Transitions in Care Implementation of a Cross-Continuum Palliative Care Program

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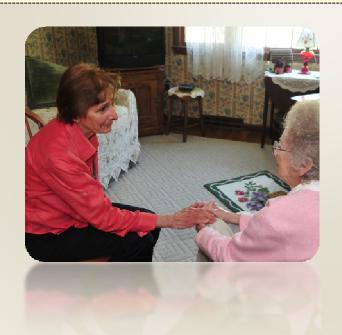






Provide the right care for each patient at the right time in the right care setting.

Palliative Care Program





Palliative Care Program

- Cross continuum (Hospice-Hospital) collaboration to shift the culture of our acute care facilities regarding approaches to chronic illnesses and end of life care
- Creation of a Steering Team to drive the project through creation of policies, processes and a communication plan
- o Creation of a Palliative Care Team to provide consultation and to begin modeling 'the difficult conversation'.

Palliative Care Team

Membership includes:

Director of Hospice

Physician knowledgeable with palliative care

Psychiatrist

NP or Nurse knowledgeable with palliative care

Pain Resource Nurse

Hospice Nurse

Chaplain

Social Work

Pharmacist



Benefits of the Program as per NHPCO "Hospital – Hospice Partnerships in Palliative Care"

- o Enhanced pain and symptom management
- o Care concordant with patient-family preferences
- o Improved patient and family satisfaction
- Reduced costs via shorter length of stay, decreased readmissions and less acute treatment ordering
- Earlier transition of care to
 Bridge or Hospice care



Financial Implications

- o Palliative Care services are non-billable
- Financial benefit is directly related to the Palliative Care Team's ability to
 - reduce and/or eliminate unnecessary testing and procedures
 - utilize less expensive and more effective medications
 - reduce unavoidable readmission

Patients who are discharged average savings ~ \$1696*

Patients who die in the hospital average savings ~ \$4900*

Morrison et al published an article in The Archives of Internal Medicine 2008;168(16):1783-1790. "Cost Savings Associated with US Hospital Palliative Care Consultation Programs"

It's about how you live.



