



Hospice Change Package

Provider Name: _____ Date: _____

Provider Number: _____ Name of Provider Contact Person: _____

Please Check One or More	Interventions	Targeted Population (Ex: Heart Failure, PN, or AMI patients)	Planned Start Date	Actual Start Date
1. Patient/Family Education				
	1a. Promote patient- and family-focused care; involve the patient and family in the development of the Plan of Care and in subsequent updating of the Plan of Care.			
	1b. Educate/reinforce with patients and families re: disease progressions and available care options in the home or LTC facility.			
	1c. Implement INTERACT tools such as Early Warning Assessment and End-of-Life Communication. Both are interventions designed to reduce acute care transfers among nursing home residents and can be found at www.qualitynet.org . Click on the MedQIC tab and type "INTERACT" in the search box.			
2. Advance Care Planning				
	2a. Educate patients and families re: disease progressions and available care options in the home or long-term care facility.			
	2b. Introduce INTERACT; implement INTERACT concepts and tools as appropriate (End-of-Life Communication Tools).			
	2c. Encourage staff to assist residents and families in advance care planning.			



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3. Multidisciplinary Staff Education				
	3a. Introduce all staff to Care Transitions.			
	3b. Educate clinicians on the identification of residents at risk of re-hospitalization; implement a hospital risk assessment (HRA) tool relevant to hospice services.			
4. Physician, Cross-provider, and Community Education				
	4a. Review/revise education to physicians, other providers, and community groups to incorporate concepts of transitional care coordination; utilize INTERACT communication tools as appropriate.			
5. Patient- and Family-centered Handover Communication				
	<p>5a. Promote effective communication channels with ED physicians and clinicians.</p> <ul style="list-style-type: none"> • Provider transfer of customized, real-time critical information about the patient to ED staff • Request timely information about the patient from other care providers (e.g., medications, laboratory results, advance care planning information) • Collaborate with ED staff to ensure identification of hospice patients; collaborate on care protocols to be consistent with hospice protocols 			
6. Hospice Quality Improvement				
	6a. Review goals of CT Initiative; identify ways to incorporate CT efforts into new National Hospice QI Requirements.			
	6b. Implement use of INTERACT's Unplanned Transfer Review Tool.			
	6c. Review QI process and team participation to support facility and staff in implementation of selected CT interventions.			
	6d. Review and revise (as needed) the facility's process of monitoring the implementation of best practices.			

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7. Other Facility-chosen Interventions				