Clinic-Based Palliative Care: The Leading Edge

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Disclosures

- There are no relevant financial relationships to disclose.

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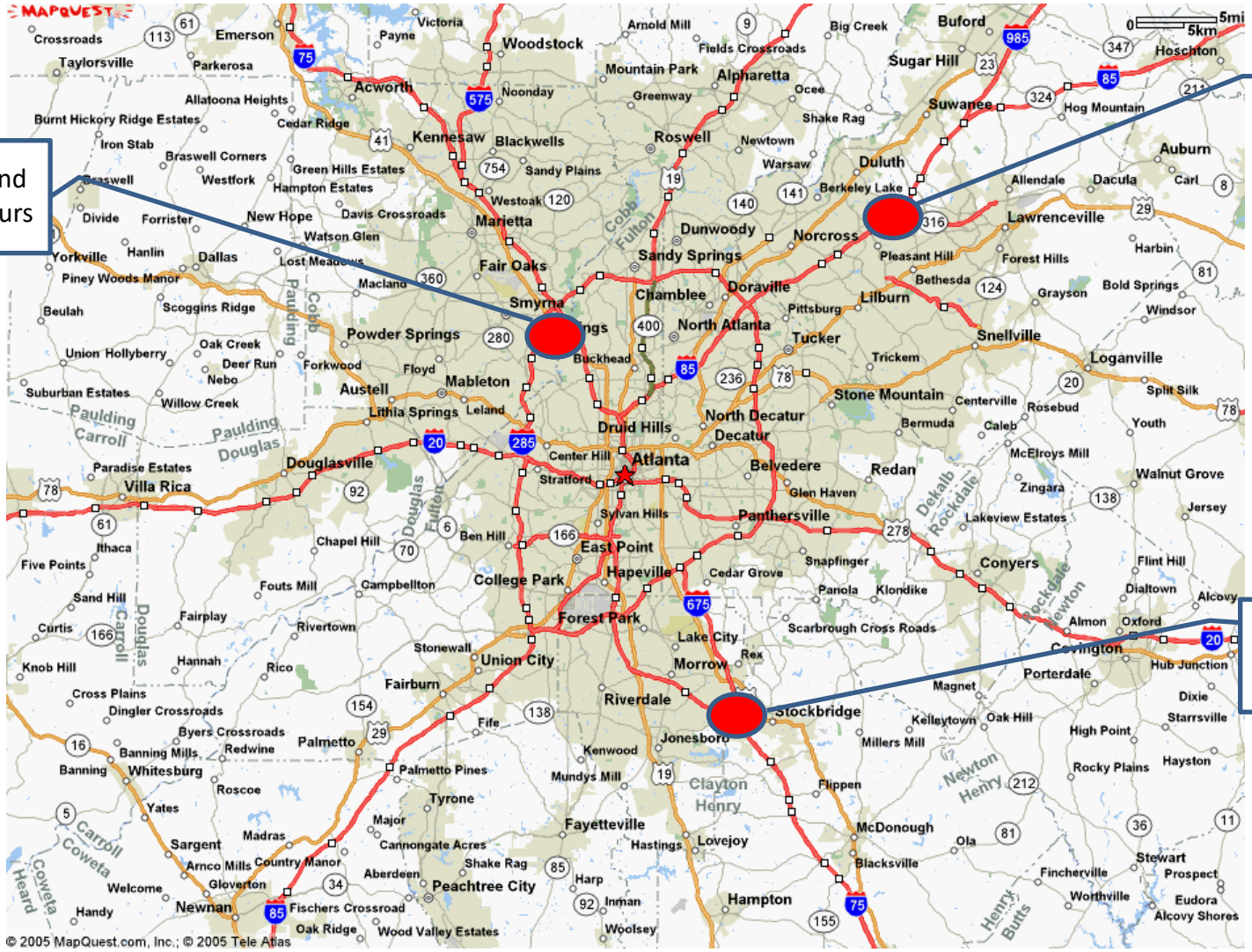
Objectives

Describe “pre-palliative care” processes which may help up-stream patients receive benefits from palliative care clinic

List two ways of incorporating palliative care into other outpatient clinics

Explain ways to use phone call and in-person follow-ups to improve upon both physical and non-physical suffering

KPGA Palliative Care Clinics



KP-GA Palliative Care Clinics

- Three locations – Gwinnett, Cumberland, Southwood
- Team consists of physician, nurse practitioner, registered nurse, social worker, chaplain, and clinical pharmacist
- Typical day:
  - Follow-ups 9:15, 10:00, 10:45, (11:30)*
  - Consults 1:15 & 3:00, (4:30)*
    - * emergency follow-up slots
- 1000+ patients seen and followed in clinic since 2012
  - Cancer, Heart failure, Pulmonary diseases, ESRD, Neurologic diseases

