OPTIMISTIC Project Leadership

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➔Greg A. Sachs, MD – Co-Project Directors
Objectives

1. Describe the integration of palliative care as an intervention to reduce potentially avoidable hospitalizations of nursing home residents.

2. Describe a protocol, involving stakeholders at multiple levels, to implement standardized Advance Care Planning in nursing homes.

3. Identify 3 challenges to implementation of palliative care programs in nursing homes and strategies to overcome these challenges.
Who lives in nursing homes?

➔ 1.4 million people; over 15,000 facilities
➔ Care for patients with acute rehab and long term care needs
➔ 2/3 with moderate - severe cognitive impairment
➔ Over 1/3 are incontinent
Audience Poll:

What % of people die in a nursing home?

- 5%
- 10%
- 25%
- 50%
Nursing homes (NH) are an important site for palliative care

Near the end of life:

➔ By 2020, NHs will be the site of death for an estimated 40% of the U.S. population

➔ 70% of people with advanced dementia die in NHs

Need for symptom management:

➔ Over 1/3 report pain in last 5 days
Currently, we fall short…

➔ Inconsistent quality

➔ Poor pain control

➔ February 2014 OIG report – an estimated 22% of patients experienced an adverse event after admission to a NH
  – Substandard treatment
  – Inadequate resident monitoring
  – Failure or delay of necessary care
Distressing symptoms, including dyspnea (46.0%) and pain (39.1%), were common.

In the last 3 months of life, 40.7% of NH residents underwent at least one burdensome intervention.
Hospital transfers are common, expensive, and burdensome…

➔ In 2011, NHs transferred ¼ of residents to hospitals for inpatient admissions
  – Medicare spent $14.3 billion on these hospitalizations

➔ Impact on residents and their families:
  – Disruption of care
  – Risk of complications and infections
  – Likelihood of reduced functioning on return

ASPE 2010; OIG 2013
Many hospital transfers are unnecessary

➔ 30 - 67% of hospitalizations of NH residents are considered “potentially avoidable”

- Could have been treated in facility

- Could have been prevented altogether

- Unwanted or inconsistent with goals of care
Multiple reasons unnecessary transfers occur

→ Physician/NP presence in the facility for on-site assessment for a change in status

→ Inconsistent access to timely treatments and diagnostic tests

→ Fears of liability

→ Staff time and training

→ Communication breakdowns among staff/families/residents/providers
Key palliative care gaps in NHs contribute to hospital transfers

➔ Lack of systematic Advance Care Planning

➔ Nursing home staff with limited time, knowledge, skills related to palliative care
Centers for Medicare and Medicaid (CMS) Demonstration Project

Initiative to Reduce Avoidable Hospitalizations of Nursing Facility Residents

- Funded through the CMS Innovation Center and Medicare - Medicaid Coordination Office
- Goal: Identify and scale-up successful demonstration projects to transform health care in the United States
- 4 year initiative (2012 - 2016)
- 15 partner facilities required, with average census >100 residents
CMS Enhanced Care and Coordination Provider Demonstration Sites

Source: Centers for Medicare & Medicaid Services
Intervention

OPTIMISTIC
Optimizing Patient Transfers, Impacting Medical quality, and Improving Symptoms: Transforming Institutional Care

19 partner facilities in Central Indiana

Core components:
- improving medical care
- enhancing transitional care
- access to palliative care

RN (19) embedded in each facility to lead delivery of the intervention, supported in managing residents by NPs (6) who cover a group of facilities
OPTIMISTIC RN Duties

➔ **Acute Change in Condition**– INTERACT implementation; mentoring and coaching

➔ **Support NPs** – identify patients; communication

➔ **Advance Care Planning** – goal 2-3 patients per week

➔ **Collaborative Care Reviews** – gather information

➔ **Quality Improvement** – transfer root cause analyses; integrate into facility QI efforts

OPTIMISTIC NP Duties

➔ **Acute change in condition**

➔ **Transition Visits**

➔ **Collaborative Care Reviews** – assess; provide recommendations

➔ **Support RNs in education efforts**
The OPTIMISTIC Model

Data Driven Quality Improvement

Education and Training

Medical Care Support

Palliative Care Support

Transitional Care Support

Nursing Home

Long Stay Residents and Families
Medical Care Core Goals

Interdisciplinary team approach with patient-centered, standardized care protocols to:

- Enhance care of chronic conditions and geriatric syndromes
- Identify and treat emergent acute conditions
Transitional Care Core Goals

➔ When transfer from the facility is needed:

– Improve provider-to-provider communication

– Facilitate medical information exchange

– Follow-up transition visits on return to reduce adverse events and readmissions
Palliative Care Core Goals

➔ Reduce burdensome treatments, reduce transitions, increase referral to specialist palliative care and hospice, as appropriate:

– Education

– Palliative care consultation

– Advance Care Planning

– Symptom management
Palliative Care Core Tools

➔ End-of-Life Nursing Education Consortium (ELNEC) Geriatric

➔ Palliative care case consultation
  – once a month NPs bring cases to a palliative care specialist to discuss and provide recommendations
Audience Poll:

Are you in a state with a POLST program?

