Palliative Care: Breaking the Cycle of Readmissions

NANCY D. ZIONTS
CHIEF PROGRAM OFFICER
JEWISH HEALTHCARE FOUNDATION
PITTSBURGH REGIONAL HEALTH INITIATIVE
MAY 2012

JEWISH HEALTHCARE FOUNDATION

History of the Jewish Healthcare Foundation (JHF)

- The Foundation was established in 1990 following the sale of Montefiore Hospital

- Our mission is to support and foster the provision of healthcare services, healthcare education and medical and scientific research, and to respond to the medical, custodial and other health-related needs of elderly, underprivileged and underserved populations

JEWISH HEALTHCARE FOUNDATION

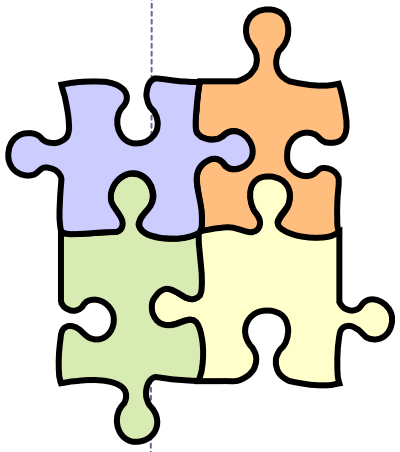
"A *Think*, *Do*, *Train* and *Give* Tank"

- **A public charity with two supporting organizations**
  - Pittsburgh Regional Health Initiative (PRHI)
  - Health Careers Futures (HCF)

Our Staff

40+ Staff

- **Think**
  - Researchers
  - Data analysts
  - Communications, media, writers
  - Policy analysts
  - Evaluators
- **Give**
  - Program officers
  - Grant managers
  - Fiscal agents for HIV/AIDS funds
  - Accounting

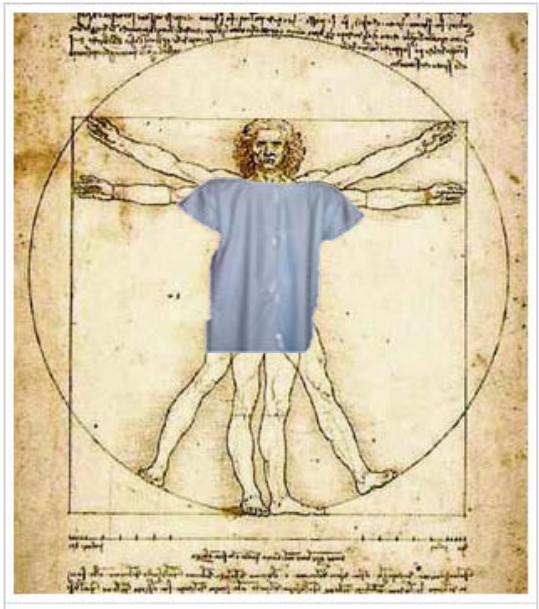


- **Do**
  - Program directors
  - Event planners
  - Trainers
  - Grant writers
  - Web designers
  - Public relations
- **Train**
  - Curriculum developers
  - Coaches and trainers

JEWISH HEALTHCARE FOUNDATION

Our Focus: The Complex Patient

Who is frequently hospitalized?



