Hospital Palliative Care Advisory Group

March 25, 2014

Meeting Summary

Attendance (based on sign-in sheet and phone introductions): Isaac Braun; Sandra Brownell (phone); Mary Rossi-Coajou; Joan Daugherty; Cathy Hamel; Tara Holicky; Cathy Livingston (phone); Susan Lyons; Rene Mayo; Angela Pope Ries; Barbara Spencer; Nicole Stallings (phone); Jaya Vijayan (phone); Kathryn Walker; Julie Wright; Ivan Zama (phone).

Y'vonne Darcy and Dr. Wilkes of Suburban attempted to attend via phone, but could not get through to the conference line.

HSCRC Staff: Sule Calikoglu (phone); Oscar Ibarra.

MHCC Staff: Linda Cole; Rebecca Goldman; Bruce Kozlowski; Paul Parker; Srinivas Sridhara; Ben Steffen.

Introductions and Meeting Updates:

Paul Parker welcomed attendees in person and on the phone. Linda Cole summarized the outcome of previous meetings. The full Advisory Group met on January 29th. At that meeting, there was agreement by the group to use Center for the Advancement of Palliative Care (CAPC) data for program level information and the Health Services Cost Review Commission (HSCRC) discharge database information for patient level data. The following subcommittees were formed: Definitions and Discharge Database; Standards/Best Practices; Out of Hospital Data; Satisfaction Surveys.

The Definitions and Discharge Database Subcommittee met on February 25th and March 4th. This group discussed that the V-code was too broad a definition to use, but could possibly be used as a comparison group. The top 15 diagnoses were also recommended as a possible comparison group. A definition of palliative care for use in this study was recommended. It will be discussed below.

Review of Study Design:

Palliative Care Program Information:

Rebecca Goldman reported that she obtained CAPC registration and data release from six of the ten pilot hospitals. She is missing releases from: Meritus; MedStar Union Memorial; Hopkins; and Suburban Hospital. Both Meritus and MedStar said that this had been sent. Ms. Goldman will follow up with the hospitals.

In-Hospital Palliative Care:

Paul Parker introduced the flagging rule recommended by the Definitions Subcommittee including the following definition for palliative care patients:

Flag all patients who were referred to the hospital palliative care program and obtained a palliative care consultation to address serious, complex, and potentially life-limiting or life-threatening conditions.

There was general agreement with this approach. Mr. Parker then said that staff was considering options going beyond the flag dealing with whether patients accept a palliative plan of care on discharge. He explained that staff has spoken with both HSCRC staff as well as staff of St. Paul's Center, and the flagging process is quite doable. This would involve the creation of a new flag, to be used only for the palliative care pilot hospitals. Staff also met with the clinical and data entry staff at MedStar Union Memorial to discuss this process. This was an initial meeting. Similar meetings (in person or by phone) will be held with all 10 pilot hospital staff regarding how the flagging process will work best at individual sites.

There was discussion on this topic:

- Kathryn Walker described research that she had done at MedStar Union Memorial. For patients who received a palliative care consult, 75% were readmitted within 30 days. For patients who had received a palliative care consult and also accepted a palliative care plan on discharge, 7% were readmitted within 30 days.
- The process would involve clinical palliative care staff providing a list of patients (and medical record numbers) to their data staff to flag the patients on a monthly basis. This would also include information on the discharge plans for the patients.
- There was some discussion about what a "palliative care discharge plan" entails and whether or not it includes hospice. Definitions will need to be established.
- The research needs to include two denominators to show the impact of palliative care: 1) all palliative care patients; 2) those who chose to accept palliative modes of care. The Union Memorial work indicates that these two groups would be expected to have a different pattern of hospital readmissions.
- A possible list of discharge categories, each with its own flagging code, was discussed, as follows:
    - 0= All patients who received a palliative care consult. As an option, this patient group could be disaggregated into three categories, as follows:
    - 1= Patients who received a palliative care consult and also accepted a palliative care discharge plan
    - 2= Patients who received a palliative care consult, but did not accept a palliative care discharge plan
    - 3= Patients who received a palliative care consult and were referred to hospice at discharge
- There may be some overlap between categories 1 and 3, but the concept seems to make sense. There was general support in the discussion.
- There were some questions about where this would appear on the discharge tape and whether it would be one or two fields. This will be addressed by staff.

Staff will reconvene the Definitions Subcommittee to refine the definitions for the discharge categories. Staff will then meet with the clinical and data staff of each hospital to review the process for flagging and coding palliative care patients.

Out of Hospital Palliative Care:

Mr. Parker said that one option explored by MHCC staff would be to try to link data from the HSCRC discharge database to the Commission's Medical Care Data Base that includes claims data for all payers. Since there is not patient level data with common identifiers, it was determined that this would l be difficult to accomplish and might, at best , provide a data set with so many questions related to its accuracy and completeness that its value would be dubious. The other option is to wait for the implementation of the Master Patient Identifier (MPI), expected in FY 2015, which will permit us to more reliably link the two databases. Srinivas Sridhara cautioned that the MPI will not be available initially for Medicare patients. MPI will hopefully be implemented by mid 2015. This time frame makes the ability to include such data in the report problematic.

Mr. Parker noted that outpatient services (e.g., services provided in Emergency Room visits following discharge) are capable of being tracked through HSCRC data base Additionally, we will want to include in the report any information on use of outpatient and other non-general hospital services that pilot hospitals have developed, tracking their own patients.

A question was raised about the need for review by Institutional Review Boards (IRB). This would not be a requirement associated with data extracted from the hospital discharge database through flagging. Satisfaction Surveys might require IRB approval. Any publications based on the data would also require IRB approval. Kathryn Walker said that she would check with her staff about this issue. Hospitals might want to be proactive and protect themselves up front.

Satisfaction Surveys:

This is not a specific requirement identified in the legislation but is recommended as a useful report component. There are some standardized satisfaction surveys. The currently required Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys are not specific to the palliative care population. It was pointed out that palliative care patients might go to nursing homes, assisted living, or hospice programs, and not get such surveys.

The discussion noted that satisfaction surveys are difficult to conduct with this population for many reasons. Patients are often in the ICU and may not be able to respond. Palliative care patients may be (or perceived to be) dying or close to death and this circumstance creates a difficult environment in which to obtain objective assessments of satisfaction with care from patients and families. Issues raised require follow up with bereavement counseling.

Tara Holicky said that GBMC has conducted both patient and physician satisfaction surveys since 2007. This is separate and distinct from required hospice surveys (at Gilchrist). This will be further discussed by the Satisfaction Subcommittee.

Cathy Livingston at Holy Cross asked to be added to the Best Practices Subcommittee.

Next Steps:

Mr. Parker announced that based on the discussion the following steps would occur:

1. Reconvene the Definitions Subcommittee to revisit and refine the definitions of flagging protocol based on categories of discharged palliative care patients.
2. Meet by phone with 10 pilot hospitals (both clinical and data entry staff) to discuss the final flagging and coding process.
3. Convene the Satisfaction Subcommittee.
4. Convene the Best Practices Subcommittee.