

# Providing Palliative Care for Elderly Patients with Dementia in the ED

**CANP**

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# Disclosures

- **Conrad Rios FNP-BC, PA, MS** has no financial relationships with commercial interests to disclose
- Any unlabeled/unapproved uses of drugs or products referenced will be disclosed

# Objectives

- 1. Define the difference between palliative care versus hospice care**
- 2. Identify the criteria recommended by Medicare to determine eligibility for palliative care/hospice care**
- 3. Analyze one's feeling about the use of palliative care in the ED**

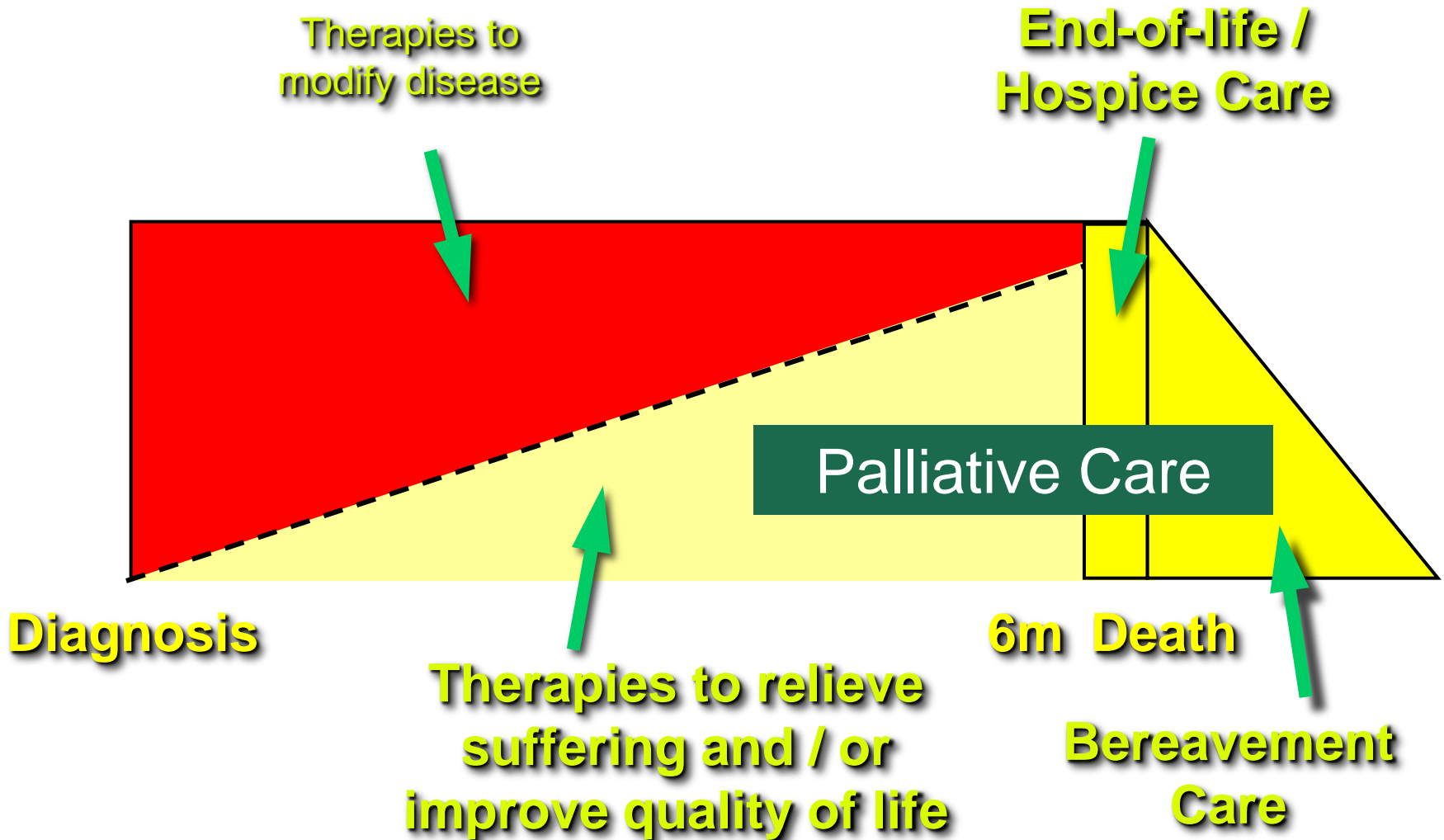


What is your journey and experience?

