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Katherine Virkstis on *Preventing Avoidable Readmissions*

October 17, 2011

Featured Speakers For Today's Webcast:

Katherine Virkstis, ND, Senior Consultant,
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Government & Industry Affairs, Siemens Healthcare
Chair of the HIMSS Board of Directors

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Key Healthcare Delivery Reforms

Mandatory:

- **Hospital Value-based Purchasing Program – Inpatient Final Rule**
  - Establishes VBP for hospitals where a percentage of payment would be tied to performance on Quality Measures
- **Readmissions**
  - Hospitals with higher than expected readmission rates will get decreased reimbursement for all Medicare discharges. Initial information released in FY 2012 IP PPS Final Rule
- **Hospital-acquired Conditions - Inpatient**
  - More penalties and expansion to Medicaid (effective 7/1/2011, states have 1 year grace period)

Voluntary:

- **Accountable Care Organizations - NPRM**
  - Shared Savings Program to award ACOs as well as Pioneer option announced from CMMI (May 2011)
- **Payment Bundling**
  - CMMI offering announced with 4 options (August 2011) and national payment bundling pilot (awaiting regulation)

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HIT Policy Committee Testimony
Meaningful Use Workgroup – October 5th, 2011

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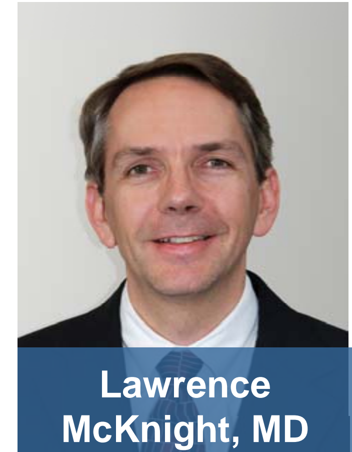
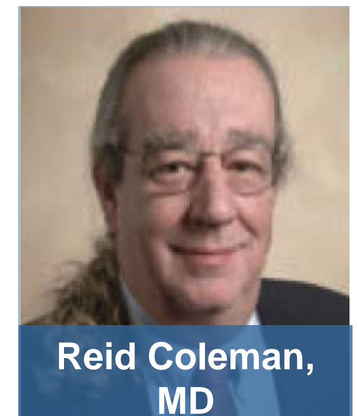
Dr. Lawrence McKnight, Siemens Healthcare testified on developing systems to meet Meaningful Use III



Asked the committee:

- For more lead time for customers to implement.
- For more clarity in the objectives and measures, earlier in the process.
- For better mechanisms for customers to claim certification.
- To remember those that are not achieving MU, and removing barriers to ensure that they can become meaningful users.

Dr. Reid Coleman, former CMIO of Lifespan testified on developing systems to meet Meaningful Use III



Addressed the committee with the following:

- We don't lack data, we just can't share it meaningfully
- Implementing data standards and transmission standards will provide significant improvements in our ability to use and share information
- Meaningful Use has been shown to be effective in accelerating this implementation of standards

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Siemens Customers Who Have Achieved Meaningful Use

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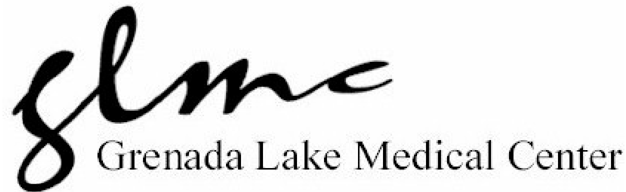

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Preventing Avoidable Readmissions

Coordinating Care for Complex Patients Across the Continuum

NURSING EXECUTIVE CENTER

Roadmap for Discussion

I — Building a Readmission Prevention Strategy

II — Coordinating Care for Complex Patients Across the Continuum

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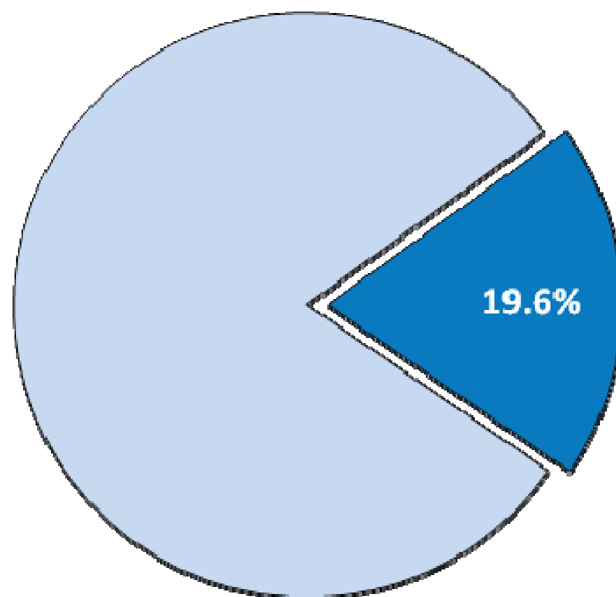
Readmissions an Alarmingly Frequent Occurrence

Percentage of Medicare Patients Readmitted Within 30 Days

2005



Source: Jencks SF, et al., "Rehospitalizations among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine*, 2009, 360: 1418-1428; Nursing Executive Center analysis.

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Hospital Readmissions a Universal Problem

Percentage of AMI[1] and HF[2] Readmissions by Hospital Type

Hospital Type	AMI	HF
Less than 100 Beds	16.7%	11.2%
100 to 399 Beds	16.1%	10.7%
400+ Beds	15.4%	10.1%
Nonprofit	16.0%	10.6%
Proprietary	16.4%	10.7%
Teaching Status – Yes	15.0%	9.9%
Teaching Status – No	16.3%	10.8%

1 Acute Myocardial Infarction.
2 Heart Failure.

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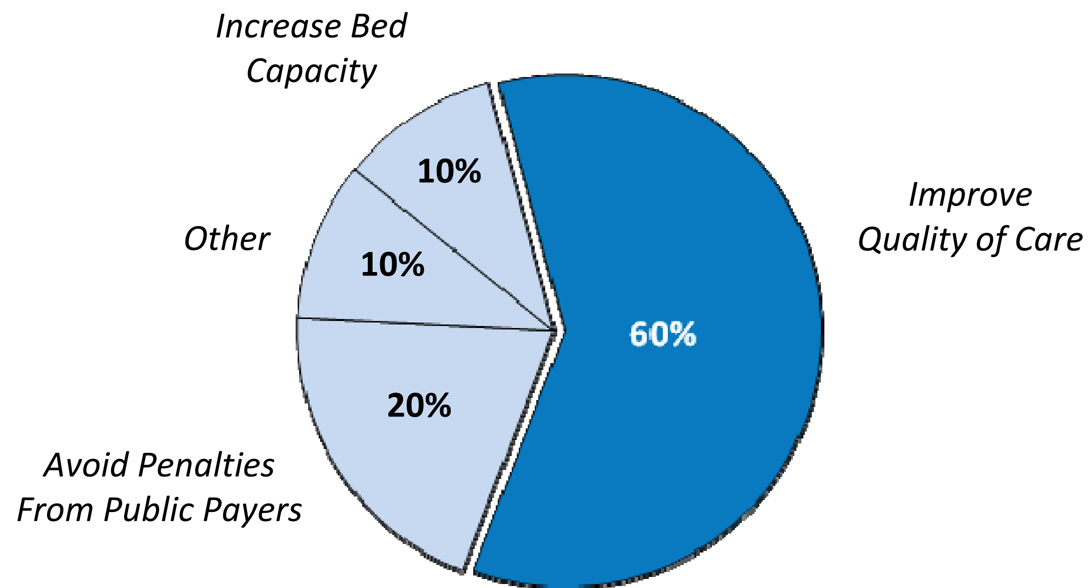
Source: Krumholz HM, et al., "Patterns of Hospital Performance in Acute Myocardial Infarction and Heart Failure 30-Day Mortality and Readmission," *Circulation Cardiovascular Quality and Outcomes*, 2009, 2: 407-413; Nursing Executive Center interviews and analysis.

Quality the Primary Driver for Reducing Readmissions



Source: Advisory Board Company 2010 Member Survey on Readmissions; Nursing Executive Center interviews and analysis.

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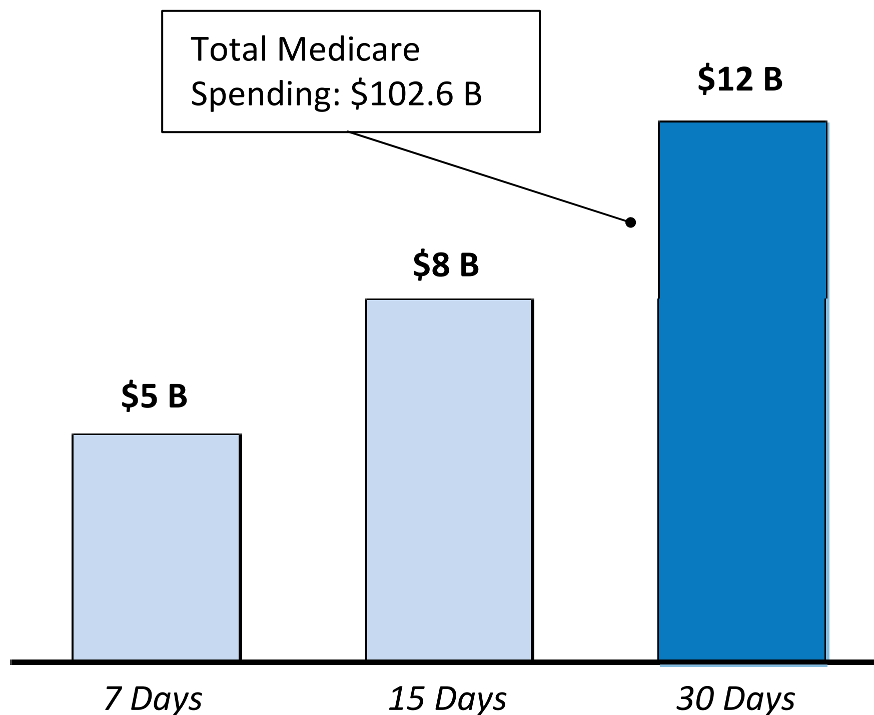
A Multibillion-Dollar Opportunity to Reduce Unnecessary Health Care Spending



Source: Jencks SF, et al., "Rehospitalizations among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine*, 2009, 360: 1418-1428; MedPAC June 2007; Nursing Executive Center analysis.

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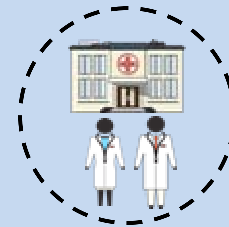
Health Reform Creating New Financial Incentives

Short-Term Incentives	Mid-Term Incentives	Long-Term Incentives
		
Readmissions Penalties	**Episodic Bundling**	**Shared Savings**

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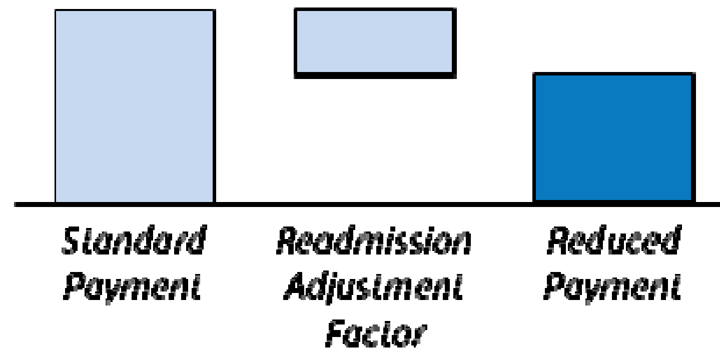
Source: Nursing Executive Center interviews and analysis.

Modeling the Impact of the Readmissions Penalty

Hospital Readmissions Reduction Program



Policy in Brief: Medicare's Hospital Readmissions Reduction Program

- Begins in or after October 2012
- Targeted DRGs payments reduced by adjustment factor based on readmissions deemed "excessive"
- Adjustment factor calculated as percentage of revenue paid for excessive readmissions divided by total revenue
- Projected $7.1 B in reduced payments (2013-2019)

Source: U.S. House of Representatives, "Amendment in the Nature of a Substitute to H.R. 4872, as Reported," March 18, 2010; U.S. Senate, "The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act," December 24, 2009; Nursing Executive Center interviews and analysis.

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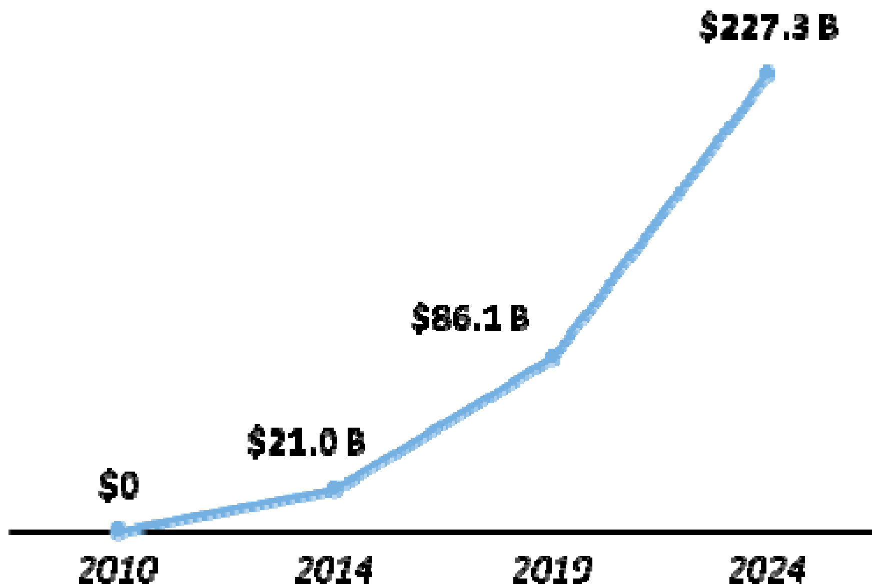
Evaluating the Longer-Term Impact of Bundled Payment

Cumulative Medicare Savings Potential From Inpatient Bundling



Study in Brief: "A Path to a High Performance U.S. Health System"

- Report uses a model to demonstrate the impact of major health reform plans on stakeholder groups
- Analysis assumes inpatient bundling will yield a 15% decrease in Medicare payment to hospitals for readmissions[1] alongside reductions in payments for PAC, inpatient physician, and ER use[2]
- Analysis includes adjustment for decrease in update factors[3] for Medicare payment

1 Readmissions defined as admissions for the same MDC within a 30-day window.
2 Hospitals paid 85% current mean payments for readmissions; 90% current mean payment for PAC; 95% current mean payment for inpatient physician services.
3 Update factors are assumed to be cut year after year under bundling due to provider increases in efficiency; these cuts correspond to .50 percentage points from 2010-2012, .75 percentage points from 2013-2015 and 1.0 percentage points from 2016 onward.

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Source: The Lewin Group, "A Path to a High Performance U.S. Health System: Technical Documentation," 2009, available at: http://www.lewin.com, accessed September 3, 2010; Nursing Executive Center interviews and analysis.

Acknowledging All-Cause Readmissions Beyond Our Control

CMS Definition of Readmissions in Brief

CMS[1] uses three risk-adjusted readmissions measures, endorsed by the NQF,[2] that capture readmissions to any hospital:

- 30-day all-cause HF readmissions
- 30-day all-cause AMI readmissions
- 30-day all-cause pneumonia readmissions

All-cause readmissions capturing both preventable and unpreventable cases

1 Centers for Medicare and Medicaid Services.
2 National Quality Forum.

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Source: U.S. House of Representatives, "Amendment in the Nature of a Substitute to H.R. 4872, as Reported," March 18, 2010; U.S. Senate, "The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act," December 24, 2009; Nursing Executive Center interviews and analysis.

