Hospice and Palliative Care 2023

...A new continuum of end-of-life care

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Who We Are...
Spectrum Health Hospice and Palliative Care
(2006)
Hospice and Palliative Care

A continuum of services for the seriously ill…

Hospice and Palliative Care
Corewell Health West
2023
Palliative Care 2023

Inpatient/ Ambulatory
- 1 Practice Manager
- 6 RNs
- 2 PSRs
- 2 LPN
- 6 MSWs
- 4 Chaplains
- 16 APPs
- 7 MDs

Home Palliative Care
- 1 Manager
- 3 MDs
- 3 PSRs
- 4 RNs
- 4 MSWs
- 1 Chaplain
- 12 APPs
Value add of the interdisciplinary team:
“right person, right place, right time”

- Physician Leadership
- Midlevel Case Management
- Nursing Navigation
- Social Work Systems Support
- Spiritual Care
- Home Health Aides
Palliative Care Inpatient Consults

New inpatient consults
# Palliative Care Outpatient Clinic

## Clinic Volumes

<table>
<thead>
<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
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<th>Nov</th>
<th>Dec</th>
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<tbody>
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<td>Heart Failure</td>
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<td>9</td>
<td>10</td>
<td>10</td>
<td>2</td>
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<td>10</td>
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<tr>
<td>Total Clinic Consults</td>
<td>152</td>
<td>134</td>
<td>194</td>
<td>178</td>
<td>167</td>
<td>177</td>
<td>157</td>
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Telling the story...
Palliative Care: Quality Outcomes

First to Last Assessment Score Improvement: Patients with moderate to severe symptoms (excludes day 1 scores of 0 and 1; excludes all scores of 7 and 9)

<table>
<thead>
<tr>
<th></th>
<th>Pain</th>
<th>Anxiety</th>
<th>Nausea/Vomiting</th>
<th>Dyspnea</th>
<th>Bowel Movement</th>
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<tbody>
<tr>
<td>N</td>
<td>60</td>
<td>36</td>
<td>8</td>
<td>7</td>
<td>NA</td>
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<tr>
<td>Improved %</td>
<td>90.0%</td>
<td>83.3%</td>
<td>100%</td>
<td>100%</td>
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First to Last Assessment Pain Improvement – Moderate & Severe Symptoms Only

Surrogate Decision Maker

Recent Data Last Updated on Jan 11, 2022 at 18:05. Excludes patients with unknown or in a status for chosen variable.
Corewell Health Home Palliative Care

Average ED and Rehospitalizations Pre & Post Home Palliative Care Admission

<table>
<thead>
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<th>ED Cost Savings</th>
<th>after HPC Admit</th>
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<tr>
<td>2022</td>
<td>$1,100,595</td>
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<td>2021</td>
<td>$708,786</td>
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<td>2020</td>
<td>$359,913</td>
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<td>2019</td>
<td>$102,625</td>
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<td>2018</td>
<td>$55,906</td>
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<table>
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<th>Hospitalization Cost Savings</th>
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<tr>
<td>2021</td>
<td>$7,797,901</td>
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<tr>
<td>2020</td>
<td>$3,312,092</td>
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<tr>
<td>2019</td>
<td>$1,459,935</td>
</tr>
<tr>
<td>2018</td>
<td>$737,458</td>
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Home Palliative Care
…reduces cost by reducing ED visits and re-hospitalizations

• But it’s not just about the numbers…..

• Keeps patients at home where they want to be
• Provide real time, in home, assessment and intervention in collaboration with the PCP
• Provides services where there were previously none
• Allows for timely conversation about options and accurate information
• Superpowers of the hospice team moved further upstream
• Less crises, less patient suffering
Palliative Care and Oncology
The Bow Tie Model of Palliative Care

Benefits of **early** palliative care involvement

- Relationship building with patients, family and caregivers
- Symptom Management – anticipating/preventing/treating
- Exploration of understanding around prognosis, treatment goals, values
- Advanced care planning
- Coordination of care

Impact of Palliative Care Involvement on Quality Measures for Gynecologic Cancer Patients

End-of-Life Quality Indicators (final 30 days of life)

- Emergency Department (ED) use
- Hospital or Intensive Care Unit (ICU) admission
- Chemotherapy administered ≤14 days of death
- Death in hospital

Aggressive care defined as ≥1 of the following within the last 30 days of life:

- ≥2 ER visits
- ≥2 new hospitalizations
- ≥1 ICU admission

Impact of Palliative Care Involvement on Quality Measures for Gynecologic Cancer Patients

