The impact of using an Advanced Illness Resource (AIR) clinician to support healthcare navigation and advance care planning for patients in a small, rural hospital.

Atrium Health
Hospice & Palliative Care of Cabarrus County

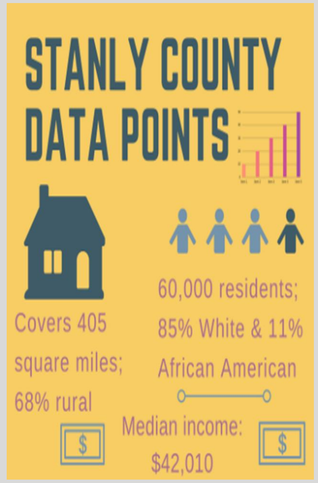
Introduction

Current State: Providing palliative medicine in rural communities remain a challenge.

Most recently, a study shared by ***BMC Palliative Care*** demonstrated the successful use of an advanced illness nurse navigator to bridge the gap to meet this challenge as an option to meet the need.

In Charlotte, North Carolina, there are several robust inner-city palliative programs and a large deficient group of surrounding rural communities that have and need palliative support, such as Stanly County.

Research from a Community Health Improvement Study conducted by Atrium Health in 2017 led to a focus on how we can better improve the health of at-risk patients in Stanly County, North Carolina.



Intervention: A needs assessment was conducted to better understand the specific advanced illness resource needs for Stanly County.

Input was gathered by all stakeholders, including:
- Hospital and nursing leaders
- Frontline teammates
- Community members
- Hospitalists
- Case management
- Quality and Patient Experience departments
- Local hospice agencies

Identified needs:
- Advanced illness healthcare navigation
- One hospice education process
- Advance directive support, and
- A community education plan inclusive of skilled nursing facilities, physicians and community groups.

Program Description

An Advanced Illness Resource clinical role was created to provide palliative care support and goals of care conversation facilitation with patients and families in Stanly hospital. The program started with a nurse trained in hospice and palliative care.

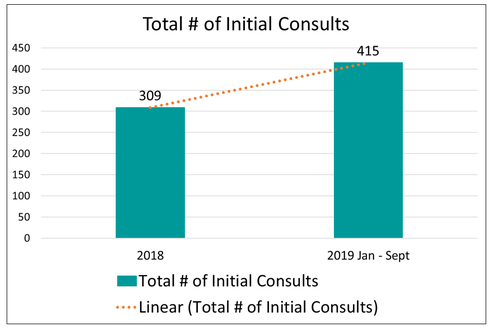
- ✓ Advanced Illness Resource RN
  - ½ Day in Hospital
  - Palliative Care RN in local Skilled Nursing Facility
- ✓ Providing support for Goals of Care conversations
- ✓ Navigating Advance Directives, Care Alignment Tool (CAT) completion, MOST form
- ✓ Education for medical community

The AIR clinician provides consultative support to patients and families in the hospital needing help with goals of care, advance care planning or hospice education. Symptom management support is also available.

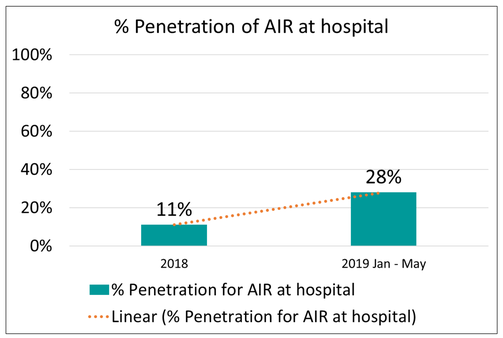
What is the Care Alignment Tool?

The Care Alignment Tool (CAT) is built into the hospital system's electronic medical record. Any time goals of care conversations are held, patient/family wishes are expressed, or advance care planning occurs, healthcare workers can document on this Tool in the patient's chart. The CAT illustrates the evolution and status of individual patient advance care planning.

Outcomes



Impact since program implementation (2017):
- **724 total patients received an Advanced Illness Resources consults**
- **100 MOST forms completed (Medical Order for Scope of Treatment)**
- **79 HCPOA forms completed**
- **176 DNR forms completed**
- **20% hospice conversion rate**



Community Education Plan

Civic / Community

Who:
- Faith-based communities
- Rotary Clubs
- Volunteer organizations

What:
- Advance Directives

Responsible:
- Your Care Your Choice (train the trainer format)

MD / Providers

Who:
- Primary Care Practices
- Specialists
- Hospitalists

What:
- CAT Completion
- Advanced Illness Resources
- MOST Form

Responsible:
- Hospital - AIR Nurse
- Physician Practices – Hospice Transition Coordinators

Facilities

Who:
- Skilled Nursing Facilities (SNFs)

What:
- MOST Form
- Navigating Advance Directives
- Respecting Choices

Responsible:
- AIR Nurse
- Hospice Case Managers, Hospice Social Work and Chaplain

Lessons Learned

- Advanced illness resource education is an ongoing need for providers, nursing staff and case management to ensure appropriate use of consult
- When the AIR Nurse is present and visible on the unit, consults increase
- The need to understand the reason for consult in order to appropriately triage and prioritize AIR Nurse schedule
- Need ability to track number of patients discharged prior to AIR Nurse conducting initial consult to build justification for increased staff or program funding

Next Steps

- Continue collecting data to justify adding AIR / Palliative Care provider to grow the program
- Expand program to include more of a community focus (i.e. consider contracts with additional SNFs in Stanly County)
- Review Community Education Plan and refocus efforts in the community (i.e. Meet the Doctor)
- Streamline process when patients are seen by AIR/Palliative Care in the hospital and need to be followed by Palliative Care in the SNF
- Vet possible trigger tool

Resources

- Pesut, B., Hooper, B., Jacobsen, M., Nielson, B., Falk, B., O'Connor, B. (2017). Nurse-led navigation to provide early palliative care in rural areas: a pilot study. BMC Palliative Care 16(37).
- 2017 Community Health Improvement Study, Atrium Health Stanly, Stanly County

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