Bridging the Gap: Advancing Goal-Concordant Care and Better Outcomes Through a Home Health Palliative Bridge Program

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About Us

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Session Objectives

- Identify barriers to timely hospice enrollment and describe the financial, clinical, and quality-of-life consequences of late starts of care.
- Analyze outcomes of a Palliative Care Bridge Program (PCBP), including earlier referrals, improved symptom control, caregiver preparedness, and increased hospice conversion rates.
- Apply strategies to operationalize early hospice transitions through standardized triggers, interdisciplinary collaboration, and education such as serious illness conversation training.

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What is a "Serious Illness"?

- Serious illness refers to a "health condition that carries a high risk of mortality AND either negatively impacts a person's daily function or quality of life, OR excessively strains their caregivers" (Kelley, Bollens-Lund, 2018).
  - Advanced cancer
  - Heart failure
  - COPD
  - Dementia/frailty
- "Would you be surprised if this patient died within the next 6 months?"

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Serious Illness Care Gap

- Patients with advanced illness frequently experience fragmented care, uncontrolled symptoms, and delayed conversations about future care planning.
- Nearly 20% of (all) Medicare patients are readmitted within 30 days of discharge (CMS, 2024).
- “Critical illness associated with ICU admission should be treated as a lifetime diagnosis with associated excess mortality, morbidity and the requirement for ongoing health care support” (Cuthbertson et al., 2010).

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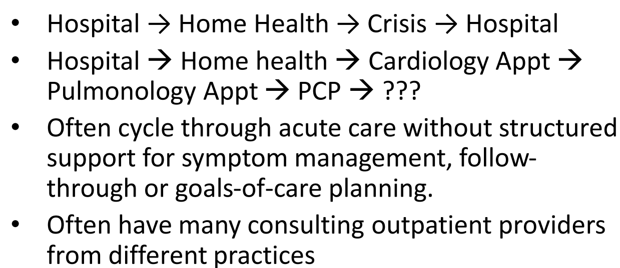
Current System Structure



- Hospital → Home Health → Crisis → Hospital
- Hospital → Home health → Cardiology Appt → Pulmonology Appt → PCP → ???
- Often cycle through acute care without structured support for symptom management, follow-through or goals-of-care planning.
- Often have many consulting outpatient providers from different practices

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Impact on Patients and Families

- Uncontrolled symptoms
- Repeated hospitalizations
- Caregiver/patient distress
- Limited time to benefit from hospice services
- Delayed ACP conversations

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Increased readmissions
- Readmissions cost Medicare $26 billion annually, with $17 billion considered avoidable

Throughput delays
- Each avoided readmission frees approx. 6.4 bed-days on average (DeAngelo et al., 2025) → days can be repurposed to higher-margin cases, de-crowd ED

HRRP penalties
- HRRP payment reductions apply to all DRG base payments; small improvements in excess readmission ratio (ERR) for targeted conditions can decrease penalty

Impact on Healthcare System

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Why Home Health Is Critical

- Home health clinicians are uniquely positioned to identify early signs of decline and support patients before crises occur.
- Provide option for ongoing (appropriate) medical care at home, rather than in the hospital

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Introducing the Bridge Model

- A structured support layer embedded within home health that stabilizes symptoms and facilitate smoother care transitions.
- PCBP operates as a consultative layer within home health rather than a separate clinical program.
- Operates under the home health episode.

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Home Health Model

- Within the home health episode (require a qualifying home health skill, homebound)
- Continuity with existing care team
- An advantage of home health services is that they often combine rehabilitation with the competencies of palliative care to alleviate distressing symptoms, facilitate discussion around realistic goals of care, and secure documentation of advance care planning.
- “Palliative home health care (sometimes referred to as home health-based palliative care) is typically provided by an interdisciplinary team utilizing the home health model for infrastructure and financial support.” (UpToDate, 2025).

