INTEGRATION OF PALLIATIVE CARE INTO THE PCMH MODEL:
ENHANCING PALLIATIVE CARE SKILLS FOR CARE TEAM

Phase II: Enhancing Palliative Care Skills for Care Team

Last Updated: March 29, 2017
CONTENTS

HOW TO USE THIS IMPLEMENTATION TOOLKIT ....................................................... 3
Overview: Integration of Palliative Care into PCMH Model - Phase II .......................... 4

PREPARING FOR IMPLEMENTATION ................................................................. 8
  Convene Project Work group .............................................................................. 8

IMPLEMENTATION GOALS ................................................................................ 9
  Goal 1: Implement Best Practices for Pain Management in Primary Care ............... 9
  Goal 2: Conduct Goals of Care Conversations with Patients with Serious Advanced Illness ........................................................................................................... 13
  Goal 3: Develop Community Partnership for Hospice Referrals for Patients at End-of-Life ........................................................................................................... 18
HOW TO USE THIS IMPLEMENTATION TOOLKIT

This Implementation Toolkit: Integration of Palliative Care into the PCMH Model - Phase II was developed by OneCity Health to enable primary care partners/sites to launch projects and oversee project performance.

The Toolkit is organized into three specific goals that address the integration of palliative care into primary care across the disease trajectory.

1. Implement best practices for pain management in primary care
2. Conduct goals of care conversations with patients with serious advanced illness
3. Develop community partnership for hospice referrals for patients at end-of-life

ONECITY HEALTH SUPPORT DESK

If you have any questions, please contact the OneCity Health support desk:

Phone Number:
646-694-7090

Email ochsupportdesk@nychhc.org,
with the subject line “Palliative Care Project”

Hours of Operation:
Monday through Friday from 9am to 5pm ET
OVERVIEW: INTEGRATION OF PALLIATIVE CARE INTO PCMH MODEL - PHASE II

PROJECT OVERVIEW

In the groundbreaking 2014 report Dying in America\(^1\) the Institute of Medicine recommended that all people with advanced serious illness have access to palliative care specialists. While the recommendation is important, the reality is that there are not enough specialist palliative care providers to meet all of the current or future need in the US. This gap is likely to grow as people live longer and the population ages. Explicit integration of palliative care into primary care has been recommended by a number of health care experts as a means to strengthen primary care relationships and fulfill an unmet need while reserving scarce specialist palliative care for the most complex cases.\(^2\)

Phase II of the Integration of Palliative Care into the PCMH model (“palliative care project”) will build on the success of Phase I: Simple Advanced Planning, and focuses on providing training and quality improvement support for incremental but impactful strengthening of palliative care interventions in the primary care setting.

The objectives of Phase II are to strengthen the palliative care skills of primary care teams, including:

- Safely managing chronic pain (e.g., non-pharmaceutical options for pain management, standard safe practices for opioid prescribing)
- Improving the frequency and quality of goals of care conversations between primary care teams and patients as well their family members Using tools and resources that help patients at end of life (e.g., Medical Orders for Life-Sustaining Treatment (MOLST), hospice referral)


IMPLEMENTATION STRATEGY

The implementation of Phase II is broken down into three goals.

Phase II Goals:

1. Implement best practices for pain management in primary care
2. Conduct goals of care conversations with patients with serious advanced illness
3. Develop community partnership for hospice referrals for patients at end-of-life

The goals are based on the milestones provided by New York State for completion of this project and on evidence of what strategies work to improve the integration of palliative care into primary care. This toolkit also utilizes the Institute for Healthcare Improvement (IHI) Model of Improvement as the framework to guide this work. Each goal will consist of specific steps to help achieve implementation and prepare for using the IHI Framework to test assumptions about how to achieve change.

You may find that your organization has already worked on and achieved improvements in some or all of these areas. If this is the case, then the Palliative Care Project is an opportunity to further strengthen and enhance your work in key areas.

OVERVIEW OF MODEL FOR IMPROVEMENT

The Model for Improvement is a conceptually simple model that health care practices can apply as they begin their journey toward improvement. Two primary components of the Model for Improvement are identifying small tests of change and conducting Plan, Do, Study, Act (PDSA) cycles that allow for care to continue to be delivered while clinicians apply small changes to processes. OneCity Health will provide information and guidance on using the Model for Improvement throughout this toolkit, and additional materials about the Model for Improvement can be found in Appendix A.

