WESTERN CONNECTICUT HEALTH NETWORK

DANBURY HOSPITAL

Palliative Care Program

Damanjeet Chaubey 2014

Palliative Care Constitutes a Change in Focus from Usual Care

	Usual Care		Palliative Care
Goals of Care:	Delayed until end of life is near	➡	Established early in disease trajectory
Treatment Strategy:	Includes primarily curative treatments	➡	Includes a combination of curative and symptom-focused treatments
Service Utilization:	Pursues curative treatments even when low-yield, high-cost, and burdensome for patient	➡	Pursues treatments that align with patient goals

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

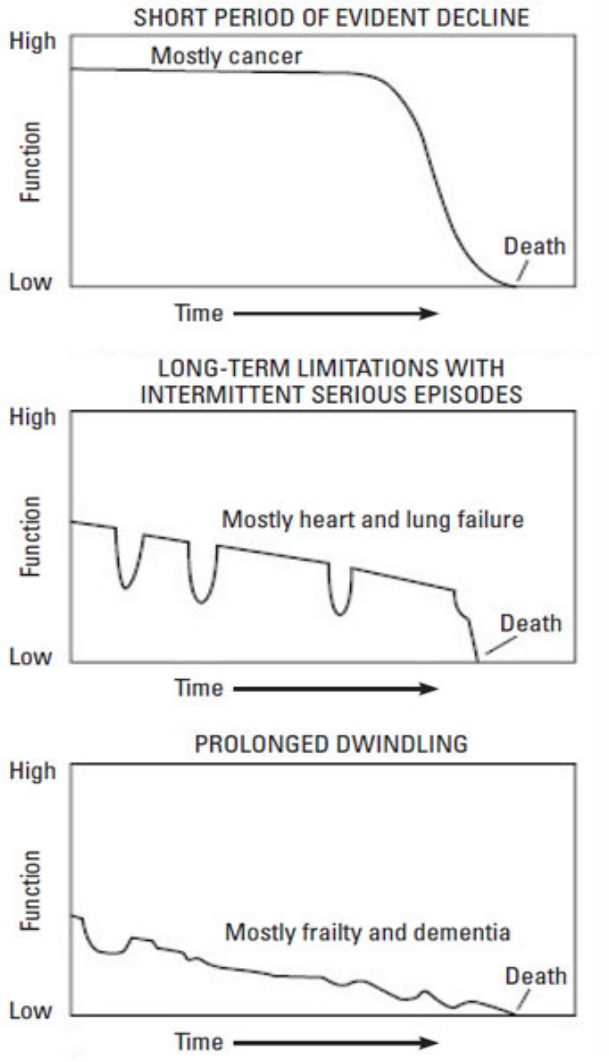
- Excellence
- Integrity
- Teamwork
- Respect
- Fiscal Responsibility

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

Western Connecticut Health Network

Danbury Hospital

Chief Medical Officer WCHN
Dr. Matthew Miller

↓

Chair of Medicine & VP MA Danbury Hospital
Dr. Patricia Tietjen

↓

Chief Hospital Medicine
Dr. Damanjeet Chaubey

Denial Management

Medical Director –
Dr. Aparna Oltikar

Physician Advisors:
AO, GA, JP, DC, CA

Palliative Care Program

Karen Mulvihill – Director
Julia MacMillan – Coordinator
Bernadene Lawrence-Philip – Coordinator

Physicians:
Jeanine Famiglietti, JoAnn Maroto-Soltis & Heather Sung

- Inpatient consult service
- Outpatient consult service
- Praxair Cancer center
- SNF
- Home visits

Inpatient Hospitalist Service

- Primary medical attending for all inpatient medical cases except one PCP
- Medical consult service including Pre-Op evaluations
- Teaching service: inpatient core faculty for Internal Medicine and Primary Care Residency Program
- Organizational initiatives – project leaders, task forces, committees
- General palliative care

Medical Observation Unit

- Chest Pain
- Syncope
- TIA
- Atrial Fibrillation
- Gastroenteritis
- Allergic Reactions

