Listening Session 2: Optimizing the Mix of Palliative Care and End-of-Life Care in PB-TCOC Models

Presenters:

Subject Matter Experts

- Kurt Merkelz, MD, FAAHPM – Senior Vice President and Chief Medical Officer, Compassus
- Natalie C. Ernecoff, PhD, MPH – Full Policy Researcher, RAND
- Ira Byock, MD, FAAHPM – Emeritus Professor of Medicine and Community & Family Medicine, Dartmouth Geisel School of Medicine
- Betty Ferrell, RN, PhD – Director and Professor, Division of Nursing Research and Education, Department of Population Sciences, City of Hope
Listening Session 2: Optimizing the Mix of Palliative Care and End-of-Life Care in PB-TCOC Models

Kurt Merkelz, MD, FAAHPM
Senior Vice President and Chief Medical Officer, Compassus
Opportunities for Enhancing Palliative Care and Related Outcomes in PB-TCOC Models

Kurt Merkelz, MD, FAAHPM
Chief Medical Officer
Compassus
June 11, 2024
Background: Kurt Merkelz, MD, FAAHPM

- MD (Practicing Palliative Care Physician, Geriatrician)
  - Chief Medical Officer Compassus
  - Right Care Foundation Member

- Applied Science/Research focused on supporting frail/chronically ill individuals in their homes (successful aging)
  - Substantive model of care that supports outcomes necessary for patients to be successful in their homes

- Developed and implemented a system wide Care Delivery Model that supports successful aging at home
  - Trained over 10,000 clinicians in standardized best practices to support individualized care
  - Substantial improvement on HQRDP metrics and HH Star ratings

“We need to redefine outcomes of success. Recovery, Restoration of function - should not be the measures of effectiveness and quality of care. Prior level of function (performance) is what led them to the hospitalization to begin with”
Compassus Integrated Home-based Care

Compassus is a nationally-scaled provider of integrated home-based care to more than 100K patients annually. We are continually evaluating community needs nationwide for expansion and integration opportunities across service lines.

**CORE SERVICE LINES**

- **HOME HEALTH**
  - 49 programs

- **HOME INFUSION**
  - 3 programs

- **PALLIATIVE CARE**
  - 43 programs

- **HOSPICE**
  - 151 programs

**Selection of value-added partnerships**

- Ascension
- VNS Health
- Bon Secours Catholic health system
- Diversicare
- Complete Health

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3
Our Research

COMMUNITY BASED - grounded in the needs, issues, concerns, and strategies of communities and the community-based organizations that serve them. PARTICIPATORY - directly engaging communities and community knowledge in the research process and its outcomes. ACTION BASED AND ORIENTED - supporting and/or enhancing the strategic action that leads to community transformation and social change.
PB-TCOC Models Employing Palliative Care

- Improved symptom management
- Improved advance care planning
- Timely transition to hospice care, increased use of hospice care
- Reduced hospitalizations

EPIDEMIC OF RISK IN CARE FOR THE FRAIL, ELDERLY, and SERIOUSLY ILL IN OUR COMMUNITIES

individuals who have multiple complex chronic conditions, disability, and frailty are more highly associated with High Needs High Cost

References:
Current State of the Art: 92-year-old with chronic osteoarthritis, hip injury, cerebrovascular disease, hypertension, atrial fibrillation

In my opinion, this patient meets requirements for acute inpatient rehab. The patient has functional deficits which are described above; goal is to discharge home with improved functional independence. This can be accomplished through multidisciplinary approach utilizing physical and occupational and speech therapy if required as available at this facility. Therapy services will be focused on enhancing independence through aggressive exercises individualized by the rehabilitation team. Modalities will be utilized as well as emerging technologies to enhance functional recovery in addition to conventional exercise-based treatments. The focus will be on gait training, transfer training, self-care activities, toileting, bathing, balance activities, coordination and improving overall endurance. We will also assess any needs for DME. Because of the medical issues described above, the patient requires physician availability to mitigate any potential complications and to evaluate the patient on a daily basis and adjust treatment plan in a timely manner.
Evolution of the Definition of Independence

- Original understanding arose from veterans coming out of WWII
- Focus was on recovery of physical function – limb loss
- Current system continues to over-emphasize independent goal attainment
- Patients want AUTONOMY – NOT SELF-RELIANCE
- For the seriously ill the problem(s) are often never cured, never stable and results in lingering health issues.

