What Your System-Wide Palliative Care Strategy Needs
Today’s Presenter

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Senior Consultant
Population Health Advisor
Road Map for Discussion

1. Making the case for palliative care’s value
2. System-wide governance structure
3. Change management
4. Standardization of palliative care program operations
5. Staff education and awareness
First Things First
Agreeing on a Common Definition of Palliative Care

Characteristics of Palliative Care

- Prevents and relieves suffering and symptoms
- Enhances quality of life for patient and family
- Emphasizes goals of care and aids in decision making
- Plans for end-of-life care
- Provides psychosocial and spiritual care
- Is appropriate at any stage of a serious illness, including alongside curative treatments

Source: Population Health Advisor
A Fundamental Shift

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>
<tr>
<td>Treatment Strategy:</td>
<td>Includes primarily curative treatments</td>
<td>Includes a combination of curative and symptom-focused treatments</td>
</tr>
<tr>
<td>Service Utilization:</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>
</tr>
</tbody>
</table>

“[Shifting] the usual hospital care pathway is neither a simple nor straightforward process, given the highly patterned treatment culture of the US hospital, which is structured to prolong life and avert death at all costs.”

R. Sean Morrison, MD, et al. for the Palliative Care Leadership Center’s Outcomes Group

## The Case for Palliative Care

### Benefits in Every Payment Scenario

<table>
<thead>
<tr>
<th>Improved Care Quality</th>
<th>Reduced Inpatient Costs</th>
<th>Lower Total Cost of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reduces patient symptom burden and aggressive EOL(^1) care</td>
<td>• Saves hospitals thousands of dollars per inpatient case(^2)</td>
<td>• Reduces unnecessary hospitalizations and ED visits</td>
</tr>
<tr>
<td>• Lengthens EOL survival time</td>
<td>• Reduces ICU LOS,(^3) contributing to cost savings and freeing up capacity</td>
<td>• Lowers readmission rates</td>
</tr>
<tr>
<td>• Improves patient experience of care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Benefit Under Fee For Service**
- ✓

**Benefit Under Risk Contracts**
- ✓
- ✓
- ✓

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\(^1\) End-of-life.
\(^2\) Savings compared with usual care.
\(^3\) Length of stay.

Source: Physician Executive Council interviews and analysis.
Significant Quality Benefits

Palliative Care Improving QOL\(^1\) and Survival

**Patients Have Lower Symptom Burden, Less Depression**

**FACT-L\(^2\) Symptom Management Scores**

<table>
<thead>
<tr>
<th>Usual Care Patients</th>
<th>Palliative Care Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>92</td>
<td>98</td>
</tr>
</tbody>
</table>

Higher scores indicate fewer symptoms, better quality of life

**Percentage of Patients with Symptoms of Depression**

<table>
<thead>
<tr>
<th>Usual Care Patients</th>
<th>Palliative Care Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>38%</td>
<td>16%</td>
</tr>
</tbody>
</table>

**Palliative Care Patients Live Longer Despite Less Aggressive Care**

**Patients Receiving Aggressive End-of-Life Care\(^3\)**

<table>
<thead>
<tr>
<th>Usual Care Patients</th>
<th>Palliative Care Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>54%</td>
<td>33%</td>
</tr>
</tbody>
</table>

**Patients’ Median Survival (Months)**

<table>
<thead>
<tr>
<th>Usual Care Patients</th>
<th>Palliative Care Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.9</td>
<td>11.6</td>
</tr>
</tbody>
</table>


1) Quality of life.
2) Functional Assessment of Cancer Therapy – Lung measures symptoms on a scale from 0-136, where higher score means better quality of life.
3) Patients classified as receiving "aggressive care" if met one of the following: chemotherapy within 14 days of death, no hospice care, or admission to hospice 3 or fewer days before death.
Improved Patient Care Experience

Palliative Care Yields Enhanced Patient Satisfaction Over Usual Care

Patient Care Experience Scale

Higher scores indicate patients were more satisfied with care, felt greater sense of control, and that their wishes were taken seriously.

<table>
<thead>
<tr>
<th></th>
<th>Usual Care Patients</th>
<th>Palliative Care Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>p=0.04; n=275, n=237</td>
<td>6.6</td>
<td>6.9</td>
</tr>
</tbody>
</table>

Doctors, Nurses/Other Care Providers Communication Scale

Higher scores represent greater caring, respect, understanding between patients and providers.

