

NHPCO Project ECHO

July 27, 2022

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- Judith Redona, RN, CHPN | Clinical Quality and Compliance Nurse Specialist

ECHO Session Facilitator

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Disclosures

Disclosure

The planners and faculty disclose that they have no financial relationships with any commercial interest.

Data Collection

In order to support the growth of the ECHO® movement, Project ECHO® collects participation data for each ECHO® program. Data allows Project ECHO® to measure, analyze, and report on the movement's reach. Data is used in reports, on maps and visualizations, for research, for communications and surveys, for data quality assurance activities, and for decision-making related to new initiatives.

Evaluation

You will be receiving an email with a link to complete a short survey about this session. Please complete the survey within 48 hours. Completion of this evaluation is required for Quality Connections credit. We ask all participants to take the survey as it will help us to improve future clinic sessions.

Today's Agenda

- Welcome and brief introductions
- Introduction of the case presenter and subject matter experts
- Brief didactic presentation and review of UR tool - case presenters discuss case details and specific questions or ponderings.
- Questions and clarifications – subject matter experts and participants
- Final thoughts

Ground Rules and Video Teleconferencing Etiquette

- This is an all share-all learn format; judging is not appropriate
- Respect one another – it is ok to disagree but please do so respectfully
- Participants - introduce yourself prior to speaking
- One person speaks at a time
- Disregard rank/status
- Remain on mute unless speaking and eliminate or reduce environmental distractions to improve sound/video quality
- Use video whenever possible; make eye contact with the camera when you are speaking
- **Do not disclose protected health information (PHI) or personally identifiable information (PII)**

Introductions

Session Presenters

- Jennifer Plude, RN, BSN, CHPN | Chief Clinical Officer
- Judith Redona, RN, CHPN | Clinical Quality and Compliance Nurse Specialist
Montgomery and Prince George's Hospice, Rockville, MD

Subject Matter Experts

- Bernice Burkath, MD, HMDC, FAAHPM, Chief Medical Officer, Tufts Medicine Home Health Foundation, MA
- Roseanne Berry, MSN, RN, Principal/Consultant R&C Healthcare Solutions, AZ
- Leslie Foster, LMSW, Bereavement/Volunteer Manager, Vitas, TX

Today's Case Themes

- Long Length of Stay
- Documentation of Eligibility
- PEPPER Reports
- Role of Quality Improvement and Process Redesign

The Regulations

§ 418.3 Definitions

“Terminally ill means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.”

§ 418.20 Eligibility requirements.

- In order to be eligible to elect hospice care under Medicare, an individual must be--
 - (a) Entitled to Part A of Medicare; and
 - (b) Certified as being terminally ill in accordance with § 418.22.

How do Local Coverage Determinations (LCDs) apply?

- LCDs are all about coverage and payment
- Established by Section 522 of the Benefits Improvement and Protection Act
 - Decisions by MACs whether to cover a particular service.
 - Is it reasonable and necessary?
- Guidelines
 - Yet frequently referred to as criteria

Quote from All MACs

“Some patients may not meet these guidelines, yet still have a life expectancy of six months or less. Coverage for these patients may be approved if documentation of clinical factors supporting a less than six-month life expectancy, not included in these guidelines, is provided.”

CMS Database. <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>

Documentation of Prognosis

- **Paint the picture** – narrative is necessary!
- Remember Function, Cognition, Nutrition
- Use objective LCD data when it's available
- If the patient doesn't "meet" a specific LCD, describe why they are terminally ill anyway; often more than one diagnosis is contributing to the prognosis.

Recertification

- Hospice physician can recertify a patient's eligibility for hospice care up to **15 days** before the start date of the next benefit period.
- Recertifications for the 3rd and subsequent benefit periods require a hospice physician or NP to complete a face-to-face (F2F) visit to assess hospice ongoing eligibility.
 - F2F visit may be completed up to **30 days** before the start date of the next benefit period.
- Clinical information from the F2F visit (in addition to other patient info) is utilized by the certifying hospice physician to determine eligibility and certify the patient.

Discharge – No Longer Terminally Ill

- If a hospice physician determines that the patient no longer meets Medicare eligibility requirements, the patient must be discharged.
 - Should never be a last-minute event for patient and hospice.
 - Consistent evaluation leading up to determination to discharge for this reason should have been over a period of time.
 - Discussion of disease plateau should have been discussed with patient and family prior to notice of discharge.



Discharge Process

- CMS notes, “Discharge is not expected to be the result of a single moment that does not allow time for some post-discharge planning”.
- When IDG is following their patient, and if there are indications of improvement in the individual’s condition such that the patient may soon no longer be eligible, then discharge planning should begin.

Discharge – Federal Regulations

§418.26 Discharge from hospice care.

(b) Discharge order. Prior to discharging a patient for any reason listed in paragraph (a) of this section, the hospice must obtain a written physician's discharge order from the hospice medical director.

If a patient has an attending physician involved in his or her care, this physician should be consulted before discharge and his or her review and decision included in the discharge note.

Discharge – Federal Regulations

§418.26 Discharge from hospice care.

- (c) Effect of discharge. An individual, upon discharge from the hospice during a particular election period for reasons other than immediate transfer to another hospice—
 - (1) Is no longer covered under Medicare for hospice care;
 - (2) Resumes Medicare coverage of the benefits waived under §418.24(e); and
 - (3) May at any time elect to receive hospice care if he or she is again eligible to receive the benefit.
- (d) Discharge planning.
 - (1) The hospice must have in place a discharge planning process that takes into account the prospect that a patient's condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill.
 - (2) 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.

Discharge Notice

- The Notification:
 - A two-day minimum notice of discharge provided to patient / family.
 - If state regulations require more than two (2) days discharge notice, then the hospice follows the more stringent requirement.

