NHPCO Project ECHO

April 2021

Case presentation by Hospice of Douglas County, MN

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)**

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.

What Are We Looking for in a Case?

- Poses difficult issues for the interdisciplinary team
- May be an outlying or a frequent situation that involves clinical/emotional/psychosocial/ spiritual challenges
- May involve process of care issues
- Could be a case in the hospice or palliative care space
- Is relevant to today's hospice and palliative care environment
- Quality focused

Submit a case - https://www.nhpco.org/projectecho/

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.
- Case Summary by facilitator
- Questions and clarifications – participants and subject matter experts
- Request for Recommendation – participants and subject matter experts
- Summary of Recommendations by facilitator

Introductions

Case presenter

- Patty Marriott and Brandy Safe, Hospice of Douglas County, MN

Subject Matter Experts

- Roseanne Berry, MS, RN
  R&C Healthcare Solutions

- Eric Bush MD,RPh,MBA
  Chief Medical Officer, Hospice of the Chesapeake/Chesapeake Supportive Care

Visits at the End of Life

Jennifer Kennedy, EdD, BSN, RN, CHC

NHPCO

NHPCO

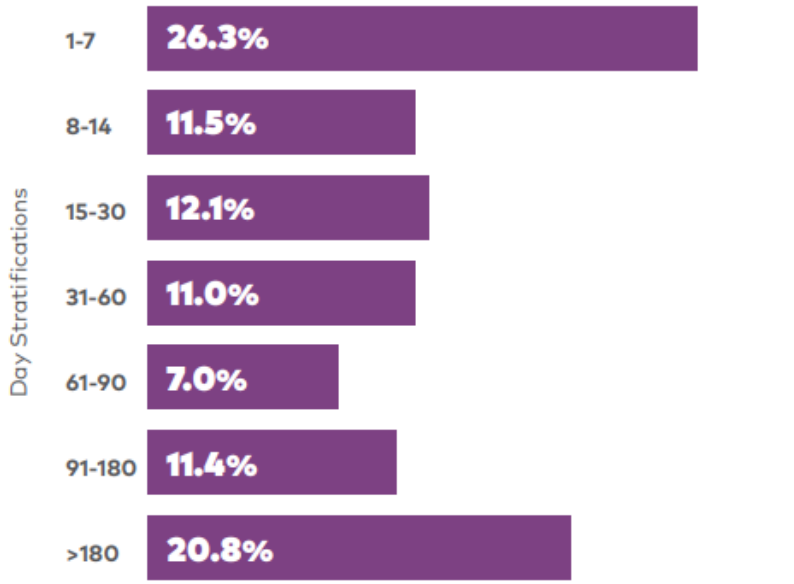
The Issue of Short Length of Stay

- 2016-2018 Data from NHPCO indicates there is an upward trend of patient's who are admitted to hospice care in their last week or last days of life.
- Additional research shows that patients who are admitted to hospice care in the late stage of their terminal illness and receive shorter exposure to hospice services undergo less chance of achieving optimal end-of-life closure and preparation for death and bereavement.

Days of Care

Days of care over multiple years by percentage of patients*

Figure 14: Days of Care Between 2016-2018 by % of Patients



*These values are computed using all days of care that occurred between 2016 through 2018 highlighting extended care beyond 180 days that covered multiple years vs just 2018.

Source: CMS Data sourced by HCCI for NHPCO

Skilled Visits in Last Days of Life

- Percentage of Decedents Not Receiving Skilled Visits at the End of Life (on Routine Home Care Days), Calendar Years (CYs) 2015-2019

	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019
No skilled visits on last day (and last day was RHC)	22.7%	20.4%	19.4%	19.5%	19.6%
No skilled visits on last two days (and last two days were RHC)	11.0%	9.3%	8.3%	7.8%	7.5%
No skilled visits on last three days (and last three days were RHC)	6.8%	5.7%	5.0%	4.6%	4.4%
No skilled visits on last four days (and last four days were RHC)	4.6%	3.8%	3.2%	2.9%	2.8%

Source: Analysis of Medicare hospice claims and administrative data (CY 2015-2019) accessed from the CCW on January 15, 2021.

