pain and symptoms that cause distress to the patient are effectively managed, the patient and family are better able to focus on their vision of a "good death." Effective pain and symptom management include the ongoing assessment of the patient's physical, psychosocial, emotional and spiritual needs and re-evaluating the effectiveness of the current plan of care in order to address those needs.

Evaluations

Evaluations occur with each visit/contact and formally at IDT/IDG reviews/meetings. Evaluations are intended to assess if the plan of care is effective; i.e., making progress to improving outcomes, patient comfort. If not, what needs to change; what can be done to make progress towards achieving the outcomes/the goal(s)?

Ask the following questions:

1. Have the problems been resolved? For example, has the wound healed? DNR in place? Moved to assisted living?
2. Are there new problems/issues/needs that need to be care planned?

Consider implementing a standard process/format to review the POC. See page 13 for example.

SECTION 4: Updating The Plan Of Care

Based on the comprehensive assessments and evaluations, the IDT/IDG should have determined the progress or lack of progress towards the goals. In determining the need to update the plan of care consider the following:

1. Have the goals been met? (Think progress or lack of progress towards the goals/outcomes.)
2. Does this remain an ongoing problem/need?
3. Are there different needs, problems?
4. Are the new problems/needs identified in the comprehensive assessment and care planned?
5. Have the goals changed? Are they achievable?
6. Is the time to accomplish goal realistic? Should it be revised?
7. Should different interventions be considered?
8. Is the IDT/IDG in alignment with the plan of care? Communicated through IDT/IDG (are we on the same page)?
9. Does the patient / family agree with and understand the plan of care?

State Operations Manual / Tag L553
§418.56(d) - A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the plan of care.

Procedures and Probes §418.56(d) Ask the hospice to describe the plan of care review process. How does the hospice IDT/IDG (in collaboration with the individual's attending physician, if any) ensure that each patient's individualized plan of care is reviewed, and revised if warranted, no later than 15 days from the previous review?

SECTION FIVE: Cases

CASE #1

76 year old admitted with chronic obstructive pulmonary disease (COPD) and atherosclerotic heart disease (ASHD). Depressed and anxious because of disease. Comprehensive assessment indicates:

- Pain – 6 /10 using verbal pain scale. Angina with exertion. 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 morphine sulfate (MS), oxygen and nebulizers, but he frequently takes off his oxygen.
- On PRN opioid with bowel regimen started on admission.
- Gait increasingly unsteady – holds on to walls and chairs with ambulation – won't use a walker.
- Hints at spiritual struggle

> **Problem:** Chest Pain
>
> **Goal:** Pain will be managed at patient defined acceptable pain level of 3 or less
>
> **Interventions:**
>
> 1. Assessment of pain level by all disciplines every visit using the verbal scale & RN notified if greater than 3
> 2. Skilled nurse (SN) to assess the effectiveness of pain medications and use of breakthrough medications

3. Social worker (SW) / Spiritual Counselor (SC) provide non-pharmaceutical interventions, i.e., meditation, guided imagery, etc.
4. New order for nitrates for symptom relief, SN to instruct on use
5. SN Instruct in use of MS 5 – 10 mg q1h prn pain / dyspnea
6. SN Education related to use of pain medications and side effects
7. SN frequency – 3 x week for 1st week then reevaluate
8. SC and SW - 1 time week for 1st week then reevaluate

IDT/IDG update: Pain has been above 3 several times in past week as patient is not taking medications as ordered. Will provide further education and increase SN visits to 4 times a week (every other day) for reinforcement. Will reassess effectiveness of medication regimen. Chaplain to increase visits for meditation and presence.

Problem: Dyspnea with activity

Goal: Patient's goal is dyspnea to be controlled to a mild level per patient report.

Interventions:

1. SN Increased O2 to 3 – 4 liters
2. SN Evaluate effectiveness of nebulizers
3. All Encourage patient to wear O2 at all times and especially with any activity
4. SN Teach energy conservation techniques
5. SN frequency – 3 x week for 1st week then reevaluate
6. Assessment of dyspnea by all disciplines every visit using a verbal scale of mild, moderate, distressing & notify CM if greater than mild

IDT/IDG update: Dyspnea continues at a moderate level, especially with activities of daily living (ADLs). Continue to encourage him to use O2. Has agreed to help and Hospice Aide will be added to the plan of care and for 3 times/ week to assist with ADLs.

