Coleman Supportive Oncology Initiative

Palliative Training Module

Topic: **Goals of Care**

Presenters: Megan McMahon, PhD, Lauren Wiebe, MD,
and Betty Roggenkamp, BA

Version: 08282018

Learning Objectives

By the end of this module you should be able to:

1. Define goals of care
2. Adapt conversations and recommendations for a goals of care plan to a patient's individual wishes and preferences, even when barriers exist
3. Explain how and when to broach the subject of hospice care within a goals of care discussion

Goals of Care Defined

- Can include cure, maintaining function/quality of life, symptom management, prolongation of life, a personal goals, remaining home and achieving a good death
- Are determined by a patient's priorities, values, hopes and fears
- Often change over time and should be revisited regularly
- Clinical skills are needed to help patients and families navigate decision-making along the cancer journey
- Can be described in plain language without reference to procedures or medical interventions
- Consider summary documentation with advance care planning in a defined area in the electronic health record (EHR)

“How To” Communicate

- **Assess preferences for communication**
  - When
  - With whom present
- **Ask-tell-ask:. “What do you know about….?”**
  - “OK. Here is what the tests are showing us…”
  - “Does that make sense? Do you have questions about that?”
    - You can ask them to explain it back to you to check for understanding.
- **Tell me more:** ***“Tell me more about…”***
  - Use this when you are not entirely sure what someone is talking about, rather than making an assumption
  - You can also use this if you’re just not sure what to say next
- **Use “I wish…”**
  - Enables you to ally with the patient while acknowledging the reality of the situation
  - Expresses empathy inherently

VITALtalk, http://www.vitaltalk.org/clinicians/establish-rapport

Common Barriers to Communication of Serious News

- Feeling responsible for maintaining the patient’s or family’s hope
- Patients' incapacity to make goals of care decisions
- Disagreement among family members about goals
- Patients’ or family members’ difficulty understanding the limitations and complications of life-sustaining treatments

VITALtalk, http://www.vitaltalk.org/clinicians/establish-rapport

Common Barriers to Communication of Serious News

- **Assuming:**
  - Cure is the goal of all patients
  - What information the patient/family knows or does not know
  - What information the patient/family wants to know or does not want to know
  - What is important to the patient and/or family
- **Talking too much/listening too little**
- **Ignoring your own feelings or those of the patient and/or family**
- **Not understanding cultural differences**

VITALtalk, http://www.vitaltalk.org/clinicians/establish-rapport

Conversations and Recommendations: REMAP Mnemonic for Goals of Care Discussion

- **Review** cancer stage and prognosis

  Review for initial goals of care discussion

OR

- **Reframe** why the status quo is not working and redefine goals of care as needed

  Reframe if the patient is physically deteriorating or there has been a progression as well as when the goals of care may need revisiting
- **Expect** emotion and empathize
- **Map** the future
- **Align** with the patient's values
- **Plan** medical treatments that match these values

Remember, conversations should flow naturally.

This mnemonic is not meant to be followed letter by letter in a specific order, but to be used as guidance on what to include in a goals of care conversation. The conversation should remain fluid, meeting the needs of all participants.

Adapted from VITALtalk, http://www.vitaltalk.org/sites/default/files/quick-guides/REMAPforVitaltalkV1.0.pdf

REMAP – "R"

Review cancer stage and prognosis.

Have a conversation with the patient about their disease and stage, taking into consideration what the patient knows and wants to know. Keep in mind, some patients may not want to know everything.

- "Can you tell me what you know about your cancer?"
- "What are your expectations about your treatment/care?"
- "What are your personal goals?"

Adapted from VITALtalk, http://www.vitaltalk.org/sites/default/files/quick-guides/REMAPforVitaltalkV1.0.pdf

REMAP – “R”

Reframe why the status quo is not working.

Examples of how to start a discussion about bad news such as an unfavorable scan, progression of disease, or change in prognosis:

- “We’re in a different place now.”
- “Things aren’t going as I would have hoped.”
- “Given this news, it seems like a good time to talk about what is next.”

VITALtalk, http://www.vitaltalk.org/sites/default/files/quick-guides/REMAPforVitaltalkV1.0.pdf

REMAP – “E”

Expect emotion & empathize.

How to address an emotional response with empathy:

- “This must be pretty hard to hear/accept.”
- “Tell me what you are most worried about.”
- “I can see you are really concerned about ______.”
- “Is it OK for us to talk about what this means?”

VITALtalk, http://www.vitaltalk.org/sites/default/files/quick-guides/REMAPforVitaltalkV1.0.pdf

REMAP – “M”

Map the future.

How to start a discussion about the future:

- “Given this information, what is most important for you?”
- “When you think about the future, what are the things you want to do?”
- “As you think of the future, what concerns you?”

VITALtalk, http://www.vitaltalk.org/sites/default/files/quick-guides/REMAPforVitaltalkV1.0.pdf

REMAP – “A”

Align with the patient’s values.

How to acknowledge and address the patient’s values:

- “As I listen to you, it sounds like the most important things are {X,Y}. Does that sound right?”
- “Let’s look at the best way to plan your care to meet those goals.”

VITALtalk, http://www.vitaltalk.org/sites/default/files/quick-guides/REMAPforVitaltalkV1.0.pdf

REMAP – “P”

Plan medical treatments that match the patient’s values.

