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Palliative Care: Evaluating and Designing Process Improvements for an Inpatient Consultative Program

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Palliative Care: Evaluating and Designing Process Improvements for an Inpatient
Consultative Program

Capstone Project Paper

A paper submitted in partial fulfillment of the requirements of the
Master of Public Health
in the
University of Kentucky College of Public Health

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Abstract

The purpose of this capstone project paper and study was to evaluate an inpatient palliative care consultation service and then make recommendations for improving the program. This paper includes a literature review related to palliative care models and best practices in structuring a successful inpatient palliative care service. The project included an analysis of how the program at one university based hospital measured success of the program and SWOT analysis based on interviews with members of the program's team and leadership. Data sources used for the analysis included palliative care consultation utilization data from the identified hospital; other metrics used by the palliative care team; interviews with the clinical and managerial staff; and, the literature review. The capstone project includes a series of recommendations focused on how the team can better measure the performance and effectiveness of the palliative care program and a number of other general improvements that can be made to make the program more integral to the care of patients at the hospital and in the patients' communities. The literature review and study also make a case for the use of palliative care as an integrated public health strategy. In conclusion, it is important for an inpatient palliative care program to include resource components based on nationally accepted guidelines and principles. The program in this evaluation has structured its program in alignment with those standards. However, the hospital now needs to take the next step in the ongoing improvement of its palliative care program. Specifically the program should utilize clinical and social criteria (triggers) for targeted patient collection; consider linkages to or creation of community palliative care programs; improve the connectivity between the program and referring physicians; overhaul the "dashboard" used for monitoring metrics; and, measure the performance of the program against established benchmarks.

Purpose

The primary objectives of this project and paper were to review UK HealthCare's (UKHC) palliative care consultative service and make recommendations on how to improve the program. This includes a literature review focused on palliative care program structure and performance measurement, an overview of UKHC's program, a discussion of the program's current performance monitoring, a SWOT analysis of the program and recommendations on how to improve the program in the near term. The paper is intended to serve as a roadmap to evaluate the current palliative care program in order to design interventions to increase its effectiveness and value to the UK HealthCare organization.

From a public health policy perspective it is important to consider strategies that increase the availability of palliative care to more patients and their families. This paper focuses on ways to improve a palliative care program. This is important as more hospitals consider the value and viability of offering palliative care as part of their array of services. Palliative care should be considered in the context of improving quality of life and avoiding unnecessary cost of expensive care. Hospitals, healthcare systems, payers and government agencies should consider these alternative services.

Introduction

The disproportionate costs of end of life care and care for the most seriously ill are well documented and discussed, but are important to review in framing the impetus for palliative care. According to a 2012 statistical report from the Agency for Healthcare Research and Quality, the top five percent of the population in the US accounted for almost fifty percent of all healthcare expenditures¹. The Center to Advance Palliative Care (CAPC) divides that top five percent of patients into three subgroups: patients in their last year of life (eleven percent); patients that have expensive acute care needs over a year, but later return to baseline (forty-nine percent); and, those with long-term chronic serious illness with consistently high health care costs (forty percent)². As the US population ages and medical advances continue to lengthen life expectancy, this concentration of health expenditures will grow. Patients in these categories need access to care that preserves quality of life, avoids unnecessary treatment and is cost effective. From a policy perspective, the nation faces unsustainable healthcare costs, almost half of which can be contributed to care provided in the categories listed above. An important strategy to address both the individual patient's and healthcare system's needs is ensuring that palliative care is an option available throughout the continuum of care.

According to the National Consensus Project for Quality Palliative Care (NCP), the goal of palliative care is “to prevent and relieve suffering and to support the best possible quality of life for patients and their families”³. The Center to Advance Palliative Care refines the targeted population of this service as those individuals with serious illness⁴. The goal of palliative care is to provide relief from symptoms regardless of

diagnosis, age or stage of illness. It can be provided in conjunction with life-prolonging treatment or on a stand-alone basis. This type of care can be provided by a health care professional already treating a patient, by a specialist or interdisciplinary specialty team. This type of care is most often provided in the hospital, but can be provided in any setting including outpatient clinics, nursing homes, cancer centers and the patient's home.

I. Literature Review

Introduction

Palliative care programs have grown substantially over the past ten years⁵ and the structure and organization of these programs have evolved. This review of the literature focuses on the prevalent models of palliative care delivery with an emphasis on inpatient care; the basic composition of an interdisciplinary palliative care team; and finally, a discussion of the measurement of program effectiveness including economic value, consumer satisfaction, standards for palliative care and trigger systems. These topics are included in this review to provide context around the UK HealthCare Palliative Care program and provide guidance related to needs identified during the evaluation of that program.

