A Clinical Framework Integrating Palliative Care into the Inpatient Care of COPD Patients

UNMC UNIVERSITY OF NEBRASKA MEDICAL CENTER

Jana Braklow, RN, MSN, APRN-C Olathe Medical Center, Olathe, KS

Lufei Young PhD, RN, APRN-NP College of Nursing, University of Nebraska Medical Center and Beatrice Community Rural Critical Access Hospital

Purpose

Demonstrate the effects, feasibility and sustainability of a rural-based, hybrid, integrated program in providing palliative care throughout the continuum of illness and across multiple rural healthcare settings.

Background

Program Information

- Name of program: Advanced Illness Management (AIM)
- Program director: Michael Havekost, MD
- Program start-date: December 2014
- Institutional setting: Beatrice Community Hospital and Health Center
- Type of institution: Rural critical access hospital
- Team members: 0.5 FTE MD, 1 FTE nurse, 0.25 FTE hybrid role of nurse practitioner and research personnel, shared social worker, and case manager with hospital

Service Components

- Inpatient and outpatient consultation
- Initial and subsequent symptom management
- Care coordination
- Case Management

Funding Sources

- Hospital salary support
- Patient Service Revenue
- Foundation and Charity

Patient Population

- Hospital-based clients: individuals utilizing emergency and acute care services
- Community-based clients: individuals who live at home independently, assisted living, skilled nursing and long-term care facilities

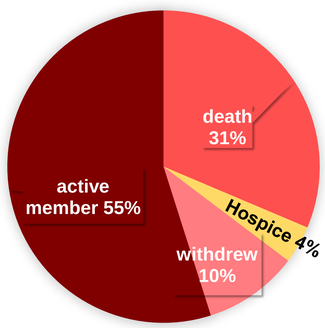
Program Goals

- Help the patient and family understand the status of their chronic illness.
- Help the patient and family set goals and advance care planning regarding their treatment.
- Assist the patient with early detection of complications and symptom management.
- Assist the patient and family in identifying and accessing resources.
- Provide the patient and family an extra layer of support in managing their chronic, complex conditions.
- Coordinate care and communicate goals of care with the patient's caregivers.

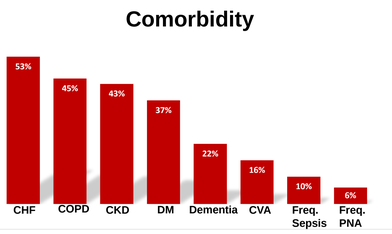
Results

Labels	Mean and range	Labels	Mean and range
Age	80 (49-97) yr.	LOS in program	105 (2-318)
Female	49%	PPS	54 (20-80)
Caucasian	99%	Average reduction of hospital LOS	1 (5-0)
Married	27%	% DNR	60%
High school education	85%	% symptom improvement	95%
Medicare	97%		
Common bill codes	99356/7, 99309/10, 99223, 99349/50,		

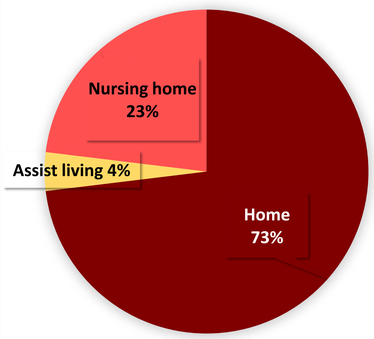
Patient Status



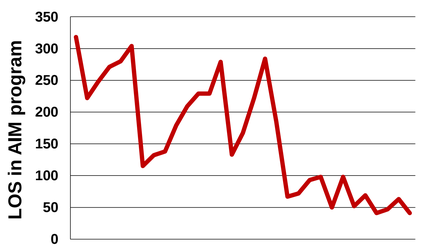
Comorbidity



Discharge Disposition

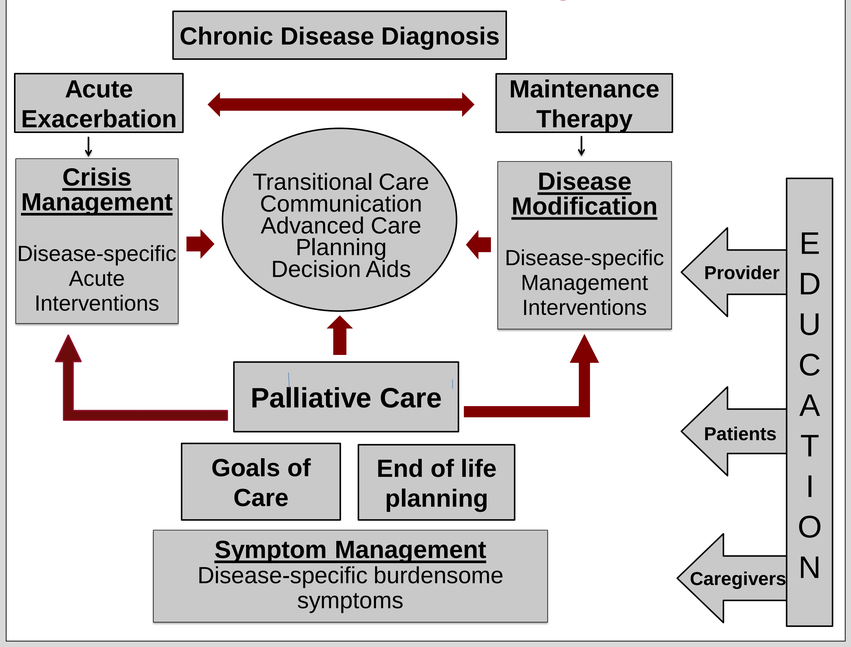


Correlation Between LOS In AIM Program And Frequency Of IP/ED Admission



Frequency of healthcare utilization (readmission and ED visits)

Palliative Care Integration Model for Chronic Disease Management



Conclusion

- Both programs were developed to help relieve patients' unnecessary suffering by providing comprehensive care based on respect for patients' goals, preferences, and choices
- Palliative care is a CULTURE CHANGE for an institution. It takes time to ***unfreeze, change, and re-freeze*** clinical practice.
- Palliative care should be provided across care settings and throughout the continuum of illness trajectory.
- Palliative care should be integrated into the existing health care system to
  - ❑ Sustain palliative care programs
  - ❑ Meet institutional goals related to Value Based Purchasing regulations for chronic disease readmission and patient –centered care.
- Palliative care programs should be provided by an interdisciplinary team
- Ongoing staff education is critical
  - ❑ The content of clinical staff education should be focused on disease-specific primary palliative intervention.
  - ❑ Interdisciplinary professionals train their own team members, who in turn become integral in identifying patients who would benefit from palliative care.
  - ❑ With training, many consults come from rehabilitation and respiratory professionals caring for chronic disease patients.
- The establishment of goals of care and advance care planning is key.
- Patients and their families are overwhelmingly appreciative when a competent and compassionate interdisciplinary palliative care team offers comfort and dignity to people facing serious, end stage illness.
- Palliative care is also found rewarding by healthcare professionals. When asked what aspect of their work offers the most satisfaction, some responses were:
  - ❑ "…knowing that in some way I've made a difference in a patient's life by not being afraid to initiate a very difficult and awkward discussion at a very difficult time of their life…..(Interviewee cried)"
  - ❑ "…a great sense of professional and personal gratification in knowing individuals trust me enough to share most intense and intimate moments of their lives with me…... (Interviewee became tearful)"

Acknowledgement

With appreciation, we distinctly recognize Michael Havekost, MD, from Beatrice Community Hospital and Health Center and the Critical Care Staff, Consultants in Pulmonary Medicine, and the Quality Department at Olathe Medical Center. The programs would not have been possible without their clinical expertise, guidance and dedication. Their contributions were crucial for the successful integration of the projects.

Purpose

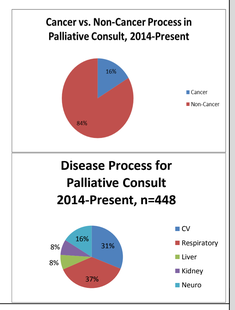
- To disseminate the evidence evolving in symptom management and transitional care through palliative interventions in COPD in the acute care setting of a non-profit community hospital.
- To test the effects, feasibility, and sustainability of an integrated palliative care program on patient reported outcomes (e.g., symptom improvement, quality of life) and healthcare utilization outcomes (e.g., length of stay and readmission rates).

Background

The Palliative Care Team began in 2009 in the critical care unit and expanded into a formal hospital-wide consultative team in 2011. The team directly reports to the Critical Care Unit and consists of:

- Pulmonary/Palliative Care Boarded MD
- Acute Care Nurse Practitioner
- Critical Care Nurse
- Chaplain
- Social Worker
- Physical therapist

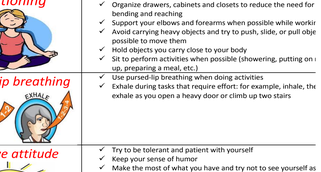
The patient population: hospital clients utilizing acute services and the Emergency Room.



Method & Results

***** This project is ongoing with data collection as part of a QI Project***

Palliative Intervention Components of Program



- Symptom Assessment and Management
  - ❑ Dyspnea
    - ❖ 6th Vital sign
    - ❖ VDS for acute dyspnea
  - ❑ Anxiety and Depression
    - ❖ Hospital Anxiety and Depression Scale
    - ❖ Depression and anxiety management
  - ❑ Fatigue and Functionality
    - ❖ Teaching 6Ps
    - ❖ Pulmonary Rehabilitation
- Establish goals of care and introduce concept of "Ceiling of Treatment" discussion on admission (this is integrated in ICU Rounds)
- Communication
  - ❑ Interdisciplinary team meeting, including patient/family and other healthcare professionals
  - ❑ Development of individualized symptom plan (dyspnea)
  - ❑ Discussion of support/resources for caregivers
  - ❑ Introduction of palliative newsletter for chronic disease
- Care coordination across settings, including Hospice
- Education
  - ❑ COPD patient and caregiver education, including palliative information that is consistent throughout continuum of care
  - ❑ Clinical staff training in palliative care components for COPD patients

Toolkit

- Acute Dyspnea Plan
- Transitional Planning
  - ❑ Identification of COPD patients at risk for Emergency Room visits and readmissions
  - ❑ Implementation of High Risk for Readmission Nursing Plan of Care
- Documentation and dissemination across settings of advanced care directives and "Ceiling of Treatment"