NHPCO Palliative Care Playbook for Hospices

Staffing

This toolkit is part of NHPCO's comprehensive Palliative Care Playbook that is available to members as a benefit of membership. Learn more about Community-Based Palliative Care Resources at www.nhpco.org/palliativecare.

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As part of the work you will do, or have done through your comprehensive Business Case development, your answers to the various questions (e.g. who will you serve, who will provide care, what services you will provide) will help identify the staffing needs for your program. As discussed in the chapter, Making the Case for Palliative Care, one of the critical decision points is to determine the care model for your organization. Some hospices may want to adopt multiple models based on a variety of factors identified through the needs assessment process (e.g. patient population, location of services, payor source agreements). Each model has its own unique staffing considerations. As stated in this chapter, it is best to focus on one model until your program matures, and you validate your Business Case and SWOT analysis.

This chapter will discuss the importance of setting your staffing metrics efficiently based on the model of care you choose and solutions that can be employed to manage towards best practices associated with team-based palliative care.

The importance of team-based palliative care

The National Consensus Project for Quality Palliative Care's 4th Edition of the Clinical Practice Guidelines for Quality Palliative Care, hereinafter referred to as NCP and NCP Guidelines, promotes the interdisciplinary team in Domain 1: Structure and Processes of Care. Because palliative care is holistic in nature, the NCP Guidelines state programs providing palliative care should include a team of individuals who supports the individual patient and their family through that patient's trajectory of illness. To be successful in this goal, a full complement of clinical and non-clinical staff (e.g. physicians, non-physician providers, nurses, social workers, chaplains and others based on need) is important.

It is important to remember the NCP Guidelines have been developed as a gold standard, and a standard to strive for when providing palliative care. These guidelines are not intended to be seen as an absolute structure of care that must be adopted. Your program may never be able to fully implement all of its recommendations. Depending on the type of model your organization launches and the financial parameters that govern your program, you will determine the most effective and efficient staffing model for your organization. Initially, you may only include one or two members of the interdisciplinary team as employees of your palliative care program; however, there are ways that you can supplement other members of the interdisciplinary team.

Due to reimbursement constraints and the variety of program types the feasibility of individual programs financially supporting an interdisciplinary team can be, very challenging. As you strive to achieve best practice according to NCP Guidelines, there are ways to provide interdisciplinary focus without the financial burden of hiring all clinician types it outlines.

Providing interdisciplinary team care without employing its full complement of staff is possible. At times it takes a little creativity and partnership. The NCP Guidelines outline what the interdisciplinary team could do to support patients throughout its eight domains. It does not say that your program individually provides that care. Through various structural designs of your program, and through developing partnerships within your community and with your community stakeholders, your program can knit an interdisciplinary team together. We will explore these opportunities and options as we review a set of staffing model examples.

Staffing Models

There is no right or wrong way in putting your program's staffing model together; however, it is important to stay as true to the principles of palliative care outlined in the NCP Guidelines as your organization can. As your model of care matures it is important to incorporate additional recommendations into your program structure. We often comment "if you've seen one palliative care program, you've seen one palliative care program". Although true not all incorporate the principles of palliative care outlined in the NCP Guidelines; some are in name only.

For the purposes of this chapter we will look at community-based palliative care programming from the perspective of a free-standing hospice/home health organization. These are typically represented through, or variation of:

- Hospice outreach
- Home health bridge
- Integrated transitions program
- Medicare Part B practice program
- Payer contracted program

It is important that your program considers its staffing needs across the following areas:

- Leadership
- Administrative
- Clinical

Leadership

Determining your leadership framework is critical to the success of your program. These individuals are crucial to ensure governance and sustainability of the program. Your organizational structure may determine the type and scale of your leadership role(s). This may be dependent on the regulations that govern your organization. If your organization is a hospice organization, hospice regulations will likely play a larger role in how you manage your program. If your organization is a home health organization, home health regulations will likely play a larger role.

Leadership roles to consider (not all are necessary):

- Program Director
  - Do you need someone that is a clinician, or a non-clinician?
- Medical Director
  - Do you want to employ or contract this individual?
  - Are there state regulations that govern this relationship?
- Business Manager
- Operational Manager

Each of these may be considered necessary at some stage of your program development. The last two may be positions that you want to develop after your program has matured or its complexity requires additional skill sets to manage (e.g. provider practice, ACO, various payer contracts). Initially, most programs choose to employ a Program Director who can provide day-to-day oversight, implement your structure, manage any regulations, policies and procedures that govern the program, and develop and deliver reports to your stakeholders.

