Primary Palliative Care: Getting Started

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Objectives

• Discuss primary palliative care
• Identify patients that benefit from palliative care services in the outpatient setting
  – Supportive and Palliative Care Indicators Tool (SPICT)
  – “Surprise” Question
  – Integrated Palliative Outcome Scale (IPOS)
• Discuss implementation strategies
Elements to Succeed

• Administrative Education and Engagement (think VBP)
• Information Technology Engagement
• Provider Education and Engagement
  – Residents
  – Faculty
  – NP/PA
• Clinical and Nonclinical Staff Education and Engagement

“Palliative Care is a Bridge”

https://www.youtube.com/watch?v=lDHhg76tMHc
Excellus Hospital Performance Improvement Program

eMOLST

Delivery System Reform Incentive Payment Program (DSRIP)

Value in more, better, and earlier conversations

The Quadruple Aim

Population Health  Patient Experience and Outcomes  Provider Satisfaction

Value &

Lower costs
Recognizing Patients’ PalCare Needs

- Responsibility to manage patients’ overall health needs
- Patients with *Serious Illness*
- Stable or gradually declining health
- Numerous and diverse unmet needs across multiple dimensions
- Troublesome symptoms are usually the reason for visits
- Care focuses upon comfort and continued treatment for Serious Illness(es)

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Primary Palliative Care

“COMMUNICATION BUNDLE”

- Identification of a Health Care Proxy Agent and completion of documentation
- Initiation, documentation and stewardship of Advance Care Planning and goals of medical treatment discussions
- End of life care treatment preferences and code status

“PAIN AND SYMPTOM BUNDLE”

- Basic assessment, documentation and management of pain and symptoms
- Basic assessment, documentation and management of depression and anxiety
- Basic assessment and documentation of functional status
Program Goal

• Integrate Primary Palliative Care Into the Family Medicine Program Model Unit

Sister Rose Vincent Family Medicine Center

• HPSA – 18
• Urban Poverty
• Refugee Resettlement Status
• Low level of Health Literacy
• Health Insurance Profile
Educational Goals

1. Gain facility in addressing and completing the HCP
2. Employing the Serious Illness Conversation
   a. Patient Centered Goals
   b. End of Life Preferences
   c. Code Status
3. MOLST/POLST across healthcare transitions
4. Assess and treat anxiety and depression as well pain, symptom and disease management
5. Adopt the role of FM in Primary Palliative Care

Strategies to Improve the Delivery of a Basic Palliative Care Approach in a Primary Care Environment

- Set up a registry of patients
- Multidimensional needs assessment
- Care Management Approach
- Team Based Care
- Decision Aids including guidelines
- Provider Education
- Practice Coach Support
- Rapid Cycle PDSA Quality Projects
- Financial/Technical Support

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Provider Engagement: Residents

**Behavioral Medicine Integration**
- Serious Illness Communication Workshop in the first year

**Palliative Care Elective**
- Improve Serious Illness Communication Skills
- Scholarly Activity
- CAPC Modules

**First Year Mandatory Rotation**
- Palliative Care Inpatient and Outpatient
- Hospice home visits
- Interdisciplinary Group Participation
- CAPC Modules:
  - Communication
  - Pain Management

**Longitudinal**
- Morning Report
- Practice Management
- Quality Projects

Attitudes Regarding Health Care Proxy

Do YOU routinely ask patients about HCP completion?

- No 92%

Comments:
- Often forget.
- Only do for PE
- Not educated in the process
- Wasn’t taught
- Not conditioned to do so
- Never mentioned that we should do it.

