

Hospital Palliative Care Advisory Group

February 23, 2015

Meeting Summary

Attendance: Joan Daugherty; Tara Holicky; Rene Mayo; Angela Poppe Ries; ; Allen Twigg; Kathryn Walker; Julie Wright

By phone: Cathy Livingston; Susan Lyons; Tom Smith; Jaya Vijayan; Ivan Zama

HSCRC Staff: Oscar Ibarra

MHCC Staff: Linda Cole; Rebecca Goldman; Bruce Kozlowski; Paul Parker; Denise Ridgely

Introductions and Meeting Updates:

Paul Parker welcomed the attendees in person and by phone and thanked them for their participation. Linda Cole summarized what staff had been working on since the last full Advisory Group meeting on March 25, 2014.

- March: Commission staff finalized agreement for CAPC data collection; finalized flagging protocol; worked with HSCRC on pilot's data submission
- April: Commission staff presented status report to Commission
- May: Satisfaction Subcommittee met; Results of the meeting included a recommendation to not use a standard tool during this pilot project but to report individual pilot program results, if available
- June: HSCRC published final regulations regarding pilot data collection; Commission staff met by phone with all pilot hospitals regarding coding; all pilot hospital palliative care staff agreed to code 1,2, or 3 and that no 8's are needed
- July: HSCRC data collection period began
- September: Commission staff received preliminary data from Maryland Cancer Collaborative
- October: Commission staff received 2012 CAPC data for 9 of the pilot programs
- January: Commission staff followed-up with pilot hospitals using '8' code for HSCRC data to determine how the use of '8' code can be minimized

Ms. Cole then asked pilot programs to briefly summarize what they had been working on during the past year.

MedStar Union Memorial Hospital: Rene Mayo and Kathryn Walker reported that they have been reviewing the quarterly HSCRC data collection and it looks fine. The next quarter will be available for review on March 2nd. They also conducted a family satisfaction survey via tablet before and after a family meeting during last summer and fall and started a telehealth project that has been up for about three weeks that permits palliative care staff to follow patients post-discharge utilizing tablets. Results

from the satisfaction survey are still preliminary. Ms. Walker would be happy to share them when available.

Carroll Hospital Center: Julie Wright reported a large growth in their program (up 138% from last year). They are looking into inappropriate consults when they are called in too close to death. They are also reaching out to high utilizers including nursing homes, assisted living, and independent living center staff to help them do needs assessment for palliative care. The focus is on educating staff to use key words at key times. Ms. Wright said that her hospital is supportive of the program, but that is not the case for all community physicians. Post-discharge tracking is a problem. They do have home care that is a bridge to hospice. They are trying to work with the hospital's ACO, but it has been slow, due in part to a lack of staff at physicians' offices who have the skills and abilities to discuss things like advanced directives or goals of care and community physicians do not have the time to have in-depth conversations with patients. Carroll Hospital has discussed a free outpatient clinic that could reduce readmissions.

Ms. Mayo added that she thinks it is important to understand the needs of the administration regarding proving benefits of palliative care, which is becoming more important with global budgeting, but the need changes over time. At one rural MedStar hospital, they collaborate with the emergency department because so many people come in to use it as primary care; others work with community physicians; at Union Memorial, they have actually seen fewer patients, but more appropriate referrals, as physician awareness grows.

Peninsula Regional Medical Center: Joan Daugherty reported that they conducted an End of Life Study (which has been published and sent to Commission staff) and they are repeating the study to see if there has been any improvement. This analysis should be completed by the end of this year. They are also doing a focused five-point patient satisfaction survey in an outpatient oncology clinic.

Ms. Daugherty agreed with Ms. Wright that the demand for palliative care is growing exponentially. They are also working on identifying and better managing inappropriate consults and looking at employee practices to determine how they can get patients educated closer to initial diagnosis during a primary care visit. New initiatives include working with the outpatient oncology program and a cardiologist who has employed a palliative care certified physician.

