ADVANCED INTERDISCIPLINARY HOSPITAL BASED PALLIATIVE CARE
Kaiser National Geriatrics and Palliative Care Conference
June 19-21 2008

INTRODUCTION
- WELCOME!
- OUTLINE OF THE DAY
- BUSINESS ISSUES
  - Please pagers/cells silent
  - Please answer call outside
  - Restrooms
  - Evaluations
  - Education Credits

OUTLINE OF THE WORKSHOP
- 1:50-2:10 Earlier Consults/QA
- 2:10-2:50 Complex Communication
- 2:50-3:10 Break
- 3:10-3:40 Team Stuck with QA
- 3:40-4:10 Team Hooked with QA
- 4:10-5:00 Emotionally Charged Issues/QA
- 5:00-5:10 Conclusion/Questions
SPEAKERS
FROM
COLORADO KAISER INPATIENT
PALLIATIVE CARE TEAM

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OBJECTIVES

- Outline effective strategies for consults with emotionally charged or complex communication issues.
- Describe useful techniques to use when the team is stuck or hooked during a consult or on an issue.
- Recognize processes to obtain earlier consults from your referral sources when the attending and/or pt/family aren’t ready yet.

BARRIERS TO CONSULTS

- Identify the barriers at your hospital during the presentation today
- Each barrier requires creative problem solving- often involving more than one team member
- Barriers often reappear in slightly different forms
- Attending “not ready”
- Pt/family “not ready”

BARRIERS

- Attending doesn’t know what you do
- Attending thinks they do PC- what is it that you do that I don’t do?
- Attending doesn’t know how to introduce the team
**BARRIERS**
- Concerns about delaying discharge
- Attending senses resistance/hesitancy from pt/family
- Attending worries that you decrease hope
- Don’t harm my pt- what’s that?
- Delay or prevent medical eval once PC called

**BARRIERS**
- Attending concern consult might anger the pt/family or sub specialists
- Worry that PC may confuse the picture
- Misperceptions around palliative care:
  a) “greased –slide to hospice”
  b) PC means giving up aggressive care

**BARRIER BUSTERS**
- Be brave- start the conversation
- Ask what is the pt/family are not ready for?
- Ask the attending what are your concerns?
- Give words to introduce the team
  a) usually in complex cases we have the PC team assist
  b) AAHPM definition advanced illness and life limiting conditions
Your words to introduce the team

BARRIER BUSTERS
- Availability-phone numbers too
- Marketing
- Presentations
- Education- one on one, small groups on going
- Develop champions in all areas
- Introduce yourself/team to others

BARRIER BUSTERS
- Walk your talk and deliver what you advertise- communicate, communicate
- Emphasize the benefits of the team
- Highlight the power of getting pt/family on the same page
- Look for entry point- overhearing a conversation
BARRIER BUSTERS
- Ask for referrals - case finding rounds
- Use others to help direct your case finding - charge nurse, case managers
- Express gratitude to the referral source
- Ask referral sources to help you advertise
- Don’t look too busy
- Be honest - admit mistakes

BARRIER BUSTERS
- Honor the work of the referring doc
- Acknowledge the attending’s role in the hospital - they are in charge
- Acknowledge the attending’s relationship with the pt/family
- Beware of a high profile consult - pull out the stops

QUESTIONS
Stopping the Aging Process...

OUR REASONS FOR THIS WORKSHOP
- At times we left wondering: “What in the world happened in there?”
- “That felt bad/good to me, how about you?”
- “I can’t believe I said that! Did I really say that?”
- “Why/When did it turn so difficult?”
- “Guys, I thought that we were good at this.”

KNEE-JERK RESPONSES
- Starbucks - double
- Chocolate - stat
- Blame something - anything will do
- Blame someone - anyone will do
- Find fault with the team
- Cry
- ”I really am no good at this..”
BETTER RESPONSES
- Use the team to ID what was going on
- Discuss the issues with the team
- We offer the categories of:
  1) emotionally charged or complex communication issues
  2) Team hooked or stuck.

