



Compliance for Hospice Social Workers & Chaplains

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Today's Presenter: Katie Wehri, CHPC



Katie has been working in the hospice, home health, private duty, and palliative care industries for over 25 years and has held executive-level positions. She is the Director of Operations Consulting for Healthcare Provider Solutions in Nashville and provides education, conducts operational reviews, and works with the HPS clinical team on mock surveys and chart reviews. She is also certified by the Health Care Compliance Association in health care privacy compliance.

Katie has worked for organizations in a variety of settings, including multiple locations in multiple states, a hospice inpatient unit, pediatric hospice, and adult and pediatric palliative care. In addition, Katie has an extensive background in health care regulation and accreditation standards interpretation; compliance and quality assessment; performance improvement; and opening and expanding sites for home health, hospice, and palliative care services. Katie has been consulting, presenting, and educating in these areas since 2009.

Compliance – Regulatory

Survey and Certification and Payment

- Assessments
- Plan of care
- Reasonable and necessary
- Eligibility
 - For the hospice benefit
 - Levels of care

Medical Social Services

Medical social services must be provided by a qualified social worker, under the direction of a physician.

Social work services must be based on the patient's psychosocial assessment and the patient's and family's needs and acceptance of these services.

Medical Social Services

Qualified:

- Must have one year of experience in a health care setting
- Degree
 - MSW degree from a school of social work accredited by the Council on Social Work Education (CSWE)
 - BSW degree from a school of social work accredited by CSWE **AND** supervised by a qualified MSW
 - Baccalaureate degree in psychology, sociology, or other field related to social work **AND** supervised by a qualified MSW

Spiritual Counseling

The hospice must:

- Provide an assessment of the patient's and family's spiritual needs.
- Provide spiritual counseling to meet these needs in accordance with the patient's and family's acceptance of this service, and in a manner consistent with patient and family beliefs and desires.
- Make all reasonable efforts to facilitate visits by local clergy, pastoral counselors, or other individuals who can support the patient's spiritual needs to the best of its ability.
- Advise the patient and family of this service.

Bereavement Counseling

- Bereavement counseling is available to the patient and his or her immediate family to provide emotional, psychosocial, and spiritual support and services before and after the death of the patient and to assist with issues related to grief, loss, and adjustment for up to 1 year after the patient's death.
- Bereavement counseling consists of counseling services provided to the individual's family before and after the individual's death. Bereavement counseling is a required hospice service, provided for a period up to 1 year following the patients' death. It is not separately reimbursable.

Bereavement Counseling

- The hospice must make bereavement services available to the family and other individuals identified in the bereavement plan of care up to 1 year following the death of the patient
 - ❖ Family and other individuals
 - ❖ Bereavement plan of care

Bereavement Counseling

- Organized program
- Furnished under the supervision of a qualified professional with experience or education in grief or loss counseling
- Bereavement extends to residents of a SNF/NF or ICF/MR when appropriate and identified in the bereavement plan of care
- Volunteers in bereavement

Bringing it Together



Targeted Probe & Educate

- TPE
- Implemented October 2017
- Three rounds
- Each MAC chooses probe topics
 - Length of stay
 - Non-cancer
 - SNF, NF, LTC
 - General Inpatient (GIP) level of care
 - Eligibility

Hospice Social Worker & Chaplain

- Eligibility
 - For the hospice benefit
 - Levels of care
- Assessments
- Plan of care

Medicare Hospice Eligibility

- Defined process from referral to admission
 - Lays out responsibility for obtaining the clinical information
 - Communication flow
- Nurses and physicians – document against the local coverage determination (LCD) and level of care criteria
- Social workers and chaplains – reiteration and supportive documentation

Eligibility

Ongoing Eligibility

- Every update to the comp assessment
- IDG summaries
- Visit notes

Hospice Eligibility

- Decline in clinical and functional status
- Documentation guidelines
 - “Paint the picture”
 - Individual patient information
 - Objective criteria

Hospice Eligibility

- Cognitive status
- Functional status
- Nutritional status

SEVERITY

Hospice Eligibility

Cognitive status

- “Had nice conversation with patient.”
- “Patient – no change.”
- “Patient alert and greeted me with a smile. She is having an exceptionally good day.”
- “Patient no longer knows my name.”
- “I greeted patient but she does not respond like she used to.”
- “Daughter upset because her mother ‘does not even look at her anymore – stares straight ahead’.”
- “Patient confusing actors on TV with family.”

