Are We There Yet? Progress on Inpatient Palliative Care Spread

Presenters:
Richard Della Penna, MD
Helene Martel, MA

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1. Describe history and relevance of KP's palliative care research to today's KP practices.

2. Identify key features of how successful practices are spread in KP.

3. Apply learnings from the palliative care experience to envision how other elder care work might gain focus and momentum, e.g., dementia and falls care.
History Of Palliative Care At KP

Current activity has a history and context

1999 - Kaiser Permanente’s Care Management Institute (CMI) Elder Care Sourcebook created.
   - Features Compassionate End-of-Life Care section

2001 - CMI Elder Care focus is on Palliative Care.
   - Palliative Care Sourcebook includes Promising Practices

2001 - Denver Palliative Care Roundtable with HI, NW, CO, and MAS participating and informed by Joanne Lynn MD, Richard Brumley MD, Mark Blum MD, Jeanne Twohig (RWJ) and Dan Tobin MD

2002 - Garfield Memorial Fund funded and KPNAN sponsored 3 complementary, multi-site, randomized controlled trials (RCTs) in 3 settings.

2004 - NCAL and SCAL participate in series of End-of-Life Collaboratives.
CMI identified several promising practices in its review leading to the GMF supported multi-site RCTs beginning in 2002 in 3 settings of the continuum: Home, Hospital and Office.

Findings

• The studies have all been completed; peer-reviewed journal articles have been published for the home and hospital studies.

• All three studies demonstrated significant improvements in quality and patient satisfaction and resulted in lower costs for those receiving palliative care. “Triple Bottom Line”

• The Home-Based PC program won a Vohs Award for measured improved performance and excellence in quality demonstrated in earlier studies.
What RCT Studies Told Us

- Palliative Care programs across the continuum “work” and are sustainable
- A system and the features of Palliative Care need to be available to patients regardless of where they receive care. All clinicians should provide elements of palliative care. Expanded palliative care services can supplement the work of these clinicians.

Reasons
- Improves care quality and satisfaction for patients and families actually receiving palliative care and it supports staff and infrastructure
- Demonstrates that improved quality can be provided at lower cost
- Is an important step in building a care system that better matches the needs of members with advancing illness as their conditions worsen, function declines, and they live out and complete their lives
Palliative Care’s Inclusive Umbrella: We Need Palliative Care Everywhere

*Hospice includes palliative care but not all Palliative Care is done in/with Hospice.

**includes SNFs, LTC, Assisted Living facilities
Interdisciplinary Palliative Care Efficiently Meets Patient and Family Needs

Patient

Physical

Psychological

Social

Spiritual
Team-based care makes sense of the whole person and results in a comprehensive, patient-centered action plan rooted in communication and understanding the patient’s goals, values, hopes and fears.
Draft Palliative Care Vision: patient-centered and systems-based:

• All KP patients with advanced illness have the opportunity to understand and make values-based and preferred treatment decisions and action plans that meet their medical, social, emotional and spiritual concerns.

• KP will provide evidence-based patient-centered interdisciplinary palliative care to these patients and their families in and across all care settings, including hospital, office, home and community care facilities.

• The essential elements of palliative care should be understood and provided by KP providers in all settings – not just by specialized palliative care teams.

Does this Vision align with the thinking at your medical center and region?
• KP’s vision is to implement a comprehensive palliative care programs (hospice, office, home, and community-based palliative care) over time.

• KP’s vision is to improve the competencies of all clinicians and staff who care for people with advancing illness.

• IPC is aligned with KP programwide focus on hospital care.

• IPC requires relatively lower level of effort to get off the ground.
Multi-site (Colorado, Portland, California) randomized trial of inpatient palliative care consultation vs. usual hospital care

Intervention: Team-based (MD, RN, SW, chaplain) consultation

512 adult (mean age 73 years) patients with advanced illness

Key results:

- Greater patient/family satisfaction with hospital care and communication (p<0.001)
- Improved pain control (p=0.04), ↓ anxiety, ↑ hope (P<0.003)
- ↑ Completion of advance directives (91% vs. 78%, p<0.001)
- Decreased utilization and costs
  - ↓ ICU admissions, ↓ Costs for readmissions (p=0.009)
  - Increased outpatient utilization, ↑ Hospice LOS (24 vs. 12 d, p=0.04)
  - Colorado cost avoidance = $12,288 per patient across mean survival time of 120 days and no difference in mortality

Charge to the National Inpatient Palliative Care Initiative

To faithfully replicate KP Colorado’s evidence-based Inpatient Palliative Care (IPC) Full Team Approach across the Program to ensure 3 major benefits:

1. Improve outcomes for more members through the use of consistent, patient-centered care pathways (patient and provider satisfaction)

2. Lower costs to each region and to the program overall by implementation of an evidenced, sustainable, measurable practice

3. Establish a core set of services available to older members in all regions to allow for consistent national marketing/branding and demonstration of KP’s integration
Inpatient Palliative Care Is Spreading....

