Delivering Palliative Care Across the Continuum

- Creating partnerships
- Overcoming barriers
- Finding solutions in the absence of a payment model
MemorialCare Health System Palliative Care Across the Continuum

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MemorialCare Begins with ME
1. Describe key steps needed to make the business and care quality case for a system-wide approach to delivering palliative care services.

2. Describe key steps in overcoming physician barriers to palliative care delivery in the hospital setting.

3. Describe key steps to running an ambulatory palliative care clinic and at-home program.
85 year woman
- Lives alone in mobile home park, Adult children involved but not on daily basis
- No advanced directive, HCP, or DPOA
- Carries diagnoses of CHF, COPD, depression, distant breast cancer, osteoarthritis, early dementia (long list gathered up in EMR)
- Prescribed 10+ medications some of which are too expensive, too difficult to take, of uncertain purpose to her mind (last full review of medications during a 15 minute post hospital visit with her PCP)
- In the last year, she has had three inpatient hospitalizations for fall, respiratory failure with COPD exacerbation and pneumonia, and syncope
- During these hospitalizations, she received a pacemaker, a pinned hip, more prescriptions
- Post hospital, she varyingly went to SNF for therapy or home with home health
- At her post hospital PCP visits, she gets some papers about advance care planning and a quick mention to “take a look” by her PCP
- Today she presents to the ER dyspneic and is admitted for CHF exacerbation
- Sound familiar? What can we offer her to improve her quality of life and help break the readmission cycle?
If you want to understand today, you have to search yesterday.

(Pearl S. Buck)
Changing Patterns of Mortality in the Post World War II Period, 1945–Today

Leading Causes of Death in the US
Numerous factors, including social, economic, political and scientific processes, shape and influence understanding and response to new diseases, according to the New England Journal of Medicine.

202.2 deaths per 100,000 were attributed to influenza and pneumonia in 1900
355.5 deaths per 100,000 were attributed to heart disease in 1950
192.9 deaths per 100,000 were attributed to heart disease in 2010

Leading causes of deaths in the U.S. since 1900
Number of deaths per 100,000

<table>
<thead>
<tr>
<th>Year</th>
<th>Influenza and pneumonia</th>
<th>Heart Disease</th>
<th>Cancer</th>
<th>CHD</th>
<th>Diabetes</th>
<th>Stroke</th>
<th>Respiratory disease</th>
<th>Accidents</th>
<th>All Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1900</td>
<td>285.1</td>
<td>38.2</td>
<td>4.0</td>
<td>5.1</td>
<td>3.0</td>
<td>1.0</td>
<td>6.9</td>
<td>2.4</td>
<td>100.0</td>
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<tr>
<td>1950</td>
<td>105.0</td>
<td>32.0</td>
<td>10.0</td>
<td>15.0</td>
<td>10.0</td>
<td>5.0</td>
<td>12.0</td>
<td>1.0</td>
<td>100.0</td>
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<tr>
<td>2010</td>
<td>65.0</td>
<td>25.0</td>
<td>10.0</td>
<td>15.0</td>
<td>10.0</td>
<td>5.0</td>
<td>12.0</td>
<td>1.0</td>
<td>100.0</td>
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Influenza and pneumonia, 1918: 50 million people died worldwide in the 1918 influenza pandemic, making it one of the deadliest epidemics in history.

Heart Disease, CHD, Diabetes, Stroke, Respiratory disease, Accidents, All Causes.
Why? Advances in Public Health

- Acceptance of Germ Theory
- Vaccines, hygiene and public sanitation, clean food, adequate nutrition: most impact on young and population increases as more children live to reproductive age, fewer women die in childbirth
Late 19th century to World War I:

- Professionalization of physicians with medical education standardized and taken over by universities.

- Hospitals become central to medical education and practice. Previously places where homeless, poor, “insane” came to die, now “work places for the production of health” and appealing to affluent classes and growing urban populations.

- “Giving medicine the confidence that its major justification as a profession was its scientific base.”
20th Century: Hospitals

- “Demonstration of show and even conspicuous waste” symbolizing wealth of new American
- Luxurious settings, even during the Great Depression
- Projecting “ideals of specialization and technical competence”
20th Century: Physicians become powerful

- By WWII physicians no longer “weak, divided and financially insecure” but “prosperous, united and respected, able to move medical care from the home into the marketplace.”

- “Doctors exploited progressive belief in science over populist support of self-reliance.”
Hospitals became places where medicine was practiced by independent entrepreneurs...following their patients into the hospitals and driving demand for increasingly technological and sophisticated services and therapies.”

