



The Connecticut
hospice
Inc.

**MEDICARE HOSPICE BENEFIT
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**PATIENT and FAMILY OPTIONS
for
COMFORT MEASURES
END OF LIFE CARE and SUPPORTIVE TEAM ASSISTANCE**

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PROGRAMS AVAILABLE

- **Hospice Inpatient Care**
 - Inpatient – 52 beds
 - 3 and 4 bed – multi-bed rooms
 - Pediatric Room(s)
 - Negative Pressure Rooms
 - Private Rooms for Isolation
 - **Hospice Home Care**
 - At Home
 - Skilled Nursing Facility
 - Assisted Living
- **Cansupport Program – Palliative Care**
 - Patient continues to receive active treatment
 - Curative Goals – Chemo, transfusions, dialysis, radiation, etc.
 - Patient / Family not prepared for “Hospice” terminology
 - Patient remains in home environment - Must meet “home bound” criteria

SETTINGS FOR DELIVERY OF C

- Inpatient Hospice Setting
 - The Connecticut Hospice – Branford, CT
 - Hospice beds in local hospitals (14 day maximum):
 - Norwalk Hospital
 - Griffin Hospital
 - John Dempsey Medical Center (UCONN)
 - St. Vincent's Hospital
 - Level II Bed in a Skilled Nursing Facility
 - Final days of life (Maximum 14 days)
 - Hospice Agency is paysource for all care and room & board
 - Home Setting
 - Skilled Nursing Facility (the facility is considered the patient's home
 - Prior to the final days of life the patient is financially responsible via either personal payment or Medicaid payment
- Assisted Living

CRITERIA FOR DETERMINING APPLICABLE PROGRAMS and ELIGIBILITY

- Patients are reviewed on an individual basis by applying *and* specific guidelines which pertain to:
 - Terminal Diagnosis - Medicare Guideline used for prognosis
 - Patient and Family goals
 - Caregiver ability (home setting)
 - Plan of Care
 - Paysource – Medicare, Medicaid, Commercial Insurance, Anthem, BC, Aetna, CIGNA, etc.), Gratis.
- Commercial Insurance – Coverage varies plan-to-plan case managed.
- Gratis – Reviewed case-by-case with financial data

HOSPICE INPATIENT

Criteria is established in accordance with Medicare Hospice *Guidelines*; same criteria is applied to Medicaid coverage.

These *guidelines* are used as a determination-tool for all patients regardless of the pay source.

- Referral from MD, Hospital Care-Coordinator, D/C Planner, Social VNA Agency, directly from family member, patient, etc.
 - Intake department / Hospice Liaison RN will follow-up on patient review clinical information and coordinate a transfer to service if patient meets criteria.
- Patient / Family goals = comfort measures; no further aggressive
- Terminal Diagnosis
- A prognosis of less than two months of life is provided by the Primary Physician's Assistant or Advance Practice RN

"It is my professional judgment, based on the medical information available, that *Mr. Smith* has a terminal illness with a life expectancy of less than 2 months of life if the illness runs its anticipated

HOSPICE HOMECARE

Criteria is established in accordance with Medicare Hospice *guidelines*. These *guidelines* are used as a determination-to patients regardless of paysource.

- Referral from MD, Hospital Care-Coordinator, D/C Planner, Social Agency, directly from family member, patient, etc.
 - Intake department / Hospice Liaison RN will follow-up on patient review clinical information and coordinate a transfer to service patient meets criteria.
- Patient / Family goals = comfort measures; no further aggressive
- Terminal Diagnosis
- A prognosis of less than six months of life is provided by the Physician's Assistant or Advanced Practice RN

"It is my professional judgment, based on the medical information that *Mr. Smith* has a terminal illness with a life expectancy of 6 months of life if the illness runs its anticipated course

Home Care ctd.

- Safe Plan that provides adequate care:
 - Competent caregiver
 - Agency Involvement:
 - Skilled Nurse - "Eyes & Ears" for Physician
 - Physical Therapy
 - Pharmacist
 - Home Health Aid
 - Social Work
 - Spiritual Care
 - Arts, Music, Creative Writing, Storytelling, Journaling
 - Complimentary Medicine - Massage, Reiki, Aroma therapy
 - Medications directly related the terminal diagnosis
 - Durable Medical Equipment
- Transition to inpatient setting if needed

HOMECARE – *Cansupport*[®] PROGRAM

- Patient & family goals are for ongoing treatment in the of a terminal diagnosis or chronic disease.
- Payscale (Medicare, Medicaid, commercial insurance) the criteria and the homecare services available per patient each patient
- Patient must meet "Homebound" criteria
- Agency Involvement
 - Skilled Nurse - "Eyes & Ears" for Physician
 - Home Health Aid
 - Social Work, PT, OT, ST as ordered & covered

FACTOIDS

- The Connecticut Hospice, Inc. is licensed as an acute care hospital with a specialty in Hospice and Palliative Care.
 - **End of Life Care** - comfort measures with focus on quality of life from the Interdisciplinary Team ~ anticipatory grief counseling
 - **Symptom management** with goal to return home with maximum supportive services
 - **Palliative Care** - Management of a terminal or life threatening illness that focuses on symptom control and quality of life rather than cure or life prolongation.

- **Discharge Planning**

- 30 percent of patients in the inpatient hospice identified for discharge planning.
- Actual discharges from the inpatient facility - 15%
 - Home with safe & adequate care - with support services from Hospice
 - Skilled Nursing Facility - with supportive services from Hospice
 - Discharge to a Medicare Rehab for physical therapy (no Hospice services)

- Home Care

- Emergency coverage by RN 24 / 7
- Contact w/Hospice RN is first line contact
- Primary MD or Specialist remains in charge of care
- Ongoing orders obtained from MD
- RN is the liaison between the patient and M

GOALS

PATIENT and FAMILY GOALS and WELL-BEING

- Identify the patient/family that can benefit from services
 - Hospice Program vs. CanSupport
 - Home vs. inpatient
- Customize the delivery of care for patient/family goals
 - Transfer from hospital setting to Hospice inpatient for comfort measures and terminal care.
 - Transfer from hospital setting *following an acute event* for symptom management / recuperation with goal to leave home setting:
 - Placement (SNF / AL) with supportive services
 - Medicare Rehab (short term) for strengthening w/goal home
 - Directly home with competent caregiver

GOALS cont.

- o Home with supportive services with plan for death at home
 - Continuous-care services in final days of life
 - RN or Home Health Aid up to 24 hours per day
- o Home with supportive services with transfer to inpatient disease and symptoms progress.
- o Home with supportive services with transfer to inpatient caregiver can no longer provide safe and adequate care.

Interdisciplinary Team Approach

Services in *both* home care and inpatient setting:

- Medicine - Physicians
- Nursing – RNs
- Pharmacy
- Social Work
- CNA / Home Health Aid
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Nutritionist
- Arts (Participatory and Observation)
 - Tactile, Visual, Music, Journaling, Participatory, Portraiture History
- Spiritual
- Wellness Seminars
- Bereavement

- **Complementary Med**

- Massage
- Reiki
- Pet Therapy

- **Volunteer Services**

- Companionship
- Transportation
- Meal Preparation
- Home Projects

- **Spiritual Care**

- Clergy

- **Bereavement Services**

- Telephone contact
- Follow-up Mailings - Interval mailings for one year
- Scheduled Support Groups
- Referrals to additional support groups

The *goal* of all disciplines is to assist patient and family to live their lives to the fullest capacity, with comfort and dignity the moment that the patient's life, on

Earth, comes to an end.

After the death of a friend or family member bereavement services are offered for a minimum of 18 months.