Generalist Palliative Care

David E. Weissman, MD
Professor Emeritus
Medical College of Wisconsin
www.palcareeducation.com
Learning Objectives

• Describe differences between generalist and specialist palliative care.

• List three features of three different communication skills necessary for patient-centered care.

• Describe three options for personal improving care of seriously ill patients.
Your practice

When you care for seriously ill patients, what do you find most problematic, anxiety producing, stressful?
When you hear *Palliative Care* ...

<table>
<thead>
<tr>
<th>Old Thinking</th>
<th>New Thinking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death/Dying</td>
<td>Patient-centered care</td>
</tr>
<tr>
<td>Failure</td>
<td>Responsive/Problem solving</td>
</tr>
<tr>
<td>Emotional</td>
<td>Reducing unwarranted medical care</td>
</tr>
<tr>
<td>End-of-life service line</td>
<td>Care across the continuum</td>
</tr>
</tbody>
</table>
The past 10 years
Not where we used to be…
Revolution …

Old

Life Prolonging Care

H

Bereavement

New

Life Prolonging Care

Palliative Care

Hospice Care

Bereavement

Dx

Death
Educational Domains

- Ethics
- Communication Skills
- Psycho-Social-Spiritual Family Care
- Community Resources/Hospice
- Pain and Symptom Management
Medical Reality

BELIEFS       HOPES       EMOTIONS

HEALTH CARE TEAM

Palliative Care

PATIENTS/FAMILY

Medical Reality
What is in the Palliative Care syringe?

- Symptom management
- Prognosticate/Communicate
- Establish Patient-Centered Goals
- Plan for the future
Palliative Care Outcomes

- Reduced time to symptom relief
- Improved patient and family satisfaction
- Earlier hospice referral
- Reduced readmissions/inpt. mortality
- Reduced ICU days
- Reduced hospital $ loss
Outpatient cancer care
Temel, NEJM, 2010

Early palliative care
11.6 mo

Standard care
8.9 mo
p=0.02
# Reduces Resource Utilization

Zhang, Arch Int Med, 2009

<table>
<thead>
<tr>
<th>Measure</th>
<th>Standard Care N (%)</th>
<th>Early Palliative Care N (%)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aggressive EOL Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No hospice</td>
<td>30 (54)</td>
<td>16 (33)</td>
<td>0.05</td>
</tr>
<tr>
<td>Hospice ≤ 3 days</td>
<td>22 (39)</td>
<td>15 (31)</td>
<td></td>
</tr>
<tr>
<td>Chemo within 14 DOD</td>
<td>5 (15)</td>
<td>1 (3)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12 (24)</td>
<td>7 (18)</td>
<td></td>
</tr>
<tr>
<td><strong>Hospital/ER Admissions within 30 DOD</strong></td>
<td>31 (55)</td>
<td>19 (39)</td>
<td>0.12</td>
</tr>
<tr>
<td><strong>Days on hospice</strong></td>
<td>4 (0-269)</td>
<td>11 (0-117)</td>
<td>0.09</td>
</tr>
<tr>
<td><strong>Documented Resuscitation Preference</strong></td>
<td>11 (28)</td>
<td>18 (53)</td>
<td>0.05</td>
</tr>
</tbody>
</table>
## Cost Avoidance

Cost and ICU Outcomes Associated with Palliative Care Consultation in 8 U.S. Hospitals

<table>
<thead>
<tr>
<th>Costs</th>
<th>Live Discharges</th>
<th>Hospital Deaths</th>
<th>Δ</th>
<th>Δ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Day</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Usual Care</td>
<td>$867</td>
<td>$1,515</td>
<td>$183*</td>
<td>$446</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>$684</td>
<td>$1,069</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Admission</td>
<td>$11,498</td>
<td>$23,521</td>
<td>$1,506</td>
<td>$6,690</td>
</tr>
<tr>
<td>Usual Care</td>
<td>$9,992</td>
<td>$16,831</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palliative Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory</td>
<td>$1,160</td>
<td>$2,805</td>
<td>$327</td>
<td>$1,033</td>
</tr>
<tr>
<td>ICU</td>
<td>$6,974</td>
<td>$15,531</td>
<td>$5,248</td>
<td></td>
</tr>
<tr>
<td>ICU</td>
<td>$1,726</td>
<td>$7,755</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICU</td>
<td></td>
<td>$7,776</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>$2,223</td>
<td>$6,063</td>
<td>$186</td>
<td></td>
</tr>
<tr>
<td>ICU</td>
<td></td>
<td>$3,622</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imaging</td>
<td>$851</td>
<td>$1,656</td>
<td>-$208</td>
<td></td>
</tr>
<tr>
<td>ICU</td>
<td></td>
<td>$1,475</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Died in ICU</td>
<td>X</td>
<td>X</td>
<td>18%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Shifts care out of hospital

Patients Who Died from CHF, COPD, or Cancer Palliative Home Care versus Usual Care, 1999–2000

Evolution of Services

- Hospice
- Hospital Palliative Care
- Community Palliative Care
- Generalist Palliative Care
## Comprehensive Palliative Care Program

<table>
<thead>
<tr>
<th>Inpatient Consultation Team 24/7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient unit in large hospitals</td>
</tr>
<tr>
<td>Routine ID of all patients with unmet needs</td>
</tr>
<tr>
<td>ED/ICU Palliative Care Initiatives</td>
</tr>
<tr>
<td>Outpatient specialty palliative care clinic</td>
</tr>
<tr>
<td>Outpatient embedded services: primary care, ACO</td>
</tr>
<tr>
<td>Outpatient embedded services within specialty clinics</td>
</tr>
<tr>
<td>Generalist training initiative</td>
</tr>
<tr>
<td>Physician Fellowship</td>
</tr>
<tr>
<td>Program data reported to <em>National Palliative Care Registry</em></td>
</tr>
<tr>
<td>The Joint Commission <em>Advanced Palliative Care Certification</em></td>
</tr>
</tbody>
</table>
But, there is still work to be done…
Problems

• Poor Advance Care Planning
  • “Frequent flyer” ED visits and hospital admissions
  • ICU terminal admissions/
    Avoidable inpt. deaths
• Too much: “its not time for palliative care”
• Not enough specialists
• Generalists abdicating their role
“I wish you’d called me sooner, Mrs. Moodie.”
What is Broken?