Case Management

Director –
Kathy Ferrara-Tesla

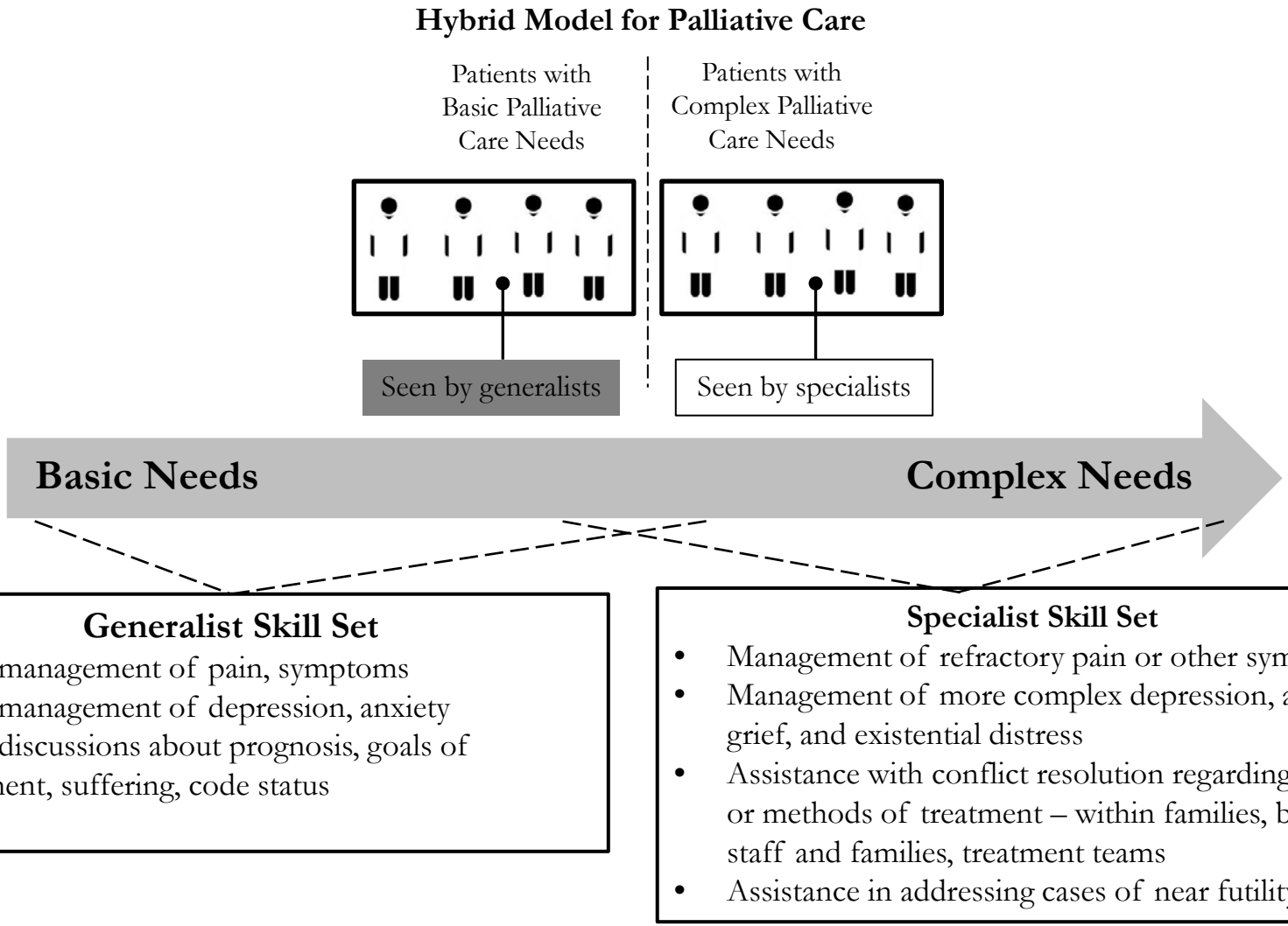
Medical Director –
Dr. Aparna Oltikar

Internal Medicine and Primary Care Residency Program

Associate Program Director –
Dr. J. Periyapperuma

Core Faculty Physicians:
SS, AO, DC, LS, GA, JP

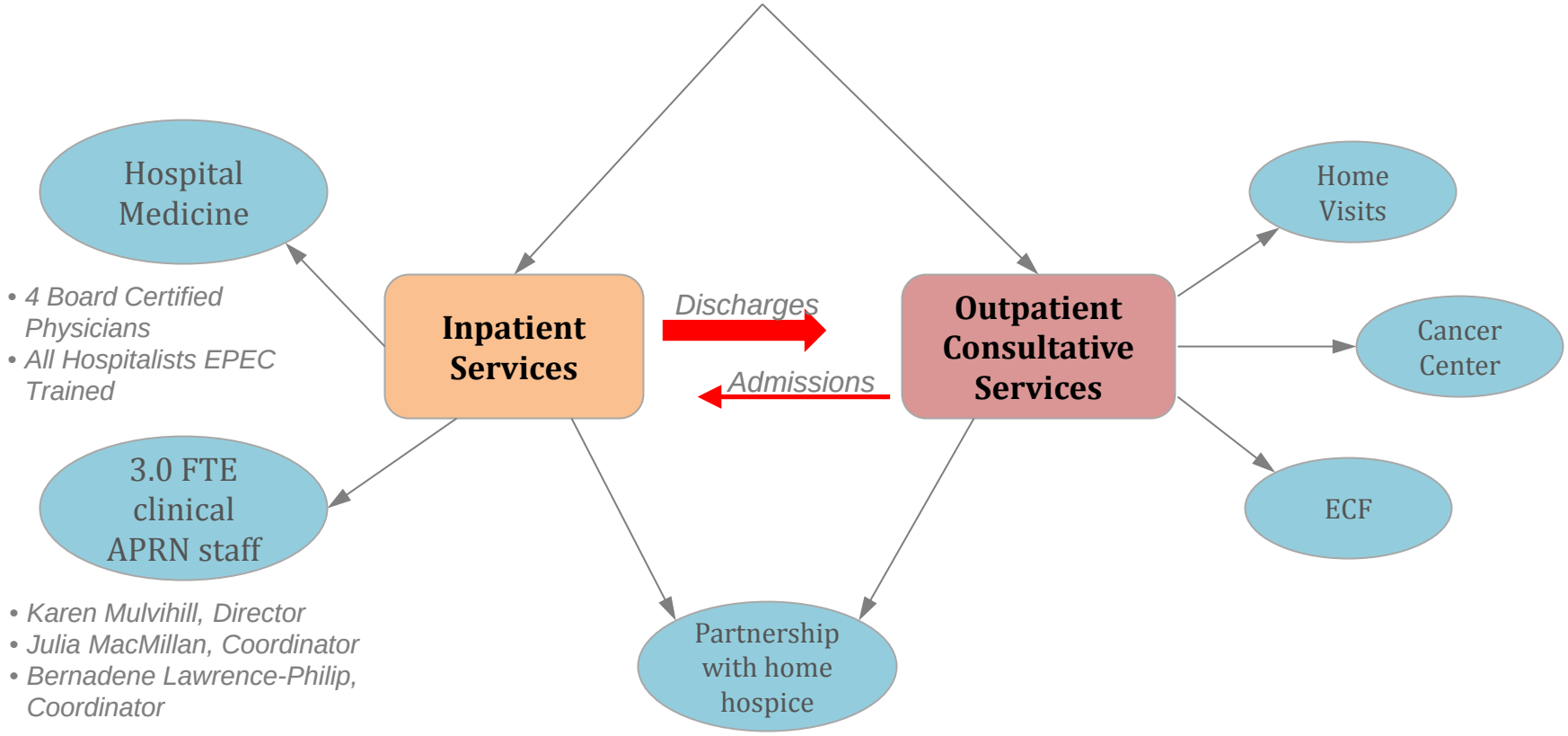
Generalists Treat Basic Needs, Specialists for Complex Cases



Source: 2013 The Advisory Board Company

Palliative Care Program at Danbury Hospital

Damanjeet Chaubey, MD - Medical Director



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/ASA Scientific Statement: Palliative and End-of-Life Care in Stroke: A Statement for Healthcare Professionals From the American Heart Association/American Stroke Association.
- AHA Scientific Statement: Decision Making in Advanced Heart Failure: A Scientific Statement From the American Heart Association Circulation
- An official American Thoracic Society workshop report: assessment and palliative management of dyspnea crisis.
- 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

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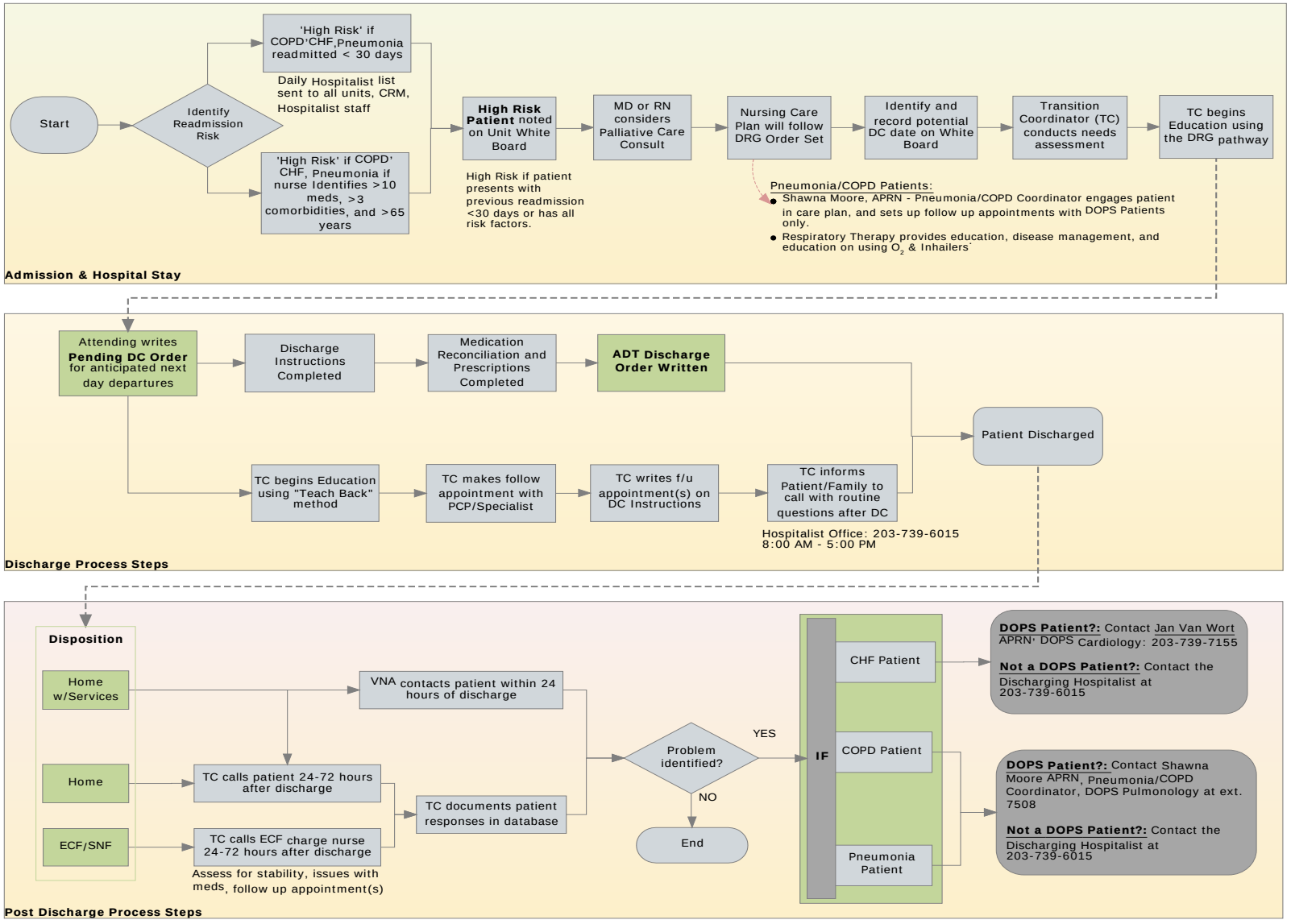
Quality Discharge Process Flow - Reducing Readmissions for **COPD, CHF, Pneumonia**

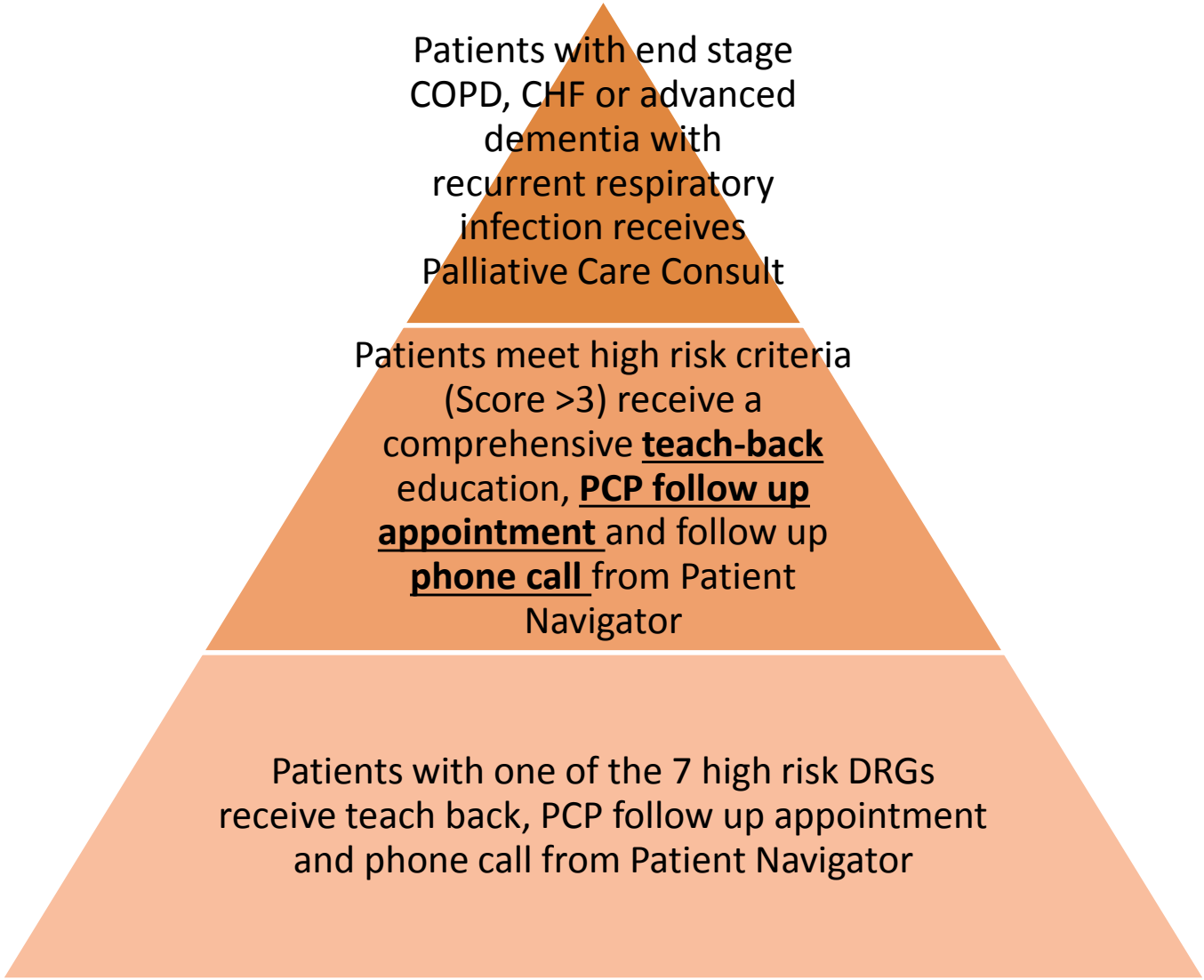


Transition Coordinators:
Sarah Schoeneberger, ext. 7041
Sheila Osborne, ext. 8145

