Renewing Our Commitment to Compassionate Care
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A Message from Our Leadership

At the UPMC Palliative and Supportive Institute (PSI) we believe that the quality of life for seriously ill patients deserves serious, innovative and thoughtful care. In recent years, UPMC has taken bold steps in advancing and growing both specialty and primary palliative care to help the patients and families who rely on us during difficult times.

Since its inception in 2011, PSI has worked to find new and better ways to serve our patients’ needs and wishes. First, we built specialty palliative care consult teams to serve all UPMC Health System hospitals. Then we expanded our reach to outpatient clinics and skilled nursing facilities throughout the health system to increase patients access to palliative care specialists.

Today, PSI is reaching beyond hospital walls and palliative care specialists to offer patients and their families palliative care wherever they are and whenever they need it. We’re working to ensure that every clinician at every UPMC site has the skills needed to provide excellent palliative care to seriously ill patients. In particular we are working with our home care programs to provide the best palliative care for our patients in their communities and with our hospice programs. In addition, we are working to better communicate among our programs so that we can promote the care that meets our patients’ goals, across the continuum.

Through education, research, community partners and clinical programs, PSI is discovering and implementing innovative ways to enhance quality of life for all patients and families living with the burden of serious illness.

We’re proud of all we’ve accomplished in the past years, and we look forward to touching and improving the quality of life for more people who need our compassionate care.

Sincerely,

Robert M. Arnold, MD
Medical Director,
UPMC Palliative and Supportive Institute

Deborah S. Brodine, MHA, MBA
President,
UPMC Community Provider Services
Chair, PSI Advisory Council

Our Mission and Vision

The mission of the UPMC Palliative and Supportive Institute is to ensure high-quality, coordinated care for patients with serious illnesses, to increase palliative care capacity and expertise across the UPMC continuum of care, and to provide access to consistent education, training, and technical assistance for health care professionals who care for people with serious illness.

Our vision is to promote enhanced quality of life for all patients and families living with the burden of serious illness through attentive symptom management, including hospice. We recognize the importance of treating patients and their families according to their own goals and wishes for care, whatever the illness or prognosis.

The clinicians of the UPMC Palliative and Supportive Institute work collaboratively with other health care professionals throughout UPMC to provide the support and services that can make life’s transitions less stressful. We focus on managing and treating symptoms, and helping patients have the best possible quality of life during their illness.

Life always has meaning. We are here to ensure that patients, families, and caregivers have the opportunity to experience each moment with dignity and grace.

“"When we first started delivering palliative care, we had a small program with a couple of good doctors. Now we have so many amazing clinicians who are contributing to palliative care and research, and expanding the knowledge and capabilities of the entire institution.”

Dr. Robert Arnold
In 2017, we helped 32,288 patients receive palliative care across the continuum.

UPMC Palliative and Supportive Institute is working to promote good specialty and primary palliative care in every setting where seriously ill patients may be. That means expanding clinical programs to people everywhere from traditional places like hospitals to community settings like outpatient clinics, doctors’ offices, skilled nursing facilities, and private homes.

With our expanding efforts, patients in cancer, cardiopulmonary, geriatric, renal, and HIV programs have greater resources through our growing outpatient specialty care clinics. And nurses throughout the system are identifying at-risk hospital patients and helping to coordinate their care after discharge.

We are empowering and enabling physicians and nurses at every level to provide primary palliative care. This helps us reach a greater number of patients and allows our palliative care specialists to focus on the more complex and challenging cases.

“Dying isn’t a medical failure. It’s a part of life. There’s been a big change in health care because people are seeing the value of palliative care.”

Sharon Hudak
PSI Clinical Care Manager
UPMC Presbyterian and UPMC Montefiore Hospitals
Clinical Excellence In The Hospital

The growth of palliative care in the hospital setting has been constant. Throughout UPMC hospitals and facilities, palliative care is concurrent care, not an afterthought or a last step. Rather, it’s a recognition along the continuum of care that palliative care is important to every patient’s quality of life, and receiving this care as early as possible is critical.

Dr. Andrew Thurston, Medical Director of Palliative Care at UPMC Mercy, has seen this need firsthand and, in fact, an early experience started him on his career in palliative medicine.

“I can remember the exact moment when I decided I wanted to work in palliative care,” Dr. Thurston said. “I went to medical school thinking I’d get into geriatrics. As an intern, I had a classic eye-opening experience when I was called to evaluate a patient in the middle of the night who was really declining. I was reading through his medical records and saw that he was supposed to be discharged the next day before he took a dramatic turn for the worse. So I sent him to ICU. But in the course of six hours, despite all of our efforts, he ended up dying.

We were doing all we could to resuscitate him and I could see the family was anxious for more information. I remember wishing that I could do more for them. I felt torn between helping the patient and comforting and informing the family. And I thought there has to be a better way of coping with and addressing end of life in the hospital setting. From there I was convinced that I wanted to work in palliative care. I couldn’t imagine being in any other field, because it’s constantly growing. In fact, I feel like our work is never done.”

Some of my best consults are when I am involved before the final diagnosis comes in. This gives me an opportunity to help the patient and family plan and prepare for what may come.

Dr. Andrew Thurston
Clinical Assistant Professor of Medicine
Medical Director of Palliative Care, UPMC Mercy

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Giving Patients Without Family a Caring Presence

No One Dies Alone Program
Not everyone who is seriously ill has family or loved ones who are able to visit and sit by the bedside. Yet so much comfort can come from having a caring person nearby. No One Dies Alone is a national program in place at several UPMC hospitals and skilled nursing facilities to provide volunteer companions to dying patients who would otherwise be alone. With the support of nursing staff, the Compassionate Companions are able to offer patients the invaluable gift of human presence and a dignified death.

More than 30 chaplains, and a large complement of ministers, priests, nuns, and volunteers provide bereavement and spiritual care throughout UPMC hospitals.

“Everybody only dies once. So we only have one chance to get it right.”

Dr. Robert Arnold
Managing Grief
When a patient is dying in the hospital, our specialized bereavement counselors strive to be on hand to help family members cope. We respect the family’s privacy and wishes, offering help in ways that can ease the immediate sense of loss. Acute bereavement support involves sympathy, psychological guidance and prayer if requested.

A social worker may also refer family members and caregivers for additional support.

In several UPMC facilities, free, hospital-based support groups are available. And we’re working to establish a system-wide, grief-support volunteering program, where trained volunteers offer follow-up help to comfort the bereaved.

PSI also provides training to volunteers who provide bereavement follow-up calls to family members whose loved one died on palliative care. So far, volunteers have been trained at UPMC Presbyterian, UPMC Shadyside, UPMC East, UPMC St. Margaret, UPMC Mercy, and UPMC Passavant.

Bereavement care for the family

The Healing Patch, a resource of Home Nursing Agency, part of UPMC, is a unique, peer support program in Cambria and Blair counties designed specifically for children and their families who have suffered the loss of a loved one, such as a parent, sibling, grandparent, or close family member. This is a volunteer-driven, free service to the community. The Healing Patch is a safe environment where grieving children and their families can discover they are not alone in their grief by interacting with others who have encountered similar losses. By sharing memories and experiences, families discover that what they are going through is normal and that hope and healing are possible.

It is a privilege to work with bereavement support specialists who provide extremely important help to normalize the pain of loss and create a safe place for a bereaved person to express feelings of sadness and heartache that accompany a loss.

Ed Lewis
Bereavement & Spiritual Support Coordinator
Palliative and Supportive Institute UPMC Passavant

“...It is a privilege to work with bereavement support specialists who provide extremely important help to normalize the pain of loss and create a safe place for a bereaved person to express feelings of sadness and heartache that accompany a loss.”
Clinical Excellence in Outpatient Services

The reach and mission of PSI’s clinicians goes beyond those patients admitted to a hospital. Our network of outpatient services is making a difference in the lives of patients who are able to be at home.

Dr. Richard L. Weinberg is the Clinical Associate Professor of Medicine, Associate Medical Director for Community Palliative Care, and has seen the importance of outpatient services firsthand.

“The number of consultations is growing at each of the community sites. What we’ve seen is that the cancer programs in particular have been excited about the opportunity to have outpatient palliative care clinics and really spurred the effort to approach our clinicians for the clinics to be started,” Dr. Weinberg said.

“They have been referring patients consistently for a variety of services, including symptom control.” Dr. Weinberg continued. “Medical oncologists at UPMC East, UPMC Mercy, and UPMC Passavant encouraged us to set up outpatient palliative care clinics at each of their sites and have been actively sending us patients. Of course, this enhances the inpatient services we are able to provide, as well. The presence of the palliative care teams at the hospitals and the quality of the care they’ve provided to both inpatients and outpatients has lead clinicians to recognize the value of palliative work. Once they experience what we do, they are more aware of when we can help their patients.”

Palliative care is now regarded as part of the standard of care for patients, especially among oncologists, but also among other disciplines at every hospital. We’ve been told that having palliative care imbedded in the hospital has transformed the culture of the hospitals where we provide services.

Dr. Richard Weinberg
Clinical Associate Professor in the Division of General Internal Medicine, Section of Palliative Care and Medical Ethics

“A community of care and compassion”
Hillman Outpatient Clinic

UPMC Hillman Cancer Center’s Outpatient Clinic is involved with any care that enhances quality of life for cancer patients. Here, palliative specialists see a diverse range of cancer patients from diagnosis to survivorship, and help them with pain and symptom management, dealing with side effects from cancer treatments, optimizing coping and psychosocial supports, and planning for the future.

“Oncology has had a leading role in palliative care. It’s one of the earliest disciplines to embrace the value of palliative care. In the beginning, the tendency was for the oncologist to only refer to palliative care after there were no more cancer treatments available for the patient. Patients found that to be a bad model and often felt abandoned by their oncology team when they had to meet a new team of doctors at a crisis point. It felt overwhelming,” Dr. King said.

“Now we are meeting patients close to the point when they are diagnosed and following them throughout their treatments. Our involvement will increase or decrease depending on what their needs are. But we are part of their care team the whole way. It’s a continuum of care as opposed to a transition point in their care. They want all of their doctors’ engagement — both oncologists and palliative doctors — throughout their treatment.”

Growth in Outpatient Care

Volume of outpatient clinic visits has increased by more than 30 percent over the past five years.
“Everything was lifted off my shoulders, all the burdens of my real life, outside of being there next to my mother. I feel blessed. I’m not sure all families have that opportunity.”

Becky Close
Daughter of Palliative Patient

Mrs. Gibson’s Last Days and Final Wishes

At 88 years old, Mrs. Gibson was a woman of strong faith. She was also severely osteoporotic and in terrible pain. In October 2016, she went to the emergency room at UPMC East and was admitted to the hospital. Her surgeon presented options, but Mrs. Gibson was fast in her decision. “My work is done here,” she said, pointing to the heavens. She then expressed two things that were important to her. She wanted to be sure her son and her daughter were okay with the decision, and she wanted to discuss her spiritual concerns about stopping treatment.

Becky supported her mother’s decision, and so did the palliative care team, including Palliative CRNP Donna Durant, who talked to her and allayed her concerns. “It was such a blessing to see a family of one accord,” remarked Donna. “I am still touched by the opportunity to meet this family. Being able to allow Mrs. Gibson to rest in the arms of UPMC’s Family Hospice team was just what they needed. Having worked at Children’s Hospital’s ICU in my early days and now in palliative care I embrace our ability to meet and help people at every single step of their journey. I am grateful to wear the UPMC logo on my jacket as I am grateful for all of things my co-workers and I can do to help families.”

The next day, Mrs. Gibson was transferred to the Family Hospice and Palliative Care inpatient facility in Mt. Lebanon. There, Becky appreciated how the staff kept her mother comfortable and never lost sight of her goals and values. Becky was grateful for their support and the time they took to explain medications, a subject around which there is often fear and misperception.

Five days later, Mrs. Gibson passed away. Becky said she was completely at peace, knowing that she had carried out her mother’s wishes.
Building On a Relationship

Growing Stronger with Family Hospice and Palliative Care

Building on a ten-year relationship with UPMC Palliative and Supportive Institute, Family Hospice and Palliative Care (FHPC) is now formally part of the team. In the past, PSI provided full-time physicians to FHPC and used its two inpatient hospice units in Lawrenceville and Mt. Lebanon as a training lab for fellows. In fact, most palliative care physicians in the region have received board certification due to time spent in FHPC’s dedicated inpatient units.

As a large, 500-patient hospice with experienced, full-time physicians, FHPC is able to offer some medical comforts and services that aren’t available at most smaller hospice systems. Home visits by hospice physicians board-certified in palliative medicine are one of the most appreciated and unusual services that FHPC provides. And because the doctors are full-time, they also provide day-to-day care.

PSI and Family Hospice are launching an annual symposium for both internal and external audiences. The first symposium topic will be “No Patient Is Typical” and will speak to the reality that every patient and circumstance is unique, and there is no such thing as a typical hospice patient.

The partnership is positioned to grow to meet the emerging needs of patients and families. While UPMC already has a large Advanced Illness Care (AIC) program for UPMC Health Plan members, FHPC is collaborating as part of UPMC Home Healthcare to provide the blended home care benefit and looking to integrate smaller hospices to grow the footprint and increase access to services.

Hospice Patient Finds Peace

For the past two years, Hannah Baldwin-May battled an undiagnosed disease, which developed into Stage 4 Gastroparesis, or stomach paralysis. Hannah passed away this year at the age of 24.

After many visits to hospitals and doctors, it became evident that her disease could not be cured. When she was told traditional pain management would no longer work, she turned to UPMC’s Family Hospice and Palliative Care. That is when she said a huge sense of peace and relief washed over her.

“I knew I was out of other options and I was told that due to the nature of my progressively declining illness, I needed hospice-level pain control if I was going to feel any comfort at all,” Hannah said. “Once the nurses started me on their level of pain control, my life was changed. It was the most comfort, from medication, and comforted, from a personnel standpoint, that I had felt throughout my entire illness. Knowing that my condition would continue to decline, I wish I would have found hospice sooner to be able to better enjoy the remainder of what time I have left.”

Although her life was cut short, she lived it to the fullest. Hospice also has allowed her to fulfill her bucket list and spend meaningful time with family and friends. “All my dreams came true with a ceremony for me to get pinned with my flight nurse wings,” Hannah said. “I also got a couple of extra weekends with family and friends when I was kept comfortable enough to get some beautiful final memories with all of them. Because of hospice, I can say that I got to go out of here the way I would have dreamed.”
The UPMC Supportive Services Program

Some hospital patients have a higher risk for readmission and decreased quality of life based upon the complexity and severity of their conditions. UPMC Health Plan established the new Supportive Services Program at UPMC Presbyterian, UPMC Mercy, and UPMC Montefiore Hospitals to capture those patients and offer a new kind of support.

Nurses with the Supportive Services Program screen UPMC Health Plan patients who are 65 and older for geriatric and palliative care needs. When patients qualify, the nurses follow them as consultants throughout their hospital stay and up to thirty days after discharge. They work as a team with social workers, attending physicians, primary care physicians and the UPMC Health Plan case managers to coordinate care that matches each patient’s goals and values.

Our nurses make sure symptoms are managed so patients remain comfortable. They refer them to home health or hospice programs and help them get the medical and social support they need.

Most importantly, they’re there to have heart-to-heart conversations about goals of care and what is most important to patients who live with serious illness. For some people this means talking about what are the opportunities for experimental therapies. For others it means planning if their illness worsens. Talking one on one, people open up about what is most important, their fear of dying, or their worries about their families. Nurses with Supportive Services listen closely and coordinate care that responds to the patients’ personal needs and values.

