Palliative Care Medical Home Model

Sharon Tapper, MD

Palo Alto Medical Foundation

tappers@pamf.org

The Problem

Over 60% of US hospitals with >300 beds have inpatient PC programs

What happens to these patients/families before and after hospitalization in a vertically UNINTEGRATED system?

Case Study: Old and New Paradigm

OLD PARADIGM

- Mrs. Smith: 84 years old. 5 previous admissions over last 12 months for CHF. EF<20% and she is NYHA Class IV. Admitted and deteriorates and intubated in the ICU.
- Prior to this, she had been seeing her cardiologist and PCP with med adjustments. She was unable to manage at home due to family issues.
- She's also been to the ER 5 times in the last year and has called her PCP and cardiologist numerous times.

NEW PARADIGM

- It turns out she never wanted intubation and hates going to the hospital.
- Her doctors see that she is deteriorating and have a social worker meet with her and her family in their office or refer her to a palliative care and supportive care clinic for goals and options of care. She is placed on the palliative care service and home visits are made as necessary. Hospice as an option of care is discussed and she is admitted.
- At every care transition, medication reconciliation occurs and her PCP/specialist is updated. She dies peacefully at home within the year.

PAMF's Current State (2009)

COMMUNICATION GAPS:

Between care settings regarding plan of care, medication reconciliation, advanced care planning.

EDUCATION GAPS:

Providers understanding when patients are failing and what palliative care can offer. Having tough conversations. Patients needing knowledge about disease process.

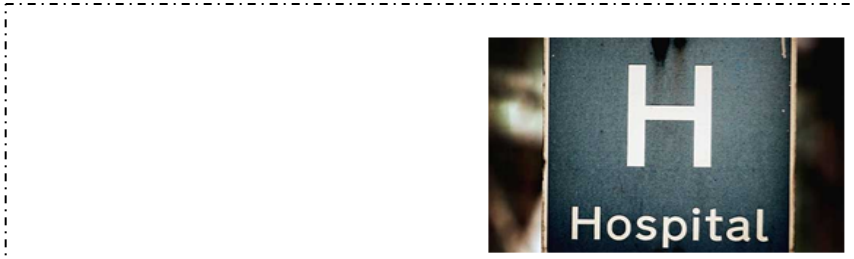
FRAGMENTATION OF SERVICES:

Most end of life care occurring within days or weeks of death when patients are sent to hospice. Fragmented access to education like the Health Resource center. Fragmented access to Palliative Care (hospitals, some via home health).

CARE COORDINATION GAPS:

Palliative Care should be a "team sport" linking specialists, PCP's and patients.

