

Comprehensive Goal Setting to Support Palliative Care

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WYCoA ECHO in Geriatrics

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Palliative care as a medical specialty

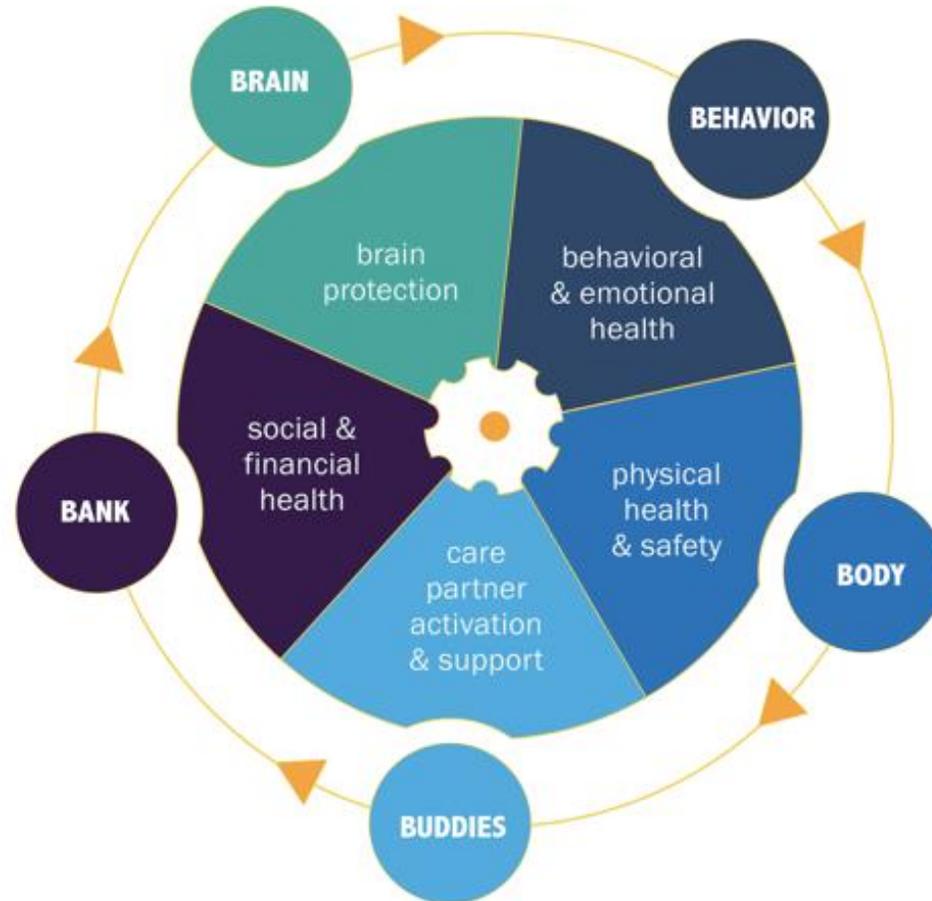
- Developed for people with **serious illness** and their families
- Distinct from hospice – **life expectancy not a criterion**
- Focuses on **improving quality of life**
- Delivered by an **interdisciplinary team** that works with patients, families, and others to provide an added layer of support
- Appropriate at **any age, any diagnosis, any stage** of serious illness, and **with any disease treatment**

Palliative care as a way of thinking

- Applies to **any chronic (i.e. incurable) disease or condition**
- Focuses on **managing risk and optimizing function, experience of living, and health/wellbeing of individuals and caring networks**
- Built into **“age-friendly” institutions and communities**
 - Any clinical setting (individual provider, team, staff, clinic, hospital, assisted living community, nursing home)
 - Any building, neighborhood, store, transit system, city, state...
- **Accommodates complexity** – *inclusive, transdiagnostic, domain-based*

Using palliative thinking in clinical care: a domain-based approach to managing care

Figure 5. FIVE PART MODEL



Step 1: Identify where the problems are

- Brain
 - Primary organ of function, connection with others, and adaptation.
 - Key questions: Is brain function compromised? How and how much? How does it affect everyday life? What risks does this cause?
- Behavior/emotion
 - How we feel in ourselves, act, and get along with others
 - Key questions: Is emotional wellbeing impaired? How? Has mood or behavior changed? What's going on? Are behaviors risky or harmful? What helps?
- Body
 - Disease status, medications, other treatments, ability to self-manage
 - Key questions: Is mobility compromised? What are the medical, physical or safety risks this person may face?