Administrative Staff

There are a host of activities a palliative care program will be tasked to perform on a daily basis. It is critical that your program understand how everything will be accomplished on a daily, weekly, monthly basis. These activities may include, but are not limited to, the following:

- Scheduling
- Billing
- Data collection
- Marketing
- Patient record management
- Provider credentialing
- Payor contracting
- Human resource management

It is unlikely that you will be able to hire one individual who has the skill set to provide support for all these services. This is an opportunity to look more broadly across your organization to determine how you can task existing resources who perform these functions within your hospice and/or home health program to also support your palliative care program.

Example: You have decided to develop a Medicare part B practice program. Your organization develops a shared agreement between your palliative care program and your hospice division to provide the necessary infrastructure to support a number of the tasks outlined above. You work with:

- Hospice to perform scheduling and marketing tasks
- Human Resources to manage program HR tasks
- Billing department to perform billing, contracting and credentialing tasks

If your billing department is unable or does not have the necessary skills to complete the Medicare Part B billing, contracting and credentialing tasks. You may contract with an outside vendor that can provide these services. Vendors can also provide your credentialing and contracting services. By looking more broadly across your organization, you can meet your administrative needs without adding employees.

This example can easily be applied to a hospice outreach, or a home health bridge palliative care program in the same way. How can you utilize resources already within your organization to support your program efficiently without additional labor costs?

Clinical Staff

The type and structure of your program will determine the disciplines and staff needed. This may include one or more of the following:

- Registered Nurse
- Advance Practice Registered Nurse (nurse practitioner, clinical nurse specialist)
- Physician
- Chaplain
- Social Worker
- Care Coordinator/Transitions Coordinator
- Therapy (PT, OT, ST, RT)
- Pharmacists
- Certified Hospice/ Home Health Aides
- Certified Nurse Assistants
- Psychologist/Licensed Clinical Social Worker

Each of these clinicians serves a distinct role/skill set. Your program will determine the type of clinicians needed.

Hospice Outreach.

For this type of program, you may decide to hire a Registered Nurse Care Coordinator. Your goal is likely to provide upstream support to patients who may not be emotionally ready or who are not yet eligible for hospice. This type of program typically provides care management support, working with the patient and family through telephonic contact or through other non-direct care activities. Consider the NCP Guidelines to choose how you will provide interdisciplinary support? This can easily be achieved through the utilization of your hospice interdisciplinary team.

Example: Your RN Care Coordinator determines a patient is clinically appropriate for hospice and is struggling spiritually. You may determine that your Chaplain is best suited to meet with the patient for an informational visit. He or she performs the informational visit and the patient decides to elect his/her hospice benefit, orders are obtained and the hospice RN performs the hospice admission.

Example: Your RN Care Coordinator determines a patient is not clinically appropriate for hospice and is struggling spiritually. Your RN Care Coordinator talks with your hospice Chaplain to determine what resources are available in the community for the patient. This may involve a referral to a psychologist or a licensed clinical social worker.

Both these examples show the appropriate use of members of your interdisciplinary team or resources outside your hospice staff that represent an aspect of your interdisciplinary team. It is important not to overstep your primary program and the regulations that govern it, and the policies and procedure that you have developed that provide programmatic boundaries that guide your program and staff.

In a hospice program, it is important to maintain a non-direct care approach for patients who are not yet on your hospice services. The main reason for maintaining this boundary is that you are not allowed to provide direct patient care outside your hospice license. From a legal perspective, providing care outside your licensure could be viewed as providing free care to solicit referrals.

Team-based Palliative Care		
Palliative Program	**Primary Program (Hospice)**	**Community Partner**
RN Care Coordinator	Receptionist	Psychologist
Program Manager	Sales Associate	Licensed Clinical Social Worker
	Chaplain	Chaplain, Priest, Pastor
	Social Worker	Physician
	Medical Director	Pharmacist
	Pharmacy Provider	

Home Health Bridge.

For this type of program you may decide to hire a Registered Nurse Transitions Coordinator. Your goal is likely the same as the hospice outreach program; it is just from a different perspective. Here you are working to provide upstream support to patients who may not be emotionally ready or who are not yet eligible for hospice.

The biggest difference between a hospice outreach, and a home health bridge program is the ability of the home health bridge program to provide direct patient care. This is achieved by incorporating palliative care goals and interventions into the patient's home health plan of care. When a patient is discharged because they no longer meet the requirements for home health services and you feel that individual is appropriate for ongoing palliative care oversight, the approach is no different than that outlined under the Hospice Outreach section. It is important to maintain a non-direct care approach.

