Thank you for joining us!

VCU Palliative Care ECHO will start shortly.

*ECHO: Extension of Community Healthcare Outcomes

VCU Palliative Care ECHO*

October 10, 2019

Outpatient Palliative Care

*ECHO: Extension of Community Healthcare Outcomes

Continuing Medical Education

October 10, 2019| 12:00 PM | teleECHO Conference

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Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Continuing Nursing Education: 1.5 CE Contact Hours

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Disclosures

October 10, 2019| 12:00 PM | teleECHO Conference

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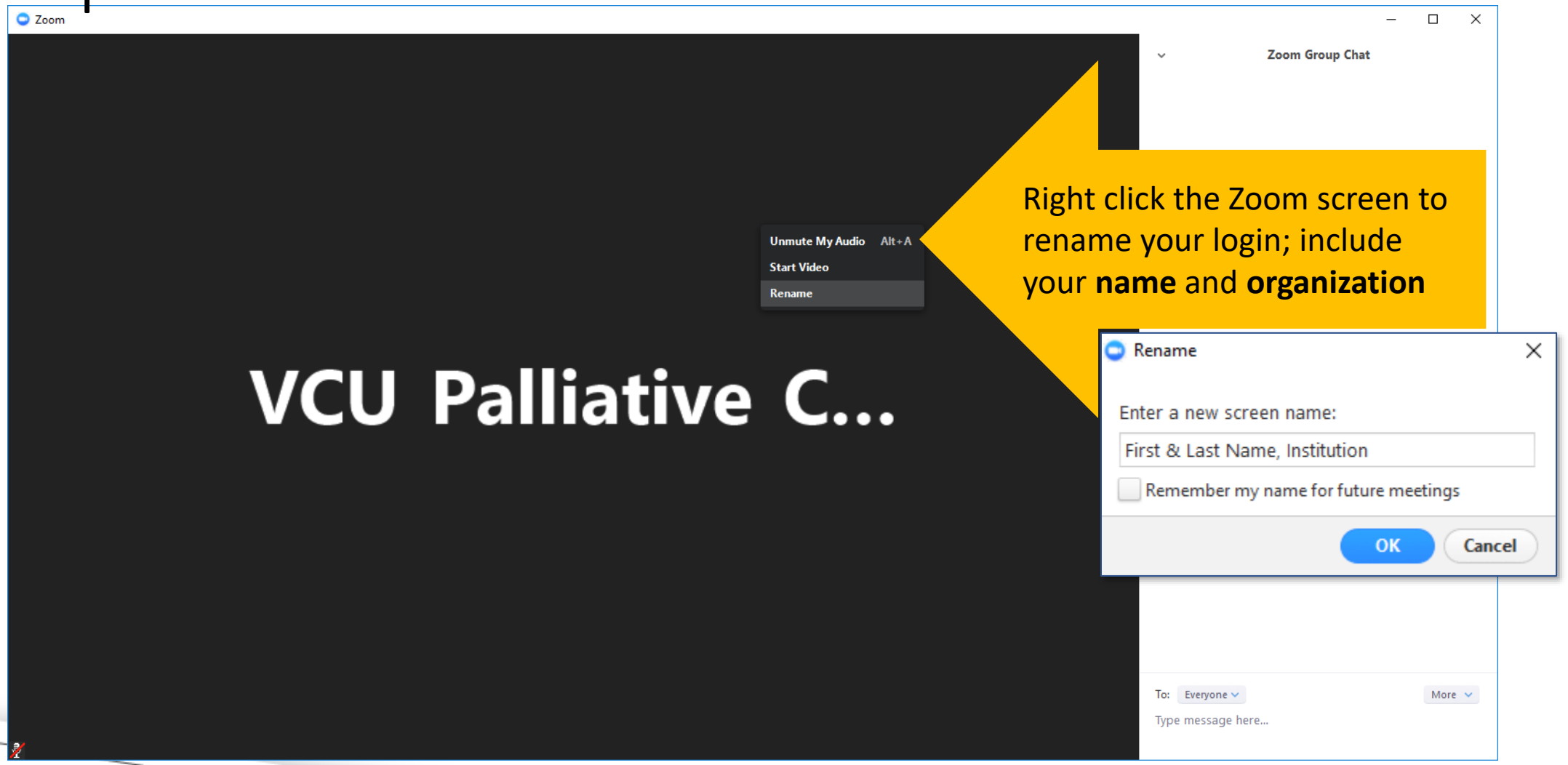
The following Planning Committee and Presenting Faculty Members report relevant financial relationships to disclose:

The following Planning Committee and Presenting Faculty Members report having no relevant financial relationships:

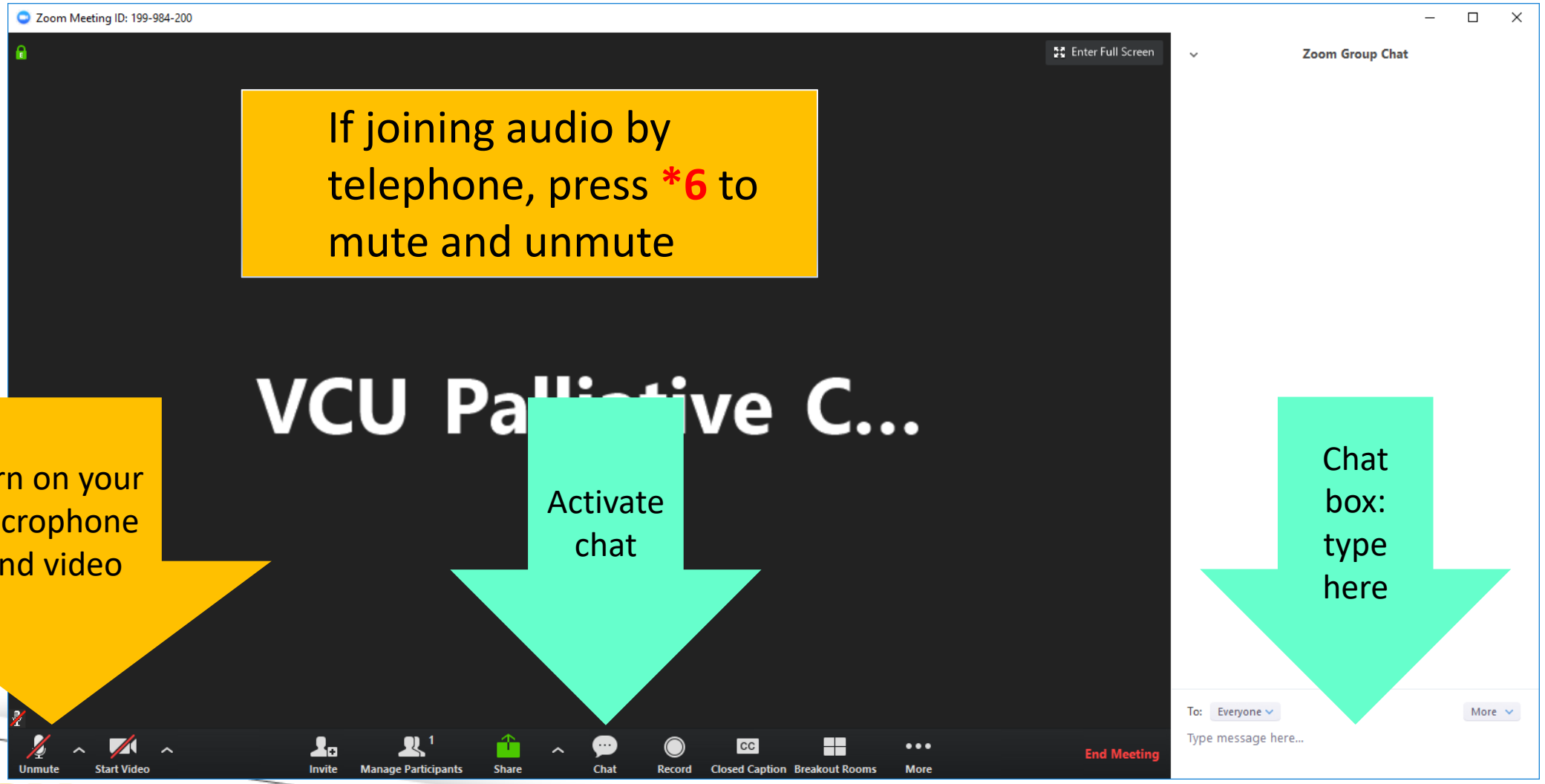
Emily B. Rivet, MD MBA FACS FASCRS
Danielle Noreika, MD

No commercial or in-kind support was provided for this activity

Helpful Reminders



Helpful Reminders



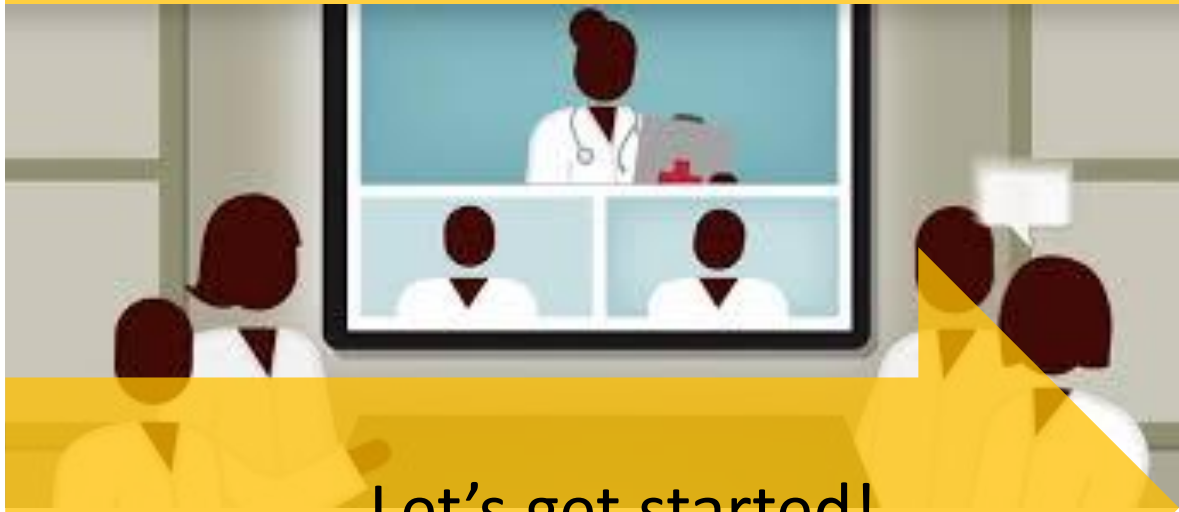
What to Expect

I. Didactic Presentation
   20 minutes + Q&A

II. Case Discussions
   - Case Presentation
     5 min.
   - Clarifying questions from spokes, then hub
     2 min. each
   - Recommendations from spokes, then hub
     2 min. each
   - Summary (hub)
     5 min.

III. Closing and Questions

- Bi-weekly tele-ECHO sessions (1.5 hours)
- Didactic presentations developed by inter-professional experts in palliative care
- Website: www.vcuhealth.org/pcecho
- Email: pcecho@vcuhealth.org



Let's get started!

Hub Introductions

VCU Team	
Clinical Directors	Egidio Del Fabbro, MD VCU Palliative Care Chair and Program Director Danielle Noreika, MD, FACP, FAAHPM Medical Director/Fellowship Director VCU Palliative Care
Clinical Experts	Candace Blades, JD, RN – Advance Care Planning Coordinator Brian Cassel, PhD – Palliative Care Outcomes Researcher Jason Callahan, MDiv – Palliative Care Specialty Certified Felicia Hope Coley, RN Diane Kane, LCSW – Palliative Care Specialty Certified Tamara Orr, PhD, LCP – Clinical Psychologist
Support Staff Program Manager Telemedicine Practice Administrator IT Support	 Teri Dulong-Rae & Bhakti Dave, MPH David Collins, MHA Frank Green

Spoke Participant Introductions

Name and Institution

Case Presentation

Emily Rivet MD MBA FACS FASCRS

- CC: Patient is a 69 year old female initially presented to ED via EMS transfer from OSH for “scalp mass”
- HPI: The growth has been present for ~ 40 years or possibly her entire life but for most of that time, small, “thumb-sized.” Has grown rapidly over the last several months
  - + Discharge
  - Denies any fevers, chills, nausea, vomiting, unintentional weight loss, or night sweats
- PMH: Arthritis, super-morbid obesity, has not seen a physician in 40 years
- PSH: Denies
- SH: negative for alcohol, tobacco, + marijuana
- FH: reports sister and daughter with similar birth marks

- ROS: negative
- Meds:
- Allergies: none

- Physical exam:

  VS: 37.1 169/65 94 17 99

  Height 170 cm, weight 218 kg, BMI 75

  General: comfortable, no acute distress

  Eye: no scleral icterus

  HEENT: Palpable firm lymphadenopathy to the R neck. None detected to L neck or supraclavicular space b/l, exam limited by patient habitus. Large fungating head mass on the R posterior aspect of the head, approximately 9 cm wide. Open and draining brown and purulent fluid.

