Improving Key Hospital Metrics through a Generalist Palliative Care Initiative

Aurora West Allis Medical Center
Learning Objectives

➔ List four key steps of a palliative care systems-change initiative in a community hospital.

➔ Describe three elements of clinician education necessary to teach Goals of Care conversations.

➔ Describe potential benefits from an education and systems change initiative focused around goals of care.
Specialist Palliative Care: Outcomes

- Reduced time to symptom relief
- Improved patient and family satisfaction
- Earlier hospice referral
- Reduced readmissions/inpt. mortality
- Reduced ICU days
- Reduced hospital $ loss
But, there is still work to be done…
Problems

➔ Poor Advance Care Planning
  ➔ “Frequent flyer” ED visits and hospital admissions
  ➔ ICU terminal admissions/
      Avoidable inpt. deaths
➔ Too much: “*its not time for palliative care*”
➔ Not enough specialists
➔ Generalists abdicating their role
Meeting the Need …

Specialty Palliative Care
Truisms

✔ The real work of the future is to improve care decisions long before the “terminal” admission.

✔ There will never be enough palliative care specialists.

✔ Improving the work of generalist clinicians is essential to a broad based movement to improve patient-centered care.
Who are generalists?

- Primary Care, Oncologists, Hospitalists, Pulm/CC, Nephrology, Neurology etc.
- Ward/ICU/ED/Clinic nurses
- Unit social workers/DC planners
- Hospital chaplains
Case Study

➤ Aurora Healthcare
  – Largest health system in Wisconsin/Northern Illinois
  – 15 hospitals
  – 6 hospitals w/ palliative care clinicians/programs

➤ Aurora West Allis Medical Center (AWAMC)
  – Second largest system hospital - 350 beds
  – Specialty Palliative Care since 2010
Impetus

➔ Palliative Care staff came to Chief Medical Officer
  – Failure to Plan
  – Preventable Suffering
  – Poor Advance Care Planning

Resulting in ....
Mortality Review: 50 charts

✓ No screening of patients at high risk for unmet palliative needs
✓ Too many ICU deaths
✓ Comfort care orders written < 24 hours from death
✓ Goals of care discussions not completed early in the stay
✓ Advance directives completion poor
✓ DNR orders not always followed
✓ System failures
What was Broken?

- Poor communication skills
- Lack of accountability

Failure to Plan

Suffering

LOS/ICU deaths/Inpt. Mortality
CMO and CQO agreed: A New System was Needed!
Solution

- Improve communication skills
- Hold staff accountable

Timely Planning

Suffering

LOS/ICU deaths/Inpt. Mortality
Current System

Referral Based Palliative Care

Clinician Referral

Clinic
Consult Service
Inpatient Unit
Home-care
The Goal: Patient Centered Approach

All patients assessed

Palliative Care needs met by generalists

Specialist services as needed
Project Team

➔ Tim Jessick - Palliative Medicine physician
➔ Kay Fischer - Palliative Medicine APRN
➔ Andy McDonagh - CMO
➔ Suzie Feuling - Director of Quality
➔ Rick Keller - President AWAMC
➔ Medical Executive Committee
➔ David Weissman - Consultant
Generalist Focus

➔ Hospitalists
➔ Emergency Room Physicians
➔ Others
  – Oncology
  – Cardiology
  – General Surgery
  – Case managers
The Approach

➔ Senior leadership engagement
  – Medical Executive Committee

➔ Data driven
  – Case review
  – Frequent, consistent feedback
  – Ongoing assessment of outcomes, risk and harm

➔ Literature based best practices
  – Focus on variation and effect on the patient
Generalist Education

- Ethics
- Communication Skills
- Psycho-Social-Spiritual Family Care
- Community Resources/Hospice
- Pain and Symptom Management
What to teach?

