collaborative team activity **improves outcome**

The Palliative Care PROGRAM

• PROJECT SUMMARY •

Palliative Care Program
- Implemented Palliative Care Program along with various screening and intervention tools and processes to improve **care coordination**, **communication**, and **care transitions**
- Program employs 3 full time RNs, 2 APNs, 1 Discharge Navigator
- Palliative Services offered 24/7 with 1 RN & 1 APN on call for evening and weekend hours

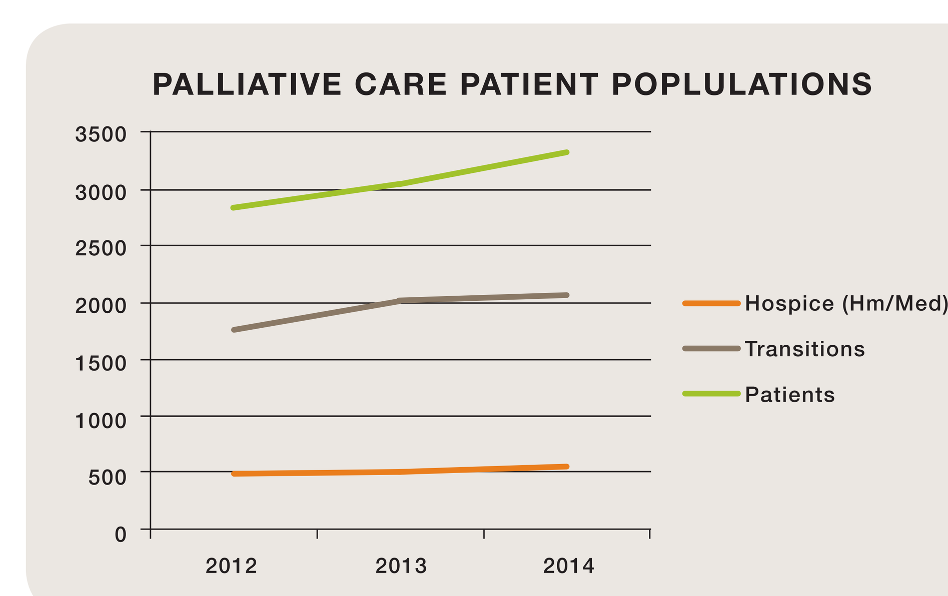
Screening Tools
- **Edmonton Symptom Assessment Scale (ESAS)**
  - Utilized to assess and initiate symptom management interventions
- **Palliative Performance Scale (PPS)**
  - Identifies and tracks potential care needs of palliative care patients
- **LACE Tool**
  - Length of stay, Acuity of admission, Comorbidities, and Emergency room visits in the last 6 months
  - Utilized to identify patients with a greater risk for readmission and complex discharge planning and navigation needs

Intervention Tools & Programs
- **Symptom Management**
  - Order Sets & Protocols initiated by APNs
- **Treatment Preferences & Family Discussions**
  - Family discussions centered around treatment preferences and prognosis occur routinely and are documented for continuity of care and DNR patients were reviewed to obtain OOHDNR when appropriate improving transitions to post-acute care settings
  - Incorporated Spiritual/Pastoral Care in treatment discussions to address all aspects of care for patients and family
- **Post Acute Care Navigation Program**
  - HF patients with a LACE score of 11+ with chronic conditions of CHF or DM, are placed on work-list to receive discharge navigation calls from a Chronic Care Professional

Benefits & Outcomes Summary
- The Palliative Care program provides support and resources to the clinical staff, resulting in additional referrals. The team conferences and care coordination activities improve communication and aid in better outcomes for patients through the interventions initiated by Palliative Care.
- By implementing screening tools and intervention protocols and policies, we can increase care coordination and communication to improve continuity of care across departments and facilities.