# Objective 1

- **Define the difference between palliative care versus hospice care**

# Palliative Care: NEW model



# Palliative Care is a philosophy and approach to care

- Is **NOT**

- Only end of life care/Death
- Only for cancer patients
- Only for patients who stop treatment
- Same as hospice
- Euthanasia
- A fringe movement
- Only physical distress

- **IS**

- Expert Pain and Symptom Management for all stages of a life threatening illness.
- Skilled Counseling regarding difficult medical decisions
- A complement to hospice
- Social, psychological, spiritual, cultural, financial
- A growing subspecialty

## Palliative Care (WHO, 2005)

- Palliative care: an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other physical, psychosocial and spiritual problems



- Aren't we doing this?
- Doesn't this automatically happen?
- Unfortunately, no:
- IOM reports: 1997, 2000, 2011
- Journal of Pain and Symptom Management, Palliative Medicine, Journal of Hospice and Palliative Nursing.. etc

# Hospice Care

- Language matters HOSPICE IS WHO WE ARE-- PALLIATIVE CARE IS WHAT WE DO
- An intensification of palliative care in the last month/weeks of life
- Prognosis dependent; eligibility criteria
- Medicare benefit
- Home hospice vs. Inpatient hospice vs hospice in SNF
- Home hospice requires a primary caregiver
- Does not mandate DNR status
- TPN, blood transfusions, fluids, etc, considered on individual basis
- Avoiding ER visits; 24 hour RN on-call; emphasis on comfort

## OBJECTIVE 2

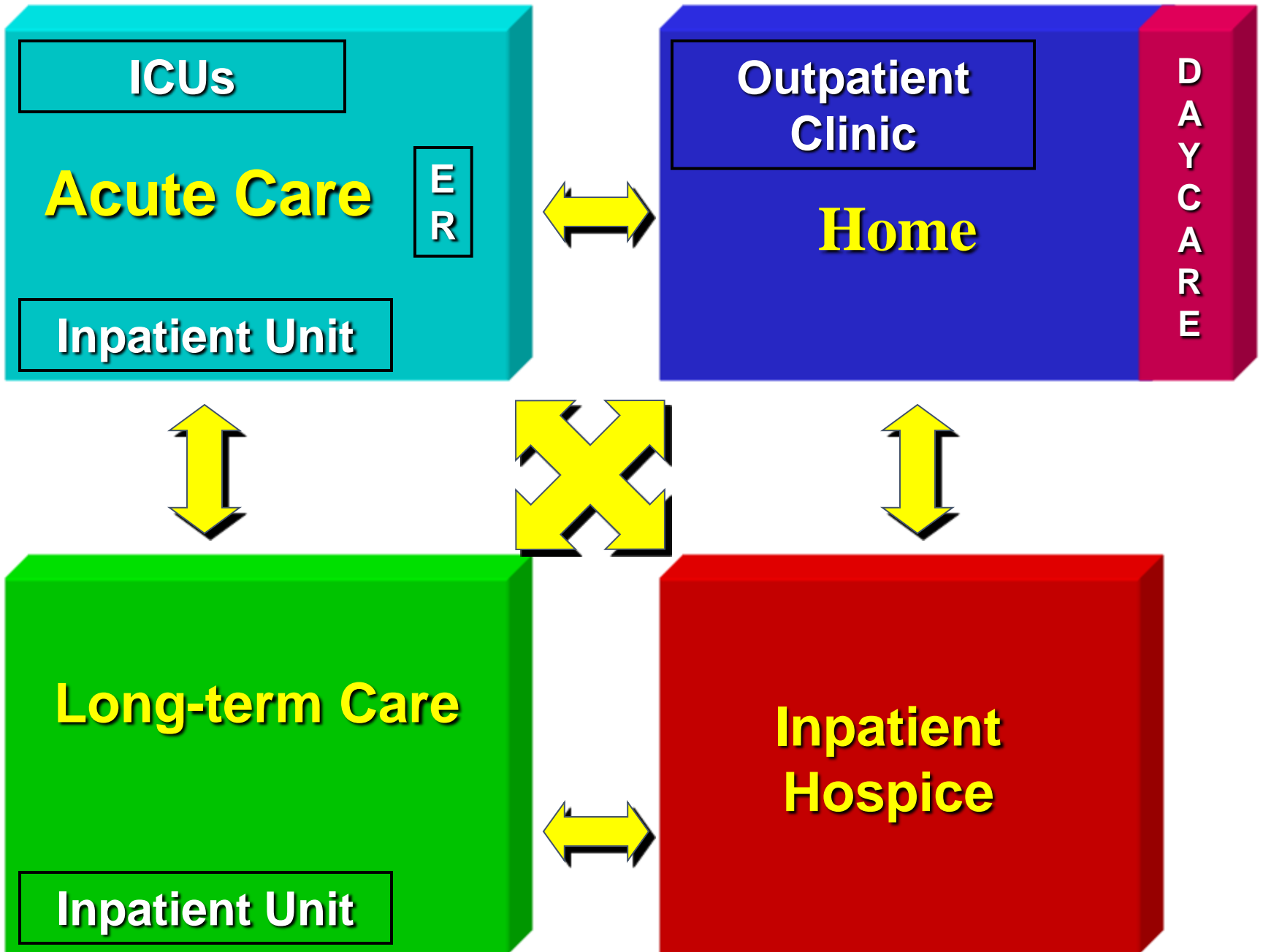
### Identify the criteria recommended by Medicare to determine eligibility for palliative care/hospice care

#### Palliative Care

- Debility/Failure to Thrive
  - Pt/family desire for low-yield therapy
- Cancer
  - Introduced when disease progresses despite therapy
- Heart Disease
  - Stage III or IV heart failure despite optimal medical management
- Dementia
  - Behavioral problems
  - Frequency of ER visits

#### Hospice Care

- Debility/Failure to Thrive
  - No desire for aggressive Tx
- Cancer
  - Any pt with metastatic or inoperable cancer
- Heart Disease
  - Heart failure symptoms at rest
  - Ejection Fraction less than 20%
- Dementia
  - Unable to walk ,bathe or dress self without assistance
  - Less than six intelligible words
  - Frequent ER visits



# Major Discrepancies

- Patients say they want to die at home
  - <25% do; 60-80% die in an institution (Muramatsu et al., 2008, Place of death among older Americans, Med Care. 2008 August; 46(8): 829-838)
- Patients say that good pain and symptom management are essential
  - 64% of patients with advanced disease/metastatic cancer will experience pain ( van den Beuken-van Everdingen MH et al., Prevalence of pain in patients with cancer: a systematic review of the past 40 years. Ann Oncol 2007; 18 1437-1449.)
  - 1 out of 2 patients with advanced cancer have undertreated pain (Deandrea et al., Prevalence of Undertreatment in Cancer Pain. A Review of Published Literature; Ann Oncol. 2008;19 (12): 1985-1991)
- Patients say they want to relieve the burden on their families
  - Families commonly must work a second job, take additional loan/mortgages, deplete savings to pay for care for terminally ill patients ( Emanuel et al., Ann Intern Med 200 Mar 21; 132(6):451-9. Understanding economic and other burdens of terminal illness: the experience of patients and their caregivers.)

# Why is this important?

- Each year approximately half of the U.S. population (150 million people) are touched by the death of a loved one or a close friend (Bill Moyers, “On Our Own Terms, “ [http:// www.pbs.org/wnet/onourownterms](http://www.pbs.org/wnet/onourownterms))
- Early palliative care can improve survival (Temal et al. N Engl J Med 2010; 363:733-742)
- Aging Population : Americans are living longer ,
- There are proportionately more older adults than in previous generations
- In 2030, when the last baby boomer turns 65
- One of every five Americans—about 72 million people—will be an older adult.
- <http://www.cdc.gov/aging/pdf/state-aging-health-in-america-2013.pdf>

# Life Expectancy at Selected Ages

## National Vital Statistics Reports 2005

• AGE	MEN	WOMEN
• 65	16.6	19.5
• 70	13.1	15.7
• 75	10.2	12.4
• 80	7.7	9.4
• 85	5.7	6.9
• 90	4.2	5.0
• 95	3.2	3.7
• 100	2.5	2.8

# Life Expectancy at Selected Ages by Gender and Health Status

MEN				WOMEN			
• Age	Robust	Ave	Frail	• Age	Robust	Ave	Frail
• 70	18	12.4	6.7	• 70	21.3	15.7	9.5
• 75	14.2	9.3	4.9	• 75	17	11.9	6.8
• 80	10.8	6.7	3.3	• 80	13	8.6	4.6
• 85	7.9	4.7	2.2	• 85	9.6	5.9	2.9
• 90	5.8	3.2	1.5	• 90	6.8	3.9	1.8
• 95	4.3	2.3	1.0	• 95	4.8	2.7	1.7

Adapted from JAMA 2001; 285:2759



# Top 10 causes of death in the US

- Over 2 million deaths per year in U.S

1. Heart Disease
2. Cancer
3. Chronic Low Respiratory Disease
4. CVA
5. Unintentional Injury
6. ALZHEIMER'S DISEASE
7. Diabetes Mellitus
8. Nephritis
9. Influenza and Pneumonia
10. Suicide

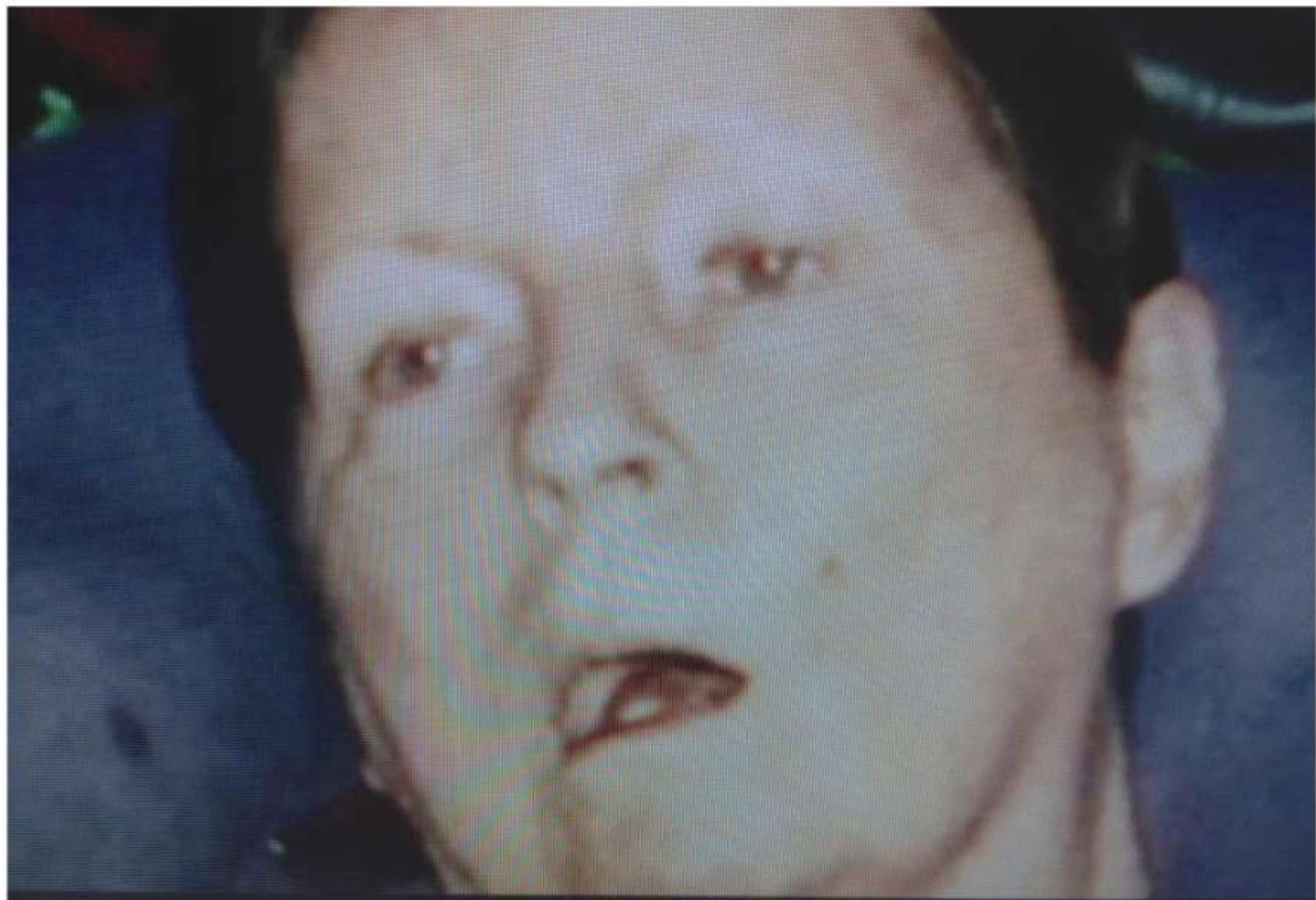
- [www.cdc.gov](http://www.cdc.gov) 2010

