iPall – Advanced Disease

Palliative Care Assessment Tool

Providence HEALTH CARE

Identify who would benefit from a palliative care approach

1) ASK yourself

- Would I be surprised if this patient died in the next 6-12 months? **YES** or **NO**

2) LOOK for one or more *general* clinical indicators

- Performance status poor (limited self care; in bed or chair over 50% of the day) or deteriorating
- Multiple hospitalizations in the past 6 months
- Patient needs more care at home or is in a residential care facility.
- Patient has multiple comorbidities causing symptoms/functional decline

3) LOOK closer for two or more *disease* related indicators

Cancer

- Increasing age
- Serum calcium >2.8mmol/liter
- DVT or PE
- Brain mets or CNS involvement in hematological malignancies
- Spinal cord compression
- Malignant pericardial effusions
- Serum albumin <35 mmol/l

COPD

- Body mass index <21
- Severe airway obstruction (FEV1<30%) or restrictive deficit (vital capacity <60%)
- Persistent breathlessness at rest or on minimal exertion despite optimal tolerated therapy (exclusive of exacerbation)
- Six minute walk distance of <100 meters
- Comorbidities of symptomatic heart failure or obstructive sleep apnea
- Depression, anxiety, living alone
- Increased emergency admissions for infective exacerbations and/or respiratory failure

Dementia

- Increasing age
- Male gender
- Dyspnea
- Recurrent lung aspiration
- Pressure ulcers
- Low oral intake/weight loss/BMI< 18.5

Frailty

- Age> 75
- Serum albumin < 35
- Presenting for care with one or more of:
  - Unable to do self care (ADL) without assistance
  - Malnutrition (weight loss > 10%)
  - Heart failure
  - Creatinine >265 mmol/l
  - Delirium

Heart Failure

- NYHA class III / IV heart failure due to valve disease, or coronary artery disease not amenable to surgery/angioplasty
- Persistent symptoms (breathlessness/chest pain) despite optimal tolerated therapy
- Renal impairment (eGFR <30 ml/min)
- Cardiac cachexia: progressive loss of lean body mass, reduced muscle strength, anorexia, fatigue
- Markers of chronic inflammation/cachexia: anemia: hemoglobin ≤ 115, Uric acid ≥ 565, albumen < 32
- Two or more episodes needing intravenous (furosemide and /or inotropes) therapy in last 6 months

HIV/AIDS

- Age > 65 years
- CNS lymphoma
- Viral load on HAART > 10,000
- Poor performance status
- Other life-limiting co-morbidities

Liver Failure

- Age > 50
- Serum bilirubin > 237 that does not respond well to therapy
- eGFR < 40ml/min
- Ascites present
- Encephalopathy present

Renal Failure on Hemodialysis

- Age >80
- Albumin < 35
- Peripheral vascular disease
- Dementia
- Other comorbidities such as heart or liver disease, stroke, diabetes with end-organ damage

4) If I WOULD NOT be surprised AND the patient meets criteria from LOOK categories – patient benefits from palliative approach

Integrate palliative approach into assessment

It is much more important to know what sort of a patient has a disease than what sort of a disease a patient has. - William Osler

Patient as Partner

Use an interpreter, avoid medical jargon, attend to their story, encourage feedback

Physical Symptoms of Advanced Disease

Ask about function. Use ESAS on Chartscan in SCM or www.palliative.org Clinical Information/Assessment Tools.

Psychosocial / Spiritual Symptoms

"How do you feel things are going? … How is this affecting you? … How do you see your illness affecting your future?"

