

The Lewin Group
Palliative Care for Older Adults Dually Eligible for Medicare and Medicaid
December 5, 2018 12:00 p.m. EST

Caroline Loeser: Thank you. My name is Caroline Loeser. I'm with The Lewin Group. Welcome to the webinar, "Palliative Care for Older Adults Dually Eligible for Medicare and Medicaid."

This is the sixth session of our 2018 Geriatric-Competent Care Webinar Series. Today's session will include a 60-minute presenter-led discussion followed up with 30 minutes for a discussion among the presenters and participants. This session will be recorded, and a video replay, a copy of today's slides will be available on our website, www.resourcesforintegratedcare.com.

The audio portion of the presentation will automatically stream through your computer. Phone lines for this presentation are also available. To access the number, click the black phone widget at the bottom of your screen.

And on this slide please note that the planners and faculty have no affiliation with or financial interest in any commercial interest but may have direct interest in the subject matter of this presentation.

Continuing medical education and continuing education credits are available at no additional cost to participants. AGS is accredited by ACCME to provide continuing medical education for physicians and by NASW to provide continuing education for social workers. CMS is also accredited by IACET to issue CEUs. We strongly encourage you to check with your specific regulatory board for other agencies to confirm that courses taken from these accrediting bodies will be accepted by that entity.

And you'll see on this slide that we've laid out the various continuing education credit options. If you're a social worker you could obtain continuing education credits through NSAW if you complete the pretest at the beginning of the webinar and complete the post one. And if you're a physician you can obtain CMEs through AGS if you complete the pretest at the beginning of the webinar and complete the post-test. And CMS is also offering CEUs for other individuals looking to obtain credit for attending this webinar. In order to obtain these credits you must complete the post-test through CMS's Learning Management System. But please note that because today is a federal holiday the post-test through CMS's Learning Management System will open tomorrow, December 6.

And additional guidance about obtaining credits and accessing the links to the pretest and post-test can be found within the Continuing Education Credit Guide in the resource list on the left-hand side of your screen or at the Resources for Integrated Care website.

This webinar is through the Medicare-Medicaid Coordination Office at the Centers for Medicare and Medicaid Service. MMCO is helping beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered

services in those programs. To learn more about current efforts and resources, please visit our website, or follow us on Twitter for more details. Our Twitter handle is [@integrate_care](https://twitter.com/integrate_care).

And at this time I'd like to introduce our moderator. Carol Regan is a Senior Advisor to Community Catalyst Centers of Consumer Engagement and Health Innovations and has over 30 years of experience with national and state-based public policy and advocacy organizations. Carol?

Carol Regan: Thank you, Caroline, and welcome to the conference, the webinar. So, just a moment, Community Catalyst is a national consumer health advocacy organization whose mission is to sustain a powerful consumer voice to ensure that all individuals and communities can influence decisions that affect their health. And we've had a program that focuses on older adults and others with complex health needs through our center, and we've been coordinating these Geriatric-Competent Care Webinars with the American Geriatric Society, The Lewin Group, and MMCO for years, and we are delighted to bring this one forward to you all today.

So we have a really wonderful panel of speakers. I'm going to briefly introduce them and share their bios with you and then move into the next part of the program.

So, we are delighted to have Diane Meier, who's a physician, the Director of the Center to Advance Palliative Care, which is a national organization devoted to increasing the number and quality of palliative care programs in the United States. Under Diane's leadership the number of palliative care programs in the U.S. hospitals has more than tripled in the last 10 years.

She is a Professor of Geriatrics and Palliative Medicine and a Professor of Medical Ethics at the Icahn School of Medicine at Mount Sinai in New York City. In 2009-2010 she was a Health and Aging Policy Fellow in Washington, D.C. And Dr. Meier has gotten a number of significant national awards, including a MacArthur Foundation Fellowship. She's recognized as one of the 20 Americans who make health care better in 2010. And she has recently been -- she also won the National Academy of Medicine's award in recognition of outstanding leadership and achievement in improving personal health in the United States in 2017. So we're very happy to have Dr. Meier.

Our next speaker will then be Dr. Isaac Bromberg, who is a Palliative Care Specialist working for the Commonwealth Care Alliance in Massachusetts in the role of a medical director for their Clinical Group West and the medical director for palliative care. Dr. Bromberg attended medical school at Albany Medical College and worked in a community emergency department for eight years before completing a Hospice and Palliative Medicine Fellowship at Johns Hopkins and the VA Medical Center in Baltimore, Maryland. Dr. Bromberg is board-certified in emergency medicine and in hospice and palliative medicine.

Then we'll be joined by Karen Blair, who's a registered nurse who's worked in the community on comfort care for over 40 years. Karen for the past 28 years has worked in hospice and palliative care in a variety of roles, including direct care, management, on-call, quality, and education. She has presented palliative and dementia care education for Hospice and Palliative Care Federation of Massachusetts, the Alzheimer's Foundation -- excuse me, Association, and the Bay State

UMass Medical, Geriatric, Palliative Emersion Course. We're really delighted to have Karen join this team.

And then we have, we are very lucky to have Linda Thompson and Lisa Thompson. They are sisters, and they were family caregivers for their mother, who was enrolled in Commonwealth Care Alliance and received palliative care.

So we have a great lineup. So let's go to the next slide and get a little information from you all who have registered for this conference, this webinar.

Let me first go over the learning objectives. You can see here on the screen what the learning objectives for this webinar, and we're hoping that we'll be able to sort of go through these and you'll learn from our speakers today about the barriers, the strategies, the definitions, and how to recognize ways to communicate around this with families and their loved ones.

Next slide. So, here's the outline of -- we'll have poll questions next, and then we'll go through each speaker. Dr. Meier will talk about matching care to beneficiaries' needs, Dr. Bromberg about their approach to palliative care. Karen Blair will give us examples of palliative care, concrete examples, and then we'll have the family caregiver perspective and then turn it over to questions and answers from you all, and then an evaluation. Thank you.

So the next slide, it says here we have an opportunity to learn from you all. So can you tell us quickly what's the following best describes your professional area? For those of you who are in both, just choose the best one that describes it, administration, clinical services, health plan management, policy. So choose one of those. Another two seconds. Great.

And let's see a little bit about who we have on the phone. Okay, all right. So this is about a quarter of you are in social work. We've got a number of people with health plans. Management, that's terrific. And medicine and nursing, some clinical professionals, and administration. Thank you. Great.

And next poll. So how would you describe your primary role? Again, your primary role. Are you a coordinator, administrator, family caregiver? Okay, take two more seconds. Great. Okay.

Let's see what we have here. Great. Well, almost half, 40 percent of you are care coordinators, a number of administrators and clinicians and educators. Great. Wonderful. Thank you.