## **OBJECTIVE THREE**

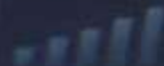
**Analyze one's feeling about the use of palliative care in the ED**

# It's OK to DIE

- “There are things I generally miss about not attending in the emergency department anymore. But one thing I don't miss is pulling back the sheets on a nursing home transfer on a clearly end-stage patient whose family is demanding “everything” be done”.
  - What does “everything” mean anyway?
- 
- [It's OK to Die by Greg Henry MD](#)
  - <http://www.epmonthly.com/columns/oh-henry/it-is-ok-to-die/>



42:27 / 48:48



How can I communicate more effectively with patients and families?

# Effective Communication Techniques

## The COMFORT Model

- **C-Communicate**
  - Learning to bear witness
  - Using person-centered messages
  - Recognizing communication expectations
- **O-Orientation and Opportunity**
  - Gauging health literacy levels
  - Acknowledging vulnerability
  - Understanding cultural humility
  - Formulating a pathway of care
- **M-Mindful Presence**
  - Practicing empathy
  - Engaging in active listening
  - Demonstrating cultural humility
  - Employing nonverbal communication

# Effective Communication Techniques

## The COMFORT Model

- **F-Family**
  - Viewing the family as an open or closed system
  - Recognizing predictable family communication patterns
  - Responding to the varying needs of family caregivers
- **O-Openings**
  - Identifying pivotal events of change in patient/family care
  - Communicating despite tension
  - Practicing complementary disclosure

# Effective Communication Techniques

## The COMFORT Model

- **R-Relating**
  - Embracing the multiple goals of patient/family
  - Accepting inherent conflicts in goals
  - Using communication with patient/family to practice care
- **T-Team**
  - Contributing to interdisciplinary collaboration
  - Distinguishing successful collaboration from group cohesion



# Effective Communication Techniques

- Spend adequate time
- Use private, quiet location for communication
- Use appropriate nonverbal communication as much as 70- 83% of communication includes non-verbal behaviors
- Be seated, if possible
- Establish and maintain eye contact
- Demonstrate empathy
- Address patient and loved ones by name

# Barriers to Good Communication

- **Premature and/or inappropriate advice**
- **False reassurance /placating**
- **Switching the topic**
- **Passing the buck**
- **Premature problem solving**
- **Avoiding the patient**
- **Closed questions**
- **Leading questions**
- **Only discussing neutral issues**
- **Ignoring cues**

# Cultural Considerations

- How would patient like information to be handled/shared
- How would the patient like decisions made regarding their health care
- Are there particular spiritual/religious beliefs or traditions that are important?
- Importance of language, customs re: eye contact, use of touch, privacy , gender
- Translator Considerations



# Communication, Communication, Communication



# Introductions: Build Relationships

- Introduce yourself, have participants identify themselves and their relationship to patient
- Identify the legal decision maker or family designated decision maker
- Review your goals; ask family if these are the same or different from their goals
- Establish ground rules
  - Everyone can talk
  - No interruptions
- How much does family want to know?

# Empathetic Listening

- Eye contact, relaxed posture, nodding, facial expressions to convey attention, interest, receptivity
- Sitting down
- Request/encourage more information:
  - Can you tell me more?
  - “Help me understand”
- Use empathetic comments:
  - “It seems that it has been very hard for you”
  - “It sounds like things have been difficult lately”
- Minimize interruptions, change of subject, or movement in new direction until patient/family done
- Say back what you heard
- Minimize giving advice

# Silence, Respond to Emotions

- Allow silence, give patient/family time to react and ask questions
- Be Present
- Acknowledge and validate reactions prior to any further discussions
- Invite questions/clarifications

# More than death itself people fear:

- Dying alone
- Dying in Pain
- Being a burden to family/friends



# Key Points

- Palliative care can be provided to all patients who present to the ED
- The growing number of patients presenting to the ED at the end of life means an increase in the proportion of patients for whom the default resuscitation approach is less applicable
- Rapid identification of treatment goals with the terminally patient or surrogate prevents unwanted resuscitation and application of burdensome life-prolong therapies
- The most prevalent distressing symptoms that require immediate attention for the patient who is dying in the ED are pain and dyspnea
- Unrestricted access of the family to the dying patient can be successfully implemented in the ED



What is your journey and experience?