The Admission Decision - Who's on First?

Ensuring best processes for decision-making along the admission process.

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Objectives

- Understand the environment of scrutiny for hospice
- Identify the risks to hospices with poorly defined admission processes
- Review the admission process using NHPCO's Admission Care Map
- Implement best practices for admission processes –to avoid forever that sinking feeling 'how did this person get admitted?'

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Environment of Scrutiny

- ADRs
- ZPIC Audits
- RAC
- PEPPER Reports
- Determination & Documentation of related and non- related conditions

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Environment of Change

- Diagnosis Coding
- Medicare D
- Claims details – GIP, Drugs, Infusion pumps
- Hospice Information Set (HIS)
- Quality reporting & future public reporting
- Hospice Experience of Care Survey

The impact this is having on the industry….

- Definite concerns for on-going viability – Fear
- Process changes, computer system upgrades, more fixed costs in staff to manage new requirements
- Observing more hospices hesitant to admit patients fearing denials
- The top reason for denials – #1 Documentation does not support terminal illness

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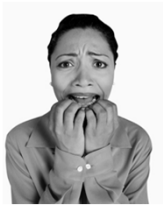
Fear factor

- **Question:** What do the following hospices have in common?
  - Southern Care
  - Solaris
  - Odyssey/Gentiva
  - Hospice of Arizona
  - AsceraCare
  - Three Rivers Hospice
  - Hospice of the Comforter
  - Hernando Pasco Hospice
  - Harmony Hospice



Fear Factor

- **Answer:**
  - They all (in addition to others) entered into Corporate Integrity Agreements (CIAs) during 2012 and 2013
  - A few had whistleblower suits
  - Payback& fines ranged from $1 Million to $25 Million

The Rise and Fall of an Industry Leader

San Diego Hospice and Institute for Palliative Medicine

- Established in 1977; non-profit
- Grew to become nationally and world renown for palliative medicine and hospice care
- First and only hospice-hospital in California
- Center of education for hospice and palliative medicine
- Medicare audit found many patients 'ineligible'
- Decrease census late 2012 from 1000 to 400
- February 2013: Bankruptcy and transition of patients to Scripps/Horizon Hospice

Was there fraud or did the government over-reach?

- Yes, there has been fraud in the hospice industry over the past years
  - Intentional admission of poorly eligible patients
  - Intentional growth of programs through kick backs to physicians, nursing homes, assisted living facilities
  - Intentional marketing and outreach to non-eligible patients
  - Intentional recertification of patients who are no longer eligible

Was it fraud?

- Often times it was NOT "*fraud*"
  - Hospice agency administrators knew the regulations & understood the Medicare criteria but …
    - neglected to educate staff including physicians
    - neglected to correct forms to meet regulatory requirements
    - neglected to enforce and correct issues related to documentation that would prove eligibility
    - neglected to create, improve and enforce policies to ensure compliance with regulations

More on scrutiny and importance of getting it right

Government focus

- Long lengths of stay
- Nursing home hospice patients
- Non-cancer diagnosis
- General Inpatient LOC
- Continuous Care (highest pay LOC)
- Hospice in Assisted Living Facilities (ALFs)

Getting it Right

- Staying out of orange jumpsuits

In a perfect world…….

- Information supporting hospice eligibility is provided in the initial referral
- Staff documentation is excellent and consistently supports eligibility
- Physician narrative speaks to the LCDs
- Face to face documentation provides measureable data elements to support decline and eligibility
- Forms are pristine and meet all regulatory requirements
- IDG flows with communication and documentation in a timely manner
- Plan of Care can be easily followed and carried out

Who is on First?

The processes for admission are unique to each hospice and their particular service areas. When your hospice considers a patient "admitted" is determined by each organization.

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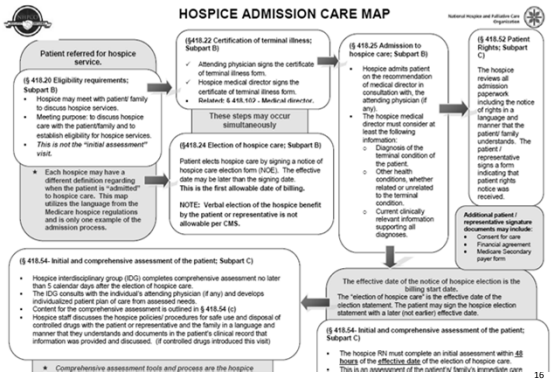
In developing best admission practices the following needs to be considered.

