Spotlight on the IOM Report: “Dying in America”

What is the hospice and palliative care community’s role in prioritization and implementation?

Sponsored by the National Coalition for Hospice and Palliative Care
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Don Schumacher, PsyD, President and CEO, NHPCO

National Coalition for Hospice and Palliative Care

National Hospice and Palliative Care Organization

Social Work Hospice & Palliative Care Network
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Speakers
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Overview

• IOM 2013 EOL Committee
• Role of IOM – Public Policy
• “Dying in America” – Recommendations
• How we can use the recommendations
IOM Committee on Approaching Death: Addressing Key End of Life Issues

Why does the IOM matter?

• IOM secures services of eminent professionals to examine policy matters pertaining to the health of the public.

• IOM under the National Academy of Sciences through its congressional charter as advisor to the federal government.

• “IOM” recommendations can have a lot of influence in health care policy decision-making.
IOM has now made clear (in 6 reports): Palliative care IS essential to quality

Institute of Medicine Quality Cancer Care Report: Charting a New Course for a Health System in Crisis (2013)

2013 Committee Statement of Task

Current state of end-of-life care with respect to:
- Delivery of medical care and social supports
- Patient-family-provider communication of values and preferences
- Advance care planning
- Health care costs, financing and reimbursement
- Education of health professionals, patients and loved ones, and the public at large

NOTE: abbreviated version. Full statement of task in committee report.
IOM Report Key Conclusions

• The committee identified persistent major gaps in care near the end of life that require urgent attention from numerous stakeholder groups.

• The committee believes a patient-centered, family-oriented approach to care near the end of life should be a high national priority, and that compassionate, affordable and effective care for these patients is an achievable goal.

Key Areas for Findings and Recommendations

• Delivery of person-centered, family-oriented care
• Clinician-patient communication and advance care planning
• Professional education and development
• Policies and payment systems
• Public education and engagement
Recommendation 1: Delivery of Care

Government health insurers and care delivery programs as well as private health insurers should cover the provision of comprehensive palliative care for individuals with advanced serious illness who are nearing the end of life.

Delivery of Care Opportunities for Nurses

- Nurses are integral to structure and processes of care
- Care coordination: quality and cost effective care
- Research to further define the nursing role and contribution, measuring quality
- Infuse principles of palliative care into nursing standards across settings
- Reimbursement and regulation
Delivery of Care
Opportunities for Nurses

• “Nurses have been doing it all along, but it really hasn’t been recognized...” Peter McMenamin

• Recognize the value of what you do

• Stories matter

Delivery of Care
Opportunities for Social Work

• Every consult is an opportunity to identify support needs and answers.

• Bring the expertise of the IDT approach, whole-person perspective, and experience with prognosis to the acute care and long-term care setting.

• Inform administrators and increase advocacy for the role of palliative care delivery
Delivery of Care
Opportunities for Physicians

- Lead initiatives to assure that patients and families have 24/7 access to seamless comprehensive care, delivered by qualified professionals.
- Develop, test and implement quality metrics
- Create dialogue about IOM report findings to educate, inform and advocate for increased hospice and palliative care services in your organization and community.

Recommendation 2: Communication and Advance Care Planning

Professional societies and other organizations that establish quality standards should develop standards for clinician-patient communication and advance care planning that are measurable, actionable and evidence-based. These standards should change as needed to reflect the evolving population and health system needs, and be consistent with emerging evidence, methods and technologies. Payers and health care delivery organizations should adopt these standards and their supporting processes, and integrate them into assessments, care plans and the reporting of health care quality.
Communication & ACP
What does this mean for the Field?

- Spotlight cultural, ethnic, social and economic diversity issues to ensure that palliative care is available to underserved and vulnerable people
- Ensure that spiritual needs are considered
- Assure that all health care professionals who care for persons with serious illness demonstrate proficiency in communication and advance care planning.
- Develop, test and implement metrics of quality communication and advance care planning.

