Health System Strategies: Using Data and Information to Prioritize Staffing and Growth

Rachel M Adams, MD, Physician Executive Director Palliative Care Service Line, MedStar Medical Group and Division Chief Division of Palliative Care, Medstar Georgetown University Hospital

Jennifer Hicks, MSHA, MBA, Administrative Director Center for Palliative and Supportive Care, University of Alabama at Birmingham

Jessica Schmidt, FACHE, Senior Operations Director Palliative Care, MedStar Health

Rodney O. Tucker, MD, MMM, FAAHPM, Director Center for Palliative and Supportive Care and Professor, University of Alabama at Birmingham

Kat Walker, PharmD, BCPS, FAAHPM, *Assistant Vice President Palliative Care, MedStar Health and Associate Professor, University of Maryland School of Pharmacy*

Moderator: ***Tom Gualtieri-Reed, MBA****, Partner, Spragens & Gualtieri-Reed*

CAPC Webinar
May 24, 2022

Center to Advance Palliative Care™
capc

Context

- This is the 2nd in a series of CAPC webinars designed to support program teams and leaders in building **consistent** and **reliable access** to quality palliative care within health systems *(See: 10/2021 "How to Design a Health System-Level Palliative Care Strategy and Service)*

- A growing number of health systems are asking palliative care program leaders and teams to lead and run a palliative care service across multiple hospitals, clinics, and other sites.

- This trend is an indicator that palliative care is increasingly recognized as **a critical element of a health system's broader strategy** and a standard service like other medical specialties and services.

- There are opportunities to leverage system-wide data and information to prioritize staffing and growth opportunities.

Objectives

Today we will hear experiences from two programs to support the following learning objectives:

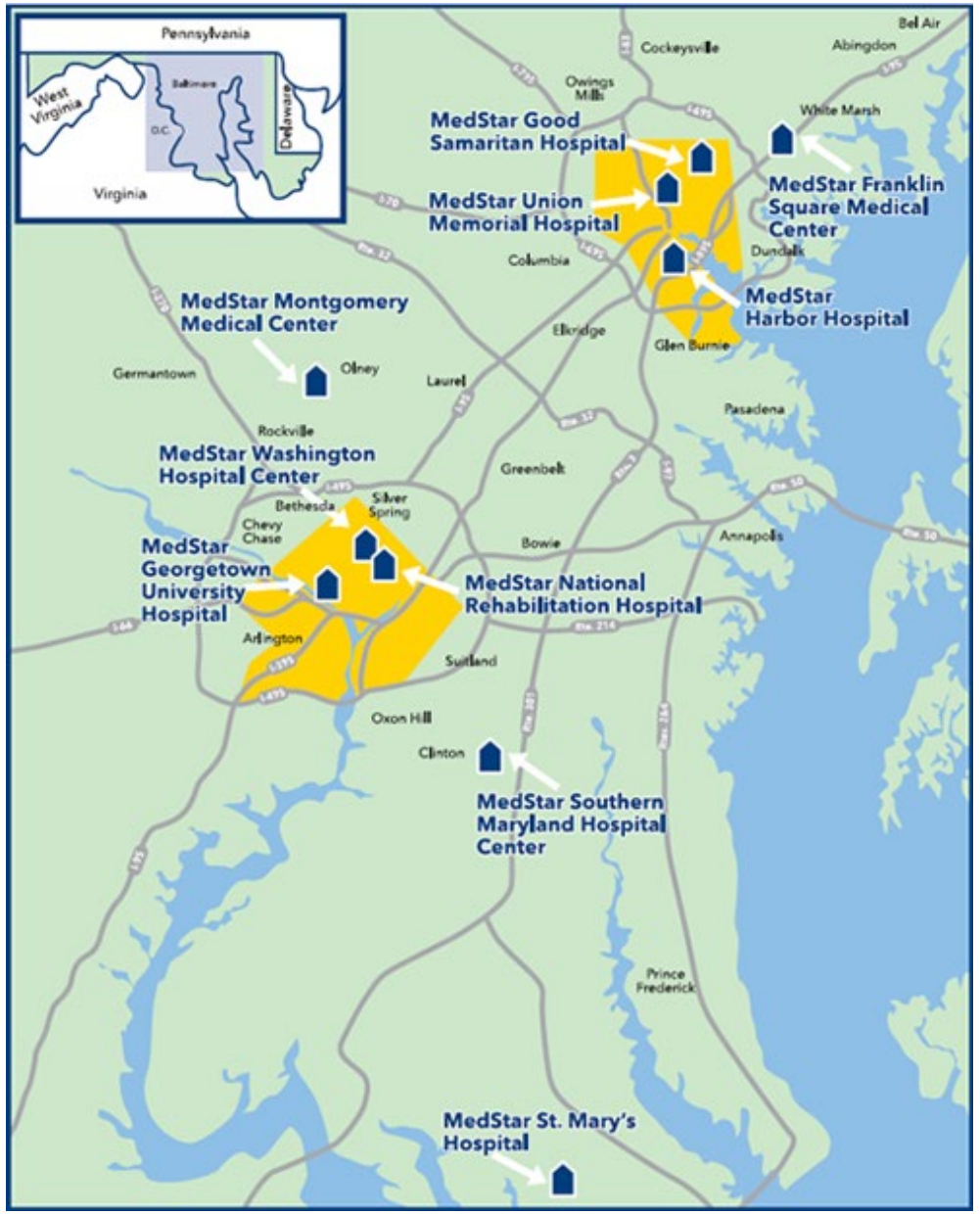
- Describe options for how palliative care programs can organize within a health system
- Understand strategies for accessing program information across sites to demonstrate impact and value
- Identify 2 methods for using health system data to develop staffing plans in hospital and clinic settings