Patient's Journey Through Outpatient Palliative Care

Referral
is made

RN assesses
and
schedules

Pharmacist
Reviews medicines

Patient arrives,
completes ESAS,
has physical exam

Family Consult

1 week call

Patient-specific follow-up

SW

RN

CH

MD

PH

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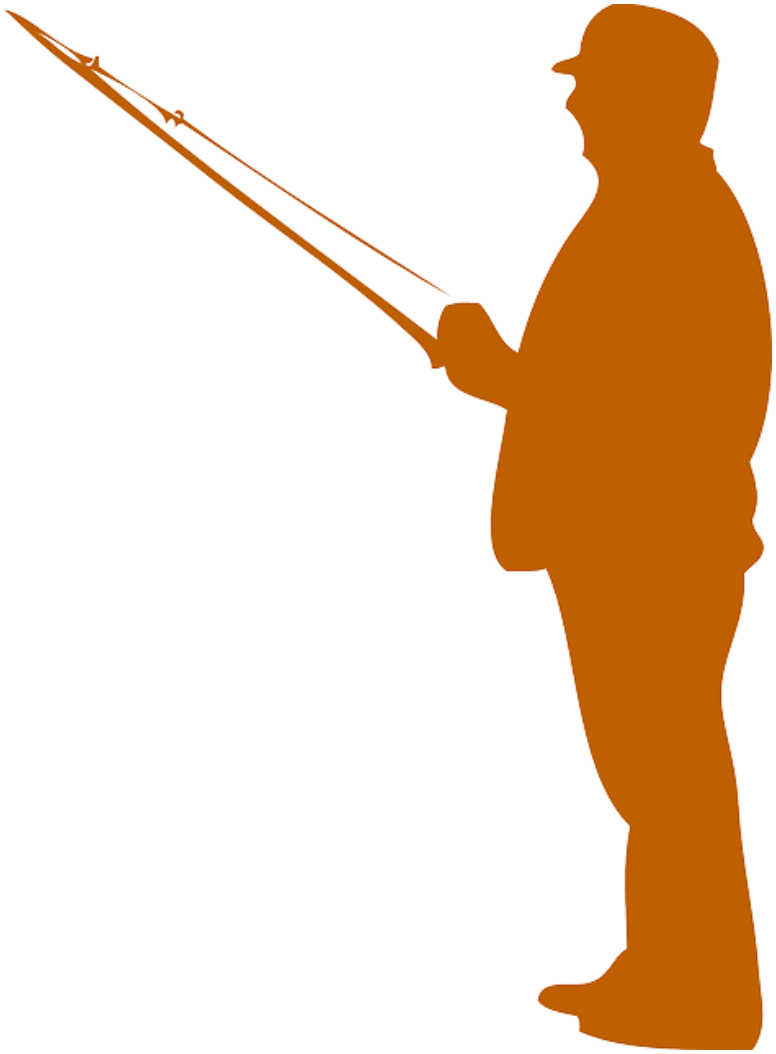
Case #1: Mr. AS

- 55 year old male
- Past Medical History significant for: Bladder cancer, radical cystectomy with ileal conduit, loop diverting colostomy
- Many losses and stressors
- Wife has life-long anxiety and initial resistance to palliative care
- Patient quiet and introspective



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Licensed Clinical Social Worker's Role

- Present and explain ESAS (symptom tool) and provide patient information summary on initial visit
- Provide psychosocial support, resources, coping strategies, education to patients and families through initial consult and Advanced Illness Care Coordination (AICC) Program
- Provide bereavement support at time of death and beyond
- Provide strategies for parenting of teens while coping with illness
- Participate in Colorectal Tumor Board Meeting, Heart Failure Clinics and Heart Failure University
- Ongoing support for patients and staff in Oncology Infusion Centers
- Participate in IDT meetings
- Education for KP Providers about Palliative Care

Advanced Illness Care Coordination (AICC)

- **What is AICC?**
  - A free no co-pay program where patients and/or family members sit down with one of the psychosocial team members (LCSW or chaplain) and focus on emotional health, coping strategies, resources, advance care planning
  - Counseling related to serious illness
  - Can be used as “pre-palliative” care when the primary complaint is acute adjustment reaction to a new diagnosis or when a patient/family is unwilling to meet with the full palliative care team

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Interventions

- Regular Advance Illness Care Coordination (AICC) visits with the patient's wife
- Focus on coping strategies
- Build trust to overcome resistance
- Focus on quality of life and its meaning to patient
- Hospice and EOL education
- Bereavement support

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Case #2: Mr. JV

- 80 year old male
- Past Medical History significant for: Lung & Bladder cancer
  - Relevant comorbidities: DM, HTN, Afib, TIA, remote MI
- 4 year history of Tarceva (erlotinib) use for lung cancer
- Patient and wife travel to NE to stay with family for months at a time

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Clinical Pharmacist's Role

- **Medication reconciliation**
  - Identify discrepancies, polypharmacy issues, and medications that may be appropriate for discontinuation due to prognosis
  - Identify drug interactions (including chemotherapy and herbals/supplements)
- **Identification of adverse effects**
- **Symptom management**
  - Pain management and education
- **Chronic disease state management**
  - Ex. DM, HTN, Osteoporosis
- **Vaccination status (Pneumovax, Prevnar, Zostavax)**

