Providing innovative solutions for strengthening hospice programs, leaving you more time to do the work that makes such a difference...

OHPCA & WSHPCO Spring Intensive 2018
Handouts

March 19, 2018
This presentation is for educational and informational purposes only.

It is not intended to provide legal, technical, or other professional services or advice.

Presenters

LYNN STANGE, RN, BSN, MA, CHC – President

Lynn Stange is the President of Weatherbee Resources, Inc. Lynn first joined the Weatherbee team as an Associate Consultant in 2006, and was promoted to Director of Consulting in 2007. In February 2018, Lynn was promoted to President of Weatherbee Resources, Inc.

In her role, Lynn is responsible for strategic growth initiatives in the areas of compliance, quality, and education. Lynn works with consulting clients in the areas of Quality Assurance Performance Improvement (QAPI), mock surveys and compliance audits, Joint Commission accreditation, State Licensure preparation, plans of correction, pursuit of the Malcolm Baldrige National Quality Award, hospice acquisitions/sales, and program development. Lynn will also oversee all aspects of Weatherbee’s Hospice Compliance Network (HCN) and Weatherbee’s product line. Lynn’s breadth of experience with a variety of regulations and standards allows her to connect with clients quickly to aid them in identifying their most critical needs thereby assuring excellent outcomes.

Lynn is a nationally recognized speaker in both the hospice and compliance arenas, having spoken at both the National Hospice and Palliative Care Organization (NHPCO) annual Management and Leadership Conference and at the annual Health Care Compliance Association (HCCA) national conference. Lynn is a member of the NHPCO Regulatory Committee since 2014. As a member of Weatherbee’s Speaker’s Bureau, Lynn teaches on a variety of regulatory, compliance, and leadership-related topics and is a permanent faculty member of Weatherbee’s renowned Hospice Regulatory Boot Camp.

Lynn has been a registered nurse for 26 years with a Bachelor’s degree in nursing from Carroll College in Helena, Montana and a Master’s degree in Organizational Management from the University of Phoenix, Las Vegas. Lynn has been a State surveyor in both Montana and Nevada, and earned her Certification in Healthcare Compliance (CHC) in 2014.

COLLEEN O’KEEFE, RN CHPN – Senior Consultant & Project Specialist

Colleen O’Keefe is the Senior Project Specialist for Weatherbee Resources, Inc. She is certified in Hospice and Palliative Care and is also a Hospice and Palliative Nurses Association (HPNA) Approved Educator. Colleen has served as an RN Case Manager, Supervisor for a Continuous Home Care team, Clinical Educator, and Compliance Officer. Her clinical, regulatory, and leadership expertise allows her to deliver uncompromising consulting services.

As an Senior Consultant & Project Specialist with Weatherbee Resources, Colleen conducts clinical record audits for hospice organizations facing Additional Development Requests, writes independent expert cover letters to support technical and clinical eligibility for hospice care, and provides assistance and guidance throughout the appeals process. Colleen conducts comprehensive baseline assessment audits and mock surveys to assess regulatory compliance and identify potential risk exposures, and devises action plans to address problem areas. She also conducts education for hospice organizations across the country. Colleen also has experience and expertise in conducting investigations for hospices facing payment-related scrutiny by governmental agencies.

Colleen is a registered nurse and holds a Bachelor’s degree from Northwestern University.
**Oregon Hospice Association**  
Location: The Heathman Lodge, Vancouver, WA  
Intended Audience: Members of the Interdisciplinary Group

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<td><strong>Registration, Breakfast buffet available</strong></td>
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<td>Welcome, Introductions &amp; Announcements</td>
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<td>When Your Patient’s “Home” is a Facility</td>
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<td>Ending Hospice Care: Discharge, Revocation &amp; Transfer</td>
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Eligibility, Part I: Technical / Administrative Requirements for Payment

Lynn Stange, RN, BSN, MA, CHC
OHPCA and WSHPCO Spring Intensive 2018

Learning Objectives
Upon completion, learners will be able to:
1. Define the term “technical eligibility”
2. List the documentation and other requirements associated with technical eligibility and payment of Medicare hospice claims
3. Discuss the risks associated with non-compliance

“Technical” Documents
1. Election
   - Notice of Election (NOE from hospice to MAC)
   - Election Statement (patient/legal rep signs)
2. Plan of Care
3. Covered later in session #3
   3. Initial Certification of Terminal Illness
      - Hospice physician
      - Attending physician, if any
   4. Recertifications (hospice physician)
   5. Physician Narrative Statements
   6. Face-to-Face Encounters
418.24 Election of hospice care

(a) Filing an election statement.
(1) General. An individual who meets the eligibility requirement of 418.20 may file an election statement with a particular hospice. If the individual is physically or mentally incapacitated, his or her representative (as defined in 418.3) may file the election statement.

(b) Notice of election. The hospice chosen by the eligible individual (or his or her representative) must file the Notice of Election (NOE) with its Medicare contractor within 5 calendar days after the effective date of the election statement.
418.24 Election of hospice care

(a) Filing an election statement, cont’d

(3) Consequences of failure to submit a timely notice of election. When a hospice does not file the required Notice of Election for its Medicare patients within 5 calendar days after the effective date of election, Medicare will not cover and pay for days of hospice care from the effective date of election to the date of filing of the notice of election.

(4) Exception to the consequences for filing the NOE late. CMS may waive the consequences of failure to submit a timely-filed NOE specified in paragraph (a)(2) of this section. CMS will determine if a circumstance encountered by a hospice is exceptional and qualifies for waiver of the consequence specified in paragraph (a)(3) of this section.

(3) These days are a provider liability, and the provider may not bill the beneficiary for them.
418.24 Election of hospice care

(a) Filing an election statement, cont’d

(4) A hospice must fully document and furnish any requested documentation to CMS for a determination of exception. An exceptional circumstance may be due to, but is not limited to the following:

- Fires, floods, earthquakes, or similar unusual events that inflict extensive damage to the hospice’s ability to operate.
- A CMS or Medicare contractor systems issue that is beyond the control of the hospice.
- A newly Medicare-certified hospice that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its Medicare contractor.
- Other situations determined by CMS to be beyond the control of the hospice.
**NOE–Crucial Info**

- As of 10/1/14, the hospice NOE must be filed with, and accepted by, the hospice’s Medicare Administrative Contractor (MAC) within 5 calendar days of effective / start of care (SOC) date.
  - If not, the hospice will not be paid by Medicare and cannot bill the patient/family.

**NOE–CMS Examples**

The date of hospice election is October 1:
1. A timely-filed NOE would be submitted and accepted by the MAC on or before October 6.
2. The NOE was not submitted and accepted by the MAC until October 10. Provider liable days would be October 1 through October 9.

**418.24 Election of hospice care**

**(b) Content of election statement. The election statement must include the following:**

1. Identification of the attending physician that will provide care to the individual. The individual or representative must acknowledge that the identified attending physician was his or her choice.
418.24 Election of hospice care

(b) Content of election statement, cont’d

(2) Identification of the particular hospice that will provide care to the individual.
(3) The individual’s or representative’s acknowledgement that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual’s terminal illness.

Election Statement–Crucial Info

• Claims may be denied if the election statement does not specifically state that hospice is “palliative rather than curative care”


418.24 Election of hospice care

(b) Content of election statement, cont’d

(4) Acknowledgement that certain Medicare services, as set forth in paragraph (d) of this section, are waived by the election.
(5) The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement.
(6) The signature of the individual or representative.
418.24 Election of hospice care

(c) Duration of election. An election to receive hospice care will be considered to continue through the initial election period and through the subsequent election periods without a break in care as long as the individual--
   (1) Remains in the care of a hospice; and
   (2) Does not revoke the election under the provisions of 418.28.

418.24 Election of hospice care

(d) Waiver of other benefits. For the duration of an election of hospice care, an individual waives all rights to Medicare payments for the following services:
   (1) Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice).

418.24 Election of hospice care

(d) Waiver of other benefits, cont’d
   (2) Any Medicare services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or that are equivalent to hospice care except for services—
      (i) Provided by the designated hospice;
418.24 Election of hospice care

(d) Waiver of other benefits, cont’d
(ii) Provided by another hospice under arrangements made by the designated hospice; and
(iii) Provided by the individual’s attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

418.24 Election of hospice care

(e) Re-election of hospice benefits. If an election has been revoked in accordance with 418.28, the individual (or his or her representative if the individual is mentally or physically incapacitated) may at any time file an election, in accordance with this section, for any other election period that is still available to the individual.

Crucial Info:
Assuming s/he is terminally ill and eligible for readmission.
418.24 Election of hospice care

(f) Changing the attending physician. To change the designated attending physician, the individual (or representative) must file a signed statement with the hospice that states that he or she is changing his or her attending physician.

418.24 Election of hospice care

(f) Changing the attending physician, cont’d

(1) The statement must identify the new attending physician, and include the date the change is to be effective and the date signed by the individual (or representative).

418.24 Election of hospice care

(f) Changing the attending physician, cont’d

(2) The individual (or representative) must acknowledge that the change in the attending physician is due to his or her choice.

(3) The effective date of the change in attending physician cannot be before the date the statement is signed.
418.56
Plan of care
(payment-related requirements)

POC and Payment

In order to be paid for the care and services provided to eligible patients, the hospice must:
• Establish a POC before care is provided
• Include the attending physician (if any), hospice physician, IDG, pt/family, and facility staff (if applicable) in the care planning process
• Ensure that all care is reasonable and necessary for the palliation or management of the terminal illness and related conditions

POC and Payment

The hospice must also:
• Ensure that the attending physician (if any), hospice physician, and IDG periodically review the POC as frequently as the patient’s condition warrants but no less frequently than every 15 calendar days

15 DAYS
**POC and Payment**

And, the hospice must:

- Ensure that all care and service is provided in accordance with the POC (including but not limited to inpatient settings/care)
- Include medical supplies needed for the palliation and management of the terminal or related conditions in the POC (DME, medications, etc.)

**POC and Payment**

Lastly, the hospice must:

- Include care coordination with other healthcare professionals actively involved in patient’s care
  - Consulting providers, if any (oncologists, etc.)
  - Nursing, assisted living, and other facilities
- Submit the entire POC for all dates of service under review if the clinical record is requested by the MAC or other auditor

**Remember...**
418.20 Eligibility requirements

In order to be eligible to elect hospice care under Medicare, an individual must be—
(a) Entitled to Part A of Medicare; and
(b) Certified as being terminally ill in accordance with 418.22.

Social Security Act – 1861(dd)(3)(A)

The statutory definition of “terminally ill” means having a medical prognosis that the individual’s life expectancy is 6 months or less

418.21 Duration of hospice care coverage—Election periods

(a) Subject to the conditions set forth in this part, an individual may elect to receive hospice care during one or more of the following election periods:

1. An initial 90-day period;
2. A subsequent 90-day period; and
3. An unlimited number of subsequent 60-day periods.
Election periods – Crucial Info

1. Each patient must be admitted/readmitted into the correct Medicare election period
2. Medicare-pending patients must be formally “certified” into their 1st 90-day election period on the day Medicare becomes effective
   – All other “new admission” requirements must also be addressed at this time as if the patient is a brand new admission (NOE, narrative, assessments, etc.)

Election periods – Crucial Info

3. Do not wait until the end of an election period to discharge an ineligible patient
4. Understand that ALL patients in 60-day election periods are considered to be “long length of stay” patients (>180 days) and, therefore, are more likely to be audited (ADRs, etc.)

418.25 Admission to hospice care

(a) The hospice admits a patient only on the recommendation of the medical director in consultation with, or with input from, the patient’s attending physician (if any).
(b) In reaching a decision to certify that the patient is terminally ill, the hospice medical director must consider at least the following information:
418.25 Admission to hospice care

(b)(1) Diagnosis of the terminal condition of the patient.
(b)(2) Other health conditions, whether related or unrelated to the terminal condition.
(b)(3) Current clinically relevant information supporting all diagnoses.

