How Palliative Care and Hospice Can Help Hospitals Live with the Affordable Care Act

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Objectives

• Describe how in-patient palliative care can help hospitals to meet quality standards
• Discuss how palliative care might help to prevent frequent readmissions to the hospital.
• Describe how out-patient palliative care can be utilized upon hospital discharge.
Palliative Care
Interdisciplinary care that aims to relieve suffering and improve quality of life for patients with advanced illness and their families.

It is offered simultaneously with all other appropriate medical treatment. Focus is on management of symptoms and goals of care (not just pain management).

Who Provides Palliative Care?
- Who: hospital, hospice, nursing facility, insurance company
- Where: hospitals, out-patient clinics, nursing homes, community outpatient
- Possible team members – varies
Patient Protection and Affordable Care Act (ACA)
- Signed into law in 2010 – intended to expand coverage, control costs, and improve the quality of health care
- Hospitals will be affected by the cost control efforts, will need to follow standards of care, and patient satisfaction will be measured

CMS Need for Cost Control
- Top 5% of pts account for 50% of U.S health costs (top 1% - 22% of costs averaging $88,000 per year)
- CMS and insurers need to find ways to provide alternative care for the high utilizers of ER and hospital services; may need to consider other models of care (e.g. Accountable care organizations - ACOs)

Patient Satisfaction
Not measured by whether we follow standards of care and best practices and achieve good outcomes
- Good communication (doctors and nurses)?
- Pain managed?
- Medicine regimen explained?
- Clear discharge instructions?
- Responsiveness of staff to patient needs?
HCAHPS: How did we get here?

- "Hospital Consumer Assessment of Healthcare Providers and Systems"
- 2002 Development & Testing, Department of Health & Human Services
- October 2006 CMS implements HCAHPS Survey
- March 2008 First public reporting of HCAHPS
- 2005 Deficit Reduction Act creates additional incentive for acute care hospitals to participate in HCAHPS
- July 2007 Hospitals subject to the Inpatient Prospective Payment System (IPPS) must collect and submit HCAHPS data to receive full payment update or be subject to payment reduction of 2%
- 2010 Affordable Care Act strengthens incentive for IPPS hospitals by including HCAHPS performance in the calculation of the value-based incentive payment

HCAHPS

- Standardized survey instrument
- Measures patients' perspectives on hospital care
- 32 questions in length
- Administered to a random sample of adult inpatients between 48 hours and six weeks after discharge
- Patients admitted to medical, surgical and maternity service lines
- Hospitals must survey patients throughout each month of the year and achieve at least 300 completed surveys

HCAHPS

- Expressed Goals:
  1. Produce comparable data that allows objective and meaningful comparisons between hospitals on domains that are important to consumers
  2. Public reporting of the survey results to create incentives for hospitals to improve quality of care
  3. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of hospital care provided in return for the public investment
HCAHPS: 9 Key Topics

1. Communication with doctors
2. Communication with nurses
3. Responsiveness of hospital staff
4. Pain Management
5. Communication about medicines
6. Discharge information
7. Cleanliness of the hospital environment
8. Quietness of the hospital environment
9. Transition of Care

HCAHPS: Questions

- “How often” format: Always, Usually, Sometimes, Never

1.5. During this hospital stay, how often did nurses (doctors) treat you with courtesy and respect?
2.6. During this hospital stay, how often did nurses (doctors) listen carefully to you?
3.7. During this hospital stay, how often did nurses (doctors) explain things in a way you could understand?
13. During this hospital stay, how often was your pain well controlled?
14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?
19. During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
23. During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.
24. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.

HCAHPS: Reporting

- Publicly reported on the Hospital Compare Web site: www.medicare.gov/hospitalcompare
- Graphs:
  - % Patients who reported that their doctors “Always” communicated well
  - % Patients who reported that their pain was “Always” well controlled
  - Compared to state and national averages
What does Palliative Care (PC) and Hospice have to do with HCAHPS?

- PC/Hospice can help address some of the inherent challenges in dealing with complex medical patients
  - Pain Management
  - Non-Pain Symptom Management
  - Weighing Benefits and Burdens of proposed treatments
  - Difficulty in effectively communicating with patients and families about complex medical information
  - Transitions of Goals of Care
  - Transitions to other care models and/or settings
- These challenges are what HCAHPS evaluates

Our Patient-Centered goal?