This will include a facilitated panel discussion and Q&A

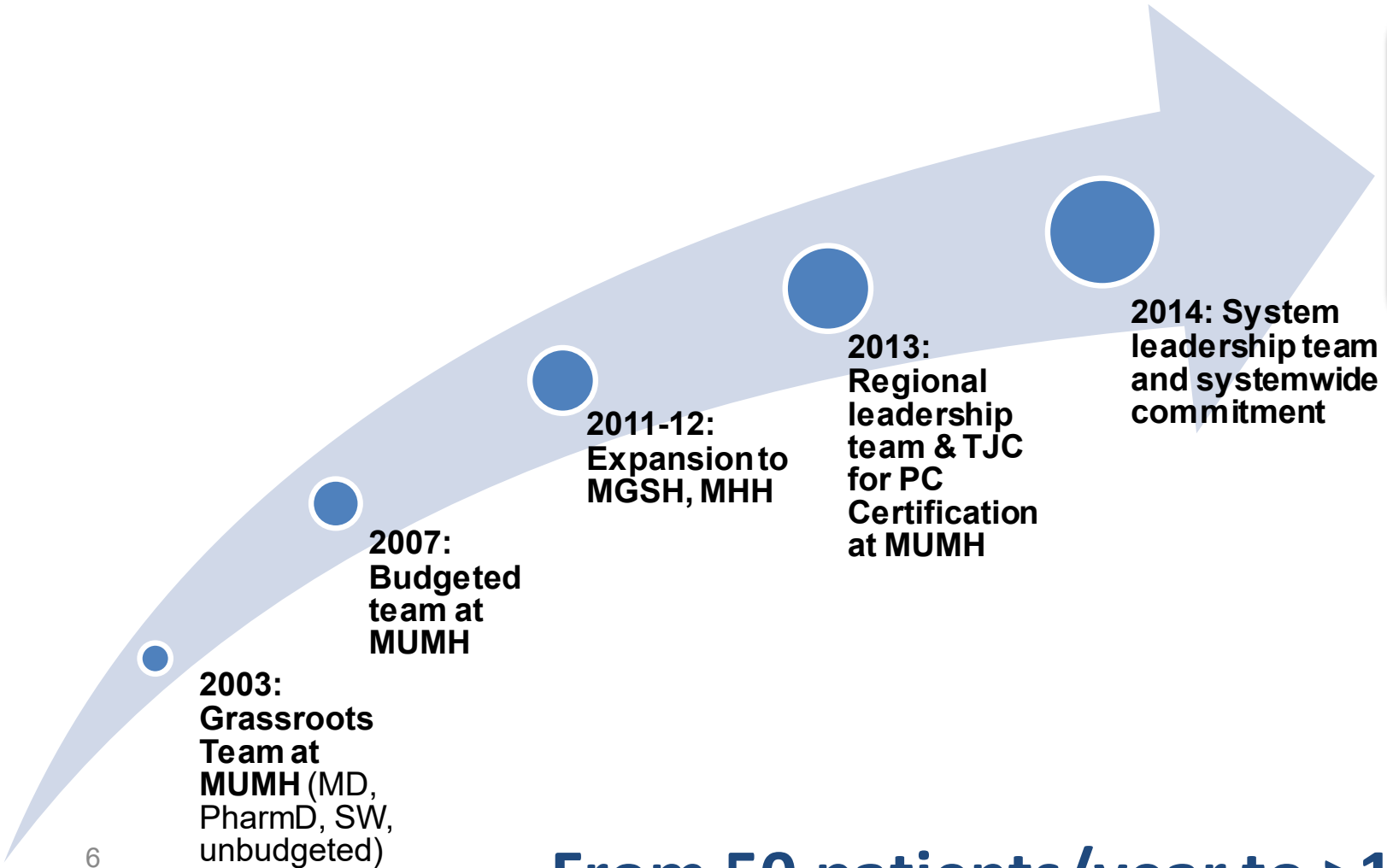

MedStar Health

Overview of MedStar Health

- 10-hospital learning health system in the Baltimore/Washington area.
- Inpatient palliative teams in all 9 of our acute care hospitals
  - 10k inpatient PC consultations this FY
  - Support our National Rehabilitation Hospital PRN
- System level programs
  - PATCH (PC Telehealth Connecting to Home) since 2016: avg census 130 patients
  - Advance Care Planning Program since 2020: >5k visits split between IP/OP
  - PCTC (PC Telehealth Cross-coverage) since 2020: avg 30 patient daily census per weekend coverage
  - Payer partnership with CareFirst since 2020: $1M investment in bundled payment model for inpatient PC



Evolution of Palliative Care at MedStar Health



2014-16: Recruit and advocate for teams at other 6 hospitals

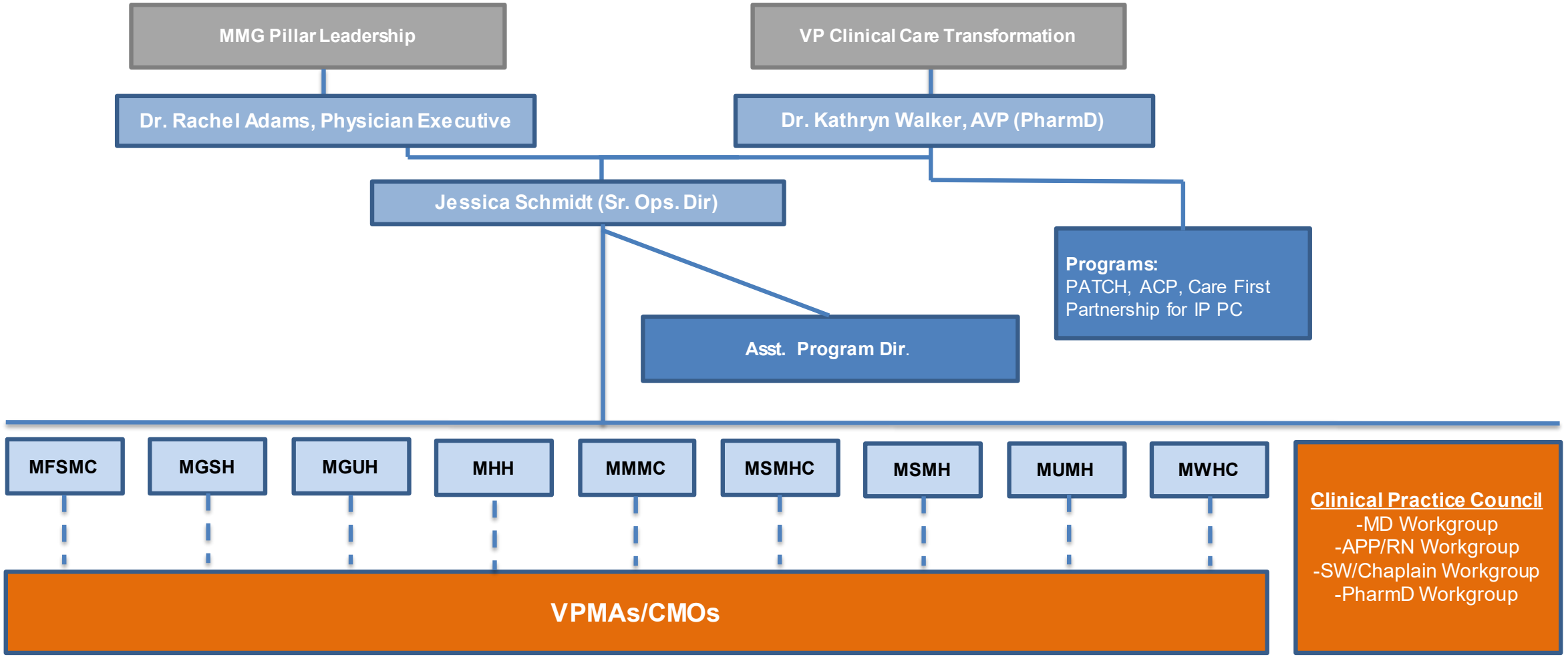
>2016: Team Growth + Innovative Program Development

- **2015**: PATCH Program (Palliative Telehealth Connecting to Home)
- **2020**: Advance Care Planning Program
- **2020**: PCTC (PC Telehealth Cross Coverage)
- **2020**: CareFirst Payer Partnership

From 50 patients/year to >10,000!

capc Center to Advance Palliative Care

Matrix Relationships= Teamwork at all levels



capc Center to Advance Palliative Care

MedStar PC Teams

	Hospital beds	PC consults	FY 22-3 Breakdown by discipline						FTE
			MD	NP	RX	SW	RN	CH	
MFSMC	348	1,155	1	2.6	1	2	0	0	6.6
MGSH	137	833	1	1	1	1	0	0	4
MGUH	609	1,164	4	2	2	2	0	1	11
MHH	139	637	1	0	1	1	0	0	3
MMMC	115	677	1	0	0	1	0	0	2
MSMH	109	755	0.6	1	0	0.5	0	0	2.1
MSMHC	262	1,032	2	1	0	1	0	1	5
MUMH	192	1,011	1	2	1	2	0	0.2	6.2
MWHC	912	2,865	6	2	3	4	1	3	19
PATCH	n/a	260	.4	1	1	2	2	0.2	6.6
MSH*	**n/a**	**10,389**	**18**	**12.6**	**10**	**16.5**	**3**	**5.4**	**65.5**

*Not including learners: 4 MD fellows, 1 NP fellow, 2 PGY2 PharmD residents, 1 SW fellow, 4-6 chaplain interns per year

MedStar Principles

- Team model is KEY
  - All perspectives necessary for high quality care and outcomes
  - Anyone can start a consult
  - Aim for TRANSDISCIPLINARY
  - Language matters: first names, not “my patient”
- NCP guidelines serve as our quality standard:
  - https://www.nationalcoalitionhpc.org/ncp/

Our Mascot…

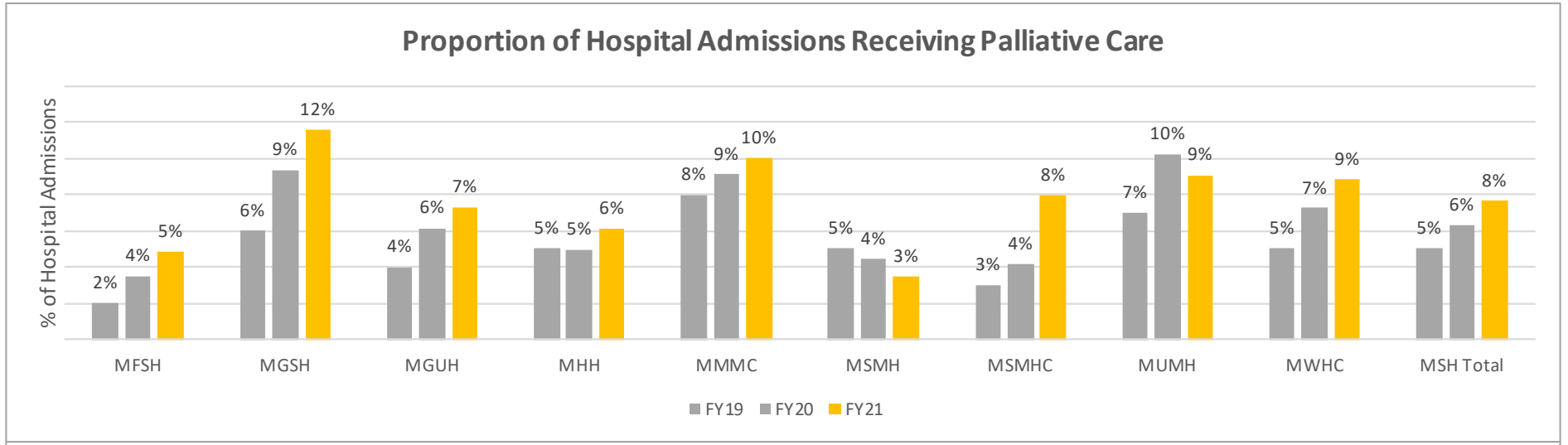
Medstar Health PC Systemness Evolution

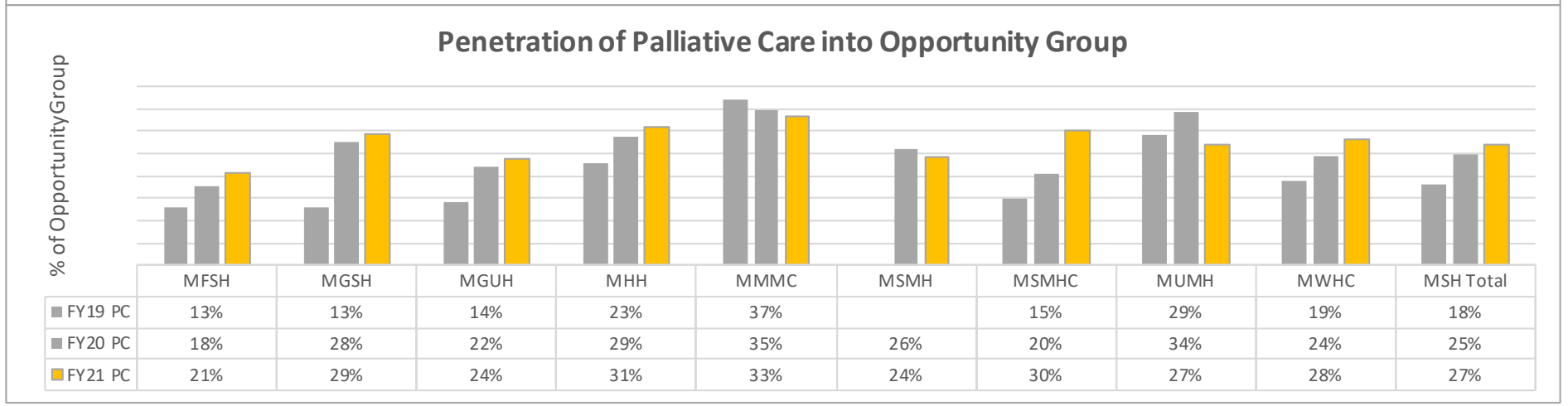
- Leveraging the MATRIX
- PC Connectedness – weekly Lunch Bunch for just in time questions, sharing life and team-based learning (inter professional continuing education provided)
- All associates and providers under a single employer entity (MedStar Medical Group)
  - Consistent onboarding/training/compensation practices
  - Advocating for discipline-specific career ladders
- Interdisciplinary Team (IDT) governance and leadership
  - Sharing best practices, clinical protocols
- Cross-coverage models for weekends, vacations, leave of absence (LOA), vacancies
  - PCTC (PC Telehealth Crosscoverage)
- Clinical alignment and system approach creates opportunity for payer partnerships and innovation (e.g., telehealth, CBPC, advance care planning program)

MedStar's Use of Data and Analytics

- GIGO (garbage in garbage out): long long long (continual) process of workflow alignment and data mapping
- Outcomes tracking has helped make a case to continually grow IDTs
  - Making case for IDT staffing model to rationalize growth (e.g. 500 consults = 1 IDT or 3.5 FTE)
- Payer partnerships based on meeting clinical criteria
- Close partnership with leadership and sites to individualize value and prioritize outcomes
- Important to develop deep understanding of quality measurement logic and payment/penalties

Palliative Care Penetration Rates

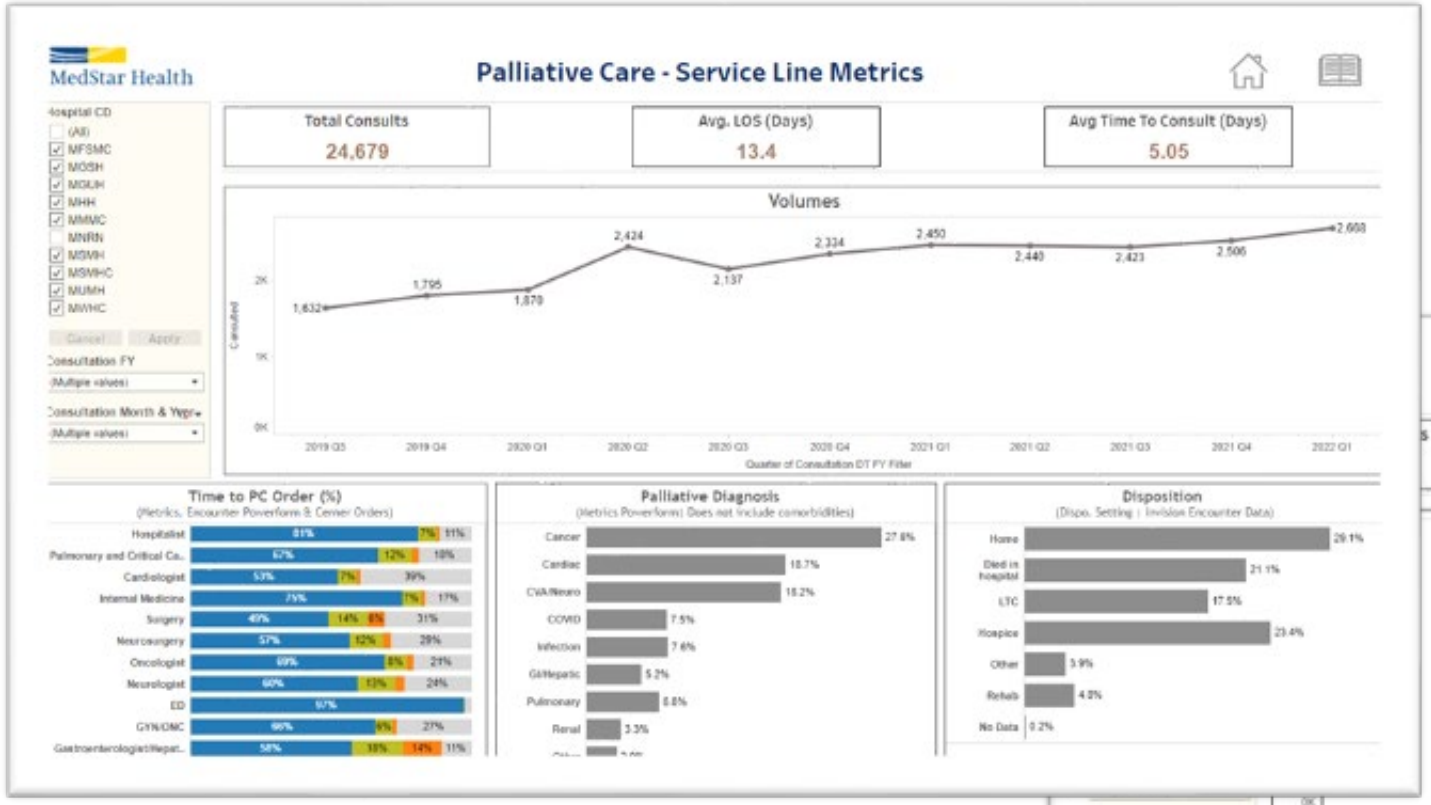


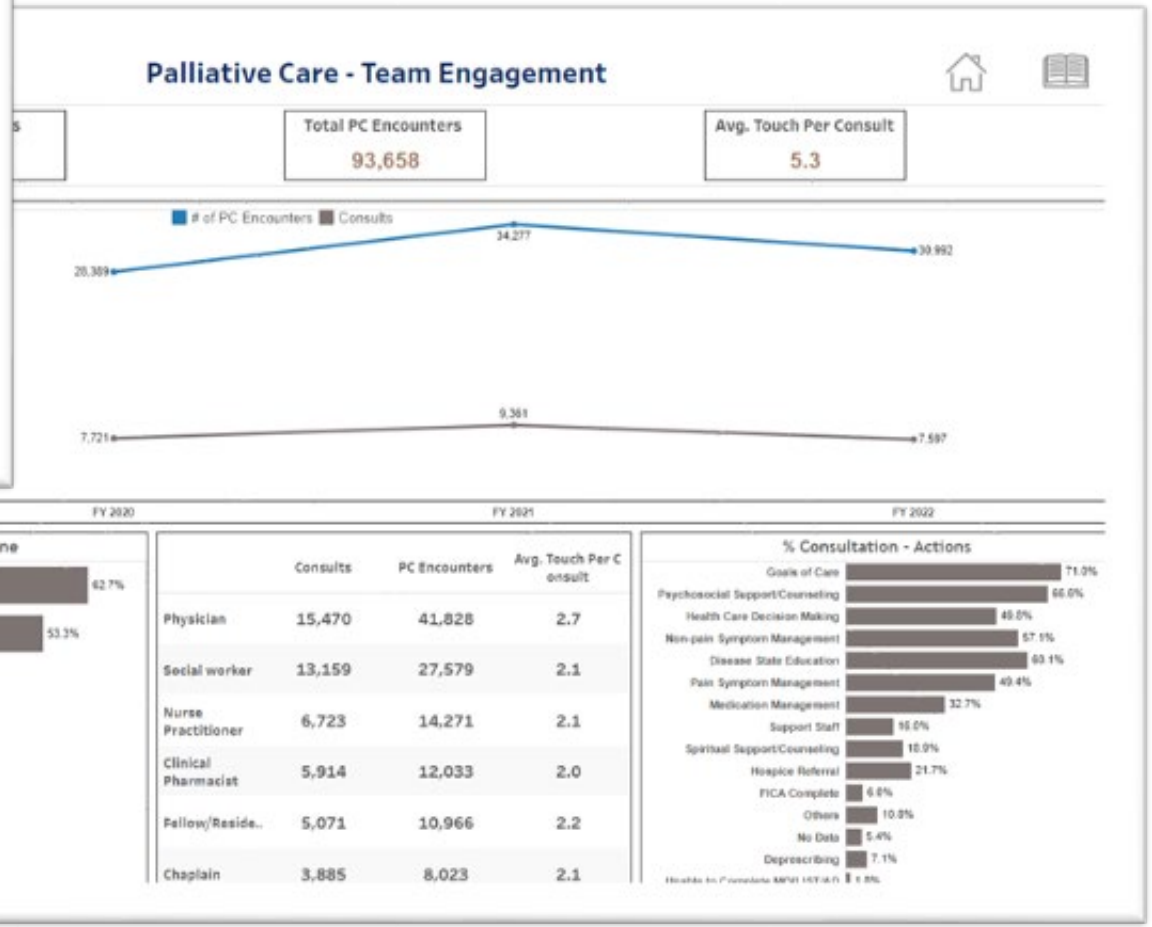


	MFSH	MGSH	MGUH	MHH	MMMC	MSMH	MSMHC	MUMH	MWHC	MSH Total
