Primary Palliative Care and the Primary Care Provider

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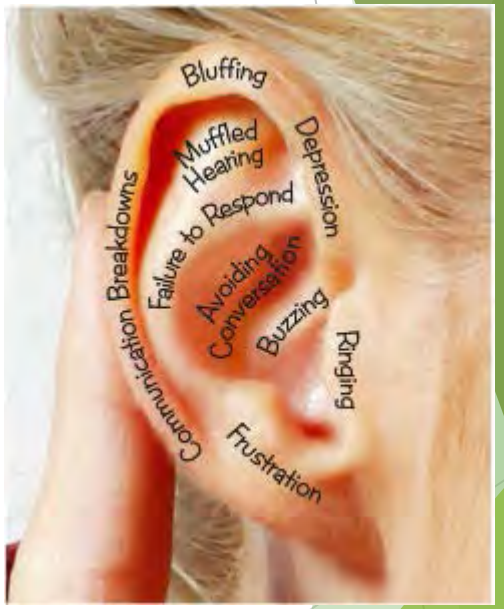
Case Study: Wendy White

- 77 yo F with presumed metastatic RCC to GI tract, cachexia, HOH admitted for GIB
  - Hard of hearing, concerns about misunderstanding
    - Years prior declined renal biopsy
    - Treatment: chemotherapy, immunotherapy
    - Can’t communicate over the phone
  - Consulted palliative care, patient declined discussions
  - Added patient to panel at clinic after meeting inpatient



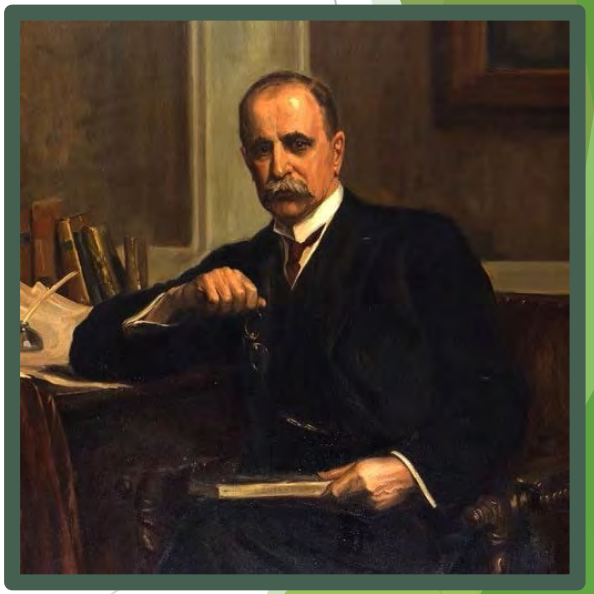
Objectives

- Define primary palliative care and the role(s) of the primary care provider (PCP).
- Describe primary care residency training in palliative medicine.
- Describe how aspects of palliative medicine are currently implemented into practice in PCP offices.

Define primary palliative care and the role(s) of the primary care provider (PCP)

Primary Care Provider

- First mentioned 1966: “not upon individual organs and systems but upon the whole man, who lives in a complex social setting”
- Continuity
  - First point of contact
  - Overall responsibility
  - Coordination of care* within a complex system
- Comprehensive
  - Chronic, preventive, acute care
  - Outpatient and inpatient settings*
  - Physical, mental, social well-being
- Community
  - Devoted to a defined patient population
  - Education, advocacy roles



PCP Roles

- Family medicine, general internal medicine or general pediatrics*

Table 1. Number of Office-Based, Direct Patient Care Physicians by Specialty, 2019

Physician Type	Number of Physicians	Percent of Primary Care Physicians	Percent Total
Total Physicians	730,026	–	100.0%
Non-Primary Care Physicians	501,089		68.6%
Total Primary Care Physicians	**228,936**	**100.0%**	**31.4%**
Family Physicians	91,037	39.8%	12.5%
Geriatrics	4,495	2.0%	0.6%
General Practice	5,579	2.4%	0.8%
General Internal Medicine	78,984	34.5%	10.8%
General Pediatrics	48,842	21.3%	6.7%

Source: American Medical Association (AMA) Physician Masterfile, 2019

Primary Palliative Care (PC)

- “Provided by clinicians who are not palliative care specialists”
- Limit of PCP knowledge/skill levels varying
- Skill set versus “palliative approach”

Representative Skill Sets for Primary and Specialty Palliative Care.

