Practice Guidelines for Providers

Home Connections Palliative Care Program

Clinical Practice Guideline

Approved by the Clinical Quality Committee 5/17/2011
Approved by Physician Ad-hoc Committee 4/10/2010
Definition

The program is designed for the member who has been diagnosed with an advanced and progressive illness.

An advanced and progressive illness is defined as a condition for which the need for symptom management exceeds the response to aggressive treatment.

Advanced and progressive illness affects people of all ages, and may include the following diagnoses:

- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Malignant Disease
- Liver or Pancreatic Disease
- Acquired Immune Deficiency Syndrome
- Progressive Neurological Disorders
- Cardiomyopathy

Guidelines for Admission

Documented symptomatic progression of disease including, but not limited to:

- Three or more ER visits in 6 months
- Three or more hospitalizations in 6 months
- Three or more medication changes specific to the same condition in 6 months
- Decline in functional status:
  - NYSHA Class III or IV
  - FAST (functional assessment staging) 6 or worse
  - Palliative Performance Scale (PPS) 50 or less
- Patient is not ready for transition to hospice care
- Program is available for patients who would benefit from palliative care, with or without active treatment
Palliative Care Team

The focus point of the team is the patient and their family.

The team includes:

- Primary Care Physician
- Palliative Care Physician
- Health Plan Case Manager
- Palliative Care Nurse and Social Worker

The goal of this team is to promote close communication to meet the changing needs of the patient and their family.

Objectives

- Implement an interdisciplinary approach that provides comprehensive physical and emotional care for patients with advanced and progressive illnesses.
- Maintain the patient’s quality of life throughout a progressive illness.
- Increase the knowledge of the patient and their family about the disease process.
- Educate the patient and their family to participate in the decision making process related to treatment options.
- Foster close communication with team members to ensure that the patient’s treatment options are optimized.
- Support the treatment plan agreed upon by the patient, family and physician.
- Reduce ER visits/hospital admissions for uncontrolled symptoms with continued monitoring by a Home Connections Palliative Care professional.
- Refer appropriate patients for earlier entry into hospice.
Symptom Management

- For patients at risk for:
  - Dehydration
  - Uncontrolled Pain
  - Shortness of Breath
  - Depression
  - Fractures
  - Weight Loss
  - Anorexia
  - Constipation

- Recommend effective symptom and pain management.
- Monitor the effects of medications on quality of life and comfort.
- Educate patient and their families on the side effects of all medications, and what actions to take if side effects occur.
- Educate patient and their family about coping mechanisms for dealing with complicated regimens.
- Provide alternatives when oral dosing is not an effective option.
- Evaluate patient compliance with medications and communicate with team members for needed changes.
- Educate on the importance of continued use of medications to prevent rebound effects.
Palliative Care Interventions

- Identify changes in patient condition and communicate with physician(s) to promptly implement strategies to prevent unnecessary ER visits or hospital admissions for symptom management.
- Educate patient to use stress management techniques to minimize symptoms.
- Assist patient and family to develop effective coping strategies for deteriorating health.
- Assist family with role transition secondary to illness.
- Explore pain and symptom management options with patient and physician.
- Align patient’s medication regimen with patient’s goals of care and clinical condition.
- Educate patient/family for improved communication with physician team.
- Identify non-clinical issues impacting family for resolution.
- Assist patient/family to access needed community resources (financial, supportive).

Goals

- Patient will complete an advanced directive, a health care proxy and/or living will with copies distributed to treating physicians and health care facilities.
- A M.O.L.S.T. (medical orders for life sustaining treatment) form will be completed with discussion of resuscitation status for appropriate patients.
- Patient will transition to hospice, as appropriate.
Planning Advance Directives With Your Patients

1. Should each of my patients have a Health Care Proxy?
   Every adult resident in New York state should have a proxy.

2. Why is it important to discuss a Health Care Proxy with my patients?
   This is important so that the patient can discuss her/his wishes prior to incapacitation. Without a living will or health care proxy, there is a possibility that aggressive care may be provided that is not consistent with the patient’s goals of care. Physician liability is decreased if a health care proxy is involved in the decision making process. A proxy agent can assist in resolving family conflicts.

3. Can I act as my patient’s Health Care Proxy agent?
   No. An attending physician cannot simultaneously act as the patient proxy.

4. Where should the completed form be kept?
   The patient’s attending physician should have an updated copy of the proxy in the medical chart at the office. Patients should give a copy of the form to their designated agent, and inform family members of the decisions within the proxy. Additionally, patients should bring a copy of the proxy to all hospital admissions.

5. When should a Do Not Resuscitate/Do Not Intubate (DNR/DNI) be discussed?
   A DNR/DNI order should be discussed with any patient who is seriously ill before a critical event occurs. NYS requires a non-hospital DNR for a patient who does not wish to be resuscitated at home.

Contacts

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