INTRODUCTION

- WELCOME!
- BUSINESS ISSUES
  - Please pagers/cells silent
  - Please answer calls outside
  - Restrooms
  - Evaluations
  - Education Credits

OUTLINE OF THE DAY

- 1:50 - 2:40 Introduction to the Consult
- 2:40 - 2:50 Questions
- 2:50 - 3:10 Break
- 3:10 - 3:50 Family Meetings
- 3:50 - 4:00 Questions
- 4:00 - 5:00 Examples
- 5:00 - 5:10 Conclusion/Questions
SPEAKERS
FROM
COLORADO KAISER INPATIENT
PALLIATIVE CARE TEAM

FACULTY

Sharon Dahlinger, RN,CHPN
Kaiser Permanente Denver, CO
Sharon.Dahlinger@KP.org

John Girten, MDIV Manager, Spiritual Care
Exempla Good Samaritan Medical Center,
Lafayette, Co GirtenJ@exempla.org

Daniel Johnson, MD FAAHPM  Director Life
Quality Institute and Regional Dept Chief
Palliative Care Kaiser Permanente Denver CO
Daniel.Johnson@kp.org

FACULTY CONTINUED

Kathleen McGrady, MD,FAAHPM, MS MA
Inpatient Palliative Care  Kaiser Permanente
Denver, CO Kathleen.McGrady@kp.org

Alan Rastrelli, MD Director Inpatient Palliative
Care Kaiser Permanente Denver, CO
arastrell@msn.com

Nancy L Roth, LCSW Palliative Care Program
Manager Kaiser Permanente Denver, CO
Nancy.L.Roth@kp.org
FACULTY CONTINUED

Lisa Sharpe, BSW Inpt Palliative Care
Exempla St Joseph Hospital Denver, CO
sharpel@exempla.org

REFLECTION TIME

Stopping the Aging Process...
• By 2010, America’s 77 million baby boomers will begin turning 65

• America’s population over the age of 65 will double by the year 2020.

SUPPORT Study: How We Die

- 38% spent at least 10 days in the ICU
- Nearly 1/2 of patients received mechanical ventilation in the last 3 days before death
- 1/2 of patients had moderate to severe pain at least 1/2 of the time prior to death
- 1/3 patients preferred no CPR, but <1/2 of their MDs accurately reported preferences
- 31% families reported using all/most of savings


Distribution of Health Care Costs

>30 percent of Medicare payments cover the cost of care for people in the last year of life
Quality of Life at the End of Life: What Patients and Families Want

- Pain and symptom control
- To avoid inappropriate prolongation of the dying process
- To achieve a sense of control
- To relieve burden on family
- To strengthen relationships with loved ones

Singer et al, JAMA 1999

Project on Death in America, 1998-2000 Report on Activities

90% of adults prefer to be cared for in their own home if terminally ill

DEFINITION OF PALLIATIVE CARE

- Palliative care is INTERDISCIPLINARY care that aims to RELIEVE SUFFERING and IMPROVE QUALITY of life for PATIENTS with advanced illness and THEIR FAMILIES.

AND....
Definition of Palliative Care

- It is **IDEALLY** initiated at the time of diagnosis of any serious or life-threatening illness, independent of prognosis, and is **DELIVERED IN CONCERT** with curative or life-prolonging efforts, provided these latter therapies are **BENEFICIAL** to the patient.

Diane Meier "Geriatric Care" 2003

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**PALLIATIVE CARE**

- Care is patient centered
- Care is comprehensive
- Care is holistic
- Pt /family together are the unit of care
- Interdisciplinary team approach addresses spectrum of needs of pt/families
- Focus on enhancing quality of life

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**Palliative Care**

- Shown to improve satisfaction
- Shown to reduce hospital costs
- Shown to ease transitions through progressive illness
- Shown to ease suffering
Without Palliative Care

- Goals of care not clarified
- Cycle of repeated episodes of short-term life-prolonging efforts usually in the hospital
- Only about 1/3 of pts spending just a few weeks of their life in hospice

Inpatient Palliative Care

Colorado

2 non-KP hospitals
2 full-time PCT – RN, MD, SW, Chaplain and now with consultative Pharm D
Seeing 1300 pt/year
1/3 are referred to hospice at the time of consultation
Our model is based on a Randomized Controlled study

Gade et al JPM 2008: 11 (8)

STUDY RESULTS:

- More advance directives for IPC
- Hospital re-admission IPC less ICU stays
- Patients had more hope
- Pain was reduced
- IPC longer hospice stay 58 days vs. 33
- IPC patients lower total costs
STUDY RESULTS: Satisfaction

IPC patients reported significantly greater satisfaction with their health care team for:

- Communication with their providers
- Communicating about Ads / advance care planning
- Treatment wishes followed

STUDY RESULTS: Satisfaction Cont’d

IPC patients reported significantly greater satisfaction also in:

- Greater sense of control to refuse care or RX
- Opportunity to discuss possible death
- Given information about care and treatment choices

What This Means

- Higher quality care
- Higher satisfaction
- Cost effective
- IPC implementation nation wide for KP
- Model was a full team? Why a full team?
The Full Team: Philosophical Rationale

Palliative care: interdisciplinary health care specializing in the relief of suffering...

