# Optimizing Home Health to Hospice Transitions: Leveraging Processes and Technology to Drive the Right Decisions

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# Learning Goals

- Identify the basics of hospice appropriateness
- Learn the benefits of hospice transition for your agency
- Understand how technology can can help to identify patients eligible for hospice
- Demonstrate the ability to discuss goals of care and the benefits of hospice with patients and caregivers

# Maxwell Healthcare Associates (MHA)

- MHA is a team of post-acute industry veterans passionate about helping home health and hospice providers thrive amid healthcare's disruptive environment. Our team boasts an average of 20 years of experience in the industry, allowing MHA to keep a pulse on what's relevant in the industry. We advance care in the home by creating excellent solutions focused on people, process, and technology.

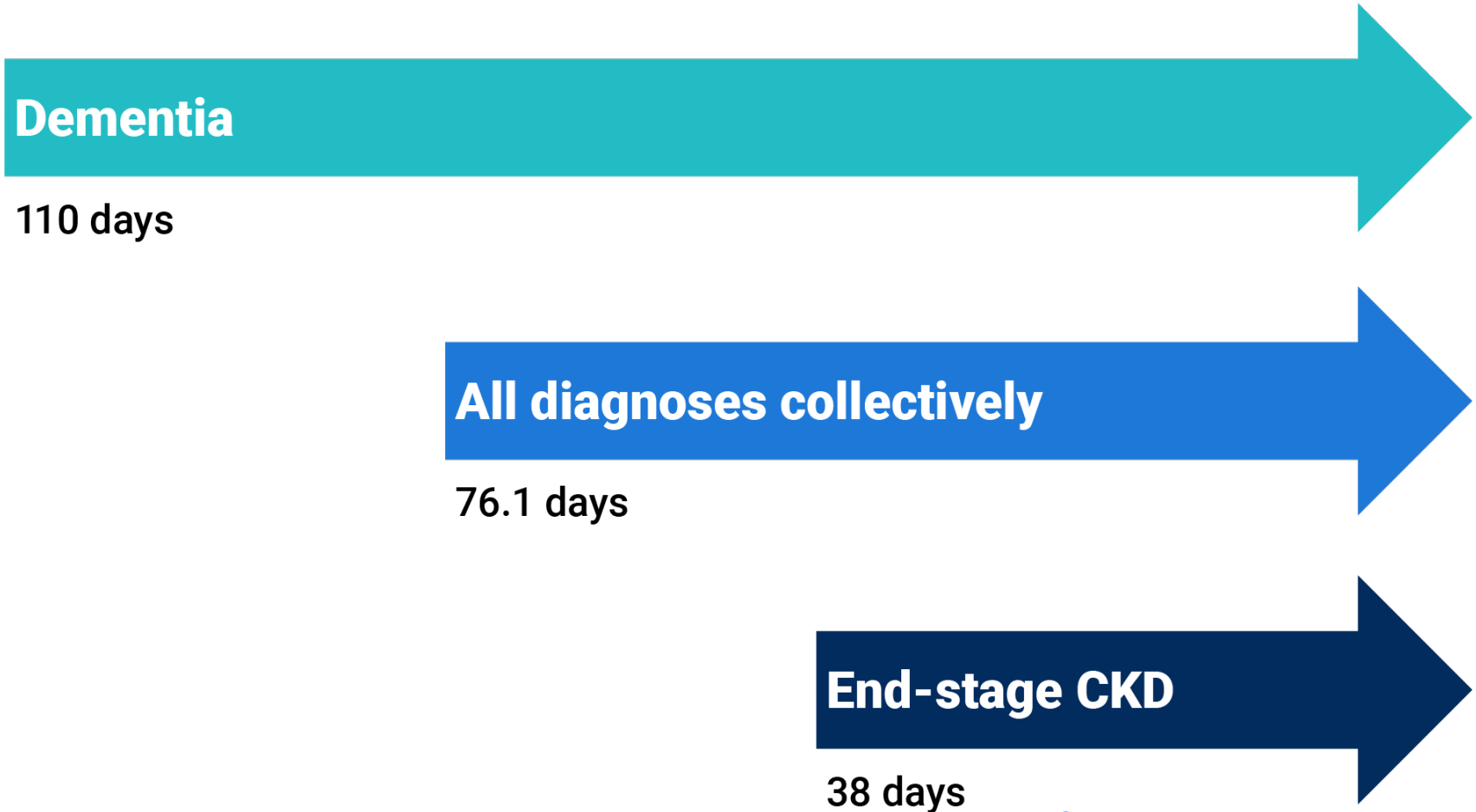
# Chapter 1

## Painting the Picture for Hospice Eligibility

# What Is Hospice?

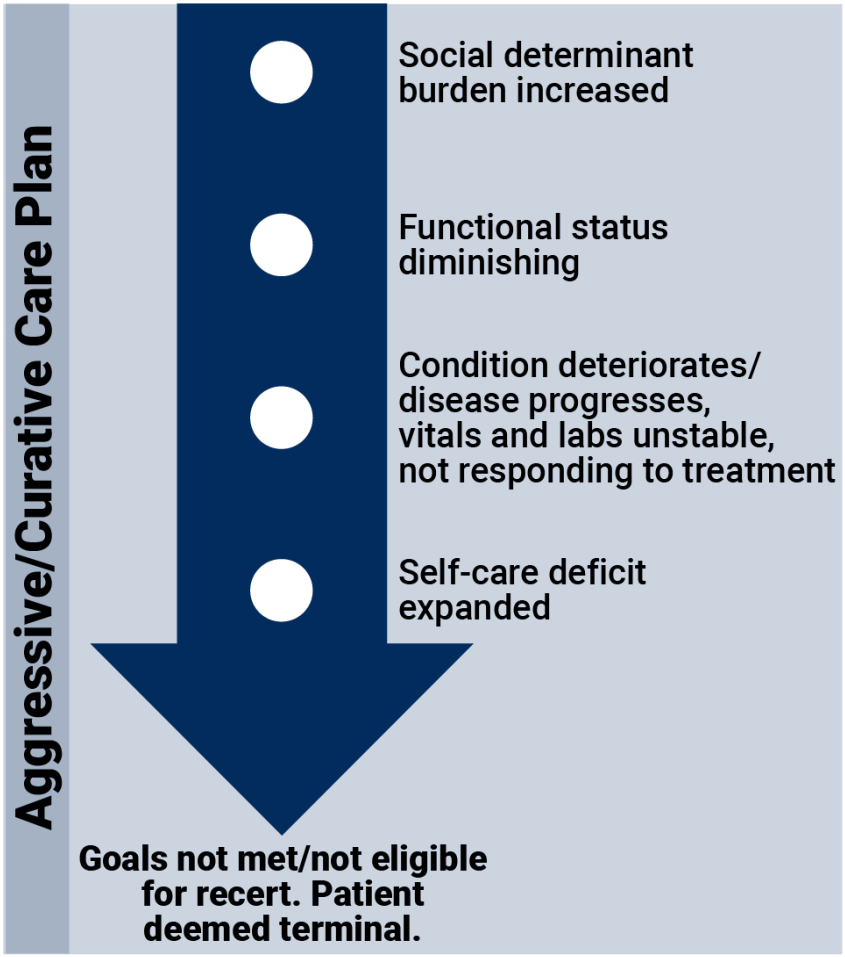
- **Key components**
  - Life expectancy of six months or less, may be recertified
  - Provides four levels of care for appropriate treatment
    - **Routine home care:** private residence or facility
    - **Inpatient:** hospice unit or hospital contract bed
    - **Continuous care:** crisis care in home with nursing
    - **Respite:** relief for caregivers in blocks of days

