Hospice & Palliative Care Network of Maryland
ANNUAL CONFERENCE
Wednesday, November 16

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Eric Bush, MD, RPh, MBA
Kathryn A. Walker, PharmD, BCPS, CPE

Community-Based Palliative Care: A Unique Certification for Home Health and Hospice Providers
Objectives

• Describe three different models of a community-based palliative care program
• Review funding sources for community-based palliative programs
• Discuss operational barriers and solutions as they apply to the launching and sustaining of a community-based palliative care program
Session Outline

• Orientation – Dr. Baker
• Residential Care Settings – Dr. Bush
• Telemedicine – Dr. Walker
• Home and Office Settings – Dr. Baker
• Questions and Discussion
Dr. Baker

ORIENTATION
Palliative Care

• Palliative Care – from the Latin “palliare” or “to cloak” – focuses on relieving or preventing suffering related to serious, complex, life-limiting, or life-threatening diseases that affect quality of life or functional ability.
Palliative Care

According to the World Health Organization, Palliative Care is “An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.”
Palliative Care

• Medical Specialty recognized by Medicare Part B
  • Available for any stage of any illness, even while undergoing curative treatment
  • Provides effective management of patients with debilitating chronic disease and life-threatening illness, even if the disease is not terminal
  • Symptomatic treatment of pain and distressing symptoms, managing patient stress
  • Provides for Health care provider/patient/family communication
  • Provides for education and support of staff, patients, and families, facilitating goal setting and life planning
Palliative Care

**Alleviating pain and suffering** for people with serious or life-threatening illnesses

- Can be provided at any stage of the illness
  - Patients do not have to meet Hospice criterion of being terminally ill

- Can happen anywhere:
  - Hospital
  - Residential Care (Nursing Home, Assisted Living)
  - Outpatient (Home, Office)
  - Telemedicine
Promotes quality of life
Treats the whole person
Supports the family
Is an “extra layer of support” for all

Community Hospital of the Monterey Peninsula
Dr. Bush

RESIDENTIAL CARE SETTINGS
Palliative Care for Skilled Nursing Facilities

Eric Bush MD,RPh,MBA
Chief Medical Officer-Hospice of the Chesapeake & Chesapeake Palliative Medicine
“Well, here we go again. ... Did anyone here not eat his or her homework on the way to school?”
Global Budgeting Reimbursement

- Global Budget Revenue ("GBR") methodology is central to achieving the three part aim set forth in the All-Payer Model of promoting better care, better health, and lower cost for all Maryland patients. In contrast to the previous Medicare waiver that focused on controlling increases in Medicare inpatient payments per case, the new All-Payer Model focuses on controlling increases in total hospital revenue per capita. GBR methodology is an extension of TPR methodology, which encourages hospitals to focus on population-based health management by prospectively establishing a fixed annual revenue cap for each GBR hospital.
Maryland Hospital Preventable Re-Admissions (MHPR)

- Hospital readmissions are sometimes indicators of poor care or missed opportunities to better coordinate care. Research shows that specific hospital-based initiatives to improve communication with beneficiaries and their other caregivers, coordinate care after discharge, and improve the quality of care during the initial admission can avert many readmissions.

- For Medicare, readmissions contribute significantly to that cost of care as 18% of all Medicare patients discharged from the hospital have a readmission within 30 days of discharge, accounting for $15 billion in spending nationally (Medpac 2007).
Rationale

While not all of readmissions are avoidable, many clearly are. For the MHPR proposed initiative, HSCRC is using the Potentially Preventable Readmissions (PPR) methodology developed by 3M Health Information Systems which defines readmissions as return hospitalizations that may result from deficiencies in the process of care and treatment (readmission for a surgical wound infection) or lack of post discharge follow-up (prescription not filled) rather than unrelated events that occur post discharge (broken leg due to trauma).
In Maryland, based on analysis of 2007 readmission data using the PPR methodology:

