Session 103AB
Challenges and Opportunities in Community-Based Palliative Care

Presented by:
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Challenges and Opportunities in Community-Based Palliative Care

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Disclosure of Relevant Financial Relationships

The following faculty of this continuing education activity has no relevant financial relationships with commercial interests to disclose:

• Adam D. Marks, MD MPH
• Christie Herrick, LMSW
Faculty

- Adam D. Marks, MD MPH
- Christie Herrick LMSW

Learning Objectives

- Frameworks for community-based palliative care delivery systems

- Describe the opportunities, challenges, and outcomes of Arbor Palliative Care, a community-based palliative care program in Southeast Michigan
Agenda

• Palliative Care Overview
• Community-Based Palliative Care (CBPC)
• Arbor Palliative Care

How We Live in America
Living in America: Living Longer

![Graph showing life expectancy at birth.]

Living in America: Living with Disease

![Graph showing population with chronic conditions and percentage of population.]

2017 CONGRESS ON HEALTHCARE LEADERSHIP
Basic Mortality Statistics

Mortality Rate

1980 1990 2000

© Cartoonbank.com

“There’s no easy way I can tell you this, so I’m sending you to someone who can.”
Definition of Palliative Care

“Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness – whatever the diagnosis.

The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, social workers and other specialists who work with a patient's other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.”

CAPC 2013

Hospice vs. Palliative Care

<table>
<thead>
<tr>
<th>Hospice</th>
<th>Palliative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part A</td>
<td>Part A or B</td>
</tr>
<tr>
<td>Prognosis &lt;6 months</td>
<td>Anytime with serious illness</td>
</tr>
<tr>
<td>Primary focus is on comfort, while foregoing aggressive disease-specific therapy</td>
<td>Attends to comfort, while continuing to pursue disease-specific therapy</td>
</tr>
</tbody>
</table>

Both use an interdisciplinary team approach to attend to the physical, emotional, psychological and spiritual needs of patients with life-threatening illness.
Traditional Medical Model

Continuum of Care
When to consider Palliative Care?

When a patient is facing a serious illness and struggling to maintain their quality of life due to:

- Uncontrolled physical symptoms
- Emotional or spiritual distress regarding the diagnosis/prognosis
- Clarify goals of care or advanced care planning
- Accelerating need for medical care or hospitalizations
- Need for informed decision making regarding life-sustaining treatments, i.e. feeding tube or tracheostomy

Key Talking Points

- Interdisciplinary approach focused on quality of life
- A subspecialty of medicine designed to help patients live as well as they can for as long as they can
- Supports optimism in the face of uncertainty and recognizes [for some patients with advanced disease] more aggressive care is not better care
- Reduction in symptom burden
- Improved patient and family satisfaction
- Reduced costs
Benefits of Palliative Care

N=524 family survivors

Overall **satisfaction markedly superior** in palliative care group, p<.001

Palliative care improves:
- emotional/spiritual wellness
- information/communication
- care at time of death
- access to services in community
- well-being/dignity
- care + setting concordant with patient preference
- pain
- PTSD symptoms


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**...But Also Improves Survival**

151 patients with a new diagnosis of stage IV - metastatic lung cancer (**Average life-expectancy of 9-12 months**)

At the **time of diagnosis patients were randomized:**
- standard cancer care alone
- palliative care integrated into standard cancer care

Patients with integrated palliative care:
- Had less symptoms
- Reported higher quality of life
- Were more likely to have had a discussion about their preferences for end-of-life care
- Received less aggressive care
- Lived almost three months longer

Temel et al NEJM 363(8) 2010
How Palliative Care Reduces Length of Stay and Cost

Palliative care:

- assists with decisions to leave the hospital, or to withhold or withdraw death-prolonging treatments that don’t help to meet their goals by:
  - clarifying goals of care with patients and families
  - helping families to select medical treatments and care settings that meet their goals