Primary Palliative Care

- Basic management of pain and symptoms
- Basic management of depression and anxiety
- Basic discussions about
  - Prognosis
  - Goals of treatment
  - Suffering
  - Code status

Specialty Palliative Care

- Management of refractory pain or other symptoms
- Management of more complex depression, anxiety, grief, and existential distress
- Assistance with conflict resolution regarding goals or methods of treatment
  - Within families
  - Between staff and families
  - Among treatment teams
- Assistance in addressing cases of near futility

“Basic” Palliative Care Skills

Representative primary and subspecialty palliative care skills in each domain

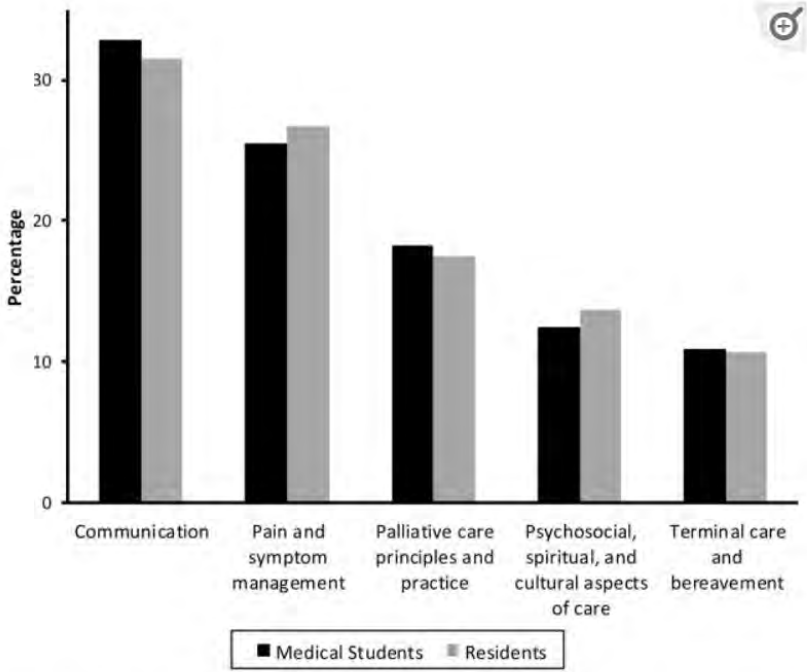
Primary palliative care skills	Subspecialty palliative care skills
Assessment/treatment of physical symptoms	
▪ Basic pain management ▪ Basic management of other physical symptoms ▪ Basic use of adjuvant pain relievers ▪ Equianalgesic dose conversion	▪ Management of refractory pain ▪ Management of other refractory symptoms ▪ Methadone transition when large doses of opioids are being used ▪ Patients with addiction problems and serious illness
Psychological, social, cultural, and spiritual aspects of care	
▪ Basic management of depression/anxiety ▪ Exploration of psychosocial suffering ▪ Basic exploration of spiritual and religious views ▪ Basic exploratory family meeting	▪ Management of more complex depression, anxiety, grief, and existential distress ▪ Severe religious/spiritual suffering
Serious illness communication issues	
▪ Exploring patient goals in light of circumstances ▪ Making recommendations about code status ▪ Seeking consensus among treating professionals ▪ Seeking consensus among the patient and family	▪ Dying patients who want "everything" ▪ Major conflict among family members ▪ Major conflict among treating teams ▪ Requests about assisted dying
Care coordination	
▪ Coordinating care among specialists ▪ Clearly defining the primary treating team ▪ Managing transitions to hospice care ▪ Managing transitions out of the hospital	▪ Transition to hospice with no clear provider ▪ Patient/family major resistance to discharge ▪ Conflict with the designated outpatient provider

Case Study: Wendy White

- Several 40 minute outpatient appointments
- Communication with oncologist
- Capacity ☑ declined renal biopsy and possible treatment
- Talked frequently about her dogs: Poncho and Candy

Describe primary care residency training in palliative medicine.

