Clinician Connection: Cardiac Disease and COPD
Eligibility and Care Planning

December 2019
Subscriber Webinar

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About the Speaker

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With more than 25 years of operational, clinical and regulatory compliance leadership experience within the hospice industry, Roseanne Berry, MSN, RN has a proven track record as a nursing and business professional.

In her current role as a hospice consultant and a founding partner of R&C Healthcare Solutions, Roseanne uses her in-depth expertise to provide a range of services, including regulatory and operational support, QAPI development and compliance program development to hospices and industry professionals across the country.

She is a long standing member of the NHPCO Regulatory Committee. As an educator and a recognized leader in the hospice industry, she is a frequent speaker at conferences.

About the Firm

R&C Healthcare Solutions offers a range of consulting services as diverse as the challenges that face your hospice. Our mission is to help you achieve your goals and unlock your potential.

- Compliance and QAPI Program review, enhancement and support
- Medical Review
- Risk assessments
- Education
- Survey readiness
- Operational/process improvement

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This Session

- Eligibility related to cardiac disease and COPD (cardiopulmonary)
- Drilling Down on the Assessments
- Care Planning and Eligibility
- Actions of The Prudent Hospice

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Eligibility

LCDs and More

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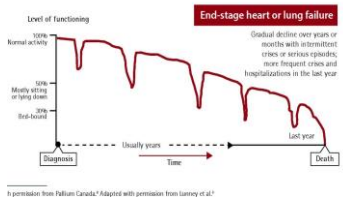

n permission from Pallium Canada.[4] Adapted with permission from Lunney et al.[5]

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Four Paths to Eligibility

1. Meets **ALL** the Local Coverage Determination (LCD) criteria
2. Meets most of the LCD criteria AND has documented **rapid clinical decline** supporting a limited prognosis
3. Meets most of the LCD criteria AND has **significant comorbidities** that contribute to a limited prognosis
4. **Physician's clinical judgment** is that the patient has a limited prognosis

All four paths lead to the same destination:
identification and support of a six-month prognosis

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Local Coverage Determinations (LCDs)

- Developed by MACs to provide medical criteria for determining prognosis
- Not the legal standard but are guidelines used by medical reviews
- Some patients may not meet all or any of these guidelines, yet still have a life expectancy of 6 months or less and documentation must contain enough information to support terminal status upon review.

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Cardiac LCD (excerpt) CGS & NGS

- Is or has been already optimally treated for heart disease or are either not candidates for surgical procedures or who decline those procedures.
- CHF or angina should be NYHA Class IV
  - Inability to carry on any physical activity
  - Symptoms of heart failure or of the anginal syndrome may be present even at rest.
  - If any physical activity is undertaken, discomfort is increased.
  - EF of less than or equal to 20% but is not required if not already available.
- Following factors may be present:
  - Treatment-resistant symptomatic supraventricular or ventricular arrhythmias;
  - History of cardiac arrest or resuscitation;
  - History of unexplained syncope;
  - Brain embolism of cardiac origin;
  - Concomitant HIV disease.

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Pulmonary Disease LCD (excerpt) CGS & NGS

- Severe chronic lung disease as documented by both of the following:
  - Disabling dyspnea at rest, poorly or unresponsive to bronchodilators, resulting in decreased functional capacity, e.g., bed to chair existence, fatigue, and cough; (Documentation of Forced Expiratory Volume in One Second (FEV1), after bronchodilator, less than 30% of predicted is objective evidence for disabling dyspnea, but is not necessary to obtain.)
  - Progression of end stage pulmonary disease, as evidenced by increasing visits to the emergency department or hospitalizations for pulmonary infections and/or respiratory failure or increasing physician home visits prior to initial certification. (Documentation of serial decrease of FEV1>40 ml/year is objective evidence for disease progression but is not necessary to obtain.)

