

Title:

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

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Session Title:

End-of-Life Care

Slot:

H 01: Monday, 30 October 2017: 2:45 PM-3:30 PM

Scheduled Time:

2:45 PM

Keywords:

Advanced Illness Management, Barriers to nursing practice and Nurse Practitioner led innovative change

References:

Casarett, D. T. & Teno, J.M. (2016). Why population health and palliative care need each other. *Journal of American Medical Association*, 316, 27-28.

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Diegel, JA. (2012). Managing advanced illness. *Trustee*, 10: 35

IOM (Institute of Medicine). (2016). *Assessing progress on the Institute of medicine report: the future of nursing*. Washington, DC: The National Academies Press.

Lustbader, D., Mudra, M., Romano, C., Lukoski, E., Chang, A., Mittelberger, J.,... Cooper, D (2017). The impact of a home-based palliative care program in an accountable care organization. *Journal of Palliative Medicine*. 20, 23-28.

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Abstract Summary:

Organizations are seeking ways to improve end of life care aligned with advanced illness management. This session will describe an innovative approach, using Nurse Practitioners, providing care consistent with patient goals. The program elements, assessment, and barriers to the initiation of the timely start of care will be discussed.

Learning Activity:

LEARNING OBJECTIVES	EXPANDED CONTENT OUTLINE
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The learner will be able to describe the elements of a Nurse Practitioner led Advanced Illness Management Program.	Improving nurses' skills in caring for home health patients identified as having an advanced illness Engaging patients in discussion of advance directives and communicating the patients' decisions Providing care with an NP Home Visit Practice
The learner will be able to discuss Advanced Illness Management program performance indicators.	Impact of an Advanced Illness Management Program Data indicating a benefit to the health system. Data indicating benefits to hospice Data indicating impact on quality for palliative care and hospice
The learner will be able to explain how an Advanced Illness Management Program is impacted by current Nurse Practitioner barriers to practice.	Discussion of lessons learned in planning and implementation Discussion of barriers impacting timely referrals. National policies that limits scope of practice and timely referrals

Abstract Text:

The Institute of Medicine (IOM) report on the Future of Nursing states that nurses should function at the full extent of their education and training and that they be full partners in redesigning health care in the United States (IOM, 2016). This innovative program, with the full support of the Health System's leadership, was designed by a nurse practitioner (NP). This NP led program provides care delivered by nurses and specialty care by NPs and has allowed for patients to remain in their preferred setting of care, their own home, until the end of their life.

A community Advanced Illness Management Program provides palliative care within the home health operating unit with a patient centered, value based approach for those with advanced illness. The program has 3 components:

1. Improving nurses' skills in caring for home health patients identified as having an advanced illness
2. Engaging patients in discussion of advance directives and communicating the patients' decisions
3. Providing care with an NP Home Visit Practice

A NP provides collaboration with the nursing staff to focus on the palliative care needs of the patient in determining symptom burden and prognostic signs of advanced illness. This collaboration is done in a case conference approach with recommendations to promote optimal health during the advance stage of a chronic illness or while receiving cancer treatment, education to promote confidence in advance care planning discussion and identification of the risks and benefits of treatment options. These are the tenants of primary palliative care (Casarett & Teno, 2016). Given the limited number of palliative care specialist, this approach provides high quality palliative care access for a large volume of home health patients maximizing the time of a nurse practitioner palliative care specialist. In a JAMA 2016 Viewpoint article Casarett and Teno encouraged the development of this type of non-traditional palliative care/population health model.

To compliment the case conference, a Nurse Practitioner provides home visits with a fee for service arrangement. The practice receives referrals from home health nurses for patients who need ongoing assessment and care after a home health episode in conjunction with the home health episode. The NP

also receives referrals directly from patients/families, acute care palliative consult service, primary and other specialty services. The patients that meet criteria for this service have multiple co-morbidities, advanced chronic illness, and frailty or debility related to advanced age. Many of these patients have been hospitalized several times over the past year. The practice communicates patient assessments and any change in treatment with the primary care provider. Such care allows primary care providers to have access to palliative care consultation beyond the walls of the hospital.

