The Coleman Palliative Medicine Training Program

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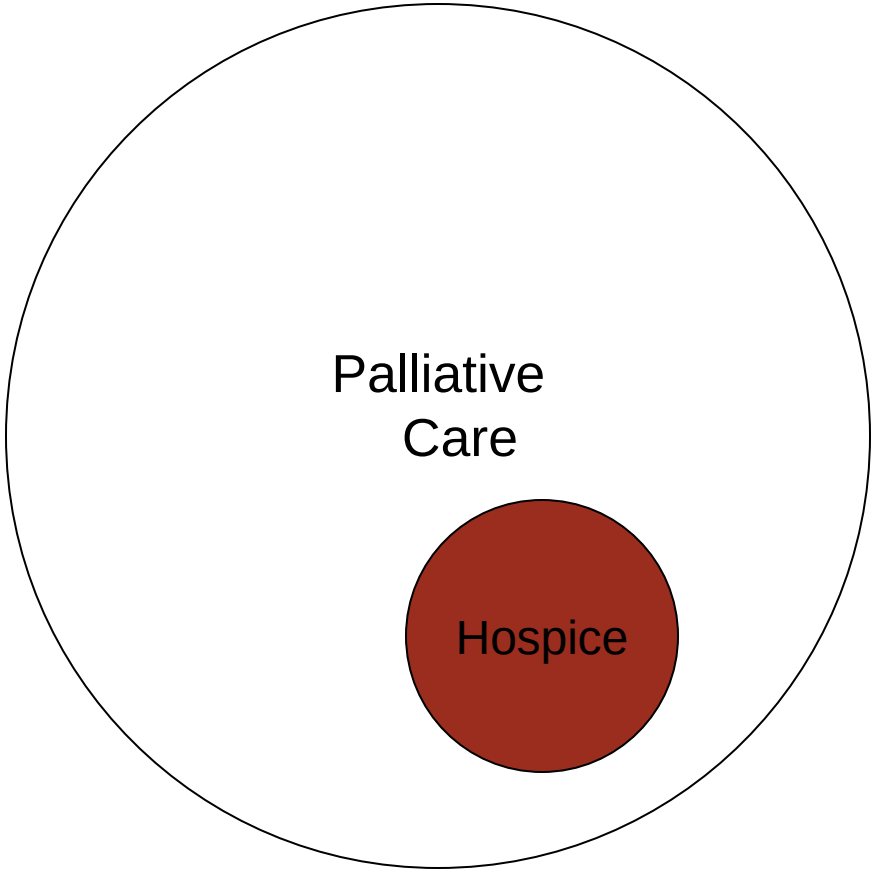
Objectives

1. Review history of palliative care (PC)
2. Describe palliative care and its components
3. Discuss healthcare imperatives and how PC helps
4. Describe growth of PC and workforce shortage
5. Discuss benefits of the Coleman Palliative Medicine Training Program for Interdisciplinary Providers

Palliative care vs Hospice

All of hospice is palliative care, **but not all of palliative care is hospice**



Palliative Care, Why?

#1 Reason

Medical Progress…

…has changed the way we live

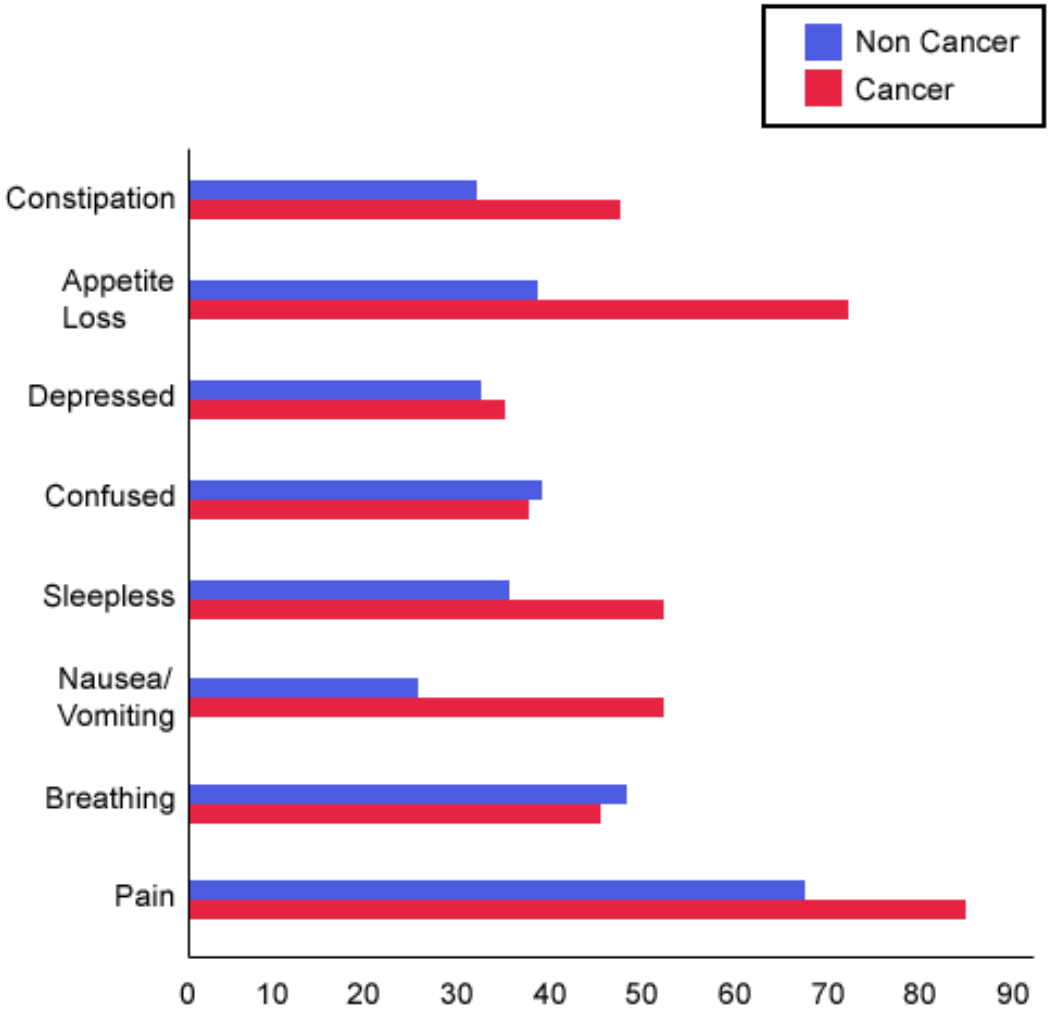
…has changed the way we are sick

…has changed the way we die

Current State of Care for Seriously Ill Patients and their Families

- High degree of unmanaged or under-managed symptoms in patients with chronic and/or debilitating illnesses
- Poor to non-existent communication regarding patient goals of care
- Lack of coordination with patient and family preferences-need for advanced care planning