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Interventions

- **Medication reconciliation s/p hospitalization**
- **DM and HTN f/u with medication adjustments**
- **Manage adverse effects and DDI**
  - Erlotinib/Famotidine dosing
  - Mitomycin/Renal dysfunction
  - Hematuria/Rivaroxaban and ASA use - bleeding interfering with ability to receive mitomycin treatments
  - Megestrol use - hx afib and TIA
  - Statin use s/p TIA - Atorvastatin/Rivaroxaban, Simvastatin/Tarceva DDIs

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Phone calls pre- and post- visit

- **Medication reconciliation**
  - **A lot can be done even prior to the clinic appointment such as :**
    - **Knowing how many pain pills a patient is taking**
    - **Working on constipation**
    - **Flagging high risk meds in the elderly**
    - **Vaccination status – being prepared to get patient's uptodate**
  - **Follow-up calls to help titrate pain meds or taper off insulin or BP meds**
- **LCSW, Chaplain and Nurse follow-ups via phone based on topics in consult**
  - **Resources**
  - **Reaching out to home church groups**
  - **Making sure DME arrived**

A little levity and learning…

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Poop Quiz #1

Which medicine is a placebo in opioid-induced constipation (OIC)?

A) Sennakot
B) Miralax
C) Docusate
D) Lactulose

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Poop Quiz #1: Answer is Docusate (C)

- Docusate sodium (stool softeners of any name) did not demonstrate efficacy in randomized controlled studies for Opioid-induced constipation (OIC) compared with placebo.

Tarumi Y, Wilson MP, Szafran O, and Spooner GR. Randomized, Double-Blind, Placebo-Controlled Trial of Oral Docusate in the Management of Constipation in Hospice Patients. Journal of Pain and Symptom Management 2013; 45(1): 2–13.

Case #3: Mr. JR

- 60 year old male
- Past Medical History significant for: CAD s/p MI and 4V CABG in 2007; CHF in 2013; ICD with BiVi upgrade 2014, a flutter s/p ablation
  - Relevant issues: unable to tolerate anticoagulants (plavix, coumadin, pradaxa); O+ blood type
- Patient and spouse with two children in 20s; patient is a small business owner

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Physician's Role

- **Medication symptom management**
  - including continued discussions of de-escalation of medications
- **Coordination of Care = "Quarterback"**
- **Pathophysiology education and goals of care discussions**
  - Making recommendations that meet goals of care and reality of disease process

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Interventions

- **Mirtazapine for insomnia and anxiety**
- **Liquid morphine 0.25mL (5mg) for dyspnea**
- **Miralax for constipation**
- **Physician Order for Life Sustaining Treatment (POLST)**
  - "functional or a memory"
  - "either the glory of God or the glory of transplant"
  - Agreed with milrinone but decided against LVAD over the course of multiple discussions

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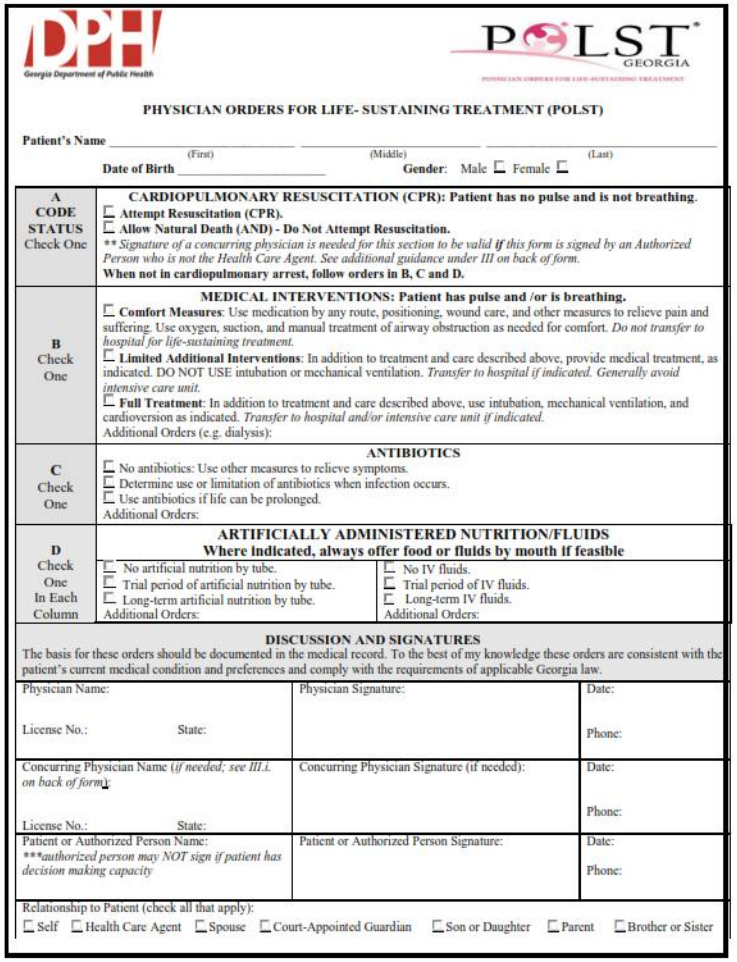
POLST



DPH Georgia Department of Public Health

POLST GEORGIA

PHYSICIAN ORDERS FOR LIFE- SUSTAINING TREATMENT (POLST)

Patient's Name _____ _____ _____
(First) (Middle) (Last)

