Palliative Care at RUHS-MC

October 2, 2018

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DISCLOSURES

None of the faculty, planners, speakers, providers nor CME committee has any relevant financial relationships with commercial interest

There is no commercial support for this CME activity

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Objectives

- **Participants will be able to accurately identify patients for Palliative Care at RUHS Medical Center.**
- **Participants will be able to identify appropriate Palliative Care discussions.**
- **Participants will utilize non-pharmacologic therapies that Palliative Care at RUHS Medical Center has to offer.**
- **Participants will review the outpatient Palliative Care program at RUHS Medical Center.**

No Disclosures

Palliative Care Team Introduction:

- Ronald McCowan MD, Palliative Care Medical Director Inpatient
- Amar Dave MD, Palliative Care Physician
- Faheem Jukaku MD, Palliative Care Medical Director Outpatient
- Cori Hendra RN, BSN, CHPN, Palliative Care Coordinator
- Javier Chavez MSW, Palliative Care
- Margaret Kennedy Chaplain, Palliative Care
- Antonia Ciovica, PhD Psychologist, Palliative Care
- Alyson Michael, Music Therapist

PALLIATIVE CARE

- Palliate means to “alleviate without cure.”
- The basic definition of palliative care is to improve the quality of life of patients and families who are facing life-threatening illness through prevention and relief of suffering.
- Palliative interventions affirm life and treat dying as a natural process.
- Pain and symptom management are essential components of palliative care.

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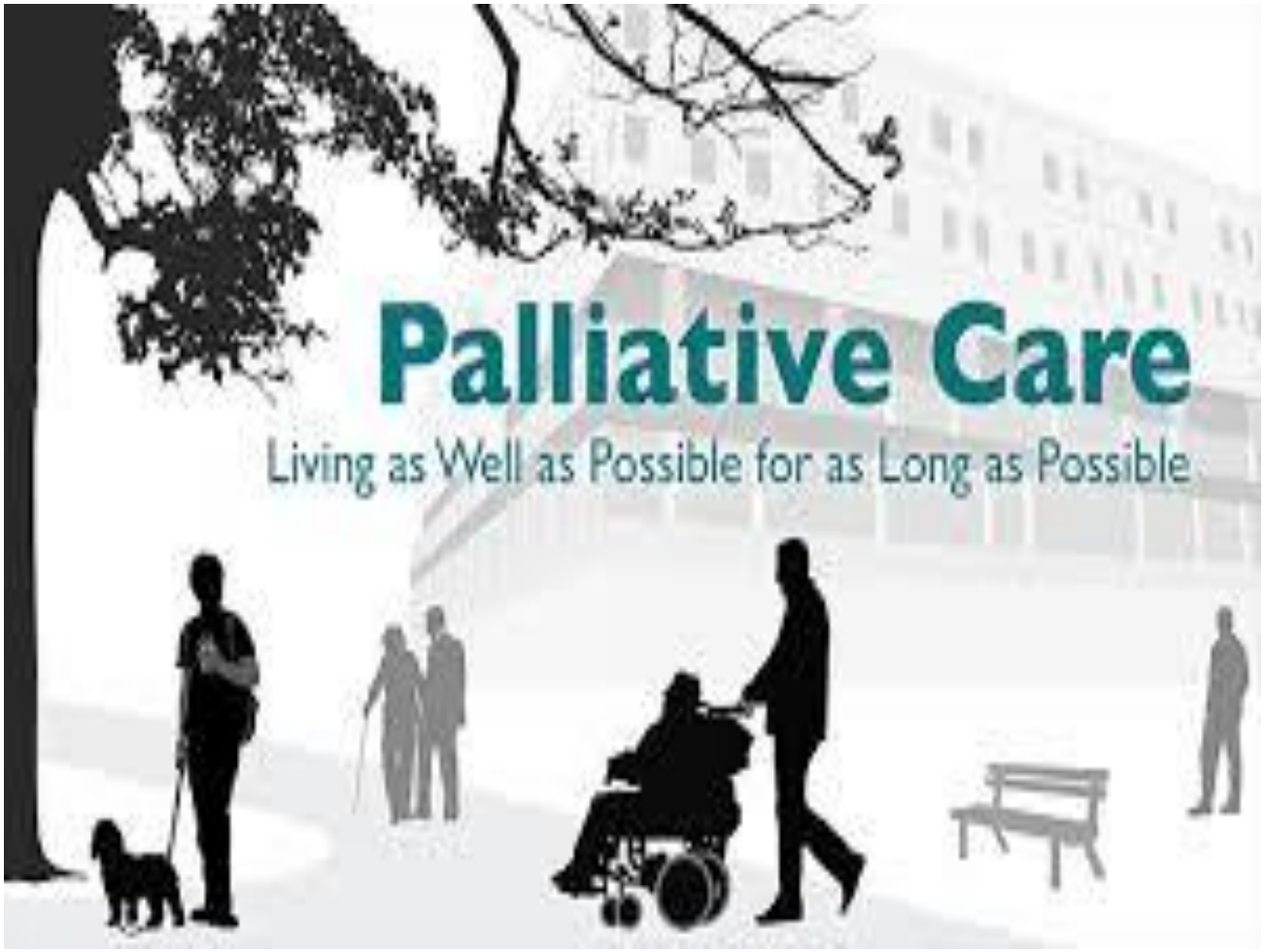

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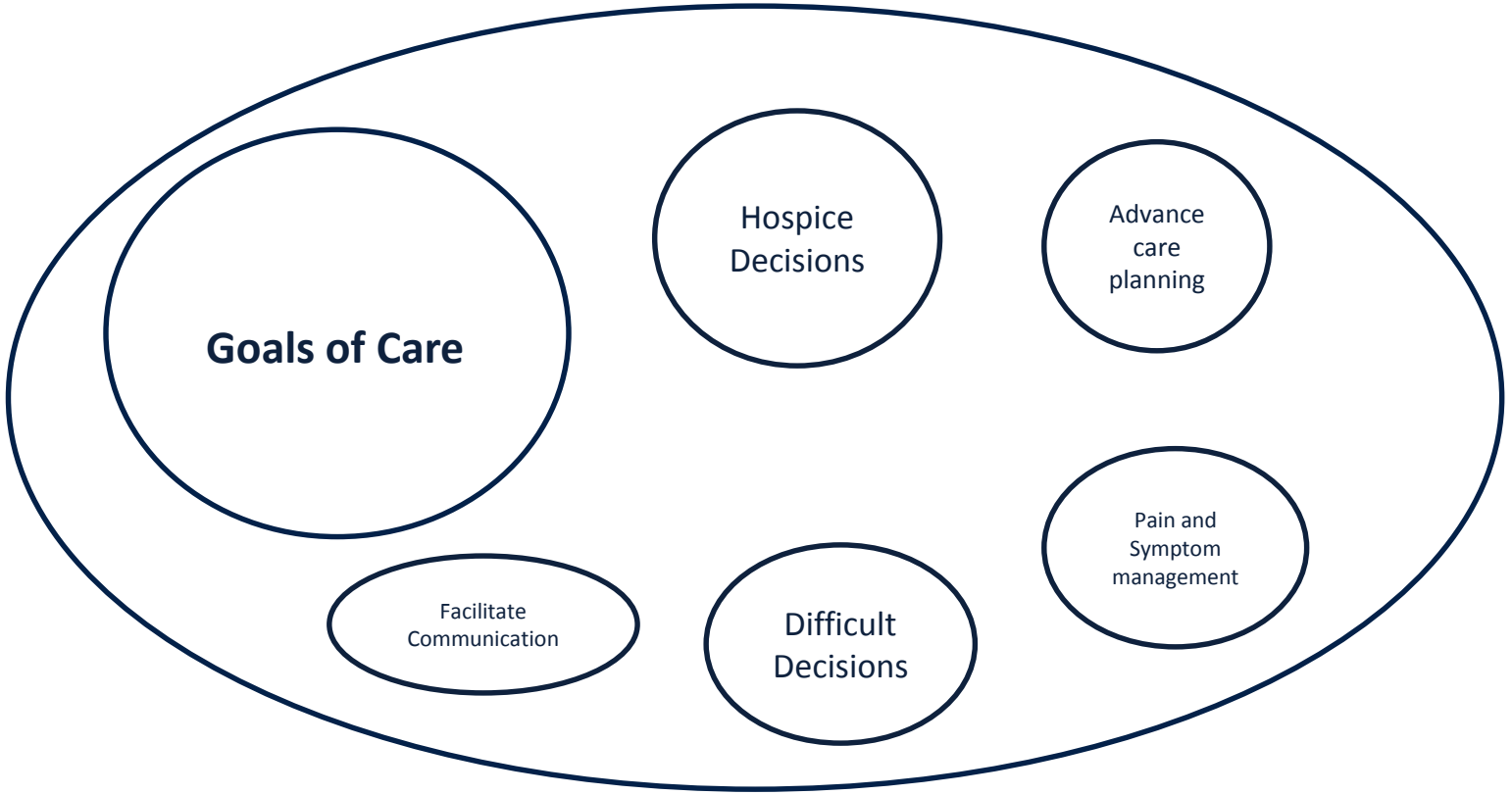
Palliative Care Components



