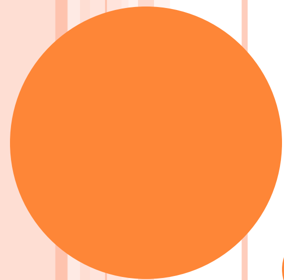
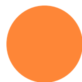
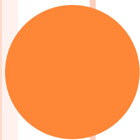




PALLIATIVE CARE

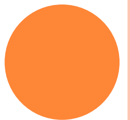
PAST,PRESENT,FUTURE

Jan 2013

Becca Wolfe

Palliative Care /Conversation

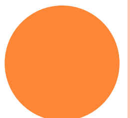
"There's no easy way I can tell you this, so I'm sending you to someone who can."



DEFINITION

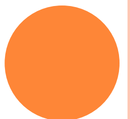
- Palliative care is specialized medical care for people with serious illnesses. It is focused on providing patients with relief from the symptoms of pain, and stress of a serious illness-whatever the prognosis. The goal is to improve the quality of life for both the patient and the family.

- A world Health Organization statement describes palliative care as "an approach that improves the quality of life of patients and their families facing the problems associated with life threatening illness."



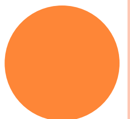
History

- Palliative care began in the hospice movement and is now widely used outside of traditional hospice care.
- The first US hospital –based palliative care began in the late 1980's at a handful of institutions. Now there has been a dramatic increase in hospital based PC program now numbering more than 1400. 80% of U.S. hospitals with more then 300 beds have a program.
- 1983 JACHO Initiates hospital hospice accreditation.



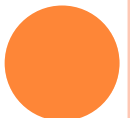
ACCEPTANCE

- The results of 2010 study in The New *England Journal of Medicine* showed that lung cancer patients receiving early palliative care experienced less depression, increased quality of life and survived 2.7 months longer than those receiving standard oncologic care.



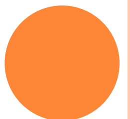
Palliative Care is *NOT* Hospice

- In the United States, hospice and palliative care represent two different aspects of care with a similar philosophy.
- Hospice is end of life care. It does not offer curative care but provides comfort care and pain relief while maintaining dignity and quality of life for the terminally ill.
- Palliative care offers management of treatment side effects as well as helping patients and families determine goals of care. Curative care can be combined with palliative care.



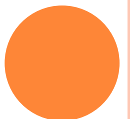
Types of Palliative Care

- Hospital based care can offer an interdisciplinary team composed of palliative care and hospice certified physicians, nurse practitioners, RNs, spiritual care, social workers and allied therapies working collaboratively to assess, develop, implement, evaluate, and monitor a patient and family centered palliative plan of care.



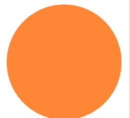
Smaller Palliative care groups

- Smaller teams consisting of FNP's and RN's who participate in the shared process of advance care planning (e.g. advance directives, life support, DNR status, power of attorney for health care) and patient and family goals of care.



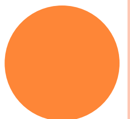
Defining the Problem

- Problem for the Healthcare provider
  - Need to identify goals of care
  - Need to identify the decision maker
- Problem for the Patient/Family
  - Perception of unmet needs
  - Lack of information
  - Need to identify goals of care
- Problem for the Health care system
  - Disproportionate care/cost and resource use at end of life



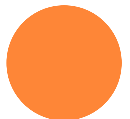
The high cost of end of life care

- $67 billion dollars a year are consumed by the chronically ill in the last 24 months of life.
- One-half of the dollars are consumed in the last two months of life.
- The new mandate by Medicare to not to pay for readmissions less than 30 days with the same diagnosis makes having the conversation paramount in saving health care dollars.