Identifying small tests of change

While all changes do not lead to improvement, all improvement requires change. The ability to develop, test, and implement changes is essential for any individual, group, or organization that wants to continuously improve. After generating ideas, run Plan-Do-Study-Act (PDSA) cycles to test a change or group of changes on a small scale to see if they result in improvement. If they do, expand the tests and gradually incorporate larger and larger samples until you are confident that the changes should be adopted more widely.

Some tips for consider when conducting small tests of change:

- Plan multiple cycles to test a change
- Scale down the size of the test (the number of patients or location)
- Test with volunteers
- Do not try to get complete consensus, “buy-in,” etc.
- Be innovative to make the test feasible
- Collect useful data during each test
- Test over a wide range of conditions
- Try a test quickly

3. http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx
**Conduct PDSA cycles/ small tests of change**

Once you have identified the changes you wish to test, use the framework of the PDSA cycle to begin tests of change. Below are the core activities for each step of a PDSA cycle. Additional examples and worksheets can be found in Appendix A.

**Plan**
Plan the test or observation, including a plan for collecting data.

- State the objective of the test
- Make predictions about what will happen and why
- Develop a plan to test the change (Who? What? When? Where? What data need to be collected?)

**Do**
Try out the test on a small scale

- Carry out the test
- Document problems and unexpected observations
- Begin analysis of the data

**Study**
Set aside time to analyze the data and study the results

- Complete the analysis of the data
- Compare the data to your predictions
- Summarize and reflect on what was learned

**Act**
Refine the change, based on what was learned from the test

- Determine what modifications should be made
- Prepare a plan for the next test
Tips for Using the Model for Improvement

Each goal in this toolkit will require PDSA cycles to test assumptions about how an intervention is working, review how current processes are working, and make changes based on small tests of change. Below are some general principles that can guide this work:

• Start out very small with one change, or bundle a group of changes with a very small population in a specific setting. For instance, if your practices decide to implement a risk assessment and a treatment agreement for all patients starting opioids, it may make sense to group these two activities together in one PDSA and view them as a bundle. Alternatively, it may be easier to start out with one element per PDSA, such as the risk assessment, and add others afterwards.

• Don’t be too concerned about the specific terminology in the PDSA cycle, but rather think about what is a manageable, realistic scope for this first test of change. Remember, one of the benefits of using the Model for Improvement is the ability to quickly test small changes and then decide to either keep it, refine it or drop it!

• Once you have conducted several tests of change on a small scale, develop a plan to both sustain the change in the current setting and spread the change to other settings. For instance, if you started conducting a test with one provider, develop a plan to begin implementing the change with other providers. If you have started to implement a change in one particular clinic, develop a plan to begin implementing the change in different clinic settings.

PHASE II TRAINING SUPPORT

To support primary care teams in this work, OneCity Health has partnered with the Center to Advance Palliative Care (CAPC), a national organization dedicated to increasing the availability of quality palliative care services for people facing serious illness. All employees at OneCity Health partner organizations may obtain free access to CAPC member benefits, including a number of helpful training resources and tools. Through CAPC, free online continuing medical education (CME) and continuing education (CE) units are available for thirty-five courses on palliative care, ranging from basic front-line education to technical courses for symptom management and prescribing. In addition, members may access tools and participate by phone in regularly scheduled expert faculty office hours.

Please reach out to the OneCity Health support desk (ochsupportdesk@nychhc.org | 646-694-7090) to obtain access for your staff, or visit www.capc.org.
PREPARING FOR IMPLEMENTATION

CONVENE PROJECT WORK GROUP

Palliative Care Work group
Convene a work group to lead the implementation and development of the Palliative Care Project. Consider including work group members from a variety of backgrounds and roles, such as:

- Physicians
- Nursing
- Social work
- Palliative care specialists
- Care coordination/case management
- Pharmacy
- Health education
- IT staff

Implementation Leader
Identify an implementation leader to oversee the implementation. Specific tasks include:

- Engaging with clinical and administrative leadership to advocate for implementation and provide progress updates and reports
- Organizing work group and scheduling and facilitating meetings
- Ensuring that any necessary trainings are scheduled and attended
- Monitoring and troubleshooting implementation
- Ensuring that all steps of the project are completed on time

