

*GIP: Getting It Right*  
August 2016  
Subscriber Webinar

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*The Plan for This Session*

1. Identify the regulatory requirements for general inpatient level of care
2. Describe patients who are eligible for and can benefit from higher level of care
3. Documentation principles to support the general inpatient level of care and the connection with care planning

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*Levels of Care (LOC)*

Medicare pays the hospice a *per diem* rate based on one of four levels of care

- Routine Home Care
- Inpatient Respite Care
- General Inpatient Care
- Continuous Home Care

Level of care determination

- Made by the hospice interdisciplinary team (IDG)
- Reevaluated by the IDG on a regular basis to assure appropriateness
- Requires a change to the plan of care (POC)

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*Hospices Not Providing All Levels of Care*

Category	No GIP	No CHC	No Respite	No GIP or CHC
All Hospices	28%	58%	25%	19%
By total # of Medicare Pts in 2013				
Less than 100	57	71	54	41
100 – 199	25	60	22	17
200 – 299	17	58	11	10
300 – 499	8	50	6	5
500 or more	2	39	2	1

MedPAC Report to the Congress: Medicare Payment Policy March 2015

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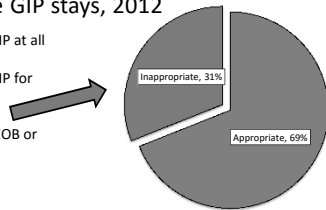
*OIG Interest in GIP March 2016 Report*

**Inappropriate GIP stays, 2012**

20% - did not need GIP at all

10% - did not need GIP for part of stay

1% - no evidence of EOB or terminal illness




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*OIG March 2016 Report On GIP*

- Hospices did not meet care planning requirements for 85 percent of GIP stays
- 72 percent of GIP stays, the hospice care plan was missing at least one key element
- In about half the stays, the hospice care plan was not developed by all the required parties

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*OIG Recommendations to CMS*

1. Increase its oversight of hospice GIP claims and review Part D payments for drugs for hospice beneficiaries;
2. Ensure that a physician is involved in the decision to use GIP;
3. Conduct prepayment reviews for lengthy GIP stays;
4. Increase surveyor efforts to ensure that hospices meet care planning requirements;
5. Establish additional enforcement remedies for poor hospice performance; and
6. Follow up on inappropriate GIP stays, inappropriate Part D payments, and hospices that provided poor-quality care.

CMS concurred with all six recommendations.

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*Ongoing GIP Issues Identified by CMS*

- Documentation does not support the higher level of care
- Long stays
- Inappropriate use
- No plan initiated for discharge from GIP level of care
- Use of GIP for caregiver breakdown when medical symptoms do not support GIP
- Quality of care issues

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*Compliance Challenges of Higher Level of Care*

- Ensuring care is provided in accordance with the plan of care and meets professional management responsibilities
- Documenting the rationale for moving to / from higher level of care
- Documenting to support higher level of care
- Increased scrutiny

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*A View of the Regulations*

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*General Inpatient Care (GIP)*

- A day in which a patient receives hospice inpatient care for procedures necessary for pain control or acute or chronic symptom management that cannot feasibly be provided in other settings
- Where
  - Contracted hospital (Medicare-certified)
  - Contracted skilled nursing facility (Medicare-certified)
  - Hospice inpatient facility – a hospice's own or contract (Medicare-certified)
- Facility must have RN 24 hours/day who provides direct care  
*Medicare Hospice Conditions of Participation*

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*General Inpatient Clarification*

- Final Rule CMS-1539 effective August 2007
- Clarified
  - GIP should only be used based on the patient condition
  - When an individual's pain and symptoms must be closely monitored or the intensity of interventions that are required cannot be provided in any other settings
  - GIP can not be used due to caregiver breakdown
  - Advised respite should be used in these circumstances (respite cannot be used for residents of a nursing facility)

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*General Inpatient Care*

- The decision to change a patient’s care to the general inpatient (GIP) level is based on the clinical condition of the individual
- General inpatient care requires the documentation of an acute change in the patient’s condition, requiring aggressive, intensive treatment for the management of symptoms
- Why was the hospice unable to manage the symptoms at the current level of care?

