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Introduction to GIP Hospice Care:

BACKGROUND:

General Inpatient (GIP) Care is one of the four levels of hospice care required to be available under the Medicare Hospice Benefit (MHB). GIP level of care is a valuable tool for overall quality patient care to provide clinical services at a higher level of intensity. It is intended for patients with specific circumstances and for a short duration of time and thus must be carefully managed from start to finish.

WHAT IS GIP?

A general inpatient care day is a day on which a patient receives care in an inpatient setting for pain control or other symptom management, in which symptoms are severe enough that they cannot be managed in other settings.

GIP is initiated when other efforts to manage symptoms are ineffective. GIP is a step up from routine home care. Note that there is no particular disease, condition, or symptom specified that is a qualifier for GIP. Each patient and his or her symptoms will differ, therefore GIP may be helpful to one patient and not to another with the same disease. Examples of symptoms include: pain, dyspnea, nausea/vomiting, delirium with agitation, and diarrhea.

GIP care carries specific requirements regarding where the services may be provided, as well as types and levels of staffing. GIP care cannot be provided in the home, in an assisted living facility, a hospice residential facility, or in a nursing facility that does not have a registered nurse available 24 hours per day to provide direct patient care.

GIP is intended to be a **short term** intervention (similar to an acute hospital stay). However, there is no limit on the number of days or number of episodes of GIP each patient receives.

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Assessment for GIP Appropriateness:

WHEN IS GIP APPROPRIATE?

GIP may be initiated when the interdisciplinary group (IDG) determines that the patient's pain and symptoms cannot be effectively managed in the patient's home or other residential setting. Changes may occur suddenly, such as a new onset of grand mal seizure activity, or they may occur gradually as the patient is declining along a natural disease trajectory and the changes become overwhelming in their frequency or volume.

When the IDG (including the attending physician and/or the hospice Medical Director) assess that the patient requires a higher level of skilled nursing care to achieve effective symptom management then the IDG should consider a change to GIP level of care. The IDG's clinical skills and judgment determine ***when*** and ***if*** GIP is appropriate. A physician's order is necessary to change the patient's level of care and update the clinical/medical interventions implemented during the GIP transfer.

If there is a need for pain control or symptom management, which cannot be feasibly provided in the home setting at hospital discharge, GIP is an appropriate consideration.
The following examples of patient status triggers may lead to the change to GIP level of care:

- Pain or symptom crisis not managed by changes in treatment in the current setting or that requires frequent medication adjustments and monitoring
- Intractable nausea/vomiting
- Advanced open wounds requiring changes in treatment and close monitoring
- Unmanageable respiratory distress
- Delirium with behavior issues
- Sudden decline necessitating intensive nursing intervention
- Imminent death – **only** if skilled nursing needs are present

WHEN IS GIP NOT APPROPRIATE?

It is also important to keep in mind what GIP is not.

- It is not intended for caregiver respite. If a caregiver is not in the home, or unable to help the patient adequately, other arrangements can or should be made.
- It is not intended as a way to address unsafe living conditions in the patient's home.
- It is not an "automatic" level of care when a patient is imminently dying. There must be pain or symptom management and skilled nursing needs present (intensity of care).

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Cares Provided to GIP Patients/Families:

WHAT ARE THE HOSPICE MANAGEMENT RESPONSIBILITIES FOR GIP?

Admission/Transfer to Facility

- The hospice should arrange for transfer to the appropriate inpatient setting that can meet the patient's needs. Per CoP 418.56(e)(4) the hospice colleagues must share information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement. Contracts with appropriate facilities for GIP services should be clear regarding the IDG oversight role, scope of services, communication, and all the other federal and state regulatory requirements regarding services by arrangement. The written agreements may also clarify payment rates and procedures (CMS, 2008).
- Common appropriate facilities are hospitals, inpatient palliative care units, and inpatient hospice facilities.
- The team needs to provide report to the inpatient staff and furnish a copy of the patient's current plan of care.

Professional Management and Oversight

Regardless of care setting, the hospice IDG is responsible for the professional management of the patient's care in accordance with the hospice plan of care as set by the IDG.

Visits from the Hospice Team When GIP is in a Contracted Facility

Compassus RNs will make daily visits to assure professional management, coordination of the plan of care, communication with the patient and family, continuity of care and evaluation of continued eligibility for this level of care. The IDG should also continue services provided by Social Workers and Chaplains as needed and continue support and communication to the family and caregivers during a GIP stay. Compassus physicians are not required to visit hospice patients while on inpatient hospice, but are available for questions regarding their care.

WHERE CAN GIP BE PROVIDED?

Per CoP 418.108, GIP must be provided in a participating certified Medicare facility as follows:

- A Medicare-certified hospice that meets the conditions of participation for providing inpatient care directly as specified in §418.110.
- A Medicare-certified hospital or a skilled nursing facility that also meets the standards specified in §418.110(b) and (e) regarding 24-hour nursing services and patient areas.

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Documentation:

HOW SHOULD THE IDG DOCUMENT GIP LEVEL OF CARE?

Documentation during GIP level of care must be thorough and reflect the need and intensity of care for this level at all phases of care. Implementation of the plan of care must be directed to stabilizing the acute or chronic symptom management, obtaining a positive palliative outcome (did the care make a difference), and moving the patient to a lower level of care at the appropriate time.

