Palliative Care for Older Adults Dually Eligible for Medicare and Medicaid

Credit Information

- If you are a social worker in a National Association of Social Workers (NASW) state and would like to receive CE credits through NASW for this event, please complete the pre-test posted here: [https://www.research.net/r/PreTest_PalliativeCare](https://www.research.net/r/PreTest_PalliativeCare)
  - You will also be required to complete a post-test; a link to this test will appear at the end of the presentation.
- For more information about obtaining CE credit for social workers in non-NASW states, psychologists, PAs, nurses (NP, APRN, RN, LPN), pharmacists, marriage and family counselors, etc. or CME credit via the Centers for Medicare & Medicaid Services Learning Management System, please visit: [https://www.resourcesforintegratedcare.com/GeriatricCompetentCare/2018_GCC_Webinar/Palliative_Care](https://www.resourcesforintegratedcare.com/GeriatricCompetentCare/2018_GCC_Webinar/Palliative_Care)

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Palliative Care for Older Adults Dually Eligible for Medicare and Medicaid
Overview

- This is the sixth session from the “2018 Geriatric-Competent Care” Webinar Series

- This session will be interactive (e.g., polls and interactive chat functions), with 60 minutes of presenter-led discussion, followed by 30 minutes of presenter and participant discussions.

- Video replay and slide presentation are available after each session at: https://www.resourcesforintegratedcare.com.
Accreditation

- Individuals are strongly encouraged to check with their specific regulatory boards or other agencies to confirm that courses taken from these accrediting bodies will be accepted by that entity.

- This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME). The American Geriatrics Society is accredited by the ACCME to provide continuing medical education for physicians.

- The American Geriatrics Society is accredited by the National Association of Social Workers (NASW) to provide continuing education for social workers.

- The Centers for Medicare & Medicaid Services is accredited by the International Association for Continuing Education and Training (IACET). The Centers for Medicare & Medicaid Services complies with the ANSI/IACET Standard, which is recognized internationally as a standard of excellence in instructional practices. As a result of this accreditation, the Centers for Medicare & Medicaid Services is authorized to issue the IACET CEU.
Disclosure Statement

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  No relevant financial interests or affiliations.

- Nancy Wilson, MA, MSW
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- Diane E. Meier, MD
  No relevant financial interests or affiliations.

- Isaac Bromberg, MD
  No relevant financial interests or affiliations.

- Karen Blair, RN
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# Continuing Education Information

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<th>Credit Options</th>
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| **Social Worker**             | The American Geriatrics Society designates this webinar for a maximum of 1 Continuing Education (CE) credit hour through NASW | 1. Complete the pre-test at the beginning of the webinar  
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Support Statement

- This webinar is supported through the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) to help beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. To support providers in their efforts to deliver more integrated, coordinated care to dually eligible beneficiaries, MMCO is developing technical assistance and actionable tools based on successful innovations and care models, such as this webinar.

- To learn more about current efforts and resources, visit Resources for Integrated Care at: https://www.resourcesforintegratedcare.com.
Introductions

- **Diane E. Meier, MD**
  Catherine Gaisman Professor of Medical Ethics and Professor of Geriatrics and Palliative Medicine, Mt. Sinai School of Medicine
  Director, Center to Advance Palliative Care

- **Isaac Bromberg, MD**
  Medical Director for Palliative Care, Commonwealth Care Alliance

- **Karen Blair, BSN**
  Palliative Care Coordinator, Commonwealth Care Alliance

- **Lisa Thompson & Linda Thompson**
  Family Caregivers
Learning Objectives

- Recognize barriers and identify strategies for providing optimal care to older adults dually eligible for Medicare and Medicaid with serious illness
- Define and differentiate palliative care and hospice care
- Identify distressing symptoms associated with serious illness and promising practices to alleviate these symptoms
- Recognize effective strategies to improve communication and care planning with older adults with serious illness, their families, and caregivers
Webinar Outline/Agenda

- Poll Questions
- Palliative Care Futurist: Matching Care to Beneficiaries’ Needs
- Commonwealth Care Alliance’s Approach to Palliative Care
- Palliative Care Case Example
- Family Caregiver Perspective
- Q&A
- Evaluation
Palliative Care Futurist: Matching Care to Beneficiaries’ Needs

Diane Meier, MD
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Catherine Gaisman Professor of Medical Ethics and Professor of Geriatrics and Palliative Medicine, Mt. Sinai School of Medicine
Director, Center to Advance Palliative Care
What is Palliative Care?

