# Integrating Palliative Care into Nursing Homes

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# Objectives

- Dying in the NH
- Models of integration
- Challenges to integration
- Changing environment and higher stakes

# NH Population

- 2004 1.5 million people living in 16,000 NH

  88% aged 65 and older

  45% aged 85 and older

  71% female and 87 Caucasian

http://www.cdc.gov/nchs/fastats/nursingh.htm

# Where do People Die?

| | 1989 | 1997 | 2004 |
|---|---|---|---|
| • Acute Hospital | 64% | 51% | 46% |
| • Home | 18% | 24% | 25% |
| • Nursing Home (NH) | 17% | 24% | 25% |

30% NH residents die within 1 year of admission *

- Teno Jl. Brown Atlasin the US available at http://www.chcr.brown.edu/dying/brownsodinfo.htm
- http://www.cdc.gov/nchs/nvss/mortality/gmwk309.htm
- * AHPCR December 2000, AHRP no. 01--0010

# Major Concerns

- Pain and symptom management
- Advance care planning
- Autonomy, quality of life
- Quality of care
- Costs of care and unplanned hospital transfer
- Psychosocial and bereavement support

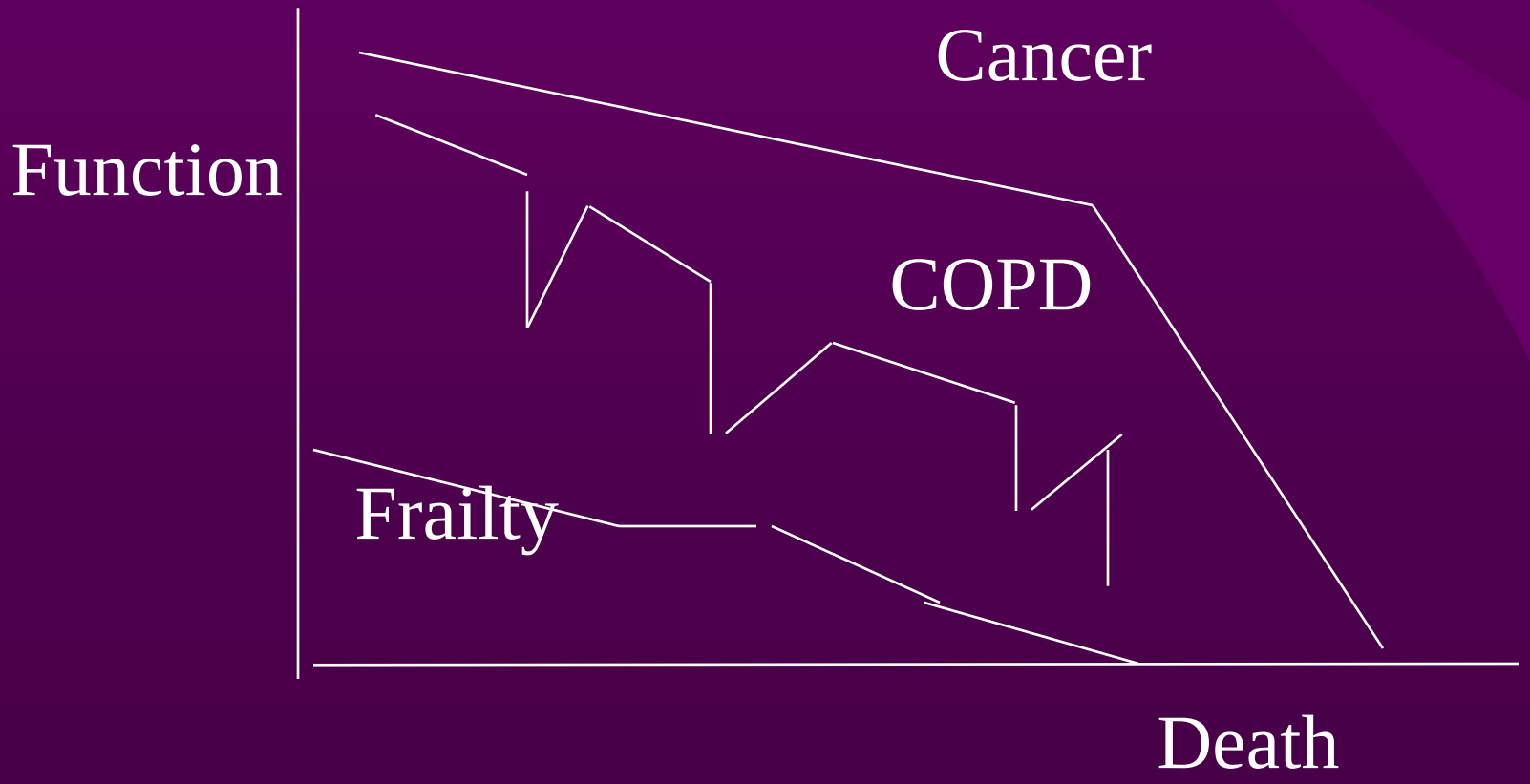
# Nursing Home Outcomes JAMA 2004

- 31 % inadequate pain , 56% inadequate emotional comfort
- 32% not always treated with respect
- 49% wanted but not have, or had inadequate contact with physician
- 30% concern about emotional support to family
- 20% staff did not know enough to provide best care
- 41% received excellent care

# How Do People Die in LTC?

- 500,000 annual deaths, majority expected
- 40% Hospital stay in last 30 days of life
- Sudden Death (7%)
- Steady decline, short terminal phase (22%)
- Slow decline, periodic crisis, sudden death (organ system failure: 30%)
- Frailty (42%)
- Lunney, Lynn et al. 2002 , JAGS 50: 1108

# How do People Die in LTC



# Models of Palliative Care (PC) in the Nursing Home (NH)

- Hospice interdisciplinary team
- PC consult services: np/physician based consult, independent/hospice employed
- NH based: facility employing their own NP, staff training and PC process, Evercare model

# Targeting

- Very sick (disabled, dependent, debilitated) and getting worse (end-stages of chronic illness, advanced malignancy, terminal illness)
- Would you be surprised if patient dies over next 6-12 months?
- Do you expect patient to die in this community?
- MDS indicators: BMI weight loss, functional decline, hospice criteria, goals for care

# Hospice Care in Nursing Homes

- Medicare Hospice Benefit: prognosis of 6 months or less, forgo curative treatment for their terminal condition and agree PC plan
- 87% of all facilitates have contracts with hospice providers, very uneven use
- 22% of all hospice enrollees live in NH, older, non-cancer, longer los

MedPAC Report to Congress March 2009

