ArMA/ AOMA Joint Physician Task Force on End of Life Care

2016-18
Task Force Composition

• About 25 physicians from Phoenix, Tucson, Cottonwood, Flagstaff 5 DO’s 1 Med student, 1 resident

• Primary Care, Specialties (Palliative Care, Cardiology, Oncology, Pulmonary / ICU)

• ER

• Mission: to review EOL care in Arizona and make recommendations
Task Force Activities

• Compiled reference list for physicians
• Conducted Phone Surveys of medical schools and residency programs in Arizona
• Heard testimony from members on relevant issues affecting EOL care
• Collaborated w/ AzHHA on Lovell Grant
• Designed and implemented survey of over 500 Arizona physicians Oct – Dec 2017
Goals of Physician Survey

To Explore Physician:

• Attitudes toward End of Life discussions
• Knowledge of and perceived access to Palliative Care
• Interest in education on EOL issues
• Attitudes on Medical Aid in Dying
• Attitudes on POLST (Physician Orders for Life Sustaining Treatment)
Az Physician survey: Methodology

- Email invitation ArMA, AOMA, ACP, MCMS, PCMS
- Questionnaire developed and pretested
- Professional pollster engaged
- 8000 sent w/ several reminder emails
- Oct-Dec 2017
- 588 responses/ 466 completed
- Margin of error 4.5 %
- Population sampled: "physicians who are interested in EOL issues who completed the survey"
Profile of respondents

• Specialty
  – 36% Primary Care
  – 26% IM Subspecialty
  – 11% Surgical specialty
  – 5% Palliative Care

• Facility
  – 29% Hospital
  – 33% Clinic
  – 16% Academic
  – 6% Integrated system (FQHC, ACO)
Profile of respondents

• Geography
  – 58% Phoenix area
  – 25% Tucson area
  – 17% Rural/ other

• Age
  – 22% 25-45yr
  – 50% 46-65yr
  – 28% 66+

• Gender
  – 32% Female
  – 68% Male
Amount of Training in Palliative Medicine

- Specialist in Pall Med: 5.5%
- Significant training: 13.5%
- Limited training/CME: 29%
- No formal training: 52%
How often do you encounter patients at EOL?

68% of sampled physicians routinely care for patients near EOL.
How comfortable are you with skill sets needed for EOL care?

<table>
<thead>
<tr>
<th>Skill Description</th>
<th>Totally Comfortable</th>
<th>Pretty Comfortable</th>
<th>Not That Comfortable</th>
<th>Does Not Apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discussing Advance Directives with a patient or family members</td>
<td>52%</td>
<td>34%</td>
<td>8% 6%</td>
<td></td>
</tr>
<tr>
<td>Discussing a recommendation for hospice</td>
<td>48%</td>
<td>34%</td>
<td>8% 10%</td>
<td></td>
</tr>
<tr>
<td>Discussing bad news with a patient or family member</td>
<td>43%</td>
<td>46%</td>
<td>8% 3%</td>
<td></td>
</tr>
<tr>
<td>Discussing a change in treatment approach from curative to comfort care</td>
<td>40%</td>
<td>42%</td>
<td>9% 9%</td>
<td></td>
</tr>
<tr>
<td>Assessing patient decision making capacity</td>
<td>33%</td>
<td>51%</td>
<td>9% 7%</td>
<td></td>
</tr>
<tr>
<td>Deciding when a patient is appropriate for palliative care</td>
<td>31%</td>
<td>50%</td>
<td>10% 9%</td>
<td></td>
</tr>
<tr>
<td>Pain management</td>
<td>30%</td>
<td>47%</td>
<td>16% 8%</td>
<td></td>
</tr>
</tbody>
</table>

ArMA | AOMA Joint Task Force End of Life Care
When do you discuss end of life issues with patients?

- When the patient receives a serious diagnosis of a life-limiting illness: 57%
- When the patient is diagnosed with a terminal illness (<6 months to live): 52%
- When the patient’s prognosis worsens: 49%
- When death is imminent: 46%
- Routinely, with older patients: 37%
- None of the above: 9%
What deters you from having these conversations?

