A Review of the Recently Updated Clinical Practice Guidelines for Quality Palliative Care

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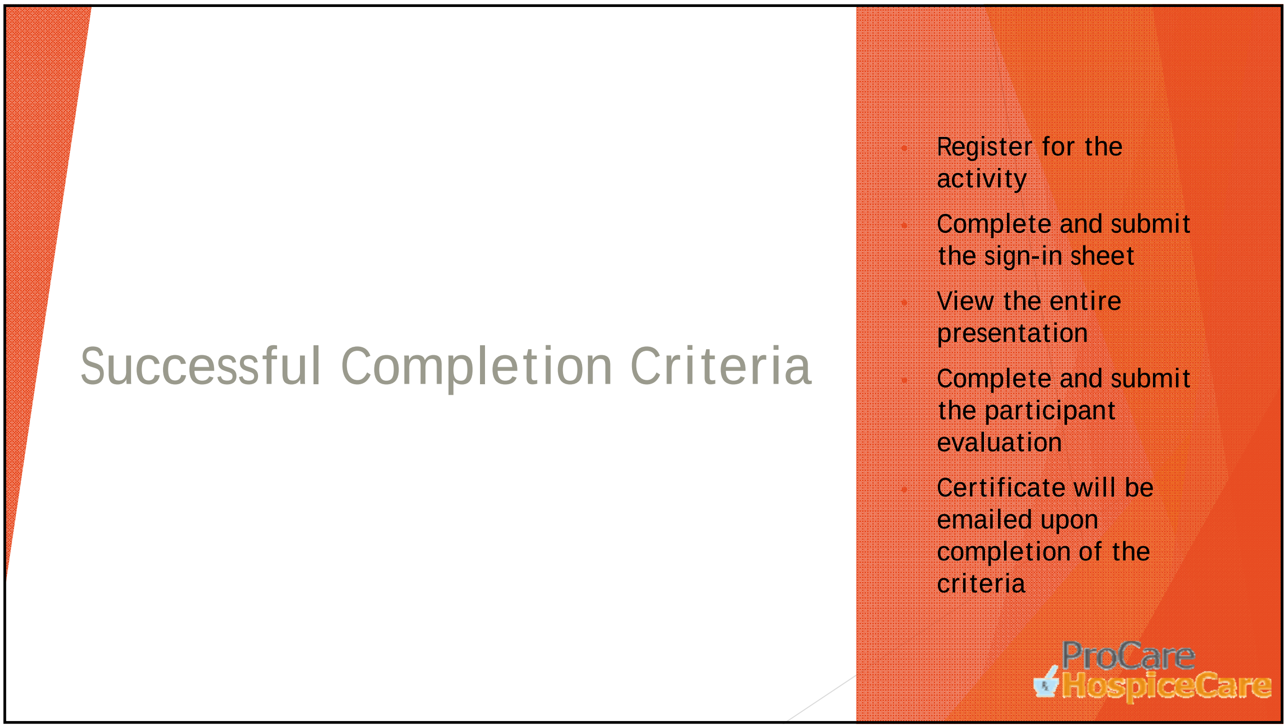

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Objectives

- Explore the eight domains that comprise the recently updated guidelines
- Summarize the recommendations for each of the eight domains
- Identify the key updates to each of the eight domains
- Apply the updated guidelines to three clinical case studies

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Assess Your Knowledge

True or False?

The clinical practice guidelines for quality palliative care only apply to clinicians that specialize in hospice and palliative care.

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Background

- In 2001, leaders gathered to discuss the development of consensus guidelines for quality palliative care
- In 2004, the first edition of the National Consensus Project's Clinical Practice Guidelines for Quality Palliative Care (NCP Guidelines), which described core concepts and processes and identified eight domains of practice, was published
- The NCP Guidelines were updated in 2009 and again in 2013
- In 2018, the NCP Guidelines were updated yet again with the goal of improving access to quality palliative care for all people with serious illness regardless of setting, diagnosis, prognosis, or age. The update also encourages a collaborative approach among all clinicians across the care continuum to integrate palliative care principles and best practices.