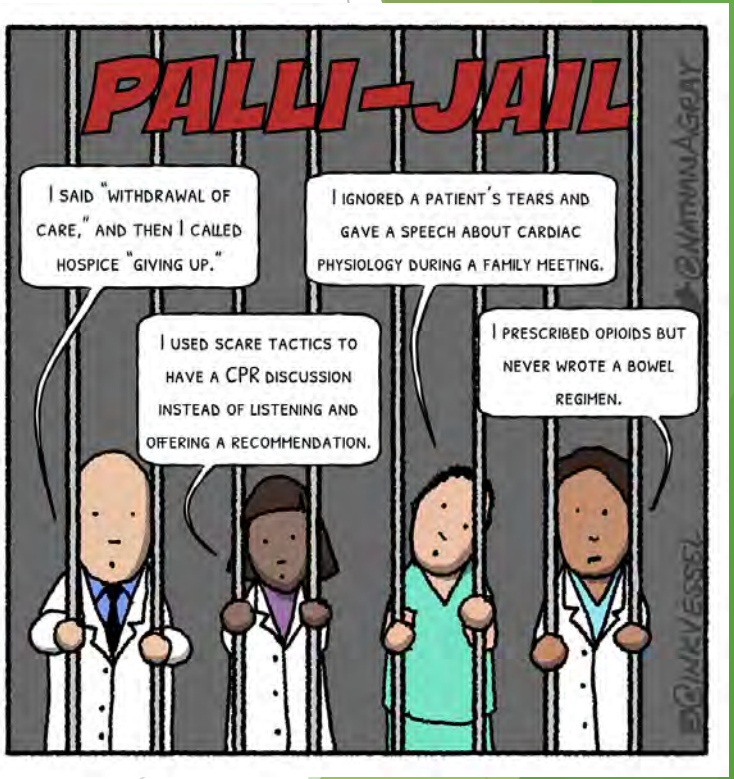
Competency Domains



Relative weight of importance of competencies assigned by 68 experts to each of five palliative care domains. Developed from a survey of 71 palliative care experts (data from 3 participants were missing or not given).

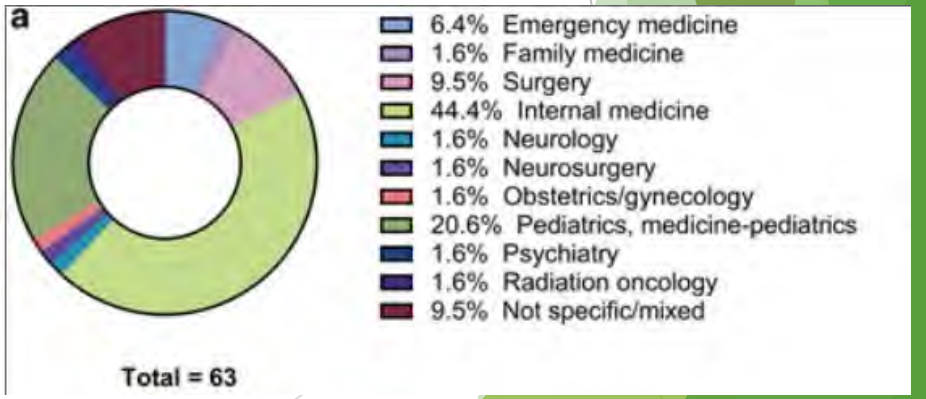
Palliative Education for Residents

- Overall improving
- Lack of information about *current* educational modalities implemented in primary care training
- 1990's: attempts to improve resident education began with IM residencies
- Palliative specialist presence is key!
- Evolving with recent emphases on
  - Communication skill training
  - Curriculum development
  - Rotations



PPC: Educational Interventions

- Interventions
  - Didactics
  - Clinical rotations
  - Skill retreats
  - Discussion
  - Role play, standardized patients
  - Web-based learning, ASL
- Clinical likely more effective than didactic experiences

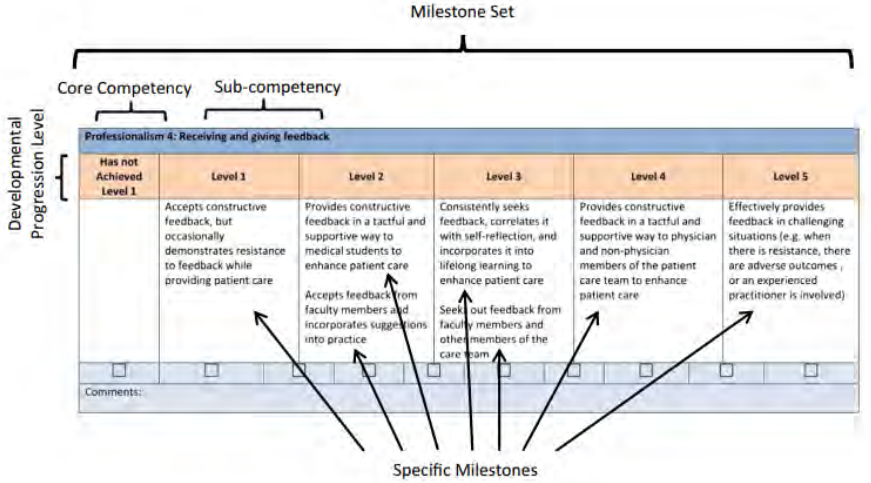


Outpatient ACP/GOC Training

- Vast majority of these skills are taught or witnessed in the inpatient setting
- Only a handful of very recent studies have assessed educational interventions *beyond advance directives* for trainees
- For primary care physicians, this is important!

Residency Milestones

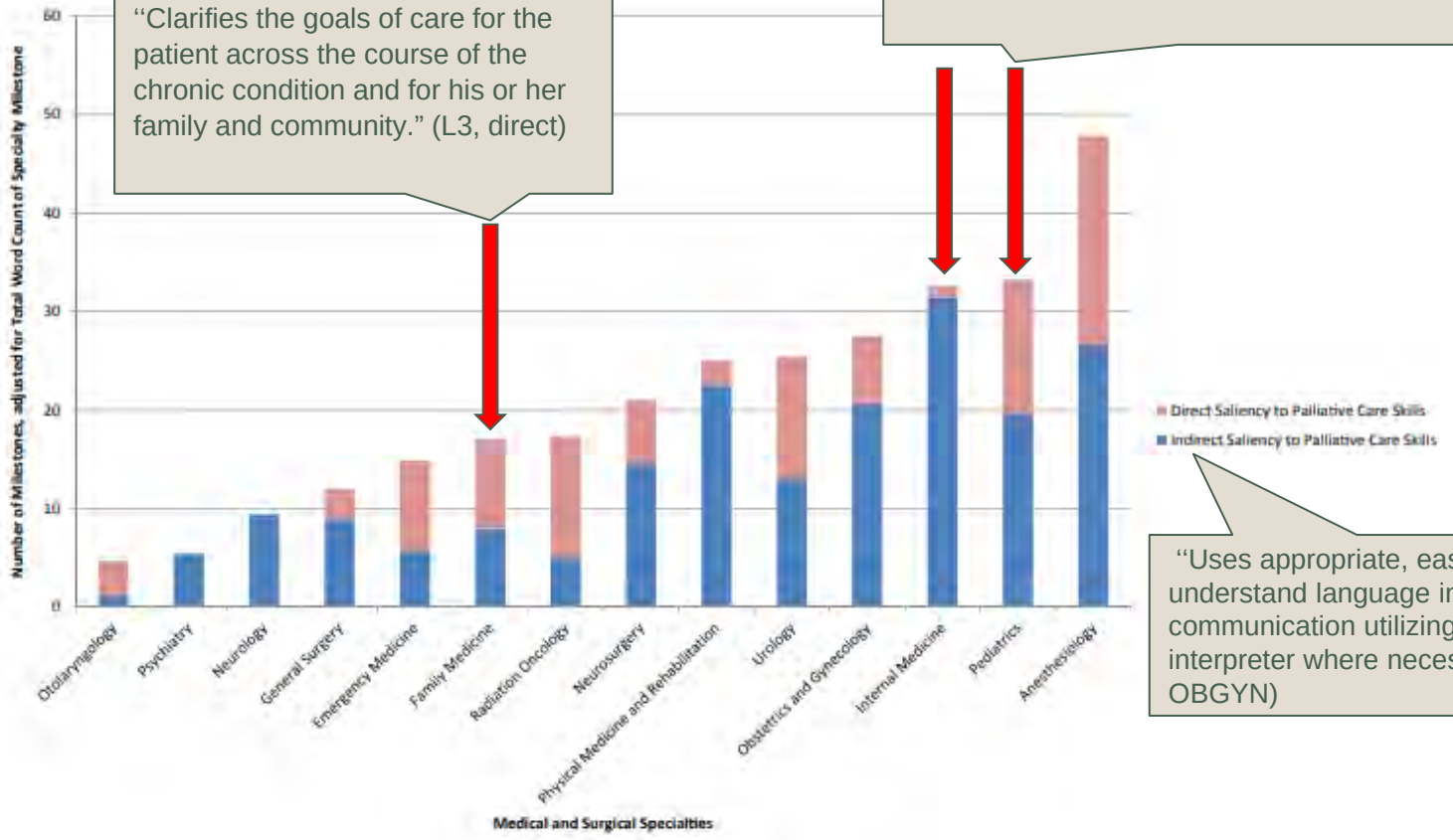
- Mandated by ACGME starting 2013
- Varying #'s of milestone sets and sub-competencies amongst specialties