Self-determination. The ability to have solutions/systems in place that meet the needs of the patient
## Treatment Plans

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Treatment Plans</th>
<th>Performance Components</th>
<th>Self-Reliance Activities</th>
<th>Safety Risk Reduction</th>
<th>Medical Condition Management</th>
<th>Autonomy</th>
<th>Burden of Care &amp; Quality of Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehab Hospitals</td>
<td>28</td>
<td>1,607</td>
<td>61%</td>
<td>36%</td>
<td>&lt;1%</td>
<td>&lt;3%</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>113</td>
<td>9,712</td>
<td>70%</td>
<td>26%</td>
<td>&lt;1%</td>
<td>&lt;3%</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>LTACH</td>
<td>11</td>
<td>391</td>
<td>81%</td>
<td>16%</td>
<td>&lt;1%</td>
<td>&lt;3%</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Home Health</td>
<td>34</td>
<td>11,388</td>
<td>54%</td>
<td>38%</td>
<td>&lt;1%</td>
<td>&lt;10%</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td></td>
<td>186</td>
<td>23,098</td>
<td>66.5%</td>
<td>29%</td>
<td>&lt;1%</td>
<td>&lt;5%</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

### OUTCOMES

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>Net increase of 8 risks (avg &gt;40) avg 62</td>
</tr>
<tr>
<td>Autonomy</td>
<td>34/51</td>
</tr>
<tr>
<td></td>
<td>(&gt;30% chance of 6 month readmission. Basic needs not met in 5 of 13 categories on average)</td>
</tr>
<tr>
<td>Medical Condition</td>
<td>1 Yes 6 No's</td>
</tr>
<tr>
<td>Caregiver Burden</td>
<td>Net increase in Caregiver Burden</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>Poor. No net gain.</td>
</tr>
<tr>
<td>Self-Reliance</td>
<td>Progressive decline over time, punctuated by steep declines. PLOF=readmission</td>
</tr>
</tbody>
</table>
Integration of Palliative Care throughout the Continuum

• Current models of care are not designed to meet the needs of frail, seriously and chronically ill individuals.
• Community-based Palliative care for serious/chronically ill requires a new paradigm – current training does not address solutions/systems to meet the needs of the patient.
• Over-emphasis of symptom management, medications, acute medical care
• Most of the patients in need of specialized supportive care are not yet hospice appropriate.
• It’s not about prognosis, it’s about the success of the patient in 6 critical areas.
• The Palliative care clinician is perfectly situated to be integrated into the treatment team to support “quarterback” the care plan and outcomes.
Redefining the Quality Equation – Driving the 6 Key Outcomes

Palliative care, deploying an outcomes-focused methodology, is the only high value care that will significantly impact people with serious illness.

Medical Condition Management * Safety * Autonomy * Burden of care * Aging in Place * Quality of Life

\[
\text{QUALITY} = \frac{\text{What the provider delivers}}{\text{What the system expects}} \times \frac{\text{patient needs}}{\text{patient receives}}
\]
Compassus’ Care Delivery Model

Six elements of the model support disease-specific clinical pathways and outcomes-driven accountability

- Decreased polypharmacy
- Elimination of potentially inappropriate Meds
- Reduced drug adverse events
- Standardized pain assessment
- HIS #1637: Pain Screen & Assessment
- Screening for Pain & Interviewing for Comfort
- Comprehensive Symptom Management for your patients
- Edmonton Symptom Assessment System Score
- Individualized, Person-centered care
- Visits in Last Three Days of Life
- Identification of Resident Safety Risks
- Hospice Best Practice Indicator – Rx per patient
- Drug Adverse Incidents per 1K patient days
- The One Thing
- Storyboard
Applying the Principles of Care Delivery Model

Medical Condition Management
There are 7 key goals
Community Engagement

What is RIGHTCARE currently doing with this advanced care methodology.

