COMMUNITY GAPS PALLIATIVE MEDICINE

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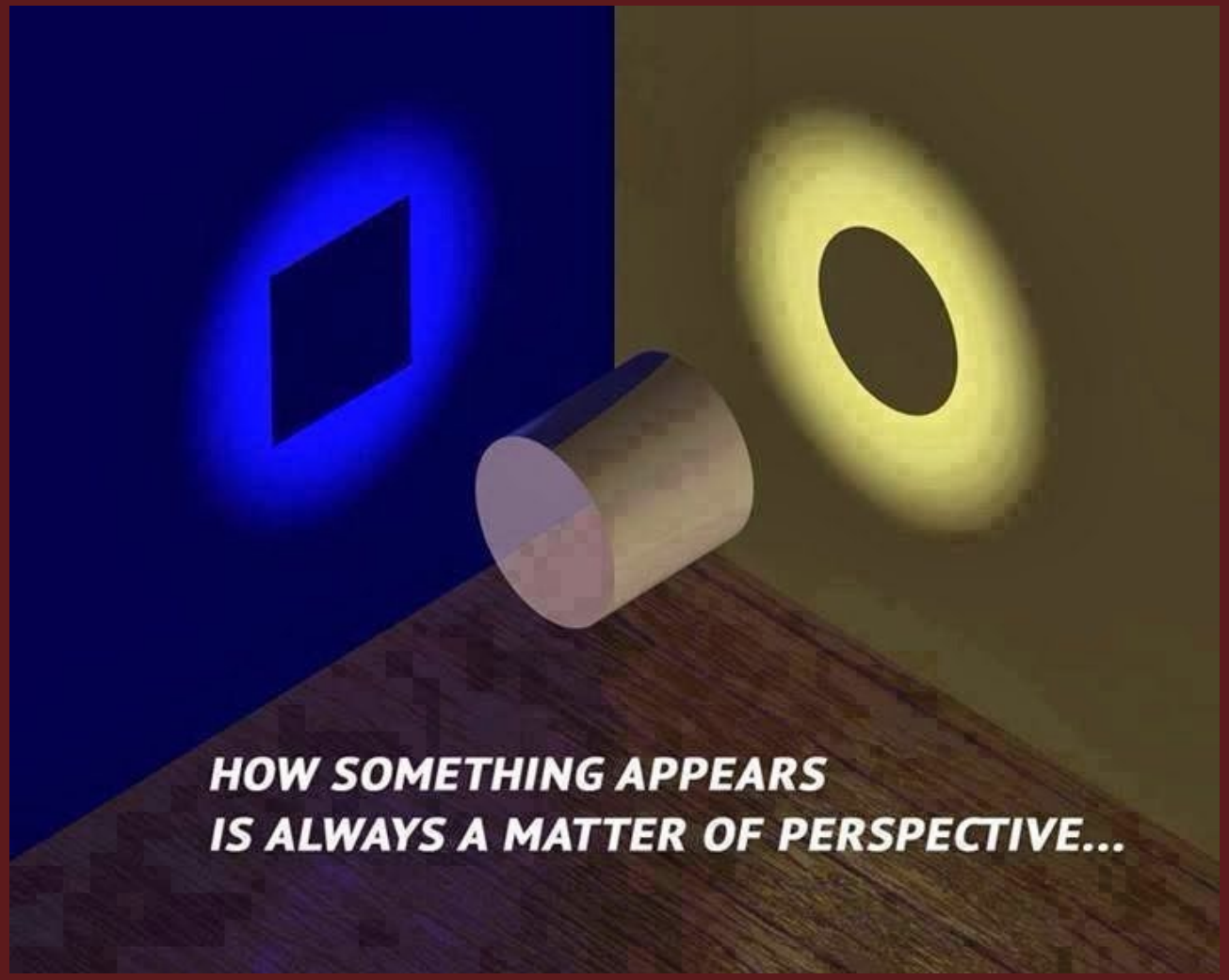
DISCLOSURES

- We have no financial disclosures.