- To make sure the Patient gets the right Services at the right Time in the right Place
- Requires:
  - Needs Assessment
  - Understanding of the stage of disease progression
  - Knowledge of the home/discharge setting

The Palliative Care Intervention

- Comprehensive Needs Assessment
  - Symptom management
  - Psychosocial or spiritual support
  - End-of-life planning
  - Post hospital care
- “Unit of care” = patient + loved ones
- Assist with patient/family’s interpretation of medical information
  - especially with regard to treatment options and prognosis
- Clarify Goals of Care
- Plan for disease progression
Palliative Care is Interdisciplinary

- “Interdisciplinary” ≠ “Multidisciplinary”
- Truly a “Team” approach
- Team: Nurse, Social Worker, Chaplain, Physician
- Regular “huddles” among team members

6 Core Features of a Palliative Care Consult¹

1. Assessment and management of physical symptoms
2. Assisting patients to identify personal goals for end-of-life care
3. Assessment and management of psychological and spiritual needs
4. Assessment of the patient’s support system
5. Assessment and communication of estimated prognosis
6. Assessment of discharge planning issues

Has anyone studied this?

- Yes!
- “Impact of an Inpatient Palliative Care Team”²
- Randomized Control Trial
- Journal of Palliative Medicine, 2008
- 517 patients, 6 month follow-up
- Randomized to Interdisciplinary Palliative Care Service (IPCS) vs. Usual Care
- Consultation, not primary, service
Impact of an Inpatient Palliative Care Team

**Findings:**
- Patients/Family surrogates reported improved satisfaction with the care experience and communication by medical team
- Measured via the MCOHPQ (Modified City of Hope Patient Questionnaire)
  - Pain management
  - Symptom relief
  - Psychological and Social Support
  - Discharge Planning
  - End-of-life Planning
  - Level of Caring and Respect felt from providers
  - Ease of understanding from providers
- Sounds a lot like HCAHPS!

Impact of an Inpatient Palliative Care Team

**Findings:**
- More Advance directives completed (91.1% vs. 77.8%)
- No difference in survival (Median = 30 days)
- Less readmission to ICU
- Less cost to system per patient ($4,855/patient)
  - *corrected for cost of staffing palliative care team

Impact of an Inpatient Palliative Care Team

**Findings:**
- Hospice:
  - Longer median LOS (24 vs. 12 days)
  - Median time to referral shorter (1 day)
  - % admitted to hospice did not differ
- No difference in symptom management
Impact of an Inpatient Palliative Care Team

• Improved Symptom Management demonstrated in other studies\textsuperscript{4,5}
  – Both pain and non-pain symptoms
• Improved insight of cancer patients into their disease\textsuperscript{6}
  – Sounds like HCAHPS #3, 7, 24:
    • “When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.”
    • “During this hospital stay, how often did nurses (doctors) explain things in a way you could understand?”

PC Integration into ICU\textsuperscript{3}

• Associated with:
  – Improved quality measures, like communication
  – Higher rates of AD completion (33\%-80\%)
  – Increased hospice utilization
  – Lower use of non-beneficial, life-prolonging treatments
• No change in survival time

Palliative Care’s Impact is Changing

• Consultation Numbers Increasing\textsuperscript{7}
  – Palliative Care Delivery System Task Force, West Virginia
  – 300\% Increase in PC consultation from the year 2000 to 2003 (#280 to 1087)
• Changing Reasons for Consultation\textsuperscript{7}
  – In year 2000:
    • Symptom Management – 37\%
    • Goal Clarification – 29\%
  – In year 2003:
    • Symptom Management – 20\%
    • Goals of Care Discussions – 57\%
Making the Connection

• Patients’ paths can cross Palliative Care and Hospice Services in a number of places
• Dependent on where the patient is in the trajectory of their illness
• Dependent on each patient’s individual goals of care

Making the Connection

• Hospice Referral if the Patient:
  – Has a life-limiting diagnosis
  – Prognosis likely ≤ 6 months
  – Goals consistent with a symptom-focused plan of care
• Palliative Medicine Referral
  • Inpatient
  • Outpatient

Readmissions Within 30 Days…

• Affects 18 - 20% of Medicare beneficiaries; $17 billion per year
• Beginning in 2012 hospitals were monitored for patients with coronary artery disease, heart failure, or pneumonia who came back to the hospital within 30 days of hospital discharge
• 66% of hospitals received a average penalty of 0.42% ($280 million) the first year
Readmissions Within 30 Days

- In October 2014 CMS will add COPD and elective hip and knee replacements to the diagnoses being monitored for readmissions.
- Financial penalties increased by 1% this year and will again increase next fiscal year.
- Hospitals are looking at EHR screening tools to help to identify patients at high risk for readmission.

