

Nursing Home End-of-Life Care The Nursing Home/Hospice Partnership (& Collaborative Solutions)

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Presenters

- **Project PI – Susan C. Miller, Ph.D.**
- **Project Consultant – Kathy Egan, MA, BSN, CHPN**
- **Project Consultant – Cherry Meier, RN, MSN**
- **Panel of Site Representatives:**
 - ◆ **Janet Bull, MD, Vice President of Medical Services, Four Seasons Hospice & Palliative Care, Hendersonville, NC**
 - ◆ **Sara-Jo Faucher, RN, MSN, CHPN, VP of Clinical Operations, TideWell Hospice and Palliative Care, Inc., Sarasota, FL**
 - ◆ **Christine Lau, RN, LCSW, Palliative Care Program Director, Four Seasons Hospice & Palliative Care, Hendersonville, NC**
 - ◆ **Bernadette Revicky, Administrator, Hunterdon Care Center, Flemington, NJ**



Background--Hospice In Nursing Homes

Hospice enrollment associated with higher level quality –

- ◆ **More likely to have pain assessed & treated**
- ◆ **Less likely to be hospitalized and to die in a hospital**
- ◆ **Less likely to have invasive treatment**

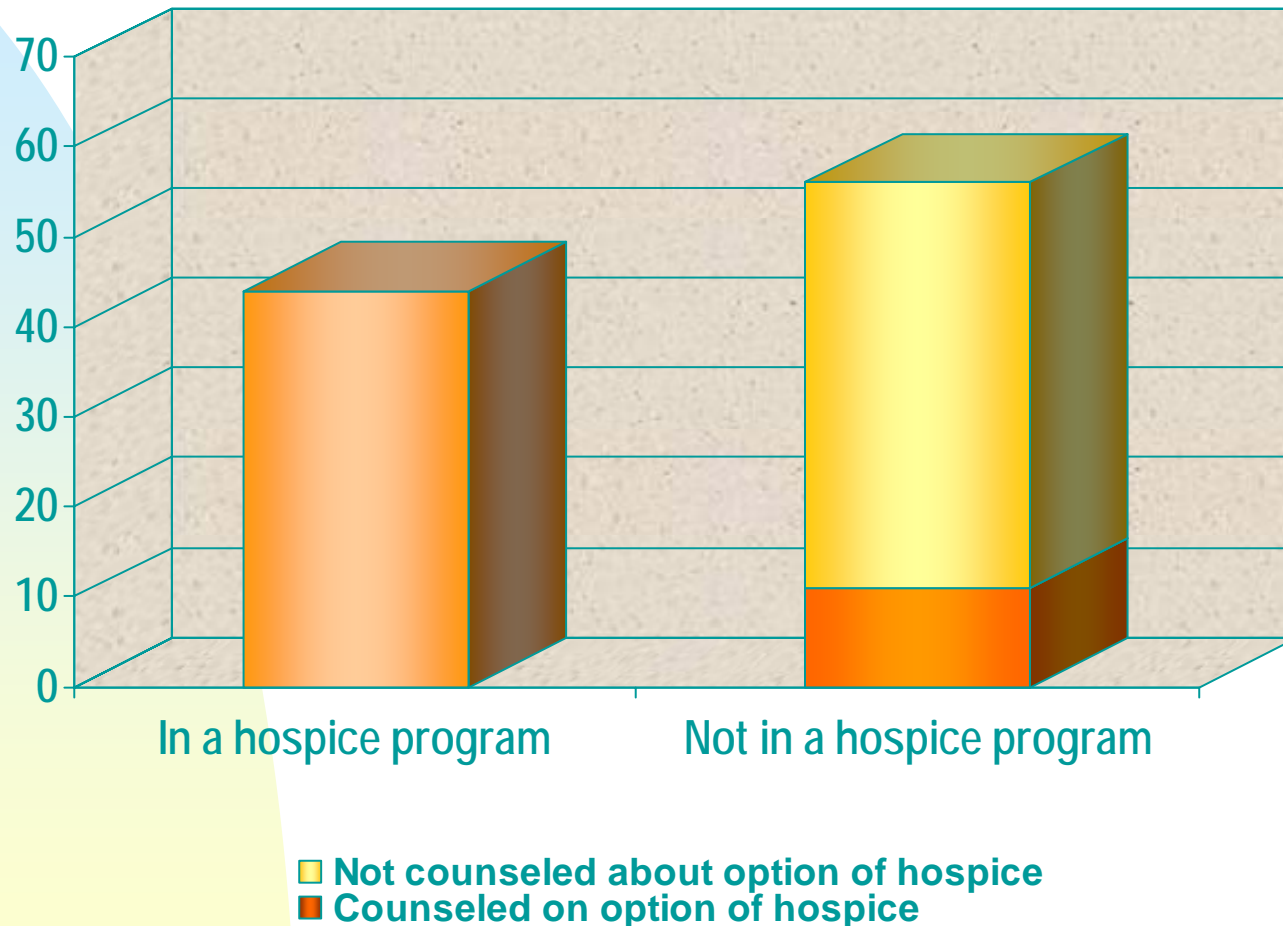


Background

