

# HOMEPAL PROGRAM MANUAL

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## **Core Components of HOMEPAL**

The HomePAL (for *home*-based *palliative* care) program builds on the evidence-based model developed and tested within Kaiser Permanente. It is defined by core features that work together in a particular way to achieve certain outcomes, including high levels of patient and family satisfaction with care. The core components of HomePAL are as follows:

- The unit of care comprises the patient and family caregiver(s).
- An interdisciplinary team (IDT) directs and provides care. Core team members are the patient and family caregiver(s) plus a physician, nurse, social worker, and chaplain.
- The team's health providers assess the physical, medical, psychological, social, and spiritual needs of the patient and family.
- Based on the assessment, the team develops a plan of care to provide coordinated care that emphasizes supportive services.
- Home care is emphasized. Limited personal care services are available to support the patient and family. If needed, community-based services such as Meals-on-Wheels and in-home supportive services are sought to help fill gaps in personal and home care.
- Pain and other symptom management is emphasized.
  - Comprehensive primary care is provided to manage underlying conditions with the goal of preventing acute exacerbation.
  - Aggressive treatment of an acute exacerbation of illness is provided at the patient's request.
- Inpatient services are provided, when necessary, to ensure both appropriateness of care and continuity of care for patients who cannot be managed at home because of acute complications or because their family cannot manage terminal care for them at home.
- Telephone support via a toll-free number and after-hours home visits are available 24 hours a day, seven days a week as needed by the patient and family.
- Volunteers may help provide support and assistance to patients and families.
- Bereavement services are provided to help the family cope with social and emotional needs following the death of the patient.

## **Program Operations**

### Staffing

HomePAL uses an IDT approach with the core team consisting of the patient and family plus a physician (MD, NP, or PA) and registered nurse (RN or RNP), both possessing expertise in pain and symptom management, and a social worker (LCSW or MSW) and chaplain, both proficient in bio-psychosocial and spiritual care. This team approach encourages patients, family members, and professional caregivers to exchange knowledge and facilitates communication on treatment preferences. Typically, a nurse and social work team act in the capacity of care managers for the patient, remaining a constant in the patient's life throughout his or her stay in the program.

Collectively the IDT improves outcomes by proactively anticipating problems and working to prevent them, rather than waiting for consequences to manifest. The core team is responsible for coordinating and managing care across all settings and providing assessment, evaluation, planning, care delivery, follow-up, monitoring, and continuous reassessment of care.

Depending on the needs of the patient and family, additional team members may join the core team in service provision. These adjunct staff members provide care under the supervision of the core team. Adjunct team members include the following:

- Certified home health aides (CHHA)
- Rehabilitative therapists (physical, occupational and speech therapist)
- Pharmacists
- Dietitians
- Bereavement counselors
- Volunteers

These additional team members may be available through contractual relationships with local hospice providers.

### Team Goals

In HomePAL, the patient/family unit and the healthcare providers are equal partners. The patient and his or her family actively participate in developing and evaluating a plan of care and attaining outcomes that reflect their personal wishes, values, and goals. Overall, team goals are to:

- focus on the patient/family as the unit of care
- develop a plan of care consistent with patient and family goals
- provide appropriate management of the patient's medical condition
- prevent crises
- coordinate care and communicate with each other, including with primary and specialist physicians, on a planned and regular basis
- discuss the patient's prognosis and reasonable expectations for the patient's health and well-being
- discuss basic pathophysiology of the patient's disease and the effects of various measures being taken to improve health
- provide support and education to the patient and family, including teaching them about the expected course of the disease, preventive care, medication use, and self-management and crisis intervention in the home
- teach the family how to successfully provide end-of-life care
- discuss advance care plans
- plan for home death, if possible and desired by the patient
- provide 24/7 support and access to care

Team goals are directed at delivering care that meets the patient's personal preferences, treatment goals, and service needs. They also aim to help patients and their family members anticipate and avoid problems, thereby averting potential crises.

### Interdisciplinary Team Conference

The IDT depends on clear, open, and positive communications among team members to work effectively to meet patients' needs and goals and to avoid unnecessary duplication of services. Regular team meetings help foster such communication. They also synthesize and augment individual expertise, leading to the collective development of a comprehensive, collaborative, and coordinated plan of care.

All IDT members, including both core and adjunct members, meet to discuss ongoing care of patients at least once every two weeks. During each one- to two-hour conference, about 40-50 patients are presented and discussed. The palliative care physician leads the discussions. An IDT conference note is completed following each team meeting.

### The Plan of Care

HomePAL patients maintain a sense of control over their lives by expressing their preferences for palliative and end-of-life care in a written plan of care. Developed within a week of admission, the care plan marks the start of the patient's palliative care journey. Updated at regular intervals thereafter, it provides guidance for the end of the journey as well. Continual use of the plan of care enhances communication among the patient, family, and healthcare providers, which in turn helps ensure quality of care.

A palliative care nurse drafts the plan of care based on a comprehensive in-home assessment of the patient and family. This assessment helps patients establish personal goals and allows for assessment of patient and family support systems. It also fosters communication that can facilitate the development of a caring relationship between nurse and patient. During the assessment, patients and their family members have an opportunity to both receive and provide important information. In discussions with the nurse, the patient and family learn about the goals and services of HomePAL, find out more about the patient's illness and prognosis, receive education and instruction in managing the patient's care at home, and obtain information about advance care directives and the process of designating a healthcare proxy. In those same discussions, the nurse learns more about the patient and his or her family: What are the patient's preferences for treatment and care? What ancillary services are needed to support the family? Are there ongoing needs for education and instruction? The nurse also obtains information via a medical history review, a physical assessment, a home safety assessment, and a medication review.

