A NOVEL APPROACH TO OUTPATIENT PALLIATIVE CLINIC FLOW:

Scheduling an Outpatient Multi-disciplinary Clinic

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BACKGROUND

The practice of palliative care is fundamentally dependent on the multidisciplinary team. As outpatient palliative care clinics continue to grow, there can be a struggle to maintain the multi-disciplinary team model including: 1) mismatch between the traditional physician-based clinical template 2) needs of a palliative care patient and 3) wellness of the multidisciplinary team itself.

Derived from World Health Organization definition of palliative care, 1998

Palliative care integration in the outpatient setting can decrease hospital cost expenditures, improve patient experience and enhance overall quality of life [1,2]. The use of a multidisciplinary palliative care team in the outpatient setting is crucial for full assessment and management of the four corners of wellness: physical, social, psychological and spiritual.

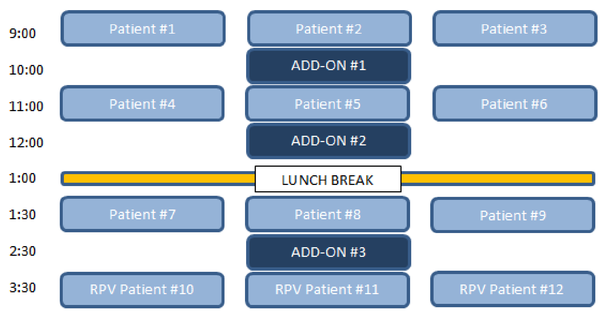
1- 2014 Institute of Medicine (IOM) Report, *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life.*
2- National Consensus Project (NCP) for Quality Palliative Care. (2013). *Clinical practice guidelines for quality palliative care, 3rd edition.* **Accessed March 6, 2016** from http://www.nationalconsensusproject.org/NCP_Clinical_Practice_Guidelines_3rd_Edition.pdf .

CLINIC STRUGGLES

Problem	Associated Obstacles
• Traditional physician-only schedule template versus team template	▸ Inability for patients to obtain discipline-focused assessments
• Large number of same-day cancellations / no shows	▸ Vacancies in appointment slots go unused
• Patients late to appointments	▸ Clinic runs late leading to decreased staff wellness
• Need for same day add-ons or urgent appointments	▸ Difficult to accommodate “last minute” higher acuity patients
• Need for appointments post discharge from hospital for follow up	▸ Inability to schedule in timeframe needed
• Inability to see new patients within 7 days from time of referral	▸ Mismatch of time allotted for proper patient care
• Patient acuity independent of new versus return status	

INTERVENTION METHODS

- Full team meets for morning huddle to triage clinic flow and overnight messages/requests
- At least one Add-on slot remains open daily to allow for last-minute additions to clinic
- Urgent/Crisis patients always added into next available Add-on slot
- End of the day slots reserved for return patients only
- When full team is not available, the schedule is adjusted accordingly (team functions better as whole)



- Team members rotate between patients based on arrival to clinic.
- New patients see all disciplines for initial assessment of ongoing needs

CLINIC DEMOGRAPHICS

- Outpatient program started in 2012
- Embedded in academic nationally-recognized cancer center serving all cancer types including thoracic, breast, GI, head and neck, GU, hematologic, and BMT
- Ten half-day clinic sessions per week
- Staffing FTE: 0.9 Physician, 1.0 APN, 1.0 Care Coordinator, 1.6 LCSW, 0.5 Chaplain
- Number of unique outpatient palliative care patients per year: ***
- Number of encounters per year: ***

OUTCOMES

- Able to maintain a full multidisciplinary approach to care
- Decreased number of unused appointments by 80% since template slots no longer reserved for patient type (new versus return)
- Clinic flow improved by allowing for flexibility of unforeseen patient variables (e.g. tardiness, no shows)
- Enhanced availability to schedule urgent and same day add-on appointments
- 100% of team report improved wellness and job satisfaction
- Promotes and rewards team based model of care versus individualized practice
- Improved timeframe for completion of documentation as reported by clinicians
- Improved ability to meet post-hospital discharge follow ups and referrals within 7 days (or patient preference) to 75% success