Hospital Medicine and the Role of Primary Palliative Care

All-City Palliative Care Lecture Series 3/3/2023

Objectives

1. Provide an overview of Hospital Medicine
2. Explore concept of “primary palliative care” as it pertains to Hospital Medicine
3. Discuss role for primary vs. specialty palliative care for patients admitted to the hospital

When poll is active, respond at **PollEv.com/caralevin179**

Text **CARALEVIN179** to **22333** once to join

What is Hospital Medicine?

- Physicians and non-physicians clinicians who care for patients admitted to the hospital
- Typically trained in internal medicine, general pediatrics or family practice
- Shift work – 8-12 hour shifts
- Manage day-to-day care of all patient care needs, including diagnosis, treatment, procedures
- Support safe transition of patient care from the hospital to the community
- Primary team and consulting on patients admitted to non-medicine specialties

History of Hospital Medicine & Palliative Care

1974: Balfour Mount coins term "Palliative Care"

1996: Bob Wachter coins "Hospitalist"

1996: Academy of Hospice Physicians -> AAHPM

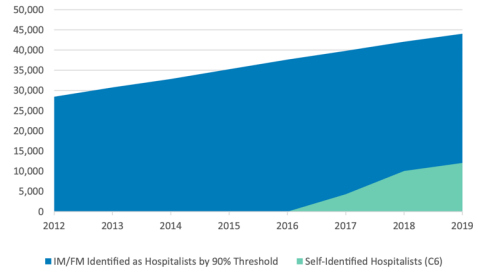
1997 Society

1997: IOM "Approaching Death: Improving Care at the end of life

1999: IOM "To Err is Human"

2004: clinical practice guidelines for quality palliative release

2006: ABMS and ACGME recognize palliative care as its own subspecialty



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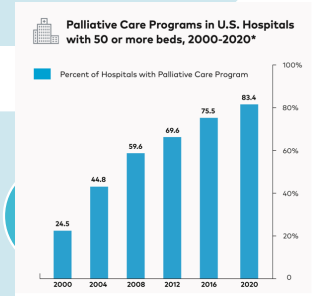

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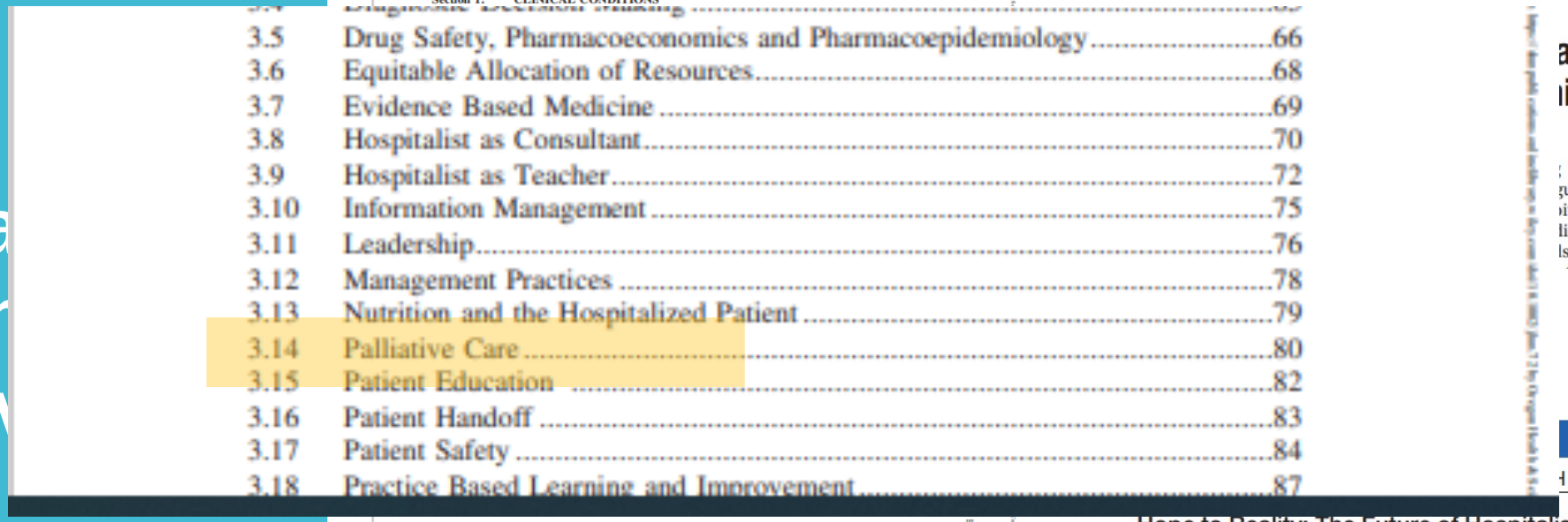

THE CORE COMPETENCIES
IN HOSPITAL MEDICINE
A Framework for Curriculum Development
by the Society of Hospital Medicine

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Section 3: HEALTHCARE SYSTEMS

EDITORIAL

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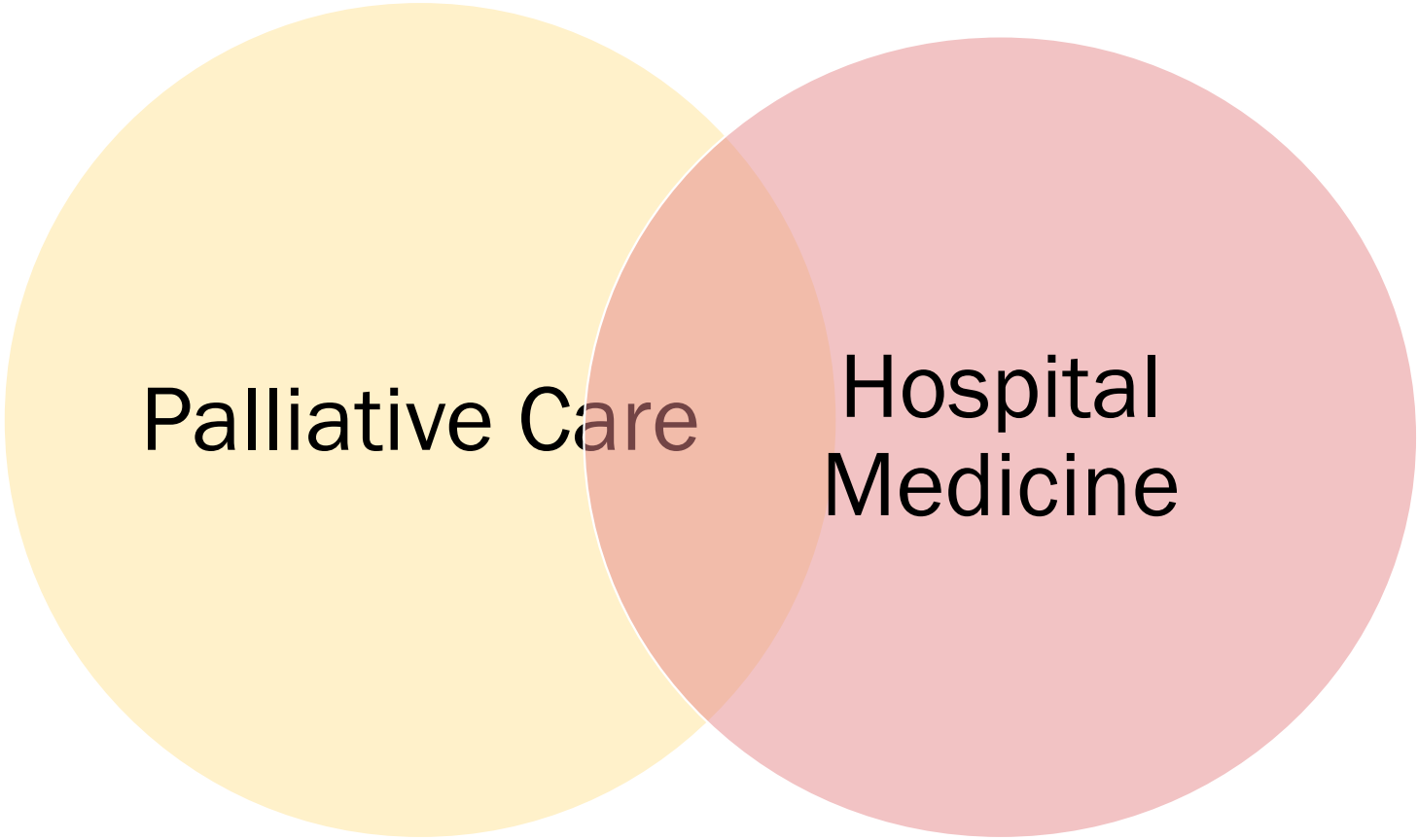
ls recognize the need to develop systems to

