Practices to Optimizing Patient End of Life Outcomes in Long Term Care

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Objectives

- Describe a novel approach to develop individualized hospice care plans that incorporate medical, psychological, and social support
- Recognize how hospice improves nursing home quality while ensuring goal-concordant care helping residents stay in location of choice and out of ED and hospital
- Identify best practices in coordinating hospice and LTC partnership of care through a state survey lens

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Paradox of Care

What Americans Want	What Americans Get
71% choose quality of life over interventions, receive the opposite (Wehri, 2011)	30% of documented care aligns with preferences (Wehri, 2011) Over-medicalized care in last year of life accounts for 25% of Medicare spending (Califo, 2004)
80–90% prefer to be at home at end of life	Only 1/3 of deaths occur at home (CDC, 2014) 30% are in the ICU the month preceding death (Teno, 2013) 33% experience 4+ burdensome transitions in last 6 months life 50% of older adults in emergency department last month of life
Not to be a burden on their family	25% seniors are bankrupted by medical expenses (Kelley, 2013) 46% of caregivers perform nursing tasks, such as wound care and tube feeding (Reinhard, 2012) In the last year of a patient's life, family care averages nearly 66 hours per week (Rhee, 2009)

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What Constitutes a Good Death

Patient	Proportion
Preferences for dying process	94%
Pain-free status	81%
Emotional well-being	64%
Dignity	67%
Life completion	61%
Treatment preferences	56%
Religiosity/spiritualty	61%
Presence of family	61%
Quality of life	22%
Relationship with HCP	39%
Other: costs, pets, touch	28%

Family Members in a NH
Basic resident care
Recognize and treat symptoms
Continuity of care
Respecting end of life wishes
Offering environmental, emotional, psychosocial, and spiritual support
Keep family informed
Promote family understanding
Establish partnership with family and guide through shared decision-making

Meier, et al. "Defining a good death (successful dying): literature review and a call for research and public dialogue." *The American Journal of Geriatric Psychiatry* 24.4 (2016): 261-271.
Gomella, et al. "Good end-of-life care in nursing home according to the family carers' perspective: A systematic review of qualitative findings." Palliative Medicine 33.6 (2019): 589-606.

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Background

- Over 25% of US deaths occur in US nursing homes
  - 20% cancer, 25% COPD, 50% dementia
- Hospice remains underutilized by about 1 million US deaths per year, with 84% being related to non-cancer conditions
- 24% of NH patients eligible for hospice care, 6% are enrolled
- 49% general population die with hospice compared to 40% NH
- Patients on average have 3 transitions in last 90 days of life
- 30% of decedents use the skilled benefit in the last 6 months of life with about 1.5% being referred to hospice at time of discharge

Teno, et al. "Change in end-of-life care for Medicare beneficiaries: site of death, place of care, and health care transitions in 2000, 2005, and 2009." JAMA 309.5 (2013): 470-477.
Wang, et al. "End-of-life care transition patterns of Medicare beneficiaries." Journal of the American Geriatrics Society 65.7 (2017): 1406-1413.
Cagle, et al. "Hospice utilization in the United States: A prospective cohort study comparing cancer and noncancer deaths." Journal of the American Geriatrics Society 68.4 (2020): 783-793.

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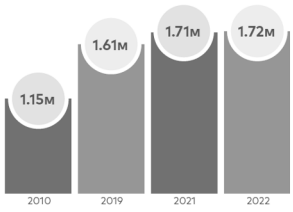
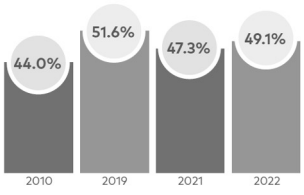
Who Receives Hospice Care

Number of Hospice Users in Millions



Share of Medicare Decedents who Use Hospice



2024 Hospice Facts and Figures

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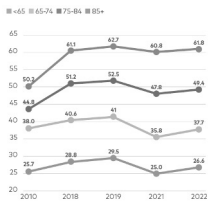
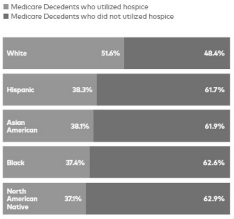
Who Receives Hospice Care, Cont.

