Integration of Palliative Care and Primary Care

Russell S. Phillips, MD
Director, Center for Primary Care
Harvard Medical School
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Observations

- Inserted palliative care specialist into primary care practice. Few referrals as primary care physicians did not want to assign end of life decision-making, conversations and management to others
- I have a panel that numbered 250 patients consistently for 40 years. During that time, I have cared for more than700 patients due to attrition, death, moving away or choosing another doctor, yet I have had about 100 patients die when I was caring for them, and most of them died of severe illness.
- Losing a patient to death from severe illness is a common experience in primary care

Principles of Chronic/Severe Illness Care

- Patient, family and community centered
- Continuous/relationship based
- Comprehensive and equitable care for all, from first contact to end of life
- Team-based collaborative-inclusive of social workers, nurse, clergy
- Coordinated and integrated-with open channels of communication
- Accessible 24/7 coverage
- High value/extend quality time, prevent unwanted services, especially at end of life

Care model: Collaborative Care Model for Supportive Care

- Patient centered care team
- PCP, advanced practice nurse(APN) or physician's assistant, population health manager, medical assistant(MA)
- Identify patients with serious illness (according to prognostic index, surprise question, other)
- Create registry for patients with severe chronic illness
- Discussion with PCP or APN on preferences for care, health care proxy, preferences for site of care at death(home vs hospital)
- Monitor symptoms over time(MA) and identify poorly controlled symptoms including depression and substance abuse)
- Intervene as needed(dx tests, treatment, referrals)ss and track response to interventions
- Visits with PCP, APN, even if in hospice,

Barriers and Facilitators

- Payment: move to value based prospective payment with extra payment for palliative care/supportive care services
  - Includes all team members, virtual care
- Quality metrics, severity adjustment, incentives to serve as hospice care physician of record
- Expertise: Training through ECHO models, learning collaboratives, develop nurse specialist role within practice
- Patients want care from PCP at end of life/no time is more important
- PCPs want to care for patients at end of life/no time is more important

Reforms to Facilitate Integrated Palliative and Specialty Care(1)

- Clinician-Adequate training in symptom management, advance care planning, and other palliative care competencies
- Patients-Education about the benefits of palliative care
- Delivery System-Integrating nurses and physician assistants with palliative care expertise into primary care/establishing relationships with hospice/creating referral guidelines for palliative care specialists
- Policy Level-Adequate payment for care of patients with serious illness, preferably as capitated amount/reinforcing primary care competencies amongst all healthcare providers/re-defining palliative care as appropriate at earlier stages of illness that when death is imminent

(1) Parikh R, Lepp A and Phillips RS. A More Cohesive Home: Integrating palliative and primary care for seriously ill patients, Health Affairs Blog, August 3, 2015