APPLICATION FORM

Title of Entry: Better Care for the Hospitalized Dying Patient

Division: Large Organizations

Award: Excellence in Care

Entrant’s Name and Title: Jeannie Marie Vogt, MSN, MBA, RN, CHPN, CHPCA
Clinical Director

Phone: (610) 969-0399
Email: Jeanne.vogt@lvhn.org

Organization: Lehigh Valley Health Network
2166 South 12th Street, 4th Floor
Allentown, Pennsylvania 18103

Date Implemented: 04/01/2015
Date Results Achieved: 06/01/2016

Team Members:
Monica RIng-Striba, RN, CHPN Hospice Patient Care Coordinator
Maryann Rosenthal, RN, MSN Director Clinical Services
Jennifer Divine, RN, MSN Unit Director Clinical Services
Marlene Ritter Director of Quality
Jane Grube, MBA CHCP Lean Coach
Matthew McCambridge, MD Quality Project Lead
Michael Pasquale, MD Co-Chair Quality Project Lead
Sarah Nicklin, MD, CHPCP Hospice Medical Director
Susan Lawrence VP of Patient Services
Dan Ray, MD Chief of Palliative Medicine
Executive Summary
Better Care for the Hospitalized Dying Patient

Dying in America has transformed through the years from dying in the comfort of our own homes surrounded by loved ones, to dying in our hospitals. The CDC reports that 35% of those over 65 are still dying in our hospitals. Most of these patients are dying without the benefit of end-of-life care. Our program, “Better Care for the Hospitalized Dying Patient” addresses the goal of the provision of excellence in end-of-life care for those dying in our hospitals.

Description of the problem: The mortality rates served as a starting point for problem identification. Through the use of Lean methodology we conducted Gemba Walks, investigated the scope of the problem, conducted analyses, and established care partnerships. The information collected affirmed our need to provide better care for our hospitalized dying patients and their loved ones. The “medicalized” care of dying patients observed in three primary areas of the hospital; the ICU, medical surgical units, and the emergency room and supported our need for change. A summary revealed significant findings including: discrepancies in the assessment of patient comfort, the lack of comprehensive emotional and psychosocial support, and physician orders reflective of acute care rather than established best practices for comfort care. There were also significant findings demonstrating a lack of knowledge, competence, and performance impacting patient outcomes. Loved ones were observed left alone during critical times of the dying process while hospital nurses and physicians tended to more acutely ill patients. Many nurses were reluctant to speak with physicians about prognosis or perceived futile care of the patients they collectively cared for and they were uncomfortable being with family members after the death of the patient.

Interventions: Guided by the Institute of Medicine 2014 report on Dying in America and the IHI Triple Aim – Better Care, Better Health, Better Cost, our hospital network embarked on the project titled “Better Care for the Hospitalized Dying Patient” and the “Hospice Response Team” was born. A focus group formed and met weekly. The group was interdisciplinary, consisting of both hospital and the hospice team members. Interventions identified patients with a prognosis of 48 hours or less to live and too fragile to transport out of the hospital. A hospice partnership was established.

The hospice and hospital team met with the patient and their loved ones and established a plan of care based on the expressed wishes of the patient and/or their loved ones. The care team partnership model offered holistic person-centered patient and family care with the goal of comfort and dignity above all else. The hospice team implemented just-in-time training for the hospital staff in addition to didactic education. The education initially included 3 hour CE and CME trainings. There are two 13 hour End of Life Nursing Education Curriculum (ELNEC) trainings scheduled in Fall of 2016 and Spring of 2017.

Results: Data ending April 30, 2016 demonstrates exciting progress meeting our goal of the provision of excellence in end-of-life care to those dying in our hospital. Over 550 patients have been referred to the program, far greater that the goal of 175 demonstrating a cultural paradigm shift in the need for comprehensive excellence in end of life care.

The nurses’ perception of care for these patients is improved; hours of interdisciplinary end of life care at the bedside increased and physician orders now consistently reflect the need for comfort and dignity. Loved ones now have emotional support at the bedside and bereavement care following a loved one’s death. Program evaluations of the formal nursing education demonstrate 100% of nursing engaging in the didactic education stated that they learned new knowledge from the activity; they would be able to apply what they learned; and they felt it would improve their job performance.