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Part B Palliative Model

- Many community palliative programs operate as outpatient services using Part B billing
- NP led (typically manage a caseload of approx. 100-120 patients)
- In-person visits scheduled based on acuity
- Some programs prescribe; some do not

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Contrast Home Health Based Pall Model vs. Part B Model

PCBP Model

- Billing
  - CMS pays agency per period
- Revenue
  - Through home health with qualification
- Visit frequency
  - As required by plan of care/physician orders
- Eligibility
  - Homebound, certified plan of care, skilled need

Part B Model

- Billing
  - Bills under part B for professional services
- Revenue
  - Billable work typically by NP
- Visit frequency
  - NP visit frequency based on complexity
- Eligibility
  - Billable need (serious illness, high symptom burden, high utilization, functional/clinical decline)

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Program Goals

- Improve quality of life for patients with serious illnesses
- Provide early pain/symptom management and psychological support
- Facilitate a smooth transition to hospice, if/when appropriate
- Reduce unnecessary hospitalizations and emergency department visits
- Support patients, families, referring providers with education and resources

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EXTRA LAYER OF SUPPORT

Needs Evaluation
Symptom Management
Education for Patients & Families
Advanced Care Planning
Care Coordination
Emotional Support

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Who Could Benefit?

- Qualifying home health skill
- A serious or life limiting illness (ex CHF, COPD, cancer, dementia)
- Frequent hospitalizations or ER visits in the last 3 months
- Progressive functional decline despite medical treatment
- Pain and/or symptom burden that impacts quality of life
- Patients who are not yet ready for hospice but may benefit from additional support

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Ensuring Compliance

- Patient/caregiver/referral source expresses interest in/request for discussion of hospice
- Documentation of patient choice
- Provided list of alternative hospice agencies
- Attending physician notified of patient's status (decline)
- Referral only made with patient consent/at their request
- Intake team handles enrollment process
- Continuing home health services until hospice admission
- Respect for patient decision to choose alternative agency

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Bridge Model Framework

- The model includes five core functions that guide program workflow
  - Identify
  - Engage
  - Stabilize
  - Align
  - Transition

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Identify

- Identify patients at risk of decline using standardized triggers and referral pathways.
- Standardized trigger set; referral sources and EHR pathways; clinician identification, referral source identification, analytics data, hospitalization report.

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Standard Intake Triggers

Trigger Category	Operational Definition / Examples
Serious illness trajectory	Progressive or advanced disease (e.g., advanced COPD, CHF, ESRD, dementia, cancer, ALS, liver/kidney disease).
Symptoms/complexity	Uncontrolled symptoms despite current treatment (pain, dyspnea, fatigue, anxiety, nausea, appetite loss) or complex regimens (e.g., multiple pain medications).
Utilization risk	Frequent hospitalizations or ED visits; two or more unplanned admissions in the past three months; recent discharge with high readmission risk.
Function/frailty	Declining ADL/IADL independence; PPS 40% or lower; notable weight loss or frailty.
Values/readiness signals	Clinician “surprise question” concern; desire for advanced care planning assistance

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Disease Specific Triggers

Condition	Examples of Trigger Signals
Cardiac disease (CHF/CAD/valvular)	NYHA Class III or IV symptoms despite optimal therapy; recurrent hospitalizations for heart failure exacerbations; dyspnea at rest or minimal exertion; significant fatigue limiting daily activities
Pulmonary disease (COPD/ILD/fibrosis)	Dyspnea at rest despite maximal therapy; frequent exacerbation hospitalizations; chronic oxygen requirement; progressive weight loss and declining function.
Oncology (advanced/metastatic)	Declining response to therapy or no further disease-directed options; uncontrolled cancer-related symptoms such as pain, nausea, dyspnea, or fatigue; increasing caregiver burden.
Neurologic/neurodegenerative (stroke, Parkinson's, ALS, dementia)	Falls, dysphagia, or loss of independence; progressive weakness; recurrent aspiration pneumonia; late-stage dementia, dependence in ADLs.
Renal disease (CKD 4-5/ESRD)	Declining function despite dialysis; repeated hospitalizations for fluid overload or electrolyte imbalance; consideration of dialysis withdrawal.
Liver disease (cirrhosis/ESLD)	Recurrent ascites requiring paracentesis; hepatic encephalopathy despite treatment; frequent liver-related hospitalizations; MELD score greater than 15 with declining function.

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Engage

- Initial visit, occasionally phone call, to build trust and assess patient and caregiver needs.
- Assessment visit; caregiver assessment; explanation of bridge program.
- In-depth chart review of active problems, missed items from hospital to home transition, medication discrepancies.

