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

Register at www.capc.org/events/
Office-Based Palliative Care Practices: Strategies for Success

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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
<table>
<thead>
<tr>
<th>Practice</th>
<th>Inception Date</th>
<th>Type</th>
<th>Current FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mount Sinai Hospital Supportive Oncology</td>
<td>March 2013</td>
<td>Embedded Co-management</td>
<td>2 MDs (total 14 sessions per week) 1 NP (total 5 sessions per week) 2 RNs</td>
</tr>
<tr>
<td>Mount Sinai Chelsea Supportive Oncology</td>
<td>October 2018</td>
<td>Embedded Co-management</td>
<td>1 MD (total 7 sessions/week) 1 RN</td>
</tr>
<tr>
<td>Mount Sinai Queens Supportive Oncology</td>
<td>May 2018 <em>Pilot project</em></td>
<td>Embedded Consultative only</td>
<td>0.1 FTE NP &amp; 0.1 FTE SW (1 session per week)</td>
</tr>
<tr>
<td>Mount Sinai Hospital Supportive Cardiology</td>
<td>May 2018</td>
<td>Embedded Consultative</td>
<td>1 FTE NP (~ 1.5 sessions per week, remainder of time inpt w/ CHF team)</td>
</tr>
<tr>
<td>Mount Sinai Hospital palliative care (fellows; some geri-PC)</td>
<td>1990s</td>
<td>Co-located Co-management</td>
<td>9 sessions/week (~ 0.2 FTE attending MD)</td>
</tr>
<tr>
<td>Mount Sinai Downtown palliative care (fellows; some geri-PC)</td>
<td>2013 (merger)</td>
<td>Co-located Co-management</td>
<td>9 sessions/week (~ 0.3 FTE attending MD)</td>
</tr>
</tbody>
</table>
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!
FOCUS ON ONCOLOGY:
• Reduction in Emergency Department utilization
• Reduction in hospital admissions
• Increase in hospice referrals
• Reduction in hospital mortality

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 $\rightarrow$ 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!

<table>
<thead>
<tr>
<th>?</th>
<th>Specifics</th>
<th>Answer</th>
<th>Mount Sinai Supportive Oncology Pearls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who</td>
<td>Who is the target population?</td>
<td>Clinician vs. criteria initiated referrals</td>
<td>Did not start with trigger referrals. Goal: build trusting relationships first. Would need to identify criteria and match volume to PC capacity</td>
</tr>
<tr>
<td></td>
<td>Who provides palliative care?</td>
<td>MD/NP/RN SW Chaplain</td>
<td>Onc has disease-specific SW &amp; outpatient chaplain. Shared SW allows PC to be more embedded in oncology. No physical space for extra SW visits</td>
</tr>
<tr>
<td></td>
<td>Who refers the patients?</td>
<td>Med onc, rad onc, surg onc</td>
<td>Any team member (MD, PA, NP, RN, SW)</td>
</tr>
<tr>
<td></td>
<td>Who provides administrative support? Who answers calls?</td>
<td>Onc for registration, vitals, and scheduling. PC AA for daytime calls</td>
<td>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</td>
</tr>
<tr>
<td>What</td>
<td>What is PC’s role?</td>
<td>co-manage or consult?</td>
<td>When practice started, PC MD offered individual needs assessment with every oncologist. Each oncology provider had slightly different view.</td>
</tr>
<tr>
<td></td>
<td>What is the scope of practice?</td>
<td>Decide on scope of specialty-PC</td>
<td>What can PC provide? Does your skill set overlap with that of an addiction specialist, chronic pain specialist, psychologist?</td>
</tr>
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## Take Time to Plan in Advance!

