Objectives

At the end of this presentation, participants should be able to:

- Describe what Palliative Medicine is
- Describe and discuss the difference between Hospice and Palliative Medicine
- Understand techniques to discuss goals of care with patients and families
- Discuss different models and the future of Palliative Medicine in long term care facilities
What is Palliative Medicine?

Palliative Medicine is a medical specialty that provides management to the growing population of patients with debilitating acute or chronic disease and life-threatening illness. Palliative medicine programs provide systematic treatment of pain, distressing symptoms, and patient stress, providing dignity, respect and symptom management based on the patient’s goals.

Trajectory of Care

Palliative Medicine Interdisciplinary Team (IDT)

- Successful palliative medicine requires attention to all aspects of patient’s suffering, often accomplished through a multidisciplinary approach
- Ideal Core Interdisciplinary Team Members
  - Physician/ARNP/PA
  - Social Worker
  - Chaplain
- We all provide “palliative care” as caring clinicians

How does Palliative Medicine help Clinicians?

- Supports the primary physician’s care of the patients with serious and often life-threatening illness
- Assists the care team treating seriously ill patients who require pain and symptom management or have a high demand for patient/family communication
- Matches treatment to patient goals
- Helps discuss patient’s prognosis
Managing Symptoms

May be related to the illness or treatments. Most common symptoms include:

<table>
<thead>
<tr>
<th>Pain</th>
<th>Constipation/Obstruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weakness/Fatigue</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Dyspnea</td>
<td>Depression</td>
</tr>
<tr>
<td>Insomnia</td>
<td>Nausea/Vomiting</td>
</tr>
<tr>
<td>Anorexia</td>
<td>Confusion/Delirium</td>
</tr>
</tbody>
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Palliative Medicine vs. Hospice

<table>
<thead>
<tr>
<th>Patients Served</th>
<th>Palliative Medicine</th>
<th>Hospice</th>
</tr>
</thead>
<tbody>
<tr>
<td>• At any stage of acute, chronic, advanced or life-threatening illness</td>
<td>• Prognosis of 6 months or less</td>
<td>• Dying Patients of any age</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Services Provided</th>
<th>Palliative Medicine</th>
<th>Hospice</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Throughout duration of chronic illness</td>
<td>• End of Life</td>
<td>• Curative treatment is no longer an option</td>
</tr>
<tr>
<td>• Patients can continue with curative care</td>
<td>• Coordinated pain and symptom control</td>
<td>• Care of spiritual needs</td>
</tr>
<tr>
<td>• Simultaneous with other treatment</td>
<td>• Family support</td>
<td>• Family support</td>
</tr>
<tr>
<td>• Coordinated pain and symptom control</td>
<td>• Assistance in making decisions and transitions between care settings</td>
<td>• Assistance in making decisions and transitions between care settings</td>
</tr>
<tr>
<td>• Care of spiritual needs</td>
<td>• Care of primary physician and other specialists</td>
<td>• Bereavement care for survivors</td>
</tr>
<tr>
<td>• Family support</td>
<td></td>
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</tr>
</tbody>
</table>
“Palliative Care is About Matching Treatment to Patient Goals”

Diane Meier, MD
Director, CAPC
Mount Sinai School of Medicine

Goals of Care: Why

- Everyone has a personal sense of what brings the greatest meaning to their lives
- We make choices based on diagnosis, risks, benefits, and personal priorities
- Over time our goals of care may change
Key Points in Discussing Goals of Care

- Explore the patient’s understanding of their illness
- Explore the patient’s values and expectations
- Understand the likely outcome of CPR
- Make a recommendation consistent with the patient’s goals
- Check for patient/family understanding
- Do not force a decision – be sure to follow-up/try to establish a relationship
- Continue to provide good medical care to support physical, emotional and spiritual needs
- Address other related issues
  - DPOA-H
  - POLST
  - Living Will i.e. role of Artificial fluid/nutrition
  - Five Wishes
  - Hard Choices