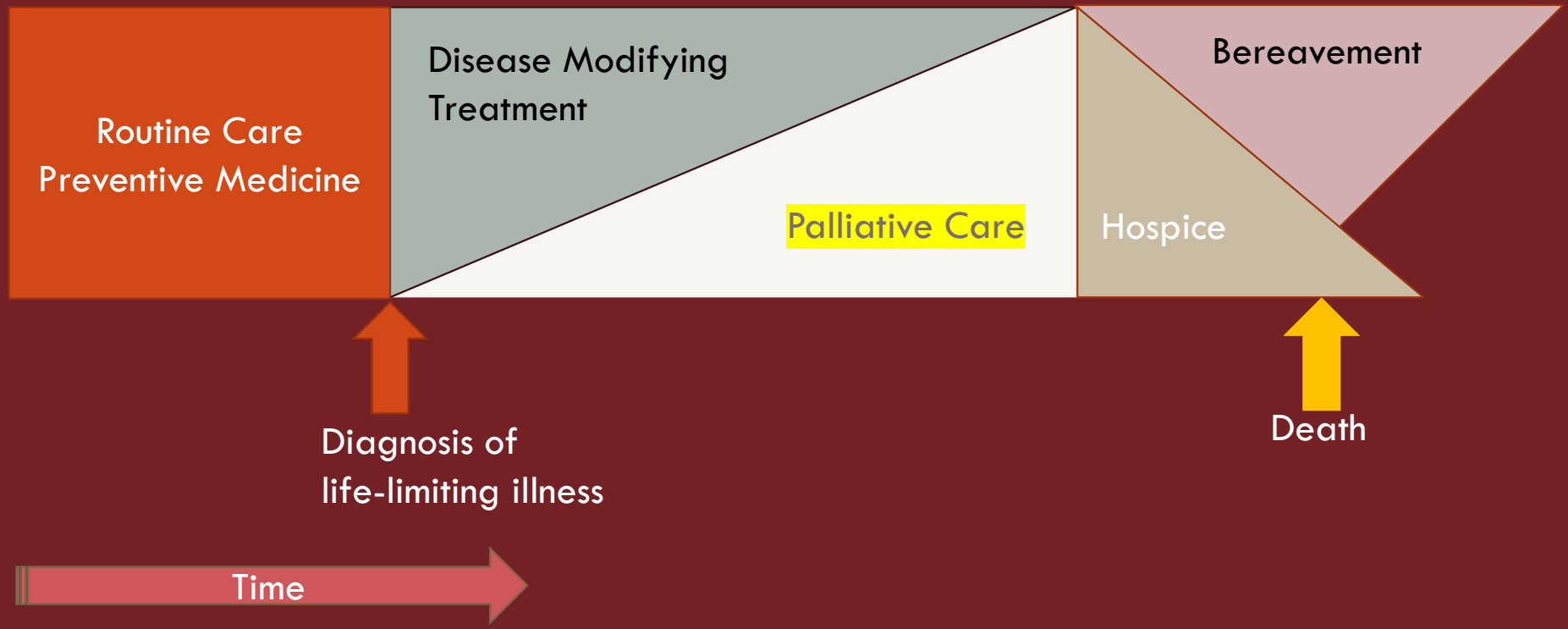
- However, we are human beings, with biases, judgements, and all sorts of non-objectivity.



AGENDA

- Define Palliative Medicine
- Discuss common reasons for consult
- Discuss what you can expect when Palliative Medicine is involved

