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 cancer 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 or other people want to access these afterwards there’s a YouTube link.

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 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 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

00:02:50.008 --> 00:02:52.654 learning more today about how we can

00:02:52.654 --> 00:02:55.098 help them at the the end of their

00:02:55.098 --> 00:02:57.288 cancer journey or as they get more

00:02:57.288 --> 00:02:59.268 advanced in their cancer journey.

00:03:01.470 --> 00:03:04.242 I want to introduce my Northeast

00:03:04.242 --> 00:03:06.690 Medical Group colleague, Dr.

00:03:06.690 --> 00:03:08.810 Ola Rosinski.

00:03:08.810 --> 00:03:11.474 She received her undergraduate degree in

00:03:11.474 --> 00:03:16.707 She then went on to medical school

00:03:16.707 --> 00:03:19.970 at Yagolonian did I get it right?

00:03:19.970 --> 00:03:22.50 University Medical College in Poland,

00:03:22.50 --> 00:03:24.272 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 an special interest in the ancient Near East.
I’ll pass it along to you. And for your introductions, 
I on now? That’s helpful, I’d like to introduce Doctor Morgan Bain. He’s currently the section head for palliative care at Greenwich Hospital. 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 complex medical needs. His passions are patient care and medical education, and he has taught hundreds of medical students 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 a national award given every

00:05:50.695 five years to 40 leaders in the

00:05:52.668 field of palliative care.

00:05:53.770 So fantastic work, Christian.

00:05:57.090 And then finally Doctor Liz Persich.

00:06:02.730 She’s a physician specializing in

00:06:05.410 medical oncology and palliative care.

00:06:08.780 degree from George Washington.

00:06:11.840 University School of Medicine and did

00:06:14.660 her residency and fellowship at Brown.

00:06:17.324 She is certified.

00:06:21.660 she had a fellowship also at Brown

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. And 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 ******. The mass is firm, with no tenderness of the mass itself, but there is tenderness of the surrounding tissue. 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 a couple of 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
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 this 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 next steps.

For the moment,

I think my communication pros will come
00:12:34.132 --> 00:12:36.004 in after the next part of this case.
00:12:36.010 --> 00:12:37.487 So I'll talk about that then.
00:12:40.700 --> 00:12:43.017 So we’re going to continue the case.
00:12:43.020 --> 00:12:45.188 The patient afterwards underwent
00:12:45.188 --> 00:12:47.898 lumpectomy with lymph node dissection.
00:12:47.900 --> 00:12:51.267 She had 12 or 14 Sentinel notes
00:12:51.267 --> 00:12:53.500 positive for metastatic disease.
00:12:53.500 --> 00:12:55.528 About four months later,
00:12:55.528 --> 00:12:58.570 the patient really begins to decline.
00:12:58.570 --> 00:13:00.970 The work up at that time included a
00:13:00.970 --> 00:13:03.644 pet CT that showed avid mediastinal
00:13:03.644 --> 00:13:06.144 bilateral hilar and left internal
00:13:06.144 --> 00:13:08.683 mammary lymph nodes that were
00:13:08.683 --> 00:13:10.647 highly suspicious for metastasis,
00:13:10.650 --> 00:13:13.608 avid multifocal liver and osseous metastasis,
00:13:13.610 --> 00:13:15.596 lytic metastasis involving
the right occipital condyle.

Her daughters at this point are with her in the appointment,

and I’ve heard that even with Mets, some patients can be cured.

Her declining functional status is noted.

She has by this point been spending more than half her time in bed during the day.

So the question that we have is how do you transition her goals of care at this juncture?

And I think Doctor Edwards is going to talk a little bit more about that.
through some of the communication tools and some of these would have been appropriate even in the first conversation that I had with this patient. So that’s really important to recognize. You may have seen some of these tools already there. While we do think of them as palliative care tools, they’re really just communication tools and some of them you will have seen in other forms that do communication. So whether it’s leadership training or education or patient standard relation communication, you may have seen similar
00:14:21.492 --> 00:14:22.950 phrases that are used.

00:14:22.950 --> 00:14:24.230 So I’m going to go through each one of these.

00:14:28.510 --> 00:14:31.318 I’m sorry the the slide I think got.