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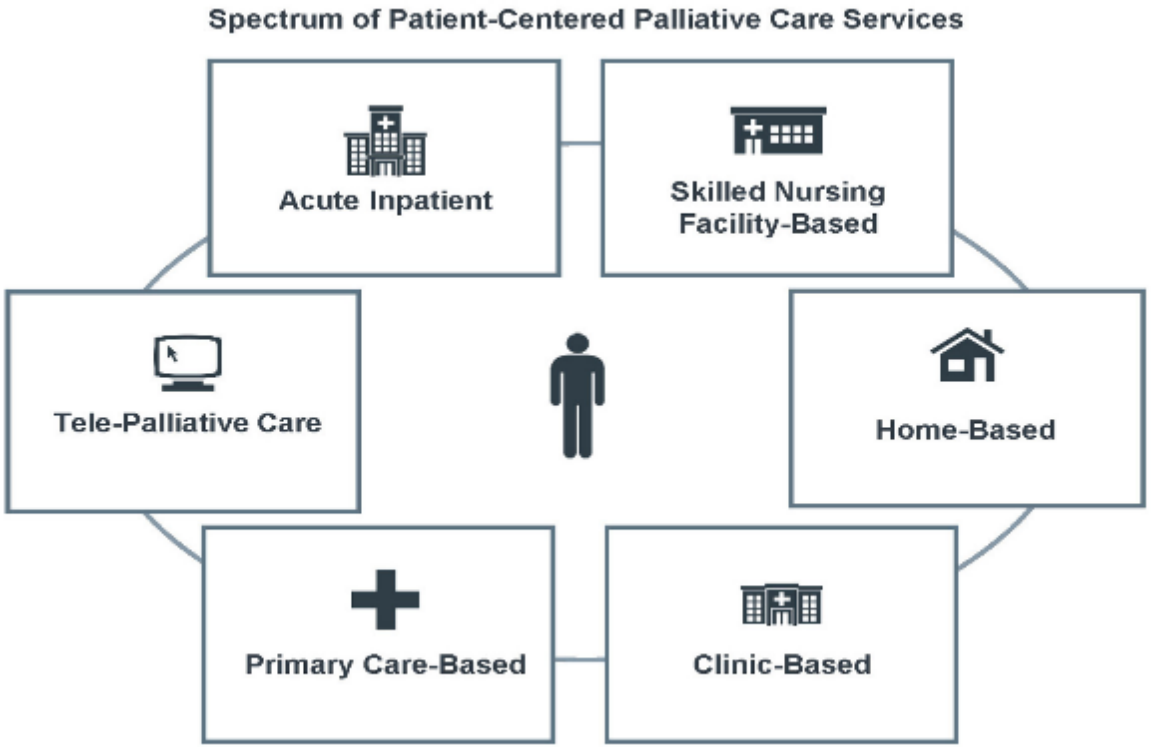
What is Palliative Care

- Palliative Care comes in many formats and is offered in many settings.
- All of these services are currently available at RUHS.



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Palliative Care Clinic RUHS-MC

- Dr. Jukaku & Dr. Dave
- Offers symptom management, medication management, advance care planning.
- Appropriate for patients who need symptom management but also want to pursue disease directed therapy.

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PCQN Demographics and Characteristics - Riverside Univ Health System

Discharge Period: 01/01/2018 to 07/09/2018

	TOTAL			
	Member		PCQN	
	N	%	N	%
Reason for Consult [1]				
Goals of care/Advance Planning	290	74.4%	18,244	75.0%
Pain management	78	20.0%	3,775	15.5%
Other symptom management	18	4.6%	2,987	12.3%
Withdrawal of interventions	10	2.6%	677	2.8%
Transfer to comfort care bed	0	0.0%	504	2.1%
Comfort care	28	7.2%	1,613	6.6%
Hospice referral/discussion	79	20.3%	3,462	14.2%
Support for Patient/Family	43	11.0%	6,979	28.7%
Support for Providers	0	0.0%	0	0.0%
Integrative Therapies	0	0.0%	0	0.0%
No reason given	1	0.3%	330	1.4%
Other	9	2.3%	1,052	4.3%

	TOTAL			
	Member		PCQN	
	N	%	N	%
Diagnosis				
Cancer (solid tumor)	147	37.7%	6,751	27.7%
Cardiovascular	37	9.5%	3,471	14.3%
Pulmonary	26	6.7%	3,009	12.4%
Vascular	2	0.5%	242	1.0%
Complex chronic/failure to thrive	52	13.3%	2,468	10.1%
Renal	10	2.6%	740	3.0%
Trauma	23	5.9%	487	2.0%
Congenital / Chromosomal	8	2.1%	44	0.2%
Gastrointestinal	5	1.3%	626	2.6%
Hepatic	16	4.1%	772	3.2%
Infectious / immunological/HIV	5	1.3%	996	4.1%
In-utero complication	0	0.0%	4	0.0%
Neuro / Stroke	22	5.6%	2,103	8.6%
Dementia	35	9.0%	919	3.8%
Hematology	1	0.3%	431	1.8%
Other	1	0.3%	591	2.4%
Unknown	0	0.0%	353	1.5%
Pending	0	0.0%	327	1.3%

