BRIDGING THE GAP: JASPER COUNTY HOSPITAL PALLIATIVE CARE PROGRAM AND PREVENTION OF RE-HOSPITALIZATION

by

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EVIDENCE-BASED PRACTICE PROJECT

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ACKNOWLEDGMENTS

I would like to thank Karen Rients, the captain of our ship at Jasper County Hospital Home Health Care and Hospice, for mentoring my management pursuits and sharing her experience with me. Her true dedication to nursing, sense of humor, trust and patience has made our workplace a family. I would also like to thank my amazing husband, Mike, and my children, Katelyn and Liam, for sacrificing so much while I pursued my degree. Thank you for loving me and understanding. I love you all so much!
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ABSTRACT

Purpose: An evidence-based project is proposed to determine if the implementation of a palliative care program for individuals with chronic illnesses will decrease re-hospitalization within the first 30 days after discharge from an acute hospital stay.

PICO(T) question: “In individuals suffering from a chronic illness, does participation in a palliative care program reduce re-hospitalization rates within the first 30 days after an acute hospital stay in comparison to those who do not participate in a palliative care program?”

Significance of the problem: An estimated one in five people discharged from the hospital will be readmitted within 30 days and many of the others will return to the emergency department for treatment (Lavizzo-Mourey, 2013). These readmissions not only cost health care millions, but it costs the patients quality of life and the benefit of comprehensive care. According to the Wall Street Journal, approximately 65% of healthcare spending is attributed to the sickest 10% of patients to the amount of almost $160,000 per patient every year (Rockoff, 2014). Most of these individuals suffer from chronic or life-threatening illnesses that would qualify them for a palliative care consult.

Summary of synthesis of evidence: Palliative care programs offer formal health care management for those not meeting eligibility requirements for hospice or home health care. Palliative care bridges the gap by offering supportive services and case management to improve quality of life, health and symptom management. Research demonstrates that palliative care program
implementation results in cost effectiveness and improved patient outcomes and experiences.

**Recommended implementation for practice change:** A palliative care program proposes a new way of caring for patients designed for higher quality of care, lower healthcare expenditures and penalties, improved patient satisfaction and lower rehospitalization. Palliative care is designed to offer comprehensive, coordinated care and symptom management. Evidence based practice calls for development of a palliative care program.

**Conclusion/recommendations:** An outpatient palliative care program proposal not only serves as a recommendation for a program at JCH, but proposes a way of caring for patients designed to provide higher quality of care, lower healthcare expenditures and penalties, improved patient satisfaction and lower rehospitalization rates. It has been demonstrated that palliative care programs can help achieve all of these goals. The development and implementation of an outpatient palliative care program over the next 6 months is recommended.

**Keywords:** Palliative care, rehospitalization, comprehensive care, symptom management and outpatient palliative care.
SECTION 1

Bridging the Gap: Jasper County Hospital Palliative Care Program and Prevention of Re-hospitalization

Those who suffer from chronic, life-limiting illnesses struggle to manage their disease state and symptomology on a day-to-day basis. Various reasons contribute to the struggle like lack of knowledge, routine and resources to empower individuals to improve their overall health. There appears to be an invisible “revolving door” for these patients on the hospital units they frequent. Nurses see the same faces come in and go out on an acute care carousel because their diseases are not managed at home. There is a gap between the hospital and home, where home health care rules and regulations prevent it from going.

Purpose:

An evidence-based project is proposed to determine if the implementation of a palliative care program for individuals with chronic illnesses will decrease re-hospitalization within the first 30 days after discharge from an acute hospital stay. Will providing this service bridge the gap between hospital and home, leading to improvements in patient care and readmission rates?

