



# Physician Engagement in Palliative Care

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# Disclosures

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The following presenters have no relevant financial relationships with commercial interests to disclose:

- Jim McGregor, MD, ACQHPM
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# Objectives:

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Participants will be better able to:

- Differentiate between Palliative Care and Hospice.
- Integrate Advance Care Planning conversations in daily practice
- Demonstrate a strategies to encourage conversations around Advance Care Planning and goals of care.
- Describe a process in which to engage physicians and allied health professionals from different settings in transitions of care for palliative patients.

# Palliative Care

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- Medical care provided by an interdisciplinary team of health care professionals focusing on relief of suffering and support for the best possible QoL for patients facing serious life-threatening illness and for their families
- Team members include physicians, nursing, social work, chaplaincy and other allied health professionals
- Can be in concert with disease modifying therapy

# Benefits of Palliative Care

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- Extends principles of hospice care to a broader population
  - Earlier in disease course than hospice
  - Comprehensive and specialized
  - Pain and symptom management, advance care planning, psychosocial and spiritual support, coordination of care
  - Definition may be able to be expanded to all aspects of medical care

# Hospice

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- Comprehensive and coordinated care for patients with limited life expectancy of 6 months
- Provided both at home and in institutions
- Bio-psycho-social-spiritual model
- Focused on comfort, dignity and healing at the end-of-life
- Medicare benefit

# How Hospice Can Help?

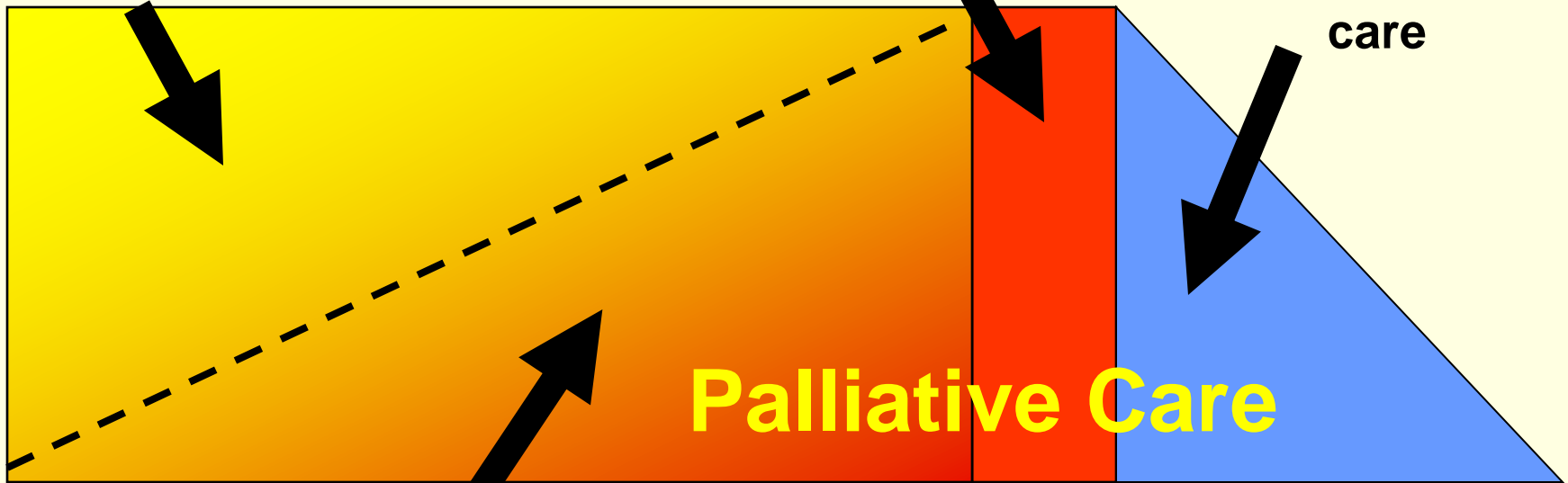
- Nursing home residents who had a “hospice informational visit” had fewer acute care admissions (mean 0.28 vs. 0.49;  $p = .03$ ) and fewer acute care days (mean 1.2 vs. 3.0;  $p = .03$ ) than those who did not. Casarett et al. JAMA 294:211-217, 2005
- Patients with advanced lung cancer lived up to 3 months longer on hospice than those receiving “standard care”. NEJM 2011
- Patients receiving hospice live longer. NHPCO

# Advance Care Planning in the Continuum of Palliative Care

**Disease-modifying therapy**  
(curative, life prolonging, or palliative in intent)

**Hospice**

**Bereavement care**



**Palliative Care**

**Death**

**Symptom control,  
supportive care**

Presentation/  
diagnosis  
(EPEC 1999)