Problem: Constipation

Goal: Bowel movement at least every 3rd day

Interventions:

1. Each visit each discipline asks when last BM and if 3rd day with no BM, notifies RN.
2. SN Assess abdomen
3. SN Education patient/family to follow bowel protocol per physician's orders.

IDT/IDG update: Plan of care effective; is having BM every 2 – 3 days

Problem: Spiritual Struggle

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

Interventions:

1. Patient and family will be provided of options for spiritual care.
2. Patient will be reconnected with his faith community in 1 month.
3. SC frequency – 1 time every 14 days

IDT/IDG Update: Patient would like SC to contact pastor and arrange a visit.

CASE #2

83 year old man with Alzheimer's disease, lives in nursing facility (NF) for past 2 years. Hospitalized 2 times last 6 months with uncontrolled agitation and once after fall with head injury (prior to hospice admission). Decline with weight loss (10% in past 4 months), weakness and more difficulty eating. Moderate assistance with transfers, eating; completely dependent for dressing and bathing. Nonambulatory. Incontinent bowel and bladder. Stage 3 pressure ulcer coccyx. Daughter is MPOA and visits weekly.

Problem: " Please no more hospitalizations. Don't let the nursing home send my Dad to the hospital. I know he gets agitated but no more hospitalizations, they just make it worse"

Goal: No further hospitalizations

Interventions:

1. SN, SW, SC Coordinate with NF through frequent conversations with NF staff and attendance at NF care conferences on what goals of care are for patient and family
2. SN, SW, SC Ensure advance care planning is clearly communicated to facility
3. SN, SW, SC Communicate plan with daughter who is POA, dgt wants to be called after each visit and gives permission to leave voice message.
4. SW Communication plan with other family members on futile care
5. SN, SW, SC Frequent reinforcement of decisions
6. SN frequency 2 times per week
7. SW frequency 2 times per week times 1 week. 1 times per week times 1 week.
8. SC frequency – 1 time every 14 days

IDT/IDG Update: SN and SW will attend NF care conference next week. Advance directive is in NF record. NF care plan addresses no more hospitalizations.

Problem: Stage 3 pressure ulcer coccyx

Goal: Wound free of infection.

Interventions:

1. SN Provide education to NF on best skin care practices per protocol
2. SN Provide and instruct on use of adult briefs

3. SN Evaluate discuss with caregiver/family of pros and cons on use of Foley
4. SN Provide wound care per orders 1 time per week. Collaborate with NF for other dressing changes.
5. SN Evaluate effectiveness of wound care
6. SN Evaluate caregiver's ability for dressing changes
7. SN Frequency 2 times per week

IDT/IDG Update: Daughter prefers to use adult briefs and avoid use of Foley at this time. Wound remains free of infection. Continue wound care per orders.

SECTION SIX: Getting Starting On Improving Your Care Planning

An effective and compliant care planning process needs to address all patient and family problems/needs as identified in the initial and ongoing assessments. This section provides some suggestions if your hospice is needing a place to get started on improving your care planning and not quite sure where to begin.

Guiding Principles (think of this as your "To Do List")

1. Use this Care Planning Primer as reference.
2. Use the Cycle of Care as your care planning framework.
3. Focus on patient and family identified problems /needs and goals of care.
4. Start small and focus on one thing at a time.
5. Ensure there are measurable goals that allow the IDT/IDG to know there is progress towards to goals (is the care making a difference?).
6. Implement a standard process/format for reviewing the plan of care.

Here's one idea on getting started; focus on new admissions starting with the Initial Assessments and Care Planning and Hospice Item Set Measures (HIS)

Start with an initial programmatic focus (next 3 to 4 months) where every new admission with 1 or more of the problem/needs, as listed below, have a more focused and individualized care plan. This would include a measurable goal(s)/outcome(s) and individualized/specific interventions.

Note that most EMRs have the Hospice Item Set (HIS) embedded in the initial assessment and all patients must have the HIS addressed.

For all new admissions, use assessment information from the initial assessment as a starting point with all new admissions. Of course, you will need to continue to address all problems/needs but enhance the care planning process and focus on the following 5 areas (4 are included in the HIS).

1. Pain (HIS)
2. Dyspnea (HIS)
3. Bowels (HIS)
4. Preferences/advance directives (HIS)
5. Wounds

A hospice may want to give consideration as to whether this could be/should be a performance improvement project.

At each IDT/IDG meeting, those 5 care plan problems, as applicable, are reviewed for progress or lack of progress towards the goals/outcomes.

