NAPCRG 52nd Annual Meeting — Abstracts of Completed Research 2024.

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Title

I survived hospice: Live discharges from a Medicare-certified home hospice program

Priority 1 (Research Category)

Palliative and end-of-life care

Presenters

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Abstract

Context: Hospice aims to manage a patient's symptoms as they near end of life. While not the ideal case, patients may be discharged alive from hospice for a number of reasons, including: patient revocation of care, improved prognosis, or transfer of care to a different facility or geographic area. Live discharges may be problematic if they lead to high rates of hospice readmissions, high rates of hospital utilization following discharge, or occur after 180 days in hospice. Medicare routinely reviews U.S. claims data to assess patterns of live discharges and may revoke funding for hospice programs with high rates of live discharges. Thus, hospice programs may endeavor to review their patterns of live discharges and identify areas of improvement to reduce live discharges. Objective: Quantitate live discharges from a Medicare-certified home hospice program, determine rates of hospital utilization within 6 months of discharge, and review the discharge planning process including coordination of follow-up with a primary care physician following hospice discharge. Study Design: Secondary data analysis; quality research.

Setting or Dataset: Medicare-certified home hospice program in a Midwest U.S. metropolitan area. Population Studied: Patients admitted to home hospice and discharged alive in 2022. Intervention/Instrument: N/A. Outcome Measures: Reason for live discharge, length of hospice stay, discharge planning steps documented, clinical course for 6 months post-discharge. Results: A total of 87 patients were discharged alive from the home hospice program in 2022. Most discharges occurred either in the first 30 days (38%) or after 180 days (24%). Over half of discharge patients voluntarily revoked care (60%) and 49% of these patients reenrolled in hospice within 6 months. Across all discharges, 43% had at least one ED visit or hospitalization within 6 months of discharge. Coordination of PCP follow-up was done for 13% of discharged patients and 22% had documentation of at least one step of the discharge planning process (e.g. ordering meds). Conclusions: High rates of hospice readmission and hospital utilization following live discharges was observed, and documentation of

discharge planning steps was limited for these patients. This project suggests room for improvement in the explanation of hospice services/philosophy and the discharge planning process.