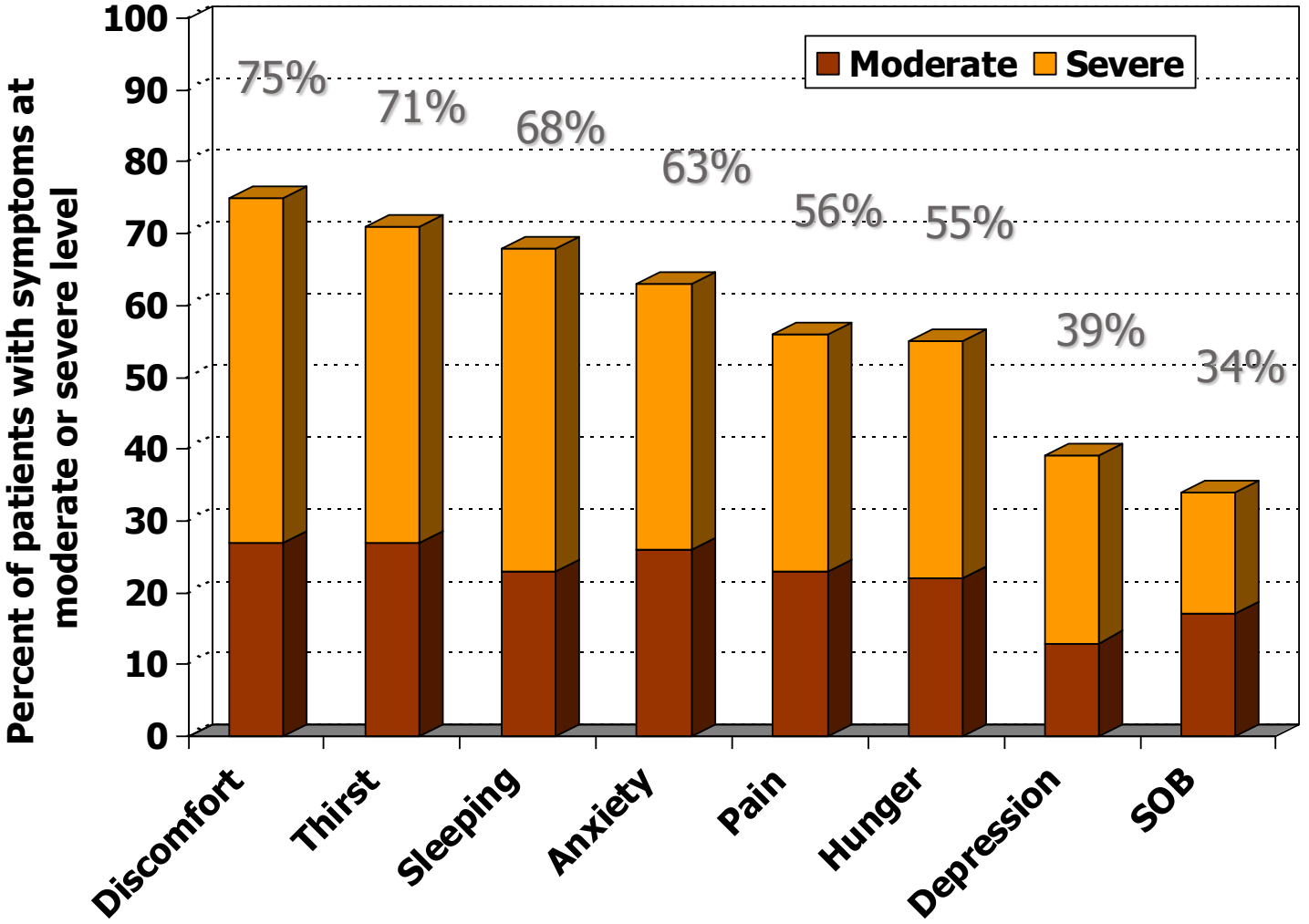
Symptom Prevalence Last Year of Life



http://painconsortium.nih.gov/

Self-Reported Symptom Experience of Critically Ill Cancer Patients Receiving Intensive Care

Nelson JE, Meier DE, Oei EI et al. *Crit Care Med* 2001;29:277-282



The Reality of Advance Directives

- **50%** of terminally ill patients have advance directives in their medical records
- **29%** of patients change their minds about life-sustaining treatment over time
- **30%** of surrogates incorrectly interpret their loved ones' written instructions
- **64%** of dying patients' living wills do not cover the clinical realities they face
- **78%** of patients with life-threatening illnesses prefer to leave decisions about resuscitation to their physicians and families

"More Americans Discussing -- and Planning -- End-of-Life Treatment," The Pew Research Center for the People & the Press, Jan. 5, 2006

What do Seriously Ill Patients Want?

- Appropriate treatment of pain and other symptoms
- Achieve a sense of control
- Communication regarding their care
- Coordinated care throughout the course of illness
- Avoid inappropriate prolongation of the dying process
- Relieve burdens on family
- Strengthen relationships with loved ones
- Sense of safety in the healthy care system

What Do Family Caregivers Want?

Study of 475 family members 1-2 years after bereavement

- Loved one's wishes honored
- Inclusion in decision processes
- Support/assistance at home
- Practical help (transportation, medicines, equipment)
- Personal care needs (bathing, feeding, toileting)
- Honest information
- 24/7 access
- To be listened to
- Privacy
- To be remembered and contacted after the death

Tolle et al. Oregon report card.1999 www.ohsu.edu/ethics

Why Healthcare Delivery Needs to Improve

- **Chronically ill, aging population is growing**

-The 63% of Medicare patients with 2 or more chronic conditions account for **95%** of Medicare spending (CDC)

