

Office-Based Palliative Care Practices: Strategies for Success

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The Center to Advance Palliative Care

NATIONAL SEMINAR

NOVEMBER 14-16, 2019

Atlanta Marriott Marquis

Pre-Conference Workshops:

Boot Camp and Payment Accelerator

WEDNESDAY, NOVEMBER 13



Join us for upcoming CAPC events

→ Upcoming Webinars:

- **BRIEFING: Best and Worst States Providing Access to Palliative Care**

Friday, October 4 at 12:30pm ET

- **Analyzing Trade-offs and Making Decisions (A Staffing and Workload Webinar)**

Wednesday, October 30 at 12:30pm ET

→ Virtual Office Hours:

- **Training All Clinicians in Core Palliative Care Skills**

Thursday, September 19 at 12:00pm ET

- **Specialty Palliative Care Delivery in the Clinic**

Tuesday, October 29 at 2:00pm ET

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Objectives

- Obtain buy-in and conduct an initial needs assessment
- Determine target patient population and scope of practice
- Identify and measure key program metrics
- Plan for growth while preventing burnout

Overview

MOUNT SINAI HEALTH SYSTEM

Mount Sinai Health System

→ Mount Sinai Health System

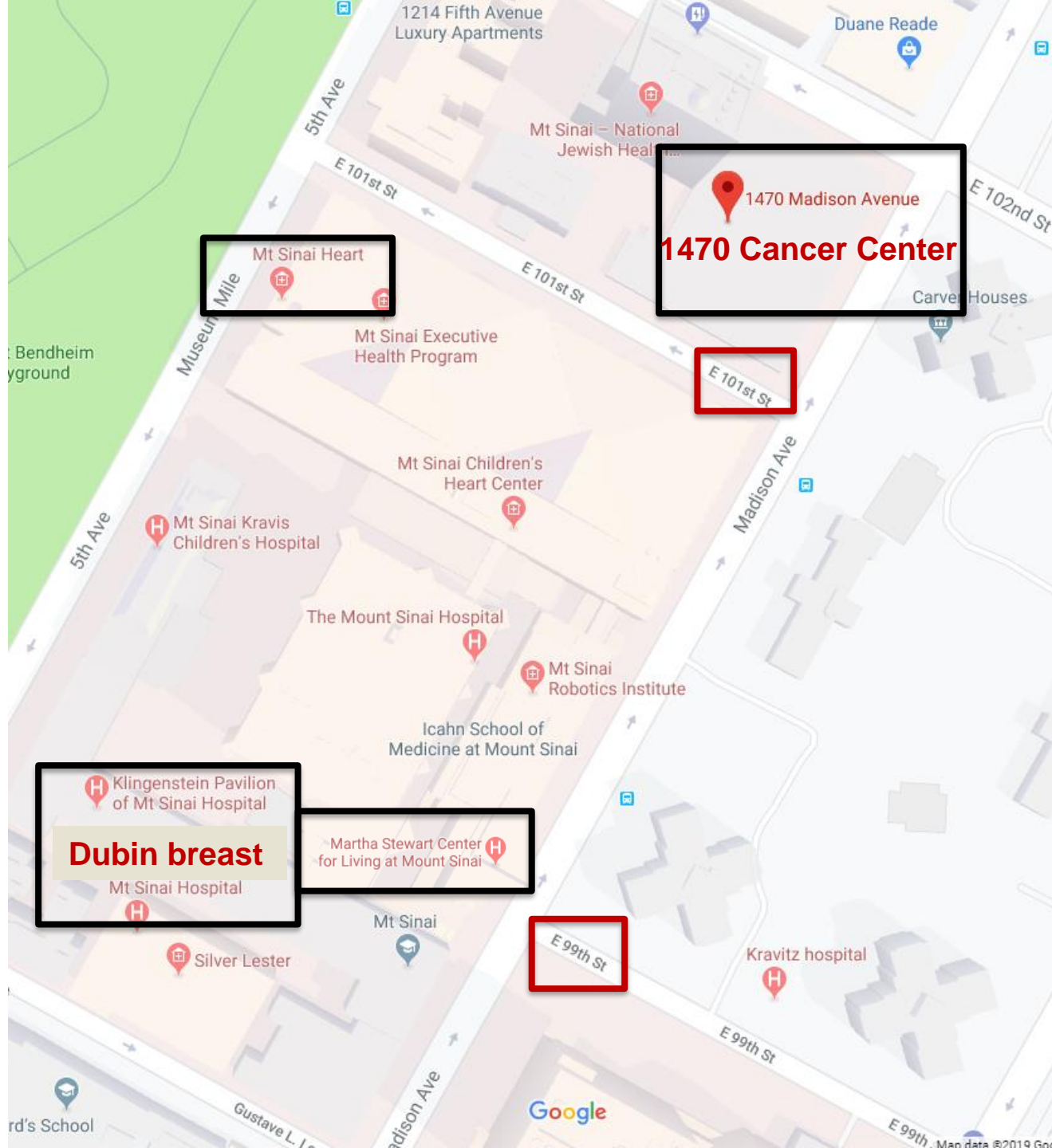
- 7 hospitals throughout New York City
- Over 6,600 primary and specialty care physicians
- 3,360 beds (system); main hospital has ~ 1100 beds
- ~ 136,000 inpatient admission and ~ 500,000 Emergency Department Visits per year

