Timing Really Is Everything

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Introduction

Most residents of a Skilled Nursing Facility (SNF) die from chronic debilitating disease. Recent estimates suggest that up to 80% of nursing home residents could benefit from a palliative care consultation. Atrium Health has a growing palliative care skilled nursing facility team. Members of this team are currently embedded in four of Atrium Healths five owned skilled nursing facilities. A recent analysis of the SNF PC teams impact revealed a gap in consistent facility to facility follow up. Patients seen by the Inpatient Palliative Care team were not consistently being followed by the Skilled Nursing Facility Palliative Care team upon admission to the Skilled Nursing Facility.

METHODS

An initial review of the data, showed us that 43% of those patients seen by the Inpatient Palliative Care team did not receive an order for the SNF Palliative Care team to initiate a consult.

We designed a process that would facilitate 100% of all patients seen by the inpatient palliative care team to receive an order form the skilled nursing facility team at the time of skilled nursing facility admission. Thus reducing the time that it takes to obtain an order and timely consult initiation in the skilled nursing facility.

- Identified key stakeholders
- Reviewed current state
- Drafted a process
- Established a "go live" date
- Educated key stakeholders designated staff
- Established every other week quick check in for discussion and feedback for 90 days

Use of an Electronic Medical Record and Identification of Key Stakeholders can facilitate a seamless transition of patients from an acute care hospital Inpatient Palliative Care team to a SNF Palliative Care team through utilization of a timely and reliable process

Discussion

Since our “go live” date August 2020, we have received 100% of all referrals from the Inpatient Palliative Care team, which then translated into an order at the time of the patient’s admission to the Skilled Nursing Facility within a 24 hour timeframe.

The implementation of an very other week “touch base” with stakeholders supports open communication and timely feedback for tweaking the process.

Future State

Information gained from this 90 day pilot will be reviewed and incorporated into a larger Atrium Health Initiative to improve communication about Palliative Care consults as patients transition across the continuum of care that includes Atrium Health owned and Non-Atrium owned facilities.

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