Eligibility

- The physician is ultimately responsible for the determination of a patient’s eligibility
- Likewise, they are now mandated to be an active team member in the determination of continuing eligibility after admission
- A big part of this role is demonstrated in the crafting of appropriate narratives

Eligibility

- All pertinent diagnoses must be placed on all claim forms
- The process of determining all appropriate diagnoses should be a physician function
- CMS expects coverage of terminal prognosis versus diagnosis
POC and Payment

- Many hospices receive claim denials for not submitting POC updates for all dates of service under review
- Some hospices receive claim denials for not submitting visit notes for all disciplines per the minimum visit frequency cited in the POC

CLAIM DENIED

Compliance – Crucial Info

All “technical” forms/EMR screens must be:
- Valid
  - Labeled appropriately
  - Compliant format/layout
  - Contains all required elements/content
- Completed appropriately and timely
- Executed timely
- Dated by the signatory (in most cases)
- Submitted to MAC, if/when requested

WARNING

Non-Compliance – Crucial Info

If clinical record is reviewed by MAC or other auditor, the following may be at risk of non-payment if forms are invalid, untimely, or missing:
- Election Statement: Entire length of stay
- Initial CTI, Recert and/or Physician Narrative:
  - 1-90 days
- F2FE: 1-60 days
- POC: 1-90 days
Non-Compliance – Crucial info

If one clinical record contains invalid forms the likelihood is that others will too, which could trigger a larger audit and result in significant financial losses.

Q & A

Thank You!
Eligibility, Part II:
The Initial and Comprehensive Assessment of the Patient

Colleen O'Keefe, RN, CHPN
OHPCA & WSHPCO Spring Intensive 2018

Learning Objectives
Upon completion, attendees will be able to:
1. Identify key information to be gathered during intake to begin the establishment of baseline clinical data for future comparison
2. Cite the required timeframes for completing initial and comprehensive assessments
3. List the 8 required elements of the comprehensive assessment

Establish Clinical Baseline
• What prompted the referral today?
• Was there a precipitating event?
  – Recurrent hospitalizations, MD, and/or ER visits
  – Changes in goals of care
**Establish Clinical Baseline**

- Has anything changed in the past week, month, 3 months, 6 months, year?

- Labs
- Imaging reports
- Weight
- Body Mass Index (BMI)
- Symptomology
- Living situation
- ADL status

**Establish Clinical Baseline**

If speaking with referring physician, ascertain:

- Principal diagnosis
- Date of onset
- Prior treatment and response
- Secondary/co-morbid conditions
- Current life expectancy

**Establish Clinical Baseline**

- Local Coverage Determination (LCD) guidelines are the accepted industry standard for determining hospice eligibility
Establish Clinical Baseline

• Ensure sufficient, documented evidence of terminal status
• Obtain and document measurable data for comparison over time (e.g., weight, BMI, labs, PPS/KPS, FAST, NYHA, etc.)

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Establish Clinical Baseline

• Paint a picture as to why and how the patient is eligible for hospice – now
• Explain why/how this particular patient has a prognosis of 6 months or less

---

Establish Clinical Baseline

• Admitting based on verbal information is permissible, but info must be validated and documented in clinical record ASAP
Establish Clinical Baseline

Obtain current:
• H&P (within the past year)
• Labs
• Other diagnostic reports
• Any consultations
• Physician office visit notes
• Hospital discharge summaries
• Facility documentation
• Etc.

Rapid Decline

• Illnesses such as cancer have a progression that ends in a steady inexorable decline in function until death
• The MHB was predicated on this pattern of decline and death

Saw Tooth

• Cardio-pulmonary and other organ system failures / conditions (HIV, Liver, Renal, etc.)
• A slow incremental decline punctuated by multiple episodes of acute exacerbations

Dwindling

- Typical course of AFTT, Dementia, Stroke & Coma, Parkinson’s, etc.
- Steady progressive disability leading to death


Establish Clinical Baseline

- What’s the pt’s pre-admission disease trajectory/pattern of decline?
- Is current trajectory/pattern consistent with diagnosis?
  - If yes, does it depict decline, mild fluctuation, or relative stability?
  - If no, why not (is something else going on)?

Admitting the Patient:
The Initial and Comprehensive Assessment
418.54 CoP

Initial & comprehensive assessment:

• 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.

418.54 CoP

5 Standards:

1. Initial assessment
2. Time frame for completing comprehensive assessment
3. Comprehensive assessment content
4. Comprehensive assessment update
5. Outcome measures

418.54(a) CoP

Standard – Initial assessment:

• The hospice registered nurse must complete an initial assessment within 48 hours after the election of hospice care…(unless the physician, patient, or representative requests that the initial assessment be completed in less than 48 hours.)
418.54(a) CoP

Standard – Initial assessment:

• The purpose of the initial assessment is to gather the critical information necessary to treat the patient/family's immediate care needs. The assessment needs to take place in the location where hospice services are being delivered.

State Operations Manual Appendix M - Guidance to Surveyors: Hospice Interpretive Guidelines 418.54

418.54(b) CoP

Standard – Time frame for completing comprehensive assessment:

• The hospice [IDG], in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care…

418.54(b) L-Tag: L523

Standard: Timeframe for completion of the comprehensive assessment
418.54(c) CoP

Standard – Comprehensive assessment content:
• The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process.

Must reflect health status related and unrelated to terminal prognosis; and,
• The comprehensive patient assessment must accurately reflect the patient's current health status and include information to establish and monitor a plan of care.

State Operations Manual Appendix M - Guidance to Surveyors: Hospice Interpretive Guidelines 418.54

418.54(c)(1)

Nature and condition causing admission:
• Including presence or lack of objective data and subjective complaints.

For example:
– What does the patient self-report?
– What does the family report?
– What do the caregivers report?
418.54(c)(2)

Complications and risk factors that affect care planning:

For example:

• Secondary/co-morbid conditions
• Patients leaving service area
• Unapproved medication changes
• Patients, families, and/or facility staff calling 911 rather than the hospice

418.54(c)(3)

Functional status:

…that affect care planning…including the patient’s ability to understand and participate in his or her own care.

Things to consider

Functional Status

For example:

• Activities of Daily Living (ADLs)
• Cognitive status
• Individualized POC with achievable goals
• How the PCG’s age and/or health status impacts caregiving
Functional Status

ADLs include:

1. Ambulation (non-purposeful mobility / movement = dependent)
2. Continence (catheter, ostomy, B&B program = dependent)
3. Transfer
4. Dressing
5. Feeding
6. Bathing

"Time to Task Completion"

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<th>Y</th>
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<td>Is the patient caregiver dependent for any ADLs? Indicate documented level of support required and time to task completion (&quot;T2TC&quot;).</td>
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<td>ADL Dependence: None Mild Moderate Total T2TC (if documented)</td>
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<td></td>
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<td>Ambulation</td>
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418.54(c)(4)

- Hospices may utilize an abbreviated IDG admission assessment for imminently dying patients
- The full comprehensive assessment must be completed by day 5 if the patient is still on service
418.54(c)(5)

Severity of symptoms:
Interpretive Guidelines (instructions to surveyors):
• Ask clinical staff to describe how they obtain all relevant information necessary to complete the comprehensive assessment.

418.54(c)(5)

Severity of symptoms:
Interpretive Guidelines:
• Is there evidence in the clinical record and during home visits that the reasons for admission, complications and risk factors that could affect care planning, functional status, imminence of death, and symptom severity have been identified and are being addressed?

Things to consider:

• Document pt/PCG self-identified threshold (SIT) scores
  – “What is your current level of pain, and what level would you like it to be?”
Severity of symptoms:

• Train all IDG members to ask about, report, and document symptom severity every visit as well as the response to intervention(s)

Severity of symptoms:

• Rate symptoms every visit
• Use reliable scales (e.g., 0-10; FLACC; Faces; PAINAD; None, Mild, Moderate, Severe; etc.)
• Develop and implement practices that ensure appropriate follow-up occurs as needed

418.54(c)(6)

Drug profile:

• A review of all of the patient’s prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy.
• This includes, but is not limited to, identification of the following:
418.54(c)(6)

(i) Effectiveness of drug therapy
(ii) Drug side effects
(iii) Actual or potential drug interactions
(iv) Duplicate drug therapy
(v) Drug therapy currently associated with laboratory monitoring.

[Note: Whether “related” (covered) or not]

418.54(c)(6)

L-Tag: L530

Drug profile

418.54(c)(7)

Bereavement:
• An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death.
418.54(c)(7)

Bereavement:

- Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care.

418.54(c)(7)

Bereavement – Some factors to consider:

History of previous losses; Family problems; Financial concerns; Communication issues; Drug and alcohol abuse; Health concerns; Legal and financial concern; Mental health issues; Presence or absence of a support system; and, Feelings of despair, anger, guilt or abandonment.

State Operations Manual Appendix M - Guidance to Surveyors: Hospice Interpretive Guidelines 418.54

418.54(c)(8)

The need for referrals and further evaluation by appropriate health professionals:

- If "related": Referral should be approved and coordinated by IDG, included in POC, and palliative in nature
- If "unrelated": Share info and coordinate care with non-hospice providers to assure larger POC is appropriate
418.54(d) Standard: Update of the comprehensive assessment:

• The update of the comprehensive assessment must be accomplished by the hospice IDG (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment.

418.54(d) Standard: Update of the comprehensive assessment:

• It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care.

418.54(d) Standard: Update of the comprehensive assessment:

• The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.
418.54(e)

**Standard: Patient outcome measures:**

• (1) The comprehensive assessment must include data elements that allow for measurement of outcomes. The hospice must measure and document data in the same way for all patients. The data elements must take into consideration aspects of care related to hospice and palliation.

• Which LCD guideline, if any, applies to pt's principal hospice diagnosis?
  – Part I (Decline in Clinical Status); or,
  – Parts II & III combined (NGS/CGS)

• Does pt meet all **required** disease-specific elements?
  – If not, which elements are met and which ones are not met?
  – How/why is the pt deemed “eligible” if s/he did not meet all LCDs?
• How/why is pt eligible for hospice – at each recertification – throughout the entire course of care?
• All IDG visit notes must support, in narrative format, the assessment scores and other pt descriptors

- RN: “FAST score 7c”
- MSW: “Completed life review w/pt; she was very engaged in process…”

Clinical Eligibility Classifications

1. The patient fully and completely meets LCD guidelines and hospice eligibility is unquestioned.
2. The patient partially meets LCD guidelines; however, s/he has symptomatic secondary and/or co-morbid conditions that impact the terminal prognosis such that hospice eligibility is reasonable and supportable.
3. The patient partially meets LCD guidelines; however, s/he also has no symptomatic secondary and/or co-morbid conditions impacting prognosis. Therefore, hospice eligibility is uncertain/questionable.
4. The patient does not meet LCD guidelines, nor does s/he have any symptomatic secondary and/or co-morbid conditions impacting prognosis. Therefore, hospice eligibility is unlikely.
Q & A

Thank You!
Eligibility, Part III:
The Physician’s Role

Lynn Stange RN, BSN, MA, CHC
OHPCA & WSHPCO Spring Intensive 2018

Learning Objectives
At the end of this session, learners will be able to:
1. Choose the correct principal terminal diagnosis.
2. Identify comorbid and other conditions “related” to the terminal prognosis.
3. Discuss general and disease-specific prognostication and the role of hospice Local Coverage Determination (LCD) guidelines.
4. Discuss hospice eligibility and the physician’s role in determination and certifying eligibility.

CoP: Medical Director 418.102
The hospice must designate a physician to serve as medical director. The medical director must be a doctor of medicine or osteopathy who is an employee, or is under contract with the hospice. When the medical director is not available, a physician designated by the hospice assumes the same responsibilities and obligations as the hospice medical director.
CoP: Medical Director 418.102

Per the regulatory language, a hospice should designate one physician to serve as the “medical director”.
• Physician titles should reflect that there is only one medical director.
• The medical director may have administrative and/or clinical responsibilities.
• If contracting with a medical director, the contract should specify the responsibilities and obligations.

