



National Hospice and Palliative Care Organization
Palliative Care Resource Series

**PALLIATIVE CARE IN THE
NURSING HOME SETTING**

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INTRODUCTION

As healthcare reform rapidly moves into every sector of the care system, nursing homes are under increased pressure and scrutiny to deliver value based care - high quality care at reduced costs. Enhanced regulatory reform, decreased reimbursement rates, and increased quality reporting requirements are part of the new reality for nursing home administrators. As the majority of nursing home residents die in that setting, providing excellent end-of-life care is important. Aligning nursing home care with hospice and palliative care can create a win- win situation for both parties.

This resource will focus on ways in which palliative care programs can collaborate with nursing homes and senior administrators to enhance the care of the residents in their facilities.

CURRENT NURSING HOME ENVIRONMENT

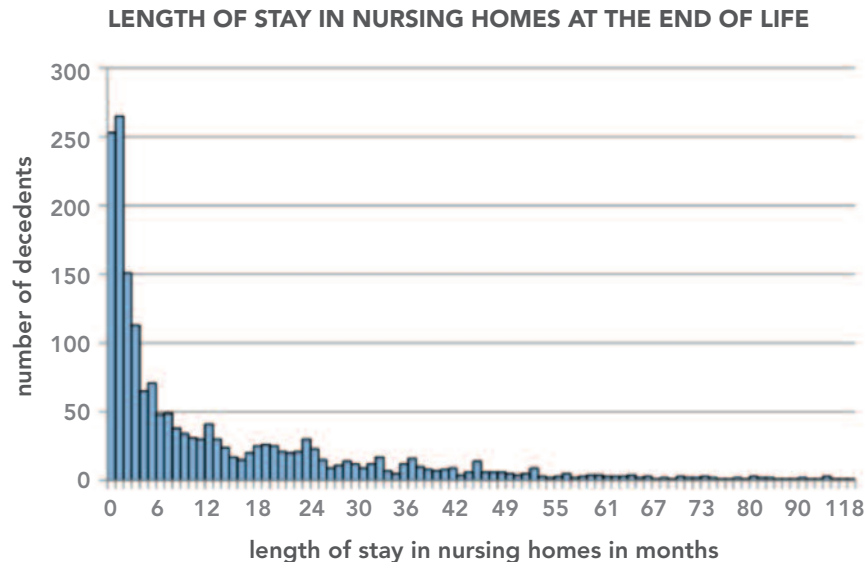
When nursing home administrators are asked "What keeps you up at night?" responses vary from low occupancy levels to high readmission rates. Following are some of the facts surrounding nursing homes today:

- Although the aging population in this country is growing, the overall number of skilled nursing facilities has decreased in the last decade from 16,179 to 15,650 facilities, with approximately 1.7 million beds.¹ The number of patients served has also dropped from 1.4 million in 2005 to 1.3 million in 2015. This change is believed to be fueled by two factors; the downturn in the economy that occurred between 2007 and 2009 and the increase in offerings of home and community based services for Medicaid patients.
- Medicaid is currently the primary payer for 57% of nursing home residents. In addition, nursing home reimbursement for Medicare patients is now at 14%. 29% is provided by private insurance plans, other payers and other individuals.²
- Nursing home administrators are dealing with multiple payors from Medicare Advantage programs, Medicaid and private long term insurance plans, each with different reimbursement streams and plans.
- Staff turnover remains a challenge as does balancing case mix ratios.
- A Star ratings program is now in place that is putting increased scrutiny on quality measures.
- New partnerships are forming with hospital or healthcare systems as nursing homes enter into bundled payment pilots or agreements with accountable care organizations (ACOs).
- Reducing readmissions has become a major focus as administrators prepare for penalties if their facility is an outlier because of the number of individuals sent back to a hospital within 30 days of their SNF admission.
- In January 2015, HHS announced a goal that by 2018, 90% of all Medicare payments will be tied to quality or value through programs such as value based purchasing and readmission reduction programs. Nursing homes, and every other Medicare provider type, have a renewed interest in partnering with those who can assist in improving quality, lowering readmission rates and lowering costs.³

BENEFITS OF COLLABORATION AND VALUE PROPOSITION OF PALLIATIVE CARE

1. Increased Proportion of Dying Patients in Nursing Homes

A recent study revealed that up to 65% of nursing home residents die within 12 months of nursing home placement,⁴ with the majority of these deaths occurring in the first six months after admission. These statistics highlight the importance of the provision of excellent end-of-life care to nursing home residents.