Clinical Champion(s)
Identify a clinical champion who is well-positioned and able to engage, educate and lead others in the site-level implementation. Specific activities of the champion include:

- Engaging and advocating for palliative care improvements with clinical leaders
- Collaborating with clinical staff to ensure they have the tools and resources needed to be successful
- Working closely with the implementation leader to ensure that necessary training and support, including staff time, is in place
- Ensuring that the site’s implementation planning is geared towards effectively improving patient outcomes
IMPLEMENTATION GOALS

GOAL 1: IMPLEMENT BEST PRACTICES FOR PAIN MANAGEMENT IN PRIMARY CARE

Unrelieved pain diminishes patients’ quality of life, decreases function, and contributes to poor health outcomes. An estimated 50 million Americans have chronic pain, and 41% of patients with chronic pain report that their pain is not controlled. Chronic pain is the most common cause of long-term disability and is associated with reduced physical, psychological, and social well-being with resultant increased use of health services. Chronic non-cancer pain is a symptom of many diseases (e.g., osteoarthritis and diabetic neuropathy) and often occurs in the absence of a specific underlying diagnosis.

Primary care physicians face dual challenges from the emerging epidemics of under-treated pain and prescription opioid abuse. These providers must address the challenge of maintaining therapeutic access for patients with a legitimate medical need for opioids, while simultaneously minimizing the risk of abuse, addiction and diversion. Safe and effective pain management requires clinical skill and knowledge of the principles of opioid treatment as well as the effective assessment of risks associated with opioid abuse, addiction, and diversion.

For Goal 1, your primary care team will implement best practices for pain management, including best practices to support safer use of opioid analgesics in the treatment of chronic pain in the primary care setting, based on the Centers for Disease Control and Prevention Guidelines released in 2016.

These guidelines are intended for primary care clinicians (e.g., family physicians and internists) who are treating patients ≥ 18 years of age with chronic pain (i.e., pain lasting >3 months or past the time of normal tissue healing) in outpatient settings. These guidelines do not refer to opioid prescribing practices for palliative or end-of-life care and may not be relevant for other physicians with patients with special needs. They do not refer to opioid prescribing in the emergency department or urgent care settings.

A sample pain management guideline, developed in conjunction with and reviewed and recommended by the NYC Health + Hospitals Palliative Care Council, can be found in Appendix B. Organizations may wish to review and revise this guideline to meet their own operational needs.

Goal 1 implementation includes the following steps:

- Step One: Conduct a meeting with the clinical team to review and discuss the guidelines
- Step Two: Map/review current work flows for management of pain in clinic
- Step Three: Identify specific area of focus to conduct PDSA cycles/ small tests of change
- Step Four: Conduct PDSA cycles/ small tests of change
- Step Five: Sustain tests of change in original location and spread to other locations/ populations

**Step One: Conduct a meeting with the clinical team to review and discuss the guidelines**

The Clinical Champion should lead this meeting. Use a scheduled meeting time or schedule a separate meeting to review the guidelines for use of opioid analgesics in the treatment of chronic pain in the primary care setting.

The agenda of this meeting is to:

- Review guidelines with the clinical staff
- Identify any areas of concern amongst the clinical providers
- Identify pragmatic barriers to following these guidelines and discuss how they can be addressed

Specific elements to review in the guidelines include use of:

- Comprehensive pain assessment including functional and psychosocial assessments
- Treatment agreement and formal risk assessment for patients being prescribed opioids
- Urine tests for patients being prescribed opioid medication
- Evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder

**TRAINING TIP!**

Take some online training modules with free CME/CEU on pain management and safe opioid prescribing from the Center to Advance Palliative Care

**IMPLEMENTATION GOALS**
**Step Two: Map/review current work flows for management of pain in clinic**

With the work group, discuss your clinic’s current work flows related to pain management. It may be helpful to begin by asking “What do we already know is true about our practice that is related to the issues of pain management and opioid prescribing?” and then write bullet point responses to the question, eliciting feedback from the full team. Some additional issues that may be helpful to discuss include:

- Characteristics of patients with chronic pain in the community that the practice cares for
- Community factors that make it more challenging or easier in caring for patients
- Challenges the practice has experienced in caring for patients with chronic pain (An optional tool to help guide this conversation is located in the appendix of this document)

Based on this information, make a list of each step in the process, grouping together all tasks done by one job function (receptionist, medical assistant, nurse, provider, etc.). Describe clearly the tasks involved in each process step, so everyone shares a complete understanding and the steps to visually represent the path taken by the patient and her/his information.

