

THE GIANT LEAP FORWARD: CARE PROVIDER TO CARE MANAGER

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OBJECTIVES

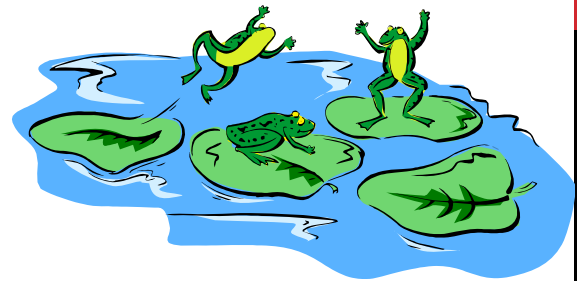
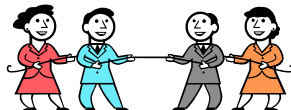
Describe the differences between care providers and care managers

Discuss trends related to healthcare delivery which impact hospice and palliative care

Identify implementation strategies and processes which reflect a shifting understanding of the role of hospice and palliative care in the system of care delivery

DISCLOSURES

No disclosures and no conflict of interest
No discussion of off-label uses for drugs



PURPOSE

Explore the shifting roles for hospice and palliative care in a changing health care delivery environment



CARE PROVIDER AND CARE MANAGER

CARE PROVIDER

Delivers actual care
Is responsible for the action of providing care or services related to care
Is reimbursed for the act of providing care (fee for service is most common)
Works independently of other care providers

CARE MANAGER

Organizes the delivery of care, may not be the actual provider of the care
Responsible to coordinate the delivery of care and services based on understanding the needs and goals of the patient
Shares information and works collaboratively to achieve patient's goals

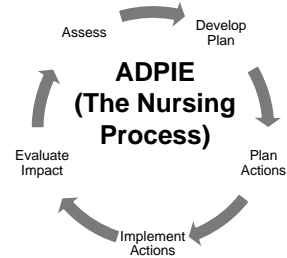
CARE PROVIDER

Hospice is a care provider model wrapped in a care manager framework

- Hospice delivers the actual care of physicians, nurses, nursing assistants, social workers, spiritual care practitioners, therapists, etc
- Hospice is reimbursed for the actual care delivered (FFS) based on the core team requirements in the CoPs
- Hospice is responsible for delivering the care according to clinical practice standards, Conditions of Participation and other regulatory mechanisms



WHAT DOES THE CARE MANAGER DO?



CARE PROVIDER

Hospice is also responsible for the professional management of the patient's care whether or not it is related to the patient's terminal illness (requires sharing of information with care providers in all settings)

The hospice medical director is responsible for the management and oversight of the medical components of care for hospice patients, whether or not they are related to the patient's terminal illness



CARE MANAGER

Core components of care coordination:

- Assess the patient and family
 - Goals of care, care delivery needs, barriers
- Develop care plan
 - Determine appropriate interventions based on assessment
- Identify care providers at all levels
 - Local/basic care; specialized care; non-clinical care
- Communicate with patient, family, and other care providers
 - Use technology and other tools to facilitate communication
- Execute the plan
- Reassess and make adjustments

CARE MANAGER

Hospices must act in the capacity of care managers – this is the true function of the IDG, *led by the designated RNCM*

Hospices are not directly reimbursed for this activity

Hospices who provide palliative care services separately are already working in this space, developing relationships and reputations as coordinators of services among a variety of care delivery systems



CARE MANAGER

Patient-and-family-centered care

- Core concepts are central to care management
 - Dignity and respect
 - Information sharing
 - Participation
 - Collaboration



CORE CONCEPTS OF PATIENT-AND-FAMILY-CENTERED- CARE

Dignity and Respect

- Healthcare practitioners listen to and respect patient and family goals of care and choices

Information Sharing

- Healthcare practitioners communicate information that is unbiased and affirming; information is timely and meaningful

Participation

- Patients and families are encouraged and supported in participating in decision-making and care-planning at the level they choose

Collaboration

- Patients and families are included as part of the organizational structure that designs, implements and evaluates policies, professional education and care delivery methods

REGULATORY CHALLENGES IN CARE COORDINATION

Most common deficiencies cited 2015

- §418.78(e) Standard: Level of activity (volunteers)
- §418.56(e)(2) Standard: Coordination of services
- §418.56(d) Standard: Review of the plan of care
- §418.76(g) Standard: Hospice aide assignments and duties