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*General Inpatient Care*

Intensity of care directed towards pain control and symptom management that *cannot be managed in any other setting*

- Close monitoring of pain and symptoms
- Level of care needed to manage pain and symptoms is the basis for the GIP level of care
  - “procedures necessary for pain control or acute or chronic symptom management” §418.202(e)

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*General Inpatient Care*

General inpatient care under the hospice benefit is not equivalent to a hospital level of care under the Medicare hospital benefit

- A brief period of general inpatient care may be needed in some cases when a patient elects the hospice benefit at the end of a covered hospital stay
- Patient continues to need pain control or symptom management
- Cannot feasibly provide in other settings while the patient prepares to receive home care

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*GIP Level of Care in a Contracted Facility*

- Hospice maintains professional management of the patient
  - Documentation by hospice staff should reflect that management
  - Should illustrate the coordination of care between the hospice and the contracted facility providing GIP level of care
- On discharge – need either a discharge summary or copy of the facility clinical record
- Includes residents of NF

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*Discharge Criteria from GIP*

- Medical reasons for admission have stabilized
- Re-established family support system

Discharge planning starts on admission and is reviewed daily

- What is Plan A?
- What is Plan B?

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*Need for GIP*

- Palliation / management of acute medical symptoms
- Observation and monitoring to control pain and other acute symptoms
- Require predominantly nursing care
- Actively dying? Must be a clinical need for services, such as pain control
- Caregiver breakdown? Must have a skilled nursing need going unmet because the caregiver is unwilling or unable to provide the skilled nursing care

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*Psychological and Social Problems*

Questions to ask & responses to document

- What is the specific patient care need going unmet as a result of the caregiver crisis?
- Why can't it be managed in the home?
- Does the patient need placement in a facility?

Does the documentation tell the story?

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*Cues for Need of GIP*

- Increase calls to the office for help
- Difficulty managing symptoms with intermittent visits
- Increase in after hours calls
- Statements of wanting to go to the hospital or to call 911
- Caregiver's anxieties and fears escalating to where no longer can provide skilled care

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*How Does GIP Work?*

*Setting Standards*

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*Making it Happen*

- Determine need for higher level of care meets the requirements (changes in comprehensive assessment)
  - What happened that the patient needs and qualifies for a higher level of care
  - Why can't the patient be managed at RHC?
  - What are the assessment findings?

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*Making it Happen*

- RN contacts the physician regarding the change in the patient's condition and completes the following:
- Documents the discussion with the physician and any order changes
  - Revises POC reflecting the level of care, new or exacerbation of problems necessitating the need for higher level of care, and any changes in interventions
  - Involves all members of IDG in the changes to the plan of care
  - Updates Hospice Aide assignment as applicable
  - Assures the Medication/Patient Profile is updated and complete.

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*Making it Happen*

- Change level of care
- Arrange for transfer
- Documentation should reflect what happened that the patient now needs and qualifies for GIP
  - Interventions attempted and response by patient

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*Involvement of the IDG*

- GIP is primarily focused on skilled nursing needs to met the unmet needs of the patient
- However ....
  - The services of SWs and chaplains should also increase during these periods of crisis
  - SW and chaplain continue to address the psychosocial / spiritual issues which may have escalated depending on the crisis

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*When the Symptoms Are Managed*

- Comprehensive assessment drives changes in POC, i.e. crisis is resolved and symptoms now managed
- Change in plan of care with IDG involvement
  - How will the POC be different?
  - What goals were met?
- Obtain physician orders as appropriate for any new medications / interventions, change in level of care

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*So, How Does Documentation Fit  
In With All of This?*