Date of Birth _____ **Gender:** Male ☐ Female ☐

A **CODE STATUS** Check One	**CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.** ☐ **Attempt Resuscitation (CPR).** ☐ **Allow Natural Death (AND) - Do Not Attempt Resuscitation.** ** *Signature of a concurring physician is needed for this section to be valid if this form is signed by an Authorized Person who is not the Health Care Agent. See additional guidance under III on back of form.* **When not in cardiopulmonary arrest, follow orders in B, C and D.**
B Check One	**MEDICAL INTERVENTIONS: Patient has pulse and /or is breathing.** ☐ **Comfort Measures**: Use medication by any route, positioning, wound care, and other measures to relieve pain and suffering. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. *Do not transfer to hospital for life-sustaining treatment.* ☐ **Limited Additional Interventions**: In addition to treatment and care described above, provide medical treatment, as indicated. DO NOT USE intubation or mechanical ventilation. *Transfer to hospital if indicated. Generally avoid intensive care unit.* ☐ **Full Treatment**: In addition to treatment and care described above, use intubation, mechanical ventilation, and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.* Additional Orders (e.g. dialysis):
C Check One	**ANTIBIOTICS** ☐ No antibiotics: Use other measures to relieve symptoms. ☐ Determine use or limitation of antibiotics when infection occurs. ☐ Use antibiotics if life can be prolonged. Additional Orders:
D Check One In Each Column	**ARTIFICIALLY ADMINISTERED NUTRITION/FLUIDS** **Where indicated, always offer food or fluids by mouth if feasible** ☐ No artificial nutrition by tube. ☐ Trial period of artificial nutrition by tube. ☐ Long-term artificial nutrition by tube. Additional Orders: ☐ No IV fluids. ☐ Trial period of IV fluids. ☐ Long-term IV fluids. Additional Orders:

DISCUSSION AND SIGNATURES

The basis for these orders should be documented in the medical record. To the best of my knowledge these orders are consistent with the patient's current medical condition and preferences and comply with the requirements of applicable Georgia law.

Physician Name: License No.: State:	Physician Signature:	Date: Phone:
Concurring Physician Name (*if needed; see III.i. on back of form*): License No.: State:	Concurring Physician Signature (if needed):	Date: Phone:
Patient or Authorized Person Name: ****authorized person may NOT sign if patient has decision making capacity*	Patient or Authorized Person Signature:	Date: Phone:

Relationship to Patient (check all that apply):
☐ Self ☐ Health Care Agent ☐ Spouse ☐ Court-Appointed Guardian ☐ Son or Daughter ☐ Parent ☐ Brother or Sister

- **Five Sections**
  - Cardiopulmonary Resuscitation (CPR)
  - Medical Interventions
  - Antibiotics
  - Artificially Administered Nutrition/Fluids
  - Signatures

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Integration

- Tumor board (s)
- Infusion Centers
- Heart Failure Clinic
- Heart Failure University (Patient education classes)

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Poop Quiz #2

Which medicine(s) are the most effective AND cost effective bowel regimens?

A) Senna
B) PEG (i.e. Miralax)
C) Sorbitol
D) Lactulose
E) Naloxegol

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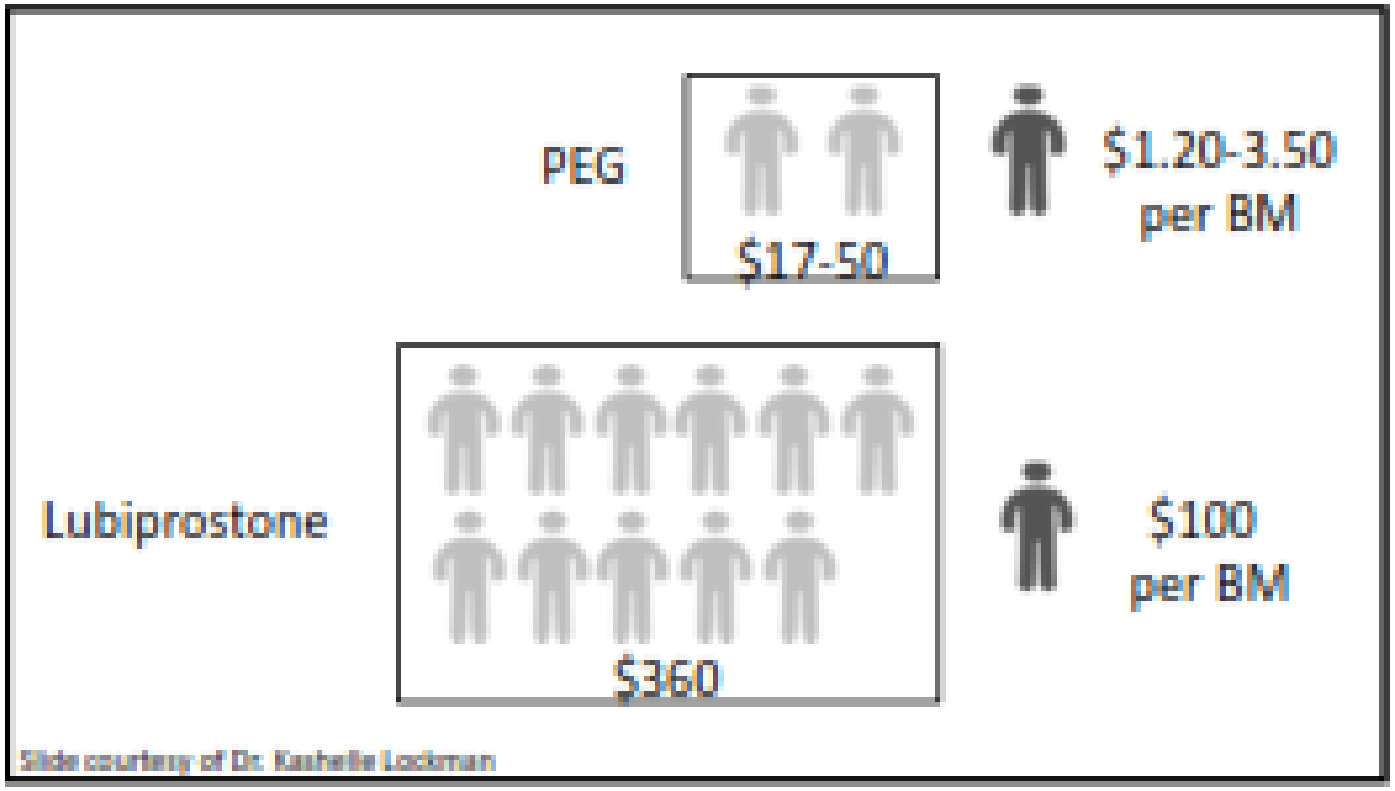
Poop Quiz #2

Which medicine(s) are the most effective AND cost effective bowel regimens? Probably PEG



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Poop Quiz #2

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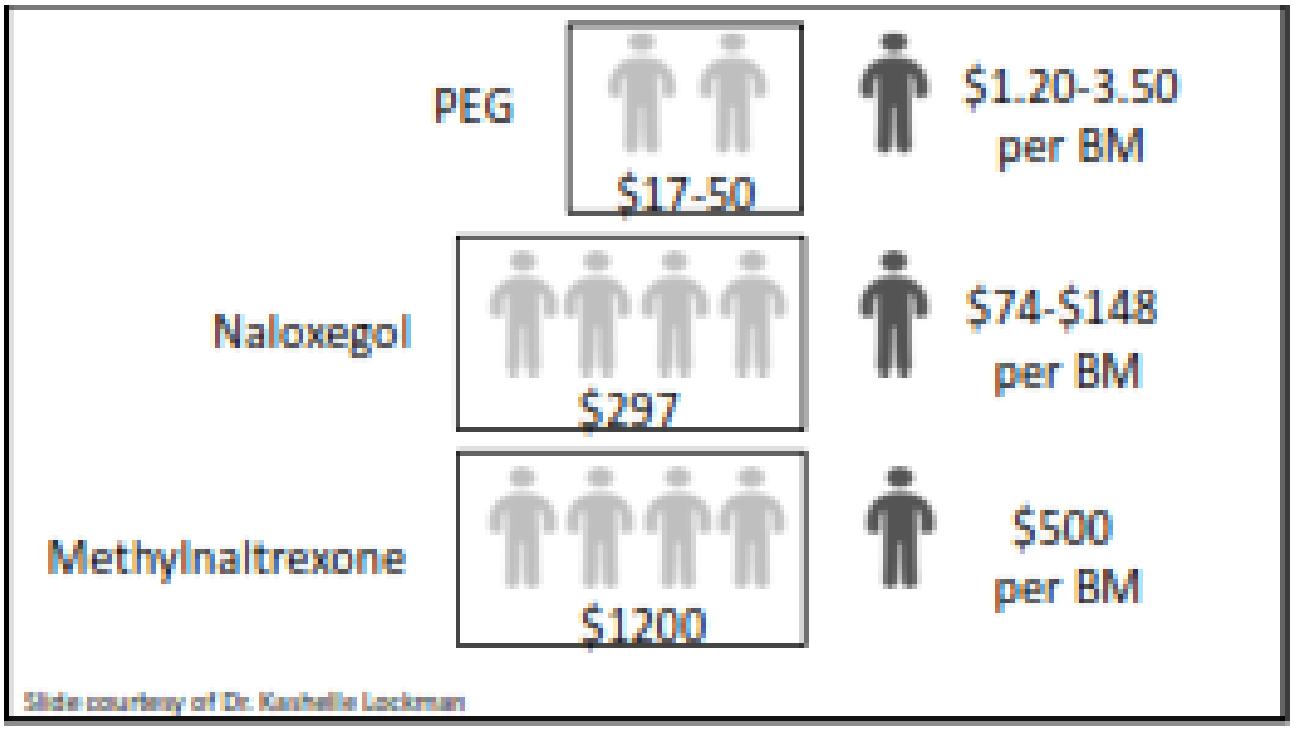

