Out-Patient Palliative Care-Lessons from a 20 Year Palliative Care Provider

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CHI Franciscan

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Financial Disclosure

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- No financial disclosures

Learning Objectives

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- List 3 clinical indications for out-patient palliative care
- List 3 barriers to developing an out-patient palliative care program
- Describe a staffing model that has shown success

Who We Are: Franciscan Hospice & Palliative Care Overview

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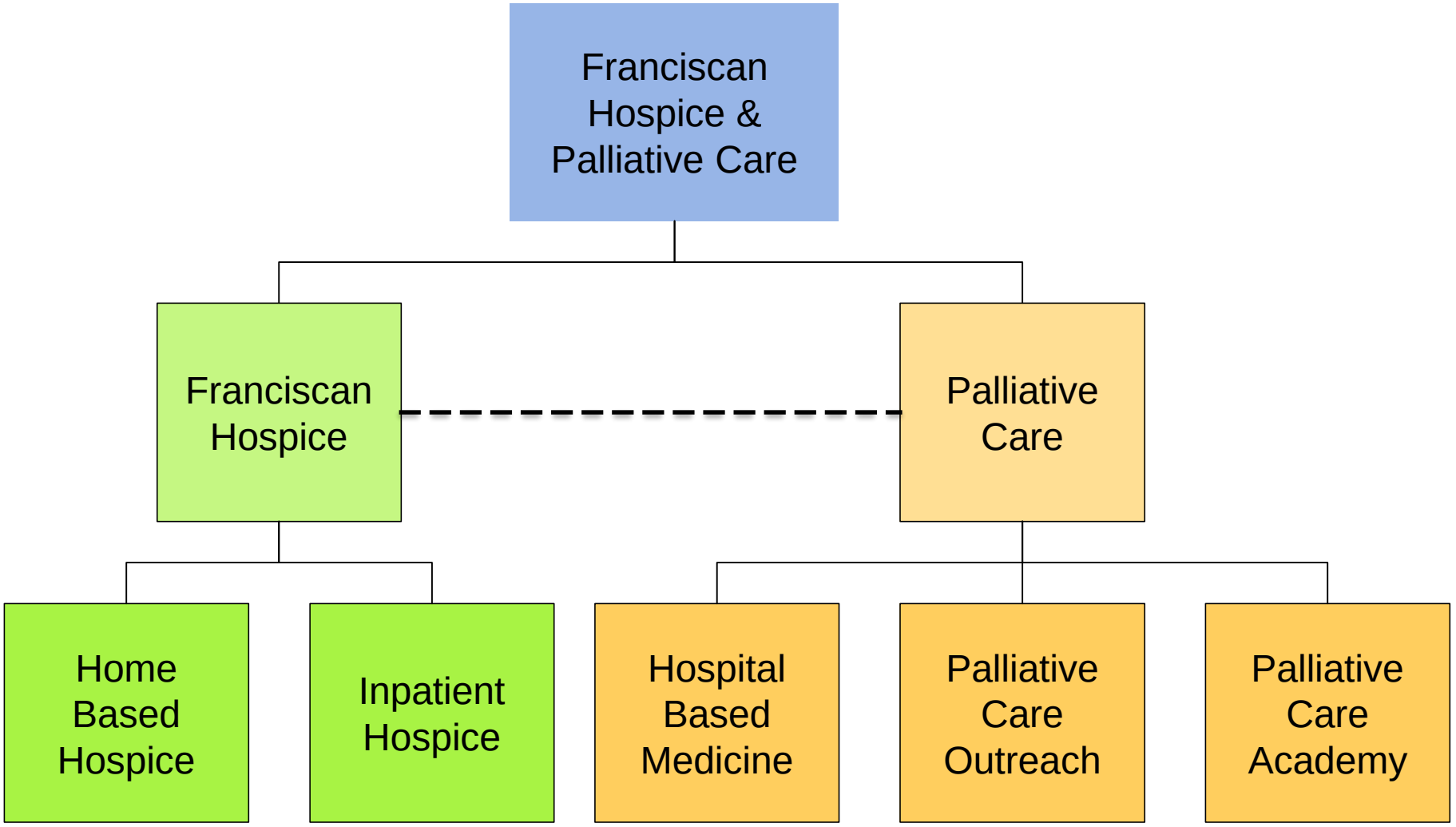

Who We Are: Our Geographic Footprint

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4,400 Square Miles

Our History

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- 1990's Ethics Consultations
- 1997 National Collaborative-IHI and Center to Improve Care of the Dying
- Developed model for clinic based "Improving Care"
- Grant funded and based on RICE values
- Total 11 Franciscan Clinics
- 2010 Palliative Care Outreach
- 2013 Cambia Funded Grant – Palliative Care Academy
- 2018 Palliative Care Outreach Re-structure

Clinical Indications for Out-Patient Palliative Care

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- Demands of aging seriously ill population to improve value by increasing quality and reducing cost
- Support and complement to population health
- Provision of care that spans the full trajectory of serious illness

Our First Model – Improving Care through EOL

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- Multi discipline & multi setting approach
- Clinic
- Office
- Home

Motivating Change at the Organizational Level

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- Why did we have to change?
- Discernment
- A new model emerges

New Model - New Measurements

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- Discovering value in a changing environment
- Operating more efficiently
- Spreading out

Benefits of Outpatient Palliative Care

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- Improved quality of life
- Better symptom management
- Enhanced psycho-social & spiritual support
- More frequent & higher quality goals of care conversations
- Improved communication across the continuum
- Decreased hospitalizations
- Appropriate timing for hospice admissions

Outpatient team consultation process

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- Setup by team after confirmed order from primary attending MD
- Home Visits
- Initial visit: 90-120 minutes
- Subsequent visits: 45-60 minutes
- Monthly and PRN
- Monthly interdisciplinary team meetings
- Subsequent visits TBD, depending on patient/family needs
- Co-management model with primary attending MD
- Verbal or written communication with referring MD before and after visits
- Documentation in EMR

Team Composition & Resources

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- Patient & Family
- MD
- NP
- Counselor
- Chaplain (borrowed from hospice)
- Office based support for care coordination
- Volunteer phone calls for six months
- Monday – Friday business hours

New Challenge for all of us

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- Where will the labor take you?
- Will you go to the clinic?
- Who will be waiting for you?

Doubling Down on Home Based Care

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- Taking stock of what we do best
- Sharing the wealth
- What does integration look like?

Getting Prepared

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- A better way to measure
- What sustains us?
- What may be next?

Resources

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- Chen, C et al. Improving Value of Care for Older Adults with Advanced Medical Illness and Functional Decline: Cost Analyses of a Home-Based Palliative Care Program. JPSM Vol 56 No. 6, Dec 2018

- Casarett, D et al. Why Population Health and Palliative Care Need Each Other JAMA Published Online May 12, 2016

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QUESTIONS

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