Example:

- IDT/IDG meeting where it is stated that the patient goal is pain at 3 or less, then it would be noted if this was achieved or not in the past 2 weeks.
- And if not, then ask "is it the right plan?". Discuss the current care plan and what needs to be updated/revised and document discussion and update.

Considerations

1. **Pain screening and comprehensive pain assessment**
   - What is the patient's pain goal?
   - Proper selection and use of standardized pain scale
   - Comprehensive pain assessments
   - How will this be care planned? What are the interventions?
2. **Dyspnea screening and initiation of treatment**
   - What is the patient's dyspnea goal?
   - What is your hospice's scale to measure?
3. **Bowels (opioids and bowel regimens)**
   - What is a measurable goal? Bowel movement every X number of days
   - Is it acceptable to have a patient on a routine opioid without a bowel regimen in your hospice?
   - What is your standard of care?
   - How will this be care planned? What are the interventions?
4. **Preferences/Advance Directives**
   - What is a measurable goal?
   - If they want further treatments, CPR, and/or do want hospitalizations-now what?
   - CPR: planned time frame for next discussion or completion of POLST/MOLST, out of hospital DNR.
   - Other life sustaining treatments: planned time frame for next discussion or completion of POLST/MOLST, out of hospital DNR
   - Hospitalizations: planned time frame for next discussion or plan to management patient concerns for needing hospitalizations
   - How and with whom do you have these discussions? How does family communicate? Who is decision maker?
   - How will this be care planned? What are the interventions?
5. **Wounds**
   - What is a measurable goal? Healing? Free of infection? Comfort?
   - How will this be care planned? What are the interventions?

Hospice Item Set
Just a reminder about the Hospice Item Set (HIS). These are process measures (did we ask the question or not) but it's the answers to the questions that can and should be used in the care planning process.

Improved processes should = improved HIS scores
Improved processes should = improved patient care outcomes

For improving patient care outcomes, you have to do something with the information and tie it to care planning.

SECTION SEVEN: Frequently Asked Questons

1. **Question: Does every single care plan for each patient need to be updated with a problems, goals, & interventions every 15 days. For example, if patient has 17 care plans (the patient has one plan of care with multiple problems goals and interventions) all 17 must be updated in all disciplines?**

Response: It depends. The plan of care is just that, a plan to deliver care. IDT/IDG assessments based on patient and family goals of care identity the problems and goals. Interventions are developed to achieve goals and care is delivered according to the interventions. Evaluations of progress or lack of progress towards the goals lets the IDT/IDG know if the care is working. A POC has multiple problems, goals and interventions that make up the POC. The comprehensive assessment is updated by the IDT/IDG 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/IDG has the most recent accurate information about the patient in order to make accurate care planning decisions.
If the POC is working (progress towards the goals) then no update is needed. If there is a goal that is not being achieved; i.e. patient pain at 5 and goal is 3, then interventions need reviewed and possibly changed.
How you document that the IDT/IDG has updated the comprehensive assessment and reviewed the POC and updated as needed is up to your hospice, your EMR and your policies.

2. **Question: When it comes to an IDT/IDG member changing/updating Careplans, are they able to do so without making a visit first to the patient?**

Response: The plan of care is developed and updated by the IDT/IDG based on the assessments. The IDT/IDG members whether they visit or not are responsible for the assessment and contributing to the update.

3. **Question: Who is responsible for reviewing and updating the plan of care?**

Response: Think about the intent/purpose of the IDT/IDG update which is to review the plan of care. Hospice is an interdisciplinary care delivery model.
There is no regulation requirement for each IDT/IDG member writing an update. However, a good practice is to discuss problems, goals and interventions at IDT/IDG and then a scribe documents progress or lack of progress towards goals. How you do it depends on your EMR and how you use it. This documentation should include a description of the involvement of all members of the IDT/IDG including the attending physician, hospice physician, and the members of the interdisciplinary group, in updating the plan of care. Keep in mind that the update to the comprehensive assessment can also be a part of the plan of care update since its about response to care and progress towards goals.

4. **Question: Do we have to have the hospice physician write an order for visit frequencies?**

Response: Visit frequencies are a part of the plan of care and as such are determined by the IDT/IDG. There is no requirement under Medicare for a physician's order for visit frequencies although your EMR may require it (but it is not regulatory). How you do it in your hospice will depend on your policies, processes and EMR.

