IMPROVING PALLIATIVE CARE WITHIN NURSING HOMES

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Objectives

- Review the definition of palliative care and how it differs from Hospice
- Review the burden of need for palliative care in the long term care setting
- Present models for the implementation of a palliative care program in nursing homes
- Discuss some barriers to implementation
- Present and discuss the NHC palliative care pilot program

- Why discuss Palliative Care?
- Why now?
- Why focus on nursing homes?
- What does all this mean?
- Why do we all need to be involved?

Case Scenario

- 85 year old white female admitted to nursing home from area hospital after treatment for CHF exacerbation
- PMH: diabetes mellitus, COPD, hypertension, CAD, CHF, atrial fibrillation
- After 1 week in SNF patient develops increasing shortness of breath, decreased O2 saturation and mild substernal chest pain.
- Pt is transferred back to the hospital for 5 days and stabilized then readmitted to nursing home
- After 2 weeks patient is noted to have significant leg edema and 10 lb weight gain
- Diuretics increased but not helping and after 2 more days patient is transferred back to the hospital

Case Scenario

- 76 year old white female with moderate dementia admitted after surgical treatment for hip fracture
- PMH: osteoporosis, dementia, CAD, history of stroke, HTN, history of breast cancer, recurrent UTIs, history of GI bleed
- Patient on warfarin for DVT prophylaxis
- Patient's family requests CPR and full treatment on POLST form

Case Scenario

- 65 year old admitted to nursing home from area hospital for rehabilitation following total knee replacement
- PMH: HTN, hypercholesterolemia, fibromyalgia, and depression due to recent loss of spouse
- After several days at nursing facility, it is apparent that patient is not progressing as well as expected due to pain and lack of motivation

- What is the most appropriate treatment for each of these patients?
- Which of these patients should receive palliative care?
- Whose responsibility is it to take the lead in addressing the specific medical and other issues in each of these cases?
- How should the care be coordinated?

Why are we discussing Palliative Care?

- Approximately 1.5 million people live in nursing homes in the United States
- Approximately 25% of Americans die in nursing homes and about one half of these patients die within 6 months of placement.
- Most long term care residents are over 65 and/or have multiple chronic health conditions affecting their cognitive and physical functioning.
- Over half require extensive assistance in bathing, dressing, toileting, and transferring.
- 50% of residents are over age 85.
- ½ of residents receive 9 or more medications.
- While some individuals return home after receiving therapy, most will remain in a long term care facility until their deaths.

Nursing home residents often have the following issues

- Pain
- Eating problems
- Dyspnea
- Constipation
- Nausea
- Pressure ulcers
- Issues with cleanliness
- Delirium
- Weight loss
- Polypharmacy

- Untreated or under treated pain in nursing homes is well documented
- 65% of nursing home residents need help with 3 or more ADLs
- A study in 2000 revealed that at least one-third of nursing home residents in the U.S. suffer from malnutrition or dehydration

In a national survey of bereaved family caregivers of nursing home residents the following results were reported

