Development of an Outpatient Palliative and Supportive Care Nurse Practitioner Practice: Dos, Don'ts and Maybes

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Objectives

- Describe at least one type of needs assessment to perform prior to implementing an outpatient program
- Identify three challenges associated with development of an outpatient program
- Discuss two different models with which to provide outpatient palliative and supportive care

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Organization

- UW Medicine is a comprehensive integrated health system consisting of:
  - Four Hospitals: one district (Valley Medical Center), one community (Northwest Hospital), two academic (Harborview Medical Center and UW Medical Center)
  - UW School of Medicine
  - Outpatient Primary and Specialty Care Clinic Network
  - Airlift Northwest (air transport and medical treatment program serving Washington, Idaho, Alaska, and Montana)
- Unique aspects:
  - Limited shared services (IT, strategic planning, executive leadership)
  - Institutional-specific budgeting and finance, salary and benefits, medical staff credentialing (no shared staffing)
  - Institutional-specific palliative care programs

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Cambia Palliative Care Center For Excellence

- Launched in 2012 after receiving a generous $10 million gift from the Cambia Foundation
- Goal: To give every patient with serious illness access to high-quality palliative care focused on relieving symptoms, maximizing quality of life and ensuring care that concentrates on patients' goals.
- Does not provide operational funding for institutional palliative care programs
- Additional information on the Cambia Palliative Care Center of Excellence can be found at: http://depts.washington.edu/pallcntr/
- Annual Report: http://depts.washington.edu/pallcntr/assets/cambiapcceannualreport2015.pdf

Northwest Hospital and Medical Center

- 281 bed, non-teaching, community hospital serving the north end of Seattle and King County
- Large geriatric population
- Maintains an outpatient network of primary and specialty clinics separate from the larger UW Medicine Outpatient Network
- Affiliated with UW Medicine in 2010
- Institutional-specific budget and finances
- Inpatient palliative and supportive care service launched in February 2013
- Outpatient primary, palliative and supportive care program relocated to Northwest Campus from Harborview Campus in September 2013

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Outpatient Primary, Palliative, Supportive Care – Clinical Setting

- Staff office located on the campus of Northwest Hospital and Medical Center in N. Seattle
- Services provided in variety of settings:
  - 90% non-clinic (private homes, assisted living facilities, adult family homes/residential care homes)
    - Service area: majority of patients reside within 20 miles of office
  - 10% embedded clinics (primary care and oncology)

Populations Served - Criteria

- “Loose” referral criteria to improve program access
- Service criteria (all programs, embedded clinic and non-clinic)
  - Anyone with a life-limiting or life-threatening illness (no prognosis required)
- Service criteria (non-clinic visit)
  - Difficulty making office-based appointments due to frailty, weakness, or other associated clinical issues
  - Frequently missed office-based appointments

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Populations Served - Criteria

➔ General criterion for **consultative palliative and supportive care** include:

- Patients with a life-limiting illness for which there is no cure (no prognosis criteria is required) and who need assistance with:
  - Management of complex pain and other associated symptoms **and/or**
  - Clarification of goals or advanced care planning **and/or**
  - Issues of grief, loss, or coping related to the care of the patient or other palliative care issues

Population Served - Criteria

- General criterion for receiving **primary palliative and supportive care**:
  - Patients with a life-limiting illness for which there is no cure (no prognosis criteria is required) and who need assistance with:
    - Management of complex pain and other associated symptoms **and/or**
    - Clarification of goals or advanced care planning **and/or**
    - Issues of grief, loss, or coping related to the care of the patient or other palliative care issues
    - Management of primary care related diagnosis and issues and;
  - Patient has no PCP, the current PCP would like to transfer care, the patient or family would like to transfer care

Populations Served – Referral Process

- Referral Sources:
  - Patients and families may self refer
  - Network primary care clinics
  - Assisted Living Facilities and Adult Family Homes
  - Oncology Clinic
  - Inpatient Palliative and Supportive Care Service
- Referral Process:
  - Internally via EPIC (EMR system)
  - Direct contact with clinic (via email and telephone)

Population Served - Demographics

- Primary Diagnoses Served:
  - Major Neurocognitive Disorders (80%)
  - Cancer (10%)
    - Primary – lung, breast, colon, prostate
  - Other (10%)
    - Primary – COPD and CHF

Populations Served - Demographics

- Primary Diagnosis by Location:
  - Embedded clinic:
    - Cancer (90%)
    - CHF, COPD, other (10%)
  - Non-clinic visit:
    - Major Neurocognitive Disorder (95% assisted living and residential care facility)
    - Cancer, CHF, COPD (5% private homes)

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Populations not Served

- Patients with life-limiting illness where the primary issue is opioid prescribing and management

- Patients who desire same day visits or appointments.
  - Due to the nature of our program, we are unable to guarantee the ability to provide same day, or on-demand services.
  - While there is always a provider on call, and a nurse available for triage during business hours, we cannot guarantee a same day requested provider visit.

