FREE WEBINAR
Hospice

Hospice Revocations:

Risk Factors and Preventive Strategies

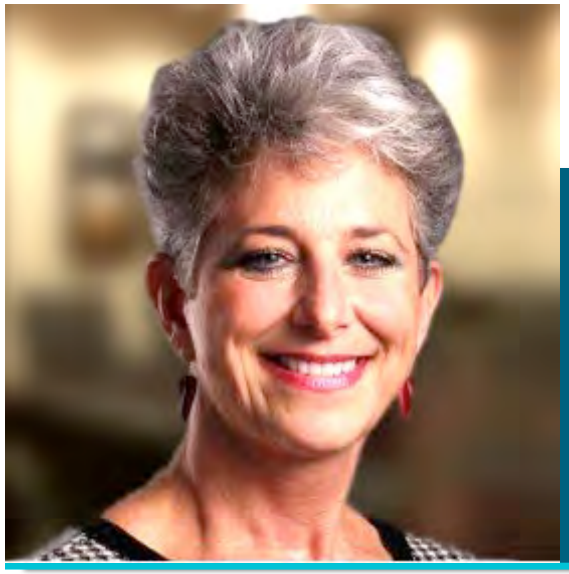
with pioneering hospice physician
Marcia Levetown, MD

Today's educational presentation is provided by

KINNSER®

The software that **powers...**
HOME HEALTH . THERAPY . PRIVATE DUTY . HOSPICE

877.399.6538 | sales@kinnser.com | kinnser.com



About the presenter

MARCIA LEVETOWN,
MD, FAAHPM

Hospice physician

KINNSER

Objectives

- Be able to list at least 5 factors that increase risk for revocation.
- Be able to identify at least 3 strategies to prevent revocation in high risk populations.
- Share ideas with colleagues about practical approaches to revocation prevention.

What is **Hospice Revocation?**

- It is NOT discharging the patient. Discharges are initiated by the HOSPICE due to a patient's improved prognosis for survival or due to concerns for staff safety that cannot be resolved
- Hospice revocation is initiated by the PATIENT and/or his/her agent.

Why is this an issue?

- Live discharge is seen by CMS as **a quality measure.**
  - **Live discharges due to improved prognosis** may mean the hospice is admitting the wrong patients (and may be committing fraud).
  - **Live discharges due to revocation** may imply patients are not receiving what they need from a particular hospice or from hospice in general.
    - May imply a problem with quality, communication or policy
    - May be due to a change of heart or circumstance of the patient/caregiver

What do the studies tell us?