Self-reinforcing cycle of new technologies, procedures and drugs: doctors market to patients, doctors demand in hospital, patients now demand as well, hospitals maintain market share by responding to these demands.
By 1930s technology and expanded services has driven cost of health care up

Great Depression leaves most Americans unable to afford care

Hospitals create low cost community insurance, enabling them to get costs reimbursed by spreading risk across membership

Blue Cross starts in 1929 with 1250 teachers

By 1940, 6 million Americans enrolled in Blues
History of Insurance

- Meant to keep charitable organizations in business
- BUT Changed behaviors – doctors controlled the “Blues,” and with improved economic conditions, physician–hospital power relations, patient expectations and medicine’s new capabilities….
- Turned cost reimbursement into income guarantees for physicians and hospitals
- Insurers began to partner more with physicians and hospitals than with their subscribers
- “Minimize competition, control prices and ease bill collection” for physicians and hospitals

The Elusive Quest: Accountability in Hospitals, Carolyn Wiener
President Truman’s effort to create a national health care system

“The health of American children, like their education, should be recognized as a definite public responsibility.” Harry Truman 11/19/1945
Defeated .... but

- Increased public attention to health care
- The “Blues” grew to 60 million enrollees
- Explosive proliferation of research:
  - “The defeat of national health insurance...(led to) promote research as the best health insurance Americans could have....
  - “The postwar economy was booming, and community hospitals added new technology, larger facilities, and a burgeoning work force of professionals and technical workers to assist physicians in the care of their patients.”
- Commercial insurance also expands: Employer based insurance introduced during WWII as worker incentive during periods of wage freeze.
Antibiotics: “discovered” in 1928; mass produced by 1945

Chemotherapy: “discovered” in use of mustard gas to treat lymphoma

Radiation therapy used therapeutically as stereotactic radiosurgery and intraoperative radiation therapy

Laparoscopic Surgery: advances rapidly in last quarter of 20th century
Life Prolonging Procedures

- Transplant Surgery – first successful organ transplant in West after 1960s
- Dialysis, Dr. Willem Kolff, first dialyzer in 1942
Life Prolonging Devices

- Pacemakers
- AICDs
- Ventilators
- LVADs
- Stents
Medicare

- Twenty years after President Truman’s vision, 56% of American seniors uninsured.

- Medicare created in 1965 when people over 65 found it virtually impossible to get private health insurance coverage.

- Led to improvements the health and longevity of older Americans.

- 20th century sees declining mortality rates in older population – living longer for the first time in human history
“If care is far more expensive, so be it. Medicare was picking up the tab for the elderly and big business had agreed to pay the bill for its employees so plenty of money was available. The vicious circle kept spiraling costs upward with each turn: research funds created a demand for more specialized researchers and scientists, who created new demands for more research funds...to support their work and their spectacular discoveries made the American people willing to pay for more...after all, this investment had produced...the ability to extend life for thousands who would have died...”

By 2014, 40 million enrollees in Medicare and 14% of Federal Budget
More people have access to care
More people receive timely care
Reimbursement model is based on volume: “More is more”
Health care industry and public perception also “More is More”
“The arsenal of modern drugs, procedures, and machines cannot “restore” health to the chronically ill. They can, however, mitigate some effects of disease and postpone death.”
Female Life Expectancy in Developed World, 1840–present
Removal of Suffering and Death from View

- People in the developed world rarely witness severe illness, and death in childbirthing mothers, children, even the elderly

- Dying is unfamiliar to most of us
The Implicit if not Explicit Promise of Immortality

- Every physician
- Every nurse
- Every patient
- Every person in our society has been given the promise of longer, better life through modern health care....
- We may accept that death will eventually come but we expect that our lives can go on well and that suffering and death can be indefinitely postponed.
Historically (and in many parts of the world still) negotiating for decline and death is not an option.

Now in the developed world and for many of us, it is perceived as an option.
My Story

- Hospitalist, taking great care of patients in the hospital
- Careful discharge planning
- So many drugs, so many interventions, so little time at home
- My patients coming back again and again
- Lots of costs but no meaningful, longitudinal impact
- Starting to burn out on an unbroken cycle
- We must be able to do better than this....
Looked Around – Like Minds

- Eager to create services to meet the needs of our patients and our communities
- Motivated in creative multidisciplinary partnership in absence of a payment model
- Grass roots within a large health system to find approaches to pay for palliative services
Objective 1:
Describe key steps needed to make the business and care quality case for a system-wide approach to delivering palliative care services.
“The only thing that stands between you and your dream is the will to try and the belief that it is actually possible.”
Hospice/Palliative Care

Home Care Management
Provides in-home medical and palliative care management by Specialized Physicians, Nurse Care Managers, and Social Workers for chronically frail seniors that have physical, mental, social, and financial limitations that limits access to outpatient care, forcing unnecessary utilization of hospitals.

High-risk Clinics and Care Management
Intensive one-on-one physician/nurse patient care and case management for the highest risk, most complex of the population. As the risk for hospitalization is reduced, patient is transferred to Level 2. Physicians and Care Managers are highly trained and closely integrated into community resources, physician offices or clinics.

Complex Care and Disease Management
Provides long-term whole person care enhancement for the population using a multidisciplinary team approach. Diabetes, COPD, CHF, CKD, Depression, Dementia.