- Family expectations or discord... 28%
- My patients are not ready 22%
- I have no time 15%
- I have had not enough education for... 9%
- I do not get paid by insurance 7%
- None of these, do not feel deterred 34%
- None of these, does not apply 24%

Patient / family unreadiness = principal deterrent
Physicians with more PC training feel less deterred (22% vs. 52%)
How often have you used CPT codes for EOL counseling?

- 85% have not used CPT codes for end of life counseling funded by Medicare in 2016
Referral to Palliative Care

• 55% refer if patient dx w/ terminal disease
• More refer if they see EOL patients frequently and if they’ve had training
Barriers to Palliative Care Referral

- Patients do not want to discuss palliative/hospice options (50%)
- Patient concerns about high costs, lack of insurance coverage (36%)
- Lack of palliative care specialists or hospice care in the area (29%)
- Not included in referral networks (26%)
- Not sure there are significant benefits for your patients (10%)
- None of the above (17%)

- Younger physicians (<45) say patients don’t want to discuss options (66% vs 32%)
How often do your patients have a good dying experience?

- Good dying experience = death expected, symptoms/pain controlled; family present, family wishes in accord with patient’s

- Most report this happens about ½ of the time

- Responses vary by degree of experience/training
  (the more experienced physicians report a higher percentage of patients having a good death)
  - Palliative Care specialists 77%
  - Some training 65%
  -- Overall 58%
Physician satisfaction in EOL care

56% of surveyed physicians find EOL care fulfilling
Training and experience assoc w/ higher satisfaction
9% found EOL care frustrating
Education / CME for EOL Care

• 42% very likely to use webinars or other

• 67% strongly favor Public Education

• Physicians with more education in EOL care more likely to view patients as receptive to EOL conversations, make greater use of pall care consultants and see fewer barriers to referral and report higher levels of professional satisfaction
POLST
Physician Orders for Life Sustaining Rx
(used in 23 states)

• Transportable medical order used to document patient wishes in the EMR and for use by prehospital first responders
• May be completed by health care proxy if the patient is not competent
• For terminally ill patients during the last year of life
• Updated if clinical circumstances change
• Available to all settings: home, nursing home,
Strong support for POLST in AZ

- 49% Support
- 17% Neither support nor oppose
- 9% Not sure
- 2% Oppose

66% support POLST in AZ
76% want education about POLST
58% believe they will use it in their practice
POLST: Collaboration in 2019

- ArMA (4000+ physicians)
- AOMA (1000 + DO physicians)

Have passed resolutions from Task Force on POLST 2017, 2018

Join efforts with AzHHA in 2019 legislative session?

Education on POLST a priority
Medical Aid in Dying

• Oregon 20+yr, California, Colorado, Vermont, Montana, Washington, Hawaii, DC, Canada

• California law
  – 2 physicians concur in dx of terminal illness and psych evaluation if question of competency
  – Proof of residency
  – 2 oral and 1 written request 15 d apart; right to rescind
  – Physician participation voluntary/ liability protection for those that participate
  – Participating physician prescribes barbiturate which the patient must self administer
Support for MAID

53 % Support MAID (33% strongly)
27% Oppose MAID (18% strongly)
## Concerns about MAID in AZ

- **Slippery slope of opting for death instead of treating suffering**
  - **47%**

- **Pressure from family to push patients, particularly low-income and elderly, toward death**
  - **40%**

- **Stands against oath for MDs/DOs not to administer lethal drugs**
  - **37%**

- **Negatively affect image of physicians as healers and advocates**
  - **35%**

- **Pressure or legal action pushing physicians who oppose physician-assisted suicide to participate in the system**
  - **31%**

- **Not enough oversight of lethal drugs**
  - **18%**

- **None of these**
  - **25%**
Policy: US Views of MAID are Shifting

– AZ sample 2017: 53% support / 27% oppose (18% strongly) 20% undecided
– Nationally 57% support / 29% oppose / 14% undecided (Medscape 2016 N=7500)
  • 2010: 46% in favor / 41% opposed
Medical Aid in Dying

• AMA to discuss policy 2018
• ArMA policy officially opposed
• ArMA Ethics committee 2018 divided on whether to change ArMA policy to “Neutral”
  – Most of the PC physicians on the Task Force were in favor as a way of alleviating suffering
  – Oregon 20 yr 0.3% of deaths
• No law likely to move forward in Arizona soon
Survey: Major Findings

• Counseling of patients too little too late
  – Only 50% of the time even, when EOL is near
  – Only 37% of the time routinely in older pts.
  – Only 15% using CPT codes for EOL counseling
  – Perceived family unreadiness the most frequent deterrent to conversations
  – Physicians with EOL training less deterred
Training on sensitive conversations—how do we engage more physicians?

