

Live Discharges Handle with Care

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What You Will Learn

- The different types of live discharges and how to distinguish the processes
- The role of the hospice leadership and the IDG in properly managing and reducing live discharges
- How your hospice can use live discharge data in your QAPI program

Today's Material

Specific to the requirements found in the Medicare
Hospice Benefit

TITLE 42--PUBLIC HEALTH
PART 418—HOSPICE CARE

Subpart B Eligibility, Election and Duration of Benefits

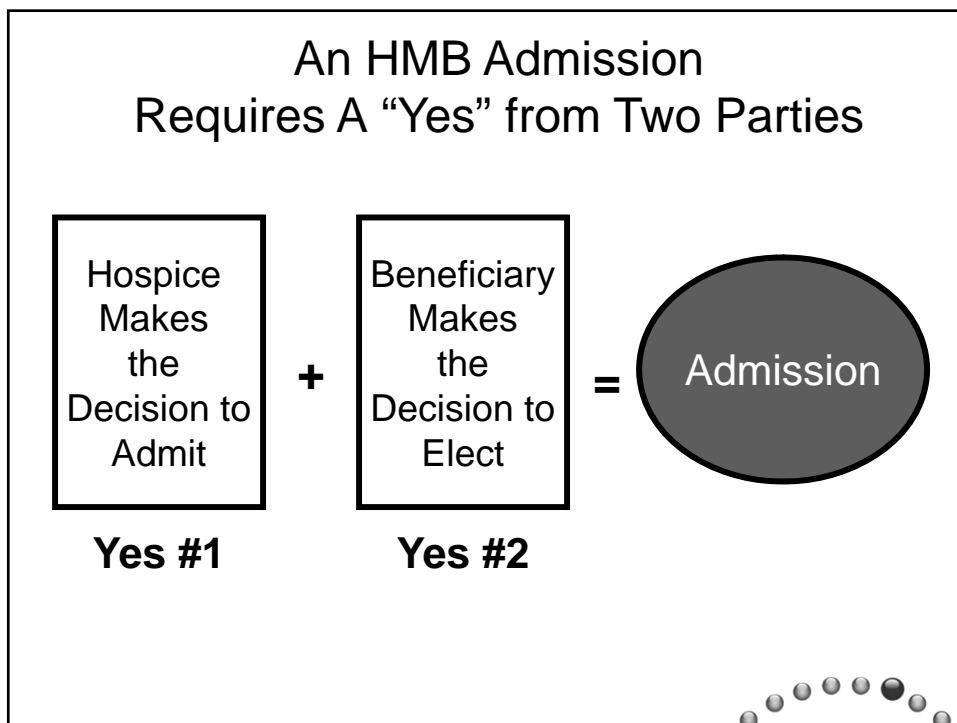

Apply to beneficiaries receiving care under the Hospice
Medicare Benefit

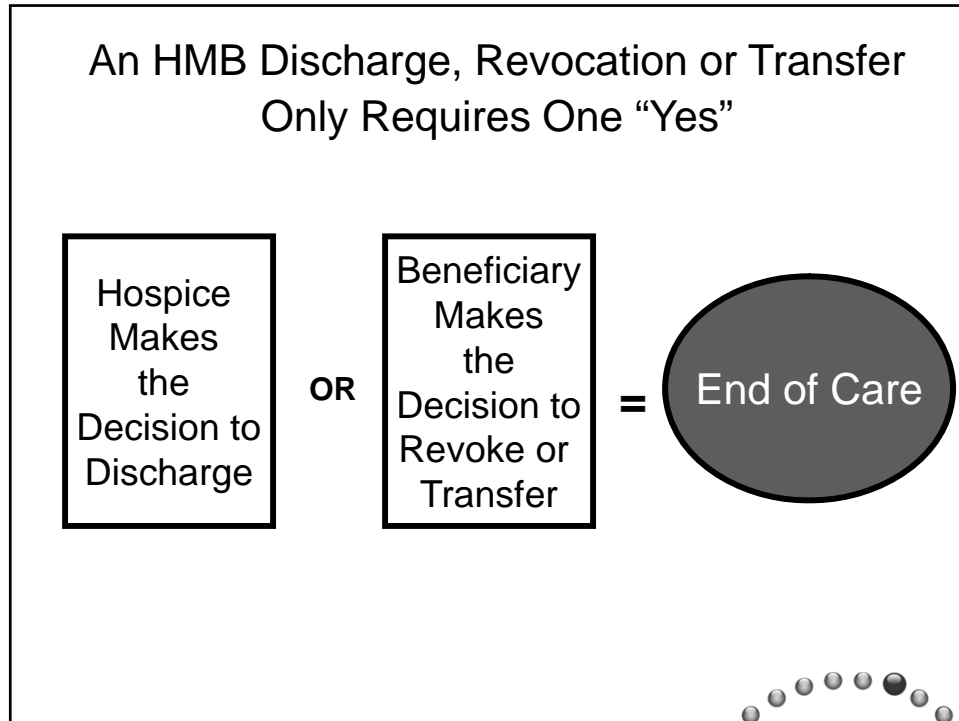
Don't forget to check your state rules!!!

