Palliative Care in the Nursing Home
Janet Bull, MD FAAHPM, HMDC

Objectives
- Understand nursing home environments, the impact of healthcare reform, and the alignment of palliative care services
- Identify ingredients of a successful palliative care program
- Discuss CMS Innovations model of care
- Define tools, process and outcome metrics that are useful in improving care, and demonstrating success
What Keeps You Up at Night?

NH Administrators
- Occupancy
- Decreased reimbursement
- Dealing with multiple payer sources – MA plans
- Partnerships
- Star ratings
- Staff turnover
- Case mix
- Readmissions

Trends
- Overall number of nursing facilities decreased by .7% to 15,643
- Occupancy decreased from 85.6 to 83% with decrease in patients from 1.6 to 1.3 million
- Increase in For-Profits => 69%
- Majority of ≥ 65 yo => need LTCF for average of 3 years, and by 85 yo, 20% for 5 years

*Kaiser Foundation Overview of Nursing Facility Capacity, Financing, and Ownership in the United States in 2011*
*Peter Kemper et al., “Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect?,” Inquiry, 42 (2005): 335-350*
Expected Growth in Nursing Homes

The 65 and Over Population Will More Than Double and the 85 and Over Population Will More Than Triple by 2050

Understanding Nursing Home Environment

- Strict regulatory requirements
- Salaries tend to be lower
- Reimbursement declining – tight margin
- Understaffing in RN and CNA positions
- Sicker patients secondary to shortened hospital stays
- High staff turnover
Mortality and LOS in LTCF

- 25% Americans die in LTCF
  - Half of these died within 5 months
  - 65% died within 12 months
  - ALOS – 14 months (other data – 2 years)
  - Males and higher financial worth had shorter prognosis


Dementia in LTCF

- Accounts for up to 2/3 of all admissions
- Death rate doubled from 1996 to 2007
- Behavioral issues often drive NH admissions
- Staff often ill equipped to handle
Bereavement Surveys - LTCF

- 32% patients have pain
- 24% patients dyspnea
- 60% inadequate emotional support
- Only 42% rated quality of care as excellent, as compared to 71% with hospice care at home

Affordable Care Act – Triple Aim

Improving Health Of Individuals & Populations
Improving Patient Experience Of Care
Reducing The Cost Of Care

Palliative Care

At least 1/3 of LTCF patients are appropriate for palliative care at time of admission!
Times are Changing

- Physician choice
- Physician Accountability

Fee for Service

Pay for Performance

Risk-sharing/ACOs

Cost/quality-directed decision making

*Outcomes-directed decision making

*Physician Accountability

Quality Demonstration

Payment/System Innovation Timeline

- CMS Innovation Center
- 1096 Increase for Primary Care (Medicare)
- State-Based All-Payer Pilots

2010

- Productivity Improvement

2011

- Bundled Payment for Acute Care Episodes
- Medicaid Primary Care Payment Up to Medicare Levels (2013/14)
- Value-Based Purchasing (Physicians)
- Reduced Medicare Payment for MAI

2012

- Value-Based Purchasing (Hospitals)
- Reduce Payment For Preventable Readmissions
- ACO Provider Shared Savings
- Capitation For Safety Net Hospitals

2013

- Independent Payment Advisory Board Recommendations
Accountable Care Organizations

- Population health
- Redesign care processes
- Focus on post acute continuum
- Infrastructure development
  - Health information exchange
  - Coordination across care settings

5 Star Ratings for Nursing Home

- Health inspections – last 3 years
- Staffing
- Quality Measures

Each category has 5 star category and is designed to help consumers compare LTCF
Quality Measures – Long Stay

- falls
- physically restrained
- UTIs
- need help ADLs
- Mod – severe pain
- depressive symptoms
- pressure ulcers
- influenza vaccine
- Incontinence
- pneumococcal vaccine
- catheter
- antipsychotic meds
- weight loss

http://www.medicare.gov/NursingHomeCompare/About/Long-Stay-Residents.html

Quality Clinical Measures

<table>
<thead>
<tr>
<th>Clinical Measure</th>
<th>All Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Residents</td>
<td>1,431,721</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Pressure Ulcers</td>
<td>5.9</td>
</tr>
<tr>
<td>Any Restraint Use</td>
<td>2.2</td>
</tr>
<tr>
<td>Incontinence</td>
<td>35.6</td>
</tr>
<tr>
<td>Feeding Tube</td>
<td>5.9</td>
</tr>
<tr>
<td>Unintended Weight Loss</td>
<td>5.9</td>
</tr>
<tr>
<td>Antipsychotic Use</td>
<td>25.5</td>
</tr>
</tbody>
</table>
Quality Measures – Short Stay

