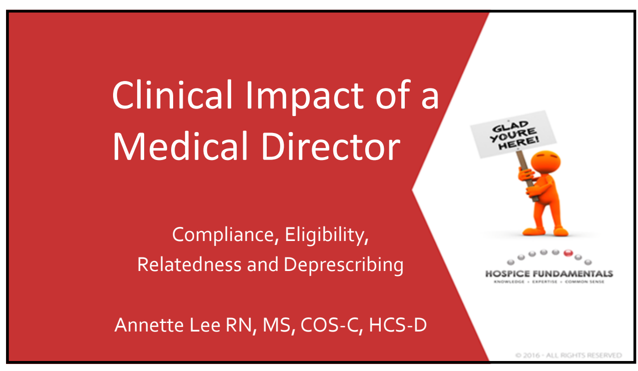

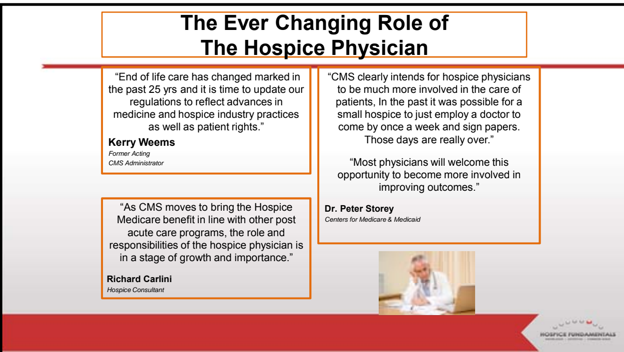

Role, Duties, Functions and Oversight of the Hospice Medical Director

Conditions of Participations (CoPs)

- CMS develops Conditions of Participation (CoPs) that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs.
- These health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries.
- CMS also ensures that the standards of accrediting organizations recognized by CMS (through a process called "deeming") meet or exceed the Medicare standards set forth in the CoPs

Background

- The role of the physician is a centerpiece in Medicare Hospice Conditions of Participation and Conditions for payment!
- The hospice appoints one physician to be the medical director and oversee the medical component of the hospice plan of care for each patient.
- The hospice medical director, and other members of the interdisciplinary team, must collaborate with the patient's attending physician, communicating the patient's wishes and status.

NHPCO - Medicare Hospice Conditions of Participation, Physician Summary, *Highlights of key changes for physicians and guidance for implementation*

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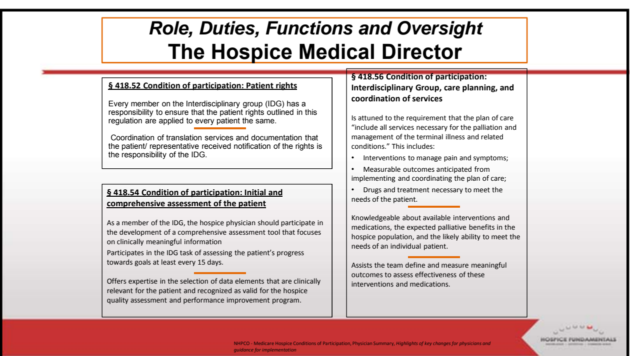

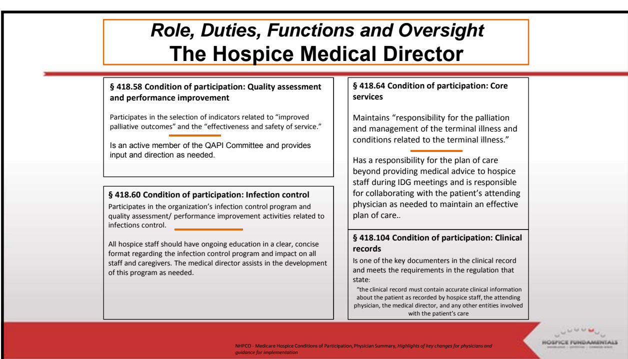

Role, Duties, Functions and Oversight

The Hospice Medical Director

§ 418.100 Condition of Participation: Organization and administration of services

Optimizes the comfort and dignity for a patient and provides care that is consistent with patient and family needs and goals, with patient needs and goals as priority.