**Step Three: Identify specific area of focus to conduct PDSA cycles/small tests of change**

With the work group, review the guidelines and current work flows to identify opportunities for improvement and select a specific area of focus to conduct PDSA cycles/small tests of change. The Appendix contains several resources that can support specific changes related to pain management, such as formalized risk assessments and patient education materials.

**Example areas of focus/ PDSA cycles**

<table>
<thead>
<tr>
<th>Area of focus</th>
<th>Sample PDSA Cycles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk assessment</td>
<td>Administer evidence based risk assessment tool to 10 patients experiencing chronic pain and currently being prescribed opioid medication in the geriatric clinic over the next two months</td>
</tr>
<tr>
<td>Nonpharmacologic interventions</td>
<td>Refer 3 patients experiencing chronic pain to community resources related to pain management (e.g., acupuncture) prior to prescribing opioid medication</td>
</tr>
<tr>
<td>Treatment agreements</td>
<td>Administer treatment agreements to 3 patients receiving opioids for chronic pain (&gt;3 months) over the next two months</td>
</tr>
<tr>
<td>Urine tests</td>
<td>Administer urine tests for 5 patients receiving opioids for chronic pain (&gt;3 months) over the next two months</td>
</tr>
</tbody>
</table>
**Step Four: Conduct PDSA cycles/small tests of change**

Under the leadership of the clinical and quality improvement champion, use the framework of the PDSA cycle to begin tests of change. Additional examples and worksheets can be found in Appendix A.

**Example of Completed PDSA cycle**

Pain management: Administer treatment agreements to 10 patients experiencing chronic pain (>3 months) and starting opioid treatment in the geriatric clinic over the next two months.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Administer 3 treatment agreements with patients beginning to take opioids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do</td>
<td>Dr. J completed 3 agreements over the past week with her patients</td>
</tr>
<tr>
<td>Study</td>
<td>Two patients were initially hesitant to sign form; engagement took long time in twenty minute visit for all 3 patients</td>
</tr>
<tr>
<td>Act</td>
<td>Nursing staff will go over the treatment agreement and provide educational material to patients prior to primary care appointment; Dr. J to test new work flow with 2 more patients</td>
</tr>
</tbody>
</table>

**Step 5: Sustain tests of change in original location and spread to other locations**

Once you have conducted several tests of change on a small scale, develop a plan to both sustain the change in the current setting and spread the change to other settings.

**Example sustaining change across settings**

**Testing a change**

Dr. J has completed 5 treatment agreements with patients prior to starting opioid regimes. Incorporating nursing and patient education into the work flow has reduced the amount of time it takes to complete the form in the primary care appointment. Patients are more receptive to the form; Dr. J is happy with the new work flow.

**Implementing a change**

The other doctors and nurses at Dr. J’s clinic begin using the new work flow and administering treatment agreements.
GOAL 2: CONDUCT GOALS OF CARE CONVERSATIONS WITH PATIENTS WITH SERIOUS ADVANCED ILLNESS

Primary care physicians and their teams often serve as the most trusted health care providers for patients and families, having built rapport and relationships over time. They often diagnose and inform patients of serious illness and routinely discuss and implement treatment options. The integration of primary care and palliative care encourages important conversations with patients and families on crucial issues including: prognosis, treatment options, goals of care and advanced care planning.⁸

For Goal 2, the primary care team will focus on conducting goals of care conversations with patients with serious illness.

Effective communication is key to helping patients adapt to the reality of living with a serious illness. Understanding the patient’s care goals in the context of a serious illness allows the clinician to align the care provided with what is most important to the patient. Discussing goals of care can and should occur throughout the disease trajectory and may be integrated into a routine visit or scheduled for a dedicated visit, depending on where the patient is in the illness trajectory and in their thoughts, goals and beliefs. Advanced care planning can be an outcome of goals of care conversations, and this toolkit will briefly review advanced care planning documents in this context, including MOLST⁹. There are other potential advance care planning outcomes of goals of care conversation, such as healthcare proxies or living wills.


TRAINING TIP!

