# Palliative Care Toolkit

# Disclaimer

- This toolkit is the property of Highmark. The information contained in this toolkit may be confidential and/or proprietary and is not to be distributed to any outside person(s) or entity(ies) without express written consent of Highmark.

- Highmark does not recommend particular treatments of healthcare services. This toolkit is not intended to be substitute for professional medical advice, diagnosis or treatment. The provider should determine the appropriate treatment and follow-up with his or her patient. This toolkit is based upon a search of literature: there may be other recommendations or suggested practices that may be suitable in the care of patients. Coverage of services is subject to the terms of each member's benefit plan. Additionally, state laws and regulations governing health insurance, health plans and coverage may apply and will very from state to state.

- The guidance, best practices and guidelines (referred to as "best practices") provided to you are presented for your consideration and assessment only. They were selected from among best practices published by various associations and organizations or discussed in studies and articles on the subject. Please assess whether the described best practices are appropriate for you. There are no requirements that you use the best practices, and the best practices are not required for any Highmark program or initiative. Please note that the successful implementation of any program or initiative depends upon many factors and variables. Therefore, Highmark makes no representation with respect to the described best practices and whether the practices will positively impact your reimbursement, value-based payment or performance under a Highmark program or initiative. The best practices are not intended to situate Highmark as a provider of medical services or dictate the diagnosis, care or treatment of patients. Your medical judgment remains independent with respect to all medically necessary care to your patients.

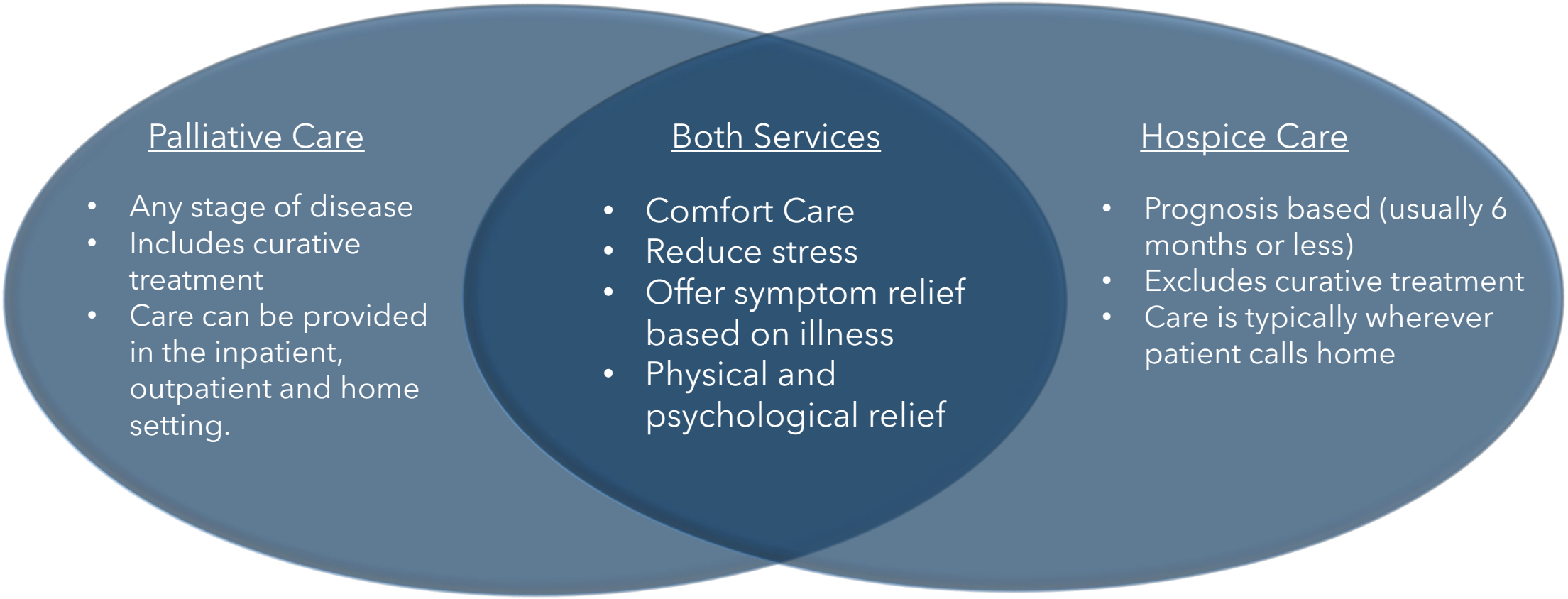
# Contents

# What is Palliative Care?

# Palliative Care[1]

- Palliative care is specialized medical care for people living with a serious illness.
- Focused on providing relief from symptoms and stress of the illness.
- The goal is to improve quality of life for both the patient and the family.
- Palliative care is provided by a specially-trained team of doctors, nurses and other specialists who work together with a patient's other doctors to provide an extra layer of support.
- Based on the needs of the patient, not on the patient's prognosis. It is appropriate at any age and at any stage in a serious illness, and it can be provided at the same time as curative treatment

# Palliative Care vs. Hospice[1,2]



# Benefits of Palliative Care

# Benefits of Palliative Care[1,3]

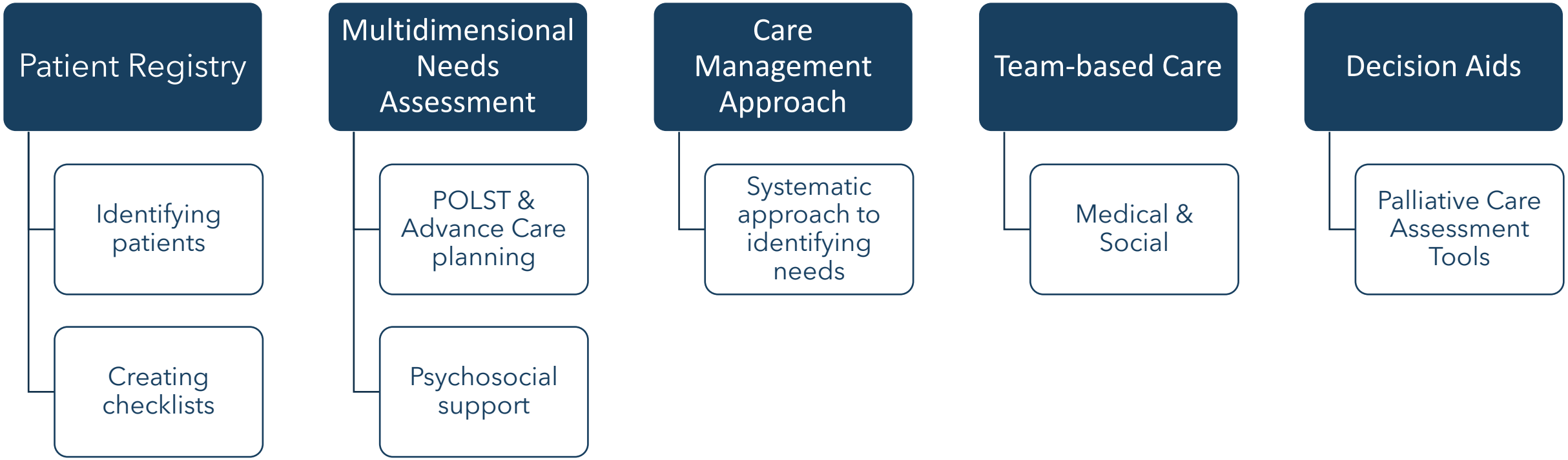
- Identifies patients with limited life expectancy
- Assessment of symptoms/suffering
- Management of pain and symptoms
- Discussions around prognosis, goals of care, quality of life and code status
- End of life planning
- Timely and consistent follow-up

# Benefits of Palliative Care[1,3]

- Improves quality of care across the continuum
- Improves staff, patient, and family satisfaction
- Increases number of outpatient services thereby reducing unnecessary inpatient hospital costs
- Increases Patient Advance Care Planning
- Decreases Emergency Department visits
- Reduces reoccurring hospitalizations
- Increased understanding of disease state and patients' ability to self-care/cope

# Palliative Care in Primary Care

# Strategies to Deliver Palliative Care in Primary Care Setting[4]



# Identify a Palliative Care Champion[5]

*Member of staff with clinical licensure*

- Volunteer for additional training in palliative care
- Serve as a local "expert" in addressing various palliative care needs
- Lead staff education and training
- Coordinate Palliative Care Quality Improvement Activities
- Address self-care and sustainability practices within the community

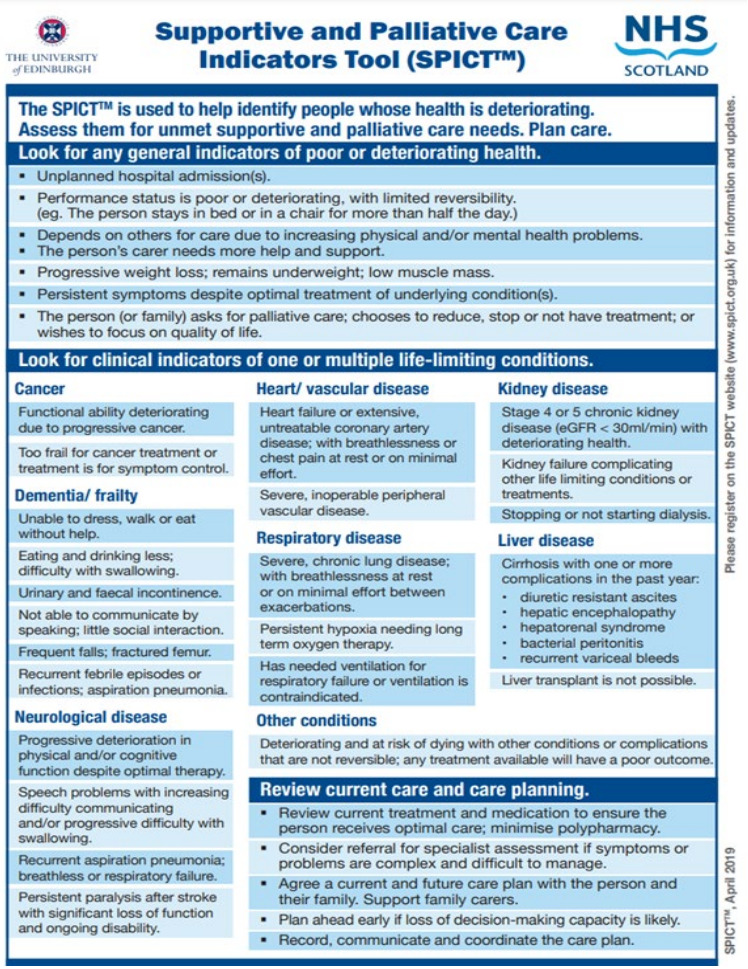
# Evaluating the Practice for Implementation[5]

**To evaluate  potential palliative care program implementation or integration into your practice answer the following questions:**

- ✓ What group of patients would benefit most from palliative care?
- ✓ Who are the clinical staff members who can offer the services?
- ✓ What additional training would be needed for staff to provide services?
- ✓ When can services start?
- ✓ What resources are needed?
- ✓ What is the cost? (training, resources)
- ✓ Can this be a revenue generating resource or cost-neutral?
- ✓ What administrative support is needed for the services to be successful?
- ✓ What barriers or challenges can be expected and how can they be mitigated?
- ✓ Why is integrating palliative care beneficial?  (Quality improvement, patient satisfaction, cost & utilization reduction)
- ✓ Are specialty palliative cares services available in the area?

