Growing Your Primary Palliative Care Skills: How to Provide Palliative Care Everywhere

Division of Palliative and Supportive Care
UK HealthCare

Financial Disclosure

We, the Palliative & Supportive Care team, do not have any relevant disclosures.

OUR TEAM

Jessica McFarlin, MD – Physician

Katrina Nickels, MD – Physician

Marianne Carter, PharmD – Pharmacist

Paige Walker, LCSW – Social Worker

Abbie Lattimer, LCSW – Social Worker

Kyle Long, MDiv – Chaplain

Foundations & Communication Skills

1:00-2:00pm

Jessica McFarlin, MD
Abbie Lattimer, LCSW

OBJECTIVES

- **Describe the evolution of palliative care within oncology** related to current national guidelines supporting early integration of palliative principles across the cancer care continuum.

- **Identify the core components of primary palliative care in oncology** to identify key skills that oncology clinicians can incorporate into routine practice, regardless of access to specialty palliative care.

- **Demonstrate foundational serious illness communication skills—** including eliciting values, discussing prognosis, and introducing advance directives—to support patients in making informed, goal-concordant decisions.

PALLIATIVE CARE DEFINITION

Specialized medical care for people living with a serious illness

Focused on providing relief from the symptoms and stress of the illness

Goal is to improve quality of life for both the patient and the family

Ferrell BR, et al. J Palliat Med. 2018;21(12):1684-1689.
www.getpalliativecare.org

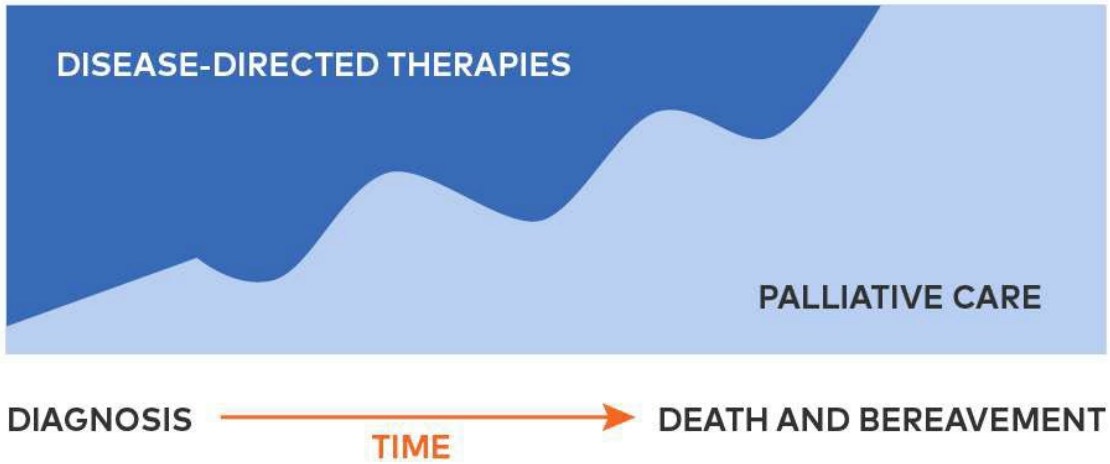
DOMAINS OF PALLIATIVE CARE

Structure and process of care
Physical aspects of care
Psychological and psychiatric aspects of care
Social aspects of care
Spiritual, religious, and existential aspects of care
Cultural aspects of care
Care of the patient nearing the end of life
Ethics and legal aspects of care

Ferrell BR, et al. J Palliat Med. 2018;21(12):1684-1689.

BEST MODEL OF PALLIATIVE CARE

Patients receive palliative care throughout the course of serious illness, and *at the same time as* disease treatment.