- Who meets with the patient and family after referral?
- Who is reviewing the clinical information to ensure eligibility?
- When does the patient/or representative sign the election statement?
- When do the initial and comprehensive assessments take place?
- What is the role of the Hospice Medical Director?



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Hospice Admission Flow

- Referral process
- Signing of 'Legals'
  - benefit election; consents etc.
- Certification of Terminal Illness –
  - Verbals/Attending Physician/Medical Director
  - Narrative completion
  - Signed & dated
- Initial & Comprehensive Assessments
- Development of the plan of care

Structure with Regulations

- Regulations provide a structure to follow when developing processes
- Provides guide for responsibilities
- Sets expectations which each hospice must follow in developing processes to efficiently meet the rules
- Not prescriptive with processes to follow, exact forms to complete (provide content)

Meetings with the Patient and Family

(§ 418.20 Eligibility requirements; Subpart B)

- Hospice may meet with patient/ family to discuss hospice services.
- Meeting purpose: to discuss hospice care with the patient/family and to establish eligibility for hospice services.
- ***This is not the "initial assessment" visit.***
- ***Does not need to be a clinician….***

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Hospice Election

- A Medicare beneficiary must elect hospice in order to receive it. Each hospice designs and prints its election statement.
- The Benefit Election Statement must include the date which hospice care is to begin – this date can be in the future but cannot be retroactive.
- And the signature of the patient or legal representative

Hospice Benefit Election Format

The election statement must include the following items of information:

- Identification of the particular hospice that will provide care to the individual;
- The individual's or representative's (as applicable) acknowledgment that the individual has been given a full understanding of hospice care, particularly the palliative rather than curative nature of treatment;
- The individual's or representative's (as applicable) acknowledgment that the individual understands that certain Medicare services are waived by the election;
- The effective date of the election; and
- The signature of the individual or representative.

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Practices for Obtaining Benefit Elections

- Hospice Liaisons or Marketing Staff
  - During facility stay (hospital, SNF, Assisted Living)
- Hospice Social Worker
- Hospice Chaplain
  - Visit to wherever patient is (home, facility)
  - Family meeting
  - Informational visit
- Hospice Nurse
  - On the initial assessment visit

Benefit Election Claim Denials

- Technical not related to eligibility
- No effective date or incomplete date
- Not signed
- Not signed by correct person (patient or legal representative
- Not present

Certification of Terminal Illness

Requirements - General

- To be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and be certified as being terminally ill. An individual is considered to be terminally ill if the medical prognosis is that the individual's life expectancy is 6 months or less if the illness runs its normal course.
- Section §1814(a)(7) of the Social Security Act (the Act) specifies that certification of terminal illness for hospice benefits **shall be based on the clinical judgment of the hospice medical director or physician member of the interdisciplinary group (IDG) and the individual's attending physician**, if he/she has one, regarding the normal course of the individual's illness

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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:

(1) Diagnosis of the terminal condition of the patient.

(2) Other health conditions, whether related or unrelated to the terminal condition.

(3) Current clinically relevant information supporting all diagnoses.

Responsibility of Determining Terminal Status

- It is the **hospice physician's** role to determine terminal status.
- This determination is documented on the certification of terminal illness and supported by the narrative.
- When a Face to Face is required prior to admission of the patient this documentation is also used by the physician to determine terminal status and is included in the narrative on the CTI (required by regulation)

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Who can sign

No one other than a medical doctor or doctor of osteopathy can certify or re-certify a terminal illness. Predicting of life expectancy is not always exact. The fact that a beneficiary lives longer than expected in itself is not cause to terminate benefits.

