Intake, Admission & Initial Assessment

Barbara Ivanko, LCSW &
Annette Lee, RN, MS, HCS-D, COS-C
June 2022

What?

- Establishing a start of care that:
  - Meets regulatory requirements
  - Prepares the family and the hospice team for meaningful and effective care
  - Establishes eligibility of terminal prognosis from the first minute
  - Reinforces to your referral sources and other providers that your hospice is the best choice

Why?

- Errors and omissions that start at the beginning escalate and compound as care progresses
- A loose disorganized start of care discourages future referrals

When?

- Before the phone rings, and every minute thereafter

How?

Before the Phone Rings

- Who is your customer?
- How are referrals received?
  - Phone
  - Fax
  - E mail or portal
- Who is responding?
  - Possibly the most important job in your hospice

Metrics

- Time to answer/respond
- Time to the bedside
- Time to admit
- Referrals per liaison
- Conversion rate
- Revocation rate
- Competence and expertise and engagement skills of liaisons and front facing personnel

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Referrals:

» This is the number of people referred to your hospice by healthcare providers, family members or others.

Conversion Rate:

» The percentage of patients who are referred that end up being admitted. If that number is very low, your hospice may be turning away eligible patients.

Live Discharge Rate:

» The percentage of patients that your hospice asks to leave your program. If it is too high, it could mean that your hospice is admitting patients who are not yet terminally ill, or discharging patients who are.

Admissions:

» The number of those referred that are admitted.

Revocation Rate:

» The percentage of patients that, after admission, choose to leave your hospice. If this percentage is high or rising, it could indicate service issues.

Time to Admit:

» The time between referral and admission. It isn't easy to call hospice. A prompt response is expected by those that refer patients to your hospice, and it is the right thing to do for patients and families.

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Managing Objections

- "I am really sick, I know that. The home health agency will send out a nurse, and a home health aide, and a physical therapist to help me get my strength back. My Medicare will pay for all my medicine. Why would I choose hospice? I don't want to die"

Certification of Terminal Illness 418.22

- For initial certifications, the hospice must obtain the signature of BOTH the Attending Physician and the Hospice Physician on a certification statement within 2 days after the election period begins. This means by the end of the third day.
- A hospice can buy time in obtaining the written certification by documenting a verbal certification in the patient's chart. If this is done, the hospice has until billing to obtain the written certification. The hospice may not bill without it.

Certification of Terminal Illness 418.22

- CR 5971 clarifies that a fax or an original written or electronic signature is acceptable. Rubber stamps and *Signatures Typed in Fancy Font* do not.
- Must be dated and include the credentials of the signer
- If a new admission has been under hospice care before, a Face to Face visit might be required as well.

Common Problems*

- Confusing an order for hospice care with a verbal or written certification
- Confusing the referring physician with an attending physician—this is especially common for patients being discharged from the hospital. The hospitalist can order hospice care, but the attending physician must give the certification
- Insisting that a patient switch their attending physician to the hospice doctor or nurse practitioner upon admission to a hospice inpatient unit

Important Definition: Attending Physician

- Identified by the patient, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care. If the patient does not have an attending physician, he or she may choose a physician or a NP who is employed by the hospice.
- The hospice conditions of participation at [S]418.52 are clear that it is the patient's right to designate his or her attending physician; therefore, a hospice provider does not have the right to change or assign the patient's attending physician to a NP employed by the hospice

What if they don't have an attending?

- That is just fine!
- The hospice physician can meet all of their needs, and only one certification is required

The Prudent Hospice Clinician Knows That...

- The hospitalist is usually not going to be the hospice attending physician, since they just met the patient.
- Just because a doctor refers a patient to hospice, they are not necessarily the patient's choice for hospice attending physician.
- It is a violation of patient rights to try to influence a patient's choice of hospice attending physician.
- It is essential to always ask the patient if they have a physician that they would like to have as a hospice attending. If they do not, or if the doctor they select does not want to serve in that role, the hospice medical director or a hospice physician can take care of all their needs. In those cases, you don't need two initial certifications of terminal illness.
- If a patient chooses a hospice attending physician, the hospice team should ask that physician how they would like to be involved and informed. Then the team can meet their expectations.

FOR MORE INFORMATION: visit **www.hospicefundamentals.com**

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Election of Hospice Care 418.24*

- The election date must be on or after the date of the signature; no back-dating
- If an individual is incapacitated or not competent to consent for treatment, the healthcare surrogate or proxy may sign
- The healthcare surrogate of proxy may not consent for treatment for a patient who is tired, sleeping, watching TV or has no arms
- Specify with detail why patient is not signing
- Obtain proof that a person that claims to be surrogate or proxy (or guardian) actually is, and put it in the chart.

