IMPROVING GENERALIST PALLIATIVE CARE
FOR HOSPITALIZED SERIOUSLY ILL PATIENTS

A RESOURCE GUIDE FOR HOSPITAL ADMINISTRATORS
AND OTHER STAFF CHARGED WITH REDUCING INPATIENT MORTALITY,
READMISSION REDUCTION, AND IMPROVING PATIENT SATISFACTION.

Provided by
The Palliative Care Network of Wisconsin
www.mypcnow.org

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EXECUTIVE SUMMARY

Improving the ability of clinicians to help seriously ill patients identify their personal goals is a key step towards improving patient centered care and associated hospital metrics: inpatient mortality, satisfaction, and readmissions. The communication skill necessary to accomplish this task in the inpatient setting is known as the Goal of Care Conversation (GOCC), aka Family Meeting (see glossary). To improve generalist clinician communication skills and embed these conversations as a routine aspect of care for seriously ill patients requires changes to the system of health care delivery, aka systems change: patient screening, new care standards, clinician training, documentation standards, and quality improvement.

KEY STEPS

The necessary steps to implement a program that will enhance GOC conversations and documentation include:

A. Making the case for change
B. Developing a plan
C. Patient screening
D. Embedding Goal of Care Conversations into routine care
E. Clinician Training
F. Quality Monitoring
G. Transition Management
H. Measuring Impact

KEY STAFF

At a minimum, the following should be engaged to help develop and oversee project planning:

- Chief Medical, Nursing and Quality Officers
- Information Services (EMR)
- Hospitalist Program Director
- Palliative Care Director
**Timeline**

- Convene Workgroup
- Gather Data on Need for Change
- Complete Action Plan
- Develop New Standards
- Develop EMR Documentation Template
- Develop Outcome Metrics Plan
- Organize/Provide Clinician Training
- Develop/Test Quality Improvement Plan
- Gather Outcome Metrics

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Glossary

Advance Care Planning (ACP)
Advance Care Planning is making decisions about the care you would want to receive if you are unable to speak for yourself. The decisions are based on your personal values, preferences, and discussions with your loved ones. Advance Care Planning includes completing a state-approved legal document that designates a surrogate decision maker. Completing an ACP document is appropriate for all healthy adults.

Advance Directive (AD)
An Advance Directive is a document that allows you to spell out your decisions about end-of-life care ahead of time. Each state has its own approved state AD form; there are other documents that are legal in multiple states, such as Five Wishes ® https://www.agingwithdignity.org/five-wishes.php.

Power of Attorney for Health Care (POAHC)
A POAHC, also known as a health care agent, is someone legally designated to make decisions for a patient who has lost decision-making capacity.

Physician Orders for Life Sustaining Treatments (POLST)
The POLST Paradigm was developed as a standardized, advance care planning document to be completed by health care professionals, together with a patient or surrogate decision-maker. The POLST form translates the values expressed in an advance directive into immediately active medical orders which do not require interpretation or further activation. POLST is designed for seriously-ill adults or those who are medically frail; POLST forms are legal in many, but not all states.
GOALS OF CARE CONVERSATION (GOCC) AKA “THE FAMILY MEETING” (APPENDIX 1)
Patient-centered goals of care are physical, social, spiritual or other patient-centered goals that arise following an informed discussion of the current disease(s), prognosis, and treatment options. These conversations typically occur at major decision points in a serious illness. For example, at the time of disease progression after cancer chemotherapy, or sustained deterioration in functional capacity in chronic heart or lung disease despite maximal medical therapy. In this document, this process is referred to as Goals of Care Conversation or GOCC.

PALLIATIVE CARE/MEDICINE
Palliative Care is specialized medical care for people with serious illnesses. It focuses on providing patients with relief from the symptoms and stress of any serious illness. The goal of palliative care is to improve quality of life for both the patient and the family. There are no restrictions on when in the course of a serious illness palliative care services can be provided.

Primary or Generalist-Level Palliative Care
Basic services in pain and symptom management, communication, prognostication, and future planning provided by all clinicians who care for seriously ill patients.

Specialist Level Palliative Care
Palliative care services provided by clinicians Board Certified in Palliative Medicine/Care *; specialists are best engaged for patients and families with complex pain and symptoms, complex decisions, complex communication encounters and complex disposition planning. Specialist services can be available in inpatient and outpatient/community settings.

