Palliative Care: Myths vs. Reality in the New Era of Healthcare

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Session W38
April 29, 2015

Purpose

- The participant will learn how palliative medical care services need to be explored as viable options in reducing re-hospitalizations and in effectively managing residents at the end-stages of chronic disease. We will discuss how the future of healthcare reform and palliative medical care services will focus on quality of life, a resident-centered plan of care, and support the resident and their loved ones through the process of understanding the prognosis.

Objectives

- Describe medical-based Palliative Care in the New era of healthcare delivery.
- Explain the myths and reality of a medically-based, physician driven, Palliative Care program.
- Explain COPD, CHF and dementia in the new healthcare era.

Palliative Care

- Definition (World Health Organization)

> Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Palliative Care - Definition

- Palliative care is specialized medical care for people with serious illnesses. It focuses on providing patients with relief from the symptoms, pain, and stress of a serious illness—whatever the diagnosis.
- The goal is to improve **quality of life** for both the patient and the family.
- Palliative care is provided by a team of doctors, nurses and other specialists who work together with a patient's other doctors to provide an **extra layer of support**.
- It is appropriate at any age and at any stage in a serious illness and **can be provided along with curative treatment.**

http//www.getpalliativecare.org/whatis/

Palliative Care- Definition

- Palliative care **focuses on symptoms** such as pain, shortness of breath, fatigue, constipation, nausea, loss of appetite, difficulty sleeping and depression.
- And it helps you have more control over your care by **improving communication** so that you can better understand your choices for treatment.
- Affirms life and regards dying as a normal process, and **intends neither to hasten or postpone death**

http//www.getpalliativecare.org/whatis/

Aspects of Medicare Outpatient Palliative Care

- Billed under Part B as a fee-for-service consultation visit
- Covers physician extenders such as Nurse Practitioners
- Has a benefit for Social Work (not Spiritual Care…yet)

Myths of Palliative Care

- Does NOT change the patient's pharmacy benefit or exclude medications, oncological treatments or surgical procedures
- Is NOT equivalent to hospice, which is a Medicare A benefit reimbursed on a daily rate
- Does NOT change the patients' primary provider

Patient "goals of care"

BEFORE decisions *have* to be made, these inquiries need to occur, regardless of the questioner:

- What is their understanding of their prognosis?
  - *Informed consent*
- What are their concerns about what lies ahead?
  - *Medical, Financial and Psychosocial Fears*
- Who do they want to make decisions when they can't?
  - *Advance Care Planning*

When to Utilize Palliative

- Palliative care consultation services
  - In response to a physical symptom(s) of progressive life-limiting illness
  - If patient or provider are unsure about continuing aggressive care
  - To establish the patients' goals of care when in doubt
  - To add psycho-social support for patients with coping difficulties
  - To assist with financial resources if needed

Why Palliative is needed

- Trying to provide long-term chronic care management in a system designed to deliver short-term acute care
- We need to go from an acute and reactionary model…
- …to a planned and proactive approach

Utilization of Palliative Services

- To, TH et al. (Intern Med J, 2011)
  - One-third of all patients admitted to hospital had goals of care consistent with palliative care but only 20% of these were offered consultation.
- Berger et al. (Arch Intern Med 2011)
  - Only 8% of California hospitals offer an outpatient palliative service

Challenges Giving Prognosis

- Giving no prognostic information
  - In one cancer survey, 23% of physicians planned to give no prognostic information to their patients 1
  - Nephrology study of HD patients with 20% 1 year mortality- None had discussed prognosis with their doctors 2

1 Lamont et al. Annals Int Med 2001
2 Combs SA, et al. Am J Kidney Dis. 2014

Challenges Giving Prognosis

- Consequences of not discussing prognosis
  - Overestimation of survival-in the prior studies:
    - 80% of lung cancer patients predicted >2 yr survival (<7% actual survival at 2 yrs)
    - Dialysis patients had similarly optimistic 1-yr and 5-yr estimates
  - Increased emotional burden
    - Cancer patients who understood terminal prognosis had:
      - better mental health and quality of death
      - Caregivers with better bereavement adjustment 3

3 Ray JPM 2006;9:1359-1368

Prognostication for Physicians

Would you be surprised if this patient died within the next year?

