Utilization of GIP & Continuous Home Care

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Workshop Session

HOSPICE FUNDAMENTALS
KNOWLEDGE • EXPERTISE • COMMON SENSE

Introduction

- Hospices are required to provide all 4 levels of care
- Knowing when and how to use these levels of care is essential to not only remaining in compliance, but also ensuring you are doing all you can to meet the total needs of the eligible patients you are serving
- This talk will explore how to do just that, with a focus on the General Inpatient and Continuous Home Care levels of care

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Objectives

After attending this session, participants will be able to:

1. List 3 ways to identify patients who would potentially benefit from General Inpatient and Continuous Home Care
2. List 3 documentation elements which help make the case for these higher levels of care
3. List 3 common potential pitfalls to adequately documenting these higher levels of care

A brief overview of the levels of care

- The 4 Levels of Care
  - Routine Home Care
  - Inpatient Respite Care
  - General Inpatient Care
  - Continuous Home Care

Some Detail

- Routine Home Care
  - Majority of patients on service
  - Usually at a home or in a facility (e.g. ALF, SNF)
- Inpatient Respite Care
  - Short-term (up to 5 days per episode)
  - Allows caregivers to get a break
  - Patient moved to a facility for this stay

General Inpatient Care (GIP)

- Short term, intensive care for a skilled need in a Hospital, Skilled Nursing Facility or Hospice Inpatient Facility
- Requires lots of oversight and staff help to maintain comfort
- Not possible in another setting: patient has to receive this higher level of care to meet their care needs
- Cannot exceed 20% of the total care days you provide in a given year

Continuous Home Care

- Short term, intensive care for a skilled need provided at the patient's home
- Requires lots of oversite and staff help to maintain comfort
- Not possible without this level of care: patient has to receive this higher level of care to meet their care needs
- Additionally, must provide at least 8 hours in a 24-hour period with more than 50% being provided by a skilled nurse in order to bill at this level of care

Notice Anything Similar?

- Criteria for GIP and Continuous Home care with respect to the kind of care required to justify the level of care are very similar
- Both short-term
- Both require a defined care need that cannot be managed without additional support
- Biggest difference: where the care takes place

Some things to keep in mind

- Higher levels of care continue to be under great scrutiny
- How we document can make **ALL** of the difference between us being paid for the great work we are doing
- Likewise, we need to make sure that those who qualify for these higher levels of care have access to it

During our time together, we will

- Discuss some of the key elements of documenting the GIP and Continuous Home Care levels of care
- Discuss ways of identifying patients who might benefit from those levels of care that are currently on service

Add intense scrutiny to the mix

- When these stays are reviewed, the surveyors often dissect a GIP stay down to the day, paying for some days and not paying for others
- Continues to be an intense area of focus
- We have to make sure our documentation demonstrates the great care we are providing

Some examples of skilled needs

So, when might someone qualify for these levels of care?

- Intensive Pain Management
- Intensive symptom Management
- Intensive Wound Care

- What else?

True/False Questions

- A patient needs to be on parenteral pain medications to qualify for GIP level of care
- A patient has to have out of control symptoms in order to qualify for GIP

Take Home Points

- It is on **US** to demonstrate why a patient needs a higher level of care and appropriate documentation is key to making our case
- Make it obvious in every note why a given patient is receiving this higher level of care
- This will make all the difference should you be asked to explain further why you have chosen a particular level of care for a patient

What may not qualify for a higher level of care?

- Patient dying, but comfortable and has no symptom issues
- Patient is comfortable at the hospital but family is unable/unwilling to take care of patient any longer at home
- Patient is comfortable at the hospital and waiting for paperwork to go through to be sent to a Long-Term Care facility
- Lots of misunderstanding amongst our colleagues about the GIP level of care as well

A common scenario

- A hospitalized patient is referred to your program for possible transfer to your IPU. You get a call from your admissions staff and they tell you they have a patient to send to the IPU. What else do you need to know to help sort out if this patient should be admitted to the IPU?

A common scenario (cont.)

- "Tell me more"
- Why are they calling us today?
- What do they need from us?
- What are the needs we would meet in an inpatient setting that could not be met elsewhere?
- What will you need to help them sort out if this patient should come to your Inpatient Unit (qualify for GIP level of care) or not?

