Enabling the Transition to Hospice through Effective Palliative Care

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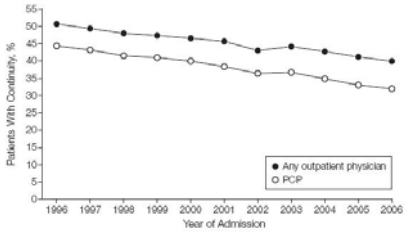
Objectives

- Identify continuity of care improvements to be realized by enhanced inpatient palliative care team/hospice collaboration
- Identify solutions to 3 common problems at the interface between hospital-based palliative care providers and hospices
- List 3 palliative care/hospice quality improvement opportunities

We Know Continuity of Care is the Goal….but What do the Data Tell Us?

Figure. Percentage of Patients Experiencing Continuity With Any Outpatient Physician or With Their PCP During Hospitalization, 1996-2006



PCP indicates primary care physician. $P<.001$ for both Cochran-Armitage trend tests for continuity with any outpatient physician or with a PCP. For all point estimates, the 95% confidence intervals are less than 0.6%.

Continuity of Outpatient and Inpatient Care by Primary Care Physicians for Hospitalized Older Adults

Gulshan Sharma; Kathlyn E. Fletcher; Dong Zhang; et al. *JAMA*. 2009;301(16):1671-1680

"Coordinating Care – A Perilous Journey through the Health Care System"

- 2005: 1/3 of pts with chronic illness and hospitalization had no post discharge follow-up arrangements
- Less than ½ of PCPs were provided discharge information / medications
- 3% PCPs involved in discussions with hospitalists re: pts d/c plans
- Infrequently notified that pt discharged

T. Bodenheimer, MD NEJM 358 March 2008

Discharge Summaries

25% never reached PCP

38% did not list lab results

21% did not list d/c meds

66% PCP contacted or treated pt before receiving discharge summary

T. Bodenheimer, MD NEJM 358 March 2008

Readmissions
What Do the Data Tell Us?

- 1 in 5 Medicare patients re-hospitalized within 30 days of discharge
- Half of these before seeing outpt MD
- Estimated cost 17.4 billion

Jencks, Williams, and Coleman
NEJM 2009, Vol 360, 1418-1428

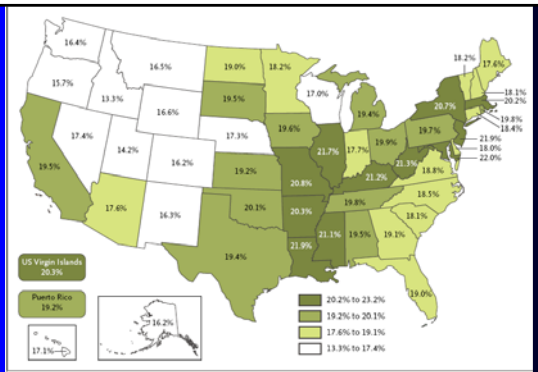


Figure 1. Rates of Rehospitalization within 30 Days after Hospital Discharge.
The rates include all patients in fee-for-service Medicare programs who were discharged between October 1, 2003, and September 30, 2004. The rate for Washington, DC, which does not appear on the map, was 23.2%.

Jencks, et al NEJM 360 April 2009

Table 2. Highest Rates of Rehospitalization and Most Frequent Reasons for Rehospitalization, According to Condition at

Condition at Index Discharge	30-Day Rehospitalization Rate	Proportion of All Rehospitalizations		
			Most Frequent	2nd Most Frequent
	percent			
Medical				
All	21.0	77.6	Heart failure (8.6)	Pneumonia (7.3)
Heart failure	26.9	7.6	Heart failure (37.0)	Pneumonia (5.1)
Pneumonia	20.1	6.3	Pneumonia (29.1)	Heart failure (7.4)
COPD	22.6	4.0	COPD (36.2)	Pneumonia (11.4)
Psychoses	24.6	3.5	Psychoses (67.3)	Drug toxicity (1.9)
GI problems	19.2	3.1	GI problems (21.1)	Nutrition-related or metabolic issues (4.9)

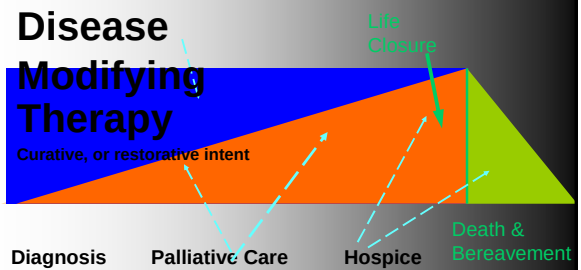
Opportunities to Improve the Continuum of Care….

