



# Palliative Screening to Positively Improve Patient Care resulting in earlier consults

Lynne Kennedy DBA-HC, MSN-HC, RN, RNFA, CHPN, CNOR, HTI-P, Clinical Director Palliative Care Inova Health System; Vera Dvorak MD, Medical Director Palliative Care Inova Health System

## Introduction

The Palliative Care (PC) teams at our health system's hospitals are at different stages. As data were gathered we recognized an opportunity to develop team integration with clinical and medical staff at each inpatient location and incorporate improved communication with the different levels of community care to reduce unplanned patient readmissions. Handoffs between service lines were improved through direct communication. Handoffs into the community were developed within our electronic health record so that our community partners could view the charts of their patients following discharge from acute care. They would be able to see the goals of care conversations that had already transpired and could pick up the conversations from the relevant point of planning rather than initiating the discussion.

## Problem Statement

Physicians who had previously consulted the PC team later in the trajectory of the patient's illness began considering earlier referrals. Physicians who had not considered the team's intervention began thinking about involving palliative providers. The result of this systematic approach led to a consistent growth in PC as a 'standard of care.' The positive impact on hospital data indicated improved pain control, nursing satisfaction with interdisciplinary team support, and interdisciplinary cooperation. The hospitalists received PC education during staff meetings, leading to increased consult requests. Our hospitals, initiating PC programs, improved readmission rates but the length of stay was slightly longer until earlier consults were routine, reinforcing the belief that early referrals accomplish both reduced length of stay and reduced readmissions, and subsequently lower healthcare cost.

## Project Goals

**Empower nursing and social worker staff to identify appropriate patients and actively pursue Palliative Care consults for their patients.**

- Improve the timing to Palliative Consults
- Equitable access to palliative care for vulnerable populations

**Create health system strategies to:**

- Improve care transitions thereby reducing readmissions
- Quality improvement through education and communication
- Integrate palliative care within the healthcare setting with psychosocial, spiritual & physical support

## Improvement Methods

Begin global palliative screening by RNs on Oncology, Medical, Telemetry, and Intensive Care Units on admission to the unit  
 Begin secondary screening at 72 hours by Case Managers if Palliative not already involved  
 Educate nurses, physicians, and other providers about palliative care:  
 Introduction to Palliative Care, Advance Directive, Options of Care, Readmission Analysis, POST, Comfort Care, Hospice, and Difficult Conversations

## Improvement Achieved and Outcomes

Communication was based on "Situation, Background, Assessment, and Recommendations (SBAR)" techniques to communicate the need for a consult to the Palliative team

Coaching helped to establish a culture of team throughout the hospitals

The nurses, social workers, dietitians, & physiotherapists felt empowered to discuss the cases with the physicians and resulted in improved timing of consult requests.

Clinicians used standardized tools to communicate at a more meaningful level with patients and families in crisis through POST Facilitator training

Physicians who had previously consulted the PC team late in the trajectory of the patient's illness began considering earlier referrals as evidenced by the differences between operating units at different levels of development

Physicians who had not considered the team's intervention, began thinking about involving palliative providers based on outcome data.

The result of this systematic approach led to a consistent growth in PC referrals, and incorporation of PC as a 'standard of care' as each program developed