Visits in Minutes

- Average Number of Minutes Provided in the Last Seven Days of Life on Routine Home Care days by Skilled Nurse and Medical Social Workers, CY 2015-2019

Year	Skilled Nurse Minutes	Social Worker Minutes	Total Minutes
2015	48.1	6.0	54.1
2016	49.5	6.5	56.0
2017	50.0	6.6	56.6
2018	50.3	6.6	56.9
2019	50.2	6.7	56.9

Source: Analysis of Medicare hospice claims and administrative data (CY 2015-2019) accessed from the CCW on January 15, 2021.

The Issue of Short Length of Stay

- Optimally, a longer length of stay allows the hospice team to accomplish this multifaceted care to achieve the best possible end-of-life experience for the patient and family.
- But, if the patient enters hospice late in their disease trajectory, hospice care must be accelerated and intensified to meet patient/family needs.
- However, providing a positive and full hospice experience in a short amount of time can be accomplished with thoughtful planning and resource utilization by the hospice provider.

CMS

- CMS believes that patient needs normally increase and intensify immediately preceding death, so they expect that provision of care would proportionately escalate to meet the increased clinical, emotional, and other needs of the hospice beneficiary and his or her family and caregiver(s).
- They state hospice providers must ensure that beneficiaries and their families and caregivers are, in fact, receiving the care necessary during critical periods such as the very end of life.

Regulatory Compliance

- §418.3 - Definitions as, “a comprehensive set of services identified and coordinated by an interdisciplinary group (IDT) to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care”.
- Conditions of Participation (CoPs) require that imminence of death be assessed by the IDT during the initial and comprehensive assessment (§418.54 Condition of Participation: Initial and Comprehensive Assessment of the Patient). Imminence of death is assessed by the IDT for the remainder of the patient’s length of stay.