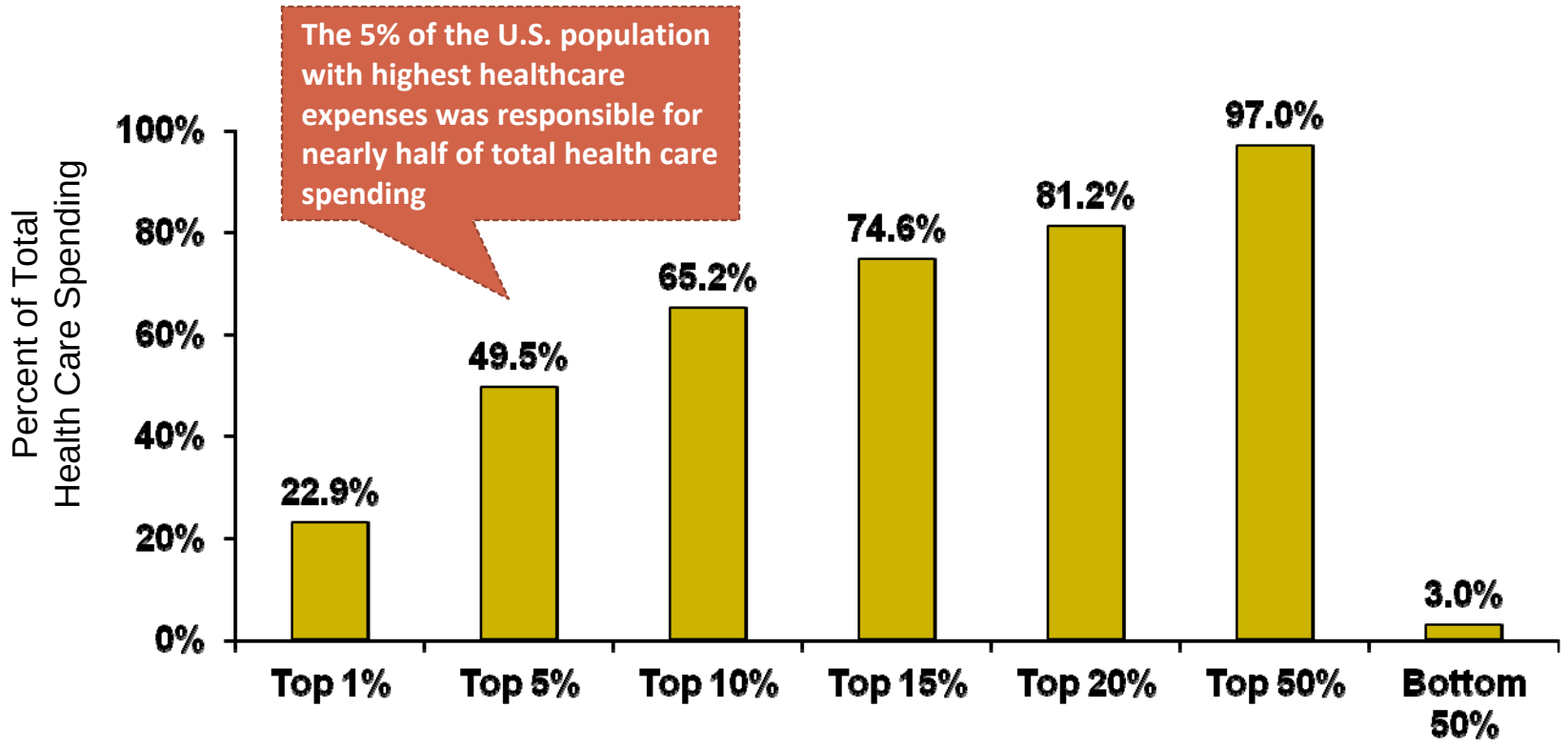
Do you know your customer?

Are you meeting their need?

