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Improved efficiency in service of patients

Team Tightens Timeline to Hasten Transition to Palliative Care

By Tyler Smith

Efforts to trim the amount of time required to rush patients to lifesaving care, such as angioplasty, clot-busting medications, and CPR, are staples of process improvement in the health care world. An initiative launched last year at University of Colorado Hospital also aims to save time, but with a different objective: transitioning palliative care patients to the next stage of their lives.

The project was the brainchild of the Palliative Care Consult Service (PCCS), which works with providers to assist patients with serious illnesses in identifying and meeting their care goals. The aim of a palliative care consult is not to cure disease or search for new avenues of lifesaving treatment, but rather to help patients and their families find the most effective routes to manage pain and symptoms and improve quality of life.

The project helped the PCCS get its own house in order, says Harri Brackett, lead advanced nurse practitioner for the service.

The PCCS developed the project through the Certificate Training Program of the Institute for Healthcare Quality, Safety and Efficiency (IHQSE). The team's original goal was to reduce the average time from hospital admission to the initial PCCS consult from six days to five. With a tighter timeline, patients would get earlier help managing their pain and other symptoms, such as depression, fatigue, and nausea.

In addition, an earlier consult would help to facilitate the patients' discharge from the hospital to home, or to the level of care best suited to their needs and those of their loved ones, with the extra support they need – a key to maximizing the quality of the time they have remaining. These efficiencies would, in turn, help the hospital manage capacity humanely as well as avoid the costs of extended stays without sacrificing the quality of patient care, the team reasoned.

Even without these benefits, sheer numbers pointed to the importance of starting the palliative care consult process earlier. In 2005, the first year of its existence, the PCCS responded to an average of 11 consult requests a month. The number rose to 55 by late 2013, when the PCCS received advanced certification from the Joint Commission. Today, the average is in the 80s, said Harri Brackett, RN, MS, lead advanced nurse practitioner with the PCCS.

What a difference a day makes. A reduction of a single day doesn't sound like much, but in a bustling academic medical environment with providers juggling crowded schedules, 24 hours can be hard to find. Beginning in January 2014, the IHQSE team worked with PCCS leaders to analyze the entire process surrounding a palliative care consult, from admission to discharge. Several months of work revealed that the first order of business for the PCCS team was not shortening the amount of time to the initial consult, as they originally thought. Rather, work was needed to trim the roughly day and a half between the time a consult request was received and when it actually took place.

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The IHQSE team developed data that told that story in stark terms. In fiscal year 2008 (July 1, 2007 to June 30, 2008), a little more than 20 percent of requested consults were delayed by a day or more. In fiscal year 2013, the percentage was well over 50 percent.

With the improvement target decided, the initial phase of the IHQSE project rested on finding ways to "move palliative care upstream," said Jeanie Youngwerth, MD, a hospitalist and medical director of the PCCS. That meant the team had to put its own house in order before it could look to providers to request consults earlier.

"We want people to think about palliative care earlier rather than later," Brackett said, "but to do that, we had to make our own team more efficient and productive."

On the clock. The changes, which were put in place in July 2014, were not dramatic in and of themselves, but taken together, they accomplished the goal of getting patients palliative care faster. This included assigning the busy pager to one person who then also scheduled times for the 90- to 120-minute consults; standardizing interdisciplinary rounds; and dividing work efficiently between the PCCS attending physicians and other team members.

Along with those improvements, the PCCS team also focused on post-consult efficiencies. These included making sure rounds started on time and that they followed a script that addresses patients' issues, including pain and symptom management, psycho-social needs, advance care planning, and spiritual support, Brackett said.

The rounds include physicians, advanced care providers, social workers, and chaplains, as well as residents, fellows, students, and other "learners," Youngwerth said. But the scripts aim to keep things tightly organized and efficient. "We encourage people to follow the script to keep us on track and make sure we are discussing important information when the entire team is present for their input," she said.

In addition, the team placed heavy emphasis on encouraging providers to document their care in the medical record on an "as you go" basis, rather than taking the work home or delaying it until the next day.

"We found that when people completed their notes earlier, they also communicated better with the entire health care team," Brackett said.

Process pay-offs. The team collected post-implementation data on about 280 patients that revealed important process improvements. Post-consult average length of stay (ALOS) for palliative care patients fell by nearly a day and a half, as did total ALOS. An analysis showed that the shorter ALOS would produce "significant cost savings per patient per day," Youngwerth said – perhaps as much as $3.4 million annually.

Jeanie Youngwerth, MD, medical director of the Palliative Care Consult Service, says the initial aim of the IHQSE project was to "move palliative care upstream" so that patients receive its benefits earlier.

The team is now looking to build on its success by returning to the original goal of getting patients to consults earlier. That effort includes expanding rounds to patients with heart failure and those with the Acute Care for the Elderly (ACE) service, Brackett said.

The hospital stands to benefit from the changes, but the work ultimately aims to improve the lives of patients and families by helping them to get the care that is most meaningful to them and matches their values and desires, Youngwerth said.

"As providers, we are the learners," she said. "We have the privilege of hearing about our patients' experiences and incorporating those back into their plans of care."

It's important that providers recognize that patients' priorities drive decisions about the next steps of their care, Brackett added.

"When in doubt, we go back to their goals," she said.

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UCHealth CENTRAL INSIDER
UNIVERSITY of COLORADO HEALTH
Volume 9 | Issue 1 | July 21, 2015 | *Page 3*

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