

# Driving Healthcare Innovation: How Palliative Care Serves as a Model

Diane Meier, MD, FACP  
Director, Center to Advance Palliative Care

J. Brian Cassel, PhD  
Palliative Care Research Director, VCU School of Medicine

March 6, 2018

# Join us for upcoming CAPC events

- Upcoming **Improving Team Effectiveness** Series Events:
  - **Role Clarity for a Highly Effective Interdisciplinary Team:**
    - Thursday, March 22, 2018 | 3:00 PM ET
  
- Other Upcoming Webinars:
  - **Hospices as Providers of Community-Based Palliative Care: Demystifying the Differences**
    - Thursday, April 12, 2018 | 2:00 PM ET
  
- Virtual Office Hours:
  - **Marketing and Messaging with Andy Esch, MD, MBA and Lisa Morgan, MA**
    - March 7, 2018 at 1:30 pm ET
  - **Business Planning Using CAPC Impact Calculator with Lynn Spragens, MBA**
    - March 9, 2018 at 10:00 am ET
  - **Metrics that Matter for Hospices Running Palliative Care Services with Lynn Spragens, MBA**
    - March 9, 2018 at 12:00 pm ET

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# Specialist Palliative Care

- Adds a crucial layer of support for patients with serious illness and their families
- Interdisciplinary team works to
  - Prevent and relieve pain, other symptoms, stress
  - Clarify prognosis and determine patient-family priorities for care
  - Address bio-psycho-social-spiritual needs of both patient and family
- In the US, palliative care is distinct from hospice care; there is no revenue stream specific to palliative care → barrier to dissemination

# Selected Milestones in Palliative Care

Year	Milestone	Category
1975	Dr. Balfour Mount establishes first palliative medicine program, Montreal Canada	Innovation
1986	Journal of Pain and Symptom Management begins publishing	Dissemination
1988	First comprehensive palliative program in the US established at Cleveland Clinic	Innovation
1988	Palliative medicine recognized as subspecialty in the United Kingdom	Professionalization
1993	Oxford Textbook of Palliative Medicine published	Professionalization
1999	Center to Advance Palliative Care founded at Mt Sinai / Icahn School of Medicine	Dissemination
2001	Oxford textbook of palliative nursing published	Professionalization
2004	National Consensus Project publishes first guidelines for palliative care	Standardization
2008	First ABMS-recognized HPM board-certifying exam for physicians	Professionalization
2010	NEJM article from Temel RCT: early PC improved QOL, increased survival	Dissemination
2010	Palliative Care Research Cooperative Group established (funded by NIH/NINR)	Innovation
2011	Oxford Textbook of Palliative Social Work published	Professionalization
2011	Joint Commission Advanced Certification in PC begins for US hospitals	Standardization
2014	World Health Organization global resolution on PC access (WHA67.19)	Codification
2014	California mandates access to CBPC for Medicaid managed care	Codification
2016	“Measuring What Matters” recommendations from AAHPM/HPNA	Standardization