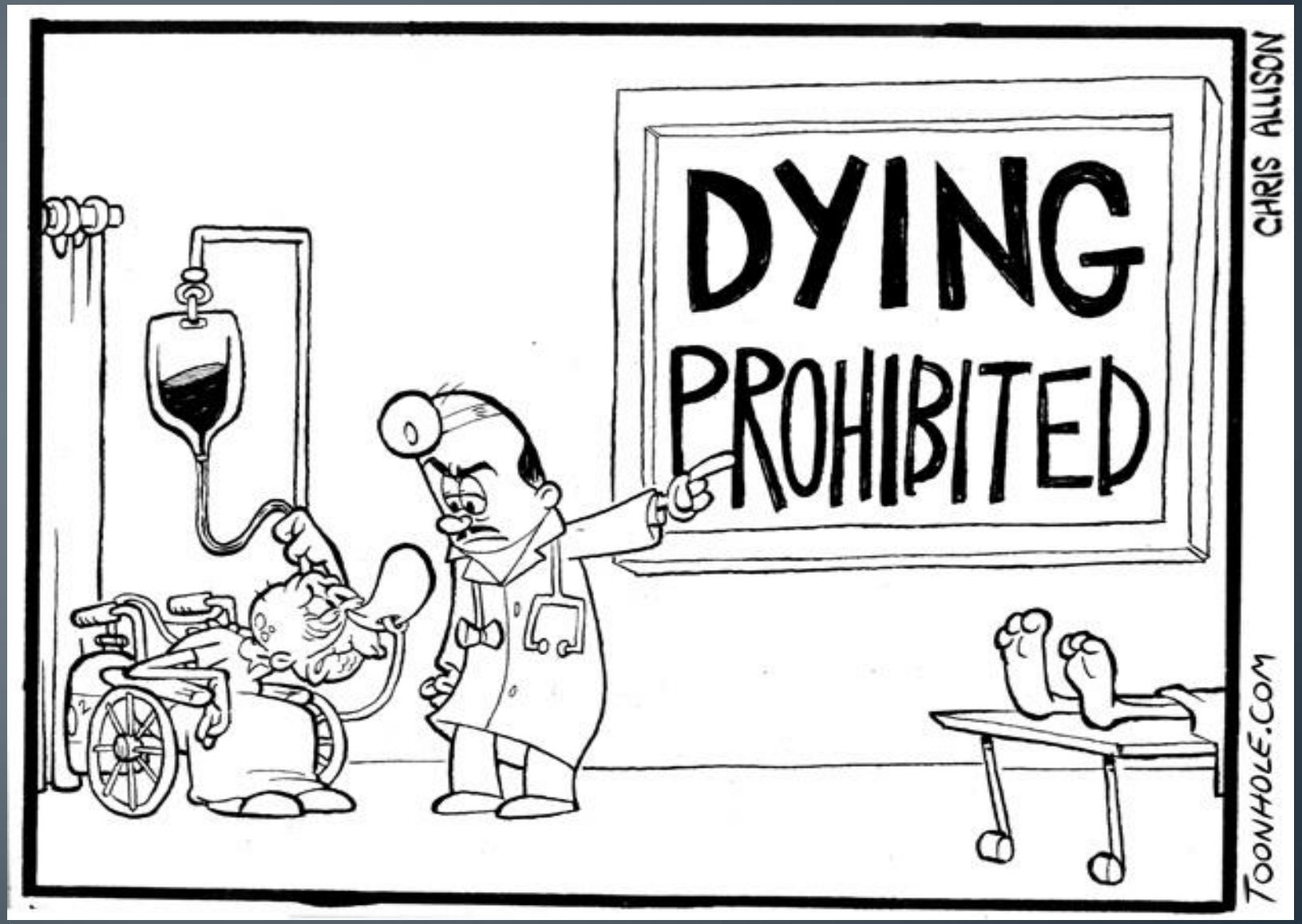
- Approximately 25% of patients that had experienced either pain or dyspnea did not receive adequate treatment
- Almost 60% reported receiving inadequate emotional support during their loved ones terminal illnesses
- Only 42% rated their loved one's quality of life in the nursing home as excellent

Where do Americans die?

- Studies have shown that approximately 80% of Americans would prefer to die at home, if possible.
- Despite this, 60% of Americans die in acute care hospitals, 20% in nursing homes and only 20% at home.
- A minority of dying patients use hospice care and even those patients are often referred to hospice only in the last 3-4 weeks of life.

Thus, we need to shift focus from longevity to quality of life for our patients

TRADITIONAL MEDICINE



MODERN MEDICINE

"The purpose of a doctor or any human in general should not be to simply delay the death of the patient, but to increase the person's quality of life"

- Dr Hunter "Patch" Adams

- A study looking at palliative care consults in nursing homes found that palliative care consults in the nursing home resulted in a significant reduction in hospitalizations in the last 30 days of life.

- Research on nursing home palliative care models has found that palliative care consultations led to lower rates of hospitalization and burdensome transitions as well as reduced symptom burden.

Reference available upon request

Need for palliative care in the nursing home setting

1. Increased Proportion of Dying Patients in Nursing Homes
   By 2030 the number of people living in nursing facilities in the US is expected to double to over 3 million
2. Increased medical acuity of patients admitted to nursing homes
3. Nursing homes held accountable for quality
4. Nursing homes are likely to be penalized for high readmission rates
5. Reimbursement shifting to “pay for performance”

- Hospitals are heavily focusing on Palliative Care in the acute setting
- Response to hospitals' expectations of a post-acute Palliative Care Program
- As a leaders in the industry, we must be advocate for our patients to improve quality and outcomes.

What is Palliative Care?

- Palliative care, also known as palliative medicine, is specialized medical care for people living with serious illnesses. It is focused on providing patients with relief from the symptoms and stress of a serious illness — whatever the diagnosis. The goal is to improve quality of life for both the patient and the family.

- Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.


"You've got six months, but with aggressive treatment we can help make that seem much longer."

What is the Difference Between Palliative and Hospice Care?

Palliative Care ≠ Hospice

1. The objective of both hospice and palliative care is pain and symptom relief.

2. The prognosis and goals of care tend to be different. Hospice is comfort care without curative intent; the patient no longer has curative options or has chosen not to pursue treatment because the side effects outweigh the benefits. Palliative care is comfort care with or without curative intent.

Hospice eligibility requirements

- In order to be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and certified as being terminally ill by a physician and having a prognosis of 6 months or less if the disease runs its normal course.

