

Addition of the Nurse Triage Role in Improving Inpatient Consultation Delivery



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Introduction

The Inpatient Palliative Care team at Baystate, a 700+ bed academic medical center, has been physician led since 2012. Consults were placed by primary teams via the consult pager, which were triaged by busy palliative care clinicians. Due to increasing number of consult requests as the service grew, this process was identified by the team as inefficient and a contributor to team burnout. The Baystate Palliative Medicine team shares some of the possible replicable benefits of incorporating a triage nurse role into an inpatient Palliative Care consult team



Methods

Palliative Care Quality Network (PCQN) data was used for number of consults seen and family meetings attended by the team practitioners. The time period considered was six months prior to and six months post the initiation of the Nurse Triage role. Palliative Care team members shared their written reflections on how adding this team member improved their quality of life at work.

Results

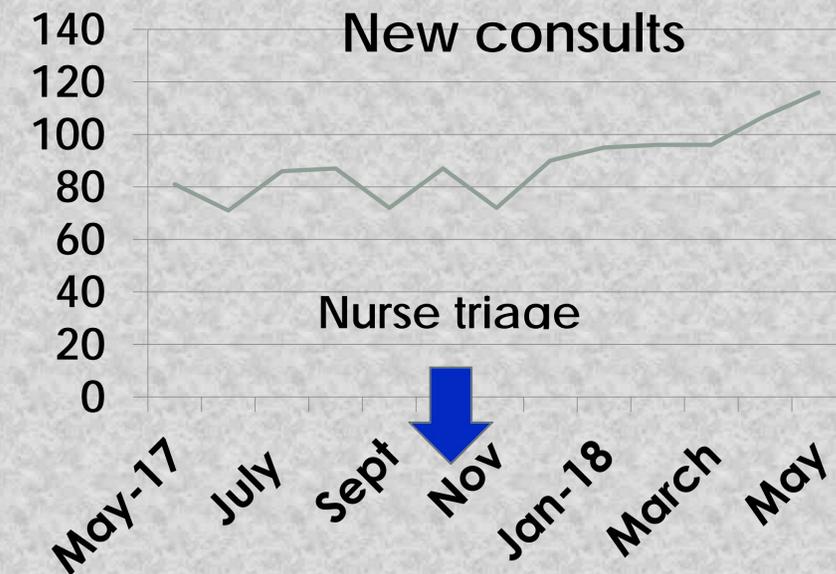
- Number of new consults per month increased from 81 patients to 100 patients
- Average number of family meetings per day increased from 1.2 to 1.3.
- The prevailing themes in the interdisciplinary team members' narratives were: (1) Nurse Triage improved the coordination of care, (2) Improved communication between palliative team members and the referrers, and (3) Clinicians' capacity to focus on taking care of their patients without distractions was increased.

Team Quotes

- “Often family meetings are scheduled prior to initiation of consultation, which saves unbillable clinician time.”
- “Inappropriate consults (i.e. case management or hospice consults) are diverted to appropriate resources.”
- “She holds the pager, which decreases my daily anxiety dramatically.”
- “She provides much needed centering throughout the day...can vent about clinical frustrations or dilemmas.”

Conclusions

Though this data does not take into account the fluctuating FTE of the providers on the team, there is a trend of improvement in both measured quantitative parameters after initiation of the Nurse Triage role. Qualitative data was resoundingly positive in terms of improved well-being and pride in the quality of the work done by the team. Nurse Triage is an effective and possibly replicable model to improve delivery of care in Palliative Care inpatient consult teams. The benefit can be seen in greater penetrance of the team, possibly an increase in the number of family meetings, and a subjective improvement in the well-being of both the clinician and non-clinician team members.



Palliative Care Chaplaincy Coverage Based on Source of Data and Degree of Chaplaincy Support

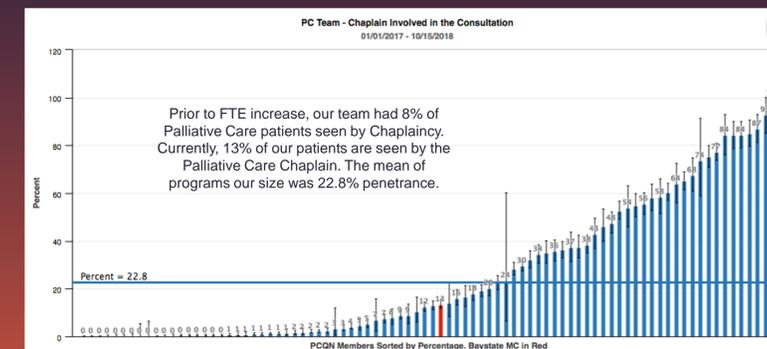
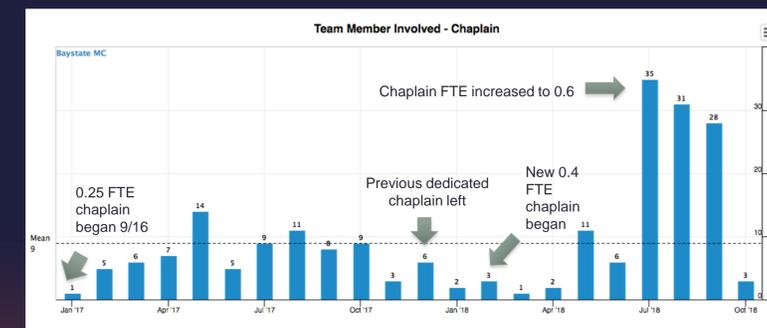
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Palliative Care for inpatients at this large teaching hospital in western Massachusetts continues to grow at an unprecedented rate. Chaplaincy care for our team was provided by our chaplain group at large, which was insufficient for our patients with serious illness. We were able to shift to a dedicated chaplain model for Inpatient Palliative Care. In an effort to make a data-driven pitch for increased dedicated chaplaincy support, we used our PCQN data first and then developed a quality improvement cycle to better measure the impact and value of chaplaincy in Palliative Care.



