

Home Based Palliative Care for advanced COPD and CHF with serious illness

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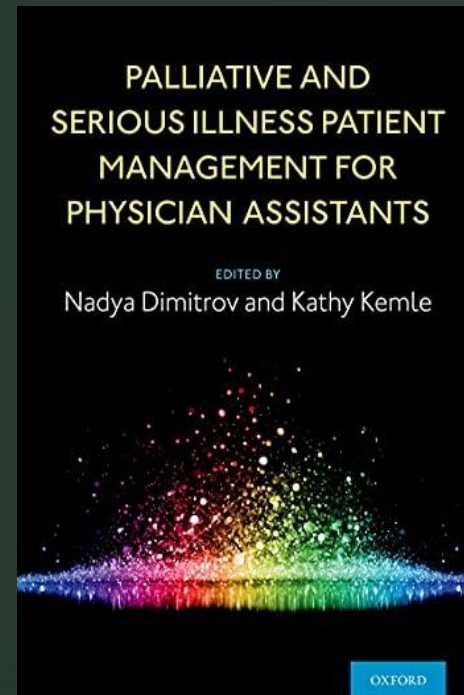
No financial disclosures

- All information in this presentation has been gathered through my own personal medicine practice or it has been collected through evidence-based research. None of the information shared in this presentation is intended to be used for medical device sales purposes.





Kathy Kemle, MS, PA-C



Objectives:

1. Discuss the socioeconomic impact and prevalence of advanced COPD and CHF
2. Explain home palliative care services and how it is used in advanced COPD and CHF
3. Explore ways PAs can integrate palliative services through community partnerships while improving patient QOL, and patient/caregiver satisfaction.

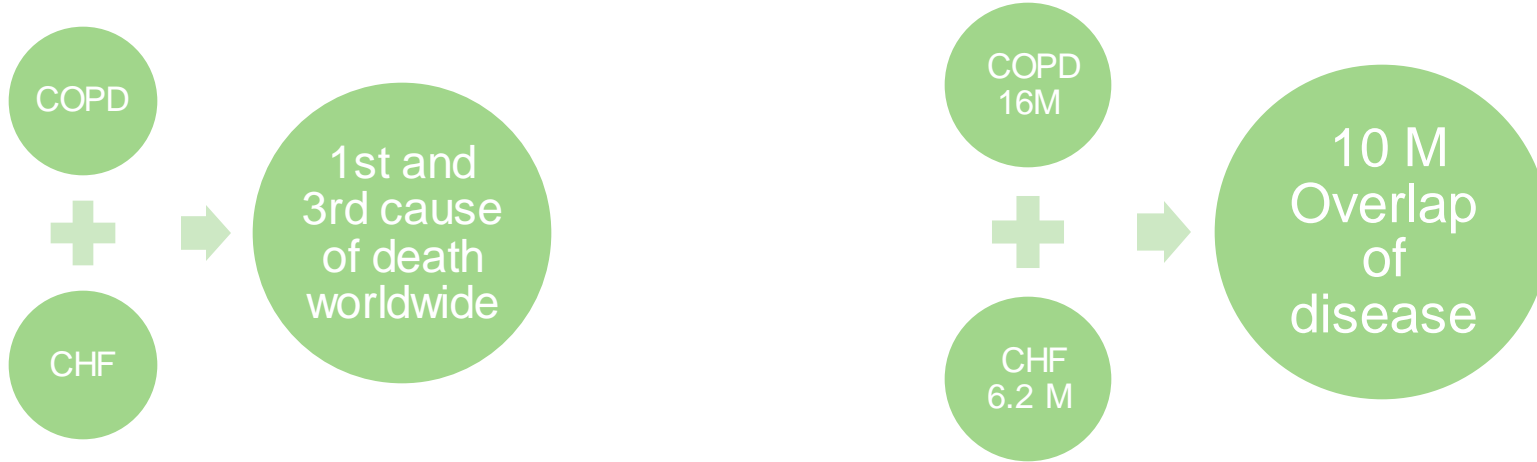


What is Serious Illness?

- ▀ *Serious illness is a health condition that carries a high risk of mortality and either negatively impacts a person's daily functioning or quality of life or excessively strains his or her caregivers.*

Amy Kelly, MD

Prevalences and Mortality of COPD and CHF



CHF and COPD are directly related to high utilization of healthcare services in offices, ERs and hospitals due to exacerbations and the need for oxygen therapy or medical equipment or medication

***Chronic obstructive pulmonary disease (COPD) is a common condition with an estimated global prevalence of almost 12 percent in adults over age 30 years. Prior to the onset of the COVID-19 (coronavirus disease 2019) pandemic, COPD was the third leading cause of death worldwide. www.UptoDate.com and <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2639415/>

Economic Cost of COPD in the US

Estimated 50 billion in 2009 which included 29.5 billion in direct health care expenditures, 12.4 billion for indirect mortality cost and 8 billion for indirect morbidity costs

This cost is projected to increase or remain constant

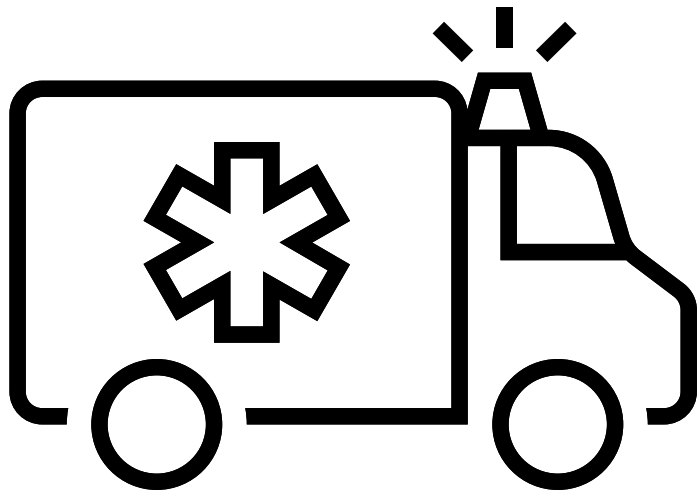
Total economic cost from COPD continues to be 50 billion each year

Economic Cost of CHF in the US

By 2030, US heart failure costs are expected to be at least \$70 billion per year (\$244 per every US adult) with total cost of caring for patients with heart failure reaching \$160 billion.

The annual median total medical costs for heart failure care were estimated at \$24,383 per patient, with heart failure-specific hospitalizations driving costs (median \$15,879 per patient) in 2014-2020

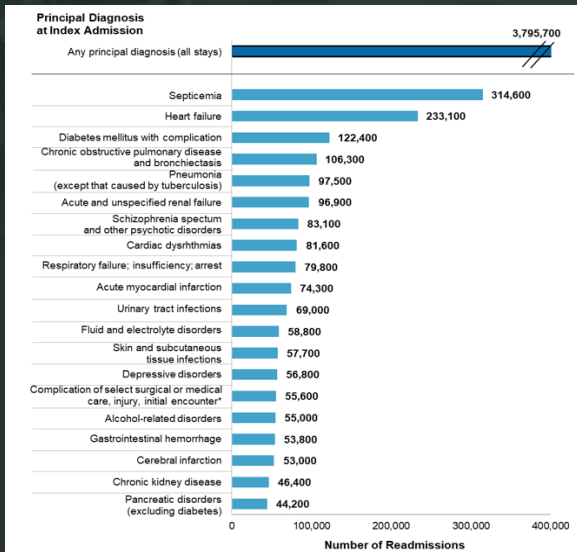
Prevalence projected to increase by 46% and direct medical costs to reach **\$53 billion by 2030.**



How does this affect
hospital admission and
re-admission data?

Evidence-based researched facts are:

- ✓ Nearly 1 in 4 heart failure patients are readmitted in 30 days and ½ are in 6 months
- ✓ ¼ of those readmitted are suggested to have been preventable
- ✓ Approximately 20% of patients discharged with a COPD exacerbation are readmitted for any reason within 30 days.



Why are they frequently admitted?

