

Good evening and welcome back to another episode of Yale Cancer Answers. I am your host this evening, Dr. Stephen Gore. I am joined tonight by my guests Dr. Bonnie Gould Rothberg, who is the Medical Director of the Extended Care Clinic at Smilow Cancer Hospital and Vanna Dest, Manager of Oncology Advanced Practice Providers. We are here this evening to discuss extending care options for patients with cancer.

Gore Bonnie and Vanna, thank you very much for joining me tonight.

Vanna Thank you so much.

Bonnie Thank you.

Gore It has already been such a great challenge to have to spell out all these syllables, extended care clinic. What is an extended care clinic?

Bonnie The extended care clinic is a focused urgent care clinic where we can see our Smilow patients in a quiet, thoughtful manner. We also provide opportunities for the patients who need supportive care outside of normal clinic hours – transfusions, extra-hydration, management of pain or nausea.

Gore So, this would only be open after the clinic is closed?

Vanna The extended care clinic is open 16 hours a day, from 7 a.m. to 11 p.m. and it is by appointment only. So, no walk-ins.

Gore I see. Why can't these patients be accommodated in the regular treatment setting?

Bonnie We try to maintain our patients getting treated in the infusion plots that we have, but this is a way to minimize the amount of patients that are going to the emergency room.

Gore I see. What are the disadvantages for a cancer patient going to an emergency room?

Bonnie It is not really a disadvantage. I mean, we can all relate to emergency room experiences of our own. It is a noisy environment, the wait times can be longer than we would like and thinking about an oncology patient, the providers in an emergency room obviously deal with a broad-spectrum of medical conditions and are not always in-tune with the specific needs of a cancer patient. So, we provide a service that tries to fulfill those types of urgent needs with a set of providers that are specifically trained in oncology care.

Gore Are these emergency room physicians who have a specialty in oncology?

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Vanna The advantage of the extended care clinic is that there is continuity of care of our patients. So, the APPs which are advanced practice providers, both nurse practitioners and PAs, are specialized not only in urgent emergency

medicine, but also in oncology. There is a lot of communication that still happens with their primary oncologist and also the advanced practice providers and their disease team.

Gore You said this is by appointment only. That seems like sort of an oxymoron, if it is an emergent facility and you have to have an appointment, I think I am going to have an emergency tomorrow, can I have an appointment?

Bonnie Let me provide an analogy. There are certain restaurants where you need a reservation and you can walk in, but you may have to wait an hour and a half to be seated. If you have a reservation, you come in at the time and they bring you to your table. Unfortunately, we only have 6 spots. So, we want to make sure that we can accommodate the folks who need to come to us and we do not want people that need care to have to wait. If we know when somebody is coming in advance, we can assure that they have space, but again, it does not have to be hours in advance or days in advance, we need patients to call their primary disease team providers. The primary disease team provider will at that moment reach out to us, talk to us, we will sort out space management and then we will either invite the patient to us or if we unfortunately do not have any room at that time, we will work with the emergency department to facilitate appropriate care. Having said all that, there are certain conditions where we feel strongly that the patient should go to the emergency department, so for example, chest pain where they are concerned about having a heart attack, extreme shortness of breath where they may be concerned for the patients not being able to continue breathing without a breathing tube and obviously if somebody is feeling that they are having a stroke. Those are things that the emergency department are much better at than we are.

Gore So real critical things you should go to the emergency room, regardless it seems like. How long has this unit been operating?

Vanna It has been open since April 3, 2017. We have actually been in operation now for a little bit over 9 months, and I think what is really very impressive is that we have seen over 2000 patient visits.

Gore That sounds like a lot. Vanna And out of those 2000 patients that have been seen, 70% of those patients are able to go home.

Gore Instead of being admitted to the hospital.

Vanna Exactly.

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Gore Do you have any sense for if you did not have this unit available and if the patient had to go to the emergency department, how many might have been admitted?

Vanna We have looked at data, probably about 5 years ago and we looked at the number of oncology patients that had gone to the emergency room and 90% of those patients were actually getting admitted. And their length of stay

was about 5-6 days, so there was also an increase in hospital cost, so that really helped us to start to look at what can we do to make this better for our patients. We want the patients to be home with their loved ones and to be cared for by other supportive services that we do have.

Gore That seems like quite an impressive change if 90% of these emergency department treated oncology patients used to get admitted and now only maybe 30% of these people come to this clinic.

Vanna We are able to draw in a lot of our supportive services, such as palliative care and also pain management to really help our patients be better managed at home.

Gore What should a patient expect if they were going to be seen in this extended care unit?

Bonnie All patients are immediately triaged by the advanced practice provider and a nursing team. The advanced practice providers are the primary care providers in the extended care clinic.

