PALLIATIVE MEDICINE
QUALITY OF LIFE, NOT END OF LIFE.
WORKING WITH YOU TO HELP YOUR PATIENTS WITH LIFE LIMITING ILLNESS.

Purpose of presentation
- Overview of Palliative Medicine
- Differentiating Palliative Medicine and Hospice
- How/when to refer: inpatient and outpatient consults
- How Palliative Medicine can:
  - Improve quality of life indicators
  - Decrease hospital readmissions
  - Improve mortality rates
  - Symptom management
  - Exploration of understanding about illness and prognosis
  - Clarification of treatment goals
  - Assessment of support and coping needs
  - Assistance with medical decision making
  - Coordination of care with providers
  - Advanced Directives

What is Palliative care?
- To Palliate:
  - Make less severe or unpleasant without removing the cause
  - Allay or moderate
  - Disguise the seriousness or gravity
  - Synonyms: alleviate, ease, relieve, soothe, assuage, moderate, temper, diminish, decrease, blunt
Definition of PC

- A medical and interdisciplinary subspecialty that aims to relieve suffering and improve quality of life for patients with advanced illness, and their families.
- Provided simultaneously with all other appropriate medical treatment
- (www.capc.org)

Palliative care is…

- Excellent, evidence-based interdisciplinary treatment
- Vigorous care of pain and symptoms throughout illness
- Care that patients want at the same time as efforts to cure or prolong life
- Not “giving up” on a patient
- Not in place of curative or life-prolonging care
- Not the same as hospice

Palliative care is…

- …matching treatment to patient goals
- …providing the right care at the right time
- …participating as neutral advisors of prognosis and goals of care, burdens and benefits of treatment
- …improving quality of life for patients and families facing serious illness
Palliative care is helping to/with…

- honor patient wishes
- pain and symptom control
- avoid inappropriate prolongation of the dying process
- achieve a sense of control
- relieve burdens on family
- strengthen relationships with loved ones

Palliative Care can…

- Help support transitions to more appropriate care settings
- Help lower costs (for hospitals and payers) by reducing hospital and ICU length of stay, and direct costs (such as pharmacy).
- Palliative care improves continuity between settings and increases hospice/homecare/nursing home referral by supporting appropriate transition management.

Never underestimate the power
Differentiating PC and Hospice Care

Hospice
- For patients who are expected to die within less than 6 months.
- For patients who are no longer candidates/refusing further curative therapy
- Patients requiring active symptom management, who are too tenuous to move, or are actively dying may be eligible for in-patient hospice. In these patients death is expected within 5 days.

Palliative Care
- For patients who you would not be surprised if they die within the next 6-12 months.
- Patient does not have to forego curative treatment or hospitalization
- Appropriate for all patients with chronic/serious illness

Chronic Disease Trajectories
Appropriate Patients

- Patients who have a life-threatening or life-shortening illness—Cancer, COPD, CHF, Stroke, CAD, End-Stage Renal Disease, ALS, Other (necessary criteria) and…
- Complicated symptoms—pain, dyspnea, diarrhea, constipation, anorexia, nausea, insomnia, anxiety, depression, fatigue
- Family, Spiritual, Social, Emotional and Physical Concerns

Review of published, peer-reviewed outcomes research, including both observational studies and controlled trials of nonhospice outpatient palliative care services
- Assessed patient, family, caregiver, and clinician satisfaction; clinical outcomes including readmission rates, hospice use, and cost.

Results:
- Four well designed randomized interventions as well as a growing body of nonrandomized studies indicate that outpatient palliative care services can:
  1) improve patient satisfaction,
  2) improve symptom control and quality of life,
  3) reduce health care utilization, and
  4) prolong survival in a population of lung cancer patients.

Conclusion
- Available evidence supports ongoing expansion of innovative outpatient palliative care service models throughout the care continuum to all patients with serious illness.
Examination of 2004-2007 data to determine effect on hospital costs of palliative care team consultations for patients enrolled in Medicaid at 4 New York state hospitals.

- On average, patients receiving palliative care incurred $6,900 less in hospital costs during a given admission than a matched group of patients who received usual care.
  - Included $4,098 in hospital costs per admission for patients discharged alive
  - $7,563 for patients who died in the hospital

- Palliative care recipients:
  - Spent less time in the ICU
  - Less likely to die in ICU
  - More likely to receive hospice referrals than matched usual care patients

Palliation of symptoms (fatigue, dyspnea, compromised exertion)

- Interventions to address the neurohormonal alterations in HF and symptoms
  - ACE inhibitors
  - Beta blockers
  - Aldosterone blockade
  - Screening for sleep-disordered breathing
  - Loop diuretics
  - Dietary intervention
  - Oral nitrates
  - Oral opioids for dyspnea
  - Antidepressants
  - Antianxiety interventions
  - Exercise

