Continuous Home Care

What Does It Mean and How Does a Hospice Make It Work?

December 2016 Webinar

What We Will Cover Today

1. A review of the regulatory requirements for continuous home care level of care
2. A description of patients who are eligible for and can benefit from continuous home care level of care
3. Documentation principles to support this level of care
4. What a hospice should have in place to have a successful continuous home care program
5. The audits and monitors to have in place

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)
- Requires a change to the Plan of Care (POC)
- Reevaluated by the IDG on a regular basis to assure appropriateness

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

The Medicare Regulations

Relating to Continuous Home Care

Subpart F Covered Services
§418.204 Special Coverage Requirements

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

Continuous Home Care

A period of crisis is a period in which a patient requires continuous care, of which *more than half is nursing care, to achieve palliation* or management of acute medical symptoms and only as necessary to maintain the patient at home

Subpart F Covered Services
§418.204 Special Coverage Requirements

Where It Can Be Provided

Private residence

Long term care (when patient is not receiving Part A skilled care)

Assisted living facility

Group home

Hospice residential facility

Continuous Home Care Payment

Payment for continuous home care up to 24 hours/day

Minimum of eight hours of care during a 24 hour day (begins and ends at midnight)

More than half in any 24 hour period must be provided by a hospice employed RN or LPN

If a previously scheduled visit was made on the same day but prior to the start of the crisis, the visit time is not included in the continuous care hours

Continuous Home Care

Provided by a hospice employed RN or LPN/LVN

May enter into arrangements with another hospice program or other entity for the provision of core services in extraordinary, exigent, or other non-routine circumstances.

- Short-term temporary event that was unanticipated
- An unusual circumstance (not routine)
- Must maintain professional management

Continuous Home Care

Continuous home care hours are counted in 15 minute increments

- Rounding to the next whole hour is not permitted
- Units should only be rounded to the nearest increment

Care does not need to be continuous

All hospice aide or homemaker hours must be included in the computation

May not "discount" any portion of the hours in order to meet the requirement that the care be predominantly nursing care

More Rules around Counting Hours

CHC billing should reflect direct patient care during a period of crisis

Time that cannot be counted

- waiting for the patient to arrive
- time taken for meal breaks, used for educating staff, used to report etc.
- Post mortem care
- Modification of the plan of care and supervision of aides

Overlapping of Hours

May be circumstances when patient's needs requires more than one covered discipline at a time
- Results in an overlapping of hours between the nurse and hospice aide

Overlapping hours are counted separately

Ensure that these direct patient care services are clearly documented and are reasonable and necessary

Would be an unusual circumstance

What is Defined as a Crisis?

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

Remember, CHC is an attempt to solve / manage the crisis while allowing the patient to remain at home

Continuous Home Care

Nursing care
- Skilled observation and monitoring when necessary
- Skilled care needed to control pain and other symptoms

May be provided to residents of nursing facilities

If a patient's caregiver has been providing a skilled level of care and the caregiver is unwilling or unable to continue providing care
- May precipitate a period of crisis because the skills of a nurse may be needed to replace the services that had been provided by the caregiver

Cues Indicating the Need for Continuous Home Care

- Increase in 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
- Patients discharged from hospital still requiring short term skilled care needs

How Does It Work?

Making it Happen

Determine need for CHC meets the requirements (changes in comprehensive assessment)

- What happened that the patient needs and qualifies for CHC?

Change in plan of care with IDG involvement

- Comprehensive assessment drives changes in POC, i.e. what is the change in condition
- What care is going to be provided to manage the needs that qualified the patient for CHC?
- How will the POC be different?

As appropriate, obtain physician orders for any new medications or interventions

How Does It Work

Change level of care and provide appropriate staff

Documentation shows what happened that the patient now needs and qualifies for CHC

- Interventions attempted and response by patient

When the Crisis Is Resolved

Comprehensive assessment drives changes in POC, i.e. crisis is resolved

Change in plan of care with IDG involvement

How will the POC be different?

Obtain physician orders as appropriate for any new medications or interventions, change in level of care

When ending

Monitor for few more hours to ensure patient crisis is really over – not just "will stop CHC at end of shift"

Involvement of IDG

Continuous home care is primarily focused on skilled nursing needs to maintain the patient at home

However ….

- The services of SWs and Chaplains are expected during these periods of crisis
- Make sure SW and Chaplain continue to address the psychosocial and spiritual issues which may have escalated depending on the crisis
  - Assessments and plan of care

So How Does Documentation Fit In With All This?

Documentation Is…

The final chapter of the life story of a person

Subjective description of objective reality

How we communicate about the patient and families needs, goals and care

Provides a mechanism for understanding what is working and what still needs to be managed effectively

Supports what is medically reasonable and necessary to support payment

CHC Documentation

Must clearly support the reason (or crisis) and the need to intervene

Document as frequently as necessary to support continued CHC - suggested at least hourly

- Services provided
- Symptoms managed
- Skilled nursing care/interventions provided
  - Monitoring
  - Care provided & response to care
  - Frequency of medications
- Patient's condition and response to care
- Type of personnel providing care

Documentation by the RN Case Manager

Daily visits by the RNCM should tell the story of why CHC, effectiveness of interventions and care required to manage crisis

Provide a summary of the last 24 hours and a plan for the next

- What interventions have been provided
- Response to care
- Plan

CHC for Patients in Nursing Facilities

Documentation not only reflects care provided by hospice staff but also care provided by NF staff

Include copy of NF MAR to reflect medications administered during the period of crisis if hospice staff not administering

Documentation includes care coordination with NF staff

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
- The clinical need such as services for pain control, must be clearly evident in the documentation
- Response to interventions tried

Admitting Documentation

- Document failed interventions tried prior to initiation of CHC
- Reasons why new interventions can't be provided by the current caregiver(s)
- Why the family (or for NF residents why the NF staff) can no longer provide the care

Paint a clear picture about why management in their current environment is not realistic

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 CHC admission?

Admitting Documentation

What about this case?

Reason for CHC: Patient resides in a NF. Recent CVA with left sided paralysis, difficulty swallowing resulting in the need for thickened liquids and pureed diet. Difficulty with speech.

Documentation of CHC Level of Care 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
- Shouldn't read the same as the routine home care notes

Expect to include
- Medication adjustments or other stabilization treatments
- Supporting documentation that the family / NF cannot provide needed care

Ongoing Documentation

Should include
- What the reason for level of care now is (today)
- Assessment of signs and symptoms
- Medication changes, titration, patient response
- ADL needs and dependency
- Vital signs
- Caregiver teaching

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

Ongoing Documentation

Pain management requiring skills of nurse
- Complicated technical delivery of medication
- Can include teaching to patient or family on how to administer
- Frequent evaluation
- Frequent medication adjustment
- Aggressive treatment to control pain

Ongoing Documentation

Symptom Changes

- Sudden deterioration, requiring skills of nurse
- Uncontrolled nausea/vomiting
- Unmanageable respiratory distress
- Frequent, skilled wound care
- Open lesions requiring frequent skilled care
- New or increased delirium, agitation

Clinical Notes Must...

Continuously and consistently support the terminal prognosis and reason for higher level of care

- Reason for admission or continued stay
- Measures being taken to resolve the reason for admission or continued stay

Documents to problems, interventions and goals in POC

Provide the reader with a visual of the whole case, rather than a stagnant snapshot in time

Continuous Care Documentation

Does this tell the story of why?

Death is imminent and family is unable to cope

- *Actively dying*
- *No output*
- *No blood pressure*
- *Falling oxygen levels*

What would be a better description?

What is the real reason for CHC?