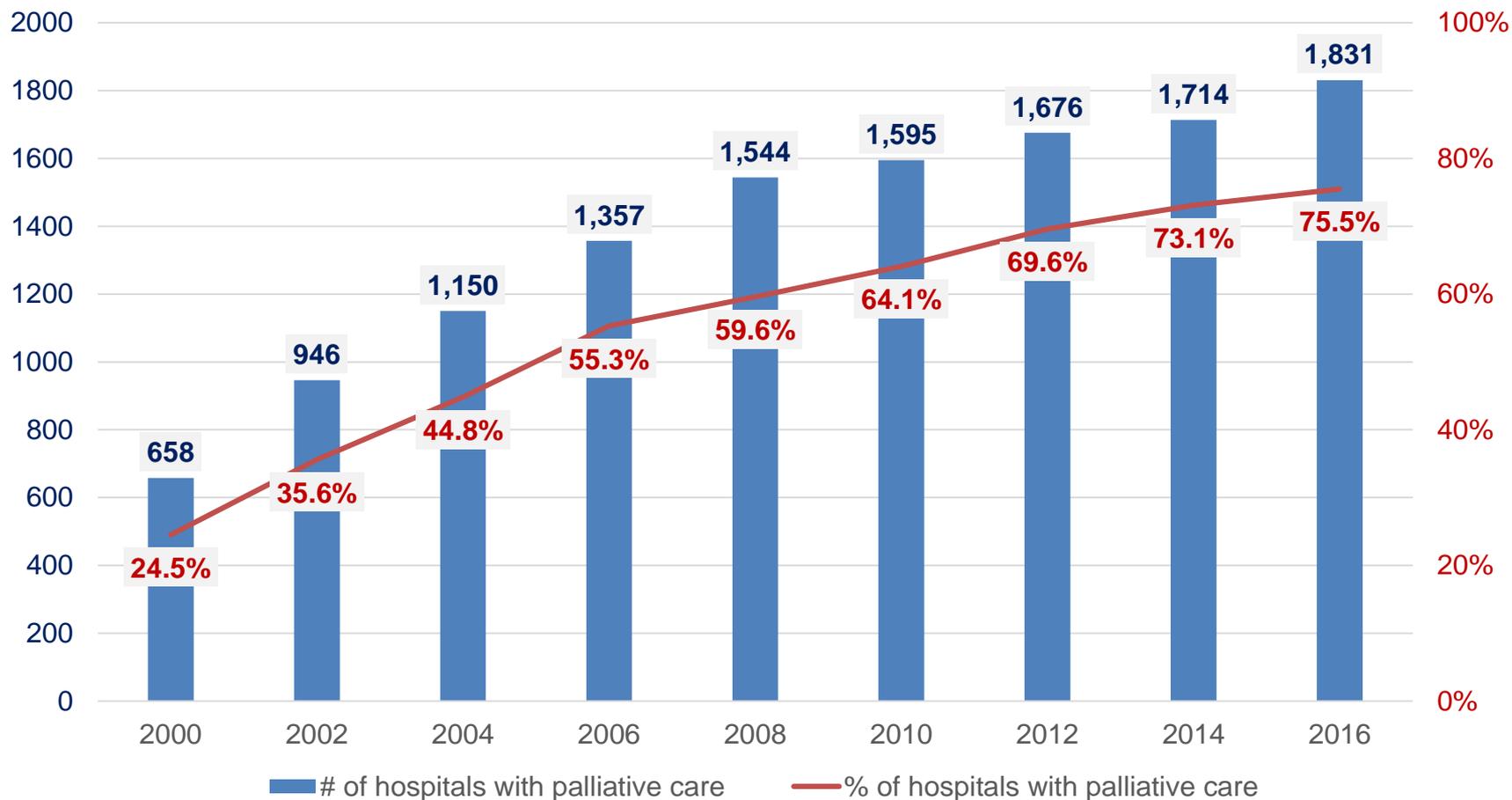
# Diffusion equals voluntary adoption

- Evidence demonstrates the beneficial impact of a range of palliative care delivery models on achieving the Triple Aim: improved quality, patient and family experience, and use of health care resources
- *However*, the adoption of this high-value program is entirely voluntary

# Barriers

- No distinct funding stream
- Cost of interdisciplinary team typically exceeds fee-for-service revenue
- Workforce shortage and training deficits
- Runs counter to the dominant medical culture in US
- Not required by payers or accrediting bodies such as The Joint Commission

# Hospitals (50+ beds) with Palliative Care



# How did this growth occur?

## Social Entrepreneurship

1. Recognizing that the status quo is broken; it is stable, but unjust and inadequate
2. Envisioning a new approach that fundamentally challenges the status quo
3. Developing innovations and prototypes
4. Promoting the adoption of tested models so that a new approach supplants the former

• Martin & Osberg “Social Entrepreneurship: The Case for Definition” SSIR, Spring 2007.

9 • Martin & Osberg “Two Keys to Sustainable Social Enterprise” HBR, May 2015.

• Skoll Foundation <http://skoll.org/>

# Step One: Understanding the status quo is inadequate

- **Understanding** the system of care is broken
  - Providers are inadequately trained in serious illness care – prognostication, communication, symptom management
  - Medical culture is authoritarian and partialist-driven
  - Subspecialization is rewarded above holistic care
  - Financial incentives and training skew care to overtreatment of organs and diseases to the detriment of quality of life

# Step Two: Challenging the status quo

- **Envisioning** patient-centered care that effectively addresses symptoms and distress
- **Articulating** how care of people with serious illness must begin with, and orbit around, the priorities and concerns of the patient and the family

# Step Three: Development and innovation

## → Building and testing prototype models

- Early palliative care programs in hospitals and other settings
- Testing and publishing evidence of successful innovations
- Replicating and modifying these models

→ Much of this is funded by philanthropy

# Step Four: A new approach that supplants the former

## → Promoting widespread adoption

- Professionalization – developing the workforce (board certified)
- **Dissemination through technical assistance, training, education**
- Standardization – what quality programs should look like (NCP)
- Codification in regulations, laws, payment policies – the new normal (TJC, payment for ACP, etc.)