- The top performing hospitals had risk/severity adjusted 15-day rates of readmission just below 4%.
- The bottom performing hospitals had risk/severity adjusted 15-day rates of readmission just above 8%.
- The 15-day readmission rate was 6.74%.
- The 30-day readmission rate was 9.81%.
- For readmission in 15 days, there were $430.4 million (5.3%) estimated associated charges.
- For readmissions in 30 days there were $656.9 million (8.0%) estimated associated charges.
## Top 10 Medical APR DRGs for Frequency of PPRs, by SOI (Florida 2005-2006)

<table>
<thead>
<tr>
<th>Medical APR DRG</th>
<th>All Pts</th>
<th>SOI 1</th>
<th>SOI 2</th>
<th>SOI 3</th>
<th>SOI 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chains</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>194 Heart Failure</td>
<td>15,053</td>
<td>1,304</td>
<td>8,151</td>
<td>4,675</td>
<td>923</td>
</tr>
<tr>
<td>Rate</td>
<td>12.5</td>
<td>8.9</td>
<td>11.7</td>
<td>15.0</td>
<td>19.4</td>
</tr>
<tr>
<td>140 Chronic Obstructive Lung Disease</td>
<td>8,271</td>
<td>1,737</td>
<td>3,745</td>
<td>2,416</td>
<td>373</td>
</tr>
<tr>
<td>Rate</td>
<td>9.7</td>
<td>7.3</td>
<td>9.3</td>
<td>12.7</td>
<td>17.3</td>
</tr>
<tr>
<td>750 Schizophrenia</td>
<td>7,592</td>
<td>3,382</td>
<td>3,931</td>
<td>251</td>
<td>28</td>
</tr>
<tr>
<td>Rate</td>
<td>17.7</td>
<td>17.1</td>
<td>18.1</td>
<td>20.8</td>
<td>16.8</td>
</tr>
<tr>
<td>139 Other Pneumonia</td>
<td>7,579</td>
<td>393</td>
<td>3,295</td>
<td>3,394</td>
<td>497</td>
</tr>
<tr>
<td>Rate</td>
<td>7.7</td>
<td>2.7</td>
<td>6.5</td>
<td>11.4</td>
<td>16.4</td>
</tr>
<tr>
<td>751 Major Depressive Disorder</td>
<td>5,608</td>
<td>1,814</td>
<td>3,391</td>
<td>339</td>
<td>64</td>
</tr>
<tr>
<td>Rate</td>
<td>10.9</td>
<td>8.3</td>
<td>12.6</td>
<td>16.5</td>
<td>10.8</td>
</tr>
<tr>
<td>198 Angina Pectoris &amp; Coronary Atherosclerosis</td>
<td>5,151</td>
<td>1,414</td>
<td>2,685</td>
<td>982</td>
<td>70</td>
</tr>
<tr>
<td>Rate</td>
<td>5.6</td>
<td>3.7</td>
<td>6.2</td>
<td>9.9</td>
<td>17.3</td>
</tr>
<tr>
<td>753 Bipolar Disorders</td>
<td>4,830</td>
<td>2,366</td>
<td>2,260</td>
<td>179</td>
<td>25</td>
</tr>
<tr>
<td>Rate</td>
<td>14.0</td>
<td>12.7</td>
<td>15.3</td>
<td>18.8</td>
<td>11.6</td>
</tr>
<tr>
<td>720 Septicemia &amp; Disseminated Infection</td>
<td>4,370</td>
<td>46</td>
<td>881</td>
<td>1,808</td>
<td>1,635</td>
</tr>
<tr>
<td>Rate</td>
<td>12.6</td>
<td>3.6</td>
<td>8.3</td>
<td>12.7</td>
<td>19.3</td>
</tr>
<tr>
<td>460 Renal Failure</td>
<td>4,288</td>
<td>92</td>
<td>471</td>
<td>3,250</td>
<td>475</td>
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<tr>
<td>Rate</td>
<td>12.8</td>
<td>11.0</td>
<td>10.6</td>
<td>12.5</td>
<td>21.1</td>
</tr>
<tr>
<td>201 Card Arrhythmia &amp; Conduction Disturbance</td>
<td>4,066</td>
<td>898</td>
<td>1,950</td>
<td>1,070</td>
<td>148</td>
</tr>
<tr>
<td>Rate</td>
<td>6.3</td>
<td>4.0</td>
<td>6.4</td>
<td>10.2</td>
<td>16.0</td>
</tr>
<tr>
<td><strong>All Other Medical APR DRGs</strong></td>
<td>41,412</td>
<td>8,036</td>
<td>15,942</td>
<td>13,011</td>
<td>4,423</td>
</tr>
<tr>
<td>Rate</td>
<td>2.9</td>
<td>1.7</td>
<td>2.5</td>
<td>5.0</td>
<td>9.4</td>
</tr>
<tr>
<td><strong>Total Medical APR-DRG</strong></td>
<td>108,220</td>
<td>21,482</td>
<td>46,702</td>
<td>31,375</td>
<td>8,661</td>
</tr>
<tr>
<td>Rate</td>
<td>5.0</td>
<td>3.2</td>
<td>4.7</td>
<td>7.4</td>
<td>11.7</td>
</tr>
</tbody>
</table>
Patient/Family Centered Care

