Are There Hospice Patients Living in Your Home Health Agency?

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Executive Leadership Summer Series: Clinical Model Management, Part II

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Executive Leadership Series

Part I. Organizational Structure Matters:
Learning How to Support Your Changing Model of Care (June 28th)

Part II. From Home Health to Hospice: Care Management Along the Continuum (July 10th)

Part III. Having the End of Life Conversation: Practical Concepts for Advocacy within the Continuum of Care (July 24th)

Objectives

• Understand the context for needed change within an evolving healthcare delivery system;

• Identify executive leadership’s responsibility for clinical modeling within their organization: form follows function;

• Discuss methodology to support continuous process improvement within the clinical model/care management; and

• Discuss how leaders can optimize advocacy while supporting smart business strategy.
Home Health Future Challenges
Reimbursement decreasing as cost of doing business increases:
• 2012 Home Health PPS – Proposed payment changes
  ✔ 1.3% reduction of rates in CY2013
Quality counts
• Home Health Compare – what is your ACH rate?
• How satisfied are your patients?
• How well do you understand and work toward meeting the needs of the healthcare system?
• How well do you understand and work toward meeting the human needs of those you serve?

Hospice Future Challenges
Reimbursement challenged as cost of doing business increases:
• 7 year phase out of the Budget Neutrality Adjustment Factor (BNAF) – key element in Medicare Hospice Wage Index calculation
• 2010 Patient Protection Affordable Care Act – additional changes to rate formula further cut rate payments by ~11.8% over next 10 years
• U-Shaped reimbursement potential
• Challenges to inappropriate length of stay
Quality counts
• Quality measure data gathering continues under revisions

Healthcare Delivery System Challenges
• Spend more than 50% more per capita than any other developed country, (number 1 in business): quality ranks 37th in the world.
• Challenges to traditional acute care as historical “Revenue” shifts to “Expense”.
• Healthcare reform initiatives will penalize poor outcomes, provoking more effective chronic disease management; including recognition of and effective care for people at end of life.
Persont-Centered Care

- **Partnering** with individuals impacted by illness and their caregivers in management of disease.
- Empowering individuals with educated choices.
- Providing individuals with the tools they need to effectively manage disease process, with assistance as needed and indicated.

The Human Context for Change

- The work of being sick is high.
- Chronic disease dominates healthcare demands.
- The challenges of managing complex and co-morbid disease often manifest in referrals to skilled intermittent home health.
- Home Health leaders too often take for granted the ability of their clinicians to figure out how to handle the complexity; especially when illness progresses toward end of life.
- Patients and Caregivers get attached; sometimes to the detriment of the soul who is sick.

Respect for an Individual's Value System Must Dominate These Concepts

- We must be aware of intersecting value systems and not impose our value system on the patient and/or their caregivers.
None of us Get Out of Here Alive

If the home health clinician cannot identify patients approaching end of life, detriment to both patient and agency may occur:

- Increased pain and suffering to patient
- Increased stress to family members and caregivers
- Increased cost to the agency to manage complex care
- Increased hospitalization and cost to the health system

Red flags of denial, entrenched value systems, disease state ignorance and or poor understanding of ‘what to do’ are prevalent in practice.

Pay Attention to Your Continuum

RED Flags

- Loose care management model
- No process to identify goal directed care in HH
- Transfer of the actively dying person from HH to Hospice
- Low Median LOS in HH and Hospice continuum
- Re-hospitalized HH patients discharged to the care of Hospice

Got Red Flags?

Does your agency have a process for best practice Care Management, which will:

- Identify what our patient’s objectives are?
- Identify what our clinicians’ perception of the realistic/optimal outcome of care will be and ‘pressure test’ it?
- Align a plan of treatment to advocate for the patient's goals and focus every visit on an established and realistic goal?
- Provide resource to clinicians to learn to more effectively prognosticate, communicate and plan?
- Partner effectively with physicians in advocacy for effective care at end of life?
If Not, Why Not?

Care Management form and function will be increasingly important as we work to:
- Optimize outcomes
- Save money, lose waste
- Compete
- Advocate for a growth population of need
- Enhance transition to advanced illness, palliative care and hospice programs
- Adapt home health and hospice to meet the needs of future healthcare models (ACO's, bundled payment, etc)

Other Barriers to Effective Transition to End of Life Care

- Communication patterns, culturally comfortable.
  HAVING THE END OF LIFE CONVERSATION
- Attachment to clinicians; how have we prepared our staff or product line for this predictable pattern? Palliative Care programs are not exempt from problems with transition to hospice!
- Recognition of the right to have an advanced directive; it is the law; how do your clinicians identify and integrate advanced directives into treatment plans.