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*Steps to Successful Documentation*

1. Identify the precipitating event(s) that led to need for higher level of care including any less than successful attempts to control symptoms that occurred prior to starting GIP
2. Identify specific symptoms that are being actively addressed
3. Document skilled care that patient requires and which cannot be managed without GIP
4. Describe the services provided

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*Documentation Prior to the Crisis*

There must be a clinical need precipitated by a crisis for this level of care to be warranted

- What did the assessment show prior to initiation
- Clinical need such as services for pain control, must be clearly evident in the documentation
- Response to interventions tried

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*Admitting Documentation*

- What is the clinical need precipitated by the crisis
- Document failed interventions in the other setting (home, NF, ALF, etc.)
- Reasons why new interventions can't be provided in the other setting
- Why the family can no longer provide the care
- For patients in contract GIP in NF, how will the NF care be different? More intense?
- Involvement of IDG and attending physician in the decision to change to GIP

*Paint the picture why management in their current environment is not realistic*

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*Documentation of GIP Should...*

- Answer these questions
  - Why here?
  - What is happening that can't be managed in the home or at current level in facility setting?
- Reflect a more intensive level of care – should not read the same as routine home care notes
- Expect to see
  - Changes to the plan of care and interventions
  - Medication adjustments or other stabilization treatments
  - Measures being taken to resolve the reason for admission or continued stay
  - Supporting documentation that the family / NF cannot provide needed care

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*Plan of Care*

- Revise the plan of care
  - Problems, interventions and expected outcomes
- Ensure assessments drive the plan of care
- Document response to plan of care and progress / lack of progress towards goals
- If no progress towards goals, adjust Plan of care

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*Admitting Documentation*

- Does this paint the picture why admitted?

*Patient continues to have increased dyspnea, respiratory distress, and associated anxiety, despite increase in steroids and other medication changes over the past 2 days. Patient in need of inhalation treatments every 2 – 3 hours and IV medications every 4 - 6 hours*

- Would it support GIP admission?

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*Daily Documentation*

Should include

- What is the reason for level of care now (today)
- Assessment of signs and symptoms being managed
- Medication changes, titration, patient response
- Quantitative data
  - ADL, needs and dependency
  - Vital signs
  - Intake and output
  - % of meals taken and quantity
  - Pain ratings
- Caregiver teaching
- Discharge planning

Paint the picture of the patient and patient needs as identified on the Plan of Care

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*Visit Notes Must...*

- Continuously and consistently support the terminal prognosis and reason for GIP
  - Reason for admission or continued stay to GIP level of care
  - Measures being taken to resolve the reason for admission or continued stay
- Contain objective measures
  - Contain vital signs, weights, body mass measurements, lab data/values, meal percentages, other objective data
- Documents to problems, interventions and goals in POC
- Wounds – why is this complex care?
- Interventions such as suctioning, positioning, spiritual support

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*Discharge Planning*

- Should begin before patient is admitted to GIP
- Document discharge planning daily
- Delays should be documented along with “Plan B” and attempts to resolve barriers for discharge
- If there is no documentation to support GIP level of care, should change to routine home care

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*GIP Actual Documentation*

- Change in LOC order – GIP
  - Anasarca, decreased urine output
  - POC SN frequencies changed to 5xWeek
- Progress note – GIP
  - Continues to have weeping from edema of upper extremities, RR=20. Medicated with Ativan and Morphine. No anxiety at this time, afebrile. B/P 108/60. Will continue to monitor on GIP for any further decline

Does this paint the picture of why GIP?

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*GIP Documentation*

- Day 1 – admitted from hospital for dyspnea. Is O2 dependent. No pain on admit. Use of accessory muscles, cough, increase secretions, but no other descriptors. On sublingual MS and Ativan every 4 hours as needed.
- Day 2 – tachycardic; use of accessory muscles for breathing. Breathe sounds coarse. O2 4.5 liters via mask. Very short of breath with transfer bed to chair. MS and Ativan 2X in past 24 hours.
- Day 3 – up in chair most of day. Always short of breath. MS 5 times in 24 hours and Ativan 2 times in 24 hours.