Source: capc.org/research-and-references-for-palliative-care/citations

Medical Care Received in the Last Week of Life by End-of-Life Discussion

<p>| Table 3. Medical Care Received in the Last Week of Life by End-of-Life Discussion |
|-------------------------|-----|-----------------|-----------------|</p>
<table>
<thead>
<tr>
<th></th>
<th>Total (N=322)</th>
<th>End-of-Life Discussion</th>
<th>Adjusted OR (95% Confidence Interval)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care received in the last week</td>
<td>332</td>
<td>123 (37.0)</td>
<td>209 (63.0)</td>
<td></td>
</tr>
<tr>
<td>ICU admission</td>
<td>31 (9.3)</td>
<td>5 (4.1)</td>
<td>26 (12.4)</td>
<td>0.35 (0.14-0.90)</td>
</tr>
<tr>
<td>Ventilator use</td>
<td>25 (7.5)</td>
<td>2 (1.6)</td>
<td>23 (11.0)</td>
<td>0.26 (0.06-0.83)</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>15 (4.5)</td>
<td>1 (0.8)</td>
<td>14 (45.7)</td>
<td>0.19 (0.03-0.80)</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>19 (5.7)</td>
<td>5 (4.1)</td>
<td>14 (45.7)</td>
<td>0.39 (0.13-1.03)</td>
</tr>
<tr>
<td>Feeding tube</td>
<td>26 (7.9)</td>
<td>11 (8.9)</td>
<td>15 (7.3)</td>
<td>1.30 (0.55-3.10)</td>
</tr>
<tr>
<td>Output hospice used</td>
<td>213 (66.4)</td>
<td>93 (75.2)</td>
<td>120 (67.4)</td>
<td>1.50 (0.91-2.48)</td>
</tr>
<tr>
<td>Output hospice &gt;1 wk</td>
<td>173 (53.3)</td>
<td>80 (65.6)</td>
<td>93 (44.4)</td>
<td>1.65 (1.04-2.63)</td>
</tr>
</tbody>
</table>

Abbreviation: ICU, intensive care unit; OR, odds ratio.
A The propensity-score weighted sample was used for these analyses. Logistic regression models were also adjusted for patients’ treatment preferences, desire for prognostic information, and acceptance of terminal illness.

### Shifting Care from Hospital to Home

**Service Use Among Patients Who Died from CHF, COPD, or Cancer Palliative Home Care versus Usual Care, 2005–2006**

- **Usual Medicare home care** vs. **Palliative care intervention**

<table>
<thead>
<tr>
<th>Service Use</th>
<th>Usual Care</th>
<th>Palliative Care</th>
<th>Δ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health visits</td>
<td>35.0</td>
<td>13.2</td>
<td>-21.8*</td>
</tr>
<tr>
<td>Physician office visits</td>
<td>11.1</td>
<td>5.3</td>
<td>-5.8*</td>
</tr>
<tr>
<td>ER visits</td>
<td>2.3</td>
<td>0.9</td>
<td>-1.4*</td>
</tr>
<tr>
<td>Hospital days</td>
<td>9.4</td>
<td>2.4</td>
<td>-6.9*</td>
</tr>
<tr>
<td>SNF days</td>
<td>4.6</td>
<td>0.9</td>
<td>-3.7*</td>
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</table>


### Hospital Palliative Care Reduces Costs

**Cost and ICU Outcomes Associated with Palliative Care Consultation in 8 U.S. Hospitals**

<table>
<thead>
<tr>
<th>Costs</th>
<th>Live Discharges</th>
<th>Hospital Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Usual Care</td>
<td>Palliative Care</td>
</tr>
<tr>
<td>Per Day</td>
<td>$867</td>
<td>$684</td>
</tr>
<tr>
<td>Per Admission</td>
<td>$11,498</td>
<td>$9,992</td>
</tr>
<tr>
<td>Laboratory</td>
<td>$1,160</td>
<td>$833</td>
</tr>
<tr>
<td>ICU</td>
<td>$6,974</td>
<td>$1,726</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>$2,223</td>
<td>$2,037</td>
</tr>
<tr>
<td>Imaging</td>
<td>$851</td>
<td>$1,060</td>
</tr>
<tr>
<td>Died in ICU</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>18%</td>
<td>4%</td>
</tr>
</tbody>
</table>

*p<.001  **p<.01  ***p<.05  Morrison, RS et al. Archives Intern Med 2008;*
Patients who died and received palliative care consultation versus matched usual care

Mean direct costs/day

- Usual care
- PC consult day 7
- PC consult day 10
- PC consult day 15

Patients who died and received palliative care consultation versus matched usual care

It’s a Matter of Perspective

**Patient**
- Relieve symptom distress
- Navigate medical system
- Understand and participate in the plan of care
- Palliation of suffering along with curative treatment
- Practical and emotional support for caregivers

**Clinician**
- Saves time
- Bedside Management
- Promote patient and family satisfaction

**Payer**
- Improved treatment of complex advanced illness
- Patient-centered care
- Increase patient and family satisfaction
- Improve staff satisfaction and retention
- Meet JC quality standards
- Rationalize the use of hospital resources, cost containment & avoidance
Access to Palliative Care