Palliative and hospice care simply begins with listening to what a patient really wants.

Sharon Hudak
PSI Clinical Care Manager
UPMC Presbyterian and Montefiore Hospitals
Our Community-Based Supportive Services

A Network of Compassionate Care for Patients Outside the Hospital

Today, we’re doing a better job than ever of identifying and talking to hospital patients who need palliative care. But what happens when those patients are well enough to leave the hospital? UPMC Palliative and Supportive Institute has developed new ways for these patients to continue to receive the best palliative care, whether they go to nursing facilities or decide to stay at home.

Through a variety of programs and services, we’re able to coordinate and provide care that helps patients manage post-acute needs—without going back to the hospital whenever possible. Nurse practitioners, nurses, and social workers are available to treat many problems in place, rather than transporting patients by ambulance to the hospital for issues like cellulitis, eye infections or urinary tract infections. Trips to the emergency room can be costly, disruptive and frightening. Through the UPMC Home Healthcare Palliative Program, patients benefit from post-acute transitions to continue pain and symptom management. These programs help patients get the care they want and need, in the comfort of the environment they choose.

— Susan Saxon
Director, Community and Home-Based Advance Practice Palliative Care

Our Nurse Practitioners are amazing. They’re experienced, knowledgeable and kind. They have a difficult job going into all kinds of home environments to provide care.

— Susan Saxon
Director, Community and Home-Based Advance Practice Palliative Care

“Advanced illness care can facilitate earlier referral to hospice for appropriate patients. We are exploring ways to make referrals to AIC more seamless between hospital or nursing facility and home. Because our clinicians overlap with the Home Transitions program, it offers another opportunity for us to provide cohesive care of our patients.”

— Dr. Mamta Bhatnagar
Medical Director, Advance Illness Care Program

Advancing Innovative Payment Models

The Advanced Illness Care (AIC) Program

What happens to patients with serious illness in between hospital or doctor visits? Often these people have post-acute needs, but feel left on their own. How do they handle their medications and deal with their serious illness?

UPMC Palliative and Supportive Institute has teamed up with the UPMC Health Plan to create the Advanced Illness Care Program (AIC), a safety net to help seriously ill members stay as healthy and stable as possible at home. Through AIC, community-based nurse practitioners and social workers visit patients in their homes. They coordinate care, help with pain management, make sure patients are taking their medications, and facilitate sometimes difficult conversations with family members about goals of care. They also keep an eye on patients, checking in once a month or so to make sure everything is okay. If their illnesses progress, the nurse practitioners can help patients transition to nursing facilities or hospice.

Dr. Mamta Bhatnagar
Medical Director, Advance Illness Care Program

“Creating a safety net with the Care Transitions Program and the Advanced Illness Care (AIC) Program for UPMC Health Plan members

• Boosting care in nursing homes through the RAEN Initiative
• Growing UPMC Home Healthcare Palliative Program

Community Highlights

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Home Healthcare Success

There are many stories of how our home healthcare services have helped patients and their families have a voice in their care and where that care will take place. This is done through expert care coordination and case management where nurses follow a patient through all levels of their care.

Patty Jo Kelley, RN, BSN, MPA, CCM, Senior Manager, Home Transitions/Advanced Illness Programs, UPMC Home Healthcare has seen the difference this care can make in providing comfort to patients and their families.

“Our AIC team was contacted by a physician’s office and asked for assistance with a hospice referral,” Kelley said. “The physician knew a hospice referral was appropriate, but it just was not happening at the physician office level. The patient and family were reluctant to have a discussion. The physician made a referral to our AIC program. The Care Transition Coordinator discussed the program with the patient and made arrangements for a nurse practitioner and social worker to meet with the patient and family in the home. They discussed the patient’s illness, the type of care the patient wanted, and where the patient wanted that care to take place. The patient was then transitioned to hospice at the patient’s request. The patient experienced her final days in the care of the hospice team. In this case, the AIC functioned as an extension of the physician’s care.”

“Another patient that the AIC team worked with had multiple hospitalizations related to medication noncompliance. One of the patient’s goals was to avoid going to the hospital. The patient was enrolled in the AIC Vivify program, which enables two-way video communication from our UPMC network to the patient’s tablet or smart phone. Our Care Transition Coordinator dug a little deeper and discovered it was not that the patient did not want her medications, but that she would simply forget to take them. The patient would then go to the hospital Emergency Department or get admitted due to poor symptom management. The CTC arranged for the patient to get a large pillbox and enlisted the assistance of a daughter and another caregiver to fill the pillbox weekly. It ended up that the patient did not have any hospitalizations while on our AIC Vivify program and took her medication as ordered.”
Social Work to Extend Our Reach

Social workers play a critical role in the continuum of palliative care. These services can include meeting with families and patients about their medical issues and their treatments, as well as practical issues like helping them get set up with rides to doctors, meals, home accessibility issues, and more. They can also help with paperwork like advanced directives, medical power of attorney, and living wills.

Elana Gonzalez, MSW, LCSW, OSWC, is a Senior Clinical Medical Social Worker working for UPMC Home Healthcare in the UPMC Home Transitions and Advanced Illness Care Program. She works in teams that include a social worker, a nurse practitioner, and a clinical nurse.

“I worked in a hospital setting before and it was often during a crisis situation,” Gonzalez said. “But in my role as a social worker, I can help patients make decisions about their health, and make sure a patient’s wishes are understood before it’s a crisis. Anticipating their needs is important.”

Gonzalez’ work also reaches a patient’s family members.

“Families value my role because I’m someone who is going to spend an extra bit of time listening to them and taking into account everything impacting their lives. When you meet someone in their home, you get a bigger picture of what they can handle and how they are doing. We get to know patients over the long term. So I become intimately familiar with their wishes and needs, and help families make the best decisions. That’s why we want to get palliative care going as soon as possible. That gives us more time with them to develop a trusting relationship. Patients know you want what’s best for them. They know we aren’t there with an agenda. We are there to make sure their wishes are respected.”

Susan Saxon
Director, Community and Home-Based Advance Practice Palliative Care

Health care is moving from just taking care of people in hospitals to developing models for them to be cared for at home. We’re keeping pace with national programs that are all new.

Susan Saxon
Director, Community and Home-Based Advance Practice Palliative Care
Patient Stories

Thomas McKenna’s Nursing Home Stay and Palliative Care.

Thomas McKenna, father of UPMC employee Liz McKenna, was diagnosed with dementia and over time it became necessary for him to receive care in a nursing home. And having access to palliative care in this setting was proved to be critically important for his family. Particularly for Tom’s wife, Alice, there were so many new tasks connected with caring for someone with dementia that consume each day. So it was often hard to step back and put in context the incremental changes that occurred over time. Alice realized that she needed help as she saw her husband become less verbal, eating minimally, unable to focus, and sleeping more and more.

This was where PSI CRNP Connie Coble-Roe was able to help bridge any gaps in Tom’s care or assist with the family’s wishes in making sure he received it.

“It was so valuable to have someone like Connie, with her expertise in palliative care, to explain the process of the disease, what these changes meant, and how we could adjust our approach to his care,” Alice remembers. “When someone no longer wants to eat, it’s hard not to feel a sense of failure and even neglect. Connie helped us understand that his physical needs were changing and helped us navigate that emotionally. Treating Tom from a place of comfort didn’t mean an absence of care; it was adjusting the focus of what was most important and securing the additional support and expertise to address those changing priorities. Connie was at the heart of those efforts, extending comfort and reassurance to my whole family throughout his illness.”

“In skilled nursing facilities, a robust palliative care program is so important. Multiple chronic illnesses and the care required for them have gotten so much more complex through the years. By the time a patient reaches skilled care, he or she often has seen many specialty doctors and may feel confused. Care may seem fragmented. But with a palliative perspective, I can look at treating the whole person. I can help manage symptoms, improve the quality of life, and formulate goals of care.”