Team-based Palliative Care		
Program	**Primary Program (HH)**	**Community Partner**
RN Care Coordinator	Receptionist	Psychologist
Program Manager	Sales Associate	Licensed Clinical Social Worker
	Social Worker	Chaplain, Priest, Pastor
		Physician
		Pharmacist

Integrated Transitions Program.

For this type of program you may decide to hire a Registered Nurse Transitions Coordinator. This type of program can be considered a hybrid of the previous two programs. For organizations that have both hospice and home health, it may be preferable to develop a palliative care program that integrates palliative care across the organization.

It is preferable to have the Registered Nurse Transitions Coordinator trained to deliver care in all care settings (e.g. palliative care, home health, hospice). The information outlined in both the Hospice Outreach and Home Health Bridge section continues to apply. The difference is that the Registered Nurse Transitions Coordinator helps to manage patients across your care continuum.

This type of program works well as a standalone department/division; however, you can designate either your home health or hospice as the primary program. The advantage to your program being a standalone department/division is maintaining a neutral perspective that is not overly influenced by budgetary or census goals that your hospice or home health are held accountable.

Team-based Palliative Care			
Program	**HH**	**Hospice**	**Community Partner**
RN Transitions Coordinator	Receptionist	Receptionist	Psychologist
Program Manager	Sales Associate	Sales Associate	Licensed Clinical Social Worker
	Social Worker	Chaplain	Chaplain, Priest, Pastor
		Social Worker	Physician
		Medical Director	
		Pharmacy Provider	

Medicare Part B Practice.

Before you enter into this type of model, it is advised that you seek legal counsel to determine how the Corporate Practice of Medicine Laws may impact your ability to practice medicine, and who you may or may not be able to hire to deliver medical care. There are several other considerations that must be determined prior to implementing a program of this type (e.g. credentialing with payers, billing, consent to treat, malpractice insurance, etc.) that have been outlined in other Chapters.

Programs of this type will either hire a physician, nurse practitioner or clinical nurse specialist who perform medical visits for medically necessary care. Additionally, you may decide to hire a Registered Nurse Transitions Coordinator. Your goal incorporates the information outlined above depending on whether you are set up to provide Hospice Outreach services, Home Health Bridge services, or have an integrated program that lays across your hospice and home health service lines. Its difference, and most important concept to understand is that its primary function is to deliver medical care. This type of program needs to be thought of as a medical practice no different than a physician office practice. Through your provider(s), your program is delivering specialty palliative care to medically complex patients. For many programs, the most cost-effective model is to hire a nurse practitioner coupled with a RN Transitions Coordinator.

The medical care provided is billed through Medicare Part B benefits at a fee-for-service rate. Medicare pays the provider 80% of the billed services, and the organization must bill the patient for the remaining 20%. Providing this care does not impact the patient's ability to access their Medicare Part A benefits (e.g. home health, hospice and skilled nursing).

Team-based Palliative Care			
Program	**HH**	**Hospice**	**Community Partner**
RN Transitions Coordinator	Receptionist	Receptionist	Psychologist
Program Manager	Sales Associate	Sales Associate	Licensed Clinical Social Worker
Provider	Social Worker	Chaplain	Chaplain, Priest, Pastor
		Social Worker	Physician
		Medical Director	
		Pharmacy Provider	

Job Descriptions

Job descriptions are as important as the policies, procedures and guidelines that govern your program Job Descriptions guide your staff and organization to provide a consistent approach in the care of individuals in your program. No matter the type of palliative care program you implement, the interdisciplinary staff designation should not change dramatically; however, the

duties of their position may change depending on the staffing models discussed above.

At a minimum, a job description for your Program Manager, RN Care Coordinator or Transitions Coordinator. For other interdisciplinary team members that you may utilize from your hospice or home health programs, update their current job descriptions with additional elements that you want them to perform for your palliative care program.

Resource: Appendix A Job Description examples

Education and Skills Development

There are many educational options for clinicians to engage in that will provide ongoing skills development. These options are can be found in many of the national organizations such as the National Hospice and Palliative Care Organization, Hospice and Palliative Nurses Association, Center to Advance Care, and the American Association of Hospice and Palliative Medicine. These associations, along with others, provide specific educational opportunities and skills development for your program's staff.