In essence, the residents of nursing homes want to have a fulfilled life according to their definition of such a life. Researcher Joanne Lynn noted that there are seven promises that patients and families want from their health care providers:

- Medical treatment that is appropriate and evidence based
- No overwhelming symptoms
- Continuity of comprehensive care
- Planning ahead for complications and death
- Care customized to their preferences
- Care adapted to serve the patient’s family
- Help to live as fully as possible

A comprehensive palliative care & hospice program within the nursing home setting would allow clinicians to fulfill these promises to their residents and families, thus improving the satisfaction for the resident and care provider.
Maryland Palliative Care

• In 2013, the Maryland legislature passed, and the governor signed into law, House Bill 581. This law requires that by 2016, Maryland hospitals with 50 or more beds have an accredited palliative care (PC) program, and all hospitals provide access to information and counseling regarding PC services appropriate to a patient with a serious illness or condition.

• Randomized trials have shown that for patients facing serious illnesses, early integration of PC (concurrent with standard and disease-focused care) is associated with equivalent or improved survival, decreased symptom burden, enhanced satisfaction with treatment experience, better symptom management, and improved quality of life for caregivers.

• Furthermore, for patients with life-threatening illnesses (e.g., cancer, chronic obstructive pulmonary disease, stroke), early receipt of PC resulted in fewer hospital days and average health care costs roughly $4800 to $7500 less than patients receiving standard care alone.

• Despite the benefits of timely receipt of PC, evidence suggests that it remains underused. Potential clinical barriers include physician attitudes, avoidance of palliative and end-of-life discussions until all treatment options have been exhausted, and a lack of knowledge by providers about the types of services available through PC, patient eligibility, & best time to initiate referrals.
Table 3
Plan for PC Program Expansion and Providers’ Views on Barriers to and Opportunities for Enhancing PC

