Designing Cross-Continuum Palliative Care Programs

Extending services to primary, specialty, and post-acute care
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The Case for Palliative Care
Palliative care is specialized care for patients with serious illnesses that aims to improve the quality of life for patients and families. This multidisciplinary approach focuses on providing patients with pain and symptom management as well as psychosocial support, no matter the prognosis of the disease.

While palliative care is gaining prominence, many patients, families, and even clinicians confuse palliative care with end-of-life care or hospice. Supporting patients at the end of life is one important component of palliative care, but palliative care has a much broader focus than treating patients at the end of life. Unlike hospice, palliative care is suitable for patients at any stage of their disease and may be offered concurrently with curative therapies.

Comprehensive palliative care programs provide clinical and non-clinical support in a team-based environment. Specialized physicians, nurses, social workers, and other support staff (e.g., chaplains, rehabilitative therapists, pharmacists, and dietitians) collaborate to implement a care plan that aligns treatment with the priorities of patients and their families.

Defining the Benefits of Palliative Care

**Psychosocial Support Complements Medical Care for Advanced Illnesses**

**Key Elements of Patient-Centered Palliative Care**

- Interdisciplinary care team
- Define patient’s goals for care and create care plan; plan shared across care team
- Patient and family active in decision making
- Smooth transitions to hospice, when appropriate

- Pain management
- Symptom management

- Psychological monitoring and management
- Grief counseling
- Focus on patient’s social needs
- Caregiver support
- Spiritual, religious care

**Clinical Practice Guidelines for Quality Palliative Care, Definition of Palliative Care**

“The goal of palliative care is to prevent and relieve suffering and to support the best possible quality of life for patients and their families, regardless of the stage of the disease or the need for other therapies. Palliative care is both a philosophy of care and an organized, highly structured system for delivering care. Palliative care expands traditional disease-model medical treatments to include the goals of enhancing quality of life for patient and family, optimizing function, helping with decision making, and providing opportunities for personal growth. As such, it can be delivered concurrently with life-prolonging care or as the main focus of care.” (emphasis added)

In response to increases in serious and chronic illnesses, the number of hospital-based palliative care programs has more than doubled in the last decade. The Center to Advance Palliative Care (CAPC) projects that nearly 84% of hospitals will provide palliative care programs by the end of 2014.

Although overall access has improved, there are a number of barriers to receiving palliative care. First, access to palliative care in small hospitals (fewer than 50 beds) has not expanded as quickly as in large hospitals (300+ beds). The prevalence of palliative care varies by region as well: 42% of hospitals in the South offer palliative care versus 53% of hospitals in the Midwest, 55% in the West, and 74% in the Northeast.

Further, access to palliative care in the outpatient or home setting is limited. Hospital leaders—particularly those in smaller hospitals—question whether they can financially support outpatient programs. Although public and most private insurers reimburse palliative services through professional billing, the level of reimbursement rarely covers all program costs given the time-intensive nature of palliative care.


1) Data includes only hospitals with 50 or more beds.
The demand for palliative care services continues to grow as a result of a rapidly aging population, the rising prevalence of chronic diseases, heightened attention on improving the quality of care, and increasing financial pressure to reduce the overall cost of care. Through both private innovation and public regulation, palliative care is already evolving in four key areas: workforce, access and delivery, reimbursement, and consumer awareness. Underlying these developments is an emphasis on cross-continuum palliative care that promotes more appropriate utilization of health care resources and accountability for clinical and cost outcomes.

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<th>Today’s Gaps</th>
<th>Tomorrow’s Solutions</th>
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<td>Workforce Shortage</td>
<td>Rise of the Palliative Care Generalist</td>
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<td>Limited Access to Palliative Care</td>
<td>Passage of Workforce Legislation</td>
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<td>Insufficient Reimbursement</td>
<td>Increase in Upstream, Community-Based Services</td>
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<td>Minimal Consumer Understanding of Palliative Care Services</td>
<td>Innovation by Private Insurers</td>
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<td>Response of Public Insurers</td>
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<td>Rebranding of Palliative Care</td>
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Source: Population Health Advisor research and analysis.
Assessment of Palliative Care Models
Today’s best-in-class palliative care programs span the entire care continuum and provide services to patients with advanced and chronic illnesses. These models aim to address the physical, psychological, social, spiritual and religious, cultural, ethical, and legal aspects of patient-centered care. The selection of any of these models depends on an institution’s identified population needs, current clinical capabilities, strategy, size, budget, partnership opportunities, and local market dynamics.

