Implementing a Successful Nurse-Driven Community-Based Palliative Care Program in a Skilled Nursing Facility with Primary Care Medical Support.

Atrium Health
Hospice & Palliative Care of Cabarrus County

Introduction

Current State – The need for Community Based Palliative Care in skilled nursing facilities within Charlotte, North Carolina (and surrounding areas)

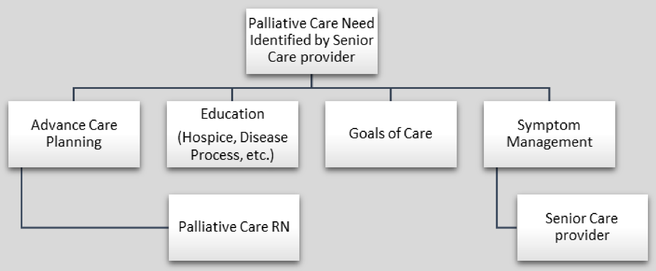
- Most palliative care programs are offered through the inpatient hospital setting, along with some outpatient palliative care clinics.
- Goals of care and advance care planning conversations are often started in the hospital and risk the possibility of not continuing when patients are discharged home or to a long-term care setting.
- The opportunity exists to better support vulnerable adults residing in Skilled Nursing Facilities as they navigate their disease process and decision making.

The Solution - Embed a Palliative Care Nurse into a Skilled Nursing Facility with an already committed Primary Care Medical Support Team

- Hospice & Palliative Care of Cabarrus County (HPCCC) has developed and implemented a nurse-driven palliative care program at Huntersville Oaks, a 168-bed skilled nursing facility in Huntersville, NC.
- Both HPCCC & Huntersville Oaks are part of Atrium Health, a health care system primarily located in North Carolina, which has over 40 hospitals and 900 care locations across the continuum of care.

Program Description

- At Huntersville Oaks, primary care services are provided by Senior Care, Atrium Health's geriatric medical management group.
- Providers consult the on-site Palliative Care Nurse for support with goals of care conversations, advance care planning or educational needs (i.e. hospice, disease progression, etc.).
- Senior Care handles pain and symptom management, with exception to highly complex cases when they consult our palliative care nurse who will work in conjunction with our palliative care nurse practitioner to make recommendations.



The Model

"Contributing to the success of this program has been the method of embedding the Palliative Care Nurse into the facility team and culture."

The Palliative Care Nurse:

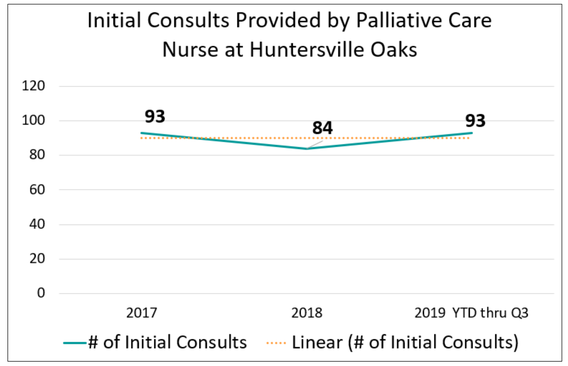
- Facilitates obtaining referral/order for palliative care services from provider, triages the consult and follows patients until goals are met, patient discharges home or transitions to hospice
- Functions as an Advanced Illness Resource for providers and staff
- Offers educational opportunities for facility caregivers
- Participates in rounds
- Is involved in care plan and discharge meetings to help with healthcare navigation
- Participates in monthly Quality meetings to review trends in hospice and palliative care services

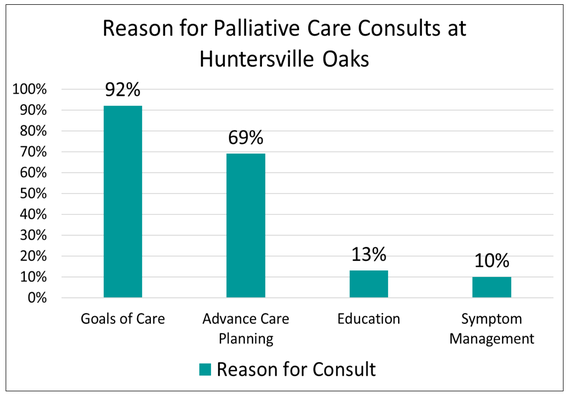
Impact since 2017 program implementation:

- ***270 patients with initial consults***
- ***Average length of stay (ALOS) on Palliative Care service: 56 days***
- ***34% hospice conversion rate***
- ***Supported completion of 87 MOST forms and 43 HCPOA documents***

Outcomes

Results since 2017 program implementation:





Lessons Learned

- Palliative Care services for SNF patients under the Medicare A benefit for rehabilitation can provide earlier support for making informed healthcare decisions.
- To mitigate the patient/family misconceptions of Palliative Care, it is beneficial for the Primary Care team to start the goals of care conversations first and then consult Palliative Care second. Goals can be established earlier and reviewed frequently to help guide the physicians plan of treatment according to the patient's desire, resulting in better outcomes.
- Administrative and medical director support helps promote understanding and earlier access to Palliative Care.

Next Steps

- Justification for additional palliative care staff – to include nurses and social workers.
- Replicate nurse-driven palliative care program at all Atrium Health-owned skilled nursing facilities.
- Continue building relationships with skilled nursing facilities in the community (non-Atrium Health facilities) to extend community based palliative care using an NP / RN / SW model.
- Partner with our System resources on Advance Care Planning (Your Care, Your Choice).

Case Study

Mrs. M is a 91 year old female who moved to Huntersville Oaks when her daughter was no longer able to care for her at home. She has a history of bipolar 1 disorder, lithium use, chronic kidney disease stage IV and late onset Alzheimer's disease with behavioral disturbance. She also lacks decision making capacity.

Mrs. M's daughter has historically struggled with decisions regarding code status, re-hospitalization, hydration at the end of life and feeding tubes. Palliative Care was consulted for ongoing goals of care conversations. During the initial family meeting, the daughter voiced the desire for ongoing aggressive curative measures, as well as her fears of seeing her mom in pain or distress. She expressed the desire for her mom's last days to be as active and comfortable as possible.

The Challenge - Recognizing why the goals discussed were centered around quantity of life verses quality of life and how to support the goals that didn't align with the patient's disease and prognosis.

The Interventions - Follow up conversations with the daughter to establish a relationship and provide support, IDT social worker assisted with coping and grief support, education for the daughter on disease processes and the risks vs. benefits of healthcare decisions. The team also addressed the daughter's misconceptions of hospice care and promoted the benefit of having additional medical support at the patient's residence, Huntersville Oaks.

The Outcomes - The daughter kept Mrs. M's out-patient appointments with the neurologist and nephrologist. Over the course of 19 months, the patient remained involved in facility activities even entering the Beauty Pageant contest complete with gown, make-up and tiara. The daughter was able to initiate dialogue about end-of-life with involved medical providers. Conversations aligned with prior IDT conversations and code status was changed to DNR. She elected hospice services and her goals are now comfort oriented. Mrs. M is currently under hospice care in her final months of life.

Pictured: Huntersville Oaks

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