



Abstracts from
Center to Advance Palliative Care National Seminar
Practical Tools for Making Change

November 9–11, 2017
Phoenix, Arizona

The topic areas for abstract submission include:

- Measuring impact and value
- Patient identification and assessment of palliative care needs
- Expanding access to palliative care through workforce education
- Disease-specific palliative care models
- Pediatric palliative care
- Integration of palliative care to specific care settings (e.g., hospital, ICU, home, nursing home, clinic)
- Staffing models that are responsive to patient needs
- Leveraging technology to expand services (e.g., EMR design, telehealth)
- Equitable access to palliative care for vulnerable populations
- Advocacy and coalition building
- Implementing palliative care across the health system
- Sustainable financing of palliative care services
- Partnering to provide seamless care transitions
- Aligning care with patient goals
- Team health/wellness
- Quality improvement projects for the palliative care team

* * * * *

media experts as well as certified Navajo interpreters to tackle the job of developing clear, concise, linguistically accurate and culturally sensitive video tools explaining common topics covered in Palliative Care consultations.

Our team determined the topics of highest importance to focus on during the initial project year. These include the following: What is Palliative Care, Understanding Code Status and CPR, Understanding Advance Directives, and Understanding Tracheostomy and Percutaneous Endoscopic Gastrostomy (PEG) Tubes. Original scripts for each video were written by the Palliative Care practitioners, and then revised and edited by interdisciplinary team members. Scripts were then submitted to a group of bilingual clinicians and non-clinicians for cultural sensitivity. Our certified Navajo interpreters then translated the videos into Navajo language. Production, filming, and editing was overseen by NAH Communications and Media team. Each video was recorded in both English and in Navajo.

In the state of Arizona there are 21 tribes and nations located on 26% of Arizona land, comprising nearly 1/8 of all American Indians in The United States. The interface between western and traditional medicine is highlighted for those of us living and working in Northern Arizona. Our hope is that both patients as well as other providers in institutions that serve Native American patients will benefit from the Navajo Video Project.

*Special Recognition

22. The Advance Practice Nurse: An Anchor for Family Physicians Providing End-of-Life Care in the Home

Freeman Centre for the Advancement of Palliative Care, North York General Hospital
Toronto, Ontario, Canada

Team/Contact Information:

Shana Haberman, MA (Primary Contact)

Project Coordinator

4001 Leslie Street

Toronto, Ontario, Canada

(416) 756-6444 x3548

shana.haberman@nygh.on.ca

Project Team Members:

Tina Parassakis, RN, MN

Karen Weisz, MD

A.M. Nina Horvath, MD

Daryl Roitman, MD

Topic: Palliative Care in Specific Settings

Description

Patients living with advanced cancer often wish to receive end-of-life (EOL) care at home. Challenges to providing high quality care in this setting include: symptom management, caregiver support/education, and seamless around-the-clock care. The Freeman Centre for the Advancement of Palliative Care strives to meet the complex needs of these patients through an interdisciplinary approach to care that optimizes the patient and family experience with a goal of improving quality of life.

The Freeman outreach program enables adults living with advanced cancer, whose wish is to die at home or remain living at home for as long as possible, to receive in-home care from an Advanced Practice Nurse (APN) with the support of a Freeman outreach Family Physician (FP) and other community care providers.

We aim to describe the Freeman outreach model in which the APN acts as an anchor to Freeman outreach physicians and

navigators for the interprofessional team. Further, the model helps support community FPs who wish to provide palliative care at home for their own patients. A key feature of this model is the provision of care 24 hours a day and 7 days a week. The APN acts as the primary contact for patients and families, manages symptoms, and provides patient and caregiver support, as well as anticipatory guidance in preparation for EOL care at home. Other roles include: mentoring and coaching primary care nurses, and quarterbacking the coordination of care with all community care providers.