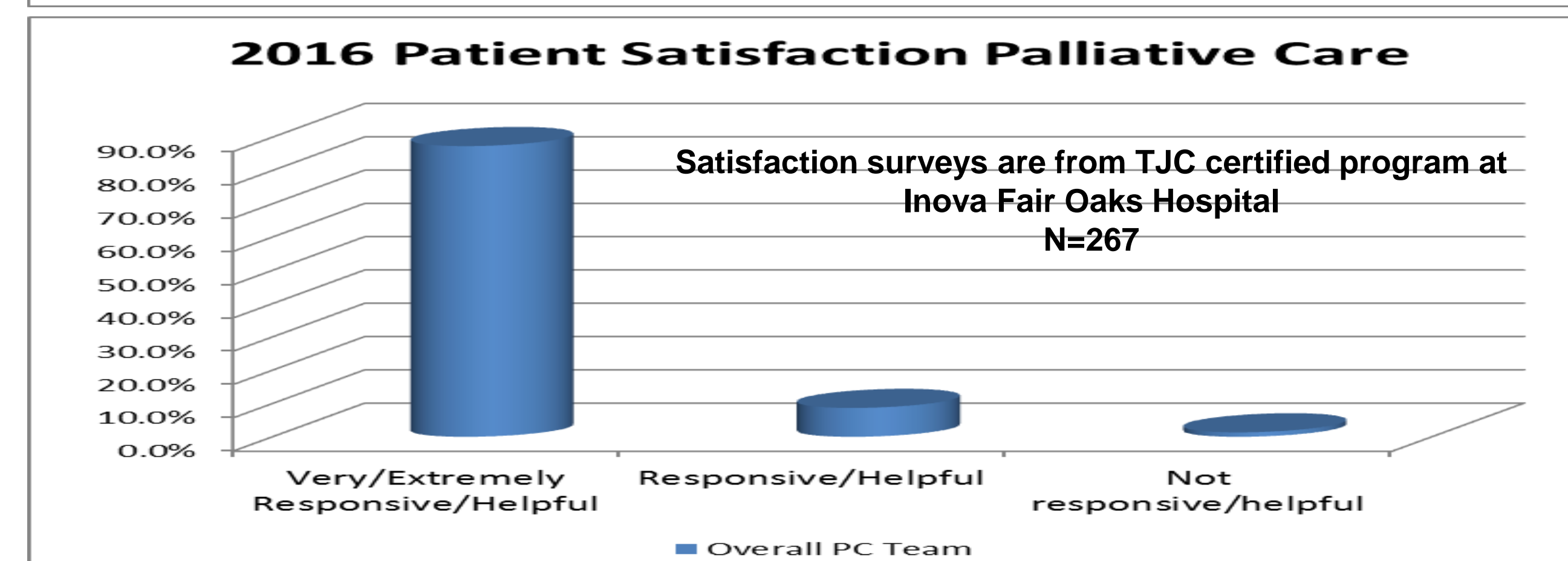
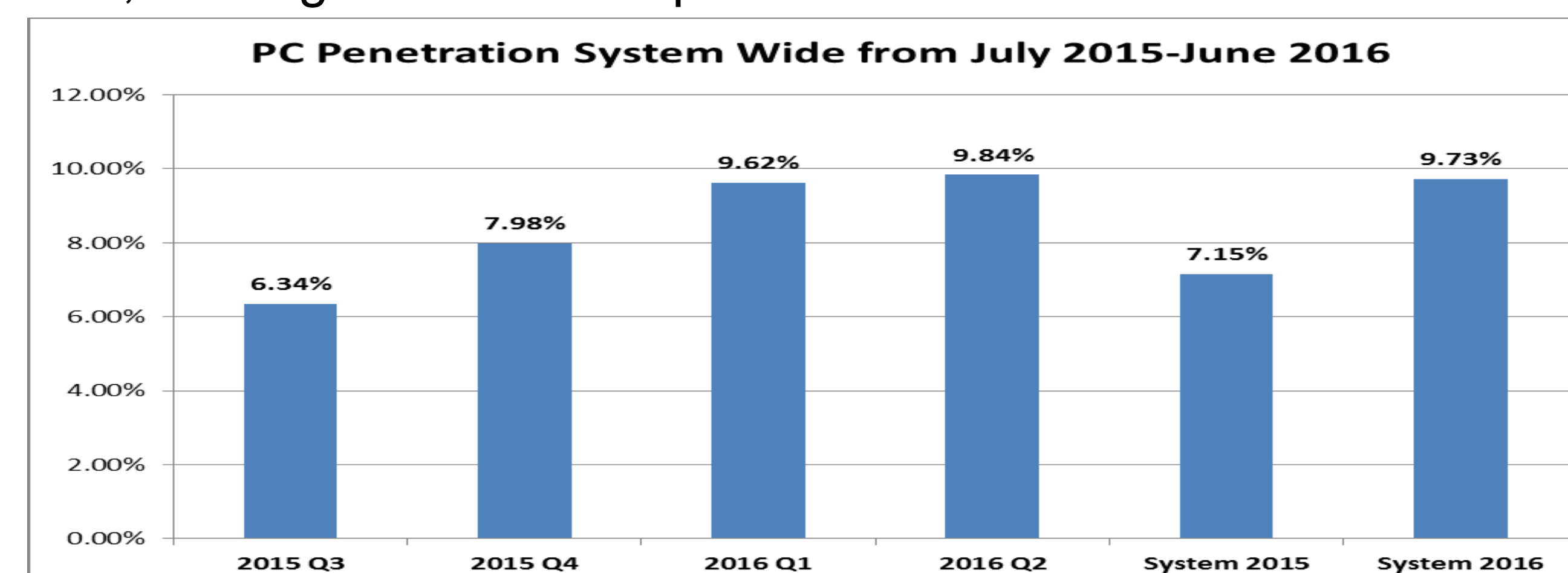
Positive impact on hospital data indicated improved pain control; nursing satisfaction with interdisciplinary team support and cooperation

