PALLIATIVE CARE PROGRAM DESIGN: PUTTING THE PIECES TOGETHER

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PROGRAM DESIGN

**Learning Objectives**

- Describe attributes of palliative care models and how they might best fit within an organization.
- Outline palliative medicine programs in various health care settings.
- List steps that will position an organization to initiate or support partnerships improve access to palliative care.
WHAT’S WRONG WITH OUR SNF’S

- Lowest Satisfaction Scores of all health care agencies
- What do people want?
  - Loved one cared for, comfortable, dignity
- What do people get?
  - Regulatory: MDS 3.0 states declining weight and functional status as negative quality indicators
  - Financial: When a patient in a SFT is unwell, they can go to the hospital and the SFT will collect money for a bed hold, then the patient will qualify for a skilled need upon return.
  - Education: No required education for SNF staff on palliative care
- Result:
  - Goals not listened to or met
  - Excessive treatment when not desired by patient

PALLIATIVE CARE

What is it?
1. Pain & Symptom Management
2. Communication/Counseling
3. Care Planning
# PALLIATIVE CARE: PAIN & SYMPTOMS

## 1. Pain & Symptom Management
- **Sx’s:** Nausea, Anorexia, Anxiety, Delirium, Diarrhea, Dyspnea
- **Education:**
  - O2 and the Management of Dyspnea
- **Systems:**
  - Advocacy for opioid availability, including proper dosing forms

## PALLIATIVE CARE: COMMUNICATION

## 2. Communication
- Determining the Decision Maker or Process
- Facilitating decision making
- Determining Goals of Care
- Preferred Intensity of Care
- Delivering Bad News
- Prognostication

### Counseling
- Grief Counseling
- Anticipatory Guidance
- Parenting
- Depression
- Spirituality
COMMUNICATION: GOALS FIRST!

<table>
<thead>
<tr>
<th>Goals</th>
<th>Treatments</th>
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<tbody>
<tr>
<td>Cure</td>
<td>Mechanical Ventilation</td>
</tr>
<tr>
<td>Restore Function</td>
<td>CPR</td>
</tr>
<tr>
<td>Maintain Function</td>
<td>Electrical Cardioversion</td>
</tr>
<tr>
<td>Live Longer</td>
<td>Artificial Nutrition</td>
</tr>
<tr>
<td>Be at Home</td>
<td>Rehospitalization</td>
</tr>
<tr>
<td>Avoid Bankruptcy</td>
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<tr>
<td>See the birth of a grandchild</td>
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COMMUNICATION: GOALS FIRST!

- What do you call your problem [sickness]? What name does it have?
- What do you think has caused the problem?
- Why do you think it started when it did?
  - What do you think the sickness does? How does it work?
  - How severe is it? Will it have a short or long course?
- What kind of treatment do you think the patient should receive?
  - What are the most important results you hope she receives from this treatment?
- What are the chief problems the sickness has caused?
- What do you fear most about the sickness?

PATIENT EXPLANATORY MODEL

KLEINMAN
What do you call your problem [sickness]? What name does it have?
Qaug dab peg. That means the spirit catches you and you fall down.

What do you think has caused the problem?
Soul loss.

Why do you think it started when it did?
Lia's sister, Yer, slammed the door, and Lia's soul was frightened out of her body.

What do you think the sickness does? How does it work?
It makes Lia shake and fall down. It works because a spirit called a dab is catching her.

How severe is it? Will it have a short or long course?
Why are you asking us those questions? If you are a good doctor, you should know the answers yourself.

What kind of treatment do you think the patient should receive? What are the most important results you hope she receives from this treatment?
You should give Lia medicine to take for a week but no longer. After she is well, she should stop taking the medicine. You should not treat her by taking her blood or the fluid from her backbone. Lia should also be treated at home with our Hmong medicines and by sacrificing pigs and chickens. We hope Lia will be healthy, but we are not sure we want her to stop shaking forever because it makes her noble in our culture, and when she grows up she might become a shaman.

What are the chief problems the sickness has caused?
It has made us sad to see Lia hurt, and it has made us angry at Yer (Lia's older sister).

What do you fear most about the sickness?

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PALLIATIVE CARE: CARE PLANNING

**Personalized Care:**

1. Recommend treatment plans to match goals
   - Don’t recommend treatments that won’t accomplish stated goals.

2. Facilitate Continuity of Care Plan Across Settings
   - Discharge Planning / Case Management
   - Clear documentation
   - Rational DNR/LLST Orders
   - POLST
Harvard Oncology Group Study

Patients who received Palliative Care:

- Less Depression
- Less Chemotherapy
- Less Hospitalization
- More Likely to Die at Home on Hospice
- More likely to be DNR
- Higher Quality of Life
- *Life Expectancy:

  2.7 months longer!!!
PALLIATIVE CARE: EXPERTISE

- **Physician:** Board Certified Specialty (same as Cardiology, etc)
- **Nurse:** HPNA, Hospice & PC Certification. ELNEC Training
- **Chaplain:** Clinical Pastoral Education, Board Certification
- **Social work:** Palliative Care Certification
- **Administrator:** Certification (NHPCO)

