Palliative Care

101 Training

Ascension

Agenda

Duration	Topic	Facilitator
2 minutes	Opening Remarks	Moderator
3 minutes	Review Learning Objectives	Moderator
40 minutes	Palliative Care 101 Presentation	Moderator
15 minutes	Open Forum, Q&A	All

Speaker/Planner Disclosure

All Ascension planners and reviewers have no relevant financial relationships with ACCME-defined commercial interests.

The following speakers have no relevant financial relationships with any ACCME-defined commercial interest* to disclose.

Colleen Brown, MD; Sara Damiano; Olumuylwe Adeboye, MD

A commercial interest is any entity producing, marketing, re-selling, or distributed health care goods or services consumed by, or used on, patients.

Speaker Disclosure for Paul Tatum, MD

I have a financial relationship with University of Maryland and Compassus. The nature of that relationship is professor to their Master's in Palliative Care program and Scientific Advisory Board Member.

The following speakers, Paul Tatum, MD will not discuss off label use and/or investigational use in their presentation.

Speaker Disclosure
John Hendrix, MD

I have a financial relationship with Iris Plan. The nature of that relationship is a stockholder/investor.

The following speakers, John Hendrix, MD, will not discuss off label use and/or investigational use in their presentation.

Learning Objectives

1. Define palliative care and its impact on quality of life for patients and their families

2. Identify patients who can benefit from palliative care

3. Identify the role care team members can play in providing primary palliative care and when to refer to a palliative specialist

4. Describe the key components of completing Advance Care Planning

Defining Palliative Care

1. Define palliative care and its impact on quality of life for patients and their families

Defining Palliative Care

PALLIATIVE CARE

Palliative care is an added layer of support that 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.

*A **serious illness** is a health condition that carries a high risk of mortality and either negatively impacts a person's daily functioning or quality of life or excessively strains his or her caregivers.*

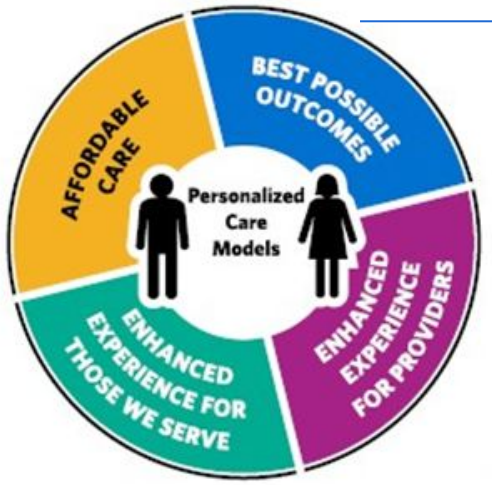
Defining Palliative Care

PALLIATIVE CARE

Palliative care is provided by a team of doctors, nurses, social workers, chaplains 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 an illness, and it can be provided along with curative treatment. Palliative care is based on need, not prognosis.

Palliative Care Delivers on the Quadruple Aim



- Improves quality of life scores, lowers symptom burden, may improve survival
- Provides assistance with difficult conversations, addressing goals of care and complex symptom management, decreases moral distress and reduces burnout in front-line staff
- Promotes goal concordant care, improved patient and family satisfaction
- Reduces admission rates, readmission rates, ED visits; may improve length of stay; lower costs per day and lower overall costs, increases hospice referrals

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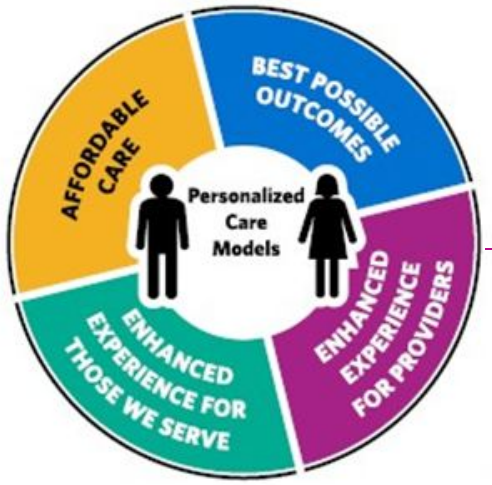