Inpatient Palliative Care Programs:
• Almost 90% of Hospitals (300+ beds) provide palliative care
• No requirement for palliative care standards
• Gap in continuum of care outside the hospital

Outpatient Palliative Care Programs:
• Clinic based palliative care services have struggled getting seriously ill patients from their home to the clinic setting
• Community Based Palliative Care (CBPC) services have struggled in a FFS environment

Goals
• Reduce hospitalizations/ED visits
• Improve QOL
• Earlier goals of care/advance care planning conversations
• Earlier enrollment in hospice

Models
• RN/SW based (lower-cost, primarily telephonic support)
• NP/Physician based (higher cost, F2F visits + telephonic support)
CAPC Recommendations for CBPC

Interdisciplinary Team-Based Care
- MD/NP
- SW
- RN
- Spiritual Care

24/7 Meaningful Clinical Response
- Capacity to support and provide meaningful and responsive care 24/7

Integrated with Concurrent Care
- Services available concurrently with or independent of curative or life-prolonging care

Impact of CBPC
- Reduced average number of hospitalizations (1.36 per pt per 6 months vs 0.35 in CBPC group)
- Reduced total hospital days reduced between the groups by 5.13 days
- More likely to have completed advance directives (69% vs 98%)

Chen et al JPM 2015 18(1); 38-44
Impact of CBPC

- Cost savings apparent in the last 3 months of life ($6804 PMPM in the CBPC group vs $10712 PMPM in the control group)
- Enhanced utilization of hospice (70% versus 25%)
- Longer length of stay on hospice (median 34 days versus 9 days)

Kerr et al JPM 2014 17(12); 1328-35

Impact of CBPC

Analysis results from 11 CBPC programs:

- Decreased hospitalizations (31% vs 39%)
- Decreased ER visits (28% vs 34%)
- Decreased risk of dying in the hospital (16% vs 28%)
- Overall improved reports of QOL in the months preceding enrollment in hospice

Seow et al BMJ 2014 June; 348: g3496
Arbor Palliative Care: A History

• Developed by Arbor Hospice in 2012 as a community-based palliative care (CBPC) program
  – To serve the same geographic area as Arbor Hospice
  – Designed to serve patients with a life-limiting disease (prognosis of years) to maximize QOL and to focus on advance care planning
• Initially designed as a consult-only model based on the input from the community
  – NPs performed all visits (with MD oversight) and relayed recommendations back to the ordering physician
  – Provided telephonic support during business hours
  – No SW, Spiritual Care or VS support

• In 2013:
  – Moved to have the ability of active management
    • Allows the medical team to take over management of symptoms
    • Prescribing of medications including CII scripts
    • 24/hr phone support provided by existing on-call hospice structure

• In 2013-2014:
  – Began the development of SNF “clinics” for palliative care
Arbor Palliative Care: A History (cont)

• In 2015:
  – Added SW, Spiritual Care and VS support

• In 2016:
  – Affiliation with HOM
  – Christie Herrick as Statewide Director
  – Growth into other markets outside SE Michigan
The Palliative Care Team Functions

**Palliative Physician**

- Active Management includes prescriptions for schedule II medications
- Oversight of interdisciplinary team
- Care plan oversight
- Direct assessment and management of complex patient and family needs, when necessary

**Nurse Practitioner**

- Comprehensive assessment, treatment and care management of patients
- Works in collaboration with Palliative Medical Director and Attending Physician to manage complex illness
- Oversight of RN Case Manager

**RN Case Management**

- Collaboration with NP and Palliative Physician
- Liaison and advocate for patient and family for community support services
- Assess needs of patient and family as illness progresses
- Care Coordination
- Assist with navigation and transitions of care
- Community education
- Patient/family education
- Telephonic support

**Social Work/SCC/Volunteers**

- Collaboration to assess psychosocial, spiritual and volunteer needs
- Advocacy for community support to meet psychosocial, spiritual and practical needs
- Assist with transitions of care
- Telephonic support