TRANSITIONS OF CARE



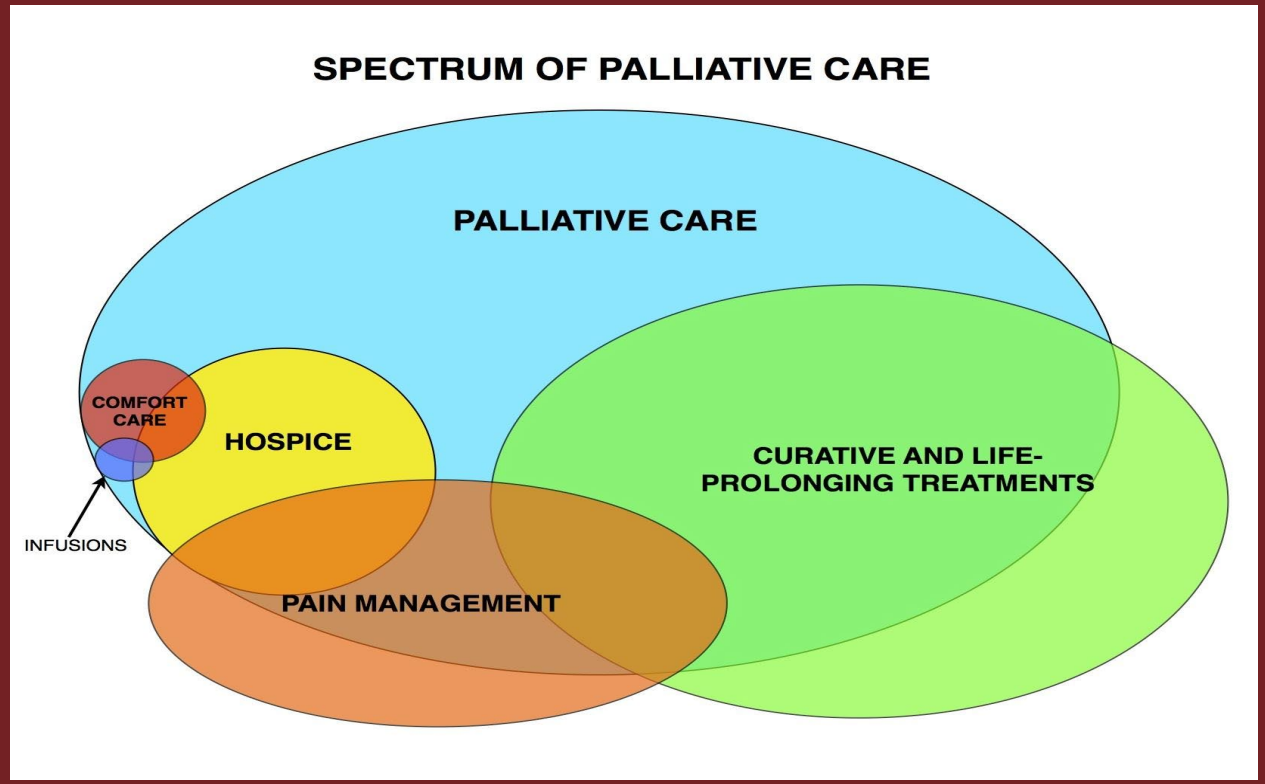
PALLIATIVE MED VS HOSPICE

MYTH

- Palliative Care = Hospice

REALITY

- All Hospice is Palliative Care
- NOT all Palliative Care is Hospice



PALLIATIVE MEDICINE

An extra layer of support for patients with a life limiting illness	•Clinicians, SW, chaplains, inpatient and outpatient teams
Symptom management	•Pain, shortness of breath, nausea, constipation, anxiety . . .
Communication	•Goals and values, medical decision making, family dynamics, family meetings . . .
Transition to comfort focused end of life care	•Help with transition to Hospice or comfort focused care in the hospital

WHO IS ON THE PALLIATIVE CARE TEAM?

- Clinicians (Doctors, Nurse Practitioners, Physician Associates)
- Primary care, non-palliative specialists, and Palliative Medicine specialists
- Nurses, nurse navigators, nursing assistants
- Medical Social Workers
- Spiritual Care (Hospital/Healthcare based Chaplains, home spiritual community . . .)
- Home health aides
- Therapists (Physical, Occupational, Respiratory, Recreational, Music, Art . . .)
- Volunteers

DISEASE SPECIFIC CONSIDERATIONS

Cancer	• Pain, nausea
COPD	• Shortness of breath, delirium
CHF	• Shortness of breath, fluid overload
ESRD	• Fluid overload, electrolyte imbalances
ESLD	• Trust, substance use (causes and sequelae)
Dementia	• Decision making capacity, nutrition

What do we offer?

