Palliative Care
St. Joseph Hospital, Orange

Palliative Care Co-Directors
Brian J.W. Boyd, MD
Melvyn L. Sterling, MD

St. Joseph Health
St. Joseph Hospital

Sacred Encounters
Perfect Care
Healthiest Communities

In-Patient Palliative Care

St. Joseph Health
St. Joseph Hospital

Sacred Encounters
Perfect Care
Healthiest Communities

Medical Model

- Dr. Brian Boyd
  Board Certified in Neurology and Pain Management
- Dr. Melvyn Sterling
  Board Certified in Internal Medicine and Palliative Care/Hospice
- Lisa Traucht, MSW
- Oliver Lee, MDiv, MS, Board Certified Chaplain
- Rosemary Le, NP, MSN
- Peggy Delmastro, NP, MSN

Why Program Developed

- US elderly population growing; 10,000 reach age 65 daily.
- Cost of caring for increasing elderly population a national – and local – concern.
- Palliative care programs proven to increase patient and family satisfaction while decreasing costs.
- Palliative care programs facilitate discussion of goals of care while acknowledging difficulty in predicting outcome in serious illness.
- Consistent with ethics and values of SJH.

How Program Works

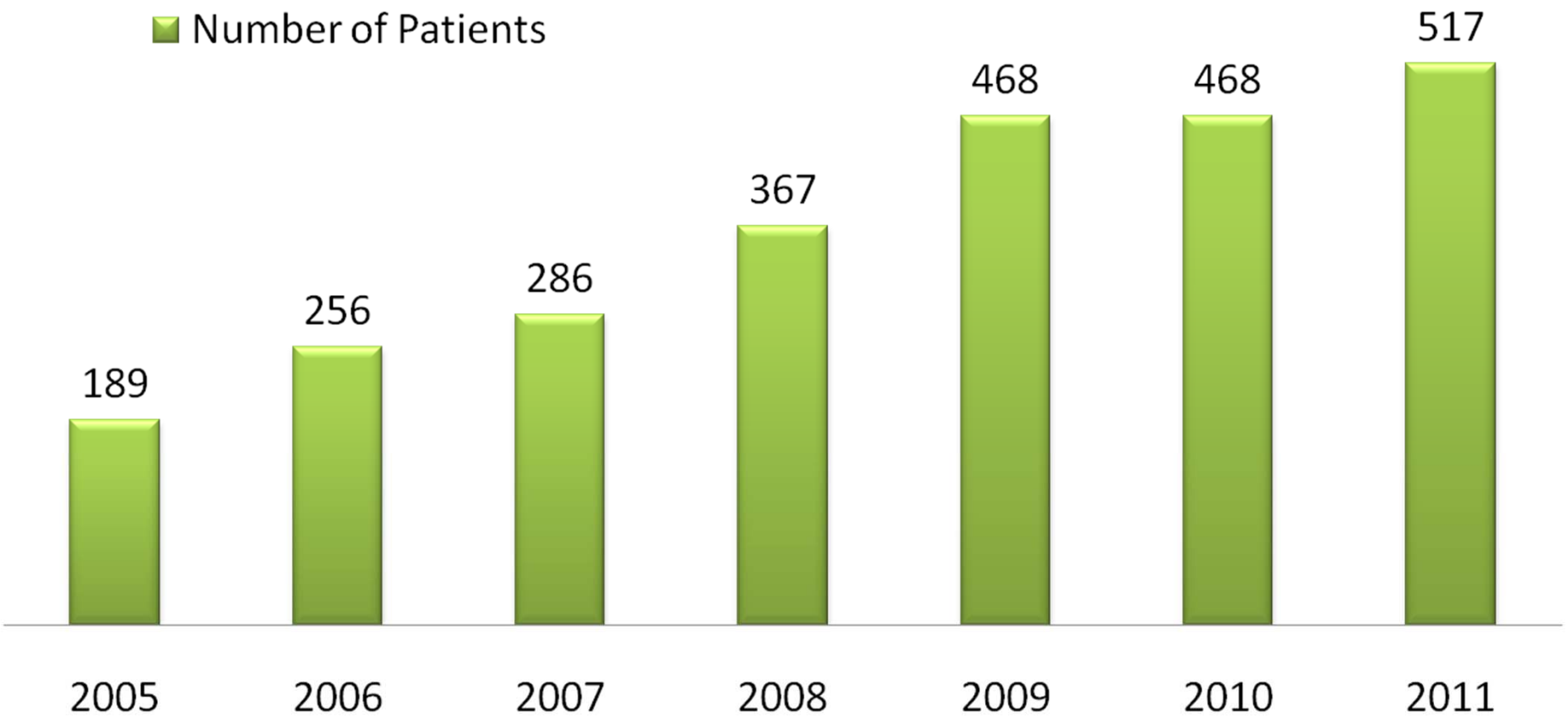
- Nurse practitioner in hospital 10 to 12 hours per day
- Consult is received by doctor or nurse practitioner from referring physician
- Nurse practitioner usually sees reviews chart, speaks to bedside nurse, case manager, and/or social worker and then sees patient/family
- History and physical performed

- Medical director then sees patient/family and a plan is formulated
- Doctor or nurse practitioner sees patient every day or more depending on symptoms
- Social worker sees patient daily if needed
- Spiritual care provider sees patient daily if needed
- Weekly meeting: discuss patient/family plan of care and administrative issues if needed