Relevance:

“The federal government has pegged the cost of readmissions for Medicare patients alone at $26 billion annually, and says more than $17 billion of it pays for return trips that need not happen if patients get the right care,” (Lavizzo-Mourey, p.3, 2013). With sky rocketing healthcare costs, legal requirements for health
insurance and an increasing chronically ill population, something needs to change. An estimated one in five people discharged from the hospital will be readmitted within 30 days and many of the others will return to the emergency department for treatment (Lavizzo-Mourey, 2013). Individuals with chronic illness return to the hospital time after time for various reasons. Many lack health literacy, others fail to follow physician recommendations. Some people may not be able to care for themselves at home and others may not be able to afford needed medications. These are just a few of the countless reasons, but the question becomes what can be done to change the trajectory of their medical care? In an article published in the Journal of Palliative Medicine, a study resulted in demonstration of a risk for readmission decrease from 17% to 9% with the implementation of a palliative care program (Ranganathan, et al., 2013).

**Clinical question (PICOT):**

“In individuals suffering from a chronic illness, does participation in a palliative care program reduce re-hospitalization rates within the first 30 days after an acute hospital stay in comparison to those who do not participate in a palliative care program?”

**Potential Outcomes:**

Palliative care programs, staffed by baccalaureate level nurses, in conjunction with a patient’s own primary care physician, can stand to bridge the gap between wellness and hospitalization by monitoring chronic illness and promoting early intervention to prevent acute care needs. In development and implementation of a palliative care program, the goal is to decrease re-hospitalization rates for sufferers of chronic illness within the first 30 days after an acute hospital stay, when patients are recovering and more vulnerable.
and CMS imposes a penalty for readmissions. In 2013, The Centers for Medicare and Medicaid Services (CMS) began adjusting reimbursement to hospitals with high readmission rates of patients that had been in the hospital within the previous 30 days starting at 1% and increasing by 1% each year until 2015 for a total 3% penalty (CMS, 2014). Acting as the go between for physicians and patients, palliative care programs can help manage patients with chronic illnesses and not only decrease re-hospitalization, but decrease penalties to hospitals for re-hospitalization implemented by CMS. Overall, it could mean a financial benefit for hospitals and a health benefit for patients. Once an established concept, reimbursement from CMS and insurance may mean further income for hospitals implementing the programs.
SECTION 2

Review of Literature and Synthesis of Evidence

A review of the literature through use of the terms palliative care, re-hospitalization, cost, chronic illness and home care was performed to search the following databases: The Cochrane Library-Cochrane Database, CINAHL with Full Text and Google Scholar. Full text, English language peer reviewed journal articles were the focus of this search relating to the subject matter in the PICO(T) question. Nine articles were retrieved for relevance for providing evidence to support the clinical question and background information on why consideration of an evidence based-proposal relating to this issue should be evaluated. Articles were used that contained study samples, designs and methods that evaluated either the palliative care program implementation cost effectiveness or the role that care played in patient outcomes. Due to limitations in research specifying chronic illness and confusion in research specification between palliative care and hospice care, a total of five final studies were included to address the clinical PICO (T) question. “In individuals suffering from a chronic illness, does participation in a palliative care program reduce re-hospitalization rates within the first 30 days after an acute hospital stay in comparison to those who do not participate in a palliative care program?” The following themes were identified from the review of the literature.
Effects of Palliative Care on Patients:

Patients suffering chronic illness often bounce between healthcare providers and facilities in a series of failed attempts at managing symptoms. Traditionally, physicians refer these patients to home health care services to help monitor conditions. With strict CMS guidelines, not all those who suffer from chronic illness meet home health care requirements at all times throughout their chronic illness.

Definition.

Palliative care refers to a “specialized medical care for people with serious illnesses. It is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work together with a patient's other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment,” (Center to Advance Palliative Care, 2014).