Palliative Care Models

Site Specific Delivery Models

Palliative care programs exist in a number of settings accessible to patients at various points in their care. The literature divides the types of palliative care by location of care. Delivery of palliative care can be provided across the continuum of care in settings that range from a patient's home to an intensive care unit. One of the most frequently cited articles related to palliative care models divides delivery into four distinct models: Ambulatory Clinics, Home-Based Care, Inpatient Units (Palliative Care Units or PCUs) and Inpatient Consultation Services⁶. Each of these models has pros and cons

and the presence of these services contributes to the continuum of care in any community. For purposes of this review and paper, the focus will be on the two inpatient care models: Inpatient Palliative Care Units and Inpatient Palliative Care Consultation.

Inpatient PCUs are co-located beds in a dedicated hospital unit with specially trained staff for palliative care patients. These units concentrate the efforts of the interdisciplinary teams and allow hospitals to dedicate specially trained physicians, APRNs, nurses, and other support staff that can address all the needs of complex patients. A study conducted in 2011⁷ demonstrated that these units result in patients and families that were more satisfied with the palliative care service. However, a relatively low number of hospitals have a dedicated PCU⁸. This may be the result of available space, budgetary constraints related to bed occupancy, continuous provider coverage and an absence of a national benchmark model related to PCU staffing.

Inpatient consultation is the most prevalent hospital based palliative care model⁹. This model is much less resource intensive, but can be very effective. An inpatient consultative program includes trained palliative care physicians and / or APRNs with a close relationship with a team that includes nurses, social workers, chaplains, volunteers and therapists. Consultation is less resource demanding since it does not require dedicated space and 24/7 on-site staff. Wiencek and Coyne found that this model can be implemented more quickly, is more cost effective and is easier to maintain even with a changing patient population⁶. Another study¹⁰ found that the consultative model has a significant positive impact on family and patient perception of care; increased scores around communication and emotional care; and, increased benefit

from earlier consultation in the course of overall treatment. However, there is evidence that there are risks of poor outcomes in using this model¹¹. This is particularly true if the primary admitting service does not coordinate well or follow the palliative care consultative service's plan of care for the patient. There is less opportunity to standardize the care around palliative services and there may not be 24/7 coverage available under this model⁶.

It is important to note that recent literature also delineates differences among the levels of palliative care provided within each delivery model. Quill and Abernathy divide the levels into primary and secondary palliative care¹². Primary palliative care includes basic pain and symptom management, working with patients to define goals of care, resuscitation / code status discussions and prognostication. Secondary palliative care includes complex or refractory pain management, depression, grief or existential crisis management, recognition and discussion of futility and facilitating conflict resolution among patients, families and providers.

Integrative versus Consultative Model

Palliative care delivery can also vary in the manner in which it is either integrated into disease specific care or provided separately by a consultative team. The literature discusses how palliative care can be integrated into the care provided by hospitalists, intensivists, oncologists and other specialty admitting services that have primary responsibility for the patients while in the inpatient setting¹³. These studies outline the advantages of an integrated approach as first, that all patients can be potential recipients of palliative care since no consult is needed; and, second that there is a

shortage of palliative care trained providers available for the consultative model^{14,15}. However there are disadvantages outlined in the literature. One the most prevalent in the literature is that there is considerable variability in how well trained different specialties are in palliative care¹⁶ and several specialties perform poorly in this area on patient surveys. The evidence suggests that even with added training, some specialties continue to perform poorly in the areas of communication, psychosocial counseling, comfort care delivery and end-of-life care^{17,18}.

The literature around palliative care makes a strong case for the advantages of a consultative service team that can focus on comprehensive comfort care and symptom management. The advantage is the specialized training related to palliative care and the coordination of the team that is focused on alternatives to traditional acute care¹³. Studies have shown that with the presence of a consultative palliative care program there is significant decreases in the length of stay in inpatient settings¹⁹. There is also less use of non-beneficial life-sustaining or potentially inappropriate treatments^{13,20}.

The disadvantages to the consultative model include the lack of qualified palliative care trained providers¹⁵. There is also an increased chance for fragmenting the care of already very complex patients²¹. Some primary services may not be open to adding a consultative service and in some areas, such as the ICU, the culture may not be conducive to collaboration²². Also, in some cases the service primarily responsible for the patient's care (or admitting service) may not follow the plans of care delineated by the palliative care consultative service¹³.

Palliative Care Team Composition

Recent published literature and guidelines are consistent in defining or recommending the personnel that should be included in an interdisciplinary palliative care team. The National Quality Forum (NQF) in its “National Framework and Preferred Practices for Palliative and Hospice Care Quality” report has outlined specific components that should always be present in a palliative care program²³. The first preferred practice is that the care should be provided by an interdisciplinary team of skilled palliative care professionals including physicians, nurses, nurse practitioners, physician assistants, social workers, pharmacists, spiritual care counselors and other healthcare professionals. Additional literature goes on to suggest that staffing ratios for these and other professionals should be determined by the population to be served²⁴. The framework for the ideal palliative care team goes on to specify that the professionals should be trained, credentialed or certified in palliative care and provide 24/7 coverage or availability.