# Benefits of Hospice Care for Nursing Home Residents

- Pain control improved
- Use of hospital, tube feeding decreased
- Family satisfaction with care improved
- Support and education for staff
- Bereavement support
- Costs of care ?
- Permission to die?

Miller SC JPSM 2003, Munn JC JAGS 2008 , Gozalo HSR Feb 2008

# Non-hospice models of palliative care

- PC consult model: physician /NP teams available for pain and symptom management, education, f/u hospital patients, available for skilled patients
- PC consult from community hospice
- NH PC programs: using salaried np and medical directors, facility resources

CAPC report

# PC Integration
## (challenges and opportunities)

- Regulatory oversight
- Financial incentives
- Clinical care, care process and culture
- Education and training
- Relationship with community and acute care

# Regulation and Oversight

- New Conditions of Participation for Hospice: quality outcomes, care coordination, education and training
- F309 Interpretative Guidelines and PC
- OIG concerns: 82% of claims not meeting coverage requirements (care planning, election, provision of services)
- CMS/MedPAC concerns: growth, LOS, payment reform

# Regulation and Oversight

- “Prime Directive” and resident decline
- MDS 3.0: preferences for care, pain assessments dyspnea assessment, functional status, nutritional status and prognosis,  hospice
- Quality Indicators: pain prevalence and outcomes in short and long stay residents

# Financial Incentives

- Medicare Part A skilled benefit
- Conflicting Incentives Medicare and Medicaid
- RUGS: higher rehabilitation categories but greater focus on clinically complex and extensive categories
- Hospitalization of acutely ill residents
- No direct payment for palliative care outside of hospice

# Clinical Care and Culture

- Availability of RNs
- Availability of Physicians
- Staff and leadership turnover
- Education and training needs; frontline workers
- Culture directed at preservation of function, maintenance and rehabilitation

# Relationship with Acute Care

- 2/3 admissions to LTC come form the hospital
- 19% recurrent admissions back to hospital within 30 days
- Transitional palliative care services
- Care coordination with duals
- NH as part of continuum  of care
- Need for POLST

# Process of Care

- Early identification and targeting
- Assessment and goal setting and shared decision making
- Development and implementation of palliative care plans
- Training and team development, physician support and POLST
- QI and outcomes

# Stakes are Going Up!

- Health care reform: recurrent hospitalization, ACOs and coordination of care for duals
- Regulatory and oversight challenges in both hospice and in LTC
- Acuity of patient population and NH deaths increasing