2024 VIZIENT CONNECTIONS SUMMIT

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Impacting Readmissions Through Palliative Care

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Learning Objectives

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- Discuss the impact of palliative care interventions on readmissions
- Explain the benefits of advance care planning program implementation.

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Advance Care Planning

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- ACP is a process that supports adults in sharing their values, goals, and preferences regarding future medical care.

- The goal of ACP is to help ensure that people receive medical care that is consistent with their preferences.

Sudore RL, et al. J Pain Symptom Manage, 2017
Sokol-Hessner L, et al. IHI White Paper , 2019

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ACP Workflow

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Screening on admission

Admitted at Medical RNF
- PRI ≥ 0.7
- RRS > 0.4
- >65 y/o and code status: History/needs assessment
- Pal Med not involved

Referrals:
Surgical, Geri/psych, ED

- Legal surrogate documentation (AD)
- Explores wishes/values/worries
- TCP conversation with surrogate/s & doctor/s
- Addresses code status if: "History/needs assessment" or patient ≥65 and frailty CFS≥5
- Identifies who may benefit from Pal Med, or hospice (based on clinical, PPS, or Frailty)
- ACP note and billing (99497)

Abbreviations: ACP=Advance Care Planning; PRI=Patient Review Instrument, RRS=Rapid Response System, ED=Emergency Department, AD=Advanced Directive, TCP=Transition Care Planning, CFS=Clinical Frailty Scale, PPS=Palliative Performance Scale

