
HQI
HEALTH QUALITY INNOVATORS
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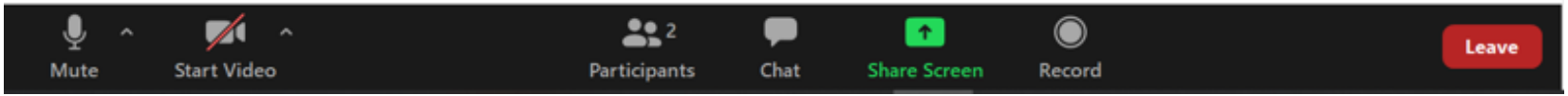
Health Quality Innovation Network

HQIC Office Hours

March 14, 2024

Logistics – Zoom Meeting



To ask questions, click on the **Chat** icon. At the end of the presentation, you will also be able to unmute to ask a question verbally.

You may adjust your audio by clicking the caret next to the **Mute** icon.

Resources from today's session will be shared after the call.

Health Quality Innovation Network

Moving Beyond Mortality: Embracing a Palliative Approach to Quality

Health Quality Innovation Network

Today's Presenter

Ashland Evans, MHA, CHPCA

Interim External Director
Baystate Home Health and Hospice

Moving Beyond Mortality

Embracing a palliative approach to managing hospital quality

Ashland Evans, MHA, CHPCA

Agenda/Outline

Understanding EOL Continuum

- ✓ Define hospice and palliative care
- ✓ Compare and Contrast
- ✓ Clarify common misconceptions

Why is Hospice and PC Important?

- ✓ Value to Patients
- ✓ Value to Clinicians
- ✓ Value to Hospitals

Integration into Hospital Quality

- ✓ Core Measures
- ✓ Public Reporting
- ✓ Reimbursement

Pulse Check

1. Are you a clinician by training/licensure?
    a. Yes, I am a clinician by training and have/currently provide direct patient care.
    b. Yes, I am a clinician by training but not provided direct patient care in more than 5 yrs.
    c. No, but I would play a great one on tv.

2. Have you (or someone you know) had a personal experience with palliative care?
    a. Yes, I was very involved in the care and became aware of palliative care.
    b. Yes, but I was not very involved nor understood their services.
    c. No, I have no personal experiences with palliative care in any setting.

3. Have you (or someone you know) had a personal experience with hospice?
    a. Yes, I had an unbelievably ***positive*** experience with hospice and tell others about it!
    b. Yes, but unfortunately ***not a positive*** experience.
    c. No, I have not had any personal experiences with Hospice.

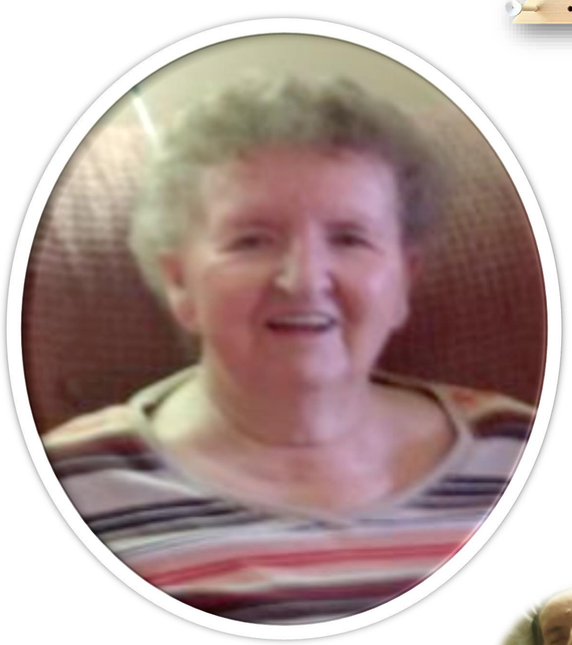
Poll #1

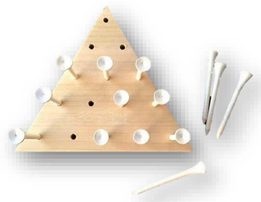
Who is Attending?

Before we begin...

Let me introduce to you to someone

Meet Attaree





Pulse Check

1. Does your hospital currently provide inpatient palliative care consultations?
    a. Yes, we have a dedicated specialty palliative care consultative service
    b. No, we do not currently provide palliative care consultations in my hospital

2. Does your hospital currently provide hospice care to admitted inpatients?
    a. Yes, patients have access to hospice services while in the hospital
    b. No, patients only have access to hospice services upon discharge from the hospital

3. If your hospital currently provides palliative and/or hospice, are these services contracted out to community providers/agencies?
    a. Yes, a community agency and/or provider provides these services and not owned by hospital.
    b. No, these services are owned by the hospital and not contracted out.
    c. Not sure, I know these services are provided but not aware if owned or contracted out.

Poll #3-

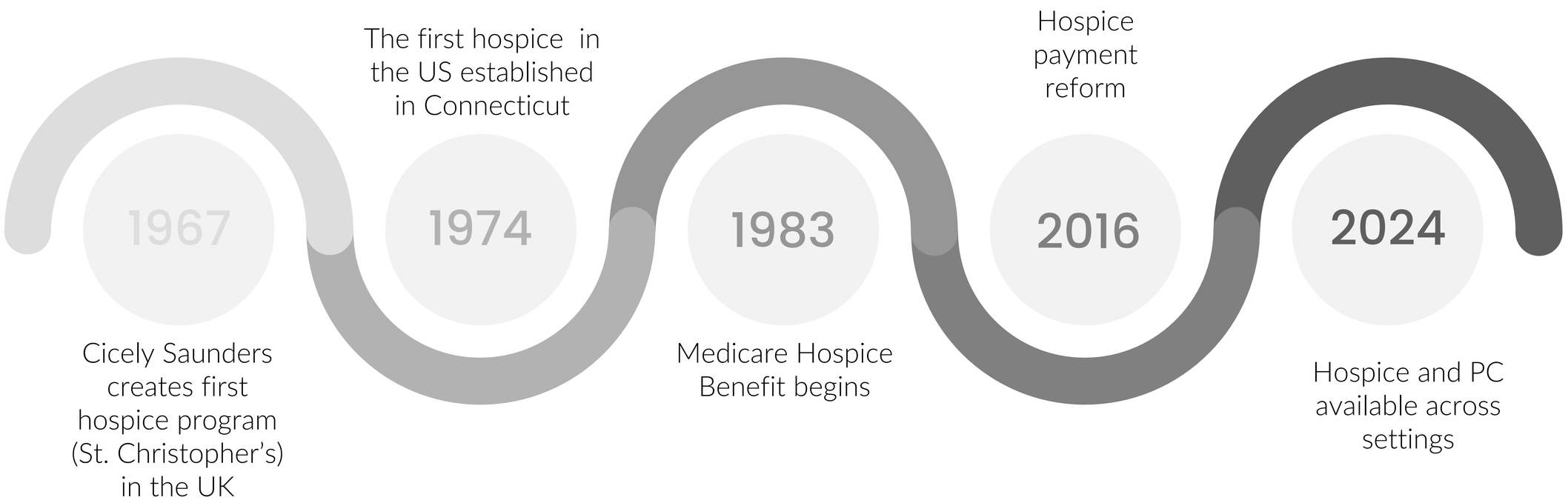
Where is your organization today?

PART ONE:
Understanding the End-of-Life Continuum

An introduction to palliative and hospice care

A Brief History

Palliative Care and Hospice were synonymous until the 1980's when Hospice Benefit began.

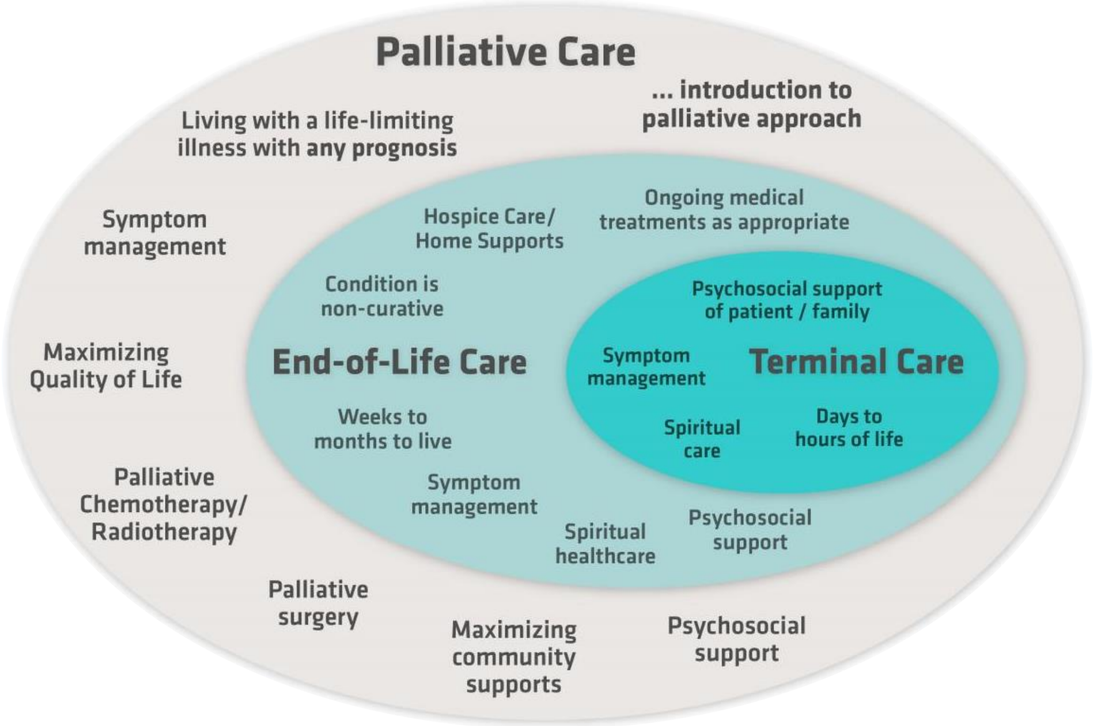


The End-Of-Life Continuum

Terminology can get confusing….

palliate-

to make (a disease or its symptoms) less severe or unpleasant without removing the cause.



Palliative Approach

Philosophy

Generalist/Primary

Years

Palliative Care

Concurrent

Specialists/Consultative

Months to Years

Hospice Care

End of Life/Terminal Care

“Blanket” of support

Days, Weeks, Months

Post-Death

Family & Friends

Individual and group

13+ months post-death

A Palliative Approach

An approach to care that supports the clinical, emotional and spiritual needs of individuals and their families coping with a life-limiting illness, while offering opportunities for meaningful and recurring quality of life conversations.

Advance Care Planning

Serious Illness and Goals of Care Conversations

Pain & Symptom Mgt

Early assessment and mitigation

Emotional, Psychosocial, Spiritual Support

Holistic, Patient-Centered,

Quality of Life

Treatments and interventions aligned to optimize and promote

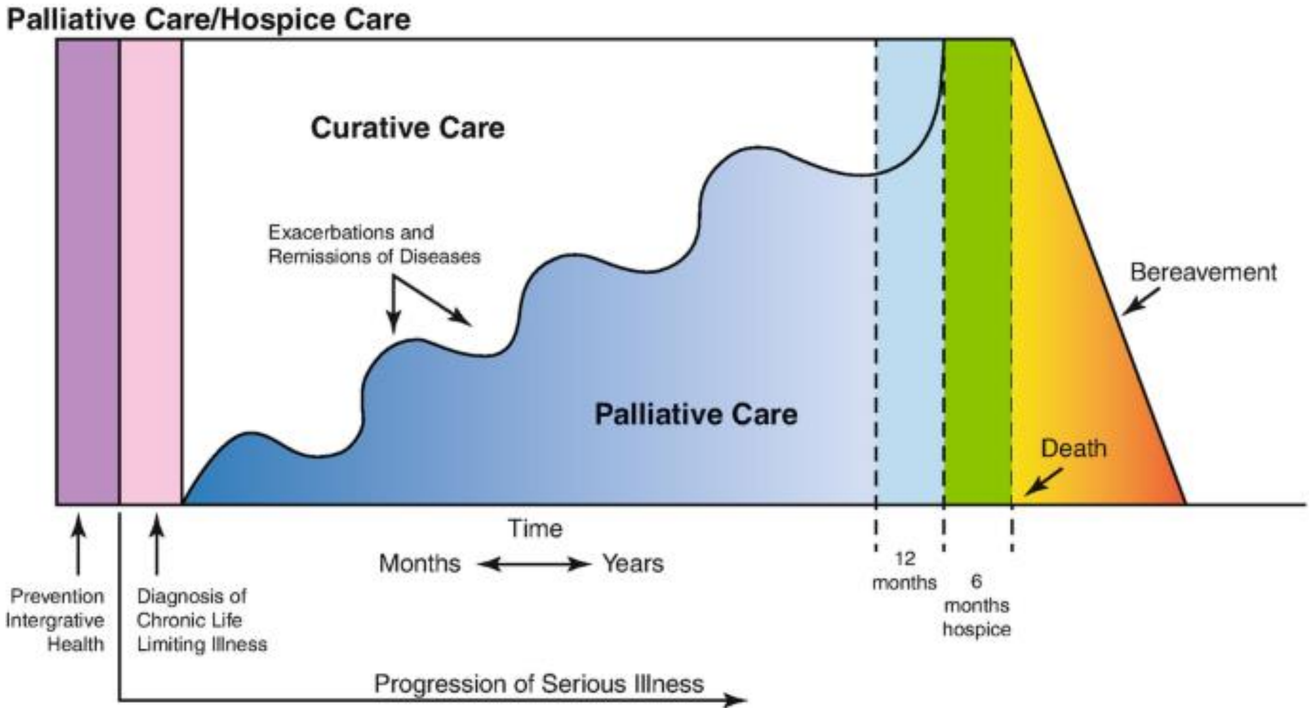
Education

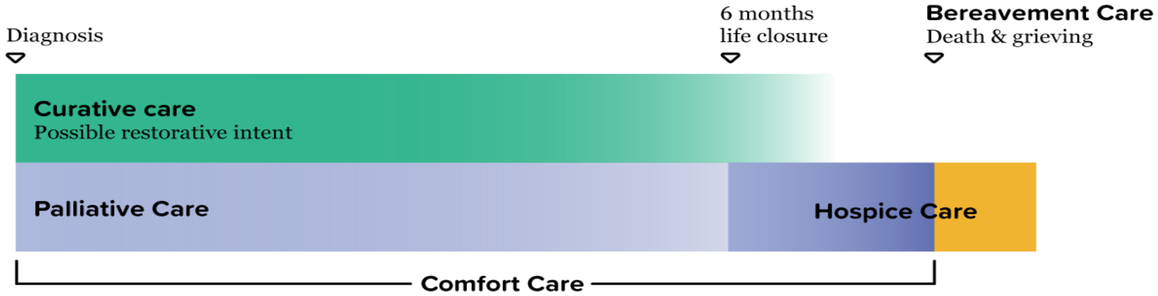
Information on health condition for patients and families

Coordination & Communication

Upstream and timely referrals to support

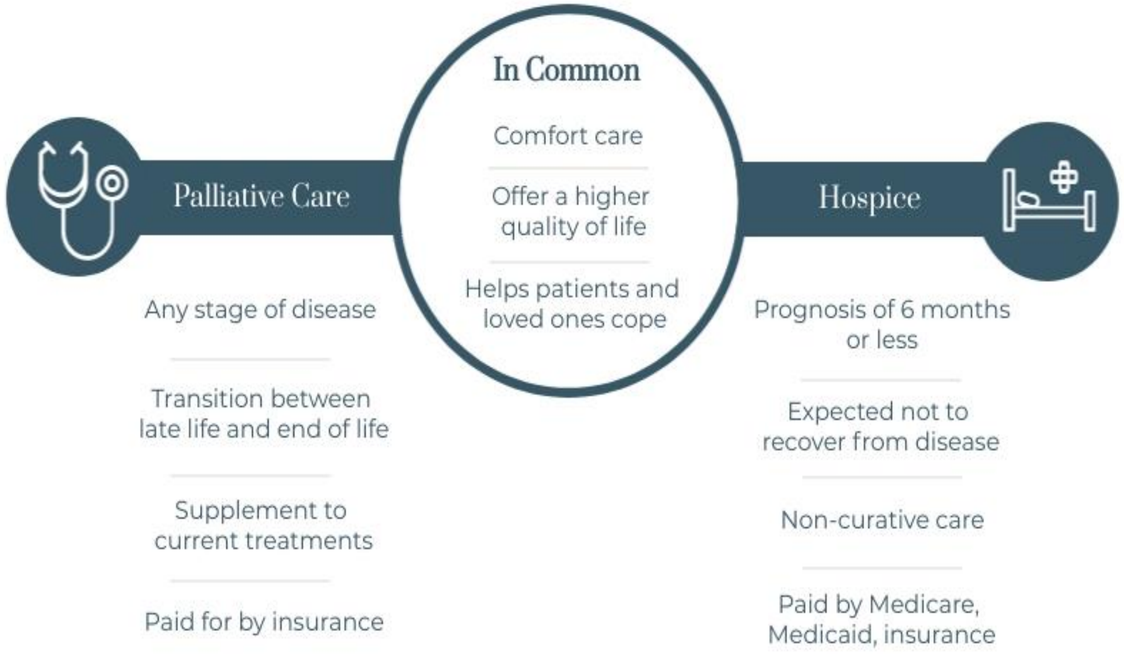
Hospice and Palliative Overview





All palliative care ***is not*** hospice care.

All hospice care ***is*** palliative care.



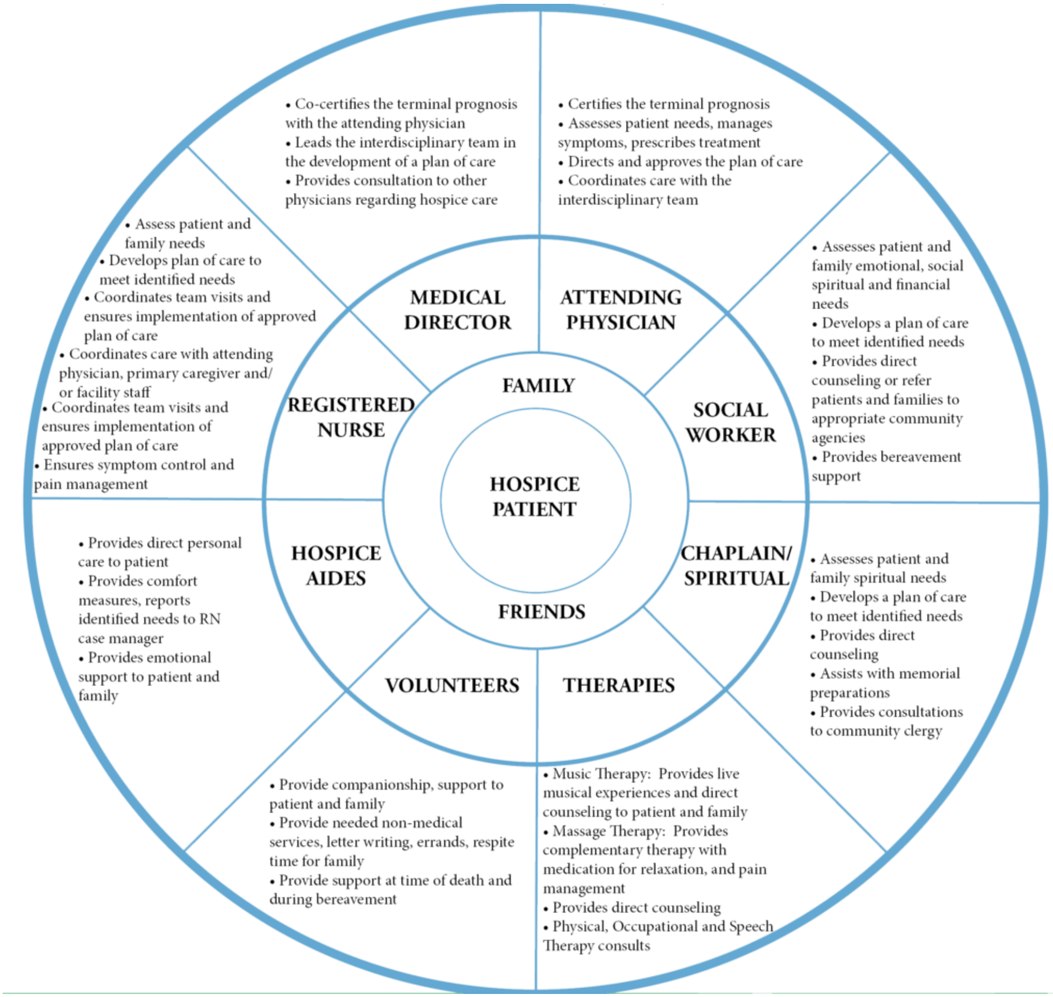
Source:
Goring, T.N., Nelson, I.L. (2022). Care at the End of Life: Palliative and Hospice Care—Symptom Management. In: Sydney, E., Weinstein, E., Rucker, L.M. (eds) Handbook of Outpatient Medicine. Springer, Cham. https://doi.org/10.1007/978-3-031-15353-2_5

A Circle of Care

Team-based care is the backbone of hospice and palliative care

Palliative Care

Hospice



	Palliative Care	Hospice Care
Who can receive this care?	Anyone with a serious illness, regardless of life expectancy, can receive palliative care.	Someone with an illness with a life expectancy measured in months, not years.
Can I continue to receive treatments to cure my illness?	You may receive palliative care and curative care at the same time.	Treatments and medicines aimed at providing comfort and relieving symptoms are provided by hospice.
Does Medicare pay?	Some treatments and medications may be covered just like other medical treatments.	Medicare pays all charges related to hospice including durable medical equipment and medications related to the terminal illness.
Does Medicaid pay?	Some treatments and medications may be covered.	NH Medicaid pays for all charges related to hospice as described above.
Does private insurance pay?	No, there is no 'palliative care' package, the services are flexible and based on the patient's needs.	Most insurance plans have a hospice benefit that covers charges related to durable medical equipment and medications related to the terminal illness.
Is this a package deal?	No, there is no 'palliative care' package, the services are flexible and based on the patient's needs.	Medicare and Medicaid hospice benefits are package deals.
How long can I receive care?	This will depend upon your care needs, and the coverage you have through Medicare, Medicaid or private insurance.	As long as you meet the hospice's criteria of an illness with a life expectancy of months not years.

Pulse Check

Poll #2

True or False:

Common Misconceptions

1. A patient must have a signed *Do Not Resuscitate* (DNR) order before being admitted to hospice.
    a. True
    b. False
2. Patients must stop eating and drinking when they are on hospice or hospice will make them stop.
    a. True
    b. False
3. Hospices typically have more cancer than non-cancer patients
    a. True
    b. False
4. Patients must have a physician referral to be admitted to hospice services.
    a. True
    b. False
5. A patient can live at home alone and still be on hospice.
    a. True
    b. False

Hospice Myth vs. Fact

Myth: Enrolling in hospice means giving up on living.	Fact: Enrolling in hospice is choosing to focus on quality of life and focused care. People enrolled in hospice actually live, on average, 29 days longer.
Myth: To get hospice care, I will have to leave my home for an inpatient facility and give up my primary care doctor.	Fact: Hopsice is not a place, it is a service. 67% of hospice patients receive hospice services in their own homes.
Myth: Hospice care is expensive and my family won't be able to afford it.	Fact: Hopsice is often available at little or no cost to the patient. Hospice is a covered benefit under Medicare and many private insurance companies.
Myth: Hospice care is just for people with a cancer diagnosis.	Fact: Hospice serves people of any age dealing with any life-limiting illness, and is not limited to those with a cancer diagnosis.
Myth: All hospice providers are pretty much the same.	Fact: Hospice providers are independent from one another and can be profit or not-for-profit, providing a wide range of different services.
Myth: If it's time for hospice, my doctor will talk to me about it.	Fact: Many doctors wait for the patient to bring up hospice, leading to late enrollment. Families and patients often wish they had enrolled in hospice earlier.

Sources: Comparing hospice and nonhospice patient survival among patients who die within a three-year window, Journal of Pain Symptom Management. 2007 Mar;33(3):238-46; Quality of Life in Hospice Patients With Terminal Illness, Western Journal of Nursing Research, 2004, 26(1), 113-128; NHPCO's Facts and Figures, Hospice Care in America, 2014 Edition

"Hospice" is a kind of care center for terminally ill patients.

Though it sounds similar to the word "hospital," hospice is actually a type of physically and mentally supportive care for the terminally ill; it is not a building or facility. Hospice care is delivered by medical professionals at whatever location is home to the patient.

Hospice care is only for patients with terminal cancer.

Hospice care can be appropriate for patients with advanced cancers, but it is also for those diagnosed with other chronic, terminal illnesses. Many hospice patients have advanced stages of conditions such as heart and lung disease, kidney disease, Alzheimer's, HIV/AIDS, and neuromuscular disease.

If I choose hospice care for a family member, it will seem as if I'm giving up on him or her

Hospice care is meant to provide comfort, not a cure or treatment; it simply strives to bring peace of mind and body toward the end of a patient's life. Still, it doesn't mean you are giving up on the family member; it shows that you care about his or her state of mind and bodily comfort during a difficult period. Hospice care includes important physical, emotional and spiritual support services for the patient and family. It allows them to prepare together for the end of life, approaching the transition in a peaceful and uplifting way with as little pain and discomfort as possible.

Hospice is too expensive for most people to afford.

Medicare and Medicaid hospice benefits cover 100 percent of the care a patient needs, so there is no cost to the family under those plans. If a patient has private insurance or a managed care plan, the hospice provider can work with the individual and his or her family to understand and handle any out-of-pocket costs there may be. Hospice care generally is less expensive than hospital care, as it does not include the overhead costs of a hospital stay. In hospice care, the patient pays only for the services that he/she or the family cannot provide, and that are not covered by insurance.

A patient must be bedridden to begin receiving hospice care.

Many hospice patients are not bedridden. Hospice care is ordered after a terminal prognosis, regardless of the patient's current physical condition. The patient, family, doctor, and hospice provider work together to decide when it's appropriate for care to start.

Once my family member enters hospice care, he or she no longer will be able to see our regular doctor.

Breeze Hospice places a high value on the collaborative, communicative relationship between the patient and his or her entire care team. The hospice patient's regular doctor is always an integral part of that group.

If my loved one begins hospice care, he or she will no longer be allowed to go to the hospital if needed

Hospice patients can be transferred to the hospital if necessary – for example, in cases of severe pain or other serious discomfort. Medicare hospice benefits cover short-term inpatient care at the hospital if the individual has symptoms that can't be controlled at home.

I can't bring up the subject of hospice care for a family member; the doctor has to do that

The patient does have to receive a physician's order before actual hospice care can begin. But the Breeze team can meet with patients and family members at any time, at their request, to discuss hospice benefits.

Only the doctor can decide which hospice care provider my family member can use.

Your loved one's doctor does have to provide an order for hospice care, and he or she can recommend hospice providers. But the patient and family have the right to decide which to use.

My family has to sign a DNR (Do Not Resuscitate) order before my loved one can get hospice care.

Patients can receive hospice care without a DNR in place.

I should wait until the end to inquire about hospice care for a family member.

Actually, it's a good idea to ask early on about the possibility of hospice care for a loved one. It can make a significant difference in his or her quality of life by managing key issues such as discomfort and pain. Hospice also provides important emotional and spiritual support to help families and patients deal with end-of-life issues in a healthy and positive way.

Hospice care isn't available to people in assisted living facilities.

Hospice care can be provided in any setting that is home to the patient. This can include private residences, nursing facilities, independent living centers, and assisted living residences.

Hospice Levels of Care

R

Routine

- Lowest Acuity;
- Tier 1 (Days 1-60) and Tier 2 (Days 60+);
- Home or ALF/SNF service location

RSP

Respite

- 5 Days
- Caregiver Burnout
- Must be in setting with 24/7 nursing

GIP

General Inpatient

- Hospital service location
- Uncontrolled symptoms in home setting
- 24/7 RN support

CC

Continuous Care

- 8+ hours of direct care in home setting
- Severe and aggressive pain and symptom management
- Short-duration (up to 72 hours)

Hospice in the Hospital (General Inpatient- GIP)

GIP Requirements

- Patients must need 24/7 RN supervision, uncontrollable symptom management.
- Discharge plan if/when stable.
- Avg LOS should not exceed 3-5 days

Reimbursement

- GIP is reimbursed at a very high rate (when compared to Routine and Respite).
- Per diem rate $1k+/day in most geographies.

Regulatory Compliance

- Fraud and abuse due to $$
- Inappropriate use to “*cook the books*”

Inpatient Units (IPUs)

- IPUs are dedicated spaces within inpatient setting.
- Hospice Houses

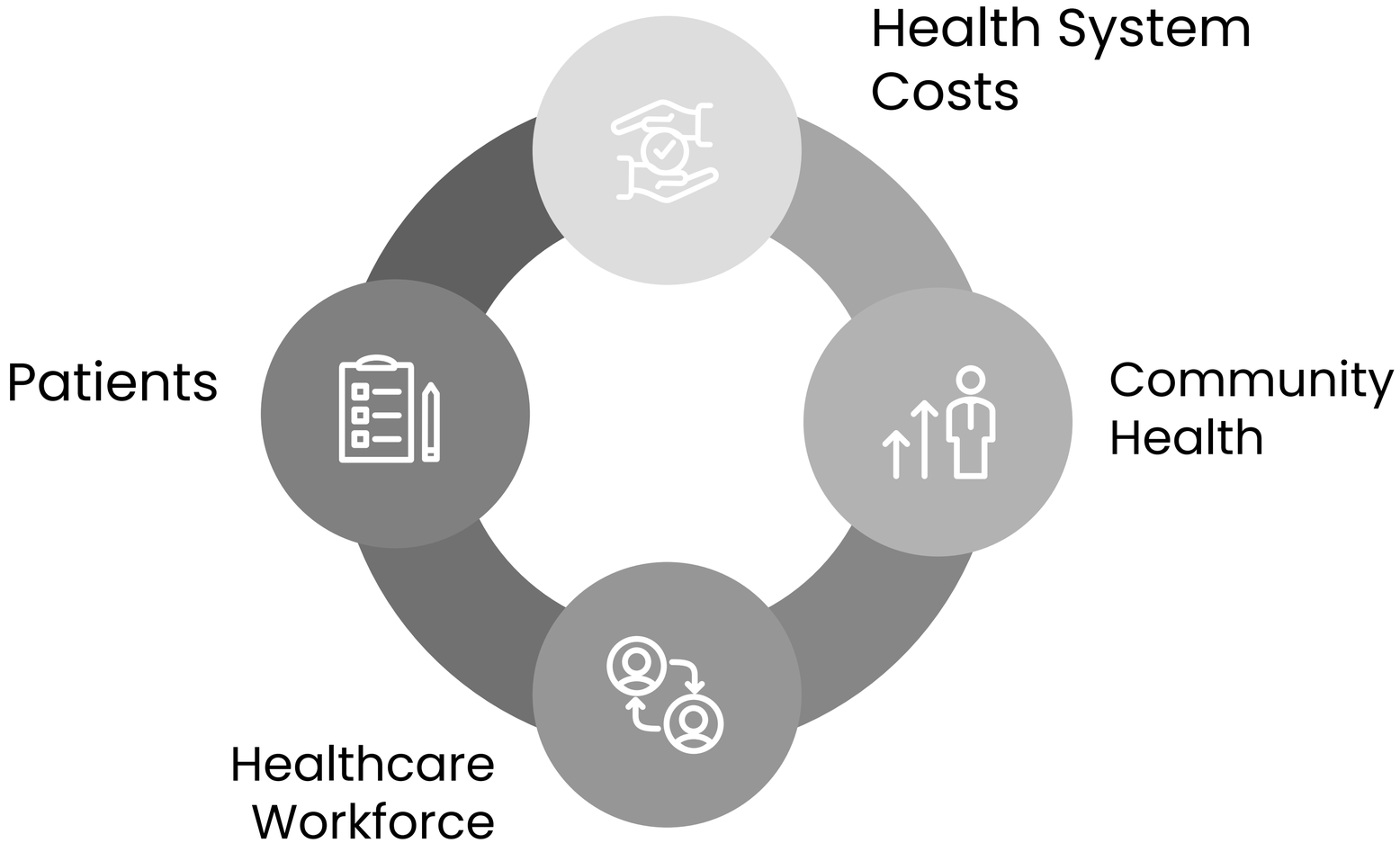
PART TWO:

Why is Hospice and Palliative Care Important?

Value added to patients, clinicians, and the health system has been proven

“A Quadruple Reasons”

The Quadruple Aim of Healthcare



PART THREE:

A Palliative Approach to Hospital Quality

It extends well beyond mortality rates…

Quality: A Common Thread

Quality Management is very similar across settings, including hospitals and hospices.

CMS Core Measures

-Mortality, Readmissions, etc.
-Public Reporting,

Reimbursement

Value-based care and alternative payment models

Public Reporting

Medicare Care Compare
HQRP- (HCI, HIS, HVLDL)

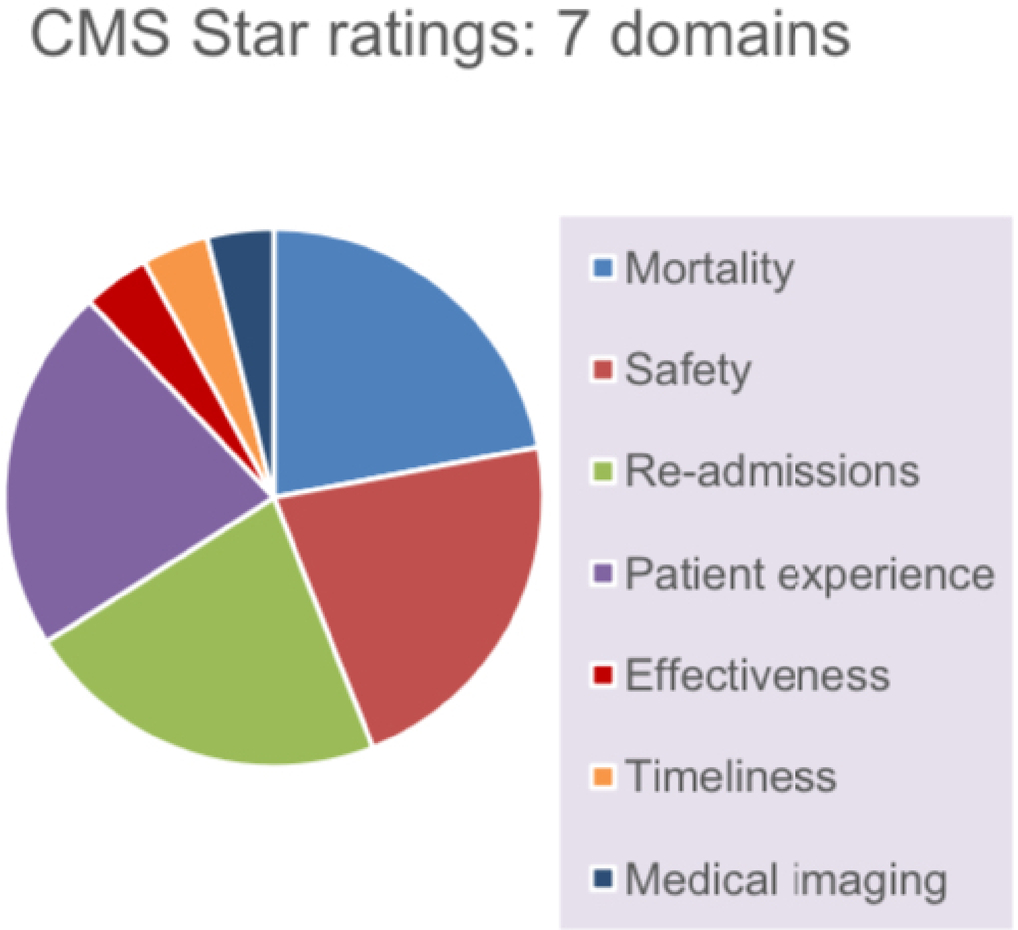
Community Perception

The hospital “where you go to die”

HCA Healthcare accused of pushing patients toward end-of-life care to boost performance metrics

Why do Administrators Care About Mortality?

- CMS includes 30-day mortality in Value-Based Purchasing which affects inpatient reimbursement
- CMS includes 30-day mortality in star ratings which are visible to the public
- US News & World Report and other entities include 30-day mortality and/or in-hospital mortality in their scores which are visible to the public
- Benchmarking entities such as Vizient and Premier calculate in-hospital mortality and the scores are visible to all members



Hospital Mortality

Inpatient mortality
How many hospitalized patients die while hospitalized?
Death during acute admission (DRG)

30-day mortality
How many hospitalized patients die within 30 days of admission?
Death in any setting or payment scenario

Comfort care code (Z515) and DNR code (Z66)

- No entity (CMS or other) collects billing/administrative data on actual encounters with specialist palliative care teams.
- The Z515 "palliative care encounter" ICD10 code is best thought of as a comfort care code, because it refers to the goal or intent of hospitalization, not necessarily the involvement of palliative care specialists. Referring to this as the comfort care code avoids confusion.
- Keep in mind that these entities are using hospital billing data, not physician billing data.
- Comfort care intent (as denoted via Z515 comfort care code in hospital billing) does not affect evaluation of 30-day mortality for Medicare's value-based purchasing or star ratings, or US News & World Reporting rankings.
- Comfort care intent does not exclude any deaths, but may improve the risk-adjustment for HealthGrades, IBM Watson/Truven, Premier, or Vizient mortality calculation; for some of those, this is only if the Z515 code was denoted as "present on admission" (POA).
- Enrolling hospitalized patients into hospice care does exclude them from some mortality calculations when evaluated by HealthGrades, IBM Watson/Truven, Premier or Vizient, but doesn't affect CMS or USN&WR 30-day mortality scores.
- DNR status (Z66 code) factors into some risk-adjustment but this may depend on whether it was flagged as "present on admission" (POA).

How does Discharge from Inpatient status to Hospice impact mortality?

Inpatient mortality
- Patient survives acute admission (even if physically in same bed in GIP hospice)
- Hospital stay is still in analysis but not as an observed death

30-day mortality
- No impact for CMS unless happens on 1st day of hospital stay
- Healthgrades removes patients discharged to hospice from whole analysis for 13 conditions

- Hospital reimbursement for the acute stay may be affected by discharge to any subacute care setting (e.g., SNF, rehab, hospice), if the length of stay (LOS) for the acute stay is short: Medicare prorates the reimbursement for *some* DRGs, *if* the patient is transferred to a subacute setting *and* the LOS is at least 1 day less than the mean national LOS for that DRG. As of Oct 2018, Medicare's post-acute transfer policy (PACT) includes hospice among these subacute settings.
- If a patient was enrolled in hospice at any point in the 12 months prior to an acute hospitalization, CMS will remove them from 30-day mortality scoring.

Mortality and Public Reporting

Inpatient mortality
More easily gamed than 30-day mortality
Used by Healthgrades, IBM-Watson-Truven, Vizient, Premier

30-day mortality
Better measure of hospital care
Used by CMS, USN&WR, Healthgrades, IBM-Watson-Truven

FAQ	Answer
"Consultants just told our hospital executives that inpatient hospice will reduce mortality and improve our Medicare reimbursement and star ratings – is that true?"	Inpatient yes, 30-day no No
"Does palliative care involvement remove a deceased patient from hospital mortality scores?"	No
"Does it matter if DNR code or comfort care goals are documented as present-on-admission?"	Yes for some entities
"We are overwhelmed with innumerable measures of hospital re-admissions and mortality – which ones do we really need to pay attention to?!?"	Ask your stakeholders

	CMS	US News & World Report	HealthGrades	IBM Watson / Truven	Premier or Vizient
Inpatient or 30-day mortality	30-day	30-day	Both	Both	Inpatient
Effect of comfort care code (Z515)	None	None	Risk-adjustment regardless of POA, for 16 conditions	Risk-adjustment regardless of POA	Risk-adjustment if POA
Effect of DNR code (Z66)	None	None	Risk-adjustment regardless of POA, for 12 conditions	Risk-adjustment if POA	Risk-adjustment if POA
Effect of discharge into hospice care	None unless on 1st day of hospital stay	None	Patients excluded for 13 medical conditions	None	Not a hospital death; case remains in data as a hospital survivor

Sources:
JB Cassel, CAPC, « *Update on Hospital Mortality Measures and Their Implications* » February 2020
CMS: https://www.qualitynet.org/
Healthgrades: https://www.healthgrades.com/quality/2018-methodology-mortality-and-complications-outcomes.
IBM Watson/Truven: http://truvenhealth.com/Portals/0/assets/100topAssets/100-Top-Hospitals-Study.pdf
https://media.beam.usnews.com/8c/7b/6e1535d141bb9329e23413577d99/190709 bh methodology report 2019.pdf

What can Hospitals Do to Embrace HSPC?