# Supportive & Palliative Care Indicator Tool (SPICT)[6]

- SPICT is used to assist providers in identifying people whose health is deteriorating.
- Provides an opportunity to initiate palliative care and identify unmet needs



THE UNIVERSITY of EDINBURGH

**Supportive and Palliative Care Indicators Tool (SPICT™)**

NHS SCOTLAND

**The SPICT™ is used to help identify people whose health is deteriorating. Assess them for unmet supportive and palliative care needs. Plan care.**

**Look for any general indicators of poor or deteriorating health.**

- Unplanned hospital admission(s).
- Performance status is poor or deteriorating, with limited reversibility. (eg. The person stays in bed or in a chair for more than half the day.)
- Depends on others for care due to increasing physical and/or mental health problems.
- The person's carer needs more help and support.
- Progressive weight loss; remains underweight; low muscle mass.
- Persistent symptoms despite optimal treatment of underlying condition(s).
- The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.

**Look for clinical indicators of one or multiple life-limiting conditions.**

**Cancer**

- Functional ability deteriorating due to progressive cancer.
- Too frail for cancer treatment or treatment is for symptom control.

**Dementia/ frailty**

- Unable to dress, walk or eat without help.
- Eating and drinking less; difficulty with swallowing.
- Urinary and faecal incontinence.
- Not able to communicate by speaking; little social interaction.
- Frequent falls; fractured femur.
- Recurrent febrile episodes or infections; aspiration pneumonia.

**Neurological disease**

- Progressive deterioration in physical and/or cognitive function despite optimal therapy.
- Speech problems with increasing difficulty communicating and/or progressive difficulty with swallowing.
- Recurrent aspiration pneumonia; breathless or respiratory failure.
- Persistent paralysis after stroke with significant loss of function and ongoing disability.

**Heart/ vascular disease**

- Heart failure or extensive, untreatable coronary artery disease; with breathlessness or chest pain at rest or on minimal effort.
- Severe, inoperable peripheral vascular disease.

**Respiratory disease**

- Severe, chronic lung disease; with breathlessness at rest or on minimal effort between exacerbations.
- Persistent hypoxia needing long term oxygen therapy.
- Has needed ventilation for respiratory failure or ventilation is contraindicated.

**Other conditions**

- Deteriorating and at risk of dying with other conditions or complications that are not reversible; any treatment available will have a poor outcome.

**Kidney disease**

- Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.
- Kidney failure complicating other life limiting conditions or treatments.
- Stopping or not starting dialysis.

**Liver disease**

- Cirrhosis with one or more complications in the past year:
  - diuretic resistant ascites
  - hepatic encephalopathy
  - hepatorenal syndrome
  - bacterial peritonitis
  - recurrent variceal bleeds
- Liver transplant is not possible.

**Review current care and care planning.**

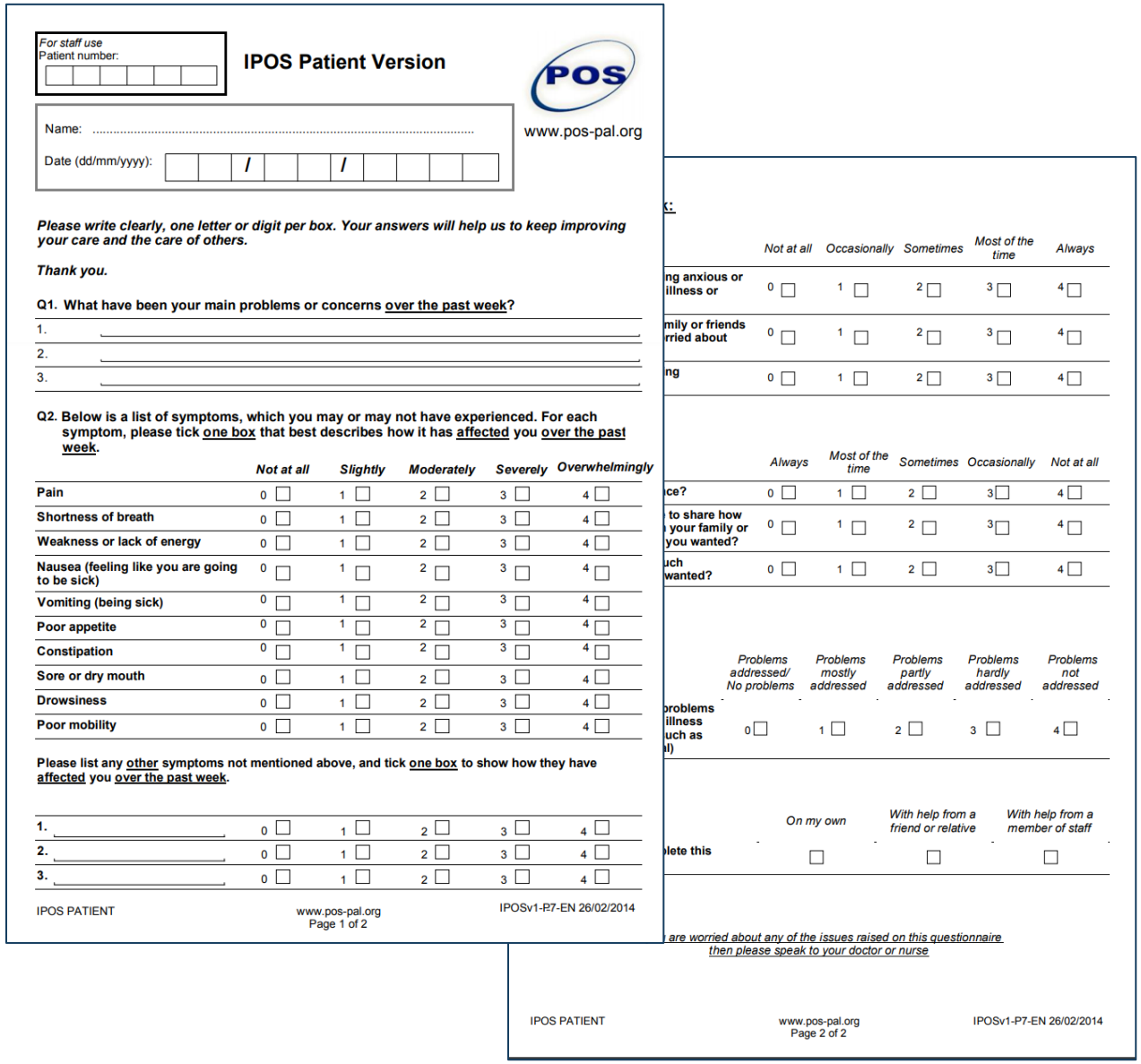
- Review current treatment and medication to ensure the person receives optimal care; minimise polypharmacy.
- Consider referral for specialist assessment if symptoms or problems are complex and difficult to manage.
- Agree a current and future care plan with the person and their family. Support family carers.
- Plan ahead early if loss of decision-making capacity is likely.
- Record, communicate and coordinate the care plan.

Please register on the SPICT website (www.spict.org.uk) for information and updates.

SPICT™, April 2019

# Integrated Palliative Care Outcome Scale Assessment (IPOS)[7]

- The IPOS was developed to evaluate, and measure continued work of the palliative care support team
- Patient or caregiver survey to be administered regularly to assist in evaluation of support services and care goals



For staff use
Patient number:

**IPOS Patient Version**

www.pos-pal.org

Name: .....

Date (dd/mm/yyyy): / /

***Please write clearly, one letter or digit per box. Your answers will help us to keep improving your care and the care of others.***

***Thank you.***

**Q1. What have been your main problems or concerns over the past week?**

1. _____
2. _____
3. _____

**Q2. Below is a list of symptoms, which you may or may not have experienced. For each symptom, please tick one box that best describes how it has affected you over the past week.**

| | *Not at all* | *Slightly* | *Moderately* | *Severely* | *Overwhelmingly* |
|---|---|---|---|---|---|
| **Pain** | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **Shortness of breath** | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **Weakness or lack of energy** | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **Nausea (feeling like you are going to be sick)** | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **Vomiting (being sick)** | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **Poor appetite** | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **Constipation** | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **Sore or dry mouth** | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **Drowsiness** | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **Poor mobility** | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |

**Please list any other symptoms not mentioned above, and tick one box to show how they have affected you over the past week.**

| | | | | | |
|---|---|---|---|---|---|
| **1.** _____ | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **2.** _____ | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **3.** _____ | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |

IPOS PATIENT www.pos-pal.org Page 1 of 2 IPOSv1-P7-EN 26/02/2014

| | *Not at all* | *Occasionally* | *Sometimes* | *Most of the time* | *Always* |
|---|---|---|---|---|---|
| **ng anxious or illness or** | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **mily or friends rried about** | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **ng** | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |

| | *Always* | *Most of the time* | *Sometimes* | *Occasionally* | *Not at all* |
|---|---|---|---|---|---|
| **ce?** | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **to share how your family or you wanted?** | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **uch wanted?** | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |

| | *Problems addressed/ No problems* | *Problems mostly addressed* | *Problems partly addressed* | *Problems hardly addressed* | *Problems not addressed* |
|---|---|---|---|---|---|
| **problems illness uch as al)** | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |

| | *On my own* | *With help from a friend or relative* | *With help from a member of staff* |
|---|---|---|---|
| **lete this** | ☐ | ☐ | ☐ |

*are worried about any of the issues raised on this questionnaire then please speak to your doctor or nurse*