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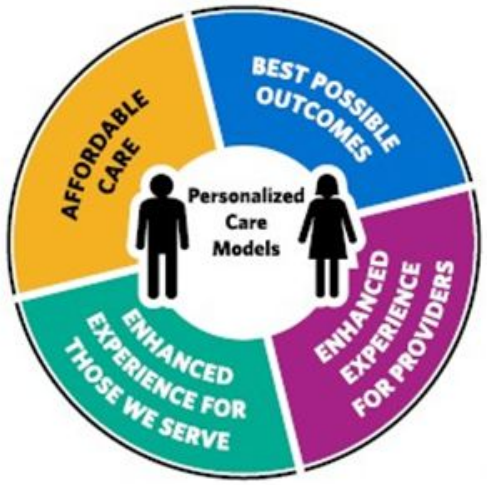

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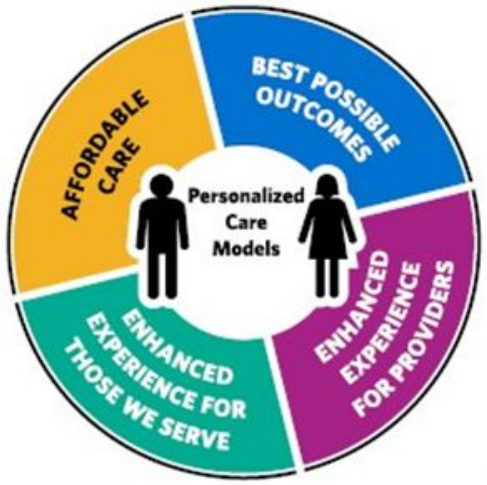

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Palliative Care Delivery Should be Available in all Settings

HOME

Care Management
Assisted Living Facility
Nursing Home
Virtual Care

ACUTE SETTINGS

Hospital
Long-term Acute Care
Virtual Care

AMBULATORY SETTINGS

Provider Offices
Wound Care Center
Virtual Care

SPECIALIZED TREATMENT CENTERS

Dialysis Center
Cancer Center
Pulmonary Clinics
Heart Failure Clinics

HOSPICE

Home
Assisted Living Facility
Nursing Home
Hospital

Ascension's Palliative Care Model

Our model aims to provide support to patients across all stages of their diagnosis.

Stage 1: Early Onset or diagnosis of a Chronic/Serious Conditions	**Stage 2**: Progressive illness: increasing symptom, require interventions to control	**Stage 3**: Continued progressive illness or disease w/higher sx and complication burden.	**Stage 4**: Patient has 6 months or less	**Death of patient**
Call to Action Address and complete advanced care plan. Enhance communication skills and pain/symptom management.	Consider speciality palliative care for complex symptom burden or difficult ACP discussions	Refer to specialty palliative care	Refer to Hospice	

Palliative Care and Hospice

Palliative Care is for those living with serious illness. Hospice is for those in the last 6 months of life.

PALLIATIVE CARE		HOSPICE
• Based on patient and family need, not prognosis	**Eligibility for Services**	• Certified prognosis of < 6 months • Utilization of hospice benefit (those insured)
• Any stage of serious illness, including prenatal • Bereavement for families	**Timing for Services**	• Life expectancy </= 6 months (median LOS = 24 days) • Bereavement for families
• Concurrent with all appropriate treatments and services	**Concurrent Treatment**	• Must waive “curative” care for terminal illness
• Fee-for-service - Medicare Part B, • Contracts with payers using a range of payment models	**Payment for Services**	• Defined Medicare and other payer benefit
• Available in acute setting • Growing presence in outpatient and community settings	**Prevalence of Services**	• Available in community and institutional settings

Knowledge Check

1. Palliative care is a team-based speciality with specialty certification for physicians, nurses, social workers, and chaplains.

TRUE

FALSE

2. Serious illness can affect quality of life and the ability to function for both the patient as well as their loved ones.

TRUE

FALSE

3. The true impact of palliative care cannot be measured.

TRUE

FALSE

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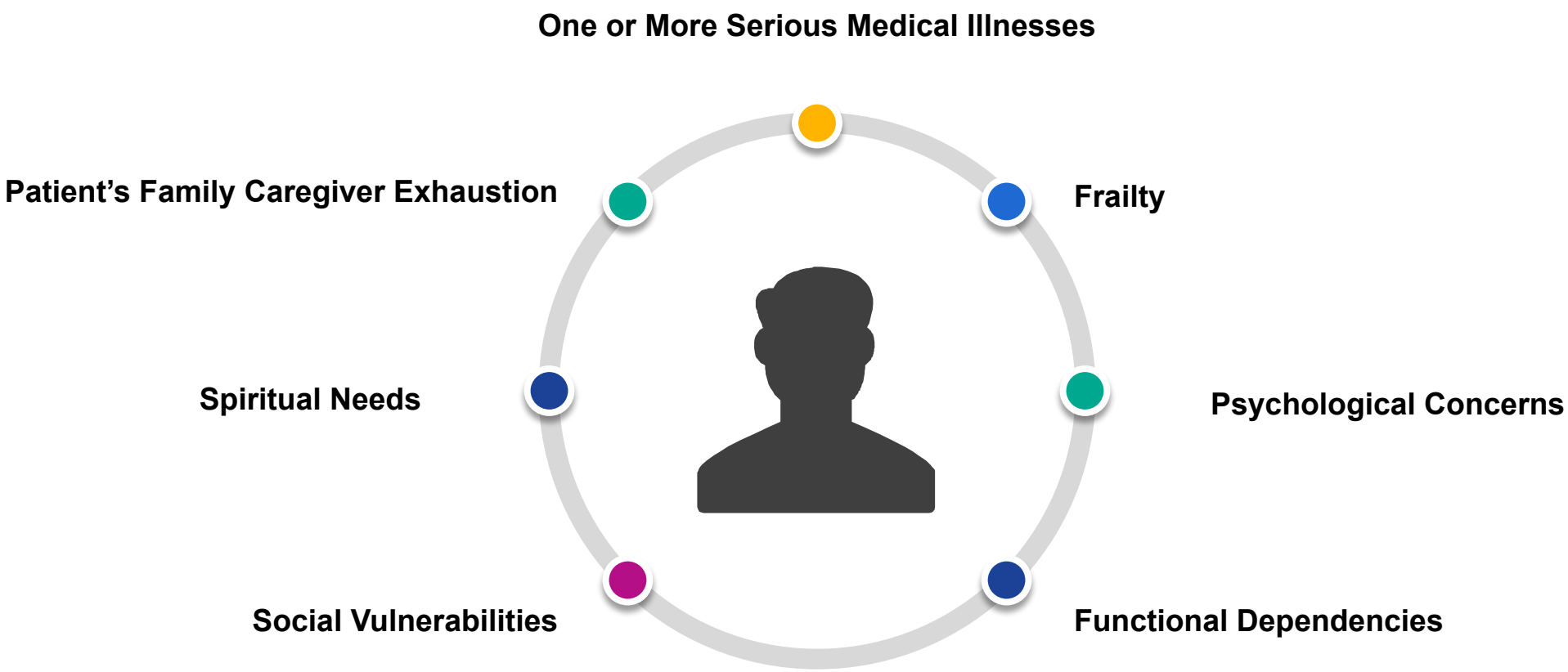
FALSE

Identifying Patients for Palliative Care Services

2. Identify patients who can benefit from palliative care

Identifying Patients who Benefit from Palliative Care

Palliative Care may be beneficial for patients with one or more of the following situations/conditions:



