Home Sweet Home

Succeeding in Community Based Palliative Care

Visiting Nurse Association
Advanced Illness Management
Community/Home-based Palliative Care

Mary Fox, MD - CMO
Deborah Jeffery, DNP - Director
Michelle Schultz, MD – AIM Physician

1

2

From Our Own MHPCA Newsletter…

3

CMS Innovation Center (CMMI)

- Tests new payment and delivery models
- Improve patient care, lower costs and better align payment systems to promote patient-centered practices
- Demonstration Project – **Medicare Care Choices Model (MCCM)**
  - Allows Medicare beneficiaries to receive support services from hospice providers while continuing usual care
- Extended through 12/31/21

4

Findings

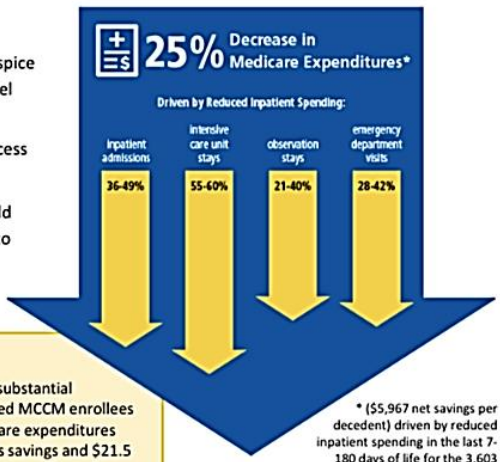
- **Beneficiaries in MCCM were 20 percent more likely to enroll in the Medicare hospice benefit (MHB)** and elected MHB one week earlier, on average, than the comparison group (two weeks earlier when including beneficiaries who enrolled in MCCM more than a year prior to death).
- **Reductions in total Medicare expenditures differed substantially** for MCCM enrollees who transitioned to MHB compared to those who did not transition to MHB in the last 30 days of life ($9,934 vs. $345, respectively).
- **Caregiver experience of care:** Caregivers of MCCM enrollees who transitioned to MHB reported highly positive experiences in the model. Caregivers of enrollees who did not transition to MHB held less positive views of MCCM. Caregivers of those enrolled in MCCM for less than 30 days reported the least satisfaction. These individuals may not have had sufficient time to benefit from the full range of services offered by hospices participating in MCCM.

5

84% of enrollees elected the Medicare hospice benefit after an average of 99 days in the model and 46 days prior to death.

12% died while enrolled in MCCM with access to supportive services through the model.

96% of caregivers indicated that they would definitely or probably recommend the model to friends and family members.



* ($5,967 net savings per decedent) driven by reduced inpatient spending in the last 7-180 days of life for the 3,603 MCCM enrollees who died before September 30, 2019.

KEY TAKEAWAYS

Initial impact findings indicate that MCCM led to substantial reductions in total Medicare spending for deceased MCCM enrollees during the first 3 years of the model. Total Medicare expenditures decreased by 25%, generating $26 million in gross savings and $21.5 million in net savings, largely by reducing inpatient care through increased use of MHB. Most caregivers reported positive experiences in the model. Caregivers of enrollees who did not transition to MHB reported lower satisfaction rates.

6

Visiting Nurse Association
of Greater St. Louis

Advanced Illness Management (AIM) Program

7

7

WHY?

8

"Every day I walk for 30 minutes, I drink 8 glasses of water, and I eat 5 fruits and vegetables... BUT I'M STILL GETTING OLDER!"

9

9

THE CONTINUUM OF PALLIATIVE CARE

Palliative care can be - and must be - available across all settings, offering an array of services in venues that matter most to patients and families, in ways that ensure smooth transitions between settings.