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Case #4: Mr. WM

- 70 year old male
- Past Medical History significant for: Alcohol induced liver cirrhosis with a history of Hepatocellular Cancer s/p mass ablation
  - Relevant issues and comorbidities: anxiety, shortness of breath, thrombocytopenia, portal HTN, splenomegaly, severe aortic atherosclerosis with aneurysms
- Patient, MPOA out-of-town son, 2 daughters involved in daily care

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Registered Nurse's Role

- **Triage clinic based palliative care calls for:**
  - Symptom management
  - Re-education
  - Resources
  - Where patients should go for higher acuity needs
  - Support
  - Refills
  - Hospice and normalizing signs at end of life
- **Assess referrals for appropriateness and schedule appointments**
- **Rooming patients for MD exam**

Direct phone line to clinic

- Triage
- Reinforcement of treatments (ie, how to increase senna or miralax for constipation)
- Hospice referrals via phone:
  - All clinic nurses have hospice training so when patient and more often family call, a home hospice discussion can take place without physician involvement

Interventions

- **Build rapport with patient and family**
- **Continuation of patient and family education**
- **Triage clinic based palliative care phone calls for: symptom management, resources, and hospice education**
  - Several clinic visits and phone call between the time of initial consult in 2014 to death in 2015
  - Discussions about hospice and resources occur multiple times
  - RN initiated transfer to in-patient hospice via phone
  - Symptoms improve and patient is transferred home and died peacefully surrounded by family

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Case #5: Mr. MG

- 45 yo male with ALS
- Married with 2 children, aged 10 and 15. Wife working full-time and sleeping average of 2-3 hours per night. Children needing support around diagnosis.
- Complicated relationship with patient's mother who lived with them for most of the years of their marriage

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Chaplain's Role

- Patient and family support around issues of spiritual distress and End of Life
- Support for parenting children through illness based on this chaplain's specialized experience and training
- Legacy Building
- Bereavement support at time of death and beyond
- Facilitate family consults
- Facilitate IDT meetings
- Provide spiritual support to Palliative Care Team Members and other KP providers

Chaplaincy at EOL

- American Hospital Association's Annual Survey and outcome data from The Dartmouth Atlas of Health Care in a cross-sectional study of 3,585 hospitals.
- The analyses found significantly lower rates of hospital deaths ($\beta = .04$, $p < .05$) and higher rates of hospice enrollment ($\beta = .06$, $p < .001$) for patients cared for in hospitals that provided chaplaincy services compared to hospitals that did not.

Flannelly *BMC Palliative Care* 2012

Interventions

- Regular chaplain visits with patient and wife focusing on depression and spiritual distress of the patient.
- Regular chaplain visits with children, especially young son, for coping strategies and support.
- Multiple extended conversations with patient and wife around End of Life and hospice services. Home visits after patient accepted home hospice services.
- Bereavement support at time of death, including officiating funeral service.

Integration & Staff Support

- The chaplain often spends one day a week in the infusion center speaking with known palliative care patients and introducing palliative care to new patients (chaplain version of AICC)
- Bereavement work, grief support, and mindfulness meditation with providers, nurses and staff

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A little levity and learning…

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Poop Quiz #3

Should we use fiber supplements in opioid-induced constipation (OIC)?

A) No
B) Yes

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Poop Quiz #3: Answer is No!

Bulk forming laxatives (psyllium or fiber) require at least 1.5 L of water to be effective and can actually lead to worsened constipation with inadequate fluid intake. Most palliative and hospice patients have a very hard time taking in 1.5L of water per day. Due to this, most guidelines do not recommend fiber supplements for a bowel regimen in opioid-induced constipation.

Kyle, G. Constipation and Palliative Care - Where Are We Now? International Journal of Palliative Nursing 2007; 13(1): 6–16.
Larkin PJ, Sykes NP, Centeno C, Ellershaw JE, Elsner F, Eugene B, Gootjes JRG, et al. The Management of Constipation in Palliative Care: Clinical Practice Recommendations. Palliative Medicine. 2008; 22(7): 796–807.

Case #6: Mr. TD

- 55 yo male with NSCLCa
- Married (2nd marriage) with 3 children, aged 30, 28 and 12
- History of PTSD from watching his mother and sister die in a car wreck while he was also trapped in the car at age 7

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Interventions

- Regular chaplain visits with patient focusing on his faith and spirituality
- AICC with LCSW but also need for emergency Behavioral Health involvement during one visit
- Conversations about how chemo can help or harm based on performance status.
- Multiple extended conversations with patient and wife around End of Life and hospice services.
- Bereavement support at time of death, including officiating funeral service.

