VNAA BLUEPRINT FOR EXCELLENCE

BEST PRACTICES TO IMPROVE THE CONTINUUM OF CARE AT THE END OF LIFE

Training Slides 070116
Institute of Medicine Report: Dying in America found -

• Gaps in care at the end of life
• Many people are not engaged in thinking about and expressing their preferences for end of life care.
• Systems for curative care are not well integrated with palliative and hospice care.
• Improvements in quality of care at end of life could improve quality of life for patients, reduce the use of unwanted services, and improve the experience of patients and families.
• Home-based care is patient-centered care
• Better continuum can improve the patient experience
• More appropriate level of care reduces admissions, ED use
• Referral potential:
  ▪ New partnerships
  ▪ More comprehensive services
• Revenue potential by integrating a continuum of care
Thank you
VNAA Quality Council –
Hospice – End of Life Work Group
Best Practice Information, Case Studies, Resources and more information

Vnaablupeprint.org
Condition specific, medication management, care initiation

5-Star Best Practices (Members only):
http://vnaablupeprint.org/5-star-best-practices/5-star-best-practices-HH.html
About the Blueprint

• Expert recommendations from VNAA member Work Groups
• Based on evidence, but evidence not always available
• Work in progress – knowledge continues to evolve
• Identifies multiple options for improvement
• Blueprint is used in conjunction with Clinical Pathways, accreditation, electronic tools, regulatory compliance and other requirements for home health agencies
• Users identify strategies that work in their organization, given size, workforce availability, caseload, customer needs
Engage the Community:
• Identify grant funding for the hospice to produce advanced care planning sessions or seminars
• Identify sites for community outreach presentations on advanced care planning, including senior centers, Knight of Columbus, assisted living
• Use tools already developed such as the Conversation Project or POLST programs
• Provide advanced care planning information in multiple languages
• Conduct community outreach by making information available to the patient in the community. Promote tools such as the Conversation Project, National Hospice and Palliative Care Organization’s CaringInfo material for patients and caregivers
• Use terminology that works in your community: sometimes ‘advanced care planning’ is tolerated better than ‘end of life discussions.’
Interventions

Partner with Local Physicians to Increase Advance Care Planning

- Develop information for physicians on how to bill for Advance Care Planning (ACP) services
- Develop trusted relationships with referral source physicians, those serving elder populations in particular
- Build a network of practitioners supportive of palliative and hospice care by educating them on ACP as a billable service
- Host sessions on ACP with local geriatricians and internists
- Partner with local physicians by presenting to community groups on ACP and referring patients to their own physicians for a personalized session that can be billed by the MD
Partner with Hospitals to Build a Continuum of Services

- Identify key sources and contacts within the hospital who may support initiatives to improve the continuum of care. This may include hospital case managers, discharge planners, and hospital based palliative care teams.
- Use data to engage hospitals and ACOs on the importance of end of life planning, including evaluation of data on deaths in the hospital and use of the ED at end of life
- Identify a model for a continuum of care that includes inpatient and home-based palliative and hospice programs and work with the hospital to implement the model
- Join a care transition team at the hospital
- Start a ‘Conversation Project’ committee at the hospital or ACO.
VNA-Hospital Partnership to Improve Access to Palliative Care and Hospice

The Concord Regional VNA (CRVNA) in Concord, New Hampshire is collaborating with a local hospital to increase access to palliative care for residents of nursing facilities and other community sites. Goals: improve end-of-life care, ensure that patients not ready for hospice are able to access comprehensive palliative care; decrease emergency department use, increase hospice census, and decrease the number of patients enrolled in hospice three days or less. The program uses shared staff and increases access to palliative care for patients in nursing facilities and the community.
Interventions

Understand and work with other stakeholder needs:

- Research key regulatory drivers and performance measures of other partners such as hospitals and nursing facilities e.g. reducing readmissions
- Offer solutions to partners that help them meet requirements
- Build community capacity for a better end of life continuum. For example, offer the agency as a site for practicums or mentoring for health professional students
Build palliative care capacity within the agency:

- Consider a blended hospice and home health organization
- Identify patient need and potential for improved quality of life
- Identify innovative payment options
- Document the ‘business case’ for each payer, using return on investment tools and all available data
- Identify ‘value’ of palliative services for different stakeholders: patients, providers, payers
- Consider revenue implications: increased hospice referrals and/or increased hospice length of stay.
Tools for making the case for palliative care
courtesy of Michelle Dahlkemper, Visiting Nurse and Hospice Care, Santa Barbara

Powerpoint Presentation: What is Outpatient Palliative Care?
Powerpoint Presentation: Demonstrating ROI for Palliative Care
Prototype ROI Calculator (excel file)
Presentation for Payers on the ROI of Palliative Care
Palliative Care Scope of Services description
Palliative Care Referral Form
Illinois Homecare & Hospice Council (IHHC) ‘massive open online course (MOOC)’: The Role of Palliative Care in Reducing Hospital Readmissions. This free course requires registration, and may be available for nursing continuing education in the future.

End of Life Nursing Education Consortium (ELNEC)

Center to Advance Palliative Care – training schedule

COMFORT Communication training - interdisciplinary team training for palliative care (California focused)
Benefits of improved continuum of care cut across programs:

- Improve agency relationships with providers
- Improved awareness in the community
- Better patient experiences
- Reduced unwanted acute care
- Improved referrals and LOS for the hospice
- Better performance on hospice metrics
Illinois Homecare & Hospice Council (IHHC) developed a ‘massive open online course (MOOC)’ focusing on the role of palliative care in reducing hospital readmissions, and recommends a suite of measures the assess the impact of programs at the end of life. These include:

Integration and Coordination
- % Advance Care Planning Discussions
- % Advance Directive Completion
- % Palliative care patients transitioned to Hospice
- % Patients with documentation of pain management
- Patient Satisfaction

Palliative Care Utilization
- Readmission to Hospital
- ED Visits
- LOS in Hospital or Nursing Home
- Cost Savings/Avoidance
Measurement and Evaluation

Required Reporting on End of Life

CMS Hospice Quality Reporting page

CMS Hospice Experience of Care Survey (CAHPS)

Private Sector Quality Measurement Initiatives

AAHPM Measuring What Matters

CHCF “Palliative Care Measures Menu”

National Quality Forum Palliative and End of Life Measures

Joint Commission recommendations on palliative care measures

Center to Advance Palliative Care (CAPC) recommendations for palliative care measures
Engaging Patients and Caregivers:

- **Respecting Choices – Advanced Care Planning**: A program of the Gunderson Health System designed to support providers and patients in making decisions about end of life, and to get leadership buy in for a system wide initiative.

- **National Hospice and Palliative Care Organization’s CaringInfo**: Includes materials for patients and caregivers on advance care planning, hospice and palliative care, and grief.

- **The Conversation Project**: A website that includes information and a kit to help people start talking about their end of life wishes

- **Physician Orders for Life Sustaining Treatment (POLST)**: The National POLST Paradigm is an approach to end-of-life planning based on conversations between patients, loved ones, and health care professionals designed to ensure that seriously ill or frail patients can choose the treatments they want or do not want and that their wishes are documented and honored. There are many state specific POLST initiatives as well.

- **“Being Mortal” – Atul Gawande**

- **Caregiver Support**: Roslyn Carter Institute for Caregiving
Palliative Care Program development

- **California Health Care Foundation’s Community-Based Palliative Care (CBPC) Resource Center** This resource center includes robust information on resources to support development of community based palliative care programs. It includes links to resources to help ‘make the case’, including payment models, clinical guidelines, model program descriptions, and an interactive tool to assist users in selecting appropriate evaluation measures.

- **Coalition for Compassionate Choices in California** Includes information and materials to assist organizations in developing community based palliative care programs.

- **COMFORT Communication training** - interdisciplinary team training for palliative care (California focused)
Contact

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