Innovation AND Excellence

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Integration of Palliative Care and Hospice Programs for Optimal Patient Care Across the Continuum

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National Hospice and Palliative Care Organization

Objectives

- Describe the differences between palliative care and hospice care.
- Describe an example of an integrated hospital and community based palliative care program.
- Identify barriers in developing an integrated palliative care program.
- Introduce Decision Aid for Palliative Referral (DAPR) screening tool utilizing case study examples.
- Describe strategic opportunities for integrative palliative care programs.

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Palliative Care Model Overview

- **Palliative Care Model overview:**
  - Palliative Care is specialized medical care for people with serious illnesses, advanced or chronic disease process.
  - Interdisciplinary approach to care focusing on providing patients with relief from the symptoms, pain and stress of a serious illness and improve quality of life, whatever the diagnosis.
  - Addresses symptom management, psychosocial, spiritual, emotional, ethical, advance directives.
  - Offered *simultaneously* with other appropriate medical treatments in accordance with the patient's goals of care.

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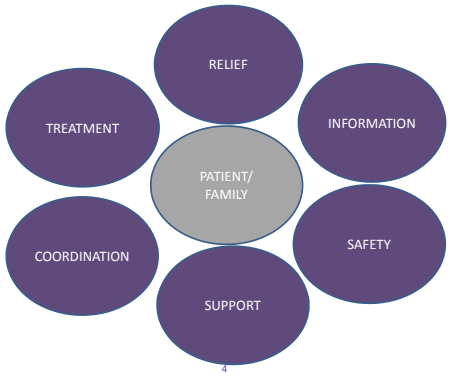
Palliative Care Model Overview



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Palliative Care Settings

- Hospital
- SNF/ Other Facility
- Physician Practice/Outpatient Clinic
- Community Based Home Care or Hospice

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Models of Palliative Care Delivery

- Consultation service team
- Dedicated inpatient unit
- Combined consultative service team and inpatient unit (hospital and nursing home)
- Combined hospice program and palliative care program
- Hospital or private practice based outpatient clinic
- Hospice based palliative care at home
- Hospice based consultation in outpatient setting

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Hospice & Palliative Care Framework

- National Quality Forum-Framework for Hospice and Palliative Care (National Consensus Project)
- Eight Domains:
  - Structure & Process of Care
  - Physical Aspects of Care
  - Psychological & Psychiatric Aspects of care
  - Social Aspects of Care
  - Cultural Aspects of Care
  - Care of the Imminently Dying Patient
  - Ethical and Legal Aspects of Care

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Hospice & Palliative Care Framework

- National Quality Forum's Framework for Hospice and Palliative Care (National Consensus Project)
- NQF Guidelines for Palliative Care
  - Endorsed by NQF Board of Directors
  - Published January 2007
- Preferred Practices:
  - Chapter 2 in *Framework*
  - 38 Preferred practices
  - Evidence-based
  - Apply to both hospice and palliative care

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Palliative Care and Hospice

- **Goals of Palliative Care:**
  - To improve quality of life for both the patient and family. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided in conjunction with curative treatment.
  - Palliative Care Goals:
    - Expert symptom management
    - Coordination of care and transitions across the fragmented medical system
    - Provision of practical support for patients, families and clinicians

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Palliative Care and Hospice

- **Goals of Hospice Care:**
  - Provides an added layer of support to enable the patient to remain at home and continue an alert, pain-free life for as long as possible and to manage other symptoms so that the patient's last days can be spent with quality and dignity, surrounded by family and friends.

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Palliative Care and Hospice

- **Differences Between Palliative Care and Hospice:**
  - **Hospice:**
    - Hospice is a type of Palliative Care provided to patients at end of life.
    - Terminal Illness/End of Life care (six month prognosis).
    - Admission criteria/Hospice Benefit requirements.
    - Hospice Interdisciplinary Group approach to manage care.
  - **Palliative Care:**
    - Begins at the point where life prolonging treatment and chronic comfort care interface.
    - Appropriate for any stage in a serious illness (no six month prognosis requirement).
    - Can be provided together with curative treatment.
    - Team provides an added layer of support to supplement other medical treatment, including hospice care.

