

**PRACTICE IMPROVEMENT PROJECT ABSTRACTS**  
**Implemented 2013 - 2015**

<b>Hospital or Health Care System</b>	<b>Project Title</b>	<b>Coleman Palliative Medicine Fellow</b>
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Presence St. Joseph Hospital, Elgin	Development and Utilization of an Internal Palliative Care Tracking Form and Database with the Goal of Creating a Sustainable Process to Extract Key Indicators and Outcomes	Patty Lamp, APN <a href="mailto:cplamp@comcast.net">cplamp@comcast.net</a> Susie White, MD <sup>2</sup> <a href="mailto:swhite6077@gmail.com">swhite6077@gmail.com</a>

Hospital or Health Care System	Project Title	Coleman Palliative Medicine Fellow
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## Evaluation of a New Pediatric Palliative Care Program: Utilization and Attitudes

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**Background:** Pediatric palliative care offers comprehensive, family-centered care for children with complex, life-threatening or chronic conditions. Whether suffering is physical, emotional, social, or spiritual, the pediatric palliative care team provides treatment to relieve children's symptoms of distress and enhances quality of life. Evidence suggests that adult healthcare professionals' have positive attitudes towards palliative care, but little evidence exists about the attitudes of pediatric healthcare professionals.

**Goal/Purpose:** The purpose of this quality improvement project was to: 1) describe health care provider attitudes regarding palliative and supportive care and our palliative care program, and 2) evaluate utilization of the pediatric palliative and support care program over the 18 months since its inception

**Program Description:** In October of 2012 a pediatric palliative care program was developed at Advocate Children's Hospital – Oak Lawn campus. This consultative program focuses on coordination of care, assisting assistance with complex decision making, and pain and symptom relief. The program consists of a pediatric nurse practitioner, social workers, chaplains, and child life specialist. The palliative care team works in collaboration with your child's other health care providers and specialists, helping to provide seamless care coordination and communication.

**Methods:** Participants: The survey was distributed to the inpatient providers that covered the following units: pediatric surgical heart, pediatric intensive care, and neonatal intensive care, general pediatric, cardiology and hematology / oncology units. These providers were: physicians, nurses, respiratory therapist, social workers, child life, care managers, and chaplains. Measures: A) 23- item adapted survey was utilized to evaluate the perception of healthcare providers that care for pediatric palliative and supportive patients. The survey was broken down into four sections of measuring the satisfaction of palliative rounds, teamwork, communication and impact on safety of the pediatric palliative and supportive care program. B) Program utilization was evaluated by the number of pediatric palliative care consults entered in the computer over the 18 months of the program. Data Analysis: Descriptive statistics were used to analyze the survey data.

**Results:** Consultations for palliative care have increased dramatically over the first year to an average seven new consults per month. Having a dedicated pediatric palliative care program recognizes the presence and important role the interdisciplinary team plays in shaping the experience and care choice for patients and families with life threatening illnesses. Pediatric palliative care is a valuable resource for children, families and health care professionals that address an unmet need in the pediatric hospital setting. Overall, pediatric healthcare professionals at our organization feel they have a voice in rounds, there is a high level of collaboration, and goals of care are understood amongst families and the medical team.

**Abstract:**

Increasing advanced-care planning discussion and completion of POLST forms in the homebound population; increasing timely hospice referrals with increased length of stays; and decreasing hospitalizations in the medically complex homebound patient population.

**Background:** Advocate runs a homebound palliative care program that began in 2011 with only five admissions. Since that time, it has grown exponentially and currently has more than 1,000 admissions. The patient population is medically complex and includes both Medicare-risk and commercial patients. These patients are homebound, and have been identified by care managers as being at risk for multiple hospitalizations. As the program has grown there is an increasing need for a designated place in the EMR to be created for ACP's, which could ease the communication across sites of care and among clinical providers.

**Goals:**

- Increase the number of ACP discussions and completed POLST forms; and identify a uniform location within the EMR for the completed forms.
- Track data for health care utilization after admission to palliative care; including hospitalization rates, admission to hospice, LOS in hospice, and death location.
- Assess the current criteria for identifying high-risk patients eligible for home-based palliative care.

**Methods:**

- Use a chart audit tool to perform a retrospective review of 30 charts to identify advanced directive documentation.
- Use a chart audit tool to conduct a retrospective review of 50 patients seen in the home-based palliative care program between July 2013 and Oct 2013. Review outcomes as measured by number of hospitalizations, LOS in hospital, hospice referrals, LOS in hospice, and location of death.
- Use a chart audit tool to review the above selected charts of patients referred to home-based palliative care who required a status change after initial assessment.

**Results & Outcomes:** In looking at Advanced Care Planning (ACP) of 30 admissions from July through October 2013, 78.57% of the patients had ACP discussions resulting in 50% completing the POLST and 43% completing POA forms. Only 46% of the patients' EMRs included mention of POLST or POA, and those mentions were primarily noted in progress note or problem lists.

50 charts were reviewed in an attempt to determine if the current criteria for referral (i.e. chronic disease, multiple hospital admissions, and cancer diagnoses) resulted in appropriate referrals. Of the 50 patients, 84% were appropriate for palliative care, 10% were referred to home MD, 2% to substance abuse counseling, and 4% to home health.

Among the utilization outcomes of 50 patients for the period of July through October 2013, there were 15 hospitalizations averaging 4 days per patient. 38% of the patients were referred to hospice with 70% of those patients dying at home.

**Summary:** Progress has been made in our ACP discussions as well as completion of POLST and POA forms, but there is a need to continue working to create a dedicated place in the EMR for the POLST form. As the use of palliative care programs continues to grow, clinicians have an opportunity to positively impact the end of life with fewer hospitalizations, earlier hospice admissions, and improved communication across the continuum of care.

## Palliative Care in the Emergency Department

Ellen Norton, APN  
St Alexius Medical Center, Hoffman Estates

**Background:** Emergency Department (ED) patients often have unmet palliative care needs. The Emergency Department asked for the Palliative Care Service to join efforts to advance palliative care in the Emergency Department.

**Goals:**

1. Needs assessment of Emergency Department to assess knowledge of palliative care and existing consultative service in the Hospital.
2. Identify and recruit Emergency Department Champion Physician
3. Develop palliative care screening tool relevant to the ED
4. Implement the screening tool and process for follow up

**Methods:** Literature review of palliative care in the ED to be shared with the task force. Review of the IHI-IPAL ED program and needs assessment tool and assessment of the ED staff knowledge of palliative care. After the assessment was completed there were meetings with the ED educator to outline presentation to the ED staff of the pilot program. Direct phone line was established for the ED to call palliative care teams. The Palliative Care Consultants followed with periodic rounding in the Emergency Department to build relationships with the staff. A pocket guide was also developed by the ED educator for quick reference of criteria for appropriate referrals. Patient referrals from ED physicians and RN case managers were tracked that met criteria for palliative care interventions. All referrals need an order from the primary care physician.

**Results:** Palliative Care screening tool was developed and is actively used to identify appropriate patients with unmet palliative care needs. The Emergency Department can identify patients with specialized palliative care needs. ED physicians are able to directly contact the palliative care service although the bulk of referrals are made via email from RN case managers who have increased the number of patients who meet screening criteria threefold. Of the patients who screen appropriate for palliative care intervention 30% have been referred by Primary Care Providers for consultation.

**Conclusion:** IPAL-ED has been introduced to the Emergency Department and RN Case Managers have been very active in screening appropriate patients. There has been a partnership established and it is sustainable. The Palliative Care Consultant has been asked by ED physicians to participate in patient care while in the ED as well. Approximately 50% of the patients referred to Palliative Care have a diagnosis of metastatic cancer with oncologic symptom burden that brought them to the ED.

There is an opportunity to encourage earlier referral to palliative care in the acute care setting and in the community. Also earlier Hospice referrals when curative and palliative therapies have been exhausted.

## Upstream Palliative Medicine Referral Program

Heather Augustyniak, NP-C  
Cadence Health

**Background:** In November 2012 the clinical leaders within Cadence Health Oncology Service line identified an opportunity to improve the management and multidisciplinary approach towards treating cancer related symptoms utilizing the existing palliative medicine service. A brief survey of the medical oncologist and palliative medicine revealed that the palliative medicine service was being underutilized as a whole in oncology. It was also recognized that when palliative medicine was consulted it was near the end of the patient's life when the patient was experiencing moderate to severe symptoms related to his or her cancer. Thus, a new start up program, supported by Cadence Health's oncology leadership and administration, was initiated in January 2013. This program is based on the upstream concept that identifies three existing targeted patient populations that require complex management of the care related to symptoms and complications related to treatment(s) that could benefit from the early integration of palliative medicine with a consult at the time of diagnosis. The identified targeted populations are all patients diagnosed with stage IIIB and IV lung cancer, advanced pancreatic cancer (defined by medical leadership as patients that are not candidates for surgical resection), and glioblastoma multiforme that are treated at Warrenville Cancer Center.

**Goals:** 1) The treating oncology providers will consult palliative medicine within three weeks of diagnosis for all patients with the diagnosis of a) stage IIIB and IV lung cancer, b) advanced pancreatic cancer, and c) glioblastoma multiforme (GBM) by January 2015.

**Methods:** We retrospectively investigated stage IIIB and IV lung cancer, advanced pancreatic cancer, and GBM patients that were diagnosed and treated at the Warrenville Cancer Center in the following time frames: a) January 2012 to December 2012 b) January to June 2013 and c) July to December 2013. The three benchmarks that we measured were a) the percentage of patients with each diagnosis that were referred to palliative medicine, b) when a patient was referred to palliative medicine, the average amount of days between initial diagnosis and palliative medicine consult and c) when a patient was referred to palliative medicine, the average amount of days between first medical oncology contact and palliative medicine consult.

### **Results:**

***The percentage of patients with each diagnosis that were referred to palliative medicine:*** In 2012 the percentage of palliative medicine referrals for each identified patient population were 50% or lower. For the time frame January to June 2013 there was an increase in referrals to palliative medicine for stage IIIB and IV lung cancer patients by 13% and GBM patients by 16%. The advanced pancreatic cancer patients were referred to palliative medicine 7% less often in comparison to overall in 2012. However, from July to December 2013, the percentage of referrals increased in this patient population to 66.7% overall. The GBM patients were also referred more frequently with a percentage of 85.7%, approximately 35% more than in 2012. The lung cancer patient population actually had a 15% reduction in referrals in the July to December 2013 timeframe.

***The average amount of days between the initial diagnosis and actual consult to palliative medicine:*** The overall target for all identified patient populations is that each patient has a palliative medicine consult within 21 days (3 weeks) from initial diagnosis or first medical oncology contact. The stage IIIB and IV lung cancer population did not meet the target in all measured timeframes. However, with each timeframe the trend continued to decline in the average number of days between initial diagnosis and palliative medicine consult. The advanced pancreatic cancer patients had a notable increase in the average amount of days for the July to December 2013 timeframe, going from 12 days to 99 days. The GBM patients in 2012 consulted with a palliative medicine provider on average 109 days after initial diagnosis.

**Future Work:** In order to reach our goal by January 2015, it is imperative that the Upstream Palliative Medicine Referral Program at Warrenville Cancer Center become ingrained into the culture of our staff and multidisciplinary clinics as we move forward. A strategic plan has been implemented to require the palliative medicine consults be built-in into the applicable clinical pathways. As a Coleman Palliative Medicine Fellow, I will continue to use this unique opportunity to promote an early intervention approach by closely working with the medical oncology providers, nurse navigators, and palliative medicine team to ensure that all team members are knowledgeable of the benefits that their patients receive when palliative medicine is consulted at the time of diagnosis.



## Evaluating the Need for Palliative Care Services through a Physician Needs Assessment

Kelli Nickols, MSN, APN, FNP-BC  
Ingalls Health System

**Background:** The need for cost effective and efficient health care consistently plays an important role in the quality of care patients receive. Palliative care services are beginning to be integrated into the mainstream of health care services, and have a foundation to meet the needs of patients and families. Physicians are the main referral source for palliative care services, yet many patients are not referred and are unaware of the benefits of palliative care.

**Goal:** To ascertain the physician perspective of the goal palliative medicine and reasons for patient referral.

**Methods:** A quantitative survey needs assessment design was conducted to evaluate the physician perspective of palliative care services. The survey consisted of 13 questions to assess knowledge, patient referrals, and service expectations. Distributions of 30 surveys were delivered to physicians affiliated with Ingalls Memorial Hospital. Responses were received from 10 physicians. Participants were predominately oncology specialized physicians (50%) and internal medicine (50%) with the majority between the ages of 35-45 years old.

**Findings:** Survey findings suggested that the physicians did not have a clear understanding of palliative care services, with 80% of respondents stating that patient receive services when they are no longer seeking medical intervention. The physicians recognized the benefits of services such as: goals of care, social work services, symptom management, bereavement services, and transition to hospice care. On the other hand, 60% of physicians felt a sense of control would be lost if patients were referred for palliative care services.

**Conclusion:** Recognizing and addressing the concerns of not only the patients, but the providers that are referring the patients is essential. Creating an environment of trust and collaboration will improve the quality of care patients receive. Ingalls Memorial Hospital has conducted a Rapid Improvement Project to further expand the program. The home care department has increased their program enrollment, and has full support from the administrator. Future plans involve the development of an inpatient palliative care program.



## An Educational Practice Improvement Project in Palliative Care

Melody Aspinwall, MS, APN-BC  
KishHealth

**Background:** An educational initiative for Palliative Care was implemented for the medical professionals at KishHealth System and the community of DeKalb County that would improve access to palliative care for patients with cancer and other serious illnesses.

**Goal:** To educate target health providers and consumers including Hospitalist, community physicians, Oncologist, social workers, other members of the healthcare system and the community about Palliative Care in general and the specific services offered at KishHealth System through the newly developed Supportive Care-Palliative Medicine program.

**Methods:** In the fall of 2012 I was accepted into the Coleman's Palliative Medicine Fellowship. This was a three year fellowship that included online learning modules, conferences, clinical observation with an assigned mentor and supplemental readings. Information booths at five community and Hospital health care fairs were set up to increase visibility of KishHealth System Palliative Care Program and to provide written and verbal education about palliative care. Ten formal and numerous informal educational sessions were provided through in-services, program brochures, and other educational materials. A Palliative Medicine CME/ Grand Rounds presentation was organized and offered to healthcare professionals at the two key campuses of Kishwaukee Hospital and Valley West Hospital. This was presented by Dr. Ilena Leyva, a palliative care physician from Cadence Health, Coleman Mentor and planning committee member. Education and increased awareness of the Supportive Care-Palliative Medicine program was further enhanced by attending several medical and hospice staff meetings.