– Yes
– No
– I don’t know
Palliative Care Core Tools (cont.)

➔ Implementation of Indiana version of Physician Orders for Life-Sustaining Treatment (POLST)
  – First available in Indiana on July 1, 2013

➔ Respecting Choices Last Steps® POLST Facilitation
The POLST Paradigm

➔ POLST = Physician Orders for Life Sustaining Treatment
  – Converts treatment preferences into actionable medical orders
  – Advanced chronic progressive disease and frailty; terminal illness
  – Transfers across treatment settings with patient
  – Recognizable, standardized order form
Respecting Choices®

➔ Last Steps Respecting Choices® POLST facilitation

➔ Conversations about goals, values and the POLST that take 45-60 minutes to complete

➔ 6 hours of on-line training and about 20 hours of in-person role-play and instruction
ACP Implementation

Prior to launching this component of OPTIMISTIC, members of the leadership team met with corporate NH owners and managers, as well as primary care providers:

– Integration into facility policy; model policy provided
– Documentation protocol in EMR, paper charts
– Understanding of current practices to document patient wishes and identification of areas of improvement
– Identify and address concerns regarding nurse-led ACP discussions
## OPTIMISTIC ACP Outcomes*

<table>
<thead>
<tr>
<th>Preliminary Characteristics</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Facilities Characteristics</strong></td>
<td></td>
</tr>
<tr>
<td>Nursing Facilities participating in OPTIMISTIC</td>
<td>19</td>
</tr>
<tr>
<td><strong>Population (August 2013-December 2014)</strong></td>
<td></td>
</tr>
<tr>
<td>Average Daily Census OPTIMISTIC Enrollees</td>
<td>1833</td>
</tr>
<tr>
<td><strong>ACP Intervention (August 2013-December 2014)</strong></td>
<td></td>
</tr>
<tr>
<td>Number of Unique Residents</td>
<td>894</td>
</tr>
<tr>
<td>Median number of ACP conversations per resident</td>
<td>1</td>
</tr>
<tr>
<td>(Range: 1-7 ACP conversations per resident)</td>
<td></td>
</tr>
<tr>
<td>Number of ACP conversations</td>
<td>1328</td>
</tr>
<tr>
<td>Number of ACP conversations resulting in a change in orders Number of new POST forms completed</td>
<td>699</td>
</tr>
<tr>
<td>Average length of time for ACP discussions (min)</td>
<td>575</td>
</tr>
</tbody>
</table>

*Preliminary Data

*Source: Buente et al., 2015 (poster)*
## ACP Audit Results
### April 2015 “Snapshot”

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>n = 1591</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence of ACP Discussion</td>
<td>669</td>
<td>42.0%</td>
</tr>
<tr>
<td>ACP by OPTIMISTIC staff</td>
<td>465</td>
<td>69.5%</td>
</tr>
<tr>
<td>ACP by other</td>
<td>204</td>
<td>30.5%</td>
</tr>
<tr>
<td>No Evidence of ACP in file</td>
<td>922</td>
<td>58.0%</td>
</tr>
</tbody>
</table>
## Audit: Barriers to ACP

### Reasons for No ACP Discussion

<table>
<thead>
<tr>
<th>Reason</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have not gotten to this resident yet</td>
<td>531</td>
<td>47.2%</td>
</tr>
<tr>
<td>Other orders in place/ACP by facility staff</td>
<td>204</td>
<td>18.1%</td>
</tr>
<tr>
<td>Ineligible</td>
<td>193</td>
<td>17.2%</td>
</tr>
<tr>
<td>Unable to schedule</td>
<td>90</td>
<td>8.0%</td>
</tr>
<tr>
<td>Resident/Family Member/Guardian Declined</td>
<td>56</td>
<td>5.0%</td>
</tr>
<tr>
<td>Facility staff gatekeeping</td>
<td>35</td>
<td>3.1%</td>
</tr>
<tr>
<td>Not ready to talk about it yet</td>
<td>16</td>
<td>1.4%</td>
</tr>
</tbody>
</table>
Audit: Most Recent Orders in Medical Record

<table>
<thead>
<tr>
<th></th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>POST Form</td>
<td>462</td>
<td>29%</td>
</tr>
<tr>
<td>POST – Full Code</td>
<td>73</td>
<td>16%</td>
</tr>
<tr>
<td>POST – DNR</td>
<td>389</td>
<td>84%</td>
</tr>
<tr>
<td>Non-POST Orders</td>
<td>1120</td>
<td>71%</td>
</tr>
<tr>
<td>Full Code</td>
<td>459</td>
<td>41%</td>
</tr>
<tr>
<td>DNR</td>
<td>662</td>
<td>56%</td>
</tr>
<tr>
<td>Do Not Intubate</td>
<td>49</td>
<td>4%</td>
</tr>
<tr>
<td>Do Not Hospitalize</td>
<td>8</td>
<td>1%</td>
</tr>
</tbody>
</table>

*N=1582* *missing data on n = 10*
### Audit: Who Prepared the POST?