Optimism Can Cloud Reality and Reduce Advocacy

- Physicians overly optimistic by 530% - our own experience indicates that they are not alone.
  *British Medical Journal; Extent and Determinants of Error in Doctors Prognoses in Terminally Ill Patients; Prospective Cohort Study, Vol. 320(7233), 19 Feb 2000 pp.469-475*
- How do we set treatment objectives if not tied to reality?
  - How do misguided treatment decisions and care plans prepare patients and their families for inevitable outcomes?
  - This denial comes at a cost.
Palliative Care Bridge
Advanced Illness Management

- Evolving programs
- Payer – specific expertise impact agency financial and outcome performance
- Sometimes an effective bridge
- Sometimes another silo; working around ineffective transition to end of life care

It’s About Advocacy

“The continued application of traditional treatment strategies which are valuable to the patient at an earlier time in their health experience has the opposite effect on patients at end of life resulting in inferior outcomes.”

-Daniel Hoefer, MD  Associate Medical Director
Sharp HospiceCare

PROGNOSTICATION

- Use evidence based prognostication to anticipate and plan effective care and transition of care
  - Local Coverage Determination (LCD) for Hospice Determining Terminal Status
    www.cms.gov/medicare-coverage-database/
  - Cardiac Troponin T (Tn T) Serum levels in heart disease
  - Functional Assessment Staging Scale (FAST) for dementia
  - Patient Reported Outcome Mortality Prediction Tool (PROMPT)
  - NHO Non Cancer guidelines
In debate and evolving as treatment options evolve.
These are guidelines to minimally increase awareness.
PROGNOSTICATION
Heightened Anticipation to Guide Intuition

- Triggers for awareness:
  - "Would you be surprised if this patient were to die in the next six months?"
  - Is the patient choosing comfort care vs. disease intervention? Is the focus on quality of life vs. prolonging the life?
  - What are the clinical indicators of disease state?
    - Cancer?
    - Organ Failure?
    - Frail elderly/dementia?
    - Nutritional compromise?

Track and Trend by Practitioner and Product Line

- Look for workarounds to discomfort with end of life; or ease and comfort of status quo which does not serve...
- Be wary of falling prey to a new silo in which patients can, against the goals of the program, get 'stuck' along the continuum:
  - How Palliative Care Bridge programs can serve or hinder timely transition into end of life care
  - A bridge is good, if it is going somewhere

Position Yourself Optimally in the Marketplace

Provide Continuum Solutions to Healthcare Delivery Challenges
Evaluate the Business Opportunity and Impact of Effective End of Life Care

- Accountable Care Organizations (ACOs): Work together, lower costs and improve quality.
- Bundled Payments: One payment to cover the services for the patient across health sectors.
- Value Based Contracting: Rewards and penalties.
- Patient Centered Medical Home Program: Physician manages cases and share in savings. More patient focus.
- Care Transition Programs: Improve quality and improve patient experience during transitions of care...Chronic care or all patient focus.

Leadership Responsibility

- Be aware of ‘red flags’
- Create a more effective Care Management Process
- Within Care Management, pressure test objectives of care provision: realistic, aligned with patient goals?
- Empower Care Management within Organizational Structure
- Provide case specific education to enlighten and empower proactive intervention at end of life.
- Monitor for trends of ‘silo-stick’ by practitioner or service line
- Build tools for home care clinicians, as well as referral sources, to better identify the hospice appropriate patient.
- Up the awareness and education around recognition of hospice and palliative care options in liaisons/transitional care coordinators/referral sources/health systems/our practitioners

Within Advocacy Lies Business Opportunity

- As chronic disease management consumes financial resources, the marketplace will look for solutions.
- Anticipate heightened market debate (death-squads).
- Can your agency effectively meet both patient needs and market needs?
- Can your clinicians have confidence that they understand how best to serve patients near end of life?
Refresh Your View of How You Serve

- Visit metrics and concepts with your leadership team.
- Visit concepts and resources with clinical teams.
- Make sure the form of your agency fits optimal function for effective CARE MANAGEMENT, through desired transition to end of life care.

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