Innovative Delivery of Palliative Care to Older Adults: 3 Examples from the US

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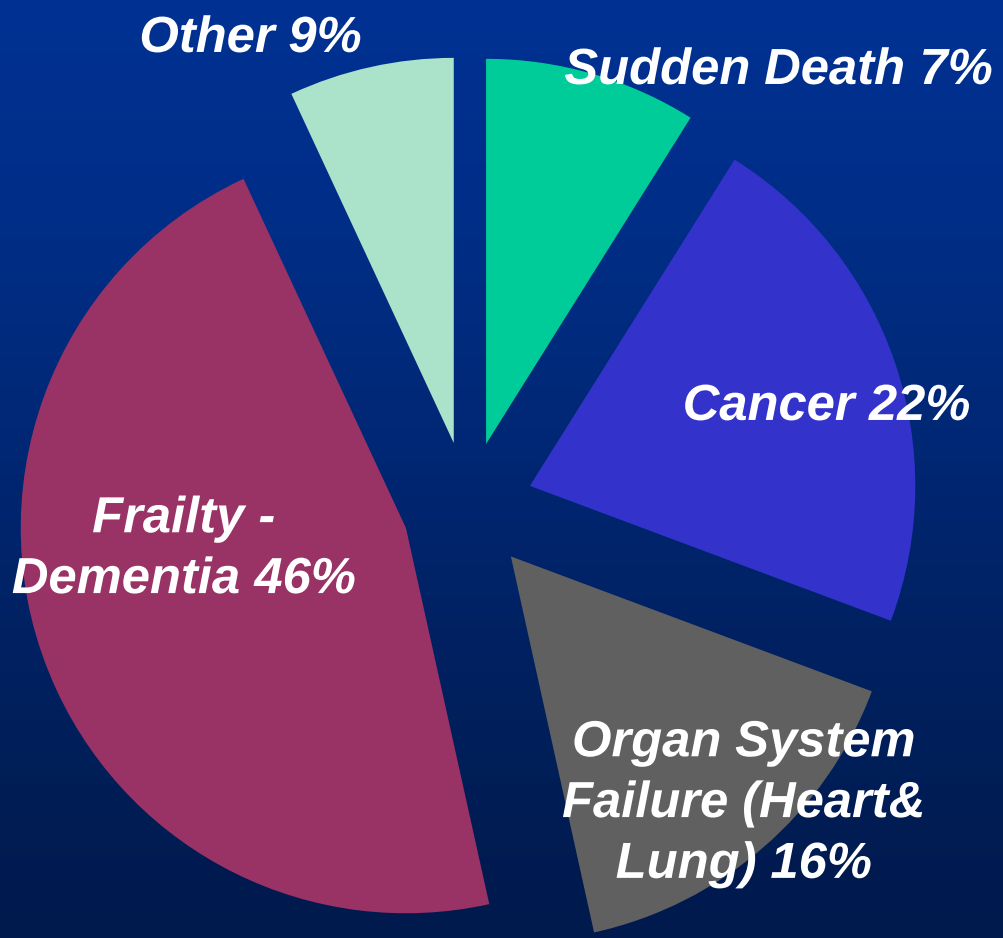
CHSPR Conference 2011: Boomerangst, February 23

