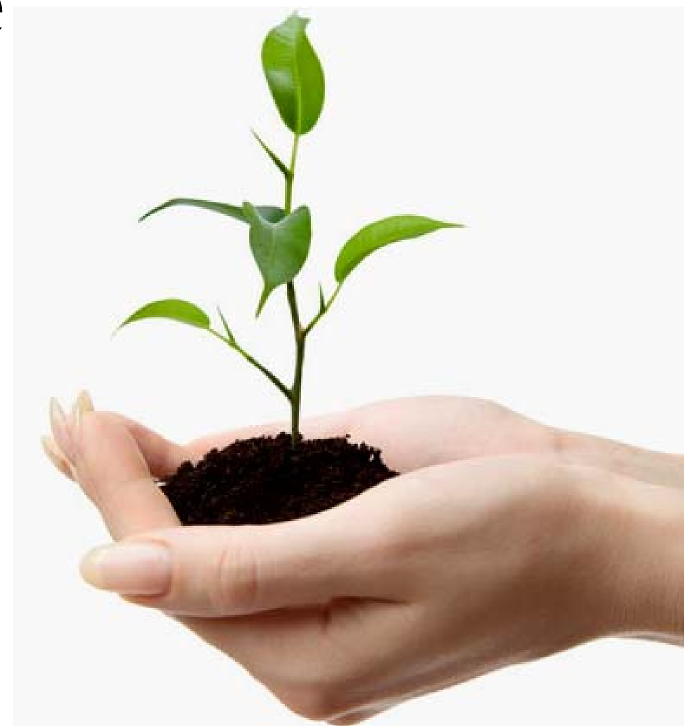
Heritage Provider Network

Enhancing Care Management with a Palliative Care Partnership



Presented by:

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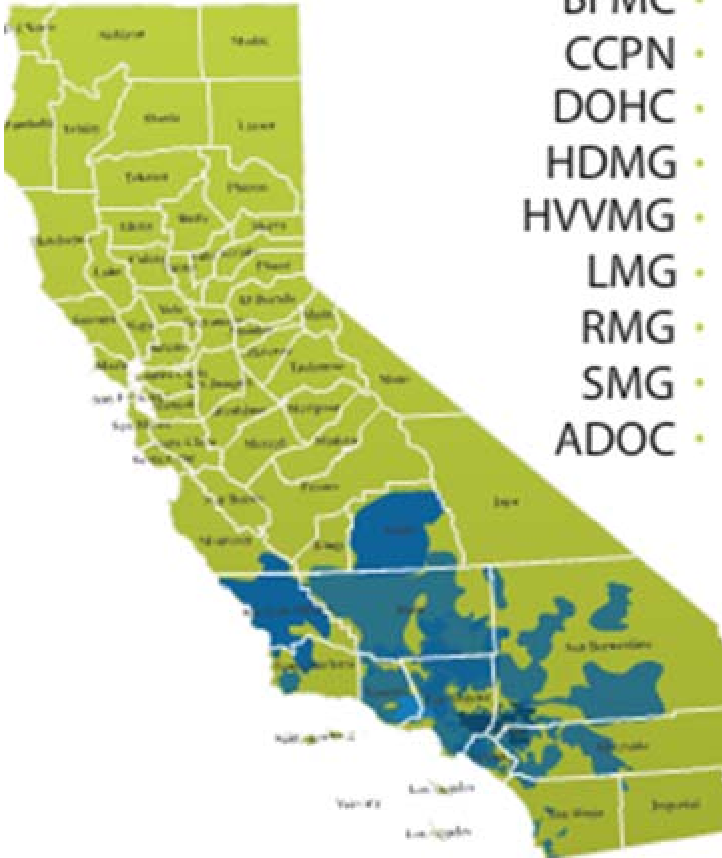
Family Hospice Care

HERITAGE PROVIDER NETWORK



- HPN is a limited Knox-Keene licensed organization in California.
- HPN has a coordinated care network composed of over 2100 PCPs, 3000 Specialists and over 100+ Facilities.
- We are one of the most competitive and cutting edge providers in the nation and one of the largest health delivery systems in California.

FAMILY HOSPICE CARE and DESERT OASIS HEALTHCARE

- **Desert Oasis Healthcare** is the largest Medical Group/IPA, serving the Coachella Valley for over 30 years. Over 100 Primary Care Physicians and 200 Specialty Providers.
- **Family Hospice Care**, created in 2005, licensed and Medicare certified in 2006-a leading provider of hospice care for 6 years, a sister organization to Desert Oasis Healthcare.
- Both DOHC & FHC – part of HPN family

CONTINUUM OF CARE

- Desert Oasis Healthcare Programs:
  - Intense Case Management
  - Telephonic Case Management
  - Physician Home Care Program
  - Medication Management
  - Home Health
  - Diabetic Screening Clinic
  - Cardiac Clinic & Disease Management
  - Senior Only Evaluation Clinic
  - Priority Care Clinic

  In summary, the development of extensive continuum of health care planning.

