



Introduction to Palliative Care

Welcome!

House Keeping



Virtual Etiquette

Meeting participation:

- If you're connecting on your computer, close-down all other apps and browser windows to eliminate notifications
- We will be using the raise your hand feature by clicking on the little blue hand
- We will be using the chat function
- When we are taking breaks be sure not to leave the meeting but rather mute your audio and video

Environment:

- Be aware of your backgrounds to not be distracting.
- Position yourself in the light.

Expectations

What do you want to get out of this training?

Learning Outcome

Participants will be able to identify patient focused approaches for the delivery of palliative care in the primary care setting

Learning Objectives

- **Define** palliative care
- **Differentiate** palliative care from hospice care
- **Explain** why palliative care is integral to primary care
- **Describe** the domains of palliative care
- **Discuss** social aspects of care
- **Recognize** members of the multidisciplinary care team
- **Identify** palliative care assessment tools that may be used in primary care settings

Palliative Care: YOU Are a Bridge



<https://www.youtube.com/watch?v=IDHhg76tMHc>

Palliative Care and Hospice Care

A Population Health Approach

Definition of Palliative Care

“Palliative care is an approach that improves the quality of life of patients and their families facing the problems 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.”

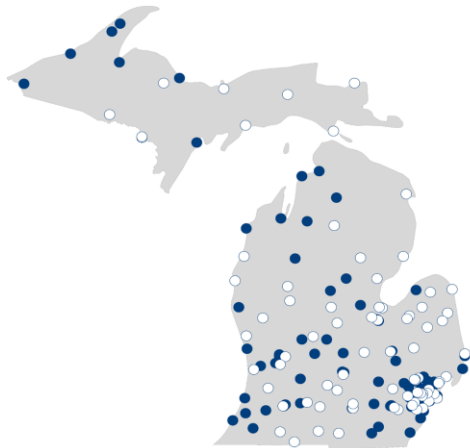
Comparing Palliative Care and Hospice Care

Palliative Care	VS	Hospice Care
Physical and psychosocial relief		Physical and psychosocial relief
Focus on quality of life		Focus on quality of life
Multidisciplinary Team Approach		Multidisciplinary Team Approach
<i>Any stage of disease</i>		<i>Prognosis 6 months or less</i>
<i>May be concurrent with curative treatment</i>		<i>Excludes curative treatment</i>