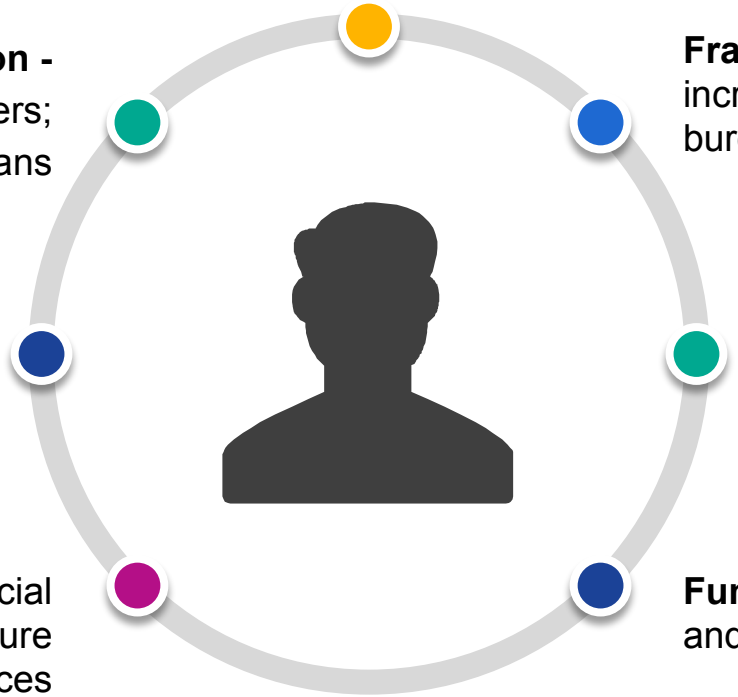
How Identified Patients Benefit from Palliative Care

In addition to improved relief of pain and symptoms, patients and their families may benefit from palliative care services in the following ways.

One or more serious medical illness - Can make sure your illness symptoms and any side effects are being treated; overall improvement of quality of life

Patient's Family Caregiver Exhaustion - Can provide support for family and caregivers; help with understanding of treatment plans

Frailty - Can redesign a care plan to meet the increasing needs of patient care while avoiding burdensome interventions that may no longer help



Spiritual Needs - Can provide holistic support that focuses on mind, body and spirit

Psychological Concerns - Can reduce cases of depression, anxiety, and substance abuse.

Social Vulnerabilities - Can provide Social Determinants of Health needs to ensure patients are connected with needed resources

Functional dependencies - Can decrease crises and increase independence at home.

Case Study: Quality of Life Improvement

Sally has congestive heart failure and does not take her medication regularly. Sally is currently living with her daughter, who is doing a wonderful job caring for her. However, with her frequent falls, decreased appetite, and laps in taking her medicines, she has visited the ED 3 times in the past 4 months.

Sally
Age: 72
Divorced

With Primary Palliative Care	Without Primary Palliative Care
• Sally has had a fall risk assessment with interventions has had no new falls or ED visits in the past 6 months	• Caregiver exhaustion and increased stress and anxiety worrying about her mother sustaining a severe injury from her falls
• Sally's symptoms are being better managed resulting in improved appetite & no new falls or ED visits in the past 6 months	• Sally may develop behavioral health issues: depression, functional decline, social isolation, family distress, and suffering
• Sally's daughter has less stress and anxiety over caring for her mother with the additional resources offered by the primary care team	• High Cost/High Utilization: Multiple 911 calls leading to 3 ED visits and hospitalizations.
• Sally's medication adherence has improved with consistent monitoring by her primary care team	• Increased hospital visits could potentially worsen the above behavioral health concerns and could put her at risk for significant delirium falls or other health risks associated with admissions for elderly patients

Care Team Roles

3. Identify the role care team members can play in providing primary palliative care

Non-Palliative Care Specialists can provide Palliative Care Services

2018 > 1 palliative care specialist : 800 eligible patients

2038 > 1 palliative care specialist : 1,300 eligible patients

Specialist capacity is, and will continue **to be,** far outweighed **by** the number of patients and families in need of care.

Many of the practices and principles of palliative care can, and should, be utilized by **all** clinicians that work with seriously ill patients.

By making sure that every clinician has the knowledge and skill they need to effectively manage the symptoms that their patients are living with, we strengthen access to palliative care.

Clinician's Role in Providing Primary Palliative Care

Clinicians can leverage existing patient-provider relationships to facilitate conversations around end-of-life goals and advance care planning while managing pain symptoms, medications, and functional status.