Lynn, 2005

Palliative Care Outcomes

- Temel, et al. (NEJM 2010)
  - Randomized controlled trial of outpatient palliative care for NSCLC
  - Average of four outpatient visits per patient during the course of the study
- Results:
  - Improved QOL (FACT-L score 98.0 vs 91.5, P=0.03)
  - Fewer depression symptoms (16% vs. 38%, P = 0.01)
  - Improved survival (11.6 months vs. 8.9 months, P = 0.02)

These results were achieved despite reduced aggressiveness of end-of-life care (33% vs. 54%, P = 0.05).

Palliative Care Outcomes

- Hospital admission rates are reduced for palliative patients.
  - Study of 390 patients receiving homecare with or without palliative care
  - 30 day Re-hospitalization rates for homecare patients:
    - Without palliative visits- 17.4%
    - With palliative care - 9.1%

Ranganathan et al. J Palliative Med 2013

Barriers to Coordination of Care

Medication Compliance

- Old prescriptions
  - "I thought I was supposed to go back to what I was taking"
  - "I didn't feel right so I took this pill from my other doctor"
- Medication Reconciliation
  - Standardized discharge form- cause for concern? (Medication discrepancy in one study1: 4.6 per pt visit)[4]
- Caregiver Judgment
  - "Mom was always confused on that pill so I changed it"

4 Hoeksema et al, JPSM; Feb 2012

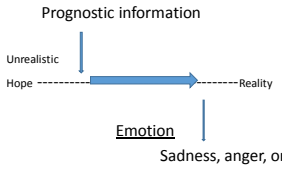
Effective Communication

- A patient and family meeting is a procedure
- Can't be done in one conversation
- Facing one's mortality and understanding the limits of medicine is a PROCESS, not an epiphany
- Multiple sessions over time

Barriers to Good Communication

- Not being prepared
- Not being present and engaged
- Making assumptions
- Feeling responsible for maintaining the patient's hope
- Ignoring your own feelings
- Talking too much

Honest information precipitates emotion



Needs of terminally ill patients

- Spiritual needs assessment study- 23 question interview
- Top 5

	Rating (4 point scale)
Sharing your thoughts and feelings with people close to you	2.77
Finding meaning in your experience of illness	2.63
Finding hope	2.69
Worries you have about your family	2.56
Finding peace of mind	2.48

Sharma et al, JPSM 2012

Needs of terminally ill patients

- Bottom 5

	Rating (4 point scale)
Someone to bring you spiritual texts	1.66
Visits from fellow members of your faith community	1.80
Visits from a hospital chaplain	1.83
Death and dying	1.87
Getting in touch with other patients with similar illnesses	2.11

Advance Care Planning

Advance Care Planning

- A process aimed at extending the rights of competent adults to guide their medical care through periods of decisional incapacity.
- The process, when accomplished comprehensively, involves three steps:
  - (1) thinking through one's values and preferences,
  - (2) talking about one's values and preferences with others,
  - (3) documenting them.

Advance Care Planning

- How is advance care planning different from advance directives?
- Advance care planning is the process.
- Advance directives
  - the written documents that provide information about the patient's wishes and/or her designated spokesperson.
  - If official forms are not used, health care providers should document the result of their advance care planning conversations in a medical record progress note.

Advance Care Planning

- Completion of a legal advance directive does NOT complete the patients' advance care planning journey.
- It must be accessible, understood, and honored
- It must be reviewed periodically in light of changing circumstances
- Prior advance care documents achieve these goals less than 50% of the time 5

5 Willinson A et al; U.S. Department of Health and Human Services; Literature Review On Advance Directives. June 2007

Advance Care Planning

Components include:

- Identifiable outcome
- Comprehension of the medical condition trajectory
- Planning for expected outcomes:
  - Early disease course
  - Mid course
  - End stages
- Decision making models

Barriers to Advance Care Planning

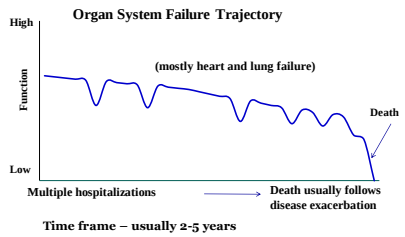
- 18% of Medicare patients who died in 2008 underwent an inpatient surgical procedure in the last month of life.
- However, many are not supportive of advance directives preoperatively and may not operate on those who do not suspend their AD postoperatively. Why?

Kwok AC et al. Lancet,2011

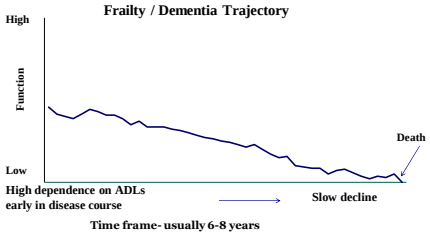
Barriers to Advance Care Planning

- -confidence in the patient's understanding of the procedure
- -medicare 30 day mortality statistics
- -physician's emotional concerns/professional pride/regrets

Disease Trajectories



Disease Trajectories



Prognosis

Important factors to consider

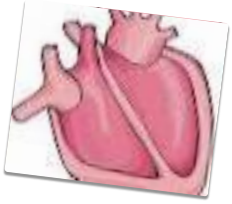
- Co-morbid illnesses
- Rate of decline
- Nutritional status
- Functional status
- Number of hospitalizations in past year
- Other (psychosocial, emotional and spiritual)
- Will to live
- Cognitive status
- Age and gender

Heart Disease

Arrhythmias

Atherosclerotic Heart Disease

Chronic Heart Failure



Cardiovascular Disease

- Recent cardiac hospitalization (3 x 1 yr mortality)
- Elevated creatinine >1.4
- SBP <100 or tachycardia > 100 (2 x 1 yr mortality)
- LVEF < 40%
- Ventricular dysrhythmias
- Anemia (1 mg/dl= 16% mortality)
- Hyponatremia
- Cachexia
- Reduced functional state
- Co-morbid illnesses

EPERC Fast Fact Concept #143

Heart Disease

- Additional CHF factors to consider:
  - Frailty >3 ADL deficits
  - Walking speed >8 seconds for 5 meters
  - Unable to complete any of the Short Physical Performance Measure at discharge = 50% 1 year mortality
  - BMI <22.5 or wt loss >5% over 6 mo

Fox et al, HEART 2011

Cardiovascular Disease

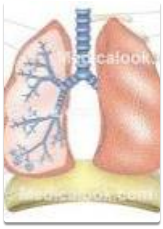
- Most patients with ASHD or CHF have a 4 or 5 drug course of therapy (ACE, Beta blocker, Aspirin, statin, diuretic)
- Most will have a cardiologist and a primary care physician involved regularly
  - What then is the palliative role in medical therapy?
    - Compliance assessment
    - Goals of therapy

Pulmonary Disease

Chronic Obstructive Pulmonary Disease

Pulmonary Fibrosis

Asthma



COPD - Prognosis

BODE – point system

- Body Mass Index (BMI < 21)
- Obstruction – FEV1
- Dyspnea scale (MMRC)
- Exercise capacity – 6 min distance walked

Better predictor than FEV1 alone, but still not predictive of 6-month prognosis

http://www.icumedicus.com/clinical_criteria/bode.php
NEJM, 2004

COPD - Problems

Inspiratory force for some MDIs need to exceed 60 LPM- unlikely that GOLD stage IV patients will be able to sustain this

