Screening Criteria to Find Unmet Palliative Care Needs

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Learning Objectives

- Describe common patient or disease based consultation criteria in both ICU and non-ICU settings
- List pros and cons to using patient or disease-based criteria for palliative care consultations
- Describe key steps for integrating consultation criteria into a system-wide effort to improve primary palliative care

Why Develop Criteria?

- Improve patient/family outcomes
  - Symptoms, communication, support, disposition, satisfaction
- Reduce variation in care
  - Equal access to all services
  - Improve satisfaction/reduce cost
- Make palliative care part of a systems-based approach to care
  - Making it routine, rather than “special”
- Culture change

The Problem

Palliative care teams face many “late referrals” or never see patients with …

- Multiple co-morbid conditions and declining function
- Difficult-to-control physical or psychological symptoms
- Long length-of-stay, especially in the ICU

Why?

A. Attitudes/values among referring clinicians:

- Negative association of palliative care with end-of-life care and hospice
- Fear of provoking, and then needing to respond to patient/family emotions
- Peer/Family pressure; fear of not “doing everything”

B. The clinicians experience with the palliative care team

- Helpful to the clinician, or not
- Respectful/collegial, or not

C. Training Gap

- Failure to recognize uncontrolled symptoms, poor prognosis, family distress.

What would the ideal system look like?

A more patient-centered approach would be to design a system where referrals are based on ***patient and/or disease factors***, rather than clinician attitudes/values.

- Patients are fully informed about treatment options.
- Patients have equal access to all hospital resources.
- Patients receive only the life-sustaining treatments they desire/are appropriate to their medical condition/prognosis.

What does change look like?

A *risk assessment pathway* to indentify patients who are most likely to have palliative care needs based on . . .

Disease variables	Patient variables
• End stage renal disease • Parkinson's • Relapsed acute leukemia	• More than 2 hospitalizations within 3 months • Weight loss of more than 10% of body weight • ICU length of stay greater than 4 days

Common screening programs

- All admissions *
- ICU
- Emergency department
- Oncology clinic
- Special populations
  - LVAD/CHF
  - Nursing home admits
  - PEG or tracheostomy consideration

*__Source:__ Weissman DE and Meier DE. Identifying patients in need of a palliative care assessment in the hospital setting: consensus recommendations. J Pall Med 2011;14:1-7.

ICU triggers—common examples

- Length of stay
- Multi-organ failure
- Metastatic cancer
- Prolonged unconsciousness
- Nursing home admission

Sounds easy, but . . .

Implementation is challenging:

- Getting the data that demonstrates that change is needed
- Obtaining buy-in of key stakeholders
- Mapping out a work plan that staff can accomplish along with their other duties
- Predicting the impact of change on the palliative care team
- Imagining the unintended consequences of change

Decision Points

1. **Why do you want to adopt a trigger system?**

- Increase palliative care referrals?
- Address the needs of a defined population (e.g. LVAD, BMT)?
- Meet an identified problem from institutional leadership?
- Better integrate palliative care as part of routine care for all patients?

Key Questions

2. Is the palliative care team staffed to manage an increase in referrals?

- Does a screening system fit within team's mission and strategic plan?
  - Projected clinical/staffing growth and financial support
    - ✓ Is there buy-in from the palliative care team?
    - ✓ What is the level of stress/burnout on the team?

Key Questions

3. Is there buy-in from target stakeholders (e.g. ICU director)?

- Do you have data demonstrating a problem in need of fixing?

✓ Care variation/excess LOS/cost

- Can a trigger system help the stakeholder?

✓ Improve mortality stats/reduce ED diversion

Key Questions

4. What are the best triggers?

– Little data to define the “best”
  - ✓ Use common sense
  - ✓ Develop collaboratively with stakeholders

Key Questions

5. One step process of two?

- Trigger to palliative care consult vs.
- Trigger to triage (e.g. chart review) to palliative care consult vs. other schema
- If triage, who will do?
  - ✓ Palliative care team member, discharge planning staff, other?

Pitfalls

4. Little buy-in from target stakeholders
    4. Trigger systems are perceived as loss of control by clinicians
- Poor projection of added workload
- Excessive false positives
- Adds to work of others
- Dumping of primary palliative care duties onto
- palliative care specialists

A conundrum

4. For the foreseeable future there will not be enough specialist palliative care clinicians to manage all the palliative care needs.

Estimate of hospice and palliative medicine physician workforce shortage. AAHPM. J Pain and Symptom Management; 2010, 40:899-911.

- Triggers that only serve to increase referrals for already overworked specialist palliative care clinicians will only make this worse.

A different approach to triggers . . .

4. Identify patients at greatest risk of unmet palliative care needs on admit and daily during stay.

- Standardize/improve assessment/documentation and basic palliative care management skills by primary clinicians (nurse, social worker, chaplain, physician).
- Reserve specialist palliative care for complex problems.

