



# Live Discharge in Hospice

Challenges and Opportunities when patients transition



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“Throughout our organization we've always looked to bring together the right skills and knowledge to support our technology development, network growth, and customer service. With experience that goes beyond the healthcare and IT industry, our experts are laser-focused on bringing to market the latest Management Solutions and dedicated client support. “

# We exist to improve patient experiences.

Our company was founded because of a negative, personal experience with DME at a family member's end of life. We knew there had to be a better solution. Today, we deliver peace of mind to caregivers, family members and patients by existing at the intersection of technology and patient care. As a visible extension of our clients we understand that few things are more important than providing a positive experience for our mutual patients.



**PIONEERS WITH 22 YEARS**  
of Pharmacy & DME-  
Technology Experience



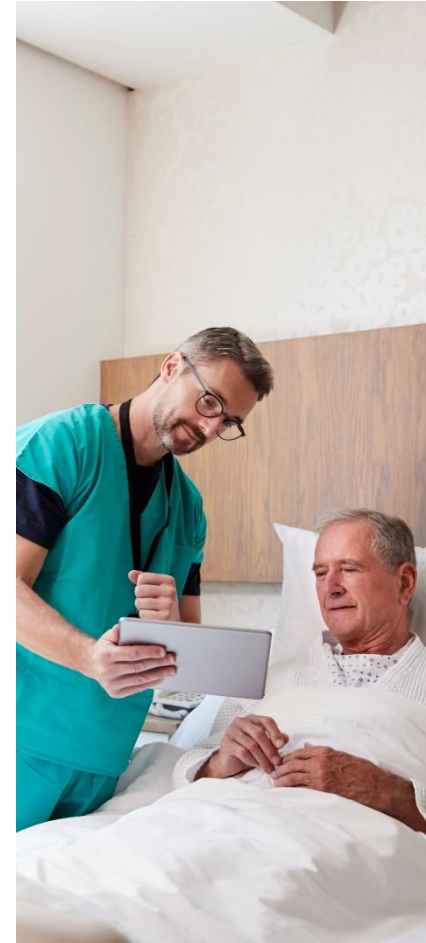
**3,050**  
DME Locations  
Across 50 States