The hospitalists, who were participating in monthly education, increased referrals by almost 3% over the entire Health System.

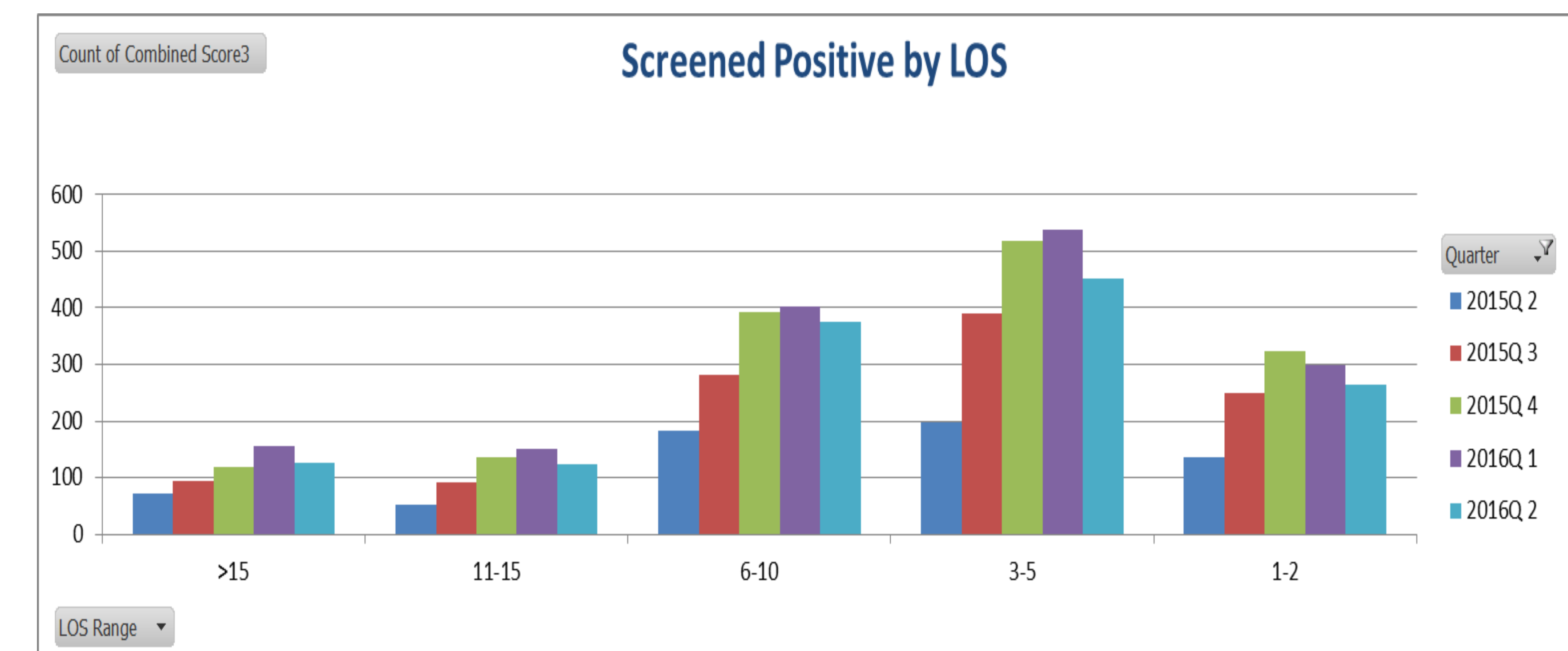
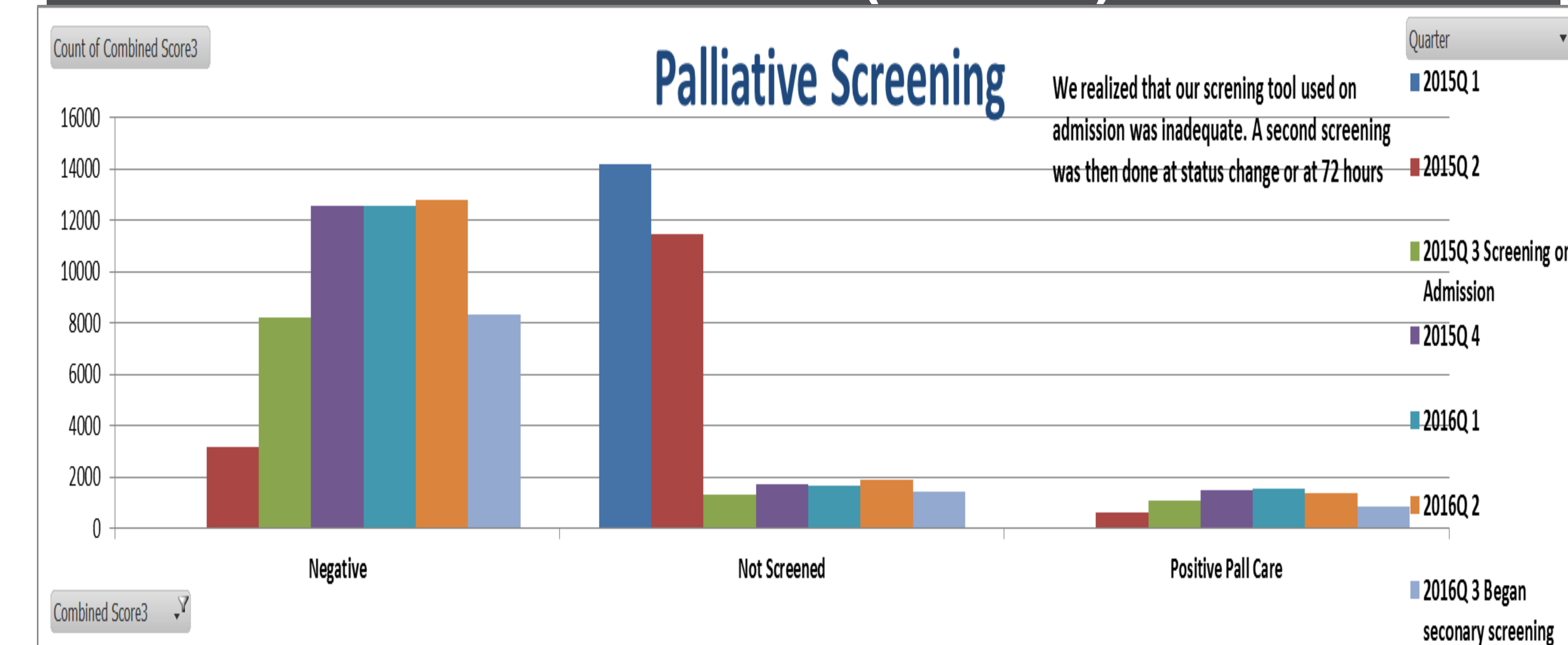
The hospitals, where PC programs were just starting, improved readmission rates but the length of stay was longer than established units, reinforcing the belief that early referrals accomplish reduced length of stay but needs enculturation which takes time