Program Effectiveness

Palliative care has seen substantial growth⁵ as providers and policy makers have recognized the service’s ability to add value. Palliative care has largely been shown to improve outcomes and reduce costs^{25,26}. A consultative palliative care program’s effectiveness and importance to the organization can be measured in a number of ways. In the literature, the prominent measurements of effective programs include the economic value and increased patient and family satisfaction. The outcomes of an

effective program discussed here are not exhaustive of all the benefits of a palliative care program and are interrelated (e.g. avoiding non-beneficial treatments and increasing patient satisfaction can have a positive economic impact).

Patient Satisfaction / Outcomes – The literature shows that consultative palliative care consistently improved family satisfaction with hospital care²⁷. There have been multiple studies now that show that an inpatient palliative care program can have a multi-factorial improvement on patient and family perceptions around care. This includes a perception of improved quality of life²⁸, increased satisfaction with overall care and reduction in family distress²⁹. There is also support in recent studies that palliative care programs are associated with improved physician – patient communication, better perception of emotional support and higher patient satisfaction³⁰. In addition, there is evidence of a marked decrease in reported pain, dyspnea and nausea and an increase in the utilization of hospice services when needed³¹. In these studies the measure of satisfaction varies and appears to be non-standard in relation to the manner in which overall patient satisfaction is measured within the hospital setting.

Economic Value – The economic advantages of palliative care programs are multi-faceted. The literature shows that there is economic value to the hospital, payer and healthcare system. There is a perception of a significant economic impact to the patient and family, but this is an area identified in several articles that needs further study^{28, 29, 30}. Consultative inpatient palliative care has been shown to reduce hospital length of stay³¹ and specifically stays in hospital intensive care units^{29,30}. There is evidence that these programs can decrease readmission rates, ICU admissions and use of the emergency department³¹. Controlled studies have shown that the palliative

care consultation can reduce hospital costs by an estimated 19.2% per admission²⁴. If paired with an outpatient palliative care program these savings grow significantly and successfully reduce 30-day readmission rates²⁶.

Standards

In establishing and monitoring an inpatient palliative care service, there are clearly defined standards for components that should be present in a program and how the programs should be evaluated. The third edition of the National Consensus Project (NCP) for Quality Palliative Care Clinical Practice Guidelines³ establishes eight standards for palliative care. These standards are designed to promote the growth of palliative care programs, standardize definitions of palliative care, reduce program variation, establish goals for access to palliative care, encourage goal setting and measurements of success, and increase continuity. The National Quality Forum (NQF) builds on those standards and offers a framework of 38 best practices in palliative care programs^{6,32}. According to the literature, these standards increase provider adoption of palliative care and improve reimbursement for services⁶. The NQF puts a strong emphasis on quality measurement and reporting.

The NCP guidelines and NQF practices offer a checklist for new and established palliative care programs. The Joint Commission also added a quality-focused accreditation for palliative care in 2011^{6,33}. The certification covers 40 standards in care provision, program management, information / data management and performance improvement . Using these standards and recommendations for best practices, an inpatient consultation service needs to include use of standardized symptom

assessment tools, clinical management protocols, defined scope of practice, development of the consultation relationships, identified metrics of success and strategies for data collection, management and analysis.

Triggers

The inpatient consultative model is dependent on the primary admitting service identifying a patient's need for this type of care. This can be a significant challenge for providers facing seriously ill patients with already complex care plans. Criteria for screening, or triggers, can assist in identifying patients that would benefit from palliative care consultation. The NCP and NQF models both include reference to symptom assessment tools^{3,32}, but do not yet offer a standard model. According to the literature, triggers have evolved to select patients for palliative care that could benefit from discontinuation of non-beneficial or potentially inappropriate treatments (formerly referred to as futile care), and those patients with chronic severe illness that require complex or aggressive symptom management. In one study, it was found that one in seven ICU patients met criteria for palliative care using a single set of triggers. If multiple trigger sets were used the number of patients meeting criteria increased to one in five patients³⁴.

A number of trigger systems are available, but there is not agreement on how successful each trigger set is individually or when used together¹³. How and when the triggers are utilized affect the success of the systems. The Center for the Advancement of Palliative Care (CAPC) has published a consensus report on identifying patients appropriate for palliative care in the hospital setting³⁵. The report makes the case that it

would be ideal if education of providers across the hospital setting on the importance of screening for palliative care needs was sufficient to support best practices. However, the report argues based on other studies that education alone will not change practice patterns and thus screening for patients in need of palliative care is prudent. The report recommends that patients should be screened upon admission and then daily for the need for palliative care consultation. The assessment tools as outlined by the report are included here as Table 1, 2 and 3.