Hospice Use by Age



Hospice Use by Race



Facts and Figures 2024

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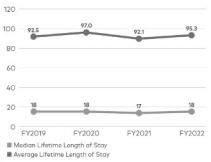
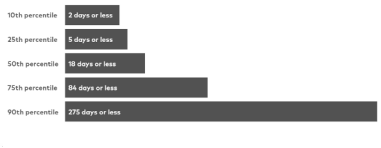
How Much Care is Received

Days of Care by Length of Stay



Average Lifetime Length of Stay



Facts and Figures, 2024

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Domains to Consider

Clinical Judgment	Would you be surprised if this patient passed within 6 months?
Nutrition	> 10% of normal body weight in 6 months > 5% of normal body weight in 1 month Declining Body Mass Index (BMI) < 22 kg/m2 Dysphagia
Physical Function	PPS, ADLs (3/6), falls, bedbound
Cognition	Awareness of self and environment, communication, consciousness
Healthcare Utilization	ED, hospital, clinic
Symptoms	Delirium, fatigue, shortness of breath, pain, and agitation
Disease-specific Decline	Cardiac, pulmonary, dementia, cancer, ESRD, sepsis

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Functional Status Predicts Hospice Eligibility*:*

The lower the PPS, the higher the mortality

%	Ambulation	Activity and Evidence of Disease	Self-Care	Intake	Level of Consciousness
100	Full	Normal Activity	Full	Normal	Full
		No Evidence of Disease			
90	Full	Normal Activity	Full	Normal	Full
		Some Evidence of Disease			
80	Full	Normal Activity With Effort	Full	Normal or Reduced	Full
		Some Evidence of Disease			
70	Reduced	Unable to Do Normal Job/Work	Full	Normal or Reduced	Full
		Some Evidence of Disease			
60	Reduced	Unable to Do Hobby/Housework	Occasional Assistance Necessary	Normal or Reduced	Full or Confusion
		Significant Disease			
50	Mainly Sit/Lie	Unable to Do Any Work	Considerable Assistance Required	Normal or Reduced	Full or Confusion
		Extensive Disease			
40	Mainly in Bed	As Above	Mainly Assistance	Normal or Reduced	Full or Confusion
30	Totally Bed Bound	As Above	Total Care	Reduced	Full or Drowsy or Confusion
20	As Above	As Above	Total Care	Minimal Sips	Full or Drowsy or Confusion
10	As Above	As Above	Total Care	Mouth Care Only	Drowsy or Coma
0	–	–	–	–	–

Hospice eligible for advanced non-curable metastatic cancer

Hospice eligible for advanced illness

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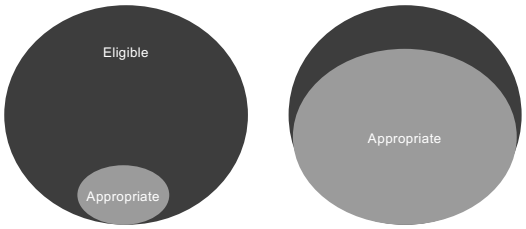
Hospice Enrollment



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The Value of a Partnership with VITAS

All hospices must provide core services, but substantial variation exists in how these services are delivered.

Hospice Core Services
Core Team | All Levels of Care | 24/7 Availability Medications | Equipment

Elevated Care
- Telecare
- Telehealth
- Intensive Comfort Care®
- Visits after hours and weekends
- Physician centric care model

Distinctive Programs
- Advanced lung
- Heart failure
- Sepsis/Post-Sepsis
- Oncology
- Dementia behavioral protocols
- ED diversion
- Academic partnerships and publications
- Robust educational platform offering CEUs, CMEs, multilingual patient and family education
- Clinical pastoral education
- Local ethics committee

Complex Modalities
- IV hydration/TPN Lyte
- IV/PO antibiotics
- Inotrope therapy
- Sub-Q diuretics
- Therapy Services: PT, OT, Speech
- Paracentesis
- Thoracentesis
- Blood transfusions
- Oncology taskforce for anti-tumor treatments (hormonal, XRT)
- PleurX drains
- Nutritional counseling
- ICDs/LVADs

