

A Hospice-Hospital Collaboration:
Making the Case to Hospital
Administrators

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Todd R. Coté MD, HMDC, FAAHPM, FAAFP
Program Director, University of Kentucky College of Medicine
Fellowship in Hospice and Palliative Medicine
Chief Medical Officer, Hospice of the Bluegrass and the
Palliative Care Center of the Bluegrass
Assistant Professor, University of Kentucky College of Medicine

1995

“Contrary to the ideal vision of death – dying at home, surrounded by loved ones , and free from pain – most Americans die in hospitals, in pain, and alone.”

The SUPPORT Principal Investigators. A controlled trial to improve care for seriously ill hospitalized patients. The study to understand prognoses and preferences for outcomes and risk of treatment. (SUPPORT), JAMA , 247(20):591-598. 1995

2015

- Hospital Health System Growth
- “Accountability”
- Post-Acute Care Models
- Readmission Penalties
- Value Added Programs (Value= Quality/Cost)

Objectives

- Review the Barriers and Challenges to Hospice-Hospital Collaborations.
- Discuss Strategies for Successful Communication with Hospital Administrators.
- Present Successful Examples of Hospice-Hospital Collaborations.

Barriers and Challenges

- Legal/Regulatory/Financial
 - Conditions of Participation: acute care hospital versus hospice(level of care/benefit periods/Eligibility/Relatedness)
 - DRG vs. Per Diem/ Contracts/ anti-kickback, safe harbors
 - The OIG and "Others".
 - Certificate of Need and Hospice Competition.
 - \$\$\$
- Process
 - Hospital Admission process and Patient in hospital transitions.
 - Electronic Medical Record
 - Bed management logistics
 - Hospice workforce availability
 - Rural Access
- Institutional Culture
 - EOL Care (Death and Dying and Denial)
 - Palliative Services in Hospital
 - Pharmacy: Pain management protocols, etc.
 - Data Driven versus Mission Driven versus Both

Benefits of Collaboration

- Hospice
 - Increase access to more patients
 - Learn about hospital care
 - Learn about Palliative Care
 - Integrate hospice within “upstream “services.
 - Timely referrals
- Hospital
 - Improve quality of EOL care
 - Learn about hospice
 - Improve continuity of care
 - Train and educate on EOL care
 - Brand hospital with hospice's quality brand
 - Resource utilization (↓cost/re-admission)

Types of Collaborations

- Independent hospice contracts with hospitals.
- A hospice program within a hospital organization or hospital system.
- Hospice provides support via advice, training, education, development, palliative care inpatient support.

Types of Collaborations (Specific Examples)

- Contracts with hospice and hospital on Medicare Hospice benefit (MHB) Hospice General Inpatient Care (GIP).
- Contracts with hospital for hospice liaison nurse/ hospice inpatient team.
- Hospice inpatient unit within hospital.
 - Hospital builds unit and hospice pays.
 - Hospice leases and/or operates.
 - Hospice staffs and operates under a management service.
 - Several hospices collaborate under a shared unit within the hospital.
- Palliative Inpatient unit within hospital (with hospice MHB contracted beds).
- Small scale hospital comfort suites.
- Inpatient palliative care consult services.
- Coordinated outpatient palliative care services (Home/ SNF).
- Separate but coordinated palliative care and hospice care services.
- Other : EOL education programs/ Ethics committee membership/ Palliative care coordinating committee/ Life transitions /Case management/Advanced Directive programs/ Managed Care projects/ Specialized –targeted population programs.

Where to Start: 3 Questions?

- 1) What Does the Hospital Need?
 - Quality of EOL care
 - Mortality Rates/Index
 - Re-admissions, bed management
- 2) What can the Hospice Do?
 - Sustainability/ Financial resources
 - Workforce resources
 - Hospice Competition
- 3) Do you understand each other?
 - “David and Goliath “ analogy
 - Expert Acute Care and Expert Hospice Care
 - Hospital and Hospice Leadership and Governance

Strategies for Successful Collaborations

Successful Collaborations

- True partnership: respect and understanding from each organization.
 - Hospice care is expert and unique.
 - Acute Hospital care is expert and unique.
- Hospice–Hospital Champions
- Outstanding Clinical Leadership
- Effective Hospice Liaisons

Preparing for Successful Collaborations

- Know the Hospital.
- Know the Hospital Administrator.
- Know what the Hospital needs.
- Know what the Hospice can do.