**Spectrum of Patient-Centered Palliative Care Services**

<table>
<thead>
<tr>
<th>Inpatient Services</th>
<th>Post-Acute Care</th>
<th>Outpatient Services</th>
<th>Home-Based Services</th>
<th>Telehealth Services</th>
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<tr>
<td>Primary palliative care(^1)</td>
<td>Embedded specialist or integrated palliative care</td>
<td>Palliative care generalist</td>
<td>House calls</td>
<td>Teleconsults</td>
</tr>
<tr>
<td>Palliative care consult</td>
<td>Palliative care consult</td>
<td>Palliative care specialist embedded, rotating, or remote</td>
<td>Remote monitoring</td>
<td>Remote training</td>
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<tr>
<td>Palliative care unit</td>
<td>Palliative care clinic</td>
<td>Palliative care clinic</td>
<td>Remote monitoring</td>
<td>Remote monitoring</td>
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1) The basic level of skill in pain and symptom management expected of all physicians.

Source: Population Health Advisor research and analysis.
Most hospitals offer inpatient palliative care consults. Consults have a wide reach, help improve patient outcomes prior to discharge, and are a relatively low-investment option compared with other inpatient palliative care models. Successful consult programs typically are staffed by a palliative care physician or advanced practitioner, a palliative care nurse/care manager, and a social worker. These team members work throughout the hospital to explain palliative care to patients and families, and to evaluate patients’ needs. They also collaborate with other providers to ensure patients’ preferences for care are understood and their symptoms, pain, and psychosocial needs are managed.

At the outset of developing a consult program, hospitals must garner physician buy-in, as the program’s success depends on physician referrals. An engagement strategy frequently includes education on what palliative care is, how the palliative care team will interact with referring physicians, and the clinical benefits of palliative care. Additionally, once the program is implemented, collecting feedback from physicians is essential to maintaining clinical and operational outcomes.

### Key Elements of Inpatient Palliative Care Consult Programs

#### Physician Engagement
- Employ a comprehensive strategy to engage physicians in designing the program, educate them about palliative care, and solicit their feedback

#### Referral Protocols
- Create standardized mechanism to identify appropriate patients, such as screening tool or triggers
- Design efficient process to order consult and ensure patient is seen in a timely manner

#### Care Team Composition
- Staff program with, at a minimum:
  - Palliative care physician or advanced practitioner
  - Palliative care nurse/care manager
  - Social worker

#### Care Coordination
- Maintain clear lines of communication between consult team and other members of the care team
- Promote sharing of care recommendations and prompt updates on patient’s status changes

### Palliative Care Consult Sample Questions
1. What do you know about your illness? What do you want to know about your illness?
2. Would you like to discuss what the potential prognosis is?
3. What symptoms are you experiencing?
4. What decisions have you made already about your care plan? Who would you like to involve in these decisions?
5. How are you coping with this illness? How are your family members coping?

Source: Population Health Advisor research and analysis.
The number of people seeking care at skilled nursing facilities (SNFs) in the United States is expected to double by 2030, reaching more than three million. SNFs must accommodate the ever-growing needs of patients living with advanced illness, suffering from untreated pain, and ill-prepared for assessing options for end-of-life care. Most staff working at SNFs are generally not trained to deliver palliative care services. Therefore, SNF and hospital leaders are looking to extend the reach of palliative care services into the post-acute care setting.

To help secure SNF staff support for palliative care, SNF leaders should describe the specific benefits to staff, including relieving them from time-intensive and difficult discussions with residents and families on the goals of care, as well as having a “go-to” expert to consult for clinical and psychosocial care plan questions.

There is no one-size-fits-all model for offering palliative care services in a SNF. Models depend on a SNF’s budget, expected patient volumes, clinical gaps of care, current staffing models, and ability to foster staff buy-in. Whichever model is chosen, diligent metric tracking is advised in order to ensure future strategic and financial support.