Common Scenario (cont.)

- Are they eligible for the GIP level of care?
- Do they have significant skilled needs that qualify them for GIP level of care, but would rather be home (consider Continuous Home Care)?
- Do the patient/family have an understanding for how ill the patient is and that the prognosis might be measured in hours?

Common Scenario (cont.)

- If the patient does indeed qualify for the GIP level of care, do the patient and family have a clear understanding of the short-term nature of this care?
- Have you talked through what happens if things stabilize?
- What is the "Plan B" should things reach a point where you need to entertain a lower level of care?
- Are the attending physician and hospital staff aligned with the short-term nature of this level of care?

Common Scenario (cont.)

It bears repeating…

- Have expectations been clarified with the patient and family about the goal of IPU placement?
- Do they understand what may happen if the patient reaches a plateau?
- What is the discharge plan should this patient stabilize?

A mile in their shoes…

- Before becoming frustrated with those who don't seem to understand why we can't accept a given patient because we do not believe they qualify for GIP level of care, remember the tremendous pressure our partners are under each and every day to find solutions for their sickest patients
- Understanding can help when you need patience the most

Typical example we have all seen

- You get a frantic phone call from someone on your admissions staff at 459P on a Friday saying we need to admit Mr. Smith right away to the IPU. "Is it okay to send them in?"
- Let's look at how this is may well have occurred
- Why are you getting this call now versus on Tuesday at 11AM?

Before we even got the referral

- The case managers have a Tuesday stand up meeting at 8AM and the supervisor asks the care manager why Mr. Jones has been hospitalized for 17 days. “We need to come up with a discharge plan ASAP”.
- The case manager goes to the floor and finds out the daughter will be in later that day

Story continued

- The case manager speaks to the daughter and has the first advance care planning discussion the daughter has ever heard about her 84yo father with advanced Alzheimer’s Disease who has been admitted to the hospital 3 times in the last 6 months. The daughter is shocked and upset.
- “What do you mean he is not going to get better?”

The story unfolds more

- The daughter has been struggling to care for the father at home by herself for the past 4 years. The patient has recovered every time before he has gone to the hospital. She says she will have to speak to her 2 brothers who live out of state and get back to the case manager.
- The case manager and daughter arrange a follow-up meeting for the the following morning at 11AM.

The days unfold

- The case manager gets an email every morning from his supervisor asking for status updates
- The daughter fails to show up for a follow-up meeting on Wednesday, does not come in on Thursday and does not return calls from the case manager
- The case manager finally connects with the daughter on Friday afternoon after multiple call attempts

See where this is going?

- Understanding the story behind ”why are they calling us now and not 3 days ago” can be really helpful as we try to maintain patience with our partners
- That perspective can help us help them
- Think about all of the missed opportunities to explore healthcare choices before Friday at 459P

Why are we speaking about this scenario?

- Very common with respect to patients referred to us in the hospital setting (and potentially eligible for these higher levels of care)
- Move away from blame/judgement and focus on what can we do to help get that call earlier next time
- Understanding the challenges our partners face can open our eyes to the opportunities to work better with them

Remember we all have challenges

- The Hospital
- The Hospital's staff
- The Attending Physician (have you spoken to a hospitalist lately about all they have to do every day?)
- Our Admissions Staff
- Us

Turn Frustration Into Action

- What can I do to help facilitate having these discussions sooner?
- Is there something we can do to help our colleagues explore health care choices before the 3rd admission of this very ill person?
- How many opportunities did healthcare providers have to discuss these options before that most recent week in the hospital?
- Think that all through

Things you will be asked to negotiate

- A hospitalized patient is clearly eligible for hospice but does not qualify for the GIP level of care

  "What do you mean you can't accept this patient in your IPU? Please have your Medical Director call me ASAP"
- A patient/family heard they can stay as long as they want in the IPU
- An attending physician just needs to "get the patient out" and doesn't understand why you won't take their patient

How do you approach?

- A hospitalized patient is clearly eligible for hospice but does not qualify for the GIP level of care
- It is Friday afternoon at 459P and you find yourself having to tell our hospital colleague an eligible patient does not qualify for the GIP level of care?

Be Proactive!!!