Patient Effects:

Patients receiving palliative care receive a team of nurses, doctors, social workers and spiritual care providers who work together to improve the quality of life for the patient. Palliative care neither encourages nor denies medical treatment and supports the patient throughout their illness. Unlike hospice care, patients are not required to give up aggressive treatment. Unlike home health care, patients are not required to be home-bound and meet other certain criteria. Palliative care is not time sensitive and is meant to be introduced early on, but is not only effective if done so.
Hospital Effects:

“Studies show that treatment of the most complex patients during their final months accounts for a disproportionate amount of health-care spending. About 25% of Medicare costs cover the last year of patients' lives, while 80% of the government health program's spending during the last month is for hospitalization,” (Wall Street Journal, 2014). An overwhelming amount of money is spent on those who suffer from chronic illnesses and the medical care they receive. On average, palliative care programs can save hospitals $5000-$7000 per patient enrolled in re-hospitalization costs (Wall Street Journal, 2014).
**PICO(T) Question:** “In individuals suffering from a chronic illness, does participation in a palliative care program reduce re-hospitalization rates within the first 30 days after an acute hospital stay in comparison to those who do not participate in a palliative care program?”

**Keywords:** Palliative care, re-hospitalization, chronic illness, acute hospital stay

**Databases Searched:** CINAHL with full text, Google Scholar

Table 1

**Summary of Reviewed Evidence**

<table>
<thead>
<tr>
<th>Author(s) and Date of Publication ONLY</th>
<th>Sample/Setting/Design</th>
<th>Data Collection Tools</th>
<th>Findings/Results</th>
<th>Appraisal of Evidence: Worth to Practice include Strengths, Weaknesses and Conclusions</th>
<th>Level of Evidence (LOE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fassbender, K., Fainsinger, R., Brenneis, C., Brown, P., Braun, T. &amp; Jacobs, P. (2005).</td>
<td>Sample: n=16282 Setting: Individuals meeting criteria from the Alberta Cancer Registry Design: Retrospective analysis and comparison of data</td>
<td>This was a retrospective comparative assessment (cross-sectional study) of persons who died of cancer between 4/1993 and 3/2000 in Edmonton or Calgary, where palliative care programs had been</td>
<td>Development of a comprehensive community-based palliative care program resulted in cost neutrality. Increased palliative care delivery decreased use of acute care beds.</td>
<td><strong>Strengths:</strong> A large data group for comparison and retrospective analysis decreases risk for bias. <strong>Weaknesses:</strong> Data was from a small geographic area and lacked a comparison group outside of that area. All costs of care, like testing, was not included in financial analysis. <strong>Conclusion:</strong> Introducing a comprehensive palliative program can be done at no additional cost to the health care.</td>
<td>LOE: VI Descriptive Study (Cross-sectional study)</td>
</tr>
<tr>
<td>Study</td>
<td>Sample</td>
<td>Setting</td>
<td>Design</td>
<td>Retrospective data analysis of hospital medical records occurred. An advance practice nurse performed the analysis of medical records. There are both financial and outcome based results that indicate success of a palliative care program, regardless of facility size or location. Small hospitals can implement palliative care programs and achieve positive financial outcomes.</td>
<td>Strengths: This study demonstrated a reduction in aggressive treatment costs can counter the costs of the palliative program. It demonstrated the initial struggles in starting a program, yet did not include these skewed data sets in analysis. Weaknesses: Financial data for those who did not die during the study time frame were excluded due to inadequate technology and charge input systems. Conclusion: A small, community-based hospital can benefit from a palliative care outpatient program both financially and for improved patient care.</td>
</tr>
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</tr>
<tr>
<td>McGrath, L.S., Foote, D.G., Frith, K.H. &amp; Hall, W.M. (2013).</td>
<td>Sample: n=201 Setting: a 145 bed, rural community hospital serving a demographic of 150,000 people in a 4 county area</td>
<td>Retrospective analysis of comparative data</td>
<td>implemented. Data was gathered from the Ministry of Health databases.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rabow, M.W., Dibble, S.L., Pantilat, S.Z. &amp; McPhee, S.J. (2004).</td>
<td>Sample: n=90 Setting: Patients from a general medicine practice of a university medical center in a large urban area serving a diverse</td>
<td>This is a randomized control study with 50 intervention patients and 40 control patients from a general medicine outpatient clinic. Data collection</td>
<td>Consultation by palliative care professionals resulted in improved patient outcomes in dyspnea, anxiety and spiritual well-being. Palliative care interventions did not improve pain or depression.</td>
<td>Strengths: 69% of participants would have liked intervention sooner and patients with access to services had less primary and urgent care visits without an increase in specialty clinic visits, emergency department visits, number of hospitalizations or days of hospitalization. Weaknesses: Over half of each</td>
<td>LOE: II RCT</td>
</tr>
<tr>
<td>Population</td>
<td>Design: Randomized control trial with segregated control and experimental groups</td>
<td>Tools included written patient surveys, retrospective review of the medical center's computerized medical and billing records, and exit interviews with intervention patients.</td>
<td>Original control group declined to be involved in the study. Very few patients received recommended analgesic or antidepressant medications. The individuals involved were mostly women, skewing the demographic.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