https://vimeo.com/manage_videos/840582293

RC CRR is equipping fire departments and their local healthcare and community with the tools and resources necessary to reduce the epidemic of emergent call volume from the AIM and SIM population that is crippling emergency response around the country. This allows the entire local community to participate in advanced community risk reduction programming.

www.rightcareministry.org

RC is currently bringing a new model of senior ministry programming to multiple major denominations around the U.S. This gives seniors and their adult children necessary resources, tools, and support to change the mSDOH profile of seniors (parents) to one of success as they navigate the challenge that come with aging with these diseases.

https://www.seniorhelpers.com/services/life-profile-service/

RC has completed a national integration roll out of the mSDOH assessment and care planning into over 300 private duty locations, significantly changing the value proposition of private duty on total cost of care for at risk populations. This has also led to the first CHAP Certified Age Friendly Care at Home office in the country, with many more to follow.
Innovative efforts most effective to improve palliative care services for patients with complex chronic conditions or serious illness

- Stop rearranging chairs and hoping for new outcome
  - Medicine works
  - The problem is everything else

- Clearly defined methodology that achieves substantive outcomes that are measurable
  - Outcomes that the payor source, clinician, and patient care about, can realize, and must achieve
  - Standardized best practice delivered in individualized ways
  - More focus on objective outcomes over subjective ratings of care
Listening Session 2: Optimizing the Mix of Palliative Care and End-of-Life Care in PB-TCOC Models

Natalie C. Ernecoff, PhD, MPH
Full Policy Researcher, RAND
Lessons Learned about Providing Concurrent Hospice Services

Natalie C. Ernecoff, PhD, MPH
Full Policy Researcher
RAND
Pittsburgh, Pennsylvania
June 11, 2024
Overview

1. Background on hospice policy & concurrent care
2. Best practices for providing concurrent hospice services
3. How models of concurrent hospice services improve patient outcomes
4. Care coordination challenges
Hospice in the United States

- Medicare Hospice Benefit developed in cancer care
  - 6-month prognosis
  - Relatively inexpensive medications
  - Home-based care
- Does not cover related disease-directed therapies
- Intended to be inclusive
Patients are forced to make the “terrible choice.”

- Hospices are unable to afford coverage of many disease-direct therapies, so they often require discontinuation before enrolling.
- E.g., palliative dialysis, blood transfusions, palliative radiation
- Patients who could benefit from disease-directed therapies are often forced to choose between therapies that can improve quality of life and hospice.

- Thus, fewer of those patients elect the hospice benefit.
- Those who do choose the hospice benefit often access these services very near the end of life with less opportunity to receive its intended benefits.
What is Concurrent Care?

• Continuation of disease-directed therapy upon enrollment in hospice to support patient goals near the end of life

1. Treatment motivated by symptom management rather than curative.
3. Treatments must be reviewed regularly.
Utility of Concurrent Care: Pediatrics

- **Context**
  - 2010: ACA Medicaid policy change
  - State-level variation

- **Findings**
  - ↑ hospice length of stay
  - ↓ live discharges from hospice
Utility of Concurrent Care: VA cancer care

- **Context**
  - 2000s: Low hospice enrollment
  - Non-Medicare rules

- **Findings**
  - Chemotherapy was used after hospice enrollment
  - Discontinued before death
  - Fewer ICU admissions
  - No change in survival
Utility of Concurrent Care: VA ESKD care

- **Population**
  - Veterans living with ESKD

- **Findings**
  - Median hospice length of stay:
    - 4 days among non-concurrent
    - 43 days among concurrent care
Utility of Concurrent Care: Hospice and Dialysis

- **Context**
  - Collaborative program between non-profit hospice & dialysis
  - Contracted rate

- **Findings**
  - ½ of concurrent enrollees did not use any dialysis
  - Mean hospice length of stay:
    - 12 days among all
    - 17 days among those who received any dialysis

*This was a way for us to let his body decide.*

-Family caregiver
Policy Landscape: Medicare Care Choices Model

- **Context**
  - Hospices paid higher per capita fee
  - FFS Medicare covers disease-directed concurrent treatments
  - Hospices responsible for administrative burden (e.g., eligibility determination)

