BACKGROUND

Over the past five years, Moffitt Cancer Center has implemented a number of initiatives to better integrate palliative care services with cancer care. Among Moffitt’s cornerstone efforts to standardize the integration of palliative care services were the development of patient screening tools and treatment pathways. While some of Moffitt’s new tools were originally designed specifically for clinics participating in its value-based contracts (i.e., oncology medical home model and cancer-specific ACO), Moffitt opted to standardize care across the institution to create greater accountability for outcomes, quality, and costs. The screening tools and treatment pathways add multiple potential avenues for integrating palliative care into routine workflows by increasing oncologists’ awareness of their patients’ palliative care needs and by defining the circumstances under which a palliative care referral is either recommended or mandated.

APPROACH

Moffitt’s systematic approach to integrating palliative care into its oncology population management includes two main components: routine screening and assessment, and clinical pathways that include palliative care consultation.

As Moffitt prepared for the launch of its oncology ACO in 2013, its leadership oversaw a multi-disciplinary effort to design a screening tool to stratify new ACO patients by level of palliative care need. The stratification tool incorporates the following: (1) a physical domain that includes age, stage of disease, and number of comorbidities; (2) a functional domain that includes fall risk, weakness, ability to conduct activities of daily living, and transportation needs; (3) a psychosocial domain that measures stressors such as anxiety, depression, family conflict, and financial need; and (4) a health care utilization domain including past ED visits and hospital admissions. Initially paper-based, the tool was integrated into the EHR for ACO-attributed patients in early 2017.

Depending on their level of need, patients are referred to a nurse care coordinator or a social worker to conduct further assessment and take steps to address the patient’s needs. For those designated as high risk, the nurse care coordinator is empowered to make direct referrals to specialty palliative care.

While this risk stratification tool is an important element of Moffitt’s Florida Blue ACO agreement, implementation has been variable in busy clinics. Moffitt has since developed a patient-reported and electronically-integrated symptom assessment tool to screen patients for palliative care needs. Patients complete the new assessment on tablets while in the waiting room before every clinical encounter and results flow directly to the EHR. Patients assess their symptom burden using the validated Edmonton Symptom Assessment Scale (ESAS). If patients score above a 6 on the 0-10-point scale for any given symptom, the EHR highlights the high score so that interventions may be considered. The system currently stops short of automated alerts or prompts for action.

After a successful pilot in 2015, the new tablet-based assessment is steadily being rolled out across Moffitt clinics, and is under consideration for use in the partnering ACO clinics. The tool has now become a platform for a new system-wide strategic initiative to use patient-reported outcomes to improve clinical care.

In addition to the assessment, Moffitt has also implemented clinical care pathways with palliative interventions included at important junctures such as diagnosis of metastatic cancer, recurrence of a tumor, or failure of second line treatment and more. To develop these care pathways, Moffitt sought the participation of palliative care specialists in an interdisciplinary collaborative effort. Together the group determined the most appropriate junctures for integrating care strategies that use symptoms as high alerts. By achieving consensus for when palliative care is needed, Moffitt gained the buy-in of palliative care specialists by generating awareness and by making their involvement much more systematic.
To date, palliative care has been included in 27 of 55 disease-specific outpatient oncology pathways at Moffitt. The cancer center is building these pathways into the EHR – including order prompts for palliative care services – to provide oncologists with real-time decision support. Moffitt leaders report that the pathways not only improve patient care, but also contribute to strong payer relationships as the processes are a means to improve quality, reduce variability, and decrease costs.

**RESULTS TO DATE**

Moffitt’s strategy has contributed to greater physician engagement by alerting to high symptom burden and supporting shared decision-making. The high score designation in the EHR has improved clinicians’ attention to pain and other symptoms, and providers have reported positive feedback on this approach.

By pinpointing target triggers for symptom relief and working toward consensus with colleagues on when palliative care specialists should be engaged, Moffitt is slowly achieving culture change in which palliative care becomes a “baked in” element of standard care delivery. While Moffitt works toward attaining its shared savings targets – which it has done in the oncology medical home model but has yet to do in the ACO – leadership continues to see promise in palliative care integration as a path to improving quality and constraining spending.

**TOOLS & VENDOR PARTNERS**

Moffitt’s clinical care pathways are developed entirely in-house and are the result of collaboration and consensus-building between multiple departments. EHR integration of the pathways is also developed with internal IT resources. The tablet-based symptom assessment tool leverages a home-grown software application to deploy the widely-used and validated ESAS. Moffitt’s assessment of risk and palliative care needs draws from multiple sources.

**CHALLENGES WITH IMPLEMENTATION**

Competition for available IT resources presented one of the biggest challenges in the development of Moffitt's tablet-based tool, requiring that departments submit a business case to determine the application’s priority in a busy project queue. Similarly, integration of the clinical care pathways into the EHR requires considerable IT resources and has necessitated patience. Of the 55 pathways developed to date, seven have been integrated into the EHR, with an additional eight planned to go live in 2018.

**KEY LEARNINGS**

- **Achieve consensus** – Culture change requires the inclusion of all stakeholders from leadership to front-line staff. Use collaborative approaches to gain buy-in by achieving consensus.
- **Plan for growth** – Integrating new palliative care entry points into standard workflows required Moffitt be prepared to meet patient needs as they were identified. Careful planning for rapid increases in patient volume was key to meeting patient needs effectively.
- **Create opportunities not triggers** – Moffitt avoided creating automatic triggers for specialist palliative care consultations in favor of creating new opportunities to identify needs and engage oncologists to recognize and meet them.

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