*NP or PA cannot sign a CTI or recertification

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Hospice Medical Director

Yesteryear

- Discuss complex cases
- Sign CTIs
- Sign POCs
- Attend IDG meetings
- Discuss changes to POC
- Give orders for palliation of symptoms
- Sign orders

2014

- Discuss complex cases
- Sign CTIs
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- Attend IDG meetings
- Discuss changes to POC
- Give orders for palliation of symptoms
- Sign orders
- Compose narratives that show eligibility (since '09)
- Make F2F visits (since '11)
- Review all history to determine most appropriate terminal condition
- Document why a condition is not related adequately enough to demonstrate to CMS why the hospice is not footing the bill for medications or hospitalizations related to the non-disease related conditions

Role of the Hospice MD

- Gone are the days when a community physician could effectively have his/her own practice while being the Medical Director for a ***growing*** hospice program. The demands and regulations now put ***substantial*** responsibilities on a hospice MD. This MD must work in unison with the Clinical Director, Administrators and Clinical Staff.

Considerations for Medical Decision-Making

How does the physician get the information needed to make a decision if the patient is terminal?

- Sources:
  - History & physical
  - Hospital discharge information
  - Labs & other test results
  - Clinical findings on initial & comprehensive assessments
  - Face to face findings

Initial and Comprehensive Assessment

Initial assessment means an evaluation of the patient's physical, psychosocial and emotional status related to the terminal illness and related conditions to determine the patient's immediate care and support needs. Complete in 48 hours.

Comprehensive assessment

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.

The comprehensive assessment must take into consideration the following factors:

(1) **The nature and condition causing admission (including the presence or lack of objective data and subjective complaints).**

(2**) Complications and risk factors that affect care planning.**

(3) Functional status, including the patient's ability to understand and participate in his or her own care.

(4) Imminence of death.

(5) Severity of symptoms.

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:

(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.

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

(8) The need for referrals and further evaluation by appropriate health professionals.

Plan of Care

Standard: Content of the plan of care.

The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments.

The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:

(1) Interventions to manage pain and symptoms.

(2) A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.

(3) Measurable outcomes anticipated from implementing and coordinating the plan of care.

(4) Drugs and treatment necessary to meet the needs of the patient.

(5) Medical supplies and appliances necessary to meet the needs of the patient.

(6) The interdisciplinary group's documentation of the patient's or representative's level of understanding, involvement, and agreement with the plan of care, in accordance with the hospice's own policies, in the clinical record.

Assumptions

- Initial and Comprehensive Assessment used to develop the initial Plan of Care for the Patient
- The Initial Plan of Care is developed with the IDG members – Including the Medical Director and the Attending Physician
- Nurses are obtaining initial orders, including frequency of services from the Medical Director or the Attending MD
- Communication is happening and everything is going smoothly

That sinking feeling…… you get when….

- The medical director says at IDG that this is the first they have heard of a patient who has been on service over a week.
- Chart audit results have no supporting documentation for eligibility
- At re-cert the IDG can't find a reason to re-certify

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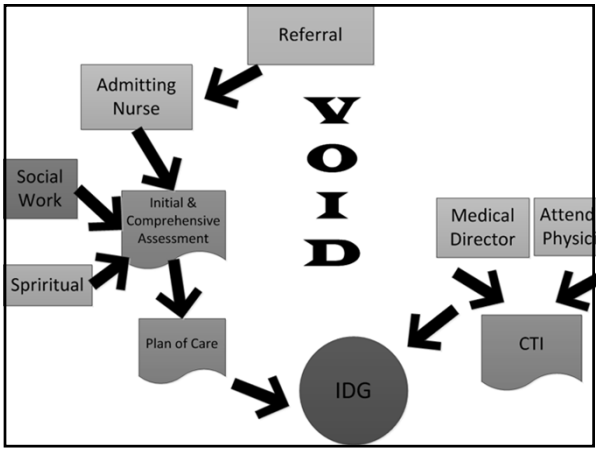
Pitfalls – Real Life Examples

When asked about how eligibility is determined Nurses say, "If the patient is on my schedule to admit, "they" already determined eligibility."

"My medical director will sign anything I give him I don't have to call"

Medical Director says "I trust the staff to admit patients that qualify, they don't need to call me with every admission."



Admissions – the thing of nightmares and/or perfect eligibility?