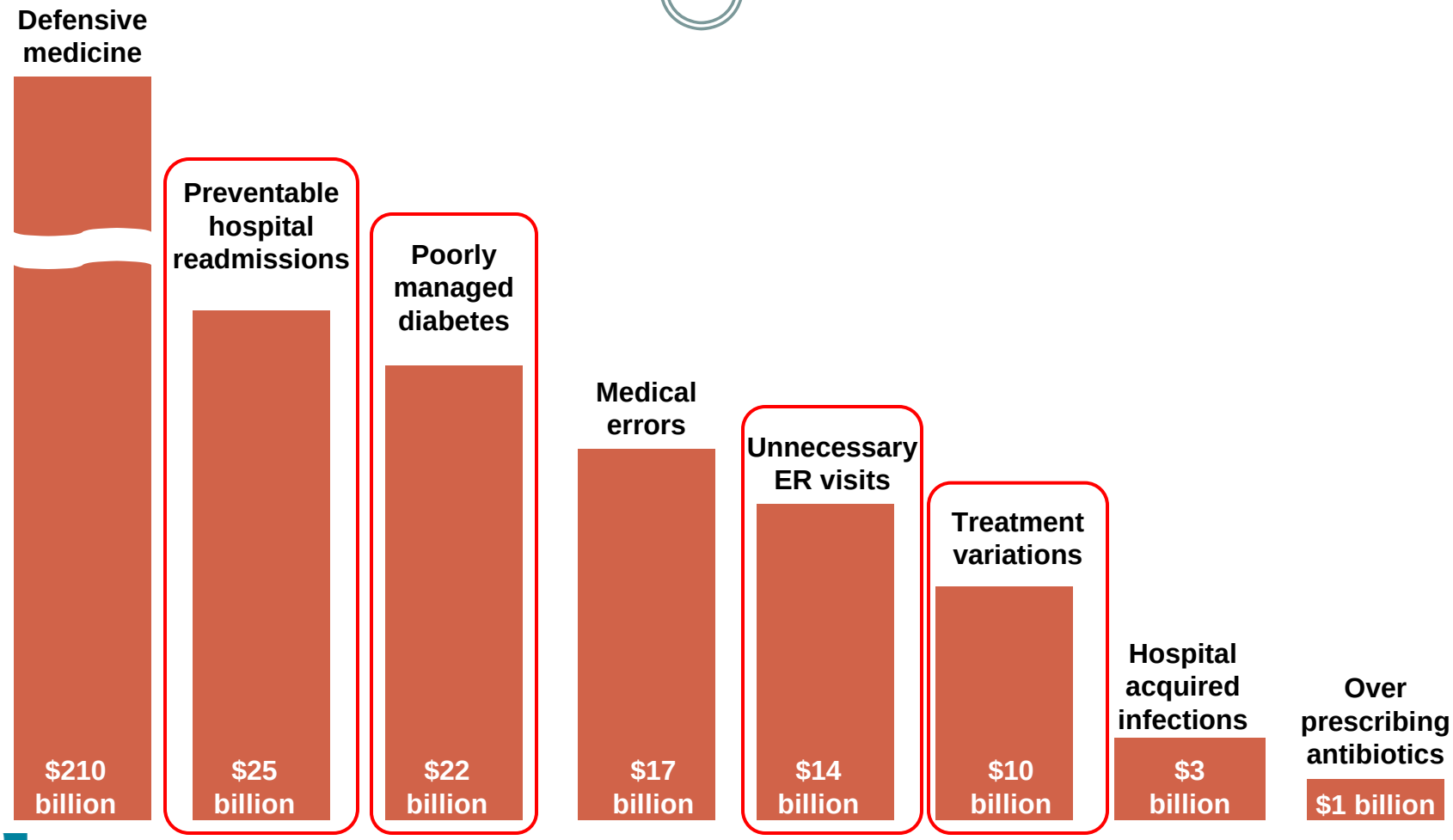
JEWISH HEALTHCARE FOUNDATION

Focus on Spending Leads to Complex Patients

Concentration of Health Care Spending in the U.S. Population, 2007



Where the Costs of Waste Lie

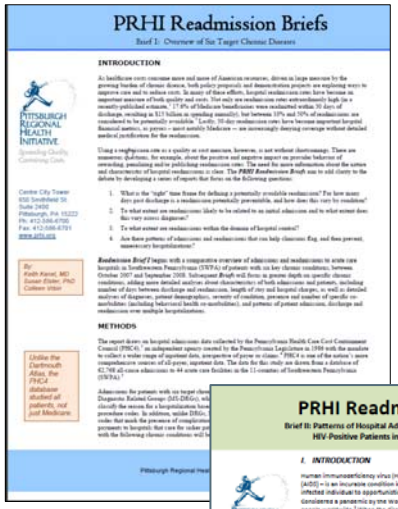


Source: Institute of Medicine (1999), "The Factors Fueling Rising Healthcare Costs 2006", PricewaterhouseCoopers (2006), Medpac (2007), American Association of Endocrinologists (2006), Center for Disease Control and Prevention (2005), Solucient (2007), U.S. Outcomes Research Group of Pfizer Inc (2005), National Committee for Quality Assurance (2005), Analysis by PricewaterhouseCoopers' Health Research Institute. 2010

JEWISH HEALTHCARE FOUNDATION

We Let the Data Guide Our Work

The Complex Patient

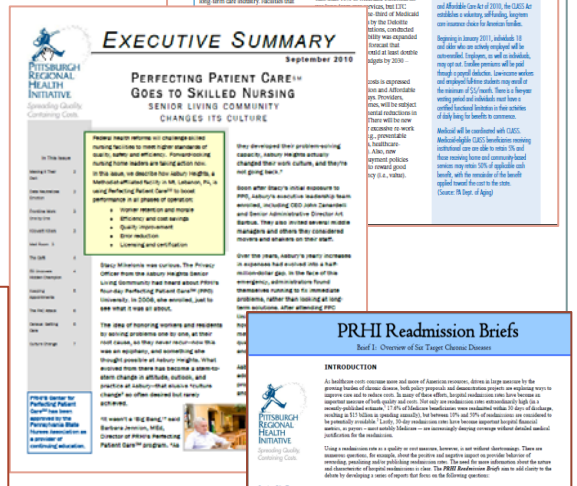


Behavioral Health and Substance Abuse

HIV/AIDS

Skilled Nursing

Chronic Disease (COPD)



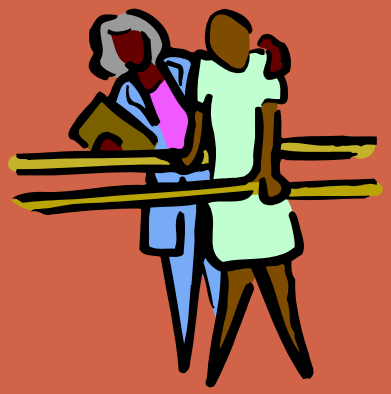
End of Life

Multiple Conditions

JEWISH HEALTHCARE FOUNDATION

The data helps us understand a series of questions

Question 1: Who Gets Readmitted?