Participate in the orientation for hospice staff, other physicians to the "hospice-specific" elements of their position and must themselves be oriented to their role.

§ 418.102 Condition of participation: Medical director

This COP, focuses on medical directors and hospice physicians:

It requires a hospice to designate one physician as medical director. Another hospice physician may be pre-selected as the "physician designee" to fulfill the duties of the medical director as needed.

It also reiterates that the hospice physician must:

1. Have a formal relationship with the hospice (employment or contract);
2. Certify and recertify the patient's prognosis taking into account a variety of
3. Be responsible for the medical component of the hospice plan of care

§ 418.106 Condition of participation: Drugs and biologicals, medical supplies, and durable medical equipment

"Ensures that the IDG confers with an individual with education and training in drug management." ." The hospice physician may be that designated individual and/or may collaborate with the pharmacist member of the IDG.

The IDG, as part of the review of the plan of care, must determine the ability of the patient and/or family to safely self administer drugs and biologicals to the patient in his or her home.

The physician must ensure that verbal drug orders or electronic transmission are only given to a licensed nurse, nurse practitioner (where appropriate), or pharmacist.

NHPCO - Medicare Hospice Conditions of Participation, Physician Summary, *Highlights of key changes for physicians and guidance for implementation*

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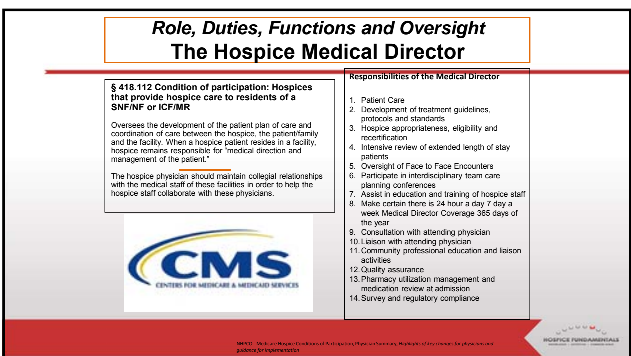

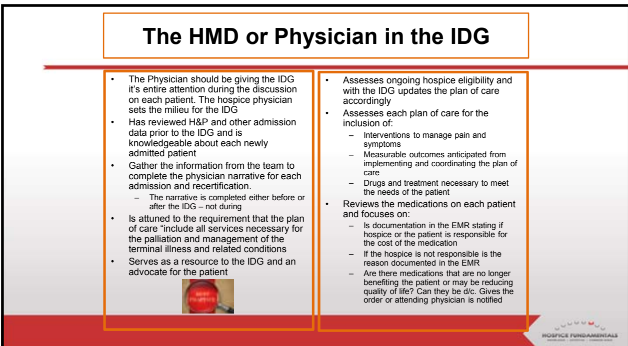

Definition of Hospice Care

Hospice care is intended to meet the physical, emotional and spiritual needs of patients and their families facing a terminal illness with a **prognosis** of **6 months or less** as certified by the primary care physician and the hospice medical director.

The goal of hospice care is to provide comfort to the patient by assisting with pain and symptom management and to enhance the quality of life for both the patient and the family.

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Medicare is Changing the Hospice We've Come to Know

- Changes in the way hospice is reimbursed
- Implementation of the HIS and soon the HOPE – beginning the collection of data from hospice organizations
- Timely filing of the NOE – notice of the election of benefits*
- Listing of all ICD-10 diagnoses and not just those related to hospice
- The F2F ruling in 2008 *
- The 2012 contract requirements outlining the relationship between hospice and skilled nursing facilities *
- Hold hospice responsible for all medications unless it is clearly documented why they are not *
- Increased number of audits on hospice claims submitted*
- Reporting of quality measures and available to the public*

