Bring Palliative Care Into Your Office

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Palliative care is both a philosophy of care and an organized, highly structured system for delivering care. The goal of palliative care is to provide the best possible quality of life for people facing the stressors of serious illness, and is provided along with curative or comfort treatments.

(Center to Advance Palliative Care, 2012)
Everyone wants good palliative care

- Education on prevention
- Treatment plan
- Goals of care
- Periodic review of plan
- And when unforeseen events occur
  - A plan to fix or mitigate any damage
  - Symptom management
  - Good follow-up
- Continued care

At the Dentist
Triggers

• Progressive, debilitating, potentially life-threatening illness
• Patient/Family request
• Unmet psychosocial needs, or spiritual distress
• Frequent, related ED visits, esp in past 60 days
• Prolonged hospital lengths of stay without evidence of progress – bouncing between the hospital and rehab
The Continuum of Care

- Disease Modification
- And / Or Curative Care
- Palliative Care
- Hospice Care
- Bereavement Support

An extra layer of Support
Hospice

• 6 months or less – in your best guess
• Focus on care, not cure
• *Aggressive* pain and symptom management
• Same team dynamics
• MD/DO must refer and certify terminal illness
• Usually provided in the home
Myths About Palliative Care

• Saying yes to palliative care is saying no to curative/continuing treatment
• Palliative care is the same as hospice
• Accepting palliative care means you are giving up
• Palliative care shortens your life expectancy
• I don’t need palliative care because my provider will take care of my needs
The Palliative Care Team

Interdisciplinary Team

- APRNs (APCHPN)
- Chaplains
- MSWs (CHP-SW)
- Physicians (PCM)*
- RNs (CHPN)
Patient Centered

What does the patient want?
• Achieve a sense of control
• Pain & symptom control
• Relieve burdens on the family
• Strengthen relationships with loved ones
Informed Decision Making

• You can’t make an informed decision without information

• Disease specific education
  • What treatments are available
  • What are the pros/cons of each
  • Disease trajectory & mitigating what’s next

• Not everything needs an immediate answer
Shared Decision Making

• How much do you want to know
• Who else needs to be part of conversations
• Who do you want to speak for you if you can’t
• What if the treatment you chose doesn’t do what you hope
• What are your concerns about symptom management
  • Addiction is generally a fear, esp if they have overcome it once
Symptom Management

• Physical
• Spiritual
• Psychosocial
  • Emotional & Family
  • Ethical & Legal Concerns

Don’t wait on this – quality of life is directly tied to how quickly symptoms are addressed, even if they aren’t managed as well as they might be. Get help if you need to - and tell them that you are getting it.
The Palliative Care Meeting
10 Steps

1. Understand the patient and their condition
2. Ready the space
3. Introduce the team
4. Listen to what they know
5. Ask – what do they want to know
6. Tell – give them the news (then stop talking)
7. Ask – what did they hear
8. Answering difficult questions
9. Explain their options – pros & cons
10. Write down what was said & plan next appointment
Where do you start?

What are your biggest concerns?

What might you recommend?
What now?

What are your biggest concerns?

What might you recommend?
By now you have had several discussions with Jim & his family.

Have your recommendations changed? How? Why?
More Talking Points

- Intubation & CPR
- Body/Organ Donation
- Pacer/AICD deactivation
- Artificial Nutrition/Hydration
- Control of Symptoms – what are they willing to tolerate as a trade for what they want to do
Billing
Prolonged-Service Codes

• When time overrides all components of medical decision making if >50% of the total face-to-face time is spent counseling/coordinating care

• Outpatient: the *patient* must be present for the time to qualify as face-to-face

• Total time, counseling time, and a brief description of the counseling must be documented in the medical record.

• *Must* document IN and OUT times
Counseling – what counts

Discussions involving

• Diagnostic results, impressions, and/or recommended diagnostic studies
• Prognosis
• Risks and benefits of management/treatment choices
• Instructions for management (treatment/follow-up)
• Importance of compliance with chosen treatment option
• Treatments initiated or adjusted
• Risk factor mitigation
• Patient & family education
Time – what counts

- Reviewing current and old records
- Patient interview and examination
- Writing notes
- Communication with other professionals
- Communication with families

- Must document IN and OUT times in the chart
ICD 10 – some examples

• Z51.5 Palliative care (inpatient)
• V61.9 Unspecified family circumstance – Encounter for circumstance, conflict, maladjustment
• Z63.79 Other stressful life events affecting family and household
• Z63.6 Case of sick family member
• Z74.2 Need for assistance with personal care at home and no other household member able to render care
Resources

- Palliative Care Education
- Guidelines & Certifications
- Fellowships
- Triggers
- Hospice Criteria
- PC Job Descriptions
- ACP Video Information
- Oregon POLST Brochure
- AICD/ANH
- E/M and Medical Decision Making