Addressing Palliative Care Needs through Home Visits

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Institute for Accountable Care Learning Collaborative

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Agenda

- What is palliative care and who needs it?
- Identifying unmet palliative care needs and mitigating risks
- *Discussion*
- Two models of meeting palliative care needs
  - Integrated competencies
  - Co-management
- *Discussion*

What is Palliative Care?

- Palliative care is specialized care for people with **serious illness**.
- It is focused on **improving quality of life for both the patient and family** by addressing pain, symptoms, and stresses of serious illness – whatever the diagnosis or stage of the disease.
- It is appropriate at any age and at any stage in a serious illness and **is provided along with regular disease treatment.**

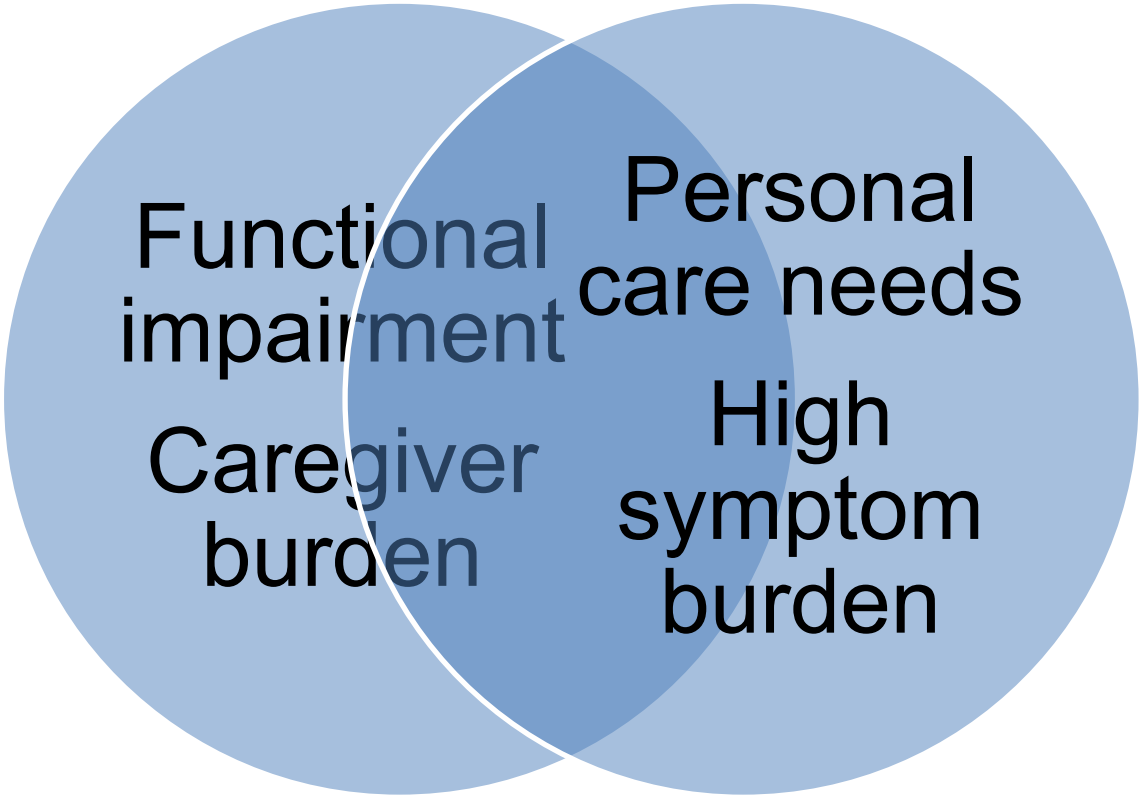
What are the Key Interventions of Palliative Care?

1. Assess for physical, emotional, and caregiver distress
2. Provide expert pain and symptom management, including 24/7 meaningful clinical response as a means to prevent and avert crises
3. Assist with decision making, ensuring an understanding of disease progression, clarifying patient and family care priorities, and helping to match treatments and services to those goals

Who are the Seriously Ill?