<table>
<thead>
<tr>
<th></th>
<th>Usual Care Patients</th>
<th>Palliative Care Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>p=0.0004; n=275, n=237</td>
<td>7.5</td>
<td>8.3</td>
</tr>
</tbody>
</table>

Reduced Inpatient Costs

Sizeable Reduction in Hospital Costs

Average Cost Savings per Admission for Palliative Care Patients Versus Control Patients

- All Adult Patients:
  - $1,696 (Patients Discharged Alive)
  - $4,908 (Patients Who Died in Hospital)

- Medicaid Patients:
  - $4,098 (Patients Discharged Alive)
  - $7,563 (Patients Who Died in Hospital)

Annual Costs Avoided by Three Hospitals’ Palliative Care Programs

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Costs Avoided per Day</th>
<th>Number of PC Cases</th>
<th>Total Saved per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A</td>
<td>$432</td>
<td>423</td>
<td>&gt;$1M</td>
</tr>
<tr>
<td>Hospital B</td>
<td>$240</td>
<td>1,720</td>
<td>&gt;$1.5M</td>
</tr>
<tr>
<td>Hospital C</td>
<td>$691</td>
<td>350</td>
<td>&gt;$0.7M</td>
</tr>
</tbody>
</table>

Source:
Lower Total Cost of Care

A Powerful Case Outside the Hospital
In-Home Palliative Care Lowers Utilization, Increases Patient Satisfaction

Results from Kaiser Permanente’s In-Home Palliative Care Intervention Pilot

1) Study conducted at Kaiser Permanente Colorado and Kaiser Permanente Hawaii from 2002 and 2004. Study included 297 homebound, terminally ill patients with a prognosis of approximately one year or less who were randomly assigned to usual care or usual care plus an in-home palliative care program.
Industry Has a Long Way to Go

Expanding Capacity Essential to Meet Total Patient Need

Spectrum of Palliative Care Models

Estimated Market Prevalence Today

Capacity to Meet Patient Need

1) Qualitative assessment of prevalence of each model.

Source: Physician Executive Council interviews and analysis.

1. No Program
   - Inpatient consult service not at capacity

2. Starter Service:
   - Consult service facing capacity constraints, poorly differentiated case mix

3. Established Service:
   - Consult service retains highly differentiated case mix, meets complex patient needs; broader medical team provides basic palliative care

4. Optimized Service:
   - Integration of inpatient service and outpatient palliative care

5. Cross-Continuum Service:
   - Consult service retains highly differentiated case mix, meets complex patient needs; broader medical team provides basic palliative care
Highest Impact Palliative Care Programs Span the Continuum

Palliative Care Services Must Work in Concert to Meet Patients’ Evolving Care Needs

Spectrum of Patient-Centered Palliative Care Services

**Acute Inpatient**
Patients admitted to the hospital are cared for by an interdisciplinary staff prior to discharge

**Skilled Nursing Facility-Based**
Palliative care services provided to skilled nursing facilities (SNFs) (or other long-term care providers) often by an external partner

**Home-Based**
One member of a palliative care team (typically an NP or SW) visits homebound patients with advanced illnesses; provides initial assessments, ongoing support, and care coordination

**Tele-Palliative Care**
Patients access palliative care specialists remotely through secure videoconferencing equipment in clinics or their homes; symptoms, medical care remote monitored

**Primary Care-Based**
Primary care physicians are trained to deliver generalist palliative care; palliative care team may rotate through primary care clinics to assist with more acute patients

**Clinic-Based**
Patients with advanced illnesses receive palliative care consults and support from an interdisciplinary team; clinics may be freestanding, co-located, or embedded in a host clinic

Source: Population Health Advisor interviews and analysis.
Guidelines for Advancing System-Wide Palliative Care

Four Key Attributes of Program Strategy and Development

- **Governance**
  - Identify system-level leaders to shape the vision
  - Determine organizational structure for decision making, communication, and accountability

- **Change Management**
  - Establish timeline for program rollout and expansion
  - Engage workgroups to translate vision into action
  - Solicit input and buy-in from key stakeholders
  - Share action plans throughout the system

- **Standardize Operations**
  - Use system-wide needs assessment to determine which program components to standardize and which to allow for local-level variation
  - Determine standardization priorities across care team composition including:
    - Service delivery
    - Patient identification and documentation
    - Care coordination
    - Funding
    - Outcomes tracking
    - Performance management