➔ Teaching focused on communication skills for generalists:

– Primary focus on the *Goals of Care Conversation* (GOCC)

– **Supporting information**

– Goal: not perfection
  
  • Awareness of personal attitudes
  
  • Awareness of personal deficiencies
  
  • Awareness of an organized step-wise approach
Goals of Care

Prognosis

Counseling Skills

Conflict

Giving Bad News

Basic Communication Skills
Training Principles

➔ Small group learning environment (< 20)
➔ Time to discuss personal attitudes that impede communication w/ cognitive re-framing
➔ Time to practice different words using role playing
  – Focus on microskills
➔ Didactic information:
  – ethics and legal issues, advance directives, prognostication, hospital policies.
## Agenda/5 hours

<table>
<thead>
<tr>
<th></th>
<th>Role Play</th>
<th>Readings/Group discussion</th>
<th>Group Discussion</th>
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<tbody>
<tr>
<td><strong>Giving Bad News</strong></td>
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<td>Prognostication: cancer and non-cancer factors</td>
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<td>Decision Making Capacity</td>
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<td>Advance Directives: clinical responsibilities/protections</td>
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<td>Informed consent: emergency exception</td>
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<td>Hospital policies</td>
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<td>Family Goal Setting meeting-Part 1</td>
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<tr>
<td>Family Goal Setting meeting-Part 2</td>
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<td><strong>Conflict management</strong></td>
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<td><strong>DNR/CPR</strong></td>
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Logistics

➔ Getting Buy-In
  – Trained the Medical Executive Committee
    • Internists, Surgeons, ED, Cardiology, Ortho

➔ Roll-Out
  – >70 hospitalists, ED physicians, specialists
  – Case managers, CNS’s,
  – CNO, CMO, Director of Quality
Logistics

➔ First, Medical Executive Committee members volunteered for the course; then …
➔ CMO, CNO and hospitalist Medical Director required the hospitalists, case managers and nurse leaders to take the course
➔ Funding split between hospital administration and the medical staff
➔ CME- 20 Performance Improvement credits
Participant Comments

“Every clinician should go through this.”

“This is the first time I’ve ever been taught a structured step-by-step approach.”

“It takes time to practice different words and find what works.”

“I hate role play, but I have to admit, it is the only way to learn how to do this better.”
Physician Follow-Up

➔ Two, one hour mentoring sessions for Hospitalists
  – Observed goals of care discussions

➔ Assistance in documentation
  – Implemented goals of care template

➔ Chart review
  – Looked for presence of and quality of the goals of care notes
Additional Education

• Pain 101 classes provided to house-staff
  – Two, 1 hour classes

• Code status 101 course provided to house-staff
  – 30 minute course

• Social Work advance care planning classes
  – *Respecting Choices™* model taught to all social workers as a baseline
Guiding Principle

Education + System Changes → Improved Outcomes
Embedding the GOCC into Practice

- Standard of Care
- Who/When GOCC
- Documentation/EMR
- Quality Monitoring
Systems Changes

➔ Quality Improvement
  – Quality Department reviews charts monthly for completion of GOC discussions and advance directive completion
  – Weekly Mortality Review Committee: missed opportunities
  – Peer review for outliers

➔ Care Coordination
  – DNR bracelet project
  – Coordination with two Skilled Nursing Homes
  – Coordination with the ED
Systems Changes

➔ Education
  – Required Hospitalist Training: GOCC

➔ Standards and Documentation
  – All patients (hospitalist service) have goals of care discussions-requirement
    • Required documentation of GOCC
    • New EMR Template for GOCC
Goals of Care Template

1. *Does the patient have an AD?*

2. *Is the patient decisional?*

3. *What is the patient’s code status and rationale?*

4. *What are the Goals of Care?*
Goals of Care
Documentation Example

➔ **Advance directives:**
  – HCPOA in EMR; Daughter is POA. DNR/DNI; Rationale: Poor prognosis, family preference

➔ **Decisionality:**
  – Patient is not decisional

➔ **Goals of Care:**
  – 85 y/o with DM, dementia and weight loss, with new infection, possibly sepsis; patient very likely to die within 12 months.
  – POA wants to try antibiotics and fluids to reverse infection. Re-evaluate progress and goals with family q24 hours.
Mortality Review Committee

**Mission:** Capture quality data, implement new standards, and improve care by identification of system failures.

➔ CMO, Director of Quality, Risk Manager, Hospitalist, Palliative Medicine Physician, Director of Case Management, Pharmacist, Quality data personnel