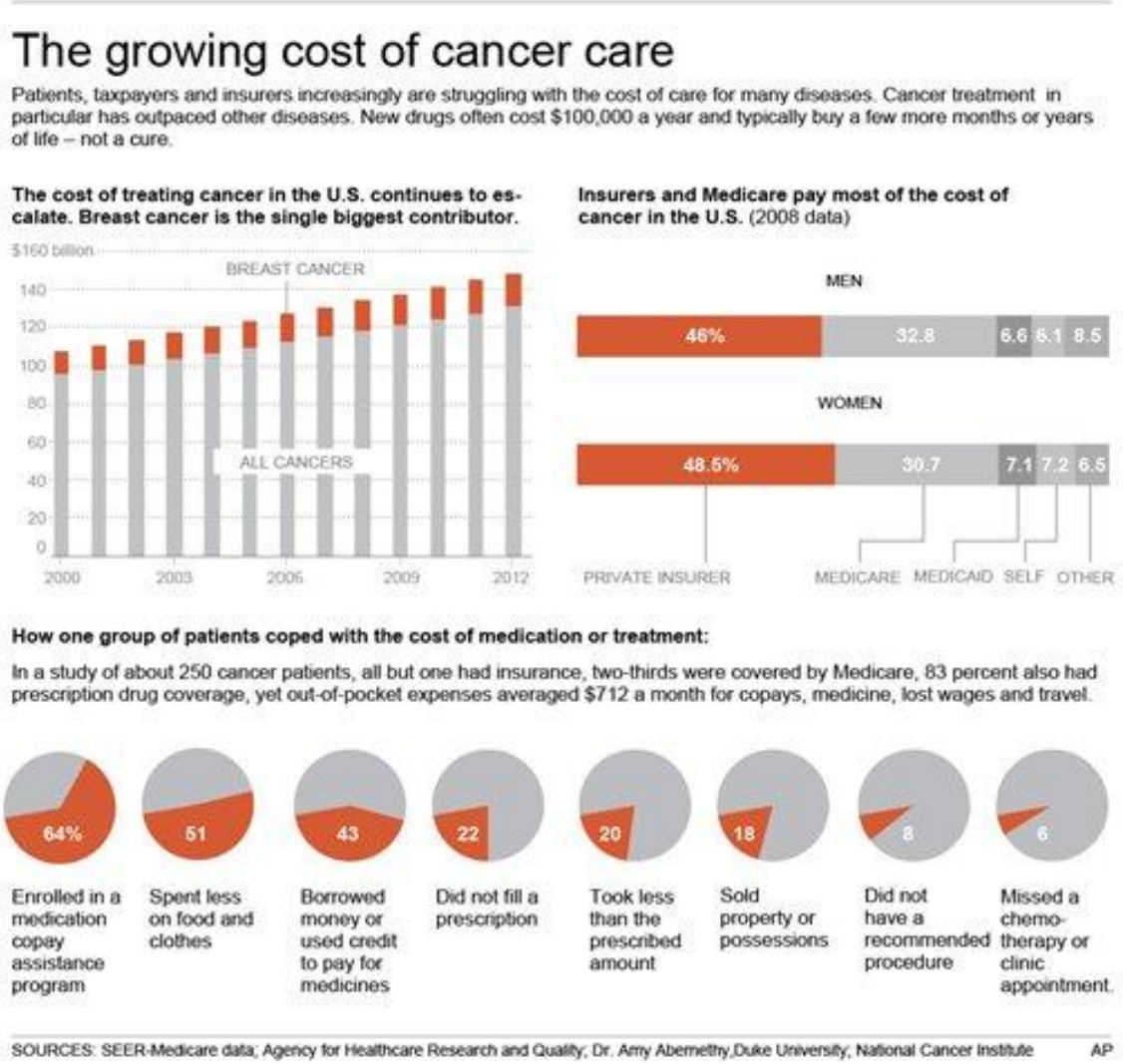
-The number of people over age 85 will double to 9 million by the year 2030 (CDC)

-Nursing home population expected to double from 1.5 million to 3 million by 2030

