Palliative Care: Interdisciplinary, Whole-Person Care

MARIANA KHAWAND-AZOULAI, MD
GRISEL FERNANDEZ VEGA MARTINEZ, APRN

Objectives

- Define palliative care and describe which patients are appropriate for palliative care referral
- Explore multi-domain approach to the palliative care patient
- Discuss roles of members in the interdisciplinary palliative care team
- Review a case study demonstrating the palliative care approach

Key

- **APP** = Advanced Practice Provider (nurse practitioners and physician assistants)
- **APRN** = Advanced Practice Registered Nurse
- **PA** = Physician Assistant
- **LCSW** = Licensed Clinical Social Worker
- **PT/OT** = Physical and occupational therapists
- **SLP** = Speech and language therapists

Audience Survey

What is palliative care?

State of Florida
DO NOT RESUSCITATE ORDER

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Patient's Full Legal Name: _____ Date: _____
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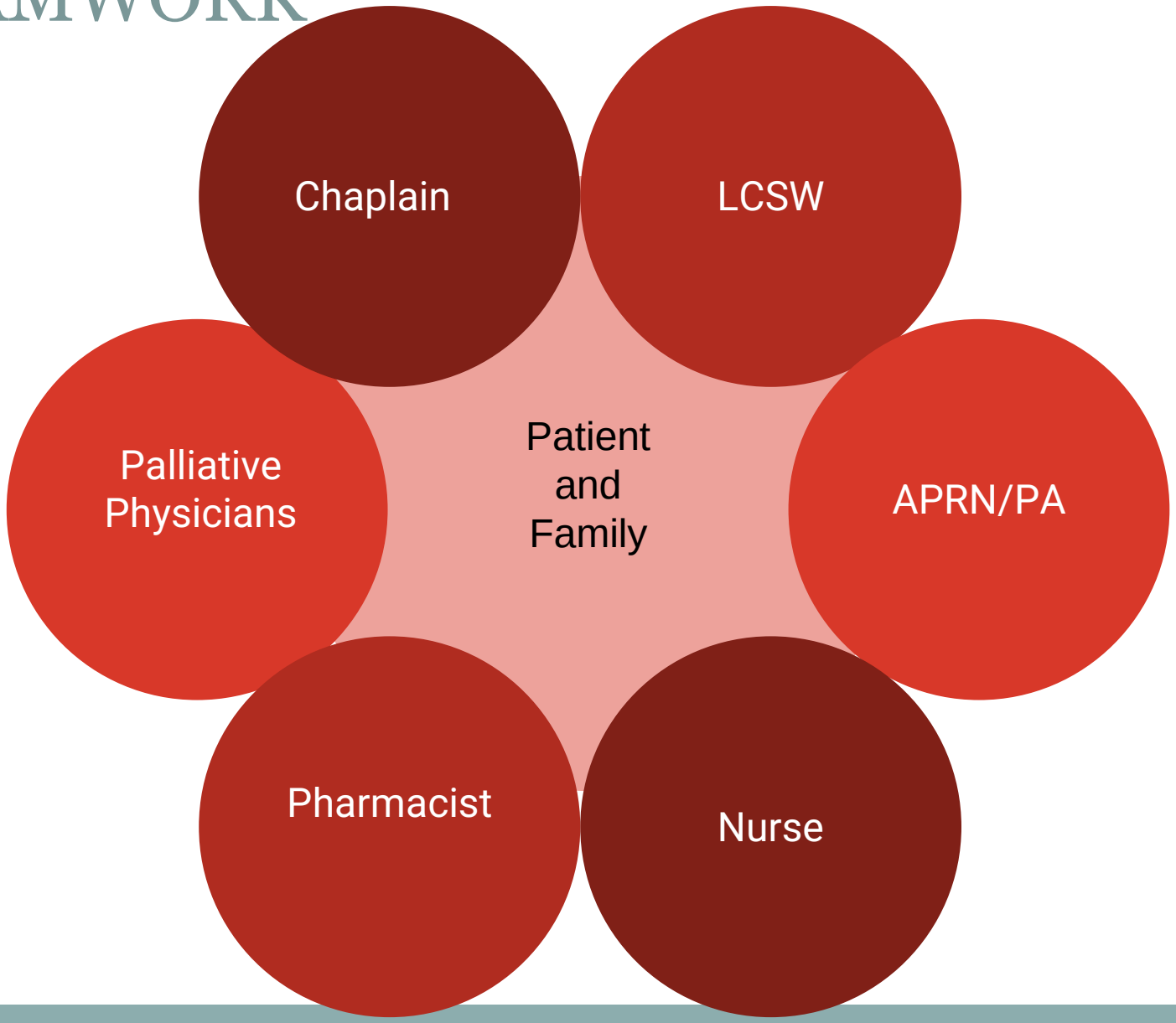
What is Palliative Medicine?