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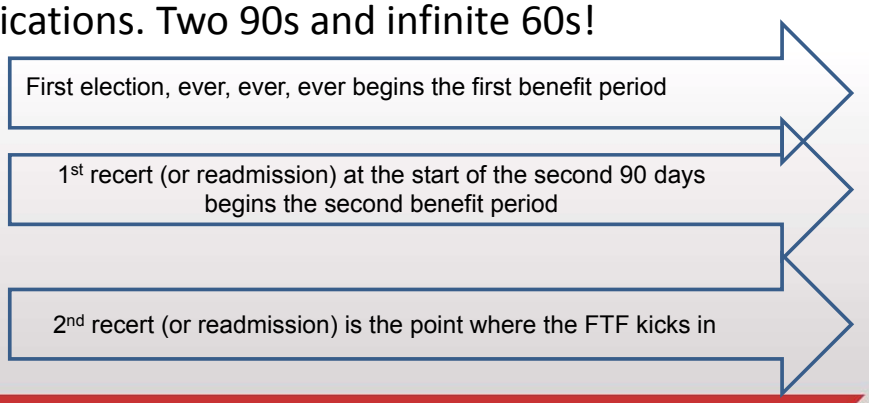
The Face-to-Face Encounter

- Required for patients entering their 3rd benefit period, and all subsequent recertifications. Two 90s and infinite 60s!



The Face-to-Face Encounter*

- A simple way to put this is that a patient about to enter any 60 day re-certification period requires a FTF visit prior to admission
- Important to remember the rules for benefit periods for readmissions, transfers and routine re-certs
- The FTF must occur within 30 days prior to the start of the benefit period, but can be done on the day of admission
  - Emergency admissions

The Face-to-Face Encounter

- The admission certification and any recertifications can be done within 15 days prior to the effective date
- A Nurse Practitioner or hospice physician can perform the FTF, but only the Physician may sign the cert or recert
- The Hospice Physician can be a contractor, but the NP must be a W2 employee
- The Attending Physician may not do the FTF

The Face-to-Face Encounter

- A hospice physician that does the FTF does not have to be the physician signing the cert, but the information must be shared
- The person that performs the FTF must document their findings and attest that the visit actually occurred, and on which date. This documentation is separate from the certification document

The Face-to-Face Encounter

- If a patient *transfers* to another hospice, the previous hospice's FTF is valid (get a copy!)
- However, if a patient is readmitted to any hospice, and the previous FTF is less than 30 days old—a new FTF is still required
- The FTF is not billable, unless it also happens to be a medically necessary visit that the hospice would have billed for anyway. Documentation is key!

Late FTFs

- If an FTF is not completed before the start of the benefit period, the patient is no longer eligible for the hospice benefit and must be discharged, and readmitted. CMS expects that during the interim the hospice continue to provide care free of charge.
- Note that now the patient has a new certification date, so the next recert is 60 days from the date of the readmission, not 60 days from the date of the original recert date.

You are not Paranoid*

- Intermediaries are checking the Election Statement, it must have four components:
  - State which hospice is being elected
  - Explain the hospice's care model (palliative rather than curative)
  - Explain that the Medicare beneficiary is waiving their right to traditional Medicare for the hospice diagnosis
  - Potential for cost sharing
  - Choice for attending
  - Signature and date
  - Opportunity for a list of non covered meds and services

We are from the government…

- "Although hospices are required to educate each patient….on the services identified in the plan of care and document the…level of understanding, involvement and agreement with the plan of care, the amount and nature of anecdotal reports and the amount and nature of non-hospice services being billed to Medicare…suggests that hospice beneficiaries may not be fully informed…"

Past Performance

- Non-hospice providers stating they cannot reach and do not receive return calls from the hospice
- Hospices that didn't know their patient was pursuing care from another provider until they received a bill
- Providers billing Medicare for services that should have been provided by the hospice
- Patients incurring expense for items and services related to symptom relief

On the Election Statement: 418.24 (b)

- The holistic, comprehensive nature of the Medicare hospice benefit
- ***Although it would be rare***, there could be some necessary items, drugs, or services that will not be covered because these items, drugs, or services are to treat a condition that is unrelated to the terminal illness and related conditions.
- Information about beneficiary cost-sharing for hospice services (co-pay for meds)
- *Notification of the beneficiary's (or representative's) right to request an election statement addendum that includes a written list and a rationale for the conditions, items, drugs, or services that the hospice has determined to be* ***unrelated*** *to the terminal illness and related conditions and that immediate advocacy is available through the BFCC-QIO if the beneficiary (or representative) disagrees with the hospice's determination.*

Election Addendum*

- A written list, available upon request by the patient and family, of the conditions, items, drugs and services that the hospice has determined to be unrelated to the terminal illness (within 3 days of the request)
  - If the request is made during the first 5 days of care the hospice has 5 days to provide it.
- The availability of immediate advocacy through the BFCC-QIO
- Provision of the same addendum to non-hospice providers
- No big deal! This information should be available in the medical record

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What % of your patients request an Election Addendum?

