

Hospital Palliative Care Advisory Group

October 20, 2015

Meeting Summary

Attendance: Cathy Hamel; Peggy Funk; Rachel Pierre-Matthieu; Rene Mayo; Angela Poppe Ries; Jaya Vijayan

Attendance by Phone: Alane Capen; Joan Daugherty; Rebecca Goldman; Kathryn Walker

Commission Staff: Linda Cole; Erin Dorrien; Paul Parker; Ben Steffen; Hui Su; Suellen Wideman

Welcome and Introductions:

Linda Cole welcomed participants to the meeting. She explained that since we are using a Go-to-Meeting format, Rebecca Goldman would be making the presentation remotely. Since the draft report has already been distributed to the members of the Advisory Group, Ms. Cole asked participants to offer their comments and recommendations while Ms. Goldman makes her presentation on the sections of the report.

Process for Implementation:

Ms. Goldman said that this includes the legislative history and the process for selection of pilot hospitals, including the Request for Application process.

Definitions, History, Issues and Existing Studies:

In this section, Ms. Goldman presented the development of palliative care, types of palliative care models, and the growth of the specialty, both nationally and in Maryland. Issues include the challenges created by confusion between hospice and palliative care. There is a lack of awareness of the existence of palliative care and late referrals to this consultation service.

The slides also include a discussion of benefits and cost savings. Ms. Goldman cited two published studies (by the AMA and Health Affairs) in which cost savings were reported. She also said that pilot hospitals (Carroll and Union Memorial) submitted evidence of lower readmission rates. Two hospitals (Johns Hopkins and Union Memorial) found greater patient and family satisfaction after palliative care consultation.

Ms. Goldman also discussed efforts, both nationally and in Maryland to standardize and expand palliative care. She also cited Maryland's Comprehensive Cancer Control Plan's chapter on improving access to palliative care.

Pilot Characteristics:

Ms. Goldman stated that palliative care programs exist at 30 hospitals across the state, though 11 hospitals participated as pilots. One hospital program (Union Memorial) is Joint Commission certified. She also discussed details on staffing relationship with hospice, and integration with ED and ICU.

HSCRC Data Analysis:

Ms. Goldman explained that the V-code (V66.7) was included as a general description, even though the group explained that this did not fully capture palliative care patients. The flagging process, using HSCRC data was therefore initiated. Data reported from the HSCRC data included: ratio of palliative care patients to total medical/surgical discharges by pilot; percent referred to hospice; palliative care patients by age, major diagnostic categories, and ethnicity/race. Patient disposition at discharge was also reported.

Ms. Goldman then referred the group to data produced on pilot hospital patients by race and ethnicity. Ms. Goldman said that the data showed that this is a diverse set of hospitals (in terms of racial breakdown) and that there did not seem to be large disparities between the racial breakdown for medical/surgical patients and the racial breakdown for palliative care patients by hospital. She noted that African American patients were more likely to decline palliative care, but this is consistent with literature on hospice as well.

Ms. Goldman noted that Peninsula Regional consulted with a higher proportion of African American patients for palliative care than for medical surgical patients. She asked whether this was a reflection of better outreach or higher severity patients. Alan Capen, Coastal Hospice, responded that the hospice is serving about 14%-15% African American patients, so some may be rejecting hospice and using palliative care. Ms. Capen also noted that the patients have a palliative care consult first and are then referred to hospice.

Ben Steffen asked if a higher percentage of African American patients declined palliative care, or if the percentage who declined was higher overall. This varies by pilot hospital.

Paul Parker stated that the total medical/surgical patient population at the pilot hospitals is included for purposes of comparison, since about 98% of palliative care patients fall into the planner-defined service of medical/surgical care.

Rene Mayo, MedStar Union Memorial, said that they compiled data on their patient population by race for their Joint Commission survey and that this data is consistent with what they produced. She also stated that African American patients had a higher rate of declining palliative care.

Case Mix Adjustment:

The next set of data concerned length of stay and charges. This data was case mix adjusted by St. Paul's, a consulting group that works with HSCRC data. She noted that this data includes patients who expired in the hospital.

Mr. Steffen said that perhaps case mix adjustment does not address severity adequately for palliative care patients. He said that patients who accept a palliative care plan of care may be placed in a different DRG than those who decline. Ms. Goldman stated that Kathryn Walker, MedStar Union Memorial, recommended excluding deaths from this data; it will be run again with this exclusion. Ms. Goldman said that she believes that the AMA and Health Affairs article referred to data which included deaths.

Joan Daugherty, Peninsula Regional, stated that we did not collect the data that we need to interpret these results.

Dr. Poppe Ries, UM Upper Chesapeake, said that another important factor is when the consult was made in the length of stay; they are often called in late. Dr. Vijayan, Holy Cross, agreed and said that patients may be in the ICU for weeks and then the palliative care team is called in to change their care plan. Ms. Cole responded that we do not have data on where in the length of stay the palliative care consult was made.

Regarding charge data, Ms. Goldman reported that patients who received palliative care consults had longer average stays and costlier total charges per stay. Patients referred to hospice had the lowest average charges per stay. There was no consistent comparison across pilot hospitals for average charges per stay for those who accepted palliative care vs those who decline. For charge per day, patients who declined palliative care had lower average charges per day than those who accepted.

Dr. Poppe Ries said that it makes no sense to her that patients who declined palliative care had the longest length of stay, but those who accepted palliative care had higher charges per stay.

Mr. Steffen recommended that the case mix adjustment be done in a more general way. Ms. Goldman said that she will be working with St. Paul's to produce this data separating out deaths. There was some discussion that patients close to death may stay in the hospital for a longer period of time. Patients flagged as "1" (accepted palliative care) had the highest rate of "expired in the hospital" at 41.7%.

There are two issues: we do not know when palliative care was introduced during the patient's stay. We also do not know how hospitals deal with patients who are close to death. Mr. Steffen recommended looking at the distribution of length of stay, charge per stay, and charge per day, and eliminating outliers.

Cathy Hamel, GBMC/Howard County, said that evaluation of palliative care is cost avoidance. It cannot be judged by one stay in the hospital; it needs to be assessed based on the cost of ongoing treatment for that patient.

Standards and Recommendations:

The last section of the report includes a review of National Quality Forum (NQF) best practices and includes the results of review of these practices by the Advisory Group at a previous meeting. Advisory Group members had no comments and were satisfied with the recommendations as presented. Ms. Goldman mentioned that she had a comment from Allen Twigg, Meritus, about text around one of the recommendations and that this would be addressed.

She also received wording recommendations from Kathryn Walker and these will also be incorporated. One issue she raised was about the inclusion of standard tools in the Appendix. One set of tools (spiritual care tools) was included as an Appendix. Another set (FAMCARE) was included as a link. The Advisory Group members recommended no changes. They felt that this presented options for developing programs, but did not limit them to a specific tool.

Comments were also received from Dr. Zama (Doctor's Community Hospital) and Dr. Nay (OHCQ) about Appendix items.

Next Steps:

Ms. Cole thanked the Advisory Group members for their participation over the past two years in developing this report. We will revise the draft report, based on comments received at this meeting. As new and updated data is prepared, it will be shared with the Advisory Group. Staff will then prepare the final report and send it to members of the Advisory Group and Commissioners. The report will be presented to the November 19th Commission meeting and then submitted to the General Assembly by December 1st.