IPOS PATIENT www.pos-pal.org Page 2 of 2 IPOSv1-P7-EN 26/02/2014

# Frailty[8]

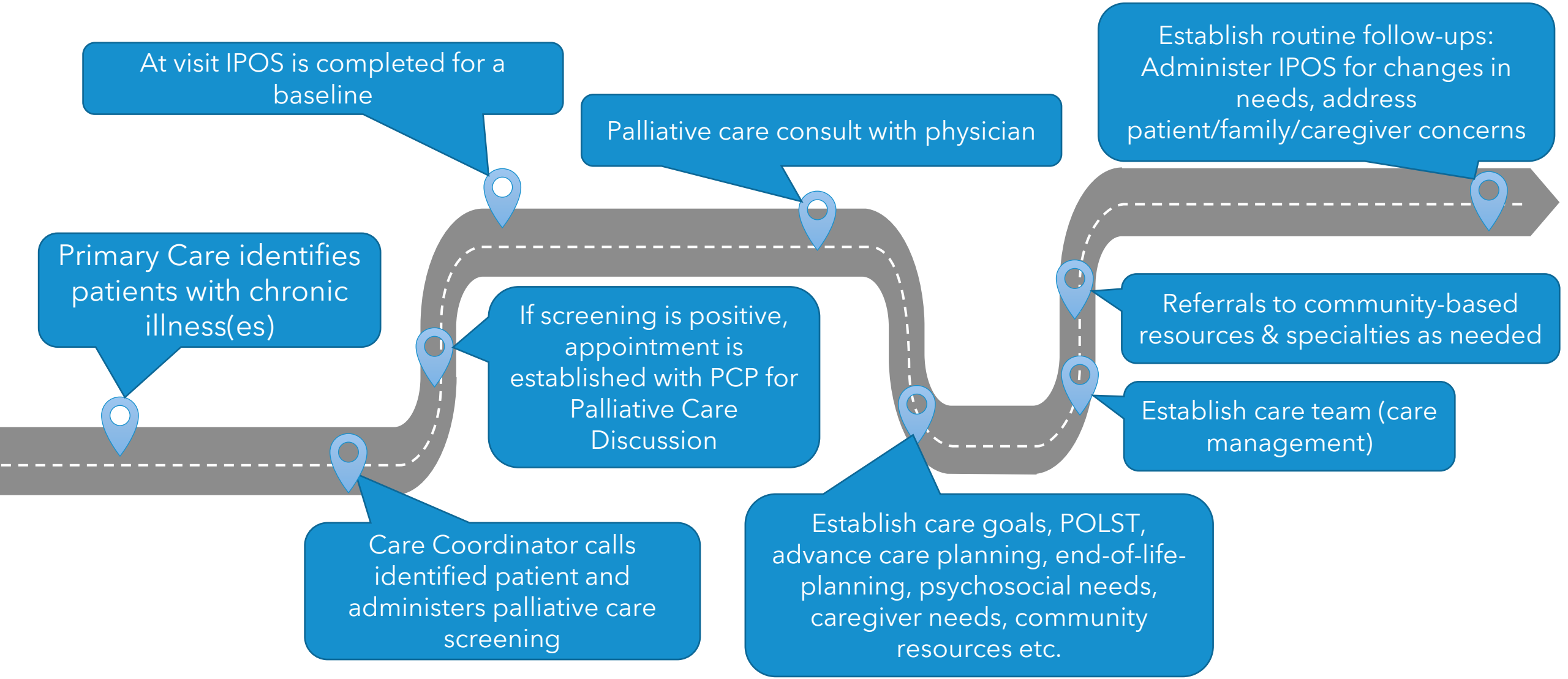
- Frailty is conceptually defined as a clinically recognizable state in which the ability of older people to cope with everyday or acute stressors is compromised by an increased vulnerability brought by age-associated declines in physiological reserve and function across multiple organ systems.

- Frailty is characterized by multisystem dysregulations, leading to a loss of dynamic homeostasis, reduced physiological reserve and greater vulnerability to subsequent morbidity and mortality. This is often manifested by maladaptive response to stressors, leading to a vicious cycle that results in functional decline and other serious adverse health outcomes.

- Proactive identification of older people in the community at risk of frailty provides opportunities to intervene and so prevent or delay functional decline.

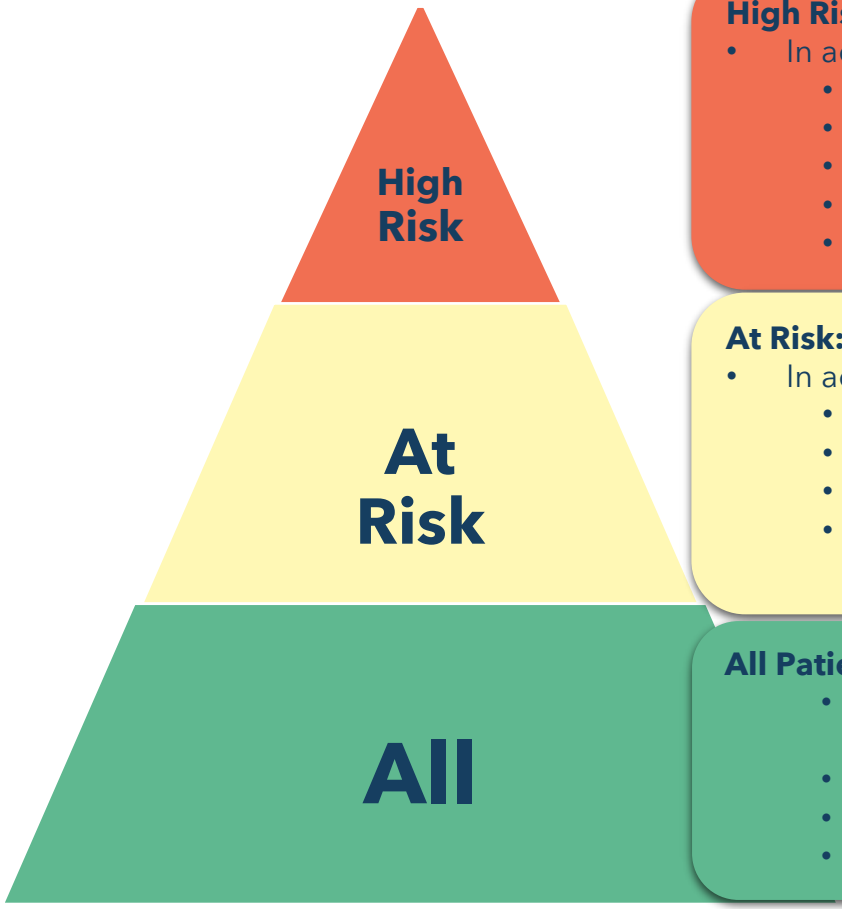
- Frailty can be a good indicator of the potential need for palliative care.

# Palliative Care Workflow (example)[9]



# Identifying and Screening Patients

# Identifying Possible Patients[5]




**High Risk: At Risk for dying in the next 1-2 years**

- In addition to all interventions for **At Risk**
  - Educate & complete POLST
  - Formalize assessment for functional status, needs for caregivers, & medical equipment
  - Formalize screening for caregiver burnout/distress
  - Refer to specialty palliative care, if available
  - Consider hospice for prognosis of less than 6 months

**At Risk: With serious illness or illnesses**

- In addition to all interventions for **All Patients**
  - Formalize routine symptom assessment (pain, depression, anxiety, etc.)
  - Develop pathways for managing symptoms & referrals to specialists as needed
  - Develop routine visits to clarify medical conditions & provide information on prognosis
  - Develop routine visits to address: patient/family concerns, goals of care, end-of-life concerns & wishes

**All Patients**

- Screen for advance care directives (adults over the age of 50) & provide support & information to encourage completion
- Identify & document surrogate decisionmaker(s)
- Conduct discussion about preferences for medical information sharing
- Document in Medical Record all the above

# Identifying Possible Patients

## One or more of the following may indicate the need for referral[1]

- The "surprise question"- You would not be surprised if the patient died within 12 months or did not live to adulthood
- Declining ability to complete activities of daily living
- Weight loss
- Multiple hospitalizations
- Difficult to control physical or emotional symptoms related to serious medical illness
- Patient, family or physician uncertainty regarding prognosis or goals of care
- DNR order conflicts
- Requests for futile care
- Use of tube feeding or TPN in cognitively impaired or seriously ill patients
- Limited social support and a serious illness (e.g., homeless, chronic mental illness)
- Patient, family or physician request for information regarding hospice appropriateness
- Patient or family psychological or spiritual distress

**Overall: Presence of a serious, chronic illness may be sufficient**

# Functional Scales

- Karnofsky Performance Score (KPS)
- ECOG Performance Status
- Palliative Performance Score (PPS)/ Palliative Prognostic Index (PPI)
- Functional Assessment Staging (FAST) for dementia

# Karnofsky Performance Score[10]

- Assesses functional status, a main indicator of health.
- Declining functional status marks the signs of disease progression.
- It is similar to the Palliative Performance Scale (PPS).
- It is a 0-100 rating scale for functionality.
- The lower the score, the worse the survival for most serious illnesses.

| KPS score | Description |
|---|---|
| 100 | Normal, no complaints, no evidence of disease |
| 90 | Able to carry on normal activity; minor signs or symptoms of disease |
| 80 | Normal activity with effort, some signs or symptoms of disease |
| 70 | Cares for self; unable to carry on normal activity or to do active work |
| 60 | Requires occasional assistance, but is able to care for most of his personal needs |
| 50 | Requires considerable assistance and frequent medical care |
| 40 | Disabled; requires special care and assistance |
| 30 | Severely disabled; hospital admission is indicated although death not imminent |
| 20 | Very sick; hospital admission necessary: active supportive treatment necessary |
| 10 | Moribund; fatal processes progressing rapidly |
| 0 | Dead |

KPS = Karnofsky Performance Score.

# ECOG Performance Status[11]

- A performance-based system to help assess functional status.
- The ECOG Performance Status only looks at general functional status.
- Primarily studied in the oncology population but is widely used as a clinical evaluation tool.

**ECOG Performance Status**

Developed by the Eastern Cooperative Oncology Group, Robert L. Comis, MD, Group Chair.*

| GRADE | ECOG PERFORMANCE STATUS |
|---|---|
| 0 | Fully active, able to carry on all pre-disease performance without restriction |
| 1 | Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work |
| 2 | Ambulatory and capable of all selfcare but unable to carry out any work activities; up and about more than 50% of waking hours |
| 3 | Capable of only limited selfcare; confined to bed or chair more than 50% of waking hours |
| 4 | Completely disabled; cannot carry on any selfcare; totally confined to bed or chair |
| 5 | Dead |

# Palliative Prognostic Index (PPI)[12]

- Utilizes clinical data in order to help provide a prognosis
- The PPS score from the previous slide is used in conjunction with the PPI to determine the estimated survival time

## Palliative Prognostic Index (PPI)

The PPI relies on the assessment of performance status using the Palliative Performance Scale (PPS, oral intake, and the presence or absence of dyspnea, edema, and delirium.

| Performance status/Symptoms | Partial score |
|---|---|
| ***Palliative Performance Scale*** | |
| 10–20 | 4 |
| 30–50 | 2.5 |
| ≥60 | 0 |
| ***Oral Intake*** | |
| Mouthfuls or less | 2.5 |
| Reduced but more than mouthfuls | 1 |
| Normal | 0 |
| ***Edema*** | |
| Present | 1 |
| Absent | 0 |
| ***Dyspnea at rest*** | |
| Present | 3.5 |
| Absent | 0 |
| ***Delirium*** | |
| Present | 4 |
| Absent | 0 |

**Scoring**

PPI score > 6 = survival shorter than 3 weeks
PPI score >4 = survival shorter than 6 weeks
PPI score ≤4 = survival more than 6weeks

# Palliative Performance Scale (PPS): Version 2[13]

- Assesses where a patient is within a disease process.
- The PPS takes five elements into account:
  - Ambulation
  - Activity
  - Evidence of Disease
  - Self-Care
  - Intake
  - Consciousness level
- The PPS rating is a rough gauge of overall health.
- Overall rating should make us consider the patient's risk of continuing morbidity, mortality, risk for hospital admission and need for supportive care services.
- Of note, most hospice eligible patients should be below 50% on this scale.