- Oxygen requirement changes, need more than 5L
- Medications changes or additional medication needs
- Overlapping of symptoms and poor understanding how to manage at home
- Do not know how to monitor at home
- No in home palliative services provided to the patient in their community

Gold Classification of COPD

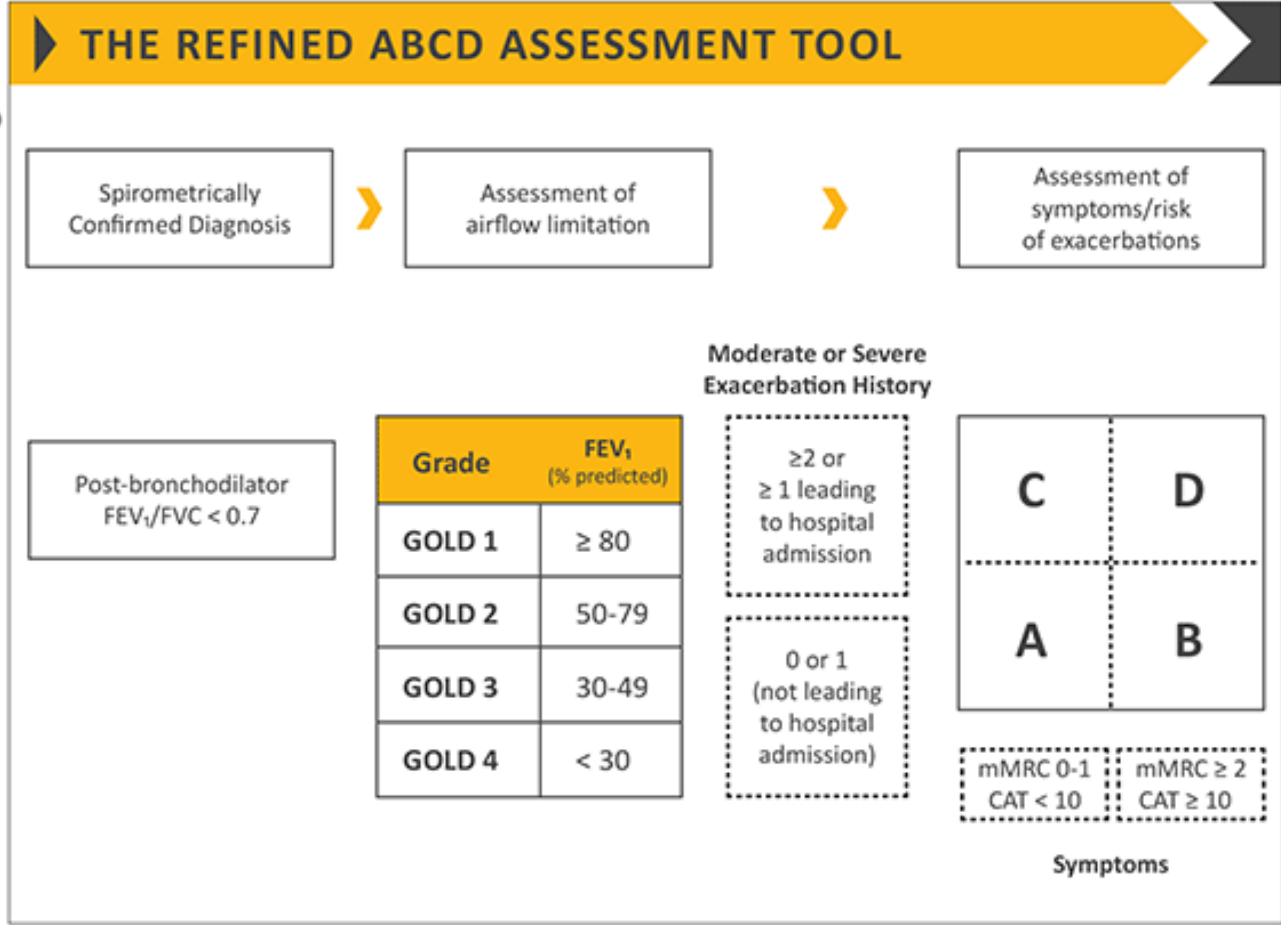
GOLD: Severity of airflow limitation (based on postbronchodilator FEV₁)

