





NO PATIENT LEFT BEHIND

Universal Screening for Palliative Needs

BY MARY HICKS, RN, MSN, APRN AND ELIZABETH DISTEFANO, RN, BSN

How can health care providers be confident their palliative care services are capturing patients at the appropriate time in their disease trajectory? Many palliative care teams struggle with evaluating patients too late, often when death is quite near. Yet standards and procedures for assessing prospective palliative care patients remain uncharted territory for many health care facilities.

Here is what happened at one 800-bed community hospital in the St. John Providence Health System — the test site for developing a palliative-care screening tool for adult patients. There were plenty of challenges along the way, but the results were remarkable: a 200 percent increase in palliative care consultation rate over a one-year period. Perhaps our story will help others in their journeys.

Five separate acute-care hospitals in southeast Michigan make up the St. John Providence Health System. In 2005, each of these hospitals had palliative consultation services in place to provide comprehensive care to those with advanced chronic disease or those with life-threatening illness. However, there was no standard measure to identify prospective palliative care patients, and the timing and nature of services varied among the hospitals. Consultations tended to be generated by a core group of physicians, but some physicians and even entire service lines did not refer patients at all.

Senior health system leadership believed palliative care services play a vital role in providing appropriate care to patients with chronic, possi-

bly life-threatening illness. They recognized that with the advancement of medical technology, people are living longer with chronic disease and the traditional medical model did not adequately serve those in this population. These patients had

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multifaceted needs that are best served with a team approach.

The leaders drew on a working relationship with Duke University's Institute on Care at the End of Life to develop and launch a quality improvement project that could build and eventually expand palliative services throughout the St. John Providence Health System.

The St. John-Duke collaboration from 2006-2008 focused on identifying health system "valued components" of palliative care and created related tools and processes that would eventu-

ally be used systemwide. This project hoped to focus attention in the following areas:

- Screening all acute care patients for palliative needs
- Development of educational programs for a variety of health care providers addressing various aspects of palliative care
- Integration of spiritual care into palliative care services
- Gathering data to quantify medical cost reduction and cost avoidance attributed to palliative care
- Engagement of local faith communities for education on palliative and end-of-life considerations
- Provision of tools to monitor culture change attributed to efforts in the focus areas

The project began at one pilot hospital, St. John Hospital and Medical Center in Detroit, an 800-bed, acute care facility on Detroit's east side and the largest hospital in the St. John Providence system.

IMPROVING ACCESS TO PALLIATIVE CARE — WHERE TO BEGIN?

We hoped to develop a universal and systemic screening process that would identify patients' palliative and end-of-life care needs, leading to improved access to appropriate care. The goal was to identify patients early and provide palliative services throughout their entire disease trajectory.

THE ST. JOHN PROVIDENCE HEALTH SYSTEM

PALLIATIVE CARE TRIGGER TOOL

(MD order required)

- Code status changed to DNR
- Conflict about stopping/starting life-prolonging treatment (e.g. dialysis, chemotherapy)
- Goals of care or code status discussion needed and/or surrogate or proxy distressed about decision-making
- Uncontrolled symptoms (pain, nausea, dyspnea, insomnia, fatigue, weight loss) that interfere with quality of life
- Marked decrease in functional status/ADLs in last 60 days
- Considering PEG tube placement
- Admitted from extended-care facility with ADL dependence or chronic care needs

The first step was to put together a work group made up of physicians, clinical managers and staff nurses along with a nurse practitioner, case manager, social worker, director of care management and nursing director.

Their task was to create a screening tool, test and adjust it based on user feedback, then measure outcomes to assess its impact.

