More than Just a Prescription

Effective Discharge Planning for Palliative Patients

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A True Story

- Elderly gentleman with progressive ALS
- Referred to home PCMD
- Admitted to hospital with pneumonia before being seen
- G-tube
- *C. dificile*
- In hospital > 1 month

The True Story - continued

- PC MD gets paged Friday afternoon
- "We're discharging him today at 4 – can you see him?"

At the end of this lecture you will be able to:

- Identify palliative patients under your care who may require specialized discharge planning
- Describe how palliative patients differ from other patients (focusing on discharge planning)
- Plan and actualize a safe, effective discharge for palliative patients

Competing Interests

- none

Question 1

Which of the following conditions is the highest predictor for mortality?

A. NSR
B. Lung Cancer
C. CHF
D. Amyloidosis
E. Chronic Kidney Disease

All of the Above

What / Who is a Palliative Patient?

3 Definitions:

- OHIP
- MOH-PCU
- Patient – Centred Definition

What / Who is a Palliative Patient?

OHIP:

- 1 Year
- Palliative care billing codes not valid after 1 year

- Important for Fee for Service
- Less so for Alternate Funding Plans

What / Who is a Palliative Patient?

MOH-PCU:

- 90 days
- Some Long term PCUs up to a year

  Co-payment after 3 months

- Importance of determining prognosis

Victoria Hospice Society

Palliative Performance Scale (PPSv2)
version 2

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity *with* Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

Medical Care of the Dying, 4th ed.; p. 120. ©Victoria Hospice Society, 2006.

How do you determine prognosis?

Traditional thinking (circa 2002):

- PPS 50% - median survival 53 days
- PPS 30% - median survival 30 days

But is it my imagination or are my patients dying more quickly?

How do you determine prognosis?

Table 4
Survival Rate (%) in Days

	Survival Rate (%) in Days[a]										
PPS Score	1	3	5	7	14	30	45	60	90	180	365
PPS 80%	100	100	100	100	100	100	81	75	46	35	10
PPS 70%	100	97	96	95	94	82	76	68	57	36	12
PPS 60%	100	100	100	98	91	65	52	41	25	10	7
PPS 50%	100	97	94	91	76	57	41	33	14	4	0
PPS 40%	98	97	96	88	73	50	36	27	16	8	1
PPS 30%	97	87	71	61	48	23	22	17	11	2	0
PPS 20%	92	72	53	42	19	8	6	5	4	0	0
PPS 10%	52	33	19	13	5	0	0	0	0	0	0

[a]Shaded cells represent approximately 50% survival rates at given PPS level.

Lau, et al., *Journal of Pain and Symptom Management*: 37:6 June 2009

How do you determine prognosis?

PPS and illness trajectory:

>70%	stable disease (month to month)
40-70%	transitional (week to week)
<40%	Final stage (day to day, hour to hour)

What / Who is a Palliative Patient?

Patient-Centred Approach:

- Would you be surprised if this patient died within one year?
- Does this patient have a life threatening or life-limiting illness?

Question 2:

Given the criteria:

- Would you be surprised if this patient died within one year?
- Does this patient have a life threatening or life-limiting illness?

Which of the following patients would be considered palliative?

A. 95 year old patient admitted with pneumonia. Walks 2 km per day.
B. 85 year old male with LVEF 45% scheduled for elective knee surgery.
C. 65 year old smoker with COPD exacerbation.
D. 45 year old dialysis patient. 17% annual mortality

CIHI data

All of the Above

What / Who is a Palliative Patient?

Patient-Centred Approach:

- Does this patient have a life-limiting condition that requires special consideration in terms of discharge planning?

Identifying the "Palliative Patient"

- What factors should you look at to identify patients who may need palliative discharge planning?

Identifying the "Palliative Patient"

- Prognosis
- Mobility
- Nutrition
- Stamina
  - CHF, COPD – SOBOE
  - Cancer – easily fatigued

Identifying the "Palliative Patient"

- Effusions
  - Ascites
  - Pleural effusions
  - If drained high risk of recurrence?
- Oedema / Anasarca

Identifying the "Palliative Patient"

- What tests may be useful – Bloodwork
  - Albumin (nutrition / liver function)
  - INR (liver function)
  - Creatinine
  - Urea
  - Calcium (along with albumin)
  - Hb A_{1c}

Identifying the "Palliative Patient"

- What investigations may be useful?
  - PA/LAT – pleural effusions
  - Ultrasound – ascites
    - rule out loculations, find good needle site
  - CT – staging
  - Echo – LVEF, effusion, RVSP

Considerations in Discharge planning

Interventions that may improve patient transition from hospital to home setting:

- Clear information about prognosis and disease progression
- Education about symptom management (particularly caregivers)
- Identify who to call in case of problems

Benzar, BS, Journal of Pain and Symptom Management 2009 (June); 37:3

Considerations in Discharge planning

Investigations:

- What tests are appropriate and necessary?
- Facilitate as inpatient

Considerations in Discharge planning

Procedures:

What is appropriate in this patient?

Facilitate as inpatient

EVEN if it delays discharge

Why?

Considerations in Discharge planning

Inpatient investigations and procedures – why?

- Patient stamina – a trip will tire them out for days
- Mobility – can they ambulate?
- Cost of ambulance / wheelchair taxi
- Cost to family (days off work, injury attempting transfers)

Considerations in Discharge planning

Getting the home ready:

- What equipment is required?
  Hospital bed, W/C, commode, bath chair, etc…
- Is the equipment in the home?
- Are the services arranged?

Considerations in Discharge planning

Follow-up:

Where is this patient going?

Who will look after him/her?

FMD, Specialist, Palliative Care MD

How will you communicate with them?

Considerations in Discharge planning

Interdisciplinary approach:

- OT
- PT
- Spiritual Care
- SW
- CCAC
- PC consult service

Consult Early

Considerations in Discharge planning

Communication:

- CCAC
- Pharmacy
- MD

Considerations in Discharge planning

Communication:

- CCAC
- Pharmacy
- MD

Considerations in Discharge planning

Communication:

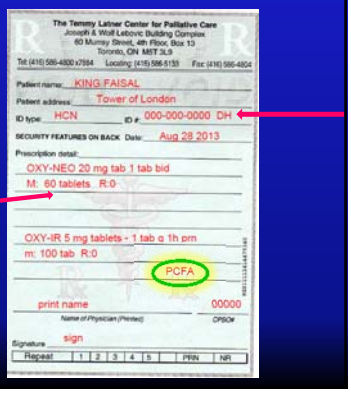
- CCAC
- Pharmacy
- MD

- Fax prescriptions
- Ensure coverage

Considerations in Discharge planning

Communication:

- CCAC
- Pharmacy



- MD

- Determine who will follow
- Contact the physician
- Referral form?

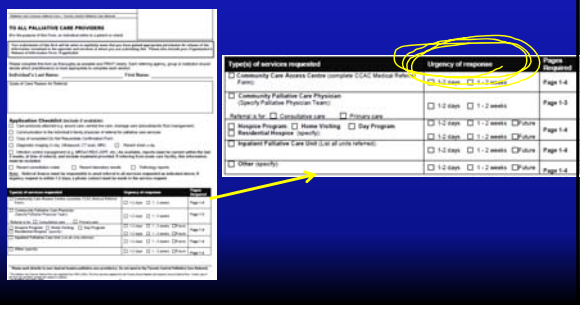
Considerations in Discharge planning

Sample referral form:

Google: "common referral form Toronto"

Common Referral Form

Toronto



Considerations in Discharge planning

Sample referral form:

Common Referral Form

Toronto

Considerations in Discharge planning

Sample referral form: Common Referral Form

Toronto

Case 1

- New referral (home PC)
- 79 YO female with ovarian cancer
- PPS 30-40%
- Presents to ER
  - Coffee ground emesis
  - Hb 70
  - Massive ascites
  - Fatigue

Case 1

What Happened:	What "might" have happened:
• Pt Dced from ER	• Admission to plan safe DC
• No equipment in the home	• Scope or PPI
• No transfusion because she was "palliative"	• Blood transfusion
• No paracentesis because "risks outweigh benefits"	• Paracentesis or drain insertion as inpatient
• Had to have abdominal drain inserted as outpatient	• Coordinated DC with rapid PC MD F/U in the home

Case 2

- 78 YO male with stage III-b lung cancer – no known mets
- Followed at home by PC MD
- Several months increasing leg weakness
- Sent to ER for rigors, found to have pyelonephritis
  - found to have kidney stone, hydronephrosis
  - Nephrostomy tube inserted
- Pt in hospital for 5 days, MRI spine – meningioma at T_{10}
- Wife told by CCAC "I hear you're going home today" - no word from medical team

Case 2

- wife told by CCAC "I hear you're going home"
- Son calls staff:
  - What about neuro-Sx opinion? "haven't heard"
  - What about hospital bed? "not arranged yet"
  - What about the kidney stone? "waiting on urology"
  - What about cancelling DC? "…ok"
- Day before DC: Medical oncology offers to get outpatient opinion from radiation oncology (not addressed by GIM)
- Day of DC: Urology will "arrange" outpatient appointment to address stone
- Medication changes not explained to family

Case 2

- PC MD attempted to contact attending team and urology team several times with no response
- DC summary, radiology reports, bloodwork not sent to PC MD (they had to be requested from medical records)
- It took 3 outpatient visits over 45 days to get the stone out

Case 2

What might have gone well:

- Timely referral as I/P to neurosurgery and Rad/onc
- Inpatient management of stone would have prevented:
  - Three trips by wheelchair-bound patient to hospital
  - Total of 5 work days missed by family members
  - Hours of sitting on wheelchair cushion in O/P clinics
- Ongoing communication with PCMD and appropriate transfer of medical records

Take home messages

- Identify palliative patients who may need special consideration in discharge planning
- Complete investigations and treatment in hospital
- Avoid numerous outpatient appointments
- Communicate effectively with families and care providers

Palliative Patients

- "The good physician will treat the disease, but the great physician will treat the patient."

  - Sir William Osler, MD

- "Good palliation and good medicine are symbiotic, you can't have one without the other."

  - Hershl Berman, MD

At the end of this lecture you can:

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Questions?