Providing Palliative Care: Everyone Has a Role

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Objectives:

- Describe 3 levels of palliative care
- Identify at least 2 elements of primary and specialty palliative care
- List at least 2 resources to help provide palliative care

Audience Poll- You Have to Choose One...

A quick death with little or no warning

Progressive illness with multiple episodes of a variety of medical care
Palliative Care

Early identification and impeccable assessment and treatments of pain and other problems, physical, psychosocial and spiritual.

World Health Organization

Continuum of Care

Where do these fit?
Aggressive care, End of Life, Comfort Care, Actively Dying, AND/DNR orders, Advance Directives

Levels of Palliative Care

Primary
Using basic palliative care skills for symptom management, goals of care discussion and advance care planning

Secondary
Consultation and specialty care for difficult and complex cases

Tertiary
Academic medical centers with specialist knowledge and research moving the field forward
Palliative Care

- **Screening Question:**
  Would you be surprised if this patient died in the next year?

Symptom Management - Physical

- Pain
- Dyspnea
- Nausea and/or Vomiting
- Constipation
- Debility/Fatigue
- Anorexia
- Many more...

Symptom Management - Physical

- Is this disease progression?
- Symptom management based on goals of care
- **Resource:** Fast Facts

**Research:** Overall survival results of a trial assessing patient-reported outcomes for symptom monitoring during routine cancer treatment. Basch E, et al. *Jama*, June 4, 2017
**Symptom Management-Psychosocial, Spiritual**

- Are you depressed, anxious?
- FICA (Faith, Importance, Community, Address in Care)
- Hope (sources of hope, role of organized religion, personal practices)

**Advance Care Planning**

- Advance Medical Directives
- Medical Power of Attorney
- Not a “one time” discussion
- Discuss outside of crisis
- No agendas or “correct” answers
- Desired outcome - understand the issues and make informed choices
- These documents support the patient's goals, what gives life meaning, what kind of legacy they hope to leave

**Advance Care Planning- Advance Directives**

- What is an advance directive? An advance directive is used to tell your doctor and family what kind of medical care you want if you are too sick or hurt to talk or make decisions. If you do not have one, certain members of your family will have to decide on your care.
- You must be able to think clearly and make decisions for yourself when you set it up. You do not need a lawyer to set one up, but you may want to talk with a lawyer before you take this important step. Whether or not you have an advance directive, you have the same right to get the care you need.
Advance Care Planning - Medical POA

- 2012 Code of Alabama
  Title 26 - INFANTS AND INCOMPETENTS
  Chapter 1A - ALABAMA UNIFORM POWER OF ATTORNEY.
  Section 26-1A-404 - Health care powers of attorney executed on or after January 1, 2012.
- Universal Citation: AL Code § 26-1A-404 (2012)

Medical POA is different from a surrogate

Advance Care Planning

- Benefits
  - Treatment preferences
  - Sense of dignity
  - Family support of care
  - Provide surrogate decision makers with patient’s voice
  - Help prevent conflict between family and care team

Advance Care Planning

More than just CPR:
- Food/fluids/PEG tube
- Antibiotics
- Tracheostomy
- Time limits for advanced therapies
  - How long to stay on the ventilator/TPN/Antibiotics?
- Other specifics based on patient unique circumstances
  - ALS patient already on a ventilator....
  - LVAD patient who had a stroke....
Advance Care Planning

- Preparation
  - Know the medical issues for this patient: recent hospitalization?
  - Understand disease trajectory
  - Realistic interventions available
  - Discuss with other consultants/specialists
- Resources:
  - ePrognosis
  - Palliative Performance Scale

Advance Care Planning

- Another important topic that I want to discuss...
- I have this conversation with all of my patients because it is important...
- Resource: VitalTips-
  - Have you talked with anyone about a living will or advance directives?
  - Have you been with family or friends when end of life decisions were made?
  - When the time comes, what is more important: quality of life or length of life?
  - What kind of medical care would you want if you were near the end of your life?
- Observe, be the observer: constructive feedback
- Ask patient/family for feedback: “was anything I’ve said especially helpful?”
- Reflect on what went well, where to improve

Facilitating the Conversation

- A skill that can be learned, improves with practice
- Resource: SPIKE protocol
  - Set up the interview
  - Perception: understanding of the medical issues
  - Invitation to share information
  - Knowledge sharing
  - Emotions
  - Summarize and plan next steps
Code Status

- Make no assumptions on level of understanding - medical literacy
- Base decisions on patient goals and quality of life
- Risk/benefits for interventions
- Comfort always part of care
- Document!

Levels of Support

- At my facility...
  - Allow Natural Death
  - No CPR/Support OK
    - noninvasive ventilation, pressors, intubation
  - Full Code
- Hospital order - Not valid outside of hospital
- Community DNR form

Alabama - Portable DNAR Order

- Passed into law October 2016
- MD/required form
- Valid until revoked
- Transfers from one health care facility to another
- EMS know what to look for
- Alabama Dept of Public Health
  - adph.org, Laws and Regulations page
MOLST/POLST/POST Forms

- Initiative underway in Alabama for MOLST
- Current planning, only MD can sign
- Language on Virginia Form....
- More than just CPR
Show Me the Money!

- As of Jan 1, 2016, Medicare Part B reimbursement for advance care planning
- Face to Face time - prognosis, treatment choices, advance directives
- Any qualified health care provider
- CPT code 99497- first 30 minutes of conversation
- CPT code 99498 each subsequent 30 minutes of conversation
  search advance care planning

In Summary:
Providing Palliative Care

- Everyone has a role
- Symptom management
- Identify/document Medical POA
- Comprehensive Advance Care Planning
  Code status discussion

References

For references not provided: