Connecting Hospice, Dialysis and Healthcare Reform

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Goal
- To encourage the early incorporation of hospice and palliative care discussions in care planning, and to underscore the need for, and benefits of, closer collaboration between hospices and dialysis clinics in the context of healthcare reform.

Objectives
- Identify how end-of-life is related to new healthcare laws
- Identify reasons and strategies for connecting hospice to dialysis patients
- Identify the issues terminal patients on dialysis encounter
- Identify advantages of incorporating end-of-life issues in the early process of care

Changing Healthcare Landscape

Healthcare Reform Acronyms

<table>
<thead>
<tr>
<th>ACA</th>
<th>CO-OP</th>
<th>HCBS</th>
<th>PCCM</th>
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<tr>
<td>ACO</td>
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<td>HAS</td>
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<td>MLR</td>
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<td>HIT</td>
<td>NAIC</td>
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<tr>
<td>CMP</td>
<td>HRP</td>
<td>PAP</td>
<td>VBP</td>
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Where We Are – Where We’re Going

Cost

Volume-Driven Health Care

Quality

Value-Driven Health Care
With Passage of Health Care Reform, CMS is Advancing Value of Medicare

**Baby Boomers Impact**
- The Baby Boomer Generation started turning 65 in January 2011
  - 2.8 million boomers qualified for Medicare in 2011
  - Medicare surge: 47 million to 80 million by 2030
- US Census Bureau estimates that over the next 20 years 10,000 new retirees will be added to the Social Security and Medicare roles each day.

**Healthcare Spending in the U.S.**
- Continues to far exceed other industrialized countries
- Accounts for $2.9 trillion ($8,650 per person a year)
  - 17.7% of the nation’s total economic output and nearly twice that of 34 countries
- It is estimated that by 2022, that amount will increase to $5 trillion ($13,710 per person a year)

**What’s the driving force behind the change?**

**Baby Boomers Impact**
- Patients’ access to care will become an issue
- Hospitals will need to address patients’ chronic care needs
  - Boomers are more likely to be admitted with more chronic conditions or multiple chronic co-morbidities

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The Cost of Dying

- Last 2 years of life patients with chronic illness account for approximately 32% of total healthcare spending
- Sickest 5% of the population account for 25% of all health care expenses
- Hospital & physician bills during last two months of patients’ lives cost Medicare $50 billion
- Hospitals have long argued ALOS figures are skewed by patients no longer responsive to curative treatments
- Publicly reported hospital mortality rates are often skewed by large percentage of chronic or terminally ill patients

Source: Centers for Medicare & Medicaid Services

Lack of Care Coordination Contributing To Waste

- $25-$50 billion annually
- Eliminating estimated avoidable emergency department visits - $21.4 billion annually
- Cost for “avoidable” hospitalizations of nursing home residents - $7.5 billion annually
- Cost of Medicare unplanned readmissions - $17.4 billion

Source: Centers for Medicare & Medicaid Services

Readmission Patient Profile

- 1 in 5 Medicare patients re-admit within 30 days
- 1 in 3 Medicare patients re-admit within 90 days
- 14-17% general population re-admit within 30 days
- >70% of people die in a healthcare facility, most of whom were admitted through the ED
- 30 day re-admissions cost Medicare $12-15 billion

Source: Centers for Medicare & Medicaid Services

Reasons for Readmission

- Failure in discharge planning
- Insufficient outpatient and community care
- Severe progressive illness

Readmission Impacts on Hospitals

- Adversely affects hospital LOS and mortality rates
- Negatively impacts hospital "Core Measure" outcomes
- Utilization challenges for managing LOS and DRGs
- Increased ED volume and extended patient wait times
- Hospice appropriate patients occupy ICU beds
- Reduced patient and family satisfaction
- Publicly reported hospital mortality rates are often skewed by large percentage of chronic or terminally ill patients

Hospital Readmission Reduction Program (HRRP)

- Part of the Affordable Care Act (ACA)
- Intended to drive meaningful reductions in all-cause readmissions by aligning payment with outcome
- Outcome measure: Hospital specific, risk standardized, all cause 30-day excess readmission ratio following index hospitalizations for AMI, heart failure, or pneumonia.
- 2013: 1% reduction in Medicare base reimbursement for inpatient services for all DRGs.
- 2014: 2% and 2015: 3%

Conditions for FY 2013 and Expansion in FY 2015

The readmissions penalty will initially apply to only three conditions: AMI, heart failure and pneumonia. In FY 2016, CMS will expand the program to include an additional four conditions, to the extent practicable.