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Pulmonary Disease LCD (excerpt continued) CGS & NGS

- Hypoxemia at rest on room air, as evidenced by pO2 less than or equal to 55 mmHg, or oxygen saturation less than or equal to 88%, determined either by arterial blood gases or oxygen saturation monitors, (these values may be obtained from recent hospital records) OR hypercapnia, as evidenced by pCO2 greater than or equal to 50 mmHg. (This value may be obtained from recent [within 3 months] hospital records.)
- Right heart failure (RHF) secondary to pulmonary disease (Cor pulmonale) (e.g., not secondary to left heart disease or valvulopathy).
- Unintentional progressive weight loss of greater than 10% of body weight over the preceding six months.
- Resting tachycardia > 100/min

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Cardiopulmonary LCD (excerpt) Palmetto GBA

Cardiopulmonary conditions are associated with impairments, activity limitations, and disability. Their impact on any given individual depends on the individual's over-all health status. Health status includes measures of functioning, physical illness, and mental wellbeing, as well as, environmental factors,

Secondary conditions

- Delirium,
- Pneumonia,
- Stasis Ulcers,
- Pressure ulcers

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Cardiopulmonary LCD (excerpt) Palmetto GBA

Ultimately, in order to support a hospice plan of care, the combined effects of the primary cardiopulmonary condition and any identified comorbid condition(s) should be such that most beneficiaries with the identified impairments would have a prognosis of six months or less.

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Heart Failure

- Marked decline in functional ability and quality of life
- Frequent hospitalizations for exacerbations despite:
  - Maximal medical therapy
  - Identification and treatment of reversible causes

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Heart Failure
General Predictors of Shorter Prognosis

- Cardiac hospitalization (triples 1-year mortality)
- Intolerance to neurohormonal therapy (i.e. beta-blockers or ACE-inhibitors) is associated with high 4 month mortality
- Elevated BUN (defined by upper limit of normal) and/or creatinine ≥1.4 mg/dl (120 µmol/l)
- Systolic blood pressure <100 mm Hg and/or pulse >100 bpm
- Decreased left ventricular EF (linearly correlated with survival at LVEF ≤ 45%)
- Ventricular dysrhythmias, treatment resistant
- Anemia (each 1 g/dl reduction in hemoglobin is associated with a 16% increase in mortality)
- Hyponatremia (serum sodium ≤135-137 mEq/l)
- Cachexia or reduced functional capacity
- Orthopnea
- Co-morbidities: diabetes, depression, COPD, cirrhosis, cerebrovascular disease, and cancer

Fast Facts and Concepts #143
Gary M Reisfield, MD & George R Wilson, MD

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End Stage COPD
General Predictors of Shorter Prognosis

- FEV1 of less than 35% of the predicted value represents severe disease
  - 25% of these patients will die within two years
  - 55% by four years
- Low body mass index (BMI)
- Serum inflammatory biomarkers (such as C-reactive protein, IL-6, and fibrinogen)
- Low PaO2 was an independent predictors
- BODE scale, consisting of BMI, exercise capacity, and subjective estimates of dyspnea (predict survival over 1 to 3 years)

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Co-Morbid Conditions

Look at the whole person-what are the combined conditions and impact of co-morbids

- Chronic obstructive pulmonary disease
- Congestive heart failure
- Ischemic heart disease
- Diabetes mellitus
- Neurologic disease (CVA, ALS, MS, Parkinson's)
- Renal failure
- Liver Disease
- Neoplasia
- Acquired Immune Deficiency Syndrome
- Acquired Immune Deficiency Syndrome/HIV
- Refractory severe autoimmune disease (e.g. Lupus or Rheumatoid Arthritis)

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Overarching Concepts

- Secondary conditions
- Comorbidities
- Functional status
- PPS
- ADL dependence
- Does the documentation support the 6 months prognosis

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Assessments, Care Planning and Eligibility

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Plans of Care "Shoulds"

1. Be individualized based on ongoing assessments
2. Change with decline
3. Support eligibility based on identified needs
4. Identify scope and frequency of services needed and provided

Examples

- HA assignment changed to bed bath as so SOB can't take a shower
- High protein supplements due to poor appetite and resulting weight loss
- Oxygen order changed from PRN to 3 liters continuous

