Palliative care for patients with advanced cancer

Julie Christenson, DNP, FNP-BC, ACHPN

Introduction:

- Julie Christenson
  - Palliative Care Nurse Practitioner – Froedtert & MCW
  - jchristenson@mcw.edu

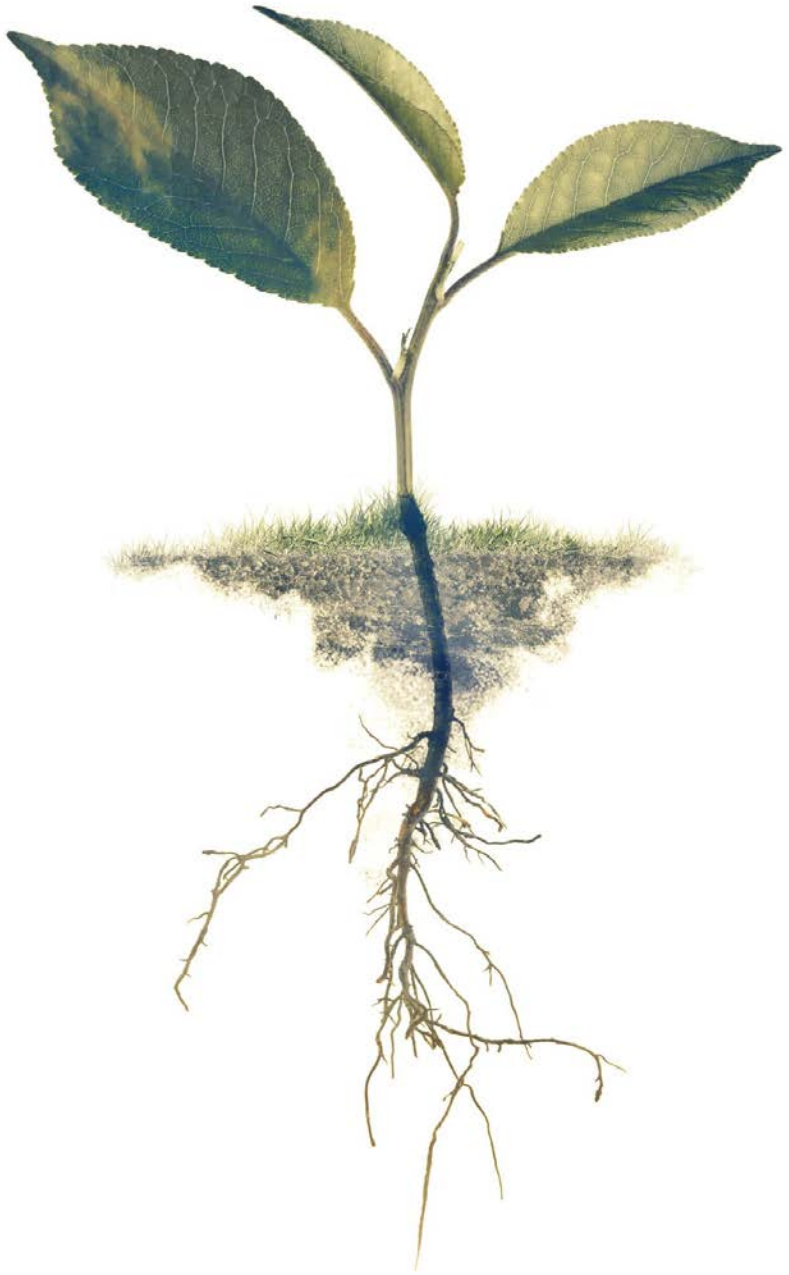
Learning Objectives:

- Define palliative care
- Briefly discuss differences between hospice & palliative care
- Discuss primary vs specialty palliative care
- Learning to recognize a patient who could benefit from hospice or palliative care (what makes a good referral?)
- Main domains of palliative care & ongoing partnerships


DISCUSSION:
What do you think of when you think of palliative care?
When do you typically consider a referral to palliative care?

Often…

- Hospice & palliative care are the same
- A patient ”goes palliative” when they stop treatment
- Suggesting or referring to palliative care will take away patients’ hope
- Patients with palliative care will die sooner than they would otherwise
- Palliative care and pain management are the same
- Palliative care is a program with lots of services for patients at home



Roots of Palliative Care:

- **PALLIATIVE** – derives from "PALLIUM:" Latin - a cloak worn by the Greeks or Romans which covers the whole person
- Palliate – to remove burden or effect without removing the cause
- Palliative Care – care for the whole person with respect for personal choices and relief of suffering (physical, emotional, spiritual)
- So why do you think it's so synonymous with hospice and dying?

What is Palliative Care?