Connie Coble-Roe, CRNP
UPMC Cranberry Place

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The Evolution of Palliative Home Care

Thelma Dibble, RN, Vice President, Compliance and Quality UPMC Home Healthcare has been involved with finding new ways to serve patients in their home. A team of stakeholders within the palliative care network was tapped to share their thoughts on what was working and not working in palliative care within home health. It was found that there was a need to be consistent in palliative training and evaluating patients correctly when it comes to who does and doesn’t need palliative care.

The team utilized joint-commission standards for palliative certification in terms of how they would evaluate their work, and looked at a variety of ways to improve their services, including public relations, and training. The result was new standardized practices, methods for referrals, and education. End-of-Life Nursing Education Consortium (ELNEC) training was used to ensure that staff are providing high-quality, standardized care to palliative patients. ELNEC is the gold standard for training in end-of-life and palliative care.

This initiative has been a big success and brought all the home health agencies together to provide the best and most appropriate care whether it is hospice, palliative, or some type of bridge service in between.

Home Care Consistency

Ensuring consistent quality is a main effort of all of our partnerships, so one of the first initiatives is to standardize care, orientation, and education for home health agencies related to palliative care. Following guidelines set by the Joint Commission, all UPMC home health and hospice agencies and UPMC Palliative and Supportive Institute are working to make sure every home health agency in the system meets compliance regulations and offers the same services, including nursing, clergy, physician oversight, interdisciplinary team meetings, and clinical care and social worker drifts. Ultimately, all nurses will have training by the End of Life Nursing Education Consortium (ELNEC). And quality of care will also be ensured by making it easy for physicians to communicate, collaborate and get weekly updates on patients through the electronic health record system.
Remote Monitoring
Between 40 to 50 UPMC Health Plan patients are taking part in the AIC’s remote-monitoring program. Three times a week, a nurse calls the patient’s home to touch base, offer support, and ask questions to catch problems before they become emergencies. Health Plan patients who are enrolled in AIC can also be set up with remote monitoring through an electronic tablet. The tablet prompts the patient to respond to a series of symptoms questions that, when out of control, provide an alert to the RN/MSN care managers. The Care Managers can face-time the patient and provide a real time assessment and, if needed, can send out the CRNP or a nurse for further assessment. This reassures the patient, can provide instructions in real time, and prevents ER visits and potential avoidable hospitalizations.

Remote monitoring can be customized to the individual needs of each patient. This innovative use of technology facilitates pain and symptom management and helps to determine the specific clinical care needed in a more timely and efficient manner.

“Once we get you home and settled, we get back in there — reinforcing conversations about how we can help you stay home, helping with pain management, and helping your family to understand what you want.”

Cindy Wilson
Senior Director,
Community-Based Supportive Services

The Crucial Role of Nurse Practitioners in Palliative Care

Our Nurse Practitioners have specific training through UPMC PSI to handle difficult conversations, deliver pain management, and educate individuals about their options. They can write prescriptions, order diagnostic testing, and work with the patient’s primary care physician to coordinate care, often communicating through the patients’ shared electronic records. Nurse Practitioners develop relationships with patients that allow them to detect changes in both physical and emotional conditions. It is care that is patient-centered at the highest level.
A Compassionate Guide for Trip and Beth Levis

Trip Levis, 56, was diagnosed with leukemia and had a stem cell transplant several years ago. However, he is now suffering from the long-term effects of the transplant, including graft-versus-host disease, in which donor cells attack the patient’s own tissues. He has been in and out of the hospital more times than his wife, Beth, can count over the past year.

Trip was identified as somebody who has been frequently hospitalized and who could benefit from palliative services as a UPMC Health Plan member. Gretchen Herda, a nurse practitioner with Community Supportive Services, called Beth to set up an appointment to explain how their various services can help Trip. This was the first that Beth had heard of these programs, and she has found the help to be critical to caring for her husband.

“I tell Gretchen all of the time that I don’t know what we would do without her. Her practical advice, expertise, and ability to navigate the UPMC system has been invaluable to us,” Beth said. “She has helped us in moments of acute distress; for example, coming to our house after we suspected that Trip had broken his hip and helping us to calmly and deliberately come up with a plan to get him assessed. Another time, we called her late on a Friday and she talked us through another acute problem, averting a trip to the emergency department.”

Beth wanted to give Trip the best fighting chance for recovery and a better quality of life. With Gretchen’s guidance, they decided a big part of this is caring for him at home and doing their best to keep him out of the hospital.

“When Trip was discharged from the hospital in a very weak state, with an active, serious infection, a new feeding tube, and many medications and therapies, Gretchen assisted us in getting comfortable with the new care requirements, and to streamline and adapt them as Trip’s health improved,” Beth said. “Gretchen has helped us obtain medical equipment, reach doctors for advice, access test results, and resolve us numerous times when Trip was having a particularly bad day.”

The services Trip received provided him with a highly skilled, empathetic, responsive medical professional in his home. This gave Beth and Trip access to practical advice, expertise, and help navigating the UPMC system. Gretchen helps the family achieve the goals of recovery, quality of life, and avoiding unnecessary hospitalization.

In a challenging time in her life, this has been a welcomed surprise for Beth. She and Trip were initially hesitant to have one more person in their home. But they have now built a solid partnership in caring for Trip. Gretchen helps to create this special care team that involves the patient, spouse, doctors, and other medical professionals.

“Initially, I had minimal expectations for how useful this service would be,” Beth said. “Those expectations have been blown away in practice. I am grateful at how responsive Gretchen has been. Help is always just a call or text away. I’m surprised that something so valuable comes at no direct cost to us. I hope that this extremely patient-focused care model is something we will see more of in the future for other families that need it.”

Gretchen is also grateful to be available and experienced in helping people when they need it the most.

“Trip and Beth have been trying to do this on their own for a long time, and it becomes more difficult as the circumstances become more complicated,” Gretchen said. “It’s a humbling position. I think of everybody as my own parents. How would they navigate this, and what would they need? If I could shout from a bridge, ‘we are here for you,’ I would.”

Patient Stories
Improving Our Skills. Sharing Our Knowledge.

Even though physicians receive a lot of training on their way to becoming doctors, that training does not often include how to have difficult conversations with seriously ill patients, or to identify and explain options for care to patients with chronic illness and their families. This is why the Palliative and Supportive Institute has made formal education and training a major thrust of its programming.

Several times a year, our palliative care clinicians gather from community hospitals, nursing homes, and community programs for “Updates in Palliative Care,” a multi-layered discussion on new developments in care and to share stories and best practices.

While this and other programs ensure our palliative care clinicians can’t possibly reach every patient in every setting. Yet every patient and family deserves to benefit from these skills and services.

That’s why teaching all members of our medical community to have palliative care skills is an important goal at PSI. Through quality improvement activities, easy-to-access guides, and innovative training, we aim to educate the entire UPMC system so patients can receive palliative care at every point of care — hospital, doctor’s office, nursing home, and home.

“We’re helping doctors and nurses who already have some skills to be open to trying something that may be a little different than the method they’ve been using for the last twenty years.”

Dr. Julie Childers
Associate Professor of Medicine
Medical Director of Palliative Care Services,
Presbyterian Hospital

Training
and
Education

Our
Educational
Programs

PSI has trained 1,402 clinicians in goals of care conversations.

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While this and other programs ensure our palliative staff is leading edge, we recognize that our palliative care clinicians can’t possibly reach every patient in every setting. Yet every patient and family deserves to benefit from these skills and services.

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Dr. Julie Childers
Associate Professor of Medicine
Medical Director of Palliative Care Services,
Presbyterian Hospital
Communication with patients is vital for all providers. We have invested in cardiac-specific communication training sessions for all fellows and faculty in the Cardiology division to improve our skills in discussing goals of care and end-of-life planning. To best navigate these discussions and to aid in making patient-centered decisions, faculty in the PSI and Cardiology divisions facilitate the sessions, providing both tools and safe practice for cardiology trainees to improve their communication skills. It has been highly received by all who have attended and continues on an annual basis.