➔ Weekly review of deaths

➔ Evaluation missed opportunities
### Mortality Review Worksheet

<table>
<thead>
<tr>
<th>Question</th>
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<tbody>
<tr>
<td>At the time of admission, was death within 6 months a likely outcome?</td>
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<tr>
<td>At the time of admission, was death likely during this admission?</td>
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<tr>
<td>Were there missed opportunities to prevent this inpatient death?</td>
</tr>
<tr>
<td>Which of the following may have helped prevent this inpatient death?</td>
</tr>
<tr>
<td>• Better communication to establish patient centered goals—</td>
</tr>
<tr>
<td>• Greater emphasis in resolving conflicts over care goals--</td>
</tr>
<tr>
<td>• Better attention to preventable complications: e.g. falls, infections, medications, bed sores, blood clots</td>
</tr>
<tr>
<td>Was the lack of an advance care planning document a contributing factor to this inpatient death?</td>
</tr>
<tr>
<td>If the patient was admitted to an ICU, was ICU admission an appropriate site of care relative the patients condition and prognosis? In other words, could ICU care realistically be expected to meet the patient-defined goals of care?</td>
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<tr>
<td>Should this case go to Peer Review?</td>
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Project Results

Control: Aug 2013-March 2014

Project Start: April 2014
## Outcomes

<table>
<thead>
<tr>
<th>Outcome Metrics</th>
<th>Outcome</th>
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<tbody>
<tr>
<td># Inpatient Deaths</td>
<td>↓</td>
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<tr>
<td># and % of ICU deaths</td>
<td>↓</td>
</tr>
<tr>
<td>LOS Inpatient deaths</td>
<td>↓</td>
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<tr>
<td>SNF to Hospital Readmissions</td>
<td>↓</td>
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<tr>
<td>Code 4 Calls</td>
<td>↓</td>
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<tr>
<td>Admission within 30 days of terminal admission</td>
<td>↓</td>
</tr>
<tr>
<td>ED visits within 30 days of terminal admission</td>
<td>↓</td>
</tr>
<tr>
<td>Hospice Referrals</td>
<td>↑</td>
</tr>
<tr>
<td>HCAHPS Scores</td>
<td>↑</td>
</tr>
<tr>
<td>Documentation of GOC discussion</td>
<td>↑</td>
</tr>
<tr>
<td># Completed Adv. Directives</td>
<td>↑</td>
</tr>
<tr>
<td>Comfort care orders within 24 hrs of admission</td>
<td>↑</td>
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</tbody>
</table>
In-Patient O:E Mortality

Observed to Expected ratio


0.72
Inpatient Deaths

Deaths/Admissions

- 2014: 1.20%
- 2015: 0.80%
Discharge Volume Trend

- Hospice or Home Hospice
- Expired

Linéar (Hospice or Home Hospice) Linéar (Expired)
Length of Stay-Deaths

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<tbody>
<tr>
<td>Mean</td>
<td>6.4</td>
<td>4</td>
<td>3.9</td>
<td>3.7</td>
<td>4.3</td>
<td>4.9</td>
<td>4.3</td>
<td>4.5</td>
</tr>
<tr>
<td>Median</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2.5</td>
</tr>
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% Deaths with Comfort Orders written within 24 hours of Admit

Goals of Care Training
% Deaths with AD on Chart

% Deaths in the ICU

![Graph showing percentage of deaths in the ICU from 2014 to 2015 with fluctuating values.]
% 30 day readmissions
Positive Data Led to …

RECOMMENDATIONS to Med Exec Committee

➔ Care process: screen all hospitalized patients for unmet ACP / Palliative care needs

➔ Standard practice: GOALS of CARE Discussion and Documentation
  – Floor patient – 24 hr. or by the first progress note.
  – ICU patient – at the time of admission

➔ Standard practice: CODE Status discussion and documentation – at the time of admission

➔ Streamline process: rapid escalation of cases to Ethics committee for resolution of care conflicts / unclear goals of care
Future

➔ Screening all patients admitted for unmet needs (not just hospitalist service)
➔ Follow-up training (Reinforcement) for the hospitalists
➔ Three more Aurora hospitals adopting training.
Take Home Messages

➔ You need top down support
  – CMO and CQO are critical
➔ Be patient, system change takes time and dogged persistence
➔ Be adaptable, but hold on to key fundamentals
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
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