ACHIEVING EFFECTIVE PARTNERSHIPS BETWEEN THE HOSPITAL AND COMMUNITY-BASED HOSPICE SERVICES

Jane Hawgood, MSW
Palliative Care Social Worker, UCSF
Jane.Hawgood@ucsfmedctr.org

Steven Pantilat, MD, Director
Palliative Care Program, UCSF
stevep@medicine.ucsf.edu

Kitty Whitaker, RN, MS
Chief Operating Officer, Hospice by the Bay
kwhitaker@hbtb.org
LEARNING OBJECTIVES

- Better understand the experience for palliative care patients transitioning to hospice care
- Describe interventions utilized to better manage the hand-off from hospital-based palliative care to hospice care
- Describe the engagement and adaptation strategies each organization embraced to better serve patients and families
- Discuss effective team-focused communication that helped ease the transition of care for team members from both organizations
DISCLOSURE

Please know that the UCSF Palliative Care Service works with many Hospice Organizations in the San Francisco Bay Area and beyond.
OUTLINE

- Description of our organizations
- Alignment and opportunities
- Challenges we face
- Case studies
- Making the partnership happen
- How it works now
- Benefits of and adaptions to partnership
- Quality data opportunities
- Pearls
UCSF PALLIATIVE CARE SERVICE

- Founded in 1999
- Interdisciplinary Team Model
- 24/7 Availability
- 800 consults in a 400-bed hospital
- Outpatient Palliative Care Clinic
  - “Symptom Management Service” for patients with cancer
HOSPICE BY THE BAY

- Incorporated in 1975
- Second oldest hospice in the United States
- Geographic areas served
- Average Daily Census
- Average Length of Stay
- Patient Demographics
- Special Programs
- Hospital Relationships
HOSPITAL-HOSPICE PARTNERSHIPS: WHY PURSUE IT?

- Longstanding referral relationship
- Sentinel case(s): “We can do better”
- Recognition of different strengths/vulnerabilities
  - PCS knows patient/family well
  - PCS knows referring and primary providers
  - Hospice knows capabilities and challenges of care at home
  - Breakdowns on either side reflect on the other
  - Mutually beneficial to manage process well
HOSPITAL-HOSPICe PARTNERSHIPS: ALIGNMENT AND OPPORTUNITIES

- Focus on patient/family
- Same philosophy of (palliative) care
- Common values
- Share reputation: “joined at the hip”
- Ensure reality meets expectations
- Honoring each other’s strengths
HOSPITAL-HOSPICE PARTNERSHIPS: ALIGNMENT AND OPPORTUNITIES

- Identifying need for closer partnership and mutual interest
- Developing a committed relationship
  - Communication
  - In-person meetings
  - Listening to each other
  - Discovering common issues
  - Developing protocols and procedures
CHALLENGES TO THE HOSPICE REFERRAL

- Failed cases with opportunities to debrief and learn
- Highly complex cases both medically and socially
- Many last-minute changes to medication regimens
- Pressure to discharge
- Abrupt changes in status
- Short hospice LOS with high acuity
- Tubes, lines, meds, wounds, emotions
- Mismatch between patient/family expectations and reality
NATIONAL TRENDS IN HOSPICE UTILIZATION
2009 VS. 2000

❖ Increasing Use
  42% of Medicare beneficiaries use hospice vs. 22%

❖ Higher Acuity
  11% GIP Level of Care in the last month of life vs. 4%
  3% Continuous Care in the last month of life vs. 1%

❖ Shorter Length of Stay
  10% Hospice LOS < 3 day vs. 5%

Teno et al. JAMA 2013;309:470-77
Mr. C is a 49-year-old man with metastatic pancreatic cancer s/p multiple cycles of chemotherapy.

Admitted to Palliative Care with nausea, vomiting and pain.

Palliative Care Service consulted.

Diagnosed with bowel obstruction that persisted despite conservative therapy, peritoneal carcinomatosis, liver mets.

Surgery deemed not helpful and silicone NG tube placed.

Pain controlled with hydromorphone via PCA.
TYPICAL UCSF HOSPICE REFERRAL

- Mr. C wanted to go home to be with his wife and two children. Extensive network of family and friends will help provide care.
- Mr. C welcomes hospice referral.
- Oncologist tells family that patient can go home with IV fluids, but does not tell the Palliative Care Service or Hospice.
- One day after discharge, NG tube falls out, and patient and wife request IV fluids.
TYPICAL UCSF HOSPICE REFERRAL

- Hospice nurse did not have silicone NG tube, patient refused usual tube.

- Patient insisted on IVF and returned to ED and was readmitted.

- He died in the hospital six days later.
WHAT DID WE LEARN?

