

Improving the Quality of End of Life Care for Older Adults in Health Centers

Session 6: Wrap Up, Innovative Programs/Models

2018-2019 Learning Collaborative Series

Thursday, February 7th, 2019



National Center for Equitable Care for Elders (NCECE)

www.ece.hsdm.harvard.edu

Who We Are- Established in 2017, the National Center for Equitable Care for Elders (NCECE) is a training and technical assistance Center that provides innovative and culturally competent models of care, inter-professional training and educational resources to health care professionals providing care to older adults

Our Mission is to build strong, innovative and competent health care models by partnering with CHCs, PCAs and FQHCs to provide quality, and inclusive care for older adults



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Health Center Resources Clearinghouse

- This comprehensive website provides easy access to a broad framework of resources, tools, and information developed by the National Cooperative Agreement (NCA) organizations, and additional partners soon! Check it out at www.healthcenterinfo.org



Session Leader



Lynn Hallarman, MD

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Health Policy Congressional Fellow, US Senate Committee on Finance



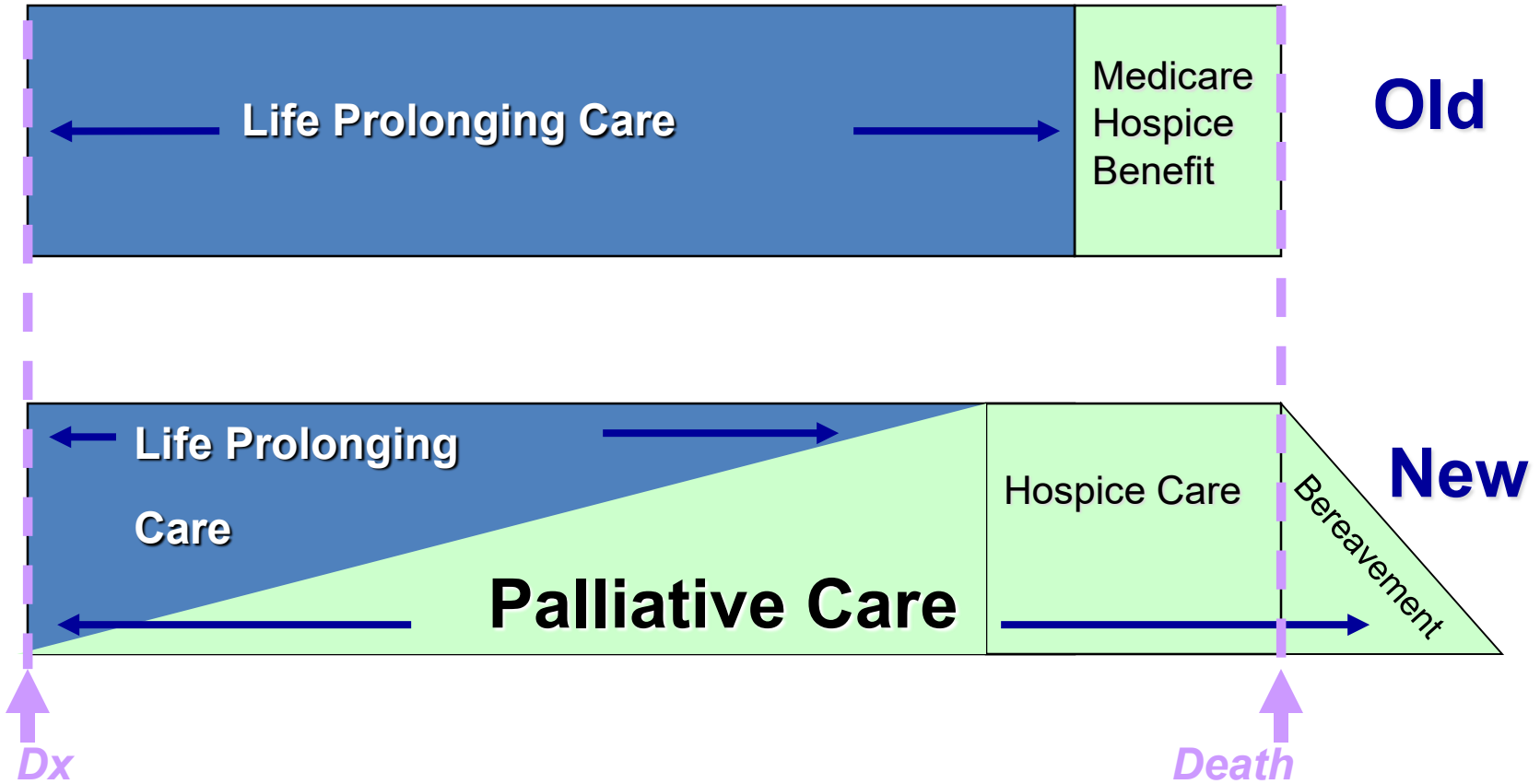
Innovations in Primary Palliative Care Delivery in Community Health Centers

