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.
Utopia Vision
Palliative Care Medical Home Model

MD Office
PC Clinic
Cancer/POE
PCP
Specialist

Patient/Family

HOME

Hospice
Home Health

SNF

Hospital

PC Clinic
Cancer/POE
PCP
Specialist
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
AIM and Outcome

Reduce hospital admissions (90 days pre compared to 90 days post enrollment) in patients participating in the palliative care service by 35% By December 2012

Primary Drivers

1. Restructuring care-delivery model to better support seriously ill patient/family regardless of their physical location

2. Getting Patients and Providers to participate

3. Having the conversation to obtain the goals of care

Secondary Drivers

1. Establishing a Care Team
2. Determining patient’s acuity level

1. Track the number of patients referred who accept enrollment into the service
2. Monitor physician referral and specialty

Change

1. Development of registry
2. Standardization of EMR documentation
3. Development of disease specific algorithms
4. Developing a system of Patient referral into the service

1. Create a list of Stakeholders to Engage
2. Monitor provider satisfaction
3. Monitor physician referral specialty

1. Developing process for documentation of goals of care in EMR
2. Tracking completion rate of POLST and advance directives
## METRICS

<table>
<thead>
<tr>
<th>PROCESS</th>
<th>OUTCOME</th>
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<tr>
<td>Patient enrollment</td>
<td>Hospice LOS</td>
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<tr>
<td>Documentation of Goals of Care</td>
<td>Percent of Deaths on Hospice</td>
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<tr>
<td>Completion of POLST and AHCD</td>
<td>Reduction in hospital admissions</td>
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MONTHLY CUMULATIVE NEW PATIENT ENROLLMENT FROM JANUARY 2012 for SC & PA

Process Metric Example
Process Metric Example

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

% have AHCD w/in 60 days of start date
% have POLST w/in 60 days of start date

goal

[Graph showing completion rates over time]
Outcome Metric Example

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

1 yr unique deaths on registry - % on hospice
Red = Average

12 Jan 12 Feb 12 Mar 12 Apr 12 May 12 Jun 12 Jul 12 Aug 12 Sep 12 Oct 12 Nov 12 Dec
Outcome Metric Example

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

- % change
- average % change last 12 mos
- goal

SEP 11  OCT 11  NOV 11  DEC 11  JAN 12  FEB 12  MAR 12  APR 12  MAY 12  JUN 12  JUL 12  AUG 12  SEP 12

-92% -88% -96% -92% -84% -88% -85% -92% -71% -72% -65% -68% -73% -68% -65% -31% -50% -30%