→ Much of this is funded by philanthropy as well

# Dissemination and Implementation

- CAPC's educational strategy is guided by the “stages of change” model
- Dissemination stages
  - Pre-contemplation
  - Contemplation
  - Preparation
- Implementation stages
  - Action
  - Maintenance
  - Avoiding relapse

<b>Palliative Care Stage</b>	<b>Growth goal</b>	<b>CAPC Dissemination and Implementation methods</b>
Pre-contemplation	Gain attention, inspire those who are unfamiliar with palliative care	Press releases, blogs, podcasts, social media, state and national report cards
Contemplation	Motivate those who are interested in palliative care	National seminars, open access to “how-to” publications and white papers, including making the business case for palliative care
Preparation	Guide the planning of those who are committed to being a part of palliative care	Courses, webinars, virtual office hours with experts, toolkits, “boot camp” for community-based program development
<b>Action</b>	<b>Help leaders operationalize their ideas – from plans to active programs</b>	<b>PCLC: mentored training focused on implementation</b>
Maintenance	Show those with new or established programs how to overcome inevitable challenges	Virtual consulting sessions (known as Virtual Office Hours) with experts, clinical and advanced technical courses
Avoiding relapse	Stay engaged with programs to increase their efficiency, enhance their programs, and demonstrate their value	Master clinician case presentations, national registry benchmarking reports, virtual consulting sessions, webinars on innovations

From Planning to Action

# PALLIATIVE CARE LEADERSHIP CENTERS™ (PCLC)

By J. Brian Cassel, Brynn Bowman, Maggie Rogers, Lynn H. Spragens, Diane E. Meier, and The Palliative Care Leadership Centers

# Palliative Care Leadership Centers Are Key To The Diffusion Of Palliative Care Innovation

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NO. 2 (2018): 231-239  
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The People-to-People Health  
Foundation, Inc.

**ABSTRACT** Between 2000 and 2015 the proportion of US hospitals with more than fifty beds that had palliative care programs tripled, from 25 percent to 75 percent. The rapid adoption of this high-value program, which is voluntary and runs counter to the dominant culture in US hospitals, was catalyzed by tens of millions of dollars in philanthropic support for innovation, dissemination, and professionalization in the

**J. Brian Cassel** (brian.cassel@vcuhealth.org) is an assistant professor of hematology, oncology, and palliative care at Virginia Commonwealth University, in Richmond.

**Brynn Bowman** is vice president of education at the

# PCLC history and approach

- Start-up funding from RWJF in 2003 to select centers, create curriculum, and subsidize costs
- Centers of excellence - exemplars of the practices necessary for implementing palliative care programs
- Team-based teaching and learning
- Focused on operational, financial, and leadership aspects of implementation
- Standard curriculum with emphasis on local customization

# Leadership Centers

- Distributed training approach – hub and spokes model instead of one national center
- Created capacity to train a larger number of teams – a factor critical to scaling-up adoption
- Geographic and organizational diversity
- Centers had demonstrated financial sustainability, commitment to measurement, and a passion for sharing lessons learned

# Education model

- Three-step training and mentoring program:
  - Online preparation for knowledge acquisition
  - 2.5 day in-person session
  - One year of mentoring for ongoing guidance and support
- Face-to-face session is key for cementing relationships within and between teams
- Customization at the local level instead of mandating exact replication