00:14:31.320 --> 00:14:32.328 Change. So the first one is

00:14:32.328 --> 00:14:33.259 actually supposed to read, ask,

00:14:33.259 --> 00:14:34.813 tell, ask and then the second

00:14:34.813 --> 00:14:36.559 one is I wish statement.

00:14:36.560 --> 00:14:37.304 So bear with me.

00:14:37.304 --> 00:14:38.919 It’s not important for the slide but it does,

00:14:38.920 --> 00:14:40.558 it does matter in terms of the the terms.

00:14:40.560 --> 00:14:41.148 So ask, tell,

00:14:41.148 --> 00:14:42.520 ask is a way we think of

00:14:42.579 --> 00:14:44.079 structuring the conversation.

00:14:44.080 --> 00:14:45.816 So actually if you go back to
that first conversation with the patient what you when you ask, you ask what they know and what they want to know. You wait for their answers and then what based on what they say then you tell them what they've asked and what the clinical update asked and what the clinical update is and then you ask again. What have they heard so that you make sure that you have explained it well? What questions do they have and what else do they want to know? And the reason to do it in this structure is it really helps pace the 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.
So simply tell me more and then the next one. That should be an I wish statement or an I worry those two things. I wish statements there to say.

When someone is expressing something that you don’t think is realistically possible. So an example would be I wish that we were going to be able to cure this cancer with more chemotherapy, and I’m worried that that may not be possible given your functional status. When you combine them that way, it does two things. 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? And that will prompt them to to discuss what’s on their mind.

Lastly, there is a pneumonic to help reinforce those empathic statements. So nurse emotions, which is stands for you, name the emotion.
00:19:05.463 --> 00:19:08.060 It it sounds like you’re very frustrated
00:19:08.131 --> 00:19:10.308 or it sounds like you’re very sad.
00:19:10.310 --> 00:19:11.948 Understand. Can you tell me a little
00:19:11.948 --> 00:19:13.390 bit more about what’s helping?
00:19:13.390 --> 00:19:15.588 What’s making you feel sad right now?
00:19:15.590 --> 00:19:16.362 I respect.
00:19:16.362 --> 00:19:19.064 So respect is we respect the journey,
00:19:19.070 --> 00:19:20.183 respect that personhood.
00:19:20.183 --> 00:19:22.409 I can understand how you might
00:19:22.409 --> 00:19:24.387 feel sad in the circumstances.
00:19:24.390 --> 00:19:26.796 I would certainly feel sad too.
00:19:26.800 --> 00:19:29.230 The support piece is really important
00:19:29.230 --> 00:19:31.597 for aligning yourself with that person
00:19:31.597 --> 00:19:33.637 for the duration of their care.
00:19:33.640 --> 00:19:35.872 I am going to be here and walk you
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 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.
This is a typical patient we would kind of see in the outpatient pitive care arena before coming to you on the Haven health system. I was at Duke as the medical director outpatient pitive care and so many patients in the Duke Cancer Center that were actively going through treatment. We weren’t at end of life scenario. This was trying to help them live as best as possible and so that’s the goal of Pitive cares to help improve quality of life. Regardless of where they are in their treatment trajectory. So how can palliative care help manage her symptoms?
So we'd like to think that we're experts in managing symptoms related to serious illness, in this case cancer we. Kind of are the ones that assess them frequently in our visits. We have some assessment tools like the Edmonton Symptom Assessment Scale, which just has 8 to 10 different questions about do you have fatigue, do you have pain, are you sleeping, are you anxious, are you nervous, are you depressed? So, so it's a regular thing that we assess for when we have patient encounters.
and not uncommon pain and fatigue

are the most common symptoms that we find for patients with cancer.

So we deal with it quite frequently.

So one is just assessing how severe are the symptoms.

Is it just mild and a mild nuisance to her or is this something that really

is moderate to severe and so it’s just trying to figure out where they’re at.

And those are through basic questions that we’re all taught through our medical training, so.

When we are taking care of patients,

we will frequently see them.

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 --> 00:25:55.013 pain medicines and that it’s really weighing the benefits and burdens of it. But hopefully our role is to help support the patient through that process so that they are aware, they know what they’re getting into, where they’re to monitor them closely.

00:25:55.013 --> 00:25:58.343 Nausea is certainly another chemo related immune related disease side effect. And so one other thing I’d like to say is that sometimes we like to pull things out of our sleeves like with fatigue certainly.