Reduced readmissions, and subsequently lower healthcare cost, is achieved through education of clinical staff, medical staff, patients and families

The options of disease-specific care and informed "goals of care" can be established, leading to fewer unexpected readmissions



## Outcomes (cont'd)



## Recommendations

It is possible that screening can eventually be eliminated from the process of consulting, when education and acceptance of palliative team involvement become part of the "standard of care." It is the process of enculturation through education and empowerment of nurses, social workers & other multidisciplinary colleagues that changes care to personalized care. Our TJC Certified hospital gets most consults without a positive screening call. On evaluating the data of existing readmissions and number of emergency room visits following discharge one may conclude that ambulatory palliative care services may facilitate achieving optimum reduction in readmissions. We are in the planning stages of system-wide ambulatory care delivery. At some facilities it will be embedded in specialist offices such as Cardiology and Oncology. In others it will be involved in our Home Health/Advanced and Complex Disease Center.

Teaching succinct communication methods such as SBAR will serve nurses and social workers to engage physicians who are considering a PC consultation.

## References

American Academy of Hospice and Palliative Medicine (AAHPM) and Hospice and Palliative Nurses Association (HPNA). 2014. Top 10 measures that matter. [https://aahpm.org/sites/default/files/AAHPM15\\_MMM\\_Handout\\_Clinical\\_FINAL.pdf](https://aahpm.org/sites/default/files/AAHPM15_MMM_Handout_Clinical_FINAL.pdf)  
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## Problem Statement

Physicians who had previously consulted the PC team later in the trajectory of the patient's illness began considering earlier referrals. Physicians who had not considered the team's intervention began thinking about involving palliative providers. The result of this shift led to growth in PC as a *standard of care*. The impact on other measures reflected improved pain control, improved nursing satisfaction with interdisciplinary team support, and, anecdotally, interdisciplinary cooperation. The hospitalists received PC education during staff meetings, leading to increased consult requests. Our hospitals, initiating PC programs, improved readmission rates but the length of stay was slightly longer until earlier consults were routine, reinforcing the supposition that early referrals reduce length of stay and readmissions, and subsequently lower healthcare cost.