VITAS-Owned HME
- Oxygen, including high-flow
- Non-invasive ventilation, BiPAP, CPAP, home ventilator, and Trilogy
- Hospital bed
- Specialized mattresses
- ADL assist devices
- Incontinence supplies
- Wound care supplies
- Hospice-specific access (24/7/365) and speed to home medical equipment (HME)

Specialty Therapies
- Respiratory therapy
- Music
- Massage
- Pet
- PT/OT/Speech
- Wound care
- Dietary
- Child-life specialist
- Bereavement/ support groups
- Veterans specialist

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VITAS Individualized Pampering (VIP) Program

- Program for patients receiving hospice services to reduce stress, promote engagement, and elevate their care experience
- Spa-like services and memory- support activities incorporated into a patient's individual hospice plan of care
- Performed by VITAS care team with a focus on comfort, relaxation, and support

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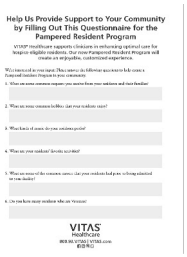
VITAS Individualized Pampering (VIP) Program (cont.)

- Clinicians complete a questionnaire for each resident to determine which VIP activities the resident may benefit from:
  - What are some of your hobbies and/or interests?
  - Is there a particular type of music that you find soothing?
  - What is your career history?
  - Are you a veteran?
  - Do you have any requests for items or activities that may relieve stress or anxiety for you?
- All items or activities are individualized and incorporated into a resident's care plan



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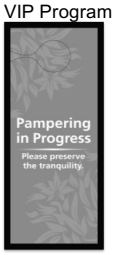
VIP Program Ordering Items



Door Hanger
This door hanger serves as a `Do Not Disturb` sign to be hung on the doors of LTC residents receiving pampering services for the VITAS Individualized Pampering Program. **OTP Item #E-10356A**

VIP Visit Card
This card is for VITAS staff to fill out and leave behind for the facility administrator, informing them that their resident was pampered today. **OTP Item #E-10356D**

VIP Pocket Folder
This is a folder is designed to hold the documents for the pampering kit used in the Pampered Resident Program.
OTP Item #E-10356C

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VIP Program Ordering Items (cont.)

VIP Recycle Bag
This recycle bag lets VITAS staff and volunteers be able to store spa-like activities and games available to patients through the VITAS Individualized Pampering (VIP) Program.
Item No: LN12813
The Company Store

VIP Lavender Touch Experience Sticker
"Lavender Touch" Hand Touch The Lavender Touch Experience is a gentle soothing experience that can be offered to both patients and family members.
Programs to order the Avery stickers for the design to be printed on.

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VIP Program Ordering Items (cont.)

Volunteer VIP Recruitment Flyer and Postcard

This is flyer/postcard is used to recruit compassionate volunteers to be a part of the VITAS Individualized Pampering (VIP) Program, providing personalized spa-like services and engaging mental activities that bring comfort and joy.
OTP Item # E-10356G & E-10356H

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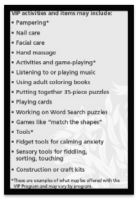
VIP Program Ordering Items (cont.)

Volunteer VIP Patient Flyer

This one-sided flyer lets VITAS staff and volunteers know about the spa-like activities and games available to patients through the VITAS Individualized Pampering (VIP) Program. Contains a custom field for the RN or social worker's phone number.
OTP Item # E-10356J



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VITAS Individualized Pampering (VIP) Program: Case Study

Case Study: MW is a 95-year-old female resident in a SLC with a terminal dx of cerebral atherosclerosis. She is bedbound, sleeps most of the day, and is unable to complete any task without assistance.

VITAS social worker completed questionnaire with MW's daughter to create an enjoyable, customized experience for MW. MW used to enjoy reading the newspaper with her breakfast every morning, manicures, and country music.

We placed a volunteer with her who reads the newspaper to her each morning while she has her breakfast. The HHA provides manicures and plays country music while providing care to MW who is awake and alert during these times. The family is overjoyed by their mother's response and the SLC is very pleased with this additional service.

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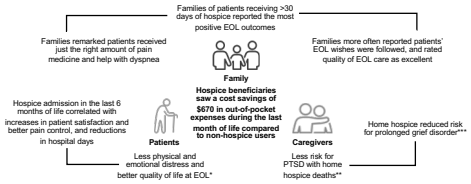
Ongoing Demonstration of Hospice Quality Advantage to Patient, Families, and Caregivers



- Aldridge M., et al. (2022). Association between hospice enrollment and total health care costs for insurers and families, 2002-2018. *JAMA Health Forum*. 3(2), e215404-e215500.
- Harrison, et al. (2022). Hospice Improves Care Quality for Older Adults With Dementia in Their Last Month Of Life: Study examines hospice care quality for older adults with dementia in their last month of life. *Health Affairs*, 41(4), 611-620.
- Kerrigan, et al. (2019). Exploring the association of hospice care on patient experience and outcomes of care. *BMC Supportive & Palliative Care*, 9(1), e13-e12.
- Kumar, et al. (2017). Family perspectives on hospice care experiences of patients with cancer. *Journal of Clinical Oncology*, 35(4), 412.
- Wright, et al. (2016). Place of death: correlations with quality of life of patients with cancer and predictors of bereaved caregivers' mental health. *Journal of Clinical Oncology*, 28(28), 4457.

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Last Place of Care Experience

Outcome	Hospice	Nursing Home	Home Health	Hospital
Not Enough Help with Pain, %	18.3	31.8	42.6	19.3
Not Enough Help Emotional Support, %	34.6	56.2	70	51.7
Not Always Treated with Respect, %	3.8	31.8	15.5	20.4
Enough Information about Dying, %	29.2	44.3	31.5	50
Quality Care Excellent, %	70.7	41.6	46.5	46.8

Teno, et al. "Family perspectives on end-of-life care at the last place of care." JAMA 291.1 (2004): 88-93.

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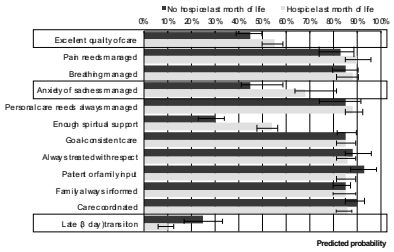
Hospice Impact Dementia Care: Patient

- More likely to die at home (76% vs. 38%)
- Less likely to die in the hospital (7% vs. 45%)
- Improved pain and symptom management
- Fewer end-of-life transitions



Shega, et al. "Patients dying with dementia: experience at the end of life and impact of hospice care." *Journal of pain and symptom management* 35.5 (2008): 499-507.
Hanson, et al. "Hospice Improves Care Quality For Older Adults With Dementia In Their Last Month Of Life: Study examines hospice care quality for older adults with dementia in their last month of life." *Health Affairs* 41.6 (2022): 821-830.

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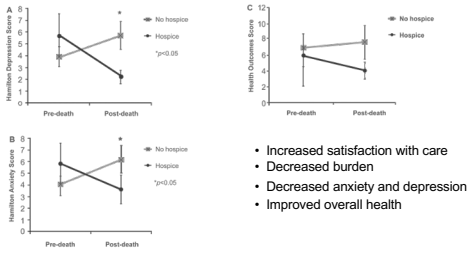
Hospice Impact Dementia Care: Family



- Increased satisfaction with care
- Decreased burden
- Decreased anxiety and depression
- Improved overall health

Irwin, et al. "Association between hospice care and psychological outcomes in Alzheimer's spousal caregivers." *Journal of Palliative Medicine* 16.11 (2013): 1450-1454.

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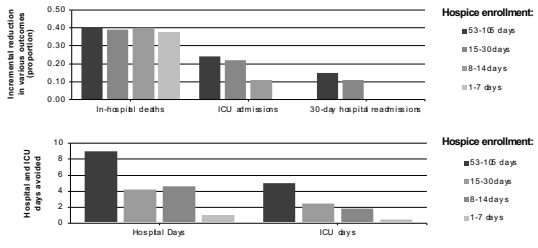
Hospice Decreases Acute-Care Utilization



Kelly, A. et al. Hospice Enrollment Saves Money and Improves Quality. *Health Affairs* 2013; 32(3):552–561.

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Total Cost of Care Comparison by Disease State and Hospice Use in Last Year of Life*

Disease Group	No Hospice	Hospice						
		< 15 Days	15 – 30	31 – 60	61 – 90	91 – 180	181 – 266	> 266
ALL	$67,192	4%	-5%	-9%	-12%	-14%	-10%	-12%
Circulatory	$66,041	7%	-4%	-8%	-10%	-11%	-8%	-10%
Cancer	$76,625	10%	-1%	-6%	-9%	-13%	-14%	-20%
Neuro-degenerative	$61,004	12%	-6%	-9%	-11%	-11%	-5%	-4%
Respiratory	$77,892	-2%	-11%	-14%	-17%	-19%	-18%	-22%
CKD/ESRD	$82,781	1%	-14%	-21%	-24%	-24%	-23%	-27%

Spending is greater than non-hospice users | Spending is less than non-hospice users | No difference / not statistically significant

- Hospice care saved Medicare approximately $3.5 billion for patients in their last year of life*
- Those patients with hospice stays of ≥ 6 months** yielded the highest percentage of savings
  - For patients whose hospice stays were between 181-266 days, total cost of care was almost $7K less than non-hospice users
  - Hospice patients with stays of > 266 days spent approximately $8K less than non-hospice users

*NORC at the University of Chicago (2023). Value of Hospice in Medicare. Retrieved from: https://www.nhpco.org/wp-content/uploads/Value_Hospice_in_Medicare.pdf

**To be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and be certified as being terminally ill. An individual is considered to be terminally ill if the medical prognosis is that the individual's life expectancy is 6 months or less if the illness runs its normal course. Only care provided by (or under arrangements made by) a Medicare-certified hospice is covered under the Medicare Hospice Benefit. The hospice admits a patient only on the recommendation of the medical director in consultation with, or with input from, the patient's attending physician (if any).

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Improving Hospice Access for Short-Stay Residents

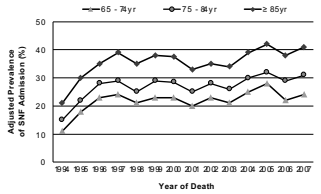

Figure 2. Adjusted prevalence of skilled nursing facility (SNF) admission in the last 6 months of life by age group. Prevalence of SNF admission in the last 6 months of life was calculated with adjustment for groups of age at death and year of death. Reported values incorporate survey weights to account for the complex survey design.

Table 2. Top 10 Medicare Provider Analysis Review File Diagnosis Related Group (DRG) Admission Diagnoses to a Skilled Nursing Facility in the Last 6 Months of Life

DRG Code	Definition	%
127	Heart failure and shock	8.3
462	Rehabilitation	5.4
236	Fractures of hip and pelvis	4.8
89	Simple pneumonia and pleurisy age > 17 years old with complications, comorbidities	4.8
88	Chronic obstructive pulmonary disease	4.4
12	Degenerative nervous system disorders	3.6
14	Intracranial hemorrhage or cerebral infarction (beginning October 1, 2004)	3.3
467	Other factors influencing health status	2.2
90	Simple pneumonia and pleurisy age > 17 years old without complications, comorbidities	2.1
82	Respiratory neoplasms	1.9

Aragon, et al. Medicare Post-Hospitalization Skilled Nursing Benefit in the Last Six Months of Life. *Archives of Internal Medicine* 2012; 172(20): 1573–1579.

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Supportive Approaches

	Hospice	Home Health	Palliative Care
Eligibility Requirements	Prognosis required: ≤ 6 months if the illness runs its usual course	Prognosis not required	Varies by program, usually life-defining illness
	Skilled need not required	Skilled need required	Skilled need not required
Plan of Care	Quality of life and defined goals	Restorative care	Quality of life and defined goals
Length of Care	Unlimited	Limited, with requirements	Variable
Homebound	Not required	Required, with exceptions	Not required
Targeted Disease-Specific Program	✓	Variable	Variable
Medications Included	✓	X	X
Equipment Included	✓	X	X
After-Hours Staff Availability	✓	X	X
RT/PT/OT/Speech	✓	✓	X
Nurse Visit Frequency	Unlimited	Limited, based on diagnosis	Variable
Palliative Care Physician Support	✓	X	Variable
Levels of Care	4	1	1
Bereavement Support	✓	X	X

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Case Study of MT

Patient
MT, 78-year-old female. Lives alone. Daughter involved in care.

