Update in Palliative Care Integration within Primary Care

Annual Meeting of the New Hampshire Academy of Family Physicians

May 18th-20th, 2018

Stephen Rust, MD, FACP, FAAHPM
Disclosures

Dr. Rust Works as the Executive Medical Director of Capital Region Palliative Care and Hospice (a collaboration of CRVNA and CH)
Objectives:

1. Identify which patient “types” in my practice might have “palliative care needs”.
2. Identify one palliative care resource within my community
3. Know how to start a conversation you find “difficult” with a patient/family.

S Rust, MD
“Quick” Review from last 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
• 1° Primary- Communication Skills-DPOAH
• 2° Secondary- More advanced communication, POLST and Sx management skills
• 3° Tertiary- dedicated highly functional inter-professional team-based
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Palliative- Levels*

* Modified version
Where do “YOU” Fit?

• There’s broad spectrum of who provides and how palliative care services are provided in our communities.
• You are (and will continue) to be responsible for a majority of PC delivery.
• Family Medicine and other primary care practices must be able to provide a majority of PC services in NH
• Outpatient PC programs are in the minority (18%)
Primary Palliative Care

Clinic

Acute Care

ALF

Hospice

Patient and family

Specialty

Mental Health

SNF

Home Health

Thanks to Betsey Rhynhart
Primary Care

Patient and family

Clinic

Acute Care

ALF

Hospice

Mental Health

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SNF

Home Health

Thanks to Betsey Rhynhart
• 76 yo male
• You’ve followed since graduating from residency
• COPD- moderate-severe
• Current smoker
• Slow decline in function- but “getting along”- Cognitively intact
• Widowed 2 years ago
• No children, no living siblings, no family

• He’s visiting you for one of his “Medicare wellness check”

• What are you going to talk about???
• His smoking?
• Your concerns about possible progressive frailty … depression (PHQ-9)
• ADLs
• IADLs
• Whatever he wants to talk about?
• How about ……..
• Advance Directives???
Dr. Seuss advance directives

https://www.youtube.com/watch?v=xy-JTh1Vo8o

https://youtu.be/xy-JTh1Vo8o

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NH foundation for Healthy Communities
Advance Directives/Healthcare Decisions Coalition

In accordance with NH RSA 137-J "A surrogate decision – maker" may be identified to make medical decisions on behalf of a patient in the following order of priority:

1. The patient’s spouse, or civil union partner or common law spouse unless there is a divorce proceeding, separation agreement, or restraining order limiting that person’s relationship with the patient.
2. Any adult son or daughter of the patient.
3. Either parent of the patient.
4. Any adult brother or sister of the patient.
5. Any adult grandchild of the patient.
6. Any grandparent of the patient.
7. Any adult aunt, uncle, niece, or nephew of the patient.
8. A close friend of the patient.
9. The agent with financial power of attorney or a conservator appointed in accordance with RSA 464 - A.
10. The guardian of the patient’s estate."
• How do you start that discussion?

• **Be Direct** - Ask the question directly - “Have you ever talked with anyone about advance directives”?

• **Normative** - “This is a discussion I have with my patients”

• **Permission** - “Is it OK to have a brief discussion now?”
NEW HAMPSHIRE ADVANCE DIRECTIVE

NOTE: This form has two sections: the Durable Power of Attorney for Health Care and the Living Will. You may complete both sections, or only one section.

SECTION I. DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, ______________________, (_____), hereby appoint ______________________

(Name) (Date of Birth) (Name of Health Care Agent)

of ______________________

(Health Care Agent’s address and phone #)

(If you choose more than one agent, they will have authority in priority of the order their names are listed, unless you indicate another form of decision making.) as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this directive or as prohibited by law. This Durable Power of Attorney for Health Care shall take effect in the event I lack the capacity to make my own health care decisions.

In the event the person I appoint above is unable, unwilling or unavailable, or ineligible to act as my health care agent, I hereby appoint ______________________

(Name of Health Care Agent)

of ______________________

(Health Care Agent’s address and phone #)

Statement of Desires, Special Provisions, and Limitations about Health Care Decisions

For your convenience in expressing your wishes, some general statements concerning the withholding or removal of life-sustaining treatment are set forth below. (Life-sustaining treatment is defined as procedures without which a person would die, such as but not limited to the following: medically administered nutrition and hydration, mechanical respiration, kidney dialysis or the use of other external mechanical and technological devices, drugs to maintain blood pressure, blood transfusions, and antibiotics.) There is also a section which allows you to set forth specific directions for these or other matters. If you wish, you may indicate your agreement or disagreement with any of the following statements and give your agent power to act in those specific circumstances.

A. LIFE-SUSTAINING TREATMENT

1. If I am near death and lack the capacity to make health care decisions, I authorize my agent to direct that:

(Initial beside your choice of (a) or (b).)

_____ (a) life-sustaining treatment not be started, or if started, be discontinued.

-or-

_____ (b) life-sustaining treatment continue to be given to me.

2. Whether near death or not, if I become permanently unconscious I authorize my agent to direct that:

_____ (a) life-sustaining treatment not be started, or if started, be discontinued.

-or-

_____ (b) life-sustaining treatment continue to be given to me.
• ZOOM FORWARD-6 months:
  • Now s/p hospitalization for COPD/ influenza
  • While hospitalized- Non-STEMI with stents
  • Now back in your office for follow up

• There’s still no completed AD’s in the chart
• ZOOM FORWARD-6 months:

• “The surprise question”- would it surprise you if the patient died in the next 12 months
• The “more urgent” AD discussion:

• You’re more concerned about Mr. Jacobson (GUIDE*)
  • G- Get Ready
  • U- Understand
  • I- Inform

* From VITALtalk ®
• The “more urgent” AD discussion:

• You’re more concerned about Mr. Jacobson (GUIDE*)
  • G- Get Ready
  • U- Understand
  • I- Inform
  • D- Deepen
  • E- Equip

* From VITALtalk ®
The Conversation Project Video- for patients and families

https://youtu.be/iTxv-20ULwQ
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-or-

____ (b) life-sustaining treatment continue to be given to me.
B. EXPLAINING YOUR INSTRUCTIONS IN MORE DETAIL
(initial next to #'s 1 and 2, if you agree)

1. _____ I grant my agent authority to request or agree to a DNR order.