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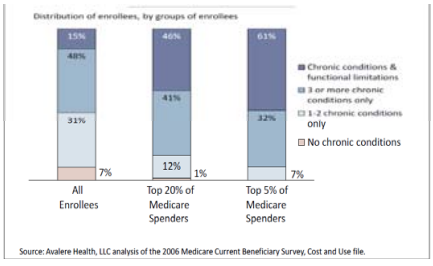
Significant Population of Medicare Enrollees with Chronic and Functional Limitations

- Distribution of Medicare Enrollees with Chronic/Functional Limitations



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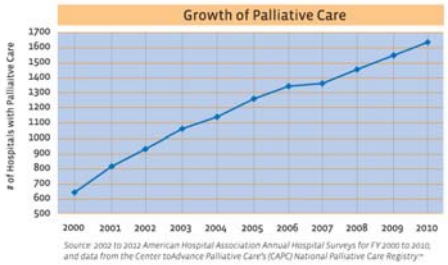
Growth of Palliative Care in U.S. Hospitals



Source: 2002 to 2012 American Hospital Association Annual Hospital Surveys for FY 2000 to 2010, and data from the Center toAdvance Palliative Care's (CAPC) National Palliative Care Registry™

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Growth in Number of Hospice Providers

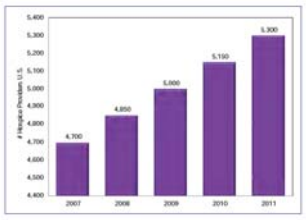

Figure 7. Total Hospice Providers by Year [1]

2012 NHPCO

NHPCO Facts and Figures on Hospice Care

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Hospice Length of Stay

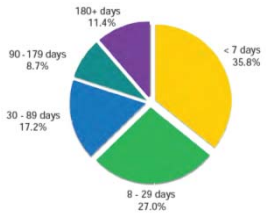

Figure 6. Proportion of Patients by Length of Service in 2011 [1]

2012 NHPCO

NHPCO Facts and Figures on Hospice Care

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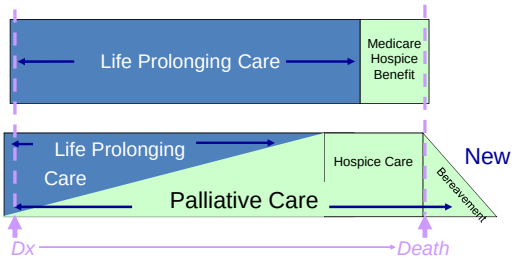
Hospice and Palliative Care Service Design Implications



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Middlesex Hospital Homecare - Introduction

- **Background:**
  - Our Homecare agency is a department of the hospital
- **12 bed inpatient unit for hospice and palliative care patients**
  - Closed unit only trained hospice/palliative care staff
  - Patient must have DNR

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Palliative Care at Middlesex Hospital Homecare

- Homecare team consists of 2 dedicated nurse case managers and one part time LCSW
- Inpatient team consists of part time APRN, LCSW, Chaplain and Medical Director
- Average Census for homecare is 30 patients
- Average inpatient palliative consults 46/month

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Palliative Care in the Hospital Setting

- Physician referral
- Initial screening to gather information and goals of referral
- Palliative APRN completes consult
- Documentation of patient goals of care, recommendations for symptom management

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Management of Palliative Care in the Hospital Setting

- Follow up provided daily by member of Palliative Care team
- Interdisciplinary team meets twice a week for rounds
- Transition to inpatient unit for symptom management
- Transition to homecare if ongoing skilled need
- Transition to SNF for rehab

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Palliative Care in the Home

- Reimbursement and regulations as per Medicare and State of CT DPH Regulations
- Case managers and LCSW meet weekly with APRN for case conference
- Discharge if no longer skilled
- Transition to Hospice

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Palliative Care in the Skilled Nursing Facility (SNF)

- Report is provided to facility with patient goals and palliative plan of care
- Families are informed that member of Palliative Care team is available for consultation for discharge planning

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Integration of Hospice and Palliative Team

- One program for inpatient and homecare settings
- All team members are trained in Hospice and Palliative Care
- % are certified in Hospice and Palliative Care
- IDG rounds weekly for homecare and 2x/week for inpatient setting

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Opportunities

- Attendance at Med/Surg IDT - offer suggestions, education, transition of patients across the care continuum
- Attendance at SNF resident care meetings - if invited by family for goals of care planning

