Hi everyone. Thank you for attending tonight. We’re excited to have our palliative care team and as part of Smile shares with the primary care. This is a series that Karen Brown and I really have developed and lots of people have helped with to really focus on. The perspective of cancer and palliative care, and and palliative care, cancer and palliative care and palliative care services for patients. And let’s see,
let’s start with the slides please.
And just so you folks know,
if you ever, if you or other people want to access these afterwards there’s a YouTube link.
And actually we’ve been having lots of folks access those earlier or earlier lectures that we’ve had.
So next slide please.
As many of you may know this is a monthly lecture series that focuses on primary care perspectives and cancer and and hematology. We love having our faculty panel with featuring featuring primary care and our smilo.
And other experts and we try for Tuesdays the first Tuesday of the month, 5 to 6. Again, you can access these afterwards. And while there are lots of different venues that can teach you about cancer topics, this is really a case based discussion that highlights key understandings and advances from the primary care perspective.

Next slide, we are going to do some introductions and then do some introductions and then we’ll jump into our cases. We have some great ones today. Next slide, I’m going to introduce, oh,
I'm a medical oncologist. I'm going to introduce Doctor or Karen Brown is going to introduce herself and then start out with our introductions. Thanks. Thank you. Thank you, Ann, and thank you to everyone joining as well as to the panelists who have prepared a really terrific session in primary care. One of our greatest challenges is caring for patients with cancer and the most challenging parts of that are when they first present and we need to make a diagnosis and at the end. In the middle, there's a lot of heavy oncologic care and they kind
00:02:45.276 --> 00:02:46.826 of know where they’re going.
00:02:46.830 --> 00:02:50.008 So I’m especially looking forward to learning more today about how we can help them at the end of their cancer journey or as they get more advanced in their cancer journey.
00:03:01.470 --> 00:03:04.242 I want to introduce my Northeast Medical Group colleague, Dr. Ola Rosinski.
00:03:04.242 --> 00:03:06.690 She received her undergraduate degree in Physiology and Neurobiology at UConn.
00:03:06.690 --> 00:03:08.810 She then went on to medical school at Yagolonian University Medical College in Poland,
00:03:08.810 --> 00:03:11.474 She received her undergraduate degree in Physiology and Neurobiology at UConn.
00:03:11.474 --> 00:03:13.690 University Medical College in Poland,
00:03:13.690 --> 00:03:16.707 at Yagolonian did I get it right?
00:03:16.707 --> 00:03:19.970 and she completed her residency and
internal medicine at Saint Vincent’s Medical Center here in Bridgeport. She was in academic medicine and was the assistant and then associate program director for Internal Medicine at Saint Vincent’s and she was also the ambulatory Education Coordinator and worked on developing the ambulatory resident curriculum. We were fortunate that she joined Northeast Medical Group in 2019. She sees patients full time in New Haven and also teaches students in her office. She is well regarded by her patients and our medical community. And in her spare time,
she likes to bake, and she’s a history buff with a special interest in the ancient Near East.

And for your introductions, I’d like to introduce Doctor Morgan Bain. He’s currently the section head for palliative care at Greenwich Hospital and former Professor of Medicine at Duke. He studied undergraduate at Wesleyan and got his Med school degree at VCU and trained at Norwalk Hospital in
Connecticut in affiliation with Yale, followed by a Geriatric Medicine fellowship at Mount Sinai in New York City. He's board certified internal medicine, hospice and palliative medicine and geriatric medicine, and he has many years experience caring for vulnerable adults with lots of complex medical needs. His passions are patient care and medical education, and having taught hundreds of medical students how to staff and physicians throughout his career. Next, I have doctor Kristen Edwards.
She’s a board certified physician, controlled medicine, Hospice and palliative medicine. She’s the medical director of palliative care at Bridgeport Hospital. She manages all aspects of the PAL care program there, including clinical care education management. She’s the site director for the Yale Geriatrics Hospice and Palliative Medicine Fellowship. She’s an assistant clinical professor of medicine at Yale. And in 2019, she was actually awarded emerging Leader.
in Hospice and palliative medicine,

00:05:49.330 --> 00:05:50.695 a national award given every five years to 40 leaders in the field of palliative care.

00:05:50.695 --> 00:05:52.668 So fantastic work, Christian.

00:05:52.668 --> 00:06:00.048 And then finally Doctor Liz Persich.

00:06:00.050 --> 00:06:02.730 She’s a physician specializing in medical oncology and palliative care.

00:06:02.730 --> 00:06:05.410 She received her medical degree from George Washington.

00:06:05.410 --> 00:06:07.094 She is certified.

00:06:07.094 --> 00:06:11.840 University School of Medicine and did her residency and fellowship at Brown.

00:06:11.840 --> 00:06:14.660 Also in sorry, she had a fellowship also at Brown.

00:06:14.660 --> 00:06:24.300 focusing on end of life and palliative care.
So she’s double fellowship, Medoc and Palliative care. She’s an assistant professor at Yale. She’s the director of adult inpatient palliative care at Yale. New Haven Hospital and firm chief for the medical oncology unit at Smile Cancer Hospital. She’s dedicated to serving patients with serious life or life limiting illness with complex medical needs. Difficult to control symptoms and supporting their caregivers. This is a just a terrific team of folks I’ve had the pleasure.
00:06:56.456 --> 00:06:58.761 of working with and so really,
NOTE Confidence: 0.854956277777778
00:06:58.761 --> 00:07:01.023 really excited about the panel tonight.
NOTE Confidence: 0.854956277777778
00:07:01.030 --> 00:07:03.627 I’m going to turn it over to
NOTE Confidence: 0.854956277777778
00:07:03.630 --> 00:07:06.228 Doctor Rosinski to to start off.
NOTE Confidence: 0.9553487
00:07:12.270 --> 00:07:13.510 Good evening everyone.
NOTE Confidence: 0.9553487
00:07:13.510 --> 00:07:17.480 So let’s get started case one.
NOTE Confidence: 0.9553487
00:07:17.480 --> 00:07:20.720 Is an 82 year old female comes to the office
NOTE Confidence: 0.9553487
00:07:20.794 --> 00:07:23.618 for an urgent visit regarding a lump in
NOTE Confidence: 0.9553487
00:07:23.618 --> 00:07:26.758 her left breast that she noted yesterday.
NOTE Confidence: 0.9553487
00:07:26.760 --> 00:07:28.640 Her last screening mammogram
NOTE Confidence: 0.9553487
00:07:28.640 --> 00:07:30.520 was 15 years ago.
NOTE Confidence: 0.9553487
00:07:30.520 --> 00:07:32.160 She doesn’t have any pain,
NOTE Confidence: 0.9553487
00:07:32.160 --> 00:07:33.960 although it does feel tender
NOTE Confidence: 0.9553487
00:07:33.960 --> 00:07:35.760 when she presses on it.
NOTE Confidence: 0.9553487
00:07:35.760 --> 00:07:39.036 She has no redness, skin changes,
NOTE Confidence: 0.9553487
00:07:39.040 --> 00:07:41.990 ****** discharge or weight loss.
The exam is notable for a mass in the left breast, 2 by 4 centimeters in the 11:00 o’clock position, 10 centimeters from the 10 centimeters from the 10 centimeters from the 11:00 o’clock position, 11:00 o’clock position, 11:00 o’clock position, 10 centimeters from the 10 centimeters from the 10 centimeters from the 10 centimeters from the 10 centimeters from the.