### **Results:**

- With FY 2015 budget KishHealth System approved .5 FTE hiring of an additional palliative APN for the Supportive Care-Palliative Medicine program. New palliative APN has been hired for the Supportive Care-Palliative Medicine program which has allowed the program to accept more patients into the program and increase our availability to established patients and their families.
- New clerical staff for Supportive program logistics 0.5 FTE approved and has been hired.
- Successful billing of NP home visits, nursing home, assistive living facilities and hospital for both initial consults and follow-up visits that covered the fiscal year 2014 budget for the Supportive Care program.
- Educated staff at Kishwaukee Hospital with specific concentration on hospitalist, oncologist and social workers about palliative care and KishHealth Supportive Care program which has resulted in an increase in referrals/admissions. Specifically from 2012 to 2013 referrals/admissions increased by 184% and from 2013-2014 referrals/ admissions increased by 85%. Informative/non-admission consults were not included in our data collection. With the approved addition of another NP we are expecting the program to grow even more in 2015.
- Attended the 2014 Illinois Hospital Association Palliative Care Conference with the Chief Medical Officer, Senior Director of Physician Operations and one of our senior leaders for KishHealth Systems which increased awareness among key hospital leadership.
- Met with the KishHealth System Cancer Center Oncologist and supporting staff to discuss Supportive Care Program. These meetings resulted in establishing an automatic referral to the Supportive Care-Palliative Medicine program for all oncology patients with Stage IV disease or primary intent of cancer treatment is palliative only. This helped to align KishHealth Cancer Care with national guidelines.
- Starting in June 2014 I established monthly meetings with Cancer Center navigators monthly to discuss mutual patients, new referrals and ways to enhance quality and access to palliative care services. Referrals from the KishHealth System Cancer Center to Supportive Care have increased from 2012 -2013 by 75% and 2013 – 2014 by 167%.
- As a result of the multiple methods of educational initiatives, growth of referrals to the Supportive Care-Palliative Medicine program has led to increased referrals to hospice care of 287% from 2012 to 2014.

Overall, the Supportive Care-Palliative Medicine program has enabled earlier and appropriate access to hospice care for patients with serious illnesses.

**Conclusion:** Because of the educational practice improvement project and increased exposure of the Supportive Care-Palliative medicine program, referrals have increased from all sources to the KishHealth System Supportive Care-Palliative Medicine Program. This educational project has shown that it is imperative that we continue to educate physicians, other healthcare providers and the community of what palliative medicine is and the benefits it provides. While implementing this practice improvement project I found that there is a lot of confusion in the medical community and the public as to what Palliative Medicine is. Many physicians associate palliative medicine with hospice so are hesitant to make referrals to palliative medicine as do not feel their patients are medically appropriate for hospice. This same misperception about palliative care was also encountered when meeting with patients and their families.

This practice improvement project found that educating a community and health care providers about palliative care not only increases referrals but also enables more patients and their families to have earlier access to palliative care services. Referrals have increased from the local Oncologist, hospital social workers, case managers, nurse navigators and all other referral sources including from other generalist and specialty physicians and providers.

## Coleman Quality Improvement Project at La Rabida Children's Hospital

Ruby Roy MD and Nancy Richer RN MSN  
La Rabida Children's Hospital

**Background/rationale:** La Rabida Children's Hospital is a 47 bed specialty pediatric hospital located on the shores of Lake Michigan in Chicago. La Rabida's mission is to provide excellent care to children with medical complexity and technology dependence. The children receive palliative care by the very nature of their conditions; however the institution did not have a formal palliative care service. Children are often admitted to the inpatient unit from other area hospitals for medical stabilization and caregiver education for transition to home care.

**Goals:** The Comfort Care Team Quality Improvement project was conceptualized after the need for improved communication regarding comfort measures and resuscitation status between facilities was identified. The goal of this project was to assure continuity of care, continued support for family choices, and compliance with regulatory agency recommendations. The QI project also served to raise awareness of palliative care needs in transferred patients, provide seamless transition of palliative care, and also served as a gross measure of culture change on the inpatient unit.

**Methods:** The Comfort Care team was recruited: this interdisciplinary team consisted of 33 members with representatives from all clinical areas and administration. A needs assessment was performed on patients and staff which highlighted the need for palliative care education and support. Based on this, the Comfort Care team initiated an educational program with case based discussions, clinical debriefs or reflective reading sessions weekly for all members of the inpatient team in July 2013. A service of remembrance for staff and family support was planned and conducted. Simultaneously, we began providing clinical palliative care services with inpatient consultations. Our team recruited nurse champions to help raise awareness of the palliative care team services and the QI project. We advocated modification to the inpatient nursing assessment in the electronic medical record to capture information on admission about comfort care services. Question fields were added to the initial nursing intake regarding comfort measures utilized in the transferring institution, a description of those, and whether the patient had previously received a palliative care consultation.

**Results:** Physician and nursing admission documentation on 15 patients was searched for reference to comfort measures or palliative care consultation. Palliative care comfort measures were only referenced in one chart. Due to the fellowship time line, we conducted our "post" survey in January 2014 after three months of initiating the EMR change. We reviewed 15 charts between January and March 2014: the section regarding comfort care had been completed on 7/15 with specific comfort care measures on 3/15. One chart indicated a "false negative" with denial of palliative care services at the transferring institution. The educational program and the service of remembrance received excellent evaluations by all attendees.

**Discussion:** We demonstrated significant change in our hospital's inpatient clinical team's awareness of palliative care services and comfort measures. Our numbers are low, but we focused only on charts of children who were transferred for long term hospitalizations for transition care, for whom palliative care needs are most important. We also noted palliative care team consultations being initiated by the nursing staff and rehabilitation staff and requested on team rounds. This project has also facilitated clinical collaboration with other institutions' palliative care teams. We have shared this data with our administration and will continue to monitor the status of our comfort care intakes. We plan to continue the palliative care consultations, the educational program and to repeat the service of remembrance annually.

## The Creation of a Pediatric Palliative Care Resident Curriculum

Kevin Smith, MD  
Loyola University Medical Center

**Background:** The American Academy of Pediatrics recommends the initiation of pediatric palliative care (PPC) into the usual care for pediatric patients with life-threatening illnesses. However, in 2008 only 58% of Children's Oncology Group centers had a PPC service despite these recommendations. Additionally, studies show that pediatric residencies provide only minimal training in pain management and PPC despite a desire for more instruction. Loyola University Medical Center (LUMC) previously lacked an educational curriculum despite caring for multiple children with chronic or life-limiting illnesses.

**Goals:** 1) To provide an educational experience for the pediatric and medicine-pediatric residents related to the principles of communication skills, symptom management, and end of life care for pediatric patients. 2) To utilize the adult palliative care service to provide an experiential component for observing goals of care and end of life discussions. 3) To use this intervention to indirectly expand the presence of PPC for our patients at LUMC.

**Methods:** Starting in 2013, we developed a needs assessment for LUMC in regards to views of and comfort level with PPC for residents, attendings, and nurses. A PPC resident curriculum was developed using lectures from The Initiative for Pediatric Palliative Care and the Education in Palliative and End-Of-Life Care (EPEC) curricula to create didactic sessions on: 1) developmentally appropriate communication including working with adolescents, 2) pediatric pain assessment and treatment, 3) symptom management including nausea and dyspnea, 4) artificial nutrition, and 5) end of life care. Additionally, the residents round with the adult palliative care service to observe and discuss the principles of communication skills and symptom management. Finally, a pediatric social worker discusses the details of pediatric hospice, and a child life specialist covers bereavement.

**Results:** A total of 117 individuals participated in our needs assessment for a total response rate of 47% (75%, 48%, and 36% for the residents, attendings, and nurses, respectively). Attendings felt more comfortable caring for children with life-limiting disease than the other groups. Additionally, more experienced faculty and staff felt the most comfortable with these patients. Interestingly, older staff and faculty were more willing to suggest or refer to PPC. For the residents, there was a positive correlation between the numbers of terminal patients cared for and a higher level of comfort suggesting palliative care. For the educational component, two residents have participated in the PPC elective, and two more are scheduled later this year. Data from the one submitted evaluation shows the quality of education score is a 3 on a 1-5 Likert scale. In addition to providing the residents with education, this intervention has expanded the presence of PPC with the number of PPC consults increasing from zero to eight.