Gore So, that would be nurse practitioners and physician's assistants?

Bonnie Correct. Myself as the attending in the clinic. I am there multiple times a day. I come in and I round on all patients. I get a chance to think about medicine, I get a chance to talk to everybody. So, personally, I want to say that I think I have the best job in Smilow.

Gore Really. Why is that?

Bonnie Because I work with a wonderfully collaborative team, a wonderfully capable team. My APPs are outstanding, I trust them all implicitly, each of them has a really strong depth of knowledge, and a wonderful manner with each of their patients. They are very thoughtful; when we do talk about patients, they have already done all of the heavy lifting, they have ordered all of the right diagnostic tests, done the physical exam, done all of the initial workup, so that when I am sitting down and working with them and sorting out what is the right best next step, I have all of the information that I need. Then, we work collaboratively. I get a chance to talk with the patients, learn a little bit more about them, learn about their life outside of the hospital and then we work collaboratively to be able to sort out what is the right disposition, and I do want to mention that the average length of stay had been 5-6 days, and even we do have to admit some patients, there

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are some patients where it is safer for them to stay in the hospital, but we are, in the extended care clinic, able to start the inpatient care plan, so we can actually shorten the length of stay by making sure they are getting the right set of antibiotics right after that, making sure that the right pain services, palliative care services are informed, so that we can do the care management right from the get-go.

Gore That sounds great. And how long, how much time was involved in planning this kind of unit? I have no idea how you start up a mini emergency room out of I guess nothing, right?

Bonnie It was probably a good 12-18 months of planning, and we had our multidisciplinary team that met every other week and then eventually once a month, to really look at all of the processes that needed to be in place.

Gore Walk us through how that started? Bonnie First, the business plan had to be put in place. We know we needed to have some money to back this.

Gore But you cannot really know what money to ask for until you know what it is you want to build?

Bonnie Then you look at the number of full-time physicians that you need in terms of the APPs, also the nursing and also our patient care technicians that we have.

Gore Do most cancer centers have a similar unit? Do you have an idea what is going on around the country?

Bonnie There are a couple of cancer centers that have units, Memorial Sloan Kettering or MD Anderson Cancer Center that are actually standalone cancer hospitals, they actually have a fully functioning ED. We did not think that those were the right models for us because we have a fully functional ED here at Yale New Haven Hospital, at the Shoreline Medical Center, at other outlying community hospitals that can provide true emergent care. So, we needed to think about how we could work collaboratively and what niche we could fill that would not be totally redundant with the services that are already provided here in New Haven. There are a couple of facilities, there is actually one in Wisconsin that we have been learning a lot from lately and trying to understand what are the growing pains in building this. There is another facility at the Johns Hopkins Medical Center as well that has provided us with useful thoughts.

Gore And has this been well received by the patients? What has been the experience of the patients?

Vanna Very much so. Patients really love coming there. They would like to avoid the emergency room as much as possible. And I think just the location, it is on the 12th floor, and it has a beautiful view of Long Island Sound and thinking of the staff, they are just so gifted, really compassionate

11:22 into mp3 file https://ysm-websites-live-prod.azureedge.net/cancer/ECC%20file_330985_5_v1.wav about the patients that are there. One way that I look at it is really an extension of the ambulatory care that we provide at Smilow.

Gore And yet it seems that you are limited by your capacity?

Bonnie We are. That is actually a really good question. When we started, we really were not sure what our patient volume was going to be. And to Vanna's

point, there was this beautiful suite on the 12th floor that we were able to repurpose for the extended care clinic. And when we wanted to think about what is the right distribution of patient spaces, we have 4 chair pods and 2 beds, frankly in this space, I do not think we could accommodate anymore patients. So, deciding that we had 6 spots was partly lead by, let's put a stake in the ground and partly driven by this wonderful space that we were given.

Gore So, start with what you got and see how it works?

Bonnie And actually now looking at our patient volume, trying to understand the right patient flow, understanding how many of our spots are filled at different times in the day and thinking, do we need to consider expanding and if so, how would we be able to execute that?

Gore This seems daunting, first of all if you are landlocked in space, and you can potentially hire more practitioners as there is only one of you, but I guess they could hire more of you too?

Bonnie I am the one who is on-call while the clinic is open from 7 a.m. to 11 p.m. 7 days a week, so 90% of the time I am the one that patients will be working with, so I do not mind. I rather enjoy this, but really the issue is going to be space if we decide to grow, it is going to be where and how and what is the right mechanism for that. But before we even think about that, we need to understand what are their needs, how full are we, while we do not like turning away patients, that is not common. It happens, but 95% of the time we are able to accommodate everybody who needs to come to us when they need to come to us. We really do encourage all of our Smilow patients that if they are not feeling well, please call your primary disease team. Even if you are not feeling well at 5:30 or 6 o'clock in the morning, please call your primary disease team because we can have you arranged to come to see us at 7 a.m. when our clinic opens.