Dr. Kathryn Berlacher
Assistant Professor of Medicine
Program Director, Cardiology Fellowship Program

A Physician’s Perspective on Training

Raquel Buranosky, MD, UPMC Division of General Internal Medicine understands the importance of taking PSI’s Communications Skills Training, even after years of experience treating patients.

“When we have conversations about goals of care in an inpatient setting, it’s usually one of the first discussions you have with a patient. And it’s important to develop a rapport with the patient and the family right away. But depending on the situation, it can be very overwhelming for patients who are not used to these conversations and doctors if they are not trained to have them. Even though I’ve been practicing for a long time, I jumped at the chance to take this training and improve my communication skills regarding patients facing the end of their lives. It was one of the best training models I’ve seen because it’s beneficial to both senior physicians and new residents.

With medical students, we have to make them realize that it’s not their job to simply get an answer out of patients or families about their goals of care. Rather, as physicians, we must give the patients what they need to help guide them through their thought process to get to the answer that is right for them. We’re not stopping their lives. We’re helping them finishing their lives. This training is standardized, compassionate, and scientifically proven to be effective. And it’s important for any health care provider who may be caring for a patient receiving palliative care.”

Simulated Scenarios Play a Starring Role

For doctors, delivering bad news is never easy. To help them react in a helpful and compassionate manner, UPMC developed a unique training tool for primary care physicians, hospitalists and fellows in specialty areas such as oncology, nephrology, critical care and pediatric care. It’s an intensive role-playing curriculum that can last anywhere from half a day to three days.

In the course, doctors work with simulated patients — trained actors who have been given a medical story, personality, and family dynamic. They are taught to react like patients to help clinicians learn to respond to strong emotions and tough questions. Working in small groups with a facilitator, the doctors learn to respond empathetically to patients who may be having a strong emotional reaction to bad news. In addition, clinicians learn how to talk about a patient’s prognosis, discuss what is most important to patients should the illness progress, and talk about topics ranging from hospice to spirituality. The group then discusses the encounters, and the facilitator offers feedback and approaches that might work better.

As one of the top hospice and palliative medicine training programs in the country, UPMC Palliative and Supportive Institute’s communication training is strong and an on-going priority. Our aim is to spread our model to other institutions about how to teach these critical skills.

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Staying Up To Date

Three times a year, palliative care specialists from across the spectrum in PSI meet for half a day to learn about updates in the field. With representatives from about eighty providers, ranging as far afield as UPMC Hamot, Northwest, McKeesport and Passavant, these sessions improve knowledge and awareness of new treatments and strategies. For example, one session discussed complementary and alternative medicine strategies — how to talk to patients about these interventions and understand how they can be helpful.

Learning How To Have Those Most Difficult Conversations

While palliative care specialists have specific training on how to talk about difficult topics such as bad news and goals of care, most other members of a patient’s medical team have not had the benefit of training. UPMC PSI received a grant for an initiative to train physicians, nurse practitioners and physician assistants on how to have conversations about advance care planning and goals of care with patients who have a serious illness or limited prognosis.

The idea is to help all providers develop the communications skills to initiate this difficult but important conversation with patients and family members. For example, a primary care physician who is seeing an elderly patient with advanced lung or heart disease is being trained to talk about advanced directives and help the family consider “what if” scenarios. Inpatient physicians who are seeing seriously ill patients are learning to discuss goals of care, use a shared decision making process, and arrive at medical decisions that make sense for the patient.

In this way, palliative care discussions aren’t limited to the reach of the palliative care team. UPMC’s vision is to train everyone on how to have a conversation with a patient about difficult topics.

Meeting regularly to learn and share
Training everyone to communicate about difficult health situations
Putting information in easy reach

| Educational Highlights |
The Value of Training to Community Physicians

Dr. Victor Colaiaco, Internal Medicine, UPMC Horizon always thought of himself as a good communicator with patients, and had a reputation as one. But he discovered there was room to improve those skills by taking advantage of PSI’s joint learning collaborative with UPMC Health Plan.

“I learned right away that I wasn’t as good as I thought,” Dr. Colaiaco remembers. “I quickly found ways to improve my skills when it comes to sharing bad news with a patient, helping them deal with all the emotions that come with those conversations, and learning to deal with conflict among family members.”

PSI offers two kinds of training. One is for physicians and one is to be a trainer of other physicians. Dr. Colaiaco participated in both. Both training programs involve role-playing with highly trained actors, that are always called patients. A participant gets a brief history of the patient and the family, and then practices discussing end-of-life care and sharing bad news. The doctor then gets feedback from the group and has a chance to brainstorm about how to deal with these difficult situations. The training is very realistic and it replicates real situations.

Communication Training for ICU Nurses:

In order to improve communication and end-of-life care in the ICUs in our hospital system, we have trained 17 nurses, to date, to be communication teachers in a new ICU Communication Training program for nurses. The goal of this program is to train all ICU nurses at UPMC on the skills of having difficult conversations, helping families explore their loved ones’ wishes, and attending to emotions of families of patients in our ICUs. With their new communication skills, ICU nurses are able to guide family meetings in our new program of regular family meetings for all patients in the ICU for more than four days. These nurse communication teachers taught a total of 156 courses, training 771 nurses. The nursing administration has been so impressed by this course they are planning on requiring it for all ICU nurses.

Communication Training for Non-PSI Providers*

588 clinicians trained
50 training sessions
175 internists
127 family physicians
42 oncologists
87 hospitalists
37 critical care physicians
120 clinicians from a variety of other specialties

*Over two-year period

“This training is an excellent way for physicians to improve their communication skills when it comes to delivering difficult news. This helps the patients, of course, but it also makes your professional practice more satisfying because that relationship with the patient is improved.”

Dr. Victor Colaiaco
Geriatrician
UPMC Horizon and UPMC Passavant

"
Every patient and family deserves to have skilled people who can respond to the emotional challenges of a serious illness and help in managing the symptoms.

“A Cardiology Fellow’s Reflections on Palliative Communication Training

As physicians we go through years of rigorous training to have the honor of fighting the uphill battle we call disease. Although most of us begin this path out of the desire to do good, we at times forget the human aspects of medicine. We begin to see everything in terms of clinical signs, symptoms, lab results, and imaging studies. Objectivity is what we are trained to strive for after all. However, physicians early in their careers should know that this doesn’t mean we can’t be human.

CardioTalks was an amazing experience for me as a fellow in training. We see raw emotion as we all attempt to deliver bad news to a grieving family member and observe how we all approach it in our own different ways. This is an eye opening experience. We explored several difficult scenarios and with the guidance of experts we de-constructed every aspect of the encounter. Just like any procedure, things may not go your way and you will need to improvise. After finishing CardioTalks, it’s safe to say that many of us felt much more confident about dealing with the difficult communication aspects of care.

Dr. Mourad H. Senussi
Cardiovascular Disease Fellow
University of Pittsburgh Medical Center

Starting The Conversation Early — at an Annual Exam

An annual check-up for a Medicare patient is an ideal time for a primary care physician to initiate a discussion on advanced care planning. UPMC has a new initiative to teach all of our primary care practices to ask elderly Medicare patients important questions, such as if they have a living will and who they would trust to speak for them in case they get sick.

Advanced Care Planning Learning Collaborative

In the past year, PSI, UPMC Health Plan and six primary care practices in Allegheny County participated in the Advance Care Planning Learning Collaborative. The goal was to develop quality improvement standards designed to assist primary care practices in implementing advance care planning conversations into their practices. This is part of the larger effort to make sure that palliative care conversations are taking place whenever or wherever a patient needs them to happen, not just when a palliative specialist is involved. The concern is, if palliative experts are the only ones having advanced care planning conversations with patients, they won’t happen as often as they should.