**Consultative vs. Active Management**

<table>
<thead>
<tr>
<th></th>
<th>Consultative Symptom Management</th>
<th>Active Symptom Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral</td>
<td>MD request required unless pt. does not have a Primary Care Physician (PCP); referrals from MD, RN, MSW, patient/family or other sources are accepted. If patient does not have a PCP, APC NP will consult with patient and help to identify a PCP.</td>
<td>Same as Consultative Symptom Management</td>
</tr>
<tr>
<td>Goal</td>
<td>Support for patients and families dealing with advanced illness, regardless of whether they choose to receive curative treatment, Eyes and ears of the referring physician in the home and suggestions are made for improved quality of life and advance care planning. Services provided by an interdisciplinary team as needed.</td>
<td>Same, however, instead of making recommendations to the referring physician for symptom control, APC physicians and Nurse Practitioners order medications directly and perform limited hands-on procedures as needed. Services provided by an interdisciplinary team as needed.</td>
</tr>
<tr>
<td>Medical Focus</td>
<td>Improved quality of life for patients with advanced illness includes; CHF, COPD, oncology; and advance care planning.</td>
<td>Same with the addition of active medication management for symptom control</td>
</tr>
<tr>
<td>Availability of Service</td>
<td>Visits are made Monday – Friday 8:30 a.m. – 5:00 p.m. After-hour calls are directed to the PCP or referring physician.</td>
<td>Visits are made Monday – Friday 8:30 a.m. – 6:00 p.m. After hours telephone support is provided (5:00 p.m. – 8:30 a.m.) by a physician. If needed, an in-person visit is scheduled next business day or, in an emergency the patient is directed to the ER. No “emergency” visits are performed through the APC program.</td>
</tr>
</tbody>
</table>
Core Palliative Care Services Delivered by Arbor Palliative Care

Specialist home-based palliative care programs should provide the essential domains of palliative care as described in the NCP Clinical Practice Guidelines. The core domains of service include:

- Expert pain and symptom management
- Skilled communication and support for complex medical decision making
- Counseling for patients, families and all staff involved in care
- Advance care planning
- Psychosocial and caregiver support
- Spiritual care
- Care coordination and transition management
- Medication reconciliation and management
- Planning for end-of-life care, and appropriate and timely referral to hospice when indicated and acceptable to patient and family
- Volunteer Services

Who Can Enroll In Arbor Palliative Care?

- Anyone with a **serious, life-limiting illness** and a **difficulty leaving the home** who is deemed to have palliative care needs by the referring provider
  - Complex symptoms
  - Goals of care/advance care planning discussions
  - Coordination of services in the home
Our Palliative Model of Care

Patient assigned to the interdisciplinary team that includes a physician, NP, Social Worker and RN

- Plan includes Home visits by:
  - MD, NP and/or LCSW
  - Telephonic care management by RN
  - 24/7 telephone on-call support by RN with MD support
  - Assistance with prescription management for life limiting illness
  - Coordination with primary physician, facility staff
Palliative Care Model Highlights - Current

<table>
<thead>
<tr>
<th>NP/Physician Model</th>
<th>SW Services</th>
<th>At Home Choices – RN Case Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>• NP providing 90% of visits to patients and families</td>
<td>• Focus on practical support</td>
<td>• One (1) face to face visit for assessment/sign on</td>
</tr>
<tr>
<td>• Visit/Contact monthly at a minimum</td>
<td>• Mainly telephonic</td>
<td>• Mainly telephonic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Phone Contact monthly at a minimum</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Shared Services with Hospice:</th>
<th>Care Collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Spiritual Support</td>
<td>• Team Meeting every 2 weeks with inter-disciplinary participation</td>
</tr>
<tr>
<td>• Volunteer Services</td>
<td></td>
</tr>
<tr>
<td>• Bereavement Services</td>
<td></td>
</tr>
</tbody>
</table>

Arbor Palliative Care: Outcomes, Challenges and Opportunities
What Does a Palliative Care Consultation Include?

- A Palliative Care physician or nurse practitioner visits patient in home, assesses needs and contacts physician with recommendations/treatment plan
- PCP/Referring Provider continues to manage plan of care with input from the Palliative Care Team
- As medically necessary, Palliative Care follows-up with patient and physician to ensure symptoms are being managed
- RN Case Manager/PC Coordinator provides telephonic support to ensure coordination of care and smooth transitions of care

Future of Palliative Care

**Palliative Care Continuum**

**Telephonic Support**

- Combines Model
  - NP/Physician
  - Telephonic

**NP/Physician Model**

- Consultative
- Active Management

**Hospice Services**
Palliative Care Model Highlights - Future

**Continuum of Services**
- All Services Based on Acuity
- Common Branding
  - Telephonic support
  - NP/Physician services
  - Combined Model