FILLING THE GAP

POINT OF CRISIS

HOSPITAL PALLIATIVE CARE

COMMUNITY - BASED PALLIATIVE CARE

OFFICE
HOME
INSTITUTIONAL

END-OF-LIFE

HOSPICE PALLIATIVE CARE

10

10

ADVANCED ILLNESS:

SERIOUS CHRONIC ILLNESSES

REQUIRING MULTIPLE INTERVENTIONS

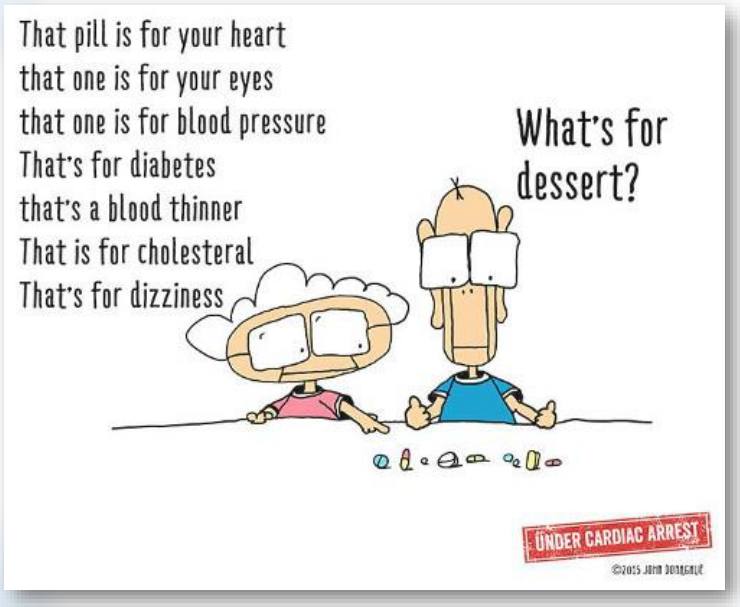
AND OFTEN FREQUENT

HOSPITALIZATONS

WITHOUT ACHIEVING STABILIZATION

11

11



12

12

Advanced Illness MANAGEMENT*

AIM is a **HOME-BASED** palliative care program established to ease the transition between

curative and comfort care

for seriously ill patients

who lack coordinated

hospital, home health and hospice care.

***MANAGEMENT IS KEY!!!**

13

13

14

14

Whom Do We Serve?

ADULT MEDICARE PART B BENEFICIARIES

WITH TRADITONAL MEDICARE

AND MOST ADVANTAGE PLANS

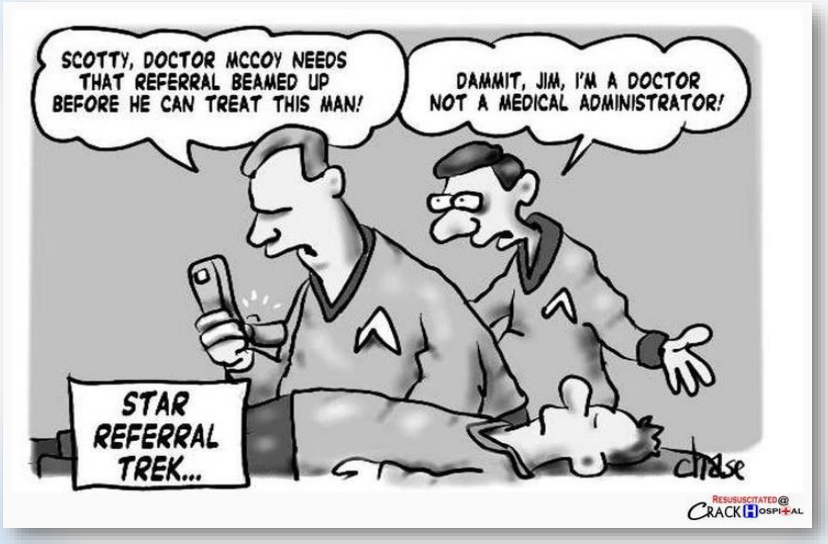
with 1 or more COMPLEX CHRONIC ILLNESSES

AND/OR

1 or more HOSPITAL VISITS in past 1 year.

