



Hospice & Palliative Care Federation of Massachusetts

BRIDGE PROGRAMS

Definition, Criteria, Reimbursement and Process

**A report of
the Standards/Best Practices Committee
Chair, Carla Braveman, VNA & Hospice of Cooley Dickinson
Hospice & Palliative Care Federation of MA
Spring, 2004**

Bridge Program Subcommittee

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Bridge Programs

A report of the Standards and Best Practice Committee

Background

In the Fall of 2002, the Standards Committee surveyed members of the Hospice and Palliative Care Federation to determine interest in the development of Best Practice “white papers”. Three were ranked as priorities: Bridge Programs, Short Length of Stay, and the General Inpatient Level of Care. The Committee added Palliative Sedation as a fourth topic.

This report summarizes the recommendations of the subcommittee assigned to develop the Best Practice paper on Bridge Care Programs. Participating committee members were:

Nancy Muse, Chair, Hospice Care, Inc.
Deborah Amato, Emerson Hospital Hospice
Suzanne Barette, Greater Lowell VNA Hospice
Vicky Gurfolino, Hallmark Health Hospice and VNA
Helen Magliozzi, Hospice of the North Shore
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In preparation for the subcommittee’s first meeting, information was gathered and references were identified that would enhance the group’s ability to provide the Federation’s membership with viable models for bridge programs. In the Summer of 2003, ten of the twenty hospices in Massachusetts that provide bridge programs in affiliation with a home health agency or visiting nurse association were surveyed to determine the characteristics of those programs, and to hear what those organizations felt were their programs’ strong points. In addition, a survey was conducted via the National Hospice and Palliative Care Organization (NHPCO) administrators’ e-mail list serve to gather the same information; eight programs nationwide responded. Articles were distributed and reviewed by the subcommittee prior to the first meeting. (See appendix for references.)

Working definitions were developed to assure that a common language would be utilized in defining and describing processes and models that would be developed by the subcommittee.

The review of the survey results and of the literature led to a lengthy discussion. (Studies to date have not yet evaluated the clinical outcomes of bridge programs.) Two models emerged. One model applies to a hospice that is directly related to or part of a certified home health agency/ visiting nurse association and is hereafter referred to as a *dual model*. The second model applies to a freestanding hospice (one that is not formally affiliated with a home health agency) that develops a formal or contractual agreement with a home health agency and is hereafter referred to as a *consultative model*.

A number of the Hospice and Palliative Care Federation member agencies provide palliative care services to patients with life-limiting illnesses earlier in the course of their disease process and who may still be in active treatment. Occasionally patients choose these services when the goal of care begins to transition from cure to the relief of pain and suffering. These bridge or palliative programs may offer pain and symptom management, assessment, consultation, or supportive services to the patient and family. They may be provided as a program of the hospice, in cooperation with a home health or visiting nurse association, through a group medical practice, or within a hospital or extended care facility.

The philosophy of a bridge program embraces the understanding of the current home care market and the desires of patients to have control, care and comfort in their home.

Definitions

Palliative Care: the care of patients diagnosed with progressive disease for whom the focus is the relief of suffering. Palliative care promotes optimal relief of pain and other physical symptoms and enhances the patient and family's quality of life through support for emotional, social and spiritual priorities.

Bridge Program: a program provided by a hospice in collaboration with a home health agency or other health care provider that provides pain and symptom management as well as emotional support during a period when a patient with a life-limiting condition may still be pursuing active treatment or is not yet ready to elect the hospice benefit. The goal is earlier identification of patients who are appropriate for hospice care. The team would provide education for the patient and family regarding hospice care and would assist them in the transition from home health to hospice. Depending on the corporate structure, a contract may or may not be needed; a policy/ procedure may be more appropriate.