Complex Communication: Follow Basic Steps for PC Consultation
- Consult Request
- Screening: Whole Patient Assessment
- Pre-Consult Team Meeting
- Team Meeting with Patient/Family
- Post-Consult Team Debriefing
- Action Plan and Follow Up

Drivers of Complex Communication Issues
- Referral source: multiple specialists
- Conflicting medical reports
- Referral source agendas
- Timing
Complex Communication: Consult Pre-work

- Identify & gather key participants
- Scheduling
- Preparation

Complex Communication: Consult Components

- Pt/family's knowledge of disease, Rx & prognosis
- Discussion of medical issues
- Assist identifying personal goals for EOL
- Assess/manage physical sx
- Assess/manage psych, spiritual & practical
- Plan communication across care continuum

WHAT IT REALLY FEELS LIKE:

The Patient's Story

Physical
Psychological
Social
Spiritual
Complex Communication Issues: Ready-Set-Go

THE FOUR HABITS MODEL
- Invest in the Beginning
- Elicit the Patient’s Perspective
- Demonstrate Empathy
- Invest in the End

Complex Communication: Issues Before, During and After the Consult
- Start where the family is
- Understand needs, goals and expectations
- Clarify and negotiate
- Identify and introduce options
- Summarize
- Follow through

Overall Picture
- Social Worker/Chaplain translation
- What tests, procedures make sense
- Reframing
- Providing context
- Varying learning styles
Shared Decision-Making

“...the patient and the health care professional share both the process of decision-making and the ownership of the decision made. Shared information about values and likely treatment outcomes is an essential prerequisite. The clinician has to be prepared to acknowledge the legitimacy of the patient’s preferences and the patient has to accept shared responsibility for the treatment decision.”

Quality of Life

- Eliciting patient values, philosophy
- Limits on medical interventions
- Difficult questions

Mirroring

- "What do you think?"
- "What is your body telling you?"
- "What do you know in your heart of hearts?"

Spring-Boarding vs. Pole Vaulting

- What is spring-boarding?
  - Building on pt/families’ perceptions
  - Incorporating pt/family words
  - Giving meaning
  - Validating
Spring-boarding vs. Pole Vaulting

What is pole vaulting?

- Working around, stepping over
- Changing the subject
- Following an agenda
- Pole vaulting benefits and risks

Complex Communication in Palliative Care

Embrace the challenges

- The better you get, the harder they get!
- The litmus test: Did we develop a relationship?

CONCLUSION AND QA
BREAK- 2:50 to 3:10

Next topic : Team Stuck

Team Stuck
- Friday afternoon
- "5th _____ patient/family this week"
- Swamped, therefore no debriefing
- WE have an agenda
- Secondary trauma

What Can We Do About it?
- Trust team members
- Take risks – step out on a limb
- Realize pt/family style
- Accept that we are not their saviors
- Seed planting
- "From what you are saying, it sounds like ___ would be a good next step/fit/etc..."
Ask Yourself…
- Is it an ethical issue?
- Is it spiritual or cultural issue?
- Are the right/wrong people in the room?
- Is it a gender issue?
- Is it a racial issue?
- Am I invested in an outcome here?
- Altered mental status pt? MPOA?
- My agenda?

Respecting Patient/Family Process
- Time to "marinate"
- Let them experience the journey
- Barriers
- Merry-Go-Round
- Suffering

Skill Set
- Attention to non-verbals
- Reflecting back to patient/family
- Allowing time to pause
- Identify the “elephant in the room”
- Awareness of family roles
- Awareness of family styles
Rabbit Holes: Definition and Examples

- Avoidance vs. Maslov’s Hierarchy of Needs
- Medical minutia
- Psychosocial concerns

Rabbit Holes: Digging Your Way Out

- Redirect/refocus conversation to goals
- Mention time limits
- Attention-getting statements
- Pole-vaulting: “What 3 things are most important to your loved one?”