- Mod – severe pain
- New Pressure ulcers
- Influenza vaccine
- Pneumococcal vaccine
- Antipsychotic med

http://www.medicare.gov/NursingHomeCompare/About/Short-Stay-Residents.html

Goals for 2015

- Dementia patients on antipsychotics
  - Goal from 20.3% ➔ 19%
- Pressure ulcer rate
  - Goal from 6.7% ➔ 6.6%
Quality Metrics for Nursing Homes

- Pay for Performance
- None of the QM pertain to end of life
- 2 Proposed additional EOL measures
  - Place of death
  - Hospice enrollment prior to death


NH Value Based Purchasing Pilot

- Pay for Performance
- Pilot – Virginia, New York, Wisconsin
- Staffing, QM, Survey Deficiencies, Hospitalizations
- Top 20% - participate in shared savings

http://innovation.cms.gov/initiatives/Nursing-Home-Value-Based-Purchasing/
Nursing Home Profile

Nursing Home Compare

The Official U.S. Government Site for Medicare

Nursing Home Compare Home | About Nursing Home Compare | About the data | Resources

Home → Nursing Home Results → Nursing Home Profile

General information | Health & fire safety inspections | Staffing | Quality measures | Penalties

Nursing Home Compare

THE OAKS AT SWEETEN CREEK
3854 SWEETEN CREEK ROAD
ARLINGTON, TX 76010
(817) 681-0904
Distance 4.2 miles
Add to my Favorites
Map and Directions

DEERFIELD EPISCOPAL RETIREMENT
1817 HENDERSONVILLE ROAD
ASHVILLE, NC 28803
(828) 274-1331
Distance 5.7 miles
Add to my Favorites
Map and Directions

HENDERSONVILLE HEALTH AND REHABILITATION
184 COLLEGE DRIVE
FLAT ROCK, NC 28731
(828) 633-8500
Distance 17.3 miles
Add to my Favorites
Map and Directions

Overall Rating

THE OAKS AT SWEETEN CREEK
Below Average

DEERFIELD EPISCOPAL RETIREMENT
Much Above Average

HENDERSONVILLE HEALTH AND REHABILITATION
Average

Health Inspection

THE OAKS AT SWEETEN CREEK
Below Average

DEERFIELD EPISCOPAL RETIREMENT
Much Above Average

HENDERSONVILLE HEALTH AND REHABILITATION
Below Average

Staffing

THE OAKS AT SWEETEN CREEK
Below Average

DEERFIELD EPISCOPAL RETIREMENT
Above Average

HENDERSONVILLE HEALTH AND REHABILITATION
Above Average

Quality Measures

THE OAKS AT SWEETEN CREEK
Above Average

DEERFIELD EPISCOPAL RETIREMENT
Much Above Average

HENDERSONVILLE HEALTH AND REHABILITATION
Above Average

http://www.medicare.gov/nursinghomecompare
Readmissions

- 25% Medicare patients readmitted within 30 days to the hospital
- 2/3 of transfers are considered avoidable
- NHs will soon be penalized
  - HHS proposal to decrease payments by up to 3% by 2017 for NH with high readmission rates
- 2018 – HHS proposes bundled payment system

Readmission Rates - Benchmarks

- 21% readmitted within 30 days
  - 25.5% - worst ranking facilities
  - 19.8% - best ranking
- 4.3% died within 30 days

- Lower readmissions correlated with better staffing ratio, but not quality indicators
  [Neuman, JAMA. 2014;312(15):1542-1551 Association Between Skilled Nursing Facility Quality Indicators and Hospital Readmissions]

- American Health Care Association (AHCA) recommends reduction to <15%
Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life

IOM Report Recommendations

- Palliative Care Training/Education
  - Symptom Management
  - Effective Communication
  - Advance Care Planning
  - Goal based Care
  - Continuity across settings
- Covering Patient’s Social Needs
## A Shifting Paradigm...

