Intricacies of Hospice and Palliative Care

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Objectives

- Know how to discern which patients may benefit from palliative care consultation
- Recognize the similarities and difference between Hospice and Palliative Care
- Be able to treat the most common symptoms seen with life limiting illnesses
- Know the differences between double effect and physician assisted suicide
- Have a clear format how to deliver bad news
- Understand the value of non-physician members on the palliative care team

- Palliative Care is Interdisciplinary Care for individuals with Life Threatening Illnesses
- Its goal is to enhance quality of life for patients
  - Clear Communication
  - Symptom Management
  - Match patient and family goals with good medical care
  - Address social, psychological, spiritual and medical issues

Grudzen CR, Richardson LD, Johnson PN, et al. Emergency Department–Initiated Palliative Care in Advanced Cancer: A Randomized Clinical Trial. *JAMA Oncol.* 2016;2(5):591–598. doi:10.1001/jamaoncol.2015.5252

- QOL improved
- Survival not shortened

Early palliative care for patients with metastatic non-small-cell lung cancer Temel JS, Greer JA, Muzikansky A, Gallagher ER, Admane S, Jackson VA, Dahlin CM, Blinderman CD, Jacobsen J, Pirl WF, Billings JA, Lynch TJ N Engl J Med. 2010;363(8):733

- Patients with metastatic non small cell lung cancer have better QOL and mood if they have early Palliative Care consultation.

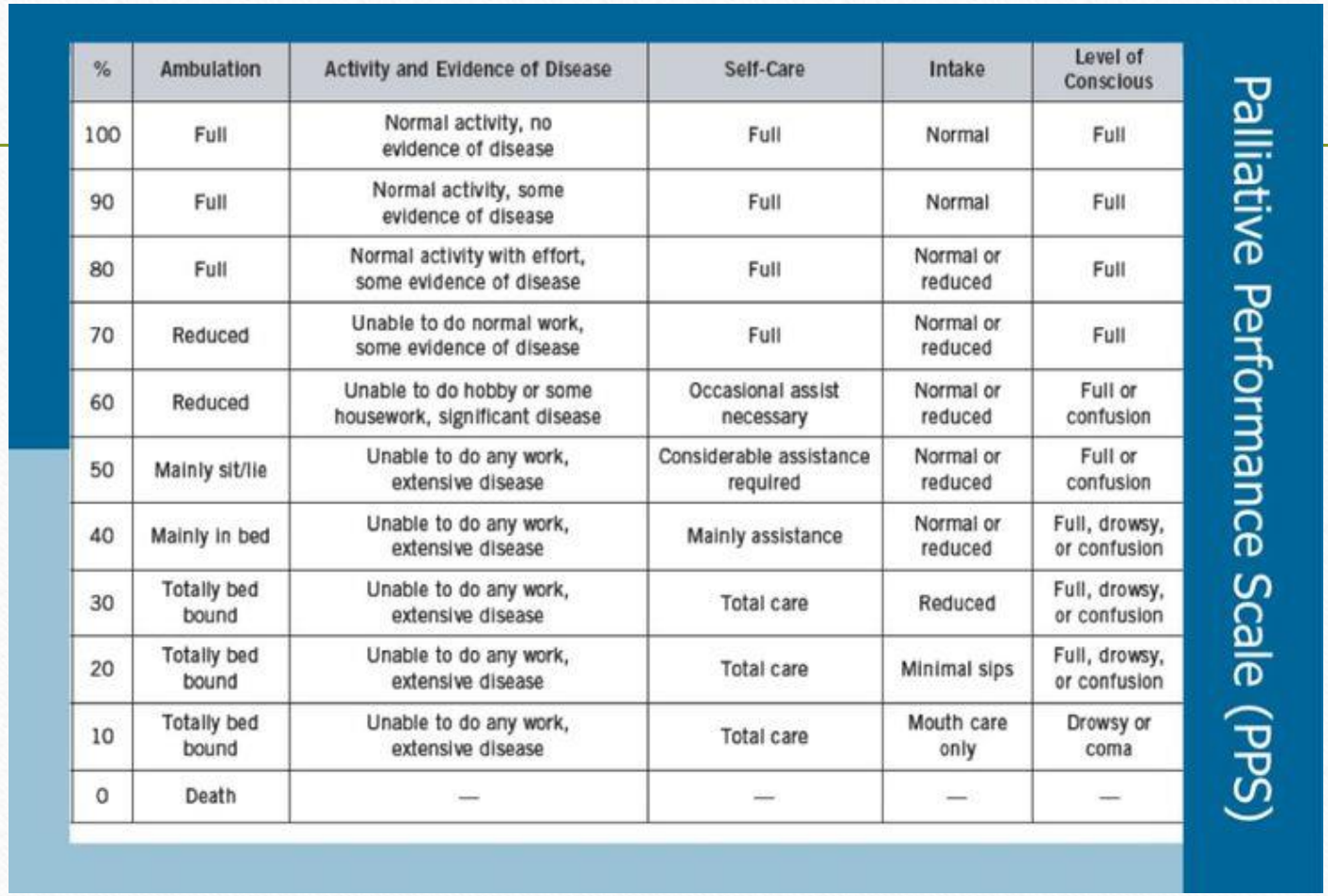
Diagnoses That May Be Considered Appropriate For Palliative Care