- Patients who desire concierge-like medical provider services

Services Provided – All Programs

- Evaluation and management (actively prescribe and write orders versus consultation with "recommendations only")
  - Pain and symptom management
  - Clarification of goals of care
  - Advance care planning
  - Hospice assessment and management
  - Referral to community-based services
  - Family support and education
  - Staff education and support via presentations and lectures

Services Provided – Primary Palliative and Supportive Care Program

- In addition to all services previously listed, NP assumes responsibility for management of all primary care services as well
- **Why?**
  - Two UW studies (Owens et al and Murphy et al) demonstrated that when primary and palliative care are managed by one provider:
    - Continuity of care is improved
    - Symptom management is improved
    - Hospitalization and ED usage are decreased
  - Increased NP satisfaction with full scope of care

Delivery Model

- NP model of care
  - APRN Consensus Model
  - Primary care provider with individual patient panel (includes clinic and non-clinic patients, as well as consultative and primary)
  - One physician who does not see or consult on patients – signs Home Health orders, CTI, and VA forms twice per week
- 24 hour ARNP coverage, rotated weekly (each NP receives an additional $6k annually to compensate for on-call time, average 7 days per month)
  - UW Medicine provides telephone triage after-hours as first line screening, calls to NP on call prn
- Nursing case management and support 5 days per week
  - Screening and triage of all incoming clinical calls during business hours
  - Telephone pain and sx assessment (triage and follow up)
  - Family updates and support
  - Rx refills and pre-authorization
  - Referrals and liaison to hospice and homecare teams, DME issues

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Delivery Model - Competencies

- **NP**
  - Master's level credentialed as staff NP
  - Clinical Doctoral level (must be DNP, not PhD) credential as attending NP (increased compensation)
  - Competency assessment annually by Practice Chief
    - HPNA *Competencies for Hospice and Palliative Advanced Practice Nurse*
    - GAPNA *Consensus Statement on Proficiencies for APRN Gerontological Specialist*
  - ACHPN certification required within one year of joining practice

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Delivery Model - Competencies

- **RN Charge RN/Case Manager**
  - HPNA *Competencies for the Hospice and Palliative Registered Nurse*
  - CHPN certification within one year of hire
- **LPN**
  - HPNA *Competencies for the Hospice and Palliative Licensed Nurse*
  - CHLPN certification within one year of hire

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Team Composition

- Palliative and Supportive Care Practice Chief
- Attending or Staff Nurse Practitioner
- NP Fellow in Geriatrics and Palliative Care
- Practice Manager
- RN Charge Nurse/Case Manager
- LPN
- Program Coordinator

Team Composition

- **Palliative and Supportive Care Practice Chief** (inpatient and outpatient programs)
  - 1.0 FTE (100% palliative and supportive care)
    - 80% clinical, 20% administrative
  - Funding: 80% billing, 20% hospital administration
  - Requirements: DNP, NP (adult or geriatric), ACHPN certification, minimal 5 years palliative care experience; DEA, NPI, unencumbered license
  - Responsibilities:
    - All clinical care and related issues and policies
    - NP supervision, mentoring, education
    - Collaboration with practice manager on operational issues

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Team Composition

- **Attending or Staff Nurse Practitioner**
  - 2.0 FTE (100% outpatient palliative and supportive care)
  - Funding Source
    - 50-60% patient billing and 40-50% hospital administration
  - Requirements:
    - Attending NP: DNP, specialty palliative certification preferred (ACPHN), at least 2 years experience in geriatric long term or primary care; at least one year experience in palliative care or hospice preferred
    - Staff NP: MSN, specialty palliative certification preferred (ACPHN), at least 2 years experience in geriatric longer or primary care; at least one year experience in palliative care or hospice preferred
    - DEA, NPI, unencumbered license
  - Responsibilities:
    - Manages a panel of 100 to 500 primary and palliative care patients
    - Takes call one week per month
    - Participates in weekly IDT

Team Composition

- **NP Fellow in Geriatrics and Palliative Care** (one year clinical fellowship)
  - 1.0 FTE (100% palliative and supportive care)
  - Funding Source
    - 50% philanthropy, 50% patient billing
  - Requirements: MSN or DNP with certification as ANP, GNP or FNP;
  - Responsibilities:
    - Manages primary and palliative care needs of small patient panel
    - Performs triage and new patient visits as assigned
    - Attends UW Medicine Palliative Care and Geriatrics Grand Rounds twice weekly
    - Completes monthly specialty rotations as assigned
    - Completes 100 CEU hours over 12 month clinical fellowship
    - Bills in accordance with UW Medicine policies

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Team Composition

- **Practice Manager** (non-clinical position)
  - 1.0 FTE (60% dedicated to palliative care, 40% other non-palliative care programs)
  - Funding Source: hospital administration
  - Requirements: MS Healthcare Administration, MBA – Healthcare; five years administrative experience in an outpatient setting
  - Responsibilities:
    - All non-clinical operational aspects of program:
      - Office-based personnel
      - Operation policies and procedures
      - Liaison to hospital administration and billing staff
      - Administrative issues – day to day operations – budget development
      - Data procurement and research
      - Works in collaboration with the Practice Chief on clinical issues