Focusing Our Efforts on Most Preventable Readmissions

Categorizing Types of Readmissions

	Planned	Unplanned
Related	Woman admitted with preterm labor; physician stops the labor and schedules her to return the following week to deliver the baby	Woman admitted for emergency appendectomy, discharged and then readmitted the following week for a surgical site infection
Unrelated	Man admitted for AMI; physician discovers lung tumor and schedules surgery to remove tumor for the following week	Man admitted for appendectomy, discharged and then returns the following week after being hit by a car

Most preventable

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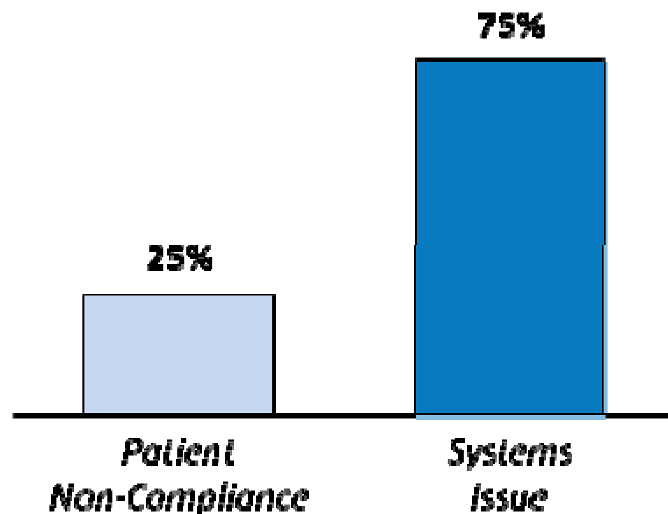
Source: Goldfield N, et al., "Identifying Potentially Preventable Readmissions," *Health Care Financing Review,* 2008, 30(1) ; Nursing Executive Center analysis.

Majority of Root Causes Within Our Control

Identified Causes of Unplanned Readmissions[1]



Case in Brief: Kaiser Permanente Southern California

- Integrated delivery system located in Pasadena, California
- Adapted Institute for Healthcare Improvement (IHI) diagnostic tool first developed by Roger Resar, MD, IHI fellow with the Transforming Care at the Bedside Project; goal to identify causes of unplanned readmissions
- Diagnostic tool piloted in two facilities; currently being rolled out to all 20 hospitals in Northern California due to its rich yield of actionable information on underlying causes of readmissions
- Results will inform a readmissions improvement strategy to be deployed in all 20 hospitals

1 Patients with initial diagnosis of heart failure.

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Source: Kaiser Permanente Southern California, Pasadena, CA; Nursing Executive Center interviews and analysis.

Advisors to Our Work on Preventing Readmissions

Alegent Health Lakeside, Omaha, NE
Aurora Health Care, Milwaukee, WI
Avera McKennan, Sioux Falls, SD
Bakersfield Memorial, Bakersfield, CA
Baystate Medical Center, Springfield, MA
Beaumont Hospitals, Royal Oak, MI
Bon Secours Health, Richmond, VA
Boston Medical Center, Boston, MA
Bryn Mawr Hospital, Bryn Mawr, PA
Carilion Clinic, Roanoke, VA
Carolinas Medical Center, Charlotte, NC
Center to Advance Palliative Care, New York, NY
Children's National Medical Center, Washington, DC
City of Hope National Medical Center, Duarte, CA
Cleveland Clinic, Cleveland, OH
Danbury Hospital, Danbury, CT
Dartmouth-Hitchcock Medical Center, Lebanon, NH
Defiance Regional Medical Center, Defiance, OH
DFWHC Education and Research Foundation, Irving, TX
Engineered Care, Inc., San Francisco, CA
Flower Hospital, Sylvania, OH
Froedtert, Milwaukee, WI
Henry Ford Macomb, Warren, MI
High Point Regional Health, High Point, NC
Huron Hospital, Cleveland, OH
Huron Valley-Sinai, Commerce Township, MI
Inova Health, Fairfax, VA
Jacobi Medical Center, Bronx, NY
John Muir Health, Walnut Creek, CA
Johns Hopkins Bayview Medical Center, Baltimore, MD
Kaiser Permanente, Oakland, CA
Legacy Emanuel, Portland, OR
Lehigh Valley Health Network, Allentown, PA
Littleton Adventist, Littleton, CO
Lovelace Women's, Albuquerque, NM
Main Line Health, Bryn Mawr, PA
Mercy Hospital, Coon Rapids, MN
Munson Medical Center, Traverse City, MI
Northwest Hospital Center, Randallstown, MD
Novant Health, Winston-Salem, NC
Paoli Hospital, Paoli, PA
Parkland Health, Dallas, TX
Piedmont Hospital, Atlanta, GA
Poudre Valley Health, Fort Collins, CO
ProMedica Health, Toledo, OH
Rapid City Regional, Rapid City, SD
Saint Luke's Hospital, Cedar Rapids, IA
Sanford Medical Center, Fargo, ND
Sentara Healthcare, Norfolk, VA
Seton Family of Hospitals, Austin, TX
Simi Valley Hospital and Health Care, Simi Valley, CA
Society for Hospital Medicine, Philadelphia, PA
South Fulton Medical Center, East Point, GA
Southeastern Ohio Regional Medical Center, Cambridge, OH
St. Anthony Central, Denver, CO
St. Rita's Medical Center, Lima, OH
Summa Health, Akron, OH
Texas Health Presbyterian, Kaufman, TX
Union Hospital, Clinton, IN
United Hospital, St. Paul, MN
Unity Health, Rochester, NY
University of Kentucky Medical Center, Lexington, KY
University of New Mexico Hospital, Albuquerque, NM
University of Pittsburgh Medical Center, Pittsburgh, PA
Vanguard Health, Nashville, TN
Virginia Mason Medical Center, Seattle, WA
Virtua Marlton, Marlton, NJ
Wake Forest Baptist Medical Center, Winston-Salem, NC
West Jefferson Medical Center, Marrero, LA
Whidbey General, Coupeville, WA
Willis-Knighton Health, Shreveport, LA

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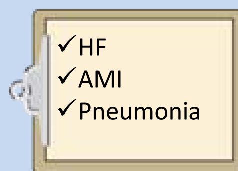
Building a Readmissions Prevention Strategy

Three Key Components

Component #1

Expand Beyond a Disease-Specific Approach

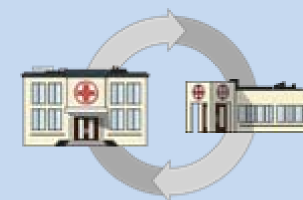


Component #2

Collect Actionable Data on Potentially Preventable Readmissions

Component #3

Strengthen Care Coordination Across the Continuum



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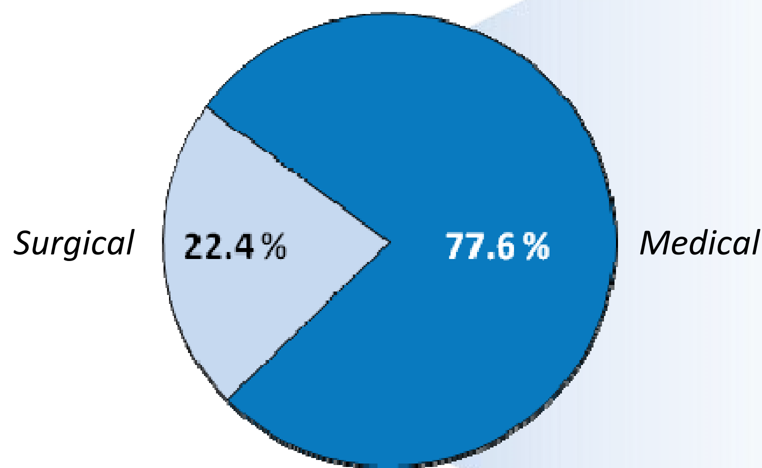
Source: Nursing Executive Center interviews and analysis.

Hospitals Targeting Key Conditions for Good Reason

Percentage of Rehospitalizations by Discharge Type

2003-2004



Top 10 Reasons for Rehospitalization Rank-Ordered by Frequency

Rank Order	Condition
1	Heart Failure
2	Pneumonia
3	Psychoses
4	COPD
5	GI Problems
6	Nutrition-Related or Metabolic Issues
7	Septicemia
8	GI Bleeding
9	Renal Failure
10	Urinary Tract Infection

Source: Jencks SF, et al., "Rehospitalizations among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine*, 2009, 360: 1418-1428; Nursing Executive Center interviews and analysis.