Coastal Hospice will be hosting a conference in July that will feature Dr. Ira Byock speaking about palliative care at Grand Rounds and an evening event. She will extend the invitation flyer to members of this group via Commission staff. They are also working with churches to spread the word about Advanced Directives.

Greater Baltimore Medical Center: Tara Holicky reported that due to staffing changes, the number of cases reported in the HSCRC data for the first quarter was lower than expected. There has been new staff hired, so they expect the numbers to rise. There has also been a Trigger set up in the electronic medical records for medical social workers to be aware and trigger a palliative care consult. This is a standard instrument that can be shared with us. GBMC uses Meditech right now and will be switching to EPIC. Ms. Daugherty responded that her hospital's EMR vendor, McKesson, does not have the ability to use triggers, so her program would not be able to implement a trigger system in an EMR. Ms. Holicky

confirmed that they have seen an increase in consultations directly attributable to using the new trigger system.

Howard County General Hospital: Ms. Holicky reported that Howard County also had a change in staffing so reported cases are down. They are also using EPIC and working on building a trigger mechanism into their records as well.

Upper Chesapeake Medical Center: Dr. Angela Poppe Ries reported that they are conducting a patient and family satisfaction survey at discharge via mail in conjunction with the American Board of Internal Medicine which has its own 30-question survey. Her goal is to get 30-40 surveys to analyze; she has about 14 at this point. Upper Chesapeake's program has benefited from the support of the medical director of the Cancer Center, who has chosen to track two of the National Comprehensive Cancer Network guidelines for palliative care as markers to be measured during 2015. They are tracking the percentage of patients getting chemo in the last days of life and ICU admissions within 30 days of death. They also want all oncology patients to have Advanced Directives if they receive services in the Cancer Center.

She agreed with previous comments that there is a big push around global budgets and population health. She sees increased interest in how palliative care can play a role in intervening in the symptoms of underlying illnesses. Because of a desire to increase exposure to palliative care, her program's clinicians now get triggered to consult with 30-day readmissions and high risk patients. Upper Chesapeake is also collaborating with nursing homes and assisted living providers in Harford County to educate staff about palliative care. The plan is to start consults at these nursing homes via a telemedicine model.

Upper Chesapeake is now part of the University of Maryland system and the UMMS system has hired a palliative care physician (for the system, based in downtown Baltimore). . UMMS has started a palliative collaborative that has meetings across the system for strategic planning. They are developing an UMMS system-wide data collection system similar to the CAPC data. In April, UMMS will have a retreat that includes palliative care as a topic to encourage the other UMMS system hospitals to start thinking about a palliative care program.

Holy Cross Hospital: Cathy Livingston reported that they have an affiliation with Holy Cross Homecare and Hospice that has recently started physician home visits for palliative care. The conversations happen before hospitalization and can be a hand-off for post hospitalization. They are also focusing on partnerships with skilled nursing facilities (SNFs) and providing resources to these programs. One of their partners, Sanctuary of Holy Cross, is developing pilot with a full palliative care team in the SNF, with Holy Cross providing resources.

Data Collection:

Rebecca Goldman presented slides on the data submitted by the pilot hospitals to both CAPC and HSCRC. For HSCRC data, Ms. Goldman thanked all of the programs for submitting the required data for the first quarter. She reviewed the definitions of each of the codes and reminded members that the '1,

2, and 3 option' was required, not the '8 option'. Although a few hospitals reported some '8's, she has followed up with them to determine the issues and correct the process moving forward. She presented the frequencies reported by each pilot hospital and percentages of 1, 2, 3, and 8 codes.

