

Hospital Palliative Care Advisory Group

June 2, 2015

Meeting Summary

Attendance: Michelle Brazil (phone); Alane Capen; Joan Daugherty; Kira Eyring; Peggy Funk; Cathy Hamel; Tara Holicky (phone); Cathy Livingston (phone); Rachel Pierre-Mathieu ;Rene Mayo; Tricia Nay; Angela Poppe Ries; Mary Rossi-Coajou (phone); Allen Twigg; Jaya Vijayan (phone); Kathryn Walker; Julie Wright; Ivan Zama (phone)

MHCC Staff: Linda Cole; Rebecca Goldman; Bruce Kozlowski; Paul Parker; Kathleen Ruben; Ben Steffen; Suellen Wideman.

Introductions and Meeting Updates:

Paul Parker welcomed attendees in person and on the phone.

Linda Cole directed attention to a membership list that staff compiled. She asked attendees to review the list and submit feedback regarding the accuracy of individuals and organizations to be listed in our report.

Rebecca Goldman reviewed the agenda for today's meeting. She introduced Kira Eyring from Maryland's Chapter of The American Cancer Society. Ms. Eyring reported on a study and journal article on Maryland hospital-based palliative care initiatives based on a surveys of 28, to be used as a baseline. For hospitals with more than 50 beds, 89 percent reported having some structured palliative care program. According to this research, barriers to developing palliative care programs include lack of knowledge among patients and families, and lack of physician buy-in. The hospitals reported that they need more networking and conferences for best practice sharing. Future plans include developing an awareness initiative for the community and providers. They are also implementing a Survey Monkey to identify preferences for networking and conferences. They hope to work with other partners in the community to offer opportunities. Ms. Goldman added that she plans to use the program profiles and information on the barriers identified in the MHCC report to the General Assembly.

Ms. Goldman reviewed the meeting purpose, agenda, and the legislative mandate in HB 581. She began discussion about staff's progress on the report to date.

Presentation on CAPC Data

Ms. Goldman presented an overview of Center to Advance Palliative Care (CAPC) survey responses. All 11 pilots responded in either 2012 or 2013. All pilots have inpatient consultations and serve adults. Two hospitals have dedicated inpatient beds, and Johns Hopkins served pediatric patients. One hospital is Joint Commission-certified. Nine out of 11 are led by a physician who is certified in palliative care or a related specialty; 2 are led by palliative care certified nurses. All use electronic medical records. Ms. Cole asked the pilot hospitals about inconsistent reporting on the use of electronic medical records between the CAPC survey and MHCC's most recent survey, which was reported by only 9 pilots in MHCC's survey. Ms. Goldman suggested that staff follow up with the specific respondents after the meeting. Ms. Alane Capen commented that Coastal Hospice uses Peninsula Regional's electronic medical record, so an employee might have reported that the hospital uses EMR, but not the hospice. She also added that her hospice services patients through an outpatient clinic, which may not be reflected in the survey

response. Mr. Ben Steffen asked about the difference in the categories that described the services offered by palliative care programs and noted that they seem similar to him. Ms. Goldman suggested that these categories could be collapsed for MHCC's purposes. Angela Poppe Ries and Rene Mayo agreed.

The next slide lists the type of collaboration between pilots and hospice. Responses varied. Most frequently reported was an informal relationship with hospices; two pilot hospitals function as one with the hospital; three own the hospice, but are separate from palliative care. One of the NQF-endorsed preferred practices is a relationship with hospice, which might be obvious to the advisory group members, but staff is interested in creating guidelines for newer programs. Jaya Vijayan noted that Holy Cross Hospital's parent company, Trinity Health, owns the hospice program to which they refer patients, which may be an important note for staff analysis. She thought that it would be appropriate to footnote that issue because it might be a trend in the future, with more hospital consolidation.

Next, the group discussed different types of plans at the pilot sites. Questions regarding four types of plans are included in the CAPC survey. 100 percent of the pilots reported having an education plan and quality improvement plan; numbers were lower on marketing plans and bereavement plans. Ms. Goldman asked whether the definitions of these plans are consistent across pilot sites, and why all programs have education and quality improvement plans: Are they required by hospital administration? Do staff feel that strongly about the importance of them? Then, in addition to that, what does "marketing plan" and "bereavement plan" mean to the pilots?