Know the Hospital



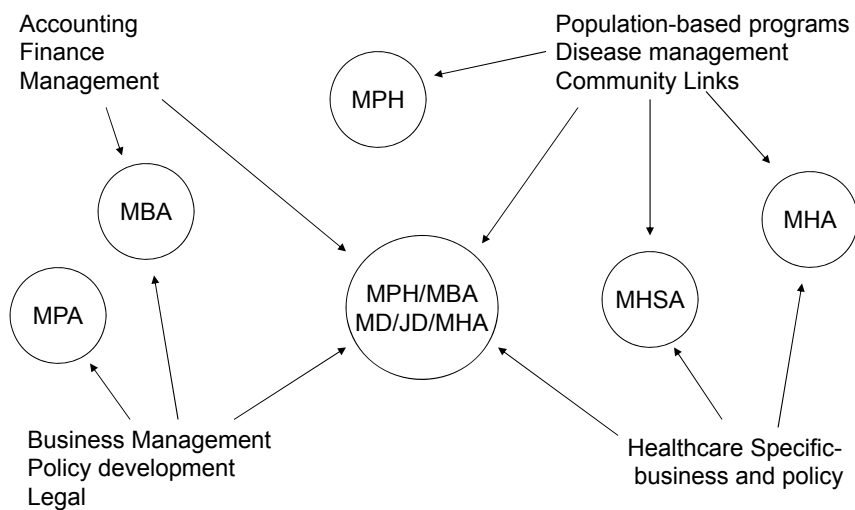
- Faith-Based/Mission?
- For Profit/ Not for Profit?
- Data Driven?
- Vision Driven ?
- What do they need?

Know Your Hospital Administrator



- Current Governance within Hospital?
- Work History (Previous Hospital and Hospital culture there?)
- Attitude toward Hospice (Are they a champion?)
- Vision/Mission or data oriented, or both?
- Any specific discipline they came from (What Degree)

Know Your Hospital Administrator



Know What the Hospital Needs



- 1) Mortality Rates/Index and pay for performance
"Observed/ Expected" death data
Risk/Acuity scoring for patient population
- 2) ↓Cost
per day/per patient and the DRG
Bed management
Emergency Room
ICU Utilization
- 3) ↓Re-admission rates
Discharge planning
- 4) ↑Quality of Care
Pain/symptom management
EOL Education
Advanced Directives

Know What the Hospice Can Do



- Sustainability/\$\$\$
- Workforce
- Working within Regulatory and Legal
- Unique expertise
- Hospice Competition

Tools for Making the Case to Hospital Administrators

Communicate a Hospice Definition

The many faces of "Hospice Care":

- **A Philosophy**: A compassionate, empathetic, approach to a person and family at life's end.
- **A Model of Care** : An Interdisciplinary care model utilizing all disciplines to help care for a patient and their family at the end of their life. (Good definition for acute care hospitals.)
- **A Place** : a building/hospice unit, administrative office ,etc.
- **An Insurance Benefit** : Care regulated and interpretatively-defined by the Hospice Medicare Benefit.

Discuss MHB and the Conditions of Participation (COPS)

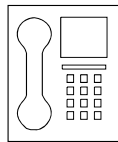
- Subpart D - §418.108 : Short-Term Inpatient Care

- 1) Must be available(for pain control, symptom management and respite).
- 2) Can be provided in: hospice unit, hospital, skilled nursing facility.
- 3) Documentation, education and written contract needs.
- 4) Limitations and Exemptions (The CAP and Pre-1975).



Acknowledge the Disparity in Clinical Care

(Hospice GIP for Patients and Families)



Minimum

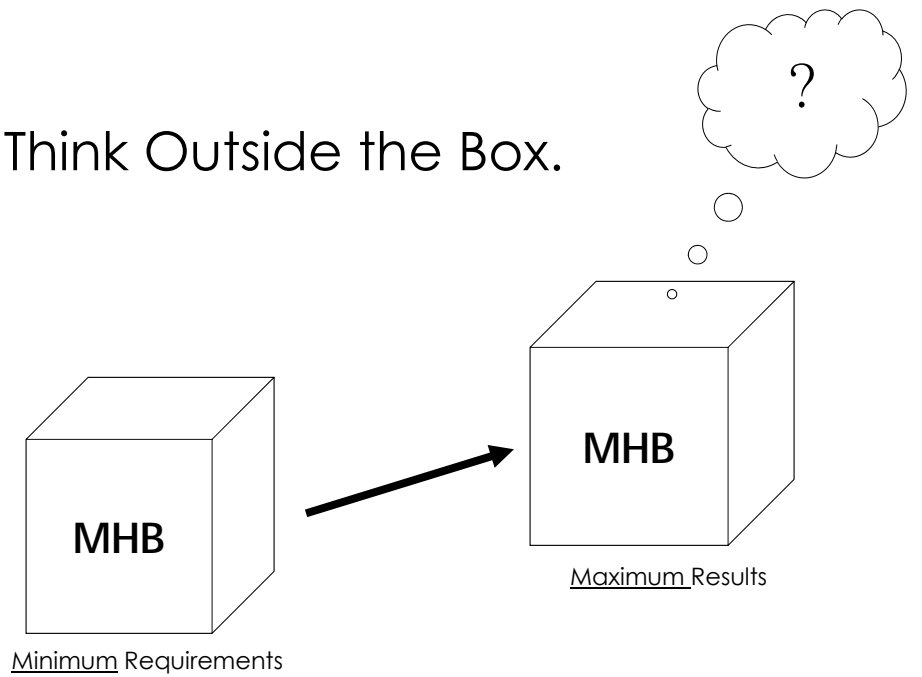
A daily phone call:
Hospice Clinician to GIP
Clinician in Inpatient
Environment



Maximum

Fully-Equipped and
Certified Hospice
Inpatient Unit

Think Outside the Box.



“Show Me the Data?!”

Know What Hospital Data is Important?

- Mortality Rates/Index
- Re-Admission rates
- Quality of care
- Cost of care
- Patient/Family Satisfaction

Evidence-Based Data for Hospice – Hospital Collaborations

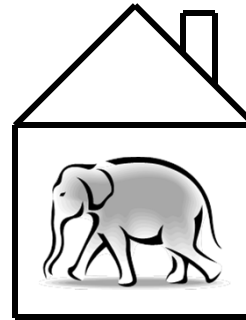
- Minimal research.
- Disparity of clinical service.

Collecting Data: A Bad Example?

A Hospice- Hospital Meeting:

Hospice CMO : "*How many people die in your hospital each year?*"

Hospital CEO: "*Ummm, I'll have to check on that.*"



Location of Hospice Patients at Death

(Approx. Number of Hospices Reporting : 450/430)

	2013 % of Patients	2012 % of Patients	Difference '09-'10
Free-Standing Hospice Inpatient Facility	23.5	24.0	-0.8
Acute Care Hospital (not operated by hospice)	7.0	6.6	0.3
Hospice -Run Inpatient Facility in Other's Facility	3.3	3.4	-0.1

(NHPCO FY2014, National Summary of Hospice Care)

Medicare “Data Mining”

(Based on Medicare Fee for Service Beneficiaries Claims 2011)

Comparison Study of Poor Prognosis Cancer Patients that Died in 2011

Outcome	Non-hospice Patients, % (n= 18,165)	Hospice Patients, % (n= 18,165) MLOS= 11 days	Risk Ratio
Hospitalization	65.1	42.3	1.5
Invasive Procedures	51.0	26.7	1.9
Death in Hospital or Nursing Facility	74.1	14.0	5.3
ICU Admissions	35.8	14.4	2.4
Overall Cost in Last Year of Life	\$71,517	\$62,819	

(Obermeyer Z, et.al.,JAMA. 2014;312.)

Medicare “Data Mining”

(Based on Medicare Fee for Service Hospital Claims 2012)

Hospital A- Rural Kentucky

Deaths Within 6 Months of Initial Hospitalization	% of Initial Discharges	% of Re-Admits in ≤ 30 Days	% Died in Hospice	% Died in Hospital	Hospice Days/Hospice death
Home	21	36	30.2	25.6	22.7
SNF	29	46	19.7	27.9	22.8
Home Health	4	18	22.2	44.4	25.0
Hospice	6	0	100		19.9
LTCH	12	25		8.3	

(Cushman J, Health Planning & Development, LLC)

Evidence-Based Data

- Palliative Care Services in the hospital can reduce hospital cost. (Prevent unnecessary inpatient utilization: ↓ LOS, ↓ Ancillary charges).
- Post-hospitalized patients referred to hospice have lower re-admission rates.
- Re-hospitalization care of hospice patients is costly to the hospital.
- Education and comfort care order sets improve end of life care for patients dying in a hospital.
- Hospice can improve patient/family satisfaction.

Tangeman JC, Rudra, CB, Kerr C W, Grant PC "A Hospice-Hospital Partnership: Reducing Hospitalization Costs and 30-Day Readmissions among Seriously Ill Adults", J Pall Med 2014; 17: 1005-1010.

Olsen M, Bartlett A, Moynihan T: "Characterizing Care of Hospice Patients in the Hospital Setting". J Pall Med .2011;14:185-189.

Bailey F, Burgio K, Woodby L, Williams B, Redden D, Kovac S, Durham R, Goode P: "Improving Processes of Hospital Care During the Last Hours of Life". ARCH INTERN MED, 2005; 165:1722-1727.

Harrison J, Ford D, Wilson K: "The Impact of Hospice Programs on US Hospitals". NURSING ECONOMICS, 2005; 23: 78-84.

