Hospice In-Patient Level Of Care & Continuous Home Care

How to Meet Patient Needs While Meeting Regulatory Requirements

Objectives

- Participants will be able to describe general in-patient and continuous care regulation, identify and document eligibility.
- Participants will be able to identify barriers to general in-patient eligibility and continuous care eligibility.
- Participants will be able to describe and identify regulatory requirements for general inpatient level of care and continuous care.
- Participants will be able to describe differences and similarities between general in-patient level of care and continuous care.
Definitions

- **In-patient care** or services is defined as short term, general in-patient care provided directly by a hospice program in their own in-patient facility, through a contract arrangement with a licensed Medicare certified long term care facility, or hospital to provide pain and symptom management that cannot be accomplished in another setting.

- **Continuous Home Care** is provided in a patient's home during periods of crisis. A period of crisis is defined as a period in which a patient requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms.

Regulations: General In-Patient CoP 418.108

- In-patient level of care must be made available for pain and symptom management as well as respite level of care in a participating Medicare or Medicaid facility.

- A hospice providing in-patient care directly must meet regulation specified in CoP 418.110.

- A hospice providing in-patient care under an arrangement agreement within a hospital or SNF must meet regulation specified in CoP 418.110(b) and (e) regarding 24 hour nursing and patient areas.
Service Level: In-Patient

- Hospices that provide in-patient care directly must provide 24 hour nursing services that are sufficient to meet the total needs of the patient in accordance with the patient's plan of care.
- Each shift must include a registered nurse that provides direct patient care.
- The medical director or his/her designee may conduct regular on-site visits including daily visits if necessary.

In-Patient Eligibility

- General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management that cannot feasibly be provided in home settings.
- Skilled nursing care may be needed by a patient whose home support has broken down if this breakdown makes it no longer feasible to furnish needed care in the home setting.
In-Patient Eligibility

Pain Requiring:
- Delivery of medication which may require skilled nursing care for calibration, tubing change or site care/adjustment due to the complexity, nature of the medication and it's delivery system.
- Frequent evaluation/assessments by nurse or physician.
- Aggressive treatment to control pain that cannot be accomplished within the home setting.
- Frequent medication adjustments.

Symptom changes:
- Sudden deterioration requiring intensive nursing intervention.
- Uncontrolled nausea or vomiting.
- Pathological fractures.
- Respiratory distress that becomes unmanageable.
- Transfusions for relief of symptoms.
- Traction and frequent re-positioning requiring more than one staff member.
- Severe agitated delirium or anxiety or depression secondary to end-stage disease process.
In-Patient Eligibility

Imminent death alone is not the criterion for the GIP level of care!

- Symptom management that requires frequent skilled nursing intervention as evidence by mottling, change in respiratory status and level of consciousness.
- Symptoms related to imminent death which cannot be managed in the home setting.

Criteria For Continued In-Patient Eligibility

- Ongoing mental status changes that require active treatment and frequent assessment
- Pain continues to require active treatment and frequent assessment.
- Symptoms such as N/V, respiratory distress, open lesions, or ongoing deterioration require active treatment and frequent assessment.
- Acute symptoms have stabilized but death is imminent within a short period of time as evidence by mottling, change in respiratory status and level of consciousness. Frequent skill nursing intervention is needed to help family that is unable to cope.
In-Patient Discharge Eligibility

- Reason for admission stabilized
- Re-established family support system
- Appropriate safe discharge plan has been developed
- Transfer to another level of care (i.e. respite)
- All of these reasons should be reviewed as a whole and not separately.

Regulations: Continuous Home Care
CoP 418.204

- Periods of crisis. Nursing care may be covered on a continuous basis for as much as 24 hours a day during periods of crisis as necessary to maintain an individual at home. Either homemaker or home health aide (also known as hospice aide) services or both may be covered on a 24-hour continuous basis during periods of crisis but care during these periods must be predominantly nursing care. A period of crisis is a period in which the individual requires continuous care to achieve palliation and management of acute medical symptoms.
Regulations: Continuous Home Care
CoP 418.204

- A hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances.

