The Future of Palliative Care

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Disclosure

- Dr. Hawkins has disclosed that neither he nor members of his immediate family have a relevant financial relationship with an ineligible company.
Objectives

1. Trace the evolution of palliative care within Medicine.
2. Identify your role in providing palliative interventions for your patients.
3. Apply specific strategies to assist patients with complex chronic illnesses.
“To cure sometimes,
to relieve often,
to comfort always”

Edward, Livingston Trudeau
1. Trace the Evolution of Palliative Care Within Medicine

- First formerly implemented after the birth of the hospice movement in the 1980s
- Hospice services are provided to ~1.65 million patients per year, 66% of which are delivered in a patient's residence and 26% in an inpatient hospice facility
- Roughly 45% of all deaths in the United States in 2011 occurred within a hospice program
- Average length-of-stay on hospice in America 2019 reached 12 days
- BUT a palliative approach to medical care isn’t restricted to hospice
Hospice is (Almost) a Categorical Decision

• DNR not required
• Some interventions can continue certain interventions
• “Open Access” hospice allowed with some health plans
• Medicare VBID is bundling hospice expenses in a total health care capitation fee for some health plans
• BUT
• Still, chemotherapy, radiation, dialysis, cardiac interventions are generally too expensive
Ramping up Palliative Interventions
Scaling Down Curative Approaches

• At any stage in a serious illness, and it is beneficial when provided along with treatments of curative or life-prolonging intent
• Provided over time
Palliative Care: A Medical Specialty

Old

Key Patient Identification Question
“Would you be surprised if this patient passed away within the next year?”

Common Disease Categories
- Cancer (Stage IV)
- Advanced Heart Failure (Class III-IV)
- Advanced COPD (Stage III-IV)
  - Advanced ESRD
  - Advanced Dementia

New
ASCO 2017

RECOMMENDATION

- For newly diagnosed patients with advanced cancer, the Expert Panel suggests early palliative care involvement within 8 weeks of diagnosis

BENEFITS

- Higher Quality of Life Scores
- Lower Rates of Depression
- Improved satisfaction with care
- Less aggressive end of life care
- Increased enrollment and length of stay in hospice

Ferrell BR et al., J Oncol Pract 2017; PMID 28972832
All Care Settings

- Primary Care Practices
- Specialty Practices
  - ASCO 2017 Early Palliative Consult, Cancer Centers Oncology Practices
  - AHA / ACC 2012 cancer centers, dialysis units, home health agencies, hospices, and long-term care providers
  - KDIGO 2021 Dialysis should be framed explicitly as a treatment choice rather than a default option
- Hospitals: Palliative Consult Services for symptom control and Advance Care Planning
- Home Health Agencies
Patient-Focused

- What is most important to the patient, what do they need?
- Including family & caregivers
- Assessing their goals and preferences
- Determining how best to achieve them
- Readdressing at intervals
Interdisciplinary

• Holistic care needs of the patient
  • Medical Nursing, Social Work, Chaplain
• Addressing symptoms: Pain, GI, Itching, Fatigue, Depression
• Help with Anticipatory Grief & Family grief counseling
Clinical Conversation #1

- Mr. Abraham Ramirez is getting worse at home
- He is bed bound with advanced Dementia (Fast Score 7c)
- He can no longer do any ADLs
- He is incontinent of bowel and bladder
- His wife is in the office with you today for prescription refills
- He now has some behavioral disturbance for which you have given an atypical antipsychotic
- She has been faithfully caring for him during his decline for many years
Clinical Conversation #1

- Do you bring up the future of his condition with her?
- Do you mention that he is hospice eligible?
- Can you frame it in a way that it helps her meet her goals
  - Keeping him at home
  - Closer supervision of his psychotropic medication
  - Ancillary support
2. Identify Your Role in Providing Palliative Interventions for Your Patients