FY19 PC	13%	13%	14%	23%	37%		15%	29%	19%	18%
FY20 PC	18%	28%	22%	29%	35%	26%	20%	34%	24%	25%
FY21 PC	21%	29%	24%	31%	33%	24%	30%	27%	28%	27%

capc Center to Advance Palliative Care

Dashboards/Analytics



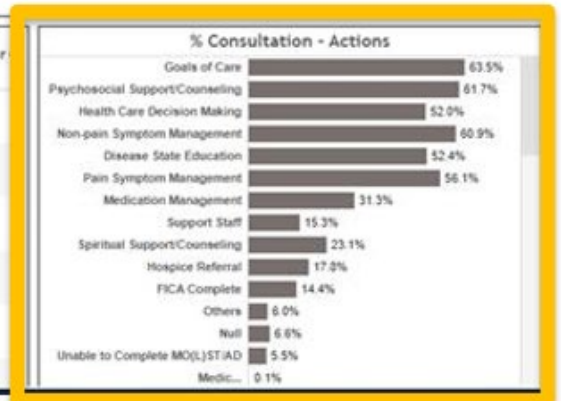


- Measure what matters
- Pull only what you need
- Tell the story of clinical impact, teamwork

Examples of Data Applications

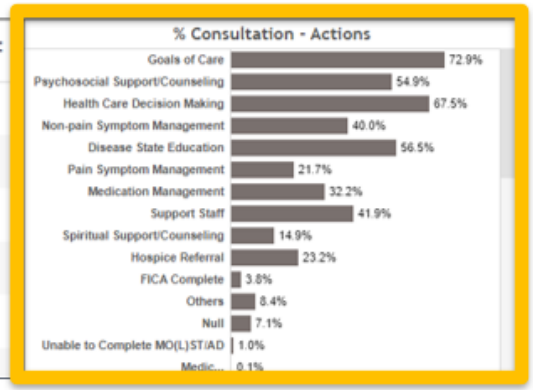
All Sites WITH PharmD (4,157 PC consults):
Mgmt 31%, Pain sx 56%, Nonpain 61%

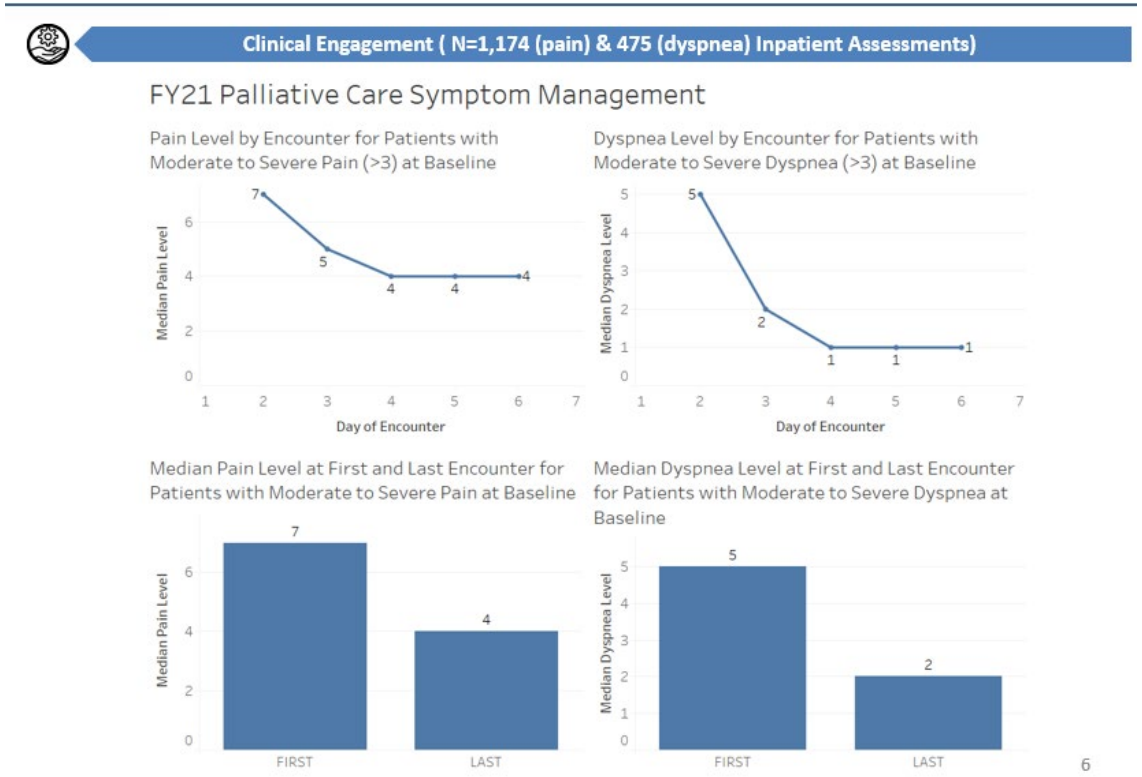
	Consults	PC Encounters	Avg. Touch Per Consult
Physician	2,323	7,573	3.3
Social worker	2,006	4,600	2.3
Nurse Practitioner	1,123	2,828	2.5
Clinical Pharmacist	1,424	3,462	2.4
Fellow/Reside..	1,195	3,239	2.7
Chaplain	928	1,904	2.1