• RESULTS •

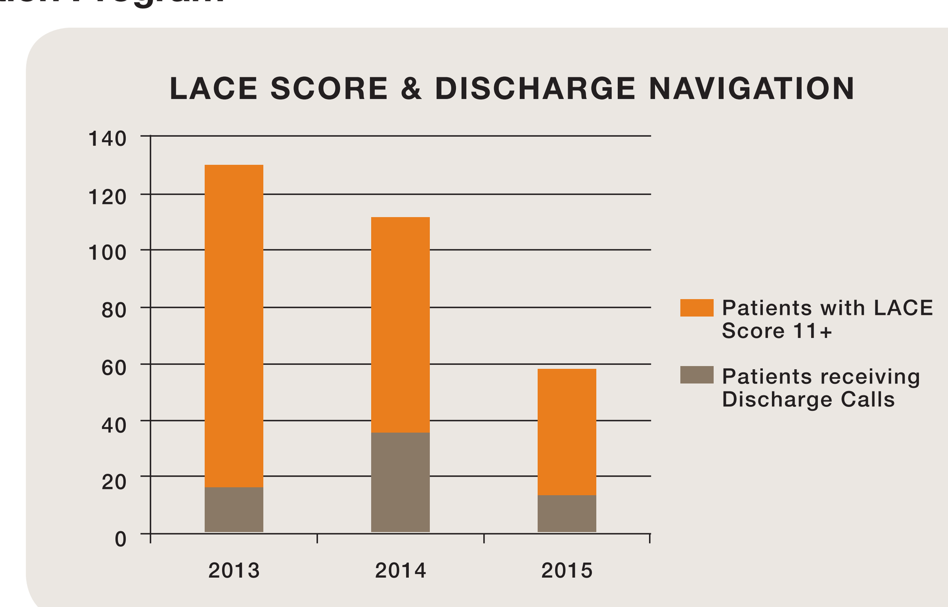
Program Accomplishments
2012 - 2014
- Increased patient volume by 17%
- Increased patients transitioned to post-acute care settings by 18%
- Increased appropriate hospice referrals by 13%



Results of Screening Tools & Interventions
- **ESAS & Symptom Management**
  - Palliative Care assessed pain and completed interventions to initiate symptom management either by Palliative or floor staff on 88% of patients presenting to the ED with pain
  - Identified that majority of Palliative Care patients reported dyspnea over pain as chief complaint

2013 - October 2015
- **Treatment Preferences**
  - Increased the documentation of treatment preferences by 80%
  - Increased OOHDNR discussions by 76%
  - Completed OOHDNR increased by 79%
  - Completed spiritual concerns discussions and documentation by 60%

2013 - October 2015
- **Discharge Navigation Program**
  - Increased the documentation of treatment preferences by 80%
  - Increased percentage of HF patients with LACE score of 11+ receiving a discharge navigation calls



• NEXT STEPS •

Program Expansion
Develop Chronic Disease Management Model by integrating Palliative Care, Heart Failure Clinic, Diabetes Management and Transitional Care to provide comprehensive coverage to patients with advanced chronic disease.

Additional Screening Tools Being Considered
- **Food Insecurity**
  - Address basic needs of patients through "food box" program
  - Referrals to area food banks and other community resources
- **Edmonton Frailty Scale**
  - Identify patients at increased risk for harm events and utilized to aid in discharge planning

Intervention Tools & Programs
- **Symptom Management**
  - Utilize ESAS to identify patients with pain score 5+ on a numeric scale and complete a comprehensive clinical assessment (Location, Severity, Character, Duration, Frequency, Relieves/Worsens, Effect on QOL) to initiate appropriate protocols and symptom management
  - Utilize ESAS to initiate symptom management related to dyspnea and other patient specific priorities
- **Post-Acute Care Navigation**
  - Increase percentage of high risk patients receiving discharge navigation calls
  - Add additional chronic disease processes to the discharge navigation call program
    - STK
  - Expand Post –Acute Care Navigation Program
  - Engage the community to provide better care transitions for advanced chronic disease populations through:
    - Patient-Centered models
    - Resources & Policies
- **Post-Acute Care Resources & Assistance**
  - Medication Assistance Programs
    - Expand program to offer assistance to out-patients in clinic settings
  - 30 – Day Diabetic Supply Kits for uninsured
    - Increase the number of patients impacted by program
  - Chronic Care Professional RNs available for resources
    - Work collaboratively with Community Health Workers to assist chronically ill with navigating the complex health system
  - Diabetes Survival Skills
    - Offer free diabetes education to uninsured and underinsured

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