- Cancer
- COPD
- CAD/CHF
- Liver Disease
- Renal Disease

Non-Disease States That May Qualify for Palliative Care

- Recurring hospitalizations or ED Visits
- Poor social support and a serious illness
- Declining ability to complete ADLS
- Previously qualified for hospice but revoked

Palliative Performance Scale



Palliative Performance Scale (PPS)

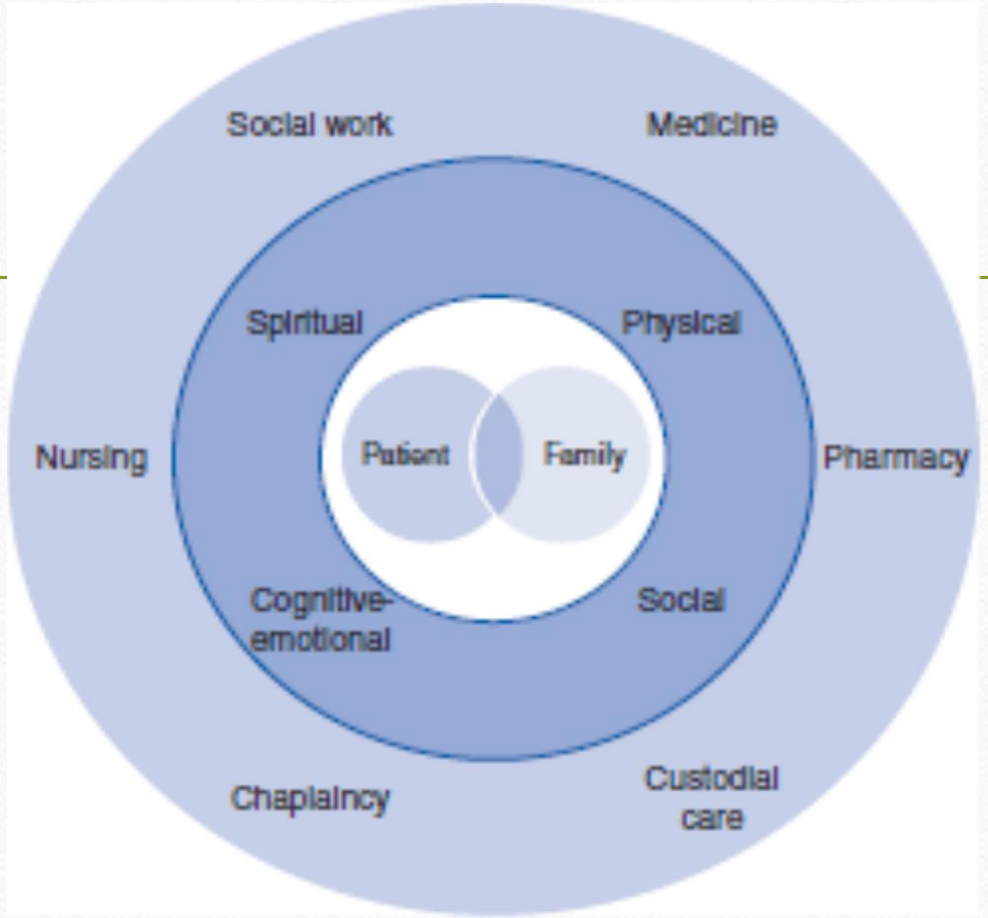
%	Ambulation	Activity and Evidence of Disease	Self-Care	Intake	Level of Conscious
100	Full	Normal activity, no evidence of disease	Full	Normal	Full
90	Full	Normal activity, some evidence of disease	Full	Normal	Full
80	Full	Normal activity with effort, some evidence of disease	Full	Normal or reduced	Full
70	Reduced	Unable to do normal work, some evidence of disease	Full	Normal or reduced	Full
60	Reduced	Unable to do hobby or some housework, significant disease	Occasional assist necessary	Normal or reduced	Full or confusion
50	Mainly sit/lie	Unable to do any work, extensive disease	Considerable assistance required	Normal or reduced	Full or confusion
40	Mainly in bed	Unable to do any work, extensive disease	Mainly assistance	Normal or reduced	Full, drowsy, or confusion
30	Totally bed bound	Unable to do any work, extensive disease	Total care	Reduced	Full, drowsy, or confusion
20	Totally bed bound	Unable to do any work, extensive disease	Total care	Minimal sips	Full, drowsy, or confusion
10	Totally bed bound	Unable to do any work, extensive disease	Total care	Mouth care only	Drowsy or coma
0	Death	—	—	—	—

