

# How to create meaningful Hospice outcomes while adhering to regulatory requirements

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## Disclosure

This presentation is provided for educational purposes only  
There is no financial disclosure or commercial interests to be disclosed by educators

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# Objectives

## Explain

Explain how to use the Interdisciplinary Team process to coordinate a compliance framework that promotes collaborative practice, addresses patient needs and impacts the quality of care.

## Describe

Describe how to use practical tools strategically to demonstrate survey readiness while demonstrating quality objective outcome measures.

## Describe

Describe a highly effective collaborative communication tool to improve patient and caregiver satisfaction.



Caring. Commitment. Community.

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Is our path visible?

- Do any of you ever feel like this photo ?
- You may have a clear objective in mind, but might not see a clear path to accomplish your goals.

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## Did the pandemic change the way your hospice conducts IDT/IDG meetings?

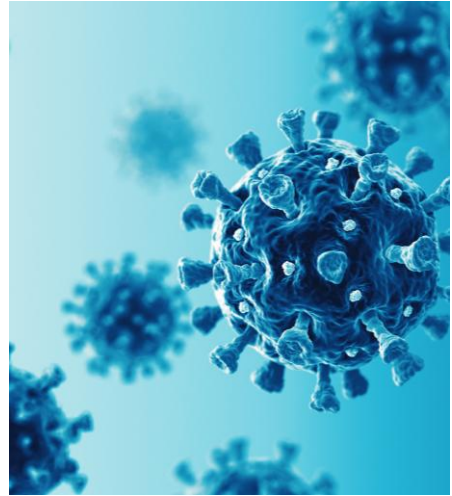
Remote meetings ?

Inability to find spaces for proper social distancing for in person meetings

How many sites or team meetings for your hospice

Utilizing new or existing technologies (Zoom, TEAMS, conference lines)

Barriers to returning to traditional type of in-person meetings



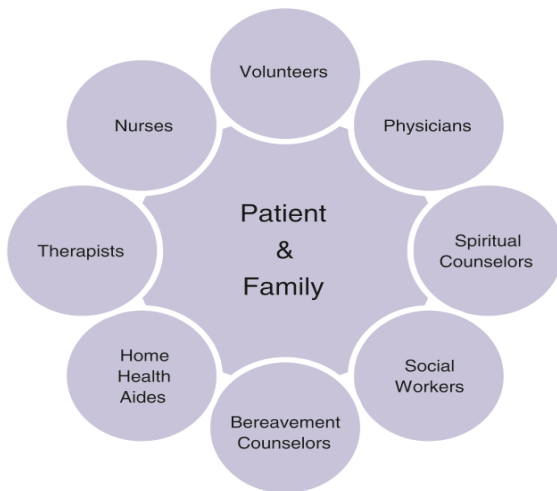
## 1. Interdisciplinary Process

## Regulatory Requirement for IDT (IDG): CMS Hospice Conditions of Participation

§418.56(d) Standard: Review of the plan of care The hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) must review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days.

§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.

## The goals of meeting as an interdisciplinary group



To coordinate care with the patient's and family's goals and preferences at the center

Identification of potential concerns that may affect the patient and family's emotional, social, spiritual and physical needs as they navigate serious illness together

Identifying and managing symptoms associated with the hospice diagnosis

Review of the plan of care to assist in coordinating services from various members of the team, such as nurses, social workers, chaplains (SC), counselors and the hospice NP/Physicians.

# Satisfaction Feedback : CAHPS



## Preparation for a Successful Role out for HOPE Survey

Over the past 2 days , how has the patient been impacted?

What is the impact on this patient's QOL if they are **short of breath**?

- Pain
- Shortness of breath**
- Anxiety
- Nausea
- Vomiting
- diarrhea
- Constipation
- agitation



- Effect on function
- Ability to perform ADLs
- Relationships
- Feeling of wellbeing
- Specialized care/ training
- Risk for Caregiver stress

## How did these quality measures help guide our new initiative for IDT?

We assessed what needed to change in our IDG documentation

- Our current documentation did not always reflect what mattered most to our patients and families
- The quality of the documentation did not always reflect the comprehensive service that we were providing
- Clinical review of the record was labor intensive for quality and for recertification
- The documentation did not always paint a clear picture of the patient current status and trajectory through serious illness

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## What were our next steps?