- Specialized care for people with serious illness and their families and caregivers
  - Focused on improving quality of life
  - Addresses pain, symptoms, stress of serious illness
- Provided by an interdisciplinary team that works with individuals, their families, caregivers, and other healthcare professionals to provide an added layer of support
- Appropriate at any age, for any diagnosis, at any stage in a serious illness, and provided together with disease treatments
# Palliative Care vs. Hospice Care: What’s the Difference?

<table>
<thead>
<tr>
<th>Palliative Care</th>
<th>Hospice Care</th>
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<tr>
<td>An option for individuals <strong>living</strong> with a serious illness</td>
<td>An option for individuals <strong>dying</strong> likely within six months and who are willing to stop treatment for terminal disease</td>
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<tr>
<td>Focuses on relief from physical, emotional, spiritual suffering</td>
<td>Focuses on helping support the beneficiary, caregiver, and family experience comfort near the end of life</td>
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<td>Includes those with chronic illnesses and progressive illnesses and those that can be cured</td>
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<td>- Most of those individuals are not hospice eligible</td>
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<tr>
<td>- <strong>Eligibility for palliative care is based on need and not prognosis</strong></td>
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The Importance of Community-Based Palliative Care

The Continuum of Palliative Care

Palliative care can be — and must be — available across all settings, offering an array of services in venues that matter most to patients and families, in ways that ensure smooth transitions between settings.

Palliative Care Growth in US Hospitals

- In 2016, more than 1,800 palliative care programs in hospitals (78% of US hospitals) were caring for over 10 million individuals.

- Palliative care prevalence and number of care recipients served has more than tripled since 2000.

- 100% of the U.S. News 2015 – 2016 Honor Roll Hospitals have a palliative care team.

Demonstrating the Need for Palliative Care Among Older Adults

- Older adults are more likely to present to the emergency department with a serious illness.
- Among older adults dually eligible for Medicare and Medicaid:
  - Frequent hospitalizations and institutional care occur more often during serious medical illness and near the end of life than other beneficiary groups.
  - The highest combined Medicare and Medicaid spending comes from older adults near “the end of life who experience acute hospitalizations and facility-based long-term services and supports care.”

Dually Eligible Beneficiaries

- Medicare provides hospice coverage and most states also cover the benefit under the Medicaid program. Which program covers what, when, and under what circumstances may be complicated and confusing for providers, beneficiaries, and payers.

- Palliative care services are covered under the Medicare hospice benefit

- Benefits and payers for palliative care services can vary state-to-state. More information on payment for palliative care services outside hospice can be found here:
  - https://www.capc.org/topics/payment/
  - https://media.capc.org/filer_public/99/1f/991fb17f-72c0-4cda-b432-4d17cb2728cd/payment_accelerator_payment_arrangement_options.pdf
Palliative Care Leads to Improved Quality and Costs

- Improved Quality
  - Symptoms
  - Quality of life
  - Length of life
  - Family and caregiver satisfaction
  - Family bereavement outcomes
  - Provider satisfaction

- Reduced Costs
  - Hospital cost/day
  - Use of hospital, intensive care unit, emergency department
  - 30 day readmissions
  - Hospitality mortality
  - Labs, imaging, pharmaceuticals

Mr. B is an 88 year old man dually eligible for Medicare and Medicaid with dementia admitted via the emergency department for management of back pain due to prostate cancer, spinal stenosis and arthritis

- Pain is eight out of ten on admission, for which he is taking acetaminophen daily
- Admitted three times in two months for pain, falls, and altered mental status due to constipation
- His family (83 year old wife) is overwhelmed
Case Study: Mr. B (continued)

- Mr. B: “Don’t take me to the hospital! Please!”
- Mr. B’s wife: “He hates being in the hospital, but what could I do? The pain was terrible and I couldn’t reach the doctor. I couldn’t even move him myself, so I called the ambulance. It was the only thing I could do.”