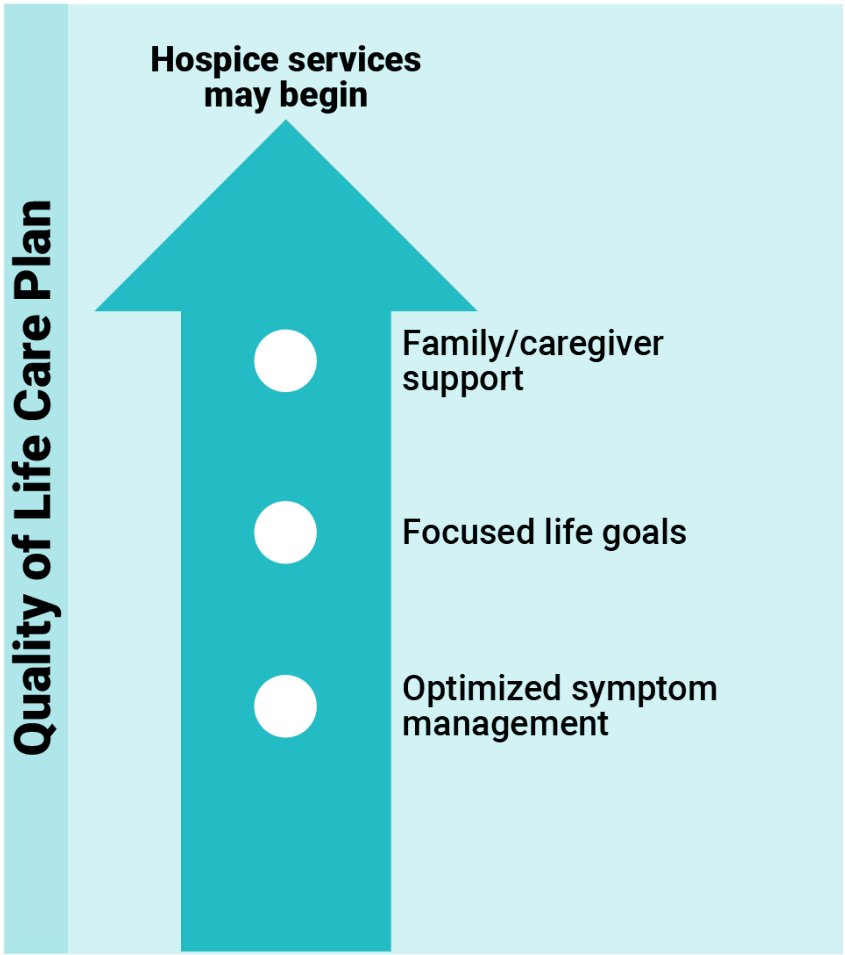
# Hospice Statistics: 2021 Average Length of Stay (ALOS) Examples




Hospice = terminal six months or less, but ALOS often shorter

# The Shift From "Quantity of Life" to "Quality of Life"



# Example: Missoula Vitas Quality of Life Index: Measuring Multiple Factors

| | | |
|---|---|---|
| **Quality of life is a subjective experience. Helping the patient reach a place that is meaningful and transformative is very rewarding.** | **Symptoms** | Experience of the physical discomfort associated with progressive illness; perceived level of physical distress |
| | **Function** | Perceived ability to perform accustomed functions and activities of daily living, experienced in relation to expectations |
| | **Interpersonal** | Degree of investment in personal relationships and the perceived quality of one's relations with family and friends |
| | **Well-being** | Self-assessment of an international condition; subjective sense of emotional "wellness" or "dis-ease"; contentment of lack of contentment with self |
| | **Transcendent** | Experienced degree of connection with an enduring construct; degree of experienced meaning and purpose in life |

Byock et al., 1998

# The Hospice Philosophy

**“Hospice care treats the person rather than the disease, working to manage symptoms so that a person’s last days may be spent with dignity and quality, surrounded by their loved ones. It’s also family-centered—it includes the patient and the family in making decisions.”**

*—Dame Cicely Saunders*

Connor & Stephen, 2007

# Identifying Hospice Appropriateness

- **Decline has been substantiated**
  - Two or more hospitalizations in past six months; doesn't want to return
  - Changes between SOC and ROC/follow-up/recert
- **Medications not effective even when maxing out doses**
- **Debility progressing**
  - Due to chronic disease/comorbidities
  - Self-care/functional deficits not responding to therapy
  - Difficulty managing escalating care needs in the home
- **Symptoms out of control and not easily managed, pain refractory to treatment**

# Identifying Hospice Appropriateness (cont.)

- **Disease progression**
  - Acute event (e.g., stroke) with deficits remaining after day 3
  - Cancer not responding to treatment
  - Chronic Illness declining with diagnostic/lab support
- **Current treatment and goals for home health creating burden/having no efficacy**
- **Stage 3–4 decubitus ulcers not healing**
- **Oxygen in use with dyspnea at rest**
- **Intake diminished and experiencing weight loss of 10% or greater**
- **Serum albumin 2.5 or less**

