A LITTLE ABOUT OUR HOSPITAL

205 Bed Community Hospital (average census 135)
- Includes comprehensive cancer center, heart and stroke center
- Larger than average population >85 years of age

Palliative RN under Hospice in place for 12 years – discontinued at new team build

Palliative Team: Part-time Medical Director (12hrs), FT - NP, RN, SW, Pharmacist + Chaplain Support

2014 Volume YTD: 770
- Referral based – 94% (includes re-admit screening process)
- Comfort Care order set trigger – 6%

24/7 pain symptom management though pharmacy pain protocol (56% palliative patients on pain protocol)
THE DAY
An overview of the survey day

Getting Started
Opening Conference
Individual Tracers
Data System Tracer
Credentialing/Competency
GETTING STARTED – CLINICAL PRACTICE GUIDELINE / TJC STANDARDS

Gap Analysis: Identify items that must be documented in your medical record – that it is readily / easily able to locate on each of your records

Provision of Care
PCPC
3 & 4 most cited

Proposed changes to standards:
Add: “and families”
More on how information received, documentation of surrogate by palliative team, pt./family preference for symptom management when death is imminent, documented quality of life assessment, team wellness/orientation
GETTING STARTED – CLINICAL PRACTICE GUIDELINE / TJC STANDARDS

Gap Analysis: Identify items that need to be in writing, and don’t fit into documentation - create a program plan to cover those topics

- **Practice Plan**
  - Mission Statement
  - Patient Referrals
    - How you receive or identify your patients
  - Assessment
    - Timing and 24/7 coverage
    - Pain/symptom scales
  - Plan of Care
    - Initiation and updating
  - Reassessment
    - How often
  - Discharge

- Patient Brochure
OPENING CONFERENCE

Cover everything on their list in the Review Process Guide

&

Things you know they will ask about – answer them here so they don’t ask later –

i.e. 24 hour coverage, patient experience data

&

Showcase a few performance improvement initiatives and data
INDIVIDUAL TRACERS

- Pick your patients (3-5)
  - Show a range of patients
  - Pain/symptom management
  - Cases with family meetings
  - EOL cases – to show attention to grief and bereavement assessment
  - Patients/families that will talk with reviewer

- Show any order sets / protocols

- It’s mostly about documentation
INDIVIDUAL TRACER

HOW TO ACHIEVE COMPLIANCE WITH DOCUMENTATION – CITED AS BEST PRACTICE

Our method:
- MD/NP Dictation
- Clinician Team Note
- Social Worker Note
- Chaplain Note
- Family Meeting Note

Prep idea: Each team member to review three charts, not their own patients and see how the documentation flows. Provide PCPC elements to check.

The problem: Tying them all together.

Solution: Each document (clinician, social, chaplain) was revised to all start with a narrative and plan of care so that all documents looked alike:
- Narrative: Includes notes of discussions with other staff
- Plan of Care: Includes reference to other palliative staff involved in care and reference to IDT plan of care
Narrative: Includes notes of discussions with other staff

Plan of Care: Includes reference to other palliative staff involved in care and reference to IDT plan of care
PCPC.5
- Referrals
- Assessment for complicated grieving
- Family informed of imminent death
- Family educated about s/s imminent death
INDIVIDUAL TRACERS

- Interviewed several nurses – no questions about the patient’s palliative plan of care
  - How do you reach Palliative?
  - Are they helpful for you?
  - Any suggestions for how they could be more helpful?

Ongoing nursing education – education fairs, online learning
Tip card given to all staff working on day of survey that morning

PALLIATIVE MEDICINE SERVICE
Tips for TJC Review on October 15th

Who’s on the Palliative Medicine Team?
Physician - Nurse Practitioner
RN - Social Work - Chaplain
Pharmacist - And others as needed

How do I request a Palliative Medicine consult?
A physician’s order.
Staff may send a SCM Communication for assistance in getting order.