THE REGULATIONS

Subpart B
Eligibility, Election and Duration of Benefits

- §418.26 Discharge from hospice care
- §418.28 Revoking the election of hospice care
- §418.30 Change of hospice provider





Hospice Medicare Benefit
Discharge History

- From the inception of the Medicare Hospice Benefit, CMS feared that hospices would discharge a beneficiary whose care became very expensive
- For that reason, very few situations warrant discharge

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



20.2.1 - Hospice Discharge

“The election of the hospice benefit is the beneficiary’s choice rather than the hospice’s choice, and the hospice cannot revoke the beneficiary’s election. Neither should the hospice request nor demand that the patient revoke his/her election.”

Medicare Benefit Policy Manual Chapter 9



§418.26

Discharge from Hospice Care

Only 3 allowable reasons a hospice may discharge a patient from its care

1. Patient moves out of the hospice's service area or transfers to another hospice;
2. No longer terminally ill; or
3. Discharge for cause

§418.26

Discharge from Hospice Care

Prior to discharging a patient for any of these reasons

- Hospice must obtain a written physician's discharge order from the hospice physician
- Attending physician should be consulted before discharge and his or her review and decision included in the discharge note

§418.26

Discharge from Hospice Care

- Must have in discharge planning process in place in the event a patient's condition stabilizes or can no longer be certified as terminally ill
- It must include
 - planning for any necessary family counseling,
 - patient education
 - or other services

§418.26 Discharge from Hospice Care No Longer Terminally Ill

- CMS notes- "Discharge is not expected to be the result of a single moment that does not allow time for some post-discharge planning"
 - When IDG is following their patient, and if there are indications of improvement in the individual's condition such that the patient may soon no longer be eligible, then discharge planning should begin
 - Discharge planning is expected to be a process, and planning should begin before the discharge date

418.26 – Discharge from Hospice Care
No Longer Terminally Ill

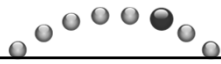
- Hospice issues Notice of Medicare Provider Non-Coverage/Generic Notice no less than 48 hours before discharge
- Requirements and process found at

http://www.cms.gov/BNI/06_FFSEDNotices.asp

§418.26 Discharge from Hospice Care For Cause

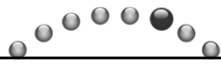
- The hospice must do the following before it seeks to discharge a patient for cause
 - Advise the patient that a discharge for cause is being considered
 - Make a serious effort to resolve the problem(s) presented by the patient's behavior or situation
 - Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services
 - Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its medical records

Potential Reasons for Cause


- Threatening behavior to staff that can't be managed after repeated attempts
 - Patient consistently refuses to allow the hospice to visit or deliver care
 - Patient continues to leave the service area making it impossible to deliver care or manage the Plan of Care
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§418.28

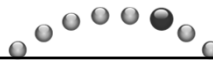
Revoking the Election of Hospice Care

- A patient may revoke their election of the hospice benefit at any time by filing a signed statement and the date the revocation is to be effective which can be no earlier than the date the revocation is made
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Important Points - Revocation

- Can only be done by the patient or his/her representative
 - Must be done in writing—no accommodation for a verbal revocation
 - Cannot backdate a revocation
 - A hospice may never “revoke a patient”
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Important Points - Revocation

- A hospice has a responsibility to counsel the beneficiary on the availability of revocation
 - Beneficiary does not have to provide a reason for revocation
 - Hospice documentation should include the circumstances around the revocation
 - Right to re-elect
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§418.30

