Describe the scope of palliative care as differentiated from hospice care.

Recognize indicators of prognosis in advanced, serious illness.

Demonstrate skills in communicating with patients and families in advance care planning.

Advent of new medical treatment and technologies.

Medical advances have led to a “culture of cure.”

“Patients do not die…they code”

Still no “cure” for many diseases but we can prolong life with these illnesses.

People now typically die after dealing with multiple chronic conditions for many years.

Hospice has become “brink of death care.”
The Old Model

Disease-Modifying Treatment

Disease Progression

Hospital to End of Life Care

New Model
Palliative Care: What it is NOT

- It is not “giving up.”
- It is not in place of curative or life-prolonging care.
- It is not based on prognosis.
- It is not the same as hospice.

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Palliative Care & Hospice

<table>
<thead>
<tr>
<th></th>
<th>Palliative Care</th>
<th>Hospice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>When</strong></td>
<td>Anywhere in illness trajectory</td>
<td>Prognosis &lt; 6 months</td>
</tr>
<tr>
<td><strong>Where</strong></td>
<td>Hospital, some outpatient programs</td>
<td>Whenever patient is typically home, NH, inpatient facility</td>
</tr>
<tr>
<td><strong>Goals of Care</strong></td>
<td>Variable</td>
<td>Comfort directed, usually avoiding hospitalization</td>
</tr>
<tr>
<td><strong>Availability</strong></td>
<td>Depends on program</td>
<td>Planned visits 24/7 on-call</td>
</tr>
<tr>
<td><strong>Team Members</strong></td>
<td>Depends on program</td>
<td>Nurses, physicians, HHAs, SWs, chaplains, volunteers</td>
</tr>
<tr>
<td><strong>Levels of Care</strong></td>
<td>Specialty Primary/Generalist</td>
<td>Routine, General Inpatient, Continuous Care, Respite</td>
</tr>
<tr>
<td><strong>How paid for</strong></td>
<td>Provider billing</td>
<td>Hospice Benefit (Medicare, Medicaid, Insurance)</td>
</tr>
</tbody>
</table>

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Palliative Care

All hospice is palliative care...but not all palliative care is hospice.
The National Priorities Partnership, a collaborative effort of 28 major national organizations convened by the National Quality Forum (NQF) in 2008 defined six national priorities and goals to transform health care.

One of those six was Palliative Care.

Eight domains:
- Structure and processes of care
- Physical aspects of care
- Psychological and psychiatric aspects of care
- Social aspects of care
- Spiritual, religious, and existential aspects of care
- Cultural aspects of care
- Care of the imminently dying patient
- Ethical and legal aspects of care

Dx of a serious, potentially life-limiting illness
- Progressive, advancing illness with multiple co-morbidities
- Frequent admissions to the hospital for the same illness
- Difficult to control symptoms (pain, anxiety, dyspnea, depression)
- Patient, family, or physician uncertainty regarding appropriateness of treatment options (goals of care)
Why Palliative Care?
- Improves quality of life for both patient & family
- Matches treatment with patient’s values & goal
- Improved quality at lower cost
- Helps to meet demands of health care reform

The good news....
- Palliative care is growing

![Graph showing the prevalence of US Hospital Palliative Care Teams]

The Opportunities....
- In hospitals, at best, only 25-50% of palliative care needs are being met
  - Variable penetration to areas of highest need:
    - ICUs, ED, Oncology, Neurology, Renal
- Between hospitals & hospice there is a large gap of palliative care needs across the continuum of health care:
  - Outpatient services
  - Long-term care
  - Home care
The Opportunities…for APRNs

- As a provider for palliative care
  - Hospitals
  - Clinics
  - Outpatient programs
- Primary or Specialty Care
- ACHPN or CHPN certification
  - hpna.org
  - “Certification Info”

Need for Prognosis

- Patients want prognostic information
  - Knowing what to expect gives sense of control
  - Accurate information is necessary to make personal decisions
  - Opportunity to get personal affairs in order prior to death
  - Decreases anxiety, fear, and uncertainty
- Patients who receive prognostic information are more satisfied with their care

Heart Disease Criteria

- Symptoms of recurrent heart failure at rest
  - NYHA Class IV
  - EF< 20%
  - Despite optimal therapy
- Other factors of decreased survival
  - Symptomatic SVT or Ventricular arrhythmia
  - Unexplained syncope
  - Cardiogenic brain embolism
  - Concomitant HIV disease
Cancer Criteria
- Stage 4 cancer
- Not seeking chemotherapy or radiation
- Weight loss 10% in past 6 months