15

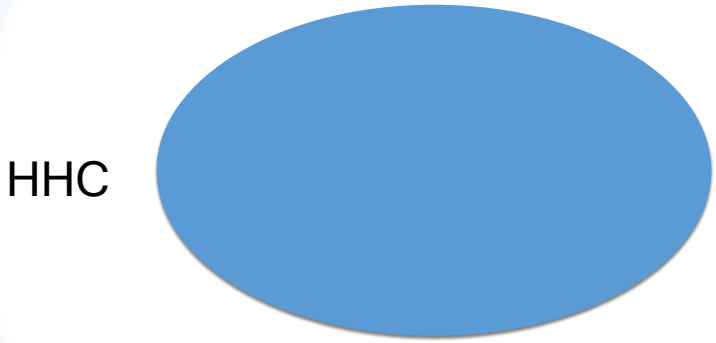
15



16

16

Whom Do We Serve?



17

17

St. Louis City and County

Estimated Number
of AIM Appropriate Patients:

21,000

Estimated Savings
Through Prevention of:

1 ER visit = $2K x 21K = 42 million

1 hospitalization = $5K x 21K =
105 million

18

18

Top Diagnoses of VNA AIM Program

COPD

CHF

CANCER

ESRD

DEMENTIA

FALLS

WEAKNESS

19

19

The CO-MANAGING Team

- PCP or Referring Physicians
- Palliative Care Physicians
- Nurse Practitioners
- Social Workers
- Spiritual Counselors
- Medical Secretaries

20

20

21

What We Ask of Patients and Caregivers

- Commitment to avoid hospital visits
- Stay in communication with the AIM team

22

VNA AIM Outcomes

- Improve quality of life for patients and caregivers.
  - Validated Quality of Life assessment tools for patient and caregivers
- Screen and manage serious chronic illness for improved symptom control.
  - RGAT (SLU)
  - IPOS 1 and 2

23

23

VNA AIM Outcomes

- Reduce unnecessary readmission and hospital utilization.
  - Per patient analysis

24

24

How Do We Measure Success?

➢ Project 50% reduction in hospitalizations including 30-day re-admission rate within 90 days of enrolling

➢ Receive at least 4 out of 5 score on the Views on Care, Assessment of Palliative Care by Patients and/or Caregivers within 90 days of program enrollment.

- Data calculated from data accessed: http://www.cdc.gov/nchs/data/nhsr /nhsr038.pdf

25

25

AIM Highlights

➢ 160 patients currently enrolled

➢ Age range at admit: 23 to 105 years

➢ Census days range: 1 to 1350 days

➢ Average LOS 150 days

26

26

AIM Highlights

From 12/01/16 thru 11/30/18

Approximate Reduction in
Total Hospital Admissions:

79%

Total ER visits

85%

27

27

Patient Satisfaction

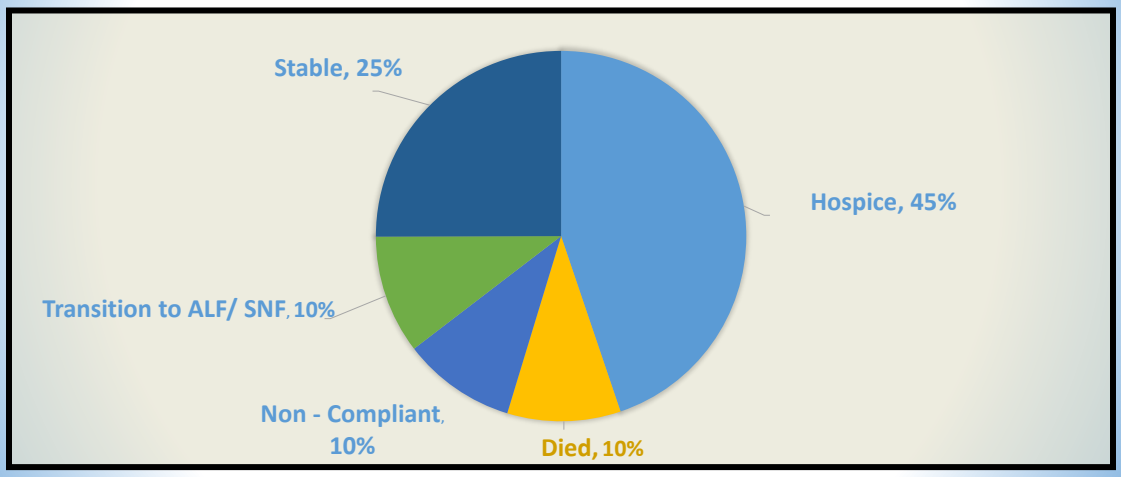
2019 FamCare 2 Survey

- 92% Very Satisfied or Satisfied
- 5% NA or Neutral
- 3% Dissatisfied

28

28

Disposition at Discharge



29

Nuts and Bolts of Patient Care

- Initial opening visit by physician: 1.5-2 hours
- NPs provide majority of follow-up visits
- Frequency and duration of visits: At least 5 visits/First 90 days

30

Nuts and Bolts of Patient Care

- What we document
  - Tools
    - Rapid Geriatrics Assessment Tool
    - IPOS 1&2
  - Medication Reconciliation
  - Usual elements of H&P
  - Assessment/Recommendations specific to problems being addressed by AIM
  - Goals of Care/Advanced Care Planning (Document date and time spent)
  - Communication with PCP +/- Specialists

31

Preparation by Administrative Staff

- Taking referral and understanding reasons/expectations
- Insurance verification
- Obtaining PCP authorization
- Preparing Family for visit expectations
  - Time
  - Insurance Cards
  - Consents
- Loading outside medical records
- Scheduling by geography

32

Billing Codes for Home-Based Palliative Care

- Initial Visit
  - Home 99344 & 99355
  - ALF/Domiciliary/Rest Home 99327 & 99328
  - SNF 99305 & 99306
- Established Patient
  - Home 99348 & 99349
  - ALF/Domiciliary/Rest Home 99336 & 99337
  - SNF 99309 & 99310

33

Billing Codes for Home-Based Palliative Care

- Billing for Prolonged F2F Outpatient Visit 99354 and 99355
- Billing for Prolonged NF2F Services (such as Review of Outside Medical Records before and after visit) Time spent >30 min 99358 and 99359
- Goals of Care/Advance Care Planning 99497 and 99498
  Document date and time spent

34

Prolonged Services Without Direct Face-to-Face Patient Contact

→ "Codes 99358 and 99359 are used when a prolonged service is provided that is neither face-to-face time in the office or outpatient setting, nor additional unit/floor time in the hospital or nursing facility setting during the same session of an Evaluation and Management service and is beyond the usual physician or other qualified health care professional service. These services may consist of, but not limited to, prolonged communication consulting with other health care professionals related to ongoing management of the patient, Evaluation and Management service performed earlier on the patient, or prolonged review of extensive health record and diagnostic tests regarding the patient."

Reference: https://www.aapc.com/blog/37804-cms-covers-99358-99359-prolonged-service/https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3678CP.pdf; https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm5972.pdf; https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-F.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending

capc Center to Advance Palliative Care

35

Non-Direct Prolonged Service

- **99358** – Prolonged evaluation and management service before and/or after direct patient care; **first hour**
- **+ 99359** each **additional 30 minutes (SO AFTER 60 MIN OF 99358)** (List separately in addition to code for prolonged service)
- Report 99358-99359 for the **total duration of non-face-to-face time** spent by a physician/provider on a given date providing prolonged service, **even if** the time spent is **not continuous.**
- Code **99358** is reported only when **30 minutes of time has been met or exceeded** on a single calendar date and is reported only once per day.
- Do not report 99358-99359 when reporting a code from 99202-99215 or with 99497 on the same date.
- Whether your prolonged time is spent with or away from the patient, **document the time** in the patient's medical record.

36

Non-Direct Prolonged Service

- Outpatient setting that is non-direct…and the physician/provider spends **time away from the patient**. The prolonged time is **either** on the **same date of a direct E/M service or on a day when** the physician/provider **does not see the patient**. Code 99358 does not require other services to be billed with it.

NOTE: IF YOU BILL FOR INDIRECT PROLONGED SERVICES BEFORE THE F2F VISIT, MEDICARE CONSIDERS THIS THE "INITIAL ENCOUNTER." THE ACTUAL F2F VISIT WILL THEN BE REIMBURSED AS A "FOLLOW UP" VISIT!

