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Building a Palliative Care Program From the Inside Out

Patsy Astarita, LCSW-C, OSW-C
Michelle Abramowski, CRNP

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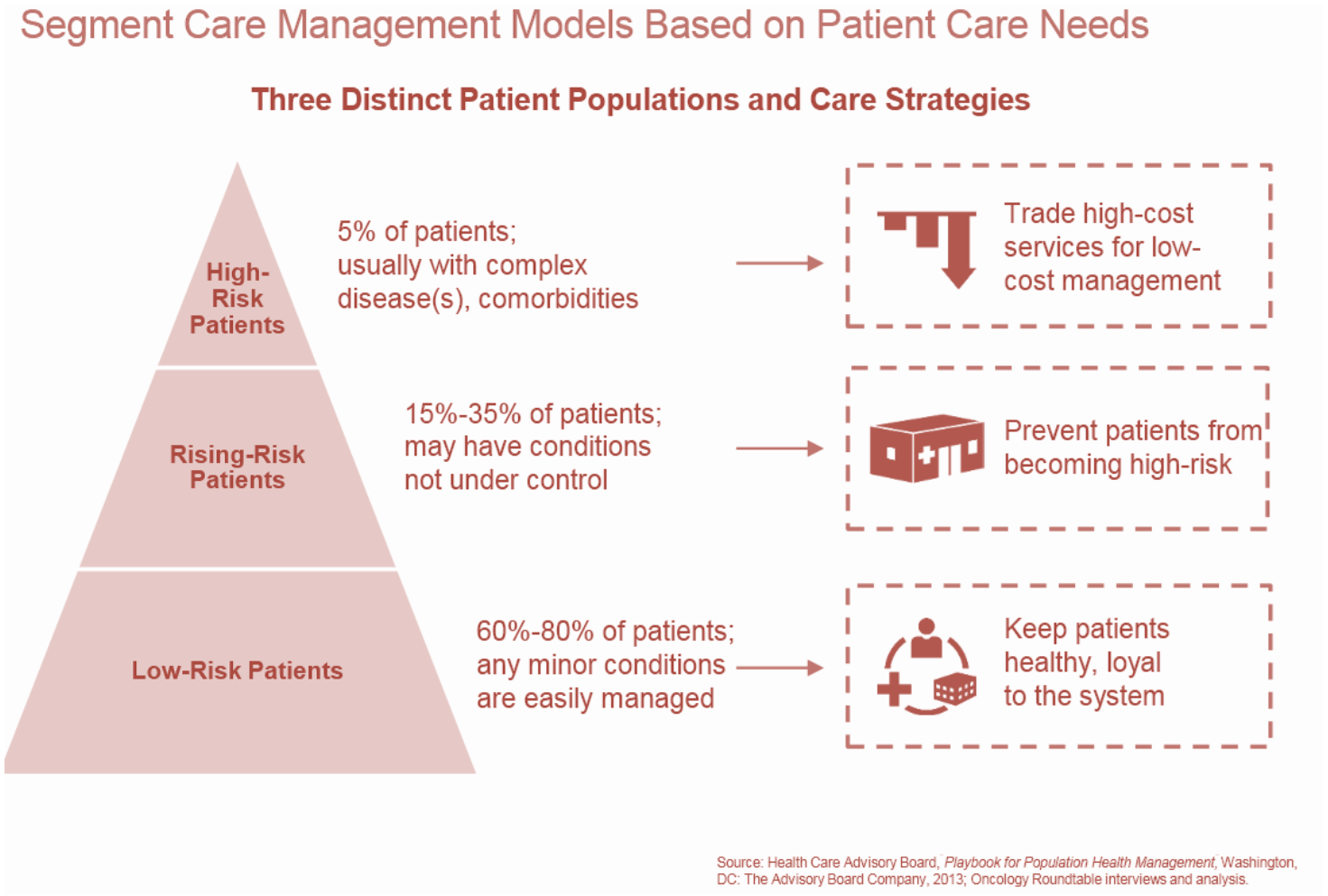
Driving Factors

- Population Health
- Cost of Oncology Care
- Choosing Wisely (ASCO & ASTRO)
- Better qualityof life at EOL (Temel, 2010)
- Standard of Care—NCCN, ASCO, CoC

Population Health in Oncology



Source: Health Care Advisory Board, *Playbook for Population Health Management*, Washington, DC: The Advisory Board Company, 2013; Oncology Roundtable interviews and analysis.

