Symptom Management and Approach to Care 3

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Program Details

- **Title:** Symptom Management and Approach to Care 3
- **Dates/Term of offering:** This activity was released on May 26, 2021 and is valid for one year. Requests for credit must be made no later than May 26, 2022.
- **Joint Providership:** This activity is jointly provided by Global Education Group and Hospice and Palliative Board Review.com.

- **Target Audience:** The educational design of this activity addresses the needs of Physicians, NPs, Nurses, and health care professionals interested in learning more about hospice and palliative medicine and those who want to earn continuing education credits and/or prepare for board certification in hospice and palliative medicine.

Program Details

- **Program Overview:** Clinicians and health care professionals are unaware of best practices to be utilized regarding differentiation between hospice and palliative care services. As such, they do not know how to adequately counsel patients and families on appropriate utilization of hospice versus palliative care.
- **Faculty:** Eric Bush, MD, RPh, MBA
- **Physician Accreditation Statement:**

  This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Global Education Group (Global) and Hospice and Palliative Board Review.com. Global is accredited by the ACCME to provide continuing medical education for physicians.

Program Details

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- **Global Contact Information:** For information about the accreditation of this program, please contact Global at 303-395-1782 or cme@globaleducationgroup.com.
- **Fee Information:** There is a fee for this educational activity.

Program Details

- **System Requirements:**
  - **PC:** Microsoft Windows 2000 SE or above, Flash Player Plugin (v7.0.1.9 or greater), Internet Explorer (11.0 or greater), Chrome, Firefox, Adobe Acrobat Reader*
  - **MAC:** MAC OS 10.2.8, Flash Player Plugin (v7.0.1.9 or greater,), Safari, Chrome, Adobe Acrobat Readers*, Internet Explorer is not supported on the Macintoch.

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Program Details

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The ***faculty*** have the following relevant financial relationships with ineligible companies:

- **Eric Bush, MD, RPh, MBA:** Nothing to disclose

The ***planners and managers*** have the following relevant financial relationships with ineligible companies:

- **Lindsay Borvansky:** Nothing to disclose
- **Andrea Funk:** Nothing to disclose
- **Liddy Knight:** Nothing to disclose
- **Ashley Cann:** Nothing to disclose
- **Eric Bush:** Nothing to disclose

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Program Details

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Learning Objectives

- Describe how to perform symptom management in the palliative and hospice setting.
- Describe how to counsel patients and caregivers on interventions in this setting and the applicable risk versus benefit for appropriate interventions.
- Describe how to perform goals of care and advanced care planning discussions with patients and family.
- Describe how to counsel patients and caregivers on appropriate goals of care and advanced care planning given the patient's disease trajectory and wishes.
- Describe how to perform triage and referral of eligible patients for palliative and hospice services.
- Describe how to counsel patients and families on appropriate utilization of hospice and palliative care services.

Why Palliative Care & Hospice?
The Need for Palliative Care & Hospice

Non-beneficial treatments in hospital at the end of life: a systematic review on extent of the problem

M CARDONA-MORRELL[1], JCH KIM[2], RM TURNER[3], M ANSTEY[4], IA MITCHELL[5], and K HILLMAN[1,6]

- Evidence from 38 studies indicates that on average 33–38% of patients near the EOL received NBTs. Mean prevalence of resuscitation attempts for advanced stage patients was 28%.
- Mean death in intensive care unit (ICU) was 42%; and mean death rate in a hospital ward was 44.5%.
- Mean prevalence of active measures including dialysis, radiotherapy, transfusions and life support treatment to terminal patient on average 30%.
- Non-beneficial administration of antibiotics, cardiovascular, digestive and endocrine treatments to dying patients occurred on average 38%.
- Non-beneficial tests were performed on 33–50% of patients with do-not-resuscitate orders.
- From meta-analyses, the pooled prevalence of non-beneficial ICU admission was 10% (95% CI 0–33%); for chemotherapy in the last six weeks of life was 33% (95% CI 24–41%).