Self-management, PCP
Provides self-management for people with chronic disease.

Population Monitoring
Preventive care, education and monitoring for the community.
The Palliative Care Landscape in California

- 7 out of 10 Californians would prefer to die at home
  - Fewer than 1 in 3 actually do
  - Only 7% would want all possible care to prolong life
- Percent of patients for whom end-of-life preferences were followed by providers: 44%
  - If language barrier present: 26%
  - If uninsured: 25%
We know who would benefit  
But there are barriers to surmount

<table>
<thead>
<tr>
<th>Patients Who Would Benefit</th>
<th>Across the country, similar barriers to implementing Palliative Care programs:</th>
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<tbody>
<tr>
<td>1. Not surprised if the patient died in the next year</td>
<td>• Physician attitudes toward program</td>
</tr>
<tr>
<td>2. &gt;1 admission for same condition within few months</td>
<td>• Internal marketing of resources for physicians</td>
</tr>
<tr>
<td>3. Difficult-to-control physical/psychological symptoms</td>
<td>• Physician time/resources for education</td>
</tr>
<tr>
<td>4. Complex care requirements (e.g., physical dependency, home support for ventilator, pain pump, antibiotics, feedings etc…)</td>
<td>• Perceived costs of building program</td>
</tr>
<tr>
<td>5. Decline in function, feeding intolerance or unintended weight loss</td>
<td>• Community perception</td>
</tr>
<tr>
<td></td>
<td>• Coverage/reimbursement</td>
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Best Practice Team

• Building a BPT for research, recommendations and advocacy at a Health System level
• Quarterly review and recommendations from BPT to leadership at Health System, Hospital, and Medical Foundation level
• Building a financial argument for ambulatory and hospital based services
• Funding staffing
• Doing more with less
What is “Excellent Palliative Care”?

We asked the Best Practice Team before our first meeting:

• Proactive interdisciplinary team-based care, working with primary team, to support patient and family
• Improves quality of life, controls symptoms, relieves suffering, provides for psychological and spiritual components
• Timely, patients are identified early with chronic disease process
• Provided in collaboration with patient and families wishes
• Coordinated across the continuum of care (inpatient, home/office, home care, SNF/LTAC)
Survey says!

• We asked the question:
  – “Overall, how would you rate the provision of palliative care services for all applicable patients at your location”

• We asked the question:
  – “How would you rate the continuity between inpatient and outpatient palliative care services”
Key perceptions from team members:

1. **Incomplete and differing** programs at each campus
2. **Variable and uncertain integration** with the outpatient environment
3. **Varied perception** (often suspicious) of Palliative Care by community physicians
4. **Significant opportunity to reduce suffering** of patients during **chronic illness and at end of life**
Executive Summary

Request/Recommendation

1. Update on work of Palliative Care BPT to date (*Informational, Endorsement*)

2. Request for 1.0 system-wide clinical support FTE (*Recommendation*)
   - Would report to Pop Health VP, shared

3. Request for feedback on next steps for “campus” specific Palliative Care team resourcing needs (*Discussion/Decision*)
   - Take back to your campus to plan?
   - How detailed a financial analysis?
   - Team members help model out further?
What is Palliative Care?

- Helps clarify what patients and families are being told
- Expert symptom management
- Identify goals
- Family conferences
- Expertise in End of Life Discussions
- Multi/Inter Disciplinary
- Triple Aim oriented
“Palliative Care System”

Relief of Suffering
Control of Symptoms

- Pain
- Nausea
- Anxiety
- Depression
- Breathlessness

Advanced Care Planning

- Identify Patient and Family Wishes
- Shared Decision Making

Improve Continuity of Care

- Care Coordination

SAFETY
Potential Areas for Special Focus

- Palliative Care in the ICU
- Pediatric Palliative Care
- Long-term Care
- Community-Based Palliative Care
- Frail elderly
- Renal – pre-dialysis and dialysis
- Cardiology – Stage 3 and 4 HF
- Pulmonary – Severe COPD
- Neurology – Severe dementia, PD
Quality & Value:
Roll-out palliative care/end-of-life recommendations to support, measure and improve quality and reduce cost

What Success Looks Like:
• “We have completed a thorough internal and external review of our opportunities to improve palliative care for key aspects including clinical care, patient-centered care and ROI
• We have evaluated the programmatic options for system-wide and/or local evaluation of palliative care, with agreement on the "best" course of action
• We have begun to activate key elements if/as approved for implementation”
ACP: Linking to the Strategic Plan

Vision
Exceptional People, Extraordinary Care, Every Time

Mission
To improve the health and well-being of individuals, families and our communities through innovation & the pursuit of excellence

- Market Differentiation & Growth
  - The reward
- Lean Mindset, Methods & Management System
- Quality & Value
  - Eliminate burden of families making end of life decisions during a time they need to focus on Comforts and care of patient
  - The results of our hard and focused work
- Financial Resilience
  - Reduce cost of unwanted Tests and procedures
- Lean Mindset, Methods & Management System