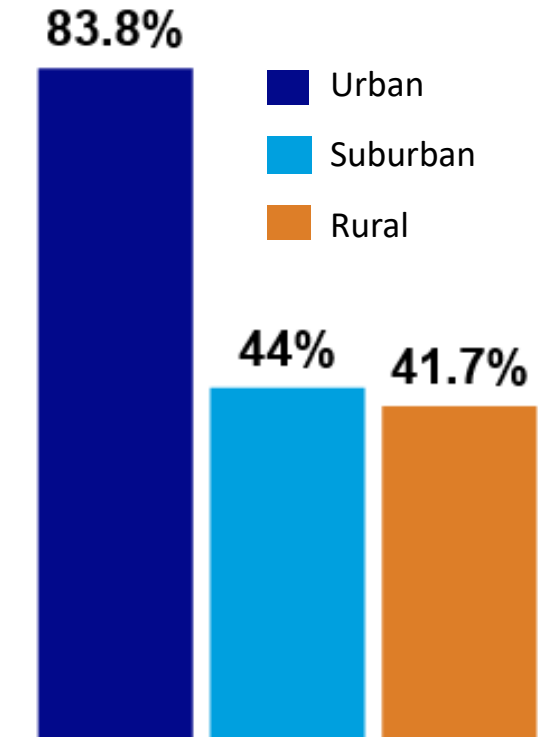
Palliative Care is a Primary Care Issue

Palliative Care Now and the Future

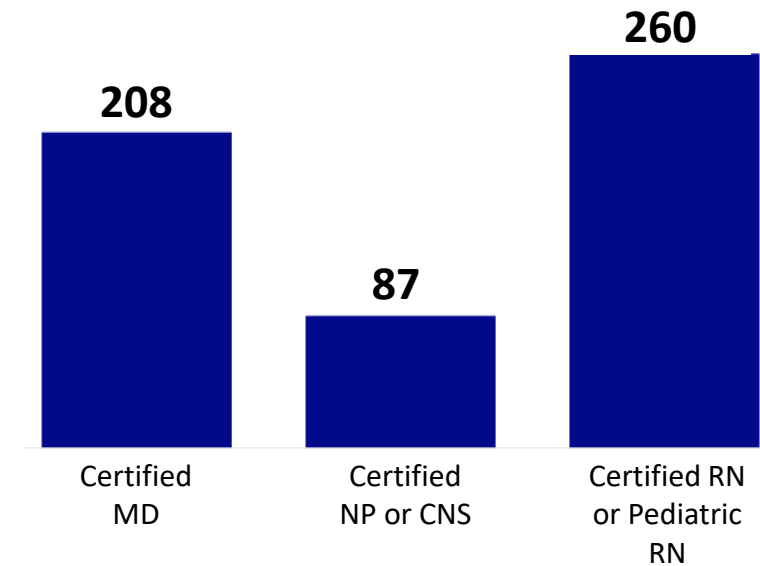
- Hospitals with palliative care programs
- Hospitals that do not currently offer palliative care



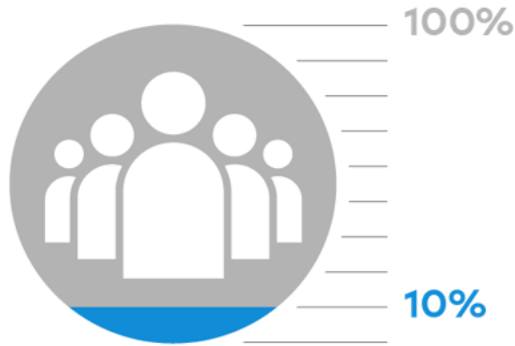
Percentage of Hospitals with a Palliative Care Program by Geographic Type



3.0 certified prescribing palliative care providers (MD or APRNs) per 100,000 residents



Concentration of spending in high-risk patient populations



The sickest 10% of the U.S. population....

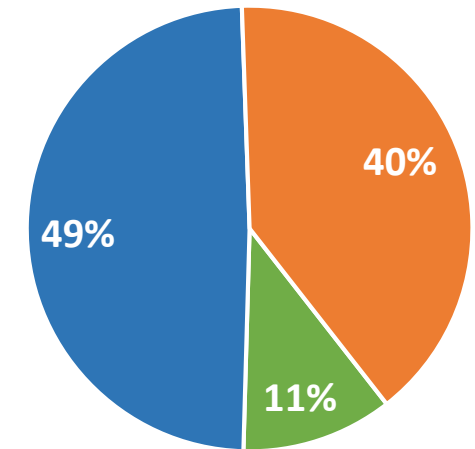


Accounts for 65% of all health expenditures.

Top 5% of Health Care Spending

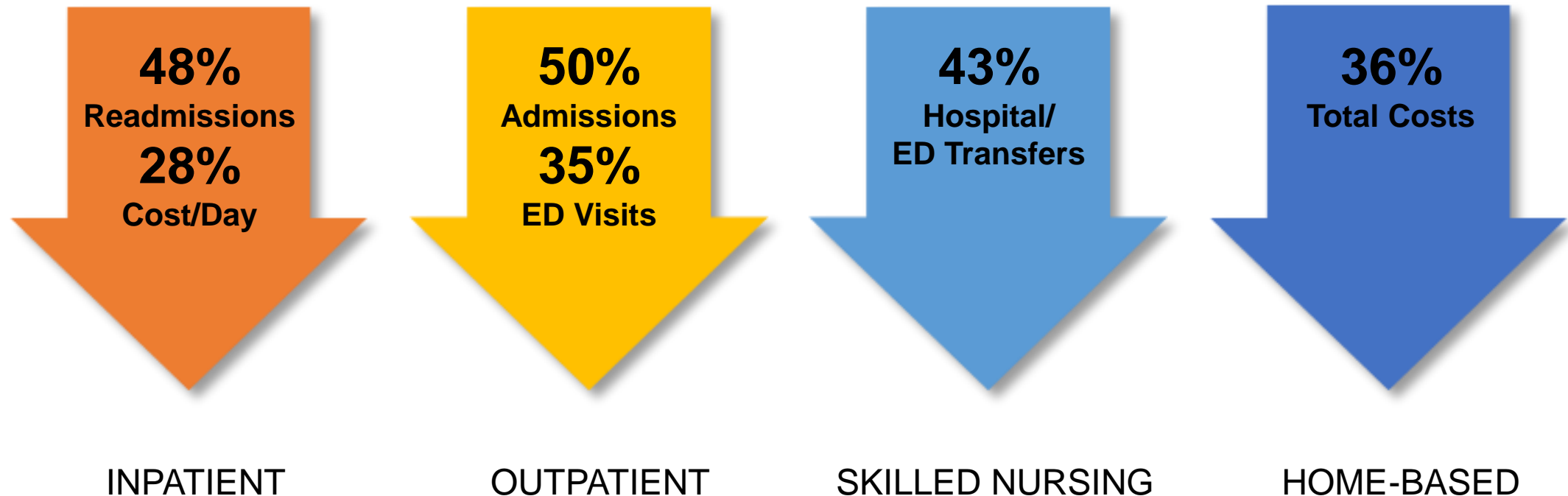
Patients who live with serious illness and chronic conditions over years are likely to fall under the category of persistent high-cost patients.

When this patient population receives palliative care, quality of life increases, crises are prevented and, as a consequence, medical costs decrease.



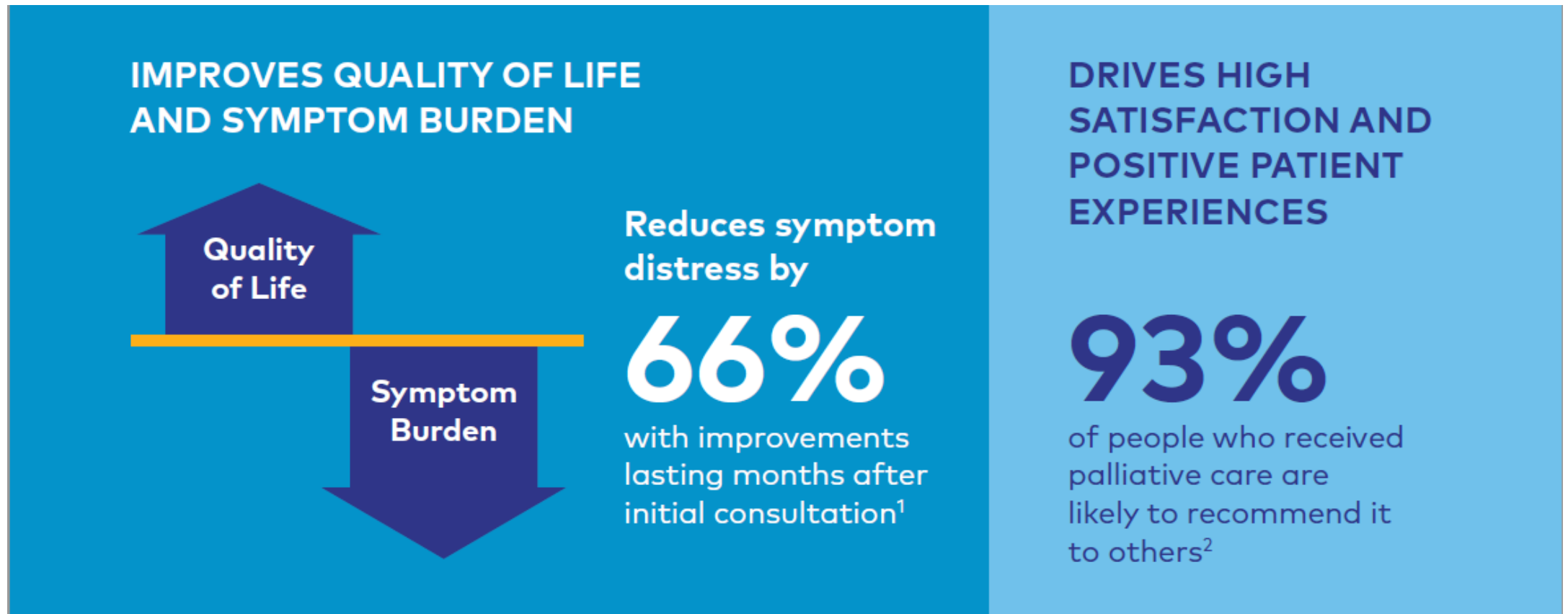
- Last 12 months of life
- Short term high \$
- Persistent high \$

Palliative Care Reduces Avoidable Spending and Utilization in All Settings



Source Centers to Advance Palliative Care

Palliative Care Improves Quality of Life



Center to Advance Palliative Care, 2018 Retrieved from <https://www.capc.org/tools-for-making-the-case/downloadable-tools/>