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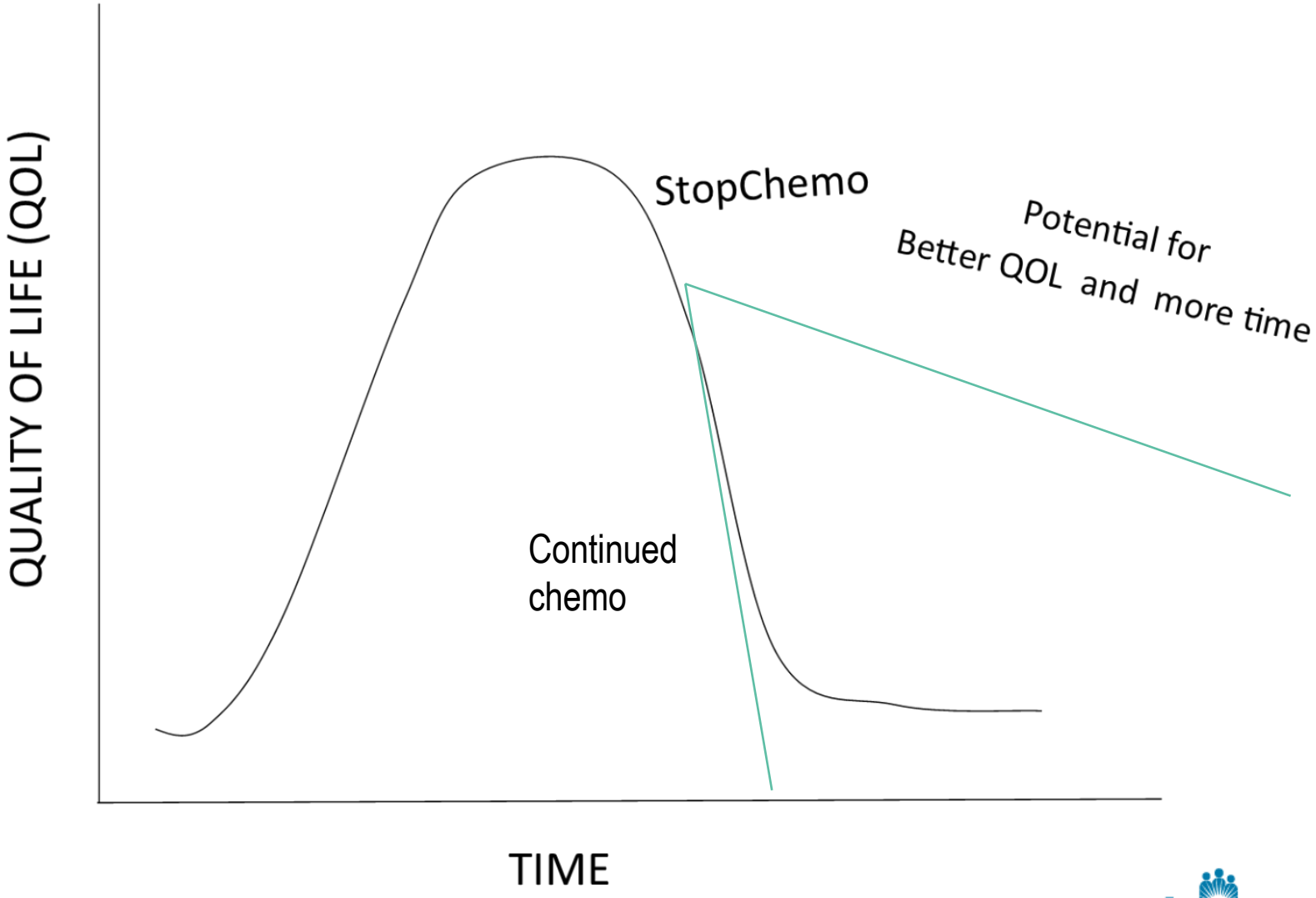
QOL versus Time

"Despite the fact that fewer patients in the early palliative care group than in the standard care group received aggressive end-of-life care (33% vs. 54%, P = 0.05), median survival was longer among patients receiving early palliative care (11.6 months vs. 8.9 months, P = 0.02)."

Temel JS, et al. **Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer.** N Engl J Med 2010; 363:733-742.

Why?



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Poop Quiz #4

What are Vaseline balls?

A) Suppositories
B) Pills
C) Topical agent

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Poop Quiz #4: Answer is B, pills

Freeze a tub of vaseline, make small pills of frozen vaseline, roll in something tasty like a spoonful of sugar, place back in the freezer for future use, take 3-4 in the morning with other bowel agents such as senna or PEG/miralax.

- Vaseline was discovered by Robert Chesebrough in 1859
- Evidence? More theory and expert opinion; clinical trials in pediatric populations are low quality but point to positive effects.
- Anecdotal, when nothing else is working for upper GI ileus related to pancreatic and gallbladder cancer or in peritoneal carcinomatosis – it may be beneficial when used with other agents.

Chesebrough Manufacturing Co (1884). Chesebrough Manufacturing Co (1884). Petroleum: Its Origin, Uses, and Future Development : a Highly Interesting Sketch. Chesebrough Manufacturing Company. p. 18. Chesebrough Manufacturing Company. p. 18.

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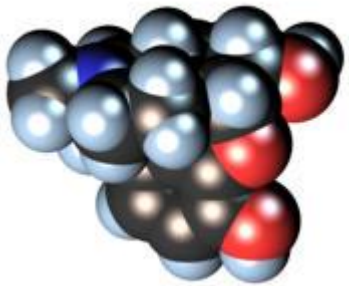
Case #7 – Mrs. RG

- 45 yo female with Stage IV Ovarian Cancer on 6th line chemotherapy now with 2nd malignant bowel obstruction complaining of acute pain crisis.
- Home regimen includes 150 mcg/hr fentanyl patch with appropriate breakthrough pain medication.
- She is placed on a morphine PCA inpatient with 2mg IV morphine Q15 minute bolus/demand. Patient is writhing in pain and asking for more pain medicine.
- Attending states this is “outside [his] parameters” and nurses are in moral distress over patient in pain but also “causing death” with increased opioids.