Physicians As Partners

Governance & Leadership

People & Culture

“The absolute foundation of our success”
## Scale concept/timeline → Building Will, and Ability

### Phase In (Year 1-2):

1. **Education for practitioners, staff on Palliative Care (PC)**
   - The need
   - How to access PC services (appropriately)
   - Language/terminology
   - Address emotions and perceptions

2. **Focus first on patients with key diagnoses (and earlier)**
   - E.g. COPD, HF, CA
   - Med/Surg setting (? ICU, not in the ED to start)

3. **+1.0 FTE system-wide resource position**
   - Program support, “Top 10” development & coordination

4. **Name/Grow the Inpatient Resource Team at each campus**
   - Core Team should include: Boarded physician champion, NP, CSW
     - Key Gaps: SMMC, MCHLB
     - Need vacation coverage
   - Opportunity to share some resources across the system and/or link
     - Start local, grow together over time…a la Population Health
   - **Support Resources:**
     - Pharm.D, spiritual care provider
     - Other roles: ED connection, “compassionate listeners”, pediatric (child life)
Lower costs for hospitals and payers (CAPC toolkit)

• Developing palliative care programs in hospitals requires a relatively low start-up investment and can have an immediate impact on “outlier cases,” overall resource use and ICU utilization.
  – Direct program costs are more than offset by the financial benefit to the hospital system.

• Hospitals with palliative care programs find that:
  – Patients are transitioned to appropriate levels of care. This transition often reduces length of stay, especially in the ICU.
  – Proactive care plans expedite treatment. Hospitals can better plan daily resource use by following the agreed-upon care approach, often reducing costs for redundant, unnecessary, or ineffective tests and pharmaceuticals.
  – They maintain high quality of care while increasing capacity and reducing costs through shorter lengths of stay and lower ancillary and pharmacy costs.
Palliative Care at MHS

Health System

PC Ambulatory Clinic (Yes)
- Stand alone (to be determined)
- Embedded (yes)

Hospital Inpatient Service (Yes)

Community Visits (Yes)
- Assisted Living/SNF (not yet)
- Home (yes)
Outcomes/Measurement:
CAPC Consultation Service Metrics

• Operational metrics
  – Date of consult, diagnosis, referring physician/service, patient age, patient gender, disposition, hospital length of stay

• Clinical metrics
  – Symptom control scores, psychosocial assessment scores

• Customer metrics
  – Satisfaction survey data: patient, family, referring physician

• Financial metrics
  – Daily pre- and post-consultation hospital cost, net loss/gain for inpatient deaths, Case–mix index
Set our Vision
1. Gain agreement on what is “Good Palliative Care”
2. Name It

Action the Key Improvement Opportunities
3. Develop and Implement Best Practice Tools
4. Build and Implement Referral Triggers to “local service”
5. Evolve our use of POLST, leveraging the EMR
6. Create Seamless Handoffs across Continuum (EMR & Human)

Provide Education
7. Develop Education Content and Plan for All Key Caregivers
8. Develop & Provide Patient & Family Resources

Identify Designated Resources
9. Advance our “Best Service Models”, over time
10. Develop key measurements and analytical support
We all got to Work: Operations IT support and Data

- Months of operational design for inpatient and outpatient, ambulatory and home programs
- Multidisciplinary strategy and team building
- EPIC build for ambulatory referrals
- Learned from successful other programs (internal and external) AND individualized program design based on ROI, funding source and goals
What about Reimbursement?

What we found:

• Billing codes are currently lacking for palliative care
  – GNP clinic bills visits as Home Health
  – CAP-C site has tools
  – Note: Fear of being called “death panels” by Medicare… stopped progress at federal level (so far)

• Opportunity connect with and continue to gain/share learnings with providers who have been successful
  – Most model inpatient based on cost reduction/visit or pmpm (vs revenue generation)
  – Providence, Sutter, SJ Orange, Gunderson
1. Consensus Statement
What is Good Palliative Care?

Recommendation: Adopt national recommendations
- 4 Key Elements from AAHPM (next slide)
- CAP-C (Center for Advancement of Palliative Care) - NQF 38 Preferred Practices (see Appendix)

http://www.aahpm.org/Practice/default/quality.html
The effort to integrate palliative care into all health care for persons with debilitating and life-threatening illnesses should endeavor to ensure that:

1. **Pain and symptom control, psychosocial distress, spiritual issues and practical needs** are addressed with patient and family throughout the continuum of care.

2. Patients and families obtain the information they need in an ongoing and understandable manner, in order to grasp their condition, prognosis and treatment options. In this process, their values and goals are elicited over time; the benefits and burdens of treatment are regularly reassessed; and decision-making about care is sensitive to changes in the patient’s condition.

3. **Genuine coordination of care across settings** is ensured through regular and high-quality communication between providers at times of transition or changing needs, and through effective continuity of care that utilizes the techniques of case management.

4. Both patient and family are prepared for the dying process and for death, when it is anticipated. Hospice options are explored, opportunities for personal growth are enhanced, and bereavement support is available for the family.

*relieve suffering * control symptoms * care of the whole person*
3. Develop Best Practices
Alerts, Tools, Guidelines

What we found:

- Epic inpatient
  - Consult notes built
  - POLST order set created
  - Absence of specific order sets

- Ambulatory settings
  - Use of POLST and 5 Wishes
  - ++ GNP Palliative Care program
  - MCMF in process of developing

- Growing external resources
  - Coalition for Compassionate Care, The Conversation Project, CAP-C, National Hospice & Palliative Care

Recommendation:

- Adapt and grow our tools for system-wide Best Practice support
  - Refine / create order sets
    - Patient type/age specific
    - Symptom management
    - Palliative sedation protocols for extubated patients on medical floors
    - Neuropathic pain
    - Pediatric comfort care set, MCH
4. Develop Referral Triggers

Referral Mechanisms

What we found:

- No clear mode for referral to Palliative Care or education
  - Variable brochures in use
- Some experience in Pediatrics on inpatient side
  - CAPC’s pediatric palliative care referral criteria implemented by all 5 CareLines at MCHLB
  - Lean workshop at LB, manual screening tool
- Epic not helpful in capturing diagnostic triggers.
  - Admitting diagnosis in Epic is typically not one of CAPC’s diagnostic triggers.

Recommendations:

- Gain clarity on Triggers – e.g.
  - Frequent admission: re-admitted with same diagnosis within 30 days
  - Hospice eligible patients not psychologically ready for hospice
  - (as grow) Identify top “8” primary, advanced adult diseases:
    - Heart failure, respiratory failure, malignancy, dementia, severe neurological disease, end-stage renal disease, end-stage liver disease, and HIV/AIDS
- Develop clean request to build in Epic trigger mechanisms, learning from MCHLB & LB pilots
5. Evolve Our Use of POLST
Leveraging the EMR

What we found:

• Lack of understanding about what a POLST is and why needed:
  – POLST = “Physician Orders for Life Sustaining Treatment”

• Non-standard process
  – Procedure varies from campus to campus, floor to floor, physician to physician, even nurse to nurse

• Kept in paper chart but difficult to access

Recommendations:

• Educate physicians to include POLST on problem list
  – [Can other members of health care team identify POLST and put it on problem list?]

• Implement POLST “banner” in chart that carries over from admit to admit
  – Under development – to be piloted at MCH

• Finalize OCMMC version of POLST order set
6. Create Seamless Handoffs across Continuum

What we found:
- Another big gap
- From current state to seamless flow:

Recommendations:
- **Develop electronic communications capability**
  - Epic screen (Epic IPA) w/banner
  - Recurrent patients: Added to in-house Palliative census
  - Centralized access (Hospice, Home Health - HH, SNF/LTAC, Medical Groups)
- **Leverage human resources**
  - Navigators link-in & update universal EHR system
  - HH Navigator conduct telephonic case conferences
  - HH Navigator connect w/PCP (every “x” weeks)
- **Connect with key audiences**
**Scale concept/timeline ➔ Building Will, and Ability**

**Longer term (Year 2-3):**

1. **Build longer-term “Palliative Care system” across the continuum**
   - Population health tie-in

2. **Evaluate feasibility of regional outpatient clinic/service for palliative care (PC) and symptom management**

3. **Continue research/learning on palliative care**
   - The art & science are evolving
   - And so is reimbursement!

*Realize this will be tough! Patient by patient, physician by physician*

*This will not be easy!*

**Focus of next 2 years:**

1. **Track volumes and evolve resources to match**

2. **Strengthen seamless inpatient <-> outpatient <-> SNF programmatic PC linkages**

3. **Educate/train PCPs on what they can do even more (e.g. not everyone needs a palliative care specialist (nor can we fund that))**

4. **Link to workforce development strategy – linkages to training programs, (H1V1) grant to extend educators to community**

5. **Focus on patient enrollment for “symptom and needs management”**

6. **Opportunity to differentiate MemorialCare!**
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<th>Theoretical construct: Ensuring seamless 2-way handoffs</th>
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### Emergent Hospital (Epic)
- IPA banner & Palliative care logo
- ED SW connect with Navigator if discharged from ED
- IP CsMgr/CSW connect with Navigator to develop discharge plan for transition of care
- Palliative NP oversees

### Physician Office (EHR)
- Patient choice and Palliative care discussion to promote quality of life
  - Pt. not accept Palliative care, Office coordinates care needs
  - Patient accepting Palliative care, HH Referral for Palliative screen

### Elective Hospital (Epic)
- IPA banner & Palliative care logo identified during Pre-op Testing
- CMgr connect with Navigator re: discharge plan for transition of care
- Follow up call within 24-48 hrs