- **Population**
  - Eligible 1° diagnoses: cancer, COPD, CHF, or HIV/AIDS

- **Findings**
  - ↑ hospice enrollment
  - Hospice ~1 week earlier
  - ↓ inpatient care → ↓ lower costs
  - ↑ Caregiver-reported experience
  - Most enrollees were from large hospices
  - Many hospices withdrew from the model
  - Difficulties identifying eligible beneficiaries based on narrow criteria
Policy Landscape: Value-Based Insurance Design

- **Context**
  - Carves hospice into Medicare Advantage
  - Hospices can provide transitional concurrent care
    - Higher per capita fee in the first month of enrollment
    - Reimbursement for concurrent care related to terminal condition
    - Retain responsibility for treatment plans & care coordination

- **Population**
  - Medicare Advantage beneficiaries near the end of life

- **Findings** (ongoing, sunsetting 2024)
  - Low enrollment
  - No change in hospice utilization outcomes in first year
Components of Effective Concurrent Care

Patient identification and referral pathways must be clear.
*From outpatient: nephrology/dialysis, oncology, primary care*
*From inpatient: hospitalists, specialty palliative care*

Good communication & workflows foster interdisciplinary collaboration.

Education & engagement for clinicians, patients, & families facilitates the Program, including early and ongoing goals of care conversations.

Coordinated care leads to smooth transitions.
Lack of coordinated care leads to rough transitions.
Key Takeaways

- **Concurrent care is a feasible and effective option** to promote timely patient-centered care via hospice access near the end of life.
  - Feasibility is driven by interdisciplinary care coordination, clinician education, & clear referral pathways.

- **Payment models for concurrent care require operational clinical models.**
  - Clinical models include include modifiable care plans, interdisciplinary care coordination, clear workflows (including for referral), and education and ongoing communication between clinicians, patients, and families.
Disclosures

• I do not have conflicts of interest.
• Portions of this work were funded by the Palliative Care Research Collaboratory.
Appendix: References & Select Reading


Listening Session 2: *Optimizing the Mix of Palliative Care and End-of-Life Care in PB-TCOC Models*

**Ira Byock, MD, FAAHPM**
Emeritus Professor of Medicine and Community & Family Medicine, Dartmouth Geisel School of Medicine
Patient Perspectives & Doctors’ Roles
in Caring Well Through the End of Life

Ira R. Byock, MD, FAAHPM
Emeritus Professor of Medicine & Community and Family Medicine
Dartmouth Geisel School of Medicine
Clinical Transformation Specialists, PLLC
IraByock.org

PTAC Public Meeting
June 11, 2024
Goals of Medicine

Problem-based, Transactional Medical Model

- Cure
- Longevity
- Rehabilitation
- Alleviating symptoms & suffering
Goals of Medicine

Problem-based, Transactional Medical Model

- Cure
- Longevity
- Rehabilitation
- Alleviating symptoms & suffering

<table>
<thead>
<tr>
<th>Problem</th>
<th>Everything the patient reports and doctor’s findings which are regarded as problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjective</td>
<td>History of the problem; what the patient feels or thinks about the problem</td>
</tr>
<tr>
<td>Objective</td>
<td>Doctors findings related with the problem</td>
</tr>
<tr>
<td>Assessment</td>
<td>Evaluation of the problem; the diff. diagnosis</td>
</tr>
<tr>
<td>Plan</td>
<td>Prescription, consultation, advice, control visit.</td>
</tr>
</tbody>
</table>
Health & Illness are Personal!
Whenever an individual receives a serious diagnosis, his or her family shares the illness.
Whenever an individual receives a serious diagnosis, his or her family shares the illness.
What Matters Most to People?

