Resource Guide

the carolinas CENTER FOR HOSPICE AND END OF LIFE CARE

General Inpatient (GIP) Level of Care: Utilization, Coordination, & Documentation

PREAMBLE

The Carolinas Center for Hospice and End of Life Care Facility Based Work Group first developed a General Inpatient level of care tool in 2006. The group has continued to raise questions, face challenges, and research the provision of this level of care. The group produced this updated resource to be compliant with the current Medicare Conditions of Participation and offers it to hospice agencies as a guide for utilization, coordination and documentation of the General Inpatient (GIP) level of care.

Use of the guide should help those providing GIP in any setting (free-standing hospice facility, long-term care facility, or hospital) to define their own policies and processes. It is not intended to define rigid criteria for the GIP level of care. Rather, the resource is intended to guide the Interdisciplinary Group's critical thinking process in assessment, goal identification, establishment of an effective plan of care, and communication of that plan to all involved in the care. Additionally, the guide provides suggestions for content and wording of documentation to support the GIP level of care.

Note: *Use of this tool does not guarantee payment. This tool is not endorsed by any state or federal fiduciary or governmental agency.*

What is GIP?

A general inpatient (GIP) care day is a day in which a patient receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings. GIP is intended to be short-term care.

Recommendations	Actions	Rationale
Identify the precipitating circumstances necessitating the need for GIP level of care.	Document pain and symptom management interventions that have been used in an attempt to manage symptoms and skilled care needs. This documentation needs to be done by the staff involved prior to and after the change in level of care.	Changes in level of care must be supported by documentation to avoid potential reduction in, or loss of, reimbursement.
	Document collaboration with others involved in care, i.e., patient, family, facility staff, hospice IDG, and the attending physician.	Regulations require collaboration between hospice staff, patient, family, the attending physician, and others involved in the patient care.
	If the patient is moving from an inpatient hospital stay to a hospice facility, the documentation must clearly show why there is a continued need for GIP level of care.	The patient has already been at a higher level of care per Medicare billing and the continued GIP level must be warranted.
A change in patient condition or level of care requires a change in the plan of care.	The interdisciplinary plan of care will be reflective of the patient and family goals.	Per the Medicare CoPs, the plan of care must reflect patient and family goals
	The plan of care will reflect the interventions to be used to manage the patient's needs.	Per the Medicare CoPs, the plan of care must include interventions to manage pain and other symptoms.
The members of the interdisciplinary team must visit the patient on an ongoing basis to determine continued eligibility for GIP level of care and to assess needs of the patient and family.	Hospice Facility: The RN will evaluate the patient at a minimum of every 4 hours. Hospice aides will monitor the patient's personal care needs at a minimum of every 2 hours as directed by the RN. Other team members will visit the patient at least weekly or as defined by the patient and family needs and goals.	Even if there is not a need for hands on care, the RN needs to visibly assess the patient. Other team members help address needs and ensure continuity of care.

	Skilled Nursing Facility or Hospital: A team member will visit the patient at least daily, with RN visits occurring at least every other day.	The SNF or hospital staff generally is not as knowledgeable as the hospice team; thus, it is essential for the IDT to make regular visits to ensure patient/family needs are met. Since the GIP level of care indicates a higher level of care is needed, the RN needs to visit more often to assess the patient and provision of care.
Each discipline must document at specified intervals to the current plan of care in a manner that supports the GIP level of care. **NOTE:** *If you provide GIP via a contract with another hospice, you must maintain responsibility for documentation to support the level of care.*	Hospice Facility: RNs will complete and document a full physical assessment every shift. Additional nursing documentation will occur at a minimum of every 4 hours at the time of care. Other disciplines will document at the time of their visits.	Each agency must define the specific form and content of each medical record entry. Documentation must clearly reflect, with individualized and specific information, the need for GIP on an ongoing basis. End of shift (block) charting is not recommended.
	Skilled Nursing Facility or Hospital: Staff will document each visit. Documentation will include a summary of the care provided by the facility staff, with special attention to care provided by the RN in the SNF.	Hospice is responsible for the professional management of the patient's care and must ensure the plan of care is implemented and patient needs are met. The Medicare Conditions of Participation require that a RN provide direct patient care on all shifts.
	All Settings: A team member will contact the patient's primary caregiver/family (if not present during visits) with any change in condition, but at least daily.	Ongoing communication with the family is necessary to provide education, solicit input into the plan of care, and address discharge planning.

Documentation must address symptoms, interventions, education and discharge planning.	Documentation will reflect needs of the patient/family and care provided by staff, including, but not limited to, symptoms (exacerbation and improvement) medication management, treatments, and non-pharmacological interventions.		The medical record is a comprehensive compilation of information and should contain complete documentation of all care, services and events.
	Documentation will contain narrative notes in addition to the information supplied in the check boxes.		Documentation needs to be individualized and many items need further explanation to fully illustrate the needs and care.
	Documentation will address education provided to the patient, family, and/or facility staff on symptom management and interventions per the plan of care.		Education is important to support efforts to move the patient to a lower level of care.
	Discharge planning will be documented to show efforts made to return the patient to a lower level of care.		Discharge planning is an ongoing process that begins at the point of admission. All team members need to assist to show continuity of care.
Utilize consistent language in all communication regarding levels of care.	**Terms to Avoid** Transfer Residential Acute	**Terms to Use** Change Routine, RHC Inpatient, General Inpatient, GIP	Documentation needs to use language reflective of regulations. Residential is a licensure type, not a Medicare certification type.
Coordination of care must occur between the hospice team members and staff of other facilities involved in providing GIP level of care.	The hospice interdisciplinary group will collaborate to facilitate coordination of care across all disciplines to include the attending physician.		Documentation must exhibit involvement of all team members, including volunteers, to promote continuity of care.
	Hospice staff will collaborate with clinical staff providing care in contract facilities to ensure continuity of care.		Medicare CoPs require that the hospice staff coordinate care with other providers to fulfill professional management responsibilities.