- **Staff Education and Awareness**
  - Educate staff throughout the system on the definition of palliative care and how it relates to day-to-day work
  - Instruct potential referrers on identifying and transitioning patients to palliative care
  - Provide physicians (both generalists and specialists) with basic palliative care education and primary palliative care skills

Source: Population Health Advisor interviews and analysis.
Road Map for Discussion

1. Making the case for palliative care’s value
2. System-wide governance structure
3. Change management
4. Standardization of palliative care program operations
5. Staff education and awareness
Engage an Interdisciplinary Committee to Set Palliative Care Vision for System

Conduct Comprehensive Gap Analysis Across All Sites of Care to Identify System- and Program-Level Needs

Early Priorities for Advancing a System-Wide Program

### Action Step

**Form a system-level palliative care taskforce**

- Select taskforce members to provide expertise on a range of areas (e.g., medical, nursing, social work, chaplaincy, finance, marketing)
- Initiate buy-in with respective stakeholder groups

**Sample Questions to Consider**

- Who should be included?
- What responsibilities will the task force have?
- How often will the task force meet before and after implementation?

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**Define palliative care for system**

- Detail rationale for system focus on palliative care
- Outline attributes of individual palliative care programs as it relates to access and delivery

**Sample Questions to Consider**

- How does palliative care differ from high-risk care management?
- How does palliative care fit into the system’s population health goals?

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**Conduct needs assessment**

- Understand the resources, staff, and IT systems already in place to support the program expansion
- Identify gaps that may impede the development of palliative care across the health system

**Sample Questions to Consider**

- Are community partners (such as hospice or spiritual care) willing to assist with implementation of palliative care?
- What is the current state of advance care planning in the health system?

Source: Population Health Advisor interviews and analysis.
Regional Councils Adapt System Standards into Local Operations

Strong Communicators Selected for Governance Council

OSF HealthCare’s Supportive Care Governance Structure

System Governance Council

- **Composition:** 21 leaders from across the OSF HealthCare system representing hospitals, OSF Medical Group, home care, hospice, and community providers
- **Responsibilities:** To determine the strategic direction of the palliative and supportive care programs
- **Frequency of Meetings:** Quarterly

Dynamic Exchange of Ideas

System Operations Council

- **Composition:** 23 selected regional council members
- **Responsibilities:** Develops methods to implement strategic decisions from Governance Council; meetings also encourage council members to share supportive care insights and expertise
- **Frequency of Meetings:** Hour-long monthly calls; half-day, quarterly in-person meetings

Regional Councils

- **Composition:** Representatives from hospitals, medical groups, home care, and hospice in the local geographic area
- **Responsibilities:** Analyze and tailor directives from Governance and Operations Councils to individual hospitals
- **Frequency of Meetings:** Quarterly; additional meetings if needed

Case in Brief: OSF HealthCare

- Integrated Catholic health care system based in Peoria, Illinois, with a combined 1,289 beds across 11 hospitals
- Since launching Pioneer ACO in 2012, palliative care efforts have included a focus on initiating advance care planning with high-risk patients
- Palliative care governance structure broken down into three councils that decide, design, and implement program structure across the health system
- Outcomes: $400 to $600 saved per patient receiving palliative care consultation compared with those who do not; 18,000 advance care plans completed

Source: Population Health Advisor interviews and analysis.
Road Map for Discussion

1. Making the case for palliative care’s value
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Determine Most Appropriate Staging for Rolling Out Changes

Best Sequence for Palliative Care Expansion Depends on Available Resources, Consensus on System Goals

**Two Approaches for Implementing System-Wide Change**

<table>
<thead>
<tr>
<th><strong>Phased Approach</strong></th>
<th><strong>Concurrent Approach</strong></th>
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</thead>
</table>
| \* Pilots sites selected based on:  
  - Presence of existing program  
  - Executive buy-in  
  - Demonstrated demand for services  
  - Strong clinical champions for program | \* All hospitals or regions are required to implement palliative care program elements within a standard time frame |
| **Advantages** | **Advantages** |
| • Achieve quick wins  
• Phase investments  
• Opportunity to learn from program successes and challenges before scaling system-wide | • Unified vision for palliative care from the outset  
• Drives standardization of program design across the system at the outset |
| **Disadvantages** | **Disadvantages** |
| • Requires a longer period of time to implement program elements and achieve returns on initial investments | • Requires dedicated staff support to manage program design and implementation, track progress across multiple programs, and drive system-wide sharing of best practices |

