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From Prognosis to Purpose: Tools for Better End-of-Life Care

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Learning Objectives

- Identify gaps in end-of-life care that can be addressed through dignity-focused measures.
- Describe how to use prognostic indicators to guide early intervention and referral to palliative services or hospice.

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Honoring Life Through the Human Dignity Index: A Holistic Approach to End-of-Life Care

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Transforming Healthcare: Our Opportunity

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Gap in Supportive Care	Beyond Survival Metrics	Redefining Quality Care	Reimagining Success
60-70% of Patients with life-limiting and terminal conditions do not receive timely, appropriate supportive care	Traditional metrics focus heavily on survival and treatment outcomes, often failing to capture what truly matters to patients in their final chapters	Comfort and dignity can be the most meaningful and impactful care we provide to patients near the end of life.	Success is not just measured by how many days we extend life, but by how well we support each day that remains.

Reference: Finestone AJ, Inderwies G. Death and dying in the US: the barriers to the benefits of palliative and hospice care. Clin Interv Aging. 2008;3(3):595-599 https://doi.org/10.2147/CIA.S2811

Transforming Healthcare: Our Solution

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INTRODUCING THE

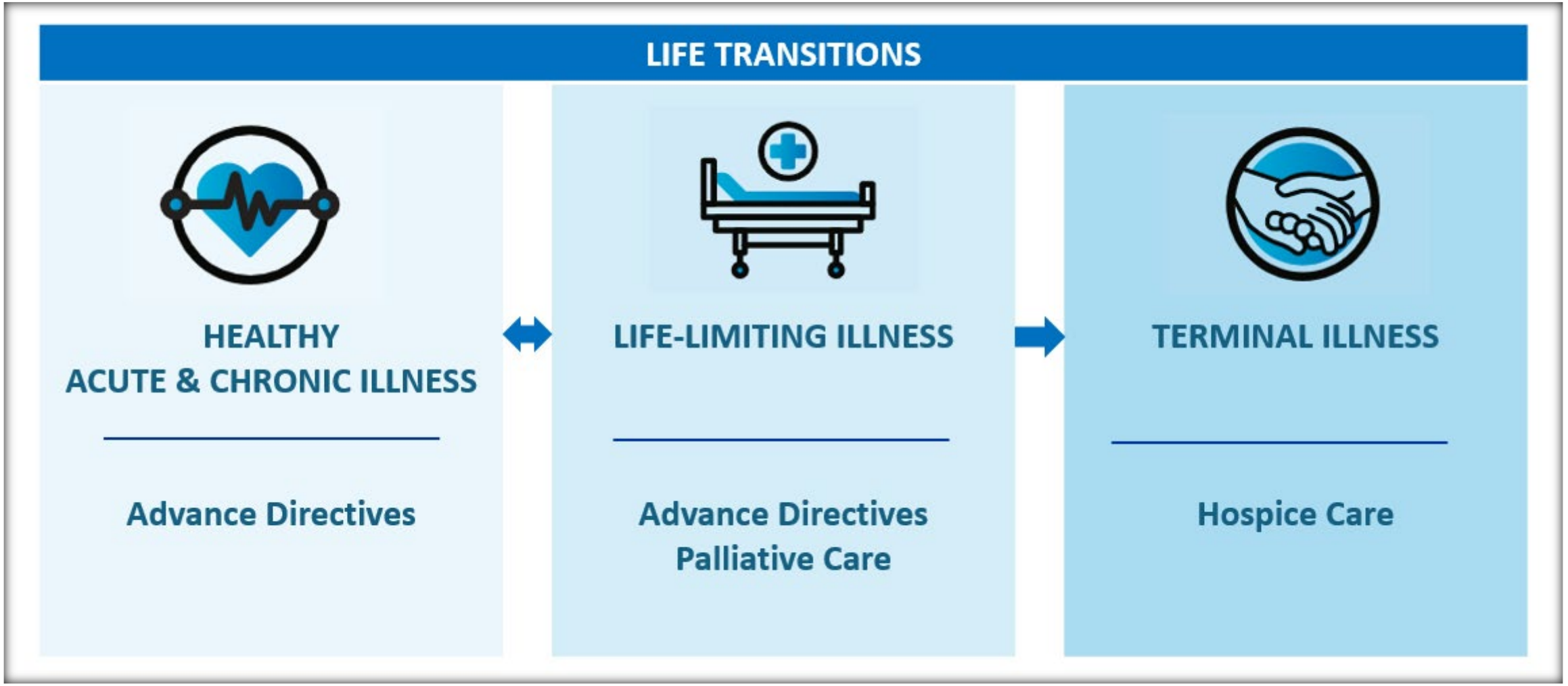
HUMAN DIGNITY INDEX

- END OF LIFE

A system metric that evaluates how effectively we partner with our community to provide high-value, compassionate and dignified care for patients facing life-limiting and terminal conditions.

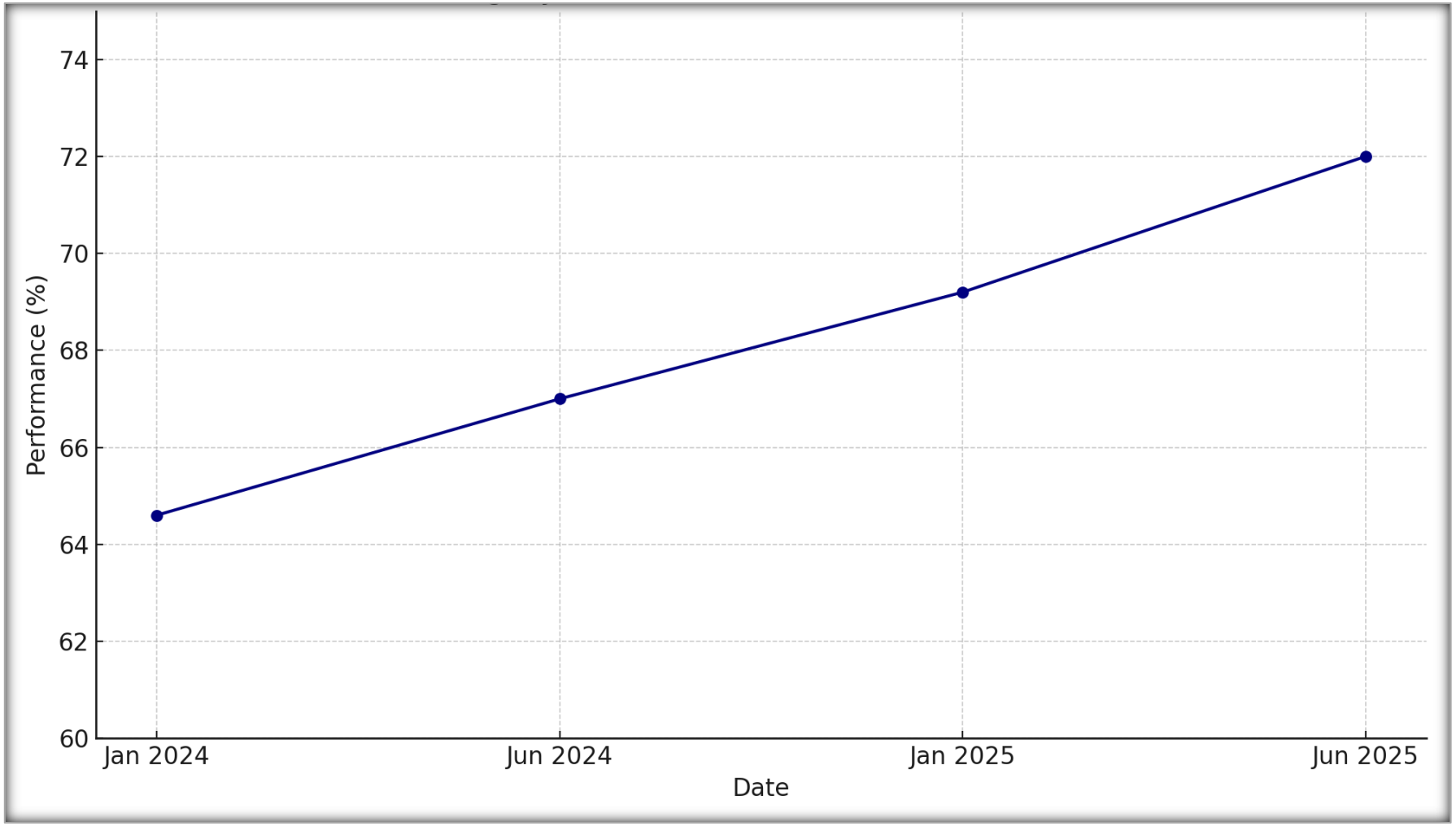
A reflection of our commitment to honoring each person's final chapter with purpose, comfort and respect.