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*GIP Documentation - continued*

- Day 4 – Fatigues with minimal exertion. Rales at bases; 2+ BLE edema. Feels good today with no SOB noted. MS x4 and Ativan x2 in past 24 hours. Cardiovascular assessment “improved”. Tentative schedule for discharge on Monday (2 days).
- Day 5 Feels well today. Using NC instead of mask.
- Day 6 – respiratory assessment – no abnormal findings. Lungs clear bilateral. O2 controls shortness of breath. Transferred to NH.

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*GIP Documentation*

- Pain well controlled with current plan of care
- Continue to monitor for comfort
- Terminal care
- Comfortable with no chest pain, coughing, fever, or seizures

What do you think of this?

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*What It Should Say*

- Pain controlled with use of a continuous drip of IV morphine. Uses IV Ativan 2 – 3 times per day to control the dyspnea at rest and gasping for air.
- Chest pain controlled with around the clock Morphine and breakthrough medication 3 – 4 times per day. After aspirating his coffee, now has a wet, non-productive cough and is unable to clear secretions, requiring oral suctioning every 2 – 3 hours. All oral medications have been discontinued.

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*Admitting Documentation*

What about this?

Patient resides at home. Was taking oral pain medication and can no longer swallow. Patient reports pain at a level of between 8 – 9 for the past 24 hours and has not slept. Suppositories have been ineffective. Medications changed to IV with titrating dosing.

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*FAQs*

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*Question*

Is there a maximum number of days a patient can be under the GIP level of care?

- No. As long as the patient qualifies for palliation or management of acute medical symptoms that needs the skilled level of care, there is no limit.
- However be aware that a very long length of stay which generates a large claim may trigger a review of the stay by your MAC

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*Question*

The medication was effective in controlling the pain and the patient hasn't had pain above an acceptable level for 12 hours, do I have to change the higher level of care to RHC?

- There is no hard rule on how long after a symptom is managed that a patient continues to qualify for a higher level of care. You need to look individually at each patient: how long did it take to get it controlled; how many adjustments did you have to make, what is the rest of the patient's condition like; what might you expect the disease progression to look like next?

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*Question*

Do the regulations require a physician's order to change LOC to GIP?

- There is no regulation requiring a physician's order to change the LOC. §418.56(d) addresses *the need to "review, revise and document the individualized plan as frequently as the patient requires, but no less frequently than every 15 calendar days"*

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*Question*

Do the regulations required a daily visit from the hospice RN when a patient is in a contracted bed for GIP?

- No, there is no regulation. However it is a good practice, good care and will help support the need for the GIP level of care.

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*Monitoring &  
Auditing*

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*Processes to Monitor*

- Review of clinical notes to support level of care
  - symptom management
  - Documentation supports ongoing need
  - IDG updates POC with changes to and from GIP

Review of any LOS exceeding 5 days

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*Summary – Key Concepts – GIP*

- §418.108 – Short – term inpatient care
  - Meant to be short term
- Medicare Benefit Manual clearly states that care under GIP must be care that “cannot feasibly be provided in other settings”
- Documentation must demonstrate why care cannot be provided at “home”

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*To Contact Us*

Susan Balfour  
919-491-0699  
[Susan@HospiceFundamentals.com](mailto:Susan@HospiceFundamentals.com)

Roseanne Berry  
480-650-5604  
[Roseanne@HospiceFundamentals.com](mailto:Roseanne@HospiceFundamentals.com)

Charlene Ross  
602-740-0783  
[Charlene@HospiceFundamentals.com](mailto:Charlene@HospiceFundamentals.com)

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## **GIP CONTRACT BED COORDINATION OF CARE GUIDELINES**

These are guidelines to be used as a reference point in developing or refining a hospice's processes for coordination of care for GIP in contract beds. This is not an exhaustive list and will need to be adapted to your hospices processes. There are 5 different processes addressed in these guidelines.

