What was the goal of the project?

The RAVEN Initiative's aim was to minimize hospital readmissions from long term care facilities, utilizing evidence-based practice and use of change in condition reporting tools. It relied, in part, on the embedding of APPs, specifically nurse practitioners (NP), within partner LTCs, to provide the clinical care element of the initiative. The Initiative focused on six medical conditions, that the Centers for Medicare and Medicaid Services had identified as frequent diagnoses responsible for hospital readmissions from nursing homes.

What is an APP?

In Pennsylvania, a nurse practitioner (NP) is an advanced practice registered nurse and a type of mid-level practitioner. With an RN license and registration as an NP, licensing to write prescriptions for medications is permissible. NPs are trained to assess patient needs, order and interpret diagnostic and laboratory tests, diagnose diseases, and formulate and prescribe treatment plans. NP training covers basic disease prevention, coordination of care, and health promotion. According to the American Association of Nurse Practitioners, NPs are educated at the graduate level to provide "primary, acute, chronic, and specialty care to patients of all ages," depending on their field of practice.

What was the main goal of the APP?

The primary function of the embedded NP was to assess and manage acute changes in condition, in the absence of or in collaboration with the attending physician. The NP was responsible for assisting in care delivery, as well as working to support, educate, mentor and train clinical staff so they were more able to improve the standards of geriatric medical practice and palliative care in the partner LTC facilities. The NPs worked on collaborative care for stable but medically complex patients. NPs used the principles of geriatric assessment and evidence-based medicine to define the best care for patients, including well care, with the ultimate goal of preventing them from developing conditions that could lead to unnecessary hospitalizations.

What is the role of the APP?

- Managing conditions in place
- Palliative care
- Hospice care
- Leading and participating in committees on:
    - Falls
    - Nutrition
    - QI/QA
    - Care Conferences
    - Advance Directive Discussions
    - Staff Education
    - IDT
    - Ethics

What is the workflow of the APP?

- Attend morning meeting
- Review 24-hour report on residents
- Round on units and devise a priority list
- Review labs
- Attend care plan meeting & schedule advance directive discussions
- Attend IDT meetings with pharmacist to review medications on residents and deprescribe as applicable
- Stand down at end of day
- Ongoing communication with physician/s and administration
- Active participation of committee meetings
- Staff education:
    - Be approachable for staff
    - Be model for care and compassion
    - Perform huddles
    - Respond to Stop and Watch, etc. with a teaching approach
    - Provide real time assessment, physiology, and care education at point of care
    - Inservice days

How did we accomplish RAVEN APP goals?

- NP within the facility 5 days weekly – Monday through Friday 8am to 5pm
- Telemedicine coverage for after hours
- Build collaborative relationships by meeting with physicians, administration, DON, ADON, department heads, nursing, and nurse aides
- Define role and functioning
- Establish identification as team member
- Identification of physician preferences
- Continual communication with staff
- Continual communication with physicians
- Establish relationships with patient and family
- Proactive redefining/redesigning provision of care
- Improving medical care via identification of acute changes in condition
- Providing safe and appropriate patient care within the facility, especially with the occurrence of changes in condition, and avoiding hospital admission/readmission if possible
- Identification and discussion of patient's POC and patient and family wishes
- Supporting palliative care via planning for goals of care and provision of hospice, palliative, and end of life care as appropriate

What were the challenges?

- Administration buy-in
- Good relationships with physicians and staff
- Establishing communication process
- Establishing process for division of labor
- Establishing parameters for provision of care
- Facility based limitations (staffing, etc.)
- Limited ability to serve whole house

What are the recommendations?

- APP to be allowed to work to the full ability of licensure
- APP should cover whole house
- There should be a coverage plan for APP absence/off hours

Palliative Care

Palliative care is specialized medical care that focuses on **providing patients relief from pain and other symptoms of a serious illness**, no matter the diagnosis or stage of disease. Palliative care teams aim to improve the quality of life for both patients and their families

"Palliate" means to ease, and the focus of palliative care is to ease the suffering that results from illness. Palliative care provides treatment for a person's symptoms, even if the underlying disease cannot be cured. The main goals of palliative and supportive care are to relieve pain and other discomfort and reduce patient and caregiver stress. Palliative care can give patients and their caregiver's tools to make living with a serious illness more manageable. It considers emotional, social, and spiritual needs in addition to managing physical symptoms. During an illness, palliative care can help patients and their families experience a better quality of life.

Palliative care is a comprehensive, patient-centered approach to improving the quality of life for people who are living with a serious or potentially life-limiting illness. Palliative care can be, and often times is, given in conjunction with treatments designed to cure a patient's underlying illness. Palliative care treatments can be helpful in managing the symptoms of an illness including pain and nausea, shortness of breath, fatigue, stress, depression and anxiety, and other distressing symptoms. The palliative care team works to create a treatment plan taking into account the individual patients goals and wishes for care. Palliative care can be provided at home, at outpatient palliative care clinics, in nursing homes, hospitals, or other specialized clinics.

Additional Resources:

www.capc.org/
www.getpalliativecare.org/
https://www.ninr.nih.gov

Hospice Care

Hospice provides palliative care and attends to the emotional and spiritual needs of terminally ill patients at an inpatient facility or at the patient's home.

While palliative care is available to any patient with a serious illness, hospice care is a specialized type of palliative care for patients suffering from an incurable illness or multiple illnesses with a life expectancy of six months or less. Hospice care is focused on improving quality of life, maintaining dignity, and making patients as comfortable as possible during the time they have remaining.

The hospice care team is a multidisciplinary team made up of doctors, nurses, social workers, trained volunteers, and spiritual advisors. Hospice care can be provided in the home or in a facility such as a hospital, nursing home, or a dedicated hospice care facility.

Patients entering hospice care understand that their illness or disease is not responding to medical treatment. By entering hospice, attempts to cure the patient's underlying illness are stopped. Stopping curative treatment does not mean discontinuing all treatment. For example, if a patient is being treated for high blood pressure with medication, he or she will continue receiving those treatments in addition to the treatments they are receiving to manage the symptoms of their terminal illness.

Patients can elect to leave hospice care at any time if he or she decides that they want to resume curative treatments. Patients may also leave hospice care if their condition improves.

Hospice Eligibility Criteria

Additional Resources:

- www.nhpco.org
- www.getpalliativecare.org

Prognostic Tools:

- www.eprognosis.ucsf.edu
- Palliative Performance Scale
- Cardiac (NYHA Class, Seattle heart failure model
- Pulmonary (BODE index)
- Dementia (FAST staging, Mortality Risk Index
- Hepatic (MELD score in end-stage liver disease