Palliative Care Access in the Community: Home Care & Assisted Living Facilities

Objectives

- Identify the need for expanding access to Palliative Care in the community
- Describe Models of Community Based Palliative Care
- Identify ways to build relationships in the community to improve palliative care access for patients
  - Home
  - ALFs
Patients access an enhanced patient-centric model of care
Decreasing acute and curative practices, and increasing palliative measures as their disease progresses and needs and goals shift
Patients need not forgo curative care in exchange for palliative care

Emphasis is on palliation of symptoms
Shift focus of care from episodic hospital care to a proactive approach helping patients remain at home
Establish advance directives
Avoid unwanted hospitalizations and interventions
Community Based Palliative Care

- Why do we need to increase access and awareness?
  - This is where patients want to be
  - This is where families want their loved ones to be
  - More proactive approach to symptom management
  - Decrease healthcare utilization = cost savings
  - Improved quality care model
  - Focus is on QOL and on patient’s goals

Palliative Care is Collaborative

- Communication, communication, communication
- Listen, listen, listen
- Must understand how palliative care can benefit:
  - Patients
  - Families and care givers
  - Clinical practice
  - Healthcare systems, ACOs
  - ALFs
  - LTC facilities
  Not about us, it is about them!
To the Patient:
- Patients stay at home
- Can be delivered concurrently with life-prolonging care
- Identifies goals of care

To the Patient:
- Facilitates symptom management
- Provides integrated psychosocial support

To the Patient:
- Facilitates Advance Directive completion.
- Assists with an understanding of disease trajectory

Medical Team benefits:
- Facilitates communication with patients and families
- Coordination of care across settings

Medical team benefits:
- Facilitates discussions regarding advance directive completion
- HCP (Health Care Proxy), DNR, MOLST

Medical team benefits:
- Symptom management allows for more time to discuss treatment options and diagnostic results
Palliative Care Benefits

Hospital benefits:
- Effective treatment of complex advanced illness
- Meet Joint Commission and NYS Palliative Care Laws

Hospital benefits:
- Rationalize use of hospital resources
- Cost avoidance (LOS, medications, ancillary tests)

Hospital benefits:
- Coordination of care across settings
- Assist with transition/discharge management
Barriers to Palliative Care

- Palliative care is NOT well understood
- Too often assumed equates to hospice care
- POC & Ownership issues
- Patient and family understanding
- Financial concerns
  - Private practice
  - CHHA
  - Medical sub-specialists
  - ALF

Awareness About Palliative Care

- Not Knowledgeable at All 70%
- Somewhat Knowledgeable 14%
- Knowledgeable 3%
- Very Knowledgeable 5%
- Don't Know 8%

2011 Public Opinion Research on Palliative Care
Research Commissioned by the Center to Advance Palliative Care
Challenges to Community Palliative Care

Challenges:
- Identify appropriate patients
- Educating and training clinicians
- Quality metrics
- Standards of practice
- Reimbursement
- Healthcare policy reform
- Increase awareness and change perceptions

Expanding Palliative Care into the Community

- Education
- Collaboration
- Advocacy
Education

- Transitional care models
- Link community palliative care to PCPs
  - Educate medical community
    - Upstream identification
    - Honor patients choices
    - How to have “the conversations”
- Educate community at large
  - Community awareness campaigns
  - Alleviate misperceptions
  - Advance directive completion
- Engage Payers

Collaboration & Advocacy

Collaboration with:
- Medical team
- Health systems
- ACOs

Advocacy:
- Public Awareness Campaigns
- Policies to mandate access
- Reinforce standards of practice
Core Components of Community Palliative Care Models

- Interdisciplinary team approach
- Access
  - Patients
  - Caregivers
  - Medical team
- Focus on Symptom Management and QOL
  - Meaningful Clinical Access & Response to patients and caregivers needs.

Core Components of Community Palliative Care Models

- Communication
  - Patient & caregiver
  - Among medical team
  - Documentation
- Identify appropriate patients & triggers
- Develop trusting relationships with referral sources
- Develop measures of success and quality outcomes.
Models of Community Based Palliative Care

- Ownership
- Consultative
- Telephonic

Ownership Model

- The Palliative team assumes ongoing primary care and palliative care responsibilities for the patient.
- The core team is responsible for coordinating and managing all care needs.
- May occur with transition of a patient from the consultative model.
Consultative Model

- Palliative IDT consult with PCP, attending physician, or health care team
- Treatment is recommended in collaboration

Telephonic Model

- Uses predictive modeling to identify patients appropriate for palliative care intervention
- Interactions with patients take place via telephone
Collaborating with ALFs

- Viewed as “home”, not LTC
- Understand Their language
- Understand Their concerns
- Understand Their regulations
  - Enhanced beds
- Understand their business model
  - Show how palliative care can benefit both the patient and their model
    - Hospital avoidance
    - Symptom management
    - Goals of care
    - Advance directive completion

ALFs: Evolving Partners

- Recognize ALF is “Residence”
  - Provide some support to individuals who can not live in their own home due to limitations
- Residents are older and more frail
- Residents have more complex medical conditions
- Not every ALF is the same
  - All are adult care facilities
  - Enhanced ACR
  - Staffing models vary
  - Not a medical model of care
ALFs : Evolving Partners

- Understand and respect ALF regulations:
  - Residents who are receiving palliative care must still go to the hospital if their condition indicates such a need.

- Residents with increased needs can remain if:
  - Medical Care team (MD) identifies additional support that is needed and how it will be met
    - Example: hospice care
  - Resident needs to hire additional services
  - Facility agrees (they can decide)

ALFs : Evolving Partners

New Relationship efforts:

- Met with Dept. of Health to understand regulations
- Listened to concerns
- Changed how ALFs were viewed:
  - not a facility, but as patient’s home
- Shared Policies: created trust and transparency
- Held a summit for education and collaboration: CHPC, ALFs, Department of Health
SMP: Supportive Medical Partners
- Formed a PLLC for delivery of palliative care
- Ability to provide palliative care collaboratively with treating clinicians across a multitude of settings
- Offered the opportunity for consultative model of palliative care focused on collaborative relationship with community clinicians
- Palliative Care Case Management Model

Home Connections Palliative Care Program
- Developed with local HMO/Medicare advantage insurance companies
- Initially was administered via a Licensed Home Health Care Agency of Hospice Buffalo (LHCSA), now under a PLLC Supportive Medical Partners
- Focused on delivering palliative care to chronically ill individuals, prognosis 12–18 months
Home Based Palliative Care Delivery

Home Connections
- Blend of best practices
  - IDT
  - Face to face personal care delivery
  - Communication and engagement of PCP / specialists is essential
  - Focus on symptom burden and QOL
  - 24/7 access to team
- Access to Palliative care specialists for care overlay / consultative collaboration

Home Connections Program
The Clinical Team
- The IDT Team
  - RN Case manager, social worker, volunteers, physician
- Emphasis on symptom control, care coordination, advance directives, community services, hospitalization and ER avoidance, MOLST completion
- Volunteers provide support, help with transportation, friendly visits and respite care
- 24/7 phone and visit support by RN
Two recently published articles:

**JOURNAL OF PALLIATIVE MEDICINE**
Volume 17, Number 12, 2014

*Cost Savings and Enhanced Hospice Enrollment with a Home-Based Palliative Care Program Implemented as a Hospice-Private Payer Partnership*

Christopher W. Kerr, MD, PhD,1 Kathleen A. Donohue, MA,2 John C. Tangeman, MD, FACP,1 Amin M. Serehali, MA,2 Sarah M. Knodel, MS, MPH,2 Pei C. Grant, PhD,1 Debra L. Luczkiewicz, MD,1 Kathleen Mylotte, MD,2 Melanie J. Marien, MS, PA-C1

**Journal of Pain and Symptom Management**

*Clinical Impact of a Home-Based Palliative Care Program: A Hospice–Private Payer Partnership*

Christopher W. Kerr, MD, PhD, John C. Tangeman, MD, FACP, Carole B. Rudra, PhD, MPH, Pei C. Grant, PhD, Debra L. Luczkiewicz, MD, Kathleen M. Mylotte, MD, William D. Riemer, Melanie J. Marien, MS, PA-C, and Amin M. Serehali, MA

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Clinical and Economic Impact of the Home Connections Program

Two recently published articles:

- 93–96% satisfaction among patients, caregivers and providers
- 88% Completion of actionable advance directives
- Early Hospice referral with LOS 77.9 days compared to 56.5 days controls
Home Connections Outcomes

- Increased patient satisfaction
- Reduced hospitalizations, ER visits
  - Up to 50%
- Timely Hospice referral
  - 70% vs 25% controls
  - Major source of cost avoidance for HMO
- Reduced costs at end of life
  - 30–50%, accelerates at EOL
- Increased Advance Directive completion
  (up to 90%)

Cost Savings of Home Connections

Overall Total Allowed $PMPM Costs Over Time

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Home Connections
HC + Program Costs
Control Group
Need to build strong trusting relationships on multiple levels with the insurance companies: medical directors, actuaries, legal, contracting, program development, case managers, and clinical staff

Collaborative efforts to educate and market program

Evidence based medicine will drive the “buy in”
Creating New Opportunities

- Continue to develop new ways to identify patients
- Defined as “value based medicine” = enhanced care delivery and decreased utilization
- Continue to publish results of improved quality

It’s not just about being ALIVE;

It’s about LIVING”

Questions:
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