IPC Consults per Quarter - California Regions

- **NCAL**
  - 2006*: 1,080
  - Q1 2007: 1,410
  - Q2 2007: 1,336
  - Q3 2007: 1,350
  - Q4 2007: 1,689

- **SCAL**
  - 2006*: 108
  - Q1 2007: 374
  - Q2 2007: 920
  - Q3 2007: 1,243
  - Q4 2007: 1,110

Note: 2007 Q3 and 2007 Q4 - Preliminary Data.

**IPC Consults per Quarter - CA Regions**

- 2006*: 1,188
- Q1: 1,784
- Q2: 2,256
- Q3: 2,593
- Q4: 2,799

**IPC Consults per Quarter - KP Overall**

- 2006*: 1,572
- Q1: 2,171
- Q2: 2,782
- Q3: 3,088
- Q4: 3,313

* 2006 annualized volume divided by 4.
Inpatient Palliative Care Is Spreading....

IPC Consults per Quarter - ROC Regions

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* 2006 annualized volume divided by 4

Note: 2007 Q3 and 2007 Q4 - Preliminary Data.

2007 Q4 data for MAS is not available at this time.
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IPC Consults per Quarter - KP Overall

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*Annualized value
Key Components Of IPC Spread: What Led To Success To Date?

• Sponsorship from Senior Leadership and Operational Leaders

• Core Elements of the Interdisciplinary Team Approach

• Trainings, Materials, Support and Site Visits

• IPC Quarterly Report (metrics and outcomes)

• Evaluation of the spread

Source: In-depth qualitative interviews with 35+ regional and national leaders conducted and analyzed in Fall 2007, CMI.
Factors Improving Likelihood of Effectively Implementing Practice

- Potential practice recipients have a compelling problem to correct.

- There is evidence of a superior practice.

- There is high level trust in the person/group sharing the information (the ‘source champion’).

- The practice is aligned with organizational goals.

Continued on next slide
• Practice transfer also has been related to leadership support including support with logistics, systems and removal of barriers.

• Resource availability.

• Presence of a culture supportive of practice transfer.

• Practice recipients have been urged to copy the original practice exactly if they are uncertain which practice features are essential to its effectiveness

Reference: Stealing Shamelessly: Practice Transfer Success Factors
Karen Tallman, PhD; Hannah King, MPH; Arthur K Huberman, MD. The Permanente Journal/Fall 2005/Vol.9 No.4.
The Institute for Healthcare Improvement (IHI) Model for Spread shows how good ideas go from one place to lots of places.

The IPC Spread Approach Matches the IHI Framework

**Better Ideas**
- Multi-regional palliative care RCTs find best results from CO’s Full Team; approach produces triple bottom line (improved quality, increased satisfaction, lower costs)

**Measurement and Feedback**
- Ongoing program evaluation
  - IPC national dashboard
  - Qualitative assessment
  - Patient satisfaction survey

**Leadership**
- Endorsement by KPPG and DSL
- Leadership at multiple levels (Program Office, Regional, Local)

**Social System**
- KPAN Network
- Program Office initiative builds on trusting relationships
- Ongoing networking opportunities (teleconferences, monthly IPC calls with regions etc.)
- Regional staff have ongoing engagement with source champions
- Video, program brochure, etc. communicate consistent message throughout KP

**Set Up**
- Kick off meeting
- National and Local Infrastructure
- Regional teams visit source champions
- IPC Trainings for all Regional IPC Teams and Program Managers
- Key components identified for spread

**Knowledge Management**
- Dissemination of IPC Business Case, Operations Manual and Spread Tools
- Development and dissemination of training materials
- Extranet for information sharing

KP has a growing wealth of knowledge and experience about how to successfully spread successful practices.

- IPC is just one example.

- Home-Based model based on RCT results has been spreading for years.

- Office-Based model has just completed the RCT testing and is just beginning to spread.
Home-Based Palliative Care Model (‘Brumley’ Model) is another example of successful spread.

The Home-Based RCT study was conducted with patients and families in the HI and CO regions.

