Palliative Care Program

Damanjeet Chaubey 2014
Palliative Care Constitutes a Change in Focus from Usual Care

<table>
<thead>
<tr>
<th>Goals of Care:</th>
<th>Usual Care</th>
<th>Palliative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Delayed until end of life is near</td>
<td>Established early in disease trajectory</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Treatment Strategy:</th>
<th>Usual Care</th>
<th>Palliative Care</th>
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<tbody>
<tr>
<td></td>
<td>Includes primarily curative treatments</td>
<td>Includes a combination of curative and symptom-focused treatments</td>
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<table>
<thead>
<tr>
<th>Service Utilization:</th>
<th>Usual Care</th>
<th>Palliative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pursues curative treatments even when low-yield, high-cost, and burdensome for patient</td>
<td>Pursues treatments that align with patient goals</td>
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</table>
Mission

• To provide collaborative care to hospitalized patients with chronic, life-limiting illnesses, with a focus on pain and symptom management, enhancement of function, physical comfort, quality of life, psychosocial support, spiritual support, and communications about goals of care for the patient as well as for their family. In addition, the team will support, guide and educate the hospital staff and act as a liaison across the continuum of care.
Vision

Our vision is to be a regional and national leader in palliative care for the benefit of all patients, families, caregivers, and policy makers, while maintaining alignment with the goals of the organization

– Provide patients with the right care in the right place at the right time
– Bring together the best people and best processes across the continuum
– Engage and empower patients and families as partners in their care
– Create an environment of continuous learning, discovery, and innovation

Values

– Excellence
– Integrity
– Teamwork
– Respect
– Fiscal Responsibility
Patients Appropriate for Inpatient Palliative Care Consults

- Patients with newly diagnosed life-threatening illness
- Patients requiring complex inpatient symptom management.
- Patients discharged home with hospice or another institution for end-of-life care
- End of life care in the hospital
Illness Trajectory

Unlike cancer diagnoses, organ failure due to chronic disease and dementia have much more unpredictable prognosis.

http://heart.bmj.com/content/98/7/579.full
Program Structure based on National Quality Forum Consensus

• Program Structure and Administration – Generalist/Specialist Model within the Hospital Medicine department

• Types of Service - Consult service available to all hospital patients 24/7
Generalists Treat Basic Needs, Specialists for Complex Cases

Hybrid Model for Palliative Care

Patients with Basic Palliative Care Needs

- Basic management of pain, symptoms
- Basic management of depression, anxiety
- Basic discussions about prognosis, goals of treatment, suffering, code status

Patients with Complex Palliative Care Needs

- Management of refractory pain or other symptoms
- Management of more complex depression, anxiety, grief, and existential distress
- Assistance with conflict resolution regarding goals or methods of treatment – within families, between staff and families, treatment teams
- Assistance in addressing cases of near futility

Source: 2013 The Advisory Board Company
Palliative Care Program at Danbury Hospital
Damanjeet Chaubey, MD - Medical Director

- **Inpatient Services**
  - 3.0 FTE clinical APRN staff
    - Karen Mulvihill, Director
    - Julia MacMillan, Coordinator
    - Bernadene Lawrence-Philip, Coordinator

- **Hospital Medicine**
  - 4 Board Certified Physicians
  - All Hospitalists EPEC Trained

- **Outpatient Consultative Services**

- **Discharges**

- **Admissions**

- **Home Visits**

- **Cancer Center**

- **ECF**

- Partnership with home hospice
Palliative Care Committee

- Damanjeet Chaubey- Medical Director & Chief of Hospital Medicine
- Karen Mulvihill – Director of Palliative Care Services
- Julia MacMillan and Bernadene Lawrence-Phillip – APRNs
- Heather Sung, Jeannine Famiglietti, and JoAnn Maroto-Soltis – Palliative Care Physicians and Hospitalist
- Marie Babia and Deanna Ballard – Inpatient Oncology
- Jamie Chadwick – Pharmacy
- Lynn Crager- Spiritual Care
- Nicole Knapp – Social Work
- Alice Jakubek – Clinical Resource Management
- Peggy O’Shea – Complimentary Nursing
- Keri Supper – Speech Therapy
- Vicki Barber – Dietary
- Karen Barrett – Performance Improvement
Core Palliative Care Team