This model assures that patients receive the level of care that respects their wishes, improves symptoms, allows them to have care at home and prevents unwanted costly care. The model also incorporates nurse practitioners, practicing at full extent of their education and training, as full partners in the patient's health care team.

The Impact and Measures of Success: In a three year review the health system saw a yearly increase in the number of advanced illness case conferences, increase documentation of advance directives, and continued referrals to the NP home visits. Quality and satisfaction for the home health agency improved in this three year time frame as measured by internal data and national reports. There has been an increase in the hospice census from 39 patients in 2014 to 80 patients in 2016 and length of time that a patient remains on hospice. Community referrals to hospice increased from 100 referrals to 239 referrals. Prior to the Advanced Illness Program most of the hospice referrals were originated from the acute care hospitals with few from the community at large. Preliminary analysis of data from our health care system has demonstrated that patients referred from the community have a longer length of stay in hospice (105 days) than those from the hospital setting (58 days). Patients remained within the health system and avoided hospitalization at end of life.

FY	Advanced illness Case Conferencing	Advance Directives	NP Home Visit	Hospice Census	Community Referrals to Hospice
2013	NA	NA	NA	31	100
2014	412	NA	158	39	130
2015	939	8%	488	54	179
2016	1576	27%	653	80	239

Measure of advance directive documentation showed an increase number of patients with an advance directive from 8% to 28% based on our internal data collection system. Other improvement measures are based on the Home Health Compare Center for Medicare and Medicaid Services (CMS) ranking. Improvement in managing pain increased from 37.3% in 2014 to 47.5% in 2016. A 60 - day Emergency Department use without Hospitalization declined resulting in improved CMS national rating of 42% in 2014 to 61.3% in 2016. The 60 - day Hospitalization rating improved from 38.7% in 2014 to 42.1% in 2016. Satisfaction measures based on Home Health Consumer Assessment of Healthcare Providers and Systems (HCAHPS) showed improvement in the three year period. The home health agencies ranking on the percent who rated the agency with the highest rank increased from 58.2% in 2014 to 62.1% in 2016. The percent who would recommend the agency went from a national ranking of 51.15 in 2014 to 73.9% in 2016 (Home Health Compare.gov 2016).

The value of integrating an Advanced Illness Management Program into a home health agency is a decrease in unwanted hospitalizations with early transitioning to hospice and an increase in patient satisfaction. There was improved patient satisfaction. From a cost review there is decrease in high cost hospitalizations that has been shown to occur for patients hospitalized at end of life and the benefit of extended hospice care.

Lessons Learned and Limits of the Review:

In building a community program it is important to collaborate with the stakeholders within the health system, community providers and the home health agency. The culture of home health for patients with advanced illness has often been seen by clinicians as an area of care only pertinent for patients on hospice. To change that mindset requires leadership support from the health system to the agency administrators and the clinical staff. A survey of our home health staff provided insight into the need for additional education and training related to end of life discussions. Additional research is needed, to quantify the impact on an entire episode of care, for patients that receive care from this type of program in contrast to those who did not.

Policy implications: Unfortunately Nurse Practitioners continue to encounter barriers to practicing to the full extent of their education and training in many states. As of the opening of Congress in January 2017 nurse practitioners still do not have authority to prescribe home health care or hospice care for Medicare beneficiaries and in many states nurse practitioners do not have prescriptive authority. Not all community physicians have the specialty of palliative care to know when a patient may meet the criteria to receive hospice services. There have been patients that could have benefited from palliative care or hospice but the physicians declined referral resulting in hospitalization and late entry into hospice. If the nurse practitioner could refer the patient directly this would benefit the patient and potentially save an unwanted hospitalization. This prescriptive authority should be within the nurse practitioner scope of practice (Dahlin & Sutermeister, 2014J. Reintroducing bills such as S. 3096 "Removing Barriers to Person-Centered Care Act" is needed to advance this effort. The bill would establish a pilot program promoting an alternative payment model for Medicare beneficiaries with advanced illnesses. It would provide opportunities to demonstrate an alternative delivery system approach to providing care and access for patients with advanced illness (Congress.gov, 2016).