HOSPICE OF THE WESTERN RESERVE

Palliative Care Management and Transition

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Objectives

- General overview of palliative care
- Define the role of palliative care
- Identify indicators for hospice eligibility

Definitions of Palliative Care

- ORC 3712
- CAPC
- CMS & NQF

ORC 3712-01 Definition

"Palliative care" means treatment for a patient with a serious or life-threatening illness directed at controlling pain, relieving other symptoms, and enhancing the quality of life of the patient and the patient's family rather than treatment for the purpose of cure.

CAPC

Palliative care, and the medical sub-specialty of palliative medicine, is specialized medical care for people living with serious illness. It focuses on providing relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family

CAPC.org

CMS and National Quality Forum Definition (2013)

Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice

Commonality to Definitions

- Holistic care
- Pain and symptom management
- Quality of life
- Serious illness

Palliative Care History

- 1960's
  - Dr. Cicely Saunders
  - Focus on dying "Hospice"
- 1970's
  - Dr. Balfour
  - "Palliative Care"

Palliative Care History

- 1980's -2000
  - Hospital based palliative care
  - Mainstream palliative medicine
- 2000's
  - Clinical Practice Guidelines
  - Studies & Research
  - Medical subspecialty

Palliative Care: An Historical Perspective Matthew J. Loscalzo(2017) doi:10.1182/asheducation-2008.1.465

Standards and Certification

- Certification in hospice and palliative care nursing
- Clinical Practice Guidelines
- Components of quality (10)
- Recognition as a sub-specialty
- Joint Commission and Community Health Accreditation Partner

CAPC Palliative Care in the Home p6-7

Hospice and Palliative Care

Palliative Care	Hospice
Serious or medically complex illness	Terminal illness
Eligibility determined by need not prognosis	Life expectancy of six months or less

Hospice and Palliative Care

Palliative Care	Hospice
Patient may continue with curative/life prolonging treatment	Patient declines curative/life prolonging treatment
Interdisciplinary team	Interdisciplinary team
Symptom management, psychosocial and decision making support	Symptom management, psychosocial support and bereavement services

Hospice and Palliative Care

Palliative Care	Hospice
Frequency of services based on patient need	Frequency of services based on patient need
Reimbursed through Fee-For-Services under Medicare, Medicaid or commercial insurance	Reimbursed through hospice benefit provided by Medicare, Medicaid or commercial insurance

Basic Models of Palliative Care

- Consultation service
- Inpatient models
- Outpatient and community models

Consultation Service Model

- Physician with nurse availability
- Nurse Practitioner with medical oversight
- RN Clinician with medical oversight

Who is consulted?

Types of consultation

- Recommendations only
- Mixed model
- Full care model

Inpatient Model

Dedicated inpatient beds	• 24/7 staffing for direct care • Targeted staff education and competencies • On call support availability
Scattered or swing beds	• Flexibility/utilization and availability • Less focused expertise
Key variables	• Acuity and intensity • Impact and control • Cost, revenue and LOS • Standards and Quality

Outpatient and Community Models

Clinics	• Reduce readmissions • Crisis prevention • Targets follow up needs • Targets primary symptom management, i.e. Pain
Home	• Home environment assessment • Targets early continuum patients • Targets advanced illness management • Symptom management
Key variables	• Co-management • Difficulty getting to appointments • Support home care

Settings

Hospital Based

- Inpatient
- Outpatient Clinics

Home Based

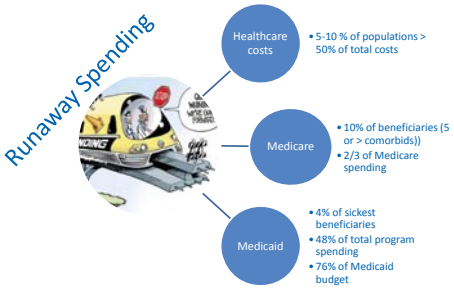
- Home
- Nursing Facility
- Assisted Living
- Independent Living
- Group Home

Why Palliative Care?

- Aging population
- Improved technologies and research
- Increased demand to improve quality of life
- Cost factor

Clinical Practice Guidelines for Quality Pal Care 2013

Cost



https://reportcard.capc.org/frequently-asked-questions/

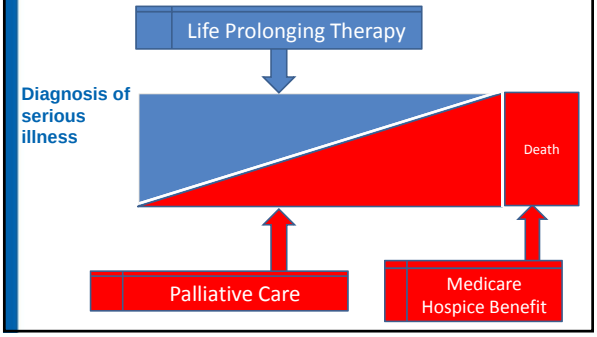
The Evidence

- Hospital consults
  - $1600 saving per admit for live discharges
  - $4000 saving per admit for death
  - 1.1 reduction in LOS (oncology)
  - 48% reduction in readmits with automatic palliative care consults
- Community based services
  - 36% lower costs = $12,000
  - 48%-56% reduction in hospital admissions

J Palliat Med, (2014)

Goals of Palliative Care

Palliative Care in the Course of Illness



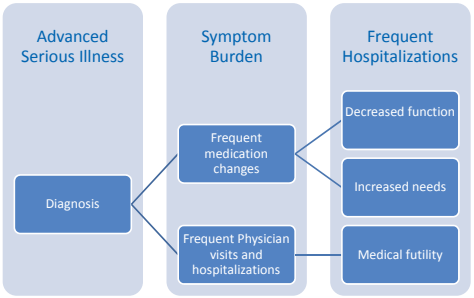
An Effective Solution

- Identify the right population
- Provide 24/7 services to avoid ED visit
- Ensure expert pain and symptom management
- Assist with decision making
- Support family caregivers

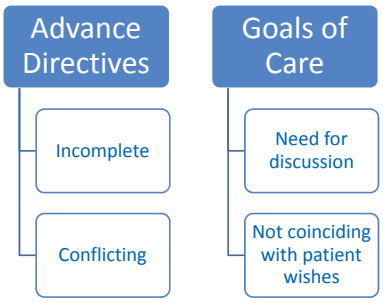
Patient Population

- Advanced serious illness
  - Functional limitations
  - Frailty
  - Caregiver burden
  - Frequent hospitalizations

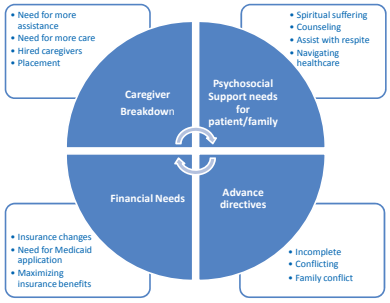
Physical Indicators

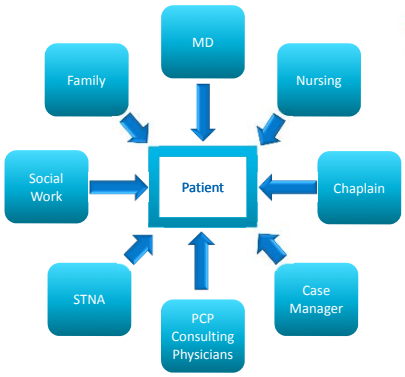


Care Planning Indicators



Community Indicators





Case Managers Role

- Identification of patient population
  - Frequent hospital admissions
  - Caregiver breakdown
  - Frequent calls for community or medical needs
- Ensure an appropriate level of care for patients
  - Palliative care
  - Hospice care
  - Home care
- Identify resources to support in discharge or care plan

Reimbursement

- Medicare
  - 80% of allowable cost
  - No Medicare "benefit"
  - Part B
- Medicaid
- Commercial Insurance
  - May have a copay
  - May have co-insurance requirements
- MIPS

Case Study

HEART FAILURE

Heart Failure (CDC stats)

- About **5.7 million** adults in the United States have heart failure
- One in 9 deaths in 2009 included heart failure as contributing cause
- **About half** of people who develop heart failure **die within 5 years** of diagnosis
- Heart failure costs the nation an estimated **$30.7 billion** each year

Heart Failure (CDC, 2016)

- Common signs and symptoms
  - Shortness of breath during daily activities
  - Having trouble breathing when lying down
  - Weight gain with swelling in the feet, legs, ankles, or stomach
  - Generally feeling tired or weak

The Patient

- 85 year old white male
- Diagnosed with CHF in 2004
- Increased dyspnea over last 6 months
- 3 hospital admissions over the last 1 year
- Was evaluated for hospice but feels that he is not "ready" for hospice at this time

Social History

- 4 daughters
- Had lived independently prior to most recent 2 hospitalizations
- Catholic
- Veteran

Family History

- Mother deceased from heart disease at age 55
- Father deceased from prostate cancer at age 75
- Three brothers living with heart disease
- Two brothers deceased from HF and dementia

Palliative Care Visit #1 APRN

- Detailed history
- Medication entry and review
- Physical exam
- Differential diagnoses based on assessment and history
- Verification of DPOAHC
- Goals of care discussion

Palliative Care Visit SW

- Additional support services in the home
- Transportation options to family/patient in their community
- Facilitate ongoing goals of care discussions with patient and family
- Facilitated determination of DPOA-HC

Palliative Care Visit Volunteer

- Prevention of isolation
  - Starts with monthly social visits
  - Becomes bi-monthly
- Monthly CP calls
- Collaboration with team
- Veteran pinning

Palliative Care Visit #2 APRN

- Medication management
- Collaboration of Care
- Nonpharmacological interventions
- DNRCC-A signed in home

Palliative Care Visit #3 APRN

- Symptom management
- Goals of care
- Education regarding disease process

Palliative Care Consult Visit #4 APRN

- Activity limitation and continued fatigue
- Heart Failure symptoms at rest
- Resting tachycardia/tachypnea
- Weight loss 12%
- Increased use of oxygen to continuous

Transition

- Discussed with patient and family regarding decline
- Review goals of care
- Presented options
- Transition to hospice

Hospice Eligibility

- Hospice philosophy
- Terminal illness with 6 month or less prognosis
- Comorbidities
- Functional limitations
- Disease specific qualifications

COPD Eligibility

- Impaired structures of pulmonary systems
- Communication limitations
- Mobility limitations
- Dyspnea at rest
- Continuous oxygen
- Resting tachycardia/tachypnea

Dementia Eligibility

- Fast of 7 or >
- ADEPT >16
- Dysphagia
- Date of onset of symptoms/diagnosis
- Albumin < 2.5 g/dL

Hospice Levels of Care

- Routine
- GIP
- Continuous Care
- Respite

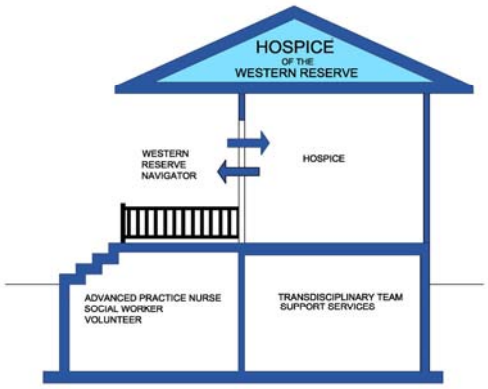
Benefits of Palliative Care: The Evidence Base

- Earlier transition to hospice
- Improved satisfaction
- Decreased hospitalizations/ER use
- Increased hospice LOS
  - *NSC lung cancer study

*NEJMedicine, 2010

Hospice of the Western Reserve

WESTERN RESERVE NAVIGATOR PALLIATIVE CARE



Western Reserve Navigator

- Support organizations mission
- Structured under palliative care program
- Separate cost center
- Reports to Chief Clinical Officer

Western Reserve Navigator

- Community based
- Links patients to community resources
- Relieves symptom burden
- Provides education
- Assists in serious illness conversations

Eligibility

- Advanced illness
- MD order
- Collaborating community physician
- Medical or psychosocial needs

Design

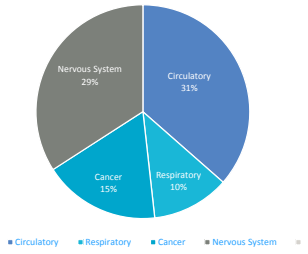
- Utilization of Advance Practice Nurse
  - Comprehensive assessments
  - Hospital consults
  - Post hospitalization visits
- Utilization of Social Worker
  - Comprehensive assessments
  - Post hospitalization visits
- Utilization of Volunteers
  - Supports monthly touch points
  - Respite, companionship, spiritual, legacy work

Current Condition 2017

- ADC 624
- ALOS 347
- MLOS 166
- Medicare % 91%
- Alt Home % 29%

Current Condition 2017

- Disease Percent



Outcomes

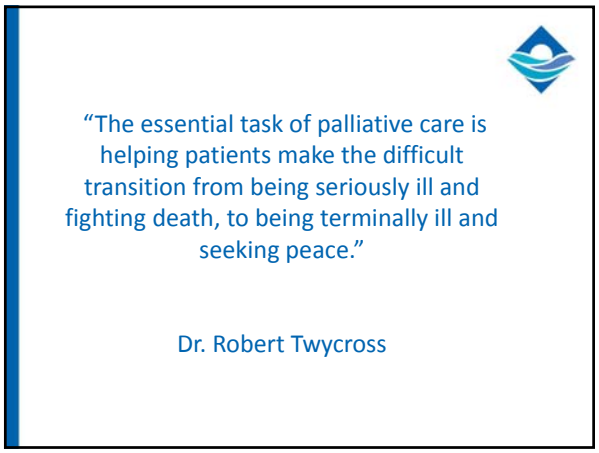
- Volunteer support 40%
- Likelihood to recommend 95%
- 90% or > with advance directives
- Conversion to hospice 84%
- Increased hospice median length of stay

Future

- Expand services in the community
- Develop appropriate quality metrics
- Strengthen palliative care workforce
- Ohio house bill 286

Conclusion

- Improve quality of life
- Improve satisfaction
- Ease burden on health-system, patients and caregivers
- Supports patients alongside treatment
- Transition to hospice: right time



"The essential task of palliative care is helping patients make the difficult transition from being seriously ill and fighting death, to being terminally ill and seeking peace."

Dr. Robert Twycross