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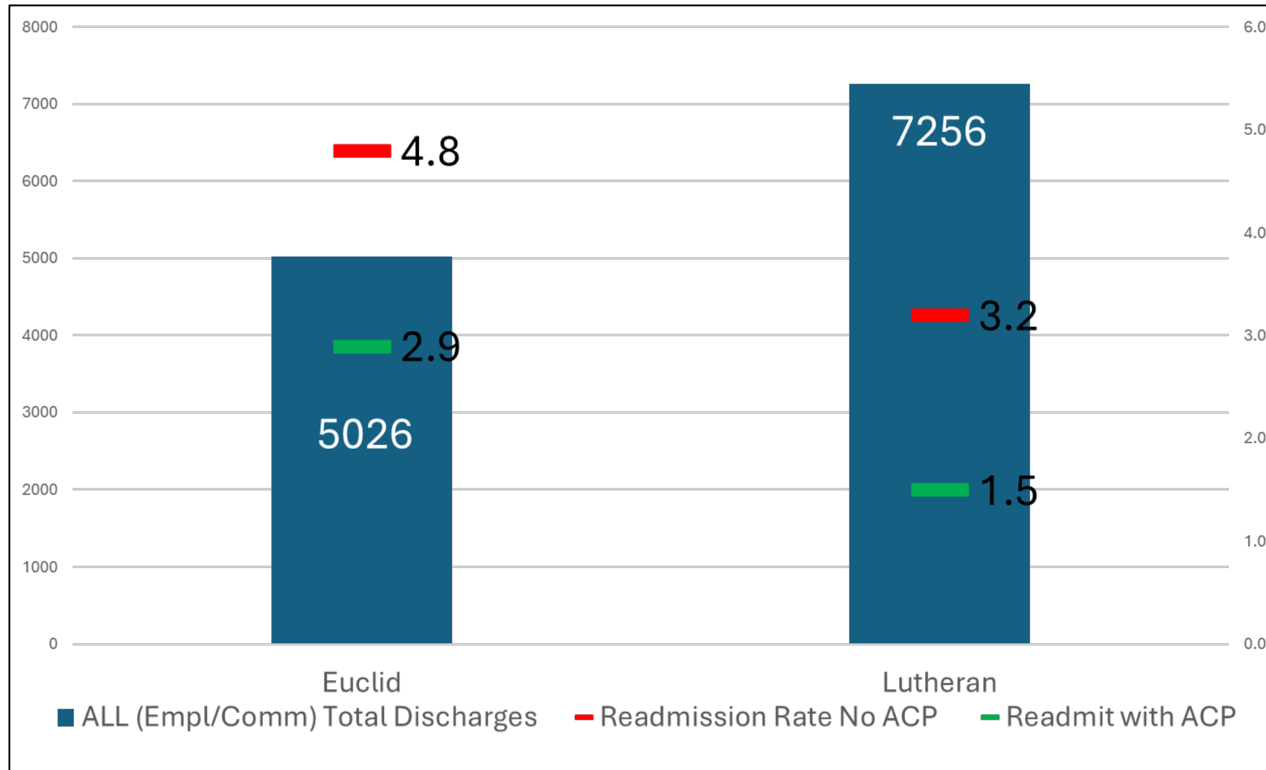
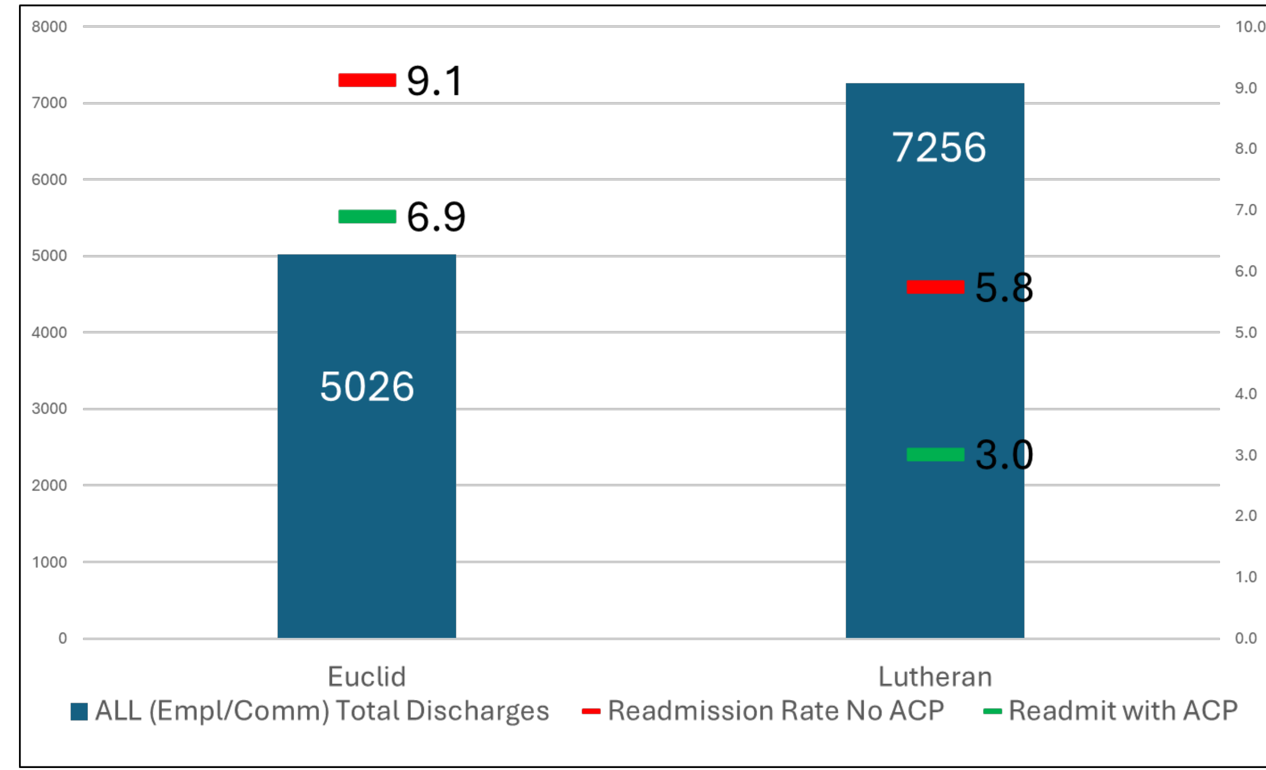
ACP Readmission Rate

ACP 7 – Day Readmission Rate



ACP 30 – Day Readmission Rate



Date range: 2023
Data source: Cleveland Clinic

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Background and Randomized Controlled Trial

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- Hospital Readmission Reduction Program[1] & Value-Based Purchasing[2]
- ↑ Hospital Readmissions: Top 3 Diagnoses:
  - Heart Failure (HF), Chronic Obstructive Pulmonary Disease (COPD), & Sepsis
- Literature Review[3,4,5,6,7,8,9,10,11,12,13,14]
- Research Question
- Methods
- Results
  - Frequencies
  - Readmissions

See reference slide for citations

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Research Question and Methods

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Do Palliative Care consults and post-discharge phone calls from the palliative care nurse impact future 30-day hospital readmission rates for patients with Heart Failure, Chronic Obstructive Pulmonary Disease, and Sepsis and prior 30-day hospital readmission rates?

