THE HOSPITAL JOURNEY IN AGEING SOCIETIES

WHAT DO SERIOUSLY ILL PATIENTS NEED IN THE MEDICAL WARD?

HOW CAN HOSPITALS SUPPORT MEDICAL WARD STAFF IN AGEING SOCIETIES?

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For information on our Visiting Scholar Program for 2018:

http://www.thehastingscenter.org/who-we-are/service-to-bioethics/visiting-scholars/

A TALE OF TWO TATTOOS: PART I

A man with a "do not resuscitate" tattoo. The signature has been blurred out.

Gregory Holt

What to Do When a Patient Has a 'Do Not Resuscitate' Tattoo

"We've always joked about this, but holy crap, this man actually did it."

ED YONG | DEC 1, 2017 | HEALTH

PRIMARY PALLIATIVE CARE: A UNIVERSAL NEED IN AGEING SOCIETIES

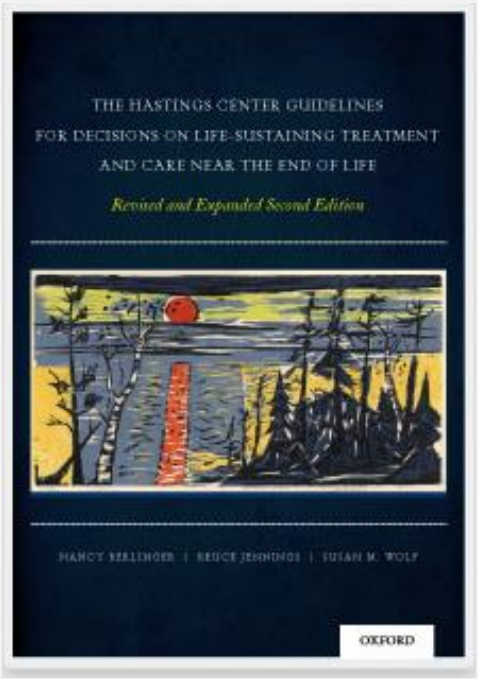
- Serious illness is age-associated. It is common in ageing societies.
- Seriously ill people need consistent access to palliative care, a proven approach for communication and for managing pain, symptoms, and distress.
- Limited size of PC specialist workforce is a barrier to access.
- **PC specialists in the US are rethinking their role**, focusing on training nonspecialists to provide most PC; creating better systems, and limiting consults to complex cases.
  - Quill & Abernethy (2013). Generalist Plus Specialist Palliative Care: Creating a More Sustainable Model. *NEJM 368*(13), 1173-1175.

HOSPITAL PHYSICIANS AS PRIMARY PALLIATIVE CARE PROVIDERS

- Hospitalists – internal medicine specialists who care for patients in medicine wards – are well-situated to function as primary palliative care providers:
  - direct most care for seriously ill adults in the hospital
  - play consensus-building role with other clinicians, and with family
- For hospitalists to be *effective* in this role, they need:
  - training and mentoring by PC specialists in primary palliative care skills
  - practical attention to integrating skills into daily medical ward tasks
  - operational support from hospital leadership, IT systems

HASTINGS CENTER GUIDELINES (1987; 2013)

IMPROVING COMMUNICATION ABOUT SERIOUS ILLNESS
COLLABORATIONS WITH HOSPITAL CLINICIANS
(2013-16; SHM WEBSITE LAUNCHED MAY 2017)



MEDICINE AND SOCIETY

Forty Years of Work on End-of-Life Care — From Patients' Rights to Systemic Reform

Susan M. Wolf, J.D., Nancy Berlinger, Ph.D., and Bruce Jennings, M.A.