Medical Director – Administrative Roles and Responsibilities

• Supervises and trains other hospice physicians/nurse practitioners (NP) as well as monitors his/her documentation, efficiency, quality outcomes, and productivity.
• Provides oversight of agency utilization and expenses related to pharmacy, DME, diagnostic services, and procedures.
• Assists in ensuring the hospice’s compliance.

Medical Director – Administrative Roles and Responsibilities

• Stakeholder in the hospice’s Quality Assurance Performance Improvement (QAPI) program.
• Provides support/expertise during payment-related scrutiny (e.g., ADRs).
• Assists with licensure surveys, hospice operations, and business development.
• Provides community education.
• Manages physician relationships in the community.
Medical Director – Administrative Roles and Responsibilities

- Management of patients’ medical needs RELATED to terminal prognosis with 24/7 availability.
- Management of patients’ medical needs UNRELATED to terminal prognosis when unmet by the patient’s attending physician.
- Medically necessary patient visits at home or in a facility at all levels of care.
- F2FE visits as required/needed.

Medical Director / Hospice Physician Administrative Responsibilities

- Determination of hospice eligibility and terminal prognosis of all patients.
- Involvement in comprehensive assessment and Plan of Care (POC) development.
- Decisions and documentation regarding relatedness (e.g., medications, procedures, etc.).
- Education, communication, and collaboration with the IDG, the patient’s attending physician (if any), and physician consultants.

Certification of Terminal Illness 418.22(c)

Sources of certification. (1) For the initial 90-day period, the hospice must obtain written certification statements (and oral certification statements, if required...) from –
   (i) The medical director of the hospice or the physician member of the interdisciplinary group; and
   (ii) The individual’s attending physician, if the individual has an attending physician.
Certification of Terminal Illness 418.22(c)

For subsequent periods, the only requirement is certification by one of the physicians listed from (c)(1)(i):

The medical director of the hospice or the physician member of the interdisciplinary group.

Initial Certification of Terminal Illness 418.102(b) and (c)

The medical director or physician designee reviews the clinical information for each hospice patient and provides written certification that it is anticipated that the patient’s life expectancy is 6 months or less if the illness runs its normal course...

Certification of Terminal Illness 418.102(b) and (c)

The physician must consider the following when making this determination:

1. The primary terminal condition;
2. Related diagnosis(es), if any;
3. Current subjective and objective medical findings;
4. Current medication and treatment orders; and
5. Information about the medical management of any of the patient’s conditions unrelated to the terminal illness.
Hospice Diagnosis Reporting: CR 8877 – October 2014

- **Terminal/Principal Diagnosis:** ICD-10 diagnosis that certifying physician determines to be most contributory to the patient’s terminal condition and designated as such on hospice claim.
- “General Debility” and “Failure to Thrive” no longer allowed as a principal diagnosis (but can be secondary conditions).
- CMS expects **ALL** comorbid and secondary conditions related to terminal prognosis to be included in the Plan of Care.

---

**Diagnosis Reporting**

- All diagnoses identified in the Initial and Comprehensive assessments, RELATED and UNRELATED, must be reported on the hospice claim.
- Rationale for comorbidities being UNRELATED to the patient’s prognosis need to be clearly documented by hospice physician.
- Your hospice physicians **must** to be involved in this critical administrative process – it promotes compliance and supports IDG documentation.

---

**Diagnostic Examples**

- **Related Comorbidities:**
  - COPD in patient with principal diagnosis of end-stage CHF.
- **Unrelated Comorbidities:**
  - Hypothyroidism in a patient with breast cancer.
Diagnostic Examples

• **Secondary Conditions:**
  - Sacral decubitus in Alzheimer’s disease patient.
  - Dysphagia in a patient with Parkinson’s disease.
  - Anorexia in patients with bladder cancer.
  - Aspiration pneumonia in patients with stroke

NHPCO Relatedness Process Flow

• Are other diagnoses caused by or exacerbated by principal hospice diagnosis? *(Pelvic DVT in Colon Cancer)*
• Are there additional diagnoses or symptoms that contribute to the < 6 month prognosis? *(COPD in ALS patient)*
• Are there additional diagnoses, conditions, or symptoms caused or exacerbated by treatment of related conditions? *(Diabetes worse from steroids for cachexia and pain)*
• If “NO” to **all of the above**, only then is the diagnosis **UNRELATED** to the patient’s prognosis.

CMS Statements of Relatedness

• “...hospices are required to provide virtually all care that is needed by terminally ill patients...”
• “...unless there is clear evidence that a condition is unrelated to the terminal prognosis, all services would be considered related.”

---

### Hospice Medication Payment Responsibility

- **Hospice**: Medications required for reasonable and necessary palliation of terminal/related diagnoses.
- **Medicare Part D**: Medications for conditions definitively unrelated to terminal prognosis.
- **Patient**: Medications that are not medically necessary (whether related or unrelated to terminal prognosis) but chosen by patient, and/or non-formulary medications without first trying formulary.

### The Conundrum of LCD Guidelines

- Some patients may not meet these guidelines, yet still have a life expectancy of 6 months or less.
- Coverage may be approved if documentation of clinical factors supporting a less than 6-month life expectancy is provided.
- Some variability exists between the LCDs of the 3 Medicare Administrative Contactors (MACs):
  - Cigna Government Services (CGS)
  - Palmetto
  - National Government Services (NGS)

### Clinical Eligibility Example

- 85 year old patient with Alzheimer’s – FAST 6E, CHF NYHA Stage III.
- Decreased oral intake (10% of meals), malnutrition (albumin 2.5gm/dL), weight loss (10% last year), BMI 18.6 despite 1:1 feedings.
- Decreased functional status (PPS 60% to 30%) last year, walker to bedbound less than 6 months ago with 1-person transfer.
- Stage III decubitus ulcer despite optimal prevention.
- Deemed terminally ill with < 6 months by certifying physician.
Is This Patient Medicare Hospice Eligible?

YES  NO  MAYBE

Non-disease Specific Decline in Clinical Status
AFTT???

- Although Palmetto has maintained an Adult FTT general disease guideline, CMS does not allow FTT to ever be used as a Primary/Principal terminal diagnosis.

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More on LCDs

- The LCDs are guidelines used to aid in the identification of Medicare beneficiaries with a life expectancy of 6 months or less.
- Created in 1996 as a guide to be used in conjunction with clinical judgement.
- Never intended to be used as public policy.
- Never validated and often ineffective at predicting prognosis.
- Many evidenced-based prognostication tools are now available to physicians.

---

ESRD Reminder for Relatedness

- Since CMS clarifications on relatedness in 2014, it is no longer appropriate for hospice agency to NOT CONSIDER financial responsibility for all dialysis treatments (and all associated costs) on enrolled hospice patients – no matter what the Principal Hospice Diagnosis may be.
- **Explanation:** ESRD and dialysis treatments nearly always contribute to a patient’s terminal prognosis.
- Hospices often play significant role in helping patients/families through complex transitions off dialysis.
Certification of Terminal Illness 418.22

• **Timing** – written certification required every benefit period within 2 calendar days after beginning of period (oral exception allowed).
  – Certification/recertification cannot be completed more than 15 days prior to the start of the subsequent benefit period.
• **Content** – based on the hospice physician’s clinical judgement and must specify < 6-month prognosis and supporting information must be included.

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Certification of Terminal Illness 418.22

• **Required of** – for the 1st 90-day benefit period, the hospice physician and the patient’s attending physician (if any).
  – For all subsequent benefit periods, written certification is only required from the hospice physician.

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Physician Narrative

• Must accompany each benefit period certification and be composed by certifying hospice physician.
• Attending or hospice physician can write narrative for initial certification; however, a hospice physician must complete narratives for all subsequent benefit periods.
• Must include an attestation signed and dated by the physician composing the narrative statement.
• Completed no earlier than 15 days prior to start of benefit period.
CoP: Physician Narrative 418.22(b) (3)(iv)

“The narrative must reflect the patient’s individual clinical circumstances and cannot contain check boxes or standard language for all patients…”

What is a Physician Narrative Statement?

- **Definition:** a story or account of events, experience or the like.
- Should be in **sentence format.**
- Should “**paint a picture**” of the patient’s prognosis, preferably in language understandable by a lay person with some knowledge of eligibility guidelines.

Narrative – Need Adequate Info!

- If physician lacks the information necessary to adequately document a terminal prognosis, **do not certify/recertify the patient:**
  - Either get missing clinical data and then certify; or
  - Don’t admit or recertify the patient.
Narrative – Need Adequate Info!

- LCD guidelines:
  - If the patient meets an applicable LCD guideline, use it.
  - If not, specifically explain why the patient is/remains terminally ill in the narrative (including patients who do not fully meet LCD guidelines).
- Focus on the patient meeting eligibility guidelines as opposed to being “appropriate”.

Physician Narrative Example #1

- Metastatic cancer.
- PPS 50% and incontinent of bowel and bladder.
- Eats 50% of most meals (include portion size – small, medium, large).
- Family requested palliative care.
- Clinically eligible for hospice?

Is Physician Narrative Example #1 Adequate?

- YES
- NO
- MAYBE
Physician Narrative Example #2

This 99 yo SNF resident has end-stage dementia from Alzheimer’s disease with FAST of 7C, reflecting her non-verbal, non-ambulatory status. Her care was complicated by a hip fracture requiring pinning 3 weeks ago. During that hospitalization she had aspiration pneumonia, and continues to frequently choke at meals…

Physician Narrative Example #2

…Her PPS is 40%, reflecting her dependence in 5/6 ADLs and sleeping >20h/day (up from 12h/day six months ago). Her BMI is 22.2 (down from 25.1 six months ago). She is having more trouble feeding herself. Considering these findings, she meets dementia guidelines (FAST 7, recent aspiration pneumonia, ongoing decline), so she is unlikely to survive the next six months, presuming disease runs its expected course.
Is Physician Narrative Example #2 Adequate?

YES  NO  MAYBE

Physician Narrative General Tips

- Use sentence format.
- State patient's age, terminal diagnosis, related conditions (severity and impact on prognosis).
- Include:
  - Functional impairments (PPS, ADLs).
  - Nutritional impairments (BMI, MAC, albumin).
  - Cognitive impairments (FAST, delirium).
- Reference basis (clinical records, F2FE info, etc.).
- Explicit prognosis statement (state timeframe).
- Use original verbiage – do not “copy and paste”.
Physician Narrative
Disease-specific Tips

- Include disease-specific and/or disabling symptoms (NYHA class, angina, applicable LCD).
- Specify burden of disease (onset, duration, response to therapy, location, frailty degree, sleep, etc.).
- Describe trajectory of disease with specific timeframes.

Face-to-Face Encounter

- Required for 3rd and all subsequent benefit periods.
- Completed by CRNP (employed) or physician (employed/contracted) no earlier than 30 days prior to each benefit period with an attestation statement.
- For re-admission into the 3rd or later benefit period, F2FE must be completed before oral or written certification (except in emergency exceptions).
- Must attest completed and provided to certifying physician to determine continued eligibility.

Face-to-Face Encounter

- Should only include clinical data (history, physical findings) pertinent to eligibility.
- Do not document conclusions or comment on prognosis.
- Administrative function included in the per diem payment.
- Physician (or CRNP, if attending physician) can submit for additional billable visit at time of F2FE only if patient has warranted symptoms, and documentation supports billing.
**FINAL THOUGHTS...**

- It all starts with finding the right Medical Director (physician leader) for your organization!
- Goal should be to hire full-time/near full-time HMD who has board certification in Hospice and Palliative Medicine (HPM) or has at least obtained Hospice Medical Director Certification (HMDC).
- They can also oversee and audit any other hospice physician and/or CRNP documentation.