<table>
<thead>
<tr>
<th>PC Program Characteristic, Barriers, or Useful Supports</th>
<th>Total n (%) of 25 Responding Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>PC services institution planning to add or expand over next three years</td>
<td></td>
</tr>
<tr>
<td>No. of PC physicians, nurses, and/or physician assistants</td>
<td>16 (64)</td>
</tr>
<tr>
<td>Educational opportunities, training, or professional development in PC for employees</td>
<td>14 (56)</td>
</tr>
<tr>
<td>PC funding and/or budget</td>
<td>12 (48)</td>
</tr>
<tr>
<td>No. of other members of the PC team (social worker, chaplain, etc.)</td>
<td>11 (44)</td>
</tr>
<tr>
<td>Establish a PC program (if a program does not currently exist)</td>
<td>3 (12)</td>
</tr>
<tr>
<td>Number of PC acute beds</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Challenges to providing PC at institution</td>
<td></td>
</tr>
<tr>
<td>Patients and/or families are not knowledgeable about PC</td>
<td>17 (68)</td>
</tr>
<tr>
<td>Lack of buy-in from physicians</td>
<td>14 (56)</td>
</tr>
<tr>
<td>Limited budget for PC services</td>
<td>13 (52)</td>
</tr>
<tr>
<td>Lack of adequately trained PC physicians, nurses, clinical social workers, others</td>
<td>11 (44)</td>
</tr>
<tr>
<td>Poor reimbursement for PC services</td>
<td>11 (44)</td>
</tr>
<tr>
<td>Patients and/or families are knowledgeable but not interested in PC</td>
<td>5 (20)</td>
</tr>
<tr>
<td>Lack of buy-in from institution leadership</td>
<td>4 (16)</td>
</tr>
<tr>
<td>PC is available at my institution, but there are few referrals</td>
<td>3 (12)</td>
</tr>
<tr>
<td>PC training opportunities for existing team members are not readily available</td>
<td>3 (12)</td>
</tr>
<tr>
<td>Concern that PC may increase hospital mortality</td>
<td>2 (8)</td>
</tr>
<tr>
<td>Limited PC needs in my institution</td>
<td>2 (8)</td>
</tr>
<tr>
<td>Lack of evidence to suggest PC improves patient outcomes</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Helpful PC supports for institution</td>
<td></td>
</tr>
<tr>
<td>Best practice sharing from other programs/hospitals</td>
<td>16 (64)</td>
</tr>
<tr>
<td>Conference on PC best practices</td>
<td>15 (60)</td>
</tr>
<tr>
<td>Participation in a network of other PC professionals</td>
<td>15 (60)</td>
</tr>
<tr>
<td>Reimbursement/billing guidance</td>
<td>12 (48)</td>
</tr>
<tr>
<td>Mentor/consultation from other programs/hospitals</td>
<td>6 (24)</td>
</tr>
<tr>
<td>Training of clinical team</td>
<td>6 (24)</td>
</tr>
<tr>
<td>Technical assistance in the development of PC programs</td>
<td>5 (20)</td>
</tr>
</tbody>
</table>

PC = palliative care.

*aStatistically significant difference (*P* < 0.05) in the percentage of hospitals describing this as a challenge or useful support by hospital size (comparing hospitals with 250 or fewer beds, to those with more, Fisher’s exact test).
Facility Based Pall Care

- Protocols
- Timeliness
- Relationships
- Supports hospice utilization
- Supports SNF/ALF-enhances quality, reduces re-admissions
- Volume accounts for >10% of integrated pall care program
Googling your symptoms when you don’t feel well is the most efficient way to convince yourself you’re dying.
Office of Health Care Quality
Grant
Evaluating Maryland MOLST
Order Form
Results from Hospitals, Nursing Homes, Assisted Living Facilities
January 16, 2016
Prepared by:
Anita J. Tarzian, PhD, RN, Program Coordinator
The Maryland Healthcare Ethics Committee Network (MHECN)
UM Carey School of Law, Baltimore, MD
The project was designed to answer the following questions:

- What is the rate of hospital compliance with the MOLST-on-discharge obligation?
- For MOLST orders written on hospital discharge, what percentage go beyond page 1?
- Is there evidence of some process underlying completion of the MOLST form?
- What is the MOLST form completion error rate?
- How often is each MOLST order section completed and with what orders?
- Who (RN, SW, MD) is discussing MOLST with whom (patient, surrogate, etc.)?
- Are methods to track the active MOLST form effective when there are multiple forms?
- What educational interventions and training materials has the facility employed, and for whom?
- Is completion of the MOLST form complementing or replacing advance directive completion?
- What is the rate of compliance with reviewing/revising the MOLST form?
Most hospital staff (82%), ALF staff (75%), and hospice staff (89.5%) have reportedly been trained on MOLST. While the percentage of NH staff trained on MOLST (41%) is lower, designated social workers are more commonly involved with facilitating MOLST completion in NHs. Therefore, MOLST training may be appropriately targeted toward a smaller percentage of NH staff.