- How can we get this patient the care s/he needs?
- How can we assure the availability of quality palliative care while also recognizing the pressure to limit/reduce hospital utilization?
- What options are available in my health care system or community?
- What payment mechanisms will exist to reimburse for services?

The Palliative Care – Hospice Continuum

How does it look?

A New Vision
Of the Care Continuum



Added Incentives for Hospital/Hospice Partnerships

The provisions of the Patient Protection and Affordable Care Act includes multiple incentives to:

- improve/extend community-based services
- avoid unnecessary hospitalizations
- finding cost-savings

3 Common Challenges at the Palliative Care/Hospice Interface

- Misunderstandings about what palliative care and hospice providers should expect from each other
- Limited or no communication at the time of hospital discharge
- Lack of clarity about what the ED can do when a hospice or hospice-eligible patient arrives at its doors

How do We Build a Better Hospice - Hospital-Based PC Partnership?

- Manage transitions between providers and sites of care to include:
  1. Rapid communication of each patient's plan of care
  2. Current/recommended medications
  3. Advance directives/preferences

What Should a Hospital Expect from its Hospice Partner?

- Prompt responses to requests for consults/referrals
- Interdisciplinary team support for the patient and the family
- Communication with a Medical Director
- On-call availability for emergent symptom management

Assessing the Quality of a Hospice Program

"Choosing a Hospice " – from the National Hospice and Palliative Care Organization:
www.caringinfo.org/LivingWithAnIllness/Hospice/ChoosingaHospice.htm

Teno, J and S Connor. Referring a Patient and Family to High-Quality Palliative Care at the Close of Life. JAMA. 301 (6) February 2009

What Should the Hospice Expect from its Hospital Partner?

- Consultation from the inpatient pc service about patients who may be appropriate for hospice care
- A status report on the plan of care and information about the patient's advance care plan preferences

What Should the Hospice Expect from the Hospital

- Timely, well-documented clinical discharge summaries including recommended medications *likely to be readily accessible in the outpatient setting*
- Telephone access to inpatient pc providers for feedback and follow-up
- Appropriate ED consultation as required

Hospital – Hospice Friction Points

- Who admits the hospice patient to the hospital?
  Hospitalist, PC Team, Inpt Hospice team
- Transfer of inpt PC patient to inpt Hospice
- Donations: Where does the $ go?
  To Hospice, Hospital, Inpt PC team?

Hospice patient in the ED: What Should the Hospital Do?

- Determine if the patient is currently enrolled on Hospice
- Call the Palliative Care Team to help determine next steps
- Notify the Hospice of the patient's ED status
- Understand that your hospital must have a written contract to deliver inpt services for hospice patients

3 Q/I PC/Hospice Opportunities

- Suggested management of ED Visits
- Reducing re-admissions
- Assuring informed patient choice

Suggested Management of ED Visits

- Include a question about hospice status on ED admission forms
- Call for a palliative care or hospice consultation when a patient's condition is such that decisions should be made about an advance care plan
- Provide the hospice partner with feedback about the circumstances that led to the ED visit.

Reducing Readmissions

- Target Frequent Flyers for Inpt PC or hospice consult
  CHF / COPD / Dementia Order sets
- Medication Reconciliation
- Facilitate Communication between settings
  Discharge summary, arrange appointment at d/c
  POLST - system wide order set

Case # 1 CHF

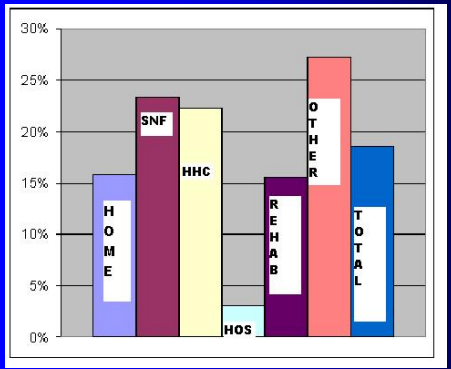
90 y.o. CHF, valvular heart disease, Afib, ICD, CRI.
Breast ca s/p rad therapy, bladder cancer, DJD, and osteoporosis with hip and lumbar fx's
6 admissions w/in last year for CHF exacerbation.
Palliative Care consult for goals of care discussion
Patient and family meeting established goal to maximize time at home and treat hip pain.
HC Proxy & DNR completed.
Patient referred to hospice at home and died at home 6 weeks later without readmission to hospital.