Utopia Vision
Palliative Care Medical Home Model



SNF

MD Office

PC Clinic
Cancer/POE
PCP
Specialist

Patient/Family

Hospice
Home Health

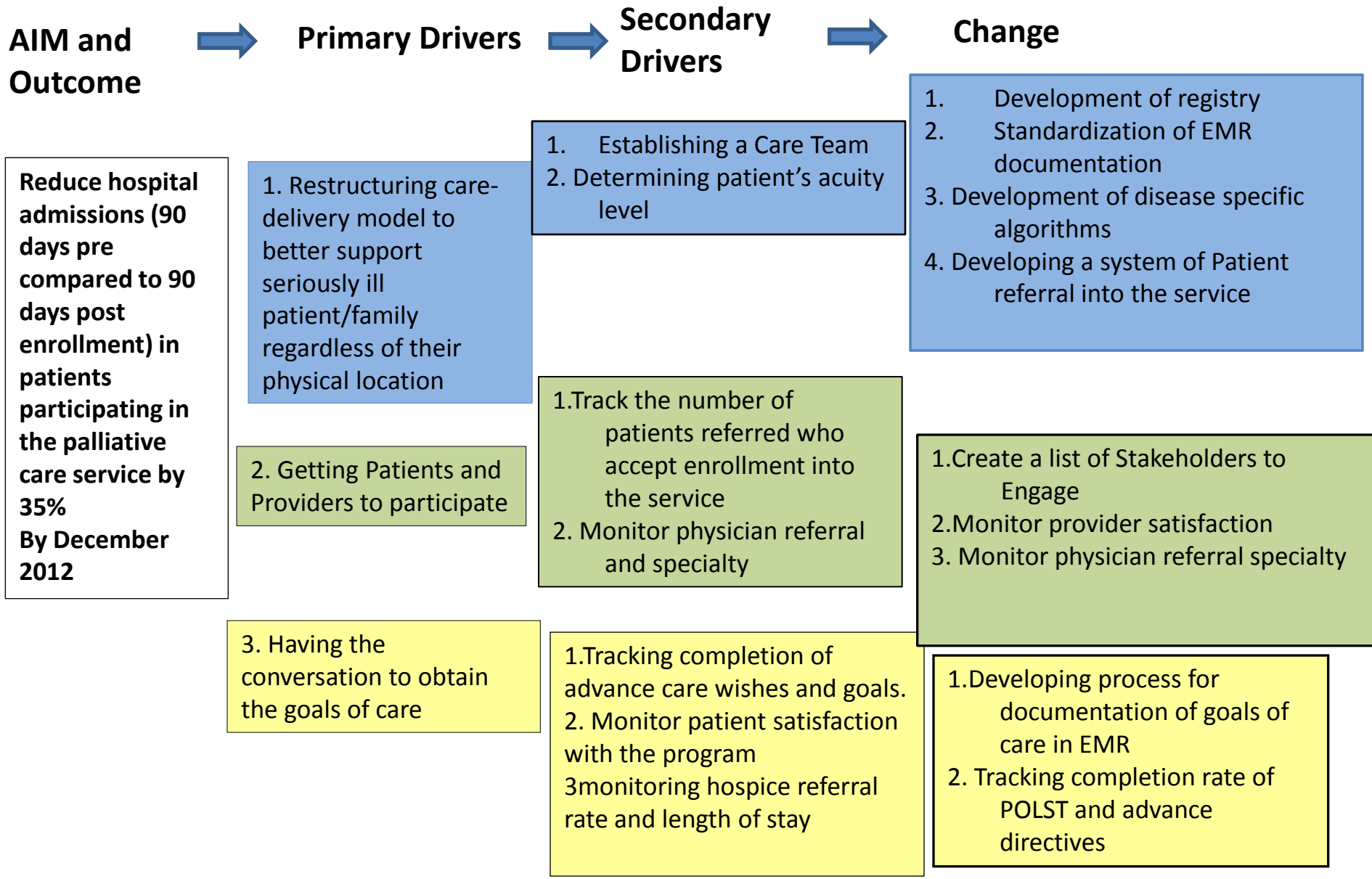
Utopia Vision

- A system of interdisciplinary care that can **identify patients** with life-limiting illness in the last 1-2 years of life and offer them **seamless case management** as well as **comprehensive palliative care**. This care would include advanced care planning, symptom management, as well as care for any existential needs such as spiritual, social or psychological issues, including bereavement services. It would be designed to **meet the patient wherever they are in the health care system** It would also offer **excellent communication to the patient's care team** including a case manager and designated physician to be "captain of the ship". It will offer support to caregivers and providers.

Program Development

- Analysis of current State
- Needs analysis-program design, metrics, business plan
- Presentation to Leadership/elevator speech
- Ramp up needs
- Pilot
- Reevaluate
- Spread (implementation)
- Continual QI and run charts

