PALLIATIVE CARE

CASE STUDY

EARLY PALLIATIVE CARE INTERVENTION FOR PATIENTS WITH SERIOUS ILLNESS

Sharp Healthcare | San Diego

Overview

Sharp HealthCare's Transitions Program provides home-based palliative care for patients with advanced chronic illness such as heart failure, COPD, dementia and cancer. When the program was launched more than 10 years ago, few health systems were thinking about outpatient palliative care. The program's architects recognized a need for a service that could help patients remain safely at home and avoid using the emergency department and allow the hospital to help manage symptoms and stresses of their advanced disease. Based in San Diego, Sharp HealthCare is a not-for-profit regional health care system with four acute-care hospitals, three specialty hospitals, five urgent care centers, three affiliated medical groups and a health plan. The health system holds multiple capitated contracts with Medicare Advantage plans, in which the health system is at full risk for the cost of beneficiaries' health care.

Identifying patients with serious illness early and providing care and support services for them at home are key. Daniel Hoefer, M.D., a family physician and Sharp's chief medical officer of outpatient palliative care, describes seeing patients for whom he and care specialists had done everything possible. Yet these patients were more likely to be admitted to the hospital than attend their next outpatient appointment. Dr. Hoefer's insight about identifying and supporting these patients in their homes — thus avoiding hospital admissions altogether — is a win-win for patients, families and for Sharp.

> Sharp HealthCare's Transitions Program consists of four core components: 1) in-home medical consultations with a focus on pain and symptoms; 2) ongoing prognostication of the inevitable consequences of disease progression and survival; 3) education, psychosocial and spiritual support for the patient's caregivers; and 4) skilled conversations to assist with treatment choices and advanced care planning.

Approach

Patients in Sharp HealthCare's Transitions Program receive palliative care in their homes from a team of physicians, nurses and social workers, as well as spiritual support, according to each patient's and family's needs. The program consists of four core components: 1) in-home medical consultations with a focus on pain and symptoms; 2) ongoing prognostication of the inevitable consequences of disease progression and survival; 3) education, psychosocial and spiritual support for the patient's caregivers; and 4) skilled conversations to assist with treatment choices and advanced care planning. Unlike hospice, the Transitions program is delivered concurrently with ongoing treatment: Patients continue to see their primary care physicians and specialists. But they also get an added layer of support, with 24/7 telephone access to Transitions nurses, who can respond to crises when they happen.

Center to Advance Palliative Care capc
American Hospital Association™ Advancing Health in America

Launch and Expansion. Dr. Hoefer and his administrative counterpart Suzi Johnson launched the Transitions program with an initial focus on home-based palliative care support for heart failure patients – a group they believed would experience immediate benefits. To secure the support of cardiologists, the program hired a cardiac nurse specialist and a hospitalist for care management, and subsequently gave them palliative training. The launch was so successful that Transitions quickly expanded to serve other groups, including patients with dementia, COPD, cancer, cirrhosis and geriatric frailty. A service for patients with late stage kidney disease is being developed.

Transitions maintained disease-specific staffing groups in the early years of the program, but this became impractical as the program grew. Nurses now are zoned by region. Transitions cares for about 200 patients in the San Diego region and will take on 100 more from Sharp Healthcare's Next Generation ACO. The program currently has four full-time nurses, two full-time social workers, one full-time physician (Dr. Hoefer), and access to health care chaplains; other physicians participate for interdisciplinary support. The program is looking closely at contracting with Medi-Cal managed care plans under a recent law (SB-1004) that mandates palliative care services for Medi-Cal patients based on criteria adapted directly from the Transitions program.

Identifying and Assessing Patients. Patients are identified by referrals from primary care providers, specialists, case managers, home health agencies and skilled nursing facilities, using general and disease-specific criteria but no specific triggers. Assessments include measures of functional abilities, laboratory results — both general and disease-specific — and the Transitions version of the "surprise question."

Many palliative care programs ask whether the referring clinician would be surprised if their patient died in the next 12 months; the Transitions program has adapted the question to ask whether the clinician would be surprised if a patient began using the hospital to manage their advanced disease. The objective is to reach patients earlier in their disease process, with the goal of improving quality of life and avoiding unnecessary utilization.

Although Transitions uses a variety of disease-specific and functional criteria to assess whether patients are suitable for the program, for patients in the advanced stages of illness, Dr. Hoefer believes that no data model or tool can supersede the judgment of the physician and the patient's family. Transitions patients do not need to have a Medicare Part A skilled need, do not need to be homebound, and do not need to have a time-limited life expectancy. A patient's primary care provider must agree to the referral to Transitions, and Transitions patients must continue to see their primary care providers and specialists as needed.

Acute and Maintenance Phases. The Transitions Program has two distinct phases: 1) an acute phase for new patients or those with changing circumstances, and 2) a maintenance phase. In the acute phase, a registered nurse helps the patient articulate medical goals such as pain management, while a social worker identifies and addresses the family caregivers' needs. During this phase of the program, the patient receives four to six weekly home visits from a registered nurse and one to three weekly visits from a social worker, as well as spiritual care as requested. When the patient's and family's goals have been met, the Transitions program moves into the maintenance phase. In this phase, home visits are less frequent, and case management continues through scheduled telephone calls.

The program is open to all Sharp HealthCare patients, including beneficiaries assigned to Sharp's accountable care organizations and traditional Medicare fee-for-service. The majority of Transitions patients are Medicare Advantage beneficiaries referred by medical groups affiliated with Sharp Healthcare, for which Sharp is fully at risk for hospital costs. Under capitated payment, the clinical and business cases for a proactive palliative care program are aligned. Transitions costs an average of $642 per beneficiary per month, and patients are enrolled in the program for an average of seven months.

Impact

From 2007 through 2017, the Transitions Program

cared for more than 5,000 patients, successfully lowering hospital usage and health care expenditures with modest program costs and high rates of patient satisfaction. A recent study comparing Transitions patients with cancer, COPD, dementia or heart failure to a matched group found that the program cut hospital admissions by half (Cassel et al, JAGS 2016).

For patients who were admitted, their length of stay in the hospital was cut by 50% or more, depending on the disease category. Dr. Hoefer says that hospital admissions for most Transitions patients are the result of falls and not disease-related crises, and the program is developing new ways to reduce fall risk for its patients.

The Transitions Program also significantly lowered rates of ICU admission within 30 days of death. Transitions produced net savings per participant per month of $4,258 for cancer, $4,017 for COPD, $3,447 for heart failure and $2,690 for dementia, equivalent to a return on investment between 4.2 for dementia and 6.6 for cancer.

Lessons Learned

Challenge assumptions. Challenge the notion that in-home care for patients with serious illness needs to be preceded by a hospitalization. Moving care "upstream" has allowed Transitions to avoid thousands of unnecessary and harmful hospitalizations for its patients.

Prove your concept. The Transitions program overcame cultural opposition to home-based palliative care by taking organizational risk to prove the concept, winning over specialists with its success. Transitions leaders recruited the support of two Sharp cardiologists to develop the program for the initial cohort of heart failure patients, despite fierce opposition from other influential cardiac specialists concerned that Transitions would take over the care of their patients. The strategy, says Dr. Hoefer, was to build the program first and apologize later.

Hire strategically. Recruitstaff who can help establish the relationships needed with patients and specialists; formal palliative training can be added later.

CONTACT

Helen Plass
Program Contractor, AHA Center for Health Innovation
847-313-9849
palcare@aha.org

Center to Advance Palliative Care capc

American Hospital Association™
Advancing Health in America