- Those more likely to end up in the hospital are:
  - Older
  - African American
  - Medicaid beneficiaries
  - Those Discharged to a Skilled Nursing Facility (SNF)

JEWISH HEALTHCARE FOUNDATION

Question 2: How Big is the Problem?

Costs:

- 6% of Medicare Long Term Care beneficiaries account for 17% of spending

- Last 6 months of life account for 10-12% of all healthcare costs

JEWISH HEALTHCARE FOUNDATION

How Big Is the Problem?

Utilization:

- Nursing homes account for a larger share of Emergency Department visits than any other residential settings
- About ½ of patients have at least one ED visit, and 1/2 of these have two or more per year
- More than 1/3 living in LTC are admitted to a hospital at least once a year, more than 40% have two or more admissions
- One year out from discharge, 67.1% of those discharged for a medical condition had been readmitted or died

JEWISH HEALTHCARE FOUNDATION

Question 3: What Clinical Conditions Result in People Getting Readmitted?

- Congestive Heart Failure
- Mental Health Disorders
- Abnormal Heartbeat
- Primary Cancer
- COPD
- Infections

JEWISH HEALTHCARE FOUNDATION

Question 3a: Is it Different *from Skilled Nursing Facilities* ?

- Most common 30 day readmission diagnoses for pts discharged to SNFs
  - **Congestive Heart Failure**
  - **Urinary Tract Infections**
  - **Renal Failure**
  - **Pneumonia**
  - **Chronic Obstructive Pulmonary Disease**
- Half of residents are readmitted for complications or infections
- One study demonstrated that 82% of residents had at least one episode of infection until nursing home discharge or two years after admission

PHC4 data (Oct 1 2007-Sept 30 2009) 11 county SWPA region

JEWISH HEALTHCARE FOUNDATION

Four Categories of Readmissions

	Planned	Unplanned
Related	Chemotherapy, staged surgery	CHF, stroke, pneumonia, medication errors, infections
Unrelated	Cardiac cath, hip replacement	Trauma and harm from environment, e.g., falls, behavioral health

Question 4: Is This a New Problem?

No, but it's growing… slowly at first, but now more quickly….

JEWISH HEALTHCARE FOUNDATION

Question 5: Why is Readmissions Reduction a Focus NOW?

- Up until now,
  - Reimbursement policy did not disincentivize readmissions at either the acute or skilled nursing home level
  - We weren't paying a lot of attention to the issue of the comorbidity of hospitalization
- That's all changing…

JEWISH HEALTHCARE FOUNDATION

What's Changing

- PPACA focus on reducing readmissions (focus on cost and continuity of care)
- New studies show that hospitalizations themselves can be contributing factors to the cognitive decline and deterioration of patients (as reported in Journal of Neurology, March 2011)

JEWISH HEALTHCARE FOUNDATION

One Possible Solution

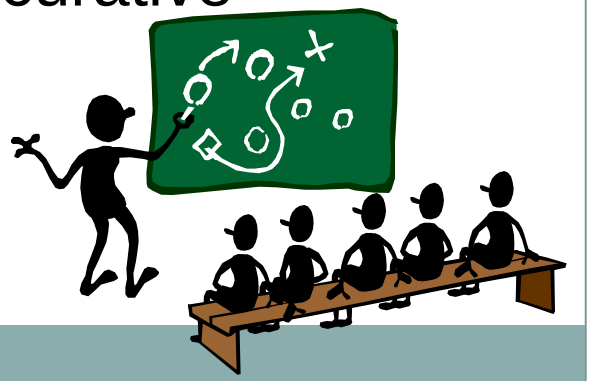
PALLIATIVE CARE

JEWISH HEALTHCARE FOUNDATION

Defining Palliative Care

- Specialized medical care for people with serious illnesses.
- Provides patients with relief from the symptoms, pain, distress of a serious illness—whatever the diagnosis.
- Goal is to improve quality of life for both the patient and the family.
- Provided by a team who work together with a patient's other doctors.
- Appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.

It is not just for the Dying!!



JEWISH HEALTHCARE FOUNDATION

Palliative Care Includes

- Providing expert treatment of symptoms such as pain, shortness of breath, fatigue, constipation, nausea, loss of appetite and many other symptoms
- Devoting time to listen, answer questions about disease and treatment options and matching treatments to your individual goals
- Helping to coordinate and share information with all other doctors and health providers.

JEWISH HEALTHCARE FOUNDATION

Palliative Care

Skills

- Assessment
- Information Sharing
- Decision Making
- Care Planning
- Care Delivery
- Confirmation

Needs

- Disease Management
- Physical
- Psychological
- Social
- Spiritual
- Practical
- End of Life Care
- Grief Bereavement

JEWISH HEALTHCARE FOUNDATION

Question 5a: Is Palliative Care a New or US Model?

