Community Based Palliative Medicine

- Hilary Bingol, MD, HMDC, SWWI Department Chair of Palliative Medicine & Hospice Medical Director

Disclosure

Relevant Financial Relationships
None

Off-Label/Investigational Uses
None
Learning Objectives

• Understand the definition of community based palliative care for our community
• Be able to recognize the difference between palliative and hospice care
• Learn criteria in order to feel comfortable in referring to palliative and hospice care.

What is Community Based Palliative Medicine?

Primary Palliative Care

Hospice

Specialty Palliative Medicine
Our Community

- We have a rich culture of both advanced care planning and documenting our wishes
- We have a strong base of philanthropy
- We have many dedicated nursing homes, assisted living facilities, group homes and community services.

Opportunities to Improve

- We lack a dedicated place for our loved ones to go for end of life care when they are unable to stay in their homes
- We are working on more collaboration between our nursing homes and hospitals for proactive palliative and hospice care.

The Chronically Ill Patient

- Often the readmissions to our hospital are related to the chronically ill and medically complex patients.
- At least 33 of our readmissions in 2018 were from facilities (many with 3 or more readmissions each.)
- Patients coming from home often wait until the last minute to call an ambulance and arrive critically ill.
What is Primary Palliative Care?

- Primary Care provider providing symptom management within the scope of their expertise
- Advance Care Planning
- Supporting the patient and their family in difficult decision making
- When do you ask for a Palliative Consultation?
  - When the symptoms are difficult to control
  - If the patient has very complex medical illness and usual medications for symptoms are not safe
  - If advanced care planning discussions are more complex or the patient is reluctant to talk to their PCP.

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Obstacles to Primary Palliative Care

- Time-short visits and large volumes in primary care
- So many boxes to check in a primary care visit
- Long medication lists and usually an acute issue to handle
- Over familiar with patient: you may not see the dramatic changes because you see them so frequently
- Like Family
- Complex Family dynamics take time and may take a team
Outpatient Clinic Consultation

- Location is currently in Mayo Skemp Clinic in La Crosse, WI
- This consult is multidisciplinary and we welcome families in person or by phone
- Future opportunities will be with Telemedicine in more remote locations where set up is available
- Occasionally we do consultations in the other specialist’s office to make the visit less complicated.

What does this Consultation look like?

- Alice is a 78 year old woman who has:
  - Combined Diastolic and Systolic Congestive heart failure (last echo EF 25%)
  - Mild Cognitive Decline
  - Living in apartment alone
  - No family
  - Recent hospitalizations
  - Still walks to KT daily and carries out all ADLs
• Get to know her: career, family, hobbies, joys, faith, what holds her back, fears
• Review Symptoms
• Medication Review
• Physical Exam
• Her Goals, ACP as needed
• Develop a plan both medically to manage her dyspnea and arthritis and future care plan
• Share plan with her care team (CHF clinic and PCP and SW plan. Chaplain Follow up)

Palliative Medicine Inpatient Consultation
• High level symptom management to improve treatment tolerance, decrease length of stay and develop a discharge plan for symptom management
• Work on Goals of Care with the patient and their family/advocates/POAs
• Complete advance care planning when appropriate
• We have multidisciplinary approach inpatient

Palliative care teams working in hospitals:
• Improve patient and family satisfaction with care [1]
• Reduce 30-day readmission rates [2]
• Reduce ICU utilization [3]
• Can save 9-25% of costs for each inpatient stay [4] through a mixture of shorter length of stay and reduced cost per day.

The Case for Palliative Care
We have found that palliative care teams, when working with the right population, are significantly effective in reducing hospitalizations and days in the hospital. Again, as with programs and different parts of the country.
James Mittelberger, MD, MPH
Senior Director and Chief Medical Officer, Optum Center for Palliative and姑姑Palliative Care
CAPC.org
Goal for the Future growth of our department

- Homebased Palliative Medicine
  - A palliative consultative service with follow-up working closely with PCP to help patients at risk to stay safe at home, prevent frequent hospitalizations if possible and ease those transitions to hospice when appropriate.

Patients in their own home

- Many have little support or live with a partner who is equally as medically complex and debilitated.
- Have limited financial resources, in addition to psychosocial challenges.
- Miss appointments due to declining health or lack of transportation.
- Have complex polypharmacy and cannot be compliant with their medications.
Is there Data to Support Homebased Programs?