She asked the programs for their comments. Ms. Holicky had already reported that staffing issues at GBMC and Howard County impacted the volumes reported. Ms. Livingston reported that the HSCRC and CAPC figures will not be the same for Holy Cross because the HSCRC data includes all palliative care at Holy Cross Hospital administered by both Holy Cross staff and Kaiser staff, but the CAPC data does not include the Kaiser volumes. Ms. Wright reported that Carroll County provides an increasingly significant amount of palliative care in outpatient and Emergency Department, which is included in CAPC data, but is not in the HSCRC data. Ms. Daugherty reported that the CAPC data for Peninsula Regional is submitted by Coastal Hospice. Commission staff reported that these data issues can be noted in the analysis.

For CAPC data, 9 out of 11 pilot hospitals reported data in 2012 and 10 out of 11 reported in 2013. This means that staff has data for each pilot hospital for at least one year. Ms. Goldman said that if program information does not change much year to year, this should be sufficient. However, Ms. Wright cautioned that they do change from year to year. Ms. Goldman responded that she expected there to be a review period before this report is finalized so group members could review Commission staff's assessment of year-to-year changes to ensure accurate interpretation. Ms. Goldman then presented on several examples of summarized CAPC findings, including program characteristics and patient population details, similar to the type of information members should expect to see in a final report.

Satisfaction Surveys:

Ms. Cole explained to the group that although the legislation does not specifically require the Commission to report on patient and family satisfaction, it is an important discussion point. Because the group's Subcommittee previously found that there was not any standardized statewide mechanism used to assist in this report, Commission staff is seeking any individualized examples of this type of work conducted at pilot hospitals, including those previously listed. Staff would need any results of these surveys no later than **June 2015** in order to incorporate results into the report.

The group explained that since HCAHPS collects hospital-wide patient satisfaction, they are precluded from conducting a post-discharge survey that targets a specific component of the hospital stay or a specific patient population. Ms. Livingston suggested that we include a description of these prohibitions in the report because even if the pilot programs wanted to conduct a survey, they are not permitted to do so.

Some pilot hospitals have managed to find ways around this prohibition to collect some information for their programs. Dr. Ries explained that at Upper Chesapeake, the survey is designed as a "physicians' survey" used as part of her credentialing process based on her performance and on requirements for certification by the American Board of Internal Medicine. Ms. Walker explained that Union Memorial framed their study as a measure of "hope and trust" before and after family meetings where bad news is shared during a patient's stay. At Peninsula Regional, the survey is limited to the outpatient oncology clinic.

Post-Discharge Data:

Ms. Goldman reported that although hospitals are only coding palliative care data in the HSCRC inpatient discharge, Commission staff has the ability to link inpatient and outpatient data collected by HSCRC from hospitals by using the EID variable in the HSCRC data set. Oscar Ibarra reported that this EID is collected by CRISP, beginning in 2013 and for Calendar Year 2014.

There was a general discussion on the interest in following the patient post discharge. At Union Memorial, under a program funded by Verizon Foundation, patients are given a tablet and they meet with staff via skype. This addresses medical and nursing issues, pharmacy issues, patient education, and reduces readmissions.

With the increased interest in population health and global health as a result of the HSCRC waiver, hospitals are trying to reduce length of stay and readmissions. According to the literature, palliative care decreases 30-day readmissions and lengths of stays. Several pilot hospitals discussed the need for education programs to deal with the symptoms related to chronic illnesses sooner before end of life care.

Ms. Cole requested that pilot hospitals submit their own individualized program details that go beyond the hospitals' data to include in the report, regarding their collection of data post-discharge.

Standards/Best Practices:

Ms. Goldman said that she is working to put together a survey to address the 38 preferred practices recommended by the National Quality Forum. Staff will be using data reported to us in previous discussions and CAPC survey responses. Staff's plan is to have the Standards/Best Practices Subcommittee review and test the survey prior to sending it out to all 11 pilot programs. Ms. Daugherty requested that a survey question include an open-ended response to report on challenges faced by the programs. Once Commission staff compiles the results of this survey, the group will reconvene to review and discuss them. Members who volunteered for the Standards Subcommittee include: Cathy Hamel; Cathy Livingston; Rene Mayo; Nicole Stallings; Julie Wright; and Ivan Zama.