Next Steps

Case presentation

Questions

- Subject Matter Experts & Participants

Recommendations

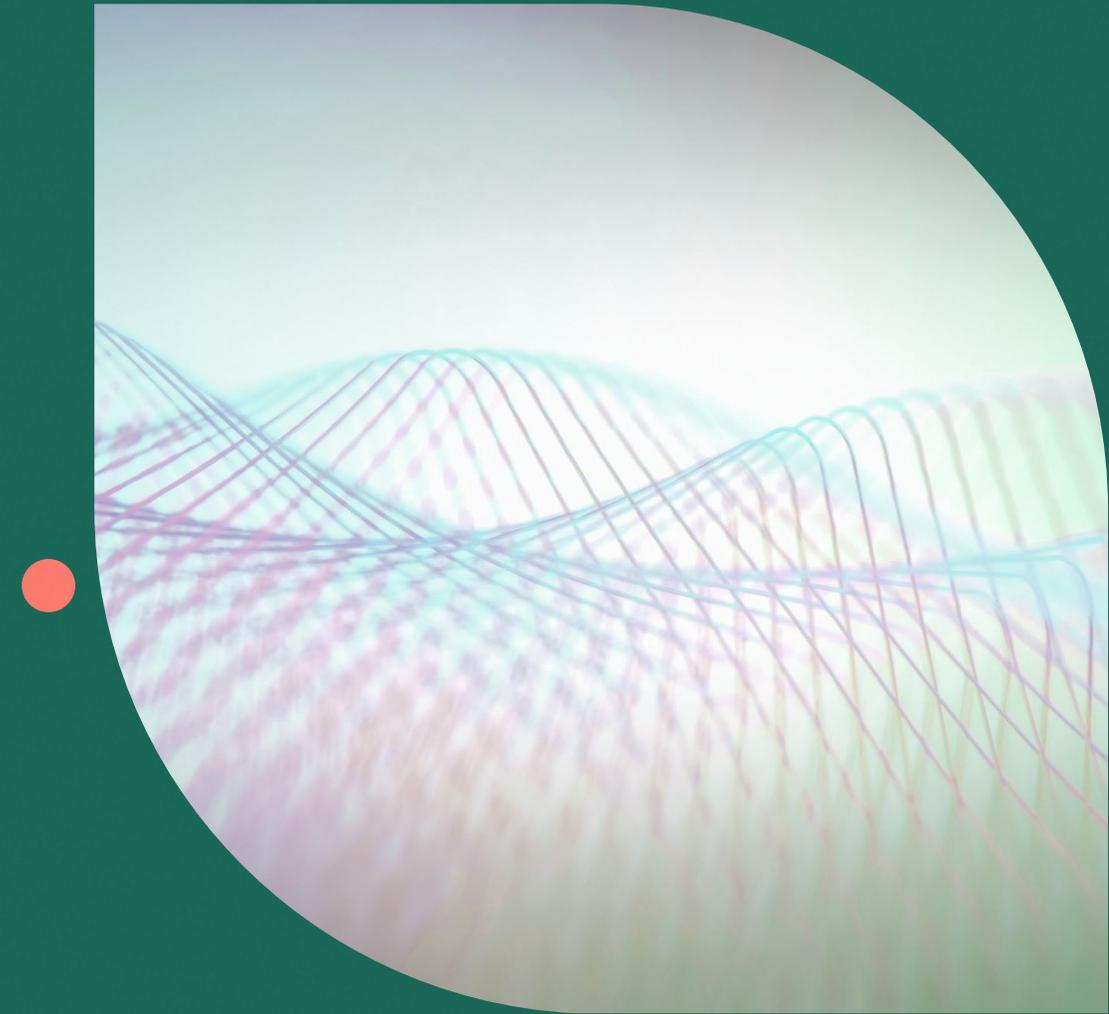
- Subject Matter Experts & Participants

Summary



Project ECHO

Hospice Utilization Review - Eligibility
Montgomery and Prince George's Hospice
Rockville, MD 20850





Montgomery Hospice, Inc.

Presented by:

Jennifer Plude, RN, BSN, CHPN Chief Clinical Officer

Judi Redona, RN, CHPN Quality and Compliance Nurse



Original Situation

PEPPER report:

Statistics for Long Length of Stay
Status- Not an outlier

However- closer analysis showed an
upward trend of long length of stay
patients from 2017 through 2019.



Background – Original Project

Often patients would be admitted very ill from the hospital to their home and have an expected two week or less prognosis.

In some cases, these patients seemed to rally when they got home and started to receive care from the hospice team.

At recertification, the team would be uncertain of the patient's terminal prognosis and choose to give the patient the benefit of the doubt, believing that the patient would continue to decline.

In doing so, we ended up with a group of long length of stay patients who had little change although they remained very debilitated.



Assessment - Process

We found that our F2F visits were being done very close to the recert date, and that our team meeting discussions were very close to the recertification dates, not leaving enough time for more in-depth review when there was uncertainty in a patient's eligibility.

We were uncertain when discharge should be considered for a patient experienced a plateau. Should we wait 30 days, 60 days?

We even asked our Medicare contractor, CGS, and they would not give us a time frame for when to consider discharging a patient for extended prognosis.



Assessment

It is impossible to determine exact prognosis. But equally difficult to determine resilience.

Patients:

Age > 80 yrs, living in private home with family/private hire caregivers, neurodegenerative diagnoses. Bedbound, incontinent, total care, contracted extremities, cachexic, non-verbal. Caregivers would spend hours attempting to feed patient, and overall gave meticulous care.

Staff:

Dedicated, compassionate, strong patient and family advocates, viewed discharge as leaving patient and family with no safety net of support. “We have to be in there”



Response

- We created a standardized process for all patients whose eligibility is uncertain – Utilization Review meetings. These meetings are more in depth and always include the Medical Director.
- Originally, we brought in each primary care team to do an in-depth verbal report and review of each patient's situation. We then compared the team's report with the documentation to see where improvements could be made.
- We also paired an NP with a primary nurse to work together with a small group of patients to strengthen our nurses' assessment skills and documentation.