**NP/Physician Model**
- NP providing 90% of visits to patients and families
- Visit/Contact based on acuity

**SW Services**
- Focus on practical support
- Transitions in Care focus
- Face to Face visits to support transitions to hospice
- Telephonic support

**RN Case Manager**
- One (1) face to face visit for assessment/sign on
- Face to Face visits at KEY facilities
- Attendance at and collaboration with Hospice IDT
- Telephonic support
- Phone Contact monthly at a minimum

**Shared Services with Hospice**
- Spiritual Support
- Volunteer Services
- Bereavement Services
- Addition of complementary therapies
  - Massage
  - Music

**Care Collaboration**
- Team Meeting every 2 weeks with inter-disciplinary participation
- Collaboration and integration with Hospice IDT
- Focus on Acuity level 3

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Palliative Program Organizational Structure
Key Benefits of our Palliative Care Program

- Team-based care planning that involves the patient and family
- Pain and non-pain symptom management
- Communication among patients, families, community providers and palliative team members
- Continuity of care across a range of clinical settings and services
- Attention to spiritual comfort
- Psychosocial support for patients and families
- Bereavement support for families of patients who die and team members who provided care to the deceased
- Continuum of care that provides Hospice care when the patient’s prognosis is limited and families choice is to transition
Core Objectives of Palliative Care

- Coordinate and implement interventions for physical, psychosocial and spiritual sources of distress or burden for the patient and family
  - Multi-dimensional assessment + Individual Care = plan to reduce distress or burden
  - Engage in informed shared decision making about health care and related goals
    - With consistent focus on individual preferences, culture and religion and spirituality
    - With repeated goal setting and advance care planning
- Coordinate care across providers and venues, and optimize access to specialized services including hospice
Consultative and Active Management

**Top 3 Diagnoses**

- **Diseases of Circulatory System**
  - Hypertensive diseases
  - Ischemic heart diseases
  - Pulmonary heart disease
  - Other forms of heart disease
  - Cerebrovascular diseases
  - Cardiomyopathy
  - STEMI

- **Diseases of Nervous System**
  - Huntington's disease
  - Parkinson's disease
  - Alzheimer's disease
  - Multiple sclerosis
  - Transient cerebral ischemic attacks
  - Cerebral palsy
  - Paraplegia and quadriplegia

- **Neoplasm**
  - Malignant neoplasms of:
    - Lip, oral cavity and pharynx
    - Digestive organs
    - Respiratory and intrathoracic organs
    - Bone and articular cartilage
    - Melanoma
    - Breast
Staffing Model

- **Panel**: the total number of patients a clinician can effectively manage to deliver high quality care. An equation to determine a panel is days worked per year x number of visits per day = panel size (this implies a long term patient relationship in which visit frequency may vary). The panel includes patients of varying need intensity requiring different levels of attention.

- **Active Caseload**: the number of higher-need individual patients a clinician carries and can actively attend to over a defined period. Average caseload may vary by discipline.
  - APNP – 60 to 80 patients; 3 to 5 visits/day
  - RN - 50 to 70 patients; 5 to 7 visits/day
  - SW – 100 to 150 patients; 4 to 6 visits/day

Considerations for Staff Caseload

- Level of service – telephonic or face to face
- Frequency of visits
- Patient acuity
- Geographic spread

Visits per day
- Initial Visit 90-120 minutes
- Follow up visit 60-90 minutes

- Caseload assignment
- Contacts per time period
### Stakeholder Metrics

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Examples of Metrics to Measure Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>Improvement in:</td>
</tr>
<tr>
<td></td>
<td>Pain, other symptoms, functional status</td>
</tr>
<tr>
<td></td>
<td>Social, emotional and spiritual needs</td>
</tr>
<tr>
<td></td>
<td>Occurrence of advance care planning</td>
</tr>
<tr>
<td></td>
<td>discussions and documented goals of care</td>
</tr>
<tr>
<td></td>
<td>Concordance between patient preference</td>
</tr>
<tr>
<td></td>
<td>and types/locations of services received</td>
</tr>
<tr>
<td></td>
<td>Satisfaction with and confidence in care</td>
</tr>
<tr>
<td>Caregiver</td>
<td>Level of:</td>
</tr>
<tr>
<td></td>
<td>Confidence in care provided to patient</td>
</tr>
<tr>
<td></td>
<td>Satisfaction with Health care</td>
</tr>
<tr>
<td></td>
<td>Level of depression, anxiety and stress</td>
</tr>
<tr>
<td></td>
<td>Out of pocket spending</td>
</tr>
<tr>
<td>Referring Providers</td>
<td>Level of satisfaction with Palliative Care service</td>
</tr>
<tr>
<td>Institutions, Systems and Payers</td>
<td>Changes in:</td>
</tr>
<tr>
<td></td>
<td>Use of the ED, hospital, ICU, office visits and hospice</td>
</tr>
<tr>
<td></td>
<td>Total cost of care per patient</td>
</tr>
<tr>
<td></td>
<td>Quality and performance metrics such as 30-day readmissions, hospital mortality</td>
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<td></td>
<td>Patient and family satisfaction</td>
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### Palliative Dashboard