Symptom Management

- Pain
- Fatigue
- Nausea
- Shortness of breath
- Anxiety
- Agitation
- Constipation
- Itching
- Existential distress . . .

Communication

- Goals of Care
- Tough Conversations
- Care Conferences
- Family dynamics
- What to expect

INTEGRATIVE APPROACHES FOR SYMPTOM MANAGEMENT

Auricular Acupressure	Acupressure	Massage
Guided Imagery	Meditation	Breathing
Aromatherapy	Music Therapy	Reiki


What if your patient is also a Veteran?

TOMAH VAMC OUTPATIENT PALLIATIVE CARE

VA OUTPATIENT PALLIATIVE CARE CLINIC

- Provider and registered nurse complete consults and follow up visits (in-person, video visits, and telephone visits available)
- Assists with symptom management, care coordination, and goals of care conversations
- Care is coordinated with primary care team and specialty care teams (VA and community care)
- Can assist with transition to hospice care when appropriate (Inpatient and Outpatient)
- Referrals can be placed by contacting VA primary care team to place Outpatient Palliative Care consult

VA COMMUNITY CARE REFERRAL

- Community care referrals can be considered when requested by a Veteran
- Contact VA Patient Aligned Care Team (PACT) or Community Care department to place referrals

VA SERVICES THAT CAN ASSIST IN SYMPTOM MANAGEMENT AND PROMOTING QUALITY OF LIFE

- Additional adaptive equipment
- Veterans Benefits
- Homemaker and Home Health Aide (H/HHA)
- Home Improvement/Structural Alterations Grant (HISA)
- Caregiver Support (CSP)
- Whole Health
  - *Acupuncture (traditional and Battlefield Acupuncture)*
  - *Healing Touch*
  - *Aromatherapy*
  - *Tai Chi*
  - *Chiropractic*
  - *Whole Health Coaching*
- Veteran specific legacy building
  - *My Story*
  - *Honor Flight*

- Palliative Care
  - (608) 372-1752
- Veteran Benefits
  - https://wicvso.org/locate-your-cvso-tvso/
- Referrals to programs/services and equipment
  - Veteran's assigned VA PACT

OUTPATIENT CASE STUDY- DEB

- 60 yr old female
- COPD, CHF, NSTEMI, Chronic Pain Syndrome, Depression
- Full Code
- Inpatient Palliative Med consult for Goals of Care during hospital admission for Acute Respiratory Failure with Hypoxia requiring BiPap in the ICU
- Inpatient Pall Med referred to Outpatient Clinic for ongoing Goals of Care after hospital discharge

BACKGROUND

- Lives independently with her cats, birds, and plants
- Previously worked in-home daycare, waitress, bar tender
- 3 "loving and supportive" sons
- Shares she escaped from an apocalyptic "cult" in her teens

  Much distress over harm done to her & her sibling historically by the cult, as well as harm still occurring present day

GOALS OF CARE

POAHC in place naming a son, although she expressed he won't engage in conversation with her when she attempts to talk about end of life wishes

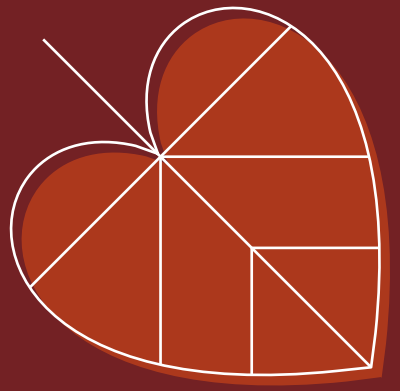
- She explains she is trying to "get everything in order so I don't leave a mess for my kids."