- Other people
- Not being a burden
- Retaining dignity
- Not suffering
- Feeling seen, heard and understood
- Not falling through cracks in system
Fostering personal wellbeing throughout life, including experiences with illness dying, caregiving, grieving AND

Caring for Whole Persons

- Cure
- Longevity
- Rehabilitation
- Alleviating symptoms & suffering
Caring for Whole Persons

- Personal opportunities
- Problem-based medicine

- HONORING & CELEBRATING
- FOSTERING WELLBEING
- ASSISTING WITH LIFE COMPLETION
- ALIGNING TREATMENTS WITH GOALS
- DIAGNOSING & TREATING
- HUMAN ESSENTIALS
A Taxonomy of Quality

- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- Equitable

Crossing the Quality Chasm:
A New Health System for the 21st Century
Institute of Medicine, March 2001
Defining patient-centered care:

“Healthcare that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients’ wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care.”

Crossing the Quality Chasm:  
A New Health System for the 21st Century  
Institute of Medicine, March 2001
ACP & GOC Conversations Can Be Hard Because They Involve Talking About Dying

- We have an awkward relationship with death – that’s true for almost all cultures
- Within Western medicine a patient’s death can feel like failure
- Death is inevitable, suffering is not
- Dying is hard and unwanted. And it is a time of life that often holds value
- Conversations with clinicians can influence how our patients die and experience of families
- Skill-building and confidence can help make these conversations professionally satisfying

Sonya Hebert / The Dallas Morning News / 12/13/08

ACP = advance care planning
GOC = goals of care
"We ask everyone about their preferences – especially who they would want to speak for them – and ask them to complete an advance directive."
Normalizing ACP & GOC Conversations

“I have an advance directive – and so does every adult in my family.”
Aligning Treatments with Personal Goals

Shared Decision Making – circa 1960
Aligning Treatments with Personal Goals

Shared Decision Making – circa 2024

Parentalism or Doctor Decides

Shared Decision Making

Autonomy or Family Decides

Achievable health outcomes

Personal values, preferences and priorities
Code Status Change: Hospitalized Patients with a Serious Illness

Change in Code Status During Admission

- No Palliative Care & No Goals of Care: 19%
- Palliative Care Only: 35%
- Goals of Care Only: 42%
- Palliative Care & Goals of Care: 63%

Providence Health system enterprise wide data 2021-2022
Improved Patient Experience with Goals of Care

<table>
<thead>
<tr>
<th>Feature</th>
<th>With Goals of Care</th>
<th>Without Goals of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likelihood of recommending hospital</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Degree all staff show compassion</td>
<td>70%</td>
<td>50%</td>
</tr>
<tr>
<td>Response to concerns/complaints</td>
<td>60%</td>
<td>50%</td>
</tr>
<tr>
<td>Attention to special personal needs</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Overall rating of care given</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td>How well your pain was controlled</td>
<td>70%</td>
<td>50%</td>
</tr>
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</table>

*With GOC (N = 192) vs without GOC (N = 772); Top-box selection; single hospital 2020; Subset of all statistically significant results (p < 0.05) analyzed GOC conversations conducted by non-palliative care clinicians.*
“Our Palliative Care team is here to provide you and your family with an extra layer of support....”

Photo: Medical University of South Carolina
https://nursing.musc.edu/admissions/our-programs/palliative-care/practice
Impact on Bed Days of Early vs Later Palliative Care

Less hospital days to:
- Fall
- Develop delirium
- Acquire infections
What Doctors Are For

Problem-based Medical Model

- Saving lives
- Preventing injuries, diseases, disabilities
- Extending life, when cure is not possible
- Optimizing function & independence
- Alleviating symptoms & suffering

https://www.modernhealthcare.com/article/20171215/NEWS/171219912/higher-patient-satisfaction-linked-to-lower-readmissions
Whole Person Caring Model

• Assisting in treatment decisions consistent with patients’ personal priorities
• Accompanying people through difficult times of illness & disability
• Improving well-being of patients within families and communities
• Preserving & fostering patients’ potential to grow individually and together with those they love
Reclaiming Primacy of Primary Care

Concierge Medicine
One model for improving clinician satisfaction & joy at work
If we had more time…

- Personalizing the EHR
- AI enabled Patient Reported Information
- Whole person wellbeing dashboards
APPENDIX

For further reading:

The Best Care Possible: A Physician's Quest to Transform Care Through the End of Life by Ira Byock 2012, Avery Penguin
Listening Session 2: Optimizing the Mix of Palliative Care and End-of-Life Care in PB-TCOC Models

Betty Ferrell, RN, PhD
Director and Professor, Division of Nursing Research and Education, Department of Population Sciences, City of Hope
“Addressing the Workforce Challenges Related to Caring for Patients with Complex Chronic Conditions or Serious Illness through Clinical Leadership”

Betty Ferrell, PhD, RN, MA, CHPN, FAAN, FPCN
Professor and Director
Division of Nursing Research and Education
City of Hope
PI, End of Life Nursing Education Consortium (ELNEC)
Nurses are the predominant profession in health care, across all health care settings and all patient populations. They are central to patient and family understanding of illness, managing distressing symptoms, transitioning between health care systems, and they are present across all settings at the time of death.
Advanced Practice Nurses are underutilized in serious illness care and have untapped potential to manage patients with serious, complex illnesses.
Nurses are vital in providing initial assessment of needs of diverse populations, care during disease focused care, transition to palliative focused care, initiating hospice care, managing urgent needs, supporting family caregivers, providing telehealth, and care at the end of life.
What are Best Practices in Complex Care in Serious Illness?

Quality palliative care is the kind of care that you would want if you or someone you care about is seriously ill. Patient centered care in complex serious illness attends to physical, psychological, social and spiritual needs.
Best practices include:

- An assessment of the person and their family needs
- Assessment of symptoms and quality of life concerns
- A clear understanding of the goals of care
- Early integration of palliative care
- Early referral to hospice
- Access to support for symptoms and changing needs
The Generalist-Specialist Model of Nursing in Serious Illness Care

“Preparing Oncology Advanced Practice Nurses as Generalists in Palliative Care”

430 Oncology APRNs trained through ELNEC to integrate palliative care into their oncology practice.

12 month follow up documented changes in practice including increased family meetings, communicating with oncologists and with patients about patient prognosis and goals of care, referral of families for bereavement support and supporting clinical staff in end of life care.

Journal of Palliative Medicine 26 (2) 2022

NCI Funded R25 CA217270 B Ferrell, PI.
Goal 2 of the Report

Ensure a well-prepared, empowered, and appropriately compensated workforce.

www.nationalacademies.org/nursing-homes
Goal 2: Recommendations

- Competitive wages and benefits
- Staffing standards and expertise
  - Full-time social worker
- Empowerment of certified nursing assistants
- Education and training
- Data collection and research
Palliative Care: Training Clinicians to Provide Quality Care in Serious Illness
ELNEC
END-OF-LIFE NURSING EDUCATION CONSORTIUM
Advancing Palliative Care

www.aacnnursing.org/elnec
ELNEC Content Addresses the Domains of the NCP Guidelines for Quality Palliative Care

- Palliative Care overview
- Pain Management
- Symptom Management
- Ethical Issues
- Cultural and Spiritual
- Communication
- Loss / Grief
- Final Hours / EOL
History of ELNEC

► Partnership between City of Hope and American Association of Colleges of Nursing (AACN)
► Began in 2000 with funding from the Robert Wood Johnson Foundation
► First Course: January 2001, Pasadena, CA
► January 2024 marked the 300th ELNEC Trainer Course!
TODAY

- Over **47,532** ELNEC trainers through national courses
- These ELNEC Trainers have returned to their institutions/facilities and educated over **1,532,311** clinicians across disciplines. Presented in every US state and DC
- Thousands have completed ELNEC training online via Relias
- ELNEC Undergraduate (1,191) and Graduate (396) School of Nursing enrolled with 90,367 + 3,512 student online complete courses, respectively
- Taught in over 114 countries
- Translated into 12 languages
ELNEC Curricula

Currently 8 ELNEC Curricula

In person courses and Online:
- ELNEC Core
- ELNEC Geriatric (includes unlicensed staff)
- ELNEC Pediatric (includes Neonatal Care)
- ELNEC Critical Care
- ELNEC APRN
- ELNEC Oncology APRN (NCI, R25 Grant)
- ELNEC Communication

Online only:
- ELNEC Undergraduate/New Grad (online)*
- ELNEC Graduate (online)*

*Supported by Cambia Health Foundation
The Nursing Workforce is Essential to Transforming Serious Illness Care