Session: Whose Death is it Anyway

Chronic Diseases are the Main Cause of Death

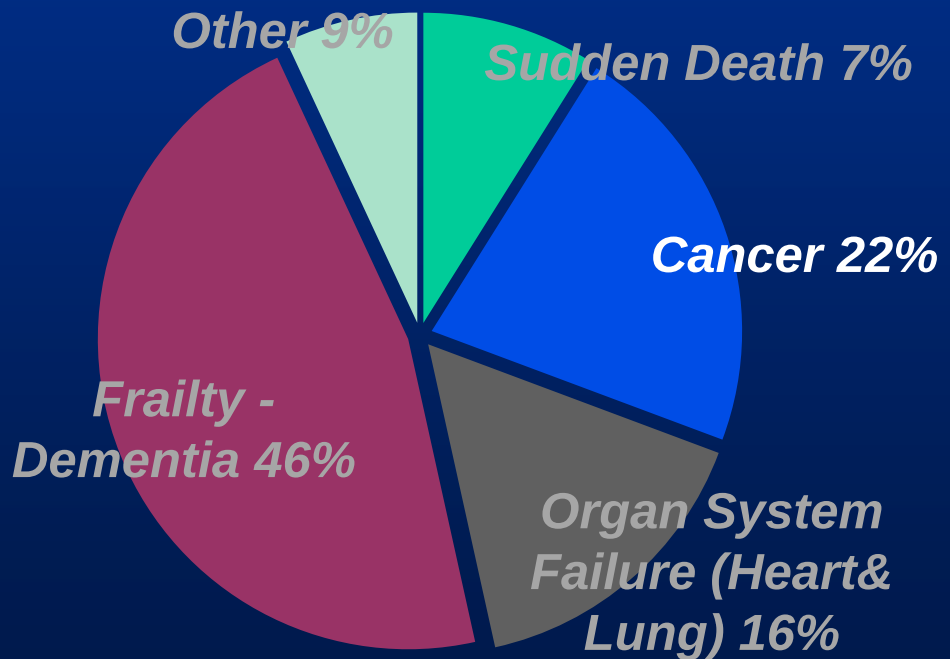
Causes of Death: Chronic Disease



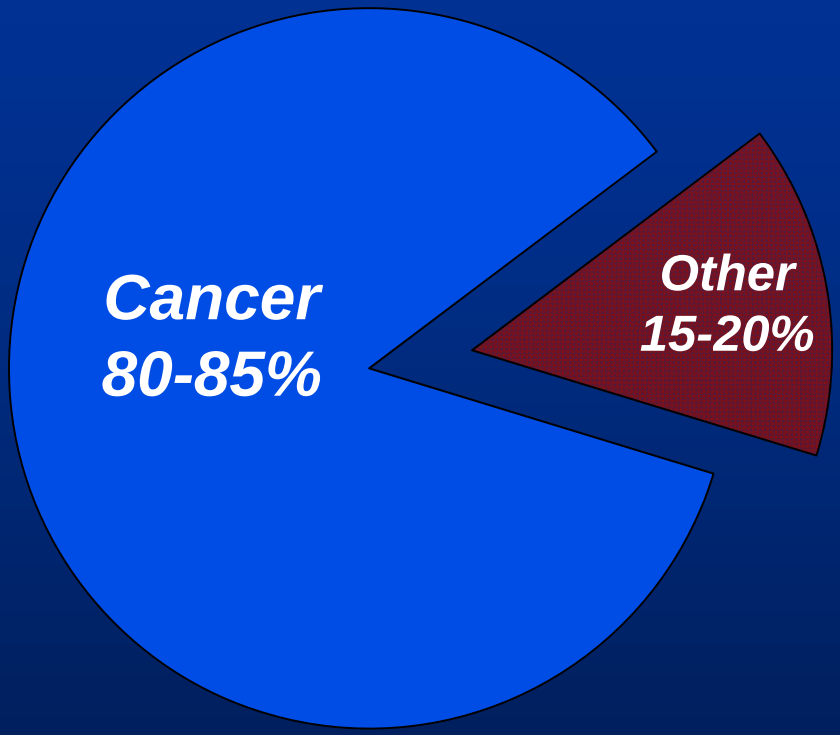
Lunney J, JAGS, 2002

Who is Accessing PC services?