Initiate Advanced Care Planning

Identify patients who can benefit from palliative care

Discussion around prognosis, suffering, and code status

Enroll in Care Management Program

Ongoing Management

- **Management & assessment of pain and symptoms, functional status and social needs**
- **Communication about achievable treatment goals**
- **Support the coordination of care across settings**
- **Management of depression and anxiety**
- **Utilize palliative care resources in your ministry**

Care Manager's Role in Supporting Primary Palliative Care

Care Managers can complement a clinician's work to help patients live their best quality of life by coordinating treatments and assessing and removing social barriers of health.

Work in conjunction with providers to develop a holistic plan of care

Assess patient and family physical, psychological, and social needs (spiritual when Chaplain is not available)

Discuss goals of care with the patient and family

Identify surrogate decision-maker and facilitate/complete advance care planning (ACP)

Ongoing Management

Be the primary contact for patients and family/providers

Provide disease / condition specific support

Provide* counseling and psychotherapy for patients and families

if Behavioral Health Care Management is available

Chaplain's Role in Supporting Primary Palliative Care

Chaplains can complement a clinician's work to assess and address spiritual distress, pain, and emotional suffering.

Assess patient and family spiritual needs

Design an individualized spiritual care plan with diagnosis

Offer interventions such as: prayer, active listening, performing a life review, faith-community connections

Identify surrogate decision-maker and facilitate/complete advance care planning (ACP)

Ongoing Management

Assess cultural and/or religious factors that may be influencing decision making

Serve as the spiritual care specialist on the care team

Principles for Referring to a Palliative Care Specialist

The following are principle considerations of when to refer to a palliative care specialist.

1. DIAGNOSIS & INTERVENTIONS NEEDED

- Consider referring to a PC specialist with certain diagnoses and advanced illnesses that require interventions beyond those that are typically provided by the primary care physician
  - Advance Coronary Artery Disease or Congestive Heart Failure
  - Severe COPD
  - ESRD on dialysis
  - Metastatic Cancer/Locally Advanced Cancer
  - CVA/ALS/MS/Parkinson's
  - Liver cirrhosis
  - HIV
  - Severe Protein Calorie Malnutrition
  - Severe Dementia (Speaks 6 words or less)
  - Overall Debility/Frailty
  - Other Life-Limiting Illness

2. PATIENT'S CLINICAL PICTURE

- Worsening KPS, PPS, ECOG
- Patient decline or lack of improvement with current interventions
- Increasing needs for symptom management
- Weight loss or persistently low albumin <2.5mg/L

3. PATIENT'S PROGNOSIS

Case Study: Quality of Life Improvement

George is self-reporting that his cirrhosis medications are not making him feel well, however, he has missed (no-show) his last 3 appointments with his PCP this year. He is calling at the last minute with prescription refill needs, but the PCP is not willing to refill his medications without seeing him, knowing he is not responding well to them. George's PCP has offered virtual visits, but he is not open to that idea. He was referred to care management, but does not answer their calls.

George
Age: 51
Widow

With Primary Palliative Care	Without Primary Palliative Care
• George's symptoms can be defined and can be addressed one by one. These symptoms need not only include physical, but also emotional, social and psychological symptoms.	• George's symptoms continue to affect his quality of live and possibly his length of life.
• The root cause of George's missing appointments can be determined. Is George too Ill to travel? Does he not have transportation? Is he afraid of what he will hear from the Clinician? What was his experience with losing his wife? Support for these impediments to treatment are made available.	• George continues to miss appointments. Loss of ability for the clinician to assess treatments and progress. There are missed opportunities to educate George about disease progression & discuss his goals of care.
• Assessment of response to therapies. Alterations in medication regimen made accordingly. Home delivery of medications can be arranged.	• Unable to assess George's response to treatment plan. Inability to alter plan to improve George's quality of life. Continued access to needed medications in jeopardy.
• George's Goals of Care discussed. Insight into disease process able to be derived. There is ongoing opportunity to give George and his family information and tailor his care to maximize his quality of life as he sees it.	• George may present to the hospital in extremis, without defined directives for his care. This is likely to result in increased physical and emotional burden for George and his family.