***Palliative Performance Scale (PPSv2)***
***version 2***

| PPS Level | Ambulation | Activity & Evidence of Disease | Self-Care | Intake | Conscious Level |
|---|---|---|---|---|---|
| 100% | Full | Normal activity & work<br>No evidence of disease | Full | Normal | Full |
| 90% | Full | Normal activity & work<br>Some evidence of disease | Full | Normal | Full |
| 80% | Full | Normal activity *with* Effort<br>Some evidence of disease | Full | Normal or reduced | Full |
| 70% | Reduced | Unable Normal Job/Work<br>Significant disease | Full | Normal or reduced | Full |
| 60% | Reduced | Unable hobby/house work<br>Significant disease | Occasional assistance necessary | Normal or reduced | Full<br>or Confusion |
| 50% | Mainly Sit/Lie | Unable to do any work<br>Extensive disease | Considerable assistance required | Normal or reduced | Full<br>or Confusion |
| 40% | Mainly in Bed | Unable to do most activity<br>Extensive disease | Mainly assistance | Normal or reduced | Full or Drowsy<br>+/- Confusion |
| 30% | Totally Bed Bound | Unable to do any activity<br>Extensive disease | Total Care | Normal or reduced | Full or Drowsy<br>+/- Confusion |
| 20% | Totally Bed Bound | Unable to do any activity<br>Extensive disease | Total Care | Minimal to sips | Full or Drowsy<br>+/- Confusion |
| 10% | Totally Bed Bound | Unable to do any activity<br>Extensive disease | Total Care | Mouth care only | Drowsy or Coma<br>+/- Confusion |
| 0% | Death | - | - | - | - |

# Functional Assessment Staging for Dementia (FAST)[14]

- The FAST score can be helpful for staging dementia.
- The FAST is a screening test to quantitatively assess the degree of disability and to document changes that occur over time.
- It is a functional assessment that contains 16 stages.
    - Stage 1 marks no difficulties for the patients while stage 7(f) describes the patient who is unable to hold his/her head up.

| FAST Stage | Characteristics |
|---|---|
| 1 | No decrement |
| 2 | Subjective deficit in word finding |
| 3 | Deficits noted in demanding employment setting |
| 4 | Requires assistance in complex tasks, such as handling finances and planning a party |
| 5 | Requires assistance in choosing proper attire |
| 6A | Requires assistance dressing |
| 6B | Requires assistance bathing properly |
| 6C | Requires assistance using the toilet |
| 6D | Urinary Incontinence |
| 6E | Fecal Incontinence |
| 7A | Speech ability limited to about a half-dozen intelligible words |
| 7B | Intelligible vocabulary limited to a single word |
| 7C | Ambulatory ability lost |
| 7D | Ability to sit up lost |
| 7E | Ability to smile lost |
| 7F | Ability to hold head up lost |

# Palliative Screening Criteria Upon Admissions[15]

Hospital admission is often when palliative care is initiated



TABLE 3. CRITERIA FOR A PALLIATIVE CARE ASSESSMENT AT THE TIME OF ADMISSION

A potentially life-limiting or life-threatening condition *and* . . .

Primary Criteria[a]

- The "surprise question": *You would not be surprised if the patient died within 12 months or before adulthood* [23–25]
- Frequent admissions (e.g., more than one admission for same condition within several months)[26–30]
- Admission prompted by difficult-to-control physical or psychological symptoms (e.g., moderate-to-severe symptom intensity for more than 24–48 hours)[6, 31]
- Complex care requirements (e.g., functional dependency; complex home support for ventilator/antibiotics/feedings)[6]
- Decline in function, feeding intolerance, or unintended decline in weight (e.g., failure to thrive)[6, 31]

Secondary Criteria[b]

- Admission from long-term care facility or medical foster home[c]
- Elderly patient, cognitively impaired, with acute hip fracture [32–35]
- Metastatic or locally advanced incurable cancer[36]
- Chronic home oxygen use[c]
- Out-of-hospital cardiac arrest[37–38]
- Current or past hospice program enrollee[c]
- Limited social support (e.g., family stress, chronic mental illness)[c]
- No history of completing an advance care planning discussion/document[6, 31]

[a]Primary Criteria are global indicators that represent the minimum that hospitals should use to screen patients at risk for unmet palliative care needs.

[b]Secondary Criteria are more-specific indicators of a high likelihood of unmet palliative care needs and should be incorporated into a systems-based approach to patient identification if possible.

[c]These indicators are included based on a consensus panel opinion.

# Subsequent Hospital Day Screening[15]

TABLE 4. CRITERIA FOR PALLIATIVE CARE ASSESSMENT DURING EACH HOSPITAL DAY

A potentially life-limiting or life-threatening condition *and* . . .

Primary Criteria[a]

- The "surprise question": *You would not be surprised if the patient died within 12 months or did not live to adulthood*[1–3]
- Difficult-to-control physical or psychological symptoms (e.g., more than one admission for same condition within several months)[6, 31]
- Intensive Care Unit length of stay ≥7 days[39–44, c]
- Lack of Goals of Care clarity and documentation[6, 31]
- Disagreements or uncertainty among the patient, staff, and/or family concerning . . .
  - major medical treatment decisions[6, 31]
  - resuscitation preferences[6, 31]
  - use of nonoral feeding or hydration[6, 31]

Secondary Criteria[b]

- Awaiting, or deemed ineligible for, solid-organ transplantation[45–46]
- Patient/family/surrogate emotional, spiritual, or relational distress[6, 31, 44]
- Patient/family/surrogate request for palliative care/hospice services[c]
- Patient is considered a potential candidate, or medical team is considering seeking consultation, for:
  - feeding tube placement[47–51]
  - tracheostomy[52]
  - initiation of renal replacement therapy[53]
  - ethics concerns[54–57]
  - LVAD[d] or AICD[e] placement[58]
  - LTAC[f] hospital or medical foster home disposition[59]
  - bone marrow transplantation (high-risk patients)[60–61]

[a]Primary Criteria are global indicators that represent the minimum that hospitals should use to screen patients at risk for unmet palliative care needs.

[b]Secondary Criteria are more-specific indicators of a high likelihood of unmet palliative care needs and should be incorporated into a systems-based approach to patient identification if possible.

# LACE Index[16]

**Use to screen for high risk of readmission**

## **LACE** index accounts for:

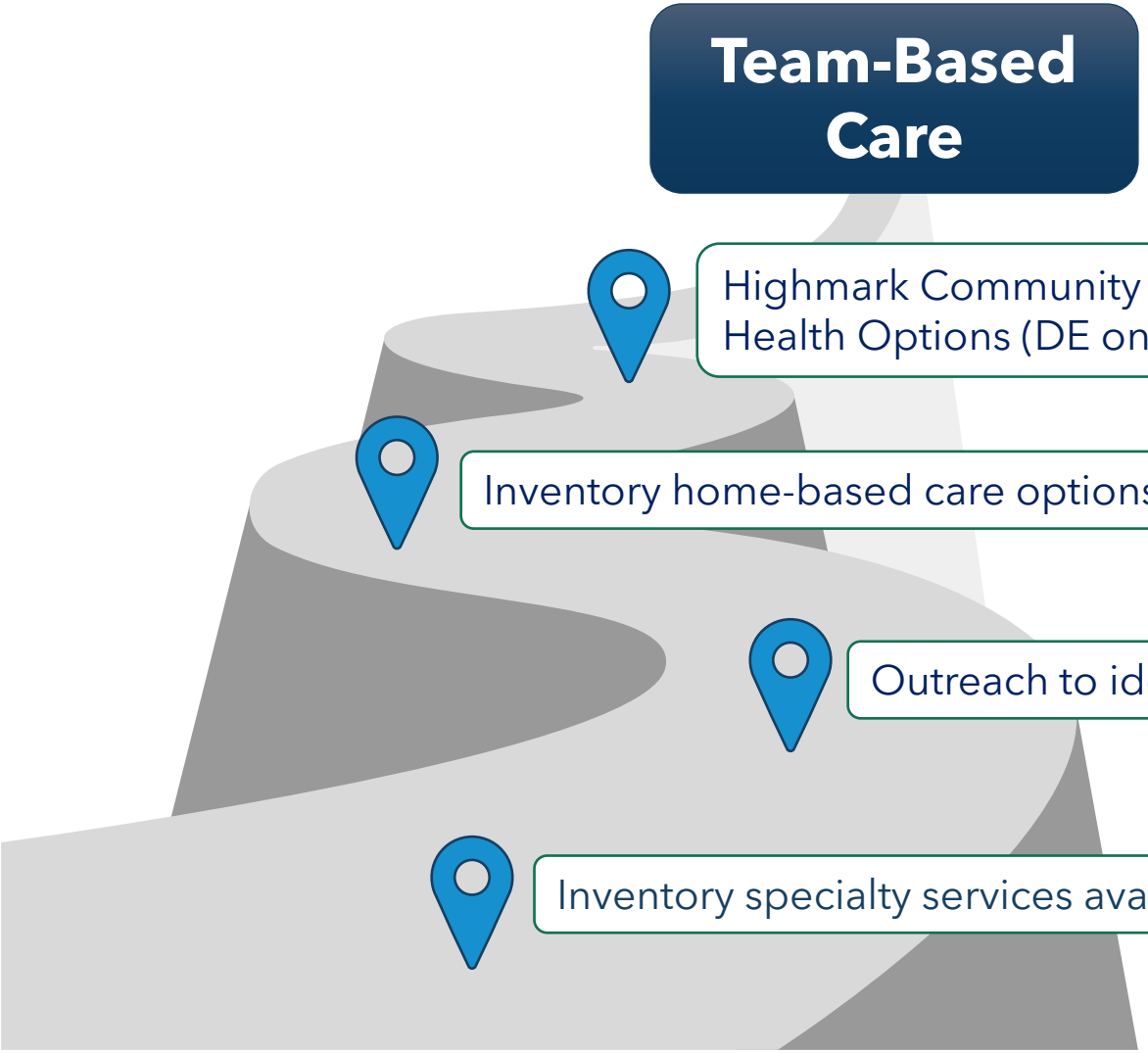
- **L**: Length of stay
- **A**: Acuity of admission
- **C**: Comorbidities
- **E:** recent Emergency department use

It can be used to quantify risk of unplanned readmissions within 30 days after discharge from hospital.

Score≥ 10 indicates a high risk of readmission

https://www.capc.org/documents/289

# Identifying Medical & Social Resources




Highmark Community Support Website: https://highmark.auntbertha.com/
Health Options (DE only): https://hmhealthoptions.auntbertha.com/

Inventory home-based care options: Home Health, Medical Aides, In-home care giving services

Outreach to identify services that can be conducted via telehealth or web-based

Inventory specialty services available to your area

# Advance Care Planning (ACP)

# Advance Care Planning[17]

- Voluntary, face-to-face service between a qualified health care professional and patient or authorized caregiver to discuss the patient's health care wishes if they become unable to make their own decisions

- Can include Advance Directives
  - Appoints an agent and records a patient's medical treatment wishes based on values and preferences.

- Can include completion of POLST (Physician Orders for Life-Sustaining Treatment)
  - POLST: Portable Medical Orders is an official order form that can be given to any health care provider who may be involved in emergency/end-of-life care to inform them of patient's wishes.

  - POLST is for people who are serious ill or have advanced frailty.

