For many terminally ill patients, hospice care offers a humane and dignified alternative to conventional medical treatment. It has become an increasingly accepted option for end-of-life care over the past two decades, with approximately 1.5 million Americans receiving hospice services from approximately 5,000 programs. These programs operate within a variety of settings, ranging from home care to hospital inpatient units, assisted living facilities and skilled care organizations.1

In order to offer consumers greater choice, some hospice providers have added new services and levels of care, and/or formed partnerships with aging services organizations. However, such expansions and alliances can present providers with new risks, which must be identified and mitigated. One major potential pitfall is failure to adhere to Medicare standards and regulations, which may result in targeted medical reviews, additional documentation requests, claim denials and Medicare audits.


This edition of CareFully Speaking® examines seven common types of administrative and clinical risk exposures associated with hospice operations:

- uninformed benefit election
- failure to certify patients as terminally ill
- inappropriate level of care
- denial of access to services
- deficient care planning and related documentation
- unsupervised volunteer staff
- lack of coordination between hospice and aging services providers2

By implementing measures aimed at improving administrative procedures, clinical documentation, communication and supervision, hospice providers can enhance their practice in these seven areas and better protect patients when they are most vulnerable and in need of compassionate attention.

UNINFORMED BENEFIT ELECTION

Medicare patients elect hospice care by filing a signed benefit election statement with the Centers for Medicare and Medicaid Services (CMS). Securing fully informed consent is of critical importance, as hospice election represents a sensitive and consequential decision, with a wide range of clinical, ethical and emotional ramifications. Election statements should minimally contain the following essential information and disclosures:

- a clear explanation of the scope and nature of hospice services – i.e., that treatment is primarily palliative rather than curative
- effective date of the election – i.e., when hospice services begin
- term of benefits – typically two periods of 90 days, followed by an unlimited number of 60-day periods
- waiver of Medicare benefits related to treatment of the terminal illness while enrolled in a Medicare hospice program

Election statements also should reiterate the patient’s basic right to change providers or revoke benefits without pressure or undue influence from hospice administrators or staff. Note that hospital admission alone does not automatically terminate benefits – i.e., that treatment is primarily palliative rather than curative.

Before hospice benefits can commence, the attending physician must certify that the patient has a terminal condition. The certification process requires physical assessment and a note written in narrative style. Form letters and check-box formats are typically deemed insufficient, because these require only a physician’s signature and are thus easily forged.

Well-documented certifications emphasize pain and symptom presentation, as well as interventions and evaluations to date. Certifications should clearly and strongly support a prognosis of six months or less, based on clinical conditions and assessment findings. Vague and inconsistent terms – such as “continues slow decline,” “is hospice-appropriate” or “needs more care” – may be subject to reinterpretation and should be avoided.

Medicare regulations stipulate that, in order to establish continued eligibility for benefits, patients who reach the 180-day recertification date must have a documented face-to-face encounter with a provider no more than 15 days prior to the recertification period. Nurse practitioners may conduct the face-to-face encounter, as long as they certify that their clinical findings were provided to the physician of record. Hospice protocols should reflect these requirements and administrators should ensure that these encounters are appropriately performed and documented.

In the event of a legitimate revocation, patients forfeit any remaining days of the election period and Medicare coverage of previously waived benefits resumes.

To ensure clarity and consistency, most organizations adopt a standardized consent form. For a sample Informed Consent and Medicare Benefit Election Form from CMS, visit http://www.cms.gov/Medicare/medicare-benefits/downloads/sample/Hospice_Election_Form_H-045-01_09-2011.pdf

FAILURE TO CERTIFY PATIENTS AS TERMINALLY ILL

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INAPPROPRIATE LEVEL OF CARE

The Medicare hospice benefit has four levels of care: routine home care, continuous home care, respite care and general inpatient care. Hospice patients generally decline steadily in their condition over a defined period of time and increased dependence on caregivers for activities of daily living.

Providers also should evaluate the appropriateness of the current level of care, noting whether patient care needs have changed from intermittent to continuous, or from routine to specialized.