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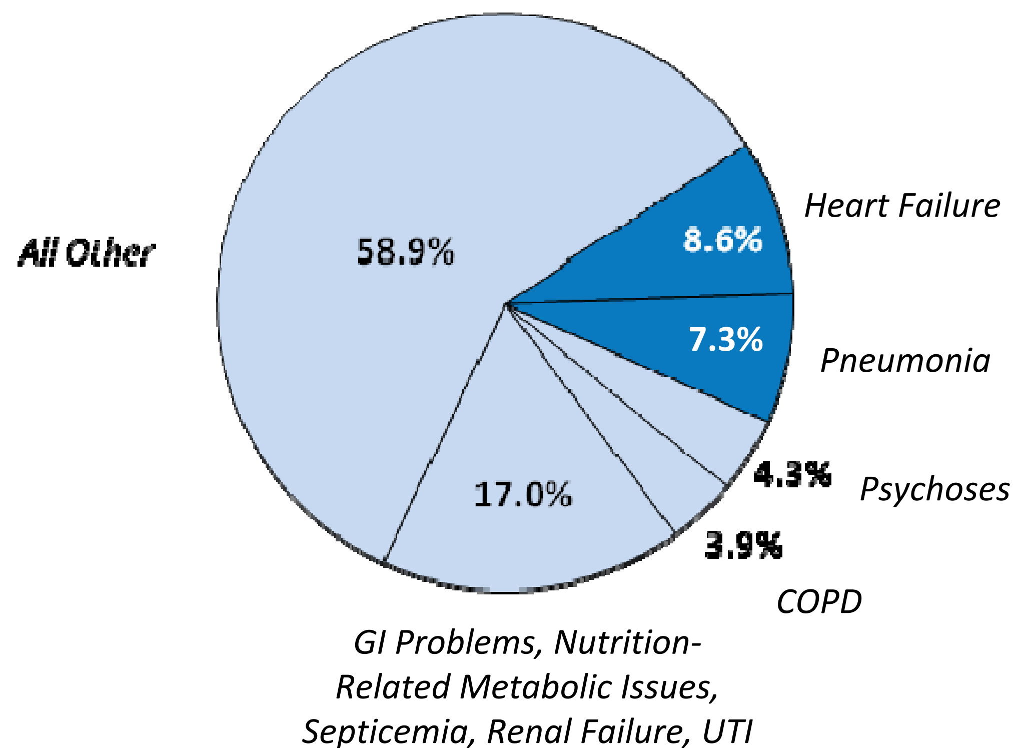
Current Strategy Only Targeting a Piece of the Pie

Reasons for Rehospitalization for All Medical Conditions at Discharge
2003-2004



Source: Jencks SF, et al., "Rehospitalizations among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine*, 2009, 360: 1418-1428; Nursing Executive Center interviews and analysis.

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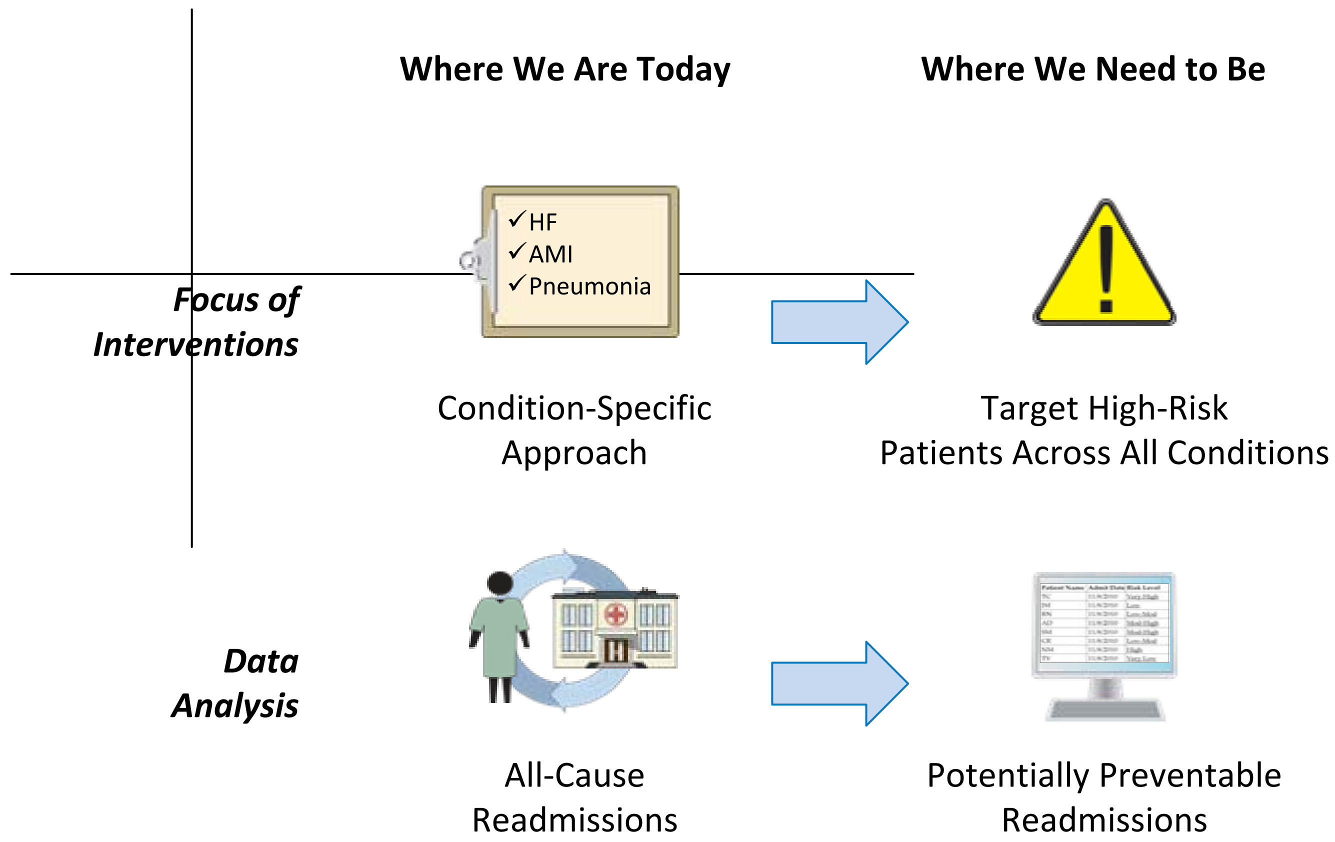
A Necessary Shift in Thinking



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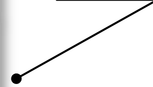
Source: Nursing Executive Center interviews and analysis.

Remembering Our Ambition

Categorizing Types of Readmissions

	Planned	Unplanned
Related	Woman admitted with preterm labor; physician stops the labor and schedules her to return the following week to deliver the baby	Woman admitted for emergency appendectomy, discharged and then readmitted the following week for a surgical site infection
Unrelated	Man admitted for AMI; physician discovers lung tumor and schedules surgery to remove tumor for the following week	Man admitted for appendectomy, discharged and then returns the following week after being hit by a car

Most preventable



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Source: Goldfield N, et al., "Identifying Potentially Preventable Readmissions," *Health Care Financing Review,* 2008, 30(1) ; Nursing Executive Center analysis.

Methods for Identifying Potentially Preventable Readmissions

Method	Description	Case Organization	Assessment
Leverage the ADT System	Admitting nurse enters whether admission was planned into a custom field of the ADT system	The Cleveland Clinic	Easiest to implement, but sensitivity analyses indicate only 60% of readmissions are accurately captured
Define Preventable Readmissions Narrowly	Readmissions are only deemed reasonably preventable if billed under the same MDC or MS-DRG, or caused by infection	United Healthcare	Narrow definition removes all readmissions except those that may be closely clinically related
Pull Out Planned and Unrelated Readmissions	Definition excludes admissions with APR DRGs indicating planned or unrelated readmissions; clinical review of each DRG enables identification of clinically related readmissions	3M	Sophisticated methodology requires either vendor-supplied platform or extremely savvy IT and time-intensive clinical review to implement
Review Cases to Build a Custom, Consensus Definition	Hospital builds custom definition of preventable readmissions by gathering key stakeholders and reviewing cases	Lehigh Valley Health Network	Time-intensive process allows hospital to zero in on most important codes, service lines impacting individual readmission rates

Source: 3M, “Potentially Preventable Readmissions Classification System: Methodology Overview” GRP-139, May 2008; Stone J and Hoffman G, “Medicare Hospital Readmissions: Issues and Policy Options” *CRC Report for Congress*, December 8, 2009; The Cleveland Clinic, Cleveland, OH; Lehigh Valley Health Network, Allentown, PA; Nursing Executive Center interviews and analysis.

