**Care Transition Coordinator Coalition Meeting**
12-8-2016

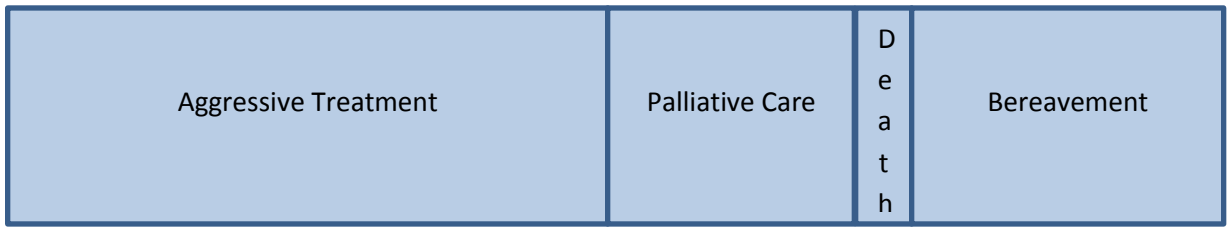
Presentation: Dr. Matthew Peachey, Vanderbilt Palliative Care Program

Notes from Presentation

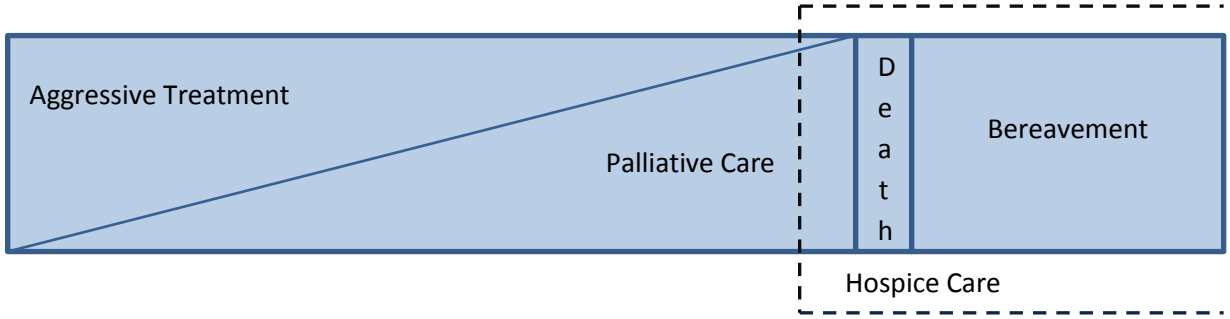
- 70% of the general public doesn't know what 'palliative care' is.
    - Palliative care gets mixed up with hospice
    - The American Academy for Hospice & Palliative Care has considered whether or not they should remain a single organization to help people understand that hospice and palliative care are distinct
- So much of what the public sees and hears about palliative care begins with physicians, and that is a problem because many physicians struggle with this
    - Patients expect the physician to take care of them
    - Physicians see death as a failure – good at curing and prolonging cure versus quality of life
        - "I missed something"
        - "I didn't do something right"
    - We don't accept death as a natural occurrence and talk about it or plan for it
    - Some physicians think palliative care physicians will "take over", but palliative care is meant to be supportive and complimentary
- Core concept of palliative care = "let's take into account what people want"
    - It is a multi-disciplinary specialty
    - Patients and their families have to be the leaders, the core
- The best way to introduce palliative care is as a symptom management program
    - "You are facing a serious illness and we want to know how to take care of you in the best possible way."
    - "Let's talk about getting you feeling better today"
        - Patients are looking for an opportunity to feel better (less dyspnea, pain, etc.)

Care Cigarette

A. Classic model of chronic disease management




B. Ideal model of chronic disease management (Coordinated approach from time of diagnosis)



- Who does Palliative Care see?
    - Individuals with a life-limiting, life-threatening, and life-changing disease, whether terminal or not
    - Focus on how disease is impacting quality of life and what patient wants
- Misperception that Hospice doesn't support aggressive care
    - Hospice is not about death, but about life—making the most of the life you have left
- In hospitals, patients lose all control – it is important to let them know their voice is still heard, and that their voice will continue to be heard when they are no longer able to speak for themselves
- TN Advanced Care Plan
    - Documenting a healthcare surrogate is very important
        - Make sure they know your wishes
        - Difficult to talk about, but empowering when done right
- Big part of palliative care is connecting with the patient
    - Respecting their beliefs
    - Treating each person as an individual – no assumptions based on culture, etc.
    - Integrate their wishes into decision process of complex care
    - Being an advocate for the patient
- Vast majority of hospice care is delivered at home
    - Expect nurse to be there all the time, so need education that care will be provided by family and friends
    - There are financial barriers to providing hospice in long term care
- Palliative Care helps O:E
    - Decreases ICU LOS and frees up ICU beds
    - Decreases ventilator days
    - NOT a transfer to hospice
    - NOT a GIP (general inpatient hospice)
    - Some variability in GIP between hospice companies
    - Palliative care doesn't make money, but can save money
- Palliative Care helps improve HCAHPS scores
- Hospice inpatient beds – some won't take ventilator patients
    - Paramedics extubate in the ambulance
    - Extubate in a palliative care unit
- Vanderbilt not using a screening tool at this time
    - Palliative care rounds in high utilization areas
- Work out a post-hospital plan for palliative care follow-up
    - Palliative care clinic
    - Palliative care in the community (available from some hospices)
    - Pilot study – tele-palliative care medicine (via phone)
        - Follow-up on Advanced Care Plan – prevent rehospitalizations