II. Capstone Project

Background – UK HealthCare Palliative Care Service

UK HealthCare (UKHC) utilizes an inpatient consultative palliative care model. The UKHC program was initiated in 2009 for inpatient hospital care. The hospital's medical staff and management govern the program; however, much of the program's staff is outsourced through Palliative Care Center of the Bluegrass, a subsidiary of Hospice of the Bluegrass. The UKHC palliative care program follows the national model for staffing closely. The interdisciplinary team includes 1.4 FTE physician / medical director, 1.2 FTE APRN, 1.0 FTE nurse case manager, 1.0 FTE social worker, 0.5 FTE chaplain and 2.0 FTE coordinators. This team also coordinates with the financial analysis team and hospital management.

Methods / Approach

This capstone project focused on evaluating the UKHC inpatient consultative palliative care program with an emphasis on program improvement. This section includes:

- an overview and brief analysis (based on interviews with team members and decision analysis partners) of the metrics of performance that the program is currently tracking;
- a summary of a SWOT analysis conducted via interviews with members of the palliative care team and members of UKHC senior leadership;

- a summary of suggested interventions that could improve the program based on the SWOT analysis and the literature review

Program Metrics

The UKHC consultative palliative care program is currently tracking a performance metric dashboard that is pushed to the team on an every other month basis (Dashboard is not included in this paper, but is on file with the author). The dashboard is used as a snapshot of overall performance for management to track trends in palliative care activity. The dashboard includes the following data elements: palliative care consults (by location), percent expired patients consulted, length of stay analysis, percent of patients consulted by day 4 & day 10, discharge status and location, consult location, consults by admitting service, consults with ICU stay, primary diagnosis and secondary goals of care. The team also self-monitors performance within regular huddles with a focus on responsiveness to consult requests.

Though the dashboard includes a robust number of metrics, there is a very limited subset of those metrics that have established goals. The team measures against self-selected goals for two metrics. The first is percent of expired patients consulted. The goal for this metric is 30 percent. The second is a measure of time to consult. This measure has a goal of 70 percent of patients by day four and 90 percent of patients by day 10 of their stay. This measure gives the team feedback on their responsiveness rate for those patients that are referred to the service and feedback on when the need for palliative care is identified, but is not a clear measure of either of those metrics.

The following is a discussion of the categories of metrics included in the UKHC Palliative Care Consult Service dashboard for adult patients. The analysis below includes a brief description of each category of metrics and then discusses the efficacy of the metric and suggested improvements or alternatives.

Number of Consults - The number of consults for the program is the closest measurement of capture rate currently tracked. This measure is a total count of consults for each period (month or year) conducted by the team. It does not reflect any measurement of consults as a rate of the opportunity consults (meaning those patients that have a defined need for palliative care or meet a specific trigger). This does give the team and management a sense of the volume that team is handling over time which is useful for staffing decisions. However, it is not measured against a productivity benchmark.

One proxy for measuring the overall consult rate would be to compare the number of consults against overall hospital discharges. Chart A shows the number of palliative care consults by year. Chart B shows the rate of consults per hospital discharge. This data shows that the consult rate has continued to rise as the PC program has matured. Still, the rate of 3-4% of all patients is still relatively low in comparison to expected rates if palliative care triggers were in place.

Recommendation: Continue to track number of consults, but also track a ratio of consults to discharges or the number of consults out of all patients that met criteria for palliative care need.

Length of Stay – The dashboard tracks total average length of stay (ALOS), ALOS days to consult and ALOS post consult. As discussed earlier, length of stay is an area in which palliative care can have a significant impact. Tracking ALOS for this specific patient population is important, but the dashboard does not include a clear target for each measure. There is an opportunity in this area to set targets for how quickly the palliative care team is engaged with a patient and how the palliative care service has an impact on how long the patients stay in the hospital after a consult.

Recommendation: Measure the effect of palliative care consults by comparing the length of stay against established national benchmarks specific to the types of patients cared for within UKHC. There may be other methods that better quantify the service's effect on length of stay and costs.

Discharge Status – This section of the dashboard allows the team to track the disposition of patients in four categories: expired, home, other facility and other. This is important to track as the team strives to provide plans of care that cover the continuum of care for their patients. The number of discharges to other facilities is growing and the team feels this is because there are fewer families able to assist with patients that have complex medical needs. There are also concerted efforts on the part of UK HealthCare to strengthen relationships with post-acute care facilities. These metrics are also important to track as the palliative care team considers how to best accommodate patients that don't have access to outpatient palliative care services.

