# The Positive Difference Can Be Palliative Care

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## Disclosures

- I have no financial disclosures.
- I have no financial affiliations

## Objectives

- By the end of this presentation participants will be able to
  - Differentiate between palliative care and hospice care.
  - Identify the barriers and gains to delivering timely, efficient, and quality end of life care for patients, families and institutions in the setting of serious illness.
  - Develop the skills necessary to provide compassionate care of the seriously ill.

## Our Health Care Dilemma for Dollars

- Health care costs in the U.S. are 1/5 of our economy.
- 95% of all health care spending is for the chronically ill.
- 64% of all Medicare spending goes to the 10% of beneficiaries with 5 or more chronic conditions.
- 1 in 5 Medicare patients re-hospitalized within 30 days of discharge.
- Despite high spending, evidence of poor quality of care.

*Center to Advance Palliative Care*

## What has changed in the last 70 years?

- Most people had a short illness and died.
- People did not live to their 80's and 90's with chronic disease.
- Advent of antibiotics and medical 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.

## Dealing with Advanced Chronic, Serious, Life-limiting Illness

- Distress to patients caused by symptoms
- Limitation on function and activities
- Burden on family caregivers
- Overuse of costly, ineffective therapies

## What is Palliative Care?

- *Patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering….throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.*

  *Medicare Hospice Conditions of Participation*

- *Interdisciplinary care that aims to relieve suffering and improve the quality of life for patients with a life-threatening illness and their families. Expert control of pain and symptoms and practical support for patient and family is integrated into every stage of illness along with all other appropriate medical treatments.*

  *Center to Advance Palliative Care*

## Why Palliative Care?

- Improves patient quality of life.
  - Reduces pain and other symptoms.
  - May prolong life.
- Improves family satisfaction and well-being.
- Reduces resource utilization and costs

  ……..and does so for the sickest 5-10% of Medicare and Medicaid beneficiaries, thus impacting the bottom line on health care costs.

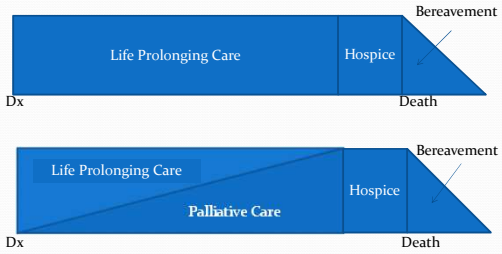
## Is Palliative Care the same as Hospice?

- *All hospice care is palliative….but not all palliative care is hospice.*
- **Hospice** is appropriate when curative treatments are no longer beneficial, when burdens of treatment exceed the benefit, or when patient is in the last weeks to months of life.
- **Non-hospice palliative care** can be offered simultaneously with life-prolonging and curative therapies for persons living with serious, complex, and life-limiting illness.

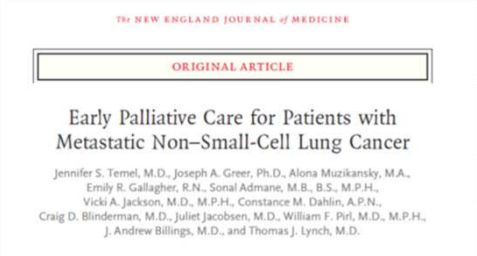
## Is Palliative Care the same as Hospice?

- **Hospice** is a form of palliative care that is paid for under a Medicare benefit (also Medicaid and many insurances); strictly limited to people who have a prognosis of 6 months or less. Focus of care on comfort VS aggressive or life-prolonging treatment.
- **Palliative Care** has no such restrictions but there is no provision under Medicare or Medicaid for payment under a similar benefit. Billed for by physicians or ARNP's same as for other specialties.

## The Old & the New Model




## Can Palliative Care Extend Life?



The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

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

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## Can Palliative Care Extend Life?

- "Yes" according to a study reported in the August 19, 2010 NEJM
- Goal of study – "to examine the effect of early palliative care integrated with standard oncologic care on patient-reported outcomes, the use of health services, and the quality of end-of-life care among patients with metastatic NSCLC."
- Study performed at the Massachusetts General Hospital in Boston – a 3 year study with 151 patients (with NSCLC), followed until the end of 2009.

## Can Palliative Care Extend Life?

- Eligible patients enrolled within 8 weeks after dx.
- Randomly assigned to one of two groups – receiving palliative care or not.
- All received standard oncologic care.
- Palliative care patients met with a member of the p.c. team in the outpatient setting at least monthly with additional visits as needed (board certified physician or APN).

## Can Palliative Care Extend Life?

- Specific attention to:
  - Assessing physical & psychosocial symptoms
  - Establishing goals of care
  - Assisting with decision making regarding treatment
  - Coordinating care on basis of individual needs
- Measured:
  - Health-related quality of life (physical, functional, emotional, & social well-being)
  - Mood – anxiety & depression screens

## Can Palliative Care Extend Life?

- Results?
  - Better quality of life in palliative group
  - Lower rates of depression
  - 2.7 month survival benefit
  - Fewer patients received aggressive end-of-life care
- Conclusion?
  - Palliative Care is appropriate and potentially beneficial when introduced at the time of diagnosis of a serious or life-limiting illness – at the same time as all other appropriate and beneficial medical therapies.

