

AWARD WINNER

PALLIATIVE AND END-OF-LIFE CARE PROGRAM
HOAG MEMORIAL HOSPITAL PRESBYTERIAN

Newport Beach, California





It started out as one faith-based community hospital's effort to improve end-of-life care within its walls. What Hoag Memorial Hospital Presbyterian in Newport Beach, California, has achieved is a sustainable model that has introduced supportive and palliative care as a routine part of treatment for the seriously ill. And it's a model that's already been replicated at a dozen other hospitals.

Just a few years ago, Hoag's clinical leaders recognized that while the hospital had embraced a number of progressive quality-of-care projects — such as staffing hospitalists and intensivists — the consistency of end-of-life care could be better. Fitting the hospital's culture of making change through process improvement, a team was formed to examine the experiences of dying patients and their families and look for ways to improve.

The result was a supportive care initiative that established a clinical pathway with a pre-printed order set and nursing plan of care to provide high-quality care to actively dying patients and their families. A social worker, Sharon Lucas, was hired as coordinator of the program in July 2000, and her successor, Cheryl Steffen, who remains the only full-time paid position, continues to enhance the program. In 2003, a palliative care team of physicians, nurses, social workers, respiratory therapists, and chaplain was established, with the leadership of pulmonologist and Ethics Committee chair Paul Selecky, MD, who brought together six other physicians interested in improving symptom and pain control for the seriously ill. The team offers its services to Hoag physicians on a consultation basis, sometimes in conjunction with the pathway for end-of-life care. They make clear that palliation is available also to patients for whom the pathway would not be appropriate.

Hoag now has a compact but robust end-of-life program that has enticed more and more Hoag physicians to use it because they don't feel they are *losing control* of their patients to other doctors or to a *cookie-cutter* process. Steffen, rather than a physician, responds to requests for supportive and/or palliative care; she can then gently persuade any skeptical physician to accept the assistance of other team members as needed or to place the dying patient on the supportive care pathway that puts into motion an end-of-life care plan, including pain control, spiritual and emotional support, and discussion of other critical issues. "We don't take over; otherwise we would never be called," Selecky notes.

They call it a *triage* model, led by a social worker. "It's a better use of the team physician's time, who is called in when needed," states Steffen. "The nurse and social worker are often the key people in identifying needs. They have the capability to make a global assessment of how much is family dynamics, how much is pure symptom management, how much is a spiritual issue." The triage model also enables the coordinator to consult informally with nurses, patients, or family members who want more information about how this program may be of benefit.

The team's job is made easier by the presence of intensivists in the ICU and hospitalists on the med/surg units, who have embraced palliative care and the pathway approach. The pathway is in use in more than one-third of hospital deaths.

The Hoag program has taken advantage of the increasing training opportunities for both nurses and physicians in palliative care. Continuing education of nursing and other staff is in place and has been extended to physician office staffs.

Hoag continues to develop innovative approaches to end-of-life care. For instance, an advance directive admission worksheet is used for all patients, resulting in 70 percent of patients having advance care planning documentation. Also, the team put together a comprehensive family education brochure in English and Spanish that

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INNOVATION HIGHLIGHTS

BROAD PHYSICIAN LEADERSHIP AND INVOLVEMENT

INNOVATIVE PAIN MEASUREMENT AND MONITORING SYSTEM

HIGH IMPACT, REPLICABLE, LOW COST PROGRAM

describes what happens physically to a terminally ill person and how to respond. Another brochure guides families after a patient's death, offering resources, contacts, checklists of things to do, and information about stages of grief, along with suggestions on handling depression and talking with children. Much of this information is available on a comprehensive website, which offers an unusually candid and complete discussion of end-of-life issues.

A perinatal loss bereavement program supports parents who lose a baby either during or right after the pregnancy. Imaging professionals as well as other hospital personnel are taught how to talk with parents when ultrasound or other evaluations reveal that their baby is in distress or has died. The program also has provided outreach to physicians' offices by providing perinatal-loss training to ensure the continuity of care. A bi-lingual social worker and RN facilitate a bereavement support group for parents.

Chaplain support is an integral part of all palliative and end-of-life care programs at Hoag. Chaplains visit all patients on the Supportive Care Pathway, and their services are offered to all other patients. In addition, chaplains run a staff support program called *Tea Time for the Soul* to address compassion fatigue of hospital caregivers.

Team leaders are careful to document their work, monitoring quality and financial indicators. Particular focus is given to pain control, physician use of the pathway, family education, and length of stay. Outcomes after four years of experience with the program remained well above *celebration level* for many indicators. Pain control within 4 hours and 24 hours of initiation of the pathway is at 99 percent to 100 percent.

Future plans include the addition of a pain resource nurse as part of the team's full-time staff. And the palliative medicine consult service is working with community hospice agencies to provide in-home palliative care service for patients who are not yet ready to enter hospice.

Hoag's team also helps other hospitals set up palliative and supportive care programs. Selecky often uses the phrase *If you build it, they will come* in talking with other hospitals that are contemplating developing a palliative care program. It is clear that each program develops in its own way, depending on the needs and resources of that institution. Lucas in her new role as private consultant has been successful replicating this program in many other hospitals, adapting it to the local resources and culture.

What appears clear from Hoag's experience is that the program will continue to grow, sometimes in unexpected ways, because the need for support and open discussion concerning end-of-life care issues and planning is so great. Although Hoag's program has been developed as an inpatient program, the coordinator fields requests weekly from outside the hospital. Patients, families, outpatient program personnel, churches, and other community organizations request counseling, education, or resource information regarding end-of-life care. Hoag's commitment to palliative and end-of-life care extends beyond the hospital walls, finding the resources to address its community's needs as they surface. •