Causes of Death: Chronic Disease

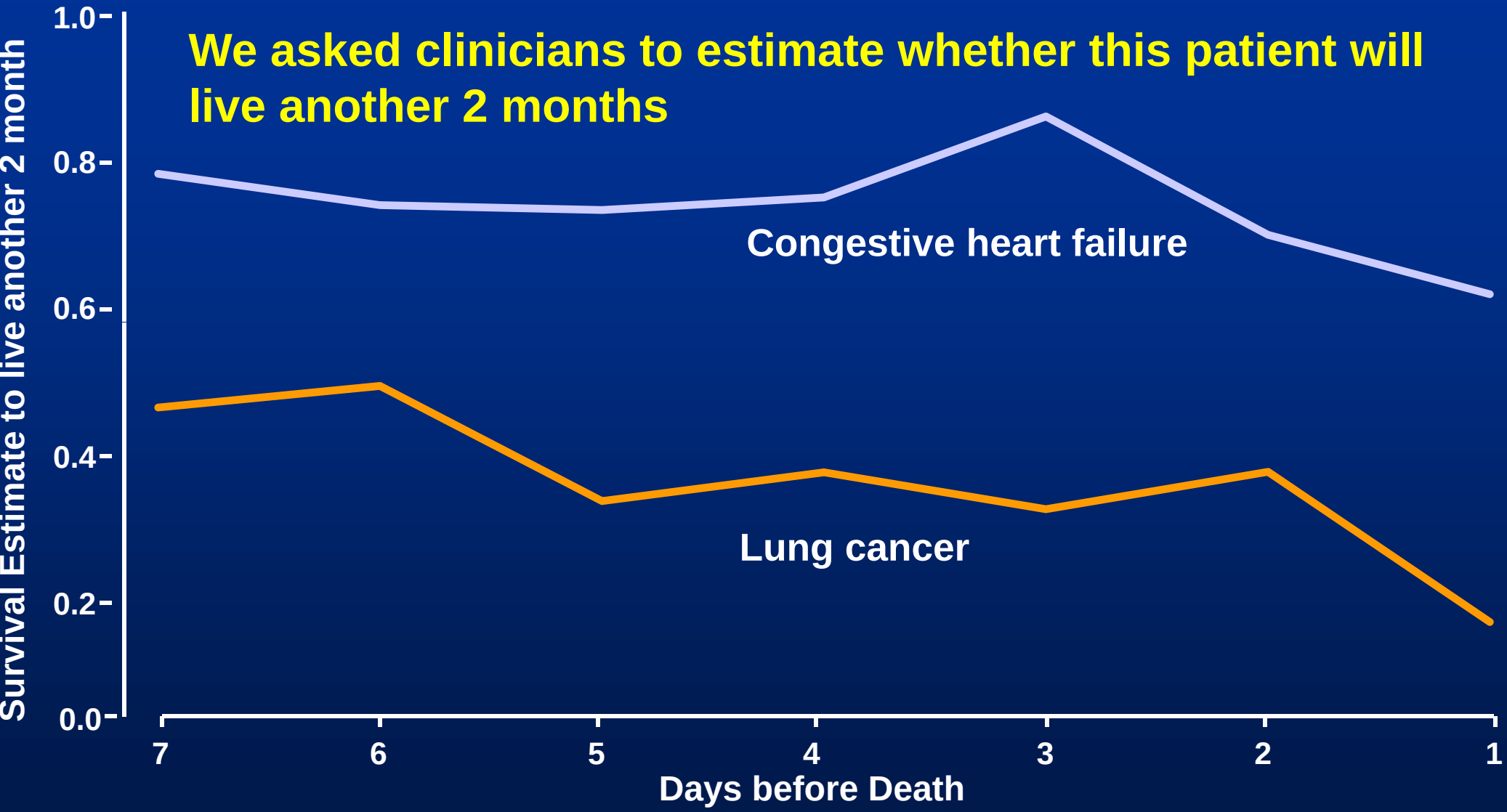


Access to PC



Only 1/4 die of cancer, yet 80-85% of HPC services are delivered to cancer patients

Prognosis Uncertain Even Near Death

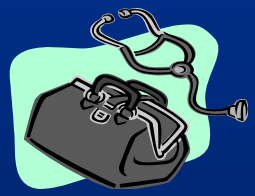


Covinsky KE, Lynn J, SUPPORT articles. JAMA. 1995.

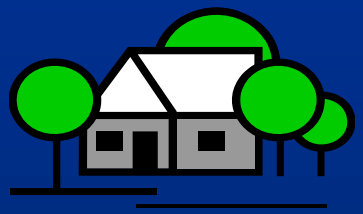
A Better Vision of PC: Summary

1. Palliative care is not about dying / “end-of-life”
2. Good chronic disease(s) management
3. Time to death / “end-of-life” is not predictable
4. Multiple chronic disease
5. Beyond cancer
6. Home and community include LTC

The Multiple Settings of Palliative Care

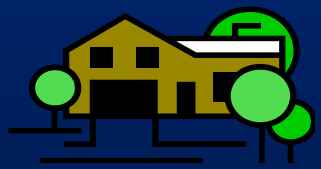


PCP office

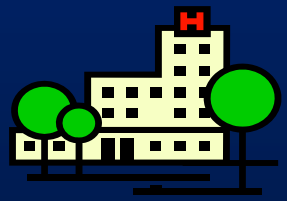


Residential Hospices

Home & Community:
homecare & support agencies



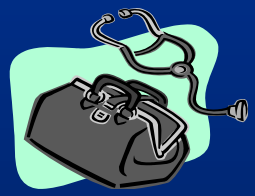
Long-Term Care



Hospital

1. PACE (Program for All-Inclusive Care of the Elderly)

LTC-eligible patients cared for in the community



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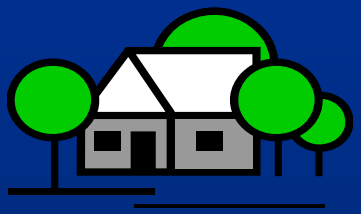
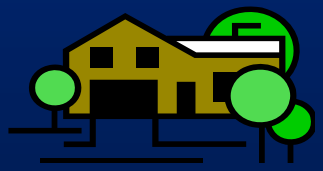