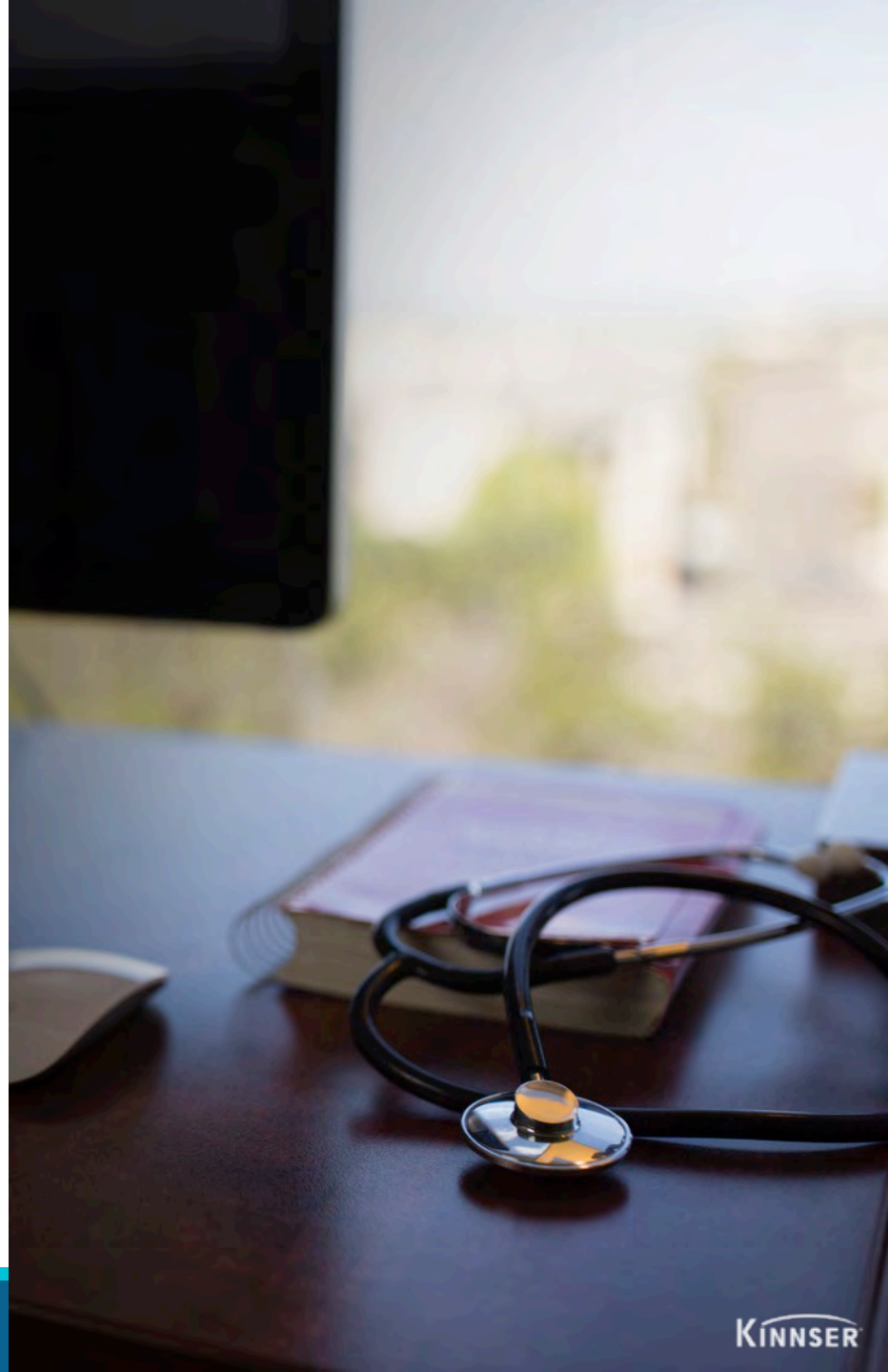
- **20%** of hospice admissions result in live discharges.
  - 75% of these are related to extended prognosis
    - Need for better prognostication where possible
    - Ongoing concern for fraud, CAP issues
  - 25% are due to revocations, primarily with acute care hospitalization as the alternative
    - Increased cost and often patient discordant outcomes
  - A small percent results from transferring agencies or locations

Trends in revocation

- Since the 1990 **Patient Self-Determination Act** (PSDA) allowed patients who are full code to sign onto hospice care, the revocation rate has risen substantially.
  - The thought was that open access (admission without a DNR) improves earlier access to hospice services. Earlier access provides time to gain trust and provide support and education about the outcome of CPR in a terminally ill patient.
  - **Are we making good on this promise?**

Four **very recent studies** of hospice revocations & related phenomena

- Hospice caregiver perceptions regarding revocation
- Family caregiver perceptions regarding revocation
- Transfer from home hospice care study
- Full code vs DNR study



Are there **predictors of increased risk** of revocation?