Take some Online training modules with free CME/CEU on discussing prognosis, clarifying goals of care, and advance care planning from the Center to Advance Palliative Care
Goal 2 implementation steps include:

- Step 1: Conduct meeting with work group to discuss current processes for integrating goals of care conversations and/or advanced care planning in primary care visits
- Step 2: Identify patient population who would benefit from goals of care conversation
- Step 3: Review the MOLST form with clinical team as an option for documenting treatment preferences at the end of life
- Step 4: Identify specific area of focus to conduct PDSA cycles/small tests of change
- Step 5: Conduct PDSA cycles/small tests of change
- Step 6: Sustain tests of change in original location and spread to other locations/populations

Step 1: Conduct meeting with work group to discuss current processes for integrating goals of care conversations and/or advanced care planning in primary care visits

Some guiding questions which may be helpful include:

- How do we currently incorporate goals of care conversations?
- How do we refer patients to specialty palliative care if needed?
- What are some examples of goals our patients may have for care?
- What types of patients would benefit from this activity?
- How are goals of care conversations different from advanced care planning, and how is this different from MOLST?
- What types of advanced care planning do we currently do in our clinic?
- For our very sick patients who are not yet at the end of life, what types of supports are available in the community outside of clinical services? How do we connect to those services?

As a result of this conversation, document the current workflow for conducting goals of care conversations and any specific protocols around advanced care planning in your clinic.
Step 2: Choose target population of patients with advanced illness to have goals of care conversations

There are many different ways to identify patients with palliative care needs who may benefit from a goals of care conversation. When selecting a target population to initially focus the intervention on, think about data that is easy to access and easy to refresh. If you do not have easy access to claims data or other quantitative methods, consider using provider or staff referral, leveraging huddles or other routine venues to review patient lists, or drawing on clinical data accessible in the EMR.

Below is some guidance from leaders in the field for core recommendations to identify patients with complex needs, particularly how to use data when utilization data is not robust:

“A first step is to pull together the data that you have. One thing to be aware of is to not let perfect be the enemy of good. There is no perfect risk prediction tool, specifically for your population or just in general. Start with what you have and refine it as you learn more about your chosen population.”

- Clemens Hong, MD, a primary care physician, and Medical Director of Community Health and Improvement for Los Angeles County, California

Potential qualitative and quantitative methods that can be used to identify patients include:

- Accessible health care utilization data and/ or predictive models
- Clinical information systems to identify individuals (e.g., diagnosis flags)
- Primary care providers referrals of individual patients

Additional materials to support patient identification methods can be found in the Appendix C.
Step 3: Review the MOLST form with clinical team

A component of discussing goals of care with patients may be completion of an advanced directive. The Medical Orders for Life-Sustaining Treatment (MOLST) is a tool for patients who are at end of life and is designed to improve the quality of care people receive at the end of life. It is based on effective communication of patient wishes, documentation of medical orders on a brightly colored pink form and a promise by health care professionals to honor these wishes.10

Under State law, the MOLST form is the only authorized form in New York State for documenting both non-hospital Do Not Resuscitate (DNR) and Do Not Intubate (DNI) orders. In addition, the form is beneficial to patients and providers as it provides specific medical orders and is recognized and used in a variety of health care settings. While it is not required that primary care teams begin to administer MOLST forms as part of this phase of the palliative care project, components of advanced care planning will be covered in the training and it is important to be aware of any advanced directives a patient has completed either in or outside of primary care. Primary care providers should also be familiar with the MOLST form, even if the form is initiated in the inpatient setting, because providers must review and sign the form every 90 days thereafter. Suggested agenda items for the meeting are below and additional materials are available in Appendices C and D:

- Overview of MOLST
- Review MOLST form and related documents (available in Appendix D)
- Q & A about MOLST and any current work flows around MOSLT at the clinic (track questions or issues that need answers)
- Discuss members’ role/responsibilities for what to do if a patient brings in a MOLST

Plan
Over the next two weeks, Dr. S will conduct goals of care conversations with 4 of her patients in the Geriatric clinic whom she identifies during morning huddles as having life-limiting diseases

Do
Dr. S conducted four goals of care conversations over two weeks

Study
Two patients were upset and were reticent to talk about goals of care; two patient’s family members were asking questions and there was not time to discuss goals of care in the appointment in depth

Act
Dr. S will document conversation in notes; collaborate with social worker for patients who need additional support for conversation

As a result of this meeting and other training resources, members of the care team should be able to:

- Define the purpose and function of the MOLST form
- Recognize the MOLST form
- Identify resources for further learning about administration of MOLST and other advanced care planning

**Step 4: Identify specific area of focus to conduct PDSA cycles/ small tests of change**

One you have identified your target population, identify a specific area of focus for a PDSA cycle/ small test of change.