| Setting: Data collected from the 1998 Mataró Death Register | Design: Comparative assessment | This was a retrospective comparative assessment (cross-sectional study) of cancer patients in Mataró who died, with a portion having received home palliative care and a portion who did not. Data compared was cost of consumption of resources and differences between control groups. | Strengths: Study was retrospective to avoid biased results or skewing of data. Data evaluated demographic data like cancer type and explained reasons for exclusion of some individuals. |

| | | The standard care group had more hospital admissions and longer lengths of stay, increased emergency and outpatient visits and greater use of nursing homes than patients in the home care group. | Weaknesses: Study looked at cancer deaths from Mataró only and only analyzed direct costs for care. Indirect costs to caregivers, etc. was not considered. |

| | | A 71% increase in cost per patient in the standard care group in comparison to the home care group demonstrated palliative care home care programs save money. | Conclusion: Home-based palliative care saves money by way of reducing hospitalization and use of emergent/outpatient medical resources. |

| | | LOE: VI Descriptive Study (Cross-sectional study) |
| **Sample:** | **Setting:** Newly diagnosed patients from Massachusetts General Hospital  
**Design:** Randomized control study included only non-small-cell lung carcinoma patients |
---|---|
| This was a randomized control trial placing newly diagnosed non-small-cell lung carcinoma patients into a control group with standard care or an experimental group with standard and palliative care.  
Early palliative care resulted in improvements in quality of life and mood.  
Patients receiving palliative care had less aggressive care at the end of life but longer average survival compared to patients receiving standard care. |
| **Strengths:** Randomized study with direct result comparison. Looked at patient care outcomes, not just financials.  
**Weaknesses:** Results came from one care facility and subjects had one particular type of life-limiting disease. Participants were not denied palliative care consultation and those who elected it from the standard care group were still reported as the standard care group, which could lead to underreporting of the positive findings. |
| **Conclusion:** Patients who receive early palliative care have less aggressive care at the end of life but longer survival, as well as improved mood and quality of life throughout the illness. |
| **LOE:** II  
**RCT** |
SECTION 3

Plan for Implementation

Current re-hospitalization rates, overall, at JCH are 16 per 100 patients discharged from the hospital (Medicare, 2014). As the Centers for Medicare and Medicaid Services continue to focus on re-hospitalization, they are instituting and enforcing penalties for re-hospitalization in increasing amounts. It is apparent that, as a smaller hospital, JCH must ensure as much reimbursement as possible to maintain the hospital’s viability.

In order to decrease re-hospitalization rates, we must focus on why people return to the hospital and what can be done to prevent these patients from reaching that point. Most often, re-hospitalization occurs in those who suffer from chronic illnesses and suffer in the gap that current health care standards have created. In order to resolve this gap, many organizations are focusing on transitional care models with palliative care programs.

