Revolutionizing Quality Care
Integrating Palliative Care in an Outpatient Cancer Center

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Schneck Medical Center
Seymour, Indiana

Seymour, Indiana

Schneck Medical Center
• Not-for-profit, county-owned hospital
• Facilities include:
  • Main campus, 95 all-private suites
  • State-of-the-art Cancer Center
  • Home Health/Hospice
  • Rehabilitation Center
  • Three Schneck Family Care practices
The Schneck Culture

• Patient First
  • Improve focus on quality of life
  • Improve focus on goal setting & advanced care planning
  • Improve patient satisfaction

• Culture of excellence
  – Expectations of certifications and accreditation
    • Cancer Center maintain accreditation by ACoS CoC
    • Magnet and Malcolm Baldrige Award

Schneck Cancer Center

• Opened in 2007
• $4.5 Million donation from the Community
• Average 10-12 radiation patients/day
• Average 9 infusion treatment patients/day

Schneck Cancer Center

• Accredited by ACoS, CoC since 1991
• Oncologist: Employed Physician 3 days/week
• Radiation Oncologist: Contracted 3 days/week
• One side of Cancer Center is radiation with 2 clinic rooms, and the other side is medical oncology with 2 clinic rooms.
Cancer Center Staffing

- 5 Oncology Nurses-Certification is required
- Radiation Therapists- 2 full time, 4 PRN Therapists
- Contract Physicist and Dosimetrist
- Cancer Registrar
- Originally-receptionist and phlebotomist

Why Do We Need Palliative Care?

- Patient Satisfaction (Press Ganey) revealed a need for better symptom management
- Hospital-wide dashboard revealed opportunity to improve length of stay and mortality rates
- New ACoS, CoC Standards requiring palliative care
- Access to valuable resources

Palliative Care Project Goals

- Improvement in Patient/Family Care
  - Improve symptom management
  - Increase discussion regarding goals of care and advanced care planning
  - Improve access to interdisciplinary services
  - Improve care coordination with oncology team
Goals for Stakeholders

• Physician/Oncologist - Allow time to concentrate on cancer treatment plan
• Oncology Team - Improve symptom management
• Home Health/Hospice - Improved coordination of referrals in a timely manner
• Cancer Committee - Meet accreditation requirements

How to Begin?
– Business plan developed
– Identified interdisciplinary team
– Identified NP with expertise in oncology & hospice/palliative care
– Where located?…Cancer Center the obvious choice

The Business Plan
• Begin with research, and determine what is best practice for your institution. Resources for plan included:
  – Center to Advance Palliative Care CAPC
  – Medical Staff
  – Press Ganey
  – Accounting Dept.
  – Visit different Palliative Care programs
The Business Plan

• Project Management Team:
  – Director of Patient Services, Inpatient Services, Cancer Center, and Pain Center.
  – Hospitalist or representative
  – Hospice/Home Services Director or Manager
  – Accounting-Controller, Revenue Cycle Supervisor
  – Registration

Where Do We Start? The Expert

• Experience in Pain/Palliative Care
• Maintain financial viability
  – Utilize in other clinics such as Oncology/Radiation/Pain Center

Donna Butler
MSN, ANP-BC, OCN, ACHPN, FAAPM

Service Model

• Palliative care clinic embedded into outpatient oncology clinic
  • Availability of certified NP with skills in symptom management
  • Space and staff available in Cancer Center to support clinic
  • Opportunity for revenue from NP professional fees
  • Distress tool assessment produces referrals to the team
Adding Palliative Care Without Adding Support Staff

- **Staffing Change:**
  - Receptionist & Phlebotomist changed to Certified Medical Assistants (CMAs)
  - The CMAs alternate their schedules for early and late clinics so that one is here to draw blood and one is here to schedule patients.
  - The phlebotomist is responsible for obtaining vital signs, placing patients in room, charting and taking off orders for Palliative Care.

