# **Community-Based Palliative Care:** Population Health Management Perspective

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# Population Health

Understanding and improving the health outcomes of a group of individuals

- Special emphasis on reducing disparities in health outcomes
- Improving value of health care
- Reducing morbidity and avoiding mortality
- Guidance for the policy development, research agenda, and resource allocation that flow from this framework
- Increasing emphasis on health outcomes – and the distribution of outcomes within the group

Kindig & Stoddart 2003
Casarett & Teno JAMA 2016

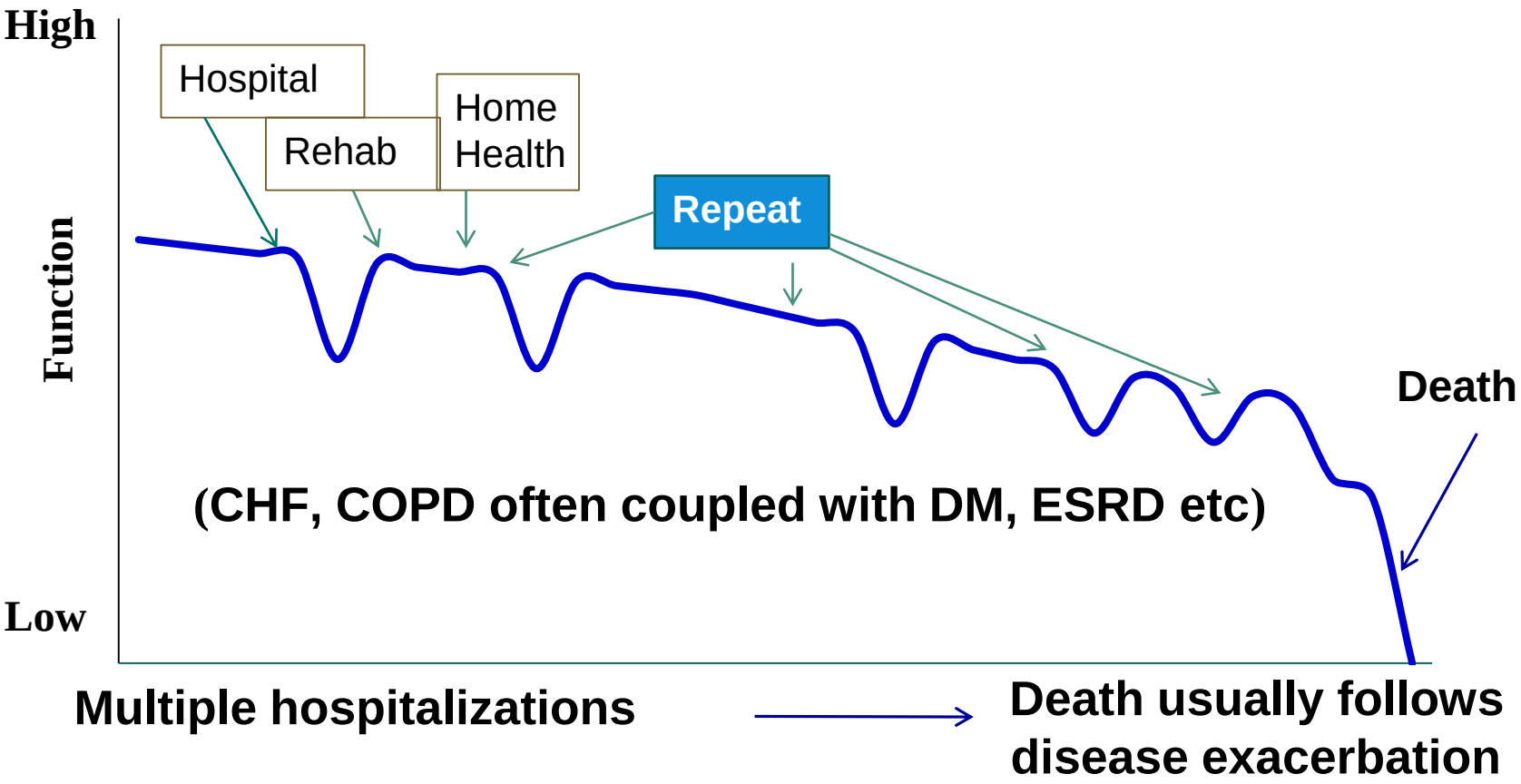
# Systematic Approach

- Sensitive and specific to identify people with serious illness – need driven
- Utilizing Population, Public, Community, Preventative Health approaches
- Right sized and matched to need
- Scalable - Increasing the populations served
- Not just the patient, but the caregiver

# Eleanor

- 88 yo AA woman, widowed, retired factory worker.
- HFrEF of 40%, ischemic heart disease s/p MI, COPD with asthmatic component, DM-IR, HTN, CKD stage 3, Mild Cognitive impairment and Arthritis with pain in her hips and knees limiting her mobility.
- Lives with her daughter and granddaughter who juggle part-time jobs to jointly provide full-time care.
  - Relying on Eleanor's Social Security to maintain their home.
- Eleanor has been repeatedly to the ED x 5 and hospitalized x 3 in the last 6 months secondary to CHF and hypoglycemia.
- She has not seen her PMD for 2 months as has missed her appointments while in the hospital.

# The bumpy decline of multiple chronic illnesses




CPC particularly cost-effective in the last year of life.

# Lack of coordination in “post-acute”

- Three types of agencies predominant: Home Health, Skilled nursing/Rehab, Hospice
  - None may be ideal or even accessible for Eleanor
    - Observation vs hospital stay
    - Not eligible for hospice care
- Only 7% of those surveyed report their organization is fully coordinated with hospital and home settings
- >90% are siloed – paper data exchange of records, no coordination of care

# Delivery System Reform

- Health services in the United States suffers from high levels of **waste and inefficiency.**
- An IOM 2012 report estimated that about **30 percent** of health spending was **wasted** on unnecessary services, excessive administrative costs, fraud, and other problems.
- Despite numerous initiatives undertaken, the degree of **fragmentation** is striking.
  - Redundancy and excessive use of services is common
    - Churn has been rewarded by FFS
  - lack of communication and data sharing among providers
- *The goal of improved efficiency through CQI, improved productivity should decrease cost without negatively impacting quality.*

Joseph Antos and James Capretta
April 20, 2017 Health Affairs Blog

**Palliative Care drives Quality Outcomes**

**Key is to incent:**

**Coordination**

**Collaboration**

**Communication**

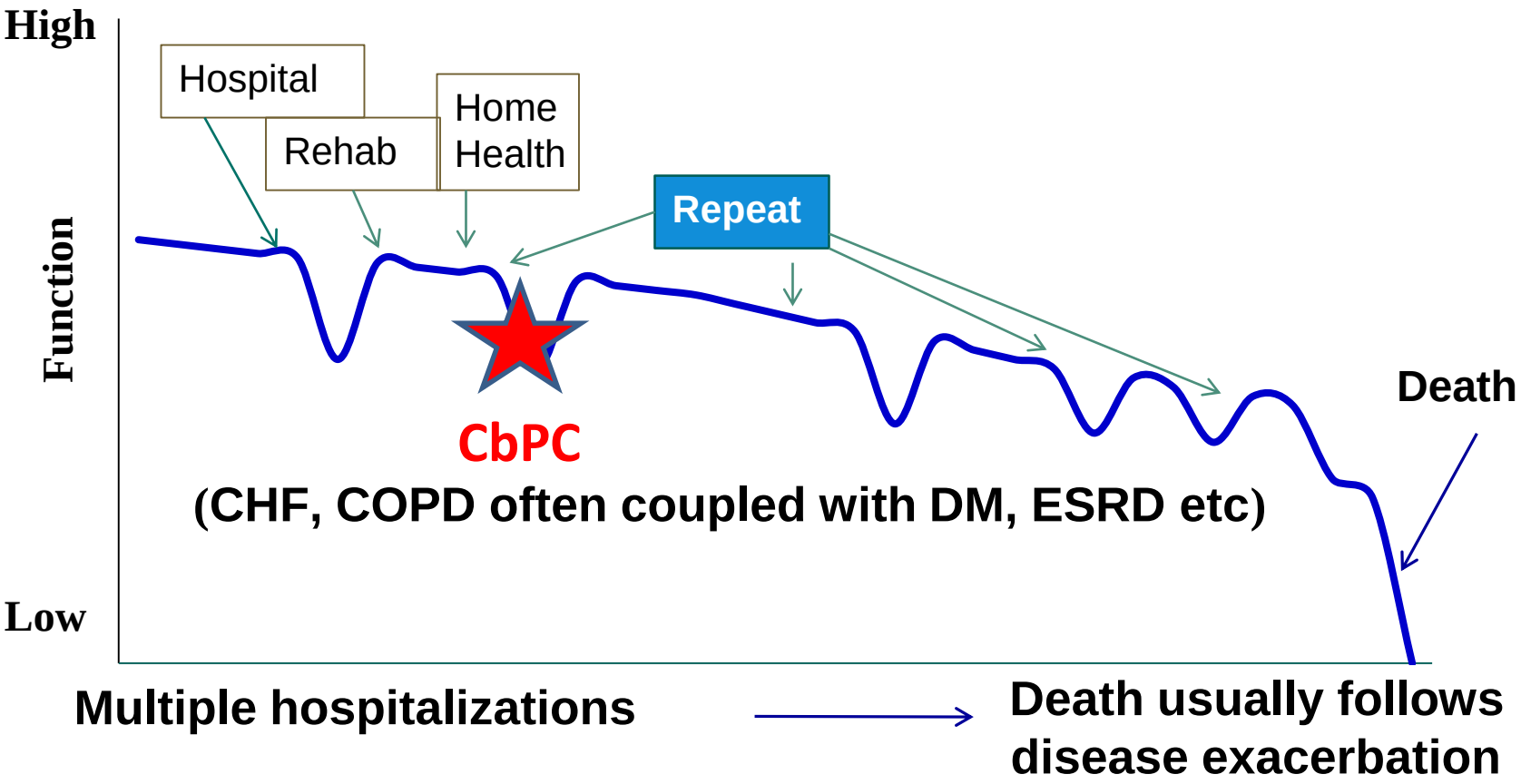
**which are the Pillars of Palliative Care**

# Palliative Care is Uniquely Effective in Achieving the Triple Aim

**Outcomes of Palliative Care:**

- Reduction in symptom burden
- Care concordant with pt/family wishes
- Improved patient and family satisfaction
- Reduced costs

# Epicenter of PC is Community-based

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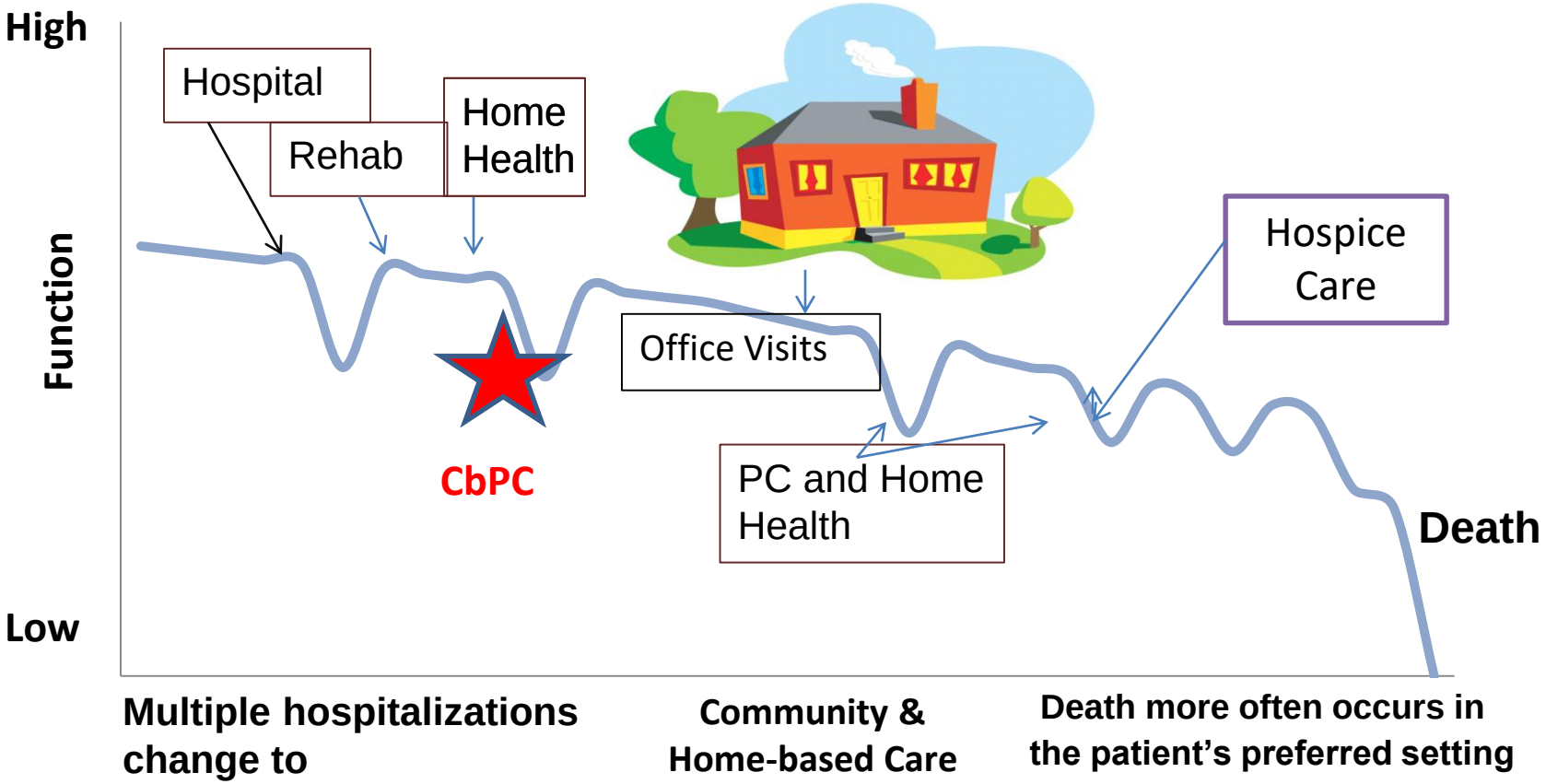
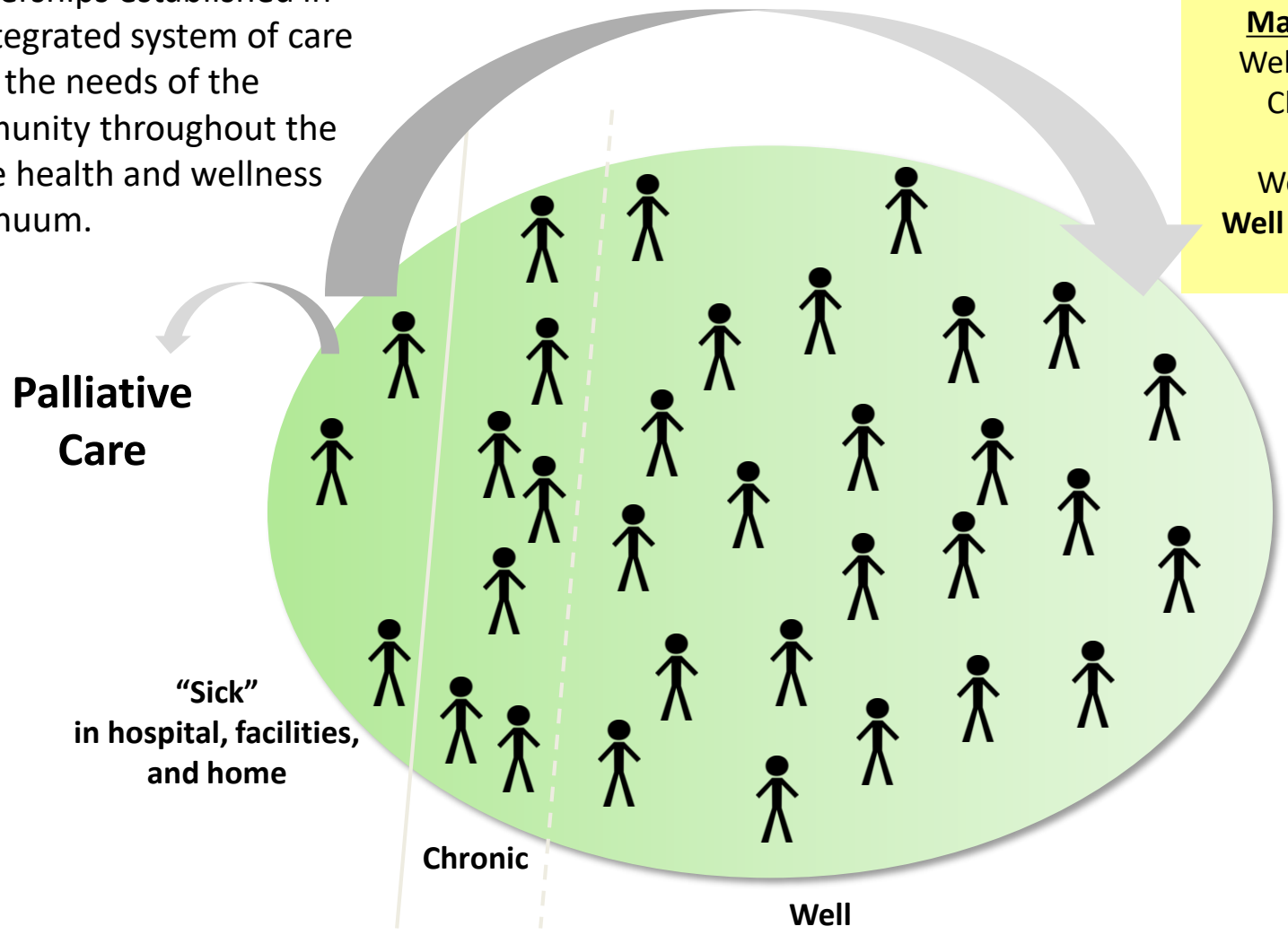
# Community-based Palliative Care (CbPC)