# Summary

- Hospice eligibility begins at a life expectancy of six months or less
- A comprehensive plan of care provides four levels of care to meet the needs of all who access hospice
- There are typical symptoms that, when combined, paint the picture of potential appropriateness for hospice
- Shifting from the goal of extending the “quantity” of life to treating symptoms for “quality” of the life remaining is an important goal of the hospice care plan

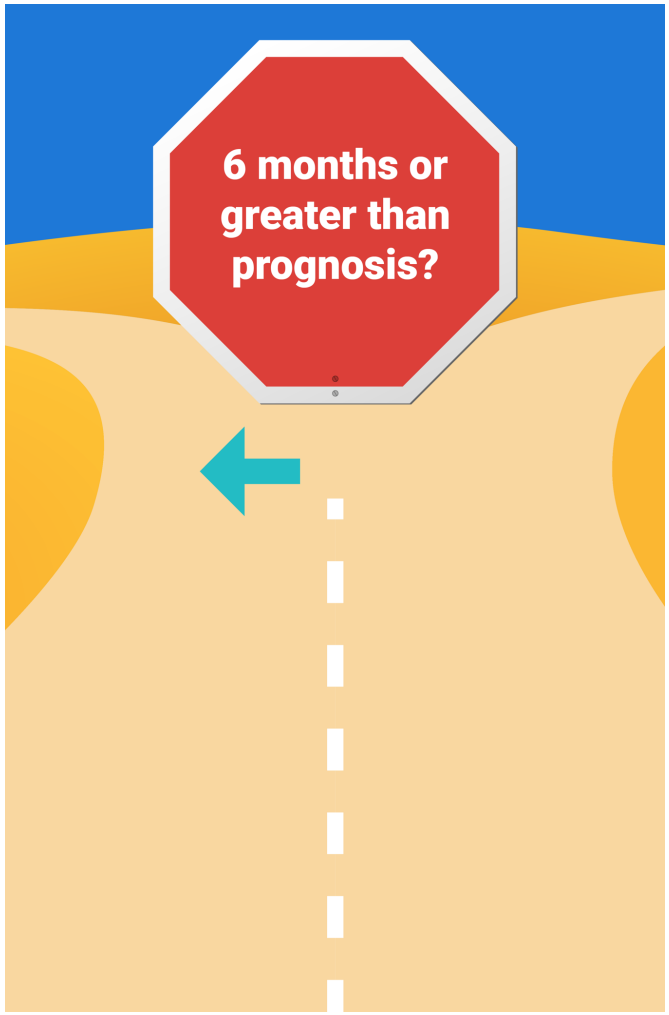
# Chapter 2

## Benefits and Impacts of Hospice

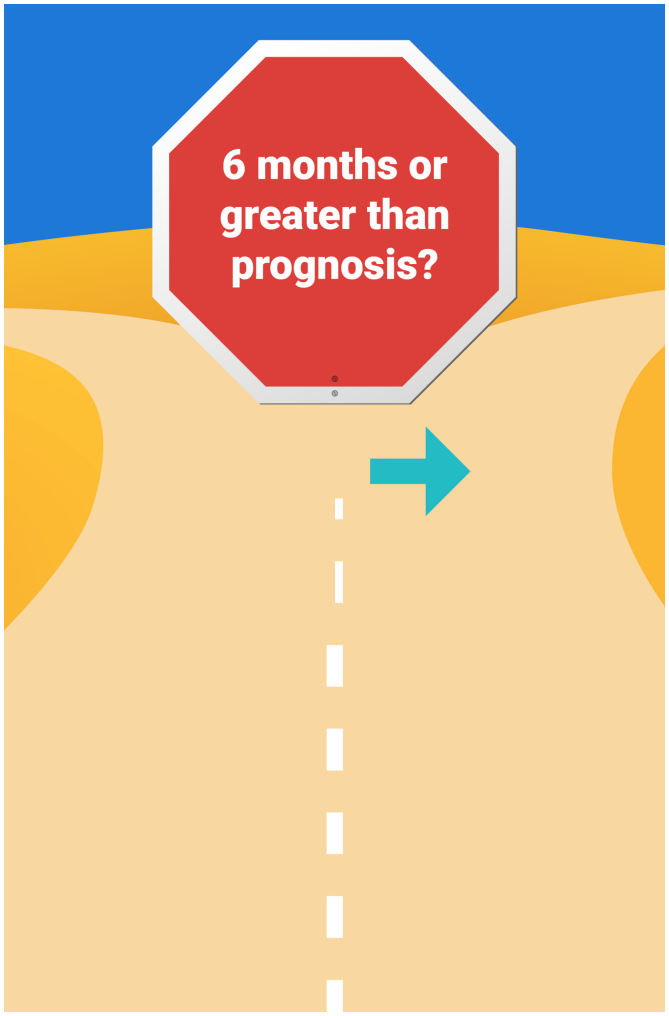
# Referring to Hospice Care When Appropriate Is a Win