The mass is firm, with no tenderness of the mass itself, but there is tenderness of the surrounding tissue. There is left axillary lymphadenopathy present.

Diagnostic mammogram and ultrasound were ordered. The patient herself is very afraid that this is cancer and that she will die.
She says that she’s not ready.

So you order the mammogram and there is a 3.2 centimeter irregular mass with an indistinct margin and the left breast at the 12:00 o’clock middle depth.

And the biopsy shows invasive ductal carcinoma poorly differentiated.

The patient would like to pursue curative treatment.

So how would you structure your conversation with this patient and would you even mention palliative care at this point?

And to help us answer those questions, I’d like to turn over to my colleague, Doctor Edwards.
Thank you. So couple things I think let me, can everybody hear me, okay, on this patient. You know really we’re still trying to find out what is her prognosis at this point. I’m sure she’s overwhelmed with emotions and really just trying to figure out what next steps are. So I think the conversation would really be a lot of listening and and I we’re going to get to some of those communication pearls in my second slide, I’m going to tackle the first question, the second question first then, which is what I mentioned palliative care.
I probably wouldn’t mention palliative care in this particular interaction because again, it’s very early and still trying to figure out what exactly is going on. And part of that is because of what the definition of palliative care is.

So if you can, go to the next slide. So there are a couple of models out there for palliative care that are helpful to understand. Palliative care used to be thought of as very sequential. So the Top Model is what’s called an integrated model, which was the new and improved way of thinking of palliative care.
00:10:03.383 --> 00:10:05.777 care about 10 to 15 years ago.

00:10:05.780 --> 00:10:07.341 Before that we thought of it really

00:10:07.341 --> 00:10:09.135 as all of these therapies to prolong

00:10:09.135 --> 00:10:11.095 life then almost a flip the switch

00:10:11.095 --> 00:10:13.209 and then there was Hospice which was

00:10:13.209 --> 00:10:14.864 approximately the last six months

00:10:14.864 --> 00:10:16.256 and bereavement care afterwards.

00:10:16.260 --> 00:10:18.180 And that was when the Hospice

00:10:18.180 --> 00:10:20.100 benefit was introduced in the 1970s.

00:10:20.100 --> 00:10:21.856 The integrated model recognizes

00:10:21.856 --> 00:10:23.612 that palliative care includes

00:10:23.612 --> 00:10:25.580 the end of life portion,

00:10:25.580 --> 00:10:27.694 but also includes all of these therapies

00:10:27.694 --> 00:10:29.973 that are geared at relieving suffering or

00:10:29.973 --> 00:10:32.220 improving quality of life along the way.
Palliative care is the other part of it's really important to understand is that there's primary palliative care and specialty level palliative care. And so everyone who's on this call already does some primary palliative care. That is the the basic how do you deliver bad news, how do you have a serious conversation, how, what symptoms are you controlling? And so whether or not you referred this patient to specialty level palliative care initially, I'm not sure that I would introduce it in this particular conversation. If it came up, I certainly would,
but and I would have that explanation that palliative care is an extra layer of support, but I wouldn’t necessarily introduce it as the first thing on my mind.

The second model that I think is important to understand is this other model, which is the bow tie model. This one came out in about 2014 and it’s one of my favorite models because it shows it’s the same diagram but it shows how they overlap.

And whether you look at it from a disease manager perspective or a palliative care perspective, you see that palliative care is
much more than just Hospice. So in fact palliative care can be done even when patients are expected to get better. This talk is obviously focused about patients with oncology, but we do palliative care in all settings. So we do palliative care for other disease serious illnesses and even include. Trauma, burn, etcetera, in which patients are definitely expected to get better. So it’s someone who has a serious illness but not necessarily terminal illness and needs additional symptom management communication and goals of care decision making along that process.
Can we go to that, my next slide,

oh, oh, sorry, let me go back,

let me go back to that one.

The the communication phrases I’m going to

I think what I would focus on

for this particular patient would

be setting the stage for her to

focus specifically on what she

wants to know about and how she

focus specifically on just the next steps.

For the moment,

I think my communication pros will come
So I'll talk about that then.

The patient afterwards underwent lumpectomy with lymph node dissection.

About four months later,

The work up at that time included a pet CT that showed avid mediastinal lymph nodes that were highly suspicious for metastasis,