Why?

- The healthcare system in the U.S. is optimized around revenue and profits - not safety and quality
- The U.S. healthcare industry is an economic unit larger than Germany
- It's currently running at over $3 trillion - per year(0.5 to $1 Trillion per yr in Non-beneficial/futile care)
- That equals over 18% of our entire GDP
- About 100,000 deaths occur each year due to medical errors
- We're the only industrialized country where medical expenses are a leading cause of personal Bankruptcy
- Lack of medicolegal reform-unnecessary costs

WHO Ranking of World Health Care

- One of the most widely cited international rankings of health care systems was published by the World Health Organization in 2000*
- It ranked the United States 37th in overall health care system performance, just behind Costa Rica and just ahead of Slovenia and Cuba
- France was No. 1 in the ranking, and Myanmar was last among 190 countries surveyed

*For the full survey, see WHO, http://www.who.int/whr/en/.
A convenient summary of the main findings can be found at
http://www.photius.com/rankings/healthranks.html

Posted Feb. 27, 2011 on Ed Dolan's Econ Blog http://dolanecon.blog

1	France
2	Italy
3	San Marino
4	Andorra
5	Malta
6	Singapore
7	Spain
8	Oman
9	Austria
10	Japan
11	Norway
12	Portugal
13	Monaco
14	Greece
15	Iceland
16	Luxembourg
17	Netherlands
18	United Kingdom
19	Ireland
20	Switzerland
21	Belgium
22	Colombia
23	Sweden
24	Cyprus
25	Germany
26	Saudi Arabia
27	United Arab Emirates
28	Israel
29	Morocco
30	Canada
31	Finland
32	Australia
33	Chile
34	Denmark
35	Dominica
36	Costa Rica
37	**United States of America**
38	Slovenia
39	Cuba

According to a recent publication from the Commonwealth Fund, the USA is ranked last of 11 Countries. The U.S. ranks last, as it did in 2006, 2007, 2010, and 2014

Value

- Hospice and palliative care are high value, high quality, patient and family centered services that should be a larger part of any population health initiative
- ASCO/NCCN 2017 Recommendations – Palliative Care consultation should be offered to every newly diagnosed stage 4 cancer patient


Seeing the Forest for the Trees

Why Talk About This?

25% of deaths occur at home - more than 70% of Americans would prefer to die at home

(Robert Wood Johnson Foundation)

Additional Reading - New Yorker

- Annals of Health Care
- May 11, 2015 Issue
- Overkill
- An avalanche of unnecessary medical care is harming patients physically and financially. What can we do about it?
- By Atul Gawande

Why Palliative Care?

- Aggressive measures for control of pain and other distressing symptoms
- Better quality and often longer life, with neither quality or quantity achieved at the other's expense
- More goal centered
- Interdisciplinary team of caregivers, participating in holistic care of patient and family

Palliative Care vs. Hospice Care

Similar but Different

Palliative Care

- Focuses on relief from physical suffering. The patient may be being treated for a disease or may be living with a chronic disease, and may or may not be terminally ill.
- Addresses the patient's physical, mental, social, and spiritual well-being. Is appropriate for patients in all disease stages, and accompanies the patient from diagnosis to cure.
- Uses life-prolonging medications.
- Uses a multi-disciplinary approach using highly trained professionals. Is usually offered where the patient first sought treatment.

Hospice Care

- Available to terminally ill Medicaid participants. Each State decides the length of the life expectancy a patient must have to receive hospice care under Medicaid. In some States it is up to 6 months; in other States, up to 12 months. Check with your State Medicaid agency if you have questions.
- Makes the patient comfortable and prepares the patient and the patient's family for the patient's end of life when it is determined treatment for the illness will no longer be pursued.
- Does not use life-prolonging medications.
- Relies on a family caregiver and a visiting hospice nurse. Is offered at a place the patient prefers such as in their home; in a nursing home; or, occasionally, in a hospital.

