Providing Continuous Care In Hospice: Should You or Shouldn’t You?
Beth Carpenter, President
Lynn Serra, Senior Associate
Beth Carpenter and Associates

Today’s Objectives
- Define the Medicare Continuous Care Benefit
- Assess the need for your hospice to offer continuous care
- Assure the clinical validity of continuous care services
- Review the mechanics of CC staffing
- Develop an implementation plan
- Evaluate benefits and outcomes

Define the Benefit
Periods of Crisis. Nursing care may be covered on a continuous basis for as much as 24 hours a day during periods of crisis to maintain an individual at home….
Federal Register continued

….Either homemaker or home health aide or both may be covered on a 24 hour continuous basis during periods of crisis but care during these periods must be predominantly nursing care…..

Federal Register continued

…. A period of crisis is a period in which the individual requires continuous care to achieve palliation or management of acute medical symptoms.

Medicare Claims Processing Manual

From Chap. 11, Rev.1494, Issued 4-29-08:
Continuous home care (CC) payment is based on the number of hours, reported in increments of 15 minutes
A minimum of 8 hours (32 units) must be provided
Nursing care must constitute at least half of the period of care (RN or LPN)
Medicare Claims Processing Manual

CC begins and ends at midnight
It need not be “continuous” within the calendar day
Only direct care can be counted—meal breaks, reporting off, staff supervision & staff education do not qualify
Aide/homemaker care cannot be discounted or provided at no charge to meet the 50% minimum for # of nursing units

The Billing Consequences

• If you don’t have at least 8 hrs of care, the day must be billed at Routine Homecare level
• If you don’t have at least 50% of the care provided by RNs/LPNs, the day must be billed at Routine Homecare level

Medicare Claims Processing Manual

Overlapping hours between nurses and aides/homemakers, when reasonable and necessary, are counted separately.
Circumstances requiring overlapping should be rare and need to be thoroughly documented.
Medicare Claims Processing Manual

Visits by staff during CC days are to be reported as with any other level of care. Nursing and Aide/homemaker visits are reported based on # of visits not hours or increments of hours. Physician, ARNP and Social Worker visits are reported based on contacts on a given day of CC not per week.

Payments for Continuous Care

Effective October 1 08--September 30 09:
Non-adjusted: $816.94 for 24 hours of care
$34.04 for 1 hour of care
$8.51 for .25 hour of care
Wage component: $561.32 (subject to Index)
Non-weighted amt: $255.62 (same for everyone)

Expectations under CC

Daily rate includes the daily costs of therapy visits, drugs, supplies and equipment. Services provided during CC days by Social Workers, Pastoral Counselors, Volunteers and others should continue if in the Plan of Care. Physician services for pain management would be billed separately.
Summary of Key “conditions” for CC
• Must be used only for “periods of crisis”
• Focus on what would be needed to “maintain the individual at home.”
• Continuous Care MUST require predominantly nursing care in the plan of care
• Custodial care needs cannot be the major reason for initiating or continuing CC
• “Impending death” or “actively dying” are not valid reasons for CC

Summary of Key “conditions” for CC
• At least 8 hours of care by nurses and aides/homemakers must be given in a calendar day in order to qualify for CC
• Of all the hours provided by nurses, aides and homemakers, at least 50% of those hours need to be provided by nurses
• As with all changes in level of care, starting and ending CC require a physician’s order

Assess the Need to Offer Continuous Care Services
You might want to pursue this service if:
• You don’t have an inpatient unit
• You do have a unit, but your service area is so large that many of your patients don’t use it when they need a higher level of care
• Many of your patients revoke to return to a hospital where you don’t have a contract
Assess the Need to Offer Continuous Care Services
You might want to pursue this service if:
• You have contracts with other facilities for General Inpatient Care but the rates you pay are extremely high
• Your patients often end up getting too much aggressive, unnecessary, unwanted care when they present at the ER, even where you do have a contract

Assess the Need to Offer Continuous Care Services
You might want to pursue this service if:
• You have many patients who revoke, are admitted to the hospital and die there
• You have many patients who are transferred to a contract bed and die there within a few days

Assess the Need to Offer Continuous Care Services
You might want to pursue this service if:
• Your Average Length of Stay is very high and you’d like to take more shorter length of stay patients to balance it out
• You are experiencing an increase in referrals of acutely ill patients and you’d like to meet their needs with a higher service level
Assess the Need to Offer Continuous Care Services
You might want to pursue this service if:
• Your "parent" organization also provides private duty and/or staffing services
• Recruiting LPNs and Aides from your community may be challenging but not impossible

Assess the Need to Offer Continuous Care Services
You might want to pursue this service if:
• You have strong competitors that are offering CC
• Your competition doesn’t offer CC and this would set you apart from them
• Your competition has an inpatient unit and this attracts patients and families who you might otherwise serve

Assess the Need to Offer Continuous Care Services
You might want to pursue this service if:
• You have someone in your organization who has managed staffing (hospital, private duty, per diem) or continuous care before
• You want to build your census, increase your referrals, add a new customer base
Assess the Need to Offer Continuous Care Services
You might want to pursue this service if:

You really want to add a service that will make difference in the lives of your patients AND the families who struggle to care for their dying loved ones at home.