**FINAL THOUGHTS...**

- HMDs can provide support and assistance for any payment-related scrutiny (e.g., ADR, ZPIC, etc.).
- Quality HMDs can improve quality scores, CAHPS, as well as oversight of compliance program.
- Lastly, HMD’s can also decrease pharmacy/DME costs and play a significant role in business development and community education.

**Q & A**

Thank You!
Eligibility, Part IV: Higher Levels of Care

Colleen O’Keefe, RN, CHPN
OHPCA & WSHPCO Spring Intensive 2018

Learning Objectives
At the end of this session, learners will be able to:
1. Define eligibility criteria for higher levels of care.
2. Discuss elements of narrative notes and other documentation that supports payment for higher levels of care.
3. Explain regulatory/compliance issues impacting higher levels of care.

Level of Care Trends

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHC</td>
<td>94.1%</td>
<td>93.8%</td>
<td>97.8%</td>
</tr>
<tr>
<td>Respite</td>
<td>0.3%</td>
<td>0.4%</td>
<td>0.3%</td>
</tr>
<tr>
<td>CHC</td>
<td>0.8%</td>
<td>1.0%</td>
<td>0.3%</td>
</tr>
<tr>
<td>GIP</td>
<td>4.8%</td>
<td>4.8%</td>
<td>1.6%</td>
</tr>
</tbody>
</table>

NHPCO Facts & Figures, Oct 2017
Hospice Reimbursement FY 2017
(with quality data reported 2016)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>RHC (doesn't include SIA)</td>
<td>$190.55 [days 1-60] $149.82 [days 61+]</td>
</tr>
<tr>
<td>652</td>
<td>CHC</td>
<td>$964.63</td>
</tr>
<tr>
<td></td>
<td>$40.19 = Hour Rate</td>
<td>(24 hr. rate)</td>
</tr>
<tr>
<td>655</td>
<td>Respite</td>
<td>$170.97</td>
</tr>
<tr>
<td>656</td>
<td>GIP</td>
<td>$734.94</td>
</tr>
</tbody>
</table>

Medicare Benefit Policy Manual
40.1.15 General Inpatient Care (GIP):
…is allowed when the patient’s medical condition warrants a short term inpatient stay for pain control or acute or chronic symptom management that cannot be provided in other settings…

CoP: 418.108
Short-term Inpatient Care
• (a) Inpatient Care for symptom management and pain control (hospice, hospital, SNF)
• (b) Inpatient Care for respite purposes
• (c) Inpatient Care provided under arrangements
• (d) Inpatient Care limitation (20% rule)
• (e) Exemption from limitation (1/1/75)
CoP: 418.110
Hospices that Provide Inpatient Care Directly

• (a) Staffing
• (b) 24 Hour Nursing Services
• (c) Physical Environment
• (d) Fire Protection
• (e) Patient Areas
• (f) Patient Rooms
• (g) Toilet and Bathing Facilities
• (h) Plumbing Facilities

CoP: 418.110
Hospices that Provide Inpatient Care Directly

• (i) Infection Control
• (j) Sanitary Environment
• (k) Linen
• (l) Meal Service and Meal Planning
• (m) Restraint or Seclusion
• (n) Restraint of Seclusion Staff Training
• (o) Death Reporting Requirements

Myths about GIP Care

• The “Dying Process” makes a patient eligible for GIP.
• An Inpatient Unit is a “Step Down” from the hospital for hospice patients at time of discharge.
• Location of the patient determines a hospice level of care.
• Discharge planning from an IPU is not necessary.
CMS Comments on GIP Level of Care

“Hospice general inpatient care is for pain control or symptom management in an inpatient facility that cannot be managed in other settings. The care is intended to be short-term and is the second most expensive level of hospice care.”

https://oig.hhs.gov/oei/reports/oei-02-10-00490.pdf

CMS Comments on GIP Level of Care

“These acute hospice services are to ensure that any new or worsening symptoms are intensively addressed so that the individual can return to his home environment under a [routine] home [care] level of care.”

-Federal Register (August 22, 2014)

GIP: General Criteria

- Acute Symptoms which cannot be managed in the ‘home’ setting and are the ‘precipitating event’.
- Documentation should reflect what interventions have been tried in the home and have not worked.
- Documentation should also reflect why this care cannot be managed in an alternate setting.

the what and the why
GIP: General Criteria

- Change in condition/treatment **MUST** be included in the IDG plan of care.
- A hospice physician’s order for LOC change should be obtained and documented (best practice).
- Must occur in Medicare-certified hospital, SNF, or your own IPU or contracted hospice facility.
- Must meet all requirements in 418.08.
- All applicable consents, recerts, F2FEs, etc. are necessary to be done in timely fashion.

GIP: Uncontrolled Acute Symptoms

- **Pain** (requiring frequent medication adjustment and/or complicated technical delivery/calibration).
- Unmanageable **Respiratory Distress**.
- Acute Agitated **Delirium** and Severe Anxiety/Suicidal ideation/psychosis.
- Intractable **Nausea/Vomiting**.
- **Hemorrhage** (CNS, respiratory, GI, GU, Cutaneous).
- Uncontrolled Grand Mal **Seizures**.
- Severe **Infection** (sepsis, GI/colicitis, meningitis).

GIP: Uncontrolled Chronic Symptoms

- Complicated wound management (fungating, purulent, hemorrhagic) requiring frequent wound care.
- Complex care of multiple draining mucocutaneous fistulas and severe atrophic mucositis/dermatitis.
- Complex care of oropharynx/trachea requiring frequent suctioning.
- Severe, non-fixated fractures (pathologic hip fracture).
- Severe myoclonus/muscle pain/spasms.
GIP: Related Palliative Procedures

- Epidural catheter placement.
- Performance of nerve block.
- Thoracentesis/Paracentesis (+/-) drain.
- Surgical debridement of stage III/IV pressure ulcers.
- Internal fixation of pathologic fracture.
- Placement of biliary/urethral/esophageal stent.
- Complicated transfusions.
- Incision/drainage of abscess.

GIP: Medication Adjustment

- When careful titration and teaching required to increase effectiveness while decreasing side effects and toxicity of the following drug class:
  - Analgesics
  - Anxiolytics
  - Respiratory and cardiac meds
  - Anti-convulsants
  - Insulin
  - Anti-coagulants

GIP: Psychosocial

- Breakdown in home support/caregiver in a patient with unmet skilled symptom management needs.
- Unsafe home environment (patient abuse, drug diversion, unfit to live, fire, etc.) only after intense community resources and patient must have unmet complex nursing care needs.
- Under these circumstances, must consider what the appropriate inpatient level is (i.e., respite vs. GIP).
Caregiver Breakdown: GIP or Respite?

“Caregiver breakdown is the loss of the individual’s support structure and should not be confused with the coverage requirements for medically reasonable and necessary care for pain and symptom management that can not be managed in any other setting. Therefore, caregiver breakdown should not be billed as GIP care unless the coverage requirements for this level of care are met.”

-NGS, Hospice GIP Coverage and Documentation (Nov. 2010)

GIP: Initial Documentation

- Must include ‘precipitating event’ on day of transfer to GIP level of care.
- Interventions tried in the home prior to transfer and how and why they were unsuccessful.
- Must update/upgrade the plan of care and drug profile – often necessary to add a new problem.
- Document collaborative planning with the attending physician, staff, ancillary providers, patient and family.

GIP: Ongoing Documentation

- Answer daily, “Why GIP?” and define symptoms.
- Document interventions and how the patient has responded (specifically use of multiple PRN meds).
- Define current and ongoing treatment plan and promote daily physician/APP visits in IPU’s.
- All disciplines should reflect similar treatments, goals and outcomes daily.
**GIP: Ongoing Documentation**

- Avoid using generic phrases (“no pain”, “no discomfort”, “no changes”, “actively dying”, etc.).
- Include quantitative data (vitals, WTs, meal %, pain ratings, labs, quotes from patient/family, etc.).
- Discharge planning from day of admit is necessary and requires a true multi-disciplinary approach.
- Once symptoms are controlled, it’s time for RHC.

---

**GIP: Discharge**

- Hospice must provide advance notice to patient when GIP level of care no longer necessary.
- Where/What/How of patient’s disposition needs developed by IDG and family mobilization essential.
- Plan of care updated with medication review/coverage.
- New diagnoses reviewed and relatedness determination.

---

**GIP: Discharge**

- If transferring to a facility for placement, must include plan of care, EOB, advance directives, etc.
- A physician order should be obtained to discontinue GIP and resume RHC.
- The day of discharge from GIP is reimbursed at the RHC per diem rate.
- When the patient is discharged deceased (i.e., dies on GIP LOC), the inpatient rate (general or respite) is paid for discharge date.
GIP: Comments from MAC

“GIP is not intended to be custodial or residential. Once a beneficiary’s symptoms are stabilized, or pain is managed, he/she must return to ROUTINE LOC. Medicare will not pay for GIP unless the beneficiary is in need of this level of care, and it is clearly documented in the medical records…”

-CGS Administrators, LLC., General Inpatient Care (updated 7/5/12)

Real Quotes From Real IPU Notes

• “Patient in IPU for end-of-life care”.
• “Patient is comfortable. No chest pain, dyspnea, fever. Good appetite.”
• “I assured the patient’s wife that she did not have to worry about discharge as long as husband continued to decline.”

Real Quotes From Real IPU Notes

• “Admit patient to the unit for general fatigue.”
• “Inpatient level of care for symptom control.”
• “Psychosocial crisis – none of nursing home beds acceptable to the patient’s wife.”
• “Patient unresponsive from CVA – arrived from hospital today – vital signs stable.”
GIP Example: Good RN Documentation

- “The patient is resting comfortably after palliation of agitation with 2 doses of PRN IV Ativan and 1 dose of PRN Morphine. This breakthrough episode of agitation last for 90 minutes.”
- “Assessed the patient and she reported an increased feeling of ‘smothering’. She requested medication and a breathing treatment. This is the 4th such episode in the past 9 hours since 0800.”

Tell the WHOLE story...

- If the patient’s symptoms are controlled in the moment, do not write, “patient resting” or “no symptoms at present.” Tell the whole story of why the patient is now comfortable. Example:
- “The patient is sleeping at present. Pain and anxiety appear to be relieved secondary to 3 doses of PRN Oxycodone IR in the past 4 hours and 2 doses of PRN Ativan (total of 4mg) IV.
- Patient now sleeping and appears comfortable. This is the first time the patient has slept in approximately 20 hours due to unrelieved pain.

Needed and Provided “Test”

Based on the clinical record documentation, was the higher level of care (GIP / CHC) both needed by the patient and provided by the hospice?
GIP Example: Good MD Documentation

• “Pt. admitted for intractable pain not managed by home regimen of ms contin 60 bid and Roxanol 10 mg q 2hrs prn from breakthrough pain – despite 4 doses of such in last 8 hrs at home prior to IPU transfer.”
• “Patient arrived with new 9/10 pain radiating from epigastric area to his spine. Subcutaneous morphine was started at 6mg/hr with 2mg bolus PCA every 10 min prn. New pain is concerning for worsening bony metastasis. May consider adding oral methadone...”

GIP: Contracted Facilities

Need to provide/share all of the following:
• Hospice election form;
• Advance directive;
• Initial certification and recertifications;
• Contact info for 24-hr on-call access to hospice personnel; and
• Current meds, physician orders, updated plans of care and covered vs. uncovered services.

Caregiver Breakdown: GIP vs Respite

“It is not appropriate to bill Medicare for GIP days for situations where the individuals’ caregiver support has broken down unless the coverage requirements for the GIP LOC are otherwise met. For a hospice to provide and bill for the GIP LOC, the patient must require an intensity of care directed towards pain control and symptom management and CANNOT be managed in any other setting.” (emphasis added)

-Medicare Benefit Policy Manual, Chapter 9 40.1.5- Short-Term Inpatient Care
OIG Report on GIP March 2016

“HOSPICES INAPPROPRIATELY BILLED MEDICARE OVER $250 MILLION FOR GENERAL INPATIENT CARE”

- Study based on a record review of stratified random samples of 565 GIP stays in 2012.
- Also reviewed Medicare Part D pharmacy data for these GIP stays.

