Embedding Palliative Care in Nursing Homes: The OPTIMISTIC Experience

Kathleen T. Unroe, MD, MHA

Tuesday, August 18, 2015

Center to Advance Palliative Care™
capc

OPTIMISTIC Project Leadership

- Susan Hickman, PhD – Palliative Care Core Lead
- 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

Julie Turkewitz, 2012

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:

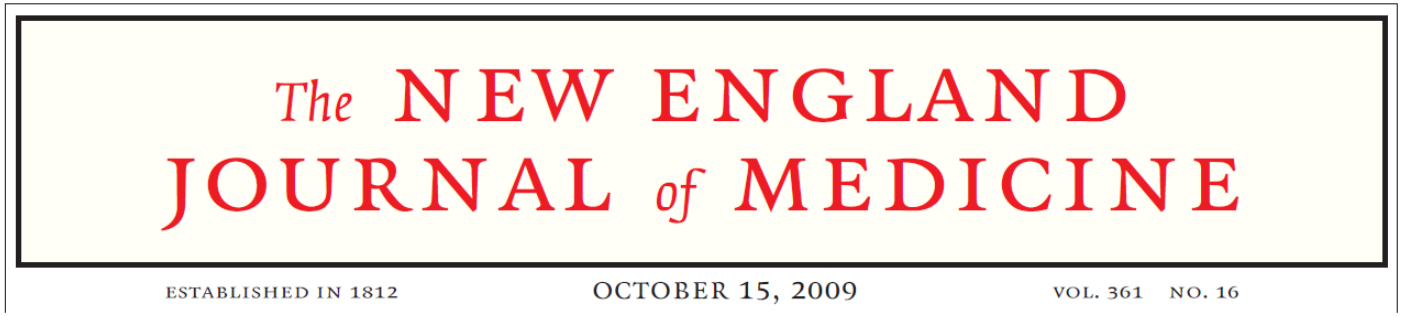
- ➔ By 2020, NHs will be the site of death for an estimated 40% of the U.S. population
- ➔ 70% of people with advanced dementia die in NHs

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



The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 OCTOBER 15, 2009 VOL. 361 NO. 16

The Clinical Course of Advanced Dementia

Susan L. Mitchell, M.D., M.P.H., Joan M. Teno, M.D., Dan K. Kiely, M.P.H., Michele L. Shaffer, Ph.D., Richard N. Jones, Sc.D., Holly G. Prigerson, Ph.D., Ladislav Volicer, M.D., Ph.D., Jane L. Givens, M.D., M.S.C.E., and Mary Beth Hamel, M.D., M.P.H.

ABSTRACT

- 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

capc Center to Advance Palliative Care

Intervention

OPTIMISTIC

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**s (19) embedded in each facility to lead delivery of the intervention, supported in managing residents by **NP**s (6) who cover a group of facilities