**Conclusions:** At LUMC, older faculty and staff were more willing to suggest or refer to PPC, and residents with a higher number of terminal patients also were more comfortable suggesting PPC. To deliver more knowledge about PPC and end of life topics, an elective was created that educates through didactic lectures and experiential exposures. In the future, I hope to create case-based learning topics, and to develop a pre/post-test to objectively measure the knowledge gained through this elective. Additionally, this elective has started to change the culture of LUMC to support PPC services.

## The Assessment of Advance Care Planning in the an Outpatient Hemodialysis Setting

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Nephrology Associates of Illinois

**Background:** Advance Care Planning (ACP) is critical to the End-Stage Renal Disease (ESRD) patient population. As the prevalence in ESRD is rapidly increasing, dialysis treatment is available to older and increasingly medically complex patients. With five-year survival rates below that of AIDS as well as many cancers and given high mortality rates, the outpatient care hemodialysis clinic presents a perfect setting to address ACP at a time where the patient is more stable than when in acute care.

### **Goals:**

- 1) To evaluate an outpatient hemodialysis setting and its position in regards to ACP
- 2) To update the patient records to reflect findings from paper, computer, and hospital charts
- 3) To implement a streamline process and documentation where all patients would be offered ACP from the time of admission. Documentation of ACP to the comprehensive initial assessment (CIA) would occur at admission, with a follow up at 90 days and annually thereafter.

**Methods:** Between June 2013 and January 2015, patient records were reviewed to assess for ACP. The outpatient clinic's paper charts and computer records (EMR initiated December 2013) were audited to identify those patients with living wills, healthcare power of attorney, and DNR forms. Patients' hospital records were also reviewed to assess for any ACP which may not have been updated to outpatient hemodialysis chart records. Conversation with patients offered clarification of ACP. Updated code status and ACP were then populated to current CIA and EMR by the social worker and/or APN during the last quarter of 2014.

**Results:** A total of 97 charts were audited. Fifty nine males and 38 females. 59 patients were greater than 65 y/o. At project completion, patients with DNR in place grew from 4 to 11. The number of patients with Advance Directives grew from 25 to 40. Two patients were missing the *admission resuscitation statement*, a mandatory document, and several DNRs were found through the review of hospital records. Prior to the fall of 2014, no supportive ACP documentation in the patient's CIA. Additional findings are as follows: 1) lack of follow up for patient stating interest in completing ACP documentation, 2) lack of follow up for change in Code Status and AD during hospitalization, back of backup system to identify DNR and AD in case of computer downtime, and 3) no system in place to identify transient patients' code status and AD.

**Conclusion:** The outpatient hemodialysis setting is in need of a streamline process to provide care that is consistent with the patient's wishes. This project was instrumental in assessing the center's position on ACP and provided the needed update to the records. New initiatives are being developed to address deficiencies found through this assessment.

## Pain Education for ICU Nurses

Kimberly Caceres, BSN, RN, CCRN  
Our Lady of Resurrection Hospital

**Goal:** Our ultimate goal was to improve pain control in the ICU population.

**Methods:** A pre and post test was given to the ICU staff RN's to assess knowledge regarding pain scales, pain types, and narcotic conversions. It was a multiple choice test. Lunch and learn in services, as well as one on one teaching was given to ICU staff. There were 3 different sessions which were given: Narcotic conversions, Pain types, and pain scales.

**Results:** The post tests did show and increase in scores regarding knowledge of the given topics. One can assume that the RN's retained some of the knowledge.

**Summary/Future Work:** I do believe that the RN's who were involved in the teaching sessions benefitted. I tried to make them see that the knowledge they were receiving would be beneficial to them wherever they practiced. There were many barriers to this project. Upon the commencement of my quality project, Our Lady of the Resurrection was put on the market for sale. This caused many employees to resign and the employees who did stay were very distracted. In a period of 3 months, approximately 50% of the staff turned over. The leadership that was initially involved in the project also left the hospital. The future work of this quality initiative is on hold and remains to be seen. Our Lady of the Resurrection was sold December 31, 2014 and is now under new leadership.

## Incorporating Advanced Care Planning in the Electronic Medical Record

Mary J. Spiller APN, ACHPN  
Presence Resurrection Medical Center

**Background:** The Electronic Medical Record (EMR) allows review of a patient's history, including medications, previous hospitalizations and provider visits, tests and radiography results and allergies. The EMR follows the patient through the various locations of healthcare. However, it has been shown that despite all of the available patient information, Advanced Directives (AD) one form of Advanced Care Planning (ACP) is frequently difficult to locate, especially in critical and emergency situations.

**Goal:** To include ACP in the EPIC EMR of Presence Health Patients.

**Method:** EPIC is a well-known and frequently used EMR. It is the chosen EMR of legacy Resurrection system of Presence Health Care. EPIC has produced a "build" for an ACP tab and distributes it to all EPIC subscribers who ask for it. This ACP tab, built into an EMR includes the AD, was been written into the systems at Kaiser Permanente, Gunderson Lutheran and North Shore system and shown to increase the number of AD in patient EMRs. EPIC sponsored a 2 day seminar at their headquarters in Verona Wisconsin and hosts a monthly forum for those systems interested in writing the ACP program to answer questions. The positive results of the previously named health systems, the benefits to patients and healthcare systems (financial savings) and the simplicity of the build were all presented to some of the Executive Leaders of Presence Health.

**Results:** The Executive Leaders were not willing to incorporate the ACP tab into the EMR of Presence Health Care patients. At the time there was significant attention toward ICD 10 and therefore it was felt that there were no resources to allow for the completion of the build.

**Summary:** The idea of incorporating the ACP tab has not deterred continued attempts at completion of this project. As new leadership joins the system, they are informed of the probable benefits of incorporating the ACP tab into the EPIC EMR.

A Study Comparing the Effectiveness of Advance Directive Informational Material on the Completion of Advance Directives Among Patients Being Treated in a Comprehensive Community Cancer Program

Mary J. Spiller APN, ACHPN  
Presence Resurrection Medical Center

**Project Background:** Following the unsuccessful implementation of the first Coleman project, a project of a smaller scale was suggested. Patients diagnosed with cancer should be aware of Advance Directives (AD), especially Power of Attorney for Health Care (POA HC) in the event of a catastrophic health crisis. Presence Resurrection Medical Center (PRMC) has a community cancer care center. Patients come to the center for Chemotherapy, Radiation Therapy and other infusions.

**Goal:** Complete a study where ADs are introduced to newly diagnosed community cancer patients through either a written format or video format. Measure the completion rate of AD for the two groups to determine if one format results in more AD completion over the other.

**Method:** An IRB application was completed and presented to the PRMC IRB for approval to complete the study. (attached)

**Results/Outcomes:** The PRMC IRB felt that cancer patients would be negatively affected by introducing ADs, especially given their recent diagnosis. The study was not approved.

**Summary/Future Work:** Advance Directives must become part of common conversation among all persons and not be considered a frightening subject. More education is needed among the general public for this to happen. When this happens, ADs will not be frightening to people, including cancer patients.



## Development and Utilization of an Internal Palliative Care Tracking Form and Database with the Goal of Creating a Sustainable Process to Extract Key Indicators and Outcomes

Patty Lamp, APN, and Susie White, M.D.  
Presence St. Joseph Hospital, Elgin

**Background:** When examining existing palliative care programs we know that clinical and financial elements are paramount in the evaluation and impact of a palliative care team. Prior to the formation of our palliative care team, our 150-bed hospital had limited experience and knowledge about palliative care.

**Goal:** Therefore, our goal was to create a process by which we could successfully track and record palliative care data that could be exported into a scorecard. This scorecard would clearly illustrate clinical elements that would demonstrate the impact of palliative care.