Response (continued)

- We had our hospice physicians do Face to Face visits for all patients with questionable eligibility
- We scheduled F2F visits earlier, between 15-30 days prior to the recert date
- We asked different nurses to do comprehensive assessments to have a “different set of eyes” on these patients
- Compliance Nurse and Nurse Managers did joint visits with primary nurses and one to one coaching regarding documentation
- Created a formal Utilization Review Committee consisting of Chief Clinical Officer, Medical Director, and the Compliance Nurse.



Originally a Long Length of Stay Project

The changes that happened

- Our long length of stay numbers decreased
- F2F visits were being done earlier and with more collaboration with the primary teams
- Clear process for what to do when eligibility is uncertain
- Improved understanding of and documentation of eligibility

What has happened in the past year

- Our length of stay has continued to decrease – partly due to COVID
- F2F visits are still being done earlier but have sometimes been done by telehealth
- We now receive requests for eligibility reviews for short length of stay patients – often COVID patients
- Challenges with documentation and reviews due to new EMR implementation





The environment changed- COVID!!!

- Shorter length of stays overall
- Some COVID patients improve/stabilize – then what?
- More UR reviews being done in 1st benefit period due to above
- Later referrals – affects overall metrics for the agency
- Asked to do more with less, and faster
- Telehealth F2F visits are challenging at times



We Changed

- New EMR
- New Medical Director
- New Managers
- New Primary Staff
- New Competitors
- New Palliative Care Program



Revised Audit Tool

Audit Tool - UR Reviews 2022

Date of Review:	Name:	P#:	Ben Pd:	Recert Date:
Primary team:		Attending Physician/NP:		
Home/ALF/NH:	Age:	Insurance:		
Primary Dx:	Secondary Dx:			

Clinical Factor	
Goals of Care	
DNR/MOLST status	
Did the admission documentation/certification support a six-month prognosis?	
Does the most recent documentation support a six-month prognosis?	
Has the patient's clinical situation declined since admission due to the disease process?	
Has the patient needed an on call, ER visit, or visit for symptom management in the last 2 months?	
Have there been any medication changes in the last 2 months?	
Are there orders for the symptom management medications?	
If required, is a FAST score documented?	
Is the FAST score higher than at admission?	
Is a PPS score documented?	
Has there been a decline in the PPS score since admission?	
Is an initial BMI, weight, or MAC recorded?	
Is there recent documentation of weight/MAC?	
Have there been changes to the Plan of Care in the last 2 months?	
Has there been a change in visit frequencies?	