• Damanjeet Chaubey- Medical Director & Chief, Hospital Medicine
• Karen Mulvihill – Director of Palliative Care Services
• Julia MacMillan and Bernadene Lawrence-Phillip – APRNs
• Heather Sung, Jeannine Famiglietti, and JoAnn Maroto-Soltis – Palliative Care Physicians and Hospitalist
• Lynn Crager- Spiritual Care
• Nicole Knapp – Social Work
Clinical Practice Guidelines

• National Consensus Project for Quality Palliative Care Clinical Practice Guidelines for Quality Palliative Care 3rd edition 2013


• AHA Scientific Statement: Decision Making in Advanced Heart Failure: A Scientific Statement From the American Heart Association Circulation


• Shared Decision-Making in the Appropriate Initiation of and Withdrawal from Dialysis
Process for Palliative Care per NQF guidelines

• Identification of a high risk patient
• Palliative care Screening tool
• Palliative Consult Referral Sources
• Transitions of Care
• Continuity of Care
Quality Discharge Process Flow - Reducing Readmissions for COPD, CHF, Pneumonia

Start

Identify Readmission Risk

- 'High Risk' if COPD/CHF/Pneumonia readmitted < 30 days
- Daily Hospitalist list sent to all units, CRM, Hospitalist staff

High Risk Patient noted on Unit White Board

MD or RN considers Palliative Care Consult

Nursing Care Plan will follow DRG Order Set

Identify and record potential DC date on White Board

Transition Coordinator (TC) conducts needs assessment

Transition Coordinator (TC) begins Education using the DRG-pathway

Discharge Process Steps

Patient Discharged

Hospitalist Office: 203-739-6015
8:00 AM - 5:00 PM

Disposition

- Home
- Home w/Services
- ECF/SNF

TC calls patient 24-72 hours after discharge

TC calls ECF charge nurse 24-72 hours after discharge
Assess for stability, issues with meds, follow up appointment(s)

TC documents patient responses in database

Problem identified?

YES

CHF Patient

COPD Patient

Pneumonia Patient

NO

End

TC informs Patient/Family to call with routine questions after DC

Transition Coordinators:
- Sarah Schoeneberger, ext. 7041
- Sheila Osborne, ext. 8145
- Sue Mangelsdorf, ext. 6015

Hospitalist Coordinator:
- Jan Van Wort, 203-739-7155
- Jan Van Wort, 203-739-7155

DOPS Cardiology APRN:
- DOPS Cardiology APRN:
- Jan Van Wort, 203-739-7155

DOPS Pulmonology APRN:
- Shawna Moore, ext. 7508

- COPD/Pulmonary Patients
  - Shawna Moore, APRN - Pulmonary/COPD Coordinator engages patient in care plan, and sets up follow up appointments with DOPS Patients only.
  - Respiratory Therapy provides education, disease management, and education on using O2 & Inhalers.

High Risk if patient presents with previous readmission <30 days or has all risk factors.

Transition Coordinator (TC)

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- Sarah Schoeneberger, ext. 7041
- Sheila Osborne, ext. 8145
- Sue Mangelsdorf, ext. 6015

DOPS Cardiology APRN:
- DOPS Cardiology APRN:
- Jan Van Wort, 203-739-7155

DOPS Pulmonology APRN:
- Shawna Moore, ext. 7508

Disposition

- Home
- Home w/Services
- ECF/SNF

TC calls patient 24-72 hours after discharge

VNA contacts patient within 24 hours of discharge

Problem identified?

YES

IF

- CHF Patient
- COPD Patient
- Pneumonia Patient

NO

End

End
Patients with end stage COPD, CHF or advanced dementia with recurrent respiratory infection receives Palliative Care Consult

Patients meet high risk criteria (Score >3) receive a comprehensive teach-back education, PCP follow up appointment and follow up phone call from Patient Navigator

Patients with one of the 7 high risk DRGs receive teach back, PCP follow up appointment and phone call from Patient Navigator
Palliative Care Screening Tool:

- If palliative care screen score is > 8, Nurse Navigator will place consult with palliative care team directly.
- If score is between 4 – 7, navigator should call palliative care office.