Programmatically

- Reduce end-of-life admissions through early involvement of office & home-based palliative care
- Engage hospital palliative care early in an admission for relevant patients
- Offer hospice enrollment (inpatient “GIP” hospice) for hospitalized patients where appropriate

Documentation and coding

- For patients admitted to hospital with POLST in place or DNR or comfort care intent at admission, hospital billing should use codes Z66 or Z515 and the “present on admission” flag as appropriate.
- Review other documentation and coding practices to ensure that severity of illness is captured.

Community strategies

- Partner with hospices to ensure your community has options for facility-based hospice

What Can Quality Managers Do to Promote HSPC?

- Know what your health system is most concerned about
  - Know thy stakeholders!
  - What payers or ratings entities do your execs pay the most attention to?
  - What scores or problems keep them up at night?
- Know your health system's status on those measures
- Debunk myths but don't get hung up on that
- Participate in quality improvement efforts
- Offer cross-cutting solutions that can hit multiple problems or ratings
- Encourage programmatic, systematic efforts that will have most benefit for patients and families

Pulse Check

Poll #4-

Quiz Time!

1. Palliative care is a specialty consultative service focused on addressing and alleviating pain and symptom management, facilitating advance care planning, and providing whole-person care to patients suffering from serious and life-limiting illnesses across care settings, including hospitals, clinics, community skilled nursing and assisted living facilities, and patient homes.
    a. True
    b. False

2. Hospital mortality rates may positively impact publicly reported outcomes for which service?
    a. Palliative Care
    b. Hospice
    c. Both Hospice and Palliative Care

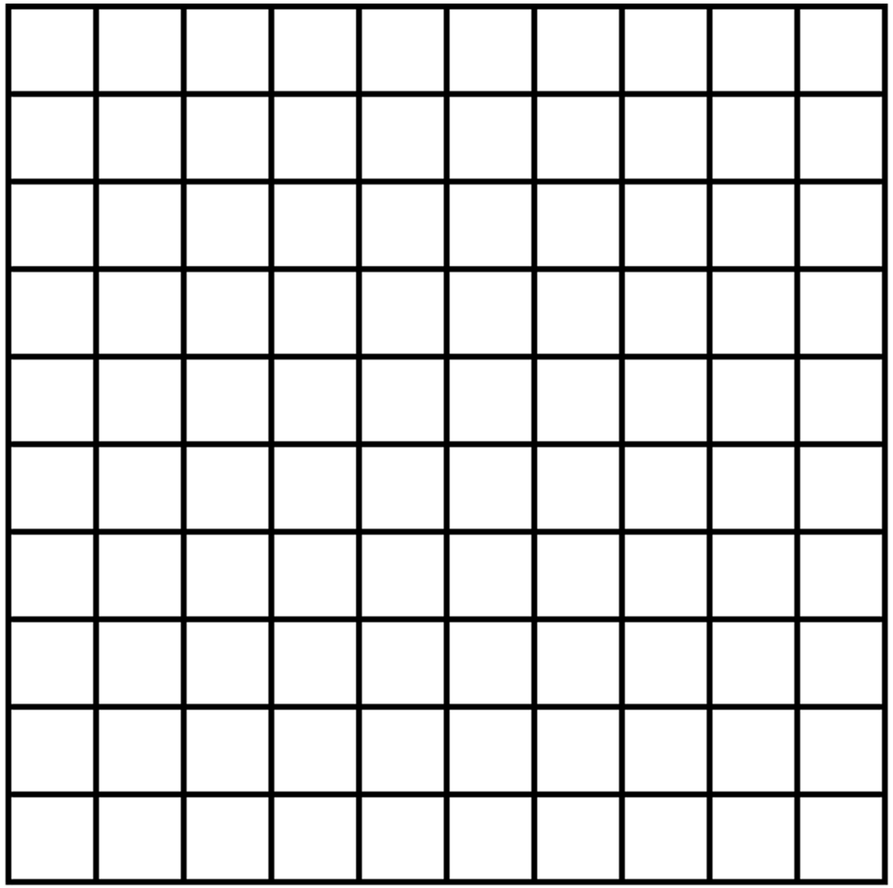
3. Hospice (and/or palliative care) may be able to be provided by a community agency if my hospital/health system does not currently offer these services.
    a. True
    b. False

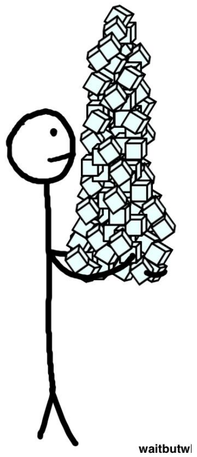
Questions/Discussion

Closing

You Only Live Once….

100 Blocks a Day- “Wait, but Why?





https://waitbutwhy.com/2016/10/100-blocks-day.html

You Only Die Once…

THE DASH

BY LINDA ELLIS

I read of a man who stood to speak
at the funeral of a friend
He referred to the dates on the tombstone
from the beginning...to the end.

He noted that first came the date of birth
and spoke the following date with tears,
but he said what mattered most of all
was the dash between those years.

For that dash represents all the time
that they spent alive on earth.
And now only those who loved them
know what that little line is worth.

For it matters not, how much we own --
the cars...the house...the cash.
What matters is how we live and love
and how we spend our dash.

So, think about this long and hard.
Are there things you'd like to change?
For you never know how much time is left
that can still be rearranged.

If we could just slow down enough
to consider what's true and real,
and always try to understand
the way other people feel.

And be less quick to anger
and show appreciation more,
and love the people in our lives
like we've never loved before.

If we treat each other with respect
and more often wear a smile,
remembering this special dash
might only last a little while.

So, when your eulogy is being read
with your life's actions to rehash,
would you be proud of the things they say
about how you spent YOUR dash?

Thank You

April Office Hours

Sepsis & Antimicrobial Stewardship

April 11, 2024
12:00 PM EST

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