**Methods:** We identified key metrics that were important for the database and the production of a scorecard that would support program growth; be in alignment with the goals of our institution; and to anticipate Joint Commission certification. We focused on four specific outcome measures: (1) consult date; (2) patient-unit location; (3) advanced directives obtained by team; (4) disposition of patients. We developed a tracking form that we used to collect patient data. This form facilitated the ease of data input by either ourselves or a secretary. We were able to collaborate with an IT specialist who navigated the palliative care database and extracted data into a scorecard. Barriers to the development and execution of this project were many. The biggest was the lack of leadership support and the breakdown of communication. Our hospital underwent a restructuring during this phase, causing delays in database access, loss of IT assistance, and time restraints

Over the course of our Coleman commitment, we were able to implement a variety of actions that supplemented our project. These included staff and physician education on palliative care, reinforcement of the importance of advanced directives, production of an inpatient patient/family and clinician educational brochure and participation in outpatient cancer care forums and multidisciplinary rounds.

**Results/Outcomes:** Our data showed significant growth in consults over the course of 2 years. The majority of consults came from ICU and the oncology floor. Opportunity for growth has been identified in our inpatient rehab units and our heart failure floor. Physicians that consulted us the most tended to be hospitalists. Gaps in data regarding POLST completion and disposition to hospice were identified. Disposition was difficult to quantify. The limitation of our database and loss of our IT specialist led to deficient data in this area.

**Summary/Future Work:** Creating a tracking system and database within the constraints of our current system truly proved to be challenging. The need to collect and present reliable data is essential to performance, outcomes and financial sustainability of any new program. Our palliative care database continues to grow as our numbers of consults increase; however, we were not yet able to implement any specific interventions that would impact our outcome measures. This was the biggest weakness of our project. We lacked the ability to quantify our disposition of patients. Future work should focus on the percentage of patient who die as inpatients or are discharged to hospice, and the number of patients that we lost due to the lack of an outpatient palliative care program. This project continues to be in its infancy stage, even after two years of data.

Our palliative care team and approach continues to evolve with the addition of new members of our palliative care team, specifically a nurse navigator, a dedicated chaplain and the success of our 'goals of care' services. Presence Health has identified the need for system wide palliative care. This provides us with continued hope for increased support and growth in the future.

## Increasing Palliative Care Awareness through the Application of Goals of Care (GOC) Discussions and Multi-disciplined Educational Sessions

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Rush Oak Park Hospital (ROPH)

**Background:** At ROPH, the benefits of a palliative care service were not available. Referrals to hospice were generally made by our case managers, nurses, chaplains and a few physicians. Most of these referrals happened at the last moments of life either in the ICU or as a result of a long stay meeting and/or overutilization. The target population for our initiative involved our medical surgical unit with frail and elderly patients from a SNF, and/or those with chronic disease such as COPD, ESRD, and CHF. Those patients identified to benefit from goals of care discussion became the focus of our initiative to increase palliative care awareness and provide alternatives to care.

### **Goals:**

- 1) Increase the number of goals of care discussions held over a six month period.
- 2) Develop a strategic toolkit to screen and identify patients, and create a communication model to engage the physician and the patient.
- 3) Develop an educational curriculum that provides all disciplines, physicians, nurses, chaplains and case management teams with an understanding of palliative care.

**Methods:** 1.) **Utilize the screening tool** to identify patient population by one or more qualifier:

**Age:** 85 years of age with serious illness or progressive chronic illness; **Diagnosis:** End stage COPD; stroke with decreased function by 50%; cardiac disease- heart failure; severe CAD/CM, advanced dementia, ESRD Stage 4 or 5, recurrent or metastatic CA. **Readmissions:** Greater than 3 hospital admissions in 6 months and/or readmission in less than 30 days. **Request** for GOC discussion; or **GOC discussion** held on previous admission. 2.) **Clinical Nurse Leader facilitates** discussion on daily rounds 3.) **Communication model** ensures physician notified of patient screening and determines if physician or team member conducts discussion. 4.) **Monthly report** generated by EPIC electronic medical record to capture GOC discussions held. 5.) **Multi-tiered educational sessions** conducted by our physician champion to other physicians, and nurse practitioners to all disciplines in nursing, case management and chaplains.

**Results and Outcomes:** Goals of Care (GOC) discussions captured monthly since February 2014. 100% of patients identified had a discussion and 5 to 10% of GOC conducted by attending. Readmission rates for patients with GOC discussion, held around 16%, a very high risk group. The GOC model is now a part of our day-to-day process. Communication pathways between our SNF partners and continuity of care have been strengthened. Training by staff discipline includes total number 203 health care providers, 89 MDs and 114 combined RN/CM/Chaplains. Hospital culture is forever changed.

**Summary/Future Work:** Sustaining GOC discussions depends upon: continuing daily rounds and risk screening; evaluating monthly activity reporting, trending and analysis; developing an educational curriculum with materials and resources; and continuing educational pursuit of all venues and opportunities. Lessons learned revolve around known quotes related to cultural change, requires all levels to believe in the need for change and change comes from within.

## Feasibility of ELNEC Training for ICU Nurses: Train-the-Trainer Approach

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Rush University Medical Center

**Background/Rationale:** Many nurses in critical care units have expressed a desire to learn more about how to deal with patients and their families who struggle with difficult decisions. However, specialized training in palliative and end-of-life (EOL) care has not been widely available to bedside nurses. We wanted to determine if by providing nurses with palliative and EOL care education using a train-the-trainer approach would have an impact on the nurses' knowledge and self-confidence in EOL care, and how they would elect to disseminate this information to others.

**Goals:** The specific goals were to: (1) identify ICU nurses' perceived barriers to and strategies for implementing palliative care in their units; (2) evaluate the effectiveness of the ELNEC training to increase knowledge and perceived self-efficacy in palliative care practice; and (3) describe the nurse-led education projects in the ICU.

**Methods:** The researchers received Internal Review Board approval for this pilot study. Eight ICU nurses, two from each of the adult ICUs at an academic medical center were recruited and consented to participate in this study. The researchers provided a 2-day training session using the End-of-Life Nursing Education Consortium (ELNEC) Critical Care standardized educational program. This training enabled the nurses to become ELNEC Critical Care trainers. Pre/post, knowledge and self-assessment surveys on palliative and EOL care were completed and analyzed, along with pre/post surveys on strategies for and barriers to EOL care. Within 6-months post training, the ELNEC trained nurses implemented self-directed unit-specific educational projects to improve palliative care and to assess the appropriateness of this educational program.

**Results:** The results showed participants' knowledge score significantly improved post ELNEC training ( $t=4.68$ ,  $df=7$ ,  $p=.002$ ). They continued improvement at post 6-month training ( $t=5.20$ ,  $df=7$ ,  $p<.001$ ). Immediately after training, participants showed improvement in 10 out of 10 self-efficacy questions with 3 questions being statistically significant. At 6-months post training they also felt more confident in "communication with palliative care patients" and "communication with other members of the healthcare team". The unit specific projects were not tested for statistical significance, but were intended to build the trainers' self-confidence regarding EOL care knowledge.

**Conclusions:** Overall more attention has been directed to palliative care at the medical center since the palliative care team was established in 2009. That program has had substantial growth, making it difficult to isolate this initiative as the sole reason why the participants were able to identify strategies to improve EOL care in their units. However, the preliminary results of training bedside ICU nurses to become ELNEC trainers are promising and should be tested in a larger population.

The researchers are preparing a manuscript for publication.



## Distress Screening and Improving Outpatient Referral to Palliative Care Services

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**Background:** Distress is an unpleasant emotional experience that can adversely affect a patient's coping if not addressed in a timely manner. The World Health Organization describes palliative care as an approach that improves the quality of life of patients facing life-threatening illness through identification, assessment, and treatment of physical or psychosocial issues. A proactive approach to improving access in the outpatient cancer care involves early identification of patients who can benefit from palliative care; therefore, facilitating timely management of physical symptoms and other psychosocial health needs. The Distress Screening tool was developed to rapidly screen distress among cancer patients making it a tool feasible for use in an outpatient setting.