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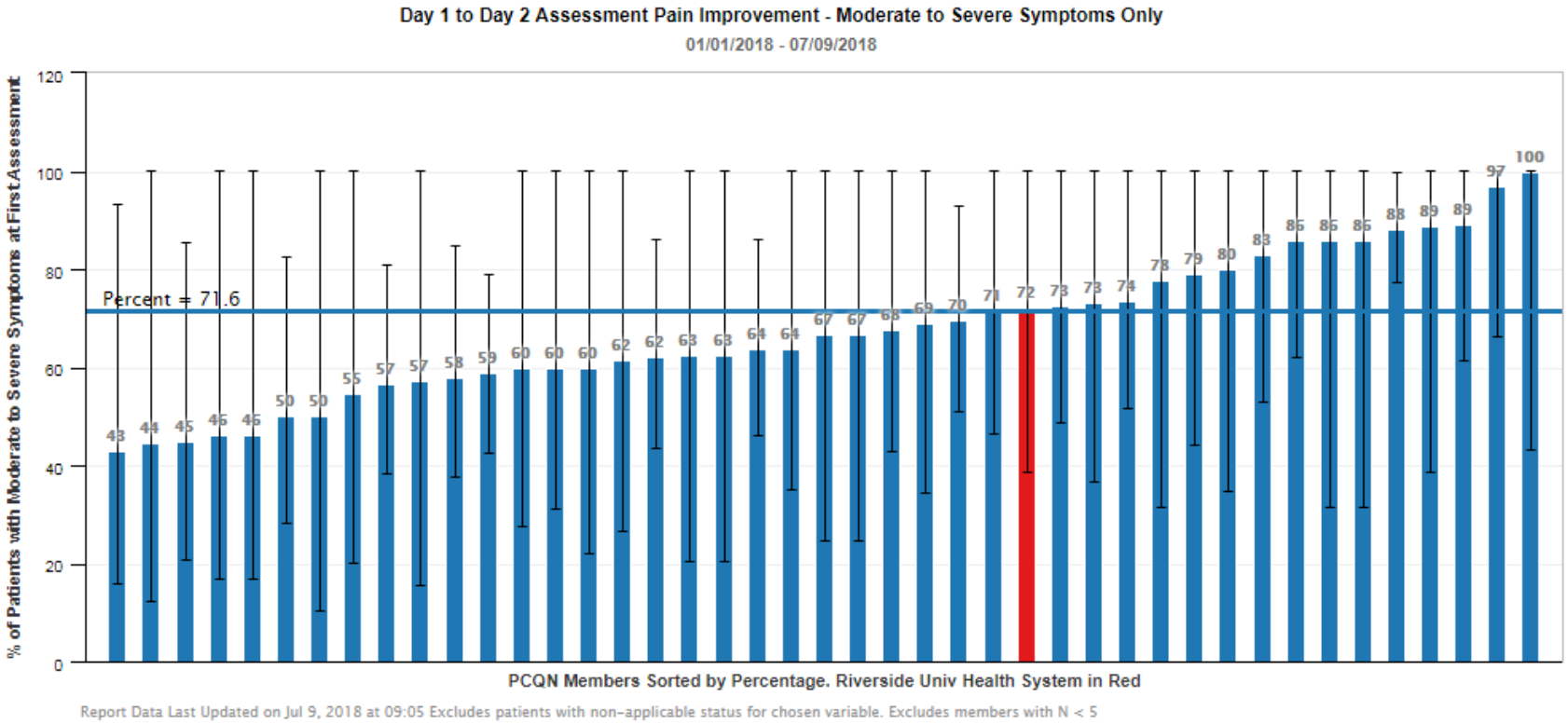
PCQN Palliative Care Quality Network
RUHS-MC data



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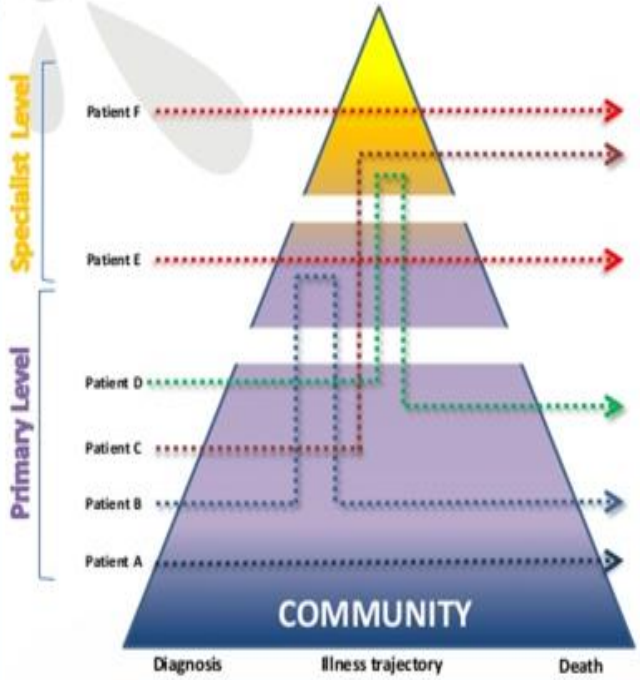
Who provides palliative care?



- A small number of patients with complex needs require transfer of care to specialist palliative care services
- May occasionally require assistance of specialist palliative team
  - consultation or shared care support
- Most patients require only primary-level Palliative Care (Palliative Care Approach)
  - Family medicine clinic
  - Oncology team
  - Internal med clinics
  - Cardiology clinics
  - COPD clinics

Pallium Canada

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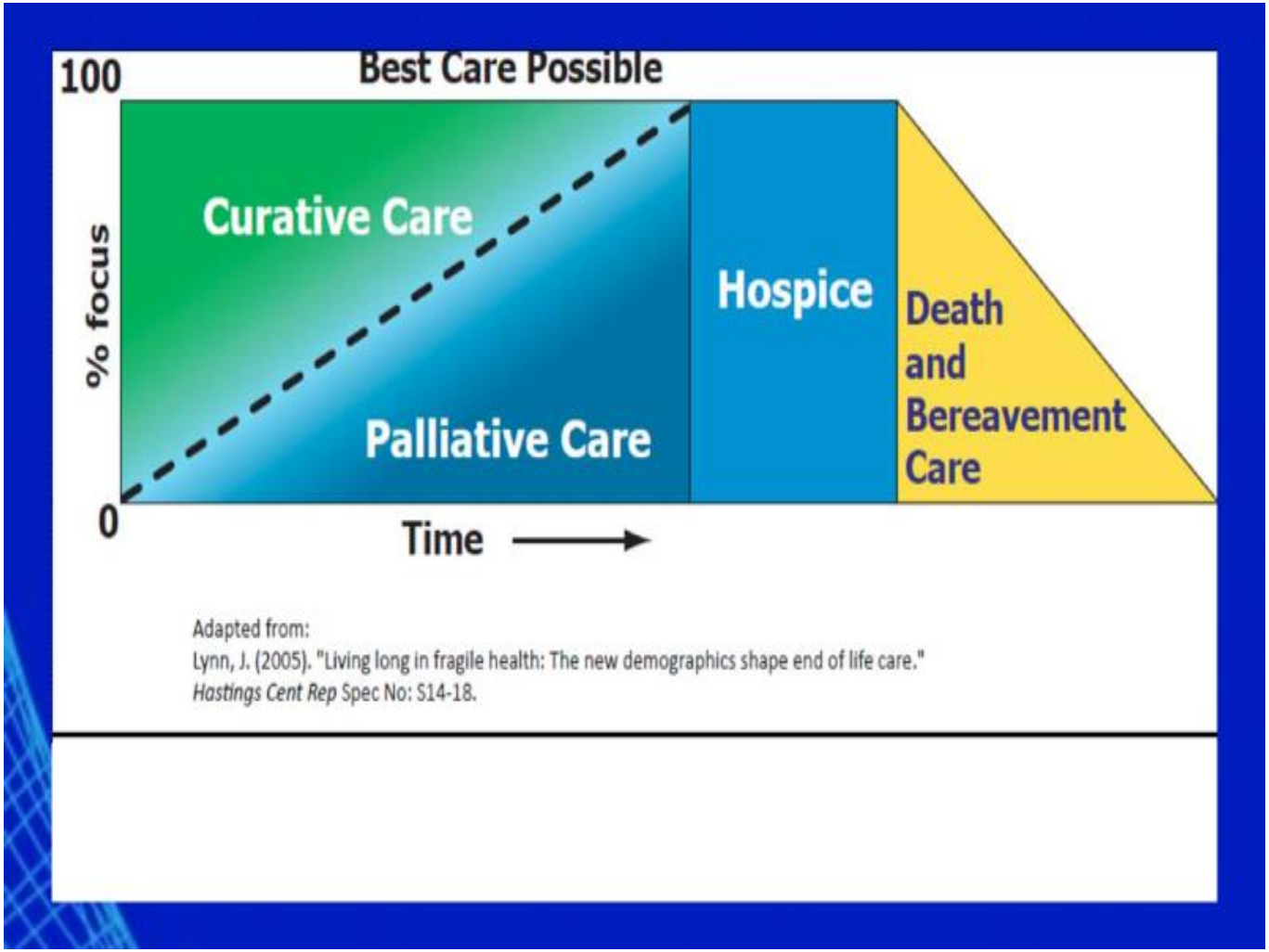

