Case Study: Mr. James Lee

Mr. James Lee is a 74 yr old retired electrician. He is married to Mary with two children in their 30's. They have been in Canada for 35 years and are fluent in English and Cantonese. James has a history of COPD, hypertension and was diagnosed with Prostate cancer 6 yrs ago (at age 68 yrs); he had an enlarged prostate identified by you (GP) during a routine physical. Subsequent investigations revealed diagnosis of prostate cancer with locally advanced disease with no distant metastasis. He was treated with surgery & radiation. Mr. Lee was followed by both an urologist and a radiation oncologist and maintained on hormone therapy; he had no symptoms and felt well, enabling him to travel and play golf. His COPD has been managed in a shared care manner with a respirologist. Every Fall you have undertaken a review of his COPD Action plan and this has kept him fairly stable. **(GP Billing code: 14053 for COPD CDM)**

Last year, (5 yrs after the original diagnosis) James indicated that he was having pain in his back and shoulder. He thought it was golf related so he had it for several months before he commented to you about the pain. You started the patient on an NSAID and arranged for an X-ray; the X-ray showed a sclerotic lesion in the scapula. You discussed with the patient the significance of this finding and arranged an urgent review by the radiation oncologist. As a result of delay in the appointment with the radiation oncologist, you also arranged for a bone scan which revealed more bone metastasis. The radiation oncologist organized radiation for pain relief and coordinated changes in hormone therapy; the radiation relieved the pain initially. **(GP Billing codes: 17100 for each office visit)**

Today (Transition One)

James has come to see you because he has more pain in his back. When you see him today, he looks tired, pale, and uncomfortable. His wife Mary has accompanied him to the office and reports he is not sleeping well due to pain and he has lost a little weight. **(GP Billing code: 17100)**

You recognize that James is moving to a different stage in the illness and you wonder if he and his wife recognize this shift as well. You prescribe more analgesia, (the NSAID and moderate level opioid), and plan to contact the radiation oncologist with a non-urgent telephone advice request before your next appointment with James which is to take place in 2 weeks. You fax off your request to the oncologist and he calls within 3 days with advice on some interim management and development of a plan to manage his symptoms. You then communicate this information to James by phone to follow up with the recommendations. Total time for GP conferencing with oncologist, developing a plan and then advising James is 20 minutes**.**

(GP billing codes: 17100 for office visit & 14016 for Community Patient Conferencing X 1 unit; Oncologist billing code: 10002)

At this next appointment, you have a conversation with James and Mary. They report the pain is better controlled; they recognize that pain control is a problem related to bone metastasis, but they are not aware that prostate cancer can progress to the extent that the bone involvement can be life threatening. You convey that information and encourage the patient and his wife to think about future wishes regarding his health care. You confirm that his goals of care at present are to be as comfortable and as active as possible for as long as possible.
(GP Billing code: 17100)

Question
How might you initiate the conversation about the possible disease trajectories for prostate cancer?

Following this appointment, you flag James for the MOA to add to your registry of patients who are possibly moving to the last year of life. You ask the MOA to arrange the next appointment to be longer so that you can initiate Advance Care Planning. You also ask the MOA to complete an ESAS with Mr. Lee at the next appointment and if pain is still a problem you plan to initiate a pain diary. The MOA can support the patient in completing this diary. Breathlessness is a problem, but James doesn't feel at this point that he wants to think about oxygen. At the next appointment, you discuss the Advance Care Plan and undertake counseling James on the outlook of his prognosis and his related anxieties – 25 min counseling visit.
(GP Billing code: 17120 for Office counselling)

Question
In addition to the advance care planning document, how would you introduce the idea of the No CPR document?

Six months pass (Transition Two)
James continued with analgesics and hormone therapy; but he is now become refractory to hormone therapy; there is now evidence of extensive bone marrow infiltration with pancytopenia. Breathlessness has become an increasing problem with some ankle swelling. There is concern that, as well as the anaemia contributing to this, he may also have a degree of cor pulmonale. James is feeling quite poorly, he is wondering if going to the hospital would be appropriate. You decide to urgently consult his respirologist on options for management in the community. The respirologist calls you within 20 minutes and you discuss the patient's current status. You undertake his advice for treatment to keep him at home, and the respirologist agrees he will see Mr. Lee on one of his upcoming transfusion days. There is little

more to do, but the family feels supported and James is comfortable with not being admitted to the hospital at this time.
(GP billing codes: 17100 for visit & 14018 for Urgent (<2hr) Telephone advice from Spec/GP with spec training; Respirologist billing code: 10001 for the urgent telephone advice)

James requires more analgesics & bisphosphonates for bone pain. You initiate morphine. The MOA is now doing an ESAS routinely at his appointments; breathlessness, constipation, tiredness, and reduced appetite are identified as

symptoms. PPS is now about 50 %.; there is quite a change in James's life style. No longer golfing due to pain and dyspnea, he limits trips to local excursions due to discomfort and anxiety about travelling too far from home. **(GP Billing codes: 17100 for office visits)** You are contacted by Raymond, James's elder son, whom you have known for years. Raymond wants to know if you are aware of his father's pain and his mother's anxiety, and "what is happening to my father". They now question whether there is a need for oxygen therapy. You arrange a meeting with the son to discuss his concerns. You undertake counseling with him that takes 30 minutes.
(GP billing would be for the son, who is 39: 00120 for Office counselling)

Questions

What resources do you have to assist with prescribing the appropriate medications for pain management? What is the medical management of dyspnea?

