



VCHIP Provider Sub-grant Program Final Report
Rutland Area Visiting Nurse Association & Hospice

Supportive Care Program

Nicole Moran, MSN, BA, RN

July 12, 2016

Table of Contents

Acknowledgements.....3

Executive
Summary.....4

Discussion.....6

 Project Description.....6

 Project Evaluation.....8

 Project Sustainability.....11

Conclusion.....12

Acknowledgements

Funding for this report was provided by the State of Vermont, Vermont Health Care Innovation Project, under Vermont's State Innovation model (SIM) grant, awarded by the Center for Medicare and Medicaid Services (CMS) Innovation Center (CFDA Number 93.624)

Federal Grant #1G1CMS331181-03-01.

Executive Summary

In 2014, The Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD) Collaborative of Rutland convened to provide an integrated model of care to prevent hospitalizations in these two populations of patients. The Collaborative includes many facilities and community based services in the community of Rutland County, including Rutland Area Visiting Nurse Association and Hospice (RAVNAH) and the Rutland Regional Medical Center (RRMC). A piece of the integrated care was to look for way to introduce increased supportive care and resources for patients in the region living with CHF and/or COPD in order to improve patient outcome and reduce the utilization of health care services.

RRMC and RAVNAH collaborated to design and implement the Supportive Care Program to assist in bridging the gap between inpatient palliative care and hospice; while expanding upon the existing palliative care program for homebound patients. The Supportive Care Program was designed to address the complex needs of seriously ill patients in the Rutland area in partnership with the Rutland Blueprint for Health and the Community Health Centers of the Rutland Region (CHCRR), which provides care to a majority of the patients in the Rutland area. Funding was received to support our pilot program to assist in supporting patients and their caregivers to clearly identify their goals and incorporate these goals into a suitable treatment plan by collaborating with their primary care providers earlier in the disease trajectory.

The introduction of the service was primarily a function of RAVNAH and therefore used the episode-based payment model. The services provided by RAVNAH included consultative palliative care support visits within the patient's home, performed by skilled nurses, licensed social workers and a nurse practitioner. Eligibility for the program included the diagnosis of COPD and/or CHF with impact on activities of daily living and quality of life. Patients enrolled in the program were not eligible for any other services (i.e. Hospice or Homebound services) provided through the organization. The program anticipated enrolling fifty patients in Rutland County based on the CHF/COPD Collaborative experience

with this particular population of patients. Patients were identified by the Collaborative as well as other health partners in the community. Between March of 2015 and June of 2016 sixty-three patients were referred to the program. The referrals came from 22 different providers in the community and included primary care physicians and nurse practitioners, hospitalists and specialists. The pulmonologist office was the largest referral source, with twenty-five referrals. From the sixty-three referrals received, forty-nine patients enrolled in the program.

In the beginning of the pilot program, the nurse practitioner for the organization performed the initial home visit to conduct the in-depth formal assessment and introduce the care plan development process. In June of 2015, this initial home visit was shifted to a skilled nurse. Subsequent visits were performed by either skilled nurses or licensed social workers to develop the care plan. Over the course of the twelve week enrollment period these visits were made weekly and addressed patient and family understanding of medical condition; physical and psychological symptoms; home safety and equipment needs; family caregiver capacity and needs; resources for housing, food, transportation and medications; and assistance with health care decision making. Visits from the nurse also focused on predictive factors that could lead to a medical crisis, as well as the identification of individualized triggers and how to reduce their occurrence. Nurses were available on-call for these patients twenty-four hours a day, seven days a week to assist with symptom management and prevention of Emergency Department visits or hospitalizations.

Patients were considered for discharge from the program when they met the following criteria:

- Symptom control achieved
- Patient or family/caregiver demonstrated ability to manage condition
- Patient became eligible and elected other services (Hospice, Homebound Services, Skilled Nursing Facility)
- Evidence of disease stability

Patients enrolled in the program were provided with Quality of Life Assessments upon admission and completion of the program in effort to track individual impact. Patient and family satisfaction surveys were sent after the completion of the program to measure success and satisfaction the services provided. Provider satisfaction surveys were also sent after completion of the program. Data was collected throughout the program to track patient progress and serve as an evaluation tool to promote changes to the program when necessary.

Throughout the time of the pilot program some variations were made along the way. These were based on changes that occurred within the organization and results of surveys and other sources of feedback. The CHF/COPD Collaborative served as the platform for ongoing cooperation throughout the pilot. Currently the Collaborative is expanding to include all-cause readmissions, not just focusing on COPD and CHF patients. Even though the Supportive Care Program is complete, the Collaboration continues to keep the health and wellness of the Rutland community a priority, along with continuing to reduce health care costs.

Discussion

Project Description

GOALS:

1. Integrate supportive care and end-of life decision making earlier in the disease process
2. Expand upon collaborative approaches with primary care, RRMC and the Rutland Community Health Team to facilitate patient care decisions based upon patients' own values
3. Avoid unnecessary hospitalization and/or re-hospitalization for patients with complex conditions and needs
4. Improve symptom management and quality of life for the patient and caregivers

5. Promote earlier referrals to hospice
6. Support the Blueprint for Health goals for improving care for patients with chronic illness

The program had overwhelmingly positive feedback from the community. Strong collaboration occurred between all stakeholders centered on the patient and family goals. The patient and family centered approach using open communication and support to proactively provide services, allowed for engagement of patients enrolled in the program. Support for patients and families were provided to help them identify their goals and take steps towards achieving them. Quality communication facilitated a high quality of care by aligning planning with patient/family desires. Individualized care helped to promote adherence to recommendations and treatment, while simultaneously decreasing emotional duress that is commonly associated with serious illness. Patients and families developed trusting relationships with the skilled nurse and social worker who visited patient in their own home, which simplified the ability to have tough conversations about end of life issues and decisions. This facilitated referrals for other services, like hospice and homebound palliative care.

Routine meetings were held with members of the oversight committee to discuss progress, barriers, evaluation and improvements. Close collaboration occurred between the program director and The Community Health Team, Care Coordinators from CHCRR offices and the Case Management team from RRMCC. When RRMCC and CHCRR initiated their new Transitional Care Nurse programs, a relationship was conceived with the program director for education, support and collaboration.

Throughout the pilot a couple of challenges were faced. The primary challenge surrounded the turnover in the program director position. There was a gap in time when the pilot was unmanaged. When the new director was hired and trained on the program, it was discovered that certain items in the plan were not being implemented. This included the quality of life assessments, patient and family satisfaction surveys, provider surveys, communication with providers or education on the pilot to stakeholders. Additionally, under the previous director, the program lacked momentum, with only six patients enrolled

one year after the start date of May 2014. In June of 2015 the new program director implemented the missing items from the plan and also began doing education and outreach to community stakeholders.

Another challenge was internal marketing of the program. Within our organization there are currently departments that operate in silos. The education about the supportive care program was found to be inadequate internally when the new director began making changes and more referrals were being received. There was a lack of understanding of who was eligible, what services the patient would receive, how long the program lasted, etc. Education was provided by the new program director at Management Team meetings, clinical staff meetings and individually.

During the design of this program the target population was non-Medicare patients who were not required to be homebound. Our organization found this to be too restrictive causing many referred patients ineligible to participate. There were many patients that met the illness criteria but were not able to participate in the program based on their insurance payor. In November 2014 we requested a change to include Medicare patients in the program. This expansion allowed us to identify and treat more patients that already met the illness criteria without impacting the deliverables of the program.

Project Evaluation

MEASURES:

- ✓ Enrollment in the program
 - Goal: enroll fifty patients
- ✓ Length of stay in the program
- ✓ Transition to hospice
- ✓ Completion of advanced directives
- ✓ Patient satisfaction
- Goal: 75% rating 4 or higher on a scale of 1-5
- ✓ Patient quality of life
 - Goal: improve a minimum of 20% from baseline
- ✓ Primary care Provider satisfaction with the program

- Goal: 75% rating 4 or higher on scale of 1-5

On completion of the program, forty-nine patients were enrolled in the program. In the original plan, the program was set to run from May 2014 through June 2016. The program did not actually enroll the first patient until March 2015. The shorter time period of operation impacted the total number of patients enrolled. In addition, leadership at RAVNAH experienced turnover during the time frame of the project. The Director of Hospice and Palliative Care that began the program resigned in May 2015 and the new Director took over in June 2015. This turnover potentially impacted the numbers of patients enrolled, as well as other outcomes. Fourteen referrals were received that choose not to participate in the program for a variety of reasons.

A possible cause for the smaller number enrolled as well as referred to the program could be related to the same barriers that are experienced with hospice enrollment. There are providers in the service area that either don't understand the benefits of these programs, are not willing to let their patients "go", are unable to have the difficult conversation with their patients, are afraid that they will lose contact with their patient. There is also a general misunderstanding of the differences between just hospice and palliative care, and adding supportive care may have only added to the confusion. Many of the referrals that were received that did not accept services didn't feel that they needed any assistance or support for any number of reasons. Also, the majority of the referrals we received carried the diagnosis of COPD. Many of these patients had a long history of making poor health related decisions and non-compliance, which could have impacted both their willingness to enroll as well as their ability to commit to a plan.

Each patient enrolled in the program was tracked by start of care and discharge dates. An excel spreadsheet was used to track dates as well as referring providers, diagnosis, age, completion of advanced directives, disposition on discharge, completion of quality of life assessments and delivery of satisfaction surveys. Of the forty-nine patients admitted, only nine were admitted with CHF, the remainder was COPD patients. A total of twenty-two different providers referred patients to the program, with the

majority from the pulmonologist office. Interestingly, only one referral was received from the cardiologist office. When contact was made with the cardiology office, they did not identify any concerns or reasons for not referring patients to the program.

Provider satisfaction surveys were sent to each referring provider two weeks after the patient was discharged from the program. The survey was created by program staff. Seventeen surveys were returned with 79% rating 4 or higher on a 1-5 scale. Several comments were received on the surveys as well.

Comments:

- “fabulous care and service”
- “service needs to continue past June”
- “I did not receive any follow-up from the Supportive Care Team”
- “thank you for aiding with these issues”
- “Can you see patients in clinic with us?”
- “very patient and concerned , helped support patient”
- “provide more visits”
- “Can we receive patient’s goals to review at follow up visits?”
- “improves end of life planning and education for patient and family”
- “made patient aware of end of life issues”
- “need to improve communication back to the provider”
- “This is the greatest thing since slice bread!”

Patient and family satisfaction with the program met the identified goal as well. Eighty-one percent of patients that returned their survey rated it 4 or higher on a 1-5 scale. Only seven surveys were returned. This also was created by staff.

Patient specific data was captured by communication between program team members and was recorded in the excel spreadsheet. Twenty-two patients (45%) worked with the social worker to complete their advanced directives. Once these were completed they were sent to all providers involved with the

patient and put in the state registry. Fourteen patients (29%) transitioned into either palliative homecare or hospice. These patients were identified by the nurse or social worker and with the comfort and trust of the patient and family; conversations about end of life decisions and planning were able to occur. There is no way to determine if these patients would have completed their advanced directives or if they would have entered into hospice or palliative care if they were not enrolled in the program.

The quality of life assessment was a difficult measure to assess. The assessment tool used was the Missoula-VITAS Quality of Life Index tool which measures five areas of quality of life based on answers to fifteen questions. Some patients had improvement in some areas, but worsened in others. It was difficult to determine what 20% improvement from baseline looked like. For example, one patient had significant worsening of symptoms, but their well-being improved. Another had significant improvement in their symptoms but dropped in function, interpersonal and well-being. There was one patient that did not experience any negative changes in the scores and one patient that did not experience any positive changes in the scores. Six patients however had worsened symptoms but their function score improved, which could be indicative of effective education on energy conservation techniques and avoidance of triggers. The results of the tool are too variable for reliable data interpretation.

Only fourteen patients completed the assessment on admission and completion of the program. The approach of using the tool probably impacted the low number of completion. The nurse would leave the assessment with the patient to allow for time to complete and then retrieve it on the next visit. Many times the tool was lost, not completed, or even completed without true understanding of what the questions were asking. The reliability of the tool is uncertain when considering this.

Going forward, the results of the program will be shared in meetings with the oversight committee as well as the Collaborative. Both groups have identified that this program was valuable to the patients served and would like to see it continue. The positive outcomes that were experienced by many who participated in the program have impacted the Collaborative to start a sub-committee for palliative

and hospice. This committee has been meeting to promote and educate both providers and the community on palliative care and hospice services. This effort includes a variety of efforts, including film discussions and presentations to provider offices and community gatherings. The committee is also looking to bring an end of life care specialist to conduct a provider to provider training session. Also stemming from the Collaborative is a provider group that will concentrate on severe illness management.

Project Sustainability:

While the outcomes of this program appear to have had a positive impact on patients, providers and the community, there is not a feasible way to continue this service in our current health care model. Without funding or a way to bill for reimbursement for the services provided, it is not sustainable. Changes on homebound criteria and skilled need for homecare would have to change. There are some pieces of the program that could certainly live on in other programs currently in existence in our agency as well as innovative ideas for the future. Health coaching is a new area of health prevention and maintenance and could be used in a similar way to assist and support those patients living with chronic severe illnesses that are struggling managing their disease. Within the state of Vermont support for these types of programs is closer than the rest of the country as the state is already looking at ways to shift the focus away towards high quality, cost effective health care systems.

Conclusion:

The Supportive Care Program was designed to address the complex needs of seriously ill patients living in our community. The goal was to assure identification and optimal care for patients seriously ill with CHF and/or COPD to meet medical, psychosocial and family caregiver needs. This was a new model of care designed to maximize patient/family/provider communication, support disease specific advance care planning, ensure quality care in the home setting and optimize and promote efficient use of health care resources. The program used principles and practices from hospice and palliative care to focus on

providing relief from uncontrolled pain, overwhelming suffering, and the stresses that accompany serious illness.

The program provided intensive, home-based care management to help improve patients' quality of life for patients not actively dying, who were at the highest risk of repeated medical crises, hospitalization, symptom distress, family caregiver stress and unnecessary medical expenditures. Throughout the length of the program, tracking of data and evaluation of outcomes occurred to help identify success made and opportunities for improvement. While the value of the program is shown in these outcome measurements, there is not a feasible way to continue the program currently. It is the hope that in the near future our health care system will include and financially support innovative care delivery models like the Supportive Care Program. In the meantime, our agency continues to work together with community partners to provide patients in our community with a collaborative approach to health care.