  Respiratory: Normal effort of breathing. Symmetric chest wall expansion

  Cardiovascular: regular rate rhythm

  Gastrointestinal: nontender, nondistended

  Neurologic: awake alert and orient to person, place and time

  Extremities: moving all extremities spontaneously

- Labs

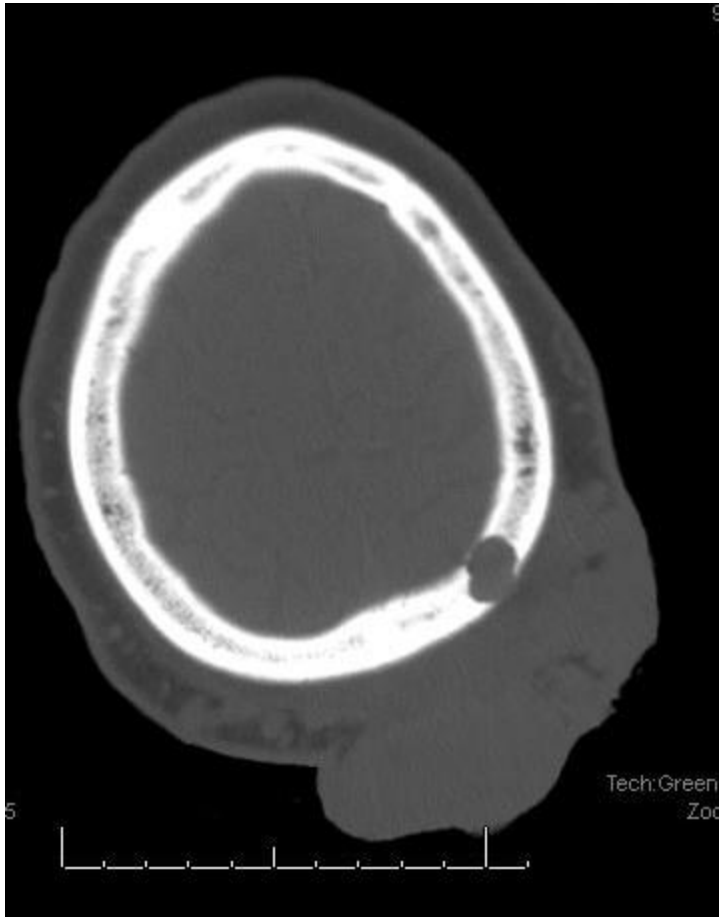
BMP (09/16 20:22) Na 131 K 4.5 Cl 100 CO2 26 AG 5 BUN 7 Cr 0.88 Glu 151 Ca 12.8

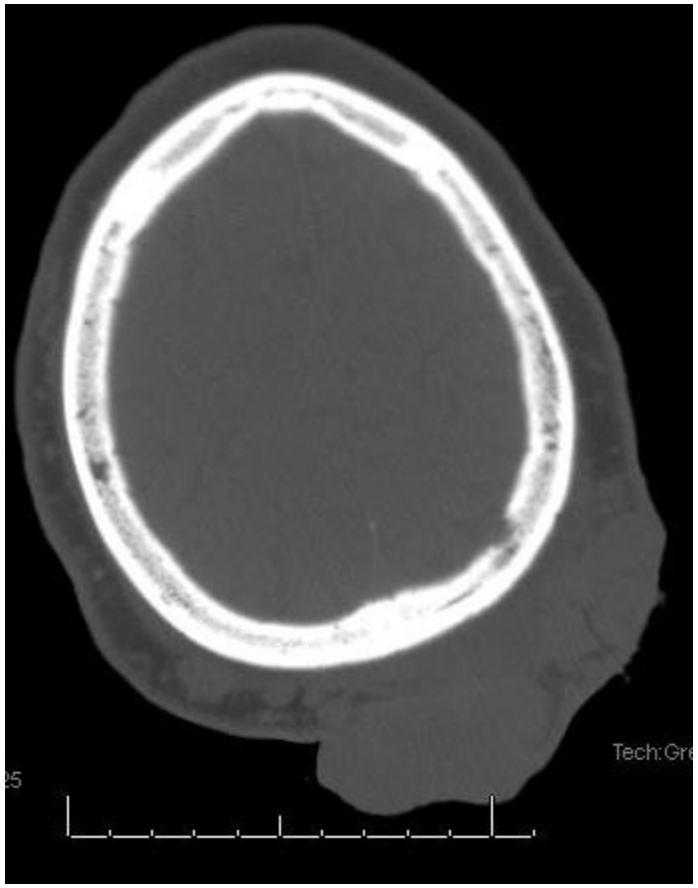
CBC (09/16 20:22) Hgb 12.1 HCT 38.2 WBC 12.4 MCV 92.3 PLT 359

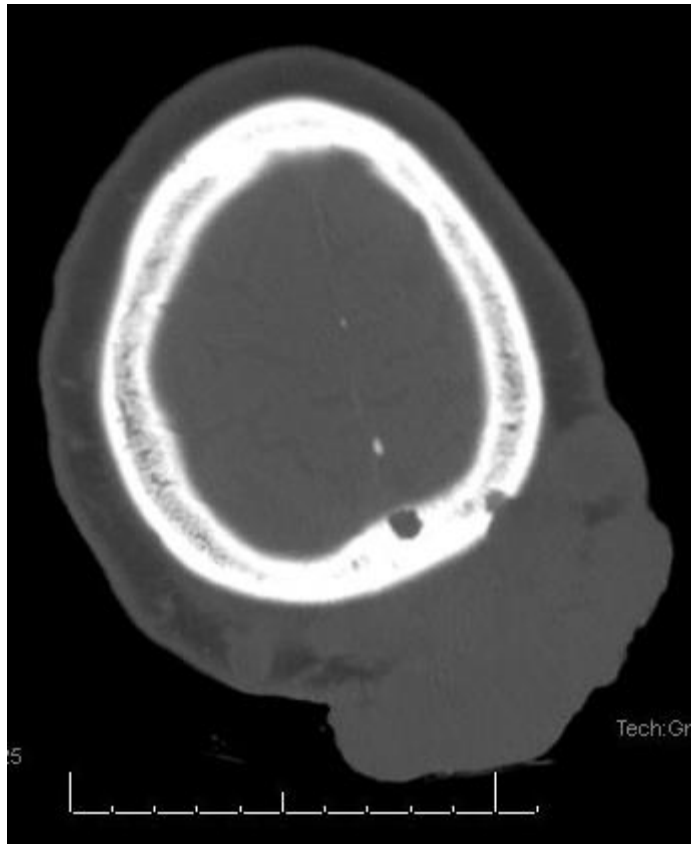
DIF (09/16 20:22) Neu 77.6% Lym 13.4% Mono 7.7% Eos 0.9% Baso 0.4%

COAG (09/16 20:22) PTT 31 PT 15.3 INR 1.2

- Imaging



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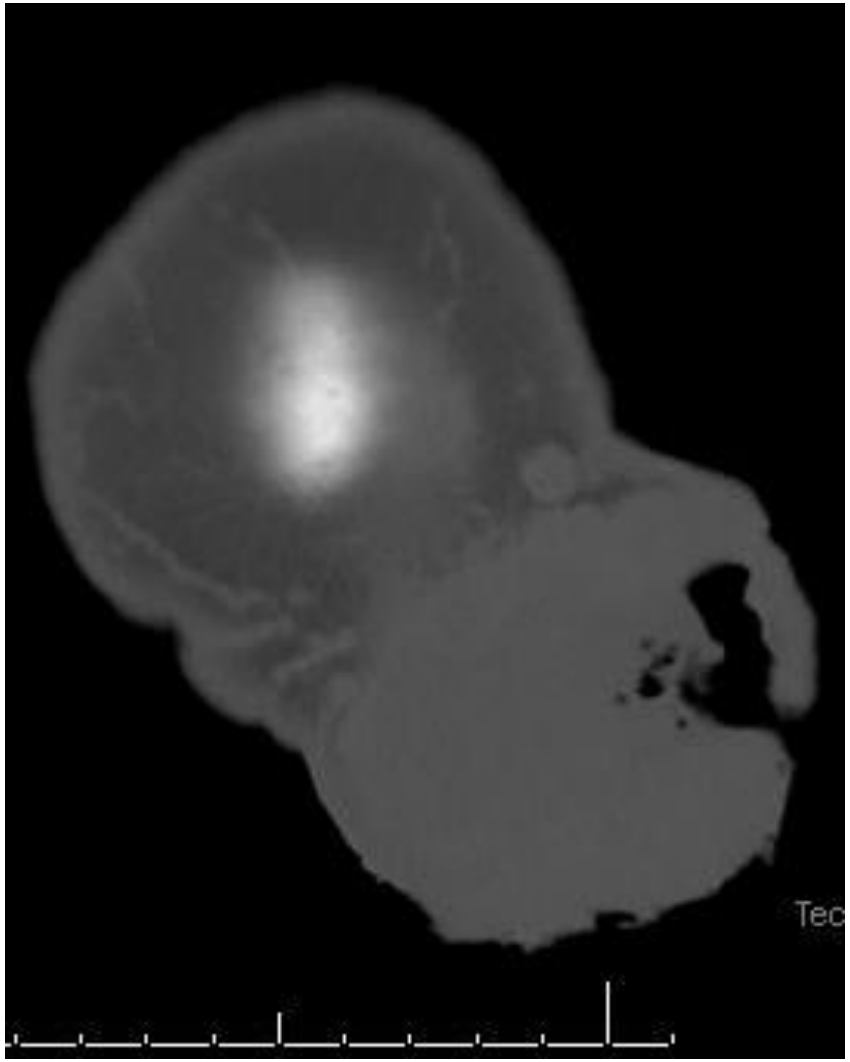


Further evaluation

- **Surgical Pathology Comment (Verified)**
- Sections demonstrate a complex, infiltrative proliferation of atypical epithelial cells with squamous differentiation. The histopathologic findings are consistent with an invasive carcinoma with squamous differentiation. The differential diagnosis includes an invasive squamous cell carcinoma, or an adnexal carcinoma with extensive squamous differentiation. Given the lack of ductal differentiation, as supported by the immunohistochemical stain EMA, an invasive squamous cell carcinoma is favored. The lesion extends to both the deep and peripheral margins in the sections examined.

Further path

- **UN Micro Interp**
- **Mass, left neck, level IIIB; ultrasound guided fine needle aspiration biopsy (smears and cell block):**
- - Malignant cells present
- - Metastatic squamous cell carcinoma.

Social Work

The patient has three adult children. Her youngest son resides in California, however, manages the household finances for the patient and her husband. Her oldest son resides in Richmond, VA. and her daughter in Pennsylvania. SNF placement is being recommended for the patient, however, she adamantly refuses this, stating "I'm going home!" PT and OT also talked with the patient about this to no avail. She is requesting assistance with transportation back home (Will need to use Alternative Funds for this purpose). Tendercare is not able to assist, stating that the patient, who weighs 505 lbs, is too wide for their wheelchair and stretcher. Richmond Ambulance is able to assist with transportation for a charge of $912.00 one way. The patient said that she may be able to pay a portion of this (She has placed a call to her son who manages the household finances; will follow up). The patient is Medicaid pending (Per Financial Counseling) and does not have Medicare. When asked about this, she stated that she has applied for Medicare on numerous occasions, however, was always turned down. The reason she was given is that she does not have enough quarters in the systen to qualify.

Hem Onc

- 69 yo female with large invasive fungal SCC of scalp with local cervical LAD, possible metastatic lesions in bones and ?lung.

#Invasive SCC of the scalp - with likely metastatic disease in the neck (awaiting FNA result from L cervical node) and possible metastasis in bone and lung

- f/u LN biopsy.. Anticipate it will be positive for metastatic SCC.
- if LN biopsy negative, would biopsy lung lesion in the RLL to r/o primary lung cancer vs. met
- pt would be a candidate for systemic therapy with cemiplimab to help shrink the primary tumor. Depending on response, could then perform surgery and even XRT after immune therapy.
- in a phase I/II trial (Migdin NEJM 2018) cemiplimab induced durable response in about 50% of patients with locally advanced/unresectable or metastatic SCC of the skin. It is now FDA approved for this indication.
- will set up with medical oncology in clinic on 9/30/19 with Dr. Rasheed to discuss regarding neoadjuvant immunotherapy
- would recommend port placement in anticipation of starting immunotherapy

#Hypercalcemia likely related to malignancy, now resolved -

- agree with zolendronic acid given per geriatrics
- check PTHrP as PTH was low

- Patient discharged with plan for out patient follow up
- Readmitted 4 days later

Pre Op Evaluation

She is largely bed bound at home, is able to independently transfer from bed to wheelchair and toilet. She has not walked in 5 years. She gets around with a wheelchair, manual, she is able to push what sounds like 20 ft before stopping The patient denies shortness of breath or chest pain when she stops. She states it is mostly due to discomfort in her legs due to the position that she sits in a wheelchair when she has to stop. She takes no medications at home besides Tylenol. She has no other known chronic medical conditions.

