Advancing Palliative Care across the Continuum

Kristen Smith, MSN, RN, MSW
Palliative Care Program Director, Inova Health System
• Palliative care across the continuum of care

• Expanding capacity among staff
  • Screening
  • PPRN

• New models
  • Home Health
  • Transitional Care

• Future of palliative care
Palliative Care Outreach

COMMUNITY
- Care Management
- Home Health
- Community Health
- Congregational Health
- Innovation Health
- Cancer Center
- Long term care/ALF/SNF

Nursing (Hospital & Community)
- Screening (integration into workflow)
- Education (Healthstream and live)
- Goal - RN FTEs OUs & Service lines clinical educators and navigators

HOSPITALS
- IFMC
- IFOH
- IAH
- ILH
- IMVH

HOSPICE
- Home
- Inpatient

Case management (Hospital & Community)
- Screening / Tracking (Optimize)
- Education (Healthstream and live)
- Goal – seamless flow across the continuum

Palliative Medicine & Comprehensive Care

Physicians

Foundation
IFMC Palliative Medicine & Comprehensive Care (a new model of care)

Program Design:
Integrated service line that strategically incorporates overlapping elements to provide an interdisciplinary team model of care

- Advanced cardiac & pulmonary
- Cancer services
- Critical care
- Nursing
- Hospitalists education and QI
- Emergency room
- Emotional and spiritual support
- Advance care planning
- Bereavement
- Longitudinal PC service navigation
- Hospice and end of life supportive counseling
Clinical Integration at IFMC

- Supportive cardiology trial
- Clinical effectiveness integration - TCM
- High flow Oxygen protocol

LTAC / NH / ALF
Home Health
Transitional Care
Community Palliative care

Palliative Care Bundle initiative
Formalize screening and consultant expectations
Compassionate weaning protocol
Staff education

CHF/Pulm

Inova Fairfax Hospital
Palliative Medicine & Comprehensive Care

ICU

Transitional Care/Longitudinal Care

Oncology Cancer Center

ER

Navigators - Life with Cancer
Work to develop clinical integration
Symptom assessment standards

Identify champions
Create Palliative Care & Hospice workflow

Hospice & Palliative Care in the Community
Hospice Preferred Provider Metrics
Longitudinal palliative care service delivery
Palliative Care in the Community

Office based practice:
- 4 offices in Northern Virginia
- Require Physician/NP referral
- Staffed by MDs and NPs

Nursing Home based practice:
- Require MD referral
- Mainly NP visits

Home based practice:
- Limited availability
- Require MD referral
- MD/NP visits

Join the future of health
Palliative Care Hierarchy

- **Primary Palliative Care** – primary team or attending provide primary palliative interventions

- **Secondary Palliative Care** – consultants with expertise and special training provide palliative care

- **Tertiary Palliative Care** – academic centers for clinical care, teaching, and research
Perspective

Generalist plus Specialist Palliative Care — Creating a More Sustainable Model

Timothy E. Quill, M.D., and Amy P. Abernethy, M.D.

Representative Skill Sets for Primary and Specialty Palliative Care.

Primary Palliative Care
- Basic management of pain and symptoms
- Basic management of depression and anxiety
- Basic discussions about
  - Prognosis
  - Goals of treatment
  - Suffering
  - Code status

Specialty Palliative Care
- Management of refractory pain or other symptoms
- Management of more complex depression, anxiety, grief, and existential distress
- Assistance with conflict resolution regarding goals or methods of treatment
  - Within families
  - Between staff and families
  - Among treatment teams
- Assistance in addressing cases of near futility
### Epic Palliative Care Screen

#### Palliative Care Screen

<table>
<thead>
<tr>
<th>General Palliative Care Domains</th>
<th>2200</th>
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<th>0200</th>
<th>0400</th>
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<tr>
<td>General Disease Category</td>
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<td>Specific Disease Category</td>
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<td>Outcome Palliative Care Screen</td>
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#### Elopement Risk Screen

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<tbody>
<tr>
<td>Elopement Risk CAT 1 Criteria</td>
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<td>Elopement Risk CAT 2 Criteria</td>
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<tr>
<td>At Risk for Elopement?</td>
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#### Braden Scale

| Sensory Perceptions            |      |      |      |      |      |      |      |
| Moisture                       |      |      |      |      |      |      |      |
| Activity                       |      |      |      |      |      |      |      |

#### Selection Form

- Uncontrolled Symptoms (dyspnea, nausea, vomiting, pain $\geq 5/10$ $\geq$ equal to 24 hrs)
- Help with complex decision-making and determination of goals of care
- Patient with AND/DNR orders
- Former Hospice patient (Pos screen)
- Innovations health identified positive screen (Pos Screen)
All staff can now identify patients screened for palliative care and view the outcome of the discussion.

<table>
<thead>
<tr>
<th>Unit</th>
<th>Age/Sex</th>
<th>Primary Problem</th>
<th>Code Status</th>
<th>Religion</th>
<th>Palliative Care Screen Outcome</th>
<th>Palliative Care Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>ST ICU TRAUMA</td>
<td>50 y.o. / M</td>
<td>Bacteremia Associated With Intravascular Line (More)</td>
<td>FULL</td>
<td>Baptist</td>
<td>Screened, met criteria for intervention</td>
<td>Physician to provide primary palliative care [MD notified]</td>
</tr>
<tr>
<td>ST STROKE</td>
<td>57 y.o. / M</td>
<td>C. Difficile Diarrhea (More)</td>
<td>DNAR w/ Supp</td>
<td>Unknown</td>
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<tr>
<td>ST ONCOLOGY</td>
<td>28 y.o. / F</td>
<td>Mds (Myelodysplastic Syndrome) (Adm Diag)</td>
<td>AND/DNAR</td>
<td>None</td>
<td>Screened, met criteria for intervention</td>
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</tr>
<tr>
<td>ST ONCOLOGY</td>
<td>70 y.o. / F</td>
<td>Pancreatic Mass With Hepatic Lesions (Principal Prob)</td>
<td>FULL</td>
<td>Unknown</td>
<td>--</td>
<td>Palliative care consult initiated or already involved</td>
</tr>
<tr>
<td>ST ONCOLOGY</td>
<td>62 y.o. / F</td>
<td>Cancer Of Pancreas (Principal Prob)</td>
<td></td>
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<td>Screened, met criteria for intervention</td>
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<tr>
<td>ST NSICU NEURO</td>
<td>41 y.o. / M</td>
<td>Ich (Intracerebral Hemorrhage) (More)</td>
<td>FULL</td>
<td>Unknown</td>
<td>Screened but did not meet criteria for intervention</td>
<td>--</td>
</tr>
<tr>
<td>ST MSICU MED</td>
<td>77 y.o. / F</td>
<td>Infection Of Prosthetic Knee Joint On Right With Mrsa (Principal Prob)</td>
<td>DNAR w/ Supp</td>
<td>Pentecostal</td>
<td>Screened, met criteria for intervention</td>
<td>Physician to provide primary palliative care</td>
</tr>
<tr>
<td>SURG ICU</td>
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<td></td>
<td></td>
<td></td>
<td>Patient/Family believe palliative care not appropriate at this time</td>
</tr>
<tr>
<td>ST MSICU MED</td>
<td>81 y.o. / F</td>
<td>Sepsis</td>
<td>FULL</td>
<td>Christian</td>
<td>Screened, met criteria for intervention</td>
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</tr>
<tr>
<td>SURG ICU</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Palliative care consult initiated or already involved</td>
</tr>
<tr>
<td>ST MSICU MED</td>
<td>69 y.o. / F</td>
<td>Ards (Adult Respiratory Distress Syndrome) (More)</td>
<td>DNAR w/ Supp</td>
<td>Catholic</td>
<td>Screened, met criteria for intervention</td>
<td>--</td>
</tr>
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RN Screening for Palliative Care

Palliative Care screen will be added to RN Admission Navigator in Epic

All nurses across the system will identify patients in need of palliative care at admission

Nurses often identify the need as a trusted caregiver & confidant of the patient & family

Goal is to empower nurses to transform the culture by advocating for earlier palliative care & addressing unmet needs

Coming in 2014!
88 nurses across the system attended the first ever PPRN program

Monthly PPRN meetings to review pain audits, discuss difficult cases & craft huddle messages

