Interprofessional Geriatrics Training Program

Palliative Care

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Acknowledgements

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What is Palliative Care?

- Palliative care aims to aggressively treat symptoms and improve quality of life for patients facing life-limiting illness
- The goal is to improve quality of life for both the patient and the family
- It provides patients with relief from the symptoms, pain, and stress of a serious illness, whatever the diagnosis
- Care and services are provided by an interdisciplinary team

(National Hospice and Palliative Care Organization, 2016)

Learning Objectives

Upon completion of this module, learners will be able to:

1. Identify the role of the interdisciplinary palliative care team
2. Differentiate between hospice and palliative care
3. Discuss clinical situations where hospice and palliative care may prolong life
4. Recognize when artificial nutrition provides no benefit to the patient

Palliative Care Services

- Pain and symptom management
- Prognostic estimates and discussions
- Coping and spiritual support
- Goals of care discussions
- Disposition planning

#1 Barrier to Palliative Care

- The misconception that palliative care = hospice

Hospice Care

- Hospice care is used when patients can no longer be helped by curative treatment, and are expected to live about six months or less if the illness runs its usual course
- Can continue for patients beyond six months

Similarities: Palliative Care and Hospice Care

Both Pre-Hospice Palliative Care and Hospice Palliative Care

- Pay meticulous attention to symptom management
- Recognize the need for and provide psychological and spiritual support to patients and families
- Use a team-based approach

Differences: Palliative Care and Hospice Care

Pre-Hospice Palliative Care	Hospice Palliative Care
For patients facing serious illness and receiving life-prolonging therapies	Life expectancy less than 6 months
Usually initiated in the hospital; but can be provided at home, skilled nursing facility (SNF), or assisted living facility (ALF)	Usually provided at home; but can also be provided at SNF, ALF, or the inpatient hospice unit

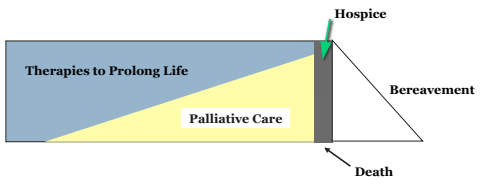
Comparison of Services: Home Palliative Care Verses Home Hospice Care

Home Palliative Care	Home Hospice
1-2 registered nurse (RN) visits per month	1-3 registered and certified nursing assistants visits a week
Palliative care agency bills per visit like home physicians	Hospice agency is paid $145 per day from hospice admission until death

Comparison of Services: Home Palliative Care Verses Home Hospice Care

Home Palliative Care	Home Hospice
Medicare continues to pay for the same level of care	Hospice agency must cover all treatments related to hospice diagnosis
Registered nurse available by phone 24-7	Registered nurse available by phone 24-7
Bereavement support for 13 months following death	Bereavement support for 13 months following death

Simultaneous Model of Care



Source: UIC Original

Dying in America: Preferences of Location Compared to Actual

Where People Prefer to Die

- Home (60-80%) (Gruneir et al., 2007)

Where Americans Die

- Hospitals: 50%
- Nursing Homes: 30%
- Home: 20% (Stanford University School of Medicine, 2016)

Checklist to Identify Patients for End of Life Care

Tool: CriSTAL

- **Cri**teria for **S**creening and **T**riaging to Appropriate **Al**ternative Care
- Most likely predictors of death in the short term (30 days) to medium term (12 weeks)
  - http://spcare.bmj.com/content/early/2014/12/09/bmjspcare-2014-000770.full

(Cardona-Morrell & Hillman, 2015)

Checklist to Identify Patients for End of Life Care

- Checklist of 29 predictors of death, including:
  - Age 65 years or older, plus either emergency admission for the current hospitalization (associated with 25% mortality within 1 year) or two or more deterioration criteria, including:
    - Change on the Glasgow Coma Score
    - Low systolic blood pressure
    - Slow or rapid respiration
    - Low or high pulse rate
    - Need for oxygen therapy or oxygen saturation less than 90%
    - Hypoglycemia
    - Repeat or prolonged seizures

(Cardona-Morrell & Hillman, 2015)

Checklist to Identify Patients for End of Life Care

Additional Risk Factors or Predictors of Short- to Medium-Term Death

- Including:
  - Personal history of active disease, such as advanced malignancy, chronic kidney disease, chronic obstructive pulmonary disease, new cerebrovascular disease, chronic heart failure, myocardial infarction, moderate or severe liver disease, or cognitive impairment
  - Previous hospitalization within the last year, or repeat intensive care unit admission (ICU) during the previous hospitalization