- Make sure our colleagues are familiar with the criteria for GIP so you are not having to try and teach them at 459P on a Friday
- Are there educational opportunities to help our colleagues think through care choices before Friday afternoon?
- Engage with case management leadership early and often

How do you approach?

- A patient/family heard they can stay as long as they want in the IPU
- Work closely with case management to have these conversations together
- Arm our colleagues with the tools to start these often difficult conversations and tee us up to further support the patient/family in these discussions
- Would training in having challenging discussions be helpful at moving these conversations upstream?

How do you approach?

- A referring physician just needs to "get the patient out" and doesn't understand why you won't take their patient
- Are you optimally engaging your Medical Director to help with these crucial conversations?
- Or, perhaps some training to help improve understanding of the levels of care prior to the next urgent referral to foster shared understanding between those who refer patients to us and what we know to be the rules?

Documentation Pearls

- So, what are some examples of ways we can clearly demonstrate that a patient needs the GIP level of care?
- When you teach your staff, what are the key elements you teach them to include in their notes?
- As with all of healthcare, how we document is key to ensuring we get credit for the great work your team does every day.

Documentation Pearls

- Why GIP? Every Note, Every Day
- Why is this care only possible in the GIP setting?
- What will it take for us to consider discharge?
- What are the things that have to be true in order for us to consider a lower level of care?

Example

- "Mr. Jones is admitted to the GIP level of care for help with his intractable pain. He is receiving frequent parenteral pain medication doses to maintain his comfort (7 doses of 3mg IV morphine in the past 24 hours). He is requiring frequent monitoring to ensure optimal palliation which cannot be provided at home. He was tried on oral morphine at home and despite this, his pain was unable to be controlled in that setting. He will remain at this level of care until his pain can be consistently controlled with 2 to 3 doses of oral medications/day for at least 48 hours."

Documentation Pearls for GIP

- Key documentation elements:
  - Why they need GIP
  - What are we doing to meet that need and how long do we need to test/monitor our intervention?
  - What have we tried that did not work in other settings (if applicable)?
  - Why can't these needs be met in any other way?
  - Criteria for when you would consider a transfer back to Routine Level of Care

Documentation Caveats

- Beware of the same note, day after day
- Beware of severity minimization in patients who have been on the unit for awhile

  What happens when everyone you see is very ill?
- Beware of discrepancies among team members in terms of what they are seeing and documenting

Caveats continued

- We can all fall into a rut; make sure providers are not writing the same note, day after day
- When you audit the documentation, does the note you are reviewing tell the story of how ill a given patient is and ALL that you are doing to help maintain their optimal comfort?
- Does the Chaplain's note portray a similar patient that the Physician's does?

Teamwork makes dream work…

- An once of prevention: Team Rounding
- Ensures EVERYONE has all of the latest information and the whole team is aligned
- The input of the entire team can help prevent same note, day after day and also ensures that ALL are on the same page in terms of the plan of care and how they document the condition of the patient and what we are doing to address it

The core of what makes Hospice Care special

- Make sure your interdisciplinary team is working together optimally when providing care to your patients at these higher levels of care
- Must be intentional and deliberate when setting up systems that will support this collaboration in the Inpatient setting
- Is a physician who rounds on patients at 6AM as likely to engage with the entire hospice team as one who engages in team rounding daily at 9AM?

What about those who are already on service?

- Individualized plan of care
- Ask yourself, are patient's needs being currently met optimally where they are right now at the routine level of care?
- If not being optimally met, why? Would placing them on a higher level of care help us take better care of them (i.e. pain not being adequately controlled)?
- Would you be surprised if patient/family/facility called 911 tonight because of symptoms/care issues we are addressing?

A higher level of care needed?

- If you answer "yes" to any of the previous questions, consider GIP or Continuous Home Care as a possible way to help meet these identified needs
- Unmet needs may be much better met at a higher level of care
- Be sure to keep these higher levels of care in mind when things aren't going perfectly

Conclusions

- We all are key to helping determine and document eligibility for GIP and Continuous Home Care
- Consider higher levels of care when things aren't going perfectly and additional support would be beneficial
- Document to tell the story
  - Why are they eligible for GIP?
  - Why they qualify for a higher level of care?
- You are essential to making sure you get credit for the great work you do!

Questions????

Contact Information:

To Contact Us

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