The Hospice Program

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Disclaimer: The information provided in this presentation is subject to revision based upon future updates and clarifications by CMS. Please consult with resources utilized for presentation.

I have no financial relationships to disclose; no conflicts of interests to disclose; and will not promote any commercial products or services.

Thank You.

Welcome

- Today's Presentation is for our Rural Hospitals, CAHs, and interested guests.
- The FOCUS is on.....

MILESTONE HEALTHCARE

Learning about the Hospice Program & exploring feasibility of establishing Hospice Program for your community.

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MILESTONE HEALTHCARE

Objectives

- Review the "Mission" and "Philosophy" of Hospice care for terminally ill individuals.
- Discuss "History of Hospice" -- when the Hospice movement was brought to the United States; and, commonly held "myths."
- Review Medicare coverage of Hospice (starting in 1983); eligibility for benefits; election of benefits; benefit periods; and, contractual services.
- Differentiate between Hospice "Core Services" and "Non-Core Services."

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Objectives (continued)

- Stress key role and function of the interdisciplinary team (IDT).
- Outline required Hospice services by Medicare inclusive of medical, nursing, counseling, volunteer and other services.
- Understand significance of "face-to-face requirements" for certification and recertification.

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Objectives (continued)

- Review the Hospice levels of care:
  - Routine Home Care
  - General Inpatient Care
  - Continuous Care
  - Respite Care
- List "admission requirements" for individual electing Hospice care and services.
- Review requirements for facilities to qualify for provision of Hospice services.

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Mission Statement

- Provide quality Hospice care to individuals with a limited life expectancy.
- Support caregivers while providing Hospice care for individual.
- Deliver care in most appropriate setting.
- Utilize interdisciplinary team to enhance the quality of life for terminally ill individual through use of palliative and specialized supportive care.

Philosophy of Care

- Emphasizes palliative care & supportive care.
- Uses a comprehensive case management approach → comprehensive POC.
- Uses an interdisciplinary team experienced in pain and symptom management.
- Emphasizes importance of patient and family as "unit" to improve quality of remaining life.
- Includes physical care, counseling & support of patient/family during end-of-life process.

Hospice Concepts

- "Death is a natural part of the life cycle. When death is inevitable, *Hospice will neither seek to hasten it nor to postpone it*."
- "Pain relief and symptom control are clinical goals of care."
- "*Psychological and spiritual pain is as significant as physical pain*, and addressing all three requires the skills and approach of an interdisciplinary team."
- "*Patients and families and their loved ones are the unit of care*."

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Hospice Goals

- Enable patients to enjoy an alert, pain-free life in a dignified fashion.
- Provide care in a manner that is respectful of each patient's needs and desires/requests.
- Address patient's physical symptoms as well as emotional and spiritual needs.
- Utilize diverse skills of *physicians*; *nurses*; *social worker*; *therapists* – PT, OT, SLP, art/music, massage; *counselors* , bereavement, spiritual, dietary, clergy; and *trained volunteers.*

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Hospice Goals (continued)

- Develop POC to guide patient and family through a *comprehensive case management approach* to enhance quality of life and to empower/support the patient and family.
- Help family members to care for loved one in home (wherever he/she calls home) and assist patient to remain at home as long as possible and appropriate.

NOTE: "Hospice is a philosophy of care; not a place."

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History of Hospice

- Middle Ages: Term "*Hospice*" referred to lodging place for weary and sick travelers.
- 1960s: St. Christopher's Hospice of London established by Dr. Cicely Saunders – *specialized care unit* for persons having few weeks/months to live.
- 1970s: Hospice movement brought to U.S. from England with first official Hospice being incorporated as *Connecticut Hospice Inc.*

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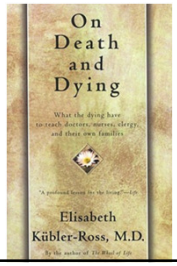
History of Hospice (continued)

- NOTE: Early Hospice care was primarily intended for cancer patients who usually had a predictable and steady decline in health (life expectancy ≤ 6 months).
- 1969: Dr. Kubler-Ross. *On Death and Dying.* Instrumental in raising awareness of choices for dying patients (remain in home for care).
- 1972: Dr. Kubler-Ross testified at first national hearing on subject of "*death with dignity.*"



History of Hospice (continued)

- 1979: Federal government approved "26 Hospice Demonstrative Projects."
- 1982: Medicare Hospice benefit enacted with temporary funding. "*End-of-life*" became a Medicare medical concern; *definition of 6 months or less life expectancy for "terminal illness" established."*
- 1986: Hospice Medicare benefit permanently funded by federal government.

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Medicare Hospice Benefit

- Hospice Medicare benefit was Medicare's *first* managed care program.
- *Starting in 1983, Hospice must abide by the regulations set forth in the Hospice CoP.*
- Each Hospice agency has FI – processes Hospice claims for CMS; and the professional organization (NHPCO) assists providers in understanding Medicare regulations.

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Medicare Hospice Benefit (continued)

- Other Hospice regulatory documents:
  - CFR – actual law
  - Publications by Medicare intermediaries to interpret the law
  - SOM/Interpretive Guidelines – surveyors
  - Local Medical Review Policies
  - CMS Central Regional Memoranda
  - State Licensure Regulations
  - Medicaid Regulations

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Medicare Hospice Benefit (continued)

- When Hospice benefit elected, *patient waives right* to all regular Medicare Part A services (Part A, Part B, Part D - *all services related to the terminal illness and related conditions*).
- Patient still receives access to all services covered under the regular Medicare benefit, only now, *Hospice manages the care*.
- Patient still receives services covered by regular Medicare that *are not* related to terminal illness.