Hospitalist Coordinator:
Sue Mangelsdorf, ext. 6015

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

DOPS Pulmonology APRN:
Shawna Moore, ext. 7508


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

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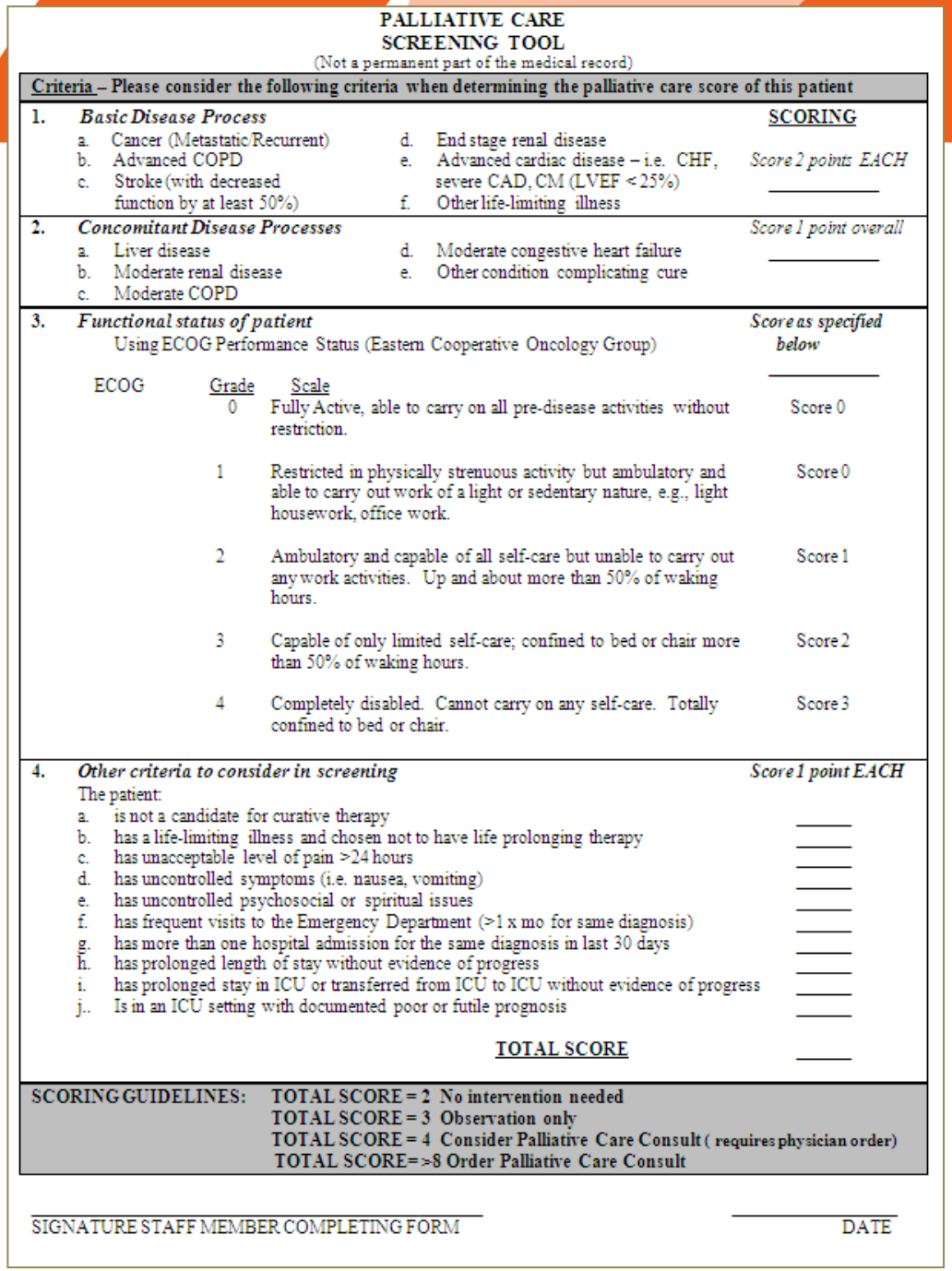
Palliative Care Screening Tool:

- 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



PALLIATIVE CARE SCREENING TOOL

(Not a permanent part of the medical record)

Criteria – Please consider the following criteria when determining the palliative care score of this patient

1. *Basic Disease Process* — **SCORING**

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

Score 2 points EACH _____

2. *Concomitant Disease Processes* — *Score 1 point overall* _____

a. Liver disease
b. Moderate renal disease
c. Moderate COPD
d. Moderate congestive heart failure
e. Other condition complicating cure

3. *Functional status of patient* — *Score as specified below* _____

Using ECOG Performance Status (Eastern Cooperative Oncology Group)

ECOG Grade	Scale	
0	Fully Active, able to carry on all pre-disease activities without restriction.	Score 0
1	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.	Score 0
2	Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours.	Score 1
3	Capable of only limited self-care; confined to bed or chair more than 50% of waking hours.	Score 2
4	Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair.	Score 3

4. *Other criteria to consider in screening* — *Score 1 point EACH*

The patient:

a. is not a candidate for curative therapy _____
b. has a life-limiting illness and 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 (>1 x 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 _____

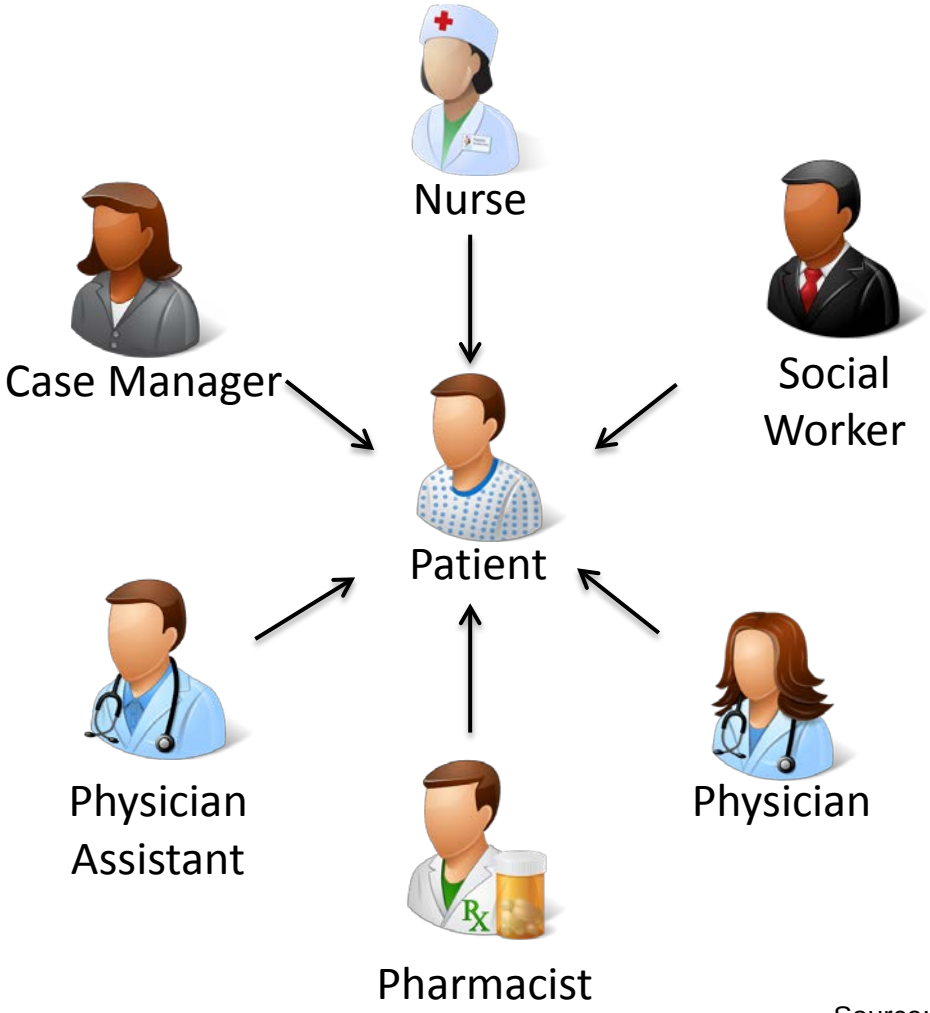
SCORING GUIDELINES:

TOTAL SCORE = 2 No intervention needed
TOTAL SCORE = 3 Observation only
TOTAL SCORE = 4 Consider Palliative Care Consult (requires physician order)
TOTAL SCORE= >8 Order Palliative Care Consult