Potential Causes of Avoidable Readmissions

- Hospital-acquired infections
- Premature discharges
- Failure to coordinate and reconcile meds
- Poor communication between patients, families, and healthcare workers
- Poor planning for healthcare transitions (there is an immediate and great need to develop collaborative relationships across care settings)

(Berenson et al. NEJM. 2012; 366(15): 1363-1365)

Factors Related to Readmissions

- Long term medication adherence was not associated
- Older age and longer length of hospital stay was associated with higher readmissions
- An office visit within 30 days of discharge helped to lower the readmission rate
Possible Interventions to Decrease Readmissions

- Better patient education - ?record discharge teaching for later review at home
- Transition nurses (up to 44% decrease in readmits)
- Earlier office follow-up
- Use of screening tools to identify high risk pts.
- Palliative care
- Other (different care or reimbursement models)

Patient Case #1

- 87 year old man with advanced diastolic right-sided heart failure; EF 35%.
- 2 hospitalizations in the last month for decompensated HF.
  - *Well enough to go home; still volume overloaded*
- Not far off from a subsequent rehospitalization
- DNR Status: full code
- PMH: previous lung cancer with pulmonary fibrosis, DM, COPD, PUD, Anemia, HTN, OA
- CC: R leg pain and dyspnea at rest

Palliative Care

1. APRN – medication/symptom management
   - Medication reconciliation post-hospitalization
   - Started Bumex 1mg qAM and 2mg qPM with cardiologist
   - Ongoing symptom management: *Fatigue, Anxiety, Dyspnea, Constipation, Pain*
   - Discussed goals of care: signed DNRCC-A
   - Weight record implemented

2. SW – psycho-social management
   - Assign DPOA-HC, discuss advance directives
Patient Case #2

- 60 y/o woman with CKD stage 4, not on dialysis.
- PMH: CVA, DM, neuropathy, hypothyroidism.
- Current meds: Gabapentin 300 mg PO BID; Aspirin 81 mg PO daily; Furosemide 40 mg PO daily PRN edema; Levothyroxine 50 mcg PO daily.
- DNR status: Full Code
- CC: nerve pain in her legs that is worse lately, especially at night. Increased irritability.

Palliative Care interventions

1. APRN – medication/symptom management
   - Change gabapentin 600 mg once daily instead of 300 mg BID (max dose for CKD Stage 4)
   - Add TCA for neuropathic pain and mood elevater
   - Discussed ESRD/dialysis
   - DNRCC eventually signed
2. SW – psycho-social management
   - Secured DPOA-HC
   - Procured diabetes management equipment in home

Patient Case #3

- 87 y/o woman with relapsing multiple sclerosis
- PPS 40, wheelchair-bound, slight dysphagia
- PMH: insignificant
- DNR Status: Full Code
- Medications: glatiramer (Copaxone) 40 mg SQ 3 times weekly, oxybutynin 5 mg PO TID, baclofen 5 mg PO BID, lorazepam 0.5mg PO q 6hrs prn anxiety.
- Chief complaint(s): shooting pain in legs, insomnia, depression
Patient Case #3

Palliative care interventions
1. APRN – medication/symptom management
   - Started Cymbalta with 3-4 week follow-up
   - DNRCC signed
2. SW – psychosocial management
   - DPOA-HC assigned
   - Transportation arranged
   - Backup caregiver plan arranged
   - Home safety assessment completed
   - Community resources to prevent isolation

Benefits of Palliative Care: The Evidence Base

- Reduced costs
- Improves quality of life, satisfaction for patients and families
- Eases burden on providers and caregivers
- Helps patients complete life-prolonging treatments
- Decreased hospital readmissions

(www.capc.org)

Home-based Palliative Medicine Consulting Service

- Used NPs with physician back-up for patients with advanced complex illnesses
- Resulted in significant decrease in total hospitalizations, total hospital days, total and variable costs, and 30 day readmissions.
- No effect of probability of an ER visit

A Review of the Evidence of the Impact of Out-patient Palliative Care

Four well-designed randomized interventions Outpatient pall care services were shown to:

• Improve patient satisfaction
• Improve symptom control and quality of life
• Reduce health care utilization
• Lengthen survival (in lung cancer patients)


Initiating Palliative Care Consultation in the ED

• Most palliative care consults are initiated after several days of hospitalization
• Patients who received PC consultation in the emergency room have shown increased pt. satisfaction and prevented admissions
• Wu et al. J Pall Med. 2013; 16:1362 – PC in the ED showed shorter LOS by 3.6 days

Inpatient Pall Care Consults and the Probability of Hospital Readmission

Comparison of Nurse vs. Interdisciplinary Team in a Kaiser Permanente hospital

• Both interventions decreased hospital readmissions at 6 months
• The pall care team intervention decreased readmission by 20%
• Potential savings per 100 patients of between $64,000 and $251,000.

Summary

- Inpatient palliative care can improve patient QOL, decrease pain and symptom burden, and enhance care coordination across sites
- Outpatient PC can help improve patient QOL, decrease readmissions, and improve collaboration with community physicians

Reference


Comments/Questions