Piloting the Care Management and Palliative Care Program (CMAP)

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Background

The goal of the Care Management and Palliative Care Program (CMAP) is to improve quality of life, and provide dignity and respect for homebound patients.

Interventions include:
- intensive care management
- incorporation of palliative medicine principles
- utilization of patient centered care strategies for decreasing hospital utilization (therefore increasing time at home)

Equally important is a focus on the patient oriented outcomes of:
- increased symptom assessment
- goals of care discussions
- completion of advanced directives

Patient Selection

We identified a population within our home visit practice which is high risk for readmission and death.

Eligibility:
- ≥ 60 years old, a hospitalization or ED visit
- approval from the patient's primary team of providers
- scoring ≥ 5 on the risk scoring tool applied after hospital/ED visit

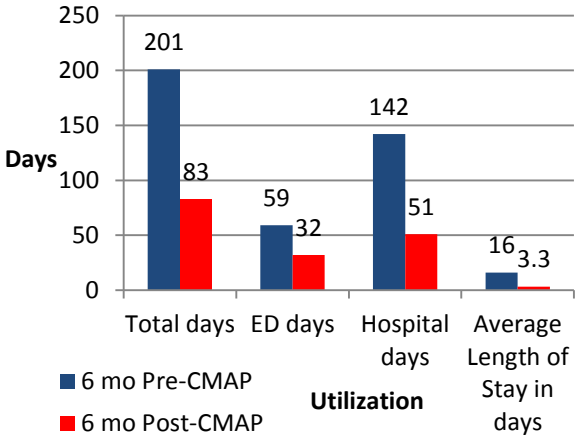
Exclusion criteria: primary mental health diagnosis, lack of POA or decisional capacity, provider declines intervention

Scoring Tool

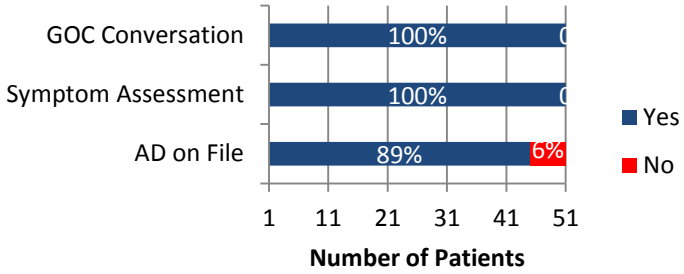
Currently being validated. Based on internal data of homebound patients with high utilization and includes:
1. Utilization of hospital or ED (numeric)
2. Number of chronic conditions (CHF, COPD, ESRD, CVA, bedbound status, stage 3 or 4 pressure ulcers, AIDS, and advanced cancer)
3. Dual-eligible status
4. Length of stay
5. Hospital readmission

Data

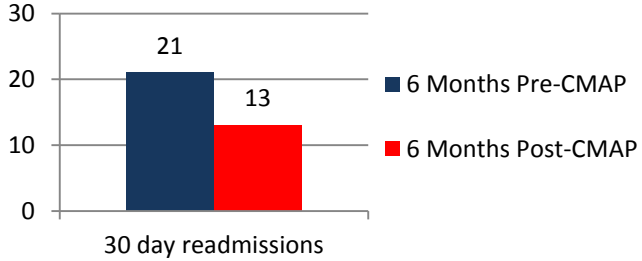
Hospital and Emergency Department Utilization (in days) 6 Months Pre and Post CMAP Intervention (n=51)



% of Patients with Advance Care Planning and Symptom Assessment (n=51)



30 Day Readmissions (# of) 6 Months Pre and Post-CMAP (n=51)



Intervention

Each patient receives a 4-week intervention which consists of:
- Weekly visits from the interdisciplinary team (physician, RN, SW) and calls from the care manager

Key components: Extra visits/calls, goals of care discussion, completion of a validated symptom assessment (Edmonton Symptom Assessment), completion of Advance Directive (if pt chooses).

Outcomes

The program demonstrates decrease in utilization of hospital/ED visits, 30-day readmission, and hospital length of stay.

The CMAP program demonstrates that using population health and palliative care principles improves outcomes for patients, paving the way for future outpatient palliative care initiatives in a home-based setting. Results also demonstrate a more consistent approach to applying palliative interventions such as goals of care discussions and symptom assessment, which were completed in 100% of patients.

Next steps include validating the risk scoring/trigger tool, comparing the CMAP group to a historical cohort, dissemination of findings, and applying for future funding opportunities to continue this work.

Ultimately the CMAP team has been able to tailor care to the individual's needs with the goal of improving quality of life and respecting patients' health care choices, while improving health care system utilization.

Acknowledgments: CCHS Chairs Leadership Council for funding support; CMAP Team: Asha Abraham, RN, Rachel Glick, NP; CCHS IAH Team, CCHS Palliative Medicine Team