Dual model: a bridge or palliative program offered by a hospice that is formally associated with a home health agency/ visiting nurse association. The patient is a home health patient who must meet all home health regulatory requirements; for example, the patient has a skilled need and is homebound. The home health agency may provide a core group of nurses with education regarding pain management and end of life issues. In addition, those staff may receive training on how to initiate a discussion regarding a

transition to hospice. The agency may choose to make up a team that includes a home health nurse, a hospice nurse, a social worker as accepted /appropriate, and a home health aide. (The MSW and HHA are included as appropriate under the home health care/VNA guidelines and the patient's home health coverage.) Some agencies educate all staff to function in both settings so that the nurse can transition with the patient. In that setting, the nurse's caseload is made up of both home care and hospice patients. Home Health Aides frequently develop a bond with patients and may transition from one care setting to the other if the patient requests, even if the nurse does not. The transition of staff is by contractual arrangement, and depends upon the policies of the agency.

Examples in Massachusetts:, VNA Hospice of Greater Lowell, Lowell; VNA & Hospice of Cooley Dickinson, Northampton.

Consultative model: a bridge or palliative program offered by a hospice that is not formally affiliated with a home health agency. The patient is a home health patient who must meet all home health regulatory requirements; for example, the patient has a skilled need and is homebound. When the home health agency staff identify a patient as having a limited prognosis, a hospice nurse can be called in through a contractual arrangement to make a preliminary visit to the patient. The purpose of the visit is to carry out an assessment of the patient's needs for pain and symptom management and for emotional and spiritual support. Additionally, the home health nurse would accompany the hospice nurse to provide an introduction at the preliminary visit. The patient remains on the home health nurse's caseload and visits continue. Subsequent visits by the hospice nurse would serve as follow-up of the effectiveness of recommendations made at the previous visit. These visits would allow the patient to begin to develop a relationship with the hospice nurse who would ultimately serve as the primary hospice nurse. The Home Health Aide would transition with the patient if the patient wished; this is a contractual arrangement.

Example in Massachusetts: Hospice Care, Inc., Stoneham

Criteria for Admission

Patients who receive care under a bridge program generally exhibit a combination of the following characteristics:

- 1.) Life-limiting condition *and* receiving curative treatment.
Curative is defined by the *patient's* goal.
- 2.) Homebound with a skilled need.
- 3.) Hospice-appropriate, but declines hospice care.
- 4.) Improvement and discharge is unlikely.
- 5.) Requires pain and symptom management *and* meets the insurer's criteria for home health care.

Education

As experts in end of life care, the hospice would provide education for the nurses in the home health agency regarding pain and symptom management and end of life issues. Additional education is necessary in psychosocial issues, communication and family concerns. Information regarding how to determine whether a patient is appropriate for either bridge or hospice care enhances the visiting nurse's ability to introduce the concept of bridge or palliative care. For example, utilizing the tools to determine prognosis would clarify many questions.

Competency

For both bridge program models, CHAP or JCAHO hospice staff must meet the same competencies as home health nurses.

Reimbursement

Home health is reimbursed differently from hospice and from payor to payor. Hospice needs to rely on the expertise of the home health agency regarding billing. Some reimbursement methodology includes 60 day episodes and fee-for-service by contract. In the case of commercial insurances and the senior plans, it is essential that the insurance case manager be included in the discussion leading up to the decision to provide care through a bridge program. Updates to the insurance case manager must continue according to the insurance company's requirements.

Hospice is responsible for its own billing and occurs in accordance with the rules and regulations of the payor: Medicare, Medicaid, or commercial insurance. Patients with Senior plans receive services under the Medicare Hospice Benefit.

In either the *dual* or *consultative* model, if the Home Health Aide follows the patient to hospice, the hospice reimburses the home health agency for those services through a contractual arrangement. Rates are negotiated by the agencies.

Under the *consultative model*, the home health agency contracts with the hospice for the hospice nurse's visits. The initial visit by a hospice nurse is reimbursed by the home health agency at a higher rate than subsequent visits. For example: for the initial visit, \$125; for subsequent visits, \$75. Rates are negotiated by the agencies.

If a social worker is included in the bridge team, those services would be reimbursed in the same manner as described above.

Any services that are not included in the patient's home care benefit may not be provided free of charge by the hospice. This could be interpreted as an inducement or an incentive to refer patients to hospice –an activity that is strictly forbidden under the Medicare Conditions of Participation.

Off-hours Coverage / On Call

While the patient remains on the Bridge Program, coverage for “as needed” visits at night and on weekends is the responsibility of the home health agency unless otherwise contracted with the hospice program.

