Conversations & Goals of Care
Introduction to Palliative Care & Hospice

Kate Lally, MD, FACP
Chief of Palliative Care, Care New England
Medical Director, Integra ACO & Care New England Hospice
Assistant Professor of Medicine (Clinical), Warren Alpert Medical School

Ana Tuya Fulton, MD, FACP
Chief of Geriatrics, Care New England
Medical Director, Integra ACO
Associate Professor of Medicine and Psychiatry and Human Behavior (Clinical), Warren Alpert Medical School
Financial Disclosure

None of the planners, speakers, and/or members of the CME committee have any relevant financial relationships to disclose.
Continuing Education Credit

- Continuing Education Credit is available for:
  - Medicine (0.75 contact hour)
  - Nursing (1.0 contact hour)
  - Pharmacy (1.0 contact hour)
  - Social Work (1.0 contact hour)

Please complete the survey at the end of the presentation in order to receive continuing education credit.
Support

• RI-GWEP is fully supported by RIGEC Grant #U1QHP28737 from the US Health Resources and Services Administration
Objectives

• Understand the difference between hospice and palliative care and their benefits to patients/families
• Recognize the role of geriatrics and palliative care in care of patients with advancing serious illness
• Appreciate how geriatrics and palliative care can improve quality of care, cost avoidance and improved patient satisfaction in collaboration with primary care
• Review goals of care conversations “best practices”
• Appreciate where to identify resources and information for further practice and study
The population

- US population is aging & living longer
- 2010 census 13% population over age 65
- By 2050 estimates of 20% population over 65
- Cases of dementia are projected to double by 2050
- Currently about 5.3 million adults have dementia
- Cost of care for dementia in US: ~ 56,000/person/year or 150-200 billion
A Patient Story

• Mrs. R is a 93 year old who lives in assisted living. She has DM, HTN, and Parkinson’s disease. She requires help ADLs but can ambulate short distances with a walker, and is cognitively intact.
• She presents to the ER with nausea, vomiting, and abdominal pain.
• Diagnosis – Small bowel obstruction
• Emergency surgery authorized by DPOA – ruptured in OR. ICU upon post-op, intubated.
• Did she go back to living independently? What outcome did she have?
# Meeting the challenges

## Geriatric Medicine
- A sub-specialty
- Only for older adults
- Focused on prevention, treatment of diseases
- **Interdisciplinary team focus**
- Focus on function and quality of life
- Managing co-morbidity
- Support for caregivers

## Palliative Medicine
- Mostly consultative
- All age groups
- Pain and symptom management
- **Interdisciplinary team focus**
- Improve quality of life for those with life threatening illness
- Support for caregivers
Why We Need Palliative Care

• 90 percent of Americans die after living with chronic and progressive illnesses, and they are at risk for distressing symptoms.

• The specialty of Palliative Care has emerged and expanded in response to these changing demographics and to a resultant gap in care options.
Why We Need Palliative Care

• There is often a **gap** between curative, high tech medical care and ... hospice
• There needs to be a **continuum** of care
Traditional Continuum of Care

Figure 1. Adapted from Frank D. Ferris, 2000.
Adding Palliative Care

Continuum of Care - Optimal

Curative/Restorative Therapy

Palliative Therapy

Presentation/Diagnosis

Illness

Death

Acute

Chronic

Life Threatening

Figure 2. Adapted from Frank D. Ferris, 2000.
Differences Between Hospice and Palliative Care

Palliative
- Unlimited life expectancy
- Symptom management and disease management
- Fee for service or part of the plan of care
- Discussion of disease progression and prognosis
- Advance Directive discussion based on disease trajectory
- Medication and equipment private
- Provided wherever the person resides

Hospice
- 6 month prognosis including end of life care
- Symptom management
- Package of services similar to managed care
- Interdisciplinary Team
- Medication and supplies covered
- Provided wherever the person resides
Palliative Care Benefits

- Prevents unnecessary hospital readmission
- Prevents advanced illness crisis
- Assists with decisions about complicated treatment options
- Allows for the discussion of end of life goals of care
- Encourages the person to define what matters most to them
Why We Need Geriatrics

To get here...

And not here
Finding Common Ground – Process of Care

- Goal oriented care
- Multidimensional assessment & ID of unmet needs
- Attention to psychosocial factors
- Attention to caregiver needs
- Value added service to frail, older adults

“Focus together on the needs of the sickest 5%, who drive half of all healthcare spending”
The Opportunity

• Now is the time
  • payment reform
  • new models of care
  • integration emphasis
  • triple aim
  • Population health
  • Partnering with Primary Care
Evidence

• Clear cut for geriatrics models of care – GRACE, PACE, Care Transitions, BOOST, HELP

• Evidence of Palliative care bringing cost avoidance improved quality is also plentiful

• Care coordination and home based geriatrics and palliative care is the future
GRACE Team Care improves the health — and lives — of frail older adults with complex needs. Working together, a team of doctors, nurses, social workers, and pharmacists use geriatric knowledge and techniques to improve patient care — not just in the clinic, but in the patient’s home and community.

