

# End-of-Life Priority Strategic Plan: Status & Implementation

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# The MCC End-of-Life Priority:

By 2010,  
prevent and reduce avoidable suffering  
up to and during the last phase of life  
for persons with cancer,  
as measured by specified data markers.

# Topics for Today

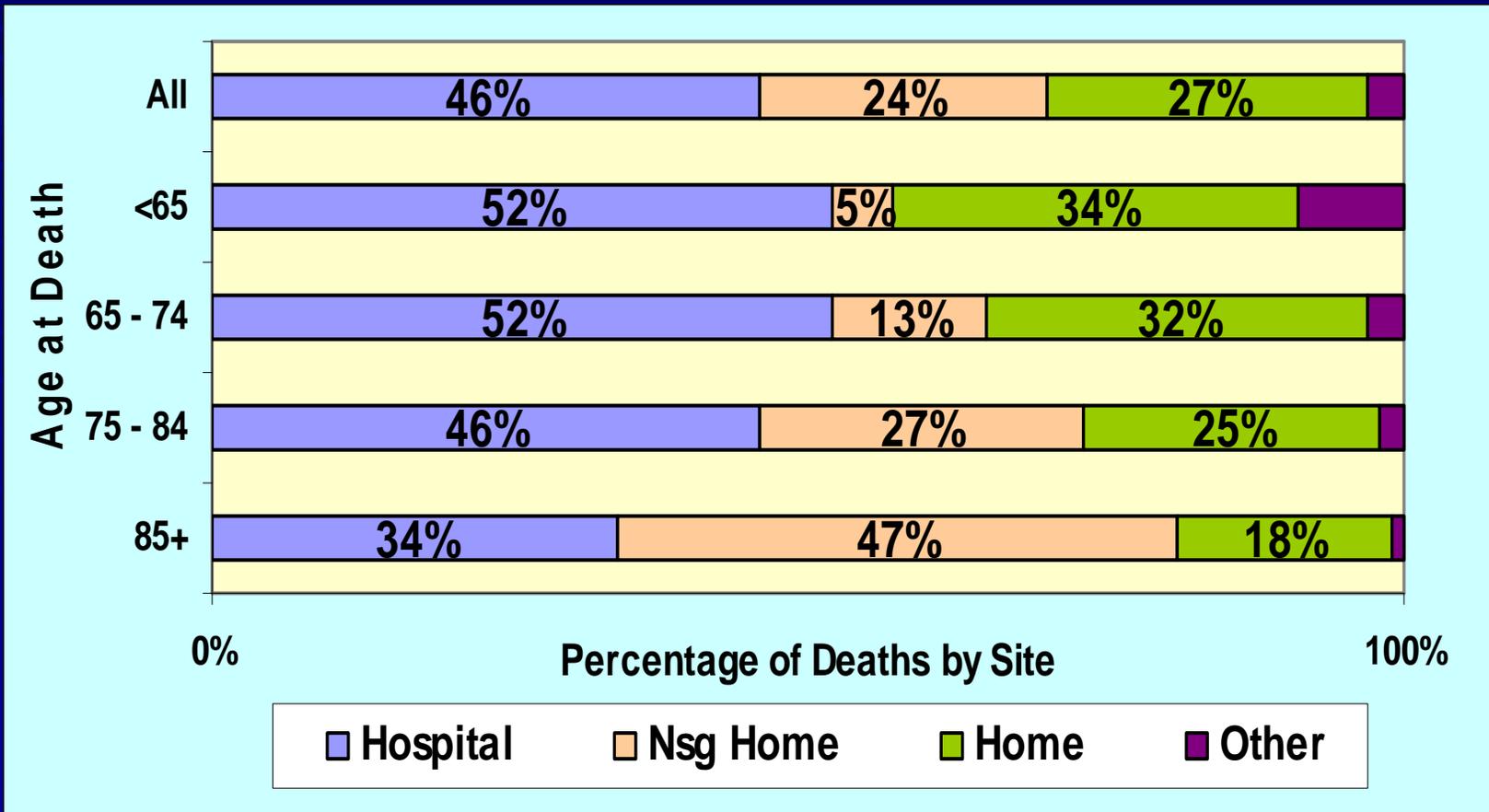
- Quick review of data that drove the strategic plan for the EOL priority
- Tap your expertise to facilitate implementation of the plan
- Summarize findings from 2006 census of hospital-based palliative care teams (handout)

The critical data that drove  
the EOL priority strategic plan...