CAPC Consensus Workgroup

Interdisciplinary workgroup first convened in 2008 to develop consensus around important aspects of palliative care program administration.
2010 Project: *Triggers for Palliative Care Assessment*

Weissman DE and Meier DE. *Identifying patients in need of a palliative care assessment in the hospital setting. J Pall Med, Jan 2011*

Available as ePub at www.CAPC.org

Click (on the left menu) Tools for Palliative Care Programs/National Palliative Care Guidelines/Primary Palliative Care Trigger Criteria (CAPC Consensus)

Primary Palliative Care Assessment

Pain/Symptom Assessment

4. *Are there distressing physical or psychological symptoms?*

Social/Spiritual Assessment

- *Are there significant social or spiritual concerns affecting daily life?*

Understanding of illness/prognosis

- *Does the patient/family/surrogate understand the current illness, prognostic trajectory, and treatment options?*

Primary Palliative Care Assessment *(continued)*

Identification of patient-centered goals of care

4.What are the goals for care, as identified by the patient/family/surrogate?

○Are treatment options matched to informed patient-centered goals?

○Has the patient participated in an advance care planning process? Has the patient completed an advance care planning document?

Transition of care post-discharge

- *What are the key considerations for a safe and sustainable transition from one setting to another?*

Primary Palliative Care Triggers
On Admission
Consensus Recommendations

A potentially life-limiting or life threatening condition AND one of the following…

- The ‘Surprise’ question
- Frequent admissions
- Difficult to manage symptoms
- Complex care requirements
- Decline in function or weight

Secondary Criteria

4. Admission from long-term care facility or medical foster home
5. Elderly patient, cognitively impaired, with acute hip fracture
6. Metastatic or locally advanced incurable cancer
7. Chronic home oxygen use
8. Out-of-hospital cardiac arrest
9. Current or past hospice program enrollee
10. Limited social support (e.g. family stress, chronic mental illness)
11. No history of completing an advance care planning discussion/documentation

Primary Palliative Care Triggers
Daily Checklist
Consensus Recommendations

4. The ‘Surprise’ question
5. Difficult to control symptoms
6. ICU LOS > 1 week
7. Lack of *Goals of Care documentation*

- Disagreement/uncertainty re:
  - Major medical decisions
  - Resuscitation preferences
  - Use of non-oral feeling/hydration

Secondary Criteria

4. Awaiting, or deemed ineligible for solid-organ transplant

- Emotional, spiritual, or relational distress
- Request for palliative care/hospice services
- Patient is considered a potential candidate, or medical team is considering seeking consultation for:
  - Feeding tube placement
  - Tracheostomy
  - Initiation of renal replacement therapy
  - Ethics consultation
  - LVAD or AICD placement
  - LTAC hospital or medical foster home disposition
  - Bone marrow transplantation (high risk patients)

Necessary Supporting Features

4. Patient/Family education resources
5. EMR Integration: Triggers and Assessment Tools
6. Standards and Policies re: assessments
   - Who does what? When? With what tools?

- QI/Metrics to Monitor Impact
- Staff Education

- Primary palliative care assessment principles

- Triggers for *Specialist Palliative Care Referral*

Take the long view

4. Developing triggers simply to increase referrals for consults is a short-term approach to a much larger systemic problem.

- Try to develop a trigger system that will help bring about a change in the *culture* of practice within your setting, that is not entirely dependent on the skills of specialist palliative care providers.
- Major culture change requires a good understanding of the *process of change.*

Pay Attention to the Process!

Educate yourself about change:

4. IHI Open School: http://www.ihi.org/lms/onlinelearning.aspx

- Kotter J. *Leading Change. 2nd ed.*
- Rogers EM. *Diffusion of Innovation. 5th ed.*
- Christensen C. *The Innovator's Prescription*

Summary & Conclusions

4. Trigger based consultations can be used for one or more reasons to improve patient/family care.
5. Palliative care teams should do a thorough needs assessment to determine the appropriate rationale and type of system that best matches the needs of patients/families/providers within their institutional culture.
6. A system-wide program of early patient identification and better utilization of primary palliative care resources may help focus palliative care specialist resources for truly specialized problems.

References

4. von Gunten CF. Secondary and tertiary palliative care in US hospitals. JAMA 2002 20;287:875-881.

- Weissman, DE. Consultation in Palliative Medicine. Arch Int Med 1997;157:733-737.
- Moss A, Ganjoo J, Sharma S, Gansor J, et. al. Utility of the “Surprise” Question to Identify Dialysis Patients with High Mortality. Clin J Am Soc Nephrol 2008;3:1379-1384.
- Lupo D et al. Estimate of current hospice and palliative medicine physician workforce shortage. JPSM 2010;40:899-910.