<table>
<thead>
<tr>
<th>Traditional Care</th>
<th>Transformational Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician led</td>
<td>Team led</td>
</tr>
<tr>
<td>Acute clinical needs</td>
<td>Goal directed care</td>
</tr>
<tr>
<td>Silo care - specialists</td>
<td>Coordinated health teams</td>
</tr>
<tr>
<td>Fee for service</td>
<td>Value based purchasing Bundled payments</td>
</tr>
</tbody>
</table>

## Going From Macro To Micro...
Opportunities for Palliative Care

- Projected 40% of all deaths in NH by 2020
- Poor pain and symptom management
- High degree of social and spiritual isolation
- Inadequate physician involvement in care
- Exclusion of resident/family in treatment decisions

Benefits of Palliative Care

- Palliative care – improves quality of care
- Coordinated care
- Higher completion of Advance Care Planning
- Reduce hospital transfers
- Higher family and patient satisfaction
- Improved staff satisfaction with education component and availability of providers
Screening Tool for PC
- Completed by MDS/admissions coordinator on all NH admissions
- Identifies all patients with a cancer diagnosis
- Identifies all patients with end stage disease, such as CHF, COPD, dementia, ESRD
- Identifies patients without Advance Directives
- Identifies patients with pain or symptom needs
- Identifies multiple hospitalizations
- If positive screen, call is placed to attending for PC consult
Defining Eligibility

- Define your program parameters. Don’t try to be all things to all people. It is better to under promise and over deliver.

- Eligibility criteria – patients with serious or life-limiting illnesses
- Excluded – chronic pain, i.e., quadriplegic
  - post surgical
  - substance abuse
  - acute pain (orthopedic)

Risk Stratification

- Demographics
- Diseases
- Clinical signs and symptoms (ADLs, cognitive and nutritional decline)
- Adverse events (hospitalizations, ER)

Predicting Death in the Nursing Home: Development and Validation of the 6-Month Minimum Data Set Mortality Risk Index
Prognosis – NH Patients

- MDS Mortality Rating Index
- Scoring system based on 10 factors and ADLs assistance

Predicting Death in the Nursing Home: Development and Validation of the 6-Month Minimum Data Set Mortality Risk Index
http://eprognosis.ucsf.edu/porock.php

**Mortality Risk Index (2004)**

Score Sheet to Estimate 6-Month Prognosis in Nursing Home Residents With Advanced Dementia

<table>
<thead>
<tr>
<th>Risk Factor From Minimum Data Set</th>
<th>Points</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities of Daily Living Scale = 29*</td>
<td>1.9</td>
<td>——</td>
</tr>
<tr>
<td>Male Sex</td>
<td>1.9</td>
<td>——</td>
</tr>
<tr>
<td>Cancer</td>
<td>1.7</td>
<td>——</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>1.6</td>
<td>——</td>
</tr>
<tr>
<td>Oxygen Therapy Needed in Prior 14 Days</td>
<td>1.6</td>
<td>——</td>
</tr>
<tr>
<td>Shortness of Breath</td>
<td>1.5</td>
<td>——</td>
</tr>
<tr>
<td>≤25% of Food Eaten at Most Meals</td>
<td>1.5</td>
<td>——</td>
</tr>
<tr>
<td>Unstable Medical Condition</td>
<td>1.5</td>
<td>——</td>
</tr>
<tr>
<td>Bowel Incontinence</td>
<td>1.5</td>
<td>——</td>
</tr>
<tr>
<td>Bedfast</td>
<td>1.5</td>
<td>——</td>
</tr>
<tr>
<td>Age &gt;83 y</td>
<td>1.4</td>
<td>——</td>
</tr>
<tr>
<td>Not Awake Most of the Day</td>
<td>1.4</td>
<td>——</td>
</tr>
</tbody>
</table>

Total Risk Score, Rounded to Nearest Integer
Possible Range: 0–19

If Total Risk Score is... | Risk Estimate of Death Within 6 Months, %
--- | ---
0 | 8.9
1 or 2 | 10.5
3, 4, or 5 | 23.2
6, 7, or 8 | 40.4
9, 10, or 11 | 57.0
12 | 70.0

*The Activities of Daily Living Scale is obtained by summing the resident’s self-performance ratings on the Minimum Data Set for the following 11 functional activities: bed mobility, dressing, toileting, transfers, eating, grooming, and locomotion. In the Minimum Data Set, functional ability is rated on a 5-point scale for each activity (5, independent; 1, supervision; 2, limited assistance; 3, extensive assistance; and 4, total dependence). A total score of 29 represents complete functional dependence.