1. Admitted directly from hospital to contract bed in hospital
2. Current hospice patient admitted to contract bed in hospital-unplanned admission
3. Current hospice patient admitted to contract bed in hospital-planned admission
4. GIP in nursing facility-Home patient placed GIP in NF
5. GIP in nursing facility-Current NF resident changed to GIP in NF

**Admitted directly from hospital to contract bed in hospital**

- 1) Initial assessment by hospice RN on day of admission and if there 5 days then complete the comprehensive assessment if not part of initial assessment.
  - a) Development of plan of care.
  - b) Obtain orders for care
- 2) Comprehensive assessment by SW and chaplain within 5 days however the assessment as soon after admission as possible supports better care.
- 3) Daily visit by RN.
  - a) Confirm with hospital billing department this is a hospice patient and your hospice is the payor source and the effective date of the change.
  - b) Daily communication/coordination plan of care with hospitalist, floor nurse, hospital case manager, patient and family.
    - i) Communicate this is a hospice patient.
    - ii) Communicate code status.
    - iii) Share hospice plan of care.
    - iv) Ask the following question
      - (1) What symptoms are being treated? Can they be managed at a different level of care?
      - (2) What are plans? With patient and family goals of care, advance directives? With what the patient wants?
      - (3) Are plans in alignment with hospice plan of care?
    - v) If plans are not in alignment, then what are next steps?
  - c) Discharge planning is the responsibility of the hospice and must be coordinated with the hospital case manager/discharge planner. The hospital should not discharge a patient without the hospice agreement and involvement.
  - d) Daily focus assessment on reason for GIP.
    - i) State clearly reason for GIP. If the reasons have changed, then indicate why.
    - ii) Review the chart, talk with staff to ensure complete information.
    - iii) Document summary of past 24 hours of care to include
      - (1) Interventions, orders, medications, procedures, diagnostics;
      - (2) Outcomes/results;
      - (3) Current status;
      - (4) Why this care cannot be provided in another setting;
      - (5) Plans.
- 4) SW and Chaplain visits individualized to meet the needs of the patient / family
- 5) After discharge from hospital to another setting:
  - a) Make tuck in visit day of discharge;
  - b) Nursing visit day after discharge and then as frequently as necessary depending on patient and family needs. Should probably several times the first week at least.
  - c) Update the POC
  - d) Obtain copy of hospital discharge summary or record.

**Current hospice patient admitted to contract bed GIP in hospital-Unplanned admission**

- 1) RN contacts physician regarding change in condition and obtains orders for care
- 2) Update the POC
- 3) Daily visit by RN
  - a) Daily confirm current reason for hospitalization (ICD 10) with hospital and determine in collaboration with hospice physician if this is related or unrelated. It should be an unusual occurrence when it is not related.
    1. If it is related, make it clear to hospital billing department your hospice is the payor source.
    2. If it is unrelated then review reason and coding with billing department daily in case there has been a change or addition.
  - b) Daily communication/coordination plan of care with hospitalist, floor nurse, hospital case manager, patient and family.
    1. Communicate this is a hospice patient.
    2. Communicate code status.
    3. Share hospice plan of care.
    4. Ask the following question
      - (1) What symptoms are being treated? Can they be managed at a different level of care?
      - (2) What are plans? With patient and family goals of care, advance directives? With what the patient wants?
      - (3) Are plans in alignment with hospice plan of care?
    5. If plans are not in alignment, then what are next steps?
  - c) Discharge planning is the responsibility of the hospice and must be coordinated with the hospital case manager/discharge planner. The hospital should not discharge a patient without the hospice agreement and involvement.
  - d) Daily focus assessment on reason for GIP;
    1. State clearly reason(s) for GIP and if it has changed, then indicate why.
    2. Review the chart, talk with staff to ensure complete information.
    3. Document summary of past 24 hours of care to include.
      - (1) Interventions, orders, medications, procedures, diagnostics;
      - (2) Outcomes/results;
      - (3) Current status;
      - (4) Why this care cannot be provided in another setting;
      - (5) Plans.
- 4) SW and Chaplain visits individualized to needs of the patient / family.
- 5) After discharge from hospital to another setting
  - a) Make tuck in visit day of discharge.
  - b) Nursing visit day after discharge and then as frequently as necessary depending on patient and family needs. Increase to more than 1 to 2 times week for first week.
  - c) Update the POC.
  - d) Obtain copy of hospital discharge summary or record

