


**Clinical Impact of a Medical Director**

Compliance, Eligibility, Relatedness and Deprescribing

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**The Ever Changing Role of The Hospice Physician**

"End of life care has changed marked in the past 25 yrs and it is time to update our regulations to reflect advances in medicine and hospice industry practices as well as patient rights."  
**Kerry Weems**  
Former Acting CMS Administrator

"As CMS moves to bring the Hospice Medicare benefit in line with other post acute care programs, the role and responsibilities of the hospice physician is in a stage of growth and importance."  
**Richard Carlini**  
Hospice Consultant

"CMS clearly intends for hospice physicians to be much more involved in the care of patients. In the past it was possible for a small hospice to just employ a doctor to come by once a week and sign papers. Those days are really over."  
**Dr. Peter Storey**  
Centers for Medicare & Medicaid

"Most physicians will welcome this opportunity to become more involved in improving outcomes."



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**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.

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**Role, Duties, Functions and Oversight  
The Hospice Medical Director**

<p><b>§ 418.52 Condition of participation: Patient rights</b></p> <p>Every member on the Interdisciplinary group (IDG) has a responsibility to ensure that the patient rights outlined in this regulation are applied to every patient the same.</p> <p>Coordination of translation services and documentation that the patient's representative received notification of the rights is the responsibility of the IDG.</p>	<p><b>§ 418.56 Condition of participation: Interdisciplinary Group, care planning, and coordination of services</b></p> <p>It is attuned to the requirement that the plan of care "include all services necessary for the palliation and management of the terminal illness and related conditions." This includes:</p> <ul style="list-style-type: none"> <li>• Interventions to manage pain and symptoms;</li> <li>• Measurable outcomes anticipated from implementing and coordinating the plan of care;</li> <li>• Drugs and treatment necessary to meet the needs of the patient.</li> </ul>
<p><b>§ 418.54 Condition of participation: Initial and comprehensive assessment of the patient</b></p> <p>As a member of the IDG, the hospice physician should participate in the development of a comprehensive assessment tool that focuses on clinically meaningful information.</p> <p>Participates in the IDG task of assessing the patient's progress towards goals at least every 15 days.</p> <p>Offers expertise in the selection of data elements that are clinically relevant for the patient and recognized as valid for the hospice quality assessment and performance improvement program.</p>	<p>Knowledgeable about available interventions and medications, the expected palliative benefits in the hospice population, and the likely ability to meet the needs of an individual patient.</p> <p>Assists the team define and measure meaningful indicators to assess effectiveness of these interventions and medications.</p>

HOPI02 - Medicare Revises Conditions of Participation, Physician Services, Highlights of Key Changes for Physicians and Addressing an Implementation

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**Role, Duties, Functions and Oversight  
The Hospice Medical Director**

<p><b>§ 418.58 Condition of participation: Quality assessment and performance improvement</b></p> <p>Participates in the selection of indicators related to "improved palliative outcomes" and the "effectiveness and safety of service."</p> <p>Is an active member of the QAPI Committee and provides input and direction as needed.</p>	<p><b>§ 418.64 Condition of participation: Core services</b></p> <p>Maintains "responsibility for the palliation and management of the terminal illness and conditions related to the terminal illness."</p>
<p><b>§ 418.60 Condition of participation: Infection control</b></p> <p>Participates in the organization's infection control program and quality assessment/ performance improvement activities related to infections control.</p> <p>All hospice staff should have ongoing education in a clear, concise format regarding the infection control program and impact on all staff and caregivers. The medical director assists in the development of this program as needed.</p>	<p>Has a responsibility for the plan of care beyond providing medical services to hospice staff during IDG meetings and is responsible for collaborating with the patient's attending physician as needed to maintain an effective plan of care.</p> <p><b>§ 418.104 Condition of participation: Clinical records</b></p> <p>Is one of the key documenters in the clinical record and meets the requirements in the regulation that state:</p> <p>"The clinical record must contain accurate clinical information about the patient as recorded by hospice staff: the attending physician, the medical director, and any other entities involved with the patient's care."</p>

HOPI02 - Medicare Revises Conditions of Participation, Physician Services, Highlights of Key Changes for Physicians and Addressing an Implementation