PRIMARY AND SPECIALIST PALLIATIVE CARE

Primary

Initial symptom assessment and management

Discussion about prognosis, goals of care, suffering, and code status

Initial and ongoing assessment of patient and caregiver needs

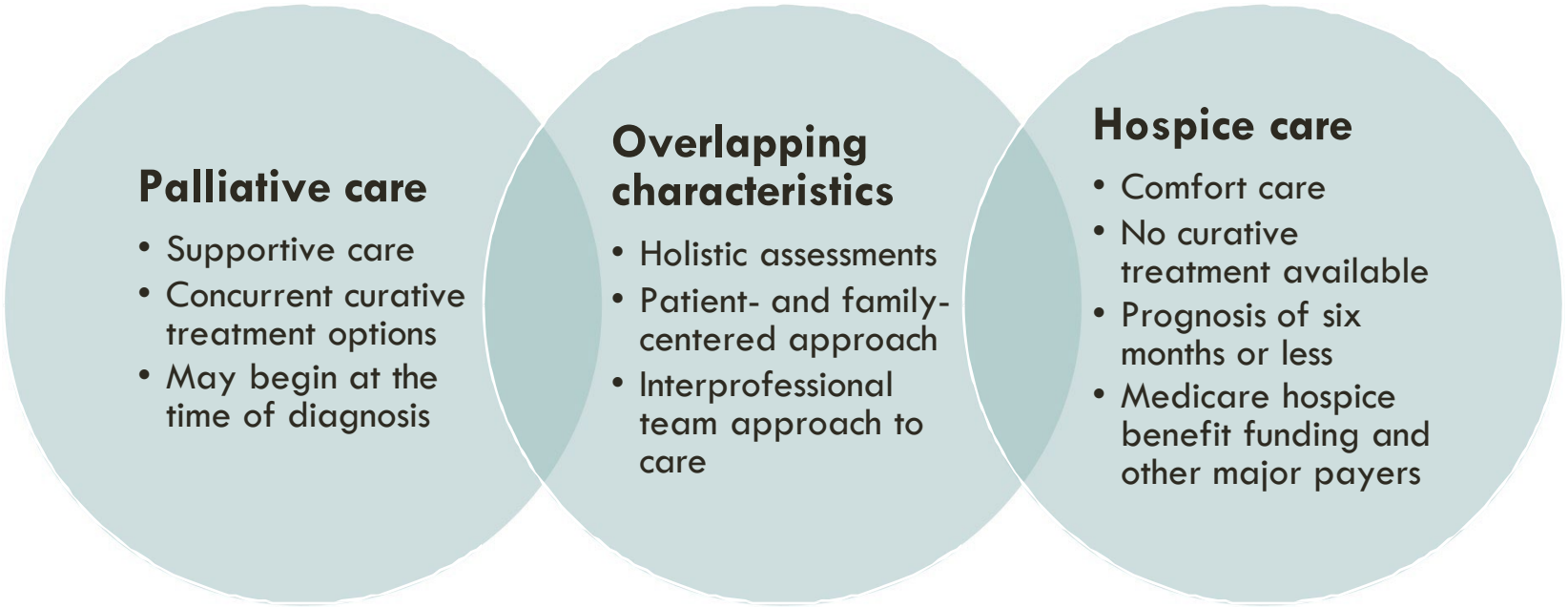
Specialist

Severe, complex, and/or uncontrolled symptoms (including psychosocial and spiritual distress)

Complex decision making and conflict resolution

Extra layer of support and care coordination for patients and their families

PALLIATIVE CARE AND HOSPICE



Beasley AM, et al. *West J Nurs Res.* 2019;41(10):1347-1369.

