Home-Based Palliative Care

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Nurses play a pivotal role in palliative care both in the hospital and at home. Palliative care patients often have pain and symptom management needs, advanced care planning and often times prefer to have their care managed outside of the hospital and at home with their family. Home-based palliative care is often provided by an interdisciplinary team lead by a registered nurse, under the direction of a physician. Typically, home-based palliative care is only reimbursed through hospice care or short term home health both of which have strict and limiting guidelines for reimbursement. However, demonstration projects, grants and accountable care agreements have expanded palliative care from the traditional home health or hospice payment structure to include expanded services to chronically ill patients with life limiting diagnoses that do not qualify for home health or hospice care based on the strict criteria of both programs.

According to a 2012 Agency for Healthcare Research and Quality report, a disproportionately large percentage of resources are spent on patient care in the last two years of life, much of it unwanted by patients and ineffective in improving quality or prolonging life (Taylor, 2013). Nearly 90 million Americans live with serious and life threatening illness, a figure predicted to almost double over the next 25 years as baby boomers continue to age (Taylor, 2013). The growth in palliative care, advance care planning and hospice services is driven by the need to improve the quality of end-of-life care, but also by its growing share of health care costs (Taylor, 2013). An article by Wholihan & Pace (2012) reported that patients who received palliative care consults while hospitalized had lower than average pharmacy costs and spent fewer days in intensive care units. Additionally, patients receiving palliative care, on average, incurred $6,900 less in cost during admission and 24% fewer patients died in the intensive care units (Wholihan & Pace, 2012).
There has been significant progress with the palliative care initiative the past few years. The Joint Commission created a hospital-based palliative care certification and certified its first program in 2012 (Zhani, 2012). The American Hospital Association (AHA) issued two reports on advanced illness management strategies, encouraging hospitals to improve care for patients with serious and terminal illness ("AIM," 2006-2013). Additionally, the Institute of Medicine formed the Committee on Transforming End-of-Life Care and expects to issue a report in 2014 (Institute of Medicine, 2013).

In response to the growing public interest, there have been a number of bills introduced in Congress to improve advance care planning and palliative care (Taylor, 2013). On the federal level, the Centers for Medicare & Medicaid Services have launched several demonstration programs to improve care for the chronically and terminally ill (Taylor, 2013). The Independence at Home Demonstration project offers primary care services in patients' homes to those with chronic illnesses to learn whether home-based care can reduce hospitalizations, lead to better outcomes and lower Medicare costs (Taylor, 2013). CMS also is exploring evidence-based interventions to reduce avoidable hospitalizations among nursing home residents and is launching pilots to improve care for the 9 million vulnerable Americans who are dually eligible for Medicare and Medicaid (Taylor, 2013).

Many advocates of advanced illness and palliative care are hoping payment models, such as accountable care organizations, will provide reliable reimbursement for end of life care in the US (McKinney, 2013). Currently, CMS eligibility for hospice care requires that patients have a life expectancy of six months or less and that they forgo curative treatments with the focus of care on comfort (McKinney, 2013). Many patients who suffer from advanced-stage diseases like heart failure, COPD and degenerative neurological disorders have more than six months to live
and may still be interested in pursuing life-extending treatments, yet don’t want to be hospitalized or utilize the emergency department for urgent needs that can be met by telephone or a home visit (McKinney, 2013).

Some specialty programs, known as advanced illness management (AIM) or home-based palliative care, are attempting to improve quality and control healthcare costs for patients who frequent the emergency departments and have frequent hospital admissions with services such as 24-hour on-call nursing support, in-home treatments, palliative care and education about the benefits of hospice care (McKinney, 2013).

Hospice of Michigan, a Detroit-based not-for-profit program, developed a program known as @HOMe Support for patients who are seriously ill but not yet ready for hospice care (McKinney, 2013). The program provides intensive telephone and home-based interventions provided primarily by nurses aimed at reducing invasive, burdensome and unnecessary tests and procedures, easing caregiver burden and curbing emergency-room visits. It also relies on a fully integrated electronic health record, proprietary predictive modeling and analytics to gather outcomes data (McKinney, 2013). In 2007, Hospice of Michigan partnered with Blue Care Network and Health Alliance Plan, two Michigan-based insurers, to pilot the test model, @HOMe (McKinney, 2013). Although home care spending rose, a 2011 costs analysis, funded by Blue Cross and Blue Shield of Michigan, revealed an overall 30% cost savings implementing @HOMe. Based on the cost savings, Hospice of Michigan was awarded a Medicare ACO contract to provide @HOMe (McKinney, 2013).