- Buddies
 - Members of an individual's caring community
 - Key questions: Who is involved? What are their jobs? Are they the right people or the right jobs? How are they doing and what do they need? Who should be involved but isn't? Is there a way to involve them?
- Bank
 - Social and financial capital
 - Key questions: Is the person socially isolated, and is this a problem? Lonely? Lack of access to essential or desirable services/activities (transportation, insurance, distance, service limitations)? General financial strain, or can't afford care/services that would help?

Why these 5 parts?

- Basic – relevant to all people regardless of disease or diagnosis
- Customizable – each person has own ‘mix’
- Measurable – can track individual change or describe a population
- Influence outcome – how a person does over time, whether well or badly, how, when, how much and how soon
 - Life satisfaction, general wellbeing, symptom control
 - Quality of relationships - harmony or conflict
 - Quality of chronic disease management
 - Risk of acute illness and injury – ED, hospitalization, death
- Match the range of helping professions
 - Identify members of a personalized ‘custom care team’

Applying the model:

85 year old widow in skilled nursing care for 5 years

- BRAIN

- Assess: mixed vascular/Alzheimer dementia, moderate severity; loss of impulse control, cognition fluctuates, often drowsy during day
- Could our care be making it worse?
 - Multiple CNS active meds (incontinence, sleep, pain) – delirium? is each med working as intended?

- BEHAVIOR AND MOOD

- Assess: depressed, angry, screams, fights, kicks when RN wakes her for night care; withdrawn, makes racist comments to staff during the day.
- Could our care be making it worse?
 - Leg dressing changes – must we do them?
- What's her story?
 - Does she know she scares people? Says cruel things? Could she have PTSD?

- BODY

- Assess:

- Hypertension and diabetes – controlled, simple med regimen working
 - Mobility – bedbound several years, chronic pain, early contractures, 1-2 person transfer assist
 - Extensive vascular disease; painful leg ulcers (vascular disease)
 - Aspiration risk apparent – coughs with eating, drinking
 - Medications –12 different med types daily, qid schedule; often refuses

- Could our care be making it worse?

- Rarely out of bed – never gets outside. Would that help?
 - Could we stop night dressing changes?
 - Could we simplify meds (fewer times a day, eliminate meds that don't help)?

- BUDDIES

- Assess: one daughter – visits 3x/week, mom often unpleasant, daughter hurt, frustrated, limits time together. No other family or visitors. Most staff dislike her and try to avoid assignment; does anyone like her? Do especially well with her? Understand her?
- Could our care be making it worse – or are we missing something?
 - We waited too long to ask what's behind her difficult behavior - staff already burned out.
 - Lack of trained mental health staff – no one to ask 'why' or advocate for her, hear staff frustration/reactions, and problem solve.

- BANK

- Assess: plenty of money but many social determinants of poor health – widowed; immigrant; WWII persecution, sole survivor, extensive lasting trauma (PTSD), alienated, isolated, lonely, no sense of purpose
- Can we rebuild some social capital?

Setting goals using the 5 part model

- PROTECT HER BRAIN: Reduce potentially harmful meds, maintain good BP and diabetes control
- SMOOTH HER BEHAVIOR: Improve mood, reduce harmful speech and actions
- SUSTAIN HER BODY: Maintain general safety, promote longer and more restful sleep
- BRING MORE BUDDIES: Deal with caregiving challenges – in plain language
- RESTORE HER BANK/SOCIAL CAPITAL: Tell the story that she can't tell; find common ground with staff she belittles/abuses; tell her the truth about how her behavior affects others

Steps toward one goal often touch several at once

- Brain and Body – can't reverse brain disease, can stop any CNS active med that's not working (i.e. most of them), keep only critical disease management meds. Stop doing things that hurt (night dressing changes). Simple massage.
- Behavior, Buddies, and Bank – can't reverse trauma or losses, can soothe loneliness and create pleasurable activities. Rx: friendly visitor/companion care; pleasant event scheduling – get her out to smell the flowers, bring her a treat. Night RN at bedside as she falls asleep, no scheduled waking for cares. Case conference with staff. Reminisce with daughter about her own history and times with mom.

SUMMARY: WHY DO ALL THIS?



Geriatric care is complex – many problems, many potential interactions between them.



Complexity arises from 5 distinct domains.



Break it down! Each person has a 5-part 'fingerprint' at any given moment in time; name any problems you find in each domain.



For each domain, can you set at least one goal? Notice how a goal for one domain may serve another domain at the same time – this is an integrative model.



Why do all this? You'll gain a stronger sense of control in caring for your patient, use more of your skills, be less likely to burn out, and bring more of your self to work!