- National Hospice and Palliative Care Organization
  - Interdisciplinary focused educational modules, program development resources, and the ability to connect your organization with others
  - https://www.nhpco.org/
- Hospice and Palliative Nurses Association
  - Nursing focused educational modules for the advanced practice registered nurse, registered nurse, licensed vocational nurse and certified nursing assistant
  - Certifications for advanced practice registered nurse (ACHPN), registered nurse (CHPN), nursing assistant (CHPNA), as well as certifications for pediatric registered nurses (CHPPN), and those associated with perinatal loss (CPLC)
  - https://advancingexpertcare.org/
  - Center to Advance Palliative Care
  - Educational resources for staff and program development resources
  - http://www.capc.org
- American Association of Hospice and Palliative Medicine
  - Provider focused educational modules for the physician and advanced practice registered nurse
  - Certifications for physicians specializing in hospice and palliative medicine
  - http://aahpm.org/

Competencies

The NCP Guidelines defines standards that can be the goals for any palliative care program. Your program competencies should be developed in a way that promote the skills they outline. Depending on the type of model you adopt and implement, the minimum competency to meet your program's structure and objectives is paramount to your organization providing quality palliative care services.

Your program's staff should meet a minimum competency within these four areas. This is not meant to be a comprehensive list.

- Symptom management
  - Assessment
  - Pain
  - Constipation
  - Nausea and vomiting
  - Depression
  - Relief of suffering

  - Dyspnea
- Medication management
  - Assessment
  - Prescribing
  - Opioids
  - Conversions
  - Side effects
  - Poly-pharmacy
- Setting management
  - Assessment
  - Right care in the right care setting
  - When is it time to move to assisted living
  - When is it time to move to long-term care
- Communication
  - Assessment
  - Delivering serious news
  - Goals of care
  - Advance care planning
  - Prognosis
  - Community Resources

Resource: Appendix B Skill Assessment examples

Summary

In summary, part of the work completed in your comprehensive Business Case answers various questions (e.g. who will you serve, who will provide care, what services you will provide) that help identify the staffing needs for your program. As discussed in the chapter, Making the Case for Palliative Care, one of the critical decision points is to determine the care model for your organization. Some hospices may want to adopt multiple models based on a variety of factors identified through the needs assessment process (e.g. patient population, location of services, payor source agreements). Each model has its own unique staffing considerations. As stated in this chapter, it is best to focus on one model until your program matures, and you validate your Business Case and SWOT analysis.

This chapter highlights the importance of setting your staffing metrics efficiently based on the model of care you choose and solutions that can be employed to manage towards best practices associated with team-based palliative care.

Appedix A: Job Discriptions

Palliative Care Transition Care Coordinator

Department Name:
Interim HealthCare

Reports to:
Director of Palliative Care

General Purpose:

The Palliative Care Transition Care Coordinator (PTCC) serves as a professional, and qualified registered nurse (RN), or licensed vocational nurse (LVN), with the responsibility to practice his/her profession commensurate with his/her licensure, training and experience in accordance with the laws and regulations governing their practice in the state in which services are performed, and all guidelines of applicable professional and accreditation agencies. The PTCC is responsible to work in collaboration with patients, their families and other caregivers, the patient's primary care physician, and other specialists as appropriate, in an active practice to deliver episodic acute care and chronic medical management for patients with progressive illnesses under the direction of the Palliative Care Advanced Practice Nurse (APN), or as directed by the plan of care and regulations of a patient's home health episode, or hospice episode.

Goal: Support patient and family transitional care needs across care settings (i.e. acute care discharges back to community setting, home health episodes, hospice, etc.), and through disease stage changes in support of the care and/or treatment preferences established through goals of care discussions.

Essential Functions:

Physical Assessment and Treatment:

- Provides and documents medically necessary services in accordance with provider (i.e. physician, APN) orders.
- Assess the patient's and family caregiver's needs and coordinates appropriate services (i.e. DME, home health care, hospice, etc.) as required either prior to the patient's transition home from an acute care stay (hospital, SNF), or at any point in their care continuum post-acute.
- Develops a plan of care in collaboration with the palliative care APN based on his/her treatment plan that maximizes the health potential as part of a patient's home health episode.
- Assists in all facets of care coordination for referrals.
- Provides disease management instruction and education to patients and their families.
- Provides clinical guidance to facility staff relative to patient care issues, assessments and interventions within scope of practice.

Administrative:

- Participates with care setting's interdisciplinary team as appropriate (i.e. clinical standup, QAPI, care coordination, clinical instruction, utilization committee, re-hospitalization committee, etc.).
- Obtains necessary medical information regarding the patient's health status, current medications and goals of care from appropriate sources.
- Acts as a clinical resource to coordinate complex cases for safe and appropriate transition to other care settings.
- Attends required Interim Healthcare Office meetings to enhance team communication, coordination of services and quality of care.
- May coordinate additional services with palliative care APN to assist client and family during any transition.
- Reviews Interim Healthcare's policies and services with referred patients and/ or family caregivers or authorized patient representative and obtains consent for medical care.
- Communicates with the Intake Nurse and the Clinical Manager to determine staffing capabilities.