Dementia diagnoses account for up to two-thirds of all nursing home admissions, and are often driven by behavioral issues. It is projected that sixteen million Americans will suffer from dementia by 2050.⁵ Deaths from Alzheimer's increased 71 percent from 2000 to 2013, while deaths from other major diseases (including heart disease, stroke, breast and prostate cancer, and HIV/AIDS) decreased. Alzheimer's disease is currently the 6th leading cause of death in the United States and the 5th leading cause of death for those aged 65 and older.⁶

In past years, there has been a high use of antipsychotic medications for patients in nursing homes with Alzheimer's and other dementias. The National Partnership to Improve Dementia Care in Nursing Homes was formed by CMS in 2012 to improve the quality of care for individuals with dementia living in nursing homes. Its specific focus is on protecting residents from being prescribed antipsychotic medications unless there is a valid, clinical indication and a systematic process to evaluate each individual's need.

Data collected by the Partnership shows that in Q4 2011, 23.9% of long-stay nursing home residents were receiving an antipsychotic medication. Since then, there has been a decrease in anti-psychotic use to a national prevalence of 17.4% in Q3 2015.⁷

2. Nursing Homes Held Accountable for Quality

Understanding the 5 Star Ratings for Nursing Homes will help palliative care organizations identify ways in which they can partner to improve ratings, especially in the area of quality measures. These ratings were created as a way to help consumers choose from among facilities, and can be found on the Nursing Home Compare website. [<https://www.medicare.gov/nursinghomecompare/search.html>]

The ratings are based on health inspections, staffing, and quality measures, which add up to one overall rating. The highest rating a facility can achieve is five stars. While none of the quality measures pertain specifically to end-of-life care at this time, they will be used in the future to help quantify pay for performance.

There are eight long stay quality metrics and three short stay measures. The long stay measures include the following:

- data on falls
- use of physical restraints
- urinary tract infections
- assistance with tasks of daily living
- moderate to severe pain
- pressure ulcers
- use of catheters
- use of antipsychotic medications

The three short stay measures include:

- moderate to severe pain
- new or worsened pressure ulcers
- antipsychotic medications

When working with a particular nursing home, it is important to understand where the facility ranks in terms of quality measures and to determine how palliative care can help improve their scores. One example is the reduction of antipsychotic use in long-stay nursing home residents. While CMS has announced that it met the initial goal of reducing the national prevalence of antipsychotic use in long-stay nursing home residents by 15.1%, the new goal is a 30% reduction by the close of 2016, using the baseline rate of Q4, 2011 scores.

3. Nursing Homes Are Likely to be Penalized for High Readmission Rates

Currently, 23.5% of Medicare patients who are discharged from a hospital to a nursing home are readmitted to the hospital within 30 days⁸. The American Health Care Association's 2013 Quality Report currently recommends decreasing 30 day readmissions to < 15 %.

Included in the Protecting Access to Medicare Act of 2014 is a value-based purchasing (VBP) program for skilled nursing facilities (SNFs). This program establishes a hospital readmissions reduction program for providers, encouraging SNFs to address potentially avoidable readmissions by establishing an incentive pool for high performers.

Palliative care programs can help reduce re-admissions by improving management of symptoms, helping patients and families to define their goals of care, and by transitioning appropriate patients to hospice.

