Drafted: March 19, 2015

## **General Considerations**

Continuous home care (CHC) is provided during a period of crisis and is covered only as necessary to maintain the patient at home. A period of crisis is a period in which a patient requires primarily nursing care, to achieve palliation or management of acute medical symptoms. A minimum of 8 hours must be provided. Hospice aide or homemaker services may be provided, but the care must be predominantly nursing care. CHC can only be provided in the patient's residence.

## **Computation of CHC Hours**

The following circumstances must be met in order to qualify and bill for CHC billing:

- The hospice must provide a minimum of 8 hours of care during a 24-hour day, which begins and ends at midnight.
- This care need not be continuous, e.g. 4 hours could be provided in the morning and another 4 hours in the evening.
- If fewer than 8 hours of care are provided, the services are reimbursed as a routine home care.
- Greater than 50% of the hours of care must be provided by an RN or LPN.
- The computation of the required 8 hours for the CHC level of care applies only to direct patient care provided by a nurse, a homemaker or a hospice aide.

## Documentation to Include

- Reason for continuous care
- Vital signs (as appropriate)
- Observations of the patient's condition
- Interventions used to achieve palliation of physical or emotional symptoms
- Services provided to the patient
- Medications given and the patient's response
- Treatments completed and the patient's response
- Contacts made to the hospice and/or attending physician
- New or changed orders received
- Family response to care (as indicated)
- Detailed discharge planning to transfer the patient back to routine home care as soon as the crisis subsides.

There is no specified frequency of documentation for CHC in the regulations. However, since CHC is for acute symptom management or some other crisis, the best practice standard is to document at least every hour.

## Criteria for Admission to Continuous Home Care Level of Care

| Date: _ |  |  |
|---------|--|--|
|         |  |  |

| Check All That Apply                    |         |        |          |  |  |
|---|---------|--------|----------|--|--|
| Criterion                               | Present | Absent | Comments |  |  |
| Medical crisis, with collapse of family |         |        |          |  |  |
| structure                               |         |        |          |  |  |
| Qualifies for inpatient admission but   |         |        |          |  |  |
| does not agree to or cannot be moved    |         |        |          |  |  |
| Uncontrolled severe symptoms requiring  |         |        |          |  |  |
| continuous assessment /intervention     |         |        |          |  |  |
| Rapid deterioration/imminent death      |         |        |          |  |  |
|   |         |        |          |  |  |