Developing an Outpatient Palliative Care Service

Michael W. Rabow, MD
Advisory Board, IPAL-OP
Director, Symptom Management Service
Helen Diller Family Comprehensive Cancer Center
Professor of Medicine, UCSF
San Francisco, CA
Objectives

• List key elements of an institutional needs assessment to identify gaps and resources
• Describe three models of outpatient programs and how each aligns with health system priorities
• Identify four challenges to sustainability inherent in outpatient palliative care service design
Real-time Polling

(1) Do you have outpatient palliative care services?
   - Yes
   - No

(2) Which services do you have? (check all that apply):
   - Clinic-Based Practice
   - Practice providing Home-based visits/services
   - Practice in Long-Term Care or Assisted Living Facilities
   - Practice in Long-Term Acute Care Hospitals (LTAC)

(3) What is the single biggest threat to the sustainability of your services?
   - Funding
   - Staffing
   - Getting enough referrals
The IPAL Project
Improving Palliative Care

SELECT AN IPAL SECTION
IPAL-ICU IMPROVING PALLIATIVE CARE IN THE ICU
IPAL-EM IMPROVING PALLIATIVE CARE IN EMERGENCY MEDICINE
IPAL-OP IMPROVING OUTPATIENT PALLIATIVE CARE
The IPAL Project Development Strategy

• Identify **Expert Panel** from the field
  – Inventory, compare, brainstorm
  – Improve, combine, and create

• Focus on the basics

• Reduce start up time by harvesting experience of others

• Keep learning – and add to the info available
The IPAL Project Tool Structure

• Overview documents

• Needs assessments (clinic & home based)

• Getting Started Guides

• Case Studies

• Other tools and resources
"It is amazing what you can accomplish if you do not care who gets the credit."

Harry S. Truman
The IPAL-OP Team

- David E. Weissman, MD
- Lynn H. Spragens, MBA* (*co-authored these slides)
- Lisa T Barbour, MD
- Susan E. Cohen, MD
- Vicki Jackson, MD
- Elizabeth Kvale, MD
- Carol Luhrs, MD
- Vincent D. Nguyen, DO, CMD
- Michael W. Rabow, MD
- Simone Rinaldi, NP
- Donna Stevens, BS
- Special thanks to Jennifer Raiten, LMSW
The Challenge

• Outpatient palliative care as the **Wild West**
• Many models/experiments/pilots (few with scale sufficient to manage growing expectations)
• Business case is very dependent on local variables
• Unclear boundaries between palliative care and other domains/specialties
The Opportunity

• Most patients spend most of their time outside of hospitals

• Outpatient PC
  – Improves quality patient care
  – Potentially decreases mortality
  – Increases efficiency in health care systems & accountable care organizations

• The frontier is an opportunity for those who know what they want
Needs Assessment is Critical

• The single most common problem encountered by palliative care programs that have started outpatient services is that they have started them incrementally and reactively...

• And then are overwhelmed

• Planning reduces this risk
Needs Assessment (cont’d.)

• Why are you considering outpatient services?
  – What are you proposing? Why?
  – Patient focus?

• Who are your stakeholders?
  – What do they want?
  – What are they willing to pay for?

• Do you have, or can you get, the staff to do this well?
Conceptual Model
(Organizing Outpatient Model Variations)
Model Considerations

• Models differ in minimum required scale (hard to field a home based program with one provider, for example)

• Operational complexity varies – scheduling & managing a clinic is very different from inpatient work

• Financial issues are central—alignment of missions is critical
  – Alignments will determine form and function
  – Be cautious of filling an unpaid “vacuum” (gaps in care safety net in the system or community)
Stand-alone Clinic

• May function like other specialty practices with reserved office space and dedicated staff for palliative care services

• These practices are administered separately from other outpatient practices

• The palliative care program has oversight and responsibility for their own staffing, billing and scheduling
Embedded Clinic

• A collaborative relationship between a host clinic (e.g. oncology) and the palliative care staff

• Typically, all costs of the clinic operations are borne by the host clinic
  – e.g. scheduling, medical assistant, palliative care team

• Patients referred predominantly from the host clinic

• Defined clinical pathways or protocols may exist defining patient flow between the host & pc staff
Co-located Clinic

- Use space and shared services from another clinic (e.g. oncology, cardiology)

- Overhead and clinic operation staff (e.g. scheduling, medial assistant) may be provided entirely by the hosting clinic, or shared with the palliative care program

- Patients seen in this clinic, may or may not share the diagnosis focus of the host clinic
Home-based Palliative Care

• Distinct from Medicare *Home Care* services
• Consultative palliative care services provided in the patient’s home
  – office-based visit is a major hardship
  – complex patients who require longer, intensive, or more frequent visits than are realistic in an office setting
  – patients in areas without an available office-based palliative care practice.
  – good model for co-management with Medical Homes
  – Often NP or SW led
Facility-based Palliative Care

