Demonstrating Outcomes of Palliative Medicine at the System Level

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Objectives

• Review the concept of Palliative Care and its benefits
• Share model for measuring operational outcomes
• Articulate the impact of Palliative Care on outcomes for a Healthcare System
The Palliative Care Patient
Case Scenario

• 45 year old patient presents to the Emergency Room with severe abdominal pain
• Patient gives history of progressive and significant weight loss over last 3 months
• CT scan of the abdomen shows multiple liver masses
When do you call Palliative Care?

Therapies to relieve suffering and / or improve quality of life

End-of-life Care

Presentation

Death

Palliative Care

Therapies to modify disease
Prognostication Challenge
CONCEPT AND BENEFITS
WHO definition of Palliative Care

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness..........

is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.
WHO model of Palliative Care
Center to Advance Palliative Care

Palliative care is provided by an interdisciplinary team and offered in conjunction with all other appropriate forms of medical treatment.

It is appropriate at any point in a serious illness and can be provided at the same time as treatment that is meant to cure.
National Quality Forum Definition

Palliative care refers to patient- and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering.

Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice.
Benefits

• Equal or better survival
• Higher patient satisfaction
• Improved prognostic awareness
• Less cost to patients, families, and society

PALLIATIVE CARE AND HOSPICE
Palliative Care and Hospice

Palliative Care is not Hospice
Palliative Care and Hospice

All Hospice Care is Palliative, all Palliative Care is not Hospice
Traditional Model: Comfort or Cure

![Diagram showing the progression from presentation to death with therapies to modify disease and end-of-life care.]
Suggested Need of Palliative Care

With permission from: Frank D. Ferris, MD, OhioHealth
Comfort and Cure Model

IMPACT ANALYSIS:
OUTCOMES
Journal of Palliative Medicine

FREE ACCESS through March 24, 2016.
Read now:

Making the Case for Palliative Care at the System Level: Outcomes Data
Parag Bharadwaj, Karen M. Heffer, Leo J. Deleon, Douglas M. Thompson, Jennifer R. Ward, John Patterson, Srijan Yennurajalingam, Joe B. Kim, Kathie S. Zimbro, J. Brian Cassel, and Aaron D. Bleznak Read Now

Using Nurse Ratings of Physician Communication in the ICU To Identify Potential Targets for Interventions To Improve End-of-Life Care
Methods and Pitfalls

- Identifying patients: V66.7/Z51.5
- Timing of intervention is crucial
- Cost analysis
- What do you want to measure?
Sentara Healthcare: Outcomes Data

- Sentara Community Hospital Data
- System wide Single DRG – Matched Pair Study
- System Financial Impact
- Sentara Community Hospital ICU Pilot
- Palliative Care and Hospice
Sentara Healthcare: Outcomes Data

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Sentara Community Hospital Outcomes Data

- Program launched November 2012
- Kept manual log of patients
- High volume, stable program
- Annual data sample: Nov ‘12 – Oct ‘13
- N=540

**Palliative Care patients**

- After 48 hours: 353
- Within 48 hours: 187
Benefit of Palliative Care Consults on Readmissions

Readmits Prior to Consult  Readmits Post Consult

Excludes patients who died or were discharged on Hospice
Benefits of Early Palliative Care Consult on LOS and Cost

Variance to Expected Length of Stay and CMI Adjusted Direct Cost/Case

- 6.28
- N=187
- N=353
- Δ = 40%
- 5.08 saved days/patient

- After 48 hrs
- Within 48 hrs
Benefit of Palliative Care Consults on Mortality

- Mortality Ratio

- > 48 Hours: 1.10
- <= 48 Hours: 1.01

Δ = 0.09
Sentara Healthcare: Outcomes Data

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Benefit of Palliative Care Consults:
System MS DRG 871-Septicemia or Severe Sepsis

- Modified Matched Pair study:
  - MS DRG 871 – Septicemia or Severe Sepsis w/o MV 96+ w MCC
  - Patients matched using “like” severity results calculated by Truven, Care Discovery
  - All Hampton Roads Hospitals, June – November 2013
  - N=114

Hospital ALOS
Non PC vs PC within 48 hours of admission

- Non PCM Patients: 7.24
- PCM Patients: 5.57

Δ=1.67 days
Benefit of Early Palliative Care Consults on ICU LOS:
System MS DRG 871-Septicemia or Severe Sepsis

