# Palliative Care in PALTC

MMDA Annual Meeting 2021

Stefan David MD, CMD and Ravi Passi MD, FACP, CMD

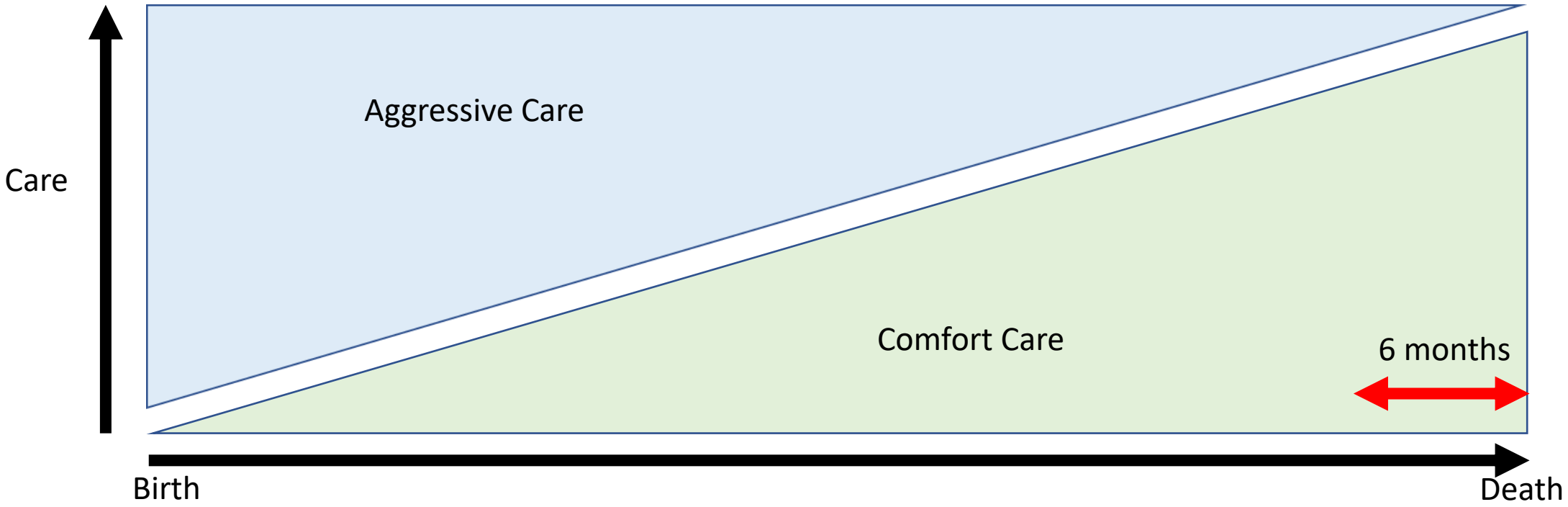
# No Disclosures

# Objectives:

Case based spiritual & religious considerations**, did it take a pandemic – COVID 19 to discuss Palliative & Hospice care?**

- Discuss spiritual & religious beliefs in providing palliative/hospice care
- During the COVID 19 crisis palliative & hospice care discussions were more prominent should we be doing the same in non- pandemic times
- Strategies for continuum of Palliative & Hospice care after transition from acute to post acute care

# Palliative Care and … Hospice



# Hospice Site of Care

Ideally at home

If Patient needs are not met … facility

Or Hospital /Inpatient hospice unit for acute needs

*Can I see him/her?*

*Will you take him/her away?*

*Costs?*

*Who is the palliative care provider at MD/NP level?*
*Credentialing?*
*Continuity of care from home/acute site?*

*What if this would be the last opiate dose administered?*
*Dual Effect*

# Hospice - Payment Mechanism

Medicare Paying for Hospice/End of Life Care

…not custodial care.

# Hospice care

- 25% of Eligible patients for hospice actually enrolled in hospice
- Average time spent in hospice is 3 weeks
- Barriers to Hospice or Palliative care: poor patient or family/ staff acceptance, billing issues, negative perception, shortage of trained & certified hospice teams.

# Stake Holders /Whom Do We Serve?

| | |
|---|---|
| Patient | Family |
| System | Provider |

# SPIKES:

- Setting
- Perception
- Invitation/Information
- Knowledge
- Empathy
- Summarize
- Strategize

# COVID19

Patient:
Suffering/Alone/Afraid

Family
Limited access

System
Transitions of care, medication ( nebs)

Provider
Strain, Burnout

*Any additional resources*

# Case 1

Mr. H is a 67 yr. OM with h/o progressive ALS and has been residing in LTC since July, 2019 his

MOLST on admission revealed that he was a “Full Code” with all measures. He also has a h/o hypertension & asthma that are under good control. He had a PEG placed in June, 2019 before being moved to SNF/LTC for nutritional support and administration of medications. His condition and prognosis have now changed, the resident no longer can make decisions. We have had a couple of meetings with the family to discuss Palliative/Hospice care, they now present an advanced directive & POA papers which they recently “found” at home and it states that Mr. H did not wish to have a feeding tube, artificial nutrition or hydration and wished to be DNR, DNI. The family & POA are resistant to stopping the PEG feedings and changing his code status and starting Palliative care.

Q: If this family came to you for spiritual/religious counselling how would you guide them ?

# Case 2

Mr P is a 84 yr OM with PMH of CAD, A Fib, HTN, COPD, DVT, Lower GI bleed, MGUS, initially followed in the Elder Medical Care Program House Call Program due to ambulation deficit.

He is Christian, he was a marine, had 2 marriages, 2 children – one of which is LGBTQ.

He gets admitted in the hospital, spouse has an arm fracture. He subsequently goes back and forth between hospital and nursing facilities with multiple problems including  urinary retention (suprapubic catheter placed),  toe osteomyelitis…

His wife ultimately just wants to bring him home with Hospice.

She gave him the chance to reconcile with his child.

…What did we miss?

# Questions:

# Thank you!!!