**Current hospice patient admitted to contract bed GIP in hospital-Hospice arranged**

- 1) Confirm with hospital billing department this is a hospice patient and your hospice is the payor source.
- 2) RN contacts physician regarding change in condition and obtains orders for care
- 3) Update the POC
- 4) Daily visit by RN
  - a) Daily communication/coordination plan of care with hospitalist, floor nurse, hospital case manager, patient and family.
    1. Communicate this is a hospice patient.
    2. Communicate code status.
    3. Share hospice plan of care.
    4. Ask the following question
      - (1) What symptoms are being treated? Can they be managed at a different level of care?
      - (2) What are plans? With patient and family goals of care, advance directives? With what the patient wants?
      - (3) Are plans in alignment with hospice plan of care?
    5. If plans are not in alignment, then what are next steps?
  - b) Discharge planning is the responsibility of the hospice and must be coordinated with the hospital case manager/discharge planner.
- 5) Daily focus assessment on reason for GIP
  - (1) State clearly reason(s) for GIP. If the reason has changed, then indicate why.
  - (2) Review the chart, talk with staff.
  - (3) Document summary of past 24 hours of care.
    - (a) Interventions, orders, medications, procedures, diagnostics
    - (b) Outcomes/results
    - (c) Current status
    - (d) Why this care cannot be provided in another setting
    - (e) Plans
- 6) SW and Chaplain visits individualized to meet needs of the patient / family.
- 7) After discharge from hospital to another setting
  1. Make tuck in visit day of discharge
  2. Nursing visit day after discharge and then as frequently as necessary depending on patient and family needs. Should probably several times the first week at least.
  3. Update POC
  4. Obtain copy of hospital discharge summary or record.

**Current hospice patient admitted to contract bed GIP in nursing facility-Home patient placed GIP in NF**

- 1) Ensure contract and 24-hour RN coverage
- 2) RN contacts physician regarding change in condition and obtains orders for care
- 3) Update the POC
- 4) Daily visit by RN.
  - a) Confirm with billing department this is a hospice patient and your hospice is the payor source.
  - b) Daily communication/coordination plan of care with hospitalist, floor nurse, hospital case manager, patient and family.
    - i) Communicate this is a hospice patient.
    - ii) Communicate code status.
    - iii) Share hospice plan of care.
    - iv) Ask the following question
      - (1) What symptoms are being treated? Can they be managed at a different level of care?
      - (2) What are plans? With patient and family goals of care, advance directives? With what the patient wants?
      - (3) Are plans in alignment with hospice plan of care?
    - v) If plans are not in alignment, then what are next steps?
  - c) Discharge planning is the responsibility of the hospice and must be coordinated with the hospital case manager/discharge planner.
  - d) Daily focus assessment on reason for GIP
    - i) State clearly reason for GIP. If reasons have changed, then indicate why
    - ii) Review the chart, talk with staff.
    - iii) Document summary of past 24 hours of care to include:
      - (1) Interventions, orders, medications, procedures, diagnostics
      - (2) Outcomes/results
      - (3) Current status
      - (4) Why this care cannot be provided in another setting
      - (5) Plans
    - iv) Ensure the NF nurses are documenting at least each shift
- 5) SW and Chaplain visits individualized to meet the needs of patient / family
- 6) After discharge from hospital to another setting
  - a) Make tuck in visit day of discharge
  - b) Nursing visit day after discharge and then as frequently as necessary depending on patient and family needs. Should probably several times the first week at least.
  - c) Update the POC
- 7) Obtain copy of NF records and MAR or a discharge summary

