

NHPCO Project ECHO

June 2021

Case presentation by Montgomery Hospice & Prince Georges Hospice, MD

ECHO session facilitator – Jennifer Kennedy, EdD, BSN, RN, CHC

Sr. Director, Quality & Regulatory, NHPCO

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 related to the case
- Case presenter presents case details and specific questions or ponderings.
- Questions and clarifications – subject matter experts and participants
- Final thoughts and lessons learned - subject matter experts and participants

Video Teleconferencing Etiquette

- Remain on mute unless speaking and eliminate or reduce environmental distractions to improve sound/video quality
- Use video whenever possible; Face and make eye contact with the camera when you are speaking
- Use respectful and appropriate language
- **Do not disclose protected health information (PHI) or personally identifiable information (PII)**

Gound Rules

- Participants - introduce yourself prior to speaking
- Respect one another – it is ok to disagree but please do so respectfully
- This is an all share-all learn format; judging is not appropriate
- One person speaks at a time
- Disregard rank/status
- There is no acceptable judging

Introductions

Case presenters from Montgomery Hospice

- Judith Redona, RN, CHPN, Clinical Quality and Compliance Nurse Specialist, Montgomery Hospice & Prince George's Hospice, MD
- Jennifer Plude, BSN, CHPN, RN, Senior VP of Nursing and Care Management, Montgomery Hospice & Prince George's Hospice, MD

Subject Matter Experts

- Mrs. Eugenia Smither, BS, CHC, CHE, CHP, RN, Vice President of Compliance and Quality, Bluegrass Care Navigators
- Christine Nidd, MSW, PMP, CPHQ, Manager of Quality and Compliance, Hospice of the Northwest

Today's case study

Hospice operation process/practice focused case

- Long length of stay
- Continued eligibility determination
- Recertification
- Discharge from hospice care

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.

Hospice Length of Stay FYs 2016 - 2019

- Patients with neurological and organ-based failure conditions (with the exception of kidney disease/kidney failure) tend to have much longer lengths of stay compared to patients with cancer diagnoses.

	FY 2016	FY 2017	FY 2018	FY 2019
Average Length of Election	74 Days	74 Days	75 Days	77 Days
Median Lifetime Length of Stay	19 Days	19 Days	19 Days	20 Days
Average Lifetime Length of Stay	95 Days	95 Days	96 Days	99 Days

Source: Hospice claims data accessed from CCW on January 15, 2021.

Average Length of Stay in Days for Hospice Users in FY 2019

Category	Number of Hospice Users Discharged at the End of FY 2019	Average Length of Election	Median Lifetime Length of Stay	Average Lifetime Length of Stay
Alzheimer's, Dementia, and Parkinson's	210,944	126.9	52	169.0
CVA/Stroke	57,100	114.7	34	148.3
Cancers	290,868	45.7	17	53.5
Chronic Kidney Disease/Kidney Failure	28,130	35.6	8	44.3
Heart (CHF and Other Heart Disease)	210,087	85.4	24	107.6
Lung (COPD and Pneumonias)	112,852	82.2	20	108.0
Other	351,977	64.2	14	82.1
All Diagnoses	1,261,958	77.3	20	98.8

Source: Hospice claims data accessed from CCW on January 15, 2021



Prognosis Indicators

- Terminal diagnosis and comorbidity status
- Performance status
 - Global measure of patient's functional capacity
 - Karnofsky Performance Status (KPS)
 - Palliative Performance Scale (PPS)
 - Decline in cognitive/physical function (KPS/PPS <50%)



Prognosis Indicators, cont.

- Recurrent serious infections
- Signs of severe malnutrition
 - Disease-related weight loss >10% in last 6 months
 - Albumin <2.5 gm/dl
 - Prolonged loss of appetite, little oral intake
- Multiple non-healing pressure ulcer, stage 3-4
- Multiple comorbidities (CHF, COPD, ESRD, etc)
- Surprise question – would you be surprised if this patient died in the next 12 months?

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 evaluative lead 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.

Case Presentation

SBAR (Situation, Background, Assessment, Recommendation)

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

Date	Time
July 27, 2021	3pm ET
August 25, 2021	3pm ET
September 29, 2021	3pm ET
October 26, 2021	3pm ET
November 30, 2021	3pm ET
December 21, 2021	3pm ET

Submit a case - <https://www.nhpc.org/projectecho/>

Thanks for joining.
We will see you next
month.