Geriatrics consulted for pre op risk stratification .

RCRI score 0. Patients METS <4 due to morbid obesity and being wheelchair bound. TTE with normal EF and no focal wall motion abnormalities.

No further cardiac workup recommended, proceed to OR.

October 10, 2019

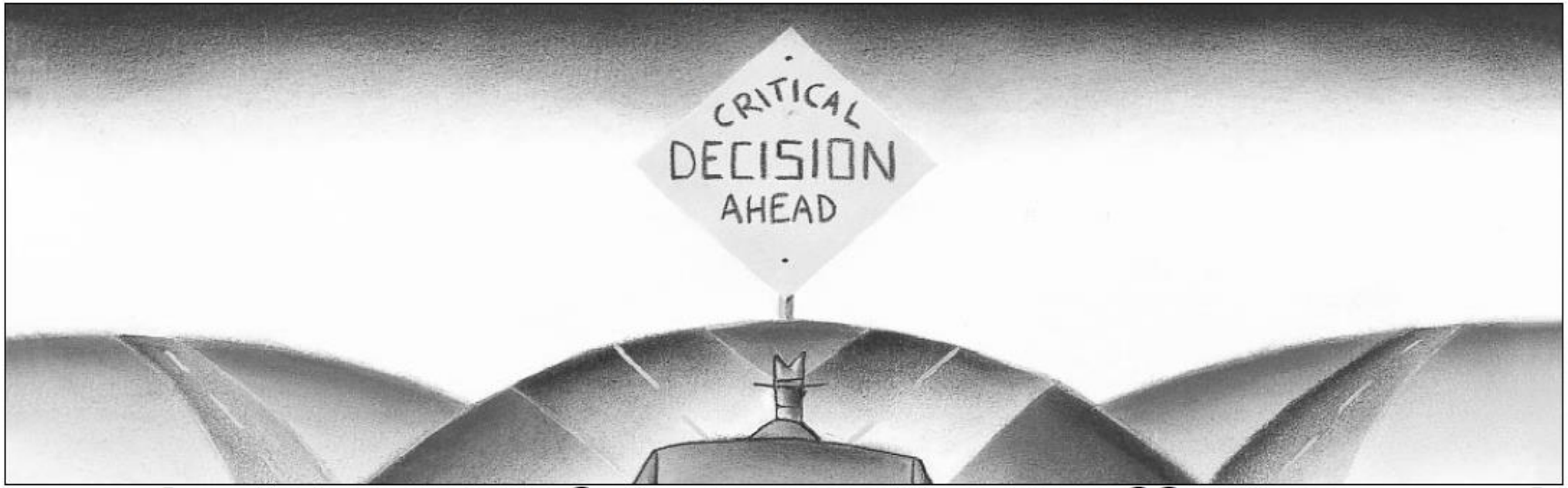
Getting Through to Physicians Resistant to Consulting Palliative Care

Emily B. Rivet, MD MBA FACS FASCRS

Objectives

- Assess gaps in current volumes from palliative- relevant procedures
- Discuss evidence on barriers to consulting palliative
- Describe rapport-building approaches for multiple disciplines

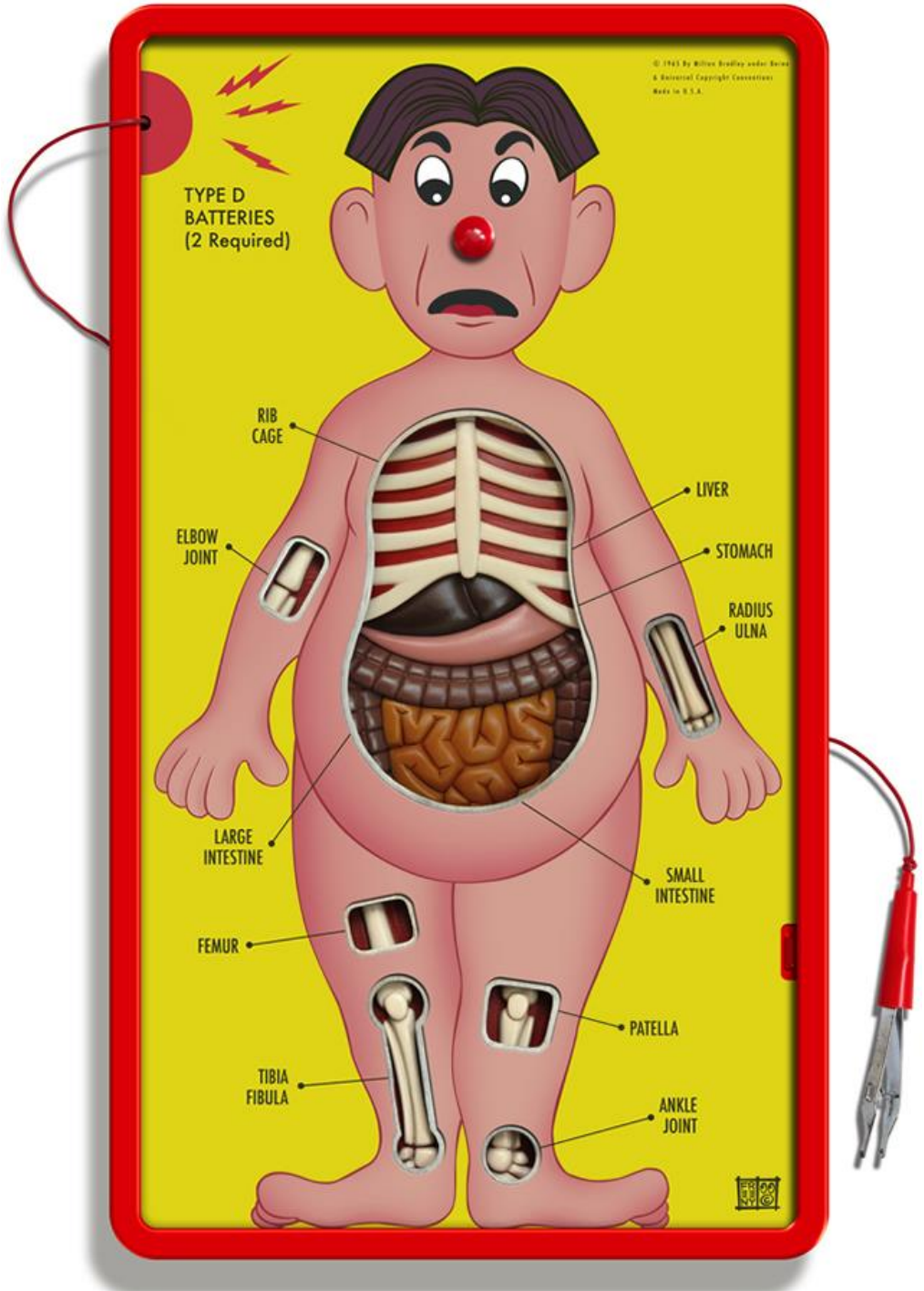
Leading Change:



Why Transformation Efforts Fail

by John P. Kotter

Kotter, John P. "Leading change: Why transformation efforts fail." (1995): 59-67.


TYPE D
BATTERIES
(2 Required)
RIB
CAGE
LIVER
ELBOW
JOINT
STOMACH
RADIUS
ULNA
LARGE
INTESTINE
SMALL
INTESTINE
FEMUR
PATELLA
TIBIA
FIBULA
ANKLE
JOINT

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The stories we tell, the stories that happen in real life …

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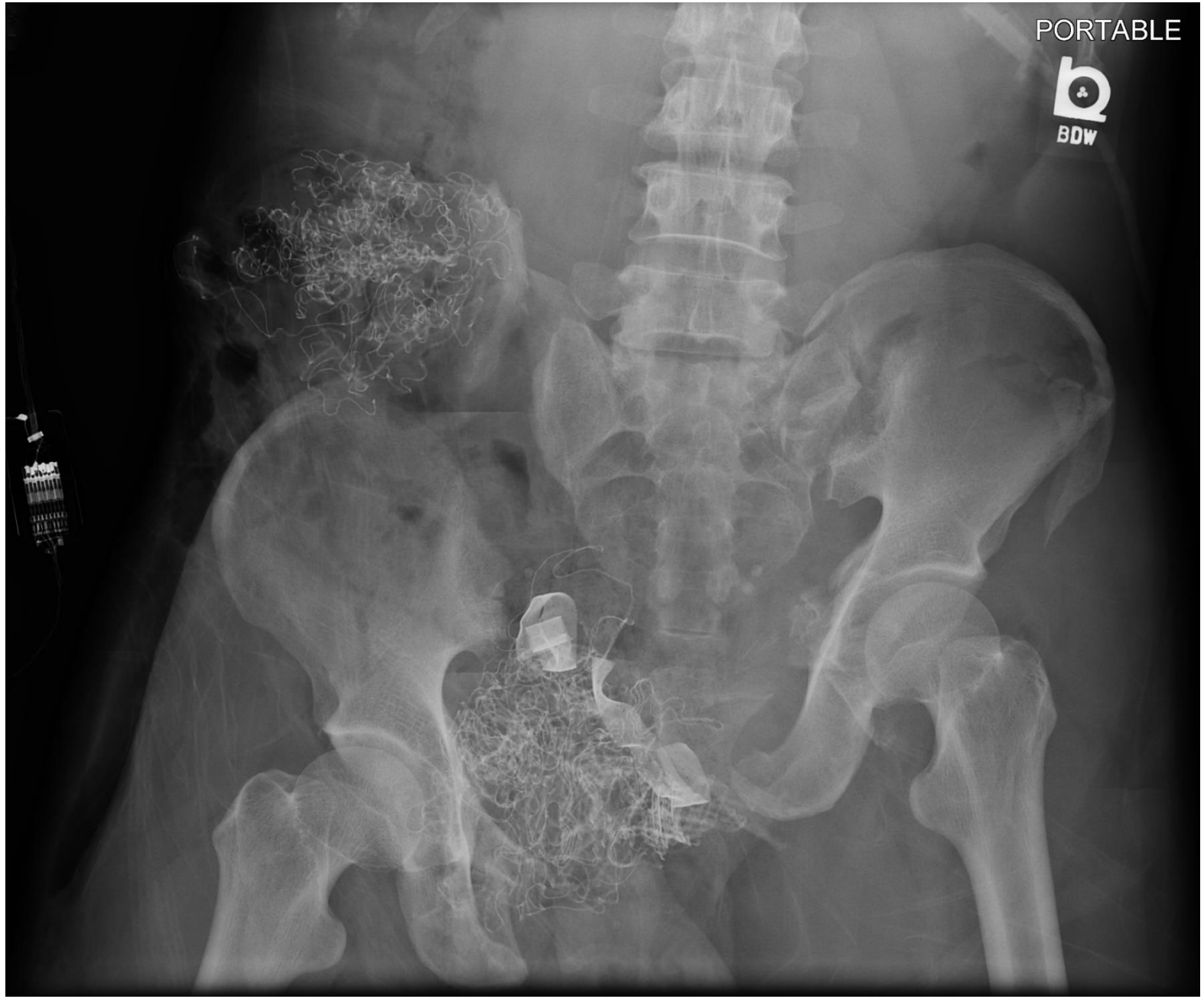
1. Establish a Sense of Urgency

- Crisis or opportunity
- “Without motivation, people won’t help and the effort goes nowhere.”
- “… a frank discussion of potentially unpleasant facts…”