→ Palliative Care Services

- Main hospital: 3 consult teams, 1 IPU, 3 outpatient practices, and home-based palliative care programs
- Other sites: mix of inpatient consult teams and outpatient practices

MSHS Office-Based Palliative

Practice	Inception Date	Type	Current FTE
Mount Sinai Hospital Supportive Oncology	March 2013	Embedded Co-management	2 MDs (total 14 sessions per week) 1 NP (total 5 sessions per week) 2 RNs
Mount Sinai Chelsea Supportive Oncology	October 2018	Embedded Co-management	1 MD (total 7 sessions/week) 1 RN
Mount Sinai Queens Supportive Oncology	May 2018 <i>Pilot project</i>	Embedded Consultative only	0.1 FTE NP & 0.1 FTE SW (1 session per week)
Mount Sinai Hospital Supportive Cardiology	May 2018	Embedded Consultative	1 FTE NP (~ 1.5 sessions per week, remainder of time inpt w/ CHF team)
Mount Sinai Hospital palliative care (fellows; some geri-PC)	1990s	Co-located Co-management	9 sessions/week (~ 0.2 FTE attending MD)
Mount Sinai Downtown palliative care (fellows; some geri-PC)	2013 (merger)	Co-located Co-management	9 sessions/week (~ 0.3 FTE attending MD)



- **Notes:**
- 1470 Cancer Center houses Supp Onc & is 2 blocks away from MSCL PC practice, and 2.5 blocks away from Dubin breast center
 - Few Dubin pts are referred to Supp Onc or MSCL
 - Few 1470 Cancer Center pts are referred to MSCL
 - Mount Sinai Heart is 2.5 blocks from MSCL; few CHF pts referred to MSCL

CREATING YOUR PLAN

Creating Your Plan

- Needs Assessment
- Metrics
- Resource Allocation
- Workflow

Needs Assessment

- What problems are you trying to solve? Why is PC needed?
 - What is the gap in available resources and patient needs? What is the outcome that needs to be improved? How can palliative care serve as a solution to a problem? Don't promise to fix something you have no control over...

- Identify key stakeholders/collaborative relationships
 - MD/RN leadership/champions (PC, referring specialties)
 - Hospital administration
 - Finance, social work, chaplain, etc

- Multiple competing specialties may want palliative care

- Needs assessment will determine primary program metrics

Reminder: Anchor your needs assessment and measurable outcomes to the needs of your stakeholders/referring teams!

