INDIANA ASSOCIATION FOR HOME & HOSPICE CARE

HOSPICE PLAN OF CARE CHECKLIST

CMS Requirement	Yes	No	Comments
Evidence all members of the IDG* participated in the development of the Plan of Care, including the • attending physician (if any), • the patient (or patient's representative) <u>and</u> • primary caregiver in accordance with the patient's needs if any of them so desire			
Plan of care is individualized			
Plan of care includes all services necessary for the palliation and management of the terminal illness and related conditions including: Interventions to manage pain and symptoms Detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs. • Measurable outcomes anticipated from implementing and coordinating the plan of care. • Drugs and treatment necessary to meet the needs of the patient. • Medical supplies and appliances necessary to meet the needs of the patient. • The interdisciplinary group's documentation of the patient's or <u>representative's level of understanding, involvement, and agreement</u> with the plan of care (in the record)			
Is there a direct link between the needs identified in the patient/family assessment and the plan of care (as such needs relate to the terminal illness and related conditions – any non-related needs can be documented but should be noted as non-related)			
Plan of care reflects patient and family goals and interventions based on problems identified in the assessments			
Evidence that the IDG is providing the care and services as delineated in the plan of care			
Evidence that the IDG is supervising the care and			

services			
Evidence that the patient and primary caregiver received education and training as appropriate to their responsibilities for the care and services identified in the plan of care.			
Evidence of a review of the plan of care • At least every 15 days or as the patient's condition requires • Performed by all members of the IDG in collaboration with the attending physician (if any)			
A revised plan of care includes • information from the patient's updated comprehensive assessment and • notes the patient's progress toward outcomes and goals specified in the plan of care.			

*Core members of the IDG are defined by CMS as:

- A doctor of medicine or osteopathy (who is an employee or under contract with the hospice).
- A registered nurse.
- A social worker.
- A pastoral or other counselor.