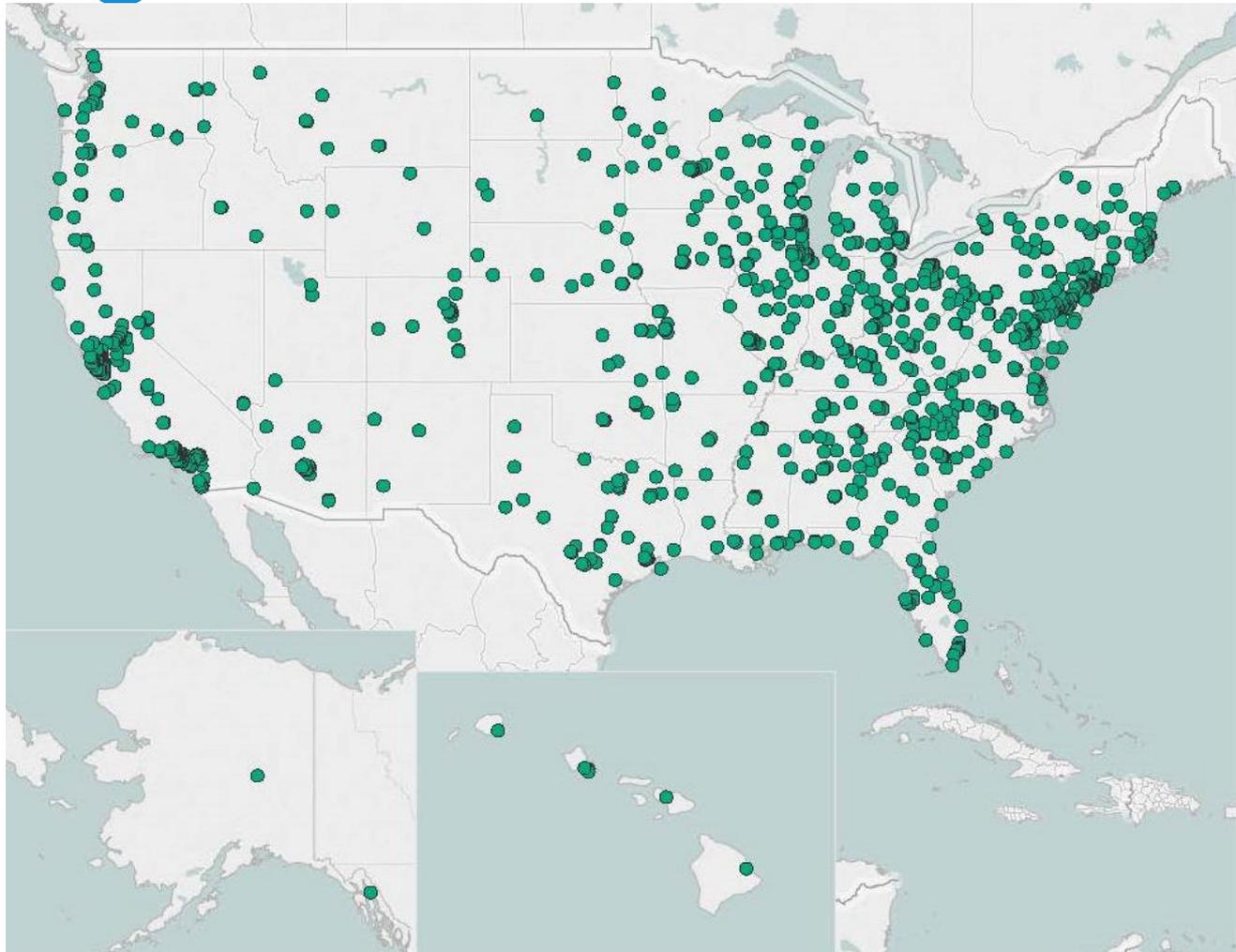
# Team building

- Held at leadership center – off-site for the trainees
- Leadership team and trainee team reflect the interdisciplinary nature of palliative care
- For some, this is the first opportunity to really get to know others with whom they will be working
- Involvement of financial experts helps to cross-train team members with different domains and perspectives