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Updating the Plan of Care

1. Are problems identified in the comprehensive assessment and updates care planned?
2. What changed in the comprehensive assessment that should result in a change to the POC?
   - Increased use of MSIR for chest pain
   - Using O2 24x7
   - Family roles

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Care Planning

- Based on this diagnosis or diagnoses and conditions, what do you expect the disease trajectory will look like?
- Prepare the family and facility
  - What to expect
  - How to manage
- Be proactive
  - Heart failure symptoms can develop over a few hours
  - Increased shortness of breath is very disturbing

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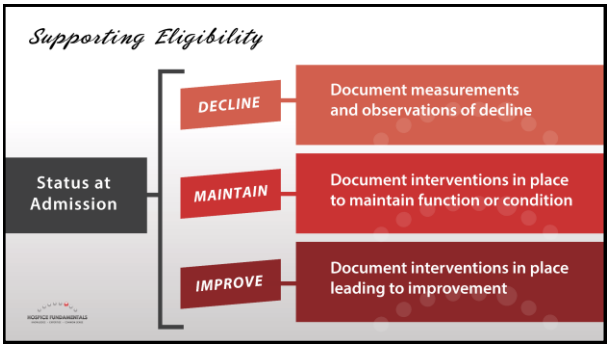

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Assessment of General Decline - Everyone Helps Out

Respiratory status
- Must stop to catch breath after a few sentences
- After meets me at door, sits down in chair next to door to catch breath

Behavioral Status
- Less interaction
- Increased difficulty to staying awake during visit
- Increased periods of sleeping

Functional Status
- Requiring more caregiver assistance/increasing dependence in ADLs
- More time in bed or recliner chair
- Incontinence as so short of breath to get to the bathroom timely
- No longer getting dressed

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Nursing Assessments

Objective measurable data
- Lung sounds
- PPS
- Weight/MAC
- O2 sats
- Edema
- Dyspnea
- Pain
- Skin breakdown

- Increased symptoms
- Medication changes
- Increase in PRN medication use
- Increase in O2 hours and liters
- Effectiveness of interventions
- Hospice Aide assignment appropriate

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Heart Failure

The 4 most common symptoms reported by patients/family members in the last 6 months of life

- Pain
- Dyspnea
- Fatigue
- Confusion

Patients with advanced heart failure often experience uncontrolled symptoms and rapid changes in their disease trajectories.

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End Stage Lung Disease

Common signs and symptoms

- Dyspnea with no or minimal activity
- Chronic cough
- Frequent phlegm production
- Weight loss
- Oxygen routinely needed

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Dyspnea

- Patient dyspnea goal
- Patient activity goal
- Interventions
  - Maximize best time of day
  - Medications
    - Routine
    - As needed
    - Opioids
- Interventions
  - Inhalers or not?
  - Oxygen
  - Therapeutic air (fan to the face)
  - Energy conservation
  - Increase hospice aide visits to support ADLs
  - Relaxation techniques

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Dyspnea

- Assessment includes signs and symptoms of dyspnea
- Increasing assistance with ADLs
  - Bathing
  - Ambulation
  - Transfers
  - Increasing incontinence
- Respiratory assessment-document what you hear

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Pain Assessments

- 90% of patients with Stage IV HF have pain
  - Often described as generalized/diffuse pain
- Comprehensive pain assessment
  - What makes it better?
  - What makes it worse?
  - Frequency of chest pain?
  - How effective NTG?
  - How long does it last?
- Use of non-pharmacological interventions
- Assess constipation related to increase in opioid use

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Pain Care Planning

- Patient pain goal
- Patient activity goal
- Interventions
  - Medications
  - Premedicate before activities
  - Increase hospice aide visits to support ADLs
  - Every visit staff ask about pain rating

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Automatic Implantable Cardioverter Defibrillator (AICD)

- Assessment of patient and family readiness for deactivation discussion
- Patient wishes/preferences
- Care planning
  - Patient family education
  - Deactivation plan

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Other Symptoms

- Fatigue
  - Underlying cause
  - Energy conservation techniques
  - DME or adaptation of home environment
- Anxiety
  - Underlying cause
  - Consider medication
  - Relaxation techniques

