Palliative Care Management

The Pathway to Shared Accountability

Scripps Clinic Medical Group
Division of Geriatrics, Palliative Medicine & Hospice Care

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Scripps Health becoming a Accountable Care Organization

- Our success will depend on multiple strategies
  - Evidence Based Medicine
  - Patient Centered Care across the spectrum
  - Coordination of care
  - Active participation in non-medical domains
  - MAJOR FOCUS: Decrease readmissions
- Solution:
  - Care Management
  - Palliative Care
  - Hospice Care

Care Management

Why are patients Readmitted?

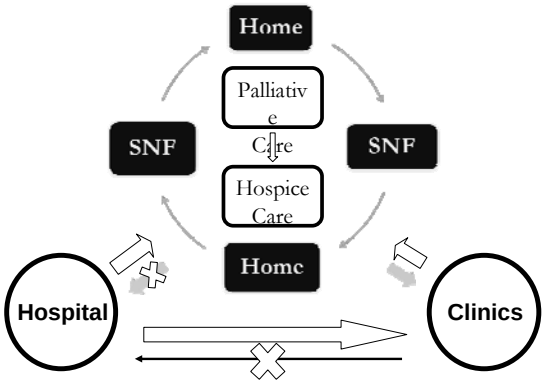
Chronic Disease: Loss of Equilibrium

- Compliance issues
  - Appointments
  - Medications
  - Treatments
  - Diet
- Poor symptom mgmt
- Drug and alcohol abuse
- Lack of nutrition
- Depression
- Dementia Behaviors
- Caregiver inadequacies
- Inappropriate Living situations
- Recurrent falling
- Loss of function
- Expectations don't match realities
- Poor finances
- Premature discharge

Care Track: Individual patient Wikipedia

- Identify risk factors
- Care Plan risk factors
- Implement and Update Care Plan
- All members of the team update the care plan: Social workers, Nurses, Home Health, PCP, Specialists, Rehabilitation therapists
- Real time document available across the continuum of care

Palliative (High) Risk: ↓30 d Readmissions



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Readmissions Bypass to SNF

- Medicare permits post acute patients within 30 days of Acute discharge to be admitted to SNF with Medicare coverage
- Divert readmissions from ED, UCC, and office settings to SUPER SNFs
- Select two SNFs with superb services, respiratory therapy, Subacute units, onsite pharmacy.
- Round daily, 7days per week

Palliative Care: Question 1

- 1. Palliative Care is for patients who are on the organ transplant list.
- 2. Palliative Care is for patients who more likely than not have a expectancy of two years or less.
- 3. Palliative Care is for patients with Stage 4 Cancer undergoing chemotherapy.
- 4. All of the above

Palliative Care

- Palliate is derived from the Latin word, palliatus, which means to cloak or cover. Wraps the patient with support to reduce the burden of illness
- Comprehensive healthcare for patients and their families who are faced with acute or chronic progressive illnesses that are life threatening.
- Palliative care may be offered concurrently with aggressive and life prolonging care or to support end of life management.

Goals of Palliative Care

(High Risk Mgmt)

- Improve Symptom Management
- Improve Quality of Life
- Promote expectations that match reality
- Clarify Goals of Care
- Complete Advance Care Planning

Question 2: Pain control in advanced illness

- What % of you are afraid of dying in pain?
  1. 20%
  2. 40%
  3. 60%
  4. 80%
  5. 100%

Question 3: Depression

- What would cause you to be depressed if you had less than one year to live?
  1. Fear of dying
  2. Fear of dying in pain
  3. Fear of being abandoned my family
  4. Loss of meaning
  5. Loss of hope

Goals of Palliative Care

- Improve Symptom Management
  - Recognize Total Pain
    - Physical: pain, shortness of breath, fatigue,
    - Psychological: anxiety, depression
    - Social: fear of abandonment, being a burden
    - Spiritual: who am I, what becomes of me after death
    - Cultural: special needs
  - Ongoing Effective management
    - Team Approach: Physician, Nursing, Social Worker, Spiritual, and Community

Goals of Palliative Care

- Improve quality of life
  - Guide patients and their families into thoughtful discussion of Quality of Life
    - **What gives their life meaning and value**
    - **What are their hopes and fears**
  - Listen and Learn of their understanding of their illness and prognosis
  - Correct Misunderstandings and Miscommunications
  - Clarify Goals of Care
  - Discuss Viable Treatment options: benefits and risks
  - Enable informed decisions

