SNF Palliative Care: Consultant/Internal Hybrid Model

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Introduction/Background:

- 1/3 of older adults receive care in a SNF in the last 6 months of life under the Medicare posthospitalization benefit
- 1 in 11 elders will die while enrolled in the SNF benefit
- Increasing age and acuity level, and increasing emphasis via incentives/penalties on hospital and SNF readmissions, make SNF/LTC setting an important focus for palliative intervention.
- Current models are limited and barrier-prone: consultant model, internal model, and hospice model.

Methods:

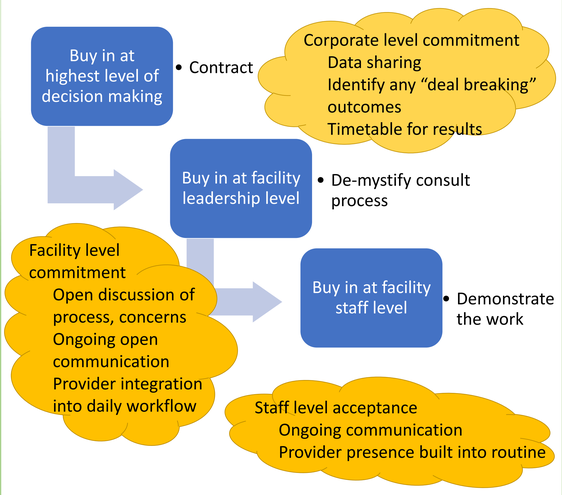
- 70 bed SNF in Howard County, MD with both SAR and LTC residents, initiated 2/23/17
- Daily presence and active communication by palliative provider
- Consult process: order received, record reviewed, patient visit, IDT discussion, documentation, follow up
- Mixed methods used for data collection and review: Patient demographics and diagnosis obtained via retrospective chart review CY 2018 and FY 2018; Productivity via provider practice metrics review, relative value units; System level cost measured via CRISP (Chesapeake Regional Information System for our Patients) pre/post analysis. Staff level culture change assessed via anonymous survey

Results:

- Patient level: **100% of patients acceptance**
- Staff level: 100% correct
- Penetration 16.7%, vs national benchmark 5.4% for inpatient
- System level: 13.8% productivity increase Geriatric attending; **Hospice average LOS increased from 61.7 to 102.87 days;** Local hospital saw **decrease in total charges** and **total visits at 30 day and 90 days;** Largest impact seen in medical/surgical and intensive care charges.

Proposed Model for Integration:

Algorithm/key process



Palliative care can be **integrated** into the **SNF**, achieve **cost savings** to the system, and **fewer transitions** in care.

Take a picture to download more info

Scan me

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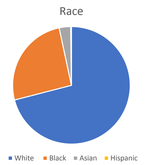
Research Objectives: Illustrate a hybrid model for palliative care in the SNF, blending the consultant and internal models. Describe benefits of this intervention on patient, provider, and larger system levels.

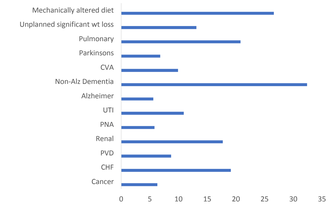
Population:

413 admissions
83.5% Short stays (<100 days)
48.7% ADL function low (MBI)



Age
65-94 88.6%
95 or greater 4.6%

Significant Diagnoses



Culture Change Assessment:

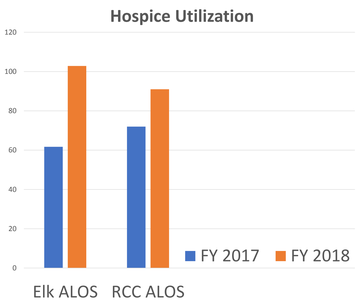
1. Is "palliative" the same as hospice? YES OR NO
2. Has having a palliative NP been a positive experience for your patients? YES OR NO
3. What kind of patients benefit from a palliative consult?
   - A. Patients with uncontrolled symptoms (Ex. Pain, constipation, nausea, agitation, etc)
   - B. Patients with serious illness (ex. Dementia, heart disease, lung disease, kidney disease, cancer, etc)
   - C. Patients whose families are struggling to understand/cope with patient's condition
   - D. Patients facing end of life
   - e. All of the above

COMMENTS:

Patient level Outcomes:

Symptom assessment- 100% ESAS documentation
AD and MOLST review- 100% review documented
Star rating- SNF improved to 5 star rating
MOLST 4b or 4c- 27%

Value to Attending: 13.8% increase in RVU



System level Outcomes: **CRISP Pre/Post results**
Report includes patients from 3 palliative sites, July 2015- Oct 2018
Patients on palliative service for at least 30 days (N= 56), and at least 90 days (N= 32)

*At both time points, significant reduction in charges and visits to hospital
*Average reduction per member at 1 month **$19,801**, at 3 months **$22,383**

Local hospital	Pre	Post
30 Day	total charges $436,585 total visits 30	$19,728 total visits <11
90 Day	total charges $227,096 total visits 21	$45,345 total visits 11