Proactive Palliative Care for Advanced Illness Patients

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Demographics

- Tertiary, Level 1 trauma center
- 714-beds divided between two campuses
- Specialized teaching hospital
- Staten Island, New York

PROBLEM: Over utilization of critical care resources in patients with predictably poor outcomes secondary to lack of in-depth goals of care conversations, leads to over spending and poor quality of care.

SOLUTION: Use screening criteria to identify patients in critical care settings with predictably poor outcomes to generate goals of care conversations to align treatment plans with patient wishes.

Two-Part Initiative:

1. AI (Advance Illness) Identification & Conversation Bundle
2. Creation of AI Team and AI Beds

Northwell Advanced Illness Definition

Patients are identified to have AI if they meet the following criteria: (1+2)

- ❑ **Chronic illness**: one or more chronic diagnoses, including frailty or dementia

Plus 2 or more of the following:

- ❑ **Declining functional status**: loss of >2 ADLs over the past 3 months or complex care requirements (e.g., functional dependency, complex home support for vent, antibiotics, or feedings)
- ❑ **Malnutrition**: unintentional loss of > 10% body weight over the past 6 months
- ❑ **Evidence of organ dysfunction**
- ❑ **Cancer, advanced or metastatic disease**
- ❑ **Readmissions:** 3 or more readmissions in 6 months

The AI Team :

- Physician, Nurse Coordinator, Nurse Practitioners (x2), Social Work, Chaplain
- All trained in Palliative Care
- Round in ICU, CCU and ED daily to assist with the process

Goals of Care Conversation Education Program - GoCCEP™

Developed by an interprofessional team of Northwell Health clinical content experts using a blended learning, multimodal methodology plus an experiential learning experience utilizing standardized patient simulation with debrief by an experienced simulation debriefer

ALL patients admitted to ICU, CCU and ED screened for Advanced Illness → AI POSITIVE screening elicits a Goals of Care Conversation → Conversation outcome = No further escalation of care or comfort measures only → Patient considered for transfer to Advanced Illness Bed

Advanced Illness Beds

- 4 designated beds
- 1:4 Nursing care
- All nurses educated in advanced illness management
- Plan of care guided by Palliative Care Team

Summary

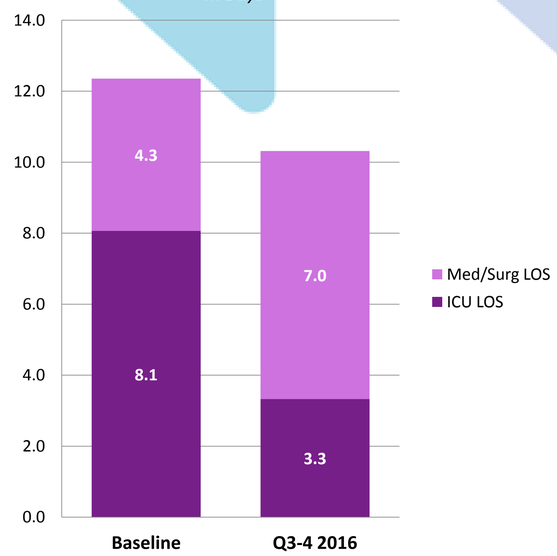
Proactive Palliative Care interventions and creating an AI team demonstrated:

- Improved patient and family satisfaction
- Documented goals of care conversations
- Increase in MOLST form completion prior to discharge
- Decreased lengths of stay (LOS) and readmissions
- Decompression of critical care areas

The creation of the AI Beds reduced number of procedures, imaging, and lab work with more focus on symptom management rather than continued workup, reflected in significant cost savings.

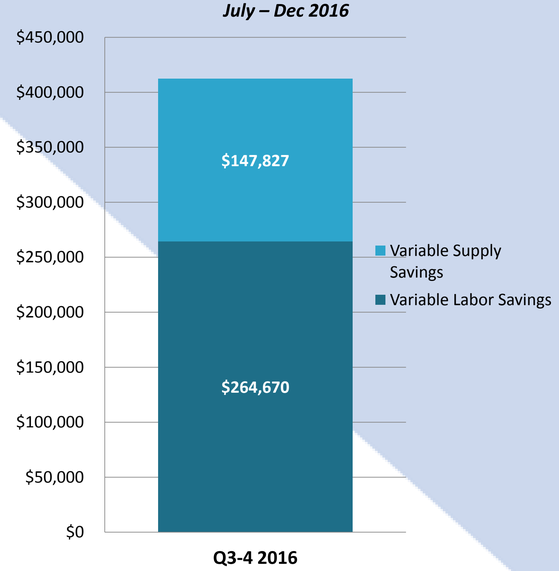
SIUH ALOS Reductions

In Days



SIUH Variable Cost Savings

July – Dec 2016



Associated Benefits

- Decreased LOS
- Reduced readmissions with increase in Hospice referrals
- Improved appropriate ICU resource utilization
- Decreased direct variable cost in ICU
- Increased documentation of Advanced Care Directives & MOLST
- Improved appropriate care transitions / increased palliative utilization
- Improved patient quality of life
- Improved end of life care