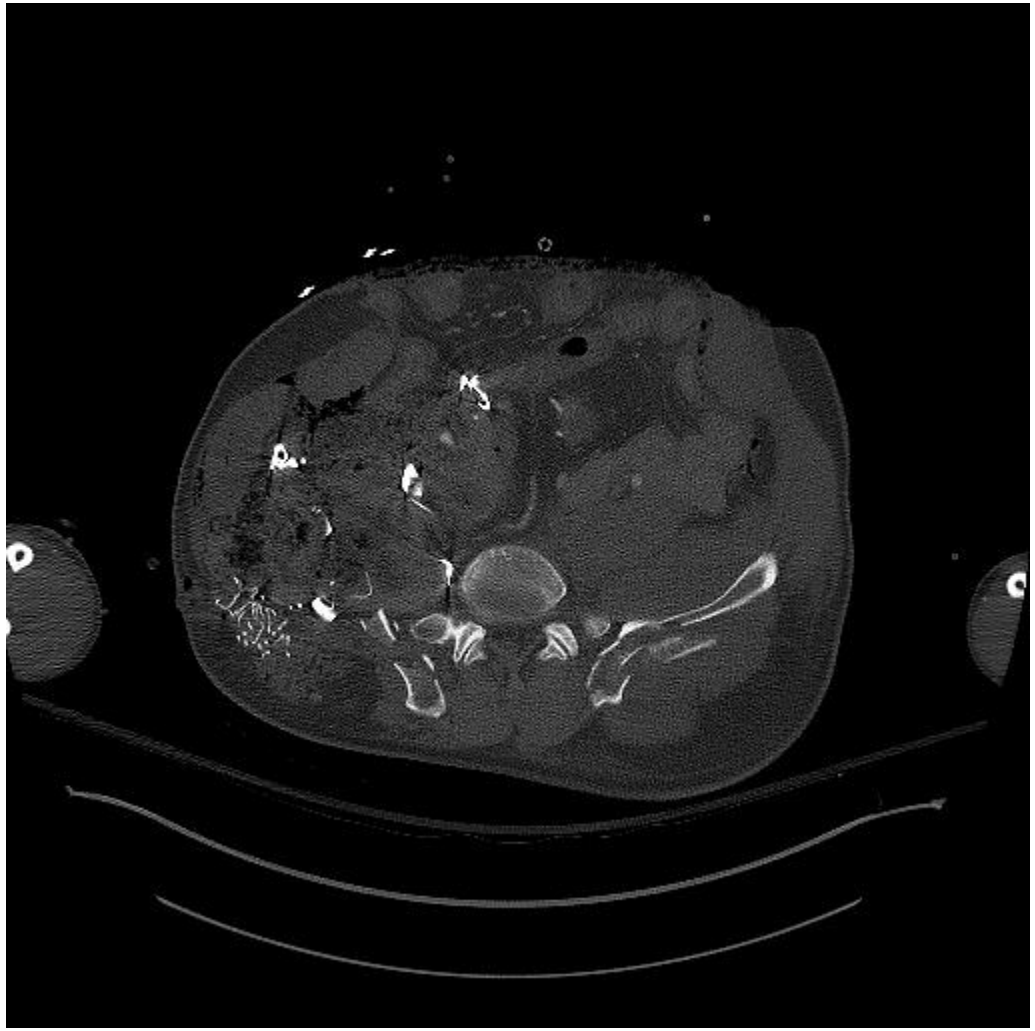
Patient DK

- Healthy 47 year old man with severe pelvic crush injury
- On arrival: BP 67/54, “weak, thready pulse” unable to move lower legs, able to answer questions
- Extensive open pelvic fracture dislocation
- Massive transfusion protocol (> 100 units, most in 1st 36 hours)
- 7 surgeries/ procedures in 4 days


PORTABLE
BDW

Patient DK

- IR
- Rectosigmoid resection
- Ligation ureters, cystectomy
- Attempted arterial shunt REIA to RCFA then ligation
- Calf fasciotomies
- Anterior external pelvic fixator
- Bilateral guillotine AKAs
- AKA washout and revisions
- Abdominal washout and closure, end colostomy



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Patient DK

- Plan to allow soft tissue to demarcate and then determine extent of resection and potential for reconstruction
- Two days after final surgery, wife began to express concern about patient's future impairments and quality of life
- Made DNR
- Patient with persistent delirium and pain
- Lack of alignment between family, physician and nursing teams]
- PC consult, ethics consult
- Multiple meetings with patient's family and friends as well as multiple members of care team
- Patient transferred to palliative care unit and received palliative sedation, died about 24 hours later

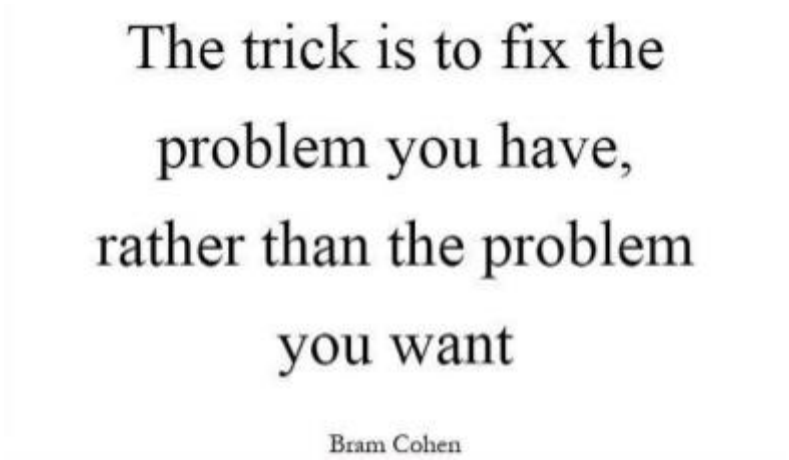
2. Form a Powerful Guiding Coalition

- By definition operates outside the normal hierarchy
- Someone needs to get people together, help them develop a shared assessment of problems and create trust and communication

Patient DK

- Schwartz rounds presentation with trauma attending
- Two nursing staff members, trauma attending and myself presented
- Trauma attending also medical director of STICU and fellowship director Surgical Critical Care fellowship

The “in real life” piece



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3. Create a vision

- Communicate in < 5 minutes and get a reaction that signifies understanding and interest

Integrate Palliative Care into the STICU

- Incorporate into FASTHUGS

Table 1. Components of "FAST HUGS BID"

FAST HUGS BID	
F	Feeding
A	Analgesia
S	Sedation
T	Thromboembolic prophylaxis
H	Head of bed elevation
U	Ulcer (stress) prophylaxis
G	Glycemic control
S	Spontaneous breathing trial
B	Bowel regimen
I	Indwelling catheter removal
D	De-escalation of antibiotics

4. Communicate the vision

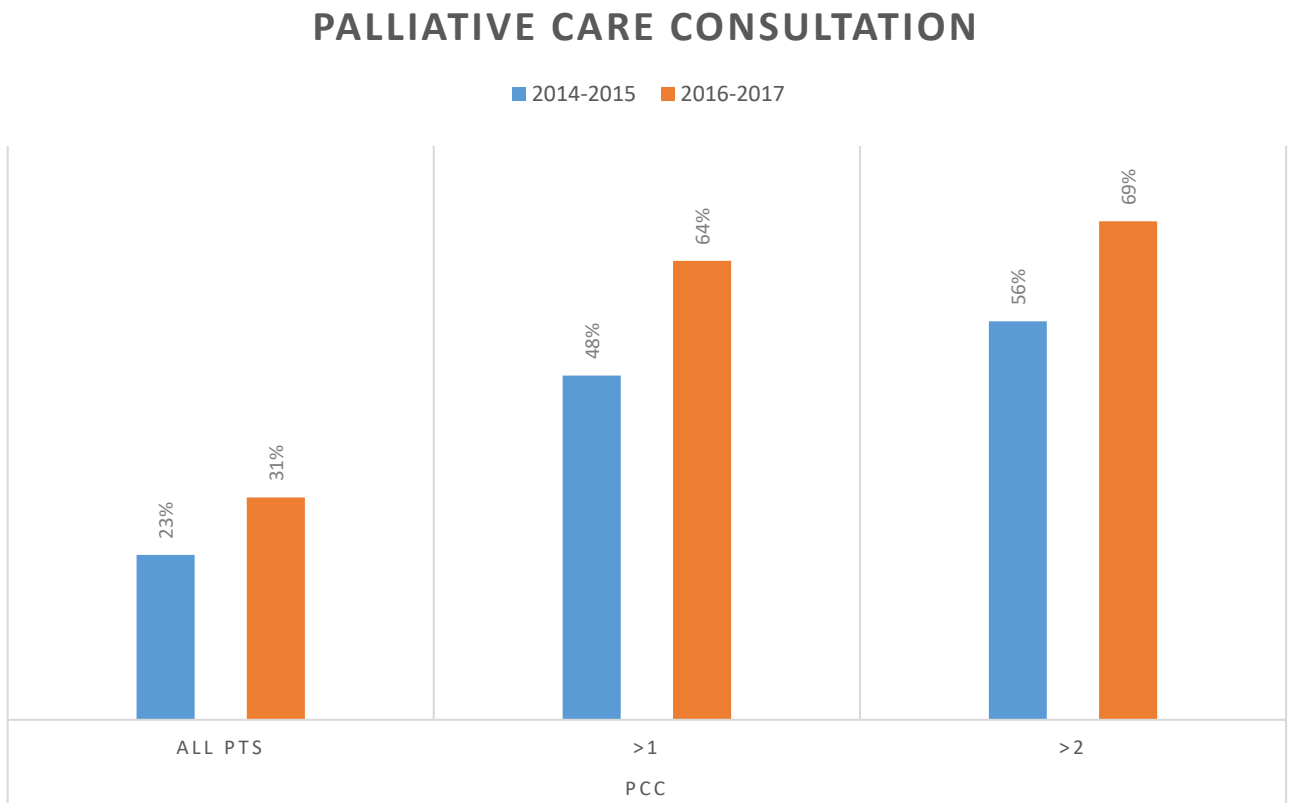
- Use all existing communication channels to broadcast the vision
- Become a living symbol of the transformation- “walk the walk”

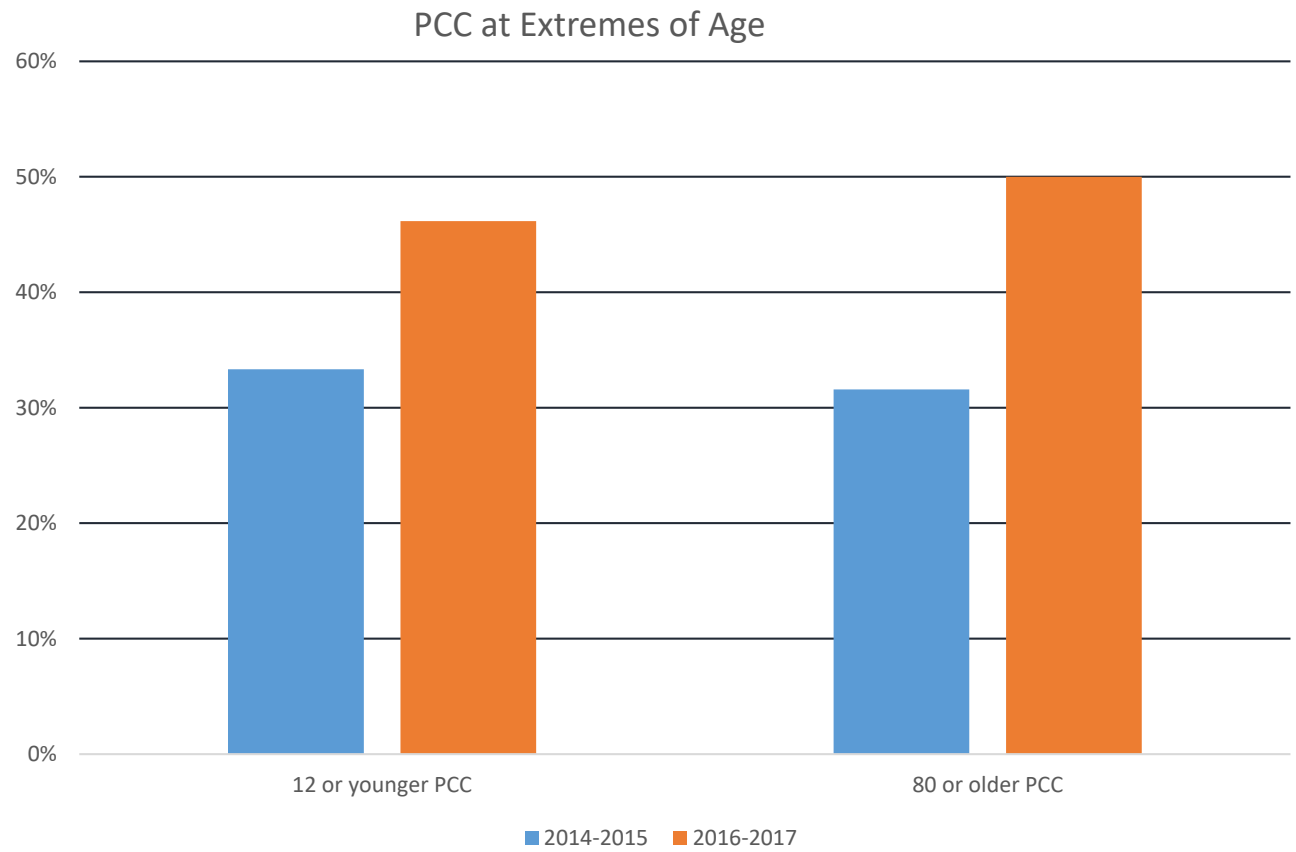
5. Empower others to act

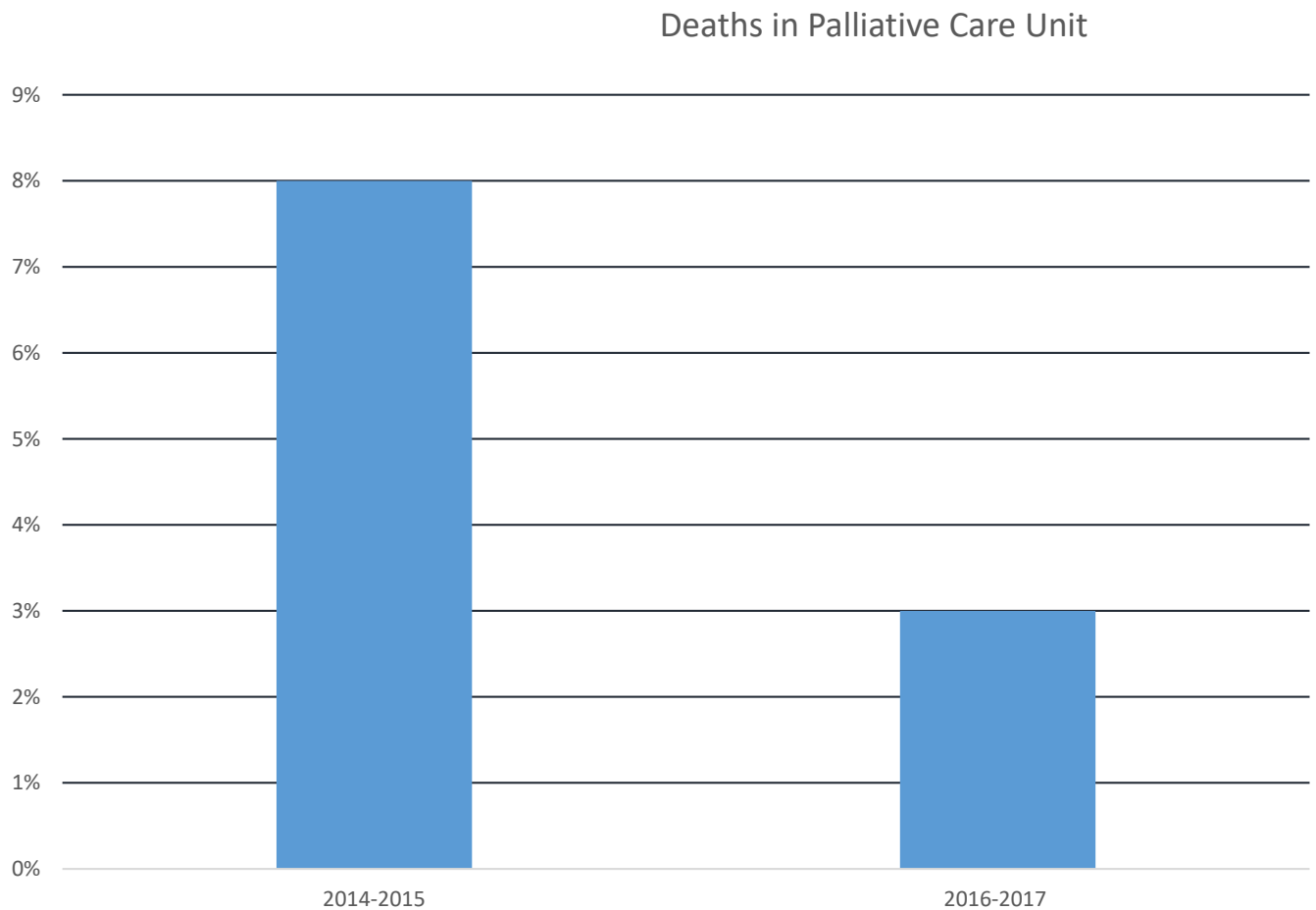
- Remove barriers
- Consider incentives
- Encourage risk taking

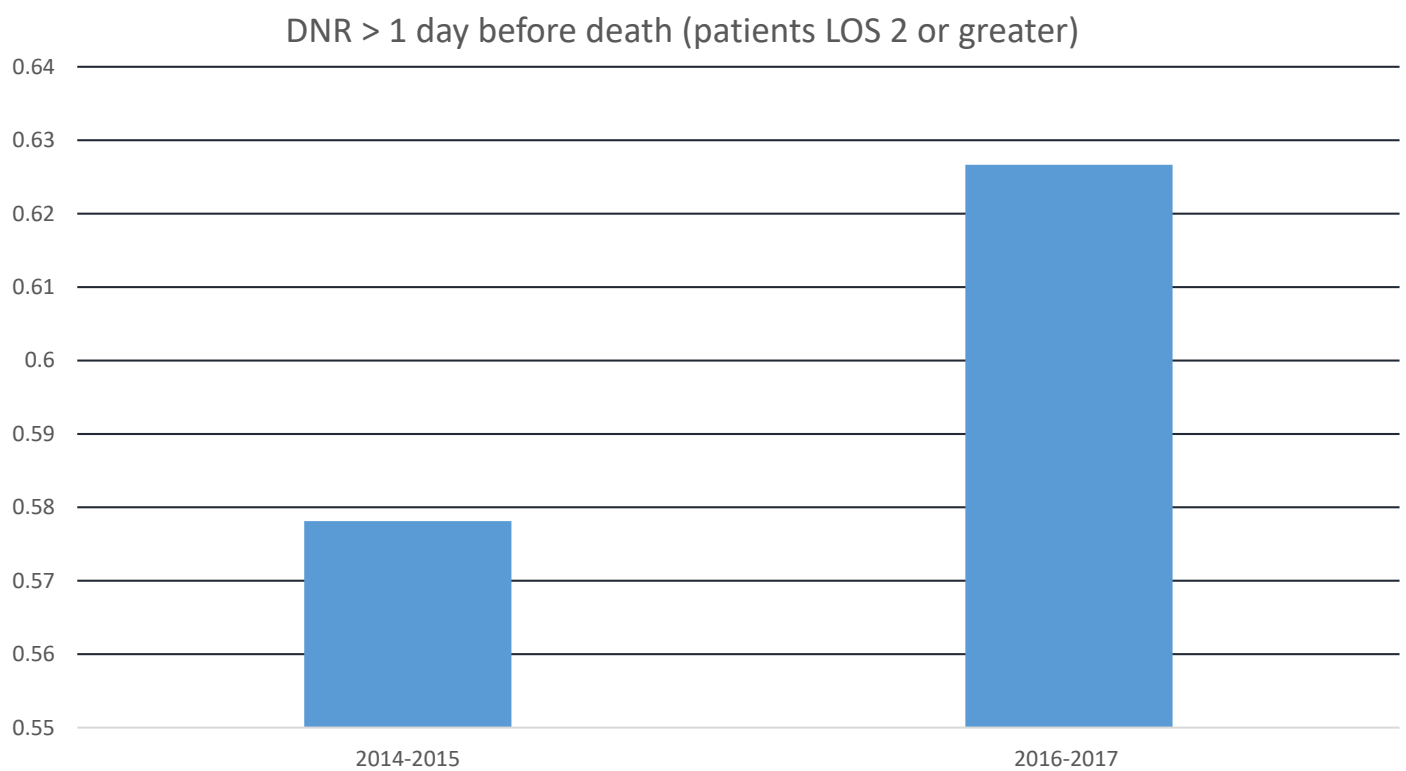
Pilot cohort study examining impact of Palliative Surgeon Intervention

- Population is patients dying from trauma, one year period pre and post intervention (Rivet rotation in trauma ICU September 2016)
- Total 332 patients
- October 2014 to September 2015
- October 2016 to September 2017
- Preliminary data


PALLIATIVE CARE CONSULTATION
2014-2015
2016-2017
23%
31%
48%
64%
56%
69%
ALL PTS
>1
>2
PCC


PCC at Extremes of Age
60%
50%
40%
30%
20%
10%
0%
12 or younger PCC
80 or older PCC
2014-2015
2016-2017


Deaths in Palliative Care Unit
9%
8%
7%
6%
5%
4%
3%
2%
1%
0%
2014-2015
2016-2017


DNR > 1 day before death (patients LOS 2 or greater)
0.64
0.63
0.62
0.61
0.6
0.59
0.58
0.57
0.56
0.55
2014-2015
2016-2017

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In real life

- Other professional priorities of guiding coalition
- Protocols that structure involvement of other care teams
- The intervention changed access to palliative care consultation and impacted some outcome measures such as timeliness of DNR and more upstream focus of palliative care consultation.
- Other measures such as location of death may be affected by other factors such as palliative care unit availability, patient condition/ survival and did not show improvement from the intervention. Prognosis is uncertain so CPR is appropriate in some patients.
- The most meaningful outcomes are those we do not routinely measure such as experience of family members and caregivers and staff member distress, burnout and resilience.

6. Plan for and create short term wins

- Identify achievable objectives and provide rewards

Surgical Innovation

Palliative Care Assessment in the Surgical and Trauma Intensive Care Unit

Emily B. Rivet, MD, MBA; Egidio Del Fabbro, MD; Paula Ferrada, MD

What Is the Innovation?

How can we prioritize the fundamental needs of patients in the increasingly technical and data-driven environment of modern health care, especially in the intensive care unit? Palliative care is a relatively new specialty that focuses on the most basic and human elements of medicine, including

- treatment of the symptoms associated with serious illness;
- attention to the social, spiritual, and psychological needs of the individual;
- collaboration among clinicians to optimize care; and
- communication with patients and families regarding prognosis, treatment plans, and care goals.

The innovation is incorporating a palliative care assessment into the daily rounding metrics in the surgical and trauma intensive care unit (STICU). The palliative care assessment is a simple question—does this patient have any palliative care needs?—that the team understands to include symptom management challenges, issues of psychosocial support, and disparities in perception of treatment plan and prognosis. Incorporating this question into the daily rounds allows these aspects of patient care to be given equal priority as issues such as hemodynamics and infection in the daily rounding discussion.

What Are the Key Advantages Over Existing Approaches?

The STICU is a complex, high-volume system whose focus on recovery from critical illness may sometimes prioritize clinical over personal needs. After the innovation was adopted, we observed an increase in specialist palliative care referrals from the STICU. Perhaps more important is that we also noted heightened attention to pain and other symptoms, discussions of clinical trajectories and prognosis, and awareness of psychosocial and spiritual aspects of care during rounds. Given the shortage of palliative care specialists in the United States, increasing the STICU team's attentiveness and responsiveness to these issues may be of greatest value. Implementation was facilitated by a surgeon with specialty training in palliative care who provided education about the role of palliative care and rounded with the STICU team for 1 month. The presence of such dual-trained physicians is not essential, but it may expedite changes in practice and has done so in other fields, such as oncology.[1] Furthermore, data from our program demonstrate that palliative care consultation can improve recognition of conditions such as delirium and increase the comprehensiveness of discussions regarding end-of-life care.[2] This integrated approach that combines primary and specialist palliative care as well as the role of each in treating patients will need to be defined by additional research and will depend on the resources of specific health systems.

How Will This Affect Clinical Care?

The emerging concept of "sudden advanced illness" provides a useful framework for appreciating why surgical and trauma patients may have particularly intense palliative care needs as a result of sudden onset of illness, uncertain prognosis, and frequent lack of existing advance directives.[3] A different but equally needy population in this setting is the subset of patients with decline due to age or chronic illness. In these cases, injury from ground-level falls is a presentation of frailty rather than a result of the mechanism in isolation. Patients facing complex decisions about the potential benefit and risk of surgery for issues other than traumatic injury are another group in the STICU with particularly robust palliative care needs. Benefits of palliative care for these patients can include improved management of symptoms such as pain and delirium, more effective communication about prognosis, improved family and patient satisfaction, and increased alignment among care team members.

Is There Evidence Supporting the Benefits of the Innovation?

Mosenthal et al[4] show that a structured palliative care intervention integrated into standard care increases discussions of pain, other symptoms, and goals of care on rounds in the trauma ICU. This study and others also demonstrate that early palliative care intervention can move upstream the timing of do-not-resuscitate orders and withdrawal-of-life-support consent without affecting mortality rates. However, although a recent single-institution study of a prospectively maintained database found that 20% of specialty palliative care consultations from surgical services were for symptom management, limited data are available regarding the outcomes of such consultations in this population.[5] Palliative care specialists improve recognition and treatment of conditions, such as delirium, that increase morbidity, mortality, and health care costs in the critical care setting.[6] A recent systematic review showed positive findings associated with palliative care in surgical patients but also noted significant limitations in evidence.[7]

What Are the Barriers to Implementing This Innovation More Broadly?