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<tbody>
<tr>
<td>% of Local Rehosp</td>
<td>%</td>
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<td>% (%  )</td>
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<tr>
<td>% of Other Rehosp</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>% (%  )</td>
</tr>
<tr>
<td>% of Local Discharge</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
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<td>%</td>
<td>%</td>
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<td>% (%  )</td>
</tr>
<tr>
<td>% of Other Discharge</td>
<td>%</td>
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NCP Guidelines for HBPC Measurement Guidelines

- General Structure and Process of Care
- Physical Aspects of Care
- Psychological Aspects of care
- Social Aspects of Care
- Spiritual, Religious and Existential Aspects of Care
- Cultural Aspects of Care
- Care for the Patient
- Ethical and Legal Aspects of Care

Of these eight domain measures programs should choose one structure or process measure for each domain, of which at least two are process measures PLUS
Four to six metrics addressing clinical or patient/family reported outcomes AND cost/utilization outcomes

Funding Sources and Payment Models

Home-based palliative care programs are generally supported by a combination of funding sources that includes:

- Revenue received for services provided (either fee-for-service, a shared savings or capitated payment model and/or via quality incentives)
- Financial contributions from the sponsoring organization
- Endowments, grants or fundraising activities
Palliative Care Payment Models

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<th>Payment Model</th>
<th>Influence on Program</th>
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<td>Primarily FFS and FFS Linked to Quality and Value</td>
<td>Billing revenue is a function of visit volume for services provided by clinicians who can bill for services. Programs supported through FFS must maximize productivity from physicians and advanced practice providers (APPs).</td>
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<td>Capitated/Population Based Payment</td>
<td>Programs receive a fixed payment to deliver services over a defined period of time for each enrolled patient. Programs can be flexible in staffing model and services provided within the fixed payment</td>
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<tr>
<td>Mixed Payment Model</td>
<td>Programs with multiple payment models can flexibly implement staffing models designed to meet each payer’s requirements. Frequent contact by nurses, social workers and care coordinators augments medical care provided by APPs and physicians.</td>
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</table>

Challenges and Opportunities

**Challenges**
- Staffing
- Market Needs
- Geographic spread
- Mission creep
- Data mining
  - Pulling data from EMR
- Measuring what matters

**Opportunities**
- Choices RN role expansion
- Integration with Hospice
- Can be scaled to specific service area
- Allows for individualization of markets
- Keeping patients within our HOM/Arbor “family”
- Timely Hospice transitions
Key components of a financially sustainable home-based palliative care program

- Program design towards achievement of outcomes aligned with stakeholder priorities needs to assure continued funding and support for the practice. If reimbursement comes exclusively from FFS billing, the program will need additional funding (philanthropy, grants, parent institution support) to cover costs.
- Close monitoring of program operations that influence financial viability:
  - Cancellation and no-show rate
  - Notification of patient admission to and discharge from hospital
  - Frequency and duration of visits
  - Scheduling efficiency for the team and cost of travel

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Dr. Adam Marks is an Assistant Professor of Medicine at the University of Michigan Health System (UMHS). In addition to his role as attending on both the adult and pediatric inpatient palliative care consult services, he serves Medical Director of Arbor Palliative Care, a community-based palliative care program. He is a Faculty Ethicist for the UMHS Ethics Committee, and also is Associate Director of the University of Michigan’s Hospice and Palliative Medicine Fellowship.
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Christie Herrick has over 20 years experience in hospice and palliative care, starting at McLaren Hospice where she initially worked as a Hospice Social Worker. Later she was Branch Manager for the Lansing Branch and then became the Manager for Bay City, MI. Prior to leaving McLaren Hospice she was the Director of Hospice. During her tenure she assisted in development of the Inpatient and Outpatient Palliative Programming within the McLaren System. She has been with Hospice of Michigan since 2015.

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