* Involve the Hospice Medical Director directly or indirectly

CMS Changes to the Hospice Benefit

Change in the way hospice is reimbursed

- CMS established a two-tiered payment system for patients receiving routine home care (RHC).
- Reimbursed a higher per diem RHC rate for the first 60 days of a patient's care, and a lower rate for days 61 and after
- Service intensity add-on (SIA) payment is made for visits conducted by RN and/or SW up to 4 hours a day (combined) during the last 7 days of a hospice patient's life

Timely Filing of the Notice of the Election of Benefits (NOE)

- Must be submitted with the MAC electronically within five days after the effective date of the election statement.
- If not submitted the timely, Medicare will not reimburse for days of hospice care from the effective date of election to the date of
- These days will be a provider liability, meaning that the provider will not be paid, although the services have been provided. In addition, the provider may not bill the beneficiary for them.

Implementation of the HIS

Beginning the Collection of Data from Hospice Organizations

- NQF #1634: Pain Screening
- NQF #1637: Pain Assessment
- NQF #1638: Dyspnea Treatment
- NQF #1639: Dyspnea Screening
- NQF #1617: Treated w/ Opioid have Bowel Regimen
- NQF #1641: Treatment Preferences (DNR – Hospital)
- NQF #1647: Beliefs/Values Addressed (Spiritual)*

The F2F ruling in 2008

- Beginning of the patient's 3rd benefit period, and prior to each subsequent benefit period, a hospice physician or **hospice nurse practitioner (NP)** must have a face-to-face encounter (F2F) with the individual to determine continued eligibility of the individual for hospice care and attest that such a visit took place

National Hospice and Palliative Care Organization, Hospice Policy Compendium, The Medicare Hospice Benefit, Regulations, Quality Report and Public Policy, Updated January 4, 2016

CMS Changes to the Hospice Benefit

Listing of all ICD-10 Diagnoses and Not Just Terminal Diagnosis

- Descriptive information completes the picture started with check-based assessments.
- Comparative information establishes longitudinal decline and may indicate decline suggestive of terminal status — particularly important in physician narratives

The 2012 Contract Requirements Outlining the Relationship Between Hospice & SNF

- The hospice and the nursing home must communicate, establish, and agree upon a coordinated plan of care for both providers
- The plan of care must include directives for managing pain and other uncomfortable symptoms
- This coordinated plan of care must identify the care and services which the SNF/NF and hospice will provide

Hold Hospice Responsible for All Medications Unless Clearly Documented Why They Are Not Responsible

- The hospice provides all of the care related to the terminal prognosis, all the diagnoses that contribute to the patient's terminal condition
- Medical conditions with which they have struggled for years but do not contribute to the patient's terminal prognosis are not provided by
- Hospice physician should document the reasons that the medical conditions are unrelated in the patient's medical record

Reporting of Quality Measures and Available to the Public

- The CAHPS® Hospice emphasizes the experiences of hospice patients and their primary caregivers listed in the hospice patients' records
- Process measures from the HIS and claims measures publicly reported

National Hospice and Palliative Care Organization, Hospice Policy Compendium, The Medicare Hospice Benefit, Regulations, Quality Report and Public Policy, Updated

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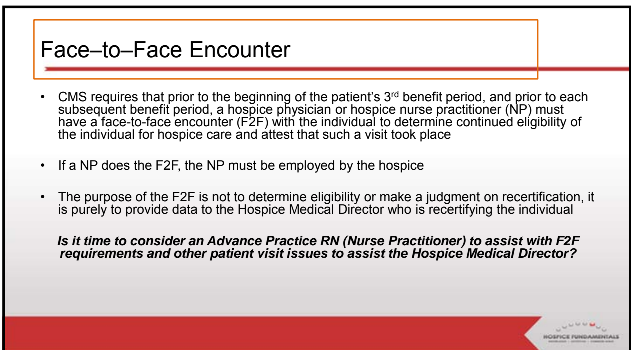