Combined Care

Hospices are the largest providers of palliative care services in the country. Many organizations work together to offer the patient a seamless continuum of care over the course of a serious illness.

CMS

Follow us on Twitter #MedicaidIntegrity

Palliative Care vs Hospice Care

- The core philosophy of Palliative Care and Hospice Care are the same: provide comfort and symptom management to maximize quality of life.
- The goals of Palliative Care and Hospice Care are generally the same, with some nuanced differences (related to the point in time on the patient's disease trajectory)

Palliative Care

- Care given to improve the quality of life of patients who have a serious, chronic or life-threatening disease.
- The goal of palliative care is to prevent or treat as early as possible the symptoms of a disease, side effects caused by treatment of a disease, and psychological, social, and spiritual problems related to a disease or its treatment.
- In short, symptom management, regardless of where the patient is in the disease process utilizing a biopsychosocial approach

Who is eligible for Palliative Care?

- Patients with life-limiting diseases who may still be seeking curative treatment
- Sufferers of chronic conditions which require aggressive pain management and symptom management
- May not have a terminal prognosis

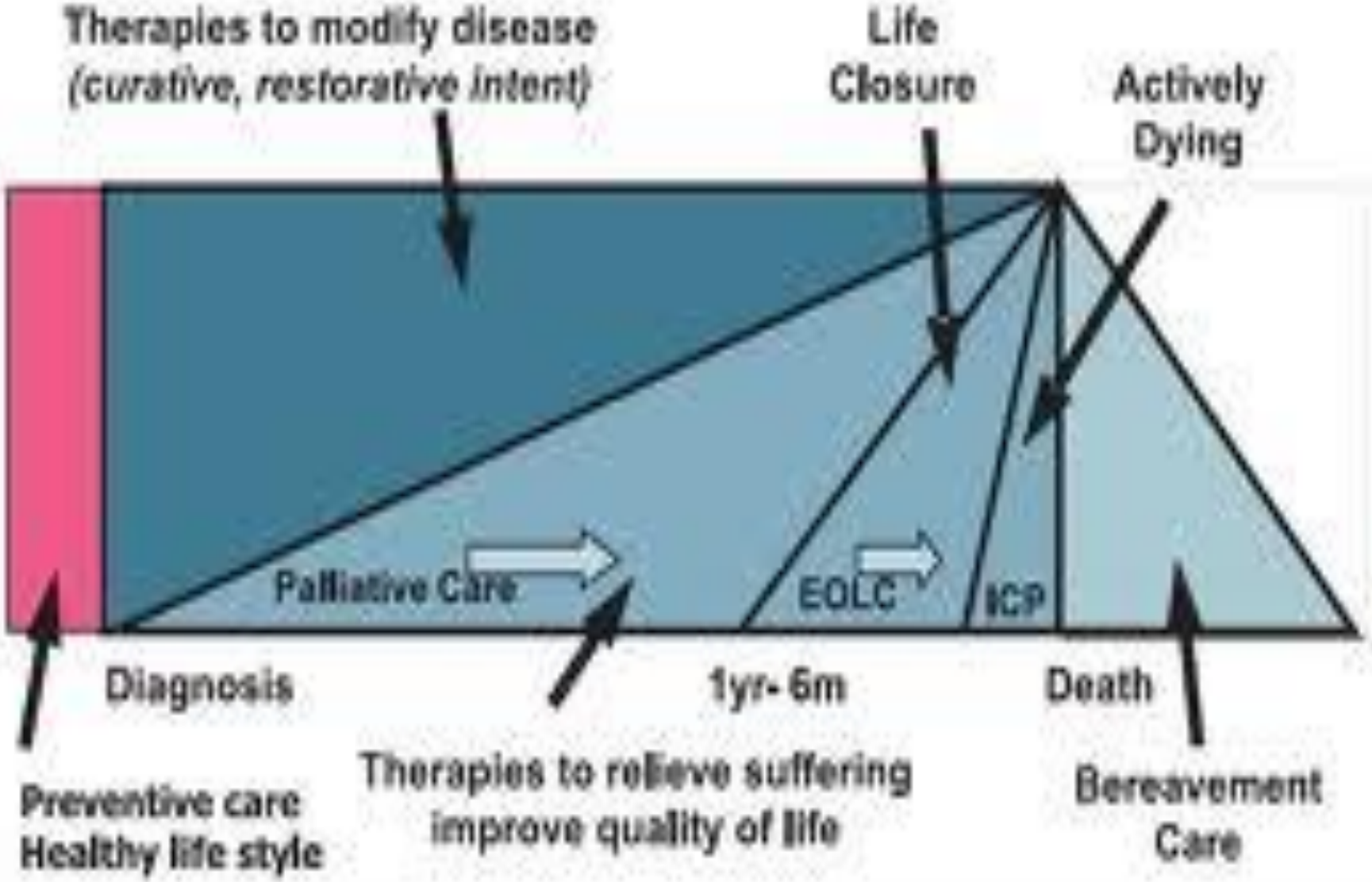
Goals of Inpatient Palliative Care

- Expert symptom management-pain, dyspnea, N&V, etc.
- Assessment of appropriate next steps in care: Hospice, comfort, SAR etc.
- Goals of care consultation should be in conjunction with primary team and pertinent specialists
- Primary resource for comfort care: order sets, standard work, policies and procedures
- Changing culture: goal of open engagement with patients and families & providers regarding goals of care and dialogue

Goals of Outpatient Palliative Care

- Expert symptom management: pain, dyspnea, N&V, etc.
- Relationship building with patients, families, providers