- **But, there is tremendous variability in whether hospice is used within a NH and in the volume of hospice used across and within U.S. states**
 - ◆ **In 2000, 76% of U.S. NHs used any hospice but,**
 - ☞ **Florida 96%; Wyoming 36%**
 - ◆ **And, 21.4% of decedents in collaborating NHs used hospice but,**
 - ☞ **Vermont 9%; 42% Oklahoma**



Use of Hospice Services for Persons Whose Death Was Expected



Source: RWJF MB, Teno, Unweighted data.



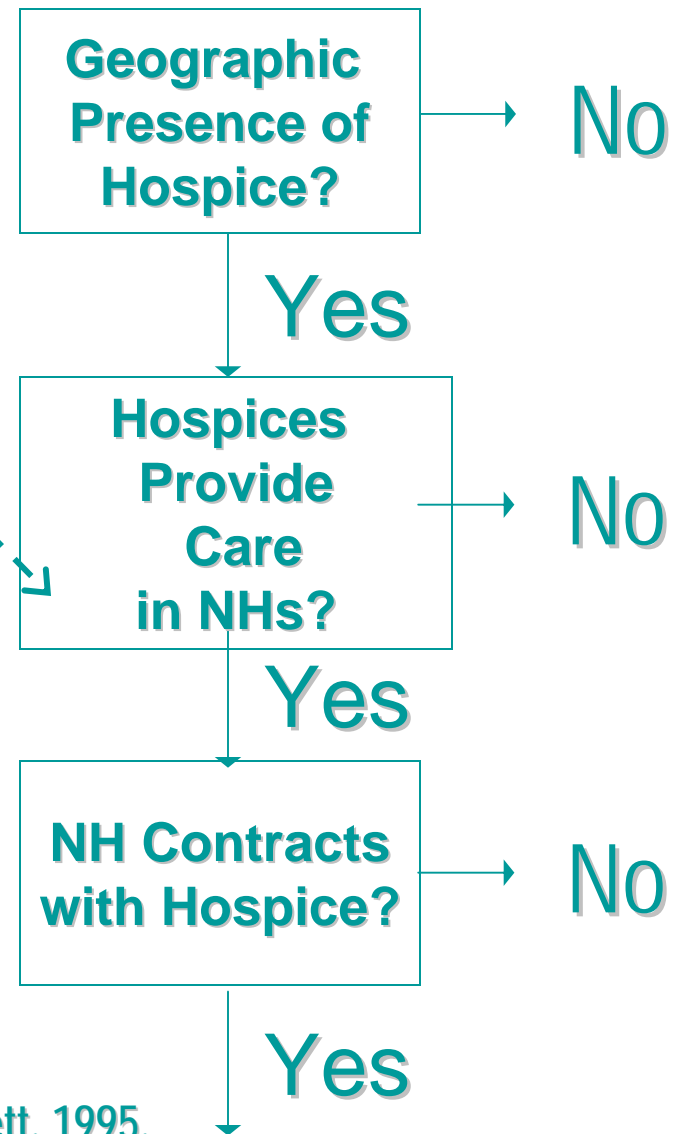
The Nursing Home Hospice Choice*

Prior Conditions
(Environment)

Knowledge
(Characteristics of
Decision-Making Unit)

Persuasion

- Perceived Characteristics of Innovation--"Nash Equilibrium" →
- What makes sense in terms of the balance of inputs/benefits-- Current Care vs. Alternative



*based on Innovation Decision Process. Rogers, Everett. 1995. Diffusion of Innovations, 4th Ed., New York: Free Press.

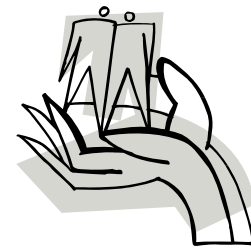


Background

Projects Premise—

There are “best practices” (“collaborative solutions”) out there, and if these are disseminated and integrated into practice, more success will result—more use of and referral to hospice—leading to higher quality of life/care at the end of life.

