

Summa Health System's Palliative Care and Hospice Services Building palliative care pathways through an integrated health system

Akron, Ohio, is a two-health-system community. When its largest and oldest freestanding hospice joined one of the city's two hospitals in 1998, AAHPM member Steven Radwany, MD FACP FAAHPM, was spurred to start a new hospice program in the Summa Health System. As Radwany began this process, he and his early partners sought to integrate hospice with Summa's other services and improve cross-sector communication. Sixteen years later, this



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initial vision has resulted in an uncommon level of coverage and connectivity of hospice and palliative care across the vast majority of service lines in a large, integrated health system. Radwany spoke with AAHPM to discuss how he and others helped build [Summa's Palliative Care and Hospice Services](#).

What is it that makes Summa's Palliative Care and Hospice Services innovative?

SR: There's no single component that's unique; it's their presence in combination that I hope is the wave of the future. We have consult services at five hospitals, two palliative care units, palliative care clinics, a consult service within an ambulatory oncology center, a nursing home consult program, a home-based palliative care program in cooperation with our insurer, a pediatric-to-adult palliative care transitions program, a hospice program and even international ties in Kenya and Hungary — all as part of Summa's integrated delivery system. Our team has also provided leadership for the System's Ethics Committee as it worked to bring [Schwartz Center Rounds](#)[®] to Summa and as it established a community-wide advance care planning collaborative.

Does comprehensive community-based palliative care require an integrated system?

SR: We're fortunate in that we operate within a multi-hospital system with many types of services which need hospice and palliative medicine integration, but no — you don't need that. Free-standing programs have been very creative in reaching out to and partnering with hospital systems, creating virtual integrated systems that bridge gaps in palliative care.

What was the motivation behind the program's creation and what were some things you had to do early on to secure institutional support for building and scaling it?

SR: The medical, moral and economic justifications for an integrated hospice program were fairly easy. The case for inpatient palliative care was initially made when, 14 years ago, our hospital — emergency department found itself closed to new ambulance traffic for hours and days at a time mainly because ICU beds were full. When the hospital administration looked at length of stay in the ICU they found a couple hundred patients who were in ICU beds for more than two weeks and then died. The hospital lost something like \$2 million real dollars annually on those cases alone. The critical care physicians who reviewed these patients' charts felt that their terminal prognosis was clear early in the hospitalization, yet saw no efforts to move patients toward a more appropriate setting or to support the patients and families as they neared the end of life. Where our own advocacy had been having little impact for several years, the clouds suddenly parted and resistance disappeared.

At the same time, our then-administrative director, John Mastrojohn, RN MSN MBA, organized a day-long Appreciative Inquiry Summit. We gathered all the interested constituencies — senior leaders from the health system, nursing and physician leaders, interested community members, board members, providers from the community, clergy — to do a visioning exercise. We started from first principles and let this group identify and build

on the System's strengths to create consensus and a broad outline of what an inpatient palliative care service would look like, starting at our highest acuity hospital. This vision held true and was then greatly expanded upon with subsequent efforts.

What drove the initial institutional support?

SR: We were all committed to providing the best care possible for the System's neediest patients and families, those trying to cope with serious or terminal illness. Our CEO gets it and is a vocal supporter of that mission. But, administrators like to say, "No margin, no mission," and we knew their buy-in would come after we were able to make the financial case for the program. That's a key takeaway – in order to sell these concepts, we identified the levers that would work based on the constituency that we were trying to persuade. We made a certain case to administrators, a certain case to oncologists and a certain case to people actually practicing intensive care. We made a different case to nursing home administrators and medical directors. You need to tell your audience how you are specifically going to help and support their work by providing the best care for patients and families.

Has your team been embraced across all of Summa's service lines, care settings, and facets of administration?

SR: We're viewed positively by the system, and we've had good support at the executive level, though some were skeptical at first. The view from other specialties has also changed over time. I can remember when I first began showing up at tumor board years back, for example, and the facilitator asked what I was doing there. Now, they expect a member of our team to be present and to participate. That's just one small indicator of how the culture can change when you make yourself visible and available, when you take a cooperative posture. With time and experience, people begin to understand the impact you can have on patients and families. As a case in point, we use palliative care order sets which have been developed with and accepted by critical care, emergency medicine, oncology and general medicine.