Adapted from:
Lynn, J. (2005). "Living long in fragile health: The new demographics shape end of life care."
Hastings Cent Rep Spec No: S14-18.

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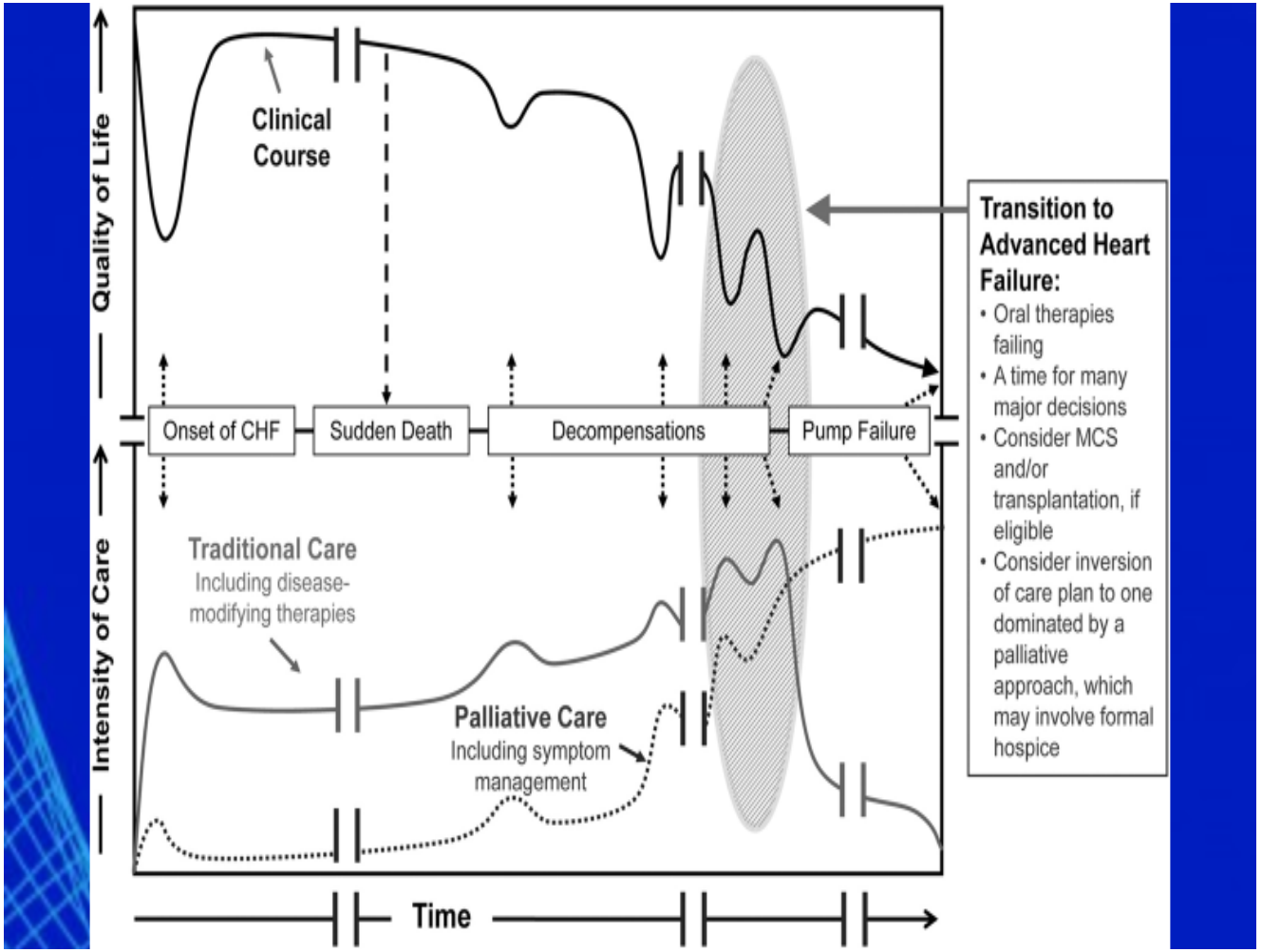

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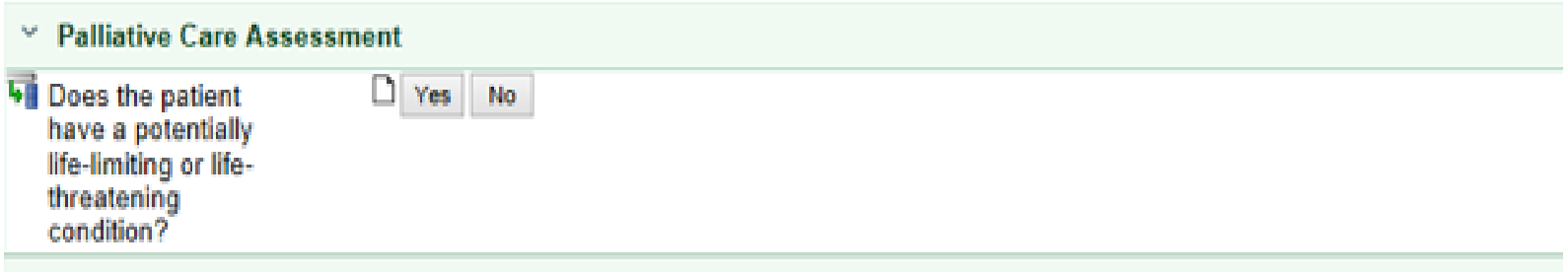
Palliative Care Triggers

1. Nurse answers question in nursing assessment. If answered yes, additional questions cascade down



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2. Nurse answers the next 4 questions. If any are answered yes, this sends a BPA to the physician