Also, in light of NH staff shortages and turnover, hospice use provides consistent availability of palliative care expertise and support



Project Aims

- **Synthesize existing research, guidelines and resources**
- **Establish project website –**
<http://www.chcr.brown.edu/NHHSP/INDEX.HTML>
- **Identify and visit “best practice” sites and disseminate “best practice” case study information**
 - ◆ **“Collaborative Solutions”**
 - ◆ **Policies, procedures, practices available on website & disseminated widely**



Identification of Domains Critical to Successful Collaboration

Informal Survey Conducted

- ◆ Administered by AASHA and NHPCO
- ◆ 23 NH administrators/CEOs
- ◆ 71 hospice administrators, coordinators & staff



Domains Critical to Success— Survey Findings

- **Administering the collaboration**
 - ◆ Fostering good relations
 - ◆ Barriers: maintaining functioning vs. dying, Medicare Part A, curative vs. palliative
- **Inter-disciplinary practice**
 - ◆ Cultivating personal relationships
 - ◆ Barriers: competition / turf issues, judgment issues, other
- **Communication**
 - ◆ Open & frequent
 - ◆ Liaisons



Domains Critical to Success

■ Education

- ◆ For hospice & NH staff, and for families
- ◆ Barriers: NH time constraints, turnover

■ Care Planning

- ◆ Joint care plan meetings, integrated care plan
- ◆ Barrier: Lack of invitation to mtgs., attendance

■ Care Provision

- ◆ Consistency of team, between settings
- ◆ Barriers: Multiple hospice providers; lack of communication regarding resident changes/needs

■ Support to resident/family & NH staff

- ◆ Memorial services



Study Site Selection

- **Pilot site:**
 - ◆ Home & Hospice Care of RI
 - ◆ Saint Elizabeth Manor, East Bay
- **Florida**
 - ◆ Tidewell Hospice
 - ◆ Pines or Sarasota
- **New Jersey**
 - ◆ Hunterdon Hospice
 - ◆ Hunterdon Care Center
- **North Carolina**
 - ◆ Four Seasons Hospice & Palliative Care
 - ◆ Brian Center Health & Rehabilitation



Study Site Selection

- **Minnesota**
 - ◆ Hospice of the Twin Cities, Inc.
 - ◆ Ambassador Good Samaritan Center
- **Michigan**
 - ◆ Hospice Care of Southwest Michigan
 - ◆ The Laurels of Galesburg (rural)
- **California**
 - ◆ Yolo Hospice
 - ◆ Alderson Convalescent Hospital



Case Study & Site Visit Protocol

- **To understand environment**
 - ◆ Used information on state policies / practices
 - ◆ Collected site and market information (size, ownership, competition, etc.)
- **To understand practices**
 - ◆ Interviewed administrators/CEO's; liaisons; coordinators/supervisors; medical directors; nurses / social workers / aides; CFOs & billing staff
 - ◆ Collected forms, other that may be useful to others



Site Visit Protocol -- Interviews

- **Interview tools based on domains and on identified practices and barriers**
 - ◆ **Example of staff question regarding communication:**
Overall, how would you describe the frequency and quality of communication between you and the staff at <COLLABORATING NH/HOSPICE>?

Probes:

- How often and when does communication usually occur?
- Would you describe communication as open?
- What is typically the topic of the communication?
- What has helped foster communication between NH and hospice staff?
- Have there been barriers to this communication? If so, please explain.



Case Study Summaries

- **Used logic model format to summarize the partnerships studied—how partnership functioned & what appeared to lead to success**
- **A logic model--**
 - ◆ shows the logical relationships among the resources that are invested, the activities that take place, and the benefits or changes that result.
 - ◆ <http://www.uwex.edu/ces/lmcourse/>



NURSING HOME / HOSPICE PARTNERSHIPS A MODEL FOR COLLABORATIVE SUCCESS*

Draft 4/4/06

ACTIVITIES

*PLANNED
RESULTS/OUTCOMES*

**Resources
/Inputs**



**Activities--
Infrastructure**



Activities--Processes



Shorter-Term



**Longer-
term**

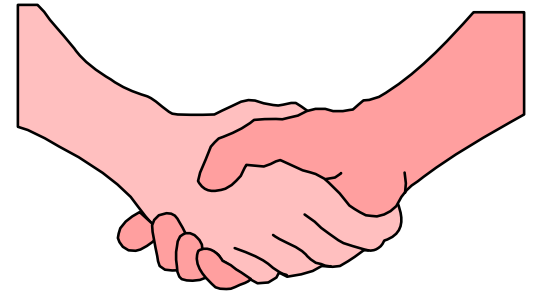


Logic Model – Resources & Inputs

- Shared philosophy of care
- Partnership mission driven
- NH acknowledges death
- Administrators committed to collaboration
- Success result of planning systems & activities
- Hospice administrator expert on collaboration
- A hospice vision for the collaboration which is easily conveyed
 - ◆ “win-win”, “customer service,” “it’s about the relationship”
- NH proactive about their expectation



Successful Collaborations...