- PALLIATIVE CARE: patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.
  - Involves addressing physical, intellectual, emotional, social, and spiritual domains
  - Facilitates patient autonomy and access to choice

(NHPCO, 2020)

7 Palliative care domains

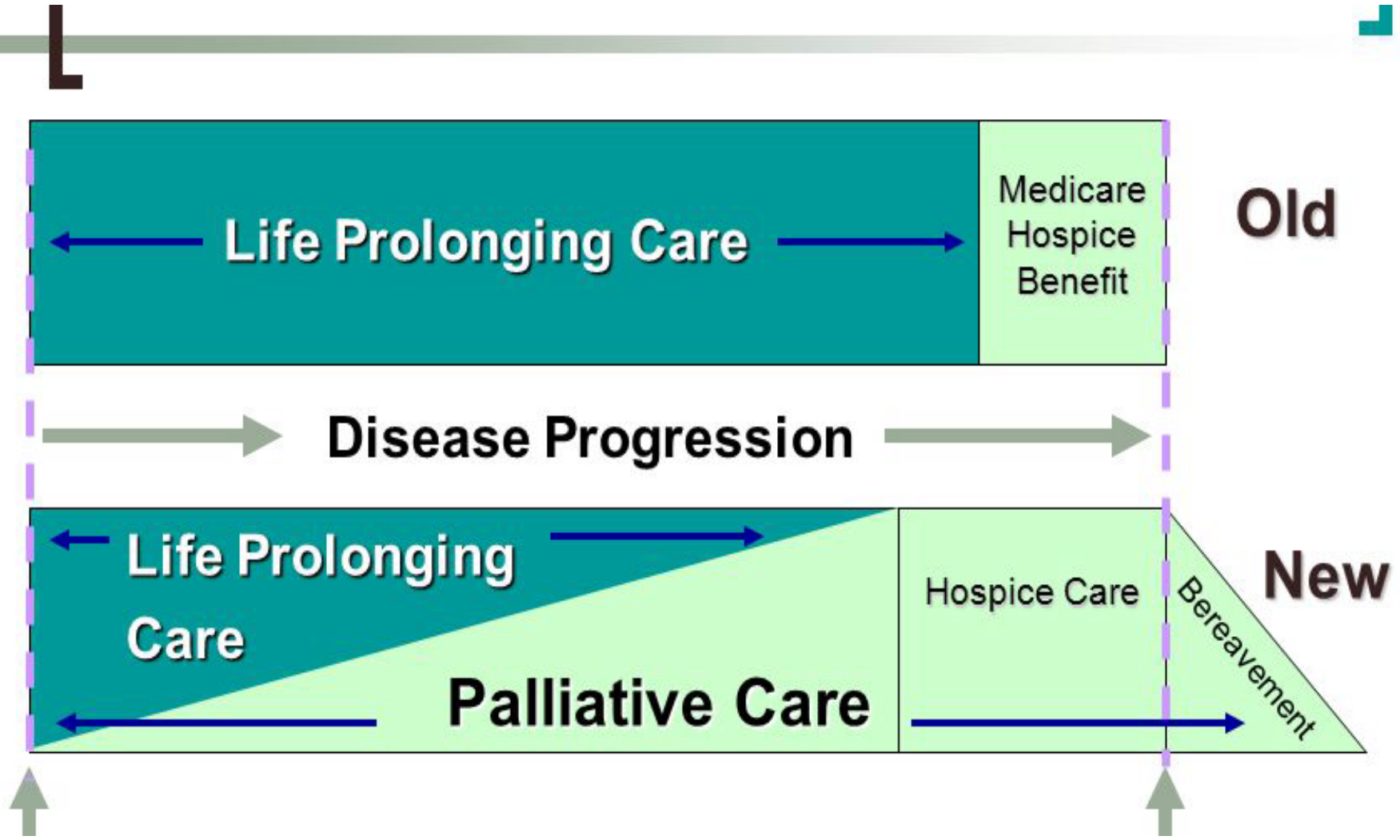
- 1. Structure & processes of care – who/what/when/where/why
- 2. Physical aspects of care – physical discomfort, symptom mgt
- 3. Psychological & psychiatric care – psych-onc, LCSW
- 4. Social aspects of care – SDOH, social burdens of advanced illness
- 5. Spiritual, religious, & existential aspects of care – chaplain
- 6. Cultural aspects of care – always important in matters of life/death
- 7. Care of the patient nearing EOL – time leading up to and just after death

National Consensus Project (Ferrell, 2019)

In other words…

- Some ways I describe what we do:
  - “There are 2 main spaces where we specialize & focus…”
  - “What did your [referring provider] tell you about how we could help?”
  - Use the referral reason
  - Use the name of our clinic (Quality of Life)

Palliative Care - Model of Care



Primary Palliative Care vs Specialty Palliative Care

Palliative care may also be provided by clinicians who are not palliative care specialists. For example, internists, family medicine doctors, cardiologists, oncologists, and many other clinicians who care for seriously ill patients may provide basic palliative care. Palliative care provided by clinicians who are not palliative care specialists is sometimes called "primary" or "basic" palliative care [2,3].

- (UpToDate, 2018)

Representative Skill Sets for Primary and Specialty Palliative Care.