If a conflict cannot be resolved, hospice organizations must follow the steps outlined in the federal Medicare hospice regulations regarding discharge with cause of a difficult patient. When a discharge is for cause, no specified appeal rights are created. At a minimum, however, hospice providers must:

- establish policies and protocols regarding discharge for cause
- advise the patient that a discharge for cause is being considered
- make a serious effort to resolve the problems caused by the patient’s behavior
- ascertain that the patient’s proposed discharge is not due to the use of necessary hospice services
- document the problem and efforts made at resolution

Guiding Access-to-care Discussions

Scheduling family meetings is an effective risk control strategy, allowing interdisciplinary group members to communicate the goals of hospice care and address potential misunderstandings or conflicts. Meetings should be documented in the hospice care record, including questions asked and answered. The following points and comments can help guide access-to-care discussions:

- Be present and acknowledge emotions – e.g., “I know that accepting this kind of prognosis is difficult and painful. Is there anything I can do to help, or any issues you’d like to talk about?”
- Negotiate goals of care – e.g., “What would you like to accomplish in terms of your own comfort and well-being? Let’s talk about how we can make that happen.”
- Focus on realistic therapies – e.g., “You’ve mentioned some treatments that we think are not going to be effective at this point, and that we don’t recommend. Instead, let’s discuss the many practical things that can be done to help you.”
- Summarize the plan for all to hear – e.g., “All of us hope that your condition goes on remission. But in the meantime, here are the specific short-term goals we’ll work on together.”
- Communicate honestly and openly – e.g., “Have you thought about what you might respond if treatment doesn’t progress as you wish? Sometimes, preparing for all possibilities reduces anxiety and makes it easier to make decisions later.”

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For the Federal Code of Regulations regarding discharging patients from hospice care, see http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=dfe29c604136796906323bb4dc73e26&rgn=dv&v=text.node44=42.3.0.1.5.2.3.1&di042
DENIAL OF ACCESS TO SERVICES

Written and verbal communications must be clear, thorough and unequivocal regarding the scope of hospice care and any limitations on available services. Omission of important details regarding access to care may lead to false assumptions and eventual conflict between providers and patients or family.

Beginning with the initial patient consultation, providers should use both written materials and face-to-face discussion to define mutual goals and ensure that patients understand the following important aspects of their care:

Routine covered services. Include general information – such as basic service offerings, start times, geographic service boundaries and medical equipment provisions – in admissions materials, in order to articulate mutual expectations and minimize potential misunderstandings. For a list of customary hospice services, as well as information on payment rates and caps, see the Medicare Learning Network’s Hospice Payment System Fact Sheet Series, which is available at http://www.cms.gov/MLNProducts/downloads/hospice_pay_sys_fs.pdf.

Limitations on care. Before admission, identify all current treatments, and ask patients whether they expect these services to continue under hospice care. In addition, formulate administrative policies to ensure that curable health problems, such as urinary tract infections or pneumonia, are managed in a timely manner. If policies to ensure that curable health problems, such as urinary tract infections or pneumonia, are managed in a timely manner.

Inpatient care. Institute written policies regarding situations when care will be provided, as well as information on payment rates and caps, see the Medicare Learning Network’s Hospice Payment System Fact Sheet Series, which is available at http://www.cms.gov/MLNProducts/downloads/hospice_pay_sys_fs.pdf.

Pursuant to the Medicare Hospice Conditions of Participation, policies should indicate where the care will be provided, typically, the hospice team is responsible for arranging inpatient care. Inpatient care. Policies should indicate where the care will be provided, typically, the hospice team is responsible for arranging inpatient care.

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Hospice providers should adopt disease-specific competence measures to improve care planning and overall team performance, and to ensure that IDG members are capable of caring for patients with a wide variety of diseases. To learn more about disease-specific care and access an organizational assessment tool, visit the National Hospice and Palliative Care Organization (NHPCO) Web site at http://www.nhpc.org/files/public/Disease-Specific-Organizational-Assessment.pdf.


Hospice volunteers – who may include relatives, friends or clergy, among others – must have well-defined roles and always work under the supervision of a designated hospice employee.

UNSUPERVISED VOLUNTEER STAFF

Federal regulations require that volunteers provide a certain amount of what are considered “non-core” patient services, ranging from shopping and housekeeping assistance to respite care. Volunteers – who may include relatives, friends or clergy, among others – must have well-defined roles and always work under the supervision of a designated hospice employee.

Volunteers who lack adequate training and supervision can harm patients and create potential liability for the hospice organization. The simple measures noted below can help minimize the most common risks associated with hospice volunteers:

- Prepare detailed written job descriptions, clearly delineating the scope of volunteer responsibilities.
- Perform criminal background checks on all prospective volunteers.
- Ensure that volunteers maintain an active license or certification, if required, based upon duties performed.
- Check that all volunteer drivers have a valid operating license, as well as sufficient automobile insurance coverage.
- Provide opportunities for orientation and training, both initially and on a continuing basis.
- Carefully document assignments, ensuring that assigned duties are correctly completed.
- Review and document competence and performance of individual volunteers on an annual basis.
- Verify that the organization’s existing healthcare professional liability insurance coverage is adequate, extending to actions or omissions of volunteers.

