Impacting Care for Heart Failure Patients; Implementing and Validation of a Standardized Disease Specific Program

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Goal/Objectives

Evidence-based literature review on **transitions from Skilled Nursing Facilities (SNFs) to hospice care**

- **Learning Objectives:**

1) Benefits of timely hospice referrals
2) Coordination of care across SNF–Hospice teams (GOC)
3) Hospice eligibility for Heart failure and other disease process (Medicare/CMS and clinical indicators)
4) Guidelines & the role of hospice in SNF transitions
5) Clinical signs of dying (last days)

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Background

- Over 51% of Medicare decedents use hospice; many reside in SNFs
- Median length of stay in hospice is 21–24 days, with many ≤7 days
- Late referrals limit symptom relief and family support
- Transitions are complex: require coordination among SNF staff, hospice, and families

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Skilled Therapy in Skilled Nursing Facilities

Research shows that residents who receive skilled therapy in SNFs experience:

- High likelihood of rapid, measurable improvement in function
- 30% faster recovery rates compared to those without skilled therapy
- Illness/exacerbation likely to resolve quickly
- Reduced risk of hospital readmission within 30 days post-discharge
- Tolerate >60 min of therapy a day, 6-7 days/week
- Enhanced mobility and independence, improving overall quality of life

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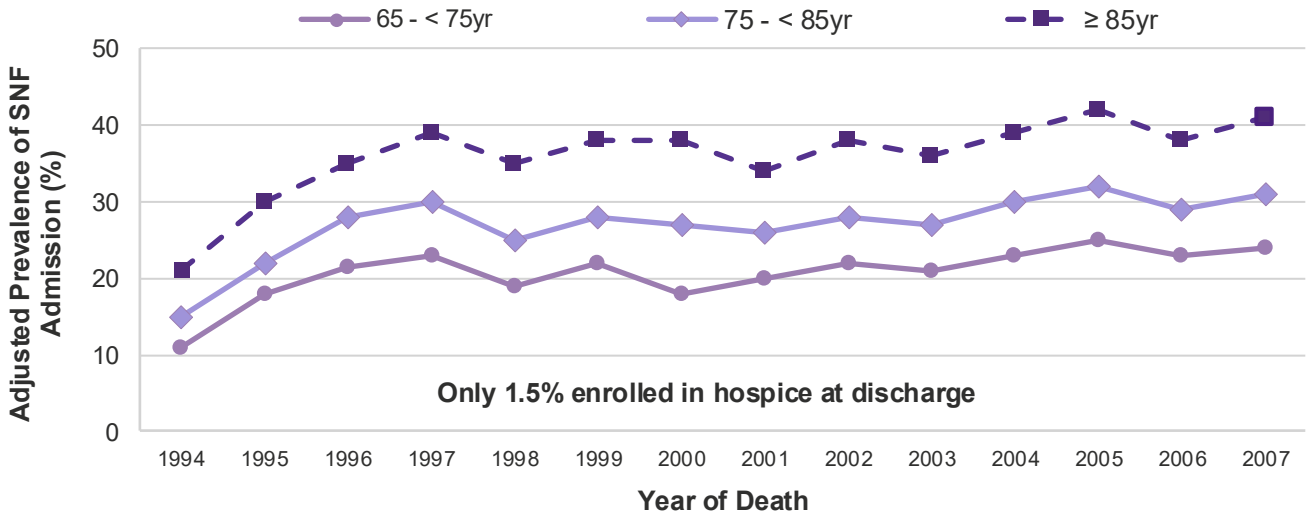
SNF Use by Older Adults in Last 6 Months of Life



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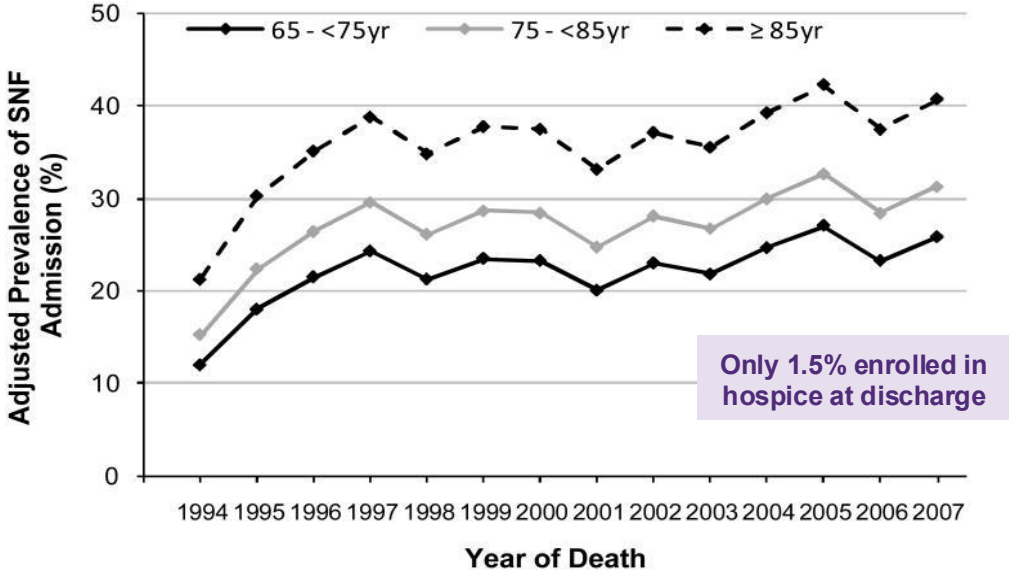
Aragon, K., et al. (2012). Use of the Medicare Posthospitalization Skilled Nursing Benefit in the Last 6 Months of Life. *Archives of Internal Medicine*, 172(20), 1573-1579.

Improving Hospice Access for Short-Stay Residents

Skilled Nursing Facility Utilization in the Last 6 Months of Life



1 in 11 die under skilled benefit

Opportunities for Impact

- Collaborate with Hospice on goals of care education, and resident and family resources
- Leverage Hospice to email information directly to resident and/or family to begin hospice conversation

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Case of Ms. Y

- **82-year-old female**
- **Advanced COPD, ischemic cardiomyopathy (EF 25%), CKD-4**
- Multiple admissions in the past 6 months
- PPS 50-60%
- Admitted to **SNF for rehab** after hospitalization for pneumonia

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SNF Course

- **Week 1–2:** Initially admitted for rehab after hospital stay. Required 2–3 L/min oxygen. Marked fatigue and limited mobility; unable to participate in meaningful PT/OT.

- **Week 3:** Decline noted—progressive dyspnea at rest, unintentional weight loss, PPS down to 40%. Increasing dependence in ADLs.

- Family Discussions: Goals of care (Yes/No)

Acute Decline

- **Day 25 in SNF:** Patient developed acute shortness of breath, confusion, and hypoxia despite oxygen escalation.

- **Decision:** Instead of initiating hospice at the SNF and focusing on comfort, family requested **transfer to the hospital** for “all possible treatments.”

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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

- Ultimate objectives:
  - Improve care transitions
  - Relieve Medicare beneficiaries of the burden of returning to the hospital
  - Relieve taxpayers of the cost of readmissions

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The MedPAC Blog. (2018). The Hospital Readmissions Reduction Program has succeeded for beneficiaries and the Medicare program. Retrieved from: http://www.medpac.gov/-blog-/the-hospital-readmissions-reduction-program-(hrrp)-has-succeeded-for-beneficiaries-and-the-medicare-program/2018/06/15/the-hospital-readmissions-reduction-program-has-succeeded-for-beneficiaries-and-the-medicare-program

Components of Readmission Measure

Component	Description
Target Population	Medicare fee for service age 65 and older discharged from acute care or VA hospital with an index condition. Beginning in FY 2019, the 21st-Century Cures Act requires CMS to assess a hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full-benefit Medicaid
Definition	Patient is discharged from the applicable hospital to a non-acute care setting and is admitted to the same or another acute-care hospital for any reason
Exclusions	Planned readmission within 30 days
Applicable Data	Three years of discharge data calculates excess readmissions
Risk Adjustment	Patient-related factors that may impact readmissions including age, gender, comorbidity and disease severity. Patient data for risk is obtained from claims for 12 months prior to and including index admission

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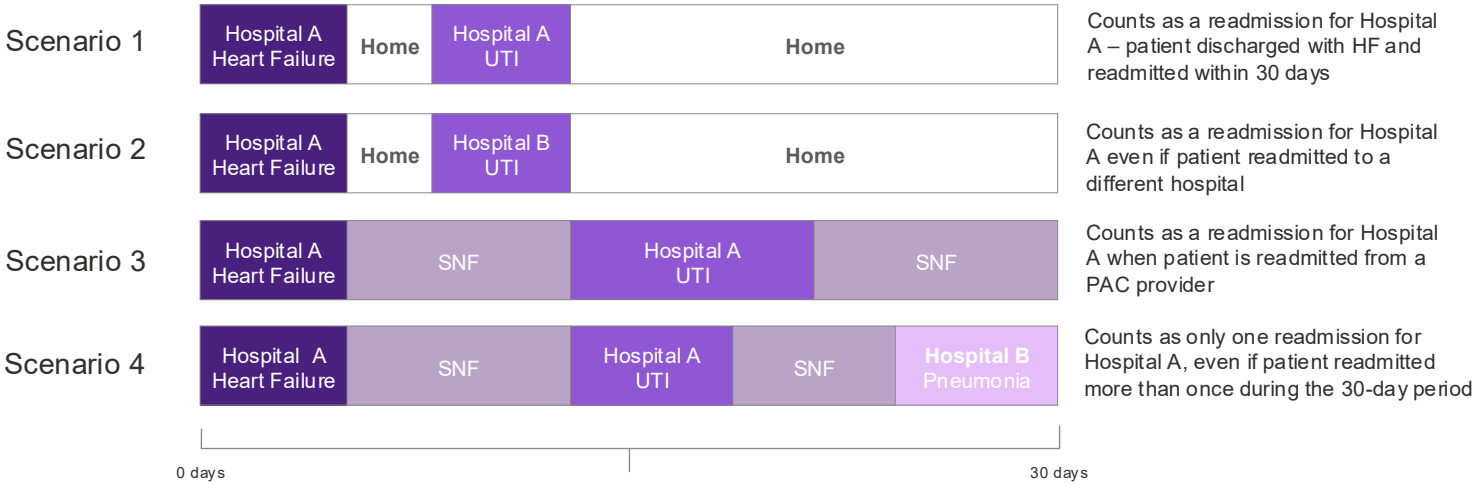
What Counts as a Readmission?

When a patient with AMI, COPD, pneumonia, or heart failure is readmitted to a hospital within 30 days of the initial hospitalization, it is considered a readmission.



Each of these scenarios would count as **ONE readmission** for **Hospital A**

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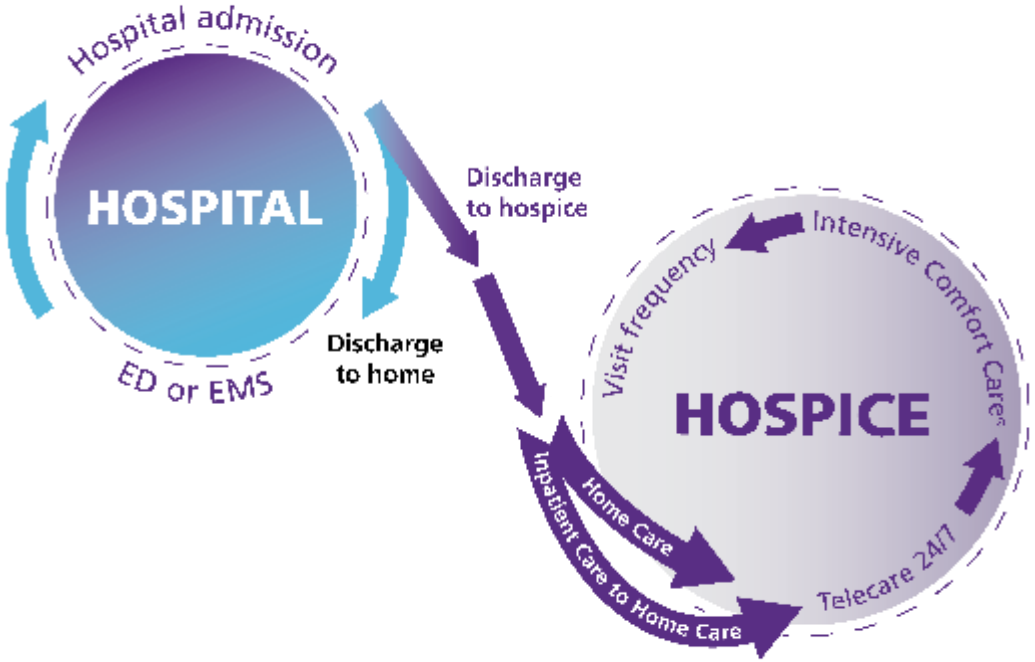
Hospice and Hospital Readmission Prevention



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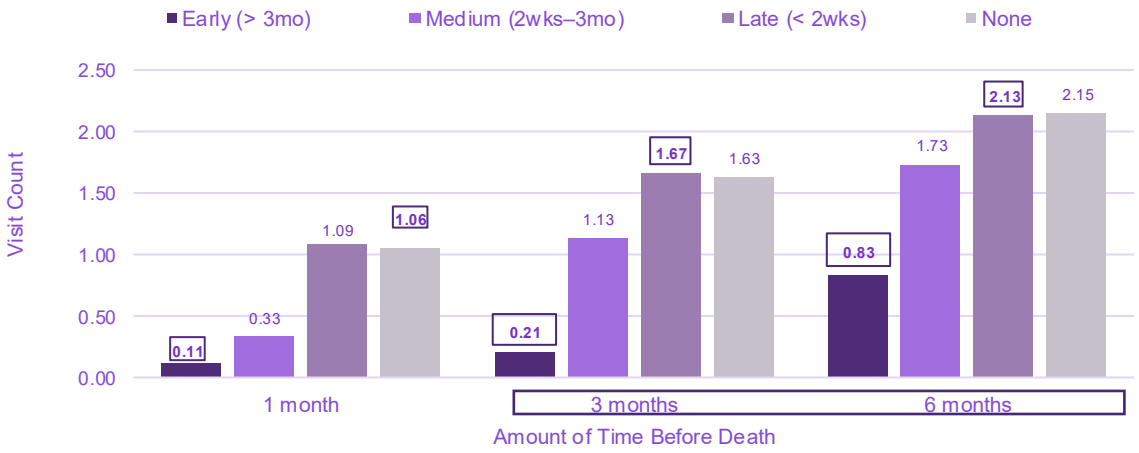
Evidence: Early Referrals Reduce Inpatient Hospitalizations

- Non-hospice patients were **10X more likely to be admitted to the hospital** during the last month of life than patients who received early hospice care
- Late-referral hospice patients were **5X more likely to visit the emergency room** during the last month of life than early hospice patients



The VITAS Advantage offers:

- 24/7/365 availability for patients, families, and our partners.
- High-acuity services to manage aggressive symptoms and prevent unnecessary hospitalizations.
- Complex modalities to ensure patients' symptoms are managed effectively in their preferred care setting

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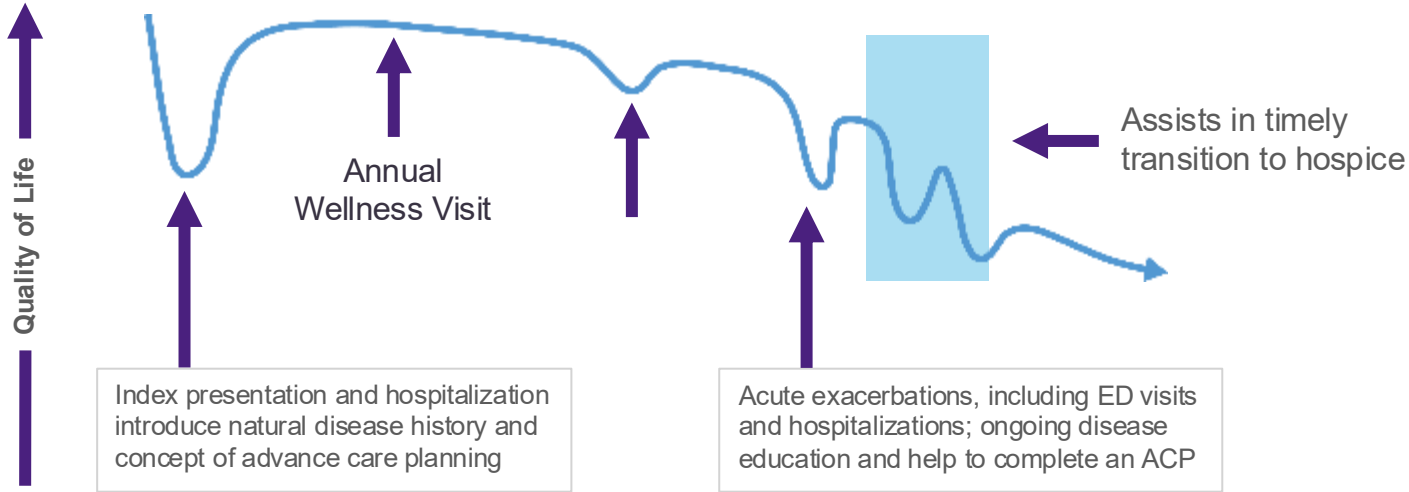
Advance Care Planning (ACP)

Conversations should occur throughout the natural history of serious illness.



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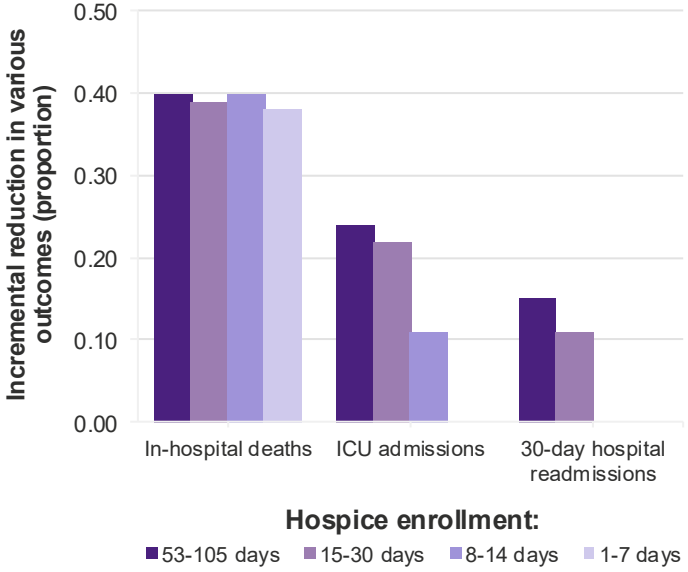
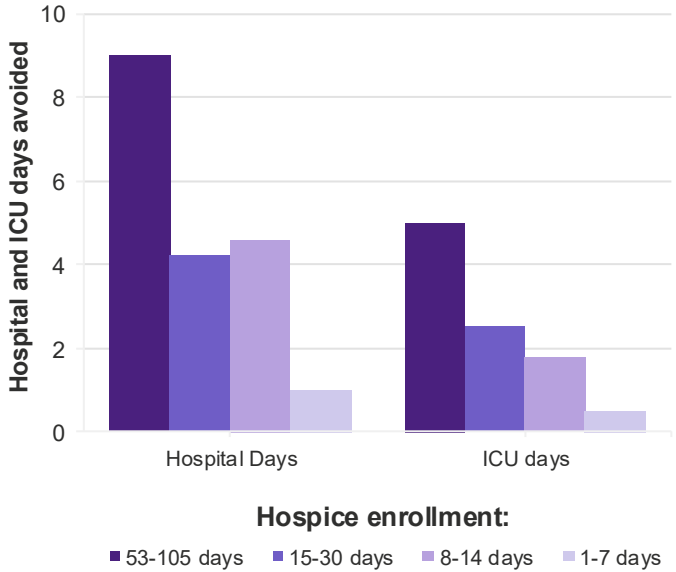
Hospice Use Decreases Acute-Care Utilization





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Kelly, A. (2013). Hospice Enrollment Saves Money and Improves Quality. *Health Affairs*, 32 (3):552–561.

Hospital Course Case Ms.Y

- Admitted through the emergency department, placed on **BiPAP** in the ICU.
- Received IV antibiotics, diuretics, and steroids.
- Despite aggressive measures, her condition worsened. She died in the hospital **five days later**, on mechanical ventilation, without hospice involvement.

Reflection Case Ms. Y

- **Impact on patient:** Distressing interventions, multiple procedures, passed away in ICU rather than familiar SNF environment.

- **Impact on family:** Later expressed regret about the suffering endured and wished they had understood hospice benefits sooner. Without the Medicare hospice benefit ineligible for social worker for memorial services and 13 months of bereavement.

- **System perspective:** Another high-cost, burdensome hospitalization that might have been avoided.

Take home message

Earlier **hospice referral** in the SNF could have allowed:

- Symptom management in place (opioids for dyspnea, comfort care plan).
- Avoidance of ICU admission.
- Emotional support for family, with bereavement follow-up.
- Highlights the **need for timely GOC discussions** and staff-family-hospice coordination.

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Pathway 2: Hospice in the SNF (Timely Goals of Care)

- At the same point of decline, staff initiated a **Goals of Care meeting**
- Hospice consulted **while patient remained in the SNF**
- **Care plan:**
    - Low-dose opioids for dyspnea
    - Discontinuation of burdensome lab draws and monitoring
    - Emotional/spiritual support for family
    - Bereavement services arranged
- **Outcome:**
    - Patient remained comfortable in her own bed at the SNF
    - Passed away peacefully 3 weeks later
    - Family felt supported, expressed gratitude for dignity and comfort

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2 Different Pathways

Domain	Hospitalization Pathway	Hospice in SNF Pathway
Location of care	Transferred to hospital/ICU	Remained in SNF
Interventions	BiPAP, IV antibiotics, labs, monitoring	Opioids for dyspnea, comfort plan
Length of stay	5 days until death in ICU	3 weeks on hospice
Comfort & symptom control	Distressing interventions, limited relief	Comfort-focused, peaceful death
Family experience	Regret, distress at suffering	Gratitude, felt supported
System impact	High cost, burdensome hospitalization	Lower cost, avoided acute transfer

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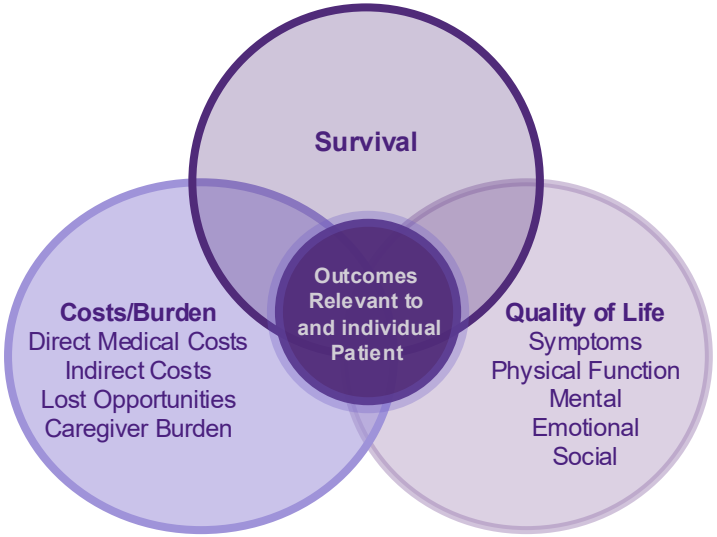
Important Elements of Shared Decision-Making for Goals-of-Care Conversations



- No more hospitals
- Minimal tests
- Improve shortness of breath
- Continue to live in house
- Enhance quality of life over quantity

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Allen et al. (2012). Decision making in advanced heart failure: a scientific statement from the American Heart Association. *Circulation*, 125(15), 1928-1952.

Defining Terminal Illness

- Not limited to specific diseases
- Life expectancy of 6 months, if the disease runs its normal course
- Patient can live beyond 6 months. Hospice re-certs at 90, 90 and every 60 days thereafter
- Patient not required to have a DNR

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Identifying Appropriate Patients

- Is the resident experiencing a progressive decline or a decline unresponsive to treatment?
- Does the resident have advance directives indicating that he/she does not desire life-prolonging measures?
- Has the resident/responsible decision-maker indicated a desire for comfort, rather than curative care?
- Has the resident been diagnosed with a terminal or life-limiting illness?
- Would you be surprised if the resident died within the next year?

