Building a Palliative Care Program From the Inside Out

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Driving Factors

- Population Health
- Cost of Oncology Care
- Choosing Wisely (ASCO & ASTRO)
- Better quality of life at EOL (Temel, 2010)
- Standard of Care—NCCN, ASCO, CoC
Segment Care Management Models Based on Patient Care Needs

Three Distinct Patient Populations and Care Strategies

- **High-Risk Patients**: 5% of patients; usually with complex disease(s), comorbidities
  - Trade high-cost services for low-cost management

- **Rising-Risk Patients**: 15%-35% of patients; may have conditions not under control
  - Prevent patients from becoming high-risk

- **Low-Risk Patients**: 60%-80% of patients; any minor conditions are easily managed
  - Keep patients healthy, loyal to the system

Studies Listed


Choosing Wisely

ASCO Recommendations
Don’t use therapy for:

- Solid tumor pts with low ECOG
- No benefit from prior interventions
- Not eligible for clinical trial
- No strong evidence supporting clinical value

ASTRO Recommendations
Don’t routinely:

- Use extended fractionation schemes (>10 fractions) for palliation of bone metastasis
- Use non-curative therapy without defining goals of treatment and considering palliative care referral
**Challenges Identified within KCC**

- Inadequate communication between department/treatment teams
- Lack of education related to PC or EOL
- No budget, use existing resources
- Lack of documentation/ data mgmt on Advance Directives
- Hospital PC team focused on ICU
- Focus of CLN team was on newly diagnosed patients, not on PC or EOL care
- Reactive versus proactive use of resources
Starting Point

- In-patient PC team
- Limited out-pt PC clinic with the KCC
- Cancer LifeNet Program in place
- Updating Advance Directive policy and in-servicing all team members
- Physician Champion--Oncologist board certified in oncology & PC and Medical Director on-board
- NP expertise
- Leadership with background in PC/Hospice care
Workgroup

- Established workgroup Summer 2014
- Identified key TMs/leaders
- Included physicians in the early planning phases
- Literature review as to what has been done
- Reviewed national metrics and determined outcome measures
- Looked at various existing models
- Developed our model
Palliative Care Models

- Embedded Specialist RN/MD
- Inpatient Consult Service
  - Dedicated Inpatient Unit
- Outpatient Clinic
  - Home-Based Care

- Existing at UM UCMC
Hallmarks of an Integrated Program
Advisory Board, 2013

✓ Oncologists trust the palliative care team

✓ Palliative care team scrupulous about care coordination

✓ Advance Care Planning routine for all cancer patients

✓ Palliative care team highly visible in cancer center

✓ Clinicians share responsibility for initiating palliative care

✓ Oncology clinicians trained to provide palliative care
Integrated Palliative Care Model, Kaufman Cancer Center

Support

- Patient-Centered Care
- Advance Care Planning
- AD & MOLST
- Body, Mind, & Spirit--Integrative Health--Meditation, Yoga, massage, MBSR, exercise
- Support Groups
- Individual & Family Counseling
- Community Resources--Hospice, Hooper House, Palliative HC
- ST Bereavement

Communication

- Patient & Family
  - KCC Providers & Team Members
  - Community-Based Health Care Providers
    - Goal of Care Meetings
    - PC Case Conference
    - EMR Documentation

Symptom Management

- Assessing symptoms--physical, emotional, psychological, financial toxicity
- Recommendations from PC Case Conference
  - Medication Management
  - Specialist Referral
- Behavioral Health & Supportive Care

Coordination of Care

- KCC Treatment Teams--infusion, Radiation, Surgery, & Support Care
- Multi-D Providers
- In-patient Care Teams--Palliative
- Out-Patient Palliative Care Clinic
- Community-based Providers--home care, hospice, other MDs
- Choosing Wisely
- PC Case Conference

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Palliative Care Decision Process

Physical
- Evidence of non-curative disease and/or
- Performance Status Assessment 2 or >

Trigger
- Nurse Navigator reminder
- Palliative Care 5-Item Questionnaire in ARIA
- Names forwarded to Multi-D secretary for conference

PC Confirmed
- Palliative Care Conference
- Communicate with oncologist the PCC recommendations
- Goals of Care Meeting with MD & MSW, other disciplines prn

Schedule Appt
- Practice schedules appointment
- Notifies Multi-D secretary to reserve consult room
## Palliative Care 5-Item Questionnaire