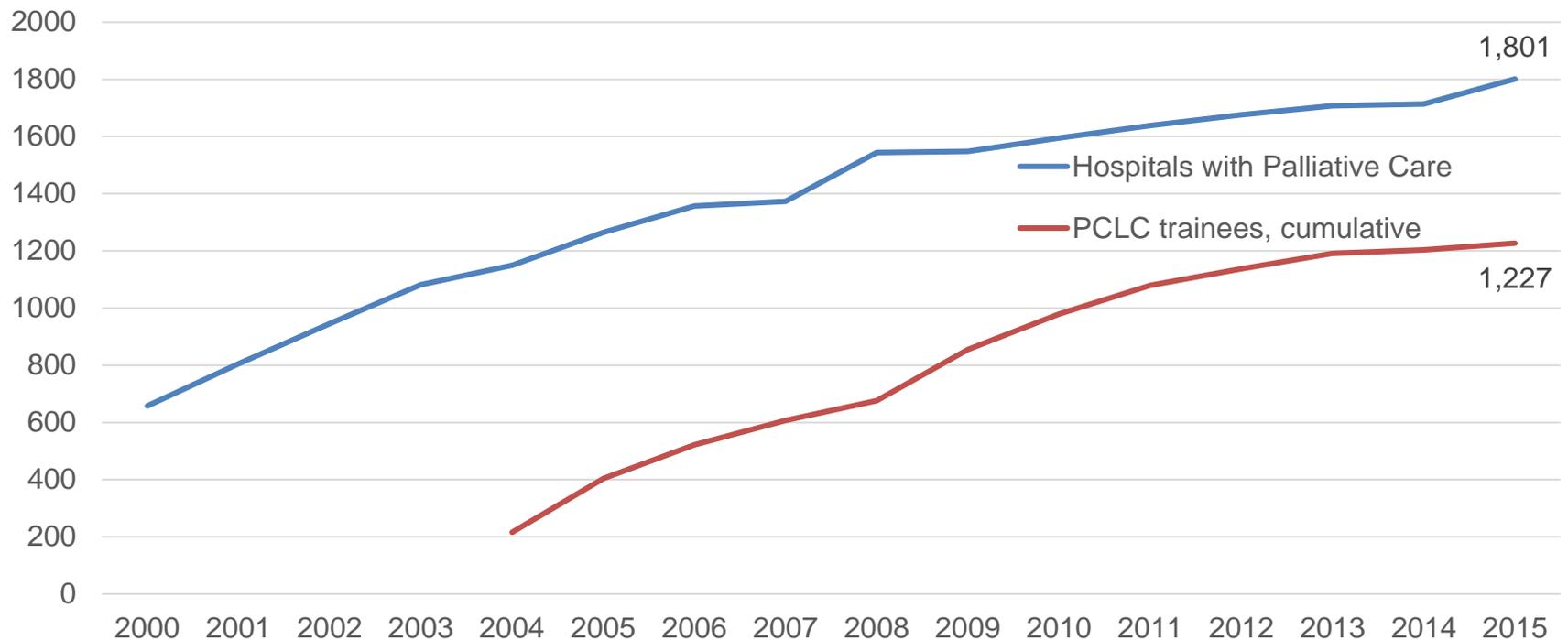
# Curriculum

- Focuses on pragmatic issues including:
  - Aligning clinical models with patient and provider needs
  - Incorporating stakeholder expectations into outcome measurement
  - Operational details
  - Financial support and sustainability
  - Educating others in palliative care principles and practices
  - “Marketing” palliative care to others – further cycles for diffusion of innovation
  - Collaborating with other teams

# Hospital teams trained through PCLC



# Two-thirds of hospitals with palliative care attended PCLC training



Sources: American Hospital Association (AHA) Annual Survey Database™, 2000-2015. Chicago, IL: Health Forum, an American Hospital Association affiliate. CAPC Palliative Care Leadership Center database, 2004-2015.

# PCLC impact

- Rapid and successful implementation
- Rapid growth in the number and quality of palliative care programs
- Local leaders have been able to demonstrate quality and financial outcomes for their institutions
- Key driver in senior executives' commitment to provide sustainable financing from operating budgets
- 80% of PCLC-trained teams have had programs up and running within two years

