

AWARD WINNER

MERCY SUPPORTIVE CARE
ST. JOSEPH MERCY OAKLAND

Pontiac, Michigan





St. Joseph Mercy Oakland Hospital in Pontiac, Michigan, a member of Trinity Health, is a 428-bed community hospital in a modest suburb of Detroit. In this community, with its share of economic and social challenges, the passion of St. Joseph Mercy Hospital staff members to improve end-of-life care has resulted in a shining model that is innovative, effective, and sustainable.

Mercy Supportive Care, a pain and palliative consultation team, composed of members from all disciplines, and led jointly by a nurse practitioner and physician, shares the core belief that extends beyond their consults and permeates the hospital; suffering is not acceptable. “The whole idea of creating a culture of compassion is that it doesn’t allow suffering to occur,” says Peg Nelson, NP and director of Supportive Care services.

“We really believe to transform the organization, the service went beyond being seen just as a program, as the philosophy and beliefs became part of how we care for patients throughout the continuum,” says Barb Hertzler, executive vice president and chief operating officer. Peg Nelson and Ken Richter, MD, medical director, believe passion, the team approach, and the scattered-bed concept have helped spread the culture of compassion.

Making palliative care part of the culture at this hospital is an ongoing commitment. An intensive training program ensures that staff is very aware of the importance of symptom and pain control. Training is unusually comprehensive — all nurses receive five hours of pain management during orientation and many choose to retake the course offered each quarter. Numerous in-services are also offered to all staff on ethics, advance directives, and end of life. Medical education has also integrated pain, palliative and ethics education and experiences within obstetrics, medical, and surgical residencies.

The impact of the program is evident in initial pain scores of patients referred to supportive care. Before the program started, overall pain scores were 7.8 on a ten-point scale, but now they’ve dropped to 3 before patients are referred to supportive care services. “Symptom management has improved across all clinical services, which shows that the culture has really changed,” Nelson says.

This new culture began in 1995 when a group of physicians and nurses reviewed resuscitation practices. As the group discussed outcomes, it identified opportunities to improve the way patients died. A multidisciplinary group then worked to reduce suffering throughout the hospital, and the consultation team started seeing patients in 2000.

The hospital didn’t stop at creating a palliative care team. For instance, when the hospital chose to seek and received JCAHO accreditation as a certified stroke center (the first in Michigan), it created a model of care for comprehensive management of stroke that included palliative care at every step as appropriate.

The palliative care program is continually analyzing its results and looking for ways to reduce suffering among patients, family, and staff. Nursing staff analysis of suffering within areas where the most death occurred also identified higher turnover rates. Subsequently, training and supports were put in place that improved satisfaction among nursing, which is very key to long-term retention and maintaining improvements, Nelson believes.

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INNOVATION HIGHLIGHTS

INNOVATIVE MODEL OF STROKE CARE THAT INCLUDES PALLIATIVE CARE

UTILIZATION PERSON ON THE TEAM TO HELP WITH COMMUNICATION WITH INSURANCE COMPANIES

HOSPITAL-WIDE CULTURE THAT SUFFERING IN ANY FORM IS NOT ACCEPTABLE

The hospital's supportive care program is remarkably simple and relatively inexpensive — relying on existing hospital staff and resources and requiring only two fulltime and two part-time staff members — and has significantly reduced the cost per case and shortened length of stay in intensive care for the dying.

Results have captured attention from other community hospitals. St. Joseph Mercy Oakland staff has been generous with their time; educating others, including competing hospitals in the hospital's own market, about the program. "At last count, we have shared our program with well over 80 organizations," says Nelson. "Many send teams of administrators and clinical staff to see how we operate so they can replicate it within their settings."

Some of that attention was generated by the program's recognition with a Citation of Honor in the 2004 Circle of Life Awards.

Among the innovations that garner the most interest from other hospitals, Nelson says, are comfort carts on every unit, which carry music, a CD player, spiritual support, hand casting supplies, and homemade blankets to wherever death occurs. Also there's a lot of interest in the "no one dies alone" program. More than 60 volunteers have been trained in the last year and served more than 2,000 hours at the bedsides of the dying. "It's become a critical component of the service as it offers relief to families who can't be with their loved one, and to staff also, who may not be able to spend the time they'd like at the bedside," says Nelson.

The services are integrated within the community by also offering an outpatient pain and palliative care clinic and case management program, which serves patients not in hospice or home care. Other unique features include a program developed within ambulatory services, which supports women undergoing miscarriage; linkages with home care, hospice, and parish nurse programs; as well as bereavement follow-up for all families who experience death at the hospital.

While Peg Nelson has been the heart of the supportive care effort over the past several years, the culture of compassion she's helped nurture is now ingrained, says Hertzler. "She's really created a critical mass of dedicated individuals across all disciplines who have made care for the suffering a routine aspect of their daily care. It's sustainable because there's such awareness, understanding, and successful outcomes."

While St. Joseph Mercy Oakland's care model runs on relatively modest funding, its growth will require a commitment from the top. "We recognize that as volume increases we'll need to commit more resources," says Hertzler. "While there's not always a direct revenue stream associated with palliative care, we've got clear evidence that it leads to more appropriate use of resources and better patient outcomes. We'll continue to invest and sustain the services because it's the right thing to do." •