COMMUNITY BASED PALLIATIVE CARE:
CREATING A CONTINUUM OF SERVICES

NHPCO’s Creating the Future of Palliative Care: A Virtual Event
February 18-19, 2015
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Hospice & Community Care
Where We’ve Been…

INTERNAL STRUCTURE & OPERATIONS
• Essential elements for success in community-based palliative care
  • Specialist palliative care in community-based programs
  • Trends that may promote program development
  • Outcomes, evaluations, staffing, and sustainability
• Documentation and billing
• Quality and financial metrics
• Legal and regulatory

…and Where We’re Going

IMPLEMENTING & COORDINATING SERVICES
• Continuum of community-based palliative services
  • Communicating between care settings
  • Identifying patients for palliative care referrals/services
  • Resistance from community provider-partners
• Hospice-hospital collaborations
• Hospice-nursing home partnerships
• Telemedicine community-based palliative care
Hospice & Community Care

- **Hospital palliative care**
  - Joint Commission accredited palliative service in a large community-teaching hospital
  - Palliative medicine consultations in other hospitals
    - current negotiations to add disciplines to form teams
- **In-home palliative medicine consultations**
  - Home(bound), nursing home
  - Dementia support, palliative wound care
- **Outpatient palliative services**
  - Episodic *ad hoc* physician visits with colleagues (decreasing)
  - Palliative Medicine clinic, expansion to palliative *care*
  - Embedded physicians in oncology clinic

COMMUNICATION CHALLENGES
Communication between Settings

- Hospitals
  - Location
    - Inpatient, emergency department, other “attached” settings
  - Role in care
    - New consultations
    - Established palliative care patients
- Outpatient
  - Other outpatient practitioners caring for patients
  - Palliative care clinics
- In-home care
  - Private home
  - Nursing homes
  - Home-health agencies

Communication Issues

*Palliative care is not just hospice “upstream.”*

- Goals
- Services
  - Types
  - Expectations
- Availability
  - Patient population
  - Rapidity and frequency of response
- Payment
  - Coverage of services
  - Charity care
Goals

*How do you describe the mission of your program?*

- Do your referral sources think you are offering only “pre-hospice” care?
  - Does your staff think so?
  - Are you?
  - Or are you offering care at “any condition, any stage, any age”?
- Does your staff think they are supposed to encourage patients/families to “stop” aggressive treatments?
  - Do your referral sources use you to do so?
  - Do they *not* use you because you might do so?

Goals

- Is your message consistent with your mission?
  - Printed materials and web sites
  - Staff understanding and ability to explain
- Is your staff ready to provide the care that you describe?
  - Clinical readiness
    - Common disease-directed interventions, expected outcomes, side effects, etc.
    - Pain and symptom management
    - Clinical ambiguity, goals of care, and decision-making
Services

*Which services do you offer...and which do you not?*

- We have discipline-specific services in hospice.
- Referring clinicians may want hospice-like services, regardless of the make-up of your PC team
  - Pain and symptom management
  - Goals of care and care planning
  - Personal care
  - Resources and placement
  - Counseling and support for patients and families
  - Bereavement

*Services*

*Which services are your referral sources expecting?*

- Same services across palliative care settings?
  - Symptom management
  - Goals of care conversations
  - Family meetings
  - Completion of POLST/MOLST order sets
  - Coordination (and coverage?) of other in-home services
    - Medications, medi-sets, O2, DME
Services

Which services are your referral sources expecting?

• Other services
  • Writing prescriptions
  • Home health orders
  • Entries in the medical record—whose?
  • After-hours calls

Availability

Who is your patient population?

• Inpatient, outpatient, nursing home, home
• Willing/accepting of hospitalization
• Children
• Cancer, heart, lung, kidney, dementia, frailty
  • Disease-directed interventions
    • Chemo, LVADs, dialysis, transplant evaluation
• Non-malignant chronic pain?
## Availability

*How quickly do you see palliative care patients?*

- Hospital palliative care subject to bylaws and consultation expectations
- Outpatient may be confused with hospice and home health even if you do not have the same expectations
  - How soon do you see newly referred palliative care patients?
  - Is this different from expectations to see hospice or home health patients? If yes, do your referring clinicians know?
- Emergency visits
  - Home, ED, inpatient

## Availability

*How often do you see palliative care patients?*

- Routine visits
  - Determined how and by whom
  - Are you taking on a primary care role?
- Acute visits
  - Called in by whom—to whom
  - Triaged how
  - Capacity to add these visits
    - How quickly
    - Which team members
    - Prevent hospitalization?
IDENTIFYING PATIENTS FOR PALLIATIVE CARE SERVICES

Methods of Identifying Patients

- Consultation-based
- Checklist/trigger-based
- Not mutually exclusive
Consultation-based Referrals

• Educate referring clinicians about your services
  • What you offer
  • Who can benefit
  • Value added
  • Expected outcomes
  • How to refer
• Maintain collegial relationships
• Deliver the promised product and quality
• Incorporate feedback from referring clinicians to enhance services

Consultation-based Referrals

• Feels familiar
  • Similar to hospice education and marketing
• Does not require a partner to develop or implement
• Flexibility for a variety of referrals
  • Meet the different needs of patients, families, and referring clinicians
  • Though lack of structure may create lack of focus and lead to backtracking later
• Can be blended with checklists that describe patients likely to benefit from palliative care
Checklist/trigger-based Referrals

- Published checklists available
  - Different settings & diagnoses
- Can work with partners to develop/adopt/adapt
  - Requires partner to implement as actual triggers
- Can be guidance or generate automatic referrals, depending on the environment and the influence of the partner
  - Make it easier to connect palliative services with those likely to benefit
  - Could overwhelm resources if well-accepted before staffing is ready
  - Don’t want to alienate referring clinicians

Checklist/trigger-based Referrals

- Still need to educate colleagues about your services
  - What you offer
  - Who can benefit
  - Value added
  - Expected outcomes
  - How to refer
- Maintain collegial relationships
- Deliver the promised product and quality
- Incorporate feedback
ENGAGING COMMUNITY PARTNERS

Strategies

Inform
• The data…
  • the guidelines …
    • and (of course) the money

Invite
• Join our team
• How can we help?
• Try it—you’ll like it!
• Could I walk with you?
  • Clinical team and care management rounds
(Some of) The Data


(Some of) The Data


## Guidelines: Cancer


## Guidelines: Cancer


Guidelines: Heart and Lung


“Show me the money!”


“Show me the money!”


“Show me the money!”


Teamwork

- *We need your help. Will you join our team?*
  - Implementation

- *What do you need?*
  - Meeting the needs of patient, families, and referring clinicians

- *Try it—you’ll like it!*
  - What went well? What could be better?

- Clinical team and care management rounds
  - Becoming part of the group that sees “your” patients.