VCU Palliative Care ECHO* Clinic

February 14, 2019

Introduction to Palliative Care

*ECHO: Extension of Community Healthcare Outcomes

Continuing Medical Education

February 14, 2019 | 12:00 PM | teleECHO Conference

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Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Disclosures

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Danielle Noreika, MD

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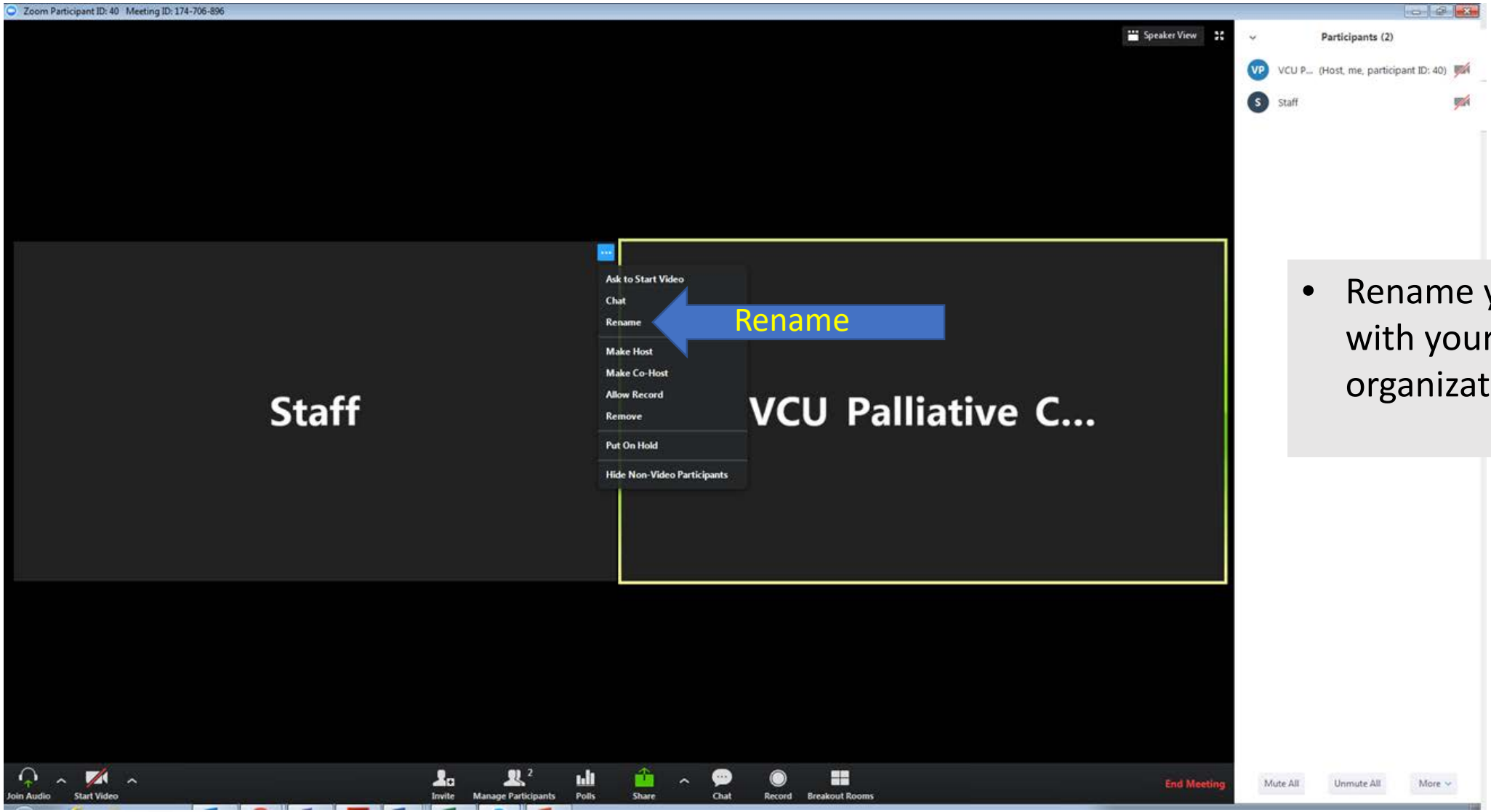
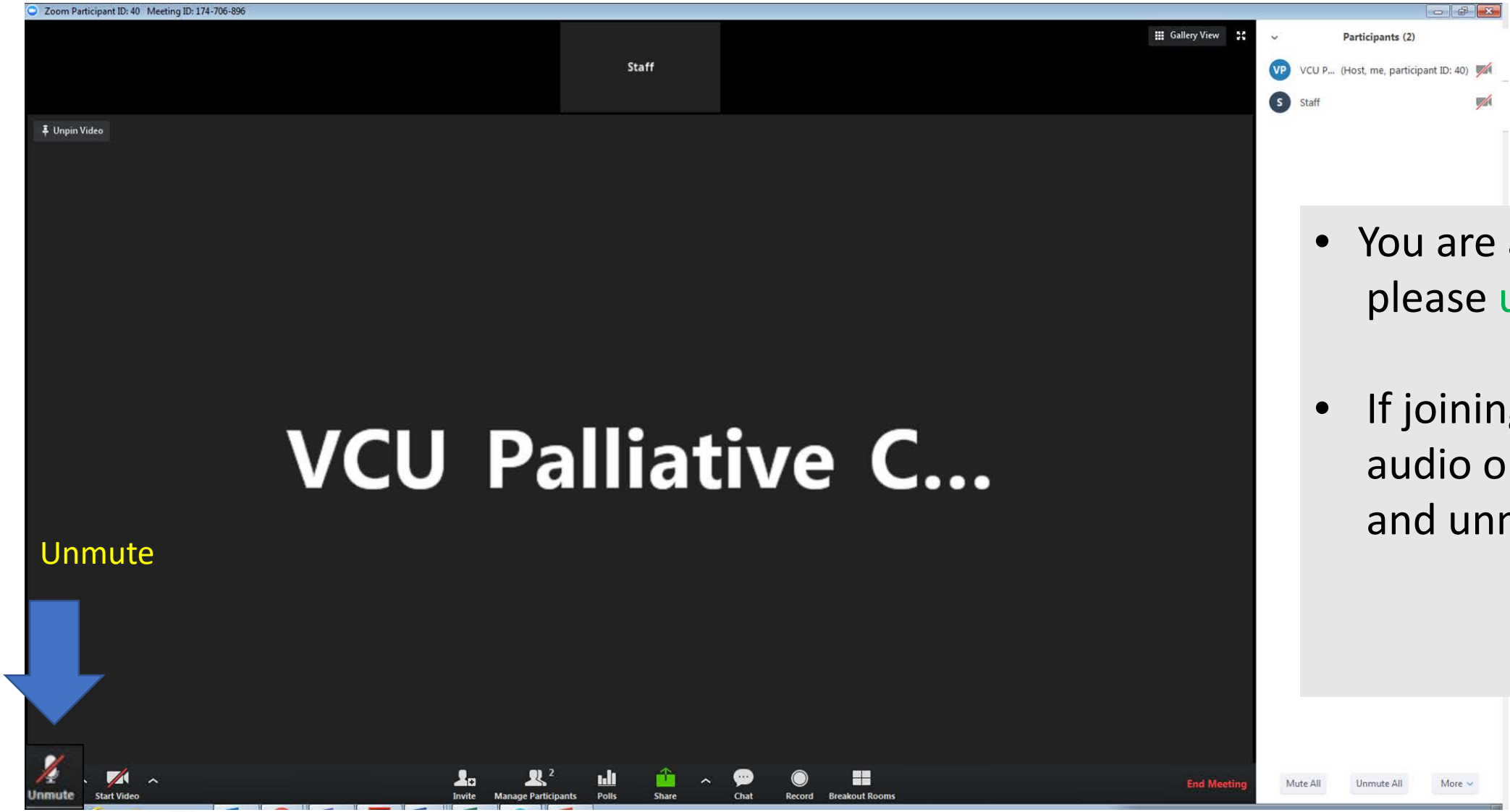
Helpful Reminders



