*Original Article*

# Clinical Impact of a Home-Based Palliative Care Program: A Hospice-Private Payer Partnership

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## Abstract

**Context.** Outpatient programs have been traditionally offered in the U.S. under programs such as the Medicare Hospice Benefit. Recommendations now emphasize a blended model in which palliative care is offered concurrently with curative approaches at the onset of serious or life-limiting disease. The efficacy of nonhospice outpatient palliative care programs is not well understood.

**Objectives.** The aim of the study was to evaluate the clinical impact of a home-based palliative care program, Home Connections, implemented as a partnership between a not-for-profit hospice and two private insurers.

**Methods.** This was a prospective, observational, database study of 499 Home Connections participants enrolled between July 1, 2008, and May 31, 2013. Measured outcomes were advance directive completion, site of death, symptom severity over time, program satisfaction, and hospice referral and average length of stay.

**Results.** Seventy-one percent of participants completed actionable advance directives after enrollment, and the site of death was home for 47% of those who died during or after participation in the program. Six of eight symptom domains (anxiety, appetite, dyspnea, well-being, depression, and nausea) showed improvement. Patients, caregivers, and physicians gave high program satisfaction scores (93%–96%). Home Connections participants who subsequently enrolled in hospice care had a longer average length of stay of 77.9 days compared with all other hospice referrals (average length of stay 56.5 days).

**Conclusion.** A home-based palliative care program was developed between two local commercial payers and a not-for-profit hospice. Not only did this program improve symptom management, advance directive completion, and satisfaction, but it also facilitated the transition of patients into hospice care,

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***Key Words***

*Palliative care, outpatient care, home-based palliative care, end-of-life care*

## Introduction

Substantial evidence supports the benefits of inpatient and outpatient palliative care under programs such as the Medicare Hospice Benefit, which is generally available to individuals aged 65 years and older in the U.S. Positive outcomes include reduced symptom burden, improved quality of life, increased patient and family satisfaction, appreciable cost avoidance, and reduction in hospitalizations.[1–7] Thus, the number of hospital-based palliative care programs has grown rapidly. In 2010, 81% of U.S. hospitals with 300 or more beds reported offering inpatient palliative care services.[8] Recommendations now emphasize a blended care model in which palliative care is offered concurrently with curative approaches at the onset of serious or life-limiting illness.[9–14]

Gaps remain in the application of and evidence for palliative care across the continuum, specifically in the outpatient setting, where most patients experience illness and receive care. The advancement of outpatient palliative care, particularly home-based models, has been limited in part by economic realities, specifically insufficient fee-for-service revenue and an absence of financial benefit or incentive for cost avoidance. The emergence of managed care has altered the alignment of economic and clinical outcomes, favoring a broader application of palliative care across settings. Four randomized outpatient palliative care interventions have demonstrated improved symptom control, patient satisfaction, and quality of life, along with reduced health care utilization and costs.[15–21] These home care studies occurred within a closed staff model insurance company, or vertical care system, where the complete spectrum of care, including financial services, is provided by a single health care organization. It is unclear whether these results will extend to horizontal care models, in which health care delivery is provided by many different and often unconnected organizations, and coordination of care is much more difficult.

Although palliative care under the Hospice Benefit has demonstrated positive clinical outcomes, there remain numerous barriers to timely access including challenges in prognostication and discussing death.[22–24] According to one report, the national median length of stay for hospice patients was only 19 days, which may hamper adequate symptom management and support before death.[25]

The present study describes the outcome of a collaborative model between a not-for-profit hospice and two private insurance companies to provide home-based palliative care upstream and outside of the Hospice Benefit. Although the current fee-for-service environment limits the provision of home-based palliative care by a provider such as hospice, there are potential savings via cost avoidance for the health care system and payer. Unlike hospice, home-based palliative care requires neither a limited prognosis nor patients to forgo or not be appropriate for aggressive and curative treatments. The impact of this model on advance directive completion, site of death, symptom severity, and satisfaction is reported. Disposition including entry into hospice and hospice length of stay are also noted.

## Methods

### *Program Description: Home Connections*

The Center for Hospice & Palliative Care (Cheektowaga, New York) established Home Connections (HC), a home-based palliative care program, in 2008. HC serves Erie County, New York, and is available to adult patients, 18 years or older, with advanced chronic illness. HC serves patients upstream from the Hospice Medicare Benefit, so patients may still be receiving aggressive or cure-focused treatments and do not necessarily have an expected prognosis of six months or less.

The HC team includes a palliative care-trained registered nurse (RN) coordinator, social worker (MSW), trained volunteers,