Residential Hospices

Home – Community CCAC & other agencies



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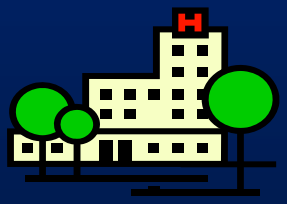


Hospital

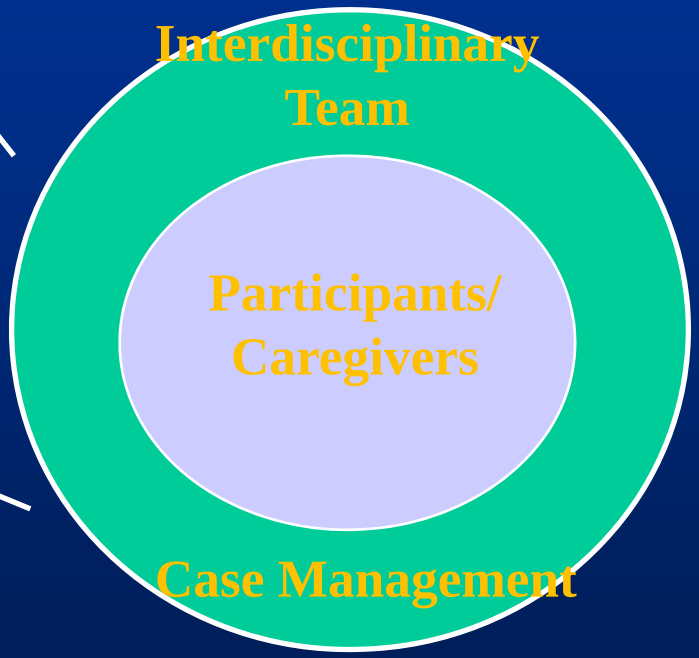
1. PACE

- **Target**
  - LTC eligible (state determined), can live in community safely
  - 50% dementia, 50% 3+ ADLS
- **What is innovation?**
  - Van transports patients to adult day care centre daily to weekly
  - Comprehensive interdisciplinary medical team
  - Focus on 1ry, 2ry, 3ry prevention & maintain independence
  - Team follows patient/provides care from that point forward
- **Evidence**
  - ↓ ED visits / hospital admits, ↓ LOS, ↑ preventive services,
  - Kane 2006, Beauchamp 2008, Nadash 2004, Wieland 2010
  - 60+ programs in US, 21K patients at a time, but limitations

1. PACE Model

Types of Care
Primary Care
Emergency Care
Hospital Care
Home Care
Palliative Care
Institutional LTC
Specialist Care

Adult Day Health
Nursing
Social service
OT / PT
Nutrition
Recreation
Personal care
Transportation
Dietician/Meals
Caregiver education / support



Interdisciplinary Team
- PACE staff physician
- Registered nurse
- Social worker
- Physical therapist
- Occupational therapist
- Rehab
- Pharmacist
- Dietician
- Home care coordinator
- Personal care aide
- Driver
- Site manager

Additional Services
Lab / X-ray / Pharmacy/ Medical Equipment / Prosthetics/ Dental / Screening / Meals

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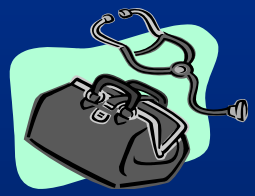
2. Visiting Home Teams

Providers (geriatrics) make home visits to delay LTC stay



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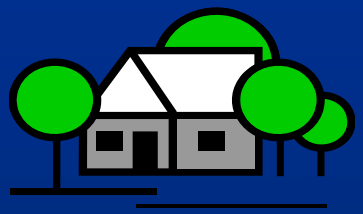

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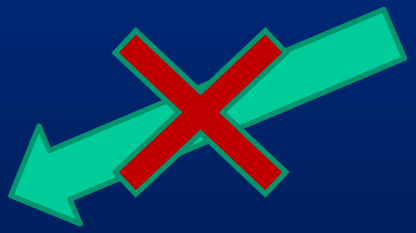