Next slide. Now, can you give us a little information about what setting you work in? Health plan, ambulatory care, community-based organization, you can see the choices there. And how would you describe the setting in which you work? And maybe two more seconds. Terrific. Okay.

So almost two-thirds with a health plan, a number of you in facilities or community-based agencies of some sort. Terrific. Wonderful. What a great diversity of people we have.

So next slide. And let me turn it over now to Dr. Diane Meier. Thank you.

Diane Meier: Thank you, Carol. Hi, everybody. On this opening slide there's a typo, in case somebody wants to email me. It's Diane with one n dot meier at mssm.edu.

Next slide, please. So, I don't have much time, so I'm going to be very brief and begin with a definition of palliative care. It is specialized medical care. It is a medical and nursing subspecialty for people with serious illness and their families and caregivers that is focused on improving quality of life by addressing pain, symptoms, and the full range of stresses that are associated with serious illness.

It's typically provided by an interdisciplinary team that works with patients, their families, other caregivers, and the whole rest of the health professional team to provide an added layer of support at the same time as all other appropriate medical care, whether curative, life-prolonging, or supportive. So it's appropriate for a patient of any age, with any diagnosis, at any stage, and in any setting, and, as I said, provided concurrently with all other medical care.

Next slide, please. And so that definition I think exposes the differentiation from hospice, but on this slide there's a definition on the right. Hospice care by statute is restricted for people highly likely to be dead within six months and who are willing to sign a piece of paper saying they are willing to give up insurance coverage for treatment of the terminal illness. Its focus is on helping the beneficiary, the caregivers, the family have the best possible experience in the weeks and months leading up to death.

In contrast, palliative care is an option for anybody living with a serious illness. Its focus is on relief from all forms of suffering and includes those with curable illness, chronic illness, and most of these individuals obviously are not hospice eligible, either because they are hoping for a cure or they may live with their disease for many years and/or they are continuing to benefit from disease treatment. So eligibility for palliative care is based on patient and family need, not on prognosis.

Next slide, please. So, what this slide shows is the continuum of palliative care. At present in the United States the great majority of hospitals with more than 50 beds are delivering some form of hospital-based palliative care. On the right-hand side of this slide you see hospice for end-of-life care. There are over 5,500 hospices in the U.S. So access to palliative care as delivered to the dying in hospice is also broadly and widely available.

In contrast, if you look at the middle of this slide, people who are getting care in their clinician's offices, who live in a nursing home or assisted living or other long-term care setting, or who are at home with functional impairment and multiple comorbidities. We have a lot of gaps in that middle space. And of course that middle space is where the great majority of people living with a serious illness are. They are neither hospitalized nor dying. So this is the gap we have to fill.

Next slide, please. You can see here the pretty rapid growth in access to hospital palliative care. There are now more than 1,800 such programs in the U.S. caring for over 10 million individual patients every year. It's more than tripled, as was mentioned, and pretty much all of the highly

ranked on various quality metrics hospitals and health systems are universally providing palliative care.

Next slide, please. Why is this so important for dually eligible beneficiaries? We know that older people are more likely to have chronic disease and multiple chronic conditions. They are much more likely to end up in the emergency department for management of chronic disease. And among those who are dual eligible this is the group with the highest utilization of emergency departments and hospitals in the weeks, months, and several years leading up to the end of life. And the highest combined Medicare and Medicaid spending is also in this patient population. So it's a very logical focus for improving access to palliative care and making sure that that palliative care is aligned with national quality standards.

Next slide, please. So, as you guys know, dually eligible beneficiaries are covered for hospice under Medicare, and most states also provide hospice under Medicaid. Which program covers what and when and under what circumstances is often complicated and confusing for clinicians, for the patients, beneficiaries themselves, and for payers. Palliative care services are covered for the dying under the Medicare hospice benefit. Palliative care consultation services are billable under Medicare Part B or Medicaid for providers -- nurse practitioners, PAs, and physicians. But the rest of the interdisciplinary team has no visible means of financial support in the fee-for-service system. There's a link here for more details on the how of payment in palliative care.

Next slide, please. So, I'm sure you guys have heard of the term "the value equation." The value equation is very simply quality in the numerator and cost in the denominator. So a very high-value intervention would be one that markedly improves quality at very little cost. A classic example of that is clean drinking water or vaccination, both of which save millions and millions of lives every year at trivial or no cost, public health interventions. Much -- in contrast, much of modern medical care in the United States is characterized by either little or no benefit or actual harm at very, very high cost. And it is that reality that is causing all this focus on improving value in health care in the U.S.

So how does palliative care fit into that equation? On the left are the outcomes that have been shown to improve quality in multiple studies with palliative care: symptom burden, quality of life -- there are now five randomized controlled trials suggesting that cancer patients receiving palliative care actually live longer than like cancer patients who do not receive palliative care, probably because they avoid the hospital and its associated hazards; better family and caregiver satisfaction; better long-term family bereavement outcomes; and actually better clinician satisfaction.

As a result of improving quality costs go down. And the reason costs go down is because crises are prevented. So you don't have people showing up in the emergency department at 3 in the morning in pain or short of breath or with a bowel obstruction from constipation, because those things have been identified, prevented, and managed in the community setting.

Next slide, please. So this is an actual patient I took care of now roughly four years ago. When I met him in the Sinai ED he was dual eligible, and he was in the ED. He has moderate dementia

and very severe low back pain which was chronic due to spinal stenosis and arthritis. He had prostate cancer but it was quiescent, and that was probably not the precipitant for the ED visit.

He described his pain as an 8 out of a possible 10. He was taking a dangerously high dose of Tylenol to manage it without benefit. And as I looked at the electronic health record turns out he had been in the ED three prior times, with three prior hospitalizations, in the previous several months, for pain, for falls, and one time for an agitated delirium that was due to a fecal impaction.

Next slide, please. He, when I met him in the ED with my medical student, he was curled in a ball facing away from us and basically furious at his wife for bringing him back to the ED and the hospital, where he never wanted to set foot again. His wife said, "He hates being here, but what could I do?" So the story was he had gone to the bathroom after dinner, sat down on the toilet and was unable to stand up because his back went into spasm. His wife tried to help him stand up. She couldn't. There were no neighbors at home because it was 5:30 at night.

She called her primary doctor's office and she got a tape that said if this is a medical emergency, hang up now and call 911. And to her and to him he was in pain. He couldn't be moved. This was a medical emergency. So we had a health care system that was perfectly designed to get the results that it got. So she called 911 and they ended up in the ED, not because they did something wrong, but because the system was designed to achieve this outcome.

Next slide, please. So, as you can see on the left here, before we met him there had been four ED visits, three hospitalizations, one of which led to somebody put a catheter in his bladder, he developed urosepsis, ended up in an ICU, had marked functional and cognitive decline and an enormous amount of strain on his poor wife.