(Cardona-Morrell & Hillman, 2015)

Checklist to Identify Patients for End of Life Care

Other Factors Include:

- Evidence of frailty
- Residence in a nursing home or supported-living facility
- Proteinuria
- Abnormal electrocardiogram findings

(Cardona-Morrell & Hillman, 2015)

Assessment Question 1

Ms. Cortez is a 75-year-old female with extensive past medical history, including osteoarthritis, diabetes, chronic kidney disease stage 4, hypertension, diabetic retinopathy and neuropathy, and has been residing in an assisted living facility for the last 4 years. She has poorly controlled diabetes mellitus because of poor medication compliance and was recently placed on hemodialysis three times a week for worsening renal functions. She has been losing weight and now needs assistance with activities of daily living (ADLs), requiring placement in a nursing home. She has been taking tramadol for joint pains but it has not been very helpful.

Assessment Question 1

She does not have a family and is scared to go through "this burden" alone and wants to be "happy again." Her depression screen is negative, and she does not have any cognitive impairment. How would you approach this situation?

Assessment Question 1

a) Order a palliative care referral for adequate management of pain, as pain seems to be a bothersome complaint
b) Order a palliative care referral to establish goals of care, as she has a multitude of medical problems and she wants to focus on her quality of life
c) Order a palliative care referral to provide emotional, religious, spiritual, and social support to the patient
d) All of the above

Assessment Question 1: Answer

a) Order a palliative care referral for adequate management of pain, as pain seems to be a bothersome complaint
b) Order a palliative care referral to establish goals of care, as she has a multitude of medical problems and she wants to focus on her quality of life
c) Order a palliative care referral to provide emotional, religious, spiritual, and social support to the patient
d) All of the above (Correct Answer)

Prognosis

Estimating Prognosis

- Oncologists overestimate prognosis in advanced cancer by a factor of 2-5
- Longer estimates when physician knows patient longer
- Longer estimates with less physician experience
- ICU doctors underestimate prognosis

(Christakis, 1999)

Communicating Bad News

SPIKES:

- Can be learned and mastered
- 6-8 step approach

Communicating Bad News

SPIKES:

Setting up the interview
assessing the patient's **P**erception
obtaining the patient's **I**nvitation
giving **K**nowledge and information to patient
addressing patient's **E**motions with empathic responses
providing patient a **S**trategy and *S*ummary

- SPIKES Resource:
  - http://hiv.ubccpd.ca/files/2012/09/Summary-on-Breaking-Bad-News.pdf

Doctrine of Double Effect

- Intention must be good
- Bad effect can be foreseen, but not intended
- Suffering must be severe enough to warrant the risk
- Bad effect cannot be the means to the good effect

Common Misconceptions

- 30-40% of patients getting palliative cancer treatments believe they are being treated with curative intent (Gattellari et al., 1999; Mackillop et al., 1988)
- 69-81% of patients with Stage IV lung and colon cancers did not report understanding that chemo was not at all likely to cure their cancer (Weeks et al., 2012)

Patient Autonomy and Informed Decision Making

- Requires dedicated time from clinicians
- Bringing up prognosis
- Relieving fears of terminal suffering and medical abandonment

End of Life Decisions: The Conversation

The Conversation Project from the Institute for Healthcare Improvement (IHI)

- http://theconversationproject.org/
- The goal of The Conversation Project is to ensure that everyone's life wishes are expressed and respected
- Includes step-by-step instructions for how to consider and discuss end of life care issues

Assessment Question 2

Which of the following statements is true?

a) Palliative and hospice care does not prolong life and may actually hasten death

b) Palliative and hospice care when initiated close to the initial diagnosis of cancer or a serious illness in a patient improves not only the quality of life but also survival by discontinuing unnecessary and potentially harmful drugs as well as better management of symptoms including but not limited to pain, anxiety, and depression

c) Palliative and hospice care does not change the prognosis and is only limited to improving pain control and discussion of goals of care

d) Palliative and hospice care is only limited to dying patients and does not affect survival

Assessment Question 2: Answer

Which of the following statements is true?

a) Palliative and hospice care does not prolong life and may actually hasten death

b) Palliative and hospice care when initiated close to the initial diagnosis of cancer or a serious illness in a patient improves not only the quality of life but also survival by discontinuing unnecessary and potentially harmful drugs as well as better management of symptoms including but not limited to pain, anxiety, and depression (Correct Answer)

c) Palliative and hospice care does not change the prognosis and is only limited to improving pain control and discussion of goals of care

d) Palliative and hospice care is only limited to dying patients and does not affect survival

