Palliative Care: The What, Why and How

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What is Palliative Care?

• Specialized medical care for people with **serious illness**. This type of care is focused on:
  o providing **relief from the symptoms**, pain, and stress of a serious illness and
  o **improving quality of life** for both the patient and the family.
What is Palliative Care?

• Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient's other doctors to provide an extra layer of support.

• Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.
“I keep telling you—it’s a chronic illness.”
Summa’s Hospice and Palliative Care Program: Clinical Team and Services

• 9 FTE HPM BC physicians; 6 APN’s; PharmD., RN, SW, Chaplain
• Hospice(s) census of ~230
• PC Consults at 4 hospitals 2400 annually
• 2 Acute Palliative Care Units (20 beds total)
• PC Consults in LTC
• PC Consults in Cancer Centers
• Palliative Care Clinics
• Pediatric to Adult Care Transitions (ACT)
• Home Palliative Care: “Comprehensive At Home Care”
Hospice

A **type of palliative care** usually provided in the home by a team of professionals and volunteers who provide medical, psychological, emotional, and spiritual support to terminally ill patients and their families. Great emphasis is given to pain and symptom control.

“2 Doctors predict less than 6 months”
Hospice

Routine Care (95%)
• Care that can be provided in home or facility settings

General Inpatient Care (5%)
• When symptoms/care require inpatient/hospital setting
• 3 east
• Medicare rules/requirements
Palliative Care vs. Hospice

• Palliative Care
  • Serves all patients at any stage of advanced or life threatening illness, not just those with 6 month prognosis.
  • Patients do not have to forgo curative care.
  • Coordinates with a variety of health care providers to prevent service fragmentation.
Palliative Care vs. Hospice

• Hospice
  • Serves dying patients of any age
  • 6 months prognosis required by Medicare and other funders
  • Coverage includes diagnosis related medications, supplies, and treatments
  • Efforts to cure or prolong life not covered
  • Over 90% of care is provided in the patient’s residence
Palliative Care Competencies for Graduating Medical Students, Developed From a Survey of 71 Palliative Care Experts, 2012

1. Ethical principles that inform decision making in serious illness
2. Reflects on personal emotional reactions to patients’ dying and deaths
3. Identifies psychosocial distress in patients and families
4. Explores patient and family understanding of illness, concerns, goals, and values
5. Philosophy and role of palliative care... differentiates hospice from palliative care
6. Demonstrates patient-centered communication techniques when giving bad news and discussing resuscitation preferences
7. Assesses pain systematically; distinguishes nociceptive, neuropathic

Palliative Care Competencies for Graduating Residents, Developed From a Survey of 70 Palliative Care Experts, 2012

1. Explores patient and family understanding of illness, concerns, goals, and values
2. Demonstrates effective patient-centered communication when giving bad news, etc
3. Assesses pain systematically and treats pain effectively with opioids, nonopioid analgesics
4. Defines and applies principles of opioid prescription, including equianalgesic dosing and common side effects
5. Defines and explains the philosophy and roles of palliative care and hospice, and appropriately refers patients
6. Describes and performs communication tasks effectively at the time of death
7. Describes and applies ethical and legal principles that inform decision making in serious illness,

Old Model

Curative/Remittive Therapies

Days?

Hospice

Pall Care

Death
Comprehensive Palliative Care?

- Advance Care Planning
- Surrogacy
- MOLST
- Curative/Remittive Care
- Palliative Care
- Hospice
- Bereavement
- Time
- RESEARCH
- EDUCATION
- COMMUNITY ENGAGEMENT
Individual Barriers

“Quit complaining. I let you keep your hair.”
What Does the Public Know About “Palliative Care”?*

*Data from a Public Opinion Strategies national survey of 800 adults age 18+ conducted June 5-8, 2011.

*Study sponsored by the American Cancer Society and the CAPC
But, informed consumers are very positive about palliative care, and want access to this care if they need it:

- 95% of respondents agree that it is important that patients with serious illness and their families be educated about palliative care.
- 92% of respondents say they would be likely to consider palliative care for a loved one if they had a serious illness.
- 92% of respondents say it is important that palliative care services be made available at all hospitals for patients with serious illness and their families.

Phase II Study of Early Palliative Care in Patients with Metastatic Cancer

- 150 patients enrolled; 88 completed the study
- Edmonton Symptom Assessment Score (ESAS) decreased by 7 points at 4 wks (p<0.0001)
- Family Satisfaction with Advanced Cancer Care Score improved 5 points at 4 wks (p<0.0001)
- Significant decreases also seen in pain, fatigue, nausea, depression, anxiety, etc...