How to Use the Guidelines

- Intended to help all clinicians and care settings improve access to and quality of palliative care
- Best available data reflected at the time of publication but not a substitute for professional judgment, and adherence to these guidelines will not ensure successful treatment in every situation
- Divided into introductory materials, eight domains with guidelines and ancillary materials for each, and several appendices (glossary, tools and resources, contributors, scoping review, and endorsing and supporting organizations)

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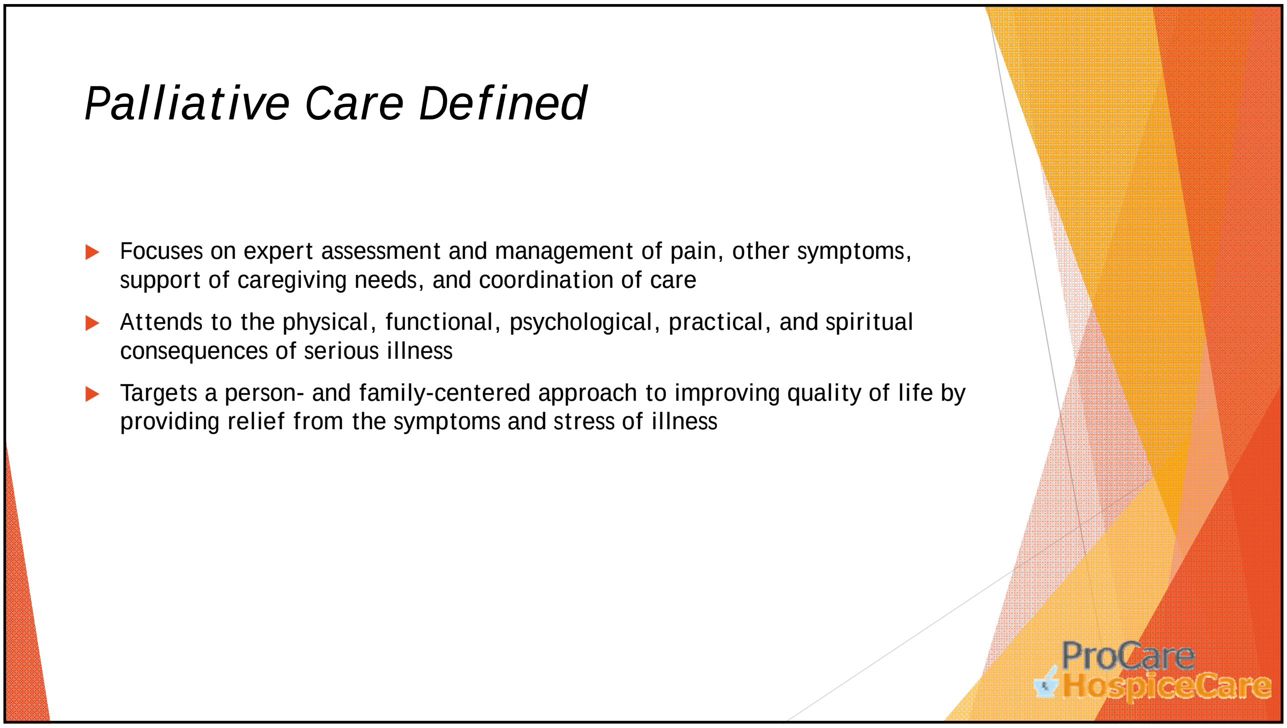
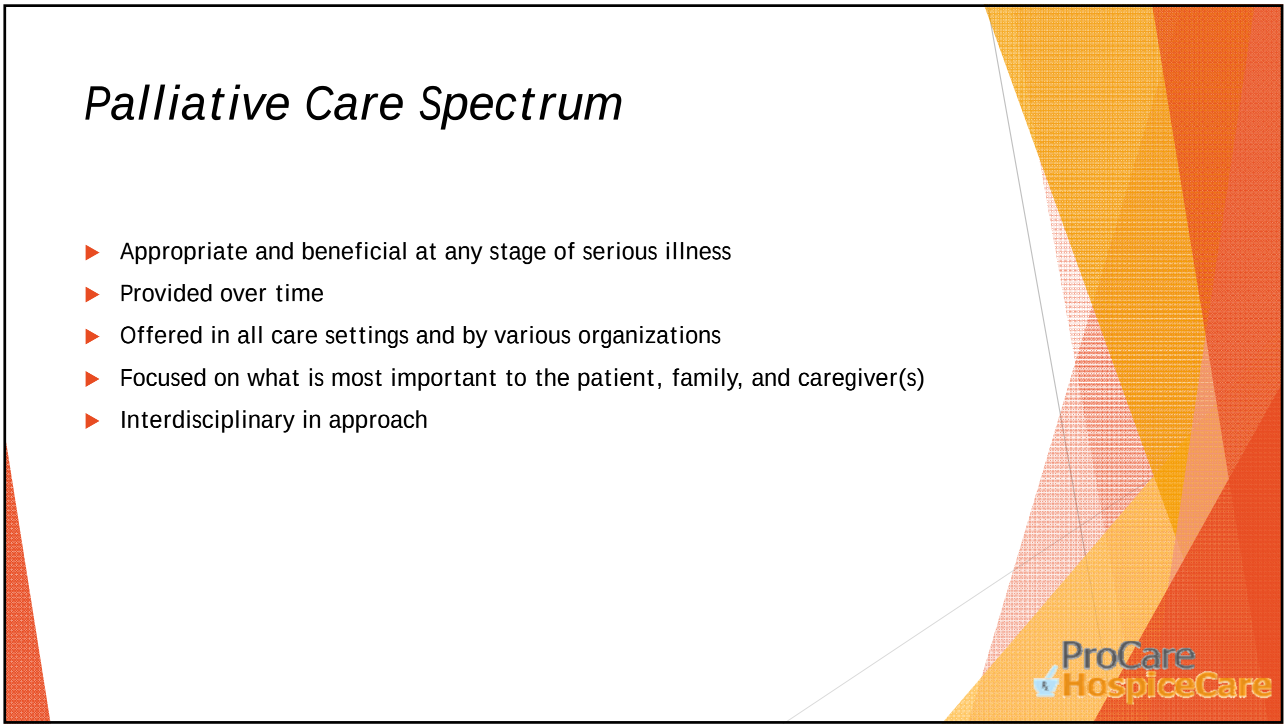


Palliative Care Defined

- Focuses on expert assessment and management of pain, other symptoms, support of caregiving needs, and coordination of care
- Attends to the physical, functional, psychological, practical, and spiritual consequences of serious illness
- Targets a person- and family-centered approach to improving quality of life by providing relief from the symptoms and stress of illness



Palliative Care Spectrum

- Appropriate and beneficial at any stage of serious illness
- Provided over time
- Offered in all care settings and by various organizations
- Focused on what is most important to the patient, family, and caregiver(s)
- Interdisciplinary in approach

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Domain 1: Structure and Processes of Care

- 1.1 Palliative care principles integrated into all appropriate health care settings, delivered by all clinicians, and supported by specialists as part of an *interdisciplinary team (IDT)*
- 1.2 Interdisciplinary *comprehensive palliative care assessment* of the patient and family forms the basis for the development of an individualized plan
- 1.3 Develop, implement, and update a *palliative care plan* in collaboration with the patient and family to anticipate, prevent, and treat physical, psychological, social, and spiritual needs
- 1.4 Defined processes to ensure access, quality, and *continuity of palliative care*, especially during transitions of care
- 1.5 Continuity of palliative care throughout illness trajectory and across all *care settings*

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Domain 1: Structure and Processes of Care, continued

- 1.6 *Interdisciplinary team education*, training, and professional development provided for the IDT
- 1.7 *Coordination of care and care transitions* anticipated, planned, and coordinated
- 1.8 *Emotional support to the IDT*
- 1.9 Develop, implement, and maintain a data-driven *continuous quality improvement* plan focused on patient- and family-centered outcomes
- 1.10 Secure funding for long-term *stability, sustainability, and growth*