How to Determine Prognosis: Advance Cancer Prognosis

The following indicators help determine prognosis and should be referred to while having a goals of care conversation with patient.

CANCER PROGNOSIS

• PPS < 40%	***17-50 Days***	• Malignant Effusions/Ascites	***4 months***
• ECOG 3-4	***1-3 Months***	• Dyspnea	***< 6 months***
• Malignant Hypercalcemia	***1-2 Months***	• Anorexia	***< 6 months***
• Multiple Brain Mets no RX	***1 month***	• Delirium	**6 weeks**
• Multiple Brain Mets XRT	***6 months***	• Metastatic solid cancer (except breast cancer and prostate cancer), acute leukemia, and high grade lymphomas not getting chemotherapy	***< 6 months***
• Multiple Brain Mets steroids	***3 months***	• Unintentional weight loss > 10%	***< 6 months***

How to Determine Prognosis: CHF and Stroke

The following indicators help determine prognosis and should be referred to while having a goals of care conversation with patient.

CHF	STROKE
• Class 4 (Severe) ***0-70 % chance of dying within a year***	• Hemorrhagic Stroke: ***52% chance of 30-day mortality*** • If volume of bleed is > 60 cc on scan or if brainstem bleed ***90% mortality rate***
• Not a candidate for advance therapies	• Non-hemorrhagic stroke **20%: *90-day mortality***

How to Determine Prognosis: Renal and Liver Disease

The following indicators help determine prognosis and should be referred to while having a goals of care conversation with patient.

END STAGE RENAL DISEASE	LIVER DISEASE
• Annual death rate at initiation of hemodialysis (HD) is 20-25%, after age 80, 61% mortality rate	• Decompensated Liver Failure *2 years*
• Mean survival after HD withdrawn: *8-10 days*	• Type-1 Hepatorenal Syndrome (rapid and severe renal failure) *8-10 weeks*
• Low serum albumin (<3.5): 50% *1-year mortality rate*	• Type-2 Hepatorenal Syndrome (chronic and less severe renal failure) *6 months*
• Poor functional status	• MELD SCORE 30-39: 40% *6 month predicted survival*

Advance Care Planning

4. Describe the key components of completing Advance Care Planning

Defining Advance Care Planning

ADVANCE CARE PLANNING

Advance Care Planning (ACP) is an ongoing process for all adults that starts with a conversation where a person shares their values and goals for future healthcare decisions if they became too sick or injured that they could not communicate them.

The ACP involves discussion of terms, addressing fears or concerns, reviewing goals of care, or future treatment preferences with the patient, family members, or surrogates. Discussions may include completion or review of forms such as an advance directive, power of attorney for health care (DPOA-H), living wills, or physician orders for life-sustaining treatment (POLST).

Defining Advanced Care Planning

ADVANCED CARE PLANNING

During an ACP discussion, the patient and provider may or may not complete relevant legal forms, known as advance directives. Advance directive documents that may* be referenced during the ACP discussions include:

- Healthcare Representative Appointment
- Living Will
- Advance Directive for Healthcare (often Healthcare Rep & Living Will forms combined)
- Physician Order for Life-Sustaining Treatment (POLST)
- Out of Hospital Do Not Resuscitate Order (DNR)
- Five Wishes

**Clinicians should confirm the forms used in your market ministry prior to discussing Advanced Care Plans with patients*

Why Advanced Care Planning Matters

ADVANCED CARE PLANNING

GOOD FOR PATIENTS -

ACP improves patient satisfaction and ensures the patient's voice is at the center of the conversation.

GOOD FOR CLINICIANS -

Clinicians report that ACP is one of the most meaningful conversations they have with a patient.

Having Advanced Care Planning Conversations

WHEN SHOULD CONVERSATIONS HAPPEN?

- During an Annual Wellness Visit
- When the patient has a new or worsened serious illness
- When the patient has been recently hospitalized for a serious / life threatening illness
- When there is a change to the patient's care setting

ACP should be reviewed annually and can be completed by patients over 18 years of age.

