Discharging Patients:
Assessment, Documentation, and Communication

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What You Will Learn

- Identify “practice gaps” with respect to discharge from hospice care
- Clearly differentiate between discharge and revocation
- Discuss the discharge planning process
- Describe a compliant, compassionate process for discharge, that takes IDG team members’ perspectives into consideration
- Identify the importance of noting discharge trends as part of the organization’s QAPI program and identifying organizational needs with respect to discharge
Important Reminder

- Today’s material is specific to the content of the Medicare Hospice Benefit
- Each state has its own licensing rules — you need to review and follow the more stringent of the rules

An HMB Admission Requires A “Yes” from Two Parties

Hospice Makes the Decision to Admit

Beneficiary Makes the Decision to Elect

Yes #1 + Yes #2 = Admission
An HMB Discharge or Revocation Only Requires One “Yes”

Hospice Makes the Decision to Discharge

OR

Beneficiary Makes the Decision to Revoke

= End of Care

What’s the Difference?

Discharge versus Revocation
The Fundamental Difference

- Who initiates the action
  - The hospice provider can **discharge** the patient only for limited reasons
  - The patient can **revoke** the benefit at any time and for any reason

- Regardless of the route, the beneficiary's end result is the same
  - No longer receiving services under the Hospice Medicare Benefit
  - Full Medicare coverage for terminal diagnosis restored

Live Discharges

- **Discharge**: Hospice takes action to cause patient not to receive benefit
- **Revocation**: Patient choice to give up benefit
Revocations

- The beneficiary or his/her representative has the right to revoke the Hospice Medicare Benefit at any time and for any reason.
- Must sign and date a written revocation.
- No retroactive revocations.
- No revocation by action.

The Written Revocation  §418.28

- To revoke the election of hospice care, the individual or representative must file a statement with the hospice that includes the following information:
  - A signed statement that the individual or representative revokes the individual's election for Medicare coverage of hospice care for the remainder of that election period.
  - The date that the revocation is to be effective.
    - An individual or representative may not designate an effective date earlier than the date that the revocation is made.
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*

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**Terminology**

A hospice may never “revoke a patient” and should strike the phrase from its vocabulary

**IMMEDIATELY!!!**
§ 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

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“‘We’re not quite there yet, are we?’
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.

Medicare Benefit Policy Manual Chapter 9

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.
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 – does not mean that attending must agree

- 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
  - other services
418.26 – Discharge from Hospice Care
No Longer Terminally Ill

- The hospice determines that the patient is no longer terminally ill
  - Hospice issues Notice of Medicare Provider Non-Coverage/Generic Notice no less than 48 hours before discharge
  - Notice of Medicare Provider Non-Coverage/Generic Notice gives the beneficiary right to an expedited determination appeal through a QIO
  - Hospice must obtain a patient signature when the hospice makes the determination that a Medicare patient is no longer eligible for hospice and will be discharged

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
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.

Each hospice must formulate its own discharge policy and apply it equally to all patients.

Must determine the meaning of “patient’s (or other persons in the patient’s home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired.”
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

Increased Scrutiny Coming

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

Why might that be?
What Are the 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 IDT and the attending physician are involved in any each step of the process
- True attempts to solve the problem are made

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
For every complex problem, there is a solution that is simple, neat, and wrong

H.L. Mencken
(1880 – 1956)

Managing Live Discharges

The Discharge Process
### NHPCO National Hospice Summary

<table>
<thead>
<tr>
<th>Live Discharges (includes live discharges, revocations, transfers)</th>
<th>2007 Mean</th>
<th>2008 Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non death discharges as a % of Total Discharges</td>
<td>15.9%</td>
<td>18.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reasons for Non-death Discharges</th>
<th>% of Total</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice initiated discharge</td>
<td>47%</td>
<td>52.8%</td>
</tr>
<tr>
<td>Patient – initiated discharge</td>
<td>49%</td>
<td>47.2%</td>
</tr>
<tr>
<td>Other reason unknown</td>
<td>4%</td>
<td></td>
</tr>
</tbody>
</table>

### Revocations

- Think of revocation as a service delivery failure—what can the IDG do to reduce revocations
  - You have promised to work with the patient and family through the end of life
- 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
Revocations

- Hospitalizations in non-contracted hospital
  - During the election of benefit 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
  - 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
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

○ 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

- Should not happen
- How to prevent
  - When you have a current patient who needs to be placed in a NF, you should provide the patient/family with a list of those contracted NFs
  - Assure continuity of care for the patient and family by placement in a contracted NF

Unplanned Hospital Admissions
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
  - Contracted hospital (Medicare certified)
  - Contracted skilled nursing facility (Medicare certified)
  - Hospice inpatient facility (Medicare certified)
- Facility must have RN 24 hours/day

Unplanned Hospital Admissions

- Patient rights
  - Receive effective pain management and symptom control from the hospice for conditions related to the terminal illness
  - Receive information about the services covered under the hospice benefit
  - Receive information about the scope of services that the hospice will provide and specific limitations on those services
- Comprehensive assessment
- Plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions
Unplanned Hospital Admissions

- Handling hospital admissions that the hospice finds out about after the fact
  - Unrelated to terminal diagnosis
  - Related to terminal diagnosis
    - Contracted hospital
    - Non-contracted hospital

Because the crystal ball has yet to be perfected…
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 the on-call activity

- Work with the hospital to see what can be done during the hospital admission process to identify hospice patients

Discharge

- No longer terminally ill
  - Population-based Palliative Care Research Network (PoPCRN) Discharge Follow-Up Study 7/00-12/01
    - 1/3 died within 6 months of discharge
  - Patients who are discharged should be evaluated frequently especially within the first weeks to months following discharge
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

Analyzing Discharge Data

- 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
Analyzing Discharge Data

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

Performance Improvement Projects

- Consider a live discharge PIP
  - High risk
  - High volume
  - Problem prone
  - Prevalence
  - Affect patient care and safety
Potential Outcome Measures

- Unplanned hospitalizations will be reduced by ___% in the next 3 months
- Hospitalizations in non-contracted hospitals will be reduced by ___% over the next 2 months
- Revocations due to service failure will be reduced by ____% over the next 2 months

Potential PIP Results

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

Resources

CMS Hospice Center
  - Hospice Care Amendments (CMS-1022-F) (issued November 22, 2005)
  - Conditions of Participation Hospice
  - Medicare Benefit Policy Manual; Chapter 9 - Coverage of Hospice Services
- MACs
- NHPCO Regulatory & Compliance Assistance
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