Residency Milestones

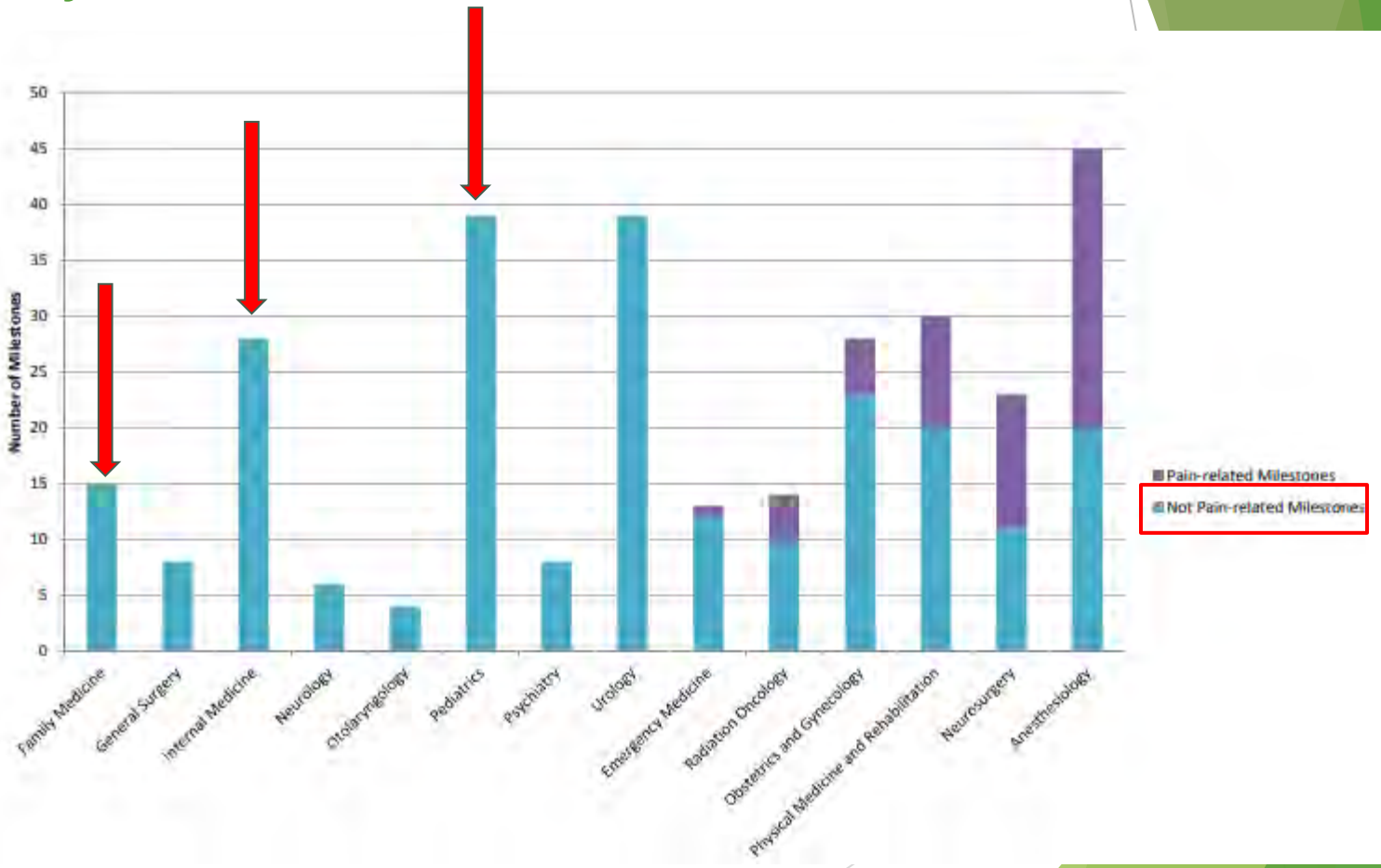
‘‘Anticipates, reads, and reacts to emotions in real time with appropriate and professional behavior in nearly all typical medical communication scenarios, including those evoking very strong, emotions; uses these abilities to gain and maintain therapeutic alliances with others.’’ (L3, direct)

‘‘Clarifies the goals of care for the patient across the course of the chronic condition and for his or her family and community.” (L3, direct)



‘‘Uses appropriate, easy to understand language in all phases of communication utilizing an interpreter where necessary.’’ (L3, OBGYN)

Residency Milestones



Family Medicine Board Exam

ABFM Certification Examination Content

Cardiovascular	**12%**
Endocrine	**8%**
Gastrointestinal	**7%**
Hematologic/Immune	**3%**
Integumentary	**6%**
Musculoskeletal	**12%**
Nephrologic	**3%**
Neurologic	**3%**
Nonspecific	**9%**
Psychogenic	**7%**
Reproductive—Female	**4%**
Reproductive—Male	**1%**
Respiratory	**13%**
Special Sensory	**2%**
Population-based Care This includes topics such as biostatistics and epidemiology, evidence-based medicine, prevention, health policy and legal issues, bioterror, quality improvement, and geographic/urban/rural issues.	**5%**
Patient-based Systems This includes topics such as clinical decision-making, communication and doctor-patient interaction, family and cultural issues, ethics, palliative care, and end-of-life care.	**5%**