Adaptability and Future Focus: Areas of future focus will evaluate the ease of access to the program by managing barriers created by the EMR, adjusting staffing patterns for the provision of referrals on a 24/7 basis, and improving the physical “medical” environment of the patients’ room. Expanding the project to increase referrals from the emergency room may reduce hospital readmissions and potentially impact patient flow. Education efforts will focus on multiple disciplines and specialties. Adopting a culture of continuous improvement, this network project will continue, until all of our dying patients and their loved ones goals are in line with their expressed wishes.
Assessment of the Hospitalized Dying Patient

The challenge of caring for the dying in our hospitals was initially assessed beginning March of 2015 when mortality rates were reviewed and evaluated. Findings revealed an increased population of patients dying unavoidable deaths without the benefit of skilled interdisciplinary care focused on end of life. (Attachment 1, chart 1)

A partnership with the hospice program was initiated to further identify the specific needs of this population. The interdisciplinary focus group formed and criteria for patient selection into the program was established. The group developed an A3 lean report to frame the project goals, actions and outcomes.

The desired end result of the project was the development of an end of life care program creating excellence in care for those dying in our hospitals considered too fragile to transport home or to an inpatient hospice facility. Excellence in care is measured by chart audits reviewing symptom identification and nurses assessment of the quality of the patient care before and after the Hospice Response Team (HRT) intervention. Gemba walks were conducted and care partnerships were established. The family and or loved ones were offered hospice care as an option for care.

The patient referrals were scattered throughout the hospital, in the ICU, Medical Surgical Units and in the emergency room. The patients seen in April, May and June helped to identify gaps in end-of-life care practices, barriers to referrals and needs for interdisciplinary care. A change in EMR systems added additional challenges as hospital staff learned this new system.

Since April 2015 a total of 557 patients were referred to the HRT program. There were 355 signed on to hospice care. Thirty patients were able to be transferred to the Hospice inpatient unit. Five patients were able to achieve the goal of getting home to die. One hundred and forty six patients did not enter the program, due to imminently dying or dying prior to hospice team arrival or family not wanting hospice intervention.

Total of 33 patients were signed onto the program in August and September 2015. Twenty of these records were reviewed. Hospital documentation was compared to hospice documentation with the following results.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Hospital Record</th>
<th>Hospice Record</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identified Pain</td>
<td>20%</td>
<td>35%</td>
</tr>
<tr>
<td>Identified Respiratory Distress</td>
<td>55%</td>
<td>90%</td>
</tr>
<tr>
<td>Identified Anxiety</td>
<td>15%</td>
<td>35%</td>
</tr>
<tr>
<td>Identified need for comfort care orders prior to hospice start of care.</td>
<td>30%</td>
<td>NA</td>
</tr>
<tr>
<td>Counseling support prior to hospice start of care</td>
<td>70%</td>
<td>NA</td>
</tr>
<tr>
<td>Counseling support after start of hospice care</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Spiritual Care referral made prior to hospice care</td>
<td>30%</td>
<td>After Care – 82%</td>
</tr>
</tbody>
</table>

Qualitative findings
- Loved ones left alone during critical times of the dying process while hospital nurses and physicians tended to more acutely ill patients.
- Resistance of hospital staff to accept a new model of end of life care.
- Perception that hospice team intervention was a reflection of inadequacies of care offered by hospital nurses and need to reframe as a compliment to their care.
- Hospital staff expressed lack of knowledge and experience in end-of-life care. (Attachment 1, chart 2)
- Hesitancy to speak with physicians about prognosis and perceived futile care of the patients they collectively cared for.
Interventions

The Institute of Medicine 2014 report on Dying In America built the foundation of our work. A focus group formed and met weekly with the aim of improving the care for those dying in our hospitals. A hospice partnership was established. The care team partnership model offered holistic person centered patient and family care with the goal of comfort and dignity above all else.