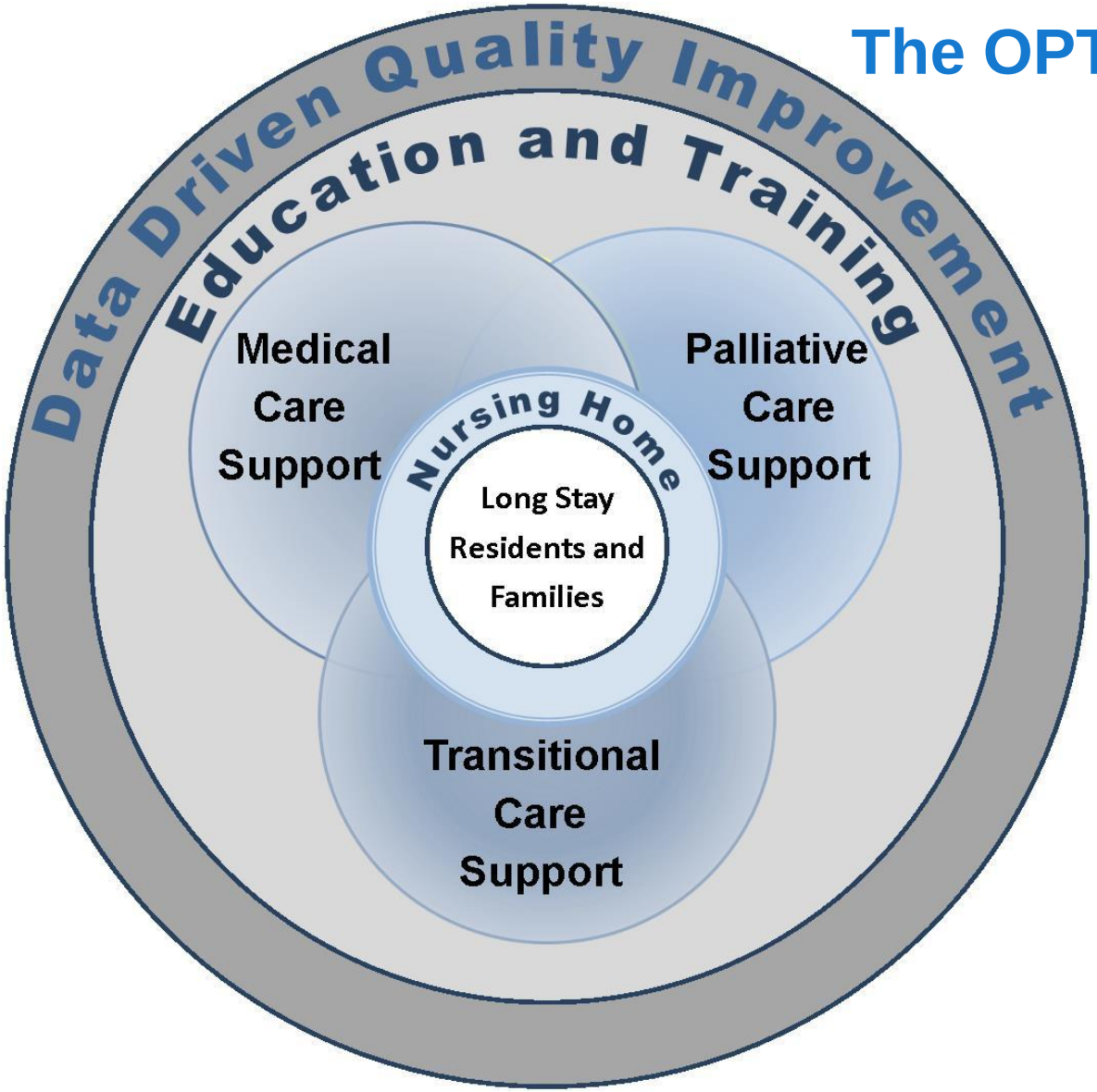
OPTIMISTIC RN Duties

- **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



capc Center to Advance Palliative Care

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

INDIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (POST)

State Form 55317 (6-13)
Indiana State Department of Health – IC 16-36-6

INSTRUCTIONS: Follow these orders first. Contact treating physician, advanced practice nurse, or physician assistant for further orders if indicated. Emergency Medical Services (EMS) should contact Medical Control per protocol. These medical orders are based on the patient's current medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section. HIPAA permits disclosure to health care professionals as necessary for treatment. Original form is personal property of the patient.

Patient Last Name	Patient First Name	Middle Initial

Birth date *(mm/dd/yyyy)*	Medical Record Number	Date prepared *(mm/dd/yyyy)*

A *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): *Patient has no pulse AND is not breathing.*

☐ Attempt Resuscitation/CPR ☐ Do Not Attempt Resuscitation (DNR)

When not in cardiopulmonary arrest, follow orders in **B, C** and **D**.

B *Check One*

MEDICAL INTERVENTIONS: *If patient has pulse AND is breathing OR has pulse and is NOT breathing.*

☐ *Comfort Measures (Allow Natural Death)*: Treatment Goal: Maximize comfort through symptom management. Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer to hospital only if comfort needs cannot be met in current location.

☐ *Limited Additional Interventions*: Treatment Goal: Stabilization of medical condition. In addition to care described in Comfort Measures above, use medical treatment for stabilization, IV fluids (hydration) and cardiac monitor as indicated to stabilize medical condition. May use basic airway management techniques and non-invasive positive-airway pressure. Do not intubate. Transfer to hospital if indicated to manage medical needs or comfort. Avoid intensive care if possible.

☐ *Full Intervention*: Treatment Goal: Full interventions including life support measures in the intensive care unit. In addition to care described in Comfort Measures and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs.

C *Check One*

ANTIBIOTICS:

☐ Use antibiotics for infection only if comfort cannot be achieved fully through other means.

☐ Use antibiotics consistent with treatment goals.

D *Check One*

ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and fluid by mouth if feasible.

☐ No artificial nutrition.

☐ Defined trial period of artificial nutrition by tube. (Length of trial: _____ Goal: _____)

☐ Long-term artificial nutrition.

E

DOCUMENTATION OF DISCUSSION: Orders discussed with *(check one)*:

☐ Patient (patient has capacity) ☐ Health Care Representative

☐ Legal Guardian / Parent of Minor ☐ Health Care Power of Attorney

SIGNATURE OF PATIENT OR LEGALLY APPOINTED REPRESENTATIVE

My signature below indicates that my physician discussed with me the above orders and the selected orders correctly represent my wishes.
If signature is other than patient's, add contact information for representative on reverse side.

Signature (***required by statute***)	Print Name (***required by statute***)	Date (***required by statute***) *(mm/dd/yyyy)*

F

SIGNATURE OF PHYSICIAN

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's **current** medical condition and preferences.

Print Signing Physician Name (***required by statute***)	Physician Office Telephone Number (***required by statute***) ( ) _____ – _____	License Number (***required by statute***)

Physician Signature (***required by statute***)	Date (***required by statute***) *(mm/dd/yyyy)*	Office Use Only

Page 1 of 2

Respecting Choices®

- Last Steps Respecting Choices® POLST facilitation
  - http://www.gundersenhealth.org/respecting-choices

- 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*

Preliminary Characteristics	*Number*
Facilities Characteristics	
Nursing Facilities participating in OPTIMISTIC	19
Population (August 2013-December 2014)	
Average Daily Census OPTIMISTIC Enrollees	1833
ACP Intervention (August 2013- December 2014)	
Number of Unique Residents	894
Median number of ACP conversations per resident	1
(Range: 1-7 ACP conversations per resident)	
Number of ACP conversations	1328
Number of ACP conversations resulting in a change in orders Number	699
of new POST forms completed	575
Average length of time for ACP discussions (min)	40

**Preliminary Data*

Source: Buente et al., 2015 (poster)

ACP Audit Results
April 2015 "Snapshot"

n = 1591	Count	Percent
Evidence of ACP Discussion	669	42.0%
ACP by OPTIMISTIC staff	465	69.5%
ACP by other	204	30.5%
No Evidence of ACP in file	922	58.0%

Audit: Barriers to ACP

Reasons for No ACP Discussion n = 1125		
	Count	Percent
Have not gotten to this resident yet	531	47.2%
Other orders in place/ACP by facility staff	204	18.1%
Ineligible	193	17.2%
Unable to schedule	90	8.0%
Resident/Family Member/Guardian Declined	56	5.0%
Facility staff gatekeeping	35	3.1%
Not ready to talk about it yet	16	1.4%

Audit: Most Recent Orders in Medical Record

N=1582*	Count	Percent
POST Form	462	29%
POST – Full Code	73	16%
POST – DNR	389	84%
Non-POST Orders	1120	71%
Full Code	459	41%
DNR	662	56%
Do Not Intubate	49	4%
Do Not Hospitalize	8	1%

**missing data on n = 10*

Audit: Who Prepared the POST?

Individual	Count	Percent
OPTIMISTIC Staff Member	356	77%
Facility Staff	58	13%
MD/NP	23	5%
Unknown Person	10	2%
Blank	15	3%
Total	462	100%

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

Education sheets

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 and 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 are 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?