Source: Population Health Advisor interviews and analysis.
Phased Program Rollout to Engage New Stakeholders Across System
Clear Milestones Articulated at Outset for Each Stage of Program Development

Year 1 Timeline for Expanding Inpatient Palliative Care Across Trinity Health

<table>
<thead>
<tr>
<th>Pre-design (2-3 months)</th>
<th>Design (4-5 months)</th>
<th>Implementation (3-4 months)</th>
<th>Sustain (ongoing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current state assessment; senior leadership meetings</td>
<td>Define 12 operational domains; create corresponding deliverables</td>
<td>Implement and improve palliative care</td>
<td>Provide continued outcome measurement, quality reporting, and performance excellence management</td>
</tr>
</tbody>
</table>

Case in Brief: Trinity Health

- 88 hospitals across 21 states; post-acute service offering 126 continuing care locations—including home care, hospice, PACE centers, and senior living facilities
- Expanded from 14 inpatient palliative care programs in 2012 to 38 programs by 2015
- Quality performance excellence management and processes established two design workgroups to develop a robust framework for palliative care
- Four “Implementation” workgroups created to standardize program elements across the system
  - Over 200 Trinity Health employees expressed interest in participating in the workgroups; hospitals could only send one representative to each of the workgroups; hospitals were encouraged to send a representative whose expertise best supported the focus of the workgroup
  - Implementation-focused workgroups met every three weeks during the “Implementation” phase of program rollout

Source: Population Health Advisor interviews and analysis.
“Design” Phase Focused on Actionable Frameworks for Palliative Care Program

Decision-Making Workgroups Lean to Increase Efficiency and Create Deliverables to Unify Vision

Workgroups Produce Guidelines and Resources to Be Adopted Across Trinity Health

1. 12 Operational Domains Identified and Defined
   - Domain 1: Program Administration
   - Domain 2: Type of Service
   - Domain 3: Availability
   - Domain 4: Staffing
   - Domain 5: Measurement
   - Domain 6: Quality Improvement
   - Domain 7: Marketing
   - Domain 8: Education (a. Provider, b. Patient)
   - Domain 9: Bereavement
   - Domain 10: Patient Identification
   - Domain 11: Continuity of Care
   - Domain 12: Staff Wellness

2. Two Workgroups Split Domains
   - Management Workgroup
     - Domains #1, 2, 3, 4, 7, 8a, 12
   - Patient Care Workgroup
     - Domains #5, 6, 8b, 9, 10, 11

3. Workgroups Create Operational Framework for Each Domain
   - Timeline: Workgroups met every 2 to 3 weeks for 1.5 hours—over the course of 4 months—to address each domain separately
   - Sample Workgroup Deliverables Include:
     - **Management Workgroup**
       - D1. Template business plan, strategic plan
       - D2. Defined service models (e.g., MD, NP, RN, SW)
       - D4. Job descriptions, competency templates, and funding support for core team
     - **Patient Care Workgroup**
       - D5. Standard measurement on operational, clinical, satisfaction, and financial metrics
       - D6. Standard pain, non-pain, psycho-social-spiritual scales; focus on provider-patient-family communication
       - D10. Template triggers, screening tools for admission, ED, specialty units (i.e., ICU)

Workgroups Produce Guidelines and Resources to Be Adopted Across Trinity Health
Transitioning System Focus from Program Design to Implementation

Operational Workgroup Created to Address Current Gaps

Four Key Takeaways from Trinity Health Palliative Care Current State Assessment

- Varying visions for palliative care across the system
- Few standards for documentation
- Inconsistencies in data collection and reporting
- No standards for education and training across staff

Implementation Workgroup
- Collaborate with individual hospitals as well as clinical and administrative leaders to strategically plan and implement the program
- Monthly calls with each hospital; focused on implementation of all the 12 domains of palliative care

Documentation Workgroup
- Design consultation order
- Implemented three new Cerner PowerNotes and two PowerForms that included documentation from each interdisciplinary team member

Metric Workgroup
- Design standard palliative care dashboard
- Choose clinical, operational, and financial metrics for uniform adoption across the system

Education Workgroup
- System-wide contracts secured for ELNEC and EPEC\(^1\) online education
- CAPC\(^2\) membership provided to all hospitals, clinics, home health agencies, and SNFs in Trinity Health network

Source: Population Health Advisor interviews and analysis.