Results of the collaborative are encouraging with advanced care planning conversations jumping from 12% of patients at the beginning of the nine-month project to 44% of patients within the primary care practices.

Using Art as a Window Into Palliative Care

One of the more innovative activities developed by PSI is a focus on humanities in medicine. Through this program, we bring a work of art into a hospital and ask the medical staff to reflect on what they’re observing and how it relates to palliative care. For example, a recent painting was of Icarus falling into the ocean. The audience reflected on suffering and the obligations of those who witness the suffering.

Making More Information More Accessible

UPMC PSI publishes an annual Symptom Guide that includes palliative care protocols for dealing with pain, nausea, breathlessness, delirium and spiritual questions. Readily available for anyone with UPMC Infonet access, the guide empowers and enables physicians at every level to provide primary palliative care.

Another publication, called Phast Phacts, is a weekly electronic newsletter sent to all the palliative care providers in the network, providing facts on the role of different medications and therapies in palliative care.

A community of care and compassion

Dr. Richard L. Weinberg
Clinical Associate Professor of Medicine
Associate Medical Director for Community Palliative Care
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Accomplishing Great Things

At UPMC Palliative and Supportive Institute, we pride ourselves on our innovative culture and collaborative spirit. While teamwork is important, we also have many individuals who have been recognized both nationally and internationally for their accomplishments. Through grants and awards for research and projects, these forward-thinking people are fueling the development of process improvements, new programs and original thinking to advance palliative care at UPMC and the broader medical community.

Most people are really grateful for palliative care because they feel they have been heard and their wishes are respected.

Elana Gonzalez, MSW, LCSW, OSWC
Senior Medical Social Worker
Our Leadership

PSI Administrative Leadership:

Robert M. Arnold, MD
Medical Director
Deborah S. Brodine, MHA, MBA
President, UPMC Community Provider Services
Chair, PSI Advisory Council
Mary Ann Sander, MHA, MBA, NHA
Vice President, Aging and Disability Services
Cynthia L. Wilson
Senior Director, Community Based Supportive Services
Kimberly L. Gottschalk, MBA
Director, Inpatient and Outpatient Palliative Care Services
Susan Saxon, CRNP
Director, Community and Home Based Palliative Care Services
Janet Leahy, CRNP
Supervisor, APP: Inpatient and Outpatient Palliative Care Services
Richard L. Weinberg, MD
Supportive and Palliative Care Consultant
Mamta Bhatnagar, MD
Medical Director, Community Based Palliative Care Services
Anita Lyons, MD
Medical Director, Home Based Palliative Care Services

Palliative Care Physicians:

Robert M. Arnold, MD
Distinguished Service Professor of Medicine
Chief, Section of Palliative Care and Medical Ethics
Anwar Bansal, MD
Assistant Professor of Medicine
Mamta Bhatnagar, MD
Clinical Assistant Professor of Medicine
Medical Director, UPMC Shadyside Palliative Care Clinical Services
Julie Childers, MD
Associate Professor of Medicine
Director, Communication Skills Training
Medical Director, UPMC Presbyterian Palliative Care Clinical Services
Rene Claxton, MD
Associate Professor of Medicine
Hospice and Palliative Medicine Fellowship Director
Helen Dorra, MD
Medical Director, UPMC East and UPMC McKeesport Palliative Care Clinical Services
Geoffrey Dunn, MD
Medical Director, UPMC Hamot Palliative Care Clinical Services
Scott Freeman, MD
Clinical Assistant Professor of Medicine
Richard Hoffmaster, MD
Medical Director, UPMC St. Margaret Palliative Care Clinical Services
Linda King, MD
Assistant Professor of Medicine
Associate Chief, Section of Palliative Care and Medical Ethics
Melanie Robbins-Ong, MD
Clinical Assistant Professor of Medicine
Lisa Podgurski, MD
Clinical Assistant Professor of Medicine
Medical Director, Magee-Womens Hospital of UPMC Palliative Care Clinical Services
Eva Reitschuler-Cross, MD
Assistant Professor of Medicine
Rebecca Sands, DO
Clinical Assistant Professor of Medicine
Assistant, Hospice and Palliative Medicine Fellowship Program
Jane Schell, MD
Assistant Professor of Medicine
Andrew Thurston, MD
Clinical Assistant Professor of Medicine
Medical Director, UPMC Mercy Palliative Care Clinical Services
Richard Weinberg, MD
Clinical Associate Professor of Medicine
Dr. Syeda S. Zaidi
Medical Director, UPMC Passavant Palliative Care Clinical Services

Palliative Care Research Faculty Members:

Yael Schenker, MD
Associate Professor of Medicine
Director, Palliative Care Research
Dio Kavalieratos, PhD
Assistant Professor of Medicine
Director of Implementation Research,
UPMC Palliative and Supportive Institute
Associate Director, Palliative Care Research
Jessica Merlin, MD, MBA, PhD
Associate Professor of Medicine
Robert M. Arnold, MD
2016 Health Care Hero Award by the Pittsburgh Business Times.

The individuals and organizations selected for this honor include those who have made significant contributions to improving health care in our region.

Distinguished Service Professor.

This designation recognizes distinctive contributions and outstanding service to the University community in support of its multifaceted teaching/research/service mission, as well as performance excellence in the faculty member’s department or school and national stature in his or her discipline or field.

Patricia Price Browne Prize in Biomedical Ethics, an award presented by the University of Oklahoma College of Medicine. The $10,000 prize, awarded every two years, was established to honor Oklahoma City community leader Patricia Price Browne by selecting an individual who “demonstrates the highest standards in the medical or professional ethics fields.” The award was presented on June 21, 2017 during the College of Medicine’s Pediatric Grand Rounds.

Julie Childers, MD
2016 Fellow of the American Academy of Hospice and Palliative Medicine (FAAHPM).

Advancement to fellowship status within the Academy honors dedication to and scholarship in the field of hospice and palliative medicine.

This distinction represents a minimum of 5 years of membership, participation in FAAHPM activities, letters of recommendation, and board certification in hospice and palliative medicine. New Fellows received their designation during the Annual Assembly in Phoenix, AZ on February 25, 2017.

Eva Reitschuler-Cross, MD
William I. Cohen Award for Excellence in Clinical Skills Instruction.

This award recognizes faculty who consistently provide outstanding clinical skills instruction for first and second year University of Pittsburgh School of Medicine students.

Jennifer Pruskowski, PharmD, BCPS, BCGP, CPE
Assistant Professor, University of Pittsburgh School of Pharmacy, Department of Pharmacy and Therapeutics

Jenn’s session “Deprescribing — the Who, What, When, Why, and How” presented at the 2017 Annual Assembly of the American Academy of Hospice and Palliative Medicine (AHAHPM) was selected as one of the “Best of” Annual Assembly recordings. This selection was based on the evaluations of learners, the number of learners, and the relevance of the content to key needs in the field.

Edward Lewis
Spiritual/Bereavement Specialist

Awards for Commitment and Excellence in Service (ACES). Ed was one of only 251 employees chosen system-wide for this honor. A celebration was held for all ACES recipients on October 22, 2016.

Laura Tycon, CRNP, was selected as the recipient of a 2016 Hospice and Palliative Nursing Foundation’s Clinical Practice Forum Conference Scholarship award.
Our research in palliative care has many different prongs, but the goal is always the same — to understand and improve the provision of palliative care.

Some of our researchers are studying why people might not be receptive to palliative care. For example, how do we overcome problems that exist with perception or language and cultural barriers?

Currently, our major research is focusing on how to effectively provide primary palliative care. This research is in oncology, as well as other serious illnesses like cystic fibrosis and heart failure. We want to learn how to better help these patients get palliative care to relieve their pain, anxiety or depression. We’re asking questions and studying new ways to improve their quality of life.

