

Establishing a Palliative Medicine Service in a Large Ambulatory Medical Group

Barney Newman, MD
WESTMED Medical Director

Maura L. Del Bene,
APRN, PMHNP-BC, ANP, APHPCN



Conflict of Interest

Barney Newman, MD

- No disclosures

Maura Del Bene, NP

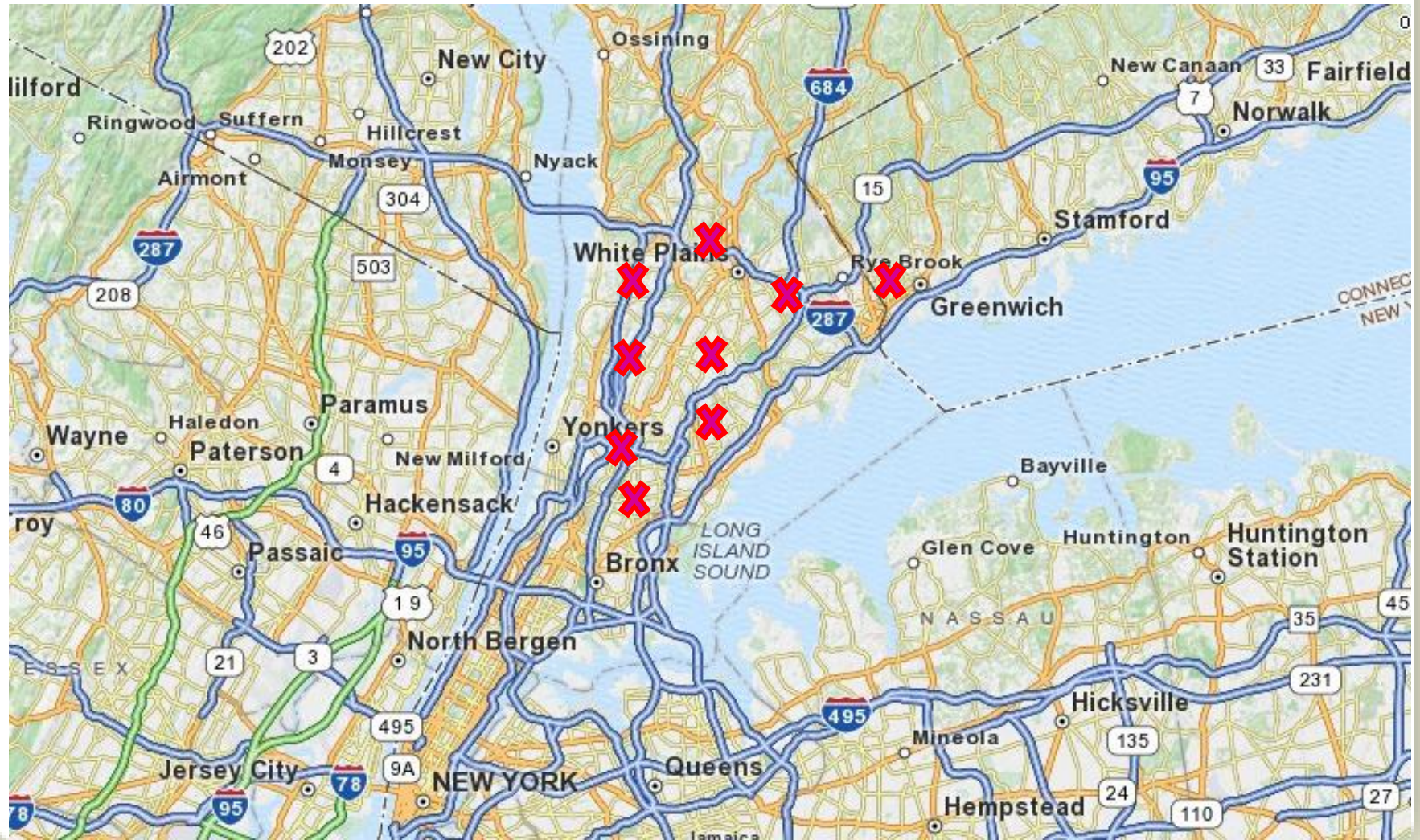
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WESTMED Medical Group



- Established 1996 by 16 physicians
- 240+ physicians caring for over 250,000 patients
- Over 30 specialties represented
- 8 offices with 4 polyclinics—90,000 s.f., 65,000 s.f., 100,000 s.f., and newest with 30,000 s.f.
- Lab and imaging services
- Advanced IT and shared EMR
- 3 Community Hospitals

Locations



Governance Structure

- Professional Corporation (PC)
- Wholly owned by physician shareholders
- “Republican” form of governance with elected shareholder Board of Directors
- Physicians in senior management roles
- No hospital or related ACO Partners

Multiple ACO-Based Contracts

- Empire Medicare Advantage
- Oxford Medicare Advantage
- Cigna Commercial
- Oxford Commercial
- Aetna Commercial
- Empire Commercial
- Medicare Shared Savings Program
- 16,000 Medicare lives
- 35,000 Commercial lives

WESTMED Shared Savings: Initial Strategic Goals

- Reduce unnecessary hospitalizations
 - Reduce unnecessary ER visits
 - Reduce “leakage” to OON facilities
 - Reduce “leakage” to OON specialties
 - Reduce unnecessary imaging, procedures
 - **Reduce inappropriate end-of-life care**
- WHILE DELIVERING HIGH QUALITY CARE**

The Right Thing to Do

- Not just a financial imperative
- Better symptom management and pain relief
- Integrates patients values and wishes into goals of care
- Better quality of life and outcomes
- Professional Responsibility – “We owe it to our patients”

Preexisting Status

- Limitations of inpatient Palliative Medicine Services
- Fragmented multiple hospice services
- Primary focus on End of Life Care
- Poor connections to outpatient system
- All too little and too late

Needs

- Outpatient pain and symptom management
- Earlier discussions of goals of care and end of life decisions
- Better coordination for transitions of care – serious illness
- Overall up streaming and integration of palliative care within WESTMED care

Economics

- FFS reimbursement not financially viable
- Private FFS Group could not justify cost
- Transition to Value Based or ACO reimbursement model shifts risk and control
- Potential for gain sharing is opportunity to invest in better care
- Requires investment and faith in PM value and ability to be successful as ACO

The WESTMED Way

- Principles and strategies employed to implement our program
- Challenges & successes: lessons learned
- Pathways, educational initiatives, tools and resources
- Future goals and plans

Palliative Care

- Specialized medical care for people with serious illness
- Providing patients & families relief from the symptoms, pain and stress of serious illness
- Regardless of prognosis
- An extra layer of support
- Working with a patient's other doctors
- Appropriate at any age and at any stage together with curative treatment

Palliative Care Specialists

- Address goals of care
- Focus on quality of life
- Offer practical support to patient & family
- Pain & symptom management
- Assist with coordination of care and transitions across fragmented medical system