- New-ish (50+ years) and growing rapidly
- But not an exclusively US idea. In fact, The US lags behind other countries in the acceptance and spread of palliative concepts and care (hospice and palliative care are coupled)
- It was only in the late 1990s that the WHO set standards for palliative care and pain control, calling it a “priority.”

JEWISH HEALTHCARE FOUNDATION

Question 6: Can Palliative Care Contribute to a Decline in Readmissions?

- Hebrew SeniorLife (Dr. Randi Berkowitz) in an AHRQ Health Care Innovations Exchange showed a 20% reduction in readmission using a three part protocol involving:
  - Standardized assessment
  - Palliative care consults
  - Root cause analysis

JEWISH HEALTHCARE FOUNDATION

- Mercy Medical Center in Cedar Rapids Iowa kept readmissions rates low through a combination of:
  - Provider collaboration
  - Early discharge planning with scheduled follow up
  - Telemonitoring
  - Strong focus on end of life care that involves palliative care teams, advanced directives and hospice care for complex patients
    - As reported by the Commonwealth Fund, March 2011

JEWISH HEALTHCARE FOUNDATION

Question 7: Can Palliative Care Reduce Hospital Costs?

- An analysis of nearly 3000 patients in eight hospitals with established palliative care programs showed:
  - $1696 in direct and $279 in direct costs per day savings for patients discharged alive
  - $4908 in direct savings and $374 per day savings for palliative care patients who died
    - Archives of Internal Medicine/Volume 168, September 8, 2008, R. Sean Morrison, MD, et al. also reported in Health Affairs, March 2011.

JEWISH HEALTHCARE FOUNDATION

Question 8: Can Palliative Care contribute to improvements in quality of life?

- Early Palliative Care with metastatic non-small lung cancer patients led to significant improvements in quality of life and mood. Less aggressive care at end of life but longer survival.
  - NEJM August 19, 2010, study by Jennifer S. Temel, MD, et al Massachusetts General Hospital

JEWISH HEALTHCARE FOUNDATION

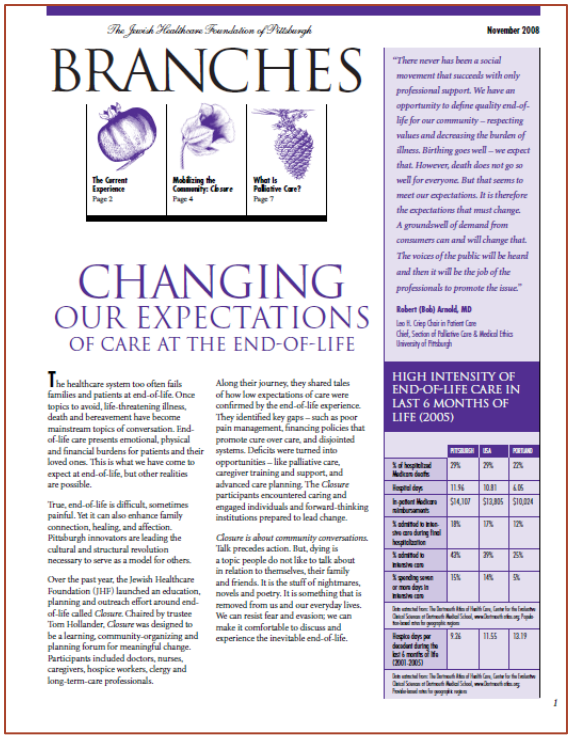
Question 9:
Why is it so difficult to change the paradigm?

What is beginning to change	What still needs to improve

• Incentive alignment
• Availability of Palliative Care services
• Training of specialty staff
	• Palliative Care is not well understood
	  ○ Associated (incorrectly) with only the dying
	  ○ Associated (incorrectly) with "giving up"
	• Training of front line staff, communication among providers and with families and patients

JEWISH HEALTHCARE FOUNDATION

The Pittsburgh Story



The Jewish Healthcare Foundation of Pittsburgh **November 2008**

BRANCHES

The Current Experience Page 2 | Mobilizing the Community: Closure Page 4 | What is Palliative Care? Page 7

CHANGING OUR EXPECTATIONS OF CARE AT THE END-OF-LIFE

The healthcare system too often fails families and patients at end-of-life. Once topics to avoid, life-threatening illness, death and bereavement have become mainstream topics of conversation. End-of-life care presents emotional, physical and financial burdens for patients and their loved ones. This is what we have come to expect at end-of-life, but other realities are possible.

True, end-of-life is difficult, sometimes painful. Yet it can also enhance family connection, healing, and affection. Pittsburgh innovators are leading the cultural and structural revolution necessary to serve as a model for others.