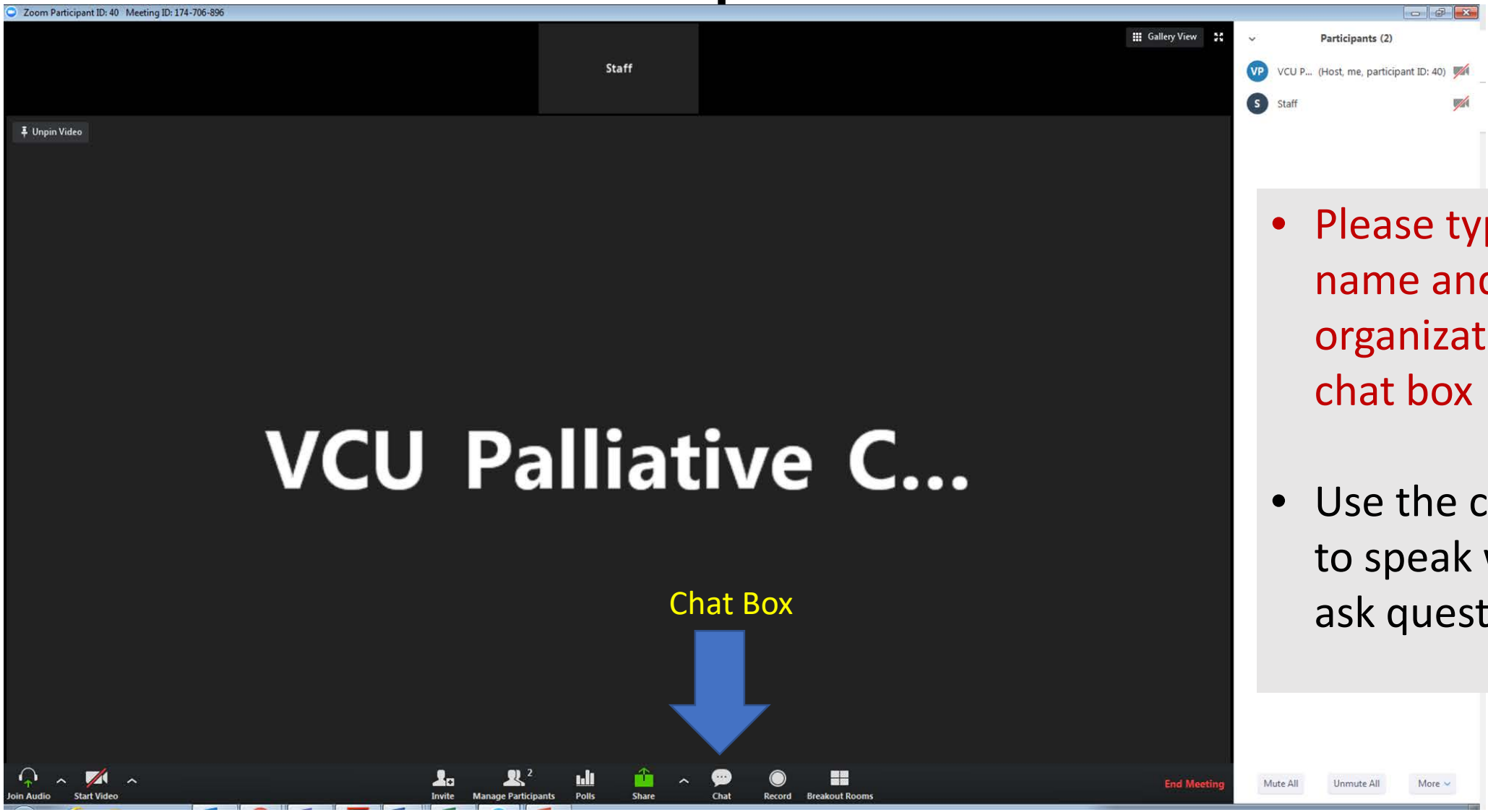
- Rename your Zoom screen, with your name and organization