Pain

Pain Background

- Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage (International Association for the Study of Pain, 2012)
- Pain affects more Americans than diabetes, cancer, and heart disease combined (American Academy of Pain Medicine, 2016)
- Chronic pain is the most common cause of long-term disability, affecting about 50 million Americans annually (American Academy of Pain Medicine, 2016)

Background

Pain Leads To:

- Disability (Matos et al., 2016; Eggermont et al., 2014)
- Social isolation (Keefe et al., 2013)
- Depression (Wood et al., 2013; Keefe et al., 2013)
- Falls (Stubbs et al., 2014)

Pain Management

For a comprehensive training module see the ENGAGE-IL module "Pain Management of the Older Adult" at engageil.com

Pain: Approach to the Patient

- Pain is subjective
  - Only the patient knows how much pain they are in, and only they can decide how far they want to go for treatment
- Pain is both a symptom and a disease
  - Eliminate dangerous and progressive diseases
  - Prevent centralization

Pain: Approach to the Patient

- Establish rapport with patient
- Find the source of the pain
- Treat both the primary source and the presenting symptoms
- Screen for non-pain problems
- Restore function as your goal

Assessing Pain

Common Terms: Pain Scales

- Numeric Rating Scale: 0-10 scale

- Wong-Baker Faces Scale: 0-10 scale
  - http://www.wongbakerfaces.org/

Medications

Special Considerations

- Lose the oral route
- Patches, sublingual, and subcutaneous delivery
- Renal and hepatic failure
- Nausea medications

Medications

Pharmacology and the Older Adult

- Older adults are at increased risk for adverse drug reactions due to age- and disease-related changes in pharmacokinetics and pharmacodynamics
- Monitor medication effects closely to avoid overmedication or undermedication and to detect adverse effects
- Assess hepatic and renal functioning

Management of Pain: Medications

Opiates

- Mild Pain
  - Codeine-containing medications (acetaminophen with codeine)
- Mild-to-Moderate
  - Hydrocodone
- Moderate
  - Oxycodone
- Severe
  - Fentanyl transdermal
  - Hydromorphone
  - Morphine
  - Methadone: requires specific DEA licensing and training

Management of Pain: Medications

Side Effects

- Nausea and vomiting
- Constipation
- Itching
- Jerky muscular movements
- Sedation
- Confusion
- Respiratory depression

Most Common Pain Reliever

Aspirin

- Most commonly used pain reliever

The Role of Opioids

- Mainstay of treatment for pain and refractory dyspnea
- Underutilized more so in end of life
  - Concern for addiction and hastening death
  - These are rarely problems in end of life care
  - Large therapeutic window

Non-Pharmacologic Pain Relief

Psychological Support

- Psychological counseling for stress management, including cognitive behavioral therapy or biofeedback
- Group counseling for couples or families to decrease interpersonal stress
- Screen for adjustment and depressive disorders
- Management of secondary symptoms such as insomnia

Non-Pharmacologic Pain Relief

- Modalities are energy sources that provide pain relief and reduce inflammation
  - Heat
  - Ice
  - Transcutaneous electrical nerve stimulation
  - Ultrasound

Interprofessional Teams

- *Referral Cue: Remember that Physical Medicine, Physical Therapists, Occupational Therapists, and Chiropractors are experts in pain management*
- Include these professionals in your care management team
- Goal of physical medicine is to treat the source, return normal function
- Physical therapy, which includes stretching and strengthening activities and low-impact exercise (such as walking, swimming, or biking), can help reduce pain
  - Other therapies include heat and massage

Interprofessional Teams

- Occupational therapy teaches how to pace activities and how to do ordinary tasks differently
- Chiropractic, massage, and manipulation may give relief of pain

Non-Pharmacologic Pain Relief

- *Referral Cue: Complementary and Alternative Medicine (CAM)*
- Acupuncture is an ancient Chinese practice that uses very thin needles at very specific points on the skin to interfere with nerve impulses; it can be used for both acute and chronic pain
- Biofeedback uses visual or sound cues to help people control their response to pain; they can learn to relax muscles and stay calm
- Herbal supplements are often useful, and are often powerful, but may interact with other medications, may have adverse effects akin to prescribed medications

Pain Management

For a comprehensive training module see the ENGAGE-IL module "Pain Management of the Older Adult" at engageil.com

Feeding

Artificial Nutrition

- Anorexia is a natural part of the dying process
- Usually no discomfort from hunger/thirst (62%)
- When hunger/thirst is present
  - It is short-lived (34%)
  - Always relieved by small amounts of food, ice chips, and lubricating lips