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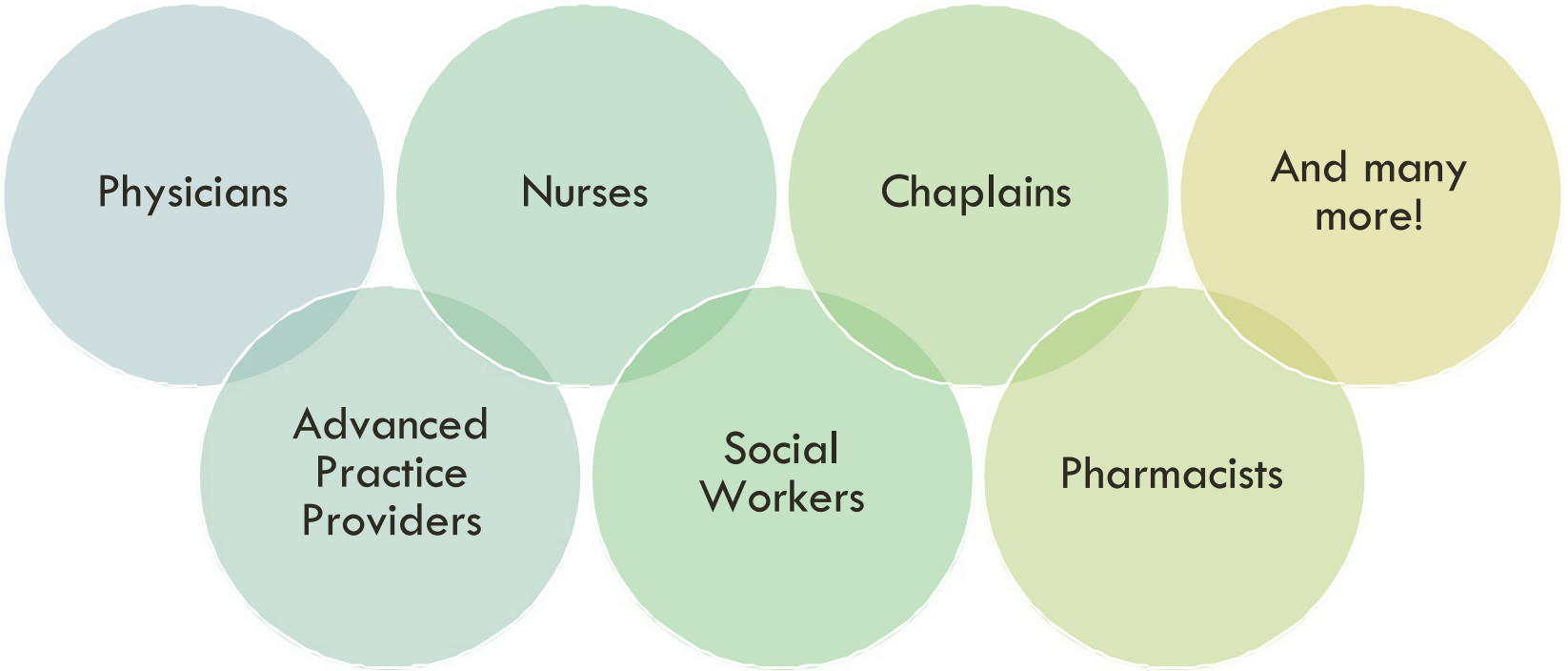
PALLIATIVE CARE TEAM MEMBERS



UK HEALTHCARE PALLIATIVE CARE

Inpatient Consult Service

Consult service only, not admitting service or specific location

Care for patients with any serious, life-limiting illness

Specialist level care to assist with symptom management, goals of care, and caregiver and care team support

Care coordination with primary and other consult teams

Palliative Cancer Care Clinic

Embedded in Markey hematology/BMT

Patient criteria:

- Established with UKHC Markey oncologist
- Receiving active treatment
- Advanced stage cancer with prognosis of two years or less

Can prescribe medications or provide recommendations in addition to psychosocial support and resource navigation

Symptom Management Essentials

2:00-2:55pm

Katrina Nickels, MD
Marianne Carter, PhamD

Objectives

- Apply evidence-based principles of cancer pain management—including opioid selection, titration, and adjuvant use—to safely and effectively treat cancer-related pain.

- Identify strategies to manage pain in patients at risk for medication misuse, including use of treatment agreements, multidisciplinary collaboration, and safe prescribing practices.

- Describe interventions for common non-pain symptoms such as dyspnea, fatigue, and nausea in patients with advanced cancer.

PHARMACIST

Assess and optimize medication therapy for patients living with serious illness across the continuum of care.

Perform symptom assessment in a patient with serious illness.

Provide pharmacotherapy consultation for hospice and palliative care patients to other disciplines and specialties.

Participate in goals of care conversations as part of the interprofessional team.

Promote and teach hospice, palliative care, and safe, effective pharmacotherapy in serious illness to pharmacists, other healthcare professionals, trainees, and students.

Lockman K, et al. *J Pain Symptom Manage*. 2022;64(1):37-48.

HIGH-RISK MEDICATIONS

Buprenorphine
Methadone
Ketamine
IV lidocaine
Patient controlled analgesia (PCA)

PHYSICIAN

ASSESS THE NEEDS AND CONCERNS OF PATIENTS

STRENGTHEN THE CLINICIAN-PATIENT RELATIONSHIP AND UNDERSTAND GOALS OF CARE

DISCUSS PROGNOSIS

MANAGE PAIN AND SYMPTOMS

PREVENT CRISES AND PLAN AHEAD

TECHNIQUES TO ADD: PLAN TO ASK WHAT PATIENTS WANT TO KNOW ABOUT PROGNOSIS

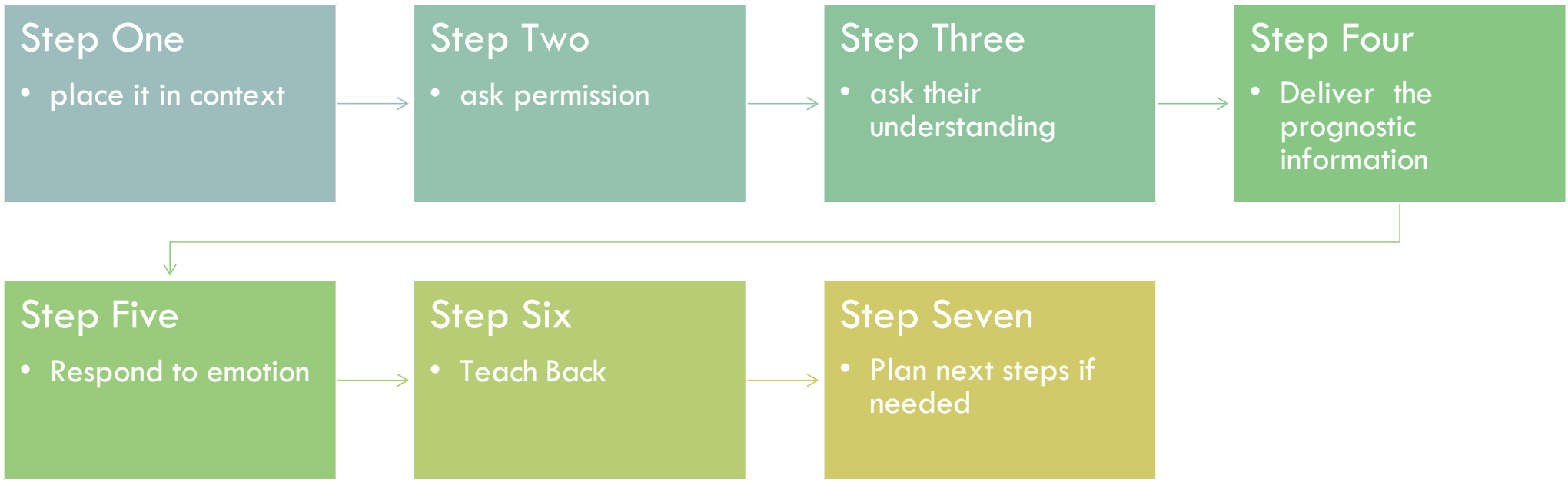
Patients prefer that physicians initiate these conversations (but we wait until asked)

Waiting too late leads to poor decision making as patients are not prepared, too ill, or distressed due to panic

Patients who have end of life discussions prior to last month of life are less likely to receive highly aggressive care such as hospitalizations and chemotherapy

Patients overwhelmingly agree that avoiding prognostic discussions are not a fair way to maintain hope