www.journalofhospitalmedicine.com
EDITION OF JHM

Hope to Reality: The Future of Hospitalists and Palliative Care

Steven Z. Pantilat, MD, MHM, FAAHPM*

Department of Medicine, University of California, San Francisco, San Francisco, California.


Palliative Care
Hospital Medicine

Case 1: AL

- 62 yo with systemic AL Amyloidosis (gastrointestinal, cardiac, renal)
- Malignant hematology attending: worried about his about ability to tolerate treatment given functional/nutritional status, lack of social support
- Hospitalist Care:
  - Adjusted nausea medications
  - Working on SW support
  - Starting to talk to him about understanding of illness/hopes/worries about future, acceptable QoL
- Day 3: Call from RN
  - “I really think he needs a palliative care consult”

Question #1

Primary PC (PPC) or Subspecialty PC (SPC)

Loading...

Hospitalist Threshold for PC consults

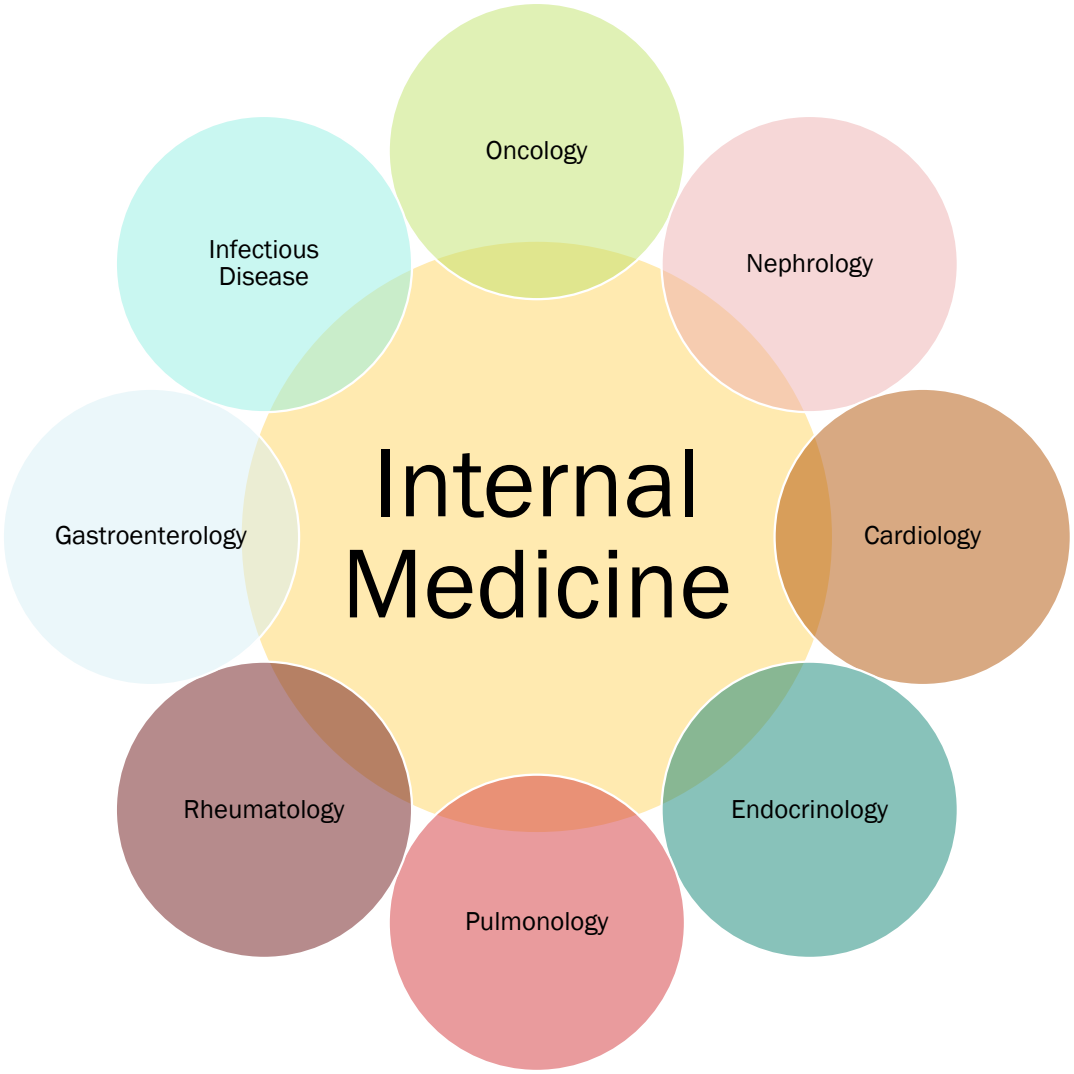
"If I'm going off service, for continuity" (Legacy Meridian Park)

"I feel it's really cultural – when I worked at a Kaiser facility [in California] we would consult for all the goals of care for efficiency, but now I rarely do" (Portland VA Hospital)

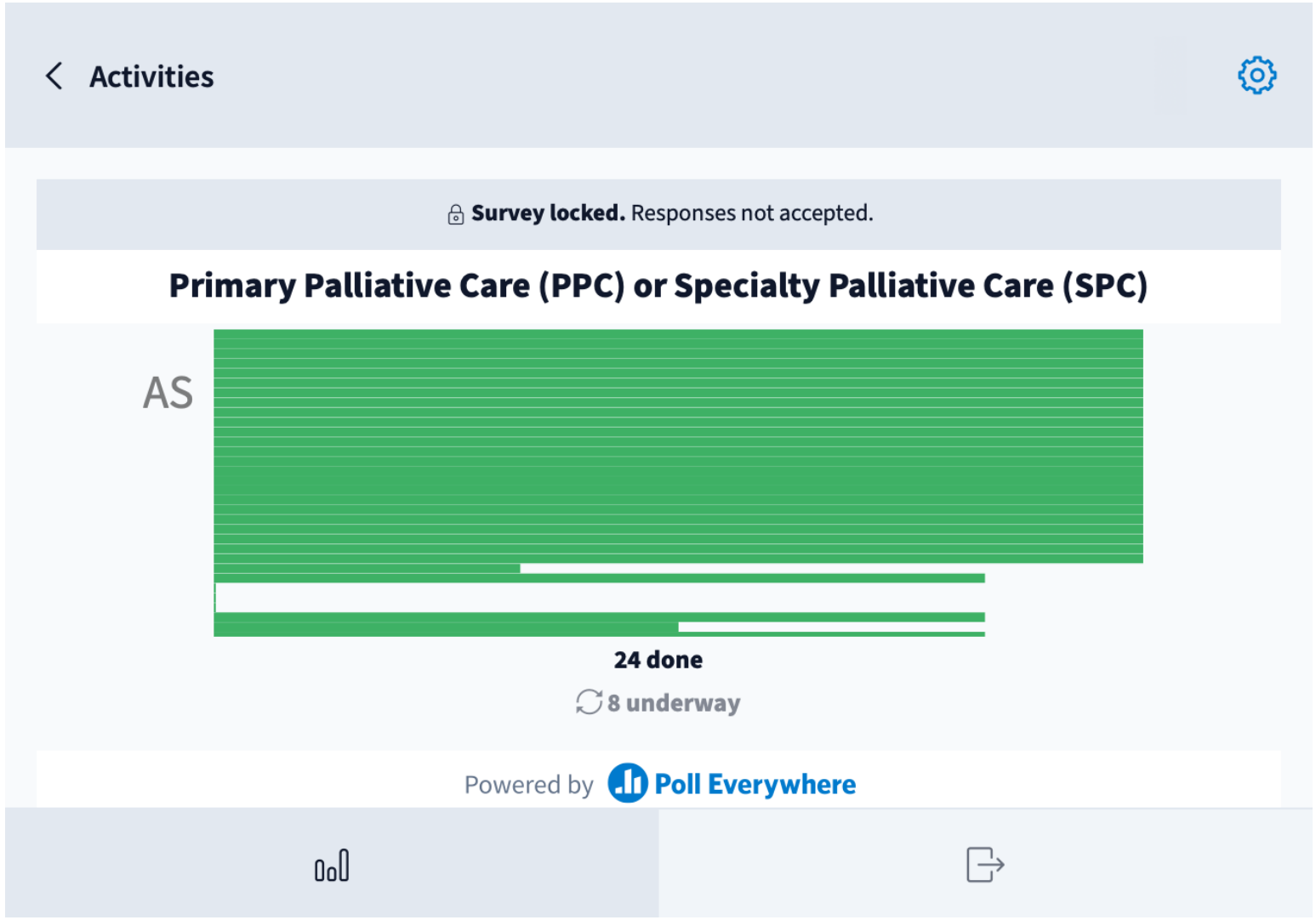
"I mostly do it when I'm not making progress and I know the person taking over for me is going to be wondering why I didn't consult already" (Providence St. Vincent's)

"It's never wrong to consult palliative care, especially if a hospitalist isn't good at those conversations. I often wish the person before me had when I'm taking over" (OHSU)

Generalist care vs. Subspecialty care



Primary Palliative Vs. Specialty Palliative Interventions



Primary PC vs Subspecialty PC

Representative primary and subspecialty palliative care skills in each domain

Primary palliative care skills	Subspecialty palliative care skills
Assessment/treatment of physical symptoms	
▪ Basic pain management ▪ Basic management of other physical symptoms ▪ Basic use of adjuvant pain relievers ▪ Equianalgesic dose conversion	▪ Management of refractory pain ▪ Management of other refractory symptoms ▪ Methadone transition when large doses of opioids are being used ▪ Patients with addiction problems and serious illness
Psychological, social, cultural, and spiritual aspects of care	
▪ Basic management of depression/anxiety ▪ Exploration of psychosocial suffering ▪ Basic exploration of spiritual and religious views ▪ Basic exploratory family meeting	▪ Management of more complex depression, anxiety, grief, and existential distress ▪ Severe religious/spiritual suffering
Serious illness communication issues	
▪ Exploring patient goals in light of circumstances ▪ Making recommendations about code status ▪ Seeking consensus among treating professionals ▪ Seeking consensus among the patient and family	▪ Dying patients who want "everything" ▪ Major conflict among family members ▪ Major conflict among treating teams ▪ Requests about assisted dying
Care coordination	
▪ Coordinating care among specialists ▪ Clearly defining the primary treating team ▪ Managing transitions to hospice care ▪ Managing transitions out of the hospital	▪ Transition to hospice with no clear provider ▪ Patient/family major resistance to discharge ▪ Conflict with the designated outpatient provider

Adapted from: Quill TE, Abernathy AP. Generalist plus specialist palliative care - creating a more sustainable model. N Engl J Med 2013; 368:1173.

Is PPC as good as SPC?

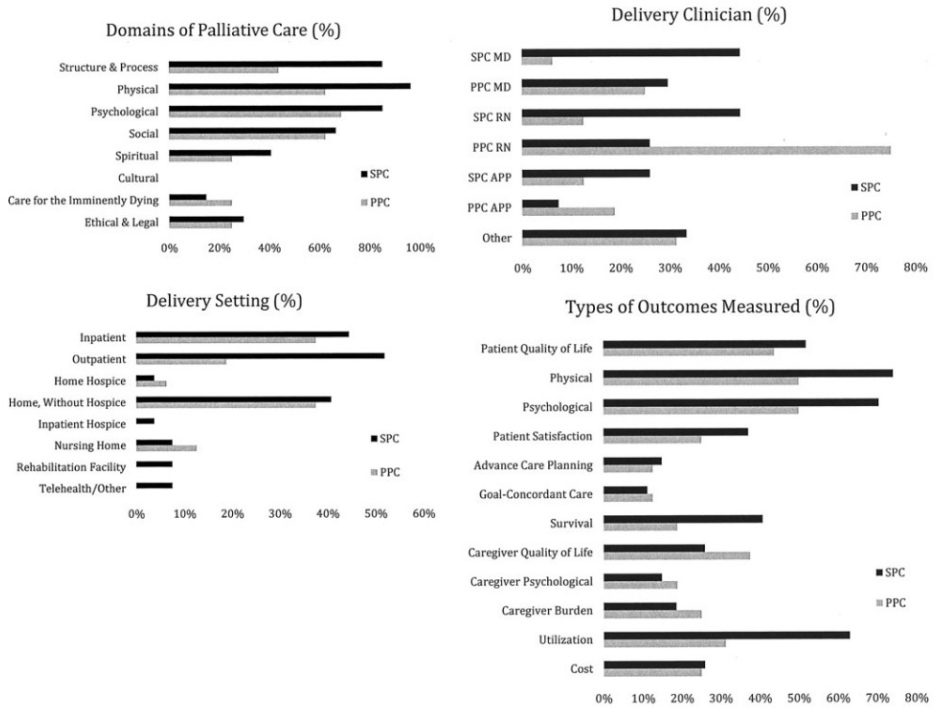
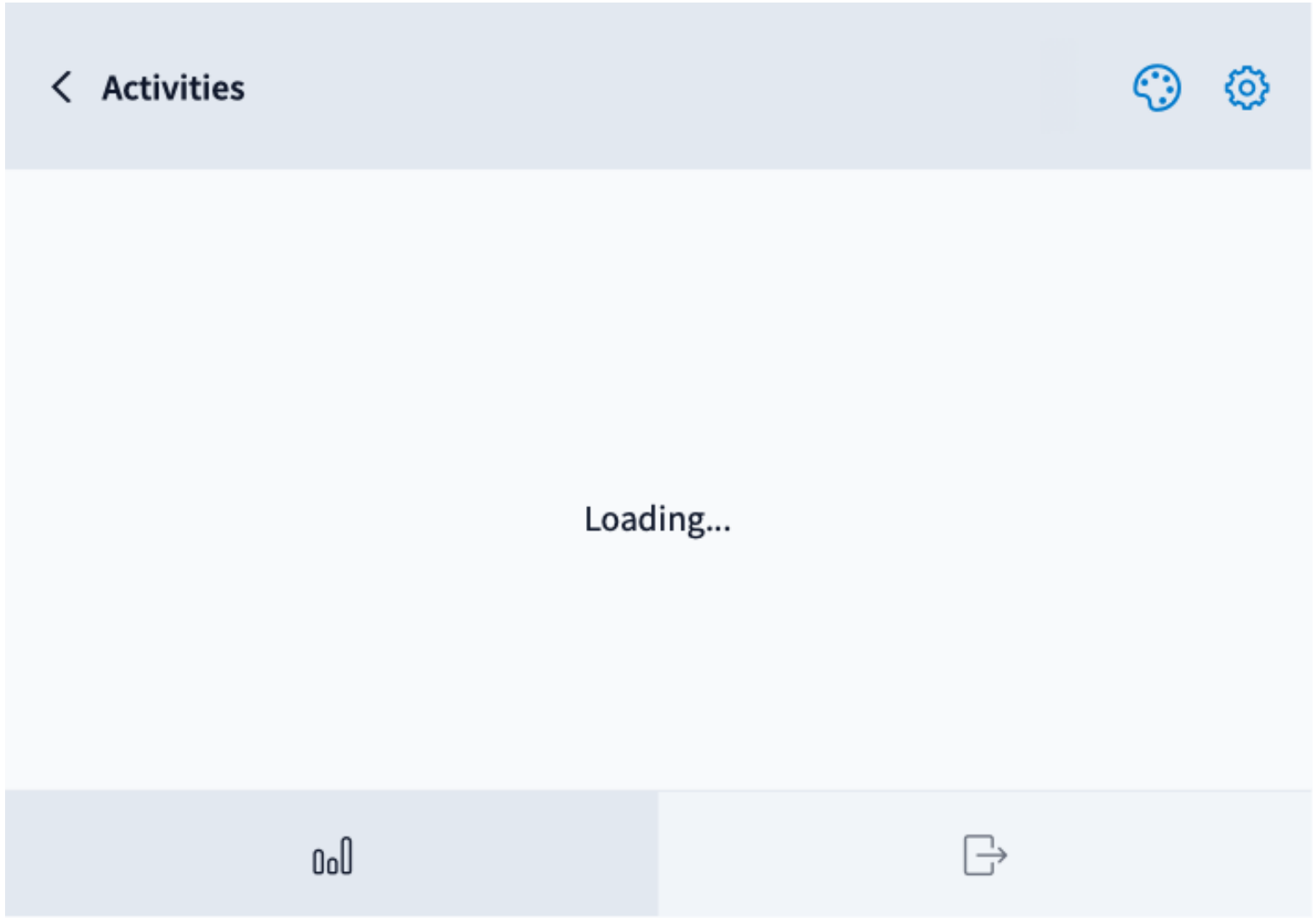


FIG. 1. Palliative care elements, delivery setting, delivery clinician, and types of outcomes measured in trials of SPC and PPC by percent. PPC, primary palliative care; SPC.

"Compared to PPC, SPC interventions were more comprehensive, were more likely to be delivered in clinical settings by specialty physicians, and were more likely to address physical and structural elements"

Ernecoff, N. C., et al. (2020). "Comparing Specialty and Primary Palliative Care Interventions: Analysis of a Systematic Review." J P
389-396.

Barriers to primary palliative care in the hospital



Barriers to Serious Illness Care for Hospitalists

TABLE 3. PARTICIPATING HOSPITALISTS' CONFIDENCE TO PERFORM SERIOUS ILLNESS COMMUNICATION TASKS

Task	*Level of confidence, n[a] (%)*	
	Not at all confident/not very confident/neutral	*Confident/ very confident*
Discuss goals of care with a patient or family	22 (7)	288 (93)
Discuss a "Do Not Attempt Resuscitation" order with a patient or family	26 (8)	285 (92)
Convey serious news to a patient or family, for example, an incurable diagnosis	32 (10)	279 (90)
Describe comfort-focused care to a patient or family	33 (10)	278 (90)
Discuss prognosis with a patient or family	40 (13)	271 (87)
Describe hospice care to a patient or family	46 (15)	263 (85)
Discuss stopping life-sustaining therapies with a patient or family, for example, mechanical ventilation, dialysis	83 (27)	(74)
Complete a physician or medical order for life sustaining treatment (POLST/MOLST)	101 (33)	211 (67)
Respond to patients or families who have not accepted the seriousness of a patient's illness	127 (41)	183 (59)
Counsel patients or families who request medically inappropriate treatments	132 (43)	179 (57)
Manage conflict among patients or families and healthcare providers	154 (50)	157 (50)
Discuss religious or spiritual issues with a patient or family	177 (57)	133 (43)
Use self-care techniques to prevent burnout and compassion fatigue	193 (62)	117 (37)

[a]Total responses for these items ranged between 309 and 312.

TABLE 4. BARRIERS TO PARTICIPANTS' ABILITY TO HAVE HIGH-QUALITY DISCUSSIONS ABOUT PROGNOSIS AND GOALS OF CARE WITH SERIOUSLY ILL PATIENTS

Barrier	*Extent of barrier, n[a] (%)*	
	Not a barrier/ minimal barrier	*Moderate barrier/ extreme barrier*
Lack of time	75 (24)	231 (76)
Unrealistic expectations about prognosis from other physicians, for example, PCPs and specialists	85 (28)	219 (72)
Lack of prior prognosis and goals of care discussions as outpatient	101 (33)	206 (67)
Difficulty finding prior goals of care discussion details in the medical record	113 (36)	191 (64)
Frequent handoffs between hospitalists	134 (43)	172 (57)
Lack of a long-term relationship with patients	140 (45)	166 (55)
Differences in culture among patients/families and clinicians	185 (60)	121 (40)
Negative reactions from patients and families	187 (61)	119 (39)
Language barriers between patients/families and clinicians	193 (63)	
Lack of clarity about hospitalists' role in these discussions	220 (72)	86 (28)
Inadequate training	217 (72)	84 (28)
Emotional toll of goals of care discussions	221 (72)	85 (28)
Lack of support from hospital leadership	229 (75)	76 (25)
Insufficient access to palliative care consultation	241 (79)	63 (21)

[a]Total responses for these items ranged between 301 and 307.

Rosenberg, L. B., et al. (2017). "Confidence with and Barriers to Serious Illness Communication: A National Survey of Hospitalists." J Palliat Med **20**(9): 1013-1019.

Varying levels of training for primary palliative skills

- Emergency Medicine, Internal Medicine, Family Medicine are the only specialties with published primary palliative care educational competencies

Surgeons vs Medical Oncologists vs Pulmonary Critical Care

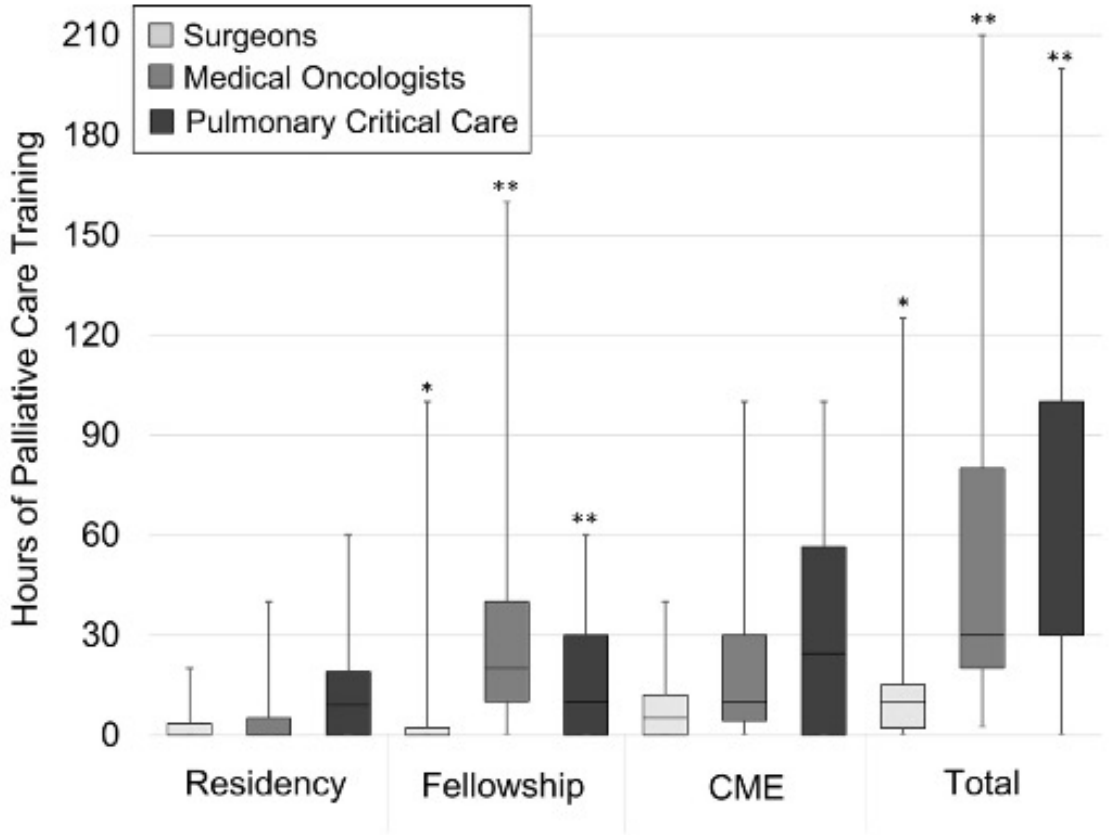
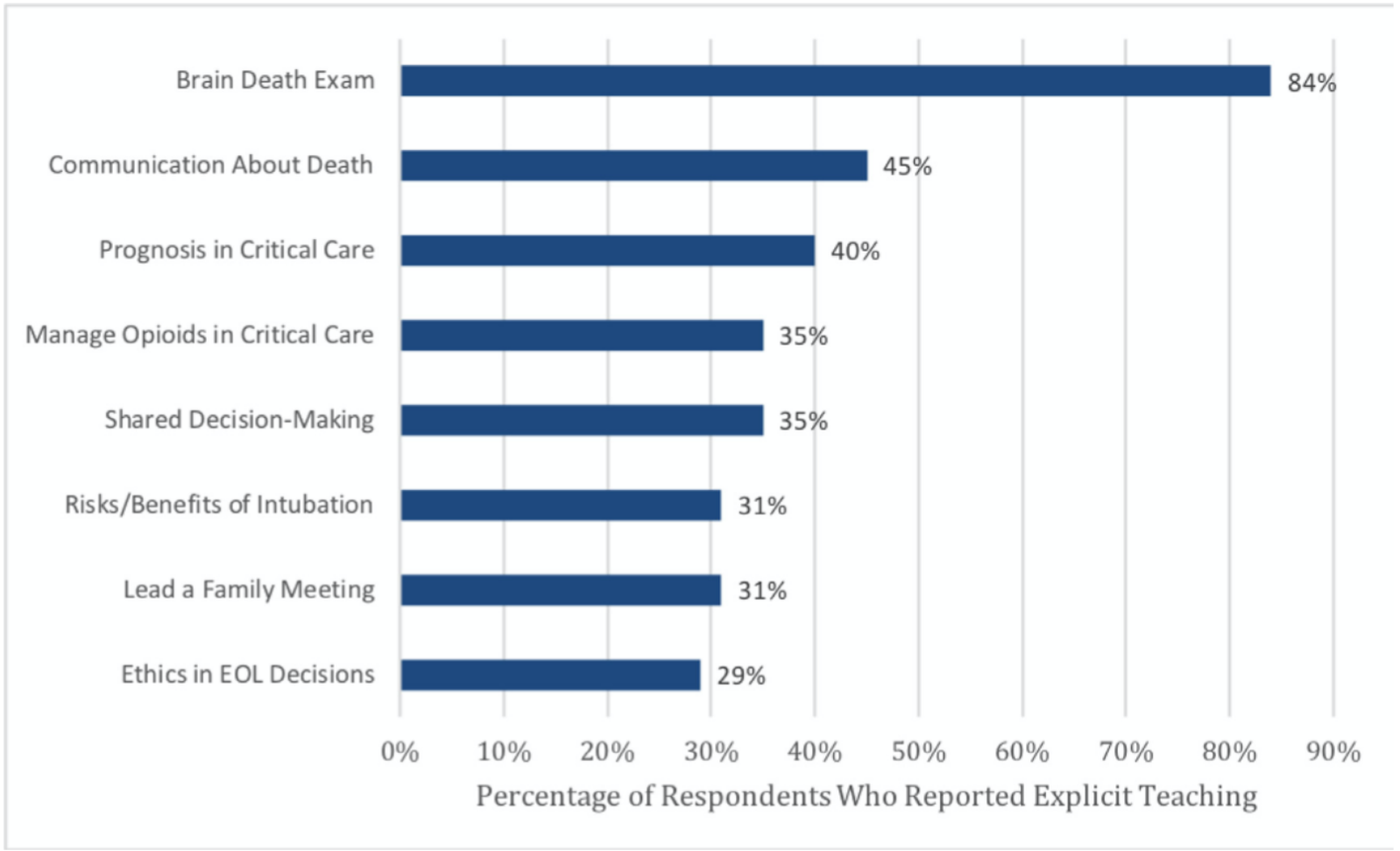


Fig. 1. Comparison of hours of palliative care training by specialty. Surgeons reported less palliative care training during fellowship and in total compared with medical oncologists and pulmonary critical care physicians (* vs ** $P < .05$). *CME*, continuing medical education.

Bateni, S. B., et al. (2018). "Palliative Care Training and Decision-Making for Patients with Advanced Cancer: A Comparison of Surgeons and Medical Physicians." Surgery.

Neurosurgery Trainees



Miranda, S. P., et al. (2019). "Palliative Care and Communication Training in Neurosurgery Residency: Results of a Trainee Survey." J Surg Educ **76**(6): 1691-1702.

Hepatology Transplant Fellows

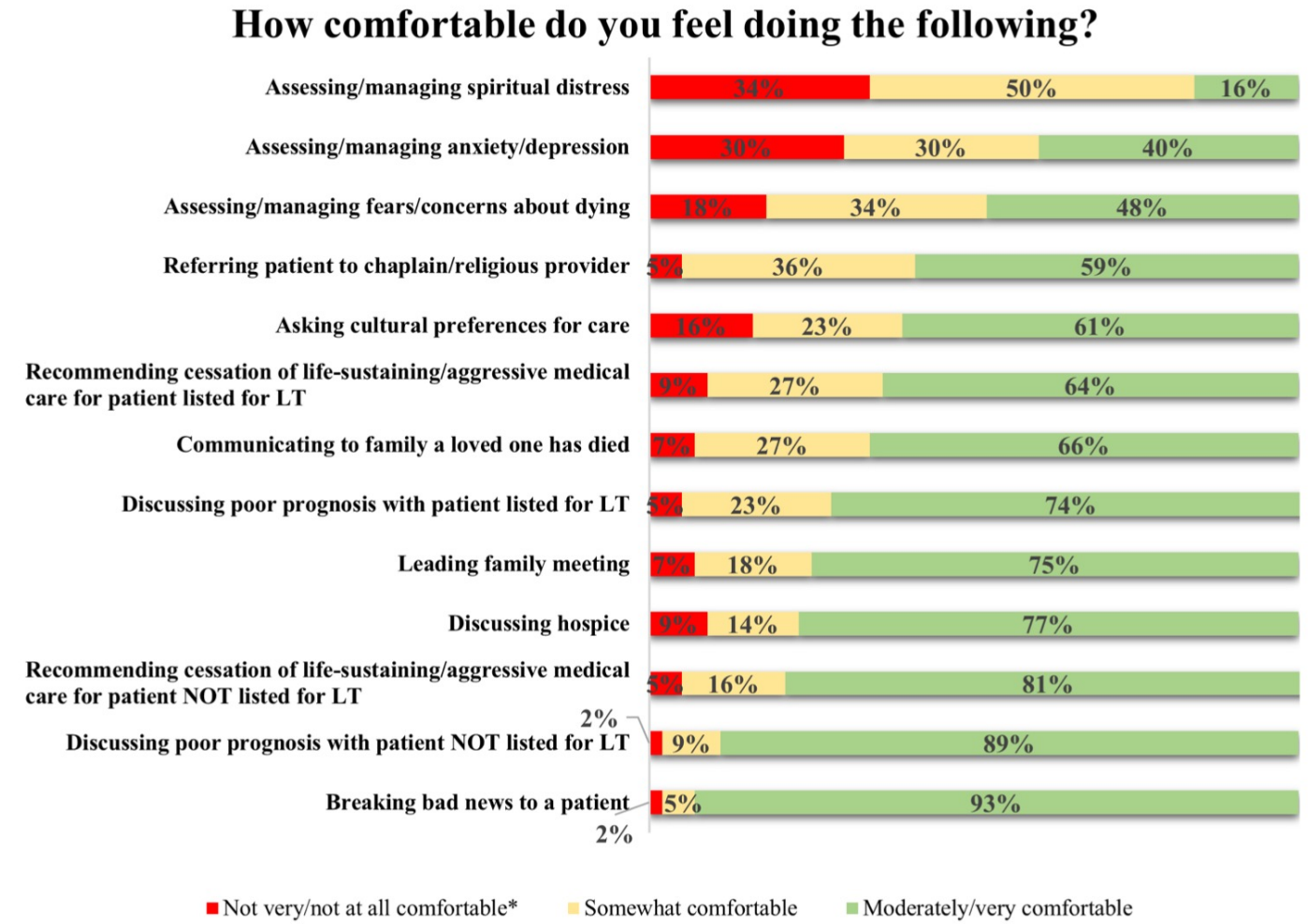


FIGURE 3 Hepatology fellows' perceived comfort levels with palliative care provision. LT, liver transplantation

Whitsett, M. P., et al. (2022). "Palliative care experience and perceived gaps in training among transplant hepatology fellows: A national survey." Hepatol Commun **6**(7): 1680-1688.

Role for primary vs specialty palliative care in the hospital

Great need for serious illness care in hospitalized patients

Specialty palliative care is a limited resource

Unclear ability for to primary palliative care to meet those needs

Hospitalists could take a larger role in delivery of PC

- Hospitalists are optimally situated to serve as primary palliative care providers
- Expected competency endorsed by Society of Hospital Medicine
- Resources and curriculum
- Aligned goals

TABLE. **Palliative Care Quality and Cost Outcomes**

Value Equation	Outcome	How Does Palliative Care Help?	Evidence
Higher quality	Patients live longer with higher quality of life	More communication, improved symptom management	Temel, *N Engl J Med*, 2010[5]
	Greater family satisfaction with quality of care	More communication, greater comfort, preferences met	Casarett, *Arch Int Med*, 2011[18]
	Improved pain, symptoms, and satisfaction with care	Symptom management and multidisciplinary team	Bernacki, *JAMA Intern Med*, 2014[19]; Wright, *JAMA*, 2008[20]
Lower cost	Lower costs per day	Goal-concordant care	Morrison, *Arch Int Med*, 2008[15]
	Shorter hospital length of stay	Improved symptom management, goal-concordant care	May, *Palliat Med*, 2017[21]
	Shorter ICU length of stay	Goal-concordant care	Norton, *Crit Care Med*, 2007[22]
	Fewer ICU admissions	Improved symptom management, goal-concordant care	Gade, *J Palliat Med*, 2008[23]
	Reduced readmissions	Symptom management and goal-concordant care with use of standardized triggers for palliative care consult	Adelson, *J Oncol Pract*, 2017[24]
	Fewer hospital admissions and inpatient deaths	Better symptom management and higher hospice utilization with in-home palliative care	Lustbader, *J Palliat Med*, 2016[25]
	Fewer 30-day readmissions	Referral to outpatient support (palliative care or hospice)	Enguidanos, *J Palliat Med*, 2012[12]

NOTE: Abbreviation: ICU, intensive care unit.

Hospital Medicine increases opportunities to reach patients with serious illness

- Consults for medical comorbidities
- Preoperative assessments
- Co-management agreements – orthopedics with fragility fractures, advanced heart failure, interventional GI procedures

Case 2: JP

Consultant Primary Palliative Care

- 66 yo man with new H&N Cancer. Optimize for resection/tracheostomy placement planned for next week.
- **Medical Conditions:** Severe COPD, Heavy alcohol use/dependence
- **Functional Status**: Has to stop at 15 feet due to shortness of breath
- **Nutritional Status: BMI 19,** severe protein calorie malnutrition. Able to swallow, but has nasogastric tube in place, tube feeds started.

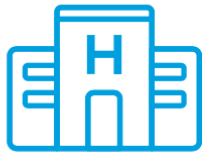
How can we ensure quality PPC for hospitalists

- Medical school/Residency
- Mid-career
  - Society of Hospital Medicine
  - CAPC – Hospitalist Toolkit
  - VitalTalk
  - Serious Illness Conversation Guide
  - Professional conferences
- Skills assessments for competency

CAPC for Hospitalists

Hospitalists: Strategies for Caring for People with Serious Illness

Last Reviewed: June 24, 2020



In the busy day of a hospitalist, one or two complex patients can lead to a backlog in daily rounds, delayed discharges, and inadequate time to communicate with patients and families. Palliative care, named as a core competency for hospitalists by the Society for Hospital Medicine (SHM), aims to improve quality of life for patients and families living with serious illness and complex need through skilled communication, pain and symptom management, and care coordination.

For many patients, hospitalists are in the best position to manage symptoms and have conversations about care priorities. Clinical training allows hospitalists to efficiently address common gaps in care for people with serious illness. For patients with the most complex needs, earlier palliative care consult leads to improved patient outcomes, improved clinician satisfaction, and reduced hospital utilization and costs.

Visit SHM's Resource Room for Palliative Care to access additional resources specific to hospital medicine strategies and hospitalists.

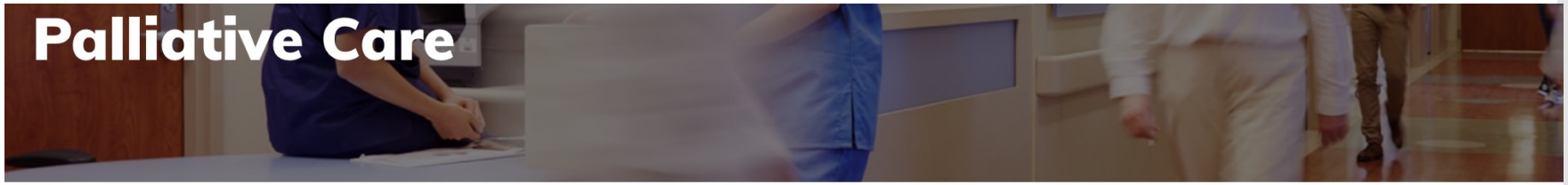
Download a course catalog with information about **continuing education credits and ABIM MOC credits** for all CAPC courses here.

What's in the Toolkit

- Why Does Palliative Care Matter for Hospitalists?
- Identify Gaps in Care for Seriously Ill Patients
- Improve Communication
- Coordinate Care
- Manage Pain and Other Symptoms
- Deliver Quality Care Transitions

https://www.capc.org/toolkits/hospital-medicine-strategies-caring-for-people-with-serious-illness/?clickthrough_doc_id=resources.toolkitpage.265&clickthrough_req_id=LDnoKh9iTIKPY14uwLW_rw&clickthrough_query=hospitalist

SHM Resources



Palliative Care: A Multidisciplinary Approach

Hospitalists are often the providers who support patients and help their families navigate their serious illness, focusing on providing palliative care to manage the pain and stress of that illness, which is a delicate process.

Improving Communication about Serious Illness

SHM's Center for Quality Improvement and The Hastings Center developed a resource to help improve care for seriously ill patients, focused on communication about prognosis and goals of care by hospitalists with the whole care team.

This resource, "Improving Communications about Serious Illness" is helpful to:

1. Individual clinicians hoping to improve their communication skills
2. Clinical champions positioned to lead projects to improve serious illness communication
3. Service and hospital leadership to understand how to best support hospitalists and their teams in providing the highest quality of care to their seriously ill patients.

Resources

Improving Communications about Serious Illness Guide →

Hospital Prognosis and Goals of Care Communication Pathway →

CAPC (Center to Advance Palliative Care) →

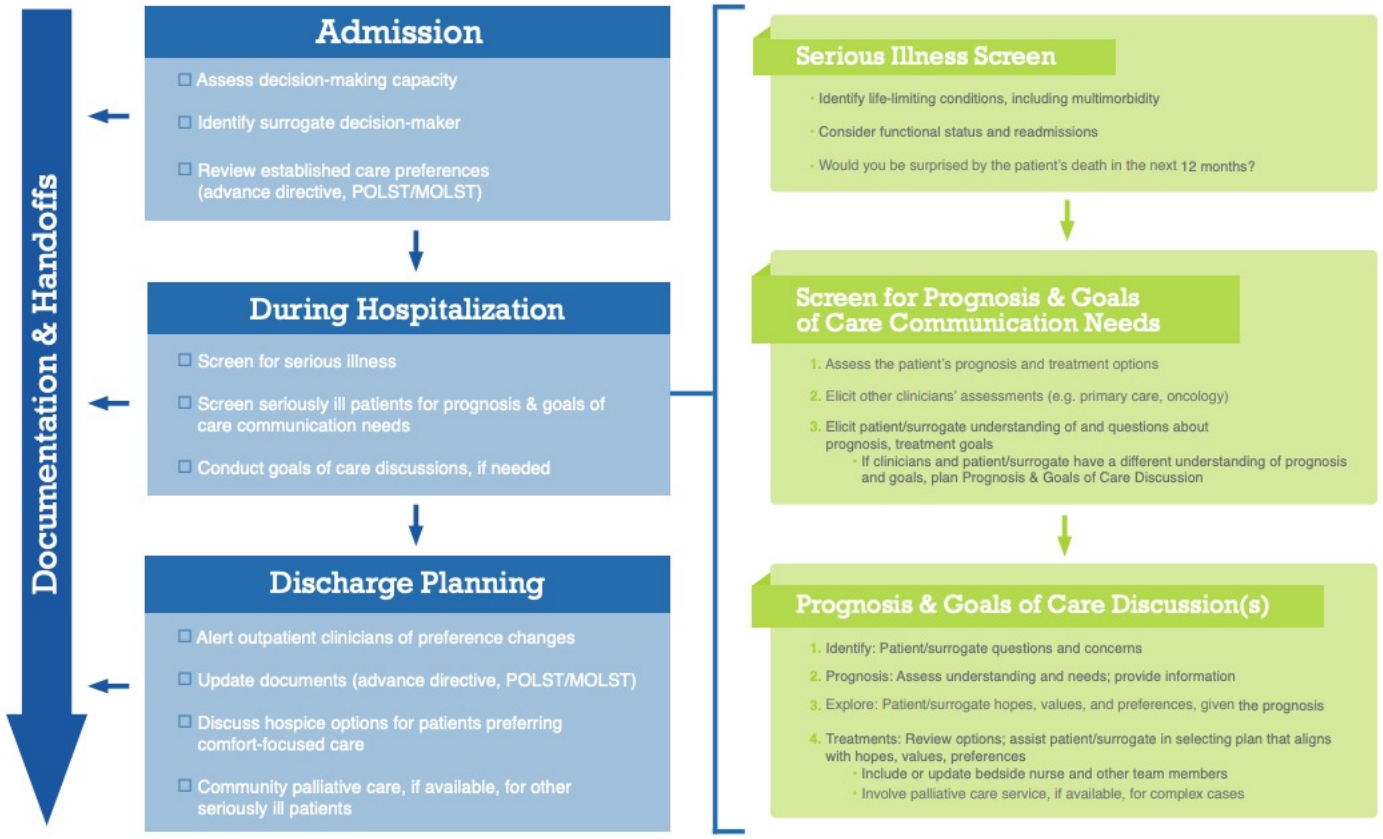
Advance Care Planning Benefit Presents Challenges →

https://www.hospitalmedicine.org/clinical-topics/palliative-care/

Prognosis and Goals of Care Communication Pathway

Figure 1: Hospital Prognosis and Goals of Care Communication Pathway

This primary palliative care pathway synthesizes best practices in hospital-based prognosis and goals of care communication identified by the work group. This Figure shows how key processes map onto time points of the typical workflow of hospitalists and their teams. Pathway implementation can be tailored by hospitals to reflect state and local law concerning advance directives, portable medical orders, and other relevant policy. Each step in this pathway must be documented in the patient's medical record, so that clinicians can view information about previous screening, care, and communication over the course of a hospitalization.



shm Society of Hospital Medicine | The Hastings Center

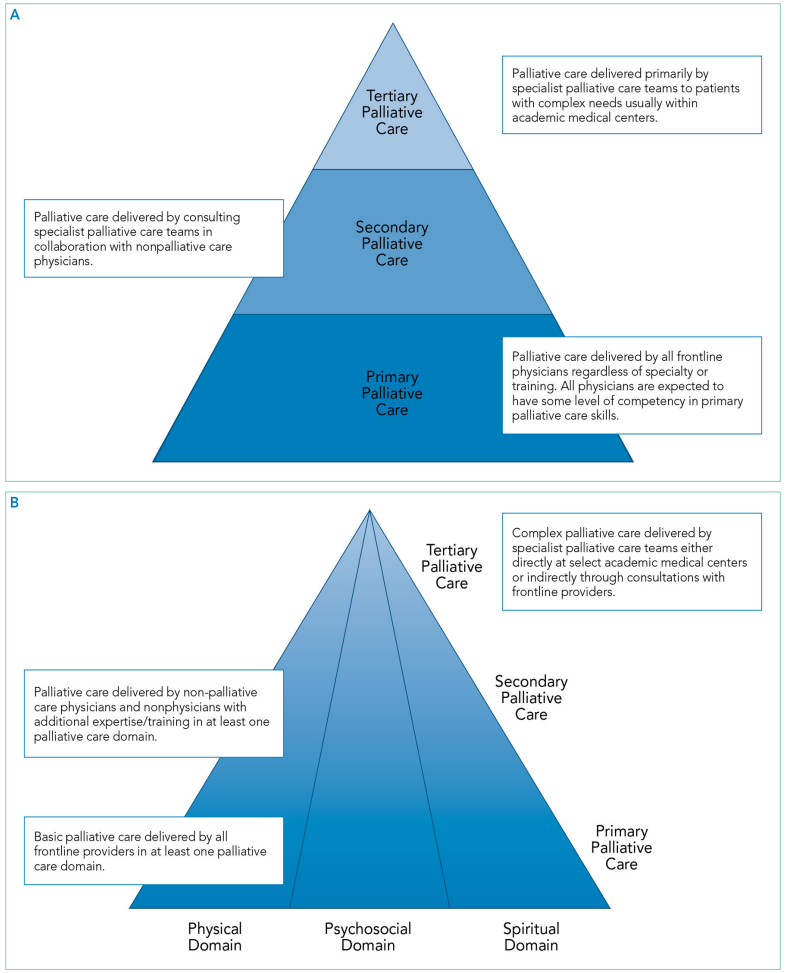
https://www.hospitalmedicine.org/globalassets/clinical-topics/clinical-pdf/ctr-16-0025-hastings-process-flow-map-eol_m1_forweb.pdf

System Changes

- Developing systems for the identification of patients with palliative care needs
- Embedding palliative care assessment into clinical work-flows
- Enabling standardized palliative care documentation in electronic medical records.
  - Triggers/checklists/hard stops
- **Enhance IDT support**
- Consider alternative structure, i.e. PRISM model

PRISM MODEL

A Model to Improve Hospital-Based Palliative Care: The Palliative Care Redistribution Integrated System Model (PRISM)



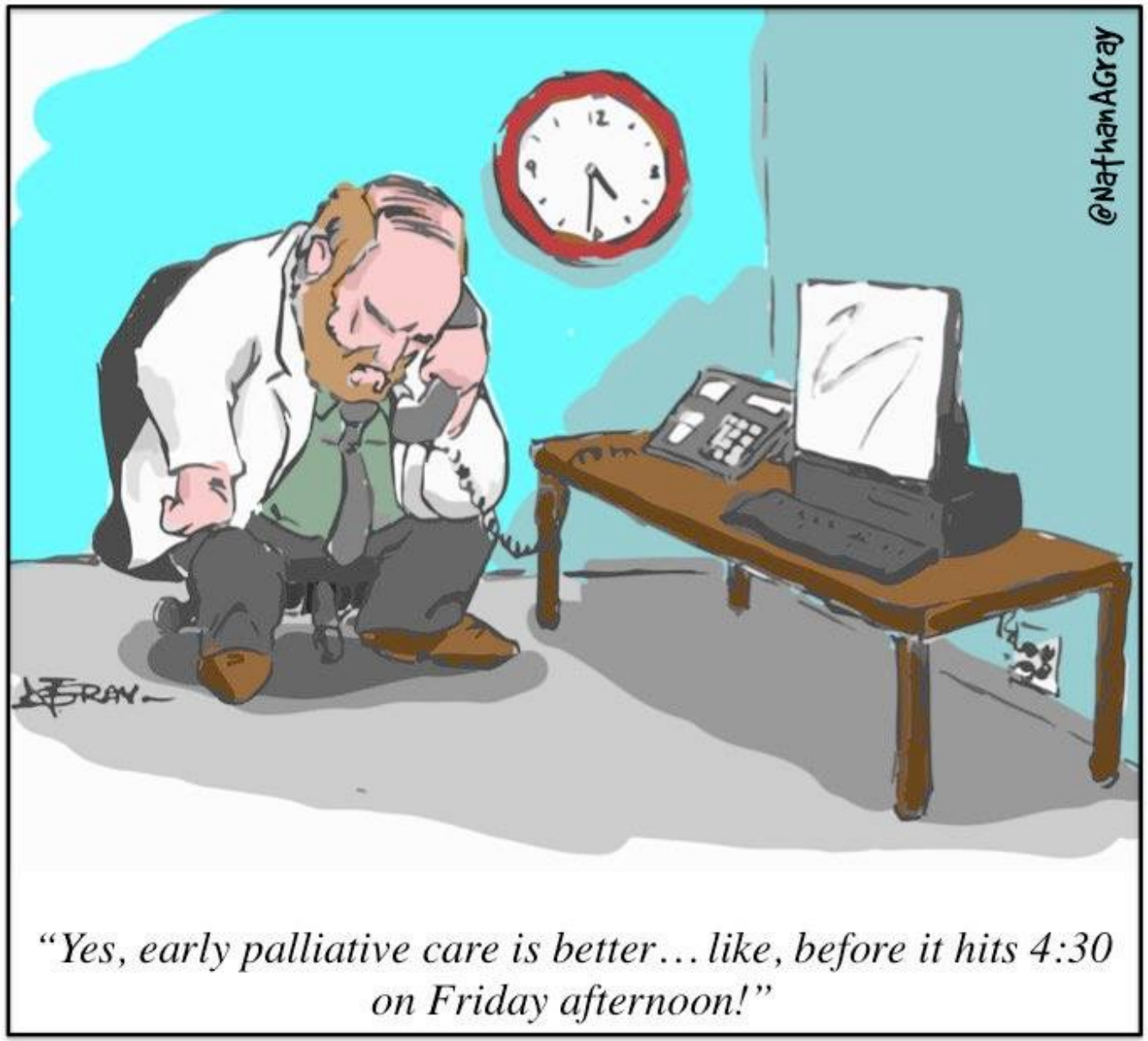
Journal of Hospital Medicine, Volume: 13, Issue: 12, Pages: 868-871, First published: 29 August 2018, DOI: (10.12788/jhm.3065)

Specialists' role in promoting PPC

- Look for opportunities to educate trainees and mid-career providers
- Clarify care model that distinguishes primary palliative skills from specialist skills
- Advocate for enhanced interdisciplinary support for all patients

Questions/ Discussion

- Qu



Resources

(2015). Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life. Washington (DC).
F

Bateni, S. B., et al. (2018). "Palliative Care Training and Decision-Making for Patients with Advanced Cancer: A Comparison of Surgeons and Medical Physicians." Surgery.

Chuzi, S., et al. (2021). "Primary Palliative Care Education in Advanced Heart Failure and Transplantation Cardiology Fellowships." J Am Coll Cardiol **77**(4): 501-505.

Cook, T., et al. (2021). "Opinion & Special Article: Next Steps in Palliative Care Education for Neurology Residents." Neurology **97**(24): 1134-1137.

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Sullivan, D. R., et al. (2023). "Collaborative Primary Palliative Care in Serious Illness: A Pragmatic Path Forward." Ann Am Thorac Soc **20**(3): 358-360.

Weissman, D. E. and D. E. Meier (2011). "Identifying patients in need of a palliative care assessment in the hospital setting: a consensus report from the Center to Advance Palliative Care." J Palliat Med **14**(1): 17-23.

Whitsett, M. P., et al. (2022). "Palliative care experience and perceived gaps in training among transplant hepatology fellows: A national survey." Hepatol Commun **6**(7): 1680-1688.