- Specialized medical care focused on providing patients with **relief** from the **symptoms**, **pain**, and **stress** of a serious illness.
- Multidisciplinary **team-based** approach, including fellowship trained physicians, social workers, chaplains, advanced practice providers, pharmacists, psychologists and many more.
- Focus on improved **quality of life** for patients and their families.
- **Whole-person** care by addressing physical, emotional, practical, and spiritual concerns.

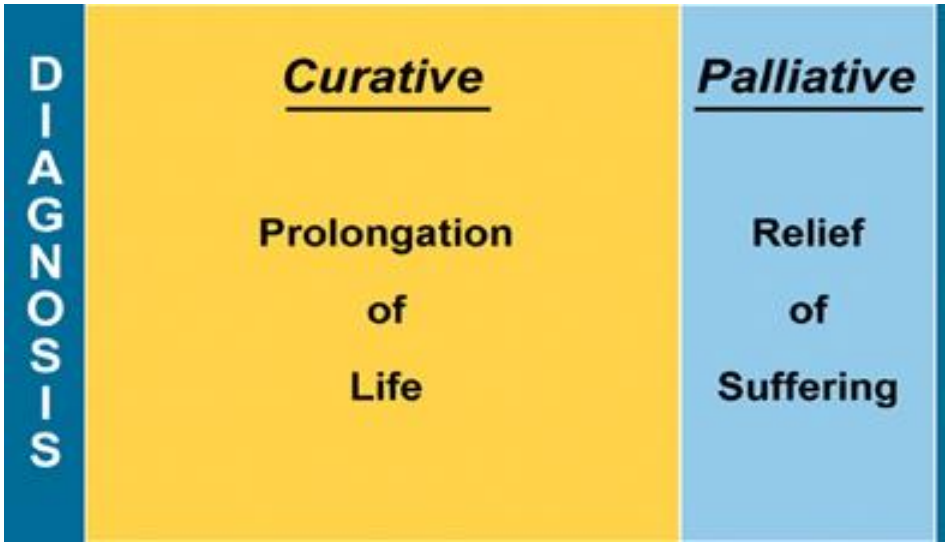
TEAMWORK


Chaplain
LCSW
Palliative Physicians
Patient and Family
APRN/PA
Pharmacist
Nurse

Palliative Care = Standard of Care

"All cancer patients should be screened for palliative care needs at their **initial visit**, at **appropriate intervals**, and as **clinically indicated**. Patients and families should be informed that palliative care is part of their comprehensive cancer care"