Recommendation 3: Professional Education and Development

Educational institutions, credentialing bodies, accrediting boards, state regulatory agencies and health care delivery organizations should establish the appropriate training, certification and/or licensure requirements to strengthen the palliative care knowledge and skills of all clinicians who care for individuals with advanced serious illness who are nearing the end of life.
Professional Education and Development Nursing

• Principles of palliative care infused in curricula
• Primary palliative care education for all nurses
• Addressing workforce issues: specialty level training and certification, scope of practice
• Demonstration of continuing competence and life-long learning (HPCC, specialty programs in schools of nursing, ELNEC)
• Measuring outcomes of certification

Professional Education Development Nursing

• Educational strategies: “Novice to Expert”
• Make education accessible: Cost and logistics
• Advocate for removal of practice barriers
• Leverage your skill: teaching and role-modeling excellence at the bedside
• Get certified!
Professional Education and Development
Physicians

• Advocate for integration of basic palliative care competencies, including communication skills, interprofessional collaboration and symptom management into UME, GME and maintenance of certification requirements.
• As professional organizations, develop and disseminate these curricula.

Professional Education and Development
Social Workers

• NASW Specialty Certification in Hospice and Palliative Care: [https://www.socialworkers.org/credentials/credentials/chpsw.asp](https://www.socialworkers.org/credentials/credentials/chpsw.asp)
• California State University, CSU- Post MSW Certificate in Palliative Care: [http://www.csupalliativecare.org/programs/postmswcertificate/](http://www.csupalliativecare.org/programs/postmswcertificate/)
• NYU Silver School: [http://socialwork.nyu.edu/alumni/continuing-education/post-masters/palliative-care.html](http://socialwork.nyu.edu/alumni/continuing-education/post-masters/palliative-care.html)
• Smith – EOL Care Graduate Certificate [http://www.smith.edu/ssw/acad_cont_graduate_elc.php](http://www.smith.edu/ssw/acad_cont_graduate_elc.php)
POLLING QUESTION # 1

• Which recommendation is most needed to establish the appropriate training/certification for all clinicians who care for patients with advanced illness and near the end of life?

Polling Question #1

• #1 Educational institutions/professional societies should provide training in palliative care throughout one’s career
• #2 Accrediting organizations should require palliative care education and training for all who are responsible for patients with serious illness
• #3 State regulatory/licensure agencies should require education and training in PC for all who care for those at the end of life
Polling Question #1

• **#4** Entities that certify specialty level health care providers should create pathways to certification that increase the number of health care professionals who pursue specialty level PC training.

• **#5** Health care delivery institutions/academic medical centers that sponsor specialty level training positions should commit institutional resources to increasing these numbers.

Recommendation 4: Policies and Payment Systems

Federal, state, and private insurance and health care delivery programs should integrate the financing of medical and social services to support the provision of quality care consistent with the values, goals and informed preferences of people with advanced serious illness nearing the end of life.
Policies and Payment Systems
Opportunities for Change

• Individuals and professional organizations need to engage in collaborative advocacy efforts at the local, state and federal level to achieve recommended changes in payment structures and required public reporting of quality metrics.
• Systemic change will require multiple stakeholder alignment and advocacy
• New payment models will be extremely difficult to implement by CMS due to lack of resources.
• Private sector is “experimenting,” w/some success.

Recommendation 5:
Public Education and Engagement

Civic leaders, public health and other governmental agencies, community-based organizations, faith-based organizations, consumer groups, health care delivery organizations, payers, employers, and professional societies should engage their constituents and provide fact-based information about care of people with advanced serious illness to encourage advance care planning and informed choice based on the needs and values of individuals.
The IOM’s Assessment for Leveraging Reports

Commonalities among reports with major impact, from Harvey Fineberg MD, immediate past president of the IOM:

- **Excellence of the product**: objective, evidence-based, grounded in science, well-reasoned, understandable, thorough and persuasive
- **Importance, Timeliness and Relevance**
- **Contending Values and Interests**
- **Communication and Promotion**
- **Repetition and Consistency**

CHANGE -Strategies to Create Change

- **Direct action/stories**
  - Replace acquiescence with outrage
- **Coalition alignment**
  - Aging, providers, elders, caregivers
- **National leaders /Legislative champions**
### What to do? Impact vs. Feasibility

<table>
<thead>
<tr>
<th>Low Feasibility</th>
<th>High feasibility</th>
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<tbody>
<tr>
<td><strong>Low impact</strong></td>
<td><strong>High impact</strong></td>
</tr>
<tr>
<td>Why bother?</td>
<td>Whine and complain Roll your eyes about politics in the U.S. Talk only within the field</td>
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- New legislation
- Change in CMS regulations, Conditions of Participation
- Sustained public awareness campaign

*Organizations: Work within effective coalitions*  
*Individuals: Write articles, blogs, use social media*  
*Give talks, webinars*  
*Explicitly link to IOM recommendations*

### Recommendation 2: Develop standards for clinician-patient communication and advance care planning that are measurable, actionable and evidence-based.

- Work with your organization leaders to implement triggers to screen for patients who need advance care planning
- Invest in communication skills training for your organization’s clinical teams
- Set institutional goals for clinician training in communication skills and advance care planning
Recommendation 3: Establish the appropriate training, certification and/or licensure requirement to strengthen the palliative care knowledge and skills of all clinicians who care for individuals with advanced serious illness.

- Implement a trigger program to identify patients with palliative care needs
- Invest in online palliative care skills training curriculum and develop an internal marketing strategy for your clinical teams
- Develop a strategy to measure the impact of palliative care training on key organizational metrics

Low Feasibility - High Feasibility

Recommendation 5: Provide fact-based information about care of people with advanced serious illness to encourage advance care planning and informed choice based on the needs and values of individuals.

- Work with your organization’s marketing team to develop patient and family educational materials about the benefits of advance care planning
- Implement internal education requirements to standardize organizational knowledge regarding advance care planning and goals of care
- Set organizational goals for utilization of advance care planning

Low Feasibility - High Feasibility
Opportunities for Immediate Action-
Key Messages for the Field

- **Access to palliative care:** Palliative care is high quality care for people living with serious illness and their families. Payers and health delivery systems must be accountable and, through payment and accreditation mechanisms, ensure access to skilled palliative care and hospice care throughout the course of illness and across settings.

- **Communication and advance care planning:** To ensure shared decision-making that accounts for evolving patient needs and respects their goals of care, the quality of clinician-patient communication must be measured and incentivized in reimbursement, licensing and credentialing.

- **Clinician training:** All clinicians who care for people with serious illness must be competent in providing basic palliative care, including communication skills, interprofessional collaboration and symptom management; and certifying bodies should require demonstration of these core competencies.

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Longer Term Goal

**Delivery and financing:** Health care financing incentives must be restructured so that providers are rewarded for high quality care that decreases the need for emergency and acute care services, coordinates care across settings and providers, and reduces the use of unnecessary medical services and those not consistent with a patient’s goals of care.
Opportunity for Coalition Work

• Work to endorse public reporting of aggregate quality and cost measures for all aspects of the health care system related to palliative and end-of-life care.

• Create new metrics and quality standards for communication and advance care planning.

• Support model quality improvement projects focused on the delivery of palliative care in all care settings (private payers, CMS, Medicare).

• Educate policy leaders on how to revise existing state and federal legislation encouraging the delivery of palliative care in all settings.

Opportunity for Coalition Work

• Identify licensure model legislation for all disciplines that states can use to ensure access to qualified palliative care professionals.

• Require the use of electronic health records that incorporate advance care planning to improve communication of individuals’ wishes across time, settings and providers.

• Encourage states to develop and implement a Physician Orders for Life-Sustaining Treatment (POLST) paradigm program in accordance with nationally standardized core requirements.
POLLING QUESTION #2

• Where should the Coalition focus its time?

1. **Access to Palliative Care / Hospice Care** to all that need it, across settings
2. **Communication – Advance Care Planning** (developing metrics)
3. **Professional Education and Development** (ensure training/certification/expanded to other providers)
4. **Policies and Payment Systems** (major reform efforts to link medical/social services)
5. **Public Engagement and Communication** (changing the climate, culture)
Report and Dissemination


• Free slide deck for download

• IOM will engage in 12-month dissemination phase:
  • Developing materials
  • Engaging relevant stakeholders and key audiences
  • Evaluating tactics to inform future activities
More than a quarter of all adults have given little or no thought to their end-of-life wishes. Have you?
Learn more: iom.edu/endoflife

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DIALOGUE – QUESTIONS
National Coalition for Hospice and Palliative Care

National Hospice and Palliative Care Organization

SWHPN Social Work Hospice & Palliative Care Network
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