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Hospice Eligibility Guidelines

General Health Decline

- General Impression
- Nutrition (Weight loss, muscle loss, dysphagia)
- Function (ADL decline, reduced ambulation, falls with injury)
- Cognition
- Health Care Utilization (ED use and hospitalizations)
- Symptoms (Delirium, fatigue, shortness of breath)

Disease Specific Decline

Cancer

Advanced Cardiac Disease
(heart failure or other heart disease)

Alzheimer's/dementia and other neurological disease (chronic and acute stroke)

Advanced Lung Disease (COPD and other forms of lung disease)

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Functional Status and Survival

PPS Level	Ambulation	Activity and Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity and work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity and work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity with effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable to perform normal job/work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable to perform hobby/housework Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bedbound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy
20%	Totally Bedbound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bedbound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	—	—	—	—

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Clinical Signs of Dying

Death Rattle

Decreased output

non reactive pupils

Apnea

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Clinical Signs of Dying

Clinical Sign	Median Time Onset to Death	Description and Positive Sign
Peripheral edema	>7 days	Accumulation of fluid resulting in swelling, location is generally most dependent parts of the body such as the arms and legs
Delirium	>7 days	Poor attention with acute onset and fluctuating course; severe confusion sometimes associated with hallucinations, abnormal drowsiness and/or restlessness, pacing, and agitation
Dysphagia of solids	>7 days	Difficulty swallowing solids
Decreased Speech	7 days	Less able to communicate through words
Cool/Cold Extremities	7 days	Skin of legs and then arms feels cold to the touch
Abnormal vitals	4-6 days	High heart rate (>100) or respiratory rate (>20); Low systolic (<100) or diastolic(<60) blood pressure
Decreased level of consciousness	5.5 days	Somnolence (sleepiness, drowsy, ready to fall asleep) and/or lethargy (drowsiness where the patient can't be easily awakened)
Dysphagia of liquids	5.5 days	Difficulty swallowing liquids
PPS 20% or less	3 days	Bedbound, unable to do any work, total care, minimal intake/sips
Peripheral cyanosis	3 days	Bluish discoloration of extremities
Decreased response to visual stimuli	3 days	Decreased response to visual cues
Drooping of the nasolabial fold	2.5 days	Decrease in prominence/visibility of nasolabial fold (see appendix for pictures)
Hyperextension of the neck	2.5 days	Neck becomes hyperextended
Cheyne-Stokes breathing	2 days	Alternating periods of apnea and hyperpnea with a crescendo-decrescendo pattern
Nonreactive pupils	2 days	Flash light into pupils to see if they react
Decreased response to verbal stimuli	2 days	Decreased response to verbal cues
Death rattle	1.8 days	Gurgling sound produced on inspiration and/or expiration related to airway secretions
Apnea	1.8 days	Prolonged pauses between each breath
Respiration with mandibular movement	1.8 days	Depression of jaw with inspiration
Decreased urine output	1.8 days	Measured volume of urine over a 12-hour period, <100 mL
Pulselessness of radial artery	1.5 days	Inability to palpate radial pulse
Inability to close eyelids	1.5 days	Eyelids do not close
Grunting of vocal cords	1.5 days	Sound produced predominantly on expiration, related to vibrations of vocal cords
Fever	1.5 days	Temperature > 100

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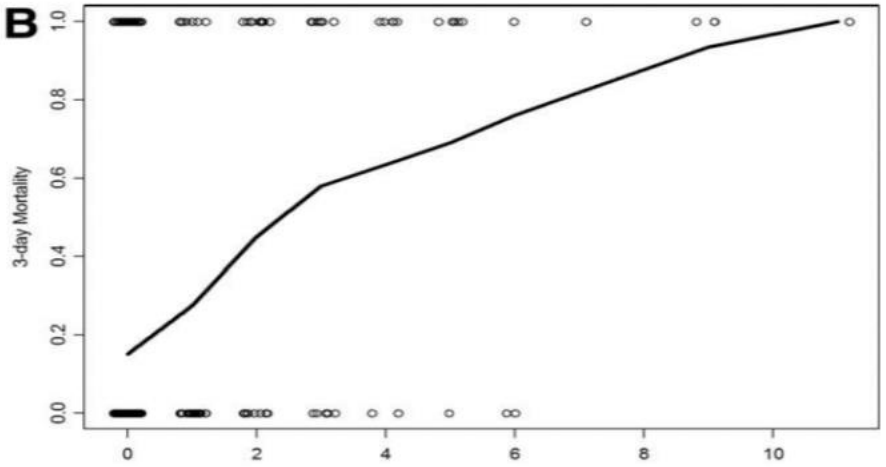
Clinical Signs of Dying

A direct relationship exists between the number of clinical signs of dying and death. The graph below demonstrates that persons with two clinical signs of dying had a 40% chance of dying, whereas those with eight had an over 80% chance.