- Serious illness is a health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life or excessively strains their caregivers
- Examples: metastatic cancer, heart failure, COPD, advanced dementia, multiple chronic conditions
- Nearly 13 million adults in the US

Overlap: the home-bound and the seriously-ill



Identifying Palliative Care Needs in Home-bound Populations

- Pain and other symptom distress
- Caregiver stress and burn-out
- Misunderstanding of prognosis
- Unarticulated values and goals
- Existential worry
- Disagreement within family

Key Assessments of Need

- Symptom Burden
  - Edmonton Symptom Assessment System (ESAS-r)
- Functional Decline
  - Karnofsky Performance Status Scale
  - Palliative Performance Scale
- Caregiver Burden
  - Zarit Burden Interview
- Spiritual Distress
  - Beck Hopelessness Scale
- Anticholinergic Burden
  - Anticholinergic Burden Scale

Another Aspect of Need: Supportive Decision-making to Mitigate Risk

The New York Times

THE NEW OLD AGE

The Elderly Are Getting Complex Surgeries. Often It Doesn't End Well.

Complication rates are high among the oldest patients. Now a surgeons' group will propose standards for hospitals operating on the elderly.

By Paula Span

June 7, 2019

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Clarifying Treatment Preferences During Serious Illness

- **A majority would *forego treatment*** if **high probability of functional (74%) or cognitive (89%) impairment** (this is true even if the treatment burden was low)
- To patients, functional and/or cognitive impairment is a worse outcome than death → Risk of mortality was not the major determinant in patient choice.

Terri R Fried MD, et al, *Understanding the Treatment Preferences of Seriously Ill Patients,* NEJM 2002; 346: 1061-66

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Clarifying Goals vs. Advance Care Planning

- Prognosis Understanding
- Fears
- Goals
- Trade-Offs

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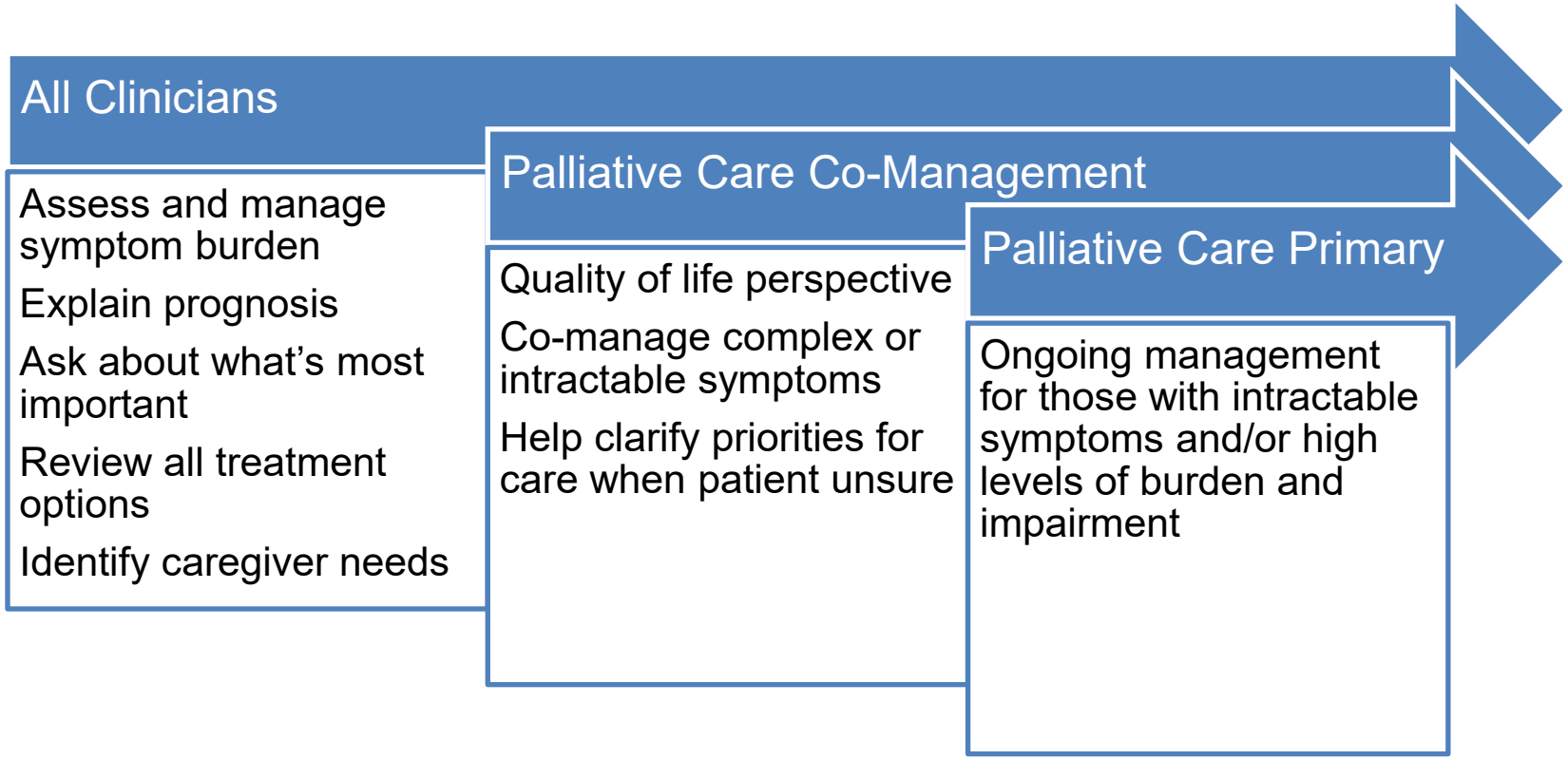
DISCUSSION

