Challenges and Opportunities in Community Based Palliative Care

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Disclosure of Relevant Financial Relationships

The following faculty of this continuing education activity has the following financial relationships with commercial interests to disclose:

Adam D. Marks, MD MPH and Christie Herrick, LMSW both work for Hospice of Michigan and Arbor Palliative Care, a community-based palliative care agency.

Learning Objectives

Review frameworks for community-based palliative care delivery systems

Describe the opportunities, challenges, and outcomes of Arbor Palliative Care, a community-based palliative care program in Southeast Michigan
How We Live in America

Living in America: Living Longer

Living in America: Living with Disease

Chang et al., 2014
Basic Mortality Statistics

<table>
<thead>
<tr>
<th>Mortality Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
</tr>
<tr>
<td>90%</td>
</tr>
<tr>
<td>80%</td>
</tr>
<tr>
<td>70%</td>
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<tr>
<td>60%</td>
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<td>50%</td>
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<tr>
<td>40%</td>
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<tr>
<td>30%</td>
</tr>
<tr>
<td>20%</td>
</tr>
<tr>
<td>10%</td>
</tr>
</tbody>
</table>

How We Die In America: A Comparison

Cdc.gov

HEALTH

An Ideal Life of Health

A Typical Life

A Chronic Early Terminal Life

Life Span

Death

Birth
Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness—whatever the diagnosis.

The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, social workers and other specialists who work with a patient’s other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.

Definition of Palliative Care

Traditional Medical Model
Continuum of Care

Benefits of Palliative Care

N=524 family survivors

Overall satisfaction markedly superior in palliative care group, p<.001

Palliative care improves:
- emotional/spiritual wellness
- information/communication
- care at time of death
- access to services in community
- well-being/dignity
- care + setting concordant with patient preference
- pain
- PTSD symptoms

Other studies demonstrating benefit of palliative care:

...But Also Improves Survival

151 patients with a new diagnosis of stage IV - metastatic lung cancer (Average life-expectancy of 9-12 months)

At the time of diagnosis patients were randomized:
- standard cancer care alone
- palliative care integrated into standard cancer care

Patients with integrated palliative care:
- Had less symptoms
- Reported higher quality of life
- Were more likely to have had a discussion about their preferences for end-of-life care
- Received less aggressive care
- Lived almost three months longer

Temel et al NEJM 363 (8) 2010
Hospital Palliative Care Reduces Costs

Cost and ICU Outcomes Associated with Palliative Care Consultation in 8 U.S. Hospitals

<table>
<thead>
<tr>
<th>Costs</th>
<th>Live Discharges</th>
<th>Hospital Deaths</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Usual Care</td>
<td>Palliative Care</td>
</tr>
<tr>
<td>Per Day</td>
<td>$867</td>
<td>$684</td>
</tr>
<tr>
<td>Per Admission</td>
<td>$11,498</td>
<td>$9,992</td>
</tr>
<tr>
<td>Laboratory</td>
<td>$1,160</td>
<td>$833</td>
</tr>
<tr>
<td>ICU</td>
<td>$6,974</td>
<td>$1,726</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>$2,223</td>
<td>$1,063</td>
</tr>
<tr>
<td>Imaging</td>
<td>$851</td>
<td>$1,060</td>
</tr>
</tbody>
</table>

Died in ICU X X X 18% 4% 14%*


How Palliative Care Reduces Length of Stay and Cost

Palliative care:
- assists with decisions to leave the hospital, or to withhold or withdraw death-prolonging treatments that don’t help to meet their goals by:
  - clarifying goals of care with patients and families
  - helping families to select medical treatments and care settings that meet their goals

It’s a Matter of Perspective

Patient
- Relieve symptom distress
- Navigate medical system
- Understand and participate in the plan of care
- Palliation of suffering along with curative treatment
- Practical and emotional support for caregivers

Clinician
- Saves time
- Bedside Management
- Promote patient and family satisfaction
- Palliation of suffering along with curative treatment
- Practical and emotional support for caregivers