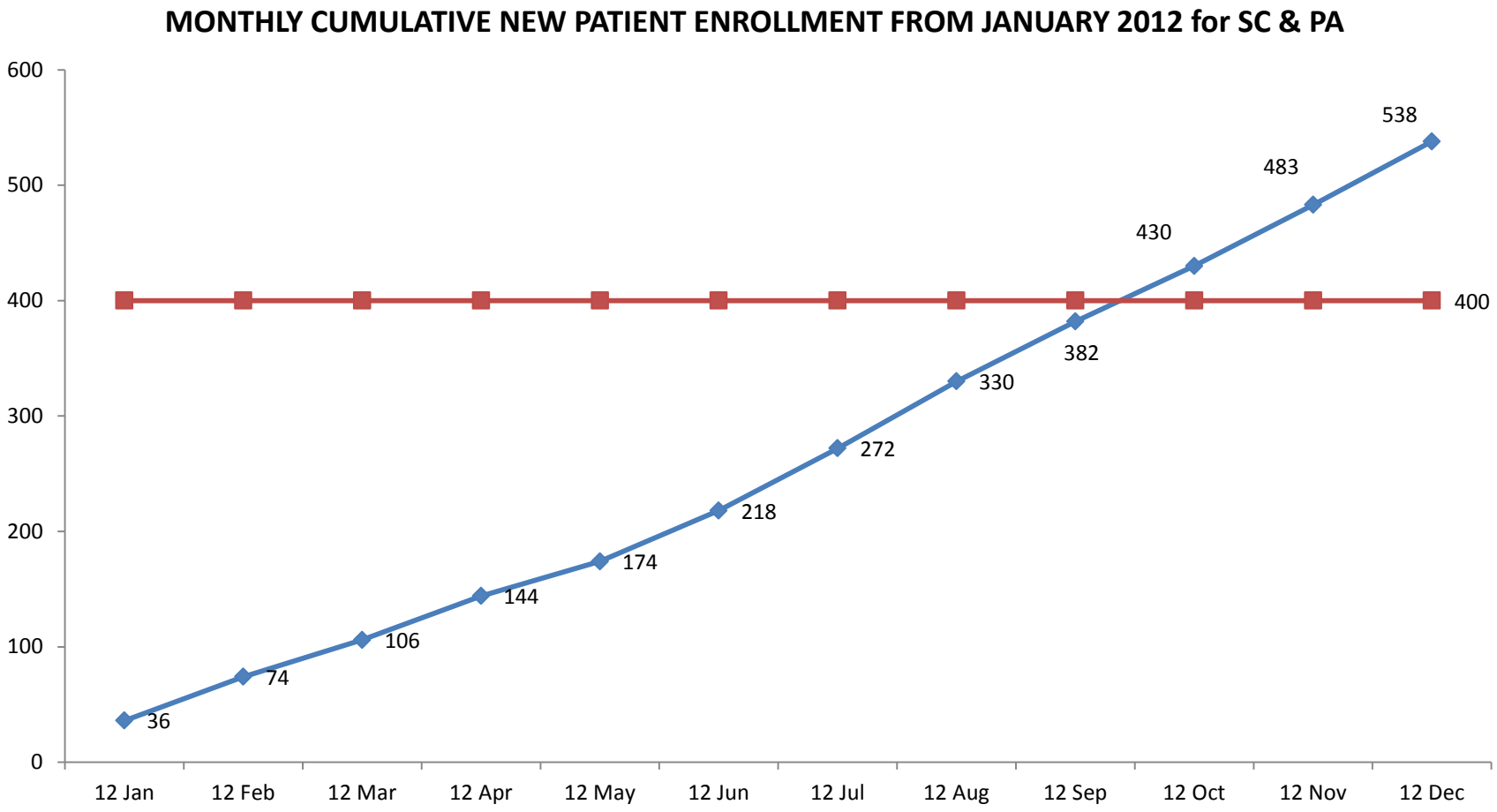
Integrated Palliative Care Delivery Model
Driver Diagram-Sharon Tapper, MD