How to Build a Successful CHC Program

Review & Evaluate Current Data

1. Referrals not admitted
2. After hours calls for increased symptom management
3. Live discharges due to hospitalizations in non-contracted facility
4. Unplanned hospitalizations
5. # of patients requiring daily visits that are lasting several hours
6. Patient / family complaints

Building Internal Awareness

Support staff as they learn how to appropriately use this new resource

Teach staff that CHC is a patient right and not staff failure

Use IDG to discuss situations where CHC could have been used to improve patient care and outcomes

Building a CHC Team

- Based on review of data, estimate number of patients / days of potential CHC
- Start small
- Staffing
  - Use of LPNs
  - Use of RNs
  - No Agency for RN / LPNs
  - Use of Hospice Aides
- Identification of educational needs

Documentation Needs

- Electronic or paper
- Sign-in logs
- Hourly documentation
- Know how your software counts staff CHC hours
  - Based on payroll / visit time?

Monitoring & Auditing

Processes to Monitor

Pre-billing review of clinical notes to support level of care
- Crisis management
- Documentation supports ongoing need
- Any patients in CHC greater than 3 days

IDG updates the POC when change level of care
- From RHC to CHC
- From CHC to RHC

CHC Processes to Monitor

Continuous home care log
- Time patient arrived
- Time patient died

Clinical notes
- Hourly documentation present

Verify logs to documentation for accuracy of times

Predominantly nursing care (RN/LPN)

Summary – Key Concepts CHC

§ 418.204 – Special coverage requirements

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R&C HEALTHCARE SOLUTIONS

YOUR ACHIEVEMENT IS OUR GREATEST GOAL...

Symptom	Documentation Reflects
Pain Control	✓ At home, pain was out of control despite medication changes ✓ Through and complete pain assessment(s) ✓ Medication adjustments, interventions and response ○ Route, titration, use of prn, frequency ✓ Use of any complimentary therapies and response
Respiratory Distress	✓ Breath sounds / or lack of ✓ Uncontrolled secretions / frequent need for suctioning ✓ Severity of dyspnea ✓ Associated tachypnea ✓ Cough with evidence of symptoms such as anorexia, nausea, vomiting, exhaustion, rib fracture, musculo-skeletal pain ✓ Anxiety level ✓ Difficulty sleeping / sleeping position ✓ Restlessness ✓ Elevation of head of bed ✓ Inability to complete a sentence without gasping ✓ SVN treatments
Nausea / Vomiting / Diarrhea	✓ Nausea / diarrhea intractable at home with current anti-emetic / anti diarrhea regime ✓ Assessment of nausea /diarrhea and interventions ✓ Frequency, amount, type of emesis or diarrhea ✓ Complaints of nausea without emesis ✓ Effects of diarrhea on skin integrity ✓ Hydration status
Family Caregiver Teaching	✓ Caregiver need to learn new modality ✓ Caregiver willingness to learn ✓ Modifications to plan of care to adapt into a home setting ✓ Actual caregiver teaching provided and level of understanding
Insomnia	✓ Lowered pain threshold ✓ Sleep patterns ✓ Assessment of psychosocial history

Symptom	Documentation Reflects
Wound Care	✓ Type of wound ✓ Painful ✓ Malodorous ✓ Disfiguring ✓ Frequent dressing changes ✓ Description of wound ✓ Medication(s) required prior to dressing changes ✓ Dressing changes and other treatments ✓ Patient's response to treatments, dressing changes
Agitation	✓ Description of patient behaviors ✓ Need for presence to control ✓ Effect of agitation on patient and family ✓ Amount, frequency, and effectiveness of medication required to control agitation
Ascites	✓ Respiratory compromise ✓ Diuretic history and response ✓ Response to paracentesis (if applicable) ✓ Abdominal girth ✓ Other edema
Fluid Overload	✓ Position of patient ✓ Oxygen needs ✓ Amount of dyspnea ✓ Edema (amount and location) ✓ Difficulty sleeping at night ✓ Cardiac status
Imminent Death	✓ Terminal restlessness o Agitation o Delirium o Hallucinations ✓ Clinical signs and symptoms of imminent death ✓ Inability for family to cope with the patient dying at home o Psychological interventions o Spiritual interventions