

**Wake Forest™**  
Baptist Health

**And Now We Talk....**  
*Implementing Medical Palliative Care Nurse Liaisons in Critical Care*

2015 ANCC National Magnet Conference

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**Medical Center Snapshot**



- 885 beds
- Academic Medical Center
- Brenner Children's Hospital
- Comprehensive Cancer Center
- Level 1 Trauma Center
- Magnet since 1999
- First in the Carolinas, 14<sup>th</sup> in US

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**Objectives**



- Discuss the importance of assessing goals of care early in the critical care environment to offer an improved hospital experience
- Review our experience of creating a nursing position for early identification and support of MICU patients and families who, following assessment, desired a pathway toward palliation without interruption of bedside nursing or medical care
- Review patient outcomes and results following implementation of MICU liaison program

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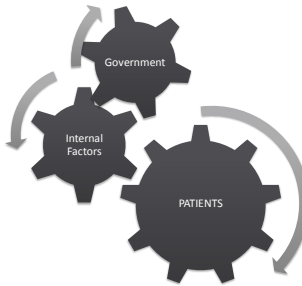
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## Driving Forces



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## Driving Forces

- Patient and family understanding HCAHPS scores patient comfort and decision-making
- Governmental changes healthcare reform
- Affordable Care Act (ACA)
- Readmissions
- Analyzing and understanding your own internal metrics surrounding morbidity and mortality

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## Background



- Despite aggressive treatment, many ICU patients die or remain chronically critically ill
- 20% of Americans (500,000/ year) and > 30% of Medicare recipients die in or shortly after ICU care. 100,000 ICU "survivors" continue with critical illness on a chronic basis
- Most importantly for some critically ill patients, ICU treatment is more burdensome than beneficial and/or inconsistent with their values, goals and preferences



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Medicare.gov

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## Background: What's the Cost?



- To care for ICU patients who die or have poor functional outcomes is also formidable. From 1994 to 2004, annual Medicare cost for ICU care increased by 35.7%—from \$23.8 billion to \$32.3 billion and ICU care overall consumes one percent of the US GDP.
- Medicare spends > \$50 billion on physician and hospital care for patients in the last 2 months of life. An estimated 20%-30% of these expenditures **have no meaningful impact on medical outcomes.**

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## Setting... Medical Intensive Care Unit Snapshot

### • Medical Intensive Care Unit (MICU)

*4<sup>th</sup> Floor Reynolds Tower 24 beds- comprised of 2 teaching services*

*4<sup>th</sup> Floor 'C' 11 beds- this area is managed by Advanced Practice Practitioners*

*Average daily census combined 30*

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## Background: The real cost....



*Again...*

- For some critically ill patients, **ICU treatment is more burdensome than beneficial and/or inconsistent with their values, goals and preferences**



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## Impetus for Change



- Everyone in the current healthcare environment seems to be searching for optimal blend of nursing staff, cost effective practice, improved patient outcomes, and increasing patient satisfaction.
- A necessary tool or resource that was missing from our multidisciplinary team was palliative care nursing support
- Historical data was examined with support from chaplain services to determine the amount of time bedside, direct care nurses were spending on these tasks

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## Impetus for Change

- The primary aim of our project was to improve patient experience while supporting direct, bedside nurses who were caring for the critically ill



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## Our Journey



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## Proposal

- A dedicated MICU Palliative Care RN focused on the palliative care needs of MICU patients 7 days/week and 12 hours/day will greatly increase the number of MICU patients identified with palliative care needs.

## Our Hypothesis

- As patients receive more appropriate palliative care, the number of transfers to palliative care and hospice will increase, and the ICU LOS will decrease for patients at very high risk for death and a poor functional outcome.

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## The Team



- Nurse Manager (MICU)
- MICU Palliative Care Specialist
- Charge RN
- Bedside RN
- Palliative Care Coordinator
- Attending physician
- Director of Nursing
- Resident
- Chaplain
- Care Coordination
- Multidisciplinary Weekly Meeting

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## Pilot Approach



- Create a MICU Nurse Palliative Care Liaison role (MNPCL) for our adult, medical critical care
- The liaison will work day shift 7a-7p, 7 days a week
- Will require 4-8 weeks of training/ education prior to implementation

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## Planning: Financial Requirements

### FTE requirements for the position

- FTE calculation based on the need of having 1 nurse per day, seven days a week, working 12 hours a day...  $(1RN/12 \text{ hour days}) \times (7 \text{ days/week}) = 84 \text{ hours per week} / (40 \text{ hours per week}) = 2.1 \text{ FTE's}$   $\times 1.12 \text{ PTO factor} = \mathbf{2.4 \text{ FTE's}}$
- Approximate Annual Salary Cost: \$175,968
- Approximate Salary Cost for 3 month pilot: \$43,992
- Quality of life= Priceless