REGULATORY CHALLENGES IN CARE COORDINATION

Most common deficiencies cited CY 2015 (CMS)

- §418.76 (h) Standard: Supervision of hospice aides
- §418.56(b) Standard: Plan of care
- §418.54(c)(6) – Drug profile



CURRENT TRENDS IN HEALTHCARE

Aging Facts from the CDC:

- By 2030, More than 72 million people will be age 65 and over, accounting for more than 20% of the total population
- About 10,000 people a day will turn 65 over the next 20 years
- 66% of Americans have multiple chronic conditions accounting for 2/3 of the annual healthcare budget
- Heart disease, cancer, lung disease, stroke and Alzheimer's are the top 5 causes of death for those over age 65 – all of which are supported by palliative and hospice care



REGULATORY CHALLENGES IN CARE COORDINATION

Most common deficiencies cited 2015

- §418.56(c) Standard: Content of the plan of care
- §418.56 (c)(2) Standard: Content of the plan of care (scope and visit frequency)
- §418.54(b) Standard: Timeframe for completion of the comprehensive assessment



CURRENT TRENDS IN HEALTHCARE

Multiple chronic conditions

- Increased risk for avoidable hospitalizations
- Increased risk for drug interactions
- Increased risk for conflicting medical advice/instruction

CDC will focus on many psychosocial and cultural aspects of health in next 10-20 years

- Issues of sexual identity
- Mental distress including grief and isolation
- Health literacy



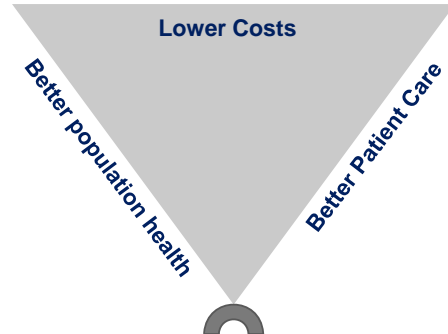
CURRENT TRENDS IN HEALTHCARE

US Census 2010

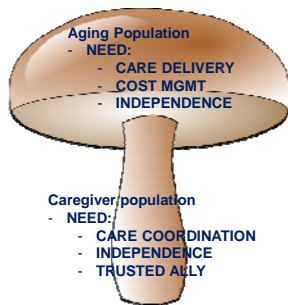
- Single households on the rise – now make up 25% of reported
- Fewer young kids – only 30% of households reported kids under 18 in 2010
- Blended families and undefined family relationships including “steps,” cousins, unrelated members of the family structure and foster relationships
- Racial and ethnic changes are extremely rapid with numbers of self-identified Hispanics and Asians doubling in 20 years
- Men living longer

CHANGE IS NOT A 4-LETTER WORD!

Impact of hospice and palliative care



HOW DOES IT ALL FIT TOGETHER?



* Innovation to find solutions which provide care management at a lower cost and with emphasis on choice, independence and individualization

* Services which are customized to the individual, which are holistic and which are least disruptive (avoid inpatient as long as possible)

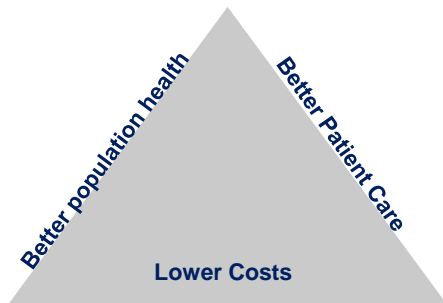
CHANGE IS NOT A 4-LETTER WORD!

Impact of hospice and palliative care on symptom management

- Pain management advances
- Increased awareness
- Demand for better
- Quantitative metrics
- Qualitative metrics
- Holistic approach

CHANGE IS NOT A 4-LETTER WORD!

Impact of hospice and palliative care



MAKING THE LEAP

A cog in the wheel of healthcare's machine or a gear needed to shift care delivery forward?

- Use data to drive process change, looking specifically at outcomes associated with care planning and care coordination (CAHPS responses, internal review of clinical records, live discharges, purchased services, service failures)
- Identify partnership options in the community which may be responsive to care coordination or care management



USING THE TEAM TO ITS POTENTIAL

Nurses and social workers are trained in collaborative care and can be maximized in their professional roles to provide solutions

Consider the role of the case manager at your hospice:

- Is the RNCM performing case management or visit nurse duties?
- Does your documentation support the role of the case manager via evidence of care coordination and care plan development?
- How does your clinical services manager provide care coordination oversight?