**400,000**  
Patients Served Daily

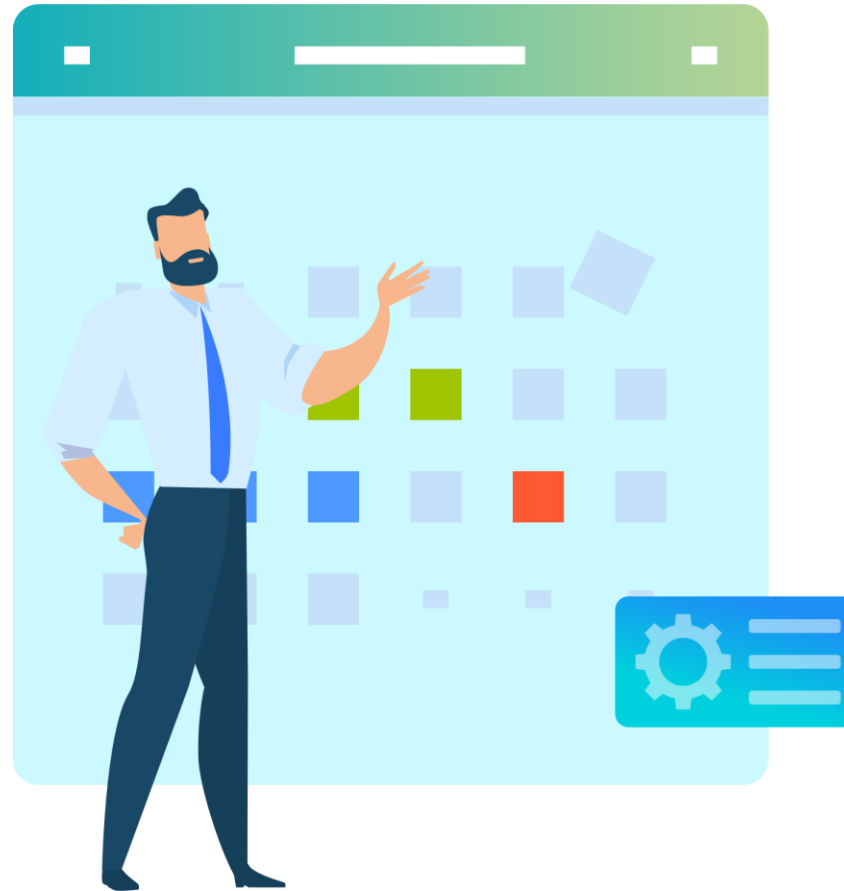


**70+**  
Direct-to-Patient  
Distribution Centers



# Learning Objectives

- Understand what the complexities of managing a patient that is “graduating” from hospice
- Develop a Best Practice guideline when transitioning care.
- Review practicing patterns and the impacts on patients with discharge risk during discharge transition.
- Develop a checklist to facilitate improved patient experience during a transition. reputation



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# Hospice Impacts: In News

## Article News :

“The experience overall has been a roller coaster, but hospice care has really been such a big support system for caring for her,” Yates said.

Her grandmother has been in hospice care for the past two years. “She can’t leave the house anymore to go to doctor’s appointments.”

“Dementia patients deserve dignity, not discharge. They cannot fight for themselves”, said Yates.

# Patient Eligibility

## How Does Someone “Graduate?”

To qualify for the Medicare hospice benefit, patients must be certified by their physicians as having a life expectancy of six months or less.

To be recertified after six months, patients in the hospice program must show progressive decline in their condition.

Ineligible Patients need to be transferred to another care setting

- Home Health
- SNF
- PACE
- ISNP
- LEAD Program
- ACO Program

Other reasons to for care transition

- Transferring to another Hospice
- Transferring to another Healthcare program
- Reinitiating curative treatment



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# Types of Graduation

## Discharge

Patient has graduated from hospice because they are no longer declining in hospice care.

## Revocation

Patient has chosen not to continue on in hospice. Common reasons to revoke are that they are seeking therapeutic measures outside of the hospice goals of care.

## Transfer

Patient may have to move to another location or choose another hospice provider causing them to move.

# Patient Discharge

## Why would a Hospice elect to discharge?

### Live Discharge

Patients most Impacted are long length of stay patients that do not follow the same trajectory as a standard patient <6 months

### Managing the Mix

#### High LOS diagnoses:

Dementia  
Failure to thrive  
Debility unspecified

#### Shorter LOS diagnoses:

Cancer  
End-stage cardiac disease  
Pulmonary disease

### Recommendations on Managing the CAP

- Establishing a Long Length of Stay Clinical Review Programs
  - > 180 Days
  - > 270 Days
  - > 365 days

### Suggested Action Items

Create a Rolling CAP Projection Report

Review Monthly assessing

- Average Length of Stay
- Median Length of Stay
- Length of Stay by Diagnosis
- Length of Stay by Referral Source
- % of Patients >180 days and >365 Days

# Admission Criteria

## General Admission Criteria

General terminal decline indicators (any diagnosis)

- Unintentional weight loss  $\geq 10\%$  over 6 months
- Albumin  $< 2.5\text{--}3.0$  g/dL when available

- Progressive functional decline in ADLs despite treatment
- $\geq 2$  hospitalizations or ED visits in the past 6 months
- Palliative Performance Scale (PPS)  $\leq 50\%$

- Dysphagia or aspiration risk
- Recurrent infections
- Progressive frailty or cachexia
- Stage 3–4 pressure ulcers non-healing

## Dementia (PLWD)

### Dementia (PLWD) specific indicators

- To avoid recertification discharge for "stability," ensure:
  - **FAST Stage 7C or greater**
  - Inability to ambulate, dress, and bathe without assistance
  - **Incontinence of bowel and bladder**
  - **Limited verbal output ( $< 6$  words/day)**
  - **Comorbid complications** in last 12 months:
    - aspiration pneumonia
    - recurrent UTIs
    - sepsis
    - stage 3–4 pressure ulcers
    - 10% weight loss
    - albumin  $< 2.5\text{--}3.0$
    - frequent falls or fractures

## Cardiac Disease

### Cardiac disease

- NYHA Class III–IV symptoms
- Optimized therapy with persistent symptoms
- EF  $\leq 20\%$  (if measured)
- Recurrent CHF exacerbations
- Weight loss, fatigue, poor appetite

## Pulmonary Disease

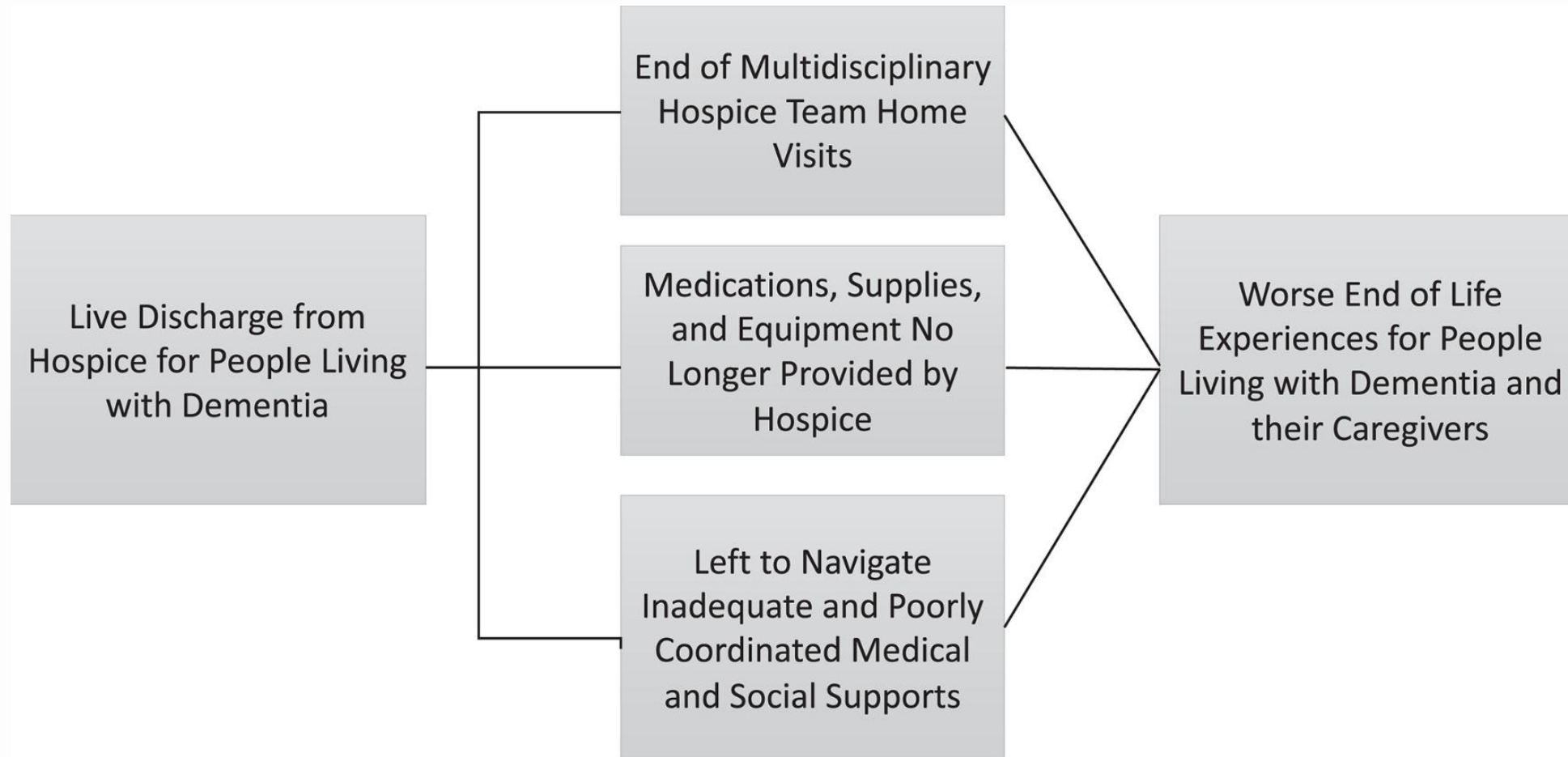
- FEV1  $< 30\%$  predicted (if available)
- Resting **O2 saturation  $\leq 88\%$**
- Progressive dyspnea at rest
- $\geq 3$  steroid bursts or hospitalizations in 6 months

# Strengthen Hospice Eligibility & Recertification Practices

- Long LOS patients require strong clinical documentation of decline.
  - Conduct structured recertification reviews before every benefit period.
  - Use standardized decline indicators:
    - PPS (Palliative Performance Scale)
    - FAST scale for dementia
    - NYHA class for cardiac disease
    - BMI/weight loss trends
    - Functional decline (ADLs)
  - Require face-to-face visits to clearly document decline.
  - Implement medical director review for all patients >180 days.



# Live Discharges with PLWD



# Types of DME and Coverage

- **Hospital Beds:** Adjustable beds provide comfort, support, and ease of movement for patients with limited mobility or bedridden individuals. They can be customized by height and feature helpful elements, like side rails.
- **Wheelchairs:** Manual and electric wheelchairs enable mobility for patients who cannot walk or have limited strength.
- **Oxygen Equipment:** Oxygen concentrators or portable oxygen tanks deliver supplemental oxygen to patients with difficulty breathing or requiring respiratory support.
- **Mobility Aids:** Devices such as walkers, canes, and crutches assist patients with mobility challenges, helping them maintain balance and stability while walking.
- **Lifts and Transfer Equipment:** Patient lifts, transfer boards, and slings aid in safely transferring patients from beds to chairs, wheelchairs, or other surfaces, reducing the risk of injuries for patients and caregivers.
- **Pressure Relieving Mattresses:** These specialized mattresses are designed to reduce the risk of pressure ulcers or bedsores, providing optimal comfort and support to patients who spend extended periods in bed.
- **Wound Care Supplies:** Various wound care supplies like dressings, bandages, and specialized cushions are used to manage and treat wounds, ensuring proper healing and preventing infections.
- **Enteral Feeding Equipment:** Feeding pumps, tubes, and related supplies are utilized for patients who cannot eat or drink orally.
- **Bathroom Safety Equipment:** Grab bars, raised toilet seats, shower chairs, and bath transfer benches are essential in promoting safety and independence for patients in the bathroom.
- **Communication Devices:** Devices such as amplifiers, speech-generating devices, or alternative communication methods enable patients with speech or hearing impairments to communicate effectively

# Evaluating Qualification



The Centers for Medicare and Medicaid Services (CMS) provides guidelines for supplemental oxygen therapy and sets the standard for nearly all adult oxygen prescriptions. To qualify for coverage, your oxygen saturation level must be below 88% while at rest, or below 90% while engaging in an activity. Claims for oxygen must be supported by medical documentation in the patient's record. Medicare will provide coverage for the rental of a portable oxygen concentrator if all criteria are met.

- 13% of Hospice patients meet this guideline
- 50-60% of Hospice patients receive oxygen.