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Cross-Training Clinicians

- Visits completed by interdisciplinary staff (primarily nursing, but also PT/OT)
- Complete home health orientation, hybrid hospice/pall orientation, classroom intensive learning sessions
- Focus on disease understanding, symptom and pain assessment, advanced care planning
- Serious illness conversation training

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Stabilize

- Address symptoms, review medications, and prevent crisis-driven care.
- Symptom triage plan; medication review and recommendations; anticipatory guidance and escalation plan.

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Align

- Support decisions that match values and prognosis.
- Goal-of-care documentation support; MOLST/POLST facilitation where appropriate; shared plan communicated to teams.
- Assessment of HCP identification and shared conversation of wishes.

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Transition

- Enable a seamless move to hospice, if appropriate.
- Hospice readiness criteria; warm handoffs; expedited admission and continuity plan.

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Patient Journey

Stage	Entry Criteria	Key Actions	Exit Criteria
Stage 1: Identification	Meets trigger criteria; high readmission risk; clinician concern.	Add to palliative EHR team; add to tracking list; schedule informational visit.	Informational visit completed and plan documented.
Stage 2: Engagement/Assessment	Initial visit scheduled/completed.	Symptom assessment; caregiver assessment; illness understanding; goals of care; education.	Clear plan communicated; follow-up scheduled or stepped down.
Stage 3: Stabilization	Active symptoms, complex regimen, recent discharge, or rising risk.	Targeted palliative visits; medication recommendations; escalation pathway; closed-loop provider comms.	Symptoms stabilized; fewer crises; patient/caregiver understanding improved.
Stage 4: Alignment	Values conflict, uncertainty, or decision points emerging.	Advance care planning; MOLST/POLST support; anticipatory guidance; ensure documentation visibility.	Goals clarified; decision points documented and communicated.
Stage 5: Transition (if appropriate)	Eligibility and consent for hospice align; persistent decline.	Hospice education; warm handoff; expedite admission; continuity plan.	Hospice SOC completed; post-transition check-in completed.

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Operational Maintenance

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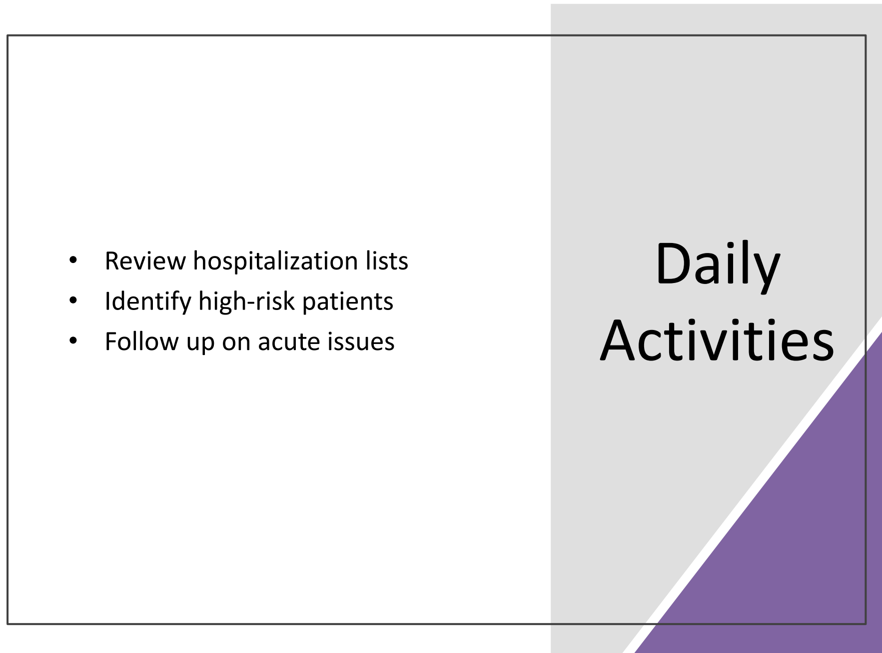

Daily Activities

- Review hospitalization lists
- Identify high-risk patients
- Follow up on acute issues

