INCREASING EARLIER HOSPICE REFERRALS THROUGH CHRONIC CARE MANAGEMENT

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Objectives

- Describe the Chronic Care Management model
- Indentify 3 ways that CCM can provide palliative care to patients
- List 2 ways that CCM leads to earlier hospice referrals

Chronic Care Management (CCM)

- CMS program established in 2015 for Medicare Patients who have 2 or more chronic conditions.
  - Conditions are expected to last at least 12 months or until death and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline

(ACP, 2015)

CCM Regulations

- Patient has been seen by their provider within the last year
- Patient gives verbal consent to program
- Patient receives a minimum of 1 phone call per month from the case manager
- CCM nurse creates a care plan and document calls that include:
  - Assessment of the patient's medical, functional, and psychosocial needs
  - Timely receipt of recommended preventative care
  - Medication reconciliation and review of adherence and ability of self-management
  - Time spent with patients needs = at least 20 minutes per month

(ACP, 2015)

Goals/Focus of CCM

- Improve patient health
- Create a continuous relationship with a member of the care team
- Receive support for chronic diseases to achieve health goals
- Receipt of preventative care
- Patient and caregiver engagement
- Timely sharing and use of health information
- Reduction in ER visits and hospitalizations
- Create a care plan that is continually revised/updated with focus on the chronic conditions being managed with treatment goals aligned with the patient's choices and values
- Accessibility of community resources

(Caresync, 2017)

Can CCM Provide Palliative Care?

- Palliative care definition – medical care for people with serious illness with the goal of improving quality of life for the patient and providing an additional layer of support
- Focus of palliative care- symptom management, improved communication among providers, patients and family members, identifying clear patient goals/values, providing coordination of medical care delivered by several disciplines

(Verret & Rohloff, 2013)

Barriers to Palliative Care

- Thought to be only for those at end of life
- Reluctance of primary care physicians
  - Lack of time to speak at length with patients, families, and lack of training to have difficult conversations
- Lack of availability of palliative care providers

(Verret & Rohloff, 2013)

LAKE REGIONAL PALLIATIVE CARE, CCM, & HOSPICE JOURNEY

Palliative Care 2014

- 2 palliative care certified nurses in the cancer center to cover acute care and cancer
- No ability to generate revenue
- Clinic patients left out
- No continuous program for those not ready for hospice
- No metrics kept, poor understanding of palliative care with administration and providers
- Palliative = hospice in community mind

What LR Knew:

- Palliative care patients were hospitalized less in their final months of life compared to those who were not in palliative care.
- The cost of end of life care was less for those in palliative care compared to those who were.
- LR wanted to provide palliative care but had difficulty allocating resources.
- Providing palliative through CCM was the answer.

(Gorman, 2017)

May - September of 2015

- The 2 palliative care nurses where re-assigned
- CCM started in September of 2015
- Initially called PCCM
- Slow start

Hospice Opens April, 2017

- Referrals primarily from inpatient hospital
- CCM patients began talking more to their case managers and hospice referrals starting to increase from CCM

New Pulmonologist – August 2017

- Understood value of palliative care, saw that it could be delivered by the CCM model
- Wanted a CCM nurse in his office to talk face to face initially and follow up by phone
- Admin said "No." Did it anyway

Thank God for Dr. Sohal

Turning point for CCM and Hospice with implementation of CCM nurses in the clinic and physician's use of shared decision making

Shared Decision Making Elements

- Recognizing that a decision needs to be made
- Knowing and understanding the best available evidence and treatment options
- Incorporating the patient's values, goals, and preferences into the decision along with the the provider's guidance

(Legare & Witteman, 2013)

Use of Shared Decision Making

- Patient specific
- Collaboration to make a decision
- Knowledge of factors that affect the patient clinician interaction such as mutual trust, language concordance, cultural factors or discordanance between patient and health care provider.
- Used most often with conditions of uncertainty.
  - Preference sensitive
  - More than one medically reasonable option or the evidence is insufficient

(Legare & Witteman, 2013)

Shared Decision Making

Benefits for patients

- Better understanding of health condition
- Realize decision needs to be made
- Provided information, pros/cons
- Better prepared
- Collaborate to make the right decision for them
- More likely to follow through with the decision

(NHL, 2013)

Benefits for the provider

- Patients are better able to discuss their health care options
- Helps the patient understand what the provider is trying to do
- Builds trusting relationship
- Improves physician and patient satisfaction

Barriers

- Perceived time constraints
- Care providers views regarding which patients want to, should or can engage in shared decision making
  - Patients want more engagement, particularly older patients, less educated, report less opportunity for SDM but could benefit the most
  - Patients can learn communications skills and become increasingly confident in their ability to engage in decisions about their health

(Legare & Witteman, 2013)

Communication Examples

- *Sometimes things in medicine aren't as clear as most people think. Let's work together so we can come up with the decision that's right for you.*
- *People have different goals and concerns. As you think about your options, what's important to you?*
- *Do you want to think about this decision with anyone else? Someone who might be affected by the decision? Someone who might help sort things out?*

Source: *Six Steps of Shared Decision Making. © 2012 by Informed Medical Decisions Foundation.*

Shared Decision Making & Relationship Based Care with Deciding on Hospice

- Key elements of quality end-of-life care
  - To have trust and confidence in care provider
  - Not to be kept alive on life support if no hope for meaningful recover
  - Information about the disease communicated in an honest manner
  - Have the same nurse looking after you
  - To receive help making difficult treatment decisions

(Heyland, et al., 2006)

Trust

- This study found that there was an increase in patient enablement (ability of the patient to cope with his illness after consultation with the doctor) when there was a higher level of trust
- The better the doctor-patient concordance showed a high association with the trust in the physician.
  - same gender, culture, language, higher socio-economic status show better concordance

(Banerjee & Sanyal, 2012)

CCM

- Similar focus to palliative care
  - Focus on goals, symptom management, creating a relationship
  - Use of shared decision making
  - Focused on relationship based care
    - Improves trust
    - Allows for better communication

Lake Regional Statistics

CCM prior to Hospice	With out CCM prior to hospice
ALOS = 65.6 days	ALOS =33.67 days
11% had a LOS <= to 7 days	29% had a LOS<= to 7 days

Patient Examples

- Patient A – copd, cant afford medications, multiple exacerbations
- Patient B – COPD joins CCM 9/1/17, moves to hospice on12/05/17, still living
- Patient C – he wanted to die, mad when he woke up, spoke with CCM nurse multiple times with questions about hospice, put on speaker phone with wife, decided they would try

Why does a Longer Length of Stay in Hospice Matter? Cost Savings

- Medicare fee-for-service beneficiaries with poor-prognosis cancer, those receiving hospice care vs not (control), had significantly lower rates of hospitalization, intensive care unit admission, and invasive procedures at the end of life, along with significantly lower total costs during the last year of life
- Largest cost savings was seen with hospice care lasting 5-8 weeks

(Obermeyer, et al., 2014)

Comfort and Support

- Hospice patients and families are provided interdisciplinary support, comfort measures, symptom management, improved quality of life, improved mood, and often live longer than those who are not in hospice
- Greater patient/family satisfaction
- Follow-up bereavement care

Satisfaction Scores for Hospice

- 100% for 2 quarter
- 90% for 1st quarter

Questions?

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