TALKING ABOUT PROGNOSIS…



PARTICIPANT PREFERENCES FOR COMMUNICATION OF PROGNOSIS

Doctors should ask each patient if they would like to discuss prognosis; preferences are personal

Doctors should not make assumptions based on ethnicity but should explore how it impacts "how and why" patients may choose to discuss prognosis

Doctors should be direct, empathic and willing to spend time on the discussion

Doctors should acknowledge that prognosis is uncertain

Patients' desire to discuss prognosis increases as prognosis is shortened

Physician initiated conversations

Psychosocial & Spiritual Care

3:10-4:05pm

Paige Walker, MSW
Kyle Long, MDiv

Objectives

- Choose brief, validated approaches to screening for distress in patients with cancer, including tools such as the NCCN Distress Thermometer and targeted questions to identify unmet psychosocial needs.

- Describe core principles of spiritual and existential care by applying brief assessment frameworks to recognize and respond to spiritual suffering in oncology settings.

- Identify strategies to support families and caregivers of patients with cancer, including addressing communication challenges, clarifying decision-making roles, and connecting families with practical and community resources.

SOCIAL WORK

Education

Support

Resource navigation

Assess and address patient, caregiver, and family, biopsychosocial needs and the impact they may have on treatment, activities of daily living (ADLs), and overall quality of life.

Palliative versus hospice care

How to talk to your provider(s)

Care coordination

Resource navigation

Palliative team roles

Advance care planning

- Code status
- Healthcare surrogacy
- EMS DNR
- MOST form

SOCIAL WORK: EDUCATION

SOCIAL WORK: SUPPORT

Assess/observe patients from person-in-environment perspective

Address anticipatory grief for patients and caregivers

Co-morbidities (mental health counseling)

Suicidality

Cultural considerations

Facilitate conversations related to goals of care and ensure that medical needs/interventions match goals of care (GOC)

Building bridges between care teams for continuity of care and care coordination

Assess for and address vulnerabilities in the following areas:

Financial toxicity

Transportation dependence

Housing insecurities

food insecurities

Health literacy

Substance use disorder(s)

SOCIAL WORK: RESOURCE NAVIGATION

CHAPLAIN

Basic Tasks of Chaplaincy

Provide a supportive presence

- Non-anxious presence, reflective listening

Assess need for spiritual and emotional support

- Attend to what is being expressed from heart and mind

Assist with spiritual practice

- Provide sacraments, sacred text, ritual resource, etc.

Chaplaincy on the Palliative Care Team

Participate in co-visits

- Provide support alongside colleagues

Contribute to GOC conversations

- Hold awareness of spiritual and existential perspective

Collaborate with the interdisciplinary team

- Speak to spiritual and emotional need in patient care

CHAPLAIN

FICA Spiritual History Tool

Faith: Determine if patient identifies with a particular expression of faith or spirituality

- *Is spirituality important to you? Do you have beliefs or practices that help you cope?*

Importance: Explore the importance of spirituality on patient's life and decisions

- *How important is your spirituality to you? How might it affect your healthcare decisions?*

Community: Learn if patient is part of a spiritual community

- *Is your community supportive of you? In what ways do they help you?*

Address: Develop a plan to address spiritual health issues and/or provide support

- *How would you like us to address spiritual issues in your healthcare?*

REGISTERED NURSE

First point of contact/managing referral

Defining/explaining palliative care to patients

- It is about improving quality of life during serious illness, providing an extra layer of support, and having a team focus to patient care.

Reinforcing the difference between palliative care and hospice

- This is a common question/misconception when these patients are first contacted.

REGISTERED NURSE

I can discuss treatments with the patients and work through common side effects having chemo infusion experience.