\(^1\) End-of-Life Nursing Education Consortium (ELNEC) and Education in Palliative and End-of-Life Care (EPEC).
\(^2\) Center to Advance Palliative Care.
Road Map for Discussion

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Use Needs Assessment to Identify Program Components to Standardize
Reconcile Local Cultural and Operational Dynamics with Desired System Standards

Multiple Options to Define Palliative Care Program Attributes

<table>
<thead>
<tr>
<th>Operational Attribute</th>
<th>Examples of System-Level Standards</th>
<th>Examples of Local-Level Variation</th>
</tr>
</thead>
</table>
| Care Team Definition  | • Team must be interdisciplinary (physician/nurse practitioner, nurse, social worker, spiritual care)  
|                       | • Program normally led by physician                                                               | • Palliative care is a team approach, but FTE staffing levels may vary  
|                       |                                                                                                   | • Program may be led by physician, nurse, or social worker                                         |
| Care Coordination      | • Interdisciplinary team must discuss patients’ conditions at least once a week                   | • Individual palliative care programs determine mode of communication, and frequency of care team information exchange |
|                       | • If patient is admitted for more than 72 hours, there must be a family meeting to discuss the goals of care |                                                                                                   |
| Documentation          | • Use of same EMR across all hospitals                                                              | • Use of different EMRs across all hospitals                                                        |
|                       | • Use of same patient screening tools                                                               | • Use of different screening tools                                                                 |
| Outcomes Tracking      | • Mandate regular reporting of certain operational, clinical, and financial data by all palliative care programs | • May have different targets for each hospital depending on population, services offered, team composition, etc. |
| Performance Management | • Require that all hospitals meet certain targets for service delivery and defined action steps for those missing the mark | • Monitoring of improvement and action steps determined by local leaders                            |
| Funding                | • Prescriptive budgetary guidelines set by system leaders for individual programs                | • Each program submits individual budgets  
|                       |                                                                                                   | • Funding must include a one- to five-year business plan to accommodate for program growth and increased staffing |

Source: Population Health Advisor interviews and analysis.
Team Roles Standardized, but Flexibility in Staff Ratios

Local Leaders Exemplify Palliative Care Ideals, May Be Physicians, Nurses, and Social Workers

System Required Interdisciplinary Teams for All Inpatient Palliative Care Programs

- **Medical Services**
- **Social Services**
- **Pastoral Care**

**Workloads depend on hospital site, available staff, and patient demand**

<table>
<thead>
<tr>
<th>FTE Ranges</th>
<th>MD/APN: 0.1-1.0 FTE</th>
<th>Social Worker: 0.25-1.0 FTE</th>
<th>Clergy: 0.1-0.5 FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
<td>0.5-1.0 FTE</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Team Leadership**

- All palliative care teams have strong physician involvement, however, program directors can either be physicians, nurses, or social workers
- Ideal attributes of a palliative care leader:
  - A commitment to palliative care
  - Experience with symptom management
  - High-scoring patient satisfaction measures
  - Respect among medical staff
  - Articulate and firm disposition when advocating for needs or beliefs

**Case in Brief: OSF HealthCare**

- Integrated Catholic health care system based in Peoria, Illinois, with a combined 1,289 beds across 11 hospitals and two long-term care facilities
- Palliative care programs consist of interdisciplinary teams, including individuals from at least medical services, social services, and pastoral care
- One dedicated palliative care team per OSF hospital; teams also provide services to non-OSF hospitals

Source: Population Health Advisor interviews and analysis.
Clear Coordination Processes Central to Continuum Partnerships

Key Elements of Palo Alto Medical Foundation's Care Coordination Strategy for Palliative Care

**Care Coordinators**
- Team of physicians, nurses, social workers, nurse practitioners, and care coordinators (MD, MSW, RN, CC) are dedicated to outpatient palliative care program
- Follow patients wherever they are in the care continuum
- Schedule patients’ appointments
- Organize team meetings

**Patient Registry**
- PAMF Palliative Care actively manages a centralized repository of all its patients
- Tracks details on where the patient is in the care continuum (e.g., hospital, SNF, home)
- Reviewed weekly at team meetings to reassess acuity and need for services

**Connection to Hospice**
- All hospice locations to which PAMF Palliative Care refers patients have a point person to coordinate with the program
- PAMF Palliative Care engages community hospices on an ongoing basis to promote more timely referrals to hospice, increase length of stay
- Hospices notify PAMF Palliative Care when a patient dies

