Driving Healthcare Innovation: How Palliative Care Serves as a Model

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March 6, 2018
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→ 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

Register at www.capc.org/providers/webinars-and-virtual-office-hours/
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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

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

- Number of hospitals with palliative care:
  - 2000: 658
  - 2002: 946
  - 2004: 1,150
  - 2006: 1,357
  - 2008: 1,544
  - 2010: 1,595
  - 2012: 1,676
  - 2014: 1,714
  - 2016: 1,831

- Percentage of hospitals with palliative care:
  - 2000: 24.5%
  - 2002: 35.6%
  - 2004: 44.8%
  - 2006: 55.3%
  - 2008: 59.6%
  - 2010: 64.1%
  - 2012: 69.6%
  - 2014: 73.1%
  - 2016: 75.5%
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

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

PALLIATIVE CARE LEADERSHIP CENTERS™ (PCLC)
Palliative Care Leadership Centers Are Key To The Diffusion Of Palliative Care Innovation

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...
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

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

https://reportcard.capc.org/
Hospital size (number of beds) and tax status

Adoption of high-revenue vs. low-revenue programs

Among hospitals with 300+ beds, 2015

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

➔ pclc.capc.org

➔ *Health Affairs*, February 2018 Issue
Questions?

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

Enter your question here.
Thank you