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Medicare Hospice Benefit (continued)

- Medicare, Medicaid and most private insurers pay Hospice a daily rate for services covered in the benefit.
- For Medicare and Medicaid, this *daily rate covers all services* no matter how much or how little is provided each day.
- Medicare rate adjusted annually and based upon wage/price index for area where patient resides and level of care received.
- *Coinsurance amounts by Hospice.*

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Benefit Coverage – Summary (Chapter 9; Medicare Benefit Policy Manual – Hospice Insurance; 09.14.18)

- Reasonable & necessary for palliation and management of terminal illness &related conditions.
- Individual must elect Hospice care.
- POC established and periodically reviewed by attending physician, medical director, IDG.
- POC established before care provided.
- Services provided must be consistent with POC.
- Certification completed within timeframe.

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Core Services

- Hospice must provide core services *directly by Hospice employees consistently within accepted standards of professional practice:*

Physician services (*Medical Director* & an *Alternate Medical Director*):

1. Oversees patient's medical care & IDT.
2. Consults other health care providers/ physicians when there are concerns/issues.
3. Provides community education.
4. Ongoing patient visits.

Core Services (continued)

Nursing/case management (RNs)

1. All nursing services must be provided by or under supervision of RN.
2. RN ensures adequate staffing & services.
3. RN ensures that patient care needs are met as identified in assessments:
   - *Initial* – completed within 48 hours;
   - *Comprehensive* – within 5 days;
   - *Reassessment* – when condition changes.

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Core Services – Nursing (continued)

4. APRN may write patient orders when allowed by Hospice policies & State Law.
5. Highly specialized nursing services may be contracted (complex wound care; infusion specialist; pediatric care; etc.).

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Core Services (continued)

Medical Social Services

1. Provided by qualified SW: Active State License; MSW; 1 year work experience (NOTE: BSW allowed if employed by Hospice prior to 12/2008).
2. SW services based upon patient/family needs as identified in initial and follow up *psychosocial assessments.*
3. Patient/family accepting of SW services.

Core Services – Social Services

- According to the CoP, the social work assessment is part of the comprehensive assessment; and, MUST be completed by SW within five (5) days of the election of Hospice.
- NOTE: Comprehensive assessment completed by disciplines identified in initial assessment (completed by RN); defined as: *"Thorough evaluation of patient's physical, psychosocial, emotional & spiritual status related to the terminal illness and related conditions."*

Core Services (continued)

Counseling Services

1. Must be available for patient/family to assist them in minimizing/alleviating stress and other problems that arise from the terminal illness, related conditions, and dying process.
2. Must include:
   - Spiritual (chaplains/clergy)
   - Bereavement
   - Dietary (end of life nutritional needs)

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Core Services (continued)

Spiritual Counseling

1. Advise patient/family on availability of spiritual counseling.
2. Assessment of patient's/family's spiritual needs (i.e. personal needs/beliefs/practices).
3. *Services provided to meet their spiritual needs in accordance with their wishes.*
4. Visits arranged/facilitated by local clergy, pastoral counselor, or other persons who can support patient's/family's spiritual needs.

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Core Services (continued)

Bereavement Counseling

1. Provision of emotional, psychosocial and spiritual support/services *before and after death of patient* - assist with issues related to grief, loss & adjustment.
2. Organized program under supervision of *qualified professional* (experience/education in grief or loss counseling); responsible for:

   Bereavement POC – outlines services to be offered to family & frequency of services (up to 13 months following death of patient); includes SNF, NF or ICF.

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Core Services (continued)

Dietary Counseling

1. Provision of services by qualified person (*dietitian, nutritionist or RN*).
2. *Assessment* of patient's dietary needs and preferences.
3. *Education* provided for patient/family regarding appropriate nutritional intake as patient's condition progresses.
4. *Nutritional* interventions to supplement caloric requirements.

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Core Services (continued)

REMINDER: *Core services cannot be contracted out; however, CMS does have exceptions - extraordinary or non-routine circumstances:*

- ***High patient loads (high census)***
- ***Staffing shortages (flu epidemic)***
- ***Disasters (hurricanes, tornado)***

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NON-Core Services

- Services specifically mentioned in State & Federal regulations as *covered* Hospice services.
- Services must be provided in a manner consistent with accepted standards of practice directly or through a written contract and include the following:
  - *Therapies* – PT; OT; SLP; Art, Massage, Music, Respiratory Therapy

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NON-Core Services (continued)

- *Medical Supplies (wound care items; dressings; incontinent supplies; etc.)*
- *Durable Medical Equipment*
- *Pharmaceuticals & Other Biologicals*
- *Labs & Diagnostics*
- *Special Modality (Chemotherapy/Radiation)*
- *Ambulance Services*
- *Other covered Medicare palliative services*

Point of Clarification: *Hospice is responsible for financially covering any of these items when/if they are related to the Hospice diagnosis.*

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NON-Core Service: Volunteers

- Must be supervised by Hospice employee.
- Volunteer's involvement in patient's care must be evident in POC.
- Volunteers may provide both administrative and direct patient care services:
  - Assistance with household chores
  - Shopping
  - Transportation
  - Companionship

*ALL services are **without** compensation*

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Volunteers

- U.S. Hospice movement was founded by volunteers & continues to play an important role in Hospice care & services.
- According to NHPCO, Hospice volunteers provide services in 3 general areas:
  1. Direct Support/Patient Care: Spending time with patients and families.
  2. Clinical Support: Providing clerical & other services to support patient care & clinical services.
  3. General Support: Fundraising, outreach, education, and serve on board of directors.

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NHPCO – Volunteer Service

Volunteers

In 2016 the majority of volunteer time was for direct patient care and the majority of volunteers were designated as direct care volunteers.