Palliative Care Outcomes

Patients assigned to early Palliative Care:

• Had a better QOL on the FACT-L: 98.0 vs 91.5; p=0.03
• Had fewer depressive symptoms: 16% vs 38%; p=0.01
• Were less likely to receive chemotherapy within 14 days of death and more likely to receive hospice care: p=0.05
• Had a longer median survival: 11.6 vs. 8.9 months; p=0.02

NEJM 2010;363:733-42
Palliative Care Outcomes

Cost Savings Associated with US Hospital Palliative Care Consultation Programs

• 5,018 patients who received palliative care during the index hospital admission were matched with 20,652 controls
• Average cost savings per hospital admission were $2,225
• Mean daily costs tracked before and after palliative care consultation showed that they dropped only after the consult was done

Arch Intern Med 2008; 168: 1783-1790
Palliative Care Outcomes

Palliative Care Consultation Teams Cut Hospital Costs for Medicaid Beneficiaries

- Examined 2004-07 Medicaid data from four New York hospitals
- Patients with advanced cancer, AIDS, CHF and COPD
- 475 patients receiving palliative care were matched with 1,577 controls
- $5,488 average reduction of costs per admission for patients receiving palliative care consult

Health Affairs 2011; 30: 454-63
Palliative Care Outcomes

Comparing Hospice and Non-hospice Patient Survival among Patients Who Die Within a Three Year Window

- Studied 4493 Medicare patients who died within 3 years with breast, lung, colon, prostate or pancreatic cancers and CHF
- Survival greater for hospice patients with CHF, lung cancer, and pancreatic cancer; marginally longer for colon cancer vs. non-hospice patients
- No difference for breast and prostate cancer

J Pain Symptom Manage 2007;33: 238-46
Palliative Care Outcomes

What if we control for survival?
• Medicare data for hospice vs non-hospice enrollees with advanced cancer within equivalent time period prior to death
• Over 18,000 patients in each group
• Hospice patients had significantly fewer hospitalizations, ICU admits and invasive procedures
• Hospice patients were much more likely to die at home and have $9000 less in health care costs in the last year of life

Indications For A Palliative Care Consult

• Goals of care
• Symptom control/unrelieved suffering
• Developing a treatment plan
• Advance care planning
• Terminal extubation help
• Evaluation/appropriateness for hospice
• Melding symptom management and disease modifying treatment
• Spiritual support
• High complexity social support needs
PALLIATIVE CARE – when to refer?

"My parents died. Their parents died. Their parents died... it runs in the family."
Summa Health Triggers

- **ICU**
  1. irreversible/severe conditions affecting 2 or more: heart, lung, liver, kidney, brain, skin (Stage 4 decub)
  2. Stage 4 Malignancy
  3. status post CPA (inpatient or outpatient)
  4. Intracerebral Hemorrhage requiring mechanical ventilation
  5. Advanced dementia with dependence in ADLS
  6. Admission from any long term care ECF or LTAC
  7. COPD on home oxygen with dyspnea at rest and 2 or more hospitalization in the last 6 months.
  8. Two ICU admissions in last 6 months
Summa Health Triggers

**Trauma**
1. Cervical spinal fracture in age 65 years and older
2. TBI on ventilator
3. Hip fracture age 65 years and older

**Oncology**
1. Stage 3b or higher lung cancer
2. Glioblastoma
3. Stage 4 pancreatic or GI Cancers
4. Stage 4 melanoma
Summa Health Triggers

• Cardiac
  1. Two admissions in a year with CHF
  2. Class 3 or 4 Heart Failure despite optimal medical therapies
  3. Poorly controlled angina with no re-vascularization options
  4. CHF with progressive renal failure (increasing BUN)
  5. Home inotropes
  6. ICD appropriate shock (more than one)
  7. Hypotensive on optimal therapies, intolerance to medication
  8. Resistance to diuretics – using Lasix >160mg/day or use of Metolazone
Summa Health Triggers

• Medication triggers

1. COPD on chronic daily oral steroids, home O2
2. Alzheimer’s disease on scheduled antipsychotics (Haldol, Seroquel, risperdnone)
3. Stroke or Alzheimer’s disease on antibiotics for aspiration pneumonia
4. Stroke or Alzheimer’s disease on 2nd line UTI agent (FQ, Fosfomycin)
5. Cirrhosis on rifampin, spironolactone 200mg, Lasix 80mg
6. CKD on sevelamer 1200mg TID and bumetanide 4mg
7. CHF on bumetanide 4mg, metoprolol 200mg, furosemide 160mg, digoxin, isosorbide mono/dinitrate 120mg, hydralazine 200mg (ALL ARE DAILY DOSES)
8. TPN for nonacute cause
9. Parkinson’s on Levodopa >1000mg/day
For the palliative care referral:

• “I’ve asked a team to come by to help you with your [pain, sob, etc...]…
• They can also help us plan for where to go from here…
• And speak with you about your goals and how we can best achieve them…
• To give you and I an extra layer of support to see that you get the best care possible”
And for the hospice referral:

• “Hospice is a free service for you to give you help at home (or in the nursing home). They are there to help you get the most out of every day”
• “You do not have to give up any of your current doctors to enroll in hospice.”
• “You can quit hospice at any time after signing up.”
• “How about if we just have one of their people come to explain the benefit to you.”
• “At some point in every illness, you are likely to live better and longer with hospice.”
Etiologic components in addition to the noxious physical stimulus that affect the patient’s experience of pain

- Fear, spiritual crisis, isolation
- Anger (especially with perceived inadequacies in doctors, nurses, etc...)
- Helplessness, dependency
- Frustration with bureaucracy
# Opiate Conversions

<table>
<thead>
<tr>
<th></th>
<th><strong>PO</strong></th>
<th><strong>IM/IV/SQ</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>30 mg Q3H</td>
<td>10 Q3Hmg</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>7.5 mg Q3H</td>
<td>1.5 mg Q3H</td>
</tr>
<tr>
<td>Methadone</td>
<td>10 mg Q6H</td>
<td>5 mg Q6H</td>
</tr>
<tr>
<td><strong>Variable conversion ratio</strong></td>
<td><strong>Methadone</strong></td>
<td><strong>5 mg Q6H</strong></td>
</tr>
<tr>
<td>Oxycodone</td>
<td>20 mg Q3H</td>
<td>NA</td>
</tr>
</tbody>
</table>

Note that these conversion ratios only provide general guidelines. Individual patients require close attention and follow-up
Opiate Conversion Ratios

• **Morphine to Fentanyl Transdermal:**
  Divide the total daily oral morphine dose by 3 to convert to mcg/hr fentanyl patch
  
  \[ \text{e.g.: } \frac{210}{3} = \text{approx } 75 \text{ mcg/hr patch} \]

• **Morphine to Hydromorphone:**
  
  4 to 1 orally
  6 to 1 IV/IM/SQ

Nelson. J Pain Symptom Mgmt 97;13:262
Methadone: Advantages

- Long half-life; may be dosed Q8H or even Q12H in some individuals
- Inexpensive and high potency
- Liquid form available
- Incomplete cross tolerance

Starting dose in adults:

- 5-10 mg Q8-12H PO
- Or 2.5 to 5mg po/2.5 parenteral in the elderly
Overdose/Toxicity?

- Constricted Pupils
- Fatigue/Lethargy
- Clonus
- Bradycardia
- Apnea
- Death

- But what if they have normal pupils??
Other unusual meds

- Nausea/vomiting
  - Haldol, Steroids, Benzos, Zyprexa
- Bowel obstructions
  - Steroids, octreotide
- Uncontrolled Pain
  - Lidocaine infusions, ketamine infusions, PCAs
- Dyspnea
  - OPIATES, OPIATES, benzos, fans
- Fluid overload
  - Lasix, nitro, CPAP/BIPAP
Pathophysiology of Nausea / Vomiting

Chemoreceptor Trigger Zone (CTZ)

Vomiting center

Neurotransmitters
- Serotonin- 5HT3
- Dopamine
- Acetylcholine
- Histamine
- Neurokinin 1

Cortex

Vestibular apparatus

GI tract
Management of nausea / vomiting

• Dopamine antagonists (Haldol, Reglan)
• Antihistamines (Vistaril, Benadryl)
• Anticholinergics (Scopolamine)
• 5HT3 antagonists (Ondansetron)

• Prokinetic agents (Metoclopramide, erythromycin)
• Antacids
• Steroids
• Somatostatin analogue (Octreotide)
Some day, we will all die, Snoopy!

True, but on all the other days, we will not.
How to get ahold of us?

- Palliative Consult is not Hospice Consult
- 3 East Conference Room or Secretary
- Page us, call us, join us
- Someone is on call 24 hours a day
Our Goals

• To find meaning in our work

• To care for, support and learn from our patients

• To teach

• To be present

• To be open