Case study modified from and with thanks to Dave Casarett
Mr. B: Before and After Palliative Care

Before Palliative Care

- 4 calls to 911 in a 3 month period, leading to:
- 4 ED visits and
- 3 hospitalizations, leading to:
  - Hospital acquired infection
  - Functional decline
  - Family distress

After Palliative Care

- House calls referral for home-based primary and palliative care
- Pain management
- 24/7 phone coverage
- Support for caregiver
- Home-delivered meals through the Area Agency on Aging
- Friendly visitor program through faith community
- No 911 calls, ED visits, or hospitalizations in last 3.5 years
How Does Palliative Care Work?
Top 6 Characteristics of Effective Palliative Care

1. Adequately educate interdisciplinary care team (ICT) staff
   1. ICT members include nurses, social workers, chaplains, physicians, case managers, physical/occupational/speech therapists, licensed professional counselors, etc.

2. ICT staff members can screen, then target the people with the greatest need

3. Goal setting: Ask people what matters most to them using a person-centered plan

4. Support family and other caregivers

5. Expert pain/symptom management

6. 24/7 access, all settings
Adequately Educated Staff: Training Examples

- The Center to Advance Palliative Care offers trainings on topics such as:
  - Pain management
  - Communication skills
  - Symptom management
  - Non-pain symptom management (dyspnea, nausea, constipation, depression, etc.)
  - Relief of suffering across the disease trajectory
  - Crisis prevention through whole-person care
  - Building your hospital or community program
- To learn more about these trainings, visit: [https://www.capc.org/membership/curriculum-catalogue/](https://www.capc.org/membership/curriculum-catalogue/)

- See the resource slide for additional trainings on palliative care such as a HRSA training module for palliative and end-of-life care for persons living with dementia
Screen and Target the People with the Greatest Need

- Recommended palliative care screening criteria
  - Serious illness(es)
  - Prior hospitalization or skilled nursing home stay in last year
  - Functional and/or cognitive impairment
    - Clinical Frailty Scale (Dalhousie University)
    - Mini-Cog
    - Katz Index of Independence in Activities of Daily Living

- Presence of all three criteria predicts 50% chance of re-hospitalization and 22% chance of death in the next year

Goal Setting: Ask People What Matters Most to Them

- Create a person-centered care plan based on what is most important to the individual, who may choose to include family members, friends, and others in the planning process.

- Survey of Senior Center and Assisted Living
  - 357 subjects, dementia excluded, no data on function.
  - Asked to rank order what is most important:
    1. Independence (76% rank it most important)
    2. Pain and symptom relief
    3. Staying alive

Support Family and Other Caregivers

- Family caregivers reporting stress have significantly higher morbidity, mortality, and health care utilization
- Research demonstrates that support for unpaid caregivers, via support groups and clinician attention to supporting the role and needs of the unpaid caregiver...
  - Significantly reduces utilization
  - Decreases the likelihood of nursing home placement
  - Improves experience and satisfaction
- More information on supporting family caregivers can be found here: https://resourcesforintegratedcare.com/GeriatricCompetentCare/2017_GCC_Webinar_Series/Caregivers

Expert Pain/Symptom Management

- There is an increased need for training on safe and effective management of pain and other symptoms for all health professionals serving people living with serious illness.
- Symptom distress is the number one cause of unplanned 911 calls, ED visits, and hospitalizations.
  - Effective management of symptoms is associated with reduced suffering; reduced health care utilization; higher beneficiary, family, and caregiver satisfaction; and lower mortality.
Palliative Care: 24/7 Access, All Settings

- 24/7 access, in all settings is a goal for optimal palliative care
- 24/7 coverage: calls are returned within 15 to 20 minutes by someone who can make a clinical decision or prescribe medicine
  - 24/7 coverage is an essential element of improving care and reducing cost for this high-need population
- Most pain and symptom crises do not occur during working hours
  - Beneficiaries may wait until symptoms are unbearable to seek help for fear of bothering their doctors or long wait times
- Telephone access around the clock is a user-friendly, low-cost means of seeking advice and help before the situation leads to a 911 call
Commonwealth Care Alliance’s Approach to Palliative Care