We will share Freeman outreach data that highlights the value of the APN role in providing EOL care in the home. This includes data on referral sources to the outreach program from hospital, community service providers, and outpatient clinics. We will also present data on discharges from the outreach program including: home deaths, direct transfers to Palliative Care Units (PCU), direct transfers to an inpatient unit, and emergency room visits. We will showcase the scope of the APN role by presenting data on independent home visits, telephone follow-ups, and visits with outreach FPs. We will also illustrate how the model functions through a patient story.

Overall, there is justification to showcase this unique outreach program within the Freeman Centre for the Advancement of Palliative Care. Our outreach model of care is likely associated with significant cost savings, representing a high value-based program while simultaneously providing exemplary patient- and family-centered care in the home that aligns with patient and family values. We will also highlight opportunities for, and challenges to, future growth.

23. Improving Bedside Palliative Care through Simulation

Greenwich Hospital

Greenwich, Connecticut

Team/Contact Information:

Donna E. Coletti, MD (Primary Contact)

Registered Nurse

4 Charter Oak Lane

Greenwich, CT 06830

(203) 921-7836

donna.coletti@greenwichhospital.org

Project Team Members:

Gina Trovato, RN

Nicole Melshenker, RN

Cheryl Mayeran, MPH, EMT

Topic: Education Strategies

Description

Previous research has demonstrated that nurses face numerous challenges in providing high quality palliative and end-of-life care. Specifically, nearly half of all nurses report that they do not feel competent in delivering adequate end-of-life care, and 63% report feeling as though they had not received adequate training in end-of-life care (Betcher, 2010).

The Greenwich Hospital Palliative Care Resource Nurse training program was developed to highlight the aspects of palliative and hospice care that its nurses need to review and practice, based on data collected from a hospital-wide survey created by Dr. Donna Coletti in 2013. Two of these aspects include initiating crucial conversations with patients and family members, as well as appropriately administering as-needed medications at the end-of-life.

To support this data, a literature review of 10 articles specifically addressing palliative and end-of-life simulation was conducted, and a gap in the literature was found. The focus of the research was on nursing students and not licensed, practicing

nurses. However, the literature overwhelming cited a lack of preparation of nursing students in the area of hospice and palliative care – due to lack of education, application of the information, or both (Sperlazza & Cangelosi, 2009; Ellman et al., 2012; Fabro et al., 2014; Moreland et al., 2012; Tuxbury et al., 2012; Eaton et al., 2012). It can then be assumed that the licensed, practicing nurse is ill-prepared after graduation to work with this population unless specifically trained on the job. Heretofore, the Palliative Care Simulation Program was created as an adjunct to and expansion upon the Palliative Care Resource Nurse training program. The purpose of the Palliative Care Simulation Program is to create a safe environment for clinicians to practice having crucial conversations with patients and family members in need of palliative care. The pre-test, post-test intervention study will determine the effectiveness of a palliative care simulation intervention in promoting self-efficacy of graduate nurse residents for the provision of palliative care.

24. Improving the Accurate Completion of Do Not Resuscitate Documentation

Harlem Hospital Center/Columbia University
New York, New York

Team/Contact Information:

Michael Oriakhi, MD (Primary Contact)

620 Lenox Avenue, Apt 2J

New York, NY 10037

(917) 741-8875

drmikerikhi@yahoo.com

Project Team Members:

Camille Edwards, MD

Leyla Warsame, MD

Oloruntobi Rahaman, MD

Meena Ahluwalia, MD

Abdul-Razak Mohammed, NP

Renee Gatlin, RN, BSN

Topic: Strategic Quality Improvement

Description

Purpose: Honoring patient preferences is of paramount importance in providing quality end-of-life care and facilitates respect for patient autonomy, nonmaleficence and beneficence. New York State law mandates that DNR status must be clearly documented after a patient and/or family indicates a preference for DNR status. Despite this explicit statute, there remain high rates of ambiguous DNR documentation in patients' medical records. In a study by Sulmasy et al in 2004, 31% of patients who had a DNR order lacked documentation, 30% of orders were not signed by an attending physician and 2% of patients had unwritten DNR orders. In 2014, at Harlem Hospital Center, DNR status was uncertain in 30% of palliative care patients due to incomplete or missing DNR documentation. To address this patient safety issue, we partnered with hospital administration, the medical teams, nursing staff, social work and the Palliative Care Department to design a performance improvement project and form a project team. Our pilot project aimed to achieve 100% compliance with DNR documentation within 24 hours of initiation of DNR status in a one year period.