Palliative Care in the Course of Serious Illness

Life Prolonging Therapy



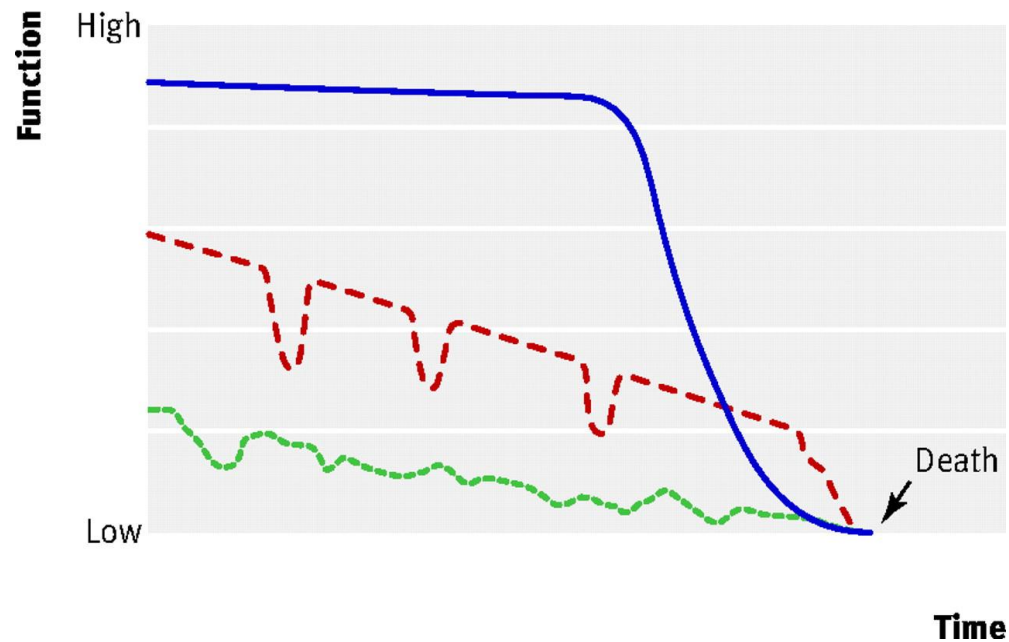
Palliative Care 2013

- Poorly Understood
 - Specialty, components, access, importance
 - Limited exposure to learn
- Continues to be dichotomy of
 - Living or Dying
 - Treatment or No Treatment
 - Hospice or Home Care
 - DNR or Full Code

Trajectories of illness/death

Number of deaths in each trajectory, out of the average 20 deaths each year per UK general practice list of 2000 patients

- Cancer (n=5)
- - - Organ failure (n=6)
- · - · - Physical and cognitive frailty (n=7)
- Other (n=2)



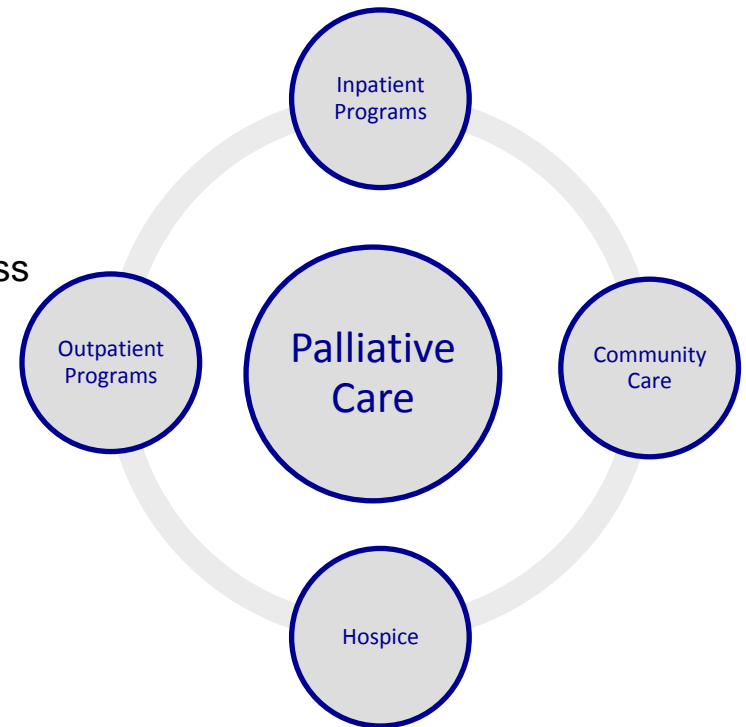
Values or Patient Needs

Hospital Data:

- Primarily based on VALUES
 - Readiness of patient and/or physician
 - Still being treated and hopeful
- Not based on patient needs
 - Pain
 - Suffering
 - Information for decision making

Spectrum of Palliative Care

- Inpatient -- hospital based
 - High risk for mortality; significant debility
 - Acute care needs preparing for living or dying
 - 75% of hospitals NYS; 62% US with 70% in Northeast
 - Joint Commission Certification 2011
- **Outpatient -- office based/clinic base**
 - Provide continuity of care over the course of illness
 - Moderate to high risk for mortality
 - Upstream concurrent with cure oriented interventions prior to crisis
 - Symptom Management, Advance Care and LT planning needs
- Community – home care model
 - VNS model with enhancements
 - RN vs. NP vs. SW model
- Hospice Care
 - High expectation for mortality – prognosis < 6 months
 - Standard interdisciplinary model
 - Formal structure within federal benefit*