How to acknowledge and address the patient’s values:

- “Here’s what we can do now to help you do those important things:
  - ○ *Detail plan A*
  - ○ *Detail plan B*
  - ○ *Detail plan C*

  What do you think?”

Expect questions about more anti-cancer treatment.

- “My experience tells me that more chemotherapy or surgery would do more harm than good at this point.”

VITALtalk, http://www.vitaltalk.org/sites/default/files/quick-guides/REMAPforVitaltalkV1.0.pdf

Hospice Referral

- **Hospice care should be mentioned early in goals of care conversations, long before this level of care is needed.**
  - Early discussions can assist more timely hospice enrollment and may improve satisfaction with end-of-life care.
- **When there is reason for a hospice referral:**
  - Discuss the concept fully and robustly before introducing the actual word "hospice"
    - Confirm the patient's understanding of their disease and prognosis
    - Adding "I wish" can be helpful

      "I wish there were other curative options, but at this time, there are none"
    - Asking the patient to communicate their worries or concerns
    - Discuss what care may be needed in the near future

      "We've talked about wanting to conserve your energy for important things. One thing that can help us is having a nurse come to your home to adjust your medications so you don't have to come in to clinic so often.
  - The overall aim is to discuss a patient's goals of care, revising as needed, then present hospice as a means to achieve those goals.

See also Palliative Training Module #7, Reasons to refer to Hospice and Palliative Care

VITALtalk, http://www.vitaltalk.org/sites/default/files/quick-guides/REMAPforVitaltalkV1.0.pdf; Casarett 2005; Casarett 2009.

Summary of Points Covered

- Defining goals of care
- Understanding the methods and questions to use when tailoring goals of care conversations and recommendations to a patient's individual wishes and preferences
- Broaching the how and when of hospice care within a goals of care discussion

Next Steps

For more detailed training on this topic, you can go to the following resources:

National Comprehensive Cancer Network® (NCCN®)

- **NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) Palliative Care Version 1.2018**
  http://www.nccn.org/professionals/physician_gls/PDF/palliative.pdf

VITALtalk

- **Vitaltalk: Training oncologists to be better communicators: honest, hopeful, empathic—online and f2f**
  - **www.vitaltalk.org**
  - **www.vitaltalkconversations.com**

Education and Training for Health Professionals, EPEC-O

- **EPEC,** Education in Palliative and End-of-Life Care
  http://www.epec.net/example-EPEC-materials.php
- **EPEC™-O-Self-Study**
  http://www.cancer.gov/resources-for/hp/education/epeco

ONCOTALK®

- **ONCOTALK®**
  http://depts.washington.edu/oncotalk/

Faculty Bio for Megan McMahon, Ph.D.

Dr. McMahon has a Ph.D. in Clinical Psychology with an emphasis in health and behavioral medicine. Her specialty is working with couples who are coping with chronic illness. In 2003 Dr. McMahon developed the program Partners Empowered™, a six-week structured intervention aimed at facilitating adjustment and softening the impact a cancer diagnosis has on a couple's relationship. In 2011, Dr. McMahon was named the Cancer Wellness Center Clinical Director.

For additional information:
https://cancerwellness.org/about/our-staff/

Faculty Bio for Lauren Wiebe, MD

Dr. Lauren Wiebe attended medical school at the Columbia University College of Physicians and Surgeons, then she completed an Internal Medicine residency and fellowship in Medical Oncology, both at the University of Chicago. She completed additional fellowship training in Clinical Medical Ethics at the MacLean Center, and Hospice and Palliative Medicine at Northwestern University.

Dr. Wiebe joined the faculty practice at NorthShore University HealthSystem in January 2017 with dual appointments in Palliative Medicine and Gastrointestinal Medical Oncology. She specializes in the treatment of gastrointestinal cancers with a focus on improving quality of life.

For additional information:

https://www.northshore.org/apps/findadoctor/physicians/lauren-a.-wiebe?oqs=doctor%3dwiebe

https://www.linkedin.com/in/lauren-wiebe-7b5aba2/

Faculty Bio for Betty Roggenkamp, BA

Ms. Roggenkamp has over 8 years of experience in cancer care improvement, through multiple projects in the Chicagoland area. Betty is a facilitator for the Coleman Supportive Oncology Initiative (CSOI) providing project coordination for the Palliative and Hospice design team. Ms. Roggenkamp has facilitated cancer survivor workshops and group discussions to generate areas of need in cancer care. She is also involved with several care initiation projects and cancer survivorship plan creation. Ms. Roggenkamp has Collaborative Institutional Training Initiative (CITI program) certification in human subjects research.

Betty consulted prior to 2010 as an architectural project coordinator for 10 years including planning, design and construction coordination. She also co-lead a team consisting of community, staff, elected officials and Chicago Public School (CPS) executives in an academic turn around of a CPS School that included an addition of a new building, doubled enrollment, increased test scores and improved community relations.

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Back A, Tulsky J, Arnold RM. (2009) *Mastering communication with seriously ill patients*. Cambridge, UK: Cambridge University Press.

Back AL, Arnold RM, Baile WF et al. When praise is worth considering in a difficult conversation. Lancet 2010 Sept 11; 376:866-7.