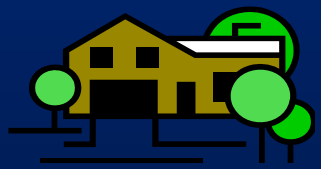

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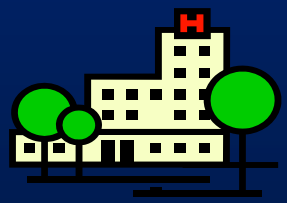

Hospital

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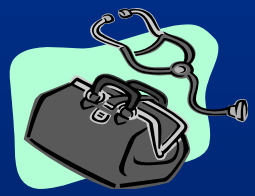

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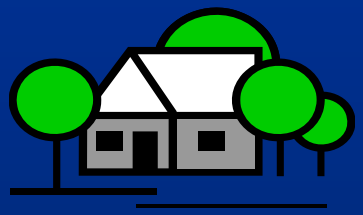

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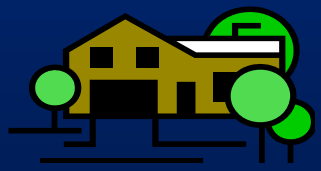

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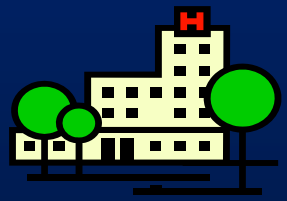


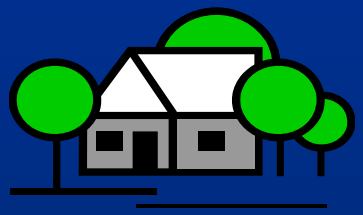
Hospital

2. Visiting Home Teams

- **Target**
  - Patients now at home, who are at-risk of NH
  - More broadly, patients very sick and dying (complex needs)
- **What is innovation?**
  - Stable, multidisciplinary team (PCP, nurse, other)
  - Makes home visits as needed
  - 24-hour on-call nursing care
- **Evidence**
  - ? Variation and definitions of “teams” / programs
  - ↓ ED and hospital use, ↓ costs, ↑ non-hospital deaths
  - Brumley 2007, Aiken 2006, etc.

3. Evercare (Long-Term Care)

Advanced Practice Nurses / Physician Assistants who support LTC patients to prevent avoidable ED visits



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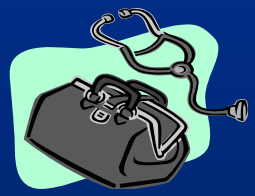

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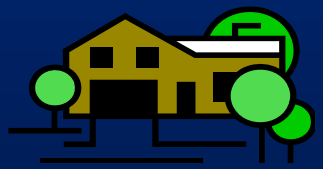

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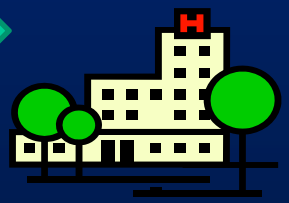

Hospital

3. Evercare LTC

- **Target**
  - frail nursing home residents, avg 85+ yrs old
  - 85% have moderate-severe dementia, 75% 4+ ADLS
- **What is innovation?**
  - Proactive primary care by frequent NP/PA visits
  - Collaborate with staff to enhance care: goals of care/ACP, communication, manage acute episodes onsite
  - ↓ costs, early identification/treatment, ↑ informed decisions
- **Evidence**
  - ↓ ED visits, ↑ preventive services, ↑ satisfactions
  - ↓ pressure ulcers, falls, anti-psycotics, feeding tubes
  - Kane RL. Evercare. 2000, 2001, 2002, 2003, 2004, 2006.

Summary: Common Elements

1. Comprehensive assessment
2. Evidence-based care planning
3. Continual monitoring
4. Prevention focus; Maintain independence
5. Coordinate with interdisciplinary team
6. Patient / Family engagement in self-care

Conclusion: Barriers

1. Do not have stable, sustainable funding!
2. Difficulty funding providers that move across settings (e.g. nurse navigators)
3. Need information sharing across settings
4. Care does not follow the patient for the rest of the care continuum
5. Need to redefine palliative care as chronic disease management

“ When you dream, do not be realistic and fit your dreams to what exists and is possible. Fit your dreams to what should exist and should be possible.”

June Callwood