Leadership in Palliative Care: Strategies for APNs

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Objectives

• Discuss the financial and clinical case to demonstrate the value of palliative care
• Identify two strategies to extend the impact of palliative care through APN roles
• Describe current and future trends impacting APN practice in palliative care
Dialogue with Attendees

• Who is here?
• Why are you attending this session?
• What do you hope to learn?
Plan for session

• What APNs need to know about making the clinical and financial case for palliative care today
• Discuss the role of APNs in improving care of patients and families
• What lies ahead for APNs/RNs as palliative care evolves
Part One: PC Impact Cascade

**Primary impact is on the patient**
A. Prevention & relief of pain & other symptoms; attention to social, emotional, spiritual, practical needs
B. Clarification of prognosis and goals of care
C. Greater concordance between preferences and setting/types services received

**Secondary impact is on those around patient**
D. **Family** – less confused, more satisfied, better coping
E. **Nurses, doctors** – appreciate specialist help, less distress

**Tertiary impact is on institutions, systems, payers**
F. Fiscal and operational changes:
   • Frequency, intensity, duration, settings, costs, revenues for services
G. Impact on quality & performance metrics

Cassel (2013). “The importance of following the money in the development and sustainability of palliative care”. Palliat Med 2013 27(2) 103-104.
What is the clinical and financial (business) case?

• Persons with serious illness often have high utilization of expensive services in last months of life, some of which is avoidable

• Hospital-based care improves symptoms: patients feel better

• Hospital-based palliative care decreases cost as patient preferences align with plan of care

• Outpatient palliative care improves symptoms, coordinates care and reduces ED visits and hospitalizations in last months of life
When goals match plan of care → less resource use

(Pantilat, 2015)
Palliative Care Service consultation within the first 24 hours of hospital admission ensures that patient preferences are assessed and followed from the outset impacting care for the entire admission (Pantilat, 2015)
Growing evidence of benefits of OP PC

- **Temel NEJM 2010:**
  - Outpatient PC for late-stage NSCLC patients
  - Improved: survival, quality of life, depressive symptoms

- **Bakitas JAMA 2009:**
  - Psychoeducational sessions for patients with advanced cancer
  - Improved: quality of life, depressive symptoms

- **Brumley JAGS 2007:**
  - Home-based PC for home-bound pts with Ca, CHF, COPD
  - Improved: satisfaction, at-home deaths, fewer ED visits and hospitalizations

- **Rabow Arch Intern Med 2004, JPSM 2003:**
  - PC in primary care clinic for late-stage COPD, CHF, Ca patients
  - Improved: dyspnea, anxiety, spiritual well-being, sleep quality, satisfaction with PCP and medical center

Predictable OP PC impact on utilization

↓ Acute care hospitalizations/readmissions
↓ Emergency department/urgent care visits
↓ Deaths in acute care facilities
↓ Aggressive care in final month of life
↓ Total costs of care

↑ Hospice utilization
↑ Hospice length of service

... but significance of reduced utilization will vary, because fiscal and quality incentives are not always aligned
## How/why PC has positive outcomes for patients, families, hospitals and payers

<table>
<thead>
<tr>
<th>PC Impact on Pt/Family</th>
<th>Secondary Outcome</th>
<th>Best Published Evidence</th>
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<tbody>
<tr>
<td>More communication, greater comfort, preferences met</td>
<td>Patients live longer and with higher QoL</td>
<td>Temel NEJM 2010; 363:733-742</td>
</tr>
<tr>
<td>More communication, greater comfort, preferences met</td>
<td>Greater patient / family satisfaction</td>
<td>Casarett Arch Int Med 2011; 171:649-655</td>
</tr>
<tr>
<td>Goals of care clarified, and often changed</td>
<td>Lower costs per day</td>
<td>Morrison Arch Int Med 2008; 168:1783-90</td>
</tr>
<tr>
<td>Goals of care clarified, and often changed</td>
<td>Shorter ICU length of stay</td>
<td>Norton Crit Care Med 2007; 35:1530-35</td>
</tr>
<tr>
<td>Greater comfort, access to hospice</td>
<td>Shorter hospital length of stay among survivors</td>
<td>Wu J Palliat Med. 2013 Nov;16(11):1362-7</td>
</tr>
<tr>
<td>Clinical documentation of symptoms, discharge to home care or hospice</td>
<td>No increase in hospital mortality rate</td>
<td>Elsayem JPM 2006; 9:894-902; Cassel JPM 2010; 13 (4): 371-374</td>
</tr>
<tr>
<td>Better symptom management with in-home PC</td>
<td>Fewer ED visits and hospital admissions</td>
<td>Brumley JPM 2003; 6:715-724</td>
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<td>Better symptom management with in-home PC</td>
<td>Fewer hospital admissions and inpatient deaths</td>
<td>Brumley JAGS 2007; 57:993-1000</td>
</tr>
<tr>
<td>Better symptom management with home care or hospice</td>
<td>Fewer 30-day re-admissions</td>
<td>Enguidanos JPM 2012;15(12):1356-1361; Ranganathan JPM 2013 16(10):1290-1293.</td>
</tr>
</tbody>
</table>
Evidenced based interventions to positively impact finances

• For ACOs, home based programs decrease total costs of care, increase hospice LOS
• Early palliative care for patients with advanced cancer and other life-limiting illnesses
• Communication Initiatives, for example Serious Illness Care discussions
Discussion

• What challenges have you faced in describing the clinical outcomes and/or financial impact?

• What has worked well in advocating for palliative care?
Part Two: Nurses’ Contributions to Palliative Care

• Definition of nursing: patient’s response to illness, strength based, pt + family, advocate
• Prevalence of nurses in all sites of care, with all ages and variety of serious illnesses
• Awareness of the impact of social needs on health → critical
• Navigate processes to promote continuity/transition and failures/gaps
• Trusted by patients and families
Primary and Specialty Palliative Care

• Primary: skilled in symptom management, communication, psychosocial and spiritual support, transitions of care
• Specialists: major focus, certification, fellowships
• Primary: skilled in symptom management, communication, psychosocial and spiritual support, transitions of care
• Both are essential in all care settings
• Both need systems and processes to support the work
APN Roles in Primary and Specialty Palliative Care

• Roles in non-palliative care services: Heart Failure, Primary Care, Geriatrics, Pediatrics

• Educators, Policies, Ethics Committee Members
  – Represent primary palliative care
  – Advocate for specialist involvement

• Members of Specialty Teams in hospitals, home-based programs or clinics
What Health Care Looks Like to People with Serious Illness

Community

Hospitals

Physicians, APPs
Site staff
Pharmacists
Care managers
Payer networks
Internet

Clinics

ED

Transitional Care

Nursing Facilities

Home

Home Care

Hospice
What if...

• Nurses were comfortable, supported and looked to for information about patient goals, values, preferences ➔ EMR, family meetings

• Nurses’ ability to tackle symptoms with finely tuned assessment and medication management was recognized and highlighted

• Nurses’ ability to use non pharmacological interventions was seen as essential versus ‘nice to do’
High Impact Roles in Palliative Care

- Teacher-coach-mentor
- Integrate palliative care in processes, pathways, guidelines
- Role model in your own clinical practice
- Focus on “pillars” of palliative care everywhere
  - Symptoms: evidenced based assessment/management
  - Anticipatory guidance to document patient understanding of prognosis, patient preferences
  - Transfer of care plan across settings with eye to feasibility and practical implications and relationships with care coordinators
  - Collaboration with psychosocial and spiritual colleagues
Focus on Communication Initiatives

• Goals of care discussions at specific points in time
• Serious Illness Conversations with systems to support implementation (education, mentoring, documentation)
• Role play for specific skills with practice and feedback
Lead Successful Palliative Care Program Development and Expansion

• Assess need: share your vision, hear from stakeholders, confirm your impressions

• Identify your patients
  – Who, when, how, by whom
  – Define your clinical model

• Select measures and process to evaluate
Program Design Elements

Patient Volume ← Service Features

Program Design

Staffing Plan
Program Components

• Needs Assessment
• Develop Clinical Model and define partners
• Select Measures (operational, financial, clinical, satisfaction)
• Education
• Marketing
• Evaluation and ongoing strategic planning
Needs Assessment

• What is the gap?
• Why does this exist?
• Who else is working on this? Or on overlapping areas?
• Who “owns” this problem?
• Can we find data to illustrate the gap and identify how/where we will intervene?
• What services are most important to your stakeholders?
Questions to Address Clinical Aspects for your program

- Patient eligibility
- How are referrals made?
- How are appts scheduled? How many/patient?
- Who will see the patient?
- Who is on your team?
- On call, other partners, documentation
Part Three: Future Trends and Opportunities

- “Palliative Care Everywhere”
- Role of the Community in meeting palliative care needs
- Aligning incentives: Payer-provider partnerships
- Population Health: identifying patients at risk, involving care coordination, stratifying interventions to level of need, transitions
- Technology
- Continuing workforce shortage (example: APRN externship program)
- Promoting understanding of benefit of palliative care
The Triple Aim + Improving Work Life of the Health Care Team

• Recognizing importance

• Challenges:
  – Workforce shortages
  – Working at “top of license”
  – Interdisciplinary synergies
Resiliency for Nurse Leaders

• Think about someone you have admired...
• What were they like?
• How would you describe them?

• Knowing ones self and what you stand for ➔ follow direction from inner compass
Resiliency and Knowing Oneself

- Self awareness: what are your triggers?
  - How do you respond?
- What is *not* helpful from a nurse leader?
  - Inconsistency, subjective decisions
  - Passivity
- What can I control/influence and what is out of my control
  - Courage to persevere
  - Who can help?
  - Developing and maintaining a self care plan
Revisit objectives

• Financial and clinical case
  – improves quality of life
  – Well demonstrated in hospitals
  – Good evidence for home based and outpatient clinics
  – ACO examples

• Strategies
  – Focus on palliative care, increasing skills and developing process to support communication and palliative care principles

• Trends
  – Greater recognition of impact of social needs
  – Increasing role of the community
  – Collaborating with new partners: example, payers
  – Continuing workforce shortage creates opportunities
  – Your own resiliency is critical
Discussion
Resource List

• http://advancingexpertcare.org/aprn-externship/
• Stagman-Tyrer, D. Resiliency and the nurse leader: the importance of equanimity, optimism and perseverance. (2014). Nursing Management, 46-50
• https://www.ariadnelabs.org/areas-of-work/serious-illness-care
• http://Vitaltalk.org/