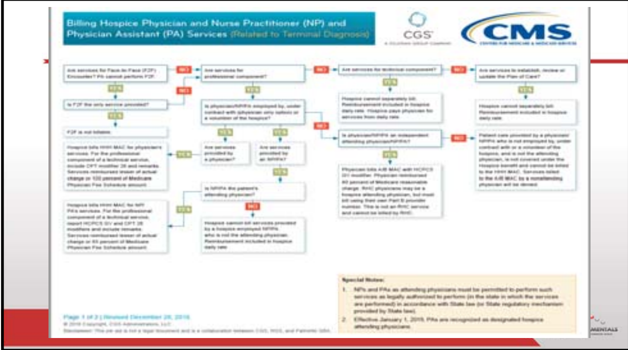

Prognostication Tools

- Local Coverage Determinations (LCDs)
- BMI/Weight
- ADL's
- MMSE/Clock Drawing
- PPS/Karnofsky
- Utilize Supportive Data From:
  - Primary Diagnosis
  - Rate of Decline
  - Co-Morbidities
  - Secondary Conditions
- Disease Specific Tools
  - FAST
  - MELD
  - NYHA
  - Albumin
  - Creatinine Clearance
  - BNP
  - CO_2

The Local Coverage Determinations (LCDs)

- Non –Specific Guidelines
- Cancer
- Dementia (Specific ICD 1-10 Codes)
- Heart Disease
- HIV/AIDS
- Liver Disease
- Pulmonary Disease
- Neurologic Disease
- Renal Disease
- Stroke
- Coma

- CMS "medical criteria" for determining prognosis
- Guidelines, not regulations, but…"given much weight when making a coverage determination"
- Developed by and specific to each Medicare Administrative Contractor (MAC)

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Industry Standard Tools used in Hospice

- Palliative Performance Scale (PPS)
- FAST Scale for Assessing Dementia
- New York Heart Association Functional Classification for Heart Disease
- Numerical Pain Scale (0 – 10)
- Wong Baker Faces Scale for assessing pain in non verbal patients

Table 2: Functional Assessment Staging (FAST)-Stage 7

Stage	Characteristics
7a	Speech ability is limited to six words
7b	Speech ability is limited to one intelligible word per average day
7c	Ambulatory ability is lost
7d	Unable to sit up without assists
7e	Loss of ability to smile
7f	Loss of ability to hold up head independently

Levels of Care – A Brief Overview

Routine Hospice Care

The most common level of hospice care. With this type of care, an individual has elected to receive hospice care is at their residence, which includes a private residence, Assisted Living Facility or Skilled Nursing Facility.

General Inpatient Care

Provided for pain control or other acute symptom management that cannot feasibly be provided in any other setting. General inpatient care begins when other efforts to manage symptoms have been ineffective. General inpatient care cannot be provided in a private residence, an assisted living facility, or a hospice residential facility. However, general inpatient care can be provided in a Medicare certified hospital, hospice inpatient facility, or nursing facility that has a registered nursing available 24 hours a day to provide direct patient care.

Continuous Home Care

Care provided for between 8 and 24 hours a day to manage pain and other acute medical symptoms. Continuous home care services must be predominately nursing care, supplemented with homemaker and hospice aide services and are intended to maintain the terminally ill patient at home during a pain or symptom crisis.

Inpatient Respite Care

Available to provide temporary relief to the patient's primary caregiver. Respite care can be provided in a hospital, hospice facility, or a long term care facility that has sufficient 24 hour nursing personnel present on all shifts to guarantee that patient's needs are met. Respite care is provided for a maximum of 5 consecutive days.

Because patients require **differing intensities of care** during the course of their disease, the Medicare Hospice Benefit affords patients **four levels of care to meet their needs**: routine home care, continuous home care, inpatient respite care, and General Inpatient Care.

94%of hospice care is provided at the routine home care level.