_____ SIGNATURE STAFF MEMBER COMPLETING FORM

_____ DATE

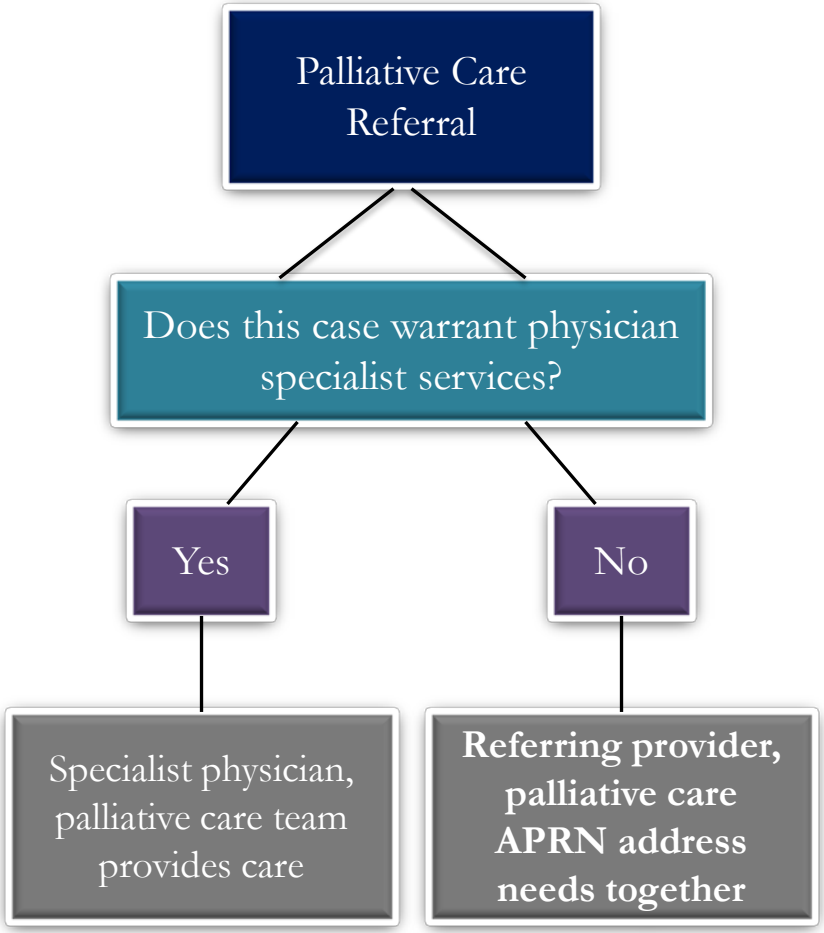
Members of a Patient's Care Team Who May Identify Palliative Care Needs



Source: 2013 The Advisory Board Company

Referring Provider an Integral Player

Palliative Care Service Delivery Pathway



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

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Advanced Treatment Plan

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
❑A trial of Tube Feeding via Nasogastric Tube (NGT)
❑Long-term feeding tube if needed
❑NO Intravenous Fluids (IVF)
❑A 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 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

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Plan of Care Across the Continuum

Palliative Care Consult

End of Life Pathway

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
☎Palliative Team

Admit

Discharge

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Palliative Care Imbedded in Organizational Goals

Integrated Care 2014 SCORE CARD

Accountable: Pat Tietjen MD

Jul-14

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

Sub-Project	Quality Admission	Quality Discharge	Partner with ECF/VNA	Quality Stay - LOS	Med Reconciliation	Palliative Care
Sub-"A"	*Pat Broderick MD*	*Bob Carr MD*	*Moreen Donahue, CNO*	*Aparna Oltikar MD*	*Eric Jimenez MD / Pat Tietjen MD*	*Damanjeet Chaubey MD*
	30 Day Readmissions for 5 med/2 sur diagnoses listed below.			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.	AMR: 80%; DMR: 86%	30D Re - <10% palliative consult cases

Lagging Indicator	CHF	PNA	AMI	STROKE	COPD	EKR	EHR
Goal	19.70%	12%	14.30%	10.40%	16%	4%	4%
YTD Actual	20.2%	15.7%	19.5%	10.4%	22.0%	2.3%	1.7%

Sept - July 2014

Lagging Indicator	CHF	COPD
Goal	4.26 days	4.16 days
YTD Actual	4.39	5.14

Sept - July 2014

Lagging Indicator	AMR	DMR
Goal	80%	86%
YTD Actual	88.72%	87.61%

March Audit, N=197

Lagging Indicator	30D Re for Pall Consults
Goal	9.70%
YTD Actual	

YTD through July 2014

Lead Indicator 1	Increase number of referrals to physician home visit program (10 per month).	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.	Evaluate % of appointments kept for patients discharge to home.	CHF/COPD patients will have a PENDING DISCHARGE ORDER one day before discharge. (Baseline: 7%)	Weekly feedback to physicians not performing med req. requirements.	Number of palliative care follow ups: Base: 30 per month / Goal: 60 per month / YTD:
Lead Indicator 2	Increase number of patients discharged from ED who were potential readmits by 10%.	85% of Patient discharged to home will be contact within 48 hours by case manager.	Evaluate % of appointments kept for patients discharged from ECF.			Admit to consult: Base: 5.4 days / Goal: 3 days / YTD: 4.6 days
Lead Indicator 3	Use ED Playbook to effective transition patients to home and other support. (used with 25% of potential readmission patients)	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.				
Lead Indicator 4	CHF: Percenetage of Cardiology Patients receiving IV Lasix in the WCMG Office. Baseline = 0. Goal = 2 per month.	Develop system of care coordination post discharge from skilled nursing facility.				

Western Connecticut Health Network

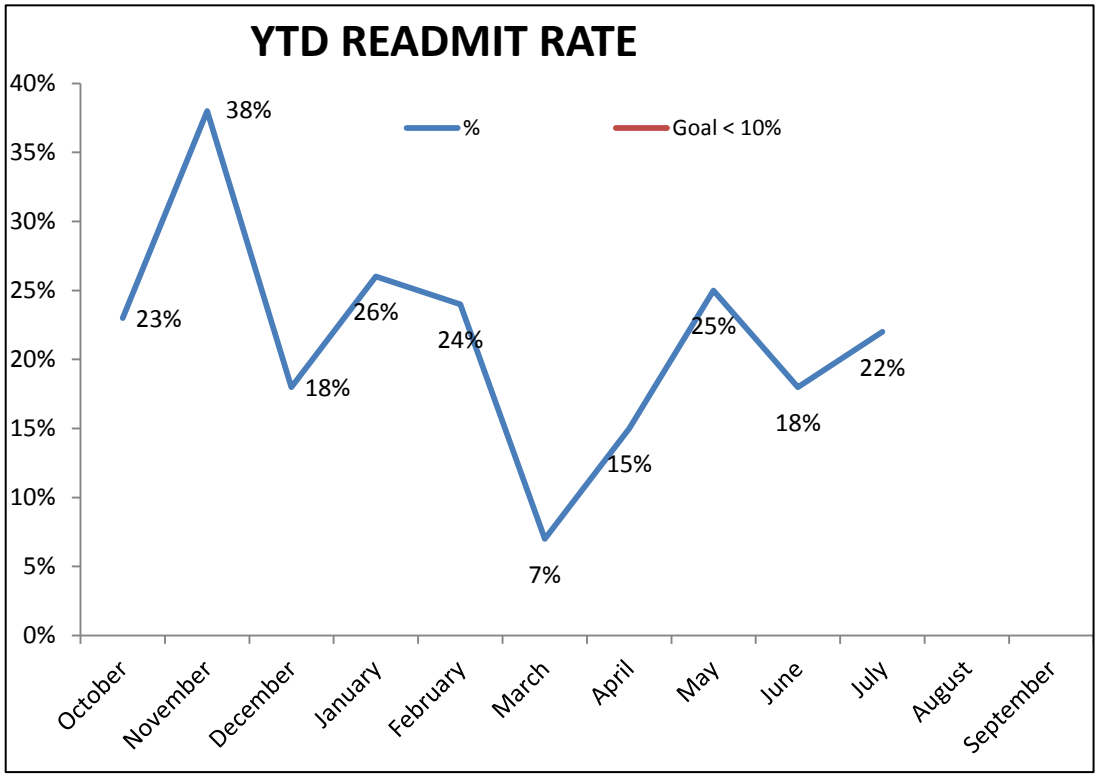
Danbury Hospital

Palliative Care Dashboard

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			YTD READMIT RATE %
New In	555		
New Out	90	OCT	23%
Advance Directives	60.00%	NOV	38%
YTD Readmits Rate	22.0%	DEC	18%
Days to median consult	3.0	JAN	26%
		FEB	24%
		MAR	7%
		APR	15%
		MAY	25%
		JUN	18%
		JUL	22%
		AUG	
		SEP	
			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

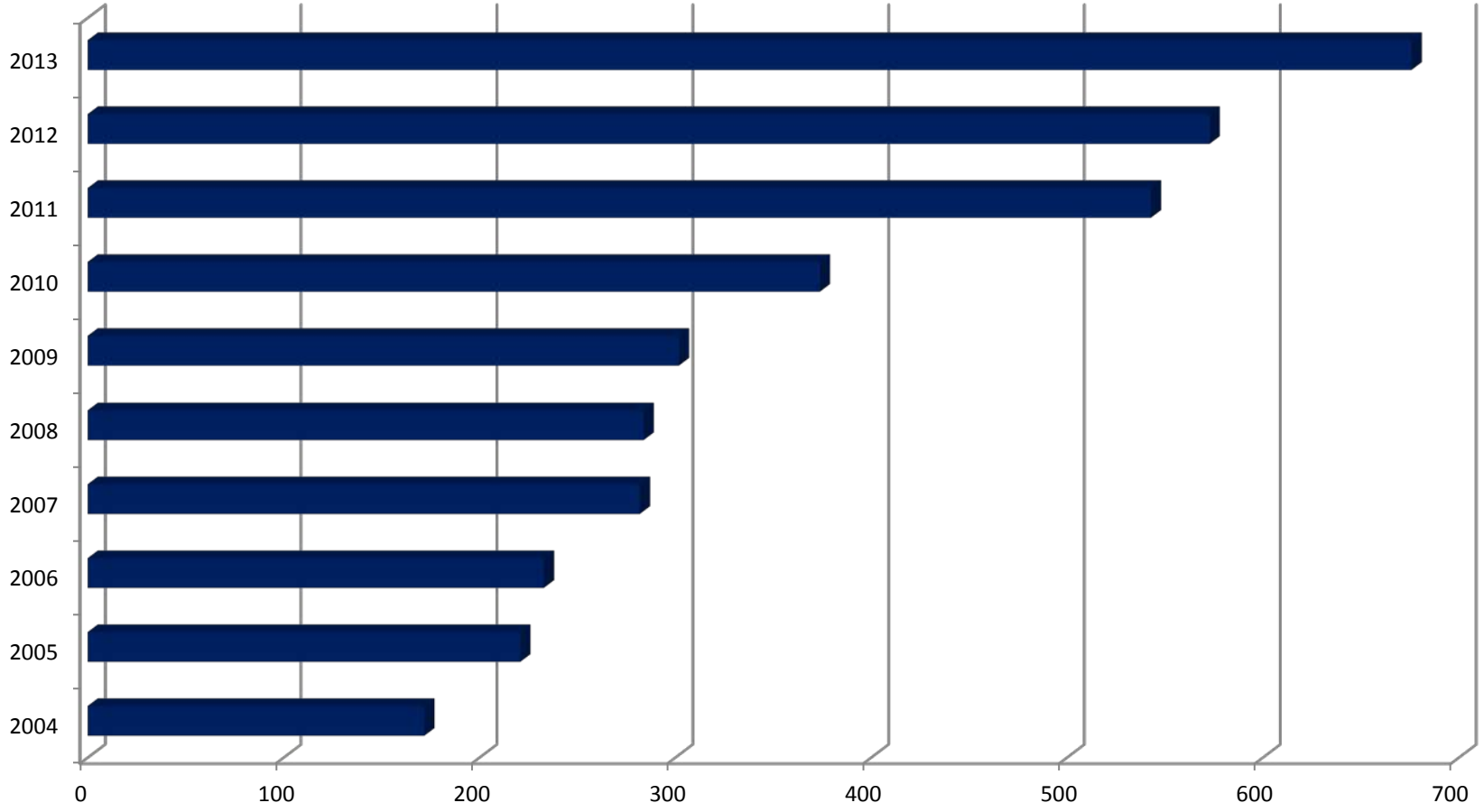
Metrics per NQF recommendations

- Measurement –
  - Operational metrics
  - Clinical Metrics
  - Customer Satisfaction metrics
  - Financial Metrics

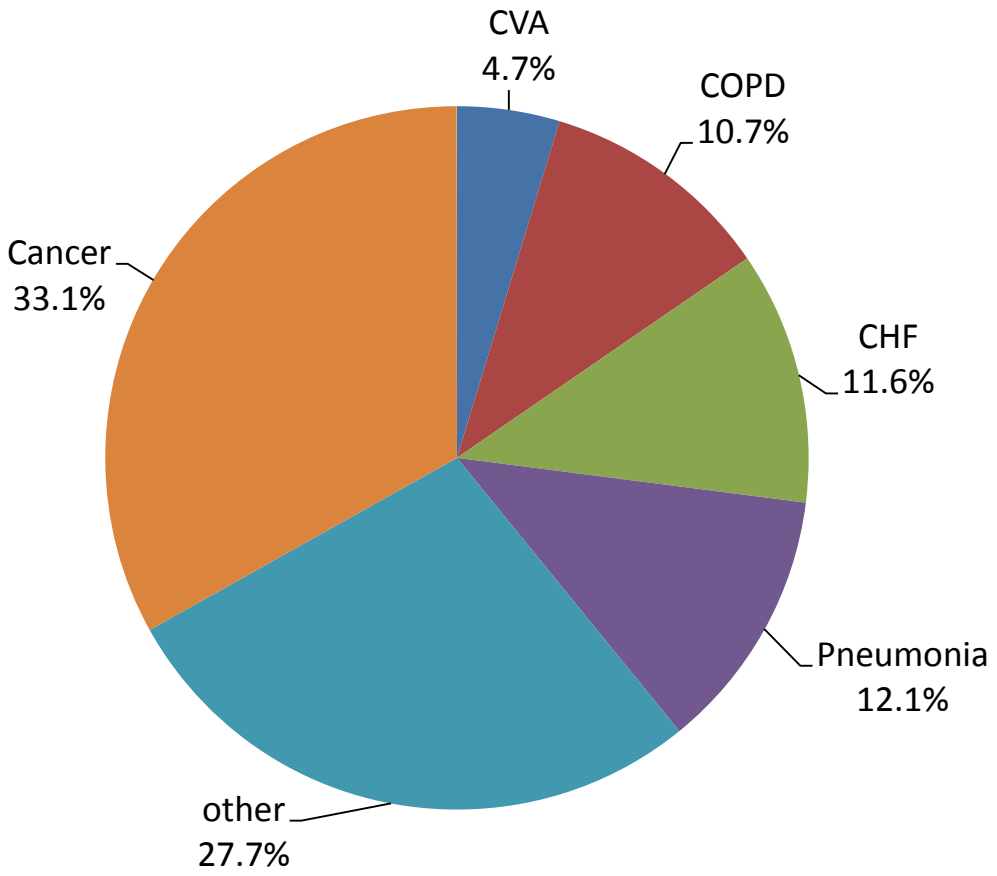
Operational Metrics

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

Referrals by Fiscal Year



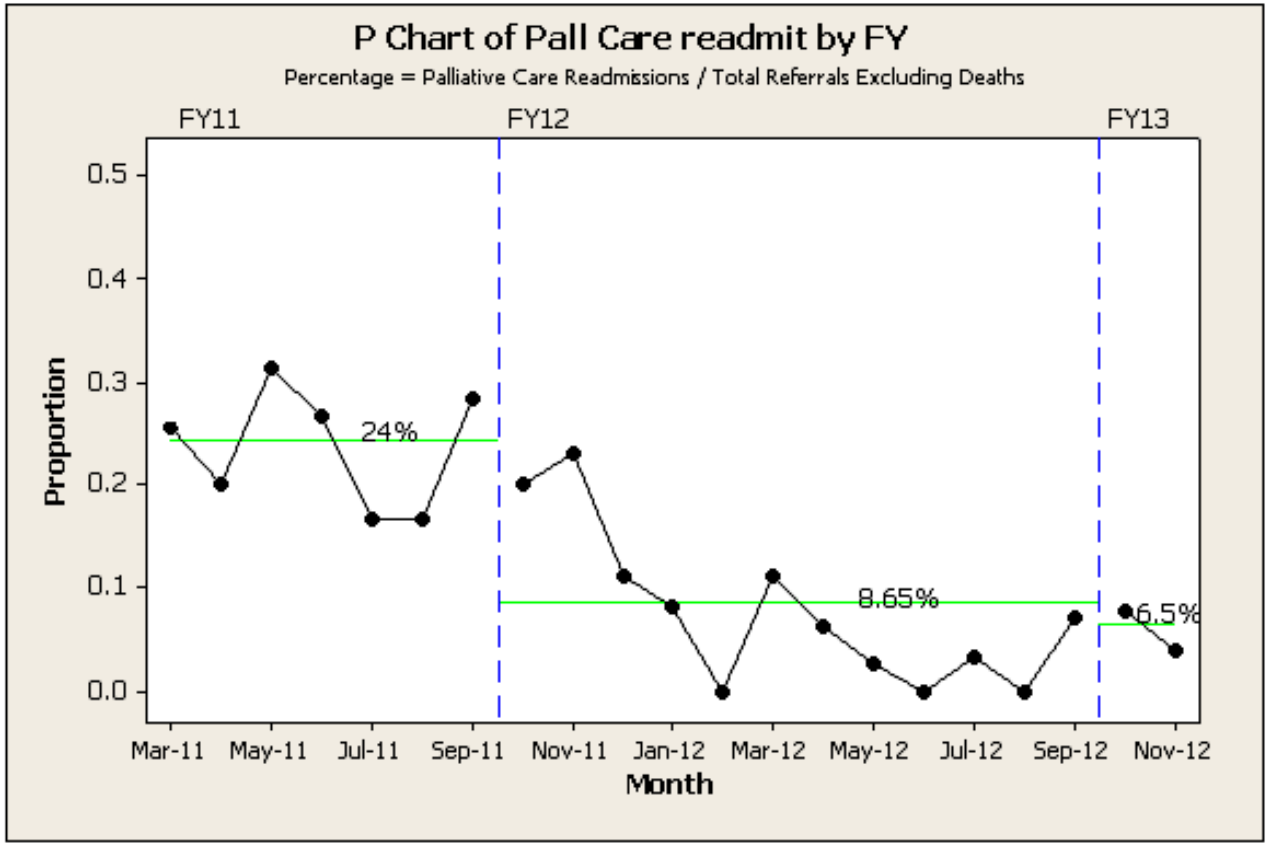
FY2012 Palliative Care Consults by Diagnosis



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%



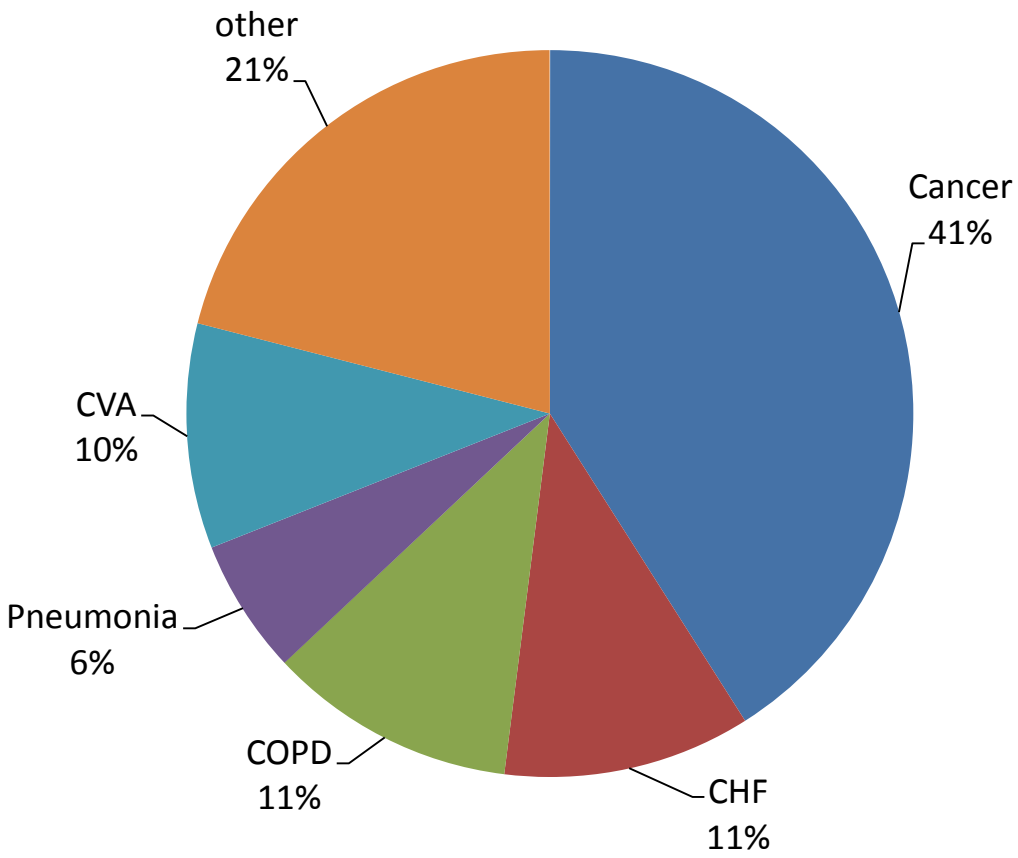
Danbury Health Care Experience

- 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

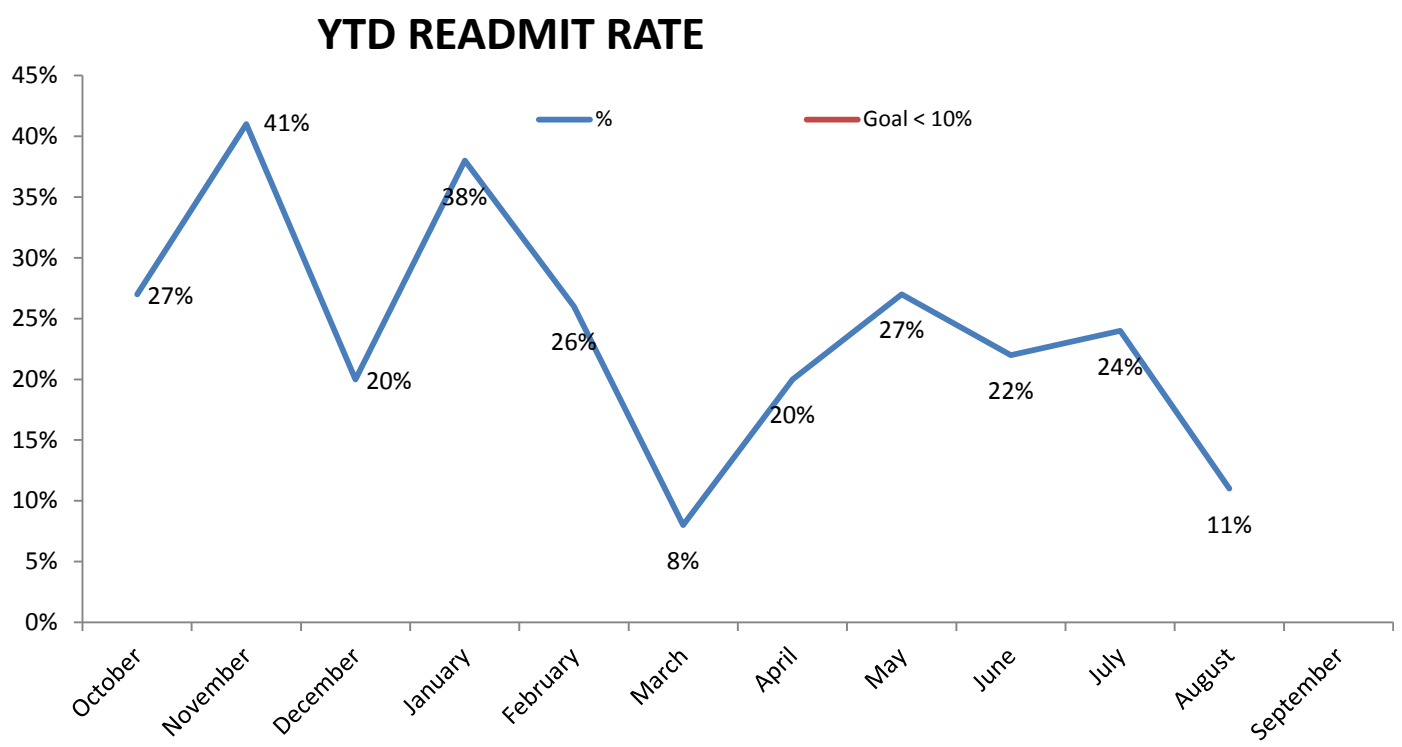
- 75 outpatient oncology referrals since April 2013
- 127 Nursing home referrals since 2010

FY2014 Palliative Care Consults by Diagnosis

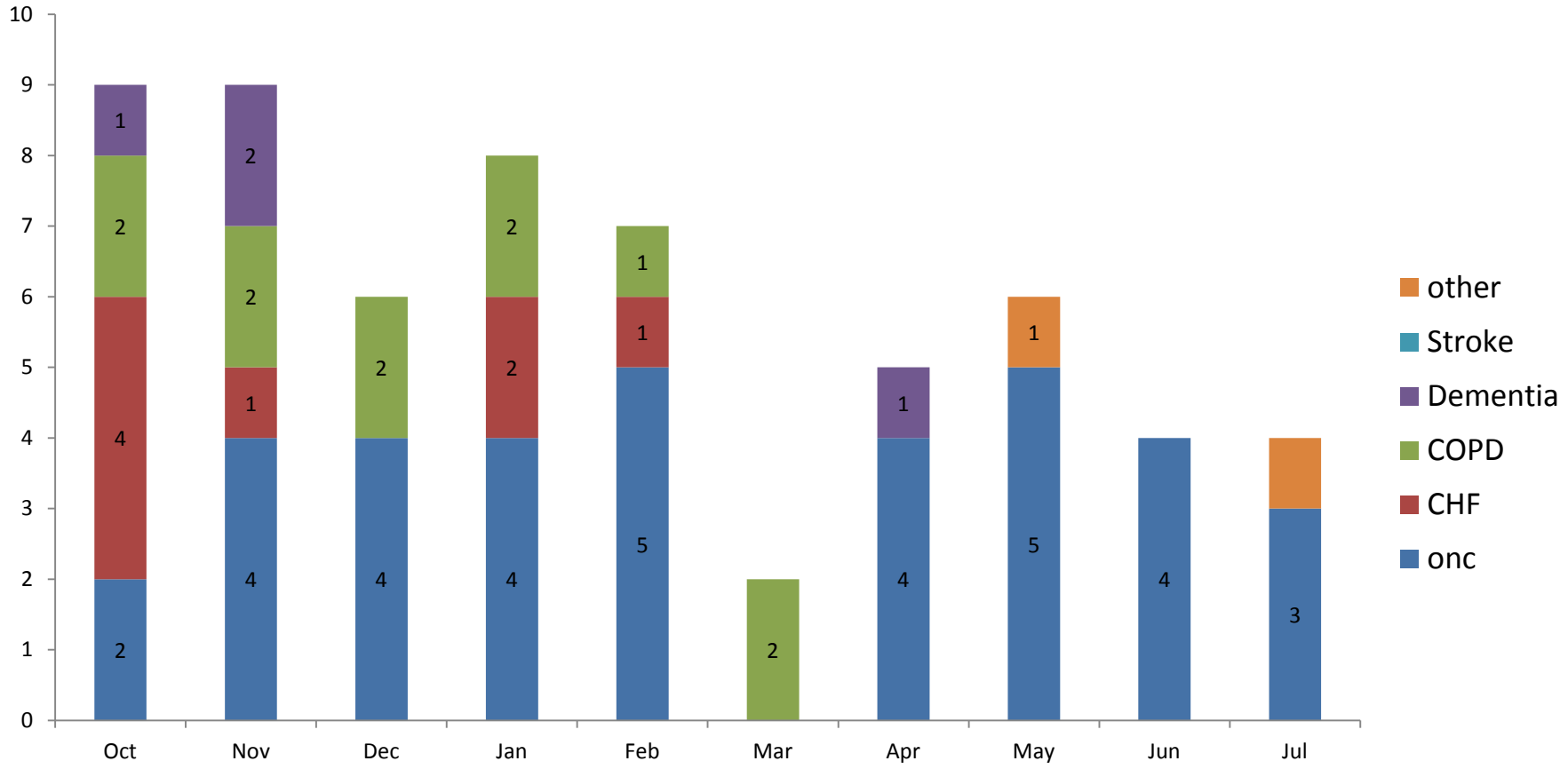


Readmission rate 2014

	YTD READMIT RATE
	%
October	27%
November	41%
December	20%
January	38%
February	26%
March	8%
April	20%
May	27%
June	22%
July	24%
August	11%
September	
	YTD 20%
	Goal < 10%



Readmissions by Diagnosis



FY 2014 YTD

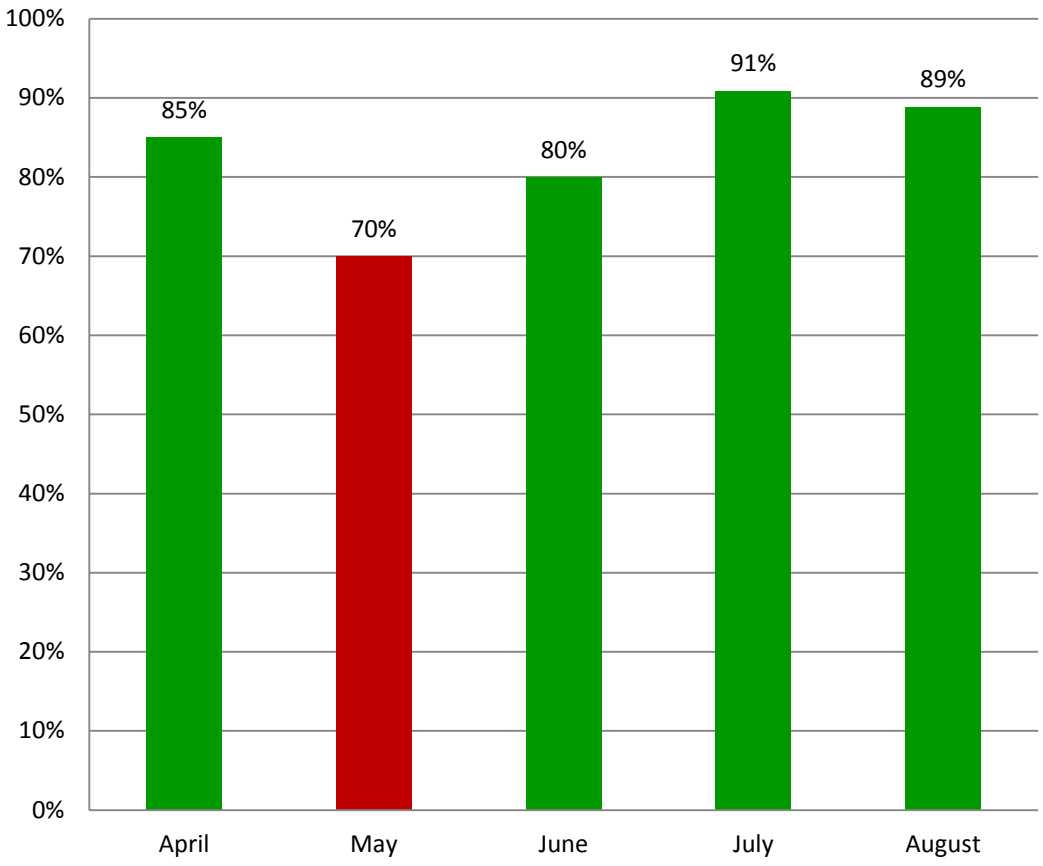
CLINICAL METRICS

- 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

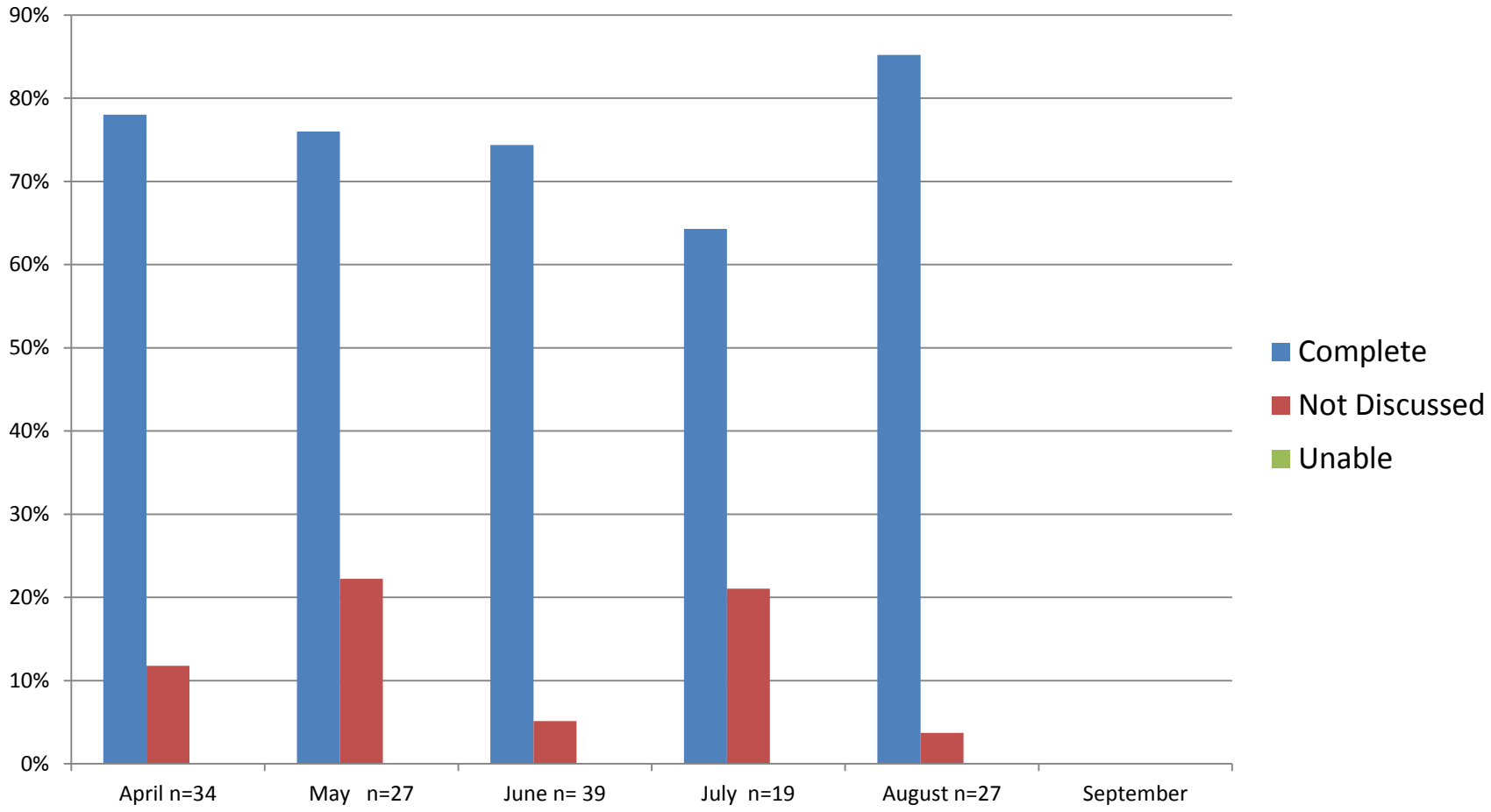


	Numerator N=improved pain at 48 hrs	Denominator N=	%improved
April	12	14	85%
May	14	21	70%
June	12	15	80%
July	10	11	91%
August	8	9	89%
September			

Advance Care Planning

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

Advance Directives



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

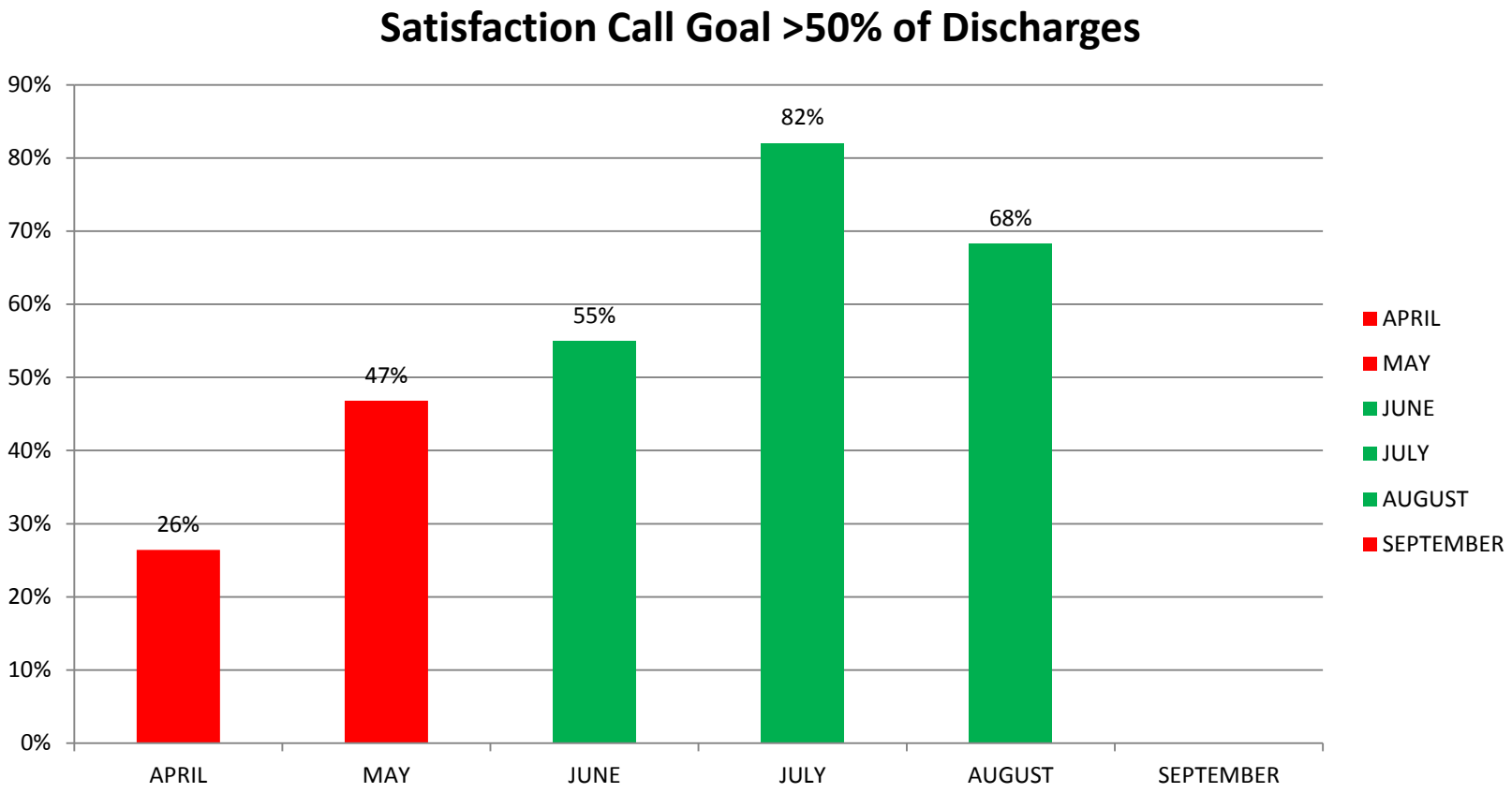
Let's get started on the survey:

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.

	Excellent (4)	Good (3)	Fair (2)	Poor (1)	Not applicable
1. If pain was an issue, how did the palliative care team do in controlling your/[patient name]'s pain?	☐	☐	☐	☐	☐
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?)	☐	☐	☐	☐	☐
3. How well did the team do at giving you information about your or [patient name]'s illness in an understandable and sensitive way?	☐	☐	☐	☐	☐
4. How did the team do with involving you and your loved ones in making decisions about treatments and tests?	☐	☐	☐	☐	☐
5. How effective was the palliative care team in responding to your and [patient's name] spiritual or religious needs?	☐	☐	☐	☐	☐
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)	☐	☐	☐	☐	☐

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	Always	Sometimes	Not at all	Not applicable
7. Was the palliative care team helpful?	☐	☐	☐	☐
8. Was the palliative care team respectful?	☐	☐	☐	☐

SATISFACTION CALL



Financial Metrics/Cost Savings

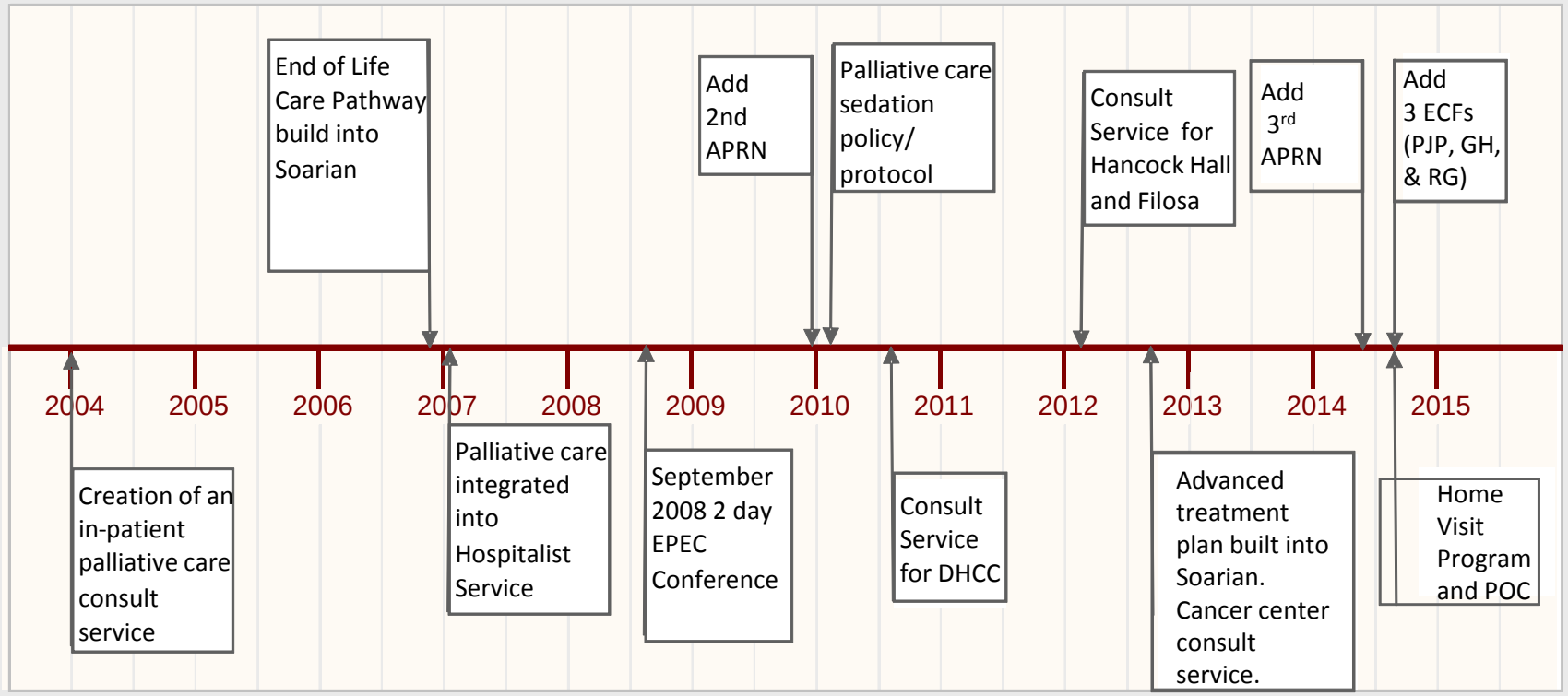
Cost Savings Associated With US Hospital Palliative Care Consultation Programs

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

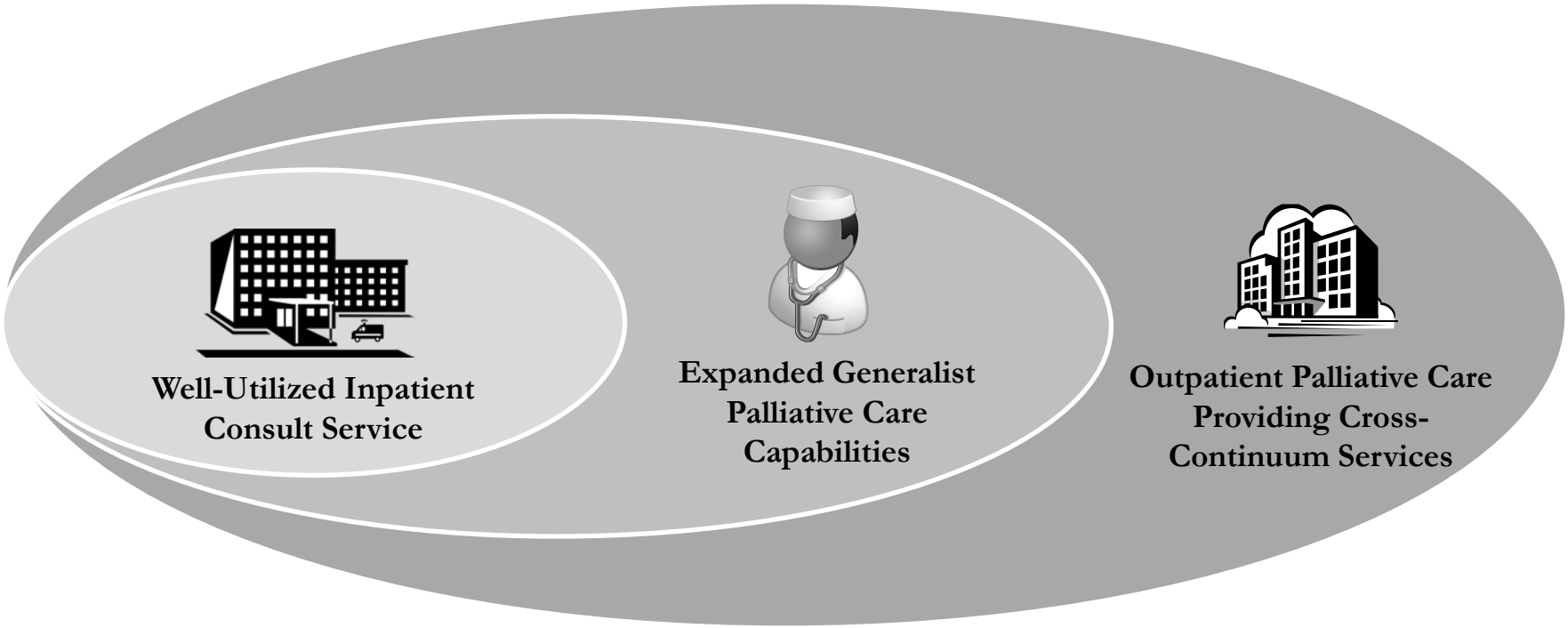
COST SAVINGS

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

Palliative Care Program Timeline



Increasing Number of Patients Served by Palliative Care Service



Increasing Value Gained through Palliative Care Service

Source: 2013 The Advisory Board Company