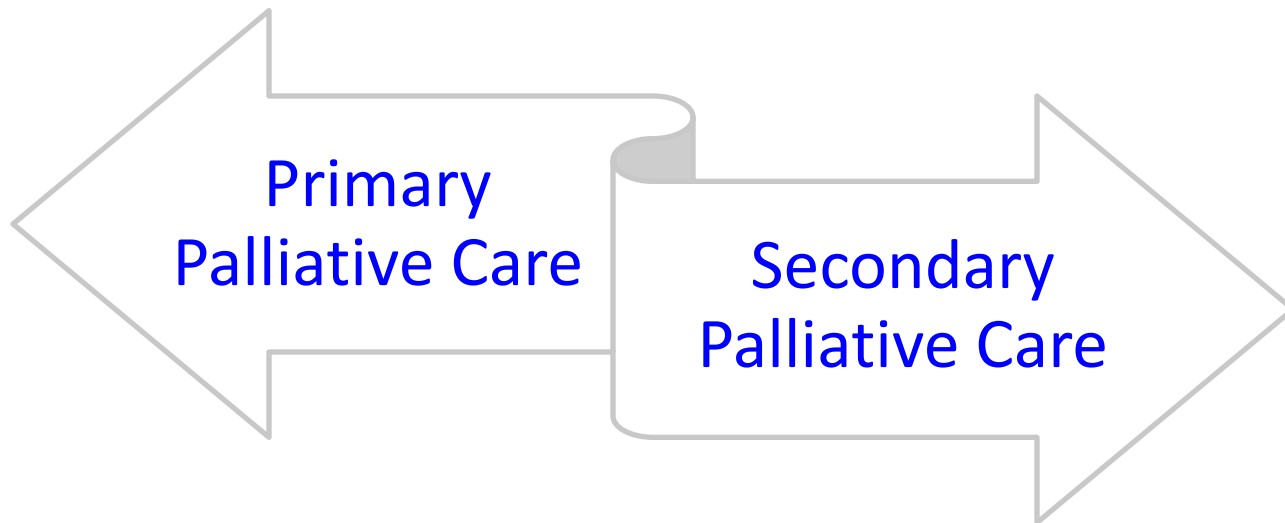


CAPC 2011 State-by-State Report Card on Access to Palliative Care

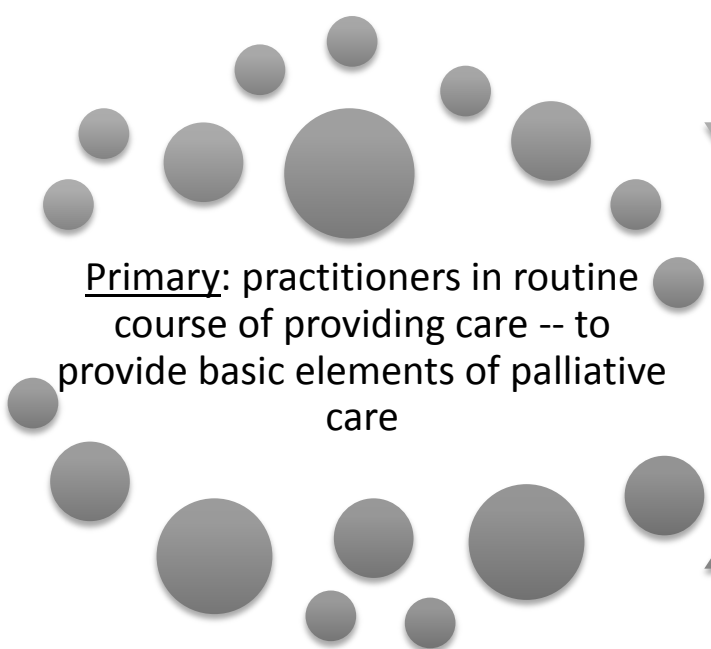
- National barriers for expansion of palliative care services
- Principle limitation of trained specialists
- One palliative medicine physician for every 1,200 persons living with a serious or life-threatening illness.
- Heralds an imperative to develop skills in **primary palliative care**

Strategy

- Continuum of care for serious illness
- Engage in culture change
- Targeted specialty engagement



Primary vs. Secondary



Primary: practitioners in routine course of providing care -- to provide basic elements of palliative care



Secondary: reserved for complex problems with higher level assessment & more comprehensive intervention through consultation



"I'm going to take your blood pressure, so try to relax and not think about what a high reading might mean for your chances of living a long, healthy life."