Organizational fit:

As a community hospital, JCH prides itself on a commitment “to provide the highest quality of health care in a compassionate manner to our patients and to those in the local community we serve,” (JCH, 2012). In accordance with this mission, JCH would be not only be providing the highest quality of care to patients, but also helping to ensure the future of a hospital in this community. Providing a palliative care program to meets the needs of the community and its chronic illness population adheres to the quality of care and resources that JCH
has envisioned for itself. Developing a palliative care program to run alongside home health care and hospice also adheres to the goals of these departments. Home Health Care seeks “to promote healing, minimize the effect of illness or injury and encourage the independence of the individual,” while hospice “focuses on comfort, support and dignity during the last phase of life,” (JCH, 2012). A palliative care program mission would ideally combine these concepts to help support patients and bridge the gap in care. As Home Health Care began at JCH in 1985 and, a few years later hospice, a palliative care program could be implemented with the same marked success.

Stakeholders:

As a county owned hospital, JCH stakeholders involve not only administrative staff and management, but also a Board of Directors and county officials. The hospital President and CEO, T.S., the JCH Board of Directors and the Board of County Commissioners will be the focus of a palliative care program proposal. As passive stakeholders, they are essential to the success by approval and endorsement rather than day-to-day operations. The board must also approve the development of any new programs offered by JCH. The target population for a palliative care program are individuals within the home health care service area, including two whole counties and small portions of three additional counties surrounding JCH. These individuals must be diagnosed with a chronic and/or life-limiting illness, but do not meet criteria for home health care and are not yet ready to elect hospice. Management support would be provided by the Vice President of Nursing Services, S.K., as is with Home Health Care and Hospice.
Active stakeholders include the Director of Home Health Care and Hospice, K.R., my clinical liaison and the proposed Director of the palliative care program. Also, the hospice Medical Director, Dr. S., Social Worker, T.H., Chaplain, R.R. and myself, the Hospice Coordinator, as these roles would also translate to the palliative care program.

**Barriers to Implementation:**

As with any new project or program, there are barriers to development of a palliative care program. Most logically, there will be an expense in providing these services. However, palliative care programs are traditionally consist of visits with a palliative care physician and/or a nurse practitioner. These visits are billable through Medicare and most insurances. Additional support is provided to patients via telephone by a skilled nurse or nurse practitioner. These calls are not billable, but can be covered by the re-hospitalization costs saved and payment for program services.

Another barrier to implementation is the need for referrals and physician support. Because the palliative physician or nurse practitioner does not take over care, but rather coordinates care with other physicians, a need for establishing relationships presents itself. In order to establish these relationships and, in turn, secure referral sources, a program introduction should be given to physicians with rights at JCH. Referrals can also come from Home Health Care patients, Hospice referrals who wish to seek treatment and JCH inpatient discharge.
planning referrals. As these relationships have already been built for Home Health Care and Hospice, so they could be built for palliative care.

Another potential barrier, as many passive stakeholders may present, is the additional workload on staff. In answer to that barrier, Dr. S has emphatically pushed for a palliative care program as his early retirement has left him with availability and desire. Additionally, he is certified in hospice and palliative care.

The social worker has also expressed desire and is currently a salaried employee and can be arranged in availability as training and delegation of duties to the newer role of Volunteer Coordinator, held by R.K., has decreased role responsibilities. The chaplain, R.R., is currently employed under a job description which states 20-40 hours per week. His average hours are currently approximately 24 hours per week, with room to expand for purposes of a palliative care program. As for myself, in the role of Hospice Coordinator, development of my role in the program hinders more on management and oversight, as does the role of K.R., the director. We both have vested personal and professional interest in the need for this program in the community we serve. As the program expanded, the need to employ a nurse practitioner, part-time, would be paid for in the reimbursement of the program. The nurse practitioner and an additional nurse to assist with office consultations, perhaps already employed by JCH, would be the only additional cost.
Facilitation strategies for EBP Implementation:

As the overall goal of a palliative care program, this project seeks to bring the health care gap for those individuals, large in number, who fail to meet home health care requirements provided by CMS, but wish to continue seeking medical treatment for their conditions based on their personal desires for scope of treatment. This desire to seek treatment excludes them from hospice, but makes them perfect candidates for a palliative care program to help provide needed resources for health care management, decision-making and support.