**Goal:** To create and implement an efficient outpatient palliative care referral process using the NCCN distress screening tool that facilitates the assessment and identification of specific patient needs for a timely referral to palliative care.

**Methods:** A pilot study was conducted using the NCCN distress screening tool in identifying specific needs and levels of distress. It involved an oncology provider, nurse, psychosocial oncologist, chaplain, a social worker from the American Cancer Society, and a palliative care provider. The tool was distributed to 52 patients in a multidisciplinary outpatient cancer clinic. The screening tool was distributed upon arrival in the clinic and reviewed by the nurse. Screening scores of 5 and above were reported to the provider, who determined the need for referral to palliative care, psychosocial care, social services, or chaplain services.

**Results:** The findings of the pilot study showed 37% of patients responded to having one of the practical problems, 31% family problems, 40% emotional, 10% spiritual, and 83% physical problems. The five distress domains indicated in the screening tool was helpful in uncovering unmet supportive care needs as it provided a snapshot of factors contributing to their levels of distress at the time of the study, allowing providers to evaluate and address specific areas of concern; thus, facilitating timely referrals to palliative care or other supportive care services as needed. Out of the 27% of patients with a distress score of five and above, 50% of these patients declined referrals to supportive care services. In addition, the limited resources in supportive care were a potential barrier to addressing the needs of patients if the distress screening tool were to be distributed to all patients.

**Project Outcomes:** Plans are now underway to screen all patients in the outpatient clinic. A distress screening process is in place and can be documented in the patient's electronic medical record (EMR). Distress screening results are entered manually in the EMR; providers receive a notification that a patient has been screened, prompting them to evaluate the patient further if the score is four and above and initiate referrals as indicated in the distress screening protocol. Patients with a score of four or more are referred to providers based on their areas of concern; such as, patients with physical concerns will be referred to palliative care. Today, the outpatient clinic has the support of more palliative care providers, an additional dedicated social worker, financial counselor, and dietician to assist with the supportive care needs of patients.

**Future Work:** Patients need to be screened for distress and referred promptly for palliative care or other supportive care services. Considering the number of patients who declined referrals during the pilot study, follow-up and reevaluation of these patients remains equally important as the initial screening to address potentially distressing factors and help design an individualized plan of care that corresponds to patient's specific needs.

## Pain Management in End of Life for Primary Care Physicians and Hospitalists

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Silver Cross Hospital

**Background:** Despite recent advances in the understanding of pain management, pain is often undertreated. Consequently, a significant number of patients needlessly suffer physical pain and mental distress at the end of life. The Pain Management in the End of Life for Primary Care Physicians and Hospitalist project, is presented in one web-based module, consisting of lesson slides, a pre and a post test and a CME activity evaluation. The importance of doing this module is because pain management in this specific setting is one of the most challenging tasks physicians face when providing care for patients.

**Goals:** The learner should be able to: 1) recognize the importance of pain assessment and reassessment in end of life situations, 2) review the neurophysiologic mechanisms of pain. 3) discuss treatment plans to manage pain in this setting, and 4) develop confidence in managing opioids and their side effects

**Methods:** Primary Care Physicians and Hospitalist will be doing a web-based module, consisting of lesson slides, a pre and a post test and a CME activity evaluation. This module will be available at Silver Cross Hospital Intranet. Each physician will log in to the module with an identification number and a password. The learner will proceed to review the slides, study the content, and complete the activity tests/evaluation in order to obtain his/her certificate of completion with a minimum grade level required to obtain *AMA PRA Category 1 Credit*<sup>TM</sup>: 80%. The estimated time to complete the course is 60 minutes. The release date was October 2014 and this module will be available online until October 2017.

**Results:** At the end of the module learner will be able to: 1) Titrate opioids in an End of Life case with uncontrolled pain, 2) Select opioids in an End of life case with uncontrolled pain, 3) Use the different observational pain scales, 4) Switch to a different opioid medication using the opioid equivalents conversion doses. The module is for Internal Medicine (IM) and Family Practice (FP) physicians. There are 80 Internal Medicine and 54 Family Practice physicians at Silver Cross Hospital. We plan to target at least 60% of the IM and FH physicians to complete the module. The module was released in October of 2014. Unfortunately, by the end of December of 2014 only 3 physicians have completed the module. The module will be available online until October 2017.

**Conclusions:** The challenge for physicians is to provide aggressive pain management and implement strategies to alleviate suffering in patients with pain that is difficult to control.

# Establishment of Year-Round General Palliative Care Services in a Community Hospital Serving the Underserved and Providing Education to Interdisciplinary Groups to Improve Awareness, Self-efficacy and Attitudes Towards Such Services

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Sinai Health System

**Background:** Community hospitals especially serving the underserved communities remain an important source for general palliative care programs. These hospitals are also confronting enormous resource constraints to establish such programs. We set out to establish a Mt. Sinai Hospital Palliative Care Services (both inpatient and outpatient) and to increase Palliative care education.

**Goals:** 1) To provide year round palliative care services to the patients and the community the hospital serves 2) To increase the access and quality of such services. 3) To provide Palliative care education to various interdisciplinary teams; the clinical providers and the community to enhance their understanding on palliative care. 4) To assess the impact of such education on participants awareness and attitude towards palliative care.

**Methods:** An exploratory committee, then a steering committee and palliative care committee were established to guide us through the process after a written needs assessment and leadership engagement. Staff and clinician interest in providing palliative care services was determined to assess in-system resource availability. Partnerships with various palliative and hospice agencies were explored to improve access to care and educational components of the program. A year round palliative care service was established in October 2014 after one year of exploration and resource accrual and one year of educational sessions. Palliative care educational sessions were planned and implemented in both Internal Medicine and Family medicine resident conferences as well as in grand rounds. Palliative care curriculum was incorporated into the general curriculum of IM and FM residencies. Education of the nurses was achieved through such lectures, panel discussions as well as micro-talks. Process based and outcome based measures were included to quantify improved access and quality of general palliative care. Some of these measures are number of consults, reasons for consults, and discussion of advanced directives, referral sources, and timeliness of consults, ACD/EOL documentation, and patient/family/provider satisfaction. Data was collected prospectively and retrospectively based upon the measure.

**Results:** Themes include: (1) Two years was the time to establish a year round inpatient consult service (2) Improved awareness of need for palliative care services among various disciplines (3) Increased self-efficacy in provider recognition of the need for such services in individual patients (4) 33% increase in consults in the year of needs assessment, resource accrual and exploratory phase of program development; 50% increase during the educational phase and up to 100% increase in 2014 from 2011 (before Coleman foundation involvement) (5) Improved documentation of ACD/EOL services by FM/IM residents. (6) Increased participation of residents in EOL discussions (7) Inclusion of Palliative and EOL care in the residency curriculum.

**Conclusions:** Aid from foundations like Coleman foundation, partnerships with palliative care and hospice agencies and continued leadership engagement will most possibly lead to improved access to general palliative care in community hospitals with resource constraints. The process itself improves awareness, self-efficacy, utilization of the palliative care services and satisfaction among patients, care providers, FM/IM residents and clinicians from various disciplines.

# Lowering the Boredom Factor: How to Teach Opioid Management to Hospitalists in an Era of Advanced Illnesses and Lower Attention Spans

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Stroger Hospital, Cook County Hospital and Health Systems

**Background:** There are a growing number of patients with medical conditions that require opioid pain control but there are concerns that providers are not meeting the needs of our patients. This is evidenced by poor HCAHPS scores and fears of opioid misuse leading to inadequate pain control. Hospitalists often are looked to as teachers of opioid use despite limited training.