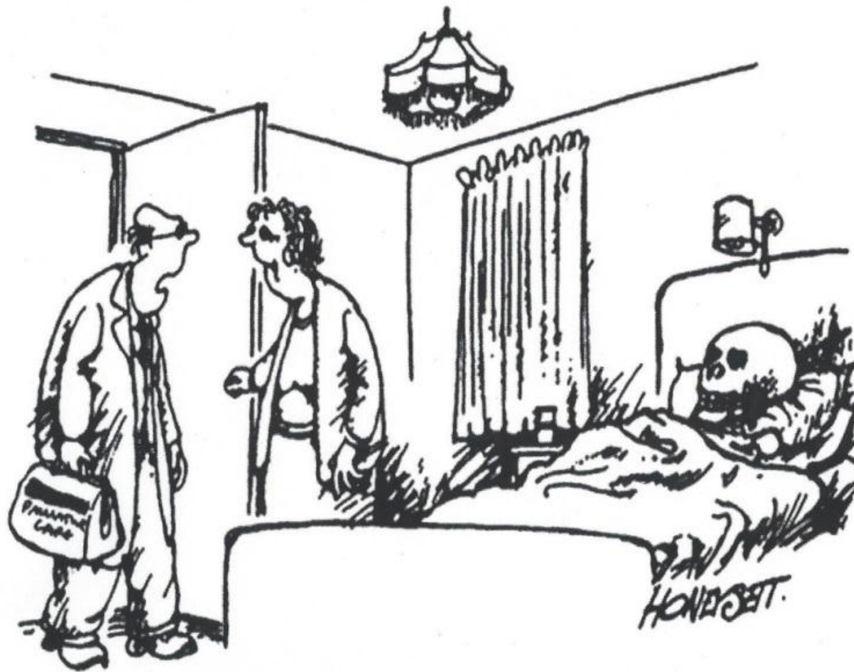


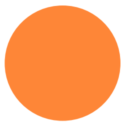
Palliative Care Triggers

- Increased length of hospital stay
- Frequent admissions (3 or more in past 3 months)
- Multi-system organ failure
- Metastatic disease
- Chronic COPD/CHF
- No hx or documentation of Advance Directives
- Emotional, spiritual, or relational distress
- Med team is considering gastronomy tube placement, tracheostomy, or initiation of hemodialysis



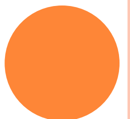
Don`t Wait





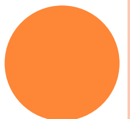
WHEN

- When should the conversation be started?
- When the answer to the question "Will I be surprised if this patient dies within the next 12 months?" is "NO."
- As part of the therapeutic plan and counseling upon diagnosis of a life threatening illness.
- When the patient or family asks.
- When significant changes happen in the clinical condition.



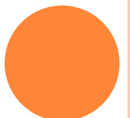
Helpful Phrases

- I want to help you navigate this journey.
- I am here to help you understand.
- I need you to help us understand.
- We can do a lot to you but what do you want us to do for you?
- Did your family member ever share their wishes regarding their care at end of life?
- No decision is a decision. Decisions can be changed.
- Burden vs. Benefit.



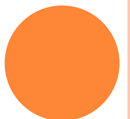
WHY

- Palliative care is an interdisciplinary method that focuses on:
  a. A more patient/family - centered approach
  b. Patient and family are fully informed about all treatment and non-treatment options
  c. Ensuring patients have equal access to all hospital resources
  d. Support decisions of patients/families to decline or to receive the life sustaining treatments they choose after being fully informed of their medical condition and prognosis. This includes a discussion of benefit/burden and proportionate/disproportionate issues of treatment options.



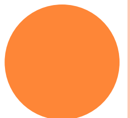
TOOLS

- What kind of medical care would you want if you were too ill or injured to express your wishes?
- Advance Directives are legal documents that allow you to convey your preferences /or decisions about end of life care ahead of time. They provide a way for you to communicate your wishes to family and health care professionals .



Tools

- These tools include:
  - Living Will
  - Statutory Short Form Power of Attorney for Health Care
  - Department of Public Health Uniform Do Not Resuscitate
  - Mental Health Treatment Preference Declaration



HEALTH POWERS OF ATTORNEY FORM FOR INDIANA RESIDENTS

I, ____(Insert your name and address as principal) appoint _________________________Insert name and address of the person appointed) as my agent (attorney-in-fact) to act for me in any lawful way with respect to the Health Care Powers that may include acting as my agent with respect to mental health and addictions treatment services, as defined and described in the Annotated Indiana Code, which is incorporated by reference herein:

Health care powers. (Indiana Code § 30-5-5-16)

Sec. 16. (a) This section does not prohibit an individual capable of consenting to the individual's own health care or to the health care of another from consenting to health care administered in good faith under the religious tenets and practices of the individual requiring health care. (b) Language conferring general authority with respect to health care powers means the principal authorizes the attorney in fact to do the following:

(1) Employ or contract with servants, companions, or health care providers to care for the principal.