Back AL, Arnold RM. Discussing Prognosis: "How Much Do You Want to Know?" Talking to Patients Who Are Prepared for Explicit Information. J Clin Oncol. 2006;24:4209-13.

Back A, Tulsky J, Arnold RM. (2009) *Mastering communication with seriously ill patients*. Cambridge, UK: Cambridge University Press.

Back AL, Trinidad SB, Hopely EK, Edwards KA. Reframing the goals of care conversation: “We’re in a different place.” J Palliat Med 2014 Sept 17(9):1019-1024.

Baile WF, Buckman R, Lenzi R et al. “SPIKES-A six-step protocol for delivering bad news: Application to the patient with cancer.” Oncologist 2000; 5:302-11.

Casarett D, Karlawish J, Morales K, Crowley R, Mirsch T, Asch DA. Improving the use of hospice services in nursing homes: a randomized controlled trial. JAMA. 2005; 294:211-7.

Casarett DJ, Quill TE. “I’m Not Ready for Hospice”: Strategies for Timely and Effective Hospice Discussions. Ann Intern Med. 2007; 146(6):443-449.

LeBlanc, T.W., Duke University School of Medicine, Duke Cancer Institute, Evidence-based Communication Strategies for Discussions at End of Life, 2015 ASCO Annual Meeting

Quill TE. “I wish this were different: expressing wishes in response to loss, futility and unrealistic hopes.” Ann Intern Med 2001; 135(7):551-5.

Quill TE. “Recognizing and adjusting to barriers in doctor-patient communication.” Ann Intern Med, 1989; 111(1):51-7.

VITALtalk. http://vitaltalk.org/. Accessed January 22, 2016.

You JJ, Downar J, Fowler RA, et al. on behalf of the Canadian Researchers at the End of Life Network (carenet) Barriers to goals of care discussions with seriously ill hospitalized patients and their families: a multicenter survey of clinicians. JAMA Intern Med. 2015;175:549–56.

Coleman Supportive Oncology Initiative

Palliative Training Module

Topic: **Advance Care Planning Over Time**

Presenters: Amy Scheu, MSH CHPCA and Catherine Deamant, MD

Version: 08282018

Learning Objectives

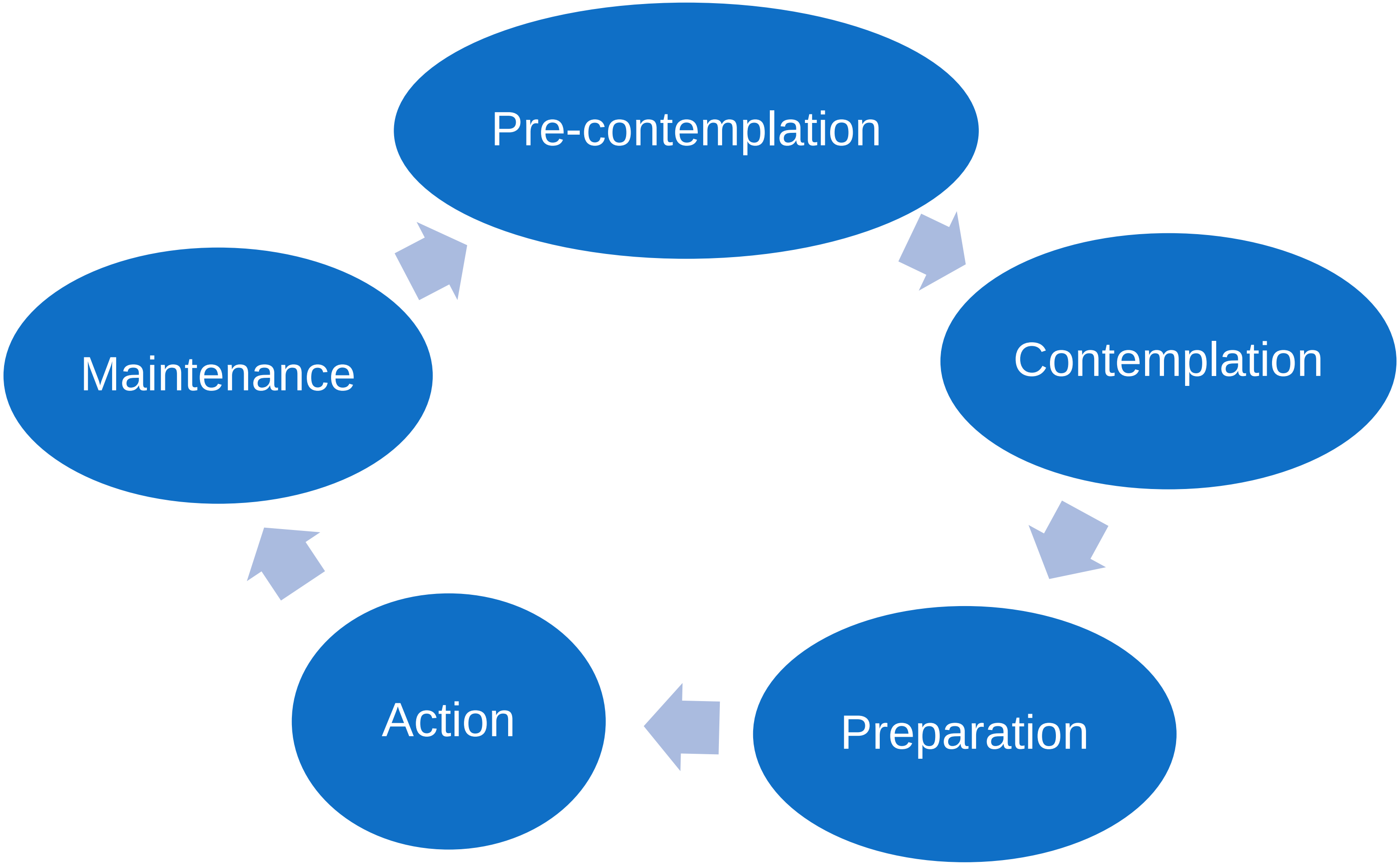
By the end of this module you should be able to:

1. **Explain the components of an advance care planning discussion tailored to stages of health**
2. **Describe the elements of an advance care plan based on a model of stages of change for health behaviors**

Paradigm Shift: Advance Care Planning

- **Paradigm shifts from a legal process to a communication process.**
- **Discussion should be tailored to patient readiness and stage of health.**
  - Content and specifics should be targeted based on the patient’s clinical condition.
- **Advance care planning is a process over time, not a form.**

Model: Stages of Change for Health Care Behaviors



Pre-contemplation

Contemplation

Preparation

Action

Maintenance

Proschaska JO, Velicer WF, et al. Stages of Change and Decisional Balance for 12 Problem Behaviors. Health Psychology 1994;13(1):39-46.
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Advance Care Planning:
Based on Model of Behavior Change

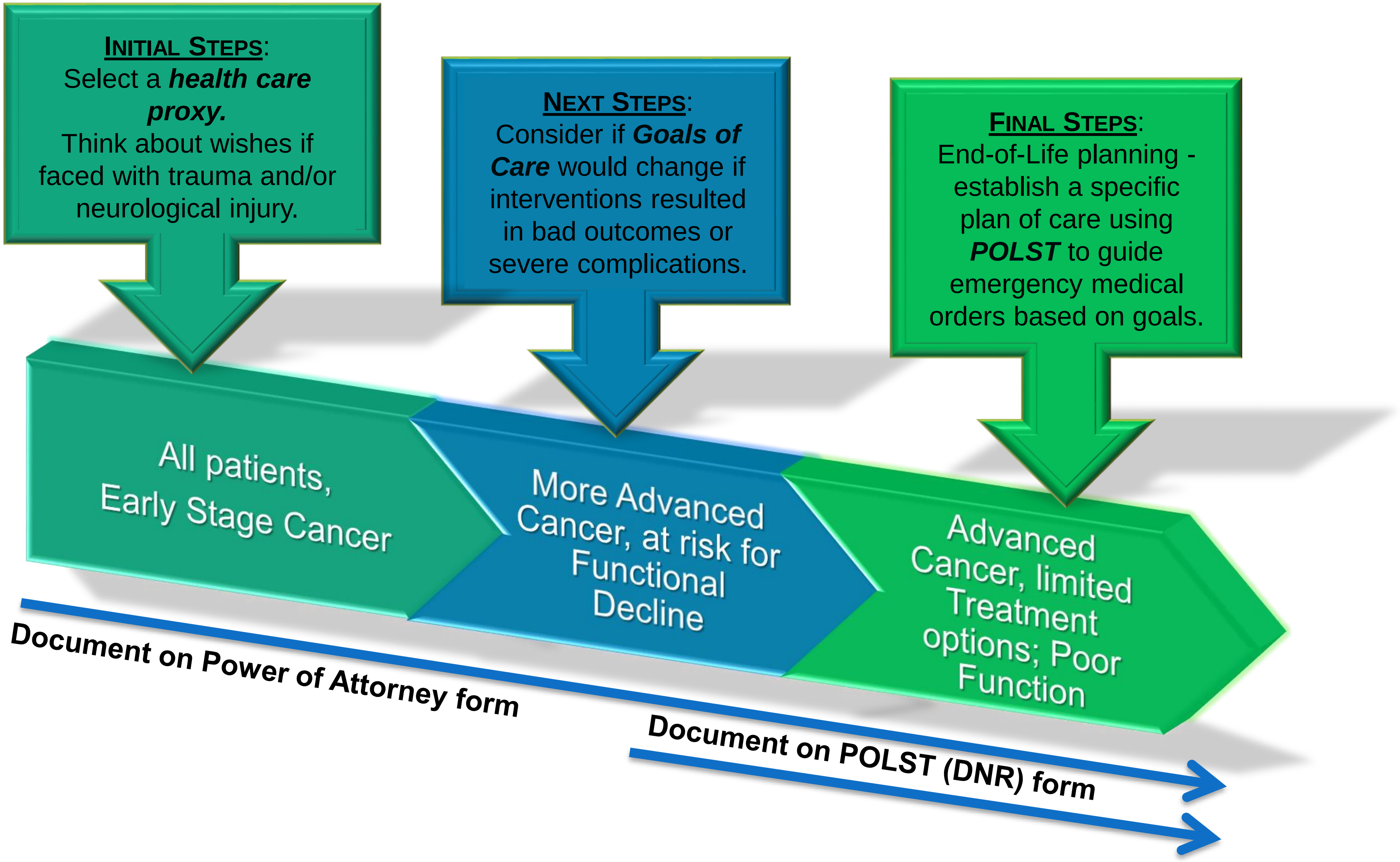
- **Contemplation/Awareness**
  - Determine patient familiarity with advance care planning
  - Make the patient aware of the need for this plan
- **Preparation**
  - Educate and motivate the patient
  - Reflect on the patient’s situation
  - Explore patient values and priorities
- **Taking Action**
  - Discussion with a proxy (family or friends)
  - The provider and the patient talk, plan and document
  - A proxy present for discussion
  - Advanced care planning is completed over time
- **Maintenance**
  - Review and revise with changes in condition