“Palliative care is an integral part of high quality oncology care, and we are working hard to identify, develop and test effective models to ensure that it’s available to all patients.”

Dr. Yael Schenker
Associate Professor and Director of Palliative Care Research

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In CONNECT, nurses ask patients open-ended questions about what’s important to them beyond the cancer therapy. Patients have really opened up. They’ve had a lot to say. It can happen alongside a focus on treatment.

Dr. Yael Schenker
Associate Professor and Director of Palliative Care Research

Can Oncology Nurses Play a Bigger Role in Palliative Care?

The CONNECT Project. Funded by the National Cancer Institute, CONNECT is a cluster randomized trial of a primary palliative care intervention currently underway at UPMC oncology practices. The study is training oncology nurses at half of these practices to provide primary palliative care, including symptom assessment and management, emotional support, advance care planning, and care coordination — without relying on palliative care specialists. The other half of the practices serve as a control group.

The trained nurses meet with patients before or after their regularly scheduled oncology clinic visits. Patients report their experiences using a symptom assessment scale and a distress thermometer. Together, they create a shared plan to increase patient and family involvement in their care. The nurses then provide feedback to the oncologists. The study is assessing whether these primary palliative care visits improve patient quality of life.

The tool lets patients report their experience using a symptom assessment scale and a distress thermometer. The standardized questions are designed to measure quality of life and help us discern whether the intervention can improve it in patients with advanced cancer.

Better Communication for Better Care

In a health system as large as UPMC, how do you make sure a patient’s palliative care wishes are understood and followed throughout their care? PSI developed a communication system that allows us to make electronic notes, so physicians and nurses at each step are able to see our treatment plans, recommendations, and patient preferences. We also developed an email alert system to let palliative care specialists at different sites know when a patient is leaving the hospital and going to a long-term care facility. This creates a “warm hand-off” between locations, and makes sure patients don’t get lost in the system.

Studying Meds

UPMC Palliative and Supportive Institute has a strong pharmacy component that looks at the rational use of medications in seriously ill patients. Research projects are studying, retrospectively, how medication usage dictates patient-oriented outcomes. We’re also looking at how drugs are delivered into the body, how well they work, and what administrative burdens they might add or relieve.

Research Highlights

- Evaluating nurse-led interventions in CONNECT
- Studying the use of medications to align with quality of life
- Focusing on educational interventions to improve communication in partnership with The Wolff Center at UPMC
Deprescribing is an interdisciplinary process that involves input from the patient, family, clinical pharmacist, physician, social worker, and clergy. Our goal is to reduce unnecessary burdens on the patients, family, and caregivers to administer drugs that no longer improve quality of life.

Jennifer Pruskowski, PharmD, BCPS, BCGP, CPE
Assistant Professor, University of Pittsburgh School of Pharmacy, Department of Pharmacy and Therapeutics
One Researcher’s Unique Opportunity

Dio Kavalieratos

Ph.D. Assistant Professor of Medicine, Section of Palliative Care and Medical Ethics, and Director of Implementation Research, UPMC Palliative and Supportive Institute, has been doing palliative care research for about ten years. In high school, his father died of cancer. And while going through that, he saw how important hospice care was, although he thought it was implemented too late. He realized that his family’s experience could have been better, and entered into research that looks to improve the ways health care systems treat patients with serious illnesses.

“I wanted to do my research at UPMC,” Kavalieratos said. “There really aren’t that many places in the country that have this strong of a palliative program. Plus, we have this unique partnership with the University of Pittsburgh, the health system, and the health plan. And given how much palliative care we deliver, it is the ideal environment for a researcher like me who wanted to look at real life palliative care scenarios. I get to work alongside clinicians and administrators to investigate how we care for patients and their families.”

Kavalieratos realizes that as a researcher, he has a unique opportunity to advance his research.

“Ph.D.s like myself are usually in schools of public health and they do their research from the sidelines,” Kavalieratos said. “What’s great about my role is that I get to roll up my sleeves and intimately evaluate how health care is delivered in real time. In the next year, there are a number of projects to improve how clinicians talk to patients about their goals and what matters the most to them in customizing their health care to reflect their values. There are a number of other projects we have involving training clinicians to better identify and treat symptoms and to have discussions about the treatment with patients. It’s a rare opportunity to be part of the clinical enterprise.”

But the interaction with clinicians is only one of the advantages Kavalieratos enjoys here.

“PSI has had such a strong palliative care program for so many years, it’s truly changed the culture of UPMC from top to bottom. We’re seeing residents and fellows in medical school being trained in palliative care topics. So the next generation of clinicians are much more open to delivering this kind of care and working with palliative specialists. PSI is leading the charge in this culture change and palliative care to becoming imbedded throughout the system.”

“I don’t think of ideas in abstract. I get to interact with clinicians and pick their brains about improving care. Often these discussions help me develop a research study based on what’s going on at the front lines of palliative care. It’s real time research informed by clinicians and their patients.”
Growing Stronger Together

The need for more and better palliative care stretches beyond our hospitals, clinics and staff. We can’t go it alone. That’s why we’re joining forces with partners throughout the region. Our relationships with existing organizations that align with our goals are having a real, positive impact on the delivery of more consistent and standardized palliative care.

“We’re providing a seamless continuum of care within UPMC. Our partnership helps UPMC provide the right level of care in the right setting for seriously ill patients and their families.”

Dr. Keith Lagnese
Chief Medical Officer at UPMC’s Family Hospice and Palliative Care

Our Partners

Growing Stronger Together
The Coalition for Quality at the End of Life (CQEL) has championed the implementation of Pennsylvania Orders for Life-Sustaining Treatment (POLST) for many years. CQEL has frequently collaborated with PSI in training and to advance the appropriate and effective use of POLST utilizing the expertise of the PSI team. CQEL is a communication resource to PSI in regard to the national, state and local status of POLST and particularly the status of potential POLST legislation recently introduced in both the Pennsylvania House and Senate. One outcome is that PSI has been able to follow up with legislators in a timely manner to express its support of such legislation. Passage of this legislation will remove barriers to greater recognition and acceptance of POLST and can result in more individuals’ wishes being respected at the end of life.

Marian Kemp
Pennsylvania POLST Coordinator
Coalition for Quality at the End of Life

Improving End of Life Care
Coalition for Quality at End of Life

UPMC is an active participant in the Coalition for Quality at the End of Life (CQEL). The coalition is comprised of leading health systems, providers, insurers, citizen groups, government agencies, and other organizations concerned about the quality of care that is available to seriously ill and dying people and their families in western Pennsylvania. The coalition was founded over a decade ago by Dr. Robert Arnold, Medical Director of PSI, Nancy Zionts, Chief Program Officer of the Jewish Healthcare Foundation (JHF), and Dr. Judith Black who was Medical Director, Senior Markets at Highmark at the time and is now physician advisor to JHF. Today about forty organizations including UPMC Health Plan, Family Hospice, Highmark, and United Health Care Optum participate in CQEL and meet three to four times a year. CQEL members share information and discuss ways to engage the community in better end of life care, build capacity for the delivery of skilled and compassionate care, focus attention on regulatory and financial barriers to quality end of life care, and on how to promote appropriate standards and measures.

One of the group’s objectives has been to increase the awareness and use of the Pennsylvania Orders for Life-Sustaining Treatment (POLST). The POLST form is a document that converts a patient’s end of life treatment preferences into medical orders that follow the patient across care settings. The POLST is not for everyone and is offered to those who have advanced illness, “those for whom you would not be surprised if they died within the next year.”

A major accomplishment of CQEL has been the development of the POLST training program which has been presented numerous times across the state to train health care professionals of all disciplines in the POLST process and on how to have effective goals of care conversations.

Another accomplishment has been the ability of CQEL members to work across competitive lines to promote advance care planning, POLST, and palliative care throughout the state. The PSI has been a vital partner advancing our work on POLST both at the regional and state level and has done so much to advance the high quality goals of care conversations under Dr. Arnold’s leadership.