Payer
- Improved treatment of terminal advanced illness
- Patient-centered care
- Increase patient and family satisfaction
- Improve staff satisfaction
- Improve patient satisfaction
- Meet JC quality standards
- Reduce the use of hospital resources, cost containment & avoidance
Access to Palliative Care

**Inpatient Palliative Care Programs:**
- Almost 90% of Hospitals (300+ beds) provide palliative care
- No requirement for palliative care standards
- Gap in continuum of care outside the hospital

**Outpatient Palliative Care Programs:**
- Clinic based palliative care services have struggled getting seriously ill patients from their home to the clinic setting
- **Community Based Palliative Care (CBPC)** services have attempted to bring PC services to the home

**Integrating CBPC**

**Goals**
- Reduce hospitalizations/ED visits
- Improve QOL
- Earlier goals of care/advance care planning conversations
- Earlier enrollment in hospice

**Models**
- RN/SW based (lower-cost, primarily telephonic support)
- NP/Physician based (higher cost, F2F visits + telephonic support)

**CAPC Recommendations for CBPC**

**Interdisciplinary Team-Based Care**
- MD/NP
- SW
- RN
- Spiritual Care

**24/7 Meaningful Clinical Response**
- Capacity to support and provide meaningful and responsive care 24/7

**Integrated with Concurrent Care**
- Services available concurrently with or independent of curative or life-prolonging care
Impact of CBPC

- Reduced average number of hospitalizations (1.36 per pt per 6 months vs 0.35 in CBPC group)
- Reduced total hospital days reduced between the groups by 5.13 days
- More likely to have completed advance directives (69% vs 98%)

Chen et al. JPM 2015 18(1): 38-44

Impact of CBPC

- Cost savings apparent in the last 3 months of life ($6804 PMPM in the CBPC group vs $10712 PMPM in the control group)
- Enhanced utilization of hospice (70% versus 25%)
- Longer length of stay on hospice (median 34 days versus 9 days)

Kerr et al. JPM 2014 17(12): 1328-35

Shifting Care from Hospital to Home

Service Use Among Patients Who Died from CHF, COPD, or Cancer Palliative Home Care versus Usual Care, 2005–2006

Impact of CBPC

Analysis results from 11 CBPC programs:

• Decreased hospitalizations (31% vs 39%)
• Decreased ER visits (28% vs 34%)
• Decreased risk of dying in the hospital (16% vs 28%)
• Overall improved reports of QOL in the months preceding enrollment in hospice

Seow et al BMJ 2016 June; 348: g3496

Arbor Palliative Care

In 2012: Developed Community-Based Palliative Program

• Serving patients with a life-limiting disease who have difficulty leaving the home
• Focus on advance care planning
• Designed as a consult-only model
• NPs performed all visits (with MD oversight)
• Recommendations to primary physician
  – Telephonic support during business hours
  – No SW, Spiritual Care or Volunteer support
Arbor Palliative Care: A History (cont)

In 2013: Offered active management
- Medical management of symptoms
- Prescribing medications including CII scripts
- 24/hr telephonic support utilizing on-call hospice platform

In 2013/2014: Developed skilled nursing facility “clinics”

In 2015: Added SW, Spiritual Care and Volunteers Services

In 2016: Affiliation with HOM
- Growth into other markets outside SE Michigan

Palliative Interdisciplinary Team

Core Palliative Care Services
as described in the NCP Clinical Practice Guidelines.

- Expert pain and symptom management
- Skilled communication and support for complex medical decision making
- Counseling for patients, families and all staff involved in care
- Advance care planning
- Psychosocial and caregiver support
- Spiritual care
- Care coordination and transition management
- Medication reconciliation and management
- Planning for end-of-life care, and appropriate and timely referral to hospice when indicated and acceptable to patient and family
- Volunteer Services
The Palliative Care Team Functions

- **Palliative Physician**
  - Oversight of interdisciplinary team
  - Care plan oversight
  - Active Management includes prescriptions for schedule II medications
  - Direct assessment and management of complex patient and family needs, when necessary