**1. Basic Disease Process**
- a. Cancer (Metastatic/Recurrent)
- b. Advanced COPD
- c. Stroke (with decreased function by at least 50%)
- d. End stage renal disease
- e. Advanced cardiac disease – i.e. CHF, severe CAD, CM (LVEF <25%)
- f. Other life-limiting illness

**2. Concomitant Disease Processes**
- a. Liver disease
- b. Moderate renal disease
- c. Moderate COPD
- d. Moderate congestive heart failure
- e. Other condition complicating care

**3. Functional status of patient**

<table>
<thead>
<tr>
<th>ECOG Grade</th>
<th>Scale</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Fully Active, able to carry on all pre-disease activities without restriction.</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light housework, office work.</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours.</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Capable of only limited self-care; confined to bed or chair more than 50% of waking hours.</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair.</td>
<td>4</td>
</tr>
</tbody>
</table>

**4. Other criteria to consider in screening**

- a. Is not a candidate for curative therapy
- b. Has a life-limiting illness and has chosen not to have life prolonging therapy
- c. Has unacceptable level of pain >24 hours
- d. Has uncontrolled symptoms (i.e. nausea, vomiting)
- e. Has uncontrolled psychosocial or spiritual issues
- f. Has frequent visits to the Emergency Department (>1x mo for same diagnosis)
- g. Has more than one hospital admission for the same diagnosis in last 30 days
- h. Has prolonged length of stay without evidence of progress
- i. Has prolonged stay in ICU or transferred from ICU to ICU without evidence of progress
- j. Is in an ICU setting with documented poor or futile prognosis

**TOTAL SCORE**

**SCORING GUIDELINES:**
- TOTAL SCORE = 0 - No intervention needed
- TOTAL SCORE = 1 - Observation only
- TOTAL SCORE = 2 - Consider Palliative Care Consult (requires physician order)
- TOTAL SCORE = ≥3 - Order Palliative Care Consult

**Signature:** Staff member completing form

**Date:**
Members of a Patient’s Care Team Who May Identify Palliative Care Needs

- Nurse
- Case Manager
- Social Worker
- Physician Assistant
- Physician
- Pharmacist

Source: 2013 The Advisory Board Company
Referring Provider an Integral Player

Palliative Care Service
Delivery Pathway

Palliative Care Referral

Does this case warrant physician specialist services?

Yes
Specialist physician, palliative care team provides care

No
Referring provider, palliative care APRN address needs together

Source: 2013 The Advisory Board Company
Nurse-led Referral

- Consult initiated with a palliative care screening tool completed by an RN navigator
- If screening identifies potential palliative care need, RN reviews results with a member of the palliative care team
- Palliative care team flags patient for potential referral through a note in the record or by contacting the physician

Case Manager-led Referral

- Consult initiated by a Case manager based on the risk score and patient needs
- Case manager makes the palliative care referral order after discussion with a physician
- Physician can give verbal assent for referral
- Case manager ensures the palliative care team sees the patient

Source: 2013 The Advisory Board Company
Advanced Treatment Plan (ATP)

- Discussion held with patient
- Discussion held with legal next of kin
- Designated Health Care Representation
- Designated Conservator

If the patient has a developmental disability please consult with Clinical Resource Management before making a DNR

- DNR with FULL MEDICAL TREATMENT

Instructions for Intubation and Mechanical Ventilation

- Trial Period of Intubation and mechanical Ventilation
- Noninvasive Ventilation (BiPAP) if appropriate

Artificial Nutrition and Hydration

- No Feeding Tube
- Trial of Tube Feeding via Nasogastric Tube (NGT)
- Long-term feeding tube if needed
- NO Intravenous Fluids (IVF)
- Trial period of IVF as directed by Physician

Other treatments to be withheld:

- Dialysis
- Vasopressors
- Transfusions
- Pacemaker
- Other (please specify): ____________________________

Comfort Measures Only
Comfort Measures are medical cares and treatment provided with the primary goal of relieving pain and other symptoms and reducing suffering. Reasonable measures will be made to offer food and fluids by mouth. Medication, turning and repositioning, wound care and other measures will be used to relieve pain and suffering. Oxygen and suctioning of airway will be used as needed for comfort.