Stage	Severity	FEV ₁ (percent predicted)
In patients with FEV₁/FVC <0.7:^Δ		
GOLD 1	Mild	≥80
GOLD 2	Moderate	50 to 79
GOLD 3	Severe	30 to 49
GOLD 4	Very severe	<30

GOLD "ABCD" groups: Assessment of symptoms and risk of exacerbations for initiation of COPD therapy

Assess exacerbation risk: Exacerbations/Hospitalizations	Assess symptoms	
	mMRC* 0 to 1; CAT <10 [†]	mMRC ≥2; CAT ≥10
0 or 1 exacerbations without hospitalization	A	B
≥2 exacerbations or ≥1 hospitalization	C	D

Figure 1



ABCD: Group A low risk/low symptoms, Group B low risk/high symptoms, Group C high risk/low symptoms, Group D high risk/high symptoms; CAT: COPD Assessment Test; FEV_1 : forced expiratory volume in 1 second; FVC: forced vital capacity; GOLD: Global Initiative for Chronic Obstructive Lung Disease; mMRC: modified British Medical Research Council.
 Source: Reference 1. Reprinted with permission.

American College of Cardiology

New York Classification of Heart Failure

Comparison of ACCF/AHA Stages of HF and NYHA Functional Classifications

ACCF/AHA stages of HF		NYHA functional classification	
A	At high risk for HF but without structural heart disease or symptoms of HF	None	
B	Structural heart disease but without signs or symptoms of HF	I	No limitation of physical activity. Ordinary physical activity does not cause symptoms of HF.
C	Structural heart disease with prior or current symptoms of HF	I	No limitation of physical activity. Ordinary physical activity does not cause symptoms of HF.
		II	Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in symptoms of HF.
		III	Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms of HF.
		IV	Unable to carry on any physical activity without symptoms of HF, or symptoms of HF at rest.
D	Refractory HF requiring specialized interventions	IV	Unable to carry on any physical activity without symptoms of HF, or symptoms of HF at rest.

ACCF: American College of Cardiology Foundation; AHA: American Heart Association; HF: heart failure; NYHA: New York Heart Association.

Reproduced from: Yancy CW, Jessup M, Bozkurt B, et al. 2013 ACCF/AHA guideline for the management of heart failure: A report of the American College of Cardiology Foundation/American Heart Association Task Force on practice guidelines. J Am Coll Cardiol 2013; 62:e147. Table used with the permission of Elsevier Inc. All rights reserved.

Palliative Performance Scale (PPSv2) version 2 ²						
PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level	
Stable	100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
	90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
	80%	Full	Normal activity with effort Some evidence of disease	Full	Normal or reduced	Full
Transitional	70%	Reduced	Unable to do normal job/work Significant disease	Full	Normal or reduced	Full
	60%	Reduced	Unable to do hobby/housework Significant disease	Occasional assistance necessary	Normal or reduced	Full or confusion
	50%	Mainly sit/lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or confusion
	40%	Mainly in bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or drowsy +/- confusion
End-of-Life	30%	Totally bed bound	Unable to do any activity Extensive disease	Total care	Normal or reduced	Full or drowsy +/- confusion
	20%	Totally bed bound	Unable to do any activity Extensive disease	Total care	Minimal to sips	Full or drowsy +/- confusion
	10%	Totally bed bound	Unable to do any activity Extensive disease	Total care	Mouth care only	Drowsy or coma +/- confusion
	0%	Death	-	-	-	-

How can hospital re-admission be avoided?

- Partnerships with in-home palliative programs
- Home health companies can pilot a program with you and your patients but need a provider (NP or PA) to see patient in the home
- Televisits and phone visits
- Collaboration with the other pulmonary and cardiology/heart failure teams
- Remote patient monitoring

Home-Based Palliative Care

What is it ?

- Different than hospice and other in-home services, must be a distinguished difference
- Address the needs of serious illness in the home and aim to prevent hospitalizations or readmissions
- Can have these services and still go to in office visits and receive treatments
- Do they target COPD and CHF patients?
- Are they certified by the Center to Advance Palliative Care?



Symptom and medication management

Review Medications



- Are there too many?
- Do they know what they are for?
- Keep it simple and eliminate the fluff!