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Preferences

- Advance directives
- DNR
- Hospitalizations

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Mr. Smith

78 year old admitted with ASHD. Depressed and anxious because of disease. HIS answers & assessment findings are as follows

- Pain – 6 /10 using verbal pain scale. Angina with exertion and occasionally at rest. Comprehensive pain assessment completed.
- Shortness of breath with any activity. Use of accessory muscles. Treatments consist of use of MS, oxygen and nebulizers.
- On PRN opioid with bowel regimen started on admission.
- Confirmed still does not have an Advance Directive, but considering it
- Ambivalent about future hospitalizations as he has always gotten better before
- Patient reported life feels meaningless

How does all this translate to a Plan of Care?

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Plan of Care

Patient's goal is pain 3 or less

- Added Nitrates for symptom relief
- MS 5 – 10 mg q1h prn pain / dyspnea
- Education related to use of pain medications and side effects
- Assessment of pain level by all disciplines every visit using the verbal scale & CM notified if greater than 3

Patient's goal is dyspnea to be controlled to a mild level.

- Increased O2 to 3 – 4 liters as needed
- Evaluate effectiveness of nebulizers
- Encouraged to wear O2 at all times and especially with any activity
- Teach energy conservation techniques
- Assessment of dyspnea by all disciplines every visit using a verbal scale of mild, moderate, distressing & notify CM if greater than mild

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Plan of Care

Problem: Unsure of future hospitalizations

Goal: Assist pt / CG with clarification of Advance Directives and future hospitalizations within next 4 weeks

Interventions

- SW to provide information on Advance Directives and provide follow up in 2 weeks
- CM and SW to discuss futility of any further hospitalizations with patient & family
- Inform patient / caregiver of option of use of GIP for symptoms / pain not managed

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Plan of Care

Problem: Existential distress/ life feels meaningless
Goal: Alleviation of spiritual distress by reducing patient reported level of distress
Interventions

- Chaplain to introduce self and establish relationship
- Life review of the patient from the caregiver / family perspective
- Determine patient and family spiritual goals
- Explore living will/advance directives in collaboration with SW
- Open ended questions, listen to their story, tap into emotions and their meanings
- Chaplain to begin bereavement support for pending loss

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NYHA Functional Classification

- Provides a simple way of classifying the extent of heart failure
- Places patients in 1 of 4 categories based on
  - How much they are limited during physical activity
  - Limitations / symptoms in regards to normal breathing
  - Varying degrees in shortness of breath and / or angina pain

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New York Heart Association Functional Classification

Class I	Mild No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, or dyspnea (shortness of breath) or angina
Class II	Mild Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation, or dyspnea or angina
Class III	Moderate Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation, or dyspnea, or angina
Class IV	Severe Unable to carry out any physical activity without discomfort. Symptoms of cardiac insufficiency or the angina syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased

The Criteria Committee of the New York Heart Association. *Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Great Vessels.* 9th ed. Boston, Mass: Little, Brown & Co; 1994:253-256.

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End Stage Heart Disease- Prognostication

NYHA Class	1 Year Mortality
I	5-10%
II-III	10-15%
IV	30-40%

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Palliative Performance Scale (PPS)
Probability of Death within Six Months

PPS	30	40	50	>60
Cancer	98.3%	95.5%	92.8%	89.1%
Cardiovascular Disease	89.8%	74.2%	65.3%	51.8%
Dementia	73.6%	54.9%	51.4%	36.6%
Pulmonary Disease	92.4%	79.9%	71.6%	63.8%
Stroke	67.4%	48.4%	39.4%	32.6%

Harris, et al
Can Hospices Predict which Patients Will Die within Six Months?
Journal of Palliative Medicine; Vol 17, Number 8,2014

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Mr. Smith

78 year old admitted with ASHD. Depressed and anxious because of disease. Wife states his function has declined lately. His medical records show he has CHF, COPD, HTN, anemia, and a history of TIA's. Echocardiogram of 4 months ago notes an EF of 25%. His hemoglobin is 10.3

Mr. Smith denies any real complaints. States "I don't have the same energy as I used to, probably should quit smoking". He does admit to having some chest pain with exertion.