- Randomized Controlled Trial
- A priori 95% (n=138)
- Phone Calls 7-10 & 17-20 days
- Inclusion Criteria:
  - ≥ 18 years of age
  - Acute & Intensive Care Units
  - HF, COPD, Sepsis – AND – 30-day readmission
  - DC to Home (with or without home health or hospice)

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Results

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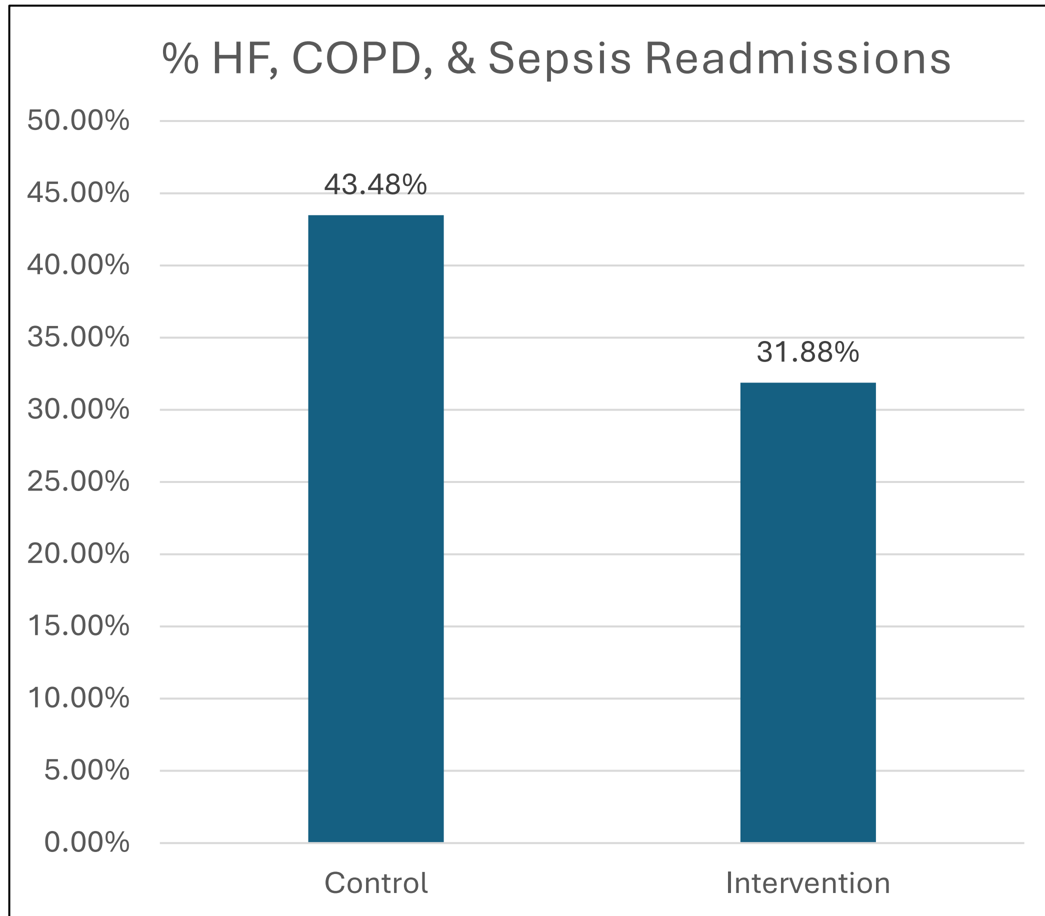