Mount Sinai Program Metrics

What leadership wants

FOCUS ON ONCOLOGY:

- Reduction in Emergency Department utilization
- Reduction in hospital admissions
- Increase in hospice referrals
- Reduction in hospital mortality

Metrics tracked

- ED visits before vs after initial PC visit
- Admission before vs after initial PC visit
- Last care site at time of death
- Hospice length of stay, compared with national/regional data (Dartmouth Atlas)
- Time from referral to initial PC consult
- ED visits and hospital days saved
- Hours of PC appts → estimated volume of new medical oncology appointments opened for patients when Supp Onc addressed issues the oncologist would have otherwise addressed

Take Time to Plan in Advance!

?	Specifics	Answer	Mount Sinai Supportive Oncology Pearls
Who	Who is the target population?	Clinician vs. criteria initiated referrals	Did not start with trigger referrals. Goal: build trusting relationships first. Would need to identify criteria and match volume to PC capacity
	Who provides palliative care?	MD/NP/RN SW Chaplain	Onc has disease-specific SW & outpatient chaplain. Shared SW allows PC to be more embedded in oncology. No physical space for extra SW visits
	Who refers the patients?	Med onc, rad onc, surg onc	Any team member (MD, PA, NP, RN, SW)
	Who provides administrative support? Who answers calls?	Onc for registration, vitals, and scheduling. PC AA for daytime calls	Night/weekend calls through onc service. Primary onc must be aware of treatment-related complications and determine need for admission. Oncologists should have primary PC skills for symptom management
What	What is PC's role?	co-manage or consult?	When practice started, PC MD offered individual needs assessment with every oncologist. Each oncology provider had slightly different view.
	What is the scope of practice?	Decide on scope of specialty-PC	What can PC provide? Does your skill set overlap with that of an addiction specialist, chronic pain specialist, psychologist?

Take Time to Plan in Advance!

?	Specifics	Answer	Mount Sinai Supportive Oncology Pearls
When	When will you be available?	Defined sessions Phone calls M-F	Balance accessibility and boundaries
	When to expand?	When sessions about 50-60% full	It may take longer than expected to analyze data for proposals & receive approval
Where	Where will services be provided?	Embedded within oncology clinic	Tentative plan to un-embed Supp Onc (~ Year 4) prevented after noting that other PC practice 2 blocks away not used by onc (“out of sight, out of mind”)
Why	Why is ambulatory PC needed?	Hospital metrics	Plan in advance: which data will you collect to match outcomes to metrics? Who will collect it? Who will analyze it?
How	How will referrals be made?	Require EPIC referral	Purpose: (1) data tracking, (2) minimize e-mail traffic, (3) restrict practice’s access to onc (order restricted to onc EPIC contexts), and (4) in 2017 started to use it to screen/triage referrals
	How long will patients see pal care?	Define scope: Pts with “ongoing specialty-level PC needs”	Pts who complete curative-intent treatment & become NED, may be followed for ~ 1 more year, depending on recurrence risk. We are not a survivorship practice. (<u>stakeholders!!</u>)

Workflow: Create processes that streamline workflow and track data

Free text

Comments

Newly diagnosed esophageal mass. Complains of upper abdominal pain everyday 4-5/10 with pain level spiking to 8 at times.

Order Questions

Question	Answer	Comment
Reason for Referral	Physical symptoms and advance care planning	
Last anti-neoplastic treatment	Ongoing/currently receiving treatment	
Current symptom regimen	Opioids	

Order Questions: Each has buttons to click; choose from these options:

- **Reason for referral**: (1) Physical Symptoms, (2) Advance Care Planning, (3) Physical Symptoms and advance care planning
- **Last anti-neoplastic treatment**: (1) Ongoing/currently receiving, (2) None but with new disease progression/evidence of metastatic disease, (3) None, no clinical concern about disease recurrence
- **Current symptom regimen**: (1) opioids, (2) adjuvants, (3) OTC analgesics, (4) anti-emetics, (5) none

Resource Allocation

- Secure resources from people who control those resources
 - Example: Oncology MD leadership felt expansion in Supp Onc program was needed, but they did not have control over position approval
- What will you do if resources are promised and not delivered?
 - Example: After 3 months, temporarily pulled PC NP out of an outpatient CHF clinic due to lack of resources

TARGET POPULATION & SCOPE OF PRACTICE

Who to see?

- Many guidelines exist
- Must match referral volume to available resources
 - Avoid excess wait times for new patient appointments
 - Avoid patient and team frustration
- Smarter to start with what is feasible and scale up, rather than overpromise and not deliver

Managing Capacity: Prioritizing Specialty Palliative Care Consultation Referrals

Patient Characteristics

- Limited anti-cancer treatment options
- High risk of poor pain control
- High symptom burden
- Palliative stenting/venting gastrostomy
- Frequent ED visits or readmissions
- Resistance to engaging in ACP discussions or need to clarify goals of care
- High distress score
- Rapidly progressive functional decline or persistently poor ECOG
- Request for hastened death

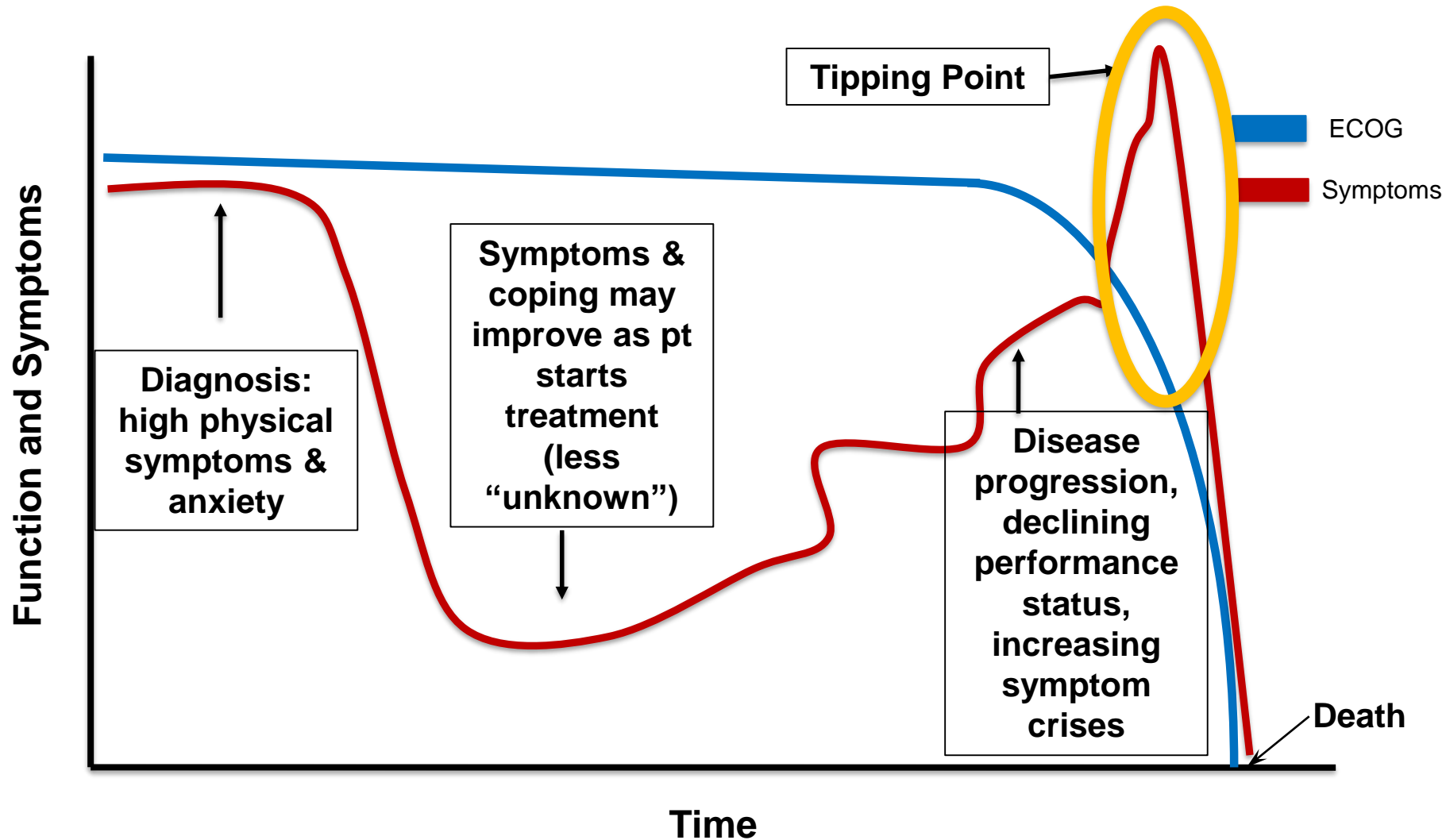
Social Circumstances or Anticipatory Bereavement

