Partnering with Hospice: Reducing Skilled Nursing Facility to Hospital Readmissions

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Objectives for Today

• Quick review of regulations that lead us to there we are.
• Examine structure of hospice
• Partnering with hospice agencies
• How Palliative Care can help
• Barriers to hospice

Readmissions Reduction Program (HRRP)

• The Affordable Care Act established the Hospital Readmissions Reduction Program, which required CMS to reduce payments to hospitals with excess readmissions, effective for discharges beginning on October 1, 2012.
• Defined readmission as an admission to a hospital within 30 days of a discharge from the same or another hospital.

-Centers for Medicare and Medicaid Services
In FY 2011, nursing homes transferred one quarter of their Medicare residents to hospitals for inpatient admissions, and Medicare spent $14.3 billion on these hospitalizations. Nursing home residents went to hospitals for a wide range of conditions, with septicemia the most common.


Nursing homes hospitalize residents when physicians and nursing staff determine that residents require acute-level care. Such transfers to hospitals provide residents with access to needed acute-care services.

However, hospitalizations are costly to Medicare, and research indicates that transfers between settings increase the risk of residents' experiencing harm and other negative care outcomes.

The Skilled Nursing Facility Value-Based Purchasing Program

The Skilled Nursing Facility Value-Based Purchasing Program (SNFVBP) rewards skilled nursing facilities with incentive payments for the quality of care they give to people with Medicare.

The SNFVBP Program starts in fiscal year 2019.

The SNFVBP Program promotes better clinical outcomes for skilled nursing facility patients and makes their care experience better during skilled nursing facility stays.

-Centers for Medicare and Medicaid Services

Medicare reimbursement rates for SNFs will be based partially on their performance scores. SNFs with the highest rankings receive the highest incentive payments and SNFs with a zero or low ranking will receive the lowest incentive payments. Effectively, the lowest 40 percent of SNFs will be reimbursed less than they otherwise would in the absence of this program.

-California Association of Long Term Care Medicine
The Skilled Nursing Facility Value-Based Purchasing Program

To fund the payment pool, CMS will withhold 2% of SNF Medicare payments starting October 1, 2018. CMS will then redistribute 50-70% of the withhold back into to SNF's by way of incentive payments. CMS will keep the balance, 30-50% as savings to Medicare.

- California Association of Long Term Care Medicine

The Skilled Nursing Facility Readmission Measure (SNFRM) is the first measure used to evaluate SNFs in the Value Based Purchasing Program. The program ties portions of SNF’s payments to their performance on this measure, which is calculated by assessing unplanned hospital readmissions for Medicare Fee For service SNF patients within 30 days of discharge from a prior proximal hospitalization.

Skilled Nursing Facility Potentially Preventable Readmission Measure

The Skilled Nursing Facility Potentially Preventable Readmission Measure (SNFPPR) assesses unplanned, Potentially Preventable Readmissions (PPRs) for Medicare Fee-For-Service SNF patients within 30 days of discharge from a prior hospitalization.
Percent of Medicare Beneficiaries Discharged From a Hospital to a Nursing Home and Rehospitalized Within 30 Days
Q3 2015 – Q2 2016
- Qualis Health Performance Reports, 2016

Why Partnering With Hospice is Good Care, and Will Help Decrease Readmissions

• Philosophy and Structure of Hospice
• How to Effectively Partner with Hospice Providers
• Looking at Palliative Care
• Barriers to Partnering

Hospice Philosophy and Structure

• Keep patients in place if at all possible.
• Clarification of treatment goals.
• Clarification of comfort goals.
• Explore meaning of quality in life.
Hospice Philosophy and Structure

- Interdisciplinary approach addressed holistic issues, not only medical.
  - Psychosocial needs.
  - Spiritual needs.
  - Comfort therapies.
- Hospice staff are expert at facilitating difficult and delicate conversations.
- Hospice considers cultural implications as well as medical.

Common Reasons for Readmission

- Septicemia as per CMS
- Symptom management
  - Pain
  - Anxiety
- Resident/family electing curative or aggressive treatment.
- Falls or other unanticipated events.

Many hospice-related symptoms can be managed without hospitalization

Pain and anxiety medication management:
- PCA pumps
- IV pain meds
- Other routes such as patches, topical, suppositories
- Non-medication intervention
  - Massage and music therapies
Family education and support

- Natural and commonly expected aspects of decline
- How to be present with their loved one during endstage care
- Anticipatory grief
- Addressing spiritual distress
- Assisting with funeral plans and other needs

How to Effectively Partner with Hospice

- Encourage and facilitate efficient to-way communication:
  - Request hospice staff sign in during visits
  - Request hospice staff check in with SNF team
- Encourage facility staff to update hospice staff on any changes in status:
  - Changes in orders
  - Falls, infections, or other events
  - Test and labs that have been ordered
  - DME needs

- Request copies of notes and care plans
- Include hospice staff in care conferences:
  - Before admission
  - During hospice care
  - Debriefing and reviewing care if indicated

- Take advantage of hospice education and support:
  - Request inservices
  - Grief and loss services for staff
Taking a Look at Palliative Care

• Palliative Care consults are needed at the SNF level, and at hospitals:
  • Facilitate goal clarification
  • Explore what comfort and quality mean
  • Make recommendations for comfort medications, etc.

Defining Palliative Care

The Oncology Roundtable defines Palliative Care as a program built on the following platform:

• Delivering aggressive symptom management
• Working with patients to set treatment goals
• Providing psychosocial support to families and patients
• Planning for end-of-life care

Defining Palliative Care

• Palliative care encourages the use of appropriate levels of care, which may lead to reduced hospitalization and, therefore, reduced readmissions. Such programs often target the same group of patients who are at high risk for readmission, including the highly complex, co-morbid patients who may otherwise slip through the cracks. In fact, we often hear that being a “frequent flyer” is one element of the criteria for receiving a palliative care consult.
Defining Palliative Care

• Further, palliative care programs are able to keep patients out of the hospital by providing symptom management so that a patient does not bounce back the next week due to uncontrolled pain. Delivering palliative care through an outpatient model has been proven to reduce avoidable hospitalizations and ED visits, suggesting that the model would also lead to reduced readmissions.

Different types of Palliative Care programs:
• Inpatient Consult Service
• Palliative Care Outpatient Clinics
• Community Based Programs

Palliative Care can be concurrent with skilled therapy at the SNF level, or with home health care at the ALF level.

Barriers to Hospice Care

Facility Barriers:
• Confusion about programs
  • Basic premise of hospice
  • Hospice criteria and eligibility
  • Difference between hospice and palliative care
  • Discomfort with the topic
  • Physicians’ reluctance to refer and give a px of <6 mo.
Barriers to Hospice Care

• Facility staff reluctance to engage with hospice staff:
  • Cultural differences
  • Lack of knowledge about hospice
  • Staff losses are not acknowledged so they are reluctant to care for dying residents
  • Poor communication between patients and providers, and lack of care coordination. (National Quality Forum, 2014)

• Hospice Barriers:
  • Delayed response time
  • Poor coordination and communication with facility staff
  • Hospice not recognizing needs of facility staff
    • Educational needs
    • Emotional needs
  • Lack of support for facility staff

QUESTIONS?