Geri-Palliative Care (GPC)

John Seymour MD
Geriatric Medicine Fellow
URMC
GPC is like a PB&J Sandwich... Great Together
Learning Objectives

1. What is Geriatrics-Palliative Care?
2. Integration of Geriatrics-Palliative Care in daily practice
3. Limitations in Geriatrics-Palliative Care
Demographic Shift

- Number of Americans ages 65 and older is projected to nearly double from 52 million in 2018 to 95 million by 2060, and the 65-and-older age group’s share of the total population will rise from 16 percent to 23 percent.

- More diverse in ethnicity and race. Projected non-hispanic White older population will decrease from 77 percent to 55 percent.

**FIGURE 1**
The Number of Americans Ages 65 and Older Will More Than Double by 2060.

Source: PRB analysis of data from the U.S. Census Bureau.
Clinical Case

65 yo male with no medical history presents with complaints of abdominal pain. Per patient, abdominal pain x1 wk, located Rt side band like towards his Rt lower back. Pain was described as sharp and intensity 8/10. Associated symptoms included nonbloody and Nonbilious emesis, diarrhea x1 week. Symptoms are worse at night. Pain is relieved by eating food on occasions. No history of colonoscopy or family history of cancer. Denies fever, chills, nausea, weight loss, anorexia, melena, bloody stools, headache, palpitations, chest pain, or urinary symptoms.

ROS: all negative except above
Clinical Case (cont’d)

PMH: none

PSH: none

Social Hx: 1 pack per day (ppd) for 20 years and quit 5 years ago. Social drinker: one beer at holiday parties, lives alone and currently works factory.

Allergies: NKDA

No HCP or Advance Directives

CODE Status: Presumptive Full Code
Clinical Case- Physical Examination

GA: Patient is NAD, AAOX3

Skin: warm, dry and normal color

HEENT: NC/AT, PERRLA, EOMI, conjunctiva clear, palpable Supraclavicular LN.

CVS: normal S1 and S2, RRR no murmurs, rubs or gallops.

Resp.: CTAB

Abdomen: soft, bowel sounds hypoactive, hepatomegaly, RUQ tenderness.

Musculoskeletal: normal ROM, strength +5 BL, normal gait
Imaging

*Ct Abd/pelvis with contrast:* Constellation of findings seen compatible with stage IV disease. Primary likely related to abnormal wall thickening pattern seen at distal sigmoid colon. Regional lymphadenopathy, likely metastatic, is present. *Extensive metastasis w/in the liver are seen with porta hepatis region borderline lymphadenopathy, likely reflecting metastatic disease as well.*

*CT chest w/ contrast:* no signs of metastasis.
Consult: Palliative Medicine

Chronic malignant pain-
- Morphine 2 mg IV every 6 hours as needed and Morphine 2 mg IV every 3 hours as needed for breakthrough pain.
- Morphine 15 mg PO every 12 hours

Advance Care Planning: Full code Status. MOLST completed.

Health care Proxy: Maria Brown (sister) was appointed, no HCP prior to this hospitalization.
Goal of Care: Upon Interviewing with Maria(sister) and Niece Jane, numerous female members have a history of malignancies. Patient was unaware of family history of malignancies. They all agreed to seek advice from specialties about possible treatment plan.

Religion: Christian (Catholic)

Outcome

- Patient was discharged on initial diagnosis and re-admitted due to rapid progression of the malignancy.
- IR liver biopsy metastatic adenocarcinoma, consistent with lower GI tract primary.
- Patient failed both Colonoscopy prep.
- Patient was referred to surgery for debunking Palliative Surgery
- Patient unfortunately expired due to complications of the surgery.
Geriatric Medicine

- is a specialty of medicine concerned with physical, mental, functional and social conditions in acute, chronic, rehabilitative, preventive, and end-of-life care in older patients.

- improving and maintaining functionality in older adults.
Geriatrics: Age-Friendly Health System
Multicomplexity
...describes the whole person, typically an older adult, living with multiple chronic conditions, advanced illness, and/or with complicated biopsychosocial needs

Mind
- Mentation
- Dementia
- Delirium
- Depression

Mobility
- Amount of mobility; function
- Impaired gait and balance
- Fall injury prevention

Medications
- Polypharmacy, deprescribing
- Optimal prescribing
- Adverse medication effects and medication burden

What Matters Most
- Each individual’s own meaningful health outcome goals and care preferences
Palliative Medicine

- approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. (WHO)

- 67% of hospitals with more than fifty beds have palliative care programs and 90% of hospital systems with over 300 beds now have access to palliative care
Palliative Care Pillars