00:25:58.350 --> 00:26:06.630 00:26:12.890 00:26:16.024 00:26:19.370 00:26:21.770 00:26:23.574 00:26:24.927 Most commonly, we recommend exercise. Sometimes we’re talking about 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. 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
00:26:59.476 --> 00:27:01.456 a long prognosis of many years.

00:27:01.460 --> 00:27:03.060 Certainly steroids we use for

00:27:03.060 --> 00:27:04.660 pain management as an adjuvant,

00:27:04.660 --> 00:27:07.028 but we don’t want to put people on

00:27:07.028 --> 00:27:09.324 steroids for several months to years

00:27:09.324 --> 00:27:11.880 knowing the side effects of that.

00:27:11.880 --> 00:27:14.262 There’s certain things that we wouldn’t

00:27:14.262 --> 00:27:16.280 recommend if prognosis is short,

00:27:16.280 --> 00:27:18.480 things like total parental nutrition

00:27:18.480 --> 00:27:20.680 for help with nutritional support.

00:27:20.680 --> 00:27:22.560 If the prognosis is less than three months,

00:27:22.560 --> 00:27:23.928 the literature would generally

00:27:23.928 --> 00:27:24.954 not support that.

00:27:24.960 --> 00:27:27.599 So it definitely plays a factor into

00:27:27.599 --> 00:27:30.885 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
00:28:02.475 --> 00:28:05.170 about at length in another venue,

00:28:05.170 --> 00:28:06.970 but it’s important for patients

00:28:06.970 --> 00:28:09.586 to know that sometimes for life

00:28:09.586 --> 00:28:11.330 planning and other things.

00:28:11.330 --> 00:28:12.690 Moving to the last question,

00:28:12.690 --> 00:28:14.586 what is the role of primary

00:28:14.586 --> 00:28:16.650 care in the care team here?

00:28:16.650 --> 00:28:17.220 As mentioned,

00:28:17.220 --> 00:28:18.645 I’m trained in geriatric medicine,

00:28:18.650 --> 00:28:20.198 Hospice and palliative medicine.

00:28:20.198 --> 00:28:22.133 And in those two disciplines

00:28:22.133 --> 00:28:23.926 it’s very much a team sport.

00:28:23.930 --> 00:28:26.729 I know that I can’t provide the care myself.

00:28:26.730 --> 00:28:28.078 It takes, you know,

00:28:28.078 --> 00:28:30.146 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. So there’s not a lot of trust build up yet. 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, or 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
00:30:35.702 --> 00:30:37.560 needs and not necessarily prognosis,
NOTE Confidence: 0.950317
00:30:37.560 --> 00:30:40.143 but it’s a it’s an entry question
NOTE Confidence: 0.950317
00:30:40.143 --> 00:30:42.230 to figuring out the trigger.
NOTE Confidence: 0.950317
00:30:42.230 --> 00:30:44.180 Certainly people are coming to
NOTE Confidence: 0.950317
00:30:44.180 --> 00:30:46.040 the hospital frequently if they’ve
NOTE Confidence: 0.950317
00:30:46.040 --> 00:30:48.110 had a severe decline in function,
NOTE Confidence: 0.950317
00:30:48.110 --> 00:30:50.082 unintended decline in weight.
NOTE Confidence: 0.950317
00:30:50.082 --> 00:30:52.054 Secondary criteria include things
NOTE Confidence: 0.950317
00:30:52.054 --> 00:30:54.430 such as an elderly patient,
NOTE Confidence: 0.950317
00:30:54.430 --> 00:30:57.510 metastatic or locally advanced cancer,
NOTE Confidence: 0.950317
00:30:57.510 --> 00:31:00.510 cardiac arrest. So it goes on and on.
NOTE Confidence: 0.950317
00:31:00.510 --> 00:31:02.586 And so they exist out there.
NOTE Confidence: 0.950317
00:31:02.590 --> 00:31:04.732 We in the hospital here have a
NOTE Confidence: 0.950317
00:31:04.732 --> 00:31:06.608 resource card which we carry around
NOTE Confidence: 0.950317
00:31:06.608 --> 00:31:08.701 and it has a number of questions.
NOTE Confidence: 0.950317
00:31:08.710 --> 00:31:11.034 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,
run into staff who, you know, we hear the words patient is not ready for palliative care and that is a barrier. If they’re not ready for palliative care or don’t want palliative care, then we’re not allowed to be involved in their care. And so it’s trying to highlight the positive things about palliative care. You know, palliative care is there to help improve quality of life. And that’s the focus talking about Hospice, talking about stopping treatments, talking about death is certainly very charged and very powerful and patients don’t readily.
Embrace that and that is often a barrier to getting high to care involved. So, this is 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
00:33:23.769 --> 00:33:25.881 that Kristen already brought up and we use those tools in these conversations.
00:33:27.580 --> 00:33:29.236 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 is just
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? 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.