In planning for implementation, a team of program supporters formed into a committee would act as facilitators and collectively oversee the program’s development and successful implementation. This committee would include: S.K., Vice President of Nursing Services, K.R., Director of Home Health Care and Hospice, myself, Hospice Coordinator, and Dr. S., Medical Director.

In addition, the current staff of JCH Home Health Care and Hospice would play a vital role in facilitating this program. Currently, this department has an on-call system with nursing that would be made available to palliative care program patients. Traditionally, in home care this may result in a home visit. In the case of the palliative care program, it would provide a tele health-like program offering advice, direction and connection to physicians, which would include the Medical Director who is already available for the purposes of hospice. This availability when on-call is already a job requirement of staff nurses.
Resources needed:

_JCH Transitions_ program strives to bridge the gap for those who suffer with chronic and/or life-limiting illness between the hospital and hospice. The current offerings of both home health care and hospice have already put into place multiple resources for a Palliative Care program. This includes staff, on-call systems, management, policies, licensure, regulation and financial support. Resources needed, not yet in place, are limited to an office location in which to see palliative care patients for consults. Currently, the outpatient department presents as an ideal location in which to see palliative care patients. In offers exam rooms, equipment, a waiting room, office setting and easy access to the lab, radiology, and various other services offered by JCH. As care is collaborated and managed between specialists and the palliative care staff, access for evaluation and continuity of care is close to home for patients who would otherwise likely present to an emergency room.
Table 2

*Estimated Timetable Blueprint for Implementation*

<table>
<thead>
<tr>
<th>Task</th>
<th>Estimated Date of Start</th>
<th>Estimated Date of Completion</th>
<th>Person Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program proposal President/CEO and Vice President of Nursing Services</td>
<td>December 15, 2014</td>
<td>December 15, 2014</td>
<td>K.R and S.H.</td>
</tr>
<tr>
<td>Program proposal Board of Directors and Commissioners</td>
<td>January 8, 2015</td>
<td>January 8, 2015</td>
<td>K.R. and S.H.</td>
</tr>
<tr>
<td>Voting and Approval</td>
<td>January 8, 2015</td>
<td>January 8, 2015</td>
<td>Board of Directors</td>
</tr>
<tr>
<td>Branding</td>
<td>January 8, 2015</td>
<td>January 16, 2015</td>
<td>S.W. Community Relations</td>
</tr>
<tr>
<td>Presentation to Medical Staff</td>
<td>January 22, 2015</td>
<td>January 22, 2015</td>
<td>S.H. and K.R.</td>
</tr>
<tr>
<td>Presentation to HHC/Hospice Staff</td>
<td>January 21, 2015</td>
<td>January 21, 2015</td>
<td>S.H. and K.R.</td>
</tr>
<tr>
<td>Presentation to Referral Sources</td>
<td>January 23, 2015</td>
<td>January 26, 2015</td>
<td>S.H.</td>
</tr>
<tr>
<td>Public promotion</td>
<td>January 26, 2015</td>
<td>To be determined</td>
<td>S.W. Community Relations</td>
</tr>
<tr>
<td>Set-up outpatient schedule</td>
<td>January 23, 2015</td>
<td>January 30, 2015</td>
<td>S.H.</td>
</tr>
<tr>
<td>Begin accepting and admitting referrals</td>
<td>January 22, 2015</td>
<td>None</td>
<td>S.H.</td>
</tr>
<tr>
<td>First clinical consult office day</td>
<td>February 3, 2015</td>
<td></td>
<td>Dr. S., S.H., and nurse TBD</td>
</tr>
</tbody>
</table>
SECTION 4

Plan for Evaluation

The concept of palliative care programs is evidently needed to provide another means of health care support to patients. The question comes in the way of value. Does it reduce re-hospitalization, and therefore reduce costs to hospitals in the way of care costs and penalties? The true value in having a palliative care program has created a buzz in healthcare and gone as far as being discussed in *The Wall Street Journal*. Care providers are catching on to the idea of care continuity and the need to keep patients in their homes and out of hospitals. As a small, community-based hospital, JCH cannot afford the coming penalties of rehospitalization. We know that it cannot afford the current drain on hospital finances with the ever-decreasing reimbursement for hospitalization in general. As the push of the Affordable Care Act (ACA) proves to be towards home care, the ACA is just getting started. If hospitals, both large and small, want to maintain viability, they must look at ways to reduce costs, penalties and expenditures. Home care is the way to go and palliative care bridges the gap between current home care programs.

**Baseline Data:**

Baseline data for this project will be collected from quality reporting data, which includes rehospitalization rates within 30 days following an acute stay. Additionally, with the CMS rate of penalty and this quality data, a forecast of penalty amounts can be established. Currently, as a critical access facility, JCH
does not receive penalty for rehospitalization. However, being in confidential
talks with two major health care systems could bring about a change to this
status or, as health care regulation changes, this exemption may disappear.
Looking at penalties is a must now to begin improvements for later. Being
proactive only makes the coming transitions smoother. In collecting baseline
data, an analysis of the most recent, complete fiscal year will provide valuable
data. This will be done retrospectively, as the implementation of this program is
imminently needed. Once the program has begun, both a 6 month and one year
analysis should be performed and presented to senior management and the
Board of Directors. The 6 month analysis provides time to work out any potential
problems while presenting program benefits and direction. The one year data will
prove the financial benefit of an established palliative care program. The data will
be collected, analyzed and reviewed by K.R. (Director), S.K. (V.P. of Nursing)
and myself, S.H. (Coordinator). Data will be pulled from a computer charting
system already in use by Home Health Care and Hospice under a new service
line office title Palliative Care.

**Compliance:**

Patients in the program will be surveyed in 3 month intervals after
enrollment for the first year of the program. After that first year, patients will be
surveyed once every 6 months for quality assurance and information will be
included in bi-annual reports to the Board of Directors. Reports will include
pertinent financial data, cost reporting and program reimbursement data
collected. All data is collected and organized in the current computer system
utilized. Additionally, as coordinator, I will oversee day-to-day compliance under the supervision of the Director, K.R.

**Interpretation of Data:**

Data analysis and interpretation will be undertaken by several entities. Once the data collection and synthesis is completed by myself and K.R., it will be reviewed by S.K. and presented to President and CEO, T.S. This data will then be presented by T.S. and S.K. to the Board of Directors. Upon request, likely annually, the data will also be presented to County Officials. When CMS completes its Medicare Choices Model and the resulting monitoring goes into effect for palliative care programs, these reporting and compliance measures will be undertaken and overseen by K.R. and myself. Data interpretation will be overseen with three main goals:

- Reduction of rehospitalization rates of at least 5% within the first year.
- Decrease in rehospitalization expenditures by JCH, deducting the Palliative Care Program Costs, within 12 months of program initiation.
- Palliative care program overall patient satisfaction of 80% or greater.
Table 3