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Engaging Key Stakeholders to Identify PPRs[1] at LVHN

Gather an Interdisciplinary Team

Convene stakeholders including: coders, finance, IT, VP Care Continuum, Chief of Internal Medicine, and nursing representative

Develop a Principled Process to Define PPRs

- ✓ Pull all patients readmitted to hospital within 30 days of index admission in past year
- ✓ Sort patients by ICD-9 Codes, MDCs
- ✓ Identify clinical patterns indicating unpreventable readmissions
- ✓ Exclude codes and MDCs indicating unpreventable readmissions using automated algorithm

Reach Consensus on PPR Definition

PPRs Exclude:

- ✓ Elective admissions
- ✓ Certain obstetric medical services
- ✓ Principal diagnosis codes of V58.0, V58.11, V58.12, V58.41
- ✓ SNF and hospice admissions
- ✓ Patients who left against medical advice
- ✓ Newborns and expired patients

Case in Brief: Lehigh Valley Health Network

- Three-hospital, 951-bed health system headquartered in Allentown, Pennsylvania
- Gathered an interdisciplinary committee to build a custom, consensus definition of preventable readmissions
- Reports preventable readmission rates to physician groups and unit nurse leaders

1 Potentially preventable readmissions.

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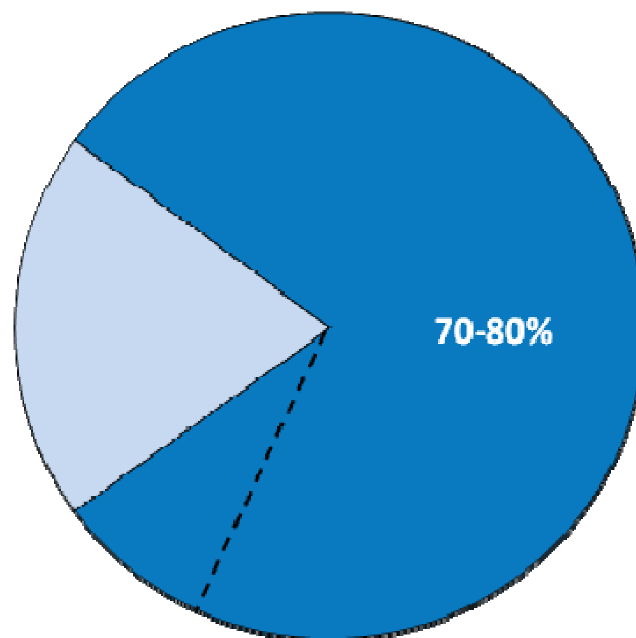
Source: Lehigh Valley Health Network, Allentown, PA; Nursing Executive Center interviews and analysis.

Failing to Provide Complete Discharge Instructions

Percent Heart Failure Patients Discharged With Incomplete or Missing Discharge Instructions
Joint Commission and Heart Failure Registry Databases



Source: Fonarow G, "Discharging Our Responsibility," *Morbidity and Mortality Rounds on the Web,* available at: http://www.webmm.ahrq.gov/case.aspx?caseID=159, accessed November 19, 2010; Nursing Executive Center interviews and analysis.

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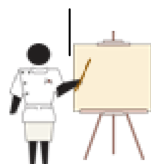
Gaps in Cross-Continuum Coordination Leading to Readmissions

Representative Patient Scenario



Education provided on day of discharge; patient confused about how to manage own care

Medication list at discharge does not match patient's medication regimen at home

Patient discharged home despite requiring a higher level of care

Patient never schedules follow-up appointment

Patient readmitted for related condition

Inpatient Setting

Post-Acute Setting

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Source: Nursing Executive Center interviews and analysis.

Preventing Avoidable Readmissions

Coordinating Care for Complex Patients Across the Continuum

Leveraging the Inpatient Stay to Equip Patients for Long-Term Self-Management

I

Scale Interventions to Level of Risk

II

Identify and Activate Key Learners

III

Equip Patients With Accurate and Easily Actionable Post-Discharge Instructions

Facilitating Seamless Transfer to the Post-Acute Care Setting

IV

Ensure Patients Are Discharged to the Appropriate Care Setting

V

Elevate PAC Quality to Ensure Safe Care for Complex Patients

VI

Enable a Safe Transition Home With Immediate Follow-Up Care for Most Vulnerable Patients

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Leveraging the Inpatient Stay to Equip Patients for Long-Term Self-Management

I

Scale Interventions to Level of Risk

1. Root Cause-Focused Readmission Analysis
2. Risk-Based Intervention Prompts

II

Identify and Activate Key Learners

3. Key Learner Identification
4. Three-Day Integrated Teach-Back

III

Equip Patients With Accurate and Easily Actionable Post-Discharge Instructions

5. Simplified Discharge Instructions
6. Post-Discharge Medication Audit

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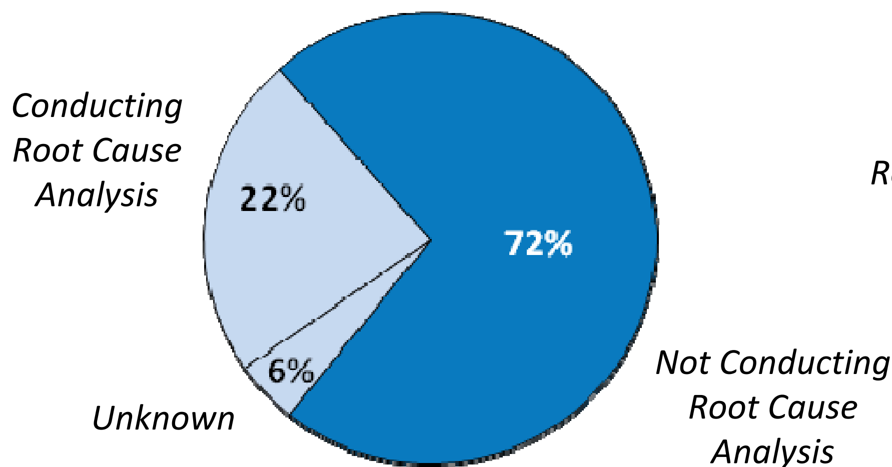
Few Hospitals Scaling Interventions to Level of Risk

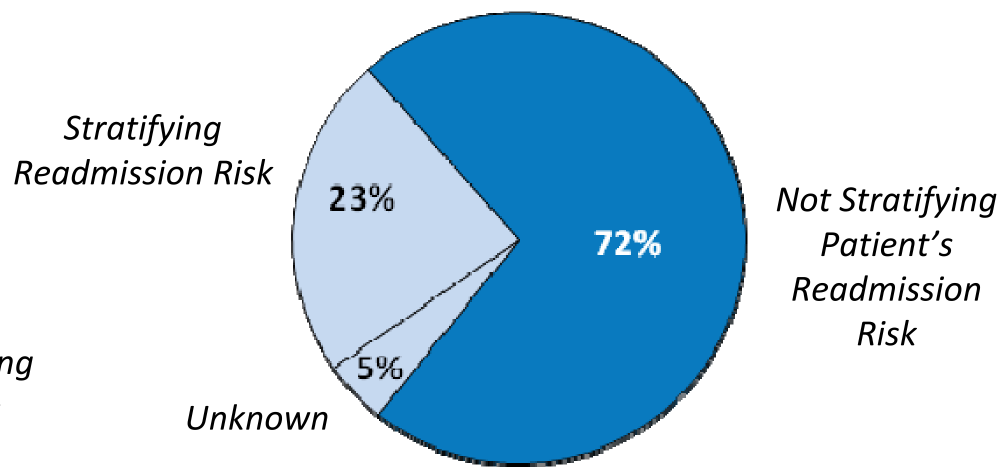
Percent of Hospitals Assessing Root Causes of Readmissions Through Patient Interviews[1]

n = 65



Percent of Hospitals Scaling Interventions by Stratifying Patient's Readmission Risk[2]

n = 65



1 Survey question: "Does your hospital regularly conduct interviews with patients and their families at the time of readmission to discuss reasons for re-hospitalization?"
2 Survey question: "Does your hospital apply risk stratification criteria to determine a particular patient's likelihood of being readmitted to the hospital?"