NCCN


DIAGNOSIS
Curative
Prolongation
of
Life
Palliative
Relief
of
Suffering

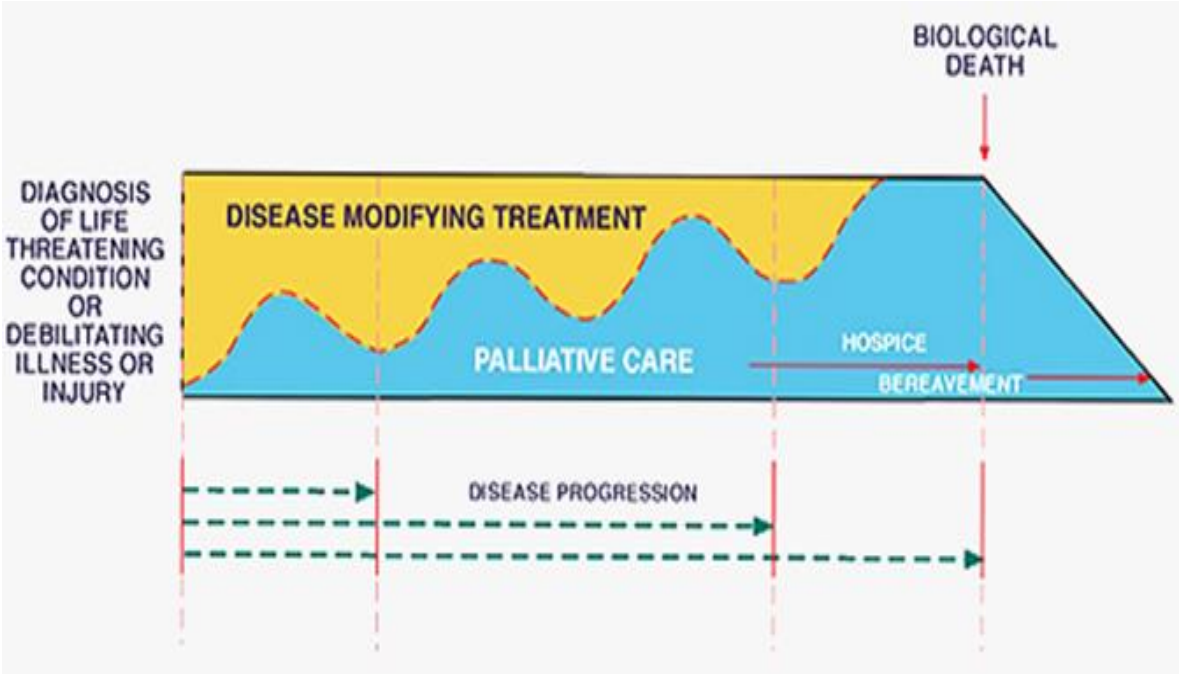

BIOLOGICAL DEATH
DIAGNOSIS OF LIFE THREATENING CONDITION OR DEBILITATING ILLNESS OR INJURY
DISEASE MODIFYING TREATMENT
PALLIATIVE CARE
HOSPICE
BEREAVEMENT
DISEASE PROGRESSION

TABLE 1

PALLIATIVE CARE VS HOSPICE

Palliative Care	Hospice
Based on patient and family need, not prognosis Concurrent with disease treatment	Certified prognosis of < 6months Patient agrees to give up insurance coverage of disease treatment
Appropriate at any stage of serious illness from disease onset to bereavement for families	Life expectancy ≤ 6 months, and bereavement for families.
Concurrent with all appropriate treatments and services	Must forego "curative" care for terminal illness as condition of enrollment
Widely available in hospitals; limited but growing access in community settings	Widely available in community and institutional settings (>5,500 programs in US)

Levels of Palliative Care

Primary palliative care

Secondary palliative care

Palliative Medicine Consultations - Models

- Locations: Inpatient , Outpatient
- Scope: Consultative vs Comanagement vs Embedded Model

When to Refer

Combined standard oncology care and palliative care should be considered **early** in the course of illness for **any** patient with **metastatic cancer** and/or **high symptom burden** (ASCO)

- Appropriate at **any age** and **any stage** in serious illness
- May be provided together with **curative** treatment

Early Palliative Care for patients with Metastatic Non-Small Cell Lung Cancer; Temel Et Al, NEJM 2010

- less aggressive care at end of life
- longer survival (11.6 vs 8.9 months)
- better quality of life scores
- fewer depressive symptoms

When to Refer

- Symptoms not controlled by standard approach
- Presence of metastatic or locally advanced cancer
- ECOG 3-4
- Serious comorbid diseases
- >1 hospitalization in the last 30 days

When to Refer – Additional Criteria

- Prognosis 12 months or less
- Geriatric patients with multiple co-morbidities and/or declining function
- Patient refusal of treatment
- Moderate-severe distress in patient/family, related to diagnosis, therapy, disease course, or decision making

Mission

To provide comprehensive palliative care:

- as a **routine** part of cancer care
- **early** on in the course of illness
- as an **extra layer of support** for patients, their families, and the cancer care team

Mission- continued

Improve patients' **quality** of life and help them to live **maximally** in the face of life-limiting illness.

Mission- continued

Elicit, **understand**, and **honor** patient preferences, while promoting illness understanding and assist in delineation of treatment **goals**.

