Preventing & Managing Unplanned Hospitalizations

Subscriber Webinar
March 2016

Today's Plan

- Importance of minimizing unplanned hospitalizations
- Preventing unplanned hospitalizations
- Managing unplanned hospitalizations
- Staff competency needs
- Measuring and monitoring

Parts A and B Non-Hospice Spending During Hospice, FY2013

Hospice Site of Service	% of Total Hospice Service Days	Total Non-Hospice Utilization	% of Total Non-Hospice Utilization
Total	100%	$694,30,854	100.0%
Assisted Living	15.1%	$72,161,946	10.4%
Patient's Home	56.0%	$300,133,298	43.2%
Nursing Home	25.7%	$199,007,402	28.7%
Inpatient facility	1.9%	$106,508,724	15.3%
All other	1.3%	$16,319,484	2.4%

Medicare Hospice Payment Reform: Analysis of How the Medicare Hospice Benefit is Used
Abt Associates
December 3, 2015

Parts A and B Non-Hospice Spending During Hospice, FY2013

Hospice Site of Service	Total Non-Hospice Utilization	% of Total Non-Hospice Utilization
Total	$694,30,854	100.0%
DME	$44,493,765	6.4%
Home Health	$29,671,882	4.3%
Inpatient	$198,561,453	28.6%
Outpatient Part B	$115,376,289	16.6%
Physician/Supplier & Other Part B	$269,186,392	38.3%
Skilled Nursing Facilities	436,841,072	5.3%

Medicare Hospice Payment Reform: Analysis of How the Medicare Hospice Benefit is Used
Abt Associates
December 3, 2015

Hospital Readmissions

20% of Medicare beneficiaries are rehospitalized within 30 days

67% of Medicare patients discharged from a hospital were rehospitalized or died within the first year after discharge

26.9% of Heart Failure patients were readmitted to the hospital within 30 days

22.6% of pulmonary disease patients were readmitted within 30 days

50% of patients rehospitalized within 30 days after a medical discharge to community did not visit PCP or physician

NEJM: Rehospitalizations among Patients in the Medicare Fee for Service Program (2009)

6

Regulatory Connections

418.52(c) Standard: Rights of the patient

The patient has a right to the following:

(1) Receive effective pain management and symptom control from the hospice for conditions related to the terminal illness

(7) Receive information about the services covered under the hospice benefit

(8) Receive information about the scope of services that the hospice will provide and specific limitations on those services

418.56(c) Standard: Content of the plan of care

…Plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions…

20.2.1 – Hospice Discharge

"Once a hospice chooses to admit a Medicare beneficiary, it may not automatically or routinely discharge the beneficiary at its discretion, even if the care promises to be costly or inconvenient, or the State allows for discharge under State requirements."

Medicare Benefit Policy Manual
Chapter 9 Hospice Services

Re-Hospitalizations and the Terminally Ill

These patients have a decline with each hospitalization and usually don't recover to baseline

Family may see hospitalization as one of many acute episodes

Patients and families are used to the hospital as the safety net; always go and get better

Family often doesn't see the gradual decline

Hospital Readmissions

Common reasons for hospital readmissions

1. Failures in discharge planning/lack of continuity of care
2. Untimely or insufficient follow up care
3. Medication management or lack thereof
4. Lack of goal setting for patients with chronic life limiting illnesses

What Do People Want?

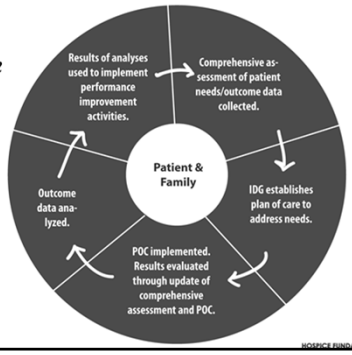
1. Adequate pain/symptom control
2. Avoiding inappropriate prolongation of dying
3. Achieving sense of control
4. Relieving burden
5. Strengthening relationships with loved ones

Singer, et. al., *Quality End-of-Life Care - Patients' Perspectives*, JAMA, 1999; 281:163-168 (Jan 14)

IDG

Assessments & Care Planning

The *Cycle* of Care



Root Causes

- Inadequate assessments
- Poor symptom management and follow up
- Generic care planning
- Ineffective case management
- Not understanding disease trajectory and what symptoms / changes to plan for
- Lack of accountability

Developing Standards

When do you go and what's the follow up?

- After hours calls
- Increase in symptoms/change in patient status
- New medication
- New caregiver/out of town arrival

Tuck-in calls

- Weekends
- Changes in status
- Change in medications

Start at the Beginning

During the sign-on process, provide list of contracted hospitals

Review the list with the patient/family

- Determine if they use another hospital and plan to use that hospital in the future
- If so make sure to care plan this issue and attempt to obtain a contract with the hospital

Hospice Item Set Preferences

What do you do with the information?

- F2000 – CPR
- F2100 – Life Sustaining Treatments
- F2200 – Hospitalization

Does the care plan reflect preferences?

Are all team members aware of them?

Define Standards

New hospice admission

- Tuck in call night of admission
- Visit day after admission

Educate to call hospice any time

- The right people-systems approach
- The right language
- Repeatedly reinforced

Patients with history of frequent hospitalizations / high risk

- Front load visits and contacts including weekends and holidays
- Identify triggers and care plan

The 4 Ps

Teach all disciplines to ask at every visit

- **P**ain level
- **P**roduct needs (briefs, other supplies)
- **P**oop (last BM, changes)
- **P**ill's (Are there any running low? Do you have any questions about?)

Managing After the Fact

Standardize Process

Notification
- Who
- How

Rapid response
- Who goes
- How quickly
- Gathering information

The Determination

- Unrelated
- Related
  - Contracted Hospital
  - Non-Contracted Hospital

A Few Words About

Hospice, Hospitalizations and Relatedness

Hospice determines what is and isn't related determined

- Hospitals should not bill for any related stays
- Requires exceptional professional management by the hospice
- Requires close and frequent communication on ICD 10 coding for anything not related

Denials or paybacks from hospitals can occur and sometimes much after the fact

- Would have to seek payment from hospice or beneficiary

Unrelated

Should be very clearly unrelated - an unusual occurrence

Discussion with hospital case manager and billing department (what ICD codes)

Make daily visits to ensure remains unrelated

- Communicate with patient and caregiver
- Communicate with hospital case manager
- Communicate with hospitalist

Document discussion with hospice physicians and determination of why unrelated

Related but in Non-contracted Hospital

As of July 2012 (CR 7677) considered to be a "move out of service area" and identified as legitimate reason for discharge

Before using discharge option CMS suggests to consider

- Beneficiary's length of stay in the hospital
- How it affects the plan of care

The suggestion makes no sense because if beneficiary is not discharged he/she would be responsible for payment

- Document considerations in the clinical record

Offer to move the beneficiary to your contracted facility

Related in Contracted Hospital

Update POC with the IDG, including hospice and attending physician

Daily visit by RN
- Case management responsibilities & communication

Visits by SC and SW as appropriate depending on needs

Documentation to support higher level of care

At discharge, obtain hospital discharge summary or record

Get Ahead of the Problem: Communication

"They are just non-compliant. We keep telling them not to go to the hospital but they do it anyway…"

Effective Communication

Experts have concluded that if a patient is given an opportunity to speak without interruption for 2 minutes at the beginning of an encounter, the patient will provide the health professional with his or her issues and goals.

Talking with Patients (Vols 1 and 2), Cassell, E

Get Ahead of the Problem

Review all unplanned hospital admissions for a past period looking for trends
- Within first week of hospice admission
- After a symptom crisis
- When out-of-town family arrives
- Nursing facility patients

Understand the reason(s) for each one through a root cause analysis approach

Review your on-call activity - see if it ties together

Get Ahead of the Problem: Nursing Facility

Find out where the issues are

RN assessments-experienced

Protocol to respond when get a call from facility

Communication of changes in condition to attending physician

Get Ahead of the Problem: Nursing Facility

Fall and injury prevention-know the NF program and be a part of it

Advance care planning
- HIS preferences
- Make sure advance care planning is clearly communicated to facility
- Conversations with patients and families on futile care
- Frequent conversations with NF staff on what goals of care are for patient and family
- Frequent reinforcement of decisions

Get Ahead of the Problem

Work with your hospital(s) to see what can be done during the hospital admission process to identify hospice patients

Monitoring

Live discharge report
- All types
- Length of stay
- Trend quarterly
- Ensure data differentiates unplanned hospitalizations

On-Call
- Categories for types of calls
- Standards for visits-are they followed?

How do you monitor standards set?

Performance Improvement Projects

Consider PIP
- High risk
- High volume
- Problem prone
- Prevalence
- Affect patient care and safety

Staff Competency

Connection to assessments and care planning

Accountability to standards

IDG discussions after each unplanned hospitalization

What could we have done better/differently?

Summary

Unplanned hospitalizations are a risk area

A strategic approach to minimizing and managing is important

It's not easy but it is the right thing

Use the integrated approach of The Path of the Prudent Hospice

To Contact Us: We Are Here for You!!!

Info@HospiceFundamentals.com

Roseanne Berry
480-650-5604
Roseanne@HospiceFundamentals.com

Susan Balfour
919-491-0699
Susan@HospiceFundamentals.com

Charlene Ross
602-740-0783
Charlene@HospiceFundmentals.com