TABLE 17. VOLUNTEER TIME*

Type of Volunteer Service	Percentage of Volunteer Time
Direct Patient Care	42.7 %
Clinical Support	29.9%
Non Clinical	24.4%

*2015 and 2016 combined

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Volunteers (continued)

- CoPs mandate that minimum of 5% volunteer utilization in relation to direct patient care (Section 418.70 CoP (e): *"Hospice must document and maintain a volunteer staff sufficient to provide administrative or direct patient care in an amount that, at a minimum, equals five percent of the total patient care hours……."*).
- Documentation forms available for tracking volunteer's time.

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Volunteers (continued)

NOTE: *Volunteers are considered employees so practices related to onboarding, orientation, training, background checks, etc. should be closely aligned with the same practices as other Hospice staff. Their services are provided directly through the Hospice and not through a written contract.*

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Volunteers (continued)

NOTE: If qualified volunteer is licensed or registered, individual must meet all requirements associated with specialty practice and applicable State Laws.

- Volunteer is a key member of IDT and should provide current and relevant information regarding status of patient or family to IDT.

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Non-Core Service: Hospice Aide

- Duties performed by Hospice aide must be in accordance with Federal and State laws and applicable rules; and, must be consistent with documented training/competency skills.
- *RN responsible* for assigning Hospice aide to specific Hospice patient for care & services.
- *RN must evaluate* and document aide services at least <u>every 14 days</u> *(on site visit).*
- The written *POC, as developed by RN*, must include Hospice aide services as appropriate.

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Hospice Aide (continued)

Duties of Hospice aide may include:

- Providing hands-on personal care.
- Performing simple procedures as an extension of therapy or nursing services.
- Assisting with ambulation or exercises.
- Assisting with self-administered medication.
- Reporting changes in patient's condition to RN; IDT; physician.
- Completing required record documentation.

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Hospice Aide (continued)

RN must complete an *annual on-site visit* to observe/assess Hospice aide's performance including:

- ✓ Following patient's POC as assigned by RN.
- ✓ Creating successful interpersonal relationships with patient and family.
- ✓ Demonstrating competency with assigned tasks.
- ✓ Complying with infection control policies.
- ✓ Reporting changes in patient's condition.

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Non-Core Service: Homemaker

- Homemaker services must be provided by qualified homemaker as mandated by State.
- Homemaker services may include assistance in maintaining a safe/healthy environment which enables patient/family to carry out the Hospice POC.
- *Homemaker services do not include providing personal care or any hands-on services.*
- *Member of IDT must coordinate/supervise homemaker services.*

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Interdisciplinary Team (IDT)

Medical Director
Attending Physician
Patient/Family
RN/CM & LPN
Social Worker
HH Aide/Homemaker
Volunteer Coordinator & Volunteers
Dietician
Others (music, massage, art therapists)

Bereavement Coordinator
Spiritual Care Coordinator
PT; OT; SLP
Pharmacist

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Contracted Services

- Hospice Medicare Benefit is the ***most comprehensive*** of all Medicare services – covers many non-core services that Hospice staff ***would not*** provide directly.
- Hospice is the professional and financial manager of care/services provided for the patient & must have contracts to ensure that
  - Care needs are met;
  - Regulations are followed; and,
  - Reimbursement responsibilities are outlined.

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Contracted Services (continued)

- General Inpatient Care
- Respite Care
- Nursing Facility
- Pharmacy Services
- Medical Director & Consulting Physician
- DME / Lab / Radiology
- Ambulance Services
- Therapists
- Supplemental Staff

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Contracted Services (continued)

- Hospice Administrator only person who can sign contracts. Responsibilities and requirements include:
  - Completed / signed prior to using services
  - Orientation / sharing of key documents
  - Education (initial & ongoing)
  - Involvement with QA/PI process
  - Annual review and update of contracts and other documents associated with contract.

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Care Planning

- *The cornerstone for delivery of individualized care and treatment in any healthcare setting is CARE PLANNING!*
- Care Planning provides the *avenue for communication* between caregivers and promotes continuity of care by establishing patient goals and objectives.
- Care planning sets the stage for implementation and evaluation of care provided for the patient.

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Care Planning (continued)

- Care planning provides an opportunity for patient and family to be involved in and make decisions about his/her care.
- The structure for the Hospice care planning, to a greater extent, primarily addresses:
  - ** Pain and symptom management,
  - ** Preparation for death,
  - ** Bereavement for family, and
  - ** End-of-life tasks.

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Care Planning (continued)

- IDT *meets at least every 14 days* to develop/review every patient's POC.
- May meet more frequently when symptoms change and a higher level of care is needed.

NOTE: *State specific rules for frequency of IDG meetings may vary.*

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Eligibility For Medicare Hospice

- Individual must be entitled to Medicare Part A Hospice benefits.
- Attending physician and Hospice Medical Director **must certify** that the *individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course. (NOTE: Hospice medical director can certify as both attending & medical director if patient has no attending physician).*

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Eligibility For Medicare Hospice (continued)

- In order to validate patient's terminal illness & prognosis; and, for the Hospice to be reimbursed, the patient must meet Medicare-approved eligibility through supportive documentation *(as evident in the medical records)* including:
  1. Patient is declining, making it reasonable to believe that the patient has a 6 months or less prognosis.
  2. Patient has a terminal diagnosis

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Eligibility For Medicare Hospice (continued)

3. Patient has significant co-morbidities along with primary diagnosis that together make it reasonable to believe patient has *6 months or less prognosis* per *physician's judgment*.
4. Physician's clinical judgment that patient has *prognosis of 6 months* or less with supporting *clinical documentation.*

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Eligibility For Medicare Hospice (continued)