2016 OIG GIP Report Findings

31% inappropriate for GIP = $268 million (represents 26% of total $ paid for GIP 2012)

- 20% Beneficiary did not need GIP at all during stay.
- 10% Beneficiary did not need GIP for part of stay.
- 1% Beneficiary did not elect hospice or have terminal illness.

2016 OIG GIP Report Findings

- States with highest percentage of inappropriate GIP stays: Florida, Arizona, Ohio (all >52%).
- 48% of all GIP stays in SNF’s inappropriate.
- Medicare part D inappropriately paid for over half of drugs during GIP stay.
- Overall, hospices did not meet care planning requirements 85% of GIP stays.
2016 OIG GIP Report:

CMS:
- Contractors to increase oversight of GIP claims, review part D drug payments, and conduct pre-payment reviews for long LOS (≥ 7 GIP days).
- To ensure that a physician is involved in decision to start and continue GIP care.
- To increase surveyor efforts re care planning.
- To establish additional enforcement remedies for poor hospice performance.

CMS Response to OIG Report
3/13/17
- CMS has recently contracted with Strategic Health Solutions, a Supplemental Medical Review Contractor (SMRC) to conduct new GIP audit:
  - Post-payment review of claims for CY15 that may have been inappropriately paid.
  - 65 providers chosen randomly; up to 40 charts based on LOS.
  - A Review Results letter will be provided as well as a Discussion/Education period.

SMRC ADR Specifics for GIP Audit

Documentation to support:
- Precipitating event, attempted interventions, pain & symptom control, GIP LOC.
- Plan of care to reflect GIP LOC as well as beneficiary response and collaboration with MD/RN/MSW/Counselor.
- Physician orders, progress notes, consults.
- Appropriate signatures and credentials of professionals.
- Patient notices/elections given.
Inpatient Care Utilization Issues

Medicare Cap on Inpatient Days:
• The total number of days (GIP & Respite) used by Medicare beneficiaries in a 12 month period cannot exceed 20% of the total hospice days consumed by hospice’s beneficiaries.

PEPPER:
• No GIP or CHC provided:
  – National 80th percentile is 99% range.

Under-Utilization of GIP/CHC

• Per CMS, “Medicare CoPs require hospice to demonstrate that they are able to provide all 4 levels of care to be a certified Medicare hospice provider.” (emphasis added)
• PEPPER measure validates that underutilization of higher levels of care is on the radar as well as over- or inappropriate utilization.

When the Crisis is in the Home: Continuous Home Care
Continuous Home Care

“A period of crisis is a period in which patient requires continuous care to achieve palliation or management of acute medical symptoms.”

-Medicare Benefit Policy Manual, Chapter 9, 40.2.1 – Continuous Home Care

CoP: 418.204(a) Periods of Crisis

“Nursing care may be covered on a continuous basis for as much as 24 hours a day during periods of crisis as necessary to maintain an individual at home. Either homemaker or home health aide services or both maybe covered on a 24-hour continuous basis during periods of crisis but care during these periods must be predominantly nursing care.” (emphasis added)

CHC Details

- Must provide a minimum of 8 hrs of care in a 24-hr period that begins and ends at midnight (not required to be “contiguous” hours).
- Nursing care (APRN, RN, LPN/LVN) must constitute > half of the period of care.
- Billed in 15 min intervals and cannot be routinely contracted.
CHC Details

- Hospice aide/homemaker is the only additional discipline that can be included in calculation of CHC hours.
- Although physician, social work, counselor, and/or bereavement services are often indicated, they cannot be “counted” in CHC calculations.

CHC Goals & Indications

- Keep the patient HOME (defined as ALF/PCH, but not SNF, hospital, or IPU).
- Clinical eligibility guidelines and indications are the same for CHC and GIP!
- When a level of care changes, the medical record must show the date, time, and reason why the level of care changed.
- Education to family/caregivers essential.
- Goal to return to RHC once symptoms managed.

CHC Documentation

- Likewise, documentation and discharge planning standards for CHC and GIP are very similar.
- Coordination/collaboration with the hospice physician must occur (not at bedside like most IPU models) as well as attending physician.
- The IDG focus and goal with CHC is to de-escalate the crisis in order to keep the patient in their home without moving them to provide the appropriate level of care.
Hospice LOC Case Study #1

- 90 yo w/metastatic prostate cancer on RHC.
- His 75 yo wife is his main caregiver.
- Pt is bedbound and needs help with medication administration and ADL’s.
- Wife had a fall and is hospitalized for hip fracture.
- Pt can’t be at home by himself and there is no money for private duty caregiving.
- Pt gets admitted to contracted SNF.

What LOC for Case Study #1?

a) GIP?
b) Respite?
c) RHC?
d) CHC?

Respite
(max. 5 consecutive days)
Hospice LOC Case Study # 2

- A nurse arrives at patient’s home at 8 a.m. to initiate a continuous morphine drip for pain control and administers an IV dose of Haldol to control continuous N/V with good results.
- Total time with patient and family (including education) is 2.5 hours.
- This RN spends additional 1.5 hrs on telephone with physician and pharmacist and revising plan of care.

Hospice LOC Case Study # 2

- A hospice aide provides direct patient care in the afternoon for 3 hours.
- A return visit is required by RN in the early evening for additional 2 hrs of bedside care, including Foley catheter placement and adjustment in iv meds.
- Total hrs of care in 24-hr period:
  - Direct clinical nursing – 4.5
  - Admin. nursing – 1.5
  - Hospice aide – 3

What LOC for Case Study # 2?

a) RHC?
b) CHC?
c) GIP?
RHC

Note: Pt did not receive a total of 8 hrs of clinical nursing care (1.5 hrs was administrative so cannot be counted)

Hospice LOC Case Study # 4

- 76 yo w/metastatic breast ca with lung mets who is home on hospice routine home care level.
- Emergent nursing visits required due to increasing dyspnea; tachypnea with RR 36 and use of accessory muscles noted.
- Initial treatment is oral Morphine 15mg q 6 hrs ATC and 7.5mg q 1 hr prn and oxygen therapy.
- Repeat nursing visit the same day results in doubling of morphine dosing due to unmanaged symptoms.
Hospice LOC Case Study # 4

- Her symptoms did improve minimally but patient became less responsive; developed dysphagia with inability to swallow/absorb oral and liquid morphine.
- CHC was entertained but due to constraints of hospice staff and family it was decided to move patient to hospice IPU for GIP LOC.
- After 3 days in IPU with daily hospice physician visits and daily dose titration of both continuous and frequent prn doses of iv morphine and IV Ativan patient’s symptoms are controlled.

Hospice LOC Case Study # 4

- By day 4, pt has declined significantly and is now unresponsive and is no longer requiring prn doses of morphine or Ativan but remains quite comfortable on continuous morphine drip and scheduled iv Ativan three times daily.
- By day 5, pt remains stable and the family does not feel comfortable taking patient home and does not want patient to go to a SNF and asks the hospice physician if she can just stay in IPU.

What LOC for Case Study # 4?

a) GIP?
b) RHC?
c) Respite?
d) CHC?
RHC

**Note:** Hospice physician should write an order to change to RHC LOC and consider residential room and board charge according to facility policy if patient stays.

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### Recap: Levels of Care

<table>
<thead>
<tr>
<th>GIP</th>
<th>CHC</th>
<th>Respite</th>
</tr>
</thead>
<tbody>
<tr>
<td>40.1.15 GIP care allowed when pt’s medical condition warrants short-term inpatient stay for pain control or acute/chronic symptom management that cannot feasibly be provided in other settings.</td>
<td>40.2.1 CHC may be provided only during a crisis as necessary to maintain pt at home.</td>
<td>40.1.15 Respite care (i.e., short-term inpatient care) only when necessary to relieve the family members or other persons who normally care for the pt at home.</td>
</tr>
</tbody>
</table>
Q & A

Thank You!
When Your Patient’s “Home” is a Facility
Lynn Stange RN, BSN, MA, CHC
OHPCA & WSHPCO Spring Intensive 2018

Learning Objectives
Upon completion, learners will be able to:
1. Describe the hospice-facility standards.
2. Discuss types of scrutiny specific to providing hospice care in facilities.
3. Articulate required components of a hospice-facility contract.
5. Summarize risks, targets and remedies for hospice-facility partnerships (Survey, MDS, Star Rating, Immediate Jeopardy).

NHPCO Regulatory Alert
OIG Report on Hospice and Assisted Living
January 16, 2015

Alert at a Glance
On Wednesday, January 14, 2015, the HHS Office of Inspector General (OIG) published a report entitled "Medicare Hospices Have Financial Incentives To Provide Care in Assisted Living Facilities" (PDF). The OIG also published a podcast on this report. A summary of the report recommendations, data details, and report findings are provided by the NHPCO Regulatory Team in the Alert below.

2013 CMS Final Rule...

...Requiring Medicare & Medicaid SNF to Coordinate with Hospice Providers

- When a patient lives in a Medicaid nursing facility, he or she may receive Medicaid hospice services.
- The nursing facility may arrange for hospice services or may assist in transferring the patient to a facility that provides hospice services.
- If the nursing facility arranges that the patient will receive hospice services at the nursing facility, there must be a written agreement with each hospice provider.

2013 CMS Final Rule

In addition to CoPs 418.10 – 418.116, a hospice that provides hospice care to residents of a SNF/NF or ICF/IID, must abide by the following additional standards:
(a) Resident eligibility, election and duration of benefits;
(b) Professional management;
(c) Written agreement;
(d) Hospice plan of care;
(e) Coordination of services; and
(f) Orientation and training of staff

418.112(a) Standard

Resident eligibility, election, and duration of benefits:
- Medicare patients receiving hospice services and residing in a SNF, NF, or ICF/IID are subject to the Medicare hospice eligibility criteria set out at 418.20 – 418.30.
418.112(b) Standard

Professional management:
- The hospice must assume responsibility for professional management of the resident’s hospice services provided, in accordance with the hospice plan of care and the hospice conditions of participation, and make any arrangements necessary for hospice-related inpatient care in a participating Medicare/Medicaid facility according to 418.100 and 418.108.50.

418.112(b) Standard

Hospice is responsible for providing all hospice services including:
- Ongoing assessment, care planning, monitoring, coordination, provision of care by the Hospice IDG.
- Assessment, coordination, provision of any needed general inpatient or continuous care.
- Consultation about the patient’s care with facility staff.

418.112(b) Standard

Professional management:
- Coordination by the hospice RN for the implementation of the plan of care for the patient.
- Provision of hospice aide services, if these services are determined necessary by the IDG to supplement the nurse aide services provided by the facility.
- Provision, in a timely manner, of all supplies, medications, and DME needed for the palliation and management of the terminal illness and related conditions.
418.112(b) Standard

Professional management:

- Financial management responsibility for all medical supplies, appliances, medications and biologicals related to the terminal illness and related conditions.
- Determination of the appropriate level of care to be given to the patient (routine homecare, inpatient, or continuous care).
- Arranging any necessary transfers from the facility, in consultation with the facility staff.

418.112(c) Standard

Written agreement:

- The hospice and SNF/NF or ICF/IID must have a written agreement that specifies the provision of hospice services in the facility.
- The agreement must be signed by authorized representatives of the hospice and the SNF/NF or ICF/IID before the provision of hospice services.

418.112(d) Standard

Hospice plan of care:

- In accordance with 418.56, a written hospice plan of care must be established and maintained in consultation with SNF/NF or ICF/IID representatives. All hospice care provided must be in accordance with this hospice plan of care.

  (1) The hospice plan of care must identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care.
418.112(d) Standard

Hospice plan of care:

(2) The hospice plan of care reflects the participation of the hospice, the SNF/NF or ICF/IID, and the patient and family to the extent possible.