When transferring a patient to GIP level of care, documentation should include:

- The skilled nursing interventions being provided to the patient and the patient's response
- A Plan of Care that reflects the change in level of care and interventions to stabilize the patient's acute pain and symptom crises
- Collaboration with the facility colleagues if in a contracted facility
- Discharge planning **(remember: GIP is short-term)**

The precipitating event (onset of uncontrolled symptoms or pain) which prompted the need to change to GIP level of care should be evident in the comprehensive assessment documentation. Pain and symptom management interventions that were implemented in the home prior to initiating GIP level of care should be documented and available to the inpatient colleagues.

Documentation should be updated daily and clearly describe why the patient still requires inpatient level care. If GIP level care is no longer needed, then documentation should include a plan for discharge from the facility back to home hospice.

All IDG members should document to paint a complete picture of the patient, including the pain and symptoms not adequately managed and why the GIP level of care is necessary. Physicians and nurses need to address symptom management, observations, medications initiated and changes in medications, other changes in treatment, etc. Other IDG members need to document what they see in terms of symptom management, patient and family coping, discharge planning discussions, options for returning to the routine home care level, etc. **Copies of facility documentation to support the LOC is a required element.**

When the patient's symptoms are managed and the GIP level of care is no longer medically necessary, the patient's level of care should be returned to Routine Home Care and the patient transferred back to the residential setting as appropriate. In some cases, the patient may die

while in GIP care. In this situation, the inpatient facility would facilitate transfer of the deceased patient to the mortuary and often furnish the death certificate. The IDG members will continue to provide support to the family.

Examples of Documentation:

Case A

85 y.o. M on GIP hospice for metastatic prostate cancer. On morphine drip. Incontinent. Has dementia and confused. Discussed care changes with nursing. Will discuss with family when available. Remains hospice appropriate.

Case B

85 y.o. M admitted GIP for intractable pain from metastatic prostate cancer, mets to bone with multiple thoracic and lumbar compression fractures. Comorbid dementia, HTN. Now tachycardic in the 120-140 range (now irregular) and hypotensive, BP 85/45. Morphine drip titrated overnight from 1mg/hour to 4mg/hour with 3 bolus doses of morphine given as well as 2 doses of haloperidol for agitation. Pt continues to move frequently in bed, occasional moans. Mildly combative with cares including changing linens and depends when incontinent. Confused and not recognizing family causing emotional distress. Chaplain at bedside. Distal extremities cool and mottled. Discussed with nursing plan for drip titration this morning, continued bolus doses of morphine and haloperidol and frequent reassessments. Will continue to monitor closely and provide family further education on signs of impending death when available.

Case A & B illustrate the differences in quality of documentation for GIP patients. Both cases provide documentation about the same patient, but Case B clearly demonstrates why the patient continues to require GIP level care. Examples of improved documentation in Case B includes documentation of changes in vital signs, titration of the morphine drip and bolus doses needed (dose amounts included), additional non-pain symptoms experienced by the patient, description of nursing cares required, interdisciplinary support needed (chaplain) and education given by the physician, as well as a plan for further monitoring and change of medications.

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Communicating the Value of GIP Care

Level of Expertise

Patients requiring GIP level care often have symptoms that are challenging or difficult to control. They often require a knowledge and skill set of a physician expert in the field of hospice and palliative care. PCA use, aggressive opioid drip titration, high dose opioid or benzodiazepine use are all common in the care of hospice patients in GIP care. In addition, physicians must be vigilant and regularly screen for opioid induced toxicities or opioid induced hyperalgesia (OIH).

Nursing Support

Patients in GIP care often require increased levels of nursing care to maintain control of symptoms and avoid the worsening of wounds or increased skin breakdown. This level of support cannot be provided by untrained or nonclinical support, such as family, at home.

Family and Patient Support

Chaplains and social workers are a valued part of the interdisciplinary team that provide additional support to patients and families while on GIP care. Many families struggle emotionally and spiritually when loved ones are in the process of dying, especially if there are difficult to control symptoms. Providing additional spiritual and bereavement support allows nursing and other staff to meet the patient's medical needs while helping the family to grieve and begin healing.

Additionally, social workers are an excellent resource for patients who are able to discharge after symptoms have been controlled. Often, these patients may need a higher level of care than prior to their GIP admission, such as an Assisted Living Facility (ALF) or Skilled Nursing Facility (SNF).

Colleague Support

Providing GIP level care can be extremely challenging in the time and expertise required as well as the emotional and spiritual burdens. Hospice Medical Directors (HMDs) and the interdisciplinary hospice team can provide significant support for physicians and staff at facilities treating GIP patients. HMDs are excellent resources for colleagues with questions or concerns.

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Myths of GIP Hospice Care:

There are many misconceptions around GIP level care. Several of the common misconceptions will be discussed below. However, if you continue to have questions or a unique circumstance, please consider contacting your Regional Medical Director for further discussion.

Common Myths:

MYTH: The patient needs to die on GIP hospice.
No! GIP patients may be admitted for symptom control and discharge home on hospice

MYTH: The patient can only stay 5 days on GIP hospice.
No! GIP is intended as a short stay, but can go as long as necessary to adequately control escalating symptoms.

MYTH: GIP is for patients whose family cannot take care of them at home.
No! Respite care is intended to relieve caregiver fatigue, not GIP.

MYTH: Hospice costs money and my patient can't afford it.
No! The Medicare Hospice Benefit is free to everyone with Medicare Part A. If the patient is not on Medicare, most insurances cover hospice care completely. If the patient does not have insurance, Compassus has an Angel Fund to help cover hospice care.

MYTH: All dying patients should be GIP.
No! GIP is only for patients whose symptoms cannot be controlled as an outpatient. If patients are dying comfortably without medications, they are not GIP appropriate.