### Table 1.

Five-Item Palliative Care Screening Tool

<table>
<thead>
<tr>
<th>Screening Items</th>
<th>Points</th>
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<tbody>
<tr>
<td>1. Presence of metastatic or locally advanced cancer</td>
<td>2</td>
</tr>
<tr>
<td>2. Functional status score, according to ECOG performance status score</td>
<td>0-4</td>
</tr>
<tr>
<td>3. Presence of one or more serious complications of advanced cancer usually</td>
<td>1</td>
</tr>
<tr>
<td>associated with a prognosis of &lt; 12 months (e.g., brain metastases, hypercalcemia, delirium, spinal cord compression, cachexia)</td>
<td></td>
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<tr>
<td>4. Presence of one or more serious comorbid diseases also associated with poor</td>
<td>1</td>
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<tr>
<td>prognosis (e.g., moderate-severe COPD or CHF, dementia, AIDS, end stage renal</td>
<td></td>
</tr>
<tr>
<td>failure, end stage liver cirrhosis)</td>
<td></td>
</tr>
<tr>
<td>5. Presence of palliative care problems</td>
<td></td>
</tr>
<tr>
<td>Symptoms uncontrolled by standard approaches</td>
<td>1</td>
</tr>
<tr>
<td>Moderate to severe distress in patient or family, related to cancer diagnosis or therapy</td>
<td>1</td>
</tr>
<tr>
<td>Patient/family concerns about course of disease and decision making</td>
<td>1</td>
</tr>
<tr>
<td>Patient/family requests palliative care consult</td>
<td>1</td>
</tr>
<tr>
<td>Team needs assistance with complex decision making or determining goals of</td>
<td>1</td>
</tr>
<tr>
<td>care</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>0-13</td>
</tr>
</tbody>
</table>

Abbreviations: CHF, congestive heart failure; COPD, chronic obstructive pulmonary disease; ECOG, Eastern Cooperative Oncology Group.

Palliative Care Conference Model

PC Conference

- Weekly at 8am Palliative Care Conference Summary Sheet completed
- Interdisciplinary team reviews newly identified patients
- Recommendations communicated to oncologist for further direction and/or schedule Goals of Care meeting
- Started meeting October 2014

PC CC Team Members

- Nurse Practitioners
- Nurse Navigators
- Infusion Center Nurses
- Radiation Nurses
- Social Workers
- Nutritionist
- Pharmacists
- Hospice House rep
- In-pt PC nurse practitioner
- Physicians ad hoc
Palliative Care Conference Overview

- Patient Presented--review of current status
  - Understanding of the disease status, treatment response & overall prognosis of patient
  - Current functional status of patient
  - Patient/family dynamics

- Discipline Report
  - MD/NP
  - Nurse Navigator & Treatment Nurse
  - SW
  - RD

- Summary & Recommendations:
  - Symptom management
  - Goals of Care/Advance Care Planning Patient & Family meetings
  - Document in EMR
PC Specialists Workgroup

- Self-selected group with interest in PC
- Agree to attend meetings and commit to additional educational development
- Education module developed
- Invite subject experts to present

- Moving towards—Subject Experts i.e: Pharmacist – pain mgmt./conversions ONN – Goals of Care meetings
- Palliative Care Certifications
Goals of Care Meeting

- Pt/Family understand current medical status
- Summarize “big picture”
- Respond to emotions
- Decision-making
- Goal Setting
- Document and update team
Goals of Care & AD Resources & References

- SPIKES protocol (CMAJ, 2013)
- The Mount Sinai Hospital Palliative Care Goal-Setting-Conference Pocket Card
- Palliative Care and the Human Connection: Ten Steps for What To Say and Do (Video from, CAPC)
- The One Slide Project
- Respecting Choice
- The Conversation Project
- Advance Care Planning Canada

Setting up the interview
- **P** assessing patient’s Perception
- **I** obtaining the patient’s Invitation
- **K** giving Knowledge and information to the patient
- **E** addressing the patient’s Emotional with Empathic responses
- **S** Strategy & Summary
A Shift in Culture in the KCC

- Proactive vs reactive
- Expanded awareness & language sensitivity
- Palliative care & hospice
- Advance Directives/MOLST & Advance Care Planning
- Population Health & Value-based care
Community Partnerships

- Hospice and Palliative Care Agencies
- Meet and Greet - Dec 2014
- Hospice House Rep - March 2015
## Palliative Care Dashboard