(3) Any changes in the hospice plan of care must be discussed with the patient or representative, and SNF/NF or ICF/IID representatives, and must be approved by the hospice before implementation.

418.112(e) Standard

Coordination of Services:

• The hospice must:

  (1) Designate a member of each interdisciplinary group that is responsible for a patient who is a resident of a SNF/NF or ICF/IID, who is responsible for:

    (i) Providing overall coordination of the hospice care of the SNF/NF or ICF/ MR resident with SNF/NF or ICF/IID representatives; and

  (ii) Communicating with SNF/NF or ICF/IID representatives/other health care providers participating in the provision of care for the terminal illness/related conditions/other conditions to ensure quality of care for the patient and family.
418.112(e) Standard

Coordination of Services:
(2) Ensure that the hospice IDG communicates with the SNF/NF or ICF/IID medical director, the patient’s attending physician, and other physicians participating in the provision of care to the patient as needed to coordinate the hospice care of the hospice patient with the medical care provided by other physicians.

418.112(e) Standard

Coordination of Services:
(3) Provide the SNF/NF or ICF/IID with the following information:
(i) The most recent hospice plan of care specific to each patient;
(ii) Hospice election form and any advance directives specific to each patient;
(iii) Physician certification and recertification of the terminal illness specific to each patient;

418.112(e) Standard

Coordination of Services:
(iv) Names and contact information for hospice personnel involved in hospice care of each patient;
(v) Instructions on how to access the hospice’s 24-hour on-call system;
(vi) Hospice medication information specific to each patient; and
(vii) Hospice physician and attending physician (if any) orders specific to each patient.
418.112(f) Standard

**Orientation and training of staff:**
- Hospice staff must assure orientation of SNF/NF or ICF/IID staff furnishing care to hospice patients in the hospice philosophy, including hospice policies and procedures regarding methods of comfort, pain control, symptom management, as well as principles about death and dying, individual responses to death, patient rights, appropriate forms, and record keeping requirements.

Best Practices

Successful collaborations are partnerships where care planning, coordination and provision are performed in care environments where:
- mutual respect dominates;
- providers routinely share knowledge; and
- policies and procedures clarify the roles of each collaborating party.

Benefits of H-NH Partnership

- Care expertise in both LTC and palliative care
- Additional attention from increased number of people involved in care
- Access to counseling/spiritual care disciplines to meet the intense/varied needs that surround EOL
- Volunteers providing diversional/quality of life activities the nursing home staff do not have time to provide
- Volunteers to assist/support family so they can spend more quality time with the resident

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Miller, S. How Can Clinicians with Diverse Backgrounds and Training Collaborate with One Another to Care for Patients at the End of Life? A NURSING HOME - HOSPICE CASE STUDY. Brown University
**Benefits of H-NH Partnership**

- Continuity of care team providers
- Coverage of related medications, medical supplies, and equipment
- Professionals specializing in supporting residents and families to a more meaningful life closure
- Additional support for family providing care, and anticipating life without their loved one
- Bereavement support for family up to 12 months after the death

Miller, S. How Can Clinicians with Diverse Backgrounds and Training Collaborate with One Another to Care for Patients at the End of Life? A NURSING HOME - HOSPICE CASE STUDY Brown University

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**Know the LTC Risk Areas**

- **Survey Risk**
  - Is hospice potentially increasing survey risk for facility?
- **MDS Profile Immediate Jeopardy**
  - How does hospice care impact the resident’s MDS?
- **NH Compare 5 Star Rating**
  - How would you minimize risk and add-value to the nursing home’s 5 Star Ratings?

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**Minimum Data Set (MDS)**

- Used in Medicare/Medicaid certified nursing homes
- Completed regardless of source of payment for resident
- Required on admission to the nursing facility, change of condition, and on discharge
- Information is transmitted electronically by nursing homes to the national MDS database at CMS
MDS

Preliminarily Assesses:
• Physical
• Clinical
• Psychological
• Psychosocial functioning
• Life care wishes

MDS Clinical Assessment of Residents

• The MDS is not a comprehensive assessment; rather, it is a preliminary assessment to identify potential resident problems, strengths, and preferences.
• Care Area Assessment (CAAs) are triggered by MDS item responses that indicate the need for additional assessment based on problem identification known as “triggered care areas.”

MDS Clinical Assessment of Residents (cont’d)

• There are currently 20 CAAs in version 3.0 of the MDS
• These CAAs cover the majority of care areas known to be problematic for nursing home residents
CAAs and Care Planning (MDS 3.0)

Nursing Home Compare

- Allows consumers to compare information on nursing homes
- Only Medicare or Medicaid certified skilled NH
- Not an endorsement

5 Star quality ratings
Health and fire safety
Staffing
Quality measures
Penalties

Sample View: Nursing Home Compare
5 Star Ratings Quality Measures
Long-stay Residents

- Falls with major injury
- UTIs
- Moderate-severe pain
- Pressure ulcers
- Lose control of bowel and bladder
- Catheter left in
- Physical restraints

https://www.medicare.gov/NursingHomeCompare/About/Short-Stay-Residents.html

5 Star Ratings Quality Measures
Long-stay Residents

Percent of Residents:
- Ability to move independently worsened
- Need for ADL help increased
- Lose too much weight
- Have depressive symptoms
- Received antipsychotic, antianxiety, or hypnotic medications
- Assessed and given flu and pneumococcal vaccines

https://www.medicare.gov/NursingHomeCompare/About/Short-Stay-Residents.html

5 Star Ratings Quality Measures
Short-stay Residents

Percent of Residents:
- Improvements in function
- Re-hospitalized after NH admission
- Outpatient ER visit
- Successfully discharged to community
- Moderate-severe pain
- Pressure ulcers new or worsened
- Assessed/given flu, pneumonia vaccines
- Administered antipsychotic meds

https://www.medicare.gov/NursingHomeCompare/About/Short-Stay-Residents.html
Medicare and Medicaid Programs: Reform of Requirements for Long-Term Care Facilities

Federal Register / Vol. 81, No. 192 / Tuesday, October 4, 2016 / Rules and Regulations


LTC Regulations That May Impact Care to Residents in Hospice

483.10(c) Planning and Implementing Care
483.10(d) Choice of Attending Physician
483.10(e) Respect and Dignity
483.10(f) Self-determination
483.10(g) Information and Communication
483.12 Freedom from Abuse, Neglect & Exploitation
483.21 Comprehensive Resident-Centered Care Plans
483.45 Pharmacy Services
483.95 Training Requirements

CMS Changes – PRN Psychotropic and Antipsychotic Medications

• Changes effective on November 28, 2017
• Includes an updated definition of a psychotropic medication and a change in prescribing requirements for psychotropic and antipsychotic medications
• Expands the categories of medications that may be considered psychotropic by state surveyors
Psychotropic Medications in SNFs

- Updated psychotropic definition:
  - “Any drug that affects brain activities associated with mental process and behavior. These drugs include, but are not limited to, drugs in the following categories:
    - Antipsychotic;
    - Antidepressant;
    - Antianxiety; and
    - Hypnotic.”

Psychotropic Medications in SNFs

- In addition to the updated definition of psychotropic medication, additional classes of medications may also be considered psychotropic by state surveyors:
  - Central nervous system agents;
  - Mood stabilizers;
  - Anticonvulsants;
  - Muscle relaxants, anti-cholinergics, and antihistamines; and
  - NMDA receptor modulators

Psychotropic Medications in SNFs

- There is a 14-day limitation on all PRN psychotropic orders (excluding antipsychotics).
- Prescription for psychotropic medication may be extended beyond 14 days if the attending physician or the prescribing practitioner:
  - (1) Believes it is appropriate to extend the order – and –
  - (2) Documents clinical rationale for the extension – and –
  - (3) Provides for a specific duration of use.
Antipsychotic Medications in SNFs

- There is a 14-day limitation on all PRN antipsychotic medication orders.
- The PRN order may not be extended beyond the 14-day limit; a new physician’s order must be written.
- A new order for the PRN antipsychotic may be written if the attending physician or prescribing practitioner: (next slide)

Antipsychotic Medications in SNFs

1. DIRECTLY examines and assesses the resident. Evaluation by facility staff is NOT permitted – and –
2. Documents clinical rationale for the new order, which includes:
   a. What is the benefit of the medication to the resident? – and –
   b. Has the resident’s expressions or indications of distress improved as a result of the PRN medication?

PRN Antipsychotic and Psychotropic Medications

- These regulations do not mean that a SNF cannot use antipsychotic or psychotropic PRN medications
- Per CMS, “As always, medications should only be initiated/used in the presence of active clinical symptoms and after non-pharmacological interventions and least restrictive measures have been attempted” – CMS F757

- State Operations Manual Appendix PP – Guidance to Surveyors for Long Term Care Facilities
**NHPCO Newsletter 2017**

**SNF Probes**

New NGS Medical Review of Patients in SNF

NGS has started a new provider-specific probe for providers who have a high percentage of their patients in a SNF (Q504). Early in 2016 CMS issued an article expressing concerns regarding beneficiaries in the hospice category who reside in the SNF. This is a prepayment probe audit for providers who have >10% of patients residing in a SNF with a Q504 location code.

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**Potentially Avoidable Hospitalizations (PAH)**

**CMS Data Brief:**

Sharp reduction in avoidable hospitalizations among long-term care facility residents

The Agency for Healthcare Research and Quality (AHRQ) identified a set of measures to identify avoidable hospitalizations for largely preventable or manageable conditions.

- **Bacterial pneumonia**
- **UTI**
- **Dehydration**
- **CHF**
- **Asthma**
- **COPD**
- **Skin ulcers**

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**Next Steps**

- Do your facility contracts contain all the required components?
- Do you invite facility staff to your IDG?
- Does your hospice participate in facility care planning meetings?
- How do you share care plans when updated?
- Do your nurses offer to help update the MDS on admission? With any change in condition?
- How do you train facility staff on hospice?
Remember!

• Payment-related scrutiny also includes/involves the Plan of Care!
• Ensure that:
  – Your hospice complies with all regulatory requirements associated with care planning.
  – You submit the POC, including **ALL** updates, for **ALL** dates of service under review when clinical records are requested by your MAC or other reviewers, auditors, and/or investigators.

Q & A

Thank You!
Ending Hospice Care: Discharge, Revocation & Transfer
Colleen O’Keefe, RN, CHPN
OHPCA & WSHPCO Spring Intensive 2018

Learning Objectives
Upon completion, learners will be able to:
1. Define reasons for discharge/revocation.
2. Differentiate between “revocation” and “discharge”.
3. List the documentation and other requirements associated with live discharges.
4. Outline the hospice’s responsibilities with traveling patients.

Important Considerations
What % of:
• patients are discharged due to death?
• deaths are pronounced and/or attended by hospice staff?
• survivors “decline” bereavement services and why?
Important Considerations

- Are clinical records officially “closed”?
  - Is the plan of care concluded (e.g., were outcomes met; if not, why not?)
  - What did the team do well that could be replicated with other patients/families?
  - What could be improved?
- Are satisfaction surveys sent and what do they reveal regarding outcomes?

LIVE DISCHARGE

Medicare Benefit Policy Manual
Chapter 9 – Coverage of Hospice Services

Once a hospice chooses to admit a Medicare beneficiary, it may not automatically or routinely discharge the beneficiary at its discretion, even if the care promises to be costly or inconvenient, or the State allows for discharge under State requirements. The election of the hospice benefit is the beneficiary’s choice rather than the hospice’s choice, and the hospice cannot revoke the beneficiary’s election. Neither should the hospice request or demand that the patient revoke his/her election.
Subpart B – Eligibility, Election and Duration of Benefits

418.26 Discharge from hospice care.
(a) Reasons for discharge. A hospice may discharge a patient if—
   (1) The patient moves out of the hospice’s service area or transfers to another hospice;
   (2) The hospice determines that the patient is no longer terminally ill; or

Eligibility, Election and Duration of Benefits

(3) The hospice determines, under a policy set by the hospice for the purpose of addressing discharge for cause...that the patient’s (or other persons in the patient’s home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired.