	Documentation will reflect the coordination of care that occurs internally and externally.	The medical record entries must show compliance with regulations.
Upon return to a lower level of care, documentation will reflect all care provided.	Hospice Facility: Staff will document the change in level of care, and the change in location if applicable.	All changes must be documented to maintain a current medical record.
	SNF/Hospital: The medical record will include a discharge summary that is reflective of the care provided.	Medicare CoPs require a Discharge Summary from contract facilities.

Potential Reasons for GIP Level of Care

This list is by no means all inclusive. Utilization of General Inpatient level of care must be individualized. The following symptoms or needs could warrant GIP for some patients and not others:

- Uncontrolled pain
- Intractable nausea & vomiting
- Advanced open wounds requiring more than one person to complete complex dressing changes
- Uncontrolled respiratory distress
- Severe agitation, anxiety or delirium
- Other uncontrolled symptoms
- Imminent death—only if skilled nursing needs are present

Note: *GIP is not to be used for caregiver breakdown in the absence of a need for skilled care. There must be an intensity of care directed towards pain control and symptom management that cannot be managed in any other setting. CMS addressed this topic in the 2008 Wage Index Final Rule (**see Resources**).*

Narrative Comments

In addition to standard checkboxes, documentation must contain narrative information to help further support the need for GIP level of care. Narrative comments should be added to expand upon the information noted in the check boxes. Items that may need to be addressed in the narrative comments include, but are not limited to, the following:

- Reason for GIP—be specific, especially if a patient has been at the higher level of care for more than a few days
- Symptoms—be specific—to what extent are pain or other symptoms impacting comfort—include physical, mental, and emotional symptoms

- Frequency of nausea, shortness of breath, or other distressing symptom
- Frequency of need for staff intervention to monitor behavior
- Summary of interventions to manage symptoms and patient's response
- Decline in patient's functional abilities—physical and mental—be specific
- Medications—how frequent are PRNs used, what changes have been made during the shift, how effective are changes
- Wounds—be specific—location, size, drainage, treatment, changes in appearance
- Other interventions—suctioning, positioning, spiritual support
- Extent of education needed to patient and family, including response to education
- Details of staff involvement in discharge planning and family response to discussion
- Reason why GIP LOC is needed for a longer length of stay patient—what care is being provided that cannot be managed at a lower level of care

Phrases to Avoid

Certain words or phrases are non-specific when used alone. Additional information must be added to provide details.

Avoid	Alternate Examples
No complaints	Interventions effective in managing (insert symptom)
Patient stable	Care needs being managed by (insert intervention)
Patient sleeping	Patient resting quietly after earlier (insert intervention)
GIP for pain management	GIP to manage uncontrolled pain in (insert location); continues to require titration of (insert med)
Requires monitoring	Condition monitored ongoing for (insert symptom)
Patient nonverbal	Requires skilled nursing assessment for nonverbal signs of pain/ discomfort
Interventions effective	Effectiveness of symptom management is continuously reevaluated to achieve optimum comfort

Support given	Listened to patient express fear of dying; provided education on disease process, or similar
Complains of shortness of breath	Voiced complaint of SOB with evidence of use of accessory muscles, pursed lip breathing, unable to carry on conversation
Patient anxious	Patient asks not to be left alone, fidgeting with buttons on shirt, talking rapidly
Education provided	Explained medication changes to wife—purpose, expected outcome, side effects

Summary Notes

Summary notes written periodically (per agency policy) help to bring information from various sources (discipline visit notes, medication administration record, plan of care, physician orders, etc.) into one location for ease of medical review. This information could be captured in the interdisciplinary group meeting notes.

Information that should be considered for inclusion in a summary note includes, but is not limited to, the following:

- Synopsis of patient's status and needs—reason for GIP, symptoms being managed
- Description of care that is being provided in GIP facility that cannot be provided elsewhere
- Family needs—long-term care placement assistance, psychosocial support, financial assistance
- Education of patient and family to be able to manage the patient at home
- Collaboration with team, including hospice physician/NP, and attending MD as applicable
- Discharge planning efforts to include what the expected discharge setting will be

Resources

Medicare Hospice Regulations
http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol3/pdf/CFR-2011-title42-vol3-part418.pdf

Interpretive Guidelines for the Medicare Conditions of Participation—Appendix M of the State Operations Manual
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_m_hospice.pdf

Medicare Benefit Policy Manual, Hospice Chapter
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads//bp102c09.pdf

NHPCO Tip Sheet "Managing General Inpatient Care for Symptom Management"
http://www.nhpco.org/files/public/regulatory/GIP_Tip_GIP_Sheet_2010.pdf (*NOTE: Revision in Process*)

Caregiver Breakdown & GIP Information—Hospice Wage Index for Fiscal Year 2008
http://www.gpo.gov/fdsys/pkg/FR-2007-08-31/pdf/07-4292.pdf

NHPCO Hospice General Inpatient Care Issue Brief—available for purchase at
http://iweb.nhpco.org/iweb/Purchase/ProductDetail.aspx?Product_code=820997 (*NOTE: Revision in Process*)

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