5. **Question: Will you share with us the correct way to count visit frequencies of 1 time per month? Is the MSW visit due within 30 days of the last MSW visit or 1 time per calendar month? So if the patient was seen at the beginning of May and then at the end of June, is the visit frequency out of compliance because the time span was more than 30 days or compliant because it's once in the calendar month?**

Response: You will not see a prescriptive definition to answer your question. Keep in mind the visit frequency are based on the needs of the patient as identified in the assessments and on the POC. I am not sure how a visit frequency of 1 x/ calendar month meets the needs of the patient/family when that would be 59 days since the last visit or conversely you visit on 30th of 1 month and then 1st of next (2 days). Your hospice should have a standard of what 1x/month means. Perhaps a better practice would be to make visit frequency in days/weeks.

6. **Question: What is the "requirement" for RN visit frequency with a hospice patient?**

Response: Except for the hospice aide supervisory visit there is not a prescriptive visit frequency. All hospice services furnished to patients and their families must follow an individualized written plan of care developed by the IDT/IDG which includes a detailed statement of the scope and frequency of services to meet the patient's and family's needs. Needs are identified in the initial and ongoing assessments. Please note that RN visit frequency has come under some scrutiny by surveyors and other regulators, particularly if the RN visit frequency is 14 days or more between visits. Ensure that visit frequency is carefully followed in the plan of care following the initial and ongoing assessments.

The National Hospice and Palliative Care Organization (NHPCO) gratefully acknowledges the work of the Assessment and Plan of Care Workgroup, composed of members of the NHPCO Quality and Standards and Regulatory Committees and led by Roseanne Berry of R&C Healthcare Solutions, whose case studies, content suggestions, and helpful references have all made this resource possible.

This guide has been developed by NHPCO for informational purposes only. It should not be viewed as official guidance from CMS. It is always the provider's responsibility to determine and comply with applicable regulatory requirements. Further, this guide does not constitute legal advice and is not intended to take the place of legal advice.

References

State Operations Manual - Appendix M: Guidance to Surveyors - Hospice

Creating an Effective Hospice Plan of Care, published by the Centers for Medicare and Medicaid Services (CMS) on August 26, 2020.

OIG Report (July 2019): Hospice Deficiencies Pose Risks to Medicare Beneficiaries

Medicare Hospice Regulations, including Conditions of Participation – updated daily

Quality, Certification and Oversight Reports (QCOR) database: Contains various survey reports, frequency of survey deficiencies, and data reporting elements for surveys conducted by State Agency (SA); includes complaint survey information from both hospice Accrediting Organizations (AO) and State Survey Agencies (SA)

Quality, Safety & Education Portal (QSEP) for certified provider/supplier basic surveyor on demand training: Contains training modules used by state survey agencies and accrediting organizations. Search for hospice training modules.

Standardized Case Presentation*

1. **Start with SW and Chaplain presentations**
2. **Name, age, sex, terminal illness, secondary conditions (related) and co-morbid conditions (related and unrelated), admission date, level of care and attending physician**
3. **Review the problems on the current plan of care, one at a time and after each, report:**
   a. Is the goal measurable-do we know if we are making a difference?
   b. Any changes to the interventions of goals since the last IDT/IDG review
   c. Based on the comprehensive assessment data, are the goals met/problem resolved. Have the outcomes been met? If not, discuss what needs to change?
   d. Are the symptoms and other issues being controlled effectively with current interventions?
4. **Discuss any new problems identified through the comprehensive assessment for the plan of care. Develop goals and interventions.**
   a. New orders
   b. New services
   c. Change to visit frequency
   d. Change in interventions
5. **Do any of the IDT/IDG members have any plans for this patient and family that have not been addressed yet?**
6. **Any changes in conditions which change ICD-10 reporting?**
7. **Review of eligibility-why hospice, why still i.e., what demonstrates person remains eligible?**
   a. Reviewed at every IDT/IDG meeting
   b. More in depth review anytime there is a concern for continued eligibility and prior to recertification
   c. Disease specific
   d. Describe current status as compared to 3 to 6 months ago
   e. Weight or MAC changes
   f. ADLs
   g. Skin breakdown
   h. Falls
   i. Mental and functional status prior to admission or last 3 to 6 months compared to now
   j. Medication changes and why
   k. Plan of care changes and why

**These are basic guidelines to use as a starting point in improving case discussions at your IDT/IDG meeting through a consistent format. The flow will be impacted by your individual processes such as your electronic health record, individual make up of your hospice (inpatient facilities, length of stay, case mix).*

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