- Assessment of appropriate next steps in care & prevention of unnecessary hospitalization
- Goals of care consultation: “shared” decision making earlier in the disease course (i.e. before the roof is on fire), Do Not Hospitalize Orders in SNF’s
- Primary resource for community based palliative care
- Changing ***Macro*** culture: goal of open engagement with patients and families & providers regarding goals of care and dialogue (Conversation project, Five Wishes)

Modified from-
http://depts.washington.edu/pallcare/training/ppt.shtml



Barriers to Palliative Care & Hospice

- Lack of knowledge
- Culture
- Religion
- Limited trained providers
- Fractionated health system
- Communication
- Perception

Palliative Care Reimbursement

- Paid for by Medicare and private insurance just as any other recognized medical specialty
- Care provided by physicians boarded in hospice & palliative medicine, nurse practitioners with advanced practice in hospice & palliative medicine

Differentiation

- Hospice: if the disease follows the expected course, a prognosis of six months or less (patients often referred late, NEJM NSCLC study)
- Palliative (Supportive): symptom focused care anywhere throughout the disease spectrum, can be delivered in conjunction with curative care - WOULD YOU BE SURPRISED IF THE PATIENT DIED IN THE NEXT YEAR? IF NOT REFER TO PALLIATIVE CARE

Palliative Family/Patient assessment

- Underlying philosophy of shared decision: making and respecting autonomy
- Beneficence, autonomy
- Advanced directives, living will

Diagnoses for Pall Care Referral

- ES CHF
- COPD/Pulm Diseases-End Stage
- Neuro-stroke, ALS,MS, dementia(FAST >7A)
- Oncology-Stage 4 Disease
- Sickle Cell Disease

Case 1

- 80 YO Female with Lung Cancer
- Pain & shortness of breath
- Residing at local facility
- Symptoms managed with steroids and non-narcotic interventions
- Functionality and quality of life improved
- On Palliative care for 2 years
- Care that meets her and her family “where she is”(focused care, workup, labs, physical therapy, etc.)