# Palliative Care supports Population Based Health

The services and partnerships established in an integrated system of care meet the needs of the community throughout the entire health and wellness continuum.

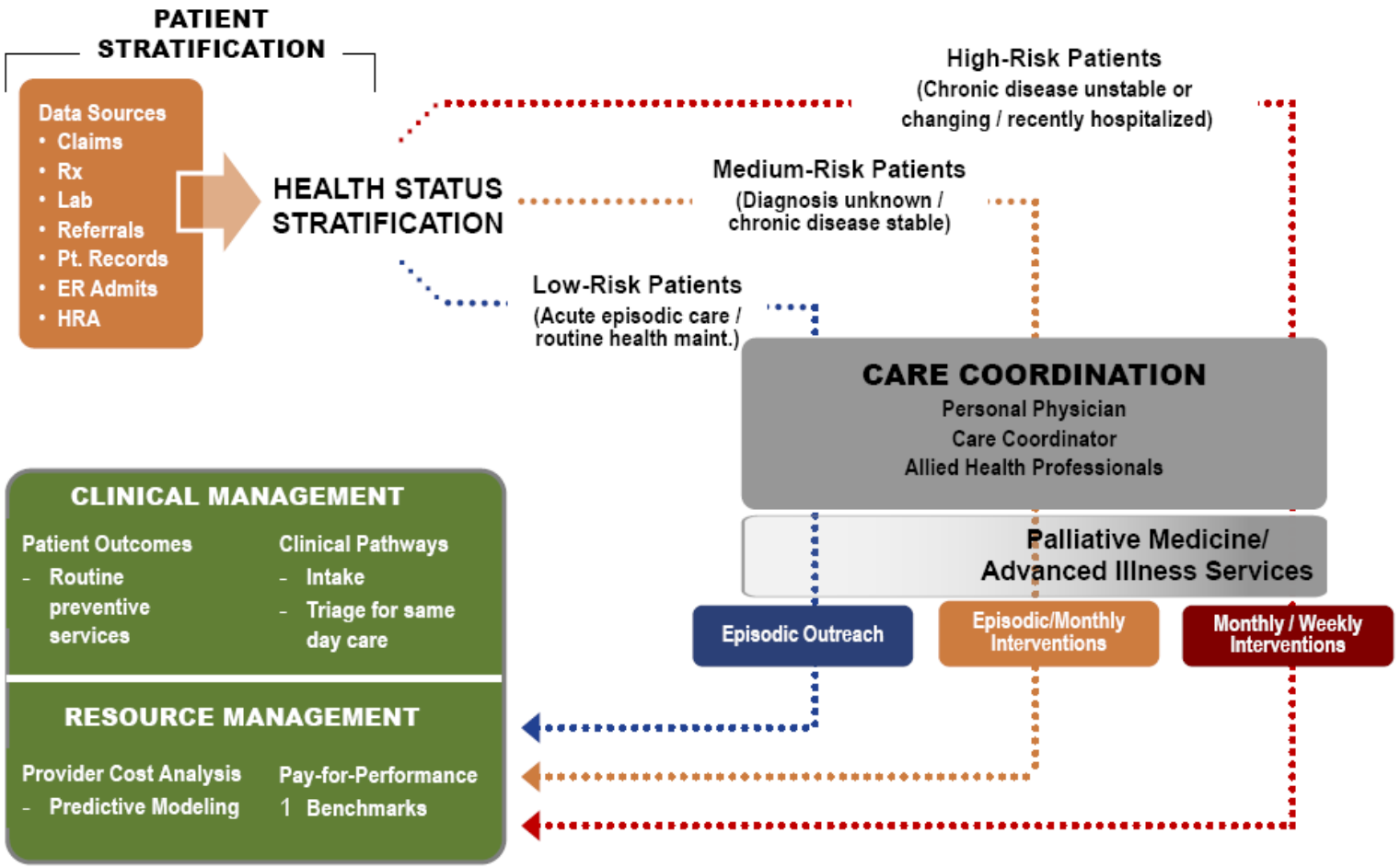
**Manage Populations**
Well = keep them well
Chronic = manage conditions
Well → Sick → Well
**Well → Sick → Palliative Care**