PALLIATIVE CARE: THE TEAM

<table>
<thead>
<tr>
<th>Interdisciplinary Team</th>
<th>Multidisciplinary Group</th>
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<tbody>
<tr>
<td>Unique model in healthcare:</td>
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<tr>
<td>- One Care Plan organized by patient issue.</td>
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<td>- Shared accountability for all issues.</td>
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<tr>
<td>- Flat</td>
<td></td>
</tr>
<tr>
<td>- MD, RN, LVN, NP, LCSW, Chaplain, Admin., Volunteer, Pharmacist</td>
<td>- Parallel Play</td>
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<tr>
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<td>- Individual care plans organized by specialty</td>
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<td>- Hierarchical, with a physician “In charge”.</td>
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<td>- Minimal shared accountability amongst group members for individual patient outcomes</td>
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GETTING STARTED: What we know....
- Standard of Care: 80% of hospitals >200 beds have programs
- Joint Commission Certification → Regulation
- Higher Patient Satisfaction
- Lower Hospital Costs by Reducing unnecessary tests
- Reduced ICU LOS
- Greater Provider Satisfaction
- Higher Quality (pain scores, patient satisfaction)
- Lower Readmission Rates

DOMAINS OF QUALITY PALLIATIVE CARE
- Domain 1: Structure & process
- Domain 2: Physical
- Domain 3: Psychological & psychiatric
- Domain 4: Social
- Domain 5: Spiritual, religious & existential
- Domain 6: Cultural
- Domain 7: Care of the imminently dying patient
- Domain 8: Ethical and legal
IMPLEMENTING PALLIATIVE CARE: ORGANIZATIONAL GOALS

- Best Practices
- Cancer Center
- Reduction in readmissions
- Health Care Proxy Identification
- Commitment to MAGNET status
- Commitment to NICHE program
- Improved patient satisfaction focus on pain management
- Pay for performance incentives-BCBS hold back
- The Joint Commission
- Commitment to ASCO Excellence
- Commitment to National Consensus Project Clinical Practice Guidelines for Quality Palliative Care
- Commitment to National Quality Framework

IMPLEMENTING PALLIATIVE CARE: PHYSICIAN GOALS

- Increased patient satisfaction
- Better actual care for patients
- Risk Avoidance
- Save Time
- Save Time
- Save Time
STRATEGIC PLANNING: SITUATION ANALYSIS

External:
- Literature Review
- Political, Economical, Sociological and Technological Analysis (PEST)

Internal:
- Brainstorming
- Performance Review
- Opportunities and Obstacles to Development (O & OD)
- Service Delivery Survey
- Self Assessments
- Problem Tree or Logic Model
- Stakeholder Analysis
- SWOT/C

PALLIATIVE CARE: NUTS AND BOLTS
CONTINUUM OF CARE

- Inpatient Consult Service
- Geographic Palliative Care Ward
- Outpatient Clinic
- Home Visits
  - Home Health
  - Transition “Bridge” Programs
  - Hospice
- Hospice
  - Routine
  - General Inpatient
  - Respite
  - Continuous Care
### INPATIENT PC MODELS

<table>
<thead>
<tr>
<th>Requires</th>
<th>MD Consult</th>
<th>Team Consult</th>
<th>Geographic</th>
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<tbody>
<tr>
<td>Nurse trained in Hospice/PC principles with MD as backup</td>
<td>Strong MD Consultant</td>
<td>More FTE's (more $)</td>
<td>FTE's, 24/7 coverage, management, scheduling, and program planning</td>
</tr>
<tr>
<td>Advantages</td>
<td>Rapport with MD's</td>
<td>More optimal Interdisciplinary care</td>
<td>Control quality, consistency of staff and orders</td>
</tr>
<tr>
<td>Dis-advantages</td>
<td>Limited expertise, Rn's can't do “consults”</td>
<td>Must find a qualified clinician</td>
<td>Expensive while starting up</td>
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<td>Fear of the “Death Ward” stigma</td>
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### DEVELOPMENT OF PALLIATIVE CARE IN 3 DIFFERENT SYSTEMS

1. Private NFP Catholic Hospital (400 beds)
2. Academic County Hospital (600 beds)
3. State District Public Hospital (350 beds)
CATHOLIC HOSPITAL

- Private, NFP Catholic Hospital
- Part of a large Catholic Health Care System of >50 Hospitals

When: 2005
Why:
- Altruism
- Concern over Quality of EOL Care
- Corporate Directive
- Hospitalist request
- Reduce ICU LOS

CATHOLIC HOSPITAL

Strengths:
- Strong Administrative Champions; CMO (critical care) & CNO former oncology nurse
- Hospitalist advocacy; ( Desired help with difficult families and with optimizing discharge planning for dying patients)
- Fellowship trained MD specialist and RN/PHD Ethicist
- Hospital owned a hospice

Weaknesses:
- Historically Poor MD/Hospital relationship
- Fractured medical community. Many small groups.
- No outpatient clinic available for PC.
- Hospice and hospital have poor collaboration dynamics