GRACE Team Care is proven to reduce costs by decreasing hospitalizations and readmissions, delaying nursing home admissions, and reducing emergency department visits.
Emily Dawson Petersen Named Center Director in Colorado

Emily Dawson Petersen has been named Center Director at InnovAge Greater Colorado PACE-North.

InnovAge is the second largest provider of PACE services in the country.

PALPA Announces New Management

The Pennsylvania LIFE Providers Alliance (PALPA) has hired DelRunner & Associates to provide strategic leadership in government relations and association management consulting services.
PACE

• Integrated care delivery system for frail elderly
• Capitated
• Coordinated care
• Community based
• Interdisciplinary
• Focused on delivering coordinated care that is patient/family centered and based on goals of care
Transitions of Care

• Eric Coleman – Care Transitions Intervention
• Mary Naylor – Transitional Care Model
• Society of Hospital Medicine - Project BOOST
HELP

• Hospital Elder Life Program
  • Delirium prevention program
  • HELP saves >$7.3 million per year in hospital costs for 7,000 patients; >$1,000 savings per patient (Rubin 2011)
  • HELP saves $831 per person-year in hospital costs (Rizzo 2001)
  • HELP saves $9,446 per person-year in long-term nursing home costs (Leslie 2005)
  • HELP saves $121,425 per year in sitter costs across 111 patients (Caplan 2007)

http://www.hospitalelderlifeprogram.org/about/results/ Accessed on 10/23/2015
Home Based Care

- Many groups have described home based team care
  - Primary care
  - Palliative care
  - Geriatrics
  - Combination of all of the above
- Strong evidence around outcomes
  - Decreased utilization
  - Decreased cost
  - Improved satisfaction
  - Better focus on goals of care/quality of life

A Patient Story

• Mrs. R is a 93 year old who lives in assisted living. She has DM, HTN, and Parkinson’s disease. She requires help ADLs but can ambulate short distances with a walker, and is cognitively intact.

• She presents to the ER with nausea, vomiting, and abdominal pain.

• Diagnosis – Small bowel obstruction

• Emergency surgery authorized by DPOA – ruptured in OR. ICU upon post-op, intubated.

• Did she go back to living independently? What outcome did she have?
A patient story...Mrs. R

• Aggressive wean off the vent – extubated after only 10 hours
• OOB on post op day 1, ambulating by day 2 with assistance
• Tight pain control, delirium prevention protocol (orientation, ambulation, sleep protocol)
• Short LOS → SNF rehab → short LOS
• Back to ALF with aides in less than 4 weeks
How?

- **NOT traditional care model!**
- **Clear goals of care at presentation**
- PACE program patient – Geriatrician PCP
- Palliative care team involved in the hospital
- Discharged with a plan for focus on function and quality of life
Summary

• “Practice redesign efforts based on coordinated care principles require no further clinical trial evidence of efficacy. Instead, practice redesign efforts based on these principles require widespread implementation with locally adapted approaches...”

• Defining quality measures and metrics
• Identify goals of care
• Model implementation
• Adapt to your setting/staffing

Callahan CM. JAGS 2015. 63: 1938-1944
Goals of Care

• Every one has a personal sense of
  • who we are
  • what we like to do
  • control we like to have
  • goals for our lives
  • things we hope for

Goals of care

• Hope, goals, expectations change with illness

• Physician’s role to clarify goals, treatment plan
Potential goals of care

- Cure of disease
- Avoidance of premature death
- Maintenance or improvement in function
- Prolongation of life
- Relief of suffering
- Quality of life
- Staying in control
- A good death
- Support for families and loved ones
Multiple goals of care

- Multiple goals often apply simultaneously
- Goals are often contradictory
- Certain goals may take priority over others
- The shift in focus of care
  - is gradual
  - is an expected part of the continuum of medical care
How do we improve skills?

• Ask-tell-ask
  • Ask an open ended question
  • After patient’s response, tell patient information in response to the question
  • Follow up with another question
  • Makes sure that conversation remains a discussion
Useful Tips

• Language matters

• Let the patient/family talk
  • Rule of thumb is family should spend >50% of conversation talking
  • Greatest predictor of family satisfaction with meeting?
    • Percentage of time family spends talking

• Use open-ended questions

• Non-verbal communication is important too!