National organizations, such as the American College of Surgeons, have endorsed the value of palliative care for surgical patients since 2005, but acceptance is not yet universal. A major factor remains the "rescue culture" of surgery and the pervasive sense that recovery and palliation are sequential rather than parallel elements of an individual's medical trajectory. Other important factors are the national shortage of specialist palliative care clinicians and the current lack of education and training of surgeons to deliver primary palliative care. Furthermore, outcome measures prioritize survival over other metrics, such as quality of life or time spent out of the hospital. Last, the financial incentive structure of the American health care system does not always effectively align the values of patients, insurance providers, surgeons, and hospitals. All of these factors may

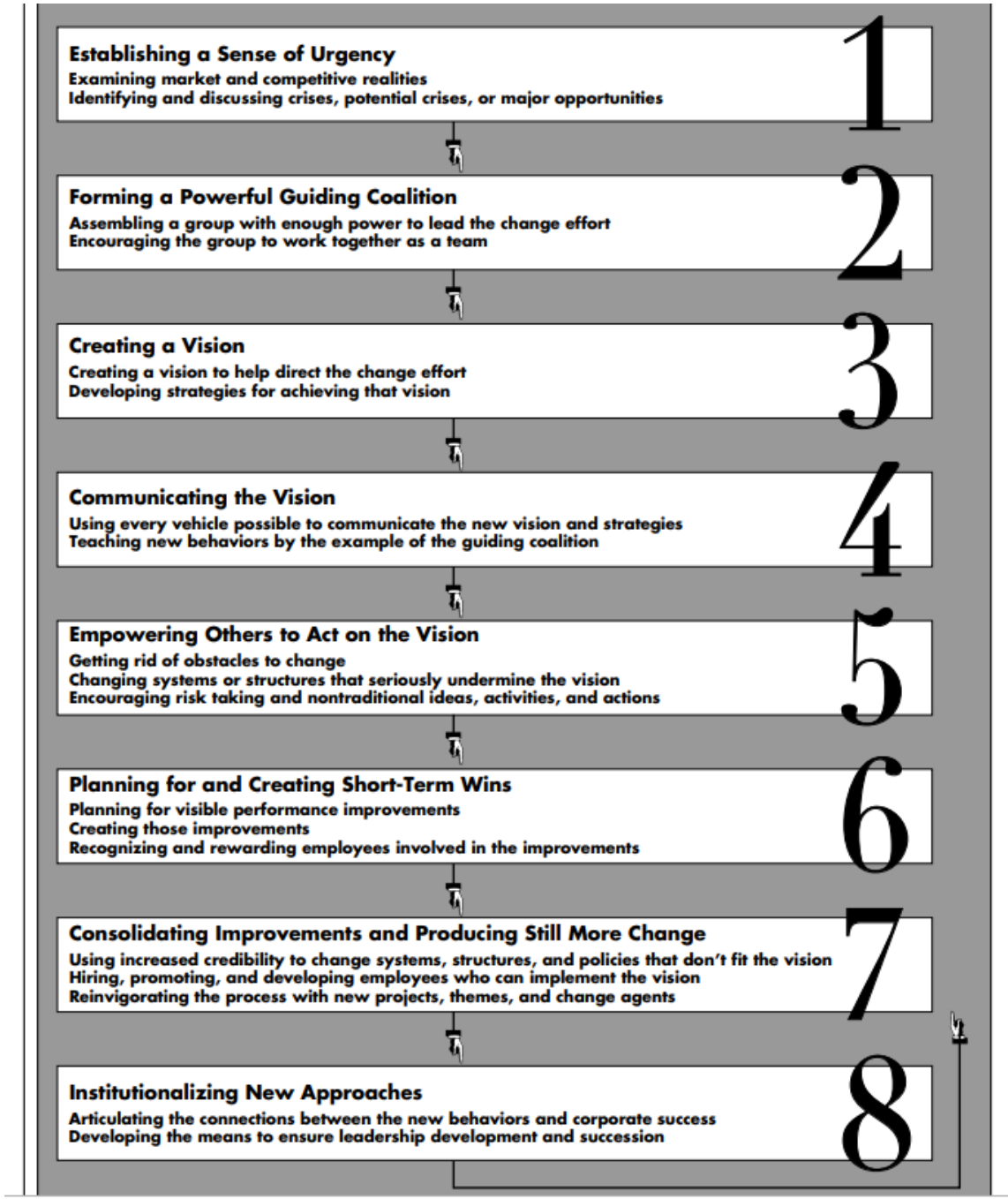
7. Consolidate and produce more change

- Don’t declare victory too soon
- Changes take 5-10 years to “sink into” organizational culture
- Use the credibility from short term wins to tackle even bigger projects
- In one successful transformation peak change in year 5, 36 months after first set of visible “wins”
- New projects
- Right people

Table 1: Characteristics of cancer patients who died during same hospitalization as major surgery		
	Median	Range
Age	61	39-94
Length of Stay	23	3-183
ICU Days	4	0-86
Days before Death DNR	2.5	0-33
	N	%
Gender		
Male	19	54
Female	16	46
Race		
Caucasian	19	54
African/African American	12	34
Hispanic	1	3
Other	3	9
Insurance Status		
Medicare	13	37
Medicaid	0	0
Private	18	51
No insurance	4	11
Distance from VCU		
< 30 miles	11	31
> 30 miles	24	68
Acuity of surgery		
Emergency	20	43
Elective	15	57
Palliative surgery	21	60
Palliative care consultation	24	68
Hospice Candidate	30	86
Location of death		
Intensive care unit	19	54
Palliative care unit	8	23
General care unit	9	26
DNR	30	86
Malignant bowel obstruction	14	40
Received CPR	7	20

8. Anchor changes in culture

- It becomes “the way we do things around here”
- Reinforce the correct connections between actions and outcomes


Establishing a Sense of Urgency
Examining market and competitive realities
Identifying and discussing crises, potential crises, or major opportunities
1
Forming a Powerful Guiding Coalition
Assembling a group with enough power to lead the change effort
Encouraging the group to work together as a team
2
Creating a Vision
Creating a vision to help direct the change effort
Developing strategies for achieving that vision
3
Communicating the Vision
Using every vehicle possible to communicate the new vision and strategies
Teaching new behaviors by the example of the guiding coalition
4
Empowering Others to Act on the Vision
Getting rid of obstacles to change
Changing systems or structures that seriously undermine the vision
Encouraging risk taking and nontraditional ideas, activities, and actions
5
Planning for and Creating Short-Term Wins
Planning for visible performance improvements
Creating those improvements
Recognizing and rewarding employees involved in the improvements
6
Consolidating Improvements and Producing Still More Change
Using increased credibility to change systems, structures, and policies that don't fit the vision
Hiring, promoting, and developing employees who can implement the vision
Reinvigorating the process with new projects, themes, and change agents
7
Institutionalizing New Approaches
Articulating the connections between the new behaviors and corporate success
Developing the means to ensure leadership development and succession
8

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Real life lessons

- Honor the perspective of others
- Low hanging fruit
- Allies
- Easy victories
- Provide a product
- Keep smiling and keep talking
- Persistence
- Emphasize the similarities
- Always keep options open and there’s always a chance for change

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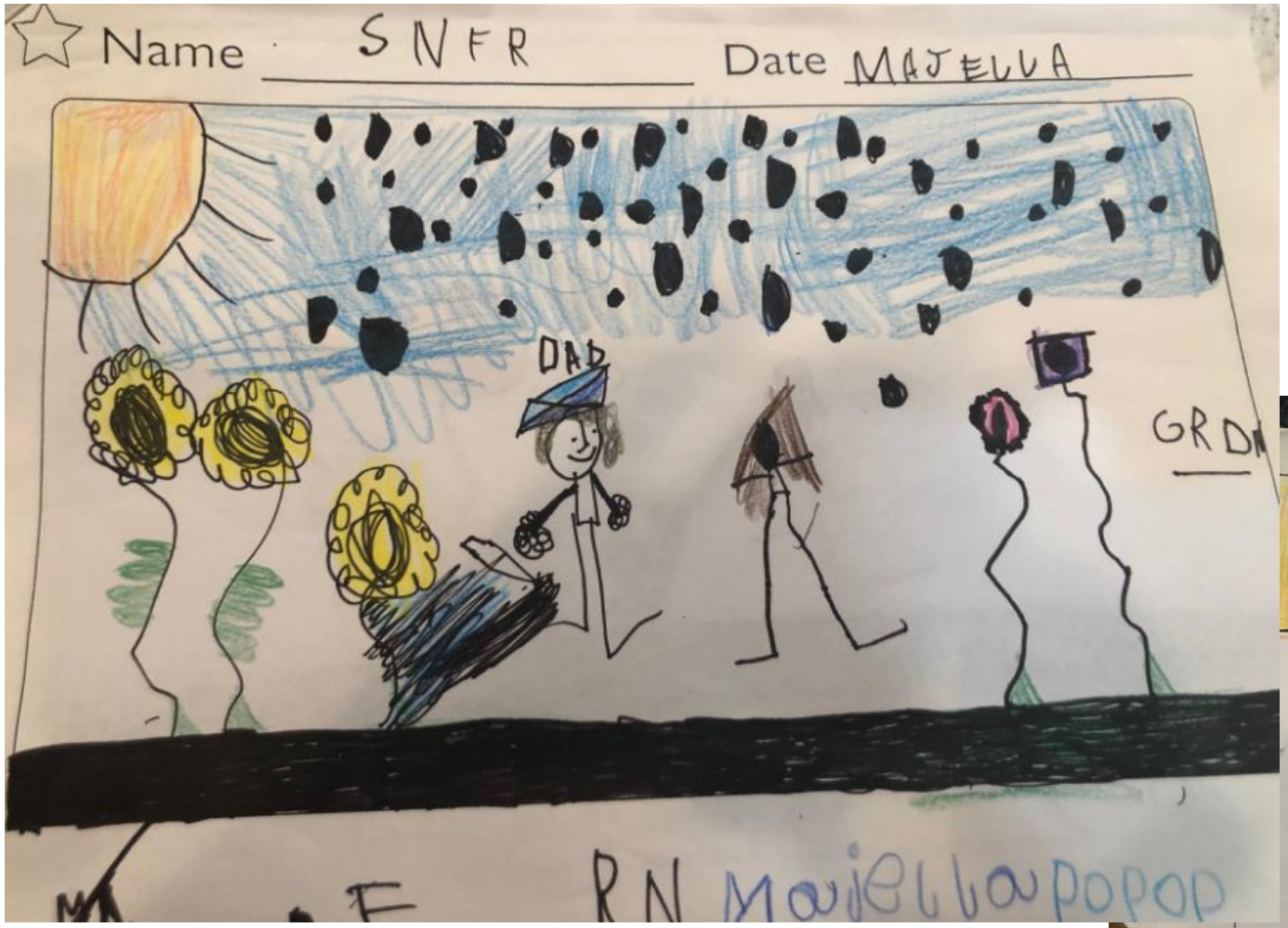
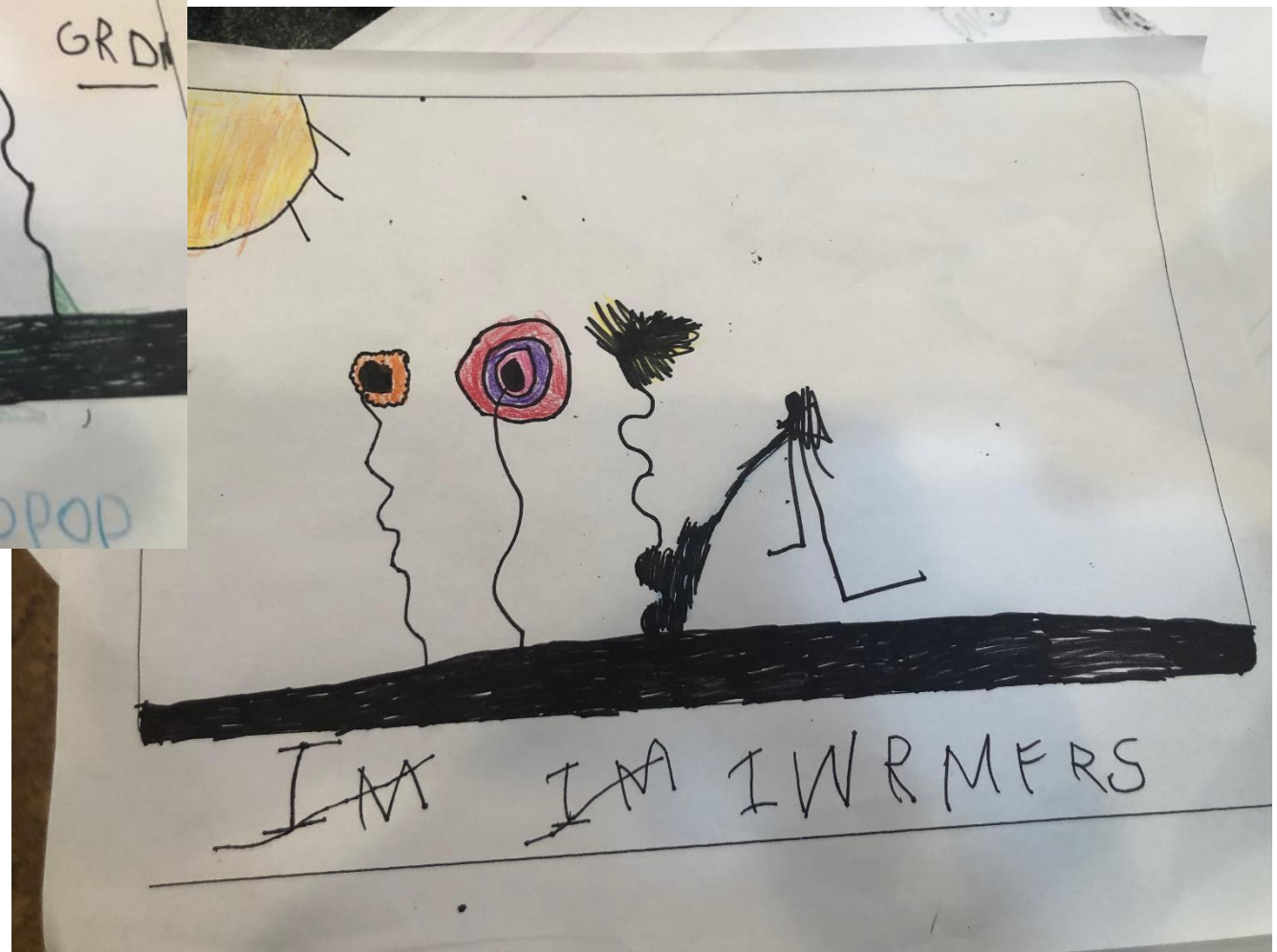
Name SNFR Date MAJELLA