- End of Life (EOL) Pathway (see EOL policy)
- If patient has an Automated Implantable Cardioverter Defibrillator (AICD), order deactivation (see policy on Discontinuation of Cardiac Devices)
Transfer of Plan of Care to Post Acute Care

• Our W10 options for plan of care are
  – Code status changed
  – Palliative care consult completed in hospital
  – DNR agreed upon by patient and/or family
  – Code status addressed, continue to address at snf
  – Continue palliative care at snf
  – Palliative care to follow at snf
  – Advance directives completed
Plan of Care Across the Continuum

End of Life Pathway

Palliative Care Consult

Palliative care added to medical care plan

Ready for Discharge

ECF Hospice Home

POC in Soarian and W10

POC Flagged in Invision

Patient Presents to ED

Flagged as having a POC

ED Physician able to view Palliative POC in Soarian and use as a guide for decision

Admit

Discharge
Palliative Care Imbedded in Organizational Goals
## Integrated Care 2014 SCORE CARD

We will meet bimonthly to review score card, discuss tasks accomplished and planned tasks to move team toward WIG.

**WIG:** Achieve 30-day readmission goals for 5 medical and 2 surgical diagnoses - CHF, PNA, AMI, Stroke, COPD, EKR, EHR

<table>
<thead>
<tr>
<th>Sub-Project</th>
<th>Quality Admission</th>
<th>Quality Discharge</th>
<th>Partner with ECF/VNA</th>
<th>Quality Stay - LOS</th>
<th>Med Reconciliation</th>
<th>Palliative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-“A”</td>
<td>Pat Broderick MD</td>
<td>Bob Carr MD</td>
<td>Moreen Donahue, CNO</td>
<td>Aparna Oltiker MD</td>
<td>Eric Jimenez MD/Pat Tietjen MD</td>
<td>Damanjeet Chaubey MD</td>
</tr>
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</table>

### 30 Day Readmissions for 5 med/2 sur diagnoses listed below.

<table>
<thead>
<tr>
<th>CHF</th>
<th>PNA</th>
<th>AMI</th>
<th>STROKE</th>
<th>COPD</th>
<th>EKR</th>
<th>EHR</th>
</tr>
</thead>
<tbody>
<tr>
<td>19.70%</td>
<td>12%</td>
<td>14.30%</td>
<td>10.40%</td>
<td>16%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>20.2%</td>
<td>15.7%</td>
<td>19.5%</td>
<td>10.4%</td>
<td>22.0%</td>
<td>2.3%</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

1/3rd shift to GMLOS for CHF and COPD achieved in the month of April 2014. This translates to 4.16 days for COPD, and 4.26 days for CHF. Team will sustain this shift for remaining months of FY14, achieving YTD 1/3rd shift to GMLOS by September 30, 2014.

<table>
<thead>
<tr>
<th>CHF</th>
<th>COPD</th>
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<tbody>
<tr>
<td>4.26 days</td>
<td>4.16 days</td>
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</tbody>
</table>

AMR: 86%; DMR: 86%

30D Re - <10% palliative consult cases

<table>
<thead>
<tr>
<th>AMR</th>
<th>DMR</th>
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<tbody>
<tr>
<td>80%</td>
<td>80%</td>
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</table>

30D Re for Pall Consults

<table>
<thead>
<tr>
<th>9.70%</th>
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### Lagging Indicators

- **Goal**
- **YTD Actual**
  - CHF
  - COPD
  - AMR
  - DMR
  - 30D Re for Pall Consults