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**Role, Duties, Functions and Oversight  
The Hospice Medical Director**

<p><b>§ 418.100 Condition of Participation: Organization and administration of services</b></p> <p>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.</p> <p>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.</p>	<p><b>§ 418.106 Condition of participation: Drugs and biologicals, medical supplies, and durable medical equipment</b></p> <p>"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.</p>
<p><b>§ 418.102 Condition of participation: Medical director</b></p> <p><i>This COP focuses on medical directors and hospice physicians:</i></p> <p>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:</p> <ol style="list-style-type: none"> <li>1. Have a formal relationship with the hospice (employment or contract);</li> <li>2. Certify and monitor the patient's progress taking into account a variety of;</li> <li>3. Be responsible for the medical component of the hospice plan of care</li> </ol>	<p>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.</p> <p>The physician must ensure that verbal drug orders or electronic transmission are only given to a licensed nurse, nurse practitioner (where appropriate), or pharmacist.</p>

HOPI02 - Medicare Revises Conditions of Participation, Physician Services, Highlights of Key Changes for Physicians and Addressing an Implementation

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### Role, Duties, Functions and Oversight The Hospice Medical Director

**§ 418.112 Condition of participation: Hospices that provide hospice care to residents of a SNFNF or ICF/MR**

Oversees the development of the patient plan of care and coordination of care between the hospice, the patient/family and the facility. When a hospice patient resides in a facility, hospice remains responsible for "medical direction and management of the patient."

The hospice physician should maintain collegial relationships with the medical staff of these facilities in order to help the hospice staff collaborate with these physicians.



CMS - CENTERS FOR MEDICARE & MEDICAID SERVICES

**Responsibilities of the Medical Director**

1. Patient Care
2. Development of treatment guidelines, protocols and standards
3. Hospice appropriateness, eligibility and recertification
4. Intensive review of extended length of stay patients
5. Oversight of Face to Face Encounters
6. Participate in interdisciplinary team care planning conferences
7. Assist in education and training of hospice staff
8. Make certain there is 24 hour a day 7 day a week Medical Director Coverage 365 days of the year
9. Consultation with attending physician
10. Liaison with attending physician
11. Community professional education and liaison activities
12. Quality assurance
13. Pharmacy utilization management and medication review at admission
14. Survey and regulatory compliance

HOSPICE FUNDAMENTALS

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### The HMD or Physician in the IDG

- The Physician should be giving the IDG it's entire attention during the discussion on each patient. The hospice physician sets the milieu for the IDG
  - Has reviewed H&P and other admission data prior to the IDG and is knowledgeable about each newly admitted patient
  - Gather the information from the team to complete the physician narrative for each admission and recertification.
    - The narrative is completed either before or after the IDG - not during
  - Is attuned to the requirement that the plan of care include all services necessary for the palliation and management of the terminal illness and related conditions
  - Serves as a resource to the IDG and an advocate for the patient
- Assesses ongoing hospice eligibility and with the IDG updates the plan of care accordingly
  - Assesses each plan of care for the inclusion of:
    - Interventions to manage pain and symptoms
    - Measurable outcomes anticipated from implementing and coordinating the plan of care
    - Drugs and treatment necessary to meet the needs of the patient
  - Reviews the medications on each patient and focuses on:
    - Is documentation in the EMR stating if hospice or the patient is responsible for the cost of the medication
    - If the hospice is not responsible is the reason documented in the EMR
    - Are there medications that are no longer benefiting the patient or may be reducing quality of life? Can they be dic? Does the order or attending physician is notified

HOSPICE FUNDAMENTALS

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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.

HOSPICE FUNDAMENTALS

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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\*

\* Require the Hospice Medical Director directly or indirectly




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### CMS Changes to the Hospice Benefit