**Goals:** 1) To provide hospitalists a discussion forum where they can discuss real life challenges to pain management. 2) To assess the impact of these sessions on HCAHPS assessment pain scores and pharmacist evaluation of pain management competency.

**Methods:** From October 2013- February 2014, 18 hospitalists participated in a voluntary lecture series on pain management. This included a lecture at our Hospitalist Grand Rounds and two additional group sessions. The group sessions were utilized both to assess hospitalist concerns around pain management and as a teachable moment. We analyzed HCAHPS scores on pain management pre- and post intervention comparing hospitalist and non-hospitalist managed units.

**Results:** Discussion points included: (1) hospitalists concerns about over-medicating patients when relying on PAS and other subjective measures, (2) ability to identify patients with secondary gain, (3) confidence with pain management scheduling and administration, and (4) knowing when to seek assistance from palliative care or pain management. Anecdotally, the participants regarded the sessions as helpful and reinforced their confidence in pain management. On hospitalist managed units, patients who states their pain was never managed dropped from 1.4% to 0.8% and the patients whose HCAHPS scores measured the pain was always managed increased from 56.9% to 59.2% ( $p=0.4$ ). There was a worsening in pain scores on the non-hospitalists managed units (never: increased from 0% to 4.2%; always: decreased from 63% to 42.7%) ( $p<0.05$ ).

**Conclusions:** Group session among hospitalists is a novel method to reinforce pain management issues among hospitalist. Qualitatively, the sessions were well received and brought up real issues that arise on a daily basis. While not statistically significant, the lecture series trended a slight improvement in overall HCAHPS score- a score that is being used for direct reimbursement to hospitals. Sustainability of such programs will require buy-in from hospital administrators.

# Educating Surgical and Emergency Medicine Residents and Medical Students about Symptom Management in Trauma Patients: A Pilot Study Using Case-Based, Interactive Modules

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**Background:** Several self-assessment educational opportunities exist online for healthcare providers interested in learning about symptom management in chronically ill and terminally ill patients; many of these are targeted specifically to those practicing in the palliative care sphere. Few such opportunities exist for those who primarily take care of acutely injured trauma patients. Although most surgical resident curricula now contain some information regarding pain/symptom management for cancer patients, there is little emphasis on translating those “best practice” principles to the post-operative or ICU patient. The purpose of this study was to pilot a case-based, interactive educational opportunity with residents/students rotating on a Trauma service at a large, urban Level 1 Trauma Center.

**Methods:** A PowerPoint lecture was developed with cases/modules addressing the following situations/issues: 1) Process for responding to an acutely “agitated” ICU patient; 2) Distinguishing Nociceptive from Neuropathic pain and comparing treatment alternatives; 3) Recognizing symptoms of Acute Stress Disorder and Post-traumatic Stress Disorder, and 4) Understanding non-pharmacologic therapies useful in symptom management in Trauma. The cases/modules were “trauma-specific” in that they were structured to reflect scenarios that the trainees might commonly see on their trauma rotation. Each case had at least one multiple-choice question to allow trainees to assess their knowledge/decision-making. The pilot lectures were live presentations by a Trauma Faculty member. The goal was to use these sessions to refine the cases and questions in order to develop an interactive, online educational opportunity that would mirror the live session. Forty medical students and residents rotating on the Trauma Service attended the sessions and anonymously completed session evaluations. Respondents were encouraged to leave comments at the end of the evaluation. The evaluation asked participants to comment on how easy the material was to understand and how useful it was, as well as whether or not they would be willing to participate in the activity were it online.

**Results:** The evaluation was scored along a standard Likert scale with the following questions and responses:

Evaluation Item	Strongly Agree or Agree	Neutral	Strongly Disagree or Disagree
Material clinically useful	100%	0%	0%
Material easy to understand	100%	0%	0%
Can now distinguish nociceptive from neuropathic pain	100%	0%	0%
Feel comfortable in approach to agitated trauma patient	100%	0%	0%
Understand non-pharmacologic therapies for patients with delirium	100%	0%	0%
Would be willing to do educational module online	70%	20%	10%

The respondents who indicated they preferred not to do the educational module online all indicated that they “liked” or “preferred” the live question and answer format. Other comments included requests for more information on hypoactive delirium and expression of appreciation for handouts given during the lecture about using Richmond Agitation Sedation Scale (RASS) and Confusion Assessment Method for the ICU (CAM-ICU).

**Conclusions:** Participants in the live-format case-based educational modules on symptom management in trauma patients appeared to find the material presented clinically useful and easy to understand. They also reported comfort in approaching agitated trauma patients, distinguishing neuropathic and nociceptive pain, and understanding non-pharmacologic therapy for delirium. When asked if they would be willing to participate in the educational module if online the majority reported that they would, but some respondents expressed preference for being able to ask

questions and interact with the live presenter. Given increasing limitations on trainees' time for in-person education, efforts are continuing to try to develop online modules that are sufficiently interactive to meet their needs; however, regular live-format presentations have continued since the pilot study, most of which are attended by students.

## Providing “Self-Care” Opportunities for Staff at an Urban Level 1 Trauma Center

Kimberly Joseph MD, FACS, FCCM  
Stroger Hospital, Cook County Health and Hospital Systems

**Background:** Healthcare providers who work in the emergency setting caring for victims of trauma are at high-risk for suffering from traumatic stress themselves. Crabbe et al reported high rates of emotional exhaustion and depersonalization among staff at a Trauma Unit, and other authors have reported the effects of “compassion fatigue” on staff turnover and productivity. The purpose of this study was to implement and evaluate a “Self-Care” program for staff at a busy Level 1 Trauma center during the summer months (during which time the center usually sees the highest volume and acuity of patients)

**Methods:** Three “Self-Care” opportunities were offered to the Trauma Unit staff during the study period: 10-minute “mini-massages” offered while staff were on their work shifts; weekly 30-minute Mindfulness sessions held during the day in the hospital chapel (and open to non-Trauma staff); and two identical workshops on “Understanding Traumatic Stress in Patients and Practitioners”. The workshops were offered on different days to accommodate the different shift schedules and Continuing Education Units were obtained via the Ohio Nurses Association. The workshops consisted of didactic presentations on recognizing/managing Post-ICU syndrome symptoms in patients and families, screening for post-traumatic stress in trauma victims, and an introduction to Mindfulness as a stress reduction technique. Attendees then participated in breakout sessions, including time with a Registered Dietician to review diet modifications to reduce physiologic stress, time with a Palliative Care Nurse Practitioner to review coping mechanisms and ways to achieve life balance, and a Mindfulness “practice session”. Pre- and Post-test questions were given to attendees as well as an evaluation for the workshop. Evaluation of the “mini-massages” and weekly Mindfulness sessions was conducted on an informal survey basis.

### **Results:**

1. Mini- massages: the mini-massages were offered 4 times during the study period to accommodate all the staff shift schedules. >90% of staff participated- 2 declined and 3 were unable to participate due to conflict with patient care duties; these latter staff members were offered free 30 minute massages with the therapist in compensation to be arranged at their convenience. Staff members who were informally queried regarding the mini-massages replied that they found them very useful and would like to see them offered regularly/periodically during work time. Several staff members asked for the therapist’s contact information with the goal of arranging for future massages
2. Weekly mindfulness sessions: staff who attended the mindfulness sessions were informally queried. The majority reported that they found the sessions useful, but that it was difficult to attend regularly as the location was not on the Trauma Unit itself. Night-shift staff who were not able to attend these sessions (they were only offered during the day) requested that some similar program be offered for them.
3. Self-Care Workshops: a total of 13 staff members attended the workshops, including 1 MD, 2 Social Work interns, and 10 nurses. Pre-and Post-test results indicated an improvement in knowledge regarding Post-intensive Care Syndrome and effects of nutrition on stress, although a high level of knowledge in all the content areas was evident on the results of the pre-test. Attendees’ evaluations of the workshops were positive, with several free-text comments that the format should be made part of regular nursing education.

