

6.1 Elements and Settings of Care: Choosing a Model

Key Points

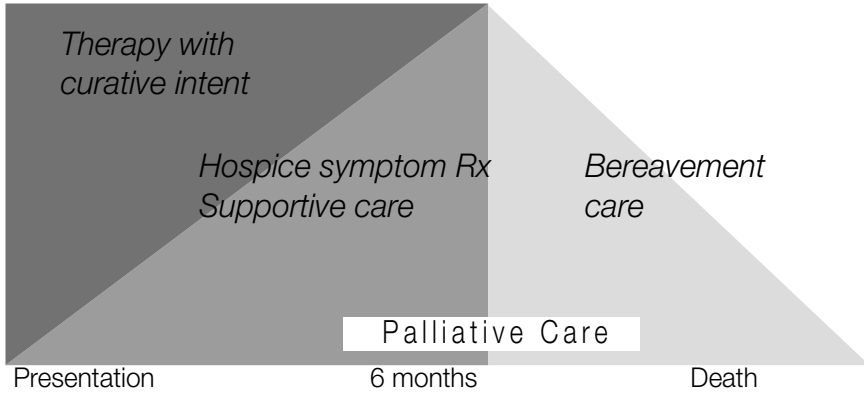
1. Most Americans die in institutions: 52% in hospitals, 24% in nursing homes, and only 24% at home. Good palliative care must occur in all settings.
2. Begin an institutional needs assessment by researching location of patient deaths in your health care system (e.g., last month, last year) and problems that occurred during the dying process.
Examples of problems include poorly controlled symptoms, overwhelmed families and patients, lack of preparation resulting in crises and surprises, depletion of resources, and emotional and spiritual isolation.
3. Assess the strengths and resources of your health-care system for End-of-Life care.
Assess competency, interest, and time of personnel. Assess space, administrative willingness, and financial resources of the facility.
4. Value added for patients by palliative care includes attention to suffering and to issues of meaning and purpose in the face of illness.
Value added to staff and institutions by palliative care includes improved patient/family satisfaction, effective resource utilization, improved staff morale, increased options for disposition for patients, and improved quality of care through development of expertise throughout the institution.
5. Value added to hospices by palliative care includes increase in referrals, earlier referrals, less crisis intervention, continuity of care, and the safety net of an inpatient setting if home management is not possible.
6. Begin palliative care efforts by matching needs with available resources to choose a model: hospital consultation, inpatient unit, ambulatory clinic, nursing home, or home health care.

Elements and Settings of Care

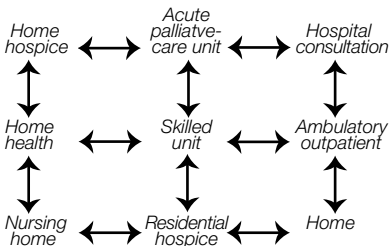
Palliative Care

- Consultation
- Inpatient palliative-care units
- Home hospice

Palliative Care Time Line



Elements



Continuity of Care

Last Year of Life of John, Age 83

- Home—lived alone in apartment
 - Brought to ER
 - Admitted to General Medical Service (progressive stage D prostate cancer)
 - Transferred to palliative-care unit
 - Discharged home when stabilized
- Home hospice*
Supportive care team from his church

... John's story continues

- Readmitted to palliative-care unit two months later
- Discharged to nursing home-hospice care
Good pain control
Friends and church members visit
Pain worsens as progression of illness interferes with taking medication
- Readmitted to palliative-care unit
Symptoms aggressively managed
John dies ten days later

Settings of Care

Home	Residential	Hospital
<i>Home Health</i>	<i>Assisted living</i>	<i>Emergency ward</i>
<i>Medicaid waver</i>	<i>Boarding home</i>	<i>ICU</i>
<i>Home hospice</i>	<i>Nursing home</i>	<i>Medical wards</i>
	<i>Residential hospice</i>	<i>Inpatient palliative-care unit</i>
<u>Deaths in USA</u>		
23%	24%	53%

Teno et. al., 1997

Assessment of Needs

- Where did people die in your health-care system last month? Last year?
- What were the problems with the care of the dying in your system?
Poorly controlled symptoms
Overwhelmed families and patients
Crisis to crisis
Lack of preparation, frequent surprises
Resources depleted
Emotional and spiritual isolation

Inventory of Strengths and Resources

Personnel	Facility
<i>Physician</i>	<i>Space</i>
<i>Nurse</i>	<i>Administrative willingness</i>
<i>Social worker</i>	<i>Financial resources</i>
<i>Chaplain</i>	
	<i>Competency?</i> <i>Interest?</i> <i>Time?</i>

Valued Added to Patient and Families

- Suffering addressed
Relief of suffering
Increased capacity to bear suffering
- Issues of meaning addressed
Assistance to find meaning and purpose in the face of illness

Value Added to Staff and Institutions

- Improved patient and family satisfaction
- Effective resource utilization
- Improved staff morale
- Increased options for disposition of patients
- Improved quality of care through development of expertise throughout the institution

Value Added for Hospice

- Increase in referrals
- Earlier referrals
- Less crisis intervention
- Continuity of care
- Safety net in an inpatient setting if home management is not possible

Choosing a Model of Care

Begin with a program that matches need with resources

- Hospital consultation
- Inpatient unit
- Ambulatory clinic
- Nursing home
- Home health

Matching Need and Resources

Palliative Nurse Consultant

- Consults in skilled unit and nursing home
- Assesses patient appropriateness for hospice
- Coordinates care of hospice patients transferred into hospital or nursing home

Matching Need and Resources

Palliative Physician Consultant

- Begins palliative medicine consult service in acute-care hospital and clinic
- Service results in improved symptom management and more referrals to hospice

Matching Need and Resources

Inpatient Palliative Unit

- Open palliative-care unit with hospital consultation to provide better palliative care to patients

Matching Need and Resources

Residential Hospice Unit

- Open residential unit to provide inpatient hospice care for patients cared for at home, in nursing homes, or in acute-care hospital

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Selected Readings

Hospital-Based Palliative Care

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Goldstein, P., D. Walsh, and L. U. Horvitz. "The Cleveland Clinic Foundation Harry R. Horvitz Palliative Care Center." *Support Care Cancer* 4 (1996): 329–333.

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