Home Based Palliative Care

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Discussion Content

- Challenges and Opportunities
- Program overview
- Results of 2 year Garfield study
- Regulatory issues
- Business plan
- Challenges and Opportunities

Palliative Care

- 53 years old
- COPD - 30 years
- Multiple Sclerosis - 20 years
- Chronic Stage III decub
- 66 pounds
- Full Code

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Life is a Journey
Live Long – Thrive – Die Well

THRIVE – Empowering chronically ill patients to maximize their well being

Opportunities:
• Engage patients and families in discussion about goals of care
• Discuss likely course of disease
• Honor patient preferences
• Increase patient, family, physician and staff satisfaction with care
• Shift focus from cure to palliation
• Shift focus from inpatient care to home care
• Hope for the best, plan for the worst

Challenges to Provide End-of-Life Care

• Aging Population
  – Medicare members increase from 12% to 20% of population by 2030
• 25% of Medicare revenue is spent on the 5% who die each year
  – Average cost of care in last year of life is $26,000 (1996 costs)
• Fragmentation of care
  – Multiple providers, subspecialists, uncoordinated

Challenges to Provide End-of-Life Care

• Curative/Restorative Care vs. Palliative Care
• Acute Care vs. Chronic Care
• Hospital Care vs. Home based Care
• Reduce care to Reduce cost vs.
  Improve care & Reduce cost
  – One percent of our members create over 30% of our costs
Organ System Failure Trajectory

(mostly heart and lung failure)

Time ~ 2-5 years, but death usually seems “sudden”

Function

High

Low

Begin to use hospital often, self-care becomes difficult

Multivariable Models for Very Sick Patients Cannot Predict Time of Death Precisely

Medians of Predictions Estimated from Data on These Days before Death

Barriers to Hospice

- Negative connotation of “hospice”
- Patient feels health care provider is “giving up”
- Difficult to predict 6 month prognosis
- Late referral
  - 20 day median LOS
  - 26% die in the first week
  - 35% die in the next 3 weeks
Someone once said:
“In Scotland, death is imminent;
In Canada, it is inevitable;
and in California, it is optional.”

Ian Morrison, PhD.
Institute for the Future

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**Palliative Care Across the Continuum**

- Outpatient
- Inpatient
- Extended Care
- Home-Based
- Primary Care Physician
- Palliative Care Consultation Team
- Home Health
- Palliative Care
- Subspecialist Physician
- Hospitalist Physicians
- Extended Care Facility
- Hospice
- Population Care Manager
- Discharge Planners
- Geriatric Assessment Clinic

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**Core Components of Palliative Care**

- Patient and family unit of care
- Interdisciplinary team directs/provides care
  - Physician, Nurse, Social Worker
  - Aide, Chaplain, Volunteer
- Home care emphasized
  - all providers make home visits
- Plan of care - coordinated and supportive services
Core Components of Palliative Care Cont.

• Physical, medical, psychological, social and spiritual needs
• Pain and symptom management
  – comprehensive primary care to manage underlying conditions
  – aggressive treatment of acute exacerbation per patient and family request
• 24 hour phone support, visits if necessary
• Volunteer support & Bereavement services

Palliative Care Admission Criteria

• CHF, COPD, Cancer, or meet Hospice criteria for disease and don’t want to be on hospice program
• Expected prognosis ≤12 months
• Deteriorating medical condition at risk for needing symptom management
• Primary Care Provider when necessary
• Emphasis of care in the home setting
• 1-2 or more ED or Inpatient admissions in the last year
• Palliative Performance Scale ≤ 50% (mainly sit or lie, unable to do any work, considerable assistance needed)
• reduced ambulation, unable to do normal work, some evidence of disease)

Multisite Project Overview

Funded by Garfield Memorial Fund

• Study replicated in Colorado & Hawaii
• 310 patients recruited from 2 sites
  – Colorado n=150, Hawaii n=160
• Randomized controlled Study: Patients assigned to usual care or Palliative Care
• Study period: 2 years (Approximately 18 months of data collection)
Satisfaction with Services:

PC group had significantly improved satisfaction at 30 (p< .001), 60, & 90 days than at BL; no significant (NS) difference in satisfaction for UC group at 30 days, improved satisfaction at 60 (p=.03), and NS at 90 days from BL. PC sat. significantly higher than UC at 90 days (p<.001).

Acute Care Service Use (n=297)

- After controlling for demographics and days on service, patients enrolled in Palliative Care continued to have lower emergency room visits and hospital days as compared to those receiving usual care (P=.018, P<.001).

