We used the Plan-Do-Study-Act (PDSA) model

• **Plan**: Gathered key stakeholders, assessed potential volume of patients and the capacity of our palliative care (PC) team. The team agreed upon the objective established criteria for the pilot and created a process flow map.

• **Do**: The pilot was initiated at CMC September 2018. Early on, we realized patients were not being referred to PC until the day of discharge. We increased our efforts to get PC recommendations to the providers as close to admission as possible. Initial barriers were misperceptions among providers and patients on what PC was and how it differs from Hospice. Providers were reluctant to order the consults due to lack of understanding regarding the benefits to the patients, families and the healthcare system. Our PC Nurse Practitioner (NP) provided education to the SHVI APP’s on PC triggers and how to introduce the topic and education on advanced heart failure treatment and symptom management to the Carolinas Palliative & Hospice Group (CPCHG). Additionally, tip cards were created to help differentiate between PC and Hospice.

• **Study**: Data was tracked manually by the nurse navigator (NN) and PC teams. The PC consult rate was obtained from the SHVI Continuum of Care PowerBI site.

Results/Outcomes

After the initiation of the pilot and PC education, there was nearly a twofold increase of PC consults to >28%. During the same period, there was a decrease in readmissions to about 10%. These findings shows that a systematic approach to involving PC with appropriate patients can be done successfully. Furthermore, this pilot supports the fact that PC care directly impacts outcomes such as 30-day readmissions to the hospital.

Through this initiative we were able to add a palliative care approach to symptom management and complex goals of care in appropriate HF patients. By establishing longitudinal relationships between the palliative and heart failure teams we are hopeful that our model will be an effective way to meet the needs of our patients and their family.

Next Steps

• Continue to assess 30 Day Readmission and 30 Day Mortality Rates
• Distribute the Palliative Care v. Hospice Tip Cards

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- Michelle Reibel, PI Coordinator
- Dana Harris, who touched every HF patient regardless whether they had PC consult or not.
- Dr. Johnela Adolphus, CHG

Goal

• Improve performance in HF related Outcome and Process Metrics to impact Public Reporting Programs & QCC Performance for CMC
  – HF 30 Day Readmissions
  – HF 30 Day Mortality
  – Palliative Care Consult Rate

Resources

- Goldstein, N Ascheim, D. What is the Clinical Course of Advanced Heart Failure and How Do Implantable Cardiac Devices Alter This Course? In Evidence Based Practice of Palliative Medicine. 2013;330-335.
- American Heart Association, www.heart.org

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Project Selection

• Heart Failure (HF) is the leading cause of hospitalizations in the Medicare population (AHA, 2019)
• Centers for Medicare and Medicaid Services (CMS) have initiated pay for performance programs that affect HF including Hospital Readmission Reduction Program and Value Based Purchasing Program
• Palliative Care (PC) has been shown to decrease acute care utilization and cost, reduce readmissions and 30 Day mortality
• Carolinas Medical Center (CMC) discharges 750 patients annually with HF
• The 1st 6 months of 2018 showed an alarming upward trend in HF readmissions at CMC

Only 9% of all CMC HF patients received PC consult between January-June 2018

Results/Outcomes

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