Benefits for Palliative Care

- Improved pt Quality Of Life
- Less harmful care, non-beneficial care
- Longer lifespan(good evidence for lung cancer)
- Decreased hospitalizations
- Differentiation - prognostically - 1yr Pall Care Referral; 6months - Hospice

Who We Are/Where We Provide Palliative Care

- Physicians, NP's and SW with advanced training, practice in Hospice & Palliative Medicine
- Homes
- Facilities (ALF'S, SNF'S)
- Ambulatory-Hussman Palliative Care Center
- Anywhere!

Why Hospice Care?

- Provides physical, emotional and spiritual support
  to individuals at end of life
- Helps patients remain in their home
- Offers pain and symptom management
- Helps individuals live the best that they can with what they have been given
- Focuses on quality of life more than quantity

What is Hospice Care?

- Hospice is a care program that provides assistance to those individuals who have an incurable disease and have chosen not to pursue any further aggressive treatment.
- Hospice considers the patient and family/caregivers as one unit of care – provides support for all.
- Hospice care is provided wherever a patient calls “home.”

Hospice Care Payment

- Medicare and Medical Assistance
  - Hospice care is paid per diem (paid a set amount per day, varies from county to county)
- Private insurances
  - Coverage varies, but most offer a hospice benefit

What Hospice Provides

- As part of per diem payment, hospice is responsible for items related to the palliation and management of the terminal illness and related conditions. Typically:
  - Medications
  - Wound care supplies
  - Durable Medical Equipment
  - Miscellaneous (blood transfusion, dialysis - goal dependent)

Who is Hospice Eligible?

Similar to Pall care dx but prognosis < 6months, consider declining final status, kps-3,pps 4

- ES CHF(NYHA 4,ACC/AHA CLASS D)
- COPD/Pulm Diseases-End Stage
- Neuro-stroke, ALS, MS, dementia(FAST >7A)
- Oncology-Stage 4 Disease

How Hospice Referral Works

- D/W PT and family, pertinent other providers
- Refer to case mgmt for Hospice
- Hospice Liaison determines LOC
- Pall care does not necessarily need to see PT before Hospice (appropriate utilization scarce resources

Case 2

- 81 yo F End Stage Multiple Sclerosis (40yr Hx) on pall care at local SNF
- Overall decline, also with brittle diabetes
- Risk/benefit meds – titrated (blood sugar in 20's)
- Pt w/nerve pain, depression
- Duloxetine started, quality of life improving
- Education provided to patient daughter
- Pt enrolled in Hospice care at SNF w/improved symptom mgmt

Levels of Hospice Care

- Routine Home Care
  - Regular visits made by Hospice team members; provided in the home setting
- Continuous Care (billed hourly)
  - For patient symptom management only – cannot be used for caregiver breakdown
  - 51% of the service must be RN/LPN level
  - Social work/counselor does not count towards the time

Levels of Hospice Care, cont.

- Respite
  - For caregiver relief
  - A five-day stay at a contracted facility
- General Inpatient
  - Admission to a hospital or inpatient Hospice unit for symptoms that cannot managed at home
  - Short stay to get patient controlled and home
  - An actively dying patient does not automatically qualify for this level

General Inpt Hospice

- Highest level of PT Care
- Highest Reimbursement
- Highest OIG scrutiny
- Should be ~3% of any hospice total days/census
- “Symptoms that cannot be managed in any other venue”
- If not GIP appropriate, we generally offer routine LOC
- Focus should not be improving O/E morality
- Markedly beneficial to PT and families when used appropriately

Residential Hospice Care

- Home, SNF's, ALF's, ILF's, etc.
- Should be the majority of Hospice Care (ie 97%)
- Multi-disciplinary care at home (CNA, RN, SW, Chaplain, MD, NP)
- Care at "home" focus on QOL
- Focus on appropriate utilization of services

General Inpatient Hospice Care

- Also known as GIP
- Based on symptoms, strictly regulated by CMS
- Improved patient and family EOL care (including bereavement care for family)
- Increased awareness of Hospice services
- Expanding spectrum of services that hospitals provide

Hospice Team Members

- Core
  - Hospice Medical Director/Attending Physician
  - Hospice Nurse
  - Hospice Social Worker
  - Hospice Spiritual Counselor/Bereavement Counselor
- Support Service
  - Hospice Aide/Homemaker
  - Patient Care Volunteer
  - Physical, Occupational, or Speech Therapist (as appropriate)

Which One Should I Choose?