Opportunities:
- ICU & Medical Wards, referrals from hospitalists

Threats/Challenges:
- Hospice (threatened by PC physician’s increasingly complex care plans)
- ICU Nurses threatened; “Don’t need help”
- LCSW’s threatened that PC was doing their job.
- Oncologists that view PC as a threat to their plans for treatment.
CATHOLIC HOSPITAL: START UP

- Placed under the Oncology Service Line (where hospice was also located)
- MD Consult model to start
  - Build on strongest clinician
  - Meet the immediate needs of the biggest advocates, the hospitalists
  - Did not assume care for any patient; consultant only
- System of care
  - PC physician worked to create comfort care order set
  - ICU nurse-driven Care & Communications bundle
  - Re-wrote the DNR order set and policy to a more useful paradigm consistent with POLST
  - Wrote ICU palliative extubation protocols
  - Brain death policy
- Education
  - RN/PHD PC nurse implemented ELNEC
  - Extensive PC introduction became part of every new nurses orientation

CATHOLIC HOSPITAL: TODAY

- 2 MD’s, 2 Rn’s, part time chaplain, administrator
- 1,500 consults/year, from all parts of the hospital and all specialties
- ICU Care & Communications Bundle
  - Regular family meetings
  - More clear documentation of decision maker, goals of care and treatment preferences
  - Significantly fewer outliers
- PC MD is now also the Hospice MD providing better continuity
- Created “Partners in Care” bridge program with the home health agency
- PC Unit to open in the next few months
## ACADEMIC COUNTY HOSPITAL

- **600 beds. 90+ ICU beds.**
- **UCSF medical school affiliated. Multiple residencies and fellowships**

### WHY PC?
- Administrative effort to Decrease ICU LOS and Decrease readmissions.

## ACADEMIC COUNTY HOSPITAL

### Strengths
- FP Department supported 3 faculty to get training in PC and staff the service.
- Hospital paid for 3 FTE's (Rn, Rn, SW) to start.

### Weaknesses
- FP faculty not able to gain credibility in the ICU.
- Lack of expertise.
- Low reimbursement for physicians, not enough to meet their salary.
- No hospice affiliation.

### Opportunities
- FP faculty staff 2/5 medicine teams.
- ICU medical director very supportive...if other staff aren’t.

### Threats/Challenges
- Paying for the faculty time.
- Gaining credibility in the ICU.
ACADEMIC COUNTY HOSPITAL

**Strategy:** Started with inpatient team consultation model
- Paid a PC expert consultant to assist with developing the PC service.
- Medical floor consultation growth by aggressive attention to customer service
- Metrics on hospitalization rates after PC inpatient consultation
- Collect collections and compensation data for faculty and present to hospital administration.
- Train an ICU nurse clinical leader to be the PC liaison
  - This role developed into a 3rd RN FTE for the PC team placed full time in the ICU.
- ICU PC RN putting together the care & communications bundle
- Wrote comfort care order set, ICU palliative extubation, brain death, and DNR policies.
- Aggressive education to house staff.
- PC faculty affiliated with 2 community hospices to facilitate better transitioning of care.

STATE DISTRICT HOSPITAL

- 350 beds. Non-teaching. Only large hospital in the poorest county in California. MD staff disproportionate amount of J-1, foreign medical graduates. No major medical group. No hospitalists—primary care docs care for their own patients—and rarely refer to consultants.

**Why start PC?**
- Limited resource hospital, need to lower ICU LOS and expedite discharges for end of life patients.
- Reduce number of SNF patients dying in the E.D.
### Strengths:
- Hospital/hospice partnership in place
- PC board certified physician available
- Strong ICU nursing support.

### Weaknesses:
- Primary MD’s and oncologists won’t refer. Doctor-centered care.
- Administration “vision”
  - Confuse palliative care (team based care) with palliative medicine (the physician specialty). Did not see the need for a PC “Team”.

### Opportunities:
- ICU; Tremendous support from ICU Rn’s, SW and medical director

### Threats / Challenges:
- Lack of referrals. Sustaining the PC physician’s practice.
- Administration inflexibility

### STATE DISTRICT HOSPITAL

#### Strategy:
- Started with MD consult model (only one administration would support).  
  - Stipend for administrative duties  
  - Physician does own billing  
- PC physician began by rounding daily in the 25 bed ICU.  
- PC physician also worked with the hospice for extra income, and to assist with better transitions of care.

Model failed!!!
- PC physician’s referrals did not sustain him. Recruited away by another facility. No other PC physician to fill the role.
- Hospital focusing now on order sets, education, and care & communications bundle to work on systems of care while they recruit another PC physician and plan to hire 1 RN and 0.5 SW as well to work around the primary physician’s aversion to request physician consultation.
SUMMARY

- Describe attributes of palliative care models and how they might best fit within an organization.
- Outline palliative medicine programs in various health care settings.
- List steps that will position an organization to initiate or support partnerships improve access to palliative care.

THANK YOU