**Current hospice patient admitted to contract bed GIP in nursing facility-Current NF resident changed to GIP in NF**

- 1) Ensure contract and 24-hour RN coverage
- 2) GIP for a resident in a NF should be very carefully reviewed to ensure a higher level of care is actually provided by the NF
- 3) RN contacts physician regarding change in condition and obtains orders for care
- 4) Update the plan of care
- 5) Daily visit by RN
  - i) Confirm with billing department this is a hospice patient has been changed to GIP level of care
  - ii) Daily communication/coordination plan of care with hospitalist, floor nurse, hospital case manager, patient and family.
    - (1) Communicate this is a hospice patient.
    - (2) Communicate code status.
    - (3) Share hospice plan of care.
  - iii) Ask the following question
    - (1) What symptoms are being treated? Can they be managed at a different level of care?
    - (2) What are plans? With patient and family goals of care, advance directives? With what the patient wants?
    - (3) Are plans in alignment with hospice plan of care?
  - iv) If plans are not in alignment, then what are next steps?
  - v) Discharge planning is the responsibility of the hospice and must be coordinated with the nursing facility
- 6) Daily focus assessment on reason for GIP
  - (1) State clearly reason for GIP. If reasons have changed, then indicate why.
  - (2) Review the chart, talk with staff.
  - (3) Document summary of past 24 hours of care to include:
    - (a) Interventions, orders, medications, procedures, diagnostics
    - (b) Outcomes/results
    - (c) Current status
    - (d) Why this care cannot be provided in another setting
    - (e) Plans
  - (4) Ensure the NF nurses are documenting at least each shift
- 7) SW and Chaplain visits individualized to need
- 8) Ensure the NF is documenting every shift and can demonstrate a higher level of care
- 9) After change from GIP back to RHC make nursing visit day after change to RHC and then as frequently as necessary depending on patient and family needs. Should probably several times the first week at least.
- 10) After change from GIP, obtain copy of NF records and MAR or a discharge summary

### General Inpatient Audit Tool

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Clinical Record # \_\_\_\_\_ GIP Location: \_\_\_\_\_ DX: \_\_\_\_\_

Hospice Admit Date: \_\_\_\_\_ GIP dates: \_\_\_\_\_ Direct admit from hospital to GIP: Yes/No

D/C from GIP reason: death / RHC home / RHC NF / other: \_\_\_\_\_

*Note: This audit should be a pre-bill sample and review to avoid overpayment issues and provide the opportunity to address any inaccuracies in the claim prior to submitting.*

Indicator	Score	Comments
GIP related to terminal condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Documentation prior to beginning GIP demonstrates clinical need precipitated by a crisis that was not able to be controlled at current LOC. (Includes documentation from direct hospital admits to address what symptoms were being addressed and the effectiveness)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Evidence physician involved with decision to change level of care at onset of GIP and provided orders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
POC updated to include change in level of care and additional care needs / interventions on day of change to GIP. (N/A on if was a direct admission to GIP)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Daily documentation supports GIP-was the reason clear and did care address the reason		
<b><u>Date:</u></b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	



Indicator	Score	Comments
<u>Date:</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<u>Date:</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<u>Date:</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<u>Date:</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<u>Date:</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Overall documentation supports GIP level of care	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Evidence physician involved with decision to change level of care back to RHC and provided orders	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
POC updated to include change in level of care and additional care needs / interventions when changed to different LOC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Documentation supports GIP days	From _____ to _____	