Staffing

- Began with NP 0.5 FTE, in one year increased to .6 FTE
- Social worker-(0.1FTE) staffed by Inpatient Patient Services department
- Chaplain- (0.1FTE) staffed by Hospice
- Psychologist- as needed
- Medical Director

Interdisciplinary Team

- Bi-weekly interdisciplinary team meetings
- Interdisciplinary team members:
  - Physician champion-Hospitalist
  - Social worker from patient services department
  - Chaplain & Palliative Care RN from hospice
  - Oncology RN from cancer center
  - Psychologist from Psychological Services
How are Oncology Referrals Made?

- **NCCN Distress Thermometer**
  - Patient completes assessment (May have family/friends help them)
  - Nurses enter assessment into Electronic Medical Record (Meditech)
  - Automatic referrals are generated to social worker, psychologist, nurse practitioner, chaplain based on this assessment.

NCCN Distress Thermometer

- **Includes:**
  - Practical Problems (childcare/transportation)
  - Family Problems (dealing with family)
  - Emotional Problems (worry, sadness, fears)
  - Spiritual/religious concerns
  - Physical Problems (breathing, diarrhea, pain)
Financing/Funding Model

- Fee for service
  - Nurse practitioner (visits 85% more than budgeted, cost 37% below expected in first year)
  - Psychologist
- Use of oncology clinic staff and infrastructure to reduce cost
- NP shared with Pain Center initially until patient numbers increased.
- NP completes fee ticket, and coders in Health Information System actually post the charges.

Statistics: NP Visits

Stats: Outpatient, Home Visits, Inpatient
Stats: New vs. Established

Results

– Top 3 symptoms: pain, feeling tired, and anxiety
– Individual care plans were developed using patient’s symptoms and life goals
– Increased focus on quality of life, advanced care planning and goal setting
– Interdisciplinary team meets bi-weekly to evaluate interventions and patient progress

Results

– Improved care coordination with home health care and hospice
– Pt/family feedback positive on Press Ganey
– Collaboration with Hospitalists
  • Feedback from Hospitalist (if patient having symptoms that can not be managed in outpatient setting, call hospitalist, we will direct admit to hospital to avoid ER visits)
Results

– Oncology nurses identified improved symptom management
– Oncologist – identified ability to focus on cancer treatment plan during office visit
  • Feedback from Oncologist (the 10-15 minutes I have with the patient can be focused on cancer treatment plan, knowing that the palliative care team is focusing on the symptoms).

Challenges

1. Huge Medicare and Medicaid population-impacts reimbursement
2. Education of staff in billing and coding processes for outpatient services
3. Training new CMAs on all processes of Cancer Center and Palliative Care.
4. Knowledge deficit of staff regarding Palliative Care-provide (annual ELNEC training to staff)

Challenges

• Medical staff concept of Palliative Care
  – Only a precursor to Hospice
  – Building trust in team
  – Will not take patients away from MD
• Scheduling NP between 3 areas and demonstrating effectiveness
Challenges

• Increase Inpatient referrals without overwhelming NP.
  – Rounding incorporated into NP schedule includes CHF, COPD, ICU rounds-(Did not work well)
  – Then changed to specific population however kept the two hour-long spots for inpatients.
  – Added palliative care to the order sets for COPD

2015: Where are we Now?

• Palliative Care Steering Committee looking at accreditation issues with The Joint Commission.
• NP now performing “Face to Face” on Hospice patients when Hospice Director out of town.
• NP continues to see follow-up Oncology patients, fewer with new IP role.

Summary

• Benefits to having outpatient Palliative Care in Cancer Center
  – Reduce cost by utilizing infrastructure and support staff
  – Access to oncology team
  – Improve care coordination with oncology staff
  – Allow oncology team time to concentrate on cancer treatment plan
Summary

• Benefits for Patient/Family and Caregivers
  – Focus on quality of life, advanced care planning & goal setting (stats from 1 year)
  • 77% of patients had advanced care planning addressed
  • 67% of patients received referral to interdisciplinary services
  – Assess patient’s symptom burden (Edmonton Symptom Assessment Scales)
  • Top 3 symptoms: Pain, Feeling Tired, & Anxiety

Any Questions?

Life is Pleasant.
Death is peaceful.
It’s the transition that’s troublesome.

Isaac Asimov
American science fiction novelist and scholar