*EBP Evaluation Plan*

<table>
<thead>
<tr>
<th>Outcome(s)</th>
<th>Measures/Measurement</th>
<th>Time of Collection/Person Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction of rehospitalization rates of at least 5% within the first year.</td>
<td>Analysis of the most recent, complete fiscal year will be done retrospectively. After program initiation, a 6 month and one year analysis will be performed and presented to senior management and the Board of Directors. The 6 month evaluation will demonstrate program benefits. The one year data will prove the overall benefit of an established palliative care program. Data will be collected from computer programs designed for these purposes.</td>
<td>Data will be collected, analyzed and reviewed by K.R. (Director), S.K. (V.P. of Nursing) and myself, S.H. (Coordinator). Data will be collected and analyzed at 6 month and 12 months marks after program implementation.</td>
</tr>
<tr>
<td>Decrease in rehospitalization expenditures by JCH, deducting the Palliative Care Program Costs, within 12 months of program initiation.</td>
<td>A forecasted penalty, under CMS guidelines, both pre and post program development, at the 6 and 12 month marks will demonstrate need and secure the program future by demonstrating savings for if/when rehospitalization penalties are reality for JCH.</td>
<td>Data will be collected, analyzed and reviewed by K.R. (Director) and S.K. (V.P. of Nursing). Data will be delivered for evaluation to the Board of Directors and senior management. Data will be collected and analyzed at 6 month and 1 year marks after program implementation.</td>
</tr>
<tr>
<td>Overall hospital expenditures both pre and post program development at the 6 and 12 month marks will demonstrate the decrease in expenditures. Doing so, additionally, in comparison to the relative costs of the program will further demonstrate goal achievement.</td>
<td>Palliative care program overall patient satisfaction of 80% or greater.</td>
<td>Patients will be surveyed in 3 month intervals after enrollment for the first year of the program. After that first year, patients will be surveyed once every 6 months for quality purposes. Information will be included in bi-annual reports to the Board of Directors.</td>
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SECTION 5
Conclusions, Recommendations and Implications

The world of palliative care is just beginning. It is in its earliest stages, but gaining momentum as the world of health care begins to take notice. The research is proving that this method of care is making a difference, both in patient outcomes and the financial bottom line. Estimates place savings to healthcare on an average $5000-$7000 per patient per year (Rockoff, 2014). This, plus reduction of rehospitalization, which reduces future penalties for rehospitalization, makes the benefit of a palliative care program common sense.

Implications:

The current state of healthcare follow-up relies on patients, without proper education and support, to navigate the realm of healthcare and make life-altering decisions. Home health care requires stipulations that most do not meet, yet those individuals need supportive care. Hospice requires an abandon of interventional treatments and makes the transition to comfort care and end-of-life preparation. Between these lies a vast gap in health care. A vast gap that palliative care, by definition, can not only bridge, but can improve the human experience. “Thomas Smith, director of the Johns Hopkins Palliative Care Program, points to studies that show patients in such programs do better on quality measures like hospital readmission rates than people who don't elect palliative care. Patient satisfaction levels improve as well. Dr. Smith also cites studies showing members who receive these benefits live as long as or longer than those who aren't participants,” (Rockoff, 2014). As our nation’s population
continues to age, we must look at ways to improve care for these individuals and help save the future of healthcare for our generation. Palliative care can be one big step down that road.

**Recommendations:**

This proposal not only serves as a recommendation for a palliative care program at JCH, but proposes a new way of caring for patients designed for higher quality of care, lower healthcare expenditures and penalties, improved patient satisfaction and lower rehospitalization. The entire hospital can benefit from this program’s development and the staff must come together in understanding and utilizing this amazing program. Further program research is needed to reinforce the various benefits and prove the need for further reimbursement from CMS and private insurances, but JCH does not have to wait for this. We can be a part of that proof with current reimbursement and establish a program model that supports reimbursement. Benefit clearly outweighs cost and the implementation plan is designed to demonstrate that.

Professional nursing, and health care as a whole, must stand up and take notice of palliative care and patient care choices. We, as healthcare professionals, are morally and ethically obligated to not only care for our patients, but to care about them. We must care about their whole person, not just their illness. We must care about the human condition. As health care has fallen away from this in recent years, the gap in care has developed. We stopped looking at people and started looking at conditions. We stopped providing comprehensive
care. Palliative care is designed to offer comprehensive care and coordination of care to improve the human experience. The time to act is now and here is the plan.
References