Oxygen/NIPPV



- Do they need a walk test?
- Are they retaining CO₂? Check ABG to verify
- Are they hypoxemic at night? Overnight pulse ox



Vitals at home?



- What is the baseline saturation at rest and with ambulation?
- Change in baseline symptoms?
- Has their functional status changed?



Symptom Management -continued

Weight management



- What is dry weight?
- if weight has increased greater than 3 lbs in 24 hours or 5 lbs in 3 days

New symptoms or diagnosis? Change in home care plan?



- Breathlessness
- Sputum changes: Quantity, Color and Consistency
- Peak flow (air flow measurement)
- Temperature
- Presence of cough wheeze, sore throat or Nasal congestion

Outcomes with in-home palliative care programs:

- Decrease hospital length of stay and readmission rates
 - Accountable Care Organizations
 - Rural versus Urban setting challenges
- Quality of life and patient/caregiver satisfaction improves
- Can spend more time on decision making
 - POLST and advance directives
 - DNR and code status conversations

Physician Orders for Scope of Treatment (POST)	Patient's Last Name First Name/Middle Initial Date of Birth
This is a Physician Order Sheet based on the medical conditions and wishes of the person identified at right ("patient"). Any section not completed indicates full treatment for that section. When need occurs, <u>first</u> follow these orders, <u>then</u> contact physician.	

Section A	CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse <u>and/or</u> is not breathing. <input type="checkbox"/> <u>R</u> esuscitate (CPR) <input type="checkbox"/> <u>D</u> o <u>N</u> ot Attempt <u>R</u> esuscitate (DNR/no CPR)
Check One Box Only	When not in cardiopulmonary arrest, follow orders in B, C, and D.

Section B	MEDICAL INTERVENTIONS. Patient has pulse <u>and/or</u> is breathing. <input type="checkbox"/> Comfort Measures Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer <u>only</u> if comfort needs cannot be met in current location. <input type="checkbox"/> Limited Additional Interventions Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care. <input type="checkbox"/> Full Treatment. Includes care above. Use intubation, advanced airway interventions mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care. Other Instructions: _____
Check One Box Only	

Section C	ANTIBIOTICS – Treatment for new medical conditions: <input type="checkbox"/> No Antibiotics <input type="checkbox"/> Antibiotics Other Instructions: _____
Check One Box Only	

Section D	MEDICALLY ADMINISTERED FLUIDS AND NUTRITION. Oral fluids and nutrition must be offered if medically feasible. <input type="checkbox"/> No IV fluids (provide other measures to assure comfort) <input type="checkbox"/> No feeding tube <input type="checkbox"/> IV fluids for a defined trial period <input type="checkbox"/> Feeding tube for a defined trial period <input type="checkbox"/> IV fluids long-term if indicated <input type="checkbox"/> Feeding tube long-term Other Instructions: _____
Check One Box Only in Each Column	

Section E Must be Completed	Discussed with: <input type="checkbox"/> Patient/Resident <input type="checkbox"/> Health care agent <input type="checkbox"/> Court-appointed guardian <input type="checkbox"/> Health care surrogate <input type="checkbox"/> Parent of minor <input type="checkbox"/> Other: _____ (Specify)	The Basis for These Orders Is: (Must be completed) <input type="checkbox"/> Patient's preferences <input type="checkbox"/> Patient's best interest (patient lacks capacity or preferences unknown) <input type="checkbox"/> Medical indications <input type="checkbox"/> (Other) _____	
	Physician Name (Print)	Physician Phone Number	Office Use Only
	Physician Signature (Mandatory)	Date	

Summary Points:

COPD and CHF have an overlapping of symptoms that often require medications, oxygen changes or NIPPV in the hospital setting.

COPD Gold stage 3 and 4 and CHF NYHA class III-V are at greatest risk of being readmitted within 30 days after discharge

Home Health is not the same as in-home palliative care.

COPD patients can become hypoxemic at night before they require oxygen during the day.

Consider doing a POLST with your COPD and CHF patients and bill for ACP.

A POLST is not the same as an Advance Directive

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Questions?



THANK YOU :-)

