Integration of Palliative Care Delivery in Family Medicine Practice

Annual Meeting of the New Hampshire Academy of Family Physicians

April 9th, 2017

Stephen Rust, MD, FACP, FAAHPM
Disclosures

Steve Rust Works as the Executive Medical Director of Capital Region Palliative Care and Hospice
is a collaboration of CRVNA and CH
Objectives:

1. Understand the key features of palliative care vs. hospice
2. Understand the potential value of primary, secondary and tertiary palliative care services as integral components of primary care.
3. Identify at least one “palliative care” skill or understanding that could be incorporated into primary care practice in the next week, month, year.
• 1° Primary- Communication Skills-DPOAH
• 2° Secondary- More advanced communication, POLST and Sx management skills
• 3° Tertiary- dedicated highly functional inter-professional team-based
• 4° Quaternary- academic center-research focused setting

Palliative- Levels*

* Modified version
• **Primary**- Communication Skills-DPOAH

• **Secondary**- More advanced communication, POLST and Sx management skills

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Palliative- Levels*  
* Modified version

S Rust, MD
Ms. Emma Jones
- 78yo female mother, grandmother, writer of children’s stories.
- 100 pack-year smoker with COPD
- Mild renal insufficiency
- Progressive non-specific abd pain “bloating”
- Increasing edema LE

Ms. Emma Jones
On exam you find a slight L adnexal fullness
Labs: Mild anemia, creat 1.3, mild decrease albumin and total protein
You refer her for a pelvic ultrasound and for lab work including a CA-125.
Ms. Jones comes back to your office to discuss the findings:

- Ultrasound showed a 1.5 cm complex mass
- CA-125 80 units/ml (n=0-35)
- Referred to Gyn-Onc
Surgery showed diffuse peritoneal studding with cytology / pathology c/w poorly differentiated Ovarian Carcinoma. (Stage IIIb)

Post operatively to moderate pain treated with prn Vicodin® (hydrocodone/APAP)

The Pt was referred to oncology for consultation.
Two weeks later:

- Chemo Tx was effective with recurrence of widely metastatic tumor about 2 years later.
- Started on second line chemo.
- Prior to her next appointment
  - Collapsed at home
  - EMS to ER
  - Admitted to ICU
- DX:
  - Acute Pulmonary embolus
  - ARDS/ COPD - respiratory failure
  - Acute/ chronic renal insufficiency
Ms. Emma Jones

- Remained in ICU for 24 days
  - Ventilated
  - Restrained
  - Multiple lines
  - Multiple decubiti
- No advanced directives
- Eventually died secondary to multi-system failure.

*Ms. Emma Jones*
Palliative care

IS:

1. Interdisciplinary team based
2. For complex /serious medical situations
3. “the best care possible” with the most “comfort possible”
4. NOT advocating for MORE or LESS medical interventions.
IS:

- NOT only for “dying people”
- NOT giving up

3° Palliative care

S Rust, MD
Palliative care, also known as palliative medicine, is specialized medical care for people living with serious illness. It focuses on providing relief from the symptoms and stresses of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family.

Palliative care is provided by an interdisciplinary team of palliative care doctors, nurses and other specialists 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.
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1. Serious Illness
2. Interdisciplinary Team
3. Extra layer of support
4. Any Stage of Serious Illness
5. Improve QOL

3° Palliative care
What is Hospice Care?

- Medicare benefit
- Prognosis less than 6 months.
- Curative treatment not an option
- Provided by an interdisciplinary team
So where does “palliative” Fit?

Modified from Wm Stanton 2005

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Patient and family

Hospital Palliative Care

Primary Care

ALF

Hospice

Mental Health

Specialty Clinic

SNF

Home Health

Thanks to Betsey Rhynhart
There’s a spectrum of who and how palliative care services are provided.
PCPs are the major component of PC delivery.
Family Medicine and other primary care practices must be able to provide a majority of PC in NH
Outpatient PC programs are in the minority (18%)
RESOURCES FOR FAMILY MEDICINE
VitalTalk®
http://www.vitaltalk.org/clinicians

Palliative Care Observation Form: www.palcof.com

Tell Me More® (hospital): www.gold-foundation.org/programs/tell-me-more/
Palliative Care Network of Wisconsin: https://www.mypcnow.org/

CAPC: www.CAPC.org

Palliative Care Programs in New Hampshire and Elsewhere: www.getpalliativecare.org

Palliative Care Education and Practice: http://www.hms.harvard.edu/pallcare/PCEP/PCEP.htm

PC Programs and Delivery Models

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National Hospice and Palliative Care Organizaton:  
www.nhpco.org

Facts and Figures about Hospice:  

Hospice Medicare Rules:  
Atul Gawande: “Letting Go: What Should Medicine Do When It Can’t Save Your Life?” - The New Yorker July 2010
Questions or Thoughts:

Discussion
* “Provision of Palliative Care Services by Family Physicians is Common”. Ankuda, Jetty, Basemore and Petterson. JABFM. March-April 2017; Vol. 30 No. 2
* “Patient-Centered Communication During Oncology Follow-Up Visits for Breast Cancer Survivors: Content and Temporal Structure. Clayton, Dudley. Onc Nurse Fourm;36;2 March 2009 E68-E79
* UTD 21- 2012
* AJCC Cancer staging Manual- 7th edition
* American College of Surgeons- NCDB 2009

References
References


* 5  Liobera 2000, Bruera 1992

* 6  Maltoni 1995

* 7  Maltoni 1995

* 8  Bruera 1992

* Use of PPS in End-of-life Prognostication
  * (from the Victoria Palliative Research Network Website)