His wife states he gets short of breath just walking around the house but not at rest. He has oxygen but doesn't like to use it. He is much less active compared to a three months ago when he was fully ambulatory with only occasional dyspnea and chest pain.

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Mr. Smith's Assessment

- Medications include Lisinopril, Nitroglycerin prn, Lasix 40 mg. daily, Albuterol prn, Atrovent and aspirin.
- Assessment shows that he gets around the house some, but spends a lot of time sitting in a chair. He needs assistance bathing, but otherwise can do his own ADLs. However, states he is very fatigued afterwards. His appetite is fair and has lost 10 lbs. (6% of his body weight) in the past 3 months. He states he is too tired to eat and nothing tastes good. His wife is worried because he doesn't eat and use to be a big eater.
- He has 2 – 3+ edema to his lower extremities. Lungs sounds have coarse rales with expiratory wheezes. O2 sat on RA is 88%.
- What is his NYHA Classification?

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Palmetto GBA & Decline

Since determination of decline presumes assessment of the patient's status over time, it is essential that both baseline and follow-up determinations be reported where appropriate. Since weight loss due to decreasing oral intake is often a good predictor of decline, it is essential that hospice staff document this information in the hospice medical record. **Obtaining and recording objective data is instrumental in showing the continual decline** of a patient when the weight loss and decreased appetite is not caused by other factors such as medication. Patients that have ceased to show on-going decline or who have plateaued from a trajectory of decline may no longer meet hospice eligibility guidelines despite a significant need for custodial care.

Palmetto GBA Documentation Tips
October 2015

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Functional Performance: Connection to Care Planning

Examples
- Fall precautions
- Oxygen safety
- Skin breakdown
- Incontinence
- Assistive devices
- DME and respiratory equipment
- Assistance with ADLs
  - Hospice Aides
  - Family education
  - Caregiver fatigue

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Care Planning Needs Related to Functional Decline

- Assessment of FAST, PPS, ADLs
- Evaluate physical demands on caregiver (placement/resources/role changes)
- Determine caregiver fatigue and isolation
- Evaluate future planning for needs
- Equipment and supply needs
  - Hospital bed
  - Evaluate need for Hoyer lift
  - Incontinent supply needs
- Hospice aide visits 4 times / week to support caregiver

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Oxygen

Oxygen usage
- PRN-how many hour they are actually using
- If using continuously, obtain order for continuous

Oxygen Saturations
- Purpose is to support eligibility not to determine need for O2
- Not necessary on every visit
- When possible, obtain while O2 is off
- When possible, obtain after activity and with O2 off and then after 5 minutes rest
- Document so retrievable

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Assessing Nutritional Status

- Weights
  - NF and ALF challenges
  - Fluid retention
  - Documentation in EMR
  - What is your standard?
- MACs
  - Consistency
  - Frequency
  - Documentation in EMR
  - What is your standard?
- Albumin

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Nutrition and Care Planning

- Assessments
- Preferences
- Family education and counseling
- Facility collaboration

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Unplanned Hospitalizations

- High risk
  - Home
  - Facility
- Treatment preferences

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Unplanned Hospitalizations Care Planning: Nursing Facility

Advance care planning

- HIS preferences
- Make sure advance care planning is clearly communicated to facility
- Conversations with patients and families on futile care
- Treatments for respiratory infections
- Treatments for fluid retention
- Frequent conversations with NF staff on what goals of care are for patient and family
- Frequent reinforcement of decisions

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Eligibility-What to Assess, Discuss and Document

- Age, reason for continued hospice eligibility, i.e., terminal, secondary and co-morbid conditions
- Why hospice, why still. i.e., what demonstrates person remains eligible. What has changed?
- Utilize LCD(s) as focusing points
- Co-morbid conditions

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Eligibility-What to Assess, Discuss and Document