avid multifocal liver and osseous metastasis,

lytic metastasis involving
NOTE Confidence: 0.941691228571429
00:13:15.596 --> 00:13:18.244 the right occipital condyle.
NOTE Confidence: 0.941691228571429
00:13:18.250 --> 00:13:19.768 Her daughters at this point are
NOTE Confidence: 0.941691228571429
00:13:19.768 --> 00:13:21.490 with her in the appointment,
NOTE Confidence: 0.941691228571429
00:13:21.490 --> 00:13:24.087 and I’ve heard that even with Mets,
NOTE Confidence: 0.941691228571429
00:13:24.090 --> 00:13:27.040 some patients can be cured.
NOTE Confidence: 0.941691228571429
00:13:27.040 --> 00:13:30.040 Her declining functional status is noted.
NOTE Confidence: 0.941691228571429
00:13:30.040 --> 00:13:33.200 She has by this point been spending more
NOTE Confidence: 0.941691228571429
00:13:33.200 --> 00:13:36.520 than half her time in bed during the day.
NOTE Confidence: 0.941691228571429
00:13:36.520 --> 00:13:38.907 So the question that we have is
NOTE Confidence: 0.941691228571429
00:13:38.907 --> 00:13:41.880 how do you transition her goals of
NOTE Confidence: 0.941691228571429
00:13:41.880 --> 00:13:45.114 her goals of care at this juncture?
NOTE Confidence: 0.941691228571429
00:13:45.120 --> 00:13:46.604 And I think Doctor Edwards is going
NOTE Confidence: 0.941691228571429
00:13:46.604 --> 00:13:48.558 to talk a little bit more about that.
NOTE Confidence: 0.9251585
00:13:49.580 --> 00:13:50.760 So if we could go to, yeah, so,
NOTE Confidence: 0.9251585
00:13:50.760 --> 00:13:52.760 so this is the slide that I’ll walk
NOTE Confidence: 0.9251585
00:13:52.824 --> 00:13:54.534 through some of the communication
NOTE Confidence: 0.9251585
00:13:54.534 --> 00:13:56.400 tools and some of these would have
NOTE Confidence: 0.9251585
00:13:56.400 --> 00:13:57.902 been appropriate even in the first
NOTE Confidence: 0.9251585
00:13:57.902 --> 00:13:59.778 conversation that I had with this patient.
NOTE Confidence: 0.9251585
00:13:59.780 --> 00:14:02.870 So that’s really important to recognize.
NOTE Confidence: 0.9251585
00:14:02.870 --> 00:14:04.862 You may have seen some of
NOTE Confidence: 0.9251585
00:14:04.862 --> 00:14:06.190 these tools already there.
NOTE Confidence: 0.9251585
00:14:06.190 --> 00:14:07.558 While we do think of them
NOTE Confidence: 0.9251585
00:14:08.470 --> 00:14:09.825 as palliative care tools,
NOTE Confidence: 0.9251585
00:14:09.825 --> 00:14:12.017 they’re really just communication tools
NOTE Confidence: 0.9251585
00:14:12.017 --> 00:14:13.583 and some of them you will have seen
NOTE Confidence: 0.9251585
00:14:13.590 --> 00:14:15.390 So whether it’s leadership
NOTE Confidence: 0.9251585
00:14:15.390 --> 00:14:17.668 training or education or patient
NOTE Confidence: 0.9251585
00:14:17.668 --> 00:14:19.102 standard relation communication,
NOTE Confidence: 0.9251585
00:14:19.102 --> 00:14:21.492 you may have seen similar
NOTE Confidence: 0.9251585
00:14:21.492 --> 00:14:22.950 phrases that are used.
NOTE Confidence: 0.9251585
00:14:22.950 --> 00:14:24.230 So I'm going to go through each one of these.
NOTE Confidence: 0.9251585
00:14:24.230 --> 00:14:28.505 Some of these are what the I wish statements,
NOTE Confidence: 0.9251585
00:14:28.510 --> 00:14:31.318 I'm sorry the the slide I think got.
NOTE Confidence: 0.9251585
00:14:31.320 --> 00:14:32.328 Change. So the first one is
NOTE Confidence: 0.9251585
00:14:32.328 --> 00:14:33.259 actually supposed to read, ask,
NOTE Confidence: 0.9251585
00:14:33.259 --> 00:14:36.559 tell, ask and then the second
NOTE Confidence: 0.9251585
00:14:34.813 --> 00:14:36.559 one is I wish statement.
NOTE Confidence: 0.9251585
00:14:36.560 --> 00:14:37.304 So bear with me.
NOTE Confidence: 0.9251585
00:14:37.304 --> 00:14:38.919 It's not important for the slide but it does,
NOTE Confidence: 0.9251585
00:14:38.920 --> 00:14:40.558 it does matter in terms of the the terms.
NOTE Confidence: 0.9251585
00:14:40.560 --> 00:14:41.148 So ask, tell,
NOTE Confidence: 0.9251585
00:14:41.148 --> 00:14:42.520 ask is a way we think of
NOTE Confidence: 0.9251585
00:14:42.579 --> 00:14:44.079 structuring the conversation.
NOTE Confidence: 0.9251585
00:14:44.080 --> 00:14:45.816 So actually if you go back to
NOTE Confidence: 0.9251585
00:14:45.816 --> 00:14:47.110 that first conversation with the
NOTE Confidence: 0.9251585
00:14:47.110 --> 00:14:49.040 patient what you when you ask,
NOTE Confidence: 0.9251585
00:14:49.040 --> 00:14:50.792 you ask what they know and
NOTE Confidence: 0.9251585
00:14:50.792 --> 00:14:52.360 what they want to know.
NOTE Confidence: 0.9251585
00:14:52.360 --> 00:14:53.950 You wait for their answers and
NOTE Confidence: 0.9251585
00:14:53.950 --> 00:14:55.895 then what based on what they say
NOTE Confidence: 0.9251585
00:14:55.895 --> 00:14:57.551 then you tell them what they’ve
NOTE Confidence: 0.9251585
00:14:57.551 --> 00:14:59.177 asked and what the clinical update
NOTE Confidence: 0.9251585
00:14:59.177 --> 00:15:00.808 is and then you ask again.
NOTE Confidence: 0.9251585
00:15:00.808 --> 00:15:03.432 What have they heard so that you make
NOTE Confidence: 0.9251585
00:15:03.432 --> 00:15:05.976 sure that you have explained it well?
NOTE Confidence: 0.9251585
00:15:05.980 --> 00:15:08.104 What questions do they have and
NOTE Confidence: 0.9251585
00:15:08.104 --> 00:15:10.538 what else do they want to know?
NOTE Confidence: 0.9251585
00:15:10.540 --> 00:15:12.572 And the reason to do it in this
NOTE Confidence: 0.9251585
00:15:12.572 --> 00:15:14.849 structure is it really helps pace the
NOTE Confidence: 0.9251585
00:15:14.849 --> 00:15:17.020 conversation for what somebody can absorb,
especially when they’re overwhelmed with emotion in a first encounter. So if you think about that very first encounter when you met her, to help her focus on those next steps, I would have used an ask, tell, ask strategy to get through that conversation. The other comments tell me more is a good one to use when you’re not sure what someone is saying or what you’re there said something but you want to explore a little bit more what’s behind the statement or the question.
00:15:43.900 --> 00:15:46.620 So simply tell me more
NOTE Confidence: 0.9251585
00:15:46.620 --> 00:15:48.258 and then the next one.
NOTE Confidence: 0.9251585
00:15:48.260 --> 00:15:50.584 That should be an I wish statement
NOTE Confidence: 0.9251585
00:15:50.584 --> 00:15:52.939 or an I worry those two things
NOTE Confidence: 0.9251585
00:15:52.939 --> 00:15:55.642 I wish and then I worry we use
NOTE Confidence: 0.9251585
00:15:55.642 --> 00:15:58.468 I wish statements there to say.
NOTE Confidence: 0.9251585
00:15:58.470 --> 00:16:01.789 When someone is expressing something that
NOTE Confidence: 0.9251585
00:16:01.790 --> 00:16:04.126 you don’t think is realistically possible.
NOTE Confidence: 0.9251585
00:16:04.126 --> 00:16:06.693 So an example would be I wish that
NOTE Confidence: 0.9251585
00:16:06.693 --> 00:16:08.950 this cancer with more chemotherapy,
NOTE Confidence: 0.9251585
00:16:08.950 --> 00:16:12.214 and I’m worried that that may not be
NOTE Confidence: 0.9251585
00:16:12.214 --> 00:16:14.949 possible given your functional status.
NOTE Confidence: 0.9251585
00:16:14.950 --> 00:16:16.868 The When you combine them that way,
NOTE Confidence: 0.9251585
00:16:16.870 --> 00:16:17.918 it does two things.
NOTE Confidence: 0.9251585
00:16:17.918 --> 00:16:18.704 One is it,
it reinforces the reality of what’s there.

It also with the I wish it aligns you with that person. And so it’s really is empathy building and relationship building.
The I worry part of it allows you to introduce some of the concerns that might come up.

It'll like again allows you to empathize and to align yourself with that person and it allows you to introduce a little bit of the humanity of you as the clinician interacting with that patient as well.

The next one here is we're
in a different place.

This comes from vital top training.

I know Liz will certainly recognize that one,

and that’s.

But this patient in particular,

she may have wanted curative intent.

You may have had suspicions that that might

not have been possible in the first time,

but it wasn’t entirely clear.

But then to say,

I know we started chemotherapy

or I know we wanted chemotherapy,

we’re in a different place

now than when we first met.