Hospice Medicare Benefit

- A form of Palliative Care
- Agree to forego curative treatment
- Estimated prognosis of 6 months or less
- Must be agreed to be appropriate by two physicians for the first 90 day certification period

- **Cancer Diagnoses**
- **Primary Criteria** Patients are considered to be in the terminal stage of their disease if they have:
- 1. Disease with distant metastases at presentation; or
- 2. Progression from an earlier stage of disease to metastatic disease with either:
- a. A continued decline in spite of therapy
- b. Patient declines further disease directed therapy
- **Secondary Criteria Notes** Note: Certain cancers with poor prognoses (e.g. small cell lung cancer, brain cancer and pancreatic cancer) may be hospice eligible without fulfilling the other criteria in this section.

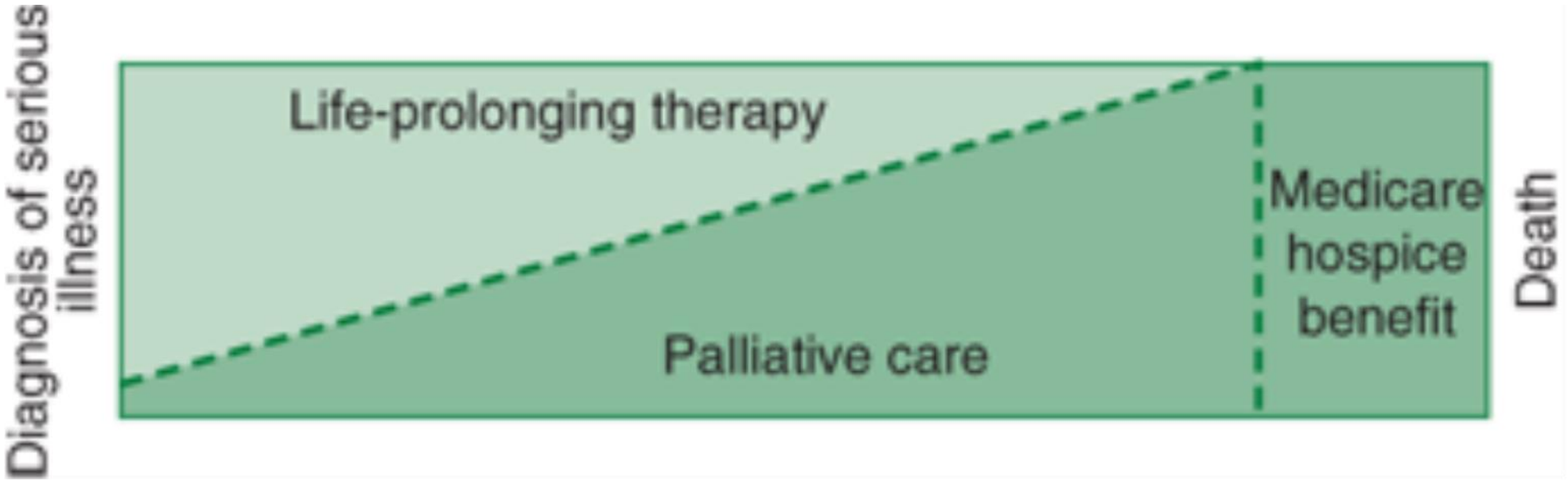
- Primary Criteria
- Patients will be considered to be in the terminal stage of pulmonary disease if they meet the following:
- (This refers to patients with various forms of advanced pulmonary disease who eventually follow a final common pathway to end-stage pulmonary disease)
- 1. Severe chronic lung disease as documented by both a and b:
- a. Disabling dyspnea at rest, poorly or unresponsive to bronchodilators, with decreased functional capacity (e.g., bed to chair assistance, fatigue, cough, or predicted FEV1<30% - is objective evidence of disabling dyspnea, but not necessary to obtain)
- b. Progression of end-stage pulmonary disease, evidence including prior increasing visits to the emergency department, hospitalizations, or increasing physician home visits for pulmonary infections and/or respiratory failure.
- 2. Hypoxemia at rest on room air; evidence : p02 ≤ 55 mm Hg or oxygen saturation ≤88% or hypercapnia; evidence pCO2 ≤50 mm Hg
- Secondary Criteria Notes
- Additional factors to assess for:
- 1. Right heart failure secondary to pulmonary disease (not secondary to left heart disease or valvulopathy)
- 2. Unintentional weigh loss of >10% body weight over past 6 months
- 3. Resting tachycardia of >100/min



