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
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](http://www.eprognosis.org)
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.”

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

One Year Mortality

<table>
<thead>
<tr>
<th>Weeks</th>
<th>Risk of ONE YEAR mortality (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;0</td>
<td>2.4% (2.2-2.6)</td>
</tr>
<tr>
<td>0</td>
<td>3.6% (3.4-3.8)</td>
</tr>
<tr>
<td>1</td>
<td>5.1% (4.9-5.4)</td>
</tr>
<tr>
<td>2</td>
<td>7.0% (6.8-7.3)</td>
</tr>
<tr>
<td>3</td>
<td>11.0% (10.7-12.0)</td>
</tr>
<tr>
<td>4</td>
<td>15.4% (15.0-15.9)</td>
</tr>
<tr>
<td>5</td>
<td>20.1% (19.9-21.4)</td>
</tr>
<tr>
<td>6</td>
<td>24.9% (23.9-26.0)</td>
</tr>
<tr>
<td>7</td>
<td>29.7% (27.4-31.6)</td>
</tr>
<tr>
<td>8-9</td>
<td>36.5% (34.4-38.7)</td>
</tr>
<tr>
<td>&gt;9</td>
<td>46.8% (43.4-50.1)</td>
</tr>
</tbody>
</table>
• 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

[Blank]

(Agent's Name) ____________________________

(Agent's Address) ____________________________

Telephone: ( ) ____________________________ work, ( ) __________ mobile

(As my agent to make health care decisions for me as authorized in this document)

Successor Agent: If an agent appointed by me dies, becomes legally disabled, resigns, refuses to act, becomes unavailable, or is unable to act, then an agent who is my spouse or designated by me shall have the following powers:

a. First Alternate Agent

Not applicable.

7. № STATEMENT CONCERNING LIFESPAN TREATMENT

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

[Blank]

(Initial, Only one of the following three paragraphs

(1) GRANT OF DISCRETION TO AGENT. I do not want any life to be prolonged or to have Life-Sustaining Treatment provided to me if any agent believes that the benefit to be derived from such treatment is not justified by the expense involved and the quality of life to which I am entitled, or the possible outcome of my life in making decisions concerning life-sustaining treatment.

OR

(2) DIRECTIVE TO WITHHOLD OR WITHDRAW TREATMENT. I do not want any life to be prolonged and I do not want Life-Sustaining Treatment.

a. If, as to my condition, it is irreversible or permanent 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 for recovery, or the cost of the procedures.

SC HCPOA

8. № STATEMENT 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 any life to be prolonged by tube feeding if any agent believes that the benefit to be derived from such feeding is not justified by the expense involved, and the quality of life to which I am entitled, or the possible outcome 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 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 Intubation is not possible, follow directions in Section A & B.

B Check One Box Only
Do Not Attempt Resuscitation (DNAR): Person is unconscious or permanently unconscious.

MEDICAL INTERVENTIONS: Person has pulse and respiration is breathing

Full Treatment:
- Use resuscitation equipment
- Administer advanced respiratory alkaline treatment
- Administer advanced respiratory alkaline treatment
- Administer advanced respiratory alkaline treatment
- Administer advanced respiratory alkaline treatment
- Administer advanced respiratory alkaline treatment
- Administer advanced respiratory alkaline treatment

Limited Interventions:
- Use non-invasive positive pressure
- Do NOT intubate
- Use other treatment modalities
- Monitor patient

Additional Orders:

ARTIFICIALLY ADMINISTERED NUTRITION: Attempt oral feeding or fluids by mouth as tolerated.

Limited Interventions:
- Do not intubate
- Do not use non-invasive positive pressure
- Do not use advanced respiratory alkaline treatment

PHYSICIAN DISCUSSION:
- Discuss with patient and family
- Discuss with patient and family
- Discuss with patient and family

Date
Physician Name
Phone Number

Signature of Person or Legally Recognized Representative (Voluntary)

Posting Date

10/11/2017

10
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?

• 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

- 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](https://www.cms.gov/Medicare/Medicare-fee-for-service-Payment/PhysicianFeeSched/downloads/FAQ-Advance-Care-Planning.pdf)
ACP Billing Codes

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

My favorite tools

- Eprognosis app
- Fast Facts (online and app)
- Hospice in a Minute app:
- GeriPal blog: [www.geripal.org](http://www.geripal.org)