

Uncovering Palliative Care Need in a Medicaid-Funded Assisted Living Facility

Submitted by: NYU Rory Meyers College of Nursing and The New Jewish Home

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Category: Reaching the Patients in Need

Overview

This primary palliative care quality improvement effort identifies and addresses palliative care need in a marginalized, frail, and vulnerable assisted living population. This project is an academic, public housing partnership that seeks to leverage quality improvement and palliative care expertise to reduce suffering in older adults with serious illness living in an established Medicaid Assisted Living Program (ALP) in the Bronx.

Funded by a two-year career development award through the NPCRC, Dr. Daniel David has embedded himself in the wellness center of the New Jewish Home (NJH) ALP two days a week to uncover palliative care need, evaluate care processes, provide education to residents and care staff, and introduce interventions to address symptoms of serious illness, support advanced care planning, and reduce avoidable hospitalization. The project is funded through salary support for Dr. David through the NPCRC (\$100K / year for 2 years) and Dr. David's start-up funds for his NYU appointment (approximately \$15K per year for intervention development, participant honorariums, equipment costs).

Impact

The NJH ALP provides stable housing, food, socialization, functional support, and modest wellness support from a nurse and home health aides for independent older adults. The population is diverse (38% black, 38% Hispanic, 7% white, 17% other). Residents qualify for this subsidized living environment through an assessment of financial need (no more \$1,477 monthly income) and functional need (independent yet requiring some functional support in meal preparation, transferring, bathing, laundry, housekeeping, medication management). Many residents are marginally housed (22% have a history of homelessness) or require support precipitated from complicated family separations which make returning to a home environment unlikely.

A large proportion of the residents have serious chronic illness (end stage renal disease, heart failure, COPD, advanced osteoarthritis) with loosely controlled symptoms (fatigue, pain, depression, anxiety, breathing, constipation). Residents must maintain self-management of their health to retain the residence. Dementia is not tolerated and cognitive impairment must be transient. Those with health need must seek resolution semi-independently with some support from a case manager, recreational therapist, and wellness staff. Transport to the emergency room via a 911 call to address medical issues is a common resolution to a wide variety of health needs. With each of these acute events, residents risk the determination that they are no longer capable of maintaining

the functional requirements of independent living. Consequently, fear dictates quiet suffering that residents endure knowing they do not want to risk returning to less stable environments or a higher level of care (nursing home) in which their autonomy will be compromised. Fewer than a handful have a documented health care proxy; only one resident has a documented advance care plan (ACP). A culture of silence pervades. The residents of NJH have overt palliative care need and individually limited understanding and resources to address them.

Staffed with a dedicated group of home health aids, a case manager, a nurse manager, nutritionist, and a recreational therapist, the crew takes an “all hands-on deck” approach to meet the many needs of the residents. The staff have some common traits that make them ripe for becoming primary palliative care leaders. While not all of the staff have a college education, they are hungry for educational opportunities to help them better serve the people they care for. The staff realize that the facility offers residents refuge from conditions that may compromise their ability to live independently in a secure apartment.

Serving as a palliative care facilitator, Dr. David is identifying opportunities for implementation of palliative care programming for nursing, administrative, home health, case management and therapeutic staff offered through CAPC Clinical Training on the CAPC website. Ultimately, NJH will serve as the test lab for palliative care innovation for the city’s most vulnerable.

Evidence-Base

This project is guided by the Consolidated Framework for Implementation Research.^{1,2} It recognizes the challenge of implementing highly controlled clinical interventions in real world environments. This framework adapts interventions to the unique context of the microenvironment. Accordingly, we are conducting an environmental scan of palliative care need and system processes.

Three methods of evaluation are ongoing. First, a medical/residential record review has been conducted to identify the characteristics of the residents, history of hospitalization, evidence of ACP, levels of family/social support, language/immigration/housing challenges, and level of primary care support. Preliminary findings are more dire than anticipated when compared to our earlier work conducted in a private pay assisted living facility.³ In that facility, residents were of higher socioeconomic status, could afford to pay \$4,000 per month, had involved family support and were older (average 90 year of age), and had milder symptoms of distress. Seventy percent of those residents completed an advanced directive upon entering the facility. In the NJH, residents come from the lowest socioeconomic strata, have less family support, are an average age of 74.8. Nearly all of the residents have multiple chronic conditions with mild-to-modest symptoms that reduce quality of life and trigger frequently unexpected hospitalization. These findings are consistent of the work of my colleague Rebecca Brown who investigates geriatric symptoms in homeless adults.⁴ With the challenging life circumstances, homeless individuals begin to show signs of geriatric frailty in their fifties. The implication of these findings is that there is a pressing need to introduce ACP earlier. At the NJH, while advance care planning is an early priority of this project, that section in the facility record is empty for 95% of the residents.

