Palliative Care

What Every Provider Should Know

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Good Help to Those in Need®
My Death

Raymond Carver

If I'm lucky, I'll be wired every whichway in a hospital bed. Tubes running into my nose. But try not to be scared of me, friends! I'm telling you right now that this is okay. It's little enough to ask for at the end. Someone, I hope, will have phoned everyone to say, "Come quick, he's failing!" And they will come. And there will be time for me to bid goodbye to each of my loved ones. If I'm lucky, they'll step forward and I'll be able to see them one last time and take that memory with me. Sure, they might lay eyes on me and want to run away and howl. But instead, since they love me, they'll lift my hand and say "Courage" or "It's going to be all right."
Objectives

• Identify the role of palliative care as part of cost-conscious care
• Describe the relationship between palliative care and hospice
• Utilize tools to identify patients with serious illness
• Adapt communication strategies for difficult conversations
Current State of Care
“The Sickest of the Sick”

High Cost
• Over 20% of Medicare patients with more than 4 conditions account for almost 70% of spending

High Utilization
• Almost 50% of decedents had at least one ICU admission during the last 6 months of life

<table>
<thead>
<tr>
<th>Place of Death</th>
<th>1997</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>51.7%</td>
<td>49.5%</td>
</tr>
<tr>
<td>Nursing Homes</td>
<td>23%</td>
<td>23.2%</td>
</tr>
<tr>
<td>Home</td>
<td>22.5%</td>
<td>23.4%</td>
</tr>
</tbody>
</table>
SUPPORT Trial

Original Contributions

A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients

The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)

- Almost 40% of those who died spent over 1 week in the ICU
- Half of the patients had moderate to severe pain during the last 3 days of life
- 63% of patients had unaddressed physical and/or emotional symptoms
- 50% of physicians did not know or respect patients’ wishes

JAMA. 1995; 274.
What do Patients Want?

Patients with serious illness want:

• Adequate pain and symptom management
• Avoidance of inappropriate prolongation of dying
• Achievement of a sense of control
• Relief of the burden on others
• Strengthening of relationships with loved ones

Are we giving patients what they want?
Definition of Palliative Care

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

- Medicare benefit
- Patients must qualify based on prognosis and must elect benefit
- Curative treatments not covered
- Treatments not related to admitting diagnosis not covered
- Is not 24/7 care but is 24/7 availability
- Financial barriers to Hospice in Nursing Facilities
- PCP or specialist can remain as attending
  - Can continue to see patient in office or other setting and bill fee for service (modifier – GV)
- Family followed for a year after death
The Impact of Palliative Care

- Enhance quality
- Improve satisfaction
- Improve transitions
- Prolong life
- Reduce and avoid costs

Cost Savings Associated With US Hospital Palliative Care Consultation Programs

R. Sean Morrison, MD; Joan D. Penrod, PhD; J. Brian Cassel, PhD; Melissa Caust-Ellenbogen, MS; Ann Litke, MFA; Lynn Spragens, MBA; Diane E. Meier, MD; for the Palliative Care Leadership Centers’ Outcomes Group

• Patients who died in 8 diverse hospitals
• Serviced by mature palliative care programs
• Length of stay from 7 to 30 days
• 2278 palliative care matched to 2124 usual care
  – Discharged $250-300/day
  – Died $350-400/day
  – Net savings $4908/admission

Arch Intern Med 2008;168:1783-90
30-Day Readmissions among Seriously Ill Older Adults

Susan Enguidanos, M.P.H., Ph.D.,¹ Evie Vesper, LCSW,² and Karl Lorenz, M.D.³

- 2 year period, >65 years old, PC consult
- 408 patients, 80 average age
- 10% were readmitted within 30 days
- Factors associated with readmission
  - Home without home care services: 25.7%
  - Nursing facility: 24.1%
  - Home with home health care: 13.3%
  - Home based palliative care: 8.3%
  - Home with hospice: 4.6%
National Growth

Growth of Palliative Care

Source: 2002 to 2012 American Hospital Association Annual Hospital Surveys for FY 2002 to 2010, and data from the Center to Advance Palliative Care’s (CAPC) National Palliative Care Registry™

National % of PC Programs (2010)
- 88% >300 beds (Up from 85% in 2009)
- 66% >50 beds (Up from 63% in 2009)

Virginia got a “B” (78%)

www.capc.org/reportcard

Good Help to Those in Need®
In the Media...

Money & Medicine

• The dramatic doctor/patient stories...illustrate the powerful forces driving excessive medical care as well as proven strategies that can reduce unnecessary medical spending

• ...exposes the painful end-of-life treatment choices made by patients and their families, ranging from very aggressive interventions in the ICU to palliative care at home.
Palliative Care Delivery

**Primary Palliative Care**
- All practitioners should be competent in the core skills of palliative care.
  - Symptoms
  - Prognosis
  - Communication
  - Advance medical directives

**Secondary Palliative Care**
- Each organization or region should have a specialized interdisciplinary team that is available for consultation on difficult palliative care issues.
Palliative Care Team

• Board certified medical specialty
• Fee for service billing
• Deliver care in variety of settings

C O P E
C Care decisions
O Overwhelming symptoms
P Psychosocial distress
E End stage disease
Palliative Care Team Approach