4. Reimbursement Shifting to Pay For Performance

As we move away from a fee for service (FFS) reimbursement stream toward pay for performance, it will be important to make the case to nursing homes regarding how palliative care adds value. On January 26, 2015, the Centers for Medicare and Medicaid Services issued a news release stating that by 2016 at least 30% of traditional FFS will be tied to quality or value through alternative models like Accountable Care Organizations, and will increase to 50% by 2018, and 90% by 2019. On March 4, 2016, HHS reported that it had met its goal of tying 30% of Medicare payments to quality more than 10 months early because of the Affordable Care Act.

In 2014, the Institute of Medicine released its report “Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life”. The Institute’s recommendations emphasized the importance of palliative care training and education. Specifically, the report addressed the following:

- the importance of symptom management
- effective communication
- advance care planning
- goal based care and
- continuity across settings while addressing patient’s social needs.

Healthcare is shifting from a traditional, physician led, acute clinical needs based, silo cared, FFS model to a transformational care model which is longitudinal, goal directed, team based and transcends care settings with payment based on value based purchasing.

DESIGNING A PALLIATIVE CARE PROGRAM

1. Develop a Sound Business Plan

Developing a sound operational and business plan for a palliative care program is extremely important. This plan should include scope of service, team structure, outcome metrics, and a budget/financial plan. Standardization around intake, administrative support, clinical care, and quality should be defined. Some programs are able to offer a wide array of services (social work, psychologist, RN case management) while others have limited funding for supportive services.

Defining the scope of a palliative care program from the start is very important. It is a mistake to try to be all things to all people; it is better to under promise and over deliver.

2. Decide Eligibility Criteria and Understand Importance of Prognostication

Eligibility criteria should include those patients with serious or life limiting illnesses. Excluded should be those who are referred for chronic pain, post-surgical issues, and substance abuse. It is helpful to develop a risk stratification model where the sickest patients are identified and prioritized. An example is a risk stratification tool which develops a 12-point system based on demographics (age, gender), disease, clinical signs and symptoms (assists of daily living, anorexia), and adverse events (hospitalizations, emergency room visits)⁹. Other tools which are helpful in prognostication are found in the Mortality Risk Index for Dementia patients¹⁰.

3. Collect Relevant Data

Palliative care programs should track their readmission rates, transitions to and length of stay in hospice, symptom scores, advance care planning completion, billing revenue, and patient/family satisfaction. The importance of collecting data from the start cannot be overstated. Analysis of data informs the overall success of the program and can help show key stakeholders the benefits of the service. It also serves as a barometer to show where the weaknesses are and where the possible opportunities lie for improvement.

4. Models of Palliative Care in the Nursing Home Setting

The Health Affairs blog, published in December, 2013, describes three models for delivering palliative care in the nursing home.

Hospice agency/nursing home partnerships. This is a partnership between a hospice agency and a nursing home, where eligible nursing home residents access their Medicare hospice benefit. An eligible resident must have a prognosis of six months or less if the disease runs its normal course and must waive other Medicare benefits upon election of the hospice benefit. About one third of nursing home decedents now access the Medicare hospice benefit before death. Hospice can bring expert symptom management, personal care services, social work services for families, other staff and residents, spiritual care, as well as volunteer and bereavement services.

Externally based palliative care. An external palliative care consultation team works with nursing home clinicians to serve a broader population of nursing home residents, including those with chronic illness. To access palliative care services, there is no need to forgo curative treatments to receive services. The consultant, a physician or nurse practitioner, bills under Medicare part B; therefore costs for these services are not incurred by nursing homes.

Facility-based palliative care. A facility may develop palliative care expertise within its own facility, allowing the creation of palliative care services that meet the needs of their residents. Staff training in the nursing home is critical to the success of this model, and to fostering a culture where a palliative approach to care is welcome and widely supported. Support for staff training and the understanding of the palliative approach to care may be a service that a hospice organization can provide to help palliative care services to be established with a strong foundation.⁹

CHALLENGES AND BARRIERS

1. Recognizing the Benefits and Need for Palliative Care

Promoting the benefits of palliative care in the nursing home setting is important. Palliative care improves quality of care, and can provide highly coordinated care leading to improved outcomes, high family and caregiver satisfaction, and improved staff satisfaction with increased education and availability of providers.