Once we got involved I spent a lot of time at the stretcher in the ED seeing how well he could tolerate very low doses of morphine to try to get this pain under control, because it was clear to me that if we kept admitting him to the hospital, (a) it would harm his quality his life, he wanted nothing to do with that, and (b) the odds of death in the hospital were going to get higher and higher with each stay, given the hazards of hospitalization in older adults. And turned out he tolerated very low-dose morphine, 5 mg is what he needed. It enabled him to turn over on the stretcher, to feel like he could sit up and walk to the bathroom with assistance. He started holding his wife's hand again and flirting with the nurses, and all of the things we worry about with opioids, at least in the short term, did not come to pass.

We spent a lot of time working with his wife to make sure she understood how to safely measure and give the appropriate amount of this drug should this recur, and, very importantly, taught her that he needed very significant doses of laxatives every day, whether he needed it or not, and what to do if he didn't have a bowel movement. And about three hours after he showed up we put them in a taxi and sent them home with a small bottle of concentrated liquid morphine and a huge container of MiraLAX, which is a laxative.

And I was worried to send him home. I had no idea what the home setting was like. So I called my colleagues in the house calls practice that we have at Mount Sinai, told them I was sending

an 88-year-old demented patient home on morphine for back pain and I needed them to see him the next morning. When they got there the next morning they found many disasters waiting to happen: no elevated toilet seat, no grab bars in the bathroom, the only couch was about a foot off the floor, so imagine you or me trying to stand up from that, for Mr. B it was impossible, and it was precipitating all kinds of pain and difficulty.

There were loose throw rugs all over the floor, electrical wires, easy to trip on. The refrigerator had only old Chinese food in it because Mrs. B could not go shopping because Mr. B would get very agitated if she left him, and his back and mobility problems were such that he couldn't go with her. So they just ordered from the only place where they had a takeout menu from.

Their only daughter lives in California and they never told her about any of this because they didn't want to worry her. They had been very active members of a faith community and had stopped going to church even though it was only three blocks away because it was too hard for Mr. B to get there.

So what the team in the home did was get PT and OT in there to get the right equipment in, to get one of those chairs where you push a button and it helps you stand up, to get Meals on Wheels through the Area Agency on Aging delivered. With their permission they contacted the daughter, who now orders groceries online every week to be delivered, and they contacted the minister in the local church, who was very embarrassed at having lost track of this couple. That church now sends a friendly visitor three afternoons a week to spend time with Mr. B. Mrs. B can go out. She can shop. She can see her friends. It's high school students two out of the three days doing community service and a member of the congregation on Friday afternoons. The church sends a car to pick them up on Sundays, gives them lunch after services, and takes them home.

Those were the interventions. And many of them were social work interventions. Many were PT/OT interventions. And they were simple things like food and security that were addressed. That was now nearly four years ago. He is still home under the care of his wife, has not once been back to the ED or the hospital. He is getting his primary and palliative care at home from a visiting house calls practice.

And I ask you all to look at these two columns and think to yourselves which one of these two columns is easier to get in the current health care system. If you work in any standard setting you will say the left-hand column is easier to get and the right-hand column is very, very difficult to get. So our task as a nation is to make the left-hand column a never event and the right-hand column the standard of care for people, frail, older adults with multiple chronic conditions, functional and cognitive impairment.

Next slide, please. So how does it actually work?

Next slide, please. So there's these top six characteristics which really all have to be present in order to get the outcomes that I showed you earlier. That is, better quality and lower cost. This is your checklist.

First of all there has to be an adequately staffed interdisciplinary team, which includes nursing, social work, chaplains, physicians, often care managers, PT/OT, and counselors, because these patients are very complex, and their needs cannot be addressed by a single discipline. And if you try to do that it won't work and the patient will end up in the ED and the hospital.

The team needs staff members that can screen and then target people with the greatest need. So you don't want to be providing high-intensity team-based palliative care to Mrs. B, for example. She doesn't need it. That would be a waste of resources. So it's really critical to identify the high-need, high-risk or rising-risk patient population and apply this very rich service, this very comprehensive service, to those who are most likely to benefit.

It's critical to talk to people about what matters most to them in the current context. Very few people will tell you what matters most to them is living forever. Most people will tell you what matters most to them is remaining independent and not having disabling pain and other symptoms.

If you don't support the family and other caregivers they're the ones who call 911 when they become overwhelmed and stressed. So it is not enough just to support the patient. It is essential to equally support, screen, assess, and support the family that are doing most of the work.

Your staff, somebody on your staff, whether an NP or a physician, has to be well trained and expert in pain and symptom management and know how to safely and appropriately use opioids in this population.

And last but not least, if a patient calls at 5:30 p.m. and they get a tape that says call 911, that's exactly what they will do. And what that translates to is an investment in meaningful, by which I mean responsive within 10 to 15 minutes, 24/7 coverage for this population.

Next slide, please. The training, most of us did not get this in nursing, social work, or medical school. It's still not a required part of the curriculum for undergraduate or graduate education. These are the components that people working with a seriously ill complex population, the skills they need to have. My organization provides comprehensive online training linked to CME and CEU for the full range of disciplines, and there are resources in the last bullet on this slide for other training options.

Next slide. The screening criteria, so how do you identify the highest risk and rising risk populations? So the screening criteria that are evidence based involves three criteria. One is the presence of one or more serious illnesses, and if you see the reference at the bottom those are the diseases that were identified in the Dartmouth Atlas Study of Care in the Last Six Months of Life. So they are things like end-stage liver disease, end-stage renal disease, COPD, CHF, Stage 4 advanced cancers, etc.

But a diagnosis is not enough to predict risk. There also have to be other factors present. And the other two factors are either a hospitalization or a skilled nursing facility stay in the prior 12 months, because that is an indicator that the management of the disease is starting to get beyond what the patient and family are able to handle at home.

And the third critical criteria is the presence of functional and/or cognitive impairment, and we list a bunch of scales there for identifying frailty, cognitive impairment, and functional impairment. And the difficulty, you can get the first two, the diagnoses and the past utilization, off claims data. The problem is you can't get the third, the functional, frailty, and cognitive status, yet those are critical independent predictors of subsequent utilization of the emergency department and hospital. So, and in fact we know the presence of all three criteria predicted 50 percent likelihood of hospitalization in the next 12 months and roughly a 25 percent risk of mortality.

Next slide, please. In terms of asking people what matters most to them, don't ask people what their goals are. That has no meaning to members of the public. That is very inside baseball jargon. Ask them what is most important to them now in this stage of their life and in the context of their illness.

This study, which was done with several hundred senior center participants, so they were relatively functional, they were able to get out of the house and go to the senior center, were asked to rank three priorities -- living longer, relief from pain and symptoms, and remaining independent -- and as you can see here the winner by a long shot was remaining independent, followed by relief from suffering, and dead last, pun intended, was living longer. And yet the entire health care system is the reverse of that, is designed based on assumptions for the reverse of that.