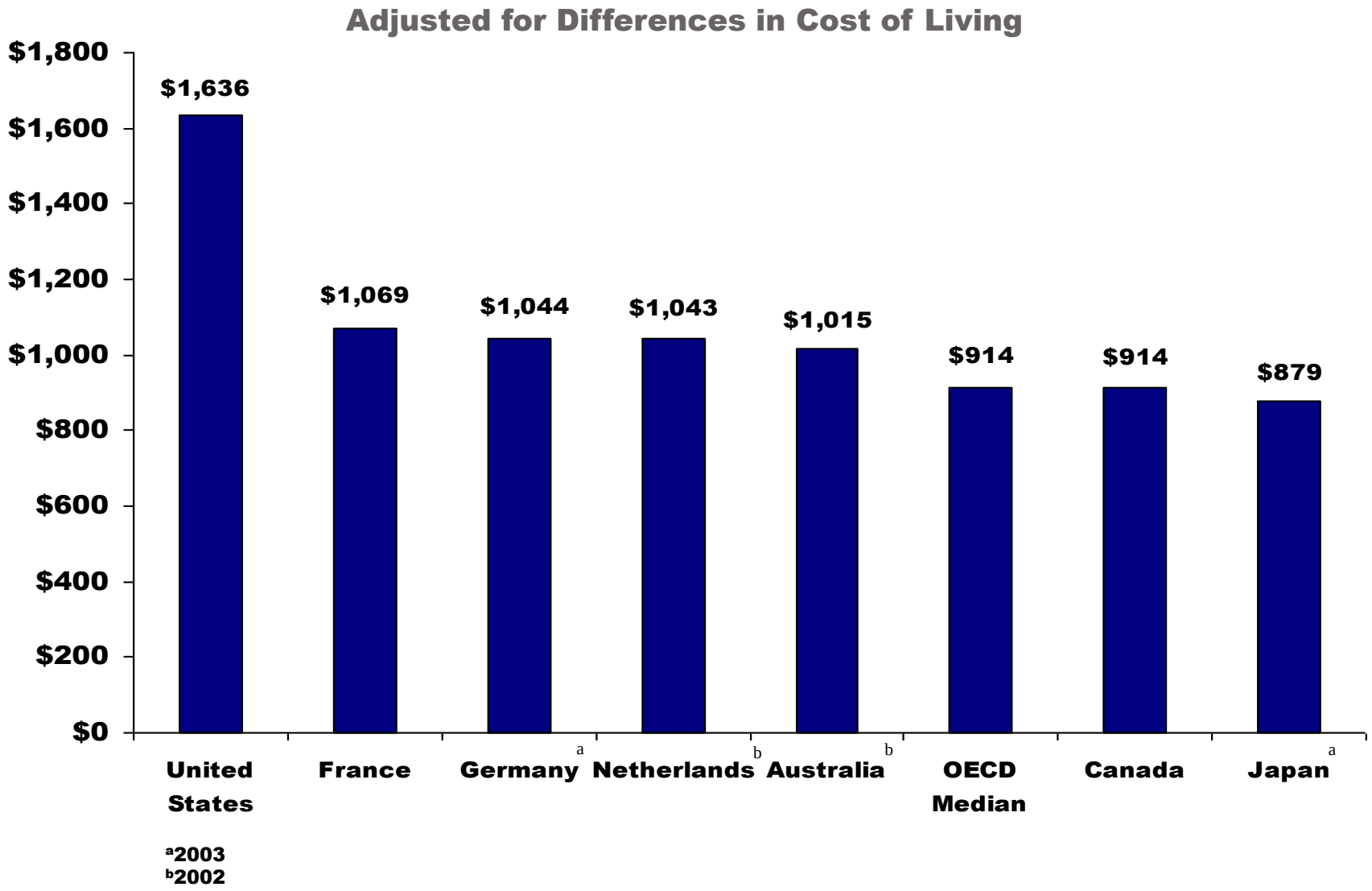
->25% of Americans will die in NH

CENTER TO ADVANCE PALLIATIVE CARE

The Cost of Cancer Care

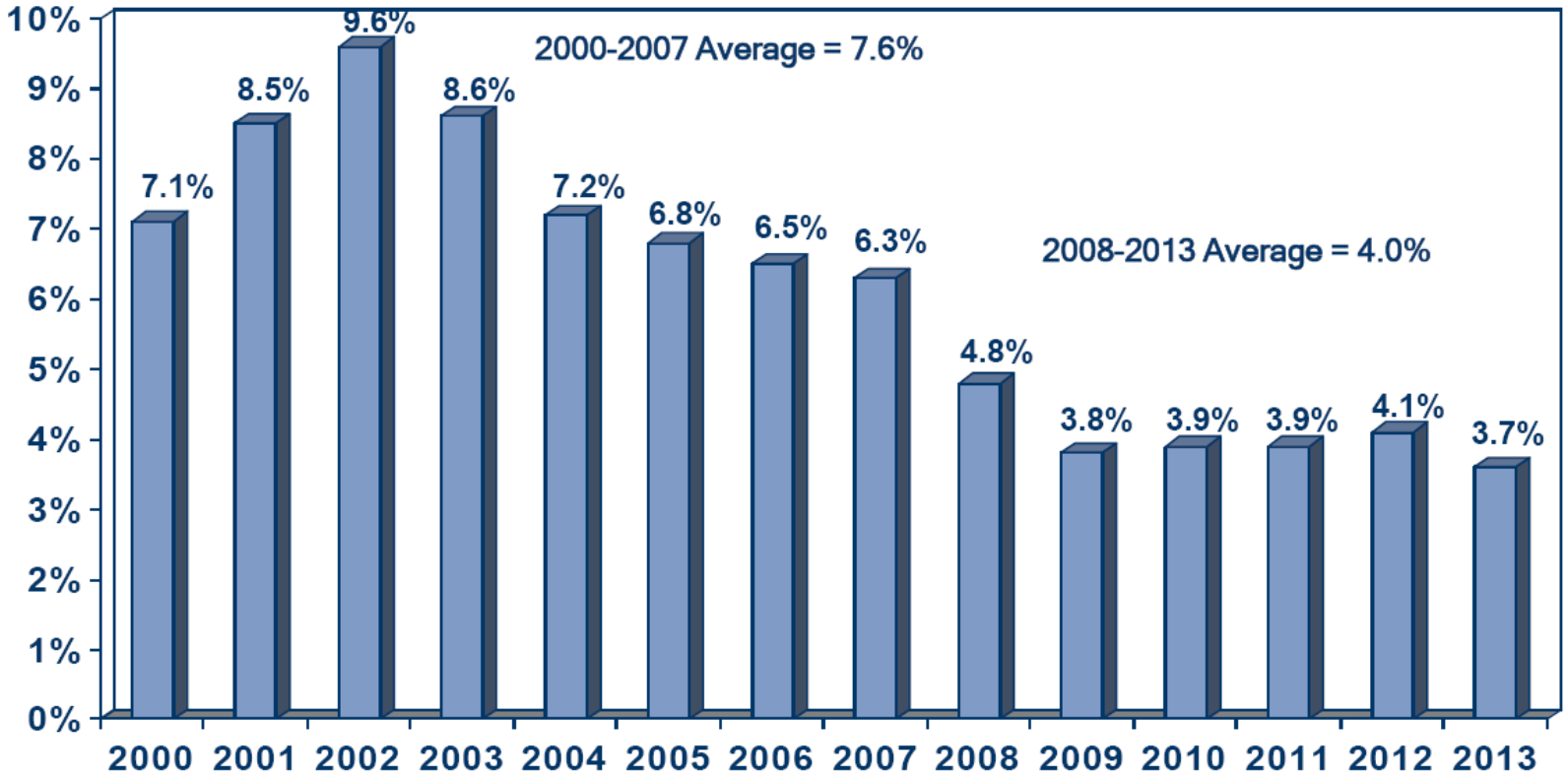


Inpatient Hospital Spending per Capita



Source: The Commonwealth Fund, calculated from OECD Health Data 2006.

National Health expenditures US 2000-2013



2013 National Health Expenditures = $2.9 trillion (17.4% of GDP)

Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary

Inernational Health Care Systems Overall Rankings 2013

COUNTRY RANKINGS

Top 2*
Middle
Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

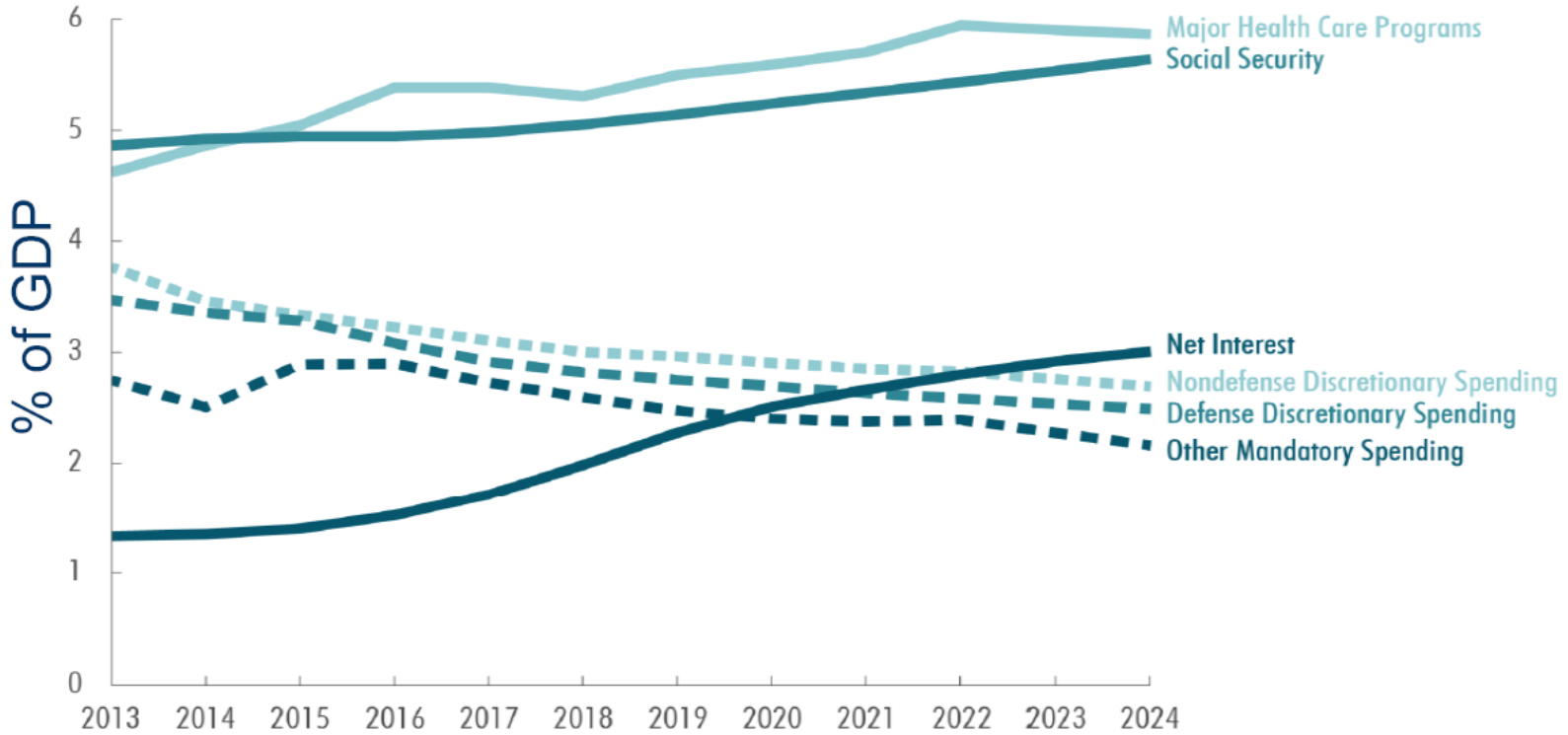
Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011;* World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

Source: Commonwealth Fund, *Mirror, Mirror on the Wall*, June 2014

Our Health Care System has incented the wrong outcomes

- volume, not value
- silos, not integration
- episodic care, not preventive care
- institutional care, not community-based care
- specialty care, not primary care
- utilization management, not care management

Health Care Expenditure Growth will continue to drive deficits



Source September 2014

Patient Protection and Affordable Care Act March 23 2010

Performance Based Purchasing Expected to Accomplish 3 Aims

Current Fee-for-Service Payment System

- Care is fragmented instead of coordinated.
- Each provider is paid for doing work in isolation.
- No one is responsible for coordinating care.
- Quality can suffer, and costs rise.

Patient-Centered Global Payment System

- Performance-based payments made to a group of providers for all care.
- Providers are put at risk for the amount and cost of services provided.
- The performance-based payment is expected to produce efficiencies and more coordinated care.

Performance Related Value Cuts

Readmissions – up to 3% cut to hospitals with higher than expected 30-day readmission rates for 5 measures – heart failure, heart attack, pneumonia, chronic obstructive pulmonary disease (COPD), and hip/knee arthroplasty

Value Based Purchasing (VBP) – up to 2% cut to hospitals based on 33 measures: 12 process (20%), 8 patient satisfaction (30%), 12 mortality (30%), and one Medicare spending per beneficiary (20%)

Hospital Acquired Conditions (HACs) – 1% cut to hospitals in bottom quartile of HAC rates for 10 measures

Health Information Technology (HIT) – price cuts for hospitals and doctors failing to achieve "meaningful use"

