The Palliative Home Care Program: Our Agency’s Experience

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SOMC Home Health Services

• First Hospital-Based Agency in OH
• Medicare-certified in 1966
• Serve three counties
• Currently opening a new office in KY
• Expanding into two additional counties in OH
• JCAHO – Accredited
• Offer traditional Medicare – certified home health services
### Why Palliative Care?

**• Definition:**
The care of patients with progressive disease

**The Goal:** Relief of suffering
- Pain and symptom management
- Advance care planning
- Improved care coordination

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### Why Palliative Care?

- Most people die now from advanced chronic illness
- 70% of Americans prefer to die at home
  **BUT**
- Three of four people still die in a hospital or skilled nursing facility
Why Palliative Care?

- Medicare expenditures in the last two years of life
  Average cost/beneficiary $46,412 (2001-2005),
- Avoidable, costly and debilitating hospital stays

1 Center for Home Care Policy and Research 2009

Why Palliative Care?

- Dr. JoAnne Lynn

2 Lynn, JoAnne (2001) JAMA 285(7); 925-932
Why Palliative Care?

- Dr. JoAnne Lynn (2001)

![Organ System Failure Trajectory](image)

Why Palliative Care?

- Dr. JoAnn Lynn (2001)

![Dementia/Frailty Trajectory](image)
Why Palliative Care?

• Recognized need for symptom control and coordination of care for patients with advanced chronic disease
• Designed for patients who are not yet ready for Hospice
• Provides specialized Home Health Services

Program Structure

• Patients qualify for skilled intermittent home health services
  - Medicare COP’s
  - OASIS, HH-CAHPS
  - Homebound
  - Skilled Care Need
  - Under the care of a physician
### Components of the Program

**“A Home Health Program with a Hospice Philosophy”**
- Patients are educated regarding treatment options
- Transition of treatment options
- Ongoing Advance Care Planning/End of Life Discussions

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### Components of the Program

- Patients may pursue “curative” treatment e.g. chemotherapy, radiation, aggressive antibiotic therapy and diagnostics
- May have a prognosis of greater than 6 months
- May choose palliative care but not Hospice care
Components of the Program

- RN Case Manager
  - Caseload approx. 20 patients
  - Productivity Standard 3 visits/day
  - **Important concept - Continuity of caregiver
- Pain & symptom management protocol

Components of the Program

- Chaplain, bereavement and volunteer disciplines are unique to the Hospice benefit and are not offered services
- Access to Hospice expertise for pain and symptom management
- PC/Hospice staff comprise the IDT which meets monthly
### Common Diagnoses

<table>
<thead>
<tr>
<th>All cancer dx’s</th>
<th>Neuromuscular Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>End Stage Renal Disease</td>
<td>End Stage Pulmonary Disease</td>
</tr>
<tr>
<td>End Stage Heart Disease</td>
<td>HIV</td>
</tr>
<tr>
<td>Advanced liver disease</td>
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### Components of the Program

- 24/7 Availability through Home Care On-Call mechanism
- Education for Skilled Intermittent Staff:
  - Pain & symptom management
  - Advance directives
  - Difficult discussions
## Palliative Care Practitioner Program

- Our newest Palliative Care service
- Palliative care-certified nurse practitioners
- Inpatient consultation – SOMC Main Campus
- Outpatient Palliative Care House Calls-
  Provided wherever the patient calls home:
  - Residence
  - Skilled Nursing Facility
  - Assisted Living

## Educating Other Members of the Health Care Team

- Physicians
- Discharge Planners
- Nurses
- Cancer Center

Palliative Care is NOT Hospice and it is NOT “Hospice Lite”
### Outcomes

#### FY '11

**Top DX’s:**

- Patients Served: 47  
- Visits: 1190  
- Visits/Patient 25.3  
- Transition to Hospice: 79%  

#### FY 2012

**Top DX’s:**

- Patients Served 196  
- ALOS 106 days  
- 14 visits/patient  
- Transition to Hospice: 52%
Outcomes