37

Billing for Telephone Encounters

CPT CODE	CPT Description
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to **an established patient, parent, or guardian** not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; **5-10 minutes** of medical discussion.
99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to **an established patient, parent, or guardian** not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; **11-20 minutes** of medical discussion.
99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to **an established patient, parent, or guardian** not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; **21-30 minutes** of medical discussion.

38

Billing the Physician Fee Schedule for Advance Care Planning Services

Center to Advance Palliative Care™ capc

CPT 99497: Advance care planning, including the explanation and discussion of advance directives such as professional standards forms (with completion of such forms, when performed) by the physician or other qualified health care professional; first 30 minutes, face-to-face with patient and/or family member(s) and/or surrogate.

CPT 99498: Each additional 30 minutes. (List separately in addition to code for primary procedure.)

RVUs and Payment	Work RVU	Average National Payment
99497 (first 30 minutes)	1.50	$82.90
99498 (subsequent 30 minutes)	1.49	$72.50

For further information:

- CMS Care Management information: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management.html
- Acevedo Consulting: www.acevedoconsultinginc.com

39

BILLING EXAMPLE

- Pt. seen F2F on X date. You spent 121 TOTAL minutes F2F on E and M = 99345 + 99354 (prolonged F2F) = 76 minutes + 31 but less than 61 minutes additional time.
- For > 15 min (more than ½ of first 30 min) of time for Advance Care Planning ADD 99497.
- You leave the pt. and review many pages of pertinent outside medical records, call 1 or 2 other providers, etc., BEFORE OR AFTER the F2F visit on DAY OF or SOME DAY AFTER = 50 MINUTES OF TOTAL TIME = 99358.
- IF YOU SPEND MORE THAN 60 MINUTES in NON-F2F care ADD 99359

40

Interdisciplinary Team

- Weekly Meetings
  - Weekend Calls
  - New Patient Review
  - Updates from Follow ups
  - Identify patients who need to be seen
  - Identify SW and chaplain needs

41

Telephone Encounters

- Triage of incoming phone calls
  - Assign to provider if needed
  - Documentation by providers as needed
  - Billing for phone calls – 99441-99443
- Status Checks
- 24/7 On Call
  - Advice regarding need for ER or UC
  - **Prescribing** medications for symptom relief
  - Lab work and x-rays