Over the past year, the Jewish Healthcare Foundation (JHF) launched an education, planning and outreach effort around end-of-life called *Closure*. Chaired by trustee Tom Hollander, *Closure* was designed to be a learning, community-organizing and planning forum for meaningful change. Participants included doctors, nurses, caregivers, hospice workers, clergy and long-term-care professionals.

Along their journey, they shared tales of how low expectations of care were confirmed by the end-of-life experience. They identified key gaps – such as poor pain management, financing policies that promote cure over care, and disjointed systems. Deficits were turned into opportunities – like palliative care, caregiver training and support, and advanced care planning. The *Closure* participants encountered caring and engaged individuals and forward-thinking institutions prepared to lead change.

Closure is about community conversations. Talk precedes action. But, dying is a topic people do not like to talk about in relation to themselves, their family and friends. It is the stuff of nightmares, novels and poetry. It is something that is removed from us and our everyday lives. We can resist fear and evasion; we can make it comfortable to discuss and experience the inevitable end-of-life.

"There never has been a social movement that succeeds with only professional support. We have an opportunity to define quality end-of-life for our community – respecting values and decreasing the burden of illness. Birthing goes well – we expect that. However, death does not go so well for everyone. But that seems to meet our expectations. It is therefore the expectations that must change. A groundswell of demand from consumers can and will change that. The voices of the public will be heard and then it will be the job of the professionals to promote the issue."

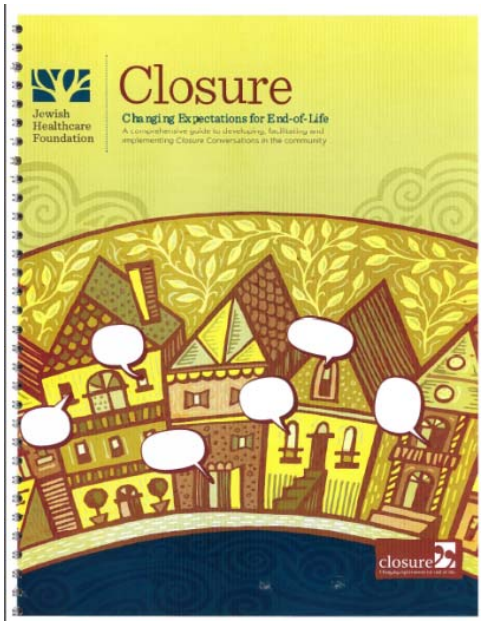
Robert (Bob) Arnold, MD
Leo H. Criep Chair in Patient Care
Chief, Section of Palliative Care & Medical Ethics
University of Pittsburgh

HIGH INTENSITY OF END-OF-LIFE CARE IN LAST 6 MONTHS OF LIFE (2005)

	PITTSBURGH	USA	PORTLAND
% of hospitalized Medicare deaths	29%	29%	22%
Hospital days	11.96	10.81	6.05
In-patient Medicare reimbursements	$14,107	$13,805	$10,024
% admitted to intensive care during final hospitalization	18%	17%	12%
% admitted to intensive care	43%	39%	25%
% spending seven or more days in intensive care	15%	14%	5%
Hospice days per decedent during the last 6 months of life (2001-2003)	9.26	11.55	13.19

Data extracted from: The Dartmouth Atlas of Health Care, Center for the Evaluative Clinical Sciences at Dartmouth Medical School, www.dartmouthatlas.org Provider-based rates for geographic regions

1



JEWISH HEALTHCARE FOUNDATION

Why We Started *Closure*

High Intensity of End-of-Life Care in Last 6 Months of Life (2005) Comparison to a Community with a Strategy

	Pittsburgh	USA	Portland
% of hospitalized Medicare deaths	29%	29%	22%
Hospital days	11.96	10.81	6.05
In-patient Medicare reimbursements	$14,107	$13,805	$10,024
% admitted to intensive care during final hospitalization	18%	17%	12%
% admitted to intensive care	43%	39%	25%
% spending seven or more days in intensive care	15%	14%	5%
Data extracted from: The Dartmouth Atlas of Health Care, Center for the Evaluative Clinical Sciences at Dartmouth Medical School; **Population-based rates** for geographic regions			
Hospice days per decedent during the last 6 months of life (2001-2005)	9.26	11.55	13.19
Data extracted from: The Dartmouth Atlas of Health Care, Center for the Evaluative Clinical Sciences at Dartmouth Medical School; **Provider-based rates** for geographic regions;			

JEWISH HEALTHCARE FOUNDATION

Where We Are

High Intensity of End-of-Life Care in the Last Month of Life (2010)

	Hospital A	Hospital B	Hospital C	USA
% of cancer patients dying in hospital	38.0%	31.6%	27.7%	29%
% of cancer patients admitted to the hospital	71.5%	63.8%	65.3%	61.3%
Hospital days per cancer patient	8.4	6.7	6.1	5.1
% of cancer patients admitted to the intensive care unit	46.0%	16.8%	29.3%	24%
ICU days per cancer patient	4.1	1.1	1.2	1.3
% of cancer patients enrolled in hospice	43.5%	55.2%	53.5%	55%
Hospice days per cancer patient	6.7	7.4	7.1	8.7

Data extracted from: The Dartmouth Atlas of Health Care, Institute for Health Policy & Clinical Practice. Quality of End-of-Life Cancer Care for Medicare Beneficiaries: Regional and Hospital-Specific Analyses.

