Hello and welcome to the Rx Counter podcast produced by student pharmacists at the university Bible College of Pharmacy where we help you stay informed about hot topics facing the profession. I'm your host, Matt Yates and with me today is Logan magician presenting the article why some patients aren't getting palliative care by Michael all of Logan, the counter is yours.

Thanks, Matt. So just go into this article right off the bat. We started out with Jeannie Martin her mother was 99 dirt when the time this article was written. So back in 2017, she was diagnosed with breast cancer and already had vascular disease. The problem was her doctors taking care of her didn't decide think she was close enough to death. So they didn't classify her as such. And therefore insurance wouldn't now pay for palliative care services. And she didn't receive it. So we come to find out her mom developed source that turned into open wounds and a lot of her symptoms could have been treated her cod He had begun countermeasures. So then it goes into like, why these problems tend to come up into society nowadays. And it also even mentions like the cost and and other aspects of how to care that some people don't think about. The next section goes into the definition of Auto Care. So the insurance has a different definition of what's comfortable for patients. So like for Auto Care, they cover pain most of the time, that's something that they can understand. But, like services delivered by nurses, social workers, chaplains that aren't necessarily covered home visits, wound care, social spiritual counseling, advanced care planning and family support. Those also aren't necessarily covered by insurance and that's a good portion of palliative care, as that's been a part of an issue that carries noticed and then going down even further, Pelletier is also still newcomer to medicine. Apparently 2006 was when it was first approved. And many people have started associating with hospice. So some patients might even believe that they're dying if they receive palliative care. And that might also be part of the problem. But then the article ends in a section titled California where it just talks about different states and how they've been incorporating healthcare into their society and their insurance models. So like California, will require 12 hours of continuing education for physicians, Medicaid, Medicaid managed care beneficiaries when I receive palliative care in California. And then it also goes in a little detail what's happening politically in certain areas like Oregon or Massachusetts, where they required doctors to educe patients on how to access palliative care, instead of actually given it themselves and then in DC Congress and the Senate have also tried to pass certain bills expanding the reach and education of palliative care, but Some of them have not been so successful. There is currently one right now, but uh, it hasn't really been pushed through just yet. So that's, that's an overview of the article. It's only like a six minute read if someone wants to go through and read it. But, uh, I guess my first question is like, are these states going too far with the requirements for physicians? Are they not going far enough? Should we be recording more training and held up here or not considering insurances being kind of rude to out of here in this scenario?

I guess like some article points out some of the problems with deciding payment problems and stuff is defining what is palliative care or who is on the healthcare team. So

I know that's kind of

a hard question for you on the spot on but who would you consider being part of the team?

That's a good question. I would consider

most people to be part of the part of care for the team team. There's the physician. There's the pharmacist. There's the social worker, chaplain nurses, everyone As a part of this decision making process, even the patient and family are, so I think everyone should get some sort of training and

Unknown Speaker 4:07
support and someone like a chat with might not be as used to associating that with healthcare. But I think the data would suggest that, you know, there's lots of benefit from incorporating that aspect into a thought of care approach and quality of life. So I think that's something that you obviously need that maybe educate the payers a little bit more on.

Unknown Speaker 4:28
And you do bring up a good point that I had mentioned just yet, but how to care is a lot about quality of life, we're trying to, we're not necessarily trying to cure the patient of their disease or trying to make them feel better about the situation like, cure their symptoms. Wouldn't you agree with that? Dr. Laughlin,

Unknown Speaker 4:45
um, so yeah, I think kind of cares about helping patients and people have the best day possible for every day that they have. Yes,

Unknown Speaker 4:55
definitely. But you're

Unknown Speaker 4:57
right about the chaplain as well. Like most people don't necessarily associated chaplain with your healthcare team. But the spiritual aspects very important for some people

Unknown Speaker 5:06
think a lot of education needs to go into the stigma that healthcare is not synonymous with hospice care. So a lot of times you know what we're thinking about the payment model, the payment model may not be created by these healthcare providers. Education is to be in place, especially when we're transferring a fee for service to the value based healthcare system,

Unknown Speaker 5:26
which it does mention fee for service been an issue because they're not going to want to use those small fees for palliative care. There are other

Unknown Speaker 5:36
treatments, right. And if it's fee for service, you're right, his costs would start increasing. I mean, we we have to draw a line of what fees and what services can be cut up. But if its value based and we're really producing healthcare outcomes that reduce overall health care costs. We have the statistic right here that those patients receiving palliative care services cost for $95 and 30. cents per day compared to $212 and 80 cents for those not receive those numbers out up for sure, absolutely. I think if we're really focusing on value based system, the answer is right in front of us with those statistics.

