Integration of Palliative Care Into Skilled Nursing Facilities and Evolving to Meet the New Stakeholders of 2015

Katy Lanz, DNP, ACHPN
Director of Geriatric Services & Director of the CMS RAVEN Initiative
University of Pittsburgh Medical Center Palliative and Supportive Institute

Melanie J. Marien MS. PA-C
Director of Clinical Relations & Business Development
The Center for Hospice & Palliative Care Hospice Buffalo

Palliative Care Definitions

• **Palliative Care** is specialized medical care for people with **serious illness**.

• *Care is focused on providing patients with relief from the symptoms, pain and stress of a serious illness.* ---**Whatever the diagnosis**

• **Active total care of patients whose diseases are not responsive to curative treatment.**

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2011 Public Opinion Research on Palliative Care Research Commissioned by the Center to Advance Palliative Care
What is Palliative Care

• *Palliative care specializes in the relief of:*  
  – Pain  
  – Physical symptoms  
  – Psychosocial symptoms  
  – Stress of people affected by illness, whatever the diagnosis.

• *Appropriate at any point in an illness*  
• *Can be provided at the same time as curative treatments*

Patient Centric Model of Care

• *Patients’ goals of care are identified, and aligned with realistic treatment options.*
Palliative Care Collaboration

• Provides supportive collaboration with medical team and assistance with:
  • complex decision making
  • Family dynamics
  • discharge planning
  • Symptom management
• Goal is to establish comprehensive access to palliative care across the healthcare continuum

• Focus is on improving quality of life

Palliative Care Improves Quality

Data demonstrates that Palliative Care:

• Relieves pain and distressing symptoms
• Supports ongoing re-evaluation of goals of care and difficult decision making.
• Improves QOL, satisfaction for patients and their families.
• Eases burden on providers and caregivers
• Facilitates discussions regarding advance directives.
• Improves transition management and reduces hospital LOS.
Medicare Spending

- In FY 2011 NH transferred ¼ of their Medicare residents to hospitals for inpatient admissions.
- Medicare spent $14.3 billion on these 1.3 million hospitalizations.
  - This was 11.4% of Medicare part A spending on all hospital admissions.
  - NH residents cost an average of $11,255 on each hospitalization.
  - NH hospitalizations were 33.2% above the average cost of hospitalization for all Medicare residents.
  - 33% of those hospitalized, were hospitalized >1.

OIG Medicare Nursing Home Resident Hospitalization Rates Merit Additional Monitoring Nov 2013

The Future of Dementia Hospitalizations and Long Term Services+Supports

- 10 fold growth in dementia related hospitalizations projected between 2000 and 2050 to >7 million.

Long Term Care

• Experts project a threefold increase in the need for formal long term care between now and 2050

– From 9 million to 27 million people!!!!

Lynn, J, Satyarthi, H. Invited commentary: Creating the future of Aging. Archives of Internal Medicine 2011; 171(20);1872-1873

Move Inpatients Through the System Safely and Efficiently:

ACE/HELP
NICHE
Palliative Care

Provide patient-centered, coordinated care:

PCMH (GRACE, Guided Care), Medical house calls, ACOs

Prevent Readmission: Care Transitions Programs

Keep some patients with acute illness out of the hospital: Hospital at Home

www.med-ic.org
Current State of Nursing Homes

Need for improved Symptom Management:
- High prevalence of undertreated pain in NH population
- Chronic pain is most common form secondary to musculoskeletal problems
- Typical myths surrounding symptom directed medicine ie: opioids and antipsychotics

Current State of Nursing Homes

- Hospice and Palliative Care are underutilized in NH.
- Residents have more complex medical problems than a decade ago.
- Discrepancy between patient need and unmet need.
- “Comfort care” is thought to be synonymous with palliative care.
- Perceived lack of the additive value of hospice and palliative care.
Current State of Nursing Homes

Variability among Facilities and Staff:
- Understanding of what Palliative
- Understanding what Hospice is
- Delivery of Palliative services
  - Pain and symptom management
    - Physical
    - Psychosocial
  - Advance directive completion
  - Outline goals of care
  - Support to family and loved ones

Evolution of Nursing Homes

Nursing Home World is Changing:
- Disincentive to hospitalize.
- Threat of bed closure.
- Accountability for readmissions.
- Need for better transitional care models.
- Residents have more complex medical problems.
- NHs provide care that was previously provided in the acute hospital setting a decade ago.
- Areas of greatest margin are under reform (ie SAR).
- Continuous shift in payer mix presents reimbursement challenges.
Palliative Care In Long Term Care: Evolving to Meet the New Stakeholders of 2014