VALUE: Approach to Improving Communication with Families

V  • Value family statements
A  • Acknowledge family emotions
L  • Listen to the family
U  • Understand patient as a person
E  • Elicit family questions

Curtis, J Crit Care, 2002;17:147
Goals of Care: How

- Create the right setting – Sit Down
- Find out what patient/family know
- Find out what they want to know
- What are they hoping for
- Suggest realistic goals/make a recommendation
- Respond with empathy
- Make a plan/follow up

Goals of Care: HOW

Treatment Goals:
- “Given the severity of your illness, what is most important to you right now?”
- “How do you think about balancing quality of life with length of life in terms of your treatment?”
- “What are your biggest fears/concerns?”
- “What are your hopes for the future?”
Goals of Care: – HOW
If patient goals are clear—Make a recommendation

If patient’s understanding of illness/prognosis is clear and their goals are clear – i.e. “Given the severity of your illness, CPR would likely be ineffective. I would recommend against it…”

OR

“We have agreed that the goals of care are to keep you comfortable and get you home. With this in mind….”

Goals of Care: How –
if patient goals are unclear

“If you were to die suddenly, we could attempt to revive you with CPR. Are you familiar with CPR? Have you given any thought as to whether you want it?”

“Given the severity of your illness, CPR would likely be ineffective, and would not help to achieve your goals of….”
Goals of Care: HOW

Avoid:

- “Do you want us to do everything” – Implies that without CPR we will “do nothing”

Instead:

- “Your dignity, respect, and symptom management will ALWAYS be part of our treatment plan”

Goals of Care: New Framework

- Physicians may have an obligation to make a recommendation regarding the best care – Need to know the patient’s goals of therapy – i.e. Patient Centered Communication

- Language and framework are the key to developing a good medical plan of care
Goals of Care: How New Framework

- It is not a matter of just asking: “Do you want CPR?” or “Are you a Full Code?”
- CPR is a medical procedure
  - * informed consent

- Is this procedure the best medical care to support the patient/family goals?
  - * Patient Centered v Disease Centered
  - * Professional Obligation

Goals of Care: Potential Pitfalls

- Failure to discuss expectations
- Offering unwanted interventions
- Failure to refer to hospice or palliative medicine programs. 80% of Americans are never referred to such programs
- Overly optimistic estimates of prognosis
Goals of Care: Barriers

- We avoid the concept of Death
- Providers are often overly optimistic about prognosis
- Unrealistic belief in technologic solutions
- Loss of hope for the future
- If no CPR – “nothing will be done”
- It takes too much TIME to talk about...

Goals of Care: PEARLS

- No one goal is inherently more valid than another
- Set goals before determining treatment plan
- Ask early in the relationship how the patient would like to handle information sharing
- “Hope for the best, but prepare for the worst”
Evolution of Nursing Homes

- Provide 24/7 skilled nursing care and rehabilitation services to people with illnesses, injuries or functional disabilities.
- Now provide much of the nursing care that was previously provided in a hospital setting a decade ago.

http://www.nursinghomeinfo.com/nhservc.html

Who Lives (and Dies) in Nursing Homes?

- 2010 - 1.4 million nursing home residents (US )
  (18,065 in WA state)
  - 88% aged 65 years and older
  - 45% 85 years and older
  - 71% female
  - 86% Caucasian

Who Lives (and Dies) in Nursing Homes?

- 25% Americans die in nursing homes
- Projected by 2030 > 3 million Americans will reside in institutional long-term care

“Good Geriatric Care is Good Palliative Care”

Pro:
Customized to each unique nursing home

Con:
Not standardized, not regulated, no quality control
Nursing Homes have incredible experience in care of the dying due to their “on-the-job training”

Palliative Medicine Consultation Model

- Reasons for consultation
  - Symptom management
  - Goals of care discussion, or
  - End-of-life care planning
- May or may not meet criteria for Hospice eligibility
The Future is NOW!