Sample tests of change include:

- Conduct 10 goals of care conversations with patients in the Adult Medicine clinic who are 70 or older AND have COPD over the next 3 weeks
- Dr. S will conduct five goals of care conversations with her patients in the Geriatric clinic over the next two weeks

**Step 5: Conduct PDSA cycles/small tests of change**

Under the leadership of the clinical and quality improvement champion, use the framework of the PDSA cycle to begin tests of change.

**Example of a Test of Change**

Goals of care conversation: Dr. S will conduct four goals of care conversations with four of her patients in the Geriatric clinic over the next two weeks.

**Step 6: Sustain tests of change in original location and spread to other locations/populations**

Once you have conducted several tests of change on a small scale, develop a plan to both sustain the change in the current setting and spread the change to other settings/ populations.

**Example**

**Testing a change**

Dr. S had completed 4 goals of care conversations with her patients. Using an updated work flow to document when goals of care conversations have been started in the medical note, and then following up at subsequent appointments has been an effective way to increase patient engagement in goals of care conversations over the course of several visits.

**Implementing a change**

Another doctor and a nurse practitioner at Dr. S’s clinic begin conducting goals of care conversations with patients on dialysis and/or who have COPD/ CHF.
GOAL 3: DEVELOP COMMUNITY PARTNERSHIP FOR HOSPICE REFERRALS FOR PATIENTS AT END-OF-LIFE

Hospice is a set of specialized services to help patients and their families cope with a terminal illness. It is usually provided in the patient’s home. Hospice services can include regular visits by a nurse and other staff, expert management of pain and other symptoms, and support for caregivers. Hospice is a Medicare benefit. Studies have shown that hospice enrollment improves quality of life for patients and their families at end of life.¹¹

Goal 3 of the palliative care project focuses on developing a strong partnership with a community hospice provider to facilitate referrals to hospice. For patients who are end of life, a potential outcome of a goals of care conversation, in addition to MOLST, may be a referral to hospice for those who are expected to have 6 or less months to live. The majority of caregivers and families of patients who have received hospice care report that they would have welcomed more information about hospice from their primary care physician at the time the diagnosis was labeled terminal. Continuity of care and multi-generational relationships allow primary care physicians to guide a patient and family through the hospice referral process with a unique knowledge of the patient’s values, family issues, and communication style.¹²

Goal 3 implementation steps include:

- Step 1: Conduct a work group meeting about using the hospice benefit with the palliative care work group
- Step 2: Conduct outreach meeting with a community hospice partner
- Step 3: Identify patients who are appropriate for hospice referral
- Step 4: Identify specific area of focus to conduct PDSA cycles/small tests of change
- Step 5: Conduct PDSA cycles/ small tests of change
- Step 6: Sustain tests of change in original location and spread to other locations/ populations


TRAINING TIP!

Take some Online training modules with free CME/CEU on communication skills from the Center to Advance Palliative Care to facilitate discussions around advanced care planning and hospice referral
Step 1: Conduct a work group meeting about referring to hospice in your clinic

There are a variety of barriers to referring to hospice that can include provider knowledge and attitudes towards hospice, family and patient’s attitudes towards hospice and end of life care, and time to conduct advanced care planning in the primary care setting.13

With your work group, assess current knowledge of hospice and provide additional education as necessary. There are a variety of education tools about hospice and hospice referrals for healthcare providers in Appendix E of the toolkit.

Once you have established a baseline knowledge of what hospice is and who may be appropriate for referral, discuss your clinic’s current process for referring patients and common barriers and solutions. Some guiding questions may include:

- What are some common barriers to hospice access and enrollment in our community? Potential barriers may include: patient/ family reluctance/ denial, lack of palliative care resources, lack of resources for uninsured patients, unclear prognosis, or lack of knowledge of hospice partners in the community.
- Who are some of the hospice partners in the community we refer to most often?
- Are there existing formal relationships (e.g., MOU, contracts) about how we refer to hospice?
- Are there any staff who can come on-site from local hospices to help facilitate referrals?
- What are some ways we can overcome these barriers and obstacles?

