Improving Operational Efficiency Through Hospice Partnerships

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Joseph Straton, MD MSCE

Objectives

Audience members will be able to:

• Describe specific hospice services and hospice levels of care
• Identify the hospice services that benefit their PACE program
• Identify hospice programs that add value
• Implement steps to create effective PACE-hospice partnerships
Presenter Biography

**Joseph Straton, MD MSCE**
- Medical Director of the Delaware County operations for Mercy LIFE
- Board Certifications: Family Medicine; Hospice & Palliative Medicine
- Hospice Medical Director,
  - Palliative care director, Univ of Penn
  - Medical Director, Penn Wissahickon Hospice
  - VITAS Hospice in Southeastern PA

Presenter Biography

**Molly Crumley, RN, BSN, MBA**
- Director of Operations for two of Mercy LIFE’s centers in Southeast Pennsylvania:
  - Sharon Hill Center
  - Valley View Center
- Prior to Mercy LIFE, worked in clinical and administrative leadership roles in Psychiatry and the Emergency Department for the Mercy Health System
Presentation Overview

In the presentation, we will review, describe, & discuss:
- Services hospices provide
- Specifics of costs for various hospice services
- How to identify which hospice services add value to PACE programs
- How to choose hospice partner(s)
- How to develop and maintain an effective relationship with your hospice partner(s)

Guiding Principle

When is hospice truly beneficial?
- The services provided by the hospice are not sufficiently provided by the PACE program AND
- The services meet a need for the participant and/or caregiver
Hospice: A Package of Services

Identify hospice services that meet PACE program service gaps

What is Hospice?

- There are many general descriptions of hospice, often focusing on the philosophy of hospice
- For our purposes, we find the most beneficial way to think about hospice is:

Hospice is an insurance-defined package of services that are designed to improve comfort for people with a life-expectancy of six months or less
### What Services are Provided by Hospice?

<table>
<thead>
<tr>
<th>Visits at home by</th>
<th>Medications</th>
<th>DME</th>
<th>Physician oversight</th>
<th>24/7 on-call nurse via phone &amp; home visit</th>
<th>Case management</th>
<th>Short-term</th>
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<tr>
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<td>DME</td>
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<td>Case management</td>
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<td>Social work</td>
<td>symptom management</td>
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<td>Chaplain</td>
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<td>Home health aide</td>
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### Hospice Levels of Care

For payment purposes, Medicare defines four Levels of Care for hospice services:

- Routine Home Care (RHC)
- General Inpatient Care (GIP)
- Continuous Home Care (CHC)
- Inpatient Respite Care (IRC)
Payment for Hospice Services

Medicare pays hospice a daily rate* based upon the level of care:

– Routine Home Care (RHC)
  • $190/day for days 1 – 60
  • $150/day for days >= 61

– General Inpatient Care (GIP) $720/day
– Continuous Home Care (CHC) $945/day
– Inpatient Respite Care (IRC) $170/day

*dollar values above are approximate

When Does Hospice Add Value?
When Does Hospice Add Value?

- Substantial overlap between
  - Hospice services, and
  - PACE services

- Thus, answering when hospice adds value is different for people who are or are not enrolled in PACE programs

When Hospice Adds Value in Non-PACE Setting

For people not enrolled in PACE, hospice provides many beneficial services for free:

- Home visits: nursing, social work, chaplaincy, HHA
- Intensive symptom management focus
- Overall IDT case management
- Free medications, free DME
- On-call nursing 24/7
- Bereavement support for caregivers

Hospice adds value: the benefit of added services outweigh anything given up to enroll in hospice
When Hospice Adds Value in PACE Setting

- Hospice costs add up
  - $190/day = $5700/month for RHC
- Added value not as clear because PACE already provides many of services hospice provides

Guiding Principle of when hospice adds value:
- Services provided by hospice are not sufficiently provided by the PACE program
  AND
- The services meet a need the participant and/or caregiver have

Service Comparison: PACE & Hospice - 1

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<thead>
<tr>
<th>Service</th>
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<th>Hospice</th>
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Service Comparison: PACE & Hospice - 2

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<td>Bereavement support for caregivers/family</td>
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<td>13 mos</td>
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Hospice Adds Value for PACE Enrollees at Home (RHC) When…

Increasing these services will decrease participant or caregiver distress:
- Added symptom management expertise
- Home visits by hospice nurse and HHA
- Hospice social work and/or chaplain support
- Home nurse visits will be needed during hours when PACE nurses are not available
What is Hospice General Inpatient Care (GIP)?

- **Short-term** stays in an inpatient setting, designed to **address symptoms** (pain, SOB, agitation, others) that **cannot be effectively addressed in home setting**
- Typically the setting provides around-the-clock nursing and daily physician visits
- Usual duration ~ 3-10 days
- Costs ~$720/day

When Does Hospice Inpatient Care Add Value?

