Building Bridges: Palliative Care in the Home Care Setting

A Model for the Future

Redwing Keyssar, RN, BA
JFCS Director, Palliative Care Program

Gwen Harris, MA
Care Manager

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The whole value of a benevolent deed is in the love that inspires it.

-Talmud
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Fundamentals of Palliative Care
What Is Palliative Care?

- Palliative Care is a philosophy and a model of care
- It provides optimum comfort, prevention of suffering and improved quality of life
- It addresses medical, psycho-social and emotional/spiritual needs of the patient/client as well as of family, friends and loved ones
“Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness - whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, social workers and other specialists who work with a patient's other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.”

CAPC 2013
Why Is It Important?

- 76 million “baby boomers” are getting older
- Palliative Care is critical in order to build communities of people who are addressing serious illness and end-of-life issues now
- Palliative Care is the bridge between acute medical care and Hospice
- It allows for dialogue among clients, families, healthcare providers and clergy
How Is It Different from Hospice?

- Hospice is a medical model, often defined by Medicare benefit
- Eligibility for Hospice is restricted:
  - 6 months or less to live
  - Patient must forego any curative treatment
- Palliative care has the ability to help people at all stages of illness or decline
- Palliative care is not restricted to clients with a terminal diagnosis
The Heart of Palliative Care

• Palliative Care is concerned with easing suffering, providing added support
• Need for spiritual/emotional/psychological care long before hospice referral
• Need for healthcare professionals to be better educated in meaning and need for Palliative Care
Palliative Care in a Non-Medical Setting
The Mission of JFCS

Providing services from cradle to rocking chair

- Seniors at Home
  - Licensed home health agency
  - Homecare and care-management services
  - Not Medicare-certified
  - Fee for service model
- Adoption Connection
- Home cleaning service called Cleanerific
- Parents Place for workshops, classes and counseling for families: children, teens, adults
- Services for New Americans (Émigrés)
- Conservatorship program
- Personal Affairs Management
The Palliative Care Program at JFCS
An Interdisciplinary Team Coordinates Care

- RN/Director of program
- Case manager / Gerontologist
- Rabbi/Spiritual counselor
- Physician
- Volunteer coordinator
Components of the Program

- Program development
  - Admission criteria
  - Staff education and development
  - Program policies and procedures
- Volunteer program
- Consultations
- Spiritual Care and Bereavement
- Community outreach
  - Meeting and collaborating with healthcare partners
  - Development of community-based educational programs
  - Training of community and family caregivers
Criteria for Admission to Palliative Care Program

- Diagnosis/prognosis
  - Normally less than one year prognosis
  - Cancer diagnosis (at any stage; considered case by case)
  - End stage-- Heart Disease, COPD, Kidney failure, Dementia, AIDS, Parkinson’s disease
  - Multiple disease processes (as in heart failure and diabetes)
  - Failure to thrive

- Disease process—chronic or terminal
  - Most palliative care clients will have a chronic or serious disease process, with or without a short-term prognosis

- Treatment options
  - Clients undergoing chemotherapy or dialysis or other “curative treatment” will be appropriate for Palliative Care
• Age (related to diagnosis)
  • A person in their 80’s or 90’s with any of the above diagnoses is appropriate for palliative care
  • Anyone, of any age, with a serious or chronic illness
• Number of hospitalizations within past year? 6 months?
  • If more than 2 serious hospitalizations in 6 months, consider consult
• Decision, with physician consult, to not return to hospital (DNR discussed/in place)
• Increased agitation or pain
• Psycho-social status
  • What is the person’s psychological status? Are there friends/family to assist? Are they still involved with others/community or are they withdrawn? Do they live alone or with others?
• Abilities to perform ADLs/ Level of care needed
• Other physical symptoms:
  • Decreased appetite/refusal to eat; Decreased urine output
  • Recurrent aspiration; recurrent UTI
  • Increased amount of time sleeping
  • Changes in consciousness/cognitive abilities
Volunteer Services Are Essential

“Compassionate Companions” is a 30-hr intensive training for volunteers who wish to serve at the bedside of clients who are seriously ill or dying.
Spiritual Care and Bereavement Services Are Integral

- Immediate and on-going support for clients who have lost a loved one
- Grief support groups
- Annual memorial event for JFCS staff
Collaborative Community Partnerships

- Inpatient Palliative Care teams
- Outpatient Palliative Care teams
- Local hospices
- Faith organizations
- Other palliative care organizations
- Community centers—Senior centers, LGBT centers
- Disease-based non-profits: Alzheimer’s assoc; Family Caregivers Alliance, Cancer centers, etc.
The Return on Investments of Palliative Care Programs
How Can You Sustain Such Services?

- Private fees for service
- Public and private foundation support
- Contracts with healthcare providers and insurers
- Individual donors
- Contributions in memoriam
Benefits to Your Agency

- Increased visibility in medical community
- Increased referrals/revenue to various agency programs
- Creates valued service for people with serious illness in your community
- Attracts new donors
- Innovative and important way to foster your mission
- Integration of spiritual care, contemplative practices and ritual into agency culture
Program Evaluation and Outcome Measures

![Bar chart showing program evaluation outcome measures for different quarters and regions.](chart.png)
Decrease Physical and Emotional Suffering

- Self-report by clients
- Family/patient satisfaction survey
- Nursing assessments and documentation
Increase Client Adoption of Advance Directives

- Advance directive completed
- Conversations with named agents and healthcare providers documented
- Introduction of POLST into conversation with clients, families, healthcare providers
Achieve Earlier Utilization of Hospice Services

- Numbers of clients utilizing Hospice
- Reasons why clients/physicians decline Hospice
Reduce In-patient Hospitalizations and Unnecessary Health-Care Costs

- Pre-hospital DNR forms completed
- Decreased emergency room visits
- Decreased need for acute care stays in hospitals, if proper care can be provided at home
- Increased quality of life
Other Benefits

- Increase Agency referrals
- Increase volunteer involvement in caring for aged and ill community members
  - Evaluations of volunteer training sessions
  - On-going documentation of client/volunteer relationships
- **DO THE RIGHT THING!**
To everything there is a season, 
a time for every experience under heaven.  
—Ecclesiastes 3:1
Thanks to Raja Hornstein for photographs