Katy Lanz, DNP, ANP, GNP, ACHPN
Adult, Geriatric and Palliative BC Nurse Practitioner
UPMC Palliative Institute
Director of Geriatric Services
Director and PI, CMS RAVEN Initiative

The Evolution: Stakeholder Analysis

• **Palliative care in LTC before the ACA**
  – Provided mostly by LTC staff, hospices and homecare agencies

• **Palliative care in LTC after ACA**
  – Stakeholder story change:
    • Health Systems
    • Insurers/Payors
    • State
    • Community MDs
    • Hospices
    • LTC
    • Patients and Families
Where is Palliative Care?
IOM Report:

• September 17, 2014 - The Institute of Medicine (IOM) released a new report authored by the Committee on Approaching Death: Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life

• Synopsis of Recommendations:

IOM Clinician Recommendations

• 24-7 Access and Interprofessional
• Consider the Whole Person
• Transparency and Accountability
• QUALITY CONVERSATIONS
  – Measurable, Feasible, and Evidence Based

“Our current system is broken and does not result in quality or cost effectiveness. There are perverse incentives that support unnecessary treatment. It is not value based and systemic change is necessary”

Donald Walker, Chair
Transforming 21st Century Care of Serious Illness
Gomez-Batiste et al. 2012

Change from: Change to:
Terminal..................................Advanced Chronic
Prognosis weeks-month............Prognosis months to years
Cancer..................................All chronic progressive diseases
Disease..................................Condition (frailty, fn’l dep, MCC)
Mortality.................................Prevalence
Cure vs. Care..........................Synchronous shared care
Disease OR palliation..............Disease AND palliation
Prognosis as criterion...............Need as criterion
Reactive................................Screening, Preventive
Specialist................................Palliative/Geriatric Care Everywhere
Institutional............................Community
No regional planning...............Public health approach
Fragmented care......................Integrated care

Where are Payers?
Fall 2014 CMS Announcements

• Value Based Purchasing for LTC
• 5 Star Rating Changes (with incentives from CMS)
• Benefit carve outs (fee for service)
• ACA implications
Oct 6th 2014 press release from CMS

CMS Announces Two Medicare Quality Improvement Initiatives
Administration redoubles its efforts to improve quality of post-acute care for Medicare beneficiaries

• Nationwide focused survey inspections
• Pay-roll based staffing reporting
• Additional quality measures
• Timely and complete inspection data
• Improved scoring methodology

Value Based Purchasing Timeline

<table>
<thead>
<tr>
<th>TIMELINE</th>
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<tbody>
<tr>
<td>FY 2014-2016</td>
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<tr>
<td>10/1/16</td>
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<tr>
<td>Secretary specifies an all-cause, all-condition readmission measure</td>
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| FY 2017 |
| 10/1/17 |
| - Secretary specifies an all-condition, risk-adjusted potentially preventable readmission rate measure |
| - Confidential feedback reports to SNFs |

| FY 2019 |
| 10/1/18 |
| The SNF VBP begins and incentives and penalties are applied |
What is the Complete List of Potentially Avoidable Hospitalization Diagnoses?

- Acute Renal Failure (AKI)
- Altered mental status
- Anemia
- Asthma
- C. Diff
- Cellulitis
- CHF
- Constipation/Impaction
- COPD
- Diarrhea/Gastroenteritis
- FTT
- Falls and Trauma
- HTN
- Pneumonia/Bronchitis
- Nutritional deficiency
- Poor glycemic control
- Psychosis
- Seizures
- Skin Ulcers
- UTI


Great Reference

Published on Annals of Long Term Care (http://www.annalsoflongtermcare.com)

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Long-Term Care Regulatory and Practice Changes: Impact on Care, Quality, and Access

Issue Number: Volume 22 - Issue 11 - November 2014
Topics: Medicare Update
Author(s): Richard G. Stefanacci, DO, MGH, MBA, AGSF, CMD
Series Editor: Barney S. Spivack, MD, FACP, CMD
Payers: Bundled Payments

• Bundled Payments for Care Improvement (BPCI)  
  Announced Jan 2013  
  – Financial and performance accountability

There are currently 43 participants/awardees who are involved in testing the BPCI third model. If the CMS Innovation Center finds testing to be successful, they will introduce this program on a national basis such that all Medicare funds for subacute services could be directed through the hospital. This would require SNFs to be contracted directly with their local hospitals as Medicare subacute payments would flow through the health system/hospital. SNFs operating in the most efficient and effective manner with regard to length of stay and reduction in avoidable hospital readmissions will benefit, as these will be the providers that hospitals seek out as partners.

Accountable Care: ACO’s

• Typically health systems, providers, and sometimes nursing homes responsible for the management and coordination of care of patients
• Fee for service for beneficiaries
• Held accountable for quality  
  – Expectations of the skilled facility
Managed Medicaid and SNF Reimbursement

- New York State’s Fully Integrated Dual Advantage
  - Starts Jan 2015
  - Funded through the Federal Coordinated Health Care Office (also within the CMS Innovation Center)
  - Will be responsible for room and board and other expenses
  - Naturally will be seeking out quality homes to integrate

Uncommon Partnerships Forming to Bring PC to LTC

- Hospices and Health Systems
- Health Systems and LTC
- Insurance Companies and Homecare Companies
- State and LTC
- Medicare and Health Systems
- And many more
LTC Administrator Mindset

• Corporate expectations
  – ROI
    • Census
    • Cost avoidance
    • Bed holds
  – Quality
  – Customer complaints
    • Public perception
  – Health Inspections
  – CMS Incentives and Disincentives
  – Hospital Relationships
  – Insurance
    • In network status

Health System Mindset

• Not that different than the SNF
• Penalties are hitting sooner
  – Do more with less
• Population management
  – Safe discharges and handoffs
  – Target high risk (avoidable conditions)
  – Need community and payer relationships
Payer Mindset

- Risk management
- High quality for less cost
- Forward thinking, and innovative models
- 24-7 access
- Boots on the ground and case management
- Population health

- THEY ARE SHOPPING

Example Model 1:
UPMC Payer and Provider Health System 2012

- Improve palliative access across the system
- Decrease the avoidable readmissions from LTC
- Improve staff retention and education in owned long term care sites
- Perform QI for high risk, high expense problems
UPMC Palliative and Supportive Institute
Why the Geriatric Palliative Nurse Practitioner?

- To implement this mission, we knew we needed the following skillsets:
  - Clinically knowledgeable
  - Scope to change orders or plan of care
  - Coordination and communication skills
  - Education skills
  - IT skills
  - Data collection skills
  - Ability to fit within the culture of the facility
  - Leadership skills
  - Team skills

Geri-Pal CRNP in LTC
Model 2: Cooperative Agreement with Medicare

- On March 15, 2012 the Medicare-Medicaid Coordination Office and the Center for Medicare and Medicaid Innovation announced the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents
- CMS is partnering with seven organizations to implement strategies to reduce avoidable hospitalizations for long-stay Medicare-Medicaid enrollees.

**UPMC Community Provider Services (Aging Institute) (Pennsylvania)**

$19.1 million

- Alabama Quality Assurance Foundation (Alabama)
- Alegent Health (Nebraska)
- The Curators of the University of Missouri (Missouri)
- Greater New York Hospital Foundation, Inc. (New York)
- HealthInsight of Nevada (Nevada)
- Indiana University (Indiana)
Model 2: CMS Cooperative Initiative

CMS Goals:
- Reduce the number of and frequency of avoidable hospital admissions and readmissions
- Improve beneficiary health outcomes
- Provide better transition of care
- Promote better care at lower costs while preserving access to beneficiary care and providers

*Focus is on long-stay (101+ days) Medicare-Medicaid residents
*Enhanced Care Providers work with 15 NF and have state and community support

A Model for Community Success: The Four P’s

- **Definition:** desired effect: the goal or intended outcome of something
- **Definition:** an arrangement where parties agree to cooperate to advance their mutual interests.
- **Definition:** any powerful or compelling emotion or feeling, as love or hate.
- **Definition:** activities that produce a specific service or product for customers

Passion

Purpose

Process

Partnership
Model 2: Unusual Operating Partners

UPMC Aging Institute (*ECCP*)
UPMC Palliative and Supportive Institute
University of Pittsburgh

*Operating Partners*
Excela Health
Heritage Valley Health System
Jewish Healthcare Foundation
Robert Morris University

Model 2: Core Program Elements

1. *Facility-based Nurse Practitioners/Enhanced Care Nurses*
2. *Assessment and clinical communication tools*
3. *Innovative education*
4. *Enhanced medication management, monitoring, and pharmacy engagement*
5. *Use of telemedicine and information technologies that enable remote clinical assessment, facilitate communication*
24/7 Access to Telemedicine Consultation

- **Internet-based telemedicine consult between on-site CRNPs and NH residents with bedside examination performed by a nurse (RN or LPN).**

RAVEN Pharmacy Interventions
Patient-Centered Enhanced Medication Reviews

**Start**
- RAVEN Clinical Pharmacist reviews clinical information (POLST, labs, medications, etc.) targeting polypharmacy, drug-disease and drug-drug interactions, adverse drug events, and psychoactive medication use.
- RAVEN Clinical Pharmacist applies trigger tool to identify potential adverse drug events related to acute kidney injury, hyperkalemia, hypokalemia, drug-induced anemia, hyponatremia, and hyperglycemia.
- When appropriate, the RAVEN Clinical Pharmacist generates a recommendation and provides it to the facility enhanced care RN/CRNP.
- The facility RN/CRNP and/or Attending Physician review and complete the recommendation.

