VETERANS HEALTH ADMINISTRATION

GRECC Connect Education Case Conference Series

Outpatient and Home Based Palliative Care

Jill Steagall NP

Date: April 21, 2023

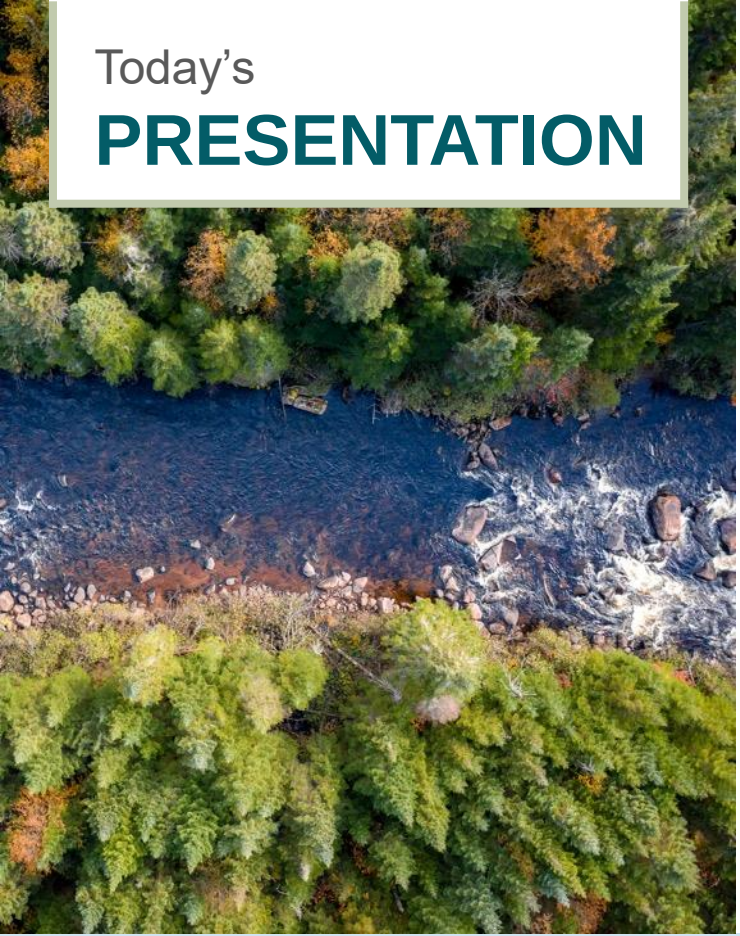
VA | U.S. Department of Veterans Affairs
Veterans Health Administration
Office of Rural Health

WHO AM I?

- 15 years working in palliative care
  - Inpatient – RN and NP
  - Skilled nursing facility
  - Outpatient
  - Home based programs
- 9 years working with hospice care – inpatient care center, home based, SNF
- 2.5 years working at the VA
  - Outpatient and inpatient palliative care

Today's

PRESENTATION



Objectives Today:

1. Identify which patients benefit from palliative care
2. Discuss need for home-based care for patients with serious or life-limiting disease
3. Discuss rurality of patient based on their zip code

WHAT IS PALLIATIVE CARE?

1. Seeks to improve quality of life for Veterans with a serious or life limiting disease
2. Helps to clarify goals and wishes of patient and caregivers
3. Provides support and education to help someone live with their disease
4. Improves symptom management
5. Improves communication and problem solving
6. Helps with emotional and spiritual grief
7. Assists with care planning, advance directives
8. Discusses preferences for life sustaining treatment – CPR directives

PALLIATIVE CARE OR HOSPICE CARE?

PALLIATIVE CARE

- No strict eligibility requirements aside from diagnosis of serious illness
- Consultative and collaborative
- Ability to seek curative treatment
- No ‘signing up’
- Not chronic health management

HOSPICE CARE

- Eligibility requirements regarding prognosis and medical oversight
- Become primary care for Veteran
- IDT approach
- Sign admission paperwork
- Nurse case management
- DME coverage
- RN triage line 24/7

WHAT IS CONCURRENT CARE AT THE VA?