Isaac Bromberg, MD

Medical Director for Palliative Care
Commonwealth Care Alliance
Commonwealth Care Alliance (CCA)

- CCA offers two health plans for dually eligible individuals
  - Senior Care Options (SCO) - Dual Eligible Special Needs Plan (D-SNP) for adults age 65 and over
  - OneCare - Medicare-Medicaid Plan (MMP) for adults age 21-64
- SCO Serves 10,000+ dual eligible members age 65 and older across Massachusetts
  - Average age is 75 years
  - 70% are at nursing home level of care but choose to live at home
  - 65% have four or more chronic conditions
  - 60% speak a primary language other than English
Interdisciplinary Team-Based Care

- Every member is assigned a **care partner** (Registered Nurse, Advanced Practice Clinician, Behavioral Health Specialist, Heath Outreach Worker; mobile or telephonic) who is responsible for care management and care coordination.

- The care partner collaborates with others who may be on the team:
  - Behavioral Health Specialist
  - Health Outreach Worker
  - Rehabilitation services: Physical Therapy, Occupational Therapy, Speech Language Pathology
  - Geriatric Support Services Coordinator/Long-Term Services and Supports Coordinator

- For members receiving palliative care, the care partner also collaborates with:
  - Palliative Care Coordinator
  - Palliative Nurse or Advanced Practice Clinician
  - Palliative Physician
Training Model for Palliative Care Staff

- CCA clinical staff are trained in a model that incorporates the principles of palliative care into the usual care that members receive
  - Communicate effectively
    - Communication is done in the members’ primary language, whenever possible
  - Complete an Advance Care Plan
    - Important for all of our members, regardless of health status
    - Covered benefit in Medicare
    - For more information, visit https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf
  - Review goals of care at times of transition or status change
    - These are opportunities to ensure that members understand their health conditions and are able to express their preferences
  - Recognize the value of independence and understand dignity of risk
    - Self-determination and the right to take reasonable risks are essential for dignity and self-esteem
Referral Triggers for Palliative Care Team

- The member is sicker: weight loss, decline in function, unable to manage symptoms such as pain, difficulty breathing, or fatigue
- New or advancing cancer
- Three or more hospitalizations in the past three months
- Advancing chronic disease (e.g., congestive heart failure, chronic lung disease, chronic renal failure, dementia)
- Possibility that member may pass away within the next 12 months due to illness
What Can the Palliative Care Team Do?

- Clarify diagnosis and prognosis
- Discuss treatment options/goals of care
  - Risks vs. benefits of treatment
  - Trade-offs between quality of life and life extension
- Discuss advance care planning
- Manage symptoms
- Provide guidance on use of community paramedics, contracted home-based palliative care providers, or hospice
  - Identify specific needs and the best resources to meet those needs based on the member’s individual situation
- Offer additional support for member/family (scheduled or urgent visits)
  - Palliative care team members can make scheduled and urgent visits, depending on the members needs
- Offer end of life/funeral planning/bereavement support
Education for Care Teams

- Members of the palliative care team attend regularly scheduled care team meetings to provide clinical input and general education.
- The palliative team meets weekly to review cases (care partners are invited to attend).
- All members of the clinical team have access to training modules from the Center to Advance Palliative Care training modules.
Palliative Care Case Example

Karen Blair, BSN
Palliative Care Coordinator
Commonwealth Care Alliance
Stages of Palliative Care

Palliative care is offered at any time during serious illness. Understanding that every situation is different and the course of illness is fluid, the following conceptualization may be helpful.

- **Early Stage:** Aware of the serious illness, thinking about what it might mean, not ready to commit, may be active in treatment, beginning to accept support, lots of denial

- **Middle Stage:** Acknowledging limitations, retaining hope but willing to entertain options, goals of care are changing, more accepting of support

- **Late Stage:** Accepting of the inevitable, making solid plans, thoughts about what end of life might be like, planning for others
Case Study: Mr. M

- 81 year old dually eligible Hispanic man who was disabled from employment due to injury
- Conditions included:
  - Diabetes
  - Polymyalgia rheumatic
  - Hypertension
  - Dyslipidemia
  - Asthma
  - Coronary artery disease with an inferior myocardial infarction
  - Heart failure
  - Chronic lung disease
- Lived in subsidized housing with his wife, who speaks Spanish only
- Adult children lived in the local area, but he did not rely on them for support
- Palliative referral was made after several hospitalizations/ED visits for heart failure
- Declined in function, increased symptoms, and complex medical management
Mr. M: Early Stage Palliative Care

- Referred to palliative care team by care partner October 2015
- Admitted his unwillingness often led to hospital admission because he waited too long to call for help
- Medical follow-up (Primary care provider and specialists)
  - Weak and short of breath after admission for fluid overload, difficult ambulation
  - No advance directives, wife did not want him to die at home
  - Unwilling to commit to avoidance of hospitalizations with an action plan
  - Met palliative physician and nurse, periodic follow up from palliative team
  - Personal Care Attendant services initiated (bathing, dressing, etc.)
  - Physical Therapy/Occupational Therapy for strengthening, durable medical equipment/seat lift chair
  - Behavioral Health support for assistance in adjustment to the illness and all its implication
Mr. M: Middle Stage Palliative Care

- Mr. M’s goals evolved as he understood that his conditions were declining
- Medically/symptomatically
  - Heart Rate<40, dusky, hypotensive
  - Pulse oximeter ordered for member for self monitoring
  - Personal Care Attendant support, Physical Therapy, nurse med prefill, increasing Physician Assistant/physician involvement
  - Committing to managing in a different way than he has: de-prescribing, avoidance of hospitalization if possible, transfer care to home
  - Comfort pack meds ordered
- Psychosocial/spiritual
  - Medical Orders for Life Sustaining Treatment (MOLST) form completed declining resuscitation, wife does not want him to die at home but is trying to accept
  - Counseling support but declines spiritual support
  - Completed advance care plan to identify appropriate health care agent and discusses what individual hopes their end of life might look like
Mr. M: Late Stage Palliative Care

- July 2016 sent to ED by wife for new stroke, no intervention available, wife takes him home.
- Medically/symptomatically
  - Difficulty swallowing, lack of bowel and bladder control, difficulty taking meds, intractable pain, delirium, bronchitis and dyspnea
  - Palliative partner, team shares almost daily visits
- Psychosocial/spiritual
  - Wife now committed to keep him home as long as they can manage
  - New Medical Orders for Life Sustaining Treatment (MOLST), member able to understand and sign
  - Wife is unable to transfer him independently and he worries about her—additional Personal Care Attendant hours, Physical Therapy.
  - Behavioral Health and Medical Assistant provide counseling support for member and wife, assistance with end of life planning, spiritual support
- He died at home in October 2016
Barriers to Receiving Care for Dually Eligible Older Adults

- Physical discomfort
- Communication difficulties (hearing, vision, speech, comprehension)
- Anxiety
- Negative past experience with medical system, illness and death
- Social determinants: food, housing, safety, access
- Cultural and language differences
- Isolation
- Caregiver’s/Individual’s goals differ
Communication Strategies

- Gradual over time
  - Develop relationship through continued conversations
- Culturally sensitive
  - Aware of general norms and cultural bias
- Multimedia
  - Not everyone learns the same way, use all the senses
- Literacy/education level appropriate
  - Include plain language and pictures
- Environmental modifications/distractions
  - Turn off TV
  - Provide privacy
Summary

- Multidisciplinary approach
- Addressing social determinants
- Psychosocial support
- Culturally appropriate communication
- Treatment plan tailored to individual preferences
Caregiver Perspective
Questions
Resources for Integrated Care – Additional Webinars

