Looking at the financials from our table setting meeting, one thing became abundantly clear from the data—hospice is a vital component of the peace health company. Where you may see margins, we see the true mission being carried out. While nursing is a career of compassion across all spectrums, caring for others as they live out the last few days of their lives requires a compassion like no other specialty. How a person dies reaches beyond their last breath. It has a ripple effect on the family that live through the process with them, the friends that visit them and hold their hand, the community that writes their legacy, and the nurses that coordinate all of it. It can be a smooth and peaceful process—full of beautiful moments and invaluable memories—or it can be a painful one that leaves everyone involved with traumatic feelings and a distaste and distrust for hospice.

On January 1, 2022, PeaceHealth made a clear statement of how much they valued palliative care and hospice when they dissolved the palliative care/hospice team. What was once a cohesive and competent team of hospitalists, care managers, social workers, and nurses became a broken system. This highly skilled team that specializes in having those difficult and delicate conversations that are so crucial, was showed how little they are appreciated and their specialty is respected. And who was left to suffer? According to the data, not peace health. However, the patients did. There are very, VERY few hospitalists that know how to approach end of life with the finesse that it requires because it makes them uncomfortable, let alone how to properly treat and medicate it. So it is the patients that are left to suffer—struggling, hurting, suffering, undermedicated, undertreated, and undervalued. The nurses caring for these patients—both inpatient and out—suffered along with them. For the inpatient nurses, we had to watch patients fight a losing battle longer and harder than they needed to because everybody was either confused or unaware of what the new process was—and it kept changing. Where once before we had a palliative care doctor on shift in the hospital and could come in at a moment’s notice to talk with a patient and family, there was no one to see these patients in a timely manner. So they sat for days—sometimes
weeks—either maintaining status quo, deteriorating and being transferred to the ICU for ongoing aggressive care, or deteriorating and dying before they could be made comfortable. Since the dissolution of palliative care, it is the latter scenario that has been happening more often than not, which is where the outpatient hospice nurses have suffered the most. By the time they get to meet some of these patients, things are out of control—symptom management, patient stability, family dynamics, etc.

The system is broken, and it didn’t need to be. You say you are working on fixing it, but you’ve said that since day one when this change took effect and it has not going any better. If there is one thing your financial data is showing you, it is that your community needs its palliative care and hospice system desperately—inpatient and out.