- **Nurse Practitioner**
  - Comprehensive assessment, treatment, and care management of patients
  - Works in collaboration with Palliative Medical Director and Attending Physician to manage complex illness
  - Oversight of RN Case Manager

- **RN Case Management**
  - Collaboration with NP and Palliative Physician
  - Liaise and advocate for patient and family for community support services
  - Assess needs of patient and family for illness program
  - Care Coordination
  - End of life/bereavement and financial planning
  - Community education
  - Telephonic support

- **Social Work/SCC/Volunteers**
  - Collaboration to assess psychosocial, spiritual and volunteer needs
  - Advocacy for community support to meet psychosocial, spiritual, and practical needs
  - Assist with transitions of care
  - Telephonic support

**Who Can Enroll?**

Anyone with a **serious, life-limiting illness** and a **difficulty leaving the home** who is deemed to have palliative care needs by the referring provider

- Complex symptoms
- Goals of care/advance care planning discussions
- Coordination of services in the home

**Palliative Care Trigger Tool**
Palliative Care Trigger Tool
A simple tool that allows or scoring of Palliative appropriate patients:
• 4 points for BASIC DISEASE
• 1 point for SETTING OF CARE AND/OR UTILIZATION OF RESOURCES
• 1 point for CO-MORBIDITIES
• 0-3 points for FUNCTIONAL STATUS
• 0 points for ADDITIONAL INFORMATION

➢ Total Score ______
<5 Review Medical Records/Discussion with Medical Director
≥6 Palliative Care Consult/Assessment appropriate

Palliative Care Continuum

Telephonic Support

Combined Model
• NP/Physician
• Telephonic

NP/Physician Model
• Consultative
• Active Management

Palliative Care Model Highlights - Current

NP/Physician Model
• NP providing 90% of visits to patients and families
• Visit/Contact monthly

SW Services
• Focus on practical support
• Primarily telephonic

RN Case Manager
• One (1) face to face visit for assessment/sign on
• Primarily telephonic
• Phone contact monthly

Shared Services with Hospice:
• Spiritual Support
• Volunteer Services
• Bereavement Services

Care Collaboration
• Team Meeting every 2 weeks with inter-disciplinary participation
Arbor Palliative Care: Outcomes, Challenges and Opportunities

Core Objectives of Palliative Care

Coordinate and implement interventions for physical, psychosocial and spiritual sources of distress or burden for the patient and family
- Multi-dimensional assessment + Individual Care = plan to reduce distress or burden
- Engage in informed shared decision making about health care and related goals
- With consistent focus on individual preferences, culture and religion and spirituality
- With repeated goal setting and advance care planning

Coordinate care across providers and venues, and optimize access to specialized services including hospice

Acuity Scale
Consultative and Active Management

Diseases of Circulatory System
- Hypertensive diseases
- Ischemic heart diseases
- Pulmonary heart disease
- Other forms of heart disease
- Cerebrovascular diseases
- Cardiomyopathy
- STEMI

Diseases of Nervous System
- Huntington's disease
- Parkinson's disease
- Alzheimer's disease
- Multiple sclerosis
- Transient cerebral ischemic attacks
- Cerebral palsy
- Paraplegia and quadriplegia

Neoplasm
- Malignant neoplasms of:
  - Lip, oral cavity and pharynx
  - Digestive organs
  - Respiratory and intrathoracic organs
  - Bone and articular cartilage
  - Melanoma
  - Breast

Staffing Model

Panel: the total number of patients a clinician can effectively manage to deliver high quality care. An equation to determine a panel is days worked per year x number of visits per day = panel size (this implies a long term patient relationship in which visit frequency may vary). The panel includes patients of varying need intensity requiring different levels of attention.