Eligibility, Election and Duration of Benefits

(b) Discharge order. Prior to discharging a patient ... the hospice must obtain a written physician’s discharge order from the hospice medical director. If a patient has an attending physician involved in his or her care, this physician should be consulted before discharge and his or her review and decision included in the discharge note.
Eligibility, Election and Duration of Benefits

(d) Discharge planning.

(1) The hospice must have in place a discharge planning process that takes into account the prospect that a patient's condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill.

Eligibility, Election and Duration of Benefits

(2) The discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she is no longer terminally ill.

Discharge: Moving Out of the Service Area
Out of Service Area

• The beneficiary moves out of the geographic area that the hospice defines in its policies as its service area. Some examples of moving out of the hospice’s service area include, but are not limited to, when a hospice patient moves to another part of the country or when a hospice patient leaves the area for a vacation.

-Medicare Benefit Policy Manual, Chapter 9, 20.2.3 – Hospice Discharge

Out of Service Area

• Another example would be when a hospice patient is receiving treatment for a condition unrelated to the terminal illness or related conditions in a facility with which the hospice does not have a contract, and the hospice is unable to access the patient to provide hospice services.

-Medicare Benefit Policy Manual Chapter 9, 20.2.3 – Hospice Discharge

Out of Service Area

• In this example, Medicare’s expectation is that the hospice provider would consider the amount of time the patient is in that facility and the effect on the plan of care before making a determination that discharging the patient from the hospice is appropriate.

-Medicare Benefit Policy Manual Chapter 9, 20.2.3 – Hospice Discharge
Out of Service Area: Important Considerations

- Does your patient plan to travel?
- What was his/her healthcare utilization prior to hospice?
- Did they use a particular hospital?

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DISCHARGE: Change of Designated Hospice

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Change of Designated Hospice

Subpart B—Eligibility, Election and Duration of Benefits

418.30 Change of the designated hospice

(a) An individual or representative may change, once in each election period, the designation of the particular hospice from which hospice care will be received.
Change of Designated Hospice

(c) To change the designation of hospice programs, the individual or representative must file, with the hospice from which care has been received and with the newly designated hospice, a statement that includes the following information:

(1) The name of the hospice from which the individual has received care and the name of the hospice from which he or she plans to receive care

(2) The date the change is to be effective
Change of Designated Hospice: Important Considerations

- What % of patients change their designated hospice?
- Why do patients change providers?
- Are changes appropriately communicated to all parties?
- Does required documentation accompany each change?
- Which hospice is responsible for evaluating and documenting eligibility?

DISCHARGE: No Longer Terminally Ill

No Longer Terminally Ill

- The **hospice physician** makes this determination
- The decision should be informed by IDT longitudinal assessment data, F2FEs, LCDs, etc.
- Extended periods of stability (i.e., lack of terminal disease progression) need to be considered in the ongoing eligibility assessment
No Longer Terminally Ill

Remember:

- Discharge planning: The hospice must have in place a discharge planning process that takes into account the prospect that a patient’s condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill.
  - Medicare Benefit Policy Manual Chapter 9, 20.2.3 - Hospice Discharge

No Longer Terminally Ill

- Once a patient is no longer considered terminally ill with a life expectancy of 6 months or less if the disease runs its normal course, Medicare coverage and payment for hospice care should cease...

No Longer Terminally Ill

- Medicare does not expect that a discharge would be the result of a single moment that does not allow time for some post-discharge planning. Rather, it would be expected that the hospice’s interdisciplinary group is following the patient, and if there are indications of improvement in the individual’s condition such that hospice may soon no longer be appropriate, then planning should begin...
No Longer Terminally Ill

- If the patient seems to be stabilizing, and the disease progression has halted, then it could be the time to begin preparing the patient for alternative care. Discharge planning should be a process, and planning should begin before the date of discharge.

-Medicare Benefit Policy Manual Chapter 9, 20.2.3 – Hospice Discharge

No Longer Terminally III: Important Considerations

- What % of patients are discharged due to extended prognosis?
- Of this patient population, how many:
  - are discharged at the end of a benefit period?
  - are immediately admitted to a competing hospice?
  - die within the next 6 months?
  - die without hospice support?

No Longer Terminally III: Important Considerations

What do you do if the:
- Hospice receives payment denials from the MAC due to “not terminally ill”?
- Patient/family appeals your discharge decision to the QIO and wins, yet the hospice physician cannot recertify based on his/her medical judgment?
No Longer Terminally Ill: Important Considerations

CMS Guidance on Discharge Timing (FAQ 3569):

- Once it is determined that the patient is no longer terminally ill, the patient is no longer eligible to receive the Medicare hospice benefit.
- When a hospice has not properly planned for a discharge, we would expect the hospice to continue to care for the patient at its own expense until required discharge planning is complete.

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DISCHARGE: For Cause

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Discharge For Cause

Subpart B—Eligibility, Election and Duration of Benefits

418.26 Discharge from hospice care

(3) ...The hospice must do the following before it seeks to discharge a patient for cause:

(i) Advise the patient that a discharge for cause is being considered

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Discharge For Cause

(ii) Make a serious effort to resolve the problem(s) presented by the patient’s behavior or situation;
(iii) Ascertain that the patient’s proposed discharge is not due to the patient’s use of necessary hospice services; and
(iv) Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its medical records.

Discharge For Cause

• The hospice must notify the Medicare contractor and State Survey Agency of the circumstances surrounding the impending discharge. The hospice may also need to make referrals to other relevant state/community agencies (i.e., Adult Protective Services) as appropriate.

-Medicare Benefit Policy Manual Chapter 9, 20.2.3 - Hospice Discharge

Discharge For Cause: Important Considerations

• What % of patients are discharged “for cause”?
• Why do these discharges occur (i.e., what are the causative factors; are there any patterns or trends)?
• Does documentation reflect the problem(s) and resolution efforts?
ADMINISTRATIVE DISCHARGE: Untimely or Missed F2FE

Untimely or Missed F2FE

- Recertifications that require a face-to-face encounter but which are missing the encounter are not complete. The statute requires a complete certification or recertification in order for Medicare to cover and pay for hospice services...

Untimely or Missed F2FE

- Where the only reason the patient ceases to be eligible for the Medicare hospice benefit is the hospice’s failure to meet the face-to-face requirement, Medicare would expect the hospice to discharge the patient from the Medicare hospice benefit, but to continue to care for the patient at its own expense until the required encounter occurs, enabling the hospice to re-establish Medicare eligibility...
Untimely or Missed F2FE

- The hospice can re-admit the patient to the Medicare hospice benefit once the required encounter occurs, provided the patient continues to meet all of the eligibility requirements and the patient (or representative) files an election statement in accordance with CMS regulations.

- Medicare Benefit Policy Manual Chapter 9, 20.1 – Timing and Content of Certification

Untimely or Missed F2FE

- The F2FE can be completed on 1st day of new benefit period [Note: “Exceptional Circumstances” apply only to patients being admitted into a 60-day benefit period – not to those already on service being recertified into a 60-day benefit period]
- Patient must be “administratively discharged” from the Medicare Hospice Benefit until F2FE is completed
- The hospice must provide free care during this time

Untimely or Missed F2FE

- When F2F is completed, patient is re-admitted to hospice Benefit
  – New Election of Benefit
  – Notice of Election
  – Certification & MD narrative
  – Comprehensive Assessment
  – Plan of Care, etc.
Untimely or Missed F2FE: Important Considerations

• What % of patients are discharged due to a late/missed F2FE?
• Why are F2FEs late/missed?
• Does the hospice “administratively discharge” these patients and provide free care in the interim?
• Upon completion of the F2FE, are these patients treated like new admissions (from a documentation perspective)?

Discharge: General Considerations

• What % of patients are discharged alive and why?
• Of this patient population, how many are readmitted and when (i.e., how soon after the discharge)?
• How many times are individual patients readmitted to the hospice?

Discharge: General Considerations

• What impact, if any, will the new payment rules have on live discharges?
• For example:
  – Will there be more live discharges at 60 days?
  – Will there be more stringent re-admission standards after 60-day first tier?
REVOCATION

Revocation

Subpart B—Eligibility, Election and Duration of Benefits

418.28 Revoking the election of hospice care.

(a) An individual or representative may revoke the individual’s election of hospice care at any time during an election period.

The patient revokes, the hospice discharges!

(b) To revoke the election of hospice care, the individual or representative must file a statement with the hospice that includes the following information:

(1) A signed statement that the individual or representative revokes the individual’s election for Medicare coverage of hospice care for the remainder of that election period.
Revocation

(2) The date that the revocation is to be effective. (An individual or representative may not designate an effective date earlier than the date that the revocation is made).

Revocation

(d) When the hospice election is ended due to revocation, the hospice must file a notice of termination/revocation of election with its Medicare contractor within 5 calendar days after the effective date of the revocation, unless it has already filed a final claim for that beneficiary.

Revocation

• Note that a verbal revocation of benefits is NOT acceptable.

-Medicare Benefit Policy Manual Chapter 9, 20.2.2 - Hospice Revocation
Revocation: Important Considerations

- What % of patients revoke their hospice benefit?
- Are all revocations “effective” on the date signed, or a later date?
- Why do patients revoke?
- Does required documentation accompany each revocation?

Revocation: Important Considerations

- Are all revocations related to ER visits / hospitalizations?

Revocation: Important Considerations

- If you get a call from the ER that a hospice patient has arrived, immediately dispatch staff to the ER to assess the situation & discuss options
- Train your local hospital ER departments to ask if patients are on hospice and to call you if they arrive there
Revocation: Important Considerations

- Have a mechanism for getting a revocation form to patients when they are needed (e.g., some hospices keep an unsigned revocation form in the patient’s home file)
- **DO NOT** get revocations signed by the patient/representative and leave the date blank!

Revocation: Important Considerations

- Track revocation reasons and compare to national averages
- If your #s are higher than the norm:
  - you may be subject to greater scrutiny
  - it may demonstrate a need to improve staff knowledge of how to provide informed consent
  - it may reflect a quality of care issue, etc.

Other General Discharge-Related Requirements

**Subpart D—Conditions of participation:**
**Organizational Environment**

418.104 **Condition of participation: Clinical records.**

(2) **If a patient revokes the election of hospice care, or is discharged from hospice in accordance with 418.26, the hospice must forward to the patient’s attending physician, a copy of—**
Other General Discharge-Related Requirements

(i) The hospice discharge summary; and

(ii) The patient’s clinical record, if requested.

Other General Discharge-Related Requirements

(3) The hospice discharge summary as required in paragraph (e)(1) and (e)(2) of this section must include—

(i) A summary of the patient’s stay including treatments, symptoms and pain management.

(ii) The patient’s current plan of care.

Other General Discharge-Related Requirements

(iii) The patient’s latest physician orders.

(iv) Any other documentation that will assist in post-discharge continuity of care or that is requested by the attending physician or receiving facility.
Discharge Planning: Important Considerations

- Starts at the beginning of care, and includes:
  - informed consent
  - identifying patient/family goals
  - identifying and proactively managing “at risk” patients/diagnoses, families, contracted facilities, and behaviors, etc.

Discharge Planning: Important Considerations

- Also includes baseline measurements graphed to establish decline or stabilization
- For example:
  - LCDs, KPS/PPS, FAST, NYHA, VS, weights, BMIs, etc.

TRAVELING PATIENTS
Traveling Patients

Subpart C—Conditions of Participation: Patient Care

418.64 Condition of participation: Core services.
Circumstances under which a hospice may enter into a written arrangement for the provision of core services include...temporary travel of a patient outside of the hospice’s service area

Traveling Patients:
Important Considerations

• What % of patients travel outside the hospice’s service area, how frequently, for what duration of time, and for what purpose?
• Is the hospice able to contract with other Medicare-certified hospices for care of the traveling patient?