# Hospital Bed

## Qualifying Diagnosis:

To qualify for a hospital bed, patients must obtain a written order from a doctor. The specific diagnosis may vary, but the doctor must document the medical necessity for the bed. Serious illnesses often make it easier to qualify, and your doctor may recommend it for rehabilitation.

## Coverage:

Medicare will cover the hospital bed as long as it's medically necessary to help your condition. Your doctor must order the bed and explain how it will benefit your health. Medicare pays for all medical equipment, including hospital beds, under Medicare Part B. Part B covers 80% of the bed's cost.



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# Medical Equipment Tasks by Product

## Oxygen

Determine Physician

Obtain Scripts after assessment

Validate Insurance and Provider that will take Billing method

Hospice Covered vs. Items Not Covered Concerns

## Bent Metal vs Small Items

Script Needed

Hospice Covered vs Items Not Covered Concerns

Evaluate long term use vs Price

Review Present Equipment / Paid in full



# Long Length of Stay Process and Considerations

## Pharmacy

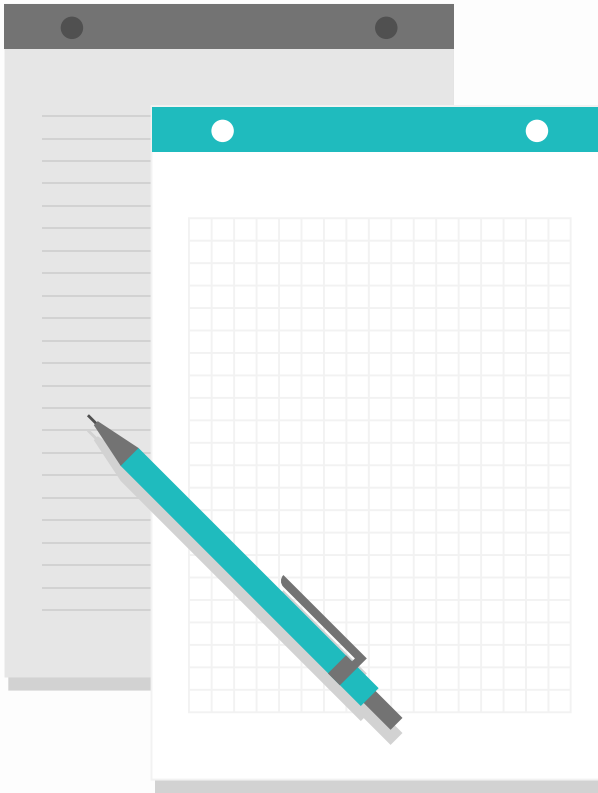
- Medication Review with Longer Length of stay
  - Pain Management Considerations - Methadone
  - Cognitive Improvement Medication -
- Prescriber Preference – Community Discussions
- Script Management
- Patient Transition Considerations
- Infusion Consideration

## Medical Supplies

- Need to place reoccurring order
- Standards on Quantity to Leave with
- Wound Care Supply Consideration