Active Caseload: the number of higher need individual patients a clinician carries and can actively attend to over a defined period. Average caseload may vary by discipline:
- APNP – 60 to 80 patients; 3 to 5 visits/day
- RN – 50 to 70 patients; 5 to 7 visits/day
- SW – 100 to 150 patients; 4 to 6 visits/day
Considerations for Staff Caseload

Level of service — telephonic or face to face
Frequency of visits
Patient acuity
Geographic spread
Visits per day
- Initial Visit 90-120 minutes
- Follow up visit 60-90 minutes
Caseload assignment
Contacts per time period

Stakeholder Metrics

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Examples of Metrics to Measure Impact</th>
</tr>
</thead>
</table>
| Patient     | Improvement in:
|             | Pain, other symptoms, functional status
|             | Social, emotional, and spiritual needs
|             | Quality of advance care planning
discussions and documented goals of care
|             | Concordance between patient preference and
|             | types/locations of services received
|             | Satisfaction with and confidence in care
| Caregiver   | Level of:
|             | Confidence in care provided to patient
|             | Satisfaction with health care
|             | Level of depression, anxiety, and stress
|             | Out of pocket spending
| Referring Providers | Level of satisfaction with Palliative Care service

Institutions, Systems and Patients

- Changes in:
  - Use of the ED, hospital, ICU, office visits and hospital
  - Total cost of care per patient
  - Quality and performance metrics such as 30-day
    readmissions, hospital mortality
  - Patient and family satisfaction

Palliative Dashboard
NCP Guidelines for CBPC Measurement Guidelines

General Structure and Process of Care
Physical Aspects of Care
Psychological Aspects of Care
Social Aspects of Care
Spiritual, Religious and Existential Aspects of Care
Cultural Aspects of Care
Care for the Patient
Ethical and Legal Aspects of Care

Of these eight domain measures programs should choose one structure or process measure for each domain, of which at least two are process measures.

Four to six metrics addressing clinical or patient/Family reported outcomes AND cost/utilization outcomes

Funding Sources and Payment Models

Community-based palliative care programs are generally supported by a combination of funding sources that includes:

Revenue received for services provided (either fee-for-service, a shared savings or capitated payment model and/or via quality incentives)

Financial contributions from the sponsoring organization
Endowments, grants or fundraising activities

Palliative Care Payment Models

<table>
<thead>
<tr>
<th>Payment Model</th>
<th>Influence on Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primarily FFS and FFS, Linked to Quality and Value</td>
<td>Billing revenue is a function of visit volume for services provided by clinicians who can bill for services. Programs supported through FFS must maximize productivity from physicians and advanced practice providers (APNs).</td>
</tr>
<tr>
<td>Capitated/Population Based Payment</td>
<td>Programs receive a fixed payment to deliver services over a defined period of time for each enrolled patient. Programs can be flexible in staffing model and services provided within the fixed payment</td>
</tr>
<tr>
<td>Mixed Payment Model</td>
<td>Programs with multiple payment models can flexibly implement staffing models designed to meet each payer’s requirements. Frequent contact by nurses, social workers and care coordinators augments medical care provided by APNs and physicians.</td>
</tr>
</tbody>
</table>
## Challenges and Opportunities

### CHALLENGES
- Staffing
- Market Needs
- Geographic spread
- Mission creep
- Data mining
  - Pulling data from EMR
- Measuring what matters

### OPPORTUNITIES
- Choices RN role expansion
- Integration with Hospice
- Can be scaled to specific service area
- Allows for individualization of markets
- Keeping patients within our HOM/Arbor "family"
- Timely Hospice transitions

## Key components of a financially sustainable community-based palliative care program

Program design towards achievement of outcomes aligned with stakeholder priorities needs to assure continued funding and support for the practice. If reimbursement comes exclusively from FFS billing, the program will need additional funding (philanthropy, grants, parent institution support) to cover costs.

Close monitoring of program operations that influence financial viability:
- Cancellation and no-show rate
- Notification of patient admission to and discharge from hospital
- Frequency and duration of visits
- Scheduling efficiency for the team and cost of travel

## Conclusions

Palliative Care is a subspecialty of medicine that can improve quality of care, patient satisfaction, and reduce cost.

CBPC is a novel means by which high-quality palliative care can be delivered to patients with advanced illness, and reduces cost while improving the quality of care delivered.

CBPC programs need to continue to innovate both in care delivery models and in payment structures to ensure continued financial viability.
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