A. Step back and see the big picture
B. Follow your instinct
C. Consider when patients have limited prognosis or palliative needs
2a. Step Back and See the Big Picture

• Be aware of Optimism Bias
• Be aware of the default expectation of doing more and more
• Factor in the Impact of Multiple Concurrent Diseases
• Take your own ”temperature”
  • Seeing your own mortality
  • Afraid of being wrong
  • Afraid of causing offense
  • Loss of objectivity
• Get a second opinion
Optimism Bias: The Glass is Half Full

- Patient optimism was associated with increased physician optimism
- Physicians were approximately three times as likely to overestimate the survival of patients
- Estimates are often a factor of 4 longer than reality for a PCP
- Estimates are sometimes a factor of 10 longer for specialists like Oncologists
- These errors in judgment can prevent patients from making timely decisions about their end-of-life care.

Ingersoll et al. *Psycho-Oncology* Vol 28, 6 June 2019 1286-1292
Prognosis

Can we predict the future?
Illness Trajectories

- Solid Tumor
- Organ Failure
  - COPD
  - CHF
- Dwindling
  - Alzheimer's

Murray SA and Sheikh A, *BJM* PMID 18397942
Heart and Lung Failure

Long term limitations with intermittent serious episodes

Function

High

Mostly heart and lung failure

Low

Sometimes emergency hospital admissions

2-5 years, but death usually seems “sudden”

Death

Time →
2b. Follow Your Instinct: The Surprise Question

• “Would you be surprised if your patient passed away in the next 6 months?”
• “Would you be surprised if your patient passed away in the next 12 months?”
2c. Consider When Patients have Limited Prognosis or Palliative Needs

- It doesn’t have to be “the end”
- You can address a serious-illness conversation throughout an illness trajectory
3. Apply **Specific Strategies** to Assist Patients with Complex Chronic Illnesses

A. Make an effort at estimating **prognosis**
B. Practice how to communicate **prognosis**
C. Bring in the **family**
D. Identify and treat palliative **symptoms**
E. Peer-peer conversation with **specialist**
3a. Estimating Prognosis

- **Disease Specific Prognosis**
  - Stage III and IV Cancers: Especially Lung, Pancreas, Kidney, Brain)
  - Stage III and IV Heart Disease: Progressive dyspnea, revascularization not possible
  - Stage "D" COPD: Repeat exacerbation, escalating oxygen requirements

- **Prognosis** based on functional assessment
- **Prognosis** based on muscle wasting
- **Prognosis** based on weight loss
3b. Communicating Limited Prognosis

- Giving Ranges
- Taking Time (SPIKES)
  - Setting, Perception, Invitation, Knowledge, Empathy, Summarize
- Listening: More than 50%
- Hope – Worry statements
- Be prepared to articulate the word death
  - “looking at the trajectory of your illness you may be dying sooner than you thought”
Hope Worry Statements

“I am hoping that the new therapies you are on for your heart disease will stabilize things for a long time, maybe even a few years, but we also need to prepare for the possibility that your disease could worsen very suddenly, and we might be faced with some difficult decisions. It would be good to talk more about what you would want if that were to happen.”

“I certainly hope that you live that long, but based upon what I’m seeing, there is a chance that you may run into difficulty earlier”

“We can still hope for the best, but prepare for the worst”
“I wish it was different”

“I wish we could slow down or stop the growth of your cancer and I promise that I will continue to look for options that could work for you. But I worry that you and your family won’t be prepared if things don’t go as we hope. I wonder if we can discuss a plan B today.”

