

NPs Can Advance Palliative Nursing Home Care

Nurse practitioners who have received proper training can provide palliative care in nursing homes.

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SALT LAKE CITY — A nurse-practitioner model can overcome regulatory and reimbursement barriers to the delivery of palliative care to patients in nursing homes, according to Dr. Jeanne Elnadry, medical director of the Hospice of Yuma (Ariz.).

"These chronically ill and terminal patients are among the most vulnerable in our society, and they have lots of needs that are not adequately addressed," Dr. Elnadry said at the annual meeting of the American Academy of Hospice and Palliative Medicine and the Hospice and Palliative Nurses Association.

"Nurse practitioners can help to fill some of that void if they have adequate training and desire," she added.

In 2004, Dr. Elnadry—along with Peggy Edwards, a nurse practitioner certified in geriatrics and palliative care management—began developing a modest palliative care service that provides consultations to Yuma's four nursing homes, which have a total of 450 beds.

Their goals were to decrease utilization of the local hospital's emergency department, to reduce hospitalizations, and to provide better and more comprehensive care to nursing home residents, said Dr. Elnadry, who also provides palliative care consultations at the Yuma Regional Medical Center.

"Palliative care in nursing homes is for patients who, for some reason, cannot receive hospice care even though they have

a prognosis of under 6 months," Dr. Elnadry said in an interview. It's also for patients who will most likely live longer than 6 months but have a life-limiting or highly symptomatic condition, or for patients who have a condition such as Alzheimer's disease who may require palliative care for an extended period of time until they are eligible for hospice care, she said.

Many nursing home patients have terminal diagnoses with prognoses of much less than 6 months, and would benefit from the types of services available in hospice, such as social work services, the assessment and management of complex symptoms by registered nurses, and bereavement support, she said.

The role of the palliative care nurse practitioner is to provide consultations (on a physician's order), to communicate directly with the primary physician, to conduct family meetings as necessary, to write symptom management orders, and to perform follow-up for symptom management and decision making, Dr. Elnadry explained.

She noted that among the challenges to the provision of palliative care in nursing homes are several myths: that such care is strictly for the end of life; that Medicare will not pay for skilled and palliative care simultaneously; that Medicare skilled beds are only for patients who are able to participate in rehabilitative care and are going to "get better"; and that palliative care services by physicians, nurse practitioners, and physician assistants is not reimbursable.

One obstacle is that Medicare will not pay for hospice care and skilled nursing care in a nursing home at the same time, and there is no payer source for palliative care interdisciplinary teams in nursing homes. Dr. Elnadry—who bills her visits under Medicare Part B, which doesn't cover all expenses—said that the Centers for Medicare and Medicaid Services needs to address the needs of these very ill nursing home patients.

"Because there is no adequate system for reimbursement for the time required for complex consultations and family meetings, some programs rely on grants, but you can't run a health care system on grants. We didn't obtain a grant and [thus] have to cover our costs through billing. That's important because a nurse practitioner costs less than a physician, so if the nurse sees enough patients, then the billing may cover her costs," Dr. Elnadry said in an interview.

Ms. Edwards noted that "ours is a heavily regulated industry with an unbelievable burden of rules and regulations that weigh against palliative care in nursing homes." There is no incentive to accept a patient into a nursing home if he or she is considered "terminal," she added.

The first step in implementing a palliative care service in the nursing home is to identify those with the authority to help you succeed, Ms. Edwards explained. "Develop your champions, including the administrator, the head of finance, the minimum data set coordinator, the director of nursing, and perhaps your director of social services. These are key people with clout."

Ms. Edwards recommended targeting appropriate patients for palliative care, such as patients with aggressive advanced disease and a poor prognosis or those who have functional decline despite receiving physical therapy rehabilitation; patients who make frequent trips to the hospital; and patients with acute, chronic, or uncontrolled pain.

"Include advance care planning with advance directives, and address psychosocial and spiritual concerns with patients and their families, and with caregivers and staff," she said.

Dying patients in skilled Medicare beds benefit from the kind of intensive symptom management that hospice would provide but cannot give in that setting. "That's where palliative care can help until the patient is through his skilled term and is appropriate for hospice," Dr. Elnadry suggested.

As their consultation service developed, several benefits became apparent to Ms. Edwards and Dr. Elnadry. Hospice care in the nursing homes increased, and more patients have made the transition to the Medicare hospice benefit.

In addition, the nursing staff enjoyed heightened confidence in their assessment and symptom management skills, and felt more empowered to approach primary care physicians about symptom management for their patients, Dr. Elnadry said. She added that the nurses also have developed a higher regard for the input of their nursing assistants.

Before starting a service, be sure to plan for growth, Dr. Elnadry advised. "We had so much growth that we could not keep up, and it's not that easy to recruit people when you have a sudden growth spurt in the number of nursing home patients."

Contracts have to be carefully worked out. Medicare Plus Choice plans often have specific hospice eligibility requirements, and sometimes will not allow hospice care if the Medicare Plus Choice program is paying for the nursing home bed, she added.

Finally, data collection is difficult when multiple institutions are involved. "If there is not adequate staff to collect data prospectively, access to data may be lost if the nursing home doesn't open its charts for review and data collection," Dr. Elnadry said. ■

Meeting the Need for Palliative Care

Over the past 5 years, the nurse-practitioner model has helped Home & Hospice Care of Rhode Island, Providence, provide 350 consults and more than 1,200 nursing home visits, said Dr. Joan Teno, who is the collaborating physician with the hospice's nurse-practitioner palliative care consult service.

"This has been a very successful model for reaching a variety of nursing homes throughout the state, and our two nurse practitioners make it economically feasible to do on Medicare billing," said Dr. Teno, professor of community health at Brown University, Providence.

"The nurse practitioners are wonderful because they shuffle very easily between the world of nursing and the world of physicians, and they're very successful at providing consults to nursing home residents who either need a pain and palliative care consult service or [would] come onto hospice services except for the financial disincentives under the skilled Medicare hospice benefit," Dr. Teno said in an interview.

Dr. Teno added her voice to those who would like to see the Centers for Medicare and Medicaid Services improve benefits for interdisciplinary team care in nursing homes.

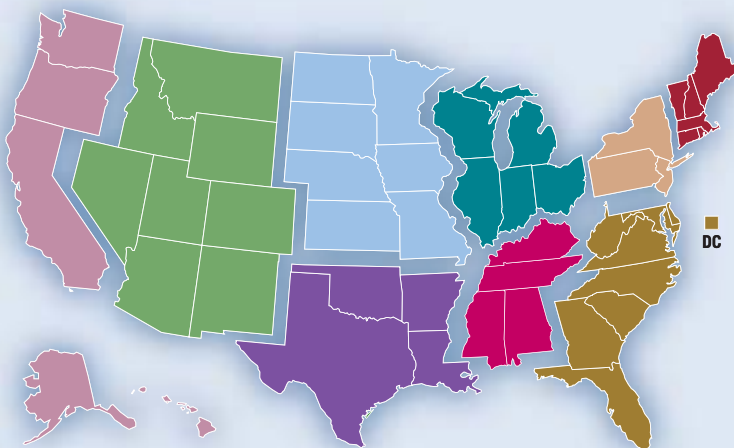
"And I would suggest that CMS [allow] an overlap program whereby people can access those skilled services and hospice at the same time," she said.

The need to provide quality end-of-life care in nursing homes is mushrooming as the population of the country ages. A survey conducted in 2000 suggested that more than 40% of the chronically ill and dying spend at least some portion of their last month of life in a nursing home, according to Dr. Teno.

"We've found that [adding a] pain and palliative contract service is one means of addressing these concerns by providing very skilled nurse practitioners to provide consultations, teach and train the nursing staff, help mobilize the existing team in the nursing home, and then address questions around advance care planning and good pain management," she said.

DATA WATCH

Western Regions Have Smallest Hospice Caseload In Skilled Nursing or Long-Term Care Facilities



Region 1 37.5% Region 2 26.3% Region 3 23.0% Region 4 27.4% Region 5 41.0%

Region 6 39.0% Region 7 31.8% Region 8 13.1% Region 9 22.6%

Note: Average percentages based on 2005-2006 data from Hospice Salary and Benefits Report. Source: Hospice Association of America