- Evidence based: **modifiable**
  - Poor symptom control
  - No OOH DNR

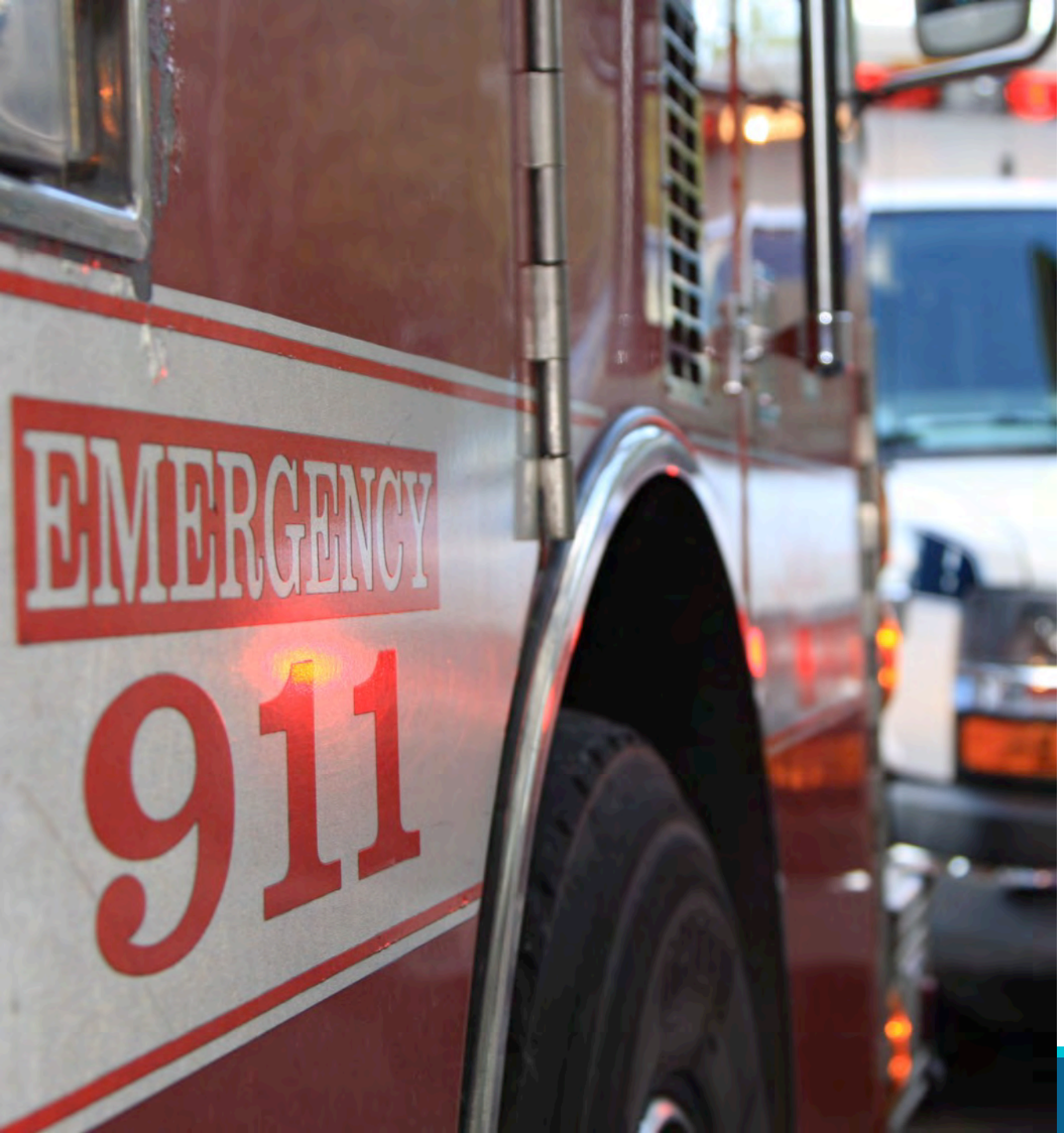
Are there **predictors of increased risk** of revocation?

- Evidence-based: not modifiable, but **manageable**
  - "Younger"
  - Non-white
  - Wish to receive care from usual caregivers or care only available in the hospital (e.g., patient develops an acute problem, like an injury or hemorrhage)
  - Do not desire death in the home
  - On hospice < 2 weeks

Are there **predictors of increased risk** of revocation?

My experience, adding to the list.
Your location may be different

- Has dependents in the home
- Under 50 years old
- Newly diagnosed with terminal illness
- Still seeing physician who does not fully buy into forgoing further intervention



Which symptoms lead to 911 calls?