How can I contact Palliative Medicine?
Daily communication via rounding
Vocera “palliative medicine service”
625-4977 (office #)
Information on the Intranet
INTERDISCIPLINARY TEAM (IDT) PLAN OF CARE
CITED BEST PRACTICE TO DATE

Elements:
- Surrogate information
- Goals
  - IDT
  - Patient/family
- IDT members present
- Narrative – simple 1-2 sentences summarizing current issue and team plan, ongoing so you can see progress of plan of care
GOALS:

HEALTH ISSUES:
Admit Dx (Pr):
• Diabetes mellitus with hyperosmolar coma. Status: Active. Description: Diabetes mellitus with hyperosmolar coma

SURROGATE INFORMATION:
• SURROGATE NAME
• SURROGATE IDENTIFICATION
• ADVANCED HEALTH CARE DIRECTIVE STATUS
Son -
advanced health care document
in chart/permanent medical record

GOALS:
• IDT GOALS
• PATIENT/FAMILY GOALS
address pain, address symptoms, address code status, address goals of care, provide family support relief of pain/discomfort, prolong life, maximize treatment, understanding what it will look like at home

MEMBERS PRESENT:
• PALLIATIVE MEDICINE TEAM
physician, nurse practitioner, RN, social worker, pharmacist, chaplain, director, RN/MFT
MPC Student
10/31 managing pain, now transitioned to oral meds. Discharge plans is under discussion, need to reach out to son for planning.

10/29 Pharmacist to see, tapering pca. Patient will have wound debridement today by Dr.

10/27 Pain management still our main goal. Pharmacy has been following closely. Unable to connect with son. Will continue attempts.

10/22 Palliative Medicine Service to continue to address pain and symptoms. Palliative Medicine Service to follow up with patient’s son regarding family meeting. To collaborate with DCP regarding patient discharge disposition.

10/20 Continue addressing pain and symptoms. Continue follow up with son for family meeting this week. Follow up on POLST.

10/17 advance care directive completed. Team would like to meet with son and schedule a family meeting.

10/13 continue to address pain/symptom management, goals of care, code state. Patient is feeling better.

10/10 day two post-op, focus on symptom management
Goals and objectives are broken into two categories, monitoring and targeted. As a new program, data is being collected to monitor the volume of consults, LOS before consults are requested, the diversity of primary diagnosis, referral locations and reasons for referrals, in order to set baselines and target future performance activities to improvement awareness and address any noted educational needs.

Targeted performance is geared towards the timeliness and comprehensive response to consult requests. The team is monitoring for initial visits to be completed within one day of request, and a comprehensive assessment is performed within five days of being on the service, the number of family meetings occurring and the percent of patients that were admitted without an advanced directive where one is completed during the stay.

Additionally the work group is monitoring the patient outcomes related to discharge, such as discharge disposition, discharge services, % of hospitals deaths seen by a Palliative team member, seven-day admit rate of palliative patients, LOS after consult and financial dashboard reports.

The work group is also focused on collecting patient experience feedback.
## SYSTEM TRACER – OUR METRICS

<table>
<thead>
<tr>
<th>Metric</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Exclusions</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of initial visits completed within one day of consult request. Source: None, internal</td>
<td># of completed initials consults - by MD, NP, RN, SW, or Pharm - completing &quot;Initial visit tab &amp; Assessments.&quot;</td>
<td># of consults requested</td>
<td>LOS post consult request &lt;24hrs</td>
<td>Any reference by any provider to psychological stressors, emotional distress, or family dynamics was accepted as evidence for attention to emotional needs. Any reference to religious or spiritual concerns or beliefs, or presence of a chaplaincy visit, was accepted for evidence of attention to spiritual needs.</td>
</tr>
<tr>
<td>Comprehensive Assessment - Percent of all patients admitted for &gt;1 day who had comprehensive assessment (pain, dyspnea, nausea, constipation, emotional/social, spiritual needs) completed within 5 days of admission. Source: The PEACE Project</td>
<td># of patients with all elements completed</td>
<td># of Palliative Medicine Service patients</td>
<td>LOS post consult request &lt;5 days</td>
<td>Defintion: A family meeting can be scheduled or spontaneous and includes key member(s) of the PC team, key members of the patient’s family, and addresses a wide range of issues (e.g. more than just symptoms or just disposition).</td>
</tr>
<tr>
<td>Number family meetings per patient. Source: Palliative Care Quality Network</td>
<td># of patients with a family meeting.</td>
<td># of Palliative Medicine Service patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of patients without AHD/POLST on admission with one on discharge. Source: PCQN</td>
<td></td>
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<td>Excludes expired patients</td>
</tr>
</tbody>
</table>
Letters of thanks

Words describing team
- Helpful
- Supportive
- Compassionate
- Caring

Graph:
- Part of palliative service?
- Palliative helpful?

Patient Experience

System Tracer
Open with overall performance improvement process at hospital, how data is reported up and who is responsible for the oversight of the data.

- Board of Trustees
- Medical Executive Committee
- Interdisciplinary Quality Committee
- Palliative Medicine Work Group

Guide to a Successful Joint Commission Data Tracer:

- Three second rule – no silences longer than three seconds. It is everyone’s responsibility to respond!

- Develop a script for yourself – for areas you have been identified as a key person and practice, practice, practice. If you would like to rehearse, call Quality Management at x.4553.

- Start with the big picture – describe the overall process and program and wait for further questions about specific data and measures.

- Answer the question that was asked – always provide a yes or no, when appropriate. Do not offer specifics unless asked.

- Consider how staff are involved – surveyors want to know how information gets to the point of care. Include performance improvement data at regular staff meetings.

- Consider how physicians are involved – how data communicated to them?

- How do you use the data to make decisions – have specific performance improvement examples in mind to discuss with surveyors.
SYSTEM TRACER – DATA USE - PREPARATION

- Prepare team ahead of time to talk about PI initiatives that have data (rehearsal meetings)
- Each team member to ‘own’ one topic and be prepared to jump in
- Ask her questions about how to do things better, best practices, how others do it

**DMAIC Worksheet (LEAN Improvement Methodology)**

<table>
<thead>
<tr>
<th>Metric:</th>
<th># of family meetings (Ethan)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Define:</td>
<td>Preferred Practice 18: Conduct regular patient and family care conferences with physicians and other appropriate members of the interdisciplinary team to provide information, discuss goals of care, disease prognosis, and advanced care planning, and offer support. During development of program in 2013 family meetings were determined to be an evidence based method of communication. The decision was made to schedule as many meetings as appropriate to facilitate discussion.</td>
</tr>
<tr>
<td>Measure:</td>
<td>Two metrics captured; # of family meetings per patient and % of families with a family meeting. The initial data collection in 2013 showed that only 27% of patients were having a family meeting.</td>
</tr>
<tr>
<td>Analyze:</td>
<td>Two issues discovered; first family meetings were occurring however the definition of a family meeting was not clear among team members and second, the number was still lower than we thought subjectively and an increase was necessary.</td>
</tr>
<tr>
<td>Improve:</td>
<td>The definition was reviewed with our registry and a definition was established as well as an increased awareness about the benefits of family meetings.</td>
</tr>
<tr>
<td>Control:</td>
<td>Add family meeting discussion to IDT meetings. Monitor results.</td>
</tr>
<tr>
<td>Measure:</td>
<td>Post definition and increased awareness 1Q14 increased to 58% but subsequently decrease to 45% 2Q14. Team now has a benchmark of having 1.1 family meetings per patient – currently at .8 per patient.</td>
</tr>
<tr>
<td>Analyze:</td>
<td></td>
</tr>
<tr>
<td>Improve:</td>
<td></td>
</tr>
<tr>
<td>Control:</td>
<td></td>
</tr>
</tbody>
</table>
COMPETENCY / CREDENTIALING

- Team must include a core team member that is palliative specialty trained or board certified or board eligible
  - LIP
  - RN
  - Chaplain
  - Social Worker
- The program defines each of the roles of the IDT member’s responsibilities.
- Evidence of palliative CEU/CME
- If using hospital services, i.e. SW or Chaplain, must show education and established competency with those services
THANK YOU

More information:
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