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Source: Advisory Board Company 2010 Member Survey on Readmissions; Nursing Executive Center interviews and analysis.

Two Options for Root Cause Analysis

1 **Short Interview With All Readmitted Patients**

Short survey tool enables nurses to conduct 10-minute interview with every readmitted patient

2 **In-Depth Review of Select Cases**

In-depth case review enables nurses to dive deep on root causes for select readmissions

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Source: Nursing Executive Center interviews and analysis.

Conducting a Short Interview With All Patients

Cleveland Clinic's Readmissions Interview

Cleveland Clinic

Readmission Patient Interview

Regarding Your Last Admission and the Events Following Your Discharge from the Hospital

Question	Response
Were you kept informed about your diagnoses during your stay in the hospital, and what was being done to further evaluate and treat them	None of time ○ Some of time ○ Most of time ○ All of time ○
At the time of your discharge, did someone talk to you about:	
1. what your diagnoses were	Yes ○ No ○ Not Sure ○
2. what tests or procedures needed to be done after you left	Yes ○ No ○ Not Sure ○
3. what to watch out for regarding worsening of your disease	Yes ○ No ○ Not Sure ○
4. what to do if you were experiencing worsening of your disease	Yes ○ No ○ Not Sure ○
5. who to contact (and how) if you were experiencing worsening of your disease	Yes ○ No ○ Not Sure ○
Were you asked about your understanding these instructions?	Yes ○ No ○ Not Sure ○
Were the discharge instructions written down and given to you before you left	Yes ○ No ○ Not Sure ○
Were the written discharge instructions and plans easy to read and understand?	Yes ○ No ○ Not Sure ○
How confident were you about understanding these instructions?	Very confident ○ Somewhat confident ○
After you left the hospital, did you have an appointment with your doctor?	Yes ○ No ○ Not Sure ○
If yes, who made the appointment?	I did ○ My family ○ the hospital staff ○ Not Sure ○
How long after being discharged did you have to wait for the appointment	A few days ○ About a week ○ About two weeks ○ Longer then 2 weeks ○ Not Sure ○
Were you able to get to this appointment?	Yes ○ No ○ Not Sure ○
How do you think you became sick enough to be readmitted to the hospital?	

QM Review: Date of Discharge ___/__/____ Date of Admission __/__/____

Reason for Readmission : ______________________________

Question	Yes	No	Not Sure
Were the discharge instructions written down and given to you before you left?	○	○	○
Were the written discharge instructions and plans easy to read and understand?	○	○	○

Answers recorded on multiple choice form, enabling easy analysis

Questions map to common process breakdowns

Short open-ended question captures readmission causes falling outside the scope of specific inquiries

For full-sized version of the Readmissions Interview Form, please see appendix.

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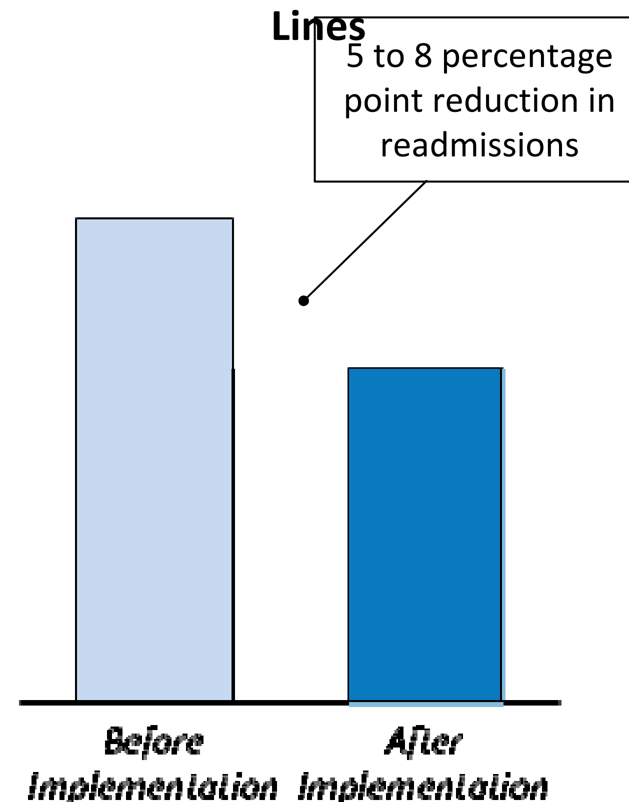
Source: Cleveland Clinic, Cleveland, OH; Nursing Executive Center interviews and analysis.

Uncovering System-Level Process Breakdowns

System Breakdowns and Corresponding Improvements Identified Through Readmissions Interviews

Problem Identified	Solution Developed
PCPs do not follow patient post-discharge instructions despite having medical record access	Focus group develops shorter, targeted discharge summary for PCPs
Drug event-related readmissions more likely to occur when non-pharmacist gathers medication list on admission	Pharmacist gathers patient medication list
Patients are scheduled for follow-up appointments but do not keep them	Case management staff assume responsibility for scheduling appointments at times convenient for the patient



Source: Cleveland Clinic, Cleveland, OH; Nursing Executive Center interviews and analysis.

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Pursuing In-Depth Review of Select Cases at Kaiser

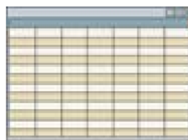
Select Cases to Review

Selection Criteria

- Primary diagnosis of heart failure
- Admitted to hospital
- EF[1] < 40%
- Patient enrolled in outpatient transition coaching program
- Clinical judgment

Collect Necessary Data

Chart Review



Provider Interview

Patient Interview

Analyze Data

Structured Data Analysis

Excel-based analysis of data collected through chart review, provider interview, and patient interview

Root Cause Assessment

Transition coach conducts root cause analysis to identify main cause of readmission based on qualitative and quantitative data

For complete version of the Case Review Guide, please see appendix.

1 Ejection fraction.

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Source: Kaiser South Bay Medical Center, Harbor City, CA; Nursing Executive Center interviews and analysis.

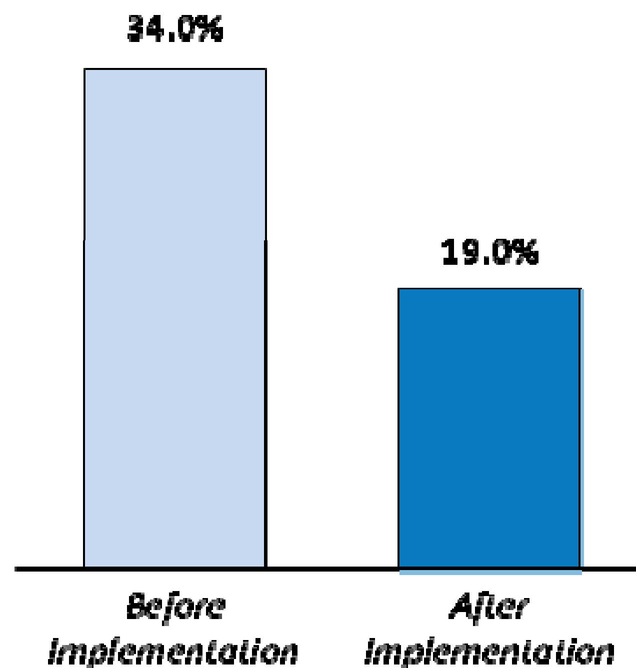
Surfacing Key Opportunities to Prevent Readmissions

System Breakdowns and Corresponding Improvements Identified Through Readmission Case Review

Specific System Issues Identified	Correlating Systems Improvements
Gaps in patient understanding of diet for HF	Improved process for referring patients to dieticians
Unmet patient social services and psychological support needs	Improved social worker assessment and further leveraged social worker across program
Medications prescribed with known side effects	Assigned physician lead to educate inpatient MDs/providers on contraindications

90-Day All-Cause Readmission Rates at Pilot Institution

Targeted Patient Population



Source: Kaiser South Bay Medical Center, Harbor City, CA; Nursing Executive Center interviews and analysis.

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Weighing the Options

Two Options for Determining Root Causes of Readmissions

	Option 1: Short Interview With All Readmitted Patients	Option 2: In-Depth Review of Select Cases
Data Sources Required	Patient interview only	Patient and/or family interview, provider interview, chart review
Time Intensity	5 to 10 minutes per case	90+ minutes per case
Sample Size	All or most readmitted patients on admission to the hospital	Time intensity allows for review of only handful of cases; demands targeting efforts at highest risk populations
Preferred Clinicians Involved	Any admitting clinician	Transition coaches or case managers overseeing patient's care in and outside hospital
Detail of Information Surfaced	Major categories of process breakdowns	Individual process breakdowns leading to readmissions

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Source: Nursing Executive Center interviews and analysis.

Facilitating Seamless Transfer to the Post-Acute Care Setting

IV

Ensure Patients Are Discharged to the Appropriate Care Setting

7. PAC Placement Decision Guide
8. Nursing-Driven Palliative Care Referral

V

Elevate PAC Quality to Ensure Safe Care for Complex Patients

9. Inter-Facility Patient Summary Tool
10. After-Hospital Ticket to Ride
11. Verbal Patient Handoff
12. PAC Quality Report Card

VI

Enable a Safe Transition Home With Immediate Follow-Up Care for Most Vulnerable Patients

13. Guaranteed Timely Follow-Up Visit
14. Volunteer Transition Partners

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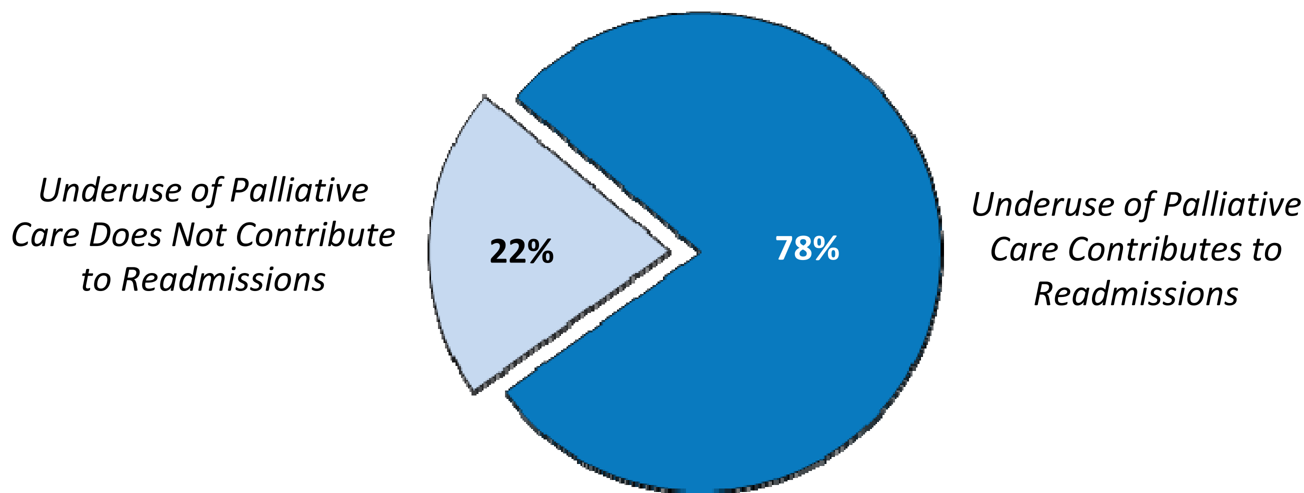
Examining a Potential Link Between Palliative Care and Readmissions



5% One hospital's data analysis revealed that 5% of patients readmitted within 30 days died in the hospital

1 Based on the survey question, "In my opinion, underuse of palliative care services contributes to readmissions at my hospital."

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Source: Advisory Board Company 2010 Member Survey on Readmissions; Nursing Executive Center interviews and analysis.

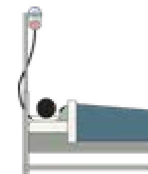
Laying the Groundwork for End-of-Life Care

Four Critical Components of Palliative Care

Delivering symptom management

Working with patients to set treatment goals

Providing psychosocial support to patients and families



Planning for end-of-life care

Differentiating Palliative Care and Hospice

- Hospice care provides palliative care for those in the last weeks or months of life
- Non-hospice palliative care is appropriate at any point in a serious illness; can be provided at the same time as life-prolonging treatment

Source: Center to Advance Palliative Care, New York, NY; Nursing Executive Center interviews and analysis.

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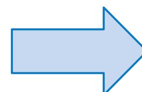
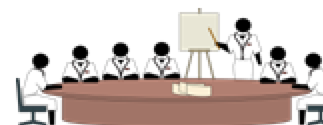
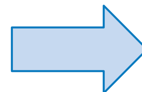
Driving Appropriate Palliative Care Utilization

Leveraging Nurses to Trigger Palliative Care Referral Conversations

Barriers to Palliative Care Utilization		Nursing-Driven Solutions
Inadequate Number of Clinicians to Conduct Palliative Care Consults		 **Foster Frontline Palliative Care Expertise**
Physician Discomfort With Palliative Care Referrals		**Trigger Referral Conversations With a Nurse-Driven Tool**

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Source: Nursing Executive Center interviews and analysis.

Creating a Palliative Care Nurse Fellowship

Responsibilities of Palliative Care Nurse Fellows at Bryn Mawr Hospital

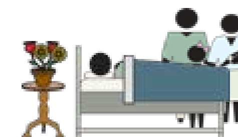
Serve as a Unit Resource

Answer frontline questions; address emerging pain and palliative care issues throughout hospital

Identify Appropriate Referrals

Identify patients who could benefit from palliative care and notify the physician or fellowship manager

Take Consults



Conduct consults independently during high volume or low capacity periods

Case in Brief: Bryn Mawr Hospital

- 307-bed hospital part of Main Line Health in Bryn Mawr, Pennsylvania
- To meet increased need for palliative care resources, hospital developed core curriculum in 2008; program fosters frontline expertise in pain and palliative care through a two-year nurse fellowship
- Pain and palliative care fellowship integrated with clinical ladder, Magnet requirements
- Fellows receive certification in palliative care after two years
- Program increased consult volume by 45%

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Source: Bryn Mawr Hospital, Bryn Mawr, PA; Nursing Executive Center interviews and analysis.

Training Frontline Nurse Fellows Across Two Years

Key Milestones in Pain and Palliative Care Fellowship Education

Year One

- 16 hours of core didactic training
- Monthly 90-minute training and 30-minute mentoring sessions
- 12 hour preceptorship; perform simple consults with clear goals

Year Two

- Mentor first years, conduct independent research
- Sit for palliative care certification
- Begin conducting independent consults

For complete list of Palliative Care Fellowship Competencies, please see appendix.

