Models of Running a Hospital-Based Consultation Service

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Learning Objectives

• Describe five benefits of a well-staffed palliative care program.
• List five planning steps for program start-up.
• Describe three reasons why programs are unable to meet their potential.
• List two components of a generalist palliative care initiative
The new forces of change

PCMH/ACO

Pall Care

Home Visits

Transition Programs

CDM

$\$$

HCAPS

Readmissions

Mortality
But old problems persist ...
Consultative Palliative Care

- Symptom management
- Prognosticate/Communicate
- Establish Patient-Centered Goals
- Plan for the future
Why Palliative Care?

- Reduced time to symptom relief
- Improved patient and family satisfaction
- Earlier hospice referral
- *Reduced readmissions/inpt. mortality*
- *Reduced ICU days*
- *Reduced hospital $ loss*
Program Development

**SIGNIFICANT EVENTS OF THE APOLLO 11 AND PROPOSED CONSTELLATION MISSION**

- **Prep/Launch**
- **Earth Orbit**
- **Escape Velocity**

NB: This diagram is representative only.
1. Planning committee
2. Needs assessment
3. Estimate volume/cost avoidance
4. Staffing levels for Years 1-2
5. Scope of Services
6. Outcome measures
7. Administrative home
8. Business and marketing plan
Needs Assessment

• “What’s broken”
• Interview key stakeholders
• Environmental scan:
  ✓ Hospice program(s)
  ✓ Pain clinics/inpatient service
  ✓ Ethics/Advance care planning
  ✓ Community PC activities
Needs Assessment

Data, Data, Data!!!

- Sentinel events
- ICU LOS and outliers
- (Re-imbursement – cost) for inpatient deaths
- HCAP data: clinician communication/pain
- Hospice referral data
- Dartmouth dataset
Average cost per day, 10 days +/– Consultation
Run the numbers

- $200-$600/day post consult X 4 days = $800-$2400 per consultation
- 300 bed hospital @ 2 consults/staffed bed
- 600 consults x $1600

$960,000/Year
FTE by New Consult Volume
Mon-Friday 8-5 Service: **No Backup**

<table>
<thead>
<tr>
<th># Consults Per Month</th>
<th>10-15</th>
<th>25-30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse (APN preferred)</td>
<td>0.6</td>
<td>1.0</td>
</tr>
<tr>
<td>Physician</td>
<td>0.2</td>
<td>0.5</td>
</tr>
<tr>
<td>Social Worker</td>
<td>0.2</td>
<td>0.4</td>
</tr>
<tr>
<td>Chaplain</td>
<td>0.1</td>
<td>0.2</td>
</tr>
<tr>
<td>Admin</td>
<td>0.2</td>
<td>0.2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1.5 FTEs</strong></td>
<td><strong>2.5 FTEs</strong></td>
</tr>
</tbody>
</table>
Scope of Services

• Indications for referral
• Diagnoses suitable for referral
• Consultation management options
  • Single visit
  • Co-Management
  • Assume attending role
  • Post-hospital role
• Team availability
Tips

- Link “The case for Palliative Care” to hospital priorities.
  - Take key leaders on a field trip.
- Engage a few key clinician supporters.
  - Don’t fret about docs who are resistant
- Be willing to compromise on staffing—to a point.
- Start measuring on Day 1.
- Learn from others.
When the boss says no.

“There is always money, its about making the decision to spend it.”

- Do **you** understand how decisions are made—where the power levers are?
- Have **you** made a case focused on issues important to the boss?
- Did **you** collect/present data of importance?
- Have **you** made “the ask” too complex/broad/lengthy/unclear?
Variations on a Theme

• Administrative Oversight
  • One boss or multiple

• Workflow #1
  • Full team assessment vs.
  • Triage model

• Workflow #2
  • Who sees the patient?
    • Initial visit
    • Follow-up visit
Variations on a Theme

- **Staffing #1**
  - With or without a physician
  - APRN or RN

- **Staffing #2**
  - SW/Chaplain integral to the team vs.
  - Unit based
• Building trust
• Clarifying daily workflow
• Teaching
• Data Collection
Consultation Styles

- **Full Contact**
  - Strong patient advocate
  - Honest communication clinician
  - “Tell it like it is”

- **Just Touch**
  - “Get-along” attitude
  - Conflict avoidant
  - Often a lack of confidence

Problems in Orbit

- Staff to workload imbalance
- Consult etiquette violations
- Failure to collect operational and outcome data
- Program finances = billing
- Inattention to team health
Program Failure

When Capacity $>>$ Demand, think violation of consult etiquette.
Consultation Etiquette

1. Determine the question
2. Triage urgency
3. Gather your own data
4. Brevity
5. Specificity
6. Plan ahead
7. Honor turf
8. Teach with tact
9. Personal contact
10. Provide follow-up

CAPC Campus On-Line: Consultation Etiquette; www.capc.org
Be careful for what you wish for.

No Data

Burnout

Admin Pressure

More Consults

More Staff

No Teaching
Stuck in “Earth Orbit”

- Increasing clinical and non-clinical demands
- Overworked / Team martyrs
- Loss of Interdisciplinary Care
- Can’t prioritize
- Feel out of control
- Request for more staff denied
- Request for more staff denied
Root Causes

- Program leader lacks administrative skills.
- Leadership views palliative care as an End-of-Life service line.
- Hospital in crisis.