Lynn Hallarman, MD
Palliative Care Educational
Consultant

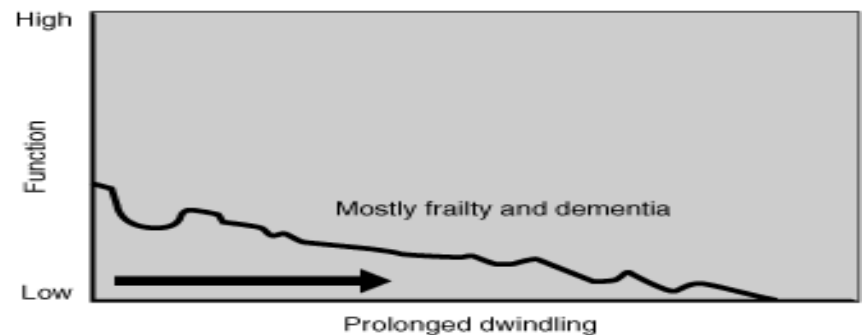
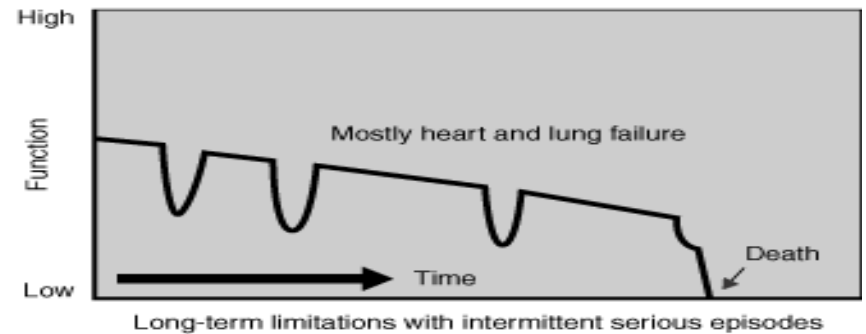
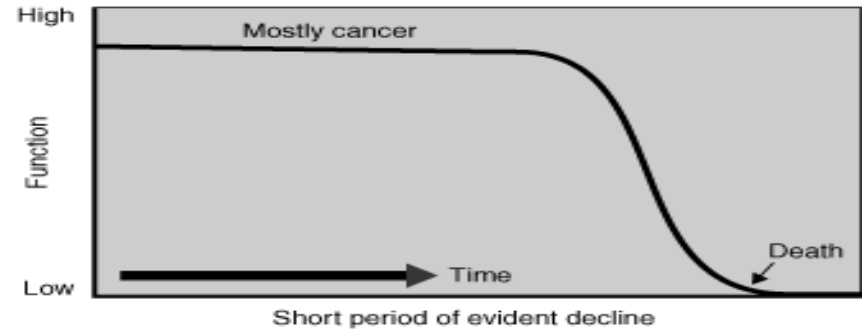
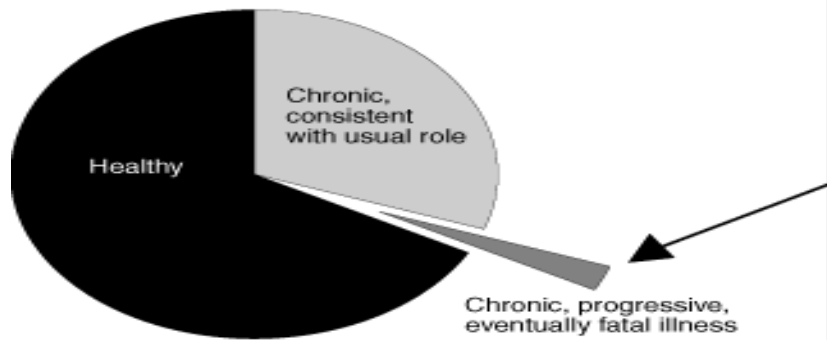
How Does Palliative Care Differ from Hospice?