FULL CODE, Selective interventions

Wants to avoid hospitalizations

Wants to resume activities that bring her joy: swimming, playing cello, journaling

SYMPTOM MANAGEMENT



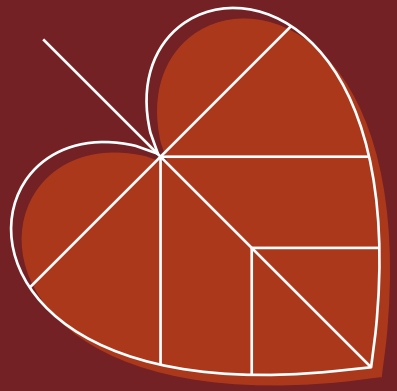
- ANXIETY and DEPRESSION
  - Extremely distressed that shortness of breath will return
    - Frequently anxious, tearful
  - CRISIS – Terrified of being home alone and "SUFFOCATING"
  - Nonpharmacologic Interventions: Encouraged warm bath, meditation, music, fan for air movement
  - Pharmacologic: Transition anti-depressant

SYMPTOM MANAGEMENT

- Chronic PAIN to low back

  Pharmacologic: provider adjusting pain medications

  Integrative: Auricular Acupressure (ear beads)



ROLES

PROVIDER

- Follow up Palliative Medicine Clinic visits approximately every 3 months
- Reviewed goals and symptom management
- Medication adjustments when needed
- Prognosis and care available when health declines
- Appropriate referrals as needed – Psychology Consult, Pain Medicine, Pulmonary Rehab, PT/OT

NURSING

- Weekly to monthly nurse phone calls:

  Symptoms

  Medication tolerance and effectiveness

  Education

  Active Listening and Support
- Auricular Acupressure (weekly) for symptom management

ROLES

CHAPLAIN

- Routine clinic and phone visits
- Identified herself as Non-Specific Christian
- Burdened by childhood and teen years in a "cult." Father and step- mother were leaders in the group. Identifies cult hurt her and knows others are at risk
- Provided spiritual support and prayer if desired
- Deb identifies "God is with me." Helps her remain in the present rather than be pulled into the distress of the past or worry for the future.

SOCIAL WORK

- Clinic visits and phone visits focused on coping
- Community Resources & collaboration:
  - ADRC
  - Inclusa

DME
- Walker
- Toilet riser

- Paperwork
  - FMLA for son

NEW DIAGNOSIS

Deb was able to achieve goals for just over a year

Then hospitalized and found to have new Small Cell Lung Cancer with mets to the Liver

Understood diagnosis was terminal; Deb chose chemotherapy treatment to focus on minimizing symptoms and hoping having more time.

- Much fear of chemo related to friends' historical experiences with chemo side effects

Within a month: Increasing back pain – new mets found in lumbar and sacral spine. Treated with radiation and pain medications

Pall Med reviewed with Deb her goals of care, supported her choices, provided education, and encouragement

DEB'S CAREGIVERS

Deb had been unaccompanied to visits the first year of care

Deb's sister moved in with her after cancer diagnosis to be her caregiver which greatly pleased Deb. < 1 month, falling out and sister left

Neighbor became paid caregiver – supportive and organized which Deb appreciated

POAHC son began attending Pall Med Clinic appts and engaging with team

Enrolled with Inclusa

- With all caregivers Palliative Med offers:
- Welcome
- Support – provide the tools and contacts
- Available- make plans and respond promptly
- Education- diagnosis, meds, services, staff, tests, etc
- What's next? – known and unknown
- Caregiver fatigue is Real!!!