2. Reluctance to Refer to Hospice Care

Some nursing homes may see the value of palliative care and feel that this service meets the needs of the dying patient. Often “approval” to discuss hospice services is required by the Administrator since there is a desire to maximize skilled days and a concern over a decreased reimbursement with hospice. Some nursing homes set a maximum number of patients who can be receiving hospice care at any given time. This has been the major issue in many nursing homes.

The message that hospice is the gold standard in providing excellent palliative care at the end-of-life and that the type of resources provided by hospice programs can never be matched by palliative care services alone needs to be reinforced. Unfortunately, under the current reimbursement stream for palliative care, where revenue is limited to Part B provider billings, many palliative care programs need to be supported financially through another entity such as a healthcare system, nursing home, hospice organization or community philanthropy.

3. Understanding Legal and Regulatory Issues

A nursing home is under high levels of scrutiny from the state survey agency and from other auditors who review the delivery of patient care services, quality of care, sentinel events, consumer and family complaints. By law, state nursing home surveys are conducted at a 15 month survey interval, with a 12 month statewide average. Survey results are publicly reported in Nursing Home Compare, adding importance to the survey process and pressure for the nursing home administration.

Minimum Data Set

A nursing home uses a patient level data collection document, called the Minimum Data Set (MDS) to collect data on each new nursing home resident. The functions of the MDS include clinical assessment, identification of care plan problems, identification of quality measure data for public reporting and for focused nursing home surveys, information for payment by Medicare and Medicaid, and research data.

If a resident is at the end of life, either choosing hospice (and the O100(k) Hospice Care box is checked on the MDS, or a physician certifies that the resident has a six month prognosis, (and checks the J1400 box on the MDS and documents in the medical record), the surveyor will not write a deficiency for care provided to these patients. This allows the nursing home to provide the kind of care that is appropriate at the end of life, with no fear of negative outcomes or reduced Star ratings. When neither box is checked on the MDS, the patient is not designated as “end of life” and a surveyor may issue a deficiency based on negative quality indicators.

CMS CASPER Report

The nursing home has access to their CMS "CASPER" report, listing all patient-specific quality indicators for their nursing home, indicating the quality indicators with negative outcomes. The surveyor will begin the nursing home survey looking at patients with negative quality indicators, checking to see the true condition of the patient and assessing what care they are receiving.

Interpretive Guidelines

The Nursing Home Interpretive Guidelines can be found in Appendix PP of the State Operations Manual. Of particular importance for hospice and palliative care providers is F-tag 309, Quality of Care. It is this citation that is the basis for the surveyor protocol for patients at the end of life. (42 CFR 483.25) A CMS State Survey Agency letter, dated September 27, 2012, provides the essentials of the end of life protocol, found below:

Review of a Resident at or Approaching End of Life

Assessment and Management of Care at End of Life – In order to promote the physical, mental, and psychosocial well-being of a resident who is approaching the end of life, the facility and the practitioner must:

- Identify the resident's prognosis with supporting documentation; and initiate discussions/considerations with the interdisciplinary team regarding advance care planning and the resident's choices to clarify resident goals and preferences regarding care as the resident is approaching the end of life. Preferences may include, but are not limited to, controlling pain and other symptoms and maintaining mental, physical, spiritual and psychosocial functions. Advance care planning should also address the resident's wishes regarding the treatment of acute illness, hospitalization for treatment of acute illness, and hospitalization for other reasons.
- Recognize and advise the resident and/or the resident's legal representative when the resident is approaching the end of life. If the resident is not already receiving palliative care, advise and educate the resident about palliative care options, including hospice care, if appropriate and when care might include a more palliative focus.
- Provide and periodically review a resident's plan of care, addressing services and support that accommodate and honor the resident's choices and rights and manage pain and other physical, mental and psychosocial and spiritual needs.¹⁰

CMS published proposed reform of the Nursing Home Requirements of Participation in mid-2015. These regulations, called Conditions of Participation for other health care providers, proposed to dramatically change the Medicare requirements for nursing homes and are expected to put additional stress on nursing homes to provide higher quality care for less reimbursement. More than 8,500 individuals and organizations submitted comments on the proposed rule. CMS is expected to issue a final rule sometime within the next 2 years.