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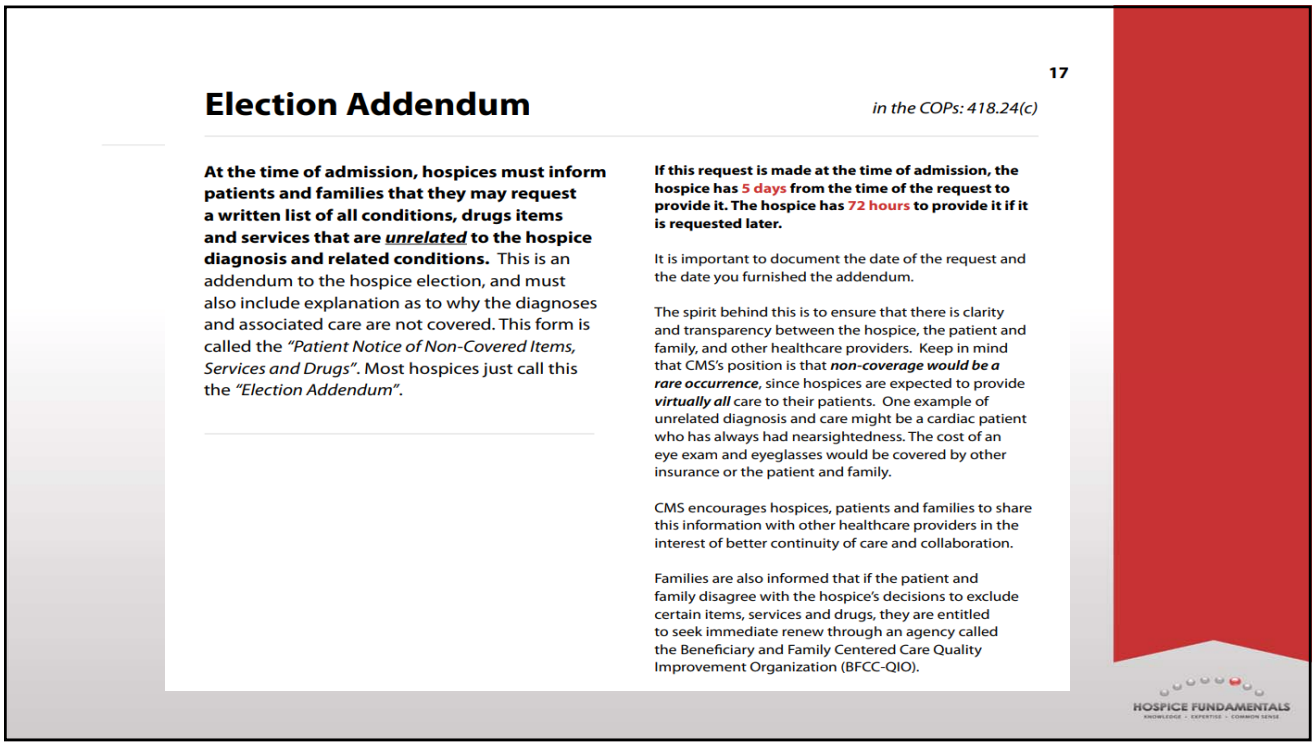
In case you hadn't heard….

- "we reiterated our position that services unrelated to the terminal illness and related conditions ***should be exceptional, unusual and rare…..***"
- ***"We continue to have concerns that these decisions as to what hospices will cover and not cover are based on a more narrow view of the overall condition of the individual"***

Furthermore*

- This requirement is a condition for payment
  - Does not imply the patient and family agree to the statement, only that they acknowledge it was provided
  - The addendum does not have to be submitted with claims, unless ADR
  - Presence of the signed addendum in the patients
  - Requesting patients medical record
  - No separate consent is required to share this addendum with other providers



Admission Process

- Get there, fast
- "Legals" can be completed by a non-nurse
  - Must have expertise and engagement/objection-handling skills
  - Social Workers often used. Is this costly or inefficient?
  - Liaisons!
  - Parallel to the nursing assessment
- Separate set of employees, or should the team members admit their own?

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Case for Admission Team vs. Primary RN*

- Admissions are good news
- Improved response time
- Different skill set; efficient, communication skills, hand-off skills
- Relationship building with facility-based admissions
- Prevents interruptions to care

Meeting the Patient and Family

- No acronyms and jargon
- Expectation management
  - Deliveries
  - Paperwork
  - Hospice team
- Repetition of key points
- Bulleted collateral materials
- Warm and soft hand-off to the teams

Initial Assessment

- **§ 418.54 Condition of participation: Initial and comprehensive assessment of the patient.**
- The hospice must conduct and document in writing a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services, and the patient's need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions.
- (a) ***Standard: Initial assessment.*** The hospice registered nurse must complete an initial assessment within 48 hours after the election of hospice care in accordance with § 418.24 is complete (unless the physician, patient, or representative requests that the initial assessment be completed in less than 48 hours.)

Initial Assessment*

- This is about capturing the **bold-font,** get-it-done stuff that gets the patient and family off to a safe start
  - Pain control
  - Caregiver
  - Imminent death needs
  - Housing placement
- Why not just do the Comprehensive Assessment out of the way?

Eligibility

- The initial assessment must establish terminal prognosis and level of care
  - Why now? Precipitants to admission
  - Previous, unsuccessful attempts at treatment
  - If admitting directly to General Inpatient Care (GIP), why not Routine Home Care?
    - Imminently dying is insufficient to support GIP

Questions????

Contact Information:

To Contact Us

Hospice Fundamentals
561-454-8121
heretohelp@hospicefundamentals.com

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Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

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