Palliative & End-of-Life Care in Nursing Homes

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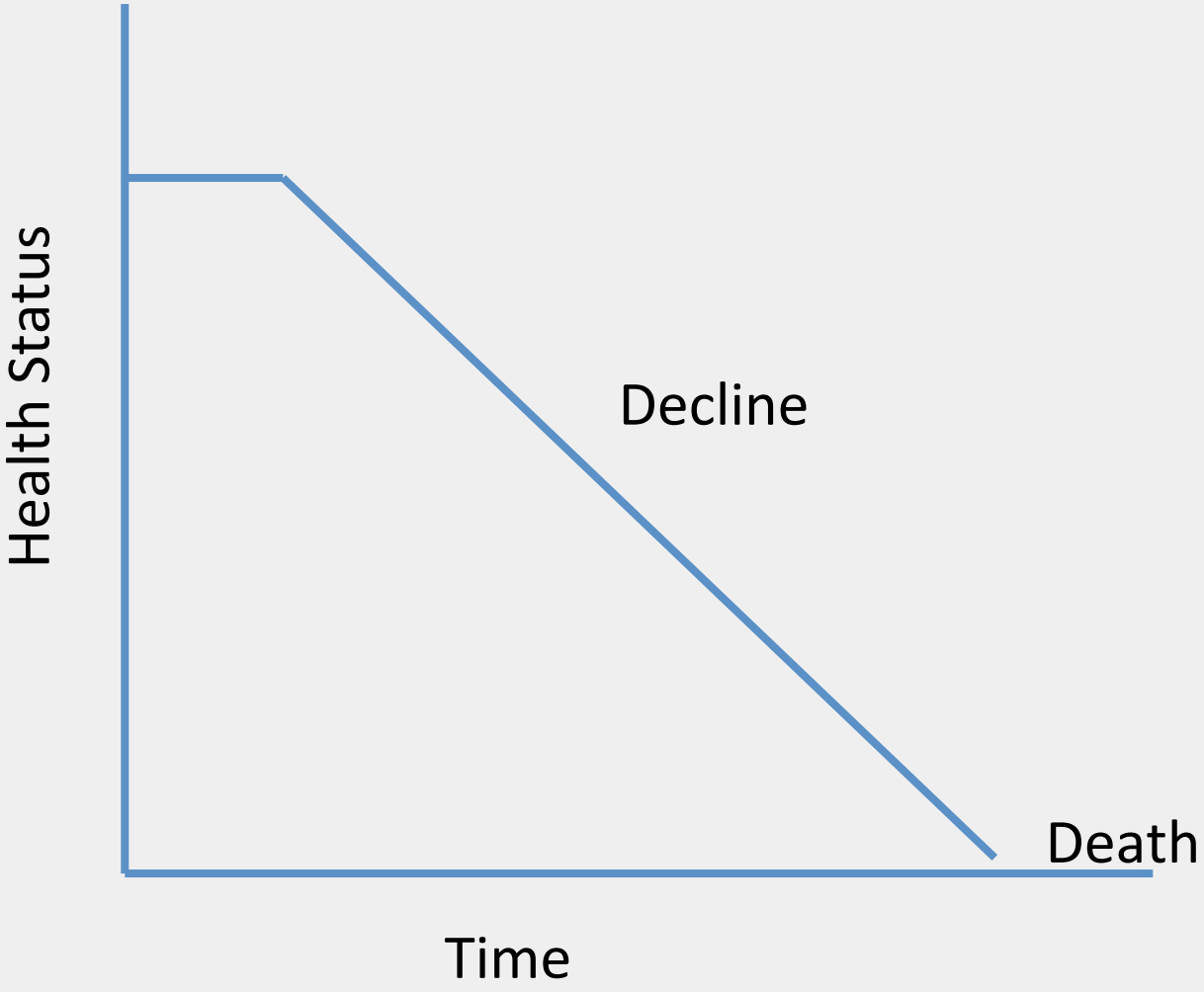
Nursing Homes & Death

- By 2030, 40% US deaths in nursing homes
- All permanently placed residents will die
- Residents are older, more frail, acutely ill, physically & cognitively impaired
- Emphasis on rehabilitative care
- Significant variation in the quality of care at end of life
    - e.g., end-of-life preferences, pain & symptom management, satisfaction with care

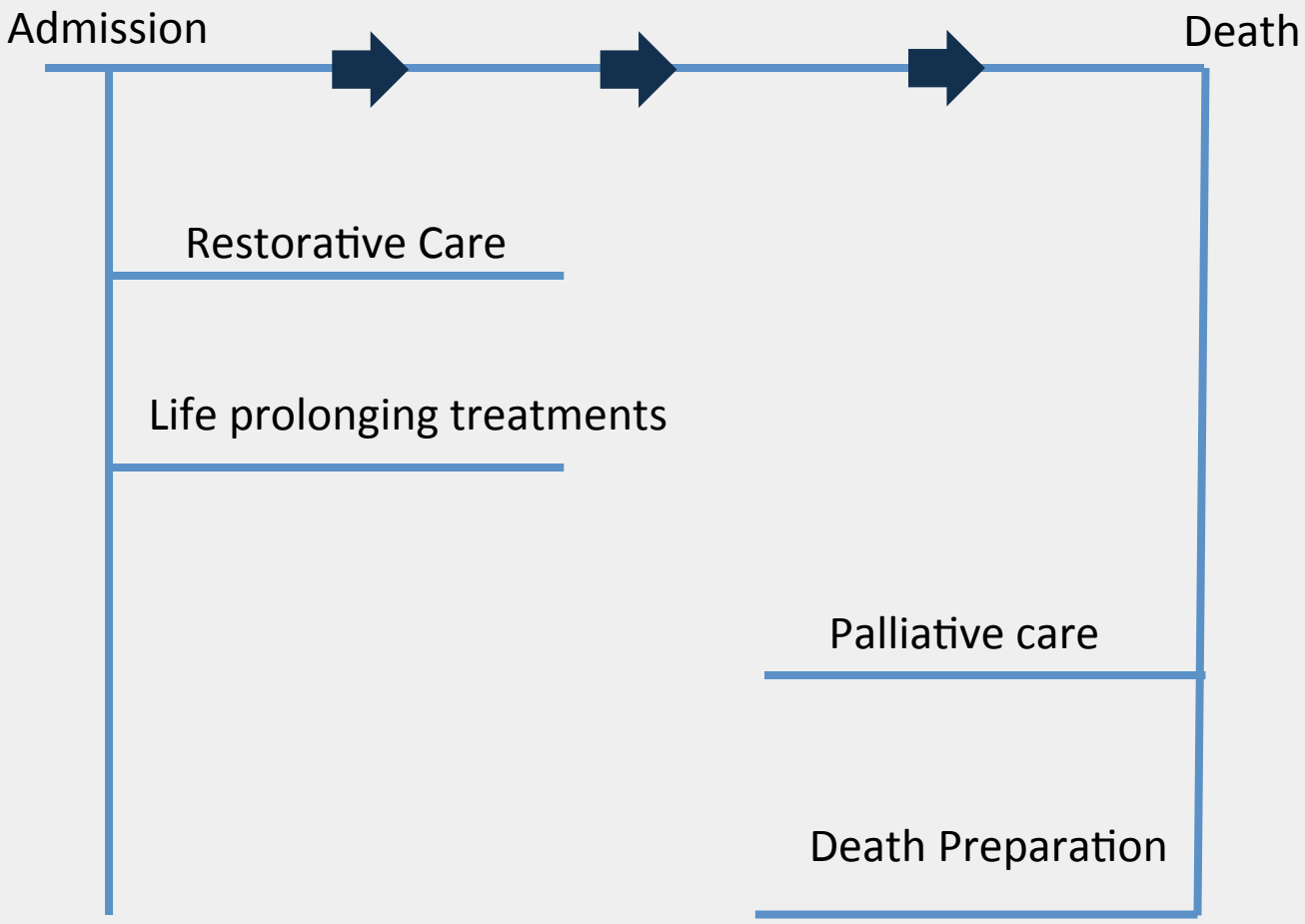
Nursing Homes & Death

- Untreated or undertreated pain & other symptoms
- Approximately 39% NH residents hospitalized last 30 days of life
- Up to 60% all hospitalizations deemed inappropriate

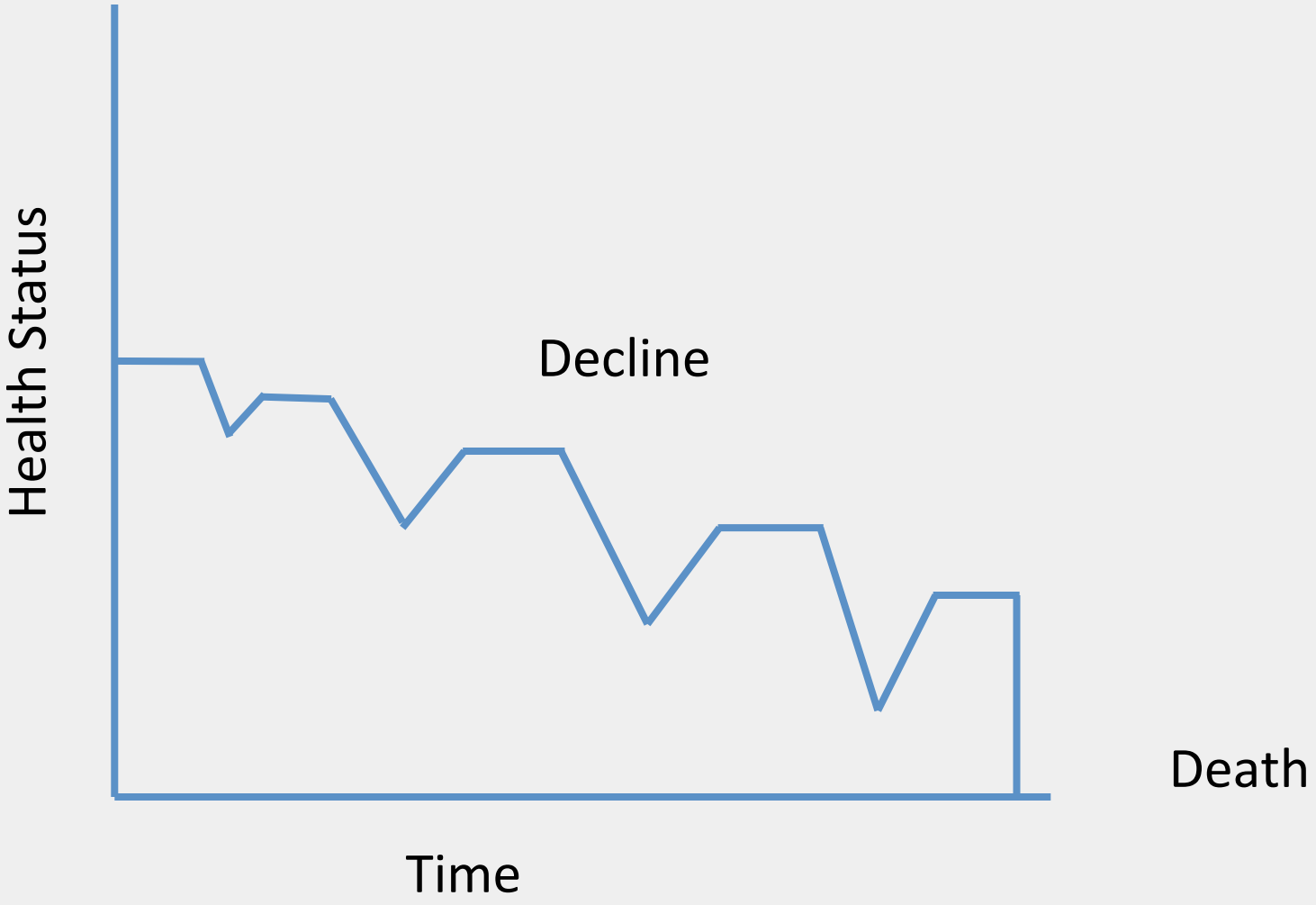
Terminal Decline



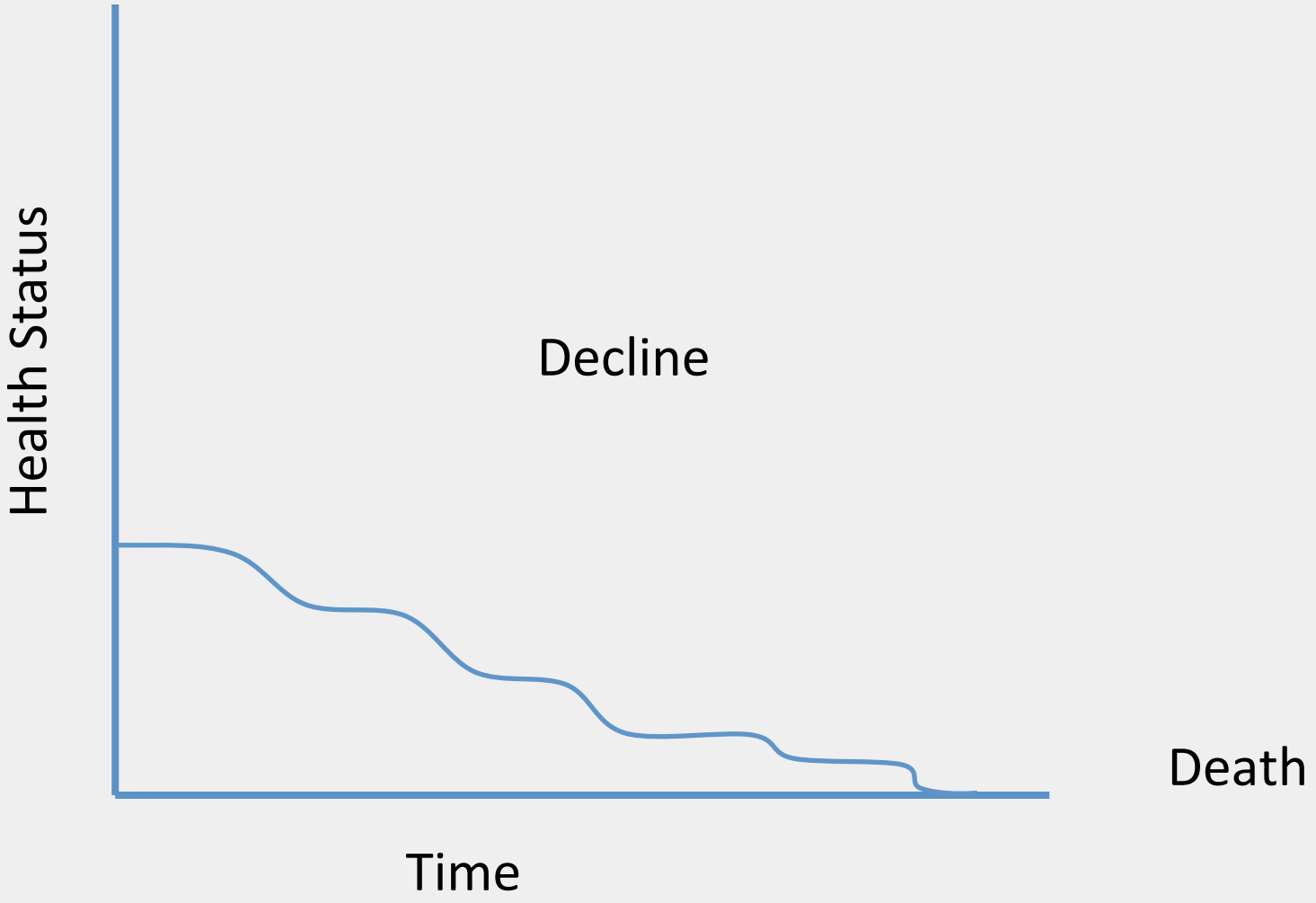
Traditional Approach to Care



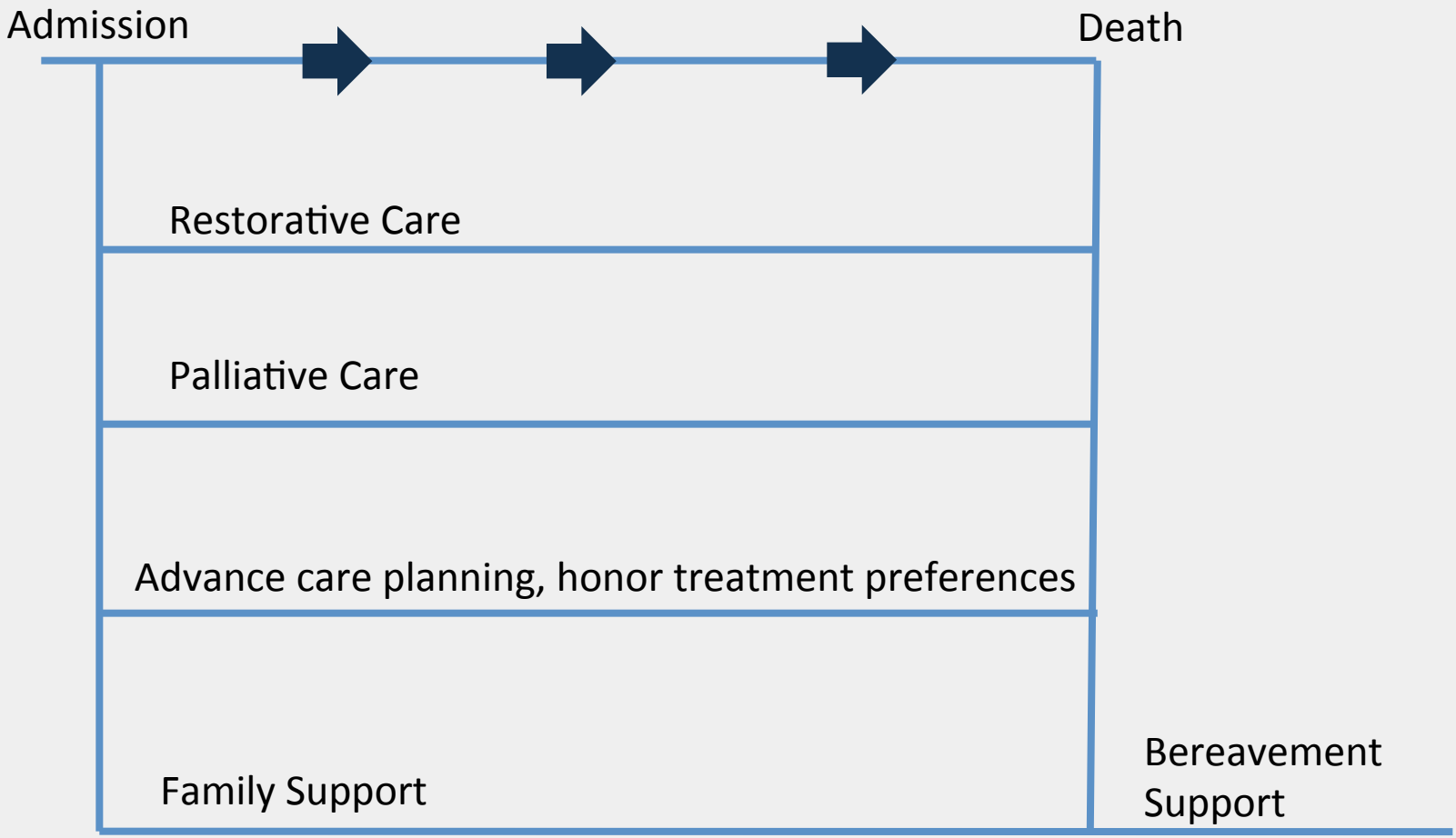
Advanced Chronic Illness



Frailty



Simultaneous Approach to Care



Optimal Resident Care

- **Restorative Care:** Maintains and promotes optimal resident functioning including physical, psychological, and social

- **Palliative Care:** Improves quality of life of *patients and families* who face life-limiting illness, by providing pain and symptom relief, spiritual and psychosocial support from *diagnosis* to the *end of life* and bereavement.

Good Palliative Care

- Ongoing communication regarding treatment goals
- Honor personal preferences for treatment
- Resident-family centered care
- Psychosocial and spiritual care
- Aggressive symptom management
- Death is normal and inevitable
- Death is not hastened or prolonged
- Based on evidence