- Non-hospice palliative care is appropriate at any point in a serious illness. It can be provided at the same time as life-prolonging treatment. *No prognostic requirement, no need to choose between treatment approaches.*
- Hospice- a form of palliative care provides care for those in the last weeks-few months of life. Patients must have a 2 MD-certified prognosis of <6 months + give up insurance coverage for curative/life prolonging treatment in order to be eligible.

Conceptual Shift for Palliative Care



Is the Patient with a Serious Illness in their lives the way they want to be? (RAND Corp)



PRIMARY PALLIATIVE CARE AS A MEANS TO IMPROVE SYSTEMS LEVEL CHANGE IN THE CARE OF THE SERIOUSLY ILL PATIENT



What is Primary Palliative Care?

Primary Palliative Care

The Palliative Care skills every clinician must know to provide

Palliative Care to their patient population.

Secondary Palliative Care

A consultative model where a board certified PC clinician helps support a primary team in caring for complex, seriously ill patients through intermittent consultation.

Tertiary Palliative Care

An intensive model of collaboration where the PC team co-manages the patient along with the primary team.

What is the focus of Palliative Care Interventions?

✓ Inadequate treatment of pain and symptoms

✓ Poor understanding of prognosis

✓ Lack of information about treatment options and/or resources for support

✓ No goals of care discussion or advance care planning decisions documented

✓ Patient/caregiver stress and burden

✓ Undue financial burden from medical expenses

*“You’ve got to start with the customer experience
and work back toward the technology
– not the other way around”*

-Steve Jobs

No Standardization

Everyone can do it



Standardized

Specialist needed

Do You Know Your Practice Community?

Community Based Social Resources	Personal Knowledge?		Established Partnership/Relationship?		Comments
	Yes	No	Yes	No	
Housing					
Homeless Shelter?					
Transitional Housing Services?					
Clothing and Furniture Banks?					
Subsidized Housing?					
Food					
Food Banks?					
Supermarkets?					
Farmer's Markets?					
Community Gardens?					
Transportation					
(Is your practice site accessible by public transit?)					
Bus Route?					
Subway/Trains?					
Pedestrian Walkways?					
Transportation for disabled?					
Jitney?					
Family Supports					
Child Care?					
Caregiver Resources?					
Social Service Offices?					
Legal Aide Offices?					
Local Government?					
Religious Organizations?					
Charitable Organization?					
Community Outreach?					
Libraries with Open Access Computers?					
Parks/Playgrounds?					
Community Based Health Resources					
Hospitals?					
Urgent Care Centers?					
Federally Qualified Health Centers?					
Primary Care Providers?					
Dental Providers?					
Rehabilitative Services (PT/OT/ST)?					
Mental Health Services/Providers?					
National Alliance on Mental Health (NAMI)?					
Addiction Services/Detox?					

**Performance Improvement
Team Project #1:
Caregiver Screen**

Caregiver Assessment: *Ask Them*

What are you most worried about?

How are things going?

What works well for you?

What do you need that might make things easier?

Zarit Burden Interview (ZBI)

http://dementiaphways.ie/filecache/edd/c3c/89-zarit_burden_interview.pdf

Integrated Palliative Care EMR Documentation

Discharge Planning	Not Formalized / Comfort Care in Hospital / Long Term Care / Long Term Care with comfort / Sub-acute Rehab / Home Hospice / Inpatient Hospice / Home / Home with home care / Agency == / MOLST form completed / OTHER
Referral	Spiritual Care Referral=== / Legal Assistance Referral=== / OTHER Psychosocial Referral: Social Worker / Psychologist
Caregiver Distress Screen Performed	Yes / No / OTHER
Palliative	Karnofsky ===% / ECOG == Functional Status: Same / Worse / Improved / OTHER Expanded Pain Assessment: Location === / Duration == / Intensity ==/10 / Quality == / Pain pattern === / Last bowel movement === / OTHER CAM Delirium Scale: 1 / 2 / 3 / 4 / OTHER

