

VETERANS HEALTH ADMINISTRATION VISN 3

Brooklyn, New York

Sometimes organizations make internal changes and wonder if they'll ever have a real impact on people. The Department of Veterans Affairs Integrated Service Network (VISN) 3, which serves veterans in New York and New Jersey, didn't have to wait long to see how new connections between its palliative care program and community hospices would bear fruit.

A veteran was receiving a home hospice visit when his wife had a heart attack. He couldn't stay home alone while his wife was in the hospital, so hospice and VA palliative care staff went into action to find an open bed in the New York area for a patient who hadn't used the VA system in decades. This extraordinary collaborative effort involved dozens of phone calls among hospice and VA nursing home staff. The man's son came in from out of town, and by the time he arrived his father was in a VA nursing home that had been ready with a bed and his father's prescription medications. "The son said, 'It's like magic! I thought with the VA there's so much red tape it takes an act of Congress to get anyone in there,'" recalls Doris Quijano, Geriatric and Extended Care coordinator for VA's VISN 3.

Most of the people involved were not assigned specifically to this man's care, but they stepped beyond their regular responsibilities to fill in potential gaps in the continuum. "Just a few weeks earlier, we had a Hospice-Veterans Partnership meeting where contact names at the various agencies were shared. They came in handy in his case," Quijano explains.



Outreach with local hospice agencies is one of the critical elements of VISN 3's special emphasis on palliative care. Responding to a national VA initiative on the topic, leaders in the New York region took the mandate further, setting up a program that transcends boundaries along the continuum of care and emphasizes use of data to fuel performance improvement. "Our goals were to set up a network-wide palliative care program to provide uniform palliative care to patients in all venues of care, including acute care hospitals and nursing homes," says Carol Luhrs, MD, director of Palliative Care for VISN 3, who is based in Brooklyn. The approach emphasizes relationships both within VA and with community organizations such as hospices and veterans groups.

Those relationships are allowing the VA to give more seamless care at the end of life. "We have all learned from each other," Luhrs says. "Where there's been a best practice at one site it's been readily adopted at another site. There's

a degree of cooperation that's unusual — it's a special group of people who commit themselves to palliative care."

Another program strength is its ability to gather data from the various clinical templates that each caregiver fills out. "The VA has a lot of templates and things caregivers have to do," says Luhrs, prompting some concern that they would resist more paperwork. But templates that guide a comprehensive palliative care consultation and collect psychosocial and spiritual information not only allow practitioners to follow a single standard of care, but also collect useful information.

Those data are processed through the VA's powerful information systems. The outcomes are fed back to the palliative care teams, offering valuable perspective on their work. "Once you can see your progress, you're really empowered to do better," says Luhrs. And for those locations where outcomes are not what they could be, teams meet to review the data and participate in changing processes. This cooperation is what's made VISN 3 successful. "Having a network that has pockets of expertise and can bring them together has been one of our biggest strengths," Luhrs says.



INNOVATION HIGHLIGHTS

STRONG RELATIONSHIPS WITH COMMUNITY HOSPICE

TRAINING OF CNAs IN PALLIATIVE CARE

COMMITMENT TO OFFERING PALLIATIVE CARE TO LONG-TERM CARE PATIENTS IN HOME AND COMMUNITY-BASED PROGRAMS