### Home Health (EHR)
- Office/Hospital Palliative referral
- Navigator coordination of services
- Follow-up call with patient/family
- Case conferences routinely
- Connect with Physician routinely
7. Develop Education Plan for All Key Caregivers

What we found:
• HUGE gap, from basic to mid-level understanding of Palliative Care
  - Why, what, who, when, where, how, which

( Opportunity to leverage “CTS-like” model, vary according to target - campus and continuum )

Recommendations:
• Develop comprehensive education plan, modular, e.g.
  - Definitions – what PC is, care/symptoms, POLST
  - Early discussion is key
  - How to have the conversation
  - Role of a PC team vs Hospice
  - Considerations for ethnicity/diversity
  - Pain management
  - Resource availability
  - Metrics that matter

• Create algorithm of what tools can be used, & when
• Create CME/CEUs
• Create shared resource library, blog, connections
What we found:
- Variability in how we describe and “market”
- Opportunity for standardization of educational material content campus to campus

Recommendations:
- Develop persuasive resources for patient/family
  - Develop a variety of options for delivery depending on learning method preference/opportunity
    - Brochures, videos, one-on-one education
    - Keep it simple
- Educate ambulatory physicians and hospitalists on patient education tools
9. Advance Our “Best Service Models”, over time

What we found:

- Need for programmatic support for inpatient and for continuum
- Outpatient focus and inpatient focus varies (see next slide)
- Each of our hospitals is different in terms of size/type.
  - Consideration of ratios/bed size, population-specific influences (pediatric, geriatric, cancer)
  - Where to start, capacity and mindset varies

Recommendation: Identify key team members, start/grow and then scale up

- Year 1-2 Phase-In (see detail)
  1. Education for practitioners & staff
  2. Focus first on patients with new diagnoses
  3. +1.0 system-wide resource position
  4. Name the Inpatient Resource Team
  5. Foster cross-campus collaboration
  6. Pursue improved access, care and cost efficiency for outpatient service(s) starting with Medical Foundation models (MG, IPA)

- Year 2-3 Longer-Term (see detail)
  1. Build longer-term “Palliative Care system” across the continuum
  2. Evaluate feasibility of regional outpatient clinic/service for PC and symptom management
  3. Continue research/learning
Location matters
Focus varies across the Continuum

Outpatient focus:
- Early identification
- Education
- Symptom management
- Focus on avoiding ED and inpatient days
- Providing continuity

Inpatient focus:
- Identification can be “late or too late”
- Key need is to triage
- Stabilization of symptoms while in house
- Start education but can’t finish
- Need to refer out for post-discharge follow-up
5. **Foster cross-campus/continuum collaboration and learning**
   - Through system-wide practice, leverage champion model to foster behavior change (and link those practitioners together)
     - Peers set/share examples
     - Address local culture, patient population
     - Leverage embedded model
     - Comprehensive enough so cover all settings

6. **Pursue improved access, care and cost efficiency for outpatient service(s)**
   - Starting with Medical Foundation models (MG, IPA)

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**Focus of first 2 years:**

1. **Develop and foster sharing of best practice, materials, tools**
2. **Engage stakeholders – demonstrations -> success/spread**
3. **Show value, build program**
   - Avoiding ICU transfers or moving patients out earlier (comfort care)
   - Think Lean – design for the way we want to end up, but scale up
4. **Creating continuity from community and back – Transitions**
   - Align with MCMF for MG/GNP admissions
5. **Leverage experts to help educate/give talks**
   - Our own Palliative Care practitioners
   - Hospice agency leaders
10. Data, data, data

Develop key measures and analytical support

What we found:
- We have very little, outside of MCMF data and some at Long Beach from their program
- This is analytics intensive

Recommendations:
- Develop data sets to help us better understand our opportunity and track progress (but don’t wait for)
- Develop a True North metric set (dashboard set)

Triple Aim Metrics (and level of complexity)

**Quality/Outcomes**
- % Patients with Advance Directives (AD)
- Interval between AD and death
- Degree of effective symptom management
- Advance Directives followed
- % Deaths with Hospice & Palliative Care

**Experience of Care**
- % of Heart Failure, and of Cancer, patients with > 2 admissions that receive PC consults
- HCAHPS rating of pain control in chronic disease
- Satisfaction of PC patients (optional Avatar module)
- Location of death
- Satisfaction of families
- Quality of Life score

**Affordability/Total Cost**
- # of ICU days before an inpatient death
- Hospital days (managed lives)
- ED visits (managed lives)
- Total cost of care
Handoff Vehicles to Explore

Develop electronic communications capability

- Epic screen (Epic IPA) w/banner or logo
  - Palliative care screen w/team referral
  - DC print-out (AVS additional page)
  - Pt/family post onto Frig
- Recurrent patients: Added to in-house Palliative census
  - Status updated each encounter
- Centralized access (Hosp, HH, SNF, Med Groups)
  - Navigators link-in & update on-demand universal EHR system