<p><b>Change in the way hospice is reimbursed</b></p> <ul style="list-style-type: none"> <li>• CMS established a two-tiered payment system for patients receiving routine home care (RHC).</li> <li>• 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.</li> <li>• 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.</li> </ul>	<p><b>Implementation of the HIS Beginning the Collection of Data from Hospice Organizations</b></p> <ul style="list-style-type: none"> <li>• NQF #1634: Pain Screening</li> <li>• NQF #1637: Pain Assessment</li> <li>• NQF #1638: Dyspnea Treatment</li> <li>• NQF #1639: Dyspnea Screening</li> <li>• NQF #1647: Treated w/ Opioid have Bowel Regimen</li> <li>• NQF #1641: Treatment Preferences (DNR – Hospital)</li> <li>• NQF #1647: Beliefs/Values Addressed (Spiritual)</li> </ul>
<p><b>Timely Filing of the Notice of the Election of Benefits (NOE)</b></p> <ul style="list-style-type: none"> <li>• Must be submitted with the MAC electronically within five days after the effective date of the election statement.</li> <li>• If not submitted timely, Medicare will not reimburse for days of hospice care from the effective date of election to the date of</li> <li>• These days will be 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.</li> </ul>	<p><b>The F2F ruling in 2008</b></p> <ul style="list-style-type: none"> <li>• Beginning of the patient's 2<sup>nd</sup> 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.</li> </ul>

National Hospice and Palliative Care Organization, Hospice Policy Corporation, The Medicare Hospice Benefit, Regulations, Quality Report and Public Policy, updated 1/18/15




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### CMS Changes to the Hospice Benefit

<p><b>Listing of all ICD-10 Diagnoses and Not Just Terminal Diagnosis</b></p> <ul style="list-style-type: none"> <li>• Descriptive information completes the picture started with check-based assessments.</li> <li>• Comparative information establishes longitudinal decline and may indicate decline suggestive of terminal status — particularly important in physician narratives</li> </ul>	<p><b>Hold Hospice Responsible for All Medications Unless Clearly Documented Why They Are Not Responsible</b></p> <ul style="list-style-type: none"> <li>• The hospice provides all of the care related to the terminal prognosis, all the diagnoses that contribute to the patient's terminal condition</li> <li>• Medical conditions with which they have struggled for years but do not contribute to the patient's terminal prognosis are not provided by</li> <li>• Hospice physician should document the reasons that the medical conditions are unrelated in the patient's medical record</li> </ul>
<p><b>The 2012 Contract Requirements Outlining the Relationship Between Hospice &amp; SNE</b></p> <ul style="list-style-type: none"> <li>• The hospice and the nursing home must communicate, establish, and agree upon a coordinated plan of care for both providers</li> <li>• The plan of care must include directives for managing pain and other uncomfortable symptoms</li> <li>• This coordinated plan of care must identify the care and services which the SNF/NF and hospice will provide</li> </ul>	<p><b>Reporting of Quality Measures and Available to the Public</b></p> <ul style="list-style-type: none"> <li>• The CAHO's* hospice emphasizes the experience of hospice patients and their primary caregivers listed in the hospice patients' records.</li> <li>• Process measures from the HIS and claims measures publicly reported</li> </ul>

National Hospice and Palliative Care Organization, Hospice Policy Corporation, The Medicare Hospice Benefit, Regulations, Quality Report and Public Policy, updated 1/18/15




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### Face-to-Face Encounter

- CMS requires that prior to the beginning of the patient's 3<sup>rd</sup> 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
- If a NP does the F2F, the NP must be employed by the hospice
- The purpose of the F2F is not to determine eligibility or make a judgment on recertification, it is purely to provide data to the Hospice Medical Director who is recertifying the individual

**Is it time to consider an Advance Practice RN (Nurse Practitioner) to assist with F2F requirements and other patient visit issues to assist the Hospice Medical Director?**

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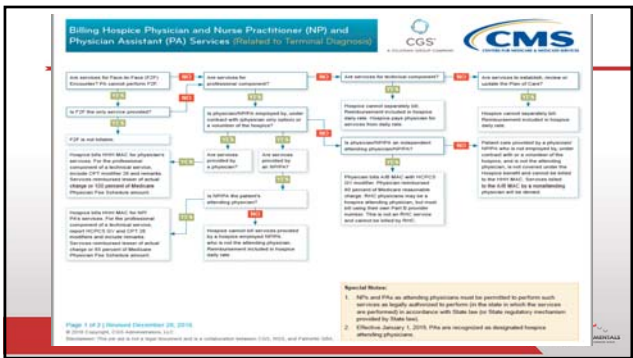
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### Prognostication Tools

- 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<sub>2</sub>

#### 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

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

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### 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 at their residence, which includes a private residence, Assisted Living Facility or Skilled Nursing Facility.