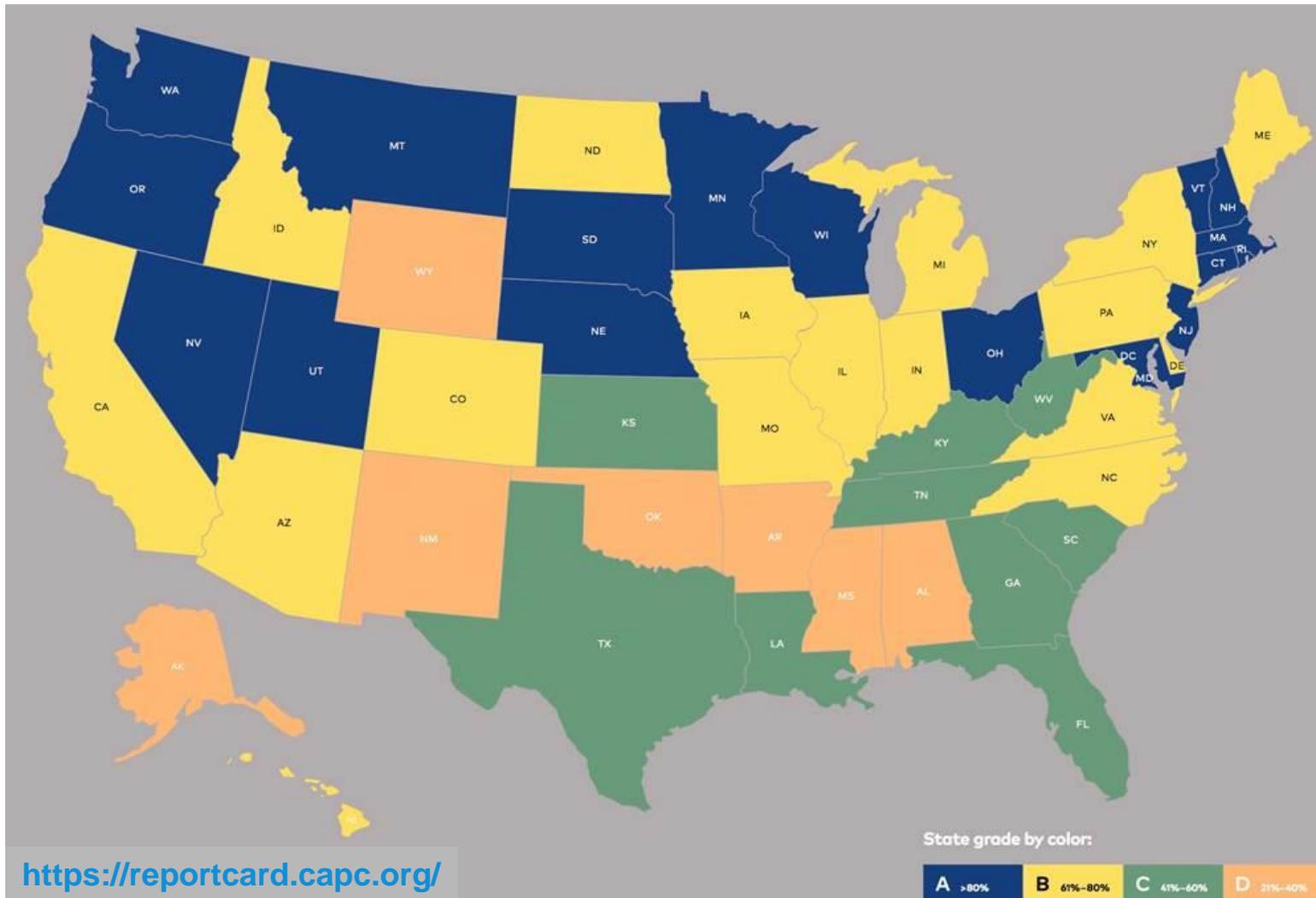
# Return on investment

- Palliative care helps hospitals and health systems to achieve the Triple Aim, starting with improved outcomes and quality for patients and families
- PCLCs are now expanding access to palliative care in home and community settings
- Both inpatient and community-based palliative care programs have shown positive ROIs
- PCLC helps programs to achieve these outcomes more rapidly, measure these outcomes for stakeholders, and sustain these efforts and support over time

