Changing the System to Improve Care

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Learning Objectives

1. Learn three components of systems change work to improve palliative care services.

2. Describe educational and administrative options for enhancing palliative care service delivery.

3. Construct a list of common barriers and solutions to improving generalist palliative care.
Our Intervention

- Interdisciplinary teams
  - Patient-centered goals of care discussion
    - Realistic prognostication
  - Pain and symptom relief
  - Disposition planning reflecting patient goals
  - Patient/Family support
  - Bereavement support
Key Palliative Care Outcomes

– Reduced ICU length of stay
– Rapid symptom relief
– Earlier referral to hospice services-longer
– Greater patient/family satisfaction
– Lower hospital cost
– Prolonged survival (outpatient intervention)
What is left to accomplish?

• In hospitals, at best, only 25-50% of palliative care needs are being met.
  – Variable penetration to areas of highest need:
    • ICUs, ED, Oncology, Neurology, Renal
• Between hospitals and hospice there is a large gap of palliative care needs across the Continuum of health care.
  – Outpatient services
  – Long-term care
  – Home care
"I wish you'd called me sooner, Mrs. Moodie."
Improving Pall Care Services

• Provider Education—Yes, but ...

• Improving the system of care is vital to support the clinician to “do the right thing, at the right time”
Systems Approach

• An organized, deliberate approach to the identification, assessment, and management of a complex clinical problem. A systems-based approach may include
  – checklists
  – treatment algorithms
  – provider education
  – patient/family education
  – quality improvement initiatives
Who are generalists?

• Ward/ICU/ED nurses
• Unit social workers/DC planners
• Oncologists, hospitalists, Pulm CC, Nephrology, Primary Care, etc.
• Hospital chaplains
• Therapists, pharmacy, psychology, Child Life, etc.
Improving the System

1. Finding the unmet need
2. Integration projects
3. Standards/Policies
4. Documentation of “full” informed consent
5. Patient/Family education/Resources
6. Generalist education
7. QI projects
8. Provider accountability
1. Find the Unmet Needs

A patient-centered approach would be to design a system where palliative care interventions are based on *patient and/or disease factors*, rather than clinician attitudes/values.

- Patients are fully informed about treatment options.
- Patients have equal access to all hospital resources.
- Patients receive only the life-sustaining treatments they desire/are appropriate to their medical condition/prognosis.
Common screening systems

- **ICU**
  - Length of stay
  - Multi-organ failure
  - Metastatic cancer
  - Prolonged unconsciousness
  - Nursing home admission

- Emergency department

- Oncology clinic

- Special populations
  - LVAD/CHF
  - Nursing home admits
  - PEG or trach consideration
Primary Palliative Care Criteria
On Admission

A potentially life-limiting or life threatening condition AND one of the following...

✓ The ‘Surprise’ question
✓ Frequent admissions
✓ Difficult to manage symptoms
✓ Complex care requirements
✓ Decline in function or weight

Primary Palliative Care Criteria

Daily Checklist

- The ‘Surprise’ question
- Difficult to control symptoms
- ICU LOS > 1 week
- Lack of Goals of Care documentation
- Disagreement/uncertainty re:
  - Major medical decisions
  - Resuscitation preferences
  - Use of non-oral feeling/hydration

2. Integration Projects

- Spread palliative care principles into locations of high unmet needs, through …
  - setting collaborative goals
  - early patient identification (screening)
  - routine family meetings
  - quality improvement-data driven change
Models for Structuring an ICU Palliative Care Initiative


**Consultative Model**
- Palliative Care Team
- Palliative Care Consultation
- Usual ICU Care by Critical Care Team

**Integrative Model**
- Palliative Care Principles/Interventions Embedded in Usual ICU Care

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Observed Models: ED-Palliative Care Integration

