Palliative Medicine in Stroke Care

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Hospice

• A place or an organization
• A philosophy of care
• In the US, it is a governmental program known as the Medicare Hospice Benefit
Hospice: History Lesson
( sort of )

• Greeks and Romans often cared for their sick in religious temples
• Modern Hospice movement credited to Cicely Saunders who opened St. Christopher’s Hospice in London
• 1970’s first programs in US
• 1982 Congress gets involved
Nothing more we can do?

- Hospice is not “giving up”
- Medical team won’t abandon patient
- Aggressive symptom management
- Holistic care of the patient and family – body, mind, and spirit
- Goal of hospice is a dignified, peaceful death with support and closure for the patient and family
Rules on Hospice?

Very “few” Medicare rules govern care
However, Hospice agencies are BUSINESSES

- DNR
- Antibiotics
- Feeding tubes
- Radiation / Chemotherapy
- Transfusions
“Death Trajectory”

The graph shows the death trajectory of two conditions: Cancer (blue line) and COPD (red line) over the course of a year, from 1-Jan to 1-Dec. The y-axis represents the function, and the x-axis represents the months of the year.
Prognosis

• Goals mean everything
• Amazing medical system – but are we listening to our patients?
• Cancer prognosis challenging – COPD and CHF impossible
Discussing Hospice

- Elephant in the Room
- Never easy to talk about
- Families, and staff “waiting”
- Patients can change their mind – “try” hospice
- Ultimately an exercise in COMMUNICATION!
What is Palliative Medicine?
What is Palliative Medicine?

- Newly recognized medical subspecialty
- ACGME July 2006
- Medical care that aims to relieve suffering and improve quality of life *simultaneously* with all other appropriate treatments for patients with advanced illness, and their families
Hospice and Palliative Medicine
Clinicians can help with: ...

• Symptom control
  – Pain, nausea, vomiting, dyspnea, delirium

• Communication
  – Breaking bad news
  – Education about end-of-life
  – Helping patients and families make challenging medical decisions
Curative Model of Care

Curative Intent

Diagnosis

6 mo

Hospice

Death
Why we need Hospice and Palliative Care

- Aging Population – Living longer with chronic illnesses
- Baby boomers demanding more (wishes)
- Expensive care at the end of life
- Poor symptom control
Barriers to Palliative Medicine

• Public – Tide Turning
• Medical Staff – Familiarity growing
• Hospital Systems – Resources and payment structure changing
• Payors – Recognizing benefits
Palliative Care Misconceptions

• It is just like hospice – for end-of-life care only.
• They are “not ready” for palliative care.
• PC has an “agenda” – stop all treatment and go to Hospice.
• PC will take over care and cut us out.
• Will manage pain long term?
Palliative Care …

• Helps educate and prepare families for the future.
  – Relieves fear of the unknown
  – Gives patients control
• Shouldn’t have an agenda
  • Should supplement care of the primary and other specialists
Temel Article

  - 2 arms – standard oncologic care vs. standard oncologic care with integrated palliative care.
  - Measure QOL, mood, end–of–life care.
  - Findings = improved QOL, better mood, longer hospice care and document wishes, and SURVIVAL improvement from 8.9 months to 11.6 months.
Who is Appropriate for Palliative Care?

- Challenging symptoms
- Frequent hospitalizations
- Challenging family dynamics
- Complicated discharge situation
- Education
- Family meetings
What is a Palliative Care Program?

- Initially definition very loose and self-reported
- Home Care Agencies – Palliative Home Care
- The Joint Commission launches Advanced Certification in Palliative Care
Understanding Benefits – Complicated

- Medicare “Homecare” Benefit – RN visits, criteria to qualify (homebound, skilled need, often time-limited)
- Insurance “Homecare” Palliative Care – RN visits with varying criteria
- Medicare Part B and Insurance Physician and NP visits for the specialty of Palliative Care are paid on a per visit basis like any other specialist and can be done in a clinic, home or facility
History of Outpatient PC

• 15 Years ago outpatient PC programs were closing the doors (show me the money)
• Medical reform is contributing to a push to rethink the benefits of outpatient PC (help us reduce admissions)
Omaha Outpatient PC

• VNA home and facility visit program supported by philanthropy.
• Others attempting Outpt PC – mixed results
• Outpatient clinics starting
Review

Hospice is good palliative care for patients at the end of their life
Hospice is only a small part of how palliative care can help patients

Palliative care can help patients and families deal with chronic illnesses

- Controlling symptoms
- Facilitating good communication and education
- Helping with difficult decision making
Questions?
Communication or Breaking Bad News: A 6 Step Guide
A recipe for success

• How important is a recipe?
  – Chocolate chip cookies
• How about a routine?
• Mornings–
  – What do you do Monday – Friday?
  – What do you do on Weekends?
What is Important when Breaking Bad News?
A 6 Step Guide

1. Set the stage
2. What does the patient know?
3. How much does the patient want to know?
4. Share the information
5. Respond to feelings
6. Plan next steps and follow-up
1. Set the Stage

- Environment
- People
- Background
- Interruptions
2. What does the patient know?