Debbie: Regaining a Quality of Life



<https://www.youtube.com/watch?v=5M-b1c2spPE>

Debbie's quality of life changed with the addition of palliative care

Debbie's experience before receiving palliative care:

- Disabling pain due to chemotherapy side effects
- Depression, functional decline, social isolation, and suffering
- Family distress
- Several 911 calls for pain crises led to 3 ED visits and hospitalizations

Debbie's experience after receiving palliative care:

- Expert pain management
- 24/7 phone coverage
- Ongoing relationship with the palliative care team
- Support from social worker, chaplain, yoga, and art therapists
- Resumed work, her family role, and going to church
- **No 911 calls, ED visits, or hospitalizations in last 12 months**

Break



<https://www.youtube.com/watch?v=5M-b1c2spPE>

Personal Perceptions of Palliative Care

Group Activity

**“We are trained to see disease,
we are not trained to see suffering...”**



<https://www.youtube.com/watch?v=WKSS9E2qy8A>

Domains of Palliative Care

Domains of Palliative Care

- Structure and Processes of Care
- Physical Aspects of Care
- Psychological Aspects of Care
- **Social Aspects of Care**
- Spiritual Aspects of Care
- Cultural Aspects of Care
- Care of Imminently Dying
- Ethical & Legal Aspects of Care

Structure and Process of Care

- Begins with a comprehensive assessment and a care plan that is consistent with a patient's values and goals
- Advance Care Planning: patient and family treatment goals are clearly documented
- The primary non-medical needs expressed most frequently include: a need to express emotional pain, a need to explore spiritual pain, and a need for practical financial and legal help.

Physical Aspects of Care

- Assessment should focus on relieving symptoms, improving/maintaining quality of life and functional status
 - Symptoms may include pain, shortness of breath, fatigue, nausea, constipation, etc.
 - Lack of assessment is the most common cause of unrelieved pain
- Care is delivered in a manner that is patient centered as defined by the patient's wishes

Psychological and Psychiatric Aspects of Care

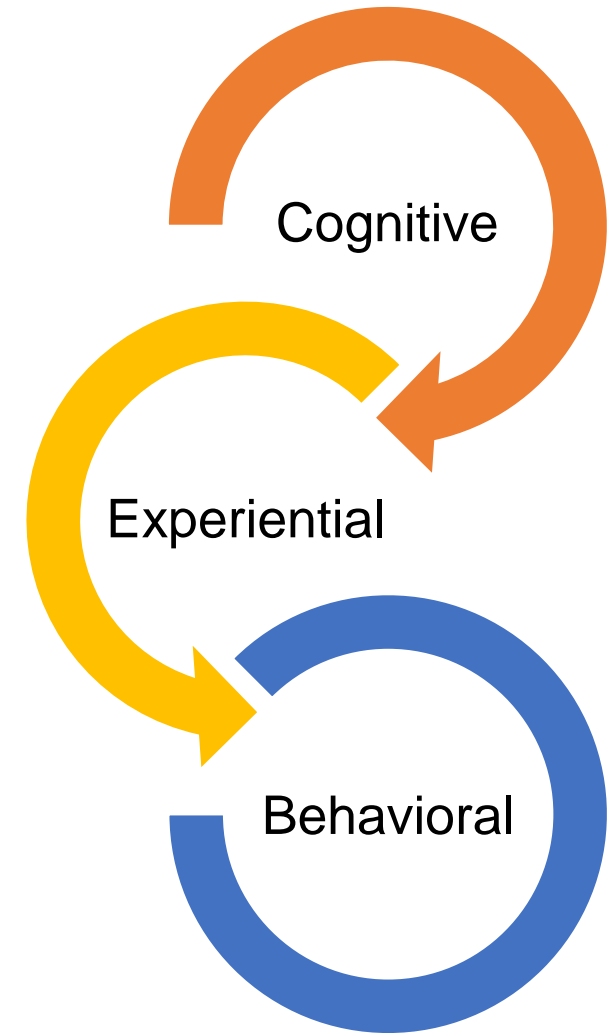
- Psychological status needs to be assessed and managed
- Watch for signs of family members struggling with psychological issues
- Programs and resources should be available to patients and families based on assessed need for services
- Process for appropriate referrals:
 - Directly
 - Through Consultation
 - Specialist Referral

Social Aspects of Care

- Social assessment should address environmental and social factors, including, but not limited to:
 - Social support network
 - Financial barriers
 - Access to care (e.g. transportation, medications)
- Family Meeting: powerful clinical tool for completing the comprehensive assessment and planning process
- Warm handoffs and referrals to local/community service providers

Spiritual, Religious, and Existential Aspects of Care

- Spirituality is a multifaceted, multidimensional human experience that includes religious and nonreligious factors
- Care Team members must acknowledge their own spirituality
- Offer support of spiritual counselor: priest, pastor, chaplain, rabbi, imam, or other religious leader
- Faith, Importance, and Influence, Community and Application (FICA) assessment



Cultural Aspects of Care

- Racial and ethnic minorities experience persistent health care disparities
- Cultural origins influence the way patients and health care providers think about palliative and end of life care
- Respect values, beliefs, and traditions related to health, illness, family caregiver roles and decision making
- Incorporate culturally sensitive resources and strategies into the plan of care
- Remove barriers to communication by ensuring that linguistic needs are met

Care of Imminently Dying

- Whenever possible, early access to hospice care should be facilitated
- Place particular emphasis on days leading up to and just after death of the patient
 - Ensure patient receives adequate management of pain and other symptoms
 - Avoid inappropriate prolongation of dying
 - Address spiritual and cultural needs
- Signs and symptoms of impending death are recognized and communicated to patients and families
- Provide support and education to the family
 - Assist in making critical decisions
 - Relieve possible burdens imposed on loved ones
 - Develop post-death care and bereavement follow up plan

Ethical and Legal Aspects of Care

- Address guardianship and goals of care
 - Identify the health proxy
- Honor patient preferences or those made by legal proxies or surrogate decision makers
- Maintain professional boundaries
- Remain knowledgeable of organizational policies
- Communicate prognosis essential for informed decision making

Break



<https://www.youtube.com/watch?v=5M-b1c2spPE>

Identify Members of the Multidisciplinary Care Team

**What patients do you think would benefit
from palliative care?**

Who do you think would benefit?

- High-risk patients
- Socially vulnerable
- Exhausted family caregivers
- Patients with:
 - Cognitive impairment
 - Multiple comorbidities
 - Frailty
 - Functional dependency
- Palliative care can help with illnesses other than cancer:
 - Advanced lung, heart, kidney and liver disease
 - AIDS
 - Alzheimer's disease and dementia
 - Cystic Fibrosis
 - Disabling stroke and other neurological diseases
 - Motor Neuron Disease and multiple sclerosis

Who provides palliative care?

Who Provides Palliative Care?

- Physician
- Advanced Practice Provider
- Registered Nurse
- Social Worker
- Pharmacist
- Medical Assistant
- Dietitian/Nutritionist
- Patient
- Family Member or other Loved Ones
- Spiritual Advisor
- Community Health Worker
- Front Office Staff

Aspen's Palliative Care Experience



<https://www.youtube.com/watch?v=OgWdwsNYY3Q>

Patient Focused Approaches

- Decisions are driven by the patient's goals of care and wishes
- Provide support to patient to express wishes
- Provide support to family and caregivers so that patients may realize goals of care
- Navigate, coordinate a complex/confusing healthcare system, understand the plan of care

Family: Members of the Care Team

Central to the delivery of care are family members and/or caregivers:

- Provide insights into progression, improvement, and quality of life
- May advocate for patient needs, wishes and desires
- Source of emotional support and reliability for patients in ever-changing circumstances
- Provide long-term, 24 hour care with minimal emotional and psychological support

Family members benefit from the support of the palliative care team:

- Experience physical, emotional, and mental stress caring for family member or friend
- Prone to social isolation and caregiver burden
- Benefit from support of the overall palliative care team in the form of information, counselling, or practical assistance and training

Family Related Challenges

- Family Functioning
 - May have less than optimal relationships
- Incongruent patient and family member needs
- Communication process barriers
- Impaired concentration
- Timing and amount of information
- Family members not wanting to bother the health care team
- Family members' rejection of support
- Cultural issues and provider comfort level

Family Meeting

- When possible, the patient should determine who they would like to be present
- Identify the health proxy
- Helpful to have members of the care team available to the patient to aid in decision making
- Ensure an environment where patients and families feel comfortable sharing information

Shared Decision Making

- Engages patients and families in decisions about their care
- Increases their involvement and satisfaction
- Helps patients and families clearly communicate their goals and needs
- No “one right way” to intervene

Integrating Palliative Care into the Primary Care Setting

Challenges and Opportunities

Group Activity

Challenges and Opportunities

Challenges

-  Shortage of palliative care specialists
-  Lack of knowledge of palliative care still exists with some providers
-  Regional, socioeconomic, racial and ethnic groups influence access to palliative care
-  Care team members may be reluctant to discuss palliative care; fear patients will lose hope
-  Many patients are unaware of palliative care services

Opportunities

-  Increase access to primary palliative care
-  Develop communication strategies to help patients through the decision making process
-  Leverage EHR and HIE technology to facilitate appropriate referrals
-  Educate all providers and staff about palliative care
-  Increase patient satisfaction, while reducing provider burnout

Value of Palliative Care in Primary Care

- Increased primary care involvement in the care of seriously ill individuals is associated with:
 - Improved quality of life
 - Reduced inpatient and ED utilization for seriously ill patients
 - Improved quality measure outcomes near the end of life
- Clear guidelines and indications for subspecialty referrals exist for hospitalized patients; these should be adapted for the outpatient setting as well
 - PCPs responsible for care management
 - Specialists available for patients with complex needs

How and Where of Palliative Care

Gaining Access to Palliative Care

- Referral from PCP
- Referral from specialist
- Referral from care team member
- Hospitalization
- Self-referral
- Hospice

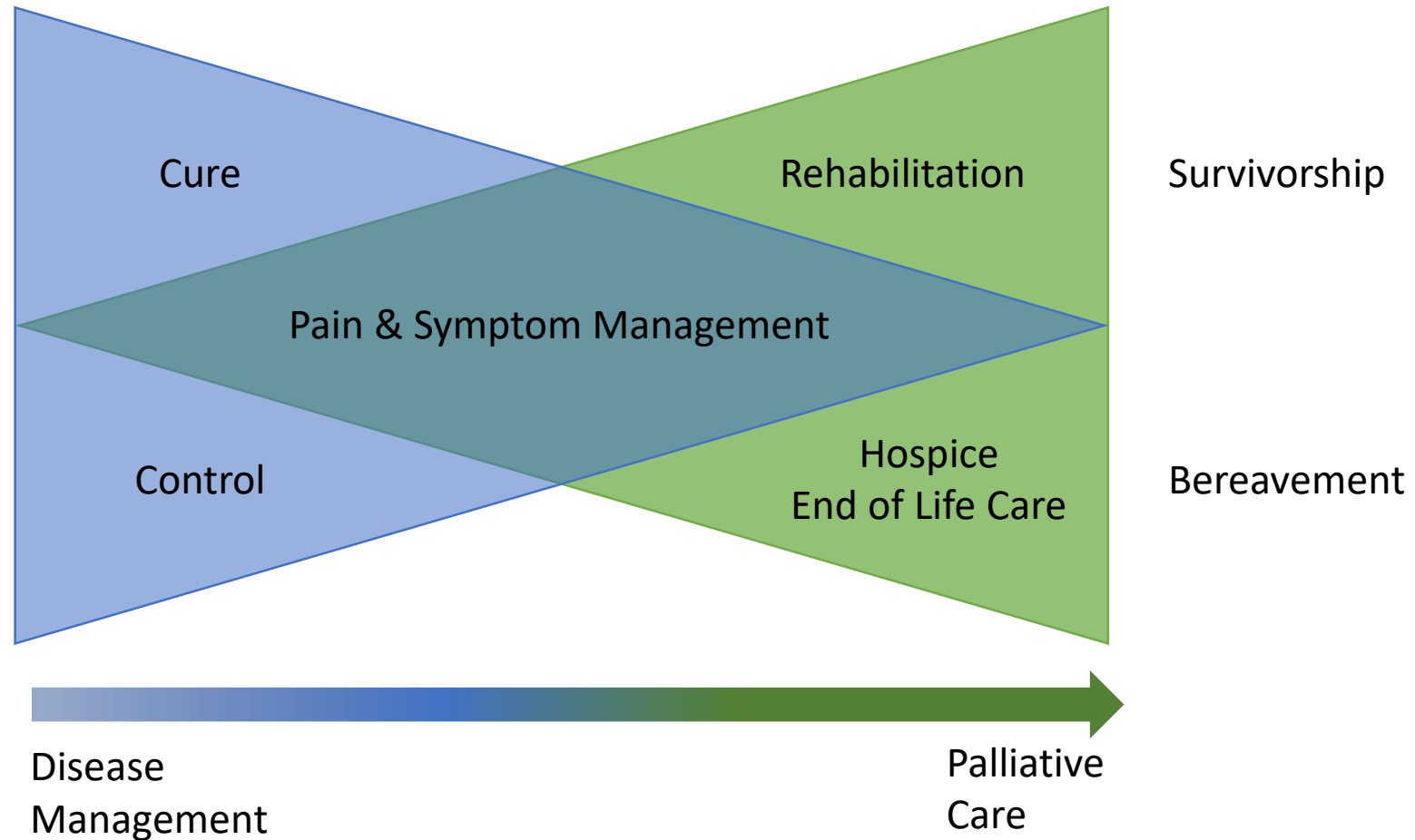
Locations for Palliative Care

- Patient's home
- Nursing home
- Assisted living
- Hospital
- Ambulatory practice/clinic
(Primary Care and Specialty Care)
- Community-based facility

Medicare Cost Sharing

- Eliminate beneficiary cost sharing for patient-centered services
 - Advance Care Planning
 - Chronic Care Management
- Create and expand existing Medicare alternative payment models
 - Improved quality of care
 - Quality of life
 - Health outcomes in patients with serious illness
- Ensure that all models allow concurrent palliative care and disease treatment

Palliative Care Enhanced Care Model



Value of Assessment Tools

- Patient assessment is a critical step in identifying palliative care needs
- PCPs need to consider the palliative care needs of all patients with life-limiting illnesses including metastatic cancer, end stage organ failure and advanced degenerative neurological conditions
- Assessment should address prognosis, current and anticipated symptoms, distress, and the availability and support needs of family and caregivers

Examples of Tools Useful in Palliative Care

- Physical Aspects of Care
 - Edmonton Symptom Assessment Scale (ESAS)
 - Frailty Score
- Psychological and Psychiatric Aspects of Care
 - PHQ9
 - GAD7
- Social Aspects of Care
 - SDoH screening
- Spiritual, Religious, and Existential Aspects of Care
 - FICA Spiritual Assessment
- Ethical and Legal Aspects of Care
 - Advance Directives
- General Assessment Tools
 - [Karnofsky Performance Scale \(KPS\)](#)
 - [Palliative Performance Scale \(PPS\)](#)
 - [PEPSI-COLA Checklist](#)

Questions

Criteria for Successful Completion of Introduction to Palliative Care

- Attend Introduction to Palliative course, **in-person or virtual**
 - If the Learner misses > 30 minutes; the course will not be counted as “completed” and the learner will need to retake the course.
 - If the Learner misses < 30 minutes; the course will be counted as “completed”. The Learner will need to review the missed course content located here:
<https://micmt-cares.org/training>
 - If course is virtual – must attend by audio and video/internet
- Complete the Michigan Institute for Care Management and Transformation (MICMT) Introduction to Palliative Care **post-test** and **evaluation**
 - Achieve a passing score on the post-test of 80% or greater. If needed, participants may retake the post-test

**You will have (5) business days
to complete the post-test.**

Development Team

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Michigan Medicine



A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association



Michigan Institute for Care Management and Transformation (MICMT)

Who We Are

Partnership between University of Michigan and BCBSM Physician Group Incentive Program (PGIP)

Goal of MICMT

To help expand the adoption of and access to multidisciplinary care teams providing care management to populations served by the physician community in order to improve care coordination and outcomes for patients with complex illness, emerging risk, and transitions of care.



Introduction to Palliative Care Curriculum Development

- Please provide the following as an appropriate reference if you use this material:
 - “Material based on the Introduction to Palliative Care course developed through a collaborative effort by the following Michigan organizations: MICMT, PTI, IHP, Priority Health, BCBSM, and Michigan Medicine.”
- Questions about using or replicating this curriculum should be sent to: micmt-requests@med.umich.edu
- Please follow this link to apply to become an approved trainer for this curriculum: www.micmt-cares.org

Appendix

Resources

Videos

- [Palliative Care, a Different Voice in Healthcare](#)
- [Introducing the Palliative Care Team](#)

Readings

- [Palliative Care Clinical Practice Guidelines \(2018\)](#)
- [Implementation Tools and Resources](#)
- [Advanced Care Planning](#)
- Awdish, R. (2018). *In Shock: My Journey from Death to Recovery and the Redemptive Power of Hope*
- Ferrell, B.R., Twaddle, M.L., Melnick, A., and Meier, D. (2018). National Consensus Project Clinical Practice Guidelines for Quality Palliative Care Guidelines, 4th Edition. *Journal of Palliative Medicine*, Volume 21, Number 12.
- Gawande, A. (2015). *Being Mortal*

Resources

- American Academy of Hospice and Palliative Medicine
 - <http://aahpm.org/>
- Center to Advance Palliative Care
 - <https://www.capc.org/>
- National Hospice and Palliative Care Organization
 - <https://www.nhpco.org/>
- National Palliative Care Research Center
 - <http://www.npcrc.org/>

Resources

Cain, C., Surbone, A., Elk, R. & Kagawa-Singer, M. (2018). Culture and palliative care: Preferences, communication, meaning, and mutual decision making. *Journal of Pain and Symptom Management*. 55:5.

