

Delaware Health Care Commission End-of-Life Workgroup

Workgroup Meeting
January 8, 2016



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Agenda

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Recap of Last Meeting

- A 'key themes' document has been developed to capture and group information shared at the initial meeting
- For feedback: what else needs to be included to ensure the delivery of a comprehensive report to the Health Care Commission?



State Innovation Model

Overarching Goals

- Improve health, health care quality and patient experience
- Be one of the five healthiest states
- Be among the top 10% of states in health care quality and patient experience
- Bring the growth of health care costs in line with GDP growth
- Improve the provider experience

State Innovation Model

Core Elements

- 1) Supporting local communities to enable healthier living and better access to primary care;
- 2) Transforming primary care so that every Delawarean has access to a primary care provider and better coordinated care
- 3) Facilitating a shift to payment models that reward high quality and better management of costs, with a common scorecard;
- 4) Enabling providers to access better information about performance and consumers to engage in their own health;
- 5) Providing resources to the current health care workforce and employing strategies to develop the future workforce

SIM Committees

Five committees operate under the SIM model, each with a specific focus relative to the goals of the initiative

Committee	Relevant Initiatives for EOL
Patient and Consumer	<ul style="list-style-type: none">• Improving health literacy and access to care• Launching a public website of health resources
Healthy Neighborhoods	<ul style="list-style-type: none">• Launch several 'Healthy Neighborhoods' to improve integration among community organizations and care delivery system
Workforce and Education	<ul style="list-style-type: none">• Undertake workforce capacity planning initiatives• Provide training and education to providers at all levels
Clinical	<ul style="list-style-type: none">• Provide practice transformation support across the state• Specific focus on care coordination and BH integration
Payment Model Monitoring	<ul style="list-style-type: none">• Tracking and monitoring outcomes-based payment models across all payers

Data Review

At the December meeting, the workgroup discussed gathering Delaware-specific information relative to our charge. The next several slides include information and discussion points re:

- Where people die (in DE and nationally)
- Findings from the recent Palliative Care Council Survey of hospitals
- Compendium of palliative care programs in Delaware
- Other data collection tools

Existing Data: DE Population Statistics

Death Location Data, Delaware and U.S.

Death Location*	2001	2006	2011	Pct. Change	U.S.**
Inpatient	40.27%	33.95%	29.29%	-27.27%	36.0%
ER-Outpatient	8.89%	7.87%	7.07%	-20.47%	7.0%
Dead On Arrival	0.63%	0.41%	0.31%	-50.79%	
Status Unknown	0.05%	0.35%	n/a	n/a	
Nursing Home	18.34%	20.97%	17.52%	-4.47%	21.7%
Residence	27.56%	27.95%	30.19%	9.54%	25.4%
Other	4.26%	8.48%	14.25%	234.5%	
Not Classifiable	0.00%	0.03%	1.38%	n/a	
All Other	n/a	n/a	n/a	n/a	9.9%

*Source: http://www.dhss.delaware.gov/dhss/dph/hp/bthsdths_pubdata.html

**Based on 2007 figures, the most recently available data.

Source: CDC Data, Place of Death, Over Time: United States, 2007.



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Palliative Care Council Survey

- Conducted in 2015 by the Delaware Healthcare Association's Palliative Care Council
- Surveys were distributed to all non-profit hospitals in Delaware; response rate was 100%
- Palliative care programs were defined as a structured hospital-based program that employs a multidisciplinary team that may include doctors, nurses and other specialists who work together with a patient's other healthcare providers to provide palliative care

PCC Survey Key Findings

- Five of six respondents reported having a palliative care (PC) program; one respondent had none
- None of the existing programs is Joint Commission certified. The biggest barriers to certification include:
 - Staffing challenges (specifically, the Joint Commission's 24/7 coverage requirement)
 - Lack of financial resources for certification
 - Newness of the program
- Two respondents have registered with the Center to Advance Palliative Care's National Registry

PCC Survey Key Findings

- Programs are most often led by a physician (60%) or APRN (40%) with support from RNs, clinical social workers/social workers, chaplains, dietitians, pharmacists and patient advocates
- 80% of hospitals with a PC program provide specialized training to staff and 80% provide training or information to others in the community
- Conversations re: palliative care are most often initiated at the request of the provider or patient and family
- *Referrals* for PC consultations are typically initiated by physicians or mid-level providers