Palliative care's contribution to value doesn't necessarily translate into revenue. How heavily is your program subsidized?

SR: I'll tell you, the funding for our program is incredibly complex and remains a challenge. We receive support from Summa's Medical Education department for faculty salaries through our [fellowship program](#). We receive support from participating hospitals with whom we have contracts to provide palliative care services. We have partnered with our system's insurance company, SummaCare, to develop a home-based palliative care program. And then we have professional fees generated through patient encounters in our palliative care and hospice programs. Hospice per diem payments provide support for medical director roles and functions as well. In the end, professional fees comprise only 40 to 50 percent of what's needed to support the program.

Similar programs elsewhere rely very heavily on philanthropic support. Is your ability to find other funding streams another benefit of being a part of an integrated system?

SR: Absolutely, and each little piece of the program is supported differently. When you crunch the numbers for, say, the palliative care consultation services in nursing homes, the downstream referrals to the hospice program easily support the consult service. In addition, there's the intangible benefit of having a presence that allows us to provide expertise and support in so many nursing homes. We have philanthropic support, but it's not programmatic. It's used to support new initiatives, education and capital projects, such as our first Acute Palliative Care Unit, which we built eight years ago.

What benefits do you see in system-wide diffusion of palliative care?

SR: The whole point is to manage populations by keeping people in their homes and preventing unnecessary hospital and ED visits, because bad things will happen there. The closer to home and the more independent you can keep people, the better off they will be. So, if we can provide a network of services that helps to support

people so that they don't have to go to the hospital, they're happier, health care providers are happier and, when it becomes time for hospice, all parties are better prepared.

Have you been able to look at globalized data and tie cost savings or quality improvement to the work you are doing?

SR: Frankly, it's very hard and labor intensive. We did two studies of the [downstream impact](#) just of our palliative care unit and demonstrated an [\\$848,000 annual benefit](#) in terms of cost savings. The difficulty of doing that analysis underscores why it's so important to share information, and it explains why we fall back so often on [previous work](#) demonstrating cost savings on inpatient consults for Medicare and Medicaid patients. Our financial leaders have bought that model, but it's helped that we've done internal studies that show the value of a palliative care unit. That's a project not everybody has the resources to undertake.

What challenges did you face when you were working to build this program, and what challenges do you continue to face?

SR: Initial challenges included finding time, funding, support and talent. When we started 13 years ago, there were very few people committed to getting a hospital-based palliative care program going, but I was fortunate to partner with a very effective nurse practitioner, Hallie Mason, who has skill as a clinician-educator and advocate for our inpatient program. Our hospice leadership has also been very strong, first with John Mastrojohn and now Kim Kousaie, RN BSN CHPA. It seems like every time we needed to start a new program, we found a talented, committed person to get it going. After finding the right people, the challenge is striking a balance among staffing, opportunity, freedom and support to make something happen.

On an ongoing basis, there are always financial challenges. We've built a program for tomorrow's prospective payment system, yet we have to survive in today's mostly fee-for-service environment. Now, in the case of the palliative care service, we've gotten used to making the case for the downstream benefit to the hospital. When you're working in the outpatient arena, you're looking for a different kind of justification for different partners. To maintain palliative care's financial viability in other settings, we partnered with our insurer and are working to create a viable partnership with Summa's accountable care organization in order to keep our feet firmly in both worlds during this transitional period.

Do you have advice for colleagues looking to start a comprehensive community-based palliative care service?

SR: You have to begin by identifying a need you perceive as important, but that has to be followed by a determination of how you can make it work financially. If you think it's viable, then you identify what kind of support you'll need. Then, you identify *who* will be your supporters and how to go about persuading them. Referring physicians require a certain angle of approach. Administrators require a business plan. Oncologists and intensivists don't care about your business plan, but they want to know how you're going to help patients and families and how you're going to coordinate with them and not work against them. You have to show each group how you will support and enhance their normal processes.