By law, volunteer services must comprise at least 5 percent of the total patient care hours performed by all paid hospice staff. To prove compliance, volunteer activity must be documented. See 42 CFR 418.78.

Verify that the organization’s existing healthcare professional liability insurance coverage is adequate, extending to actions or omissions of volunteers.
HOSPICE Care-related Deficiencies

According to the U.S. Department of Health and Human Services, the two care-related deficiencies cited most frequently during Medicare certification surveys and complaint investigations are patient care planning and quality. Common areas of concern within these two categories are listed below.

**CARE PLANNING:**
- issues include failure to...
  - assess client needs and identify requisite services
  - state the scope and frequency of services provided
  - establish and maintain a plan of care for each individual
  - review and update plans at specified intervals
  - instruct registered nurses (RNs) to provide written patient care instructions to nursing aides
  - offer bereavement services that meet family needs

**QUALITY OF CARE:**
- issues include failure to...
  - provide services in accordance with recognized standards of practice
  - direct staff and service providers to ensure that all needs identified in patient care plans are being met
  - make nursing and physician services and drugs available on a 24-hour basis
  - offer appropriate level, scope and frequency of home health services, based on licensure and resource level
  - schedule RN home visits at least every two weeks, if nursing aide services are provided
  - assure continuity of care in all settings
  - maintain adequate clinical records for each client
  - document evaluations, treatments and progress notations
  - conduct regular self-assessments of the quality and appropriateness of care

Source: Department of Health and Human Services, Office of Inspector General, Medicare Hospices: Quality of Care. Issues include failure to...

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LACK OF COORDINATION BETWEEN HOSPICE AND AGING SERVICES PROVIDERS

In recent years, federal regulators have more closely scrutinized written agreements between hospice care providers and aging services organizations regarding end-of-life care. The last round of revisions to the Conditions of Participation produced significant changes in the areas of assigned responsibilities, coordination of care and communication. Most notably, hospices are now responsible only for delivering and managing care related to the terminal illness, with IDG members accountable for identifying the specific services required and determining who will provide those services.

Successful care planning begins with a concerted effort by IDG members to communicate with aging services partners on a routine basis. The following strategies can help improve collaboration between the parties to a hospice care contract:

- Establish joint dedicated teams to coordinate care and serve residents in a consistent manner.
- Adhere to an established schedule, so that the aging service facility’s staff is prepared for visits.
- Create opportunities for regular dialogue and communication, including attendance at scheduled care planning meetings and provision of quarterly reports to aging services administrators.
- Designate one individual to serve as a liaison to the aging services organization, maintaining a system to address any conflicts that may arise.
- Exchange regular information on the quality of the partnership, in terms of client, organizational and regulatory expectations.

The NHPCO has endorsed a reference guide on working with aging services providers for the delivery of hospice care. Contracting with a Nursing Facility: Hospice and Nursing Home/Assisted Living Contracting Toolkit is available for a reduced cost to members at http://www.nhpcoc.org/4a/pages/index.cfm?pageid=5050. (Scroll down to NHPCO Member Resources.)

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End-of-life palliative care services continue to evolve and grow, presenting organizational leadership with an array of managerial and clinical challenges. The strategies described in this resource can help hospice providers comply with regulatory mandates and minimize exposure while safeguarding the rights, dignity and comfort of terminally ill individuals.

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**RESOURCES**

- **Regulations and Guidance:**
  - Centers for Medicare and Medicaid Services, Conditions of Participation: Hospice Care, at https://www.cms.gov/CFCA sandsCops/05_Hospice.asp
  - Code of Federal Regulations, Title 42, Part 418, Medicare Program, Hospice Care, at http://ecfr.gpoaccess.gov/cgi/tex-tid?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr418_main_02.tipl

- **Accreditation Organizations:**
  - Accreditation Commission for Health Care (ACHC), at www.achc.org/
  - Community Health Accreditation Program (CHAP), at www.chapinc.org/
  - Joint Commission, at www.jointcommission.org/

- **Resource Organizations:**
  - American Academy of Hospice and Palliative Medicine (AAHPM), at www.aaaphm.org/
  - End of Life/Palliative Education Resource Center (EPERC), at www.eperc.mcw.edu/EPERC
  - Hospice Foundation of America (HFA), at www.hospicefoundation.org/
  - Hospice and Palliative Nurses Association (HPNA), at http://www.hpcan.org/
  - National Hospice and Palliative Care Organization (NHPCO), at www.nhpcoc.org
  - National Palliative Care Research Center (NPCRC), at www.npcrc.org/
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