# Data Sources / Project Sponsors

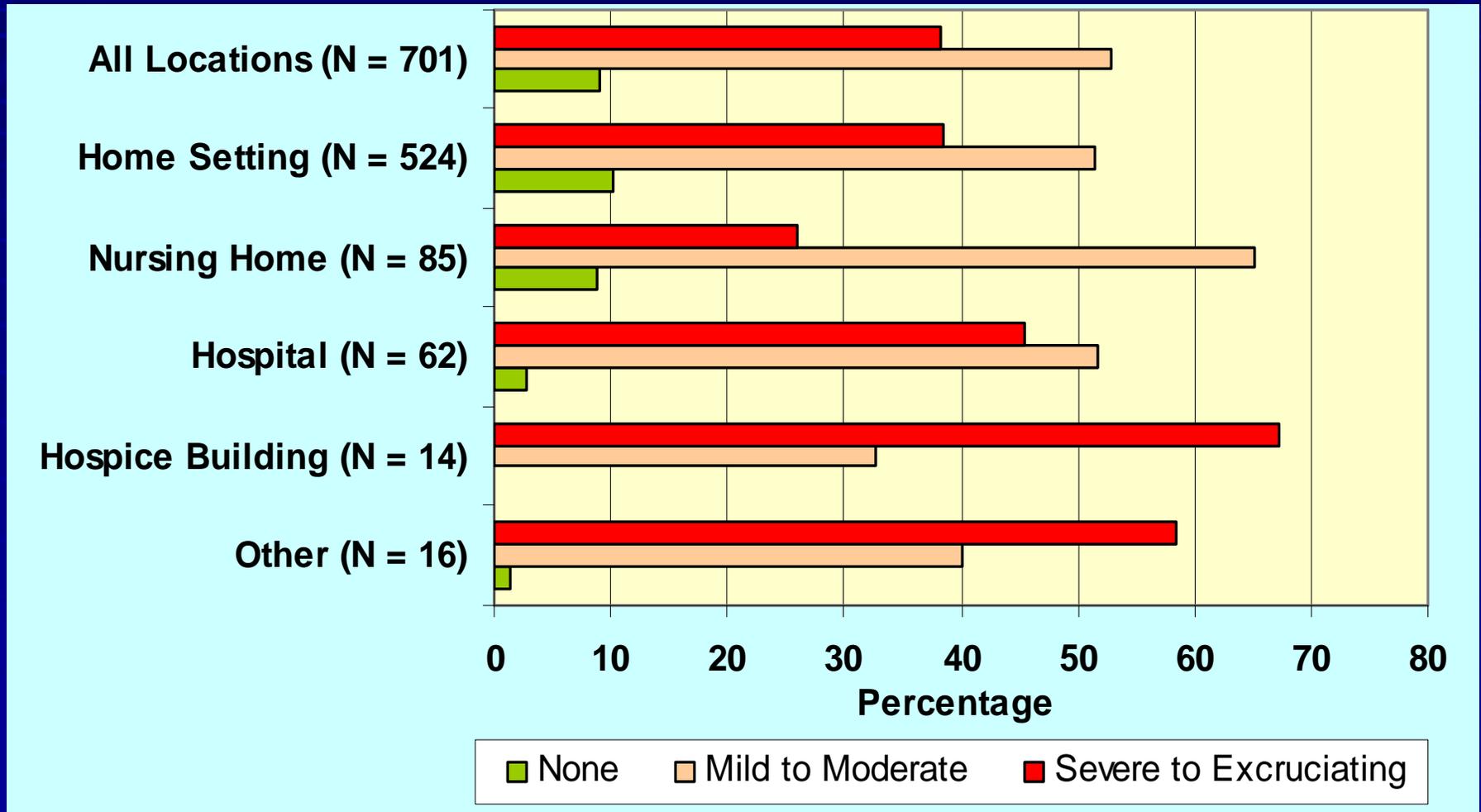
- 2004 EOL Needs Assessment  
Michigan Dept of Community Health
- 2004 Special Cancer Behavioral Risk Factor Survey, EOL Module  
Michigan Public Health Institute  
Michigan Hospice & Palliative Care Org
- 2006 Census of Hospital-Based Palliative Care Programs  
Michigan Cancer Consortium