- Intermountain Healthcare program showed decrease of $1900 per patient per month after beginning homebased palliative care due to decreased ER and inpatient stays. Additionally hospice census grew 25% and hospice length of stay increased 6 days.
- Home based palliative care in New York ACO:
  - The cost per patient in final three months of life was $12,000 lower with HBPC than with usual care
  - 35% reduction in Medicare Part A ($16,992 vs. $26,171)
  - 37% reduction in Medicare Part B ($3,114 vs. $4,913)
  - Hospital admissions were reduced by 34% (3073 vs. 4640)
  - 35% increased hospice enrollment rate
  - 240% increased median hospice length of stay compared to usual care (34 days vs. 13 days)

Home based palliative care supports ACO
**Homebased Palliative Medicine Model**

- Patient identified as likely benefitting from homebased palliative medicine
- Develop a care plan
- Follow up visits (in person or via telemedicine) by RN and MSW
- Follow-up by Provider (Palliative or possibly PCP trained in primary palliative medicine) as often as necessary based on assessment

**Barriers to Homebased Palliative Care**

- Reimbursement for provider visits can be covered but the rest of the care team can be a challenge
- Windshield time
- Safety in the homes similar to hospice

**Opportunities**

- Technology would be beneficial-Telemedicine
- Partnering with insurers
- Fits into an ACO Model
- Is best for the patient and their family.

**The When, What and Where of Hospice**

- Hospice is a program that provides care for patients with a prognosis of less than 6 months.
- Hospice is provided by an interdisciplinary team (IDT) that partners with the patient to help the patient meet their end of life goals.
- Hospice provides all the care needed for the patient’s terminal condition and the palliation of symptoms.
Who Qualifies for Hospice?

• Anyone with a terminal illness where you could ask, Would I be surprised if they died in the next 6 months and you answer, "no."
• Diagnosis: We should not get too stuck on this. I trust your judgement, if you know your patient, have seen a decline and think they have a poor prognosis but you are struggling with which diagnosis to use for hospice, I am happy to help.

Common diagnoses we see in hospice:

• Heart Failure, COPD, Multisystem Organ Failure, Renal Failure, Liver Failure, Dementia, ALS, Parkinson's, terminal Cancers, etc.
• The key is they do not continue to pursue aggressive treatment for their terminal diagnosis but they maintain their benefits for their unrelated diagnoses.

What are the Goals of Hospice Care?

• Care for the patient:
  • Pain management
  • Other symptom Management
  • Spiritual Support
  • Emotional Support
• Care for the family:
  • Spiritual Support
  • Emotional Support
  • Bereavement Support
Dispelling Myths of Hospice

- To help your patients to live longer lives with less symptom burden.
- To keep them as active as possible for as long as possible but also help prepare for their expected continued decline
- To minimize medication burden so that they have the least side effects possible.
- To help avoid re-hospitalizations and ER visits.

Why do our patients come into the hospital?

- Pain crisis
- Status epilepticus
- Delirium
- Non-hospice related diagnosis i.e. AMI, COPD exacerbation, Fracture
- Patients who are dying can have complex illnesses which need to be cared for and sometimes these symptoms cannot be managed in the home setting

Respite Care

- Caregiver fatigue
- Caregiver illness
- Caregiver death
- Caregiver absence
What is GIP, General Inpatient Hospice?

• GIP is general inpatient hospice care, another ‘level of care’ in hospice
• GIP is for those requiring symptom management that can not be provided in the home setting
  • Pain management requiring IV meds and frequent assessment/titration
  • Complex wound care
  • Uncontrolled bleeding
  • Interventions unavailable in the home setting- continuous suction, continuous infusions of unstable meds (seizures)

Opportunities for improvement

• Patients prefer to stay in their “home” and not go back and forth from hospital.
• Discussions on goals of care need to happen earlier in terminal diagnosis.
• Multidisciplinary approach to care in the “home” (facility or home) would offer patients additional support and potentially transition to hospice care earlier, allowing them to fully utilize the benefit.
• A Hospice House in our community for anyone who needs care that cannot happen in their home.

Thank you for your time!

• Questions?
Resources

- Mayo Clinic Enterprise Palliative Medicine Departments
- CAPC.org/resources
- AAHPM annual assembly 2011 Session 305: Community-based Opportunities for Extending the Palliative Care Continuum
- AMGA 2019 Annual Conference, Atrius Hospital in Home, Acute Hospital Care in the Home: Year One Results and Lessons - Slide Set, March 29, 2019