Regarding bereavement plans, Ms. Rene Mayo thought all of the types of plans are important, but the amount of resources at each pilot site vary. In addition, some pilots may have reported that they do not have bereavement plans because they arrange for bereavement services through hospice. It did not make sense to do their own because hospices already do that for the community. She believes that process achieves better patient care at Union Memorial. Ms. Vijayan concurred that the palliative care staff at Holy Cross does not provide bereavement services because that is provided through hospice. All hospices are required to provide bereavement and referred to do bereavement for the community, whether they are hospice clients or not. Dr. Ries recommended that MHCC's best practice recommendations include that palliative care programs should establish a relationship with hospice to provide bereavement services, instead of specifically providing bereavement services themselves. Dr. Zama added that Doctors Community Hospital also does not provide its own bereavement services, but uses hospices for that. Ms. Rossi-Coujou confirmed that CMS required hospices to offer bereavement to the community, whether the individuals are affiliated with hospice or not, according to their Conditions of Participation. Mr. Twigg added that Meritus forged this type of relationship with hospice out of necessity to provide more efficient services. Patients receive a formal referral to hospice at that site when they need bereavement services. Joan Daugherty suggested that a recommendation of this group should be focused on ensuring access to bereavement services.

The discussion moved to the pilots' interpretation of education plans. Ms. Capen and Ms. Daugherty have learned that Peninsula Regional and Coastal Hospice must explicitly differentiate palliative care from hospice care. For example, they removed the word hospice from palliative care staff name badges and brochures. Ms. Mayo believes that marketing and education plans are two different things. Union Memorial's marketing plan calls for and responds to learning obtained from conducting patient interviews and reviewing literature on the subject of promoting palliative care. That includes public relations efforts because they want to increase awareness broadly. Education plans include outreach to staff and patients; marketing is broader. Still, she stressed that not all palliative care programs have the resources to conduct marketing and she would not want to see a program forego an important part of

their programs in lieu of providing a required level of marketing. Several around the room agreed. Dr. Ries added that Upper Chesapeake's marketing is separate from education. The latter includes staff development and internal hospital activity, including nurse practitioners and those who have privileges at the hospitals. Marketing is considered external. Ms. Daugherty added that it is important to include community physicians in education plans and activities. Mr. Steffen added that it is probably not appropriate to require a certain level of marketing or marketing plan.

The discussion moved to the interpretation of Quality Improvement Plan. Dr. Kathryn Walker noted that it was important to understand where and how performance measures are reported at the hospital. While all the pilots report that they have quality improvement, she would recommend that they be reported and incorporated into a formal hospital structure like a committee based on Union Memorial's experience. She also recommended differentiating between general education and specialized palliative team education. The specialized team can assist with general education. Julie Wright added that it might be more appropriate for newer programs to mature before they attempt to formally institute quality improvement plans. Her program at Carroll Hospital is in its fourth year and is just beginning to look at quality improvement reporting.

Ms. Goldman displayed results on patient diagnoses. Only five hospitals responded to this question in the CAPC survey in 2013, but she wanted to show that the patient population appears to be different across pilot sites. Dr. Walker noted that the patient level data reported by Union Memorial on this survey was based on the codes offered in the survey and what the palliative care staff treats, not necessarily why the patient is dying. Fifteen percent of her patients are dying from things from which they should not be dying, like diabetes. It was also noted that the bolded categories in the slide reflect the most frequent diagnosis reported by pilots in order to highlight that the pilots serve different types of patients, which should be accounted for in analysis. It might be more appropriate to look for this diagnostic data from other sources, such as HSCRC data.

Presentation on Pilot Alignment with NQF-endorsed Preferred Practices Survey

Ms. Cole reported on some of staff's findings resulting from the survey on pilot alignment with the 38 National Quality Forum (NQF)-endorsed preferred practices. Regarding patient tracking, Ms. Cole reported that it is hard to interpret the responses. Suburban has begun phone tracking. She would like to better define this issue. Ms. Capen responded that they track some patients after discharge if they are admitted to hospice. They track patients who receive further services at the outpatient clinic and if they are oncology patients. They do not follow patients who go to skilled nursing facilities. Ms. Daugherty agrees that tracking patients after discharge is a great idea, but is not sure that it is doable; it may be a goal. Most programs likely do not have the necessary staff or tools to follow patients. Dr. Ries added that it is currently not feasible based on technology limitations. Some programs are working with Chesapeake Regional Information System for our Patients (CRISP) to develop ways to notify the hospital if a patient does not show up for scheduled visits or if they are admitted anywhere else in the hospital. Delaware is making progress in this realm, with a project called Delaware Health Information Network (DHIN), similar to CRISP. Cathy Hamel cautioned that a limitation to tracking is that the patients who are frequently admitted to the hospitals are disenrolling from CRISP. She also suggested that staff make an effort to differentiate between recommendations for health systems and hospitals, as she noted before.