- Advance Care Planning CMS MLN Fact Sheet and Billing Codes: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/advancecareplanning.pdf

# Differences between Advance Directives and POLST[18]

| Characteristics | Advance Directive | POLST |
|---|---|---|
| **Population** | All adults | For the seriously ill |
| **Timeframe** | Future Care | Current Care |
| **Who completes the form?** | Patients | Health Care Professional |
| **Where is it completed?** | Anywhere | Medical Setting |
| **Resulting Form** | Power of Attorney, Living Will | Medical orders based on shared decision-making |
| **Becomes Effective** | When patient is incompetent, and" permanently unconscious or has end-stage medical condition | When signed and dated by medical professional or medical decision maker |
| **Health Care Agent or Surrogate role** | Cannot complete forms | Can engage in discussion if patient lacks capacity |
| **Portability responsibility** | Patient/family | Provider |
| **Periodic Review** | Patient/family | Provider |

# Palliative Care Metric Quality Blue Hospital

# Palliative Care for Patients- with Advanced Illness (Medicare Advantage - Hosp03.3) (Commercial – Hosp03.4)

Source: CMS 2023

Percent of admissions of identified members 18 years of age and older referred for a palliative care consult or advance care planning (ACP) while in the hospital, AND one of the following during the 14 days prior to the admission or 14 days post discharge during the measurement period – hospice admission, palliative care consult, Transitional Care Management (TCM), Advance Care Planning (ACP), or Chronic Care Management (CCM).

| Numerator | Denominator | Exclusions |
|---|---|---|
| • The number of admissions, of appropriate members, with at least one palliative care consult or advanced care plan during the hospitalization (count once per member inpatient admission) AND one of the following 14 days prior to date of admission or 14 days post-discharge during the measurement period - hospice admission, palliative care consult, Transitional Care Management (TCM), Advance Care Planning (ACP), or Chronic Care Management (CCM). | • All admissions during the measurement period for members 18 years of age and older with advanced chronic or serious life-threatening illness identified in any setting within one year prior to the inpatient admission.<br><br>• *Please see individual masthead measure guide for additional details. | • None |

# Palliative Care in QBH Program

## Numerator

**The number of admissions, of appropriate members, with at least one palliative care consult or advance care plan during the hospitalization AND one of the following two weeks prior to date of admission or two weeks post-discharge.**

### During Hospitalization

- **Palliative Care Consult – Z51.5**
- **Advance Care Planning – 99497, 99498**

***Required***

**AND**

***One or Both***

### 2 weeks prior to Hospitalization

- **Palliative Care Consult – Z51.5**
- **Advance Care Planning – 99497, 99498, 1123 F, 1124 F**
- **Transitional Care Management – 99495, 99496**
- **Chronic Care Management – 99487, 99489, 99490, 99491, 99439**
- **Enrollment in ECCM or similar palliative support program – Medicare Advantage and Highmark Individual ACA patients only**

### 2 weeks post Hospitalization

- **Palliative Care Consult – Z51.5**
- **Hospice Admission – Disposition codes 50 or 51**
- **Advance Care Planning 99497, 99498, 1123 F, 1124 F**
- **Transitional Care Management – 99495, 99496**
- **Chronic Care Management – 99487, 99489, 99490, 99491, 99439**
- **Enrollment in ECCM or similar palliative support program – Medicare Advantage and Highmark Individual ACA patients only**

# Palliative Care Consult Note

# Example Template
# Palliative Care Consult Note[12]



**SAMPLE PALLIATIVE MEDICINE CONSULTATION NOTE TEMPLATE:**

1. Patient name
2. Visit location
3. Hospital day number
4. Primary care physician
5. Requesting physician
6. Chief complaint
7. Palliative Performance Score (PPS)
8. Palliative Prognostic Index (PPI)
9. Palliative diagnosis
10. Clinician's estimate of prognosis ( minutes, hours, days, weeks, months, unknown)
11. Advance directive
12. POLST
13. Patient's preference for surrogate decision maker
14. Patient's preference for care setting

# Example Template
# Palliative Care Consult Note[12] (continued)

**Palliative Prognostic Index: *****
**Survival estimate is: *****

| Prognostic domains | Partial score value |
|---|---|
| **Palliative Performance status*** | |
| 10 to 20 | 4.0 |
| 30 to 50 | 2.5 |
| ≥60 | 0 |
| **Clinical symptoms** | |
| **Oral intake** | |
| Moderately reduced | 1.0 |
| Severely reduced | 2.5 |
| Normal | 0 |
| **Edema** | 1.0 |
| **Dyspnea at rest** | 3.5 |
| **Delirium** | 4.0 |

# Example Template
# Palliative Care Consult Note[12] (continued)

***Goals of Care and Symptom Management***

15. Assessment and Planning:
    a. Goals of care
        i. Met with the patient
        ii. Plan
    b. Symptom management
        i. Pain
            1. Prescription Drug Monitoring Program (PDMP) review
        ii. Dyspnea
        iii. Constipation
        iv. Nausea/Vomiting
        v. Anorexia/Weight loss
        vi. Anxiety / Depression
        vii. Renal
        viii. Other

# Example Template
# Palliative Care Consult Note[12] (continued)

16. History of present illness
17. Past medical/surgical history
18. Family history
19. Social history
20. Family supports
21. Coping
22. Mental health history
23. Religious/Cultural/Spiritual history
24. Drug allergies
25. Medications
26. Labs
27. Review of systems / Edmonton Symptom Assessment Scale (ESAS)
28. Physical exam
29. Vitals

# Example Template
# Palliative Care Consult Note[12] (continued)

**(Use this phrase if you are billing on time based counseling)**

Total time spent with the patient was (*** minutes) and greater than 50% time was spent face-to-face counseling regarding (**********) (examples: goals of care, advance care planning, prognosis, symptom management, community resources, etc.…)

Thank you for the consultation,

Supportive Care and Palliative Medicine

Cell: (XXX) XXX-XXXX

# Medication Considerations in Palliative Care

# Best Practices[19-21]

**Reassess need for each medication by evaluating and aligning time to benefit, goals of care, treatment targets, and life expectancy**

- *Is there an appropriate indication for the drug?*
- *Is the medication effective for the condition?*
- *How long is therapy required/is the duration of therapy acceptable?*
- *Are treatment goals appropriate for patient's age and comorbidities?*

**Deprescribe any medications that may no longer provide benefit or increase risk for the patient**

- *Consider any tapering that may be required to minimize withdrawal symptoms*
- *When prioritizing deprescribing, consider which drugs have greatest harms, which are easiest to discontinue, and which the patient is most willing to discontinue*

**Check for any clinically significant drug-drug or drug-disease interactions**

**Consider any cost-effective alternatives**

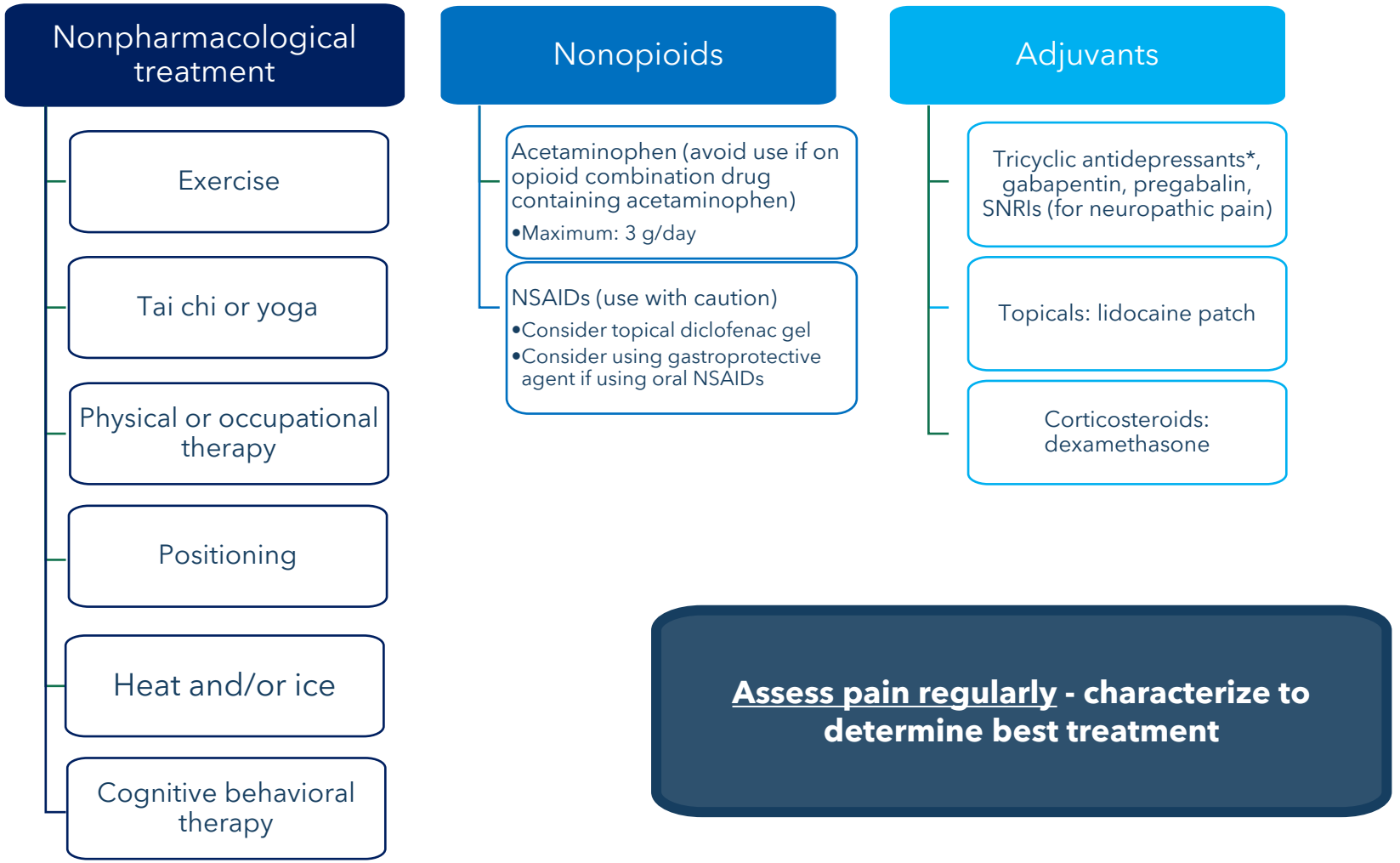
**Consider collaborating with a pharmacist to evaluate and address each of these best practices**

**Complete symptom assessment to address any untreated symptoms to improve quality of life**

- *Identify any symptoms that may be drug-related*
- *Reassess symptoms frequently to prevent patient discomfort*
- *Many symptoms are addressed differently in palliative care because of changes in risk/benefit assessment based on patient prognosis*