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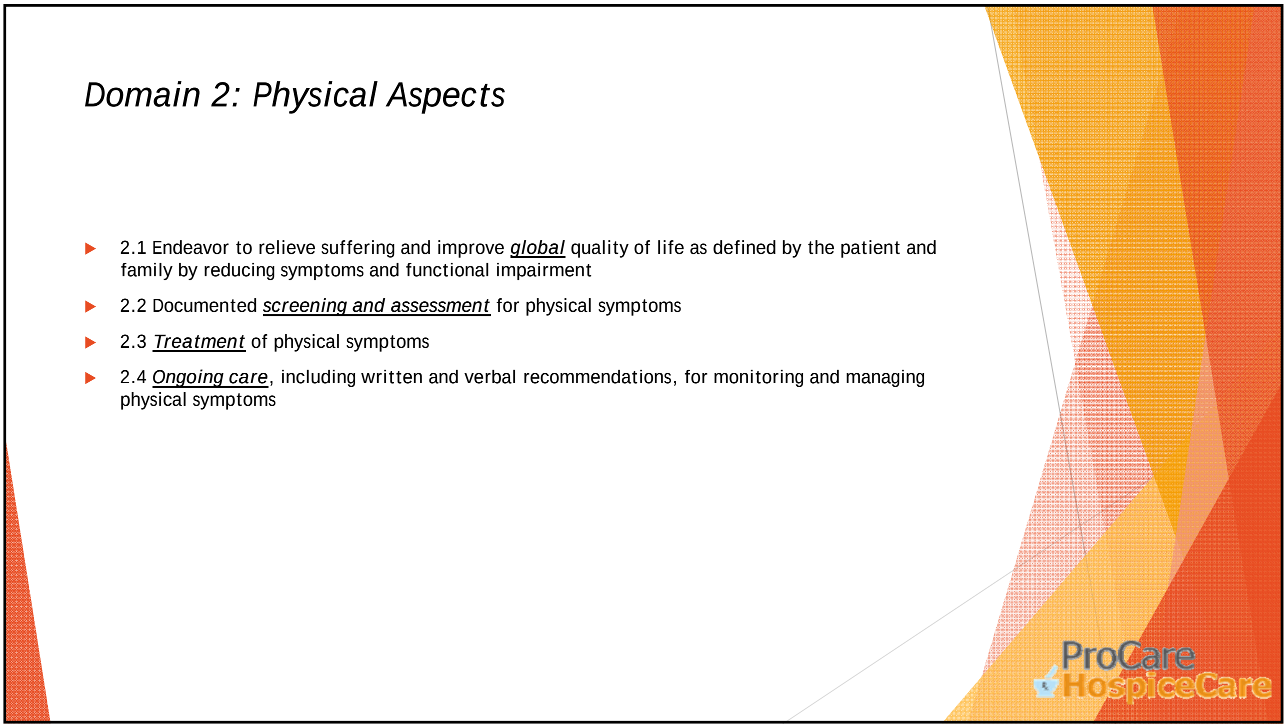
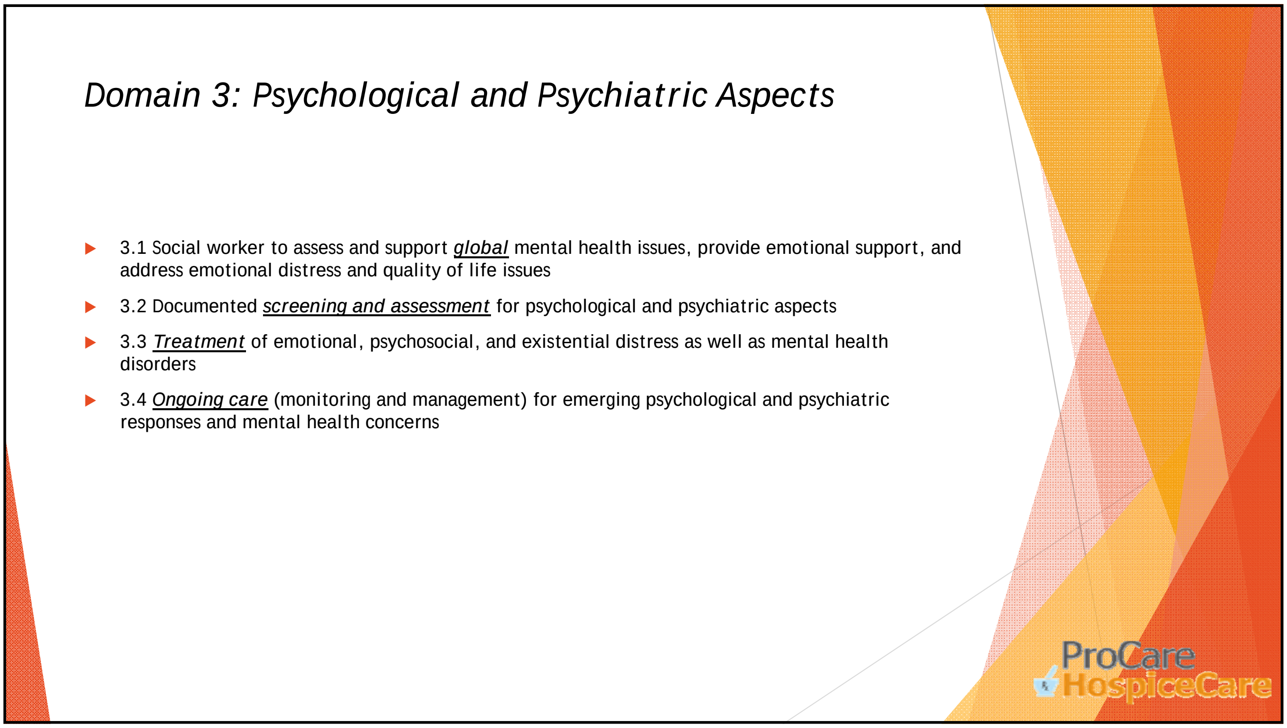