- Family/caregiver limitations
- Inadequate social support
- Intensely dependent relationships
- Limited access to care
- Family discord
- Patient's concerns regarding care of dependents
- Unresolved/multiple prior losses
- Children < 18 living in the household

Staff Issues

- Complex care coordination issues
- Compassion fatigue
- Moral distress
- Burnout

When: It's too early until it's too late



Outpt PC > 90 days prior to death (vs < 90 days prior to death) = lower ED, ICU, and hospital admissions and \$5198 less per pt (Scibetta et al J Palliat Med 2016)

GROWTH AND SUSTAINABILITY

Growth Timeline

2012 Planning:

- Needs assessment
- Resource negotiation
- Budget proposal

2014:

- Jan: RN hired; MD 8 sessions/week
- July: 6 week wait for new pts; hospital approves 2nd MD salary line

2016:

- Ongoing growth
- May: internal analysis for next growth
- Aug: 1 FTE NP requested & approved

2018:

- Apr: internal analysis for next growth
- Oct: proposal to add 2nd MD & RN

2020 Planning: automatic referrals

2012

2013

2014

2015

2016

2017

2018

2019

2020

2013:

- Mar: 4 MD sessions/week
- Sept: 0.5 FTE NP (empty) converted to 1 FTE RN

2015:

- Oct: 2nd MD starts; practice expands to 12 sessions/week

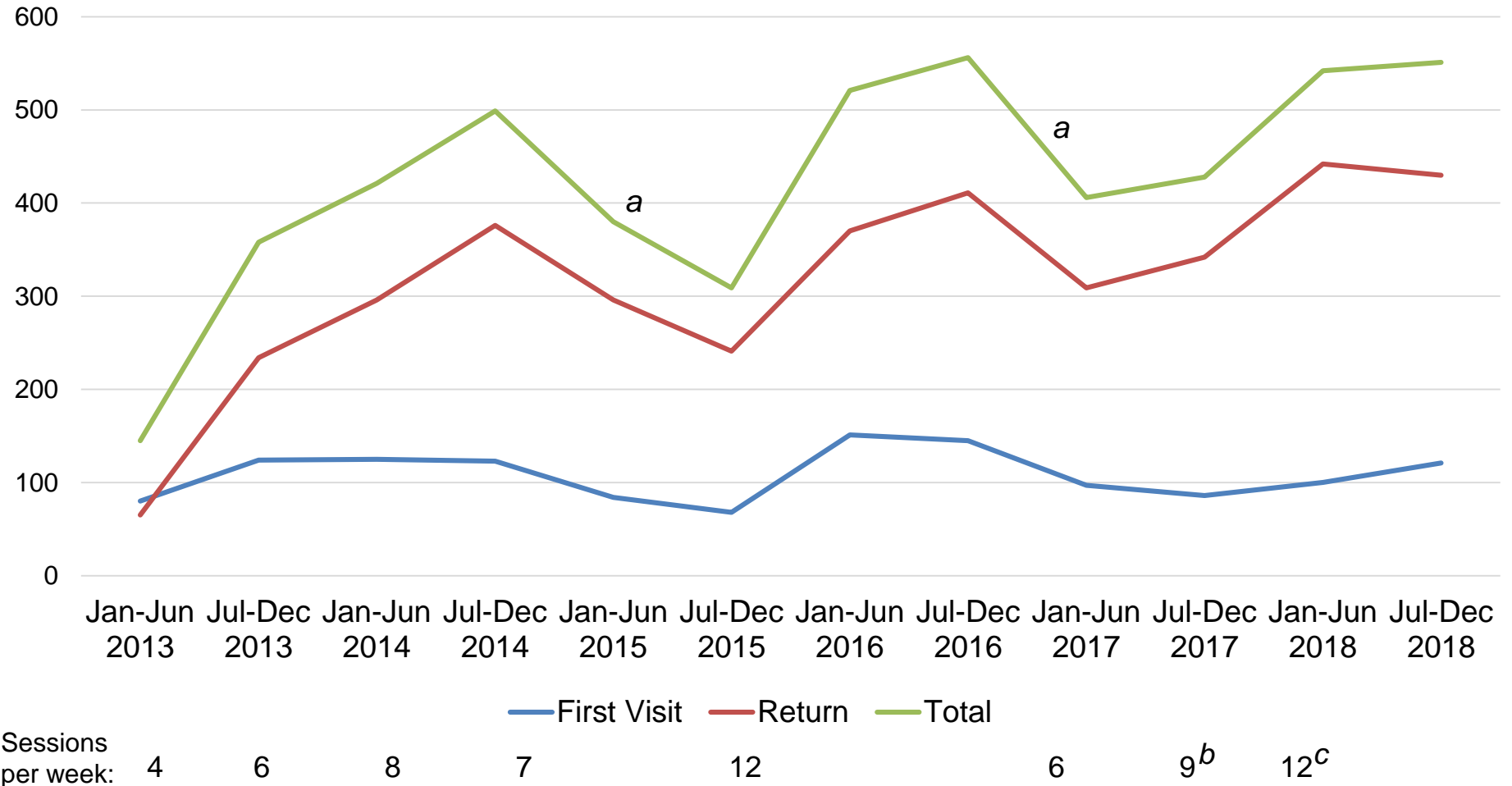
2017:

- Jan: 1 MD leaves
- June: NP starts

2019:

- Mar: 2nd MD starts
- June: 2nd RN starts
- Aug: 1st RN promoted

Supportive Oncology (MSH) Volume



^a Periods of high acuity followed by recovery or mortality

^b 6 MD sessions and 3 NP sessions; NP sees only established patients

^c 6 MD sessions and 6 NP sessions; NP sees only established patients

Sample Daily Schedule

Built in time for urgent visits



9:00-9:30AM	9:30-10:30AM	10:30-11:00AM	11:00-11:30AM	11:30AM-12:30PM	12:30-1:00PM	1:00-2:00PM	2:00-2:30PM	2:30-3:30PM	3:30-4:00PM	4:00-5:00
Follow-up	New patient	Follow-up	Follow-up	New patient	Urgent visit	Lunch; overflow	Follow-up	New patient	Follow-up	Urgent visit

Considerations in providing high-quality care:

- How many new vs established patients can be seen per day?
- How much time do you need per patient?
- How much time and what time of day for care coordination?
 - When do daytime phones switch on/off?
 - When will your day be busiest (we are often busiest after 3PM)
 - Should every team member work from 9-5?
 - Mount Sinai example: RNs work 4 10-hr days (8AM-6PM). Letting NP decide if she wants to try to work 9-5 or ~ 9:30-5:30.
- How might you accommodate urgent visits?
- What is the no-show rate? (may differ between new vs established patients)
- When can/should you say no?

Estimating Capacity & Volume per FTE

→ Patient Considerations:

- Acuity: visits once/week vs once/year?
- Visit Length/Content: symptoms, ACP, or both?

→ Workflow: during vs between visits...