Integrate palliative care into practice: *Useful Phrases* and therapies

The good clinician treats the disease; the great clinician treats the patient who has the disease. - William Osler *(adapted)*

- **Talking about end-of-life does not remove hope – it allows the patient to be a better partner in decision-making.** Patient readiness to talk about end-of-life does not depend on disease stage. Clinicians need to ask…
- Prognosis information needs: ***"Some people like to know all the details, others just want the big picture and some prefer not to discuss it at all. What is best for you?"*** If information desired start with: ***"Tell me what you understand about your illness."*** If prognosis uncertain: ***"We are not very good at predicting how long people live with your disease but I would estimate years/months/days."***

- Communicate/prepare: ***"We cannot cure your disease but our goal is to help you live as well as you can for as long as you can." "Although we do not have any further treatments to reverse the disease there is always something we can do to help you feel better."***
- Aware of all options? ***"There may come a time when we suggest treatments you don't feel comfortable with or a time when you want to stop a treatment. We will understand and support you in this decision and will continue to make sure you live as well as possible." "What do you fear most about the future? Is there anything that would be worse than death for you?"***
- Advance care planning: ***"Have you discussed your thoughts about the future with your family or ever put them down in writing?"*** If no plan in place: ***"We will hope for the best but always have a plan for the worst." "If you were unable to speak for yourself who will make decisions for you?"***

- CPR Discussion: ***"We will do everything we can to help you live as well as you can for as long as you can but when you die we will help you to have a peaceful and natural death."***
- **Control dyspnea and pain:**
  See POP Tool; PHC Clinical Page/Palliative Care Companion/Symptom Management
- **Symptom control = quality of life:** especially dyspnea/anxiety/depression/
- Review and revise: ***"Does the treatment you are receiving feel right to you?" "As your illness gets worse, what is most important to you?"***

Involve other healthcare providers or services

- **Essential community services : Family Physician, Home Care Nursing**
- **See Palliative Care Companion on PHC Clinical Page**
- **Consider involving Palliative Outreach and Consult Team (POCT) for:**
  - Difficult to control physical or psychological symptoms
  - Disagreements or uncertainty among patient/family/staff regarding goals of care
  - Family distress despite explanation
- **POCT: SPH pager 33600; MSJH pager 33951; Residential Care pager 33003**

References: Boyd K. & Murray S. British Medical Journal 2010; Weissman D., Meier D. Journal of Palliative Medicine 2011; Salpeter S. et al Am. J Medicine 2011; Salpeter S. et al J. Palliative Med. 2012; Freeman L. Curr Opin Support Pallat Care 2009; Celli R. Respiratory Medicine 2010; Crockett et al. Qual Life Res 2002; Louvet et al. Hepatology 2007; Mitchell S. et al. JAMA 2010; Fausto & Selwyn Prim. Care Clin. Off. Pract. 2011

Goals of Care Conversation

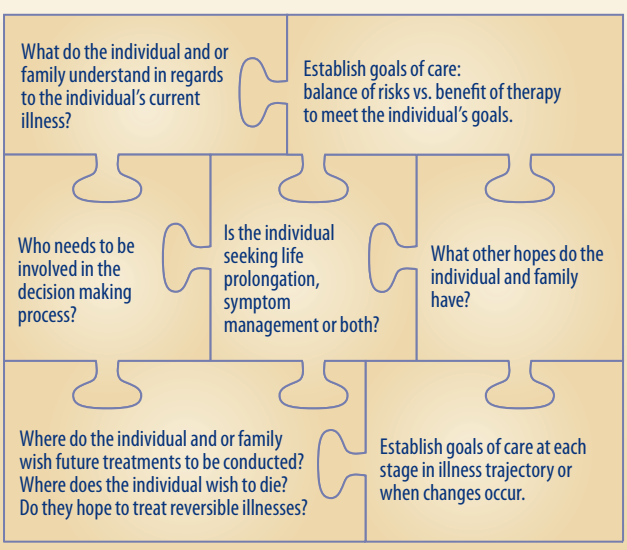
Health care team members must appreciate that not all individuals and families are looking for life prolongation when presented with a life limiting disease/diagnosis. Decisions are made based on:

- General Medical Condition
- Personality
- Life Experiences

The gold standard in Palliative Care is to establish individual and family goals of care. This involves understanding what approach to care would be consistent with the person's beliefs and values. - *PHC Palliative Outreach Consult Team & MSJH End of Life Council Feb 2012*

Goals of Care Companion

Piecing together a preference for care



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