• We need to do this to get better at it
Communicating prognosis

• Helps patient / family cope, plan
  • increase access to hospice, other services

• Offer a range for life expectancy
  • Hours to days
  • Days to weeks
  • Weeks to months
  • Months to years
Truth-telling and maintaining hope

- False hope may deflect from other important issues
- True clinical skill to help find hope for realistic goals
Mrs. K

- 75 yo woman with Ovarian CA
- Underwent pelvic exenteration, no further evidence of cancer
- Progressive functional decline
- Progressive edema
- Now bed bound, unable to tolerate food or TPN
- Severe malnutrition
Mrs. K

- Prognosis poor
- Daughter at side- “when can I take mom home”
- Patient getting progressively more delirious
- Discussed daughters understanding of illness
- She saw her mother getting worse
- Had seen her mother talk to her grandmother
- “If she is dying, I want to take her home”
Mrs. K

- Upon discharge planning mother said she had known for a while she was very sick
- Had lots of recipes to pass on, things to teach grandchildren
- Happy to get home for whatever time she had left.
It is a procedure.
Language with unintended consequences

- Do you want us to do everything possible?
- Will you agree to discontinue care?
- It’s time we talk about pulling back
- I think we should stop aggressive therapy

Language to describe the goals of care.

- I want to give the best care possible until the day you die
- We will concentrate on improving the quality of your life
- We want to help you live meaningfully in the time that you have
How to use non-verbal communication

• Use empathic gestures
  • Nod head, lean in to conversation
• Repeat 2-3 words from the last sentence
• Use silence
• Acknowledge feelings
• Don’t change the subject
Summary

• Challenging times
• Host of opportunities
• Evidence is clear to support geriatrics & palliative care infused programs
• Strength in collaboration – geriatrics + palliative care + primary care
• Palliative care for support of advanced illness
• Goals of care conversations early and often
Resources

• Contact us:
• Kate Lally, MD at kmlally@kentri.org
• Ana Tuya Fulton, MD at afulton@carene.org
Tools to determine prognosis

- UCSF eprognosis
Tools for teaching and training about conversation skills

- https://www.capc.org
- http://www.vitaltalk.org
  - Download the app on iTunes for 2.99
- ihi.org/conversationproject
- TheConversationProject.org
- https://palliative.stanford.edu
• Member based organization with membership fee
• Fantastic resources for all aspects of palliative care
• CME/CEU courses
  • Pain management
  • Communication skills
  • Palliative care across settings
  • Getting leadership support
• Gives you sample patient statements and asks for your response
• $2.99 app for the iPhone
• Can review before a difficult conversation or debrief after
• Can choose to focus on specific skills
• Detailed advice
  • If unsure what patient is feeling ask- “What is going through your mind?”
  • Notice and respond to emotion
  • A moment of silence helps
• Allows you to watch an expert
IHI Open School

The IHI Open School brings you essential training and tools in an online, educational community to help you and your team deliver excellent, safe care. When you engage with the Open School courses and Chapters, you join more than 250,000 learners from universities, organizations, and health systems around the world in building core skills in improvement, safety, and leadership.

There is a free course available that is related to today’s topic:

• ihi.org/conversationproject
• Great mix of video and text
• Free CME/CEU!
• You must be a registered IHI.org user.
• Focus on why this is so important
• Focus on engaging with your own family

http://www.ihi.org/education/ihiopenschool/Pages/default.aspx
The Conversation Project starter kit
TheConversationProject.org

**Where I Stand Scales**
Use the scales below to figure out how you want your end-of-life care to be. Select the number that best represents your feelings on the given scenario.

<table>
<thead>
<tr>
<th>Question</th>
<th>Scale 1</th>
<th>Scale 2</th>
<th>Scale 3</th>
<th>Scale 4</th>
<th>Scale 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>As a patient, I'd like to know...</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Only the basics about my condition and my treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All the details about my condition and my treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>As doctors treat me, I would like...</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My doctors to do what they think is best</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To have a say in every decision</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If I had a terminal illness, I would prefer to...</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Not know how quickly it is progressing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Know my doctor's best estimation for how long I have to live</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

www.TheConversationProject.org

Institute for Healthcare Improvement www.ihi.org

Care New England
Questions?

Type your question into Chat
(make sure to send to All Participants)

or

Press #7 on your phone to unmute your audio line
and ask your question over the audio
Reminder

• After you close out of this webinar, you will receive a survey:
  https://www.surveymonkey.com/r/FPYV92Q

• Please complete this survey to receive continuing education credits.

Thank you!