(Phongtankuel et all, JPM, 2017)

- Dyspnea
- Pain
- Lethargy/ change in mental status
- Edema
- Falls
- Anorexia
- Bleeding

Let's get into this…

- Lethargy/ change in mental status, edema, falls, anorexia are common issues in the dying and do not cause THEM distress.
- **Answer:** Better education and reinforcement
  - Teach back
  - *"I know you must have other questions are concerns about how your mom's illness will evolve. Most people do. Let's talk about those and how they can be managed."*

Common **distressing symptoms** at EOL

- Dyspnea
- Pain

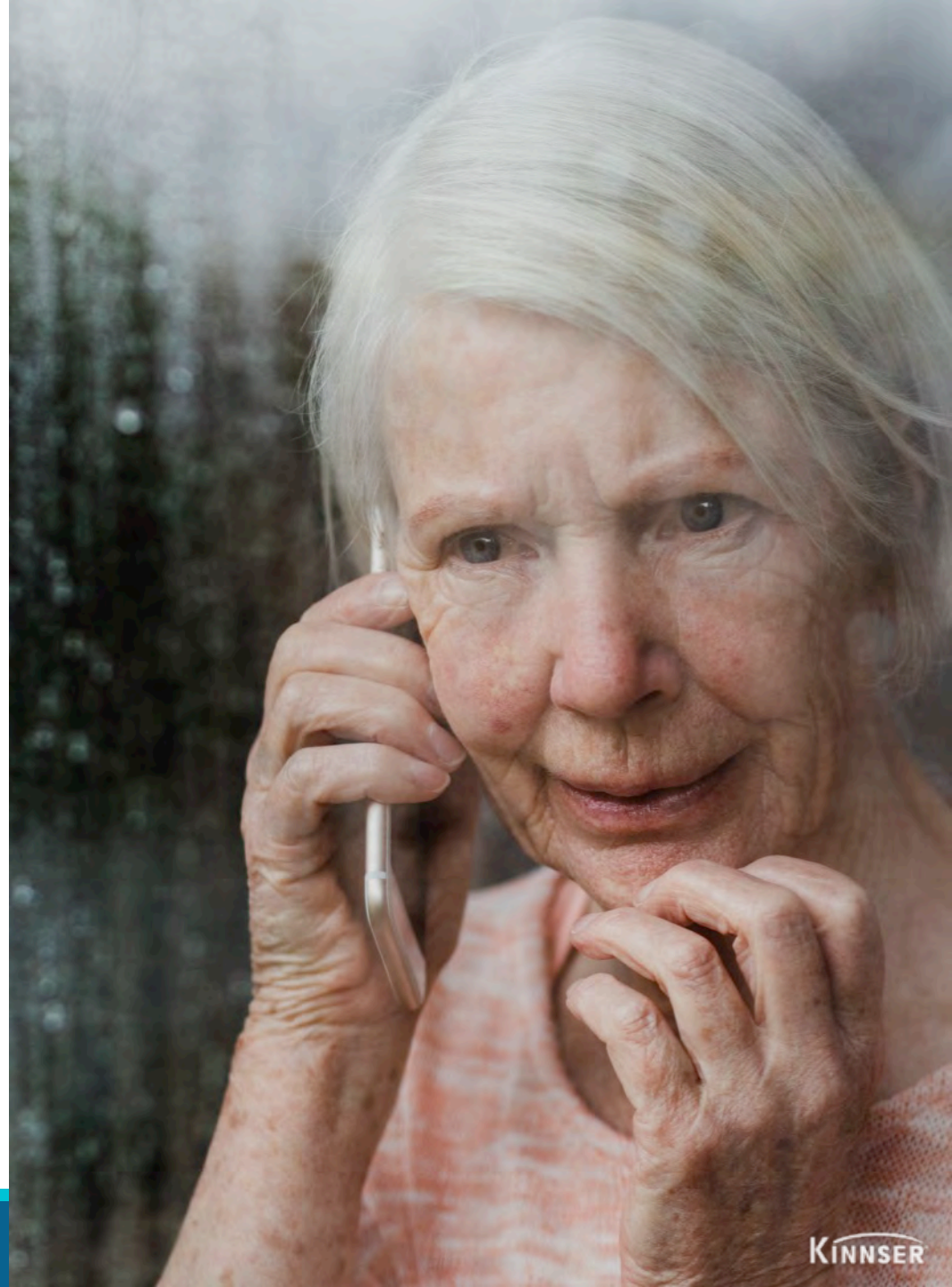
Identification/ teaching of all potential caregivers, listening to their concerns. Anticipatory guidance/ return demonstration.

Rapid response, escalation of dosing, call back several times on the same day to see if it worked until the symptom is relieved.

If frequent dose changes cannot be accommodated at home, consider inpatient hospice admission.