Palliative Access Through Care at Home (PATCH) is another program based at home (Holley, Gorawara-Bhat, Dale, Hemmerich, & Cox-Hayley, 2009). PATCH was developed through the University of Chicago’s Section of Geriatrics and Palliative Medicine in 2006 and
funded by a grant from the Aetna Foundation (Holley, et al, 2009). PATCH was developed with two primary goals: to reach at risk older adults with limited access to medical care and to teach medical trainees the importance of delivering palliative care (Holley, et al, 2009). Patients are eligible if they are aged 65 and older; are enrolled in Medicare Part B; have an existing University of Chicago affiliation; are homebound as defined by Medicare; and have a limited life expectancy of a year or less (Holley, et al, 2009). PATCH primarily focuses on medical education but also plays a limited role in home management with physicians and nurse practitioners. Only one home assessment is provided with most support being telephonic and 24 hour on-call support (Holley, et al, 2009). Patients who are homebound with a skilled need qualify for home care and may be referred to home health for care (Holley, et al, 2009). Many home health agencies across the nation, including my own, employ hospice and palliative care certified nurses in order to provide palliative care while managing the short term skilled care. Holly’s, et al (2009) research included that there were several European-based studies that found home-based palliative care may decrease emergency department visits and hospitalizations, improve advance care planning, increase the number of in-home deaths, improve symptom control, and increase patient and family satisfaction.

The program most familiar in my area is Sutter Health’s Advanced Illness Management (AIM) program, which coordinates care for patients with late or end-stage chronic illness. The AIM program consists of primarily nurses and social workers who assist patients and families make informed choices about treatments and procedures (McKinney, 2013). Outcomes data released in early 2011 showed an average savings of $2,000 per enrolled patient a month, a 75% reduction in days spent in the intensive-care unit and a 50% drop in hospitalizations (McKinney, 2013). In March 2013, Sutter Health’s AIM program received a $13 million grant from the
Center for Medicare & Medicaid Innovation to expand the program to five more areas across Northern California (McKinney, 2013). With the planned expansion, Sutter Health estimates AIM will save more than $29 million over the next three years (McKinney, 2013).

Nursing has a significant role in all palliative care efforts. The Institute of Medicine (2010) in *The Future of Nursing* report recommends a transformation of nursing education, suggesting that nurses are critical to the success of health care reform, and that nurses need participate in leadership, achieve higher levels of education in order to practice to the fullest of their ability, and be full partners with other health care professionals (Giovanni, 2012). In order for nurses to become advocates and experts in end-of-life care, advanced and specialized education must occur (Giovanni, 2012).

As a health care professionals, we need to be able to have transparent, successful advance care planning conversations with our patients and their families. Independent of our profession, we should be having the same conversation with our own physician and family about our own advanced care plans (Giovanni, 2012). We need to become comfortable talking about dying with those we love and interact with the most, in order to become comfortable talking about end-of-life care in our healthcare system (Giovanni, 2012).

Nurses have a pivotal role in bringing comprehensive palliative care into the patient’s home. Hospice and home health care are both nursing driven programs. Both programs are licensed and certified by the state and federal government and reimbursed by Medicare, Medicaid and private insurances for specific conditions. Progression of the accountable care organizations will solidify the need for palliative care to fully transition and integrate into the patient’s home. It just makes sense that palliative care programs will be integrated into home care programs whether the hospice criteria for a six months or less prognosis changes or
reimbursement structures are revised, hospital-based programs will be incentivized to provide home-based care for a subset of patients that are high utilizers of the hospital setting. I truly believe that nurses will lead the transition to provide and coordinate the comprehensive end of life care to patients and their families.
References


doi:10.1111/j.1532-5415.2009.02452.x:


