BUILDING PALLIATIVE CARE:

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“Palliative care” means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.
What is Palliative Care?

- “An extra layer of support for people with serious or chronic illness, appropriate from diagnosis onwards.”

- “Care that is focused on quality of life and the relief from symptoms, pain and the stress of serious or chronic illness.”

- “Care for the patient and his or her family.”

- “Care that is provided by a team focused on the patient and his or her family’s physical, emotional, and spiritual wellbeing.”

“The best care possible.”
LEARNING OBJECTIVES:
By the end of this session, participants will be able to:
• Create their own plan for implementing a palliative care program
• Identify where they are on the path to implementing a palliative care program.
• Use an array of tools and resources to maximize the value of their planning and the likelihood of a successful program.
Implementing Palliative Care Today…

The Usual Prescription …

- Take one busy clinician
- Add administrative responsibilities
- Borrow staff from other functions
- Expect teamwork

- Take another busy (and now frustrated) clinician and ask for referrals …
… How it looks to the Patient and Family

- “Pallia-what?”

- “Why do you want that? You’re not dying…”

- “We don’t have that here”
• **Issues:**
  – Palliative care = hospice and hospice = giving up hope and dying
  – Lack of referrals because doctors haven’t been provided education and tools to refer – triggers
  – Late referrals
  – Palliative care team is often just a physician or nurse practitioner
  – Multidisciplinary team, not really interdisciplinary
  – Palliative care is not seen as a consult but as a competitor
  – How to be reimbursed
  – How to demonstrate the ROI of palliative care
to begin to do or use (something, such as a plan) :

to make (something) active
What has to Change?

- Siloed implementation
- Commitment without investment
- “Hand-me down” education
- Another project vs. organizational and cultural change
- A good thing to do vs. ROI and predictive analytics
to form, coordinate, or blend into a functioning or unified whole

to end the segregation of and bring into equal membership in society or an organization
Integrating Palliative Care

The 5 Principles –

1. Palliative care is not a project but an organizational or community-wide commitment …

2. Begin with a team and a map …

3. Create a clear, critique tested plan including ROI

4. The Three E’s – Educate, Evaluate, Enhance

5. Recognize it is a change on every level …
1. Palliative care is an organization- or community-wide commitment

   - Plan to plan and be SMART
   - If you don’t think you will be able to get commitment when you are done, DON’T START
   - Engage key stakeholders/partners
   - Have a goal of consistency – inside and out
Engage Your Key Stakeholders/Partners

EXTERNAL
STAKEHOLDERS

INTERNAL
STAKEHOLDERS
Engage Your Key Stakeholders/Partners

How to Engage Your Stakeholders!

W hat’s
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The California State University
Institute for Palliative Care
… How it looks to the Patient and Family

- “Palliat-what?”
- “Why do you want that? You’re not dying…”
- “We don’t have that here”

… How it should look to the Patient and Family

- Palliative care? Of course, let’s talk about what you need and how to get you connected to our program …
2. Begin with a team and a map ...

- Strategically choose your team

- Clearly define your process

- Do your research on what others have done
  - What are the models?
  - What has worked? What has not worked?
2. Begin with a team and a map

   – Identify your focus – organizational/community

   – Assess the REAL Needs
     • Case a wide information net
     • Focus your question(s)
     • But get ALL the data

   – Strategies for collecting data
     • Interviews
     • Focus groups
     • Surveys
2. Begin with a team and a map
   - Collect data relevant to “your world”
   - Some sources
     - The Health Indicators Warehouse
     - Centers for Disease Control
     - Medicare’s Compares
     - State data
     - CHCF’s Uneven Terrain
     - Medicare Claims Data
     - Dartmouth Atlas
     - YOUR LOCAL PARTNERS …
3. Have a clear, critique tested plan
   - Describes the process and opportunity
   - Reports the environment and needs
   - Describes current capacity
   - Identifies the gaps
   - Recommendations
   - **Financial plan with ROI**
   - Resources required
   - **Outcomes and metrics**
   - Implementation strategy
• Where is the Business Case?
  – Reducing Hospital Utilization
    • Penalties to hospitals related to Medicare readmission reduction program
    • Reveal existing negative net margins from EOL hospitalizations even in fee-for-service context
    • Increase patient and family satisfaction
    • Reinforce the clinical/ethical imperative
The 5 Principles of Palliative Care Integration

- Where is the Business Case?
  - Partner with hospital/health system on institutional data and analyses
    - What is utilization, costs, revenue for palliative care-relevant patients?
    - Which patients are receiving palliative care? Which are not?
    - How many patients could be met earlier by palliative care proactively
  - Opportunity analysis for a population of decedents:
    - Frequency, duration, intensity of hospitalizations, total and trended
    - Frequency and timing of ED visits
    - 30 day re-admissions
    - In-hospital and 30 day deaths
Modeling Expected Impact: SFGH
- About 1/3 of patients who die of cancer present >3 months prior to death and could be referred to an outpatient palliative care clinic
- Clinic could expect to impact 50 patients/year
- Assume 40% reduction in inpatient utilization (38 admissions)
- Direct cost per admission =$25,800
- **Expected Cost Avoidance - $980,400**
- Clinic staffing needed =.2 FTE for MD, APRN, SW in 2 half day clinics
- **Cost = $88,290**

10 X ROI!

Courtesy of K. Kerr and J. Brian Cassel
4. The Three E’s – Educate, Evaluate, Enhance

- Educate who??? **Everyone!**
- Specialist Palliative Care Team(s)
- Towards certification
- Interprofessional practice
4. The Three E's – Educate, Evaluate, Enhance

- Educate who?? Everyone!
- Generalist palliative care knowledge
  - Physicians/providers
  - Nurses
  - Social Workers
  - Chaplains
  - ALL health professionals
4. The Three E’s – Educate, Evaluate, Enhance

- Educate who??? **Everyone!**

- Patients and families
4. The Three E’s – Educate, Evaluate, Enhance

- Evaluate
  - Match measures to outcomes
  - Measure what is feasible
  - Measure What Matters
4. The Three E’s – Educate, Evaluate, **Enhance**
5. Recognize it is a change … on all levels
   - Ensure you have a champion
   - Define few clear, simple messages that resonate – repeat and repeat
   - “Arm” your stakeholders
   - Support your early adopters
   - Share your wins and fix the problems
   - Report early and often
   - Communicate, communicate, communicate
   - Despite the need for speed, it won’t happen over night
IMPLEMENTATION IS EASY …

INTEGRATION IS NOT

But its worth it!
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5. Recognize it is a change on every level …
• Successful integration of palliative care requires many things:

  – A clear focus on process
  – The tools to succeed
  – An organizational commitment
  – The clinical and interprofessional skills to deliver exceptional care
Tools and Resources

• The Business Case for Palliative Care
  https://csupalliativecare.org/programs/businesscase/

• The Community Based Palliative Care Series
  https://csupalliativecare.org/organizations/roadmap/

• Supportive Care Calculators:
  http://coalitionccc.org/tools-resources/palliative-care/
Institute for Palliative Care
Leading the Way in Palliative Care Education

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CSUPALLIATIVECARE.ORG