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HRSA Service Category Title: <b>(RWGA only)</b>	<b>Hospice Services</b>
Local Service Category Title:	<b>Hospice Care</b>
Budget Type: <b>(RWGA only)</b>	<b>Unit Cost</b>
Budget Requirements or Restrictions: <b>(RWGA only)</b>	Not applicable.
HRSA Service Category Definition: <b>(RWGA only)</b>	<i>Hospice services</i> include room, board, nursing care, counseling, physician services, and palliative therapeutics provided to clients in the terminal stages of illness in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services for terminal clients. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Programs.
Local Service Category Definition:	Services, including services provided by unlicensed personnel under the delegation of a registered nurse or physical therapist, provided to a client or a client's family as part of a coordinated program consistent with the standards and rules adopted under this chapter. These services include palliative care for terminally ill clients and support services for clients and their families.
Target Population (age, gender, geographic, race, ethnicity, etc.):	Individuals diagnosed with AIDS residing in the Houston Eligible Metropolitan Area (EMA).
Services to be Provided:	Services must include but are not limited to medical and nursing care, palliative care, psychosocial support and spiritual guidance for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Programs.
Service Unit Definition(s): <b>(RWGA only)</b>	A unit of service is defined as one day of hospice services including admission and discharge dates that includes a full range of physical and psychological support to HIV patients in the final stages of AIDS.
Financial Eligibility:	Refer to the RWPC's approved <i>Financial Eligibility for Houston EMA Services</i> .
Client Eligibility:	Individuals with an AIDS diagnosis and physician certification that the client (patient) is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less.
Agency Requirements:	Provider must be licensed by the Texas Department of State Health

	Services as a hospital, special hospital, special care facility or Home and Community Support Services Agency. Agency must have the capability to bill Medicaid/Medicare for clients served at Medicaid eligible facilities.
Staff Requirements:	Services must be provided by a medically directed interdisciplinary team, qualified in treating individual requiring hospice services.
Special Requirements: <b>(RWGA only)</b>	<p>These services must be:</p> <ul style="list-style-type: none"> <li>a) Available 24 hours a day, seven days a week, during the last stages of illness, during death, and during bereavement;</li> <li>b) Provided by a medically-directed interdisciplinary team;</li> <li>c) Provided in a home, nursing home, residential unit, or inpatient unit according to need. These services do not include inpatient care normally provided in a licensed hospital to a terminally ill person who has not elected to be a hospice client.</li> </ul>

FY 2012 Service Category Definition - Ryan White Part A  
 March 15, 2011

***FY 2012 RWPC “How to Best Meet the Need” Decision Process***

<b>Step in Process: Council</b>		Date: 06-09-11
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		
<b>Step in Process: Steering Committee</b>		Date: 06-02-11
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		
<b>Step in Process: Quality Assurance Committee</b>		Date: 05-19-11
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		
<b>Step in Process: HTBMTN Workgroup #2</b>		Date: 04-26-11
Recommendations:	Financial Eligibility:	
1.		
2.		
3.		

Local Service Category:	<b>Hospice Services</b>
Amount Available:	<b>To be determined</b>
Unit Cost	
Budget Requirements or Restrictions:	Maximum 10% of budget for Administrative Cost
Local Service Category Definition:	<p>Hospice services encompass palliative care for terminally ill clients and support services for clients and their families. Services are provided by a licensed nurse and/or physical therapist. Additionally, unlicensed personnel may deliver services under the delegation of a licensed nurse or physical therapist, to a client or a client's family as part of a coordinated program. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less.</p> <p>Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Programs.</p>
Target Population (age, gender, geographic, race, ethnicity, etc.):	Individuals with AIDS residing in the Houston HIV Service Delivery (HSDA).
Services to be Provided:	Services must include but are not limited to medical and nursing care, palliative care, psychosocial support and spiritual guidance for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program.
Service Unit Definition(s):	A unit of service is defined as one (1) twenty-four (24) hour day of hospice services that includes a full range of physical and psychological support to HIV patients in the final stages of AIDS.
Financial Eligibility:	Income at or below 300% Federal Poverty Guidelines.
Client Eligibility:	Individuals with an AIDS diagnosis and certified by a physician as having a life expectancy of 6 months or less.
Agency Requirements:	Provider must be licensed by the Texas Department of State Health Services as a hospital, special hospital, special care facility or Home and Community Support Services Agency with Hospice Designation. Agency must have the capability to bill for Medicaid eligible clients served.
Staff Requirements:	Services must be provided by a medically directed interdisciplinary team, qualified in treating individual requiring hospice services.
Special Requirements:	<p>These services must be:</p> <ol style="list-style-type: none"> <li>Available 24 hours a day, seven days a week, during the last stages of illness, during death, and during bereavement;</li> <li>Provided by a medically directed interdisciplinary team;</li> <li>Provided in nursing home, residential unit, or inpatient unit according to need. These services do not include inpatient care normally provided in a licensed hospital to a terminally ill person who has not elected to be a hospice client.</li> </ol> <p>Must comply with the Joint Part A/B Standards of Care.</p>