Gore We have been talking about the implementation of an urgent care facility for cancer patients that was implemented in the past 12 months at Yale Cancer Center as well as other approaches potentially for expanding the ways that cancer patients can be cared for. Perhaps it would be interesting to our listeners to hear if you have any anecdotes of some patients who might have otherwise had to be hospitalized and for whom this kind of approach was able to mitigate the circumstances.

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Bonnie I like to think about this one woman who came to us, having a really hard time being at home. Her family was having a hard time caring for her at home with the type of support that she was needing, and we sat down, we talked for about an hour, I was trying to understand what were the specific barriers, was it an issue of needing more hands on, not being able to eat, not being able to get to the lady's room in time, and throughout the conversation, it became clear that her cancer was progressing to the point that she would not be able

to stay at home. One of the things that we were able to do in our clinic was to coordinate with hospice care, coordinate with care coordination and make that transition so that she would come into the hospital for 2 or 3 days to be able to have that transition happen so that her family would not have to be over-extended while all of the paperwork was being processed.

Gore So, this patient was going to an inpatient kind of hospice facility or?

Bonnie I think she transitioned back to home with a higher level of nursing care at home.

Gore Which is even better, I suppose.

Bonnie And ultimately was moving towards an inpatient facility.

Gore It is so frustrating for the families as well as the patients and everybody else when they are in the hospital with no real acute needs, but just because they are not able to be managed while at home because the right set of things are not in place, and Vanna, you work a lot with the patients and their families, what is your experience?

Vanna I think that is true, and it is really our responsibility to recognize what the needs are of both the patient and the family at home and our goal is really to make sure that the patients can stay at home for as long as they possibly can.

Gore And patients and families do not always know when they are out of their league, right? That seems to make a lot of pressure, for some caregivers they think, I have to keep him at home, this is my obligation but it is too much for me, and I hear a lot of that.

Bonnie And that is why our multidisciplinary team is so important, between social work and care coordination. And also, with our oncology care model that we have for patients that are on Medicare and are getting active treatment, we actually have care coordinators that look at that and they meet with the families and also the patients and assess what the needs are.

Gore And that is a federally sponsored program, is that right?

Bonnie Correct.

Gore Trying to both maximize patient services and reduce cost at the same time somehow?

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Vanna Right. And also improve quality care that is being provided.

Gore And do you think that is working?

Vanna It is.

Gore That is good to know. It is so overwhelming I think for patients and families when they are dealing with cancer, especially ones that are progressive.

Do you find that in a lot of these situations the families are in a panic when they are coming in or is it not usually so bad?

Bonnie When they come to us, they are in a bit of a panic. I do not like using the word panic, but there is a little bit of a sense of being overwhelmed. I think one of the things that we can offer is the opportunity to be thoughtful and it is something we see on a regular basis that it is a routine part of our practice that might not be offered in the emergency department. When the patients and families present like this to the emergency department, they might not have the facilities and the resources to address these issues in the ED, so the only way to get these issues addressed is to admit the patient, bring them into the hospital and then have an oncology-focused care team sort these out. We can do that in our clinic so that we can completely bypass the need for an inpatient stay as much as possible.

Gore I am going to throw you guys a curve ball, which is going to give you an opportunity to get yourself in trouble perhaps, but I am wondering, you pointed out some of these situations that are in some ways social and situational, do you think that even the need for your facility might be decreased if some of these things can't be done as well as they should be because it is too noisy. even in the clinic, because social work is stressed, but once they come to your place, it is kind of like waving a red flag like help?

Bonnie Actually, while we do have social work at our disposal and we can call in for lack of bed or ward reinforcements, most of that is actually done by myself and my APPs. We only in a rare instance bring in social work and it is only at the time once we have come up with a plan and we ask social work can you help us or care coordination can you help us by calling this facility or this agency and put this stuff in place. Gore So, you guys are doing sort of a super-human work here it seems. Vanna I will say, from working in Smilow and I work mainly in outpatient, I also cover the extended care clinic at times. Our goal is really to be able to provide the patient and the family with the best care that we can and that includes not just the physical needs of the patients but also the

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psychosocial and I think that is one of the things that from the disease team perspective we really started there, and again with extended care, it really is an extension of that care that we are able to really provide what the patients needs are at that particular time.