Moving Forward
Planning

Team Health

Scope of Services

Workflow

Service Standards
Strategies for Maximizing the Health/Function of Palliative Care Teams

A resource monograph from the Center to Advance Palliative Care

https://shop.capc.org

Altillio, T, Dahlin C, Remke S, Tucker R, Weissman D.
Workflow Assessment

- Can you increase efficiency without abandoning palliative care principles?
  - Can you sign off?
  - Consults outside staff knowledge/skills?
  - Consults outside the program scope of practice?
- Percent of specialty level vs. generalist level consults?
- Can some generalist-level requests be managed by curbside advice?
Scope of Services

Re-Define Team Boundaries

- Indications for referral
- Diagnoses suitable for referral
- Consultation management options
  - Single visit
  - Co-Management
  - Assume attending role
  - Post-hospital role
- Team availability
Service Standards

- Daily operations
- Who does what, when
- Team rules
  - Interface with referring clinician
  - Charting
  - Discharge/transition planning
If you don’t know where you are going, you may not get there.

- Strategic Analysis
  - Stakeholder interviews
  - Data review
  - Environmental Scan
- Goal Setting
- Action Planning
• Annual strategic planning
• Admin and team goals aligned
• Proactive team health activities
• Staffing realistic for modest growth
• Work on advanced health system priorities
<table>
<thead>
<tr>
<th>Health System Comprehensive Palliative Care Program</th>
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<tbody>
<tr>
<td>Inpatient Consultation Team 24/7</td>
</tr>
<tr>
<td>Inpatient unit in flagship hospital or hospital &gt; 300 beds</td>
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<tr>
<td>Routine ID of all patients with unmet needs</td>
</tr>
<tr>
<td>ED/ICU Palliative Care integration Initiatives</td>
</tr>
<tr>
<td>Outpatient palliative care specialty clinic</td>
</tr>
<tr>
<td>Outpatient embedded palliative care services: primary care, ACO</td>
</tr>
<tr>
<td>Outpatient embedded palliative care services: specialty clinics</td>
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<tr>
<td>Generalist clinician initiative</td>
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<tr>
<td>Physician Fellowship</td>
</tr>
<tr>
<td>Program data reported to <em>National Palliative Care Registry</em></td>
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<tr>
<td>The Joint Commission <em>Advanced Palliative Care Certification</em></td>
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## Hospital Type/Size Matters

<table>
<thead>
<tr>
<th>Service</th>
<th>Large Academic</th>
<th>Community</th>
<th>Small/Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation Service</td>
<td>✅</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Unit</td>
<td></td>
<td>✅</td>
<td></td>
</tr>
<tr>
<td>Specialty PC Clinic</td>
<td>✅</td>
<td></td>
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<tr>
<td>Embedded Clinics</td>
<td>✅</td>
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<tr>
<td>Generalist Initiative</td>
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</tr>
<tr>
<td>ICU/ED integration</td>
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Truisms

✓ The real work of the future is to improve care decisions long before the “terminal” admission.

✓ There will never be enough palliative care specialists.

✓ Improving the work of generalist clinicians is essential to a broad based movement to improve patient-centered care.
Referral Based Palliative Care

Clinician Generated Referral

Clinic
Consult Service
Inpatient Unit
Home-care
Patient Centered Pall Care

All patients assessed

Palliative Care needs met by generalists

Specialist services as needed
Generalist Initiatives

• Clinical training
  ✓ Communication skills
  ✓ Attitudes/Ethics/Law
  ✓ Skills practice

• Systems Change
  ✓ Identifying the at-risk patient
  ✓ Standards for:
    o Patient assessment
    o Goals of care
  ✓ EMR changes
  ✓ QI
• Communication Training
• 8 hours; Cohorts of 20 learners
  • Required for hospitalists/RN care managers
  • Inpatient RN case managers
  • ED physicians asked to attend
  • Miscellaneous specialist physicians
  • Hospital opinion leaders
## Communication Training

### Giving Bad News
- Prognostication: cancer and non-cancer factors
- Decision Making Capacity
- Advance Directives: state law
- Informed consent: emergency exception
- Hospital policies

### Decision Making Capacity

### Advance Directives: state law

### Informed consent: emergency exception

### Hospital policies

### Family Goal Setting meeting-Part 1

### Family Goal Setting meeting-Part 2

### Conflict management

### DNR/CPR

<table>
<thead>
<tr>
<th>Role Play</th>
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<th>Role Play</th>
<th>Role Play</th>
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</thead>
<tbody>
<tr>
<td>Readings/Group discussion</td>
<td>Group Discussion</td>
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</table>
Comments

- Every clinician should go through this.
- This is the first time I’ve ever been taught a structured step-by-step approach.
- It takes time to practice different words and find what works.
- I hate role play, but I have to admit, it is the only way to learn how to do this better.
West Allis: Systems Change

- All patients have a goals of care discussion.
- GOC template embedded in EMR.
- The Quality Department reviews charts monthly for completion of GOC discussions and advance directive completion.
- Weekly mortality review for GOC discussions. Missing = peer review.

Early data:
- ↓ Inpatient mortality
- ↑ Patient satisfaction re: clinician communication
Evolution of Services

Hospice

Hospital Palliative Care

Community Palliative Care
IN CASE OF FIRE
YOU SHOULD EXTINGUISH IT

1. BLOW IT OUT
   - If the flame is caught in a small flame, it can be blown out if you notice it.

2. STOMP IT OUT
   - If the flame is a large one, it can be stamped out.

3. USE THE FIRE EXTINGUISHER
   - Use the fire extinguisher if it is too large to blow or stamp out.

DO NOT LEAVE THE ROOM TO GET HELP TO EXTINGUISH A FIRE IN THE LASER CUTTER. USE THE FIRE EXTINGUISHER.
Contact me

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www.palcareeducation.com

• Strategic Planning
• Education Program Design
• Generalist initiative
• Communication skills training