- Communicates essential patient information to care setting clinicians who will be initiating care.
- Provides training and continuing education for staff.
- Assists in development of clinical practice guidelines/standards in support of quality care.
- May assist with obtaining Physician orders as required.
- Responds to inquiries regarding care services and programs to accurately identify the needs of each patient.
- May have access to and use of personal health information ("PHI") as necessary to fulfill the above duties and responsibilities.
- Performs all functions in compliance with federal, state, local law and regulation, as well the policies, procedures, and practice standards of Interim Healthcare.
- Assists with Insurance eligibility and authorization process, when appropriate.
- Performs other duties as assigned.

Integrity:

- Follows policy and procedures as directed.
- Brings concerns forward appropriately to supervisor.

Compassion:

- Promotes an environment of high integrity and teamwork.
- Works collaboratively with patients and their family caregivers, physicians, supervisors and other staff to facilitate effective transitions from one care setting to another.

Customer Focus:

- Takes appropriate and timely measures to meet the needs of the patient, their family and care setting staff.
- Maintains mature problem-solving approach under stressful circumstances.

Innovation:

- Assists in problem solving strategies with the patient, family, PCP, and setting staff to facilitate safe care of the patient.

Financial Responsibility:

- Works collaboratively with Intake Department in verification of coverage or payment.

Minimum Education & Experience Requirements:

- Valid nursing (RN/LVN) License in the State(s) in which service is provided.
- Minimum of 3 years nursing experience preferred.
- Minimum of 3-5 years of experience with home health, hospice/palliative care strongly preferred.
- Advance certification in hospice and palliative nursing care (CHPN/CHPLN) preferred; required within 18-months of hire.

Knowledge, Skills & Abilities Required:

Professional Requirements:

- Maintain appropriate licensures and certifications.
- Practice within established protocols and provider (physician, APN) orders.
- Adhere to state regulations regarding practice act.
- Maintain a broad base of technical knowledge and skills to perform all assigned clinical/ administrative duties.
- Knowledge of home/hospice regulations, end of life care services, and advance care planning.
- Demonstrate excellent teaching skills to relate medical information to the patient, family and other nursing staff.
- Possess excellent communication, interviewing and counseling skills, and the ability to explain medical problems and treatments in accurate and understandable lay terms.

- Must be able to coordinate and communicate effectively with colleagues, managers, and medical staff, and be able to teach and develop others.
- Must have the ability to prioritize, make decisions and set clear expectations for others.
- May have access to personal health information ("PHI") necessary to fulfill the above duties and responsibilities. Access to use and ability to disclose PHI is further defined by each organization/department.

Other Requirements:

- Computer proficiency including the ability to utilize software programs used by the organization.
- Able to perform and prioritize multiple functions or tasks.
- Able to read and interpret technical instructions related to the care of the patient/ client.
- Able to effectively deal with multiple changes.
- Able to engage in moderate amount of (90%) local travel.
- Able to provide proof of valid driver's license, if applicable.
- Able to provide proof of valid liability insurance if assignments include driving own vehicle.
- Evidence of annual TB test and other state required tests.

Working Conditions & Physical Requirements:

- Works in community care settings (home, SNF, ALF, and hospital).
- Able to stand, bend, stoop, squat, kneel and reach freely.
- Able to freely lift to a maximum of 50 pounds.
- Able to assist patient/client with standing, walking, sitting, and rolling in bed.
- Visual/hearing ability must be sufficient to communicate written and verbally.
- Sedentary physical activity that may require occasional lifting, carrying, pushing or pulling up to 10 lbs. in order to carry out daily job functions and related activities that may be required.

Key	
Occasionally	Activity/conditions exist 0-2.5 hrs./day or up to 30%
Frequently	Activity/conditions exist 2.5–5.5 hrs./day or over 30%
Constantly	Activity/conditions exist 5.5+ hrs./day or over 60%
Sedentary	Lifting/carrying up to 10 lbs.
Light	Lifting/carrying/pushing/pulling up to 20 lbs.
Medium	Lifting/carrying/pushing/pulling up to 50 lbs.
Heavy	Lifting/carrying/pushing/pulling over 50 lbs.
Very Heavy	Lifting/carrying/pushing/pulling over 100 lbs.