Phases of Life and Care Needs



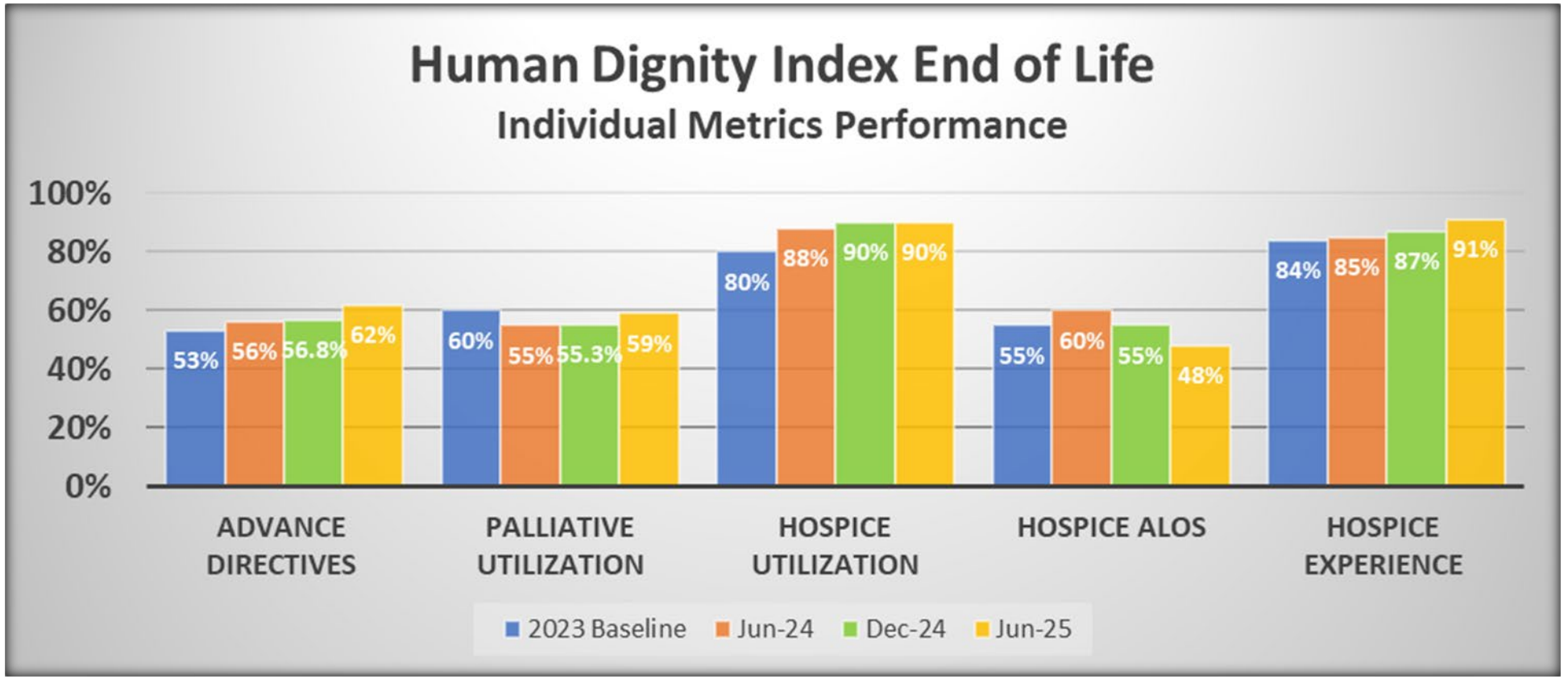
Human Dignity Index – End of Life: **5 Levers**

