Growing a Respected Hospital Palliative Care Team through Relationship Building & Collaboration

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In the Beginning...

**History**: Several rough starts with only one or two providers

**Catalyst for Change**: PPACA and leadership changes fueled the already fervent commitment of lead clinical and medical staff

**Comprehensive Business Plan**:
- Operational and Financial Impact of PC Program at MUSC
  - Increase quality of care and satisfaction scores
  - Decrease LOS, costs, and patient & family suffering
- Research findings of lower readmissions from Palliative Care Team vs. Palliative Care Single Provider
- Both Consultative (PC consults, of course) and Integrative Plan (embed palliative care principles and interventions into daily practice)
Getting Buy-In…
Creating an Inclusive Steering Committee

Adult and Pediatric Stakeholders
Administrator of Cancer Center
Chief Quality Officer
Strategic Planning Officer
Medical Directors for Adult & Peds Hospitalist Services
Senior Adult Oncologist
VA Hospital PC Physicians
Pain Consult Nurses
Palliative Care Nurse Practitioner and MD
ICU Nurse Managers
Service Line Director and Medical Director

Result: An Egalitarian, Collaborative and Transformative force
Dripping Water on a Rock…

• Progress was slow, but at every meeting there was at least one “win” to keep the committee energized
• Palliative Care Education Committee (Interdisciplinary) was created
  • Nurses sent to ELNEC courses to become trainers
  • Collaborated with local hospital to provide ELNEC courses locally
  • Currently have unit nurse champions to give monthly 5 minute Palliative Care education
• Steering Committee spoke to everyone possible to promote the cause

Result: Two Years later a Full Palliative Care team was in place!
Viola!!!
The Palliative Care Team - dedicated staff

Medical Director, also serves as Pediatric Physician
Program Director, NP also serves as Adult Provider
Program Coordinator
Program Administrator
Adult Providers: 2 NPs, 3 Physicians (2 internists, 1 neurologist)
Pediatric Providers: 1 Physician and 1 NP
Volunteer Coordinator
Chaplain
Social Workers (2)
Fellowship (Physician) to start July 2016
Monthly Learners (pharmacy, social work, & medical students, nurse practitioners, interns & residents)
Now, to get referrals….

Some groundwork had been done…

- Program Director was nationally respected in PC
- Medical Director had been well liked and respected by physicians and staff as a resident in our Children’s Hospital
- One provider transferred from Hospitalist service
- One provider transferred from Neurology service
- One provider transferred from Peds Cardiology ICU

Massive PR Campaign to expand definition of PC from an end of life service to a true support service for those with serious illnesses and conditions to help “ease the burden of” and help with difficult medical decision making.
Move away from....
Upstream Palliative Care

- Focus on psychosocial and physiologic need of seriously and chronically ill patients; despite goals of treatment.
- Manage Symptoms: delirium, refractory dyspnea, malignant pain, nausea/vomiting, mucositis, existential pain, etc.
- Educate primary providers regarding primary palliative care
- Provide consultative services to the emergency department
Media Blitz

'Thumbs up' just what the palliative care doctor ordered

Dr. Marshall Esherick literally gets a thumbs up from a cancer patient when she asks how he's feeling. It was just the sign she'd been waiting for.

On his landlady's 90th birthday, Mark Smith celebrated in a hospital room July 3 trying to find the will to live.

He wasn't able to talk. He wasn't eating or drinking. Horrible mouth sores caused in part by his cancer chemotherapy treatments were making him miserable. He had been diagnosed with NHL in 2011, but went through a depression and skipped taking his medications.

"I really didn't care and had given up," he said, tearing up. "I really didn't care about his arrival post."
PR Campaign

• Office of PR published articles in our newspaper, Online newsfeed, Twitter, and Facebook highlighting our staff providing supportive care before the end of life and some “thinking outside the box” solutions we have used, as well as how we collaborate with other disciplines.

• Our Medical Staff presented at every medical department staff meeting, asking their previous experience with our service and how we could help their service going forward, with a major focus on integrative care for symptom management.

• Program Director is presenting to all clinical staff meetings and our physicians are presenting to medical resident groups to educate them on the true definition of PC and how it can change things dramatically for our patients.

• Created Intranet Palliative Care website; Internet soon to come
Overarching approach for our staff

• We always remember we are a consult service and are respectful of the primary team’s sometimes differing views
• We clarify the consult request: symptom management, goals of care, or both. We don’t initiate more than requested.
• We try to make the primary team’s job easier
• We respond promptly to referrals and clearly communicate our recommendations to the primary team
• We provide support to staff caring for patient and ask for their assessment of patients’ and families’ coping
• We pull together information from other consult services and disciplines to provide a holistic approach to caring for the patient and family
• We strive for a fine mix of persistence in promoting Palliative Care and of respect for the territory of others
Interdisciplinary approach to Palliative Care

IDTs developed for pediatric and adult palliative care programs

- Physical Therapist/Occupational Therapist
- Pain consultant
- Speech & Language Therapist
- Dietician
- Respiratory therapist
- Child Life specialist
- Volunteer Coordinator
- Psychiatric Liaison Nurse
- Ethicist
- Chaplain
- Social Workers/Nurse Case Managers
- MDs/APRNs

Members meet twice weekly for Adult Program, once for Pediatric Program
Beyond Traditional Inpatient Consults

- Adult Palliative Care Clinic half day weekly
- Adult ALS clinic – PC imbedded as needed
- Adult LVAD Candidates, soon Heart Transplant & TAVR
- Pediatric Clinics – we see child in specialty clinic
  - HIV
  - Heart failure/transplant
  - Cystic Fibrosis
  - Multiple Sclerosis in the future
- Fetal Medicine Clinic
  - All Trisomy 13 & 18
  - single ventricle heart defects
  - others having uncertainty of viability
Involving Clinical Staff

- Identifying discipline PC Champions; inviting them to IDT

- Providing emotional support to clinical staff individually and as a unit group for high moral distress or grieving

- Promoted Hospital policy allowing any person (staff, family, patient) to request a Palliative Care Consult (We then confer with Primary team before seeing patient.)

- Involving nurses in a Moral Distress research project measuring if the ability to make a Palliative Care Consult has an ameliorating effect on their Moral Distress
Take-Aways

• Working on relationship building helps Palliative Care Programs gain the trust of referring services and individuals

• Collaborating with other disciplines aids us all with new ways of looking at a patient’s problem

• Combining our expertise and truly respecting each other’s views can lead to innovative plans for our patients and their families

• How has your team overcome barriers to working with other disciplines and gaining respect from referring services?
Thank you!

Questions, comments, feedback?