University of Maryland Upper Chesapeake Health

Studies Listed

- Glare, P.A., et al. (2011). Palliative Care in the Outpatient Oncology Setting: Evaluation of a Practical Set of Referral Criteria. *Journal of Oncology Practice, 7(6)*, 366-370.

- May, P., et al. (2015). Prospective Cohort Study of Hospital Palliative Care Teams For Inpatients with Advanced Cancer: Earlier Consultation Is Associated With Larger Cost-Saving Effect. *Journal of Clinical Oncology, 33*, 1-8.

- Temel, J.S., et al. (2010). Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer. *New England Journal of Medicine, 363(8)*, 733-742.

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

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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

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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

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Palliative Care Models

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

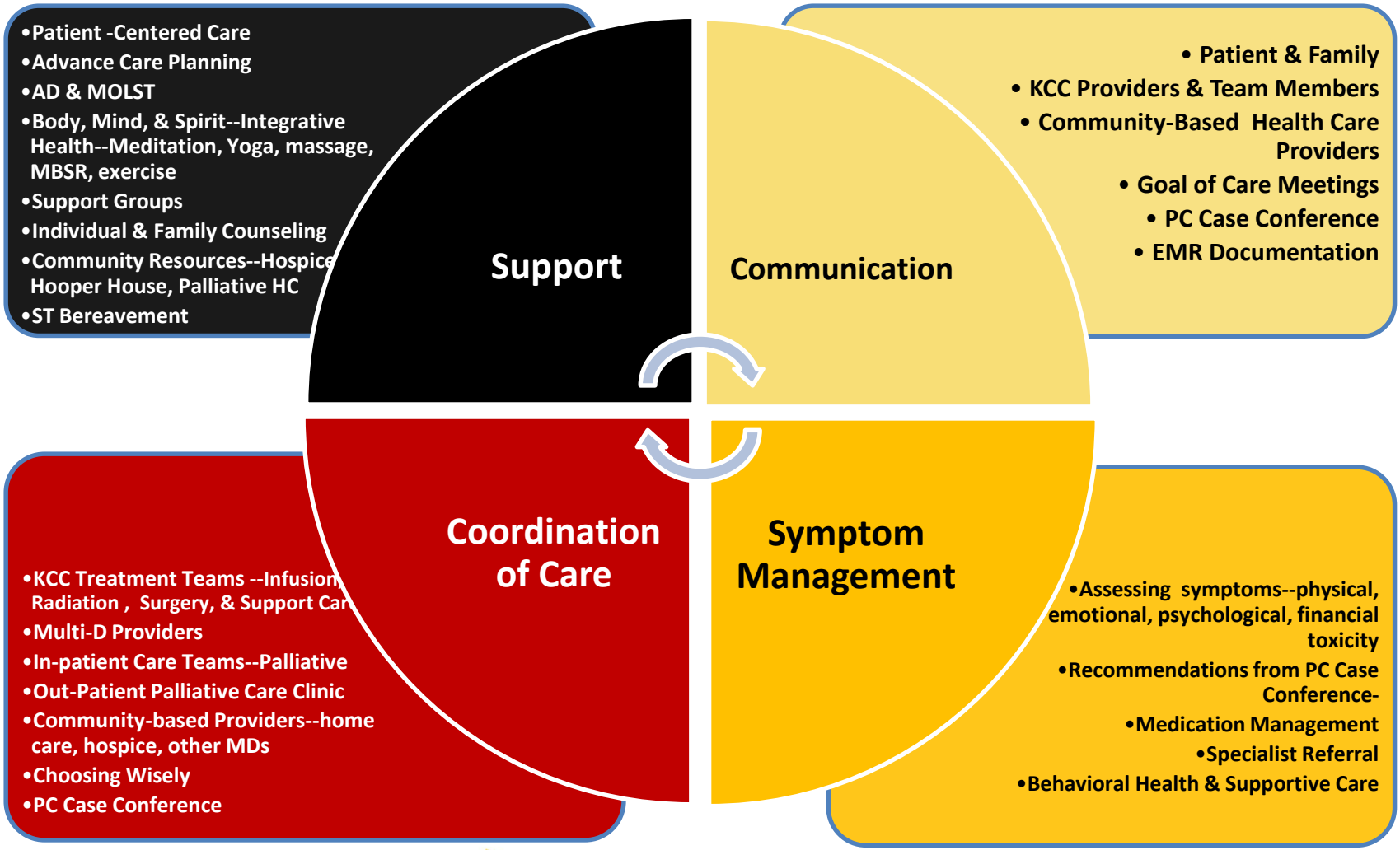
✓ Existing at UM UCMC

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



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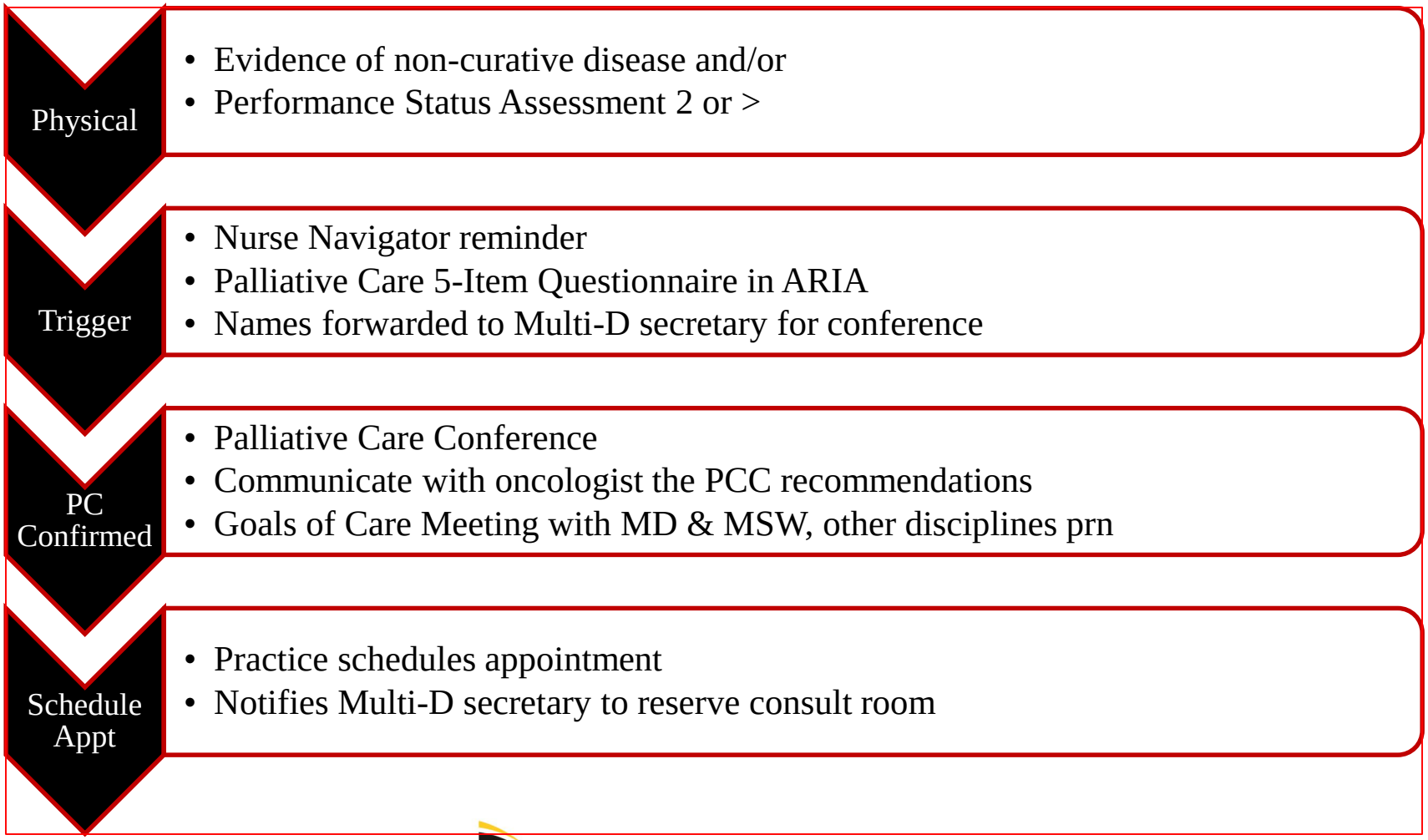
Palliative Care Decision Process



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Palliative Care 5-Item Questionnaire

Table 1.

