Palliative Care in the Community Setting

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Objectives

1. Discuss the framework for building a palliative care program in the community setting
2. Identify the setting for providing community based palliative care.
3. Identify the scope and practice of the community based palliative care team members.
4. Review the acuity and frequency of community based palliative care visits
5. Define the criteria for eligibility for palliative care-how and when to refer
Specialized medical care for patients with serious illnesses. It focuses on providing relief from the symptoms, pain and stress of a serious illness—whatever the diagnosis. The goal is to improve the quality of life for both the patient and the family.

PC is provided by a team of doctors, nurses and other specialists who work together with the patient’s other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be used in conjunction with curative treatment.
Palliative Care Constitutes a Change in Focus from Usual Care

<table>
<thead>
<tr>
<th></th>
<th>Usual Care</th>
<th>Palliative Care</th>
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</thead>
<tbody>
<tr>
<td><strong>Goals of Care</strong></td>
<td>Delayed until end of life or near</td>
<td>Established early in disease trajectory</td>
</tr>
<tr>
<td><strong>Treatment Strategy</strong></td>
<td>Includes primarily curative treatments</td>
<td>Includes a combination of curative and symptom-focused treatments</td>
</tr>
<tr>
<td><strong>Service Utilization</strong></td>
<td>Pursues curative treatments even when low-yield, high-cost and burdensome for patient</td>
<td>Pursues treatments that align with patient goals.</td>
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</table>
Term hospice, from same linguistic root as “hospitality”, can be traced back to medieval times when it referred to a place of shelter and rest for weary or ill travelers on a long journey.

Defined as: Team oriented approach to medical care, symptom management, and emotional and spiritual support tailored to the needs of a patient with a terminal illness or injury.

Eligibility for Medicare Benefit: Patient is eligible for hospice care if two MD’s (One should be a Hospice MD) determine the patient has a prognosis of six months or less or less.
Further Definition of Palliative & Hospice Care

Both Palliative Care and Hospice Care provide symptom management, enhance quality of life and respect patient’s desires and preferences. Hospice care is specifically devoted to **End of Life care**.

So, **ALL** Hospice Care is also Palliative Care, but **NOT ALL** Palliative Care is also Hospice Care.
Outpatient Palliative Care - Why?

- Aging Population - 10,000 individuals turn 65 each day
- Increasing incidence of serious, chronic illness
- High cost of inpatient care, need for collaboration with ACO, other “managed care” payors
- Continuation of care for patients identified in the inpatient setting
- My own personal experience
“We must start to think of the patient and the patient’s family as the sun, and the health care delivery system as one of the many planets that orbits around the sun. Home-based palliative care is the future of quality medical care for the sickest and most complex patients and their families.”

Diane Meier, M.D.
Director, CAPC
Benefits of INPATIENT Palliative Care

- Shorter ICU length of stay
- Shorter Hospital length of stay among survivors
- Lower costs per day

**Higher Patient/Family satisfaction scores**
Benefits of OUTPATIENT Palliative Care

- Decrease in ED visits
- Decrease in hospitalizations/readmissions
- Decrease in deaths in facilities
- Decrease in total cost of care
- Increase in hospice utilization
Franciscan Approach

- Perform a Needs Assessment: A CAPC questionnaire examines organizational characteristics, stakeholder input and potential funding sources.
- Recognition of the Need
- Inpatient Palliative “Frequent Flyers”
- Requests from Specialists (cardiologists, pulmonologists)
- Benefits to ACO
Franciscan Approach

Exploring the Models
• Free Standing Clinic
• Imbedded Clinic (Specialty, PCP)
• Care in the Residence

Getting Started
• Start small to ensure success
• ACO-affiliated Facilities
• Follow patients home when feasible
Outpatient Palliative Opportunities

• Increase Access to Patients at Home
• Provide Education to Staff in PCP Offices
• Consider Presence in Heart Failure Clinic
• Demonstration of Value to Organization
Outpatient Palliative Obstacles

- Geographic Constraints
- Insufficient Fee for Service Reimbursement
- “Ownership” of Patients
- Variation in Communication Preferences
PREP-CPC
The Integrated Model

Curative Treatment
Palliative Treatment
Hospice

Diagnosis
Incurable/Untreatable
Death
Bereavement
Setting for Outpatient Palliative Care

- Home, Assisted Living
- Nursing Home (LTC)
- Rehab (SNF)
- Doctor’s Office or Clinic
Nurse Practitioners
- Symptom Management
- Education regarding disease management and prognosis
- Advance Care Planning

Physicians
- Assist with 24/7 on-call coverage
- Collaboration regarding complex cases
- CTI for hospice referrals
Registered Nurses

- Triages & Phone Support
- Process new referrals
- Assists with home-visits as needed
- Care Coordination - connects patients to community resources (CICOA, transportation, Veteran’s benefits, etc.)

Faith Community Nurses, Chaplains, Social Workers
<table>
<thead>
<tr>
<th>Physical</th>
<th>Psychological</th>
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<tbody>
<tr>
<td>Functional Ability</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Strength/Fatigue</td>
<td>Depression</td>
</tr>
<tr>
<td>Sleep &amp; Rest</td>
<td>Enjoyment/Leisure</td>
</tr>
<tr>
<td>Nausea</td>
<td>Pain Distress</td>
</tr>
<tr>
<td>Appetite</td>
<td>Happiness</td>
</tr>
<tr>
<td>Constipation</td>
<td>Fear</td>
</tr>
<tr>
<td>Pain</td>
<td>Cognition/Attention</td>
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Quality of Life

<table>
<thead>
<tr>
<th>Social</th>
<th>Spiritual</th>
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<tbody>
<tr>
<td>Financial Burden</td>
<td>Hope</td>
</tr>
<tr>
<td>Caregiver Burden</td>
<td>Suffering</td>
</tr>
<tr>
<td>Roles and Relationships</td>
<td>Meaning of Pain</td>
</tr>
<tr>
<td>Affection/Sexual Function</td>
<td>Religiosity</td>
</tr>
<tr>
<td>Appearance</td>
<td>Transcendence</td>
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ELNEC, 2017

http://prc.coh.org

Franciscan HEALTH
| Level 1 | Fewest co-morbidities  
Minimal or no functional impairment  
Requires least intervention | Face to face every 1-3 months |
|--------|----------------------------------------------------------|
| Level 2 | Few co-morbidities  
Moderate functional impairment  
Requires moderate level of intervention | Face to face every 2-3 weeks |
| Level 3 | Multiple co-morbidities  
Poor functional status  
Multiple ED or hospital visits  
Requires highest level of intervention | Face to face 1 to 2 times per week  
All REHAB/SAR patients |
Patients with *life limiting illness*

Three hospital admissions in past 6-months

COPD Stage 3 or 4

CHF Class 3 or 4

CKD Stage 3 or 4

Patient with cancer who is not believed to benefit from cancer directed therapy
Questions?
References

https://www.capc.org/

End of Life Nursing Education Consortium (ELNEC) Train the Trainer 2017