- Monthly report of phone encounters per provider
- Ex: 100 RN phone encounters, estimating 30 mins/call = ~ 50 hrs/month of phone coordination per RN.

→ Team Health:

- How much work can be done per day and still have reserve for the next day?

→ Bottom line @ Sinai: Estimate ~ 23 unique pts/session/year for a practice with 1 MD and 1 RN

Growth, Expansion, Scalability

→ When demand exceeds capacity

- How do you maintain relationships with stakeholders
AND:

- Know when & how to effectively say no
- Protect the health of your team and prevent turnover

→ Mount Sinai Examples:

- Oncology wants embedded PC in each cancer center site. Can we do this? If not, what else can we offer?
- In 2018, asked whether we could implement trigger program for ~ 200 patients/year...
 - Hmm...this would require 1 FTE MD we did not have...
 - How did we respond?

Growth, Expansion, Scalability

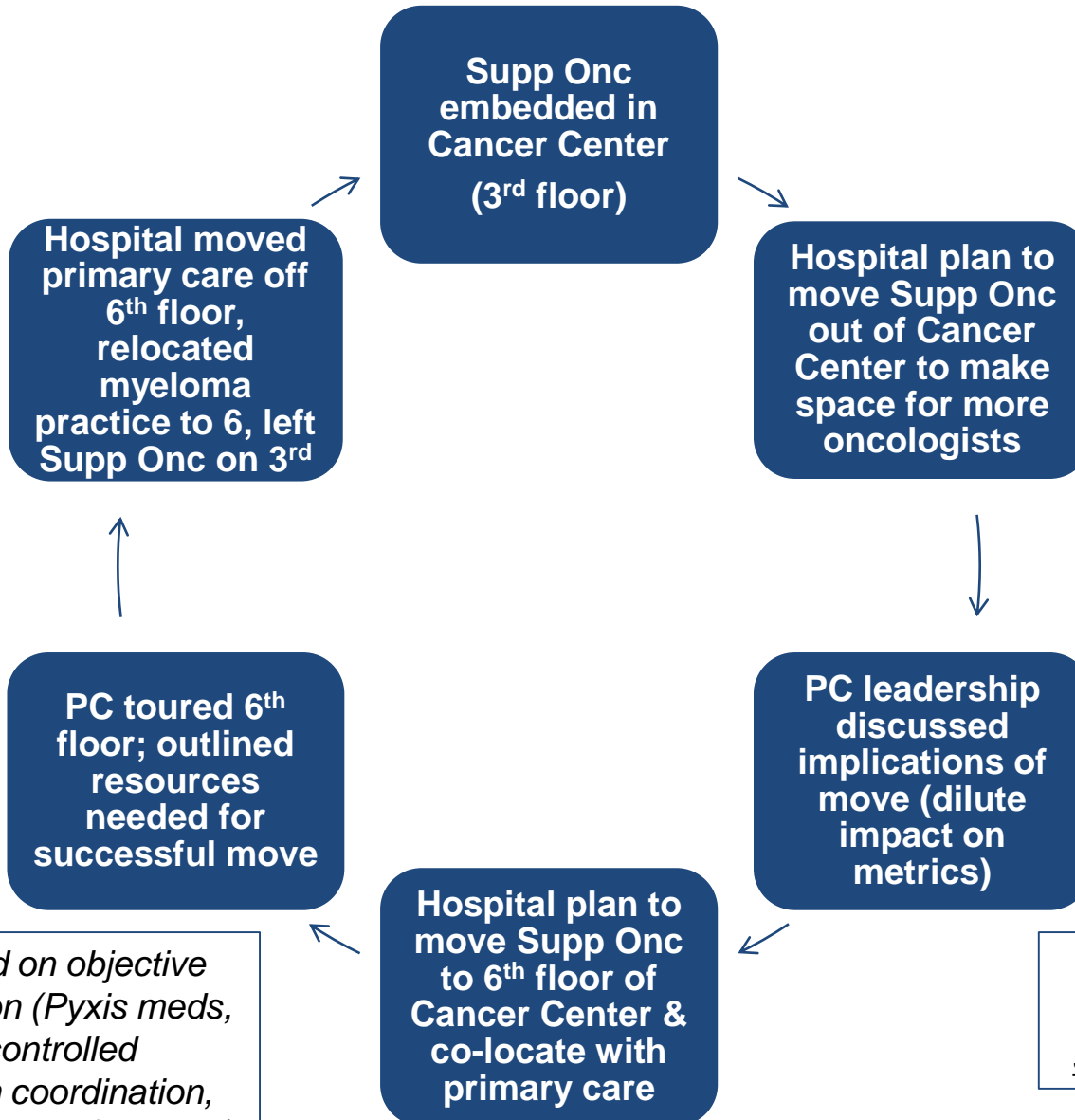
→ Resource negotiation

- Every expansion requires re-negotiation of resources
- Has the program improved your stakeholders' metrics?
- Can you also demonstrate indirect benefits?
 - Example: Calculate how much time PC saves an oncologist and how many new oncology appointments this opens up

→ Regular check-ins: Where are you now?

- What's working?
- What are the hospital's priorities at this time?
- What can be improved?
- Did you pilot a program that can see 50 patients a year? Will your model still work if there is demand for 500 patients a year? Will your team burn out?

Case Example: Resources