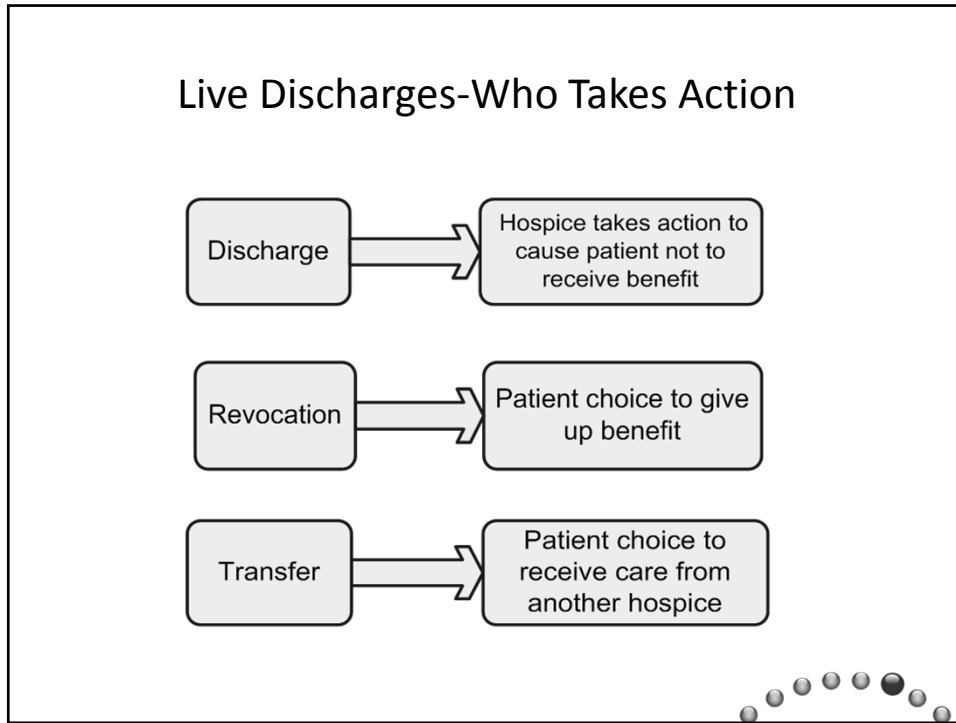
Change of Designated Hospice

- A patient may change or transfer hospices once in a benefit period by filing a statement with the current and new hospice and the effective date of the change/transfer
- If transferring to a new hospice out of the service area, strongly consider discharging
- Cannot transfer hospices again in the same period
 - Must revoke from the current hospice and elect with the new hospice or in case patient leaves the service area it could be a discharge by the hospice

In Either Case

Coordinate closely with other hospice to

- Promote continuity of care
- Minimize billing nightmares



NHPCO National Hospice Summary


	2008 NHPCO	2009 NHPCO
	Mean	Mean
Non-Death (Live) Discharges (includes live discharges, revocations and transfers)		
Non death discharges as a percentage of Total Discharges	18.1%	19.2%
Reason for Non-death Discharge	Percent of Total	Percent of Total
Hospice initiated discharge	52.8%	52.9%
Patient-initiated discharge	47.2%	47.1%

Where Do You Stand?

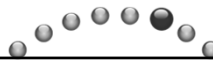
- Capture and analyze number of live discharges on on-going basis by
 - Category
 - Team
 - If necessary, individual clinician
- How do they compare to benchmark figures?

MANAGING LIVE DISCHARGES

Unplanned Hospital Admissions

- Hospices are required to provide general inpatient care for pain control or other symptom management that cannot be effectively managed in other settings
 - Patient rights
 - Comprehensive assessment
 - Plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions
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Unplanned Hospital Admissions

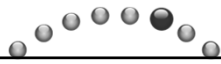
- Handling hospital admissions after the fact
 - Unrelated to terminal diagnosis
 - Related to terminal diagnosis
 - Contracted hospital
 - Non-contracted hospital
 - If a patient is hospitalized, you are responsible for counseling them on his/her option to revoke and any advantages or disadvantages of this decision
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Think of revocations as
SERVICE DELIVERY FAILURES

Revocations

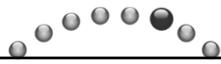
- What can the IDG do to reduce revocations
 - You have promised to work with the patient and family through the end of life
 - Comprehensive assessments, communication and care planning
- Have an escalation process in place where leadership is notified immediately of any discussion of revocation
- Take necessary steps
 - Understand the reason for the revocation
 - Attempt to correct any actual or perceived service issues