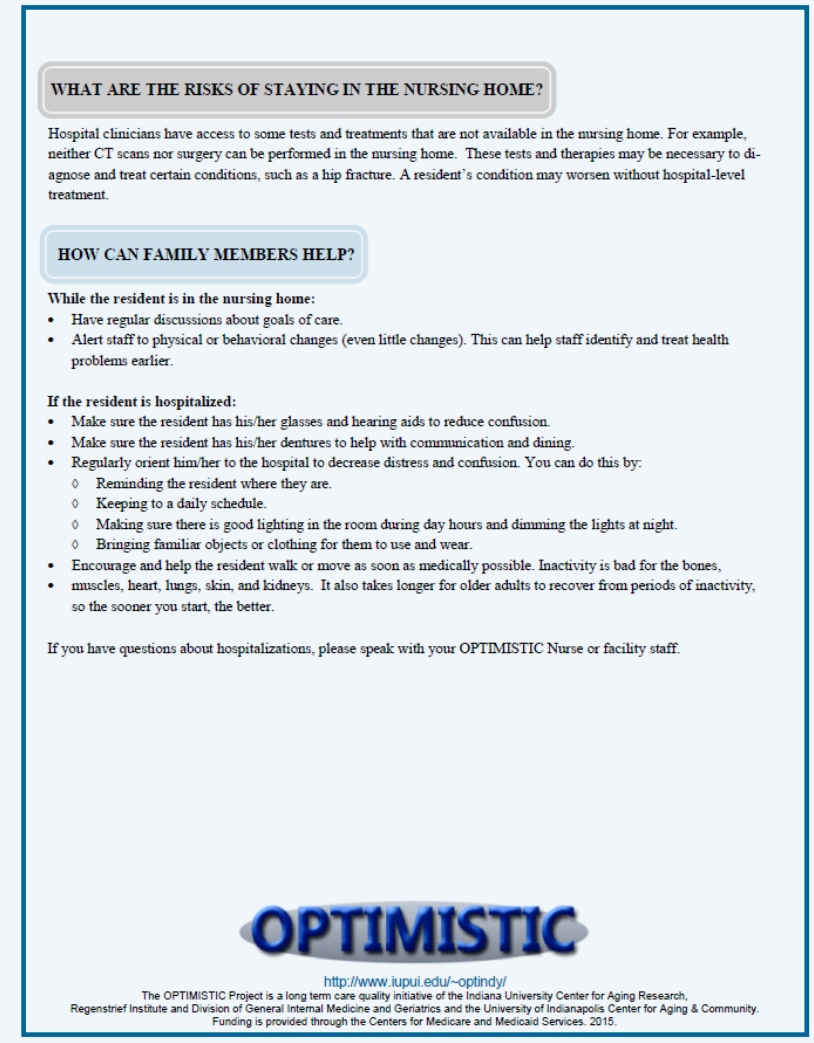
Going to the hospital exposes the resident to a new environment and schedule which may be stressful. For older adults, hospitalization may also result in other harms including drug reactions, delirium (sun-downing or confused thinking), falls, hospital-acquired infections, loss of independence due to being bed-bound, malnutrition and/or dehydration, declines in one's ability to do self-care, and pressure ulcers/bed sores 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 tests and treatments, including lab tests, x-rays, oxygen, antibiotics, monitoring with measuring vital signs (such as blood pressure) we well as medical care. A decision to decline hospitalization "right now" can always be changed, if needed.

OPTIMISTIC

Optimizing Patient Transfers, Impacting Medical Quality, and Improving Symptoms: Transforming Institutional Care
http://www.iupui.edu/~optindy/



WHAT ARE THE RISKS OF STAYING IN THE NURSING HOME?

Hospital clinicians have access to some tests and treatments that are not available in the nursing home. For example, neither CT scans nor surgery can be performed in the nursing home. These tests and therapies may be necessary to diagnose and treat certain conditions, such as a hip fracture. A resident's condition may worsen without hospital-level treatment.

HOW CAN FAMILY MEMBERS HELP?

While the resident is in the nursing home:

- Have regular discussions about goals of care.
- Alert staff to physical or behavioral changes (even little changes). This can help staff identify and treat health problems earlier.

If the resident is hospitalized:

- Make sure the resident has his/her glasses and hearing aids to reduce confusion.
- Make sure the resident has his/her dentures to help with communication and dining.
- Regularly orient him/her to the hospital to decrease distress and confusion. You can do this by:
  - Reminding the resident where they are.
  - Keeping to a daily schedule.
  - Making sure there is good lighting in the room during day hours and dimming the lights at night.
  - Bringing familiar objects or clothing for them to use and wear.
- Encourage and help the resident walk or move as soon as medically possible. Inactivity is bad for the bones,
- muscles, heart, lungs, skin, and kidneys. It also takes longer for older adults to recover from periods of inactivity, so the sooner you start, the better.

If you have questions about hospitalizations, please speak with your OPTIMISTIC Nurse or facility staff.

OPTIMISTIC

http://www.iupui.edu/~optindy/

The OPTIMISTIC Project is a long term care quality initiative of the Indiana University Center for Aging Research, Regenstrief Institute and Division of General Internal Medicine and Geriatrics and the University of Indianapolis Center for Aging & Community.
Funding is provided through the Centers for Medicare and Medicaid Services. 2015.

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."

Unroe et al JAGS 2015

The OPTIMISTIC Clinical Team

The OPTIMISTIC Leadership Team

Thank you!

Retrieved from http://www.wthr.com/story/25406891/2014/05/01/optimistic-health-care-study-aims-at-saving-lives-money

Kathleen Unroe

kunroe@iu.edu

@kathleenunroe