Stuck: Dealing with Secondary Trauma

- May be why you are stuck
- May be why you dread seeing a type of pt
- May be the cause of unexpected tears, anger, or irritability
SECONDARY TRAUMA

"Vicarious trauma is not a problem which overtakes less competent professionals; this is what happens to skillful, committed, effective care-providers... Those who have enormous capacity for feeling and expressing empathy tend to be more at risk of compassion stress."

- Charles Figley, Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized

What can you do about it:
Be aware

- **Empathy** is an interpersonal skill based on identification with another person’s pain.
- **Compassion** is also an interpersonal skill but is **NOT** based on identification. Instead, from being deeply centered in your self, find a quiet place within which you are simultaneously fully present, compassionate, and detached.
- **Save Empathy for personal life, loved ones.**

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SECONDARY TRAUMA

- Awareness
- Indicators: hurt, anger, dispiritedness
- Attachment to outcome can result in being hooked
- How to let go: work without personalizing the outcome

– Henry Tobey, PhD, 2006
What does it look like?

- All about me vs. human connection, engagement
- Hooking our emotions from past experiences
- "Misty-eyed" moments: individual vs. shared experience

"You've got six months, but with aggressive treatment we can help make that seem much longer."
Indicators of Being Hooked

- Perseverating on topics
- No resolution likely to occur
- Dreading the consult
- Working harder than the patient/family

Video Examples “Hooked”

- Video – Social Worker asked hypothetical question
On Choice and Autonomy...

“Giving patients a choice, without context or a professional recommendation, is a false application of the principle of patient autonomy and ignores the professional duty of physicians to provide counsel about the appropriateness of medical decisions.”

Why Do We Get Hooked?
- Pet peeves
- Professional issues
- Personal issues
- Parallel processes

How Do We Un-Hook Ourselves?
- Accept our limits
- Pre-team
- Debriefing
- Team cues
- Changing topics
- Graceful exit

Remember:
Excellent people have gone before you.
Emotionally Charged Issues

Anticipating emotionally charged issues

Video phone call
Video don’t mention hospice

Emotionally Charged Issues
- Family dynamics
- Multiple sub-specialties involved
- Multiple admissions
- Taboo topics
- Unexpected

The Angry Pt and Family
- Directed at you, team or anyone
- Validate
- Teflon tough vs flag
- Apology
- Refocus
- Step back & let family take care of its own
**Values Neutral**

- No shaming no blaming
- Leave preconceived ideas at the door
- No agenda

“Everyone is entitled to their own perceptions, not their own facts.”

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**Sacred Space**

- Place for reflection and pt/family work
- Beyond the basic needs
- Staying present
- Explore and discover

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**Conflict Regarding Care Plan**

- “How do you make decisions as a family?”
- Redirect towards patient wishes and values
- “What concerns you the most?”
Conclusion

- We offer some pearls we find useful

PEARLS

- Value neutral
- Ask permission to tell bad news
- Be prepared to be surprised
- Remember excellent people have gone before you
- No shaming and blaming
- Set limits - don’t work harder than the patient and family

Pearls Cont’d

- Don’t make stuff up
- Remember you are seeing just a piece of the puzzle
- Do all steps, no short cuts
- You reflect the psycho-social pathology
- Be non-judgmental
- Concentrate on the Palliative issues
Pearl's Cont'd

- Watch for altered/changing mental status - decision capacity
- Define role of MPOA and find one ASAP
- Sensitivity to needs of new team members
- All team members give same message after the consult
- Every pt/family has 2 or more sides

Pearls Cont’d

- Don’t get hooked/stuck
- Get curious not furious
- Seed planting is a noble task
- Be humble
- Be present
- Always, always be thankful for the opportunity to do this work!

Q and A