And I think that is it.

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 was trying to make sure you didn’t hear my kids screaming in the background, and here we are.

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
00:39:01.907 --> 00:39:04.049 caregiving burden that so many of our patients and their families face.

00:39:04.049 --> 00:39:05.699 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.

00:39:07.545 --> 00:39:09.439 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
00:39:31.269 --> 00:39:33.173 important part of what we do as well.
NOTE Confidence: 0.931867433333333
00:39:33.180 --> 00:39:35.630 So the niece is working two jobs.
NOTE Confidence: 0.931867433333333
00:39:35.630 --> 00:39:37.949 She’s a caregiver.
NOTE Confidence: 0.931867433333333
00:39:37.950 --> 00:39:40.356 And our team offers a true
NOTE Confidence: 0.931867433333333
00:39:40.356 --> 00:39:41.559 interdisciplinary mechanism to
NOTE Confidence: 0.931867433333333
00:39:41.559 --> 00:39:43.747 support patients and families that
NOTE Confidence: 0.931867433333333
00:39:43.747 --> 00:39:45.902 are facing serious illness together.
NOTE Confidence: 0.931867433333333
00:39:45.910 --> 00:39:47.566 And what I wanted to highlight
NOTE Confidence: 0.931867433333333
00:39:47.566 --> 00:39:49.582 here is really the amazing team
NOTE Confidence: 0.931867433333333
00:39:49.582 --> 00:39:52.318 that we have both within SMILo and
NOTE Confidence: 0.931867433333333
00:39:52.318 --> 00:39:54.028 in the palliative care programs
NOTE Confidence: 0.931867433333333
00:39:54.028 --> 00:39:55.710 throughout the only Haven hospital,
NOTE Confidence: 0.931867433333333
00:39:55.710 --> 00:39:58.030 the only Haven health system.
NOTE Confidence: 0.931867433333333
00:39:58.030 --> 00:39:59.353 And I was going to talk through
NOTE Confidence: 0.931867433333333
00:39:59.353 --> 00:40:00.150 them one by one.
NOTE Confidence: 0.931867433333333
00:40:00.150 --> 00:40:02.845 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?

And 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 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,
bureavement 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
focused response there.

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 in the community, we’re not a Hospice agency. Of course, a lot of times people can found Hospice and highlighted care, but we can certainly help navigate what that system is.
inform, educate and also be a bridge if 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
terms 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, 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 some of the same tools you use are things we can apply across broader diagnosis.

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 what was originally the pulsed 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,
NOTE Confidence: 0.931785312307692
00:47:12.330 --> 00:47:13.728 it's more of a neon green,
NOTE Confidence: 0.931785312307692
00:47:13.730 --> 00:47:16.316 so it was intended to stand
NOTE Confidence: 0.931785312307692
00:47:16.316 --> 00:47:18.730 out in a written chart,
NOTE Confidence: 0.931785312307692
00:47:18.730 --> 00:47:21.446 but we don’t have written charts anymore.
NOTE Confidence: 0.931785312307692
00:47:21.450 --> 00:47:22.334 Some of my colleagues,
NOTE Confidence: 0.931785312307692
00:47:22.334 --> 00:47:23.660 it may not be just the
NOTE Confidence: 0.931785312307692
00:47:23.718 --> 00:47:25.050 completion of the document,
NOTE Confidence: 0.931785312307692
00:47:25.050 --> 00:47:26.786 but it serves as sort of a
NOTE Confidence: 0.931785312307692
00:47:26.786 --> 00:47:27.530 template for conversation.
NOTE Confidence: 0.918178208333333
00:47:29.230 --> 00:47:31.330 Yeah. And my understanding is
NOTE Confidence: 0.918178208333333
00:47:31.330 --> 00:47:34.709 it’s not as easy to scan in.
NOTE Confidence: 0.918178208333333
00:47:33.190 --> 00:47:34.709 that because it has to be green,
NOTE Confidence: 0.918178208333333
00:47:34.710 --> 00:47:36.918 So the patient has to carry
NOTE Confidence: 0.918178208333333
00:47:36.918 --> 00:47:38.390 around the green form.
NOTE Confidence: 0.918178208333333
00:47:38.390 --> 00:47:40.105 But certainly having things well
NOTE Confidence: 0.918178208333333
documented in the chart and whether
we do it from inpatient or outpatient,
these advanced care planning
has a huge free text section.
So I hope that you guys look at that
when we do that from primary care
for bidirectional communication.
I'll just add a question as well
while we wait for some in the
audience to come up with some.
So and we’re getting that diagram
that you gave which had that kind of
circle and then all the caregivers
around the patient and their family.
Sometimes I feel like, you know,
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.
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.