RN – VISIT NURSE TO CASE MANAGER

Take a look at visit frequency – patients should receive visits according to changing status and needs, including:

- Changes in medications
- Changes in symptoms
- Changes in physical, functional or other status
- Changes in caregiver needs/ capacity

Not just nurses but all IDG members!

RN – FROM VISIT NURSE TO CASE MANAGER

RNs deliberately work with the IDG in scheduling visits which maximize patient care, caregiver support and data gathering

RNs actively coordinate all care and services including the delivery of HHA services, volunteers and non-core services

RNs anticipate care needs based on disease trajectory, caregiver support and clinical experience

RNs adjust visit frequency for themselves and recommend it for other members of the IDG based on identified patient or caregiver needs

RNs recognize and respond appropriately to changes in clinical status, especially those which are indicative of approaching end of life dynamics

SWS – LEADING FROM BEHIND TO SUPPORT CASE MANAGEMENT

SWs provide coaching to the IDG regarding care coordination and case management

SWs adjust visit frequency based on skilled care needs of the patient and/or caregiver

SWs actively work with the RNCM to anticipate emotional, psychosocial or bereavement needs which may impact clinical care experiences

RN – VISIT NURSE TO CASE MANAGER

It takes at least 6 months for a nurse new to hospice to move from novice to confident and another 3-4 months before a level of expertise can be attained.

Starting with onboarding, introduce your nurses to the concepts of anticipatory care including disease trajectories, disease progression and symptom management principles

Encourage nurses to ask for help and provide periodic review – this is not part of standard nursing practice as nurses are traditionally independent thinkers and fairly self-reliant

A nurse moving from a bricks-and-mortar setting to a home-care setting also needs training in principles of care delivery at home, especially how to incorporate the full range of experts on the IDG (they don't have to do it all!)

HOW DO YOU KNOW IF IT WORKS?



USING DATA TO DRIVE THE PROCESS - COMMUNICATION

CAHPS survey results, specifically:

- Q9 - While your family member was in hospice care, how often did the hospice team keep you informed about your family member's condition?
- Q31 - Did the hospice team give you as much information as you wanted about what to expect while your family member was dying?
- Q33 - While your family member was in hospice care, how often did the nursing home staff and hospice team work well together to care for your family member?



WRAPPING IT UP

Hospice and palliative care are integral to the future of healthcare as it evolves

- It's good for people and it's good for the system

We face critical challenges in providing services as we move into the next decade

- Rapid growth in older adults with chronic illnesses
- Fewer people to provide the care
- Coordinated services will be required

Hospice and palliative care are positioned and have the experience to support care management, advance care planning and conversations about goals of care

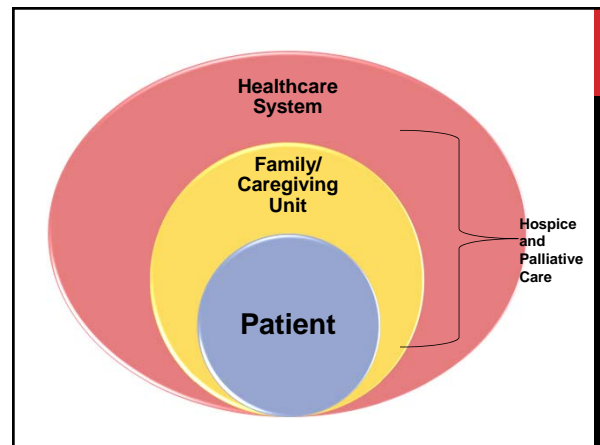
OTHER KEY CAHPS QUESTIONS (15-30)

Questions 15 – 20 = PAIN

Questions 16 – 29 = OTHER SYMPTOMS

Questions 29 and 30 = expectations

All of these questions have a common theme: Did you get enough information from the hospice to *know what to expect*?



USING DATA TO DRIVE RESULTS

Internal documentation review

- How are you evaluating the individualization of the plan of care?
- How are you tracking care coordination – especially in settings of care with overlapping care provision?

Service failures

- Do you do a root cause analysis or other method to identify why there is dissatisfaction?
- Do you identify trends and use these to drive process improvement?