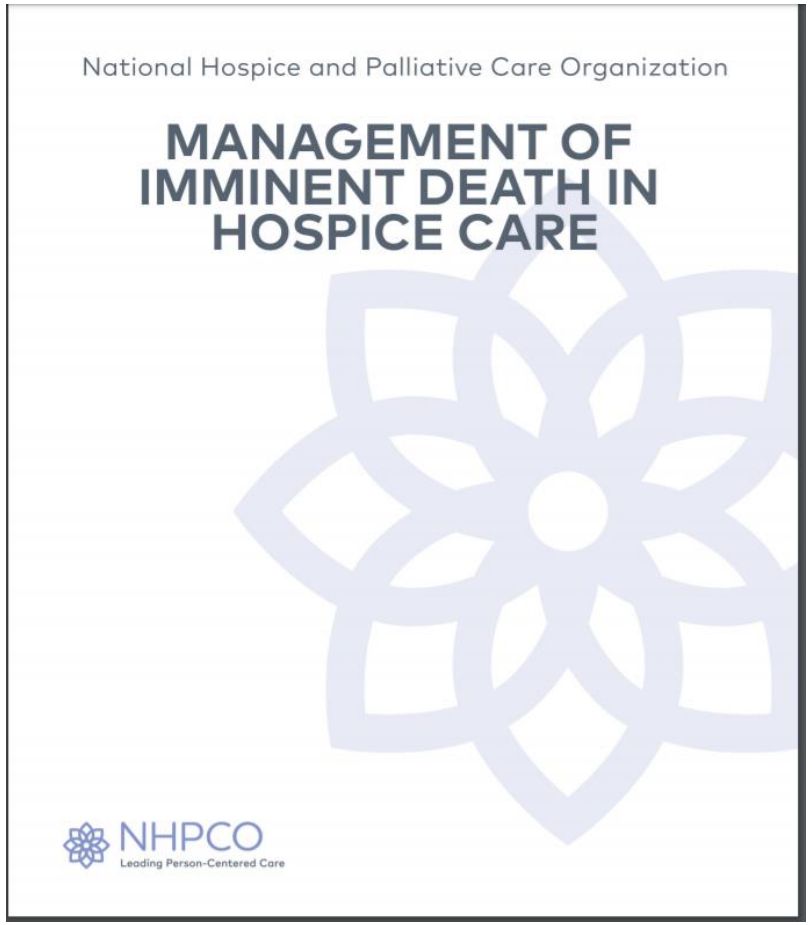
CMS Quality Measure

Measure title	Hospice Visits in the Last Days of Life (HVLDL)
Measure type	Process
Data source	Hospice claims
Measure numerator	The number of patient stays in the denominator in which the patient and/or caregiver received **at least two days with visits from registered nurses or medical social workers in the final three days of life**
Measure denominator	All hospice patient stays enrolled in hospice except those meeting exclusion criteria.

Exclusion criteria

1. Patient did not expire in hospice care as indicated by reason for discharge
2. Patient received any continuous home care, respite care or general inpatient care in the final three days of life
3. Patient enrolled in hospice less than three days.

Resource for Providers



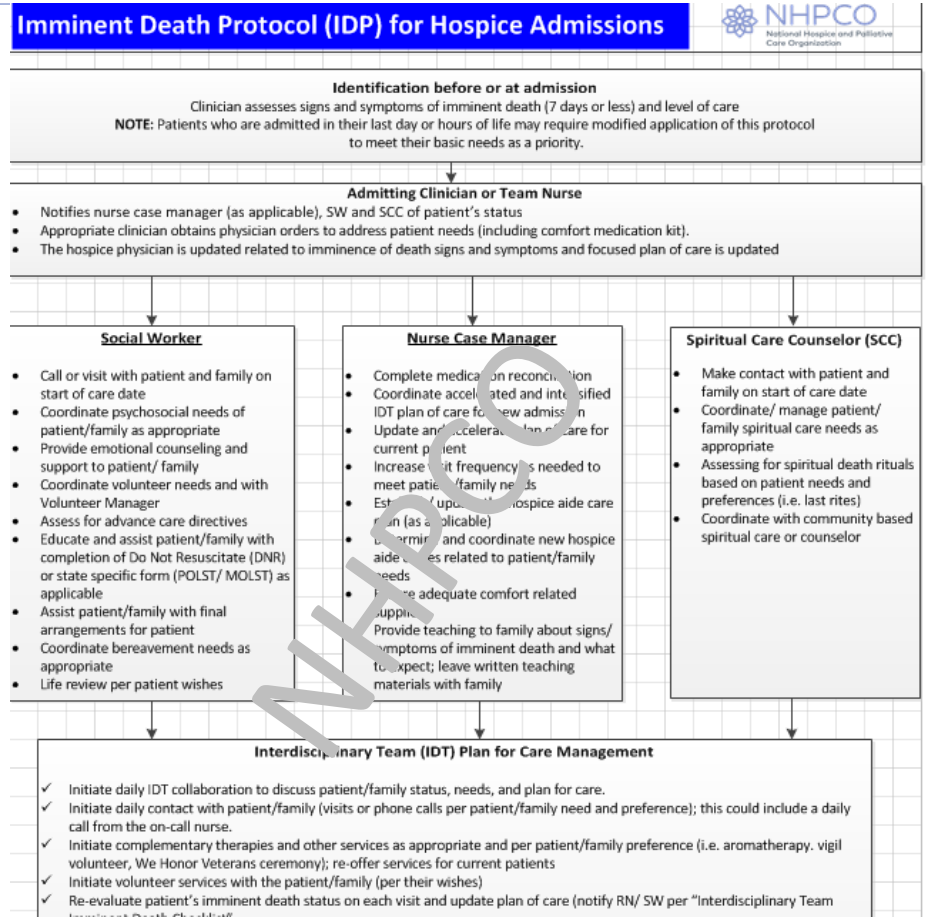
Developed by the NHPCO Quality & Standards Committee to recognize and provide guidance for the specialized care of patients/families with a length of stay of 7 days or less.