Service Category Definition - Ryan White Part B Grant  
 April 1, 2010 - March 31, 2011

***FY 2012 RWPC “How to Best Meet the Need” Decision Process***

<b>Step in Process: Council</b>		Date: 06-09-11
Recommendations:	Approved: Y_____ No: _____ Approved With Changes: _____	If approved with changes list changes below:
1.		
2.		
3.		
<b>Step in Process: Steering Committee</b>		Date: 06-02-11
Recommendations:	Approved: Y_____ No: _____ Approved With Changes: _____	If approved with changes list changes below:
1.		
2.		
3.		
<b>Step in Process: Quality Assurance Committee</b>		Date: 05-19-11
Recommendations:	Approved: Y_____ No: _____ Approved With Changes: _____	If approved with changes list changes below:
1.		
2.		
3.		
<b>Step in Process: HTBMTN Workgroup #2</b>		Date: 04-26-11
Recommendations:	Financial Eligibility:	
1.		
2.		
3.		

DSHS STATE SERVICES  
1112 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE  
HOSPICE SERVICES

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.1	<p><u>Scope of Service</u> Hospice services encompass palliative care for terminally ill clients and support services for clients and their families. Services are provided by a licensed nurse and/or physical therapist. Additionally, unlicensed personnel may deliver services under the delegation of a licensed nurse or physical therapist, to a client or a client's family as part of a coordinated program. <u>A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less.</u></p> <p><u>Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Programs.</u></p>	<ul style="list-style-type: none"> <li>• Program's Policies and Procedures indicate compliance with expected Scope of Services.</li> <li>• Documentation of provision of services compliant with Scope of Services present in client files.</li> </ul>
9.2	<p><u>Client Eligibility</u> In addition to general eligibility criteria, , individuals must meet the following criteria in order to be eligible for services:</p> <ul style="list-style-type: none"> <li>• Referred by a licensed physician</li> <li>• Deemed by his or her physician to be terminally ill as defined as having six (6) months or less to live</li> <li>• Must be reassessed by a physician every six (6) months</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation of HIV+ status, residence, identification and income in the client record</li> </ul>
9.3	<p><u>Clients Referral and Tracking</u> Agency receives referrals from a broad range of HIV/AIDS service providers and makes appropriate referrals out when necessary.</p>	<ul style="list-style-type: none"> <li>• Documentation of referrals received.</li> <li>• Documentation of referrals out</li> <li>• Staff reports indicate compliance</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.4	<u>Ongoing Staff Training</u> <ul style="list-style-type: none"> <li>• Eight (8) hours of training in HIV/AIDS and clinically-related issues is required annually for licensed staff (in addition to training required in General Standards).</li> <li>• One (1) hour of training in HIV/AIDS is required annually for all other staff (in addition to training required in General Standards).</li> </ul>	<ul style="list-style-type: none"> <li>• Materials for staff training and continuing education are on file</li> <li>• Documentation of training in personnel file</li> </ul>
9.5	<u>Staff Experience</u> A minimum of one year documented hospice and/or HIV/AIDS work experience is preferred.	<ul style="list-style-type: none"> <li>• Documentation of work experience in personnel file</li> </ul>
9.6	<u>Staff Requirements</u> Hospice services must be provided under the delegation of an attending physician and/or registered nurse.	<ul style="list-style-type: none"> <li>• Review of personnel file indicates compliance</li> <li>• Staff interviews indicate compliance</li> </ul>
9.7	<u>Volunteer Assistance</u> Volunteers cannot be used to substitute for required personnel. They may however provide companionship and emotional/spiritual support to patients in hospice care. Volunteers providing patient care will: <ul style="list-style-type: none"> <li>• Be provided with clearly defined roles and written job descriptions</li> <li>• Conform to policies and procedures</li> </ul>	<ul style="list-style-type: none"> <li>• Review of agency's Policies &amp; Procedures Manual indicates compliance</li> <li>• Documentation of all training in volunteer files</li> <li>• Signed compliance by volunteer</li> </ul>
9.8	<u>Volunteer Training</u> Volunteers may be recruited, screened, and trained in accordance with all applicable laws and guidelines. Unlicensed volunteers must have the appropriate State of Texas required training and orientation prior to providing direct patient care. Volunteer training must also address program-specific elements of hospice care and HIV/AIDS. For volunteers who are licensed practitioners, training addresses documentation practices.	<ul style="list-style-type: none"> <li>• Review of training curriculum indicates compliance</li> <li>• Documentation of all training in volunteer files</li> </ul>
9.9	<u>Staff Supervision</u> Staff services are supervised by a paid coordinator or manager. Professional supervision shall be provided by a practitioner with at least two years experience in hospice care of persons with HIV. All licensed personnel shall received supervision consistent with the State of Texas license requirements.	<ul style="list-style-type: none"> <li>• Review of personnel files indicates compliance.</li> <li>• Review of agency's Policies &amp; Procedures Manual indicates compliance</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.10	<u>Facility Licensure</u> Agency has and maintains a valid Texas Special Care Facility license and an AIDS Hospice designation.	<ul style="list-style-type: none"> <li>Documentation of license and/or certification is available at the site where services are provided to clients</li> </ul>