Hospice Eligibility

Functional status

- “Patient in wheelchair” / “Patient slumped over in wheelchair with pillows propping up her left side.”
- “He is no longer able to sit in the sun room with me as he is sleeping in bed most of the day now.”
- “Patient doesn’t shake my hand when I leave anymore. He is too weak.”
- “Patient stays in room most of the time now.”

Hospice Eligibility

Nutritional status

- “Patient eating her lunch in dining room.”
- “Patient continues to enjoy the milkshakes I bring her on visits.” → “Patient able to take only a few sips of the milkshake I brought her.”
- “Patient’s breakfast tray untouched. Asked if she wanted some juice and she said ‘No honey, I don’t want anything anymore.’”

Hospice Eligibility

- Must a patient decline in order to remain eligible?
- Does decline equal eligibility?
- Compare patient over time
 - What you see
 - What you feel
 - What you hear
 - What you smell

Levels of Care

Oversight focus on GIP

Oversight focus on proper use of
the levels of care

General Inpatient & Respite

- General inpatient (GIP)
 - Short-term
 - Provide pain and symptom mgmt that cannot be provided in another setting
- Respite

Respite

- Five consecutive days at a time
 - Only when necessary
 - Occasional basis
- Myth: only once per benefit period/month

GIP Eligibility

Imminent death alone is not the criterion for the GIP level of care

- Symptom management that requires frequent skilled nursing intervention as evidenced by change in respiratory status and level of consciousness, etc.
- Symptoms which cannot be managed in another setting.

When GIP Is NOT Billable

- Caregiver breakdown, unless patient need meets criteria
- Patient admitted to hospice while in a hospital, SNF, or hospice inpatient unit, unless patient need meets criteria
- Unsafe/unclean home situation
- While awaiting nursing home placement, unless patient need meets criteria
- Actively dying and not meeting the criteria for symptoms that cannot be managed in another setting

Inpatient Documentation Tips

Social Worker & Chaplain

Do

- Discharging planning begins on the first day of in-patient level of care and continues throughout the in-patient level stay.
- Document the team's effort to resolve patient problems at the lowest level of care.
- Address discharge plans and why patient remains eligible for in-patient level of care.
- Document patient response to interventions provided during the in-patient level of care (Were they effective? Are they still effective?).

Inpatient Documentation Tips

Social Worker & Chaplain

Do

- Describe services provided. Think of your note as a bill to Medicare. Each note must stand alone.
- Document the context and the events that led to the in-patient level of care.
- Document the failed attempts to control/manage symptoms prior to in-patient level of care admission.
- Document care that caregivers cannot manage at home (frequent changes in medication/medication titration etc.).

Inpatient Documentation Tips

Don't

- Don't use “patient is dying,” “end-of-life care,” “general decline,” or “medication adjustment” to justify in-patient level of care unless you **ALSO** document why these actions cannot take place in the home.
- Don't document resolution of the precipitating events that led to in-patient level of care without further documenting eligibility that maintains in-patient level of care status or, alternatively, documentation describing efforts to move the patient to a more appropriate setting, i.e., SNF or home.

Inpatient Documentation Tips

Social Worker & Chaplain

- “Patient anxious.”
 - “Patient asks not to be left alone, fidgeting with clothing, talking rapidly.”
- “Will be discharged when facility transfer plans are completed.”
 - “Plans for patient to transfer to [facility], patient’s choice of options, will not be complete until 7/24/18. Will discontinue GIP level of care and resume routine home care as of today [7/22/18].”
- “Support given.”
 - “Listened to patient express fear of dying. Nurse provided education on disease process earlier today.”