Center to Advance Palliative Care. <https://www.capc.org/>

Faulkner, A. (1998). ABC of Palliative Care: Communication with patients, families, and other professionals. *British Medical Journal*. 316:130.

Ferrell, B., Twaddle, M., Melnick, A., Meier, D. (2018). National consensus project clinical practice guidelines for quality palliative guidelines, 4th edition. *Journal of Palliative Medicine*. 21:12.

Hawley, P.H. (2014). The Bow Tie Model of 21st Century Palliative Care. *Journal of Pain and Symptom Management*. Retrieved from <http://dx.doi.org/10.1016/j.jpainsymman.2013.10.009>

Huddleston, P. (2004). Culture and quality: An anthropological perspective. *International Journal for Quality in Health Care*. 16:345-46. Retrieved from: <https://academic.oup.com/intqhc/article/16/5/345/1822533>

Hudson, P., Aranda, S., & Kristjanson, L. (2004). Meeting the supportive needs of family caregivers in palliative care: Challenges for health professionals. *Journal of Palliative Medicine*. 7(1).

Resources

Hudson, P., & Payne, S. (2011). Family caregivers and palliative care: Current status and agenda for the future. *Journal of Palliative Medicine*. 14(7).

Introduction to Palliative Care & Interprofessional education/Collaboration. U of M Palliative Care Education Committee.

Kelley, S., Morrison, S. (2015). Palliative care for the seriously ill. *The New England Journal of Medicine*. 373:8.

Luijckx, K. & Schols, J. (2009). Volunteers in palliative care make a difference. *Journal of Palliative Care*. 25(1):30-9.

McCormick, E., Chai, E., & Meier, D. (2012). Integrating palliative care into primary care. *Mount Sinai Journal of Medicine*. 79:579-585. Retrieved from <https://onlinelibrary.wiley.com/doi/epdf/10.1002/msj.21338>

McPherson, M., Walker, K. (2019). How to include a pharmacist in the palliative care mix. *Centers to Advance Palliative Care*. Retrieved from <https://www.capc.org/blog/how-include-pharmacist-palliative-care-mix/>

Middleton, A., Head, B., Remke, S. n.d. Role of the Hospice and Palliative Care Social Worker. Fast Facts. Palliative Care Network of Wisconsin. Retrieved from <https://www.mypcnow.org/fast-fact/role-of-the-hospice-and-palliative-care-social-worker/>

OneCity Health Services. (2017). Integration of Palliative Care into the PCMH Model: Implementation Toolkit.

Palliative Care Facts and Statistics. (2014). Center to Advance Palliative Care. Retrieved from https://media.capc.org/filer_public/68/bc/68bc93c7-14ad-4741-9830-8691729618d0/capc_press-kit.pdf

Schmidt, R. n.d. Role of chaplaincy in caring for the seriously ill. Fast Facts. Palliative Care Network of Wisconsin. Retrieved from <https://www.mypcnow.org/fast-fact/the-role-of-chaplaincy-in-caring-for-the-seriously-ill/>

Resources

Sutton, S., & Grant, M. (2015). Effective public engagement to improve palliative care for Serious Illness. Health Affairs Retrieved from <https://www.healthaffairs.org/doi/10.1377/hblog20150310.044884/full/>

The Case for Improving Communication and Symptom Management Skills. Center to Advance Palliative Care. Retrieved from <https://www.capc.org/documents/699/>

The National Consensus Project. (2018). Clinical Practice Guidelines for Quality Palliative Care. 4th edition

Twaddle MD,M. & McCormick MD, E.(2019). Palliative care delivery in the home. Retrieved from <https://www.uptodate.com/contents/palliative-care-delivery-in-the-home>

Wittenberg-Lyles E., Goldsmith, J., & Small Platt, C. (2014). Palliative care communication. Seminars in Oncology Nursing. 30:4. 280-286.