The goal of this resource is to identify opportunities for quality assessment and performance improvement for patients and their families in the last days of life at the routine level of care.

Resource for Providers

- Main guidance document
- Imminent Death Protocols (addendums)
  - New Admission
  - Patient on ongoing service
- Interdisciplinary Imminent Death Indicator Checklist (addendum)
- Interdisciplinary Focused Assessment and Plan of Care Suggestions For Short Length of Patient Stay (7 days or less) (addendum)

Imminent Death Protocol – What is it?



Imminent Death Protocol (IDP) for Hospice Admissions

NHPCO National Hospice and Palliative Care Organization

Identification before or at admission

Clinician assesses signs and symptoms of imminent death (7 days or less) and level of care

NOTE: Patients who are admitted in their last day or hours of life may require modified application of this protocol to meet their basic needs as a priority.

Admitting Clinician or Team Nurse

- Notifies nurse case manager (as applicable), SW and SCC of patient's status
- Appropriate clinician obtains physician orders to address patient needs (including comfort medication kit).
- The hospice physician is updated related to imminence of death signs and symptoms and focused plan of care is updated

Social Worker

- Call or visit with patient and family on start of care date
- Coordinate psychosocial needs of patient/family as appropriate
- Provide emotional counseling and support to patient/ family
- Coordinate volunteer needs and with Volunteer Manager
- Assess for advance care directives
- Educate and assist patient/family with completion of Do Not Resuscitate (DNR) or state specific form (POLST/ MOLST) as applicable
- Assist patient/family with final arrangements for patient
- Coordinate bereavement needs as appropriate
- Life review per patient wishes

Nurse Case Manager

- Complete medica[illegible]on reconc[illegible]ion
- Coordinate accele[illegible]ated and inte[illegible]sified IDT plan of care f[illegible]w admiss[illegible]n
- Update an[illegible]cceler[illegible]an [illegible]care for current p[illegible]ient
- Increase [illegible]it frequency[illegible]s needed to meet patie[illegible]/family ne[illegible]ds
- Est[illegible]/upd[illegible]ospice aide care [illegible]n (as a[illegible]plicable)
- D[illegible]ermi[illegible] and coordinate new hospice aide [illegible]es related to patient/family needs
- [illegible]e adequate comfort related supp[illegible]
- Provide teaching to family about signs/ symptoms of imminent death and what to expect; leave written teaching materials with family

Spiritual Care Counselor (SCC)

- Make contact with patient and family on start of care date
- Coordinate/ manage patient/ family spiritual care needs as appropriate
- Assessing for spiritual death rituals based on patient needs and preferences (i.e. last rites)
- Coordinate with community based spiritual care or counselor

Interdisci[illegible]inary Team (IDT) Plan for Care Management

- ✓ Initiate daily IDT collaboration to discuss patient/family status, needs, and plan for care.
- ✓ Initiate daily contact with patient/family (visits or phone calls per patient/family need and preference); this could include a daily call from the on-call nurse.
- ✓ Initiate complementary therapies and other services as appropriate and per patient/family preference (i.e. aromatherapy. vigil volunteer, We Honor Veterans ceremony); re-offer services for current patients
- ✓ Initiate volunteer services with the patient/family (per their wishes)
- ✓ Re-evaluate patient's imminent death status on each visit and update plan of care (notify RN/ SW per "Interdisciplinary Team [illegible]

- Resource contains two protocols
  - New admissions (7 days or less)
  - Ongoing patient transitions to imminent death
- Interdisciplinary protocol
- Directed towards assessment, coordination of care, and care planning to meet patient/family needs

Today's Case Presentation

SBAR (Situation, Background, Assessment, Recommendation)

Next Steps

Case presentation

Questions

- Subject Matter Experts & Participants

Recommendations

- Subject Matter Experts & Participants

Summary

Upcoming Project ECHO Sessions

Date	Time
March 31, 2021	3pm ET
April 27, 2021	3pm ET
May 26, 2021	3pm ET
June 23, 2021	3pm ET
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.nhpco.org/projectecho/

Thanks for joining and we will see you next month