Helpful Reminders



- You are all on mute please unmute to talk
- If joining by telephone audio only, *6 to mute and unmute

Helpful Reminders



- Please type your full name and organization into the chat box
- Use the chat function to speak with IT or ask questions

VCU Palliative Care ECHO Clinics

- Bi-Weekly 1.5 hour tele-ECHO Clinics
- Every tele-ECHO clinic includes a 20 minute didactic presentation followed by case discussions
  - Didactic presentations are developed and delivered by inter-professional experts in palliative care
- Website Link: www.vcuhealth.org/pcecho
- Email: pcecho@vcuhealth.org

Hub Introductions

VCU Team	
Clinical Director	Danielle Noreika, MD, FACP, FAAHPM Medical Director/Fellowship Director VCU Palliative Care
Clinical Expert	Egidio Del Fabbro, MD, VCU Palliative Care Chair Jason Callahan, MDiv, Palliative Care Specialty Certified Tamara Orr, PhD, LCP, Clinical Psychologist Diane Kane, LCSW, Palliative Care Specialty Certified Felicia Hope Barner, RN Candace Blades, JD, RN, Advance Care Planning Coordinator Brian Cassel, PhD, Palliative Care Outcomes Researcher
Didactic Presentation	Danielle Noreika, MD, FACP, FAAHPM
Program Manager	Bhakti Dave, MPH/Teri Dulong-Rae
Practice Administrator	David Collins, MHA
IT Support	Vladimir Lavrentyev, MBA

Spoke/ Participant Introduction

- Name
- Organization

What to Expect

I. Didactic Presentation

II. Case presentations
    I. Case 1
        I. Case summary
        II. Clarifying questions
        III. Recommendations

    II. Case 2
        I. Case summary
        II. Clarifying questions
        III. Recommendations

III. Closing and questions

Lets get started!