WHO CAN LEAD THE CONVERSATION?

- MD
- DO
- APP
- RN*, in collaboration with MD/DO/APP
- RN* Care/Case Manager*, in collaboration with MD/DO/APP

**Non-physicians, including chaplains & social workers may initiate these discussions. Please check local hospital/state guidelines regarding licensing/scope of practice restrictions for documentation or billing.*

Billing for Advanced Care Planning Services

Use the following CPT codes to bill for ACP services.

Duration	CPT Code	CPT II	RVUs
15 minutes or less	Not billable	1123F or 1124F	
16 - 45 minutes	99497		1.5
46 minutes or greater	99497 + 99498*		2.8

Add the following CPT modifiers when ACP discussions are billed alongside other procedures:

Modifier	Paired Procedure
33	Preventative Services (e.g. Medicare Annual Wellness Visit)
25	Evaluation & Management (E/M)

**Clinicians should bill an additional 99498 CPT Code for each additional 30 minutes of the ACP discussion*

Completing Advanced Care Planning in Athena

Ascension has partnered with Affirm Health, a third party vendor, to create an ACP tool that layers on top of our EHRs to ensure simple documentation, coding and billing processes for our clinicians.

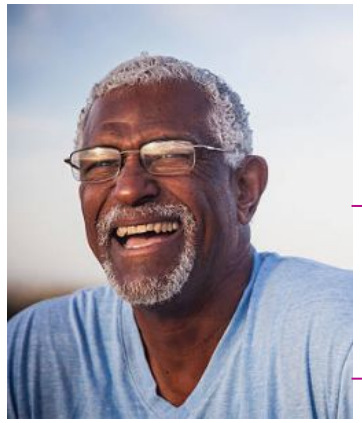
To complete a short 15-minute training on Athena's* capabilities, powered by Affirm Health, please click here.

Navigate to the Affirm ACP Tool directly from the The Third Party Applications in the Athena "hamburger" menu

**Ascension is actively working to establish similar workflows for inpatient and outpatient Cerner and Epic.*

Case Study: Quality of Life Improvement

Doug is living at home, with his wife, and has Stage 3 colon cancer. He manages his prognosis well, is connected with a nurse navigator, attends appointments regularly, has a healthy appetite, and can function on a daily basis.