* Board Certification is available for physicians, nurses, social workers and chaplains.
**Introduction**

Far too many patients, with one or more chronic life-limiting diseases, die as hospital inpatients due to poor clinician-patient communication. In particular, the following issues are often not discussed:

- The nature of the illness including natural history and realistic prognostic estimation
- Care options including the option of shifting from life-prolonging to comfort care
- An understanding of patient-centered care goals
- Future medical care and disposition options matching patient-centered goals.

Although specialist palliative care teams can have dramatic positive impacts (see The Advisory Board reference below), there are not enough palliative care specialists to meet all the needs of serious ill patients. Thus, hospitals wishing to improve the patient experience and improve key metrics (readmission, mortality, satisfaction), need to foster clinician training and systems changes to support generalist clinicians assuming a greater role in clarifying patient-centered goals for most patient situations, reserving specialist palliative care clinicians for truly complex problems.

**Root Causes**

Barriers to clinicians’ leading patient-centered goals-of-care conversations (GOCC):

- Little training in communication skills
- Personal and professional attitudes that impede honest communication (e.g. fear that discussing prognosis will lead to anger or premature death)
- Fear of malpractice if the clinician fails to “do everything”
- Poor reimbursement for communication encounters
- Lack of policies/standards that guide best practice around communication encounters and documentation.

The impact of communication insufficiency results in a failure to plan for future medical events, resulting in:

- Uncertainty, anxiety and unnecessary suffering by patients and family
- Avoidable Emergency Department and ICU admissions
- Prolonged hospital and ICU length of stay
- Excessive use of non-beneficial medical interventions
- Excessive non-reimbursable costs to hospitals (care exceeds DRG payments)
- Moral distress among hospital staff / staff turnover.
**BETTER OUTCOMES**

A 2013 report from the Advisory Board Company compiled research data that supports the benefits of hospital palliative care programs to improve quality, lower cost, and improve patient satisfaction (Advisory Board Physician Executive Council: Realizing the Full Benefit of Palliative Care, 2013.) Improving staff communication, coupled with system changes designed to support patient-centered care, can lead to:

- Improved patient satisfaction/ Reduced inpatient mortality
- Reduced preventable re-admissions
- Improved clinician competence/ self-confidence in conducting conversations with seriously ill patients and their families
- Reduced uncompensated direct (variable) hospital costs

By helping generalist clinicians improve their skills in conducting and documenting patient-centered Goal of Care Conversations (GOCC), hospitals can expect measurable improvements in key outcome metrics. This resource guide was developed following a successful multi-year education and systems change project at Aurora West Allis Medical Center in Milwaukee Wisconsin. The guide provides tools, resources and technical advice to improve and measure care that centers on identifying patient-centered goals. It is expected that each hospital will adapt the information in this guide to meet its own local needs and culture.

### NATIONAL QUALITY FORUM PALLIATIVE CARE MEASURES RELEVANT TO THIS GUIDEBOOK

**Documentation**

- Palliative and end-of-life care: percentage of patients with chart documentation of preferences for life sustaining treatments. 2010 Jan. NQMC:007590

- Palliative care for adults: percentage of patients who have treatment options, patient goals and a plan of care across care continuum documented. 2013 Nov. NQMC:009352

- Intensive Care unit (ICU) palliative care: percent of patients who have documentation in the medical record that an interdisciplinary family meeting was conducted on or before Day Five of ICU admission. 2006 Sep. NQMC:002702

**Education**

- Palliative Care For Adults: Percentage Of Clinicians Who Have Education And Training Regarding Palliative Care Concepts. 2013 Nov. NQMC:009348

- Palliative Care For Adults: Percentage Of Clinicians Who Have Training In The Use Of Scripting For Palliative Care Discussions. 2013 Nov. NQMC:009349
BUILDING BLOCKS TO IMPROVE CARE
A. MAKING THE CASE FOR CHANGE

B. DEVELOPING A PLAN

C. PATIENT SCREENING

D. EMBEDDING GOAL OF CARE CONVERSATIONS INTO ROUTINE CARE

E. CLINICIAN TRAINING

F. QUALITY MONITORING

G. TRANSITION MANAGEMENT

H. MEASURING IMPACT
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