PALLIATIVE CARE

Palliative Care in the Skilled Nursing Facility Setting: Opportunities Abound

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Objectives

- Identify two ways to approach LTC providers with palliative care that differ from the typical hospice approach.
- Identify two venues for partnering across the continuum of care.
- Describe the educational groundwork needed for successful uptake of palliative care practices in LTC.

QIO Approach

Aims

Foundational Principles:

- Enable innovation
- Foster learning organizations
- Eliminate disparities
- Strengthen infrastructure and data systems

Goals

- **Make care safer**
- **Strengthen person and family engagement**
- **Promote effective communication and coordination of care**
- **Promote effective prevention and treatment**
- **Promote best practices for healthy living**
- **Make care affordable**

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Georgia

Improving Transitions of Care

$38.2 Million

in cost savings from Georgia's QIO Program

Improving Health for Populations and Communities

40

professionals recruited/assisted with PQRS EHR 2012 reporting potentially impacting 89,814 Medicare beneficiaries

Reducing Health Care Associated Infections

69%

relative improvement rate in reduced *C. diff* among recruited participants

Reducing Potential for Adverse Drug Events

199

potential adverse drug events were prevented among participants screened

Improving the Lives of People with Diabetes

23%

absolute rate of improvement in controlling blood sugar level among participants screened

Preventing or Healing Pressure Ulcers in Nursing Homes

117 pressure ulcers healed

> $4.4 Million in cost savings

Minimizing the Use of Physical Restraints in Nursing Homes

109

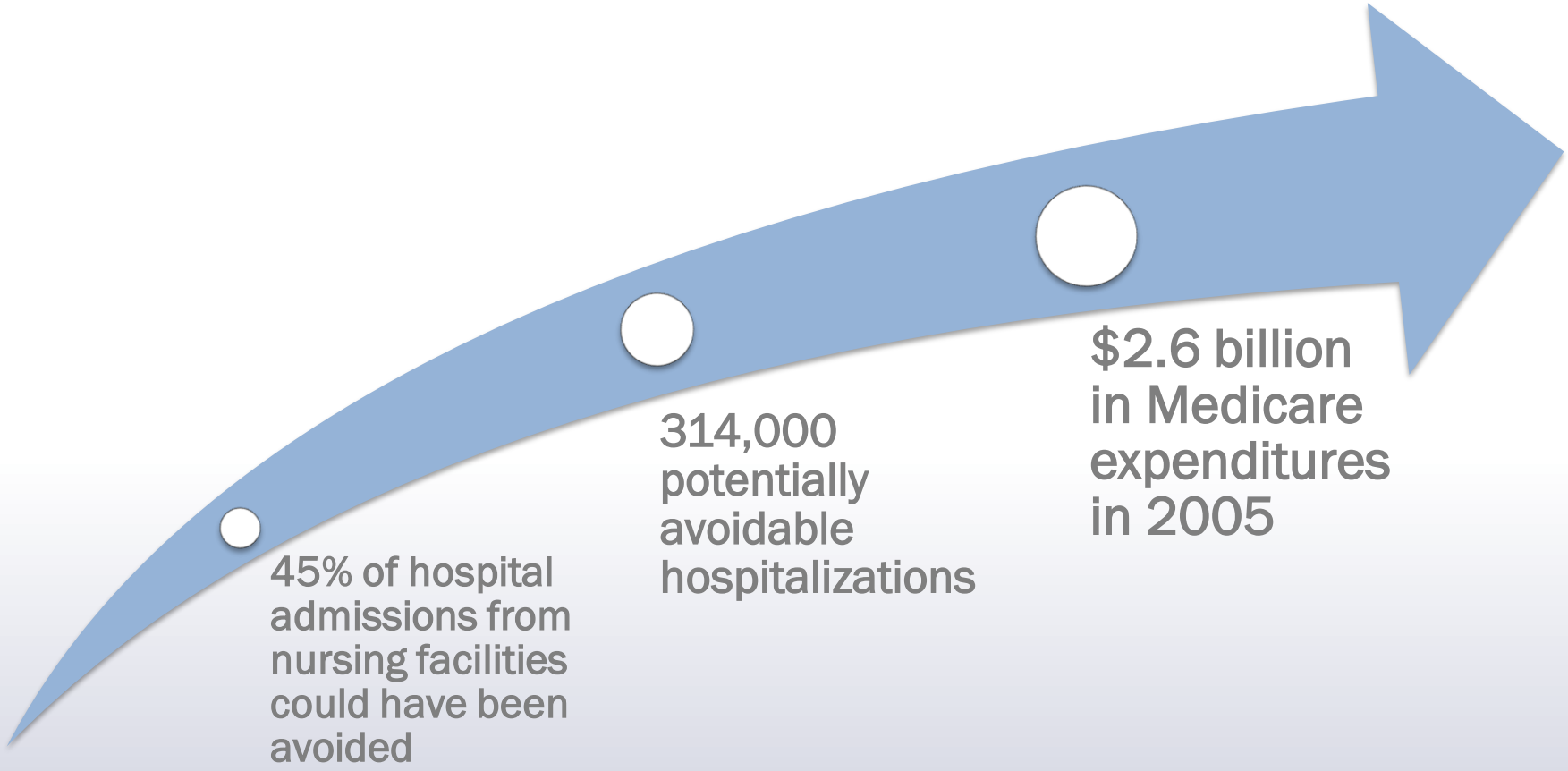
fewer Medicare beneficiaries with restraints

