Integrating Palliative Care into Nursing Homes

Howard Tuch  MD, MS
Director of Palliative Care Services
Tampa General Hospital
University of South Florida College of Medicine
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?

<table>
<thead>
<tr>
<th></th>
<th>1989</th>
<th>1997</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Hospital</td>
<td>64%</td>
<td>51%</td>
<td>46%</td>
</tr>
<tr>
<td>Home</td>
<td>18%</td>
<td>24%</td>
<td>25%</td>
</tr>
<tr>
<td>Nursing Home (NH)</td>
<td>17%</td>
<td>24%</td>
<td>25%</td>
</tr>
</tbody>
</table>

30% NH residents die within 1 year of admission *

- * 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

Function

Cancer

COPD

Frailty

Death
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?

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 from 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