Internal Medicine Board Exam

PC and EOL in elderly <2%

Cross-Content Category	Relative Percentage
Critical Care Medicine	10%
Geriatric Medicine	10%
Prevention	6%
Women's Health	6%
Clinical Epidemiology	3%
Ethics	3%
Nutrition	3%
Palliative and End-of-Life Care	3%
Adolescent Medicine	2%
Occupational Medicine	2%
Patient Safety	2%
Substance Abuse	2%

Medical Content Category	% of Exam
Allergy and Immunology	2%
Cardiovascular Disease	14%
Dermatology	3%
Endocrinology, Diabetes, and Metabolism	9%
Gastroenterology	9%
Geriatric Syndromes	3%
Hematology	6%
Infectious Disease	9%
Nephrology and Urology	6%
Neurology	4%
Obstetrics and Gynecology	3%
Medical Oncology	6%
Ophthalmology	1%
Otolaryngology and Dental Medicine	1%
Psychiatry	4%
Pulmonary Disease	9%
Rheumatology and Orthopedics	9%
Miscellaneous	2%
Total	**100%**

complications of cancer and its treatment <2%, cancer survivorship <2%

Pediatrics Board Exam

*specifically breakdown into pain management and palliative care

Content Domain	Exam Weight
1. Preventive Pediatrics/Well-Child Care	8%
2. Fetal and Neonatal Care	5%
3. Adolescent Care	5%
4. Genetics, Dysmorphology, and Metabolic Disorders	3%
5. Mental and Behavioral Health	5%
6. Child Abuse and Neglect	4%
7. Emergency and Critical Care	4%
8. Infectious Diseases	7%
9. Oncology	2%
10. Hematology	4%
11. Allergy and Immunology	4%
12. Endocrinology	4%
13. Orthopedics and Sports Medicine	4%
14. Rheumatology	2%
15. Neurology	5%
16. Eye, Ear, Nose, and Throat	4%
17. Cardiology	4%
18. Pulmonology	5%
19. Gastroenterology	4%
20. Nephrology, Fluids, and Electrolytes	4%
21. Urology and Genital Disorders	3%
22. Skin/Dermatology	4%
23. Psychosocial Issues	2%
24. Ethics	2%
25. Research Methods, Patient Safety, and Quality Improvement	2%
Total	100%

Case Study: Wendy White

- Continued caring for her for the next several months
- Home visit with “medical home” team
  - Financial strains->provided food, TP
  - Low health literacy
  - Developed rapport with family members
- Family members became my patients

Describe how aspects of palliative medicine are currently implemented into practice in PCP offices.

PCP's and their Patient Populations

- Of pts >65 yo, 8% of visits related to advanced illness
- Conditions
  - COPD **(~50%)**
  - HF **(~25%)**
  - Dementia (~10%)
  - Cancer (~10%)
  - Other: ESRD, liver failure, CVA
- Lower SES with more needs

U.S. Primary Care Visits Among Older Adults With Advanced Illness and Reported Symptoms, NAMCS/NHAMCS 2009–2011

Type of Symptom	Symptom Visits With Advanced Illness, %, $n = 39,640$
Pain	31.5
Depression	17.1
Anxiety	14.4
Fatigue	11.7
Insomnia	9.9
Dyspnea	9.9
Constipation	4.5
Nausea	<1

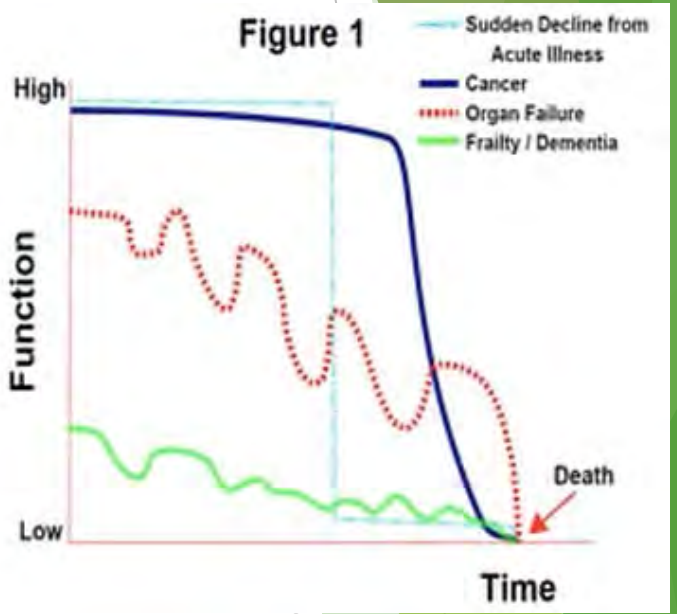
NAMCS = National Ambulatory Medical Care Survey; NHAMCS = National Hospital Ambulatory Medical Care Survey.

