# Higher Levels Of Care:
## General Inpatient Care, Continuous Care & Respite

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## The Plan for Today

1. Identify the regulatory requirements for general inpatient, respite, and continuous home care levels
2. Apply documentation principles to support the general inpatient and continuous home care levels of care
3. Recognize what monitors and audits a hospice should 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)
- Reevaluated by the IDG on a regular basis to assure appropriateness
- Requires a change to the plan of care (POC)

## A View of the Regulations

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## Respite

- Short-term inpatient care to provide relief to the family members or other persons caring for the individual
- May be provided only on an occasional basis
- May not be reimbursed for more than five consecutive days at a time
- May not be provided to residents of a nursing facility

§418.204 Special Coverage Requirements

## Respite – Where?

- Medicare-certified hospice that has inpatient facility
- Medicare-certified hospital
- Medicare or Medicaid certified nursing facility
- Must be able to provide 24-hour nursing services that meet nursing needs of all patients
  - Furnished according to the patient's POC
  - Patient must receive all nursing services as prescribed
  - Must be kept comfortable, clean, well-groomed, and protected from accident, Injury, and infection

Q Does the facility have to have RN coverage 24 hours / day?

A Not according to Medicare but dependent on individual state regulations

## 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
  - Contracted skilled nursing facility (Medicare-certified)
  - Hospice inpatient facility – you own or contract (Medicare-certified)
- Facility must have RN 24 hours/day who provides direct care

## General Inpatient Clarification

- Final Rule CMS-1539 effective August 2007
- Clarifications
  - 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)

FY 2008 Wage Index Final Rule
CMS-1539
effective August 2007

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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?

## 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)

## 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

## 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

## 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?

## Continuous Home Care

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
- 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

§ 418.204
Special coverage requirements nursing care

## Continuous Home Care

- Payment for continuous home care may be made for up to 24 hours/day
- Requires a minimum of eight hours of care during a 24-hour period that begins and ends at midnight
- More than half of the care in any 24-hour period must be provided by a RN or LPN/LVN
- Billable time stops when patient dies

## Continuous Home Care

- 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
- Only direct patient care during the period of crisis
  - Cannot count time waiting for the patient to arrive
  - Post mortem care does not count towards hours to meet the requirements
  - Modification of the plan of care and supervision of aides does not qualify as direct care nor would it qualify as necessitating the services of more than one provider
- Care does not need to be continuous

## Counting Continuous Care Hours

- CHC billing should reflect direct patient care during a period of crisis
  - It does not reflect time related to staff working hours, time taken for meal breaks, time used for educating staff, time used to report etc.
- Continuous 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

## 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

## Continuous Home Care

- Nursing care
  - Skilled observation and monitoring when necessary
  - Skilled care needed to control pain and other symptoms
- 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
- May be provided to beneficiaries residing in nursing facilities

## CHC for Patients in NFs

- 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

## CHC Documentation

- Must clearly support the reason (or crisis) and the need to intervene
- Must illustrate hour by hour, day by day
  - What services provided
  - Patient's condition/response to care
  - Type of personnel providing care

## Need for Higher Level of Care

- Guidelines / reasons for CHC are basically the same as for GIP level of care
- CHC is an attempt to solve / manage the crisis while allowing the patient to remain at home
- GIP is for when an inpatient level of care is need to solve / manage the crisis for those who cannot or do not wish to remain at home

## 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
- Caregiver breakdown? Must have a skilled nursing need going unmet because the caregiver is unwilling or unable to provide the skilled nursing care

## 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?

## The Role of the IDG

- GIP & CHC are primarily focused on skilled nursing needs to met the unmet needs of the patient
- However ….
  - The services of SWs and chaplains are expected to increase during these periods of crisis
  - SW and chaplain continue to address the psychosocial / spiritual issues which may have escalated depending on the crisis
    - Assessments and plan of care
    - Determine if the family will be able to care for the patient at home when the crisis is over

## Cues for Need of Higher Level of Care

- 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

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

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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?

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

## Documentation of GIP & CHC LOCs 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
  - 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

## Daily Documentation

Should include

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

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

**Documentation of Symptom Management**

| Pain Control | Respiratory Distress | Nausea/Vomiting/Diarrhea | Family Caregiving Teaching | Imminent Death |
|---|---|---|---|---|
| 1. At home, pain was out of control despite medication changes<br>2. Through and complete pain assessment(s)<br>3. Medication adjustments, interventions and response; route, titration, use of PRNs, frequency<br>4. Use of any complimentary therapies and response | 1. Breath sounds / or lack of<br>2. Uncontrolled secretions / frequent need for suctioning<br>3. Severity of dyspnea<br>4. Associated tachypnea<br>5. Cough with evidence of symptoms such as anorexia, nausea, vomiting, exhaustion, rib fracture, musculoskeletal pain<br>6. Anxiety level<br>7. Difficulty sleeping / sleeping position<br>8. Restlessness<br>9. Elevation of head of bed<br>10. Inability to complete a sentence without gasping<br>11. SVN treatments | 1. Nausea / diarrhea intractable at home with current antiemetic / anti-diarrhea regime<br>2. Assessment of nausea, diarrhea and interventions<br>3. Frequency, amount, type of emesis or diarrhea<br>4. Complaints of nausea without emesis<br>5. Effects of diarrhea on skin integrity<br>6. Hydration status | 1. Caregiver need to learn new modality<br>2. Caregiver willingness to learn<br>3. Modifications to plan of care to adapt into a home setting<br>4. Actual caregiver teaching provided and level of understanding | 1. Terminal restlessness<br>a. Agitation<br>b. Delirium<br>c. Hallucinations<br>2. Clinical signs and symptoms of imminent death<br>3. Inability for family to cope with the patient dying at home<br>a. Psychological interventions<br>b. Spiritual interventions |
| **Wound Care** | **Agitation** | **Ascites** | **Fluid Overload** | **Insomnia** |
| 1. Type of wound<br>a. Painful<br>b. Malodorous<br>c. Disfiguring<br>2. Frequent dressing changes<br>3. Description of wound<br>4. Medication(s) required prior to dressing changes<br>5. Dressing changes and other treatments<br>6. Patient's response to treatments, dressing changes | 1. Description of patient behaviors<br>2. Need for presence to control<br>3. Effect of agitation on patient and family<br>4. Amount, frequency, and effectiveness of medication required to control agitation | 1. Respiratory compromise<br>2. Diuretic history and response<br>3. Response to paracentesis (if applicable)<br>4. Abdominal girth<br>5. Other edema | 1. Position of patient<br>2. Oxygen needs<br>3. Amount of dyspnea<br>4. Edema (amount and location)<br>5. Difficulty sleeping at night<br>6. Cardiac status | 1. Lowered pain threshold<br>2. Sleep patterns<br>3. Assessment of psychosocial history |

# Monitoring & Auditing

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## Processes to Monitor

Review of clinical notes to support level of care

- Crisis management
- Documentation supports ongoing need

## Processes to Monitor

IDG updates the POC when change level of care

- From RHC to CHC
- From CHC to RHC
- From RHC to GIP
- From GIP to RHC

## CHC Processes to Monitor

- Continuous home care log
  - Time patient staff began care
  - 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
- 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
- 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

## 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"

# To Contact Us

## We are here for you!!!

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