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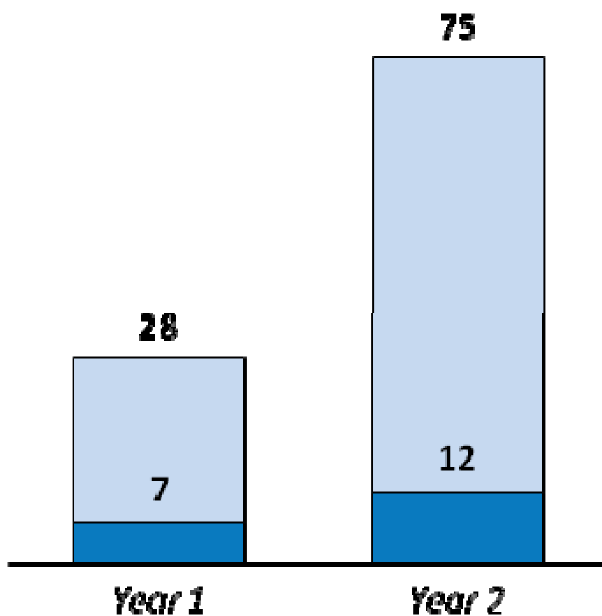
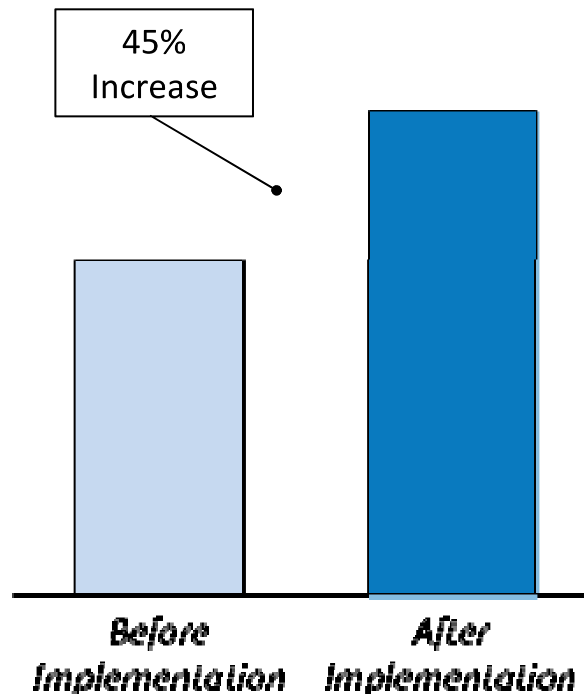
Source: Bryn Mawr Hospital, Bryn Mawr, PA; Nursing Executive Center interviews and analysis.

Expanding Consult Capacity Through a Highly Selective Program





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Source: Bryn Mawr Hospital, Bryn Mawr, PA; Nursing Executive Center interviews and analysis.

Triggering Dialogue With a Nurse-Driven Tool

Inova Health System's Palliative Care Screen

Screen Reviewed Day 1____ Day 5____ Day ____ Day ____ Day ____ Day ____

Palliative Care Screen

The following criteria have been identified which suggest a palliative care consult may be helpful in managing this patient's overall care coordination. Please select all triggers that apply to your patient. Initial screen should be completed within 24 hours of admission. Patients should be re-assessed every 5 days and when transferred to a higher level of care unit due to declining clinical condition. **If the patient has been previously enrolled in hospice program, please contact the hospice program automatically.**

General Palliative Care Domains

- ☐ Uncontrolled symptoms (dyspnea, nausea/vomiting, pain > 5/10) ≥ 24 hours
- ☐ Team/patient/family needs help with complex decision-making and determination of goals of care
- ☐ Patient (especially long-term care resident) with AND/DNAR orders

- ☐ Considering PEG and/or tracheotomy placement with evidence of poor prognosis (advanced dementia)

ICU Category

- ☐ ICU stay of ≥ 3 days without evidence of improvement
- ☐ Second ICU admission during same hospital admission
- ☐ ICU admission from a nursing home in the setting of ≥ 2 chronic, life-limiting conditions
- ☐ Ventilator Day # 6 or longer
- ☐ Glasgow score ≤ 5
- ☐ Multi-organ failure, involving ≥ 4 systems

Please Complete Outcome of Screening

____ Screened but did not meet criteria for intervention

____ Screened, met criteria for intervention. Please document results.

Results/Outcome of screen:

____ Palliative Care already involved

______ Family meeting held
______ Advanced directive completed
______ Became organ donor

____ Trach/PEG accelerated

Simple checklist indicates when further conversations with physicians about palliative care may be warranted

Screen includes both primary and secondary palliative care interventions

For complete version of the Palliative Care Screen, please see appendix.

Source: Inova Health System, Fairfax, VA; Nursing Executive Center interviews and analysis.

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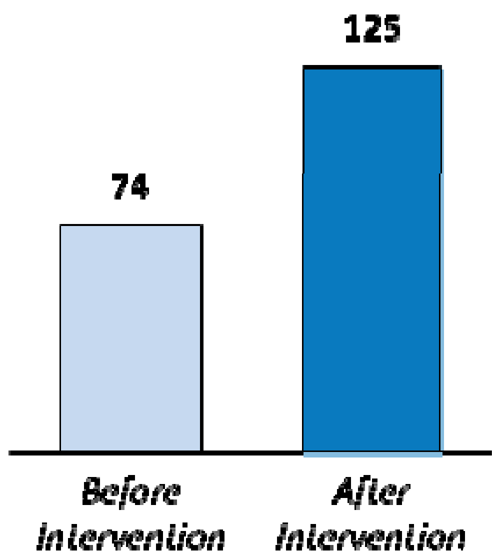
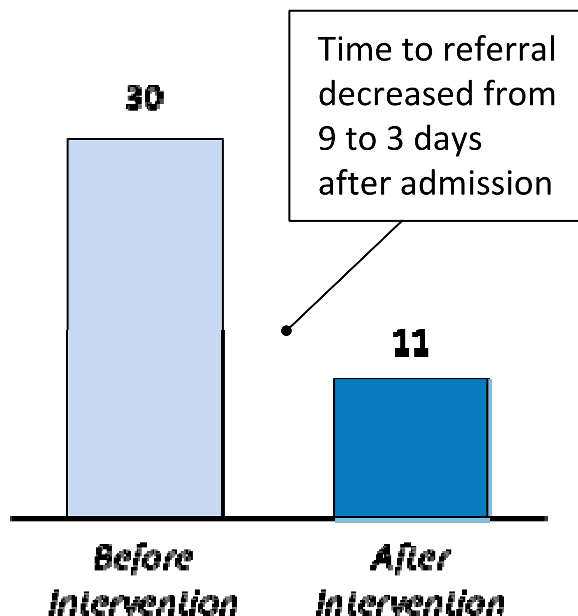
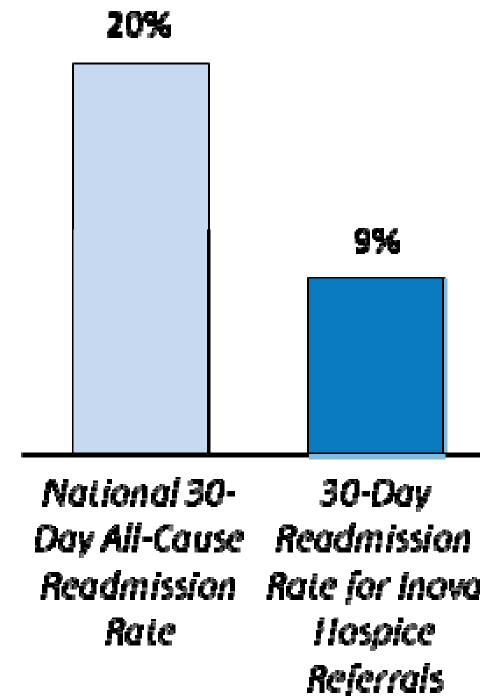
Increasing Palliative Care Utilization and Improving Outcomes







Source: Inova Health System, Fairfax, VA; Jencks SF, et al., "Rehospitalizations among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine*, 2009, 360: 1418-1428; Nursing Executive Center interviews and analysis.

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Gaining Physician Support for Palliative Care

Key Lessons for Providing Palliative Care Education to Physicians

Clearly Define Palliative Care

- Emphasize difference between palliative care and hospice
- Clarify that referrals earlier on in treatment process are in patients' best interest

Tailor the Message

- Be clear about specific benefits of palliative care program for different physician groups

Start with Physician Champions

- Target hospitalists and physician champions

Focus on the Patient

- Show that true goal of palliative care is to provide care according to patient's wishes

Share Results

- Present cases of patients receiving active treatment, symptom management through palliative care
- Share results on improved pain management, increased patient satisfaction

Propose a Partnership

- Communicate with patient's primary physician before and after consult
- Offer to share patient notes

Source: Center to Advance Palliative Care, New York, NY; Nursing Executive Center interviews and analysis.

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Preventing Avoidable Readmissions

Coordinating Care for Complex Patients Across the Continuum

NURSING EXECUTIVE CENTER