**Finish**
RAVEN OUTCOME DATA
From Medicare Claims Data

Potentially Avoidable Hospitalizations Rate of Change - PA

Model 1 and 2: Other Outcomes

- 99% POLST completion
- Decrease in facility LPN and CNA attrition
- Increase in skilled capabilities
  - Hypodermaclysis, vent withdrawal, IV meds
- Increased use of communication tools
  - INTERACT III
- De-escalation of transfers, high level treatment, antipsychotics, and depression
- Increased collaboration between hospitals and nursing facilities.
- Increase in facility census
- Standardized order sets and protocols designed to meet the needs of the population.
- Benchmarks (2.9 readmissions per 1000 resident days)
Model 1 and 2: Tools for Success

• Communication, Marketing, Recruitment and Operational Plans that all work together

• Careful facility assessments (samples available upon request)
  – Facility Staffing Assessment Tool
  – Facility Preparedness Survey
  – Individual Education Plans

• Stakeholder FAQs and early discussions (samples available upon request)
  – MDs, RNs, Administration, Resident/Families

• Evaluation built into documentation

Model 1 and 2: Lessons Learned

• If you’ve seen one nursing facility, you’ve seen one nursing facility.
  – Your model may differ slightly in each building
  – Staffing may differ
  – You are a guest

• Facility leadership buy in is key
  – “We are committed to culture change and implementing the interventions into our daily operations.”
  – “We are dedicated to getting our staff the education needed to succeed, even if we have to pay for it.”
Model 1 and 2: Lessons Learned

• You are only as strong as your data
  – Build system analytics and IT into your budget
  – Stakeholders care about very different things
• Document where they document
• Front line staff, embedded into the fabric of care, who are available 24-7 are KEY!
• Build functional, nutritional, and cognitive triggers (NOT disease specific)

Hospice Challenges in NH

• Poor Alignment
  • Patient ownership and turf issues
  • Between Interdisciplinary teams
  • Between patient, family and medical professionals
  • Lack of coordination of care
    • Poor handoff throughout the continuum of care
• NH Factors: Multiple points of Obstruction
  • culture, clinical leadership, staffing, administration
• Financial Barriers
• Patients and Families need education
• Regulatory paranoia and misinterpretation
Model 3: Hospice-NH Collaborative Model

Organizational strategy to expand current NH services to include hospice beds.

- Co-Developed designated hospice space within the partnering NH.
- Create a meaningful collaborative translation of services within the NH
- Beds are SNF licensed beds, set aside for hospice referrals first.
- Hospice philosophy buy-in by all:
  - NH administrators & clinical staff

Model 3: Hospice-NH Collaborative Model

Choosing the Right Partner:

- Nursing Home
  - Must share the mission of providing quality EOL life care.
  - Willingness to assume the same risks
  - Not viewed as an opportunity to cut back on staff or resources or provide less care.
  - MORE care is needed to meet the EOL needs of patients and families.

- Non-for profit vs for profit NH
Model 3: Hospice-NH Collaborative Model
Lessons Learned

Improved Communication:
• Collaborative effort, from leadership to frontline staff, to provide exceptional EOL care.
• Extensive orientation and training of NH staff.
• Hospice staff must become well integrated into the NH staff and culture.
• Share IDT rounds, addressing the needs of patients and families.
• Anticipate and be willing to address issues together.

Hospice Wells House: 22 Hospice beds
– Partnership with Beechwood: 272 SNF licensed beds
– Non profit, ADC 96%
– Payer mix: 20% Medicare/ HMO, 23% private pay, 57% Medicaid

• Staffing model:
  – ADDITIONAL STAFFING: 1 Xtra FT RN, 2 Xtra FT LPNs and 4.5 FT CNAs

• Buy in from leadership on multiple levels:
  • DOH
  • NH Board and Hospice Board
  • DON and clinical staff
  • Medical directors
Model 3: Hospice-NH Collaborative Model
Lessons Learned

Truly a Collaborative Model
Staffing:
  – Staff self selected, applied and interviewed.
  – Staff carefully chosen.
  – Work towards cultural integration and extensive core competency training.
  – Bereavement support offered to staff.
  – Hospice MD/NP round on unit daily.