- Poor communication skills
- Lack of accountability

Poor Planning

- LOS/Inpt. Mortality/Readmissions/Cost
The new forces of change

- Pall Care
- Home Visits
- Transition Programs
- CDM
- PCMH/ACO

HCAPS
Readmissions
Mortality
Truisms

✓ The real work of the future is to improve care decisions long before the “terminal” admission.

✓ There will never be enough palliative care specialists.

✓ Improving the work of generalist clinicians is essential to a broad based movement to improve patient-centered care.
Who are generalists?

- Primary Care, Oncologists, Hospitalists, Pulm/CC, Nephrology, Neurology etc.
- Ward/ICU/ED/Clinic nurses
- Unit social workers/DC planners
- Hospital chaplains
What do patients need?

- Advance Care Planning
- Symptom Management
- Support/Leadership
- Transitions
What does a Generalist Initiative Look like?

- Standards
- Quality Monitoring
- Training
The generalist physician can ...

- Start and titrate an opioid infusion
- Manage easy cases of delirium, nausea and dyspnea
- Present bad news with empathy
- Lead a family goal setting discussion
- Manage common sources of conflict
  - Lack of information
  - Anticipatory grief
- Manage routine aspects of the dying process
  - Family support
  - Symptom management
Generalist training

- **Didactic training**
  - Self study: CAPC E-Learning / Fast Facts
  - Structured classroom training: EPEC/ELNEC/ in house

- **Communication training**
  - Intersection of ethics/policy/law and communication
  - Practice/Observation/Feedback

- **Brief Experiential training**
  - Palliative care team rounding
Illness Impact Trajectory*

- Colon Cancer
- Congestive Heart Failure

Death unpredictable - No clear decline phase

Clear phase of decline - allows hospice referral

Time →
Key Discussions

Advance Care Planning

All adults
- Surrogate decision maker
- Big picture values
- Specific desires

Serious Illness Conversation

Serious illness:
- Current/future course
- Goals in context to prognosis
- Fears/concerns
Critical Conversation

The Family Meeting During Crisis

**Life limiting/disease progress/dying:**
- Current/future course
  - Goals in context to prognosis
  - End-of-life planning:
    - ✓ Goal-oriented treatments
    - ✓ DNR/ICU/Hospice
# Sample Communication Skills Training Agenda

<table>
<thead>
<tr>
<th>Giving Bad News</th>
<th>Role Play</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prognostication: cancer and non-cancer factors</td>
<td></td>
</tr>
<tr>
<td>Decision Making Capacity</td>
<td></td>
</tr>
<tr>
<td>Advance Directives: state law</td>
<td></td>
</tr>
<tr>
<td>Informed consent: emergency exception</td>
<td></td>
</tr>
<tr>
<td>Hospital Policies</td>
<td></td>
</tr>
<tr>
<td><strong>Family Goal Setting meeting - Part 1</strong></td>
<td>Group Discussion</td>
</tr>
<tr>
<td><strong>Family Goal Setting meeting - Part 2</strong></td>
<td>Role Play</td>
</tr>
<tr>
<td><strong>Conflict management</strong></td>
<td>Role Play</td>
</tr>
<tr>
<td><strong>DNR/CPR</strong></td>
<td>Role Play</td>
</tr>
</tbody>
</table>
Comments

• Every clinician should go through this.
• This is the first time I’ve ever been taught a structured step-by-step approach.
• It takes time to practice different words and find what works.
• I hate role play, but I have to admit, it is the only way to learn how to do this better.
Embedding the Goal of Care Conversation into Practice

- Standard of Care
- Who/When GOCC
- Documentation/EMR
- Quality Monitoring
What can you do, now!

Needs Assessment

• What needs of our seriously patients could be improved in your practice setting?

✓ Symptom needs
✓ Communication needs
✓ Transition planning needs
✓ Advance care planning
What can you do, now!

Patient/Chart Review

• **Who:**
  - ✓ Would I be surprised in this patient died...
    - ✓ During this hospitalization
    - ✓ in the next 6-12 months

• **What:**
  - ✓ Does the patient have a completed advance directive
  - ✓ Has the patient/family been counseled re: prognosis and future treatment options?
  - ✓ Does the transition management plan match the prognosis and patient-centered goals?
What can you do, now!

Plan

• What can I do in the next month to make a difference?

✓ Obtain a resource
✓ Learn a new skill
✓ Automate a process
✓ Seek out resource help
Automate Processes
Systems Changes

- Prognosticate: ask yourself the surprise question, document
- EMR triggers:
  - Goal of care conversation/Family Meeting
  - Advance care planning completion
- EMR Template: goals of care decisions
- Nursing symptom assessment—use a tool (e.g. ESAS)
Goal is to move from referral based palliative care ...

Palliative Care Specialist Services

- Clinic
- Consult Service
- Inpatient Unit
- Home-care

Clinician Referral
To this—

**Patient-Centered** Palliative Care

All patients assessed

Palliative Care needs met by generalists

Specialist services as needed
Be brave enough to start a conversation that matters.