Partnering with More Nursing Homes

121

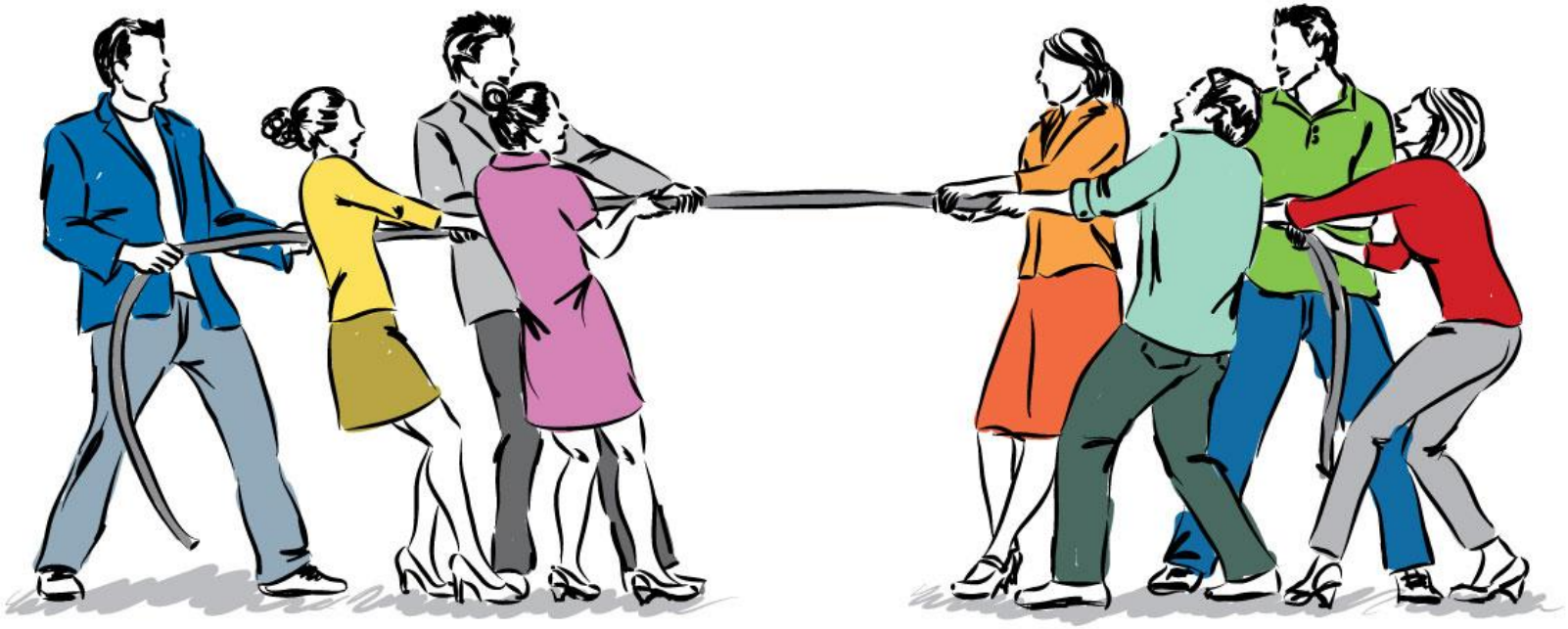
nursing homes recruited to participate in statewide collaborative

Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents



Source: http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4304

What's the relationship with NHs and hospices now?