• Consultative palliative care services can be provided in
  – long term care facilities
  – assisted living facilities
  – long-term acute care hospitals

• These services may work well as part of a portfolio of services matched to staffing plan and aligned with health system priorities

• Consider options for training & collaboration vs. direct care needs
Challenges to Sustainability

1. **Workforce** constraints
2. **Financial** support and alignment
3. Appointment **capacity** and operational/administrative capacity
4. **Clarity of purpose**, role, and criteria
1. Workforce Constraints

• Staffing the service
  – Disciplines involved, scope of service, ability to bill
  – Assume care vs. co-management vs. consultation
  – PC expertise and certification
  – Simultaneous inpatient responsibilities a challenge

• Support for staff
  – Administrative support
  – Preventing clinician burnout
# Staffing Ranges in Current Practice

<table>
<thead>
<tr>
<th>Unique patients/year</th>
<th>50-100</th>
<th>101-200</th>
<th>201-300</th>
<th>&gt;300</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barebones Staffing Model</td>
<td>0.25 MD 0.25 SW</td>
<td>1.0 NP 1.0 RN</td>
<td>0.50 MD x 4 0.25 SW</td>
<td>0.50 MD x 3</td>
</tr>
<tr>
<td>Generous Staffing Model</td>
<td>1.0 MD 1.0 RN</td>
<td>.025 MD 1.0 NP 1.0 RN 1.0 SW</td>
<td>0.25 MD 1.0 NP x 4 0.50 SW 1.0 RN</td>
<td>0.50 MD x 3 1.0 NP 1.0 RN 1.0 SW</td>
</tr>
</tbody>
</table>
2. Finances: Support & Alignment

• Most primary care practices & geriatric practices owned by hospitals operate at a loss

• Business case depends on aligning objectives (mission alignment) & identification of financial benefits

• Total costs per are approximately
  – 40% provider costs (range 30% - 60%)
  – 40% support staff
  – 20% space, supplies, etc.
2. Finances *(cont’d.*)

- If you provide outpatient clinic with long appointment times and IDT care, and cover support staff costs and overhead – **you will lose money** unless you have revenue in addition to CPT Billing
  - Billing = <50% of expenses

- Variables impact size of loss

- **Other benefits may be sufficient to justify funding**
  - Clinical
  - Financial
Temel Study: Costs

• Mean cost savings of $2,282
• Accounted for by...
  – Reduced costs
    • Inpatient visits (mean of $3,110/patient)
    • Chemotherapy (mean of $640/patient)
  – Longer lengths of hospice stays
  – Higher hospice costs (mean of $1,125/patient)

3. Clinical Capacity

• Space, time, staffing, acute needs, coverage
  – Stand alone vs Co-located/Embedded have different efficiencies

• Capacity impacts quality
  - California Study: Wait time = 10.7 days

• If you build it…(Smith Landscape Study)
  - 11/20 with staffing shortages
  - Established practices overwhelmed with referrals
4. Clarity of Purpose, Role, and Criteria

- **Be prospective, not reactive**
- Identify program objectives *before* design
  - Model and structure fitted to the goals
- Alignment of benefits and costs
  - Funding criteria must precede implementation
- **There are many gaps & needs – be cautious about taking them on**
4. Clarity of Purpose: Clinician Roles

- **Consultative Role**
  - An intervention rendering professional advice, opinions or recommendations

- **Referral Role**
  - The transfer of total care or a specific part of care from one clinician to another

- **Co-Management Role**
  - Each clinician provides input into patient care and each has responsibility for management of discrete care domains; overall responsibility still remains with the primary/referring clinician
What have we learned?

• Often good people start offering services before figuring out how to sustain or scale them

• **Health systems want outpatient palliative care**, but often have not established real business models to sustain change in delivery model

• Starting with the basics & setting limits is wise

• Our workforce limitations should lead us to creative solutions, partnering, and training (vs. doing it all ourselves)

• **Send us your good examples**
Visit The IPAL Project!

at www.capc.org/ipal
New IPAL-OP Portfolio Resources

Resources coming soon....

• Profiles for Clinic and Pediatric Programs
• Metrics and Finance

Topics in development include...

• Review of Impact Data
• Delivery of Outpatient Clinical Care
For More Information

- Visit IPAL-OP at: www.capc.org/ipal/ipal-op

Managing your screen

Questions panel

To ask the presenter, please type your question into the question panel and press send.

Minimizing and maximizing your screen

Use the orange and white arrow to minimize and maximize the GoTo panel.
Use the blue and white square to maximize the presentation area.
What did you think of today’s session?

Please take time to complete our evaluation.

• Once you or the presenter exits the webconference, you will be directed to an evaluation that will automatically load in your web browser.

• Please take a minute to provide your thoughts on the presentation.

Thank you!

Please note that the survey does not apply to webconferences viewed on demand.