Pulmonary Disease Criteria
- Severity of lung disease
  - Dyspnea at rest, bed-chair existence
  - FEV1 <30% predicted
- Progressive lung disease
  - Frequent ED visits, hospitalizations
- Cor Pulmonale
- Hypoxemia at rest on supplemental oxygen
  - PaO2 <55 on O2
  - SaO2 <88% on O2
- Hypercapnea, PaCO2 >50
- >10% weight loss in 6 months
- Resting tachycardia

Dementia Criteria
- Functional Assessment Staging
  - Co-morbidities important
  - Functional Assessment Staging Scale (FAST)
    - Stage 7
      - <6 intelligible different words in average day/interview
      - Cannot walk or sit upright w/o assistance
      - Cannot smile
      - Cannot hold head independently
  - Medical Complications
    - Aspiration pneumonia, pyelonephritis, sepsis, stage 3-4 decub ulcer, recurrent fever after antibiotics
    - Swallowing ability impaired, refusal to eat
Liver Disease

- Laboratory evidence
  - PT > 5 sec over control
  - Albumin <2.5
- Refractory ascites despite maximal diuretics
- Decline in SBP
- Hepatorenal syndrome
  - Elevated BUN, Cr with oliguria
- Hepatic encephalopathy
- Recurrent variceal bleeding

How to palliate end stage symptoms

Fast Facts
www.eperc.mcm.edu
Confirm prognosis

Confirm assessment findings

Give statistical analysis data to support recommendations for palliative care

Karnofsky Performance Scale

Unable to carry on normal activity and to work: no special care needed.

Unable to work: able to live at home and care for most personal needs: varying amount of assistance needed.

Unable to care for self: requires equivalent of institutional or hospital care; disease may be progressing rapidly.
Palliative Performance Scale

Considers location (community, home)
- ADLs
- Age
- Comorbidities
- Predict mortality
Dying Trajectories

- Refers to a change in health status over time as patient approaches death

- Helpful to understand patterns of advanced illness and dying for different disease processes
Sudden death is beyond the care of the physician
- Hallmark is lack of preparation
- Intense bereavement needs for survivors

Cancer has a relatively predictable trajectory
- Pts with advanced cancer who have taken to bed without a correctable cause will usually die within weeks

CHF, COPD, CVD, Dementia follow a unique pattern
- Overall health status is low 6-24 months prior to death
- Acute exacerbations occur intermittently
- Approx. 3 admissions in the year prior to death
- Difficult to predict death within weeks-months
Communication Skills

- Patient/Family meeting an opportunity for shared decision-making to establish goals near the end of life.
  - Skill set necessary for successful outcome
    - Group facilitation skills
    - Counseling/emotional reactivity skills
    - Knowledge of medical and prognostic information
    - Willingness to provide leadership in decision-making
- Who are you talking with?
- What is most important to that person?
- Listening can earn you the right to tell the truth.

Communication has nothing to do with what you say and everything to do with what the other person hears.

Anon

Go for the Goal

- Establish what they know.
- Use open-ended questions.
- Medical review – give the big picture.
- Allow time to react – use silence.
- Respond to emotions.
Go for the Goal

- Work in the framework of their priorities and needs.
- People want to know what you recommend.
- Present “the best care possible.”
- Help weigh the benefits and burdens.
  - Will this intervention improve function, quality, or time?

Managing Conflict

- Conflict surrounding care decisions, as patients near the end of life, are very common.
  - This is a time of emotional turmoil, uncertainty, and fear—among both the patient/family and the health care team.
- Not every conflict will be recognized by visible anger.
- Naming the problem, out loud, is an effective means of starting a meaningful dialog among the conflicted parties.

Communication Skills

- Plan A, Plan B, etc.
- Clarify – “Does this make sense to you?”
- Define “everything.”
- Use time as an ally.
Language with Unintended Consequences

- “There’s nothing more we can do.”
- “Do you want us to do everything possible?”
- “Do you want to stop treatment?”

Behaviors That Impair Decision Making

- Initiate goals of care discussions without assessing readiness.
- Assume a person has to accept a limited prognosis in order to relieve suffering.
- Label a patient/family as being “in denial.”
- Debate with patient/family over the medical reality of the prognosis.

Tools for Advance Care Planning

- Medical Power of Attorney
- Living Will
- DNR/AND
- http://theconversationproject.org/
TPOPP Form

- **Section A: Resuscitation Status**
  - For Full Blown cardiac arrest
    - Attempt Resuscitation
    - Do Not Attempt Resuscitation
  - For Significantly hypoxic cardiac arrest
    - Full treatment
    - Limited Additional Interventions
    - Comfort Measures Only

- **Section B: Medical Intervention**
  - Still with pulse and breathing but with rapid health deterioration
    - Comfort Measures Only
    - Limited Additional Interventions
    - Full Treatment

- **Section C: Medically Administered Nutrition**

- **Section D: Signatures**

This document moves with the patient across health care continuum

References

References