JEWISH HEALTHCARE FOUNDATION

Barriers to Quality Care of Complex Patients

Society – ambivalence/ ambiguity over what makes a "good" life or death; unwillingness to consider death as a part of the lifecycle

Family – lack of advanced care planning and limited awareness of palliative care options; internal conflicts that are magnified in crisis situations; need for guidance and support from healthcare community

System – "default settings of cure versus care," supported by current reimbursement structure that incentivizes treatment over palliative care

Provider – uncertainty over prognosis; reluctance to admit "failure," or disappoint patients; insufficient training and knowledge about resource availability including palliative care for life threatening/chronic illnesses

JEWISH HEALTHCARE FOUNDATION

Our Vision of the Ideal

- Patients and loved ones are informed about choices and challenges
- Resources and support systems are widely engaged and accessible in all settings, understood by physicians and families and appropriately funded
- Curricula and planning tools are widely available for professionals and community members
- End-of-life and Palliative Care issues are openly discussed, with the experience viewed as meaningful and uplifting, whenever possible

JEWISH HEALTHCARE FOUNDATION

Our Model: A Natural Network of Stakeholders Who Directly Influence Care of Complex Patients

Healthcare Providers

AIDS Specialists
Cardiology
Critical Care
Emergency Care
Family Medicine
Geriatrics
Hospice Care
Long Term Care
Oncology
Palliative Care
Pathology
Pediatric Palliative Care
Primary Care
Psychiatry
Surgery

Professional Caregivers

Adult Day Care
Home Health Care / Direct Care Workers
Hospice Care
Nursing Home Administrators
Palliative Care

Service Providers

Care Managers
Clergy
Estate and Financial Planners
Lawyers
Senior Service Providers
Social Workers

Family and Informal Caregivers

Children
Neighbors
Siblings
Spouses

JEWISH HEALTHCARE FOUNDATION

Closure Community Conversations

Overview of Issues: How do most Americans live the last 10% of their lives and why? What makes a "good" end-of-life experience for patients, families and practitioners?

The Family and Providers Experiences: What can caregivers and providers learn from each other's personal experiences from diagnosis to bereavement, the good and the bad?

Religious Values: How do these laws and their underlying values and customs influence contemporary end-of-life decisions ?

The Planning Tool Kit: What are the practical aspects for successful planning – what are the essential documents necessary for successful preparation?

Resources and Implementation: When and why should we access palliative care services and hospice referrals? Where do families find effective geriatric practices and legal planning assistance when they need them?

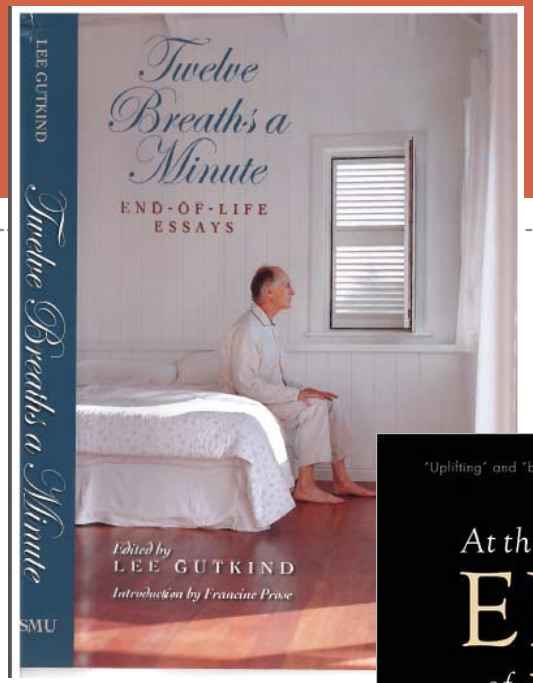
Planning for Culture Change: What can we work on as caregivers and providers together to advance the state of end-of-life care here in our community? Can we develop a working model that will benefit our region and beyond?