## Project Goals

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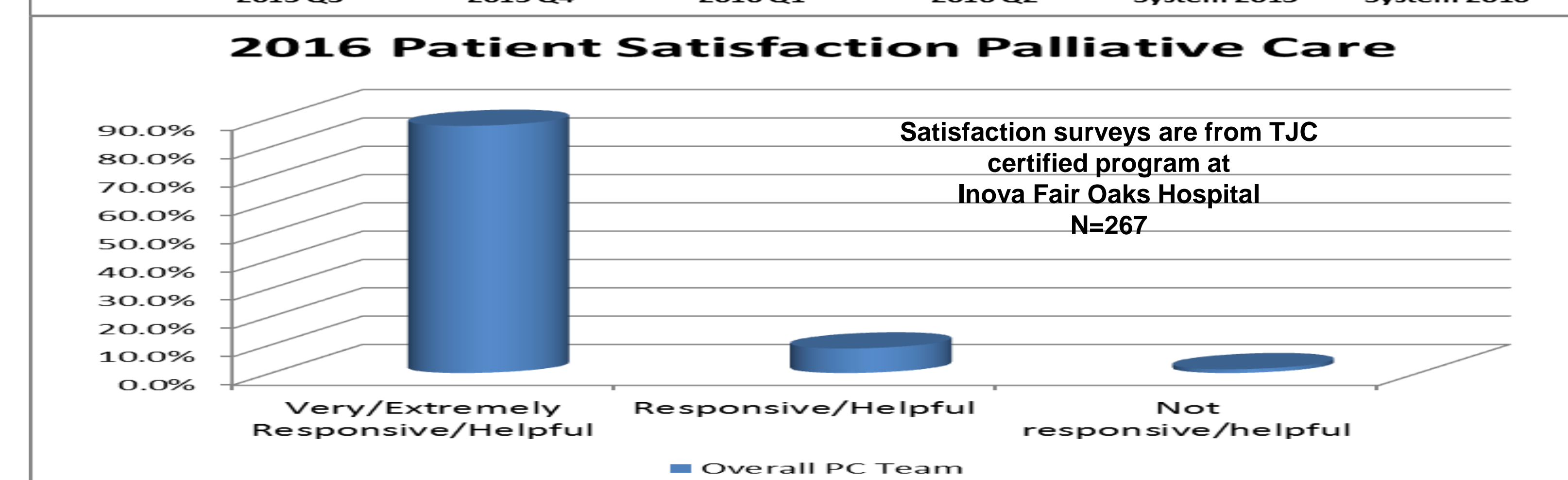
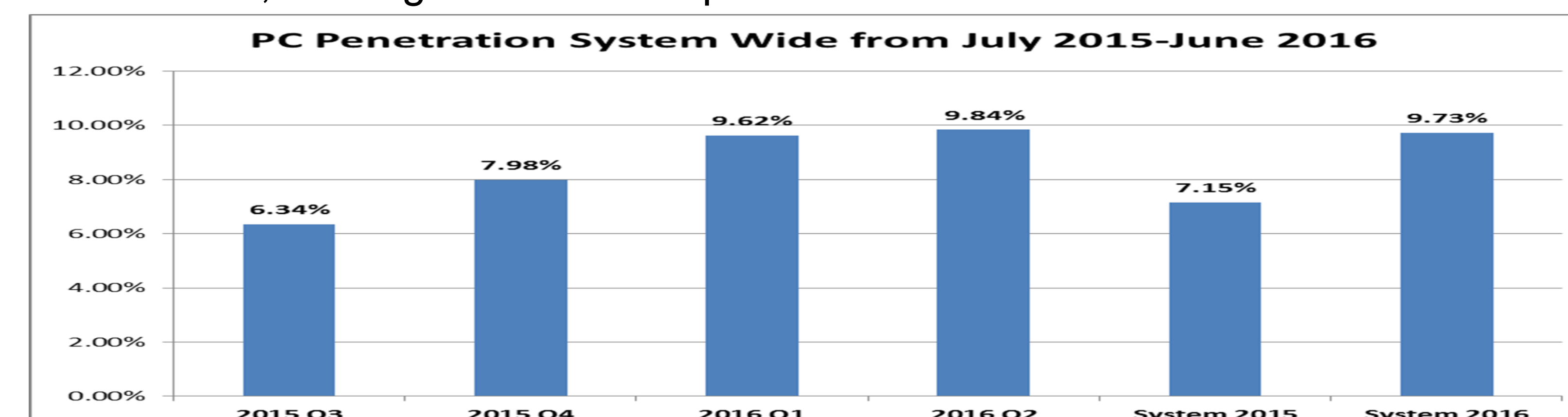
- Improve care transitions thereby reducing readmissions
- Quality improvement through education and communication
- Interwork palliative care within the healthcare setting with psychosocial, spiritual & physical support