Doug
Age: 66
Married

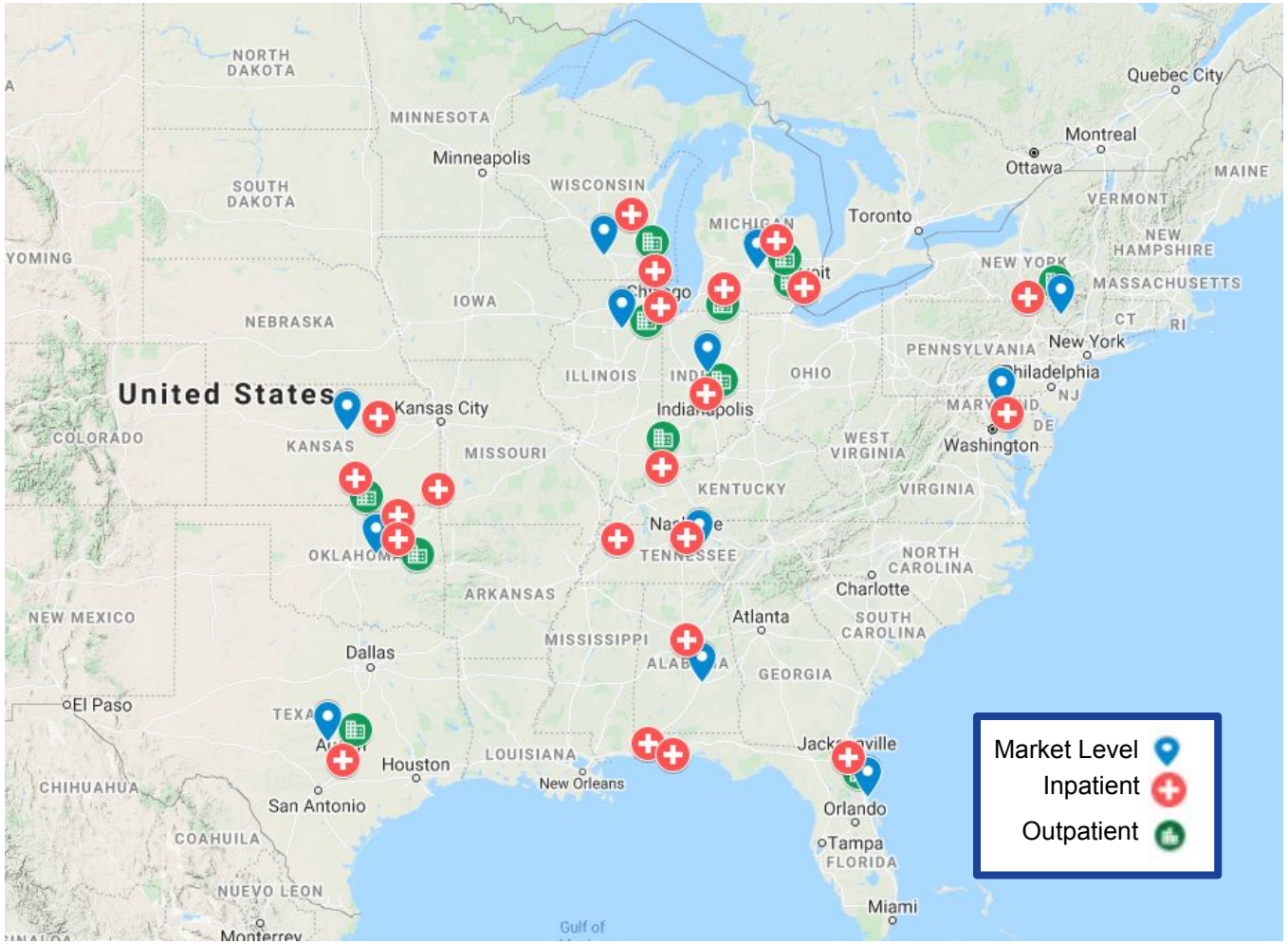
With Primary Palliative Care	Without Primary Palliative Care
• Doug meets with his primary care physician during his Medicare Annual Wellness appointment and shares in a meaningful advance care planning conversation on his goals of care in light of his recent colon cancer diagnosis.	• Doug meets with his primary care physician during his Medicare Annual Wellness appointment and lets his doctor know he is seeing an oncologist for colon cancer treatment.
• Doug is motivated to speak to his wife about his values, goals, and preferences for future healthcare decisions and completes his advance directive.	• Doug is facing increasing feelings of worry and sadness related to his health status and does not want to concern his wife so he attends his oncology appointment alone.
• Doug's nurse navigator from the cancer center does a proactive outreach call. Doug shares with her the completion of his advance directive naming his wife as his healthcare agent and the desire to include her in upcoming appointments as this helps reduce his anxiety.	• Doug asks to speak with a nurse navigator at the cancer center as he is facing insurance barriers and transportation needs. He finds it too stressful to address his feelings of isolation and fear of death. He wants to be strong and does not bring it up to the nurse.
• Doug brings his wife to his next oncology appointment. He engages in a shared decision making conversation with his oncologist that is person and family centered with discussion of treatment options that are tailored to his preferences.	• Doug is spending more time sleeping, finding a reduction in his appetite, with limited interest in activities. He sleeps in and misses his oncologist appointment. Doug continues to face increased agitation as he waits on hold for the office to reschedule his appointment.

Resources

Resources

Palliative Care Specialty Service Locations

Contact us!



Resources

Palliative Care Specific Resources

- Center to Advance Palliative Care
- American Academy of Hospice and Palliative Medicine
- The California State University Shiley Institute for Palliative Care*
- Palliative Care Network of Wisconsin
- Supportive Care Coalition
- Allay Care

*Ascension employees receive a discount on all professional education courses