Mission - continued

Provide primary palliative care education, promote palliative care, and reduce barriers to referrals

Palliative Medicine Assessment

DOMAINS

Medical

Functional

Psychological

Social

Spiritual

Palliative Medicine Assessment- Medical

- oncology history
- symptom burden
- prior treatments
- comorbidities

Symptom Management

- Pain from cancer and cancer treatments
- Nausea, Vomiting
- Poor Appetite
- Neuropathy
- Constipation
- Diarrhea
- Dyspnea
- Insomnia
- Fatigue
- Depression
- Anxiety

Palliative Medicine Assessment - Functional

Functional assessment and trends

- PPS = palliative performance scale
- ECOG = Eastern Cooperative Oncology Group

PALLIATIVE PERFORMANCE SCALE (PPS)

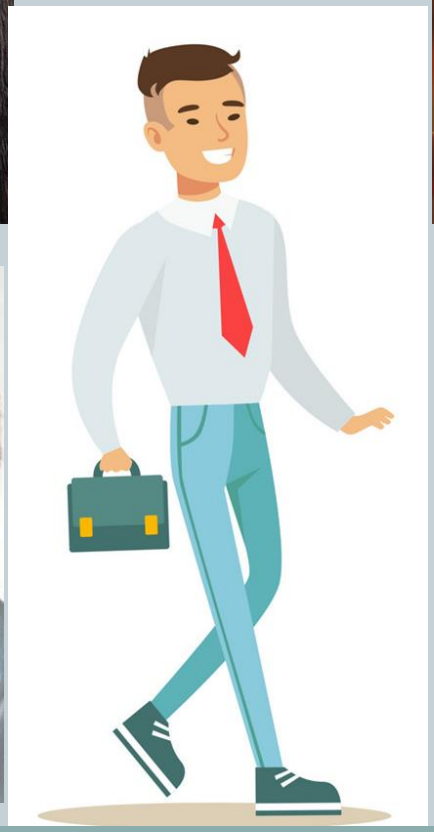
%	Ambulation	Activity Level Evidence of Disease	Self-Care	Intake	Level of Consciousness	Estimated Median Survival in Days (a)	(b)	(c)
100	Full	Normal *No Disease*	Full	Normal	Full	N/A	N/A	108
90	Full	Normal *Some Disease*	Full	Normal	Full			
80	Full	Normal with Effort *Some Disease*	Full	Normal or Reduced	Full			
70	Reduced	Can't do normal job or work *Some Disease*	Full	As above	Full	145		
60	Reduced	Can't do hobbies or housework *Significant Disease*	Occasional Assistance Needed	As above	Full or Confusion	29	4	
50	Mainly sit/lie	Can't do any work *Extensive Disease*	Considerable Assistance Needed	As above	Full or Confusion	30	11	41
40	Mainly in Bed	As above	Mainly Assistance	As above	Full or Drowsy or Confusion	18	8	
30	Bed Bound	As above	Total Care	Reduced	As above	8	5	
20	Bed Bound	As above	As above	Minimal	As above	4	2	6
10	Bed Bound	As above	As above	Mouth Care Only	Drowsy or Coma	1	1	
0	Death	-	-	-	--			

(a) Survival post-admission to an inpatient palliative unit, all diagnoses (Virik 2002).
(b) Days until inpatient death following admission to an acute hospice unit, diagnoses not specified (Anderson 1996).
(c) Survival post admission to an inpatient palliative unit, cancer patients only (Morita 1999).