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Communication

- Homecare and Inpatient staff located on the same floor
- Report to outside agencies when patient is discharged from inpatient settings
- Report to hospital staff if patient transitions back to hospital
- Transition to hospice care earlier

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Barriers and Lessons Learned

- Lack of understanding and knowledge
- “Bridge” program to hospice was not helpful-added confusion (QOL team)
- Education needed across the care continuum
- Data can be inaccurate due to Palliative and Med/Surg having same payors

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Overview of the Decision Aid for Palliative Referral (DAPR)

- MANY questions about what palliative care is and who is appropriate
- Need to identify patients who may benefit from palliative care services
- DAPR is a tool to assist direct care nurses and MSW in talking with the attending clinician about obtaining palliative care referrals
- Available to all clinical staff

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DAPR Design Process

- **No validated palliative referral screening tools**
- **Designing the DAPR:**
  - National Quality Forum guidelines
  - The Joint Commission
  - Center to Advance Palliative Care (CAPC)

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DAPR - Primary Criteria

- **Disease process:**
  - Serious illness - usually progressive, often life-limiting, advanced process in major organ systems and metastatic cancer, includes option for "other" must specify
  - Screening process stops if patient does not meet primary criteria

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DAPR Secondary Criteria

Distress indicators; many apply to family also align with NQF Framework Domains and Preferred Practices:

- Physical
- Emotional
- Social/Financial
- Existential/Spiritual
- Ethical

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Overview of the DAPR

- Tool is scored with recommendations for referral or follow-up
- If referral is indicated, discussion is held with the attending physician who ultimately decides if a consult is placed
- Review Sample DAPR Tool (Handout)

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DAPR Psychometric Testing

- **Content Validity:**

- Experts in palliative care (multidisciplinary)
- response rate of 10/10;
- n=9 one form with incomplete responses

	primary	secondary
S-CVI/ave (>0.8)	0.98	0.92
I-CVI (>0.78)	0.89-1	0.67-1.0

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DAPR Psychometric Testing

- **Inter-Rater Agreement:**

  - 3 case studies with sim-lab video scenario
  - 37 participants; 34 RNs and 3 MDs
  - Randomly assigned to one of the three cases

		primary criteria	secondary criteria
case 1	(N=14)	98%	92%
case 2	(N=9)	100%	88%
case 3	(N=14)	98%	81%

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Case Study #1 (Review Using Sample DAPR)

- Sixty year old woman with a history of COPD, CAD, chronic back and neck pain, chest pain, HTN, DM type II, Depression, Anxiety, Dependent Personality Disorder, indication of probable old silent stroke (CVA), Dyslipidemia, Diverticulitis, Right Lower Extremity Cellulitis, Anemia; Hepatitis per patient report.
- Presented to the ED with dyspnea, fatigue, and chest discomfort, recently admitted for same, ruled-out for Acute MI. 3 other admissions in the past 6 months.
- Lives at home alone with Home Health (VNA) support.

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Case Study #2 (Review Using Sample DAPR)

- Eighty-year-old woman with a history of CAD, CHF, COPD, DM, Metastatic Lung Cancer (bilateral) which progressed through chemo and is currently not being treated because of absence of feasible therapeutic options.
- Presented to the ED with 2 day history of diarrhea, new onset left sided headache near the eye, and chronic but exacerbated dyspnea and fatigue.
- Lives at home with her husband.

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DAPR Future Directions

- Currently in the process of IRB approved in-vivo inter-rater agreement testing in the CCU and homecare
- Identify the threshold score for referral
- Outcome measures
- Education plan

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Strategic Opportunities for Palliative Care

- Physician involvement and engagement
- Accountable Care Organizations
- Hospital/Health System Integration
- Proposed reimbursement changes
- Chronic disease management
- Hospital mortality and readmission rates
- Potential cost avoidance opportunities
- Compliance with Joint Commission Palliative Care Standards

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Palliative Care Resources

- National Hospice & Palliative Care Organization: www.nhpco.org
- Center to Advance Palliative Care: www.capc.org
- National Quality Forum: www.qualityforum.org
- National Consensus Project: www.nationalconsensusproject.org
- The Joint Commission (Palliative Care Standards): www.jointcommission.org

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Questions?

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