## Palliative Care Medical Home Model

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## 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.

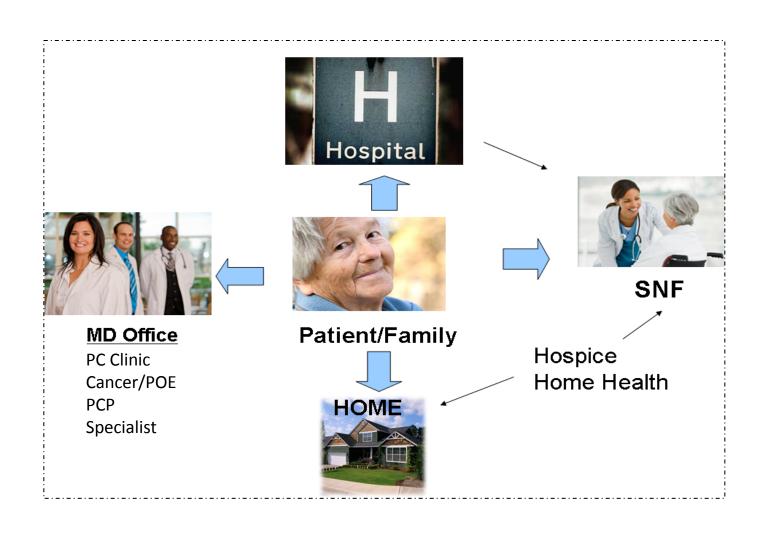
#### FRAGMENTATION OF SERVICES:

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.

# <u>Utopia Vision</u> <u>Palliative Care Medical Home Model</u>



# **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

AIM and



**Primary Drivers** 





## Change

Outcome

35%

2012

By December

**Reduce hospital** admissions (90 delivery model to days pre better support compared to 90 seriously ill days post patient/family enrollment) in regardless of their patients physical location participating in the palliative care service by

- 1. Restructuring care-
- 2. Getting Patients and Providers to participate

- Establishing a Care Team
- 2. Determining patient's acuity level
- Development of registry 1.
- Standardization of EMR documentation
- 3. Development of disease specific algorithms
- 4. Developing a system of Patient referral into the service
- 1.Track the number of patients referred who accept enrollment into the service
- 2. Monitor physician referral and specialty
- 1.Create a list of Stakeholders to Engage
- 2. Monitor provider satisfaction
- 3. Monitor physician referral specialty

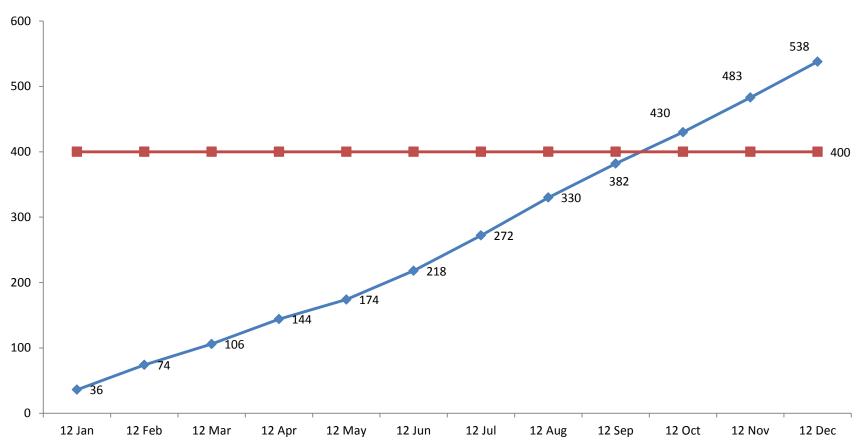
- 3. Having the conversation to obtain the goals of care
- 1.Tracking completion of advance care wishes and goals. 2. Monitor patient satisfaction
- with the program 3monitoring hospice referral rate and length of stay
- 1. Developing process for documentation of goals of care in EMR
- 2. Tracking completion rate of POLST and advance directives

## **METRICS**

OUTCOME
Hospice LOS
Percent of Deaths on Hospice
Reduction in hospital admissions

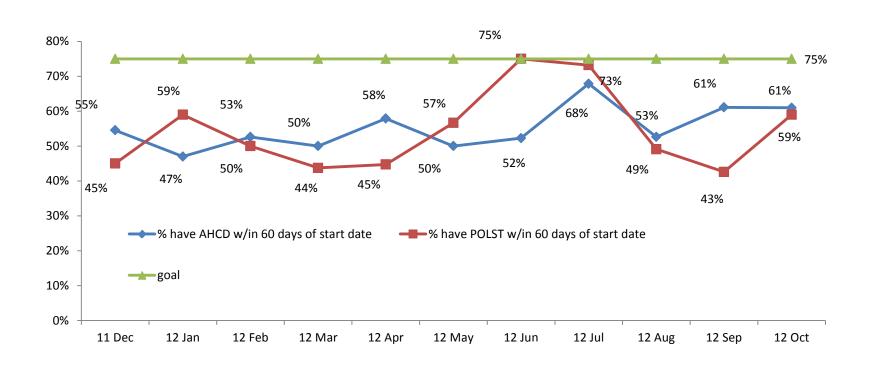
## Process Metric Example

#### MONTHLY CUMULATIVE NEW PATIENT ENROLLMENT FROM JANUARY 2012 for SC & PA



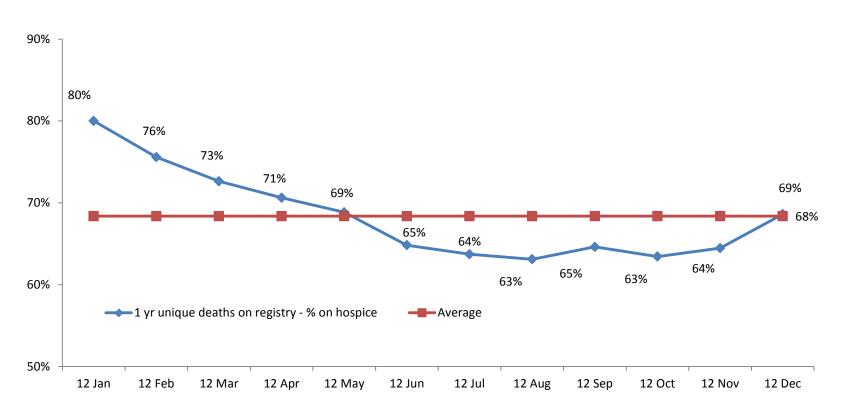
# Process Metric Example

#### COMPLETION OF POLST & AHCD 60 DAYS AFTER START DATE 2012 for SC & PA



# Outcome Metric Example

1 yr Measurement of Deaths on Registry - % on Hospice for SC & PA



# Outcome Metric Example

## Hospital Admission % change SC PC Pre & Post 90 Days by Start Date 12 Month Look Back

