Out of Sight – Not out of Mind

Effective Discharge Planning for Palliative Patients

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Outline

- Identifying "Palliative" patients
- Considerations in discharge planning
- Local Issues

• none

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

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		Pa	lliative Perform	ance Sca	version 2
PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Leve
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
5010	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				

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?

				S		Table 4 Late (%)	in Day	¥.			
	· · ·					vival Rate in Days ⁴					
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	46 57	36	12
PPS 60%	100	100	100	98	91	65	52 41	41	25	10	7
PPS 50%	100	97	.94	91	76	100	41	33	14	4	0
PPS 40%	98	97	96	88	73	65 50	36	27	16	8	1
PPS 30%	97	87	71	203	10	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

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

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 Communication:

- CCAC
 Pharmacy
- MD

Considerations in Discharge planning

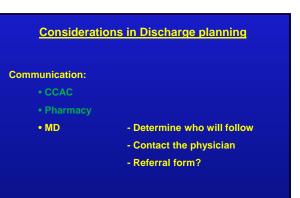




Communication:

- Pharmacy
- Fax prescriptions
- Ensure coverage





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Sample ref	erral foi	rm:	Common Referral	Form	
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Considerations in Discharge planning Sample referral form: **Common Referral Form** Addrese: ______ Apt: _____ End less Alore [] Toury Children II the Hume [] Environ Ten Hume [] Code:

Home phone mandaet	Alternate rearder:
Date of tartic powerve	Gender: Fath/Enigiers
Health card rembet:	Version code:
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Considerations in Discharge planning

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Ary additional information:
Please include relevant reports!

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:
- Pt Dced from ER
- No equipment in the home
- No transfusion because she was Blood transfusion "palliative"
- No paracentesis because "risks outweigh benefits"
- Had to have abdominal drain inserted as outpatient
- What "might" have happened:
- Admission to plan safe DC
- Scope or PPI
- Paracentesis or drain insertion as inpatient
- 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 T₁₀
- 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? + What about delaying DC? "waiting on urology" "...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

Considerations in Discharge planning

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- 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

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:

- 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