Palliative Care: The Basics and Beyond

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Objectives

- Define Palliative Care and differentiate it from Hospice
- Understand the type of patient appropriate for Palliative Care
- Understand some of the ways Palliative Care can improve the lives of our sickest patients
- Describe the role of The Conversation project in promoting end of life conversations

Mrs. Lynch

- Mrs. Lynch an 81 yo woman coming in for management of hypertension
- On exam she has a mass at the base of her tongue.
- Biopsy reveals it to be cancer.
- ENT feels she is not medically stable for surgery and recommends radiation and PEG placement.
- The patient is unsure if she wants to go forward with treatment

Palliative Care Definition

National Consensus Project for Palliative Care

- Prevent and relieve suffering
- Support the best possible quality of life for patients and their families
- Regardless of the stage of the disease or the need for other therapies

Differences between hospice and palliative care

Palliative

- Unlimited life expectancy
- Medicare Part B
- Interdisciplinary Team
- Medication and equipment private
- Provided where ever patient resides

Hospice

- 6 month prognosis
- Medicare Part A
- Interdisciplinary Team
- Medication and supplies covered
- Provided where ever the person resides

Traditional Continuum of Care

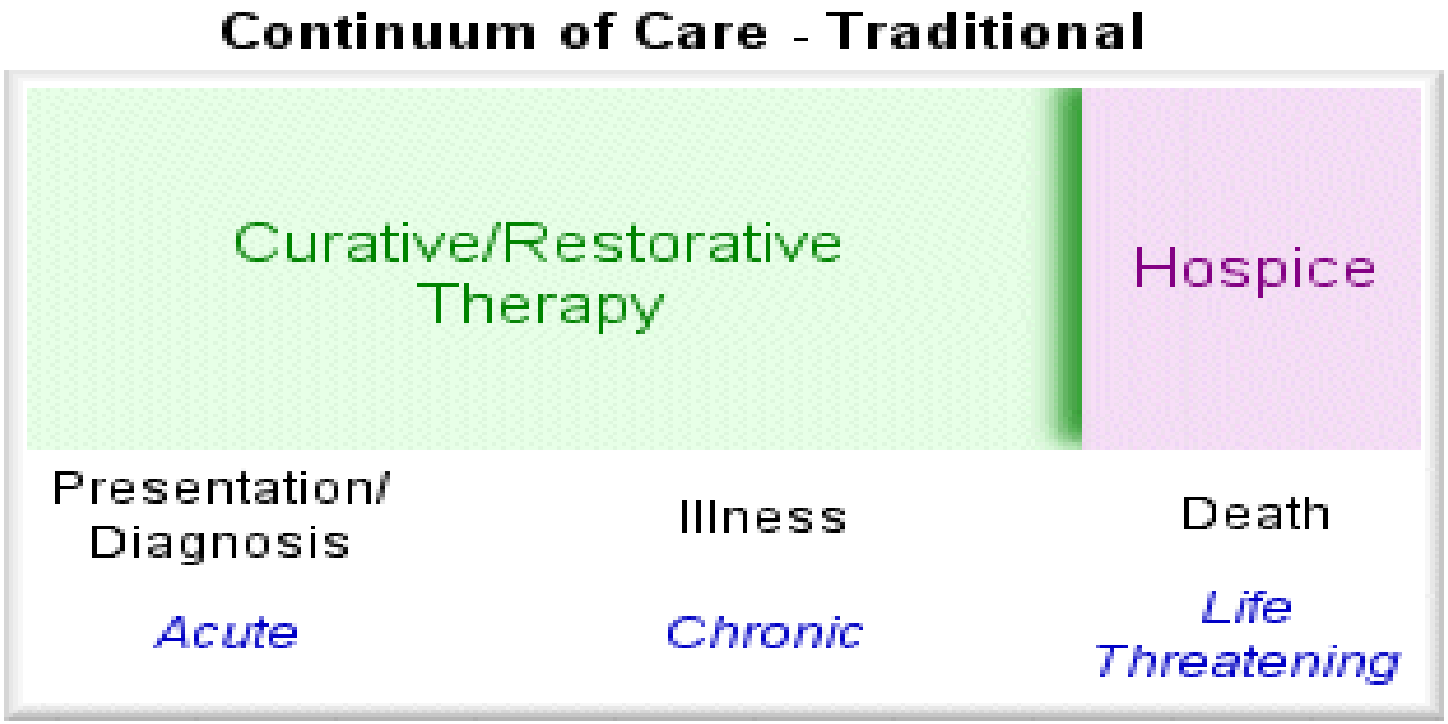

Figure 1. Adapted from Frank D. Ferris, 2000.

Adding Palliative Care

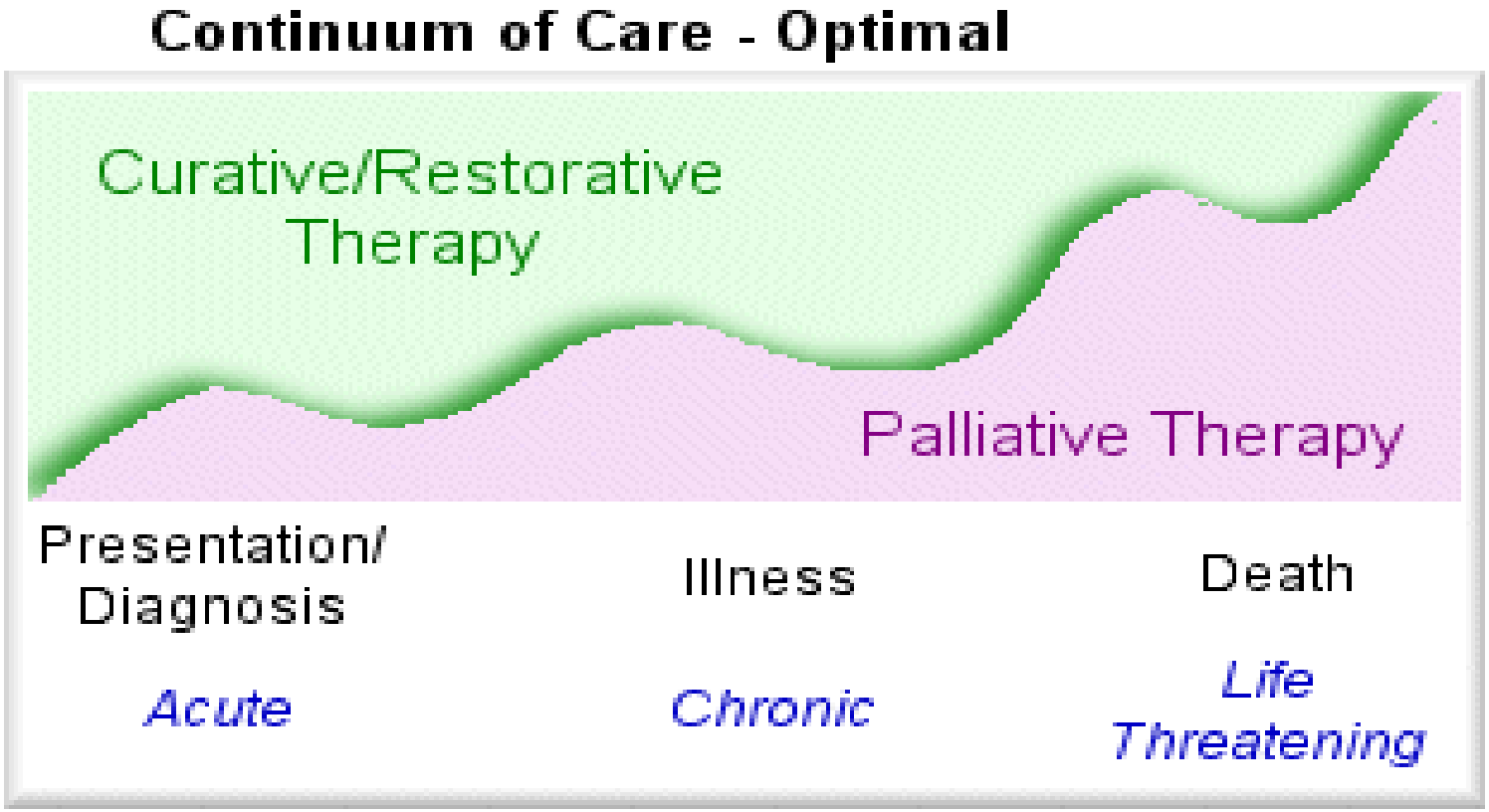

Figure 2. Adapted from Frank D. Ferris, 2000.

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ORIGINAL ARTICLE

Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer

Jennifer S. Temel, M.D., Joseph A. Greer, Ph.D., Alona Muzikansky, M.A., Emily R. Gallagher, R.N., Sonal Admane, M.B., B.S., M.P.H., Vicki A. Jackson, M.D., M.P.H., Constance M. Dahlin, A.P.N., Craig D. Blinderman, M.D., Juliet Jacobsen, M.D., William F. Pirl, M.D., M.P.H., J. Andrew Billings, M.D., and Thomas J. Lynch, M.D.

ABSTRACT

Ms. Smith

- 36 yo with cystic fibrosis
- Multiple admissions for pneumonia, cough, dyspnea
- Works as an attorney, but often misses work due to disease flare ups
- Wants to find a way to stay out of the hospital and control symptoms at home

Ms. Smith

- Enrolls with Nurse Practitioner Home visit Program
- Has an expressed goal of staying out of the hospital as much as possible
- Is able to manage her dyspnea at home with opioids, oxygen, nebulizers
- Decreasing hospitalizations from 6x a year to 1x a year
- Find her career, life more productive

The Conversation Project

- Nationwide campaign to make sure that everyone's end of life wishes are heard and respected

- Encourages people to sit around the dinner table and talk about what they want at end of life.

There's a big gap between what people say they want and what actually happens.

60% of people say that making sure their family is not burdened by tough decisions is "extremely important"

56% have not communicated their end-of-life wishes

70% of people say they prefer to die at home

70% die in a hospital, nursing home, or long-term care facility

Source: Survey of Californians by the California HealthCare Foundation (2012) and Centers for Disease Control (2005)

There's a big gap between what people say they want and what actually happens.

- **80%** of people say that if seriously ill, they would want to talk to their doctor about end-of-life care
- **7%** report having had an end-of-life conversation with their doctor

- **82%** of people say it's important to put their wishes in writing
- **23%** have actually done it

Source: Survey of Californians by the California HealthCare Foundation (2012) and Centers for Disease Control (2005)

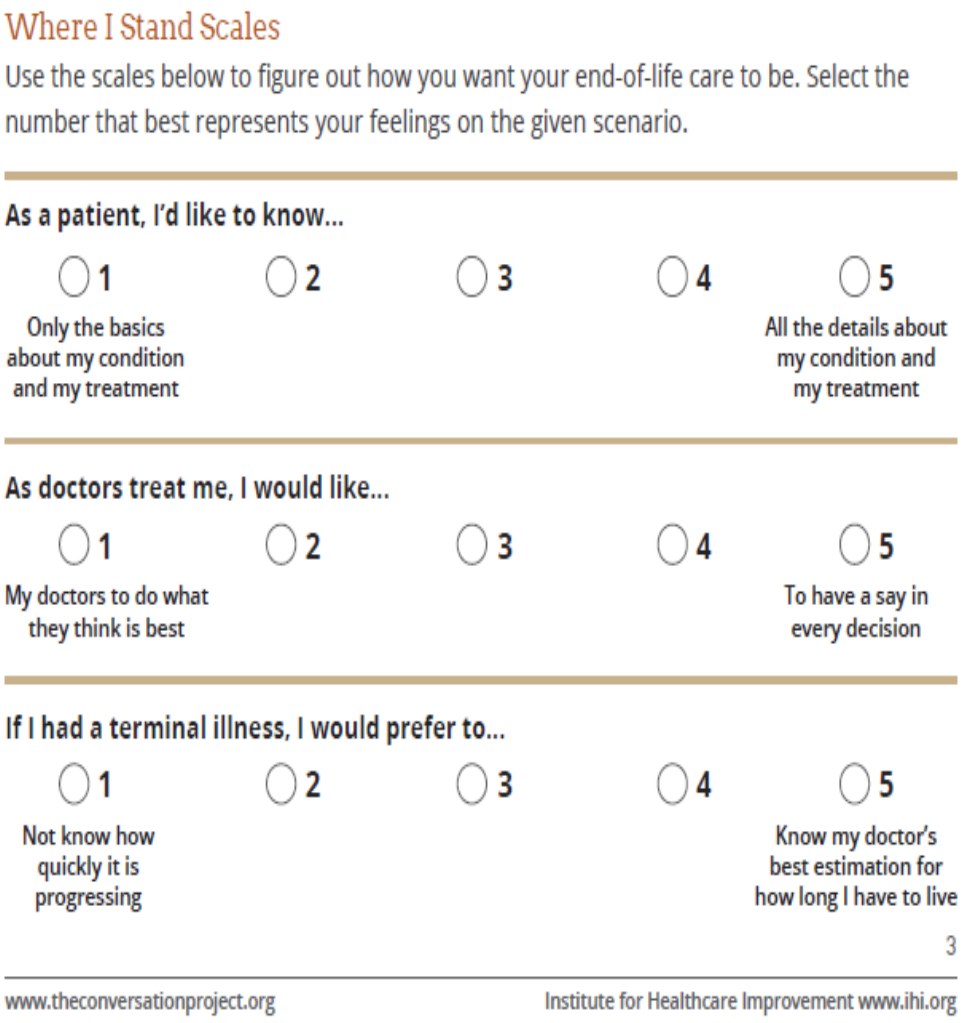
Mrs. S

- Had a large stroke several months before her hospitalization.
- Difficulty eating and with ADLs
- Daughter was her primary caretaker
- Mrs. S develops abdominal pain
- Admitted to hospital

Mrs. S

- Patient remains full code
- When asked daughter is uncomfortable changing code status
- “I don’t know what she would want, we never talked about it”
- Daughter had asked but mother told her she didn’t want to discuss such things
- Daughter tearful and anxious making decisions

The Conversation Project starter kit TheConversationProject.org



Where I Stand Scales

Use the scales below to figure out how you want your end-of-life care to be. Select the number that best represents your feelings on the given scenario.

As a patient, I'd like to know...

○ 1	○ 2	○ 3	○ 4	○ 5
Only the basics about my condition and my treatment				All the details about my condition and my treatment

As doctors treat me, I would like...

○ 1	○ 2	○ 3	○ 4	○ 5
My doctors to do what they think is best				To have a say in every decision

If I had a terminal illness, I would prefer to...

○ 1	○ 2	○ 3	○ 4	○ 5
Not know how quickly it is progressing				Know my doctor's best estimation for how long I have to live

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www.theconversationproject.org Institute for Healthcare Improvement www.ihi.org

Advance Care Planning

- Improve quality of life
- Improve patient autonomy at the end of life
- Increase time on Hospice
- Decrease futile/harmful interventions

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SPECIAL ARTICLE

Advance Directives and Outcomes of Surrogate Decision Making before Death

Maria J. Silveira, M.D., M.P.H., Scott Y.H. Kim, M.D., Ph.D., and Kenneth M. Langa, M.D., Ph.D.

ABSTRACT

BACKGROUND

Recent discussions about health care reform have raised questions regarding the value of advance directives.

METHODS

We used data from survey proxies in the Health and Retirement Study involving adults 60 years of age or older who had died between 2000 and 2006 to determine the prevalence of the need for decision making and lost decision-making capacity

What is the Value of Advance directives?

- Data from survey proxies in the Health and Retirement Study
- Adults >60 years old
- Died between 2000 and 2006
- What is the prevalence of the need for Surrogate decision making?
- Test the association between preferences documented in AD and outcomes of surrogate decision making

What is the Value of Advance Directives?

- 3746 subjects
- 43% required decision making
- 70% lacked decision-making capacity
  - 68% of these had advance directives.

What is the Value of Advance Directives?

- Subjects who had living wills were more likely to
  - want limited care (93%) or comfort care (96%) than all care possible (2%)
  - 83% of subjects who requested limited care got their preferred care
  - 97% of subjects who requested comfort care received their preferred care
- Among the 10 subjects who requested all care possible, only 5 received it
- Subjects who requested all care possible were far more likely to receive aggressive care

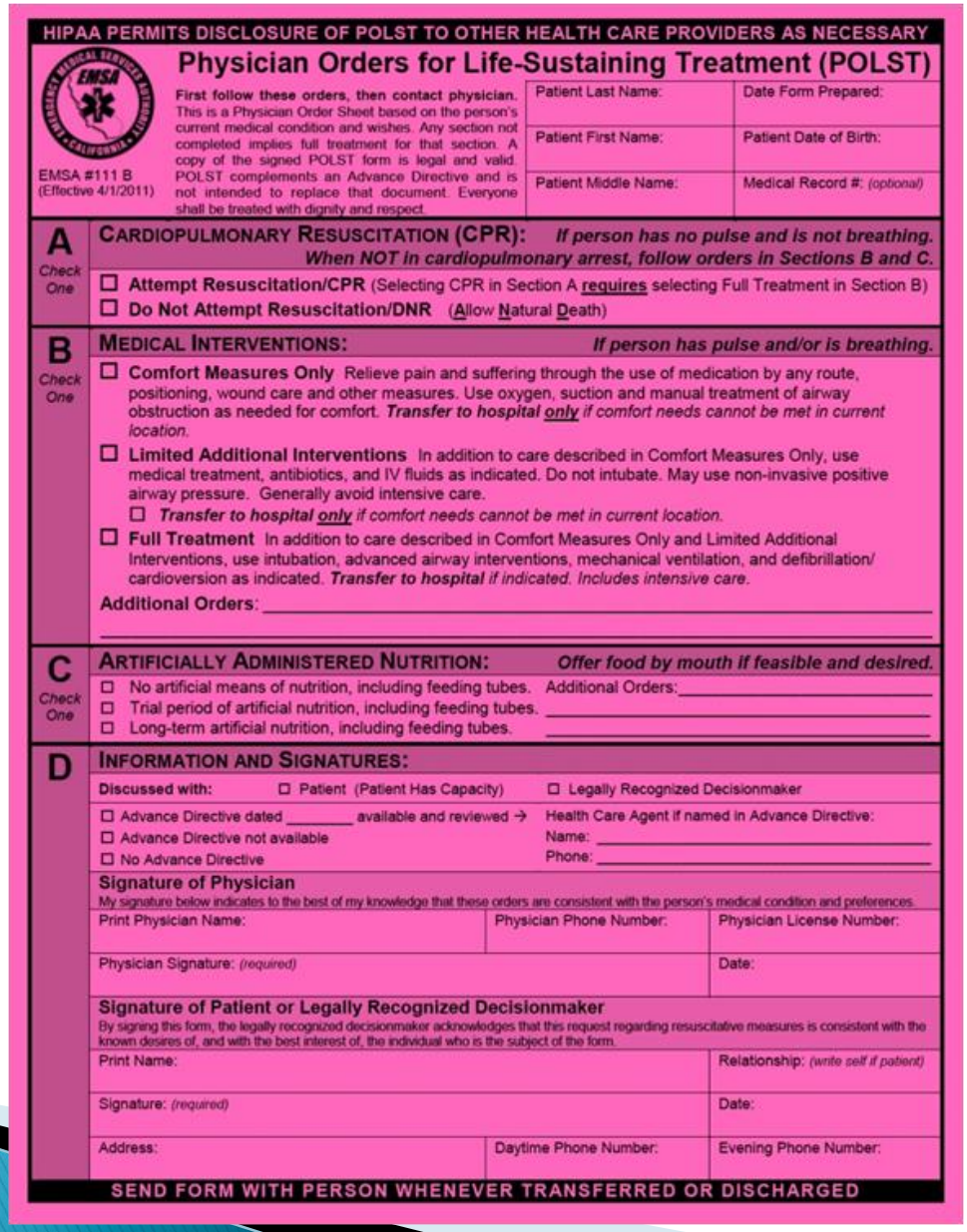
What is the Value of Advance Directives?

- Subjects who had assigned a POA for health care were less likely to:
  - die in a hospital
  - receive all care possible
- Patients with AD were more likely to get the type of care they preferred

Advance Directives are as Important as Allergies

- Mr. Smith is admitted to Kent hospital
- Informs MD he has an allergy to PCN
- Discharged to SNF, readmitted to Kent hospital
- All allergy info is deleted
- Pt is given PCN in ER
- This would be significant and intolerable adverse event
- Happens every day with code status

MOLST



HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

EMSA #111 B
(Effective 4/1/2011)

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. A copy of the signed POLST form is legal and valid. POLST complements an Advance Directive and is not intended to replace that document. Everyone shall be treated with dignity and respect.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): ***If person has no pulse and is not breathing. When NOT in cardiopulmonary arrest, follow orders in Sections B and C.***

- ☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)
- ☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B *Check One*

MEDICAL INTERVENTIONS: ***If person has pulse and/or is breathing.***

- ☐ **Comfort Measures Only** Relieve pain and suffering through the use of medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Transfer to hospital only*** *if comfort needs cannot be met in current location.*
- ☐ **Limited Additional Interventions** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
  - ☐ ***Transfer to hospital only*** *if comfort needs cannot be met in current location.*
- ☐ **Full Treatment** In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/ cardioversion as indicated. ***Transfer to hospital*** *if indicated. Includes intensive care.*

Additional Orders: _____

C *Check One*

ARTIFICIALLY ADMINISTERED NUTRITION: ***Offer food by mouth if feasible and desired.***

- ☐ No artificial means of nutrition, including feeding tubes.
- ☐ Trial period of artificial nutrition, including feeding tubes.
- ☐ Long-term artificial nutrition, including feeding tubes.

Additional Orders: _____

D

INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

- ☐ Advance Directive dated _____ available and reviewed →
- ☐ Advance Directive not available
- ☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____

Signature of Physician

My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print Physician Name:	Physician Phone Number:	Physician License Number:
Physician Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker

By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*		Date:
Address:	Daytime Phone Number:	Evening Phone Number:

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Communicating Code Status

- Allows us to communicate code status across care settings
- Will make code status conversations easier for providers who are not as comfortable
- Allow for more in depth info about patient wishes
- Allows wishes to be reaffirmed at each encounter

Resources

- TheConversationproject.org
  - Download the starter kit
- VNA of CNE- 737-6050
  - Palliative/Therapeutic Visiting nurses
  - NP home visit Program
- If hospitalized
  - Request a Palliative care consult at any CNE hospital