6 Pillars of Palliative Care

- Medical
- Psychological
- Social
- Spiritual
- Cultural
- Nursing
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<tr>
<th>Domain</th>
<th>Key Recommendations</th>
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<tr>
<td>Structure and processes of care</td>
<td>Interdisciplinary team, comprehensive interdisciplinary assessment, education and training; relationship with hospice program</td>
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<td>Physical aspects of care</td>
<td>Pain and other symptoms are managed with the use of best practices</td>
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<tr>
<td>Psychological and psychiatric aspects of care</td>
<td>Psychological and psychiatric issues are assessed and managed; grief and bereavement program is available to patients and families</td>
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<tr>
<td>Social aspects of care</td>
<td>Interdisciplinary social assessment with appropriate care plan; referral to appropriate services</td>
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<tr>
<td>Spiritual, religious, and existential aspects of care</td>
<td>Spiritual concerns are assessed and addressed; linkages to community and spiritual or religious resources are provided as appropriate</td>
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<tr>
<td>Cultural aspects of care</td>
<td>Culture-specific needs of patients and families are assessed and addressed; recruitment and hiring practices reflect the cultural diversity of the community</td>
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<td>Care of the imminently dying patient</td>
<td>Signs and symptoms of impending death are recognized and communicated; hospice referral is recommended when patient is eligible</td>
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<td>Ethical and legal aspects of care</td>
<td>Patient’s goals, preferences, and choices form basis for plan of care; the team is knowledgeable about relevant federal and state statutes and regulations</td>
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* Adapted from the National Consensus Project for Quality Palliative Care.²
Geri-Palliative

integrates the complementary specialties of geriatrics and palliative care to provide comprehensive care for older patients entering the later stage of their lives, and their families.
Severity of illness with palliative care needs

- Pediatric Palliative Care
- Specialist Palliative Care
- Generalist Palliative Care
- Geriatric Palliative Care

Birth Age 18 Adult medicine Age 65 Death

Life span
Continuum of GPC

Management of Chronic Medical Conditions, no clear "cure"
Goals of Care

- Office Visit or inpatient Family Meeting
- Medical condition
- Core Values
- Treatment & Therapy
- Care Plan
- Functional Status
- Prognosis
- Advance Directives
Challenges in GPC

- Limited clinical research trials on frail and cognitive impaired patients
- Advanced care planning and healthcare decision in frail patient with no capacity. Unwarranted hospitalizations and further harm.
- Conduct methodologically sound and ethically justified research to offer evidence-based interventions of care and training
Challenges in Clinical Case: GPC ViewPoints

- This patient had no clear and established Primary Care doctor/ Geriatrician.

- Assessing functionality and monitoring of chronic medical conditions with this patient. (i.e screening and other preventative care). This was not present.

- Medical care was fragmented, which led to lack of follow up.

- GOC was very indecisive. (Curative or Symptomatic treatment?)

- Social Support was questionable, potentially contributing to lack of medical follow up.

- Unclear prognosis, possible hospice evaluation??
Hospice Care

- transitioning to End of life care, with comfort care measures with intent of improving quality of life
- symptomatic management
- terminal illness, expected lifespan six months or less or whether illness runs its course, however can be longer than 6 months thus requiring recertification.
- less burden of unnecessary medical care (polypharmacy, doctors appointments)
Hospice vs Palliative

Palliative Care
Symptom management of a life-limiting illness.

Hospice Care
Symptom management and comfort care at the end of life.
GPC Interesting Articles
Background
aim of this study is to identify barriers and facilitators and good practice examples of collaboration and integration between palliative care and geriatric medicine. thus advocating better care for increasing number of older adult.

Method
- Four semi-structured group interviews with 32 participants from 18 countries worldwide. Participants were both clinicians (geriatricians, General practitioners, palliative care specialists) and academic researchers.
Results & Conclusion: Limited insights of what the other discipline offers, a lack of common practice and a lack of communication between disciplines and settings were considered as barriers for collaboration between palliative care and geriatric medicine. Ultimately, geriatricians and other healthcare providers should become more verse in basics of palliative care and its principle. In addition, increasing the number of academic chair, develop more education and development at the intersection of palliative care and geriatric medicine.
Main points:
Integrating proactive geriatrics and palliative care for patients with COPD could be accomplished through:

1) Education on anticipatory guidance for symptoms management.

2) Identify and managing complex symptoms and functional needs

3) Opening dialogue with family and patients about values
(4) training for clinicians who are neither geriatricians nor palliative care specialists on how to integrate principles from both disciplines into routine care, including the safe and appropriate use of low-dose opioids to preempt breathlessness crises

(5) development of referral criteria for specialist-level geriatrics and palliative care consultation.
References

Medicine of the Highest Order