

# Improving the Quality of End of Life Care for Older Adults in Health Centers

Session 4: Palliative Care and End of Life Models- Hospice

2018-2019 Learning Collaborative Series

Thursday, January 17, 2019



# National Center for Equitable Care for Elders (NCECE)

[www.ece.hsdm.harvard.edu](http://www.ece.hsdm.harvard.edu)

**Who We Are-** Established in 2017, the National Center for Equitable Care for Elders (NCECE) is a training and technical assistance Center that provides innovative and culturally competent models of care, inter-professional training and educational resources to health care professionals providing care to older adults

**Our Mission** is to build strong, innovative and competent health care models by partnering with CHCs, PCAs and FQHCs to provide quality, and inclusive care for older adults



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# Health Center Resources Clearinghouse

- This comprehensive website provides easy access to a broad framework of resources, tools, and information developed by the National Cooperative Agreement (NCA) organizations, and additional partners soon! Check it out at [www.healthcenterinfo.org](http://www.healthcenterinfo.org)



# Session Leader



**Lynn Hallarman, MD**

Director of Palliative Care Services, Stony Brook University Medical Center; Health Policy Congressional Fellow, US Senate Committee on Finance

# **Introduction to Palliative Care**

**Lynn Hallarman, MD**

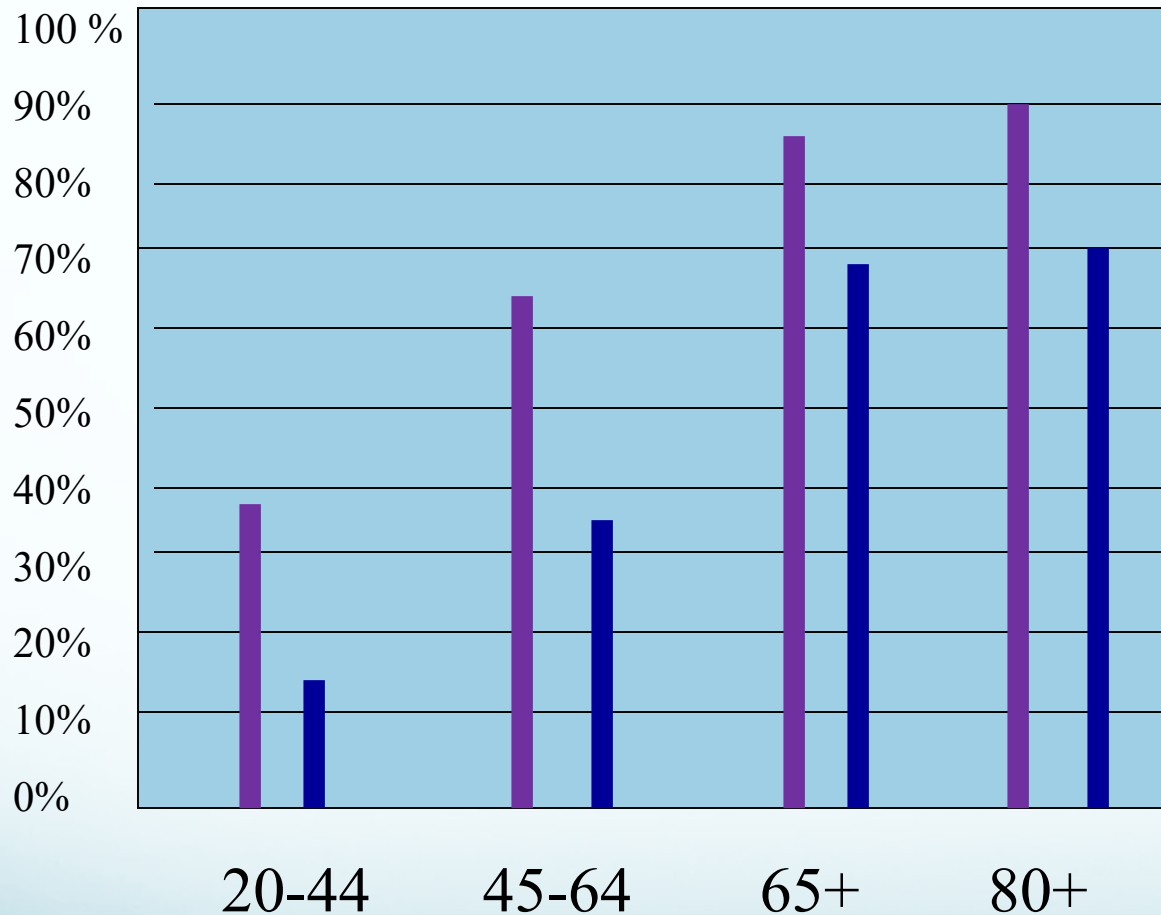
# How Americans live and die has changed dramatically in the past century...

- The advent of antibiotics at the turn of the previous century (1900)
- Astonishing medical advances in the past few decades
- Public Health Initiatives

## **These factors have led to:**

- A shift from short sudden “acute” illness to prolonged illness
- An exponential increase in life expectancy with a concurrent explosion of elders with complex and advanced illness

# Prevalence of Chronic Disease in the Elderly



# The Baby Boom Generation:

79 million strong!

*...As of January 1<sup>st</sup> 2011 the baby boom generation turns 65 at the rate of 1 every eight seconds....*



## Chronically Ill, Aging Population Is Growing!

- The number of people over age 85 will double to 10 million by the year 2030.
- The 23% of Medicare patients with >4 chronic conditions account for 68% of all Medicare spending.

US Census Bureau, CDC, 2003. Anderson GF. NEJM 2005;353:305 CBO  
High Cost Medicare Beneficiaries May 2005

Palliative  
from Latin *palliare*,  
to cloak

# How Does Palliative Care Differ from Hospice?

- Non-hospice palliative care is appropriate at any point in a serious illness. It can be provided at the same time as life-prolonging treatment. *No prognostic requirement, no need to choose between treatment approaches.*
- Hospice- a form of palliative care provides care for those in the last weeks-few months of life. Patients must have a 2 MD-certified prognosis of <6 months + give up insurance coverage for curative/life prolonging treatment in order to be eligible.

# What is the focus of Palliative Care Interventions?

✓ Inadequate  
treatment of pain  
and symptoms

✓ Poor understanding  
of prognosis

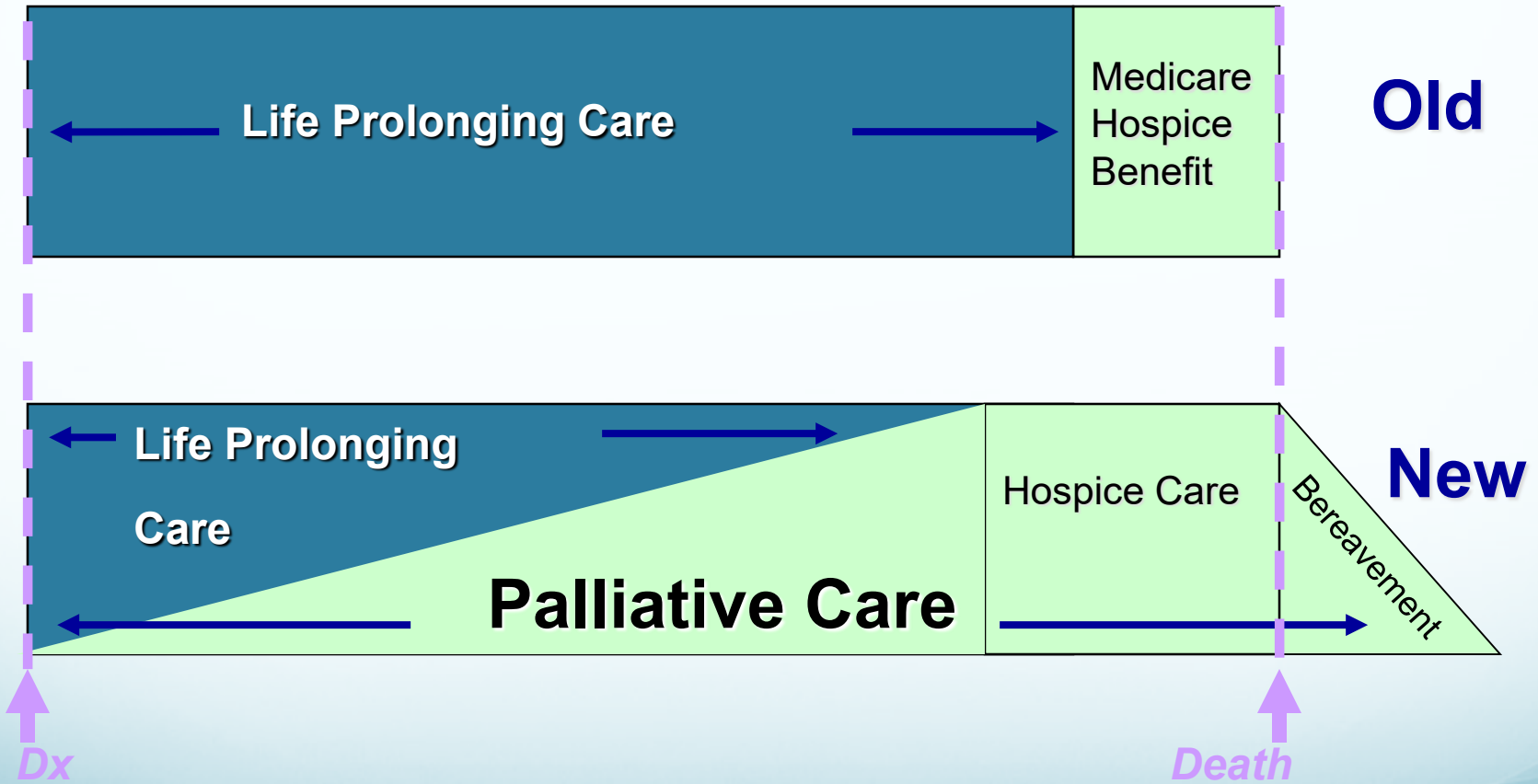
✓ Lack of information  
about treatment  
options and/or  
resources for  
support

✓ No goals of care  
discussion or  
advance care  
planning decisions  
documented

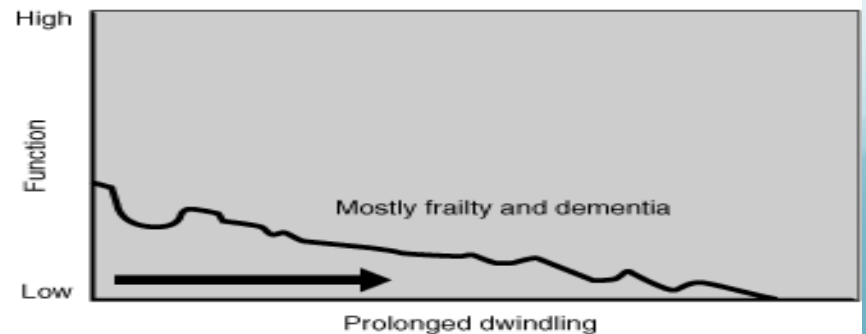
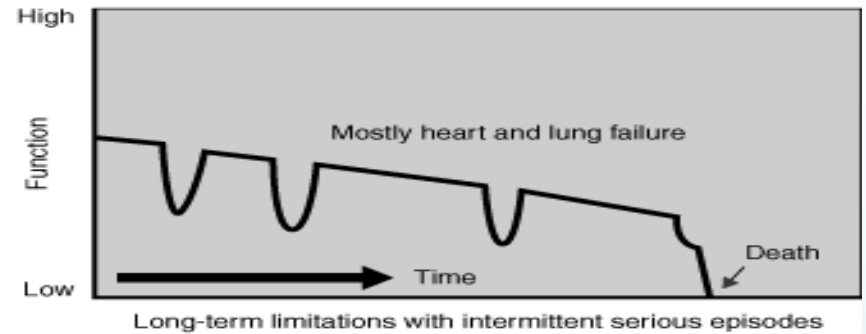
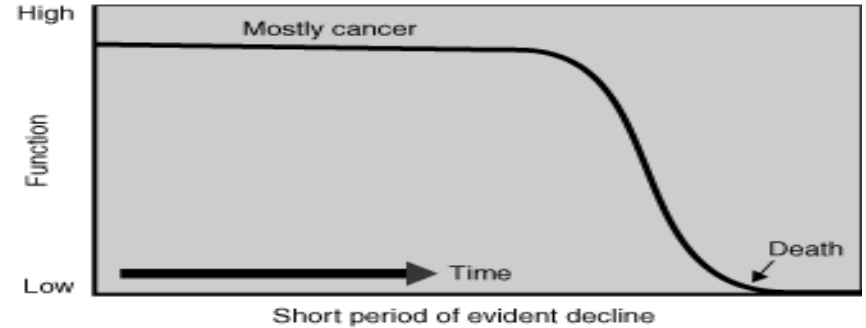
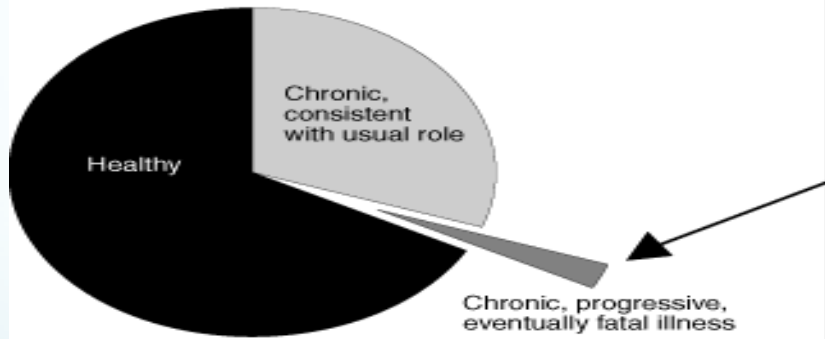
✓ Patient/caregiver  
stress and burden

✓ Undue financial  
burden from medical  
expenses

# Conceptual Shift for Palliative Care



# Is the Patient with a Serious Illness in their lives the way they want to be?



## **The Surprise Question:**

*Would you be surprised if this patient died  
within the next year?*

*Within the next 5 years?*

# Does your Community Health Center have a standard approach to screening for palliative care need?

## Validated Screening Tools

Many organizations have tools for evaluation of pain, symptoms, and mental health. Examples of these validated tools appear below.

| Assessment Tool                            | Description / Purpose:   |
|--|--|
| ESAS: Edmonton Symptom Assessment Scale    | Assesses 9 common symptoms   |
| NCCN Distress Thermometer and Problem List | Measures distress on a scale of 0 to 10. Elicits practical, family, emotional, spiritual, and physical problems. |
| ZBI-12: Zarit Burden Interview             | Screens for family and caregiver burden  |
| PHQ-4                                      | Brief screening tool used for depression and anxiety   |

# When to Seek Help

EARLY!

PROACTIVELY!



BEFORE A CRISIS!

# Palliative Care

## Levels of Expertise

- **Primary Palliative Care – Integrative Approach**

Basic knowledge and skills for all physicians

- **Specialist Palliative Care – for patients with complex needs**

Physicians with specialized training and experience in the care of seriously ill and dying patients

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

# Identifying patients/families for palliative care consultation **red** flags:

Does the patient have a serious illness?

*And...*

- **Uncontrolled symptoms?**
- **Multiple hospitalizations combined with poor social support and functional decline?**
- **Poor understanding or insight?**
- **Distressed families in conflict with the doctors/team members/other family members?**



# **Where to Start?**

## **Community Hospice Partnerships**

# Discussion Questions

# Is this a palliative care patient?

- SM is a 63 yo man with COPD. He is on maximum disease modifying therapies in addition to home oxygen.
- He lives with his wife and plays cards with his friend once a week.
- He took a trip recently to see his granddaughter
- He has been in the hospital 2x for COPD exacerbation this past year.

# Is this a palliative care patient?

- *A 63 year old Hispanic female with a history of breast cancer dx 7 years ago was admitted 3 months ago with severe low back pain and leg weakness. She is subsequently found to have an metastatic disease to the spine with impending cord compression. Emergent spinal surgery and follow up chemotherapy is recommended. She spent 6 weeks in an “acute rehabilitation center” for recovery from back surgery, she is a no show for her initial oncology appointment.*
- *You are now meeting her 3 months after this initial admission for the first time in her neighborhood community health center where she is being seen in follow-up after an evaluation in a local emergency room for worsening back pain. The patient brings imaging records from the emergency room which shows metastatic disease progression in her spine and femurs bilaterally without acute findings. ( such as a cord compression or fracture) Spanish is her first language, but she speaks some English.*

# Marianna's Real Story

- *Marianna is a 62 yo. women, single mother of two teenage children, and the sole wage earner for her family. She works as a hairdresser and is not paid when she is not at work. She has basic health care coverage with a large deductible and co-pays through her job. She relies on the public bus for transportation and has only intermittent help from her mother to babysit for her young school age children. Since being discharged from the rehab, she has had ongoing pain in her back and is unable to walk more that a few feet. She currently relies on a credit card and a small amount of savings to pay for food and rent since she is still not able to return to work full-time yet. She cannot afford the co-pays for the pain medication she was prescribed in the rehab. She attempted to take a taxi to her follow-up visit but they showed up 45 minutes late and she missed the appointment. She has a strong faith community but has not been able to attend religious services.*