# What % of patients if seriously ill want to talk about end-of-life care?

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- A:93%
- B:12%
- C:80%
- D:54%
- E:42%

# The Conversation:

80% of people say that if seriously ill, they would want to talk to their doctor about end-of-life care

7% report having had an end-of-life conversation with their doctor



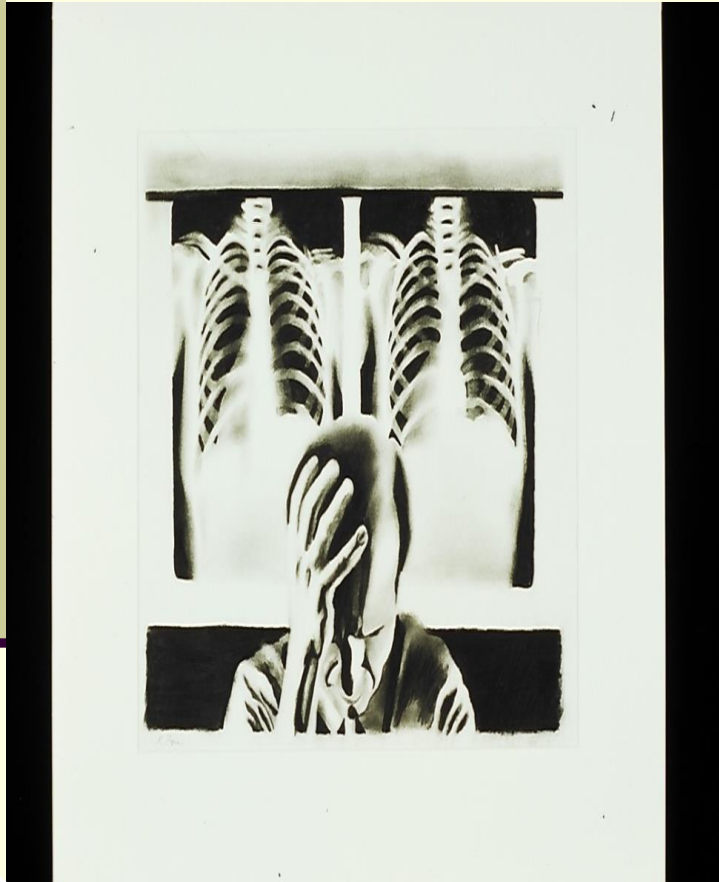
# Barriers to Advance Care Planning Discussions

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- What do you think some barriers are?



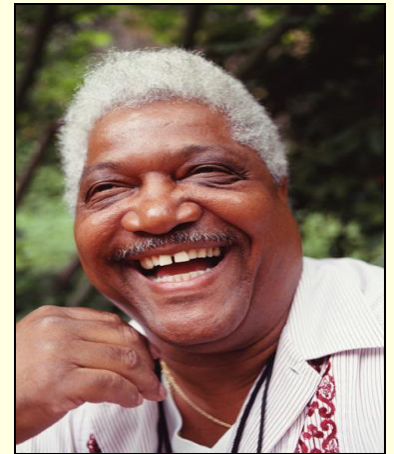
# Barriers to Communicating with Patients and Their Families



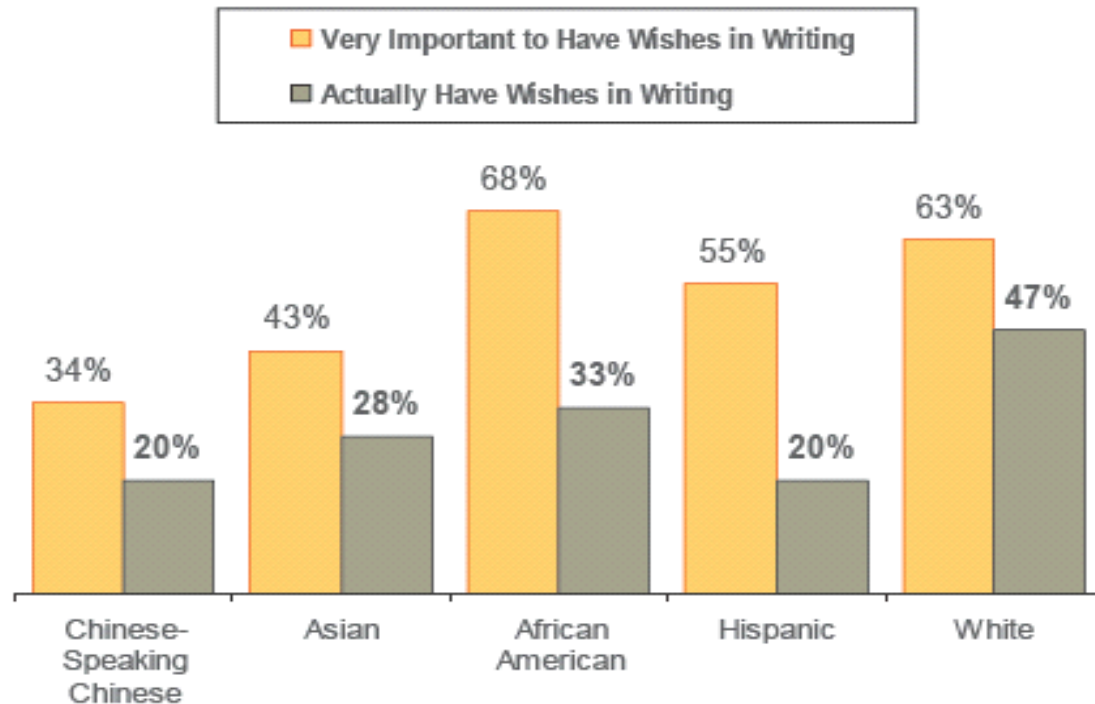
- Lack formal **training**
- Perceived lack of **time**
- Lack of **reimbursement**
- Fear of showing **emotions**
- Difficulties dealing with family responses in bearing “**bad news**”
- Provider’s personal fear of end-of-life
- Healthcare professionals believe the patient should initiate the conversation
- Patient expect the physician to initiate

# Communication Challenges...

- Culture
- Age
- Gender
- Personal & family experiences



# Variance in putting end-of-life wishes in writing



# Advance Care Planning in SNF

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- Lack of centralized document location
- Inconsistent documentation
- Habits
- Dispersion of responsibility
- Lack of time
- Under-recognition of team members efforts

# Advance Care Planning in SNF

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- Patient with cognitive impairment
- Lack of family involvement
- Asymmetry of knowledge between professional and patient/family regarding the indications and effectiveness of treatments



# Results of Discussions

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- What do you think the results of these discussions might be?

# Benefits of ACP Discussions: The Patient's Perspective

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- Facing and preparing for end-of-life
- Achieving a sense of control
- Strengthening relationships
- Relieving burdens on loved ones
- Provides opportunities to work on life closure

# Results of Discussions

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- Leads to less depression, pain and anxiety
- Empowerment
- Autonomy
- Right care in the right setting for the patient
- Decreased rates of readmissions
- Access to outpatient resources
- Increased completion of AD or POLST
- Patient/family satisfaction

# What Americans Want...

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- Freedom from pain
- To die at home
- To be in the presence of their loved ones
- Not to be a burden to their family
- Spiritual well-being
- Honest dialogue from healthcare providers

# Current ACP Practice: Causing Harm?

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- Patients and families betrayed, misled?
- Health professionals pressured to complete forms, ask for decisions
- Patient and families stigmatized if they refuse to participate/make “wrong” choices
- Health professionals disengage due to experience of AD’s not being helpful

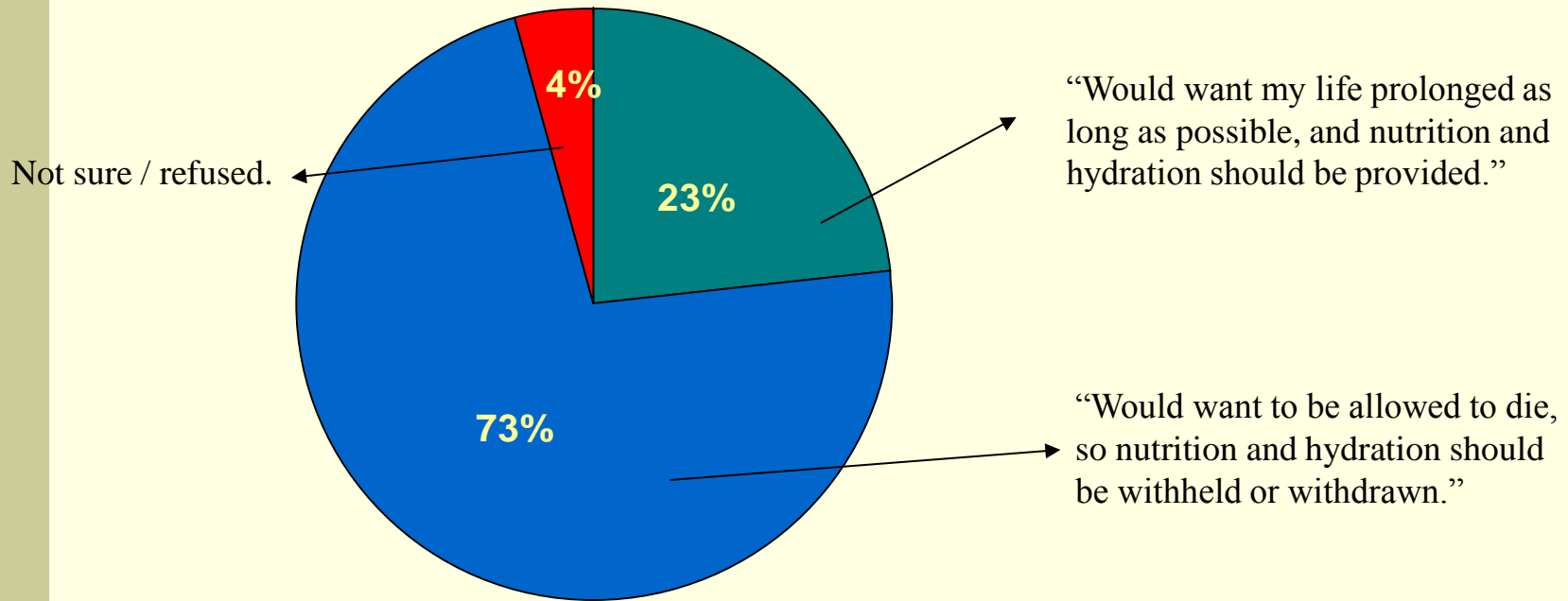
J Pall Med Vol 5, 2002

# % of Americans who would choose life prolongation if unlikely to regain consciousness?

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- A: 12%
- B: 96%
- C: 50%
- D: 23%
- E: 32%

# Preferences of Americans for receiving life-sustaining treatment if unlikely to regain consciousness



In a Spring 2005 national poll conducted shortly after the death of Terri Schiavo, nearly three fourths of those polled said that if they were unlikely to regain consciousness, they would want to be allowed to die and so nutrition and hydration should be withheld or withdrawn.

# What do people say they want?

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Three things that influence treatment decision-making:

- Treatment burden
- Treatment outcome
- Likelihood of outcome

Bradley EH. J Pall Med. 2003;6(2):237-244



# Patient Wishes

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- Survey of Massachusetts seniors older than 50: 90% said they wanted honest answers from their doctors but fewer than 20% had discussed End-of-Life issues with their doctors (AARP 2005)
- Patient's with terminal lung cancer just slightly more than ½ had had their health care provider discuss hospice. (Archives of IM- 2009)

# The approach....

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## Reductionist

- Switch to just comfort care
- Time to talk about pulling back
- Stop active treatment

## Expansive

- Concentrate on maximizing comfort
- Do as much as possible to meet your needs
- Work as hard as possible so you can visit your new great-grandbaby

# HOPE

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- **H: honest** communication
- **O: opportunities** for reflection and considering **options**
- **P: planning**, illuminates one's **potential**
- **E: engagement, empowerment, explore**

# Drivers of Change

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- Incentive: economic and non-economic
- Actors: consumers, funders, professionals
- Mechanisms:
  - regulatory,
  - administrative/professional,
  - market based

# Changing Physician Practice

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- Strong research evidence
- Clinical issues sharply drawn

# Financial Incentives

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- Pay for discussion: fear “death panels and rationing”
- Pay for performance such as decreasing length of stay, readmits, ICU days at end-of-life
- Incentivized clinical activities reached a plateau in the first year and quality of care remained higher year 2 to 4 but lower than projected

BMJ, 2011

# Non-economic Methods for Changing Professional Behaviors

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- Minimal impact: one-off info session, intermittent performance feedback
- Bigger impact: consistent performance feedback, point of decision tools for patient and provider, training and supporting opinion lead, repeated educational intervention
- Biggest impact: strong evidence, identify and address barriers to change, multimodal approach and engagement of other health care professionals

# Hospitalizations

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- Estimated 40% patients are sent to hospital 30 days before dying
- Many in the last six months of their lives live in and out of the hospital, being treated by more than 10 physicians
- 30 day re-admissions cost Medicare \$12-15 billion



# Transitions in Care Community Forum

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## Collaboration objectives...

- Hospital/SNF collaboration to establish transitions in care processes with SNF residents
- Partnership to improve staff skills in developing and implementing plans that support EOL wishes
- Spread the model to demonstrate cost-effectiveness of this approach
- Establish community standard of care

# Transitions in Care Community Forum

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- Meetings every other month
- Open agenda
- Discuss successes and challenges
- Identify opportunities for improvement in communication
- Identify educational opportunities

# Partnership for Patients

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- Billion dollar quality initiative
- Support community coalitions
- Reduce 30 day readmission rate
- Significance:
  - cost and inefficiency of 30-day readmissions
  - negative impact on the lives of patients with serious complex illnesses
  - PC pt's have complex diseases

AAHPM, Fall, 2011

# Data to support partnership...

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- 23.5% of patients admitted to SNF's were re-hospitalized within 30 days
- Few nursing home residents have identified proxies for decision-making (18%)
- Many nursing home residents have a diagnosis of dementia (over 50%)
- Transfers near end of life are common & not always beneficial
- 13% of hospital deaths of people over age 65 are preceded by a transfer from a nursing home

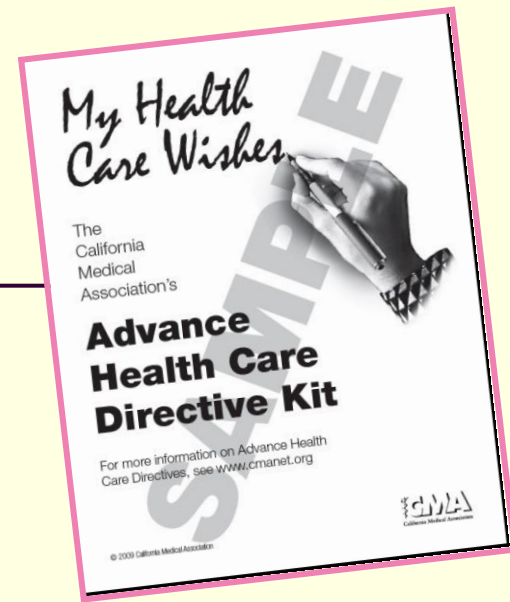
# Significance...

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- 38 % of SNF discharges are admissions to hospitals
- Up to 37% of SNF resident hospitalizations may be inappropriate/avoidable and costly
- 13% of CA hospital deaths are of residents transferred from SNFs
- SNF to hospitals transfers represent suffering and dislocation for residents
- Reducing transfers – opportunity to improve quality and reduce costs

# Tools...

- Advance Directives, 4/16 HCDD
- POLST document and policies
- Comfort Care guidelines
- S-B-A-R
- GO WISH
- INTERACT



**SBAR**  
Report to physicians

**S  
B  
A  
R**

**HPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY**

**Physician Orders for Life-Sustaining Treatment (POLST)**

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

EMSA #1110  
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Last Name: \_\_\_\_\_  
First Middle Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Date Form Prepared: \_\_\_\_\_

**A CARDIOPULMONARY RESUSCITATION (CPR):** Person has no pulse and is not breathing.  
 Attempt Resuscitation/CPR (Section B: Full Treatment required)  Do Not Attempt Resuscitation/DNR (Allow Natural Death)  
 When not in cardiopulmonary arrest, follow orders in B and C.

**B MEDICAL INTERVENTIONS:** Person has pulse and/or is breathing.  
 Comfort Measures Only Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Antisecretory drugs to promote comfort. Transfer if comfort needs cannot be met in current location.  
 Limited Additional Interventions Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.  
 Do Not Transfer to hospital for medical interventions. Transfer if comfort needs cannot be met in current location.  
 Full Treatment Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.  
 Additional Orders: \_\_\_\_\_

**C ARTIFICIALLY ADMINISTERED NUTRITION:** Offer food by mouth if feasible and desired.  
 No artificial nutrition by tube  Defined trial period of artificial nutrition by tube.  
 Long-term artificial nutrition by tube.  
 Additional Orders: \_\_\_\_\_

**SIGNATURES AND SUMMARY OF MEDICAL CONDITION:**

**D** Discussed with:  
 Patient  Health Care Decisionmaker  Parent of Minor  Court Appointed Conservator  Other:  
 Signature of Physician  
 My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.  
 First Physician Name: \_\_\_\_\_ Physician Phone Number: \_\_\_\_\_ Date: \_\_\_\_\_  
 Physician Signature (required): \_\_\_\_\_ Physician License #: \_\_\_\_\_

Signature of Patient, Decisionmaker, Parent of Minor or Conservator  
 By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.  
 Signature (required): \_\_\_\_\_ (Name print) \_\_\_\_\_ (Relationship (write self if patient))  
 Summary of Medical Condition: \_\_\_\_\_ Office Use Only: \_\_\_\_\_

**SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED**