Let’s talk about how we can

still meet your goals here.
It’s a way to signpost that we’re going to be transitioning to a different plan than we had before in terms of exploring goals. So when you do signpost, then we can transition. So what are you hoping for? Now that you’ve gone through some of that? Here’s where we are. This is what’s realistic. I like to ask what are you hoping for? It gives an understanding of what their values are. If time were short, I use were in this case because sometimes.
Well, actually almost always planning for the future and putting some distance between you and the future is actually much easier for patients to do. So if you were to get sicker, can we talk about what you would want? It’s often psychologically easier to discuss than if you do get sicker or when you get sicker. So that’s a little bit of a nuance there. And then the comment of what else are you hoping for can be useful in terms of when somebody says, well, I’m hoping to get better. Well, I’m hoping for that too.
And I’m worried if that doesn’t happen, is there something else that you’re hoping for that we can aim for? Again, it just softly redirects them to something that might be able to be achieved, rather than perhaps something that’s not realistic for them.

One of the other key things that we use is silence, obviously, to allow people to express their emotions, gather their thoughts. Most people on the giving end of information, so clinicians feel much more uncomfortable with the silence than
the person on the receiving end.

They're just trying to get their heads around whatever news has been delivered.

And so if you wait, they will usually offer what they need to say next.

And then finally, if it goes on and on, you can certainly ask can you tell me what you’re thinking?

Lastly, there is a pneumonic to help reinforce those empathic statements.

So nurse emotions, which is stands for you, name the emotion.
It sounds like you're very frustrated or it sounds like you're very sad. Understand. Can you tell me a little bit more about what's helping? What's making you feel sad right now? I respect the journey, respect that personhood. I can understand how you might feel sad in the circumstances. I would certainly feel sad too. The support piece is really important for aligning yourself with that person for the duration of their care. I am going to be here and walk you through.
through every step and then lastly is explore what else is making you sad or what would support you so.

So that’s just a little snippet of how to address emotions in an encounter. Lastly, I just wanted to leave some tools that we have within our system. So within Epic itself there are two places where you can find some advanced care planning pathway tools that can help guide these conversations. So one is the advanced care planning pathway, unfortunately it is only for inpatient right now, but it does exist. And then the other is advanced care
planning tools where there is a serious illness guide conversation, it is literally you can print it out and while that sounds, Scripted if you say, you know, I'm just going to keep these questions here because I want to make sure I cover the important things for you many times that is actually very well received by patients and families. And then lastly if you additional training on how to have some of these conversations would be through catsy vital talk and then the serious illness conversation which is the last one there.
So I think for this individual going back to the case, can we flip back one more slide backwards? So the how would I transition her from goals of care, from cure to treatment would really be that conversation. What's important to you? I do see your your functional status is declined. I'm worried that we're not going to be able to get more chemotherapy at this time. What would be important to you? And then I would go, I'm going to pass on to that. Okay, so now we're on Case 2. So case two is a 47 year old female with
a gist tumor metastatic to the liver, treated with SUTININIB, seeks advice for fatigue, abdominal pain, sores in the mouth, nausea and insomnia. Her dose was actually recently increased and she does not think this is going well. Her gist tumor was first diagnosed five years ago. At that time she underwent surgery with splenectomy. Initially she was treated with imatinib and then transitioned to sunitinib 50 milligrams due to recurrence. She’s having the abdominal pain every day.
and she wants to avoid opiate medications.

She has nausea daily.

She has trouble eating and has lost about £10 so far.

She has a sore in her mouth which prevents her from eating.

Overall, she’s feeling stressed, tired, and she can’t sleep.

So the questions are,

how can palliative care help us manage her symptoms?

How does prognosis factor into this discussion?

Remember, she does have metastatic disease to the liver.
And what is the role of primary care here now? She’s been stable for a long time, even with the metastatic disease. So I’d like to go to my colleague and thank you Doctor Brzezinski. Actually you can go back the previous slide and we can tackle some of these questions though. So this is an example of a patient who is not in the beginning of her cancer journey. She’s been diagnosed and has been undergoing treatment for many years at this point, but is experiencing a lot of side effects and disease related issues at this point and.
00:23:04.610 --> 00:23:06.822 This is a typical patient we would
NOTE Confidence: 0.911394589047619
00:23:06.822 --> 00:23:09.046 kind of see in the outpatient
NOTE Confidence: 0.911394589047619
00:23:09.046 --> 00:23:10.658 pitive care arena before coming
NOTE Confidence: 0.911394589047619
00:23:10.658 --> 00:23:12.086 to you on the Haven health system.
NOTE Confidence: 0.911394589047619
00:23:12.090 --> 00:23:14.834 I was at Duke as the medical director
NOTE Confidence: 0.911394589047619
00:23:14.834 --> 00:23:16.858 outpatient pitive care and so many
NOTE Confidence: 0.911394589047619
00:23:16.858 --> 00:23:19.063 patients in the Duke Cancer Center that
NOTE Confidence: 0.911394589047619
00:23:19.063 --> 00:23:20.528 were actively going through treatment.
NOTE Confidence: 0.911394589047619
00:23:20.530 --> 00:23:22.889 We weren’t at end of life scenario.
NOTE Confidence: 0.911394589047619
00:23:22.890 --> 00:23:25.230 This was trying to help them live as best
NOTE Confidence: 0.911394589047619
00:23:25.230 --> 00:23:27.615 as possible and so that’s the goal of
NOTE Confidence: 0.911394589047619
00:23:27.615 --> 00:23:30.276 Pitive cares to help improve quality of life.
NOTE Confidence: 0.911394589047619
00:23:30.280 --> 00:23:31.700 Regardless of where they are
NOTE Confidence: 0.911394589047619
00:23:31.700 --> 00:23:32.836 in their treatment trajectory.
NOTE Confidence: 0.911394589047619
00:23:32.840 --> 00:23:35.570 So how can palliative care help
NOTE Confidence: 0.911394589047619
00:23:35.570 --> 00:23:36.320 manage her symptoms?
00:23:36.320 --> 00:23:39.281 So we’d like to think that we’re experts in managing symptoms related to serious illness, in this case cancer.

00:23:41.960 --> 00:23:45.131 Kind of are the ones that assess them frequently in our visits.

00:23:48.008 --> 00:23:50.020 We have some assessment tools like the Edmonton Symptom Assessment Scale, which just has 8 to 10 different questions about do you have fatigue, pain, sleeping, anxious, nervous, depressed?