Unknown Speaker 6:16
So some insurances have expanded palliative care services again in California Blue Cross Blue Shield has expanded their home based palliative care program to be available in every county in California. So thankfully, more people are paying attention. And I just wanted to share with you guys I saw there was a big palliative care meeting last week, from the centers to the center to advance palliative care. And Mark ganz, who's the CEO of can be a Health Solutions spoke and I saw this tweet, I'm going to read it to you guys. I'll be interested to hear your thoughts on it. If someone at your institution asked about cost savings meeting with palliative care, don't take the bait. Cost is not unimportant, but powerful. cares about doing the right thing. It's about healing. Other metrics can tell that story. And I've heard him speak in another national meeting that I was in attendance. And he said, Palliative care is a return on humanity. And so I don't disagree that if you give people good care and the best care, you actually might save money, but I'm just interested in your thoughts on how we strike the messaging to patients and keeping that in mind.

Unknown Speaker 7:32
I think a lot of people are focused more on the money portion of it, which is why I think we were focusing on that just so that we can get that message across that it could help but I do think you're right that we need to focus on healing the patient and making sure that they're comfortable and returning to humanity. I guess, you know,
from a pharmacist standpoint, we obviously care about the eternity I'm in any part to encourage him. Hey, payers to do the same, they probably a little more financially focus However, you can still bring both opportunities to the table. And so you know, you know, this might increase short term costs or you know, this might increase this area, but at the end of the day, hopefully we can increase value in their quality of life, and maybe even reduce costs as well.

I think they're building together kind of more of the awareness of mental health and some things like that, and again, hopefully also translate that out of care, which is that understanding that we need to treat well being? Yeah.

So I was gonna say another thing. Just a side note, we talked a lot about Medicare and Medicaid. So it really needs from a professional standpoint, advocate for maybe provider status for pharmacists as well because that's only going to help us when we talk about you know, are these services covered by CMS if they are covered by CMS, technically, even pharmacists are still not allowed to Provide them. So getting that provider status is another thing that pharmacists need to focus on advocating.

I kind of had this question when I was thinking about the payment process and all that, but like, since a good portion of the services seem to not be covered, or we might even be adding more to their patients bill at this point by doing Paladin paradise, because insurance isn't necessarily covering all this other stuff like the chaplain the social worker, the spiritual aspects, but they're covering the pain and that's only part of it. So are we not adding more to a patient's bill by putting them on the service? You know, it's my bring back the humanity argument. Well, we're just improving the humanity. We're not worried about the cost of this point. But

was it this paper that talked about the campus shortage of medical professionals? BI there is a big shortage. So I was curious, I just looked up how many NPGYT residencies they were in pharmacy for Medicare specifically adding Iowa has a program that just was accredited recently and there's only 24 PGIs across the whole United States that have that. Mostly either on the East Coast or the west coast. So definitely the Midwest, it didn't look like there was anything outside of kind of Minnesota, Wisconsin, Missouri area. So definitely in capital of the country, no one's getting trained in this is specifically in pharmacies. So we've definitely had a lot of exposure, through our our coursework with kind of understand the importance of a pharmacist role in a palliative care team. So I was just curious if there's any solutions to potentially training more viruses in the specialty that might not go through a PGYT program because obviously, it's hard to just up and create something and get that going.

That could be part of an awareness of what it is to because if people have that wrongful association with palliative care, hospice and nothing else. There's a lot of people that

don't want to do that as a profession,

if we have better education as to what it is people will be more interested in. So it might come down to a general awareness sort of aspect, but I mean, it has to have a supply for increased demand. So having more programs out there for BG by to having incorporated and more curriculums, whether it's in pharmacy school, nursing school,

empty videos,

or social worker school. I think that's
probably one of the first things we can do. Obviously, probably not the easiest, but it's still certainly a step for referring wrestling health services we talked about before you create a new service or a new job, need to have a demand or need in the community and clearly states there is a need and need is not being filled by the 20 programs across the country. So I think that we know that we have that need that demand there, we can go ahead and optimize, you know how many programs and how many graduates were coming out of the program so we can fulfill the need.