## Barriers to Palliative Care

- Access
  - Medical providers
    - still seen as "hospice"
  - Refused by patient/family
    - Seen as "giving up"
  - Incorrect association for withdrawing/withholding care
- New philosophy of care
- Availability
  - 80% of large hospitals (> 300 beds) have programs
  - Outpatient care lacking
    - 99% of serious illness experienced at home.

## The Ideal

- Palliative care is a team sport – Interdisciplinary
  - Physician
  - Nurse specialist
  - Social Worker
  - Chaplain or spiritual support

## The Ideal

- Palliative Care is:
  - Assessment and treatment of symptoms
  - Support for decision making
  - Matching treatments to informed patient & family goals
  - Practical aids for patients and family caregivers
  - Mobilization of community resources to ensure a secure & safe living environment
  - Collaborative & seamless models of care across a range of settings

## Philosophy of Care

- Expert symptom management
  - Pain
  - Shortness of breath
  - Anxiety
  - Depression
  - Nausea and vomiting
  - Confusion

## Philosophy of Care

- Psychological and Spiritual Needs
  - Adjustment to terminal illness
  - Adjustment to changes in patient's role
  - Finding meaning
  - Completing relationships
- Expert prognosis
  - Honest, empathetic, and accurate information for patients

## Philosophy of Care

- Matching patient goals with treatment plan
  - Time to benefit
  - Burdens of therapies
- Collaboration for discharge planning
  - Documentation of care needs and goals
  - Communication across specialties and medical systems

## Hospice History

- Dame Cicely Saunders
- 1967 founded St. Christopher's hospice in London
- Observed that dying patient's were often neglected or ignored
- Developed the holistic care model

## Hospice Benefit

- Medicare Part A
  - 1982
  - Two 90 day certifications with unlimited number of 60 day benefit periods
- Medicaid
  - State determined
  - Kansas-215 days
- Private insurance
  - Specific hospice benefit
  - Home care benefit

## Hospice Philosophy

- Care of the terminally ill focusing on comfort
  - Alleviation of suffering including physical, psychological, and spiritual aspects
  - Emphasis on symptom management in the dying with no effort to prolong or hasten death

## Hospice Barriers

- Prognosis of 6 months or less
  - 2 physicians determine
- Focus is not curative
  - Stop life-prolonging treatments

## Hospice Admission Criteria

- Life limiting condition
- Patient and/or family elected treatment goals of relief of symptoms rather than cure
- Uni-Policy (one of the following)
  - Progression of primary disease process documented by physician assessment, laboratory, radiologic or other studies
  - Multiple ED visits or hospitalizations in the past 6 months
  - Documented recent decline in functional status
    - PPS, ADLs

## Palliative Care vs Hospice Care

| | Palliative Care | Hospice |
|---|---|---|
| Prognosis <6 months? | No | Yes |
| Insurance Benefit? | No | Yes |
| Curative treatments? | Yes | No |
| Are services provided in the home? | Not always, depends on program | Yes |

## Compassionate Care

- Understanding the perspective of patient & family
- Understanding what is important to patient & family
- Is based on **Communication**
- Not a one time event, but a process

## CLASS Protocol

- **C**ontext
- **L**istening Skills
- **A**cknowledgement of Patient's Emotions
- **S**trategy for Clinical Management
- **S**ummary

## Prepare & have difficult conversations on 3 levels:

- 1. Facts
- 2. Emotions
- 3. Identity Issues

## Case Study

- 67 y/o female "Joan"
- 14 month history of neglected breast cancer
- Initial presentation 10x20cm necrotic chest mass
  - ER/PR Infiltrating Ductal
  - Metastatic to bone and liver
  - Treated with debridement and adjuvant hormonal therapy
  - Initial goals were DNR/AND and continue medications

## Case Study

- Recent admission to hospital for multiple symptoms
  - Diagnosed with sepsis with enterovaginal fistula from uterine mass or diverticulitis with abscess
  - Diagnosed with cortical blindness from embolic stroke to occipital lobes and temporal lobe with right sided weakness
  - Recently discharged home with home health from rehabilitation hospital
- Current functional status is wheelchair needed for long distance or standby assist ambulation with assistance for bathing and dressing
- Patient states "I'm a crucivervalist" so life is not very good right now.

## Case Study

- Palliative Care Team provided:
  - Psychosocial support by SW
  - Nurse support for monitoring medications and symptom management
  - Physical and Occupational therapies for ADL retraining and adaptation to blindness
  - Spiritual support declined by patient

## Case Study

- Joan needed:
  - Expert management of insomnia and loss of vision
  - Psychological care
  - Support for decision making
  - Defining goals of care
  - Matching treatments to informed patient & family goals

## Case Study

- Joan needed:
  - Communication & coordination
    - Prognosis
    - Treatment options
    - Continuity of care and providers
  - Expert discharge planning
  - Practical aids for patients & family caregivers
  - Mobilization of community resources to ensure a secure & safe living environment
  - Collaborative & seamless models of care across a range of settings

- ***"To Cure Sometimes……."***
  - ***"To Relieve Often……."***
    - ***"To Comfort Always……."***

*Anonymous, 16th Century*

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