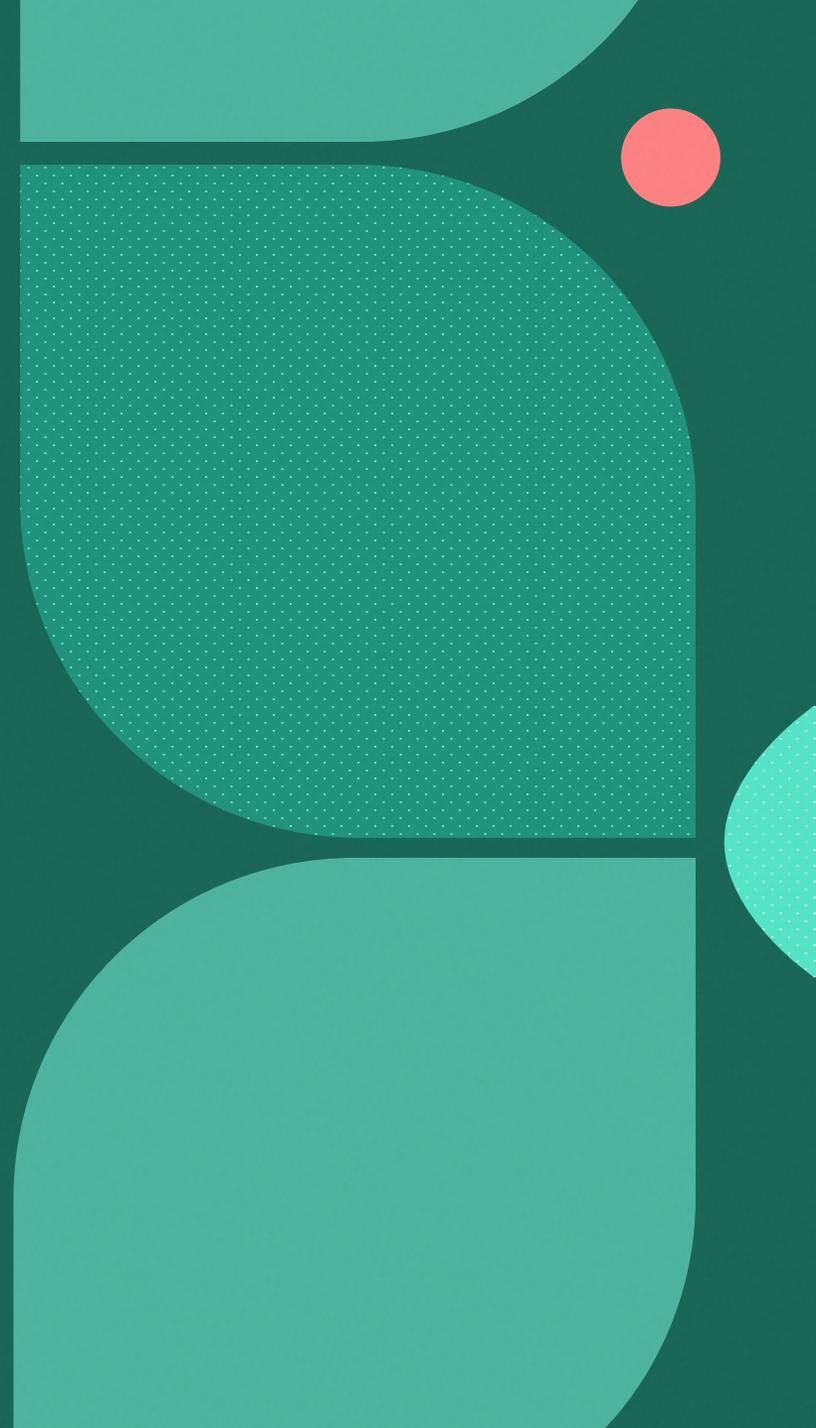
Additional Comments:

Recommendations to the Team:



How the numbers changed

- In our internal audits:
- Average Length of Stay
 - 2018 ALOS = 80.65
 - 2021 ALOS = 74.25
 - April 2022 ALOS = 57.18 (multi-factorial)
- Number of long length of stay patients – reduced by 50%
- On our PEPPER reports:
 - Went from 56% percentile to 25% percentile (CGS)





Lingering Questions

- When a patient has a plateau, when do we decide discharge is appropriate?
- Is a discharge from hospice and subsequent readmission considered a burdensome transition?
- For COVID patients who improve unexpectedly, when should they be considered for discharge?
- How do we decide when to readmit a long length of stay patient?
- How do we balance quality and organizational strength with regulatory compliance?
- How do we compare data with Medicare when the PEPPER report has statistics on discharged patients, but we look at current active patients?



Questions?

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You Too Can Present a Case!

- Could be in the hospice or palliative care space
- Quality focused
- Is relevant to today's hospice and palliative care environment
- What are we looking for in a patient-based case?
 - Poses difficult issues for the interdisciplinary team
 - May be an outlying or a frequent situation that involves clinical/ emotional/ psychosocial/ spiritual challenges
- What are we looking for in a process-based case?
 - May involve operational or clinical process issues
 - May affect patient care
 - Is a focus of quality improvement for the organization

Upcoming Project ECHO Sessions

Access our Project ECHO webpage
at <https://www.nhpco.org/projectecho/>

(On the page, scroll down to complete the case study SBAR form for submission case study for consideration)