Based on this meeting (or a series of meetings) identify one community hospice partner to reach out to and develop a more integrated referral process. A list of hospice providers in New York City can be found in Appendix E.

Step 2: Conduct outreach meeting with a community hospice partner

Once your site has identified one or more hospice partners to partner with on referrals, arrange a meeting with members of the hospice and members of the primary care work group. This meeting can either be in person or over the phone.

Goals of this meeting may include:

• A working relationship between primary care and hospice providers, which will be important over time as processes are built, evaluated, and improved

• Education between organizations about hospice services and staffing, and about the primary care practice’s patient population and team structure

• Clearer referral processes, including:
  » Specific contact at hospice for primary care staff to communicate referral
  » Communication processes for between hospice and primary care provider at time of referral and during enrollment
  » Sharing of data to monitor and support effectiveness of partnership (e.g. # or referrals and enrollments, reasons why patients don’t enroll, LOS of enrolled patients

• Identification of specific needs for the patient population, such as cultural competence (including language) needs

While the relationship does not need to be a formal contract, we recommend having a written procedure that documents the agreed upon process for patient referral. While patient choice will always remain paramount in connecting with a hospice, having an integrated relationship with a program can facilitate smooth handoffs and increase both referrals and acceptance of referrals.

Step 3: Identify patients who are appropriate for hospice referral

Only a small number of patients in a primary care panel may appropriate for hospice referral at any given time. It may make sense at the beginning to identify patients as part of the huddle, while reviewing individual patient panels, or while reviewing data on recently hospitalized patients, as opposed to using disease specific criteria or utilization data.

Primary care sites may want to explore partnering with specialty clinics such as cardiology or pulmonology to identify mutual patients who eligible for hospice referral.

Studies have found that racial/ ethnic minorities are less likely to use hospice that white populations.14 Patient outreach and engagement strategies to enhance cultural competency and outreach can be found in Appendix E.

Step 4: Identify specific area of focus to conduct PDSA cycles/small tests of change

One you have identified your target population, write a specific area of focus to conduct a PDSA cycle/ small test of change.

Sample tests of change include:

- Providers in geriatric clinic will offer hospice referral to at least 1 appropriately identified patient using the new work flow over the next month

Step 5: Conduct PDSA cycles/ small tests of change

Under the leadership of the clinical and quality improvement champion, use the framework of the PDSA cycle to begin tests of change. Remember to start small and easy. Ask primary care team members to consider a few (2-3) patients using the chosen screening method, or start out with the clinical champion piloting the process with one or more of her patients.

Discuss different work flows with your clinical team and identify the ways you would like to incorporate this work into existing clinical practices. It may be helpful to have more frequent outreach with the hospice partner as you test this work flow to identify areas for improvement and potential areas of collaboration

Example of a Test of Change: Refer to Hospice

| Plan | Providers in geriatric clinic will refer 4 patients to hospice using newly agreed on work flows over the next month |
| Do | Two providers referred two patients over a month |
| Study | Neither patient accepted hospice referral; one patient did not feel comfortable speaking with a stranger. One patient expressed confusion about what hospice was and why they needed it |
| Act | Hospice partner volunteered to send a nurse to primary care site to speak with patients in more detail about hospice and implement a warm hand off. Providers in geriatric clinic will identify at least more patients using the new work flow over the next few weeks |
Step 6: Sustain tests of change in original location and spread to other locations/ populations

Once you have conducted several tests of change on a small scale, develop a plan to both sustain the change in the current setting and spread the change to other settings/ populations.

Example Testing a Change

Two providers in the geriatric clinic referred 5 patients to hospice, and in a subsequent appointment introduced the patients and their families to a hospice nurse in person in the clinic. The hospice nurse subsequently screened 4 of these patients for hospice eligibility and provided more education about hospice to the patient and their families. Two patients were found eligible and one patient was enrolled in hospice. The providers were happy that the hospice nurse was able to complete eligibility criteria, and the patients were more receptive to speaking about hospice when the provider introduced them to the hospice nurse.

Implementing a change

Providers in the HIV clinic will begin to refer to hospice using the same work flow.