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What approach are you using now to engage NHs in Palliative Care Services?

- Sales approach?
- Back door: Use of hospice services?
- Educational approach?

Approach 1: Interventions That Work

- High-intensity interventions reduced 30 day readmissions:
  - Care coordination by a nurse,
  - Communication between PCP and hospital, and
  - Home visit within 3 days of discharge (Verhaegh, 2014).

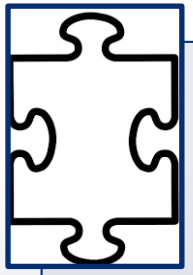
Palliative care in the nursing home can be much like this

Approach 2: Create a Plan and Partner

- Create a space to work together that incentivizes early adopters and rewards participation.
- Plan your work and work your plan.

Special Innovation Project

Funded by the Center for Medicare and Medicaid Services (CMS) through QIN-QIOs.



Opportunity to delve deeper into a specialized topic.

Innovations that advance local efforts for better care at lower costs.

Alliant's SIP Goals

To improve the access to and quality of palliative care in the nursing home setting

Ensure care is received in the right setting	Improve staff competency and knowledge r/t end of life care	Improve access to Palliative Care Services in Long Term Care Facilities	Reduce avoidable nursing home-to-hospital admissions and readmissions

Alliant SIP Approach

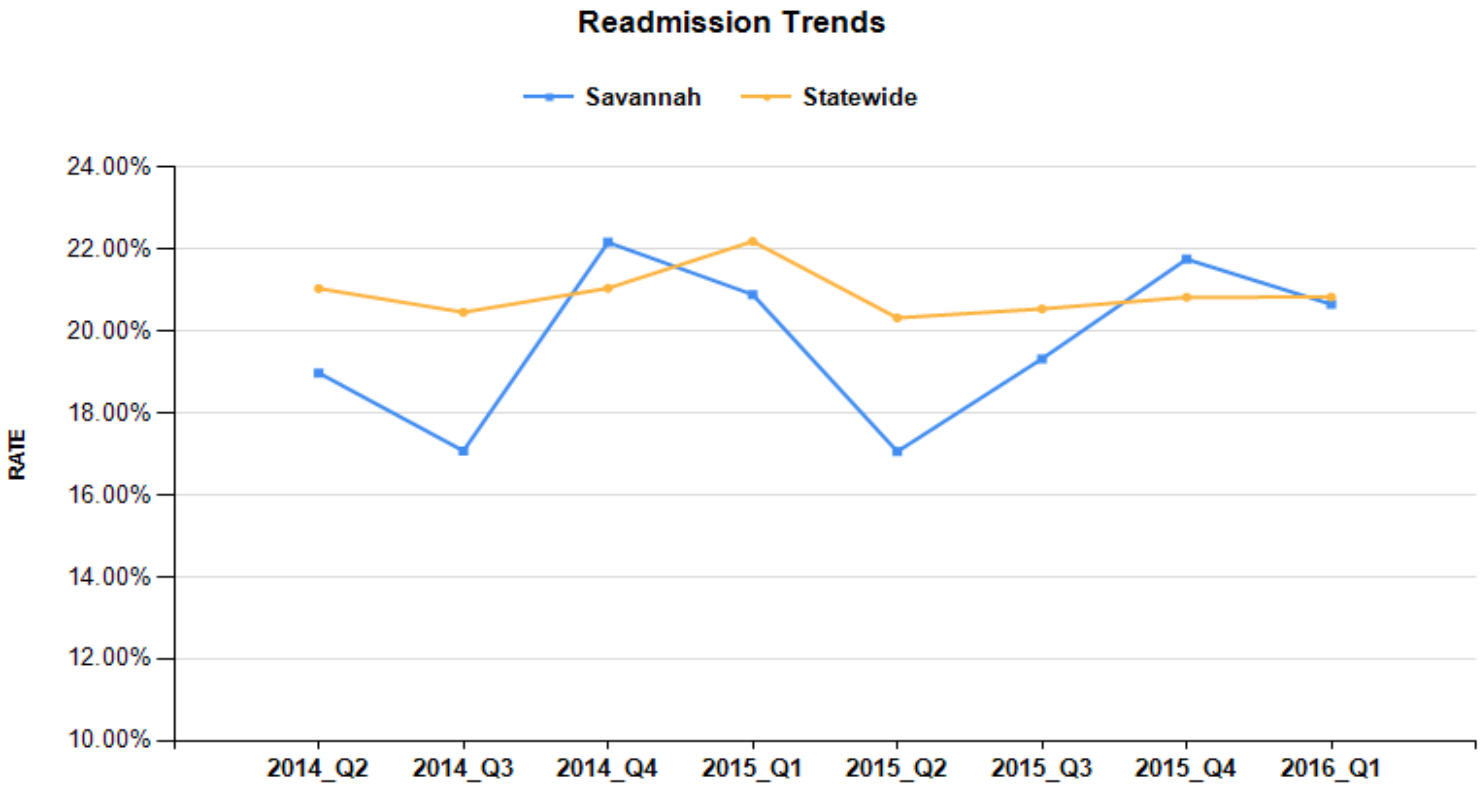
Develop a learning collaborative with recruited skilled nursing facilities and palliative care