Methodology: We retrospectively reviewed palliative care patients' charts from July 2014 to June 2015 to evaluate baseline compliance with DNR documentation. Using information from surveys with the interdisciplinary team, we formulated a fishbone diagram to highlight barriers to completion of DNR documentation. The project officially commenced in June 2015. Specific interventions included: in service training sessions,

one-on-one interactions with stakeholders, and regular staff bulletins. Plan-Do-Study-Act (PDSA) cycles were used to periodically to evaluate the impact of interventions implemented. Run charts were used to represent an analysis of the one year period.

Results: By December 2015, 86% of patients with DNR status had adequate documentation and EMR order within 24 hours of initiation of DNR status. 100% compliance with accurate and complete DNR documentation and EMR order entry within 24 hours was achieved by April 2016. This continued throughout 2016.

Conclusions: Simple but effective interventions had a high impact on outcomes. We observed a steady increase in compliance with adequate DNR documentation through 2015 followed by sustained 100% compliance throughout 2016. A major limitation was creating an interdisciplinary collaborative effort to achieve compliance. Nonetheless, this was a successful pilot project to study cost effective and proficient methods that effect a sustainable change in the DNR documentation process. Overall, we foresee a reduction in health care costs from unnecessary interventions and an improvement in providing quality end of life care at Harlem Hospital.

25. Living on a Prayer: Miracle Language and Goals of Care*

Hartford Hospital

Hartford, Connecticut

Team/Contact Information:

Erica Richmond, MDiv, MA (Primary Contact)

Palliative Care Chaplain

Spiritual Care Department

80 Seymour Street

Hartford, CT 06102

(860) 972-2251

erica.richmond@hhchealth.org

Topic: Innovative Clinical Interventions

Description

This poster looks at the ways spiritual care providers and palliative care providers identify and address miracle language. Time and time again we hear this rhetoric in prognostic conversations. Patients or families will point to the possibility of a miracle when discussing goals of care. This poster looks at the three primary frameworks in which this language appears: grief, power/culture, and theology. It names the psychosocial and theological complexity that surrounds miracle language. In looking at these frameworks, the poster provides tools for all clinicians to engage in spiritual screenings and support. I identify and explore the ethical principles surrounding spiritual and religious beliefs and their impact on medical care.

Using Dr. Daniel Sulmasy's work (Distinguishing Denial From Authentic Faith in Miracles: A Clinical-Pastoral Approach." Southern Medical Journal 100.12 (2007): 1268-272), this poster also makes a distinction between denial and theological commitments. It also showcases the ways that all clinicians can navigate these conversations in a respectful and well-informed way ("AMEN in Challenging Conversations: Bridging the Gaps Between Faith, Hope, and Medicine" by Cooper, R. S., A. Ferguson, J. N. Bodurtha, and T. J. Smith, Journal of Oncology Practice)).

The poster will outline best practices for these challenging spiritual conversations from both literature and clinical experience.

*Special Recognition

THE NEW JERSEY STATE NURSES ASSOCIATION
CONTINUING EDUCATION CONTACT HOUR
CERTIFICATE

This is to Certify

Gina Trovato BSN

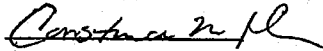
HAS SUCCESSFULLY COMPLETED

CAPC National Seminar 2017

Center to Advance Palliative Care
55 W. 25th St., Ste. 1302, New York, NY 10027

Date: November 9 - 11, 2017
Approval Number: 7834-11/17-19
Location of Educational Activity:
Phoenix, AZ

Contact Hours: 13.75



Constance Dahlin, MSN, ANP-BC, ACHPN, FPCN, FAAN
Primary Nurse Planner

This continuing nursing education activity was approved by New Jersey State Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation