

AWARD WINNER

PROVIDENCE HEALTH SYSTEM

Portland, Oregon





When quality end-of-life care is elevated to a system's top-five list, you know it has "arrived." That's precisely what has happened at Providence Health System, in Portland, Oregon. For Providence, end-of-life care isn't just a program, it's a system-wide clinical priority — so crucial that it's part of a dashboard that measures system performance, and so highly valued that it factors into the annual bonuses of all of the system's 1,000 managers.

"Quality end-of-life care is something this organization wants to do, not something we have to fight for," says Adrienne Simmons, regional director of planning, and director of the end-of-life program. "It's driven by our mission and values, and we get encouragement from every level."

In a health system as integrated as Providence, there are many opportunities to incorporate an end-of-life focus — and Providence has. Providence is the largest health system in Oregon. Its Portland service area includes two tertiary-care hospitals, a community hospital, hospice, employed and affiliated physician groups, an HMO, and a PACE site.

Providence's philosophy for its end-of-life care program is to be proactive and to span the entire continuum of care — from advance care planning during office visits with primary care physicians, to supporting families through bereavement. Each year Providence provides an average of 8,000 end-of-life interventions through hospice, chaplain visits, health-plan case management, ethics consults, its Connections volunteer program, its Supportive Care team, ElderPlace, and music thanatology. In addition, its Community Care program provides free end-of-life training sessions for churches, civic organizations, and businesses.

A center of energy for this focus is the Excellence in End-of-Life Steering Committee. This interdisciplinary group, led by a physician champion, meets quarterly to share best practices, review end-of-life activities, disseminate end-of-life measurement results, and initiate new projects.

Providence's end-of-life effort starts with advance care planning. Physicians, including medical residents, identify a proxy decision-maker for everyone over age 18, and they document this information in the electronic medical record. Physicians encourage all patients — particularly those over 65 and younger patients whose medical circumstances dictate — to complete an advance directive. For patients over 75, Providence recommends a document known as POLST (Physician Orders for Life Sustaining Treatment). Providence was involved in developing this extremely practical document — a physician order for emergency interventions such as CPR that is honored by emergency medical personnel. Its acceptance is widespread: 98 percent of PACE participants have POLST in their medical records.

"The value of advance care planning is incalculable," says Glenn Rodriguez, MD, regional medical director, health services integration. "Things can happen very quickly at any age. Thinking ahead makes a big difference. If we can do it right, we can help families make this difficult transition with a sense of support and grace and peace."

Providence's efforts to educate physicians and other clinicians about end-of-life issues are making a difference, too. Providence encourages physicians and other caregivers to attend EPEC, ELNEC and TNEEL educational programs. In addition, the system did "academic detailing," which compensated physicians for the time they spent learning about advance care planning and how to document it in the office-based electronic medical record.

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INNOVATION HIGHLIGHTS

SYSTEM-WIDE COMMITMENT TO
END-OF-LIFE SERVICES

“FAMILY OF MEASURES” INDEX FOR
QUALITY IMPROVEMENT

EMPHASIS ON ADVANCE CARE PLANNING

The wide spectrum of Providence’s end-of-life interventions includes many innovations. One that has drawn considerable attention is the system’s employment of two, full-time music thanatologists, as part of their Pastoral Care departments. These professionals create 20- to 60-minute harp vigils for patients nearing the end of life or facing a particularly painful or difficult medical procedure. The service is provided at no charge.

“We offer music that’s individually crafted to patients’ and families’ emotional, spiritual, and physical needs at the end of life,” says Laura Moya, who has offered music vigils since 2001. “Often, there’s a physical response: reduced heart or respiration rates, or an emotional release. The music reaches people at a very deep level. Sometimes, it just helps them let go.”

In another innovative approach, Providence uses nurse practitioners to assess patients in their homes, in the hospital, or in their physician’s office to help them learn about medical and community services they may want to consider. Nurse practitioners also help patients identify their care preferences and document them on advance directives and POLST.

Close collaboration between Providence’s delivery system and Providence Health Plan HMO has been a major driver of many innovations. Providence Health Plan was the first payer to reimburse for the system’s palliative care program, which provides the services of hospice without the patient having to forgo potentially life-sustaining treatment, and it continues to be an advocate with other insurance companies for this strategy. A study commissioned by the plan demonstrated that providing excellent palliative care is not only the right thing from the mission standpoint, but that it also is cost-effective. This finding has encouraged other payers to fund palliative care and other compassionate end-of-life services for their subscribers.

Finally, not to be overlooked is Providence Health System’s ability to combine compassion with business-like attention to quality measurement and improvement. Under the leadership of Marla London, a senior researcher with Providence Health System, Providence uses a family of measures index to monitor its end-of-life services. The index includes elements such as volumes, hospice length of stay, family satisfaction, physician satisfaction, and advance-care planning. An interdisciplinary team reviews results quarterly and develops an action plan to maintain positive results and improve weak performance. A long list of quality improvement activities has begun based on index ratings.

“In end-of-life care, you don’t have a second chance to make it better. The experience family members take with them lasts forever,” says Simmons. “We’ll know we provide ‘perfect’ end-of life care when every patient and family member who is touched by our services makes a statement like this one, which we recently received: ‘There is nothing that we could have wanted changed, except the need for your services to begin with.’” •