Didactic Presentation

Case Presentation #1

- 12:35pm-12:55pm [20 min]
  - 5 min: Presentation
  - 2 min: Clarifying questions- Spokes (participants)
  - 2 min: Clarifying questions – Hub
  - 2 min: Recommendations – Spokes (participants)
  - 2 min: Recommendations – Hub
  - 5 min: Summary - Hub

Case Presentation #2

- 12:55pm-1:25pm [20 min]
  - 5 min: Presentation
  - 2 min: Clarifying questions- Spokes
  - 2 min: Clarifying questions – Hub
  - 2 min: Recommendations – Spokes
  - 2 min: Recommendations – Hub
  - 5 min: Summary - Hub

Introduction to Palliative Care

Danielle Noreika, MD

February 14, 2019

About Palliative Care

Palliative care sees the person beyond the disease. It is a fundamental shift in focus for health care delivery.

Definition of Palliative Care

Palliative care, and the medical sub-specialty of palliative medicine, is specialized medical care for people living with serious illness. It focuses on providing relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family.

Palliative care is provided by a team of palliative care doctors, nurses, social workers and others who work together with a patient's other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.

Source: http://www.capc.org/about/palliative-care
Accessed 2/13/19

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patients illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Source: https://www.who.int/cancer/palliative/definition/en/
Accessed 2/13/19