# Pain Management

# Pain Management[22-25]

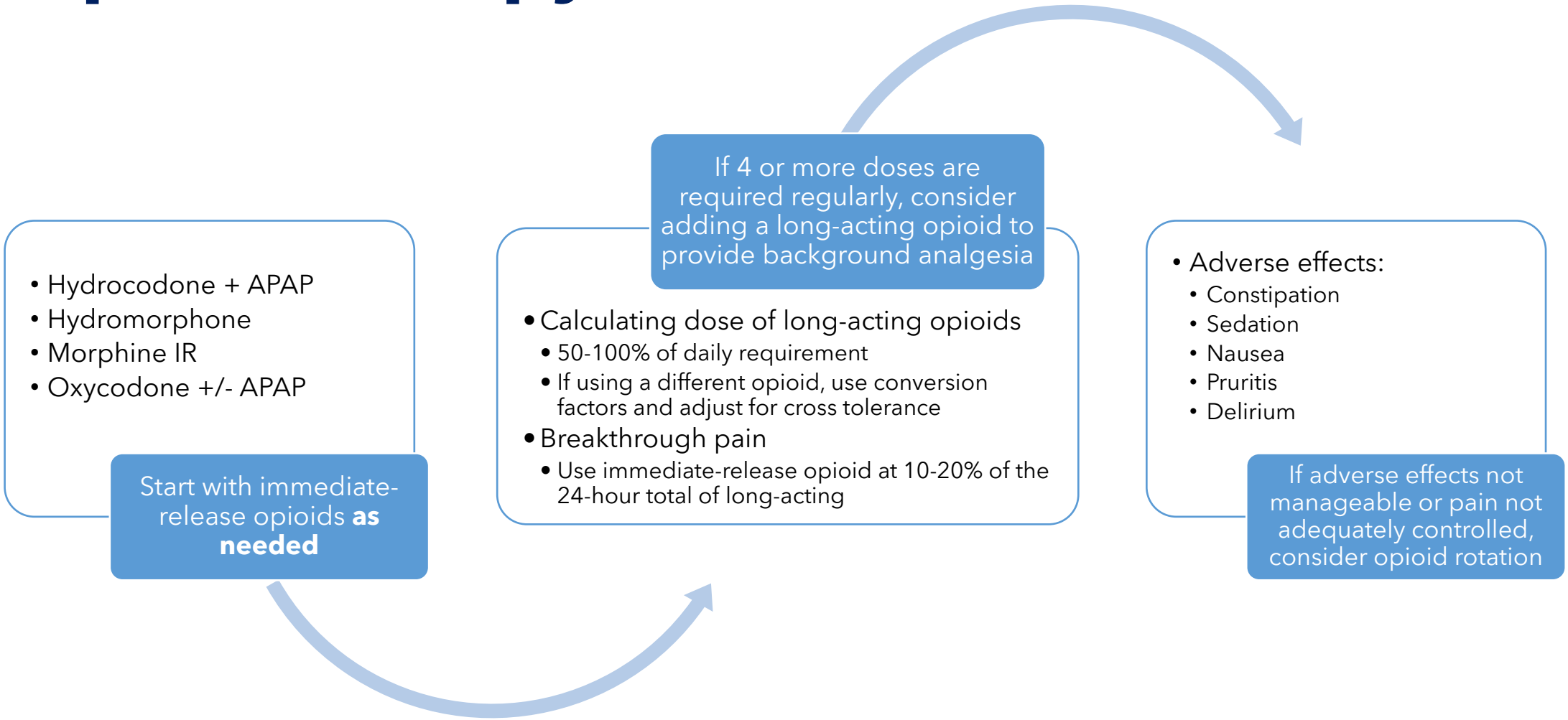



**<u>Assess pain regularly</u> - characterize to determine best treatment**



* May cause anticholinergic side effects – benefit vs. risk should be evaluated for patients over 65

# Opioid Therapy[25-26]






* May cause anticholinergic side effects – benefit vs. risk should be evaluated for patients over 65

# Opioid Considerations[25]

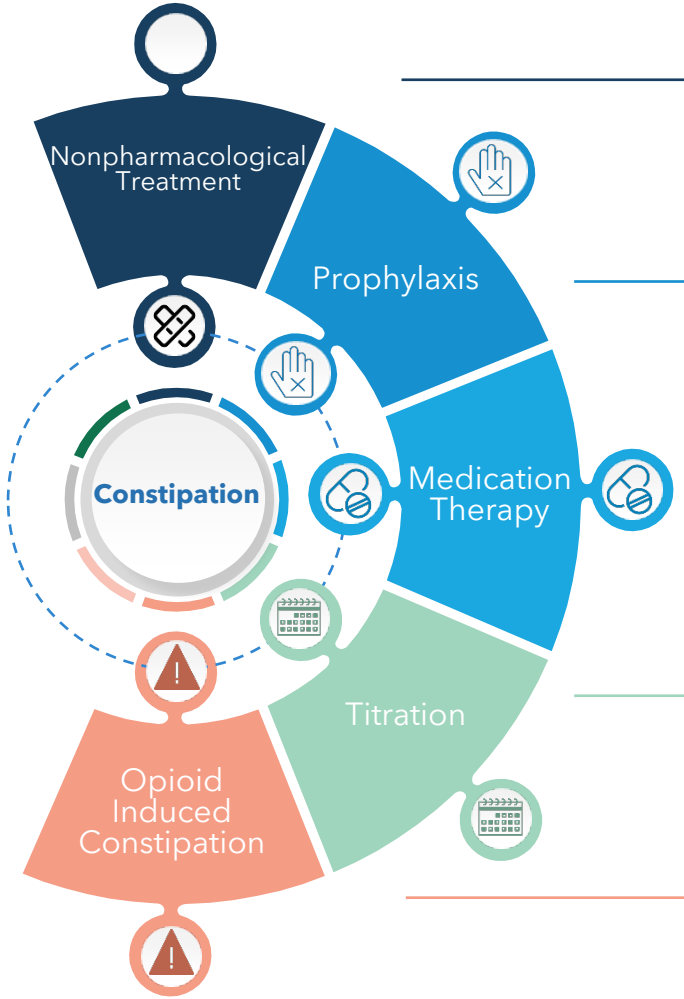
| Opioid | Duration of Action (h)* | Parenteral (mg) | Oral (mg) | Considerations |
|---|---|---|---|---|
| Morphine | 3-4 | 10 | 30 | Use with caution in patients with fluctuating renal function |
| Codeine | 3-4 | - | 200 | Avoid in hepatic or renal impairment |
| Fentanyl | | 0.1 | | In single-dose administration, 10 mg IV morphine is equal to ~100 mcg of IV fentanyl but with chronic fentanyl administration, ratio of 10 mg IV morphine is equal to ~250 mcg of IV fentanyl<br><br>Transdermal patch: 200 mg/**day** oral morphine = 100 mcg/**h** fentanyl patch |
| Hydrocodone | 3-5 | - | 30-45 | Use with caution in patients with fluctuating renal function |
| Hydromorphone | 2-3 | 1.5 | 7.5 | Use with caution in patients with fluctuating renal function |
| Methadone | - | - | - | Should consult pain specialist<br>Conversion factor increases at higher doses |
| Oxycodone | 3-5 | - | 15-20 | |
| Oxymorphone | 3-6 | 1 | 10 | Use with caution in patients with fluctuating renal function |
| Tramadol | 6 | 100 | 300 | Maximum single dose of 100 mg and maximum daily dose of 400 mg for IR and 300 mg for ER<br>Renal dose adjustments required |



* May cause anticholinergic side effects – benefit vs. risk should be evaluated for patients over 65

# Non-Pain Management

# Constipation[27]




- Maintain adequate hydration, fiber intake, and exercise

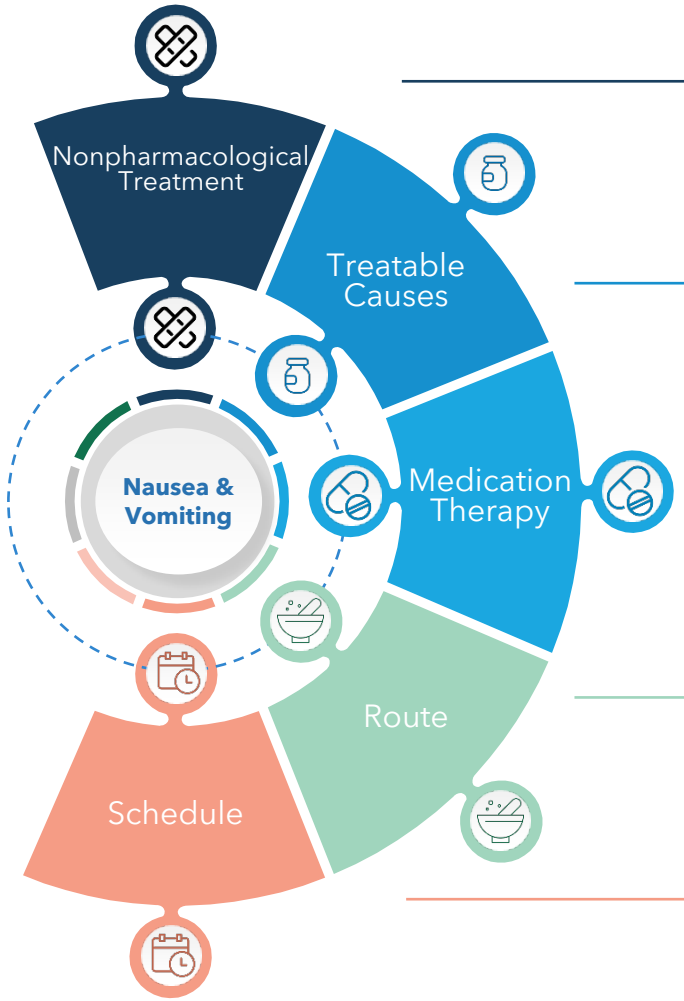
- For all patients taking opioids, consider prophylactic laxative therapy
  - Stimulant laxative (bisacodyl or senna)
  - +/- osmotic laxative (polyethylene glycol or lactulose)

- Treatment options
  - Bisacodyl oral, titrate to 10-15 mg PO daily to TID
  - Bisacodyl suppository, one rectally daily to BID
  - Polyethylene glycol, 1 capful PO BID
  - Lactulose, 30 mL PO BID-QID

- Titrate medications with a goal of 1 unforced bowel movement every 1-2 days

- Opioid Induced Constipation (last line – when refractory to laxatives)
  - Amitiza (lubiprostone)
  - Movantik (naloxegol)

# Nausea and Vomiting[27]




- Eating small, regular portion rather than large meals
- Avoiding food preparation and cooking smells
- Creating a calm and reassuring environment
- Psychological approaches such as counseling to address anxiety or depression

- Review and discontinue any medications that may contribute
- If opioid related, consider opioid rotation

- Start with single-agent therapy
- Consider combination therapy if therapeutic goals not attained

- Consider appropriate route of administration
  - Oral
  - Sublingual
  - Rectal

- Provide as needed, scheduled, or continuous (i.e., infusions) as necessary

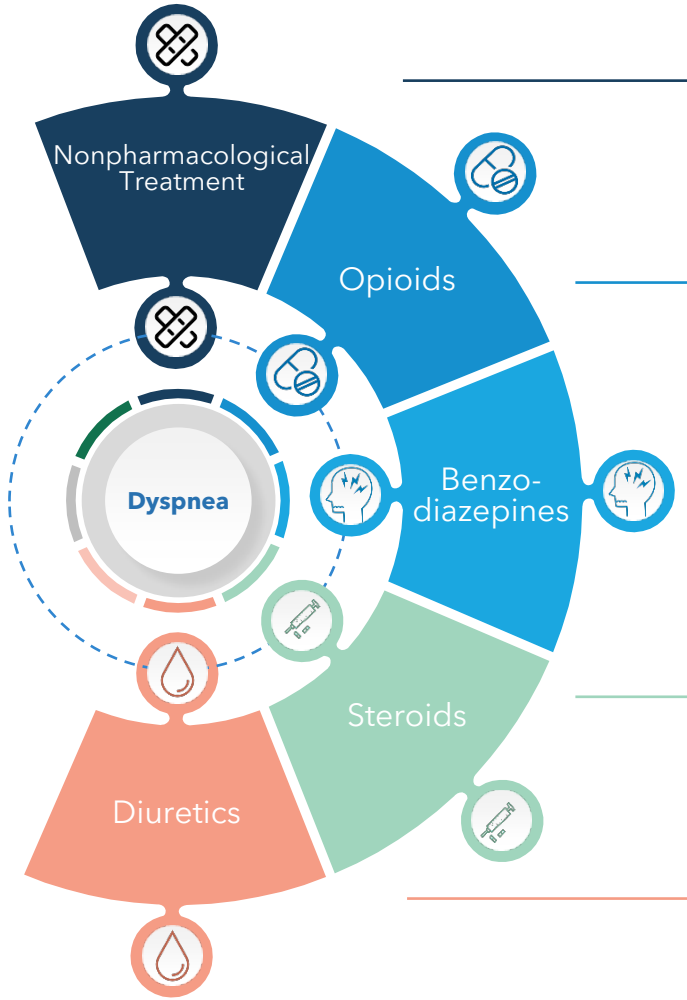
# Nausea and Vomiting[27]