9.11	<u>Multidisciplinary Team Care</u> Agency must use a multidisciplinary team approach to ensure that patient and the family receive needed emotional, spiritual, physical and social support. The multidisciplinary team may include physician, nurse, social worker, nutritionist, chaplain, patient, physical therapist, occupational therapist, care giver and others as needed. Team members must establish a system of communication to share information on a regular basis and must work together and with the patient and the family to develop goals for patient care.	<ul style="list-style-type: none"> <li>Review of agency's Policies &amp; Procedures Manual indicates compliance</li> <li>Documentation in client's records</li> </ul>
9.12	<u>Comprehensive Health Assessment</u> A comprehensive health assessment, including medical history, a psychosocial assessment and physical examination, is completed for each patient within 48 hours of admission and once every six months thereafter. Symptoms assessment (utilizing standardize tools), risk assessment for falls and pressure ulcers must be part of initial assessment and should be ongoing. Medical history should include the following components: <ul style="list-style-type: none"> <li>History of HIV infection and other co morbidities</li> <li>Current symptoms</li> <li>Systems review</li> <li>Past history of other medical, surgical or psychiatric problems</li> <li>Medication history</li> <li>Family history</li> <li>Social history</li> <li>A review of current goals of care</li> </ul> Clinical examination should include all body systems, neurologic and mental state examination, evaluation of radiologic and laboratory test and needed specialist assessment.	<ul style="list-style-type: none"> <li>Documentation in client record</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.13	<p><u>Plan of Care</u></p> <p>Following history and clinical examination, the provider should develop a problem list that reflects clinical priorities and patient's priorities.</p> <p>A written Plan of Care is completed for each patient within 48 hours of admission and once every six months thereafter or more frequently as clinically indicated. Hospice care should be based on the USPHS guidelines for supportive and palliative care for people living with HIV/AIDS ( <a href="http://hab.hrsa.gov/tools/palliative/contents.html">http://hab.hrsa.gov/tools/palliative/contents.html</a>) and professional guidelines</p>	<ul style="list-style-type: none"> <li>• Documentation in patient record</li> </ul>
9.15	<p><u>Medication Administration Record</u></p> <p>Agency documents each patient's scheduled medications. Documentation includes patient's name, date, time, medication name, dose, route, reason, result, and signature and title of staff.</p>	<ul style="list-style-type: none"> <li>• Documentation in patient record</li> </ul>
9.16	<p><u>PRN Medication Record</u></p> <p>Agency documents each patient's PRN medications. Documentation includes patient's name, date, time, medication name, dose, route, reason, result, and signature and title of staff.</p>	<ul style="list-style-type: none"> <li>• Documentation in patient record</li> </ul>
9.17	<p><u>Physician Orders</u></p> <p>Patient's physician orders are documented.</p>	<ul style="list-style-type: none"> <li>• Documentation in patient record</li> </ul>
9.18	<p><u>Bereavement and Counseling Services</u></p> <p>The need for bereavement and counseling services for family members must be assessed and a referral made if requested.</p>	<ul style="list-style-type: none"> <li>• Documentation in patient record</li> </ul>
9.19	<p><del><u>Termination of Services</u></del></p>	<p><del>• Documentation in patient record</del></p>

**Ryan White Part A Quality Management Program–Houston EMA**

# **Hospice Care Chart Review FY 2010**

**Prepared by Harris County Public Health &  
Environmental Services – Ryan White Grant Administration**

**August 2010**

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## Introduction

Part A funds of the Ryan White Care Act are administered in the Houston Eligible Metropolitan Area (EMA) by the Ryan White Grant Administration Section of Harris County Public Health & Environmental Services. During FY 2010, a comprehensive review of patient hospice records was conducted for services provided between 3/1/09 to 2/28/10. This review conducted with the only Part A funded provider of Adult Hospice Care in the Houston EMA.

The primary purpose of this annual review process is to assess Part A hospice care provided to persons living with HIV in the Houston EMA. Ryan White Grant Administration manages the review process and analyzes the subsequent data, while the reviews are conducted by TMF Health Quality Institute (TMF), under contract with Ryan White Grant Administration. Unlike primary care, there are no federal guidelines published by the U.S Public Health Service for general hospice care targeting individuals with HIV/AIDS. Therefore, Ryan White Grant Administration has utilized the legal requirements of special care facilities and those designated as a residential AIDS hospice, outlined in the Texas Statutes Health & Safety Code and the Texas Administrative Code, as well as internal standards determined by the Adult Hospice Care provider, to measure the quality of Part A funded hospice care.