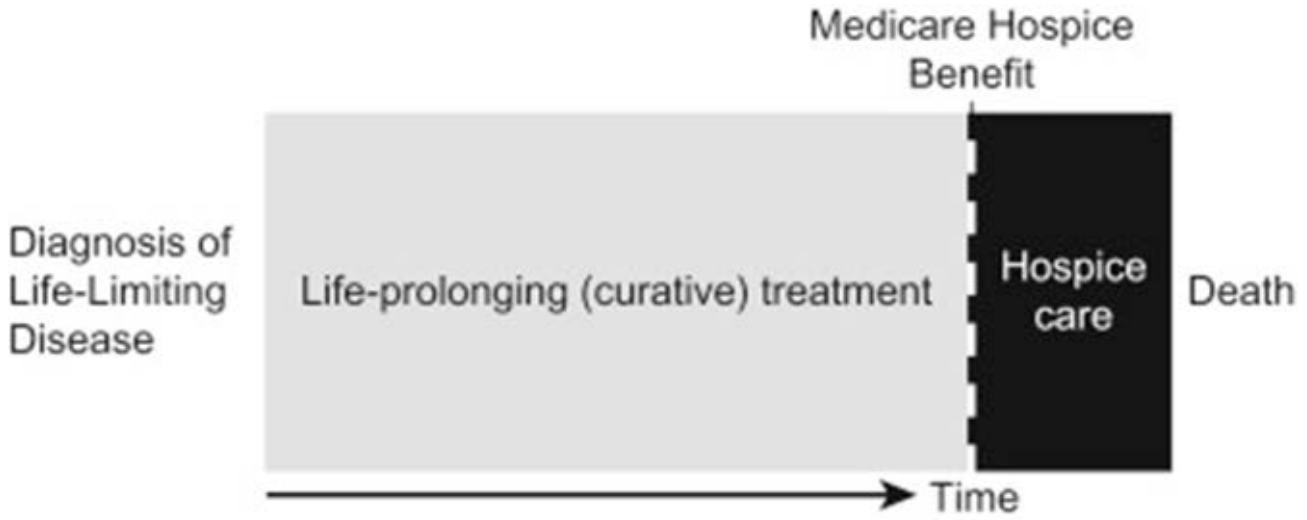
Hospice

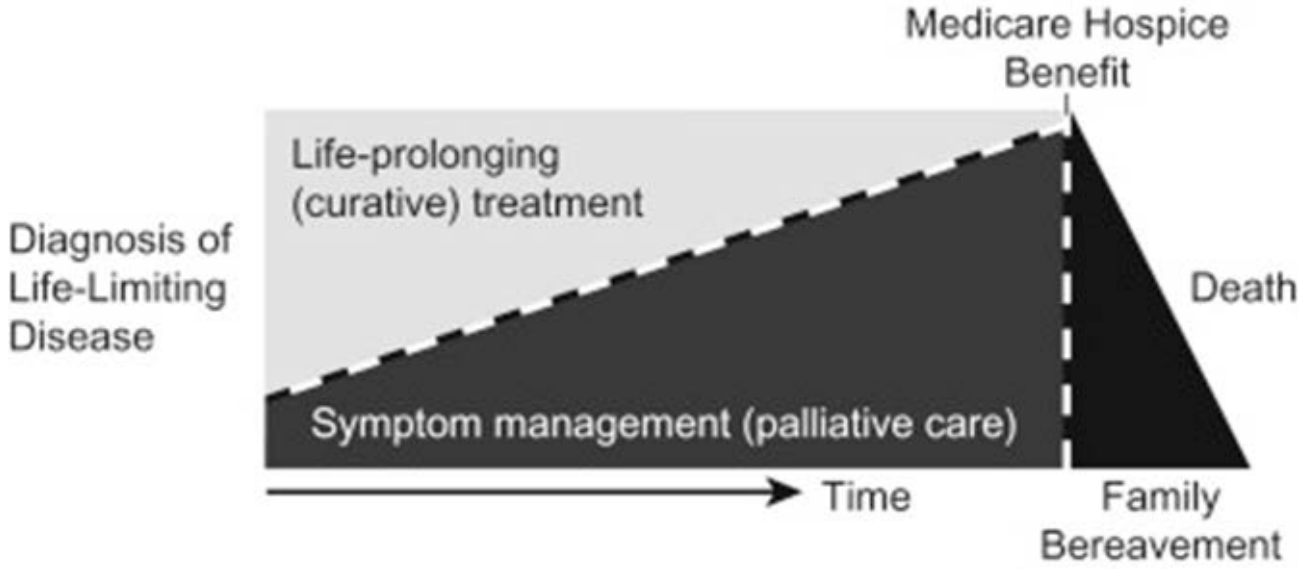
According to Title 18, Section 1861 (dd) of the Social Security Act, the term “hospice care” means the following items and services provided to a terminally ill individual by, or by others under arrangements made by, a hospice program under a written plan (for providing such care to such individual) established and periodically reviewed by the individual's attending physician and by the medical director (and by the interdisciplinary group described in paragraph (2)(B)) of the program—

- (A) nursing care provided by or under the supervision of a registered professional nurse,
- (B) physical or occupational therapy, or speech-language pathology services,
- (C) medical social services under the direction of a physician,
- (D)(i) services of a home health aide who has successfully completed a training program approved by the Secretary and
  - (ii) homemaker services,
- (E) medical supplies (including drugs and biologicals) and the use of medical appliances, while under such a plan,
- (F) physicians' services,
- (G) short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management) in an inpatient facility meeting such conditions as the Secretary determines to be appropriate to provide such care, but such respite care may be provided only on an intermittent, nonroutine, and occasional basis and may not be provided consecutively over longer than five days,
- (H) counseling (including dietary counseling) with respect to care of the terminally ill individual and adjustment to his death, and
- (I) any other item or service which is specified in the plan and for which payment may otherwise be made under this title.

Source: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html
Accessed 2/13/19

Palliative Care is appropriate at any stage of life limiting illness





It Takes a Team!

VCU PC Team

Providers (Physician/NP)	Fellows	Nursing/ Nurse Manager/ Nurse Clinician	Nurse Navigator	Social Work
RN Case Manager	Psychologist	Chaplain	Volunteer Coordinator	Program Manager
PT	Outcomes Researcher	Volunteers	Renny	Specialty services: Surg, Peds

Holistic Care

Symptom Management	Financial Worries	Advance Care Planning	Legal Paperwork
Family Support	Risk Assessment	Transitions of Care	Comprehensive Assessment

Edmonton Symptom Assessment Scale (ESAS)

Edmonton Symptom Assessment System:
(revised version) (ESAS-R)

Please circle the number that best describes how you feel NOW:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness *(Tiredness = lack of energy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness *(Drowsiness = feeling sleepy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression *(Depression = feeling sad)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety *(Anxiety = feeling nervous)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Wellbeing *(Wellbeing = how you feel overall)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No _____ Other Problem *(for example constipation)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____

Patient's Name _____

Date _____ Time _____

Completed by (check one):
- ☐ Patient
- ☐ Family caregiver
- ☐ Health care professional caregiver
- ☐ Caregiver-assisted

In what settings?

Inpatient	Community Based	Telemedicine?
• Palliative Care Unit • Palliative Care Consults – inpatient & ED	• Clinic (embedded vs freestanding) • Home • Nursing home	

For which patients?

- ???
- Cancer
- Advanced cardiomyopathy
- Cirrhosis
- COPD
- ESRD
- Neurodegenerative disorders (Alzheimer's, Parkinson's, ALS)
- Others...

