How Do You Start A Palliative Care Program When All You Have Are Hospitalists?

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Full Description:
We started by having two RNs running our palliative care service. Within one year, we have developed our program into a full service line that works in a 24/7 setting with 3 palliative care physicians as well as a designated social worker and 0.5 FTE chaplaincy. We have established our inpatient service across all service lines and now work with cardiothoracic surgery for outpatient screening for LVAD and are looking into developing outpatient service, hospice, home based palliative care. We have an ongoing educational series that benefits physicians, nurses, medical residents, as well as ancillary staff.

Background:
Mercy General Hospital is a 286 bed hospital in Sacramento, California with a robust cardiovascular and neurocritical care program. During monthly medicine meetings it became apparent that the hospital had less than optimal AVATAR scores relating to patient and their families’ impression of end-of-life experience (Figure 1). We were able to leverage this data to show the administration that a true task force to improve this aspect of care had to include a physician-led multidisciplinary palliative care service.

Plan:
We started by proposing the need for an inpatient palliative care consult service. By showing the CAPC data regarding helping with cost control for managed care plans, we were able to make a case to the CEO of our medical group to provide funding for education of interested hospitalists for specialized palliative care training.

After identifying four physicians and funding the training for their individually chosen track (Harvard’s PCEP and Four Seasons Immersion Course), physicians were able to become board certified by taking the AAHPM exam in 2012. Simultaneously, we requested and were granted funding by the hospital for creating a multidisciplinary team, including a full time palliative care trained social worker and a part time chaplain.

Starting October of 2012, we were able to make our physician-led inpatient palliative consult service available Monday through Friday. With this availability, we have increased the number of our consults from 3% of admissions to 8% within 2 years. We have also continued to hold a monthly palliative care lecture series that focuses on communication skills as well as symptom management for the entire staff, but mostly aimed at hospitalists (including support staff such as dieticians, speech therapists and physical therapists). We have been involved in early management of new cancer diagnosis as well as involvement with LVAD patients. We have implanted ‘comfort carts’ and have educated the nurses regarding end of life issues. We have held local conferences and made our presence known by presenting at a local critical care symposium. Our consults have been requested by ER, ICU, neurology, oncology, cardiovascular surgery, and mostly by hospitalists. By involving our hospitalists in our ongoing educational programs to improve communication, we have been able to show the benefits of this training in their HCAHP scores as well (Figure 2).

Starting November 2013, encouraged by our demonstrable improvement data (Figure 3) we were able to request a position for an outpatient physician who could complement our successful inpatient service. She is starting in November of 2014.

We are now planning on incorporating a local hospice program as well as including a home-based palliative care physician to complete our medical group’s vision of palliative and supportive care medicine vision. We have joined forces with our already strong geriatrics program to use their resources to jump start our outpatient service. We are also proposing to create combined palliative care/hospitalist positions to provide more flexibility for new candidates as well allow for professional development for our existing physicians.

We are aiming for Palliative Care Joint Commission certification in 2015.

Summary:
We were able to show how the passion of one clinician with adequate and appropriate training and guidance (PCEP, CAPC resources) was able to start a comprehensive palliative care service line. Starting with an inpatient palliative care service and leading to expansion to outpatient and home-based palliative service, while encouraging early consultation by multiple service lines, ensuring aligning patients’ goals and values with medical treatments offered to them during the course of their serious illness.