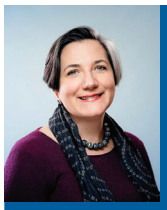
Massachusetts General Hospital
Founding Member, Mass General Brigham

Spring 2023

Living Well



Letter from the Chief

Vicki Jackson
MD, MPH

During the first wave of COVID-19 in March, 2020, palliative care clinicians embedded in the Emergency Department. We carried out goals of care conversations with critically ill patients and their families and helped with symptom management. When the second wave hit late that same year, the Division again sent clinicians to help in the ED. This was a profound experience for our palliative care clinicians, and we began to wonder if there could be a larger role for palliative care in the ED. Some people who are treated in the ED have complex medical needs or struggle with serious illness. You can read about how the Division is expanding palliative care in the ED to 7 days a week as part of a new program called Care Transitions Pathway (CTP). Because we wanted to create a program that was collaborative, we needed to bring in multiple perspectives. To do that, Mark Stoltenberg, MD, interviewed specialists in emergency medicine, palliative care and geriatric medicine from across the country to make sure that the presence of palliative care in the ED would best support patients as well as the clinicians in the ED.

As part of that same program, we are also creating a new 10-bed inpatient Supportive Care Unit for patients who need ongoing high level palliative care.

You can also read about how palliative care might be a way to improve the lives of people who have just been diagnosed with end stage liver disease, a diagnosis that can come with significant physical

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Division Expands Palliative Care in the ED

In July, the Division will launch the Care Transitions Pathway (CTP) to improve the care of patients with serious illness at Mass General. The two key components of the CTP are 1) embedding palliative care in the Emergency Department to 7 days a week and 2) creating a new 10-bed inpatient Supportive Care Unit (SCU).

The interdisciplinary team in the ED will include a palliative care physician or nurse practitioner, social worker, chaplain, case manager and a nurse navigator who will help identify patients who would benefit from palliative care. The social workers and case manager can follow patients admitted to the SCU from the ED to provide continuity of care.

Many patients who come to the ED could benefit from a palliative care perspective. This became clear during the first wave of COVID-19 in March 2020 when palliative care clinicians first embedded in the ED for several months. They helped with symptom management and conducted goals of care conversations with critically ill patients and their families. And when the second wave came at the end of 2020, they returned to help again. In a study published in 2021, ED physicians were surveyed about their experience with palliative care during the first surge, and one wrote, “please never let them leave.” Another wrote, “the gratitude is profound.”

“We had a significant presence in the ED during the pandemic and that created a lot of support at the hospital level,” said **Mihir Kamdar, MD**, Section Head of Palliative Care. “We realized that the palliative care needs in the ED extended far beyond the pandemic.,” he said.

First, the division needed to create a new model of care to meet these needs. **Mark Stoltenberg, MD**, interviewed geriatric specialists, palliative care specialists, and ED physicians from across the nation. These folks also conferenced in person to create a model that would enhance the care of those patients with significant needs.

Those patients who need intensive palliative care can be moved from the ED to the 10-bed inpatient Supportive Care Unit to receive high level palliative care. This unit will be staffed with a palliative care physician, nurse practitioners, along with a social worker, case manager, and a chaplain. The SCU allows this team to provide intensive symptom management in addition to providing emotional and spiritual support to patients and their families.

Examples of patients who can benefit from the new Care Transitions Pathway include patients with severe symptoms from progressive cancer or patients who have suffered a devastating stroke. Older adults who present to the ED with complex medical needs can also benefit from palliative care. “We’re really just helping patients and families,” said **Janet Rico, NP**, who has been working in the ED since December 2020. “What I love is the ability to connect with patients at a critical time, and alleviating suffering. We’re also giving the patient a place to talk, which is huge.”▲

First of Its Kind Schwartz Rounds for Dementia

This past fall, the Dementia Care Collaborative created the first Schwartz Rounds for Dementia. The Division has worked closely with the Schwartz Center for Compassionate Care, a nonprofit organization dedicated to increasing compassion and meaningful collaboration between medical professionals and patients. In traditional medical rounds, the focus is on sharing information or discussing an innovation. By contrast, the Schwartz Rounds are a regularly scheduled time for clinicians to discuss difficult emotional and social issues that arise in caring for patients—in this case patients with dementia. These rounds bring together clinicians from many disciplines and allows them to explore and process their experiences with patients and their family members. These rounds tend to bring insights into the patient experience. They reduce stress and burnout among clinicians, while also improving teamwork and communication among interdisciplinary team members. The Schwartz Rounds take place in hundreds of healthcare organizations in the US and Canada, the UK, Australia and Ireland. Yet, this is the first one to be devoted to exploring the care of people living with dementia.

