Crossing Traditional Boundaries in the Management of Serious Illness

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Abstract

- The strategic initiative surrounding population health and the triple aim has increased the focus on patients with chronic illness
- 2013 - an integrated healthcare system partnered with its insurance provider to develop a home based program that supports patients and caregivers with the management of chronic illness
  - An RN led interdisciplinary team
  - Utilizes palliative care principles
  - Develops a patient centered plan of care with focus on physical and mental well being using the SF12 Quality of Life tool (Ware, Kosinski, Keller, 1995) as a method to engage patients in care planning
  - Interventions are implemented in collaboration with the patient, team, family, and primary care physician
- The Plan of Care incorporates the core principles of palliative care
  - Safe effective symptom management
  - Expert communication
  - Skilled coordination
  - Continuity across the course of the illness
  - Advanced Care Planning
- Measures of care plan effectiveness include
  - SF12 (Ware et al., 1995) time 2
  - Transition to hospice
  - Changes in PPS and ESAS scales

Program Goals

- Improve quality of life for patient and caregiver
- Work with interdisciplinary team, patient, and caregiver to establish goals of care
- Provide in home supportive services for those that are hospice appropriate, but not ready to elect the hospice benefit
- Reduce the volume of ED visits, hospital admissions, and rehospitalizations during the last year of life
- Transition to hospice when appropriate

Criteria for Program Participation

Diagnoses:

- **End Stage Chronic Pulmonary Disease**
  - Stage III: FEV1<40%
  - COPD Class 4 – Very Severe: patient unable to perform activities of daily living without experiencing dyspnea
- **End Stage Congestive Heart Failure**
  - Class IV:
    - Patient with severe limitations with dyspnea at rest and may show signs of poor perfusion related to low cardiac output
    - Patient unable to perform activities of daily living
    - Ejection Fraction < 40%
- **Metastatic Cancer**
  - Any cancer that has spread from its place of origin (primary tumor site) to another part of the body
- **Decline and Debility**
  - Patients who are 75 years of age or older AND diagnosed with the following conditions:
    - Senility
    - Nutritional Debility
    - Adult Failure to Thrive (Existential Distress)

Measures

PATIENT MEASURES:

- **Satisfaction:** Based on patient survey
- **SF12:** A 12 question self-reported tool used to measure the functional health and well-being from the patient's perspective (Ware et al., 1995)

FINANCIAL MEASURES:

- **Hospitalization:** As compared to 30 day rehospitalization rate of 18.4% in 2012 (Gerhardt et al. 2013)

CLINICAL MEASURES:

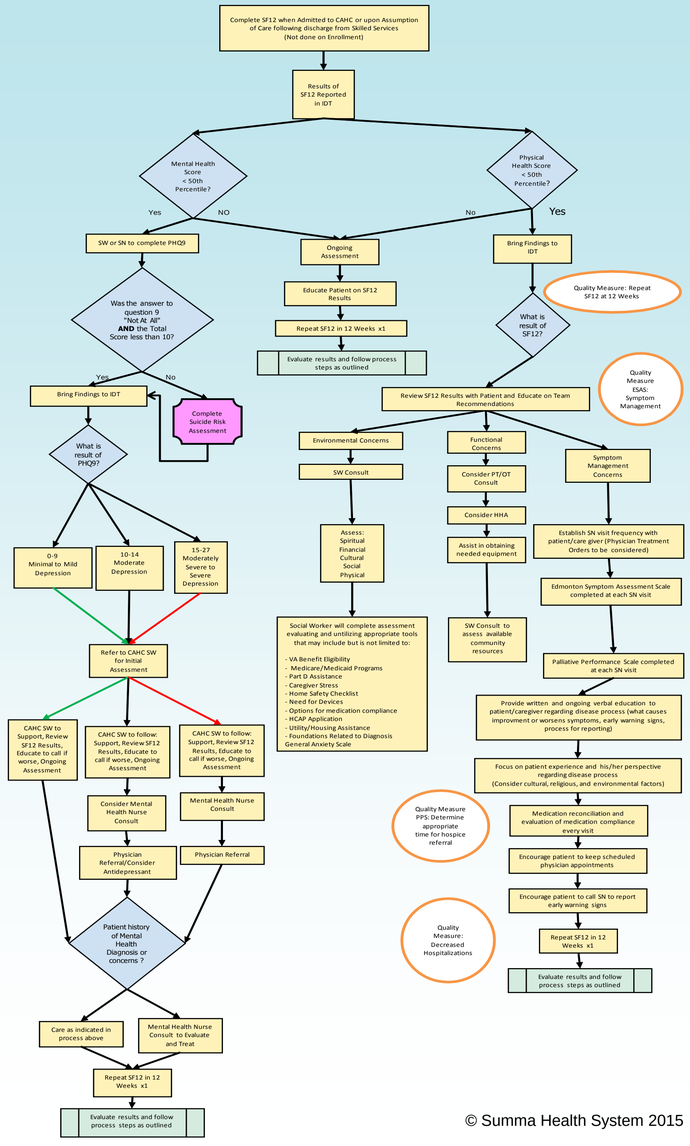
- **% Referred to Hospice:** Percentage of patients discharged to hospice services
- **Hospice length of stay:** Average length of stay in hospice following discharge from program
- **The Edmonton Symptom Assessment System (ESAS):** Assessment tool used to assess pain, tiredness, nausea, depression, anxiety, drowsiness, appetite, well being, and shortness of breath (Bruera et al., 1991)
- **Palliative Performance Scale (PPS):** Assessment tool used to report patient's functional level based on ambulation; activity & evidence of disease; self-care; intake; and conscious level (Palliative Performance Scale, 2006)

Patient Profile (N = 72)

- **Demographics**
  96% Caucasian
  49% Female
  Age: 19% 30-60, 45% 61-80, 36% 81-101
- **Primary Diagnosis**
  27% CHF
  19% COPD
  37% Cancer
  17% Other

- **Physical Descriptors**
  54% Homebound
  27% Risk Factors (smoking, alcohol, obesity, substance abuse)
  85% Hospitalized in the last 6 months (35% admitted 3 times or more)
  76% Emergency Room Use in the last 6 months (26% in ER 3 times or more)
  97% Nutritional Risk (47% at high risk)
- **Psychosocial Descriptors**
  55% Financial factors (medical, food, rent, utilities)
  46% Needed assistance with handling finances
  72% Reported their care impacts their support systems
  93% Reported good social support systems

Process



Results: June 2014 to June 2015

Satisfaction: Met or Exceeded Expectations = 100%

Hospitalization Rate (January 2015 to June 2015): 9%

Discharge Disposition:
Referred to Hospice: 54%
Expired: 20%
Other (i.e. Change in Insurance, Long Term Care, Out of Area): 26%

Hospice length of stay: 56 Days

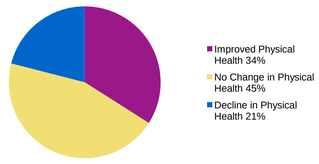
The Edmonton Symptom Assessment System (ESAS) (Bruera et al., 1991) : Ongoing - Used each visit to identify areas of concern as identified by the patient.

Palliative Performance Scale (PPS) (Palliative Performance Scale, 2006) : Ongoing – Used each visit to identify when patient may be appropriate for hospice referral.

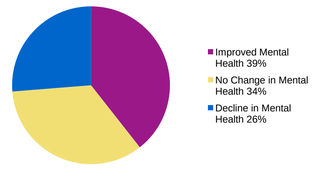
Repeat SF12 (Ware et al., 1995) - % Improved in Mental Health Scores: 39%

Repeat SF12 (Ware et al., 1995) - % Stable or Improved in Physical Health Scores: 79%

Repeat SF12: Patient Perception of Physical Health



Repeat SF12: Patient Perception of Mental Health



Next Steps

- The program needs further evaluation of its impact on population health capturing the cost of delivering care against the benefits of decreased, costly healthcare utilization on the insurance provider.

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