Serious Illness Care Research in Nursing Homes

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Disclosures

- Founder and executive officer of Probari, Inc., a healthcare start-up that provides nurse-led clinical quality reviews for nursing home residents.

Nursing Homes

- Rehabilitation and Long-Term Care
- Average of 106 beds; 1.7 million beds
- Nearly all Medicare-Medicaid certified

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Nursing Home Residents

- Over 80% of residents need help with 3 or more Activities of Daily Living
- ~90% require supervision
- 50-70% have cognitive impairment
- 70% of people with advanced dementia live their final days in a nursing facility
- Symptoms are common - up to 80% of nursing home residents experience persistent pain

https://www.healthinaging.org/age-friendly-healthcare-you/care-settings/nursing-homes#:~:text=Who%20Lives%20in%20Nursing%20Homes,%2C%20or%20were%20never%20married; Mitchell et al., 2005

Unmet needs

- Residents with dementia in nursing homes have unmet palliative needs
  - Under-treated symptoms
  - Poor quality of care
  - Burdensome interventions near the end of life.
  - In one study focused on residents with dementia, 41% underwent at least one burdensome intervention in the last 3 months of life despite preferences by surrogate decision-makers to focus on comfort

    Mitchell, Teno and Kiely 2009
- 55% of deaths of people in the U.S. with dementia occurred in NHs in 2017

  Cross, Kaufman, Taylor et al 2020
- 70% of people with advanced dementia spend time near the end of life in NHs *Mitchell et al 2005*

Most hands-on care in nursing homes is provided by low-paid, diverse, female direct care workers.

Gandhi, A., Yu, H., & Grabowski, D. C. (2021). High Nursing Staff Turnover In Nursing Homes Offers Important Quality Information: Study examines high turnover of nursing staff at US nursing homes. *Health Affairs*, *40*(3), 384-391.

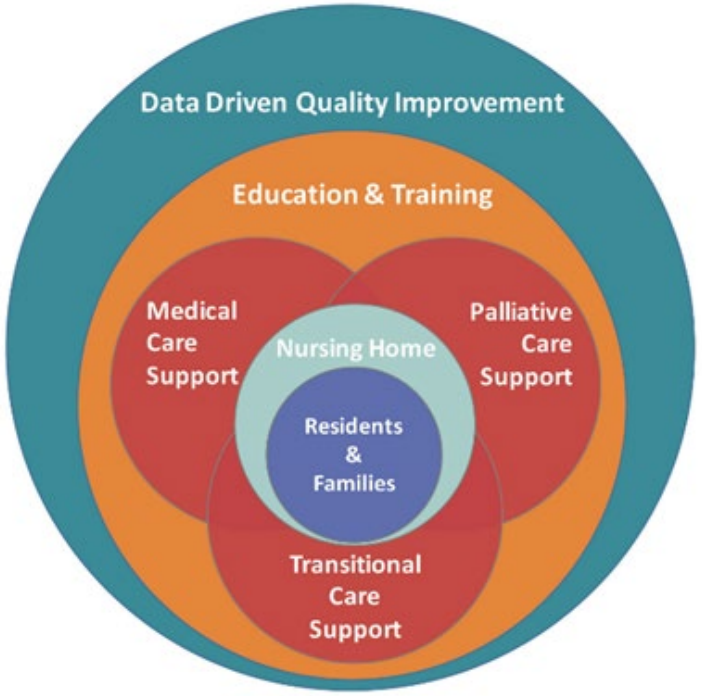
OPTIMISTIC Phase 1 Clinical Model

OPTIMISTIC RN Duties

- **Acute Change in Condition**– INTERACT implementation; mentoring and coaching
- **Support NPs** – identify patients; communication
- **Advance Care Planning** – 10 patients per month
- **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**
- **Support RNs** in education efforts



Advance Care Planning

Transitions of Care and Communication

OPTIMISTIC

OPTIMISTIC SBAR Tool

Situation *This form will guide communication with the on-call provider.*

Resident Name _____ **Age** _____ **Nurse** _____

Date _____ **Symptom/Condition Change:** _____

Background *Be sure to have the chart ready*

Associated medical conditions include *(check all that apply)* :