Acknowledgment:

I have reviewed my job description and agree to perform all duties to the best of my ability. I understand my job duties may change as the needs of the organization change. I further agree to notify my immediate supervisor if I am unable to complete any of my job duties in a timely manner.

Name _____

Signature _____

Date _____

Appedix A: Job Discriptions (cont.)

Palliative Care Advanced Practice Nurse (APN)

Department Name:
Interim HealthCare

Reports to:
Director of Palliative Care

General Purpose:

The advance practice nurse (APN) serves as a professional, and qualified provider, with the responsibility to practice his/her profession commensurate with his/her licensure, training and experience in accordance with the laws and regulations governing the practice of an APN of the state in which services are performed, and all guidelines of applicable professional and accreditation agencies. The APN is responsible to work in collaboration with patients, their families and other caregivers, the patient's primary care physician, and other specialists as appropriate, in an active practice to deliver episodic acute care and chronic medical management for patients with progressive illnesses.

Delegation of Authority:

The APN performs medical services in collaboration with a physician to diagnose and manage health care problems. The APN also serves as a healthcare resource, interdisciplinary consultant and patient advocate.

Essential Functions:

APN Practice Guidelines:

- Upon hire, annually and as needed for revisions at times other than the annual review; signs, dates and complies with the Delegation Protocol Agreements and protocols that describe prescribing privileges, treatments, tests and procedures that define the scope of APN practice.
- Uses the nursing process as the framework for managing patient care.
- Obtains Medicare and Medicaid provider statutes with the respective state carriers.
- Meets with collaborating physician in accordance with applicable state and federal law.

Physical Assessment and Treatment:

- Provides and documents medically necessary services in accordance with mutually acceptable physician/APN protocols.
- Develops the appropriate treatment plan that maximizes the health potential of the patient including, but not limited to:
  - Ordering and interpretation of appropriate diagnostic tests within scope of practice
  - Identifying appropriate pharmacologic agents
  - Identifying appropriate non-pharmacologic interventions
  - Developing an education plan as appropriate
  - Interpretation of laboratory and radiology tests within scope of practice
  - Ordering of durable medical equipment
- In collaboration with PCP, refers patients to medical specialists as indicated.
- In collaboration with PCP, refers patients to other healthcare services as medically indicated.
- Consult with collaborative physician, consulting practitioner(s), primary care physician and other specialist physicians as appropriate.
- Assists in all facets of care coordination for referrals.
- Provides disease management instruction and education to patients and their families.
- Provides clinical guidance to facility staff relative to patient care issues, assessments and interventions.
- Performs reasonable on-call services as applicable.

Administrative:

- Participates with care setting's interdisciplinary team as appropriate (i.e. clinical standup, QAPI, care coordination, clinical instruction, utilization committee, re-hospitalization committee, etc.).
- Prepares and maintains accurate patient records, charts, and documents to support sound medical practice and reimbursement for services provided, and support of appropriate medication uses.
- Acts as a clinical resource to coordinate complex cases for safe and appropriate transitions to other care settings.
- Comply with applicable laws and regulations with respect to Delegation Protocol Agreements, prescriptive authority, and APN scope of practice.
- Attends required Interim Healthcare office meetings to enhance team communication, coordination of services and quality of care.
- Reviews Interim Healthcare's policies and services with referred patients and/or family caregivers or authorized patient representative, and obtains consent for medical care.
- Provides training and continuing education for staff.
- Assists in development of clinical practice guidelines/standards in support of quality care.

Integrity:

- Follows policy and procedures as directed.
- Brings concerns forward appropriately to supervisor.

Compassion:

- Promotes an environment of high integrity and teamwork.
- Works collaboratively with patients and their family caregivers, physicians, supervisors and other staff to facilitate effective transitions from one care setting to another.

Customer Focus:

- Takes appropriate and timely measures to meet the needs of the patient, their family and care setting staff.
- Maintains mature problem solving approach under stressful circumstances.

Innovation:

- Assists in problem solving strategies with the patient, family, PCP, and setting staff to facilitate safe care of the patient.

Financial Responsibility:

- Works collaboratively with Intake Department in verification of coverage or payment.
- Initiates reimbursement for services rendered.
- Maintains productivity for his/her practice as defined by Interim Healthcare.

Minimum Education & Experience Requirements:

- Graduate of an accredited Geriatric, Adult or Family Nurse Practitioner Master's program.
- Board Certified APN (as a Geriatric, Adult or Family Nurse Practitioner preferred).
- Three years of experience as a nurse practitioner in clinical nursing care of geriatrics, adult/family practice, or oncology preferred.
- Advance certification in hospice and palliative nursing care (ACHPN) preferred; required within 18-months of hire.
- Experience with home health, hospice and palliative care strongly preferred.