All Sites WITHOUT PharmD (1,828 PC consults):
Med Mgmt 32%, Pain sx 22%, Nonpain 40%

	Consults	PC Encounters	Avg. Touch Per Consult
Physician	1,169	2,535	2.2
Social worker	775	1,481	1.9
Nurse Practitioner	358	553	1.5
Clinical Pharmacist	54	69	1.3
Fellow/Reside..	79	110	1.4
Chaplain	269	538	2.0





capc Center to Advance Palliative Care

Lessons Learned and Reflections

- It ALL goes back to TEAM
- Benefits from Team-based leadership
- Importance of partnership with site and system stakeholders
- Doing the interstitial work requires system collaboration

THE UNIVERSITY OF
ALABAMA AT BIRMINGHAM

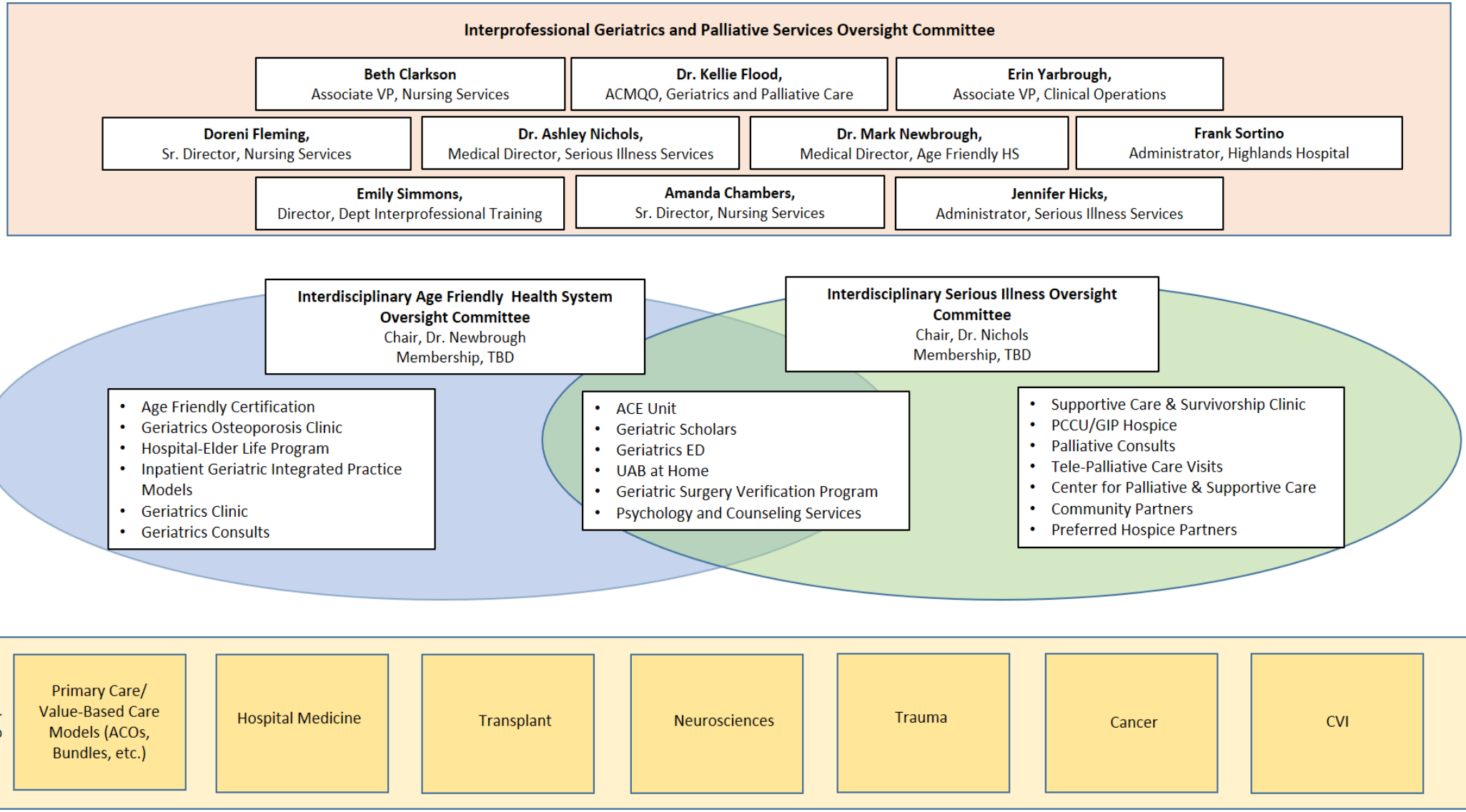
capc Center to Advance Palliative Care

The Setting

- Birmingham, AL
  - >1 Million people in metro area
  - Largest metro area in Alabama

- UAB Hospital:
  - 8th Largest Hospital in U.S.
  - Longest living donor kidney transplant chain in the U.S. (112+)
  - 1,157 beds (ADC 994)
  - Level 1 Trauma Center
  - >5,000 new cancer patients annually at O'Neal Comprehensive Cancer Center
  - 1.6 Million outpatient visits annually

Serious Illness Framework



Palliative and Supportive Care Structure

Division of Gerontology, Geriatrics, and Palliative Care

Clinical Operations

Associate Vice President, Clinical Operations

Administrator, Serious Illness Services

Focus:

- What's working well?
- What needs improvement?
- Program implementation and sustainability
- Quality and reporting
- Developing relationships with community partners
- Expanding access
- Expanding offerings to key Serious Illness stakeholders/patients
- Supporting Clinical Services – Supportive Care and Survivorship, PCCU, Consult Service
- Supporting Interdisciplinary team
- Bereavement Survey Process (survey for all hospital deaths)
- Process Mapping to improve current processes and identify needs