- Continuous care is not a highly specialized service, because while time intensive, it does not require highly specialized nursing skills.

Service Level: Continuous Home Care

- The hospice must provide a minimum of 8 hours of care during a 24-hour day, which begins and ends at midnight.
- This care need not be continuous, e.g., 4 hours could be provided in the morning and another 4 hours in the evening.
- The care must be predominately nursing care provided by either an RN, an LPN, or an LVN.
- This means that more than half of the hours of care are provided by an RN, LPN, or LVN. Homemaker or hospice aide services may be provided to supplement the nursing care.
- Disciplines such as medical social workers or pastoral counselors are not included in the statutory definition of continuous care and are not counted towards total hours of continuous care.
Continuous Care Eligibility

- Need for care and or monitoring must be constant; remember a minimum of 8 hours in a 24 hour period.
- 51% of the continuous care hours must be skilled care.
- Continuous care is an effort to de-escalate the immediate crises and possibly avoid hospitalization.
- Continuous care is covered only as necessary to maintain the terminally ill individual at home.

Symptom Management

- Seizures
- Nausea/vomiting
- Uncontrolled pain

Collapse of family structure

- Caregiver has been providing skilled care and change in patient condition warrants nursing intervention as caregiver no longer can and/or wishes to provide care.
In-Patient Documentation Tips

**Do**
- Discharging planning begins on the first day of in-patient level of care and continues throughout the in-patient level stay.
- Document the team’s effort to resolve patient problems at the lowest level of care.
- Address discharge plans and why patient remains eligible for in-patient level of care.
- Explain why care must be provided in the in-patient setting and not at home e.g. “patient requires frequent RN/NP/MD assessment and titration of medication to control pain”.

**In-Patient Documentation Tips**

**Do cont…..**
- Describe services provided. Think of your note as a bill to Medicare. *Each note must stand alone.*
- Document the context and the events that led to the in-patient level of care.
- Document the failed attempts to control/manage symptoms prior to in-patient level of care admission.
- Document care that caregivers cannot manage at home. (frequent changes in medication/medication titration etc.)
In-Patient Documentation Tips

Do cont...
- Document specific symptoms that are being addressed (uncontrolled n/v, new agitation/delirium). Describe failed attempts to manage these at home.
- Document progress/context/changes including: “symptomatic imminent death that cannot be managed at home or in SNF”
- Document patient response to interventions provided on the in-patient level of care (were they effective? Are they still effective?).

In-Patient Documentation Tips

Don’t
- Don’t use “patient is dying”, “end-of-life care”, “general decline” or “medication adjustment” to justify in-patient level of care unless you ALSO document why these actions cannot take place in the home.
- Don’t document resolution of the precipitating events that led to in-patient level of care without further documenting eligibility that maintains in-patient level of care status or, alternatively, documentation describing efforts to move the patient to a more appropriate setting, i.e., SNF or home.
Continuous Care Documentation Tips

- Documentation should reflect the symptoms that need to be controlled.
- What care needs are not being met?
- Documentation should reflect that patient is at risk for hospitalization if symptoms and or care needs are not managed and or met.
- Documentation should be hourly and should support the need for ongoing continuous care level of care.

Continuous Care Documentation Tips

**Don’t**

- Documentation time, hospice aide supervision, care plan changes, MD/NP visits cannot be used as continuous care hours.
- MSW and Pastoral Counselor visits may not be included as continuous care hours.
Documentation Tips

Create a “snapshot” that will paint a picture of the patient’s needs and what the care needs entail. The picture you paint is the picture Medicare will use to determine whether this level of care is appropriate and reimbursable.

The information in this presentation is meant to be used as a guide and not as legal authority.
QUESTIONS

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