Let's Talk About Eligibility

- Functional Decline
- Frailty Index
- Relationship between Hospice Diagnosis and Co-morbids and Secondary
- Disease Trajectory

Patient-Caregiver Care Continuum

Disease Trajectory

Grief Trajectory

Palliative Medicine Supportive Care		Hospice Care		Bereavement Care
Curative/Restorative Care		High Risk of Futile Care		High Risk for Complicated Grief
Disease Presentation Stable/Unstable Self Management Educational Needs Monitoring	Life Altering/Life Limiting Periods of Decline and Stabilization Episodic, Chronic Acute Care, Community Based Care Needs (Home Health, Skilled Rehab, Outpatient Clinics)	Life Threatening Periods of Rapid Decline Critical Care Needs	Terminal	Increased Risk for Exacerbation of Illness Post Traumatic Stress Depression, Anxiety, Insomnia Mortality

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Burden of Illness and "Normal Course of Illness"

Burden of illness and factors that influence the "normal course" of illness

- Inter-related secondary and co-morbid conditions
- Advanced age
- Degree of frailty
- Environment of care
- Access to other healthcare providers
- *Now taking into account Social Determinants of Health

Why Use A Frailty Index as a Tool for Eligibility?

- Frail older adults are less able to adapt to stressors, such as acute illness or trauma. This increased vulnerability contributes to increased risk for multiple adverse outcomes, including procedural complications, falls, institutionalization, disability, and death [1].
- Frailty in older patients often becomes apparent after adverse outcomes that are related to other geriatric syndromes, including falls, fractures, delirium, and incontinence.
- Frail patients often present with an increased burden of symptoms and medical complexity, and reduced tolerance for medical interventions.
- Frailty is a multifaceted gerontological concept that lacks a clear definition, but may result from an identifiable homogeneous cluster of bio–psycho–social–spiritual factors.

1. Clegg A, Young J, Iliffe S, et al. Frailty in elderly people. Lancet 2013; 381:752.

Common Hospice Eligibility Indicators

- Life limiting condition
- Life expectancy of six months or less
- Not seeking aggressive treatments
- End-stage diagnosis (i.e. Alzheimer's)
- Increase in recent hospitalizations
- Greater than 10% weight loss in the last six months
- Albumin < 2.5
- Requires assistance with most, or all, ADL's
- Family requiring additional support and guidance in caring for a terminal loved one at home
- Each diagnosis has specific eligibility guidelines called Local Coverage Determinations (LCD's)- published by the Medicare Administrative Contractor

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Social Determinants of Health

Environmental issues that facilitate or impede care

- Caregiver availability
- Caregiver ability
- Adaptive equipment
- Financial issues
- High/low intensity of available healthcare providers

Clinical Eligibility

The Clinical Presentation for Determining Terminal Status Should Include the Following:

- Impairment in the structure and function of body systems
- Decline in activity and functional status
- Secondary conditions
- Co-morbid conditions

Secondary Conditions

Examples of conditions that are directly related to the terminal illness:

- Dysphagia is a secondary condition of dementia
- Dyspnea is a secondary condition of CHF

Examples of a conditions that manifest as a result of the terminal condition:

- Decubitus ulcer is a secondary condition of coma
- Pneumonia is a secondary condition of ALS

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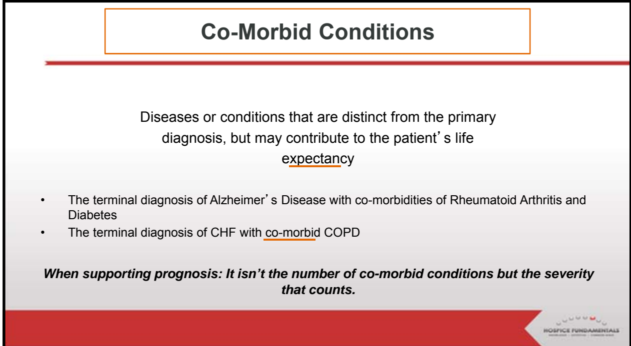