Recommendation: Continue to track discharge status and be prepared to review more closely the venues to which patients are discharged. Additional information around

other facilities or agencies that the patients use post-discharge could be valuable to the team in developing post-acute plans of care. This will become increasingly important as payers fully implement bundled payment models and hold carriers accountable for post acute care costs including readmissions.

Case Mix – The case mix index, a measure of the severity of illness, is tracked for all patients receiving a palliative care consult. This measure provides the team trended data on how complex the patients are for the service. This is important to consider in making decisions on how the team should be staffed. **Recommendation:** Continue to monitor the complexity of the patient population served by palliative care to assist in making decisions regarding staffing levels and measuring the successful reach of the program.

ICU Consults – The dashboard includes consults with ICU length of stay as a percentage (different ranges of number of days in the ICU), number of ICU palliative care consults and average number of days in the ICU before a consult is provided. **Recommendation:** The first measure of length of stay ranges is not used to track any specific outcome and should be removed. Tracking the number of consults provided in the ICU is important, but should be tracked as a rate of consults per all ICU patients and against a benchmark or trigger that represents the expected number of ICU patients that should receive a palliative care consult. The average number of days in the ICU before consult is also important as a measure of when the primary admitting service for the patients orders the consult and how long it takes for the consult to occur. This is a measure that is noted in recommended trigger sets discussed earlier. It may also be prudent to divide this data up by type of ICU for tracking. Medical ICU and surgical ICU

may have very different palliative care needs and cultures. This data should be refined to reflect the number of ICU consults as a rate of those patients that needed palliative care and consider looking at the data separately by type of ICU.

Consult Location and Admitting Service - Tracking the percent of the consults by admitting service and location gives a view of the mix of patients seen by the palliative care team. However, there is no measurement of number of consults by service as a percent of all patients on that service or as a percent of those that need palliative care services. **Recommendation:** Continue to utilize these metrics to focus efforts around relationship building and targeted education of admitting physicians, nurses, social workers and other members of the team. The service should consider looking at this statistic relative to those patients that need these services or national benchmarks.

Consults by Day 4 and 10 – These two measurements are used to measure by how early in the patient's stay a palliative care consult is made. The goal is to intervene as early as possible to be able to work with the patient, family and other caregivers to assess patient needs and develop a plan of care. As referenced earlier, these metrics are measured against an established goal.

SWOT Analysis

The following is a summary of twelve interviews conducted with members of the palliative care team and senior leadership including the program manager, medical director, transitions of care director, chief nursing executive, chief medical officer, social worker manager, chaplain and Palliative Care of the Bluegrass program administrator. The interviews were in person on the premises of UKHC. Interviews generally lasted an hour and focused on the state of the current program and a discussion on how the program could be improved to serve the needs of UKHC's patient population.

Strengths

- Strong partnership with a nationally recognized palliative care organization
- Participates in medical student and resident training and will be adding a fellowship training program in the upcoming year
- Beneficial relationship with the emergency department and especially with emergency nurses
- Dedicated social worker
- Targeted clinical areas in the hospital are aware of the service and coordinate with the program for care provision
- Nurses throughout the organization value the program for managing complex, difficult patients

Weaknesses

- Lack of awareness of palliative care service
- Lack of a trigger system for identifying patients
- Lack of an automated trigger system
- Training of staff responsible for initial evaluation of patients
- Consultative relationships and cultural differences among admitting services
- Lack of organizational home
- Residents do not integrate pc into their practice
- Limited participation in CAPC activities
- Lack of comparison to other programs
- Not planning for discharge at the time of admission
- Lack of integrated nurse education around palliative care throughout the hospital

Opportunities

- National and state emphasis on value of care and rising recognition of importance of palliative care
- Participation in national benchmarking project
- Goals of care consultation - nursing
- Improved relationship with skilled nursing facilities
- End of life training for residents
- More lectures or “grand rounds” for medical students, residents, attending physicians, nurses, social workers
- National grant application opportunity
- Joint Commission accreditation

Threats

- Absence of outpatient palliative care services in the local community and the broader regional area
- Primary provider training
- New pain clinic and drug abuse legislation
- Reliance on a contracted entity for much of the service
- Payer reform
- Hospice admission pressure
- Increased paperwork necessary to admit from palliative care to hospice
- Family perceptions of UKHC have changed – “patients come here to get better”; with this perception it is often hard to persuade families to consider palliative care as alternate to non-beneficial life-prolonging care

Recommendations and Interventions

Based on the analysis of the current metric performance tools, the discussion around those metrics and the SWOT analysis, a set of recommendations follows that should be considered by the UKHC Palliative Care Consult Team and by senior leadership. These recommendations are not exhaustive and further, more precise analysis, could be utilized to measure overall effectiveness of each component of the program.