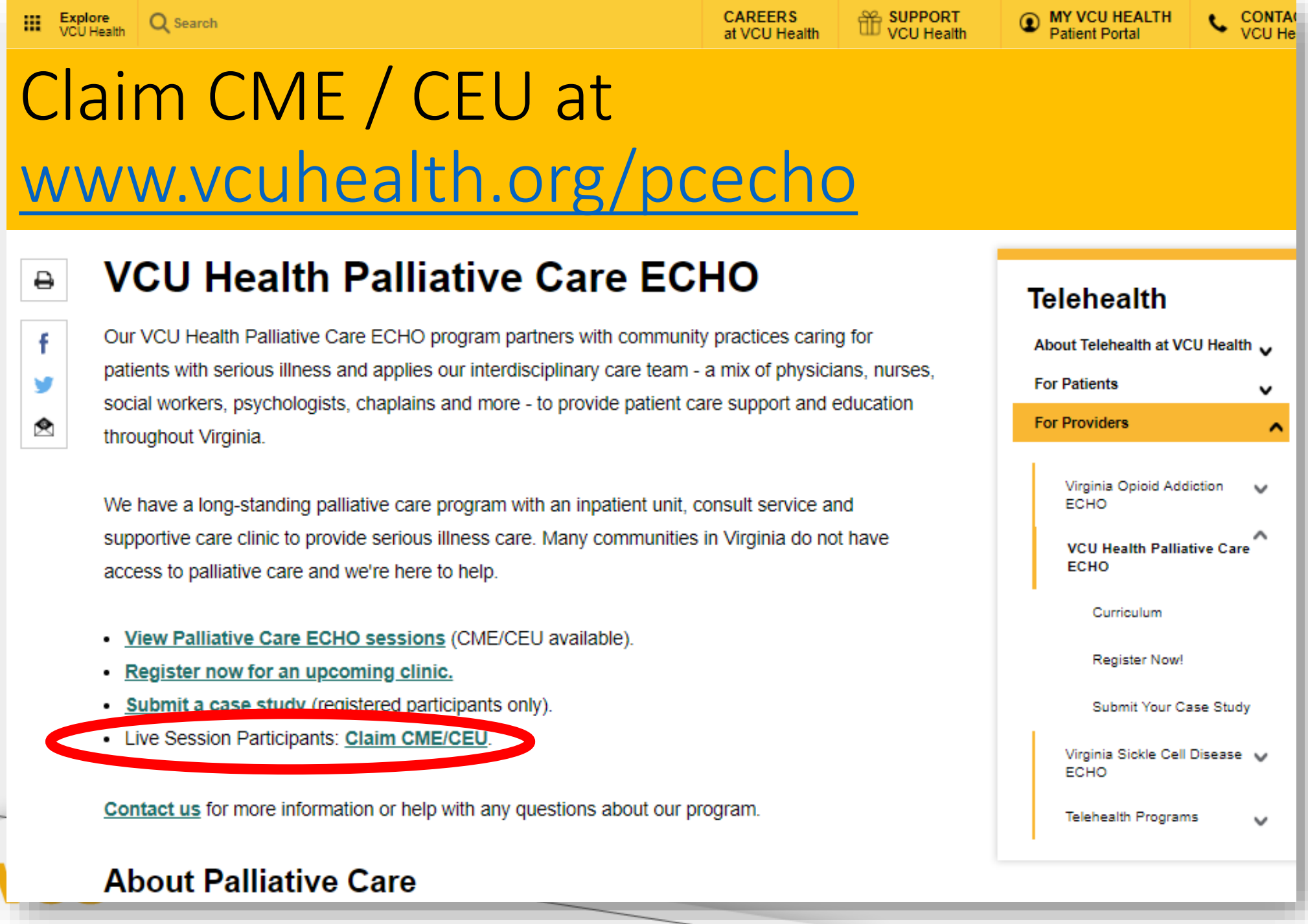
RN Majellapopop



Questions and Discussion

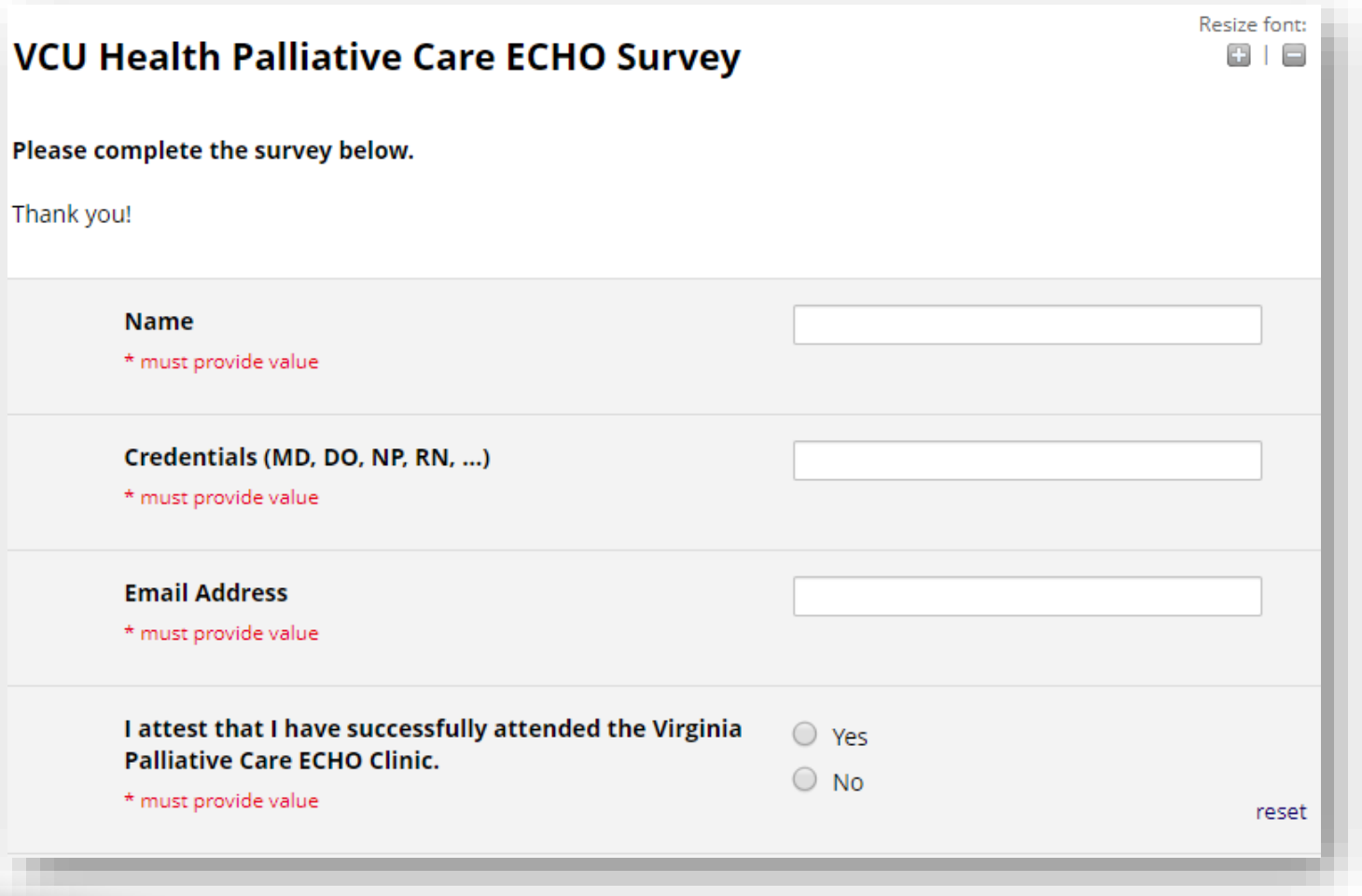
Accessing CME and CEU Credits

Claim CME / CEU at www.vcuhealth.org/pcecho



Project ECHO
Virginia Commonwealth University

Submit your evaluation to claim your CME



Resize font:

VCU Health Palliative Care ECHO Survey

Please complete the survey below.

Thank you!

Name

* must provide value

Credentials (MD, DO, NP, RN, ...)

* must provide value

Email Address

* must provide value

I attest that I have successfully attended the Virginia Palliative Care ECHO Clinic.

* must provide value

- Yes
- No

reset

View recorded sessions at www.vcuhealth.org/pcecho

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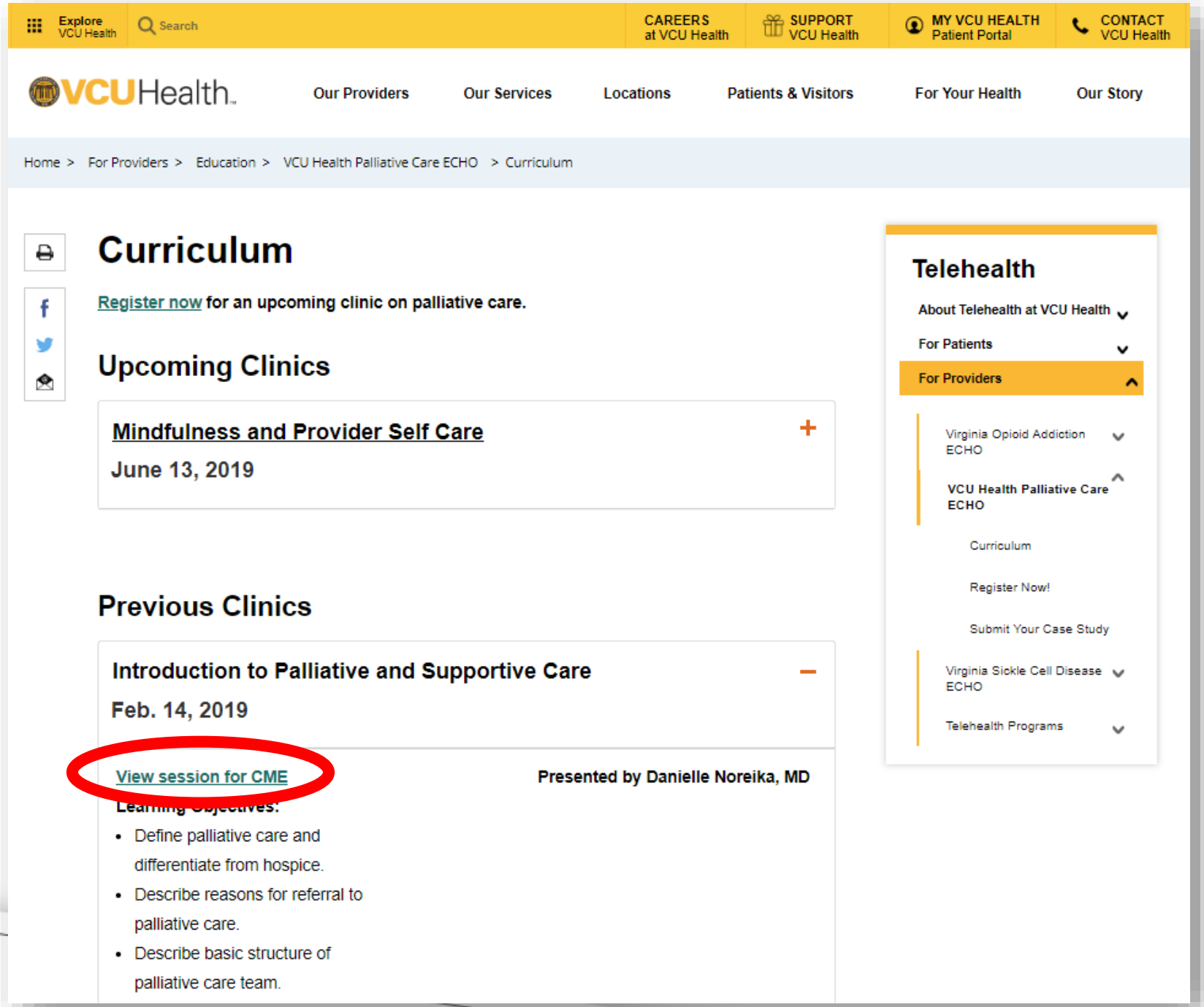

