Doors to Discharge

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Objectives

- Participants will be able to:
- Name the different ways patients can leave the hospice program
- Identify the appropriate documentation and follow up for each
- Describe risks associated with various discharge metrics

What?

- Various ways your patients will leave your program
  - Death
  - Discharge
  - Revocation
  - Transfer

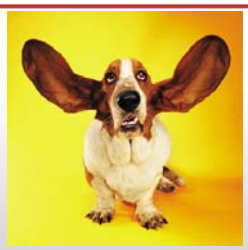
Why?

- Length of Stay and Census: It is a lot harder to replace a patient than to keep one
- There are regulatory requirements for each
- PEPPER!
- Red Flags to service issues

When?

- Discharge planning and revocation prevention begin at the start of care

How?



Death

- Most common and least popular way to leave a hospice program
- Days from admission to death are your length of stay, the longer the better (for the hospice)
- Legitimate, earlier admissions are important for hospice profitability

Discharge*

- ONE in FIVE* patients in the US are discharged alive by their hospice agency
- This varies by region, for-profit status and by diagnosis
- Believe it or not, some hospices discharge patients when their care becomes costly
  - Chapter 9, Section 20.2.3 says this is a BIG No-No- and OIG/CMS is looking for these "Costly transitions"

Teno JM, Plotzke M, Gozalo P, Mor V. A national study of live discharges from hospice. J Palliat Med. 2014 Oct;17(10):1121-7. doi: 10.1089/jpm.2013.0595. Epub 2014 Aug 7. PM

What is your live discharge rate?

Discharge

- Most common reasons for discharge:
  - No longer terminally ill
  - Moved out of service area
  - Family and patient behavior is disruptive, abusive, unsafe or uncooperative to the extent that the ability to deliver the plan of care safely is compromised

Regulatory Common Denominator*

- All live discharges by the agency (not revocation by patient/family) must have a physician's order
- "Discharge order: Prior to discharging a patient for any reason other than a patient revocation, transfer, or death, the hospice must obtain a written physician's discharge order from the hospice medical director. If a patient has an attending physician involved in his or her care, this physician should be consulted before discharge and his or her review and decision included in the discharge note."

No Longer Terminal

- When the patient seems to have stabilized to the point where death within 6 months (from today) is no longer likely or clinically evident
- This is often not met with the joy one might expect regarding prolonged prognosis
- It is not advisable to retain a non-terminal patient because "we are all they have" or decline is anticipated after discharge

No Longer Terminal

- Improvement and the expectation-setting for discharge should begin as soon as the hospice team begins discussing it
- Long lengths of stay for terminal patients should not trigger discharge
- "Discharge planning" for non-terminal patients is not covered—watch how you document!

No Longer Terminal

- Obtain an order from your hospice physician, and involve the attending physician
- Create and review a discharge plan with the patient and family

Notice of Medicare Non-Coverage

- The hospice must give the patient 2 days advance notice, and provide documentation of this notice
- The family can appeal the hospice's decision to discharge by submitting a request to the local Quality Improvement Organization (QIO) before noon on the day the care is scheduled to end.

Notice of Medicare Non-Coverage

- The QIO should provide a response within 2 days
- The hospice must continue to provide care during the appeal process
- If the QIO upholds the discharge decision, the hospice may bill the family for care on those days
- If the QIO does not agree, the hospice must continue care

Discharge for Cause

- Hospice should not knowingly participate in a Plan of Care that is unsafe
  - Unsafe wandering
  - Smoking with oxygen
  - Drug diversion
  - Illegal activity
  - Violence and threats
  - What else?

Discharge for Cause*

- Advise (warn) the patient and family, and explain the reasons
- Make efforts to resolve the problems and document those efforts and the patient and families response
- If discharge does occur, notify the MAC within 5 calendar days of discharge (NOTR)
- Do NOT provide the NOMNC (provides an appeal right)

What Chapter 9 Says*

- 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; and
- Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into the patient's medical records.
- The hospice must notify the Medicare contractor and State Survey Agency of the circumstances surrounding the impending discharge. The hospice may also need to make referrals to other relevant state/community agencies (i.e., Adult Protective Services) as appropriate.