(2) If the attorney in fact is an individual, consent to or refuse health care for the principal who is an individual in accordance with IC 16-36-4 and IC 16-36-1 by properly executing and attaching to the power of attorney a declaration or appointment, or both.

(3) Admit or release the principal from a hospital or health care facility.

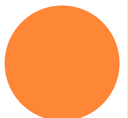
(4) Have access to records, including medical records, concerning the principal's condition.

(5) Make anatomical gifts on the principal's behalf.

(6) Request an autopsy.

(7) Make plans for the disposition of the principal's body.

If you wish your agent to be able to withdraw or withhold health care or to be able to access and discuss treatment information specific to mental health and/or alcohol or drug treatment as described below, check the respective boxes below:



Cont.

I authorize my health care representative to make decisions in my best interest concerning withdrawal or withholding of health care (pursuant to Ann. Ind. Code §§ 30-5-5-17, 16-31-1, and 16-36-4). If at any time based on my previously expressed preferences and the diagnosis and prognosis my health care representative is satisfied that certain health care is not or would not be beneficial or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.

I authorize my health care representative to access/receive specially protected treatment information and to discuss such information with health care providers to coordinate my care for the initialed areas below. __

Mental Health Records (IC 16-39-2-9) __ Drug and Alcohol Records (CFR 42

My heath care representative must try to discuss care decisions with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others to the extent they are available.

Cont.

I authorize my health care representative to make decisions in my best interest concerning withdrawal or withholding of health care (pursuant to Ann. Ind. Code §§ 30-5-5-17, 16-31-1, and 16-36-4). If at any time based on my previously expressed preferences and the diagnosis and prognosis my health care representative is satisfied that certain health care is not or would not be beneficial or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.

I authorize my health care representative to access/receive specially protected treatment information and to discuss such information with health care providers to coordinate my care for the initialed areas below. __ Mental Health Records (IC 16-39-2-9) __ Drug and Alcohol Records (CFR 42 Part II) __ HIV/AIDS Records (IC 16-41-8) __ Infectious Disease Records (IC 16-41-8)

My heath care representative must try to discuss care decisions with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others to the extent they are available.

Cont.

CHECK ONE OF THE FOLLOWING BOXES:

This power of attorney shall terminate upon my disability, incapacity or incompetence.

This power of attorney is effective immediately, and shall not be affected by my disability, incapacity or incompetence.

This power of attorney will become effective upon my disability, incapacity or incompetence.

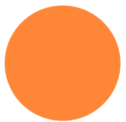
I understand that in accordance with Indiana Code 30-5-10-1, except as otherwise stated in this power of attorney form, this executed power of attorney may be revoked only in writing wherein the written revocation statement identifies the power of attorney revoked and is signed by myself, the principal. This power of attorney shall continue in full force and effect until I have executed and recorded in the Recorder's Office of the county of my domicile a written revocation hereof.

Signed this ________ day of ________________, __________.

_______________________________ (Your signature) (Your social security number)

State of ____________________. County of _________________.

On this ______________day of _______________________, ________, before me personally appeared ____ (name of principal), who is personally known to me or provided ____as identification, and acknowledged that he or she executed this health powers of attorney form.

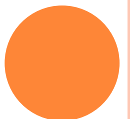


___________________________________ Notary Public

SYMPTOM MANAGEMENT

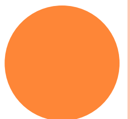
Medication:

- Medications used for palliative care are used differently than standard medications based on established practices with varying degrees of evidence. Examples include the use of antipsychotic medications to treat nausea, anticonvulsants to treat pain, and morphine to treat dyspnea.
- Route of administration may differ as many patients lose the ability to swallow. Routes of administration include subcutaneous, sublingual, intramuscular, and transdermal.