(McCann et al., 1994)

Artificial Nutrition

Reality

- Artificial hydration may increase suffering with pulmonary secretions, urinary output, nausea, vomiting, and edema
- Oral intake naturally decreases as death nears; lack of water increases endogenous opiates
- Decreased appetite is a normal part of the dying process; help allay fears of "starving to death"

Artificial Nutrition

Tube Feeds are Not Indicated:

- In advanced dementia
- In most advanced cancers
- During active dying

- Weissman's triad
  - Feeding tube
  - Restraints
  - Pulse oximetry
  - http://www.mcw.edu/FileLibrary/User/jrehm/fastfactpdfs/Concept084.pdf

Tube Feeds in Advanced Dementia

- Tube feeds do not prolong life in advanced dementia (Sampson et al., 2009)
- Aspiration pneumonia incidence is same or higher (Palecek et al., 2010)
- Restraints and pharmacologic sedation more common (Palecek et al., 2010)

Tube Feeds in Advanced Cancer

- Tube feeds do not prolong life in cancer cachexia
- Exceptions:
  - Head and neck cancers
  - Proximal GI cancers

(Koretz, 2007)

Physical Comfort Care: Feeding Problems

Feeding Problems	Approaches
Feeding tube	Offer alternative (see next slide)
Early satiety	Offer small frequent meals, use salad plate/ saucer, keep favorite foods on hand, sips and nibbles

Physical Comfort Care: Feeding Problems

Feeding Problems	Approaches
Difficulty swallowing	• Patient not hungry: provide mouth care, swabs • Patient hungry: provide thickened liquids, yogurt, or ice cream
Nausea or vomiting	• Eliminate offending foods, tastes, and smells • Provide cold or room temperature foods, bland foods, and avoid eating or drinking 1-2 hours after emesis

Assessment Question 3

Ms. Harrison is a 70-year-old woman with history of mild cognitive impairment, diabetes, hypertension, and chronic kidney disease. She stays in a senior citizen facility and has been independent with her ADLs. She was recently diagnosed with metastatic breast cancer. She is currently on chemotherapy and is receiving morphine sulfate controlled-release 15 mg BID, along with PRN morphine sulfate IR for pain relief. However she continues to be in discomfort and pain is not well controlled.

Assessment Question 3

Despite chemotherapy, her situation continues to worsen and she has a prognosis of less than 6 months. She has seen her sister die while she was on life support for 2 months and it was a traumatic experience for her. She does not want to go through such "suffering" and wants to be at home in her last moments. She also expresses wishes to discontinue chemotherapy as it has significantly affected her life with multiple admissions for infections over the last 3 months.

How would you help her?

Assessment Question 3

a) She is an appropriate candidate for hospice with her advanced breast cancer and prognosis of less than 6 months; she needs better pain management, goals of care discussion, and emotional support, all of which can be provided through hospice
b) She does not qualify for hospice, as hospice helps people only in a hospital or nursing home setting while the patient wants to be at home
c) She is a good candidate for palliative care, as she has a prognosis of more than 3 months
d) She will not benefit from hospice service, as she is not imminently dying

Assessment Question 3: Answer

a) She is an appropriate candidate for hospice with her advanced breast cancer and prognosis of less than 6 months; she needs better pain management, goals of care discussion, and emotional support, all of which can be provided through hospice (Correct Answer)
b) She does not qualify for hospice, as hospice helps people only in a hospital or nursing home setting while the patient wants to be at home
c) She is a good candidate for palliative care, as she has a prognosis of more than 3 months
d) She will not benefit from hospice service, as she is not imminently dying

Palliative Care

Palliative Care

Does Early Palliative Care Prolong Life?

- Randomized control trial of 150 patients with stage-four lung cancer
  - Control group received usual care
  - Intervention group received palliative care and usual care
    - Survival 2.7 months longer (11.6 months vs. 8.9 months, $p = 0.02$)

(Temel et al., 2010)

Does Early Palliative Care Prolong Life?

- Retrospective study of 4,493 patients with end-stage congestive heart failure or cancers
  - Selected markers suggesting short life expectancies in congestive heart failure and five types of cancer
  - For example, switching to second-line combo chemo for lung cancer within six months of the initial therapy or being on a ventilator without a myocardial infarction (MI) for congestive heart failure patients

Results

- Overall, patients in the hospice cohort lived 29 days longer
- No significant difference for breast and prostate cancer
- The other four cohorts prolonged life less than 1 month

(Connor et al., 2007)

When to Consult?