Collaboration

Pilot Project to Regular Operations

Quality Improvement

Process Improvement

Publication and Education

Education & Research

Center for Palliative and Supportive Care

Program Director and Program Managers, Center for Palliative and Supportive Care

Focus:

- Center and SIIPSC Strategic Planning
- Securing philanthropy and non-clinical revenues
- Managing projects paid for by philanthropy
- Managing the IRB process for certain QI projects
- Oversight of PCLC and CTA Training Programs
- SIIPSC and Summit 2020
- UWIRC (University-wide Interdisciplinary Research Center) Status
- Event Planning – Fellowship Reception, Cocktails and Conversations, etc.
- Community Outreach (Magic City Art Connection, etc.)
- PREP Pilot Grant Program

capc Center to Advance Palliative Care

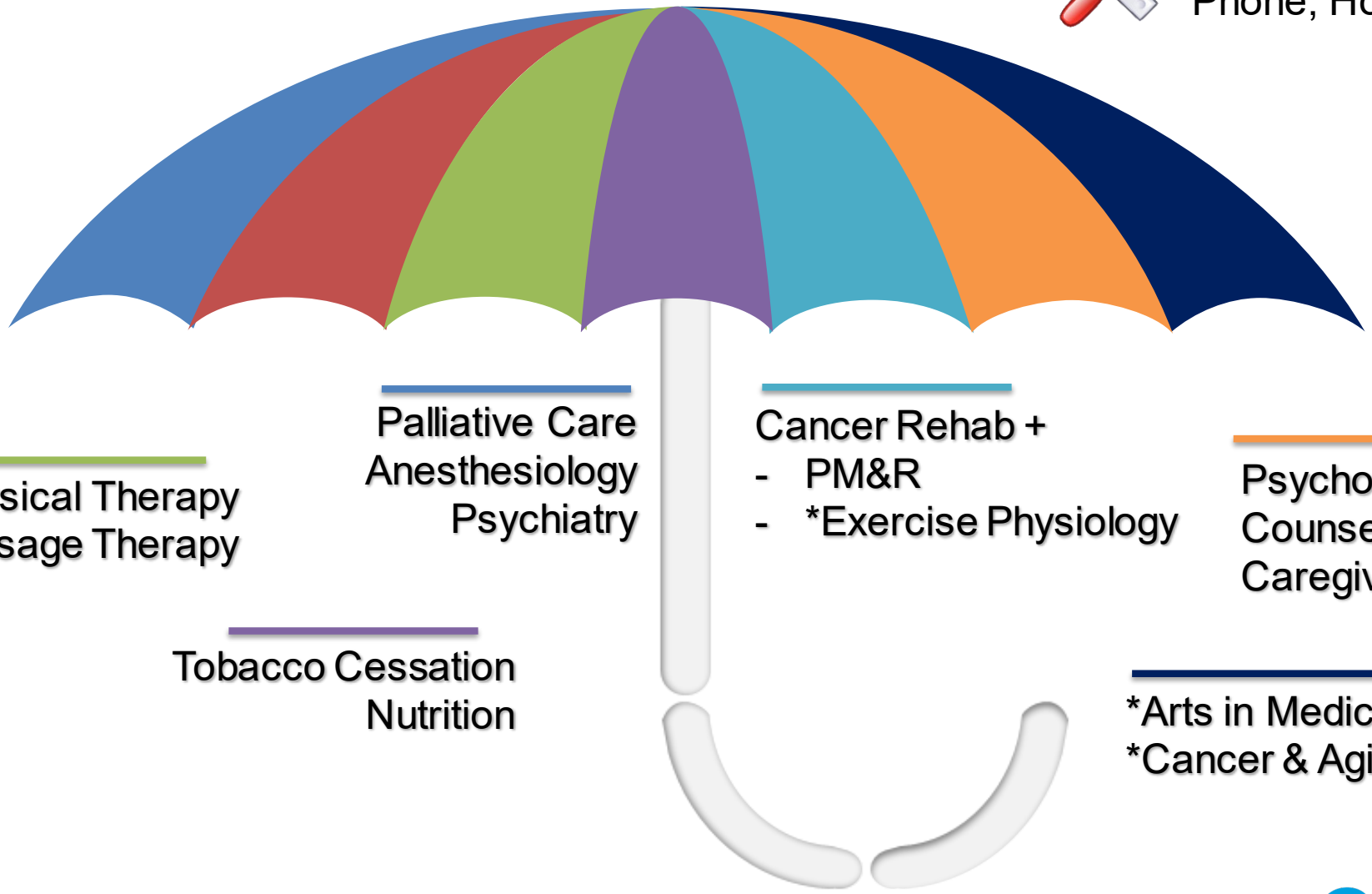
Connecting the Care Continuum

Community-based Palliative Care

- One Patient Population
- Three routes of Connection
- Continuity
- Evidence-Based
- Community Supported