Dementia Care Collaborative

New Research Grants for Aging and Serious Illness

This summer, the division's Center for Aging and Serious Illness, in partnership with the Department of Psychiatry Center for Health Outcomes and Interdisciplinary Research (CHOIR) will launch a program to help train the next generation of researchers in palliative care and geriatric medicine. The program is called Bridging the Science-to-Service Gap, (Bridge-The-Gap) and it will bring postdoctoral research fellows from around the country to learn how to conduct research to improve the quality of life of persons with chronic or serious illnesses. Bridge-The-Gap is funded by a training grant (a T32 grant) from the National Institute on Aging. The grant will be focused on training scientists to do research that will benefit the lives of older patients and those with complex illnesses. The research will support the development of interventions in all care settings, including the hospital, nursing homes, and the home. These fellowships can last from one to three years in duration and fellows can come from any clinical background, spanning from psychology, nursing, social work, and rehabilitation sciences to physicians who specialize in palliative care and geriatric medicine, neurology, or other subspecialties.

"This is a great opportunity for both physicians and non-physicians alike who might be interested in doing research in aging or serious illness care but haven't yet had the opportunity to get training in research. Through the training they receive, they will be well-prepared to become researchers who advance the field," says Christine Ritchie, MD, MSPH, Director of Research for the Division, who co-leads this initiative with Ana-Maria Vranceanu, PhD, Director of CHOIR. They worked together to craft the proposal for the grant.

The first two fellows will start the program this summer. Ritchie notes that this opportunity is special because it focuses on preventing the negative effects associated with aging-related conditions or serious illness, regardless of illness stage. "We need to find better ways to care for people with serious illness or chronic complex conditions. There are a multitude of research gaps on how best to intervene in those at risk for or living with chronic or serious illness. We want to train the next generation of researchers to fill those gaps."▲

LiverPAL Study Update

People who find themselves hospitalized with end stage liver disease often experience distressing symptoms such as jaundice, pain, fluid retention, and internal bleeding. They may feel overwhelmed in the hospital and confused about what the future may hold. These patients would seem to be a natural fit for palliative care, yet few of them receive it.

In 2021, transplant hepatologist Nneka Ufere, MD, MSCE created a pilot study to examine how palliative care might help these patients. Nine patients were followed for three months beginning with their first hospitalization with end stage liver disease. Nancy Mason, CNP, worked with patients in the pilot program. The goals were to help patients and their caregivers understand the diagnosis, develop coping skills, and reduce the burden of symptoms. In addition, palliative care can offer support for caregivers who may feel overwhelmed.

Three of the patients died in those first three months, three others transitioned to hospice and three received liver transplants. "We were allowed to follow them post-transplant. This was huge in the hepatology world. They recognized our value," said Mason. Palliative care clinicians are also taking note. Last November, Ufere and Mason were invited to give a Master Clinician session at the Center for the Advancement of Palliative Care (CAPC). And this past March, they also presented at the American Academy of Hospice and Palliative Medicine (AAHPM). According to Mason, these talks were well received, "People were excited about this. We know this patient population is underserved. They don't meet the system in the same way as other seriously ill patients."

The next phase will include a clinical trial that will last four years and enroll 200 patients in either standard care or standard care plus palliative care. "We want to measure the effect of palliative care on this patient population. We are hoping that we improve their lives in multiple domains," said Mason. Other team members include Kirsten Engel, MD, and Michaela Rowland, MSN, AGPBC-NP, AOCNP, ACHPN.▲

LiverPAL

Letter from the Chief

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symptoms and an uncertain future. Transplant hepatologist Nneka Ufere, MD, MDSE has been on a mission to study and describe the effect of palliative care in this setting. With the help of Nancy Mason, NP, her team has completed a pilot study on how palliative care can improve symptom management, quality of life and coping for patients and their families. This summer, her team will be starting a four-year clinical study to measure these effects. This is important research that can improve the lives of these patients, and expand our understanding of how palliative care works in different contexts.