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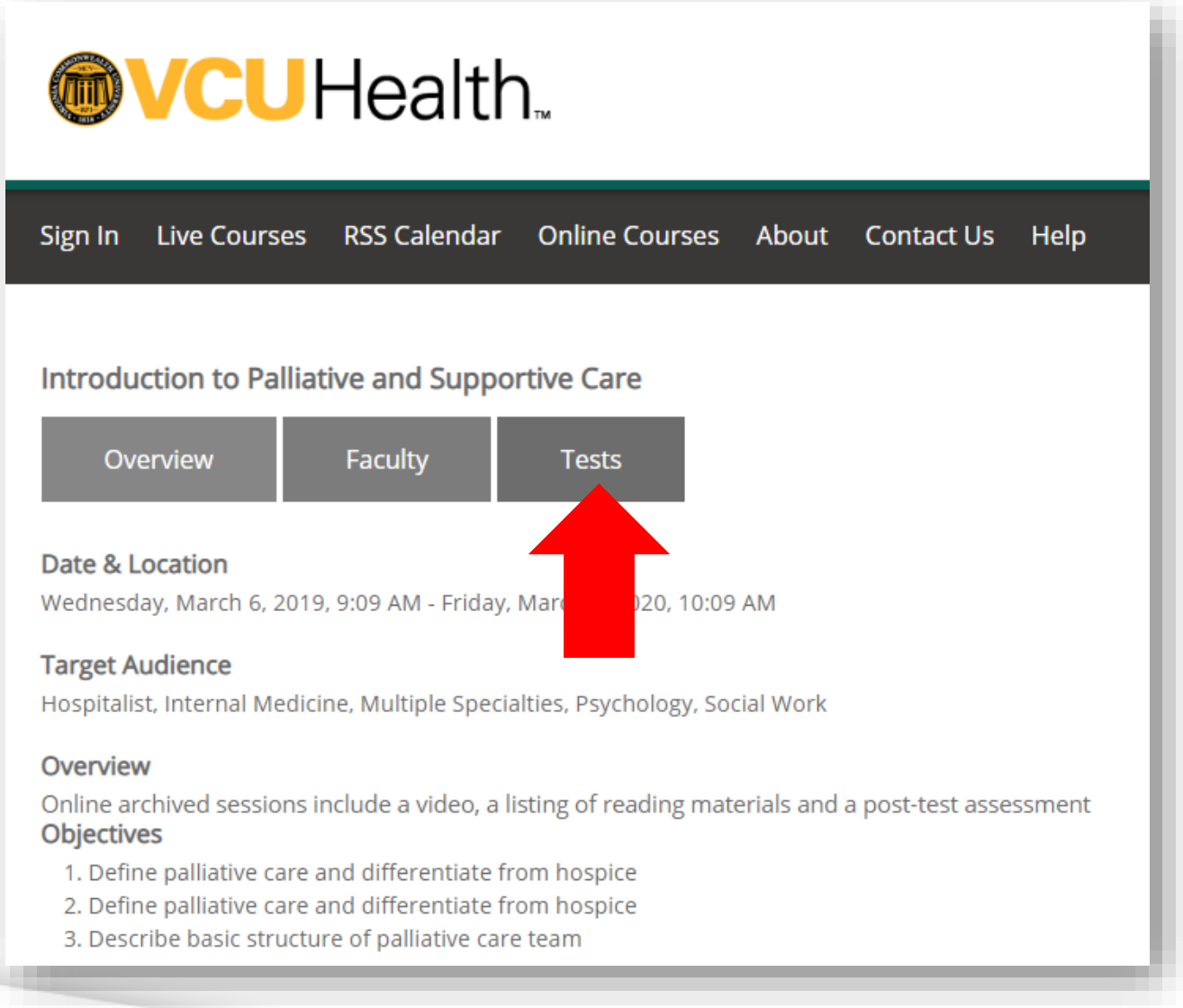
VCU

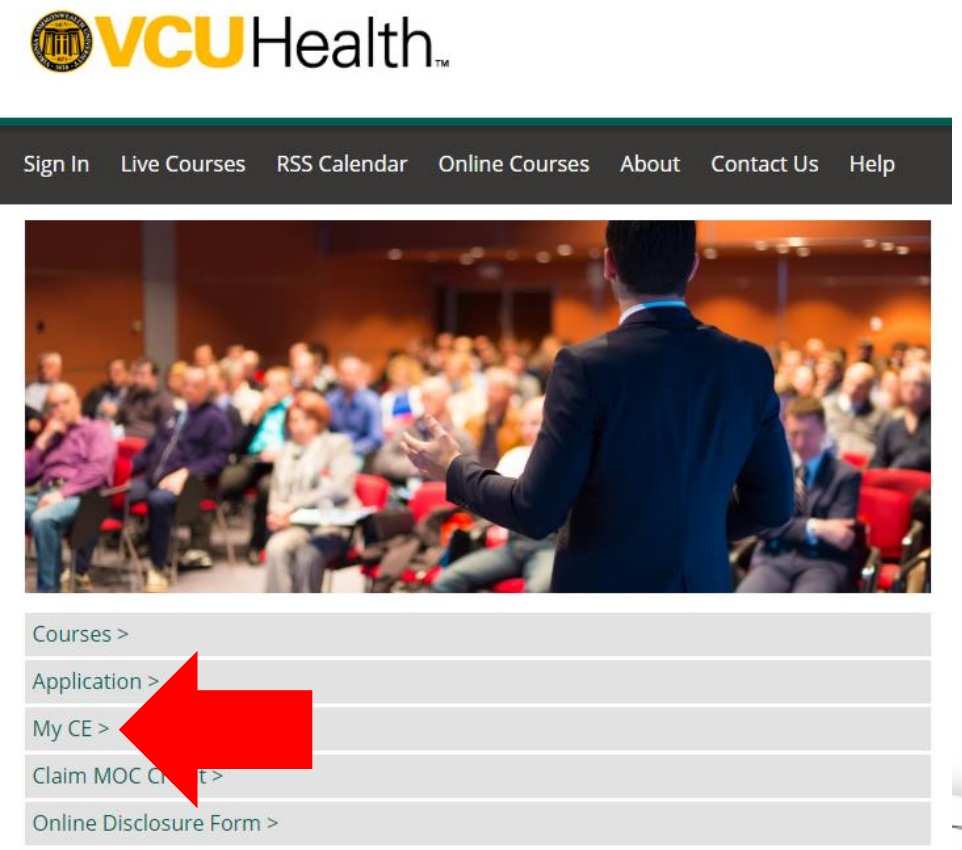
View previously recorded ECHOs for CME

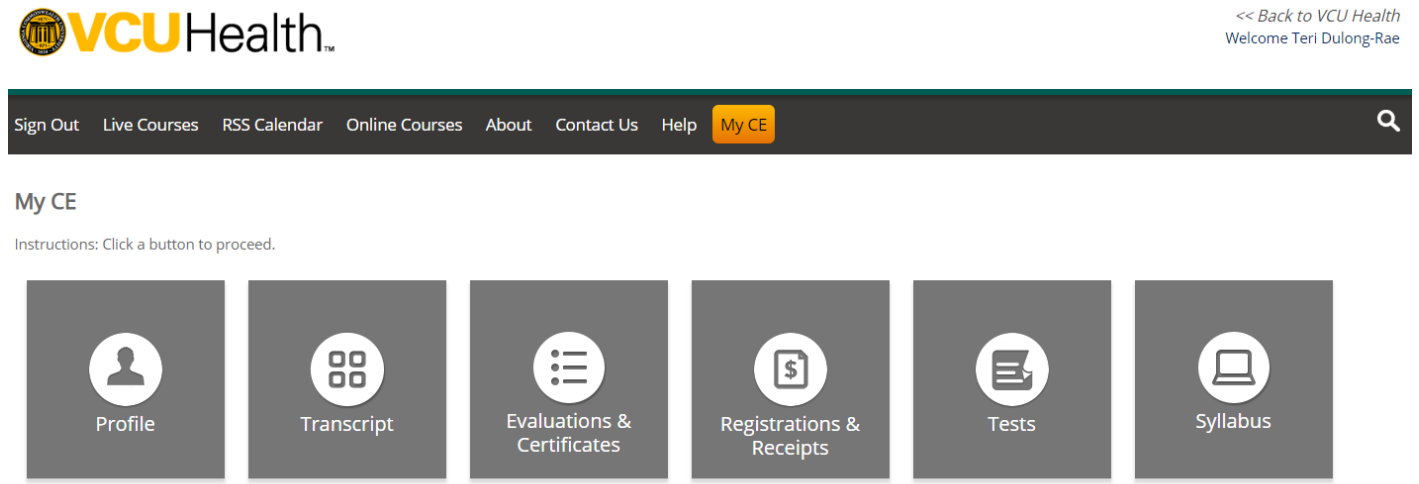
Click “Tests” to view video of the session and take a short quiz for continuing education credit



View your CME/CEU transcript

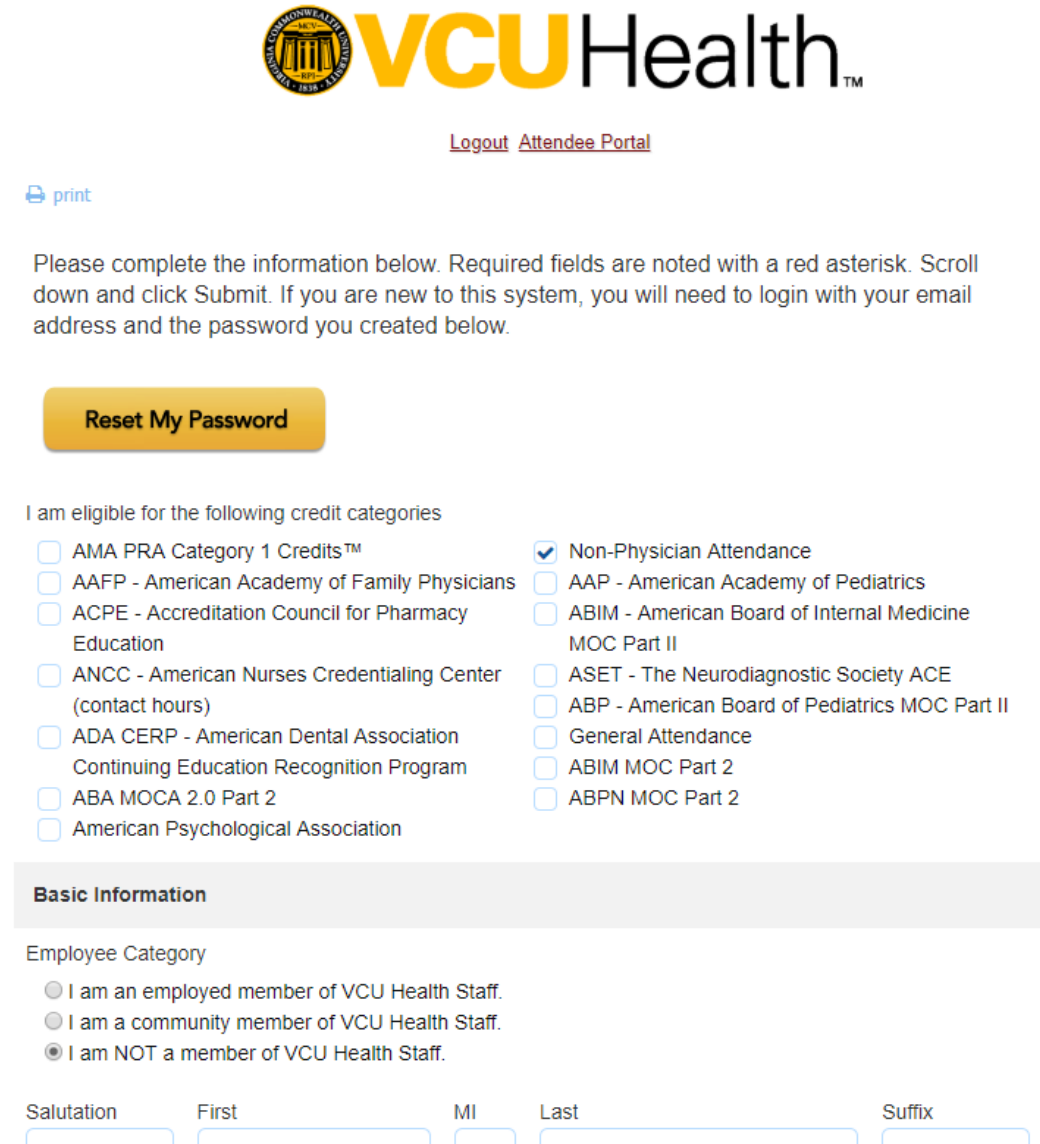
- Go to vcu.cloud-cme.com and click “My CE”
- Log in with the email you used to register for our ECHO session





View your CME/CEU transcript

If you have never logged in before, you may be prompted to enter more information before you can view your transcript



THANK YOU!

We hope to see you at our next ECHO