- Veterans may receive hospice care AND ongoing care from their VA medical team(s), as long as that care is aimed at improving quality of life
- Cost of concurrent care covered by VA regardless of hospice payor
- Not curative care
- Eligibility for hospice care remains the same
- Care coordination is key
- Examples include radiation therapy for pain control, immunotherapy, or paracentesis

WHAT DOES OUR PALLIATIVE CARE TEAM PROVIDE NOW?

ECHCS PALLIATIVE CARE – ROCKY MOUNTAIN REGION

Outpatient

1. In person visits
2. Veteran Video Connect visits
3. Telephone calls
4. Telehealth visits

Inpatient

1. IDT – MD/NP/SW/psych/Tootsie
2. Fellows/Learners
3. Consultative model

IN PERSON VISITS

POSITIVES

- Assessment optimized
- Presence of pharmacy/RN staff
- Preferred by Veteran and Providers

CONCERNS

- Transportation issues
- Limited clinic space/availability
- Difficult for inclusion of non-local family and friends
- Difficulty for long waiting at clinic given serious illness, such as O2 requirements
- Community care eligible?

VETERAN VIDEO CONNECT (VVC)

POSITIVES

- Ability to include family and others
- Ability to see Veteran and assess living space
- VVC now – by text to smartphone

CONCERNS

- Technology requirements
- Dependent on weather
- Limited assessment abilities
- Veterans prefer face-to-face meetings
- Lack of local pharmacy

TELEPHONE VISITS

POSITIVES

- Better for triage and follow up
- Only option to begin engagement?
- Transition to another modality?

CONCERNS

- Significantly limited assessment
- Technology requirements
- Reduced quality of conversation
- Difficult for family meetings
- Prescribing limitations

TELEHEALTH AT A CBOC

POSITIVES

- No technology required by Vet
- RN/tech available to support Veteran
- Assessment capabilities
- Local travel from the Veteran's home

CONCERNS

- Transportation issues
- Various CBOC locations, may still be long drive for highly rural Veterans

WHAT ABOUT PALLIATIVE CARE FOR RURAL VETS?

- SW/NP/pharmacy interdisciplinary team
- Meet with Veterans with rural addresses by VVC or telehealth
- Ability to reduce travel time
- Reduce community care referrals for Veterans
- Designated clinic for rural or highly rural Veterans
- Collaboration with agencies in rural areas
- Collaboration with non-VA specialists

DIGITAL DIVIDE CONSULT

- SW completes assessment of Veteran connectivity (device, internet)
- Assessment for home peripherals including BP monitor, pulse oximeter, scale
- Can receive an internet enabled VA tablet
- Tablet can be utilized by any VA provider to connect for video based visits
- Telehealth Technician to assist with tablet set up and problem solving
- New ipad instructions
- Successful ipad tips

WHY HOME BASED PALLIATIVE CARE?

CURRENT HOME BASED RESOURCES FOR VETERANS

- Home Based Primary Care –
  - Waitlist for admission (6+ months)
  - Mileage limitations
  - Not only for Veterans with palliative care needs
- Community care programs – palliative care
  - Cost to VA and lack of understanding of VA funded programs
- Home hospice care – including VA, Medicare and private insurance
- Skilled home care
- Unskilled home care

WHAT IF NO RESOURCES EXIST?

GOALS FOR IN HOME VISITS

- Improved assessment compared to video/phone visits
- Cost effectiveness (travel time compared to CC)
- Improve symptom management (tools for pain/dyspnea/distress)
- Improve caregiver support
- Assist with technology if desired
- Advanced care planning document completion
- VA benefits review

VA BENEFITS

- Reviewed by SW for eligibility
- Cost of private hired care
- Veteran directed care
- Caregiver support program
- Aid and Attendance
- CNH EOL care
- Advocate for expedited enrollment for Veterans who are end of life

PROJECT GOALS FOR HOME BASED PALLIATIVE CARE

- Prioritize patient centered decisions and support of caregivers in rural areas
- Improve symptom burden (use of valid scales to track – pain/dyspnea/anxiety)
- Align priorities of Veterans with care plan to reduce unwanted care (such as hospital)
  - Advanced care planning documents
  - Crisis care plan
- Reduce community care referrals, keep Veteran care through VA
- Goal for fiscal year 2024 to complete 12-15 new consults
- Identify growth of IDT to meet the needs of Veterans (RN, OT, psych, chaplain)

WHAT HOME BASED PALLIATIVE CARE IS *NOT*?