Over a weekend when you are not on call, there is a decline in James's breathlessness, he is experiencing increased coughing and he is confused. The family members are distraught and dial 911. Mr. Lee is taken to hospital and found to be in respiratory failure. He is seen by the respirologist on call in consultation. There is a discussion about intubation and ventilation but there is resistance to this initially in the family and so non-invasive respiratory support is offered. James remains in hospital 5 days and is then stable enough for discharge after his pneumonia is treated. A 30 minute discharge planning care conference is held on Day 4 with you, the respirologist, nursing and respiratory staff and arrangements are made for increased home support. You have been providing MRP care daily to James, who has been your first patient each day. The respirologist has provided supportive care and is available to you for assistance when needed.
(GP Billing: 13008 for daily MRP care (Hospital acute care visit) plus 13338 for first visit bonus X 5 days plus 14017 for Discharge Planning care conference X 2 units on day 4; Specialist billing: 32010 for consultation plus 32006 for supportive care X 2 plus GXXXXX for Discharge Planning care conference fee on day 4)

The family is shaken by this episode, but James seems to have become "philosophical" about this turn of events. He is clear he never wants to be intubated.

Question

What does a "Sentinel event" mean? How would you approach discussion about the level of respiratory intervention with your patient? How would you record James's clear preference about intubation in your chart and ensure it is passed onto hospital staff?

James is now ready for referral to BC Palliative Care Benefits Plan and a Home Care referral for assessment of the home. Prior to initiating either of these referrals, you have a conversation with James and his wife and Raymond regarding illness progression. You indicate that you are not certain of his actual life expectancy, but you need to set up a safety net for them as his prognosis could possibly be months. You also complete the BC Palliative Care Benefits Plan referral and the No CPR form during this visit. This conversation fulfills the requirement for the palliative care planning fee. **(GP Billing: 14063 for Palliative Care Planning Fee & 17100)**

Question

Where do you find information about the BC Palliative Care Benefits Program? How might you introduce this program?

Following this conversation, you make the Home Care referral. After the Home Care nurse has visited the patient, she contacts you to discuss the likely trajectory and anticipated events. You and the nurse discuss the care plan, agree on channels of communication and ensure the MOA is aware of these priority arrangements. Total time 15 minutes **(GP Billing: 14016 for Community Patient Conferencing X 1 unit)**

Question

At the same time that you initiate the Home Care referral, you also register the patient with your local palliative care program; how would this registration take place in your community? What palliative care resources would be available through the program to support the GP in providing care in the home?

Two months later (Transition Three)

Mr. Lee is now dependent on transfusions but he is finding the trips to the cancer agency to receive the transfusions quite burdensome (his PPS is 30). Although you are aware that James had expressed his desire to remain at home as long as possible, the home care nurse is concerned the family is feeling very burdened with the situation. You decide to do a joint visit with the Home Care Nurse and assess their current goals of care and capacity to remain at home. Following the visit, you and the Home Care Nurse review and revise the plan of management based on input

from James and his family. Total 20 minute conferencing time. **(GP Billing: 14016 for Community Patient Conferencing & 00103 for House Call; 1x200 for Additional pts seen at house call)**

Based on this conversation, the family (patient, wife and adult children) now understand where Mr. Lee is on his illness journey and feel that they can commit as a family to continue caring for James at home for the time being. The next day, James's son speaks with you on the phone about his decision to stop the transfusions. **(GP Billing: 14069 for Palliative Care Telephone/E-mail Follow-up Management Fee)** The Home Care Nurse arranges for increased home support & appropriate equipment. The Home Care nurse agrees to call you at least weekly

regarding the situation and you decide to visit every couple of weeks. Plans are made for an expected death at home. **(GP Billing: 13005 for each call from home care nurse (Simple Advice to AHP) plus 00103 for each home visit whether planned or called to see)**

Question

How might you introduce the possibility of discontinuing the transfusions and focusing his care on comfort within his preferred location of care, his home?

One month later (Transition Four)

Mr. Lee is bedbound and mainly sleeping. James's wife calls to inform you that his chest sounds congested. You discuss with her that this infection will likely be the terminal event for James and you feel that a home visit to assess his condition and support the family is required. You then contact the home care nurse to teleconference and jointly agree on a revision to the management plan. **(GP Billing: 14069 for Palliative Care Telephone/E-mail Follow-up Management Fee & 14016 for Community Patient Conferencing)** You visit the home, and medication (dependent on Health Authority this may be a palliative medication kit) is arranged for the home. **(GP Billing: 00103 for House Call)** Two days following your visit, James dies peacefully at home. You are contacted by the Home Care nurse and complete the death certificate.

Question

What are the elements to consider when planning a death in the home? Where would you find this information?

Following the death (Transition Five)

You send a card to the family from yourself and the office staff; the MOA arranges for James's wife to come for visit at your office in about 4 weeks. At this bereavement follow-up meeting, you assess how Mary and her family are managing

since the death of her husband and whether there are any remaining questions & concerns.
(GP Billing: 17120 for Office counselling)

Question
How do you & the MOA debrief?