Current Diagnosis & Treatment: Geriatrics, 2e > Geriatrics & Palliative Care

Goals of Palliative Care

- Help patients understand their disease processes and options
- Manage uncontrolled symptoms
- Find Hope
- Look for life's meaning
- Identify ways to say good-bye



The place of palliative care in the course of illness.
(Adapted from Clinical Practice Guidelines for Quality Palliative Care. Available at: www.nationalconsensusproject.org.)

Case study

- Ms. Lyn is a 74 year old retired educator who has been having abdominal pain. Ct scan reveals she has colon cancer with liver mets. She says she wants to fight the cancer. Oncology starts chemotherapy. Patient hopes she can be able to attend her 50th anniversary in 5 months. You start norco for pain control. Ms. Lyn does not tolerate the initial chemo. She agrees to a lesser chemo for palliation. Her abdominal pain is worsening and she now takes MSER bid with Norco for breakthrough pain. Patient is losing weight so you start prednisone which may help with the liver metastases. She goes to her anniversary party. Soon after she feels very weak and can't tolerate chemotherapy. She requests hospice and all noncomfort meds are stopped.

How do you decide if Palliative Care is appropriate

- Initiate the discussion
- Elicit Family and Patient Perspectives
- Clarify the Prognosis
- Identify end of life goals
- Arrange a treatment plan

PALLIATIVE CARE – when to refer?

The Palliative Care Philosophy can be provided within the home, acute care hospitals and at nursing facilities

Home palliative care increases the chance of dying at home and reduces cancer symptom burden without impacting care giver grief

Gomes B, Calanzani N, Curiale V, McCrone P, Higginson IJ. Effectiveness and cost-effectiveness of home palliative care services for adults with advanced illness and their caregivers. Cochrane Database of Systematic Reviews 2013, Issue 6. Art. No.: CD007760. DOI: 10.1002/14651858.CD007760.pub2.

Frailty

A progressive decline in function that affects quality of life

- Loss of weight
- Decreasing Endurance
- Loss of Strength
- Increasing Falls
- Worsening Pain

Hospice Levels of Care

- Home Care
- General Inpatient Care
- Continuous Care
- Respite

Symptom Management-Pain

- Relieve pain with the minimal effective dose of narcotics and adjunctive pain medications
- Non-aggressive pain control or withholding narcotics because a patient is not yet on hospice is unfair.
- One third of people with cancer pain are undertreated