Traveling Patients:
Important Considerations

• How far will the patient be traveling (e.g., the next county or state or across the country)?
• How long will the trip take?
• Who will be responsible for providing care to the patient during the trip and is it feasible to do so (logistically speaking), or is discharge more appropriate with a referral to the new hospice?
Traveling Patients:
Important Considerations
• Are needs and expectations communicated to the contracted hospice as well as the patient/family (and documented)?
• Is required documentation provided to the contracted hospice?
• Does the contracted hospice provide documentation if/after services are rendered to the traveling patient?

Next Steps
• Review (and revise, as needed) your policies and procedures related to discharge and revocation to ensure compliance
• Assess rates of live discharge/revocation
• Identify any trends or opportunities
• Develop and implement strategies for improvement

Q & A
Thank You!
QAPI & HQRP: How Data Impacts Your Hospice

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Learning Objectives

At the end of this session, learners will be able to:
1. Describe the key components of a Quality Assessment Performance Improvement (QAPI) program.
2. Discuss Hospice Quality Reporting Program (HQRP) including new measures and submission requirements.
3. Discuss current and upcoming hospice transparency information.

Data...Why does it Matter?

DATA --> KNOWLEDGE --> ACTION
New QAPI CoP
(December 2, 2008)

“The Existing 418.66 CoP – Quality Assurance relies on a problem-oriented approach to identify and resolve patient care issues…During the last decade, the health care industry, including the hospice industry, has moved beyond the problem-oriented approach of quality assurance to an approach that focuses on a preemptive plan that continuously addresses QAPI.”

QAPI

• Became a regulatory requirement in 2008 and permanently changed the hospice industry.
• QAPI is the most central and overarching of the patient-centered and outcome-oriented hospice CoPs.
• QAPI has laid the foundation for the Hospice Quality Reporting Program (HQRPs).

QAPI in a Nutshell

Hospices must:
• Collect data about results of care, services, and operations.
• Use that data to identify opportunities for improvement (OFIs).
• Conduct Performance Improvement Projects (PIPs).
• Collect data to demonstrate sustained performance improvement.
**QAPI**

As the name implies, QAPI is a combination of 2 different, but related, processes:
- Quality Assessment (QA)
- Performance Improvement (PI)

**Quality Assessment**

- Evaluating different **domains** of the hospice program (clinical and non-clinical).
- Determining **measurable outcomes** and selecting manageable **quality indicators** within the identified domains.
- **Collecting** data related to the quality indicators to measure the outcomes.
- **Analyzing** the data.

**Performance Improvement**

- Using the data analysis from quality assessment activities to **identify** opportunities for improvement.
- Prioritizing areas to focus on for **improvement**
- Initiating Performance Improvement Projects (PIPs).
- Evaluating the success of PIPs, sustaining improvement, and revising as warranted.
QAPI Functions

QAPI Data on 2 Levels

• QAPI data is collected on 2 levels:
  – Patient Level; and
  – Hospice Level.

• At both levels, hospices must:
  • Collect data to assess quality;
  • Use the data to identify opportunities for improvement; and
  • Demonstrate performance improvement in one or more areas.

Patient-Level QAPI Data

• Collect data on what happened for an individual patient:
  – Initial and Comprehensive Assessment (418.54);
  – Plan of Care (418.56); and
  – Clinical Notes.

• Use data to improve quality of care and outcomes for that particular patient (418.56).
Patient-Level Cycle of Care

Example: Use of Hospice-Level Data

- Clinically focused:
  - Aggregate Hospice Consumer Assessment of Healthcare Providers and Systems (e.g., CAHPS®) Survey.
- Organization / Operations focused:
  - Employee satisfaction surveys;
  - Financial Reports;
  - Human Resources turnover statistics; etc.
- Use the data to improve clinical outcomes and non-clinical operations

418.58: Quality Assessment and Performance Improvement

- The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide, data-driven QAPI program.
- The hospice’s governing body must ensure that the program:
  - Reflects the complexity of its organization and services.
  - Involves all hospice services (including those services furnished under contract or arrangement).
418.58: Quality Assessment and Performance Improvement

- The hospice’s governing body must ensure that the program:
  - Focuses on indicators related to palliative outcomes.
  - Takes actions to demonstrate improvement in hospice performance.
- The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.

QAPI Standards

- Program scope.
- Program data.
- Program activities.
- Performance improvement activities.
- Executive responsibilities.

418.58(a) Program Scope

- (a)(1) The program must at least be able capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services.
- (2) The hospice must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations.
418.58(b) Program Data

- (b)(1) The program must use quality indicator data, including patient care, and other relevant data, in the design of its program.
- (2) The hospice must use the data collected to do the following:
  i. Monitor the effectiveness and safety of services and quality of care.
  ii. Identify opportunities and priorities for improvement.

418.58(b)(3) Program Data

- (3) The frequency and detail of the data collection must be approved by the hospice’s governing body.

418.58(c) Program Activities

- (c)(1) The hospice’s performance improvement activities must:
  i. Focus on high risk, high volume, or problem-prone areas.
  ii. Consider incidence, prevalence, and severity of problems in those areas.
  iii. Affect palliative outcomes, patient safety, and quality of care.
418.58(c) Program Activities

- (2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventative actions and mechanisms that include feedback and learning throughout the hospice.
- (3) The hospice must take actions aimed at performance improvement and, after implementing those actions, the hospice must measure its success and track performance to ensure that improvements are sustained.

418.58(d) Performance Improvement Projects

- (d) Beginning February 2, 2009, hospices must develop, implement, and evaluate performance improvement projects.
- (1) The number and scope of distinct performance improvement projects conducted annually, based on the needs of the hospice’s population and internal organizational needs, must reflect the scope, complexity, and past performance of the hospice’s services and operations.

- (2) The hospice must document what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.
418.58(e) Executive Responsibilities

• (e) The hospice’s governing body is responsible for ensuring the following:
  — (1) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually.
  — (2) That the hospice-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness.

418.58(e) Executive Responsibilities

• (3) That one or more individual(s) who are responsible for operating the quality assessment and performance improvement program are designated.

State / Accreditation Survey of QAPI

• Hospice Policy and Procedure Manual.
• Interview with staff regarding QAPI / PIPs.
• Incident reports and/or Root-Cause Analysis Reports, if applicable.
• Minutes of QAPI Committee Meeting.
• Governing body meeting minutes.
• Review of monthly, quarterly, and annual QAPI reports.
Culture of Quality: Pervasive

- Data elements incorporated into patient assessment/care plans.
- Performance improvement data posted on bulletin boards or in reports.
- QAPI is a core activity across the organization.
- Positive questioning, not finger pointing.
- Performance improvement, not criticism or punishment, is the organizational response to errors and problems.

Culture of Quality: Documented

- QAPI plan describes the program.
- Policies and procedures support the QAPI program.
- QAPI Committee minutes reflect review of data and decision-making regarding improvement priorities.
- Governing body minutes reflect involvement.
- Performance improvement projects are thoroughly documented as required.

QAPI Excellence

Going forward, what does your team need to do to have an effective QAPI Program and a Culture of Quality?
Hospice Quality Reporting Program (HQRP) & Hospice Item Set (HIS) ☑

CAHPS®

FY14 Quality Regulatory Requirements

• In the FY14 Hospice Wage Index / Final Rule (published 08/07/14), the Hospice Item Set (HIS) was introduced.
• The HIS introduced 7 quality measures endorsed by the National Quality Forum (NQF) – effective July 1, 2014.
• The Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey was effective January 1, 2015.

– Federal Register, August 7, 2013. Rules and Regulations (“Final Rule”)

CAHPS® Survey

• Hospices must contract with a CMS-approved vendor to collect the CAHPS® Hospice Survey data on their behalf and submit the data to the Hospice CAHPS® Data Center.
• Small hospices (less than 50 unique deaths per year) can apply for an exemption from CMS.
• No hospice (or affiliate) may administer its own CAHPS® survey – no exceptions!
Hospice Transparency

- In August 2017 the CMS Hospice Transparency web site was launched.
- The first publically data reported was the hospices' compliance with the HIS measures.
- CAHPS data will be publically reported in February 2018.
- CAHPS information to be posted will be from hospices' April 2015 to March 2017 data.

Hospice CAHPS Reportable Data

- Hospice Team Communication;
- Getting Timely Care;
- Treating Family Member with Respect;
- Getting Emotional and Religious Support;
- Getting Help for Symptoms; and
- Getting Hospice Care Training.
- The Two Global Survey Measures are:
  - Willingness to Recommend Hospice; and
  - Overall Rating of Hospice.

HIS

NQF Endorsed Measures for Hospice:
1. NQF #1617 – Patients treated with an opioid who are given a bowel regimen;
2. NQF # 1634 – Pain screening;
3. NQF # 1637 – Pain assessment;
4. NQF #1638 – Dyspnea treatment;
5. NQF #1639 – Dyspnea screening;
6. NQF #1641 – Treatment preferences; and
7. NQF #1647 – Beliefs / Values addressed (if desired by the patient).
HIS Data Submission

**HIS Admission and Discharge data**
- Transmitted to CMS through the Assessment Submission and Processing (ASAP) system to the Quality Improvement Evaluation System (QIES)
- Submission timeline is 30 days from the event (admission or discharge)

HIS

- Hospices were required to submit HIS data for all patients (regardless of payer) admitted after July 1, 2014:
  - Admission HIS Data
  - Discharge HIS Data
- Failure to submit HIS data would result in 2% payment reduction in FY16 (and beyond)
- Hospices were evaluated based on data submission – not on quality measure performance

HIS

- Since 2014, the threshold for satisfying the time requirement was that 70% of HIS records had to be submitted within 30 days of the event.
- For CY17, the threshold was 80%.
- **For CY18, the threshold was increased to 90%** (i.e., 90% of all HIS data has to be submitted within 30 days of the event).
- Based on a recent CMS survey, 88% of hospices met the 80% HIS submission threshold.
CASPER Quality Measure Reports

- Certification and Survey Provider Enhanced Reporting (CASPER).
- 2 Confidential provider Quality Measure ("QM") feedback reports:
  - Hospice-Level Quality Measure Report; and
  - Patient-Level Quality Measure Report.
- Intended to provide hospices a view of national average scores (comparison group).
- Most recent refresh was February 2018 and included data from 04/01/16 – 03/31/17.

Current Quality Regulations (FY17)

- As part of HQRP, 2 new measures were added effective **April 1, 2017**:
  - Hospice visits when death is imminent; and
  - Hospice and Palliative Care Composite Process Measure (Comprehensive Assessment at Admission).
  - These measures will be publically reported in 2019.

Current Quality Regulations (FY17)

- Hospice Quality Reporting Program (HQR) data became publically reported in August 2017.
- CAHPS publically reported data includes a case mix adjustment table.
- New HIS data collection instrument (HEART) – Will be a comprehensive patient assessment instrument, rather than the current chart abstraction tool.
  - Pilot to test the proposed tool launched in Jan 2018
- Any provider who does not comply with quality data submission will see a 2% reimbursement reduction.
Next Steps: Creating a Culture of Quality

1. Data – Is your Hospice currently accessing all available data to focus on and improve quality?
   - CASPER
   - PEPPER
   - HIS / HQRP
   - CAHPS®
   - Internal audit outcomes / data
   - How does your hospice share the data with leaders and staff members?

2. QAPI – What is your Hospice doing with the data?
   - Is data driving your QAPI program (or is your QAPI program driving your data?)
   - Does your hospice have sufficient resources (human and otherwise) to implement and maintain a robust QAPI program?
   - Does your hospice have evidence of everyone’s engagement with QAPI (e.g., Governing Board, leaders, staff, etc.)?
Next Steps:
Creating a Culture of Quality

3. QAPI – Does your hospice’s QAPI program improve outcomes (patient-specific and organization-specific)?
   • If yes, how so?
   • If not, why not?
   • What evidence does your hospice have to validate sustained performance improvement?

References / Resources

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References / Resources

References / Resources


Q & A

Thank You!