- Depends on where you/your loved one is on the disease trajectory
- Talk to your family and doctor sooner rather than later about your wishes, options (Conversation Project, Five Wishes, NHPCO Connections)
- Goal dependent - ie Hospice better at avoiding hospitalization, more encompassing family support

5. Is Hospice and Palliative Care Equitable?

- Studies suggest that minorities (African-American, Hispanic-Latino, Asian) less likely to receive palliative + hospice care than whites.
- Hospice data: 78% white (vs. 75% U.S.); 8% A-A (vs. 12.3% U.S.); 6% Hispanic (vs. 12.5% U.S.); 2% Asian (vs.3.6% U.S.); 6.4% multiracial.
- No ethnic-racial data on hospital palliative care consult services

Benefits for hospice care

- Improved pt Quality Of Life
- Less harmful care, non-beneficial care
- Longer lifespan(2007: *Journal of Pain and SymptomManagement; CHF, Breast, colon, lung, pancreatic CA*)
- Decreased hospitalizations

About Us

- Hospice of the Chesapeake & Chesapeake Palliative Medicine is a not for profit community based Hospice & Palliative Care organization started in 1979. We serve Anne Arundel and Prince George's Counties
- Last year we provided Hospice care to over 3000 patients in AA & PG Counties; we provided Palliative Care to more than 350 patients

“PEARLS”

- HAVE EMPATHY
- REFER “EARLY”
- PRIMUM NON-NOCERE
- FOREST FOR TREES
- BE AWARE OF TRANSFERENCE/COUNTERTRANSFERENCE
- THIS IS A TEAM SPORT,INVOLVE YOUR TEAMMATES
- RISK VS BENEFIT
- DON’T FORGET SELF-CARE
- YOU ARE THE FUTURE AND THE FUTURE IS NOW!

Hospice Regulatory

Eligibility for Admission Under Hospice Benefit

- In order to be eligible to elect hospice care, an individual must be:
  - Certified as being “terminally ill”(prognosis of six months or less if the disease were to follow its expected course)
  - Many other insurers follow Medicare lead with respect to Hospice benefits and eligibility

Areas of Increased Scrutiny

- **Hospice Eligibility**
  - Initial
  - Ongoing
  - Physician narrative
- **Certain non-cancer diagnosis**
  - Alzheimer's
  - Cerebrovascular disease
- **Level of care documentation**
  - General Inpatient, initial and ongoing

When to Document Eligibility

- **Certification**
  - Verbal certification
  - Written certification
  - Physician narrative statement
- **Admission**
  - Comprehensive assessment
- **Ongoing hospice service**
  - Every note by the IDT/IDG
  - Update to the comprehensive assessment
- **Recertification**
  - F2F(Face to Face) encounter
  - Physician narrative statement

Hospice Timeframes

- Six month eligibility broken down into initial 90 day certification with subsequent 90 day re-certification
- If patient remains eligible after six months, there are ongoing 60 day re-certification periods

Eligibility - 1st 90-day period

- Demonstration of eligibility at admission:
  - Information & consultation between attending physician and hospice physician
  - Physician narrative speaks to PT eligibility
  - Obtain medical history and recent clinical documentation
  - Comprehensive assessment by IDT documents reasons for eligibility
  - Attending physician and hospice physician certify patient based on disease progression

Co-Morbidities

Should be used in determining initial and ongoing hospice eligibility

- Chronic obstructive pulmonary disease
- Congestive heart failure
- Ischemic heart disease
- Diabetes mellitus
- Neurologic disease (CVA, ALS, MS, Parkinson's)
- Renal failure
- Liver Disease
- Neoplasia
- Acquired immune deficiency syndrome
- Dementia

Local Coverage Determination Policies (LCDs)

Guidelines:

- Developed by each MAC (CGS, Palmetto etc)
- Outline guidelines for condition-specific determination of eligibility
- Discuss documentation of secondary diagnoses and co-morbid conditions to support terminal prognosis

Local Coverage Determination Policies (LCDs), cont.