Primary Palliative Care: Whose job is it?

- PCP perception
  - feel responsible
  - highly value
  - provide majority of care in last year of life
- Patient perception
  - managing only acute needs & routine follow-ups
  - *limited* time
- Many without formal training, competency uncertain
- May not recognize their actions as providing “palliative care”

Prognostication

- Understanding may facilitate *intentional* holistic assessment of symptoms and care planning needs
- >½ inadequate prognostication training
- PCP request for accurate, timely prognostic information from specialists



Communication: Outpatient ACP, GOC

- Patients prefer discussions with a familiar provider when they feel well
- PCP barriers
  - Uncertainty about how to implement
  - Low knowledge and confidence
  - Poor insight
- ACP *discussions* in PCP setting occur in about ⅓ of patients prior to non-accidental death

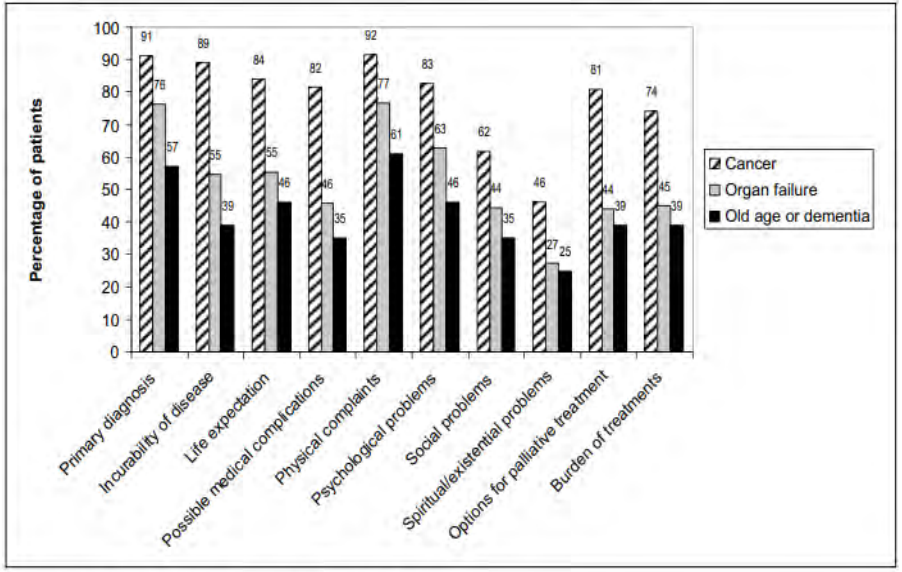


Figure 3. Prevalence of GP–patient discussion of end-of-life topics.
GP: general practitioner.

Symptom Management

- Can perform joint injections, trigger point injections, manipulation etcetera
- Symptoms: PCP report ≠ patient-report
- Delayed or no recognition of symptoms in non-cancer patients
- May need to be proactive to identify symptom needs

Table 2. Ranking of RFVs to primary care as rep

		CLINICIAN REPORTED*
RANK	CONDITION	RANK SCORE‡ (MAXIMUM SCORE WAS 20)
1	Upper respiratory tract infection, unspecified	16.7
2	Hypertension	16.1
3	Routine health maintenance	8.7
4	Arthritis (not back)	8.6
5	Diabetes	8.4
6	Depression or anxiety	7.7
7	Pneumonia	7.2
8	Acute otitis media	6.8
9	Back pain or spinal pain	6.7
10	Dermatitis	6.4
11	Cough	5.6
12	Urinary tract infection	5.4
13	Tuberculosis	4.4
14	Dyspepsia	4.3
15	Tonsillitis	4.2
16	Parasites	4.0
17	Asthma	4.0
18	Abdominal, unspecified	4.0

