To care is... to make a difference. – Jane, Age 45

Truths and Possibilities: Honoring the Process and Patient During Hospice Discharge

WITH
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• No financial conflict of interest to report.
All I Ever Really Needed to Know I Learned in Kindergarten

ROBERT FULGHUM

- Play fair.
- Clean up your own mess.
- Don’t take things that aren’t yours.
- Say you’re sorry when you hurt somebody.

- Goldfish and hamsters and white mice and even the little seed in the plastic cup – they all die. So do we.
All I Ever Really Needed to Know I Learned in Kindergarten

Pathways Home Health, Hospice & Private Duty

Agenda

I. Introduction
   - Guiding Principles
   - Regulations/CoP's

II. Integration
   - Discharge Planning Worksheet
   - Mock IDG
   - Care Conference
   - Tips for effective communication
   - Documentation

III. Review/ Questions

Learning/behavioral objectives:

“At the completion of this session, participants will be able to ...”

- Assess possible barriers to effective hospice discharge
- Effectively communicate information about hospice discharge with patients, families, facilities and coworkers
- List 5 components of a successful discharge plan
- Document a complete discharge summary
Recognizing That...

- Process needs uniformity.
- Federal regulations exist for hospice eligibility.

Whole Person Care

“The tendency of modern, specialized medicine to focus upon component medical problems while neglecting the experience of the patient/family as a whole...is a factor that risks harm to patients.”

The Discontinuation of Hospice Care: Ethical Principles for Policy and Practice” NHPCO Professional Development and Resource Series, 2004 p5.

Whole Community Care
Recognizing That...

- Staff and clients are affected by recertification process.
- When result is decertification and discharge, patients, families and staff morale may be negatively affected if discharge plan is not secure.
- Discharge from hospice may be perceived as a betrayal of the trust patients and families have extended to the hospice staff.
- Some patients and families will consider hospice discharge for extended prognosis to be good news!

Our Considerations

- Ethical Principles
- National Regulations
- Existing Pathways policies/procedures
- Interdisciplinary collaboration
- Staff education
- Clinical documentation

Comprehensive Discharge Planning Process

- Continually assess hospice eligibility.
- Document in Plan of Care.
- Discuss eligibility at IDG.
- If a patient is no longer appropriate for hospice care, the IDG will collaboratively plan a safe and effective discharge, limiting hardship on patient and family.

This not only assures compliance with federal standards but also supports patient autonomy and professional integrity.
From NHPCO...

While this process will inevitably make mistakes on both sides, thereby some patients may be admitted to hospice too late and others may be discharged that, in hind sight, are inappropriate and unfair, effective policy must minimize the incidence and risk of such erroneous decisions.


Conditions of Participation

FEDERAL MEDICARE REGULATIONS

418.26 Discharge from hospice care

• a) Reasons for discharge:
  - Patient moves out of service area
  - Hospice determines that the patient is no longer terminally ill
  - Discharge for cause

• b) Discharge order:
  - Written discharge order from HMD.
  - If patient has an attending physician involved in his care, this physician should be consulted before discharge and her review and decision included in the discharge note.

• c) Effect of discharge: resumes Medicare coverage for benefits waived
418.26 Discharge from hospice care

- d) Discharge planning.
  - (1) The hospice must have in place a discharge planning process that takes into account the prospect that a patient's condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill.
  - (2) The discharge planning process must include planning for any necessary family counseling, patient education or other services before that patient is discharged because he or she is no longer terminally ill.

Pathways Home Health, Hospice & Private Duty

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Discharge Planning Worksheet