A majority of hospital patients discharged to a MOLST-qualifying facility (86%) had a MOLST form on discharge; 47.5% had a MOLST form on hospital admission.

Most long-term care residents had an active MOLST form (95% NH & 79% ALF).

A majority of MOLST forms for long-term care residents (74% NH, 71% ALF) and hospice patients (69%) included orders on page 2.

For 65% of NH residents, 67% of hospice patients, and 94% of dialysis center patients, there was some documentation in the medical record of what informed the MOLST completion.
## Impact of AD on Hospice Use

<table>
<thead>
<tr>
<th></th>
<th># pts</th>
<th>% Hospice Use</th>
<th>LOS</th>
<th>FMH IP</th>
<th>KHH</th>
<th>Home</th>
<th>SNF/AL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case: with AD</strong></td>
<td>108</td>
<td>23%</td>
<td>43d</td>
<td>7 (29%)</td>
<td>3 (12.5%)</td>
<td>4 (16.5%)</td>
<td>10 (42%)</td>
</tr>
<tr>
<td><strong>Control: no AD</strong></td>
<td>99</td>
<td>14%</td>
<td>14d</td>
<td>6 (43%)</td>
<td>3 (21.5%)</td>
<td>3 (21.5%)</td>
<td>2 (14%)</td>
</tr>
</tbody>
</table>
Macro Plan for Success

- Optimal chance for success is placing the patient/family at center of care and truly working together
- Alignment of incentives for all
- Changing culture
- Standardization
- Allocation/re-allocation of resources that optimizes patient care
- Customize allocation of scant pall care resources to serve partners/patients best
- Coordination of care w/Hospice Business Development
Micro plan for success

- Pall care screening tool
- Order sets
- Facility input-MD vs NP vs RN/SW/Chaplain
- Pooled resources
- DPOA advocacy
- DNH enforcement
Most ROI

- AD
- MOLST-attention to page 2(DNH,preferences)
- DPOA
Lower ROI

- Increased pall care personnel
- Reallocation of pall care personnel
Dr. Walker

TELEMEDICINE
PATCH (Palliative Telehealth Connecting Hospital to Home) Program

Kathryn Walker, PharmD
Senior Clinical and Scientific Director
MedStar Palliative Medicine Service
Background

• Current Palliative Care discharge strategy

'This is the discharge nurse, she'll be able to tell you about all the services you aren't able to get any more when you leave.
PaTCH² Program
Palliative Telehealth
Connecting Hospital to Home
Purpose

• To improve access to palliative care for patients with advanced CHF and COPD
• To provide safer, more effective medication management
• Supports GOC discussions
• Provide education
• Support high levels of patient self efficacy and quality of life
PaTCH² Basics

Hospital PC Consultation
- PC Team x4
- Family Meeting
- Tablet teaching

Discharge to home
- Clinical social worker
- Clinical pharmacist

Other Providers: Cardiologist, PCP, Home Health

Knowledge and Compassion Focused on You

MedStar Health
Who are appropriate patients?