00:23:52.144 --> 00:23:53.940 It’s a regular thing that we assess for when we have patient encounters.
and not uncommon pain and fatigue
NOTE Confidence: 0.911394589047619

are the most common symptoms that
NOTE Confidence: 0.911394589047619

we find for patients with cancer.
NOTE Confidence: 0.911394589047619

So we deal with it quite frequently.
NOTE Confidence: 0.911394589047619

So one is just assessing how severe
NOTE Confidence: 0.911394589047619

are the symptoms.
NOTE Confidence: 0.911394589047619

Is it just mild and a mild nuisance to
NOTE Confidence: 0.911394589047619

her or is this something that really
NOTE Confidence: 0.911394589047619

is moderate to severe and so it’s
NOTE Confidence: 0.911394589047619

just trying to figure out where they’re at.
NOTE Confidence: 0.911394589047619

And those are through basic questions
NOTE Confidence: 0.911394589047619

that we’re all taught through
NOTE Confidence: 0.911394589047619

our medical training, so.
NOTE Confidence: 0.911394589047619

When we are taking care of patients,
NOTE Confidence: 0.911394589047619

we will frequently see them.
NOTE Confidence: 0.911394589047619

It may be every week depending upon the
severity and if we’re titrating medicine,
sometimes it’s every couple of weeks,
but for more stable people is usually
once every month they would come
and visit us and we would assess
change medications,
change treatments and then go from there, so.
So we certainly could help
this patient manage her pain.
She has a preference for not
using opioid medication.
I often say that when we’re
managing symptoms,
it’s best to use non
pharmacologic therapies first.
So that might include psychological support through cognitive behavioral therapy. It might include sort of alternative therapies like acupuncture, meditation, things of that nature. Certainly we could use pharmacological medications that don’t use opioids right up front. Sometimes we can use adjuvant medicine such as gabapentin or other. You know, nonopen medications. But when it does get moderate and severe and it’s not being controlled with the current regimen, then sometimes quite frequently we have to escalate into the stronger
00:25:48.800 --> 00:25:51.068 pain medicines and that it’s really
00:25:51.070 --> 00:25:52.988 weighing the benefits and burdens of it.
00:25:52.990 --> 00:25:55.013 But hopefully our role is to help
00:25:55.013 --> 00:25:56.543 support the patient through that
00:25:56.543 --> 00:25:58.343 process so that they are aware,
00:25:58.350 --> 00:25:59.790 they know what they’re getting into,
00:25:59.790 --> 00:26:03.030 where they’re to monitor them closely.
00:26:03.030 --> 00:26:06.630 Nausea is certainly another chemo related
00:26:06.630 --> 00:26:10.230 immune related disease side effect.
00:26:10.230 --> 00:26:12.890 And so one other thing I’d like to say is
00:26:12.963 --> 00:26:16.024 that sometimes we like to pull things out
00:26:16.024 --> 00:26:19.370 of our sleeves like with fatigue certainly.
00:26:19.370 --> 00:26:21.770 Most commonly, we recommend exercise.
00:26:21.770 --> 00:26:23.574 Sometimes we’re talking about
00:26:23.574 --> 00:26:24.927 energy conservation techniques,
but sometimes we pull out medicines that most others don’t think about or don’t use, such as methylphenidate. Sometimes for severe cases, we’ll use those kind of medications and it’s not something that many providers will know how the expertise and how to use. Moving to the second question, how does prognosis factor into the discussion? It’s a very good question as hopefully we follow these people through their journey, we will get a sense of what they’re likely prognosis is.

Certainly there are therapies that we wouldn’t recommend if it was
a long prognosis of many years. Certainly steroids we use for pain management as an adjuvant, but we don’t want to put people on steroids for several months to years knowing the side effects of that. There’s certain things that we wouldn’t recommend if prognosis is short, things like total parental nutrition for help with nutritional support. If the prognosis is less than three months, the literature would generally not support that. So it definitely plays a factor into what is going to provide the most benefit.
and minimize the burdens in those situations.

So and we get that through following the patient,

we also get it through frequent conversations with the oncologists.

The goal is to work side by side with them and that's how my experience has been.

And so it's a dialogue back and forth as to how are they doing on their regimen,

are they progressing,

are they improving,

are they changing treatments?

What does that mean for the patient?

So it's a close collaboration to get a sense of what that prognosis is.

Certainly prognosis can be talked
about at length in another venue, but it’s important for patients to know that sometimes for life planning and other things. Moving to the last question, what is the role of primary care in the care team here? As mentioned, I’m trained in geriatric medicine, Hospice and palliative medicine. And in those two disciplines it’s very much a team sport. I know that I can’t provide the care myself. It takes, you know, our social workers, our therapists,
our nurses, our other volunteers.

And so primary care is a very important part of that team collaboration.

It also depends on the scenario.

I've seen patients where they just started with a new primary care physician and don’t know them very well, haven’t had many interactions. But then certainly there’s patients who’ve been followed by their primary care physician for several years and they completely trust them.

So it’s good for us to know those things because we can go back to their
primary care physicians and try to include them in the care and sort of again have a dialogue back and forth. A lot of times patients when they’re getting cancer care, just want to know who do I call when I have a problem, you know, as opposed to just going to the emergency department. They want to have somebody at the at the ready on the phone and we kind of try to help sort that out with them and who’s responsible for what. So including primary care is certainly an important part of that next slide so.
And I was asked to talk about a few things related to this case and that the case is presented one about Pine to care triggers. When do you want to get pine of care involved? Sometimes it’s readily apparent and sometimes not so much. So this is just a list of some criteria. Certainly there’s many different lists in the literature about criteria, but quite often we’re thinking of people that have life limiting or life threatening illnesses, what we call a serious illness. There’s primary criteria,
secondary criteria, and this was published by Dr. David Weissman and his colleague Dr. Diane Meyer several years ago. But we also talk in the To Care World about the surprise question, and that is, when looking at a patient in any venue, would you be surprised that this patient died within the next 12 months? And it's used for research purposes and just an easy question to gauge whether somebody would potentially benefit from palliative care. Palliative care is more focused on
needs and not necessarily prognosis, but it’s a entry question to figuring out the trigger. Certainly people are coming to the hospital frequently if they’ve had a severe decline in function, unintended decline in weight. Secondary criteria include things such as an elderly patient, metastatic or locally advanced cancer, cardiac arrest. So it goes on and on. We in the hospital here have a resource card which we carry around and it has a number of questions. Or triggers both in the Ed and
also in the ICU.

So.

So we have tools in the system that can help people understand when they might want to get pit of care involved.

I was also asked to talk about sort of the pit of care stigma and I leave a quote from my mentor and national leader and pit of care, Dr. Diane Meyer out of Mount Sinai.

And she told me early on when I was a fellow that if you’re trying to sell death, no one is going to buy.