**A TOOL FOR DISCHARGE PLANNING**

<table>
<thead>
<tr>
<th>Timeline</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-3 weeks before ReCert or DC due</td>
<td>Discuss possible DC, distinguishing discharge vs. revocation. Assess barriers for DC. Establish timeline to meet appropriate DC plan. Consider how changes in prognosis affect POC. Determine who, when, and where to make initial contact with Pt/Family/Facility.</td>
</tr>
<tr>
<td>2 weeks before possible DC</td>
<td>Notify Pt/Family/Facility of DC probability and begin DC plan, including Family meeting and/or Facility care conference, if appropriate. Consult PMD: Identify resources required by Pt/Family/Facility for positive/appropriate DC: a. Family counseling needs and education, including indications for readmission b. Community resources c. DME plan d. Medication plan e. Confirm PMD will follow f. Re-assess goals of care in the anticipated absence of hospice</td>
</tr>
<tr>
<td>1 week before possible DC</td>
<td>Continue to evaluate timeline to meet appropriate DC plan. Is DC planning still appropriate? Obtain appropriate paperwork.</td>
</tr>
<tr>
<td>No less than 2 days before DC</td>
<td>Complete Discontinuation of Services (DC) form. Ensure family/facility knows the changes to look for &amp; how request re-evaluation of eligibility. Complete Notice of Medicare non-coverage form (for Medicare patients).</td>
</tr>
<tr>
<td>Effective day of DC</td>
<td>Obtain discharge order from HMD. Notify all agency and PMD of discharge.</td>
</tr>
</tbody>
</table>

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Pathways Home Health, Hospice & Private Duty
Case Presentation

"JOSIE'S STORY"
YOU ARE THE IDG TEAM MEMBERS:
1. TEAM FACILITATOR
2. RN CASE MANAGER
3. MEDICAL SOCIAL WORKER
4. SPIRITUAL CARE COUNSELOR
5. HOME HEALTH AIDE
6. HOSPICE MEDICAL DIRECTOR
7. BEREAVEMENT

WHAT ARE THE POSSIBLE BARRIERS TO HOSPICE DISCHARGE?

WHO WOULD YOU INVITE?
HOW MIGHT YOU EXPLAIN THE REASON FOR THIS MEETING?
WHAT IS THE CONTENT OF THE CONFERENCE?
Care Conference: Leader

- Explains reasons for conference
- Avoid using the word “stable” to describe pt. However, notice the stability that hospice has provided.
- Note that changes in pt’s condition indicate a clinical prognosis beyond 6 months.
- Sets the tone and the pacing for communicating reassurance and support of family and/or facility staff.
- States repeatedly that no change is occurring today or tomorrow.
- States what elements of pt’s life are not changing, including her place of residence, caregiver, daily visits by family, medications and palliative goals of care.
- IDG will continue to be available until discharge process is complete.

Changes to Anticipate

- Visits from Hospice team members will stop
- Source of medications will change
- DME supplier might change (hospital bed, wheelchair, bedside commode, oxygen concentrator)
- Other community resources may be available. We will be researching resources and staying in touch with family/facility staff with regularity. We usually offer 3 referrals for each resource to provide choice.

Essential Communication

- Frequent meetings/phone calls/contact with family and/or staff
- Demonstrate intentions for stable, collaborative, consistently supportive presence
- Invite sharing of family’s and facility’s concerns
- Keep communication open
Essential Communication

- Take responsibility for the agency’s decision, even though very difficult
- Acknowledge that hospice staff considers this decision carefully
- Explain that transition off of hospice needs time and careful planning to minimize disruption and optimize continuation of care for pt/family

Tips for Effective Communication

YOUR EXPERIENCES

Goals

- Present discharge as part of overall care plan for patient
- Be calm, Be positive
- Know your patient, family members – individualize your approach
- Use hospice eligibility guidelines to educate patient and families
Conversation Starters

- I want to discuss with you our present assessment of how you are doing at this time – use specifics, solicit their observations
- I understand that this may be an awkward/scary conversation to have...
- As a hospice agency, we are held to federal standards for hospice eligibility...
- At this time, what are your goals for your care...

Try to Stay Away From

- I have really bad news...
- Use of word “stable” without any further explanations
- I thought we were safe, but...
- Medicare won’t pay anymore...

Documentation

COMPONENTS OF COMPLETE DISCHARGE
SUMMARY
Discharge Documentation

- Care Plan
- Clinical course
- Summarize discharge planning process
- PMD Consultation
- Family counseling needs and education, including indications for readmission
- Community resources
- DME plan
- Medication plan

CoP’s 418.104(e)

The hospice discharge summary must include—

- (i) A summary of the patient’s stay including treatments, symptoms and pain management;
- (ii) The patient’s current plan of care;
- (iii) The patient’s latest physician orders; and
- (iv) Any other documentation that will assist in post-discharge continuity of care.

Acknowledging the generous support of:

- The staff at Pathways Home Health, Hospice and Private Duty
- Our patients and their families
All I Ever Really Needed to Know I Learned in Kindergarten

Learn some and think some and draw and paint and sing and dance and play and work some every day.
– Robert Fulghum