Current guidelines, as well as prognostic indices, do not account for inhaler technique, compliance and associated comorbidities in a dynamic fashion

Dementia

Alzheimer's
Lewey Body
Fronto-Temporal
Multi Infarct or Vascular
Pick's Disease
Various Neurologic entities

Prognosis in Dementia

Current Medicare guidelines are inadequate:

Based on FAST scoring

- 39.5 % mortality in 6 mo (poor selectivity)
- 22.2% who died had FAST 7c or greater (poor sensitivity)

FAST staging is often non linear and will affect prognosis:

- 3 months survival (linear) vs. 8 months (non-linear)

Luchins DJ, Hanrahan P, J Am Geriatr Soc. 1997

Mortality Risk Index - Dementia

Complete dependence with ADLs	**1.9**
Male Gender	**1.9**
Cancer	**1.7**
CHF	**1.6**
Oxygen therapy past 14 days	**1.6**
SOB	**1.5**
<25% po intake	**1.5**
Unstable medical condition	**1.5**
Bowel incontinence	**1.5**
Bedfast	**1.5**
Age > 83 yo	**1.4**
Sleeps most of the day	**1.4**

Mortality Risk Index

Risk of estimate of death in 6 months

0 pts	8.9 %
1-2	10.8 %
3-5	22.2 %
6-8	40.4 %
9-11	57.0 %
>_12	70.0 %

Mitchell, SL. JAMA 2004

ADEPT Risk Score- Factors

Age	Risk Index
70 < 75	1.18
80 < 85	1.46
90 < 95	1.91
>100	2.51
Peripheral edema	1.37
Bowel incontinence	1.44
Fever in prior seven days	2.15
Pressure ulcers	2.17
Shortness of breath	2.29
Recurrent lung aspirations in prior 90 days	2.45

Mitchell, SL. JPSM 2010

ADEPT Risk Score- Factors

	Risk Index
Weight loss	1.80
Insufficient oral intake	1.47
Chewing or swallowing problem	1.39
Diabetes mellitus	1.16
Arteriosclerotic heart disease	1.13
Congestive heart failure	1.44
Hypertension	1.09
Peripheral vascular disease	1.10
Stroke	1.20
Seizure disorder	0.91
Parkinson's disease	1.07
Anemia	1.17

Mitchell, SL. JPSM 2010

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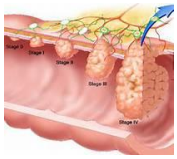
Prognosis in Dementia

- Hospitalized with pneumonia
  53% 6-month mortality vs. 13% cognitively intact
- Hospitalized with hip fracture
  55% 6-month mortality vs. 12% cognitively intact

Morrison RS JAMA 2000

Cancer



Cancer Prognosis

- Prognosis with Advanced Solid Tumors
  - 177 patients, with metastatic inoperable tumors
  - Factors negatively affecting survival:
    - 2 or more metastatic sites
      - 32 days median survival vs 119 days
    - Cerebral metastases
      - 23 days vs 70 days

Cancer Prognosis

- Prognosis with Advanced Solid Tumors
  - Karnofsky performance scale
    - 70% or greater 146 days
    - 40-60% 39 days
    - 30% or less 14 days
  - Serum albumin
    - 3.4 or greater 126 days
    - 2.4-3.3 50 days
    - 2.3 or less 30 days

Barbot et al. J Clin Oncol 2008

What is the Clinical Course?

A	Disease - Stable	Years
B	Disease - Unstable	Months
C	Deteriorating, Exacerbations	Weeks
D	End of Life	Days

Gold Framework Standard – Prognostic Indicator - 2008

"Acceptance of ones' own mortality is a process, not an epiphany"

R. Krakauer, MD

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Resources

Fast facts for prognostication and palliation
www.eperc.mcw.edu

Resource for palliative tools and guidelines
www.capc.com

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