Palliative Medicine Assessment - Psychological

- Depression screening
- Anxiety screening
- Monitoring for substance use issues

Palliative Medicine Assessment - Social



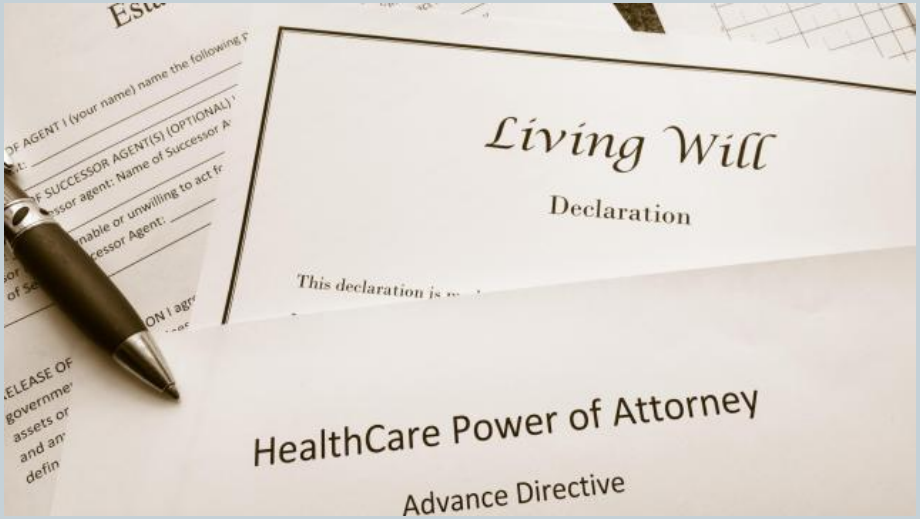
Palliative Medicine Assessment - Spiritual

Category	Sample questions
F: Faith and belief	Do you have spiritual beliefs that help you cope with stress? If the patient responds "no," consider asking: what gives your life meaning?
I: Importance	Have your beliefs influenced how you take care of yourself in this illness?
C: Community	Are you part of a spiritual or religious community?
	Is this of support to you, and how?
A: Address in care	How would you like me to address these issues in your health care?

Assessment- Goals of Care

- Information sharing preferences
- Treatment goals
- Illness understanding
- Advance directives

Advance Directives



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Multiple Domain Management - Team Effort!