SYMPTON MANAGEMENT

- Patients may experience a variety of symptoms.
- Some of the most often experienced by individuals with life-threatening illness include: pain, anorexia, cachexia, constipation, nausea, vomiting, alteration of oral mucus membranes, change in taste and odor of foods, altered mental state, fatigue, and reaction to medication, chemo and radiation therapy.



Opioid Dosing Equivalance

Drug	Dose (mg) Parenteral	Dose (mg) Oral	Duration (hours)
Morphine (IR)	10	30	3-4
Morphine, Controlled Release (MS Contin®, Oramorph SR®)	—	30	8-12
Hydromorphone (Dilaudid®)	1.5	7.5	3-4
Codeine	130	200	3-4
Oxycodone, Controlled Release (Oxycontin®)	—	20	8-12
Oxycodone (Roxicodone®, Percocet®)	—	20	3-4
Hydrocodone (Vicodin®, Lortab®)	—	30	3-4
Meperidine (Demerol®)	100	300+	2-3
Levorphanol (Levo-Dromoran®)	2	4	6-8
Methadone (Dolophine®)[,1]	10 acute pain 2-4 chronic pain		8
Fentanyl (Duragesic®, generic)	0.1	Convert present medication to 24 hour oral MS equivalent; then divide in half; this is mcg/hr dose of fentanyl	48-72
Propoxyphene (Darvon®; Darvocet®)	—	180	4

Important Note: If converting from one drug to another AND the patient's pain is well controlled, many experts recommend reducing the dose by 25% to account for incomplete cross tolerance. However, if you are converting from one drug to another AND the patient is in severe pain, dose reduction is often not necessary.

a. WARNING: Long-lived toxic metabolite; CNS stimulant, not recommended for long-term use

b. Methadone should be used with caution in older adults. Dose methadone using the following guidelines:[2-4]

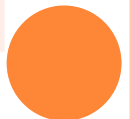
1. If the total morphine or equivalent dose per day is less than 90 mg (oral) a methadone ratio of 1:4 (methadone to morphine) is used. The total methadone dose is divided by 3 and given at 8-hour intervals.
2. If the morphine or equivalent dose per day is between 90 and 300 mg (oral), a dose ratio of 1:8 (methadone to morphine) is used. The total methadone dose is divided by 3 and given at 8-hour intervals.
3. If the morphine or equivalent dose per day is greater than 300 mg (oral), a dose ratio of 1:12 (methadone to morphine) is used. The total methadone dose is divided by 3 and given at 8-hour intervals.
4. Patient maintained on an 8-hour schedule of methadone may have 10% of the daily dose for breakthrough pain

c. WARNING: Long-lived metabolite that is toxic to the central nervous system and cardiovascular system, notrecommended for long-term use and use in the elderly.

Source: American Association of the College of Nurses 2009, Duarte, CA

Treatment of Dyspnea

Table 4: Pharmacology Treatment of Dyspnea			
Class of Drug	Examples	Mechanism of Action	Dosages/Comments
Opoids	Morphine Fentanyl	Exact mechanism for dyspnea is not completely understood	IV: 1-4mg q 15 min-4hrs SQ: 1-4mg q 30 min-4hrs PQ: 5-15mg, capsule tablet or liquid form q 1-4 hrs suppository May need to be compounded IV: 25-40 mcg q 15 min PRN SL: 25-40 mcg q 15 min PRN
Bronchodilators (used frequently in already obstruction, COPD and asthma conditions)	Albuterol Ipratropium Metaproterenol Salmeterol	Relax smooth muscles of respiratory tract relieving bronchospasm Stimulates Beta2 agonist, adrenergic receptors of sympathetic nervous system, Relaxing smooth muscles of bronchial tree	Dosages are highly variable and dependent on patient's overall health status, smoking history, age, and presence of co-morbid factors May cause anxiety, cough while worsening dyspnea Drugs are available in metered dose inhalers, nebulizers, or orally
Diuretics (used in heart failure, reduce fluid overload)	Furosemide	Inhibits reabsorption of electrolytes in ascending limb of the loop of Henle, enhancing excretion of sodium chloride, potassium, calcium and other electrolytes	PO: 20-80mg IV: 20-40mg Dosage varies widely and should be adjusted to patient's requirement and response



…Continued Benzodiazepines, Non-benzodiazepine Anxiolytic….