Rapid response: doing better

- Consider advising patients to state it is an emergency call when calling the call center for symptoms out of control.
- Consider using video calls or other telehealth technology until on-site help arrives. **(Cagle JG et al, JPSM, 2015;49:1-12)**
- Consider aligning with an ambulance service and training them to assess and intervene in a palliative way rather than transport. **(Anastasio M, EMS World 2015;28, 30, 32)**



No out of hospital **DNR**

- What is the outcome of CPR in an out of hospital setting for seemingly "healthy" people?
- What is the outcome of CPR in a nursing home?
- What is the outcome of CPR in a hospice patient?
- If the patient survives CPR for minutes to hours, what happens next?
- Why do terminally ill patients' hearts stop?

No CPR does **not** mean no acute treatment

- If patient breaks a hip and is in pain, patient may elect to go to the hospital even with a DNR.
- Patient may choose to receive a transfusion, treat infections, etc.
- Patients may choose not to do these things separately.

Are there **predictors of increased risk** of revocation?

- Evidence-based: not modifiable, but **manageable**
  - "Younger"
  - Non-white
  - Wish to receive care from usual caregivers or care only available in the hospital (e.g., patient develops an acute problem, like an injury or hemorrhage)
  - Do not desire death in the home
  - On hospice < 2 weeks

Managing **demographic risks**

- LISTEN, LISTEN, LISTEN
  - Increase in-person social work and chaplaincy visits in first 2 weeks
  - Explore worries, fears, beliefs
  - Consider (extended) family meetings, use of technology
- Offer concrete plans to address concerns
  - Continuous care, inpatient care, other options as symptoms get worse and death is imminent
  - Affirmation of a life well lived or forgiveness as needed
    - Final wishes, relationship concerns, front line veterans' needs
  - Help in securing well-being and maintaining ties with children/dependents
  - Elicitation and planning for preferred location of death

Are there **predictors of increased risk** of revocation?

My experience, adding to the list. Your location may be different

- Has dependents in the home
- Under 50 years old
- Newly diagnosed with terminal illness
- Still seeing physician who does not fully buy into forgoing further intervention

Managing **views of other physicians**

- Consider a Medical Director to Specialist phone call or visit. Be sure to read up on the latest treatments and their outcomes first!!!
  - *"Your patients can still visit you, and you can bill for your services, even while on hospice, if they designate you as their attending. It serves the patient best if we have a mutually consistent plan of care and communication strategy. Can we discuss how you would like to manage that?"*
  - *"What has it been like for your patient?"*
  - *"What treatments do you have in mind?"*
  - *"What are the possible and likely outcomes?"*
  - *"Do you have other patients who would benefit from our collaborative care?"*

Summary

- Increased **risk for revocation can be predicted** based on several criteria.
- These risks can be managed, leaving patients and families with better outcomes.
- **Better listening** and **increased intensity of services in the first 2 weeks and as symptoms intensify** are key factors to improve quality of services and reduce revocation risk.
- Consider use of technology and outside collaborations as adjunctive risk reduction strategies.

References

Claire K. Ankuda, MD, MPH, Evan Fonger, MD, and Thomas O'Neil, MD**: *Electing Full Code in Hospice: Patient Characteristics and Live Discharge Rates.*** Journal of Palliative Medicine. Volume 21, Number 3, 2018. https://www.liebertpub.com/doi/10.1089/jpm.2017.0276

Sean Burton: **Innovative Partnership Breaks Cycle of Rehospitalization in Hospice.** EMS World. January 7, 2014. https://www.emsworld.com/article/11290277/innovative-partnership-breaks-cycle-rehospitalization-hospice

Maria Cohut: ***Death Anxiety: The Fear That Drives Us?*** Medical News Today. August 11, 2017. https://www.medicalnewstoday.com/articles/318895.php

Wendy G. Evans, MD, Toni M. Cutson, MD, Karen E. Steinhauser, PhD James A. Tulsky, MD**: *Is There No Place Like Home? Caregivers Recall Reasons For and Experience Upon Transfer from Home Hospice to Inpatient Facilities.*** Journal of Palliative Medicine. Volume 9, Number 1, 2006. https://www.liebertpub.com/doi/10.1089/jpm.2006.9.100