# Place of Death by Age, Michigan 2002



Michigan Resident Death File, 2002

# Distribution of Decedents, **Any Terminal Illness**, by Site & Avg Pain Level for Final 3 Months, MI 2004 BRFSS



# Back of the envelope...

87,500

Average annual count of  
deaths in Michigan

61,250

70% die of chronic disease

23,275

38% live their final 3 months  
with average pain level at  
severe to excruciating, as  
reported by caregivers





# M I C H I G A N

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The Big House at Ann Arbor

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# Most suffering is avoidable...

## Science:

*The person in pain today does not have to wait for a better drug to be developed ~ he just needs someone to prescribe correctly what we already know.”*

(Joanne Lynn, MD, 2000)

## Stories:

- Goldie ~ Detroit metro
- Henry ~ northern MI
- Jack ~ mid Michigan
- Why not before?
- Why doesn't anyone else know what you know?
- How could you do this so quickly?

# So why is suffering widespread?

There are myriad upstream causes.

The one reported by 90% of hospice mgrs:

The pain protocol doesn't fit the type or intensity of pain...wrong drug, dose, frequency.

Underlying reason, cited by 70% of hospice mgrs:

Lack of clinician knowledge of opioid drugs, dosing, atypical pain. Can't do what they don't know.

End of Life in Michigan, Needs Assessment Report, 2005

# Other critical issues:

- Undertreatment of pain has not been embraced as an urgent problem in Michigan.
- Hospitals are slow to embrace palliative care as a clinical and business priority.
- Nursing homes struggle with pain mgt and hospice is not often used.
- Consumers expect to suffer...don't know that pain is optional at the end of life.

## What to do? End-of-life strategic objectives:

1. Establish indicators and data sources to monitor EOL burden & progress.
2. Promote system change to increase access to palliative services.
3. Increase the supply of health professionals trained in palliative techniques.
4. Increase cancer patients' and caregivers' understanding of options for care...and pain and symptom relief.

# Your expert input requested...

- **Purpose:**
  - Improve odds for action and success
- **Your role today:**
  - Focus group of expert consultants
  - Represent member organization categories
  - Look at three high impact strategies
  - Talk about barriers, motivators, etc

## Problem

- High prevalence of severe pain at EOL. Ineffective pain protocols because clinicians lack knowledge.

## Strategies (realistic, measurable, high impact)

- Increase access to palliative care consultations in health care settings across the continuum of care.
- Encourage oncology practices to participate in ASCO's QOPI project.
- Increase the number of professionals trained in pain & symptom management.

## Strategy #1

- Establish consulting relationships with palliative care clinicians for health care settings across the continuum
  - Settings: Hospital depts ~ ICU, ED, etc; cancer center; oncology practice; primary care practice; home health agency; long term care facilities. Consultants from hospice or PC team.

## Progress

- 2006 Palliative Care Census: 22 active hospital-based PC teams (handout)
- Promising ED & ICU programs

Questions Reasonable starting point? Who initiates?  
Barriers to action?  
Factors that motivate action?  
Role for the MCC Board?

## Strategy #2

- Encourage oncology practices to participate in the ASCO Quality Oncology Practice Improvement (QOPI) project (tracks pain assessment and hospice referrals).

## Progress

- 10 of 100 practices registered.

Questions Buy the need for and value of QI?  
Why would a practice *not* do this?  
What factors would motivate action?  
Could a health plan offer an incentive?  
Role for the MCC Board?

## Strategy #3:

- Increase the number of professionals trained using the EPEC-O curriculum (Education in Palliative & EOL Care for Oncology).

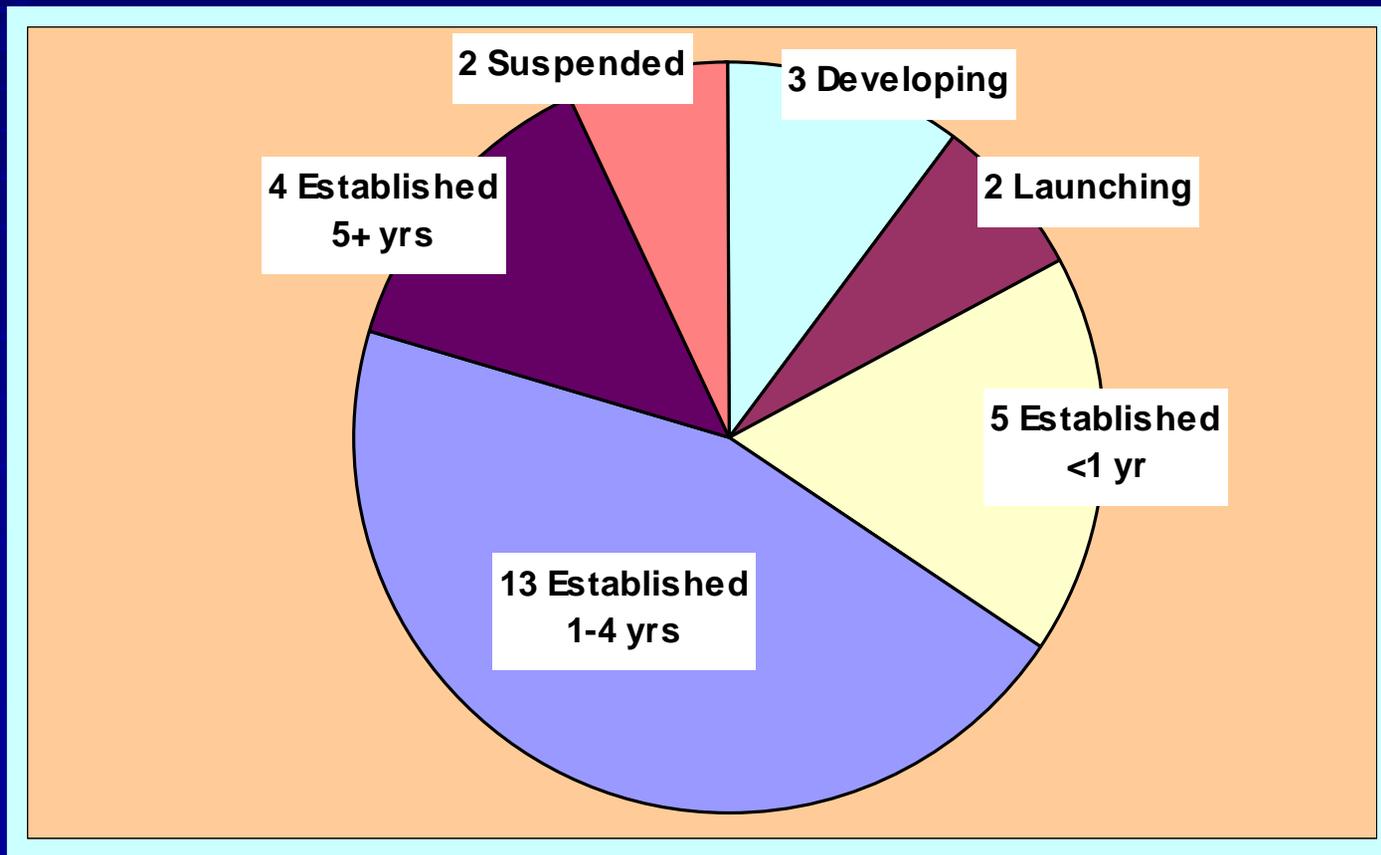
## Progress

- Joint EPEC/ELNEC training by CAPEWAYNE, Fall '06
- Dental & nursing boards require 1 CME for license renewal; physician boards 0

Questions      Buy the strategy? If not EPEC-O, what else?  
Could/would a health system *require* training  
in pain mgt for appropriate providers?  
Role for trade/professional orgs?  
Role for MCC Board?

# Palliative Care Census, 2006

Online survey of 31 known programs. Status:



# PC Recipient Profile 7/05 – 6/06

(rough estimates for 22 teams)

~ 7,400 Total patients served

~70% Met clinical criteria for hospice

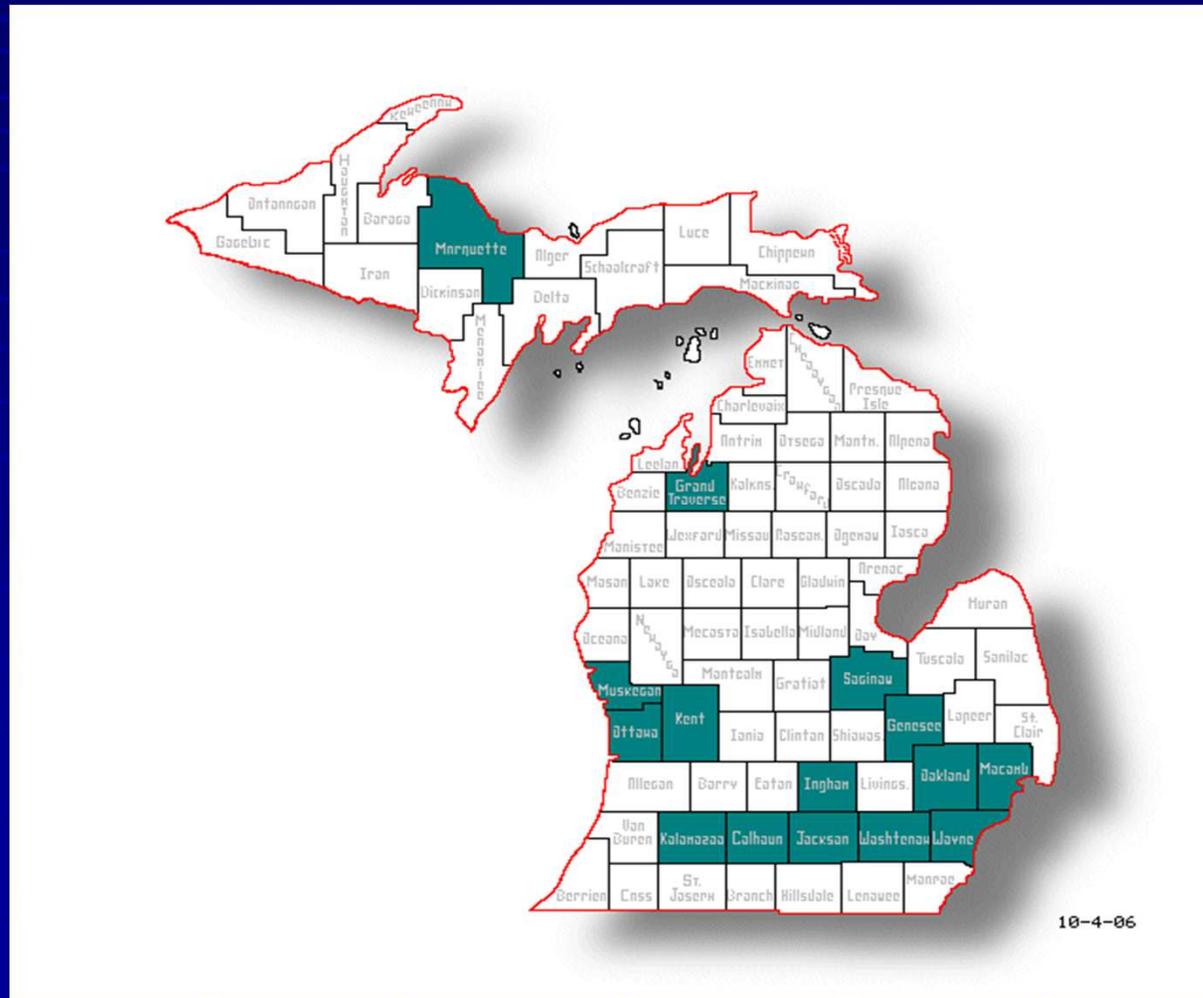
~33% Had cancer as primary dx

~31% Of inpatient decedents  
received PC services

# Palliative Care Census, 2006

- Service model = consult team
  - Well-qualified Dr & RN / APN
- Top consult reasons:
  - Treatment goals, decision-making
  - Pain/sx management
- Outcomes: Culture change
  - Reduced pain, fewer emergency ethics consults
  - Reduced expenses, increased hospice referrals

# Location of Hospital-Based PC Teams



## Michigan 2006 Palliative Care Census: Executive Brief

- Purpose** The purpose of this project was to assess the availability and scope of palliative care (PC) services in Michigan hospitals. This project supports the MCC End-of-Life Strategic Plan, specifically the objective to increase access to palliative services throughout Michigan.
- Methodology** Inpatient palliative care teams were identified via input from a number of sources, primarily hospice contacts and palliative care practitioners. A tool to assess program structure and activities was constructed using the core elements defined in 2004 by the National Consensus Project for Quality Palliative Care. The survey link was emailed in September, 2006, to all 31 known inpatient PC programs. With email and phone reminders, 29 responded by October 31. The two nonresponders are established programs and are expected to respond with further follow-up. The data for two of the survey questions were corrupted because of a problem with the survey software and therefore not analyzed. These questions will be redistributed in the future.
- Findings** The 24 functioning hospital-based PC programs are located in 15 counties, all but one of them in the Lower Peninsula. Only 4 of the counties have palliative teams in more than one hospital.
- Of the 29 responding programs, 22 (76%) are actively treating patients. The rest are developing (3), launching (2), or suspended (2). The top reasons for referral to PC services are 1) assistance with difficult conversations and decision-making and 2) management of pain and other difficult symptoms.
- Disciplines on the core team are most often a physician and nurse (36%) or a physician, nurse, and social worker or chaplain or both (56%).
- The physicians and nurses have appropriate credentials: 17 (77%) teams are led by a doctor board-certified in hospice and palliative medicine, often in combination with an advanced-practice nurse. Five of the nurses are board certified in PC management. Four teams (18%) are led by physicians and nurses with PC training via EPEC or ELNEC.
- Core PC team members communicate about patients daily in the course of treatment but conduct formal team meetings two or more times weekly (35%), once weekly (45%), or less than once weekly (20%).
- The responding programs rated their data collection efforts as beginning (32%), intermediate (45%), or advanced (23%). The top barriers to data collection are lack of tools, time, and manpower.

Almost all of the respondents rated the impact of the PC program on hospital culture as medium (59%) or high (32%). Changes they have observed include improved pain control and quality of care for seriously ill patients, improved decision-making with fewer emergency ethics consults, increased hospice referrals, and reduced inpatient expenses.

Primary challenges include physician buy-in (31%), cultivating referrals (27%), financial support (27%), and finding qualified physicians and other staff members (27%).

Of the 29 respondents, 21 (72%) indicated high interest in networking with other PC programs in the state. Emails (90%) and regional meetings (69%) gained the most votes as preferred means of connecting. Favored networking activities include exchanging successful practices (90%) and problem-solving strategies (69%), tracking common evaluation indicators (90%), and identifying training needs and resources (62%).

#### Conclusions and Recommendations

Hospital-based palliative care programs are located in the areas of the state where most deaths occur, but underserved areas remain (see map). For regional medical centers and other large hospitals, the inpatient palliative care team is a workable model of service delivery. Different approaches may be more realistic for rural areas and smaller hospitals, given the scarcity of professionals with PC credentials in those areas. It would be useful to search for models in other states.

There is great need to nurture and preserve functioning PC teams and to mentor developing programs to expand access to pain and symptom relief statewide. Given the high interest in a PC network, a credible organization or partnership should act promptly to address this need.

