Objectives:

• Discuss overlapping goals of geriatric and palliative care
• Identify 3 common trajectories of decline and issues of prognosis in older adults
• Discuss how various care environments can support palliative care goals of older adults
• Explain important dimensions of assessing palliative care needs of older adults
• Describe the nurse’s role in a multidisciplinary team approach to palliative and end-of-life care
Palliative Care

• WHO definition….
  ....the active total care of patients whose disease is not responsive to curative treatment.

• Goals…
  ...to prevent and relieve suffering and to support the best possible quality of life for patients (all ages) and their families, regardless of the stage of the disease or the need for other therapies.

Palliative care specialists less likely to receive specific training in geriatrics.
Hospice and Palliative Care

Palliative Care

Hospice Care
A NEW MODEL OF PALLIATIVE CARE FOR ELDERS

**Dichotomous model**

- Curative/disease-modifying treatment
- Hospice/Palliative Care

**Continuum-of-care model**

- Curative/disease-modifying treatment
- Pain relief and palliative care

World Health Organization, Cancer Pain & Palliative Care, 1990
Geriatric Care

- Goals of Geriatric Care
  - Foster independence/ maintain control
  - Increase quality of life
  - Collaborative care

More recent recognition
- >65 Death rate is 5200/100,000
- Geriatric fellows now receiving palliative care education
Goal of Health Care in Elderly?

- Maintain function for “natural life span”

  vs

- Extend life as long as possible?
  - Death is the enemy; can be overcome with enough health care ($)
The Old Get Sick Differently

- Acute change in mental status
- Altered pain sensation; inability to localize
- Vague symptoms
- Functional status decreases
- Falls
- Dehydrate easier due to decreased muscle mass & intracellular H2O
- Anorexia
- Unusual medication reactions

Amella, 2003, JHPN
Dying Old is Different

• Geriatric Palliative Care needs to account for:
  – Death from chronic illness
    • Top 5 chronic illnesses >75
      • arthritis, hypertension, hearing impairment, heart disease, cataracts
  – Over age 80
    • 70% have disability; 53% severe
    • 36% have mod-severe cognitive impairment
Goals of Geriatric Palliative Care:
Who: Older Adults w/ Life-limiting Illness
When: Palliative Needs Arise (?approaching end of life)
What: Improve control over life, quality of living/dying
Where: Wherever elderly are located
How: A Team Care Model (RNs are Key Members!)
WHY: Is Providing Integrated Palliative & Geriatric Care a Challenge?

- Americans live longer, healthier lives, but most will spend their last years living with disabilities or chronic illnesses.

- Chronically ill elderly have ambiguous medical prognoses.
  - They may be sick enough to die from a small complication on any day or they may live for many years.

- Symptom management and support (palliative care) services
  - Not restricted to a relatively short and easily recognizable end of life period.

- The beginning of palliative care is not the end of conventional medical care.
  - The proportion of palliative care services needed will gradually increase over time.
WHO: Which Older Adults Need Palliative Care?
Predicting Prognosis in Older Adults

- Cancer
- Heart Failure
- Dementia
Prognosis and Cancer

- Cancer is a disease of the elderly
  - 61% of new cancers >65 yrs
  - 70% of cancer deaths in >65 yrs
- Prognosis based on cancer type
  - Similar prognosis in “healthy” elderly
  - Modified by presence of comorbidities (50% of > age 70 have 3 comorbidities)
  - Comorbidities affect ability to undergo effective cancer tx & inc. tx toxicity
    - e.g. organ function, pharmacokinetics,
Palliative/Hospice Care and Cancer

- Most common reason for referral to hospice
- Should not exclude patients who can benefit from disease-modifying cancer treatments
- Tx is often palliative
  - Control symptoms
  - Extend life
Schematic course of Heart Failure

Optimal

Functional Status

SUPPORTIVE CARE

HEART FAILURE CARE

1

2

3

4

5

Death

Time
Predicting Prognosis in Heart Failure

- 5 yr mortality > 65yrs -50-60%
  - 45% for women
  - After 1\textsuperscript{st} admit for HF; 5 yr survival worse than most cancers (except lung)
  - High sudden death due to arrhythmia vs. protracted death due to pump failure
  - Implanted defibrillators will inc. deaths due to pump failure-possibly more predictable
Palliative Care of the End-stage HF patient