## Improvement Methods

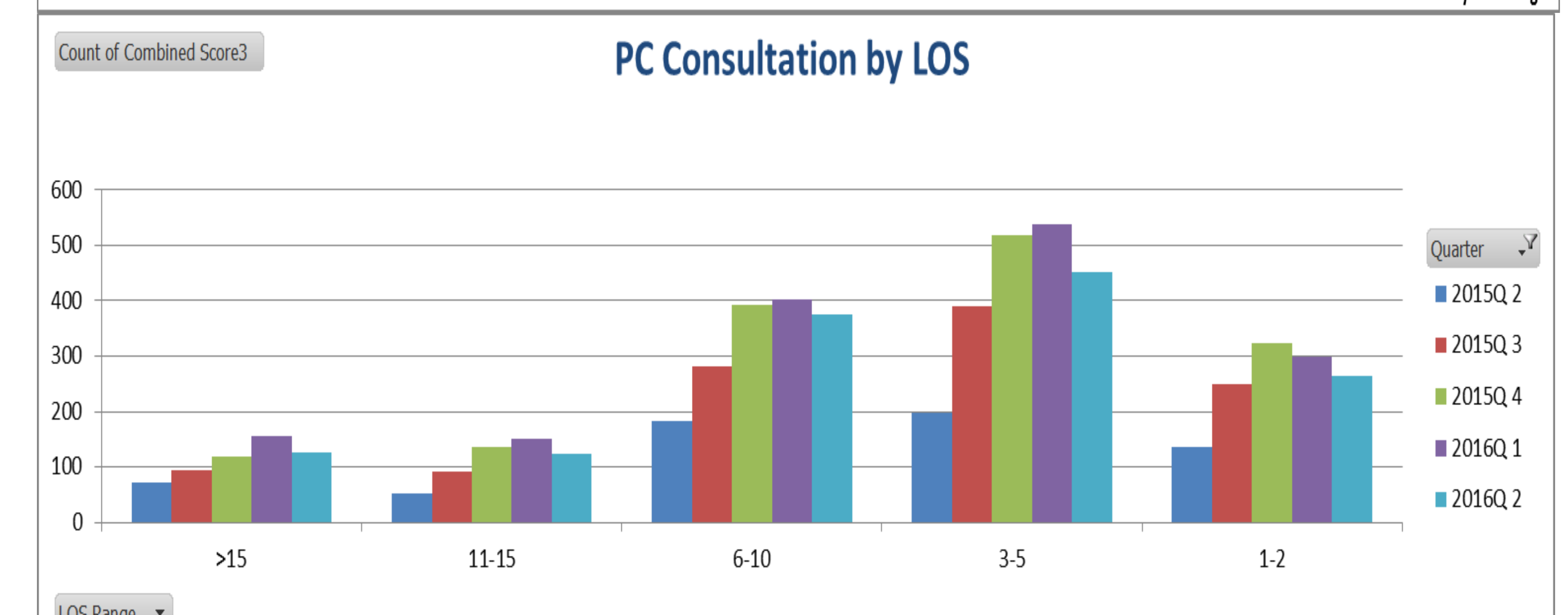
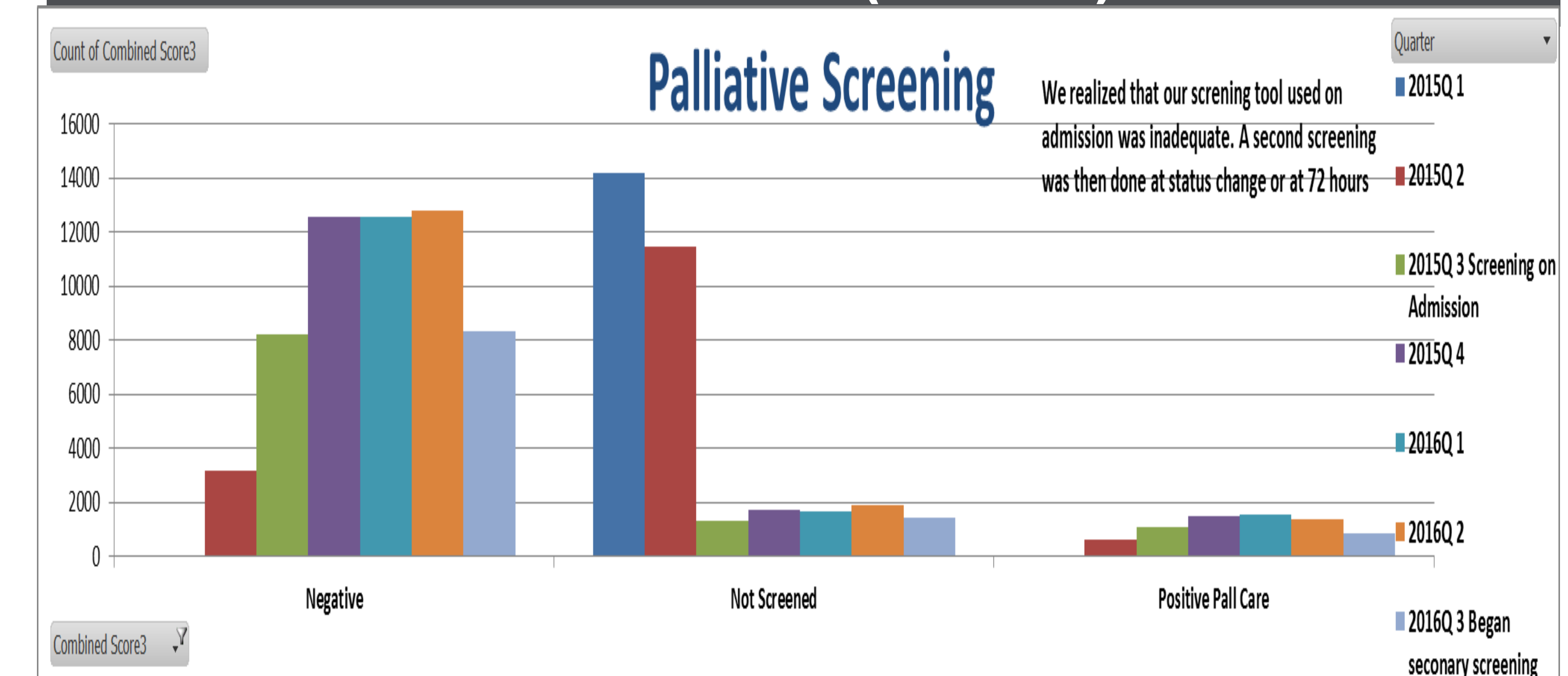
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## Improvement Achieved and Outcomes