Medical - Physicians, APPs

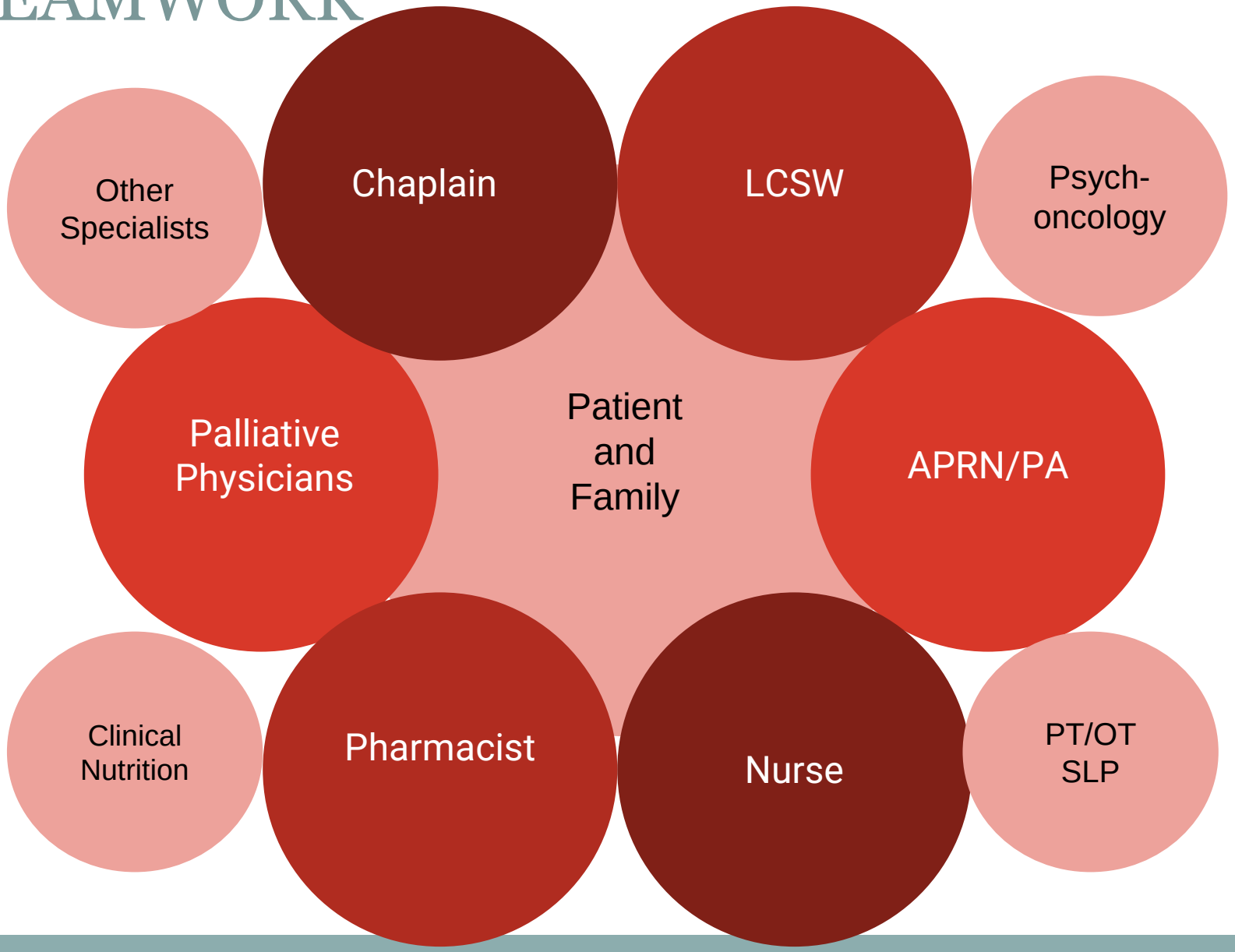
Functional - PT/OT, SLP, PMR

Psychological - LCSW, Psych-oncology

Social - LCSW

Spiritual - Chaplain

TEAMWORK


Other Specialists
Chaplain
LCSW
Psych-oncology
Palliative Physicians
Patient and Family
APRN/PA
Clinical Nutrition
Pharmacist
Nurse
PT/OT SLP

Other team duties

- Family meetings: all members
- Educational activities/in-services: all members
- Completion of Advance Directives: Physicians, APPs, and LCSW

Case Vignette

Ms. Smith is a 19 y.o. female with a newly diagnosed aggressive Ewing sarcoma of right femur with multiple sites of osseous metastases. She is admitted for inpatient chemotherapy and is experiencing severe pain in her right femur. The Oncology APRN orders a Palliative Medicine consultation.

Questions for Breakout Session

- Your colleague says, “She is too young for palliative care.” What might your response be?
- After months of treatment, she receives bad news about her most recent scans. She has emotional distress and is crying. It is difficult for you and your team. What are some ways to help this patient and the provider?
- She receives IFEX and experiences toxicity related to it. She also develops respiratory failure, requiring intubation, but the team is unsure whether or not intubation would be beneficial. Next steps?

Discussion

- Case Study demonstrates a very commonly held misperception: Palliative care is only for older patients or those who are dying.
- Besides delivery of palliative care to patients, one of the roles of palliative care clinicians is to educate colleagues about role of palliative care.
- An appropriate response to your colleague could be: “Palliative Care is a great option for her. The team can help to control her symptoms throughout the treatment spectrum.”

Discussion (continued)

- In any service line, providers develop close relationships with their patients.
- Some ways to help patient:
  - Palliative Medicine SW
  - Spiritual/Religious Support
  - Referral for Psych Oncology
- Some ways to help providers:
  - “Tag Team”
  - Debriefing

Discussion (continued)

- There is concern from ICU team that intubation would not be beneficial for Ms. S and she will be unlikely to recover… Next steps?
  - Advance directive?
  - Health care surrogate or proxy?
  - Meet with family
  - Multi-disciplinary family meeting

Benefits of Early Referral

- Quality of life
- Patient satisfaction
- Reduced distress, depression, and anxiety
- **Treatment adherence**
- Fewer hospital admissions
- Shorter length of stay
- Earlier referrals to hospice when appropriate
- Efficiency of care
- **Survival**

Successful Referral Practices

- "I want you to see someone from our team who can help with your symptoms."
- Use symptom management as a "way in"
- Reason for referral in order
- Open communication

References

- Hui D, Bruera E. Integrating palliative care into the trajectory of cancer care. *Nature reviews Clinical oncology*. 2016;13(3):159-171. doi:10.1038/nrclinonc.2015.201.
- Rabow M. New Frontiers in Outpatient Palliative Care for Patients with Cancer. *Cancer Control*. 2015;22(4): 465-474.
- Spiro SG, Rudd RM, Souhami RL, et al. Chemotherapy versus supportive care in advanced non-small cell lung cancer: improved survival without detriment to quality of life. Thorax 2004;59:828-36.