1. **Create of End-of-Life Care task force.** Members include interdisciplinary members of hospital and hospice team.
2. **Select best floors for initial project implementation** –
   a. ICU and Medical surgical units caring for dying patients,
   b. Emergency room patients meeting criteria of a 48-hour or less prognosis and aggressive care assessed as futile.
2. **Identify and stakeholders**
   a. Dying patients and their loved ones
   b. Hospital RN's, unit directors, physicians, technical partners, administrative partners, hospital chaplains.
   c. Hospice team members including RN, Social workers, chaplain and nurses' aides and the hospice medical director.
   d. Hospital case management.
   e. Coordinator of No One Dies Alone Program (NODA) and program volunteers
3. **Define patient population in need of end of life care**
   a. Patients with a prognosis of 48 hours or less and too fragile to transport out of the hospital to another care setting. (high risk of dying in ambulance)
   b. The patient or the patients primary decision maker elects comfort care instead of aggressive care and agrees to sign up for hospice care while in the hospital.
4. **Establish referral process** –
   a. Physician referral through case management.
   b. Case manager offers choices, describing program with hospice/hospital partnership and offers choice of hospice care in hospital through contracted hospice, or comfort care without hospice if patient remains in hospital.
5. **Hospice response team responds to referral within two hours of referral.** (Hospice RN and SW) and meets with the patient or the patients decision maker.
6. **The interdisciplinary care plan is established with hospital team, patient and loved ones.**
7. **Patient is discharged from hospital and admitted to hospice but remains in same bed.** A new EMR is created with new orders reflecting comfort care.
   a. If extubation planned, hospice team remains at the bedside for support and symptom assessment
   b. If patient survives extubation, transfer planned to Medical surgical unit. The hospice team follows to new floor.
8. **Conduct needs assessment based on initial patients in program through July, August Sept, 2015.**
   a. Process needs for EMR – hospital discharge, comfort orders, hospice admission, billing,
   b. Need for matching comfort care orders when patient is transferred to different floor.
   c. Staff education – all disciplines
   d. 24/7 staffing needs of hospice interdisciplinary team.
9. **Education**
   a. **Creation of 3 hour CE, CME trainings conducted at intervals throughout the year throughout as of April 2016 – 3 sessions held)**
      i. Being with Dying - 1.0 contact hour
      ii. Pain and Symptom Management – 2.0 contact hours
   b. **Fall and Spring 2016 - Two full day End of Life Nursing Education Curriculum (ELNEC) sessions scheduled with specialty focus in following areas**
      i. ELNEC Core
      ii. ELNEC Critical Care
      iii. ELNEC Geriatric Care
      iv. ELNEC Veterans Health
      v. ELNEC Pediatric
Results of Better Care for the Dying Patient Project

The initial goal of the project was to offer 175 patients integrated and collaborative care through joint partnership with the hospice team. This goal was surpassed with 550 patients referred as of May 31, 2016, and there were 355 patient signed on to the program. Table 1 of attachment 1 shows the trends in referrals as the program progressed. This also demonstrates a cultural shift in the awareness of the need for improved end of life care, and the significant benefits of a hospice team partnership to compliment the care offered in the hospital for dying patients.

A nurses survey conducted evaluated the patients comfort level and care received in the last days of life. (Attachment 2, Table 1). Nurses were asked to evaluate the pain control and the comfort with breathing of patients they cared for in partnership with the hospice team. A Likert scale of one (Terrible) to five (Almost perfect) was used for the survey. When evaluating the management of pain, a total of 46% rated the control of pain at four and 47% rated the pain controlled at five. When evaluating comfort with breathing, 60% rated comfort with breathing at a four and 26% rated the comfort with breathing at a 5%

Additional survey results evaluated the care received in the last days of life and the quality of the patient dying both with without HRT involvement. A Likert scale was also used with 1 the worst healthcare possible and 5 the best healthcare possible. Rating overall quality of care with HRT involvement 35.29% was a four and 52.94% a five. Rating the care received in the last several days of life, 39.22% rated this a four and 50.98% a five with HRT involvement compared to 21.57% a four and 11.76% a five without HRT involvement.