Wellness Services:
- Wellness Center
- Diet and Nutrition Coaching
- Mammography
- Colonoscopy
- Psychiatry / Psychology
- Women's Center
- Senior Center

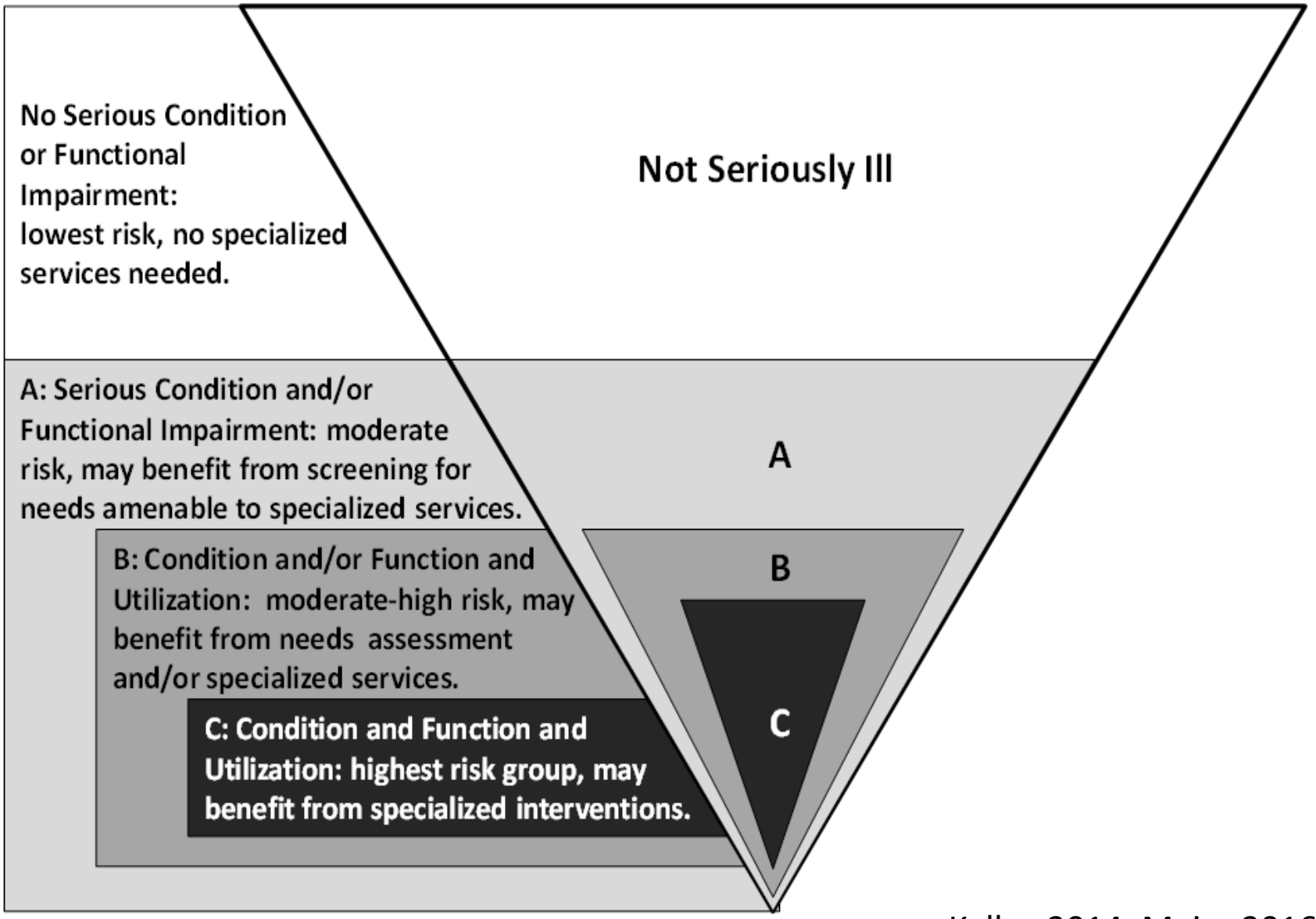

Buxton; Twaddle 2014

# Medical Home Coordinated Care Model Featuring Palliative Med / Advanced Illness Services Component




Adapted from SSB Solutions AHA-CIO Discussion Document March 2012

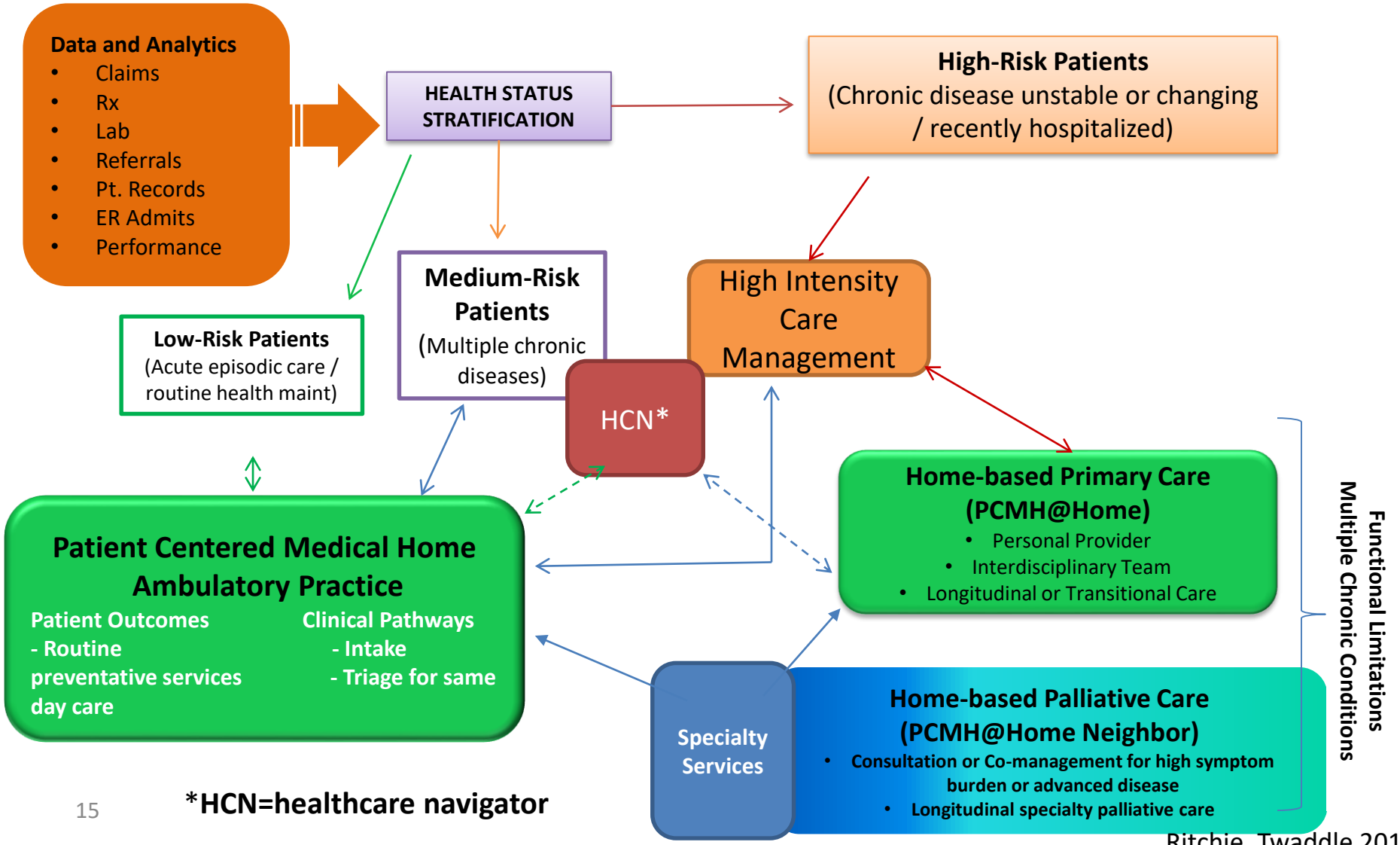
Twaddell & Twaddle 2011




Kelley 2014; Meier 2016

# Neighborhood: Home-based Primary & Palliative Care

## Population Health, PCMH@Home & PCMH@Home Neighbor




*HCN=healthcare navigator



