A Three Step Approach to Create a Palliative Medicine Co-Management Model of Care on an Inpatient Hematology Unit

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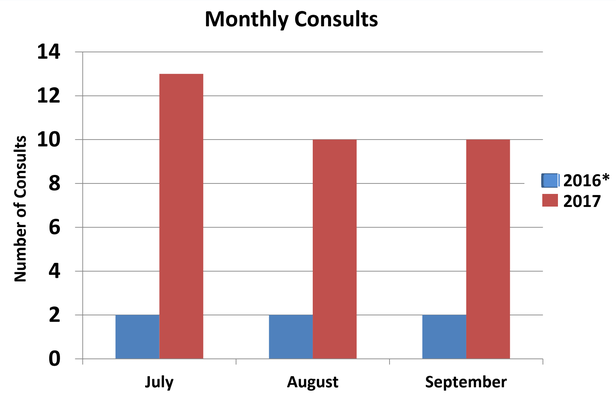
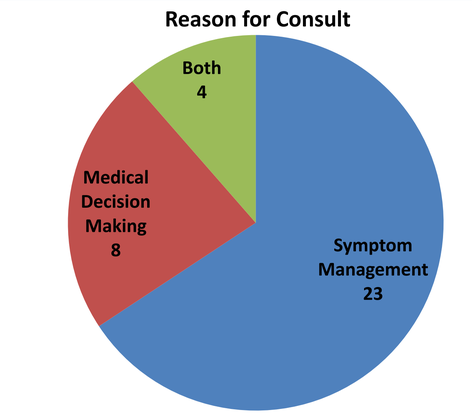
Background: Northwell Health's North Shore University Hospital (NSUH) campus has a dedicated hematology unit. This cohort of patients is under-represented on our inpatient palliative care service, comprising < 1% of initial consultations in 2016. Given recent recommendations by the American Society of Clinical Oncology about comprehensive cancer care, and recognizing the growing need for palliative care in patients with hematological malignancies, our goal was to initiate a concurrent hematologic and palliative care delivery model.[1,2]

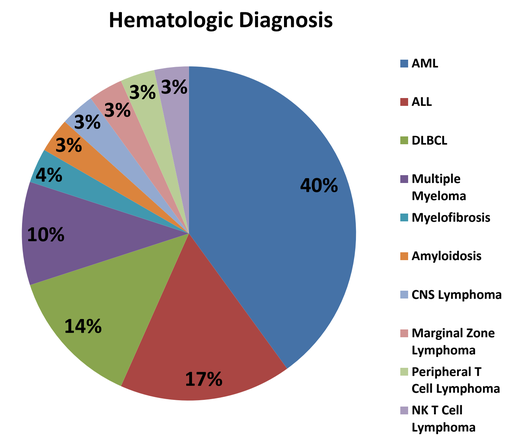
Methods: A three step process was initiated – inpatient service buy-in and joint workgroup development, concurrent care delivery, and linkage to outpatient partners. The first step was to obtain buy-in with faculty stakeholders at our institution, including Hematology-Oncology leadership. There was immediate support for a partnership. Next, a workgroup was assembled to jointly generate a needs assessment survey to determine how best to assist in the care of these complex patients. We identified key metrics to measure, and linked our inpatient service with outpatient care via our Supportive Oncology practice. These included but were not limited to hematologic diagnosis, reason for consult, time to consult from admission, length of stay, documentation of advance directives and goals of care, and outpatient referrals.

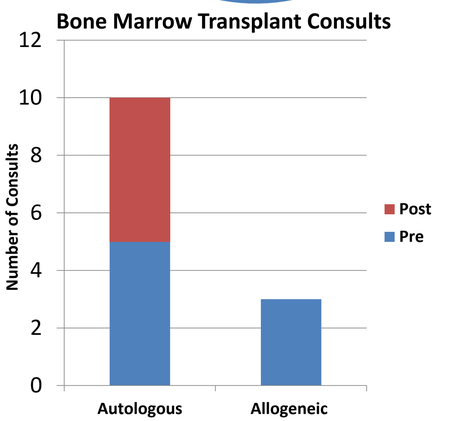
Addenda:

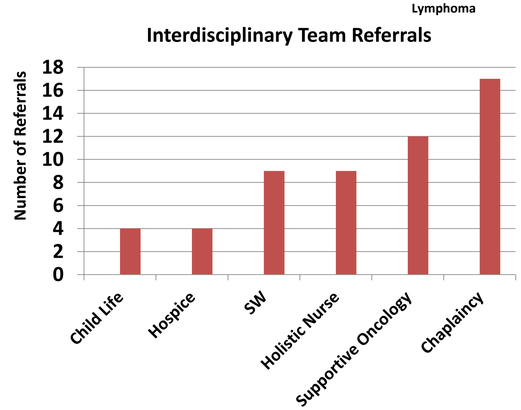
* The monthly values for 2016 were based upon an average from a total of 26 consults during that calendar year.
** Hospice care venues included home or nursing homes.
*** Sites of expiration included the inpatient hematology unit, the MICU, or the inpatient palliative care unit.

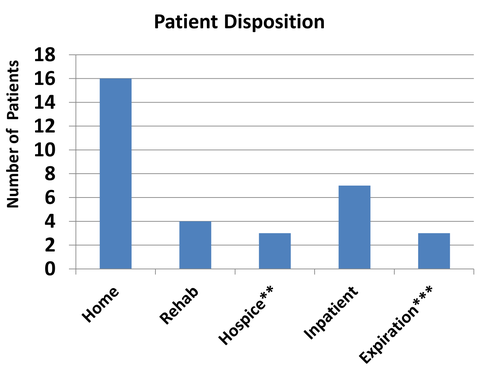












Results: Biweekly "screening rounds" with the Hematology team were initiated and used as a first step to identify high-need patients for consultation. In 2016, our consult service received a total of 26 consults from this unit. After three months of a fully initiated rollout, we received 33 consults alone. Approximately 65% of the consults were for solely for symptom management, while the remainder involved medical decision making. The most common diagnosis seen was AML, about 40% of the consults. About 57% of all consults were seen within 7 days of admission. Of the bone marrow transplant referrals, over 60% were seen before transplantation. The most common interdisciplinary team referral was Chaplaincy, for emotional and spiritual distress, in almost 50% of the cases. Patient disposition was mixed but most patients were discharged home, with 75% receiving Supportive Oncology referrals.

Conclusion: Through relationship management, workgroup development, and care transition to community, an inpatient supportive care co-management model for patients with hematologic malignancies was successfully implemented. Using a three-step process, a complex patient population supportive care program was initiated. By creating health care pathways with an emphasis on Palliative Medicine co-management, we are poised to deliver comprehensive care and measure its impact.

References:

1) Partridge Ann H. et al "Developing a Service Model That Integrates Palliative Care Throughout Cancer Care" J Clin Oncol. 2014 Oct 10;32(29):3330-6.
2) Ferrell B., et al. "Integration of Palliative Care Into Standard Oncology Care: American Society of Clinical Oncology Clinical Practice Guideline Update" Journal of Clinical Oncology 35, no. 1 (January 2017) 96-112.

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