- Get a sense of their understanding
- Where to start your discussion
- Identify misunderstandings
- Review for everyone in the patients own words
3. How much does the patient want to know?

- Big picture people vs. Detail people
- Cultural differences
- Patient has a right to refuse knowing but must do so
4. Share the information

- No medical jargon
- Be direct, and honest
- “Warning shot”
- “I’m sorry …”? 
5. Respond to feelings

- Patients will react
- We need to be QUIET !!!
- Answer direct questions as precisely as possible
6. Plan next steps and follow-up

• Next meeting
• Patient safe to drive or be alone
• News and plan will change of time – more meetings will be necessary
6 Step Protocol

• Buckman Protocol
• SPIKES
  – Setting
  – Perception
  – Invitation
  – Knowledge
  – Emotions
  – Strategy or Summary
A recipe for success

• Chocolate Chip Cookies
• A template for any news
• Practice, practice, practice
• The words you choose are important
• Inquiry before Advocacy
Meeting went well when …

- We didn’t cover too much
- Patient spoke the most !!!
Is Prognosis Important?

• Illustration: Final Exams
• Most important information for patients
• Gives patient control and ability to plan
• Helps patients make decisions
• Why do families ask their nurse or social worker?
Importance

• Most people want to know
• Strengthens physician-patient relationship
• Fosters collaboration
• Permits patients, families to plan, cope
Are we any good at it?

- When are babies born?
- Overestimate by a factor of 3–5
- Death Trajectory
- We get better the closer we are to the end of life
Communicating prognosis . . .

• Limits of prediction
  – Hope for the best, plan for the worst
  – Better sense over time
  – Can’t predict surprises, get affairs in order

• Reassure availability, whatever happens
Communicating prognosis

- Inquire about reasons for asking
  - “What are you expecting to happen?”
- Ask how that information will help family
  - “How specific do you want me to be?”
- “What experiences have you had with:
  - others with same illness?”
  - others who have died?”
Communicating prognosis

- Patients vary
  - ‘Planners’ want more details
  - Those seeking reassurance want less

- Avoid precise answers
  - Hours to days. . .months to years
  - Average
When is Hospice Appropriate?

• Listen to your patients and their families
  – Ask open ended questions (time consuming)
• Depends, at times, on their goals
• Often, especially in cancer, function and/or symptoms are important
Code Status

• “Do everything”
• DNR a la carte
• Are we asking? Or guiding.
• Intent of CPR – history
• Information helps – prognosis, process
Questions?
Objectives

» Understand the importance of and the difficulty in determining prognosis

» Know the tools available to help with prognosis
Is Prognosis Important?

» Illustration: Final Exams
» Most important information for patients
» Gives patient control and ability to plan
» Helps patients make decisions
» Why do families ask nurses?
Are we any good at it?

» When are babies born?
» Overestimate by a factor of 3–5
» Death Trajectory
» We get better the closer we are to the end of life
Why is it difficult?

» Many variables
  – Disease
  – Co-Morbidities
  – Age

» No individual person is an “average”
Tools to Help with Prognosis

» Cancer (Functional Assessment)
  – Karnofsky Performance Status
  – ECOG Performance Status

» Non-cancer Diagnosis
  – NHPCO Guidelines for Determining a Prognosis of 6 months or less
  – FAST (Dementia)
Performance status and prognosis