## Home health recert or discharge without hospice

- Decline in health, increase in symptoms, exacerbation
- ER/hospitalization likely to recur due to further decline
- Treatments present more burden or are less effective
- Limited support in home
- Homebound rules apply
- Potential caregiver burnout
- Hope diminishing for goal of recovery/ wellness
- Restorative treatments tapering off with poor outcomes
- Coping for patient and caregiver not supported
- Last days spent away from home potentially



# Referring to Hospice Care When Appropriate Is a Win (cont.)




**Discharge to hospice for focused care management**

- Home-based services + crisis care, triage, on-call and physician house visits, inpatient care and respite
- Expertise in symptom-focused treatment, including therapy
- No homebound rules—optimizing life experiences
- Interdisciplinary care for physical/spiritual/psychosocial
- Equipment/medications/services covered by Medicare
- Hope for quality of life
- Grief counseling for family
- Intensity/frequency of care increases with time
- Completion of important affairs and milestones, more quality for longer time

# Benefits for the Patient

- Receive a comprehensive care plan focused on quality of life vs. adding quantity of days
- Care delivered at home
  - With family, friends, and pets surrounding patient
  - All means of treatment can be provided in home vs. acute settings
  - Support for situations and planning unique to end of life
  - Facilitating adjunct therapies (e.g., music, reiki, massage)
- Meaningful milestones made possible with control of symptoms and support
- Bereavement care for family

# Value Add to the Agency

- Comprehensive, customizable, care plan–centered service delivery
- Transitioning appropriate patients to hospice
  - Negates death/decline/poor outcome measures for HH
  - Benefits overall goals of care
  - Provides a solid discharge plan
- Averting clinician burnout
  - Help patient transition to meaningful, achievable goals
  - Changes experience for clinicians caring for some patients suffering without hope of recovery

# Summary

- Early referral to hospice when appropriate can provide more time in comfort for living a meaningful experience
- Home health care is not ideal to support the extra needs of a patient in the final stages of life
- There are benefits to both the patient and the home health agency when a referral to hospice is the right choice
- Quality of life is a subjective experience

# Chapter 3

## Hospice Eligibility and Risk Stratification

# Disease-Specific Criteria Used to Support Hospice Eligibility

- **Cancer**
  - Disease with mets, or progression from earlier stage to mets, with continued decline or treatment ended
- **Alzheimer's dementia: stage 7 FAST**
  - Unable to walk, dress, or bathe without assist; urinary or fecal incontinence; no consistent meaningful verbal communication of six or fewer intelligible words
  - **Plus** at least one medical complication in last 12 months: aspiration pneumonia, pyelonephritis, multiple stage 3–4 ulcers, recurrent fever after antibiotics, inability to maintain sufficient fluid/caloric intake, ≥10% weight loss over six months, serum albumin <2.5 g/dL

# Disease-Specific Criteria Used to Support Hospice Eligibility (cont.)

- **ALS: KPS 50 or more**
  - Tracheostomy refused, invasive ventilation + severe nutritional insufficiency with or without G-tube, and/or evidence of critically impaired respiratory function (FVC <40% predictive +2 or more seated or supine)
  - PLUS two or more of the following: dyspnea at rest, orthopnea, accessory muscle use, paradoxical abdominal motion, RR >20/min, reduced speech, weakened cough, somnolence, confusion, anxiety, nausea
- **HIV**
  - CD4 count <25 cells per microliter or persistent viral load >100k + CNS lymphoma, wasting, various superinfections, leukoencephalopathy, systemic lymphoma, Kaposi sarcoma, toxoplasmosis, kidney failure without dialysis