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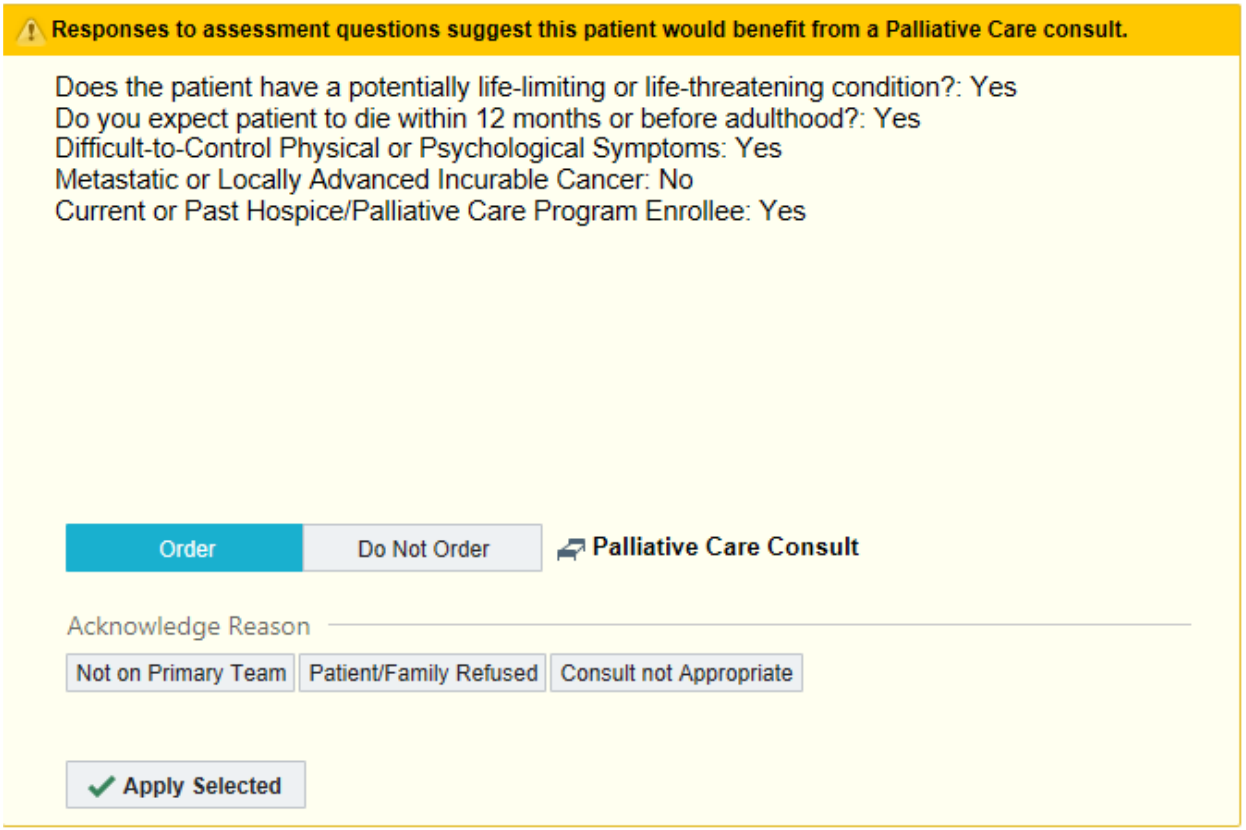
BPA



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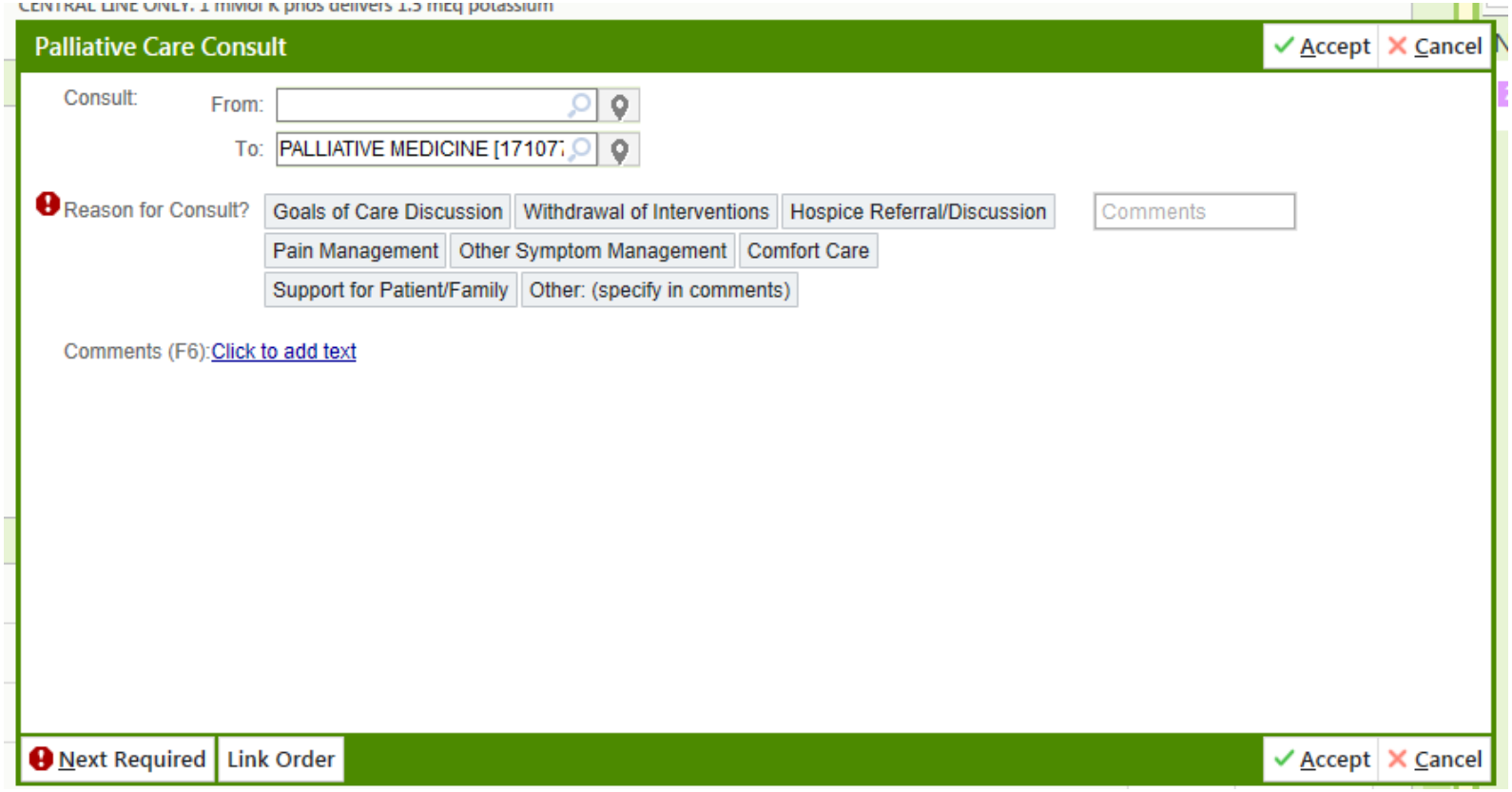
Palliative Care Consult Order