**Communication with Providers**
- Education and outreach to specific specialties on palliative care program helps facilitate confidence in and cooperation with the PAMF Palliative Care team
- PAMF Palliative Care notifies specialists when a patient dies
- EMR notifies the PCP or attending any time a patient is “touched” by the palliative care team

**Case in Brief: Palo Alto Medical Foundation (PAMF)**
- Large multispecialty medical group based in the California Bay Area of San Francisco, San Jose, Santa Cruz, Los Gatos, and the East Bay
- Outpatient palliative care provided in four geographic regions, each with a dedicated staff; program first began in 2011
- Palliative care team follows patients wherever they move in the continuum: 70%-80% of palliative care visits occur in home or SNF, 20%-30% occur in outpatient clinics (host clinics include oncology and geriatrics)
- Outcomes: Staff conducts 4-5 patient visits/day/region; about 1,000 patients served annually by whole program; 5-10 referrals received per week, per team (PAMF currently has 4 teams); average daily census across whole program: 800 patients

Source: Population Health Advisor interviews and analysis.
Standardized Documentation Promotes Performance Improvement, Accountability

Trinity Health’s Rigorous Process to Identify Current EMR Elements, Crosswalk to Quality Standards

Developing a Uniform Approach to Documenting Inpatient Consults

Decision to adopt The Joint Commission’s Standards for Advanced Certification for Palliative Care Program
• System determined priority
• Also adopted National Quality Forum’s (NQF) Endorsed Palliative Care Measures and CAPC’s quality standards

Gap analysis: Compared EMR documentation practices against The Joint Commission and NQF Measures
• No standard documentation
• Multiple EMRs
• No standard screenings, data fields

Agree to documentation standards
• Built into Cerner: Includes standard order, central folder for core team documentation, standard data fields

Implementation and adaptation
• Six-month Cerner “soft” go-live to test, provide feedback, revise, and increase familiarity
• Six-month Cerner post audit, made final revisions
• Non-Cerner Hospitals: Documentation templates and pocket guides adopted to meet standards’ standard self-reporting tool matches dashboard measurement

Trinity Health Palliative Care Documentation Standards
1. MD/NP consultation and daily progress note
2. RN initial assessment and daily progress note
3. Social work palliative care assessment: NCCN Distress Scale
4. Spiritual care palliative care assessment: PC-FACIT 12
5. Interdisciplinary team notes: Adhere to eight clinical domains of palliative care

Practice Change, Patient Impact, and Cost Savings

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days from admission to consultation order</td>
<td>0-4</td>
</tr>
<tr>
<td>Consultations completed within one day of consultation order</td>
<td>100%</td>
</tr>
<tr>
<td>Improvement in dyspnea documentation</td>
<td>94%</td>
</tr>
<tr>
<td>Improvement in documentation of pain assessment</td>
<td>84%</td>
</tr>
<tr>
<td>Patients treated with an opioid who are given a bowel regimen</td>
<td>90%</td>
</tr>
<tr>
<td>Completion of treatment preferences/advanced care planning documentation at consultation</td>
<td>67%</td>
</tr>
<tr>
<td>System-wide cost savings achieved in 24 months</td>
<td>$7.4M</td>
</tr>
</tbody>
</table>

1) Data from Trinity Health System FY2016. Out palliative care dashboard based on the standard NQF palliative care measures, including: NQF 1639 Palliative Care Measure: Dyspnea screening; NQF 1638 Palliative Care Measure: Dyspnea treatment; NQF 1634 Palliative Care Measure: Pain screening; NQF 1617: Patients treated with an opioid who are given a bowel regimen; and, NQF 1641: Treatment preferences.

All Trinity Health palliative care documentation and measurement practices meet The Joint Commission, NQF, and CAPC standards.

Source: Population Health Advisor interviews and analysis.
Establish Metric Tracking System at Outset to Demonstrate Program Value
Revisit Metrics as Program Expands and Set Benchmarks to Promote Accountability