• Address symptoms
  – Diagnoses are “symptoms” (not diseases)
• Discuss prognosis and define goals of care
  – The Narrative: Getting the story, Using the story to solve problems
• Address psychosocial & spiritual needs
• Attend to caregivers and family
• Collaborate, Communicate, Follow-up...
Palliative Philosophy

**Traditional Medical Philosophy**

- Prolong life
- Death is a failure

**Palliative Philosophy**

- Prolong life as long as there is quality of life consistent with the patient’s wishes
- Death is the last stage of life
- A “bad death” is a failure

Good Help to Those in Need®
The Conversation

• Having the conversation is part of our professional responsibility
  • Recognize the consequences of NOT having it
• How do we know **when** to have the conversation?
  – Prognostic models
  – The “look back”
  – Would you be surprised if your patient died in the next 12 months?
  – Cues from the patient and/or family
Prognosis

![Graphs showing the progression of sudden death and terminal illness over time.

- **Sudden Death**: High function remains stable until a sudden drop to death.
- **Terminal Illness**: High function gradually declines over time, leading to death.

**Good Help to Those in Need**

Bon Secours Health System
Prognosis

Prognosis

JAMA
2003;289:2387-2392.
The Conversation

“Getting the Story”
Listening

Seek alignment

Understand what they understand

Explore their hopes, fears, and preferences

“Using the story to solve problems”
Information Exchange

Clarify and negotiate

Identify and introduce options

Good Help to Those in Need®
The Palliative Toolkit

• Ask Tell Ask

• Hope for the Best, Plan for the Worst

• Normalize uncertainty

• Partner and plan
“Carol, I can see you’re slower to bounce back this time – and I hear your disappointment. Will you share with me what the doctors told you about your illness during this last hospital stay?”

Ask – Tell - Ask

“John, I sense your frustration with the way things are going. I’d like to try and support you and Joan more fully. Will you help me to understand how this illness is impacting you and your family?”
“I would like to know Mrs. Smith what is the best to you? We always want to be prepared for everything, such as if you don’t get better. I would also like to know what would be the worst, so we can avoid it.”

Hope for the Best
Plan for the Worst

“In my experience, patients with your condition often begin to experience a decline in their physical condition. While this may not happen, I would like to help you plan in case it does.”
“Shouldn’t we just see what that test shows?”
“I understand your thinking, however, now is the time to use other measures of your disease. Rather than the usual tests, I’ll keep a close eye on how far you can walk, your ability to take good care of yourself, and how well you are sleeping, for example.”

**Normalize Uncertainty**

“Uncertainty is an uncomfortable place for physicians. Much of our time is spent trying to limit uncertainty.”

“Doc, are you saying that I’m dying?”
“No Mr. Smith. Let me explain. We are both living and dying at the same time. There is not a line that separates the two. What I do know, is that your disease has progressed from a year ago, and we cannot be sure what the future holds.”
Jim, it’s a tough situation for you. I’m glad you’ve shared your story with me today. Let’s see how the treatments go over the next few weeks and revisit our plan together. How does that sound?

Partner and Plan

Susan, we’ve talked about a lot today. I want you to know that I’ll be with you through this. I would like to invite you and your daughter to learn more about Hospice. Would that be alright?
Palliative Care Resources

End of Life Online Curriculum - Modules

Overview of Palliative Care
Opioid Conversion
Palliative Sedation

Dyspnea
Prognostication
Communication

Home Hospice
Transition to Death
Bereavement

Overview of Palliative Care

This module will provide a broad overview of death and dying in the United States, the growing need for quality palliative care, current gaps in care, present definitions to introduce palliative care, and also discuss the scope of palliative care.

One of the ideas we would like to get across is that palliative care is quickly becoming a standard in American health care.

Fast Facts

What's New

# 260 Opioid Use in Liver Failure
This Fast Fact discusses the use of opioids in patients with liver failure.

# 262 Hot Flashes in Palliative Care - Part 2
This Fast Fact will cover procedural and pharmacological treatment of hot flashes. Complementary and alternative therapies will be reviewed in Fast Fact #263.

# 261 Hot Flashes in Palliative Care - Part 1
Hot flashes are a common symptom which can negatively impact quality of life. Failure to assess and offer treatment for hot flashes is common. This Fast Fact is the first in a three part series reviewing hot flash assessment and treatment.

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BON SECOURS HEALTH SYSTEM
What’s going on in Virginia?

- ACP High Value Care
  - hvc.acponline.org/
- Physicians Orders for Life Sustaining Treatments
  - www.polst.org/
- National Health Care Decisions Day April 16, 2013
  - www.nhdd.org
- Senior Navigation and Planning Act
  - www.warner.senate.gov
- Medicaid Reform and Expansion
Late Fragment
Raymond Carver

And did you get what you wanted from this life, even so? I did.
And what did you want?
To call myself beloved, to feel myself beloved on the earth.
Conclusions

• Encourage patients/families to have “the conversation”
• Keep palliative care resources in the office
• Recognize serious illness and address prognosis
• Use Ask – Tell – Ask and other communication tools
• Remain as Hospice attending for patients referred
• And...
  – Take Out the Trash
    • http://www.youtube.com/watch?v=p-3aHEhML5Q&feature=player_embedded