Conditions Addressed Beginning FY 2013
- Acute Myocardial Infarction
- Heart Failure
- Pneumonia

These three conditions made up approximately 10 percent of hospital discharges in 2008.

Conditions Addressed Beginning FY 2016
- Chronic Obstructive Pulmonary Disease
- Coronary Artery Bypass Graft
- Perioperative Transmural Coronary Artery Angioplasty
- Other Vascular Conditions

Hospital Compare National Readmissions Rate

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<tr>
<th>Condition at Hospital Discharge</th>
<th>30-Day Rehospitalization Rate</th>
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<tr>
<td>AMI</td>
<td>19.8</td>
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<td>Heart Failure</td>
<td>24.6</td>
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<tr>
<td>Pneumonia</td>
<td>18.4</td>
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What is Counted as a Readmission?

- Any time an AMI, pneumonia, or heart failure patient is readmitted to a hospital within 30 days of the initial hospitalization, it is considered a readmission.

"How does all of this relate to ESRD?"
Compare ESRD Readmission Rates to other Conditions

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<tr>
<td>ESRD*</td>
<td>34.0</td>
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*US Renal Data System: USRDS 2013 Annual Data Report

The Elderly ESRD Patient

- 76% of Medicare patients on dialysis were hospitalized in the 30 days prior to death
- Accounted for 2x hospital days as patients dying from cancer.
- % of patients admitted to ICU in final month
  - 50% Long-term dialysis
  - 25% Cancer
  - 20% Heart Failure

- 30% received intensive procedures
  - Mechanical Ventilation
  - Feeding tubes
  - Cardiopulmonary Resuscitation
- Three times higher than the rate for cancer patients
- Patients referred to hospice
  - Kidney Failure 20%
  - Heart Failure 40%
  - Cancer 55%

The Elderly ESRD Patient

- While only 45% of elderly patients receive hospice services, the number of ESRD patients is less than half of that.
- Incidence of recognized CKD in people 65 and older more than doubled between 2000 and 2008.
- ESRD cost Medicare $34 billion in 2011
  - 6% of Medicare spending.
A Clear Need for Improvement Exists

- ACEP Choosing Wisely Campaign Recommendation #3
  o “Don’t delay engaging available palliative and hospice care services in the emergency department for patients likely to benefit.”

- Renal Physicians Association (RPA)
  - A multi-professional team with expertise in renal palliative care, including nephrology professionals, family or community-based professionals, and specialist hospice or palliative care providers, should be involved in managing the physical, psychological, social, and spiritual aspects of treatment for these patients, including end-of-life care.

RPA Recommendations for End-of-life care Practices in Chronic Kidney Disease

1. Identify patients who would benefit from palliative care interventions.
2. Screen for and manage pain and other physical symptoms routinely.
3. Screen for and manage emotional, psychosocial and spiritual distress; refer to allied health professionals as appropriate.
4. Assess patients’ desire for prognostic information.
5. Enhance pre-dialysis education.
6. Provide routine advance care planning (ACP) as described in Recommendation No. 5.
7. Increase access to specialty palliative care including hospice.
8. Develop relationships with hospice providers that focus on transition of care for dialysis to hospice, bringing patients into hospice by decreasing frequency of dialysis treatments, and having the patient be in control of when they are ready to stop dialysis.
9. Provide bereavement support to patients’ families where necessary.
10. Incorporate palliative care training for all nephrology fellows...

What is Hospice and How Can It Help?

Hospice Care

- Team-oriented approach to end-of-life (EOL) care
- Experts in EOL, medical care, pain and symptom management, emotional and spiritual support
- Tailored to the patient’s needs and wishes
- Support to loved ones as well
- Provided in any setting

Medicare Hospice Benefit

Basic Hospice Benefit

- Prognosis of 6 months or less if the terminal illness runs its normal course as determined by the patient’s attending physician and the hospice medical director
- Patients elect hospice via informed consent
- Hospice reimbursed a flat per diem based on one of 4 levels of care:
  1. Routine home care
     - Includes patients living in LTC or ALF
  2. Continuous home care
  3. General inpatient care
  4. Respite inpatient care

Medicare Hospice Benefit

- Comprehensive Part A benefit
- Focus is on care in the patient’s primary place of residence
  - Private home, ALF, nursing home
- “General Inpatient” level of care for patients who require “hospitalization” or “readmission”
- “Continuous care” enables patients who would otherwise “require” an acute care (re)admission to remain at home
Readmission: Hospice Can Help