Leveraging Human resources:

- Navigators link-in & update universal EHR system
  - Hospital CMgr/SW, HH CMgr, SNF SW, Telehealth RNs
- HH Navigator conduct telephonic case conferences
  - Parish nurses, Laguna Woods SW, Sr. Centers, HHealth agencies, etc.
- HH Navigator connect w/PCP (every "x" weeks)
- Paper: Frig print-out communicates w/Fire & Police
Longer term (Year 2-3):
1. **Build longer-term “Palliative Care system” across the continuum**
   - Population health tie-in
2. **Evaluate feasibility of regional outpatient clinic/service for palliative care (PC) and symptom management**
3. **Continue research/learning on palliative care**
   - The art & science are evolving
   - And so is reimbursement!

*Realize this will be tough! Patient by patient, physician by physician*

This will not be easy!

Focus of next 2 years:
1. **Track volumes and evolve resources to match**
2. **Strengthen seamless inpatient <-> outpatient <-> SNF programmatic PC linkages**
3. **Educate/train PCPs on what they can do even more (e.g. not everyone needs a palliative care specialist (nor can we fund that))**
4. **Link to workforce development strategy – linkages to training programs, (H1V1) grant to extend educators to community**
5. **Focus on patient enrollment for “symptom and needs management”**
6. **Opportunity to differentiate MemorialCare!**
Objective 2: Describing key steps in overcoming physician barriers to palliative care delivery in the hospital.
The Work Began !!!

Saddleback Memorial Medical Center!
March 2014
Development of an Inpatient Program

Oswald Jauwena RN, MSN, ACNP-BC
Why Hospital Palliative Care?

• That’s where the sickest patients are!
• Opportunity to provide support and secure treatment alignment with patient / family goals earlier in course of illness
• Prevent avoidable hospitalizations/re-hospitalizations and ED visits
• Program continuity - SMMC affiliated Hospice and Home Health Program with onsite clinical liaisons.
Implementation of Inpatient PC Program

Palliative Care IDT Team: Palliative Care Physician/Medical Director, Nurse Practitioner, Social workers (2) and Chaplain

Palliative Care educational and certification of Social workers and Chaplain through Institute of Palliative Care at CSU San Marcos

Standardized templates for Physician/NP, Social Worker, Chaplain (few slides on this template).
Physician Challenges

- Perceived Loss of Control
- Cultural Barriers
- Educational: Palliative Care is not Hospice. It is more than end of life care!
Breaking Down PC Barriers: Education

Physicians: CME Presentations, Medical Staff meetings, 1:1 Discussions (MD-MD)

Nursing: Presentations to nursing leadership, staff, councils. Creation of PC Nurse Champion group with representation from all patient care areas. Intranet site created with educational material and resources.

Community: Palliative Care Community Panel Presentation, SMMC Patient/Family Advisory Committee

Skilled Nursing Facilities (SNF’s): Saddleback Memorial community Coalition to Enhance Care Transitions Pilot Palliative Care Pilot with local Skilled Nursing Facilities.
Nursing Staff Surveys

- Nursing Staff were surveyed on their knowledge of Palliative Care, resources, current work situation, support for advocating for patients/families and contributors to stress.

- Education was provided pre and post Palliative Care program implementation.

- Nursing surveys conducted: June 2014 and December 2014.
Nursing Survey Says

Knowledge and Ability - “My knowledge and ability is adequate”
Percent of staff who agree

- My understanding of the difference between palliative care and hospice
- My knowledge of the common diagnoses and symptoms that benefit most from Palliative Care
- My ability to ID when my Pt is appropriate for PCServices
- My comfort level discussing goals for care with family members when the outcome is uncertain

Pre-Implementation Survey
Post-Implementation #1
Contributions to Stress

Degree to which the following contributes to their overall stress

- Incompatible prognosis & pt/family goals
- Inability to provide adequate comfort (due to pain/dyspnea/anxiety)
- Disagreement within the team regarding goals of care
- Notifying physicians when patients/family state their goals are not being met
Roadmap for:
Outpatient Palliative Care Services

- MemorialCare Medical Group (MCMG): Dr. Kleinman’s Palliative Care Clinic for ambulatory patients and MCMG At-Home PC Program for non-ambulatory patients

- Monarch Healthcare: patients referred to Monarch Outpatient Palliative Care Program

- Medicare/PPO patients: Dr. Kleinman’s Palliative Care Clinic for ambulatory patients and MemorialCare Palliative Care In-Home services Medicare patients
Palliative Care Metrics

Bar chart showing the comparison of Total IPP LOS Before Anchor date in days and Total IPP LOS After Anchor date in days across different months (January to December).
Palliative Care Metrics

The diagram shows the total inpatient length of stay (LOS) before and after anchor dates for each month from January to December. The y-axis represents the total LOS in days, with values ranging from 0 to 80.