## Scope of This Report

This report provides background on the project, supplemental information on the design of the data collection tool, and presents the pertinent findings of the FY 2010 hospice care chart review. In addition to this report, the hospice care provider reviewed will also receive an electronic copy of the raw database in order to facilitate further analysis. Also, any additional data analysis of items or information not included in this report can likely be provided after a request is submitted to Ryan White Grant Administration.

## The Data Collection Tool

The data collection tool employed in the review was developed through a period of in-depth research and a series of working meetings between Ryan White Grant Administration and the review contractor, TMF. By researching rulings for special care facilities and those designated as a residential AIDS hospice in the state of Texas, a listing of potential data collection items was developed. Further research provided for the editing of this list to yield what is believed to represent the most pertinent data elements for hospice care in the Houston EMA. Topics covered by the data collection tool include, but are not limited to the following: resident rights and resident records, including documented palliative care, bereavement services, support services, and plan of care. See Appendix B for a copy of the tool.

## The Chart Review Process

All charts were reviewed by a masters-level registered nurse experienced in identifying documentation issues and assessing adherence to published guidelines. The RN has extensive experience conducting clinical chart reviews and also is a certified healthcare quality consultant. The collected data was recorded directly onto the tool and this information was entered into a preformatted database. Once all data collection and data entry is completed, the database is forwarded to Ryan White Grant Administration for analysis. The data collected during this process is intended to be used for the purpose of service improvement.

The specific parameters established for the data collection process were developed from specialty care facility/residential AIDS hospice care rulings and the professional experience of the reviewer on standard record documentation practices. Table 1 summarizes the various documentation criteria employed during the review.

## The Chart Review Process (cont'd)

**Table 1. Data Collection Parameters**

Review Area	Documentation Criteria
Administrative Management	Documentation in the patient record includes, but is not limited to the following: Patient acknowledgement of receipt of Guidelines for Residence, documentation of patient signature for Informed Consent (addresses patient acknowledgement of receipt of Resident Rights), Personal Effects Inventory, and consent for the Release of Confidential Information.
Care and Services	Documentation in the patient record includes, but is not limited to the following: Client Demographics, Physician Orders, Medication Records, a Nursing & Psychosocial Assessment, Initial Plan of Care/Plan of Care Updates, and evidence of bereavement and support services where applicable.

## The Sample Selection Process

The sample population was selected from a pool of 65 unduplicated clients who accessed Part A hospice care between 3/1/09 and 2/28/10. The medical charts of 25 of these clients were used in the review, representing 38% of the pool of unduplicated clients.

Ryan White Grant Administration uses the EMA's Centralized Patient Care Data Management System (CPCDMS) to generate a sample of client codes that is representative of the total Part A population that accesses a particular service. The sample selector, which is a built-in function of CPCDMS, produces a sample that mirrors the demographic make up (race, ethnicity, gender, age, and stage of illness) of the total population for the service of interest. Randomly generated client codes were categorized in terms of stage of illness, as delineated by CPCDMS, in order to allow for assessment of a range of care.

In the case of hospice, both the size of the sample in proportion to the unduplicated clients accessing hospice care, as well as the use of the CPCDMS sample selector, ensure adequate representation of the clients who received care between 3/1/09 and 2/28/10.

- Asymptomatic CD4 > = 500
- Asymptomatic CD4 200-499
- Asymptomatic CD4 < 200
- Symptomatic CD4 > = 500
- AIDS CD4 < 200
- Symptomatic CD4 200-499
- Symptomatic CD4 < 200
- AIDS CD4 > = 500
- AIDS CD4 200-499

A list of client codes was forwarded to the reviewer and corresponding agency 5-10 business days before the review was scheduled to commence.

## Characteristics of the Sample Population

It is important to note that the chart review findings in this report apply only to those who receive hospice care from a Part A provider and cannot be generalized to all Ryan White clients or to the broader population of persons with HIV or AIDS. Table 2 illustrates the demographic characteristics of the sample population for FY 2009.