First line options for non-specific nausea/vomiting

| Drug | Dose | Formulations | Considerations |
|---|---|---|---|
| Haloperidol* | 0.5 –2 mg Q6-8H | SubQ, IV, continuous infusion | QT prolongation, extrapyramidal symptoms |
| Metoclopramide* | 5-10 mg QID (AC and HS) | PO, SubQ, IV | QT prolongation, extrapyramidal symptoms Renal dose adjustments |
| Prochlorperazine* | 5-10 mg 3-4x/day (max 40 mg/day) | PO, IM, IV, Rectal | Extrapyramidal symptoms |
| Olanzapine* | 5-10 mg 2-3x/day | PO | QT prolongation, extrapyramidal symptoms |
| Ondansetron | 4 mg Q4H or 8 mg Q8H | PO, IV | |

- Other agents to consider: dexamethasone 4-8 mg/day PO, meclizine 25-100 mg/day PO

# Dyspnea[27]




- Fans, cooler temperatures, stress management, relaxation therapy, etc.
- Treat underlying cause and comorbid conditions
- Oxygen therapy for symptomatic hypoxia

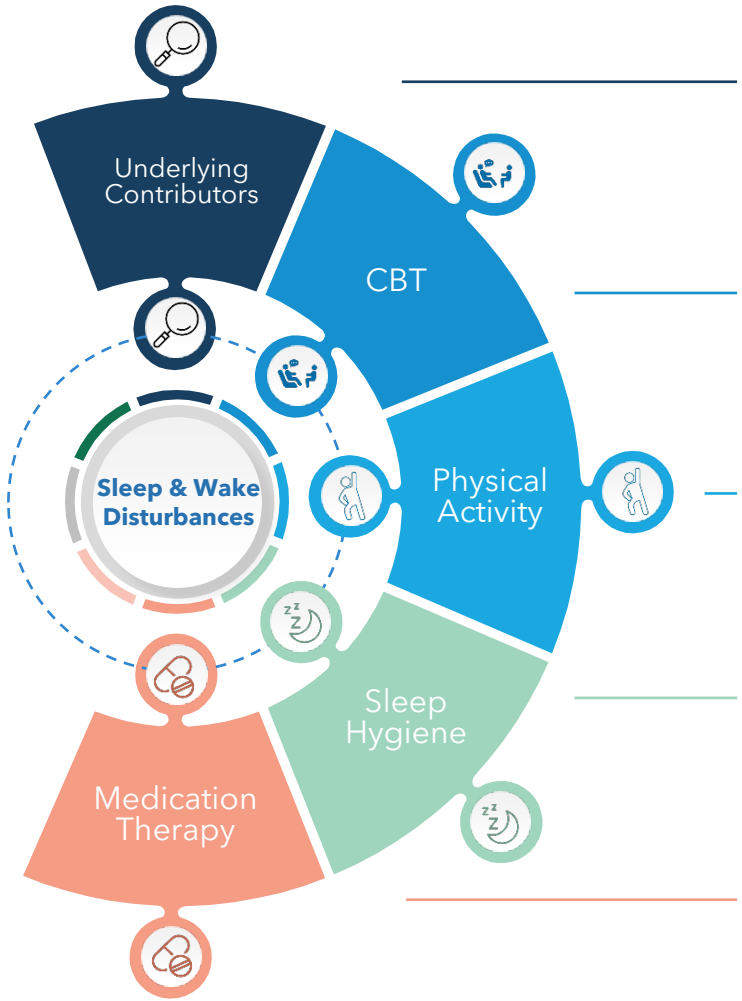
- Opioids may be considered to relieve breathlessness in patients with chronic obstructive pulmonary disease (COPD), cancer, or end-stage cardiorespiratory disease
  - If opioid naïve, morphine 2.5-10 mg PO Q2H PRN or morphine 1-3 mg IV Q2H PRN
  - If non-opioid naïve, increase dose of chronic opioid by 25% for unrelieved dyspnea

- Consider benzodiazepines in cancer patients with coexisting anxiety and life expectancy days to years
  - Lorazepam 0.25-1 mg PO Q4H PRN

- Corticosteroids may be used to reduce airway inflammation and edema in patients with terminal malignant and nonmalignant diseases

- Low-dose diuretics, such as, furosemide should be considered for dying patients with fluid overload

# Sleep/Wake Disturbances[27-28]




- Identify and treat underlying physical or psychological factors that may be contributing
  - Pain
  - Delirium
  - Nausea
  - Depression/Anxiety
  - Restless leg syndrome
  - Sleep apnea
- Cognitive behavioral therapy (CBT) for patients with emotional and behavioral factors affecting sleep disorders
- Exercise regularly (daytime physical activity)
- Educate on sleep hygiene
  - Keep sleep environment dark, comfortable, and quiet
  - Avoid naps in daytime
  - Keep regular sleep schedule all days of week
  - Use bed and bedroom for sleep only
  - Avoid use of TV, mobile phones, and tablets before bedtime
  - Avoid nicotine, caffeine, alcohol, heavy meals, or spicy foods before bedtime
- Identify medications that could be contributing to disturbances
- Consider pharmacological agents to treat disturbances

# Sleep/Wake Disturbances[27]

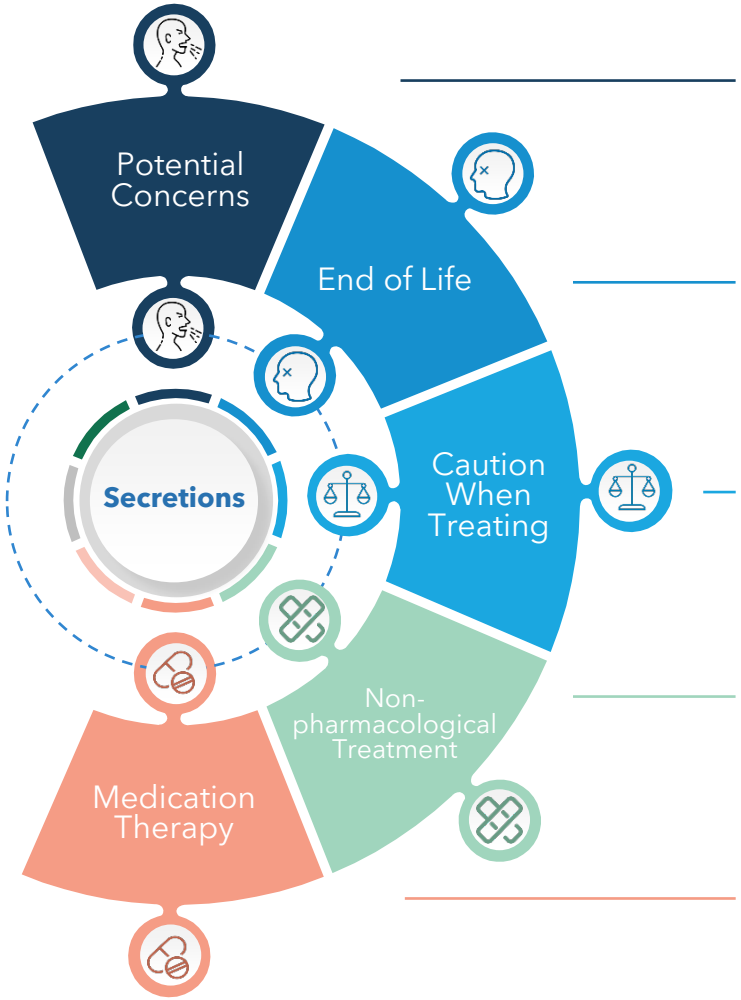
**Insomnia**

- Trazodone, 25-100 mg PO at bedtime
- Zolpidem, 5 mg PO at bedtime
- Mirtazapine, 7.5-30 mg PO at bedtime
- Chlorpromazine, 25-50 mg PO at bedtime
- Quetiapine, 12.5-25 mg PO at bedtime
- Olanzapine, 2.5-5 mg PO at bedtime
- Lorazepam, 0.5-1 mg PO at bedtime

**Day Time Sedation**

- Caffeine, 100-200 mg PO Q6H
  - Last dose at 4 PM
- Methylphenidate, 2.5-20 mg PO BID
  - 2nd dose no later than 6 h before bedtime
- Dextroamphetamine 2.5-10 mg PO BID
  - 2nd dose no later than 12 h before bedtime
- Modafinil, 100-400 mg PO each morning

# Secretions[27, 29-30]




- Increased airway secretions may
  - Interfere with a patient's ability to sleep
  - Worsen dyspnea
  - Precipitate uncomfortable coughing spells
  - Predispose to infections
- Often occurs towards the end of life and is known as the "death rattle"
- Can be distressing to family but often isn't distressing to patient
- Medications used to treat can often have other side effects (constipation, dry mouth, delirium, etc.)
- Nonpharmacological treatment:
  - Positioning patient on side to aid in draining secretion and minimizing upper airway sounds
  - Oral and pharyngeal suctioning to reduce noise
- Pharmacological treatment options:
  - Scopolamine 0.4 mg SubQ Q4H PRN
  - Scopolamine 1.5 mg patch 1-3 patches Q72H
  - Atropine 1% ophthalmic solution 1-2 drops sublingual Q4H PRN
  - Glycopyrrolate 0.2-0.4 mg IV or SubQ Q4 H PRN

# Resources

# Provider Resources

- National POLST Form: Portable Medical Order
  - https://polst.org/national-form/
  - https://polst.org/wp-content/uploads/2020/03/2019.01.14-POLST-Intended-Population.pdf

- Center to Advance Palliative Care (CAPC)
  - For more information on palliative care, and for courses for the non-palliative care specialist, visit the Center to Advance Palliative Care at www.capc.org.
  - CAPC courses for CE credits require a membership.

- Vital Talk- Clinician Communication
  - https://www.vitaltalk.org/

# Provider Resources

- For the National Consensus Project (NCP) Guidelines, go to www.nationalconsensusproject.org.
- For the National Quality Forum (NQF), National Framework and Preferred Practices for Palliative and Hospice Care Quality, go to www.qualityforum.org.

# Having Difficult Conversations with Seriously Ill Patients and their Families

- "Ten Steps for What to Say and Do"
  - https://getpalliativecare.org/resources/clinicians


**"Disclose Serious News"**
**https://www.vitaltalk.org/topics/disclose-serious-news/**

# Referral Resources

- Center to Advance Palliative Care (CAPC)
  - Assisting New and Emerging Programs www.capc.org
  - CAPC courses for CE credits require a membership

- Locating Palliative Care Providers
  - www.getpalliativecare.org

- Highmark's Case Management Disease Management team can assist in facilitating Palliative Care options
  - Located on Availity

# Palliative Care Provider Search[1]

## Palliative Care Provider Directory

Search Results: 20 results found

ENTER ADDRESS, ZIP CODE OR CITY & STATE

Hershey, PA

RADIUS

Closest 20 results

CHECK THE ONE THAT APPLIES:

☑ Hospital ☐ Nursing Home ☐ Office/Clinic ☐ Home

Search

The Palliative Care Provider Directory is a resource to help you or a loved one locate palliative care in your area. It includes all programs that have listed themselves with us. Please contact the palliative care program directly to confirm eligibility.

| | |
|---|---|
| Milton S Hershey Medical Center | 2.06 mi |
| Women and Babies Hospital of Penn Medicine Lancaster General Health | 22.06 mi |
| York Hospital | 23.79 mi |
| Lancaster General Hospital | 24.58 mi |
| Wellspan Ephrata Community Hospital | 25.6 mi |
| Reading Hospital | 37.04 mi |

## Palliative Care Provider Directory

Search Results: 20 results found

ENTER ADDRESS, ZIP CODE OR CITY & STATE

Hershey, PA

RADIUS

Closest 20 results

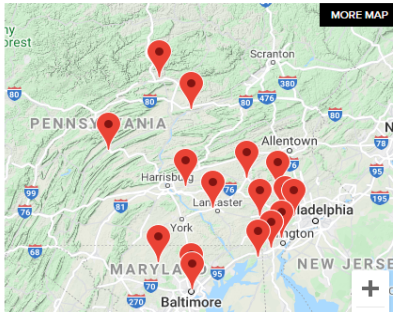
CHECK THE ONE THAT APPLIES:

☐ Hospital ☐ Nursing Home ☑ Office/Clinic ☐ Home

Search

The Palliative Care Provider Directory is a resource to help you or a loved one locate palliative care in your area. It includes all programs that have listed themselves with us. Please contact the palliative care program directly to confirm eligibility.

| | |
|---|---|
| Milton S Hershey Medical Cente | 2.06 mi |
| Ann B Barshinger Cancer Institute of Penn Medicine Lancaster General Health | 21.88 mi |
| Women and Babies Hospital of Penn Medicine Lancaster General Health | 22.06 mi |
| Palliative Medicine Consultants | 22.12 mi |
| Reading Health Physican Network Palliative Medicine | 36.52 mi |
| Geisinger Medical Center | 47.17 mi |



# Enhanced Community Care Management (ECCM)

- Enhanced Community Care Management (ECCM) is supportive care for chronically ill patients who wish to remain independent in the community.
- ECCM provides specialized care coordination and palliative care coordination that focuses on leading patients to live their best life possible.
- Our interdisciplinary care team, including physicians, advanced practice providers (nurse practitioners and physician assistants), nurses, social workers, and care coordinators, offers person and family-centered care and solutions.
- ECCM focuses on activating patients to engage in self-management of their chronic conditions, improving quality of life, reducing symptom burden, and increasing emotional well-being.
- Effective communication, continuity of care and addressing care giver burden and advance care planning are hallmarks of ECCM.
- ECCM care is provided telephonically, virtually, and in the home to ensure we are meeting patients where they are and matching them with the appropriate team member and resources based on their changing needs.  Our model is flexible, reducing disruption for the patient, family, and caregiver by providing care during the most complex parts of the care continuum (chronic, complex care and palliative care).  Our team is the extra set of eyes and hands in the home coordinated with the primary care provider to monitor your patient more closely when they need it the most.

# Enhanced Community Care Management (ECCM)

- Patients are not required to be homebound or meet skilled level of care criteria to be eligible for services.
- Patients can receive home health and ECCM care at the same time.
- This service is offered free of charge for Highmark Medicare Advantage, Highmark Individual ACA patients, Wholecare Dual Eligible and Wholecare Medicaid.
- Referrals to ECCM can be made via Epic, Epic Care Link/Healthy Planet, Email, Fax, Phone and Care Port.

# Patient and Family Education Resources

- General Palliative Care Overview for Patients:
  - https://getpalliativecare.org/handouts-for-patients-and-families/
- Advance Directives
  - https://prepareforyourcare.org/welcome
- Physician Orders for Life Sustaining Treatment (POLST)
  - https://polst.org/frequently-asked-questions-for-patients/
- Hospice
  - https://www.nhpco.org/patients-and-caregivers/about-hospice-care/
- Caregiver resources
  - Respite care
    - https://www.nia.nih.gov/health/what-respite-care

# References

# References


1. *What is Palliative Care?* (n.d.) Retrieved June 15, 2023, from https://getpalliativecare.org/whatis/
2. *What are the differences and Commonalities Between Hospice and Palliative Care? (n.d.) Retrieved June 15, 2023 from https://www.vitas.com/hospice-and-palliative-care-basics/about-palliative-care/hospice-vs-palliative-care-whats-the-difference*
3. Ahia, C.L., Blais, C.M. (2014). Primary palliative care for the general internist: integrating goals of care discussions into the outpatient setting. The *Ochsner Journal*,14(4), 704-11.
4. Nowels, D., Jones, J., Nowels, C., Matlock, Daniel. (2016). Perspectives of Primary Care Providers towards Palliative Care for Their Patients. *Journal of American Board of Family Medicine, vol 29* (no.6), pg 748-758. https://www.jabfm.org/content/jabfp/29/6/748.full.pdf
5. Parrish, M., Kinderman, A., Rabow, M. (2015). *Weaving Palliative Care into Primary Care: A Guide for Community Health Centers*. https://www.chcf.org/wp-content/uploads/2017/12/PDF-WeavingPalliativeCarePrimaryCare.pdf
6. Supportive & Palliative Care Indicator Tool (SPICT). (2021). *The University of Edinburgh*. Retrieved June 16, 2023, from *https://www.spict.org.uk/*
7. Palliative Care Outcome Scale. Cicely Saunders Institute. (2012) Retrieved June 15, 2023, from https://pos-pal.org/maix/ipos_in_english.php
8. WHO Clinical Consortium on Healthy Ageing. Report of consortium meeting 1–2 December 2016 in Geneva, Switzerland. Geneva: World Health Organization; 2017 (WHO/FWC/ALC/17.2). Licence: CC BY-NC-SA 3.0 IGO. https://apps.who.int/iris/bitstream/handle/10665/272437/WHO-FWC-ALC-17.2-eng.pdf
9. Greco, L. (2019). *Implementing Palliative Care into Primary Care*. Retrieved June 18, 2023 from https://carecompassnetwork.org/wp-content/uploads/2019/10/15_Palliative-Care-Toolkit.pdf
10. Karnofsky Performance Status Scale. Retrieved June 16 2023 from http://www.npcrc.org/files/news/karnofsky_performance_scale.pdf
11. Oken, M., Creech, R., Tormey, D., et al. (1982). Toxicity and response criteria of the Eastern Cooperative Oncology Group. Am J Clin Oncol;5:649-655.
12. Stone, C., Tierman, E., Dooley, D. (2008). Prospective Validation of the Palliative Prognostic Index in Patients with Cancer. Reprinted from Journal of Pain and Symptom Management, Vol. 35, 617–622. https://www.sciencedirect.com/science/article/pii/S0885392407007981
13. Palliative Performance Scale Version 2. (2001) Victoria Hospice Society. Retrieved June 15, 2023, from http://www.npcrc.org/files/news/palliative_performance_scale_PPSv2.
14. Reisberg, B. (1988). Functional Assessment Staging (FAST). Psychopharmacology Bulletin. 24, 653-659.
15. Identifying Patients in Need of Palliative Care Assessment in the Hospital Setting: *A Consensus Report from the Center to Advance Palliative Care*, David E. Weissman, M.D., and Diane E. Meier, M.D. https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/pcp/chcf_pca_jpm_article.

# References


16. Van Walraven C., Dhalla I.A., Bell C., Etchells E., Stiell I.G., Zarnke K., Austin P.C., Forster A.J. Derivation, and validation of an index to predict early death or unplanned readmission after discharge from hospital to the community. *Can. Med. Assoc. J.* 2010;182:551–557. doi: 10.1503/cmaj.09111
17. National POLST Coalition. (2022). POLST & Advance Directives. Retrieved June 16, 2023, from https://polst.org/polst-and-advance-directives/
18. Sabatino, C., Karp, N. (2011). Improving Advanced Illness Care: The Evolution of State POLST Programs. Retrieved June 16 2023, from https://assets.aarp.org/rgcenter/ppi/cons-prot/POLST-Report-04-11.pdf
19. Holmes, H. M., Hayley, D. C., Alexander, G. C., & Sachs, G. A. (2006). Reconsidering medication appropriateness for patients late in life. *Archives of (Internal Medicine*, 166(6), 605. doi:10.1001/archinte.166.6.605 Reprinted from Journal of Pain and Symptom Management, Vol. 35, No. 6, Stone, C., Tierman, E., & Dooley, B., Prospective Validation of the Palliative Prognostic Index in Patients with Cancer, 617–622, Copyright (2008) https://www.sciencedirect.com/science/article/pii/S0885392407007981
20. Scott, I. A., Hilmer, S. N., Reeve, E., Potter, K., Le Couteur, D., Rigby, D., . . . Martin, J. H. (2015). Reducing inappropriate polypharmacy. *JAMA I nternal Medicine, 175*(5), 827. doi:10.1001/jamainternmed.2015.0324(22)Reeve, E. (2020). Deprescribing tools: A review of the types of tools available to aid deprescribing in clinical practice. *Journal of Pharmacy Practice and Research, 50*(1), 98-107. doi:10.1002/jppr.1626
21. Reeve, E. (2020). Deprescribing tools: A review of the types of tools available to aid deprescribing in clinical practice. *Journal of Pharmacy Practice and Research, 50*(1), 98-107. doi:10.1002/jppr.1626
22. World Health Organization. (2018). WHO guidelines for the pharmacological and radiotherapeutic management of cancer pain in adults and adolescents. World Health Organization. https://apps.who.int/iris/handle/10665/279700. License: CC BY-NC-SA 3.0 IGO
23. Korff, M. V., Saunders, K., Thomas Ray, G., Boudreau, D., Campbell, C., Merrill, J., . . . Weisner, C. (2008). De facto LONG-TERM Opioid therapy for Noncancer Pain. *The Clinical Journal of Pain, 24*(6), 521-527. doi:10.1097/ajp.0b013e318169d03b
24. Groninger, H., & Vijayan, J. (2014). Pharmacologic Management of Pain at the End of Life. *American Family Physician, 90*(1), 26-32.
25. National Comprehensive Cancer Network. (2021). *Adult Cancer Pain (version 1.2021).* Retrieved June 16, 2023, from https://www.nccn.org/professionals/physician_gls/pdf/pain.pdf
26. Cancer pain (pdq®): Health professional version. Retrieved June 21, 2023, from https://pubmed.ncbi.nlm.nih.gov/26389387/?dopt=Abstract
27. National Comprehensive Cancer Network. (2021). *Palliative Care (version 2.2021).* Retrieved June 21, 2023, from https://www.nccn.org/professionals/physician_gls/pdf/palliative.pdf
28. Irish, L. A., Kline, C. E., Gunn, H. E., Buysse, D. J., & Hall, M. H. (2015). The role of sleep hygiene in promoting public health: A review of empirical evidence. *Sleep Medicine Reviews, 22,* 23-36. doi:10.1016/j.smrv.2014.10.001
29. Wee, B., & Hillier, R. (2008). Interventions for noisy breathing in patients near to death. *Cochrane Database of Systematic Reviews.* doi:10.1002/14651858.cd005177.pub2 ?? PAGE 56
30. Campbell, M. L. (2015). Caring for dying patients in the intensive care unit. *AACN Advanced Critical Care*, *26(2),* 110-120. doi:10.1097/nci.0000000000000077