Model 3: Hospice-NH Collaborative Model
Lessons Learned

Hospice Benefits:
  – Full Medical oversight of patients in the hospice units.
  – Increased aggregate census with NH.
  – Extension of Care Continuity:
    – A discharge disposition from HIPU for patients who no longer meet HIPU criteria.
    – Referrals from existing palliative care programs.
  – Discharge disposition from surrounding palliative care services within hospitals, NH, ALFs, & within the Community.
Model 3: Hospice-NH Collaborative Model
Lessons Learned

Hospice Benefits:

- Opportunity to transfer knowledge and skill sets to other care settings.
- Partnering to create continuity of care.
- Expand opportunities with hospitals, directly impacting discharge efficiencies and re-admission rates.
- Create a template to expand this palliative care model outside of hospice.

Model 3: Hospice-NH Collaborative Model
Lessons Learned

NH Benefits:

- NH viewed as a community partner.
- Hospice is viewed as added service offering with “brand / destination value.”
- Opportunity to increase bed occupancy with specialized offering.
- Honor family requests for hospice.
- Honor patients wish not to die in a hospital.
- Enhance complex case mix index.
Model 3: Hospice-NH Collaborative Model
New Opportunities

- **Transformational period where NHs need to develop their own niche:**
  - Now NHs have specialized offerings: cancer, orthopedic care
  - Hospice EOL care sets them apart

- **Offers an opportunity to bridge the gap between need and unmet need.**

Model 3: Hospice-NH Collaborative Model
New Opportunities

*NH benefits from strengthened relationship / position with hospitals:*

**SNF relies on hospital relationships:**

- NH created a d/c disposition for difficult to place patients in the hospital.
- Provide a safe place for EOL care for patients that are unable to transition back home.
- Dramatically reduce readmission rates.
- Created new NH business offerings.
- NH viewed as a partner...Enhanced position with the hospital system to receive other non-hospice patients.
Model 3: Hospice-NH Collaborative Model
New Opportunities

Other NH Benefits:
- Reimbursement
- Financial Risk Aversion Model
  - It is easier to assume relative risk for short stay residents.
  - Patients with “short term” (<30 days) needs are more likely to be more profitable.
- Less burn out strain on staff = less staff turnover
- Increased staff retention, satisfaction, and expanded skill set.
- Mission enhanced—board & community support.

Model 3: Hospice-NH Collaborative Model
New Opportunities

NH Benefits:

Understanding the Reimbursement Benefits:

- Higher percent of residents can afford private pay for a short stay.
- Medicaid spend down period yields higher reimbursement for NH.
  - Less challenges with “Medicaid-pending” reimbursement strain
- The complexity of the hospice / EOL patient can enhance case mix index.
Model 3: Hospice-NH Collaborative Model
Outcomes

Wells House: Time frame 6/1/13 – 10/9/14

• 117 patients admitted to Wells House
  – 8 patients transferred out
    • 2 transferred underwent ER evaluation only
    • 6 patients were admitted, all for unrelated events
    • 7 of the 8 patients that were transferred returned to Hospice Wells House.
    • 1 patient expired in the hospital s/p PE

  – 5% re-admission rate (6/117 residents).

• LOS 28.89 days

Model 3: Hospice-NH Collaborative Model
Future Directions

• Unique partnerships that offer enhanced quality EOL care to patients and support to families.
• Helped close the quality gap between need and unmet need in NH.
• Offered an opportunity for NH to do things differently and “set themselves apart.”
• Offers the NH new business opportunities and leverage with hospitals.
• Positive impact on hospitalization rate and Medicare spending.
• Future direction is to develop a NH palliative care unit under Medicare A skilled benefit.
Model 3: Hospice-NH Collaborative Model
Outcomes

• Opportunities are emerging for hospice organizations to extend the reach of home-based services to more patients through new palliative care coordination initiatives.

• It’s clear that hospice and palliative care will play central roles as our population ages and healthcare shifts to “right-time, right-place” care. “

Model 3: Hospice-NH Collaborative Model
Future Directions

• Work with HeathCare Systems.
  – Work with EDs, align with Choosing Wisely strategy as a destination for safe and timely ED disposition, avoiding hospitalizations.
  – Form strong relationship with discharge planners
  – Viewed as a hospital avoidance alternative for difficult to place patients with lack of family or social support.
References


- See more at: http://www.ascp.com/sites/default/files/2013/06/20.pdf!