Reconfigure the Palliative Care Dashboard – The program should consider focusing on fewer points of data that are more actionable. Each data point should have a target to measure against and when appropriate rates should be used rather than raw totals. The service should use specific benchmarks for palliative care in all cases in which they are available.

National Benchmarking – The palliative care team should measure the program against the NCP Guidelines and the NQF 38 best practices on a regular basis to ensure that structurally the UKHC team is consistent with best practices for inpatient palliative care consultative programs. The organization should consider Joint Commission accreditation for the program or consider becoming accreditation eligible (adhering to the standards regardless of Joint Commission status). The UKHC program should consider participating in CAPC or other benchmark data programs. A national benchmark program could provide targets for the metrics that the program is tracking. This may also serve as the basis to automate data collection and trigger systems. In addition, the program should be measuring economic benefit to the organization on a regular basis. The literature supports that a palliative care program has a positive financial impact for hospitals^{28,29,30}, but an analysis specific to UK HealthCare benchmarked to other programs in similar sized hospital systems would be very beneficial. Finally, benchmarking the program to others across the nation could give UKHC meaningful data to measure productivity and make decisions regarding appropriate staffing levels.

Trigger System – The Palliative Care program should consider utilizing criteria for identifying patients that could benefit from palliative care services, known as trigger systems. The CAPC consensus report on identifying patients³⁵ could be utilized as a

foundation for establishing a trigger system. The team should consider piloting a trigger system within a targeted admitting service to prove the efficacy of a system and work through any problems that might occur. The optimal system would be automated and have buy-in from admitting services. Partnering with a specific service such as the hospitalist group or ICU pulmonary intensivists would allow the team to concentrate their efforts around developing a trigger system and then tailoring it for other areas of the hospital.

Education and Consultative Relationship Building – The team should consider building stronger linkages with physicians, patient care managers, nurse leads, learners (medical students, residents, fellows, nursing students, etc.) and social workers in targeted specialty service areas. This could be achieved through ongoing education around criteria for palliative care services, benefits for patients and the advantages for providers. This is also an opportunity to create professional connections between the team and admitting services.

Explore Outpatient Services – One of the most serious threats identified in the SWOT analysis was the lack of outpatient palliative care services available to patients upon discharge. Palliative Care of the Bluegrass previously had an outpatient clinic in Lexington available for patients as they continued their plans of care post discharge. This clinic was closed by the organization in 2014 as part of larger reorganization. In addition, it is the team's perception that recent legislation related to pain clinics and drug abuse cause local primary care providers to be more reluctant to continue plans of care that include very aggressive symptom management. This likely increases the chance of readmission for UKHC's patient population. The UKHC team should consider the

establishment of a palliative care clinic either alone or in partnership with Palliative Care of the Bluegrass or other providers in the area. This would require a significant amount of clinical and financial analysis, planning and provider and staff recruitment.

Conclusion

Over the past six years, UK HealthCare has established a strong inpatient palliative care consult program that has demonstrated growth in total numbers of consults and has likely had a positive impact on patient specific outcomes. However, the program has struggled to demonstrate the success of the program with defined benchmarked performance metrics. The interviews were an opportunity for the participants to reflect on how far the program has come and to think critically about issues facing palliative care in the near and long term. As UK HealthCare continues to grow to meet the needs of the Commonwealth, the palliative care program will be an important part of providing a comprehensive continuum of care. It is my hope that these recommendations can be used as a basis for improving the program and I hope to participate in the maturation of this essential service.

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IV. Tables and Figures

Table 1. Primary Palliative Care Assessment Components

Pain/Symptom Assessment

- Are there distressing physical or psychological symptoms?

Social/Spiritual Assessment

- Are there significant social or spiritual concerns affecting daily life?

Understanding of illness/prognosis and treatment options

- Does the patient/family/surrogate understand the current illness, prognostic trajectory, and treatment options?

Identification of patient-centered goals of care

- What are the goals for care, as identified by the patient/family/surrogate?
- Are treatment options matched to informed patient-centered goals?
- Has the patient participated in an advance care planning process?
- Has the patient completed an advance care planning document?

Transition of care post-discharge

- What are the key considerations for a safe and sustainable transition from one setting to another?

Source: Weissman D, Meier D. "Identifying Patients in Need of Palliative Care Assessment in the Hospital Setting." *Journal of Palliative Medicine* 14.1 (2011): 17-23.

Table 2. Criteria for a Palliative Care Assessment at the Time of Admission

A potentially life-limiting or life-threatening condition and . . .