- Solicit Champions in each field to carry the message
- Mentoring role for senior physicians
- Primary Care/ Hospitalists
- Specialists
- Include Team (nurses, SW, etc.)
- Focus on how this role helps patients and improves satisfaction
Physicians strongly support education for the public

• What should the message be?
  – Living fully and dying peacefully are achievable but require planning and communication with your physicians and your family
  – Ask your physician about your disease, its likely course and treatment options available with risks and benefits for each--Informed patients are empowered patients
  – Prepare Advance Directives,(POLST) and appoint a proxy (durable power of attorney for health care)
Physicians role: important and evolving

• Care for the patient thru the end of life
• Provide information and guidance to patient/family
  – On the nature of the disease and likely trajectory
  – Options/risks/benefits
• Consider Palliative Care team to address:
  – What does comfort care look like?
  – Elicit patients goals, wishes, fears
  – Jointly complete Advance Directives/POLST
Physician engagement

- Task force of 25 +
- Survey: Nearly 600 gave long thoughtful responses to open ended questions
- Topic on agenda of the medical associations: ArMA, AOMA, MCMS, PCMS, ACP
- Topic for discussion ACEP, ACP state conferences
- Participation with AzHHA
Changing the Culture around EOL

- From avoidance of death/ dying to viewing EOL as part of life...
- Hospice has done a wonderful job making the very end of life comforting
- Palliative care can help make the last years comfortable and meaningful
- Informed patients can avoid “over medicalizing” a natural process
- A team of physician, nurse, SW, chaplain with support from PC and Hospice can be effective and improve satisfaction of patients and providers
An Oncologists’ View

“Some conditions are difficult to watch as a physician when we cannot change the course of suffering. The conversation in the community is very important to help all of us how to approach end of life care. I see people with cancer therapy and see prolonging suffering as worse than death. It’s a good thing to be able to talk about for all of us.” (from open comments: Arizona physicians survey 2017)
Task Force Members

- Ron Fischler MD Peds HH Chair
- Paul Stander MD Geriatrics/ PC VA/ Education
- Tim Fagan MD Int med (retired) Survey/ Policy
- Gobi Paramanandam MD PC HOV Statistics
- Chip Finch DO ER Educ/ Policy
- Alan Molk MD ER Educ: Professional / Public
- Greg Mayer MD ASU Health Solutions/ PC
- Jud Tillinghast Pulm/ ICU (Retired) HH
- Emma Lee Kennedy MD PC Flagstaff
- Bruce Peek MD Cardiology Cottonwood
- Evan Kligman MD Ger Tuc
- Stacie Pinderhughes MD PC Optum
- John Manfredonia DO Hospice Tucson
- Bree Johnston MD PC Banner Tucson
- Tom Fitch MD PC/ Onc Mayo
- Jeanette Boohene MD PC HH
- Rama Kunkle DO PC HH
- Chikal Patel MD PC Banner
- Patty Mayer MD PC Banner
- Michael Powers MD Neuro(retired) Ethics chair
- Bunnie Richie DO Neurology
- Heather O’toole FP HH
- Lisa Stearns MD Pain Management HH
- Sarah Wypiszynski MD FP HH
- Danny Hinze UA Tucson
- Gretchen Alexander MD Psych MC
- Phil Keen MD Path
- Dan Aspery MD BC/BS
- Akash Shah MD FP/PC Resident
- Mandy Weaver Coordinator
- Ingrid Garvey ArMA Staff
- Susan Brown ArMA Staff
- Pete Wertheim AOMA ED