

AWARD WINNER

THOMAS PALLIATIVE CARE UNIT
VCU MASSEY CANCER CENTER

Richmond, Virginia





With some foresight and understanding, it's possible to have a better experience in the hospital when experiencing a serious illness. Pain and other uncomfortable symptoms can be controlled, unnecessary tests and procedures can be avoided, and family crises over difficult decisions can be rendered unnecessary.

That concept is well understood at Virginia Commonwealth University Medical Center and Massey Cancer Center, where the palliative care team has been working together for more than a decade to not only transform care for the seriously ill in Richmond, Virginia, but also to get the message out to other hospitals through training and mentoring.

The tight-knit team members have made the effort to document everything they do and are among the first to show that palliative care can actually contribute to the bottom line by providing more appropriate care in the final stages of serious illness. The hospital administration was supportive of their efforts, but they knew that a program that can carry its own weight is more likely to survive. Once the numbers were crunched, they found that eliminating tests and procedures that failed to improve outcomes, along with keeping patients out of the ICU, cut ancillary costs for these patients in half.

The program has evolved since its beginnings in 1994 as a nurse-centered palliative care consult service led by Patrick Coyne, an oncology nurse who helped build the program along with oncologist Thomas Smith, MD. By 2000, they found that the consult model wasn't having enough impact because their orders were not always followed. With money from a foundation, they were able to construct an inpatient palliative care unit. "The benefits are huge," says Jill Laird, nurse manager in the unit. "We can provide palliative care in a much better way."

The unit is a calmer environment than the typical medical unit and is open to families 24 hours a day. "It's a place where patients and families could have a quieter time; there's a lot less hustle and bustle," Coyne explains. "You have the time and quietness to get your thoughts together."

In choosing the inpatient unit model, the team researched the options, looking at the choices other hospitals had made in designing their palliative care programs. "They had different environments and cultures," Coyne says. "We had to figure out what would be successful here." Serving nearly 600 inpatients a year in a large academic medical center made their service busy enough to support a dedicated unit, the team decided.

Another benefit to the unit, Laird notes, is that it has cultivated a team of nurses who have become very well versed in palliative care.

The group continues to educate both physicians and patients and their families that the unit is not a hospice — the goal is to make seriously ill patients more comfortable so they can go home. Less than a third of patients die on the unit.

The team's philosophy is strong on pain control — "there's no limit to what we will do to treat pain," Laird says — and offering a home-like atmosphere on the 11-bed unit. Families, including pets, are encouraged to spend time there and hold special events, which have included birthdays, a high school graduation, a wedding, a baptism, and even a crab festival.

A top priority for the program is addressing symptoms immediately and in a coordinated manner. To that end, the team established a set of algorithms to allow nurses to independently initiate management of a number of symptoms that are

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INNOVATION HIGHLIGHTS

PALLIATIVE CARE UNIT FOR BOTH
CONSULTATIVE AND PALLIATIVE CARE
TEAM PATIENTS

USE OF TEEN VOLUNTEERS AT BEDSIDE

USE OF PALLIATIVE CARE BEDS FOR
MOTHERS WITH STILLBORN CHILDREN

likely to occur in the palliative care unit. The algorithms were based on current medical evidence, reviewed by hospital management, and continue to be updated as new evidence becomes available.

As a safety net hospital for its community, VCU sees more indigent patients than a typical community hospital, and part of the palliative care program's mission is to care for the medically indigent. The program also cares for inmates of correctional facilities. Members of the team studied the barriers faced by medically-indigent cancer patients as part of the Project on Death in America, and as a result the team worked with case managers and social workers to resolve problems such as language and communication barriers, lack of transportation, caretaker problems, and out-of-pocket resources.

Plans for the future include branching into outpatient care, establishing a clinic to which patients can return and get follow-up care from the same medical team who saw them in the hospital.

Palliative care at VCU has flourished because of the dedication of team members. In the early years those involved in the consult service took it on as an added duty. "We ran a marathon and if we stopped running in 1997 or 1998 we never would have got here," Coyne says. "We tried to keep it in everyone's focus that this was important and had value."

At the same time, they argue that no hospital can afford to ignore palliative care because of the financial benefit of giving more efficient, effective, and appropriate care. In fact, the team has become a leader in documenting the benefits of palliative care within a hospital. Their innovative financial analyses are being replicated by other palliative care programs. "The message of our analyses is that hospitals can afford to invest in palliative care; that it is not financially risky," the team writes. "In fact, we argue that hospitals today, especially large teaching institutions, cannot afford to continue without palliative care." •