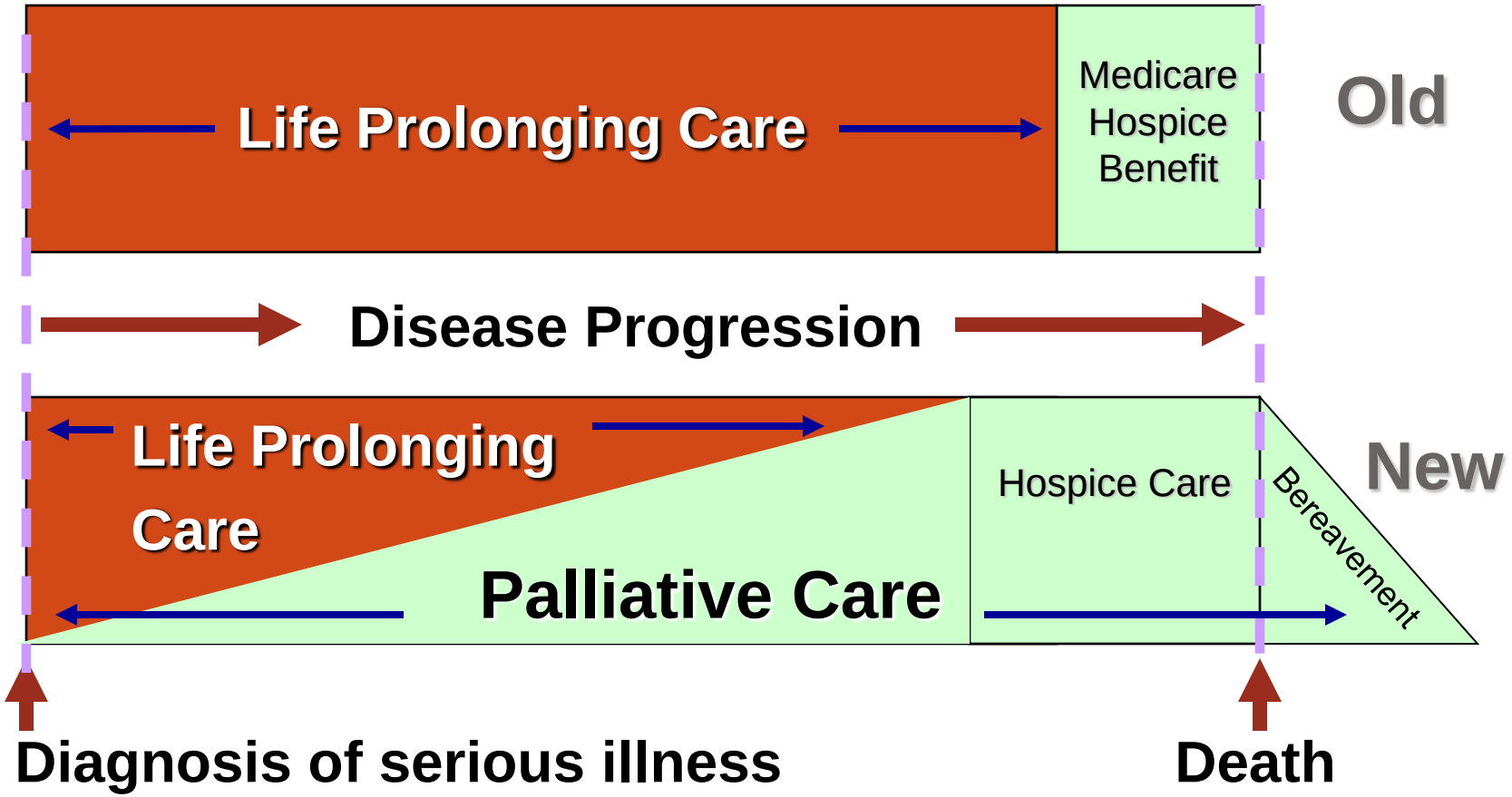
Accountable Care Organization

"An organized network of health care providers

- that provides, or arranges
- a full, coordinated continuum of services
- to a defined population;
- and is willing to be held fiscally and clinically accountable
- for the health status and costs of caring for the population served."

The Good News: Palliative Care Can Help

Old vs New Approach



Factors that are Promoting Hospital Based Palliative Care

- Demographic shift
- Shift to accountable care: avoidance of hospital readmissions, HCAHPS scores
- Cost avoidance and enhanced operational efficiencies
- Ranking of hospitals based on utilization of hospice and demonstration of provision of palliative care (V66.7 code) by payers and CMS

Palliative Care Benefits to Hospitals

- Improved patient and family satisfaction
- Improved quality of care for patients and their families
- Meets the needs of an aging population
- Assists in compliance with hospital care quality (Joint Commission)
- Transition of patient to appropriate level of care-often reducing length of stay, especially in the ICU
- Decreased hospital costs and resource utilization
- Improved staff satisfaction and retention

Palliative Care Improves Quality

Data demonstrate that palliative care:

- Relieves pain and distressing symptoms
- Supports on-going re-evaluations of goals of care and difficult decision-making
- Improves quality of life, satisfaction for patients and their families
- Eases burden on providers and caregivers
- Helps patients complete life prolonging treatments
- Improves transition management

Campbell et al, Heart Lung, 1991; Campbell et al, Crit Care Med, 1997; UC Davis Health System News; 2002; Carr et al, Vitas Healthcare, 1995; Franklin Health, 2001; Dartmouth Atlas, 2000; Micklethwaite, 2002; Du Pen et al, J Clin Oncol, 1999; Finn et al, ASCO, 2002; Francke, Pat Educ Couns, 2000; Advisory Board, 2001; Portenoy, Seminars in Oncol, 1995; Ireland Cancer Center, 2002; Von Roenn et al, Ann Intern Med, 1993; Finn J et al ASCO abstract. 2002; Manfredi et al JPSM 2001; Schneiderman et al. JAMA 2003; Higginson et al JPSM 2002 & 2003; Smith et al. JCO 2002, JPM 2003; Coyne et al. JPSM 2002; www.capc.org.

Palliative Care Is Cost-Saving,

Supports transitions to more appropriate care settings

- Palliative care lowers costs (for hospitals and payers) by reducing hospital and ICU length of stay, and direct (such as pharmacy) costs.
- Palliative care improves continuity between settings and increases hospice/homecare/nursing home referral by supporting appropriate transition management.

Lilly et al, Am J Med, 2000; Dowdy et al, Crit Care Med, 1998; Carlson et al, JAMA, 1988; Campbell et al, Heart Lung, 1991; Campbell et al, Crit Care Med, 1997; Bruera et al, J Pall Med, 2000; Finn et al, ASCO, 2002; Goldstein et al, Sup Care Cancer, 1996; Advisory Board 2002; Project Safe Conduct 2002, Smeenk et al Pat Educ Couns 2000; Von Gunten JAMA 2002; Schneiderman et al JAMA 2003; Campbell and Guzman, Chest 2003; Smith et al. JPM 2003; Smith, Hillner JCO 2002; www.capc.org.

Palliative Care Benefit to Ambulatory Setting: "Concurrent Care"

- "Early Palliative Care of Patients with Metastatic Non-Small-Cell Lung Cancer"Temel, J, NEJM 363;8
- 151 patients with new diagnosis metastatic NSC Lung Cancer
- Randomized to Onc Care OR Onc Care + Palliative Care

Hospital palliative care is associated with significant hospital cost savings.