Primary Palliative Care

- Basic management of pain and symptoms
- Basic management of depression and anxiety
- Basic discussions about
  - Prognosis
  - Goals of treatment
  - Suffering
  - Code status

Specialty Palliative Care

- Management of refractory pain or other symptoms
- Management of more complex depression, anxiety, grief, and existential distress
- Assistance with conflict resolution regarding goals or methods of treatment
  - Within families
  - Between staff and families
  - Among treatment teams
- Assistance in addressing cases of near futility

Recognizing Palliative Care - Appropriate Patients (Outpatient)

- **Frequent rehospitalizations**
- **A potentially life-limiting or life-threatening condition**
  - Any **chronic** condition that is known to be life-limiting, such as:
    - Dementia
    - COPD
    - Chronic renal failure
    - Metastatic cancer
    - Liver cirrhosis
    - ALS, Huntington, Parkinson
    - CHF

(Weissman et al., 2011)

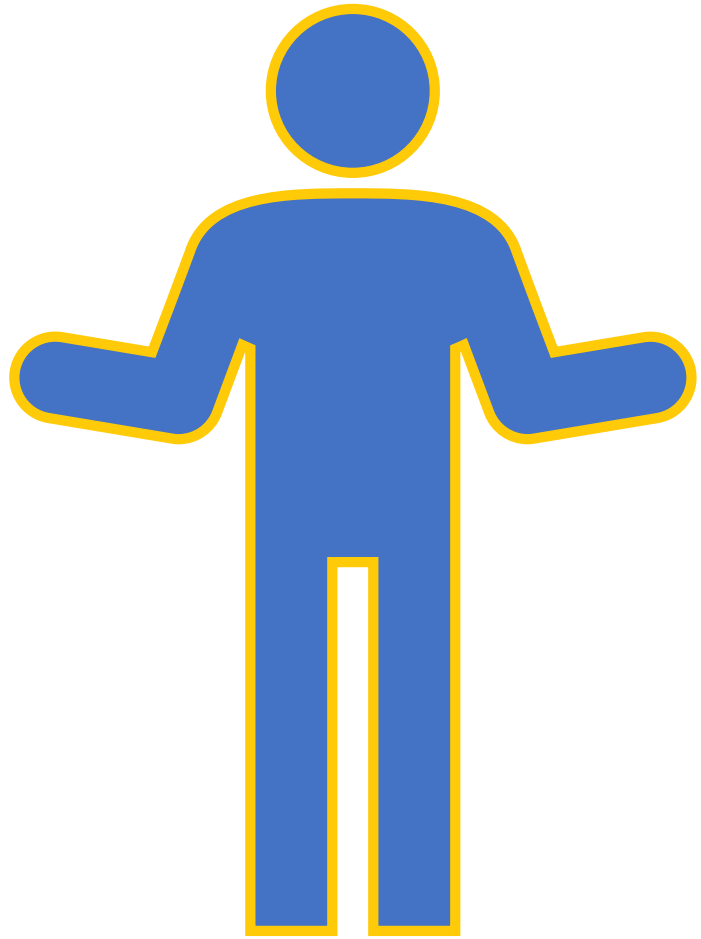
Recognizing Palliative Care -Appropriate Patients (Inpatient)

- **A potentially life-limiting acute condition (often requiring hospitalization):**
  - Any condition that has a high chance of leading to death, e.g.:
    - *COVID-19
    - Sepsis
    - Multi-system organ failure
    - Major trauma
    - Complex congenital heart disease
    - Stroke
    - Acute Kidney Failure

Weissman et al: Identifying Patients in Need of a Palliative Care Assessment in the Hospital Setting. A Consensus Report from CAPC. J. Palliat Med 2011;14, 1-7

The “Surprise” Question

- Use it to think about referral for either palliative care or hospice
- Consider The “Surprise” Question:
  - *“Would you be surprised if this patient died during this hospital stay?”*
  - *“Would you be surprised if this patient died in the coming weeks or months?”*
  - *“Would you be surprised if this patient died within a year?”*



How is Hospice Different?

- Hospice IS Palliative Care!
- A specialty within a specialty

How is Hospice Different?

Specialized palliative care provided by an interdisciplinary team in a variety of settings

Final stage of a terminal illness

Patient Prognosis = 6 months or less

An option when no further curative treatment is being pursued

Talking to patients about hospice

- Talking about timing… “I usually recommend hospice when 2 things are true…”
  - Helps pt/families understand when hospice is or is not appropriate
- Know the myths about hospice as a way of talking about it
  - Do not need to stop all medications
  - Nothing will be done to hasten death
- Know the services; what they are and what they are not
  - Hospice not present in a home 24/7
  - Family caregivers are needed at home and provide bulk of care at direction of hospice staff
  - Often private duty help needed (and not covered) to stay at home

Palliative care at Froedtert & MCW

- **Inpatient** – Robust team consulted for recommendations
  - Examples of reason for consult:
    - Complex cancer-related pain management
    - Need for specialty GOC discussion or family meeting
    - Part of team in cases with complex ethics questions
- **Outpatient** – Clinic-based team
  - Will follow along for course of cancer care
    - In cases of prolonged NED or stable chronic disease, often will hand off management
  - Good partnerships & collaboration
    - Mgt of complex cancer-related pain (do not manage chronic pain)
    - Longitudinal relationships are helpful – ex: often start for assist with pain but ”get it all”

QUESTIONS?