Quality Outcome Data

- Indicators are based on the Center for Advancement of Palliative Care (CAPC)
- Proactive follow-up and interventions to manage pain and symptoms – Edmonton Symptom Assessment System (ESAS)
- Prevent costly and unnecessary hospitalizations
- Opportunity to improve pt/family satisfaction
- Opportunity to clarify goals of care

Palliative Care Consults by Year



St. Joseph Health
St. Joseph Hospital

Sacred Encounters
Perfect Care
Healthiest Communities

Palliative Care
Critical Care Patients

Year	Total Palliative Care Patient Consults	Palliative Care Patients in Critical Care	Average LOS for Palliative Care Critical Care Patients	Total LOS
2005	189	33	11.3	14.3
2006	256	26	8.5	12.5
2007	286	35	8.0	12.3
2008	367	84	7.6	14.7
2009	468	68	7.5	14.5
2010	468	79	7.9	12.2
2011	517	62	6.1	10.2

Palliative Care Length of Stay

Year	Total Consults	Number of Days from Admission to Consult	Number of Days in Palliative Care	Total Length of Stay
2005	189	6.7	7.6	14.3
2006	256	3.7	8.8	12.5
2007	286	5.1	7.2	12.3
2008	367	4.1	6.5	10.6
2009	468	3.6	5.6	9.2
2010	468	3.6	5.9	9.5
2011	517	2.8	5.3	8.1

Patient Goals

Goals	Percent of Goals Met				
	2007	2008	2009	2010	2011
Control of pain	100%	99.3%	99.8%	99.8%	98.9%
Control symptoms other than pain	100%	100%	100%	93.1%	100%
Discharge home	77.3%	71.4%	100%	83.3%	81.3%
Return to pre-hospital function	44.0%	62.5%	0%	66.7%	50.0%
Supportive end-of-life care	97.9%	100%	100%	100%	100%

Primary Reason to Order Palliative Care Consult

Year	Total Consults	Goal Clarification	Pain Management	Symptom Management
2005	189	31%	57%	11%
2006	256	32%	66%	1%
2007	286	21%	75%	3%
2008	367	11%	86%	2%
2009	468	6%	91%	2%
2010	468	6%	91%	3%
2011	517	6%	90%	4%

Lessons Learned

- Importance of Interdisciplinary team
- Importance of evaluation and treating psychological and spiritual distress as aggressively as physical stress
- Remembering the role of the palliative care team is to support the patient, the family, and the referring doctor

St. Joseph's Home-Based Palliative Care Out-Patient Setting

St. Joseph Health
St. Joseph Hospital

Sacred Encounters
Perfect Care
Healthiest Communities

St. Joseph Palliative Care Model

Our Specialized Consultation Team:

- Dr. Boyd, Palliative Care Medical Director
- Liz Wessel RN, MSN, Program Director
- Nurses trained in Advanced Pain and Symptom Management, Infusion, and Oncology
- Social worker, pharmacist
- Hospice collaboration and cross-over between programs
- Education: Eight hours of orientation for all disciplines
- Continuing education and mentoring
- Ability to manage complex patient needs across the continuum

St. Joseph Health
St. Joseph Hospital

Why Program Developed

- Gaps in care identified: Patients who are not ready to transition to hospice, yet still require unique supportive care
- A strong commitment to improving care across the continuum
- Need for improved pain and symptom management
- Frequent re-admissions for symptom management

- Offer expert medical advice to PCP or patient's consulting physician
- Need for increased family support – MSW referral requested at time of referral for all patients
- Need for supportive care when the patient's condition declines with a smooth transition to hospice, as appropriate
- Need for proactive approach by anticipating needs and avoiding potential suffering

How Does It Work?

- Dr. Boyd on-site for weekly participation in patient and family conferences
- Identify patient for consultation based on need through close collaboration with team members
- Telephone outreach calls to patients and family members
- Patient and family participation by telephone
- Recommendations faxed to treating MD with a follow-up telephone call
- Patient phone follow-up and/or SNV or within 24-48 hours of change in plan

St. Joseph Health
St. Joseph Hospital

Quality Outcome Data

- Indicators are based on the Clinical Practice Guidelines for Quality Palliative Care (National Consensus Project)
- Proactive follow-up and interventions to manage pain and symptoms
- Prevent costly and unnecessary re-hospitalizations

Quality Outcome Data

- **Patient Satisfaction:** Recipient of Avatar Award for Exceeding Patient expectations for five consecutive years. Mean: **90.68%**

Re-hospitalizations: 12% (National Average 24%)

- Pain & its mgt. assess at 77% improvement
- Instruct on bowel program (if on opioid): 70%
- Evidence DNR discussed: 100%
- Pre-hospital EMS form: 67%
- Symptoms controlled: 83%
- Complex conference every 60 days: 82%
- Conference when symptoms worsen: 86%

Transition from Palliative Care to Hospice Last Quarter

- Patients referred to hospice – (62/153) 40%
- All referrals admitted to hospice – (62/62) 100%
- Length of stay for hospice patients referred from Palliative Care Team:
  - Median LOS *(discharged cases)* = 13 days
  - Average LOS *(discharged cases)* = 32 days
  - Length of stay greater then 7 days *(active and discharged)* = 66%

Lessons Learned

- Seamless provision of care from the in-patient consultations to the out-patient setting
- Valuable to help transition patient/family from Palliative Care to hospice
- Significant impact in reducing hospital re-admissions
- Significant impact in reducing stress for patient/family