- Education
- Best Practice Sharing
- On site education on care delivery
- Results Measurement/ Data Support

Why Savannah?

- Prior work on POLST
- Engaged Palliative Care provider participating in community care connections meetings (CHCCs)
- Readmissions from NHs
- Large geographic area- rural and urban
- 28 NHs from which to recruit

Readmissions in Savannah from NHs



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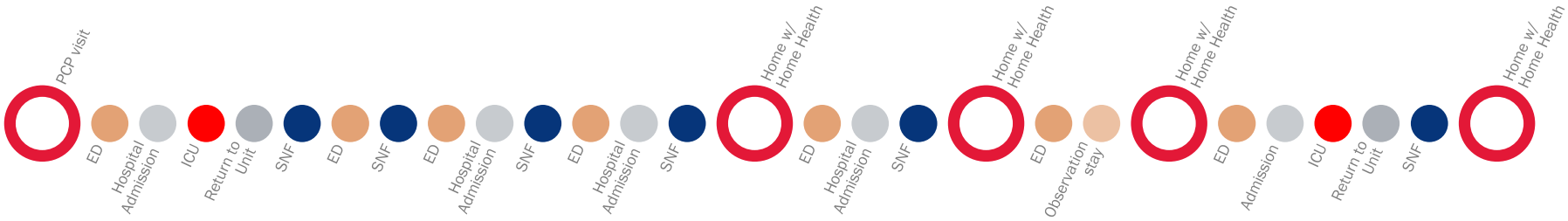
The Most Common Scenario: Meet Mabel

- 75-year-old female
- Other chronic diseases:
  - COPD
  - Diabetes
  - Dementia
- Mabel's husband, Sam, is Mabel's RP. He's 79 years old and has beginning stages of dementia, but is otherwise healthy.
- All of their children live out of state.

It's a Journey



(03/12 – 03/14)

- 27 transitions of care
  - 6 emergency department visits – 4 resulting in admissions; 1 observation stay, and 1 release back to skilled nursing facility
  - 2 Intensive Care Units stays
- 10 providers coordinating care
  - 2 acute care hospitals; 4 skilled nursing facilities; 2 home health agencies; primary care physician; pulmonologist .
- Palliative Care
  - 2 emergency department visits
- Hospice

(03/14- 04/14)

Realizing the Opportunities

Beginning a conversation about Mabel's current condition and her anticipated decline could:

1. Lessen the decision making burden on Mabel's husband and children.
2. Lessen Mabel's suffering at end of life.
3. Improve the satisfaction for Mabel's family at end of life.
4. Improve the satisfaction of the family and staff with every day care.

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Why Palliative Care?
Equipping yourself for the conversation

Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.

Palliative care throughout the continuum of illness involves addressing *physical, intellectual, emotional, social, and spiritual needs* and to facilitate patient autonomy, access to information, and choice.

CMS Survey and Certification Group (2012)

Why Palliative Care?

Drivers of Poor Care Transitions

- Inappropriate end-of-life care identified
- Lack of patient activation and incomplete communication between providers

Need for palliative care education and support

The Business Case: Skilled Nursing Facilities

- **Value Based Payment** for Nursing Homes: Performance Period for the 2018 payment adjustment is 2016.
- **Quality measures** are publicly reported and impact patient/family decision in choosing a facility.