Key Points:
- Ongoing treatment of HF is palliative during transition to EOL
- Continue oral HF regimen as long as patient’s clinical status allows
- Treat underlying depression/anxiety
- Address ICD deactivation
Hospice and Heart Failure

• Second most prevalent reason for referral
• Referral (to palliative care) should be based on pt need not “terminal diagnosis”
• Prognosis or living greater than 6 mo should not be barrier to hospice referral
  – pts can be recertified or d/c after 6 mo. and re-enrolled at later date
Prognosis and Dementia

• Prevalence
  – 1% of person’s age 65
  – 40% of person’s older than 85

• “Terminal Disease”-3.3 yrs median time diagnosis to death

• Prognosis based on stage of disease:
  – Early, middle, or late stage disease
  – Stage based on functional issues

Kapo et al, 2007
NHPCO Hospice Guidelines in Alzheimer’s

• Inability to communicate in a “meaningful way”
• Need assistance w/ ambulation
• And at least one dementia-related medical complication, such as:
  – Aspiration pneumonia
  – Upper urinary tract infection
  – Sepsis or other overwhelming infections
  – Worsening bedsores
  – Weight loss greater than 10 percent over the past six months
Nursing Home Resident w/Dementia- Mortality Risk based on Minimal Data Set (MDS)

Relative Risk “Points”

- 1.9 Complete dependence ADLs
- 1.9 Male
- 1.7 Cancer
- 1.6 CHF
- 1.6 O2 tx in last 14 days
- 1.5 SOB
- 1.5 <25% food eaten at most meals
- 1.5 Unstable medical condition
- 1.5 Bowel incontinence
- 1.5 Bedridden
- 1.4 Age >83 yrs
- 1.4 Not awake most of the day
Nursing Home Resident w/Dementia-Mortality Risk based on Minimal Data Set (MDS)

<table>
<thead>
<tr>
<th>Total Points</th>
<th>Risk of death w/in 6mo</th>
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<tr>
<td>0</td>
<td>9%</td>
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<tr>
<td>1-2</td>
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<tr>
<td>9-11</td>
<td>57%</td>
</tr>
<tr>
<td>≥ 12</td>
<td>70%</td>
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</tbody>
</table>
Alzheimer’s: Life Extension or Comfort Care

• Medical interventions considered “life extending” in late stage
  – Antibiotics
  – CPR
  – Dialysis
  – Tube feedings

• Comfort Care?
  – Use of meds to improve cognitive function
  – Often receive inadequate pain meds due to inability to communicate

Kapo et al. 2007 & Alzheimer's Association's Ethics Advisory Panel
Alzheimer’s: Recommendations for Comfort Care

• Connecting w/ late-stage Alzheimer's through their senses
  – **Touch.** Hold hands, Brush his or her hair. Give a gentle massage to the hands, legs or feet.
  – **Smell.** The person may enjoy the smell of a favorite perfume, flower or food.
  – **Sight.** Videos can be relaxing for people with Alzheimer's disease, especially ones with scenes of nature and soft, calming sounds. Many nursing homes have a giant bird cage inside so that the residents can watch and listen to songbirds.
  – **Hearing.** Reading to the person also can be comforting, even if he or she can't understand the words. The tone and rhythm of your voice are soothing.
Where: People Die*

- Hospital 48% (707)
- Nursing Home 20% (280)
- Home 17% (262)

*All deaths in 3 NH/VT counties surrounding DHMC
Care Systems of Chronically Ill Older Adults Approaching EOL

- Home Health Care/Hospice
- Residential Care & Assisted Living
- Nursing home
- Acute Care Hospital
- Intensive Care Unit
Palliative/Hospice Care at Home

• Medicare Hospice Benefit
  – Provides home health RN, LNA
  – Social support-MSW, chaplain, volunteers
  – DME
  – Meds
  – Oxygen
  – 24 hr access to nsg services (to avoid hospital admission)
  – Interdisciplinary team approach
  – Can be applied in other settings such as nsg home, residential care, etc.
Providing Palliative Care in Residential Care & Assisted Living