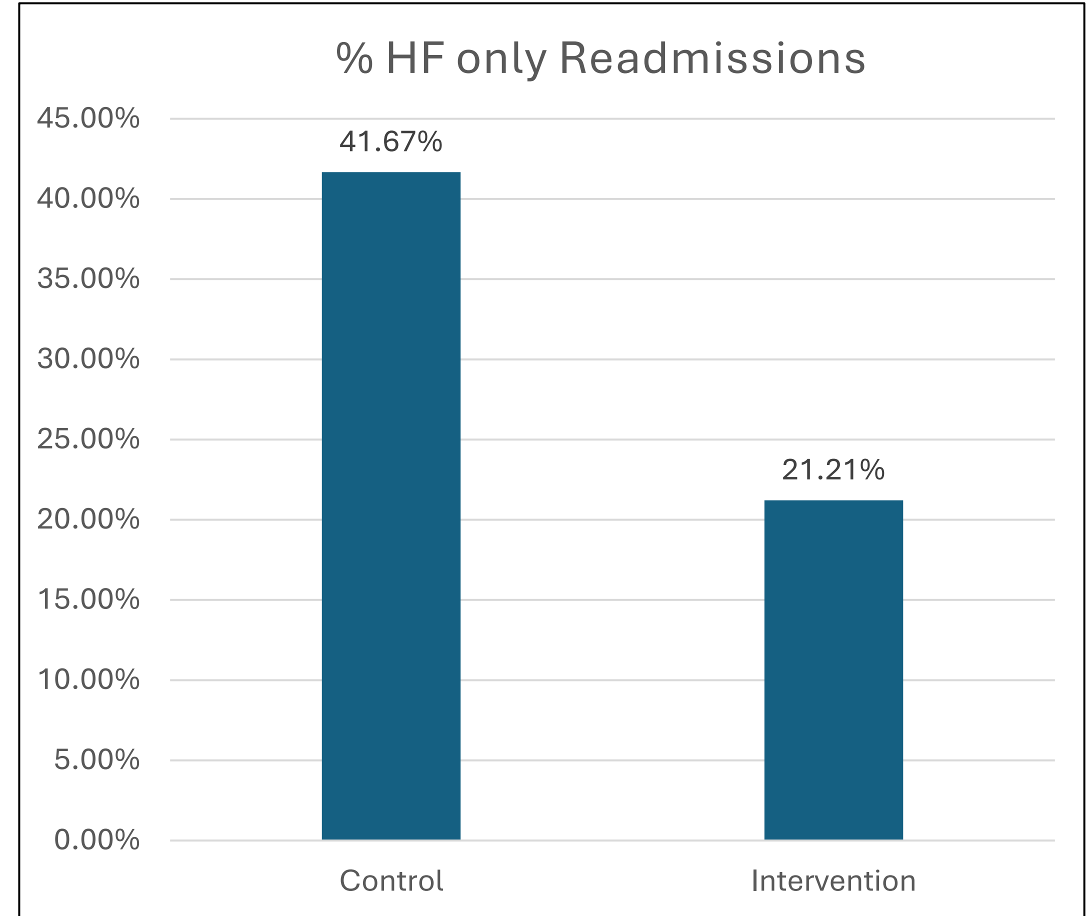

p = 0.0800

p = 0.0343

Two-Sample Test of Proportions
Data Source: Houston Methodist

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Lessons Learned

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- Create a relationship with hospital leaders
- Partner with other services performing ACP documentation
- Risk stratification by scoring will give an incomplete picture of patients
- Screening for eligibility
- Phone Calls
  - Timing
  - Designated RN
  - Calendar notifications
- Phone Call Scripts
- Data Management & Statistician
- The Research process

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Key Takeaways

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- A program to increase ACP documentation in the hospital can positively impact readmission rates.
- Other positive impacts:
  - Increased documentation of advance directives
  - Increased documentation of patient’s surrogate decision maker
  - Decreased rate of patients with “History Needs Assessment” code status
- Experienced APPs are a great fit for navigating ACP discussions.
- Nurses CAN conduct Research
- Take PRIDE in Randomized Controlled Trial
- Repeat the Study
  - Multi-site, larger & more diverse population
- Engage the statistician from the beginning
- Nurse-driven Palliative Care team
  - at a community hospital
  - using post-discharge phone calls
  - DID impact 30-day readmissions!

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Questions?

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