“I wish you could return to your previous state of health, ... unfortunately, it appears like your illness is progressing and we need to make plans for what comes next”
Communication, Continued

- You will not harm your patient by talking about end-of-life issues
- Managing your own and the patients’ anxiety are key tasks in this conversation.
- Patients want the truth about prognosis
- Giving patients an opportunity to express fears and worries is therapeutic
Communication: Opening the Door & Listening (Use of Silence, and the Pause)

Sample Phrases

- NORMALIZING “I have these conversations with all my patients”
- TRANSITIONAL “I think it is time for us to discuss where this is all going”
- WORRY “I’m worried about you” (After these hospitalizations or after this decline)
- SUMMARY “Has any of this caused you to look at your future?”
- PICKING UP CUES ”You mentioned you want to stop your medication”
Communication: Listening for Cues

The medical encounter is busy, often preventing us from hearing the quiet voice inside the patient and coming out

- “I’m getting more tired.”
- “I find it hard to go on?”
- “Should I be doing this?”
- “My wife (son, daughter) wants me to .......”
- “It doesn’t seem to be working”
- “I stopped taking the medicine”
- “I haven’t seen my specialist in a while”
Don’t Interrupt

• Most doctors interrupt within 6 seconds
• COUNT!
• Just wait... Even though you are uncomfortable
• This allows mental processing for the patient
• This also prevents you from “rescuing” them from the difficult thought-work that they need to do
Explore Key Topics

• What are your **biggest fears** and worries about the future with your health?

• If you become sicker, **how much are you willing to go through** for the possibility of gaining more time?

• **What abilities are so important to your life** that you can’t imagine living without them?

• **What gives you strength** as you think about the future with your illness?

• **How much does your family know** about your priorities and wishes?
3c. Bring in the Family

- As a Family Physician, you are well positioned to know who surrounds the patient
- You can ask if their family is aware
- You can ask how the family is adjusting, supporting, directing
- “He is a Fighter” (does he want to be?) (does he think they expect him to be?)

- Medical Power of Attorney
  - Ideally someone who can be objective
  - You can identify a person at an annual wellness and commission a family ACP conversation
  - You can facilitate a family meeting, if asked
3d. Identify and Treat Palliative Symptoms

- Pain
  - Neuropathic, Somatic
- Nausea
  - Central, Peripheral
- Constipation
  - Especially with opiates
  - Regular dosing with stimulant laxatives, not just stool softener, not just prn
- Itching
- Fatigue
- Depression
The Specialist Perspective & Prognosis

• “You’re doing great!”
  • Some specialties have difficulty seeing death
    • Feeling like a Failure
    • Opportunities for more intervention
    • Have not dealt with their own mortality
    • Undulating course of illness and humility
    • Perception of the risk of being wrong
    • Optimism Bias
Specialist Care: Cancer, Cardiac, Pulmonary, Kidney

- Often the specialist will offer a patient all options and then deliver them in sequence
- If the patient is prepared to continue, the specialist is prepared to offer more treatment
- Often the patient does not know that they can say know or don’t have the information of the relative success of the treatments
- You see the patient holistically
- A different approach can be against-the-grain, but you may need to advocate
Clinical Conversation #2
Mr. Hernando Corazon and his Daughter

- 80-year-old HM widowed 2 years ago, lives with Daughter
- DM II, MI x 2 and CABG 2009
- PCI 2015 after resuscitation from cardiac arrest
- Now systolic HF (HrEF) chronic peripheral edema & periodic pulmonary edema EF 20% with ICD in place
- Hospitalized 3 x this year including a protracted SNF stay
- Acute on chronic Kidney failure during a recent admission and was offered hemodialysis but refused and recovered
- COPD “D” on long-acting bronchodilators and 2 Liters of oxygen
- Stopped smoking 10 years ago after 60 pack years.
- You are thinking that due to his decline within the past year, he may have less than six months to live and are considering hospice
Clinical Conversation #2

• What is his prognosis?
• Is he hospice eligible?
• Should you bring it up?
• Should you discuss it with the cardiologist?
• How would you bring it up with her?
Summary

• The Future of Palliative Care is moving it upstream as a regular part of primary care
• The Future of Palliative Care is you!
• You can develop the skills for
  • Symptom Control
  • Advance Illness Conversations
  • Family Interventions
  • Hospice referrals