2 nurses on every unit serve as content experts and peer resources

Champions for palliative care screening & advance directives

Planning for new class of PPRNs in 2014
Advance Care Planning (ACP)

Advance care planning training for congregations and nursing homes

Epic AD Task Force to create alerts for missing documentation & process for completion

Getting Started with advance care planning:

- Learn about life-sustaining treatments
- Reflect on your values
- Decide what you want & what you do not want
- Talk to others

National Healthcare Decisions Day

Building ACP coalition with local health systems, SNFs, hospices, home health, & congregations

Advance directives toolkit on InovaNet

New hospice & palliative care brochures for patients & families
Home Health: AD Algorithm

Advance Directives Documentation Algorithm

For info r/t Durable Do Not Resuscitate (DDNR) status:
- Clinical Explorer
- Notes
- Admission Note
- Referral Information
- Pertinent History

Patient does not have an Advance Directive

- Answer any question patient may have to the best of your abilities
- Provide patient with resources made available by VNAH HH
- Make a referral to MSW
- Direct patient to:
  - Physician
  - Attorney
  - Document interventions/recommendations made in clinical note

Patient has an Advance Directive

Provide Pt/Cg. with handout that explains patient’s rights concerning medical care and advance directives (included in admissions packet)

1. Document on the Admissions Agreement form

2. Request copy of advance directives to be submitted to the agency

3. Document patient’s choice regarding CPR

If patient makes this choice

4. Notify patient’s physician and obtain DDNR orders
5. Document in Clinical Explorer:
   - Patient Profile
   - Advanced Directive
   - Directives (drop down)
   - Select Do Not Resuscitate
6. If home health aide is part of the care team → Document in Telephony Care Plan
7. Notify members of the care team of patient’s code status

If patient has a signed state EMS form, instruct patient to:
- Display the form in easy to access/visual spot in the home
- Keep a copy of the DDNR form with them at all times
If patient does not have a signed EMS form, refer pt/cg.
to: http://www.vdh.virginia.gov/oems/files/page/ddnr
www.virgi niaregistrgy.org
Home Health: Palliative Care Screen

- Select all the triggers that apply to your patient
- **Selection of two or more triggers indicates a positive screen**
- Initial screen to be completed during episode of care
- Patient should be re-screened when readmitted to home care after a readmission to a higher level of care due to declining clinical condition

### General Palliative Care Domains

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<th>Trigger</th>
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<tr>
<td>✔️ Uncontrolled symptoms (Dyspnea, nausea/vomiting, pain&gt;5/10) &gt; 24 hours</td>
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<td>✔️ Patient/caregiver/family under psychological or spiritual distress and need help with complex decision-making and determination of goals of care</td>
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<tr>
<td>✔️ Patient (especially long-term care resident) with AND (Allow Natural Death) and DNAR/DNR (Do Not Attempt Resuscitation) orders</td>
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### General Disease Category

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<td>□ Multiple hospitalizations: 2 or more in past 6 months for the same or similar diagnosis</td>
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<tr>
<td>□ Age ≥ 70 years in the presence of two or more life-threatening co-morbidities (ESRD, severe CHF)</td>
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<td>□ Declining ability to complete activities of daily living</td>
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### Specific Disease Category
Transitional Care

- Follow for 30 days post discharge (CHF, COPD, Diabetes)
- Self management model based on 4 pillars
  - Medication reconciliation
  - MD follow-up appointment in 7 days
  - Patient and/or caregiver have knowledge of red flags and appropriate response
  - Patient centered record
- Telephonic (minimum of 5 calls), using “call scripts” by disease
- Identify gaps in care and secure services
- Model includes palliative care screening, advance care planning and referrals to hospice or palliative care if appropriate
Future of Palliative Care

- Palliative care conversations in the community
  - Congregations
  - Schools
  - Media

- Palliative care in the outpatient setting
  - Patient-centered medical home
  - Home-based models
  - Hospice partnerships
  - Telemedicine
  - Transitional care & discharge clinics
  - Case management services
  - Specialty clinics (cardiology, oncology)
  - Partnership with payers
Models for Palliative Care

- Inpatient Consult Service
- Telemedicine
- Inpatient Unit
- Provider Home Visits
- Outpatient Specialty Clinics
- SNF Consult Service
- Outpatient PCP Clinics