For any provider or palliative care team going into a nursing home, a contract may be necessary to provide palliative care services. Make sure you consult with a knowledgeable health care attorney when developing the palliative care services plan, and specify the patient population that is most likely to need palliative care services.

TIPS FOR SUCCESS

1. Use A Palliative Care Screening Tool

A palliative care screening tool should be completed by someone in the nursing home environment such as the MDS Coordinator or Admissions Nurse. Ideally, it would serve to identify appropriate patients and would include screening for those with metastatic cancer, advanced cardiac, pulmonary, renal disease and dementia, as well as those with acute symptom needs. Also, recognizing patients without completed advance directives and those with multiple recent hospitalizations could help identify those in greatest need for palliative care.

2. Develop Facility Preference Lists

Understanding the nursing home environment is critically important for palliative care team members. Developing facility preferences which list the key decision makers and explain the culture of that particular facility is helpful. In some facilities it is the MDS coordinator who is the key person while in others it may be the Director of Nursing or the Administrator.

3. Understand What is Important For Each Nursing Home

Remember you are a guest in their “home” and need to have a humble attitude and work together to create a win-win situation. Defining what is important for each nursing home is crucial so that expectations can be met. Some nursing homes are in need of education or training for staff or help in managing difficult symptoms or divisive family issues. These needs are certainly in alignment with the purpose of palliative care. Others, however, may be focused on preventing readmissions or improving a particular quality score.

4. Consider Using Evidence Based Tools To Improve Clinical Care

- To enhance clinical care and communication the “Interventions to Reduce Acute Care Transfers” (INTERACT) are helpful for front line nursing home staff in early identification, assessment, communication and documentation about acute changes their residents face.¹¹ The communication tools have forms for SBAR (Situation, Background, Assessment, Recommendation), Medication Reconciliation, Stop and Watch, and Transfer forms/checklists.
- The Care Path Tools are a set of protocols that include management of fever, dehydration, dyspnea, congestive heart failure, GI symptoms, respiratory illness, altered mental status, change in behavior, and urinary tract infections.
- The Advance Care Planning (ACP) Tools include comfort order sets, decision around hospitalization, feeding tube education, cardiopulmonary resuscitation, and ACP tracking tool. These are great tools to ensure that standardization and evidence based practices can occur. Palliative care teams should be familiar with and operate under a similar set of guidelines.

When documenting palliative care encounters, it is important to keep the nursing home quality metrics in mind. Documentation should include the following:

- pain/symptoms and interventions
- continence issues
- cognitive status
- behavioral issues and antipsychotic medication use
- oral intake/weight and interventions
- family/patient goals
- use of physical, occupational, or speech therapy, and
- coordination with the nursing home plan of care.

Documentation in the patient's nursing home record should demonstrate that the palliative care team has been working with the patient in collaboration with the nursing home staff. Measures around quality of life, physical restraint, feeding tubes, and end of life preferences are important to include as well as orders around do not transfer and referral to hospice.

5. Track Clinical Outcomes

Well defined measures that track the quality outcomes around pain, shortness of breath, completion of ACP, readmission, and satisfaction are important to hardwire for they will demonstrate a program's success. When applying for grants, or making the case for the next nurse practitioner hire, it will be helpful to show the accomplishments that have occurred.

CONCLUSION

Partnerships between palliative care providers and nursing homes can improve care for nursing home residents by reducing readmissions and hospital deaths, improving symptom management, aligning care with patient goals, and leading to improved satisfaction of care for those who are dying.

Developing a well thought out business plan and understanding the value proposition of palliative care are important first steps. Understanding the unique challenges that nursing homes face and that future reimbursement streams will be based on quality and cost are also important factors to consider. Under the current fee for service reimbursement structures, palliative care programs will never be financially viable without support from other entities.

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