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Clinical Signs of Dying

Figure 1. Drooping of nasolabial folds. (A) Nasolabial folds are the skinfolds that run from the nose to the corners of the mouth (arrow). (B) In the last days of life, drooping of nasolabial folds may be noted, and they become less prominent because of the loss of facial muscle tone. The face appears to be more relaxed.

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Beginning the Partnership

- Nursing homes can choose whether or not they want to have a written agreement with a hospice provider
- There is no limit to the number of contracted hospice providers
- If a nursing home chooses not to have a contract with a hospice selected by a resident, then the nursing home is responsible for assisting the resident in transferring to another nursing home that will arrange for the provision of requested services

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The Value of a Partnership With VITAS

All hospices must provide core services, but substantial variation exists in how these services are delivered.

Elevated Care

- Telecare
- Intensive Comfort Care®
- Visits after hours and weekends
- Physician centric care model (> 700 employed by VITAS)
- Dedicated hospital-based staff

Distinctive Programs

- Advanced lung
- Heart failure
- Sepsis/post-sepsis
- Oncology
- Dementia behavioral protocols
- ED diversion
- Academic partnerships and publications
- Robust educational platform offering CEUs, CMEs, and multilingual patient and family education
- Clinical pastoral education
- Local ethics committee

Complex Modalities/ Concurrent Care

- IV hydration/TPN Lyte
- IV/PO antibiotics
- Inotrope therapy
- Sub-Q diuretics
- Therapy services: PT, OT, speech
- Paracentesis
- Thoracentesis
- Blood transfusions
- Oncology taskforce for anti-tumor treatments (hormonal, XRT)
- PleurX drains
- Nutritional counseling
- ICDs/ LVADs

VITAS-Owned HME

- Oxygen, including high-flow
- Non-invasive ventilation, BiPAP, CPAP, home ventilator, and Trilogy
- Hospital bed
- Specialized mattress
- ADL-assist devices
- Incontinence supplies
- Wound care supplies
- Hospice-specific access (24/7/365) and speed to home medical equipment (HME)

Specialty Therapies

- Respiratory therapy
- Music
- Massage
- Pet visits
- PT/OT/speech
- Wound care
- Dietary
- Child-life specialist
- Bereavement/ support groups
- Veterans specialist

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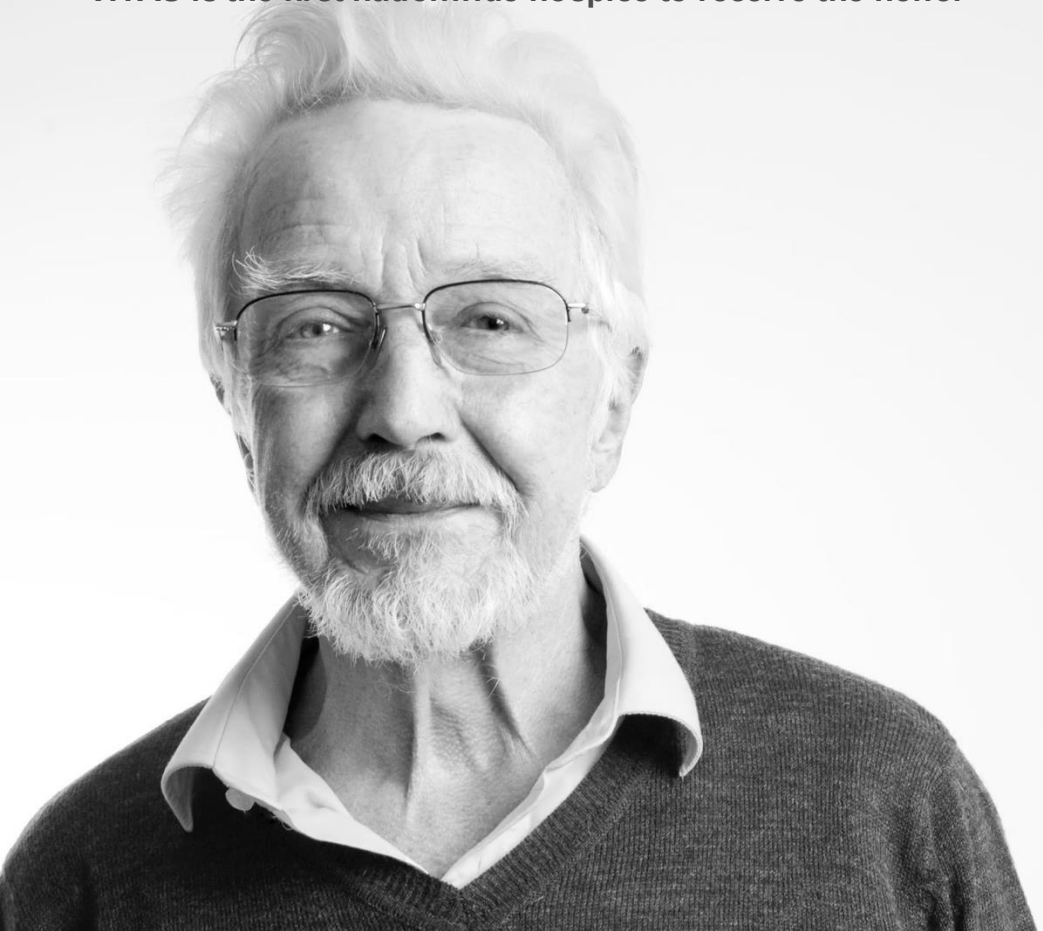
AHA Palliative/Hospice Heart Failure Certification