<b>Table 2. Demographic Characteristics of FY 09 Houston EMA Ryan White Part A Hospice Care Clients</b>				
	<b>Sample</b>		<b>Ryan White Part A EMA</b>	
<b>Race/Ethnicity</b>	Number	Percent	Number	Percent
African American	14	56%	39	60%
White	11	44%	24	37%
Asian	0	0%	1	2%
Native Hawaiian/Pacific Islander	0	0%	0	0%
American Indian/Alaska Native	0	0%	1	2%
Multi-Race	0	0%	0	0%
	<b>25</b>	<b>100%</b>	<b>65</b>	<b>100%</b>
<b>Hispanic Status</b>				
Hispanic	3	12%	11	17%
Non-Hispanic	22	88%	54	83%
	<b>25</b>	<b>100%</b>	<b>65</b>	<b>100%</b>
<b>Gender</b>				
Male	18	72%	42	65%
Female	7	28%	22	34%
Transgender	0	0%	1	2%
	<b>25</b>	<b>100%</b>	<b>65</b>	<b>100%</b>
<b>Age</b>				
18 – 24	1	4%	1	2%
25 – 34	3	12%	11	17%
35 – 44	7	28%	23	35%
45 – 54	7	28%	17	26%
55 – 64	5	20%	10	15%
65+	2	8%	3	5%
	<b>25</b>	<b>100%</b>	<b>65</b>	<b>100%</b>
<b>Stage of Illness</b>				
Asymptomatic, CD4 >=500	2	8%	7	11%
Asymptomatic, CD4 200-499	1	4%	1	2%
Asymptomatic, CD4 <200	0	0%	0	0%
Symptomatic, CD4 >=500	1	4%	1	2%
Symptomatic, CD4 200-499	0	0%	1	2%
Symptomatic, CD4 <200	0	0%	1	2%
AIDS, CD4 >=500	0	0%	2	3%
AIDS, CD4 200-499	4	16%	8	12%
AIDS, CD4 <200	17	68%	39	60%
HIV Positive/Status Unknown	0	0%	5	8%
HIV Negative/Status Unknown	0	0%	0	0%
	<b>25</b>	<b>100%</b>	<b>65</b>	<b>100%</b>

## Findings

Rule §125.6 of the Texas Administrative Code (TAC) outlines standards of special care facilities that must be adopted, implemented, and enforced. Such standards include administrative management, construction standards, personal safety and comfort, maintaining a sanitary environment, accommodations, and care & services. This review focuses on standards for administrative management and care & services.

### *Administrative Management*

#### Informed Consent (including Patient Acknowledgement of Receipt of Residents Rights)

- 96% (100% - FY 09, 100%-FY 08) of records reviewed documented the patient/rep signature

#### Patient Acknowledgement of Receipt of Guidelines for Residence

- 96% (100% - FY 09, 100%-FY 08) of records reviewed contained a Patient Acknowledgement of Receipt of Disposition Guidelines for Residence

#### Consent for the Release of Confidential Information

- 96% (100% - FY 09, 100%-FY 08) of records reviewed documented the patient/rep signature.

#### Physician Death Notification

- 100% (100% - FY 09, 100%-FY 08) of applicable records reviewed had a completed death notification form.

#### Coroner Information Sheet

- 0% (100% - FY 09, 100%-FY 08) of applicable reviewed records contained a completed Coroner Information Sheet.

#### Resident Information

- 64% (40% - FY 09, 40%-FY 08) of records reviewed indicated on the resident register the client was homeless.
- 100% (100% - FY 09, 100%-FY 08) of applicable records reviewed documented a discharge plan.
- 96% (96% - FY 09, 96%-FY 08) of sampled patients were screened for substance abuse.
- 0% of records reviewed (4% - FY 09, <1%-FY 08) indicated active substance abuse on the resident register.
- 96% (100% - FY 09) of reviewed records documented a completed Admission Orientation Checklist.
- Patients spent an average of 62 days in care. Finding from the 2009 review indicated patient spent, on average 54 in hospice care.
- 20% of patients are discharged from care. (24% - FY 09)

### *Care and Services*

#### Nursing & Psychosocial Assessment

- 100% (100%-FY 09, 100%-FY 08) of records reviewed documented a completed nursing assessment.
- The psychosocial screening was completed in 88% (93%-FY 09, 97%-FY 08) of applicable records reviewed.
- No psychosocial needs were identified in the review of the applicable records (7% - FY 09).
- 20% (18%- FY 09) of records reviewed indicated the client suffered from dementia.

#### Pain Management

- 96% (91%-FY 09) of review records contained a pain management assessment tool.
- 72% (78%-FY 09) of reviewed records identified a need of pain intervention.
- Adverse outcomes, such as bed sores, etc., were documented in 4% of reviewed records (7% - FY 09).
- Patient response to treatment was documented in 100% of applicable reviewed records (100%-FY 09).

*Care and Services cont'd*

Medications

- Admission Medication Record:
  - 100% (100%-FY 09, 100%-FY 08) of records reviewed had documented the admission medication record with all scheduled meds.
- Pain Medication Record:
  - 100% (100%-FY 09, 100%-FY 08) of reviewed records documented pain medication when a pain intervention was indicated.

Physician Orders and Plan of Care

- Admission Orders:
  - 100% (100%-FY 09, 100%-FY 08) of records reviewed contained completed Admission Orders.
- Advanced Directive:
  - 88% (96%-FY 09, 100%-FY 08) of records reviewed contained completed Advance Directives.
- Care Plan:
  - 100% (100%-FY 09, 100%-FY 08) of records reviewed contained current and complete Plan of Care.