MS DRG 871
- ICU patients
- Non ICU patients

ICU ALOS
- PC patients

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<thead>
<tr>
<th>Hours</th>
<th>ICU Patients</th>
<th>Non ICU Patients</th>
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<tbody>
<tr>
<td>&gt; 48 Hours</td>
<td>4.35</td>
<td>3.23</td>
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<tr>
<td>&lt;= 48 Hours</td>
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Δ=1.12 days
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Financial Impact of Palliative Care Consults:
Patient/Family Directed Care Plan Change Methodology

Transition from aggressive to a less aggressive treatment plan due to PC intervention during hospitalization

Scale down button used in real time by PC provider on PC Navigator developed in EPIC
Financial Impact of Palliative Care Consults:
Patient/Family Directed Care Plan Change Methodology

- Data from Nov-Dec 2013
- 168 patients
- Change in cost calculated pre and post scaling down
Financial Impact of System Patient/Family Directed Care Plan Change

ROI (system): 1.5 times the cost

Annualized data extrapolated from Nov – Dec 2013
Sentara Healthcare: Outcomes Data

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ICU Palliative Care Pilot

Reasons for Initial Consult
Jan-Apr 2014

- Pain
- Other Symptoms
- Withdrawing of...
- Goals of Care

Actual Intervention
Jan-Apr 2014

- Pain
- Other Symptoms
- Withdrawing of Life...
- Goals of Care
- Hospice Discussion

No. of Patients
Benefit of ICU Palliative Care Pilot

Patient/Family Directed Care Plan Change

Methodology Annualized Cost Savings:

Positive Financial Impact

Annualized saved ICU Days\(^+\)

315

*Extrapolated from Jan – April 2014
+Obtained in collaboration with Care Coordination
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IMPACT:
Higher Quality AND Lower Costs

Quality
- 15% of PC patients were discharged on Hospice
- 69.3% of all patients discharged on hospice were referred by PC

“Palliative Care is the Solution to Bending the Cost Curve”

Cost

Nov 2013- Jan 2014
Conclusions

• Early PC has a positive impact on inpatient LOS, readmission rate, mortality rate and cost of care
• Savings at system level exceeds cost and PC improves quality of care
• Evidence that a PC ICU model can reduce ICU LOS and reduce cost
• PC increases referrals to hospice
Case Scenario

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Palliative Care at New England Quality Care Alliance and Tufts Medical Center

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Who is NEQCA?

We are a partnership of community and academic physicians dedicated to providing comprehensive, innovative, high quality, and affordable health care that brings value to their patients and the community, and expands the teaching and research mission of Tufts Medical Center and Floating Hospital for Children.

- Physician-led network of more than 1,700 members across eastern Massachusetts
- Supports a broad range of independent physician practices through 13 Local Care Organizations
- Develops and implements innovative programs and services that make it easier for physicians to succeed
Programs to Support the Quadruple Aim

- Patient Centered Medical Home
- Care Management
- Quality Improvement
- Pharmaceutical Care & Cost Management
- Healthcare Information Services
- Medical Coding & Clinical Documentation Improvement

Better Health
Better Provider Experience
Lower Costs
Better Care
Palliative Care: The Quadruple Aim

- An extra layer of support
- Improved communication
- Symptom control
- An extra layer of support
- Improved communication
- Symptom control
- Reduction in avoidable hospital admissions
- Reduction in ED visits
- Improved quality of life
- More days at home
- Improved satisfaction
- Sense of making "true" difference in people’s lives
- Improved satisfaction
- Sense of making "true" difference in people’s lives
- Improved care
- Better provider experience
- Lower costs
- Better health
- Better provider experience
- Lower costs
- Better health
- Better care
- An extra layer of support
- Improved communication
- Symptom control

Improved Outcomes

Improved Patient and Family Experience

Care Team Experience/Wellbeing

Affordable Cost

Better Health

Lower Costs

Better Care

Better Provider Experience

NEQCA
New England Quality Care Alliance
Pushing Palliative Care Upstream at NEQCA/TMC

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<tr>
<th>Hospital-based</th>
<th>Outpatient Clinic</th>
<th>Community-based</th>
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<td>• Provided by an inpatient team: MD, NP, RN, SW</td>
<td>• Currently same as Hospital based team</td>
<td>• Provided via partnership with high quality hospice and palliative care providers</td>
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Questions