Recommended Metrics for Cross-Continuum Palliative Care Programs

<table>
<thead>
<tr>
<th>Operations</th>
<th>Quality</th>
<th>Financial</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Program volume</td>
<td>• Symptom assessment on initial encounter</td>
<td>• Medicare billable visits</td>
</tr>
<tr>
<td>• Time from order to consult</td>
<td>• Symptom control score</td>
<td>• Length of stay: hospital</td>
</tr>
<tr>
<td>• Percentage of referrals by specialty</td>
<td>• Psychosocial assessment score</td>
<td>• Length of stay: ICU</td>
</tr>
<tr>
<td>• Acute discharge distribution: hospice, home</td>
<td>• Number of goals of care conversations</td>
<td>• Number of hospital admissions, average cost per hospitalization</td>
</tr>
<tr>
<td>• Patient demographics (e.g., age, gender, diagnosis, ethnicity)</td>
<td>• Number of DNR discussions</td>
<td>• Number of ED visits, average cost per ED visit</td>
</tr>
<tr>
<td>• Number of outpatient follow-up appointments</td>
<td>• Frequency of support given to caregivers</td>
<td>• Palliative care patients by payer</td>
</tr>
<tr>
<td>• Number of consults in skilled nursing facilities</td>
<td>• Hospice average length-of-stay for patients with palliative care consult</td>
<td>• Inpatient admissions for scheduled procedures</td>
</tr>
<tr>
<td>• Palliative care staff retention</td>
<td>• Patient and family satisfaction with service</td>
<td>• Unscheduled admissions for symptom management</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality</th>
<th>Financial</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Palliative care staff satisfaction</td>
<td>• Readmission to inpatient care</td>
</tr>
<tr>
<td>• Referring clinician satisfaction</td>
<td>• Total inpatient cost per day before and after palliative consult</td>
</tr>
<tr>
<td>• Documentation of transition management</td>
<td>• Pharmacy costs before and after palliative consult</td>
</tr>
<tr>
<td>• Palliative care average length-of-stay in program</td>
<td>Source: Population Health Advisor interviews and analysis.</td>
</tr>
</tbody>
</table>
Performance Management

Improvement Contingent Upon Ongoing Support for Individual Programs
Hospital Program Directors Responsible for Identifying Challenges and Seeking System Support

Performance Management Strategy Between Hospitals and System

Data Reporting
Hospitals submit data monthly to System Palliative Care Practice Manager

One-on-One Program Coaching
Hospital palliative care medical directors meet monthly with System Palliative Care Director

Hospital-Driven Agenda
- Updates
- 30-60-90-day plan
- Challenges
- Long-term goals

Shared Learning
Quarterly hospital palliative care medical directors meeting
Yearly retreat for all hospital medical directors
Group emails among all palliative care medical directors, occurring weekly or biweekly

Case in Brief: Banner Health
- Non-profit health system headquartered in Phoenix, Arizona; operates 29 hospitals and related health entities across Arizona, Colorado, California, Wyoming, Nebraska, Alaska, and Nevada
- Began palliative care program in 2010 at Banner – University Medical Center Phoenix before expanding services throughout the health system to interested hospitals; to date, there are seven hospital-based programs and one home-based program in Phoenix, and two hospital-based programs in Colorado
- System palliative care director attends monthly Clinical Practice Council meetings (composed of other clinical program directors, senior leadership, and financial leadership) and reports on system-wide palliative care achievements and targets

Source: Population Health Advisor interviews and analysis.
Individual Program Resources and Staffing Typically Funded by Each Hospital

System Often Responsible for Resources Shared Across Care Settings

**Staffing Constitutes Largest Program Cost for Hospitals**

<table>
<thead>
<tr>
<th>Role</th>
<th>Average annual salary plus benefits¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician/Medical Director</td>
<td>$263,900</td>
</tr>
<tr>
<td>Nurse Practitioner²</td>
<td>$125,480</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>$87,783</td>
</tr>
<tr>
<td>Social Worker</td>
<td>$80,746</td>
</tr>
<tr>
<td>Chaplain</td>
<td>$72,041</td>
</tr>
</tbody>
</table>

¹ Includes 30% calculation for benefits and overhead expenses.
² Nurse practitioner or RN also often takes on role of program coordinator.

**Encourage Hospitals to Seek Support from Diverse Funding Streams**

- Philanthropy
- Research Grants
- Community Partners
- Volunteers

**Annual System-Level Investments for Palliative Care**

- **System Palliative Care Leadership Team**
  Includes program director(s), coordinators, and system practice managers

- **Education Tools for Providers**
  Includes education modules for specialist care and membership into national or state associations focused on palliative care

- **Health Information Technology**
  Includes investments in IT tools that will be used for referrals, service delivery (e.g., rounding tools, telehealth), documentation, and care coordination

- **System-Hosted Shared Learning Experiences**
  Includes convening hospital-level palliative care providers to share best practices and learn from industry experts; also includes medical director meetings and retreats

Source: Population Health Advisor interviews and analysis.
Road Map for Discussion

1. Making the case for palliative care’s value
2. System-wide governance structure
3. Change management
4. Standardization of palliative care program operations
5. Staff education and awareness
Craft Education Strategy to Alleviate Early Concerns, Kick Start Training

Well-Informed Staff Foundational to Growing Program Reach

Overview of System-Wide Education on Palliative Care

STAKEHOLDERS

- Social Workers
- Case Managers

- Medical Staff
- Nursing Staff

- Program Directors
- Executive Directors

COMMON CONCERNS

- Which patients should I refer to palliative care?
- How can I talk about palliative care with my patients when I am not a specialist?
- What is the future of palliative care at my health system?