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## Planning: Expectations for New Role

Responsibilities	Daily	Weekly
Receive morning report on new admits/patient changes from charge RN	✓	
Review new admits (charts/bedside)	✓	
Attend daily huddle – with a dedicated time during multidisciplinary team huddle to discuss PC patients	✓	
Communicate with leaderships by 11am on a daily basis regarding screened patients	✓	
Join rounds for identified patients	✓	
Communicate with physicians re: newly identified patients & follow-up meetings	✓	
Schedule & attend family meetings; complete documentation; daily communication with Palliative Care team	✓	
Participate in Palliative Care interdisciplinary team rounds every Tuesday at 1pm		✓
Participate in Palliative Care primary team rounds every Friday afternoon		✓

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## Forming a new role: Training Requirements

- Training requirements: (Palliative Care Coordinator) will train MICU Palliative Care Nurse Liaison
- Training Content: Goals of Care; computer; Chain of Command; Screening Tools; and planning and arranging effective family meetings.



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Forming a new role:  
Training Requirements

- Training documentation: MICU Palliative Care Nurse Liaison (MPCNL) Education Plan; SPIKES; MICU Screening Criteria
- Estimated training plan timeline: 4-8 weeks



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Metrics



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Our Course



Metric	Baseline	Target
Number of Monthly MICU Palliative Care Consults	22	35
*Number of Monthly MICU to Palliative Care Transfers	14	20
Number of MICU Hospice Transfers	1	4

*\*Notable changes throughout project impacting definition of metrics: The medical center shifted to a mobile palliative care model, therefore closing the inpatient palliative care unit, hence the metrics to measure success have changed to reflect Hospice in Place (HIP) conversions as opposed to physical unit transfers.*

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## Metrics

- Number of Monthly MICU Palliative Care Consults
- Number of Monthly Palliative Care transfers
- Number of Transfers to Hospice



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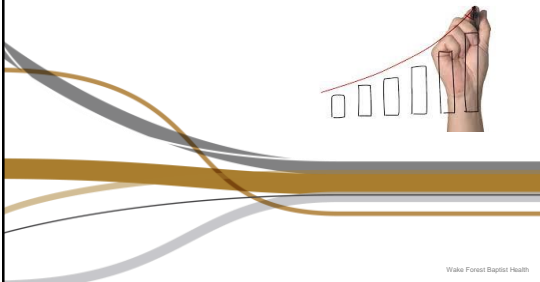
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## Results



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## Results

- Data demonstrated that the MPCNL role improved patient satisfaction, and improved nursing satisfaction in the MICU.
- Notably, bedside practitioners expressed having more time to perform bedside nursing care while the liaisons were focusing quality time meeting with families.
- Nurses felt they were better able to provide comfort care to patients transitioning them to end-of-life while in critical care.



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Results

- Patients and families in the MICU have received more information about Palliative Care and Hospice services since the introduction of the MPCNL role.
- The MPCNL's have followed approximately 85 patients per month

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Review:  
Baseline & Goals

Metric	Baseline	Target
Number of Monthly MICU Palliative Care Consults	22	35
Number of Monthly MICU to Palliative Care Transfers	14	20
Number of MICU Hospice Transfers	1	4

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Metrics

Metric	Baseline	Month 1 (September)	Month 2 (October)	Month 3 (November)	Pilot Target
Number of Monthly MICU Palliative Care Consults	22	17	59	22	35 ✓
Number of Monthly MICU to Palliative Care Transfers	14	16	21	23	20 ✓
*Number of MICU Hospice (HIP) conversions	1	5	7	10	4 ✓

\*Notable changes throughout project impacting definition of metrics: The medical center shifted to a mobile palliative care model, therefore closing the inpatient palliative care unit, hence the metrics to measure success have changed to reflect Hospice in Place (HIP) conversions as opposed to physical unit transfers.

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## Future Directions



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## Future Directions



- Having this role and structure has enhanced communication and sharing of services/ resources.
- Continuing to monitor trends in palliative/ end-of-life care

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## Lessons Learned



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**Thank you!**

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### Our Experience Taught Us...

- When considering this type of role formation it is beneficial to have nurses who have critical care experience/ established relationships with the existing team
- Positively impacts quality of life and experience of patient and family
- Demonstrated positive implications, staff satisfaction for bedside critical care nurses

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### Our Experience Taught Us...



- Most importantly this approach is patient-family centered, and has directly helped more patients and families determine goals of care EARLIER offering resources and alternative options to aggressive critical care management such as hospice and palliative care – above all

***NOW WE TALK...***

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References

- Medicare.gov <https://medicare.gov/hospitalcompare/Data /30-day-measures.html>

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