Taking into account all this information, the nurse, in conjunction with the IDT, drafts a plan of care, which is reviewed, discussed, and revised by all IDT members, including the patient and family. The care plan must include an assessment of the patient's needs, treatment goals, designation of the primary caregiver in the home (or an alternate plan), and identification of scope and frequency of services. The palliative care physician must sign each plan to indicate approval. The care planning process does not end here, however.

A dynamic process, care planning is ongoing and changes as the patient's and family's needs change. At least every 60 days, and more often if necessary, the IDT reviews and updates the plan of care to ensure that it continues to reflect the patient's personal preferences, treatment goals, and service needs. These revisions also document the provision of IDT interventions. Once a revised care plan is approved by the IDT and signed by the palliative care physician, all services must be provided in accordance with this new plan. An IDT nurse ensures that the new plan of care is filed, along with the patient's medical records, in a binder that is left in the patient's home, so that all IDT members have easy access to information they need.

### **Patient and Family Services**

Patient and family services include ongoing care provided by all members of the IDT, after-hours services, and inpatient care.

### Ongoing Care: Core Services

Physician Visits: The palliative care physician (or, in some programs, an NP or PA) visits the patient at home within a week of admission, with follow-up visits every 4-8 weeks or as needed. The physician will make more frequent visits if medically necessary or if a patient evaluation is needed.

Physician services include, but are not limited to: evaluation and management of the patient's medical condition, including pain and other symptoms. The palliative care physician discusses with the patient advance care plans and treatment goals. He or she also ensures that consensus about care is reached between specialists and other physicians involved in the patient's care.

Nurse Visits to Home: Skilled nursing services are provided by or under the supervision of a registered nurse, in accordance with the patient's plan of care. An IDT nurse visits the patient at home as often as required by the patient. Typically, this means 2-3 weekly visits during the first few weeks in order to establish a strong relationship with the patient and help him or her manage care at home. The nurse may visit less frequently thereafter, but never less frequently than every other week, unless the patient's condition stabilizes. The IDT must approve visits that are less frequent than every other week. More frequent visits may again be needed in the few weeks before death as patient and family needs for bio-psychosocial support increase.

Skilled nursing services include, but are not limited to: patient assessment, evaluation and management of the patient's nursing needs, performance of any prescribed medical treatments for pain and symptom control, provision of emotional support to both the patient and his or her family, and the instruction of caregivers in providing personal care to the patient. Skilled nursing services are available on a 24-hour on-call basis.

Social Worker Visits to Home: Social workers provide counseling and emotional support to help patients and their families address their economic, psychosocial, and spiritual needs. An IDT social worker completes an initial assessment of the patient and family within one week of admission. Thereafter the social worker conducts either a telephone consultation or an in-home visit at least monthly and more often if necessary.

Social work services include, but are not limited to: psychosocial assessment of the patient and family, counseling to help the patient and family cope with the stress of a terminal illness, assistance in planning care, and help with obtaining and coordinating of community-based services.

#### After-Hours Services

As advanced illness is not time bound, telephone support via a toll-free number and after-hours home visits are available 24 hours a day, seven days a week as needed by the patient and his or her family. Palliative care registered nurses manage these after-hours services, providing guidance based on established treatment guidelines, obtaining physician orders, arranging for prescription medications, and providing other services as needed based on a telephone assessment of the patient and family. Palliative care physicians also are available 24/7 to support patients and their families as well as the after-hours staff.

All after-hours telephone interactions with patients and families are documented in the patient's medical record. The nurses relay information from these calls to the IDT and follow-up with patients and the family as needed.

#### Inpatient Care

Inpatient services are provided, when necessary, to ensure both appropriateness of care and continuity of care for patients who cannot be managed at home because of acute complications or because their family cannot manage terminal care for them at home.

Inpatient care is provided at the least-acute level that can deliver necessary treatment in accordance with the patient's plan of care. If possible, inpatient care is delivered in a non-acute setting such as a skilled nursing facility or a hospice-like inpatient unit. Following an acute care admission, the patient is transferred to a non-acute setting as soon as possible when consistent with the patient's preference and treatment goals. Inpatient terminal care is available as needed, generally for ten days or less, if possible.

#### Additional Services

Medical supplies, durable medical equipment (DME), oxygen, and medications are provided as needed in accordance with the patient's health plan. Prescriptions are provided under the patient's prescription drug benefit.

#### **Patient Discharge**

Patients are discharged from HomePAL when any one or more of the following events occur:

- The patient converts to the hospice benefit.
- The patient/family no longer meet the palliative care admission criteria or do not agree with palliative care goals.

- The patient's condition stabilizes or symptoms are under control with minimal risk of decline.

#### Transition to Hospice Care

The HomePAL team aims to transition patients to hospice care when they meet hospice eligibility criteria and agree to the hospice terms of care. Given the additional benefits patients gain from hospice enrollment, the team strives to make these transitions as soon as it is appropriate for the patient. Because the HomePAL team uses adjunct team members from local hospice organizations (e.g., certified home health aides, therapists, etc.), referrals to these hospice teams can help preserve continuity of care for patients.

#### Discharge Process

The IDT team discusses possible discharge from HomePAL in advance with the patient and family. The outcomes of these discussions are recorded in the patient's chart, including relevant actions and decisions leading to the patient's discharge from the program. Discharge plans delineate how services will be provided after the patient departs HomePAL.

If a discharged patient subsequently re-enrolls in HomePAL, the patient's assessment and care plan will be updated or completed anew, as recommended by the HomePAL physician.