Human Dignity Index – End of Life: Performance over time



Froedtert ThedaCare Health North Region Human Dignity Index – End of Life Data Performance from Jan 2024 to June 2025

Human Dignity Index – End of Life: Metric Performance



Froedtert ThedaCare Health North Region Human Dignity Index – End of Life Data Performance from Jan 2024 to June 2025

Future Work

❖ Now	Near	Future
• Advance Directives completed for 65 year old and above	❖ 2024 KPI's and… • Expand Advance Directives • Completion of Goals of Care Conversation in the ambulatory setting	❖ 2024/2025 KPI's and… • Expand Advance Care Planning to ages 18 and older
• Palliative Support (completion of referral)	• Expand Palliative Support for patient with serious and life-limiting condition	• Enhance Psychological support services for anxiety, depression, etc.
• Hospice Support for patients at the time of death in the hospital • Hospice Average Length Of Stay • Hospice Experience for patients and their family (CAHPS Satisfaction survey)	• Honoring Patient Preferred location of death • Hospice Experience survey during service	• Honoring Patient Preferred space of death • Expand Hospice support for patients who pass away outside of our system

Lessons Learned
Insights From Our Journey

Vision Casting & Connecting to Purpose

Collaborative Engagement

Progress Over Perfection

Humanize the Data

Key Takeaways
What You Can Start Doing Now

Define Foundational Metrics

Equip Clinicians with Compassionate Communication Skills

Integrate the Index into Enterprise Analytics

Elevate the Conversation at All Levels

Prioritize Action Over Perfection

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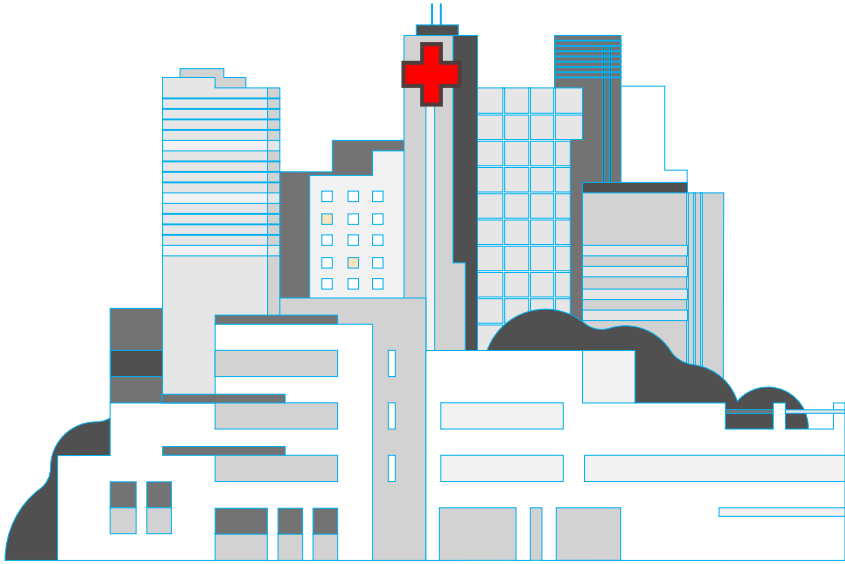
A Novel Prognostic Tool for Early Identification at End-of-Life to Reduce Mortality Index