- **Total LOS Before Anchor date in days** (blue bars)
- **Total LOS After Anchor date in days** (green bars)

The data indicates a significant variation in LOS across different months, with peaks in August and September.
Palliative Care-In Home

PC Census Data

PC: 70.9
Total Days of Service: 2765
Average LOS (days): 854

Hospice: 31.6
Our Work Continues

• Development of Operational and Clinical Metrics to evaluate our Palliative Care Program initiatives and support program expansion (ROI)

• Continued Palliative Care Education of staff and community (panels / health fairs)

• Explore opportunity to utilize Electronic Medical Record to identify potential Palliative Care patients
Objective 3: Describe key steps to running an ambulatory palliative care clinic and at-home program.
KEYS for developing at home program:

- Choose the right team
- Choose the right vendor
- Be very organized before launching
- Carefully define inclusion and exclusion criteria for program
- Have operations and workflow including IT plan clear and test drive a few times and then troubleshoot as you go
- Define communication plan within team and to key stakeholders ie. PCP, hospitalists
- Plan for data collection and metrics: what matters to this program?
Supportive Home Care: Medical Group Full Risk Seniors

- **Inclusion criteria:**
  - Medicare Advantage patient
  - Desire to stay out of hospital, ER and manage symptoms at home
  - Support family member
  - Patient at home (not SNF), Assisted Living okay in some cases

- **Exclusion criteria:**
  - Board & Care
  - Dialysis
  - Pure social determinants of health*
Supportive Home Care: Operations

Referral sources:
- Daily inpatient hospitalist rounds lead by Medical Director
- Discharge clinic

Operations:
- Once identified and at home, patient and family contacted by our dedicated Social Worker either at discharge clinic or by phone.
- Eligible patients presented at biweekly Interdisciplinary Team Meeting
- PCP always contacted for consent to enroll patient
- PCP receives all IDT notes
Supportive Home Care

- Weekly and PRN nurse visits, 24/7 physician back-up:
  - Many needs not fundamentally palliative in nature, but supportive allowing people to stay at home
  - Allows trusting relationship to build for advanced care planning, POLST, transition to hospice

- IDT:
  - Medical directors, vendor nurse leader, team including social work, referral coordinators, case managers, IT support when needed.
  - Potential new patients and current patients reviewed.
  - All participate in enrollment decisions
  - All participate in creative solutions for patients

- Who has responsibility for the patient?
  - Co-management. Want patient to continue relationship with PCP with additional layer of support.
Success Stories

“I used to call 911 every time I felt my heart ‘boom boom boom.’ Now I know that my heart is 99 years old and a 99 year old heart goes ‘boom boom boom’ sometimes. I take a few deep breaths and relax.”

“Instead of going back to the hospital, I got my marigolds ready for my granddaughter’s wedding in my backyard.”
Palliative Care Program
Outcomes Analysis (Pre and Post enrollment – Total Population)
ER – Dollars spent

-21 members included in Total Population
-Total E.R. savings post enrollment: $23,800
-This equals 67% reduction in utilization
Palliative Care Program

Outcomes Analysis (Pre and Post enrollment – Total Population)

SNF – Dollars spent

- 21 members included in Total Population
- Total SNF savings post enrollment: $133,000
- This equals 93% reduction in utilization
Palliative Care Program
Outcomes Analysis (Pre and Post enrollment – Total Population)
Hospitalizations – Dollars spent

-21 members included in Total Population
-Total Hospitalization Savings post enrollment: $220,000
-This equals 75% reduction in utilization
Supportive Home Care ROI

- First year ROI
- 21 patients
- Spent $48,000
- Saved $375,000
- 680% return
MemorialCare: Ambulatory Clinic

• Operational
  – Large Meeting Room
  – Medical Assistant
  – Centralized scheduling
  – 0.2 PC FTE
  – Insurance billed
  – Referrals from PCP’s/Specialists/DC Clinic
Presented to Medical Group BOD: starting with the basics

- What is palliative care?
- What value does it hold for my patients?
- What value does it add to my practice?
- What financial impact will it have for our group?
Out on the Street!

- Dr. Lowell Kleinman

- All 30 PCP offices and educated the teams about Palliative Care, POLST, and our services.

- What is Palliative Care and why is it good for my patients?

- Demystifying What Palliative Care Does for both PCPs and Hospitalists
Convincing physicians

- We emphasize partnership
- We emphasize service to OUR patients
- We keep it simple
- Made referrals easy in our EMR
- Made communication strong – Verbal and written communication with PCPs, oncologists, other team members increases patient, family and clinician satisfaction.
MemorialCare Health System Palliative Care Across the Continuum

1. Describe key steps needed to make the business and care quality case for a system-wide approach to delivering palliative care services.

2. Describe key steps in overcoming physician barriers to palliative care delivery in the hospital setting.

3. Describe key steps to running an ambulatory palliative care clinic and at-home program.
MemorialCare Begins with ME: Where we are now...