- Describe any mental and functional decline over past 3 – 6 months compared to now
  - Weight loss
  - Functional decline (PPS, FAST, ADLs)
  - Swallowing, choking
  - Intake
  - Skin integrity (Stage 3 and 4)
  - Infections
  - Agitation
  - Sleeping
- Medication changes
  - Pain medication
  - PRN frequencies
  - Antibiotics
- Plan of care changes
  - Change in frequencies
  - PRN visits
  - Interventions

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Nursing or IDG Recertification Summary

COPD with with co-morbid of Alzheimer's

Functional
- O2 dependent 2.5 LPM via nasal cannula continuously, 3 months ago only wore O2 during activity
- O2 sats 88% on RA.
- SOB with ambulation of 15 feet.
- FAST 6e.
- PPS 40%. 6 months ago was PPS 50%.
- Moderate assistance with eating, transferring, ambulation. This is a decline as 4 months ago she needed minimum with eating and ambulation.
- Complete assist with toileting, dressing and bathing. This is a decline as 4 months ago she could go to the shower with moderate assistance.
- Sleeps about 16-18 hours/24 hour day, from about 12 hours / 24 hours last benefit period.

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Nursing or IDG Recertification Summary (continued)

Nutritional
- Appetite fair to poor, eating a mechanical soft diet due to dysphagia. Consumes approximately 50% of her meals as compared to 75% last benefit period. Remains high risk for aspiration as evidence of coughing with liquids.
- She continues a slow progressive loss of weight due to her decreased appetite. June 146 lbs; August 136 lbs; current (Dec) 133 lbs. Total wt loss of 13 lbs (-9.1%) past 6 months. June BMI was 21.3, now 19.3.

Medication changes
- Palliation of anxiety with Ativan 0.25 mg po q4h prn at least daily this period, was only occasionally last benefit period.
- MSIR started for SOB.

POC changes-Nursing frequencies increased to daily for 1 week this period due to increased SOB.

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Auditing and Monitoring

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Know Your Data

- PEPPER
  - LOS Cardiac
  - LOS Respiratory
- Palmetto NCLOS
  - Diseases of Circulatory System
  - Diseases of Respiratory System
- Comparative Billing Report
- Live discharges due to unplanned hospitalizations (revocations for contracted or out of service area for noncontracted)

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Auditing Plan

- How are the fundamentals?
  - PPS
  - NYHA
  - Respiratory assessments
  - Measurable goals
- Focus on risk areas
- LOS > 1 year
- Provide usable reports to teams

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Actions of the Prudent Hospice

- Ensure all staff has competency in understanding eligibility in those with end stage cardiac disease and end stage pulmonary disease
- Ensure understanding of use and scoring of NYHA and PPS
- Standardize documentation of O2 usage and O2 sats
- Require discussions and documentation to include "as evidenced by…"
- Monitor for high risk areas (know your data) and target auditing on those risk areas
- Audit those most important areas and provide reports in usable manner
- Put efforts into tying eligibility to care planning (because they really are!)

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Resources

- LCDs https://www.cms.gov/medicare-coverage-database/indexes/national-and-local-indexes.aspx
- Fast Facts https://www.mypcnow.org/
- Courtesy of R&C Healthcare Solutions
  - Documentation Tips Cardiac Disease (provided)
  - Documentation Tips for Pulmonary Disease (provided)
  - Four Paths to Eligibility (provided)
  - Guidelines for Assessments (provided)

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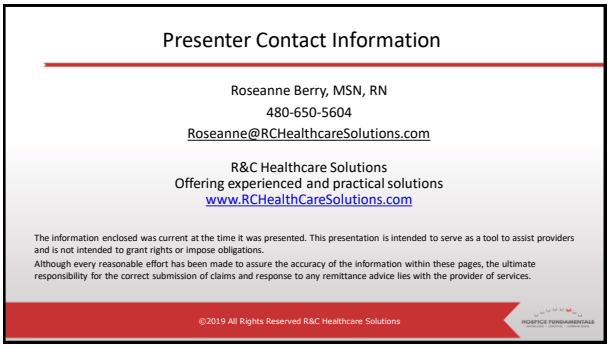

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