There is an app for that

- Fentanyl 150mcg/H patch = 300mg oral morphine = 100mg IV morphine in a 24 hour period.
- PRN should be 10% of daily basal dose.
- Breakthrough dose would be 30 mg oral morphine or 10 mg IV morphine. If someone were in excruciating pain, you increase by 50-100% of current dose = 15 to 20 mg IV morphine would be appropriate in this woman. 15 mg IV morphine = 2 mg IV hydromorphone (8-10 po hydromorphone).



Shewmon D, Marcellino C. Opioids Dosage Conversion. Oct 08, 2014

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What can the nurses say at the bedside…

- Opioids do not hasten death at EOL
- The Principle of Double Effect does not exist – stop using it!!!
- Instead, consider saying something like this:
  - The [opioid] will help with pain and shortness of breath. When dosed correctly, as the doctor is doing, pain and shortness of breath will improve. It will not take time away, instead, it will allow [loved one] to use their energy for other things instead of using energy to fight pain or to struggle to breathe. It takes a lot of energy to fight pain or struggle to breathe.
  - They may get more sleepy. This is more likely the fact that they have tired themselves out significantly due to pain/dyspnea and now they can actually get some rest. Sometimes opioids can add to confusion or make people less alert but we find at EOL, it is more likely the disease process itself that does this.

Mazer MA, Alligood CM, Wu Q. The infusion of opioids during terminal withdrawal of mechanical ventilation in the medical intensive care unit. J Pain Symptom Manage. 2011 Jul; 42(1):44-51.

Wilson WC, et al. Ordering and administration of sedatives and analgesics during the withholding and withdrawal of life support from critically ill patients. JAMA. 1992 Feb 19;267(7):949-53.

Maltoni M, Scarpi E, Rosati M, et al. Palliative sedation in end-of-life care and survival: a systematic review. J ClinOncol. 2012;30(12):1378-1383.

Case #7 – Mrs. RG

- Started solumedrol IV
- Patient given 5mg IV morphine Q15minute boluses
- Basal fentanyl restarted while PCA boluses given
- Converted fentanyl and morphine PCA to methadone inpatient while venting PEG placed
  - Total 650 mg oral morphine equivalent = 45 mg methadone – started methadone 15mg po Q8H while in hospital and then pt went home on methadone 20mg po Q12H to simplify
- Once tolerating po, converted solumedrol to po decadron
- Went home with hospice; lived at home with husband and did fairly well for 6 more weeks

Highlighting Innovations: Summary

- Advanced Illness Care Coordination (AICC)
  - Psychosocial and emotional support via coping, goal building, resources
- Clinical pharmacist medication reviews and phone follow-ups
  - Education focused on symptom management and minimizing polypharmacy and interactions
- Integration with Colorectal Tumor Board and Heart Failure Clinic
  - Better integrated patient care with “upstream palliative care” and improved education of colleagues
- Direct nurse phone line
  - Symptom management and triage
- Spiritual care
  - Support at all stages including bereavement and legacy work

Highlighting Innovations: Summary cont'd

- Use graphs and pictures
- Use a phone app for opioid conversion
- Help non-palliative trained clinicians find the right words to explain what we do so they can carry on our good work
- POLST, POLST, POLST!
- Poop quiz answers:
  - There is a lot of $ in opioid-induced constipation (OIC) business; cheap stuff works best.
  - Stool softeners are placebos in OIC
  - Senna and miralax are probably the most effective AND cost effective agents we have
  - Fiber isn't a good option in palliative/hospice patients
  - Vaseline balls? Why not.

Resources

- Bruera E, Kuehn N, Miller MJ, Selmser P, Macmillan K. The Edmonton Symptom Assessment System (ESAS): a simple method for the assessment of palliative care patients. *J Palliat Care* 1991; 7:6-9.
- Engelhardt JB, McClive-Reed KP, Toseland RW, Smith TL, Larson DG, and Tobin DR. Effects of a Program for Coordinated Care of Advanced Illness on Patients, Surrogates, and Healthcare Costs: A Randomized Trial. *The Am J of Managed Care* 2006; 12: 93-100
- Underwood LG, Teresi J. The Daily Spiritual Experience Scale: Development, theoretical description, reliability, exploratory factor analysis, and preliminary construct validity using health related data. *Annals of Behavioral Medicine 2002; 24*, 22-33.
- Flannelly K, Emanuel L, Handzo G, Galek K, Silton N, Carlson M. A National Study of Chaplaincy Services and End-of-Life Outcomes. *BMC Palliative Care* 2012;11:10
- Adler ED, Goldfinger JZ, Kalman J, Park ME, Meier. Palliative Care in the Treatment of Advanced Heart Failure. *Circulation* 2009; 120: 2597-2606
- http://www.gapolst.org/
- https://agingwithdignity.org/five-wishes/about-five-wishes

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Thank you!

Any questions?

If we don’t have time, feel free to contact me via email!

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