Home Based Palliative Care

Practical Aspects of Palliative Care
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MGH Home Based Palliative Care Program
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Disclosures:

• Neither Martha nor I have any conflicts to report...

Objectives:

• Identify the “issue”: are we all looking to solve essentially the same problem?

• Review some of the key components to consider in structuring and staffing a home based palliative care program.

• Use a series of case-based studies to review operational issues as well as clinical management of the home based palliative care patient.
Mind the Gap:
Is anyone here not looking to solve this problem?

Key questions for operationalizing community-based palliative care:

- Structure:
  - Who are you and what is your role in your health care community?
  - Whose strategic mission are you on and who are the stakeholders?

- Process:
  - Referrals: a) defining your target population; b) who is initiating the referral and c) education around appropriate referrals for your particular program.
  - Defining who is assuming clinical responsibility for what… while recognizing that everyone will want/need/expect something different!
  - Care coordination critical: existing resources that can be accessed or do you need to create your own structure?
  - Communication critical: how and how often?

- Outcomes:
  - Keeping it SMART: simple, measurable, actionable, relevant/realistic and time-specific.
  - Moving towards a standard of care in the community.


MGH Home Based Palliative Care (HBPC):
Brief overview

- Structure:
  - Partners Population Health developed and supports the Intensive Care Management Program (iCMP) for advanced, complex illness patients.
  - Recognition that iCMP patients have comprehensive palliative care needs.
  - Development of palliative care programs to meet those needs align patient wishes with resource utilization.
  - Bottom line: targeted PC support for patients with an MGH/Br下达PCP within the ACO/Risk Based Insurance Plan.

Patients identified by algorithm for enrollment in iCMP.
MGH Home Based Palliative Care (HBPC):
Peeling the onion of care in the community from a PCP referral base.

Other FAQs...

- Billing:
  - All of our providers are members of the Division of Palliative Care and
  credentialed through MGH.
  - MD and NP visits are billed through Medicare Part B or the commercial
  payer (we bill just like MDs or NPs in a clinic).
  - Documentation must state why the home visit was necessary:
    - Taxing effort to leave the home, unable to leave the home on that
      particular day due to symptoms, assessment of the plan of care at home
      specifically with regards to medication compliance.
- Skilled home health needs:
  - A patient can be on home health (receiving skilled RN visits, PT or OT
    visits) and also be seen by a HBPC provider.
  - Billing different and, in the case of our program, MD and NP visits
    provide a different level of care.
  - Our social worker does not bill.

Emerging patient patterns:

- Group #1:
  - The "rapid transition to hospice" patient

- Group #2:
  - The "unstable" patient
    - More advanced palliative care needs and goals of care and/or
      coordination of care needs.
    - This patient will either "stabilize" in the coming weeks to
      months and transition to Group #3 or will continue to decline
      and transition hospice.

- Group #3:
  - The "stably/unstable" patient
    - Primary palliative care needs and/or primary care needs; often
      fully home-bound patient.
    - Potential to shift back and forth into Group #2 but generally
      will experience a more gradual transition to hospice.
Group #1: Mr. K

- 79 yr old man with recurrent adenocarcinoma of the stomach diagnosed in February; h/o depression, CRI, HTN, afib on Coumadin.
  - March - April: multiple oncology visits; patient reports doing “fine” but requiring intermittent IVF for increasing Cr/K, SBP in the 90s, weight dropping.
  - Early May admitted with SBO; hospice discussed and patient refused; iCMF care manager now places referral to HBPC.
  - Mid May: initial HBPC consult;
    - MOLST completed; still refusing hospice; symptom management.
    - Follow up calls the week after the initial consult.
    - Attempted visit 5/28 but patient struggling to get to coag clinic.
    - Patient agreed to a visit 5/29; support around transition to hospice.
  - Patient seen by hospice the following day and enrolled.
  - Died the following week.

But what about groups #2 and #3....

How do those patients fit into your home based PC program?

- Assessing prognosis
  - Necessary information; toxic clinical experience.
- Documenting markers of decline
  - Frailty; PPS or ECOG; FASS; weight loss; falls.
- Complex care plans in the home
  - Use of advanced PC interventions in the community.
- Communication
  - The importance of ensuring that your involvement is acknowledged.
  - Collaborative as opposed to parallel care.
- Defining your role over time....or not.
  - Episodic as opposed to longitudinal care.
The case of Mr. E.....

- 62 yr old man with advanced COPD (FEV1 .82/24% of predicted) on O2, chronic steroids, advanced HF with non-ischemic cardiomyopathy, an EF of 12%, wears an external debrillator/life vest; hospitalized 6 times in the past year.
- Was receiving skilled nursing services and when discharged was referred to that agency's home based PC program.
- Seen last year for an initial consult by that PC program and for one f/u visit a month later.
  - Was discharged from their program as he was “maximally medically managed, continued to see his subspecialists and expressed the desire to remain full code”.
- Lost to home based palliative care follow up and was eventually seen by us for an initial visit nearly 10 months later.

The case of Mr. E.....

He saw his cardiologist one week ago and did not require changes to his medications: SBP 108, HR 88, RR 22, weight at goal, exam without evidence of volume overload, BNP 4963 (always high...), Cr/Bun .76/17 with GFR >60, Na 139. Medications include: metoprolol, lisinopril, furosemide, duonebs, advair, spiriva, prednisone and lorazepam prn.

He reports dyspnea with any movement and is using bipap (which was started after his last admission) more frequently. No fevers or chills, no change in sputum. Physical exam is unchanged. You check a pulse ox at rest: 97% on 2L and on RA is 90%.

The case of Mr. E.....

Which of the following options would you consider recommending to the PCP to help mitigate his breathlessness:

a) Increase the O2 to 4L at rest
b) Consider the use of saline nebulizers
c) Schedule the lorazepam 2-3 times a day
d) Recommend using a small hand held fan and initiate an opioid prn
e) Consider taking the life vest off
f) Have him return to the cardiologist for evaluation
g) Consider a trial of nebulized furosemide
The myriad of “inputs” driving dyspnea

<table>
<thead>
<tr>
<th>Possible Afferent Sources for Respiratory Sensation*</th>
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<tbody>
<tr>
<td>Sudden death (shock, cardiac arrest)</td>
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<tr>
<td>Primary motor-coordinated breathing</td>
</tr>
<tr>
<td>Cardiac or hemodynamic instability</td>
</tr>
<tr>
<td>Sleep apnea</td>
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<tr>
<td>Anxiety, depression</td>
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<tr>
<td>Pulmonary artery hypertension</td>
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</tbody>
</table>

The Importance of a Systematic Approach

- DDx based on pathophysiology
  - Even if you have maximized the medical management of the primary diagnosis, look for another reversible cause.
- Think like an “interdisciplinary team”
  - Contributing environmental, psychologic or social factors (“meaning” of the symptom and its impact on QoL)
- Treatment
  - Pharmacology
    - Opioids (oral, IV) > dyspnea, benzodiazepines > anxiety, O2 if hypoxemic, albuterol/steroids > bronchospasm, anti-emetics/hydration, chemotherapy, nebulized saline may help with tenacious secretions, nebulized lidocaine, risk/benefit profile of nebulized furosemide suggests further studies.
  - Interventional
    - MRI, biopsies, lasers, Pleurx catheter, CPAP/BiPAP, transfusions, pulmonary rehab, ventilating, fans, cool air across face
  - Alternative Approaches
    - Acupuncture, mindfulness, yoga lack strong evidence but low harm

Operational or clinical thoughts/questions?
The case of Mrs. C....

- 97 yr old woman with HFpEF, paroxysmal AF on warfarin, chronic renal insufficiency and chronic LBP.
- She has frequent ED visits due to her daughter’s concerns around weakness, low blood pressure, edema.
- Complex psychosocial dynamics and caregiver stress.
- Daughter calls PCP office after hours about increasing LE edema; PCP triages call, increases dose of furosemide overnight and in the morning requests an evaluation by the Partners Mobile Observation Unit (PMOU), an NP staffed community urgent care service that is part of Partners Health Care at Home.