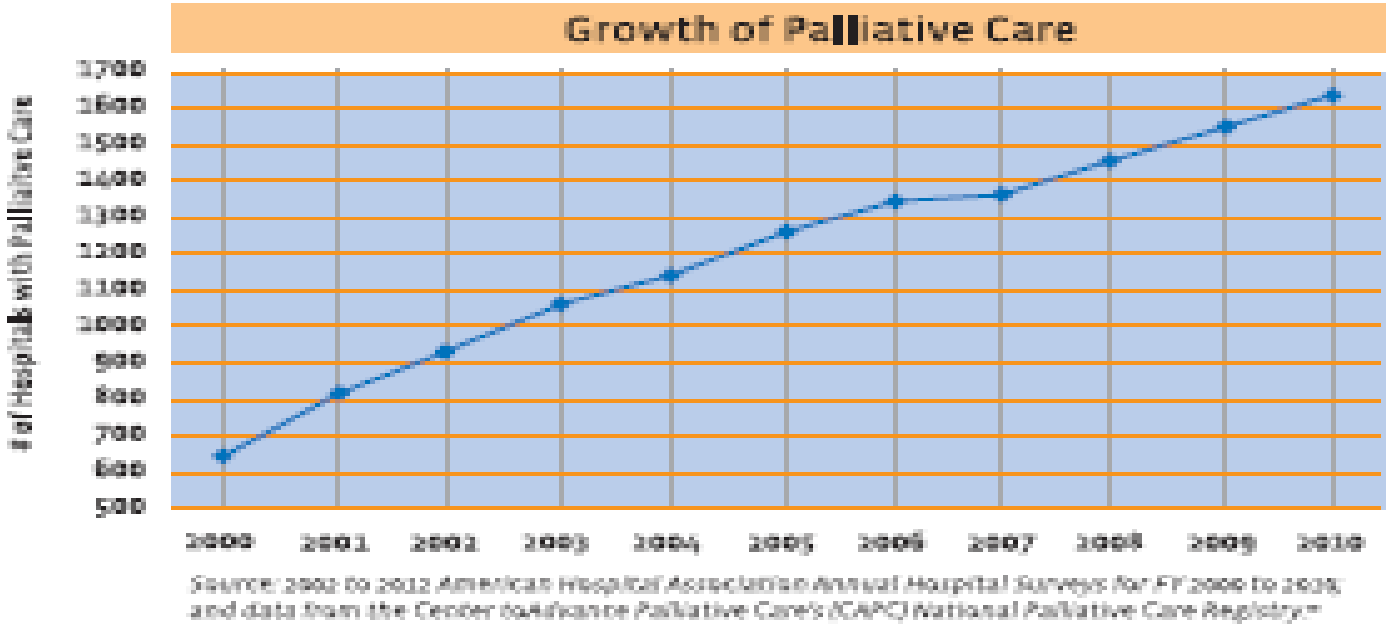
Researchers found:

- For palliative care patients who were discharged alive, there was a savings of $1,696 in direct costs per admission and $279 in direct costs per day.

- For palliative care patients who died in the hospital, there was a savings of $4,908 in direct costs per admission and $374 in direct costs per day.

Source: Cost Savings Associated with U.S. Hospital Palliative Care Consultation Programs, R. Sean Morrison, Joan D. Penrod, J. Brian Cassel, Melissa Caust-Ellenbogen, Ann Litke, Lynn Spragens, Diane E. Meier, for the Palliative Care Leadership Centers' Outcomes Group, *Arch Intern Med.*2008;168(16):1783-1790

Growth in number of palliative medicine teams in U.S. hospitals



Source: 2002 to 2012 American Hospital Association Annual Hospital Surveys for FY 2000 to 2010, and data from the Center to Advance Palliative Care's (CAPC) National Palliative Care Registry™

Growth of palliative care has occurred primarily in response to the increasing number of Americans living with serious and chronic illnesses and to the caregiving realities faced by their families.

But…

- Number of palliative care programs, specialists not sufficient to meet patient need
- Only approximately 200 Physicians get ACGME fellowships each year.
- Very few advanced training programs for APNs, SWs or Chaplains in palliative care
- In absence of comprehensive palliative care programs and PC specialists, physicians need basic PC clinical skills

Team based care

- A prerequisite for coordinated care across the continuum that addresses psychosocial and spiritual well being of patients and families
- Essential to ameliorate the financial impact on patients and families of chronic illnesses
- 2013 IOM report emphasized the need to include chaplains and social workers into the care of people living with serious life threatening illnesses
- Very few programs exist for advanced training for social workers and chaplains

Palliative Care and Hospice Education and Training Act

- **Academic Career Awards**: aimed at junior faculty in academic medical centers who will spend a majority of their funded time teaching and developing skills in interdisciplinary education in palliative care.
- **Palliative Care and Hospice Education Centers**: are aimed at improving the training of interdisciplinary health professionals in palliative care.
- **Career Incentive Awards:** funding for advanced practice nurses, clinical social workers, pharmacists, students of psychology who are pursuing a doctorate or other advanced degrees in palliative care or related fields in an accredited health professions school.

Workforce Shortage & Its Impact

- Shortage of physician specialists in PM
- Many hospitals trying to start or grow existing programs with limited resources, lack of knowledge
- MDs and mid-level providers hired to fill the gap with little training and administrative support
- Low-income and minority patients disproportionately affected by access
- Biggest gaps are in the smaller hospitals and community hospitals

Lupu D, Journal of Pain and Symptom Management Volume 40, Issue 6 899-911, December 2010

Hospital Quality Measures

- Percent of decedents enrolled in hospice in the last 6 mos. of life
- Percent of deaths associated with ICU admission
- Percent of deaths occurring in hospital
- Patient rating of hospital overall
- Hospice days per decedent during the last 6 mos. of life

http://www.dartmouthatlas.org/keyissues/issue.aspx?con=2944

The Original Chicagoland HPM Physician Collaborative

- Regional non-profit hospices

-Rainbow, Midwest, Hospice of Northeastern IL, Fox Valley, Horizon

- Major academic medical centers

-Rush, University of Chicago, Northwestern, Lurie Children's, Loyola, University of Illinois

- Other established PC/teaching hospitals

-Cook County, NorthShore, Central DuPage, Lutheran General, Advocate IL Masonic

The Coleman Palliative Medicine TRAINING PROGRAM

GOALS

- Improve the quality of and access to palliative care services for patients with cancer and other life threatening illnesses
- Build a supportive network of palliative care providers across Chicago and outlying areas

Intermediate Outcomes

- Establish permanent local provider network to share resources and quality data
- Expand pool of Chicago attending physicians and nurse practitioners with clinical competency in palliative care
- Increase hospice utilization, discussion of advance care plans, palliative care consultations, and reduce costs of care
- Increase patient, caregiver, and consumer satisfaction with quality of care
- Develop a core set of metrics for benchmarking palliative care service and hospice activities across Chicago communities

Long Term Outcomes

- Improve practice patterns to result in
  - fewer deaths in ICUs
  - earlier referrals to hospice
  - Increased hospice utilization
  - improvements in HCAPS scores
  - greater patient/family satisfaction
- Reevaluate practice patterns for continued improvements in these domains

Data that we will need to collect

- HCAHPS survey data from hospital quality improvement offices annually
- Provide data on health service utilization: hospice enrollment, ICU admissions, consultation volume for palliative medicine, hospital deaths annually, identifiers for patients who receive palliative medicine consultations
- Provide data for the local palliative care registry: team composition, consultation volume, clinical characteristics of patient population, services provided by the palliative team

  for 2012 and 2014
- Data will be housed within REDCap, a secure web-based application designed specifically to quickly and securely build and manage online surveys (http://project-redcap.org/).
- Supply contact information for relevant hospital leaders and financial analysts/ decision support staff to Aliza Baron and Tricia Johnson

Data Collection Process

- Fellows and Junior Mentors Provide Key Contacts at respective sites
- For the Outcomes Study – Quality Manager is the key contact
- For the Local Palliative Care Registry Study – Palliative Care Program Director is key contact
- Contact information will be requested via online form
- Faculty and Program Coordinator from the Coleman Palliative Medicine Training Program will work with each institution to facilitate the data collection.

