FAST FACTS AND CONCEPTS #415
GENERAL INPATIENT HOSPICE CARE
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Background  Questions regarding hospice resources commonly arise when caring for an actively declining, symptomatic hospice or hospice-eligible patient. This Fast Fact addresses questions and concerns regarding hospice general inpatient care (GIP) and distinguishes GIP from routine hospice care within the Medicare Hospice Benefit (MHB). GIP care is relatively common among MHB recipients; recent data suggests about a quarter of all MHB recipients receive GIP care (1). See Fast Facts #82, 87, 90, 139, and 140 for further information about the MHB including other levels of hospice care in the US.

What is GIP Hospice Care?  The Code of Federal Regulations regarding the MHB requires all hospice entities to be able to provide four levels of care to patients: GIP, routine (most hospice care at home or in long-term care is routine), continuous care (short term intensive symptom care, provided in the patient’s own place of residence), and respite (short term facility-based care for family respite needs) (2). GIP is an inpatient care plan for a hospice patient who has short-term symptom management needs that cannot be provided adequately in any other setting.

When is GIP appropriate?  While GIP criteria can be individualized, at minimum it requires appropriate orders and documentation of acute symptom management needs. Importantly, anticipated survival of hours-to-days (i.e., imminent death) is not justification alone to meet GIP standards. GIP cannot be used for caregiver stress relief or respite. GIP is aimed at ‘short term’ admission (usually 5 days or less) for aggressive palliative interventions and discharge to a prior level of care when acceptable symptom control is achieved. Additional supporting evidence for GIP criteria include, but are not limited to (3,4):

- Analgesic needs that cannot be managed at home, such as complicated delivery mechanisms (e.g., subcutaneous, IV, epidural), frequent dose titration, and skilled nursing care with frequent monitoring.
- Symptom management for nausea, vomiting, respiratory distress, or terminal complications such as seizures or bleeding that would be uncontrollable with the resources available elsewhere.
- Advanced, open wounds requiring frequent dressing changes, frequent monitoring, or more than one person to complete.
- Severe delirium with behavioral manifestations not manageable elsewhere.

Where is GIP provided?  GIP most commonly occurs in a dedicated hospice inpatient unit, which could be located within a hospital, skilled nursing facility, or a freestanding facility. GIP occurs less commonly in regular hospital (33%) or skilled nursing facility beds (8%) (1). The facility must either be appropriately licensed to provide hospice care or have a contract with a hospice entity. GIP cannot be provided in a patient’s own home, assisted living facility, or other long-term care facility where federal requirements for providing GIP care cannot be met. Regardless of site, additional GIP requirements include (2):

- 24-hour nursing care services with the ability for an RN to provide direct patient care on all shifts.
- Availability of spiritual and psychosocial care and assistance.
- A home-like atmosphere to preserve patient dignity and privacy.
- Ability to receive visitors at all times.

Initiating GIP in patients who are already hospitalized  Under some circumstances, appropriately selected hospitalized patients can receive GIP care even if they were not previously established on the MHB. The hospital must have an established partnership contract with a hospice agency. The patient can then be bureaucratically discharged from their original hospital stay and immediately readmitted as an enrolled hospice GIP patient, without ever leaving the hospital or even their bed (if the hospital does not have a hospice unit). The patient must meet GIP criteria as described above. For example, a terminally ill patient is admitted to a hospital with pneumonia. After 2 days, the family opts for hospice enrollment and signs onto the MHB. The patient has severe agitation and cannot safely be discharged home. The hospital has a contract with a hospice agency to provide GIP, but no hospice unit. This patient can be “discharged” from their original hospital stay, and immediately readmitted as a hospice GIP patient for ongoing management of their delirium and comfort, without leaving their hospital bed. If they stabilize, they may need to be discharged to a different level/location of hospice care.
GIP in a hospital is always complex from both a regulatory and practical standpoint. Logistic care issues are common such as questions regarding who the attending physician should be, the roles of hospice versus hospital unit nurses, and the role of the hospice medical director to name a few. Proactive, close collaboration between hospice and hospital personnel (including leadership, business administrators, and clinicians) is vital for these programs to be successful.

References

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