Supportive Care Clinic

In-person, Telehealth,
Phone, Home Visits



Physical Therapy
Massage Therapy

Palliative Care
Anesthesiology
Psychiatry

Cancer Rehab +
- PM&R
- *Exercise Physiology

Psycho-Oncology
Counseling
Caregiver Support

Tobacco Cessation
Nutrition

*Arts in Medicine
*Cancer & Aging

capc Center to Advance Palliative Care

Outpatient Care Coordination Infrastructure

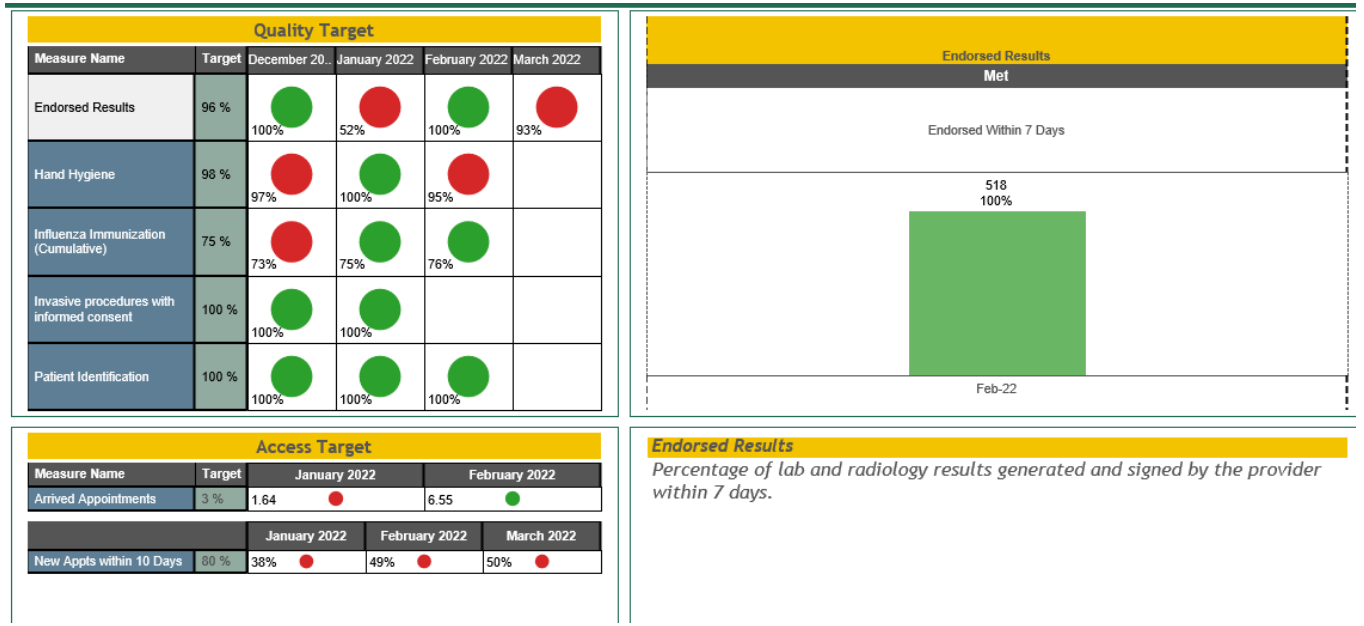
- Most important part of ambulatory Palliative Care:

  Care Coordination

  - 4 RN Clinical Care Coordinators
  - Navigate patients into the program and between all the providers and supportive resources within clinic
  - Manage between-visit care
  - Responsive phone support
  - Telemonitoring*

Data Driven

- clinic access metrics
- quality indicators
- patient experience
- arrived visits
- room/space utilization
- individual provider statistics
- wRVUs
- patient education engagement (EMMI patient education system)



Quality Target

Measure Name	Target	December 20..	January 2022	February 2022	March 2022
Endorsed Results	96 %	100%	52%	100%	93%
Hand Hygiene	98 %	97%	100%	95%	
Influenza Immunization (Cumulative)	75 %	73%	75%	76%	
Invasive procedures with informed consent	100 %	100%	100%		
Patient Identification	100 %	100%	100%	100%	

Access Target

Measure Name	Target	January 2022	February 2022
Arrived Appointments	3 %	1.64	6.55

	January 2022	February 2022	March 2022
New Appts within 10 Days (80 %)	38%	49%	50%

Endorsed Results

Percentage of lab and radiology results generated and signed by the provider within 7 days.

capc Center to Advance Palliative Care

Using Data to Inform Staffing: RN Coordinator FTE Request

- Justification for more RN Coordinators included:
  - Increased clinic visits over past 3 years (trending at a 25%+ increase year over year)
  - Phone and portal message volumes
  - Proposed Orders by type
  - Additional services added to program
  - Overtime of current staff
  - Roll-out of Distress assessment to all cancer areas

Leveraging the Health System

- Bundles
- ACO – Accountable Care Organization
- Post-acute Strategies
- Readmission Strategies
- Service Line Partnerships (e.g., Cancer Service Line, Cardiovascular Institute)

Summary
and
Panel Q&A

Helpful Resources

National Reference Points

- Palliative Care Quality Collaborative (PCQC) www.palliativequality.org
- CAPC (tools, references) www.capc.org
- Colleagues

Baseline Checklist for Multi-site Data Collection

Health Systems: Successful Palliative Care Strategies

Baseline Data Collection Tool

Center to Advance Palliative Care™ capc

Organizing your Regional or Site-Specific Data
Use this as a checklist to organize information about each site or market. This may help you ID similarities across sites, unique strengths, or needs. **Work with stakeholders to gather this information!!**

Inpatient/Hospital	Palliative Care – History & Baseline Footprint
# of beds, % of beds that are ICU, annual admissions, occupancy rate, ALOS, proportion of admissions for older adults. % of admissions from the ED. Annual inpatient deaths, d/c to hospice, d/c with highest Risk of Mortality score (4) with or without palliative care consults. Payer mix with special focus on % with significant risk contracts. **What are the challenges and strategic initiatives for this hospital?** **What are its strengths?** **Who is the leadership champion for palliative care at this site?**	If there is an inpatient service: • Leadership history, reporting relationships & funding sources • Staffing (mix and FTEs) • New patient volume & total visits • Billed visits & net collections • Patient mix and referral sources Presence of staff with training in palliative care, even if not part of the team? Receptivity to training? To collaboration with other sites? ***TIP:*** *many health care professionals have received training at sites with palliative care programs in the past 20 years. Therefore, their knowledge of and interest in palliative care services may be high and engagement of their ideas about gaps and opportunities is wise.*
Community Footprint	**Palliative Care Footprint & Potential Partners**
Cancer Center: designations & referral patterns, annual patients served & mix by stage & diagnosis. Staffing – private practices, group practice, etc. Financial relationship with hospital or system? **Physician practices:** what is the culture and ownership/coordination between PCPs and system, key specialist groups and system, and hospitalists and intensivists? What is the inpatient or community presence of **geriatric practices**? Are there gaps that impact palliative care or are there strengths?	Presence of outpatient palliative care clinic and/or home-based services? By system team or through contract? History, volume (patients served per year, total visits, referral sources, etc.) Community and/or inpatient initiatives for communication/family engagement/ACP? Hospice and home health services: provided by a system entity or contract? **Strategic partners and joint initiatives and history?** Collaborative volunteer groups, local assets to help patients and families?

Staffing & Metrics Tools

Measurement Best Practices

Last Reviewed: June 22, 2020

Measurement tells the story of your palliative care service: what it does, whom it serves, and its impact on outcomes important to patients, families, leaders, decision makers, funders/payers, and other stakeholders.

This toolkit provides guidance on measurement so that your program can:

- Demonstrate value to stakeholders
- Align your services with national palliative care quality standards
- Manage your program operations
- Perform continuous quality improvement

What's in the Toolkit

How and What to Measure +

Using Data +

Hospital Palliative Care Impact Calculator

Palliative care increases patient and family satisfaction and improves quality of care.[1] Building high-impact palliative care programs requires matching resources and program investment with strategic priorities. The Hospital Palliative Care Impact Calculator can help you plan your inpatient consult service by providing an estimate of expected hospital savings attributable to your palliative care team.

Input Values

Total Annual Admissions or Discharges

# of Annual Palliative Care Initial Consults

Total Palliative Care Team FTE

CALCULATE

Go to: www.CAPC.org

capc Center to Advance Palliative Care