MOLST

LEGAL

**Caregiver Distress/
Anticipatory Grief**



The Family Meeting: An Essential Palliative Care Intervention

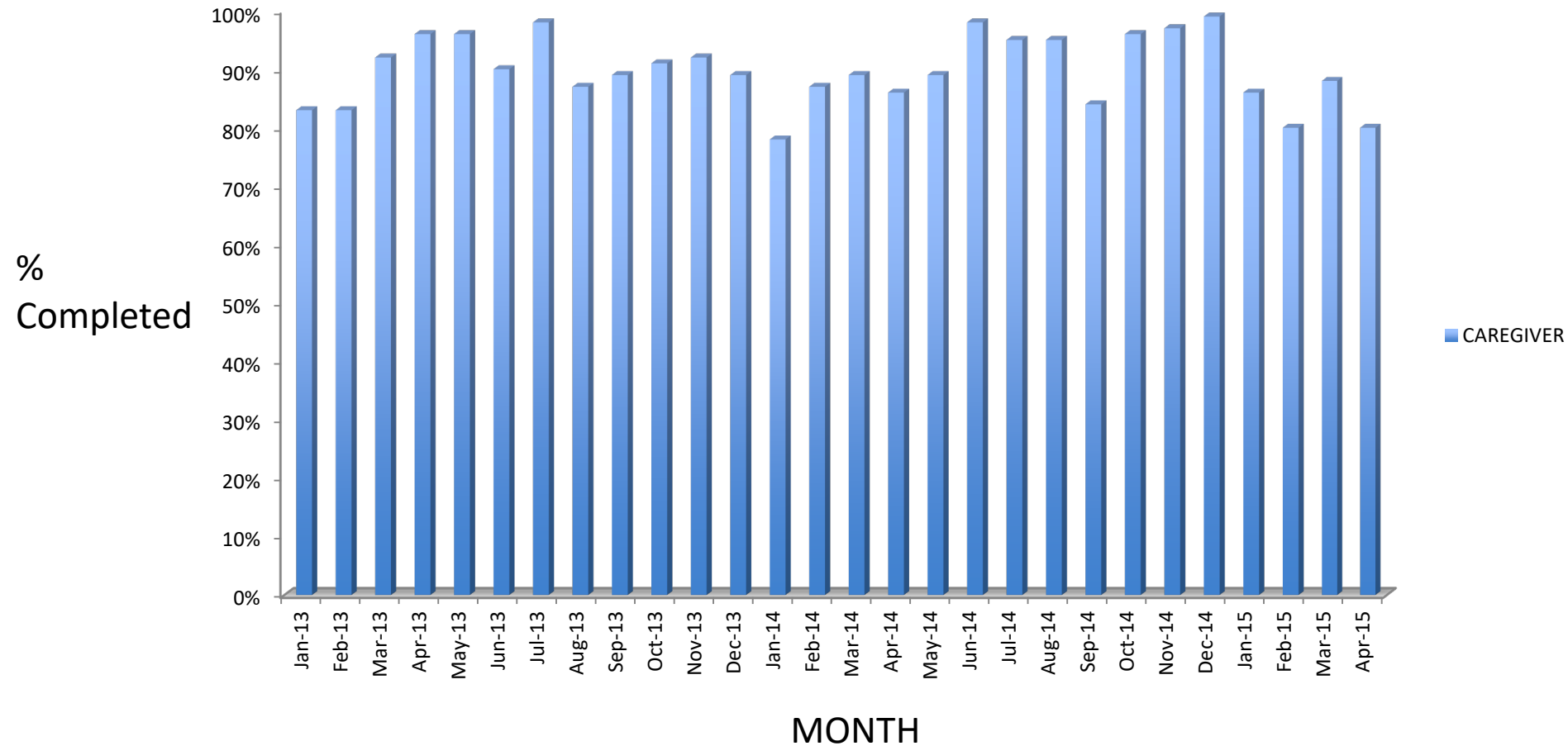
Family Meeting

Family Meeting Scheduled for	==(Date)
Advance Directive	Document is in the Chart and Reviewed / There is an advance directive but not available at this time / No Advance Directive / OTHER
Health Care Proxy Document	Document is in the Chart and Reviewed / There is a Healthcare Proxy Document but not available / No Healthcare Proxy/Next of Kin Surrogate Only / OTHER
Health Care Proxy*/Identified decision maker	Name: == / Phone Number: == / Relationship: == / OTHER
Code Status	Full code / DNR / DNR/DNI / Comfort Protocol in place / Not determined / OTHER
The patient's wishes are known because	Patient has capacity / Written Advance Directive / Patient's wishes are previously known / OTHER
Family Meeting Attendees	OTHER
Family Meeting Summary	OTHER
Family Meeting	Patient in attendance / Patient permission obtained to meet separately / OTHER
Issues Addressed	Medical/Clinical Status / Goals of Care / Hospice / Support Only / OTHER
Outcome	Patient/family verbalized understanding/satisfaction / All questions answered / Patient/Family Agrees to care plan as outlined in narrative / Team will continue to monitor symptom management / Team will provide ongoing assessment / No decisions/care plan changes at this time / OTHER
Follow up Plan	OTHER
Discharge Planning	Not Formalized / Home / Home with home care / Sub-acute Rehab / Long Term Care / Home Hospice / Comfort Care in Hospital / Long Term Care with comfort / Inpatient Hospice / Agency == / OTHER
Referral	Spiritual Care Referral == / Legal Assistance Referral == / OTHER Psychosocial Referral: Social Worker / Psychologist