Dr. Judy Black

“...result in more individuals’ wishes being respected at the end of life...”

“...has done so much to advance the high quality goals of care conversations under Dr. Arnold’s leadership...”

The PSI has been a vital partner advancing our work on POLST...
Ninety percent of people say they know advance planning is important, but only 30% have actually done it. Our aim is to improve those numbers.

Amy Kowinsky
Improvement Specialist, at the Wolff Center at UPMC

Relying on a Great Resource
The Aging Institute of UPMC

PSI collaborates with the Aging Institute to share information and develop programs and resources for older adults and their caregivers. Staffed with renowned researchers, scholars and clinicians, the Aging Institute is an excellent resource on geriatric care, including what is the latest thinking and where caregivers can turn for help. We often refer seniors, their families, caregivers and medical professionals to the Aging Institute to learn more about everything from advanced planning and chronic care coordination to dementia, respite, grief, and loss.

The RAVEN Initiative
Working with Medicare to Bring More Care Into Nursing Facilities

If you’re a nursing facility resident, getting sent to the hospital can be distressing. This is why the Palliative and Supportive Institute has supported the Aging Institute’s participation in the CMS demonstration project locally called RAVEN (Reduce AVoidable hospitalizations using Evidence based interventions for Nursing facilities in Pennsylvania).

During the initial four-year funding period (2012-2016), Medicare’s independent evaluator reported a positive impact from RAVEN. Avoidable hospitalizations, all-cause hospitalizations and ED visits were reduced, which has led to a second phase of funding for the project.

As our participation in RAVEN continues, we are working with more nursing facilities in Pennsylvania. The project is currently testing the effects of a new payment model that provides reimbursement to skilled nursing facilities and practitioners for the onsite treatment of six specific conditions (pneumonia, congestive heart failure, COPD/asthma, skin ulcers/cellulitis, dehydration, and urinary tract infection) that account for the majority of potentially avoidable hospitalizations of nursing home residents.

The objective is to test whether payment structures can incentivize behavior among skilled nursing practitioners that will enhance care onsite and reduce avoidable hospitalizations.

The initiative is ongoing. Today, UPMC has monthly calls with partner facilities to provide administrative updates and encourage the sharing of best practices, cultivating a learning community among nursing facilities.

Success In Avoiding Unnecessary Hospitalizations From Patients at Skilled Nursing Facilities

• Changing facility culture toward treating residents in-place
• Empowering facility staff by improving skills and confidence
• Hiring dedicated and effective staff
• Providing strong organizational support for nurses

“Ninety percent of people say they know advance planning is important, but only 30% have actually done it. Our aim is to improve those numbers.”

April L. Kane
MSW, LSW, RAVEN Co-Director
Testing Out New Ideas

The Wolff Center at UPMC

The experts at the UPMC Palliative and Supportive Institute are constantly thinking up new ways to improve palliative care and get the word out to the community at large. For help in testing and implementing the ideas, we often turn to The Wolff Center at UPMC, our corporate engine for quality. One successful program that has come out of the collaboration is The Day of Conversation, an annual event designed to educate communities, hospital employees, and patients about the importance of advanced care planning.

The Wolff Center also helped us put together a Palliative Education Day for hospitals through the UPMC system. A group from the Institute worked with teams at each hospital on a project designed to educate and engage hospital staff.

UPMC Palliative and Supportive Institute and The Wolff Center have been key collaborators with the Department of Critical Care Medicine to develop and implement a highly effective strategy to support patients and families in ten UPMC ICUs. The program, called the PARTNER program, involves deploying a structured family support pathway and training nurse leaders in each ICU in advanced communication skills regarding supporting families. This program is an example of what can happen when we fully engage the entire interdisciplinary team of clinicians to support patients and families,” said Dr. Douglas Whra, the project lead and UPMC Endowed Professor of Critical Care Medicine. The results of the initiative have been overwhelmingly positive in terms of families’ ratings of the quality of care and decreased health care costs.

The creation of a hospice liaison is another idea that was piloted at UPMC Hamot and is now being tested at UPMC Mercy. This liaison is a nurse or a social worker who takes care of all the tasks involved in making hospice arrangements for patients, creating a fast track for those who have decided to go into hospice and providing them quickly with all the information they need. The goal is to develop a model for this role for all UPMC hospitals.

Working Through Complexities

At UPMC Hamot, the desire to improve the patient’s experience for those moving from the hospital to hospice is being addressed collaboratively by the Palliative and Supportive Institute, the liaisons for home healthcare and hospice under hospital care management, the Wolff Center, and Great Lakes Home Healthcare and Hospice. Hamot was considered a “pilot UPMC hospital” for these purposes, and for the Erie-team representative, of the complexities and limitations associated with these transitions.

Poor understanding of the hospice benefit and of the options available on the part of patients and families often resulted in delayed discharges to home or to a more residential setting. The same factors also contributed to frequent readmissions to the hospital, an avoidable disruption for these seriously ill patients.

Together, these four entities identified a streamlined clinical data set and work flow process to ensure patient safety in these transitions. Additionally, automated hand-off to hospice agencies of clinical data for those discharges was instituted, as well as standardized capture of all hospice patients at each level of care.

These efforts resulted in an improved patient experience, better service to the hospital in terms of consolidated and consistent data, and increased, appropriate utilization of hospice. Qualitatively, this initiative fostered learning about the complexities of patients who desire hospice but cannot go home. PSI continues to collaborate with the Wolff Center, hospital care management and hospice care providers across the continuum to address these circumstances.
Collaborating with the Health Policy Institute

The University of Pittsburgh’s Health Policy Institute (HPI) supports the work of a health economist to collaborate with PSI to try to build the business case for palliative and supportive services. Julia Driessen Ph.D., Assistant Professor of Health Policy and Management in the Graduate School of Public Health at The University of Pittsburgh has worked very closely with PSI in designing demonstrations that will advance public policy around the recognition of the value of palliative care, and also the economic arguments for why it makes sense for the health care system to move in that direction. These health economics resources are provided to PSI to bring HPI’s analytical support and methodological rigor to bear for palliative and hospice care research.

Everette James, JD, MBA, Director of the Health Policy Institute and Executive Director of the Stern Center for Evidence-Based Policy has championed HPI’s support of palliative issues and Dr. Driessen’s participation with PSI initiatives. “There are not a lot of health economists who truly understand long-term, palliative, and hospice care,” James said. “Dr. Driessen does. She was selected for the prestigious national Health and Aging Policy Fellows Program; and the partnership with community provider services and PSI gives her a wonderful opportunity to do applied research.”

Dr. Driessen is also exploring how the Medicare Hospice Benefit would be configured if carved into Medicare Advantage. She is working as a Health and Aging Policy Fellow with the National Hospice and Palliative Care Organization (NHPCO) on a potential framework for a Hospice Carve-in demonstration among a few Medicare Advantage plans, which UPMC supports.

To that end, UPMC Health Plan has introduced Dr. Driessen to multiple health plans as well as trade associations so they can share feedback on a potential demonstration and how rates, risk adjustment, and benefit structure would be configured.

Going forward, The University of Pittsburgh’s Health Policy Institute will continue to look for potential areas of focus and collaboration with PSI as evidence is gathered about the needs of the region.

“Each year UPMC hosts a Day of Conversation to discuss the often difficult subject of advance care planning. Last year the focus of the Day of Conversation was on UPMC employees who are also caregivers. We teamed up with the UPMC Caregivers Team called HALO (Helping Aging Loved Ones) to attend several caregiver resource fairs where we could talk one-on-one with caregivers about the importance of advance care planning. These conversations proved to be extremely valuable for everyone we talked to, because we were able to share precisely the information they needed, right when they needed it.”

Amy Kowinsky
Improvement Specialist
at the Wolff Center at UPMC
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