Primary Criteria

- The ‘‘surprise question’’: You would not be surprised if the patient died within 12 months or before adulthood
- Frequent admissions (e.g., more than one admission for same condition within several months)
- Admission prompted by difficult-to-control physical or psychological symptoms (e.g., moderate-to-severe symptom intensity for more than 24–48 hours)
- Complex care requirements (e.g., functional dependency; complex home support for ventilator/antibiotics/feedings)
- Decline in function, feeding intolerance, or unintended decline in weight (e.g., failure to thrive)

Secondary Criteria

- Admission from long-term care facility or medical foster home
- Elderly patient, cognitively impaired, with acute hip fracture
- Metastatic or locally advanced incurable cancer
- Chronic home oxygen use
- Out-of-hospital cardiac arrest
- Current or past hospice program enrollee
- Limited social support (e.g., family stress, chronic mental illness)
- No history of completing an advance care planning discussion/document

Source: Weissman D, Meier D. “Identifying Patients in Need of Palliative Care Assessment in the Hospital Setting.” *Journal of Palliative Medicine* 14.1 (2011): 17-23.

Table 3. Criteria for Palliative Care Assessment during Each Hospital Day

A potentially life-limiting or life-threatening condition and . . .

Primary Criteria

- The "surprise question": You would not be surprised if the patient died within 12 months or did not live to adulthood
- Difficult-to-control physical or psychological symptoms (e.g., more than one admission for same condition within several months)
- Intensive Care Unit length of stay ≥ 7 days
- Lack of Goals of Care clarity and documentation
- Disagreements or uncertainty among the patient, staff, and/or family concerning . . .
 - major medical treatment decisions
 - resuscitation preferences
 - use of nonoral feeding or hydration

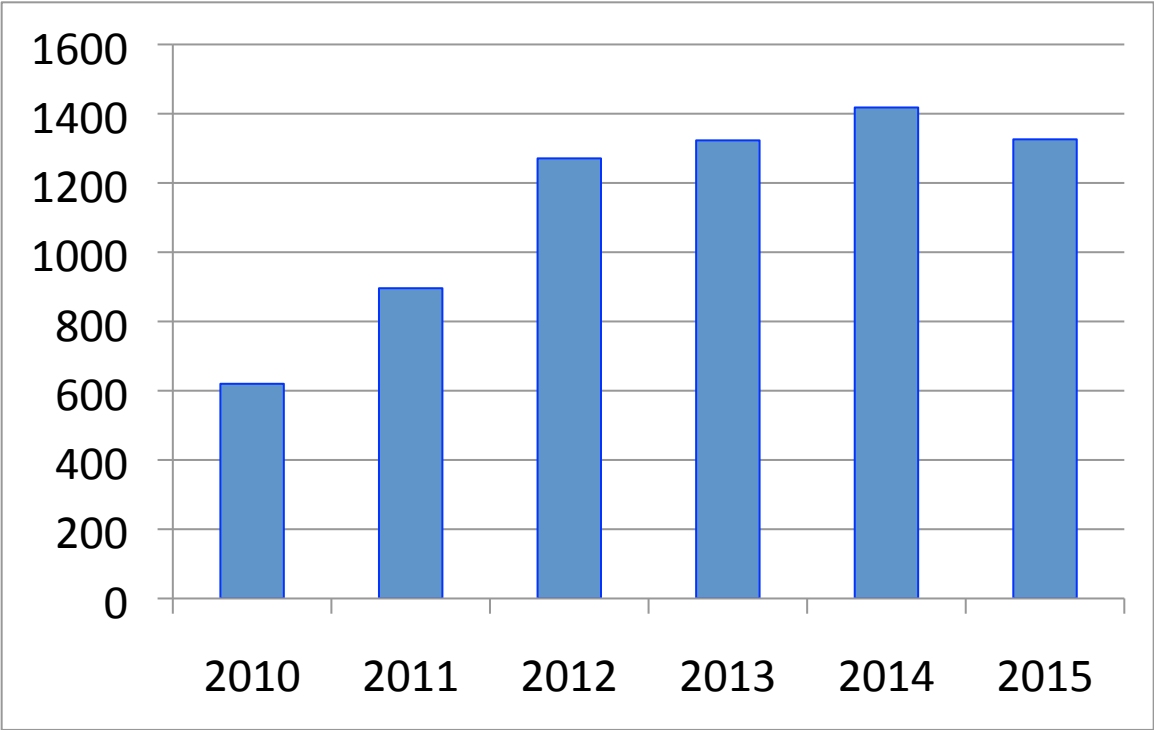
Secondary Criteria

- Awaiting, or deemed ineligible for, solid-organ transplantation
- Patient/family/surrogate emotional, spiritual, or relational distress
- Patient/family/surrogate request for palliative care/hospice services
- Patient is considered a potential candidate, or medical team is considering seeking consultation, for:
 - feeding tube placement
 - tracheostomy
 - initiation of renal replacement therapy
 - ethics concerns
 - LVAD or AICD placement
 - LTAC hospital or medical foster home disposition
 - bone marrow transplantation (high-risk patients)

Source: Weissman D, Meier D. "Identifying Patients in Need of Palliative Care Assessment in the Hospital Setting." *Journal of Palliative Medicine* 14.1 (2011): 17-23.