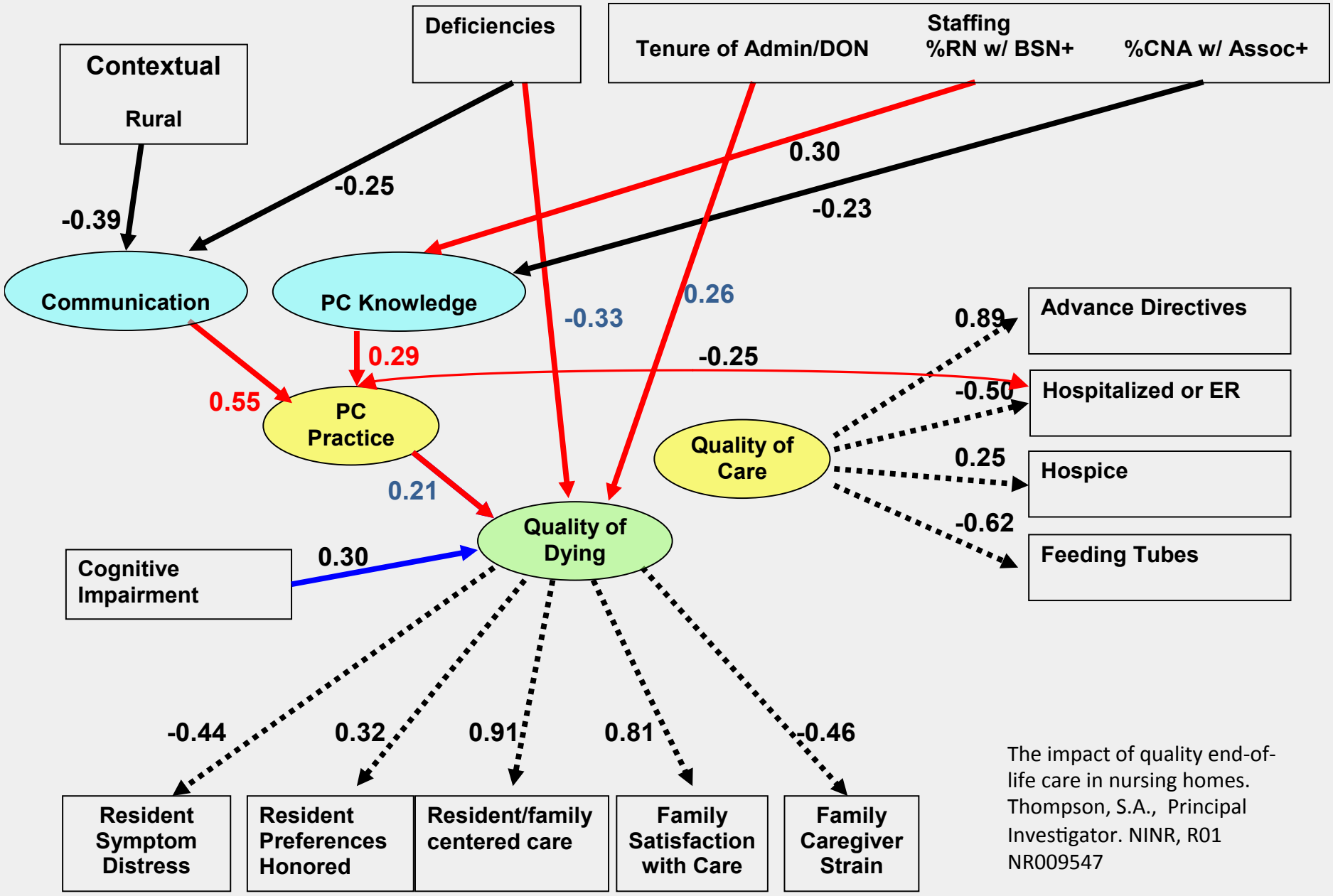
Barriers

- Regulatory push for restorative care
- Misperception that restorative and palliative care are incompatible
- Skilled Medicare benefit promotes hospitalization
- Higher reimbursement for skilled care: IVs, tube feedings
- Cannot have Medicare skilled & hospice care at the same time

Barriers

- Lack of staff with palliative training
- Lower proportion of RNs
- High staff & administrative turnover
- Administrator & DON attitudes toward palliative care

Results of Full SEM

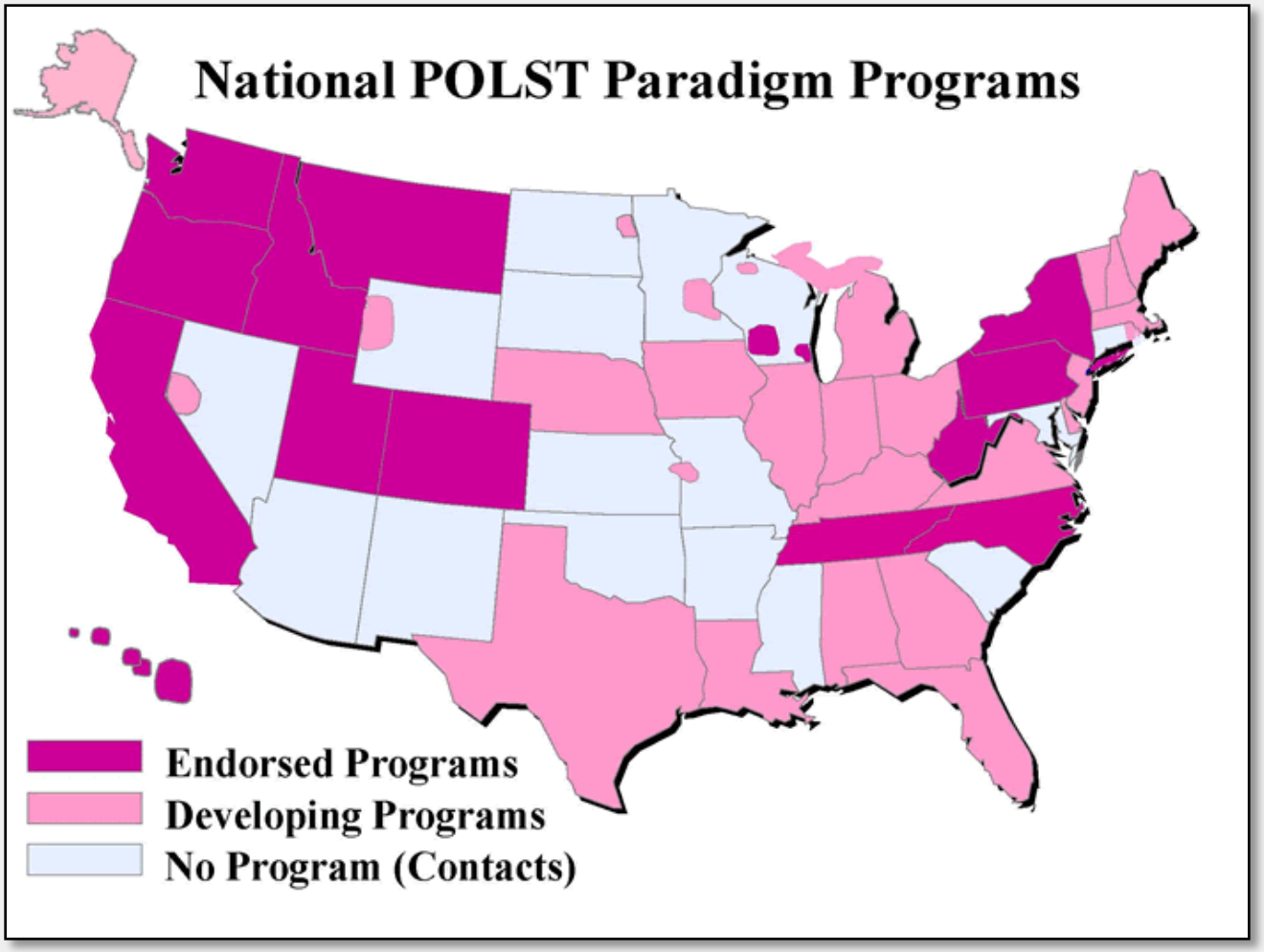


The impact of quality end-of-life care in nursing homes. Thompson, S.A., Principal Investigator. NINR, R01 NR009547

Policy Implications

- Fragmentation between Medicaid & Medicare
  - Little incentive, currently, for states
  - Bundled payments, integrated models may change incentives
- Medicaid Payments: > $10 per diem rate
  - Decrease hospitalizations
  - Decrease in persistent pain
  - Higher staffing levels

Strong state support for advance care planning such as with POLST or FIVE Wishes



Policy Implications

- State and provider incentives to reduce turnover
- Leadership of NH administration
- Education requirement/s for palliative care
- Palliative care consulting service
  - Diffusion of hospice-like care throughout NH
- Palliative care program/focus within NH

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