They started with a literature review and found more than 20 hospice and palliative care screening tools already in use around the country. These examples helped them better define and organize the kind of patient information that would point to palliative needs. Grouping of patient information was key and they developed a primary checklist (along with multiple identifiers). Any element checked would trigger a request to the attending physician to order a palliative care consultation. The main screening information groups were:

- Critical incident/ventilation
- Hospitalization
- Diagnosis
- Physical/functional status
- Psychosocial and decision-making issues
- Hospice/palliative care

TESTING THE TOOL

The next step was to try out the tool. It quickly became clear that we needed a test unit in the hospital where it would be easy to use, evaluate and revise the tool and process. We chose the 20-bed medical intensive care unit, small enough to allow for rapid identification of any issues and easy changes — plus, the management, staff and ICU physicians supported the idea of screening for palliative care needs.

Next came figuring out the process for using the tool. The work group determined the case management team (case manager and social worker) possessed enough information to fill out the checklist and had the time and expertise to complete the required follow-up with physicians. They were assigned to complete the tool on Monday and Thursday of each week during multidisciplinary rounds.

FACING A BARRIER

An early barrier to the process involved attending physicians who were reluctant to order a palliative care consultation. Among their common stated reasons: "It's too early," "I'm not sure the family is ready for that" and "let's give it some more time."

Though the reactions were not surprising, they frustrated the ICU physicians and staff. This led to policy change, approved by the medical executive



committee, which allowed ICU physicians to order a palliative care consultation. This revision allowed us to work alongside the ICU team to meet patient needs while we made a continued effort to communicate with the attending physician. The result was an immediate upsurge in palliative care consultations in the medical intensive care unit, ultimately reaching a 200 percent increase over a one-year period.

REFINING THE TOOL

During this initial 12 months of patient screening, user feedback led us to make multiple revisions to the palliative care screening tool and, four months into the screening process, add people to the palliative care team.

Then we were ready to expand the trial. We added the screening tool process to the oncology unit and a medical unit. We found these patients had less identified palliative care needs than the ICU population, and again we met some attending physician resistance. Users also pointed out that the length of the screening tool was proving troublesome.

Based on this feedback, we did a data review of the more than 1,500 patients who had been screened and identified nine common indications for palliative care. We named them the “palliative care triggers” and used them as a new screening method in all acute care patient units. Feedback told us the quick-look triggers were more user friendly, and we incorporated them into the nursing database for screening all patients on admission.

Data collection and evaluation occurred throughout the project and led to significant changes in process and in the actual tool. Besides noting the common patient characteristics indicating a need for a palliative care consultation, we also tracked:

- Number of consults per year
- Average time to palliative care consult from admission and discharge
- Percentage of patients discharged alive
- Number of units referring five or more patients per year
- Cost savings attributed to palliative care
- Yearly hospice referrals

WHAT WE LEARNED

Looking back at St. John Providence’s work to launch universal palliative care screening, here are lessons that other hospitals or systems might use in the same type of quality improvement project. In summary:

- Screening must be backed up by ability to provide care
- Screening must be incorporated into existing procedures — and must be mandatory

- Staff must be trained in screening procedures and required follow-up

- Each unit will have different levels of need for palliative care

- Physician acceptance will vary — understanding and acceptance must be built

- It takes time and persistence to change behavior

NEXT STEPS

Our goal was equitable distribution of palliative care services to all patients that pass through our doors, and screening for needs seemed to be the perfect answer.

We continue to work on rolling out screening to all the hospital sites in the St. John Providence Health System, and we continue to work on process refinements too. For example, St. John Providence is currently transforming written documentation into an electronic medical record. As part of that changeover, the palliative care triggers will be incorporated into the new electronic system so nurses can continue to make those assessments when a patient is admitted. This will ensure that all patients are assessed in the electronic medical record for palliative care needs at every St. John Providence hospital.

Looking ahead, we hope to develop palliative care triggers specific to home care, the emergency department and nursing home facilities. St. John Providence Health System views palliative care as an integral part of the mission to provide holistic, spiritually centered care with special attention to the poor and vulnerable.

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JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

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Reprinted from *Health Progress*, January-February 2011
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