Positive outcomes for patients, families, hospitals and payers

Outcome	How does PC help?	Evidence
Patients live longer with higher QOL	More communication; Symptoms and Depression improved	Temel NEJM 2010
Greater family satisfaction with quality of care	More communication, greater comfort, preferences met	Casarett Arch Intern Med 2011
Improved pain, symptoms and satisfaction with care	Symptom management and multidisciplinary team	Higginson JPSM 2003 El-Jawahri JSO 2011
Lower costs per day	Goals of care changed	Morrison Arch Int M 2008
Shorter ICU length of stay	Goals of care changed	Norton Crit Care Med 2007
No increase in hospital mortality	Symptoms, transfer to PCU and discharge to home care or hospice	Elsayem JPM 2006 Cassel JPM 2010
Fewer ED visits and hospital admissions	Better symptoms with in-home PC	Brumley JPM 2003
Fewer hospital admissions and inpatient deaths	Better symptoms with in-home PC	Brumley JAGS 2007
Fewer 30-day readmissions	Support with home PC or hospice	Enguidanos JPM 2012

Community-based palliative care outcomes

Program / Population	Positive effects	Source
PC in primary care clinic for adv CHF, COPD, cancer	Dyspnea, anxiety, spiritual well-being, sleep quality, satisfaction with care	Rabow Arch Int Med 2004 Rabow JPSM 2003
Outpatient PC for adv NSC lung cancer	Survival, quality of life, depressive symptoms	Temel NEJM 2010 Temel Palliat Med 2016
Home-based PC for home-bound Ca, CHF, COPD	Satisfaction, more at-home deaths, fewer ED visits and hospitalizations	Brumley JAGS 2007
Home-based PC for all conditions (cancer, CV, respiratory, etc.)	Anxiety, appetite, dyspnea, well-being, depression, nausea; hospice use; lower healthcare costs	Kerr JPM 2014 Kerr JPSM 2013
Home-based PC for MSSP (ACO) beneficiaries	Increased hospice enrollment & length; less hospital use & lower costs	Lustbader JPM 2017
Home-based PC for MA; CHF, Cancer, COPD, dementia	Less hospital use and lower healthcare costs; patient experience high	Cassel JAGS 2016
Psycho-educ telehealth for adv cancer & caregivers	Patient survival, caregiver depression	Bakitas & Dionne-Odom JCO 2015

Case Studies and Feedback

- Case studies
  - Submit: www.vcuhealth.org/pcecho
  - Receive feedback from participants and content experts
- Opportunity to formally submit feedback
  - Survey: www.vcuhealth.org/pcecho
  - Overall feedback related to session content and flow?
  - Ideas for guest speakers?
- Questions: pcecho@vcuhealth.org

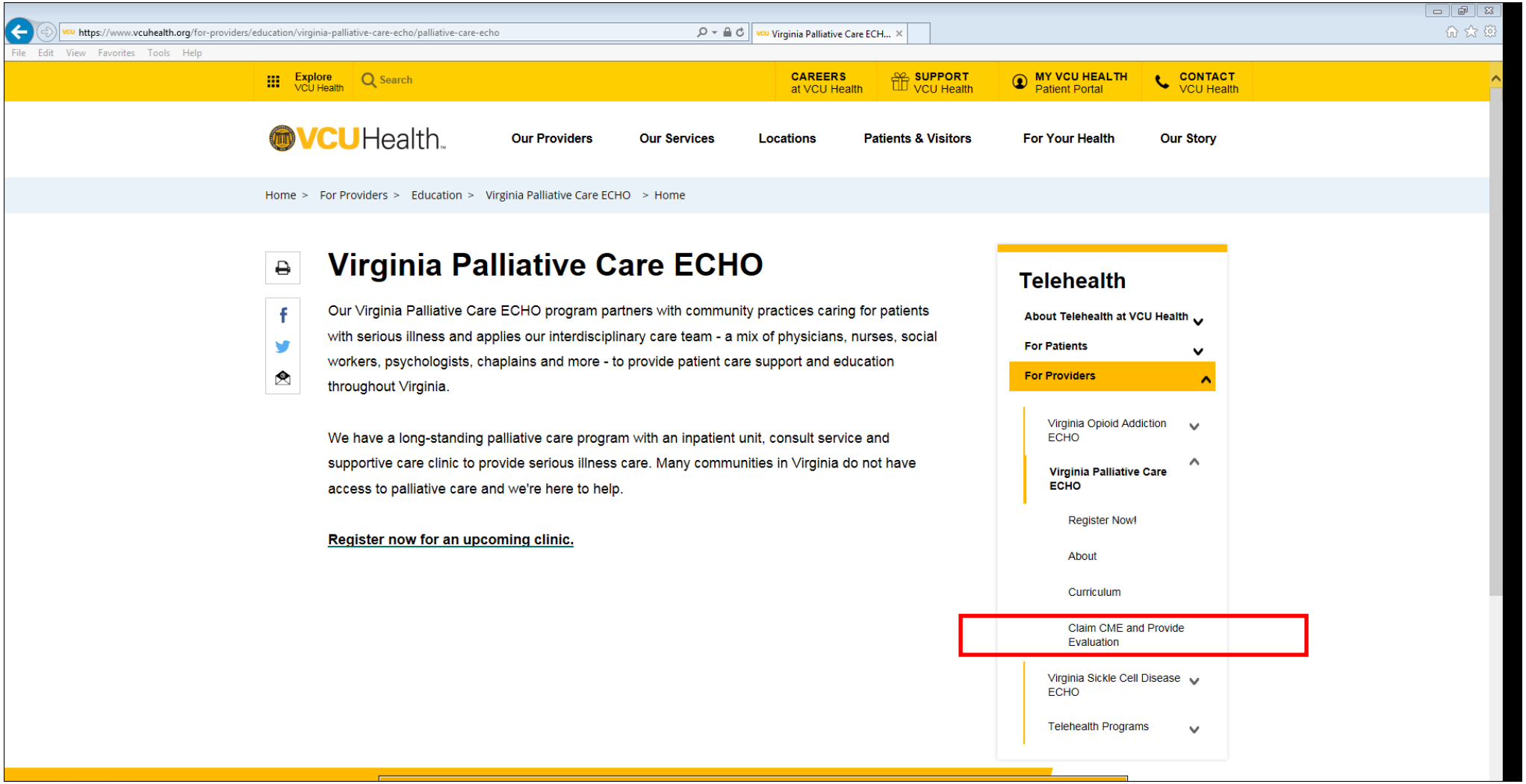
What does palliative care look like?