Next slide, please. I mentioned the importance of supporting family and other caregivers. Family caregivers reporting stress are much more likely to get sick, are much more likely to die, and are much more likely to use a lot of health care resources. Support for unpaid caregivers, i.e., family, through support groups and through us, the clinician, paying attention to the experience of the caregiver and their needs, has very consistent beneficial outcome: reduces utilization, decreases the odds of nursing home placement, and improves experience and satisfaction. And there are some resources on this slide for that, as well.

Next slide, please. I mentioned that the team has to know what they're doing in managing symptoms. In fact, if you look at the data, use of the emergency department in over-65 Medicare beneficiaries, uncontrolled symptoms associated with chronic disease is the number one -- accounts for 90 percent of ED visits. Is it pain, is it shortness of breath, is it agitation, is it not having had a bowel movement in days and days? One out of ten ED visits in over-65 are due to a fall. Nine out of ten are due to symptom distress that could have and should have been identified and managed in the community, could have been prevented.

We know that effective management of symptoms, there are now several randomized, controlled trials showing, predominantly in cancer patients, but no reason to think it doesn't apply to others, that proactive identification and management of symptom distress markedly reduces suffering, health care utilization, and actually reduces mortality, which makes sense. So I can find you those references if anybody needs them.

Next slide, please. Twenty-four/seven access. We know that this is not widely available in the United States, and because it is not widely available people turn to the only place that is available to them, which is 911 and the ED. And as expensive as it is to provide 24/7 coverage, it is much more expensive not to provide it for this population.

Next slide, please. And I'll turn it over to Isaac.

Isaac Bromberg: Thank you, Diane. So, I am going to talk a little bit about how palliative care is delivered at Commonwealth Care Alliance. First I want to just give us some basic information about our organization.

Next slide, please. So, Commonwealth Care Alliance is a health care organization that was founded in 2003 to serve medically and socially complex vulnerable individuals in Massachusetts. We offer two plans currently for duals, one called Senior Care Options, which is a dual eligible special needs plan, or D-SNP, for those of you that speak that language, for adults age 65 and over. And the other is a program called OneCare, which is also a duals plan for adults age 21 to 64. We're going to spend the rest of our time today talking about our Senior Care Options program and members in it.

So, in Massachusetts our Senior Care Options program serves about 10,000 dual eligible members across the state, and the average age of our member is 75 years. Approximately 70 percent are -- have medical complexity that would make them eligible for nursing home care, but they prefer to be at home when they can be, and with our assistance we allow them to achieve that. Sixty percent have four or more chronic medical conditions, and 60 percent speak a primary language other than English, the most common being Spanish.

Next slide, please. So, a little bit about our model of care. So, when members enroll with us we use a stratification model that takes into account their medical complexity, their needs for support in activities of daily living, the social supports they have, how engaged they are with their care system. And we assign them a care partner to help them with care coordination and care management. And we have care partners from a range of disciplines, including nurses and advanced practice clinicians. Behavioral health specialists is what we call our social work staff, and health outreach workers.

And so we choose from among those disciplines as well as decide whether we feel like we can the member well telephonically primarily or in what we call a mobile -- with a mobile care partner, someone who's expected to go out and see the member at home on a regular basis for visits. Regardless of the model that someone is stratified into, their care partner has access to other members of the multidisciplinary team, so if they have a care partner who's a telephonic nurse, but they have needs that a behavioral health specialist or health outreach worker could better serve, then we can deploy someone from that discipline to meet with the member and also to participate in a team-based approach to manage their care. In addition, we have our own in-house rehabilitation team, and we also coordinate with the geriatric support services and long-term support services in the area to provide the support and services, much of which Diane mentioned, for our members.

In addition to that, and specific for our topic today, we do have a group of palliative care dedicated staff who are available to also add to the team-based approach that members receive, and that starts out with a review by our palliative care coordinator and then the ability to deploy a nurse or advanced practice clinician and also have some input from a highly trained physician in the care of the member.

Next slide, please. So, one of the main principles at CCA is that palliative care doesn't just reside within the palliative-trained staff. It really is something that we ensure that all of our staff, our care management staff, who are part of what we call our clinical groups, have some training in areas that really are thought of as kind of the main principles of palliative care. And these include effective communication, so preferably in the language that the member speaks, the understanding that advanced care planning is crucial for our members, and also that at times of change in their health, in particular, that discussing goals with them, and, as Diane said, the word "goals" might not mean something to the individual, but the concept certainly of reviewing with them what they understand of their current health situation and what they care about is something that we make sure that all of our staff have some knowledge of.

The other principle that is pretty important throughout the organization is the idea of a dignity of risk, of really valuing people's independence and allowing them as best as possible to tell us what they need as opposed to us making that judgment for them. And that really grows out of CCA's origins, as one of our early care sites was a primary care office that served individuals with neurological and developmental disorders, spinal cord injuries, and so there's a long history in CCA of work with and supporting the disability community and disability rights, which is where the dignity of risk concept comes out of and is why we ensure that all of our staff have that understanding and background.

Next slide, please. So when a care partner identifies or feels that a member might have palliative needs, they can ask for some additional support for members. And this is a fairly standard kind of trigger list of ways just to remind the staff of who might have palliative needs. So if member's illness is advancing, if they are experiencing weight loss or a decline in function, if they have symptoms that are out of control, if they have a new cancer diagnosis or an advancing cancer, if they've had frequent hospitalizations, as Diane mentioned, that's often a clear indicator that their underlying chronic diseases are not being managed well.

And then we have on there the last bullet, the possibility the member might pass within the next 12 months due to illness, which is in line with the surprise question that people may have heard about that's used in a variety of settings mainly just to kind of to stimulate the clinician or the person involved to just think about in a broad general way is this somebody who I think is declining. We certainly don't limit our services based on somebody with a 12-month prognosis, as Diane mentioned in her early slides that the palliative care really is for someone at any stage of illness if they have -- needs control. But it's a little bit easier, I think, for people, for our staff to think about what does the next 12 months look like for this person just to give them a sense of is this somebody who would benefit from additional services.

Next slide, please. So the members of the palliative care team are apt to get involved to provide some specific assistance or guidance for the member for their caregivers and family, and also to

help our own team, our own care partners, guide or mold the care. And the things that the palliative care team can do is to clarify diagnosis and prognosis or assist with that, discuss treatment options and goals with members, and sometimes that's with them directly in their home, sometimes that's assisting them at a visit with their primary care doctor, oncologist, cardiologist or specialist to kind of make sure that they're understanding the information that's being given to them and that they're able to ask the questions about the things that they care most about.

Certainly to participate in advanced care planning. We are able to help with symptom management either by giving recommendations to the provider that's in charge of the member's care, or in situations where we actually have a prescriber involved we often have a conversation about some co-management where we can actually do the prescribing of the symptom management meds so that we can have some ownership of that.