References

Barbara Gomes, Natalia Calanzani, Jonathan Koffman and Irene J. Higginson: ***Is Dying In Hospital Better Than Home in Incurable Cancer and What Factors Influence This? A Population-based Study.*** BMC Medicine 2015.
https://www.biomedcentral.com/about/press-centre/science-press-releases/09-10-2015

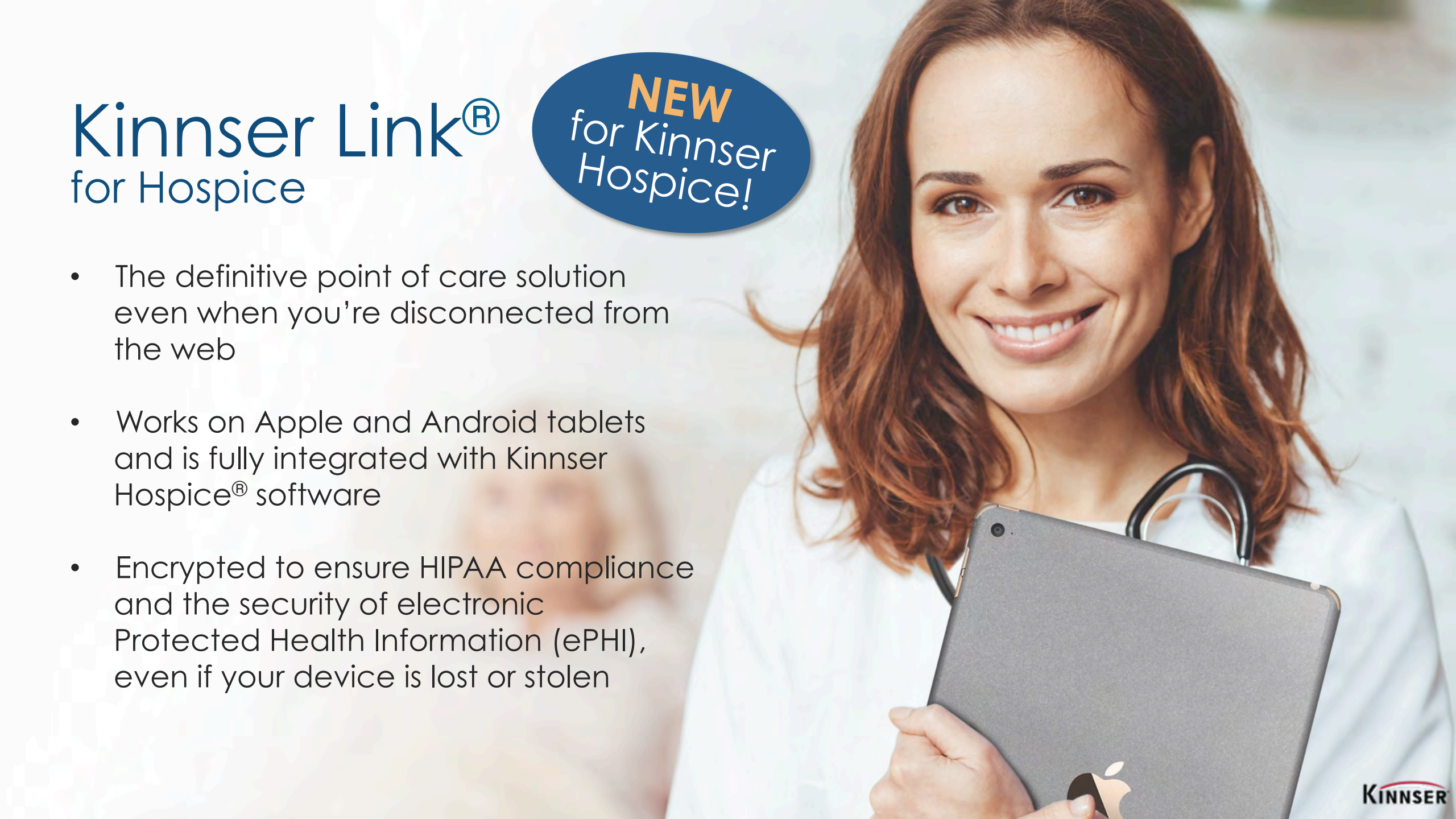
Veerawat Phongtankuel, MD, Benjamin A. Scherban, BA, Manney C. Reid, MD, PhD, Amanda Finley, MSW, Angela Martin, AOS, Jeanne Dennis, BA, MSW, and Ronald D. Adelman, MD**: *Why Do Home Hospice Patients Return to the Hospital? A Study of Hospice Provider Perspectives.*** Journal of Palliative Medicine. Volume 19, Number 1, 2016
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4692121/