Allergies:

- ☐ CHF
- ☐ chronic pressure ulcer
- ☐ diabetes
- ☐ HTN
- ☐ CAD or hx of MI
- ☐ COPD/asthma
- ☐ Dementia
- ☐ Hospitalized within past 30 days
- ☐ Surgery within past 30 days
- ☐ Other_____

☐ Full Code ☐ DNR ☐ Do not hospitalize POST: Y/N:

POST Section B:	POST Section C:	POST Section D:
☐ Comfort Measures	☐ Use antibiotics only if comfort cannot be achieved fully through other means	☐ No artificial nutrition
☐ Limited Intervention		☐ Defined trial of artificial nutrition
☐ Full Intervention	☐ Use antibiotics consistent with treatment goals	☐ Long term artificial nutrition

If no POST, describe the patient's/ family's preferences for treatment if known:

_____

Assessment *You do not have to complete every section*

Temp	Pulse	Resp. Rate	02 Sats	B/P	Blood Sugar	Weight/ Change?	Most recent BM

Common Conditions

Qualifying Diagnosis v. 11-26-2018

Pneumonia

(maximum benefit duration 7 days)

THIS **OR TWO or more** of THESE

Chest X-ray confirmation of a *new* pulmonary infiltrate

- * Fever ≥ 100° F (oral) or two degrees above baseline
- * Oxygen saturation level ≤ 92% on room air or on usual O_2 settings in patients with chronic oxygen requirements
- * Respiratory rate ≥ 24 breaths/minute
- * Evidence of focal pulmonary consolidation on exam including rales, rhonchi, decreased breath sounds, or dullness to percussion

Facility Code: G9679 Practitioner Acute Nursing Facility Care Code: G9685

Assessment

Phase 1 Reduction in Medicare Utilization and Expenditures – Summary (2014-2016)

Outcome	Effect (% of mean)
Medicare Utilization (probability of event per resident)	
All-cause hospitalization	-19.3%
Potentially avoidable hospitalization	-32.6%
All-cause ED visit	-3.9%
Potentially avoidable ED visit	-15.9%

Outcome	
Average Spending Reduction per resident per year	$1,589
Total Spending Reduction	$13,456,242
Total Initiative Net Savings	$3,413,965

Ingber MJ, et al. Initiative To Reduce Avoidable Hospitalizations Among Nursing Facility Residents Shows Promising Results. Health Aff (Millwood). 2017 Mar 1;36(3):441-450.

Pragmatic Approach Needed

UPLIFT
UTILIZING PALLIATIVE LEADERS IN FACILITIES TO TRANSFORM CARE

Core Intervention Elements	Flexible Intervention Elements
• External PC consultations, expected minimum of 4 resident consults per week • In-house champions, trained by study team (minimum 2, at least one LPN or RN) • NH staff participation in education • Process for goals of care conversations, PC assessments and regular reviews, including identification of residents and tracking in EHR	• Visit schedule • Job role of the champions – RN, LPN, social services, or chaplain • Schedule of education topics and format of delivery • Meeting schedules; modification of the EHR vs. use of existing templates • Additional elements, e.g., additional meetings with families, bereavement support, use of volunteers

Phase III Clinical Trial NIA# R01 AG066922

National Institute of Aging

Key Intervention Elements

PC lead role

- At least 2 per facility, one RN or LPN
- Receives training on PC, trained to conduct PC assessments and make referrals to PC consultants

All staff education

- Providing education on PC to all staff interacting with UPLIFT-AD residents
- Topics include overview of PC, UPLIFT-AD objectives, resident-centered care

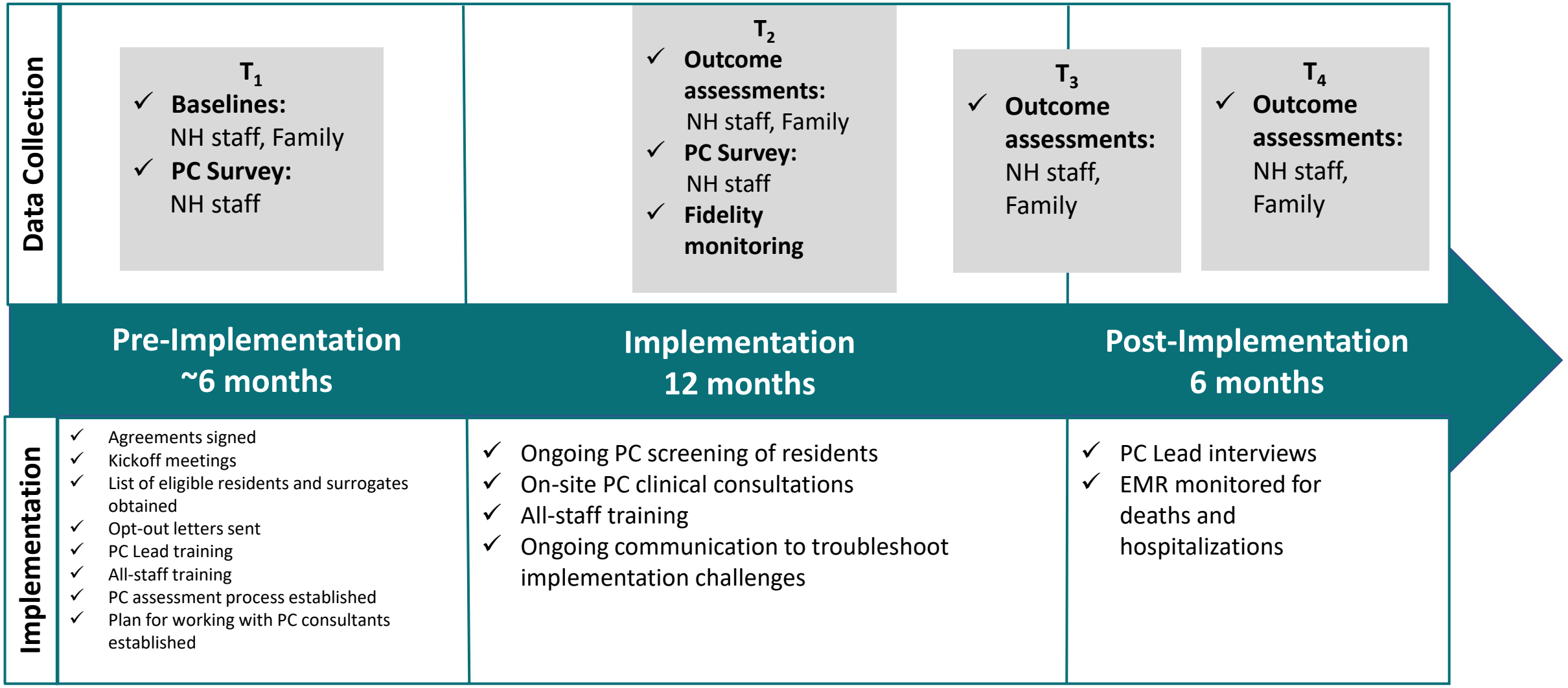
PC screenings

- PC leads identify residents who would benefit from PC consults using the PC screening tool

PC consultations

- PC consultants provide on-site consult visits with residents and family members

TIMELINE OF ACTIVITIES IN EACH NURSING HOME



Creating Connections

Key Takeaways and Next Steps

- Nursing home residents have substantial, unmet care needs
- Despite evidence of best practices, consistent implementation and delivery remains challenging
- Areas of needed research include symptom assessment and management, models for delivering supportive care, targeted trainings, and financing for serious illness care delivery
- Implementation planning is critical; interventions must be tested in the nursing home setting
- Multidisciplinary collaborations, partnerships with industry and ongoing investments are needed to test interventions and impact care in nursing homes