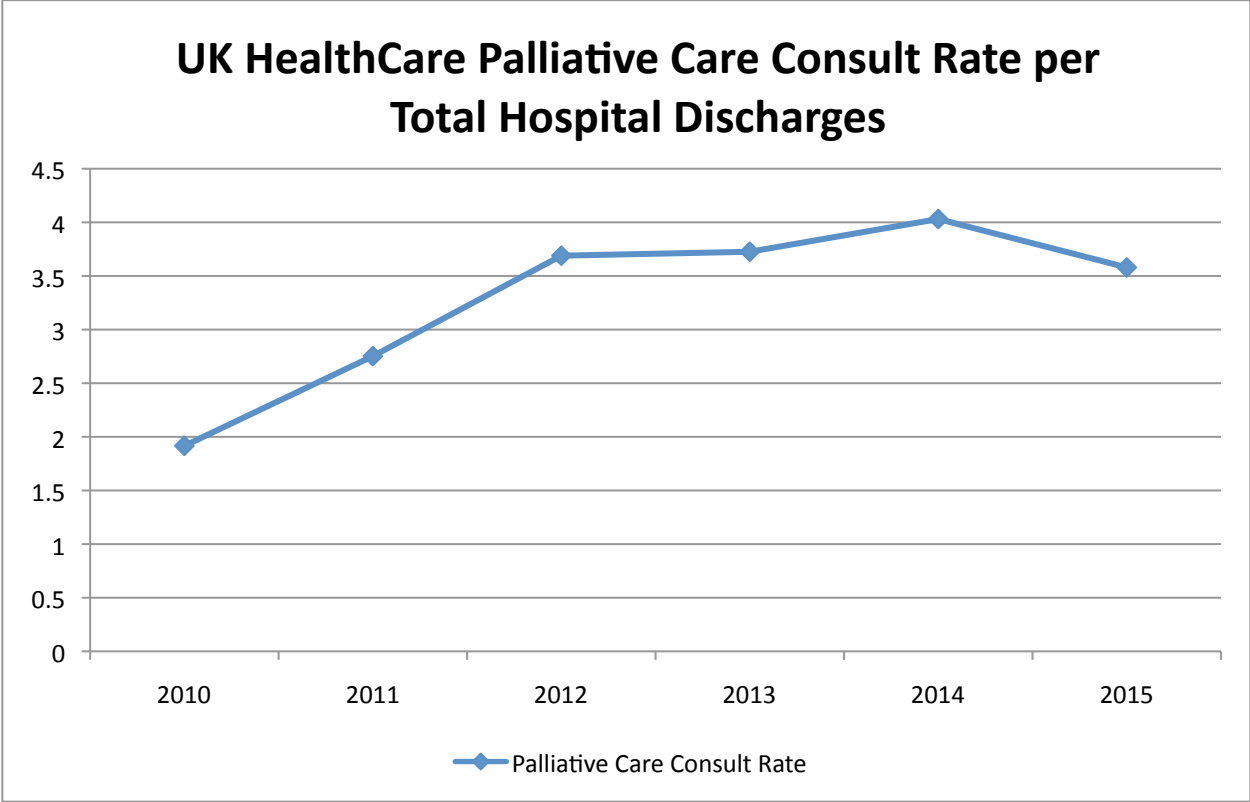
Chart A

UK HealthCare Palliative Care Consults



Note: 2015 data includes only ten months of data.

Chart B



Note: 2015 data includes only ten months of data.

V. Biographical Sketch

Shawn M. Crouch is currently the Director for Operational Integration at UK HealthCare. Shawn began his career as an administrative resident at UK Chandler Medical Center immediately after graduating from the University of Kentucky with a BHS in Health Administration. He was the Director of Government Relations and Legal Affairs for a regional health plan for six years. He then served the Commonwealth of Kentucky for four years in the roles Director of Health Policy, Deputy Secretary for the Cabinet for Health Services and finally, Medicaid Commissioner. In 2008 he returned to UK HealthCare as Chief of Staff for Clinical Operations. Shawn is a native of Albany, Kentucky but has been a resident of Lexington for over twenty-three years. Shawn and his partner of nine years, Sam Carneal, share a home and their life together with two fun Norfolk Terriers, Cubby and Yardley.

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