Domain 2: Physical Aspects

- 2.1 Endeavor to relieve suffering and improve *global* quality of life as defined by the patient and family by reducing symptoms and functional impairment
- 2.2 Documented *screening and assessment* for physical symptoms
- 2.3 *Treatment* of physical symptoms
- 2.4 *Ongoing care*, including written and verbal recommendations, for monitoring and managing physical symptoms



Domain 3: Psychological and Psychiatric Aspects

- 3.1 Social worker to assess and support *global* mental health issues, provide emotional support, and address emotional distress and quality of life issues
- 3.2 Documented *screening and assessment* for psychological and psychiatric aspects
- 3.3 *Treatment* of emotional, psychosocial, and existential distress as well as mental health disorders
- 3.4 *Ongoing care* (monitoring and management) for emerging psychological and psychiatric responses and mental health concerns

Domain 4: Social Aspects

- 4.1 Identify and address the *global* social factors that affect patient and family quality of life and well-being
- 4.2 Documented *screening and assessment* of patient and family social supports, social relationships, resources, and care environment
- 4.3 *Treatment* of social aspects (social services)
- 4.4 *Ongoing care* to address the social aspects of care

Domain 5: Spiritual, Religious, and Existential Aspects

- 5.1 Address and respect the *global* spiritual beliefs and practices of the patient and family
- 5.2 Documented *screening and assessment* (spiritual screening, spiritual history, and a full spiritual assessment) of the patient and family
- 5.3 *Treatment* of spiritual needs of the patient and family
- 5.4 *Ongoing care* to address the spiritual care needs of the patient and family

Domain 6: Cultural Aspects

- 6.1 Deliver care that respects the patient and family's *global* cultural beliefs, values, traditional practices, language, and communication preferences and builds upon the unique strengths of the patient and family
- 6.2 Support the patient and family's preferred style of *communication and language*
- 6.3 Documented *screening and assessment* of patient and family's cultural preferences regarding healthcare practices, customs, beliefs and values, level of health literacy, and preferred language
- 6.4 *Treatment* follows a culturally sensitive plan of care that reflects the degree to which the patient and family wish to be included

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Domain 7: Care of the Patient Nearing the End of Life

- 7.1 *IDT* includes professionals with training in end-of-life care, including symptom management, communicating with patients and families about signs and symptoms of approaching death, transitions of care, and grief and bereavement
- 7.2 Documented *screening and assessment* of physical, psychological, social, and spiritual needs as well as patient and family preferences for care setting, treatment decisions, and wishes during and immediately following death
- 7.3 Develop, implement, and update a *treatment plan prior to death*
- 7.4 *Treatment during the dying process and immediately after death* respects and supports the patient and family's needs and requests
- 7.5 *Bereavement* support is available to the family and care team

