Building the Case for Palliative Care: Lessons from Mount Carmel Health

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Why Palliative Care? Why Now?

- CEO attended a conference and heard “Palliative Care is answer to helping manage complex and high cost care”
- You have a new team member who came from a Palliative Care program and wants the same
- You recognize a gap in service. Many re-admissions, patients dying in the hospital or home care
Objectives

In this webinar, participants will learn about
• clinical
• operational and
• financial components
of the “business case” for palliative care, and hear about successful models and plans.

Palliative Care

• Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.

• Addresses physical, intellectual, emotional, social, and spiritual needs and facilitates patient autonomy, access to information, and choice, throughout the care continuum.
Defining Palliative Care

National definitions of Palliative Care are very similar:

- The Centers for Medicare and Medicaid Services, CMS
- World Health Organization, WHO
- Center to Advance Palliative Care, CAPC

All Identify Primary Tenets of Palliative Care:

Primary Tenets

- Any patient, any age with serious illness
- Symptom management
- Establishing goals of care that are in keeping with the patient’s values and preferences
- Consistent communication between the patient and all those involved in care
- Interdisciplinary approach
- Coordination across care settings
- Benefits and Burdens conversation
Key Differences & Similarities
Palliative Care, Hospice, Home Health

Differences

• Hospice care provided to terminal patients, final months of life, elect hospice benefit, no longer pursuing curative treatments, comfort/symptom management focus

• Palliative care is provided to patients with a serious illness but may also be pursuing curative treatments

• Home health care provides specific skilled care, often to patients who are expected to recover from their illness or injury or have potential to stabilize/improve their health

• Hospice, Palliative Care and Home Health differ in location, timing, payment, and eligibility for services

Similarities

• Share the philosophy of maintaining and managing the patient’s quality of life
How is PC different from other types of care??

• Palliative care is broader, more comprehensive and coordinated in scope
• Palliative care is for all patients with advanced illness
• Palliative care systematically uses, rather than duplicates, related services, making use of geriatricians, pain experts, case managers and hospice programs as appropriate.

But not TOO expansive

• It is clearly defined and efficient--systematically managing the whole patient’s needs for pain and symptom control, emotional support and social services throughout illness.
• By reducing fragmentation of services and using hospital resources more appropriately, it also reduces costs.
Defining Palliative Care

Four Critical Components

- Delivering aggressive symptom management
- Working with patients to set treatment goals
- Providing psychosocial support to patients and families
- Planning for end-of-life care

Source: Oncology Roundtable interviews and analysis.

Mount Carmel Health

- Sr VP & Chief Transformation Officer
- Mount Carmel Medical Group
- Mount Carmel Health Partners
- Geriatrics and Home Based Services
- Neighborhood Services
- Service Lines
  - Cardiovascular Services
  - Ortho Clinical Services
  - Women’s Health
  - Neurological
  - Oncology Services
  - Palliative Care Services
### Three Primary Models

<table>
<thead>
<tr>
<th>Description</th>
<th>Consultative Team</th>
<th>Dedicated Inpatient Unit</th>
<th>Outpatient Clinic</th>
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<tbody>
<tr>
<td>Consultative Team provides consults to patients throughout the hospital</td>
<td>Palliative care team cares for patients on dedicated inpatient unit</td>
<td>Palliative care team sees patients in outpatient setting independently or in collaboration with patient’s treating physician</td>
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| Benefits | • Lower costs  
• Team can more easily educate clinicians and patients about palliative care | • Team has total control over patient care  
• Can improve hospital throughput  
• Easier to attract philanthropic support | • Meets needs of patients living at home  
• Reduces unnecessary hospitalizations  
• Encourages earlier referrals |
|----------|--------------------------------------------------|-------------------------------------------------|-------------------------------------------------|

| Drawbacks | • Team has less control over patient care  
• Creates logistical burdens for team | • Palliative care team has lower visibility  
• Treating physicians may be reluctant to relinquish control of patient care  
• Space limitations | • Cost savings cannot be used to offset program costs  
• Unpredictable patient demand  
• Space limitations |
|----------|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|

