A Nurse Practitioner’s Innovative, Value Approach to Redesigning Access to End of Life Care

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This session will describe how an innovative approach to improving access to end of life care aligns with the IOM Future of Nursing Report
Nurses have a key role to play as leaders for a reformed and better integrated patient-centered health care system

Nurses should be full partners in redesigning the health system in the United States
• Board level engagement and support
• Innovative program designed and led by a Nurse Practitioner
• Cultural change of moving advance care planning discussions into the plan of care
The Triple Aim

- Improved Quality Care
- Increased Access
- Decreased Cost
Practice to the Full Extent of Education and Training

- Improving nurses’ skills in ACP and identifying disease trajectory
- Maximize the role of the nurse practitioner palliative care specialist model beyond the walls of the hospital
Identify patients with advanced illness

Promote patient centered care based on knowledge of patients advance directives

Provide Advance Practice Nurse Palliative Care Specialist referrals in the community setting
Model Enables Nurses to Lead Change

- Discussion of total patient care
- Maximizes communication skills
- Provides collaboration in multi-levels of nursing
Work Flow Redesign

- Predictive report
- 5 minute conference
- Transitions to appropriate care
- Referrals
Lessons Learned

• Nurses can impact community infrastructure
• Nurse have a role in redesigning healthcare
## Impact on Quality Measures for the Home Health Agency

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Patients with improved management of pain</th>
<th>60 day Emergency Department use without hospitalization rating</th>
<th>Percent who rated the agency with the highest rank</th>
<th>Percent who would recommend the agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>38.5%</td>
<td>43.9%</td>
<td>41.5%</td>
<td>60.4%</td>
</tr>
<tr>
<td>2015</td>
<td>40.5%</td>
<td>54.7%</td>
<td>63.5%</td>
<td>69.4%</td>
</tr>
<tr>
<td>2016</td>
<td>67.5%</td>
<td>55.8%</td>
<td>69.1%</td>
<td>74.3%</td>
</tr>
<tr>
<td>2017</td>
<td>75.0%</td>
<td>55.8%</td>
<td>79.1%</td>
<td>78.9%</td>
</tr>
</tbody>
</table>

Based on the Home Health Compare Center for Medicare and Medicaid Services Ranking Numbers from Home Health Compare.gov
## Impact and Measures of Success

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Number of Advanced Illness Case Conferences</th>
<th>Percent of VNA patients with an Advance Directive</th>
<th>Number of NP Home visits</th>
<th>Hospice Average Daily Average</th>
<th>Number of Community Referrals to Hospice</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>NA</td>
<td>NA</td>
<td>0</td>
<td>31</td>
<td>100</td>
</tr>
<tr>
<td>2014</td>
<td>412</td>
<td>NA</td>
<td>158</td>
<td>39</td>
<td>130</td>
</tr>
<tr>
<td>2015</td>
<td>939</td>
<td>8%</td>
<td>488</td>
<td>54</td>
<td>179</td>
</tr>
<tr>
<td>2016</td>
<td>1576</td>
<td>27%</td>
<td>653</td>
<td>80</td>
<td>239</td>
</tr>
<tr>
<td>2017</td>
<td>3154</td>
<td>50%*</td>
<td>660*</td>
<td>100</td>
<td>258*</td>
</tr>
</tbody>
</table>

* As of August 2017
Continuous Improvement

- Nurses partnering with primary care practices
- Nurses instituting the advanced illness management model into primary care
Policy Implications

- Improved information exchange
- Removing scope of practice barriers through legislative practice