Compared to those who received late palliative care, those with early palliative care were:

• 25% less likely to receive aggressive care at EOL
• 40% more likely to access supportive care services at EOL
• 30% less likely to be admitted to ICU in the last 30 days of life
• 30% less likely to die in the hospital
• 35% less likely to receive late chemotherapy (if very early palliative care)

Compared to those who received late palliative care, those with no palliative care were:

• 2.5 times more likely to receive late chemotherapy
• 6 times more likely to be admitted to the ICU in the final 30 days of life
• Equally likely to die in the hospital or receive aggressive end-of-life care

Our story of relationship building: Palliative Care and Gynecologic Oncology

1. Intentional discussions between providers
   How can we help? Barriers?
2. Involvement at tumor board discussions
3. Inpatient consults
   Palliative Care Clinic follow up for continuity
4. Palliative Complex Pain Panel
What makes a successful partnership between Gyn Onc and Palliative?

• Buy-in from all members of the Gyn Onc Team (nurses, MSW, APPs, physicians, etc)

• Consulting early in the course of advanced cancer diagnosis

• The providers sell the referral to their patients and share quality data “live longer and better”

• Discussing survival expectations at diagnosis and again at recurrence so patients are well prepared when meeting with the palliative team

• Palliative care involved both inpatient, ambulatory space, and in the home
Present Barriers and Obstacles

1.) Late referrals

2.) Common misconceptions persist within the medical community and with patients
   - “palliative is essentially hospice”
   - “palliative cannot coexist with aggressive treatment”
   - “palliative will always talk with the patient about hospice”
   - “palliative is just for the very end of life”

“We discussed ongoing options including continued medical management versus palliative/withdrawal of care”
   – quote from a provider

3.) Availability of palliative care services / Response time for urgent consults
### Box 1

Barriers to the integration of palliative care into standard gynecologic oncology care

**Physician Factors**
- Optimistic view of patient's life expectancy
- Lack of awareness of palliative care/lack of training
- Fear of upsetting patient
- Admission of failure

**Patient Factors**
- Optimistic view of patient's life expectancy
- Lack of understanding of the meaning of palliative care
- Fear of upsetting the physician

**Institutional Factors**
- Inadequate resources
- Poor reimbursement for palliative care services
- Minimal formal training in palliative care for physicians
- Late palliative care referrals

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Example of Palliative Care Triggers: In the setting of a life limiting illness (patient does not need to meet all of the below)

- Repeat Hospitalizations (1 or more admission or ED visit in last 12 months?)
- Frequent Infections, increase in fall OR general patient decline
- Goals of care discussion needed with family/decision makers
- Complex medical treatment decisions to be made
- Significant symptom management concerns related to serious illness
- Complex social determinants impacting care
- Surprise question: Would you be surprised if patient died in the next 12 months?
Communication

The language we use matters
“Goals of Care” – what are we really talking about

What is often heard:

• “we will have “the talk” with the patient with the most favorable outcome being a signed DNR and hospice referral”

What Palliative Care means:

• We will collaborate with YOU and then connect with the patient and family as much as needed to ensure:
  • they understand their illness and treatment options fully
  • we know what’s most important to them
  • care aligns with what the patient and family want.
How to talk about palliative care with your patients

• “There will be several members of our team who will be involved with your care and one of our partners is the palliative care.

• Palliative care specializes in symptom management and works with us to ensure your optimal comfort.

• The palliative team is also helpful in decision making as there are often several decisions throughout the course of your treatment that you will need to make.

• The palliative team works with us to help clarify your goals so that what’s important to you is clear to our team.

• In summary: “Palliative care partners with us to ensure you are comfortable, are informed about your illness and treatment options and receive the care and treatment you want.”
• Excellence in care and timely response is a must
• Interdisciplinary team is critical - invest in that!
• Leadership team matters: dyad, leaders who have done that work
• TOP two priorities: patient care, team member care
• You have to do the math and show them the value-add
• Learn to tell your story to your executives:
  – The patient story
  – The metrics – they do matter
  – Excellent end of life care is the exclamation mark on the pt/family experience
• Doing the right thing for patients will ALWAYS drives the metrics
Outcomes of Timely Use of Palliative Care

- Improve Quality of Life and patient experience
- Better patient and family coping
- Increase in patient satisfaction
- More consistent care with patient goals
- Reduction in inpatient mortality rates
- Reduction in ED visits and unnecessary rehospitalizations
- Lower cost of care
- Increased provider satisfaction and less emotional distress
- Increase in equity of care
- Social determinants of health addressed
Thank you

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