- FY 2013
  - Patients Served 112
  - ALOS 192 days
  - Visits/patient 20
  - Transition to Hospice: 43%

Top DX’s
- Subendocardial Infarct (410.72)
- Lung CA
- CHF

Challenges

- Communication
- Turnover – New staff in HH, Hospice, Hospital Discharge Planners, Cancer Center
- Ongoing education
- Home Care nurses’ discomfort On-Call
- Transitions
Case Management/Team Structure

Palliative Care

Patient- Centered Approach

Home Care Case Management
- Palliative Care CM
- Smaller case load
- Extended service area
- Attend office visits
- Facilitate family meeting visits – hospital & home

Hospice Philosophy & Support
- Knowledge of Hospice care
- Use Pain/Symptom Management protocol
- Initial intake per Hospice
- Hospice Social Worker covers patients

The Case for Bob

Demographics:
- 78 y/o Congestive heart failure, Diabetes, Hypertension, Chronic Renal Failure
- Spouse Hospice patient (former PC patient)
- EF decreased from 30% to 15% since admission
- Only 1 hospitalization
- Utilized Telehealth daily
- Multiple exacerbations, medication changes and education needs
- Able to attend multiple Dr. appointments
- Obtained standing orders for lab/increased diuretics
- Length of stay = 160 days
The Case for Bob

- Declined DNRC
- Until after Dyspnea Episode ED Visit w/o Admission
- EF Declined to 15%
- Recognized Decline & Agreed to Hospice Care
- Passed Peacefully At Home 5 Days after Hospice Admission

CHF Management

- Due to non-reimbursement if readmission in 30 days, PC provides CHF patients with:
  - Aggressive education and frequent visits
  - Better continuity due to smaller case loads
  - Frequent communication with their physician
  - Telehealth monitoring (includes weight, BP, et pulse oximetry) for chronic intervention and management of disease
  - Encouragement of SNV before ED if non-emergent
  - 24 hour on-call service per Home Care staff
- Physicians more willing to give standing lab/diuretic orders based on assessment.
The Case for Angie

Demographics:
- 34 y/o married mother of 3, diagnosed with cervical cancer in 2009
- Metastasis to lymphatic system, bilateral pleura, et pericardium
- Multiple chemotherapy attempts at The James Cancer Center OSU, Cancer Treatment Centers of America in Chicago, and lastly with local oncologist
- Referral made for pain/symptom management and disease process teaching
- Utilized IV pain control per CADD pump
- Length of stay = 56 days

The Case for Angie

Palliative Performance Scale (PPS) 60%1
Upon Admission

MSW Involved for Advanced Directives
Remained Full Code

Significant Decline in Activity
Increased Dyspnea & Pain

The Case for Angie

Oral Pan Meds Ineffective
Oncologist Agreed to Dilaudid Pain Control

Initiated Oxygen Continuously
3L per NC with Albuterol Nebulizer Q2

Palliative Performance Scale 40%
Within 30 Days of Episode

Within 30 Days of Episode

The Case for Angie

Received Two Treatments Chemotherapy

Thoracentesis Performed for Pleural Effusions
Minimal Effectiveness

Increased Ativan
For Increased Dyspnea

Pain Control Increased
Dilaudid to 6mg/hr
The Case for Angie

- Oxygen Saturation Decreased to 84%
- Continued Education on Disease Progression
- Transferred to Hospital 2 Days After last HC Visit
- Continued Daily Visits Last 16 days of PC in Hospital

The Case for Angie

- Palliative Performance Scale 20%
- Physician Called PC to Explain DNRCC & Hospice
- Transferred to Inpatient Hospice Center With PC Case Manager
- Hospice Admitted at Center Remained until Death 24 hours Later
Summary

• Our Palliative Care program has been the vision of both Homecare & Hospice leaders and Administration.
• Ultimately, we have the ability to provide Excellent Patient-Centered care with a genuine team approach.

Palliative Care offers a Home Care program with a Hospice philosophy

Any Questions?

Safety ♦ Quality ♦ Service ♦ Relationships ♦ Performance