The Business Case: Skilled Nursing Facilities

- **Bundled Payments, Accountable Care Organizations, Managed Care payers** all require care elements that align with palliative care.
- Alignment with **resident centered care** initiatives.

Palliative care is relevant to many nursing home regulations for which state surveyors review facilities

- Accommodation of Needs: F246
- Comprehensive Assessment: F27
- Comprehensive Care Plans: F27
- Quality of Life: F240
- Resident Rights: F154, F155, F156
- Self-Determination and Participation: F242
- Quality of Care: F309
- Mental/Psychosocial Treatment: F319

The Business Case: Palliative Care Providers

- Increased partnership and penetration with long term care providers.
- More streamlined process:
  - Residents have better prognosis information and have experience with goals of care conversations – better use of resources.

Bridge Between the Hospital and NH

- Inpatient consultation services for hospitals
- Build relationships with NHs
- Partner with HHAs who are now getting discharged NH patients

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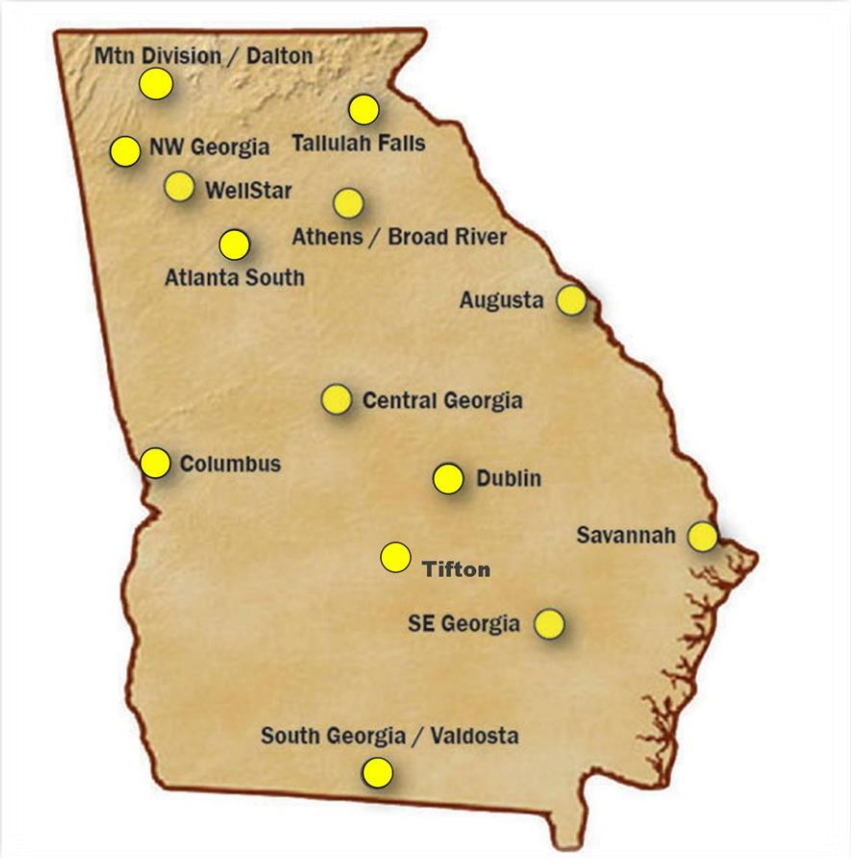
What's to be Done?

- Get palliative care professionals in the door
- Build relationships
- Improve nursing recognition of residents appropriate for palliative care intervention
- Education

What are the educational needs of nursing home employees?

Approach:
Six Care Domains

If I'm not in Savannah…



- Community Healthcare Connections
- Care Coordination Quick Calls

In Summary

- Approach is critical and needs to be different.
- Partnership is paramount.
- Key purpose is educational growth and broadening of thinking about the use of palliative care, not as a gateway to hospice, but as a specialty of its own.

Questions?

Making Health Care Better

This material was prepared by GMCF, for Alliant Quality, the Medicare Quality Innovation Network - Medicare Quality Improvement Organization for Georgia and North Carolina, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. 11SOW-GMCFQIN-SIP1-16-05