# Disease-Specific Criteria Used to Support Hospice Eligibility (cont.)

- **Heart disease: need 1, and 2–3 supports**
  1. Failed optimal treatment for heart disease (not on vasodilators due to complications (e.g., hypotension or kidney disease) **OR** patient not a candidate for/has declined surgery
  2. Has CHF (EF ≤20% if available) or angina, meets criteria for New York Heart Association Class IV (inability to carry on any physical activity without increased discomfort)
  3. Treatment-resistant symptomatic supraventricular or ventricular arrhythmias, history of cardiac arrest or resuscitation/unexplained syncope/brain embolism of cardiac origin, concomitant HIV disease

# Disease-Specific Criteria Used to Support Hospice Eligibility (cont.)

- **Pulmonary disease: 1 and 2 needed, 3–5 support**
  1. Severe chronic lung disease with disabling dyspnea at rest, bronchodilators ineffective (<30% predicted value post), decreased function + fatigue + cough **PLUS** progression of end-stage pulmonary disease with ER/hospitalization for pulmonary infections/respiratory failure or increasing home visits
  2. Hypoxemia at rest on room air ($pO_2$ ≤55 mmHg, $O_2$ sats ≤88%, **OR** hypercapnia ($pCO_2$ ≥ 50mmHg)
  3. Right-side heart failure secondary to pulmonary disease
  4. Unintentional progressive weight loss >10% in six months
  5. Resting tachycardia >100/minute

# Disease-Specific Criteria Used to Support Hospice Eligibility (cont.)

- **Liver disease: 1 and 2 should be present, 3 supports**
  1. Both prolonged PT (more than 5 seconds over control of INR >1.5) **AND** serum albumin <2.5 g/dL
  2. **PLUS** one of the following: ascites refractory to treatment or noncompliant, spontaneous bacterial peritonitis, hepatorenal syndrome (elevated creatinine and BUN with oliguria [<400 mL/day] and urine sodium concentration <10 mEq/L); hepatic encephalopathy, refractory to treatment or patient noncompliant
  3. Supporting: progressive malnutrition, muscle wasting with reduced strength/endurance, continued alcoholism, hepatocellular carcinoma, chronic hepatitis B, hepatitis C refractory to interferon

# Disease-Specific Criteria Used to Support Hospice Eligibility (cont.)

- **Stroke**
  - KPS or PPS Performance Scale ≤40%
  - Can't maintain hydration/caloric intake, plus one of the following:
    - Weight loss >10% in past six months or >7.5% in past three months, serum albumin <2.5g/dL, current history of aspiration, not responsive to speech treatment, dysphagia preventing intake without artificial nutrition and hydration
    - Current history/evidence on scan
- **Coma**
  - Abnormal brain stem response/absent verbal response/absent withdrawal response to pain, serum creatinine >1.5mg/dL

# Disease-Specific Criteria Used to Support Hospice Eligibility (cont.)

- **Kidney disease (chronic): 1 + 2 or 3; 4 supports**
  1. Not seeking dialysis or transplant
  2. Creatinine clearance <10 cc/min (<15 diabetic) or <15 (<20 diabetic) with comorbidity of CHF
  3. Serum creatinine >8.0 mg/dL (>6.0 for diabetic)
  4. Symptoms of kidney failure: uremia, oliguria (<40 cc/24 hours), intractable hyperkalemia (>7.0 mEg/L) not responsive to treatment, uremic pericarditis, hepatorenal syndrome, intractable fluid overload not responding to treatment
- **Kidney disease (acute): 1 and either 2, 3, or 4–5 supports**
  1. Not on dialysis or seeking transplant
  2. Creatinine clearance <10 cc/minute (<15 cc/minute for diabetics) or <15 cc/min (<20) with comorbidity of CHF
  3. Serum creatinine >8.0 mg/dL (>6.0 diabetics) with CHF
  4. Estimated glomerular filtration rate (GFR) < 10 ml/min
  5. Comorbid conditions: ventilator, malignancy other organ, chronic lung disease, advance cardiac or liver disease, immunosuppression/AIDS, albumin <3.5 g/dL, platelet count <25,000/microL, DIC, GI bleeding

# How OASIS Can Help Support Your Hunch

## SOC

- Does this patient have a chronic illness that has progressed?
  - Cardiac/circulatory/neurological/ respiratory
- How does the patient present today related to
  - Function: self-care/ambulation/ dressing/toileting/bathing
  - Availability of caregiver
  - Presence of wounds/urinary incontinence/recurrent UTIs (more than three in six months?)
  - Dyspnea at rest and/or with exertion
  - Have they been hospitalized? If so, how many times in the past year and for what?