Suffering:
“A state of severe distress associated with events that threaten the intactness of the whole person…”
Eric Cassell

10 Reasons for the Full Team Model

1. Portrays & delivers comprehensive, “whole-person” care

2. Patient friendly, less burdensome, & validates diverse needs of pts/families

3. Is effective: process supports complex decision-making and eases difficult transitions

10 reasons for the Full Team Model

4. Is efficient: team processes key information together

5. Facilitates real-time “reframing” of pivotal issues from varied perspectives

Patient: Mr. L is a 67 y/o retired mason admitted w/ advanced colon cancer and severe pain.

“Stop chemotherapy? Wow. I’m not sure... I don’t think I could trust God any longer.”

Family Meeting, Ines Kollar
10 Reasons for the Full Team - Cont’d

6. Strengthens communication & education efforts through natural, discipline-specific links with hospital staff
7. Provides quality care at a lower total cost
8. Provides team members a means for emotional support

10 reasons for the Full Team Model - Cont

9. Is personally and professionally satisfying
10. Is valued by patients and families

From the husband of a 55 y/o woman suffering from pain and advanced ovarian cancer:

“Hospital care has a tendency to be incredibly impersonal. The palliative care team functioned on a very personal basis...and that is invaluable.”

Full Team: Challenges

- “Costs too much”
- “Too many people in the room”
- “People will talk too much”
- “Too inefficient”
- “I can do it alone” (no “I” in “team”)
- “Team is too ‘touchy, feely’”

Patient: Ms. G is a 45 y/o mother admitted with altered mental status and liver failure. Fiancée, tearful:

- “I think she’s come to the end.”
- “I couldn’t take her off life support... no way.”
- “What can I tell her boys?”
- “Her joy? That’s easy – her dogs.”
IPC Implementation

Four keys to success:

1. Constant, recognizable presence
2. Consultative “hospitalist-type” model
3. “Upstream” referrals – support for more than just those “near death”
4. Presence of a full team

Role descriptions

- Chaplain
- Nurse
- Social Worker
- Physician

Chaplains Role

- Assess/explores pt/fx existential, spiritual, and emotional needs
- Helps pt/family identify what is meaningful
- Validates pt/fx experience-offers emotional, spiritual support
- Supports completion of written directives
Chaplains Role Cont’d
- With permission, shares with hospital chaplain pts faith community/social systems
- F/u with ongoing existential/spiritual needs
- Supports PC team's existential/spiritual needs
- Education to team and hospital

Social Worker Role
- Assess pt/family social support, family dynamics
- Seeks information about functional status and adjustment in previous places of care
- Validates pt/family experience, offers psychological/emotional support

Social Worker Role Cont’d
- Information about benefits and resources
- Communicates with case management
- Often moderator of pt/family meeting
- Education to team and hospital
Nurses Role
- Reviews chart, seeks hx and conducts screening intake with pt/family
- Assess pt's bedside needs for comfort
- Integrates the above info during the consult to insure key pt/family concerns and needs are addressed

Nurses Role Cont’d
- Shares results of the consult with the hospital RN/providers and advocates for pt/family goals
- F/u with ongoing nursing needs
- May schedule Pt/family meeting
- Education to team and hospital

Physician Role
- Clarifies with referring MD referral
- Reviews pt's Dx, Rx, involved providers & future plans for care
- Clarifies dx, prognosis as needed/desired by Pt/family
Physicians Role Cont’d
- Assess and manages sx/pain involving other team members to address total pain
- Communicates consult outcomes to docs
- Advocates with other involved providers for pt/family goals of care
- Education to team and hospital

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

APPROPRIATE PTS FOR PC
- Startling: “Would you be surprised if this patient died within a year?”
- Any patient with a serious or life threatening condition - American Academy of Hospice and Palliative Medicine 2008
- Anywhere in the hospital - includes ED, ICU
OUR IPC Consultation: What it is….and isn’t

IPC Consultation is:
- Centered on patient/family needs, values and goals
- Provided by an interdisciplinary team
- Best practiced from a “values-neutral” position
- Cost effective at a population level

Our IPC Consultation is Not:
- A chronic pain management service
- A hospice service (or a “grease slide” to hospice)
- An ethics consultation service
- Bedside “rationing” or “gate keeping”

Unlikely Pts for PC
- Chronic pain pts without life threatening or serious dx
- Non-decisional pts without surrogate
- Pts who are comfortably dying without family/staff concerns
- Pts who are hospice appropriate and ask for enrollment
Common Reasons for Referral

- To help clarify care goals and options
- To provide pain and sx relief
- To support emotional, social and spiritual needs

Reasons for Referral Cont’d

- To support the medical team/staff in discontinuing life-sustaining therapies that are unhelpful
- To facilitate discharge planning
- Pts having goals of care in conflict with their advance directives

Reasons for Referral Con’t’d

- To help work with conflicted families or staff
- Requests from the ethics committee
- Balance Palliative Care in concert with curative or life-prolonging efforts
Reasons for Referrals Cont'd