The total cost of the “Self-Care” program was ~\$4500: this included the compensation for the massage therapist, purchase of MP3 players loaded with Mindfulness Apps provided free for workshop attendees, catering services for the workshops, and preparation of educational materials.

**Conclusions:** The “Self-Care” program implemented for the staff of the Trauma Unit was positively received, with participants reporting that the elements were helpful and that they should be integrated into the education and service routine of the Unit. The most significant barriers to implementation were limitations regarding location and timing of the weekly mindfulness sessions and overall expense of the program. Efforts are currently underway to try to arrange for a consistent method to fund and possibly expand the program.

## Effects of Spirituality on Levels of Compassion Satisfaction and Compassion Fatigue

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**Background:** Oncology patients at the end of life need their providers to be open to having discussions on spirituality. However, research shows that oncology providers lack the training to address the spiritual needs of their patients. Studies indicate that providers who are in touch with their own spirituality are more open to being present to and addressing the spiritual needs of their patients. In addition to its relevance for patients, cultivating spirituality has important implications for health care providers as higher levels of spirituality are thought to be associated with reduced stress and burnout. The object of this research was twofold- to evaluate whether spirituality training workshops for oncology nurses would impact their levels of compassion fatigue and compassion satisfaction while developing a Continuing Nursing Education approved spirituality curriculum.

**Methods:** The program consisted of six weekly 1.5 hr sessions directed at increasing spiritual well-being for volunteer oncology nurse participants. It was recommended that the nurses attend all six sessions. The topics included: Meditation and Healing; Music, Sound and Healing; Art and Healing; Prayer and Healing; Dance and Healing, and Love the Healer. Each session consisted of experiential training followed by quiet reflection on mind-body changes that occurred, followed by small group discussion. To assess the impact of the sessions a pre (1<sup>st</sup> session) and post (6<sup>th</sup> session) test was performed utilizing the Professional Quality of life (ProQOL ) Scale and Spiritual Well-Being Scale. The ProQOL consists of three subscales: compassion satisfaction, burnout, and compassion fatigue. Compassion satisfaction is the pleasure you derive from being able to do your work well. The average score is 37. Higher scores on this scale represent greater satisfaction related to your ability to be an effective caregiver in your job. Burnout is associated with hopelessness and difficulties dealing with work or in doing your job effectively. The average score is 22. Higher scores on this scale indicate an increased risk of burnout. Compassion fatigue/secondary trauma measures work-related, secondary exposure to extremely stressful events that can result in fear, difficulty sleeping, intrusive images, or avoidance.. The average score is 13. Higher scores on this scale indicate increased risk of CF. The Spiritual Well-Being Scale (SWBS) provides an overall measure of the subjective state of well-being. The SWBS is composed of two sub-scales: the Religious Well-Being Scale (RWBS) and the Existential Well-Being Scale (EWBS). The RWBS provides a self-assessment of one's well-being in a religious sense. The EWBS provides a self-assessment of one's sense of life purpose and life satisfaction

Overall SWB is scored from 1-6 with a higher number representing greater well-being. A score in the range of 20-40 reflects low overall spiritual well-being. A score in the range of 41-99 reflect moderate spiritual well-being. A score in the range of 100-120 reflects high spiritual well-being. The RWB score in the range of 10-20 reflects a sense of unsatisfactory relationship with God. A score in the range of 21-49 reflects a moderate sense of religious well-being. A score in the range of 50-60 reflects a positive view of one's relationship with God. A EWBS score in the range of 10-20 suggests low life satisfaction and possibly a lack of clarity about one's purpose in life. A score in the range of 21-49 suggests a moderate level of life satisfaction and purpose. A score in the range of 50-60 suggests a high level of life satisfaction and a clear sense of purpose.-Baseline demographic information was obtained along with their level of comfort with having a spiritual discussion with patients(assessed pre and post intervention). A short qualitative post test was completed by participants collecting information on whether participation in the sessions increased their spiritual awareness?, Whether attending the sessions had any lasting influence in their life? Whether they planned to practice these tools in their life?

**Results:** Five female oncology nurses ` participated in this study. Their ages ranged from 30-65. 80% were employed full time. 40% were single or divorced. All identified as Christian although 60% attended church less than twice a year. At pre-test 60% identified that they were somewhat uncomfortable having spiritual discussions with their patients. The post test revealed that only 20% were somewhat uncomfortable having spiritual discussions with their patients. The results of ProQOL show an average increase of 0.2 on Compassion Satisfaction scores, an average decrease of 2.4 on Burnout scores and an average decrease of 2.2 on Compassion Fatigue scores. The SWB scale post intervention reflected an average increase of 1.6 for Spiritual Well- Being, an average increase of 1.2 for Religious Well-Being, and an average increase of 0.4 in Existential Well-Being. All participants answered yes to having a greater sense of

spiritual awareness after completion of the workshop. Four out of five participants indicated that they planned to practice these tools in their daily life and one stated she needed more instruction.

Feedback was significantly positive. Representative comments include: “I enjoyed learning something new to help myself and others”, “a nice feeling of releasing all inhibitions, very calming effect”, “ we need a retreat at least once a year in this line of work”, “it made me at peace with myself”, “reinforced importance of self-care and self-love”, “healing effect”. Facilitator noted that the workshop triggered lively discussions and many relevant and thought-provoking questions.

**Conclusions:** We successfully developed a continuing medical education course to teach important tools to professional employees to help deepen their spiritual awareness. Pre and Post test results suggest improvement in quality of life and spiritual well-being of participants after the six sessions were completed. The results from this pilot study suggest that implementing a 2 day spirituality retreat is likely to have a significant positive impact on nurses. This in turn has the potential to improve providers’ ability to address the spiritual needs of cancer patients at the end of life.

## Improving Advance Care Planning for UICC Oncology Patients

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**Background:** Advance care planning (ACP) in the ambulatory setting is underutilized and poorly documented at the University of Illinois Cancer Center (UICC). A baseline 8 week review noted 8.8% of metastatic solid tumor patients had ACP documentation in the electronic medical record (EMR) by the third visit and 23% in the previous two visits.

**Goal:** Our aim was to increase ACP documentation to 75% of UICC metastatic solid tumor patient charts by the third visit through development of a standardized process for ACP discussion and documentation.

**Methods:** A multidisciplinary team of oncology physicians, nurses, social workers (SW), and palliative care created a process map of ACP discussion. A new process for SW consults was piloted over 6 weeks. Additionally, all clinic staff participated in a standardized curriculum for ACP discussions. Post intervention data was prospectively collected over six weeks. This will be repeated in 2015.

**Results:** Total 94 encounters occurred during the pilot evaluating ACP in metastatic solid tumor patients of which 37/55 (39.4%) had documented ACP discussion. SW consults occurred in 18/94 (19.1%), leading to 18/18 (100%) with Power of Attorney (POA) forms in EMR. Evaluation by tumor subtypes showed 14/21 (66.7%) of gastrointestinal patients had ACP documentation with 9/21 (42.9%) with SW consults leading to 11/21 (52.4%) with POA forms in EMR. Of 39 total thoracic patients, 19/39 (48.7%) had ACP documentation of which 9/39 (23%) with SW consults and 7/39 (17.9%) with POA forms in EMR.

**Conclusions:** UICC successfully piloted the creation and implementation of a process for ACP consults and standardization of ACP discussion and EMR documentation. While our initial aim of 75% a chart was not reached, the piloted process increased SW consults and completion of POA forms, as well as greater multidisciplinary effort and patient engagement. Compared to the pilot period, a multidisciplinary approach and use of the new process did improve ACP documentation. We plan to expand to repeat the process improvement project in 2015 and will likely broaden the number of patients targeted.

