

CHARTER FORM

Project Title: Palliative Care Utilization in the ICU Setting

University/Organization Name: Wright State University Boonshoft School of Medicine

Health System Sponsor Name: Kettering Health Network (Mentor: Dr. Rebekah Wang-Cheng)

What are we trying to accomplish?

Aim statement (How good? For whom? By when? 1-2 sentences):

Our aim is to increase utilization of the palliative care team for patients in the medical ICU from 3% to 9% by April 2013.

Problem to be addressed (Defines WHAT broadly; 2-3 sentences)

At our institution, palliative care is rarely consulted in the medical ICU setting. This may be due to individual resistance from physicians, nurses, patients and families, misconceptions about what palliative care provides, and/or system-level barriers that prevent palliative care from being utilized more readily (i.e. a complicated consult process).

Reason for the effort (Defines WHY; 4-5 sentences)

Palliative care teams have been shown to increase patient, family and provider satisfaction, as well as decrease ineffective care at the end of life. In some studies, they even decrease length of stay and hospital costs. We want to make sure that patients and families experience the best possible end-of-life care, which in many cases includes referral to palliative care.

Expected outcomes/benefits (Defines WHAT specifically, still not HOW; 3-4 sentences)

We hope that there will be increased utilization of palliative care (PC), and more positive attitudes about the many services PC can offer an ICU team. Improved attitudes will help change the culture of the ICU, thereby supporting a long-term increase in utilization. Also, by providing more patients and families access to palliative care, we hope they will have more positive experiences surrounding end-of-life. Long-term outcomes may be shorter lengths of stays and decreased hospital costs, especially at the end of life; an improvement in conditions and quality of care for patients; and, improved patient, family and provider satisfaction.

How do we know that a change is an improvement?

(Identify outcome, process, and balancing measures; 4-5 sentences)

Outcome measures: The rate of palliative care consults will be monitored to assess progress and success. An improvement will be noted if the rate of palliative care consults increases. Long-term outcome measures that extend beyond the scope of this project include decreased length of stay and decreased hospital costs.

- % of palliative care consults for medical ICU patients per week

Process measures: We will measure interventions that lead to increased rates of consultation.

- % of patients who are screened in the medical ICU, on Day 0, Day 3, and Day 6. (As a reference, we will also measure % of patients who would have received consults if screening tool had been in place during past several months)
- % of providers who attend educational sessions

Balancing measures: We will ensure that other parts of the system are not negatively affected by this increase in palliative care utilization:

- Staff satisfaction with increased involvement of palliative care team.
- Staff satisfaction with screening tool and educational sessions.

What changes can we make that will lead to improvement?

(Initial changes, barriers, key stakeholders; 4-5 sentences)

Initial activities: First, we will speak with the stakeholders: palliative care nurses and physicians, and ICU nurses and physicians. We hope to learn if they view palliative care interventions in a positive light, what barriers they see in terms of increased utilization of palliative care, and what sorts of interventions they think would be successful.

Next, we want to develop a simple and effective screening tool that can be used by any member of the ICU team, to help providers decide when the palliative care team should be consulted. Our stakeholders will have input on the development of the tool. We will validate this screening tool by reviewing several weeks of medical records, determining if the tool positively identifies patients who could qualify for palliative care. This will give us a goal for the number of consults we might expect on a weekly or monthly basis.

Then, we will implement an educational session for ICU nurses and physicians, discussing the goals and misconceptions surrounding palliative care. During these sessions, we will show the data: only 3% of our ICU patients are receiving palliative care consults, while the literature suggests that 25-50% of patients meet criteria for palliative care involvement.

We will continue to have weekly or bi-weekly feedback sessions to assess staff satisfaction with the interventions and tool.

Barriers: We may come up against negative provider attitude and behavior. We may also face negative patient and family attitudes. In addition, the screening tool will be on paper (in an ICU run on electronic medical records), so ensuring that paper charts are monitored and referred to on a daily basis will be crucial to successful utilization of the screening tool.

Key stakeholders: We will work closely with nursing and physician leaders both in the ICU and palliative care. We will also include one or two families of patients to get their perspective. Other stakeholders include residents, social workers, and medical quality staff.