The Risks of Continuous Care
You might NOT want to add this service if:
• Your organization is risk averse
• You can’t afford to invest up front in the staff, the learning curve, the management challenges
• Your community doesn’t want a hospice that takes care of challenging patients
• You don’t have someone in the organization you trust to make it happen

The Risks of Continuous Care
You might NOT want to add this service if:
• You aren’t willing to add staff to cover the increased load for HR, payroll
• You’re looking for something easy
• You measure success on each patient’s individual profit/loss
• You won’t be able to sell your board on the merits of a reduced margin but an increased bottom line
Assure the Clinical Validity of Continuous Care—Expertise

- Assessment by RN
- Physician's order to begin
- Physician's order to stop
- Continue MANAGING patient in IDG

Assure the Clinical Validity of Continuous Care—Initial Need

- Skilled observation and monitoring
- Skilled care to control/manage pain and symptoms
- Acute medical symptoms
- Loss of caregiver support that provided the skilled care
- Probability that patient can no longer be managed at home

Assure the Clinical Validity of Continuous Care—Ongoing Need

- Daily assessment by an RN to determine if need for CC is still present
- Careful, complete documentation of assessment, findings
The Mechanics of CC Staffing

- How do you identify patients that might be appropriate?
- How many staff do you need?
- How do you organize and manage the staff?
- How do you schedule the cases and staff?
- How do you make it work financially?

Identifying Patients

- Include CC criteria in pre-admit process, especially for those referrals from hospitals
- If Admission RN believes patient might be eligible, and following the review of the ARN’s assessment by a representative of IDG, include orders for CC in Initial Plan of Care
- At every visit, prompt evaluation for CC eligibility is conducted

Identifying Patients

- Use weekly IDG
- Identify every patient whose acuity levels are increasing by primary nurse
- Team Manager to continue tracking those patients daily with assigned RN along with additional patients identified during scheduled visits
Identifying Patients

- Team Director to review on call reports daily
- Team Director to call patients who’ve had an on call visit after hours or on a weekend and those who have called after hours more than once in the last week for pain issues, caregiver stress, other indications of deterioration
- Team Director to schedule primary RN visit to assess patient’s need for CC

Staffing Considerations

- 1 patient per day staffed 24 hours per day every day requires 4.2 FTE staff.
- For an average daily census of 3 CC patients, be ready to cover:
  -- 500 hours of staffing per week (168 X 3)
  -- 250 hrs of LPN care/250 hrs of Aide care
- Use LPNs for most cases rather than RNs
  - with team or on-call RN available for daily assessment

Staffing Considerations

- Create a per diem pool
- Hire/Appoint a Continuous Care Manager to manage the staffing, contract with agencies, assure quality of service to patients
- Hire only staff willing to work the days and hours you need them
- Use contracts with agencies as last resort
Staffing Considerations

- Be competitive with rates and differentials
- Consider paying weekly
- Offer incentives—bonuses and increases—when staff meet set milestones (total hours worked)
- Don’t ROUTINELY pay additional mileage reimbursement

Scheduling Considerations

- 12 hr shifts are easier to manage than 8 hr shifts; in some states, this is more costly
- LPN shifts 8p-8a; Aide shifts 8a-8p
- Include a few per diem positions as “starters” to get CC set up on first day in order to maximize chance for reimbursement on day 1
  --example: Aides who work 4p-8p

Scheduling Considerations

- When possible, START cases @ 4p with an Aide, then LPN @ 8p (8hrs/50% nursing)
- When possible, end cases after 8am and after RN has been able to do “transfer” assessment (8hrs + RN Visit time/50+% nursing)
Scheduling Considerations

• CC Manager schedules staff for cases until consistently providing services for a ADC ≥ 5

• At 5 ADC, add a Scheduler position 10a-6p, including weekends - if you have a lot of transfers to CC on weekends

Develop an Implementation Plan

• Create a proforma to establish your potential profit/loss BEFORE initiating the service
• Develop a hiring, orientation and training process specific to the needs of continuous care staff
• Create staffing tools for the CC Manager that will assist in tracking how cases are staffed

Develop an Implementation Plan

• Hire a CC Manager that will be both expert and advocate for continuous care
• Assign responsibility for managing the continuous care patient to the TEAM Manager
• Assign responsibility for staffing continuous care cases to the CC Manager
Develop an Implementation Plan

- Assure that all staff understand the Continuous Care benefit: Senior Mgmt, Admissions, Team Staff, Marketing Team
- Create plans for communicating the service and its benefits/conditions to:
  --Referral sources
  --Patients/families in admissions process
  --Patients/families on continuous care

How Do You Manage It Financially?

- Keep hiring and orientation costs in line by not overhiring in anticipation of a demand for services
- Minimize the number of days that you staff a CC case that does not meet the 8hr and 50% nursing criteria
- Keep overtime at a minimum but use it when necessary to meet nursing hours requirement

How Do You Manage It Financially?

- Identify and track “pre-need” cases in order to get them transferred to CC as soon as eligibility is appropriately assessed
- Encourage team staff to identify cases across the week, not just Fridays
Benefits and Outcomes

• Added customer satisfaction and gratefulness for this special kind of care
• Improved patient outcomes in pain and symptom management
• Increased capability to care for complicated patients
• Additional revenue stream at a much higher daily rate than other levels of care

Benefits and Outcomes

• Decreased revocations and therefore, increased days of care
• Reduced loss of patients who revoke and never return
• Reduced costs for ambulance transportation to units/contract beds
• Reduced re-admit costs for patients who revoke and return

Thank you

.....for your attendance today!

For further questions, comments or suggestions:
bcarpenter@bethcarpenterandassociates.com or lserra@bethcarpenterandassociates.com

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