Tuberculosis

- 100% (82%-FY 09) of records reviewed contained documentation of TB screening.
- None of reviewed records documented a need for TB treatment (7% - FY 09).

Spiritual Services

- 88% (89%-FY 09, 100%-FY 08) of reviewed records contained a spiritual needs assessment for the patient.
- 52% (80%-FY 09, 89%-FY 08) of applicable records identified needs for spiritual support services for patients.
- 94% (89%-FY 09, 100%-FY 08) of applicable records contained a spiritual needs assessment for the family.
- 50% (90%-FY 09, 88%-FY 08) of applicable records identified needs for spiritual support services for client's families.
- Where a need was identified, 100% (100%-FY 09, 100%-FY 08) of applicable family records contained a spiritual service referral and 100% (97%-FY 09, 100%-FY 08) of applicable patient records contained a spiritual service referral.

Care Education

- 76% (91%-FY 09, 100%-FY 08) of applicable records reviewed documented evidence of patient teaching.
- 94% (100%-FY 09, 100%-FY 08) of applicable records reviewed documented evidence of family teaching.

## Conclusions

The findings of the FY 10 Hospice Care Chart Review illustrate a continuation of the provider's consistent, superior performance in the documentation of administrative management and service delivery requirements (care & services) per TAC when compared to findings in the FY 09 review.

The data collection tool used in this year's chart review process focused less on administrative documentation and more on quality of life issues such as pain management. In examining these areas, chart review findings demonstrated excellent care. Although there was a slight decrease in the percentage of reviewed records with a pain assessment tool, the rate remains high (96%-FY 10, 100%-FY 09). Additionally, of the 72% of reviewed records that identified a need for a pain management intervention, 100% of those records documented a pain management strategy.

Based on the history of superior care by our hospice provider and the relatively small number of clients for which this service offers care, the sample size for this year's chart review was reduced by approximately 50% of the number of charts reviewed during FY 09. However, the results of this year's findings still serve as a reliable indicator of the quality of care delivered by our provider, as 38% of the records for the total population served were reviewed. We look forward to continued excellent care in the coming year.

## Appendix A—FY 10-HOSPICE Chart Review Data Collection Tool

Mar 1, 09 to Feb 28, 10 Site: 1= XXXX Date: \_\_\_\_\_ # \_\_\_\_\_

Pt. ID # \_\_\_\_\_ Site Code: \_\_\_\_\_

1. AGE: \_\_\_\_\_ Stage of Illness: \_\_\_\_\_

2. Sex: **1 – Male 2- Female 3-Transgender**

4. Admission Date: \_\_\_\_\_

5. Discharge Date (other than death): \_\_\_\_\_ Date of Death: \_\_\_\_\_

6. Medical record contains patient acknowledgement of receipt of Resident's Rights (on Informed Consent):

**Y-Yes, pt/rep signed N-No, not found**

7. Medical record contains patient acknowledgement of receipt of "Guidelines for Residence" regulations including disposition guidelines:

**Y-Yes, pt/rep signed N-No, not found**

8. Medical record contains patient signature giving "Informed Consent for Resident Participation":

**Y-Yes, pt/rep signed N-No, not found**

9. Medical record contains patient signature giving most recent "Consent for Release of Confidential Information":

**Y-Yes, pt/rep signed N-No, not found**

10. The *Admission Orientation Checklist* as found on the "Admission Info/Resident Information" is:

**Y-Yes, complete N-No, not complete**

11. The medical record contains Admission Orders:

**Y-Yes N-No, not found**

12. The medical record contains Advanced Directive:

**Y-Yes N-No, not found**

13. The medical record contains "Medication Administration Record"

**Y-Yes N-No, not found**

14. The medical record contains current Plan of Care:

**Y-Yes N-No, not found**

15. "Resident Register/Demographics" form states client is homeless:

**Y-Yes, homeless N-No, not homeless**

16. The medical record contains TB Screening

**Y-Yes N-No, not found**

17. The medical record contains documentation of prescribed TB treatment.

**Y-Yes N-No, not found N/A**

18. The medical record contains documentation of the continuation of TB treatment.

**Y-Yes N-No, not found N/A**

**Hospice Chart Review Data Collection Tool** (continued)

19. The medical record documents client has been screened active substance abuse (SA):  
**Y-Yes            N-No**
20. Nursing Assessment & Psychosocial Assessment forms states client has active substance abuse (SA):  
**Y-Yes, active SA            N-No active SA**
21. The medical record documents contains Substance Abuse referral:  
**Y-Yes            N-No            NA**
22. The medical record documents client has been screened active psychiatric illness (MI) (other than Dementia):  
**Y-Yes            N-No**
23. Nursing Assessment & Psychosocial Assessment forms states client has active psychiatric illness (MI):  
**Y-Yes, active psychiatric illness            N-No active psychiatric**
24. The medical record documents contains psychiatric referral:  
**Y-Yes            N-No            NA**
25. The medical record documents patient has Dementia:  
**Y-Yes            N-No**
26. The medical record Pain Assessment Tool:  
**Y-Yes            N-No**
27. Patient identified with pain management need:  
**Y-Yes            N-No**
28. Documented pain intervention:  
**Write-in Value**
29. The medical record documents patient response to treatment:  
**Y-Yes            N-No            NA**
30. The medical record includes evidence and documentation of screening for Spiritual Service needs for patient:  
**Y-Yes            N-No**
31. Patient identified with Spiritual Services need:  
**Y-Yes            N-No**
32. The medical record includes evidence and documentation of screening for Spiritual Service needs for patient family:  
**Y-Yes            N-No            NA-NA, no family**
33. Family identified with Spiritual Services need:  
**Y-Yes            N-No**
34. The medical record documents contains Spiritual referral:  
**Y-Yes            N-No            NA-No Need Identified**

Hospice Chart Review Data Collection Tool (continued)

35. The medical record includes evidence and documentation of patient teaching:

**Y-Yes            N-No            NA**

36. The medical record includes evidence and documentation of family teaching:

**Y-Yes            N-No            NA**

37. The medical record contains a completed Coroners Information Sheet:

**Y-Yes            N-No            NA-NA, pt not deceased**

38. Physician is notified of patient's death :

**Y-Yes            N-No            NA-NA, pt not deceased**

## Appendix B – Resources

Texas Administrative Code. Title 25, Part I, Chapter 125, Rule §125.6—Standards. Amended to be effective February 9, 2000, 25 TexReg 787.

Texas Statutes Health & Safety Code. Title 4, Chapter 248, §248.029—Residential AIDS Hospice Designation. Effective September 1, 1993.

# The Benefits of Hospice Care for the Terminally Ill

By Bridgette Gilchrist

This year thousands of people will suffer from a life threatening or terminal illness and not receive the help available to them through a hospice program. There are many reasons for this. One primary reason is that families do not want to bring up the word "hospice" to their loved ones because they feel it will dash their hope of recovery. Many families are in denial that their loved ones will die and urge the patient to continue drugs that make them so sick, their quality of life is miserable. Hospice is a service that can provide not only care for the patient but also emotional and spiritual support to everyone involved. It's available to patients of any age, race, religion or illness. Hospice is covered under Medicare, Medicaid and most private insurance plans. They focus on caring, not curing. Most of their patients have been diagnosed with a life expectancy of 6 months or less. Hospice is available 24 hours a day, 7 days a week.

## Takeaways

- Hospice is a family-centered approach
- Counseling services are available
- Medicare and Medicaid will pay 100% of hospice

Hospice is a family-centered approach that includes nurses, social workers, counselors and trained volunteers. They focus on the dying patient's physical, psychological, and spiritual needs. The goal is to help keep the patient as pain-free as possible, with family near by until death. They will provide needed medications, medical supplies and equipment. They will coach the family on how to care for their loved one. They will deliver special services like speech and physical therapy when needed. The majority of hospice patients are cared for in their own home. Hospice does not make all the decisions for your loved one. Typically, a family member serves as the primary caregiver and, when appropriate, make decisions for the terminally ill individual.

Counseling services for the patient and loved ones are an important part of hospice. After the patient's death, bereavement support is offered to families. These services can take place in a variety of forms, including telephone calls, visits, written materials about grieving, and support groups. Individual counseling is also offered or they may make a referral to a community resource.

Medicare will pay hospice for all your hospice care. You will pay no more than \$5.00 for each prescription drug and other similar products. To receive all the free service hospice provides, the patient's doctor will need to set up a referral. A simple phone call to your doctor is all it takes to get the program started. You may start or stop hospice any time.

Investigating the hospice program is something every terminally ill patient should look into. If you feel you are not ready to make that step, interviewing a hospice representative can at least give you insight on what they can do for your family and help you make better decisions regarding your loved one's future. By having educated decisions made in advance, uncomfortable situations can be avoided.

More resources

[hospice.com](http://hospice.com)

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# Discussing end-of-life care lowers cost: U.S. study REUTERS

Mon Mar 9, 4:07 pm ET

By Andrew Stern

CHICAGO (Reuters) - Terminally ill patients who talk over end-of-life treatments with their doctors spend less money and do not die any sooner but die more peacefully than those receiving aggressive care, researchers said on Monday.

Patients who have the discussion tend to opt for cheaper palliative care in a hospice or at home rather than costly treatments like emergency resuscitation, ventilators to breathe for them and movement to a hospital's intensive care unit.

The goal of palliative care is to relieve suffering rather than to halt progression or cure the disease.

If half of the estimated 566,000 American adult cancer patients who died in 2008 had the end-of-life discussion, the projected savings would conservatively be \$77 million, according to a report published in the Archives of Internal Medicine.