EDUCATION CONTENT

Mission Definition
- What is palliative care and why does it matter to the system

Referrals and Eligibility
- Identifying appropriate patients
- Utilizing technology to transition patients to providers

Patient Management
- Generalist and specialist training
- Care plan coordination between palliative and primary care

Program Development
- Rollout processes
- Ways to share feedback

Source: Population Health Advisor interviews and analysis.
System Responsible for Educating Stakeholders on Referrals, Service Delivery

Banner Health Uses a Combination of Technology-Based, In-Person Trainings to Foster Participation

Banner Health’s Comprehensive Education and Awareness Campaign

- **Case managers** will use triggers that are being developed on SharePoint technologies to help identify appropriate patients for palliative care.

- **Clinical Consensus Groups** developed clinical practices that help guide patient care across the health system.

- **Social Workers** attend case management academies where palliative care education sessions occur.

- **Home-based palliative care teams** receive in-service trainings from various palliative medicine directors.

- **Hospitalists** have opportunity to improve palliative care and pain management knowledge through initiatives such as online CAPC\(^1\) tools and modules.

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**Case in Brief: Banner Health**


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\(^1\) Center to Advance Palliative Care.

Source: Population Health Advisor interviews and analysis.
Varied Training Targets Diverse Providers

Education for Generalists and Specialists to Address Workforce Shortage

New Provider Orientation Session

- Reviews inpatient and outpatient palliative care resources
- Provides four-hour education session on communication skills to equip medical staff to deliver basic palliative care

Tiered Palliative Care Academy for Existing Clinicians

**Tier One: Generalist Training**

- Builds generalist palliative care knowledge and skills among providers
- Lasts one week; 40 hours of training
- Includes competency-based didactic and observational sessions
- Accommodates six to eight participants per session, grouped by inpatient or outpatient cohorts

**Tier Two: Specialist Training**

- Builds advanced palliative care skills for providers planning to focus full-time in palliative care
- Spans weeks to months, depending on participant needs
- Provides one-on-one mentoring and education
- Trains one to two participants annually

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**Case in Brief: Weisen Health**

- Five-hospital health system based in the Northwest
- Developed palliative care program by focusing on continuous care and aligning itself with health system’s goals
- Interdisciplinary palliative care team works with patient’s clinicians to provide additional support
- Education process for palliative care providers is used to coordinate and standardize program’s goals and services

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1) Pseudonym.

Source: Population Health Advisor interviews and analysis.
Population Health Advisor

Membership provides customized support for care transformation strategy and execution. Our team conducts quantitative and qualitative analyses to help prioritize key population health management investments, develop initiative-specific action plans, and provide ongoing research and expertise.

Customized Project Offerings

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Market scans, trend reports, strategic planning resources, job descriptions, patient letters, and workflow tools

Performance Acceleration Toolkits
Implementation guides, templates, diagnostics, and playbooks from high performers, online tools

Progress Audits, Engagement Support
Education resources for staff and stakeholders, benchmarking, peer networking

New Resources on Advisory.com/PHA

Integrated Pharmacist Models in Primary Care
Key elements of program development, including team composition, scope of practice, performance metrics, and financial considerations

Integrated Behavioral Health Implementation Toolkit
Resources to address six critical planning components of an integrated behavioral health program

PHA Job Description Library
Save time by reviewing and editing job responsibilities across key care transformation roles

Top Requested Projects

Care Management Survey Assessment
Survey of frontline staff and leadership to analyze roles, responsibilities, and model effectiveness

Medical Neighborhood Primer
Strategies for enhancing primary care-specialty care collaboration including workflow and process improvement

Developing a High-Performing PAC Network
Profiles for assembling the preferred post-acute care (PAC) network including provider selection, performance expectations, and outreach
Please take a minute to provide your thoughts on today’s presentation.

Thank You!

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