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Assess Your Knowledge

Matching

Autonomy	A. Making decisions on the patient's behalf based on the patient's beliefs and values
Substituted judgment	B. Allowing or enabling patients to make their own decisions
Beneficence	C. Practicing fundamental ethical, legal, and regulatory principles
Justice	D. Treating to provide maximum benefit
Nonmaleficence	E. Doing no harm intentionally

Domain 8: Ethical and Legal Aspects

- 8.1 *Global* provision of core ethical provisions (autonomy, substituted judgment, beneficence, justice, and nonmaleficence)
- 8.2 Provision of palliative care in accordance with federal, state, and local *legal considerations* and current standards of care and professional practice
- 8.3 Documented *screening and assessment* of patient's preferences and goals for care using core ethical principles
- 8.4 *Treatment and ongoing decision-making* based on the person-centered goals and plan of care within the limits of applicable state and federal laws, current accepted standards of medical care, and professional standards of practice

Key Updates

- Domain 1 - Structure and Processes of Care: coordination of care emphasized, new content on sustainability added
- Domain 2 - Physical Aspects: tools to assess and manage pain and other symptoms highlighted, impact of functional status on quality of life emphasized
- Domain 3 - Psychological and Psychiatric Aspects: responsibilities of the social worker, allied clinicians, and entire care team strengthened, grief and bereavement differentiated
- Domain 4 - Social Aspects: assessment of social supports, relationships, practical resources, safety, and appropriateness of the care environment described

Key Updates, continued

- Domain 5 - Spiritual, Religious, and Existential Aspects: responsibility of all clinicians to assess and respond to spiritual needs of patients outlined, need for training for spiritual care providers emphasized, flexible approaches to ensuring adequate spiritual support described
- Domain 6 - Cultural Aspects: elements of cultural assessment outlined, influence of culture within families delineated, specific attention to the role of the child or adolescent in treatment decisions identified, conscious practice of cultural humility emphasized
- Domain 7 - Care of the Patient Nearing the End of Life: title changed (from “at the End of Life”), importance of changing needs reflected, bereavement guideline expanded
- Domain 8 - Ethical and Legal Aspects: ethics described and integrated, surrogate obligation to represent the patient’s preferences (not the surrogate’s) duly noted

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Test Your Knowledge

Multiple Choice

When appropriate, the guidelines recommend quality palliative care:

A. for all patients
B. across all care settings
C. throughout the entire illness trajectory
D. all of the above

Case Study 1: Mrs. E. Z.

- Problem: esophageal cancer with liver mets and ascites, having increasing difficulty swallowing medications (spironolactone tablets, oxycodone ir tablets, senna-s tablets, gabapentin capsules, simvastatin tablets, multivitamin tablet, and ferrous sulfate tablets), patient's husband prefers to handle medications still despite limited mobility himself
- Setting: at home, receiving at-home hospice care
- Solution: spironolactone tablets increased, gabapentin and senna-s changed to liquids, spironolactone and oxycodone ir placed in individually marked baggies for the husband to crush, and multivitamin, simvastatin, and ferrous sulfate discontinued

Case Study 2: Mr. E. T.

- Problem: prostate cancer with liver mets and gross ascites and develops difficulty eating with “annoying hiccups” and “painful ascites” one to two times a month despite adjusting diuretics and optimizing medications, patient refuses tube placement, newest symptom is insomnia several nights a week
- Setting: at home, receiving full at home health services (full code)
- Solution: in-home paracentesis visit scheduled every two weeks, baclofen added to manage hiccups, hospice “spirit and goals” information session provided for patient and family, insomnia resolved once pain and hiccups resolved as they were the underlying cause

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Case Study 3: Mr. O. H.

- Problem: patient speaks only Spanish and is planning to move back home, current daytime caregiver is the patient’s daughter that speaks Spanish and English but nighttime caregiver is a relative that speaks only Spanish, hospice nurse assigned speaks only English
- Setting: in assisted living, preparing to go home within a week for at-home hospice care to pass away in the comfort of his own home
- Solution: family counseled before location change regarding the importance of an overlapping communication plan (in person or by phone), and qualified translator provided by phone when necessary

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Questions?

- Thank you!
- Any additional questions: bgillis@procarerx.com