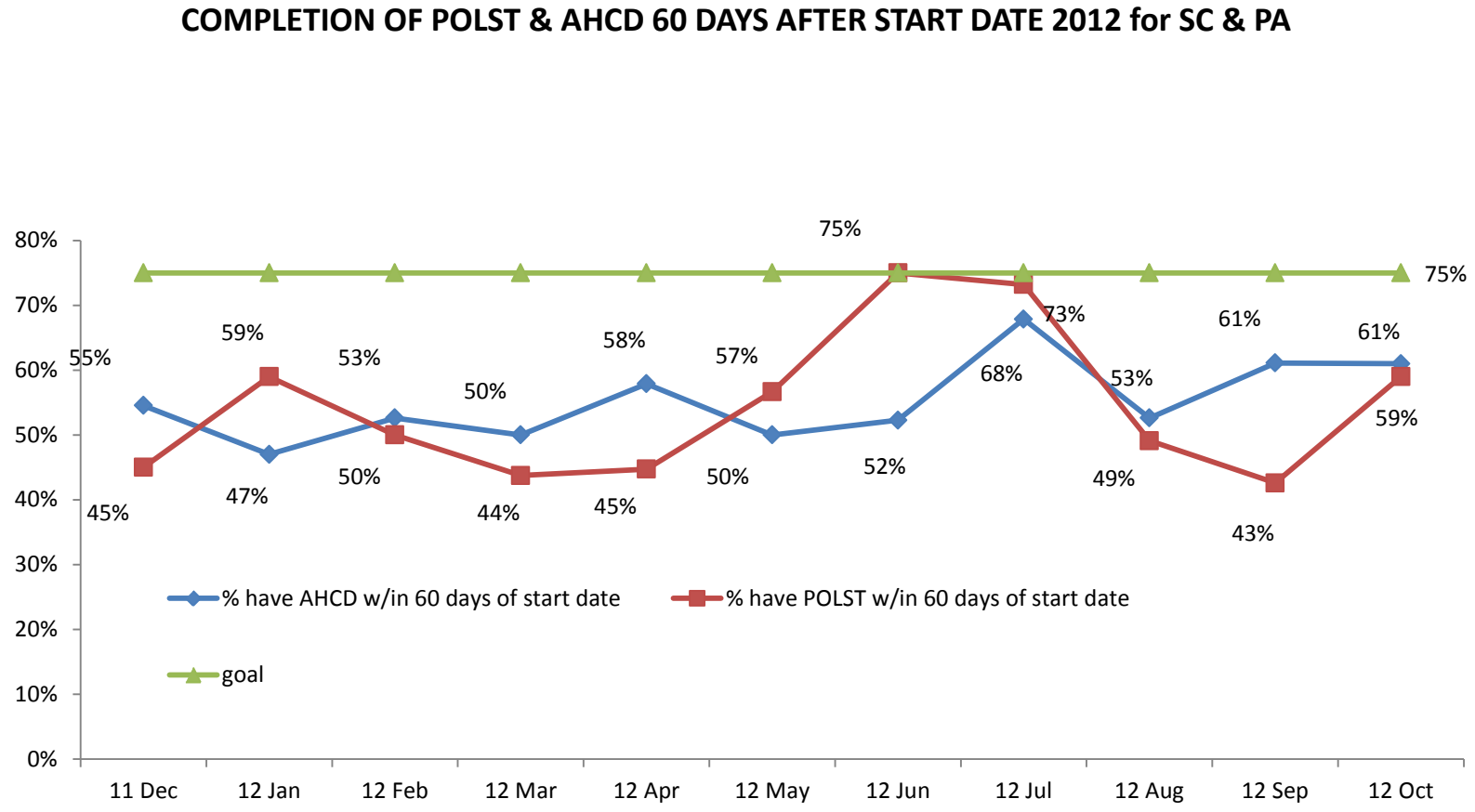
METRICS

PROCESS	OUTCOME
Patient enrollment	Hospice LOS
Documentation of Goals of Care	Percent of Deaths on Hospice
Completion of POLST and AHCD	Reduction in hospital admissions

