Implementation of a Virtual Hospice Service in a Large Academic Center: Challenges, Solutions and Discoveries

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Objective

- Describe how our institution designed and implemented a virtual hospice unit as a bridge to a future inpatient hospice unit.

Background

- Froedtert and Medical College of Wisconsin (MCW) health system strategic planning identified a gap in inpatient hospice services with a desire for a dedicated hospice unit. Hospital bed capacity constraints prevented timely plans for the hospice unit.
- Creation of a virtual hospice unit was requested by administration, with request for co-management by the MCW Palliative Care team and a respected local hospice agency.

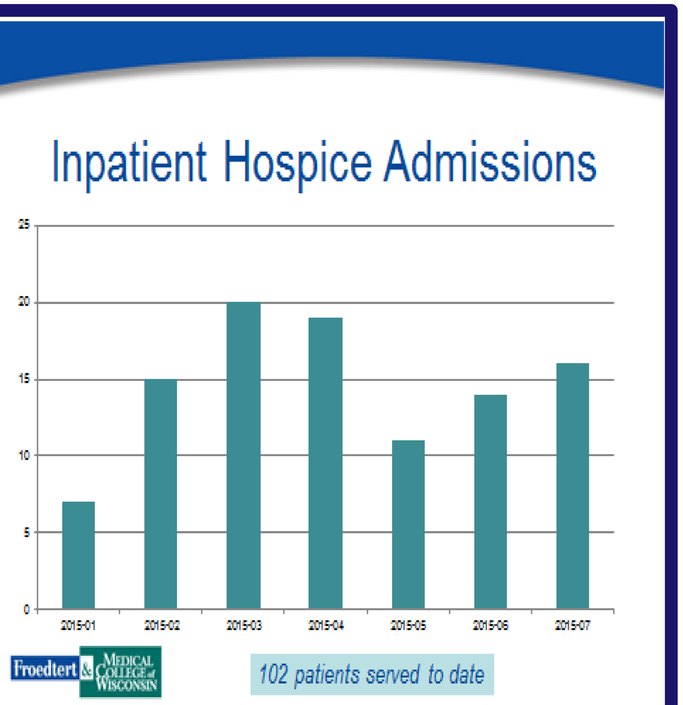
Methods

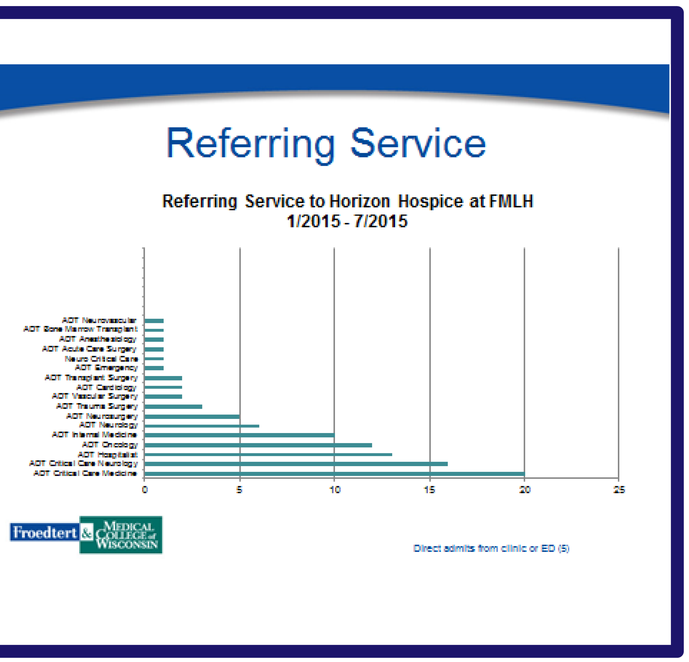
- Medical directors and nurse leaders participated in a three month planning process with the palliative care team and hospice executive director to:
  - Identify appropriate patients for the virtual hospice
  - Define the roles of the various team members
  - Develop the workflows.
- Implementation was staged, starting in medical and neurologic ICU's, pre-selected by administration due to high mortality rates.
- Virtual hospice was available house-wide to all ICU and medical wards (22) within three months.

Results

- In the first seven months:
  - 102 patients and families received services
  - Patients had an average length of stay of 1 day
  - Ten patients died while still in the ICU
  - Six patients were discharged for the hospital
  - Hospital mortality index declined by 36%.

Virtual Hospice Metrics





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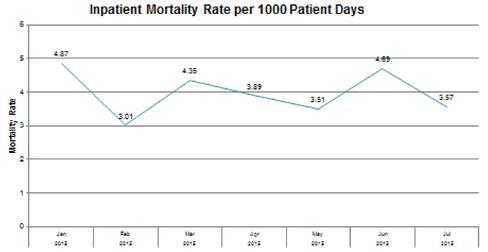

Metric	Result
Average Length of Stay (LOS)	1 day
Hospice Admissions from ICU	45%
Oncology Patients	7%
Palliative care consultation prior to hospice admit	44%

*N = 102 admissions

Challenges

- Investment of non-clinical time to develop the program
- Lack of buy-in from multiple sectors (hospital RN's, case management, referring MDs, palliative MDs) about potential benefit to patients and families
- Computer workflows
- Cost and workforce concerns.

Quality Improvement

- Several key quality improvement areas were identified during implementation, including:
  - Provider and nursing lack of knowledge regarding the difference between hospice and palliative care
  - Varying practices in opioid dosing during terminal extubation.

Conclusions

- Virtual hospice programs can enhance end-of-life experiences for patients and families with anticipated hospital death, and are feasible in the hospital setting but provide significant challenges in implementation.
- Design and implementation of our program provided a unique collaboration between palliative care providers, critical care and hospice teams.
- Key factors in the initial success of our hospice program include: tremendous support from hospital and hospice agency senior leadership, multi-disciplinary planning, flexibility in palliative medicine faculty and nurse practitioners, identification of anticipated cultural challenges prior to implementation and 24 hour support from experienced hospice RN's.