Background

- **NewYork-Presbyterian** (NYP) Quality & Patient Safety created an enterprise-wide **Mortality Index Workgroup** **in 2022** to reduce observed mortalities (increase hospice discharges)

- **Goal to identify patients at end-of-life** (EOL) for earlier goals of care (GOC) conversations and timely referral for palliative care (PC) consultation and/or hospice

- **Ideally**, align treatment goals with patient/family preferences **within 72 hours of admission**



Project Overview

- **Mandatory Surprise Question (MSQ)** added to admission order set: ***Would you be surprised if the patient died in the next 12 months?***
- **MSQ** found to have ***prognostic limitations*** (i.e., level of training, experience)
- An **initial EMR-generated report** for patients flagged as “Not Surprised” was **too long to be useful**
- **<u>As a result,</u>** a new EMR screening tool was created to improve prognostic accuracy and produce a ***succinct, actionable report.*** This supports timely outreach by PC and Case Management (CM) teams.

Understanding the Problem

- **Prognostication**, especially EOL, often difficult for primary providers
- **CMS disease-specific hospice criteria** complex, unfamiliar, or difficult to recall
- **Medical conditions associated with poor functional status** as supporting evidence for hospice often not recognized
- **GOC conversations** less likely to occur, or more difficult, without a prognostic framework
- **Lack of experience and/or training** in conversations around serious illness, particularly an offer of hospice
- **Timing of requests** for PC Consultation or hospice referral **(often too late)**

Strategy for Improvement

- Rapid-cycle performance improvement
- **Leverage EMR**: generate a daily GOC Needs Assessment Report (GOCNAR)
- **Limit the size of report**: make *actionable* by PC and CM Teams to outreach primary teams
- **Use surrogate markers**: medical conditions common at EOL associated with poor functional status, regardless of underlying illness
- **Include**: CMS criteria for supporting evidence of hospice eligibility

GOCNAR Criteria

All patients admitted to the hospital within *5 days with any of the following:*

- Failure to Thrive (FTT)
- Dysphagia
- Malnutrition
- Cachexia
- Sarcopenia
- Dehydration
- Functional Quadriplegia
- Dementia
- Aspiration Pneumonia
- Hypernatremia
- Metabolic Encephalopathy
- Acute Hypoxic Respiratory Failure (AHRF)
- Documentation of Pressure Injury (Stage 3 or 4)

Sources: ICD-10 codes, free text, pressure injury documentation from Flowsheet

GOCNAR Report Fields- Ancillary Data*

- Unit Bed
- Name
- MRN
- Hospital day (#1, #2, etc.)
- Attending
- **Age**
- **Admit Source**
- **Admit Diagnosis**
- **MSQ Response (Y,N)**
- **LACE Index**
- **Previous Visit Count (# ED visits or hospitalizations over past 6 months)**
- Hospital Account Record (HAR)
- Insurance

***In addition to the 1 or more GOCNAR criteria identified**

Outcome Measures/Methods

- The study analyzed **5,731 patients** identified by the GOCNAR tool at NYPQ in 2023

- Each of the **13 GOCNAR criteria** was individually assessed for its association (yes/no) with **mortality** or **discharge to hospice** (*See Appendix*)

- **Chi-square tests** were conducted using **SAS version 9.4** to evaluate statistical significance

Outcomes: Statistically Significant

Conditions Associated with Inpatient Mortality ($p < 0.05$)

- Hypernatremia (19.3%)
- Pressure Injury (17.5%)
- Failure to Thrive (FTT) (13.3%)
- Acute Hypoxic Respiratory Failure (AHRF) (11.8%)