N Engl J Med 2015; 372:678-682 | February 12, 2015 | DOI: 10.1056/NEJMms1410321

shm
Society of Hospital Medicine

AMERICAN ASSOCIATION of CRITICAL-CARE NURSES

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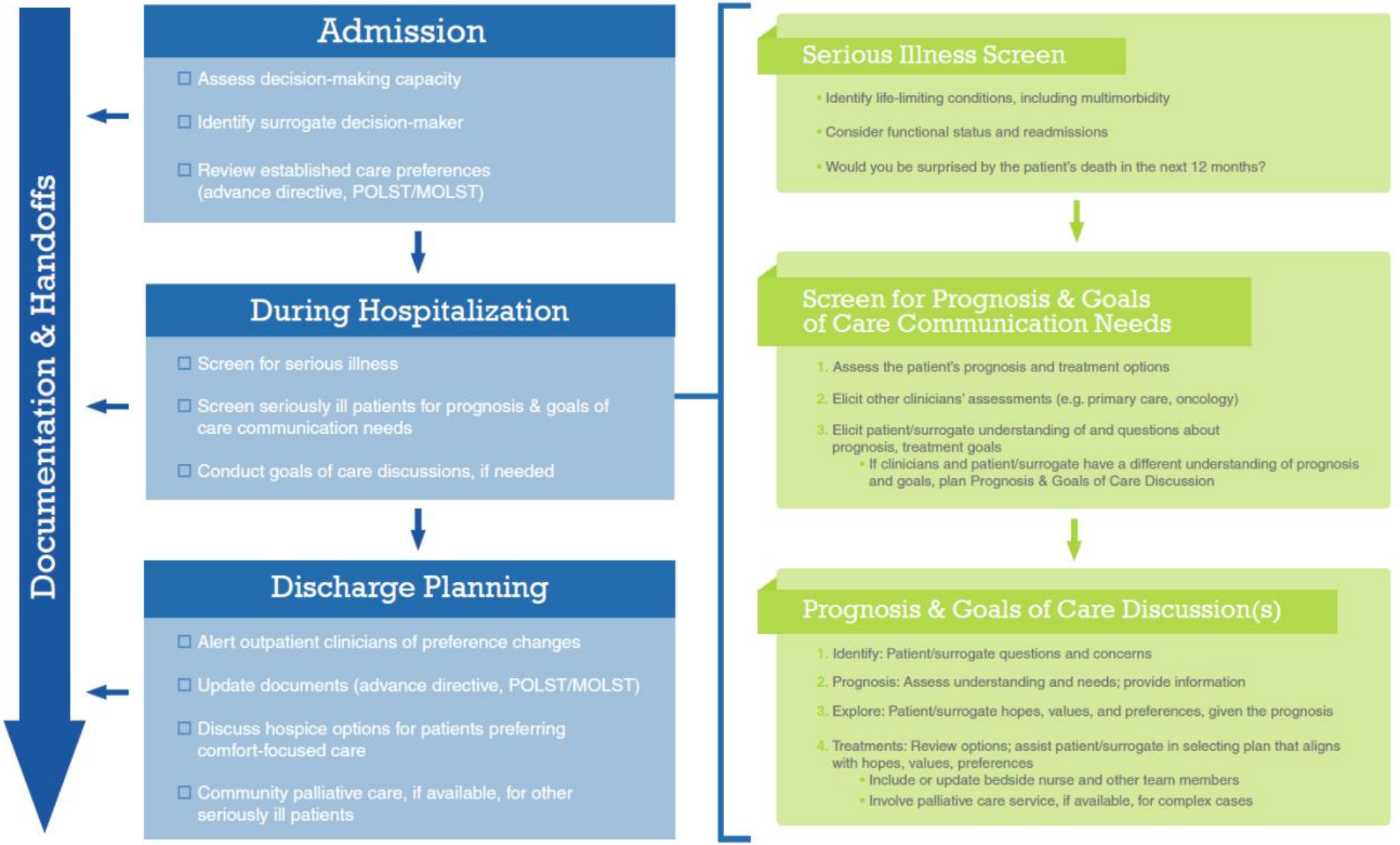
OUR RESEARCH QUESTION

- Hospital medicine is the fastest-growing medical specialty in the US.
- Hospitalists typically care for older patients experiencing acute episodes of serious illness, but most are not trained to meet the foreseeable palliative care needs of their patient population.

- *How should the field of hospital medicine recognize, strengthen, and support hospitalists in their de facto role as primary palliative care providers?*

SOCIETY OF HOSPITAL MEDICINE/HASTINGS CENTER COLLABORATION

- Launched in July 2015 through an interdisciplinary national stakeholder meeting that including members of a **hospitalist Expert Panel convened by SHM**.
- Based on meeting discussion and analysis of themes, project leaders selected **prognosis and goals of care discussions** as a key PC process for hospitalists.
- Expert Panel developed a **practical model** reflecting the reality of the hospitalist work environment.



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BEST PRACTICE: WHAT SUPPORTS PROGNOSTIC/GOALS OF CARE DISCUSSIONS IN THE MEDICAL WARD?

- **Value:** Best practice should show how discussing prognosis, clarifying patient preferences, aligning treatment with preferences, documenting goals of care so this information can guide care, and managing symptoms and distress **improve value in hospital medicine.** Standards and initial and future metrics should support high-value care delivery in the context of serious illness so clinicians and administrators share an accurate picture of what **high-value health care** looks like.