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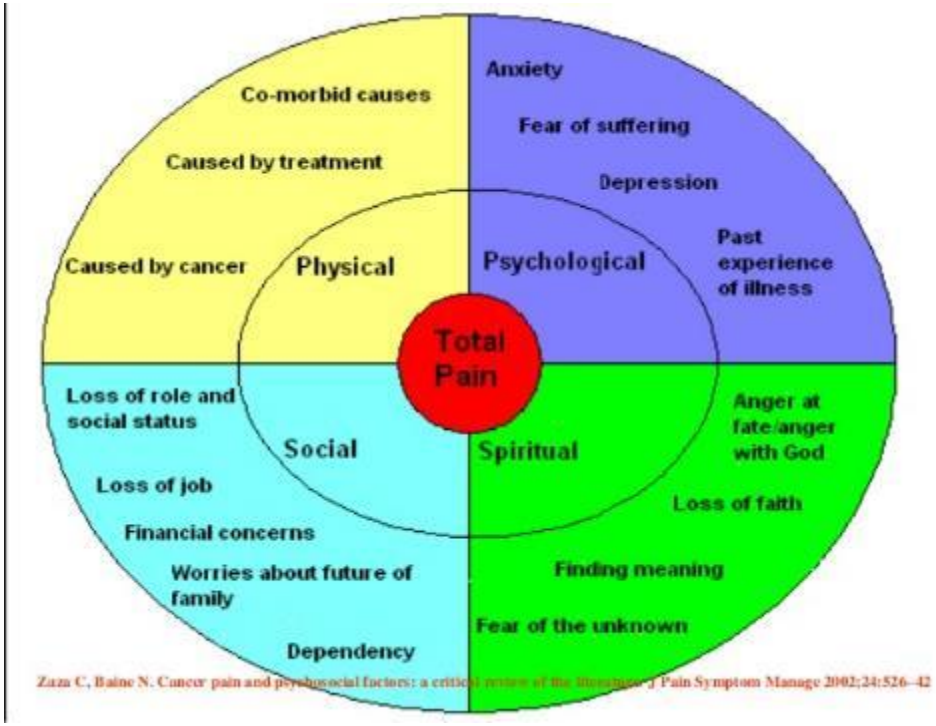
Total Pain



Zaza C, Baine N. Cancer pain and psychosocial factors: a critical review of the literature. J Pain Symptom Manage 2002;24:526–42

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CLASSIFICATION

MIND/BODY MEDICINE

- TECHNIQUES INVOLVE EXPLORING THE MIND'S ABILITY TO AFFECT THE BODY.
- BASED ON TRADITIONAL PRINCIPLES ON HOW THE MIND AND BODY ARE INTERLINKED.

- ART THERAPY
- BIOFEEDBACK
- RELAXATION TECHNIQUES
- DANCE THERAPY
- GUIDED IMAGERY
- HUMOR THERAPY
- SUPPORT GROUPS

- YOGA
- MEDITATION
- MUSIC THERAPY
- PRAYER THERAPY
- PSYCHOTHERAPY
- COUNSELING
- HYNOTHERAPY
- SPIRITUALITY

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Complementary and Alternative Medicine

Meditation
Hypnosis
Guided Imagery
Relaxation Therapy
CBT
Prayer and Spirituality
Bodywork and Movement therapy

Acupuncture
Chiropractic Therapy
Dietary Medicine
Herbal Medicine
Massage Therapy
Music Therapy

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Music Therapy

- An allied health service similar to PT, OT, ST
- Music is the therapeutic tool
- Addresses physical, cognitive, social, emotional, psychological, spiritual, and behavioral needs
- Cost-effective and evidence based

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Music Therapy

- Used since ancient times to affect human spirit and to heal.
- involves the use of music to effect clinical change.
- Used in psychiatry, drug and alcohol rehabilitation, developmental disability, geriatric treatment, palliative care, general surgery, and oncology programs.
- Patients are guided to:
  verbally process the music
  actively participate through songwriting,
  improvisation, remake of a song, or musical performance.

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a brief history of MUSIC THERAPY in the United States

1789 Earliest known reference to music therapy in the Columbian Magazine article, "Music Physically Considered"

1936 Willem van de Wall publishes the first "how to" music therapy text, "Music in Institutions"

1940s Music therapy academic programs open at Michigan State (1944), University of Kansas (1946), & College of the Pacific (1947)

1950s The National Association for Music therapy (NAMT) is formed in 1950 and establishes the Registered Music Therapist (RMT) designation in 1956

1964 The "Journal of Music Therapy" is first published

1971 The American Association for Music Therapy (AAMT) is formed, philosophically distinct from the NAMT

1982 The journal "Music Therapy Perspectives" is first published

1983 The Certification Board for Music Therapists (CBMT) is formed, establishing the MT-BC designation

1998 Members of NAMT and AAMT vote to merge, creating the American Music Therapy Association (AMTA)

2005 AMTA and CBMT begin collaboration on the State Recognition Operational Plan to ensure the MT-BC designation is officially recognized by governmental organizations

2011 Nevada signs the first music therapy license into law, requiring anyone practicing music therapy to hold the MT-BC credential

2015 AMTA hosts the strategic research symposium, Music Therapy Research 2025, to prioritize and guide future research efforts

www.ImAMusicTherapist.com

AMTA (2016); Information retrieved from www.musictherapy.org/about/history/

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Music Therapy

- MT power to induce strong emotions and effectively impact the mood of individuals
- Neuroimaging has shown that emotions evoked by music can modulate activity in virtually all limbic and paralimbic brain structures
- MT can reduce anxiety and pain and enhance communication and spiritual well-being

- MT can lead to significant improvement of quality of life in terminally ill patients compared to standard medical care only.

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Music Therapy

Active music therapy - interactive live music performances delivered by trained music therapists using singing voice and music instruments.

Receptive MT (e.g., prerecorded music)
Studies have found that live music is more effective than prerecorded music with adult cancer patients, i.e., patients over 17 years old (MacGill, 1983). Live MT allows for personalized interactions which may be particularly important for patients who relate best to music which is relevant to their special current situation (Stecher et al., 1972).

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Music Therapy: Improving Outcomes

Music interventions for improving psychological and physical outcomes in cancer patients.

Bradt J1, Dileo C, Grocke D, Magill L.

[Cochrane Database Syst Rev. 2016]

OBJECTIVES:

To compare the effects of music therapy or music medicine interventions and standard care with standard care alone, or standard care and other interventions in patients with cancer

Databases searched:

Cochrane Central Register of Controlled Trials (CENTRAL) (The Cochrane Library 2010, Issue 10), MEDLINE, EMBASE, CINAHL, PsycINFO, LILACS, Science Citation Index, CancerLit, www.musictherapyworld.net, All databases were searched from their start date to September 2010.

30 trials with a total of 1891 participants:

included music therapy interventions, offered by trained music therapists (13),
as well as listening to pre-recorded music (17), offered by medical staff.

Findings:

music interventions cause small reductions in HR, RR, and BP
Moderate anxiety and pain reduction (SMD = -0.59, 95% CI -0.92 to -0.27, P = 0.0003)
Improved mood and QOL

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Music Therapy: Improving Outcomes

Music interventions for improving psychological and physical outcomes in cancer patients.

Bradt J1, Dileo C, Magill L, Teague A.