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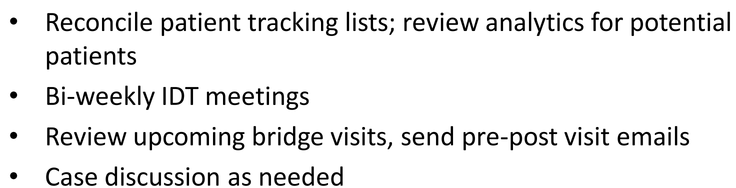
Weekly Activities



- Reconcile patient tracking lists; review analytics for potential patients
- Bi-weekly IDT meetings
- Review upcoming bridge visits, send pre-post visit emails
- Case discussion as needed

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Monthly Activities

- Census review
- Distribute PCBP patient list designated clinicians
- Check in phone calls to PCBP patients/families who remain on PCBP and/or transitioned to hospice

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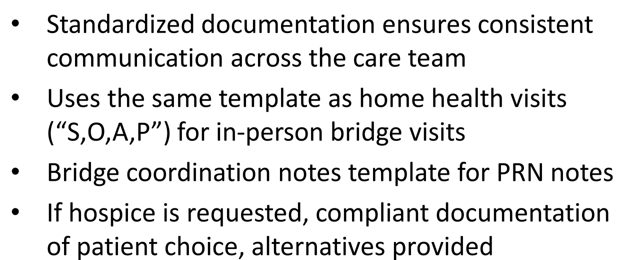
Documentation Approach



- Standardized documentation ensures consistent communication across the care team
- Uses the same template as home health visits ("S,O,A,P") for in-person bridge visits
- Bridge coordination notes template for PRN notes
- If hospice is requested, compliant documentation of patient choice, alternatives provided

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Measurement Framework

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Hospital Metrics

- Emergency department visits
- Hospital admissions
- Readmissions
- Bed throughput
- ED boarding

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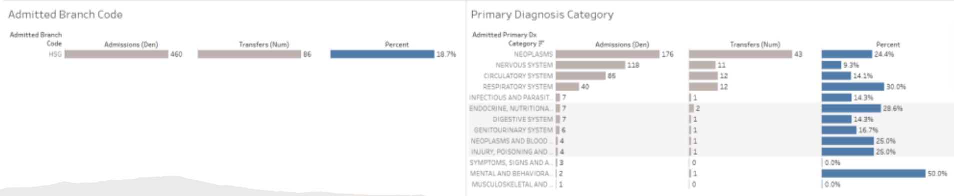

Transfers From Home Health To Hospice In 12 Month Period

- 460 Hospice Admissions
- 86 Transitioned from a Home Care episode to Hospice
- 18.7% Conversion for the year

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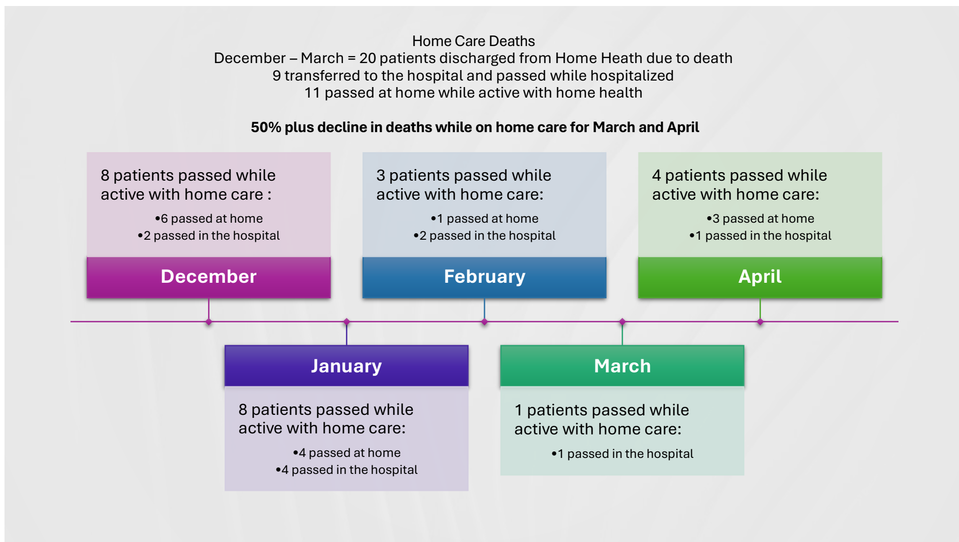