Team Composition

- **RN Charge Nurse/Case Manager** (office-based)
  - 1.0 FTE (100% outpatient palliative and supportive care)
  - Funding Source: hospital administration
  - Requirements: BSN, specialty palliative certification preferred (CHPN), at least 3 years experience in hospice and palliative care; unencumbered license
  - Responsibilities:
    - All office-based clinical issues:
      - Clinical supervision of LPNs
      - Assignment of clinical office duties
      - Telephone triage and assessment
      - DME, hospice and home health liaison

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Team Composition

- **LPN** (office-based)
  - 2.0 FTE (100% outpatient palliative and supportive care)
  - Funding Source: hospital administration
  - Requirements: licensed practice nurse, specialty palliative certification preferred (CHLPN), 3 years experience in hospice, palliative care, or long term care; unencumbered license
  - Responsibilities:
    - Duties as assigned by charge RN
    - Rx refills and pre-authorization
    - Liaison with assisted living and adult family home staff
    - Documentation, scanning, and management of medical records received from outside entities
    - Telephone support

Team Composition

- **Program Coordinator**
  - 1.0 FTE (100% outpatient palliative and supportive care)
  - Funding Source: hospital administration
  - Requirements: HS diploma, college preferred; 5 years experience in the outpatient healthcare setting; must be proficient in EPIC, MS Office; must have understanding of insurance and billing process
  - Responsibilities:
    - Scheduling of provider visits
    - Patient registration and insurance verification
    - Data collection and maintenance

Outcomes - Current

- Family satisfaction
  - DNP student capstone project to develop specific satisfaction measurements of family members of people with major neurocognitive disorder under way (completion March 2016)
  - Further development and refine TBD
- Utilization of ED and Hospital Services
  - Tool currently being developed by DNP student
- Hospital and ED revenue generated by program
- Practitioner revenue generated
- Staff satisfaction (completed via Survey Monkey in 2015)

Outcomes - Desired

- Hospice utilization and LOS (data collection currently underway)
- Location of death (limited by EMR and staffing for data collection)
- Symptom assessment and management via standardized tool (limited by EMR and staffing for data collection)
- All of the above were previously measured during IRB approved studies, but have not been measured recently due to the reasons stated

Hindsight

- Never hire new graduate NPs (without fellowship)
  - Patient complexity
  - Lack of support in home non-clinic visit program
  - Anxiety, distress, and lack of job satisfaction (for NP and other staff)

- Never do chronic pain management
  - Done initially when program launched (not currently)
  - Labor intensive
  - Lack of provider and office staff satisfaction

Hindsight

- Be cautious about moving program locations within health system
  - Different institutional cultures, different senior leadership do not always see the value of the work
- Limit geographic area
- Hire first, grow second
- Start holding weekly IDT meetings immediately

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Program Dos (Successes)

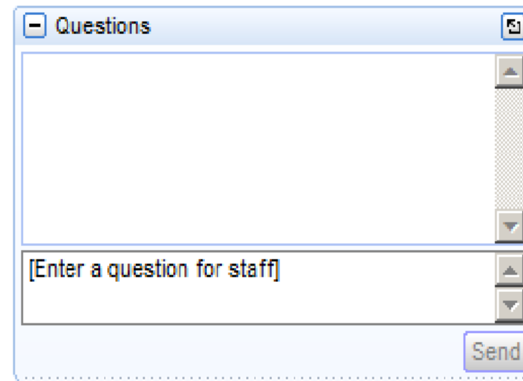
- Serve underserved populations: non-clinic visit patients, improving family and provider satisfaction
  - If possible, develop "mini" focus on people with major neurocognitive disorders – significant ability to make an impact
- Use RN/LPN office staff - allows for increased provider productivity and satisfaction
- Hold weekly IDT meetings – improved communication and team building
- NP practice, ideally with experience as a hospice RN
- Secure support from "important" executive leadership
- Provide care and support to "important" people in the community
- Build philanthropic relationship to support 50% of an NP Fellowship

Threats and Challenges

- Changes in institutional priorities (competing interest from other programs)
- Changes in leadership
- Expectations that programs will be self-sustaining in a fee-for-service system
- Rapid growth
- Lack of qualified NP candidates
- Traffic and urban area growth
- Lack of Medicare ACN growth that supports capitation

Questions and Comments

- Do you have questions for the presenter?
- Click the hand-raise icon ( )on your control panel to ask a question out loud, or type your question into the chat box.



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CAPC Events and Webinar Recording

- For a calendar of CAPC events, including upcoming webinars and office hours, visit
  - https://www.capc.org/providers/webinars-and-virtual-office-hours/
- Today's webinar recording can be found in CAPC Central under **'Webinars: Community-Based Palliative Care'**
  - https://central.capc.org/eco_player.php?id=186

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