- *"Determination of life expectancy during the course of a terminal illness is difficult…These criteria form a reasonable approach to the determination of life expectancy……Coverage of Hospice care for patients not meeting the criteria may be denied……..However, some patients may not meet the criteria yet still be appropriate for Hospice care, because of other co-morbidities or rapid decline." (Palmetto GBA: Medicare Review Policy)*

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Principal Diagnoses & Percentages

Principal Diagnosis / Percentage

- Cancer - 27.7 %
- Cardiac and Circulatory - 19.3 %
- Dementia - 16.5 %
- Respiratory - 10.9 %
- Stroke - 8.8 %
- Other - 16.7 %

MedPACT March 2019: 74% had non-cancer DX

- National Hospice and Palliative Care Organization
- https://www.nhpco.org/sites/default/files/public/2016_Facts_Figures

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Patient Gender & Patient Ages

National Hospice and Palliative Care Organization
https://www.nhpco.org/sites/default/files/public/2016_Facts_Figures

Patient Gender - 2015

- Female = 58.7 %
- Male = 41.3 %

Patient Ages - 2015

- < 65 years = 5.4 %
- 65 – 69 years = 7.5 %
- 70 – 74 years = 10.0 %
- 75 – 79 years = 12.7 %
- 80 - 84 years = 17.0 %
- > 84 = 47.4 %

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Eligibility For Medicare Hospice (continued)

- Key documentation forms to be included with patient's medical records:
  - *Hospice Physician Certification*
  - *Attending Physician Certification*
  - *Appointment of Physician Designee*

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Certification

- For initial certification period (*new admission*), *Hospice must obtain verbal or written certification* of terminal illness no later that 2 days after care begins, and written certification before the submission of claim.
- *Supporting clinical documentation* must be attached to certification form: pathology reports; lab results; recent H & P; recent physician notes; change in ADLs; recent hospitalizations; etc.

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Hospice Benefit Election

- The signed form: *"Election of Hospice Benefits"* waives regular Medicare coverage for care related to the terminal illness.
- However, patient still has Medicare coverage for services ***unrelated*** to the terminal diagnosis, but patient will be under the care coordination of Hospice.
- Patient or legal representative may stop Hospice services, and "revoke the benefit" at any time for any reason. Traditional Medicare benefits then resume.

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Hospice Election Timelines

- Obtain certification of terminal illness by Hospice Medical Director and attending physician ***within 2 calendar days*** that Hospice services elected/initiated.
- Complete "Notice of Election" and file with MAC/FI ***within 5 calendar days*** of Hospice election date.

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Entering Notice of Election (NOE)

```
 MAP1711   PAGE 01          CGS J15 MAC - HHH REGION          ACPFA052 MM/DD/YY
 XXXXXXX   SC               INST CLAIM INQUIRY                C201514P HH:MM:SS
 MID              TOB       S/LOC            OSCAR                 SV:    UB-FORM
NPI           TRANS HOSP PROV                    PROCESS NEW MID
PAT.CNTL#:                        TAX#/SUB:                 TAXO.CD:
 STMT DATES FROM          TO          DAYS COV      N-C        CO       LTR
 LAST                              FIRST                  MI    DOB
 ADDR 1                                      2
 3                                 4                                  CARR:
 5                                 6                                   LOC:
ZIP          SEX   MS   ADMIT DATE          HR    TYPE   SRC   D HM       STAT
   COND CODES 01    02    03    04    05    06    07    08    09    10
 OCC CDS/DATE 01          02          03          04          05
              06          07          08          09          10
   SPAN CODES/DATES 01                 02                03
04                  05                06                07
08                  09                10                FAC.ZIP
  DCN
      V A L U E  C O D E S  -  A M O U N T S  -  A N S I   MSP APP IND
01                      02                      03
04                      05                      06
07                      08                      09
   PLEASE ENTER DATA
      PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF7-PREV    PF8-NEXT
```

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Hospice Benefit Periods

- *First 90-day* period (certification)
- *Second 90-day* period (recertification)
- *Unlimited 60-day* benefit period (different States may have their own rules to follow for recertification)

NOTE: First billable day starts when RN initiates the POC with other team members (i.e. not necessarily the date that consent for Hospice services signed).

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Initial 90-Day Benefit Period

- Attending physician (if patient has one) and Hospice MD *must certify* patient's terminal condition.

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Initial 90-Day Benefit Period (continued)

- Physician orders *must be obtained* for all meds, labs, DME, treatments and disciplines serving patient's needs.

- NOTE: Hospice cannot bill for services until Initial POC signed by both physicians (faxed signatures on IPOC acceptable)

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Subsequent Benefit Periods

- No limit to number of re-certifications as long as patient continues to meet eligibility as determined by physician and IDT.
- Each certification requires documentation – signed by Hospice MD and IDT demonstrating continued eligibility.

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CMS / HCFA Letter (09/21/2000)

- *"There is no limit on how long an individual beneficiary can receive Hospice services as long as they meet the eligibility criteria; as long as physician continues to properly and conscientiously recertify the six month prognosis, a beneficiary can continue to receive the Hospice benefit."*

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Reminder.....

- Hospice patient may elect to stop Hospice care and choose to revoke the Hospice Medicare benefit at any time and return to regular Medicare coverage.
- Any remaining days in the Hospice benefit period are forfeited once Hospice care is revoked.
- After revocation of Hospice benefits or a live discharge, if the patient later re-elects Hospice, the next benefit period begins.