### Basic Models of Palliative Care

- Consultation service
- Inpatient Models  
  - Dedicated beds  
  - Scattered or Swing beds
- Outpatient and Community Models  
  - Clinic  
  - Nursing Home, AL  
  - Home
Models (cont)

• No one “right” model
  • Diverse and individualized clinical models
• “Fit” with your organization and goals is key
  • Size – patients needing services
  • Location – rural vs. urban
  • Acuity and Intensity
  • Staff – recruitment and retention

Hospital Models

Combine basic models. (consult, dedicated bed, outpatient)

• Consult service availability is core and fundamental
• Targeted staff education and competencies
• Acute inpatient bed availability
• Key variables
• Continuum needs by primary availability or contracts
Hospice and Homecare Model

• Homecare
  • Focused process needs
  • Targets early continuum patients
  • Targets chronic disease management
• Hospice
  • Focused on complex care needs
  • Targets later continuum patients
• Both -- carry out the Plan of Care

Outpatient and Community Models

• Clinics
  • Reduce Readmissions and Crisis prevention
  • Targets primary patient follow up needs
  • Targets primary symptom management, ie. Pain
• Traditionally ambulatory and outpatient focus
  • Bridge or Gap programs
  • Preadmission and Case Management RN driven models
• Continuum needs by contracts
  • Acute inpatient admission beds
  • IDT support
Residential and LTC Models

• New and Independent concept models
  • Reimbursement driven
  • How to maintain hospital PC standards of care
    o Interdisciplinary care
    o Holistic focus
    o Bereavement and Aftercare
    o Aggressive pain and symptom management
• Readmission issues
• Continuum needs primarily through contracts

Shared Components - All Models

• Interdisciplinary Team availability
  • Dedicated Disciplines
  • Collaborative Models
• Holistic Focus
  • Shared Goals and Preferences
  • Patient/Family/Healthcare Team
  • Patient-centered, Treat whole person
Shared Components - All Models

• Continuum of Services
  • Inpatient Care
  • Outpatient Follow up
  • Bereavement and Aftercare

• Clinical Components
  • Palliative Symptom Management
  • Benefits and Burdens conversation
  • Advanced Directives
  • Goals of Care

Palliative Care....

• Reduces high levels of suffering and distress
• Improves communication and understanding of disease and treatment and Px
• Addresses the entire family unit
• Reduce unwanted, unnecessary and painful interventions.
• Improve Survival
• Improve patient and family satisfaction
• Reduces Costs
Challenges to Establishing and Maintaining a Palliative Care Program

- Insufficient reimbursement for palliative care specialists
- Shortage of palliative care trained specialists
- Lack of understanding of palliative care goals

Source: Oncology Roundtable

Staffing Challenges

- Limited pool of prepared clinicians
- Highly marketable after working in comprehensive program
- Fluctuating census = difficult to predict growth
- 24 hour call and/or travel
- Home and Community visiting
- Hospice and Palliative Care skills
- Positions need to be dedicated, not “added on tasks” to job
Priorities Re: Resources Needed

- Staffing: Consult Team and Direct Care plan
- Locate Acute Palliative Care Units or partners
- Understand and access financial systems
- Define service to payers
- Training and Education
  - Define palliative vs hospice care vs home care;
  - Define program structure, patient types, routine processes, tools

Data and Quality Metrics

**Measurement** provides administrative and clinical information for

- **Planning** - needs assessment data helps locate greatest areas of need, referral base, educational deficits, and predicting potential volume.
- **Sustaining** - validate to the corporation and to others, the impact on quality and financial stability.
- **Improving** - know what process changes are needed to improve outcomes (Pain, family meeting measure, etc).
Commitment to Quality Improvement: Building Quality Processes into the Program

• Patient, family, physician and PC Team determine care plan together
• Plan checked daily by the palliative care team
• Benefits/burdens of treatment weighed daily
• Active discharge planning initiated on entry
• Family support throughout