In 2014, the Institute of Medicine released its report “Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life”. The Institute’s recommendations emphasized the importance of palliative care training and education. Specifically, the report addressed the following:

- The importance of symptom management
- Effective communication
- Advance care planning
- Goal based care
- Continuity across settings while addressing patient’s social needs

Interventions for improving palliative care for older people living in nursing homes

Cochrane Database 2011

OBJECTIVES:

- The primary objective was to determine effectiveness of multi-component palliative care service delivery interventions for residents of care homes for older people. The secondary objective was to describe the range and quality of outcome measures.

Author's Conclusions:

- "We found few studies, and all were in the USA. Although the results are potentially promising, high quality trials of palliative care service delivery interventions which assess outcomes for residents are needed, particularly outside the USA. These should focus on measuring standard outcomes, assessing cost-effectiveness, and reducing bias."

Where do we go from here?

NHC PALLIATIVE CARE INITIATIVE

- Recently an internal evaluation of palliative care provided by NHC resulted in the recommendation for an updated and more consistent palliative care pathway throughout NHC including SNF/Long Term Care and Home Health
- An NHC palliative care committee was thus formed, and members continue to meet on a regular basis with the purpose of program development and implementation, first focusing on palliative care in the SNF/long term care setting
- The committee consists of NHC representatives from nursing, social services, pharmacy, clergy, physical therapy, home health, hospice, administration, and a medical director.
- Four members of this committee attended the annual CAPC (Center to Advance Palliative Care) meeting in Orlando to gain valuable information needed to develop a corporate wide palliative care pathway across post-acute settings.
- The committee collaborates with area hospitals to develop pathways for smooth transition from the acute setting to the post acute environments.

The Center to Advance Palliative Care (CAPC) is the nation's leading resource for palliative care development and growth

Mission
The Center to Advance Palliative Care is a national organization dedicated to increasing the availability of quality palliative care services for people living with serious illness.

Vision
CAPC is an organization with a simple vision – palliative care everywhere.

Mission and Vision carried out in 3 ways:

- Improving the knowledge and skills of all clinicians who serve seriously ill patients and their families
- Helping health organizations to reliably support and deliver high quality palliative care to patients and families in need
- Increasing public understanding of palliative care so that all patients and families will know to ask for it when faced with a serious illness

Models of Implementation

Models of Palliative Care in the Nursing Home Setting

- The Health Affairs blog, published in December, 2013, describes three models for delivering palliative care in the nursing home.

Hospice agency/nursing home partnerships

- This is a partnership between a hospice agency and a nursing home, where eligible nursing home residents access their Medicare hospice benefit. An eligible resident must have a prognosis of six months or less if the disease runs its normal course and must waive other Medicare benefits upon election of the hospice benefit. About one third of nursing home decedents now access the Medicare hospice benefit before death. Hospice can bring expert symptom management, personal care services, social work services for families, other staff and residents, spiritual care, as well as volunteer and bereavement services.

Externally based palliative care

- An external palliative care consultation team works with nursing home clinicians to serve a broader population of nursing home residents, including those with chronic illness. To access palliative care services, there is no need to forgo curative treatments to receive services. The consultant, a physician or nurse practitioner, bills under Medicare part B; therefore costs for these services are not incurred by nursing homes.

Facility based palliative care

- A facility may develop palliative care expertise within its own facility, allowing the creation of palliative care services that meet the needs of their residents. Staff training in the nursing home is critical to the success of this model, and to fostering a culture where a palliative approach to care is welcome and widely supported. Support for staff training and the understanding of the palliative approach to care may be a service that a hospice organization can provide to help palliative care services to be established with a strong foundation.

Designing a Palliative Care Program

- Develop a sound business plan
  - Scope of service
  - Team structure
  - Outcome metrics
  - Budget
  - Define standardization
- Decide eligibility criteria
  - Risk stratification tools
- Collect relevant data
  - Length of stay
  - Readmission rates
  - Advanced care planning completion
  - Transition to hospice
  - Patient and family satisfaction

NHC Nursing Home Palliative Care Pilot

- The pilot program will focus on palliative care in the skilled/long-term care centers.
- Development of the pilot program began in 2017.
- 2 centers representing two regions have agreed to participate in the pilot program
  - NHC - Murfreesboro
  - NHC Healthcare - Franklin
- HPCC certification (Hospice and Palliative Credentialing Center) will be encouraged for the appropriate team members (credentialing for nurses and nurse practitioners
  - http://hpcc.advancingexpertcare.org
- National Association of Social Workers (credentialing for social workers)
  - http://www.socialworkers.org

Pilot

- Each center will have representatives from nursing, social services, and a nurse practitioner who will serve as “team champions”. They will collaborate with the director of nursing and palliative care committee to identify and educate appropriate personnel at the centers who will comprise the “palliative care consult team”.