<table>
<thead>
<tr>
<th>Individual</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPTIMISTIC Staff Member</td>
<td>356</td>
<td>77%</td>
</tr>
<tr>
<td>Facility Staff</td>
<td>58</td>
<td>13%</td>
</tr>
<tr>
<td>MD/NP</td>
<td>23</td>
<td>5%</td>
</tr>
<tr>
<td>Unknown Person</td>
<td>10</td>
<td>2%</td>
</tr>
<tr>
<td>Blank</td>
<td>15</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>462</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
Implementation Challenges

➔ Time – logistic challenges of setting up meetings and setting aside time for discussions
  – Family availability
  – Need for multiple conversations

➔ Facility engagement – ownership of other staff in facilities for ACP

➔ Lack of specialized palliative care consultation or expertise available
Implementation Strategies

➔ Creativity and persistence in scheduling
  – Take advantage of care plan or other meetings
  – Conference in family members via phone

➔ Enlist providers to encourage residents and families to participate

➔ Structured approach using ACP assignment list to target conversations and track
Implementation Strategies

➔ Continued meetings with facility leadership needed to emphasize importance and foster collaborative approaches

➔ After training a facility staff member, continue to support him/her in trying out new skills
Implementation Strategies

➔ Increase in residents with identified goals of “comfort care” and clearly stated desire to avoid hospital transfer leads to need for increased skills to manage symptoms in place

  – Education of OPTIMISTIC NPs to provide specialized care

  – Continued case consultations with OPTIMISTIC palliative care MD

➔ Education sheets for facility staff and for families/residents on palliative care topics
MAKING DECISIONS ABOUT GOING TO THE HOSPITAL
for RESIDENTS & FAMILIES

WHY ARE DECISIONS ABOUT GOING TO THE HOSPITAL IMPORTANT?
Hospitalization has risks and benefits. The decision to go to the hospital should be based on residents’ overall goals of care. If the main goal of care is to keep the resident comfortable, it may be possible to avoid going to the hospital to receive supportive care in the nursing home.

WHAT ARE THE BENEFITS OF GOING TO THE HOSPITAL?
If the goals of care include aggressive medical care or intensive comfort care that cannot be safely provided in the nursing home, the hospital may be the best option. Some of the most common reasons a resident may go to the hospital are to treat infections like pneumonia or manage symptoms like difficulty breathing, swelling, or heart irregularities that could result in harm or death if untreated. Hospitals are able to provide services such as CT scans and access to specialty medical care that is not available in a nursing home. The hospital can also manage severe pain as well as treat broken bones, cuts that need stitches, and other symptoms that cannot be safely managed in the nursing home.

WHAT ARE THE RISKS OF GOING TO THE HOSPITAL?
Going to the hospital exposes the resident to a new environment and schedule which may be stressful. For older adults, hospitalization may also result in other harms including drug reactions, delirium (confused thinking), falls, hospital-acquired infections, loss of independence due to being bed-bound, malnutrition, and dehydration, declines in one’s ability to do self-care, and pressure ulcers among others.

WHAT ARE THE BENEFITS OF STAYING IN THE NURSING HOME TO RECEIVE CARE?
The benefits of staying in the nursing home include being in a familiar environment with personal belongings, receiving care from staff and clinicians who know the resident well, and avoiding hospital-associated medical problems. A resident may be able to stay in the nursing home and receive care and treatments, including lab tests, x-rays, oxygen, medications, monitoring with measuring vital signs (such as blood pressure) as well as medical care. A decision to decline hospitalization “right now” can always be changed, if needed.
Next Steps

➔ Development of comfort care order sets

➔ Development of a specialized palliative care RN role
  – Support all RNs in ACP
  – Staff education in palliative and end of life skills
What does success look like?

➔ ACP discussions are the standard of care
  – All residents and families are given the opportunity to engage in them

➔ ACP is clearly and consistently documented.

➔ Point people in the facility develop ownership for ACP and palliative care – integrated into their jobs

➔ Ability to treat in place, particularly for people who want to avoid hospital transfers, becomes an expectation
Testimonial from the field
“I’m a new RN and wasn’t sure what to do when I realized one of my residents was actively dying. She had advanced dementia and her family was clear they did not want her hospitalized again. The OPTIMISTIC nurse was at my side and guided me through taking care of her. She showed me how to position her for increased comfort, tracked down a radio so we could play her favorite music, and talked with me about what to expect. The OPTIMISTIC nurse made the process seem natural for me. She coached me through talking with the family. When she passed away during my shift, I felt confident that I had given the best care that I could.”
The OPTIMISTIC Clinical Team
The OPTIMISTIC Leadership Team

Mary Ersek  Melanie Parks
Steve Counsell  Greg Arling
Bryce Buente  Kathleen Unroe
Samuel Gurevitz  Tom Haithcoat
Anne Thomas  Shannon Effler
Brittany Bernard  Greg Sachs
Russell Evans  Kathy Frank
Arif Nazir  Ravan Carter
Monica Tegeler  Greg Gramelspacher
Lidia Dubicki  Laura Holtz
John Price  Ellen Miller
Thank you!

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