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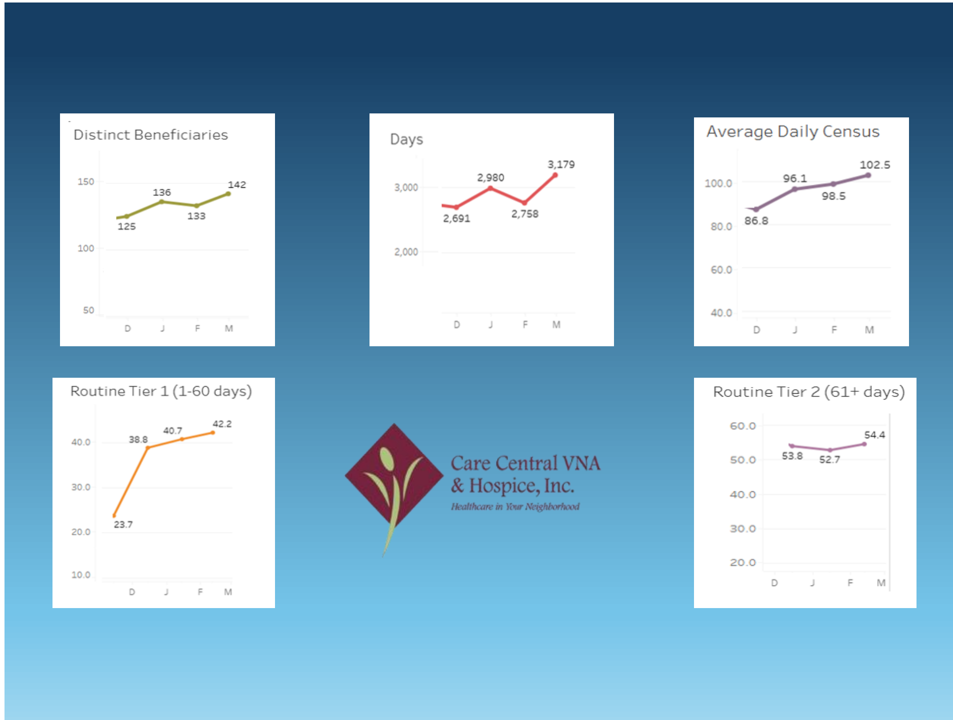

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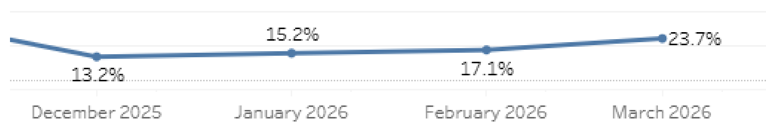
Internal Referrals - Service Transfers

Admits Last Month for all Service Lines

Prior Service Line (From)	Days from Prior DC	Admitted Service Li... HOSPICE Admits	% of Total (down)
None (New Admission)	NA	22.00	57.9%
HOME HEALTH	0-45	5.00	13.2%
	46+	8.00	21.1%
HOSPICE	0-45	2.00	5.3%
	46+	1.00	2.6%
Total		38.00	100.0%

Due to staffing capacity, visits made by home health clinicians vs cross trained clinicians. Saw a decrease in conversion due to this.