- Diagnosis: Parkinson's disease; no longer walking, now in wheelchair.
- Transfer from "other hospice"; 15th benefit period; COPD pulse ox 92% on RA. No record of infections; exacerbations for ever.
- End Stage Liver: Encephalopathy; independent in ADLs and no blood-work on file for 5 years;
- Alzheimer's: FAST scale 7a; no recent infections; no weight change for two years; having conversations about the weather

- CHF; SOB with activity; Oxygen at night; No record of Ejection fraction; no exacerbations for over 1 year; no edema noted; no orthopnea noted.
- CVA – Four years post stroke; 10 pound weight loss over 3 months with a baseline of 200 to 190 (5% weight loss).

Why is this a problem?

- Fraud – Most obvious
- Financial – Ordered medications, supplies, DME. Visits made, time spent creating patient record etc.
- Referral Source – Patient accepted onto service – now may have to discharge. "Do we know what we are doing?"
- Patient/family – emotional upheaval; time and mistrust

Best Practices

The keys to implementing best practice are to consider

- Practical application – easily implemented and replicated
- Least steps – fewer opportunity for errors
- Use technology
- Roles assigned and staff are knowledgeable of role responsibilities
- Processes are followed – evaluated - monitored

Suggested Practices

- Small hospice
  - Nurse conducting initial assessment contacts the Medical Director with clinical findings and discusses eligibility, obtains verbal certification of terminal illness and initial orders for plan of care
  - Referral Center or Intake Nurse Obtains the Verbal or written Certification of Terminal Illness from the Attending Physician as part of the referral process OR Admitting Nurse contacts the attending to obtain the Verbal Order

Suggested practices

- Larger Organization
  - Admitting Nurse conferences with Clinical Manager – who reviews admissions daily with Medical Director/Hospice Physician, obtaining initial verbal CTI and approval of initial POC.
- Very large organization
  - Team model. Admitting nurse conferences with Clinical Lead after assessment. Clinical lead conferences with Medical Director.

Key Components

- Getting information to physician for decision-making on admission to hospice
- Decision-making on eligibility
- Medical best guess on prognosis with information provided
- Information must be helpful in making decision

Information Needs

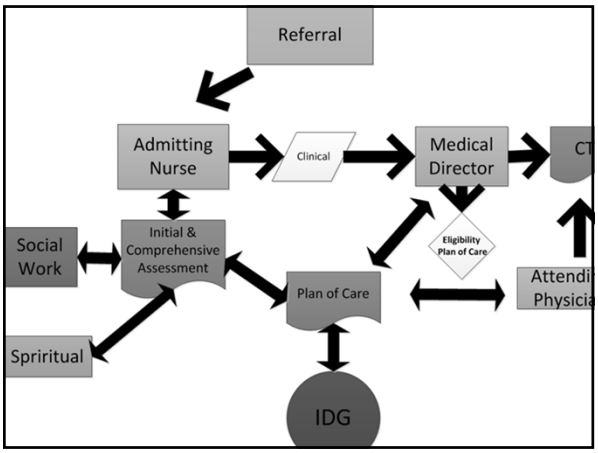
- Concise
- Accurate
- Data driven
- Data provided relevant to the LCD and patients terminal condition and related conditions

Communication Methods

- Structured conversations which assist with communicating important information; relevant to what is required to make decisions
- SBAR (Situation – Background – Assessment – Recommendations)
- Avoids missing or forgetting information

Examples

- Situation:
  - "Pt referred after a 10 day hospitalization for pneumonia"
- Background:
  - 90 year old. Long history of COPD, O2 dependent at home. Co-morbids of CAD, Diabetes and depression. No code status.
- Assessment:
  - Wt. loss reported of 20 lbs in past month; BMI 19; Pulse ox on RA is 85%, SOB with any exertion; freq. chest pain inhibiting activity. NYH scale of 4. KPS 40%; taking Roxinol for pain with relief. 2 + pitting edema bilateral feet;
- Recommendation
  - COPD primary. Nursing visits 3 x weekly; aide daily to assist ADL; MSW eval 1 w 1; Spiritual eval 1 w 1
  - Appears declining physical status. VO for Terminal Status?
  - Approval for initial POC?



Results

- Improved decision-making regarding eligibility
- Reduced risk for the organization
- Improved communication
- Better care for the patients

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