Primary Palliative Care

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No financial disclosures

Objectives

- Discuss palliative care and how it differs from hospice
- Explore how to manage patients' goals and expectations in serious illness
- Discuss options to minimize polypharmacy in patients with multiple comorbidities
- Review prognostication and best ways to convey this information in outpatient setting
- Review advance directives to use in outpatient setting

What is palliative care?

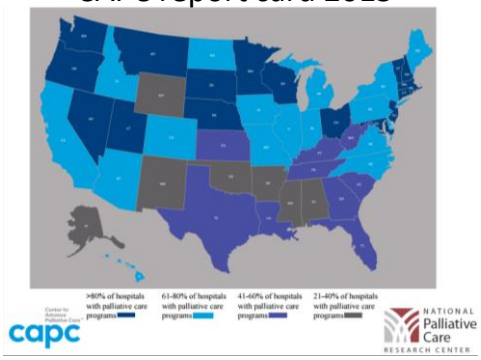
- "Palliative care is specialized medical care for people living with serious illness. It is focused on providing patients with relief from the symptoms and stress of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family…. appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment."

CAPC.org

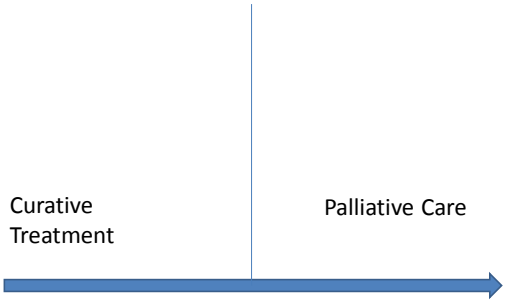
Team

- PC team usually composed of physician, advanced practice provider, social worker, chaplain, etc

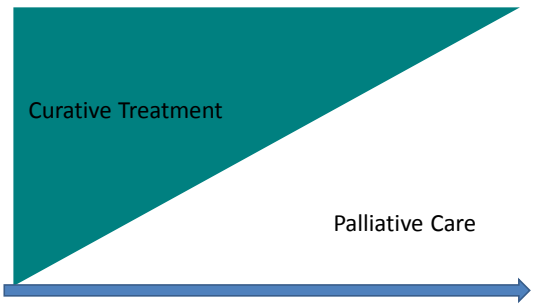
CAPC report card 2015



Old Model of Care



New Model of Care



Hospice

- Definition: philosophy of care for dying patients that states that patient must have terminal illness with expected prognosis of 6 months or less if "illness runs its normal course"
- Medicare benefit since 1980s
- Hospice care can be delivered:
  - Patient's home
  - Nursing home (SNF)
  - Inpatient hospice unit

****Remember that palliative care ≠ hospice****

Which of these patients qualifies for palliative care vs hospice?

- 62 year old man with chronic systolic CHF and CKD stage IV
- 85 year old woman with moderate Alzheimer's dementia
- 45 year old woman with newly diagnosed pancreatic cancer

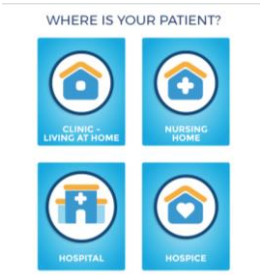
Prognostication

Various prognostic tools exist for specific diseases:

Seattle Heart Failure Model
MELD or Child's-Turcotte-Pugh
ECOG or Karnofsky
BODE Index Score
FAST Staging

Prognostication

- www.eprognosis.org



WHAT TIME FRAME BEST FITS THE CLINICAL ISSUE?

One Year Mortality

Points	Risk of ONE YEAR mortality (95% CI)
< 0	2.4% (2.2-2.6)
0	3.6% (3.4-3.8)
1	5.1% (4.9-5.4)
2	7.8% (7.4-8.3)
3	11.3% (10.7-12.0)
4	14.6% (13.8-15.5)
5	20.1% (18.9-21.4)
6	24.9% (23.3-26.5)
7	29.5% (27.4-31.6)
8 - 9	36.5% (34.4-38.7)
> 9	46.8% (43.4-50.1)

Prognostication: PPS

PALLIATIVE PERFORMANCE SCALE (PPS)

%	Ambulation	Activity Level/ Evidence of Disease	Self-Care	Intake	Level of Consciousness	Estimated Median Survival in Days (a)	(b)	(c)
100	Full	Normal *No Disease*	Full	Normal	Full			
90	Full	Normal *Some Disease*	Full	Normal	Full	N/A		
80	Full	Normal with Effort *Some Disease*	Full	Normal or Reduced	Full		N/A	108
70	Reduced	Can't do normal job or work *Some Disease*	Full	As above	Full	145		
60	Reduced	Can't do hobbies or housework *Significant Disease*	Occasional Assistance Needed	As above	Full or Confusion	29	4	
50	Mainly sitting	Can't do any work *Extensive Disease*	Considerable Assistance Needed	As above	Full or Confusion	30	11	41
40	Mainly in Bed	As above	Mainly Assistance	As above	Full or Drowsy or Confusion	18	8	
30	Bed Bound	As above	Total Care	Reduced	As above	8	5	
20	Bed Bound	As above	As above	Minimal	As above	4	2	
10	Bed Bound	As above	As above	Mouth Care Only	Drowsy or Coma	1	1	6
0	Death							

(a) Survival post-admission to an inpatient palliative unit, all diagnoses (Virik 2002).
(b) Days until inpatient death following admission to an acute hospice unit, diagnoses not specified (Anderson 1996).
(c) Survival post admission to an inpatient palliative unit, cancer patients only (Morita 1999).

How do we translate prognostication to patients?

- "hope for the best and plan for the worst" → complete an advance directive
- Elicit goals and frame treatment decisions around these goals
- Adjust medication regimen based on patient's goals
- Refer to hospice for added layer of support if appropriate

Case 1

71 yo M with h/o COPD on 2L home O2, CKD Stage IV, HTN, pulmonary HTN. He has intermittent medication compliance and misses his appointment with vascular surgery to discuss AV fistula placement. At his visit with you, he says he'll start dialysis "if it will help me."

Case 1

- What is his prognosis?
- Should he have AV fistula placed?

One Year Mortality

Points	Risk of ONE YEAR mortality (95% CI)
< 0	2.4% (2.2-2.6)
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Clin J Am Soc Nephrol. 2013 Jul 31; 8(8): 1421–1428. PMCID: PMC3731917
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Considerations in Starting a Patient with Advanced Frailty on Dialysis: Complex Biology Meets Challenging Ethics

Mark Swidler[✉]

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Table 1.

Mean life expectancy by quartile following dialysis initiation according to age and renal phenotype

Renal Phenotype Quartiles	Life Expectancy by Age Group (yrs)					
	65–69	70–74	75–79	80–84	85–89	90+
25th Percentile (0–25; frail)	0.9	0.7	0.5	0.4	0.3	0.2
50th Percentile (25–75; vulnerable)	2.5	2.1	1.7	1.3	0.9	0.6
75th Percentile (75–100; healthy)	4.6	4.3	3.7	3.0	2.3	1.7

Adapted from reference 33, with permission.

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Conservative Management of End-Stage Renal Disease without Dialysis: A Systematic Review

Nina R. O'Connor, M.D.[1] and Pallavi Kumar, M.D.[2]

- Purpose: To summarize evidence on conservative, non-dialytic management of ESRD regarding 1) prognosis and 2) symptom burden and quality of life
- Median survival with conservative management ranged from 6.3 to 23.4 months
- Two studies found little or no survival benefit with dialysis vs conservative management in elderly patients

- What does this patient value?
  - Life expectancy of months to couple years with medical procedures, dialysis 3 days per week, higher risk of hospitalizations VS.
  - Shorter life expectancy of months without medical procedures and hospitalizations

How should I manage his medications?

- Continue medications and inhalers that improve quality of life and hope to prevent hospitalizations
- Continue to optimize volume status with diuretics for CKD
- Consider discontinuing non-essential medications to minimize polypharmacy (ie statins)

How do we document these provider-patient discussions about goals of care?

Advance Directives

- HCPOA
- POST/POLST/MOLST
- Living will
- Durable POA

South Carolina HCPOA

SOUTH CAROLINA HEALTH CARE POWER OF ATTORNEY

1. DESIGNATION OF HEALTH CARE AGENT

I, _____, hereby appoint:
(Principal)

(Agent's Name) _____

(Agent's Address) _____

Telephone: home: _____ work: _____ mobile: _____

as my agent to make health care decisions for me as authorized in this document.

Successor Agent: If an agent named by me dies, becomes legally disabled, resigns, refuses to act, becomes unavailable, or if an agent who is my spouse is divorced or separated from me, I name the following as successors to my agent, each to act alone and successively, in the order named:

a. First Alternate Agent:

SC HCPOA

not apply.

7. STATEMENT OF DESIRES CONCERNING LIFE-SUSTAINING TREATMENT

With respect to any Life-Sustaining Treatment, I direct the following:

(INITIAL ONLY ONE OF THE FOLLOWING 3 PARAGRAPHS)

(1) ____ GRANT OF DISCRETION TO AGENT. I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, my personal beliefs, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

OR

(2) ___ DIRECTIVE TO WITHHOLD OR WITHDRAW TREATMENT. I do not want my life to be prolonged and I do not want life-sustaining treatment:

a. if I have a condition that is incurable or irreversible and, without the administration of life-sustaining procedures, expected to result in death within a relatively short period of time, or

b. if I am in a state of permanent unconsciousness.

OR

(3) ____ DIRECTIVE FOR MAXIMUM TREATMENT. I want my life to be prolonged to the greatest extent possible, within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedures.

SC HCPOA

8. STATEMENT OF DESIRES REGARDING TUBE FEEDING

With respect to Nutrition and Hydration provided by means of a nasogastric tube or tube into the stomach, intestines, or veins, I wish to make clear that in situations where life-sustaining treatment is being withheld or withdrawn pursuant to Item 7, (INITIAL ONLY ONE OF THE FOLLOWING THREE PARAGRAPHS):

(a) _____ GRANT OF DISCRETION TO AGENT. I do not want my life to be prolonged by tube feeding if my agent believes the burdens of tube feeding outweigh the expected benefits. I want my agent to consider the relief of suffering, my personal beliefs, the expense involved, and the quality as well as the possible extension of my life in making this decision.

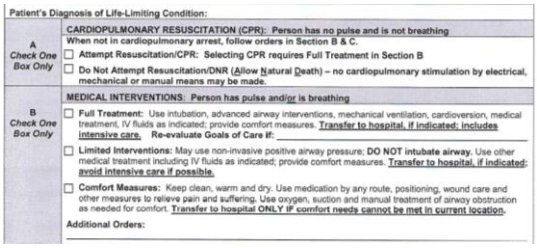
OR

(b) _____ DIRECTIVE TO WITHHOLD OR WITHDRAW TUBE FEEDING. I do not want my life prolonged by tube feeding.

OR

(c) ____ DIRECTIVE FOR PROVISION OF TUBE FEEDING. I want tube feeding to be provided within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedure, and without regard to whether other forms of life-sustaining treatment are being withheld or withdrawn.

South Carolina POST



Patient's Diagnosis of Life-Limiting Condition:

A *Check One Box Only*

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing

When not in cardiopulmonary arrest, follow orders in Section B & C.

- ☐ **Attempt Resuscitation/CPR: Selecting CPR requires Full Treatment in Section B**
- ☐ **Do Not Attempt Resuscitation/DNR (Allow Natural Death) – no cardiopulmonary stimulation by electrical, mechanical or manual means may be made.**

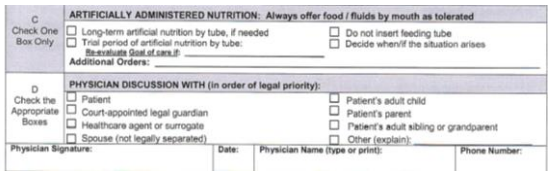
B *Check One Box Only*

MEDICAL INTERVENTIONS: Person has pulse and/or is breathing

- ☐ **Full Treatment:** Use intubation, advanced airway interventions, mechanical ventilation, cardioversion, medical treatment, IV fluids as indicated; provide comfort measures. **Transfer to hospital, if indicated; includes intensive care. Re-evaluate Goals of Care if:** _____
- ☐ **Limited Interventions:** May use non-invasive positive airway pressure; **DO NOT intubate airway.** Use other medical treatment including IV fluids as indicated; provide comfort measures. **Transfer to hospital, if indicated; avoid intensive care if possible.**
- ☐ **Comfort Measures:** Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Transfer to hospital ONLY IF comfort needs cannot be met in current location.**

Additional Orders: _____

POST



C Check One Box Only

ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food / fluids by mouth as tolerated

- ☐ Long-term artificial nutrition by tube, if needed
- ☐ Trial period of artificial nutrition by tube:

Re-evaluate Goal of care if: _____

- ☐ Do not insert feeding tube
- ☐ Decide when/if the situation arises

Additional Orders: _____

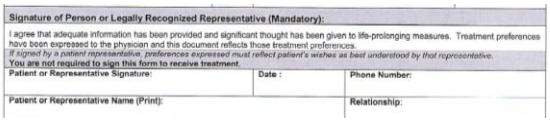
D Check the Appropriate Boxes

PHYSICIAN DISCUSSION WITH (in order of legal priority):

- ☐ Patient
- ☐ Court-appointed legal guardian
- ☐ Healthcare agent or surrogate
- ☐ Spouse (not legally separated)
- ☐ Patient's adult child
- ☐ Patient's parent
- ☐ Patient's adult sibling or grandparent
- ☐ Other (explain): _____

Physician Signature:	Date:	Physician Name (type or print):	Phone Number:

POST



Signature of Person or Legally Recognized Representative (Mandatory):

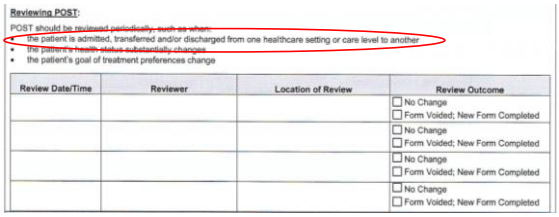
I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician and this document reflects those treatment preferences.

If signed by a patient representative, preferences expressed must reflect patient's wishes as best understood by that representative.

You are not required to sign this form to receive treatment.

Patient or Representative Signature:	Date :	Phone Number:
Patient or Representative Name (Print):		Relationship:

POST



Reviewing POST:

POST should be reviewed periodically, such as when:

- the patient is admitted, transferred and/or discharged from one healthcare setting or care level to another
- the patient's health status substantially changes
- the patient's goal of treatment preferences change

Review Date/Time	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ Form Voided; New Form Completed
			☐ No Change ☐ Form Voided; New Form Completed
			☐ No Change ☐ Form Voided; New Form Completed
			☐ No Change ☐ Form Voided; New Form Completed

Case 2

79 yo F with h/o IBS presents with weight loss and mild abdominal discomfort. Imaging reveals pancreatic mass with multiple liver and lung mets. How do you proceed?

Case 2

- What is patient's prognosis?
- What are her goals?

Hospice Criteria

- Cancer:
  - Clinically widespread disease + PPS <70% + Decision to forego curative treatment
  - Supporting documentation:
    - Cachexia/weight loss
    - Recurrence/spread despite treatment
    - Hypercalcemia
    - Malignant ascites/pleural effusions

Hospice Criteria

- Dementia
  - FAST Stage 7C + one or more in last 12 months:
    - Aspiration pneumonia
    - Pyelonephritis
    - Septicemia
    - Multiple pressure ulcers (stage 3-4)
    - Recurrent fever
    - 10% weight loss in last 6 months

Hospice Criteria

- Heart Disease
  - NYHA Class IV symptoms +
  - Patient is treated with optimal medical therapy (ACE-I, diuretics, vasodilators, or hydralazine/nitrates) OR
  - Angina at rest resistant to nitrates

Hospice Criteria

- Liver Disease
  - Evidence of end stage disease with either PT >5 or INR >1.5 and serum albumin < 2.5 +
  - One or more of the following:
    - Refractory ascites
    - Spontaneous bacterial peritonitis
    - Hepatorenal syndrome
    - Refractory hepatic encephalopathy
    - Recurrent variceal bleeding

Hospice Criteria

- Lung Disease
  - Dyspnea at rest + decreased functional capacity + little response to bronchodilators +
  - Increased ED visits/hospitalizations +
  - Hypoxemia or hypercapnia on room air

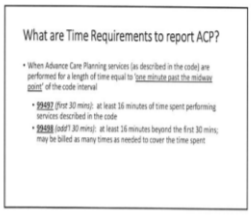
Billing for Advance Care Planning

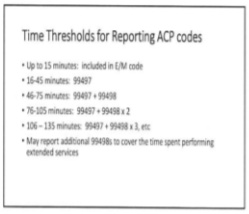
- ACP codes can be used as of January 1, 2016
- https://www.cms.gov/Medicare/Medicare-fee-for-service-Payment/PhysicianFeeSched/downloads/FAQ-Advance-Care-Planning.pdf

CPT Code 99497- Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

CPT Code 99498- each additional 30 minutes (List separately in addition to code for primary procedure)

ACP Billing Codes





**I most commonly use 99497 when completing HCPOA with patients

My favorite tools

- Eprognosis app
https://itunes.apple.com/us/app/eprognosis-cancer-screening/id714539993?mt=8
- Fast Facts (online and app)
https://itunes.apple.com/us/app/palliative-care-fast-facts/id868472172?mt=8
- Hospice in a Minute app:
https://itunes.apple.com/us/app/hospice-in-a-minute/id511997344?mt=8
- GeriPal blog: www.geripal.org