• Patients admitted to hospice as part of discharge planning are unlikely to be "readmitted" to the acute care setting, as a need for a return to inpatient care would be covered by the hospice under the General Inpatient level of care or the patient could remain home on continuous care.
  o Exception would be if patient chose to revoke the hospice benefit to access disease modifying interventions

Readmission: Hospice Can Help

Nursing home residents on hospice were less likely to be hospitalized than residents not on hospice (OR 0.47; 95% CI: 0.45–0.5)

Gozalo, 2007

Nursing home residents who had a "hospice informational visit" had fewer acute care admissions (mean 0.28 vs. 0.49; p = .03) and fewer acute care days (mean 1.2 vs. 3.0; p = .03) than those who did not.

Casarett, 2005


Retrospective Chart Review, (Freund, 2012)

• Patients who died at the Univ of Iowa hospital
  • Penultimate admission within 12 months of death
    o 60% (125/209) of patients met NHPCO guidelines for hospice at that hospitalization episode
    o 84% (175/209) of patients were within 6 mo. of their actual deaths on the previous admission
    o Only 59% (103/175) of patients who died within 6 mo. of the admission met NHPCO guidelines; the guidelines are not predictive of all deaths

Documentation of Hospice Discussion

o Terminal admission: 23%
  o Penultimate admission: 14%

Palliative Care Consult

o Terminal admission: 47%
  o Penultimate admission: 5%

Conclusion: “Appropriately timed hospice discussions and referrals would lead to a decrease in 30-day hospital readmission rate, lower healthcare expenses, and improve comfort, while tending to the goals and emotional needs of patients and families at the EOL.”


Case Study

• Patient D.V.
  o 69 yr. female NH resident
  o Referred by hospital
    • Multiple admissions in prior 90 days.
  o Dx of ischemic Heart disease
  o Also had ESRD
    • Hemodialysis on T/TH/Sa x 3 years
  o Last admission after presenting with mental status changes and shortness of breath.
  o History of psychiatric disorders including possible bipolar disorder.

Case Study (continued)

• Other comorbidities
  o Hypertension
  o Alcohol and other substance abuse
  o Malnutrition

• Secondary conditions
  o Recent VRE UTI
  o Decrease intake leading to PEG tube placement in the past.
Case Study (continued)
• Shunt for hemodialysis in right upper extremity.
• Labs included
  o BNP level of 3,510
  o Albumin of 2.7
  o BMI of 15
  o Needed assistance with 5/6 ADLs
• DNR at admission and comfort measures only

Hospice Admission Date: 6/26/14
• Team worked closely and cohesively with family and facility staff to teach comfort meds utilization for optimal symptom management and support of patient and family.
  o Hospice Admission Date: 6/26/14
  o 7/7/14 family decided to discontinue hemodialysis
  o 7/14/14 seen by our NP. Patient wanted to go for a smoke. Symptoms well controlled and pt. appeared comfortable.
  o 7/30/14 began to show signs of decline, including restlessness and agitation and appeared weaker. Comfort meds were already in place and adjusted for optimal symptom management.

Case Study (continued)
• 8/5/14 pt. again visited by NP for delirium. Stopped eating, tube feeds cut, stopped smoking and had generalized weakness. We immediately initiated intensive comfort care (CC) with rapid titration of meds to ensure comfort. Discussions with family to confirm goals of care were comfort.

• 8/7/14 family decided to discontinue hemodialysis.

• 7/14/14 seen by our NP. Patient wanted to go for a smoke. Symptoms well controlled and pt. appeared comfortable.

Case Study (continued)
• 8/11/14 ICC discontinued. Pt. was lethargic but arousable and symptoms well-controlled.

• 8/12/14 Pt. passed peacefully in the facility as per her family’s goals.

Case Study (continued)
• Patient received visits from
  • Cardiac NP (5)
  • RN CM (17)
  • HHA (17)
  • Social Worker (9)
  • Chaplain (5)
  • Music Therapist (3)
  • On-Call Staff (5)
  • Volunteer (1)
  • ICC shifts (17)

  • Total of 62 visits; plus 6 days of continuous care over the 47 days.

Timing is everything
• Start the education process early
  o The best time to learn about hospice is long before it is needed or appropriate.
• Dispel the myths
  o Educate your clinicians as well as your patients.
• Empower your patients’
  o These are complicated issues. Sound decisions can only be made when accurate and complete information is provided.

Our Focus Should Always be the Patient
Questions?

References (continued)