BEST PRACTICE: WHAT SUPPORTS PROGNOSTIC/GOALS OF CARE DISCUSSIONS IN THE MEDICAL WARD?

- **Leadership:** Best practice relies on the **explicit support of hospital leadership.** The safety and quality improvement research literature demonstrates that social change in complex systems proceeds from leadership buy-in and endorsement. Supporting the integration of primary palliative care into normal hospital care with the goal of greater value for seriously ill patients also supports organizational progress.

BEST PRACTICE: WHAT SUPPORTS PROGNOSTIC/GOALS OF CARE DISCUSSIONS IN THE MEDICAL WARD?

- **Role clarity:** Best practice should be supported by system recognition of how primary palliative care is integrated into normal hospital care. Hospitalists collaborate with other physicians as co-managers of a patient's care, or may assume responsibility for a patient's medical care during a care transition from a surgical or intensive care setting.
- **Explaining how hospitalists collaborate** with medical and surgical specialties, including palliative care specialists, and with nurses and other team members, **prevents confusion and conflicts about roles** and scope of practice.

BEST PRACTICE: WHAT SUPPORTS PROGNOSTIC/GOALS OF CARE DISCUSSIONS IN THE MEDICAL WARD?

- **Tasks:** Best practice for hospitalist-initiated goals of care discussions should realistically reflect the **task-based work environment** of hospitalists and bedside nurses, with close attention to how primary palliative care needs are identified and responded to from admission through discharge, and the skills needed for these tasks.
- How **information about patient preferences** is documented, shared during handoffs and with nurses and other team members, and conveyed to outpatient providers are key **operational** aspects of primary palliative care that support best practice.
-

BEST PRACTICE: WHAT SUPPORTS PROGNOSTIC/GOALS OF CARE DISCUSSIONS IN THE MEDICAL WARD?

- **Resilience:** The implementation of best practice for hospitalist-initiated goals of care discussions and other core components of primary palliative care should include attention to the **emotional aspects of discussing prognosis**.
- In addition to learning how to communicate effectively with patients and families under stressful conditions, hospitalists and bedside nurses also need **opportunities to reflect on and discuss challenging cases** and to develop resilience.
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Center for Quality Improvement
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and Patient Safety

Improving Communication about Serious Illness-Implementation Toolkit

Overview

This Resource Room is the product of a two-year collaboration between the Society of Hospital Medicine (SHM)'s Center for Hospital Innovation and Improvement and The Hastings Center. This collaboration created a new task-based pathway to improve care for seriously ill patients, focused on prognosis and goals of care communication by hospitalists in collaboration with nurses and teams.

The Society of Hospital Medicine hopes that this implementation toolkit will be helpful to:

1. individual clinicians hoping to improve their communication,
2. clinical champions who might lead projects to improve serious illness communication,
3. to service and hospital leadership, to understand how to best support hospitalists and their teams in providing the highest quality of care to their seriously ill patients.

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This project was made possible through a generous grant from the Milbank Foundation, with additional support from the Donaghue Foundation's R3 grant program for project development.

BARRIERS AND CHALLENGES TO IMPLEMENTATION OF BEST PRACTICE: ADDRESSING WHAT HOSPITALISTS AND NURSES WORRY ABOUT

- Time
- "Ownership" of the patient
- Clinician discomfort/discord
- Fear of patient/family emotion
- Language/cultural barriers
- Patient/family resistance

TRAINING AND MENTORING IN COMMUNICATION SKILLS: WHAT HOSPITALISTS AND NURSES CAN LEARN FROM PC SPECIALISTS

- Set up the conversation
- Assess prognostic awareness
- Assess information preferences
- Share prognostic information
- Use silence/respond to emotion
- Explore what matters most to this patient – what do they value, hope for, fear?
- Make a recommendation for treatments that match values/goals and allay fears
- Summarize plan and next steps