Rationale focused on objective resource allocation (Pyxis meds, 2nd RN to waste controlled substances, team coordination, oncology scheduler on floor, etc)

Rationale must be focused on stakeholders' metrics!!

Case Example: Program Expansion

At capacity;
oncology
wants
expansion

- 4+ week wait for new patient appointments
- Capacity to see ~ 5% of oncology patients
- No capacity to see additional patients

Business
Proposal
Submitted

- Requested 1 FTE MD & 1 FTE RN
- Practice data (↓ acute care utilization; ↑ hospice utilization)
- Goals: decrease wait time for new patients, expand capacity, see patients earlier in trajectory

Hospital
prioritizing
oncology
expansion

- Submitted updated outcomes data:
- # hospital days saved
- # of hours of oncology appts opened by PC addressing pts' symptoms

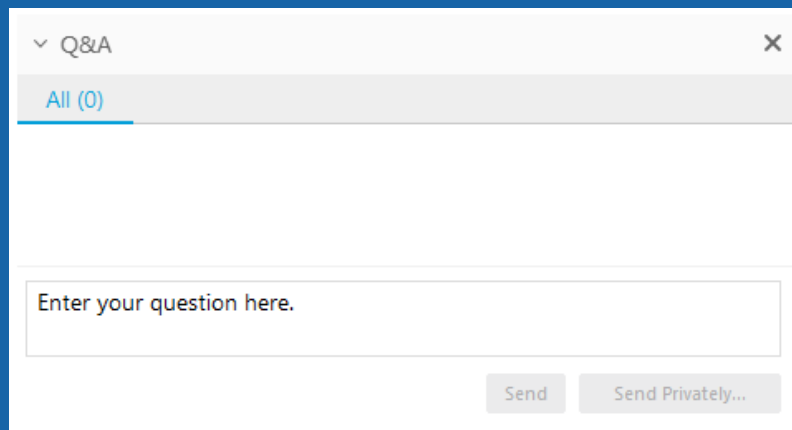
Positions
approved!

Take Home Points

- Align palliative care's vision with stakeholders' vision
- Design program based on committed resource allocation
- Find a balance between being malleable without compromising the program's integrity
- Deliberate data analysis: match to needs assessment
- Ongoing practice improvement: Pilot, assess, revise

Questions?

Please type your question into the questions pane on your WebEx control panel.



A screenshot of the WebEx Q&A pane. The pane has a title bar with a dropdown arrow, the text "Q&A", and a close button (X). Below the title bar is a tab labeled "All (0)". The main area of the pane is empty. At the bottom, there is a text input field with the placeholder text "Enter your question here." and two buttons: "Send" and "Send Privately...".