Source: American Association of the College of Nurses 2009, Duarte, CA

Treatment of Anorexia/Cachexia

Table 2: Anorexia/Cachexia: Pharmacologic Interventions		
Class of Drug	Examples	Comments
Gastrokinetic Agents	Metoclopramide 10mg PO TID	Useful in patients complaining of nausea or early satiety.
Corticosteroids	Dexamethasone 4 mg PO am, then taper gradually to the minimum effective dosage	Highly effective in improving appetite in the short term, with side effects at the dosage recommended; may lose efficacy after a few weeks.
Progesterone Analogs	Megestrol acetate 400-800 mg PO QA Medroxyprogesterone acetate 100 mg PO TID	80% of patients will show improvement in appetite; significant decreases in nausea and vomiting occur in more than 50%; abnormalities of taste are often reduced and weight gain (of fat, fluid, and lean body mass) is seen in nearly all patients except those in the most terminal stages. Treatment with recommended dosage costs $2/day (more expensive but has fewer side effects than steroids).
Cannabinoids	Dronabinol 2.5 mg PO BID 1 hour PC	AS effective appetite stimulant in low doses, without the usual side effects of drowsiness and muddled thinking.

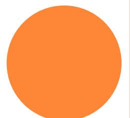
…Continued Alcohol, Vitamins….

Source: American Association of the College of Nurses 2009, Duarte, CA

Treatments for Diarrhea

Table 4: Pharmacology Treatment for Diarrhea			
Class of Drug	Examples	Mechanism of Action	Dosages/Comments
Opioids	Diphenoxylates hydrochloride Loperamide hydrochloride	Suppress forward peristalsis and increase sphincter tone	5 mg PO QID Start at 4 mg PO, then 2 mg after each loose stool, not to exceed 15 mg a day
Bulk-Forming Agents	Psyllium	Promote absorption of liquid and increase thickness of stool	Give 1-3 times a day, many preparations available Patient must be able to drink at least 8 glasses of water daily; if they are unable to do so, this is not the appropriate choice of medication
Antibiotics	Metronidazole	To eliminate Infections processes	Antibiotic choice is based on etiology

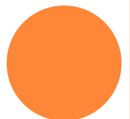
…Continued Steroids, Somatostatin….



Source: American Association of the College of Nurses 2009, Duarte, CA

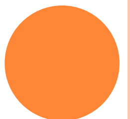
Non-Pharmaceutical treatments

- Physical modalities
- Physical therapy
- Cutaneous Stimulation
- Exercise
- TNS
- Acupuncture
- Massage, healing touch
- Psychosocial & Spiritual Intervention
- Relaxation & Spiritual Intervention
- Music
- Education patient & family
- Hypnosis
- Prayer
- Biofeedback
- Aromatherapy



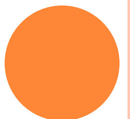
Reimbursement

- 1. Medicare (36-74%)
  2. Medicaid (0- 20%)
  3. Private Insurance (10-34%)
  4. Indigent Funds (17-20%)
  5. Self-Pay (2-11%)
  6. Medicaid SSI (0-6%)



Advance Practice Nurses in End of Life Care

- Studies increasingly are demonstrating the APN role can improve quality of life in a cost-effective way.
- As a member of the interdisciplinary palliative care team, the Advanced Practice Nurse assumes many roles as he/she interfaces with families, staff, colleagues, and community. She/he is an advanced clinician, educator, researcher, and consultant.



THERE IS AN END.

The patient's good and the ends of medicine
"If medicine takes aim at death prevention, rather than at health and relief of suffering, if it regards every death as premature, as a failure of today's medicine- but avoidable by tomorrow's- then it is tacitly asserting that its true goal is bodily immortality... Physicians should try to keep their eyes on the main business, restoring and correcting what can be corrected and restored, always acknowledging that death will and must come, that health is a mortal good, and that as embodied beings we are fragile beings that must stop sooner or later, medicine or no medicine."
Kass LR. JAMA 1980;244:1947
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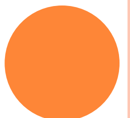

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