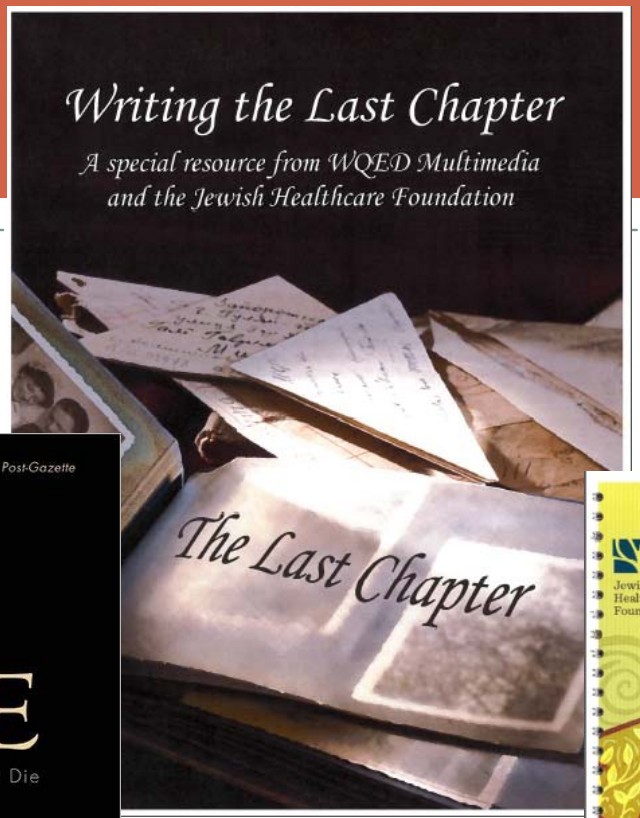
JEWISH HEALTHCARE FOUNDATION

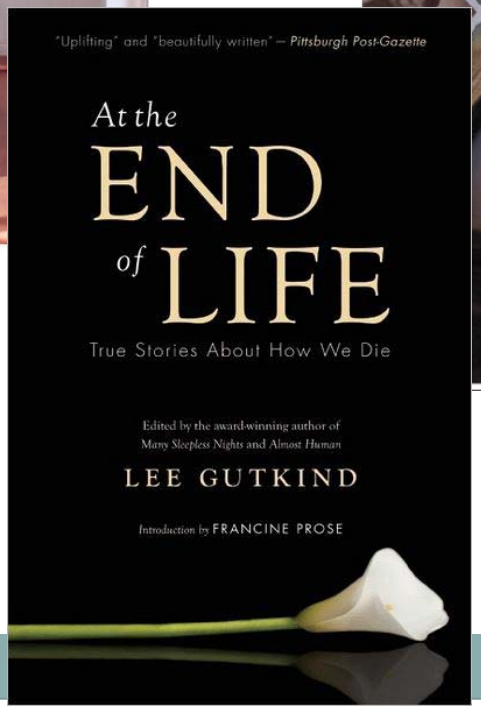
Resources: Closure.org

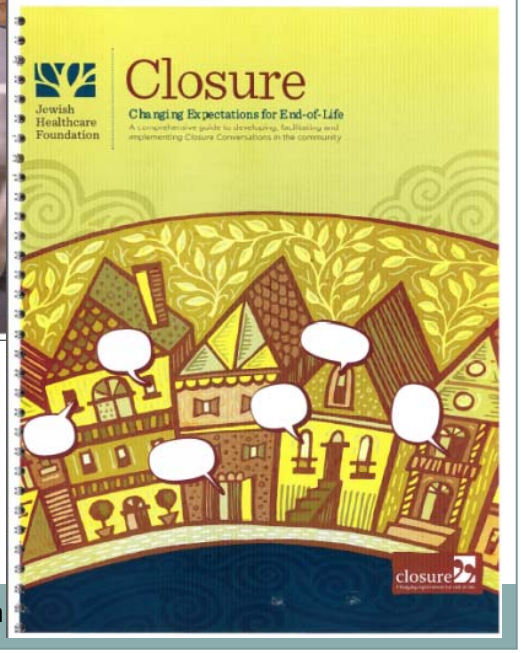
JEWISH HEALTHCARE FOUNDATION

Publications









JEWISH HEALTHCARE FOUNDATION

Our Current Agenda

- Palliative Care Policy Changes – Education and Practice
- A Network Across the State with Common Goals and Voice
- Long Term Care Champions: Demonstration Projects in LTC that include education and engagement of staff, patients families, providers across settings

JEWISH HEALTHCARE FOUNDATION

Our Desired Outcomes

- Increased access to palliative care at acute, skilled and community levels
- Increased training and proficiency among front line staff
- Enhanced communication across settings
- Increased family engagement and advanced care planning
- Reduction in unnecessary emergency room visits and avoidable readmissions and costs

JEWISH HEALTHCARE FOUNDATION

For Additional Information

Nancy D. Zionts

Chief Program Officer

Jewish Healthcare Foundation

412 594 2559

zionts@jhf.org

- Websites:
  - Jhf.org
  - Closure.org

JEWISH HEALTHCARE FOUNDATION