Emphasize functional decline

- Must have details to document the extent of decline(tangible)
  - Need to consider the impact of disease on patient's quality of life
- **Be familiar with the LCDs that are used for your region**

Documentation Using LCDs

- Documentation needs to address:
  - Impairments in function & structure
  - Activity limitations
  - Secondary diagnoses & co-morbidities

The Physician Narrative

- Components of a comprehensive and adequate physician narrative should include:
  - Explanation of the clinical findings that support initial &/or ongoing hospice eligibility
  - Reference to specific LCDs if appropriate
  - Reference to prognostic indicators or symptom management as indicated

The Physician Narrative, cont.

- Components of a comprehensive and adequate physician narrative should include:
  - Reference to functional status, tangible decline
    - PPS - Validated in palliative care
    - ECOG - Cancer
    - Karnofsky - Cancer
    - FAST - Dementia
  - Be ***specific***

The Physician Narrative, cont.

- Components of a physician narrative should include:
  - Evidence of tangible decline
  - Recent hospitalizations
  - Information about co-morbidities
  - Other LCD guided statements that support eligibility
  - Statement should be concise
- Statement should contain prognostic indicators

IDG/IDT

Interdisciplinary group or interdisciplinary team:

Required:

- Physician
- RN
- SW
- Chaplain
- Meet every other week for each patient
- Patient must be seen at least once every 14 days by RN to maintain hospice eligibility

HOSPICE QUALITY

CMS Hospice Quality Reporting Web Page:

- Information posted on CMS web site as it becomes available:
  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/index.html

- Other CMS Resources:
  http://www.cms.gov/Hospice-Quality-Reporting/

  NHPCO(National Hospice and Palliative Care Organization)-also excellent resource

Hospice Item Set

- Consists of data elements to collect standardized patient –level data for specific domains of care that include:
  - Pain
  - Respiratory Status
  - Medications
  - Patient Preferences
  - Beliefs and Values

Experience of Care Survey & Other Items

- CAHPS survey similar to Hospital surveys
- Other items - visits in the last 3 and 7 days of life

Medicare Part D (Drug Coverage) and Hospice

- Area of scrutiny
- Hospice should cover all symptom management medication & medications related to primary hospice diagnosis
- For further info/guidance go to: http://www.medicareadvocacy.org/hospice-and-access-to-medications-new-cms-guidance/

PEPPER Report

- The Program for Evaluating Payment Patterns Electronic Report (PEPPER)
- Hospice-specific data statistics
- CMS sets PEPPER focus areas

PEPPER Details

- Focus on services at risk for improper payments
- Three years of claims data
- Hospices can use the data to support internal auditing and monitoring activities
- PEPPER compares a hospice's Medicare billing practices with other hospices in the:
  - State
  - Medicare Administrative Contractor (MAC) jurisdiction
  - US

PEPPER Details, cont.