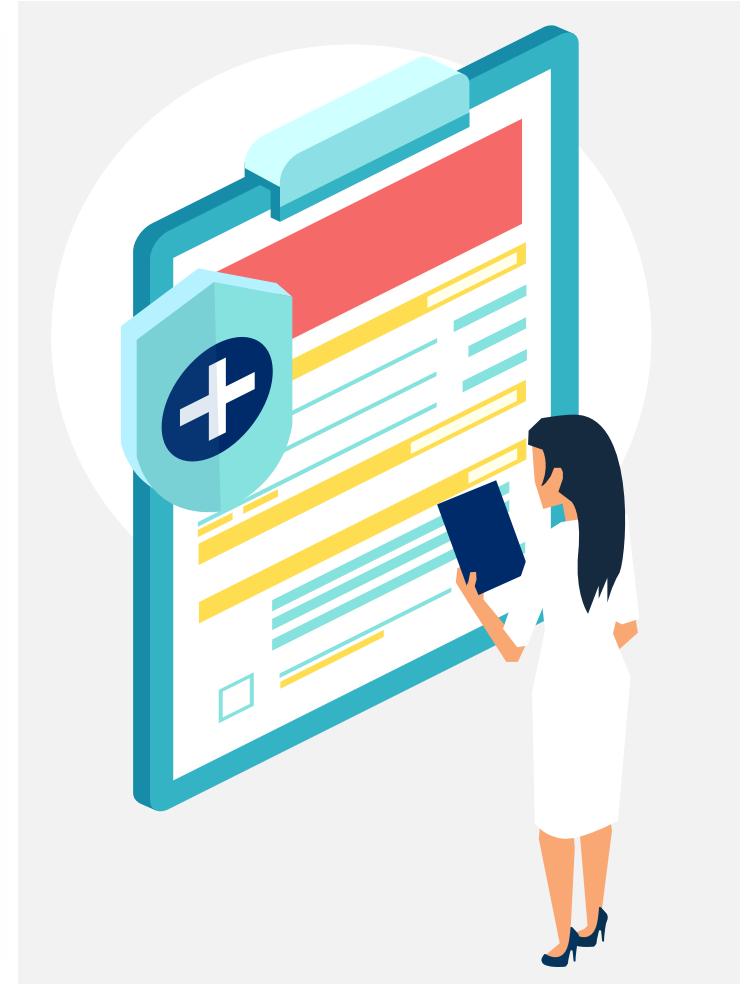
# Why Develop a Best Practice Guideline?



- Managing Oxygen and DME is difficult and time consuming with staff
- One in Seven Patients are impacted.
- Live Discharges are the #1 reason for Hospices incurring lost equipment charges
- Respiratory Distress is one of the top reasons that patients experience Re-Hospitalization during patient transition.
- One third of the patients being live discharged will die within 6 months
- **It creates a better patient Experience**

# Considerations When Developing Guidelines

- **Coordination and Gather information**
  - Care Giver Coordination
  - DME Competitive Bid Landscape
  - Validate Payment Changes with Local DME
  - Review Options based on DME Coverage with Family
- **Communication and Documentation is Key**
  - Review DME and Respiratory Items Dispensed
  - Respiratory Considerations when transitioning home
  - DME Availability
  - Standards for Transition Time
  - Communication Guidelines for Patients
  - DME Vendor Communication



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# Coordinating the Transition of Care

## Considerations based on healthcare destination, regionality and socioeconomic support

- When patient is transitioning odds are they are not in good health.
- Families will receive less support, so care givers are often burdened with more care. Over 53 million family care givers provide care for their loved ones each year.
- Interdepartmental transfers should consider having Home Health and Hospice nurses coordinate the visit together with trusted community physician.
- Review the goals of care of the patient/family and create a care plan with key navigation points to support patients.
- Medication profile will need to be reevaluated and reassessed to make sure that you are achieving the plans of care.
- The discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she is no longer terminally ill.
- Equipment that was prescribed to the patient might be seen as unnecessary and may need to remove.
- Provider Selection of DME, Patient Diagnosis can increase complexity surrounding transitions
- Patient locality and Social and Economic Status may cause concerns around health equity.
- Community resources may be available for your consideration.

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# Live Discharge Policy and Procedure Suggestions

## Identify Governance Committee

It is essential to make sure that you establish clear leadership that will create clear policies for the transition of patients as you assess your programs readiness and a continued governance committee to manage patients with clear oversight.