- Need to debrief
- Listen to our staff
- Focus on patients and families
- Open minds
HOSPICE REIMBURSEMENT REALITIES

- Per Patient Day Rate
- Sequestration impact
- Managing highly complex, high-cost patients
- Organizational commitment
- Opportunities to collaborate
- Accepting and managing care
- Bottom line of serving patients at end of life
**LET’S TALK ABOUT PATIENT CARE EXPENSES**

**Hospice by the Bay (All Pts)**
- Patients served in 2012 = 2,362
- Average Length of Stay = 65 days
- Median Length of Stay = 21 days

**Hospice by the Bay (UCSF Pts)**
- Patients served = 159 or 6% of total patients
- Average Length of Stay = 26 days
- Median Length of Stay = 12 days
PATIENT CARE EXPENSES

- On average, the cost of caring for a patient from UCSF Palliative Care is 32% higher compared to a non-UCSF patient.

- What accounts for the increased costs?
  - Time for Admission
  - Ambulance Charges
  - Infusion Costs
  - RN/Team visit frequency
  - Wound Care – special supplies
UNDERSTANDING THE BIG PICTURE

- Let’s not walk away
- Having the conversations about the cost of care
- Staying ahead of the curve
- Part of the partnership is understanding the trends
- Asking the questions together
- Looking to the future
- Being part of the solution
HOSPITAL-HOSPICE PARTNERSHIPS: HOW IT WORKS NOW

- “Transition Team”
- Intake coordinator
- Access to hospice medical directors and nurses
- Hospice representatives come to the hospital
- PCS sets clear expectations and communicates these to hospice
- PCS social worker manages transition
  - Medications, devices, treatments
- Importance of communication
PARTNERSHIP AND OPPORTUNITIES: ZEN HOSPICE PROJECT

- Inpatient 6-bed hospice unit
- Zen House provides beds and nurses, but is not a provider of hospice services
  - UCSF and Zen needed hospice partner
- Goal is rapid discharge of patients to Zen House
  - Many patients are too complex for home
- Zen House/UCSF and HBTB collaboration
BENEFITS TO UCSF

- Smoother transition
- Streamlined intake process
- Better access to hospice team including physicians
- Ability to review data and improve quality
- Opportunity for teaching clinicians about hospice
HOW WE HAVE ADAPTED AT UCSF

- Choose management approach that works
- Closer contact with referring and outpatient providers
- Inform hospice of psychosocial issues and treatments tried
- More active role with discharge medications
- Proactive discussions with patients/families about expectations
- Anticipate issues
  - Fluids, medications, interventions
HOW WE HAVE ADAPTED AT HBTB

- HBTB management support
- HBTB model supports in-hospital collaboration
- Hospice medical directors and nursing support more accessible
- Continuous care model provided to qualified patients
- Learning to be flexible
- Improved nursing clinical interventions/skills
- Anticipate what can go wrong
- Active communication with UCSF
BENEFITS TO HBTB

- Supports our mission
- Creates a collaborative relationship
- Reminds team what patients/families go through prior to discharge
- Helps nurses maintain their clinical skills
- Keeps HBTB in the forefront of developments in end-of-life care
BENEFITS TO PATIENTS AND FAMILIES

- Personalized care to support seamless transition
- Supportive team environment
- Expectations match reality
  - Fewer unmet expectations
- Anticipate and plan for contingencies
- Supports patient/family medical choices
- Anticipatory grief support
- Bereavement support
Ms. S is a 32-year-old woman with refractory AML admitted with nausea, vomiting. She was diagnosed with a bowel obstruction managed with medications and a venting gastrostomy.

She has pancytopenia and has been receiving frequent blood and platelet transfusions.

The hematologist started TPN.

Pain has been controlled with a morphine PCA.
POST COLLABORATION

- Ms. S has an extensive network of friends from around the world who are committed to help care for her.

- She wants to leave the hospital with hospice services and go to a friend’s beach house.

- The palliative care team discussed TPN and transfusions with the hematologist and the patient. Decision made to stop TPN and transfusions but continue IVF for five days until friends arrive from out of town.
POST COLLABORATION

- Pain controlled with morphine via CADD pump. PCS team sent patient home with extra needles for accessing port (systems compatibility).
- Patient also sent home with silicone NG tube in case gastrostomy malfunctions.
- Beach house was a one-hour drive from hospice office over windy road.
- Hospice provided continuous care for the first three days to manage pain and stabilize patient at home.
POST COLLABORATION

- Pain managed by hospice team resulting in significant increase in basal rate and bolus doses of morphine insuring patient comfort.
- Venting gastrostomy clogged and hospice nurse placed silicone NG tube.
- Ms. S’s pain was well controlled on higher morphine dose and nausea resolved with NG tube.
- Ms. S died seven days after discharge surrounded by friends at the beach house.
DATA COLLECTION OPPORTUNITIES

- HBTB participating in UCSF Palliative Care to hospice study
- HBTB tracking of UCSF Palliative Care patients through FEHC
- Opportunity to sit on *UCSF Palliative Care for Seriously Ill Workgroup* with goal of participating in the future evolution of the palliative care continuum
PEARLS

- Don’t wait for a “sentinel event”
- Work from shared mission and values
- Remain patient focused
- Strive to understand the other perspective
- Maintain good and open communication
- Find the win-win
- Develop a transition team
- Anticipate what can go wrong