Regarding ongoing assessments of patient and family needs, Ms. Capen reported that her program certainly conducts assessments, but they may not need to be ongoing. Dr. Ries thought the idea of ongoing services was good, but questioned how often her staff was doing it, compared to the hospital or hospice staff. She thought that mandating ongoing assessments was not something that was attainable,

nor should be included in staff's recommendations. While there are tools that can be used, no one is decided on the best. Ms. Mayo added that the Joint Commission does not define ongoing assessments. Union Memorial uses a standardized social worker tool, FICA, to meet current requirements.

Regarding satisfaction, Ms. Daugherty replied that, if required, they could use two tools or incorporate questions into the hospital's tool. They could use the NCR Picker and force a sample size developed based on the percentage of palliative care referrals, or they could conduct their own study. As has been discussed previously, hospitals conduct satisfaction studies hospital-wide and do not break down this data by program. Ms. Walker added that the ESAS tool is used to assess symptom management, not assess satisfaction. She thought that programs should be accountable to measure patient satisfaction, but they could only do it by developing their own tool.

Regarding palliative care staff assessments of spiritual services, Dr. Ries replied that her program staff often cannot even access personnel to perform last rites, so this really is not feasible at her site. Dr. Walker added that they survey patients at Union Memorial at family meetings, but not post-discharge.

Regarding addressing hospice, Ms. Mayo reported that they do address hospice if death would not be surprising within one year, but look to physicians to decide the right time. She explained that it is not appropriate for staff to bring it up every time and does not believe that it should be required for every patient. She also sees patients who are fairly upstream and not incapacitated. In other circumstances, program staff waits for the patient or family to request this. She added that the Joint Commission does not expect Union Memorial to comply with this 100 percent of the time. Ms. Capen added that her program has a compliance goal of 90 percent. Dr. Ries agreed that it is most important to understand the patient's and family's wishes. If hospice is not a close enough need to be appropriate, it should not be offered.

Wording is very important. Ms. Goldman observed that the NQF-endorsed preferred practices seem to be more hospice-focused, as opposed to differentiating between hospice and palliative care. Many agreed with this assessment.

Presentation on HSCRC Data

The group discussed the coding of patients as 1, 2, or 3. Union Memorial representatives reported that they interpreted the use of the codes a little differently than other pilot sites. Code 1 was used when patients accepted palliative care and that changed the trajectory of care, such that they were de-escalating other treatment in favor of a palliative care plan. These patients agreed not to return to the hospital. Code 3 was used in cases where patients were more upstream and accepted recommendations, but did not yet change their course of aggressive care. Ms. Daugherty added that her interpretation of Code 1 included those patients that Ms. Walker described in Category 3. They included patients who stayed on their same trajectory; who, for example, continued chemotherapy but also accepted MOLST and symptom management. Dr. Ries believes that Union Memorial may have reported data differently than the other pilots. Any time she altered a patient's medication to deal with nausea, Dr. Ries coded it as 1. Dr. Walker expressed concern that her program is not tracking the Code 3 patients in the same way that other programs appear to be.

Ms. Wright suggested that the ratio of consults to medical-surgical discharges might reflect the degree of programs maturity. She recommended that staff look into the maturity of the programs, the growth, and the number of years in operation. She also thought it might be useful to consider how the programs target patients. Mr. Steffen observed that the percentage of hospice referrals correlate with the use of hospice by county.

Ms. Goldman reported on her observations on average charges per day. She thought that the patients who were flagged 1 have a higher charge per day. To her, that makes sense, because they are receiving more services. Mr. Steffen directed that staff refine the interpretation of this HSCRC data before final release.

Dr. Zama pointed out that the charges reflect the total patient stay, while the patient may have received palliative care for only a portion of those days, or at the end of the stay. Mr. Steffen suggested we might evaluate the spending in the last 60 days for patients who expired, though he is not sure if that is possible. Ms. Daugherty thinks that separating patients who died from those who did not in terms of evaluation might be important.

The time allotted for the meeting was coming to a close and Ms. Goldman reported that staff's plan was to continue further discussion of the NQF recommendations via conference call after she had a chance to summarize today's discussion and draft some staff assessments of alignment with NQF preferred practices. There is a need to incorporate different considerations regarding the HSCRC data and incorporate the third quarter of data, scheduled to be released in June.