Jour Clin Ethics 1996;7(3):205-213

Advance Care Planning: Elements of Conversation

- **Identify an appropriate health care proxy**
- **Elicit the patient's understanding of their illness and assess prognostic awareness**
- **Explore prior experiences with serious illness**
- **Explore understanding of treatment options and impact**
- **Explore what is most important to the patient in the context of their values**
- **Identify priorities and trade-offs**

Advance Care Planning Over Time



<u>INITIAL STEPS</u>:
Select a ***health care proxy.***
Think about wishes if faced with trauma and/or neurological injury.

<u>NEXT STEPS</u>:
Consider if ***Goals of Care*** would change if interventions resulted in bad outcomes or severe complications.

<u>FINAL STEPS</u>:
End-of-Life planning - establish a specific plan of care using ***POLST*** to guide emergency medical orders based on goals.

All patients,
Early Stage Cancer

More Advanced Cancer, at risk for Functional Decline

Advanced Cancer, limited Treatment options; Poor Function

Document on Power of Attorney form

Document on POLST (DNR) form

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Health Status-Early Stage Cancer (1 of 2)

- **Assist in identifying a health care proxy**
  - “If you were too sick to speak with me, is there anyone you trust to make medical decisions for you? Have you talked with this person about what is important?”
- **Explore the patient’s goals and values for medical care**
  - Wishes about care if the patient experienced an unanticipated event, such as traumatic injury or complications, and unlikely to recover
- **Explore specific or personal beliefs that may influence decision-making**

Jour Clin Ethics 1996; 7(3):205-213

Health Status-Early Stage Cancer (2 of 2)

Action Items:

- May complete Power of Attorney for Health Care form
- Discuss with the identified health care proxy to determine their willingness to serve as agent
- The patient reviews their values with the health care proxy

Health Status-Progression of Cancer: At Risk for Functional Decline (1 of 5)

Explore the patient's understanding of their illness and potential complications

- "What is your understanding of your illness?"
- "How has your illness affected your life?"
- "What have you been told about the possible complications that can occur from your illness or the treatment?"
- "How much information would you like to know about what may transpire/happen during the course of your illness?"

J Gen Intern Med 2012;27(11):1460-6.
JAMA Intern Med. 2014:174(12):1994-2003.

Health Status-Progression of Cancer: At Risk for Functional Decline (2 of 5)

Explore prior experiences:

- “Have you had experiences with yourself or family or friends who became seriously ill and decisions about life-sustaining treatment had to be made?”
- “What did you learn from those experiences?”
- “When you were in the hospital recently, what was that experience like for you?”

Patient Educ Couns 1995; 26:353-36.
J Am Geriatr Soc. 2014 July ; 62(7): 1304–1309.

Health Status-Progression of Cancer: At Risk for Functional Decline (3 of 5)

Cultivate prognostic awareness

- “What is your sense of what the future holds?”
- “What is your sense of what is happening now?”
- “What has your team told you about your illness and what to expect?”
- “Have you ever had times when you think about what it might be like if you get sicker?”

J Palliat Med 2013;16(8):894-900.

Health Status-Progression of Cancer: At Risk for Functional Decline (4 of 5)

- **Explore the patient's goals, fears and worries:**
  - "If your health situation worsens, what are your most important goals or desires?"
  - "What are your biggest fears and worries about the future in terms of your health?"
- **Identify the patient's priorities for function and possible trade-offs:**
  - "What abilities are so critical to your life that you can't imagine living without them?"
  - "What side effects are you willing to experience as you undergo treatment?"
  - "If you become sicker, how much are you willing to go through for the possibility of gaining more time?"
  - "How much does your family know about your priorities and wishes?"
  - Offer to meet with the health care proxy or family

JAMA Intern Med 2014;174(12):1994-2003

Health Status-Progression of Cancer: At Risk for Functional Decline (5 of 5)

Action Items:

- Identify a health care proxy and complete the Power of Attorney form, if not previously done
- Remember to respect the patient’s information preferences, i.e., the way the patient prefers to hear and receive information from a medical team member.
- Schedule a meeting with the health care proxy or family based on the patient’s preference for information-sharing

Health Status-Advanced Cancer: Limited treatment Options and Functional Decline (1 of 3)

- **Explore the patient's understanding of their illness and complications**
- **Explore the patient's prior experiences**
- **Advance the patient's prognostic awareness**
  - "How much do you want to know about the likely course of this illness?"
  - Assess patient readiness: "Would it be important for you to have information about how much time you might expect to live?"
  - "What kind of information do you want about the future?" (e.g., average time to live, best/worse case scenario, functional decline)

J Palliat Med 2013;16(8):894-899.
J Clin Onc 2006;24(25):4209-4213.

Health Status-Advanced Cancer: Limited treatment Options and Functional Decline (2 of 3)

Provide support and guide communication if making recommendations for comfort care

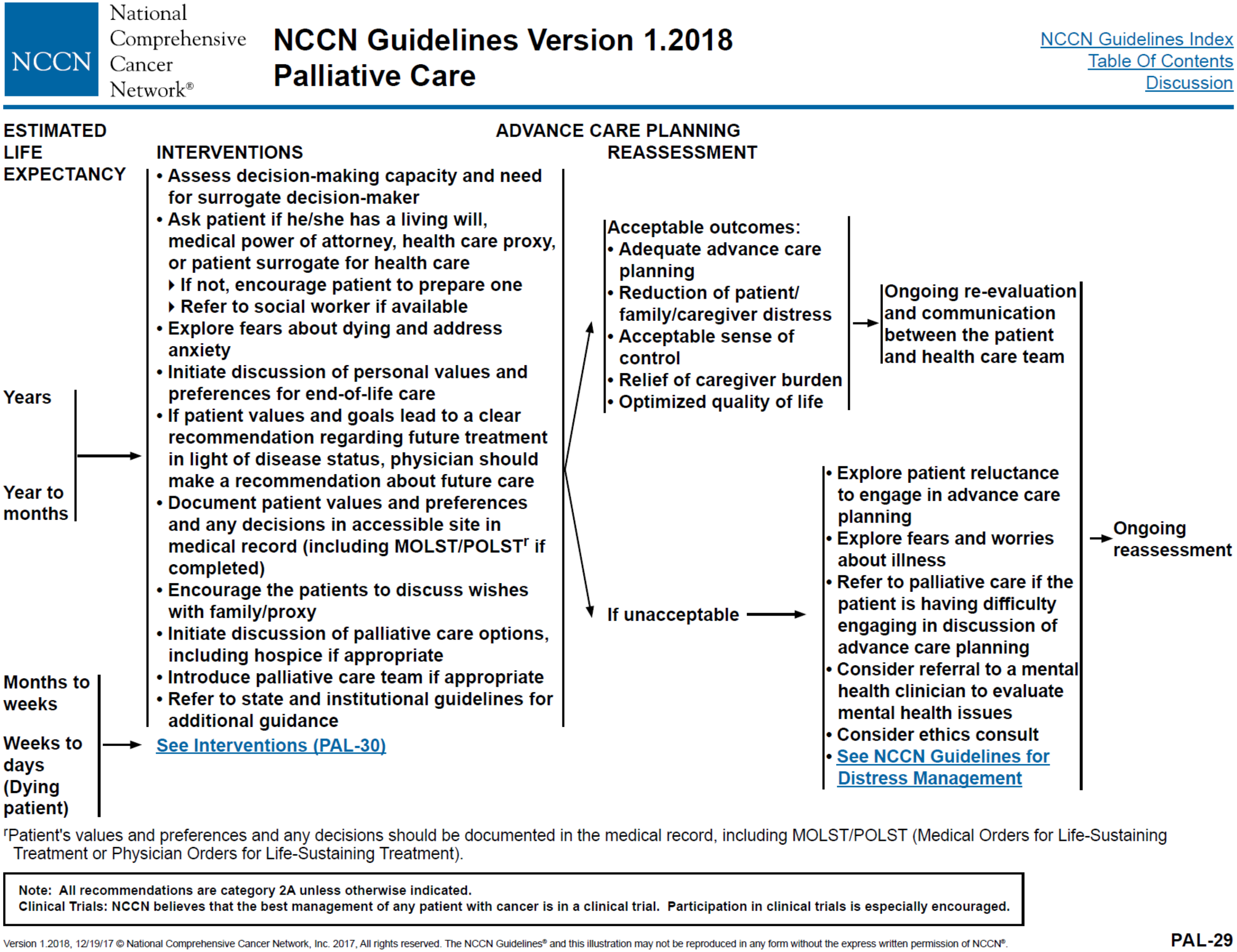
- “Tell me what you are most worried about.”
- “What are you hoping for?”
- “What is most important to you about how you spend your time?”
- “Who is a support in your life?”
- “How do you define quality of life?"
- Offer hospice as an option of support for patients when their goals are for comfort, or when there are limited treatment options or poor functional capacity

Health Status-Advanced Cancer:
Limited treatment Options and Functional Decline (3 of 3)

Action Items:

- Identify a health care proxy and complete a Power of Attorney form, if not previously done
- Establish a plan for care and a framework for addressing patient wishes about life-sustaining treatment decisions (e.g., CPR, intubation, selected interventions, comfort care, artificial nutrition)
- Complete the POLST (Physician Orders for Life-Sustaining Treatment) based on patient goals (see training course, POLST)
- Prepare the patient, family and staff for possible course of functional decline

NCCN Guidelines: Advance Care Planning



National Comprehensive Cancer Network®

NCCN Guidelines Version 1.2018
Palliative Care

NCCN Guidelines Index
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Discussion

ADVANCE CARE PLANNING

ESTIMATED LIFE EXPECTANCY

Years

Year to months

→

INTERVENTIONS

- Assess decision-making capacity and need for surrogate decision-maker
- Ask patient if he/she has a living will, medical power of attorney, health care proxy, or patient surrogate for health care
  - If not, encourage patient to prepare one
  - Refer to social worker if available
- Explore fears about dying and address anxiety
- Initiate discussion of personal values and preferences for end-of-life care
- If patient values and goals lead to a clear recommendation regarding future treatment in light of disease status, physician should make a recommendation about future care
- Document patient values and preferences and any decisions in accessible site in medical record (including MOLST/POLST[r] if completed)
- Encourage the patients to discuss wishes with family/proxy
- Initiate discussion of palliative care options, including hospice if appropriate
- Introduce palliative care team if appropriate
- Refer to state and institutional guidelines for additional guidance

REASSESSMENT

Acceptable outcomes:
- Adequate advance care planning
- Reduction of patient/family/caregiver distress
- Acceptable sense of control
- Relief of caregiver burden
- Optimized quality of life

→ Ongoing re-evaluation and communication between the patient and health care team

If unacceptable →
- Explore patient reluctance to engage in advance care planning
- Explore fears and worries about illness
- Refer to palliative care if the patient is having difficulty engaging in discussion of advance care planning
- Consider referral to a mental health clinician to evaluate mental health issues
- Consider ethics consult
- See NCCN Guidelines for Distress Management

→ Ongoing reassessment

Months to weeks

Weeks to days (Dying patient) → See Interventions (PAL-30)

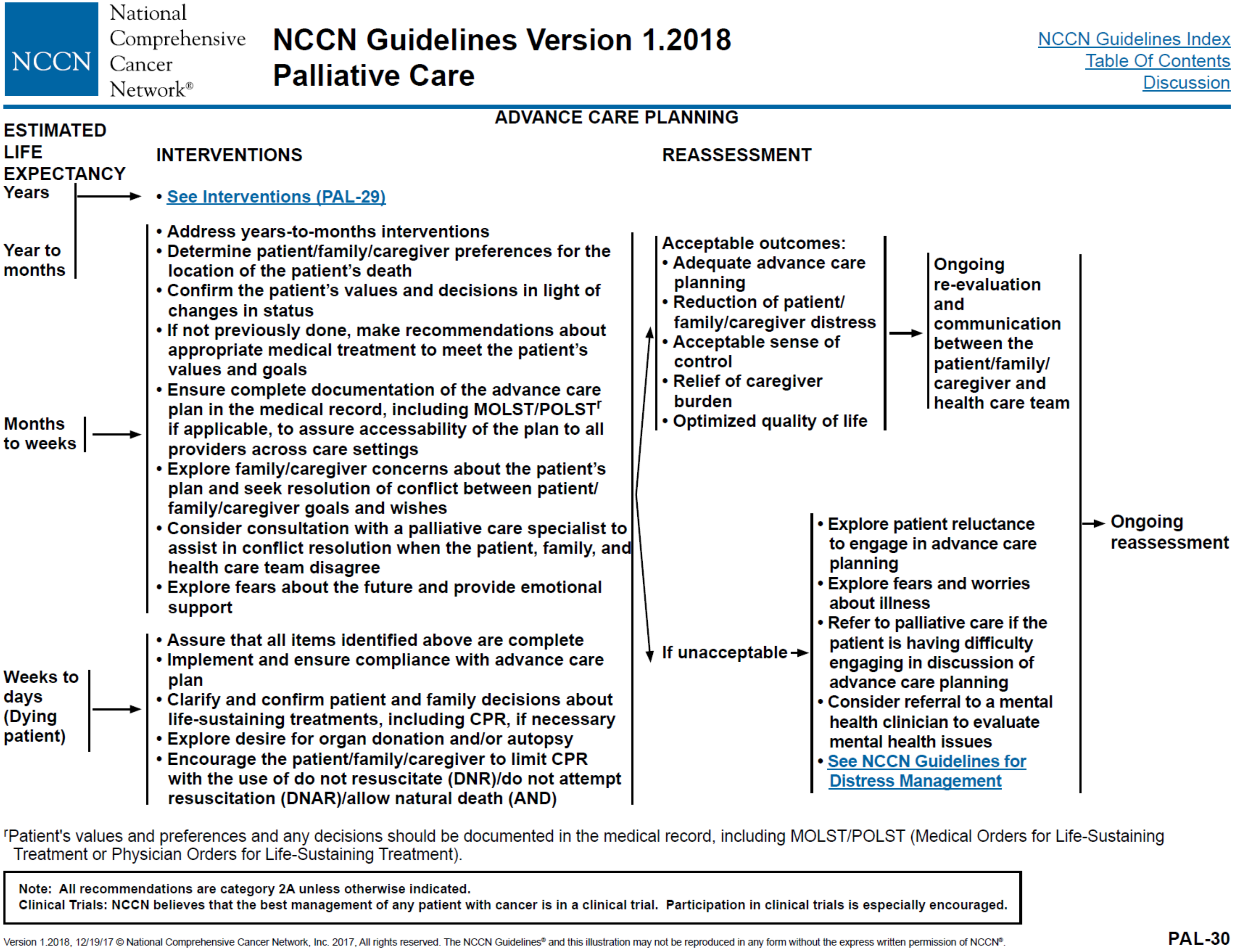
[r] Patient's values and preferences and any decisions should be documented in the medical record, including MOLST/POLST (Medical Orders for Life-Sustaining Treatment or Physician Orders for Life-Sustaining Treatment).