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Entering Notice of Termination/ Revocation – NOTR (8XB)

```
 MAP1711   PAGE 01          CGS J15 MAC - HHH REGION          ACPFA052 MM/DD/YY
 XXXXXXX   SC               INST CLAIM INQUIRY                C201514P HH:MM:SS
 MID              TOB      S/LOC          OSCAR                   SV:    UB-FORM
NPI           TRANS HOSP PROV                  PROCESS NEW MID
PAT.CNTL#:                        TAX#/SUB:              TAXO.CD:
 STMT DATES FROM          TO         DAYS COV      N-C       CO      LTR
 LAST                              FIRST               MI    DOB
 ADDR 1                                    2
 3                                 4                                 CARR:
 5                                 6                                  LOC:
ZIP          SEX   MS   ADMIT DATE        HR    TYPE   SRC   D HM      STAT
   COND CODES 01    02    03    04    05    06    07    08    09    10
 OCC CDS/DATE 01          02          03          04          05
              06          07          08          09          10
   SPAN CODES/DATES 01                 02                03
04                  05                06                07
08                  09                10                FAC.ZIP
  DCN
      V A L U E  C O D E S  -  A M O U N T S  -  A N S I   MSP APP IND
01                  02                03
04                  05                06
07                  08                09
```

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Face-To-Face Requirements ("FTF")

- Regulation/law requires that Hospice physician or Hospice nurse practitioner *have* **face-to-face encounter** with Hospice patient *prior to third recertification period* and for *every subsequent period thereafter*.
- Failure to meet the encounter timeframes results in failure by Hospice to meet the patient's recertification of terminal illness eligibility requirement; thus, *patient would cease to be eligible for Medicare Hospice*

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Rules -"FTF" Encounters

- FTF Encounter: Must document the clinical findings supporting a life expectancy of 6 months or less.
- FTF Timeframe: Must occur within 30 calendar days prior to the start of the 3rd benefit period and each subsequent recertification. In documented exceptional circumstances, for a new Hospice admission in the third or later benefit period, the FTF encounter is considered to be timely when performed within 2 days after admission. *Examples included (next slide):*

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"FTF" Exceptional Circumstances (continued)

- An *emergency weekend admission* and the patient cannot be seen by the Hospice physician or the nurse practitioner until the following Monday.
- *Unavailable CMS data systems* resulting in the inability for the Hospice to determine if the patient is in the 3rd benefit period.
- If the *patient dies* within 2 days of admission, a FTF encounter is considered to be complete.

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Rules - "FTF" Encounters (continued)

- Untimely Face-to-Face Encounter: When encounter does not occur timely, the beneficiary is no longer certified as terminally ill, and therefore, is not eligible for the Medicare Hospice benefit.
- In these cases, Hospice must discharge the beneficiary from the Medicare Hospice benefit because patient is no longer considered terminally ill for Medicare purposes.

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Hospice Levels of Care

- **Four Levels:**
  - ❖ Routine Home Care
  - ❖ General Inpatient Care ("GIP")
  - ❖ Continuous Care
  - ❖ Respite Care
    1. Determines category of care received;
    2. Affects documentation;
    3. Determines where care provided; and,
    4. How Hospice reimbursed.

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Hospice Levels of Care (continued)

- Assessed by RN at every visit.
- Changes in care levels decided by IDT.
- Physician order required to change levels.

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Routine Home Care

- Majority of days in Hospice are under "Routine Home Care."
- Care provided wherever patient calls "home" (private residence, NH, ALF, homeless, etc.).
- Care provided per Hospice POC by members of IDT with focus on symptom management, & social, spiritual and psychological support.
- Reimbursed daily regardless of frequency or intensity of services provided.

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Routine Home Care (continued)

- RN responsible for assessing patient's level of care needs and collaborates with physician to ensure that needed care is delivered.
- Level of care includes all Hospice services related to terminal illness & may include:
  - Medications
  - Equipment
  - Supplies
  - Therapies

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General Inpatient Care ("GIP")

- Available for patient during an *acute medical or psychosocial episode.*
- Provides *symptom management* for palliation and management of severe clinical problems related to terminal condition.
- Cannot be managed in regular home setting (wherever that may be).

NOTE: ***No more than 20%*** *of Hospice's total care days should be provided at the inpatient or respite level of care.*

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General Inpatient Care (continued)

- Services provided include routine home care and additional services needed to stabilize an acute medical or psychosocial episode:
  1. Acute pain control & symptom management which cannot be provided in another setting.
  2. Breakdown in home support (i.e. care can no longer be provided in home setting).
  3. Transition patient discharged from hospital who is not ready to return home & is not ready to manage own care.
  4. Inpatient respite for caregiver relief (short term).

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General Inpatient Care (continued)

- Must be provided in contracted SNF, Hospice inpatient unit, or acute hospital setting.
- The center must have a RN in the building to deliver care 24-hours daily / 7 days a week.
- "GIC" is short-term (several days to a week).
- When symptoms resolve, patient returns to home care level of care.
- Need for level of care must be documented in medical record.

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"GIP" – Care In SNF

- Hospice bills Medicare or Medicaid for inpatient stay.
- Hospice is paid at inpatient level rate.
- Hospice pays SNF – agreed upon contracted rate for room and board.
- Hospice pays for all related DME, drugs, supplies, etc. during the inpatient stay; plus, Hospice physician visits; and consulting services.

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"GIP" – Care In Hospital

- Rate determined by how much Medicare pays the Hospice and agreed-upon rate between Hospice and hospital.
- Rate inclusive of all medications, services, DME, supplies, etc. during the inpatient stay.
- ***Possible inpatient care reasons:***

- Nausea/Vomiting/Diarrhea:
  Uncontrollable/protracted even with current anti-emetic/anti-diarrhea treatment.

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"GIP" – Care In Hospital (continued)

- *Possible inpatient care reasons:*
  - Mucositosis:
    Mouth pain/soreness; unable to eat; weight loss.
  - Pain:
    Uncontrolled despite medication changes or requires frequent adjustments.
  - Pruritis:
    Uncontrolled symptoms (related to eczema, allergy, candidiasis, drug reactions, malignant skin lesions, etc.)