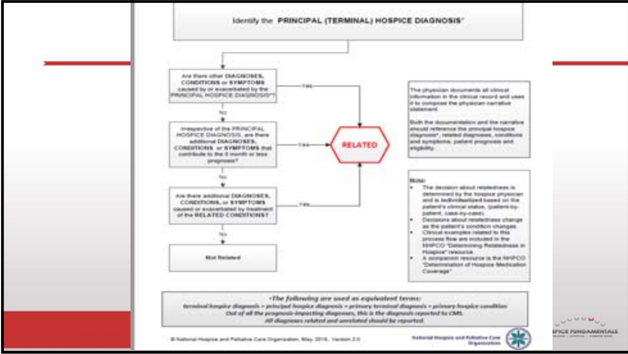

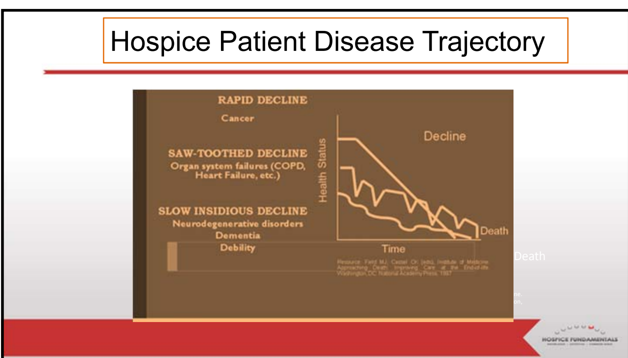

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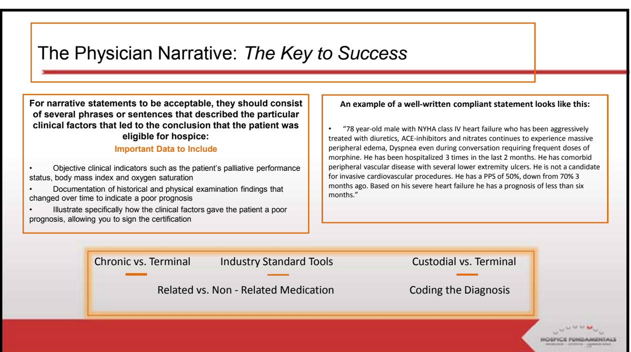

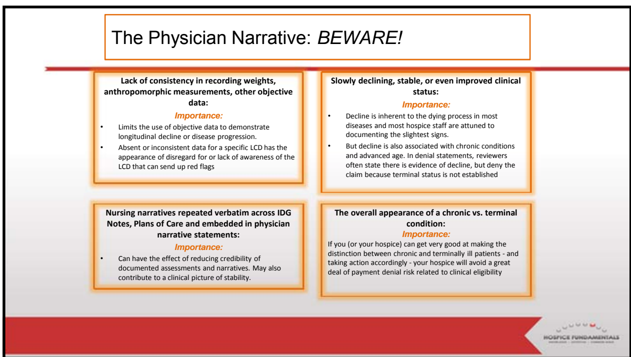

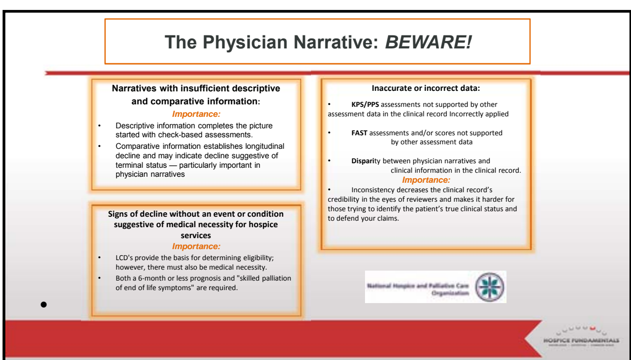

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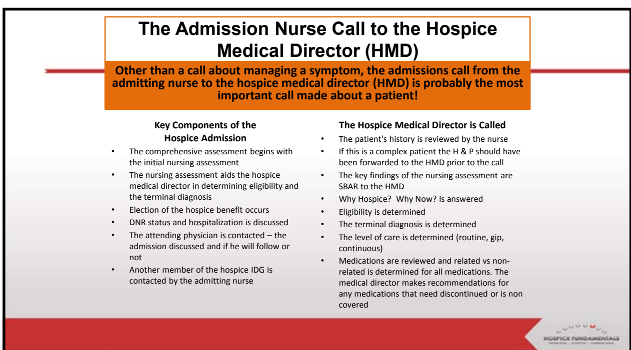