I. TRADITIONAL CONSULT
- No specific initiatives/programmatic goals

II. BASIC INTEGRATION
- Mutual agreements/initiatives regarding process and function
- Mutual workflow e.g., direct admit to palliative care unit

III. ADVANCED INTEGRATION
- Basic engagement elements and...
  - Education/QI Partnership
  - Use of palliative care "triggers"
    - and/or
  - ED-palliative care focused assessment & documentation tools

IV. ED - ADVANCED
- Advanced engagement elements and...
  - Routine generalist palliative care by the ED
  - ED-palliative care subspecialist

Intensity of ED Engagement in Palliative Care

Palliative care principles should be integrated into all facets of the health care delivery system. Building on the work of specialist palliative teams now in place at the majority of US hospitals, this integration is easily achievable.

The IPAL Project, an initiative of the Center to Advance Palliative Care, is designed to provide a central venue for sharing expertise, evidence, tools and resources essential to the integration and improvement of palliative care in specific health care settings. Our first project was IPAL-ICU (Improving Palliative Care in the ICU), launched in June 2010, led by Judith Nelson, MD, JD with support from the National Institutes of Health. Our second project was IPAL-EM (Improving Palliative Care in Emergency Medicine), launched in November 2011, led by Tammie E. Quest, MD, with support from the Olive Branch Foundation. Our third project is IPAL-OP (Improving Outpatient Palliative Care), co-led by Lynn H. Spragens, MBA and David E. Weissman, MD, with support from The Fan Fox and Leslie R. Samuels Foundation, Inc.

Join the Discussion

Ipal.capc.org
3. Policies/Standards

- Basis for best practice/quality improvement
  - Develop by consensus among key stakeholders

- Examples:
  - SQ opioid infusion policy
  - Ventilator withdrawal policy
  - Opioid dosing interval prescribing policy
  - Standard for documenting informed consent (full)
  - Standard for timing of ICU family meetings
4. Documenting Informed Consent

*Doctor: Mr. Jones, your mother’s kidneys are failing, I recommend we start dialysis.*

*Son: Well ... Uh .. I guess that’s ok;*

Full informed consent includes*:

– Proposed treatment
– Benefits/Risks
– Alternatives, including no life-sustaining treatment

*http://www.eperc.mcw.edu/EPERC/FastFactsIndex/ff_164.htm*
5. Patient/Family Ed.

- Readily available in all care sites
- Reading level/language appropriate
  - Hospice/Palliative Care defined
    - Program brochures and contact info
  - Artificial nutrition/hydration
  - DNR/CPR
  - Last days
  - When is enough, enough?
  - Other
6. Generalist Education

• No single best format
• Mix of didactic and experiential is optimal
  – In person or e-learning for didactic
  – Mentored clinical experience
• Continuing education credits
• Minimum requirement for credentialing
7. Quality Improvement

- ED to ICU admits
- Long ICU LOS
- Spiritual care engagement
- Documentation of informed consent
- Pain control within 24 hours of admission
- Documentation of family meetings, goals of care
- Bowel regimen with opioids
8. Provider Accountability

Hospitalist: I want to ask Palliative Care to see your patient to help with pain.
Oncologist: No

Current options are rarely effective at behavioral change..
• Peer review; Report to CMO or medical staff committee

Fear of legal action and loss of patient referral have limited the impact of hospitals to influence behavior.
Provider Accountability (PA)

• Health Reform is a golden opportunity to improve PA as it is in the hospital’s best interest (reduce mortality, readmissions)
  – Standards tied to QI
    • Family meeting within 48 hours of ICU admission
  – Education requirement for credentialing
  – Routine review of outlier clinicians
  – Chain of Command
Chain of Command

Poorly Managed Pain

Primary Doc/Ward Nurse → Unit Manager → Service Line Chief → CMO/CNO
Summary

• The opportunity is here to foster improved palliative care beyond the specialist team.
• Systems-based thinking requires different approach from pure education:
  – Processes
  – Data
  – Outcomes