Second, we are conducting a process analysis of care trajectories through interviews with staff (administrative, financial, nursing, recreation, nutrition, and a visiting primary care physician). As with many long-term care facilities, staff turnover is high and institutional knowledge has been lost. Residents, in fact, serve as great historians for changes in care pathways as they tend to stay at the facility longer than the staff. The institution is also challenged with siloed processes, inadequate record keeping, limited resources for staff education, and catastrophic adaptive challenges in the shadow of COVID-19 management. In spite of these limitations, the analysis has revealed innate institutional strengths and low-hanging opportunities to improve care. The staff are open, willing, and eager to improve the conditions of care for the people they serve.

Third, we are conducting an IRB-approved mixed methods study to evaluate stakeholder perspectives of assisted living need as well willingness to engage social support of families and palliative care support through telehealth. Simultaneously, a QI initiative has begun to identify staff perspectives and comfort with introducing palliative care interventions for the residents.

Feasibility

Where do we go from here? Three evidenced-based projects were proposed within the first month of system evaluation. First, residents and staff are palliative care naïve. A safe environment in which to discuss their concerns and communicate goals and values must be created. Programming has been developed to introduce the concept of palliative care based upon Dr. David's post-doctoral training at the division of geriatrics and palliative care at UCSF.^{5,6} He has received buy-in from the residents' council and staff. Second, in an attempt to improve palliative care access, Dr. David will work with the residents and staff to adapt a telehealth intervention to address palliative care need in assisted living. This has received funding from the NPCRC and will seed future NIH grant applications. Third, Dr. David will build on his past academic work in Advance Care Planning to introduce ACP interventions at multiple points of care at NJH.⁷⁻⁹ Preliminary analysis has revealed 4 opportunities within already established processes to introduce, plan, implement, and revisit advance care planning in the standard of care.

Scalability

Lessons learned from this partnership will serve as the foundational study to address palliative care need of the 4,200 Medicaid funded assisted living residents in New York. While the benefits of the potential improvement to quality of life are often immeasurable, savings through reduced health utilization are more concrete. Using a simple conservative estimate - \$700 cost to Medicaid per emergency room visit for older adults, and one visit per year for each resident, may result in a savings of \$2.94M.¹⁰

Sustainability

As a PhD-trained nurse with expertise in advanced quality improvement methods, NIH-funded, technology-based palliative care intervention research and hands on clinical bed-side community hospital nursing experience, Dr. David is uniquely qualified to identify palliative care opportunities for this population. As a nurse provider, Dr. David completed his dissertation on heart failure rehospitalization in community dwelling older adults. His work demonstrated that the inclusion of an advanced practiced nurse in an inpatient cardiology service reduced rehospitalization by 50%.¹¹ In a deeper dive into why this may have occurred he identified lapses in continuity

of care that nurses identified (deficient self-care confidence, patient autonomy and unrecognized cognitive impairment)^{12,13}. As an educator, Dr. David teaches quality improvement to nursing students from the undergraduate to doctoral level. At New York University in Meyers College of Nursing, he mentors and teaches “Health Outcomes through Quality Improvement” to DNP students that undertake quality improvement capstone projects. Each year, DNP students will accompany Dr. David to the facility for guidance on implementation of palliative care interventions tailored to Medicaid-funded ALPs. The ultimate goal is to develop a cadre of doctoral prepared nurse leaders trained to implement palliative care innovation in long-term care and other palliative care settings.

The NJH and Dr. David have begun their work of integrating primary palliative care into the care pathways at the facility. In July of 2020, Dr. David met with Liz Weingast, VP director of excellence, Cathy Burke, director of ALP, and Johana Sanchez, nurse manager of ALP. NJH expressed a desire to begin addressing palliative care need in the institution. Integrated primary palliative care offered a coordinated practical approach that leverages the dedicated and specialized staff to overcome the inefficiencies of the environment. This top-down approach has been necessary to ensure facility buy-in. Similarly, the facility plans to sustain the project by developing written protocols, providing learning opportunities for staff, and supporting the need of residents to live independently with the support of the facility.

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About the Challenge

The John A. Hartford Foundation Tipping Point Challenge is a national competition to catalyze the spread of skills, ideas, and solutions that will improve health care delivery for all people living with a serious illness. It is sponsored by the [Center to Advance Palliative Care](#) and [The John A. Hartford Foundation](#).

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