

# Integrated Palliative Care Nursing Home Program

## Background and Significance

In June 2007, the Center to Advance Palliative Care (CAPC) at Mount Sinai, with the support of the Samuels Foundation, analyzed barriers to delivering palliative care in nursing homes across the country. CAPC found inadequate training and education of front line staff and families, high staff turnover, lack of leadership support, lack of palliative care geriatric trained physicians, organizational issues surrounding transitions of care, and inadequate finances. One exemplary model, the Nursing Home Services Integrated Palliative Care model, placed a geriatric nurse practitioner in the home and used an integrated interdisciplinary team approach to symptom management and advance care planning. Although Jewish Home Lifecare has long supported a palliative care program and is one of few long-term care facilities in the country with a dedicated palliative care consult service, the need for palliative care and the number of referrals has the potential to be significantly higher. The current project is implementing a variation of the Nursing Home Services Integrated Palliative Care model using a fellowship-trained palliative care certified geriatrician (hereafter termed "PC geriatrician"), working collaboratively with and drawing on the expertise of CAPC, spearheading a new approach to palliative care within the Jewish Home & Hospital.

## Methods

This PC geriatrician is being integrated into each long-term care unit (now referred to as a "community" since JHL has adopted culture change) for several months at a time, and working closely with all members of the primary care team, residents and families. A key component of this role involves informal education of staff, and particularly, role modeling communication with families. Palliative care experts believe that palliative care skills are best taught through modeling, so this method of teaching holds great promise to effect change. The physician has been conducting four to six brief informal education sessions on each unit on key palliative care topics, including pain and symptom management, breaking bad news, and psychosocial support at the end of life. Staff are completing pre- and post-tests to assess changes in their knowledge, attitudes, and satisfaction with palliative care. The evaluation component of this initiative will focus on changes in numbers of palliative care patients, numbers of completed advance directives, numbers of pharmacy orders for symptom management, and family satisfaction with care. The general goal of the project is to educate and empower line staff to recognize the need for palliative care and to implement this approach in all appropriate cases. A secondary goal is to increase family satisfaction with care.

The presence of the PC geriatrician is not a replacement for the palliative care team, nor is she a replacement for the primary care physician on a particular community. While she is assigned to a particular community, she works collaboratively with the primary care physician but will follow and write orders related to symptom management on those residents the teams (including family) feel need a palliative approach. After the PC geriatrician completes her

time on a community, the palliative care team follows and is involved with the palliative care patients on that community. Members of the palliative care team also interact with patients with whom the PC geriatrician is actively involved.

**Current Status**

The project has been moving along according to schedule, and the PC physician has completed the intervention in the Sutro building and is in progress in the Friedman building. The accompanying pre-and post-tests are also underway. To date, the project has been met with a relatively high degree of enthusiasm from participants.

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