Conditions Associated with Hospice Discharge ($p < 0.05$)

- Hypernatremia (25.3%)
- Failure to Thrive (FTT) (18.2%)
- Pressure Injury (14.4%)
- Acute Hypoxic Respiratory Failure (AHRF) (6.6%)

Lessons Learned

- CMS disease-specific hospice criteria: challenging for primary providers, especially in real time

- EMR limitations: difficult to identify patients who meet disease-specific hospice criteria because of insufficient/delayed documentation or lack of specificity in ICD coding

- Medical conditions associated with poor functional status at EOL are easily recognizable regardless of underlying condition

Key Takeaways

- Functional decline-related conditions are common at EOL and *usually apparent at the time of admission.*

- The GOCNAR tool can generate a daily, actionable EMR report to identify EOL patients for active, early outreach to improve hospice referrals and reduce mortality index.

- Four Criteria identified to be statistically significant and may allow for a more succinct, actional report.

- GOCNAR criteria are flexible and can be tailored and tested for a hospital's unique population.

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Questions?

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Appendix

GOCNAR Criteria Chi-Square Analysis

Condition (n = 5,731)	% with condition who expired	% expired who had the condition (# expired = 537)	% with condition with hospice discharge	% with hospice discharge who had the condition (# discharged to hospice = 422)	p value for expired	p value for hospice discharge
Pneumonia acute hypoxic respiratory failure (n= 54)	14.81% (n= 8)	1.49% (n= 8)	12.96% (n= 7)	1.66% (n= 7)	p=.1677	p=.1134
Pneumonia (n= 103)	14.56% (n= 15)	2.79% (n= 15)	9.71% (n= 10)	2.37% (n = 10)	p=.0680	p=.3578
Metabolic encephalopathy (n= 1080)	8.7% (n= 94)	17.5% (n= 94)	8.8% (n=95)	22.51% (n=95)	p=.4042	**p=.0454**
Malnutrition (n= 27)	11.11% (n= 3)	0.56% (n= 3)	11.11% (n=3)	0.71% (n=3)	p= .7557	p=0.4548
Hypernatremia (n = 202)	19.31% (n= 39)	7.26% (n= 39)	25.25% (n= 51)	12.09% (n=51)	**p<.0001**	**p<.0001**
Functional Quadriplegia (n= 21)	9.52% (n= 2)	0.37% (n= 2)	9.52% (n= 2)	0.47% (n= 2)	p=.9807	p=.7041
Failure to thrive (n = 368)	13.32% (n= 49)	9.12% (n= 49)	18.21% (n= 67)	15.88% (n=67)	**p=.0073**	**p<.0001**
Dysphagia (n= 434)	8.53% (n= 37)	6.89% (n= 37)	7.14% (n= 31)	7.35% (n=31)	p=.5299	p=.8548
Dementia (n= 250)	3.2% (n= 8)	1.49% (n= 8)	10% (n= 25)	5.92% (n= 25)	**p=.0006***	p=.1027
Cachexia (n= 12)	8.33% (n= 1)	0.19% (n= 1)	0% (n= 0)	0% (n= 0)	p=.9018	p=.3282
Acute hypoxic respiratory failure (n = 2,928)	11.75% (n= 344)	64.06% (n = 344)	6.59% (n= 193)	45.73% (n=193)	**p<.0001**	**p=.0222**
Dehydration (n= 823)	5.47% (n= 45)	8.38% (n= 45)	6.93% (n= 57)	13.51% (n= 57)	**p<.0001***	p=.6035
Pressure Injury (n = 298)	17.45% (n= 52)	9.68% (n= 52)	14.43% (n= 43)	10.19% (n=43)	**p<.0001**	**p<.0001**

*Although p<.05 for expired, the direction of association for dementia and dehydration were in the opposite direction, with absence of dementia and dehydration associated with greater percentage expired.