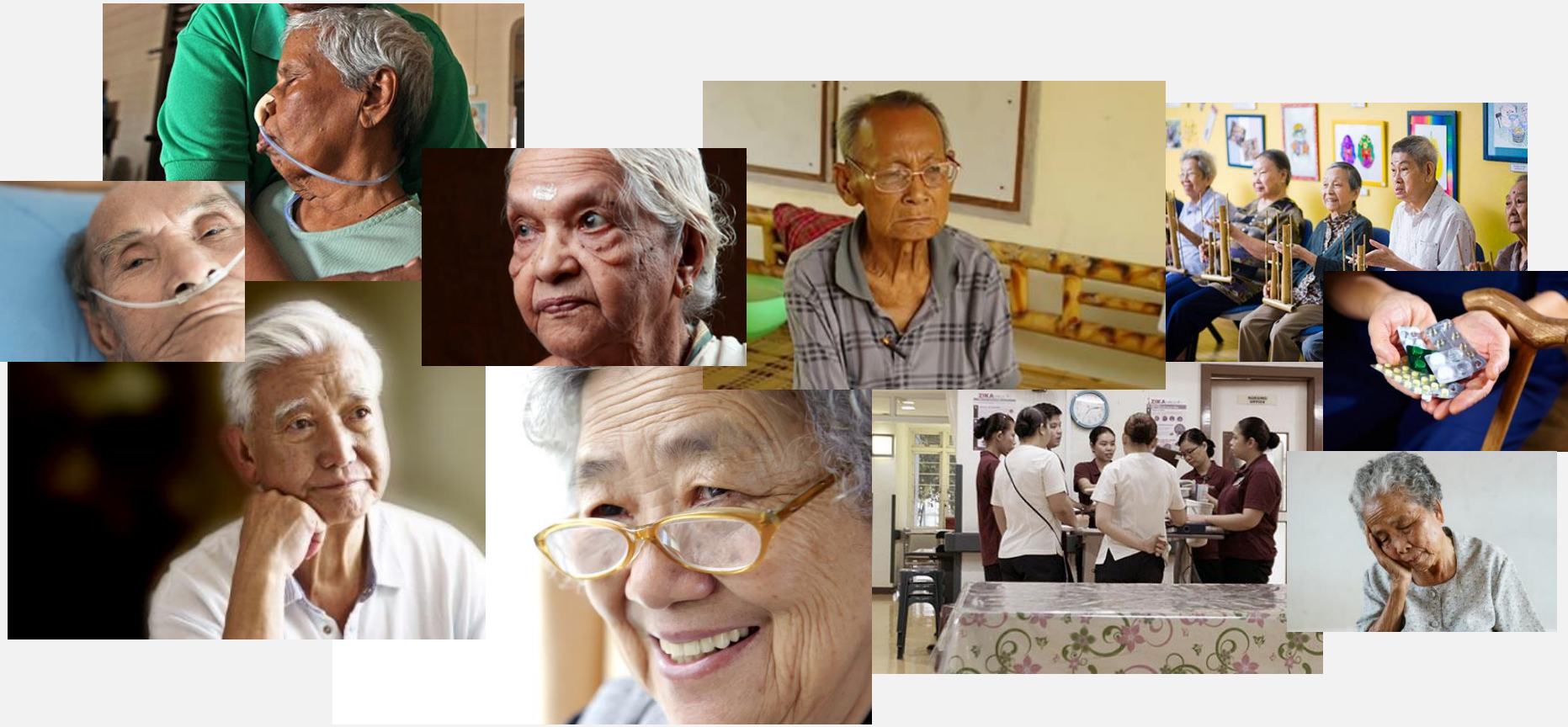
TAKEAWAYS

- Population ageing is a **societal challenge that affects the everyday work of physicians and nurses** in medical wards across ageing societies.
- Rethinking the relationship between palliative care specialists and the frontline workforce, from a referral/consultation model to a training/mentoring model, can **close the gap between supply and demand** for palliative care services in the medical ward.
- This shift requires **leadership support**, and is consistent with efforts toward **high-value health care**.

A TALE OF TWO TATTOOS: PART 2

RESOURCES

- WG Anderson, N, Berlinger, J Ragland, L Mills, B Egan, B Hendel-Paterson, C Wiencek, H Epstein, E Howell. "Hospital-Based Prognosis and Goals of Care Discussions with Seriously Ill Patients: A Pathway to Integrate a Key Primary Palliative Care Process into the Workflow of Hospitalist Physicians and their Teams." Society of Hospital Medicine and The Hastings Center, 2017. **Full toolkit: http://www.hospitalmedicine.org/Web/Quality___Innovation/Implementation_Toolkit/EOL/Palliative_Care_Home_Society_of_Hospital_Medicine.aspx**
- JJ Chin, N Berlinger, MC Dunn, CWL Ho, MK Gusmano, eds., *Making Difficult Decisions with Patients and Families: A Singapore Bioethics Casebook, Volume I* (NUS, January 2014); JJ Chin, N Berlinger, MC Dunn, MK Gusmano, eds. *Caring for Older People in an Ageing Society: A Singapore Bioethics Casebook, Volume II* (NUS, May 2017) **Full text, education guide, training videos: www.bioethicscasebook.sg**



Caring for Older People in an Ageing Society

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