Palliative Care Conversations: Advocating for the Patient and Involving Your Physicians

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Learning objectives, "At the conclusion of this session, participants will be able to …"

- *Identify areas in their setting where palliative care concepts could easily be incorporated into routine patient management.*
- *Identify institutional barriers to achieving this culture shift.*
- *Understand the importance of Tag-team POLST and advance care planning conversations on all seriously ill patients admitted.*
- *How to start Palliative Care conversations.*
- *The importance of supporting physician champions in the shifting culture*

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Abstract

- The provision of palliative care must shift from its present almost universally believed focus on “end of life care” to best practice medicine in the care of anyone seriously ill entering the healthcare system. Excellence in pain and symptom management, improvements in communication between interdisciplinary team members, family and patients, timely and appropriate transitions along the continuum of care should not be something we strive for – instead it should be the baseline to achieve a win-win-win for patient, hospital and payer.

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3

The goal

…starting with the end in mind.

- Can we agree…
- … for appropriate patient’s receiving palliative care?
- ***The outcome/goal is for us to provide the right care at the right time, for the right reason, in the right location to maximize the benefit of the care being provided.***

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4

Patient Criteria

- Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness — whatever the diagnosis.

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Where are patients seen?

- Hospital
- Skilled Nursing Facility
- Assisted Living/RCFE
- Office/Clinic Setting
- Home

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What prompts the request?

- Primary reason for request for consult –
  - goals of care, advance care planning and completion of advance directives/POLST.
- *Secondary*
  - Pain and symptom management
  - Physician support with complex decision making
    - *(e.g. tube feeding, withdrawal of dialysis/ventilator support)*

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Inserting ourselves

- Where can palliative care concepts easily be incorporated into routine patient management?
  - ER
  - ICU
  - Out-patient Clinic

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Institutional Barriers

- *Are there institutional barriers to achieving this culture shift?*
- *How do we support physician champions in this shifting culture?*

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It takes a tag-teaming village…

- *What is Tag-team POLST?*
- *How do we provide advance care planning information on all seriously-ill patients admitted?*

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No more passing the buck

"There's no easy way I can tell you this, so I'm sending you to someone who can."

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11

A Concept: Communicating With Patients and Families

- *Starting/beginning Palliative Care conversations.*
- *Facilitating patient/family meetings.*
  - Setting the stage:
    - be prepared, don't rush, listen more, talk less, review options, be supportive and empathic.

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12

ACCESSIBILITY AND RESOURCES

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  - Direct/Mobile – 949.355.6000
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- *Resources*

  www.vitas.com VITAS Hospice

  www.capc.org Center to Advance Palliative Care

  www.capolst.org California POLST

  www.coalitionccc.org Coalition for Compassionate Care of California

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13