And I think frequently my colleagues and I run into patients,
00:31:38.390 --> 00:31:40.706 run into staff who, you know,
NOTE Confidence: 0.943913124545454
00:31:40.710 --> 00:31:43.718 we hear the words patient is not ready
NOTE Confidence: 0.943913124545454
00:31:43.718 --> 00:31:46.470 for palliative care and that is a barrier.
NOTE Confidence: 0.943913124545454
00:31:46.470 --> 00:31:47.946 If they’re not ready for palliative
NOTE Confidence: 0.943913124545454
00:31:47.946 --> 00:31:49.710 care or don’t want palliative care,
NOTE Confidence: 0.943913124545454
00:31:49.710 --> 00:31:51.530 then we’re not allowed to
NOTE Confidence: 0.943913124545454
00:31:51.530 --> 00:31:53.350 be involved in their care.
NOTE Confidence: 0.943913124545454
00:31:53.350 --> 00:31:57.984 And so it’s trying to highlight the
NOTE Confidence: 0.943913124545454
00:31:57.984 --> 00:31:59.669 positive things about palliative care.
NOTE Confidence: 0.943913124545454
00:31:59.670 --> 00:32:01.812 You know, palliative care is there
NOTE Confidence: 0.943913124545454
00:32:01.812 --> 00:32:03.799 to help improve quality of life.
NOTE Confidence: 0.943913124545454
00:32:03.800 --> 00:32:07.651 And that’s the focus talking about Hospice,
NOTE Confidence: 0.943913124545454
00:32:07.651 --> 00:32:09.639 talking about stopping treatments,
NOTE Confidence: 0.943913124545454
00:32:09.640 --> 00:32:11.875 talking about death is certainly
NOTE Confidence: 0.943913124545454
00:32:11.875 --> 00:32:14.110 very charged and very powerful
NOTE Confidence: 0.943913124545454
00:32:14.190 --> 00:32:16.110 and patients don’t readily.
Embrace that and that is often a barrier to getting high to care involved. So, so this is a what I call a Diane Meyerism that sticks in my head and it's always to try to highlight the positive things that high to care does. We certainly do help manage with end of life situations, but we don't sort of bill ourselves as that next slide. Another part of support for patients and especially the Cancer Center is about advanced care planning. Most patients and families don't know exactly what advanced care planning is.
but really the goal of it in our
daytoday conversations is to enhance
patient and family education about
their illness about likely prognosis.
Outcomes of alternative care plans,
we hear what treatments they’re on.
We gauge how well they’re
doing with those treatments.
We kind of want to know what other things
might be available if it doesn’t work.
So we take the time to talk to patients and
families about all those different things.
Certainly, we wanted to find key priorities
in the end of life care and develop a
care plan that addresses these issues.
A lot of those conversations is something
that Kristen already brought up and we use those tools in these conversations. And also to help shape future clinical care to the fit the patient’s preferences and values, you know, do they want to go to the emergency room? If they should get sick, would they want to be transferred to the intensive care unit? Would they want to be resuscitated? These are all conversations that we have every day in the hospital. And if we can move some of these conversations into the nonemergent setting, into the primary care office or to
the Cancer Center visit, you know.

It’s a better conversation in that sense.

There are certainly documents in Connecticut that help with these things.

Most recommended I would say is the healthcare representative form.

If a patient lacks capacity to make decisions in the hospital, the providers are going to be looking for somebody that can make decisions for that person. And we want the patient to maintain control as much as possible. And so through this document they can designate who they trust to make medical decisions for them.
Living Will is sort of another document that exists. It’s.

Not the greatest tool in my sense, but certainly helps with promoting the conversation.

And then the last document is the medical orders for life sustaining treatment which exists in Connecticut.

We do have conversations but it’s not most common.

I’d say the healthcare representative conversation is the most common that we have.

The next picture on the slide is just go back one.
how for all of our encounters,

all of our patients,

we always keep them in the center when we work as a team.

We're all working around the patient.

And so certainly primary care is part of those, one of those surrounding circles along with physicians and others.

So it’s just again A-Team sport and we just need to communicate with each other.

This is the last slide I have.

It’s just some common things that we are concerned about when we engage with patients and families,
we sort of look at, you know, suffering as a total, total pain scenario. You know, what are they suffering from? Is it physiologic, is it social, is it spiritual, is it emotional? So questions that we have are are there distressing symptoms? Is there significant social concerns, spiritual concerns affecting their daily life? Does a patient, family surrogate understand the current illness? There’s many a times when I speak to patients who have incurable disease,
but they still think that it is curable and we do have to help with those conversations to help transition the goals at that point. We also asked what are their goals, what treatment options they prefer? Have they completed advanced care planning documents or conversations? And then lastly, what are the key considerations for a safe and sustainable transition from one setting to another? Certainly, we see patients that come back and forth from home to the hospital or hospital to nursing home,
nursing home back to the hospital.

And so we are familiar with a lot of transitions and we try to help support it as best we can.

Okay. So this is our last case. It is a 65 year old female with metastatic lung cancer who presents as a new patient due to a recent move. She is being managed by a new oncologist and is not responding to the current regimen. She is on causing great distress to her. The patient had to move in with her niece.
as she lost her house due to mounting medical bills and inability to work. The patient herself has no children. She needs help with toileting, dressing meals and ambulates only with a Walker for short distances in your office. She is in a wheelchair. The niece has bags under her eyes and she looks very upset throughout the entire encounter. You ask her what is the matter and she begins to cry. The niece tells you she is under a lot of stress, taking care of her aunt and working full time. She feels like she is working two jobs.
She is not taking care of her own. Diabetes and her blood sugars have been in the three hundreds recently. This is clearly an argument the Paris had in the past. The patient states she does not want anyone else in the House because she would not trust them and she’s far too young to go to an old folks home. Also she says she has no money and if her niece does not take care of her, she will be out on the street. So this is a very difficult situation. So how can you take care of the patient and help the niece as well?
And how can palliative care help you in this scenario?

So I’m going to turn over to my colleague.

Liz, you’re on mute.

I am so sorry about that. I was trying to make sure you didn’t hear my kids screaming in the background, and here we are.

So I’m Liz persichen.

Thank you so much for giving me the opportunity to speak here today.

I think what struck me most about that last slide is the comment that the niece felt that she was working two jobs.

And I want to take a moment to acknowledge the significant
caregiving burden that so many of our patients and their families face.

And I know that many of you in the primary care field have seen your own patients be caregivers and seeing the significant caregiving burden that many of your patients require for care.

And I think one thing just to step back is to define palliative care. And palliative care is really a team-based interdisciplinary means to support patients facing serious illness as well as their caregivers and addressing the caregiver distress and the caregiver needs is an
important part of what we do as well.

So the niece is working two jobs.

She's a caregiver.

And our team offers a true interdisciplinary mechanism to support patients and families that are facing serious illness together.

And what I wanted to highlight here is really the amazing team that we have both within SMiLO and in the palliative care programs throughout the only Haven hospital, the only Haven health system. And I was going to talk through them one by one.

So many times people think you know.
Patient is very sick. They need certain resources. Let’s send a referral to palliative care and what exactly does that mean? What do you get with a palliative care referral? What do you get with a palliative care consultation? I want to make sure folks know that consultations are available in the inpatient setting for patients with all diagnoses and in the outpatient setting. Our current availability is really only for the patient population with
cancer and that is a big limitation,

I understand,

but.

We are working on that in the background today,

we’re going to talk about resources we’re going to talk about resources

for patients with cancer.

So when you do place a palliative care consultation or referral,

you’re getting an entire interdisciplinary team that’s working together

with expertise for supporting patients facing serious illness.

We have a team of physicians,

nurse practitioners.

Social work chaplains,
bereavement care as well as ancillary services within and without our palliative care program, including medical, legal support, psycho oncology, integrative medicine and also relationships with Hospice caregivers. So our social work groups offer individual and group programs including both bereavement and grief support groups, not just for patients but also their caregivers. So a mechanism to connect with other people who are...
facing loss or serious illness.

Whether you are the patient or whether you are the caregiver is really important.

Our spiritual care chaplains are available both inpatient and outpatient. They help with Value-based resources, spiritual resources, support for existential concerns, and also help complete some of the advanced care planning that Morgan had discussed earlier. Our palliative care chaplain at Yale is actually one of 20 palliative care certified chaplains in the country, which he’s really proud of. So really a dedicated and
Our Psycho Oncology team has support for resilience building, emotional support skills, CBT as well as expressive therapy and art therapy and we contract with the art therapist who is part of our services as well. And then we have a very well structured bereavement group as well for both telephone outreach in real time, monthly bereavement seminar support groups and also support around times of holidays and memorials for patients and families.
So this is all clearly kind of. Some of this is at end of life and post end of life, but available for patients and caregivers throughout the disease process. And of course we have our physician and APP colleagues who work with primarily symptom management and also navigating these difficult conversations for goals of care, medical decision making, et cetera. So when you reach out for a palliative care consult, you’re getting all of these different services. I did want to speak briefly about
the medical legal support system. So within Yale we have a relationship with Yale Law School and they have a pro bono program for medical legal support for patients that are in need, whether that be related to financial constraints, social constraints or health related issues, so. Guardianship Wills financial complex situations that need to be dealt with in a time sensitive manner, whether that be in the hospital, in the patient’s home, etcetera. We’ve helped navigate guardianship
instant for instance for patients that are facing serious illness that have either minor children or dependent adult children, where times of the essence and these are very important things, not just logistically but also in terms of bringing peace and a sense of closure to families, knowing that their loved ones will be cared for and. Things that are important to them that they value are done.

We also work with our integrative medicine colleagues who have both inpatient and outpatient services.
For patients that are within the system, they offer massage therapy, Reiki, aromatherapy as well to patients in and out of the hospital, which is a huge support. And then also we work closely with Hospice. So if there’s any questions about the Hospice referral program resources in the community, we’re not a Hospice agency. Of course, a lot of times people can find Hospice and highlighted care, but we can certainly help navigate what that system is,
inform, educate and also be a bridge if and when Hospice is appropriate for patients and families, so. You know, I think we have a lot to offer besides symptom management and goals of care and a lot to offer throughout the trajectory of a patient’s serious illness. I think that alludes to Kristen slides. You know from the time of diagnosis whether the intent is curative or whether this is a lifelong illness or some an illness of the very short prognosis, palliative care has a lot to offer in
of improving quality of life,
not just for patients but also for their caregivers.
And I think we all recognize the enormous financial, social, psychological and medical challenges that so many people face with serious illness.
I think I answered all the questions that I was hoping to get to. I’m really looking forward to Q&A. I hope this has been a helpful presentation and I look forward to discussing more with our audience and other panelists.
Thank you so much. That was.
Really great with a lot of very practical pearls in addition to kind of a nice theoretical concept of palliative care. I love the specialty versus nonspecialty palliative care because I think in primary care we are doing palliative care all the time. And so it’s nice to hear that, kind of recognize it and realize that some of the same tools you use are things we can apply across broader diagnosis. I think just a couple of housekeeping things is there will be a survey at the end and that’s how you get the CME. Doctor Chang just posted that and we do have our upcoming talks.
In the meantime, I want to make sure that we open up for questions. We’ve had some really good attendance and I’m interested to hear questions that people have. And Ola, I don’t know if you have any questions, additional questions on the cases that you presented before we move to those who are watching. I guess my just my one question is actually in terms of the medical orders for life sustaining treatment, I feel like that is a very useful
tool and I’m wondering how we can get that in Connecticut. So the Department of Health actually will send them to you for free. That’s how we get it here in Greenwich Hospital. It differs from state to state. It’s based upon the paradigm out of Oregon? The physician orders for license taking treatment. My years in North Carolina. The document was what we called Pulsar Pink, very bright pink. Here in Connecticut,
00:47:12.330 --> 00:47:13.728 it’s more of a neon green,

00:47:13.730 --> 00:47:16.316 so it was intended to stand

00:47:16.316 --> 00:47:18.730 out in a written chart,

00:47:18.730 --> 00:47:21.446 but we don’t have written charts anymore.

00:47:21.450 --> 00:47:22.334 Some of my colleagues,

00:47:22.334 --> 00:47:23.660 it may not be just the

00:47:23.718 --> 00:47:25.050 completion of the document,

00:47:25.050 --> 00:47:26.786 but it serves as sort of a

00:47:26.786 --> 00:47:27.530 template for conversation.

00:47:29.230 --> 00:47:31.330 Yeah. And my understanding is

00:47:31.330 --> 00:47:33.190 that because it has to be green,

00:47:33.190 --> 00:47:34.709 it’s not as easy to scan in.

00:47:34.710 --> 00:47:36.918 So the patient has to carry

00:47:36.918 --> 00:47:38.390 around the green form.