Primary Palliative Care

- Pain & Symptom Management
- Advance Care Planning
 - Advance directives
 - Goals and values for living with illness
- Goals of Care
 - Understanding of illness trajectory & prognosis
 - Expectations for treatment

WESTMED “Feeders”

- Internal Medicine/ACO
- Medical Specialties
 - Oncology: Medical, Breast Surgery, Gyn, Radiation
 - Cardiology, Renal, Neurology, Pulmonary
- Hospital Base
 - Hospitalist program
 - 3 locations
 - Existing Palliative Medicine Services
- Long Term Care Settings
 - Dedicated medical services
 - All with hospice contracts

Our Community

- 3 Hospital Based Palliative Care Service
- 3 Community based / Home Care Palliative Care
- 5 Hospice programs
- 4 Wound care comprehensive clinics
- 4 Hospice inpatient units
- 1 Hospice residence
- 1 Acute Care Hospital: Oncology/Palliative
- 2 VA Systems with Palliative Services
- Community non for profit organizations
- Geriatric Care Management Services

Secondary Palliative Care

- Reserved for complex problems
 - Higher level & more comprehensive assessment & intervention
- Consultations
 - Multiple locations
 - Co-management / Concurrent / Consult
- In House Resource
 - Pain and symptom management
 - Communication of difficult topics/family dynamics
 - Hospice eligibility and clarification of care
 - Steward of Resources

WESTMED Model

- NP developed and staffed
 - Certified with extensive clinical experience
 - Stand alone
 - Office based consultations
 - Off Site Consults
 - Long Term Care setting
 - Hospital (with existing patients only)
 - Open to all patients with **serious illness**
 - Referred by primary MD or specialist
 - Collaborate with existing interdisciplinary resources
 - Billing for services

WESTMED Model

- We chose NOT to:
 - Home based evaluations for new referrals
 - Be a primary psychosocial model for PC
 - Assume hospice referral process
 - Define psychiatric illness as serious illness
 - Provide de novo consults in hospital
 - Fill missing gaps in services

Automatic Referrals

- NSCLC, GBM, Pancreatic
- HF Stage C or D (symptomatic) or Class III or IV (declining functional status)
- COPD with 2 admissions 6 months
- CKD Stage IV & ESRD on dialysis
- Any Serious Illness with:
 - Symptom issues above specific threshold
 - 2 or more hospitalizations in one month

Initial Marketing Strategies

- Meet & Greet: specialty and location
 - Informal conversations
 - Needs assessment
- Grand Rounds - 3 major practice locations
- Community engagement
 - All community based organization & hospitals
- Providing Consultations

Initial Marketing Strategies

- Brochure –
 - Palliative Medicine
http://www.westmedgroup.com/uploadedFiles/Palliative_NEW.pdf?n=7831
 - Advanced Care Planning
<http://www.westmedgroup.com/uploadedFiles/WMG/specialties/files/AdvanceDirectives.pdf?n=9884>
- Listed in online provider directory
- Internal referral – EMR listing
- Palliative Medicine Toolkit – intranet based

Palliative Medicine Toolkit

Maura Del Bene ▾



InsideWESTMED ▾



I Like It



Tags & Notes

HOME

OUR PEOPLE

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HR

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OUR COMPANY

FACILITIES

OUR SERVICE

COMPLIANCE

Palliative Toolkit

Triggers

Calculators

Hospital Based

Blogs

Hospice

Physician Education

Patient Family Resources

Advance Directives

Disease Management

Pain Management

Palliative Medicine Toolkit

The toolkit is being developed to serve as a broad resource to providers and clinical staff specific to the area of palliative medicine and delivery of care. The resources offered are not exhaustive of those in the field rather the favorites that have provided key support in focused areas of practice.

If you have additional resources that are not listed that you would like to share please let us know.

Palliative care is comprehensive medical care that concentrates on the patient and his/her family while living with serious illness, at any stage, regardless of prognosis. It is focused on providing patients with relief from the symptoms, pain, and stresses of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family.

Palliative care is an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.

Palliative care interventions are aimed at relieving the symptoms such as pain, shortness of breath, fatigue, constipation, nausea, loss of appetite and difficulty sleeping.

Palliative care helps clarify goals of care as part of advanced care planning including long term care planning, advance directives, medical decision making for treatment or other interventions, and choices related to end of life care.

The goal of palliative care is to relieve suffering and provide the best possible quality of life for both the patient and their family.



Triggers



Calculators



Hospital Based



Blogs

Primary Palliative Care

- Internal Medicine
 - Outpatient
 - Hospitalist/Intensivist
 - LT Care setting
- Specialty Practices
 - Neurology
 - Cardiology
 - Renal
 - Oncology

Primary Palliative Care: Hospitalist

- Weekly hospitalists didactic/rounding hour
 - EPEC Modules and EPERC Fast Facts
 - Symptom management A to Z
 - Pain management
 - Acute and Chronic; parenteral, transdermal, interventional, oral; adjuvant therapy and transition to DC
 - Withholding / Withdrawing life support discussions
 - DNR, cessation of dialysis, Artificial N&H
 - End of life management
 - Medical management, communication, hospice
 - Hospice eligibility & care
 - Inpatient, community or facility

Hospitalist Tools

- Pocket Card
 - Symptom Management Guide
 - End of life order sets
 - Checklist for admissions & daily rounding
 - DC Planning checklist
- Palliative Medicine Toolkit
 - Intranet based resources
- Palliative Medicine Service
 - How to maximize collaborations

Intensivist – CCU

Limitations noted:

- Separate care system from hospitalists
- Limited access to data from hospitals
- Palliative Care skills vs. concept understanding
- “Chronic Critical Illness”
- Compartmentalized
 - Discrete not on hospitalist continuum
 - Continued vs. interrupted palliative care principles and momentum

Primary Palliative Care Skills: Long Term Care

- Systems support
 - Screening tools
 - End of life order sets
 - Hospice criteria
- Onsite consultations & established office hours
 - Volume, consult outcomes and need –
- Monthly in-service to IDT/ Administration
 - Advance Care Planning
 - Family Meetings – Goals of Care
 - Pain & symptom management
 - Hospice eligibility and collaboration
 - End of Life Care

Primary Palliative Care: Internal Medicine

Training & exposure to palliative care (circa 2007)

- Education
 - Screening Tools – Referrals, Pain, Symptom Management, Hospice
 - Advance Care Planning (ACP)
 - Prognostication
 - Consultation & Curbside conversations
 - Pain Management
- EMR
 - Templates (guide practice and document/track quality)
 - Systematic assessments
 - Pain
 - Symptoms (ESAS)
 - Access to forms / resources
 - ACP, Patient Education Materials, PC Community Services, Hospice resources & referrals
- Intranet Based
 - Palliative Medicine Toolkit

Primary Palliative Care: Oncology

- Primary screening for unmet palliative care needs
 - ESAS
 - Pain
 - Psychosocial Evaluation
- Symptom Management protocols
 - Pain
 - Fatigue
 - Depression
 - Medical marijuana
- OP Referral Pathway
 - NSCLC, GBM, Pancreatic
 - Solid tumors with metastatic disease
 - Symptoms above specific threshold
- Disease management
 - ✓ Referrals to hospice (aka stopping chemotherapy)
 - ✓ Managing patient-family conflict
 - ✓ Acute management in hospital
 - ✓ Discussing prognosis

Primary Palliative Care : Cardiology

- Primary screening for unmet palliative care needs
 - KCCQ – HF specific health status
 - PHQ- 9
 - GAD-7
 - MSAS-SF
- OP Referral Pathway
 - Stage C or D HF
 - Class III/IV
 - 1 or > hospitalizations in 6 months for exacerbation
 - Anorexia, weight loss, wasting
 - “Not surprised if patient were to die in next year”
- Disease management
 - Advanced Care Planning & Prognostication
 - Advanced Care Decisions – transplant/LVAD destination and bridging
 - Preparedness Planning – deactivation of devices, catastrophic complications etc.
- Symptom Issues
 - Dyspnea
 - Fatigue
 - Pain
 - Anxiety
 - Depression

Secondary Palliative Care

Consultation Template

HPI:
**Illness & Treatment
Summary**

**Pain & Other
Symptoms:**
Assessment /History

**Functional
Assessment:**
PPS/ECOG

**Advance Care
Planning:**
Proxy Designation

Goals of Care:
**Medical decision
making**

Psychosocial History:
**Care system,
network, &
resources**

**Understanding of
illness & prognosis**

Decisional Capacity

Life Expectancy:
Prognosis

**Palliative
Recommendations**

Provide documentation:

- Value of specialty PM services
- Stay within PM purview
- Always patient centered

Prognosis

- Diagnosis - terminal?
 - Incurable
 - Progressive
 - Severity of disease
 - Functionally dependent
 - Rehab potential poor
 - Co-morbidities
- Treatment - maximal?
- Factors to Consider
 - Rate of decline
 - Nutritional Status
 - Functional Status
 - Cognitive Status
 - Age/Gender
 - Hospitalizations in past year
 - Will to live
 - Psychosocial, emotional and spiritual

Year One Metrics

Goal of Metrics

- Measure impact of care not # consults
 - Patient/family satisfaction
 - Quality improvement
 - Cost savings
- Keeps focus on “Patient Centered Care”

Systematic Screening

- All EMR templates include:
 - Standard Pain Assessment
 - Edmonton Symptom Assessment Scale
 - Advance Directives
- Observation terms
 - Tracking and reporting for quality
 - Scores trigger suggestion for Pall Med referral
 - Feeds QI process

Year Two Metrics

What We Learned

- Change is difficult
 - ‘non captive’ audience with limited exposure
- Many providers unaware of resources available
 - Unable easily mobilize resources
- Names are important
 - Palliative what?
 - “Symptom Management Team” - Oncology
- Who expects what:
 - IM: Consultation Role
 - Oncology: Co-management & Assume Care
 - Neurology: Co-management & Consultation
 - Cardiology: Crisis management
 - Renal: Consultation role

What We Learned

- Advanced care planning is limited
- Patients have a poor understanding:
 - Illness
 - Decisions at hand
 - Symptom control
 - Life expectancy
 - Options for care
- Limited communication of prognosis & expectations
- Difficulty with transitions of care
- Limited use of hospice generally
- Limited pain & symptom management skill set

What We Know

- We have opportunities to be helpful / effective
- We see the gaps and know where to build resources and education
- We provide consultations that effect change
- We hope to provide resources to help them find their solutions
- We have complex patients
- We have quality care and resources

Goals: Year 2

- Increased staffing (NP/PA/RN)
 - Imbedded clinic presence
 - Oncology
 - Radiation Oncology
 - Increased general access for acute issues
 - Pain & Symptom Management
 - Hospital Consultations
 - Increase primary palliative care skills, collaboration and improved transitions
- Increased Nursing and SW
 - ACP, LT Planning, Care Coordination
 - CM interface
- Established Protocols
 - Oncology
 - Cardiology
 - Neurology

} "Symptom Management Team"

Appendices

- Hospitalist Rounding Tool
- Communication Phrases
- Palliative Medicine Consult Triggers/Hospice Criteria
- Advanced Pain Assessment and Opioid Management Tool
- Palliative Medicine Consultation - screen shots
- Generalist resources

Resources

- American Academy of Hospice & Palliative Medicine <http://www.aahpm.org/>
- End of Life Palliative Education & Resource (EPERC) Fast Facts
<http://www.eperc.mcw.edu/EPERC/FastFactsandConcepts>
- Center to Advance Palliative Care
<http://www.capc.org/ipal/> *Download IPAL-OP portfolio products
<http://www.capc.org/ipal/ipal-op/monographs-and-publications>

Blog Resources

- PalliMed <http://www.pallimed.org/>
- GeriPal <http://www.geripal.org/>

ACP Resources

- The Conversation Project <http://theconversationproject.org/>
- Compassion & Support – End of Life Choices
http://www.compassionandsupport.org/index.php/for_patients_families
- Get your s*** together <http://getyourshittogether.org/blog>
- National Institute on Aging
<http://www.nia.nih.gov/health/publication/advance-care-planning>