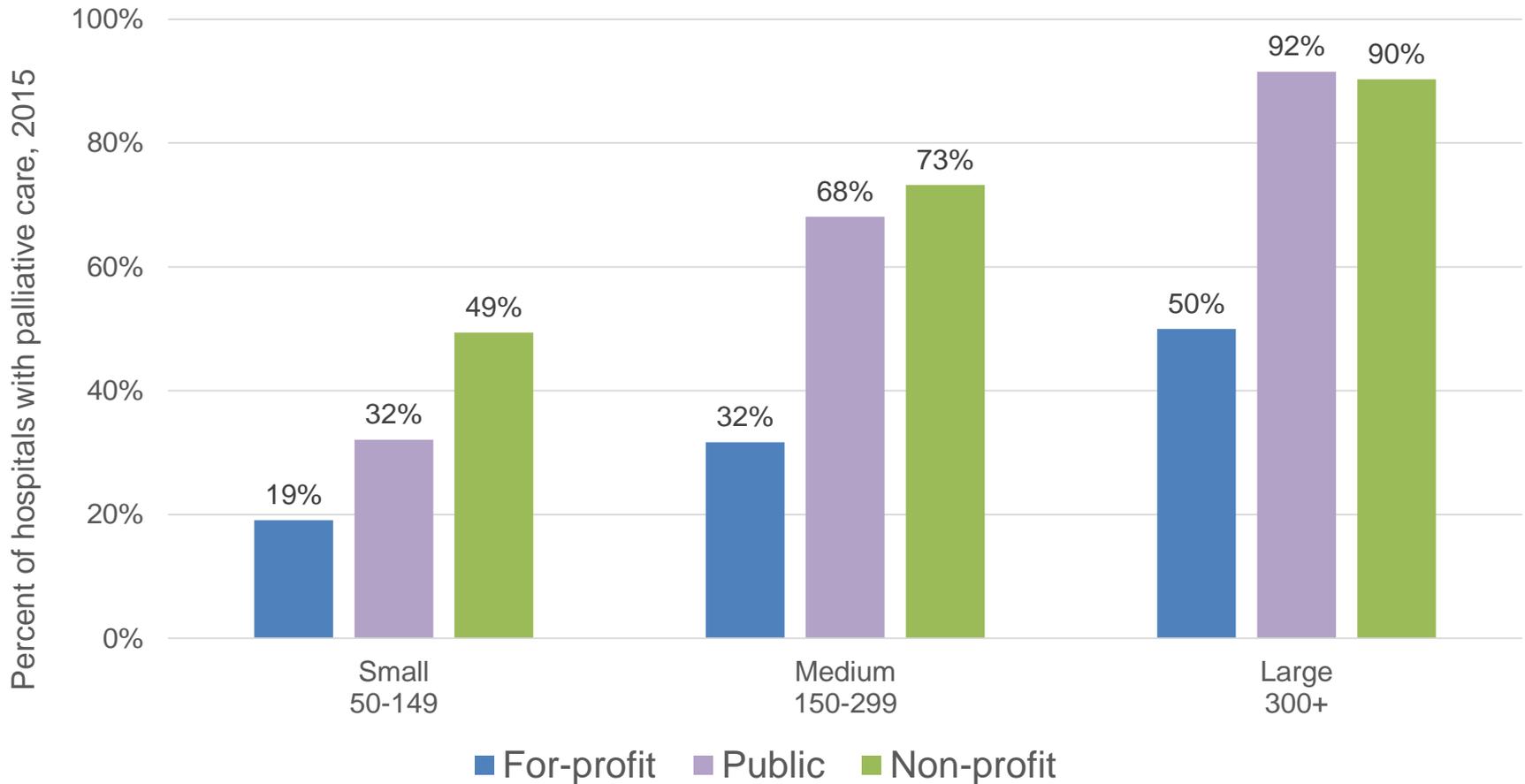
*The limits of diffusion*

**Voluntary adoption equals  
uneven adoption**

# National report card, 2015

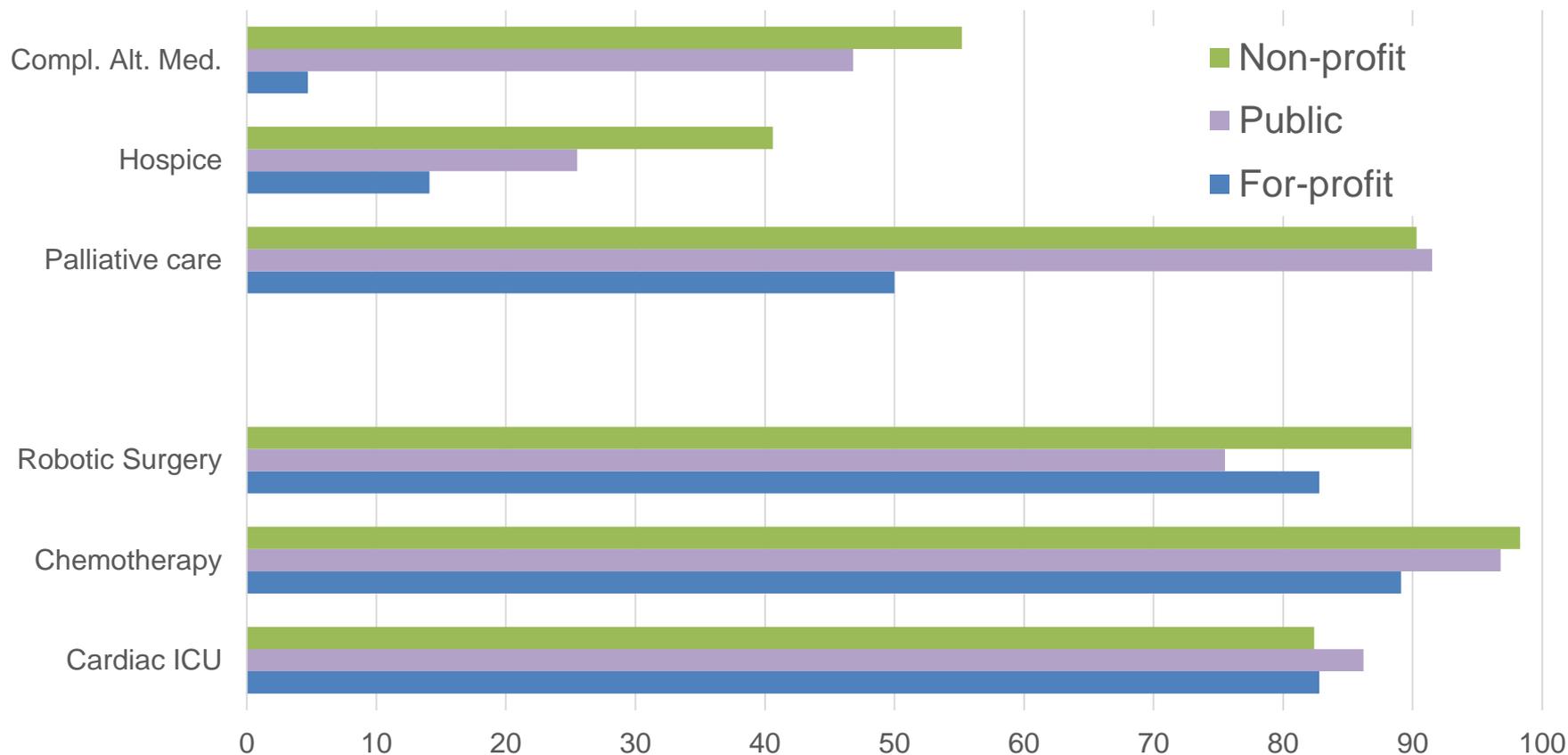


# Hospital size (number of beds) and tax status



# Adoption of high-revenue vs. low-revenue programs

*Among hospitals with 300+ beds, 2015*



Source: American Hospital Association (AHA) Annual Survey Database™, 2015. Chicago, IL: Health Forum, an American Hospital Association affiliate.

# Conclusions

- Large-scale adoption of high-value, low-revenue innovations in health care takes dedicated expertise, persistence, and ingenuity
- Passive dissemination (e.g., publishing research on innovations) is necessary but insufficient
- Implementation assistance is key
- Key characteristics of the PCLC model should be applicable to other high-value interventions
  - Multiple centers of excellence