U.S. policymakers are hoping to find ways to rein in soaring healthcare costs, and researchers said end-of-life care merits a close look.

The one in 20 Medicare patients who die each year use up almost one-third of expenditures by Medicare, the government health insurance program for the elderly and disabled.

One third of expenses in the last year of life are spent in the final month, according to the report, with aggressive treatments in the final month accounting for 80 percent of those costs.

## WASTE OF MONEY

"This is a waste of money ... The real cost differences could be substantial," said Holly Prigerson of Dana-Farber Cancer Institute at Harvard, who helped perform the study.

The researchers interviewed 603 terminally ill cancer patients and estimated conservatively that those who spoke with their doctors about end-of-life care incurred \$1,876 in medical costs in their final week of life, compared to \$2,917 for those who did not.

After interviewing the patients' caregivers and nurses, the researchers concluded that palliative care led to more comfortable deaths, and aggressive care did not prolong life.

"The more aggressive care you get, the worse your quality of life. The longer you're in hospice and receive palliative care, the better your quality of life in that last week," Prigerson said.

Some patients do hope for a miracle cure, she said.

"We're not saying these conversations are easy," she said, suggesting physicians ill-equipped for the job pass it on to those that are, such as palliative care specialists. "Patients aren't significantly more distressed after these conversations. Letting false hope persist is not really helpful."

Another study published in the journal by Boston University researchers found that black and Hispanic Medicare patients incurred higher costs than whites in their final six months.

The intensive end-of-life treatments provided to minorities reverses the lifetime pattern where they received less medical care than whites, according to the report.

Researcher Amresh Hanchate and colleagues speculated that lack of familiarity or distrust of the medical system, as well as religious beliefs, could help account for the gap.

A third study showed patients fear their doctors abandon them as death approaches.

"Physicians are aware of this fear and attempt to address it with reassurance or continuity strategies. Yet, as death approaches, some patients and families may feel abandoned nonetheless," wrote Dr. Anthony Back of Fred Hutchinson Cancer Research Center and the University of Washington, Seattle.

(Editing by Maggie Fox and Cynthia Osterman)

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<http://www.sciencedaily.com/releases/2008/12/081222074603.htm>

## Eligibility Criteria Contribute To Racial Disparities In Hospice Use

ScienceDaily (Dec. 22, 2008) — A new study finds that hospice services—care that is provided by physicians, visiting nurses, chaplains, home health aides, social workers and counselors—have restrictions that reduce usage by many patients who are most in-need, particularly African Americans. The research, published in the February 1, 2009 issue of *CANCER*, a peer-reviewed journal of the American Cancer Society, indicates that the eligibility criteria for hospice services should be reconsidered.

In order to enroll in hospice, patients must have a prognosis of six months or less if their illness runs its usual course. They must also accept the palliative nature of hospice care. African American patients are less likely than white patients to use hospice, but the reasons for this difference have remained somewhat unknown.

In the current work, investigators at the University of Pennsylvania designed a study to explore the reasons for racial disparities in hospice care among cancer patients. To define and compare preferences for cancer treatment and perceived needs for hospice services among African-American patients and white patients, Dr. David Casarett and colleagues interviewed 283 patients who were receiving cancer treatment at six oncology clinics within the University of Pennsylvania Cancer Network. Patients were asked about their perceived need for five hospice services and their preferences for continuing cancer treatment, and they were followed for six months or until death. The researchers theorized that if disparities in hospice use were the result of preference for aggressive treatment among African Americans, then their rates of hospice use could be increased by redesigning hospice eligibility criteria. Conversely, if African Americans were less likely to want hospice services, then changes to the benefit may not be necessary, but modifications to the services that are offered may be warranted.

Dr. Casarett's team found that African-American patients had stronger preferences for continuing their cancer treatments as well as greater perceived needs for hospice services. The greater perceived need for hospice services among African Americans was attributed largely to differences in self-reported finances—poorer patients wanted more services.

"These findings suggest that the hospice eligibility criteria of Medicare and other insurers requiring patients to give up cancer treatment contribute to racial disparities in hospice use," the authors wrote. "Moreover, these criteria do not select those patients with the greatest needs for hospice services," they added.

The basis for these disparities is likely related to both cultural differences and economic characteristics. The results from this study indicate that hospice access could be made fairer by using eligibility criteria that are more directly need-based. For example, the investigators suggested that eligibility might be determined by assessing needs for specific hospice services such as pain or symptom management.

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**Journal Reference:**

1. Jessica Fishman, Peter O'Dwyer, Hien L. Lu, Hope Henderson, David A. Asch, and David J. Casarett. **Race, treatment preferences, and hospice enrollment: Eligibility criteria may exclude patients with the greatest needs for care.** *Cancer*, Published Online: December 22, 2008; Print February 1, 2009 DOI: [10.1002/cncr.24046](https://doi.org/10.1002/cncr.24046)

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