1. Skilled home care for management of wounds, medications, catheters
2. Replacement of primary care
3. Replacement for home hospice care
4. Availability of team 24 hours/day
5. Chronic pain management alone without presence of serious illness

CASE STUDIES

VETERAN #1

- 77 year old male Veteran
- Home address 100% rurality
- CAN score 99
- Initial meeting with palliative care team after discharge from RMR
- Planned for hospice care enrollment
- No home care/hospice care available, no technology for video visit
- Severe frailty once home, lack of DME, lack of plan
- What mattered most to Vet = no hospitalization, die at home

GRECC<->Connect

Geriatric Health Care for Rural Veterans

VETERAN #2

- 81 year old man with metastatic lung adenocarcinoma
- 100% rurality
- Received immunotherapy until cancer progressed despite treatment
- Caregivers were family
- Complicating factors – his daughter with early onset dementia also lived in home
- No available local hospice despite payor source, no other home care available
- Symptoms of edema, dyspnea, pain, weakness, fatigue, anxiety
- What mattered most to the Veteran - to ABSOLUTELY avoid local hospital or LTC
- Priority to die at home

HOW DO WE DETERMINE ELIGIBILITY?

- Rural status
- Home bound status
- Eligible for palliative care – presence of serious illness
- Lack of other home based support
- Lack of technology ability or preference to avoid
- Care Assessment Need (CAN) score

RURALITY CALCULATOR

- Office of Rural Health (ORH) FY 2022 Rurality Calculator
- Rural-Urban Commuting Area (RUCA) is a tool for rurality developed by the Department of Agriculture. This is updated every decade based on survey data from questions in the American Community Survey by the Census Bureau, and metro area designations by the Office of Management and Budget (OMB).
- Project goal to focus on Veterans > 50% rural (> 75% highly rural)

CAN SCORE

- Care Assessment Need score
- Resource available through CPRS → tools
- Risk assessment tool that provides a predictive score 0-99
- The higher the score the more ‘risk’
- Risk = likelihood of ED, hospital or death in time period (typical 90 days)
- Factors include vital signs, lab values, medical visits, pharmacy, ER use and co-morbidities

WHAT ARE SOME IDENTIFIED BARRIERS?

- No 24/7 availability
- No specific eligibility criteria
- No current funding for time and travel – GRECC Connect Clinical Innovation Project
- No inclusion of other provider types like RN, OT, MD, chaplain, psychology
- No plan for expansion to include Veterans living in non-rural areas

QUESTIONS?

REFERENCES

Morrison, R., and Agha, Z. (2021). *A Practical Guide to Implementing a Home-Based Palliative Care Program*. https://s8637.pcdn.co/wp-content/uploads/2021/10/A-Practical-Guide-to-Implementing-a-Home-Based-Palliative-Care-Program.pdf

Roberts, B., Robertson, M., Ojukwu, E. I., & Wu, D. S. (2021). Home Based Palliative Care: Known Benefits and Future Directions. *Current geriatrics reports*, *10*(4), 141–147. https://doi.org/10.1007/s13670-021-00372-8

Ruiz, J. G., Priyadarshni, S., Rahaman, Z., Cabrera, K., Dang, S., Valencia, W. M., & Mintzer, M. J. (2018). Validation of an automatically generated screening score for frailty: the care assessment need (CAN) score. *BMC geriatrics*, *18*(1), 106. https://doi.org/10.1186/s12877-018-0802-7