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</thead>
<tbody>
<tr>
<td><strong>When</strong></td>
<td>When will you be available?</td>
<td>Defined sessions Phone calls M-F</td>
<td>Balance accessibility and boundaries</td>
</tr>
<tr>
<td></td>
<td>When to expand?</td>
<td>When sessions about 50-60% full</td>
<td>It may take longer than expected to analyze data for proposals &amp; receive approval</td>
</tr>
<tr>
<td><strong>Where</strong></td>
<td>Where will services be provided?</td>
<td>Embedded within oncology clinic</td>
<td>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”)</td>
</tr>
<tr>
<td><strong>Why</strong></td>
<td>Why is ambulatory PC needed?</td>
<td>Hospital metrics</td>
<td>Plan in advance: which data will you collect to match outcomes to metrics? Who will collect it? Who will analyze it?</td>
</tr>
<tr>
<td><strong>How</strong></td>
<td>How will referrals be made?</td>
<td>Require EPIC referral</td>
<td>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</td>
</tr>
<tr>
<td><strong>How long will patients see pall care?</strong></td>
<td>Define scope: Pts with “ongoing specialty-level PC needs”</td>
<td>Pts who complete curative-intent treatment &amp; become NED, may be followed for ~ 1 more year, depending on recurrence risk. We are not a survivorship practice. (stakeholders!!)</td>
<td></td>
</tr>
</tbody>
</table>

Scarborough et al. J Palliat Med 2018
Workflow: Create processes that streamline workflow and track data

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

Order Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for Referral</td>
<td>Physical symptoms and advance care planning</td>
<td></td>
</tr>
<tr>
<td>Last anti-neoplastic treatment</td>
<td>Ongoing/currently receiving treatment</td>
<td></td>
</tr>
<tr>
<td>Current symptom regimen</td>
<td>Opioids</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Patient Characteristics</th>
<th>Social Circumstances or Anticipatory Bereavement</th>
<th>Staff Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Limited anti-cancer treatment options</td>
<td>• Family/caregiver limitations</td>
<td>• Complex care coordination issues</td>
</tr>
<tr>
<td>• High risk of poor pain control</td>
<td>• Inadequate social support</td>
<td>• Compassion fatigue</td>
</tr>
<tr>
<td>• High symptom burden</td>
<td>• Intensely dependent relationships</td>
<td>• Moral distress</td>
</tr>
<tr>
<td>• Palliative stenting/venting gastrostomy</td>
<td>• Limited access to care</td>
<td>• Burnout</td>
</tr>
</tbody>
</table>
| • Frequent ED visits or readmissions | • Family discord | }

## Social Circumstances or Anticipatory Bereavement

- High distress score
- Resistance to engaging in ACP discussions or need to clarify goals of care
- Rapidly progressive functional decline or persistently poor ECOG
- Request for hastened death

## Patient Characteristics

- High symptom burden
- Palliative stenting/venting gastrostomy
- Frequent ED visits or readmissions
- Request for hastened death
- Resistance to engaging in ACP discussions or need to clarify goals of care
- High distress score
- Rapidly progressive functional decline or persistently poor ECOG
- 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
When: It’s too early until it’s too late

Function and Symptoms

Diagnosis: high physical symptoms & anxiety

Symptoms & coping may improve as pt starts treatment (less “unknown”)

Disease progression, declining performance status, increasing symptom crises

Time

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

### 2013:
- Mar: 4 MD sessions/week
- Sept: 0.5 FTE NP (empty) converted to 1 FTE RN

### 2014:
- Jan: RN hired; MD 8 sessions/week
- July: 6 week wait for new pts; hospital approves 2nd MD salary line

### 2015:
- Oct: 2nd MD starts; practice expands to 12 sessions/week

### 2016:
- Ongoing growth
- May: internal analysis for next growth
- Aug: 1 FTE NP requested & approved

### 2017:
- Jan: 1 MD leaves
- June: NP starts

### 2018:
- Apr: internal analysis for next growth
- Oct: proposal to add 2nd MD & RN

### 2019:
- Mar: 2nd MD starts
- June: 2nd RN starts
- Aug: 1st RN promoted

### 2020 Planning:
- automatic referrals
Supportive Oncology (MSH) Volume

Periods of high acuity followed by recovery or mortality

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

6 MD sessions and 6 NP sessions; NP sees only established patients
Sample Daily Schedule

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

Hospital moved primary care off 6th floor, relocated myeloma practice to 6, left Supp Onc on 3rd

PC toured 6th floor; outlined resources needed for successful move

Hospital plan to move Supp Onc out of Cancer Center to make space for more oncologists

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.