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

PAL-29

The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) Palliative Care (Version 1.2018). © 2018 National Comprehensive Cancer Network, Inc. Available at: NCCN.org. Accessed August 28, 2018. To view the most recent and complete version of the NCCN Guidelines®, go online to NCCN.org.

NCCN Guidelines: Advance Care Planning



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Palliative Care

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ADVANCE CARE PLANNING

ESTIMATED LIFE EXPECTANCY | **INTERVENTIONS** | **REASSESSMENT**

Years →
- See Interventions (PAL-29)

Year to months
- Address years-to-months interventions
- Determine patient/family/caregiver preferences for the location of the patient's death
- Confirm the patient's values and decisions in light of changes in status
- If not previously done, make recommendations about appropriate medical treatment to meet the patient's values and goals

Months to weeks →
- Ensure complete documentation of the advance care plan in the medical record, including MOLST/POLST[r] if applicable, to assure accessability of the plan to all providers across care settings
- Explore family/caregiver concerns about the patient's plan and seek resolution of conflict between patient/family/caregiver goals and wishes
- Consider consultation with a palliative care specialist to assist in conflict resolution when the patient, family, and health care team disagree
- Explore fears about the future and provide emotional support

Weeks to days (Dying patient) →
- Assure that all items identified above are complete
- Implement and ensure compliance with advance care plan
- Clarify and confirm patient and family decisions about life-sustaining treatments, including CPR, if necessary
- Explore desire for organ donation and/or autopsy
- Encourage the patient/family/caregiver to limit CPR with the use of do not resuscitate (DNR)/do not attempt resuscitation (DNAR)/allow natural death (AND)

Acceptable outcomes:
- Adequate advance care planning
- Reduction of patient/family/caregiver distress
- Acceptable sense of control
- Relief of caregiver burden
- Optimized quality of life

→ Ongoing re-evaluation and communication between the patient/family/caregiver and health care team

If unacceptable →
- Explore patient reluctance to engage in advance care planning
- Explore fears and worries about illness
- Refer to palliative care if the patient is having difficulty engaging in discussion of advance care planning
- Consider referral to a mental health clinician to evaluate mental health issues
- See NCCN Guidelines for Distress Management

→ Ongoing reassessment

[r] Patient's values and preferences and any decisions should be documented in the medical record, including MOLST/POLST (Medical Orders for Life-Sustaining Treatment or Physician Orders for Life-Sustaining Treatment).

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

PAL-30

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Summary of Points Covered

In this training module we addressed:

- **Advance care planning is a process over time.**
- **It should be discussed with all patients and tailored to their health status.**
- **Completion of an advance directive, such as a POA form, is relevant for ALL patients and does not mean the patient is a DNR.**

Next Steps

For more detailed training on this topic, you can go to the following resources:

- **Gundersen Health System®, Respecting Choices® Advance Care Planning**
  http://www.gundersenhealth.org/respecting-choices
- **Ariadne Labs, Serious Illness Care**
  https://www.ariadnelabs.org/programs/serious-illness-care/
- **EPEC®, Education in Palliatve and End-of-life Care**
  http://www.epec.net/
- **PREPARE, Patient education website tool**
  https://www.prepareforyourcare.org/

National Comprehensive Cancer Network® (NCCN®)

- **NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) Palliative Care**
  http://www.nccn.org/professionals/physician_gls/PDF/palliative.pdf

Faculty Bio for Amy Scheu, MSH, CHPCA

Amy Scheu, MSH, CHPCA, joined Advocate at Home, the home care division of Advocate Health Care, in 2007 and currently serves as Administrator of Advocate Hospice and System Palliative Care. In this role, she has led implementation and operations of hospice programs across the Chicago area and central Illinois that serve more than 2,200 patients annually. In 2010, Amy was asked to lead efforts to further assure care across the continuum by designing and implementing a system wide palliative care program for Advocate Health Care. Through her efforts, Advocate has launched successful home- and skilled nursing facility-based programs; established four outpatient clinics serving patients in the south, west and north areas of the city and suburbs; and expanded inpatient palliative care services at several hospitals. Amy has also been instrumental in initiating physician palliative medicine education efforts through Advocate Physician Partners, Advocate Health Care's PHO. She has also worked with Advocate Medical Group to secure funding and implement a palliative care pilot serving Medicare Advantage patients on Chicago's south side.

Amy has been certified as a hospice and palliative care administrator by the National Hospice and Palliative Care Organization. She received her bachelor of arts degree from Marquette University and a master's degree in health services administration from Cardinal Stritch University, Milwaukee. She also has a certificate from Harvard School of Public Health in Healthcare Project Management.

Faculty Bio for Catherine Deamant, MD

Catherine Deamant , MD, graduated from Rush Medical College and completed her internal medicine residency at Michael Reese Hospital in Chicago, IL. From 1990-2014, she worked as a general internist in the Division of General Internal Medicine at Cook County Health and Hospitals System (CCHHS), with a focus on HIV care and homeless healthcare. In 2001, she established the Palliative Care Program for CCHHS.

From 2012-2014, she served as the Program Director for the Hospice and Palliative Medicine Fellowship, in collaboration with Rush University Medical Center and Horizon Hospice. She was an assistant professor at Rush Medical College.

She is board certified in hospice and palliative medicine. Currently, she is an associate hospice medical director for JourneyCare.

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