PROGRESSION AND TRANSITION

3 months from cancer diagnosis Deb was pleased with how well she tolerated chemo and radiation. She had received good news from Onc providers regarding her cancer's response to treatment

2 weeks later she was hospitalized with Altered Mental Status and metastasis to the brain was found

Deb and sons were prepared progression would occur. Open to Hospice enrollment

Deb's goal was to remain in her home with Hospice care and to have her sons and cats near her

Care transition to Hospice Team

BERTHA

- 87 year old woman diagnosed with vascular dementia 2 months ago, lives alone in ALF
- Daughter came to visit, noticed rotting food in the fridge and medications in disarray

BERTHA

- Daughter began organizing patient's apartment, found that her mother was not eating consistently, and seems more confused than usual
- Bertha becomes combative when her daughter suggests they go out for dinner
- Daughter called 911 because she could not get her mother to calm down or eat anything

BERTHA

- Bertha is taken to the ER, found to have acute on chronic renal dysfunction, dehydration and malnutrition
- Bertha remains combative and ER team gives Seroquel
- No one knows which of her daily medications she has been taking

Atorvastatin

Clopidogrel

Lisinopril

Levothyroxine

Gabapentin

Omeprazole

Senna

BERTHA

- Admitted to the hospital with AKI on CKD, low urine output, dehydration, agitation
- Bertha refuses home medications, is attempting to remove IV tubing
- Seroquel dose is increased, Bertha becomes somnolent

BERTHA

Internal medicine team consults nephrology for consideration of dialysis and behavioral health for assistance with behaviors

Daughter asks if they can see Palliative Medicine

Internal medicine places consult to Palliative team

BERTHA

Palliative Care team reviews chart and notes that daughter, Elaine, is power of attorney for health care

Palliative Care team calls to ensure Elaine will be present

Palliative Care physician and RN meet with Bertha and her daughter

- What have you heard about what is going on with Bertha's health?
- What are you hoping for?
- What are you worried about?
- Acute symptom management challenge: behaviors

BERTHA – GOALS OF CARE

- Bertha does not recall anything about medical situation, but is able to express some opinions
- Elaine reports understanding that her mother is dehydrated from not eating/drinking at home, has chronic kidney disease, and may need dialysis
- Elaine reports Bertha has always been independent and "sassy," never wanted to live in facility, husband died 2 years ago, she misses him a lot, frequently talks about "when we are together again"
- Elaine is hoping Bertha will "get back to normal," and "go to a nursing home, because she really can't take care of herself, and I have to go back to work."

BERTHA – GOALS OF CARE

- Bertha perks up enough to express, "I want to go home, can't you just take me home?"
- Long discussion about safety risks of living alone, Bertha becomes agitated again, yells, "I can take care of myself, just let me go home!"
- Elaine feels "stuck," would like to care for her mother at home, but needs to return to work, wants her mother to get dialysis to live longer, but patient will not cooperate with simple IV line
- Palliative team provides active listening and supportive exploration of emotional complexity

BERTHA – GOALS OF CARE

- Elaine eventually admits that she wants her mother to live as long as possible, but Bertha has been ready to die for some time
- Palliative team asks permission to talk about what comfort focused plan of care might look like, discusses hospice philosophy and services
- Elaine feels this would most closely align with her mother's wishes, rather than forcing her to do dialysis and live in a nursing home long term

BERTHA – SYMPTOM MANAGEMENT

- Palliative team recommends, and begins process to, activate POAHC
- Palliative team recommends multiple non-pharmacologic interventions to support mental status

  Ensure Bertha has her glasses and dentures

  Frequent reorientation

  Daughter present as much as possible

  Stop IVF and avoid restraints
- Palliative team recommends optimizing medications for comfort, given goals

BERTHA - TRANSITION

- Palliative team discusses with SW, plan to transition to hospice at discharge
- Palliative team, primary team, bedside team collaborate to optimize symptom control while “tuning her up” as much as possible before discharge
- Patient returns to ALF with plan for hospice enrollment same day
- Elaine plans to take FMLA and recruits her cousin to help her care for Bertha until she dies

SUMMARY

- Palliative Medicine is patient-oriented care focused on optimizing quality of life for patients with serious illness.
- It is appropriate to involve the palliative team when a patient is suffering with a life-limiting illness.
- The palliative team will utilize resources from medicine, nursing, social work, spiritual care, and many other modalities, to explore patients' and their loved ones' values and goals and ensure the best possible management of the symptoms and stresses of a serious illness.

QUESTIONS?