OBJECTIVES:

To assess and compare the effects of music therapy and music medicine interventions for psychological and physical outcomes in people with cancer.

Databases searched:

Cochrane Central Register of Controlled Trials (CENTRAL) (2016, Issue 1), MEDLINE, Embase, CINAHL, PsycINFO, LILACS, Science Citation Index, CancerLit, CAIRSS, Proquest Digital Dissertations, ClinicalTrials.gov, Current Controlled Trials, the RILM Abstracts of Music Literature, http://www.wfmt.info/Musictherapyworld/ and the National Research Register. We searched all databases, except for the last two, from their inception to January 2016;
Included music therapy interventions offered by trained music therapists, as well as music medicine interventions (23), which are defined as listening to pre-recorded music (29), offered by medical staff.

22 new trials were included in this update. In total, the evidence of this review rests on 52 trials with a total of 3731 participants.

Findings:

music interventions cause small reductions in HR, RR, and BP
Moderate anxiety, pain, and fatigue reduction
Improved mood and QOL

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Music Therapy

Efficacy of a single music therapy session to reduce pain in palliative care patients.

200 inpatients - University Hospitals Case Medical Center were enrolled 2009 to 2011.

Randomized: standard care with scheduled analgesics vs standard care with music therapy

Result - mean change in Functional Pain Scale scores was significantly greater in the music therapy group (difference in means $P<0.0001$): A single music therapy intervention incorporating therapist-guided autogenic relaxation and live music was effective in lowering pain in palliative care patients.

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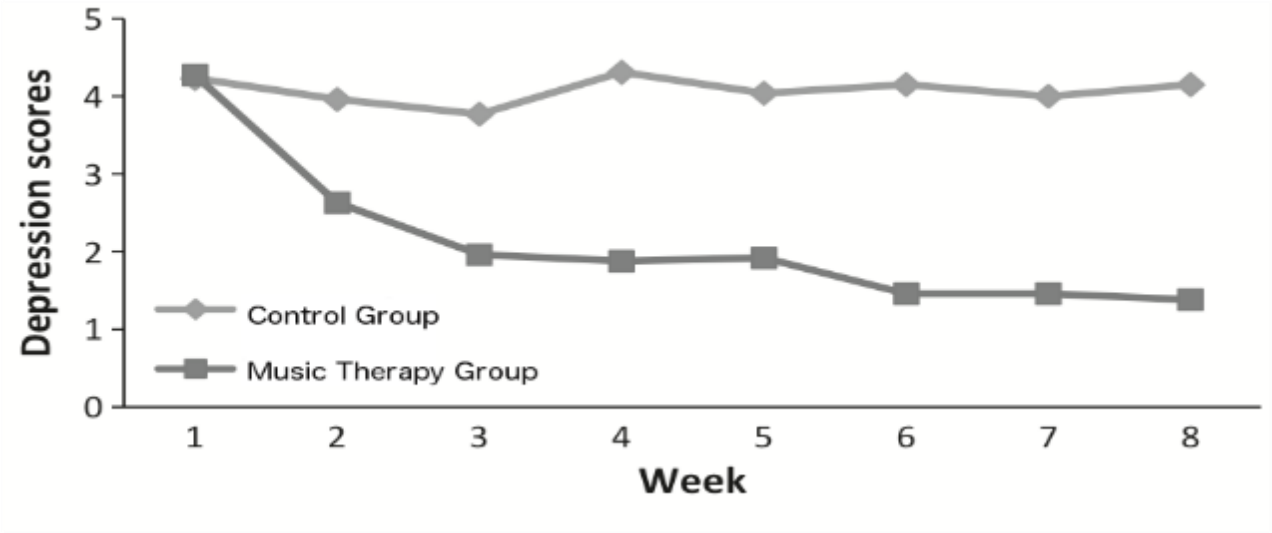
Music Therapy

- Music therapy for 30 minutes per week over an 8-week period to a group of 50 older people with depression.
- Control group -24 participants
- Music therapy group of 26 participants
- Depression levels were assessed once a week using Geriatric Depression Scale (GDS-15
- A statistically significant reduction of depression levels was observed starting week 4.

HEALING SOUNDS



Chan, M. F., Wong, Z. Y., Onishi, H., Thayala, N. V. (2011) . "Effects of Music on Depression in Older People: A Randomized Controlled Trial". Journal of Clinical Nursing. 21: 776 – 783

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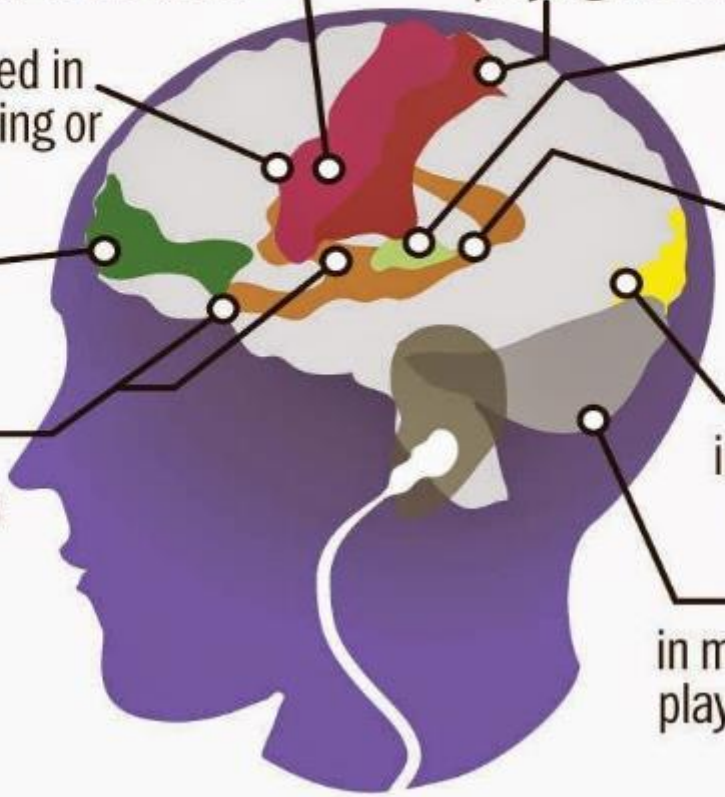
Music and the brain

Playing and listening to music works several areas of the brain



Corpus callosum: Connects both sides of the brain

Sensory cortex: Controls tactile feedback while playing instruments or dancing

Motor cortex: Involved in movement while dancing or playing an instrument

Auditory cortex: Listens to sounds; perceives and analyzes tones

Prefrontal cortex: Controls behavior, expression and decision-making

Hippocampus: Involved in music memories, experiences and context

Visual cortex: Involved in reading music or looking at your own dance moves

Nucleus accumbens and amygdala: Involved with emotional reactions to music

Cerebellum: Involved in movement while dancing or playing an instrument, as well as emotional reactions