Training Program Overview

- 2 year commitment
- Fellows Agreement - Responsibilities
  - $5000 stipend
- Year 1: Educational experiences
  - 2-day Opening Workshop & 1-Day Workshop in the Fall 2015
  - Learner needs assessment surveys and tests
  - E-learning curriculum (20 hours)
  - Experiential training (40 hours direct contact)
  - Social worker and chaplain seminar series
- Year 1: Project Efforts
  - Intent to Change Contract
  - Designing and implementing practice improvement project
  - Baseline data collection
  - Monthly contact with designated mentor

Training Program Overview: Year 2

- Educational components
  - 2-day bi-annual workshops
  - Junior Mentors attend 1-day sessions
- Focus on practice improvement projects
  - implementing
  - evaluating
  - sustaining
- Culminating in poster presentations at Winter 2017 Conference
- Plans for sustainment
- Cost $20,000/fellow (vs $110,000 ACGME)

The Coleman Palliative Medicine TRAINING PROGRAM

AN EDUCATIONAL INITIATIVE FOR PHYSICIANS, NURSES, SOCIAL WORKERS AND CHAPLAINS ACROSS THE CHICAGO AREA LED BY REGIONAL LEADERS IN PALLIATIVE CARE TO IMPROVE THE QUALITY OF AND ACCESS TO PALLIATIVE CARE FOR PATIENTS WITH CANCER AND OTHER LIFE THREATENING ILLNESSES.

- 2013-2017
- Supported by a grant from the Coleman Foundation

The Coleman Palliative Medicine TRAINING PROGRAM

Education in Palliative and End-of-Life Care (EPEC) Workshop
E-Learning
Teaching Case-of-the-Month
Direct Observation
Mentoring

E-Learning in Palliative Care

Many excellent educational materials exist on topics in palliative and end-of-life care. The following have been selected by Coleman program directors, with acknowledgements and thanks to the authors, institutions and organizations who produced these outstanding works for public access. LEARN ABOUT E-LEARNING REQUIREMENTS AND OPTIONS. Instructional levels vary. Please explore and select the materials best suited for you.

ALL PEDIATRICS Here...

RED = FREE E-LEARNING OPPORTUNITIES

INTERACTIVE PATIENT CARE SIMULATION IN PALLIATIVE CARE. By the Iowa Geriatric Education Center, University of Iowa. ENTER HERE

VIRTUAL GERIATRIC PATIENT CASES: PAIN MANAGEMENT IN THE ELDERLY. 6 cases. 2 hrs. each. Save and return option. CME credit available for a fee. Harvard University School of Medicine. VIEW TOPICS. ENTER HERE (Click "View Course List." Select "GERI1" and "GERI2.").

CE CREDITS ON A WIDE SPECTRUM OF PALLIATIVE CARE TOPICS FOR NURSES. Over 40 courses. On administrative, clinical, pediatrics, psychosocial, cultural and spiritual issues, and more. By the Hospice and Palliative Nurses Association (HPNA). Free for members. Fee-based for others. VIEW TOPICS. ENTER HERE

CANCER PALLIATION. Video lectures. 1 hr each. By Stanford School of Medicine eCampus CancerPEN. VIEW TOPICS. ENTER HERE

PALLIATIVE AND END-OF-LIFE CARE FOR PATIENTS WITH HIV/AIDS (Adults and Pediatric). Training modules provide Powerpoint slides with speaker's notes. Video triggers available and more. By the Center for Palliative Care Education. VIEW TOPICS. ENTER HERE

CORE WORK GROUP

Sean O'Mahony, MB BCh BAO, MS -- Director, Section of Palliative Medicine, Rush University Medical Center

Stacie K. Levine, M.D. -- Director of Geriatrics and Palliative Medicine Fellowship; Director of Hospice and Palliative Medicine Education; Co-Director of Palliative Medicine Program University of Chicago

Aliza R. Baron, M.A. -- Education Coordinator, Section of Geriatrics and Palliative Medicine, University of Chicago

Aziz Ansari, M.D. -- Associate Director of the Division of Hospital Medicine, and Medical Director of Loyola's Home Hospice program.

George Fitchett, D.Min., Ph.D. -- Professor and the Director of Research in the Department of Religion, Health, and Human Values at Rush.

Joel E. Frader, M.D. -- A. Todd Davis Professor of Academic General Pediatrics and Professor of Medical Humanities and Bioethics at Northwestern University's Feinberg School of Medicine

Ileana M. Leyva, M.D., F.A.A.P., F.A.A.H.P.M. -- board certified in both pediatrics and hospice and palliative medicine and Medical Director of the Palliative Medicine Service at Northwestern Medicine Central DuPage Hospital since 2003..

Holly Nelson-Becker, Ph.D., L.C.S.W. -- Professor & Hartford Faculty Scholar Loyola University Chicago School of Social Work

Program Mentors

Responsibilities

- 2-year commitment
- Paired with 1-3 Fellows each
- Provide experiential learning to Fellows through direct observation of practice
- Guide Fellows in practice improvement projects
- Mentors Agreements

Time Frame	Objectives	Tools and Recommendations
April - May 2015	Provide Guidance in Planning a PIP/ICC	Review and discuss a draft Intent to Change Contract (ICC).
	Determine Fellow's Palliative Care Learning Needs	Learning needs and opportunities may include administrative, leadership, teambuilding, and networking skills and responsibilities as well as clinical.
Next 6 months	Facilitate Learning through Direct Observation	Use case based teaching approaches Direct fellow to educational resources including those on the Coleman Website
Ongoing with At least monthly check in calls	Support Fellow in "Implementing & Evaluating a PIP and making adjustments in response to institutional change and potential roadblocks"	Provide on-going feedback and advice Facilitate trouble shooting Advocate for fellow with institutional feedback

Junior Mentors

- Will complete intent-to-change agreements
- Provide guidance to new fellows as they implement their projects
- Help coordinate meetings with institutional leaders and fellows
- Participate in didactic activities connected with the project
- Facilitate the development of curricula

Fellows' Learning Objectives

- Teach and model the fundamentals of palliative care to health care professionals at respective hospitals and care settings.
- Disseminate new methods and means of improving palliative care to patients and families