HPM Fellow Outpatient Experiences 2019-20

	Symptom Management Service (Oncology PC)	Palliative Care Clinic (Non-Oncology)	Bridges (Home-Based)
Location	Mission Bay (palliative care now embedded in outpatient cancer generally)	Parnassus	Mostly patient homes in SF near Parnassus, with some visits by video. Occasionally assisted living facilities, residential hospices, and skilled nursing facilities to foster continuity.
Interdisciplinary Team (IDT) structure	RN routinely; cancer center SW as available; PC chaplain typically offline/scheduled	Full interdisciplinary team, including RN, SW, chaplain & MDs	Full IDT including: home-visiting social worker and chaplain; nursing support by phone and over video telemedicine. Use of in-person and video interpreters in the home PRN.
IDT interaction	During clinic session with SMS RN and Physician attending routinely; Weekly with the rest of the TDT (including psychologists, nutritionist, physical therapists, etc)	Patients and families seen together as an interdisciplinary team during each clinical encounter	Regularly during week for patient follow-up, urgent care and care-coordination; weekly interdisciplinary team meeting
Patient population	• Demographics: Regional/National referral center • Diseases: Solid and hematological malignancies (although most heme cancers seen at SMS at Parnassus)	• Demographics: patients of widely ranging age, race & ethnicity, SES, and primary language. Majority of patients live outside San Francisco, often in more rural and underserved parts of Northern California. 40% of visits conducted by telehealth. • Diseases: wide range of non-cancer serious illnesses, including degenerative neurologic diseases such as ALS, advanced heart failure and pulmonary htn, chronic lung diseases including COPD and interstitial lung disease, cirrhosis, chronic renal failure, and complex multi-morbidity	• Adults who are medically homebound and living in San Francisco. • Typically about 60% patients with cancer (many who are younger i.e. < 60 yo with high symptom burden); 40% patients with other serious illness i.e. CHF, ESRD, ESLD (often older adults)
Precepting structure	Two dedicated physician preceptors (Mike Rabow and Sarah Adkins) working with 2 fellows each per clinic	Attending will be in clinic at the same time as the fellow and both the attending and fellow will have reduced schedules to allow time for dedicated precepting between each clinic visit. The fellow will also receive substantial feedback from the nurse, SW, and/or chaplain who are present with them for the interdisciplinary encounters.	For at least first three months but possibly for full six months, preceptor will attend all NEW patient visits with fellow in-person to provide direct teaching on home-based palliative and mentorship on the fellow's clinical skills and communication. Fellow will be expected to lead these visits. Follow-up visits can be staffed by video with preceptor at end of visit. Option for preceptor to be present in-person or by video for entire visit at fellow/preceptor discretion.
Degree of independence	High	Fellows will manage their own panel of patients in a longitudinal fashion between scheduled encounters, with support from the interdisciplinary team and input from the attending as needed.	Very high (likely higher than clinic given nature of setting)

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Ancillary staff/support service	High, including all cancer center support staff (including MA, RN, scheduler)	High, including nursing and admin support to triage phone calls, pend prescriptions, follow-up with patients between scheduled visits, communicate with pharmacies and insurance companies, schedule urgent visits, etc	In addition to team described above, administrative support for office-based tasks including home visiting scheduling, patient calls, DME etc
What's unique about it? (Top reasons to do this site)	• The chance to do continuity with your patients (6-12 months), learning those skills and enjoying the benefits of a relationship over time with patients and their families (the excitement and experience here is very different than the acute drama of inpatient training) • Dedicated physician preceptor • One of the most well-established outpatient palliative care fellow training sites in the country! • Chance to work with the population that accounts for most of the outpatient palliative care work in the US	• Opportunity to care for patients with a broad range of clinical diagnoses • Opportunity to work directly with and learn from an exceptional interdisciplinary team during each clinical encounter • Clinic is located on the Parnassus Campus, which is convenient during inpatient consult months at Moffitt and makes it easy to visit clinic patients who are hospitalized at Moffitt	• Care for patients longitudinally in their homes over 6-12 months including across care settings and when patients transition to home hospice care • Dedicated preceptor; many opportunities for direct observation on communication and interpersonal skills given new patient intake structure described above • Learn how to deliver care in the setting that is at the cutting edge of palliative care program delivery and innovation • Gain a heightened awareness of patient/caregiver experience and transitions of care by providing care at home • Collaborate closely with community agencies that benefit homebound seriously ill adults (i.e. home health, IHHS, meal delivery services). • Gain skills in the palliative care of the older adult and patients with multimorbidity • Many opportunities to learn symptom management and hone communication given high-acuity of homebound population