Medical Service Use (n=297)

* P<.01
Total Service Costs

- Enrollment in Palliative Care, adjusted for age, disease, severity of illness, and days on service, explained 16% of the variance in total service costs.
- Adjusted costs of care for those in PC were 32.6% less than those receiving UC.

Site of Death (n=217)

- Studies show that most people prefer to die at home. 
- Patients enrolled in the Palliative Care program were significantly more likely to die at home (71% vs. 51%; p=.001).

Hospice vs. Palliative Care Patient Distribution

- TriCentral May, 2005

*(Townsend, Frank, Fornette et al., 1990; Karlsson & Ashdown-Ball, 1990; Hays et al., 2001)
Length of Stay- Days
Hospice and Palliative Care
June YTD, 2005

Hospice and Palliative Care Deaths
vs. Usual Care Deaths
Bellflower Medical Center 2005

Hospice and Home Health
Conditions of Participation

- Dually certified Hospice and Home Health
- Terminally ill patient with skilled care under Home Health benefit is eligible
- HHA may coordinate care with and contract with the Hospice staff to provide care
- Plan of Care reflects Hospice philosophy
- Expect patient to eventually elect Hospice
- Palliative Care part of Home Health
Home Health Benefit

• Skilled Care
  – Observation and assessment
  – Procedures
  – Teaching and training activities
  – Management and evaluation of Plan of Care
• Homebound
• Deteriorating medical condition

Management and Evaluation

1. The patient must be at risk for hospitalization or exacerbation of a health problem if the plan is not implemented properly.
2. The plan must be complex and unskilled (multiple meds, treatments, equipment or supplies)
3. The caregiving situation is unstable.
4. The registered nurse must be involved in the patient’s care.

Separation of Hospice and Palliative Care

• Charts
  • Consents
  • Forms
  • Plan of Care
  • File Room
• Patient Census
• Daily Activity Record
• Staff Timecards
• Budgets, cost centers
  • Prorated DA, ADA, Team Leads, visiting staff
  • Supplies
Barriers to the Replication Process

• Funding & Staff Resources
  – Sufficient start-up and ongoing funding and time to implement
  – Adequate staff in place for initial growth

• Training if EOL naive
  – Initial assessment of baseline knowledge
  – Complete training curriculum - classroom and field work
  – Longer clinical mentorship
  – In person vs... phone mentoring

Barriers to the Replication Process cont.

• Administrative Issues
  – Lack of experience with cost management, staffing decisions, and administrative interactions

• Organization Barriers
  – Difficulty moving $ from inpatient budget to support the home based PC program
  – Interaction between multiple care management programs and Hospice and Palliative Care
  – “Culture of Change”

Palliative Care Replication Challenges

• Who is the champion?
• Justify new program within constraints of current budget climate
• Marketing
• What End-of-Life “infrastructure” is in place?
  – Hospice, Bio Ethics Committee, Advance Care Plans, Physician comfort/communication with EOL care
• Late referrals
• Integration within the Continuum of Care
Home Health Referrals diverted to Hospice and Palliative Care
TriCentral February, 2004

• Review of 70 referrals for 3 day period
• 20% possibly appropriate for H or PC
• Age of Patients with Possible Referral

<table>
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<tr>
<th>Age Range</th>
<th>Referrals</th>
<th>%</th>
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<tbody>
<tr>
<td>36 – 45 years old</td>
<td>1 referral</td>
<td>8%</td>
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<tr>
<td>46 – 55</td>
<td>1</td>
<td>8</td>
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<td>56 – 65</td>
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<td>66 – 75</td>
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<td>76 – 85</td>
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<tr>
<td>86 – 95</td>
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Home Health Referrals diverted to Hospice and Palliative Care
TriCentral February, 2004

• Consider Hospice vs. Palliative Care admission:
  • SK, 44, Pancreatic Cancer, DVT, recent sepsis
  • JH, 68, Chronic Lymphocytic Leukemia, history of sepsis, pneumonia
  • KE, 70, AODM, “severe” COPD
  • RH, 84, CHF, caregiver stress, marked failure to thrive
Palliative Care

Usual Care
02/02 to 01/03
- 12 acute admissions
  - 63 days
  - 2 intubations
  - 22 different physicians
    admitted/discharged
- 14 home health admissions
  - focus on decub care

Palliative Care
02/03 to 12/03
- No acute admissions
- Palliative Care Team
  - developed plan of care
    for relief of dyspnea
  - caregiver support
  - consistent palliative care
    team

Palliative Care

- Palliative Care has made a large improvement
  in my life
- I’ve been given a second chance in my old age
- I’m able to spend more time with my loved
  ones - my mother, my best friend, and my
  children
- I thank Kaiser Permanente for making a
difference in my life