» Independent prognostic factor
» Karnofsky Performance <50: survival <8weeks
<table>
<thead>
<tr>
<th>Palliative Performance Score</th>
<th>100</th>
<th>Normal no complaints; no evidence of disease.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Able to carry on normal activity and to work; no special care needed.</td>
<td>90</td>
<td>Able to carry on normal activity; minor signs or symptoms of disease.</td>
</tr>
<tr>
<td>Unable to work; able to live at home and care for most personal needs; varying amount of assistance needed.</td>
<td>80</td>
<td>Normal activity with effort; some signs or symptoms of disease.</td>
</tr>
<tr>
<td>70</td>
<td>Cares for self; unable to carry on normal activity or to do active work.</td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>Requires occasional assistance, but is able to care for most of his personal needs.</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>Requires considerable assistance and frequent medical care.</td>
<td></td>
</tr>
<tr>
<td>Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly.</td>
<td>40</td>
<td>Disabled; requires special care and assistance.</td>
</tr>
<tr>
<td>30</td>
<td>Severely disabled; hospital admission is indicated although death not imminent.</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Very sick; hospital admission necessary; active supportive treatment necessary.</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Moribund; fatal processes progressing rapidly.</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>Dead</td>
<td></td>
</tr>
</tbody>
</table>
NHPCO Guidelines

» Developed in mid-90’s by NHPCO to be a guide for predicting when patients would qualify for Hospice services

» Not evidence based

» Shown to be poor

» However, organizations (Hospices, CMS) use it a lot
Local Coverage Determinants

Stroke and Coma

Patients will be considered to be in the terminal stages of stroke or coma (life expectancy of six months or less) if they meet the following criteria:

Stroke

1. Karnofsky Performance Status (KPS) or Palliative Performance Scale (PPS) of < 40%

2. Inability to maintain hydration and caloric intake with one of the following:
   a. Weight loss > 10% in the last 6 months or > 7.5% in the last 3 months;
   b. Serum albumin < 2.5 gm/dl;
   c. Current history of pulmonary aspiration not responsive to speech language pathology intervention; Sequential calorie counts documenting inadequate caloric/fluid intake;
   d. Dysphagia severe enough to prevent patient from continuing fluids/foods necessary to sustain life and patient does not receive artificial nutrition and hydration.
Local Coverage Determinants

Coma (any etiology):

1. Comatose patients with any 3 of the following on day three of coma:
   a. abnormal brain stem response;
   b. absent verbal response;
   c. absent withdrawal response to pain;
   d. serum creatinine > 1.5 mg/dl.

2. Documentation of the following factors will support eligibility for hospice care:
   a. Documentation of medical complications, in the context of progressive clinical decline, within the previous 12 months, which support a terminal prognosis:
      1. Aspiration pneumonia;
      2. Pyelonephritis;
      3. Refractory stage 3-4 decubitus ulcers;
      4. Fever recurrent after antibiotics.
Local Coverage Determinants

3. Documentation of diagnostic imaging factors which support poor prognosis after stroke include:
   a. For non-traumatic hemorrhagic stroke:
      1. Large-volume hemorrhage on CT:
         a. Infratentorial: greater than or equal to 20 ml.;
         b. Supratentorial: greater than or equal to 50 ml.
      2. Ventricular extension of hemorrhage;
      3. Surface area of involvement of hemorrhage greater than or equal to 30% of cerebrum;
      4. Midline shift greater than or equal to 1.5 cm.;
      5. Obstructive hydrocephalus in patient who declines, or is not a candidate for, ventriculoperitoneal shunt.
   b. For thrombotic/embolic stroke:
      1. Large anterior infarcts with both cortical and subcortical involvement;
      2. Large bihemispheric infarcts;
      3. Basilar artery occlusion;
LCD for Hospice

» Medicare coverage of hospice depends on a physician’s certification that an individual’s prognosis is a life expectancy of six months or less if the terminal illness runs its normal course.

…..

» Some patients may not meet these guidelines, yet still have a life expectancy of 6 months or less.
CMS Letter to Hospices

» Under the law, Medicare beneficiaries are eligible for hospice care when they decide to choose palliative and other care from a hospice, and a physician and the hospice medical director certify that they have a medical prognosis of six or fewer months to live if their illness runs its normal course. ....

» As long as a physician continues to properly and conscientiously recertify the six-month prognosis, a beneficiary can continue to receive the hospice benefit.
Disease Specific Guides

» “Fast Facts” through EPERC (End of Life / Palliative Education Resource Center) through the Medical College of Wisconsin

» Many Models
  – Cancer – Karnofsky, ECOG
  – Dialysis – Charlson Comorbidity Index (CCI)
  – Liver Failure – Child’s–Turcotte–Pugh (CTP) and Model for End–stage Liver Disease (MELD)
  – End–stage COPD – BODE Index
  – Dementia – FAST and Mortality Risk Index Score (Mitchell)
  – CHF – challenging for many reasons
Best Approach

» Ask how that information will help family

» Give range of time expected (hours to days, days to weeks, weeks to months, many months)
Questions?