Implementation of an Ad Hoc Hospital-Based Palliative Care Consult Service

Jean S. Kutner, MD, MSPH, Tracee Metcalfe, MD, Kieu O. Vu, MSPH, Regina Fink, RN, PhD, Paula Nelson-Martens, RN, PhD, John D. Armstrong, MD, MA, and Paul A. Seligman, MD

Introduction

Nearly 50% of Americans who die from chronic illness die in acute hospital settings, underscoring the critical need to better address the complex needs of terminally ill patients and their families in the acute care setting.1 A number of efforts have been undertaken to improve care for hospitalized terminally ill individuals.2–4 One approach is a palliative care consult service (PCCS). Studies indicate that PCCSs are effective in improving symptom control, facilitating understanding of diagnosis and prognosis, contributing to appropriate discharge disposition, changing patterns of care, and reducing resource utilization.5,6 PCCSs are also rich resources for teaching hospice and palliative medicine.7

The PCCS at the University of Colorado Hospital (UCH) arose from the desire of members of an interdisciplinary group of faculty and staff to improve end-of-life care in the acute care setting. UCH, a 393-bed tertiary care facility, is the teaching hospital of Colorado’s only academic medical center, the University of Colorado Health Sciences Center (UCHSC). Baseline surveys (1998) found that most (67%) UCH clinicians thought care of dying patients could be improved, with 88% favoring creation of a multidisciplinary team. These data were presented to the UCH hospital administration, which was supportive of the concept of beginning a PCCS.

Intervention

Faculty physicians, volunteering their time to provide palliative care consultations in the acute care inpatient setting, initiated the UCH PCCS in July 2000 on an ad hoc basis. The PCCS consists of five physicians with significant hospice and palliative care experience, four of whom have American Board of Hospice and Palliative Medicine (ABHPM) certification. Faculty physicians bill for their clinical services but do not receive specific financial support for their participation in the PCCS or training in palliative care. Third year internal medicine residents also participate in the PCCS as a component of their required medicine consult rotation.

Clinician surveys were conducted prior to and one and one-half years following initiation of the PCCS. The baseline (1998) survey included a broad spectrum of UCH clinicians: attending physicians, fellows, residents, nurses, social workers/case managers and chaplains. The 2002 survey included the same categories of clinicians with the exclusion of residents.

Survey questions ascertained respondents’ opinions regarding effectiveness of and satisfaction with end-of-life care, and barriers to quality end-of-life care, at UCH. The survey also asked about respondent characteristics such as age, gender, specialty, discipline, number of years’ experience in respective field, and number of dying patients cared for in the previous year. The 2002 survey was identical to the 1998 survey with the addition of questions regarding the use and helpfulness of the PCCS. Health care
professionals who were not directly involved in patient care at UCH or who did not care for dying patients were not included.

Results

Of 1448 eligible participants in 1998, 346 completed the survey (response rate 25%). Of 446 eligible participants in 2002, 106 completed the survey (response rate 24%). The study population for the 2002 survey was much smaller than the 1998 study population due to the exclusion of residents from the 2002 survey.

Effectiveness of End-of-Life Care: 2002 vs. 1998

Significantly more respondents in 2002 (78%) than in 1998 (32%) felt that the care of dying patients could definitely be improved (Fig. 1). Respondents rated the effectiveness of end-of-life care issues such as pain assessment, pain management, and non-pain symptom management. The only issues for which there was a statistically significant difference between 1998 and 2002 was pain assessment, with a higher percentage thinking that pain assessment was very effective in 2002 compared to 1998 (36% vs. 24%, $P = 0.03$).

<table>
<thead>
<tr>
<th>Table 1 Barriers to End-of-Life Care</th>
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<td>Identified as a Severe Barrier</td>
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<td>1998 (n = 346)</td>
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<td>2002 (n = 106)</td>
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<td>$P$</td>
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<td>Lack of knowledge about palliative care by health care providers</td>
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<td>Patient avoidance of issues around dying</td>
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<td>Lack of knowledge of existing policies/procedures by health care providers</td>
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<td>Communication difficulties among health care providers and patients/families</td>
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Satisfaction with End-of-Life Care: 2002 vs. 1998

Of the seven areas of satisfaction with end-of-life care that were measured, there was a significant increase between 1998 and 2002 in the percent of respondents who were dissatisfied with the extent to which palliative care is provided (35% vs. 46%, $P = 0.05$), and the extent to which palliative care is discussed by health care professionals (39% vs. 52%, $P = 0.02$).

Barriers to End-of-Life Care: 2002 vs. 1998

Out of 20 potential barriers to providing optimal end-of-life care in the acute hospital setting, four items were identified by a significantly higher percentage of respondents in 2002 compared to 1998 (Table 1).


A greater percentage of 2002 respondents compared to 1998 respondents (69% vs. 54%, $P = 0.006$) felt that the transition from a curative to a palliative model is made too late. A high majority of respondents both years (91% in 2002 and 92% in 1998) indicated that they were comfortable initiating the transition from a curative to palliative focus of care. Most (89% in 2002 and 90% in 1998) respondents also felt
that it was appropriate to simultaneously provide palliative and curative treatment.

Only 35% of respondents had ever used the PCCS, perhaps reflecting the low visibility of the program. Of the respondents who had used the service, most found it helpful, suggesting the service would likely be of great benefit if it were used more often. However, given the low response rates and the fact that 72% of the 2002 survey respondents were nurses, we cannot be assured that these results reflect the opinions of all UCH health care providers.

Implications for Practice

We believe that the increased perception of need for improvement in the care of dying patients is due to a growing awareness of the inadequacy of end-of-life care, rather than an actual decline in the quality of end-of-life care at UCH. The palliative care team is using the results of this study to: 1) address issues of visibility among the hospital services, particularly with physicians; 2) work with hospital administration to more actively integrate palliative care into the mission and activities of the hospital; and 3) justify the need for funding for dedicated time for palliative care team members, to permit increased visibility, both for clinical consultations and for education. In response, hospital administration has provided financial support and actively participated in a site visit via the Palliative Care Leadership Center (PCLC) Initiative. Based on these data and data generated via the PCLC experience, hospital administration is now committed to a long-term goal of integrating palliative care throughout the acute care setting and providing the financial support to make this possible. The growing dissatisfaction with end-of-life care demonstrated in this study offers an opportunity to implement change and increase use of the PCCS by readdressing the structure of and support for the service with the hospital administration.

References