RESPIRATORY THERAPISTS ROLE IN END OF LIFE CARE FOR THE PULMONARY PATIENT

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PRESENTATION GOALS

• Define palliative care
• Define hospice care
• Discuss pulmonary/hospice criteria
• Identify ways respiratory therapists can help improve the quality of life for those individuals with end stage lung disease.
• Provide ways and resources RTs can assist families, physicians, health care providers and the community in development of individuals plan of care for those with life-limiting pulmonary disease.

"We have to concern ourselves with the quality of life as well as its length."

- Dame Cicely Saunders
WHAT IS PALLIATIVE CARE?
• Palliative care (from Latin palliare, to cloak) is the medical specialty focused on improving overall quality of life for patients and families facing serious illness. Emphasis is placed on pain and symptom management, communication and coordination of care.
• Palliative care is provided by a team of professionals working together with the patient, family, caregivers and primary doctor. It is appropriate at any point in a serious illness and can be provided while seeking aggressive treatment of disease.

WHAT IS PALLIATIVE CARE?
• Palliative care relieves symptoms such as pain, shortness of breath, fatigue, constipation, nausea, loss of appetite and difficulty sleeping. It helps patients gain the strength to carry on with daily life. It improves their ability to tolerate medical treatments. And it helps them better understand their choices for care.
• Often, patients can receive non-hospice palliative care in the hospital through a Palliative Care program.
• Palliative care can also be provided through Palliative Care clinics.
• Some treatments and services are covered by Medicare and Medicaid as well as insurance programs. Reimbursement should be verified for specific patient needs.

WHAT IS HOSPICE CARE?
• Hospice care (from the Latin term hospes, a word which referred both to guests and hosts) focuses on improving the quality of life for patients and families facing a life-limiting illness.
• Primary goals of hospice care: to provide comfort; relieve physical, emotional and spiritual suffering; and promote the dignity of terminally ill persons.
• Hospice care neither prolongs nor hastens the dying process.
• Care is palliative (not curative) to control pain and symptoms associated with the terminal illness.
WHAT IS HOSPICE CARE?

• Hospice treats the whole person, not just the disease.
• It focuses on the needs of both the patient and the family.
• Care is provided by an interdisciplinary team.
• Hospice addresses patient and family needs such as:
  • pain and symptom management
  • emotional, psychosocial, and spiritual support
  • help with funeral planning and arrangements
  • bereavement for family/caregivers after the patient’s death
• Where is hospice care provided?
• Who pays for hospice care?

WHAT IS HOSPICE CARE?

• Hospice care is a philosophy or approach to care rather than a place.
• Care may be provided in a person’s home, nursing home, hospital, or independent facility devoted to end-of-life care.
• Hospice was originally designed to be a non-institutional benefit. However, it is possible to receive Medicare covered hospice care while residing in a nursing facility.
• There is a Medicare hospice benefit for Medicare part A beneficiaries

WHEN IS HOSPICE APPROPRIATE?

End-stage pulmonary diseases should have both 1 and 2 to qualify for hospice care. 3, 4, and 5 support diagnosis and prognosis of 6 months or less.

• 1. Disabling dyspnea at rest / poorly or unresponsive to bronchodilators resulting in decreased functional capacity (bed to chair existence/fatigue/cough, FEV1 <30% of predicted - not necessary to obtain)
  • AND
  • 2. Progression of end stage pulmonary disease as evidenced by increasing visits to ER or hospitalization for pulmonary infections and/or respiratory failure or increasing MD home visits (decrease in FEV1 >40mlyr is evidence of disease progression – not necessary to obtain)
PULMONARY HOSPICE CRITERIA, CONT.

- 2. ______ Hypoxemia at rest on room air as evidenced by pO2 <55mmHg OR
- ______ Oxygen saturation <88% on supplemental O2 OR
- ______ Hypercapnia as evidenced by pCO2 >50mmHg within 3 months
- 3. ______ Cor pulmonale
- 4. ______ Unintentional progressive weight loss >10% of body weight over past 6 months
- 5. ______ Resting tachycardia >100/min

PULMONARY HOSPICE CRITERIA, CONT

- Non-disease specific guidelines to be used in conjunction with above criteria (both A and B should be met)
  - A. Decline in Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) <70% (See back)
    - Click here for KPS ______
    - Click here for PPS ______
  - B. Must be dependent on 2 or more of the following ADLs
    - Feeding _____ Ambulation _____ Continence _____
    - Transfer _____ Bathing _____ Dressing _____

PULMONARY HOSPICE CRITERIA

- Other ______
- Co-morbid conditions:
  - COPD _____ CHF _____ Ischemic heart disease _____
  - Diabetes mellitus _____ Neurologic dx _____ Renal failure _____
  - Liver disease _____ Neoplasia _____ AIDS
COPD

- Chronic Obstructive Pulmonary Disease (COPD) causes approximately 726,000 hospitalizations per year.
- COPD is now the 3rd leading cause of death in the United States.
- Average cost of hospitalization for COPD: $18,975, excluding professional fees.
- Of those who receive hospice services only 3-7% have a primary admitting diagnosis of COPD. Approximately 20% of those individuals graduate from hospice.
- Average hospice patient lives 29 days longer than those not receiving hospice (non disease specific)

LUNG CANCER

- Lung cancer is the leading cancer killer in both men and women in the United States.
- In fact, more people die from lung cancer than colon, breast and prostate cancer.

KEY COMPONENTS FOR PULMONARY HOSPICE MANAGEMENT

- In order to meet the unique needs of the pulmonary patient and their families, following are key considerations that should be addressed by the healthcare team as well as hospice care team once patient is accepting hospice services.
KEY COMPONENTS CONT.

- Patient and family understanding of the exact nature of the specific lung disease.

- Discussions with patient and family regarding end-of-life wishes in regards to, but not limited to:
  - Hospitalizations
  - Use of medications such as antibiotics
  - DNR/DNI status

INHALED MEDICATIONS

- Symptom management via inhaled medications for those suffering from respiratory diseases such as asthma or COPD requires ongoing assessment of:
  - Effectiveness of inhaled medication.
  - Ability of patient or caregiver to properly administer medication.

INHALED MEDICATION DEVICES

- Is the patient using a spacer with their inhaler?

- If not using a spacer, what are the barriers?

- If patient/caregiver unable to coordinate medication delivery via an inhaler with a spacer, then a nebulizer should be considered.
BREATHING TECHNIQUES

• Managing shortness of breath is related in all the key components of management of the symptoms of lung disease.

• Using breathing techniques such as pursed lip breathing and potentially diaphragmatic breathing should be considered in conjunction with other therapies.

AIRWAY CLEARANCE

• As RTs we know those who suffer from lung disease often have thick, sticky secretions that are difficult to expel.

• This causes fatigue, shortness of breath and anxiety, as well as potential pain.

• Controlled cough techniques or potential airway clearance devices should be considered.

OXYGEN SYSTEMS

• If patient is on supplemental oxygen, it is recommended this be assessed ongoing via oximetry as order by physician.

• Oxygen is delivered in various ways, such as continuous flow or via conserving devices. As patient status changes, the oxygen needs may change.

• Remember oxygen is a drug and should be treated as such. In some cases too much oxygen could potentially hasten death and should used as prescribed.
PHARMACOLOGICAL INTERVENTIONS

• In conjunction with bronchodilators, medications such as opioids have shown to be highly effective in the management of air hunger for those with all types of lung disease.

• These should be considered an integral part of patient symptom management and offered to patient ongoing as per physician orders.

ADDITIONAL INTERVENTIONS

• Reduce need for exertion by assessing environment.
• Reposition patient using recovery positions or if patient in bed, raise head of bed.
• Improve air circulation.
• Adjust humidity (de-humidifier, humidifier, air conditioner).
• Avoid strong odors, fumes and smoke.
• Avoid any triggers that cause dyspnea.
• Help patient and family prepare for scenarios of shortness of breath and anxiety.

RESPIRATORY THERAPISTS KEY ROLES

• Identification of patients who may be medically eligible for hospice as evidenced by pulmonary hospice criteria
• Evaluation and education of:
• Inhaled medications
• Breathing techniques
• Airways clearance
• Oxygen needs
CONTROVERSIAL TOPICS

• BIPAP
• Suctioning
• Diaphragmatic Pacers
• Ventilators
• How much oxygen is too much?
• Narcotic use

“You matter because of who you are. You matter to the last moment of your life, and we will do all we can, not only to help you die peacefully, but also to live until you die.”

- Dame Cicely Saunders

PULMONARY HOSPICE INDICATORS

• 6-month survival cannot be predicted with certainty. Patients who fit the following parameters may be eligible for hospice if they have:
  - Severe debilitating pulmonary disease
  - Shortness of breath at rest
  - Right heart failure/COPD pulmonale-documented Echocardiogram, EKG, chest x-ray
  - Oxygen dependent-SaO2< or = to 88% on supplemental O2
  - Frequent hospitalizations
  - Resting tachycardia > 100/minute in patient with known severe COPD
RESOURCES

- Patient physician
- National Hospice and Palliative Care Organization (http://www.nhpco.org)
- http://www.hospiceresources.net
- Centers for Medicare and Medicaid Services-42 CFR Part 418, Medicare and Medicaid Programs: Hospice Conditions of Participation; Final Rule (Pgs. 32216-32217)

REFERENCES

- National Hospice and Palliative Care Organization.
- EndLink – Resource for End of Life Care Education (Northwestern University)
  - http://endoflife.northwestern.edu/index.cfm
- Centers for Medicare and Medicaid Services-42 CFR Part 418, Medicare and Medicaid Programs: Hospice Conditions of Participation; Final Rule (Pgs. 32216-32217)
  - http://dying.about.com/od/whatishospice/f/hospice1.htm

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  - http://www.aarc.org
  - http://www.learnwell.org/endoflife
  - American Lung Association (http://www.lungusa.org/)
  - American Association for Respiratory Care http://www.aarc.org/
  - http://www.yourlunghealth.org/
  - http://www.copdfoundation.org/
  - http://www.goldcopd.com/