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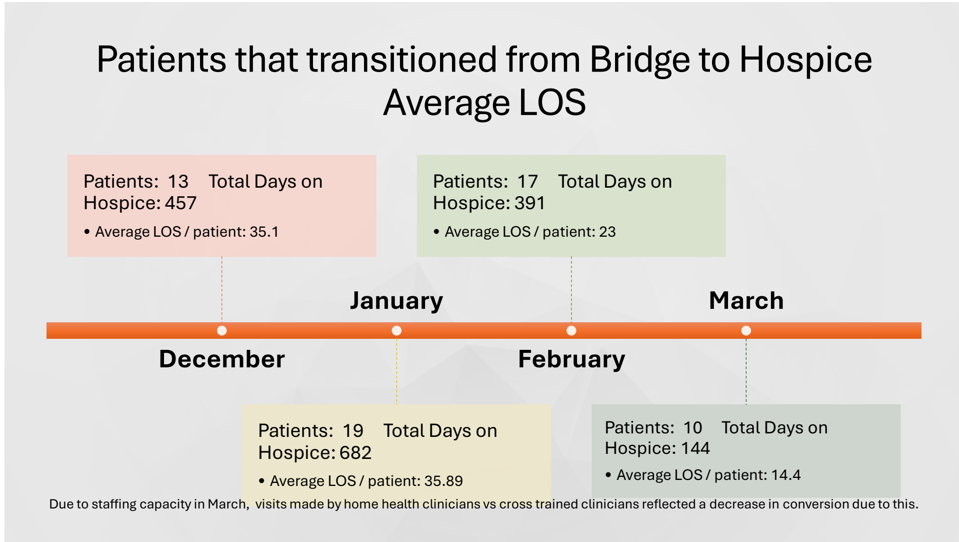

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Workforce Impact- Survey Results

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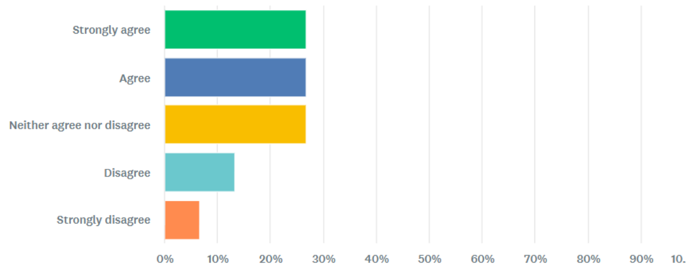
Since the Palliative Care Bridge Program (PCBP) expansion, I feel more supportec in managing complex or high-acuity patients at home.

Answered: 15 Skipped: 1



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The PCBP has enhanced interdisciplinary communication

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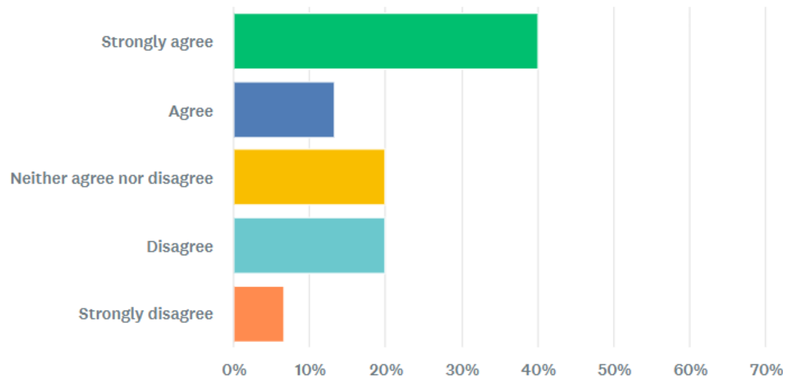

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Since expansion of the PCBP, I have noticed improved symptom management support with patients.

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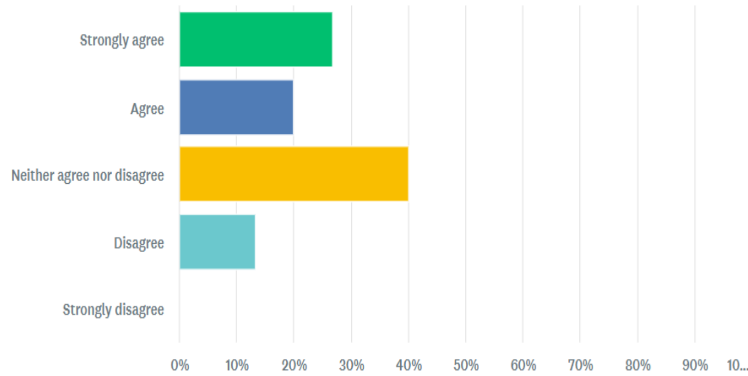