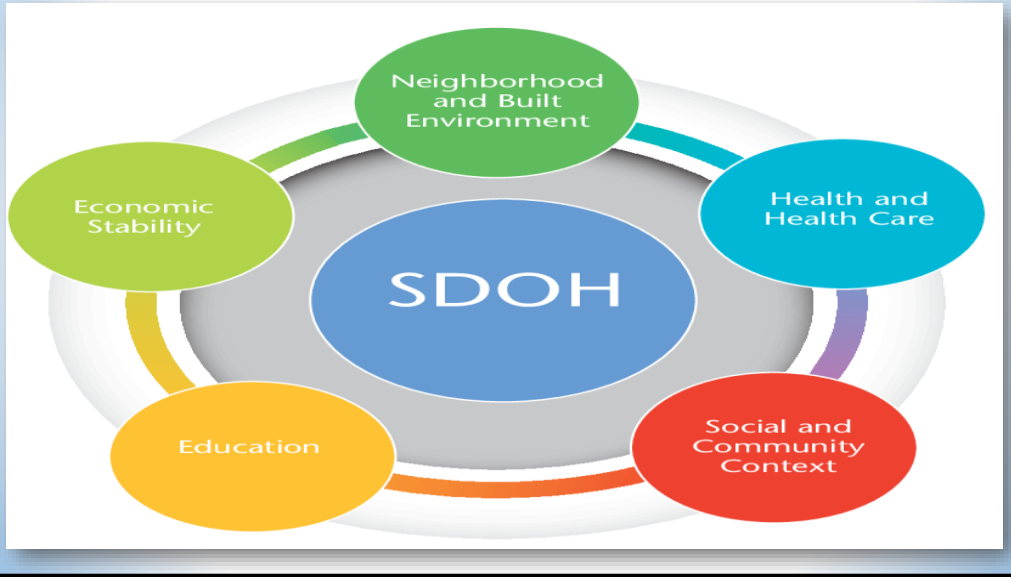
42

Making the Transition to CBPC – Things that are different for Providers…

- Aloneness
- Limited access to records
- Preparation before initial visit
- Insurance cards/Consents
- Taking Vitals
- Phone calls afterwards – docs you don't know
- Arranging HH, labs, x-rays
- Pets and other creatures
- Smoke
- Restrooms
- Eating
- Weather
- Directions
- Internet access
- Safety

43

Social Determinants of Health

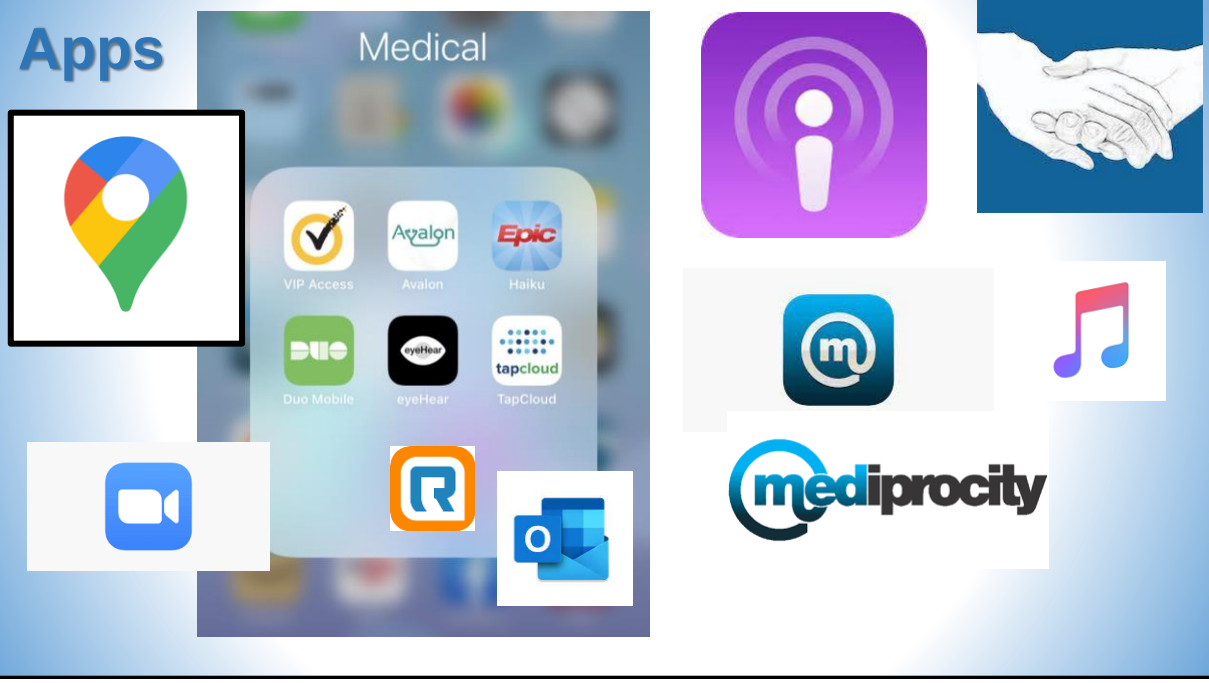


44

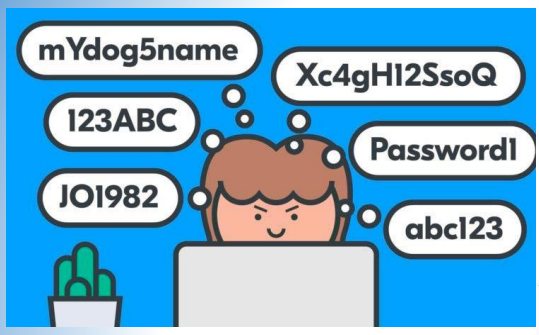
Equipment

45

Apps



46



47

Role of the Physician - The Initial Visit

- Comprehensive visit to establish rapport and trust
  - Determine where we are on the spectrum of Quantity—Quality
  - Determine unmet needs and try to meet them
  - Prognostic Awareness
  - Goals of Care – build on prior discussions if possible
- Advance Care Planning
  - Not a single event
  - Ongoing part of Serious Illness Management

48

Where are we along the spectrum of Quantity vs Quality of Life?

Prolongation of Survival

Comfort Measures

49

Advance Care Planning

- Review Advance Directives as available with patient and family
- Educate on importance of completion of Advance Directives as able
- Literature in Opening Packet
  - Description of Advance Directive
  - Sample form from the MO Bar Association
  - "Conversation Starter Kit" from the Conversation Project
  - Availability of Assistance through Meaningful Life, Carla Baum
- Completion of OHDNR
- Transition to Hospice

50

AIM Advance Care Planning Statistics

N=628	# of Patients	%
Advance Directive	471	75%
Power of Attorney	512	82%
OHDNR Order	389	62%

- Data available for 628 Admissions
- 364 signed OHDNR on initial visit
- 25 new DNR orders AFTER initial visit

51

Meaningful life

One Life. One Decision. One Story.

One Life. One Decision. One Story.

Meaningful Life offers a free community service including education, conversation, and resources for individuals, families, and professionals who are interested in learning about or making end-of-life decisions.

52

AIM New Advance Directive Completion
August, 2020 – August, 2021

- 51 referrals
- 28 completions (55%)
- Reasons for non-completion
  - Died
  - Went on hospice
  - In hospital and family doesn't contact again
  - No action - initial visit is completed/documents shared and no follow-up visit OR I make the initial contact(s) and no one calls back so I never get started.
- The Conversation Project statistics indicate that 90% of us want to complete them but only 30+% actually do them.
- 36.7% of USA adults complete advance directives*

Health Aff 2017;36:1244

53

Case Presentations

54

Case 1 - Louise

- 67 yo woman severely debilitated by morbid obesity, lung disease and musculoskeletal pain
- Chronic hypoxic respiratory failure 2/2 COPD, OSA, OHS, CHF
- Dependent on O2 (4-5L/min), nocturnal BiPAP and chronic steroids
- 5 hospitalizations in the past year

55

Case 1 - Louise

- Noncompliant with meds
  - Trelegy – can't afford $140/mo. Copay
  - Lasix – can't transfer to commode due to pain and dyspnea
- Symptoms
  - Dyspnea with minimal exertion (SaO2 drops to 70s with transfers)
  - Chronic Pain (R knee and L shoulder DJD – too sick for surgery)
  - Anxiety/Depression
  - Physical Debility
  - PPS = 60%

56

Case 1 - Louise

- Social Determinants of Health
  - Homebound, unable to get into a car
  - Struggling to afford medications
  - Hospital bed with manual controls, parts broken – Had for 2.5 yrs but can't use crank. DME company won't do anything as no longer under lease.
  - Working on walk-in shower. Only sponge bathes for now
  - Husband blind and disabled
  - Neither can cook (gas stove/O2) so eating only prepared foods
  - Home is cluttered and unclean
  - Family only helps when asked (and reluctant to ask)
  - No Advance Directive or POA

57

Case 1 - Louise

- Social Worker
  - Medicaid Application, Chore worker
  - Meals on Wheels
  - Advance Directive/POA completed

58

Case 1 - Louise

- Treated pain, dyspnea, anxiety and LE cellulitis
- One month after initial visit…
- Family Conference held
  - AIM physician
  - Husband, 3 children
  - Hospice SW
- Family educated on severity of illness and need for support

59

Case 1 - Louise

- Completed Advance Directive
- Agreed to Hospice Care – enrolled 3/6/21
- Remains on hospice with slow decline

60

Case 2 - Virginia

- 60 yo woman with end stage COPD, morbid obesity, chronic pain
- Home O2 for ~8 years; numerous hospitalizations
- Trilogy non-invasive ventilation at home since 8/2020