Five-Item Palliative Care Screening Tool

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

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

Glare, P.A., et al. (2011). Palliative Care in the Outpatient Oncology Setting: Evaluation of a Practical Set of Referral Criteria. *Journal of Oncology Practice, 7(6),* 366-370.

Palliative Care Conference Model

PC Conference

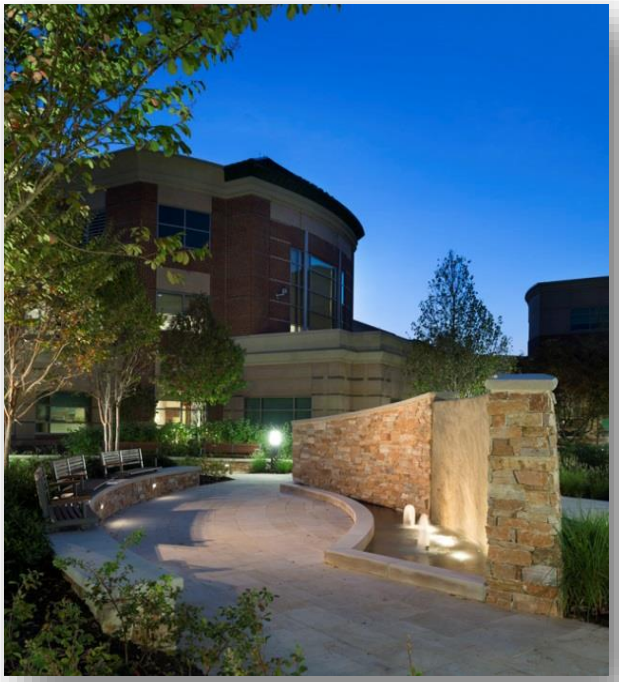
- Weekly at 8am Palliative Care Conference Summary Sheet completed
- Interdisciplinary team reviews newly identified patients
- Recommendations communicated to oncologist for further direction and/or schedule Goals of Care meeting
- Started meeting October 2014

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



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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

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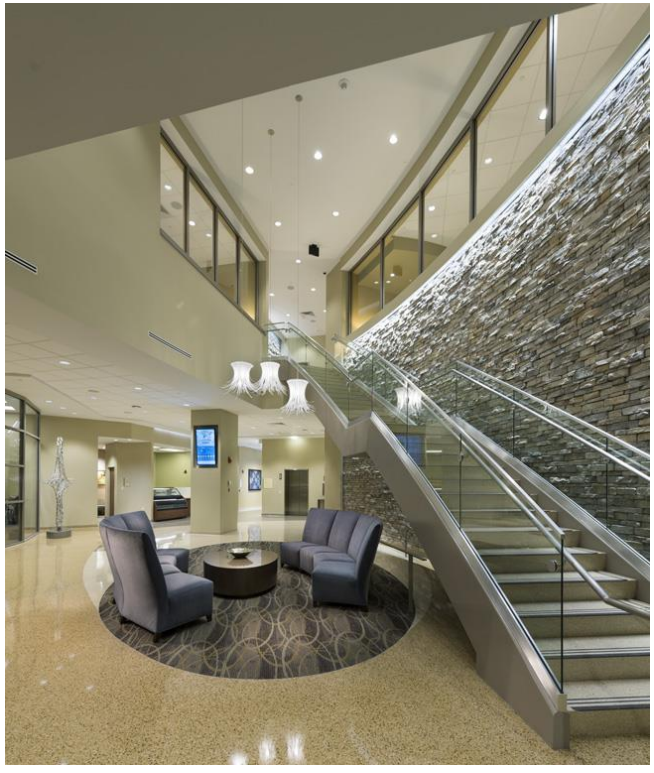
Goals of Care Meeting



- **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 http://emupdates.com/wp-content/uploads/2009/11/goal-setting-conference-pocket-card-mssm.pdf
- 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

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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

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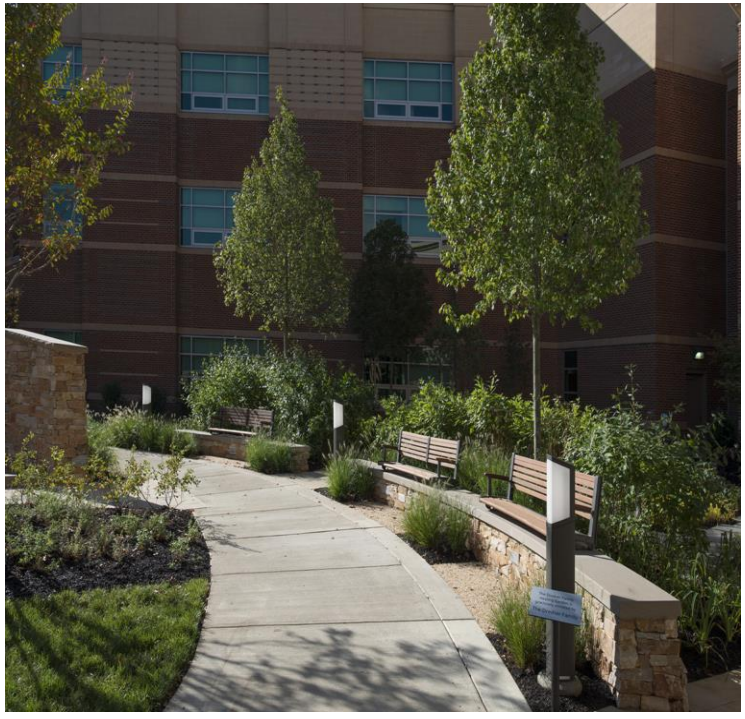
Community Partnerships



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

Palliative Care Dashboard

Advisory Board, 2013

Measure	Definition	Benchmark	Endorsed By
Process – Appropriate Utilization			
New chemotherapy at end-of-life	Percent of patients who died from cancer that started new chemotherapy regimen in the last 30 days of life	Best observed: <2%[6]	
Chemotherapy utilization at end-of-life	Percent of patients who died from cancer that received chemotherapy in the last 14 days of life	National average: 6%[15] 10th percentile: 4%[16] 50th percentile: 5.9%[17] 90th percentile: 7%[18]	NQF #0210[19], ASCO[20]
Hospitalizations at end-of-life	Percent of patients who died from cancer with one or more hospitalizations in the last 30 days of life	Best observed: <4%[7]	NQF #0212[8]
ED utilization at end-of-life	Percent of patients who died from cancer with one or more ED visits in last 30 days of life	Estimated typical performance: 8-10%[9] Best observed: 2%[10]	NQF #0211[11]
ICU utilization at end-of-life	Percent of patients who died from cancer admitted to ICU in last 30 days of life	Estimated typical performance: 8 to 12%[12] Best observed: <4%[13]	NQF #0213[14]
Acute care utilization at end-of-life	Percent of patients who died from cancer within an acute care setting	Best observed: <17%[21]	NQF #0214[22]
Hospice utilization	Percent of patients who died from cancer who were not admitted to hospice	Estimated typical performance: 65 to 85%[23] Best observed : <55%[24]	NQF #0215[25]
Hospice referral timeliness	Percent of patients who died from cancer, were admitted to hospice, and spent less than 3 days there	Estimated typical performance: 27-35%[26] Best observed: 8%[27]	NQF #0216[28]
Hospice median length of stay	Median length of stay for patients who were admitted to hospice	National median length of stay: 19.7 days[29]	NHPCO[30]

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KCC Palliative Care Outcome Measures

2014-2015	National Benchmarks	Oct Nov Dec 2014	Jan Feb Mar 2015	Apr May Jun 2015	July Aug Sept 2015	Yearly Percentages
Proportion receiving chemotherapy in the last 14 days of life	Average: 5.6%-6.4%	13%	3%	4%	1%	5%
Proportion with more than one emergency room visit in the last days of life	Average : 8-10% Best Observed: 2%	7%	14%	0%	3%	6%
Proportion admitted to the ICU in the last 30 days of life	Average: 8-12% Best Observed: <4%	4%	11%	2%	6%	5%
Proportion admitted to hospice for less than 3 days	Average 27-35% Best Observed: 8%	12%	12%	35%	6%	14%
Proportion not admitted to hospice	Average 65-85% Best Observed: <55%	55%	38%	45%	53%	50%
Advance Care Plan	Observed Average: 41%	38%	46%	87%	70%	61%

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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).

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PATRICIA D. AND M. SCOT KAUFMAN
CANCER CENTER

AN AFFILIATE OF THE UNIVERSITY OF MARYLAND
MARLENE AND STEWART GREENEBAUM CANCER CENTER

Thank you