2. _____ Even if I am incapacitated and object to treatment, treatment may be given to
me, or withheld, against my objection. This option is intended to grant your
agent additional authority, if for example you have dementia, and you try to
change the treatment being recommended by your agent and health provider.

You may include any specific desires or limitations you deem appropriate in the space
below, such as your preferences concerning medically administered nutrition and
hydration, when or what life-sustaining treatment you would want used or withheld,
or instructions about refusing any specific types of treatment that are inconsistent with
your religious beliefs or are unacceptable to you for any other reason. You may leave this
section blank if you desire.

(Attach additional pages as necessary)

__________________________________________
(Print Name)

__________________________________________
(Date of Birth)
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I hereby acknowledge that I have been provided with a disclosure statement explaining the effect of this Durable Power of Attorney for Health Care (DPOAH). I have read and understand the information contained in the disclosure statement.

The original of this Durable Power of Attorney for Health Care (DPOAH) will be kept at ___________________________ and the following persons and institutions will have copies:

__________________________________________
__________________________________________
__________________________________________
__________________________________________
__________________________________________

Signed this ______ day of ______________________, 20____.

Principal’s signature: ____________________________

[If you are physically unable to sign, this DPOAH may be signed by someone else writing your name, in your presence and at your express direction.]

THIS POWER OF ATTORNEY DIRECTIVE MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC OR A JUSTICE OF THE PEACE.

We declare that the principal appears to be of sound mind and free from duress at the time the Durable Power of Attorney for Health Care is signed, and that the principal affirms that he or she is aware of the nature of the Durable Power of Attorney for Health Care and is signing it freely and voluntarily.

Witness ____________________________ Address ____________________________
Witness ____________________________ Address ____________________________

If using a Notary Public or Justice of the Peace:
STATE OF NEW HAMPSHIRE
COUNTY OF ____________________________
The foregoing Durable Power of Attorney for Health Care was acknowledged before me this _____ day of ______________________, 20____, by ____________________________ (“the Principal”).

__________________________________________
Notary Public / Justice of the Peace
My commission expires: ____________________________

__________________________________________
(PrintName)                           ____________________________
(Date of Birth)
NH foundation for Healthy Communities

Advance Directives/Healthcare Decisions Coalition

Palliative Care EPAs (Entrustable Professional Activities)

https://www.mypcnow.org/fast-facts

S Rust, MD
National resources
National resources
National resources
VitalTalk®

http://www.vitaltalk.org/clinicians

Tell Me More® (hospital):

www.gold-foundation.org/programs/tell-me-more/
E-Prognosis®:

http://eprognosis.ucsf.edu/calculators/#/

Estimated survival
* Home
* Hospital
* Nursing Home
* Hospice
E-Prognosis®: http://eprognosis.ucsf.edu/communication/

Communicating about Estimated survival

* Addressing Emotions
* Asking Permission
* Care Consistent with Goals
* Discussing lag time to Benefit
* Ask-Tell-Ask
* Discussing Next steps
* Individualizing Prognosis
* Making a Recommendation
* Addressing Uncertainty
* Discussing Trade-offs

Prognosis
Palliative Care Network of Wisconsin:
https://www.mypcnow.org/

UptoDate:
CAPC:  [www.CAPC.org](http://www.CAPC.org)

Palliative Care Programs in New Hampshire and Elsewhere:  [www.getpalliativecare.org](http://www.getpalliativecare.org)

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

**PC Programs and Delivery Models**
National Hospice and Palliative Care Organization:  www.nhpco.org

New Hampshire Palliative Care and Hospice Organization:  www.nhhpco.org/home/
*Palliative Care Interdisciplinary Curriculum (PCIC):
https://vimeo.com/album/4063073
New Hampshire Palliative Care and Hospice Organization:  www.nhhpco.org/home/
Atul Gawande: “Letting Go: What Should Medicine Do When It Can’t Save Your Life?”- The New Yorker July 2010
Atul Gawande- The Best Day Possible- NYT -2014

https://www.nytimes.com/2014/10/05/opinion/sunday/the-best-possible-day.html?action=click&contentCollection=Opinion&module=MostEmailed&version=Full&region=Marginalia&src=me&pgtype=article&_r=0
Sustainability
* “Be a healing presence”
* “Be a humble servant”
* “Trust your team”
* “Words are important, however silence is profound”
* “Do your dance and retreat in peace”
* “Don’t be afraid to reach out and ask for help”

The “Six Whispers”
Questions or Thoughts:

Discussion

* “Provision of Palliative Care Services by Family Physicians is Common”. Ankuda, Jetty, Basemore and Pettersson. JABFM. March-April 2017; Vol. 30 No. 2

* Thomson R, Patel C. “Palliative Care Principles Primary Care Physicians Should Know” Primary Care Reports-Peer Reviewer Robert B Taylor, MD-OHSU; August 2013.


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