We do have a question that came in and the question was, is it possible to introduce
palliative care too late?

And I think, Liz, you had answered that a little

in writing, if you want to.

Yeah, I I wanted to answer that.

And you know, I, I do inpatient palliative care and a lot of oncology and and

oftentimes like our consoles do come too, too late by some traditional metrics.

I would argue to say that it’s never too late to introduce palliative care, however.

I think sometimes we’re involved very short periods of time,

but have an enormous impact on the patient,
00:49:59.640 --> 00:50:01.880 caregivers and for a sense of closure and
NOTE Confidence: 0.895637679166667
00:50:01.940 --> 00:50:04.397 sometimes the most helpful support we give,
NOTE Confidence: 0.895637679166667
00:50:04.400 --> 00:50:07.246 just making sure I’m not muted is when we
NOTE Confidence: 0.895637679166667
00:50:07.246 --> 00:50:08.938 can help support those with complicated
NOTE Confidence: 0.895637679166667
00:50:08.938 --> 00:50:10.637 bereavement needs after a patient’s death,
NOTE Confidence: 0.895637679166667
00:50:10.640 --> 00:50:11.704 let’s say, you know,
NOTE Confidence: 0.895637679166667
00:50:11.704 --> 00:50:14.090 the illness was very brief and there was
NOTE Confidence: 0.895637679166667
00:50:14.090 --> 00:50:15.920 a very difficult short hospitalization.
NOTE Confidence: 0.895637679166667
00:50:15.920 --> 00:50:17.280 There’s a lot of.
NOTE Confidence: 0.895637679166667
00:50:17.280 --> 00:50:19.950 Sense of regret or uncertainty or, you know,
NOTE Confidence: 0.895637679166667
00:50:19.950 --> 00:50:22.155 lack of closure for the family member.
NOTE Confidence: 0.895637679166667
00:50:22.160 --> 00:50:24.722 Our social workers will contact them
NOTE Confidence: 0.895637679166667
00:50:24.722 --> 00:50:26.960 and have bereavement support groups,
NOTE Confidence: 0.895637679166667
00:50:26.960 --> 00:50:27.692 one-on-one, counseling,
NOTE Confidence: 0.895637679166667
00:50:27.692 --> 00:50:28.424 telephone outreach,
NOTE Confidence: 0.895637679166667
00:50:28.424 --> 00:50:30.620 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, even. I’m so glad Liz asked that or answered that. I wanted to 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 mastatic 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. I say it’s a specialty of medicine, it’s a focus on symptoms, communication and sometimes decision making. The best way to think of it as an extra layer of support. There are other versions that whether it’s, you know, it’s a team of experts who are going to help partner with me to
manage your symptoms etcetera.

But it’s that whole concept of it’s a team.

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. That sense you, you know, I worked with the brain tumor center at Duke and it was sort of what day should we put the to care visit as they’re seeing the radiation oncologist, medical oncologist, surgical oncologist, 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 that is that 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 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, whether it was a turning point in management to more palliative care, to Hospice care or the actual death and, words that set them. Help them be comfortable with what’s happening ring especially true it helps them to you know not feel guilty or
not feel bad about how things went.
So I think 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 on any of the slides.
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

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 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. They’ve had a lot of financial stressors. Their loved ones are really struggling. You know, I’m worried about symptoms. I’m worried about. You know, ask the team or contact us directly. We’re happy to see your patients. We’re here to advocate along with you. 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 attendees, 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. 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.

So 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,

quote UN quote. So if 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.

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.