Assessments

Initial

- Must be completed by Hospice RN
- Within 48 hours after the election of hospice care is complete
 - UNLESS the physician, patient or representative requests that it be completed in less than 48 hours

Comprehensive

- Must be completed by hospice IDG, in consultation with attending physician (if any)
- no later than 5 calendar days after the election of hospice care

Initial Assessment



Must address

- Physical, psychosocial, emotional, and spiritual status related to the terminal illness and related conditions

Timeframe Completion of Comprehensive Assessment

The hospice interdisciplinary group, in consultation with the individual's attending physician (if any)

No later than 5 calendar days after the election of hospice care



Comprehensive Assessment

- Definition states “... this includes a thorough evaluation of the caregiver’s and family’s willingness and capability to care for the patient.”
- Must identify physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the patient’s well-being, comfort, and dignity throughout the dying process.
- Assessment would include, but not be limited to, screening for...

Comprehensive Assessment

- Pain
- Dyspnea
- Nausea
- Vomiting
- Constipation
- Restlessness
- Anxiety
- Sleep disorders
- Skin integrity
- Confusion
- Emotional distress
- Spiritual needs
- Support systems
- Family need for counseling and education
- Additional information, as necessary

Comprehensive Assessment

- **Must take into consideration the following:**
 - Nature and condition causing admission (including the presence or lack of objective data and subjective complaints)
 - Complications and risk factors that affect care planning
 - Functional status, including the patient's ability to understand and participate in his/her own care
 - Imminence of death
 - **Severity of symptoms**

Comprehensive Assessment

Must take into consideration the following:

- Drug profile
- Bereavement
- The need for referrals and further evaluation by appropriate health professionals
- Must include data elements that allow for measurement of outcomes

Update of the Comprehensive Assessment

Must be accomplished by the IDG, in collaboration with the attending physician (if any)

Must consider changes that have taken place since the initial assessment

Must include information on:

- Patient's progress toward desired outcomes
- Reassessment of the patient's response to care

Must be accomplished:

- As frequently as the condition of the patient requires
- BUT no less frequently than every 15 days

IDG & Care Planning

The IDG, in consultation with the attending physician (if any), must prepare a written plan of care for each patient

The plan of care must:

- Specify the hospice care and services necessary to meet the patient and family-specific needs *identified in the comprehensive assessment* as such needs relate to the terminal illness and related conditions



Plan of Care Content

Patient and family goals and interventions

Based on problems identified in the

- Initial assessment
- Comprehensive assessment
- Updates to the comprehensive assessment

Plan of Care Content

Generic goals/goals not tied to problems identified in assessment

- “Facilitate the acceptance of change/loss/process”
- “Assist patient/patient caregiver/family in processing grief/loss/pain”
- “Patient transitions peacefully through the dying process”
- “Patient is supported regarding common experiences and responses to dying”

Plan of Care Content

Must include all services necessary for the palliation and management of the terminal illness and related conditions including

- Interventions to manage pain and symptoms
- *Detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs*
- Measurable outcomes anticipated from implementing and coordinating the plan of care

Review of the Plan of Care

Hospice IDG, in collaboration with the patient's attending physician (if any) **must**:

- Review, revise, and document the individualized plan
- As frequently as the patient's condition requires
- But no less frequently than every 15 days

Review/Revision to the Plan of Care

- Direct link between needs identified in the comprehensive assessment and the plan of care
- Problem, intervention, goal
- Measurable outcomes
 - Note patient's progress toward goal
 - Are the interventions effective?

Coordination of Services

Must develop and maintain a system of communication and integration

- Provide for and ensure ongoing sharing of information between all disciplines providing care and services in all settings, whether directly or under arrangement
- Provide for ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions

Coordination – Services Provided According to Plan of Care

System of communication between all IDG and non-hospice staff



Patients in Facilities

- Must provide the facility a copy of the plan of care
- Plan of care must indicate who is responsible for what
- Assessments should include input from facility staff
- In addition to the initial/comprehensive assessment include facility staff in
 - Updates to the comprehensive assessments
 - Review of the plan of care

Directing, Coordinating & Supervising Care

- Ensure care provided is based on all assessments (don't forget bereavement)
- Ongoing sharing of information
 - Between all disciplines
 - All settings

Documentation



Questions or Comments?



Thank You for Attending!

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