- CAPC (Center to Advance Palliative Care) membership was obtained for the two pilot centers in order to obtain necessary educational materials and other resources essential to developing the program.
  - http://www.capc.org

Topics of focus and development

- Criteria for Palliative Care Consults
- Identification of patients who have had palliative care consults in the hospital
- Clinical pathways by diagnosis
- Communication and collaboration
- Education
- Metrics and measurements
- Pharmacy
- Advanced Directives

Criteria for a palliative care assessment at the time of admission

A potentially life-limiting or life-threatening condition *and*...
Primary criteria*
The "surprise question": *You would not be surprised if the patient died within 12 months or before adulthood*
Frequent admissions (eg, more than one admission for same condition within several months)
Admission prompted by difficult-to-control physical or psychological symptoms (eg, moderate-to-severe symptom intensity for more than 24 to 48 hours)
Complex care requirements (eg, functional dependency; complex home support for ventilator/antibiotics/feedings)
Decline in function, feeding intolerance, or unintended decline in weight (eg, failure to thrive)
Secondary criteria¶
Admission from long-term care facility or medical foster home[Δ]
Older patient, cognitively impaired, with acute hip fracture
Metastatic or locally advanced incurable cancer
Chronic home oxygen use[Δ]
Out-of-hospital cardiac arrest
Current or past hospice program enrollee[Δ]
Limited social support (eg, family stress, chronic mental illness)[Δ]
No history of completing an advance care planning discussion/document

* Primary criteria are global indicators that represent the minimum that hospitals should use to screen patients at risk for unmet palliative care needs.
¶ Secondary criteria are more-specific indicators of a high likelihood of unmet palliative care needs and should be incorporated into a systems-based approach to patient identification if possible.
Δ These indicators are included based on a consensus panel opinion.

DOMAINS OF PALLIATIVE ASSESSMENT

- Physical symptoms
- Psychological, psychiatric, and cognitive symptoms
  - Depression
  - Anxiety
  - Delirium
  - Coping
- Psychologic issues specific to caregivers
- Illness understanding and care preferences
- Social and economic needs of patients and caregivers
- Religious and spiritual issues
- Care coordination and continuity

Identify goals of care

- In a randomized controlled trials older adult to watch a 6 minute goals of care video on admission to nursing home or more likely to identify comfort as the primary goal compared with resident's received a verbal narrative

- In a randomized controlled trial a 20 minute goals of care video decision made about treatment options and advanced dementia designed to support discussions during the nursing home care planning process was effective in enhancing agreement on goals, increase the palliative care content of treatment plans, and reduced hospital transfers.

Pharmacist Role

- Reduce medication burden by tapering or discontinuing non-beneficial medications
- Consider nontraditional administration routes
- Individualize care
- Consider and advise on gastrointestinal issues
- Consider psychological issues

Metrics

The following measures will be evaluated during the pilot program

- Readmissions
- Medication costs
- Number of medications per patient
- Pain control
- Patient satisfaction

Barriers to providing quality palliative care in nursing homes

- Poor transfers between hospitals and nursing homes
- Staff recruitment and turnover
- Training and educational needs
- Lack of visitation by healthcare providers
- Lack of visitation by families
- Cultural differences
- Family expectations and misperceptions

Additional challenges in the Post-Acute Setting

- Medical Director involvement
- Physician/Nurse Practitioner Billing
- No extra payment to centers for providing palliative care to patients
- Hospice does not cover room and board in SNF
- Misperceptions of palliative care
- Awareness and willingness to make referral to palliative care team

- We anticipate the duration of the pilot program to be at least 12 months. Upon evaluation of the pilot program, the palliative care committee will make recommendations regarding implementation across additional centers.

- Future plans will extend the program to patients in the community setting to include home health and hospice services.

Palliative Care Committee philosophy

- Respect the autonomy and differences of each center and region and work collaboratively with Medical Directors and Administrators of each center and region
- The program should be designed to be supportive and should serve as a resource to the centers
- Direct medical care of patients is not provided or dictated by the committee members or the Palliative Care Medical Director of the pilot program
- Appreciate that there will be differences operationally in each center based on those centers needs

Summary

- There is a great need to implement palliative care in the long term care facilities
- There are no universal standards on implementation
- There are no universal standards for screening of patients
- There are significant barriers to implementation
- Each long term care center is unique and there is no “one size fits all” program
- Palliative care does not need to be a “program”, but rather should be a ideology for patient-centered care
- There needs to be a focus on evaluating the effectiveness of various strategies of palliative care delivery
- Palliative care delivery is a team effort

References for information presented available upon request

Questions?

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