Medical history
HTN, osteoporosis, DM, mild cognitive impairment, urinary tact infections (UTIs). Independent in activities of daily living (ADL). No longer drives or cooks. Recent fall w/hip fracture and hospitalization for hip replacement. Dehydration.

Signs/Symptoms
As of recent, has increase difficulty with mobility, dizziness, confusion post surgery.

Treatments
Requires intensive PT post surgery. MT is D/C from hospital to SNF for PT/OT to regain strength and mobility, including medication management

SNF Stay

MT is admitted to SNF, and care plan established for PT six days a week for six weeks.

After four weeks, MT is not meeting goals set forth by PT due to increased confusion and consistent UTIs.

4 Weeks Later

During SNF care plan meeting w/ facility DON, MDS Coordinator, SW, PT D/C plan back to home was discussed.

MT's daughter stated she is not able to care for MT at home.

SNF advises of LTC bed availability and offers assistance to begin Medicaid application process to determine if MT is eligible for LTC Medicaid for room and board coverage.

MT qualifies for LTC Medicaid, and transfers to the LTC unit in the SNF.

1 Year Later

During the course of a year, MT has been rehospitalized several times due to falls, pneumonia, UTIs, and increased delirium. She now has been diagnosed with dementia and HF NYHA Class 3.

MT is now dependent in 6/6 ADLS and has had a 10lb weight loss in last 6 months

During the facility's weekly meeting to review their at-risk residents and triggers on their resident level report in iQIES, the SW and MDS coordinator identified that MT may be eligible to receive hospice services and recommended a goals-of-care (GOC) conversation with the daughter.

2 Days Later

During a care plan meeting, the LTC team conducts a GOC conversation with MT's daughter.

Daughter wants to honor MT's care goal wishes and agrees to a hospice consult.

MT is referred to VITAS. VITAS admissions nurse meets with MT's daughter same day at facility. DTR signs consents and DNR.

MT is admitted to VITAS at LTC facility.

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How Does Hospice Help Nursing Home Quality Measures?

- Resident indicated on minimum data set (MDS):
  - O0110K1 - Hospice care
  - J1400 - Physician six-month prognosis
- Internet Quality Improvement & Evaluation (iQIES)

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CMS Nursing Home Quality Measures: Hospice Risk Adjustment

Long-Stay Resident Measures	Hospice Impact	Hospice Risk Adjustment/Excluded
Number of hospitalizations per 1,000 long-stay resident days	x	x
Number of outpatient emergency department visits per 1,000 long-stay resident days	x	x
Percentage of long-stay residents who got an antipsychotic medication	x	
Percentage of long-stay residents experiencing one or more falls with major injury	x	
Percentage of long-stay high-risk residents with pressure ulcers	x	x
Percentage of long-stay residents with a urinary tract infection	x	
Percentage of long-stay residents whose ability to move independently worsened	x	x
Percentage of long-stay residents whose need for help with activities of daily living has increased	x	x
Percentage of long-stay residents who report moderate to severe pain	x	
Percentage of long-stay low-risk residents who lose control of their bowels or bladder	x	
Percentage of long-stay residents who lose too much weight	x	x
Percentage of long-stay residents who have symptoms of depression	x	
Percentage of long-stay residents who got an anti-anxiety or hypnotic medication	x	x

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CMS Quality Measures for Nursing Facilities

Based on Medicare claims and Minimum Data Set (MDS)

The Short-Stay quality measures that are risk-adjusted and/or excluded when under hospice care:

1. Percentage of short-stay residents who were re-hospitalized after a nursing home admission
2. Percentage of short-stay residents who have had an outpatient emergency department visit
3. Percentage of residents who made improvements in function

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CMS Quality Measures for Nursing Facilities

Medicare.gov/Care Compare

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CMS Quality Measures for Nursing Facilities

Based on Medicare claims and Minimum Data Set (MDS)

Long-stay quality measures that are excluded or risk adjusted when a resident is under hospice care:

1. Number of hospitalizations per 1,000 long-stay resident days
2. Number of outpatient emergency department visits per 1,000 long-stay resident days
3. Percentage of residents whose ability to walk independently worsened
4. Percentage of residents whose need for help with activities of daily living has increased
5. Percentage of residents who lose too much weight
6. Percentage of residents who used antianxiety or hypnotic medication
7. Percentage of residents with a stage II – IV or unstageable pressure ulcers

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CMS Quality Measures for Nursing Facilities

Medicare.gov/Care Compare

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CMS Quality Measures for Nursing Facilities

Medicare.gov/Care Compare

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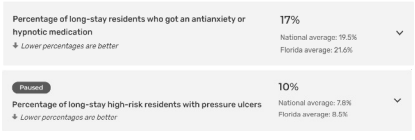
CMS Quality Measures for Nursing Facilities

Medicare.gov/Care Compare



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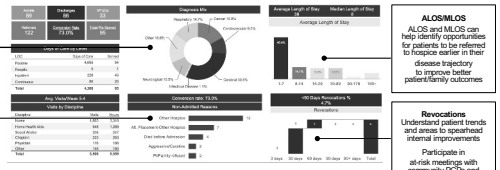
Drive Community Strategy and Execution

Partnership of Care information on mutual patients to help clinicians better understand opportunities to expand hospice care for their patients and how their current patients are being served.

Diagnosis Mix
A review of a clinician's data may reveal under-utilization of hospice for a particular diagnosis type

Not Admitted
reasons can provide insight into a clinician's referral habits



ALOS/MLOS
ALOS and MLOS can help identify opportunities for patients to be referred to hospice earlier in their disease trajectory to improve better patient/family outcomes

Revocations
Understand patient trends and areas to spearhead internal improvements

Participate in at-risk meetings with community PGPs and ALF/LTC leadership

Physician and Facility-Specific Partnership of Care provides data related to mutual patients

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NH Pressures and Benefit Hospice Partnership

Pressure	Opportunity Hospice Partnership
Staffing	**Direct Care Support:** physician, team manager, nurse, aide, social worker, chaplain, volunteer. Safe discharges for short-stay residents admitted to hospice in community, veteran support **Nursing Home Staff Retention Initiatives:** Memorial services, Blessing of the Hands, bereavement support for staff members, team building, recognition of national healthcare holidays (CNA Week, Nurses Week, Social worker Month, Nursing Home Week)
Census	Continuous Care, respite, GIP, Telecare, co-marketing/education to local community, other healthcare professionals, and feeder hospitals with VITAS Rep
Quality	Survey support, attendance at Care Plan meetings, work with MDS to identify quality measures that may trigger hospice eligibility on iQIES that are risk adjusted/excluded for hospice, Behavioral Management Protocol, and Partnership of Care meetings to review care metrics of hospice patients.
Staff training	CEU's and non-CE in-services (hospice, pain, disease specific, dementia behaviors, communication, etc, Hospice and Nursing Home Partnership, MDS and Quality Measures), Goals of Care conversation.

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Best Practices – Care Coordination

Continuing education (CE) offerings for staff on a variety of topics regarding advanced illness, including non-CE related in-service offerings

Most Requested In-Services

Education for staff in Senior living Communities:

- Change in Behavior: Delirium, Terminal Restlessness or Dementia
- Pragmatic Clinical Guide
- Advance Directives & Advance Care Planning
- Dementia at the End of Life
- Hospice Basics and Benefits
- Grief, Loss & Bereavement
- Pain Management at End-of-Life
- Palliative Care vs Curative Care
- Tracheostomy 101: Introduction to Tracheostomy Care
- Wound Care 101

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VITAS Deeply Connecting to Our Communities

Together in care, together in community

Community Engagement

From packing backpacks with school supplies, to disaster relief drives, to our participation in Pride events, **VITAS supports our communities coast-to-coast**.

We Honor Veterans

78% of VITAS programs have the highest standard of veteran care recognized by NHPCO's 'We Honor Veterans'. VITAS teams regularly perform bedside salutes and pinning ceremonies. VITAS has granted many veterans' special final wishes.

Recognition for Commitment to Inclusion

VITAS contributions to healthcare have earned us accolades like the inaugural **Trailblazer award from National Black Nurses Association (NBNA) in 2024** and the **IDEA award from American Association of Male Nurses (AAMN) in 2022**.

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