PCC Survey Key Findings: Type of Services

Prevalence of specific PC services among respondents

Preparation of a comfort care plan	100%
Pastoral care and/or spiritual consultation	100%
Psychosocial support	100%
Caregiver/family support	100%
Symptom assessment and management	80%
Pain assessment and management	80%
Bridging to hospice care (referral, IP and/or home hospice)	80%
Discussion of advance directives	80%
Bridging to community resources and services	60%
Discussion of financial planning/referral to financial counselor	40%
Other	40%
Psychiatric and mental health assessment and management	20%

PCC Survey Key Findings

- While all hospitals with PC programs are tracking the number of patients encountered and disposition at discharge, less than half are currently measuring satisfaction with PC services
- All hospitals plan to increase palliative care components within the next 3 years, especially the number of staff, provider education offerings and funding or budget increases. One-third plan to offer an outpatient PC program within 3 years.



PCC Survey Key Findings

- **The most common challenge to offering PC reported by hospitals was a *lack of knowledge about PC programs among patients and family (83%)***
- Other significant challenges reported by a majority:
 - Limited budget for palliative care services
 - Lack of adequately trained PC staff
 - Lack of knowledge/understanding of PC services offered
- Two-thirds of respondents indicated that participation in a network of other PC professionals and best practice sharing would be most useful to their PC efforts

PCC Survey Key Findings

- The PCC identified several opportunities for potentially increasing access to PC services, briefly:
 - Enhancing outpatient PC infrastructure to generate early PC referrals
 - More robust training and education for physicians and other staff to increase support
 - A statewide awareness campaign targeted to the public
 - New reimbursement models such as bundled payments and medical homes could increase PC reimbursement
 - Information sharing/technical assistance among providers
 - Integration with nursing homes, assisted living, physician practices and home care

Data to be Collected

- The next several slides are focused on data *to be collected* by the workgroup relative to our charge
- Some of this information may be incorporated into the HCC report while others may be part of recommendations for ongoing activities related to palliative and EOL care
 - For the latter, the final report can address the type of detail appropriate for future data collection efforts



Compendium of DE Palliative Care Programs

- Goal is to compile detailed information about palliative care offerings in settings including non-hospital
- For each program, we wish to document:
 - Settings in which programs are offered (hospice, home, outpatient, other)
 - Nature of programs and service offerings
 - Target audience (patients, caregivers, other)
 - Data about numbers served/reach of programs (as available)
- Data collected will enable identification of gaps and potential opportunities for service offerings

Additional Data Sources: Consumer Survey

What other tools might we employ to capture information relative to our charge?

- To better gauge the knowledge, attitudes and behaviors of general public, a **consumer survey** may be effective
- Future development/ implementation of a survey could be a recommendation for inclusion in the final report



Additional Data Sources: Consumer Survey

- Potential questions for inclusion in a consumer survey might be:
 - What information do they have or need?
 - What shapes their perspective?
 - Who would they listen to or seek out for input?
 - What choices have they made and would they be willing to make similar choices in the future?
- The workgroup might also consider including a question related to palliative/advance care in future Behavioral Risk Factor (BRFS) or other surveys

Additional Data Sources: Listening Sessions

- Important to promote through various channels to ensure solid turnout of diverse stakeholders
- Goal is to solicit public input on this sensitive issue and identify key concerns and areas for exploration
- Anticipate 20-30 minute presentation followed by open discussion. All comments will be captured in writing.
- Preliminary locations have been identified with an eye toward accessibility: one in NCC, one in Kent, one each in eastern and western Sussex
- All info will be reviewed and incorporated into final report

Draft Outline of Final Report

- A high level annotated outline of the final report to be submitted to the Health Care Commission has been developed for workgroup review and feedback. During the review we wish to:
 - Identify subcomponents of each section
 - Identify any missing areas of focus
 - Develop a strategy for gathering the information necessary to populate each section



Recap of Proposed Timeline

Due Date	Task/Deliverable
January 4	Draft outline of final deliverable
February 5	Listening sessions throughout DE
February 19	Complete first draft of report
March 4	Public comment period (completion)
March 11	Review and incorporate public feedback into report; complete and circulate second draft to workgroup
March 21	Receive and incorporate workgroup feedback into report
March 28	Complete final draft of report
March 31	Submit final report to HCC

Other Updates

- Detailed information about listening session dates, times and locations will be distributed to the group once finalized
- Next workgroup meeting: **Friday, February 12 from 10-12 a.m.**
- Reminder: the dedicated e-mail address for the workgroup is endoflife@choosehealthde.com

Public Comment