61

Case 2 - Virginia

- Hospitalized with COVID pneumonia 9/2020
  - Complicated by Pseudomonas pneumonia, stress-induced cardiomyopathy
  - Required prolonged intubation and tracheostomy 10/2020
- LTAC 10-12/2020 with successful weaning and removal of trach
- Acute Rehab with nocturnal BiPAP – lasted 2 days until 12/24/2020

62

Case 2 - Virginia

- Readmitted to ICU, tracheostomy replaced but NO PEG
- Transferred back to LTAC early January, 2021
- Determined to require permanent ventilator support at least at night

63

Case 2 - Virginia

- Initial PC consult in LTAC 2/2/21 (patient lacked capacity)
  - GOC discussion: Cont. aggressive support with ventilator in SNF vs transition to Hospice
  - Family changed code status to DNR and decided to meet with hospice team
- Patient regained decision-making capacity. Met with hospice agency who agreed to short term ventilator support at home with terminal wean. She decided against this.

64

Case 2 - Virginia

- Discharged home on ventilator 2/24/21 with referral for AIM PC
- Goals:
  - Optimal QOL on ventilator – manage SOB, pain, anxiety
  - Maximize functional status – HH PT, OT, ST
  - Remain at home rather than NH – Hired caregiver
  - Avoid hospitalizations
  - DNR

65

Case 2 - Virginia

- Initial home visit 3/1/21
  - Ventilator support 24/7, bedbound
  - Fed orally, no PEG
- 10 home visits to date
- Dyspnea, pain and anxiety controlled
- No Hospitalizations

66

Case 2 - Virginia

- Ongoing hospice discussions and one home hospice evaluation
- Treated for URI/PNA x 2 and UTI x 3
- In-home COVID vaccination
- Labs and X-rays in home several times
- On and off HH – RN, PT and OT
- Ambulates short distances in home
- As of 10/7/21 – DOING WELL AND HAPPY
  - Still getting PT

67

Case 3 - John

80 yo male admitted 02/2020

- Combined chronic systolic and diastolic heart failure/PAH/CAD—Diuretics + potassium and other meds
- h/o GERD/At risk for esophageal varices—On ASA and Xarelto
- MASSIVE non-malignant ascites with ongoing paracenteses every 1-2 weeks since 2018.
  - $100 per use of transport van to hospital for this
- H/o Falling resulting in at least 1 sig fracture. (However, pt. had stopped walking prior to initial AIM visit)

68

Case 3 - John

6 hospital visits prior to AIM

- Complications from CHF and cardiac cirrhosis including severe BLE lymphedema with cellulitis, pleural effusions and ascites

69

Case 3 - John

UNCONTROLLED SYMPTOMS

- SOB
- GERD/Abdominal discomfort/Severe ascites
- Hypotension due to 3rd-spacing of intravascular volume
- Severe BLE edema with stasis dermatitis, stasis ulcers and serous leakage
- Insomnia

70

Case 3 - John

SYMPTOM MANAGEMENT

- For ascites, hypotension and CHF--Discussed spironolactone with cardiologist and he agreed to trial.
- GERD—Restart famotidine.
- BLE Lymphedema—Spironolactone + ordered HHC w wound management and tubigrips
- Insomnia—Stop Benadryl
- Reduced mobility—Motorized wheelchair

71

Case 3 - John

OUTCOMES

- Titration of spironolactone resulted in significantly decreased ascites and lymphedema, reduction of need for paracenteses and improved QOL
- Famotidine controlled GERD symptoms and improved appetite.
- Increased mobility with motorized WC with improved QOL

72

Case 3 - John

THE REST OF THE STORY…

- NO HOSPITALIZATIONS SINCE AIM ADMISSION!
- Finally had abdominal port placed 03/2021 due to more frequent need for paracenteses and decline in function with ascites subsequently managed at home by HHC.
- Depression symptoms addressed
- Transitioned to hospice care 06/2021 and passed away a few weeks later in his home with family present.

73

Questions???

74