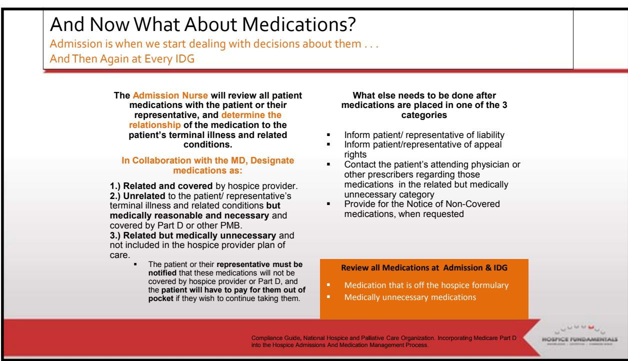

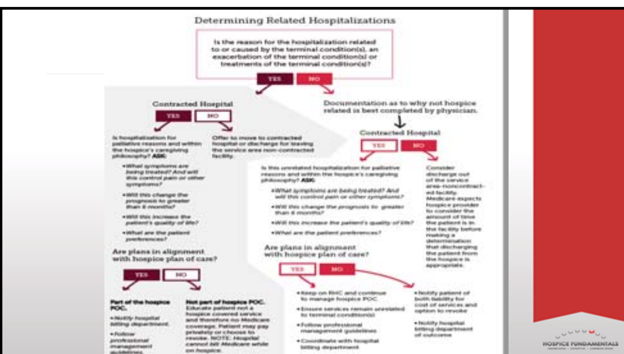

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Problems with Polypharmacy

Since the focus of hospice care is comfort and quality of life, medications that do not provide those benefits are considered unnecessary.

- There are several medications that have been identified as having limited benefit (LBMs) in hospice.
- According to a study published in 2019, approximately 30% of patients admitted to hospice continue at least one LBM.
- Patients more likely to continue LBMs after hospice admission resided in skilled nursing, non-skilled nursing and assisted living centers as compared to patients receiving hospice care at home.

Examples of Limited Effectiveness/Benefit

- Cognitive enhancers — dementia medications
- Cholesterol-lowering medications
- Anti-hypertensives
- Oral diabetes medications
- Osteoporosis treatment medications
- Anti-platelet medications
- Proton-pump inhibitors
- Vitamins and other herbal supplements

Challenges

- The psychological connection to medications**
- Fear of adverse effects from withdrawal of medications
- Patients' and families' expectations and knowledge of body changes and medication benefit at end of life
- Communication with health providers during transitions of care

The hospice medical director can have a large effect on these challenges– from education to team, patient/families, collaboration with attending physician (when applicable)

*See NHPCO Deprescribing Tool Kit for disease specific medication tool

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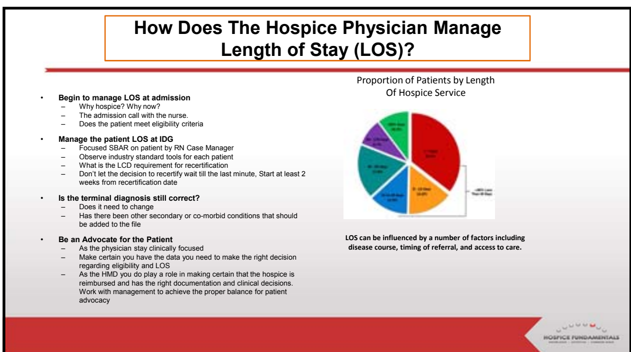

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Questions????

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