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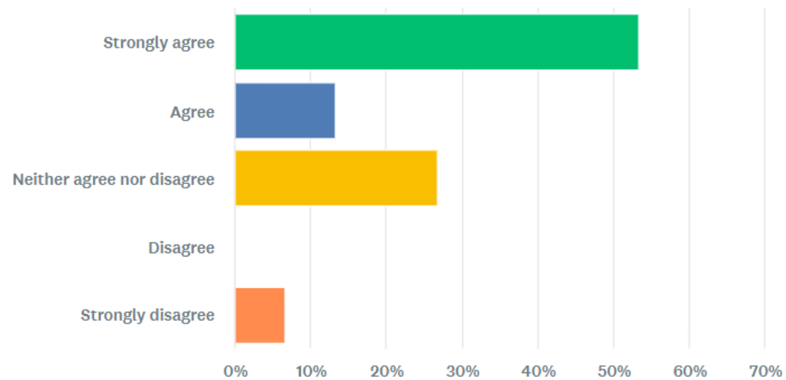
Overall, PCBP adds value to patient care within our agency.

Answered: 15 Skipped: 1



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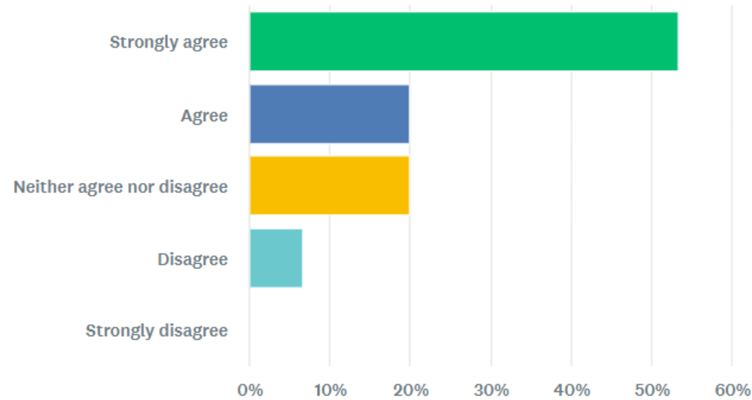
I would recommend expansion of the PCBP model.



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Free Text Responses

- Expand program to all territories. The program is terrific
- Improved communication
- Ensure nurses to follow-up phone calls with offices during visit
- I appreciate the synopsis of patient from Ashley, ultimately bringing the whole picture together. I feel as if we have also transferred some pall to hospice which is nice to see. I think it's especially important for patients to have a familiar face when they are potentially making a big decision based on their goals and health status.
- Excellent program; improved symptom management & patient support

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Implementation Strategy

- Successful implementation requires:
  - Leadership support
  - External engagement
  - Clear triggers
  - Reliable tracking systems
  - Interdisciplinary collaboration

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Risk, Equity & Sustainability Considerations

- Common barriers in home-based palliative models include workforce capacity, fragmentation across care settings, and reimbursement constraints.
- Equity considerations.
- Sustainability strategies.

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Questions and discussion

Discussion

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References

- Prince-Paul, M.J., Daly, B. (2019). Ethical considerations in palliative care. *Oxford Textbook of Palliative Nursing:* 4, 824-836. New York, NY: Oxford University Press.
- Cuthbertson, B. H., Roughton, S., Jenkinson, D., Maclennan, G., & Vale, L. (2010). Quality of life in the five years after intensive care: a cohort study. Critical care (London, England), 14(1), R6. https://doi.org/10.1186/cc8848
- Centers for Medicare & Medicaid Services (CMS). Hospital Readmissions Reduction Program (HRRP). Updated 2023. Accessed May 9, 2025. https://www.cms.gov/medicare/quality/value-based-programs/hospital-readmissions
- Kelley AS, Bollens-Lund E. Identifying the Population with Serious Illness: The "Denominator" Challenge. J Palliat Med. 2018;21(S2):S7-S16. doi:10.1089/jpm.2017.0548
- Lin, C. P., et al. (2025). Home-based palliative care: Benefits, challenges, opportunities and future directions in a super-aged society. PMC.
- Center to Advance Palliative Care (CAPC). (2019). Integrating palliative care with hospice and home health services.
- Twaddle, M. L., & McCormick, E. (2025). *Palliative care delivery in the home*. In *UpToDate*. Wolters Kluwer. Retrieved April 3, 2026, from https://www.uptodate.com/contents/palliative-care-delivery-in-the-home

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