MOBILIZING AN INTERPROFESSIONAL TEAM TO CREATE A PROGRAM TO PROVIDE HOME-BASED PALLIATIVE CARE SUPPORT FOR PATIENTS WHO FALL BETWEEN THE CRACKS (ABSTRACT ID 162)

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This study is supported in part by the Beryl Institute Patient Experience Grant Program.

Patient Experience Defined:

The sum of all interactions, shaped by an organization's culture, that influence patient perceptions across the continuum of care.

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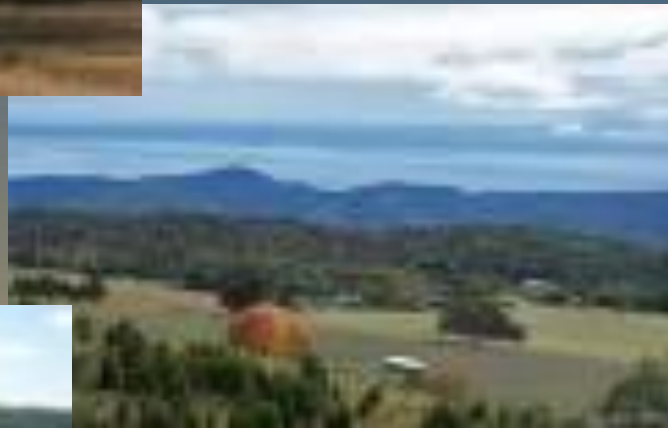
LEARNING OBJECTIVES

Upon Completion of this presentation, the participant will:

» Identify one example of successful formation of an interprofessional team to address a gap in care for a specific population.

» Examine outcomes related to the implementation of a Post Hospice Committed Care Program.



BACKGROUND

THE DILEMMA OF GOOD HOSPICE CARE

Hospice patients who no longer meet hospice criteria, are homebound, and do not meet criteria for home health, and who do not want aggressive treatment for their life limiting illnesses, are discharged to self-care.[1,2]

GAP IN SERVICE

The loss of support that made them well enough to no longer be eligible for Hospice can lead to a decline in health and:

» Readmission to Emergency Department or acute care

» Die at home without support for themselves or their families.[4]

LITERATURE

- Committed care programs are described in the literature for palliative care[3,5,6,7]
- There is little literature describing a program for home-based post hospice care.

This project addresses a gap in the literature.

HOME-BASED POST HOSPICE COMMITTED CARE PROGRAM

GOAL

Develop a home-based committed care program for patients no longer meeting hospice criteria who still need palliative support to help:

» maintain optimal control and quality of life,

» support their caregivers,

» decrease costs associated with unwarranted hospitalizations where they may receive unwanted aggressive treatments.

POST HOSPICE COMMITTED CARE PROGRAM (PHCCP)

Eligible patients identified during interdisciplinary team meetings

A Registered Nurse (RN):

- makes monthly phone contact to eligible patients and/or caregivers to assess patient needs
- collaborates with attending MD or Hospice Medical Director to manage symptoms and medications
- determines if a home visit is necessary,
- eases the transition back into hospice or home health services if and when needed

KEY FEATURES OF PHCCP

- Initial home visit and comprehensive assessment by RN
- Monthly telephone contacts by nurse
- Follow-up face to face visits to assess, decline, or manage symptoms that cannot be managed over the phone
- 24/7 access to On Call RN for emergencies
- Case manager access during regular office hours
- Monthly care plan review at IDT meetings

ANTICIPATED PATIENT OUTCOMES

- Maintained well at home
- Discharged from PHCCP if:
  - condition declines and they are admitted to hospice
  - goals change and are no longer consistent with admission goals,
  - hospitalization to manage severe symptoms if not readmitted to hospice

MOBILIZING AN INTERPROFESSIONAL TEAM

- Principle Investigator
- Medical Director
- Hospice Nurses
- Hospice Nurse Managers
- Attending Physician
- Nurse Researcher
- Medical Social Worker
- Chaplain
- Hospice Phone Triage Nurse
- Volunteers
- Nurse practitioner
- Bereavement Volunteer Coordinator as needed
- Case manager as needed

ADVANTAGES OF THE INTERPROFESSIONAL TEAM APPROACH

- Effective process of program design
- Incorporated wide range of perspectives and experience.

EFFECTIVE INTERPROFESSIONAL COLLABORATION

» Standard practice for Hospice team
» Strong, dedicated leadership
» Communicates appreciation
» Respectful sharing of ideas
» Open, frank communication
» Secures appropriate approvals
» Regular meetings

Preliminary Results

QA/QI PROJECT

HYPOTHESIS

Individuals who no longer meet hospice criteria but still need palliative support provided by PHCCP will have:

- higher quality of life scores by reducing unwanted aggressive treatments and providing ongoing physical, emotional and spiritual support during this challenging time in their life
- decreased utilization of emergency department and acute hospitalization services with an associated cost savings

STUDY DESIGN

- IRB Determined Quality Improvement Project
- Nonequivalent comparison group study design
  - Comparison group: Those discharged from Hospice in January 1 2014 through June 30, 2015
  - Intervention group: Those admitted to the PHCCP after July 1, 2015
- Measures:
  - Quality of life: semantic differential scale
  - Cost savings modeling
- Study initiated July 2015
- Enrollment target: 9 subjects per group

METHODOLOGY

» Trained Hospice volunteers will secure program consent and collect the Quality of Life data.

» Data will entered in a secured Excel spreadsheet.

» Subjects will be identified by number only.

» Sample size limits the study, but the anticipated benefits to those eligible is predicted to be significant.

» The model used during this pilot could then be replicated to reach a statistically powerful sample.

STUDY PROGRESS TO DATE

NEXT STEPS

- » Continue enrollment of study participants
- » Analyze study results
- » Solidify PHCCP if data supports

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FOR MORE INFORMATION

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