Knowledge, Skills & Abilities Required:

Professional Requirements:

- Maintain appropriate licensures and certifications, including current Department of Public Safety (DPS), and Drug Enforcement Agency (DEA) registrations.
- Practice within established protocols for prescriptive authority, including prescribing of scheduled drugs.
- Adhere to state regulations regarding practice agreement with physician.
- Maintain a broad base of technical knowledge and skills to perform all assigned clinical/administrative duties.
- Knowledge of home/hospice regulations, clinical practice, end of life care services, and advance care planning.
- Demonstrate excellent teaching skills to relate medical information to the patient, family and nursing staff.
- Possess excellent communication, interviewing and counseling skills, and the ability to explain medical problems and treatments in accurate and understandable lay terms.
- Must be able to coordinate and communicate effectively with colleagues, managers, and medical staff and be able to teach and develop others.
- Must have the ability to prioritize, make decisions and set clear expectations for others.
- May have access to personal health information ("PHI") necessary to fulfill the above duties and responsibilities. Access to use and ability to disclose PHI is further defined by each organization/department.

Other Requirements:

- Computer proficiency including the ability to utilize software programs used by the organization.
- Able to perform and prioritize multiple functions or tasks.
- Able to read and interpret technical instructions related to the care of the patient/ client.
- Able to effectively deal with multiple changes.
- Able to engage in moderate amount of (90%) local travel.
- Able to provide proof of valid driver's license, if applicable.
- Able to provide proof of valid liability insurance if assignments include driving own vehicle.
- Evidence of annual TB test and other state required tests.

Working Conditions & Physical Requirements:

- Works in community care settings (home, SNF, ALF, and hospital).
- Able to stand, bend, stoop, squat, kneel and reach freely.
- Able to freely lift up to a maximum of 50 pounds.
- Able to assist patient/client with standing, walking, sitting, and rolling in bed.
- Visual/hearing ability must be sufficient enough to communicate written and verbally.
- Sedentary physical activity that may require occasional lifting, carrying, pushing or pulling up to 10 lbs in order to carry out daily job functions and related activities that may be required.

Key	
Occasionally	Activity/conditions exist 0-2.5 hrs./day or up to 30%
Frequently	Activity/conditions exist 2.5–5.5 hrs./day or over 30%
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Very Heavy	Lifting/carrying/pushing/pulling over 100 lbs.

Acknowledgment:

I have reviewed my job description and agree to perform all duties to the best of my ability. I understand my job duties may change as the needs of the organization change. I further agree to notify my immediate supervisor if I am unable to complete any of my job duties in a timely manner.

Name _____

Signature _____

Date _____

Appedix B: Nurse Practitioner Skills Checklist / Self Assessment

NP Name _____ **Date** _____

Please indicate the level of experience/proficiency with each and, where applicable, the types of equipment and/or systems with which you are familiar. Insert letter from the Key below in Level of Competency column below. Complete this self assessment within 30 days of hire.

If additional training is needed, please indicate by inserting a √ mark. Insert Training Date after training has been completed Additional training as applicable, must be completed within the first 90 days of hire.

Use the following KEY as a guideline:

A. Theory Only/No Experience - Didactic instruction only, no hands-on experience.
B. Limited Experience - Knows procedure/has used equipment but has done so infrequently or not within the last six months.
C. Moderate Experience - Able to demonstrate equipment/procedure, performs the task/skill independently with only resource assistance needed.
D. Proficient/Competent - Able to demonstrate/perform the task/skill proficiently without any assistance and can instruct/teach.

Required Skill	Level of Competency	Needs Training	Training Date	Supervisor Signature
Knowledge of Nursing Process:				
Health history and physical exam				
Assesses response to treatment				
Establishes and revises goals of care				
Case Conference Summary				
Discharge planning				
Knowledge of QAPI				
Knowledge of EMR				
Documentation Skills:				
Accurate, complete, legible, timely				
Clinical notes/flow charts				
Summary reports				
Knowledge of Medicare Hospice Guidelines (COPs):				
Criteria for participation				
Levels of care				
Advance directives/patient rights				
Local Care Determination guidelines (LCDs) Determining Terminal Status forms DTS')				
Effective Case Coordination:				
Reports and documents information to physician, facility staff and IDG as appropriate				
Functions as a team member				