## Recert/follow-up/discharge

- Has the patient significantly declined in areas above since last OASIS?

| OASIS D | | CORRELATION TO PPS? |
|---|---|---|
| M1021 | PRIMARY DIAGNOSIS | ACTIVITY AND EVIDENCE OF DISEASE |
| M1023 | OTHER DIAGNOSIS | |
| M1028 | ACTIVE DIAGNOSES (PVD / PAD / DIABETES) | |
| M1030 | THERAPIES (IV / PARENTERAL / ENTERAL) | |
| M1033 | ***RISK FOR HOSPITALIZATION (FALLS / UNINTENTIONAL WEIGHT LOSS / MULT. HOSPITALIZATIONS / MENTAL DECLINE / EXHAUSTION / MULTIPLE MEDS / DIFFICULTY COMPLYING | |
| M1100 | LIVING ARRANGEMENTS (CAREGIVER?) | |
| M1242 | PAIN | |
| M1306 | UNHEALED PRESSURE ULCERS | |
| M1400 | DYSPNEA | |
| M1600 | UTI | |
| M1610 | URINARY INCONTINENCE | |
| M1700 | COGNITIVE FUNCTION | LEVEL OF CONSCIOUSNESS |
| M1800 - M1850 | SELF CARE (BATHING / DRESSING / TOILETING) | SELF CARE |
| M1860 | AMBULATION | AMBULATION |
| M1870 | FEEDING OR EATING | INTAKE |

# Technology

- **Equipping clinicians with meaningful tools**
  - "Fifth vital sign"
    - Indicators utilizing data science and AI to risk stratify patients in need
    - Early identification of patients potentially eligible for hospice
    - Catalyst to help minimize clinician burnout
      - Pivoting from failing treatment plan to patient-driven, achievable outcomes
      - Helps transform the patient's end-of-life experience through the clinician's facilitation of hospice care

# Summary

- Certain criteria can help establish hospice eligibility for chronic noncancer diseases
- Many of the factors pointing to hospice eligibility are also contained in the OASIS assessment
- Functional decline is a common element included in both the risk for hospitalization and hospice eligibility
- Technology can provide the insights needed to help identify the right time for hospice

# Chapter 4

## Discussing Hospice

# Questions That Can Help Start the Conversation

- What has the doctor told you about your current condition?
- Over the past year, what about your health has changed?
- How has illness altered the way you live now day to day?
- Do you depend on someone to perform basic tasks like housekeeping, helping you to bathe/dress, pay bills?
- Has your illness affected your relationships?
- Do you question the meaning of what is happening to you?
- What are your goals of care today? This month? This year?
- If something happens, do you want to go back to the hospital?

# Hospice Is About Living Your Best Life

- Well-being can be achieved when wellness cannot
- Control over events and goals can become the focus when there is no control over disease progression
- Important memories can be made while there is time
- Healing is a state of mind and heart
- No one gets a do-over for their final days
- Most people have unfinished business to complete
- The mind and soul need a care plan too
- Loved ones remember the last moments forever
- **Every minute counts**

# The Power of Hospice

- **Hospice care is unique and powerful for the staff as well in helping make important experiences happen**
  - Christmas in July
  - Weddings
  - Bucket list trips
  - Anniversary celebrations
  - Butterfly releases
  - Music therapy
  - Midwives for souls
  - World around the bed

# Summary

- A conversation about hospice can be initiated by asking key questions about current health issues and discussing potential changes in goals for care
- Hospice helps people live their best remaining days
- Important milestones and events can be at the center of the hospice care plan and can be achieved

# Webinar Summary

- Hospice is a wonderfully comprehensive model of care centered on physical, spiritual, and psychosocial needs
- When hospice is referred properly, everybody wins—the patient, the family, and the referring agency
- Begin hospice care while there is still time to focus on treatment for quality and fulfillment of life
- Key questions can help support the patient and the clinician in discussing end-of-life issues

# Bibliography

MedBridge
Optimizing Home Health to Hospice Transitions: Leveraging Processes and Technology to Drive the Right Decisions

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