Veerawat Phongtankuel, MD, Shawn Paustian, BA, Manney Carrington Reid, MD, PhD, Amanda Finley, MSW, Angela Martin, AOS, John Delfs, MD, Rosemary Baughn, RN, MSN, and Ronald D. Adelman, MD: ***Events Leading to Hospital-Related Disenrollment of Home Hospice Patients: A Study of Primary Caregivers' Perspectives***. Journal of Palliative Medicine. Volume 20, Number 3, 2017
https://www.liebertpub.com/doi/10.1089/jpm.2015.0550

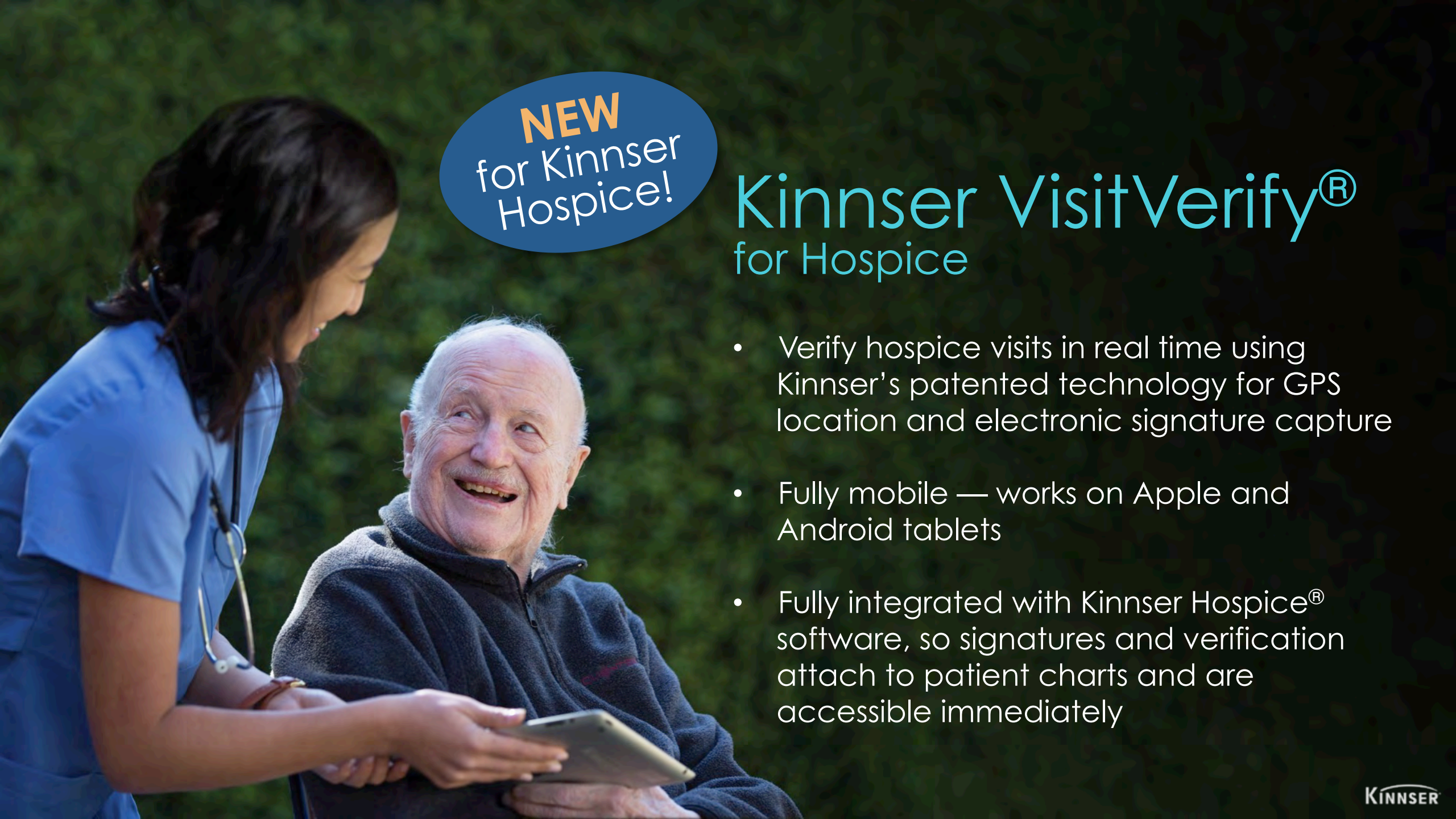
Kinnser Link®
for Hospice

NEW for Kinnser Hospice!

- The definitive point of care solution even when you're disconnected from the web
- Works on Apple and Android tablets and is fully integrated with Kinnser Hospice® software