Narcotic conversion

OPIOID ANALGESIC CONVERSION CHART						
Opioid	**IV (mg)**	**PO (mg)**	**Interval/ Duration (hr)**	**Onset (min)**	**Peak (min)**	**Comments**
Morphine (MSIR)	10	30	3–4	IM 15–30 IV < 5 PO 15–60 PR 10–20 SC 5–10	30–60 10–20 60 20–60 50–90	Injection: 2,4,8,10,15 mg/mL syringes Oral IR: 10,15,30 mg tablets Oral soln: 10mg/5mL, 20mg/mL Suppositories: 5,10,20,30 mg
Morphine SR (MS Contin®, Kadian®, Avinza®)			8–12	20 – 40	60	MS Contin (q12h): 15,30,60,100,200 mg tabs, Kadian (q12h): 20,30,50,60,80,100 mg caps, Avinza (q24h):30,60,90,120 mg caps
Hydromorphone (Dilaudid)	1.5	7.5	3–4	IM 15–30, IV < 5, PO 15–30	30–90 10–20 30–90	Injection: 1,2,3,4,10 mg/mL; Tablets: 1,2,3,4,8 mg; Oral Soln: 1mg/mL
Fentanyl inj. (Sublimaze)	0.1–0.2	0.2–0.4	IV: 0.5–1 PO: 1–2	IV 1–2	3–5 10–30	Injection: 50 mcg/mL
Fentanyl tab/loz. (Actiq, Fentora, Onsolis, Abstral)			Buccal: 1–2	Buccal 5–15		Bioavailability different for each product Dosing individual for each product
Fentanyl patch (Duragesic)			72	8 – 12 hr	24 – 36 hr	25mcg patch = 60mg oral morphine/day Patches: 12, 25, 50, 75, 100 mcg/hr
Methadone	See comments		6-12	IV 10–20 PO 30–60	30–60	PO morphine:methadone ratio (mg/day): < 90 mg (4:1); 90–300mg (8:1); > 300 (12:1)
Oxycodone (Oxycontin (CR), OxyIR)		20	IR 3-4 CR 12	PO 10–15	30–60	morphine:oxycodone ratio: 3:2 25% will require q8hr dosing with Oxycodone CR
Hydrocodone		30	3–4	PO 10–20	30–60	Lortab, Norco: 5,7.5,10mg (500,325mg)

Double Effect

- Providing medication intended to relieve suffering while risking that they may unintentionally shorten the patients life (provided it is appropriate)
- This is not voluntary active euthanasia.
- Physician-assisted suicide is legal in Oregon, Washington, Montana, California and Vermont

Adjuncts to Narcotics

- Corticosteroids
- Benzodiazepines
- Anti-Depressants
- Anticonvulsants
- Muscle Relaxers
- NSAIDs

Constipation Treatments

- Increase fluids and fiber
- Lubiprostone, Naloxegol, Methylnaltrexone

Diarrhea

- Look for underlying cause
- Medication side effect, previous radiation, cancer, IBS or infection
- Use bulking agents or OTC agents

Decreased Appetite

- Does it really need to be treated?
- Look for symptoms that may be affecting appetite (nausea, dry mouth)
- You can pharmacologically stimulate appetite
  - Corticosteroids
  - Mirtazapine
  - Dronabinol
  - Megace

Nausea and Vomiting

- Central versus Peripheral causes
- Different receptors can be affected to cause nausea (serotonin, dopamine histamine, and acetylcholine)
- There are different classes of antiemetic drugs
  - Antidopaminergic
  - Antiserotinergic
  - Antihistamines
  - Anticholinergics
  - Neurokinins

Grief and Depression

- May be a patient or their family experiencing the symptoms
- Associated often with realization in changes over life circumstances
- The goal should be to explore these feelings to prevent isolation which could lead to clinical depression
- Watch for the signs of depression: Loss of interest, withdrawal, sadness, inability to concentrate and hopelessness
- Pharmacotherapy is appropriate in this population
- In particularly difficult cases - refer to a therapist

Shortness of Breath

- Oxygen
- Cool fan
- Relaxing music
- Pharmacotherapy
  - **Benzodiazepines** & **Morphine** (make a good synergistic combination)