On evaluation that morning by the Mobile Obs NP, patient reported increased LE edema and SOB, slept in recliner past several nights d/t orthopnea; no significant change in UO over night.

Current medications include: warfarin, atenolol 50mg qday, simvastatin 10mg qday, furosemide 40mg tablets with reported dose of 80mg qday. Recent labs include Na 142, K 4.2, B/Cr 29/1.33 (GFR 33). Last BNP months ago was 5159.

On exam, SBP 110, HR 100, RR 20 97% on RA, patient is sitting in her recliner, pleasant and cooperative, no distress, lungs with crackles at bases, 3+ pitting edema.

Which of the following would you suggest initiating when you call the PCP to discuss based on your evaluation:

a) Transfer to the ED and probable hospitalization for IV diuretics.
b) Return visit the next day to give an IV dose of furosemide at home.
c) Return visit later that day to give a SC dose of furosemide at home.
d) Continue increased furosemide dose of 80mg PO bid and plan a return visit the next day to monitor response.
e) Rotation to alternative loop diuretic (ie. torsemide).
f) Addition of a thiazide diuretic (ie. metolazone) to the current dose of furosemide.
The case of Mrs. C....

Operational or clinical thoughts/questions?

The case of Mr. W....

• Lovely 90 yr old man who speaks Fuchow (dialect of Mandarin) has a history of afib (no coumadin d/t falls and epistaxis), HFpEF, CAD, PVD, diabetes now on HD; foot pain thought to be due to neuropathy and critical limb ischemia; now s/p three attempts at interventional stenting with limited improvement in pain.

• Previous consults for pain include: interventional cardiology, pain service, orthopedics, rheumatology, wound service.

• Current medications include: oxycodone 5mg q4hr prn (patient reports that it makes him sleepy and does not take often), gabapentin 300mg qhs, APAP, lidocaine patches.
On initial consult:
- daughter helped translate via speaker phone and visit was coordinated with long time home health nurse;
- patient lives with his wife who has dementia and he is the primary care giver;
- patient reports significant pain, drifts off to sleep easily and daughter reports not sleeping due to pain;
- all medications sent from pharmacy in bubble packs; multiple packs with discontinuous dates are in a drawer.
- All Mr. W wants to do is remain home with wife.

Which of the following would you suggest initiating when you call the PCP to discuss based on your evaluation:

a) Rotation to Dilaudid 1-2mg q4hr prn pain as he is not tolerating the oxycodone
b) Start Oxycontin 10mg PO bid
c) Start MSContin 15mg PO bid
d) Increasing gabapentin to 300mg PO tid
e) Add Lyrica 50mg PO qday
f) Start methadone 10mg/5ml solution; dose 1mg PO bid.
g) Trial a dose of SC lidocaine 2mg/kg at home.
h) Arrange for a PCA at home: determine basal rate, bolus dose.

Perception:
- Opioids, APAP, alpha-agonists, TCAs, SSRIs, SNRIs.

Descending Modulation:
- TCAs, SSRIs, SNRIs.

Transmission (central, synaptic, peripheral):
- Opioids, anesthetics (sodium channel blockers), anticonvulsants, anti-depressants, alpha-agonists, NMDA-antagonists.

Transduction:
- NSAIDS, capsaicin, ice, topical anesthetics, local anesthetics.
Operational or clinical thoughts/questions?

The case of Mrs. A...

- Lovely 93 yr old woman with HFpEF, moderate HTN, mild COPD, moderate renal insufficiency, moderate dementia and a distant history of breast cancer who was initially seen following a hospitalization for HF.

- Daughter reports increasing difficulty getting her mother out of the home for clinic visits; patient states that she doesn’t want to go to doctor visits or the hospital.

- Goals of care reviewed at initial visit; MOLST form completed; medication reconciliation completed and de-prescribing recommended to PCP where possible.

- Follow-up visit planned for 2 weeks to assess medication changes and symptoms; follow-up visit 4 weeks after that.

The case of Mrs. A....

- Initial consult done following several ED visits and two hospitalizations in prior year.