SOURCE: Music for Young Children

DESERET NEWS GRAPHIC

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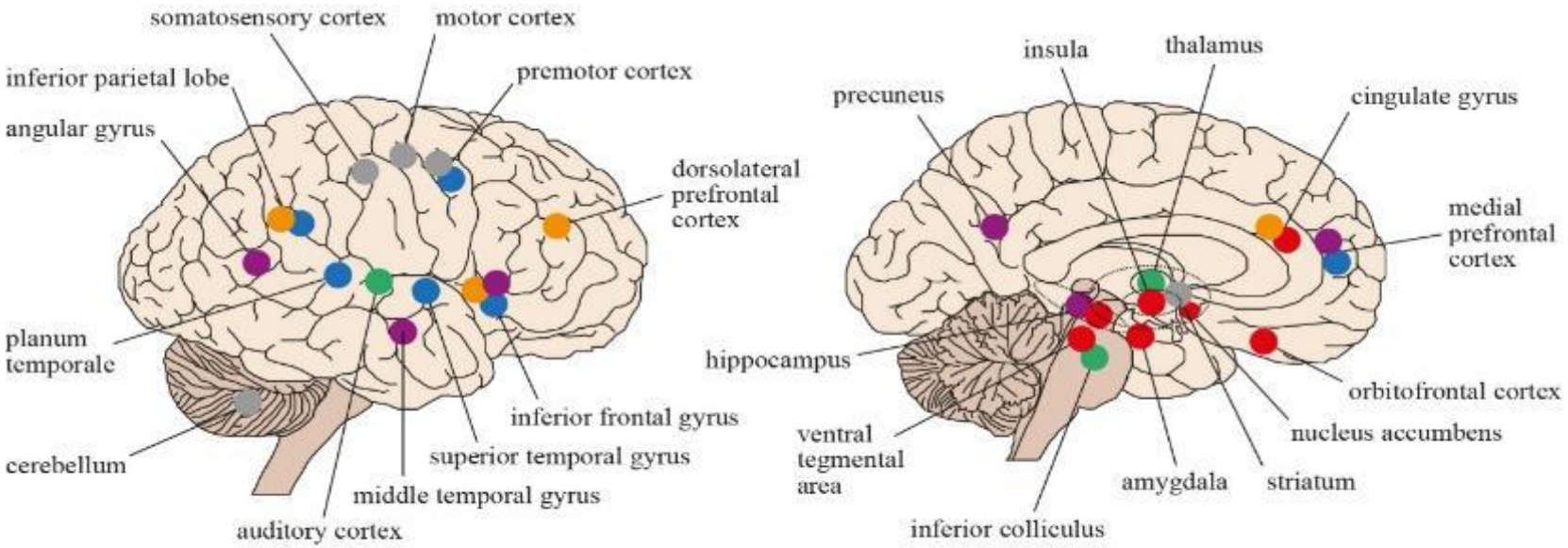
Music Therapy



- Perceiving the basic acoustic features of music (e.g., frequency, duration, loudness)
- Perceiving higher-order musical features (e.g., harmony, intervals, rhythm)
- Focusing and keeping track of music in time (attention, working memory)
- Recognizing music and recalling associated memories (episodic memory)
- Playing, singing and moving to the beat of music (motor functions)
- Music-evoked emotions and experiencing pleasure and reward

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Music Therapy

Table 1

Alternative Strategies for Patients With Pain Poorly Responsive to Opioids

Approach	Therapeutic Options
I. Opening the "therapeutic window"	More aggressive side effect treatment, eg, stimulants for sedation
II. Identifying an opioid with a more favorable balance between analgesia and side effects	Trials of different opioid drugs (opioid rotation)
III. Pharmacologic techniques that reduce the systemic opioid requirement	Coadministration of a nonopioid or adjuvant analgesic Administration of the opioid intraspinally, with or without additional nonopioid drugs
IV. Nonpharmacologic techniques to reduce systemic opioid requirement	Anesthesiologic approaches, eg, neurolysis Surgical approaches, eg, cordotomy Rehabilitative approaches, eg, bracing Psychologic approaches, eg, cognitive therapy

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Communication

- Effective Communication is key to effective patient care. This holds true with Palliative care as well.
- Patient Centered Communication:
  - elicit and understand patient perspectives (concerns, ideas, expectations, needs, **feelings and functioning)**
  - understand the patient within his or her unique psychosocial and cultural contexts
  - reach a shared understanding of patient problems and the treatments that are concordant with patient values

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Communication

- Six Core Components of Patient-Centered Communication are
  1. Fostering healing relationships
  2. Exchanging information
  3. Responding to emotions
  4. Managing uncertainty
  5. Making shared decisions
  6. Enabling patient self-management

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Communication

- Family Conference
  - The family conference is a key component of communication during end-of-life care. It is used perhaps most prominently in the intensive care unit but is also common on the general hospital units, in the clinic and in patient homes.
  - Leading a family conference can be difficult and requires a unique set of skills that often are not taught.
  - If conducted well, it fcan be a powerful tool.

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A patient's future emotional adjustment to an illness and ongoing communication with a healthcare provider is effected by two factors:

1. The manner in which the patient is told the serious news.
2. The manner in which the clinician responds to the emotion provoked by the serious news.

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https://youtu.be/7kQ3PUyhmPQ

https://www.youtube.com/watch?v=7kQ3PUyhmPQ

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Video: Family Conference

- https://vimeo.com/109391262

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SPIKES Protocol: Delivering Bad News

- S – Setting up the interview
- P- assessing the patient's Perception
- I – obtaining the patient's Invitation
- K – giving Knowledge and information to the patient
- E – addressing the patient's Emotions
- S – Strategy and Summary

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SETTING UP the Interview

- What? - check all available information, such as test results, consults. If prognosis not documented, call appropriate provider and ask
- Where? Privacy is key. Patient room, conference room, etc.
- Who? Who is going to be present at the meeting. Is it multidisciplinary. Who will break bad news?
- Introductions. Introduce yourself and also give opportunity for family/friends to introduce themselves
- Seating? It is better to communicate at eye level so have a seat. Also, offer a seat to the patient and family members.

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Assessing the patient PERCEPTION

- “What is your understanding of what is going on?”
- “What have other doctors told you about your health?”
- Use the ask tell ask approach.
- https://vimeo.com/85555368

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Obtaining the patient's INVITATION

- Find out how much the patient wants to know.
- Find out if the patient is ready to accept the information.
- “Would you like me to tell you the details of the diagnosis?”
- “Would it be okay if we talked about the results of your scan?”

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Giving KNOWLEDGE and information to the Patient

- Give a warning shot.
- “I have something serious we need to discuss.”
- Give information in small chunks
- Use concise simple language
- Avoid medical jargon
- Check reception often and Clarify
  - eg: “Am I making sense?”
- https://vimeo.com/85573836

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Addressing the Patient's EMOTIONS with empathic responses

- Don't avoid emotion.
- Only way forward is through the emotions, not around it.
- Use the NURSE mnemonic.
- Allow for therapeutic silence.

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EMOTIONS

Name	“I can see that this is frustrating.” “It seems that this is very upsetting to you.” “I wonder if you might be feeling angry.”
Understand	“I can't imagine how hard this is for you.” “I can only imagine what it is like to balance your treatments with your family life.”
Respect	“You're doing all the right things and asking the right questions.” “I've been so impressed by the care you have been providing for your wife during the many years of her illness.”
Support	“I'm going to walk this road with you.” “You're not alone in this”
Explore	“Tell me more about what worries you.”

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STRATEGY AND SUMMARY

- Plan and follow-through.
- Tell them what happens next
- Use statements like:
  - “So I know that I explained myself clearly, could you summarize what we just talked about?”

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Thank you,
RUHS Palliative Care Team

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Dr. Jukaku 18153

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Margaret, Chaplain 18618

Please feel free to contact Alicia with an questions you may have.

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