



Palliative Care in the Long-Term Setting

Creekside Rehabilitation Center
Santa Rosa, California



Background

Although most Americans still prefer to die at home, most terminally or chronically ill spend their last days or weeks in healthcare institutions with those who have little knowledge or instruction in the “art of dying.” For many of those greater than 65-years-old, home is a long-term-care facility.

The number of elderly persons in the United States (US) is increasing. According to the US Bureau of Statistics, it is estimated the number will double to 97.8 million by the year 2025; greater than 30 percent of the population. As a result of the Silver Tsunami, the number of those living in nursing facilities is expected to also double to over 3 million. Currently, 24 percent of the elderly die in nursing homes. By the year 2030, this number will increase to 40 percent.

The cost of care for patients in hospitals with chronic disease and multi-organ failure or for whom death is likely within their last year of life is exceedingly high. Accounting for more than \$600 billion a year in healthcare spending, Medicare now provides financial incentives to hospital institutions with low readmission rates for certain chronic diseases such as congestive heart failure. Coordinated efforts between skilled facilities with lower emergency room and hospital transfer rates within the community are anticipated to develop.

The \$600 billion dollar cost and the task of heroic treatments and futile measures often tends to afford no regard for the individual’s conception of “quality of life”. Numerous studies of persons with serious illness show they want vigorous treatment of their pain and symptoms, relief from worry, on-going communication about their care, assistance with understanding the health care system, and inclusion of family members in the decision making process. Limited communication between doctors, patients, and families leads to care that is not in accord with patient wishes should said patient had opportunity to understand treatment options and state his or her goals of their care.

Facility Description

Creekside Rehabilitation Center has 122 beds. The average daily census is 110 patients. Approximately 93 percent are Medicare/Medical beds. The average hospital transfer rate prior to program implementation was approximately 13%. We utilized the first six months of this program to assess the needs of the facility, staff, and patient population.



EMBRACING QUALITY
AWARD WINNER

Creekside Rehabilitation and Behavioral Health was recently awarded the Providigm Embracing Quality Award for 2014 for exceptional achievement in preventing readmissions, survey performance, and customer satisfaction. With only 305 nursing centers in the US and Ontario receiving awards in 2014, this puts Creekside in a select group of high performing skilled nursing facilities.

Program Inception

May 2013-Dr. Eran Matalon introduces and spearheads the concept of providing palliative care services to the residents of Creekside Rehabilitation Center. Nurse Practitioner recruited (NP).

Aug 2013-Team assembles and begins meeting to determine program objectives, develop processes, and establish quality metrics.

Sept 2013-Program progressing and has gained momentum. Ability to refer patients remains available only to a limited number of select physicians.

Apr 2014-Observable decrease in patient and family suffering indicates success of program. Retrospective review of 50 charts validates program is having positive effect on meeting objectives.

Objectives

Improve Quality of Life

Reduce Hospital Readmissions

Align Care
with
Patient Directives and Wishes

Communicate Care Planning Goals

Methods

Development:

- Review of best practices across the nation
- Review of recommendations from palliative care organizations
- Review of different models of application

Implementation:

- Bluegrass Model-Lexington, Kentucky (*modified*)
**Nurse Practitioner rounds closely on patients who meet palliative criteria
- Team meetings to review processes, on-going

Quality Metrics:

- **Documentation Metrics**
 - general demographics
 - service dates (admit/dc/disposition)
- **Clinical Metrics**
 - goals of care identified
 - Physician Orders for Life Sustaining Treatment: POLST completion
 - care provided based on goals
 - conversion to hospice
 - hospitalizations reduced
- **Customer Satisfaction Survey**
 - Patient/Family
 - Referring physician

Retrospective Review Findings

Total new consults: 50

Top 6 diagnosis triggering consultation:

- CHF
- COPD
- Stroke
- Recurrent Aspiration Pneumonia
- End-Stage Dementia
- Malignant Neoplasm

Total FNP patient visits: 112

POLST completion: 90%

Estimated deferred ER transfers: >50

(goals, pain, and multi-symptom management)

Hospital readmission rate: 5%

Patients transitioned to hospice: 90%

Average days on hospice: 20

Cost of hospitalization for CHF: \$15,000.00

Total cost of program: \$1600.00

Total cost of NP: Reimbursement-Medicare Patient/Family satisfaction:

*Although all families have verbally expressed great gratitude for the care provided to loved ones by our team, to date no surveys have returned. Process improvement discussions are in progress. Phone interviews to replace mailed surveys.

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Resources

Available on hand out.