Medicare Benefit Policy Manual, Ch 9, Section 20.2.3

Readmission

- If the patient is subsequently admitted to another hospice or your hospice, they will automatically enter another benefit period

Moved out of Service Area

- If the patient moves to a location outside of hospice agency's service area
  - May also consider transfer
- If the patient goes to an non-contracted facility that is within the hospice's service area

Metrics

- Track your own live discharge rate against PEPPER data, local benchmarks and your own history
- Variances and outliers can mean:
  - Admitting people that are not terminal
  - Discharge of patients that are terminal
  - Poor understanding of evidence of terminal prognosis.

Big Questions*

- Will Medicare guarantee payment for a patient that the hospice retains because the QIO says they have to?
  - Billing code
- Is a safe household in an "unsafe" neighborhood cause for discharge?

Revocation

- A patient and family can revoke the hospice benefit at any time, for any reason, just by signing a form
- No verbal revocations, no back-dating
- Common reasons:
  - Decision to pursue curative care
  - Skilled admission to a nursing facility following hospitalization
    - Hospice may advocate to family that SNF rehab focus may be the complete opposite of a palliative approach that had been chosen.

Revocation

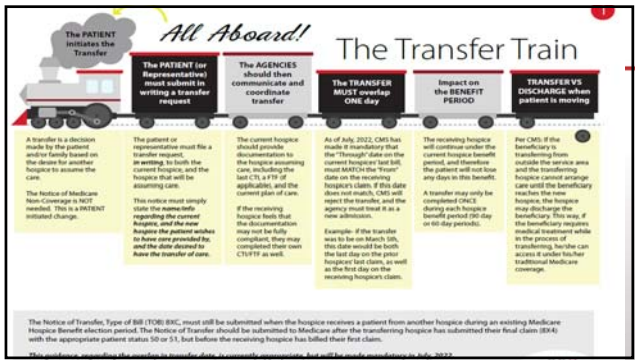
- There is no need to provide an Advance Beneficiary Notice or Notice of Medicare Non-Coverage; they are breaking up with you
- Revocations may flag service issues or deficits in explaining the benefit and prognosis to patients and families. Track revocations and the reason for each with detail and attention

Keeping in Touch

- Discharges and revocations can be followed up with check-in calls on a periodic basis
- If they do come back to hospice care, you want it to be your hospice!

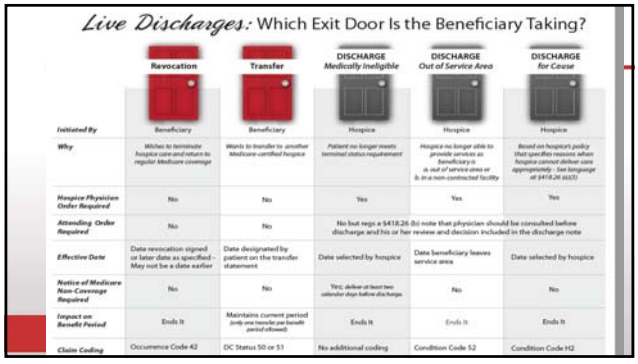
Transfer*

- Patients can transfer to another hospice if they leave your service area, or to a competitor
- No change of benefit period, unless……..
  - If for some reason they transfer a second time in the same benefit period, the second time would need to be a revocation and readmission
- This affects whether or not a face-to-face visit is due since a readmission may put the patient in a later benefit period
- MUST end/begin care on SAME DAY
- No need for a NOMNC



Big Question*

- On transfers, what happens when there are emergencies enroute?
  - May be another reason it is prudent to suggest a discharge/clean admission



Questions????

To Contact Us

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