I think as pharmacy students, we have a hard time grappling with qualitative measures. We spent a lot of time at the beginning here trying to come to terms with palliative care and how it relates to cost and trying to quantify quality of life. And that's just hard for, like I said, pharmacy students, so I think we need more exposure to what is quality? How do we justify that to ourselves and to our patients. And if we know what quality is, then we can help share with the people that we're treating whether we're a palliative care pharmacist, or a community pharmacist or anyone that's dealing with empathy. That we can share that with the populations were treating. And that way we don't have to have a PGY to in palliative care. We can be a general pharmacist and know what Palliative care is how to share it and then connect our patients that may need the most of it to the specialists.

And maybe that's a way to get around the shortage of healthcare pharmacists, it just explosive enough people to it that they just kind of are adopting the mindset anyway. And you don't need to be very specialized in that field. That's a good solution. There is no objective measurement for us to quantify the quality of life. So think teaching, you know, public health coach, how to talk to patients and listen to their stories as somebody wants to listen to their needs. It's I think sometimes we get lost in the healthcare profession that we are the top dogs, we are the smartest one to be make the decisions. It's that's not the case. It's working with the patient. Figuring out a solution with them, and helping them figure out their goals. I think we have the opportunity because we have the education to help them figure out what their goals are through motivational interviewing, health coaching, through all sorts of empathetic communication.

Where would you recommend we get a health coaching for those that might not know to get certified and trained in health coaching?

Right? Yeah, I mean, there there is health coaching certifications. However, I think in the curriculum, I've learned how that health coach learning education about pharmacy and applying those to my communication skills on that also have been that through Farm to School doing such organizations like Toastmasters or anything like that, I think first learning those baseline communication skills is great. And then once you get that from school for therapeutic knowledge, applying that to patients being able to communicate with them, and I mean, there are there are coaching certifications out there. I think, you know, We're talking about education, a doctor and pharmacies lot higher than a health coaching certification so you can look into it. But I think the pharmacist that's kind of in their training.
The exposure I've had to health coaching is really taught me to think about the patient centered care sort of model, and then adjusted a little and look at patient directed care. Because like, as we were talking about earlier, it's one thing to put the patient in the center of the care team. But it's another thing to actually let them make all the decisions and have the care team provide the education that the patient is going to need, about their diagnosis for whatever diseases they're facing, or whatever treatment options they have available to them. And then actually let them make the decisions. I don't know I don't practice So I don't know how that works in the real world. But I imagine a lot of it goes to the wayside. And we have a patient, two people here that probably could speak to that. So where do you guys put the patient? When you are practicing with your elder care patients?

Unknown Speaker 16:19
Are they more like the ones that are driving all the decisions? Or is it kind of like, you give like these two options when you give them the choice, kind of or like how do you guys handle patients?

Unknown Speaker 16:32
I think patients want a guy they want, they want someone to show them the sign ups on the journey of their disease management, right. So, healthcare has become an incredibly, incredibly complex place to be in not just as a healthcare provider, but especially as a patient who may not have a particularly high healthcare literacy. So asking patients to make informed decisions about incredibly complex therapies like bone marrow transplantation, or large surgical procedures.

Unknown Speaker 17:19
Or someone who has a recent diagnosis of pulmonary hypertension and is going to need complex pharmacotherapy for the management of a curable goals. Those are all things that I think that we can talk about patient centered care, and we should always make the patient the center the focus. Once we understand what their goals of care are, what, what's the most important to them, and their family and those decision making processes as much as possible. But patients need to be able to look to us as a guy in Those discussions, because, quite honestly, I can tell if all of you around this table that if you were faced with some of the illnesses that Dr. Lockman and I see in the hospital, you would be at, you would have difficulty making decisions because of the complexity of some of these therapies. So trying to avoid being paternalistic, and driving the treatment as much as possible, but realizing that patients and families look to us to be a guide in these discussions as much as possible.

