Breaking Bread and Building the Tribe: Creation of a Regional, Interdisciplinary Palliative Care Collaborative

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Introduction

Palliative Care (PC) programs are flourishing nationally, with 90% of hospitals with 300 or more beds offering PC.[1] Hospitals with 500 or more beds are expanding PC team sizes, averaging 7.8 full time equivalent positions in 2014.[2] Despite this growth, smaller hospitals are less likely to have PC programs and those that do average less than half the staff members of larger institutions.[2] With high burnout rates in PC (62% in a 2014 survey with younger clinicians who feel isolated most susceptible[3]), nurturing connections with colleagues may help sustain PC providers and programs long term.

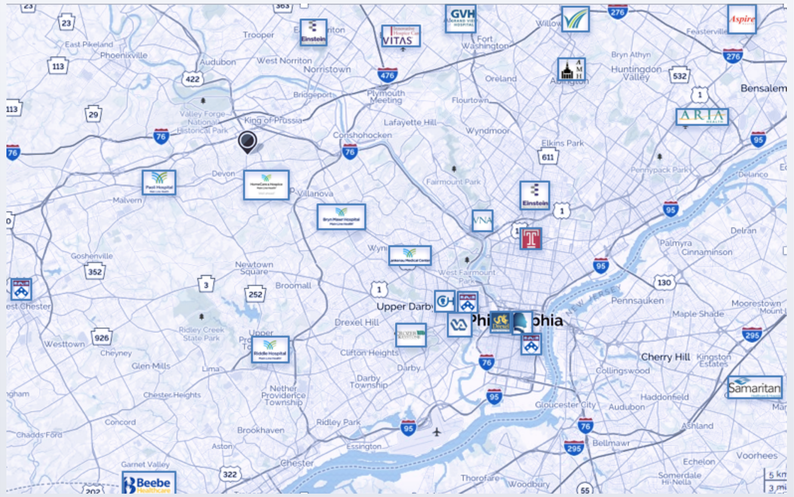
The First Step: Needs Assessment

1. During a meet-up held at the AAHPM/HPNA Annual Assembly in Philadelphia in February 2015, a group of local PC clinician leaders proposed the idea of regional collaboration.
2. Various input was sought from both local PC program leadership and other institutional stakeholders, creating regional widespread engagement.
3. Needs and challenges identified included:
    - Unfamiliarity with colleagues at other health systems and difficulty communicating with those at other systems
    - Lack of inter-system problem solving around programmatic growth and capacity challenges
    - Limited skill set at many programs around business case development and maximizing revenue capture
    - PC clinicians with few colleagues have a high burnout risk

The First Year: Planting Seeds and Nurturing Their Growth

1. A first meeting was held in a hospice conference room with pizza. 15 clinicians invited by email and word-of-mouth came to discuss their efforts at teaching Primary Palliative Care skills to colleagues.
2. A Planning Committee was created after the first meeting, comprised of 11 members from 8 regional health systems.
3. 4 meetings were held. Topics and formats included:
    - Discussion around teaching Primary Palliative Care skills
    - 1-hour lecture focused on the Institute of Medicine *Dying in America* report
    - 1-hour session of 3-6 slide, rapid-fire presentations entitled "Things I learned during the CAPC and AAHPM/HPNA conferences"
    - 1-hour discussion of future directions/goals for the group and tasks to be completed during the summer hiatus
4. Active recruitment efforts by the Planning Committee increased the group's membership to over 120 by the end of the first year (see map). These efforts included direct solicitation of local colleagues along with phone calls and emails to clinicians at health systems not represented on the committee.

DVPCC Members Come from 25 Institutions Throughout the Region



Summer and Early Second Year Successes

1. Creation of an organizational name, logo, and mission statement.
2. Web-based Planning Survey completed by many general members.
3. Completion of a website, **DVPCC.org**, with near-term functionality enhancements to include password-protected:
    - Shared PowerPoint slides repository
    - Indexed academic teaching articles
    - Searchable members' contact directory
    - Resources tab including regional PC CE/CME events
4. "Best Practice Forum" presentations by 3 regional programs to understand current successes, challenges, and program expertise.

Our Journey of 1,000 Miles: Next Steps and Potential Aspirations

1. 3 more meetings scheduled through May 2017 with topics and locations confirmed. Internal/external resources have led educational sessions.
2. Ongoing planning for continued membership growth focused on those from yet-unrepresented health systems and hospices.
3. Early planning underway for formal mentoring relationships between senior and junior clinicians to foster intentional intra-health system collaboration. All disciplines will be invited to participate.
4. With maintained momentum over the next 12-18 months, potential 2-5 year plans include:
    - Application for nonprofit status to enable grant applications and tax-free donations
    - Creation of an annual, regionally-taught Palliative Care Clinical Intensives course

Mistakes Made and Lessons Learned

- Someone must commit to ***maintain an email list*** to enable communication.
- The Goldilocks Principle must be minded – ***schedule meetings neither too early nor too late***. Too early and intended attendees will miss due to their clinical obligations or rush-hour traffic and too late limits younger clinicians' ability to see their children before bed.
- Know your local traffic patterns to ***avoid scheduling a meeting in the midst of a locale's rush-hour gridlock*** or late arrivals will disrupt the meeting.
- The ***Planning Committee should come from as many regional systems as possible*** as local Champions are instrumental to group growth.
- ***4 meetings per year*** is enough to maintain interest but not so many that the group's time together becomes burdensome.
- ***Hosting should be rotated*** between at least 4 but preferably 8 institutions to minimize planning burdens and costs to host institutions and allow members to visit others' facilities to increase the community feel.
- Attendees come for ***interaction and discussion*** – even the most dazzling hour-long presentation can leave those present unsatisfied.
- "Things I learned during the CAPC and AAHPM/HPNA conferences" ***3-6 slide micro presentations*** were a really big hit with attendees.
- Meeting notifications should be sent at least 2 months in advance and at least ***3 meeting reminder emails*** in the weeks before meetings increase attendance.
- 30 minutes before and 30 minutes after the meeting should be ***reserved for and specifically identified as networking time***. This decreases the natural inclination of members to talk only with those they already know.
- A quenched spirit does not fill an empty stomach. ***Host institutions need to feed attendees*** at least a salad with a protein if the meeting is in the evening.

References

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3. Kamal AH, Bull JH, Wolf SP, Swetz KM, Shanafelt TD, Ast K, Kavalieratos D, Sinclair CT, Abernethy AP. Prevalence and predictors of burnout among hospice and palliative care clinicians in the US. J Pain Symptom Manage. 2016 Apr;51(4):690-6.

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- For additional information, a copy of this poster, or to discuss creation of your own region's PC collaborative organization, please contact the Planning Committee at **DVPCC.team@gmail.com.**