Clinical Recommendations Patients with Advanced Heart Failure

Consensus Statement: Palliative and Supportive Care in Advanced Heart Failure
Journal of Cardiac Failure Vol 10 No 3 June 2004

Medical Management	Diuretics, ACE, Beta-blockers Inotropes, CPAP, O2
Palliation of dyspnea, fatigue, & depression	
Advanced technologies	Ventricular Assist Device, ICD, Resynchronization
Communication	Advance Care Planning, Honest Communication about the course of HF Understand patient needs for information and address this concerns
Interdisciplinary supportive care	Concurrent supportive care and HF disease management
Structure of care	Seamless transitions of care
Hospice care	

Readmissions to Ellis Hospital



Source: IPRO

Medicine Reconciliation
Fewer medicines, better *Medicine*

Reported ADRs 1998 – 2005
160% increase 35,000 to 90,000
170% Fatal ADRs 5,000 to 15,000

Seniors
13% of population 34% total presciption use
> 5 meds red flag for risk of ADR

Schneider & Campese Arch Inter Med Vol 170 2010

Medication Reconciliation

Encourage the development of a plan to provide for symptom emergencies

Assuring Informed Patient Choice

POLST

Physician Orders

for Life-Sustaining Treatment

communication

documentation

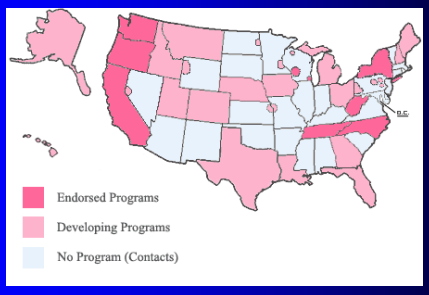
coordination

(across sites of care)

Core Elements of POLST

- Actionable medical orders
- Advanced, chronic progressive illness
- Limit or request all medically treatments
- Direction about resuscitation status
- Other types of intervention – future hospitalizations, tube feedings

POLST Paradigm Program



Paradigm of communication, documentation, and system responsiveness

POLST Paradigm Program September 2009 POLST.org

POLST Research findings

- Oregon (published studies 2000-2004)
  - Effectively communicates requests for DNR, comfort measures
  - Frail elderly make reasonable choices
  - Not all or none
- Oregon, W Virginia, Wisconsin
  - far less likely to receive unwanted hospitalization and medical interventions than are other patients.

Hickman, Nelson, et al JAGS July 2010

Palliative Care – Hospice Partnerships Additional Benefits

- Hospital culture
  - Staff support & education
- Assessment of care of deceased patients – positive outcomes
- Bereavement support to family
  - Routine post-death calls
  - Formalized support programs
- Hospital/Hospice recognition

Bodenheimer,T **Coordinating Care—A Perilous Journey through the Health Care System** NEJM. 358 (10) 2008.

CM Boyd, et al **Clinical Practice Guidelines and Quality of Care for Older Patients With Multiple Comorbid Diseases.** *JAMA.* 294 (6) August 2005 .

Choosing a Hospice National Hospice and Palliative Care Organization: www.caringinfor.org/LivingWithAnIllness/Hospice/ChoosingaHospice.htm

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Hickman, S et al. **A Comparison of Methods to Communicate Treatment Preferences in Nursing Facilities: Traditional Practices Versus the Physician Orders for Life-Sustaining Treatment Program** JAGS. 58 (7) July 2010.

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Mulligan, M et al. **Preventing Unnecessary Readmissions: Transcending the Hospital's Four Walls to Achieve Collaborative Care Coordination** The Advisory Board, 2010.

Selecky,P et al. **Palliative and End-of-Life Care for Patients With Cardiopulmonary Diseases American College of Chest Physicians Position Statement.** Chest.128 (5) November 2005.

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Medical Orders for Life Sustaining Treatment www.compassionandsupport.com