NHPCO Project ECHO

July 2021

Case presentation by Dr. Gregg Vandekieft MD, MA, FAAFP, FAAHPM

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
- **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 presenter

Gregg VandeKieft, MD, MA, FAAFP, FAAHPM

Dr. Gregg Vandekieft, MD is a Hospice & Palliative Medicine Specialist in Olympia, WA and has over 31 years of experience in the medical field.

Subject Matter Experts

- Eric Bush MD, RPh, MBA, Chief Medical Officer
  Hospice of the Chesapeake/Chesapeake Supportive Care, Maryland
- Amy Szatanek, LCSW, Director of Patient and Family Services
  Calvert Hospice, Maryland
- Marisette Hasan, BSN RN, President/CEO
  The Carolinas Center, South Carolina

Today's case study

Didactic presented by Dr. VandeKieft

Palliative care patient case study

- **Advance Care Planning in early to moderate dementia**
- **Transitions between long-term care and acute care**
- **Tele-palliative care for rural hospitals**

Dementia Severity Rating Scale: domains assessed

- Memory
- Speech and language
- Recognition of family members
- Orientation to time
- Orientation to place
- Ability to make decisions
- Social and community activity
- Home activities and responsibilities
- Personal care – cleanliness
- Eating
- Control of urination and bowels
- Ability to get from Place to place

Functional Assessment Staging Test (FAST)

- Stage 3: Mild Cognitive Impairment
  - Objective functional deficit interferes with a person's most complex tasks
- Stage 4: Mild Dementia
  - IADLs become affected, such as bill paying, cooking, cleaning, traveling
- Stage 5: Moderate Dementia
  - Needs help selecting proper attire

Alzheimer's Association: End-of-life Checklist

- Have wishes or desires for end-of-life care been discussed?
  - Has an advance directive or POLST/MOLST form been completed?
- Is a power of attorney in place for financial needs?
- Is a power of attorney in place for health care decisions?
  - If not, review whether state has a statutory hierarchy for surrogate(s)
- Is palliative or hospice care appropriate for the patient?

Transitions of Care

- CMS definition: the movement of a patient from one care setting to another
- Agency for Health Research and Quality (AHRQ) observes:
  - Transitions increase the risk of adverse events due to the potential for miscommunication as responsibility is given to new parties.
  - Hospital discharge is a complex process representing a time of significant vulnerability for patients.
  - Safe and effective transfer of responsibility for a patient's medical care relies on effective provider communication with patient comprehension of discharge instructions.

Challenges in Transitions of Care

- Nearly 20% of Medicare enrollees discharged from the hospital are readmitted within 30 days
  - Higher rates for heart failure and COPD, or for hospitals with a higher proportion of patients covered by Medicaid or patients of color
  - Historically hospitals have been targeted to improve this metric
- Community-based Care Transitions Program (2012-17)
  - Demonstration project created as part of the Affordable Care Act
  - Looked at role of community-based organizations along the care continuum to meet the needs of high-risk patients and reduce readmissions
  - Participating sites had lower readmission rates and expenses

Transitions of Care Standards Framework

- Identify patients at risk for poor transitions
- Complete a comprehensive assessment
- Perform and communicate a medication reconciliation
- Establish a dynamic care management plan that addresses all settings throughout the continuum of care
- Communicate essential care transition information to key stakeholders across the continuum of care

Palliative Care in Rural Settings

- Difficult to recruit full specialty palliative care IDT in rural settings
- Often efforts led by a local “champion” with high level of PC interest and knowledge/skill, but often not specialty trained or certified
  - May be based in hospital, clinic, home health/hospice, or health system
- Local team can be augmented virtually by other specialty IDT members via tele-health
  - Interprofessional collaboration or direct-to-patient telemedicine
  - Community-based or in rural/critical access hospitals
  - Asynchronous or simultaneous
  - Telephone or video

Two WA Tele-health Projects to Connect PC Specialists with Rural PC Teams

- WA Rural Palliative Care Initiative
  - 17 rural communities with a variety of local models
  - Led by WA DOH Office of Rural Health, with multiple additional sponsors
  - Specialty PC team – physician, nurse, social work, chaplain, pharmacist
  - Monthly tele-health case consults between local teams and virtual specialty IDT
  - Educational offerings and individualized support to help teams grow locally
- Providence Blended On-site and Virtual Tele-PC Model
  - Demonstration project with 2 Providence critical access hospitals in WA
  - Direct-to-patient/family telemedicine with on-site PC nurse and chaplain, physician and social worker participate via Zoom
  - Anticipate growing to other Providence rural hospitals, eventually to community setting and to non-Providence hospitals

References

- Dening KH, Sampson EL, De Vries K. Advance care planning in dementia: recommendations for healthcare professionals. *Palliative Care: Research and Treatment*. 2019 Feb 27. DOI: 10.1177/1178224219826579
  - https://journals.sagepub.com/doi/pdf/10.1177/1178224219826579
- Medicaid “Improving Care Transitions” web page:
  - https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/improving-care-transitions/index.html
- Super N, Kaschak M, Blair E. Health care and community-based organizations have finally begun partnering to integrate health and long-term care. *Health Affairs Blog.* 2018 Feb 2.
  - https://www.healthaffairs.org/do/10.1377/hblog20180130.620899/full/
- Transitions of Care Standards Framework
  - https://transitionsofcare.org/standards/
- Mayer DM, Winters CA. Palliative Care in Critical Access Hospitals. *Critical Care Nurse*. 2016 Feb;36(1):72-78.
- Stratis Health’s Rural Palliative Care Resource Center
  - https://stratishealth.org/toolkit/palliative-care-resource-center/

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 for 2022- https://www.nhpco.org/projectecho/

Thanks for joining. We will see you next month.