The ideal family meeting creates an atmosphere for families to breathe, think, speak, vent, ask, debrief, and grieve in a private, safe, & supportive environment

METRICS: Identifying Caregiver Needs 2013-2015

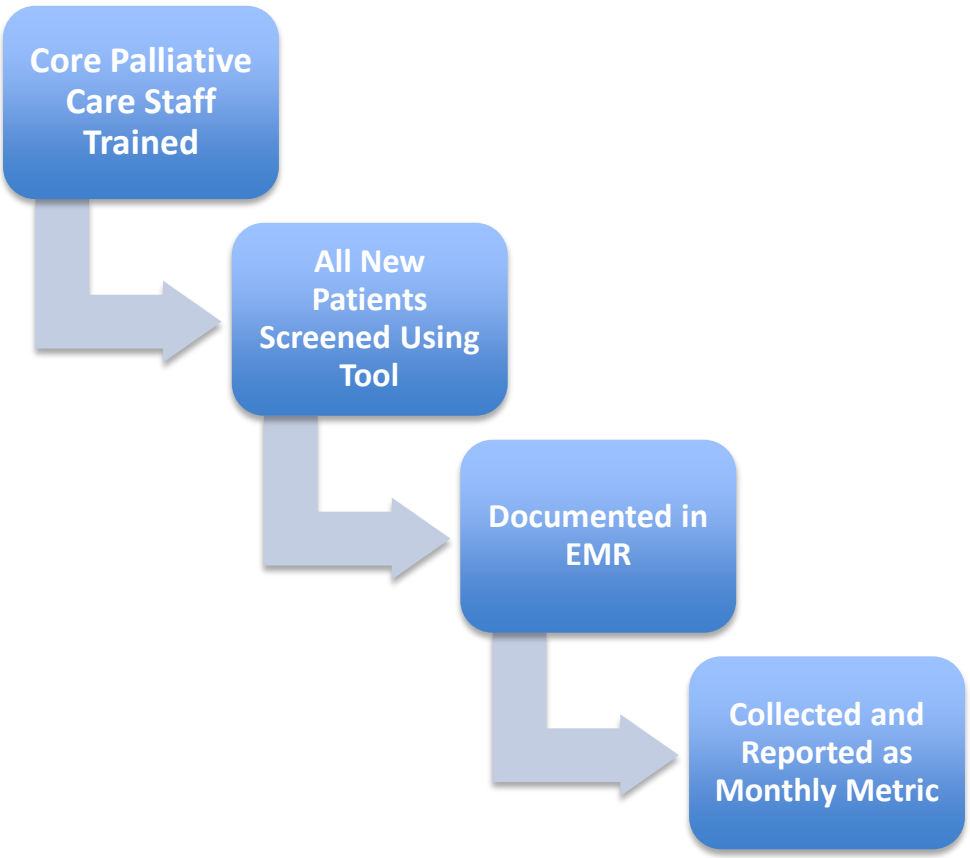
CAREGIVER



**Performance Improvement
Team Project 2:
Legal Screen**

Overall Performance Improvement Implemented or Planned: Health-Related Legal Problems Screen

Team Process



Legal Checkup

	YES	NO
HEALTH INSURANCE		
Denied health insurance coverage?		
Unable to pay for COBRA premium?		
Denied treatment by insurance company?		
Denied Medicaid application?		
Unable to meet Medicaid spenddown ?		
HOUSING		
Served with notice of eviction?		
Court date for eviction?		
Foreclosure action begun?		
Utilities shutoff?		
In emergency housing?		
FINANCIAL CONCERNS		
Lost job?		
Social security disability denied?		
Threatened or sued by medical debt collections?		
Threatened or sued by other debt collector?		
PLANNING		
Need a health care proxy?		
Need to designate power of attorney?		
Need a will?		
Need for guardian for minor or adult disabled child?		

Yes= 1point, No= 0 points

METRICS: Making Social Determinants of Health Visible... 2013-2015

Legal Screen