Unplanned Hospital Admissions – 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
 - Review your after hours activity
 - Work with your hospitals to see what can be done during the hospital admission process to identify hospice patients
- 


Unplanned Hospital Admissions – Get Ahead of the Problem

Hospitalizations in non-contracted hospital

- During the sign on process, provide list of contracted hospitals
 - Review the list with the patient/family, identify if they use another hospital and plan to use that hospital in the future
 - In these cases make sure to care plan this issue and attempt to obtain a contract with the hospital
 - Patients with a history of frequent ER visits and hospitalizations
 - Care plan this with an interdisciplinary focus for increased visits, phone calls and tuck in calls
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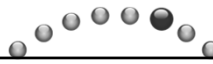
Revocations

Dissatisfied with hospice care

- Comprehensive patient/family assessments by the entire IDG resulting in interdisciplinary plan of care
 - Leadership should be actively involved with resolving any service related issues as they arise
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Revocations

Chooses skilled days over hospice

- Patients and families often choose skilled days so their room and board is paid in a SNF
 - Patient choice but do make sure that if the patient qualifies for GIP you advise the patient/family of GIP level of care (which is generally shorter stay than skilled days)
- 

Patient entered non-contracted NF

- When you have a current patient who needs to be placed in a NF
 - Comprehensive assessments and care planning
 - Social Worker actively involved in the process
 - Provide the patient/family with a list of contracted NFs
 - Assure continuity of care for the patient and family by placement in a contracted NF
- If patient/family does insist on placement in noncontracted NF
 - See if you can get a one time contract
 - If not then explain the situation and their right to
 - Transfer to the contracted hospice
 - Their right to revoke

Transfer

Within the service area (also service delivery failures)

- Immediately notify leadership
- Take necessary steps to try and understand the reason for the transfer
- Attempt to correct any perceived service issues
- Make sure you are meeting the needs of the patient and family through a patient driven interdisciplinary care planning process

Discharge

Moved out of Service Area

- Determine if you are meeting the needs of the patient and family through a patient driven care planning process so the reason the patient moves is not due to lack of supportive hospice services
- If the patient does move, make sure to help the patient find a good hospice provider in their new community
 - Provide an excellent discharge summary and communication/coordination

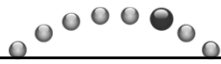
Discharge

No longer terminally ill

- How do you track and follow up on these discharges?
- Important to track live discharges
 - Better understand clinical disease course
 - Readmission
- Benchmarks

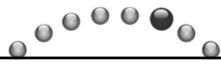
Discharge

No longer terminally ill

- Low or no discharges could mean you may be too conservative in admitting eligible patients (resulting in none to discharge)
 - Low or no discharges could mean that your hospice may not completely understand how to assess for continued eligibility
 - High numbers could indicate the need for further education on eligibility
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Discharge

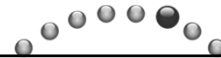
For Cause

- Little to no discharges could mean your hospice has very creative solutions to patient or staff safety issues
 - Do make sure that in fact your hospice is admitting all eligible patients and that you are not selecting out those challenging ones
 - Have an escalation/consult process
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Increased Scrutiny Coming

Recent rumblings indicate that CMS has a heightened interest in revocations and discharges

Why might that be?



CONSIDER A PIP



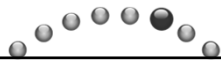
Potential PIP Results

- Reduced
 - Calls after hours
 - Complaints
 - Unplanned hospitalizations
 - Incidents to report
 - Paperwork for clinical staff
- Improved FEHC results
- Increased census

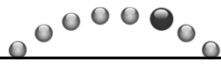
Steps of a Prudent Hospice™

- Everyone clearly understands the difference between a discharge and revocation
- Ability to explain the benefit and the right of revocation is treated as a basic competency and tested periodically
- A *Discharge with Cause* policy exists and is applied equally to all patients and families
- The IDG and the attending physician are involved in each step of the process
- True attempts to solve the problem are made

Steps of a Prudent Hospice™

- Documentation in any discharge or revocation situation is textbook perfect
 - The numbers of discharges and revocations are
 - Monitored and attempts are made to decrease them
 - Tracked by team
- 

Summary

- Within the regulatory guidelines, focus should always be on the best outcomes for patients
 - Patients/caregiver have the right to make choices which with you may not agree
 - Thorough comprehensive assessments resulting in good care planning results in timely discharges and limited revocations
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