Care provided for between 8 and 24 hours a day to manage pain and other acute medical symptoms. Continuous home care services must be predominantly 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.

#### 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 predominantly 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 site 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.  
90% of hospice care is provided at the routine home care level.

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### Let's Talk About Eligibility

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

Care/Qualification	High Risk of Falls	High Risk for Delirium
<ul style="list-style-type: none"> <li>• Medicare</li> <li>• Medicaid</li> <li>• Private Pay</li> <li>• Long Term Care</li> <li>• Assisted Living</li> <li>• Skilled Nursing Facility</li> <li>• Hospice</li> </ul>	<ul style="list-style-type: none"> <li>• Medicare</li> <li>• Medicaid</li> <li>• Private Pay</li> <li>• Long Term Care</li> <li>• Assisted Living</li> <li>• Skilled Nursing Facility</li> <li>• Hospice</li> </ul>	<ul style="list-style-type: none"> <li>• Medicare</li> <li>• Medicaid</li> <li>• Private Pay</li> <li>• Long Term Care</li> <li>• Assisted Living</li> <li>• Skilled Nursing Facility</li> <li>• Hospice</li> </ul>

Parker R, Hollis-Salis A, Twaddie M, Friend D. 2011. Used with permission

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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




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### 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-psychosocial-spiritual factors.