• **Inclusion**
  – Patient has advanced CHF (stage C or D)
  – Palliative care consultation ordered by attending physician in the hospital
  – Planned for discharged to home and eligible for home health services
  – Self-report (or family, caregiver, surrogate) of patient’s current symptoms
  – Over the age of 18

• **Exclusion**
  – Patient, family, caregiver and surrogate non-English speaking
Care Tablet:

1. Wireless access
2. Videoconferencing with patient/family
3. Accurate and updated medication list
4. Education resources
5. Messaging capability to palliative team
6. In our dreams… Video of family meeting from inpatient consultation
Videoconferencing
Meet Ms. Leila

• Consulted in her 7\textsuperscript{th} admission in 6 months
• PMH: UC, DMT2, asthma, pulmonary hypertension, paroxysmal atrial fibrillation, hyperthyroidism, h/o TIA, CHF (left sided and right sided), depression
• In hospital: c/o severe constant abdominal pain related to UC + pain in BL lower extremity due to diabetic neuropathy + pain in BL hands due to hx of carpal tunnel surgery.
  – She rates her pain as 10/10 now and 8/10 at best. In the hospital, she tolerated 2mg IV dilaudid prn, but was using 2 mg dilaudid tablets at home.
  – She lives alone but has two children and several siblings that are supportive
### Daily Medications:
- Amlodipine 10 mg daily
- Azathioprine 50 mg twice a day
- Advair Diskus 500/50 2 puffs twice a day
- Azulfidine 5 mg a day
- Bentyl as needed 3 times a day
- Cholestryramine 1 packet daily
- Clonidine 0.3 mg, given 3 times a day
- Fentanyl Patch 50 mcg/hr TD every 3 days (last placed 2/4, plans to change 2/7)
- Lasix 20 mg p.o. q. daily
- Neurontin 100 mg 2 times a day
- Hydralazine 100 mg 3 times a day
- Insulin glargine, 30 units once a day
- Iron sulfate once a day
- Losartan 100 mg a day
- Lispro 10 units with meals
- Methimazole 5 mg a day
- Multivitamin daily
- Prednisone 10 mg a day (now taking 30 mg daily and planning to continue taper as written on Rx bottle: next decrease tomorrow to 20 mg)
- Metoprolol XR 15 mg daily
- Pravastatin 40 mg a day
- Sertraline 100 mg a day
- Spironolactone 25 mg a day
- Symbicort 160 two puffs twice a day

### As Needed Medications:
- Albuterol nebs q4h prn
- Nitroglycerin SL prn
- Dilaudid 2-4 mg every 4 hours
- Mesalamine 4 mg enema as needed
- Zofran as needed
Out she goes!

- Severe anxiety over meds, tablet, leaving
- Endocrine vs PCP vs Cardiologist plan
Tell us how you've been since you left yesterday…

How much insulin did you take last night? 30 units
Great! How many did you take with breakfast this am? 20 units!
Ok, let's review the plan again…
“Getting It”

She “got it”

- Comfort level with the tablet and excitement over visits
  - “don’t leave me”
  - “I feel so lucky to have you at my fingertips”
  - “I love you”
- Easier than getting to clinic
- Less anxiety

We “got it”

- “I saw the clock move on the wall… it was the future of medicine”
- Efficient care
- We could keep relationship going and prevent problems
<table>
<thead>
<tr>
<th>Day</th>
<th>Problem</th>
<th>PaTCH(^2) Resolution</th>
</tr>
</thead>
</table>
| 0   | • Discharged on steroid taper and insulin taper but they did not match  
• Only PRN opioids but constant pain, pt resistant to try long acting opioid | • PharmD coordinated with PCP and endocrine to correct insulin/prednisone doses  
• PharmD rec fentanyl patch and pt agreed to place on while at home and on camera |
| 1   | • Pt took too much insulin (20u vs 10 u)  
• Meds delivered but no nebulizer | • PharmD reviewed plan with pt  
• Contacted PCP about nebulizer |
| 5   | • Pt refused MVNA nurse visit because he was male | • PharmD contacted MVNA |
| 6   | • Pt in severe pain, was not using dilaudid prn (fear of overdose)  
• Pt had 1 pill left of dilaudid | • CRC had PharmD call patient to address pain, and encourage us of prn opioid  
• Notified PCP, wrote dilaudid Rx; CRC picked up Rx and delivered it to pt’s home |
| 11  | • Pt received nebulizer (1.5 weeks after discharge), but did not know how to set it up | • CRC set up nebulizer for patient under direction of PharmD (also educated patient) |
| 18  | • Pt ran out of prednisone, and almost out of 2 other meds (amlodipine/ methimazole)  
• Pharmacy said they couldn’t fill them due to insurance issues | • PharmD d/w pharmacy and PCP to get a refill on all 3 meds and transfer Rx  
• CRC coordinated Rx delivery the next day |
Program Status

• 72 patients served by PATCH program
  – 11 LVAD patients
  – Discharges from program:
    • 10 patients died while in PATCH
      – 6/10 lived longer than 6 months
      – 4 went to hospice
Patient Safety Events Prevented in First 60 Days (n=44 patients)

- 46% A/B: no harm, or would not reach patient
- 29% C: would have reached patient but no harm
- 19% D: would have reached patient without harm, but required monitoring/intervention
- 6% >E: would have reached patient and likely caused harm requiring intervention

n=83 interventions
Readmission Data

Impact on Hospital Utilization (n=29 patients)

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Pre-Enrollment</th>
<th>Post-Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>13</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ED</th>
<th>Pre-Enrollment</th>
<th>Post-Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4.5</td>
<td>4</td>
</tr>
</tbody>
</table>
Lessons Learned (so far)

• Technology: easy concept in real life proves difficult in medical world
• Value of “face-time” in building trust
• The importance of language
• Unanticipated concerns:
  – Patients: $, fear of technology
  – PC Team: workload, scheduling
  – Primary team: “it’s not PC”
• The importance of the connection back to the hospital
• Challenge of making the home health connection
• Tablet retrieval/ end date?
Future Directions

• Expansion to system-staffing (adding NP role as clinical lead)
• Extend funding and duration of services provided
• Inclusion of other chronic diseases
Thank you to my Partners

• MedStar Palliative Care Team
  • Physicians, Nurse Practitioner, Clinical Pharmacists, Social Workers, Research Coordinator

• MedStar Visiting Nurses Association

• MedStar Institute for Innovation (MI-2)

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HOME AND OFFICE SETTINGS
LifeCare Model

• Consultation - we do not assume the role of primary care provider (eval only or eval and tx)
• We want the patient to come to us (office), but many cannot, so we provide in-home services
  – 20% office - 40% home - (40% residential care)
• Staff:
  – NPs with MD Director
  – Adminstrative manager, Clerks (CNA)
  – Part-time Social Worker, Chaplain
Palliative Care Visits YTD 2016

Jan-16: 17
Feb-16: 11
Mar-16: 15
Apr-16: 13
May-16: 10
Jun-16: 11
Jul-16: 19
Aug-16: 38

Graph showing the number of palliative care visits from January to August 2016, with a notable increase in August.
LifeCare Model

• Approach
  – Disease status clarification
  – Symptom management
    • Priority vs. Comprehensive
  – Goal setting and life plan discussion and counseling
  – Advance Directive/MOLST
LifeCare Model

• Assessment: comprehensive and holistic
  – History and pertinent examination, defining pain and non-pain symptoms
  – Screening
    • Depression
    • Cognition
    • Psychosocial
    • Emotional
    • Spiritual
LifeCare Model

• Financial
  – Separate business unit within Hospice
  – Shared staff with allocation of expense
  – Medicare Part B, Medicaid, commercial insurance
  – Pro forma: budget loss x18 months
    • Reality check: overhead costs vs. collectible reimbursement
    • Other revenue sources
      – Major insurers, self-insured industry
      – Long-term care insurance
      – Development/contributions
LifeCare Model

• **Ops**
  – Take all comers
    • Weed out drug-seeking persons
    • Bear the responsibility for increased scheduled drug prescribing

• **Rationale**
  – Meets mission
  – Feeds Hospice ("leader"); 25% conversion rate
  – "It's the right thing to do."
Community-Based Palliative Care: A Unique Certification for Home Health and Hospice Providers
Questions and Discussion