- Each hospice receives only its PEPPER
- Not available to the public
- Contractor provides Access database with PEPPER data to MACs, Recovery Audit Contractors
- Pay attention to any findings at or above the national 80th percentile
- www.pepperresources.org

Focus of PEPPER Report

- Beneficiaries whose episode of service ends in the reporting year, either by live discharge or death
- Areas of scrutiny:
  - **"Live Discharges"** includes all episodes where the beneficiary was discharged alive with a length of stay less than 25 days
  - **"Long Length of Stay"** counts beneficiary episodes of service that had a long length of stay -- greater than 180 days
  - Areas of scrutiny may result in TPE (Targeted Probe and Educate - previously known as ADR-Additional Data Review) by a MAC

Privacy, HIPAA & Individual Rights

Individual Rights

- The Final Rule provides individuals with the right to request that covered entities and business associates provide a copy of their PHI directly to a designated individual
- This right applies to both paper and electronic information
- Any such request must be in writing, signed by the individual, and must clearly identify the designated recipient and where the information should be sent
- Restriction of certain disclosures of PHI to their health plans

Modifications to Notices of Privacy Practices Required

- Privacy notices must include a statement regarding the right of affected individuals to be notified following a data breach and must describe certain uses and disclosures of PHI that require patient authorization related to psychotherapy notes, marketing and the sale of PHI.
- The Notice must inform patients of the right to restrict certain disclosures of PHI to health plans where the individual pays out of pocket in full.

Direct Liability for Business Associates and Amendments to Business Associate Agreements

- Business associates and business associate subcontractors are directly subject to applicable HIPAA rules including the HIPAA Security Rule and certain provisions of the Privacy Rule

New Fundraising Requirements

- Expansion of the type of information covered entities, may use to target fundraising appeals including the department of service, the treating physician and outcome information
- Permits the use of only demographic information and dates of health care provided to the patient
- Fundraising communications must provide recipients with a clear opportunity to opt-out and the method provided for the opt-out may not cause undue burden or more than nominal costs

Decedent information

- A covered entity only has an obligation to comply with the requirements of the Privacy Rule with respect to the PHI of a deceased individual for 50 years following that individual's death
- Rule permits covered entities to disclose PHI to a family member or other individuals involved in a decedent's care or payment for such care, unless such a disclosure is inconsistent with a prior expressed preference of the decedent

Other Regulatory

- Expansion of Prohibited Marketing Activities
  - HIPAA prohibits use or disclosure of PHI for marketing to individuals without obtaining authorization, with important exceptions
- Prohibiting the Sale of PHI
  - Prohibits the receipt of direct or indirect remuneration (including in-kind benefits) in exchange for PHI
  - This new restriction includes several exceptions, including disclosures to business associates, as required by law, and for treatment and payment purposes

Hospice QAPI, Levels of Care, Reimbursement

Hospice QAPI (Quality Assurance and Performance Improvement)

- Should meet regularly (at least quarterly)
- Should include PT outcome
- Measures (HIS,CAHPS)
- Should also include Bereavement, Volunteers, and contracts
- Should be multi-disiplinary (Chaplain, SW, CNA, RN, MD ETC)

Hospice Levels of Care

- General inpatient-for symptoms that cannot be treated in another venue
- Continuous care-requires symptom mgmt, 51% of care must be skilled NSG at PT residence(CNA does not count)
- Respite-5 day benefit for caregiver relief, often at SNF, ALF
- Routine home care - care at home

What Hospice Covers

- Meds
- DME
- Nursing
- CNA
- SW
- Chaplain
- MD/NP
- Bereavement
- Sometimes “expanded access”-HD, transfusions, etc – case by case

Hospice Reimbursement

- Per diem for services
- GIP reimbursed at highest level
- Continuous care 2nd highest reimbursement
- Routine home care lowest level reimbursement
- No reimbursement for F2F(face to face) visit

References

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APPENDIX

Co-Morbidities Pg 59: Notes

- Need to look beyond primary diagnosis
- New CoPs say must assess other diagnoses even if not related and be sure someone is addressing the needs

- Any of these can hasten death – make more prone to infection, reduce nutritional intake, decrease mobility, etc

- The medical policies set by our Fiscal Intermediaries often include co morbidities as a factor in prognosis – we will discuss the policies more later

POSTTEST/QUIZ

Please click on the link below to be taken to this activity's quiz. After successful completion, you can then fill out an evaluation and application for CME credit.

Symptom Management and Approach to Care 3