## Establish Communication Protocols

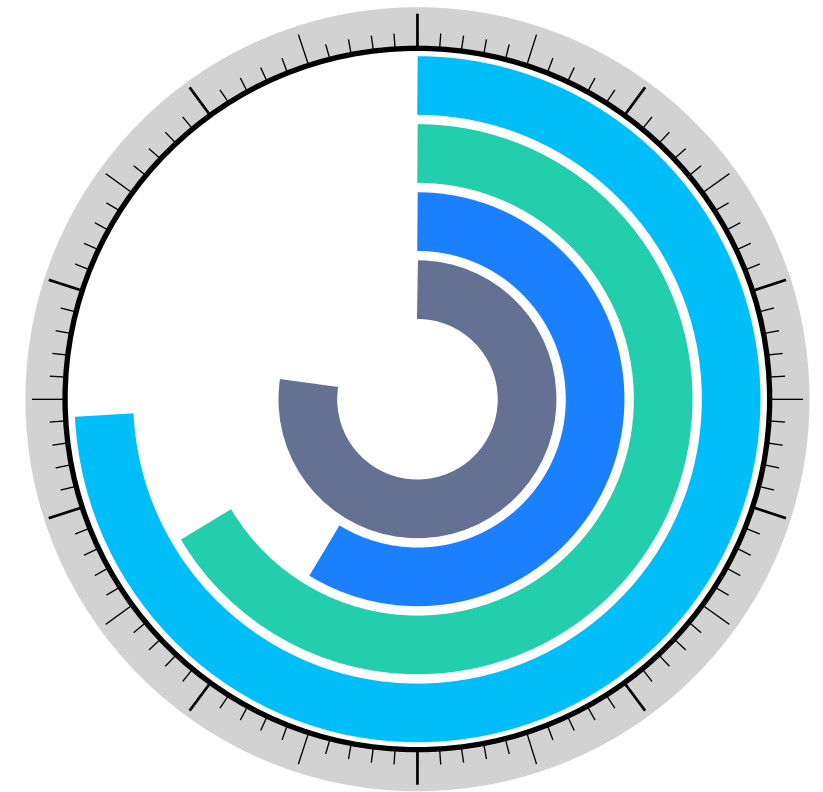
Prepare a standard template of communication both internally and externally providing you with easy access to disseminate information.

## Define Actionable Items in Clear Stages

Define specific check list for each of the stages and within each stage have specific tasks assigned to categories of patients in specific care settings

## Create an Insurance Policy

If your program is taxed and unable to take on this task to establish partnerships to aid in establishing clear guidelines to ensure patients transition designed to streamline the patients experience with the proper community resources to support their care.



# Hospice Labor Impact

## Case Study

### Hospice

500 ADC

Live Discharge Patients - 500 ADC

36,000 Patients Annually

Average Hospice Nurse Hourly Wage  
\$33.56

Hospice Hours Used 10 Hours Per Patient

Labor Cost Per Patient \$335.60 at the  
Minimum

- Average Medication Cost +15 Days
- Average Lost DME Costs (Variable)
  - Pay for Patient Days of up to \$22 on  
DME Day Model
- \$12,240,000 Dedicated to Live Discharge



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# Live Discharge Stats

- 15-20% of all Hospice Patients result in a Live Discharge.
- 70% of Lost Equipment Billed to Customer is tied to Live Discharge.
- Total Live Discharge time checked out to patients post discharge is 22 days.
- Average attempt to pick-up 3 times.
- Hospice Spends an Average of 10 Hours managing a post discharge
- Compared to 2000 when very few PLWD enrolled in hospice, by 2018, approximately 20% of hospice enrollees had a principal hospice diagnosis of dementia; another 25% had a comorbid dementia diagnosis.13-15
- Patients living with Dementia has risen over the years as the #1 Disease Treated Hospice
- Ratio for PDWL is set to increase as these Patients have a higher length of stay.
- PLWD is 3 times more Likely to experience negative impacts
  - DME
  - Pharmacy
  - Medical Supplies
  - Care Giving

# Best Practice

## Next Steps to Prepare Patient Transitions



# Questions?

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[Dementia patient discharged from hospice over Medicare requirement. Here's why it happened](#)