**Sept - July 2014**

<table>
<thead>
<tr>
<th>Lead Indicator 1</th>
<th>Increase number of referrals to physician home visit program (10 per month).</th>
<th>85% of COPD/CHF Care Coordinator visit within 5 days. 85% of patients discharged to home will have a PCP follow up within 5 days of discharge - selected practices.</th>
<th>Evaluate % of appointments kept for patients discharge to home.</th>
<th>CHF/COPD patients will have a PENDING DISCHARGE ORDER one day before discharge. (Baseline: 7%)</th>
<th>Weekly feedback to physicians not performing med rec. requirements.</th>
<th>Number of palliative care follow ups: Base: 30 per month / Goal: 60 per month / YTD:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Indicator 2</td>
<td>Increase number of patients discharged from ED who were potential readmits by 10%.</td>
<td>85% of Patient discharged to home will be contact within 48 hours by case manager.</td>
<td>Evaluate % of appointments kept for patients discharged from ECF.</td>
<td></td>
<td></td>
<td>Admit to consult: Base: 5.4 days / Goal: 5 days / YTD: 4.6 days</td>
</tr>
<tr>
<td>Lead Indicator 3</td>
<td>Use ED Playbook to effective transition patients to home and other support. (used with 25% of potential readmission patients)</td>
<td>85% of patients discharged to home will have their Medication Reconciliation completed at first contact and each readmission case reviewed by Physician and Nurse Navigator.</td>
<td></td>
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<tr>
<td>Lead Indicator 4</td>
<td>CHF: Percentage of Cardiology Patients receiving IV Lax In the WCMG Office. Baseline = 0. Goal = 2 per month.</td>
<td>Develop system of care coordination post discharge from skilled nursing facility.</td>
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</table>
Our team LAG indicator is 30 day readmission rates for patients we have seen. We have seen an increase in our readmission rate, and would like to get back down to the program baseline of less than 10%. The LEAD Indicators that will get us there are increasing our outpatient visits to greater than 60 encounters per month by the 4th quarter. Also, we feel by decreasing the admission to consult to less than 3 days will have a positive impact on our readmission rate.

Our plan to increase our outpatient visits includes services to nursing facilities as well as home visits and oncology office visits. We are expanding our consult service to local nursing facilities to a total of 6 facilities. The expansion allows us to follow our patients across the continuum of care. Our new home care program will allow us to work closely with home care and PCPs to ensure the patients plan of care is being followed.

### Descriptive Statistics

<table>
<thead>
<tr>
<th></th>
<th>%</th>
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<tbody>
<tr>
<td>New In</td>
<td>555</td>
</tr>
<tr>
<td>New Out</td>
<td>90</td>
</tr>
<tr>
<td>Advance Directives</td>
<td>60.00%</td>
</tr>
<tr>
<td>YTD Readmits Rate</td>
<td>22.0%</td>
</tr>
<tr>
<td>Days to median consult</td>
<td>3.0</td>
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</table>

### YTD READMIT RATE

<table>
<thead>
<tr>
<th>Month</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>OCT</td>
<td>23%</td>
</tr>
<tr>
<td>NOV</td>
<td>38%</td>
</tr>
<tr>
<td>DEC</td>
<td>18%</td>
</tr>
<tr>
<td>JAN</td>
<td>26%</td>
</tr>
<tr>
<td>FEB</td>
<td>24%</td>
</tr>
<tr>
<td>MAR</td>
<td>7%</td>
</tr>
<tr>
<td>APR</td>
<td>15%</td>
</tr>
<tr>
<td>MAY</td>
<td>25%</td>
</tr>
<tr>
<td>JUN</td>
<td>18%</td>
</tr>
<tr>
<td>JUL</td>
<td>22%</td>
</tr>
<tr>
<td>AUG</td>
<td></td>
</tr>
<tr>
<td>SEP</td>
<td></td>
</tr>
</tbody>
</table>

Goal < 10%
Venues for Increasing the Awareness of Palliative Care

- CME: EPEC training – MDs, RNs, PT/OT, CRM
- Grand Rounds 2010, 2012
- Patient Education
  - Town Hall meetings
  - EMMI Program for Palliative Care
- Case Studies in the Hospitalist section meetings, Ethics Committee
- One-on-One Conversations

Source: 2013 The Advisory Board Company
Hospitalist and Medical Resident Education Program

- Introduction to Hospice and Palliative Care
- Ethics
- Breaking Bad News/Code Status
- Pain Management
- Advance Care
- Symptom Management
- Dying Process
- Legal issues
- End of life care in the ICU

*Education based on the EPEC Curriculum from Northwestern University’s Feinberg School of Medicine, created with the support of the American Medical Association and the Robert Wood Johnson Foundation*
Metrics per NQF recommendations

• Measurement –
  Operational metrics
  Clinical Metrics
  Customer Satisfaction metrics
  Financial Metrics
## Operational Metrics

<table>
<thead>
<tr>
<th></th>
<th>FY2010</th>
<th>FY2011</th>
<th>FY2012</th>
<th>FY2013</th>
<th>FY2014 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases</td>
<td>317</td>
<td>484</td>
<td>554</td>
<td>676</td>
<td>556</td>
</tr>
<tr>
<td>Live Discharges</td>
<td>158</td>
<td>270</td>
<td>341</td>
<td>456</td>
<td>379</td>
</tr>
<tr>
<td>Deaths</td>
<td>159</td>
<td>214</td>
<td>213</td>
<td>220</td>
<td>177</td>
</tr>
<tr>
<td>Live Discharges</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D/C to Hospice</td>
<td>12</td>
<td>32</td>
<td>43</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td>D/C to ECF</td>
<td>76</td>
<td>107</td>
<td>133</td>
<td>164</td>
<td></td>
</tr>
<tr>
<td>D/C to Home</td>
<td>70</td>
<td>131</td>
<td>165</td>
<td>197</td>
<td></td>
</tr>
<tr>
<td>Admit to Consult (days)</td>
<td>9.6</td>
<td>6.6</td>
<td>8.1 (1)</td>
<td>4.19 (3)</td>
<td>6.9 (3)</td>
</tr>
<tr>
<td>Consult to Discharge (days)</td>
<td>7.6</td>
<td>5.3</td>
<td>5.2</td>
<td>5.06 (3)</td>
<td>6.12 (4)</td>
</tr>
<tr>
<td>Admit to Discharge (days)</td>
<td>17.2</td>
<td>11.9</td>
<td>13.3 (8)</td>
<td>9.25 (7)</td>
<td>13.02 (8)</td>
</tr>
<tr>
<td>Palliative Care Consult Rate</td>
<td>4.7</td>
<td>5.2</td>
<td>5.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palliative Care rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>757 cases=5.8 832 cases=6.4</td>
</tr>
</tbody>
</table>
Referrals by Fiscal Year

- 2013: 670
- 2012: 580
- 2011: 540
- 2010: 430
- 2009: 320
- 2008: 280
- 2007: 230
- 2006: 210
- 2005: 190
- 2004: 170

The chart shows a steady increase in referrals from 2004 to 2013.
FY2012 Palliative Care Consults by Diagnosis

- Cancer: 33.1%
- Pneumonia: 12.1%
- CHF: 11.6%
- COPD: 10.7%
- Other: 27.7%
- CVA: 4.7%
Readmission Metric

• Percent of patients who were discharged following a palliative care consult and readmitted within 30 days
Period | Palliative Care Readmissions | Referrals Excluding Deaths | Readmission Rate
--- | --- | --- | ---
FY11 | 49 | 201 | 24.38%
FY12 | 32 | 370 | 8.65%
FY13 | 5 | 77 | 6.49%

**P Chart of Pall Care readmit by FY**

Percentage = Palliative Care Readmissions / Total Referrals Excluding Deaths

Month: Mar-11, May-11, Jul-11, Sep-11, Nov-11, Jan-12, Mar-12, May-12, Jul-12, Sep-12, Nov-12

- FY11:
  - Mar-11: 0.3
  - May-11: 0.32
  - Jul-11: 0.2
  - Sep-11: 0.24
  - Nov-11: 0.22

- FY12:
  - Mar-12: 0.24
  - May-12: 0.2
  - Jul-12: 0.18
  - Sep-12: 0.15
  - Nov-12: 0.12

