


Preventing & Managing  
Unplanned Hospitalizations

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Subscriber Webinar  
August 2014



**HOSPICE FUNDAMENTALS**  
KNOWLEDGE • EXPERTISE • COMMON SENSE

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Today's Plan

- Why it is important to minimize unplanned hospitalizations
- Proactive approaches
- How to manage when unplanned hospitalizations occur
- What staff needs to understand
- Measuring and monitoring



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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...

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### 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*

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### IDG: Assessments & Care Planning



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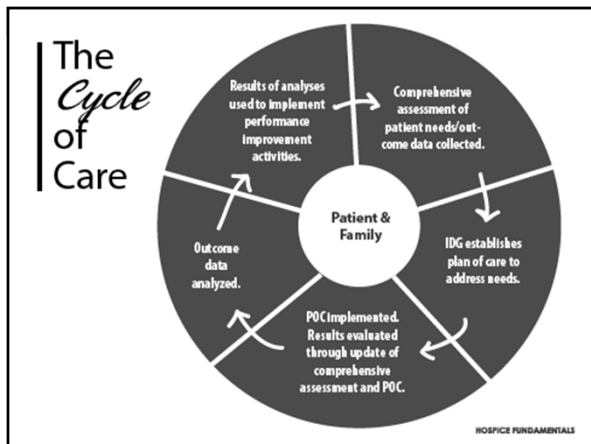
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### Root Causes

- Inadequate assessments
- Generic care planning
- Ineffective case management
- Lack of accountability



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### 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
  - F2000 CPR
  - F2100 Life Sustaining Treatments
  - F2200 Hospitalization
  - Care plan based on this information



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### Developing Standards

- New hospice admission requires visit day after admission regardless
- 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



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**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



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**Developing Standards**

- Triggers
  - Continuous home care
  - General inpatient care
- Cultural understanding



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**The 4 Ps**

**P**ain level

**P**roduct needs (briefs, other supplies)

**P**oop (last BM, changes)

**P**ill's (Are there any running low? Any you have questions about?)



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**Managing After the Fact**



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**Standardize Process**

- Notification
  - Who
  - How
- Rapid response
  - Who goes
  - How quickly
  - Gathering information



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**The Determination**

Unrelated	Related
	Contracted Hospital
	Non-Contracted Hospital



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### 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
- Document discussion with hospice physicians and determination of why unrelated



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### 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



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### Identifying the Problem



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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...”



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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



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Get Ahead of the Problem: Nursing Facility

- Find out where the issues are
  - Tracking by reason, facility, time of day, day of week
  - Falls and injuries versus others
- RN assessments-experienced
  - NF often lack hands on care/assessments by RNs especially RTC
  - More RN frequent visits (not just M – F in during the day shift) in those facilities with lower RN staffing ratio
  - What do you do when assessment findings indicate a change in condition
- Protocol to respond when get a call from facility
- Communication of changes in condition to attending physician
  - Who will do it
  - Assessment
  - Recommendations
  - Advance directives



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### Get Ahead of the Problem: Nursing Facility

- Fall and injury prevention-know the NF program and be a part of it
- Determine what the policy is of NF and alignment with NF new requirements
- Advance care planning
  - DNR, DNH, POLST, MOLST
  - Conversations with patients and families on futile care
  - Frequent reinforcement of decisions
  - Make sure advance care planning is clearly communicated to facility

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### 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

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### 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?

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**Monitoring**

If you set standards, how will you monitor?



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**Performance Improvement Projects**

Consider PIP

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



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**Staff Competency**

- Connection to assessments and care planning
- Accountability to standards
- Root cause
- IDG discussions after each one-what could we have done better/differently?



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**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



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**To Contact Us**


We are here for you!!!

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## Unplanned GIP Admission: Current Hospice Patient Admitted to Contract Bed in Hospital

- 1) Obtain an order for GIP
- 2) Update the POC
- 3) Daily visit by RN
  - a) **Payment Responsibilities:** Daily confirm current reason for hospitalization (ICD 9) with hospital and determine in collaboration with hospice physician if this is related or unrelated. It should be an unusual occurrence when it is not related.
    - i) If it is related, make it clear to hospital billing department your hospice is the payor source.
    - ii) If it is unrelated then review reason and coding with billing department daily in case there has been a change or addition.
  - b) **Care Management Responsibilities:** Daily communication/coordination plan of care with hospitalist, floor nurse, hospital case manager, patient and family.
    - i) Communicate code status
    - ii) Share hospice plan of care
    - iii) What are plans? Are plans in alignment with hospice plan of care? With patient and family goals of care, advance directives? What does the patient want?
    - iv) Ask NHPCO Questions:
      - (1) What symptom are we treating?
      - (2) Will this increase patient's quality of life?
      - (3) Will this control pain?
      - (4) Ask patient/family about quality of life, for example
        - (a) Has this changed your life?
        - (b) Are you experiencing negative side effects?
    - v) If plans are not in alignment, then what are next steps?
    - vi) Discharge planning is the responsibility of the hospice and must be coordinated with the hospital case manager/discharge planner. The hospital should not discharge a patient without the hospice agreement and involvement.
  - c) **Supporting Payment**
    - i) State clearly reason(s) for GIP and if it has changed, then indicate why.
    - ii) Review the chart, talk with staff to ensure complete information.
    - iii) Document summary of past 24 hours of care to include.
      - (1) Interventions, orders, medications, procedures, diagnostics;
      - (2) Outcomes/results;
      - (3) Current status;
      - (4) Why this care cannot be provided in another setting;
      - (5) Plans.
- 4) Other Team Members: SW and Chaplain visits individualized to needs of the patient / family.
- 5) After discharge from hospital to another setting
  - a) Make tuck-in visit day of discharge.
  - b) Nursing visit day after discharge and then as frequently as necessary depending on patient and family needs: increase to more than 1 to 2 times week for first week.
  - c) Update the POC.
  - d) Obtain copy of hospital discharge summary or record.