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- Coaching helped to establish a team culture throughout the hospitals
- The nurses, social workers, dieticians, & physiotherapists felt empowered to discuss the cases with the physicians and resulted in improved timing of consult requests.
- Clinicians used standardized tools to communicate at a more meaningful level with patients and families in crisis, driven by POST Facilitator training
- Physicians who had previously consulted the PC team late in the trajectory of the patient's illness began considering earlier referrals as evidenced by the differences between operating units at different stages of program maturity
- Physicians who had not considered the team's intervention began thinking about involving palliative providers based on outcome data.
- The result of this systematic approach led to a consistent growth in PC referrals, and incorporation of PC as a *standard of care* as each program developed
- Positive impact on hospital metrics indicated improved pain control; nursing satisfaction with interdisciplinary team support and cooperation
- The hospitalists, who were participating in monthly education, increased referrals by almost 3% over the entire Health System.
- The hospitals where PC programs were just starting improved readmission rates but the lengths of stay were longer than in established units, reinforcing the supposition that early referrals lead to reduced length of stay but needs enculturation which takes time
- Reduced readmissions, and therefore lower healthcare cost, is achieved through education of clinical staff, medical staff, patients, and families
- The options of disease-specific care and informed *goals of care* can be established, leading to fewer unexpected readmissions



## Outcomes (cont'd)



## Recommendations

It is possible that screening can eventually be eliminated from the process of consulting, when education and acceptance of palliative team involvement become part of the *standard of care*. It is the process of enculturation through education and empowerment of nurses, social workers & other multidisciplinary colleagues that changes routine care to personalized care. Our TJC Certified hospital gets most consults prior to a screening assessment.

We are in the planning stages of system-wide ambulatory care delivery. At some facilities it will be embedded in specialist offices such as Cardiology and Oncology. In others it will be involved in our Home Health/Advanced and Complex Disease Center. Teaching succinct communication methods such as SBAR will serve nurses and social workers to engage physicians who are considering a PC consultation.

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