1. To elicit Feedback from staff
2. To provide each discipline a template for documenting
  - Focus on effectiveness of their care planning, identify patient, and caregiver needs
3. To provide individualized education
  - To support clinicians who struggled with change
  - To foster confidence in their work flow
  - To acknowledge their quality work with patients and families and teammates

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Current level of Care:

Patient Status / Evidence of Decline noted in past 2 weeks

Symptom Management Focus includes (pharmacologic/ non-pharmacologic):

Emotional Spiritual needs/support of patient /family:

Identified or On-going educational needs for patient/family:

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## IDG Discussion documentation

### Before

#### IDG Note

Care Coordinator note by [redacted]

An event of jerky movement with unresponsiveness lasting one minutes followed by sleeping greater than an hour. Discussed POC, medication and Dx at IDG meeting.

Medical Social Work note by [redacted]

Patient continues to live at home with his wife [redacted] and live in caregiver. He has significant cognitive issues and requires total care for ADLs, but is content and interactive with visitors. MSW has regular visits with wife for coping assist.

Music Therapy note by [redacted]

No Music Therapy visit within last two weeks.  
Pt and wife benefit from Music Therapy services.  
MT will scheduled follow up visit within next two weeks.

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# IDG Discussion documentation

## IDG Note

### After

Care Coordinator note by [REDACTED]

Current level of Care: Routine hospice level of care at home.

Patient Status / Evidence of Decline noted in past 2 weeks: Coughing/choking with eating and dinking. Generalized edema to bilateral lower extremities and right upper extremities. Bilateral lower extremities ruddy when in sitting up for 1 minute.

Symptom Management Focus includes (pharmacologic/ non-pharmacologic) : Bilateral feet treated with antifungal ointment. Constipation palliated with medication. Skin integrity to coccyx/buttocks preventatively treated with barrier lotion and alternating pressure mattress. Pruritus managed with multiple lotions. ADLs assistance with both private caregiver and HHA services provided. Up into broda chair mid morning through later afternoon. Pt reclined in chair to offset continuous pressure. Increased sleeping and napping. Intermittently naps throughout the day.

Emotional Spiritual needs/support of patient /family: MSW and music therapy involved

Identified or On-going educational needs for patient/family: Teach and instruct on safe swallowing with easier to swallow puree foods and thickened liquids.

Medical Social Work note by [REDACTED]

This gentleman was in a 5 day respite from [REDACTED] so his wife and live in caregiver could both have a break/ No issues were reported/

Spiritual Counseling [REDACTED]

Patient receives spiritual care through companionship, empathy, active listening, affirmation, prayer, music, and contextual devotional readings.



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## 2. Practical Tools

## Using our EMR as a practical tool for survey readiness

- ❖ Types of support through our EMR for quality measures
- ❖ Utilizing existing reports (plan of care, caseloads, HIS/HOPE)
- ❖ Creating specialized reports (IDG prep, falls report, HHA supervision, bereavement templates that address acuity in bereavement contacts, etc)
- ❖ Creating templates to support meaningful documentation for IDG, Smart language or smart text



What special capabilities does your EMR have to improve the quality of your IDT discussions?

## Custom Fall reports

Hospice Fall Report [8598130] as of Wed 7/30/2025 3:32 PM

Chart Intake Hospital Account Hospice Discharge/Non-Admit

Detail List Explore

Filter

Visit Date	Encounter	Provider	Provider Phone Number	Patient Name	MRN	Contact Type (HH/HSPC)	Type of Service	Episode Type
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	FALL REPORT	[REDACTED]	Hospice
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	FALL REPORT	[REDACTED]	Hospice

Home Health/Hospice Encounter - Reporting Workbench Detailed View

Fall Report

Has the patient fallen, slipped or tripped since the last home/facility visit?: yes  
 How many falls has the patient had since the last home/facility visit?: 1  
 On what date did the fall occur?: 7/6/25  
 Was the fall witnessed?: no  
 What type of injury resulted from the fall?: minor injury  
 Describe the fall: [REDACTED]

### 3. Communication

Connecting the patient/family with their plan of care

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With the goal to communicate better with patient's and families, we created a **working tool** that can be used by all team members, patients and their caregivers, to improve communication and elevate satisfaction

- Example: Home Program (pink)



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# Home Teaching Program

Promotes continuity between the plan of care and the patient's home.  
 Encourages active collaboration and engagement at the bedside and between care-providers

VNA of Cape Cod  
Hospice

Patient Name: \_\_\_\_\_  
 Transfer assist required: \_\_\_\_\_ Device used: \_\_\_\_\_  
 Shower: YES NO DME to use: \_\_\_\_\_ (Equipment MUST be in place for aide to assist with shower)  
 Precautions/Mobility Restrictions: \_\_\_\_\_

**HOSPICE HOME CARE PROGRAM**

Date	Patient recommended home program activities for Hospice PATIENT/CAREGIVER to CALL VNA to report changes in symptoms Specific Recommendations & Home Activities initiated by Clinician; Assisted by Caregiver	Clinician Initials



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# Hospice Home Teaching Program continued

- ❖ Identify basic demographics about the patient
- ❖ Identify specialized functional needs
- ❖ Identify precautions that the family and team would need to identify to best care for the patient

VNA of Cape Cod  
Hospice

Patient Name: Jack Smith  
 Transfer assist required: Stand by Assist Device used: Rollator with seat  
 Type of Bath: DME to use: Sponge bath (Equipment MUST be in place for aide to assist with shower)  
 Precautions/Mobility Restrictions: Shortness of breath with exertion, fall safety and swallowing precautions

## Hospice Home Teaching Program continued

The first teaching component informs the patient, hospice aide/hospice team and family about the special interventions that will be provided for Jack's comfort

VNA of Cape Cod  
Hospice

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Transfer assist required: Stand by Assist Device used: Rollator with seat

Type of Bath: DME to use: Sponge bath (Equipment **MUST** be in place for aide to assist with shower)

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**Hospice HOME CARE PROGRAM**

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10/1/25	<p><b>Specific Recommendations &amp; Home Activities</b> initiated by Clinician; Assisted by Caregiver</p> <p><b>ACTIVITY:</b> any activity increases Jack's shortness of breath</p> <ul style="list-style-type: none"> <li>• Space activities to allow for rest.</li> <li>• Conserve energy by using a wheelchair for getting to kitchen.</li> <li>• Encourage rest for 1 hour before meals.</li> <li>• Use 2 L/min of oxygen with activity.</li> </ul>	

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## Hospice Home Teaching Program continued

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This is a completed form including strategies to address Jack's swallowing and sleep

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This is what bridging the gap between meeting hospice regulations and creating meaningful outcomes for patients and families

- 1. Reforming our Interdisciplinary process for documentation
- 2. Using the practical tools within our existing EMR
- 3. Creating a collaborative communication tool to connect Plan of Care to the patient/ family at the bedside

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## Unexpected outcomes

While our goal was to improve patient/ family care, support, satisfaction and education , we had bonus outcomes

Staff expressed

- Feeling appreciated for their work/ effort
- Empowered to do their jobs better with improved collaboration
- Feeling more connected
  - Happy to be part of the process and successful transition
  - Medical directors and Nurse Practitioners expressed appreciation for the concise documentation



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Now  
our path  
forward is  
visable



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4. One project end....a new one starts

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**Who:** defining roles and who can provide insight

**What:** what tools support staff documentation and quality monitoring

**When:** when does QI/ Education take the lead, when does operational leadership

**How:** How do we use different communication strategies

**Why:** What are our common goals

## How do we continue to engage our clinicians in quality?



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New templates for other documentation areas

Follow up

Using the Fall Report to expand oversight of data collection for trends and cross checked against occurrences

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Questions,  
comments or  
feedback?