Developing Referral Sources

- RELATIONSHIPS
- Physician and facility preference lists
- Developing your message – how do you benefit them with your services?
- Humble attitude in a host environment
- Plan for educating their staff
- “Rounding” tool – communicate frequently
- Create a win-win situation

Key Nursing Home Personnel

- Director of nursing
- Charge floor nurses
- MDS coordinator
- Admissions coordinator
- MD director
- Ancillary staff (dietary, PT, OT)
- Nursing home administrator
INTERACT

- Communication
- Care paths or clinical protocols
- Advance Care Planning

- Available for LTCF, ALF, home health, and ACO (under development)

http://interact2.net/tools.html
Interventions to reduce acute care transfers

INTERACT – Communication Tools

- SBAR tool
- Medication Reconciliation
- Stop and Watch – early warning on changes with residents
- Transfer forms/checklist
INTERACT Care Paths
- Fever
- Dehydration
- Dyspnea
- CHF
- GI sx – nausea, vomiting, diarrhea
- Respiratory Illness
- Altered mental status
- Change in behavior
- UTI

Advance Care Planning Tools
- ACP tracking tool
- Communication guide
- Comfort care order sets
- Decision about hospitalization
- Feeding tube education
- CPR
QTC – Quality Transitional Care Pilot

- Coordination with hospital discharge planners, primary care providers, home health, NH, and ALF’s
- RN contacts pt/families within 48 hours of discharge
  - Medication reconciliation
  - Patient education
  - Symptom assessment – QDACT Tool
  - Schedules PC visit based on acuity
- RN case manager in facility < 2x week

Results

196 Patients – Within 30 days

Readmission Before QTC

Readmission After QTC

4%
CMMI – Round 2 Innovation Grant

- The Innovation Models are organized into seven categories.
  - Accountable Care
  - Bundled Payments for Care Improvement
  - Primary Care Transformation
  - Initiatives Focused on the Medicaid and CHIP Population
  - Initiatives Focused on the Medicare-Medicaid Enrollees
  - Initiatives to Speed the Adoption of Best Practices
  - Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models

Palliative Care Teams

- PC Admin (scheduling, HIM, billing)
- PC NP (1:100)
- PC RN (1:300)
- PC SW
- PC MD/DO - oversight for team

All patients have QDACT Assessment
Eligibility: ≥ 65 yo, Medicare
Palliative care in the SNF

- Staffing ratios
  - Caseload – NP caseload - 100 patients
  - Productivity – 6-8 visits/day
- Billing
  - Intensity > Time based billing
- Support Staff
  - Scheduling, HIM, IT, Billing, Admin

Role of the Nurse Practitioner

- Understands nursing home environment and spends time with relationship building
- Understand state and federal regulations
- Responsible for risk stratification
- Assigned to 1-2 nursing homes to keep consistent care
- Provide formal education quarterly with rounding tools daily
- Available by phone 24/7
Palliative Care Progress Note

- Written with the MDS in mind
- Document:
  - Pain scores and interventions
  - Symptom assessment
  - Continence issues
  - Cognitive status
  - Behavioral issues and need for antipsychotics
  - Oral intake/weight and interventions
  - Patient/family goals
  - Progress or lack thereof of PT/OT
  - Coordination with NH plan of care

Align with NH Quality Metrics

- Patients prefer to avoid hospital deaths
- Hospice patients quality of care
- Better pain control
- Less physical restraints
- Lower use of feeding tubes
- Higher patient/family satisfaction
Building a system – QDACT v 2

Metrics to Track
- Hospice Transitions
  - LOS average and mean
- Hospital Readmissions
- Symptom Scores
- ACP
- Patient/family Satisfaction
- Billing
  - Intensity > Time based billing
Proposing a Payment Model

Figure 5 - Developing Alternative Payment Approaches

Transitional Fee for Service payment for CPC 1-3yr analysis Bundled PBPM Payment for CPC

Promote PC clinical care model Expansion

Promote best practice ACO integration of transitional care models

Financial Ecosystem changes through Legislation and Policy
- Changing Accountable Care Act implementation
- Accountable Care Organization alignment – Incentives
- Hospice – Hospital – Transitional Facility FFS/PBPM changing

Payment Approach Replication Throughout Medicare
- Dependent on Financial alignment
- Value Proposition in patient outcomes
- Value Proposition in reducing Total Cost of Care

Questions?

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