



## Learning Objectives

1. Explain the limitations of existing care delivery models for seriously ill patients
2. Discuss methods employed to design a pathway for a goal-directed care delivery model

## Background

- Chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), diabetes mellitus (DM), chronic kidney disease (CKD) and metastatic cancer accounts for 90% of mortality at MU Health Care
- For COPD patients with advanced disease, only about 49% (n=184) established palliative care.
- Patients with serious illness diagnoses who establish with Palliative Care early in their disease process may benefit from advance care planning, earlier referral to hospice (if consistent with their goals), avoidance of acute care over-utilization at the end of life, improved quality of life and support in coping with their disease.
- The goal-directed care delivery model of collaborative decision-making focuses on identifying patients with clinician defined serious illness and advanced disease diagnoses early in the disease process and aligning the patient's care goals with those of the care delivery team.

## Intervention

- A core team was formed, consisting of an executive sponsor, pulmonologists, the palliative care team, quality improvement professionals and a data analyst.
- Project launched as a pilot project for advanced COPD patients and criteria for defining advanced COPD was established.
- Baseline data on patients meeting set criteria were collected and an outcome measure was established.
- The outcome measure is the percentage of patients with advanced COPD who are established with palliative care.
- A clinical pathway was designed to connect patients with palliative care once they were identified.

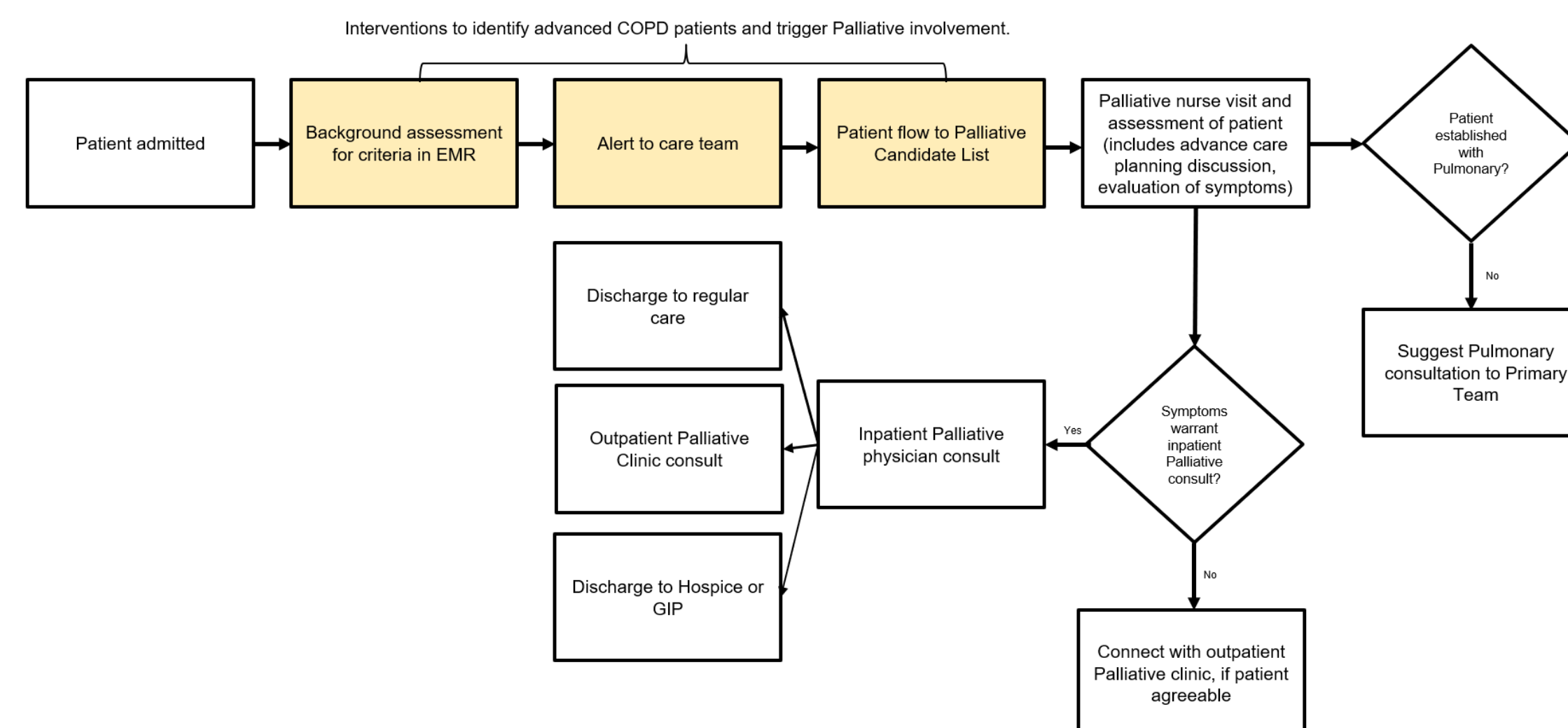
## Advanced COPD Criteria

- 1) Diagnosis of COPD
- 2) Continuous Home O2 or diagnosis of chronic respiratory failure on supplemental O2
- 3) BMI <21 or 1 comorbidity (CHF, DM, Dementia, CKD, History of Severe Sepsis with end organ failure)
- 4) 2 or more admissions in last 12 months
- 5) ≥ 60 years old

## Outcomes and Impact

- During January 1, 2023 through June 30, 2023, 113 patients with advanced COPD were identified
- Patients linked to palliative care services increased (49% to **97%**)
- Advanced COPD patients with advance directives increased (2% to **32%**)
- 35% linked to outpatient palliative care clinic
- 14% discharged to hospice facility or inpatient hospice

## Clinical Care Pathway



## Lessons Learned

Palliative care teams often encounter challenges in actively involving patients and families in medical decision-making, leading to missed opportunities for understanding their values, preferences, and goals essential for providing patient-centered care.<sup>1-4</sup>

One major challenge is that there are no standard criteria to identify patients that need a palliative care intervention early in the disease process.

While this work is not exhaustive in terms of incorporating the cornucopia of disease entities that exist, the current approach is data-driven, clinician-informed, patient centered, and collaborative. It also represents a paradigm shift from a conventional model of care to a goal-directed care delivery model of collaborative decision making.

## Key Takeaways

Defining criteria for serious illness and advanced disease is vital to identifying groups of patients for targeted palliative care intervention early in the disease trajectory.

The goal of such intervention is to understand patient care needs, establish care goals and to align those goals with that of the care delivery team.

## References

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