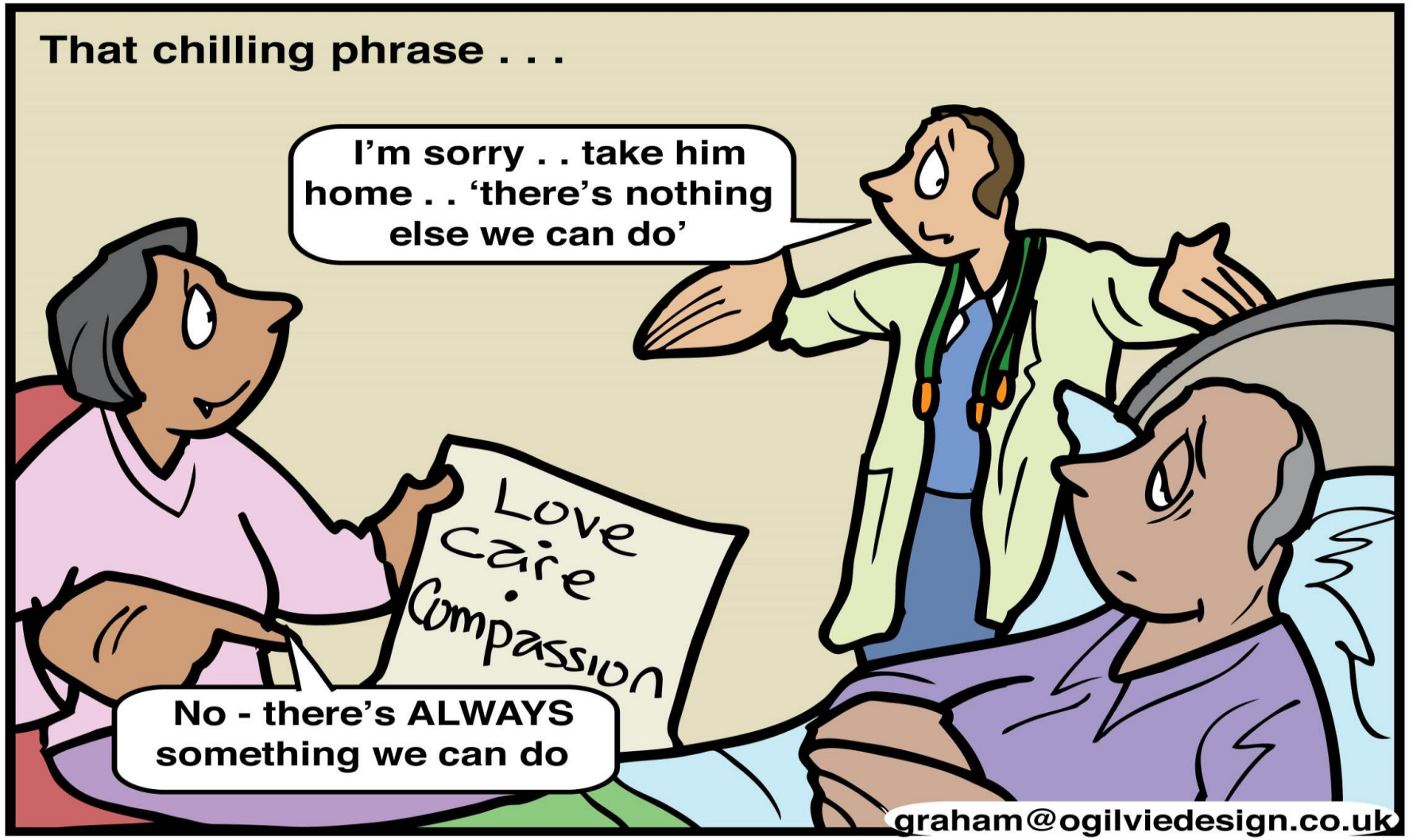
Breaking Bad News

How to get ready to deliver bad news

- Prepare yourself to feel badly
- Pick where you want to deliver the news
- Set the context
- Deliver the bad news clearly (do not be ambiguous)
- Stop (let the adrenaline stop flowing)
- Ask for questions
- Commit to Support

O'Donnell AE, Schaefer KG, Stevenson LW, et al. Social Worker–Aided Palliative Care Intervention in High-risk Patients With Heart Failure (SWAP-HF)A Pilot Randomized Clinical Trial. *JAMA Cardiol.* Published online April 11, 2018. doi:10.1001/jamacardio.2018.0589

- Patients at high risk for mortality from HF often overestimate how long they are going to live.
- Without adverse affect(depression, anxiety, quality of life) patients who talked with a social worker were more likely to change their initial survival prognostication.


That chilling phrase . . .
I'm sorry . . take him home . . 'there's nothing else we can do'
Love
Care
Compassion
No - there's ALWAYS something we can do
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