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"GIP" – Care In Hospital (continued)

- ***Possible inpatient care reasons:***

- Respiratory Difficulty:

Uncontrolled dyspnea, respiratory secretions; persistent dry or unproductive cough requiring frequent interventions.

- Terminal Restlessness:

Symptoms of uncontrolled anxiety, agitation and restlessness not manageable in current environment.

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Continuous Care

- The intent is to provide *high level 1:1 care & to keep patient at home* (wherever home might be – home, NH, SNF, ALF, etc.).
- Provided for patient in crisis (i.e. needing nursing care to manage acute medical symptoms).

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Continuous Care (continued)

- GOALS of "Continuous Care":
  1. Prevent hospitalization;
  2. Stabilize patient;
  3. Provide training for caregiver on specific procedures; and,
  4. Provide extra support when patient is declining rapidly.

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Continuous Care (continued)

- *Continuous Care Parameters:*
  1. Skilled need is for a **MINIMUM of 8 hours** up to 24 hours (midnight to midnight). NOTE: Does not have to be "continuous" in a 24 hour shift period (i.e. 4 hours in AM and 4 hours in PM).
  2. **50% or more of hours** must be provided by nurse (**RN or LPN**) and the rest with aides or homemakers.
  3. Documentation required every 2 hours.

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Continuous Care (continued)

4. No room and board coverage at this level.
5. No other discipline may be counted toward hours although family/patient may need increased help by other disciplines (needed services to be provided - counselors).
6. *Some cases may need full hours covered by only nurses depending upon acuity of patient's condition and skill level needed.*

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Continuous Care (continued)

7. Usual Hospice services and related DME, medications, supplies, etc. covered.
8. No set limits on provision of continuous care for Hospice.
9. LOS – until symptoms have resolved, usually short-term.

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Respite Care

- Focus is on caregiver relief on an occasional basis, determined by IDT.
- Reasons might include:
  - Caregiver illness
  - Caregiver needs a break
  - Prevent caregiver burnout.

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Respite Care (continued)

- Up to 5 days stay in SNF, hospital-contracted bed; or Hospice inpatient unit.
- Respite Facility not required to have RN in building 24 hours daily / 7days per week unless required by patient's condition.
- Hospice must have *respite contract signed* with Respite Facility.
- *NO "at home" respite benefit.*

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Respite Care (continued)

- Room & board covered up to 5 days. At end of 5 days, patient returns home or makes arrangement to stay at SNF, if accepted/ meets SNF criteria.
- Hospice does not cover room and board charges after 5 days.
- Hospice covers DME, medications, supplies, etc.

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Summary – Four Levels of Care

Level of Care	Site of Care	Special Requirements	Reimbursement	Comment
Routine Home Care	Patient's home, LTCF; ALF; group home; any-where called home	N/A	Market-based at per diem rate	Maximizes independence, bridges gaps in care network.
General Inpatient Care	Hospital, SNF; Hospice inpatient unit	Facility must participate in Medicare & have RN who provides care on each shift 24-hours / 7 days /week Inpatient care (general and respite combined) may not exceed 20% of total number of Hospice days	Market-based at per diem rate	24 hour skilled monitoring and intervention for pain control, psychosocial concerns & symptom management. Patients will be discharged when pain & other symptoms are under control.

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Summary–Four Levels of Care (continued)

Level of Care	Site of Care	Special Requirements	Reimbursement	Comment
Continuous Care	Patient's home, LTCF, ALF, group home or any where called home	Hospice care provides 8 to 24 hours of predominately skilled nursing (RN or LPN). Day of care begins at midnight and ends at midnight next day.	Market based at an hourly rate. Minimum of 8 hours must be provided during 24 hour day.	For crisis periods, to avoid hospitalization, where intermittent skilled monitoring is required. Provided short-term with goal of resolving crisis and controlling pain and other symptoms.

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Summary–Four Levels of Care (continued)

Level of Care	Site of Care	Special Requirements	Reimbursement	Comment
Respite Care	Hospital, SNF, Hospice inpatient unit.	Facility must participate in Medicare. Maximum stay of 5 days per episode. Inpatient care (general and respite combined) may not exceed 20% of total number of Hospice days. Respite contract must be signed.	Market-based at a per diem rate.	This level of care is to relieve family/caregiver stress and prevent burnout.

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CMS – Hospice Level of Care

Hospice Level of Care Utilization

Care Level	National Percentage of Days	Provider-Level Percentage of Days	Provider-Level Standard Deviation
Routine Home Care (RHC)	97.3%	98.1%	4.2%
Continuous Home Care (CHC)	0.4%*	0.2%	2.1%
General Inpatient Care (GIP)	1.9%	1.2%	2.9%
Inpatient Respite Care (IRC)	0.3%	0.3%	0.4%

Data Source: Hospice claims data from CY 2010-CY 2012 for beneficiaries who, in their final claim in CY 2012, were discharged (alive or deceased).

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NHPCO – Hospice Level of Care

Level of Care

In 2016 the vast majority of days of care were at the Routine Homecare (RHC) level.

TABLE 10. LEVEL OF CARE BY PERCENTAGE OF DAYS OF CARE

Level of Care	Percentage of Days of Care
Routine Home Care (RHC)	98.0 %
Continuous Home Care (CHC)	0.2 %
Inpatient Respite Care (IRC)	0.3 %
General Inpatient Care (GIC)	1.5 %

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Advantages of Hospice

- Professional clinical team available 24-hours / day – 7 days / week.
- Care management and coordination of all services and supplies related to terminal illness for provision of optimal pain control, symptom management, and psychosocial/ spiritual care that addresses emotional needs and concerns of patient and family.

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Advantages of Hospice (continued)

- Payment of items related to terminal condition (medications, medical supplies, DME) covered under Hospice benefit.
- Patient's personal physician still involved through collaboration with Hospice MD & IDT.
- Bereavement services provided for family for 13 months following patient's death.

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Identifying Hospice Eligible Patients

- *Eligibility decision ultimate responsibility of physicians;* clinicians provide information that assists physicians with decision for Hospice services: *"Further curative measures are not appropriate and palliative measures are wanted by patient."*
    1. Life expectancy of 6 months or less (must be certified by physician and Hospice medical director).

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Prognosis – "Life Expectancy"

- Physician must document in medical record: *"Patient has a life expectancy of 6 months or less if illness runs its normal course."*
- If patient has no specific diagnosis, it may be coded as: *"Non-Specific Terminal Illness."*
- According to Benefits Protection and Improvement Act (12/21/2000) – clarification: *"Shall be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness."*

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DHHS/HCFA Program Memorandum

January 24, 2001

- Reiterate definition of terminally ill as: *"Life expectancy of 6 months or less if the illness runs its normal course."*
- Reiterates physician's clinical judgment.

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Identifying Hospice Eligible Patients

(continued)

2. Patient experiencing functional decline: Score of less than 50 on Palliative Performance Scale – P.P.S. (patient generally requires considerable assistance with ADLs, may have reduced oral intake, spends most of time sitting or lying down and exhibits changes in cognition).
3. Patient experiencing nutritional decline: BMI less than 22; unintentional weight loss (10% over 6 months); serum albumin less that 2.5 mg/dL.

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Palliative Performance Scale (PPS)

%	Ambulation	Activity and Evidence of Disease	Self-Care	Intake	Level of Conscious
100	Full	Normal activity, no evidence of disease	Full	Normal	Full
90	Full	Normal activity, some evidence of disease	Full	Normal	Full
80	Full	Normal activity with effort, some evidence of disease	Full	Normal or reduced	Full
70	Reduced	Unable to do normal work, some evidence of disease	Full	Normal or reduced	Full
60	Reduced	Unable to do hobby or some housework, significant disease	Occasional assist necessary	Normal or reduced	Full or confusion
50	Mainly sit/lie	Unable to do any work, extensive disease	Considerable assistance required	Normal or reduced	Full or confusion
40	Mainly in bed	Unable to do any work, extensive disease	Mainly assistance	Normal or reduced	Full, drowsy, or confusion
30	Totally bed bound	Unable to do any work, extensive disease	Total care	Reduced	Full, drowsy, or confusion
20	Totally bed bound	Unable to do any work, extensive disease	Total care	Minimal sips	Full, drowsy, or confusion
10	Totally bed bound	Unable to do any work, extensive disease	Total care	Mouth care only	Drowsy or coma
0	Death	—	—	—	—

Palliative Performance Scale (PPS)

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Identifying Hospice Eligible Patients
(continued)

4. Patient has significant co-morbidities that affect prognosis: Different organ systems must be involved; usually several severe chronic illnesses (i.e. Heart Failure or COPD with other disease processes).
5. Diagnoses may include: Malignancy; End Stage Cardiac Disease; End Stage Diabetes; ALS; AIDS; End Stage Alzheimer's Disease; End Stage COPD; ESRD; End Stage CVA; End Stage Parkinson; End Stage Hepatic Disease; Multi-system Failure.

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Functional Assessment Staging

- Divided into 7 categories.
- Stage 6 measures difficulties with basic activities (dressing, bathing, toileting).
- Stage 7 measures speech and movement.
- Sixteen-level scale designed to evaluate/ understand the progression of Alzheimer's disease and dementia.
- Normally, patients in Hospice care for Alzheimer's are in stage 7, experiencing profound levels of difficulty communicating and moving independently.

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Functional Assessment Staging Test

Stage	Stage Name	Characteristic	Expected Untreated AD Duration (months)	Mental Age (years)	MMSE (score)
1	Normal Aging	No deficits whatsoever	--	Adult	29-30
2	Possible Mild Cognitive Impairment	Subjective functional deficit	--		28-29
3	Mild Cognitive Impairment	Objective functional deficit interferes with a person's most complex tasks	84	12+	24-28
4	Mild Dementia	IADLs become affected, such as bill paying, cooking, cleaning, traveling	24	8-12	19-20
5	Moderate Dementia	Needs help selecting proper attire	18	5-7	15
6a	Moderately Severe Dementia	Needs help putting on clothes	4.8	5	9
6b	Moderately Severe Dementia	Needs help bathing	4.8	4	8
6c	Moderately Severe Dementia	Needs help toileting	4.8	4	5
6d	Moderately Severe Dementia	Urinary incontinence	3.6	3-4	3
6e	Moderately Severe Dementia	Fecal incontinence	9.6	2-3	1
7a	Severe Dementia	Speaks 5-6 words during day	12	1.25	0
7b	Severe Dementia	Speaks only 1 word clearly	18	1	0
7c	Severe Dementia	Can no longer walk	12	1	0
7d	Severe Dementia	Can no longer sit up	12	0.5-0.8	0
7e	Severe Dementia	Can no longer smile	18	0.2-0.4	0
7f	Severe Dementia	Can no longer hold up head	12+	0-0.2	0

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Hospice Admission Criteria

ONLY Two (2) Criteria:

1. **Physician certification of eligibility.**

   "Signed by attending physician and Hospice Medical Director; specifies individual's prognosis for life expectancy of 6 months or less if terminal illness runs normal course."

2. **Patient must elect Hospice services and palliative care.**

   "Election of Hospice Benefits" completed & signed by patient or representative.

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Admission Process – 5 Steps

1. Explanation of benefits
2. Eligibility evaluation
3. Election of Benefits
4. Clinical assessment
5. Initiation of POC

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Hospice Discharge -- Reasons

- Revocation of benefits – 6.4%
- Moves out of geographic area – 1.3%
- Transfers to different Hospice (patient may transfer to another Hospice program *once during a benefit period). – 2.1%*
- Discharge for cause – 0.3%
- No longer meets eligibility requirements – 6.6%
- Death – 83.2 %

- Resource: NHPCO – 2017 Edition

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Hospice Revocation

- Federal CoP (418.28(a) states: *"Individual or representative may revoke election of Hospice care at any time during an election period."* MUST be in writing & patient driven.
- Effective date of revocation cannot be earlier than the date that revocation signed. *Verbal revocation is UNACCEPTABLE.*
- Hospice cannot revoke patient's Hospice benefit, neither should Hospice request nor require patient to revoke the benefit.

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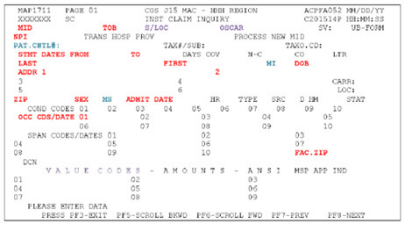
Hospice Revocation (continued)

- Hospice must file notice of termination/ revocation of election with Medicare within 5 calendar days after the effective date of the revocation.



- This prevents the patient from experiencing possible delays in accessing needed care and services.

Discharges and Transfers

In 2016 live discharges comprised 16.8 % of all Medicare hospice discharges.

TABLE 9. DISCHARGES BY TYPE OF DISCHARGE*

Type of Discharge	Percentage
Deaths	83.2 %
Live Discharges – Patient Initiated	
Transfer (change in hospice provider)	2.1 %
Revocations	6.4 %
Live Discharges – Hospice Initiated	
No longer terminally ill	6.6 %
Moved out of service area	1.3 %
Discharge for cause	0.3 %

**Calculations are based on total number of discharges which includes patients who were discharged more than one time in 2016.*

Breaking Barriers: Hospice Myths

1. Physician order required to visit a patient to discuss Hospice services.
2. Patient must die within 6 months.
3. Patient must have a DNR to be eligible.
4. There must be 24 hours/day caregivers.
5. To be eligible, patient must first stop treatment (chemotherapy, radiation therapy, and other modalities).

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Breaking Barriers: Hospice Myths (continued)

6. Under Hospice, every patient receives the same level of care.
7. A patient that is admitted to the hospital must wait until discharged from the hospital to begin Hospice services.
8. Hospice can discharge a patient when the patient refuses to follow the Hospice POC.

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Breaking Barriers: Hospice Myths (continued)

9. If patient chooses Hospice, then he/she must give up regular doctor and Hospice Medical Director assumes all care.
10. If patient is on Hospice, his/her own doctor will not get reimbursed for services.

Hospice Quality Reporting Program

- Consists of two reporting requirements:
  - Hospice Item Set (HIS)
  - Hospice Consumer Assessment of Healthcare Providers (CAHPS®)
- Outcome data from the two reporting requirements calculates performance on quality measures for Hospice Program.

HIS Record Submissions & Timeframes

- *Admission Record* (**14 days** from admission to complete); *Discharge Record* (**7 days** from discharge to complete).
- After completing HIS records, Hospice electronically submits record via QIES ASAP System (Hospice has **30 days** from patient admission or discharge to *submit completed HIS record – CHECK validation report).*
- Records should be submitted EVEN IF patient revokes Hospice benefit or is discharged from Hospice.

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Hospice Quality Reporting Program
(continued)

- HIS data used to calculate 8 National Quality Forum-endorsed measures and one non-NQF-endorsed measure:
  - NQF #1617: Patients Treated with an Opioid who are Given a Bowel Regimen
  - NQF #1634: Pain Screening
  - NQF #1637: Pain Assessment
  - NQF #1639: Dyspnea Screening
  - NQF #1638 Dyspnea Treatment

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Hospice Quality Reporting Program
(continued)

- NQF #1641 Treatment Preferences
- NQF #1647 Beliefs/Values Addressed (if desired by patient) and Hospice Visits when Death is Imminent
- NQF #3235: Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission

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Hospice Quality Reporting Program
(continued)

- Measures calculated from the CAHPS® Hospice Survey – endorsed as NQF #2651.
- Hospice must contract with CMS approved CAHPS® Hospice Survey vendor to conduct the survey on their behalf (using one of the three approved modes – mail, telephone or mixed / mail with telephone follow up).
- Hospice responsible for making sure that survey vendor meets all data submission deadlines; failure of vendor to submit data on time is responsibility of Hospice.

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Hospice Quality Reporting Program
(continued)

(CAHPS®) Hospice Survey Measures:

- Communication with Family
- Getting Timely Help
- Treating Patient With Respect
- Emotional & Spiritual Support
- Help For Pain & Symptoms
- Training Family To Care For Patient
- Rating Of This Hospice
- Willing To Recommend This Hospice

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This Completes The Presentation

- Thank you for your participation
- Questions
- Comments
- Etc.

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Resources

- Accreditation Commission for Health Care (ACHC); "Texas Survey Requirements"; www.achc.org
- CMS; "Hospice Item Set Manual For Completion of HIS" (2018).
- HCR ManorCare Hub; http://hcrmc-online.hcr-manor care.com/4h/public/.
- MED-PASS; "Policies & Procedures Manual for Hospice" (2018)
- SOM; "Appendix M – Guidance To Surveyors: Hospice" (10/09/15)
- "Texas - Licensing Standards for Home and Community Support Services Agencies Handbook" https.//hhs.texas.gov/book/export/html/4403

PLUS -- Multiple resources as identified/listed throughout "Hospice Implementation Manual"

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Contact Information

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