1. Chou A, Torres A, Kelly S, et al. Frailty in elderly people. *Lancet*. 2013; 381:2069-2078.

Item	0	1	2
1. Weight loss in last 6 months	0	1	2
2. Anorexia	0	1	2
3. Depression	0	1	2
4. Falls	0	1	2
5. Delirium	0	1	2
6. Incontinence	0	1	2
7. Confusion	0	1	2
8. Poor performance on ADL	0	1	2
9. Poor performance on IADL	0	1	2
10. Poor performance on MMSE	0	1	2
11. Poor performance on GDS	0	1	2
12. Poor performance on Barthel ADL	0	1	2
13. Poor performance on Lawton IADL	0	1	2
14. Poor performance on Folstein MMSE	0	1	2
15. Poor performance on Yesavage GDS	0	1	2
16. Poor performance on Barthel ADL	0	1	2
17. Poor performance on Lawton IADL	0	1	2
18. Poor performance on Folstein MMSE	0	1	2
19. Poor performance on Yesavage GDS	0	1	2
20. Poor performance on Barthel ADL	0	1	2
21. Poor performance on Lawton IADL	0	1	2
22. Poor performance on Folstein MMSE	0	1	2
23. Poor performance on Yesavage GDS	0	1	2
24. Poor performance on Barthel ADL	0	1	2
25. Poor performance on Lawton IADL	0	1	2
26. Poor performance on Folstein MMSE	0	1	2
27. Poor performance on Yesavage GDS	0	1	2
28. Poor performance on Barthel ADL	0	1	2
29. Poor performance on Lawton IADL	0	1	2
30. Poor performance on Folstein MMSE	0	1	2
31. Poor performance on Yesavage GDS	0	1	2
32. Poor performance on Barthel ADL	0	1	2
33. Poor performance on Lawton IADL	0	1	2
34. Poor performance on Folstein MMSE	0	1	2
35. Poor performance on Yesavage GDS	0	1	2
36. Poor performance on Barthel ADL	0	1	2
37. Poor performance on Lawton IADL	0	1	2
38. Poor performance on Folstein MMSE	0	1	2
39. Poor performance on Yesavage GDS	0	1	2
40. Poor performance on Barthel ADL	0	1	2
41. Poor performance on Lawton IADL	0	1	2
42. Poor performance on Folstein MMSE	0	1	2
43. Poor performance on Yesavage GDS	0	1	2
44. Poor performance on Barthel ADL	0	1	2
45. Poor performance on Lawton IADL	0	1	2
46. Poor performance on Folstein MMSE	0	1	2
47. Poor performance on Yesavage GDS	0	1	2
48. Poor performance on Barthel ADL	0	1	2
49. Poor performance on Lawton IADL	0	1	2
50. Poor performance on Folstein MMSE	0	1	2
51. Poor performance on Yesavage GDS	0	1	2
52. Poor performance on Barthel ADL	0	1	2
53. Poor performance on Lawton IADL	0	1	2
54. Poor performance on Folstein MMSE	0	1	2
55. Poor performance on Yesavage GDS	0	1	2
56. Poor performance on Barthel ADL	0	1	2
57. Poor performance on Lawton IADL	0	1	2
58. Poor performance on Folstein MMSE	0	1	2
59. Poor performance on Yesavage GDS	0	1	2
60. Poor performance on Barthel ADL	0	1	2
61. Poor performance on Lawton IADL	0	1	2
62. Poor performance on Folstein MMSE	0	1	2
63. Poor performance on Yesavage GDS	0	1	2
64. Poor performance on Barthel ADL	0	1	2
65. Poor performance on Lawton IADL	0	1	2
66. Poor performance on Folstein MMSE	0	1	2
67. Poor performance on Yesavage GDS	0	1	2
68. Poor performance on Barthel ADL	0	1	2
69. Poor performance on Lawton IADL	0	1	2
70. Poor performance on Folstein MMSE	0	1	2
71. Poor performance on Yesavage GDS	0	1	2
72. Poor performance on Barthel ADL	0	1	2
73. Poor performance on Lawton IADL	0	1	2
74. Poor performance on Folstein MMSE	0	1	2
75. Poor performance on Yesavage GDS	0	1	2
76. Poor performance on Barthel ADL	0	1	2
77. Poor performance on Lawton IADL	0	1	2
78. Poor performance on Folstein MMSE	0	1	2
79. Poor performance on Yesavage GDS	0	1	2
80. Poor performance on Barthel ADL	0	1	2
81. Poor performance on Lawton IADL	0	1	2
82. Poor performance on Folstein MMSE	0	1	2
83. Poor performance on Yesavage GDS	0	1	2
84. Poor performance on Barthel ADL	0	1	2
85. Poor performance on Lawton IADL	0	1	2
86. Poor performance on Folstein MMSE	0	1	2
87. Poor performance on Yesavage GDS	0	1	2
88. Poor performance on Barthel ADL	0	1	2
89. Poor performance on Lawton IADL	0	1	2
90. Poor performance on Folstein MMSE	0	1	2
91. Poor performance on Yesavage GDS	0	1	2
92. Poor performance on Barthel ADL	0	1	2
93. Poor performance on Lawton IADL	0	1	2
94. Poor performance on Folstein MMSE	0	1	2
95. Poor performance on Yesavage GDS	0	1	2
96. Poor performance on Barthel ADL	0	1	2
97. Poor performance on Lawton IADL	0	1	2
98. Poor performance on Folstein MMSE	0	1	2
99. Poor performance on Yesavage GDS	0	1	2
100. Poor performance on Barthel ADL	0	1	2




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### 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



Health Equities: Equity, Access, Affordability, Health Care, Education, Social and Community Context, Health and Behavior, Health Care Systems

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**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

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**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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### Co-Morbid Conditions

Diseases or conditions that are distinct from the primary diagnosis, but may contribute to the patient's life expectancy

- The terminal diagnosis of Alzheimer's Disease with co-morbidities of Rheumatoid Arthritis and Diabetes
- The terminal diagnosis of CHF with **co-morbid** COPD

**When supporting prognosis: It isn't the number of co-morbid conditions but the severity that counts.**




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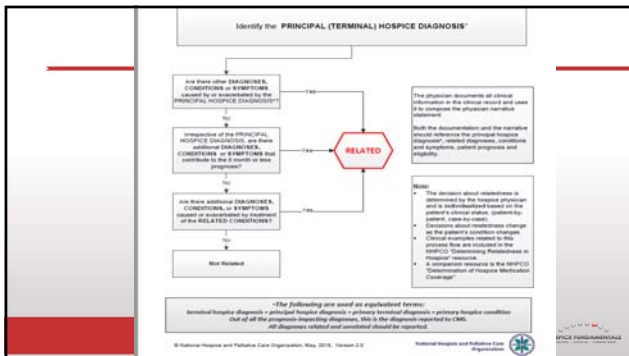
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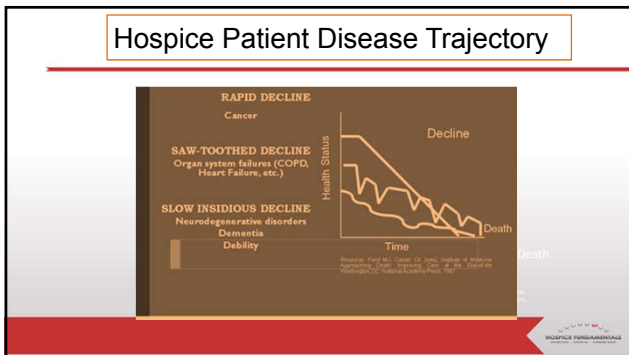
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### The Physician Narrative: *The Key to Success*

**For narrative statements to be acceptable, they should consist of several phrases or sentences that described the particular clinical factors that led to the conclusion that the patient was eligible for hospice:**

**Important Data to Include**

- Objective clinical indicators such as the patient's palliative performance status, body mass index and oxygen saturation
- Documentation of historical and physical examination findings that changed over time to indicate a poor prognosis
- Illustrate specifically how the clinical factors gave the patient a poor prognosis, allowing you to sign the certification

**An example of a well-written compliant statement looks like this:**

- "78 year-old male with NYHA class IV heart failure who has been aggressively treated with diuretics, ACE inhibitors and nitrates continues to experience massive peripheral edema. Dyspnea even during conversation requiring frequent doses of morphine. He has been hospitalized 3 times in the last 2 months. He has congested peripheral vascular disease with several lower extremity ulcers. He is not a candidate for invasive cardiovascular procedures. He has a PPS of 50%, down from 70% 3 months ago. Based on his severe heart failure he has a prognosis of less than six months."

Chronic vs. Terminal

Industry Standard Tools

Custodial vs. Terminal

Related vs. Non - Related Medication

Coding the Diagnosis

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### The Physician Narrative: *BEWARE!*

**Lack of consistency in recording weights, anthropomorphic measurements, other objective data:**

**Importance:**

- Limits the use of objective data to demonstrate longitudinal decline or disease progression.
- Absent or inconsistent data for a specific LCD has the appearance of disregard for or lack of awareness of the LCD that can send up red flags.

**Slowly declining, stable, or even improved clinical status:**

**Importance:**

- Decline is inherent to the dying process in most diseases and most hospice staff are attuned to documenting the slightest signs.
- But decline is also associated with chronic conditions and advanced age. In denial statements, reviewers often state there is evidence of decline, but deny the claim because terminal status is not established.

**Nursing narratives repeated verbatim across IDG Notes, Plans of Care and embedded in physician narrative statements:**

**Importance:**

- Can have the effect of reducing credibility of documented assessments and narratives. May also contribute to a clinical picture of stability.

**The overall appearance of a chronic vs. terminal condition:**

**Importance:**

If you (or your hospital) can get very good at making the distinction between chronic and terminally ill patients - and taking action accordingly - your hospice will avoid a great deal of payment denial risk related to clinical eligibility.

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### The Physician Narrative: *BEWARE!*

**Narratives with insufficient descriptive and comparative information:**

**Importance:**

- 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.

**Inaccurate or incorrect data:**

- KPS/PPS assessments not supported by other assessment data in the clinical record incorrectly applied
- FAST assessments and/or scores not supported by other assessment data
- Disparity between physician narratives and clinical information in the clinical record.

**Importance:**

- Inconsistency decreases the clinical record's credibility in the eyes of reviewers and makes it harder for those trying to identify the patient's true clinical status and to defend your claims.

**Signs of decline without an event or condition suggestive of medical necessity for hospice services**

**Importance:**

- LCD's provide the basis for determining eligibility; however, there must also be medical necessity.
- Both a 6-month or less prognosis and "skilled palliation of end of life symptoms" are required.

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### The Admission Nurse Call to the Hospice Medical Director (HMD)

**Other than a call about managing a symptom, the admissions call from the admitting nurse to the hospice medical director (HMD) is probably the most important call made about a patient!**

**Key Components of the Hospice Admission**

- The comprehensive assessment begins with the initial nursing assessment.
- The nursing assessment aids the hospice medical director in determining eligibility and the terminal diagnosis.
- Election of the hospice benefit occurs.
- DNR status and hospitalization is discussed.
- The attending physician is contacted – the admission discussed and if he will follow or not.
- Another member of the hospice IDG is contacted by the admitting nurse.

**The Hospice Medical Director is Called**

- The patient's history is reviewed by the nurse.
- If this is a complex patient the H & P should have been forwarded to the HMD prior to the call.
- The key findings of the nursing assessment are SBAR to the HMD.
- Why Hospice? Why Now? is answered.
- Eligibility is determined.
- The terminal diagnosis is determined.
- The level of care is determined (routine, gip, continuous).
- Medications are reviewed and related vs non-related is determined for all medications. The medical director makes recommendations for any medications that need discontinued or is non covered.

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### And Now What About Medications?

Admission is when we start dealing with decisions about them . . .  
And Then Again at Every IDG

**The Admission Nurse will review all patient medications with the patient or their representative, and determine the relationship of the medication to the patient's terminal illness and related conditions.**

**In Collaboration with the MD, Designate medications as:**

- 1.) **Related and covered** by hospice provider.
- 2.) **Unrelated** to the patient/ representative's terminal illness and related conditions but **medically reasonable and necessary** and covered by Part D or other PMB.
- 3.) **Related but medically unnecessary** and not included in the hospice provider plan of care.

- The patient or their representative must be notified that these medications will not be covered by hospice provider or Part D, and the patient will have to pay for them out of pocket if they wish to continue taking them.

**What else needs to be done after medications are placed in one of the 3 categories**

- Inform patient/ representative of liability
- Inform patient/representative of appeal rights
- Contact the patient's attending physician or other prescribers regarding those medications in the related but medically unnecessary category
- Provide for the Notice of Non-Covered medications, when requested

**Review all Medications at Admission & IDG**

- Medication that is off the hospice formulary
- Medically unnecessary medications

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### Determining Related Hospitalizations

Is the reason for the hospitalization related to or caused by the terminal condition(s) and exacerbation of the terminal condition(s) or treatment of the terminal condition(s)?

**Contracted Hospital**

Is hospitalization for palliative reasons and within the hospice's contracting philosophy? **YES** **NO**

**YES**

- What symptoms are being treated? Are they the patient's pain or other symptoms?
- Will this change the patient's quality of life?
- Will this increase the patient's quality of life?
- What are the patient preferences?

Are plans in alignment with hospice plan of care? **YES** **NO**

**Part of the hospice POC:**

- Healthy hospice billing department.
- Healthy professional management and guidelines.

**Documentation as to why not hospice related is best completed by physician.**

**Contracted Hospital**

Is this contracted hospitalization for palliative reasons and within the hospice's contracting philosophy? **YES** **NO**

**YES**

- What symptoms are being treated? Are they the patient's pain or other symptoms? Will this increase the patient's quality of life? What are the patient preferences?

Are plans in alignment with hospice plan of care? **YES** **NO**

**Part of hospice POC:**

- Healthy patient of both facility for part of services and support to be used.
- Healthy hospice billing department off facilities.

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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.



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### 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



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### 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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### How Does The Hospice Physician Manage Length of Stay (LOS)?

- **Begin to manage LOS at admission**
  - Why hospice? Why now?
  - The admission call with the nurse.
  - Does the patient meet eligibility criteria
- **Manage the patient LOS at IDG**
  - Focused SBAR on patient by RN Case Manager
  - Observe industry standard tools for each patient
  - What is the LCD requirement for recertification
  - Don't let the decision to recertify wait till the last minute. Start at least 2 weeks from recertification date
- **Is the terminal diagnosis still correct?**
  - Does it need to change
  - Has there been other secondary or co-morbid conditions that should be added to the file
- **Be an Advocate for the Patient**
  - As the physician stay clinically focused
  - Make certain you have the data you need to make the right decision regarding eligibility and LOS
  - As the HMD you do play a role in making certain that the hospice is reimbursed and has the right documentation and clinical decisions. Work with management to achieve the proper balance for patient advocacy

Proportion of Patients by Length Of Hospice Service

LOS can be influenced by a number of factors including disease course, timing of referral, and access to care.

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### Questions????

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**To Contact Us**

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