Reasons why we don’t ask

- “Not enough time” 6%
- “I don’t think it should be a routine question” 13%
- “Not part of my job” 13%

Comments:
- Trying to do it more often.
- Need to make it a routine question
- Usually just during Medicare Wellness
Provider Engagement: Faculty

- Face to Face discussions
- Faculty Development Presentations
- Self-interest/Shared Purpose
  - Complex patients
  - Multidisciplinary needs
  - Scheduling limitations
  - Chronic Pain patients
- CME/CAPC and Communication Workshops
- Supportive Care Workflow and Patient Centered Goals of Treatment Documentation in the EMR

Barriers to clinician engagement

- Too much to do
- Too little time
- Unaligned incentives
- Unclear ownership
- Clinician distress!
Engagement: Multidisciplinary Team

• NP/PA
  – Clinical Support
  – CME

• Health Information
• Referral Coordinators
• Scheduling/Reception Staff
• Behavioral Health

• Nursing
  – Identify a Champion
  – Staff Meetings
  – Workflow Improvement
  – Education and Engage:
    • HCP
    • eMOLST
    • CAPC Modules
    • Serious Illness Conversation

Patient Identification

• Frequent Admissions/Readmissions/ER, Multiple Co-Morbidities, EMR Confirmation, Referral

• SPICT

• Clinicians review office visits over 3 months and ask The “Surprise” Question
Conversations are a key component of the effectiveness of palliative care interventions

Earlier conversations about patient goals and priorities for living with serious illness are associated with:

- Enhanced goal-concordant care  Mack JCO 2010
- Improved quality of life
- Reduced suffering
- Better patient and family coping
- Higher patient satisfaction Detering BMJ 2010
- Less non-beneficial care and costs Wright 2008, Zhang 2009
Goals of Care Discussions are a Challenge

- Patient/Family resistance in acknowledging the realities of declining disease trajectory
- Positive interpretations that the patients took away from conversations with medical specialists
- Lack of comfort and experience with having these conversations among practice clinicians

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Train Clinicians

- RCTs: Communication skills training programs work (Jenkins 2002, Fallowfield 2006, Szmuilowicz 2010)
- Other studies demonstrate impact of training (Back et al. 2007)
- Key elements:
  - cognitive input
  - modeling
  - skills practice with feedback
- Improvements are maintained for at least 6 months (Maguire 2002, Sullivan 2006)
Communication Skills in Serious Illness Care

• Patient centered discussions regarding:
  • Medication use and understanding
  • Illness Understanding
  • Goals of Medical Treatment
  • End of life care preferences: Hospice/Living Will
  • Code Status
• Documented/Scanned and Shared

Serious Illness Conversation Guide

• Set Up
• Assess Illness understanding
• Share Prognosis
• Explore Key Topics
• Close the Conversation
• Document
Information Technology Support

IPOS
Advance Care Planning Documentation

Advance Care Planning Billing Codes

• The completion of an advance directive form is not a requirement for billing the service. The service is the explanation and discussion of the form.

• There are no place-of-service limitations – you can use it in acute care, nursing home, home, etc.

• There is no limit to the number of times ACP can be reported for a given beneficiary in a given time period.

• The first 16 - 30 minutes are to be billed under 99497 (1.49 RVU) and if the conversation is 46 minutes or more, both 99497 and 99498 (1.49 RVU) can be billed.
Patient Outcomes/Satisfaction

- Health Care Proxy Forms Scanned into EMR
- Advance Care Planning codes billed
- Integrated Palliative Outcome Scale Data
- Service Specific Patient Satisfaction Survey

Discussion
Join the Serious Illness Care Program Community of Practice

– Open Web Browser
– Go to: https://portal.ariadnelabs.org
– Click “Create an Account” on the right side of the page
– Complete the account information page. You will receive an email to authenticate your account.
– Return to: https://portal.ariadnelabs.org and click on the Serious Illness Community of Practice on the bottom left of the page.
– Click “Request Membership” Complete the additional profile information
– You will receive an email once the administrator has accepted your request

Resources

Center to Advance Palliative Care
https://www.capc.org/membership/curriculum-catalogue/
vitaltalk.org
• iTunes Store: http://vitaltalk.org/vitaltalk-apps/
• Vimeo: https://vimeo.com/user20181740

Fast Facts: https://www.mypcnnow.org/fast-fact-index
Medical College of Wisconsin
Thank you!

Utica, NY

Located in Central New York at
The Foothills of the Adirondacks

MVHS | www.mvhealthsystem.org

Please complete the session evaluation.

Thank you.
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