Communication with patients about dying and approach to care

End of life care for HF patients

- Deactivation of ICD

Management at end of life

- Re-evaluation of medications

Hospice care for HF patients

- Literature search from 8/12/12 forward using the terms “palliative care” and “intensive care unit”.
  - 3328 references, 37 publications included, with 30 unique interventions
  - Focus on outcomes of patient and family satisfaction, mortality, and ICU and hospital length of stay

Results
- Heterogeneity of interventions made comparison of ICU based palliative care interventions difficult
- Existing evidence suggests proactive palliative care in the ICU using either consultive or integrated palliative care interventions decrease hospital and ICU LOS, do not affect satisfaction and either decrease or do not affect mortality


- Objective: to assess the effect of specialist palliative care on quality of life and additional outcomes relevant to patients in those with advanced illness.
- Meta analysis of randomised controlled trials with adult inpatients or outpatients treated in hospital, hospice or community settings with advanced illness.

Results
- Of 3967 publications, 12 were included
- 10 randomised controlled trials with 2454 patients randomised, of whom 72% (n=1766) had cancer

Conclusion
- Specialist palliative care was associated with a small effect on quality of life and might have most pronounced effects for patients with cancer who received such care early
- It could be most effective if it is provided early and if it identifies through screening those patients with unmet needs


- Randomized clinical trial shows patients who received palliative care along with standard treatment for advanced cancer reported having better quality of life and mood than patients who did not receive early palliative care.
- Patients receiving early palliative care also scored better on assessment of their ability to cope with their disease and were more likely to discuss end-of-life care preferences with their health care team.
- Joseph A. Greer, PhD of Massachusetts General Hospital
- Enrolled 350 patients with gastrointestinal cancers as well as lung cancers. Randomly assigned to receive palliative care along with standard treatment or standard treatment alone
• nonblinded, randomized, controlled trial of early palliative care integrated with standard oncologic care, as compared with standard oncologic care alone

• early palliative care met with a member of the palliative care team, which consisted of board-certified palliative care physicians and advanced-practice nurses, within 3 weeks after enrollment and at least monthly thereafter in the outpatient setting until death. Additional visits with the palliative care service were scheduled at the discretion of the patient, oncologist, or palliative care provider

• 151 patients were enrolled in the study
Ambulatory Consults

- Referral Sources
  - Seen in hospital, follow up outpatient
  - From specialist: oncologist, cardiologist, pulmonologist
  - From PCP
  - Self-referral/family or friend suggestion

- Setting
  - Clinic office
  - ECF/Assisted living facility
  - Home visit

Inpatient Consults

- Referral from:
  - Hospitalists
  - Critical Care Intensivists
  - Specialists
    - Cardiology
    - Oncology
    - Pulmonology
    - Surgeons

- Most frequent issues
  - Goals of care
    - Code status
  - Dysphagia/failed swallow study
  - Treatment options/end points
  - Pain/symptom management
  - End of life care/transition to hospice
  - Family meetings

When to refer

- Consultive service: we manage along with you
- Refer as soon as you think of it. Don’t wait until “the end”
- Referral at diagnosis of life limiting illness
- Never too early to start the conversation
Palliative Care Team

- Physicians
  - Completion of primary residency
  - Palliative medicine fellowship trained
  - 1 year fellowship
  - Some physicians practicing longer have been grandfathered, don't need fellowship
  - Board certification
- Advanced practice providers
  - APRNs
  - PA's
- Social work
- Chaplain
- Pharmacist
- RN
- Child life
- Office Coordinator

Carle Palliative Medicine

- M-F Service, day shift, with weekend/holiday coverage
- Mostly Inpatient Consults, expanding ambulatory service
- Extensive consults for goals of care, advance directives
- Providers rotate between inpatient and ambulatory
- Imbedded providers in oncology clinic and heart failure clinic

Case Study
Closing

• THANK YOU!

References

- www.bmj.com
- Singer et al. JAMA 1999
- www.bmj.com
- www.capc.org
- www.capc.org
- Franklin S.A et al JPM 2003, 5057-1051

Resources

- Vitaltalk.org
- Communication skills for serious illness
- Globalkph.com
- Drug-related calculations
- HPNA advancingexpertcare.org
- Hospice & Palliative Nurses Association
- CAPC.org
- Centers to Advance Palliative Care
- Great module on symptom management with CE’s
- AHAHPM.org
- American Academy of Hospice and Palliative Medicine
- Many position statements:
  • Artificial nutrition/hydration at EOL
  • Palliative care
  • Physician assisted dying
  • Withholding and withdrawing non-beneficial medical interventions