...are partnerships where care planning, coordination and provision are performed in care environments where:

- mutual respect dominates;
 - providers routinely share knowledge; and
 - policies and procedures clarify the roles of each collaborating party.
- much unwritten & **PRESENCE, CONSISTENCY AND COMMUNICATION ARE KEY**



ACTIVITIES TO ACCOMPLISH GOALS

Kathy Egan, MA, BSN, CHPN



Nursing Home Residents & Staff as Customers



Administrative Alignment/Modeling Behaviors

- Be the “champion” of the partnership across H/NH
- Touch base on a regular basis & let staff know you collaborate & support the partnership
- Assign Hospice/NH dedicated staff to maximize relationships
- Provide consistency of staff assigned to NH
- Nursing Home Liaison positions/role
- “Product Line” Approach
- High hospice “presence” in NH
- Provide for responsive after hours coverage 24/7
- Understand each others systems, regulations, financing



Staff Selection

- Hire hospice staff with prior NH experience
- Good at relationship building
- Would instinctively know or learn.....
 - ◆ What would be helpful to NH resident & staff?
- Someone who can leave their ego at the door
- Comfortable as informal and formal educator
- Flexible to meet the needs of resident & staff



Hospice Staff Training

- Approach the NH as a partner, equally valued & recognized
- Leave “hospice arrogance” at the door!
- Collaborate always – as a guest in “their” home
- Acknowledge & respect NH expertise
- Not “taking over” the care of the resident
- Ask for their update & opinions before seeing the resident or making changes to the care plan
- Approach NH staff as Resident’s family
- Provide support to NH staff for cumulative loss/grief
- Provide ongoing resources for quality EOL care (articles, tools, etc.)
- Detailed information on systems/forms/procedures for each NH
- NH regulations, documentation (MDS, Profiles, etc.), financing



Receiving, Interpreting and Responding to Feedback

- **Open communication at all levels**
 - ◆ no blame, no we-they, all here for same reason
 - ◆ Intention is positive and collaborative resolution
- **Quick problem identification & communication**
 - ◆ “Pick up the phone when you have a question or concern.”
 - ◆ “Have me paged anytime.”
 - ◆ “Here is my cell phone, call anytime you or your residents’ needs are not being met.”
- **Conflict management & problem solving**
 - ◆ Involve & give feedback to all who were involved
 - ◆ Communicate common goal – quality EOL experience
 - ◆ Encourage them to problem solve with each other
 - ◆ Follow-up on outcome of collaborative problem solving



ACTIVITIES TO ACCOMPLISH AND MONITOR GOALS

Cherry Meier, RN, MSN



Communication

- It's all about the relationship
- Hospice is there to help, not to “take over”
- Hospice staff are considered to be nursing home staff
- Seen as being most helpful with resident/family emotional issues
- Hospice volunteers seen as “softening up patients” who otherwise wouldn't want to do certain things
- Notification of hospice when change occurs is a continual challenge, especially with agency staff
- Majority of communication is verbal



Communication (cont)

- Hospice has Nursing Home Preference sheet for each Home
- Notebook provided to Nursing Home with hospice articles
- When invited, Hospice staff celebrate with Nursing Home staff at social activities
- Hospice aides wear scrubs and RNs wear lab jackets to differentiate from Nursing Home staff
- Hospice and nursing home administrators use email to communicate
- Hospice values Nursing Home input, offers to help, and compliments care



Documentation

- **Social worker assists with Medicaid applications and does follow-up**
- **Assignment sheet is used by the Nursing Home to facilitate coordination. Resident information and care plan issues are on this sheet as well as whether resident is on hospice or receiving palliative care.**
- **Nursing Home has (face down) communication log sheet on back of resident's door**
- **Hospice sends faxes to Pharmacy to order medications and indicate who is paying**



Care Coordination

- **Coordination is more verbal, than written**
- **Only one site had a coordinated care plan**
- **Nursing Home care plans are easily accessible**
- **Hospice care plan meetings are occasionally held at the Nursing Home**
- **Hospice staff attend Nursing Home care plan meetings**
- **Hospice Medical Director does rounds in the Nursing Home with Nursing Home staff in attendance**



Quality Issues

- Hospice provides Nursing Home QI committee with length of stay data and other items to improve quality
- Letters to Nursing Home administrator expressing appreciation for End-of-Life experience
- Hospice obtains special DME that NH can't afford
- Nursing Home staff report that hospice increases the amount of 1 on 1 care provided



Conflict Resolution

- Practice what you preach, be part of the solution, leave the comparisons at the door
- Hospice Administrator has monthly lunches with Nursing Home Administrator
- Hospice liaison responsive to issues
- Hospice staff and Nursing Home staff communicate on an aide to aide, nurse to nurse basis.
- When problem observed, Hospice offers resources to help resolve the issue
- Match individual hospice staff with specific Nursing Homes. Remove staff if it is “not working out”.
- Hospice educator identifies problems, mistakes, and assigns staff as needed



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