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**Overview of Palliative Care Models for Skilled Nursing Facilities**

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<tr>
<th>Rotating Specialist</th>
<th>Embedded Staff</th>
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<tr>
<td>- Clinician with expertise in palliative care visits skilled nursing facility on a regular basis (e.g., weekly, biweekly)</td>
<td>- Clinician with expertise in palliative care is embedded in post-acute care facility</td>
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<tr>
<td>- Is available for support by phone</td>
<td>- Conducts initial palliative care consult</td>
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<tr>
<td>- Conducts initial palliative care consult and communicates care recommendations to SNF clinicians</td>
<td>- Manages patient’s palliative care needs throughout the duration of patient’s PAC stay</td>
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<tr>
<td>- May be provided by independent hospice-palliative care provider or by partner hospital</td>
<td>- Interacts with other SNF staff (e.g., social worker, rehabilitation therapists, etc.) to ensure comprehensive wellness</td>
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**Accessibility of Services**

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**Level of Investment**

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<th>Higher</th>
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Source: Population Health Advisor research and analysis.
As hospitals become accountable for patients’ health outside of the acute care setting, teams are beginning to embed palliative care specialists in ambulatory care sites. This improves patient outcomes, prevents hospital admissions, and treats patients in lower-cost settings. Examples of outpatient clinics that may embed palliative care teams include oncology clinics, CHF and cardiac clinics, geriatric primary care, and dialysis centers.

To engage ambulatory teams, leaders should focus on program goals, staff roles, and care processes to implement palliative care.

### Key Considerations for Embedded Outpatient Specialists

#### Define Staff Roles
- Establish from the start that the palliative care team will co-manage the patient’s care—not assume full control
- Develop standards for when the palliative team can treat patient symptoms without the primary physician’s involvement or pre-approval (e.g., prescribing antidepressants, opioids, Ritalin, etc.)

#### Manage Referrals
- Educate outpatient physicians on appropriate referrals to palliative care team
- Design processes to prioritize most urgent referrals
- Teach physicians how to handle basic pain and symptom management themselves so the palliative care team is seeing the most complex, specialized cases

#### Coordinate Care
- Hold weekly care coordination meetings between palliative care team and outpatient staff
- Submit progress notes to the EMR on palliative care consults, treatments, and changes in care plans
- Encourage informal conversations about patient care through face-to-face interaction, phone calls, and email

Source: Population Health Advisor research and analysis.
Home-based palliative care aims to reach patients proactively, before symptoms escalate. As such, home-based palliative care is useful for lowering utilization of inpatient resources, reducing the total cost of care, and enhancing quality of life, especially for patients who may be homebound or for whom travel is difficult.

Through home-based palliative care, an advanced practitioner visits patients' homes following referral from a PCP, specialist, or other social work staff.

Home-based care requires a considerable amount of travel on the part of the palliative care provider, so a clinical coordinator is essential to ensuring that referrals are appropriately triaged and that appointments are scheduled in an effective manner.

Home-based palliative care providers coordinate with the entire care team, especially a patient's primary care physician and home health providers. Regular communication should include information about the patient's health status, changes to the care plan, and patient preferences for care.

Referral sources include PCP, specialty clinician, inpatient palliative care team, hospital discharge planning staff. Palliative care clinical coordinator assesses patient's appropriateness for home-based services and urgency of the first home visit. Patients may transition into hospice or hospital.

NP conducts comprehensive palliative care assessment in patient's home, which lasts 1-2 hours. Home visits scheduled at intervals of 1-12 weeks depending on patient acuity; phone follow-up conducted as needed; care coordinated with other providers.
Telehealth is a powerful tool for improving the efficiency and reach of care teams, encouraging utilization in lower-cost care settings, and increasing regional partnerships. Given the growing need for palliative care and various barriers to palliative care access, telehealth for palliative care may be an effective solution. Providers are beginning to experiment with these models and near-term growth in this area is expected.

One of the primary uses of telehealth for palliative care is teleconsults. Telehealth may also be deployed to train providers on palliative care services, provide remote support to physicians or NPs, and share patient vitals or clinical parameters (usually from a patient’s home) to a centralized palliative care monitoring site.

### Emerging Care Delivery Model Expected to Alleviate Access Challenges

#### Delivery of Palliative Care via Telemedicine

1. **Referral:** Physician refers patient to palliative care service, ideally submitting the referral electronically to the centralized/receiving palliative care provider

2. **Scheduling:** Centralized palliative care administrator processes the referral and schedules the appointment

3. **First appointment – Logistics:** Patient is brought to a telemedicine suite (or technologically equipped room) by a nurse; patient and remote palliative care provider connected via video; patient’s family may be conferenced in through telephone

4. **First appointment – Content:** While much of the appointment is similar to any other palliative care consult, the remote palliative care physician will particularly focus on getting to know the patient and ensuring that the technology itself is not a barrier to communication

5. **Post-appointment:** Nursing or physician summary uploaded into patient’s EMR to ensure continuity of care for patient and care coordination among disparate providers

6. **Follow-up:** Additional conversations between the patient and palliative care provider conducted as needed

Source: Population Health Advisor research and analysis.