Quality Processes--Community

• Patient, family, physician and PC Team determine care plan together--
• Plan checked regularly by the team
• Benefits/burdens of treatment discussed at each visit
• Planning for condition change, symptom issues reinforced each visit
• Family support assessed/available
Data Collection

• Start small with simple info, but start somewhere
• Demographics - Age, location, payer, Dx
• Referral source
• Patient/Family satisfaction
• LOS, readmission, utilization
• Outcomes: Disposition, Clinical, Financial

The Joint Commission Certification
Palliative Care

• TJC Advanced Certification Program for Palliative Care --- Hospital inpatient standards. Community Palliative Care standards being discussed.
• NQF endorsed 14 measures for accountability and quality improvement.
• Clinical Practice Guidelines 8 Domains of Care
Financial Impact of Palliative Includes:

- Direct Palliative Program cost—program management, staff, overhead
- Palliative program revenue --- Physician and APRN billing, donations, grants
- Avoided cost---the cost reasonably expected to occur if the patient did not receive palliative intervention.

Avoiding cost depends on:

- # referrals
- Whether the PC team provides symptom management only, or helps to clarify prognosis and goals of care
- % ICU referrals
- % referrals directly from home or ED
- Re-admission rates and managing patients at home
- Post-consultation length of stay
- Degree to which the palliative care team is able to implement its recommendations
How is cost avoided?

• Move patients away from expensive treatment that is not likely to be effective to supportive treatment and goals of care. Example:
  – Moving patients out of ICUs- lower R&B costs
  – Fewer imaging and other procedures
  – Managing patient symptoms and needs at home
  – Changing from ineffective pain management
  – Honoring patient wishes and goals

Avoided Cost Metric

• Expected cost is the variable cost for the day prior to Palliative intervention, unless it is the first day of the stay
• Actual variable cost for up to 5 days in palliative care is compared with expected variable cost based on cost immediately prior to palliative intervention.
Outcomes

• Financial
• Quality
• Clinical

Many ways to measure—Look for benchmarked, researched and evidence-based

Business Planning

• Executive summary
• Institutional analysis/market review
  – Make it real for your institution
    • Clinical, financial & staff satisfaction data
  – Competing local/regional initiatives
• Operational plan for implementation
• Marketing plan
• Financial/budget summary
• Appendices
  – Data and interviews (thorough work done to make the case)
  – Letters of support from stakeholders
Impact on Patients/Families

- Coordination of care great satisfier
- Family Consensus building
- Patient-centered and based on individual goals
- Environment supportive of family system
- Regular contact with IDT, multi-disciplinary
- Symptoms attended to rapidly
- Normalize options for care of advanced illness

Health System/ Program Impact

- Navigating patient to the “best” location for care, and coordinating care
- Expediting earlier PC referrals from ICU, ED
- Implement Advance Care Planning and goals
- Training/competencies –building the generalist
- Patient/Family satisfaction
- Reduced re-admissions
- Care following patient
Success Factors—Mount Carmel

- High patient satisfaction
- Hospice Continuum
- Physician led Palliative Medicine Consultation
- Collaborative Approach and integration
- Data and Outcomes “Proved” value
- Relationships with ICUs, EDs, Hospitalists, Oncologists, Clinics, practice groups, Health plan
- High Cost savings
- Part of the Culture of Care

How does Palliative Care Impact...

- Re-Admissions
- Emergency Department utilization
- Patient and Family Satisfaction
- Overall Care
Palliative Care Leadership Centers™ (PCLC) provide intensive, operational training and yearlong mentoring for palliative care programs at every stage of development and growth. Established by the Center to Advance Palliative Care and the Robert Wood Johnson Foundation in 2004, PCLC has trained almost half of the nation’s hospital palliative care programs.
“In God we trust, all others bring data.”

“It is not necessary to change. Survival is not mandatory.”

W. Edwards Deming

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