There is now an order set in the EMR system specifically for the hospice patient in the inpatient environment. This improved the continuity of care, and allowed for improved and timely symptom management across all settings. Patients' orders initiated upon admission then followed them to the Medical Surgical units while on hospice care.

A total of three educational trainings have been held for those caring for patients in this program (attachment 3). Program evaluations from these trainings demonstrate the following:

- I learned new knowledge from this survey – 100%
- I will be able to apply what I have learned to my job – 100%
- This activity will improve my job performance and productivity – 100%

Evaluation comments:
- “...felt I learned how to better handle patients in pain”
- “...will be able to respond more appropriately to patient symptoms”
- “I will make use of everything that I have learned in caring for dying patients and their families”

Chart audits completed in May of 2016 revealed the following

- Hospital and hospice nurses appropriately identified pain equally in patients experiencing pain
- There is still an opportunity for improvement when assessing for respiratory distress. The documentation in the hospitals often indicates words such as wheezing or labored breathing, yet there is no documented action to treat and it is not identified as an unmanaged symptom.
- Counseling and support prior to hospice care was at 70% but rose to 100% with hospice care
- Spiritual care involvement rose from 32% to 82% after hospice care implemented
- The average number of additional hours at the bedside of the patient for each discipline increased from July 1, 2015 through April 30th 2016. These numbers are obtained from the hospice EMR, and are most likely understated due to nurses and other disciplines not actively in medical record during the total time with the patient.
  - RN - 1349
  - SW - 506
  - CH – 258
  - CNA - 520

Testimonials from family members

“...Most importantly I want to give gratitude for the creation of the in-patient Hospice Response Team initiative and the partnership...it was very powerful to see the collaboration between the Hospice Team and the staff.... Every care provider .....Approached the care of my father with a hospice perspective versus an acute care perspective and deeply honored and respected the need for continual family presence and involvement.”
ADAPTABILITY

Better Care for the Hospitalized Dying Patient and the Hospice Response team program continues to grow in numbers and acceptance in this hospital network. The culture has grown from one of resistance to change in the care offered to an environment where nurses now encourage physicians to refer the patient to the hospice response team program and referrals continue to rise.

Lessons learned clearly demonstrate the recognition that hospice team members bring expertise in end of life care and also additional supportive care to patients and family members during this crucial time in their life. The combined partnership compliments the hospital care offered and having additional nurses, social workers, nurses’ aides and chaplains at the bedside eases the burdens of the hospital staff and enables them to improve their productive time with all patients they are assigned to.

Hospital programs throughout the country have patients dying in their hospitals as evidenced by the IOM findings that 35% of patients are still dying in the hospital environment. The IOM proposes core components of End-of-Life Care. The frequent assessment of the patients’ physical, emotional, social and spiritual well-being as well as the management of emotional distress is suggested. Other proposed components are the management of pain and other symptoms as well as counseling and support of the patient and family. The hospital and hospice partnership strongly supports these proposals and allows the model to be replicated in hospitals throughout the country. While some suggest this information calls for systemic change, a hospital/hospice partnership offers a starting point for better care for the dying in our hospitals.

This network intends to maintain the initiative and the continued results by ongoing collaboration with the hospice team. Patient referrals have been declined at times due to increased volumes and challenges with hospice staffing particularly after hours when only one on call nurse was available.

Hospice has adjusted their staffing numbers and their hours in order to accommodate more patients. A hospice nurse and Social worker are present at the hospice admission, hospice nurses’ aides visit daily to offer personal care, volunteers from the No One Dies Alone program offer additional time at the bedside when family is not present. The hospice team remains present when a patient is being extubated to support the family and the hospice bereavement team follows the patient for thirteen months following the death of their loved one.

Initial challenges with the EMR when establishing the patients hospice account were resolved through collaboration with the IS team and the EPIC implementation team. The financial team established contractual payment plans to bill hospice for services.

There are ongoing efforts for education with ELNEC trainings scheduled in the Fall of 2016 and the Spring of 2017. This curriculum offers thirteen hours of education in specialty areas such as critical care, geriatrics, veterans’ health and pediatrics. All four of these specialties will be offered in the ELNEC courses presented and are financially supported through and end of life care educational grant.