Ritchie, Twaddle 2015

# CbPC & the PCMH

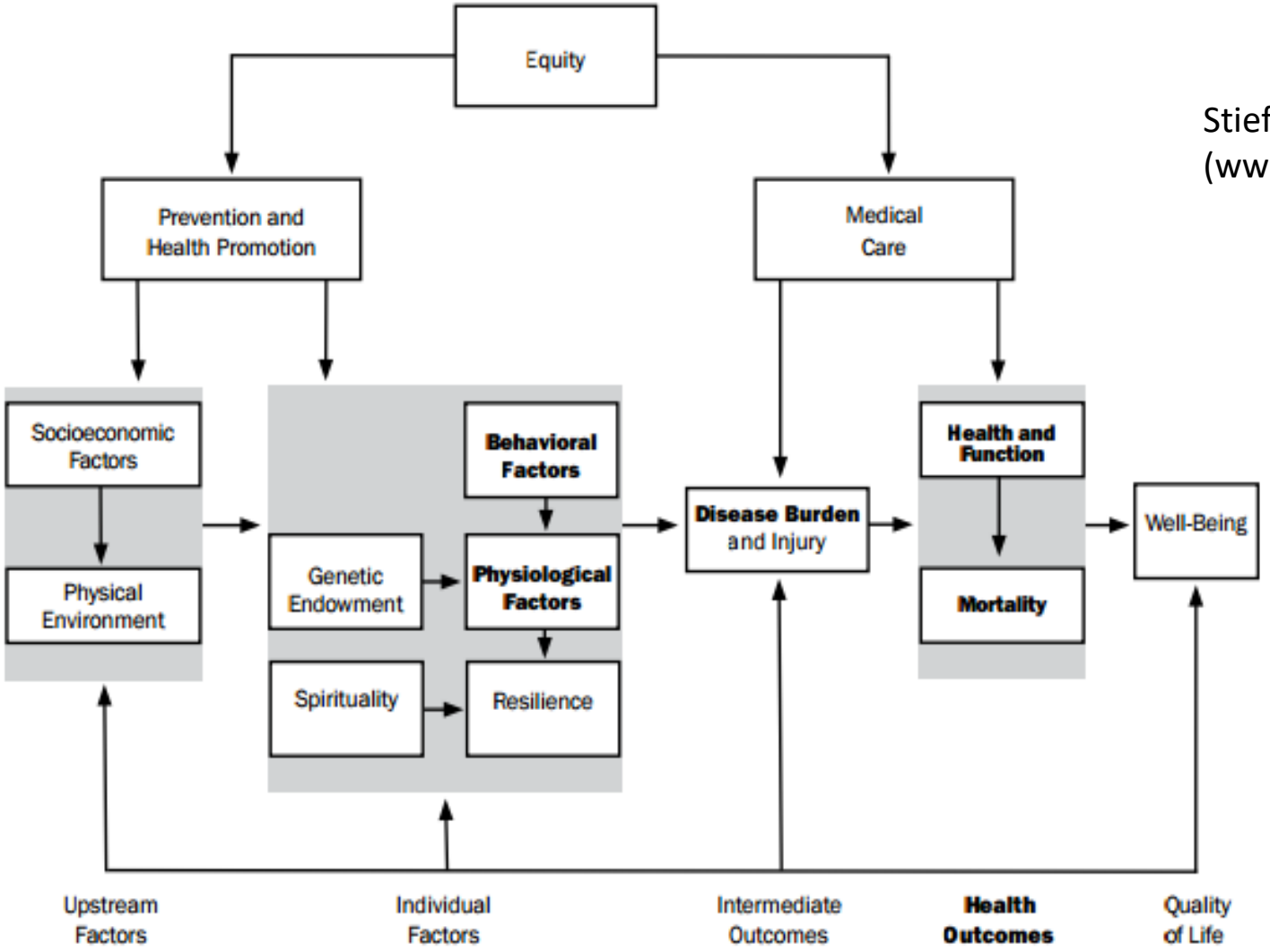
**Interdisciplinary team expertise**

- **Support for transitions** of care for high risk patients across sites of care
- **Active care management** to meet patients and families needs and thus prevent unnecessary and non-beneficial inpatient/ED utilization
- Filling gaps in existing community services and **coordinating the gaps**

# Home-based primary and palliative care

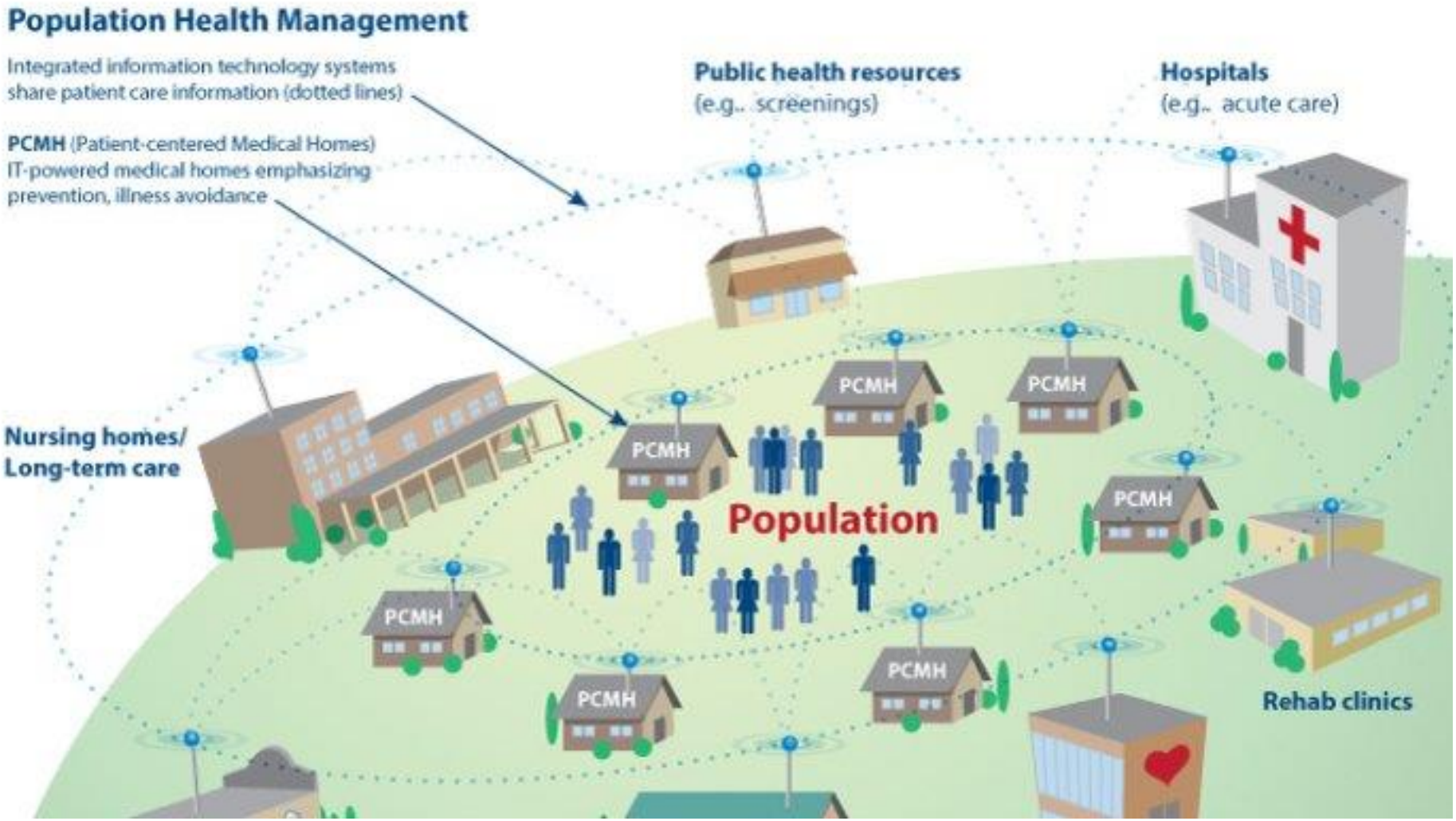
- **Integrates palliative care into comprehensive primary care** via an interdisciplinary team: integration of palliative care principles into longitudinal health care relationships.
- Patients with **multiple chronic medical conditions, high symptom burden, and/or complex care coordination needs**.
- Most often led by **physician and advance practice nurses** - can include nurses, clinical pharmacists, social workers, psychologists, and physical therapists.
- Team members with **added training and expertise in home-based care and palliative care.**
- **When home is the optimal site of care delivery – palliative care integration is essential.**