Meeting Palliative Care Needs with Skills and Specialists



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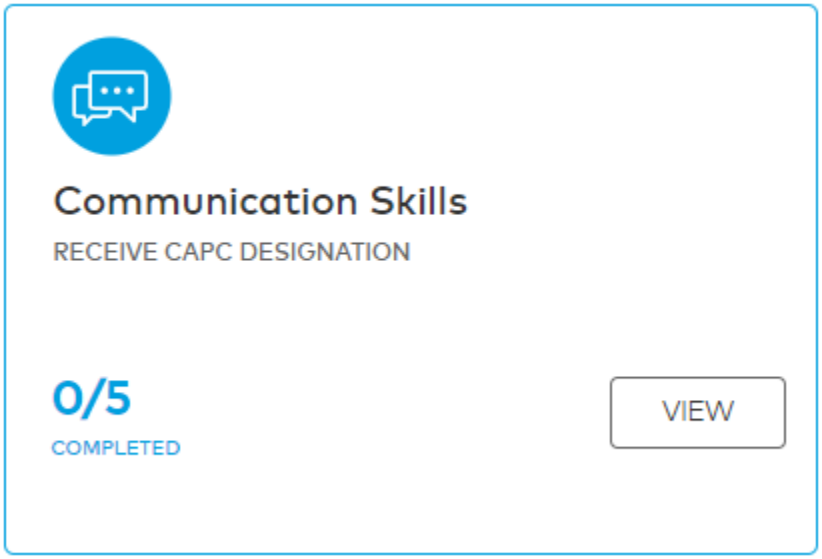
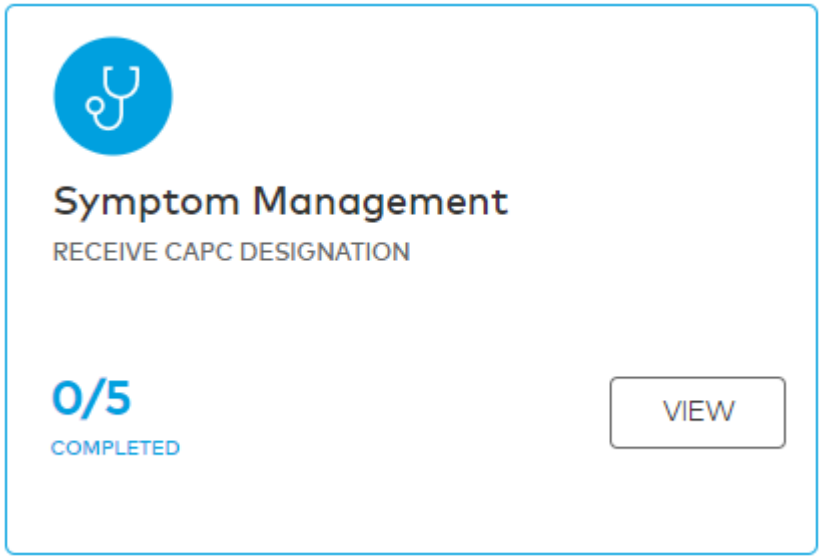
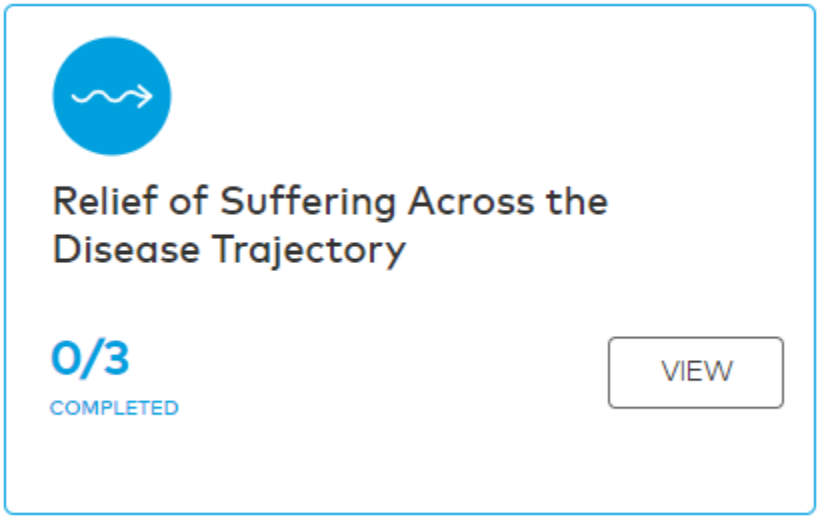
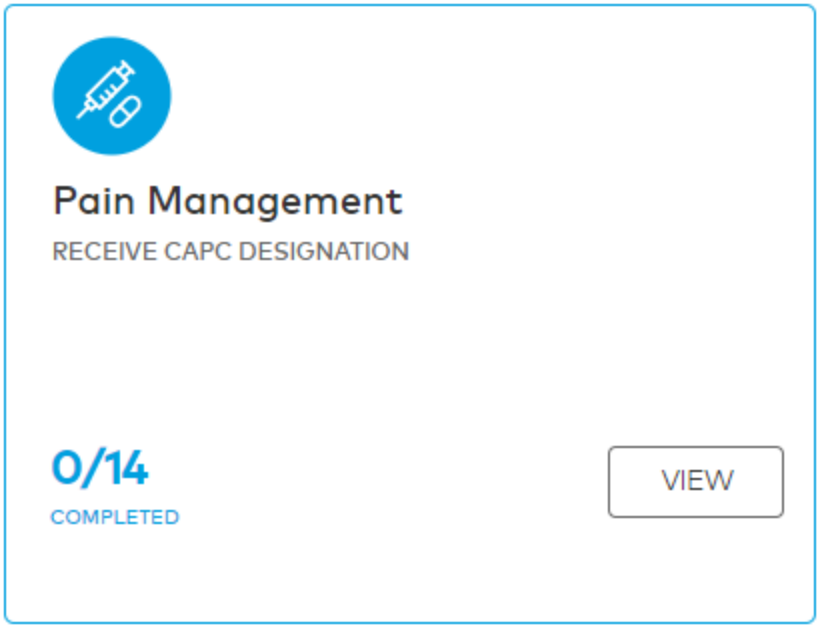
Basic Skills Can Be Taught









Optimizing Clinician Engagement in Skill Training

- Make completion as easy as possible!
- Link to personal goals
  - Reduce discomfort in certain situations
  - Improve patient-clinician relationship
  - Emphasize CE credits/MOC points earned
- Create formal recognitions
  - Not only dashboards, but celebration and recognition for training completion

Palliative Care Teams Should Consult on the Most Complex

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Some May Transition to Home-based Palliative Care

- Interdisciplinary team
  - Medicine, Advanced Practice Providers, Nursing, Social Work, Chaplaincy
- Regular in-person and telehealth visits
  - Titrate visit frequency based on need
- 24/7 clinical response to calls
- Collaborate with community para-medics for crisis pain relief and other services

Case Example: Integrated Competencies at US Med Mgt

- Developed curriculum for each member of the team
  - Communications
  - Symptom management
  - Pain management
- Staff achieved 519 Designations
- US Medical Management meeting the palliative care needs of its patients with these new competencies

Case Example: Palliative Care Co-Management at UPMC

- Home health patients assessed for unmet palliative care needs
- Specialty palliative care NP and SW team make visits to patients
  - Total 8 visits over two months
- 75% of patients have no inpatient utilization; hospice referral rates and length-of-stay have increased

DISCUSSION