• Definition--“a congregate residential setting that provides or co-ordinates personal services, 24-hr supervision and assistance (scheduled and unscheduled), activities and health-related services”
• Heterogeneous on services provided (e.g. only 35% staffed w/ FT RN -40hrs/wk)
• Paid out of pocket
• This is considered “home” so are eligible for Medicare Hospice services
A Study Comparing Death in Assisted Living vs Nsg Home

- more assisted living residents reported untreated pain (14vs2%) and SOB 12.5 vs 0% compared to nsg home residents…
- however family satisfaction w/ death in assisted living despite in adequate sx tx was greater than in nsg home…

Providing Palliative Care in Nursing Homes

- By 2020 40% of Americans will die here
- SNF-level vs. custodial
- Dyspnea vs pain most prevalent sx in last 48hrs since most die of non-cancer dx
  - 23% received no dyspnea tx
  - Only 27% received opioid
Providing Palliative Care in Nursing Homes

• 33-84% have ongoing pain that impairs ambulation, reduces qol, and increases depression
• 29% of cancer pts w/ daily pain-only a quarter received daily analgesic (often acetaminophen)
Be good to your kids, they’ll be picking out your nursing home!!!
Palliative Care in Nursing Homes

• THE Bad NEWS!!--regulatory conflicts of providing EOL care in Nsg Homes
  – Medicare part A (room/board) or Hospice (no room and board)
  – OBRA goal: maintain or improve physical functioning based on MDS
    – Sanctions/deficiencies if not meeting requirements—(e.g. need to put in tube or force feed)
  – Only 25% of Medicare-eligible nsg home residents used hospice services before death
    • Those who did were enrolled only days before death.
Palliative Care in Nursing Homes

- THE GOOD NEWS!!
  - Efforts to increase palliative and hospice in nsg homes
    - Increased training of nsg home staff in pall care
  - Hospice in some residents seems to improve care of all residents
    - Family satisfaction around death increased when resident enrolled in hospice
    - Receive more analgesics
    - Family believed hospitalizations reduced in last 30 days of life
Death in Nsg Home vs Hospital

National study (n=1.4 million nsg home residents)
- 45% of ER admits/hospital transfers inappropriate
- 25% died w/in 24h of transfer
- 50% died w/in 4 days

Costs were $10,760 more if deaths were in hospital instead of nsg home

Saliba et al. 2001; Levy et al. 2002 J Am Ger Soc
Providing Palliative Care in the Acute Care Hospital/ICU

- >65 age is 40% of all hospital d/c
  - Used 50% of all hospital days
- 30-50% elders die in hospital
- Quality of dying is poor
  - Unnecessary suffering from pain, SOB, confusion, and care inconsistent with wishes (usually more invasive and prolonged)
  - Increased # of palliative care programs in hospitals
Providing Palliative Care in the Acute Care Hospital/ICU

- Determine preferences and prognosis- Adv Directives? DNR? Rehospitalization?
- Identify goals of care
- Avoid iatrogenesis
- Involve family especially when pt lacks capacity
- Early identification of discharge plan
- Involve community care providers and palliative/hospice specialists when appropriate

****RNs provide most of the care patients receive in the hospital****
WHAT: Palliative Care Assessment Parameters of the Older Adult

- Physical, psychosocial, and spiritual problems
- Functional status / environmental status
- Accomplishment of developmental tasks of life
- Family dynamics / relationship issues / opportunities
- Grief / loss / bereavement issues
Quality of Life of Older Adult Approaching EOL

Physical
- Functional Ability
- Strength/Fatigue
- Sleep & Rest
- Neurological: Pain/Mental
- Anorexia/Cachexia
- Constipation

Psychological
- Anxiety/Distress
- Depression
- Enjoyment/Leisure
- Happiness
- Fear
- Cognition/Attention
- Decisional Capacity

Social
- Financial Burden
- Caregiver Burden
- Roles and Relationships
- Affection/Sexual Function
- Appearance

Spiritual
- Hope
- Suffering
- Meaning of Pain
- Religiosity
- Transcendence

Adapted from Ferrell, et al. 1991
How: Geriatric Palliative Care: Nursing Role

- Identify person’s values and preferences for care
- Enhance maximum comfort and function
- Encourage open and active communication among patient, family and health care team
- Coordinate/Participate in holistic interventions of multidisciplinary team
- Enhance growth through activities of life closure/legacy
HOW: Geriatric Palliative Care: Nurses’ Role

• Identify person’s values and preferences for care – ADVANCE DIRECTIVES/DNR
• Enhance maximum comfort and function EXPERT PAIN/Sx ASSESSMENT & MGMT
• Encourage open and active communication among patient, family and health care team - FAMILY MEETINGS
• Coordinate/Participate in holistic intervention by multidisciplinary team - DISCHARGE PLANNING
• Enhance growth through activities of life closure/legacy - RESPECT & REFERRAL
Summary…

• Geriatrics and palliative care have some shared goals

• Think about every elder patient through a Palliative Care lens!

• Identify patients appropriate for referral to Palliative and Hospice services

• Encourage family to participate in goals, processes and evaluation of care
Summary

• Consider older adults’ prognosis, preferences, and priorities in determining the best “site” to provide geriatric palliative care

• Nurses are key members of interdisciplinary teams providing for palliative care needs of older adults
Conclusion: Integrating Palliative & Geriatric Care

- The EOL must be understood as a period that typically spans years, not just weeks or months.
- Palliative care and conventional medical treatment (Geriatrics) should be thoroughly integrated rather than viewed as separate entities.

RAND, 2006 Lynn, J. Living Well at the End of Life; Sick to death and not going to Take it anymore!
“When medicine can no longer promise an extension of life, people should not fear that their dying will be marked by neglect, care inconsistent with their wishes, or preventable pain and other distress. They should be able to expect the health care system to assure reliable, effective, and humane care-giving. If we can fulfill that expectation, then public trust will be strengthened.”

C. Cassel, MD in Preface IOM report, vii
Acknowledgements

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- DHMC, Section of Cardiology
- Lisa Stephens, MSN, ARNP
- DHMC, Section of Palliative Medicine
Predictable, Progressive Decline: Cancer

- Mrs. Colon, 80 yo woman recurrent GI cancer
- Physical:
  - now metastasis to liver, jaundiced, still alert and oriented
  - discomfort mostly from arthritis, now some abdominal discomfort/bloating
- Psychosocial
  - home w/ VNA; 82 yo husband of 60 yrs. is main caregiver
  - Husband has osteoarthritis
  - 2 adult children live at a distance; They take turns staying w/ her
  - Has financial means to have private caregivers
Chronic, Progressive Illness, w/ Acute Exacerbations: CHF

- Mr. GI Joe-78 yo man retired military, former Farmer, widowed, 5 children live nearby, but none can live w/ him and he’s alone
- Physical:
  - s/p runs of VT; -has had multiple resuscitations; now has AICD which has discharged several times
  - EF 15%; amiodarone, intermittent claudication w/ ambulation
  - SOB; PO in the mid 80’s but no serious problems w/ breathing, On o2 ; nasal cannula
  - Former smoker-just quit
- Psychosocial
  - Most care at VA; but has some cardiac care at DHMC
  - Existence is bed – chair; neighbors and kids bring him meals
  - Understands that his hospice home care status is just so he could get “those nice volunteers”
Frail, Long-term Dwindling: Alzheimer's Dementia

• Mrs. Phoenix. 76 yo retired, knitting factory worker w/ Alzheimer's living at home w/ some family and paid caregivers
• Physical:
  – Has had Alzheimer's for 15 years; bed-bound for last 8 months,
  – not able to feed self but can swallow and eats fair when fed by hand
  – mostly non-verbal, intermittent responsiveness to voice, occasionally becomes more alert and responsive
  – Has been hospitalized for pneumonia x 3 and after antibiotics has returned home to same state
  – Developed pressure sore during last hospital admit that seems painful
  – Also has osteoarthritis
• Psychosocial
  – Has some paid and some family caregivers; one daughter is an RN and is the DPOA-HC
  – Pt had said her whole life, “I’d never want to live like a vegetable and I’d never want to be in a nursing home”