Referring to Palliative Care Specialists

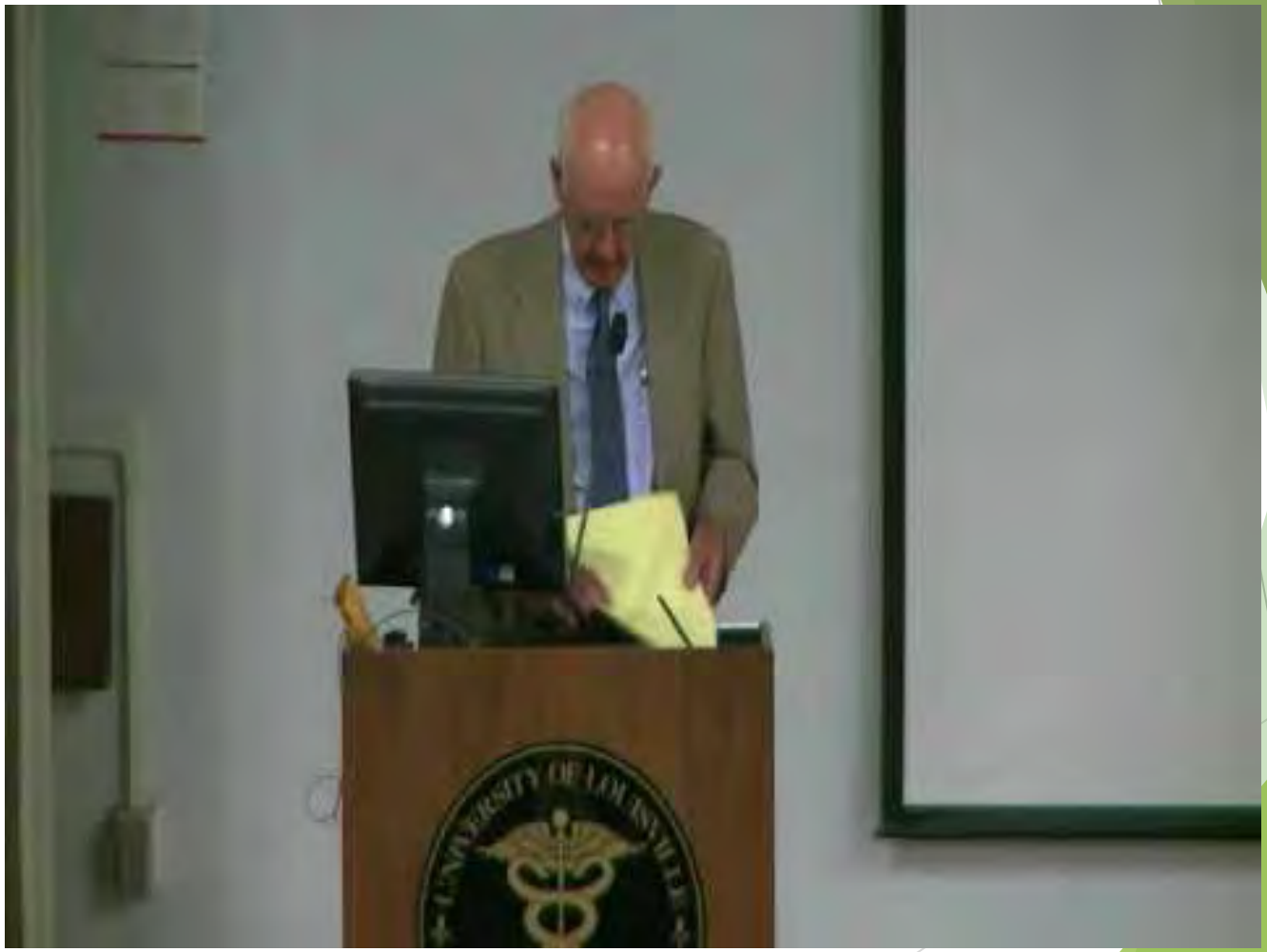
- Education of PCP's integral
  - Unclear roles and collaboration
  - Poor understanding of palliative care
  - Variation in willingness to refer
- PCP makes a *primary* attempt to meet palliative needs through provision of holistic, person-centered care before referring

Case Study: Wendy White

- Symptoms: fatigue, dyspnea relieved by PRN transfusions
- Advance directives:
  - Out of hospital DNR
  - Proxy decision maker naming daughter
- GOC: Function as independently as possible as long she can without aggressive interventions.
  - No hospital admissions
  - No chemotherapy or immunotherapy
  - Hospice once unable to perform IADL's
- Passed away in her home with hospice care fall 2019

Conclusion

- High quality, holistic primary care makes for good primary palliative care.
- There are many studies assessing interventions to improve primary palliative care education in residency. However, aside from standardized milestone and board exam content, the actual primary care residency palliative care education experience is unclear.
- PCP's may unknowingly integrate palliative care skills into their day-to-day practice. However, there are concerns for inadequate provision of primary palliative care particularly for patients with non-cancer advanced illness.



Ensuring PCP's Can Meet Primary Palliative Needs

- Education!
- Intentionally evaluate for "palliative needs"
  - The answer to the SQ is "no"
  - Recent hospitalization
  - Chronic disease progression
  - EMR integration prompt
- Logistically
  - Knowledgeable cross-cover/phone calls
  - Home visits/telemedicine
  - Coordinate care with specialists*
  - Adequate timing in visits
  - IDT support

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