Patients with a Terminal Condition And:

- Uncontrolled symptoms
- Trouble coping
- Unrealistic goals
  - Despite primary team broaching prognosis
- A need for multidisciplinary support [not in narration]
- Hospice eligibility unclear to primary team
  - If patient qualifies for and agrees to hospice, *work directly with regular social worker*

Recognize the Dying Process

- Reduced food intake
- Increased somnolence
- Social withdrawal
- Bowel or bladder incontinence
- Irregular breathing
- Fever
- Diaphoresis
- Death rattle
- Mottled extremities

Hospice Eligibility

- Life expectancy < 6 months
- Not receiving life-prolonging therapies like chemotherapy
  - Except when the Veterans Administration (VA) is the payer and the patient has a DNR status

Summary

- Palliative care prolongs life, BUT the main goal is to maximize quality
  - Interventions have marginal benefit and real harm
  - Added coordination from interdisciplinary team
  - Assistance with activities of daily living
  - Psycho-spiritual support

Assessment Question 4

Mr. Harris is an 85-year-old gentleman with advanced dementia and has been living with his daughter for the last 10 years. She has been taking care of him, with the help of a homemaker and a home health aide. He has been progressively losing weight, and his oral intake has greatly diminished over the last year. He currently weighs 90 lbs, down from 110 lbs at the same time last year. He has had 3 admissions over the last 9 months related to pneumonia, UTI, and dehydration. He had a swallow evaluation in the last admission which revealed silent aspiration.

Assessment Question 4

He currently needs help with all ADLs as well as IADLs. The daughter is worried that he has not been eating well and his health is deteriorating. She asks you, his primary care physician, if there is any way to improve his intake. She had recently read online that patients who are not eating well may benefit from the placement of a feeding tube in the stomach.

What will you recommend to her?

Assessment Question 4

a) Order a gastrostomy tube placement, as it will significantly improve the overall nutritional status of the patient
b) Order a gastrostomy tube, as it will not only improve the nutritional state of the patient but also prolong his life as well as prevent aspiration
c) Do NOT order a gastrostomy tube placement, as he has advanced dementia and feeding tubes have not been shown to improve nutritional state, morbidity, or mortality in such severe dementia
d) Do NOT order gastrostomy tube, as it does not decrease the risk of aspiration and may in fact increase the risk as well as the need for physical and chemical restraints
e) Both c and d

Assessment Question 4: Answer

a) Order a gastrostomy tube placement, as it will significantly improve the overall nutritional status of the patient
b) Order a gastrostomy tube, as it will not only improve the nutritional state of the patient but also prolong his life as well as prevent aspiration
c) Do NOT order a gastrostomy tube placement, as he has advanced dementia and feeding tubes have not been shown to improve nutritional state, morbidity, or mortality in such severe dementia
d) Do NOT order gastrostomy tube, as it does not decrease the risk of aspiration and may in fact increase the risk as well as the need for physical and chemical restraints
e) Both c and d (Correct Answer)

Interview with Expert: Tanjeev Kaur, MD

Tools and Materials

Type	Hospice and Palliative Care Organizations
CriSTAL Tool [Listen to film to hear expert, Dr. Kaur, recap]	http://spcare.bmj.com/content/early/2014/12/09/bmjspcare-2014-000770.full
The Conversation Project Starter Kit	http://theconversationproject.org/starter-kit/get-ready/
• Palliative Care: The Legal and Regulatory Requirements • Sample Palliative Care Services Agreement • Palliative Care Checklist	http://www.nhpco.org/palliative-care-legal-and-regulatory-resources

Tools and Materials

Type	Hospice and Palliative Care Organizations
Wong-Baker Faces Scale: 0-10 scale	http://www.wongbakerfaces.org/

Resources

http://www.engageil.com Accessed October 10, 2016
http://hiv.ubcepd.ca/files/2012/09/Summary-on-Breaking-Bad-News.pdf Accessed October 10, 2016
http://www.mew.edu/FileLibrary/User/jrehm/fastfactpdfs/Concept084.pdf Accessed October 10, 2016
http://www.nhpco.org/palliative-care-legal-and-regulatory-resources Accessed October 10, 2016
http://spcare.bmj.com/content/early/2014/12/09/bmjspcare-2014-000770.full Accessed October 10, 2016
http://theconversationproject.org/ Accessed October 10, 2016
http://theconversationproject.org/starter-kit/get-ready/ Accessed October 10, 2016
http://www.wongbakerfaces.org/ Accessed October 10, 2016

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