- Conversation Project
- STAAR Program (State Action on Avoidable Re-Hospitalizations 2009/4 states – including WA)
- “Top Down/Bottom Up”
  - Administrative Support
  - Staff Buy In

Palliative Medicine in Nursing Homes

Models of Palliative Medicine Delivery in NH

- Traditional Hospice
- Non-Hospice Palliative Medicine Consultation Services
  - Palliative medicine providers from the community
  - Hospice providing non-Hospice palliative medicine
- Integrated Palliative Medicine Programs developed by the NH “Home Grown”
Palliative Medicine in Nursing Homes
One Model Will NOT Serve All Needs

- Models of Palliative Medicine Delivery in NH based on:
  - Size
  - Culture
  - Staffing
  - Leadership
- Community factors
  - Availability of palliative medicine expertise (Hospice, academic centers, outside consultants)
  - Relationship with area hospitals

Non-Hospice Palliative Medicine Consultation Model

Palliative Care Center of the Bluegrass
Lexington, KY

- Patients followed by PM while in a hospital get a call upon return to the NH to assess if PM should continue to follow
- NH can call PM 24/7 for advice on opioid titrations
- ARNP doing consultation works directly with NH social workers and physicians
Non-Hospice PM Consultation Model

Lessons Learned from PCC of the Bluegrass

- PM consultants must be familiar with the layout of NH and the personnel
- Must educate NH staff about how PM consultation benefits THEM (saves time) and improves patient outcomes and satisfaction
- Consultants need to be available for and attentive to staff questions

Non-Hospice PM Consultation Model

Four Seasons Hospice
Flat Rock, North Carolina

- Primary provider of Hospice and Palliative Medicine for Henderson County serving hospitals, NHs, and most assisted living and group homes in the area
- Palliative medicine consultation provided to NH residents with serious chronic illnesses, provided by same Hospice staff, but billed differently
### Non-Hospice PM Consultation Model

**Lessons Learned from *Four Seasons Hospice***

- Hire Hospice and PM providers who are familiar with and appreciate nursing home culture
- Define differences between PM and Hospice to the NH staff as it relates to patient eligibility, regulatory requirements, and payer considerations
- Establish relationship with the NH Medical Director

### “Home Grown” PM Consultation Model

Nursing Home Integrated Palliative Medicine
- NH either train their own palliative medicine providers or hire staff with palliative medicine expertise
- Palliative medicine practices are integrated into daily operations and care plans
“Home Grown” PM Consultation Model

*Morningside House, Bronx, NY*

- External grant funding for palliative medicine physicians to come discuss cases monthly
- Use of an interdisciplinary team
- Nurse Practitioner model
- Tuition reimbursement and encouragement to nursing staff for more schooling
- CNAs are given training in palliative care

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“Home Grown” PM Consultation Model

- *Jewish Home Lifecare, Manhattan, NY*
  
  - Dedicated palliative medicine physician, on-site and salaried
  - Funded for a palliative medicine practitioner to educate staff
“Home Grown” PM Consultation Model

- Lessons Learned
  - Individual programs are difficult to replicate across NH of different demographics
  - Financial viability always a struggle
  - “Home Grown” likely to have more buy-in from staff
  - Custom-tailored programs for each NH is ideal

Barriers to Improvement

- Transitions
  - Transfers to/from hospital
  - Patient safety
  - Communication

- Staffing
  - Insufficient providers/staff

- Training/Education
  - ELNEC/In-house

- Cultural Differences of Patients/Staff
  - Language Barriers

- Regulatory Issues

- Financial Issues
  - Who is Paying?
  - Grant Availability
Take Home Message.....

There are many opportunities for seamless palliative care in the nursing home....

Resources

- Center to Advance Palliative Care  [www.capc.org](http://www.capc.org)
- National Hospice and Palliative Care Org  [www.nhpco.org](http://www.nhpco.org)
- American Academy of Hospice and Palliative Medicine  [www.aahpm.org](http://www.aahpm.org)
- [www.CaringInfo.org](http://www.CaringInfo.org)
- [www.CaringBridge.org](http://www.CaringBridge.org)
References

- "Improving Palliative Care in Nursing Homes", Copyright 2008 Center to Advance Palliative Care, www.capc.org

What questions do you have?
Thank you!