- FY13:
  - Mar-13: 0.1
  - May-13: 0.08
  - Jul-13: 0.06
  - Sep-13: 0.04
  - Nov-13: 0.02

Readmission Rates:
- FY11: 24.38%
- FY12: 8.65%
- FY13: 6.49%
Danbury Health Care Experience

• From 2010-2012, 62 Palliative Care Consults Completed
• 5 out of 62 patients readmitted during the same period with a readmission rate of 8.02%
Out-Patient Program

- 75 outpatient oncology referrals since April 2013
- 127 Nursing home referrals since 2010
FY2014 Palliative Care Consults by Diagnosis

- Cancer: 41%
- CHF: 11%
- COPD: 11%
- Pneumonia: 6%
- CVA: 10%
- Other: 21%
### Readmission Rate 2014

<table>
<thead>
<tr>
<th>Month</th>
<th>YTD Readmit Rate %</th>
</tr>
</thead>
<tbody>
<tr>
<td>October</td>
<td>27%</td>
</tr>
<tr>
<td>November</td>
<td>41%</td>
</tr>
<tr>
<td>December</td>
<td>20%</td>
</tr>
<tr>
<td>January</td>
<td>38%</td>
</tr>
<tr>
<td>February</td>
<td>26%</td>
</tr>
<tr>
<td>March</td>
<td>8%</td>
</tr>
<tr>
<td>April</td>
<td>20%</td>
</tr>
<tr>
<td>May</td>
<td>27%</td>
</tr>
<tr>
<td>June</td>
<td>22%</td>
</tr>
<tr>
<td>July</td>
<td>24%</td>
</tr>
<tr>
<td>August</td>
<td>11%</td>
</tr>
</tbody>
</table>

**Goal < 10%**
Readmissions by Diagnosis

FY 2014 YTD

- Oct: 1 other, 4 CHF, 4 COPD, 2 Stroke, 1 Dementia
- Nov: 2 other, 4 CHF, 4 COPD, 1 Stroke, 1 Dementia
- Dec: 4 other, 4 CHF, 2 COPD, 2 Stroke
- Jan: 2 other, 4 CHF, 2 COPD, 1 Stroke, 1 Dementia
- Feb: 1 other, 5 CHF, 1 COPD, 1 Stroke, 1 Dementia
- Mar: 4 other, 1 CHF, 2 COPD, 2 Stroke
- Apr: 1 other, 4 CHF, 5 COPD, 1 Stroke
- May: 1 other, 4 CHF, 5 COPD
- Jun: 4 other, 4 CHF, 3 COPD
- Jul: 3 other, 4 CHF, 3 COPD
CLINICAL METRICS

• Pain Management

• Advanced Care Planning

• Patient diagnosis
Pain Management Following Consult

• Establish baseline percentage of patients who indicate pain on initial consult and report improvement in pain level by at least one level 48 hours following a consult. Goal is 80% of patients with moderate to severe pain will have a reduction in pain at 48 hours.
Pain Improvement

<table>
<thead>
<tr>
<th>Month</th>
<th>Numerator</th>
<th>Denominator</th>
<th>% Improved</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>12</td>
<td>14</td>
<td>85%</td>
</tr>
<tr>
<td>May</td>
<td>14</td>
<td>21</td>
<td>70%</td>
</tr>
<tr>
<td>June</td>
<td>12</td>
<td>15</td>
<td>80%</td>
</tr>
<tr>
<td>July</td>
<td>10</td>
<td>11</td>
<td>91%</td>
</tr>
<tr>
<td>August</td>
<td>8</td>
<td>9</td>
<td>89%</td>
</tr>
</tbody>
</table>

Numerator: N=improved pain at 48 hrs
Denominator: N=
Advance Care Planning

• Establish baseline percentage of palliative care patient with documentation of a completed Advance Directive at the time of discharge
Advance Directives

![Graph showing advance directives status by month for April to September. The x-axis represents the months with corresponding counts: April n=34, May n=27, June n=39, July n=19, August n=27, September. The y-axis represents the percentage of patients. The bars indicate the percentage of patients who have complete, not discussed, or unable status.](image-url)
Customer Metrics
Patient and Family Satisfaction

- Establish a process for determining patient/family satisfaction. The goal >50% of patients seen by the palliative care consult service will receive a satisfaction survey phone call, within 2 weeks for live discharges and within 1 month for patients who have died.
Let's get started on the survey:
I know that you or your loved one met many health care providers in the hospital, but I want you to focus on the palliative care team when answering the following questions. For questions that address how well you think the palliative care team did, please respond with excellent, good, fair, or poor. Please let me know if the question doesn’t apply to you.