	Before (# visits)	After (# visits)
PCQN	1	4
Clinician Tally	11	25
Chaplain Tally	12	23, 15



Methods

We kept records for 2 weeks of the number of patients clinicians requested Chaplaincy to see, 1 week while Chaplaincy support was 0.4 FTE on the Palliative Care team, and 1 week when the support had increased by 50%. Also, the Palliative Care Chaplain recorded how many patients he saw, as well as how many patients he negotiated for other Chaplains to see.

Results

Before increase in Chaplain support – We found that the clinicians underreported in PCQN for that week, citing only 1 patient who was seen by the Palliative Care Chaplain. The handwritten tally did help the clinical team to report more accurately how many patients were seen that week: 11 total, 2.2 per day on average. Our Chaplain’s daily tally was more accurate and showed greater impact of his work. For the week, he made 12 Palliative Care patient visits.

After increase in Chaplain support – PCQN only showed 4 visits requested by the Clinicians for the Palliative Care Chaplain during the recorded week. The Palliative Care clinicians recorded 25 total visits on their tally, 5 visits per day on average. The Chaplain himself Recorded making 23 Palliative Care patient visits, plus coordinating 15 more patient visits seen by other Chaplains.

Summary

The data above was presented to the hospital administration. Due to their increased understanding of the need for increased Chaplaincy support for the Inpatient Palliative Care team, the increase by 50% of Chaplaincy support was approved as of July 2018.

The Impact of Goals of Care Conversations in Hospitalized Elders



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BACKGROUND

Goals of care conversations enhance patient-centered care, improve quality of life, decrease readmissions and lower costs. At Baystate Medical Center (BMC) a review of readmissions from an Acute Care for Elders (ACE) program revealed at least 30% of patients readmitted within 30 days had unmet palliative care needs; 40% lacked Health Care Proxy (HCP) documentation.

A pilot project on the ACE unit started in 2016 with a Geriatrics Physician Assistant-led Goals of Care Conversation (GOC) using the Serious Illness Conversation Guide (SICG). Patients were identified as having unmet palliative care needs by primary nurse using the Surprise Question. Patients receiving the GOC made significant changes to their care plan including changes to code status (27%) and decision to pursue hospice care (4%).

METHODS

- Starting in June 2018, all “seriously ill” patients 65+ admitted to Daly 6A inpatient unit were reviewed and triaged to either having a goals of care conversation (GOC) using the Serious Illness Conversation Guide (SICG, Ariadne Labs) or other What Matters Most (WMM) questions.
- The GOC is performed by a palliative care trained physician as a stand-alone intervention, not part of a palliative care consultation.
- All Accountable Care Organization (ACO) patients receive chart review for HCP, Code Status, MOLST, number of admissions and ED visits in previous year.

METHODS cont.

- The GOC/WMM is documented in the EHR using the pre-completed “Goals of Care Conversation Note,” and completed ACP docs are scanned into chart.
- The notes are made available in CIS under Advanced Directive, cc: to all providers involved in patient’s continuum of care, & as part of the discharge documents.
- All families are offered handouts from The Conversation Project website.
- When patients are readmitted, our team is automatically notified and makes contact with ED or admission teams to ensure they are aware of previous conversations.

RESULTS

- In the first 7 months, 86 patients received a stand-alone GOC using the SICG

6/2018 – 1/2019	Before SICG GC (n=86)	After SICG GC (n=86)
HCP in EHR	83%	99%
MOLST in EHR	29%	61%*
Code status change	--	26%**
Significant change in treatment plan	--	40%***
Enrolled in hospice (7) or CMO (2)	--	10%

* new MOLST completed only if patient chose to limit life-sustaining measures
 ** only one code change was to more aggressive status = full code
 *** significant change in treatment plan could include: code status change, choosing not to escalate care, decline procedures, hospice, CMO

RESULTS cont.

Financial & Encounter data for first 3 months of patients

6/2018 – 9/2018	3 months prior to GOC (n=28)*	3 months post GOC (n = 28)
Average 3mo acute care costs = ED visits and admits	\$12,218	\$3,774 (\$8444 cost savings per patient, 69%)
Total inpatient admissions	23	11 (52% reduction)
Total ED visits	7	5 (29% reduction)
Total encounters (inpatient + ED)	30	16 (47% reduction)

*40 total patients had GOC with SICG in first 3 months; 28 were analyzed for cost and encounters; 12 were excluded: 6 who died before 3 months and 6 others who we could not confirm were still alive

DISCUSSION

- This intervention was feasible and often led to major adjustments in care plans including decisions to enroll in hospice care.
- Hospital readmissions and ED visits appear to be reduced with this intervention, likely leading to reduced total cost of care in this ACO population.
- This triage and conversation approach may be a way to address unmet palliative care needs while conserving scarce palliative care specialty resources.