- Visit [https://resourcesforintegratedcare.com/](https://resourcesforintegratedcare.com/) to view previous webinars and obtain continuing education credit. Webinars include:
  - **Providing Culturally Competent Care: Meeting the LTSS Needs of Dually Eligible Beneficiaries**
    - [https://resourcesforintegratedcare.com/CulturalCompetency/2018_CC_Webinar/LTSS](https://resourcesforintegratedcare.com/CulturalCompetency/2018_CC_Webinar/LTSS)
  - **Supporting Older Adults with Substance Use Disorders**
    - [https://resourcesforintegratedcare.com/GeriatricCompetentCare/2018_GCC_Webinar_Series/SUD](https://resourcesforintegratedcare.com/GeriatricCompetentCare/2018_GCC_Webinar_Series/SUD)
  - **Person-Centered Approaches to Support People Dually Eligible for Medicare and Medicaid**
    - [https://resourcesforintegratedcare.com/GeriatricCompetentCare/2018_GCC_Webinar_Series/Person_Centered_Care](https://resourcesforintegratedcare.com/GeriatricCompetentCare/2018_GCC_Webinar_Series/Person_Centered_Care)
  - **Promising Practices for Meeting the Behavioral Health Needs of Dually Eligible Older Adults**
    - [https://resourcesforintegratedcare.com/GeriatricCompetentCare/2018_GCC_Webinar_Series/Behavioral_Health_Needs](https://resourcesforintegratedcare.com/GeriatricCompetentCare/2018_GCC_Webinar_Series/Behavioral_Health_Needs)
  - **Promising Practices for Meeting the Needs of Dually Eligible Older Adults with Schizophrenia**
    - [https://www.resourcesforintegratedcare.com/GeriatricCompetentCare/2018_GCC_Webinar_Series/Older_Adults_Schizophrenia](https://www.resourcesforintegratedcare.com/GeriatricCompetentCare/2018_GCC_Webinar_Series/Older_Adults_Schizophrenia)
Thank You for Attending!

- The video replay, slide presentation, and a summary of the Q&A will be available at: https://www.resourcesforintegratedcare.com

- If you are applying for CME or NASW CEU, you must complete the post-test in order to receive credit: https://www.research.net/r/PostTest_PalliativeCare

- For more information about obtaining CEUs via CMS’ Learning Management System, please visit: https://www.resourcesforintegratedcare.com/GeriatricCompetentCare/2018_GCC_Webinar/Palliative_Care

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- We would also like to invite you to provide feedback on other RIC products as well as suggestions to inform the development of potential new resources: https://www.research.net/r/MVGNWVJ
Resources

- The National Academies of Sciences Engineering Medicine Roundtable of Quality of Care for People with Serious Illness: http://nationalacademies.org/hmd/Activities/HealthServices/QualityCareforSeriousIllnessRoundtable.aspx
- Center to Advance Palliative Care Trainings on the essentials of communication about goals of care, advance care planning, and pain and symptom management: https://www.capc.org/membership/curriculum-catalogue/
  - Available with membership with sliding scale fees
- HRSA training module for palliative and end-of-life care for persons living with dementia: https://bhw.hrsa.gov/grants/geriatrics/alzheimers-curriculum
- Communication skills training: https://communication-skills-pathfinder.org/ and http://vitaltalk.org/
- National Hospice and Palliative Care Organization: https://www.nhpco.org/
- Palliative care program directory: www.getpalliativecare.org
- Information on payment for palliative care services:
  - https://www.capc.org/topics/payment/
  - https://media.capc.org/filer_public/a5/15/a5157b68-93c0-44ad-a6c4-fc2a71e6be2c/capc_paymentprimer_final.pdf
- Information on payment for hospice through Medicare: https://www.medicare.gov/Pubs/pdf/02154-Medicare-Hospice-Benefits.PDF
Resources – Additional Trainings

- Other training options:
  - Nursing only: ELNEC. [https://www.aacnnursing.org/ELNEC](https://www.aacnnursing.org/ELNEC)
  - Single courses, fee based: California State University Institute for Palliative Care [https://csupalliativecare.org/about/](https://csupalliativecare.org/about/)
  - System-wide advance care planning program: Respecting Choices [https://respectingchoices.org/](https://respectingchoices.org/)
  - [https://palliative.stanford.edu/](https://palliative.stanford.edu/)
  - [https://csupalliativecare.org/programs/](https://csupalliativecare.org/programs/)
  - [https://www.nhpco.org/education/online-learning](https://www.nhpco.org/education/online-learning)
Sources