Pronouncement of Death

While the patient is in the Home Health Agency program, the home health agency is responsible for doing the pronouncement. The hospice nurse may also visit at that time, depending on the philosophy of the agency.

If the patient’s death occurs after the transition to hospice, the hospice nurse is responsible for doing the pronouncement.

Sample Process Dual Model for a Bridge Program

- Based on the organizational structure, either a contract must be in place or policies and procedures must be developed prior to the implementation of the program.
- Certified home health agency/VNA staff who work in the Bridge Program identify a patient as having a life-limiting condition and discuss the patient’s status with the attending physician.
- In collaboration with the attending physician, the nurse begins to introduce the concept of palliative care to the patient and family.
- When the patient and family have accepted palliative care and while the patient is still able to participate in decision-making, the concept of a future admission to hospice is introduced.
- The hospice nurse and the home health nurse work together to manage the patient’s care.
- A referral to a social worker may be made as appropriate per agency policy.
- The certified home health agency/ VNA policies and procedures define the method of transition from home health care to hospice care. The home health agency may choose to allow the home health nurse to make a few visits to the patient after admission to hospice to support the patient and family in the transition.
- When the patient transitions to hospice, the Home Health Aide may remain to provide physical care if the patient wishes. (This is a contractual arrangement between the home health agency and the hospice.)
- While the patient is receiving services from the home health agency, the home health agency retains the responsibility for pronouncement of death, unless otherwise contracted with the hospice. After admission to hospice, the hospice becomes responsible for pronouncement.
- It is important to remember to contact the nurse from the other agency at the time of death, whether the patient has transitioned to hospice or not. This allows staff the opportunity to have bereavement contact with the family.

Sample Process Consultative Model for a Bridge Program

- A contract must be in place prior to implementing the program.
- The patient is identified by the home health nurse as having a life-limiting condition.
- In collaboration with the attending physician, the nurse begins to introduce the concept of palliative care to the patient and family.
- The home health nurse begins discussions with the family regarding visits by a hospice nurse for consultation, pain and symptom management, and, if appropriate, for planning for a future admission to hospice.
- The hospice nurse makes a consult visit for assessment. This is a joint visit with the home health nurse.
- The hospice nurse makes recommendations for symptom control and provides family education if appropriate.
- The hospice nurse and the home health nurse collaborate regarding the frequency of visits.
- A referral to a social worker may be made as appropriate per agency policy.
- The decision regarding transition to hospice involves discussions with the attending physician, the patient, family, the hospice nurse and the home health nurse.
- When the patient transitions to hospice, the Home Health Aide may remain to provide physical care if the patient wishes.
- While the patient is receiving service from the home health agency, the home health agency retains the responsibility for the pronouncement of death, unless otherwise contracted with the hospice. After admission to hospice, the hospice becomes responsible for the pronouncement.
- It is important to remember to contact the nurse from the other agency at the time of death, whether the patient has transitioned to hospice or not. This allows the staff to have bereavement contact with the family.

Important Points

- Honor the patient's choice.
- Provide feedback to the referring nurse with the patient's permission (HIPAA).
It is important for the home health agency nurse to be kept up-to-date regarding changes in condition and eventually the patient's death. As with hospice nurses, home health nurses form a bond with their patients. It is more likely that the nurse will continue to refer and to refer earlier if they know that they will receive information about the patient's progress and outcome.

- Provide objective feedback to the referring agency through hospice Quality Improvement data collection. For example, has the bridge relationship between the agencies had an effect on the length of stay in hospice? If not, should the program be revised? Is more education necessary? Are the right people on the team?
- Evaluate family satisfaction and revise the program as needed.

Appendix

List of Hospice & Palliative Care Federation member hospices that provide bridge/palliative care programs

Sample QA/ Tracking tool

Sample Contracts

- Bridge (Consultative Model)
- Home Health Aide Services

Reference Article

Michal, Mary, JD and Dorothy Clarke, JD, "Hospice Bridge Programs: Pitfalls and Possibilities," Hospice Managers' Monograph, Vol. 3, Winter/Spring 1998.