This yearlong endeavor has built strong relationships and strengthened the circle of care and communications for all involved. End of Life care in our network is becoming a human event rather than a medical event.
### Chart Audit Data August/September 2015

<table>
<thead>
<tr>
<th>Measure</th>
<th>Hospital Record</th>
<th>Hospice Record</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identified Pain</td>
<td>20%</td>
<td>35%</td>
</tr>
<tr>
<td>Identified Respiratory Distress</td>
<td>55%</td>
<td>90%</td>
</tr>
<tr>
<td>Identified Anxiety</td>
<td>15%</td>
<td>35%</td>
</tr>
<tr>
<td>Identified need for comfort care orders prior to hospice start of care.</td>
<td>30%</td>
<td>NA</td>
</tr>
<tr>
<td>Counseling support prior to hospice start of care</td>
<td>70%</td>
<td>NA</td>
</tr>
<tr>
<td>Counseling support after start of hospice care</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Spiritual Care referral made prior to hospice care</td>
<td>30%</td>
<td>After Care – 82%</td>
</tr>
</tbody>
</table>

### Chart Audit Data May 2016

<table>
<thead>
<tr>
<th>Measure</th>
<th>Hospital Record</th>
<th>Hospice Record</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identified Pain</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Identified Respiratory Distress</td>
<td>60%</td>
<td>90%</td>
</tr>
<tr>
<td>Identified Anxiety</td>
<td>50%</td>
<td>60%</td>
</tr>
<tr>
<td>Identified need for comfort care orders prior to hospice start of care.</td>
<td>30%</td>
<td>NA</td>
</tr>
<tr>
<td>Counseling support prior to hospice start of care</td>
<td>70%</td>
<td>NA</td>
</tr>
<tr>
<td>Counseling support after start of hospice care</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Spiritual Care referral made prior to hospice care</td>
<td>30%</td>
<td>After Care – 82%</td>
</tr>
</tbody>
</table>
### Hospice Quality Survey Results

<table>
<thead>
<tr>
<th>Rate how you think these experiences affected the quality of your patient’s dying and death.</th>
<th>1 Terrible</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 Almost perfect</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appear to have his/her pain under control</td>
<td>0%</td>
<td>0%</td>
<td>5%</td>
<td>46%</td>
<td>47%</td>
<td>2%</td>
</tr>
<tr>
<td>Appear to breath comfortably</td>
<td>0%</td>
<td>2%</td>
<td>11%</td>
<td>60%</td>
<td>26%</td>
<td>2%</td>
</tr>
<tr>
<td>Appear to keep his/her dignity and self-respect</td>
<td>0%</td>
<td>0%</td>
<td>5%</td>
<td>26%</td>
<td>68%</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overall How would you rate the quality of your patients dying</th>
<th>1 Terrible</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 Almost perfect</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with HRT involvement</td>
<td>0%</td>
<td>0%</td>
<td>5.88%</td>
<td>35.29%</td>
<td>52.94%</td>
<td>5.88%</td>
</tr>
<tr>
<td>Patients without HRT involvement</td>
<td>3.92%</td>
<td>15.69%</td>
<td>35.29%</td>
<td>27.45%</td>
<td>15.69%</td>
<td>1.96%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In your experience, rate the care your patient received in the last several days of his/her life from the healthcare team</th>
<th>1 Worst Healthcare Possible</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 Best Healthcare possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with HRT involvement</td>
<td>0%</td>
<td>0%</td>
<td>9.8%</td>
<td>39.22%</td>
<td>50.98%</td>
</tr>
<tr>
<td>Patients without HRT involvement</td>
<td>1.96%</td>
<td>17.65%</td>
<td>47.06%</td>
<td>21.57%</td>
<td>11.76%</td>
</tr>
</tbody>
</table>

### Hospice Education Series – Pain & Symptom Management Program Evaluation Results

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learned new knowledge</td>
<td>85%</td>
<td>15%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Able to apply new knowledge</td>
<td>95%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Training activity will improve job performance</td>
<td>90%</td>
<td>10%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>