VITAS is the first nationwide hospice to receive the honor



- VITAS is the first national hospice organization to earn this certification across all its programs, a recognition that our comprehensive cardiac care model meets the AHA's rigorous standards
- All VITAS clinical staff completed cardiac-specific training set by AHA prior to certification
- VITAS provides quality cardiac care at the bedside, supporting patients and families in their preferred care setting
- Metrics-driven approach designed to improve outcomes

American Heart Association®
Certified Care™
Palliative/Hospice
Heart Failure

Service Comparison

	Hospice Care/ VITAS	Palliative Care	Home Health
Eligibility Requirements	Prognosis required: ≤ 6 months if the illness runs its usual course	Prognosis varies by program, usually life-defining illness	Prognosis not required
	Skilled need not required	Skilled need not required	Skilled need required
Plan of Care	Quality of life and defined goals	Quality of life and defined goals	Restorative care
Length of Care	Unlimited	Variable	Limited, with requirements
Homebound	Not required	Not required	Required, with exceptions
Targeted Disease-Specific Program	✓	Variable	Variable
Medications Included	✓	X	X
Equipment Included	✓	X	X
After-Hours Staff Availability	✓	X	X
RT/PT/OT/Speech	✓	X	✓
Nurse Visit Frequency	Unlimited	Variable	Limited, based on diagnosis
Palliative Care Physician Support	✓	Variable	X
Levels of Care	4	1	1
Bereavement Support	✓	X	X

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Questions ?

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HRRP Penalties and Conditions

Program Year	1	2	3	4	5	6
Fiscal Year	2013	2014	2015	2016	2017	2018
Dates of Performance Measurement	8-Jun to 11-Jul	9-Jun to 12-Jul	10-Jun to 13-Jul	11-Jun to 14-Jul	12-Jun to 15-Jiul	13-Jun to 16-Jul
Conditions for Original Hospitalization	Heart Attack (AMI) Heart Failure (HF) Pneumonia	Heart Attack (AMI) Heart Failure (HF) Pneumonia	Heart Attack (AMI) Heart Failure (HF) Pneumonia Chronic Obstructive Pulmonary Disease (COPD) Hip/Knee Arthroplasty (THA/TKA)	Heart Attack (AMI) Heart Failure (HF) Pneumonia Chronic Obstructive Pulmonary Disease (COPD) Hip/Knee Arthroplasty (THA/TKA)	Heart Attack (AMI) Heart Failure (HF) Pneumonia [Expanded] Chronic Obstructive Pulmonary Disease (COPD) Hip/Knee Arthroplasty (THA/TKA) Coronary Artery Bypass Grafting (CABG)	Heart Attack (AMI) Heart Failure (HF) Pneumonia [Expanded] Chronic Obstructive Pulmonary Disease (COPD) Hip/Knee Arthroplasty (THA/TKA) Coronary Artery Bypass Grafting (CABG)
Maximum Penalty	1%	2%	3%	3%	3%	3%

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[a]Due to the COVID-19 PHE, CMS shortened the FY 2022 and FY 2023 performance periods from 36 months to 29 months. The FY 2022 performance period was July 1, 2017, to December 1, 2019. The FY 2023 performance period is July 1, 2018, to December 1, 2019, and July 1, 2020, to June 30, 2021.

Service Comparison

Service	VITAS	Home Health
Eligibility	• Physician-certified prognosis <6 months, if disease runs normal course • Hospice prognosis must be re-certified periodically • Patient agrees to palliative, not curative, plan of care • Plan of care determined by initial and ongoing doctor/team assessment, combined with patient/family wishes • **Not required to be homebound**	• Must require skilled level of care and a specific plan of care confirming need, frequency and duration of visits • Skilled nursing care need must be re-certified periodically • As skilled needs change, approved services change • **Must be homebound**, except for short durations
Length of Care	Unlimited number of visits based on patient need, if prognosis remains 6 months or less	• Limited number of visits • Must document progress within the length of service allowed
Medications Included	VITAS provides Rx and OTC medications related to hospice diagnosis at no charge to the patient	Medications are not covered under the Medicare Home Health Benefit

Service	VITAS	Home Health
Palliative Care Physician Support	Yes	No
Nurse Frequency of Visits	Unlimited based on patient need	Diagnosis driven
RT/PT/OT/Speech	Yes	Yes
Equipment Included	Yes	No
After Hours Staff Availability	Yes	No
Levels of Care	4 Levels	Home
Care Plan Review	Weekly	Variable
Targeted Disease-Specific Program	Yes	Variable
Bereavement Support	Yes	No

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