00:47:38.390 --> 00:47:40.105 But certainly having things well

00:47:40.105 --> 00:47:41.828
00:47:40.105 --> 00:47:42.207 documented in the chart and whether
NOTE Confidence: 0.918178208333333
00:47:42.207 --> 00:47:44.503 we do it from inpatient or outpatient,
NOTE Confidence: 0.918178208333333
00:47:44.510 --> 00:47:46.134 these advanced care planning
NOTE Confidence: 0.918178208333333
00:47:46.134 --> 00:47:48.422 has a huge free text section.
NOTE Confidence: 0.918178208333333
00:47:48.422 --> 00:47:51.788 So I hope that you guys look at that
NOTE Confidence: 0.918178208333333
00:47:51.788 --> 00:47:54.308 when we do that from primary care
NOTE Confidence: 0.918178208333333
00:47:54.310 --> 00:47:58.048 for bidirectional communication.
NOTE Confidence: 0.918178208333333
00:47:58.050 --> 00:48:00.570 I'll just add a question as well
NOTE Confidence: 0.918178208333333
00:48:00.570 --> 00:48:02.756 while we wait for some in the
NOTE Confidence: 0.918178208333333
00:48:02.756 --> 00:48:04.328 audience to come up with some.
NOTE Confidence: 0.918178208333333
00:48:04.330 --> 00:48:06.010 So and we're getting that diagram
NOTE Confidence: 0.918178208333333
00:48:06.010 --> 00:48:07.794 that you gave which had that kind of
NOTE Confidence: 0.918178208333333
00:48:07.794 --> 00:48:09.810 circle and then all the caregivers
NOTE Confidence: 0.918178208333333
00:48:09.810 --> 00:48:12.210 around the patient and their family.
NOTE Confidence: 0.918178208333333
00:48:12.210 --> 00:48:14.046 Sometimes I feel like, you know,
NOTE Confidence: 0.918178208333333
00:48:14.050 --> 00:48:15.620 Smilo has such complete services
that in primary care we're a little bit like in outer space around that, maybe not outer space, but in a different room. We're all on the same chart, right? But at the same time, sometimes that communication would be hard. Is it possible to initiate a palliative care consult yet palliative care advice or interact? What's the best way to kind of interact with you guys? Very good question. So different avenues. We all have main office numbers if
people want to call and hopefully we can provide that to the audience. Epic, certainly there is messaging capability from provider to provider, so that could be another platform. And those are the typical ways I communicate when I see a patient and write a note, I CC their primary care physician so that hopefully they get to see the notes as well and are up to speed with what changes may have been done. And then let’s move. We do have a question that came in and the question was, is it possible to introduce
00:49:28.430 --> 00:49:30.926 palliative care too late?
And I think, Liz, you had answered that a little
00:49:33.021 --> 00:49:34.090 in writing, if you want to.
Yeah, I I wanted to answer that.
00:49:36.242 --> 00:49:38.370 And you know, I, I do inpatient palliative
care and a lot of oncology and and
too late by some traditional metrics.
I would argue to say that it’s never too
involved very short periods of time,
but have an enormous impact on the patient,
on the family, on bereavement for the
00:49:56.000 --> 00:49:59.640 on the family, on bereavement for the
caregivers and for a sense of closure and
sometimes the most helpful support we give,
can help support those with complicated
bereavement needs after a patient’s death,
let’s say, you know,
the illness was very brief and there was
a very difficult short hospitalization.
There’s a lot of.
Sense of regret or uncertainty or, you know,
lack of closure for the family member.
Our social workers will contact them
and have bereavement support groups,
one-on-one, counseling,
telephone outreach,
in addition to whatever other support
services they may have access either through Hospice or other places. And that is a really important resource for many people. So I would argue it’s never ever too late to introduce palliative care, ever. I’m so glad Liz asked that or answered that. I wanted to piggyback on top of that because that was the other thing that I wanted to mention is the bereavements of part the other. The other thing, there’s actually a study, and I’m sorry, I don’t know the authors at the moment,
but there was a study that looked at patients, families of patients who had died and asked them how they felt about when palliative care was introduced. And most of the researchers thought that they would be too late. And no matter when in the disease trajectory, palliative care was introduced, the family thought it was the right time. Which whether that’s a psychological confirmation bias or what, it’s just interesting to me that almost always families are just grateful for when it’s offered. And the one thing I will add is
going back to that very first case.
How early can you introduce palliative care?
So, so that my one question was as as I was thinking that as this was coming up it is possible to introduce it right early on. I wouldn’t have referred that patient to palliative care at the time of diagnosis if it wasn’t metastatic and she didn’t have symptoms. But if it was either metastatic or she had symptoms needing to be controlled, then yes, absolutely would consider referring to specialty level powdered care.
And you can introduce it the way I introduce it and my guess is that my palliative care colleagues, it would be pretty similar because we have sort of a national expectation of how we stand.

The best way to think of it as an extra layer of support. There are other versions it’s a team of experts who are going to help partner with me to communication and sometimes decision making.

The best way to think of it as an extra layer of support. There are other versions it’s a team of experts who are going to help partner with me to communication and sometimes decision making.
manage your symptoms etcetera.
But it’s that whole concept of it’s a team.
So, so yes, absolutely could have referred it.
I think that my thought in that first case is she’s just getting the diagnosis, she’s completely overwhelming.
So you really just want to ground her in next steps and if she weren’t actively symptomatic, I’m not sure I would have referred at that point yet.
If I can jump in, just give talks about what I call fishing further upstream,
meaning trying to get involved earlier from the time of diagnosis for palliative cure.

Because when you’re introduced as just another part of the team, you’re not sort of looked at as the Boogeyman or boogeywoman.

I worked with the brain tumor center at Duke and it was sort of what day should we put the care visit on day one or day two. You know, it’s just it was baked in into the care as that extra layer of support.
And when you’re caring for people earlier on, you develop relationships with them, they develop trust with you and you get to know the team and know their desires basically. Earlier is better but at any time we can certainly help that’s terrific. I don’t see more questions coming in but I’ll just make one more comment and and that is that all, all of these words matter and I know that and you know Ola knows that because we see the families afterwards.
whether it’s because they’re also our patients or because we kind of do a. A later follow up that’s I think not always but often part of primary care after a longstanding relationship. And I can’t tell you how much words matter. And people will recount entire conversations that happened in those, help them be comfortable with what’s happening especially true it helps them to you know not feel guilty or
not feel bad about how things went.

So I think it’s it’s great.

We have one more question that came in.

Can you repeat information on training for having tough conversations.

I think that was one of Kristin’s slides.

Yeah.

Are these slides made available for afterwards as well because they’re actually links on them to the specifics.

It’s, yeah, it’s a recording

Maybe I can send those to you Karen,

and maybe we can send them out.

But the there there are
three sites, so one is cap CW w.capcapc.org. The next one is vital talk, which is W Vitaltalk.org I believe and then if you Google cuz the the the link was quite long the serious illness conversation would be the one that the other one.

All right so and do you wanna I think you had one more comment.

I just wanted to I know this is geared towards the primary care population and they just want to highlight how important you know you Karen was saying that
words matter and the words that you share the conversations you have with your patients matter more than any advanced care planning document or healthcare representative. Those are certainly important but for the patients and their loved ones to know what their wishes are what they would or would not want is so important in the earlier you have those conversations and more honestly and openly have those conversations they matter and.

Been involved in the care of many patients and patient who,
you know, they want to know what their PCP thinks that you know,
they've seen a million specialists,
they've been through the wringer,
they've had every test under the sun and they want to know what Dr. Brown thinks.
And so when I'm able to engage with primary care doctors,
it's like speaking to an old family friend or a loved one,
like getting that history and that collaboration and also the medical expertise is there.
And so I really value that work and want to thank everyone who's listening for that.
And also think of us if you’re worried about a patient with serious illness and you want the palliative care team to do a check, I’m worried about symptoms. They’ve had a lot of financial stressors. Their loved ones are really struggling. You know, we’re here to advocate along with you, and our team rolls deep. It’s not just doctors and nurses.
You’ve got a lot of great resources to help support your patient.

There is a question, let’s see from the attendee, will you be able to send contact information for scheduling to those that attended tonight?

I don’t know if we can put something into the chat or else. Maybe folks can repeat that for scheduling. So that’s for scheduling palliative care consultation.

You think maybe we need to clarify that question or is it, I think there’s a different way to do it inpatient and outpatient, right folks, I mean.
That’s how it kind of flows to us. It’s an ambulatory referral to palliative care and it lists the different sites. New Haven or Greenwich that is the easiest for providers through the epic system. Yeah. And it depends the, the organization is based on where their primary oncologist resides, their primary oncologist is at York Street, then they’re at main campus. If they’re at North Haven or Greenwich, then that’s where their palliative care services would be rendered. Yes, you can do it through epic.
I do it once several times a week.

We're a minute over want to thank.

I mean this is such a terrific team.

I'm so glad that you guys are here taking care of our patients and helping us.

I've learned so much from this presentation, Chris,

and I've used half of those things today when I've talked to patients.

Hola, Karen, thank you.

Thank you all for your input and thanks for folks for showing up.

And continuing to show up.

Please tell your colleagues and of course,

feel free to access this online.

Have a great night.
Thanks everybody and stay on for the questionnaire because that’s the CME.