  - Focus on teams and relationships with mentoring over time
  - Pragmatic and customized approach
  - New leadership skills – finance, marketing, proving outcomes
  - Start-up funding to establish centers and defray costs

# To Learn More

→ [capc.org](http://capc.org)

→ [pclc.capc.org](http://pclc.capc.org)

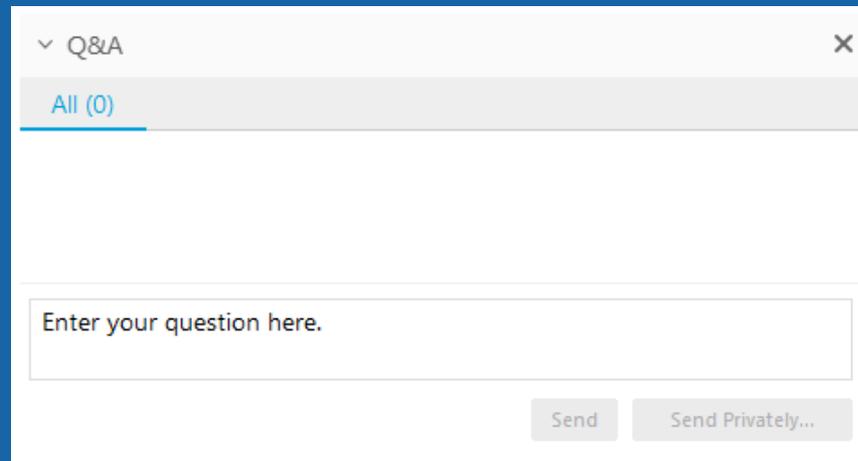
→ [Health Affairs, February 2018 Issue](#)

**PCLC** Palliative Care  
Leadership Centers™



# Questions?

Please type your question into the questions pane on your WebEx control panel.



The image shows a screenshot of the WebEx Q&A interface. At the top, there is a header with a dropdown arrow and the text "Q&A" and a close button "X". Below the header is a tab labeled "All (0)". The main area is a large empty space. At the bottom, there is a text input field with the placeholder text "Enter your question here." and two buttons: "Send" and "Send Privately...".

# Thank you