Required Skill	Level of Competency	Needs Training	Training Date	Supervisor Signature
Knowledge of community resources				
Attends IDG as requested				
Infection Control:				
Hand washing				
Proper bag technique				
Safe needle technique				
Protective equipment				
Equipment care				
Biohazardous waste disposal				
Patient Vulnerability and Home Safety				
Patient Education:				
Determines learning needs				
Sets objectives				
Develops/implements teaching plan				
Evaluates effectiveness of teaching				
Revises teaching plan				
Documents patient/family response				
Clinical Skills (General):				
Demonstrates principles of aseptic technique				
Vital signs				
Intake and Output				
Medication assessment and teaching				
– Route, dose, frequency				
– Side effects/adverse reactions				
– Home monitoring program				
– Blood levels				
Pulmonary System:				
General exam and auscultation				
Use and care of oxygen				
Nebulizer treatment				
Use of inhalers				
Home ventilator management				
Oral/nasal suctioning				
Foreign body airway obstruction				
Breathing exercises/incentive spirometry				
Pulmonary Pharmacology				

Required Skill	Level of Competency	Needs Training	Training Date	Supervisor Signature
Cardiovascular System:				
General exam and auscultation				
Pulses (apical/radial/femoral/pedal)				
Edema assessment and management				
Supine and orthostatic blood pressure				
NTG/Inhaler use				
NYHA Classifications				
CPR				
Energy conservation technique				
Cardiac Pharmacology				
Neurological System:				
General exam (pulses/LOC/grasps)				
Aphasia care				
Mini mental exam				
FAST Scale				
Seizure precautions				
Neurological Pharmacology				
Gastrointestinal System:				
General exam and auscultation				
Abdominal girth				
Tube feeding				
PEG tube care				
Ostomy care				
– Irrigation				
– Stoma care				
NG insertion, care and feeding				
Dysphagia precautions				
Impaction removal/enema administration				
GI Pharmacology				
Integumentary System:				
General exam				
Sterile dressing change				
Suture/staple removal				
Decubitus care:				
– Assessment and change				
– Prevention				
– Treatments				

Required Skill	Level of Competency	Needs Training	Training Date	Supervisor Signature
– Documentation of wound care				
Related Pharmacology				
Genitourinary System:				
General exam				
Urinary catheter care education				
Condom catheter				
Ileostomy care				
Incontinence care				
Bladder training				
Bowel training				
GU Pharmacology				
Musculoskeletal System:				
General exam				
ROM (active and passive)				
TED hose				
Devices				
– Walker/wheelchair				
– Transfers/Hoyer Lift				
Related Pharmacology				
Metabolic:				
Diabetes				
– Insulin types/teaching				
– Use/care/teaching of Glucose Monitoring System				
– Diet/exercise/sick-day teaching				
– Skin/foot care				
Coumadin therapy				
– PT/INR interpretation				
Related Pharmacology				
Psychiatric:				
General assessment				
Suicide precautions				
Psychotropic drugs				
Care of patient with dementia/ Alzheimer's disease				
Karnofsky and Palliative Performance Scale				
Home Glucose Monitoring:				

Required Skill	Level of Competency	Needs Training	Training Date	Supervisor Signature
Verbalizes purpose of test				
Specimen collection				
Quality control mechanisms				
Test correctly performed and interpreted				
Other Laboratory Specimen Collection:				
Venipuncture for specimen collection				
Urine				
Stool				
Wound culture				
IV Therapy:				
Sterile technique				
Peripheral IV placement				
Catheter protocols				
– Hickman				
– Groshong				
– Port-a-Cath				
– PICC				
– Other:				
Flushing techniques				
Blood sampling				
Cap change				
Dressing management				
Patient teaching				
IV antibiotic protocols/teaching				
IV pain management protocols/teaching				
TPN protocols/teaching				
Other:				

NP Signature_____ Date_____

Supervisor Signature_____ Date_____

Reviewed with Medical Director (Name) _____ Date_____

Appedix B: Skilled Nursing Facility Nurse Practitioner Skills Checklist / Self Assessment

NP Name_____ **Date** _____

Please indicate the level of experience/proficiency with each and, where applicable, the types of equipment and/or systems with which you are familiar. Insert letter from the Key below in Level of Competency column below. Complete this self assessment within 30 days of hire

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Reports and documents information to physician, facility staff and IDG as appropriate				

Required Skill	Level of Competency	Needs Training	Training Date	Supervisor Signature
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IV pain management protocols/teaching				
TPN protocols/teaching				
Other:				

NP Signature_____ Date_____

Supervisor Signature_____ Date_____

Reviewed with Medical Director (Name) _____ Date_____

NHPCO Palliative Care Playbook for Hospices

NHPCO
National Hospice and Palliative Care Organization