ADVANCED CARE PLANNING

Advance health care planning includes, but is not limited to:

- Advance Directives
- POLST
- Investigating what financial resources are available e.g. Medicaid Application
- Conservatorship
- Community Resources

ADVANCE DIRECTIVES

Develop a company wide culture & community awareness of advance care planning

- Ongoing education: Increase awareness among providers & their staff, employees, members and their family.
- Social Services: Vital role in education and securing forms.
- Monthly classes held to assist with completion of forms.
- Free in-home notary services provided

PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

- POLST Initiative began with assistance:
  - Tarek Mahdi, MD
    (Inland Empire Palliative Care Coalition)
- Organizational Goal:
  - Address and complete POLST with 100% of our high risk members
  - Obtain copies from SNF admissions
  - Continuing education to providers/staff
  - Maintain central database of POLST forms, accessible 24/7

CLINICAL RESOURCE SPECIALISTS

For High Risk Members:

- The CRS Team are a rapid response team of specially trained personnel who provide extensive evaluation and initiate advance health care planning.

CLINICAL RESOURCE SPECIALISTS

Team Members:

- RNs - strong clinical skills & hospice background.
- Social Workers - hospice background.

CLINICAL RESOURCE SPECIALISTS

Team Members Review:

- Acute chronic disease process
- Financial Resources
- Family support
- End of life care

CARE PLANNING IMPLEMENTATION

Implementation :

- Referrals to Appropriate Plan/Service
- Advance Directive & POLST addressed
- Medicaid Application
- Conservatorship
- Community Resources
- Referral to High Risk Program

CARE MANAGEMENT PROGRAM INTEGRATION

Referrals for High Risk Members:

- Intense Case Management
- Telephonic Case Management
- Physician Home Care Program
- Medication Management
- Home Health
- Diabetic Screening Clinic
- Cardiac Clinic & Disease Management
- Senior Only Evaluation Clinic
- Priority Care Clinic
- Hospice
  - What about our members with chronic life limiting illness who needed more help but didn't qualify for hospice or were not ready for Hospice?

VALUE PROPOSITION OF A PALLIATIVE CARE PARTNERSHIP

In California, Palliative Care can be delivered outpatient under the Hospice License.

- Permits delivery of skilled services without Home Health qualifiers & regulations (homebound not a pre-requisite).
- Not prognosis dependent (hospice < 6 months).
- Aggressive treatment can still be carried out.
- Available to those who do not yet qualify for hospice or for those who do, but fear their own mortality.
- Also available to current hospice patients who are discharged for extended prognosis.

VALUE PROPOSITION OF A PALLIATIVE CARE PARTNERSHIP

Personnel specifically trained to be comfortable with:

- Improving quality of life when quantity of life is limited
- Managing chronic, life-limiting illnesses in home setting
- Educating patients/families about disease progression
- Facilitating “end of life” discussions
- Assisting with “end of life” planning & decision making
- Initiating repeated dialogues about hospice as option

VALUE PROPOSITION OF A PALLIATIVE CARE PARTNERSHIP

Palliative Care Inter-Disciplinary Team:

- Similar model of care as hospice, but with less services
- Physician, NPs, Nurses, Social Workers, Spiritual Counselors
- 24/7 interventions to avert avoidable ED visits & admits
- Facilitates seamless transition to hospice

Palliative Care Average Daily Census

(April 2010 to YTD 2011)

120
100
80
60
40
20
0

Apr '10, May '10, June '10, July '10, Aug '10, Sept '10, Oct '10, Nov '10, Dec '10, Jan '11, Feb '11, Mar '11, Apr '11, May '11, June '11, July '11, Aug '11, Sept '11

Palliative Care Discharges to Hospice

(April 2010 to September 2011)

16
14
12
10
8
6
4
2
0

April '10, May, June, July, Aug, Sept, Oct, Nov, Dec, Jan, Feb, March, April, May, June, July, Aug, Sept '11

total d/c's   d/c to hospice   deaths   other

2011 DIAGNOSIS MIX FOR ADMISSIONS YTD

Diagnosis	Admissions
Cancer	13
Other	2
Dementia	14
Debility	46
Cardiac or vascular	22
Renal/liver	5
Pulmonary	8

There’s always ‘one more thing’ to learn. Cross-pollinate ideas with others both within and outside your company.

Learn from customers, competitors and partners. If you partner with someone whom you don’t like, learn to like them - praise them and benefit from them. Learn to criticize your enemies openly, but honestly.”

- *Steve Jobs*

Thank You!