Advisory Board, 2013

<table>
<thead>
<tr>
<th>Measure</th>
<th>Definition</th>
<th>Benchmark</th>
<th>Endorsed By</th>
</tr>
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<tbody>
<tr>
<td><strong>Process – Appropriate Utilization</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>New chemotherapy at end-of-life</td>
<td>Percent of patients who died from cancer that started new chemotherapy regimen in the last 30 days of life</td>
<td>Best observed: &lt;2%&lt;sup&gt;6&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Chemotherapy utilization at end-of-life</td>
<td>Percent of patients who died from cancer that received chemotherapy in the last 14 days of life</td>
<td>National average: 6%&lt;sup&gt;15&lt;/sup&gt;, 10&lt;sup&gt;th&lt;/sup&gt; percentile: 4%&lt;sup&gt;16&lt;/sup&gt;, 50&lt;sup&gt;th&lt;/sup&gt; percentile: 5.9%&lt;sup&gt;17&lt;/sup&gt;, 90&lt;sup&gt;th&lt;/sup&gt; percentile: 7%&lt;sup&gt;18&lt;/sup&gt;</td>
<td>NQF #0210&lt;sup&gt;19&lt;/sup&gt;, ASCO&lt;sup&gt;20&lt;/sup&gt;</td>
</tr>
<tr>
<td>Hospitalizations at end-of-life</td>
<td>Percent of patients who died from cancer with one or more hospitalizations in the last 30 days of life</td>
<td>Best observed: &lt;4%&lt;sup&gt;7&lt;/sup&gt;</td>
<td>NQF #0212&lt;sup&gt;8&lt;/sup&gt;</td>
</tr>
<tr>
<td>ED utilization at end-of-life</td>
<td>Percent of patients who died from cancer with one or more ED visits in last 30 days of life</td>
<td>Estimated typical performance: 8–10%&lt;sup&gt;9&lt;/sup&gt;, Best observed: 2%&lt;sup&gt;10&lt;/sup&gt;</td>
<td>NQF #0211&lt;sup&gt;11&lt;/sup&gt;</td>
</tr>
<tr>
<td>ICU utilization at end-of-life</td>
<td>Percent of patients who died from cancer admitted to ICU in last 30 days of life</td>
<td>Estimated typical performance: 8 to 12%&lt;sup&gt;12&lt;/sup&gt;, Best observed: &lt;4%&lt;sup&gt;13&lt;/sup&gt;</td>
<td>NQF #0213&lt;sup&gt;14&lt;/sup&gt;</td>
</tr>
<tr>
<td>Acute care utilization at end-of-life</td>
<td>Percent of patients who died from cancer within an acute care setting</td>
<td>Best observed: &lt;17%&lt;sup&gt;21&lt;/sup&gt;</td>
<td>NQF #0214&lt;sup&gt;22&lt;/sup&gt;</td>
</tr>
<tr>
<td>Hospice utilization</td>
<td>Percent of patients who died from cancer who were not admitted to hospice</td>
<td>Estimated typical performance: 65 to 85%&lt;sup&gt;23&lt;/sup&gt;, Best observed: &lt;55%&lt;sup&gt;24&lt;/sup&gt;</td>
<td>NQF #0215&lt;sup&gt;25&lt;/sup&gt;</td>
</tr>
<tr>
<td>Hospice referral timeliness</td>
<td>Percent of patients who died from cancer, were admitted to hospice, and spent less than 8 days there</td>
<td>Estimated typical performance: 27–35%&lt;sup&gt;26&lt;/sup&gt;, Best observed: 8%&lt;sup&gt;27&lt;/sup&gt;</td>
<td>NQF #0216&lt;sup&gt;28&lt;/sup&gt;</td>
</tr>
<tr>
<td>Hospice median length of stay</td>
<td>Median length of stay for patients who were admitted to hospice</td>
<td>National median length of stay: 19.7 days&lt;sup&gt;29&lt;/sup&gt;</td>
<td>NHPCO&lt;sup&gt;30&lt;/sup&gt;</td>
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### KCC Palliative Care Outcome Measures

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<tbody>
<tr>
<td><strong>Proportion receiving chemotherapy in the last 14 days of life</strong></td>
<td>Average: 5.6%-6.4%</td>
<td>13%</td>
<td>3%</td>
<td>4%</td>
<td>1%</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Proportion with more than one emergency room visit in the last days of life</strong></td>
<td>Average: 8-10% Best Observed: 2%</td>
<td>7%</td>
<td>14%</td>
<td>0%</td>
<td>3%</td>
<td>6%</td>
</tr>
<tr>
<td><strong>Proportion admitted to the ICU in the last 30 days of life</strong></td>
<td>Average: 8-12% Best Observed: &lt;4%</td>
<td>4%</td>
<td>11%</td>
<td>2%</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Proportion admitted to hospice for less than 3 days</strong></td>
<td>Average: 27-35% Best Observed: 8%</td>
<td>12%</td>
<td>12%</td>
<td>35%</td>
<td>6%</td>
<td>14%</td>
</tr>
<tr>
<td><strong>Proportion not admitted to hospice</strong></td>
<td>Average: 65-85% Best Observed: &lt;55%</td>
<td>55%</td>
<td>38%</td>
<td>45%</td>
<td>53%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Advance Care Plan</strong></td>
<td>Observed Average: 41%</td>
<td>38%</td>
<td>46%</td>
<td>87%</td>
<td>70%</td>
<td>61%</td>
</tr>
</tbody>
</table>
Next Steps

The Evolving Model

- On-going staff education and palliative expert certifications.
- Incorporating palliative consult into multi-d clinic (beginning with thoracic)
- Incorporating Palliative & Advance Care Planning information into patient education materials
- Updating our community partners-local hospice agencies & palliative home care programs
- Continuing to track outcome via Palliative Care Metrics
- Increasing visibility & awareness of in-house palliative resources(both staff & patient & families).
Thank you