A Model of Outpatient Palliative Care

Palliative Care Service
North Sacramento Valley
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KP North Valley Service Area (NVLY) Structure

- Medical Group (TPMG): two separately funded medical centers
  - Sacramento (hospital + 5 office complexes)
  - Roseville (hospital + 3 office complexes)
- Health Plan (KFH): one service area
- One continuum
Outpatient Staffing (Sacramento)

- Physician 0.1
- RN manager 0.5
- RN staff 1.0*
- LCSW (shared Sac/Ros) 0.6
- Chaplain (shared Sac/Ros) 0.5
- Admin Assistant 0.6
- Pharmacist prn

* In process of hiring
PCS Staffing (Roseville)

- Physician 0.1
- RN manager 0.5
- RN staff 1.4
- Admin Assistant 1.0
- Pharmacist prn
Oversight and budget

- NVLY CA: Michael Nanko
  - Reports to AM
- NVLY Chief Continuing Care: Michael Gunther Maher, MD
  - Reports to API C for Hospital and Continuum
- Operational budget approx. $1,300,000
PCS Admission Criteria

- Any patient with chronic progressive illness
  - Most common diagnoses handled are dementia, neuro disorders, cardiac patients, COPD
- High symptom burden
- Complex scenarios
  - psychosocial, multiple diseases, utilization
PCS Exclusion & DC Criteria

- **Exclusion**
  - Inability to participate
  - Complex psychiatric issues
  - Chronic benign pain

- **Discharge**
  - Hospice
  - Custodial or terminal SNF
  - Patient/family disenrollment
PCS Outpatient Program

- Consultative/facilitative approach
  - Mostly managed by nurses and social worker
- Care coordination
- 1:1 care planning
- Facilitation of patient/family meetings
- After-hour symptom management
After hour support

- Offered only to select patients
  - DNR
  - Comfort goals
  - Symptom meds in the home already
  - Hospice pending or appropriate
- 24 hour per day coverage, 365 days per year
- Approximately 1-2 calls per quarter
Receiving Referrals

- Referrals received from
  - Primary care, MSW, Nursing, HH or Hospice
  - Self referral
  - e-Consult
  - HC staff message
  - Phone
  - Email message
Processing referrals

- RN evaluates for appropriateness, urgency on KPHC
- May refer to other programs immediately via eConsult
- Queue for contact in 1-3 weeks messaged to administrative assistants
- Administrative assistants create a paper shadow chart and store in central location
Making patient contact

- Re-review of the chart for events since referral
- Telephonic outreach to patient and/or family member
- Assessment of current clinical condition, support system, and goals of care in the first phone meeting
- Education of patient and/or family about disease trajectory
- Create plan for follow-up and mailing of information and resources
- All documentation routed electronically to PCP and specialty folks involved in patient’s care team
PCS Tools

- Durable Power of Attorney form
- EMS Prehospital DNR form
- Disease Information Sheets
- PCS packets with brochure, phone number
- Fact Sheets regarding CPR, Artificial Nutrition and numerous topics
- Community Resource Information
Active vs Closed to Outreach

Active Patients

- Ongoing Education: Disease trajectory, AD, pre-hospital DNR
- Clarification of Goals of Care
- Ongoing Advance Care Planning
- Assess need for face to face meeting
- Active symptom management
- Ongoing spiritual issues
- Ongoing psychosocial issues
Active vs Closed to Outreach

**Closed to Outreach**

- Goals of care established and documented
- All care providers alerted to goals and care plan
- Pt/family education completed
- AD/Pre-hospital DNR education completed
- Completed AD/pre-hospital DNR scanned in HC
- Symptoms managed
- Spiritual/psychosocial issues addressed
- No further calls by PCS, but pt/family can call us at any time
Mr. S – the story starts

- 84y/o with O2 dependent severe COPD, Cor Pulmonale, Macular degeneration
- Referred by PCP 08/06
- Pt lives alone
- Uses walker, and O2 ATC
- 3 Acute Admissions prior to consult
- Initial phone contact within 2 weeks
- Goals: Comfort
- No AD in place
Mr. S – the story continues

- Numerous subsequent phone conversations
- Facilitated contact with PCP for medications when sx worsened, pt was able to avoid MD appts
- AD, pre-hospital DNR completed, scanned in HC
- Referred to telemonitoring program
- Pt closed to outreach since 06, still occasionally calls for assistance with various care coordination requests
- Pt still living independently
- 1 Acute admit 08/06, 1 admit 01/07, no admits in 08
Mrs. G

- 76 y/o with severe dementia with anxiety and escalating agitation, lives with spouse, ambulatory
- Referred by PCP 06/06
- Initial phone contact within 2 weeks
- Goals: Comfort
- AD completed, scanned into HC
- Advance Care planning: assisted spouse in decision for day care, eventually placement in ALF
- 2 Acute admissions for behavior 06, none since
Mrs. M

- 83 y/o with Mod Dementia, Breast Ca, Diabetes
- Lives with son who is CG
- Ambulates with walker
- Referred by PCP 05/07
- Contacted within 2 weeks
- Goals: Comfort
- Education regarding disease and AD
- AD, pre-hospital DNR scanned by 09/07
- Collaborated with ADP to provide caregiver information and support
- Referred to HH RN, OT, PT for CG training 6/07
- Referred to Hospice 12/07 (43 days prior to death)
# PCS Volume:
How are we doing?

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*All numbers include those patients were not opened (old Access database)*
PCS Volume:
How are we doing?

REFERRALS SINCE INCEPTION

YEAR

2002 2003 2004 2005 2006 2007

REFERRALS

SAC OUTPT
ROS OUTPT
TOTAL
Take Home Points

- A small number of healthcare providers can impact a large number of patients
- Telephonic approach is effective in empowering patients to make significant healthcare decisions
- Patients can be empowered (and expected) to call us when their health changes
- Electronic charting is a valuable tool to notify all care providers of patients’ goals