We also can provide guidance to our members and to our staff about other options available to them. So there are some specific aspects of our program or entities that we contract with that can provide some additional services or support. We have a community paramedicine program, so non-transporting paramedics trained specifically to care for our population, and they carry an expanded toolkit and can deliver home -- excuse me, deliver care in the home, not entirely to the level of the emergency department, but a lot of what an ED could provide, so being able to identify that that might be something that would benefit a member.

We also contract with hospices to provide a community palliative care service for members, as well as talking with them about hospice enrollment and when and whether that would benefit them. We offer additional support for family members, for caregivers. Another key item that Diane had mentioned is making sure the caregivers have support, because often they are the ones that drive the care, not the member themselves.

And we also have the ability to offer or at least provide some support around end of life and funeral planning and bereavement support, particularly for our members who have low or limited income and who have perhaps not made these plans in advance. This in particular can be a challenge for them or something that they struggle with in addition to just their medical illness, and it's something that we try to help people with.

Next slide, please. So as I mentioned before at the opening, the kind of a key part of our model is not just that palliative care lives within the palliative care specialty team but it really is embedded throughout the organization. And so kind of a core piece of our palliative team is to provide education for our staff. And this is both formal and informal, so participating in their interdisciplinary team meetings and providing guidance on ways that palliative care can help. We also have a meeting of our own that we invite our care partners to where we discuss cases in more detail and then provide other educational offerings. Being a member organization to the Center to Advance Palliative Care, a member of CAPC, provides us with access to the educational material that Diane had mentioned, which I as well would support as highly valuable, extremely high-quality content that we make available to our staff.

So I think with that I'm going to turn it over to Karen to talk through a case. You can go to the next slide. And it's all yours.

Karen Blair: Thank you, Isaac. Hello, everyone. I'm going to talk a bit about the concept of stages of palliative care and then talk in a real practical way about a particular case study.

Next slide. Most of us are aware that not everyone adjusts to serious illness, whether it's long-term chronic or short-term acute or some combination of those, in a linear fashion moving from one stage in grieving to the next. However, most people do experience some degree of denial, and putting off thinking about what they might be facing until they're forced to address it. Early in the illness one might be thinking about what it means for the future, the hopes and dreams, the relationships.

There could be acceptance of some support, but it's a delicate time when we need to be careful about our approach, possibly extending conversation of roles of care over months if we begin early enough. The goals one has at this stage might not be the same as later on the illness. As the limitations and discomforts become more pronounced and there may be fewer options available for disease treatment, goals evolve and the support offered can increase, as you see in the slide.

In the face of mirroring mortality, one might be considering how their family or caregivers will manage and will be making firmer plans. Our role as an interdisciplinary palliative care team is to offer the skilled supports when they are the most appropriate.

Next slide. Mr. M was an 81-year-old man with multiple chronic conditions, but his main concerns were his chronic pain, some decline in function, and some breathing difficulties. At CCA palliative referrals can be made by care partners, facilities, physicians and others. In this case the care partner referred him while he was still hospitalized so that he could be introduced to the idea of palliative support once he arrived home. He had multiple specialists involved with his care team, leading sometimes to conflicting orders, too much activity and too many people, according to him, to keep track of, none of which made him feel any better.

Next slide. When Mr. M was discharged from the hospital he was seen in a dark apartment struggling to get out of bed to the living room because of pain, weakness, and shortness of breath. Even still he was noncommittal about his health care goals. We frequently will offer to work with members on an action plan to keep them out of the hospital, and he wasn't quite ready for that, either. He was receptive to personal care assistance and counseling support in the fact of this progressing illness. Over those first few months he agreed to physical and occupational therapy to assist him in keeping safe at home and strengthening, which he did continue once he was able to move to a first floor accessible apartment to assure he had the right equipment.

Next slide. As the months progressed he developed some startling findings, including a very low heart rate and blood pressure, as well as ongoing decline in his ability to do his personal care and get around. He was offered an oximeter for home use to assist in monitoring. His intermittent physical therapy and counseling continued, along with substantial support with personal care. He finally accepted increased nursing and medical support from the physicians' assistant and palliative physician, with efforts at de-prescribing and assuring that appropriate comfort meds

were present in the home to address his symptoms and avoid the ER. He had someone to call 24/7 with questions and for support as part of his action plan, which was written and posted in the home. He finally agreed to get his wishes for avoidance of life support recorded on the MOLST form, but his wife still did not want him to die at home.

Next slide. Finally he developed signs of a stroke, and his wife brought him to the emergency room, only to be told there was nothing that could be done for him. That was a defining moment for her, and she brought him home with a firm commitment to allow him to stay there through his final days or months. During those last months he recovered a bit from the stroke but developed other physical difficulties which increased as the time went along. Many of these are common to people reaching end of life -- pain, incontinence, difficulty breathing, and delirium. The palliative team stepped up presence so that almost every day of the week someone was there checking in and assuring that these symptoms were managed.

Mr. M had refused spiritual support all along, but the medical assistant and other team members kept in mind his spiritual needs and allowed him to share what he would about any existential concerns and sources of strength. Physical therapy continued periodic support as he became more disabled to assure he had what he needed to move about safely and comfortably, especially since his wife was unable to move him independently. His PCA hours were increased, and family rallied during his last days and were present often in an effective way. They were offered lots of instruction and support, including what to expect in the dying process and funeral planning.

After his death, one year after initiation of palliative services, his wife, also a CCA member, received bereavement support. Dying is a natural process and our role is to assist in achieving the highest level of comfort possible, but the focus toward the end of life shifts to family and caregivers and assuring they have all the information and support they need during the most difficult time of their lives.

Next slide. There are many barriers that prevent older adults, especially dually eligible, who have the added burden of limited financial and other resources, to accessing and fully embracing palliative care. Mr. M had applied for housing long before we were involved and was able to move to a bright, accessible apartment for most of his final illness. In Mr. M's situation there was no negative history regarding hospice and palliative care as there sometimes is.

He was fluent in English but his wife was only able to communicate in Spanish, so we tried to assure that someone who was fluent was present at nearly every visit. They were isolated from family and formal sources of spiritual support by choice. We were trying to address goals of care in a life-threatening illness with someone who was in pain and distress most of the time. And he had preexisting anxiety and depression. As we discussed, he and his wife had differing views on their approach to illness. In this situation, though not all, we were able to assist in resolving some of these issues.

Next slide. One thing that I hope comes through clearly in our case is that the team spent time developing a relationship with the member and his wife over the course of many months, taking advantage of opportunities to discuss his goals and teachable moments as they arose in normal

conversation. We tried to assure he and his wife were understood in a cultural context and improve their comfort by having individuals who were culturally competent and were able to speak their language most of the time. All instructions were written in Spanish with pictures when possible. I know I have a hard time reading and understanding when I'm stressed, as well as demonstrations and return demonstrations.

Their new apartment was very conducive to conversation, but we were sure to switch off the TV or lower it and put the focus of attention squarely on Mr. M. There are not always people in someone's life with whom they can have a difficult conversation without false reassurance taking over the conversation and directing it to their own needs. The palliative team was able to be present, sit with them, not stand over them, at eye level and allow Mr. M and his wife to express themselves fully, even difficult topics. The palliative team does not run away from the emotion and allows for the process to unfold. Members are allowed to talk about how much they want to know or what they are concerned about, and these guidelines may change from one visit to the next.

Next slide. Palliative care, with its focus on interdisciplinary management of comfort and goals of care, is appropriate in any stage of serious illness and may enhance comfort and adjustment as end of life nears. It is critical to meet the individual and family where they are, mindful of their histories, culture, and barriers to achieving the best quality of life possible. Exploring goals of care and advanced directives is integral to the process of care planning and assessing which supports are most of value to them.

Next slide. And now I'm going to hand it over to Lisa and Linda, who were very engaged in the care of their mother during her final illness and took full advantage of palliative care team support.

Linda Thompson: Thank you, Karen, and hello, everyone. Thank you for having us. My name is Linda Thompson, and my sister --

Lisa Thompson: Hello, my name is Lisa Thompson.

Linda Thompson: We'd like to introduce our 80-year-old mother, Peggy Malanson, who was a celebrated writer, performing artist, storyteller for grownups. And she was proud of her career as a medical office consultant for 25 years, as she would tell everybody. She was originally from Boston area, a long-time Somerville resident, and since 2004 she was proud to live in Holyoke, Mass. She had an active and full life. You can look up Peggy Malanson, as she would say, on Google. You can google her obituary and discover what a huge contribution she made.

Lisa Thompson: On a personal note, our mom told us stories when we were children about how she grew up poor in Boston. She ended up living for a time in foster care, and once she was of age she married our father and they adopted her younger brother out of foster care. She was eventually able to purchase her own home, and spent her life paying off her house so she could own it outright, finally feeling safe and that no one could take it from her. Because of her traumatic childhood and after such hard work, at the end of her life she insisted on being home when she died. We promised we would be there for her to help her wish come true.

Linda Thompson: We chose palliative care because we had previously discussed hospice with mom, and she didn't like the focus on dying. Just the word "hospice" would bring up a negative connotation to her. At one point she asked us not to say the "h" word. So we spoke to her CCA nurse and asked for help and assistance with caring for my mom at home because her needs were greater than we could provide.

We were offered additional services -- PCA hours via Western Mass Eldercare, including paying family members to help, which was really helpful, because my sister was giving up time for work to take care of my mom during the daytime. And we were presented with the option of palliative care team.

Lisa Thompson: So, how Commonwealth Care Alliance helped us in this decision process, it was because our mom experienced her home as a sanctuary. She really didn't want people in her home. She just didn't -- especially people she didn't know. She wanted to rely solely on us.

Linda Thompson: But we knew we couldn't provide the round-the-clock care she needed. We asked CCA for a family meeting without my mom to strategize a way to get her to agree to in-home care, since transporting her to and from multiple providers was so cumbersome and exhausting for all involved. She also was starting to get confused as her cognitive abilities were declining.

Lisa Thompson: CCA was able to provide us with a family caregivers meeting. Her case manager at CCA recommended the palliative care team doctor could see her in her home, but we knew she would object, because she didn't know him and didn't want anyone coming to her house except for us. At that meeting we discussed her care needs and devised a creative plan to introduce mom to the palliative care doctor, framing him as a pain specialist, since that was what was most important to her at the time.

Linda Thompson: We knew the doctor could provide primary care services and help coordinate with the existing care providers, which included many specialists -- oncology, diabetes, pain therapy, surgeons, physical therapy, occupational therapy, many tests and prescriptions.

Lisa Thompson: So we arranged for her to meet Dr. Bromberg in an office she was familiar with. So in the meeting with Dr. Bromberg he took his time. He took time to get to know her, and discovered that she was a storyteller, and then, after she spoke a lot about all these different things that she had been through, he invited her to present a storytelling event for the CCA staff.

Linda Thompson: She was thrilled. She was so excited when she came home she put together the program and the visual aids. It gave her a purpose, something to look forward to, and she said that she had been missing that in her life.

Lisa Thompson: So, the palliative care nurse, Karen, and her primary care nurse, Char, explained the palliative care team concept to us as an alternative to hospice, which meant keeping existing providers that she already knew and in-home treatment options rather than replacing them with brand new outsiders run by a hospice, people that we hadn't even met.

Linda Thompson: Palliative care seemed to us the best option, because she could provide -- she could meet providers outside in the medical settings, and then we could be open to having them do in-home visits since she knew them already.

Lisa Thompson: She got to know them first, and then she was much more open to having them come here. We asked for and were able to have palliative care team that was set up for her by CCA.

Linda Thompson: Mom and her -- mom had a nurse, Char, and Brent, in charge of her case with CCA, and Dr. Bromberg, that served her as a new PCA -- PCP.

Lisa Thompson: Then arrangements were made for visiting nurses, home physical therapists, home occupational therapists, social worker services, and PCA services and medical suppliers, as needed.

Linda Thompson: She was offered social work but she declined that counseling. But everyone together seemed to really know how to work with her and give her sort of the counseling and support that she needed the way she needed it.

Lisa Thompson: They had coordinated care team approach. That was the most important to us. They communicated with each other.

Linda Thompson: So we didn't have to talk to each and every provider to set up services. CCA coordinated all that communication and scheduling to provide an in-home services.

Lisa Thompson: So, the palliative care team approach benefited our mom and us. So the pain was so unbearable to her, and so to focus on effective pain treatment was the thing that won her over. It was really amazing that Dr. Bromberg worked with the pain therapy team, got her a shot that actually worked, and I think just feeling valued, feeling connected with being able to get a kind of effective help just turned the tide for her, and she was open to having people that she knew that she knew could help her come to her home. It really made a difference, to do something concrete that was helpful.

Linda Thompson: So, in addition to that, combining the effort that she had to continue to treat her pain afterwards was really important, and to have the doctors and the nurses and the physical therapists come in and be able to provide her with that in-home care, she started to actually enjoy having visits.

Lisa Thompson: And another benefit of having a palliative care team approach was because she was in the care of CCA, when she needed tests, when she needed information about what would be the next step strategy for her, the insurance approval process was expedited, and that was really important for her at that stage in her life.

Linda Thompson: Additionally, there were so many different kinds of people coming into her home that she had originally said she didn't want people come into her home, but all of a sudden

she really liked having people come into her home, because she's really social. And so since she couldn't leave the home, having people come into the home really met a need that she had that she wasn't aware she wasn't going to be able to go out of the house to get. So it was really wonderful that a diverse group of people kept coming to the house, giving her opportunity to tell stories, uplifting her spirits, making her feel valuable and cared for, cared for in ways that she wanted. She got to the point where she actually enjoyed people visiting her in the home.

Lisa Thompson: And she got to tell her stories to new audience, which was really valuable.

Linda Thompson: So there were people who were trained to provide personal care services for mom and helped train us for safe care for her and for us. That was really important to us, because we really did not know what to do. CCA staff provided warmth, humor, sent us interesting GIFS like I guess they're called, to our cell phones that really gave us a boost of inspiration, support and understanding. They answered questions in the middle of the night, going the extra mile for us. All made it possible for us to sustain round-the-clock care for our mom in her home.

Lisa Thompson: And one example I have as a quick story is one of the nurses that came by knew that my mom really liked to cook, and he liked to cook. That's the picture you see in here. And so she wanted to make her spaghetti sauce for the first time for the nurse, and he wanted to learn it. So he knew this was important to her, so he says, well, why don't I help you make this? And that just changed everything for her about being home, too. She actually got to do something that was really valuable to her, which was cook and have someone be there with her, and that was home environment. It was so special. That's why I had to take this picture.

Linda Thompson: After having this experience, one of the things that I'd like to say is there were things that we could improve. I don't know if we have the time to do that, but just to say in a moment that we would like to recommend whoever is in charge of palliative care come up with a palliative care at-home care kit for family providers, because we don't have PCA training. And it would be great with a video instruction and a list of supplies that you should have on hand if you agree to take care of your family member at home, because there's a lot of supplies that we didn't even know existed. So that would be a great improvement for us, if we could have like a video instruction and a list of things. And did you want to add something?

Lisa Thompson: Yes, and I think like even some training. My mom ended up in the hospital, so we had a real limited time to go, oh, my God, this house has to change. We have to move the bed. We have to do this. What do we do? So they were really supportive in going, okay, this is what we do here. Talk to this OT person. We're going to order this. But some of it wasn't really in the right timing, so I think that working together with groups like CCA to come up with a sort of different kind of plan to maybe tweak it, to make arrangements that are good for the caretakers, to make sure it's actually safe. They gave us a bed that was like an institutional bed that was so wrong. But that's nobody's fault. It's just whatever they said, a hospital bed. But then they were able to replace it immediately with something that was awesome for my mom, and she was really able to surrender to it.

Linda Thompson: And so we can talk further if there's any questions about that, but I think that would be something that we could improve.

Lisa Thompson: Right. And we would offer to help put together that listing.

Linda Thompson: So thank you very much for this opportunity.

Lisa Thompson: Yes.

Linda Thompson: And that's it for us.

Caroline Loeser: Wonderful. Thanks so much Lisa and Linda, and of course Dr. Meier, Dr. Bromberg, and Karen, as well. This has been incredibly informative, and thanks so much for joining us today.

So with that we have some time for questions from the audience. So at this time if you have any questions for our speakers please submit them using the Q&A feature on the lower left of the presentation. Type your comment at the bottom of the Q&A box, and you can press Submit to send it.

So we did get quite a few questions throughout the presentation. Dr. Meier, I will start with a question that came in during your portion. So the question is that you talked about the importance of goal setting and finding out what matters most to the consumer. In your experience what care team members usually start that discussion, or is it multiple team members?

Diane Meier: That is a great question, and I really liked how Karen laid out stages, because there are stages for goal setting. In the early stage of a serious illness the most important thing is to find out who the person trusts to make decisions on their behalf if they're no longer able to make their own decisions, and that can be anybody on the team who has that conversation and is trained to talk about why this is important.

Later on in disease, when, for example, someone is having multiple hospitalizations or multiple ED visits, it's important to explain the patient that there are alternatives to that, that there are other ways to manage their chronic diseases that don't rely always on calling 911, and to explain those options and their benefits. And that usually is probably best done by a social worker, or, barring that, a nurse who can explain to the patient the benefits that are available to them, the options that are available to them that is an alternative to relying on 911 for problems that occur after 5 p.m. or on the weekend.

And then in later stages of disease, such as the patient that Karen presented, where it's clear that there's progression, it's clear that recurrent visits to the ED and the hospital are not only non-beneficial but actively harmful, I think you need a combination in that instance of multiple members of the team, especially social work and either advanced practice nursing or medicine, who can actually explain to the patient what to expect in the future with the illness. That requires somebody with a fair amount of training on the natural history of these serious chronic illnesses, prognosis assessment, and training on skilled communication about those issues.

So, for example, starting a conversation by finding out what the patient understands and the family understands. What did the other doctors tell you? Asking permission, asking if they're interested in talking about what to expect in the future. Don't assume that people want to talk about that. A small percentage don't want to talk about it. If they don't want to talk about it, asking permission to talk to someone else in the family about what to expect in the future.

If they do want to talk about it, then saying in simple language, not using jargon, what you expect the next month or weeks or year to involve, and then stop talking. Allow silence. Let the patient and family process what you've said. And that may take three minutes, it may take longer. There may be a lot of emotion when you tell the person that you think it's likely they're going to die within the next year or within a shorter period of time. And you just have to let that emotion happen and be supportive and then let people process it, as I said. And only once that has happened can you start making plans for how to manage the future.

And usually that's not asking people. It's saying "in my professional judgment, the best plan for you given what I know about what you care about would be the following." It might be hospice. It might be home-based palliative care or primary care, whatever services are available to that person. But that's a skilled conversation that takes training. Not everyone is born knowing how to do that. All of those skills are contained in the courses that CAPC provides on communication skills. So I guess my answer is it's everybody's job, and who does it varies on the stage of illness and kind of urgency of the medical decisionmaking.

Caroline Loeser: Great. Thank you, Dr. Meier. I'm going to move on to another question, and, Lisa and Linda, this is for you. And the question is what would you say was the most important or one of the most important aspects of having a care team for your mother?

Lisa Thompson: I think the communication that coordinated effort to be able to have a team actually talk to each other about all of what's happening. And every time we used to go to the doctor we'd have to repeat the same thing every single time we would go. And this time we repeated it to one person who everybody understood after that. Is there anything else that you can --

Linda Thompson: Yes, and I would say that honestly taking care of us, because we -- my mom was in charge of her care, but then when she stopped being able to really remember stuff and coordinate it very well we were kind of in a bind, and it caused a tremendous amount of stress. So as that transition went from her being in charge to us trying to kind of take charge, we needed medical professionals who knew what was what to be able to say, well, these are the options, and we can help you. And we're like yes, because we need that help, because we don't have the training. And we also don't work for CCA, so we don't know what the options are. So it was a godsend. It really was.

Caroline Loeser: Great.

Linda Thompson: And really great people that really support you and care about both sides, and funny. And humor is the best medicine. Just sayin'.

Caroline Loeser: Yeah, absolutely. Well, thank you, Linda and Lisa, for sharing your perspective there. We'll move on to a question for Karen, and, Karen, the question is if you could share with us an example of cultural differences and how you have approached something differently. I know you mentioned briefly in your case study about how Mr. M's wife was not, English was not her first language, and so you made sure to have someone present who could speak with her in Spanish. I don't know if you have any other examples you could share.

Karen Blair: We do see people from all over the world here in the Springfield area, and it's really important for us to have some perspective about their -- where they originate, what their religion and what their culture allows and doesn't allow. I do believe that every culture has a lot of variability and variation in it, and we look at people in the cultural context of where their ethnic background is, what their religion is, what their family is like, the neighborhood that they live in. Every aspect to that is part of their culture. So there are so many individual differences. But it really helps to do the research.

We see a number of people from Bhutan, actually, who come from -- come through the camps in Nepal and make their way to our area, and it's important for us to sort of understand what the cultural norms are, a little bit of what we might expect. And there's a lot of information out there. It just takes a bit of research to find out. And asking the question what is important to you. This is something that I would like to know more about just so that we're approaching things in the right way.

Caroline Loeser: Great. Thank you for sharing that.

We're getting a lot of questions in, so, thanks, everyone, for participating. Dr. Bromberg, a question came in, and I think this was touched a little bit with Lisa and Linda's presentation, but if you could just elaborate a bit. Does your team model include home visits, or are the checkups mostly at a facility or doctors' office?

Isaac Bromberg: Yes, so our model overall, kind of CCA's care model in general, not just the palliative care team, really is a home-based model. The goal with our clinical team and our care management is really to try and extend primary care certainly, and when needed other specialty services, into the home or the community where our members are.

So, as we talked about a little bit, some of our members, particularly when they are less complex and more healthy, might be managed telephonically. Usually as someone's medical and sometimes psychosocial complexity advances, we move them into a model where we can make more home visits and be more directly engaged with them. And that includes our palliative dedicated providers. So in addition to our care partners, our rehab and health outreach workers and behavioral health and social work team being able to see people in the home, our palliative care team, as well, can see members at home. So that's primarily where we see people.

The example that Linda and Lisa gave of meeting Peg in an office happened to work out in that situation if we had that available to us, because we do have a small primary care practice of our own within our organization, and Springfield happens to be located across the street, so it's just a convenient place to see people. And so when we're able to make an accommodation like that we

certainly try. But that's -- predominantly we're seeing people at home or a nursing home, occasionally in hospital.

When we're seeing people in the hospital it's often in the -- kind of under the auspices more of care coordination than being a credentialed provider in that facility, although some of our staff at some locations across the state are actually credentialed to be in and provide care. But we definitely will -- we will try to see members anywhere we can. Certainly for palliative care it's mostly in the home.

Caroline Loeser: Okay.

Isaac Bromberg: But, I mean, just as an example, in terms of just doing outreach and engagement with members, we have members that we see at the Dunkin' Donuts, because they don't want to see us at home, or we see them in the homeless shelter. So we have the flexibility to do that, and I think it's one of the reasons why we're able to provide the type of care that we do.

Caroline Loeser: Yes. Great. That was really helpful. Thank you. All right, I'm going to move on to another questions, and, Dr. Meier, I think this one can go to you but I think really any of our presenters could share. So, our ICG would like to identify risking-risk patients sooner, as Dr. Diane mentioned. Can the presenters offer some pearls of wisdom?

Diane Meier: So, that's a really important question, and it really does have to do with identifying people who are losing function, losing cognition, becoming frail, or have a family caregiver that's stumbling. And assessing, looking for those things, screening for those things allows the identification of rising risk before people start using the ER to manage those problems. And, as I think several of us mentioned, it's when families are stressed beyond tolerance, when they feel alone and functionally abandoned by the healthcare system. They do call 911, because it's the one place that has to take the patient off their hands.

And so failing to recognizing that the person calling 911 is usually not the patient, it's usually the family caregiver, and that the thing that is driving the family caregiver to distraction, to distress, is the rising needs of their loved one, whether because of cognitive impairment, because of functional impairment, or because of progressing frailty, particularly in the over 80, over 85 population. If you can screen for those things using simple tools that people can answer on their cell phone or on a tablet you will identify the rising risk.

Caroline Loeser: Great. Thank you. We have time for another one or two questions, so I'll move on. And, Linda and Lisa, this one came up during your presentation when you mentioned how your mother referred to hospice as an "h" word. And so the comment is that labels mean something. Palliative medicine and hospice are not clinical concepts embraced by patients to be considered terms such as supportive medicine or something along those lines.

Linda Thompson: So I think when my father was at the end of his life, when he was in the hospital, they used the term, they introduced the term "comfort care" to us at the time. And that just sounded so cushy and pillowy, and very desirable. And so I think, yes, I agree that terms

matter. And I think that my mom would joke around about being ready to die, but whenever I said, well, I can call hospice, she'd be like "I don't really mean it." And so I'd be like okay. So that's kind of an ongoing joke.

But there is an association of hospices helping people to die with dignity, but I also think that palliative care is kind of a technical term, and it's a new word for people. So I often will refer to it as comfort care personally, but a team approach, a palliative team that provides comfort care. And that means all the things you need when you're starting to need a lot of services but maybe can't get yourself to those services, they can bring those services to you, which is a terrific service.

Caroline Loeser: Sure, yes. No, I think that's a really helpful perspective. Thanks for sharing that.

I think at this time we are finished with our questions. So if you have any additional questions or comments, please email RIC@lewin.com. And for more information you can also find a list of resources mentioned during this presentation in the last few slides of just the presentation.

We'd also like to invite everyone to visit our website to review recordings of our webinars that aired earlier this year. These webinars include [Providing Culturally-Competent Care: Meeting LTSS Needs in Dually Eligible Beneficiaries](#), [Supporting Older Adults with Substance Use Disorders](#), [Person-Centered Approaches to Support People Dually Eligible for Medicare and Medicaid](#), [Promising Practices for Meeting the Behavioral Health Needs in Dually Eligible Older Adults](#), and [Promising Practices for Meeting the Needs of Dually Eligible Older Adults with Schizophrenia](#).

The slides from today's presentation, a recording, and a transcript will be available on the Resources for Integrated Care website shortly.

As a reminder, additional guidance about obtaining credits and accessing the links to the post-test can be found within the continuing education credit guide in the resource guide on the left-hand side of your screen or at the Resources for Integrated Care website.

Thank you so much for joining us today. Please complete our brief evaluation of our webinar so that we can continue to deliver high-quality presentations.

If you have any questions for us, please email us at RIC@lewin.com.

Thanks again to all the speakers. Have a wonderful afternoon. And thank you so much for your participation.