Case Studies

Access Your Evaluation and Claim Your CME

- www.vcuhealth.org/pcecho
- To claim CME credit for today's session

Access Your Evaluation and Claim Your CME



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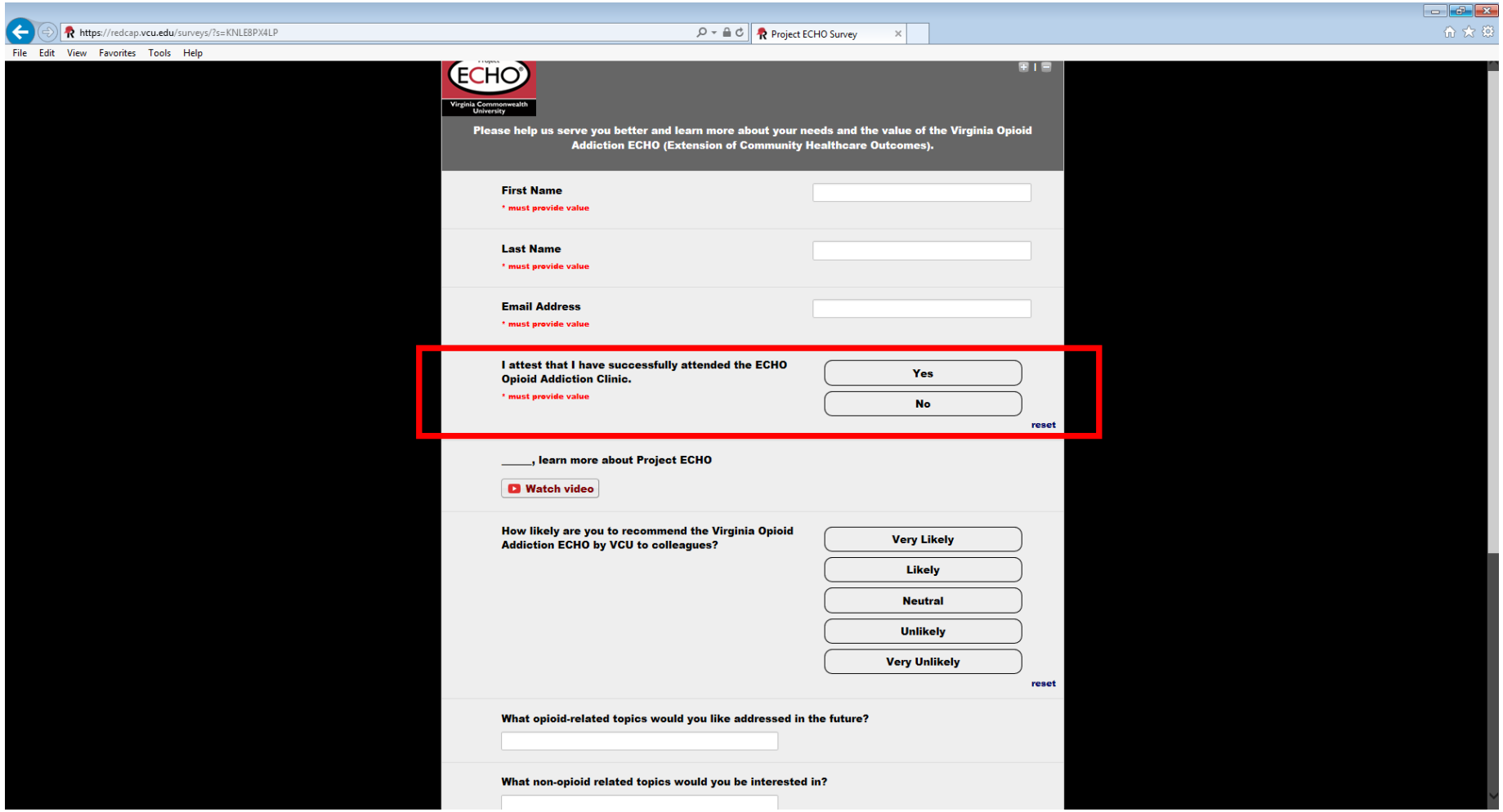
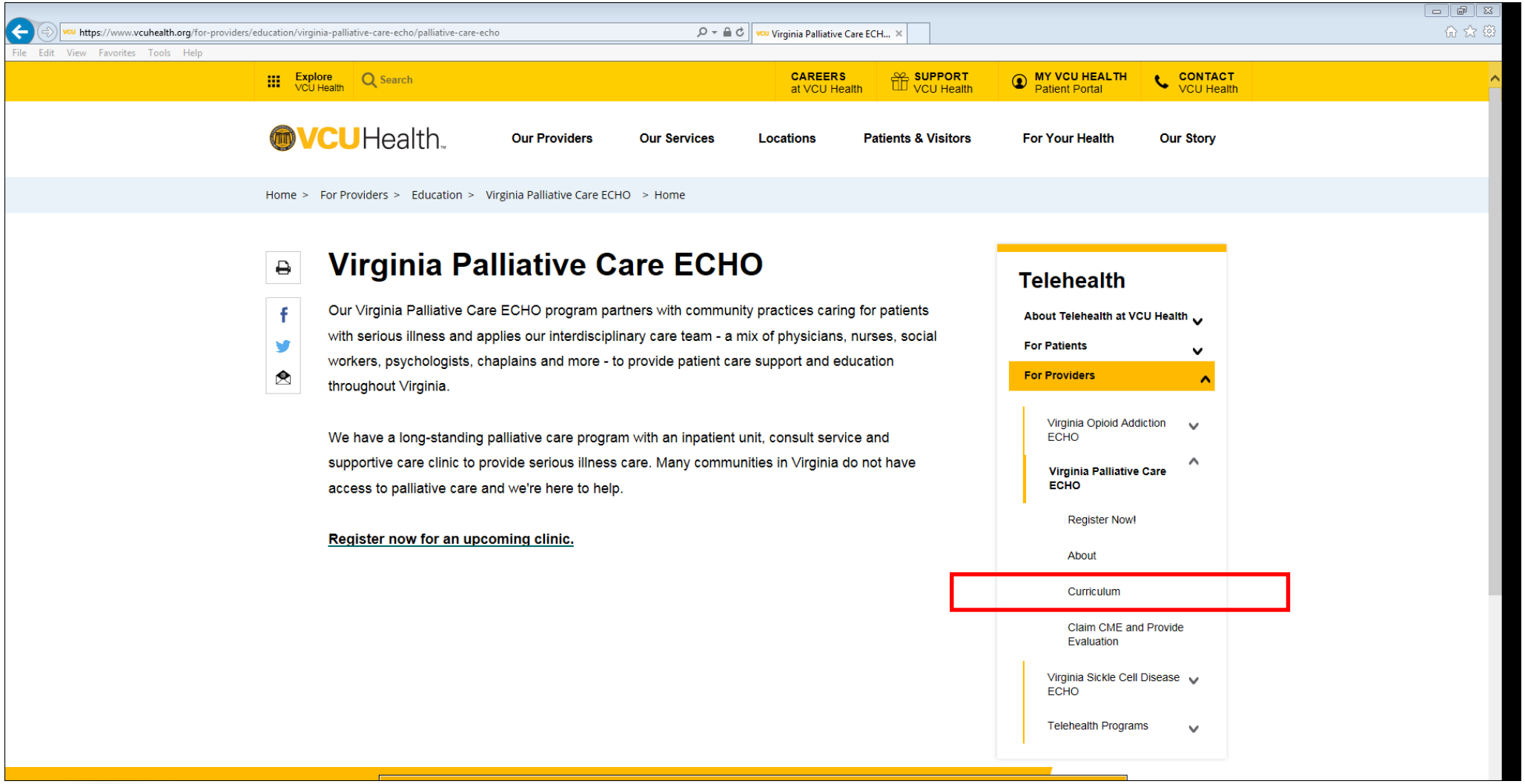


Access Your Evaluation and Claim Your CME

- www.vcuhealth.org/pcecho
- To view previously recorded clinics and claim credit

Access Your Evaluation and Claim Your CME



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Virginia Commonwealth University

THANK YOU!

VCU