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Supportive and Palliative Care for the Primary Care Physician

Announcer:

Welcome to CME on ReachMD. The following CME activity is provided by TOPEC and the Roswell Park Comprehensive Cancer Center through the generous support of BlueCross BlueShield of Western New York.

Dr. Case:

Hi there! I'm Amy Case. I'm a physician at Roswell Park Cancer Institute, and I serve as the Chair of the Supportive Care Department, the Chief of the Palliative Care Program, and Associate Professor of Medicine at the Jacob School of Medicine in Biomedical Sciences. Today, we're going to speak about supportive and palliative care for the primary care physician. Our objectives today: We hope that by the time you've watched this video that you would be able to describe the differences between supportive and palliative care and hospice; to list 3 ways supportive and palliative care may help your patients and their families; and to also demonstrate what you can do for your patient prior to consulting supportive and palliative care; judging when it is an appropriate time to call for a palliative care consult.

So, what is supportive and palliative care? Many people think they know what this is, but I'm going to just point out a few details about what we do. We work on a team and our main focus is we are experts and we're trained... and our main focus is helping patients and their families manage serious and chronic illness. Palliative care means "to make feel better." To palliate means "to improve symptoms and quality of life." We work on a team, and the approach to medical care is interdisciplinary with the following domains being important to what we do. Physical symptoms: Expert trained physicians, nurse practitioners, and nurses evaluate and treat physical symptoms such as pain, shortness of breath, constipation, or nausea. Psychosocial support: Social workers, psychologists work with us, offering family counseling to help cope with stressors related to having cancer or other life-threatening illnesses. And spiritual support: We have chaplains on our team and we feel that it's important that every patient receive all aspects of these domains of care, not just one. Another focus of what our team does is looking at healthcare planning and compassionate communication with patients and families, especially when tough decisions need to be made.

So, how does supportive and palliative care differ from hospice or end-of-life care? Well, palliative care is sometimes confused with hospice care, and people are reluctant to elect for it, just because they feel that it might be perceived in a negative way. But I'd like to say that palliative care is provided at any stage of the illness, and anyone with a chronic or serious illness can have palliative care. Hospice care, on the other hand, is intense palliative care that really focuses more on the terminal illness, specifically in the last 6 months of life, where usually the goal of care is no longer curative, and the treatment has ended. Palliative care includes hospice care, but not all palliative care is hospice care, so it's a continuum; palliative care ideally starting early in the trajectory of the illness and, as we go along, hospice care to be given at the end of life. Palliative care may indeed be provided with curative treatments and that is the ideal, because we'd rather get involved earlier with our patients anyway, and so, at that time the patient is still undergoing curative and restorative treatments.

So, how can palliative care help my patients with advancing illness? Our team works with the patient and their families pretty thoroughly to develop a plan of care focused on their needs and goals. We spend a long time with every patient. It's different than primary care where you have 15 minutes per visit. We spend an hour with our patients when we initially see them. We get to know them as a

person. We meet their family members. And followup visits are a half hour. So, our day is... we really get more in depth with the patients and we really find out what's important to them. We're able to take the time to listen, explain things, answer questions, help patients cope with having cancer or other life-threatening illnesses, and when they're undergoing treatments many of these questions come up, but remain unanswered for them. Randomized controlled trials have shown that significant survival benefits exist for patients who receive palliative care, in addition to oncology treatment, earlier in the course of their disease. Numerous studies also show that patients who receive palliative care have an improved quality of life, improved satisfaction, their pain is better controlled, and they have less depression. All of these things increase our satisfaction of our patients and families, and we often see that our satisfaction scores and things improve when palliative care is involved. And I included here, on the slide, some references which will be on the last slide in more detail.

So, many people may ask, what they should do prior to calling a supportive and palliative care consult, and this is actually called primary palliative care. I think that most primary care providers should be well-equipped to manage basic pain and non-pain symptoms, to do an assessment of pain and other symptoms, and to be able to manage that, and to know when to call an expert for help. Depression and anxiety are other common symptoms that can occur that can be managed by a primary care provider. Specifically, when initiating or prescribing opioid management for pain, it's important to refer to the literature about how to screen for those who might be at risk for misuse of opioids or addiction. There are several tools out there that can be accessed to determine whether someone might be at risk for this, and then, once initiated, to follow the CDC guidelines, as far as opioid prescribing, using universal precautions when using controlled substances, and monitoring for example, with urine toxicology screens or random pill counts, is very important. And I think most primary care providers should be comfortable just getting the conversation started. And what do I mean by the conversation? It's important to discuss with our patients and families what to expect if they want to know, what is important to them, and to review with them their fears and their worries moving forward as their disease may progress. It's very important to review with the patient the estimated prognosis and treatment goals; what are the benefits of the treatment, and what are the burdens of the treatment? Does it fall in line with the goal of the patient? And once the patient knows their prognosis, or what their prognosis might be, they can better make these decisions moving forward. Physicians and nurse practitioners, primary care physicians, we're often uncomfortable discussing prognosis, and I think that the literature shows that patient's families often want to know this information. It's imperative to ask them before disclosing it, but generally they are more reassured and more satisfied when they have more information. And finally, discussing their wishes as far as code status and advanced directives, should they ever have a crisis or an emergency, and be nearing the end of their life. There are a few documents I want to share with you. One of them is an actual advanced directive. In New York State, we have the MOLST form, the Medical Orders for Life-Sustaining Treatment, and some states have something called a POLST form. And these generally review the wishes of the patient, and these are important for physicians and providers to be familiar with, to be able to be competent to fill one of these out. Generally, it's, in New York State, it's filled out by a physician with a license. And these are important to review with our patients and their families. And it talks about our wishes about resuscitation and other treatment modalities. Along with that, we often give our patients something called *The Conversation Starter Toolkit*, put out by the Institute for Healthcare Improvement and the Conversation Project. This is a really well-designed kit and worksheet that the patients and families can go through together. I often assign it as homework when I initially start a conversation with the patient or family. You can print these out online or you can order them to be printed, and they're pamphlets that ask provocative questions to patients' families about their wishes, their goals, and their values about their healthcare. And when they fill these out, it really helps them come back later and be able to answer your questions about their wishes and goals moving forward. So, when do I call for a specialty supportive and palliative care consult? Any patient who has refractory pain or other symptoms, that when you're prescribing pain medications, and they don't seem to be working, or the patient's pain is not controlled, it's a good idea to maybe ask us to be involved. A patient with complex depression, anxiety, or grief, those who may be having existential or spiritual distress, it's really our palliative care service, palliative care services can help with, especially the social work and the psychology components of our team, and the chaplains, can be more involved with these patients. Consider an early referral, rather than waiting until too late to call us. And anyone who may have advanced-stage cancer, a non-cancer advancing illness such as CHF or COPD, those patients who may live far away who may have limited social support, it's nice to have an interdisciplinary team involved with these patients, and studies have shown that when a team-based care is employed, often they can avoid ED visits, hospitalizations, and spend more time at home, which can further improve their quality of life. So, we like to establish rapport, to get to know the families and the patients sooner rather than waiting until a crisis occurs, or that it's too late. Any patient or family conflict, or even in the inpatient setting when we have staff that are disagreeing, different healthcare teams that may have conflict, difficulty coping, and just the word "difficult" in general, when a patient or family is labeled as difficult, that's really not appropriate to do. I think that generally patients and families who are grieving and suffering tend to come off that way, but generally what they need is just a little bit more TLC, or tender loving care, as we say, and the palliative team is expert in providing that type of care for the whole person. And if you have questions about when to refer to hospice or other home-based programs, and eligibility criteria for these programs, the palliative care consult, palliative care team may be able to help with that.

So, in summary, palliative care is an interdisciplinary, team-based approach to care, focused on improving quality of life for our patients and families, offering relief of physical, emotional, and spiritual suffering. Palliative care is given along with aggressive medical treatments, which may be provided anytime during a chronic illness, compared with hospice care, which is primary focused on end-of-life care, in the last 6 months of life. The primary care team should provide basic primary palliative care, prior to calling a consult. And the palliative care consultation team may be considered earlier in the disease trajectory, rather than later, for the patient and family who may have complex physical, psychosocial, or spiritual needs. And the last slide here, are some references that you can refer to in the literature. And if you have any questions, my name is Dr. Amy Case, from Roswell Park Cancer Institute, and please feel free to contact me, Amy.Case@RoswellPark.org. Thank you.

Announcer:

The preceding activity was provided by TOPEC and the Roswell Park Comprehensive Cancer Center through the generous support of BlueCross BlueShield of Western New York.

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