- GIP is cost effective & extremely beneficial:
  - severe symptoms that otherwise would have led to ED visit and/or hospitalization
- When done well:
  - better symptom management
  - more comfortable setting
  - at less cost to PACE program
What is Hospice Continuous Home Care (CHC)

Continuous home care
– **Short-term, in-home** nursing care (RN, LPN) to manage **severe symptoms** that cannot be controlled w/o constant nursing presence.
– 8 or more hours of nursing care/24-hour day. May be supplemented with presence of HHA. >= 51% of time provided by RN or LPN.
– Up to ~$945/day

When Does Hospice CHC Add Value?

• CHC is cost effective & extremely beneficial:
  – severe symptoms that otherwise would have led to ED visit and/or hospitalization
• When done well, can lead to:
  – rapid symptom management at home
  – at less cost to PACE program
What is Hospice Inpatient Respite Care (IPC)

- Hospice respite care:
  - short-term inpatient stay
  - to provide relief for family/caregivers taking care of the individual at home
- Provided in an inpatient setting that has 24-hour nursing
- $170/day

When Inpatient Respite Care (IRC) Adds Value?

- IRC essentially costs the same as RHC
- Adds value when caregiver breakdown would otherwise lead to ED visits or hospitalization

- **Important**: transfer to inpatient setting for caregiver breakdown
  - is covered at the respite rate ($170/day)
  - not the general inpatient care rate ($720/day)
Choosing Your Hospice Partner(s)

Select a hospice partner for the services your program needs to provide effective care at the end of life

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We do need hospice services that supplement ours or cover gaps in our services.

Identify Your Hospice Service Needs

- Identify the services your program needs to supplement for your participants
  - No one-size-fits-all for PACE programs and hospice partners
- Does your program need additional help with:
  - Symptom management expertise?
  - In-home caregiver support?
  - Inpatient setting for symptom management?
  - Continuous care in the home setting?
Interview Potential Hospice Partner(s)

- Meet with the hospice leadership
  - not just the marketing representative
- Educate the hospice leadership:
  - PACE programs & regulations
  - PACE is the insurance company (not Medicare or Medicaid)
  - Services PACE provides participants
  - “We are looking to meet your service gaps/needs, not to replicate services we already provide.”

Interview Potential Hospice Partner(s) - 2

- Interview potential hospice partners
  - determine if and how effectively they can meet your service needs
- If you need general inpatient care (GIP) for aggressive symptom management, ask:
  - Where do you provide this care? Dedicated hospice inpatient unit, scattered beds in a hospital, NH beds
  - Who are the physicians/nurse practitioners who round daily for this care?
Interview Potential Hospice Partner(s) - 3

- If you need continuous care at home (CHC) for aggressive symptom management, please know:
  - CMS requires hospices to be able to provide CHC
  - But few hospices do or have the infrastructure to provide CHC (yet, all will say they can)
- So, if you need continuous care at home, ask:
  - Do you have a dedicated CHC team?
  - How many individuals received CHC in the past month?

Interview Potential Hospice Partner(s) - 4

For other service needs, ask how they are delivered
- 24/7 nurse availability for home visits:
  - How many nurses are available each night/weekend to cover how many patients in what geographic area?
- Bereavement support:
  - What services do you provide? Mailings, phone calls, support groups, individual counseling?
Choosing Your Hospice Partner(s)

• Review with your clinical team how effectively the hospice(s) will meet your program’s and participants’ symptom management and end-of-life care needs
• Choose the hospice that best fits your service needs

Effective Relationships With Your Hospice Partner(s)

Developing and maintaining mutually beneficial relationships
Initial Steps

• Discuss PACE program expectations with hospice leadership
• In-person meeting with PACE and hospice clinical leadership
  – Face-to-face relationships enhance direct communication when problems crop up
• Establish and distribute process for communication from hospice team to PACE IDT
  – e.g. Hospice nurse calls into IDT weekly to provide summary of care for each participant

Finance

PACE finance manager and hospice insurance manager meet
– Ensure that the hospice understands how to process PACE as a private insurance payor
  • Hospice submits billing directly to Medicare/Medicaid = HUGE HASSLE!
    – This will appear to CMS that the participant disenrolled from PACE
  • Hospice must submit billing to PACE program as a private insurer
Quarterly Leadership Meetings

Regularly scheduled meetings with the PACE and hospice leadership. Quarterly works well.

**Hospice attendees**
- Director of operations
- Medical director
- Admissions manager
- Team managers

**PACE attendees**
- Director of operations
- Medical director
- Nurse managers
- Compliance manager

Do not meet with only the hospice marketing liaison. You need the hospice leadership decision-makers at the table.

Quarterly Meeting Agenda

- Introductions
- Review (brief) of participants who received hospice services over the quarter
- Address any process issues
  - Clinical, financial, others
- Identify and discuss areas for improvement
  - Service needs
  - Process or communication improvements
Open Discussion

- Questions, comments, suggestions

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