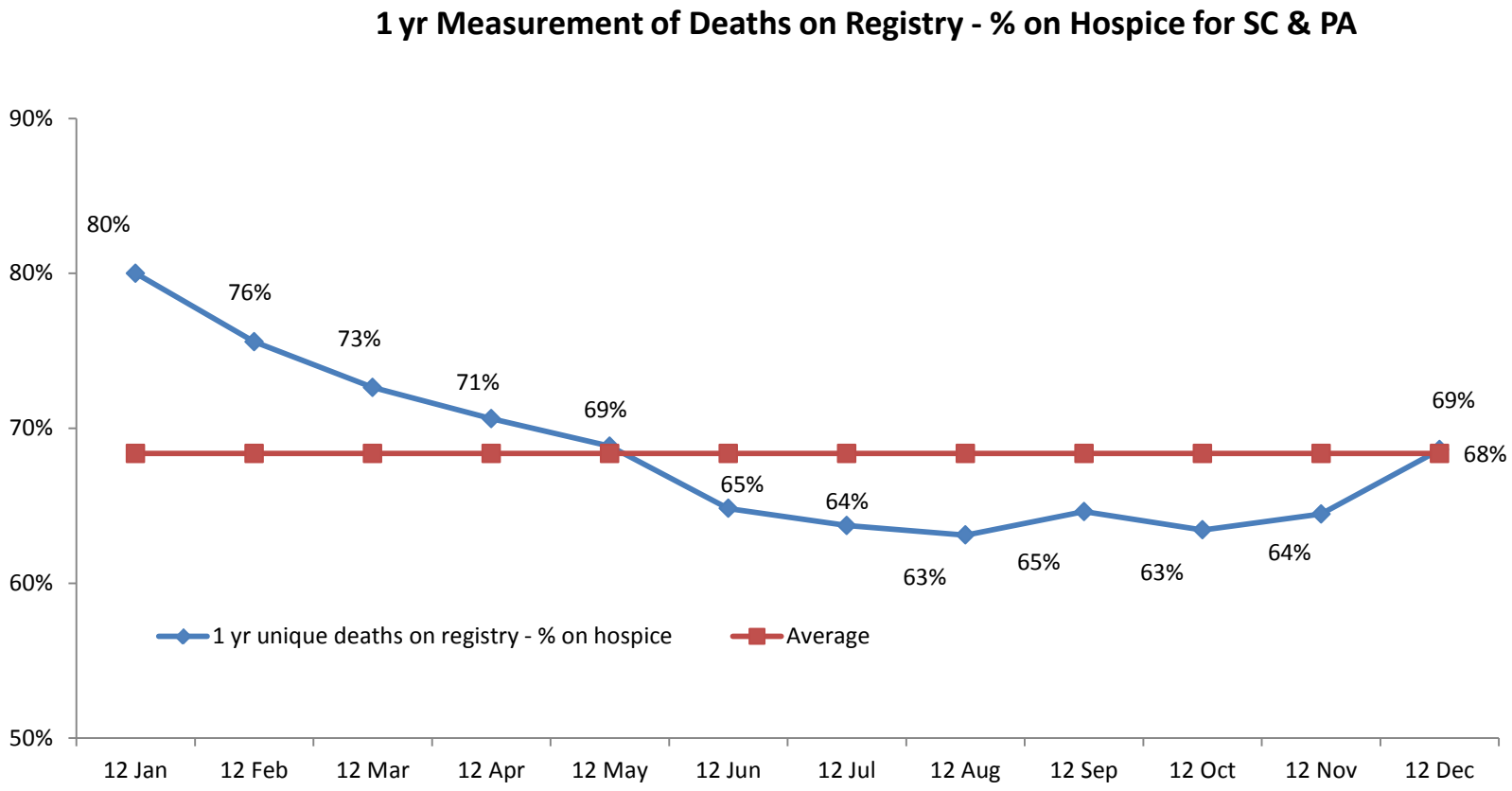
Process Metric Example



Process Metric Example



Outcome Metric Example



Outcome Metric Example