Unknown Speaker 18:40
One of the tools that I know a lot of people on our team use and I teach it to the third years in the Reno integrated pharmacotherapy module and we talked about Palliative care is best case, worst case. And so there's a great video on YouTube from University of Wisconsin, where it was created. Did where they talked about best case, worst case for dialysis. And I think it's a great example of being a guide, the doctor Ray was mentioning about might want to look into that if you haven't seen it yet. It puts the patient in the center but also gives the patient the information they need a guide them to make the best decision that aligns with what's important to the patient.

Unknown Speaker 19:26
I think it's really important to realize that

Unknown Speaker 19:33
we're trained as scientists, right. So as scientists, we do not embrace uncertainty very well. But in dealing with people who have particularly incurable, serious illnesses, there is a tremendous amount of uncertainty that happens on a day to day basis. And so when you begin to factor that in, as well as Trying to promote cultural humility. Understanding who the person is and where they're from and what what their values are and what's important to them, and meet them where they're at. Those are the kinds of things that I think we want to foster local having what we otherwise call patient center, just decision making processes.

Unknown Speaker 20:33
Get back to your last
Unknown Speaker 20:34
final, your opening question it was about our state's gone far enough. And maybe this would be the call that we have
time for about kind of that was your original question, right? That was the starting one. Yeah.

Unknown Speaker 20:43
About our state's doing enough. Are they doing too much to get payment? Well, I mean, to get payment, are they
requiring people to do too much because California was like, Oh, 12 continuing education hours. I was like, you guys
think that's too much. It's too little

Unknown Speaker 21:00
That that was originally the first question, but it's
good to start. Right. I mean, start somewhere, do I think that 12 hours is going to be sufficient?

Unknown Speaker 21:10
But I think, you know, goes along with

Unknown Speaker 21:14
those continuing education hours and practice professional practice hours as

Unknown Speaker 21:17
well. So I think it's a store, I think.

Unknown Speaker 21:22
Do you think physicians have enough training in this uncertainty aspect that Dr. Ray was talking about?

Unknown Speaker 21:29
Well, I'm not a physician. So I can attest to that. However, I think that also gained through professional experience as
well. So depending on the practice setting, perhaps, did you guys

Unknown Speaker 21:42
have any input on how as students we can get involved with our legislators are some of these bigger things with pushing
this payment process ahead, because obviously at some point, it's going to fall on to the next generation to get that
going.

Unknown Speaker 22:00
say, okay, Boomer.

Unknown Speaker 22:05
Us boomers have put it all on you guys, right? The boomers have created this problem. We, we took all the money, and
now we gave you all the death. And that's that's the reality that we're living in the last 40 to 50 years of what's
happened post World War Two. So yeah, I think your question is really critical because what we're doing in this society
is untenable as it relates to health care costs. We have some of the worst healthcare outcomes compared to anybody else
in the in the world. We have lower life expectancies, and we pay him to spend twice as much money as the next
country, which is Canada, per per capita. Right. So yeah, I think we need to make huge changes. And so one of your
questions about legislation right now. There's bipartisan bill in Congress called the shadow bill, which is to create
centers of excellence in palliative care training across the United States. So it's, that's one of the focuses of that bill, but
it's also to look at changes in reimbursement for this type of care. So, as you've heard us say before, that the hospice
Medicare benefit that was created in United States back in the early 70s, was the government's foray into managed care.
Well, the hospice Medicare benefit hasn't even kept up with the rate of inflation in this country. And in fact, there are
several hospice programs that are closing around the country because they can't keep their doors open because they
aren't getting adequate reimbursement from Medicare and Medicaid to take care of the patients that they have. So your
comment about qualitative assessments. It's a metric that no one's very good at, in assessing the value that it brings to care until we get in touch with that we're going to be in serious trouble. The center to advance palliative care just had their annual meeting last week, and it's the 20 20th anniversary of Campsie and one of the leaders of Campsie has continuously said for last 10 years, we cannot focus on claiming our value in healthcare by being a cost savings enterprise. Yes, we do save cost. But that's not what we're about. We're about driving value. And until we can show that, that piece of the equation in the business world, that value of healthcare is worth paying for. We're always going to sort of be behind the power curve about what we do and how.

Unknown Speaker 25:36
Oh, that's all the time we have. Logan, thanks for bringing this to our attention. We hope you've learned we'll catch you next time at Rx Counter

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