- See hospice qualified pts who do not seem philosophically aligned with hospice
- Help MPOA understand their role
- To help advocate for pt/family goals

Videos of Surviving Family Members

- Had a consult with interdisciplinary team
- Done post their loved one's death
- Note how the families describe a pt/family centered focus accomplished by the team

QUESTIONS?
BREAK TIME- 20 minutes
2:50 to 3:10

Next Session Family Meetings
3:10 to 4:00

COMMUNICATION

Prior to Consult
- MD seeks info on referral
- Family meeting scheduled by team member
- Screening of whole patient:
  - RN does intake evaluation
  - Confer with hospital colleagues
  - Pre-consult meeting: Share info & concerns and goals for pt/family

“I’m right there in the room, and no one even acknowledges me.”
PRE-TEAM MEETING
- Huddle - each team member shares info
- Discussion of possible team concerns
- Leave any agendas outside the room
- Become centered

Organization Matters
- Be on time
- Announce available time
- Significant others/MPOA present or phone
- Make sure pt not scheduled for test/blood
- Quiet space (no TV)
- Sign on door

Organization Matters Cont’d
- Assure pt not in pain/ uncomfortable or sedated
- Notify floor nurse of time of consult
- Sit so all members of the team can see each other and all pt/family members
- Be present in spirit, mind as well as body
An Approach to End-of-Life Communication

1° Listening

Seek "alignment"

Understand needs, goals and expectations

Clarify and negotiate

Identify and introduce options

Information exchange

Patient/Family Meeting

Generally Consists Of:
- Description of "PC" and reason for meeting
- Introductions of all present
- Assess understanding of the medical condition by all involved
- Pt/ family’s perception of dx, Rx and prognosis
- Assistance in identifying personal goals for EOL
- Pain/sx, psychological, spiritual, social, and practical needs.
- Development of a plan of care

Essential Components of an IPC Consultation

The entire IPC team should have at least one meeting with the patient and the family. Essential components of the consultation include identifying the patient’s and family’s goals of care by:
Essential Components of an IPC Consultation Cont’d

- Assessing the patient/family’s understanding of the seriousness of the illness and its course, informing patient and family about prognosis and exploring any misconceptions

Essential Components of an IPC Consultation Cont’d

- Exploring, identifying and addressing the patient’s psychological, social and spiritual needs, as well as their values, hopes and fears
- Helping with family conflicts, emotional support and difficult issues

Essential Components of an IPC Consultation -Cont’d

- Advance care planning with patient, including family decision making and completing advance care documents
- Developing a plan of care for pain and symptom control
Essential Components of An IPC Consultation-continued

- Identifying options for coordination and caregiving, including legal, financial and health care planning, options for community resources and services including but not limited to hospice.

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Palliative Care Addresses “G-A-P-S” in End-of-Life Care

- **G** = Goals of care: establishing goals around comfort, function, length of life
- **A** = Advance care planning: starting the conversation to signing documents
- **P** = Psychosocial and spiritual support
- **S** = Symptom management

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Comprehensive Assessment

The Patient's Story

- Physical
- Psychological
- Social
- Spiritual

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DO POST TEAM NOW

- Leave room together
- Summary/next steps
- Follow-up arranged
- Assign tasks

POST TEAM CONT'D

- Opportunity to receive/give feedback
- Safe/honest: intent to improve consult & team work
- Debriefing-sharing of thoughts, feelings decreasing secondary trauma
- Make list for future discussions/exploration
- Share “PEARLS” with each other
Tricks of the Trade- What We Find Helpful
- Everyone must be mentally present
- Talk with the family not at them
- Read the non-verbals from pt/family/team
- Re-direct discussion to the pt’s needs as often as necessary

Tricks of the Trade Cont’d
- Questions should be: simple, respectful, gentle, open ended
- Use active listening and reflect back
- Link next comments with previous or refocus placing the pt in the center again

Tricks of the Trade Cont’d
- Create a safe even sacred space to share
- Walk with the pt/family during the consult
- Address anger, but do not take responsibility
- Respectfully confront when necessary
Avoid side conversations
Avoid siding with a family member
Beware of attempts to divide the team
Listen respectfully to complaints on care then refocus on what can be done now

Leave your and the team's agenda outside
Assess decisional making capacity of pt BEFORE the consult and recheck
True informed consent of RX risks/benefits-how those affect the pt's expressed values

Be non-judgmental
Rescue team member by refocus to pt
Fatigued or stuck? toss the conversation ball to the team-someone will take it
Look for "forks in the road" or transitions
Tricks of the Trade Cont'd

- Normalize feelings and fears
- Don't promise
- Allow silence
- Honor all those in the room including team
- Pt/families want respect, to be listened to, and be assured that their values count

Tricks of the Trade Cont'd

- Foster hope
- Align your hopes with the pt/family
- Use all team members in the conversation
- Give contact information for the team

Questions on Family Meeting

- 3:40 – 3:50
Videos and Cases
4:00 to 5:00

CONCLUSION/QUESTIONS
5:00-5:10