- Patient followed for 2 yrs; would often refuse medications and management suggestions; daughter accepting of decline but vigilant around any clinical changes; no hospitalizations or ED visits during that time until an episode of rapidly progressive SOB; CXR with large pleural effusion; thoracocentesis negative for malignancy; returned home after two days.

- HBPC NP found new thickening of skin around area of breast during her post-hospitalization visit; transitioned to best supportive care with hospice on the assumption of new breast CA.
Operational or clinical thoughts/questions?

Moving forward:
The “mission” is the patient...

Additional references and resources...

•  https://www.capc.org
•  http://healthaffairs.org/blog/2015/08/03/a-more-cohesive-home-integrating-
  primary-and-palliative-care-for-seriously-ill-patients/
•  https://innovations.ahrq.gov/profiles/home-palliative-care-allows-more-
In the beginning...

  - Kaiser: 2002 thru 2004 enrollment from sites in CO and in HI
  - Eligible patients:
    - COPD, HF, cancer referred by discharge planner, PCP, subspecialty physicians
    - Less than 1 yr prognosis as estimated by the PCP
    - Hospital or ED visit at least once in past year
    - PPS (Palliative Performance Scale): 70% or less
  - The "team": palliative care MD, RN, social worker and other disciplines as needed
  - 24 hr phone support by nurse

Consider...

![Diagram](image)

Figure 1. Patient flowchart. "Other reasons include those re-
ferred to hospice (n = 87), those who died (n = 38), those who
were already in another study (n = 40), and those who moved
out of the area or could not be contacted (n = 22).

An “agency-payer” approach...

- Upstate NY: not-for-profit hospice partnership with local commercial insurance payer
  - Eligible patients: advanced illness patients referred to the "Home Connections" palliative care program by physicians, hospice/home health agencies, insurer, patient/family
  - The "team": palliative trained RN coordinator, SW, trained volunteers provided respite care and palliative care MD attended weekly IDTs
  - 24/7 on call palliative care RN support
  - Agency received a per member/per month fee
Consider...

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No. (%)</th>
<th>Mean (IQR)</th>
<th>Min of Enrollment</th>
<th>Max of Enrollment</th>
<th>Advanced Directive Completion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source of referral</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical freight</td>
<td>49 (30)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary cancer</td>
<td>11 (2.9)</td>
<td>23 (7–45)</td>
<td></td>
<td></td>
<td>87.6</td>
</tr>
<tr>
<td>Hospice/palliative care</td>
<td>147 (39.5)</td>
<td>12 (4–30)</td>
<td></td>
<td></td>
<td>50.4</td>
</tr>
<tr>
<td>Local insurer</td>
<td>125 (35.1)</td>
<td>12 (3–25)</td>
<td></td>
<td></td>
<td>52.1</td>
</tr>
<tr>
<td>Health care facility</td>
<td>27 (5.4)</td>
<td>12 (3–30)</td>
<td></td>
<td></td>
<td>57.6</td>
</tr>
<tr>
<td>Primary diagnosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neoplasm</td>
<td>255 (21.1)</td>
<td>13 (4–25)</td>
<td></td>
<td></td>
<td>86.4</td>
</tr>
<tr>
<td>Circulatory micro disorder</td>
<td>87 (7.4)</td>
<td>17 (7–67)</td>
<td></td>
<td></td>
<td>87.0</td>
</tr>
<tr>
<td>Respiratory disease</td>
<td>14 (3.6)</td>
<td>16 (4–39)</td>
<td></td>
<td></td>
<td>86.2</td>
</tr>
<tr>
<td>Mental disorder</td>
<td>49 (16)</td>
<td>15 (5–81)</td>
<td></td>
<td></td>
<td>91.2</td>
</tr>
<tr>
<td>Other</td>
<td>63 (12.5)</td>
<td>18 (9–42)</td>
<td></td>
<td></td>
<td>92.7</td>
</tr>
</tbody>
</table>

*Note: “Clinical Impact” article.

Independent agency approaches...


- John Morris MD, FAAHPM; VP Clinical Outreach, PC Medical Director.