<table>
<thead>
<tr>
<th>Question</th>
<th>Excellent (4)</th>
<th>Good (3)</th>
<th>Fair (2)</th>
<th>Poor (1)</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. If pain was an issue, how did the palliative care team do in controlling your [patient name]'s pain?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. How well did the team do with making sure you or [patient’s name] was comfortable during the hospital stay? (Did [patient name] get help with symptoms? Did [patient name] seem comfortable? Was the severity of the symptoms reduced?)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. How well did the team do at giving you information about your or [patient name]'s illness in an understandable and sensitive way?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. How did the team do with involving you and your loved ones in making decisions about treatments and tests?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. How effective was the palliative care team in responding to your and [patient’s name] spiritual or religious needs?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. How did the team do in acknowledging and respecting your cultural traditions? (Any traditions for the way your family makes decisions, or communicates or thinks about illness and medicine that you would want the providers to respect)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

We would also like to get your feedback about the palliative care team. Please answer always, sometimes, not at all, or not applicable to the following questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Always</th>
<th>Sometimes</th>
<th>Not at all</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Was the palliative care team helpful?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Was the palliative care team respectful?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Satisfaction Call Goal >50% of Discharges

- April: 26%
- May: 47%
- June: 55%
- July: 82%
- August: 68%
- September: 0%
Financial Metrics/Cost Savings

Cost Savings Associated With US Hospital Palliative Care Consultation Programs

R. Sean Morrison, MD; Joan D. Penrod, PhD; J. Brian Cassel, PhD; Melissa Caust-Ellenbogen, MS; Ann Litke, MFA; Lynn Spragens, MBA; Diane E. Meier, MD; for the Palliative Care Leadership Centers’ Outcomes Group
**COST SAVINGS**

<table>
<thead>
<tr>
<th>Additional Cost Avoidance (Savings):</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential cost saving for avoiding CPR and a code status change to DNR</td>
<td>$5,235.00</td>
</tr>
<tr>
<td>Deferred a brain biopsy saved more than $3000.00</td>
<td></td>
</tr>
<tr>
<td>Deferred extensive GI surgery</td>
<td></td>
</tr>
<tr>
<td>4 medical patients were discharged from ED on hospice rather than admitted</td>
<td></td>
</tr>
<tr>
<td>6 patients stopped dialysis to go on CMO or home on Hospice</td>
<td></td>
</tr>
<tr>
<td>Average days from admission to consult for this period of time was 7 days</td>
<td></td>
</tr>
</tbody>
</table>
Palliative Care Program Timeline

- **2004**: Creation of an in-patient palliative care consult service
- **2006**: End of Life Care Pathway build into Soarian
- **2007**: Palliative care integrated into Hospitalist Service
- **2008**: September 2008 2 day EPEC Conference
- **2009**: Add 2nd APRN
- **2010**: Palliative care sedation policy/protocol
- **2011**: Consult Service for DHCC
- **2012**: Consult Service for Hancock Hall and Filosa
- **2013**: Advanced treatment plan built into Soarian. Cancer center consult service.
- **2014**: Add 3rd APRN
- **2015**: Add 3 ECFs (PJP, GH, & RG)
- **2015**: Home Visit Program and POC
Well-Utilized Inpatient Consult Service

Expanded Generalist Palliative Care Capabilities

Outpatient Palliative Care Providing Cross-Continuum Services

Increasing Number of Patients Served by Palliative Care Service

Increasing Value Gained through Palliative Care Service

Source: 2013 The Advisory Board Company