Research in palliative care and geriatric medicine is so important. And that's why I'm thrilled to announce that the Division has a new training grant (T32) funded by the National Institute on Aging that will bring fellows to Mass General Brigham to learn to do research in this space. This initiative is in partnership with the Department of Psychiatry's Center for Health Outcomes and Interdisciplinary Research (CHOIR). Eligible clinicians will be post-docs who have an interest in learning to do research that helps those who are aging and those living with serious illness. Their research can investigate interventions for patients in any type of care setting, including hospitals, nursing homes, or at home. The first round of applications has already been received, and the first two fellows will begin the program this summer. With this new grant, we will be training the next generation of researchers who will test interventions and best practices for palliative care and geriatric medicine.

Sincerely,

Vicki Jackson, MD, MPH
Blum Family Endowed Chair in Palliative Care
Chief, Division of Palliative Care and Geriatric Medicine

Awards and Achievements

Sarah Byrne-Martelli was awarded the prestigious Cambia Fellowship in January. Her project will focus on spiritual care integration in inpatient palliative care teams.

Alison Kavanaugh, MSN, ANCP-BC, ACHPN, was appointed as Adjunct Instructor in the MGH Institute of Health Professions School of Nursing. She is also a co-investigator on a 20-site PCORI-funded study about primary versus specialty palliative care for patients with leukemia. The study began actively enrolling patients in the feasibility phase in 2022.

Esteban Franco-Garcia, MD, was awarded the American Geriatrics Society Fellowship (AGSF) status. He was also named co-chair of the American Geriatrics Society's Surgical Co-Management Special Interest Group.

Leah Rosenberg, MD, received the 2022 Mark Eisenberg Award for Excellence in Mentoring from the Dept. of Medicine. She was also nominated, along with Bethany Rose Daubman and Kathleen Doyle, the Brian A McGovern Award for Clinical Excellence this year.

Alexis Drutchas, MD, and Richard Leiter, MD, facilitated a palliative care storytelling event at the International Congress in Montreal in October, 2022. They have also been invited to create and lead a storytelling session for Ariadne Labs Serious Illness Care Program Summit as well as the University of Toronto Palliative Care Fellowship Program this spring.

Several palliative care providers have actively participated in LiverPAL , a pilot study that will evaluate the benefits of inpatient palliative care for patients with advanced liver disease (see story). These include **Samantha Berliss, NP, Kirsten Engel, MD, Vicki Jackson, MD, Nancy Mason, NP**, and **Michaela Rowland, NP**.

Events **All held virtually by Zoom or join by phone (EST)**

Most events are recorded and can be viewed on the Division website.

Dementia Care Collaborative

For all Dementia Care Collaborative events, RSVP to dementiacaregiversupport@mgh.harvard.edu

https://dementiacarecollaborative.org/

The Dementia Care Collaborative was created to educate and support patients, caregivers, healthcare providers, and the community. Dedicated team members offer opportunities for learning through monthly programs like our Conversation with Caregivers and our Health and Resiliency evenings, along with weekly exercise, Ageless Grace classes. We also offer individual clinical support for caregivers, support groups and fundamental skill classes. We are here to teach new ways of understanding dementia, how to best communicate and partner with those with dementia and offer support and guidance for caregivers to feel empowered to foster their own well-being and resilience.

The Dementia Care Collaborative has been funded by the generosity of supporting individuals and foundations including the Jack Satter Foundation and the Bresky Foundation, since its inception in 2017 and recently the Berkshire Bank.

Conversations with Caregivers | Third Tuesday of every month 5:30PM-7:00PM

July 18: "Legal Issues" with Judith Flynn

August 15: "PREPARE—Decision-Making as We Age" with Susan Edgeman-Levitan

September 16: "Alzheimer's Behavior Management and New Approaches" with Dr. Brent Forrester

Health & Resiliency Programs | First Tuesday of every month 5:30PM-6:30PM

July 11: "Ageless Grace" with Norie Mozzone

August 1: "Relax and Rejuvenate—Meditation" with Emily Kessler

September 12: "Tai-Chi" with Ellen Degenova

Ageless Grace Classes | Tuesdays 10:30AM-11:30AM

Zoom into a seated movement class with upbeat music based on neuroplasticity. Boost brain and body health in a fun community!

For more information or to RSVP email: dementiacaregiversupport@mgh.harvard.edu

Ways to give

For information about ways to support the Division of Palliative Care and Geriatrics at Mass General, please contact **Patrick Rooney at 857.260.4873 patrick.rooney@mgh.harvard.edu.**

@mghpalliativecareandgeriaticmedicine

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