Many respondents expressed interest in tracking common palliative care indicators. Given that most programs lack staff and expertise to develop data collection tools, expert assistance is vital. Developing such a tool should be a joint effort involving PC practitioners as well as data and evaluation experts. The process should include reviewing and where possible using or adapting already-developed resources, as from the Center to Advance Palliative Care (CAPC). Pooled statewide data is expected to be useful for tracking access to and impact of palliative services and also for making a case for palliative care with hospital administrators in underserved areas.

Given the excellent response to this survey and the high interest in networking, it is essential to maintain regular contact with the palliative care teams. This should begin as soon as possible with distribution of a map and roster of existing programs and a summary of findings.



## Palliative Care Teams in Michigan Hospitals

Facility	No. Beds	Status	County
VA Medical Center* Battle Creek		Established for ?? years	Calhoun
Genesys Regional Medical Center Grand Blanc	410	Launched in the past 12 months	Genesee
Munson Medical Center Traverse City	330	Established 1-4 years	Grand Traverse
Ingham Regional Medical Center Lansing	350	Launched in the past 12 months	Ingham
Sparrow Hospital Lansing	500+	Established 1-4 years	Ingham
W A Foote Memorial Hospital Jackson	319	Established 1-4 years	Jackson
Borgess Hospital* Kalamazoo		Established for ?? yrs	Kalamazoo
Saint Mary's Health Care Grand Rapids	325	Established 1-4 years	Kent
St John Macomb Hospital Warren	348	Established 1-4 years	Macomb
Marquette General Hospital Marquette	300	Launched in the past 12 months	Marquette
Mercy General Health Partners Muskegon	177	Established 1-4 years	Muskegon
Providence Hospital Southfield	428	Established 1-4 years	Oakland
St Joseph Mercy Oakland Pontiac	300	Established 5+ years	Oakland
William Beaumont Hospital Royal Oak	990	Established 1-4 years	Oakland
Holland Community Hospital Holland	205	Launched in Sep 2006	Ottawa
Aleda E Lutz VA Medical Center Saginaw	114	Established 1-4 years	Saginaw
St Joseph Mercy Hospital Ann Arbor	520	Established 1-4 years	Washtenaw
University of Michigan Health System Ann Arbor	729	Launched in the past 12 months (adult & pediatric teams)	Washtenaw
VA Ann Arbor Healthcare System Ann Arbor	114	Established 5+ yrs	Washtenaw

Facility	No. Beds	Status	County
Detroit Receiving Hospital Detroit	200+	Established 5+ years	Wayne
Henry Ford Hospital Detroit	903	Established 5+ years	Wayne
John D Dingell VA Medical Center Detroit	200+	Established 1-4 years	Wayne
St John Detroit Riverview Detroit	250	Established 1-4 years	Wayne
St John Hospital & Medical Center Detroit	600+	Established 1-4 years	Wayne
<b>Programs Under Development</b>			
Oakwood Hospital & Medical Center Dearborn	632	Preparing to launch within 3 months	Wayne
William Beaumont Hospital Troy	250	Program under development	Oakland
Bon Secours Cottage Hospital Grosse Pointe	245	Program under development	Wayne
Children's Hospital of Michigan Detroit	238	Program under development	Wayne
Karmanos Cancer Center Detroit	---	Program under development	Wayne
<b>Programs on Hiatus</b>			
Hurley Hospital* Flint		Program on hiatus	Genesee
Bronson Methodist Hospital* Kalamazoo		Program on hiatus	Kalamazoo
St John Oakland Hospital Madison Heights		Program on hiatus	Oakland
St John River District St Clair	68	Program on hiatus	St Clair

This roster has been compiled from a variety of sources since 2004. All of the listed facilities were contacted in September for an online census of hospital-based palliative care services in Michigan. These data are drawn from survey input received on or before October 31, 2006. Contacts from the starred (\*) facilities had not yet responded by that date. The census has been a collaborative project of the Michigan Dept of Community Health, the Michigan Hospice & Palliative Care Organization, and the Michigan Public Health Institute. It is endorsed by the Michigan Cancer Consortium.