Figure 1. A Model of Population Health

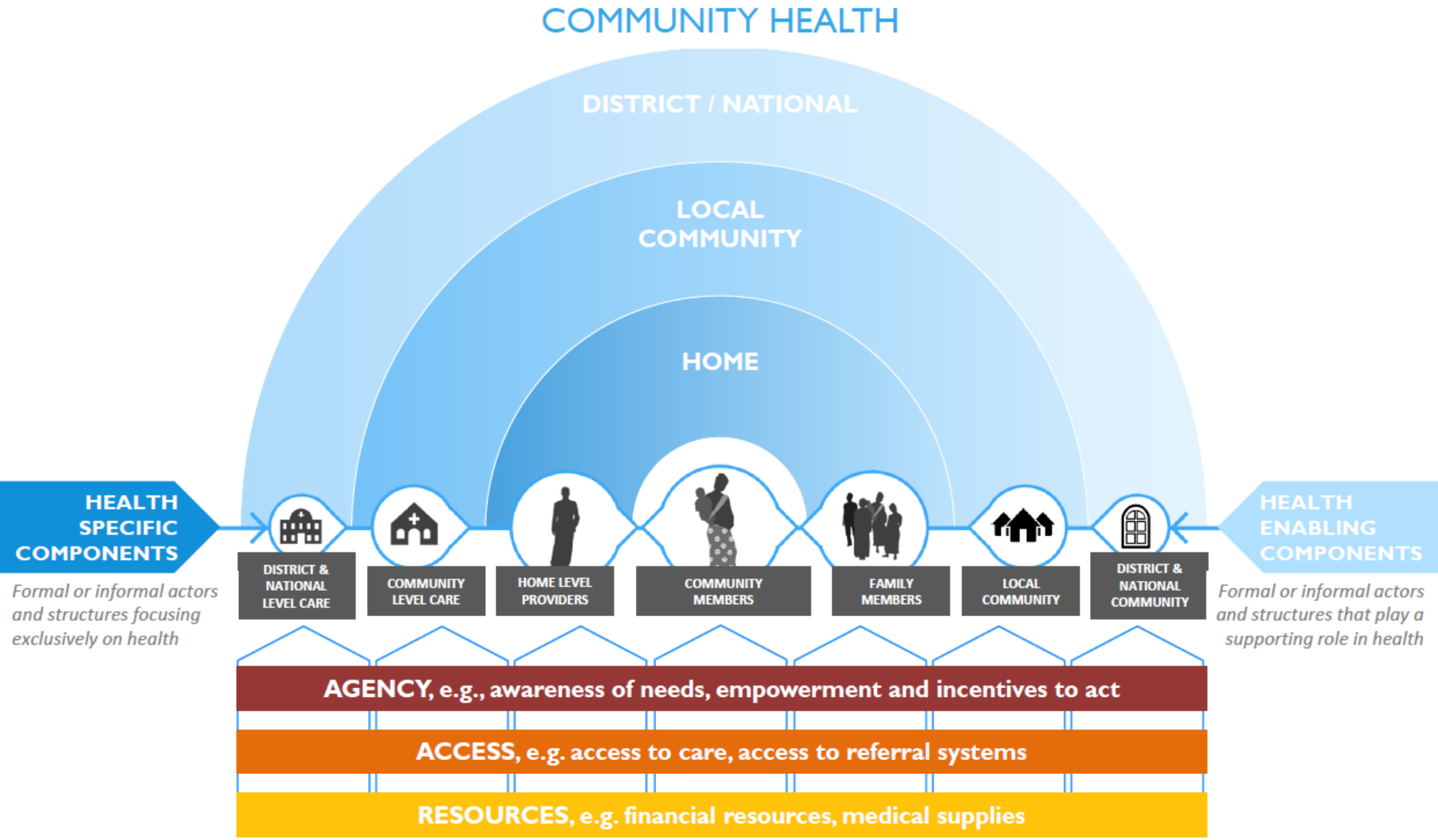



Note: Measures of population health in the Triple Aim measurement menu in Table 1 appear in **bold** text in Figure 1.

Stiefel M: IHI; 2012. (www.IHI.org)




Miguel McInnis, MPH




Dalberg Global Medical Advisors

# *"Don't ask what's the matter with me; ask what matters to me!"*

"Ultimately, good medicine is about doing right for the patient. For patients with multiple conditions, severe disability, or limited life expectancy, any accounting of how well we're succeeding in providing care **must above all consider patients' preferred outcomes**."

Reuben and Tinetti NEJM 2012;366:777-9.

# Eleanor

- Accessed home-base Primary and Palliative Care (HBPC)
- Seen regularly by a Primary Care physician at home along with APPs & a MSW trained in Palliative Care to comprise her Interdisciplinary Team.
- Meals on Wheels, assistance devices accessed and coordinated by PC.
- Hospitalization and ED utilization dropped 75%
- Adherence to care plan increased, de-prescribed non-essential medications, assessed and improved home-safety
- Caregiver reports decrease stress and worry

# The 5 Key Characteristics of Effective Population Health Palliative Care

- Target the highest risk people
- Ask people what matters most to them, and modify their care accordingly
- Ensure proactive and holistic pain/symptom management
- Support family and other caregivers
- Provide 24/7 and timely access

**CAPC 2017**

We do not learn from experience... we learn from reflecting on experience.

- John Dewey