Gore You are communicating with the primary team, so it is not like you have come to save the day when the primary team has dropped the ball?

Bonnie No, there is constant collaboration with the disease team. I have got every single attending on speed dial in my phone.

Gore I know this, you've reached out to me.

Vanna Yeah. I think I called you once Dr. Gore, about 9 o'clock at night, and

we spoke.

Gore That is no problem. If you are up, I might as well be up. I usually stay awake at least that late. You mentioned that you have turned to other care models like places in Wisconsin and Johns Hopkins and of course I think as a cancer-caring community, we all need to learn from best practices. Do you have any plans to disperse information, what you are learning, promulgate this, publish it, is there a group of like-minded places that want to think about this?

Bonnie To Vanna's point, she has got an abstract accepted at a prominent oncology nursing meeting and she will be giving that presentation. When is it Vanna?

Vanna May 17th at Washington DC.

Gore So, you will be talking about it to an audience of other high-level nursing people?

Vanna And I think one of the things that we are also doing as a working group within the extended care clinic is that we are really looking at triaging guidelines, you know that is one of the reasons why we really want the patients to be calling into their disease team and then whoever that person is that they are talking to, whether it be a nurse or another advanced practice provider or the oncology fellow or the physician, then they are calling us with the information about the patient, so we are trying to make the decision about what is the most appropriate place for the patient to be seen. And then in addition, we are really looking at treatment algorithms. If a patient comes in for a neutropenic fever, because the white blood cell count is low secondary to chemotherapy or after a bone marrow transplant, what exactly are the steps that we are going to take for that particular patient, not only in assessing but also in managing it.

Gore These are patients who do not really have much immune system to fight the infection, so you are worried it could be quite serious right?

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Bonnie To that point, there is a big research focus in the emergency medicine community of not necessarily admitting every single patient who comes into the hospital with neutropenic fever. That actually had been the standard where if you present with neutropenic fever, you are started on very broad-spectrum antibiotics, you are admitted for at least 48 hours, waiting to see if the blood cultures result in an infection or not.

Gore So, making sure you do not have an overwhelming infection?

Bonnie Right. But what we have shown now is that not every patient needs to be in the hospital under such close monitoring and we in the extended care clinic have been really focusing on the emerging literature from the emergency medicine community and applying that in our clinic. While we still do need to admit about 80% of folks with neutropenic fever, we are sending 20% of them home with close careful followup for sure, but able to manage that in the

outpatient setting. I think that is actually one of the big innovations that we have been able to do.

Gore Yeah, that is amazing. I know that the care network that you guys are involved with encompasses quite a large geographic area across Connecticut. How are you thinking about implementing similar models and other more distant sites? I know there is a presence in Greenwich which is pretty far, New London, any thoughts about that? Vanna is giving me a look like I have got enough on my plate.

Bonnie I do not think those conversations have started yet, but I can say that we have seen patients in our clinic who are coming from Greenwich, who are coming from New London, who are coming from Tolland County who are normally seen in St. Francis. So, people are coming to us. People are willing to travel to us from some of these more distant locations recognizing that the care they are going to get with us might have a slightly different flavor and might be easier for them to manage.

Gore Might be worth the drive in other words if it is going to potentially avoid a hospitalization. So, are most of the patients coming in with either fevers to be evaluated or just kind of overwhelmed family situations or are there some other scenarios?

Vanna Probably the most common presenting symptoms are fever, increased shortness of breath, not necessarily sudden shortness of breath because we obviously worry about that, weakness, nausea and vomiting, being dehydrated, pain... those are probably the most common.

Bonnie Yet at the same time, my training is as a general internist and my focus of practice is as an inpatient hospitalist. I have had to think about and evaluate some more tricky, non-cancer related medical questions. We had a gentleman that came into us once with an acute flare-up of his diabetes. We have had folks come to us with either their potassium or their sodium or another one of their blood chemicals significantly abnormal enough that we have needed to work with our colleagues in the intensive care unit to make sure that they transition to the

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appropriately safe level of care. I have had to think about kidney problems that are more typically found in a specialized kidney facility, so it has been quite challenging and quite rewarding as an internist. The other thing that I think is really exciting is we work very closely with the phase I clinic program here. We have patients on investigational drugs where for the first time, we are putting these drugs into patients and we have no idea what the side effects might be, so it is intellectually rewarding to be able to work collaboratively and contribute a little bit to the research mission.

Gore Bonnie and Vanna, it has been really great having you as guests on Yale Cancer Answers. This has been a terrific show. I hope patients and family mem-

bers listening have a better understanding about some of the ways and options that are available to them for their cancer care. Until next week everybody, this is Dr. Steven Gore wishing everybody a happy and healthy week.