Goals of Palliative Care

- Improve Quality of Life (continued)
  - Create and revise longitudinal care plans
    - Medical
    - Psychological
    - Social/Family/Community
    - Spiritual
    - Functional
  - As illness progresses, the intensity of palliative care services will also increase
  - Provide continuity of care and seamless follow-up

Question 4: Advance Care Planning

- What % of your patients who have less than two years to live, have you had advance directive discussions
  1. 20%
  2. 40%
  3. 60%
  4. 80%
  5. 100%

Goals of Palliative Care

- Complete Advance Care Planning
  - From understanding of quality of life, and goals of care, formulate Advance Care Planning
    - Discuss the "what ifs"
    - Document treatment wishes
    - Selection of Durable Power of Healthcare

Why do doctors have difficulty coping with dying patients? Question 5

- 1. Believe their job is to save life, not help with dying
- 2. Separation of Science from Spiritual/Emotions
- 3. Feelings that they failed
- 4. Fear of their own death

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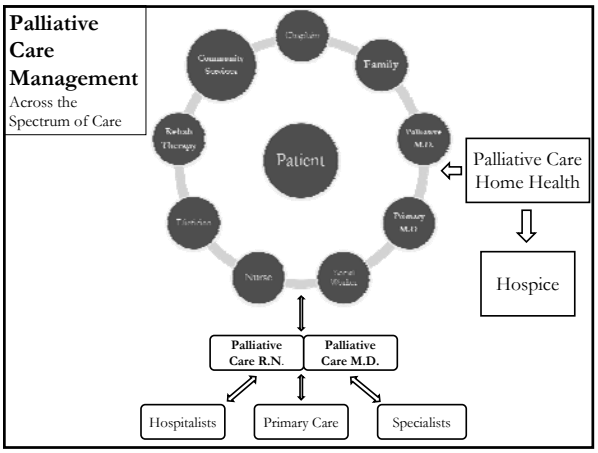
Why does Palliative Care Work?

- Empathetic listening builds trust and bridges of communication so that expectations move to reality
- Looking and helping the Whole Patient and Family
- Disease is not the focus. Patient's Life is the Focus
- Continuity of Care across the continuum
  - Hospital
  - SNF
  - Home
  - Clinics



Screening for Palliative Care

- ***Would you be surprised if this patient died in the next one year?***
- High Risk for Readmissions
  - Factors that cause loss of disease equilibrium
  - Advanced Disease state
- Expectations not matching Reality
- Total Pain Issues clouding Informed Decision Making and Plan of Care
- Need for post acute longitudinal care mgmt

Palliative Care Consultation and Hospital LOS

Journal of Palliative Medicine 2010; 13:761-767

- Analysis of Hospital Based PC programs on LOS
  - Programs have not been shown to reduce LOS
  - Early programs emphasized the ICU, and shortened length of stay by decreasing time to death
  - No programs show shortening LOS for survivors
  - Programs decrease readmissions and future use of ICU services
  - Study designs are problematic

Proactive Palliative Care in the MICU: Effects on LOS for High Risk Patients

Critical Care Med 2007; Vol 35 (6): 1530-1535

- End of Life Talks: Usual PC 14 days v Proactive 1.7 days
- Screening criteria based upon likelihood of death

Screening Criteria	Mortality Rate
Hospital stay > 10 days	54%
Age 80 + 2 ≥ Major Comorbid	55%
Stage IV malignancy	63%
S/P Cardiac Arrest	74%
ICH with Ventilation	54%

Proactive Palliative Care in the MICU: Effects on LOS for High Risk Patients

- Length of stay and Mortality

	Usual PC Care	Proactive PC	Difference
MICU	16.3 days	9.0 days	-7.3
MICU admission to hospital DC	33.9 days	26.7 days	-7.2
Mortality	38.5%	36.5%	Insignificant

- Proactive PC shortened the time to death for those who were inevitably going to die
- Proactive PC facilitated and accelerated Decision Making

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Transitional Care for Heart Failure
JAGS 52:675-684, 2004

- To examine the effectiveness of a transitional care intervention delivered by APNs to elders hospitalized with heart failure
- Risk factors for readmission
  - Complex medication regimens
  - Limited self-management skills
  - 6 Co-morbid conditions
  - EF <35%

Transitional Care for Heart Failure
JAGS 52:675-684, 2004

- RCT with 3-month APN-directed discharge planning and home follow-up
  - Hospital daily visits, face to face with MD
  - Weekly home visits for one month
  - One visit coinciding with the initial MD follow-up
  - Two visits per month for month 2 and 3
  - PRN home visits
  - Telephone availability 7 days per week

Transitional Care for Heart Failure
JAGS 52:675-684, 2004

- Outcomes at 3 months (Intervention 118 v Control 121)
  - Rehospitalization: 20% v 50%
- Outcomes at one year (Intervention 118 v Control 121)
  - Rehospitalization: 45% v 55%
    - Index related 40 v 72
    - Co-morbidity 23 v 52
  - Rehospitalization per patient/year: 1.2 v 1.8
  - Hospital days: 5.0 v 8.0
  - Rehospitalized patients: 11.1 v 14.5 days
  - Total costs: $6,152 v $9,618

Transitional Care for Heart Failure
JAGS 52:675-684, 2004

- Improved Outcomes were due to:
  - Well trained APNs
  - Flexible Protocols
  - Individualized patient care plans
    - CHF
    - Co-morbid conditions
    - Psychosocial issues: Addressing the whole person
  - Same APN case managing and in the home setting
  - Coordinated care
  - Longitudinal Care

Disease Mgmt Program for COPD
Am J Respir Crit Care Med. 2010;182:890-896

- RCT, 1 year study, 5 VA Centers
- Screening: 1 or more ED, Hospital visits in last year, Chronic home O2, use of Systemic steroids
- Intervention:
  - Attended a single 1-1.5 hour education session conducted by RT case manager
  - Individualized written action plan that included refillable prednisone and oral abx
  - Monthly Phone Calls by RT case manager
  - Encouraged to call CM if they took action plan meds or questions
    - 24 hour VA helpline

Disease Mgmt Program for COPD
1 year Outcomes

Outcome	Disease Mgmt	Usual Care
COPD Hospitalization	27.6	39.8
COPD ED	20.8	42.4
COPD ED and Hospital	48.4	82.2
Cardiac or non-COPD Pul	18.3	26.8
Mortality	10.1	13.8
Prednisone usage, mg	1,631	852
Antibiotic courses	4.2	1.6

▼ COPD Hospitalizations and ED visits by 41%

Metastatic Non-Small Cell Lung Ca
NEJM 2010: 363: 733-742

- RCT with newly diagnosed metastatic non-small cell lung cancer, enrolled within 8 w of diagnosis
- Intervention: Palliative care given throughout the continuum of care
  - Meeting within 3 weeks, monthly for three months
    - Management of symptoms
    - Psychosocial support
    - Assistance with Decision Making
- Outcomes at 12 weeks
  - Higher quality of life: ⇧ Intervention, ⇩ Control
  - Less Depression (16% v 38%)

Metastatic Non-Small Cell Lung Ca
NEJM 2010: 363: 733-742

- End of Life: Intervention v Usual Care
  - Longer life span: 11.6 v 8.9 months
    - Improved quality of life
    - Improved mood
  - Aggressive care 33% v 54%
    - Less aggressive care at the end of life didn't adversely affect survival
  - Advance Care Planning: 53% v 28%
  - Hospice Care: 11 days v 4 days

Palliative Care Metrics

- Quality of Life
  - Symptom management
  - Advance Care Planning
  - Patient and family satisfaction
  - Readmissions and Causative Factors
- Financial
  - ▼Readmissions, ED visits
  - ▼ ICU LOS on hospital deaths
  - Timely and Volume of hospice referral

Question 6: Hospice

- What % of you, as physicians, actively continue your relationship with your patient after they are referred to hospice?

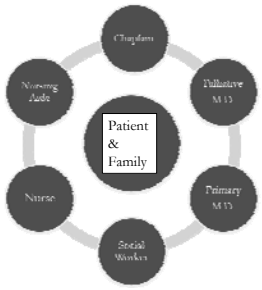
1. 10%
2. 20%
3. 40%
4. 50%
5. 75%

Benefits:
Complete system integration

- Completion of our Mission: Continuity and support at the End of Life
- Profits and Manpower to Educate and Develop our palliative care programs, **in-patient, out-patient**, across the full care spectrum to optimize our shared accountability
- Philanthropy to expand our horizons and visions
- Increase our competitive advantage with Sharp, Kaiser, and UCSD

The Keys to Successful Giving:

- **Preservation** of Continuity of Care
- End of Life Care
  - The Hospice Team
    - Bonding
    - Trust
    - Comforting
  - Bereavement
    - One year



Scripps Hospice

- Currently, Scripps Hospitals refer 1,100/year
- Scripps Green Cancer Center 80/year
- Scripps Home Health ???
- Scripps Physicians ????
- Total > 1,500 per year = Top 4.5% in USA
- Census: 275