- Encrypted to ensure HIPAA compliance and the security of electronic Protected Health Information (ePHI), even if your device is lost or stolen



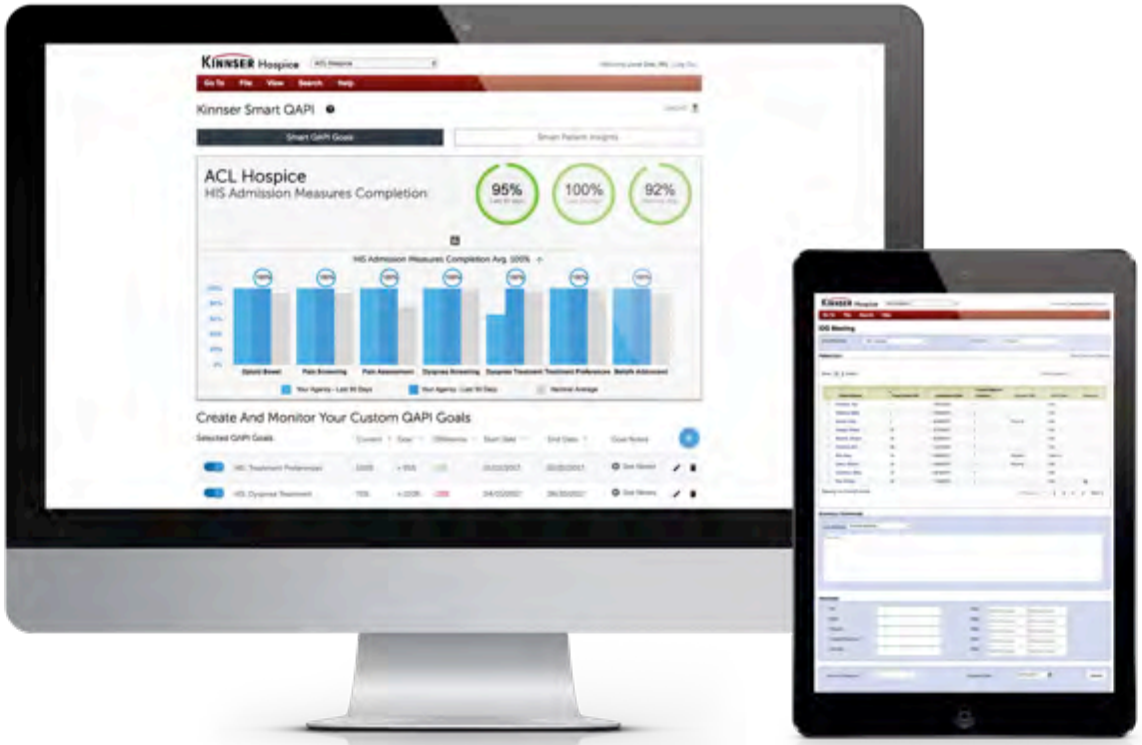
KINNSER



Kinnser VisitVerify®
for Hospice

- Verify hospice visits in real time using Kinnser's patented technology for GPS location and electronic signature capture
- Fully mobile — works on Apple and Android tablets
- Fully integrated with Kinnser Hospice® software, so signatures and verification attach to patient charts and are accessible immediately

KINNSER



Request a demo of Kinnser Hospice® today

kinnser.com/requestademo

877.399.6538 | sales@kinnser.com | kinnser.com