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

Darrell Owens, DNP
Attending Nurse Practitioner and Practice Chief
Primary, Palliative and Supportive Care Programs,
UW Medicine at Northwest Hospital and Medical Center

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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
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
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/

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
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
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)
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
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
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
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
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
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
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
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
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.
CAPC Events and Webinar Recording

→ For a calendar of CAPC events, including upcoming webinars and office hours, visit

→ Today’s webinar recording can be found in CAPC Central under ‘Webinars: Community-Based Palliative Care’