Palliative Care Across the Geriatric Continuum

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Palliative Care Across the Geriatric Continuum

- Simplify the Problem
- Emphasize Palliative Care within the PA/LTC setting
- Create Good Palliative Care Transitions
Rovolving Door
What is palliative care?

- Is palliative care the secret name for comfort care?
  a) Yes
  b) No

- Is it hospice care?
  a) Yes
  b) No
What is palliative care?

- Hospice and palliative care programs provide
  a) The same services
  b) Different services

- Now for the hard question –
  - What’s the difference between hospice and palliative care?
What is Palliative Care?

- Specialized medical care for people with serious illness and their families
- Focused on improving quality of life as defined by patients and families.

Palliative Care might be considered Marcus Welby care.

“…the modern practice of palliative care is a return to the care-giving philosophy that prevailed before the era of modern medicine.” G. Johansen, MD
Dr. Gary Johanson, Director of Memorial Hospice and Palliative Care Service for St. Joseph's Annadel Medical Group
Palliative Care…

- Is usually provided by an interdisciplinary team that works with patients, families, and other healthcare professionals to provide an added layer of support.

- Is appropriate at **ANY** age, for **ANY** diagnosis, at **ANY** stage in a serious illness, and provided **TOGETHER WITH** curative and life-prolonging treatments.

Simplify the Problem
How do we Simplify the Problem?

- What are the NEEDs of the Patient?
- What are the GOALS of the Patient?
- How do we meet the patient’s Needs and Goals?
The Frailty Trajectory

- Biologic Function & Homeostasis
- Physiologic vulnerability
- Risk factors
- Chronic illness, organ function decline
- Decreased physiologic reserve
- Organ & system dysregulation, Comorbidities

Interaction of Physiology & Function

- Isolated functional decline
- Progressive functional decline
- Dependence in multiple ADLs
- Disability
- Incapacitation

AGE

Increasing Dysregulation

Decreasing Function

Physical Function & Independence

CONTEXT: Physical & Social Environment, Economics, Services, Culture, Preferences
Umbrella of Palliative Care

Point of Diagnosis

Beliefs, Values, Goals

Ethical Issues

Psycho/Social/Spiritual Support

Symptom Management

Pain Management

Realization of Goals

Progression of Disease

Quality of Life

Hospice - End of Life

Embrace Life is personal and is related to a sense of well-being.

PC implemented early and comprehensively, provides for the realization of goals and quality of life. It brings greater likelihood for patients and families to see Hospice not as giving up, but as a safe place for holding...holding of comfort, holding of memories, holding of moments.

Early implementation of the domains of Palliative Care promotes improved realization of goals and to quality of life.

PC continues through the progression of the disease, whether long or short.

Serious or life-limiting illness may refer to limitation of functioning, limitation of options, or limitation of time remaining.

The safe place of PC is constructed by implementing the domains that provide for the meeting of patient/family needs to ensure that:
- Goals of Care reflect patient/family beliefs & values
- Ethical issues are addressed
- Psycho/social/spiritual needs are attended
- Pain & Symptom Management is provided

PC is initiated at the time of diagnosis of a serious or life-limiting illness or injury for patients who are at vulnerable to loss of realization of goals or quality of life.

Palliative - from Latin pallium, meaning to cloak, conceal, or cover: in modern application, Palliative Care (PC) refers to care that provides a safe place by reducing the violence of a disease, by easing, or alleviating, the symptoms, without curing the underlying disease.

A Conceptual Model to:
- Provide a Tool for Meaningful Education
- Express the Meaning of Palliative Care
- Differentiate between Palliative Care and Hospice
- Facilitate & Clarify Conversations about Palliative Care
- Demonstrate the What, When, Why, & Benefits of Palliative Care Implementation

References
CDHB End of Life Care Plan

Deterioration in patient’s condition suggests the patient may be dying, e.g. increasingly weak, sleepy, uninterested in getting out of bed, decreased oral intake & less interested in surroundings.

Multidisciplinary Team Assessment (MDT)

Is there a potentially reversible cause? e.g. hypercalcaemia, renal failure, infection, hypotensive delirium, drug toxicity. Could the patient be approaching the last days of their life? Is further support needed to assess & manage condition? Is a referral to the palliative care team required?

Patient is NOT diagnosed as dying

- Review the current plan of care daily based on a thorough patient assessment.

Resuscitation Status

- This needs to be addressed & discussed with the patient / family as appropriate.
- Ensure that a DNACPR form is completed.

Comfort Cares

“At the end of life each story is different.”

Physical Comfort

- It is not necessary to do further observations, bloods, tests & investigations. Constantly assess comfort in a holistic manner.
- Be alert for:
  - Discomfort & pain (failure to address psychological distress & social / cultural issues is a common cause of unrelieved pain)
  - Restlessness / agitation
  - Respiratory distress
  - Retained secretions
  - Nausea / vomiting
  - Confusion / hallucinations / delirium.
- Also check for:
  - Pressure areas / skin integrity
  - Faecal impaction / overflow. A PR may be necessary if suspected
  - Urinary retention

Psychological & Spiritual Needs

- Encourage conversations with family / whanau in an open & honest manner to elicit any fears & concerns
- Avoid withholding difficult information
- Encourage a relaxing environment, e.g. music at low volume & soft lighting
- Keep distracting noises like televisions & radios to a minimum
- Encourage loved ones to reminisce
- Respect the family’s need for privacy
- Honour their wishes. Is there a current & valid Advance Care Plan? Have there been informal advance care planning discussions?
- Offer Chaplain and family / whanau support services

Resources available:
- The pamphlet is also available from the Mortality Office ext. 81019

Medications

- Rationalise all current medications & stop those not required for comfort (including IV fluids)
- Consider route of administration – usually subcutaneous at this stage
- Chart anticipatory medications all subcutaneously (refer to the palliative care website)
  1. Opioid – pain, discomfort, shortness of breath
  2. Buscopan – secretions (death rattle)
  3. Haloperidol – nausea, confusion, agitation, delirium
  4. Midazolam – agitation, distress, anxiety, shortness of breath
- Opioids; morphine is the gold standard (renal function dependent)

Physical Cares

- Regular mouth cares (to alleviate dry mouth and thirst)
- Bowel / urinary cares
- Skin cares
- Body positioned and covered appropriately for comfort (hot / cold)
- Surroundings safe and tidy
- Encourage family / whanau involvement, e.g. holding hands, washing, mouth cares, touch & gentle massage

“Dignity and privacy are commodities beyond value in the dying”

Authorised by: Dr Kate Grundy, Clinical Director, Palliative Care Service, Christchurch Hospital | Date: Feb 2014 | Review date: Jan 2016
Hospice/Palliative Care Interface

Traditional Model of Health Care
“You’ve got six months, but with aggressive treatment we can help make that seem much longer.”
Hospice/Palliative Care Interface

Integrated Palliative Care Model
Palliative Care Transitions
RAISE YOUR HAND IF YOU HAVE A PALLIATIVE PROGRAM
Palliative Care Transitions

Providers

- Acute Hospital
- LTACH
- Inpatient Rehab
- Home Health Agency
- Assisted Living Facility
- Skilled Nursing Facilities

Care delivery

- Physician (Physicians office)
- ARNP/PA
- RN
- LPN
- CNA
- Administrators
- Case Managers
- Social Services
- Chaplin

Goal is for an Interdisciplinary Team Approach
Are we providing Palliative care across the many transitions of care???
Palliative Care Transitions

- How do we unify all the various programs?
- How do we provide consistency and continuity of the message?
- How do we establish a resource to be the bridge across the transitions of care?
MEND THE GAP - PALLIATIVE CARE EDUCATION
Palliative is a journey, not a destination
**Physician Orders for Life-Sustaining Treatment (POLST)-Florida**

**A. CARDIOPULMONARY RESUSCITATION (CPR):**
- **Cardiac Arrest:**
  - Attempt Resuscitation CPR
  - Do Not Attempt Resuscitation CPR

**B. MEDICAL INTERVENTIONS:**
- **Patient Has No Pulse and Is Not Breathing**
  - Cardiopulmonary Resuscitation (CPR)
  - Do Not Attempt Resuscitation CPR

**C. ARTIFICIALLY ADMINISTERED NUTRITION:**
- **No Artificial Nutrition by Tube**
- **Defined Time Period of Artificial Nutrition by Tube**
- **Long-Term Artificial Nutrition by Tube**

**D. PROSPECTIVE CARE:**
- **Conscious***
- **Hospice***
- **Palliative Care***

**E. Basis for the Orders:**
- **Life Limiting Advanced Illness***
- **Patient's Preference***

** signatures:***
- **Primary Physician Name**
- **Specialty**
- **Supervising Physician Name**
- **Relationship***

**SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED.**

Use of original form is strongly encouraged. Photocopies and facsimiles of completed POLST forms are legal and valid.
Palliative Care in Post Acute & Long Term Care settings
Barriers to the Implementation of Palliative Care in the Nursing Home

Christian Davis Furman, MD, MSPH, CMD; Rebecca Priddle, GNP; James G. O'Brien, MD, and Toni Miles, MD, PhD

Although residents of nursing homes (NH) could greatly benefit from palliative care, most NHs do not have a clear understanding of how to incorporate the philosophy of palliative care into the mainstream of medical care. This lack of process can lead to barriers between members of the interdisciplinary team at the NH. Specifically, barriers can result from poor communication, lack of coordination of care, inadequate pain and symptom control, and differences in the perceived value of research in the NH setting. The National Consensus Project for Quality Palliative Care lists core outcomes for palliative care. Among these core outcomes are high-quality communication, coordination of care, and control of pain and symptoms.

Palliative care is care given by an interdisciplinary team that focuses on the prevention and relief of suffering for patients and their families when the patient has a life-limiting condition. The interdisciplinary team usually consists of a physician, nurse, chaplain, and social worker, but can also include volunteers, pharmacists, nursing assistants, nutritionists, and therapists. The NH is an ideal location for the practice of palliative care because an interdisciplinary team already exists and numerous residents at the NH have life-limiting conditions.

Magnitude of the Problem

Currently, 66% of residents remain in nursing facilities to die rather than being transferred to a hospital for their final days. Now that more people are dying in the NH coupled with the growing percentage of people who will spend time in a NH, it becomes imperative that the principles of palliative medicine be practiced by all health care professionals who work at the NH.

When we tried to implement palliative care in a NH, we encountered barriers because of poor communication, lack of coordination of care, inadequate pain and symptom control, and the perceived insignificant value of palliative care research by members of the interdisciplinary team at the NH. The following cases illustrate the magnitude of the problem with implementing effective palliative care in the NH.

BARRIERS SURROUNDING COMMUNICATION

- A 90-year-old white female with end-stage Alzheimer’s dementia: The NH medical director discussed goals of care with the patient’s health care surrogate (HCS). The HCS stated that the goals were comfort only and the medical director explained the do not hospitalize (DNH) order. The HCS wanted DNH for the patient; therefore, the physician wrote this order. The NH director of nursing questioned the DNH order. She thought it meant the patient would receive no treatment. She also did not think the patient had a terminal diagnosis. The physician should have communicated and explained the orders with the nursing staff when the orders were written. The physician also should have written “End-stage Alzheimer’s dementia” along with the DNH order, which would have communicated to the staff the natural progression of Alzheimer’s dementia. The barriers in this case stem from a lack of communication about the natural progression of Alzheimer’s dementia and the meaning of DNH.

BARRIERS SURROUNDING COORDINATION OF CARE

- An 80-year-old white male with end-stage Parkinson’s disease, dementia, and a seizure disorder: The patient and his HCS completed a DNH form at the NH and a copy of it was on the chart. The patient experienced a seizure. The NH called his HCS and she agreed to send the patient to the emergency room (ER). The primary care physician, who cared for the patient at the NH, saw the patient in the ER. At the request of the primary care physician, the ER physician treated the seizures in the ER and discharged the patient back to the NH. The NH felt the patient should have been admitted to the hos-
Rethinking the Problem & Removing Barriers

- What we know now
  - Requires a strong interdisciplinary team
  - Needs ongoing education in the facility
  - Patients and families require close monitoring and frequent assessments for alleviation of symptoms, pain management, psychosocial interventions...
  - Can be a challenge to implement and pay for!
National Hospice and Palliative Care Organization
Palliative Care Resource Series

PALLIATIVE CARE IN THE NURSING HOME SETTING

Janet Bull, MD, FAAHPM, HMDC
DESIGNING A PALLIATIVE CARE PROGRAM

1. Develop a Sound Business Plan
Developing a sound operational and business plan for a palliative care program is extremely important. This plan should include scope of service, team structure, outcome metrics, and a budget/financial plan. Standardization around intake, administrative support, clinical care, and quality should be defined. Some programs are able to offer a wide array of services (social work, psychologist, RN case management) while others have limited funding for supportive services.

Defining the scope of a palliative care program from the start is very important. It is a mistake to try to be all things to all people; it is better to under promise and over deliver.
2. Decide Eligibility Criteria and Understand Importance of Prognostication

Eligibility criteria should include those patients with serious or life limiting illnesses. Excluded should be those who are referred for chronic pain, post-surgical issues, and substance abuse. It is helpful to develop a risk stratification model where the sickest patients are identified and prioritized.
3. Collect Relevant Data

Palliative care programs should track their readmission rates, transitions to and length of stay in hospice, symptom scores, advance care planning completion, billing revenue, and patient/family satisfaction.
Evaluate the model of care appropriate for your facility

**Hospice agency/nursing home partnerships**

Hospice agency/nursing home partnerships. This is a partnership between a hospice agency and a nursing home, where eligible nursing home residents access their Medicare hospice benefit. An eligible resident must have a prognosis of six months or less if the disease runs its normal course and must waive other Medicare benefits upon election of the hospice benefit. About one third of nursing home decedents now access the Medicare hospice benefit before death. Hospice can bring expert symptom management, personal care services, social work services for families, other staff and residents, spiritual care, as well as volunteer and bereavement services.
Externally-based Palliative Care

*Externally based palliative care.* An external palliative care consultation team works with nursing home clinicians to serve a broader population of nursing home residents, including those with chronic illness. To access palliative care services, there is no need to forgo curative treatments to receive services. The consultant, a physician or nurse practitioner, bills under Medicare part B; therefore costs for these services are not incurred by nursing homes.

Facility-based Palliative Care

*Facility-based palliative care.* A facility may develop palliative care expertise within its own facility, allowing the creation of palliative care services that meet the needs of their residents. Staff training in the nursing home is critical to the success of this model, and to fostering a culture where a palliative approach to care is welcome and widely supported. Support for staff training and the understanding of the palliative approach to care may be a service that a hospice organization can provide to help palliative care services to be established with a strong foundation."
Rethinking the Problem & Removing Barriers
SUMMARY

- Simplify by addressing needs and goals
- Stay consistent and keep continuity of the message through patient transitions
- Rethink the problem and remove barriers
In Conclusion…

- The End does not need to be complicated….
QUESTIONS