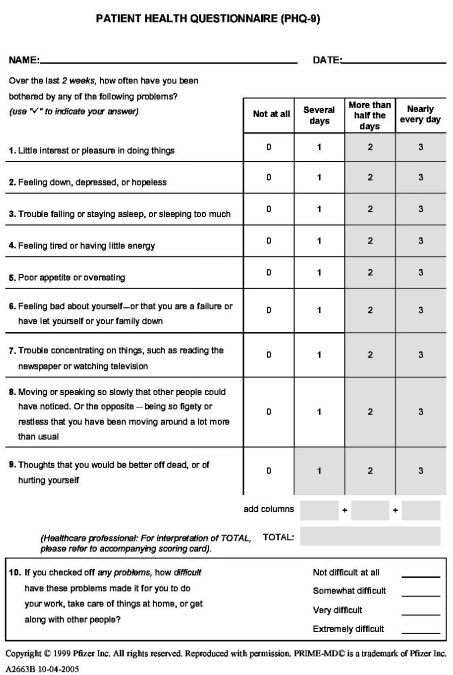
Care coordination is a large part of my job, e.g. contacting other providers when the patient has changes/concerns.

Staying flexible and being ready to pivot quickly is important, as no visit goes as planned and you might have to get them in for IVF, or send to the CAT clinic, or ED, etc.

I gained invaluable knowledge having had my Certified Hospice and Palliative Nurse (CHPN) certification.

REGISTERED NURSE: SCREENING TOOLS

%	Ambulation	Activity Level & Evidence of Disease	Self-care	Intake	Level of Consciousness
100	Full	Normal *No disease*	Full	Normal	Full
90	Full	Normal *Some disease*	Full	Normal	Full
80	Full	Normal with effort *Some disease*	Full	Normal or reduced	Full
70	Reduced	Can't do normal job or work *Some disease*	Full	As above	Full
60	Reduced	Can't do hobbies or housework *Significant disease*	Occasional assistance needed	As above	Full or confusion
50	Mainly sit/lie	Can't do any work *Extensive disease*	Considerable assistance needed	As above	Full or confusion
40	Mainly in bed	As above	Mainly assistance	As above	Full or drowsy or confusion
30	Bed bound	As above	Total Care	Reduced	As above
20	Bed bound	As above	As above	Minimal	As above
10	Bed bound	As above	As above	Mouth care only	Drowsy or Coma
0	Death				



PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

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Integration & Interdisciplinary Case Panel

4:05-5:00pm

Jessica McFarlin, MD
Katrina Nickels, MD
Marianne Carter, PharmD
Kyle Long, Mdiv
Paige Walker, LCSW

Objectives

- Identify practical strategies for integrating primary palliative care processes into oncology workflows, including triggers for activation, communication pathways, and role distribution across team members.

- Describe how interdisciplinary collaboration among physicians, nurses, social workers, chaplains, and pharmacists enhances patient-centered care for individuals with advanced cancer, particularly in resource-limited or rural settings.

- Apply a multidisciplinary approach to a complex oncology cases, to further recognize how each discipline contributes to symptom management, psychosocial support, spiritual care, medication safety, and goal-aligned decision making.

MEET FRAN

Chief Complaint

58 year old female

Presents to Palliative Cancer Care Clinic for pain management and psychosocial support

Oncologic History

Stage IV non-small cell lung cancer with metastasis to bone and brain, diagnosed in November 2024

- Right craniotomy and tumor resection upon diagnosis

Has received many lines of therapy, including:

- Carboplatin, paclitaxel, ipilimumab, nivolumab
- Zoledronic acid for bone metastases

MEET FRAN

Social History

22 year old son with Autism Spectrum Disorder who cannot work and lives with Fran

Wants to complete documents naming a caregiver and decision maker for her son

Spiritual distress

PMH, medications, and allergies

PMH: chronic pain and receiving opioids before cancer diagnosis, severe anxiety and nightmares, headaches, nausea, cannabis use

Medications:

- Acetaminophen PRN mild pain/headache
- Alprazolam 1 mg PO TID
- Gabapentin 800 mg PO Q8H
- Oxycodone IR 10 mg PO Q6H PRN severe pain

Allergies: naproxen

WHAT DO YOU WANT TO KNOW MORE ABOUT?

Think

Pair

Share

HOW DID WE CARE FOR FRAN?

PHYSICIAN

CHAPLAIN

PHARMACIST

NURSE

SOCIAL WORKER

QUESTIONS?