- Intervention consisted of interdisciplinary team (RN, SW and MD) interdisciplinary team providing pain and symptom relief, patient and family education and training, and an array of medical and social support services.
- Pharmacists, chaplains and other providers brought in as needed.
- Patient, family and team developed a care plan focused on enhancing comfort, managing pain and symptoms and improving quality of life.
- Target population included homebound, terminally ill patients with late stage COPD, CHF or cancer and a prognosis of approximately 1 year or less to live plus one or more hospital or emergency department visit in previous 12 months.
Study Findings:
• Improved patient and family satisfaction maintained over time
• Lower rate of re-hospitalization

Winner of the Vohs Award for Quality
• Award came with some limited resources provided for spread

Spread:
• Model is now ‘business as usual’ in SCaI, HI, CO, MAS, and NW.
• GA considering adopting/building.
The 3rd KP Palliative Care study examined the impact of the Advanced Illness Coordinated Care (AICC) model in a managed care environment.

- AICC tested in several NCal sites, CO and NW.
- Intervention included LCSW with end-of-life experience conducting counseling sessions with patient and family focused on education, advocacy and care coordination.
- 4 – 6 sessions held in medical offices every 2 – 3 weeks.
- Target population included pts with CHF, ESRD, Cancer with metastasis or COPD and living at home.

- Study Findings:
  - Increased communication, coping and feeling supported
  - Higher rate of advance directive completion
  - Lower costs.
Next steps towards spreading this evidence-based model is to build both leadership and front-line awareness and support.

- Tactics in NCal include presenting the study findings and a business case to leaders at all levels.

- NW leadership supports AICC and the program has continued beyond the study.

- CO has made a site visit to NW to learn first-hand how the program works and to fold those learnings into their own business case for AICC.
How Can We Apply These Learnings To Other Elder Care Work?

• What have we learned from the experience(s) of spreading different palliative care modes to other elder care work?

• How can we gain focus and momentum to improve KP’s capabilities and capacity to efficiently and effectively improve the health of our older members?

• What elder care areas are ripe for this focus?
  • Physical Activity
  • Dementia
  • Cognitive functioning
  • Falls care
  • Other?
We can use the ‘TACOS’ tool in thinking about which Elder Care practices we might want to spread programwide.

**TACOS**

**Trialability**
- Will we be able to try this on a small scale first?

**Advantage (relative to current practice)**
- Will the practice make things substantially better than they are now? Is this an important goal for the unit?

**Compatibility**
- Will the practice work in our environment/culture?

**Observability**
- Are there obvious and believable results for this practice? Can we see the practice in action at another site?

**Simplicity**
- How big a disruption/change will this be?
1. Prioritize (locally and then programwide) target conditions or domains.
   - Elder Care Leads at all levels recommend where to focus and how to prioritize these conditions or domains.
     - What are the Best Practices (internal and external)?
     - What is the evidence?
     - What is KP’s motivation for improving these priorities?
   - Must be areas where improvement is important on multiple fronts, i.e.,
     - key value to patients/members
     - clinical room for improvement
     - positive impact on resources
2. Build business cases supporting these priorities

- What are the imperatives? Why must KP address these areas? Is there a local ‘pull’ or demand?
  - How might this impact member perception of value?
  - What are the benefits of reduced variation?
  - What are the operational benefits?
  - How do these improvements align with current strategic initiatives?
3. Socialize the rationale and suggest approach at all levels of the organization.

- Build awareness of the imperative, evidence and recommendations
  - Frontline staff want/need these improvements and tools
  - Clinical leaders understand the evidence and cost of variation to their patients (quality implications)
  - Business and operational leaders believe these improvements will positively impact the bottomline (or at least not make it worse)
  - Doing this work aligns with related activities of importance
- Secure sponsorship, commitment and resources based on the above (at all levels).
4. **Resource an accountable team to spearhead the spread**
   - Member, Regional and Program Office participation
   - Time and resources provided to focus on spread activities

5. **Define and communicate the model**
   - Identify multiple forums to communicate the organization’s commitment to the selected elder care initiative.
   - Develop and disseminate tools to build local business cases, train staff and measure outcomes.
6. Provide on-going opportunities for knowledge exchange

- On-going training in multiple modes (in person, online, teleconference, etc.)
- Site visits (tacit knowledge exchange through modeling and observation)
- Key indicator reports with discussions about trends and implications.
7. **On-going technical support**
   - Consultations to trouble-shoot and overcome barriers
   - Peer-support and sharing
   - Training and data collection plans that can be sustained
   - On-going outcomes monitoring

8. **Evaluation**
   - Has this elder care initiative brought about the desired results?
   - Communicate learnings and outcomes
What Next?

Which Elder Care areas and/or practices would you prioritize for KP attention and spread?

• Physical Activity
• Dementia
• Cognitive Function (i.e., brain health)
• Falls Care
• Other?

Why?
Peer-Reviewed Journal Articles on Two of KP’s Palliative Care Randomized Controlled Trials (RCTs)


Findings from the Office-Based (AICC) Study will be submitted for publication pending additional analysis.