Teno, J.M. et. Al. "Family perspectives on end-of-life care at the last place of care", JAMA,291(1), 88-93. 2004

A Case Study

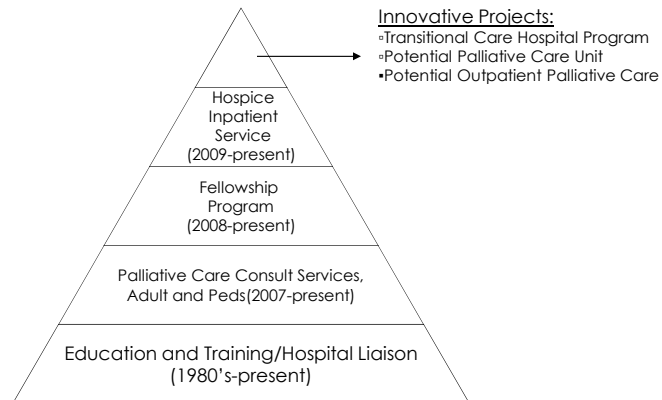
Hospice of the Bluegrass Hospice- Hospital Collaborations

- Diverse Models in Three Community-Based Hospital Systems
 - Formal In-Hospital Hospice Liaisons.
 - In-Hospital Hospice Inpatient Unit.
 - Collaborative In-Hospital Palliative Care Consult teams (1998-present).
 - Formal Education programs: Clinical Staff/Students /Residents/Fellows.
 - Transitional Care: post hospital discharge programs
- Diverse Model with University of Kentucky Healthcare System

University of Kentucky Healthcare Hospice and Palliative Care Services



University of Kentucky Healthcare Hospice and Palliative Services



“Sitting at the Table”

- What the Hospital Needed:

Starting Point



College of Medicine:

- Interdisciplinary Educational Needs
- HPM Fellowship Program

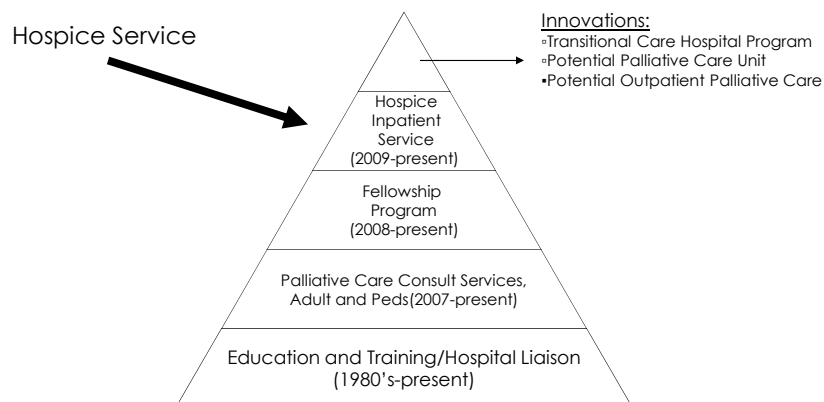
Hospital Administrators:

- Improve Quality of EOL Care
- Improve Mortality Index (University HealthSystem Consortium (UHC) Domains)
- Start a Palliative Care Hospital Service

“Sitting at the Table”

- What the Hospice could do?
 - Provide Hospice expertise.
 - Develop and support Palliative Care Services (expertise in hospitals since 1998).
 - Help address Quality and Mortality Index.
 - Had already established “True Partnership” starting with the Medical School.
 - Had already established framework for fellowship training program.

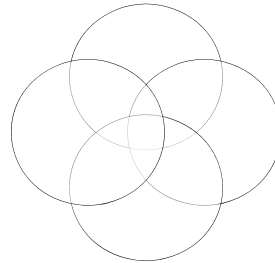
University of Kentucky Hospice and Palliative Services



University of Kentucky Hospice Service

Serving ALL areas of the
hospital:

- Fulltime In- hospital Hospice Nurse.
- Fulltime In-hospital Hospice Social Workers.
- Fulltime In-hospital Hospice Chaplain .
- Hospice Physicians are Attending Physician(Admitting and Attending hospital privileges) and visits every day and on call 24/7.



UK Specialty Service Order Sets (A-Z)

- Gastroenterology Service
- Hematology /Oncology Service
- Hospice Care Service**
- Infectious Disease Service
-
-
- Palliative Care Service



Important Outcomes



- Multiple referrals from multiple hospital services. (e.g. Neurosurgery/Trauma/ Cardiology).
- Improved Mortality Index (Observed /expected deaths) dramatically.
- “Value-added” thru improved quality and cost-effective care for dying patients in the hospital.
- Improved EOL care education and training of all staff/ providers.
- Hospice “at the table” for future hospital innovation projects.

Conclusion

- 1) Hospice –Hospital Collaborations are possible and can be a win-win for both organizations.
- 2) Barriers and Challenges can be overcome.
- 3) Financial Sustainability is feasible but “give and take” and should involve risk sharing.
- 4) Institutional Cultural differences can be overcome.

Thank you

tcote@hospicebg.org

