



INTEGRATING PALLIATIVE CARE INTO THE PCMH-N MODEL

Care of the Patient Nearing the End of Life

1

1

Welcome

- Thank you for attending this event. Please ensure you sign in using link in chat box.
- Disclosure information can be found on this PowerPoint presentation.
- Please make sure you attend the entire session and complete the evaluation. Evaluation will be shared at the end of session and link will be included in a follow up email.
- You will receive your CME/CE Certificate after completing the evaluation.
- Deadline for evaluation is 10 business days after training.
- We will be using Active Learning Strategies to support this assessment, such as break out sessions, polling during presentations and question and answer opportunities.
- It is important that you communicate with us that the content presented is clear, understandable and useful for you.
- Please ask questions and seek clarification whenever you have a concern.
- We need for you to share your wisdom and feedback with us.



2

2

Requirements for Completion

- Sign in and attend entire session.
- Complete evaluation. Evaluation will be shared at the end of session and link will be included in a follow up email.
- You will receive your CME/CE Certificate after completing the evaluation.
- Deadline for evaluation is 10 business days after training.



3

3

Disclosures

Speakers and Planners	Content Reviewers
Mary Beth Billie DNP, RN-BC, CCM (Speaker and Planner) No Commercial Relationships	Ruth Clark RN, BSN, MPA (Content Reviewer) No Commercial Relationships
Thomas Dahlborg, MSHSM (Planner, Reviewer, and Executive Oversight of Mi-CCSI) No Commercial Relationships	Anthony Clarke, MD (Content Reviewer) No Commercial Relationships
Ellen Fink-Samick, MSW, LCSW, CCM, CCTP, CMHIMP, CRP, DBH-C (Speaker, Planner, Author) No Commercial Relationships	Lindsay Gietzen, PhD, PA-C (Content Reviewer) No Commercial Relationships
Virginia Hosbach, RN, MSN (Planner) No Commercial Relationships	Joanna Krapes, BSN, RN (Content Reviewer) No Commercial Relationships
Frances Jackson PhD, RN, PRP (Speaker) No Commercial Relationships	Rosemary Rojas, MSN, RN (Content Reviewer) No Commercial Relationships
Harmony Kinkle, BBA (Planner) No Commercial Relationships	Janet Scovel, MBA, BSN, RN, CCM (Content Reviewer) No Commercial Relationships
Ewa Matuszewski, BA (Speaker and Planner) No Commercial Relationships	David Van Winkle, MD, MBA (Content Reviewer) No Commercial Relationships
Carol F. Robinson DNP, MS, BSN, RN, CHPN (Speaker, Planner, Author, Reviewer) No Commercial Relationships	Erin Zimny, MD (Content Reviewer) No Commercial Relationships
Robin Schreur BS, RN, CCM (Planner) No Commercial Relationships	
Pauline Virro-Nic MS, MBA, PMP (Planner) No Commercial Relationships	
Sue Vos BSN, CCM, RN (Planner) No Commercial Relationships	



4

4

Continuing Education

Statement of Accreditation

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Michigan State Medical Society (MSMS) through the joint providership of Practice Transformation Institute and MI-CCSI. Practice Transformation Institute is accredited by the MSMS to provide continuing medical education for physicians.

AMA Credit Designation Statement

Practice Transformation Institute designates this live course for a maximum of 1 *AMA PRA Category 1 Credit(s)*[™]. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Social Work

This course is approved by the NASW-Michigan Social Work Continuing Education Collaborative Approval # 121621-01, # CE Hours approved: 1



5

5

Presenter

Carol F. Robinson DNP, MS, BSN, RN, CHPN®



6

6

Your Role and Interests

Poll (Question 0)

Who is with us today?

1. Physician
2. APP (NP, PA)
3. Care Manager
4. Social Worker
5. Medical Assistant
6. Other (share in chat)

What do you want to get out of today?

1. Tips and tricks for palliative assessments
2. Better understanding of pain management
3. Criteria for hospice care
4. Resources for end of life
5. Working with patients from start to finish of their palliative care



7

7

Learning Objectives

- Utilize clinical and functional assessment tools that identify a patient's worsening condition and appropriateness for hospice care
- Identify barriers to meeting patient and family needs while honoring their priorities
- Create a plan of care, in the least restrictive environment, that meets the needs of the patient and family while honoring the patient's preferences
- Define the indicators for a referral to a specialty hospice care provider



8

8

The Imminently Dying Person

- Team recognizes imminence of death and provides appropriate care to person and family
- As person declines, team introduces hospice referral option
- Team educates family to signs/symptoms of approaching death in a developmentally, age, and culturally appropriate manner



9

9

Being Mortal

Medicine and What Matters in the End

Atul Gawande MD, MPH

Gawande, A.
(2015_Feb 10). Being
Mortal. *PBS Frontline*.

<http://www.pbs.org/wgbh/frontline/film/being-mortal/>



10

10

Assessment

Needs & Concerns of Person

- Comprehensive assessment using open-ended questions
- Recognize common sources of suffering for people living with serious illness
- Define palliative care and how it could benefit the person
- Assess need for adaptive equipment



Ms. V welcomes her ninth great-grandchild, 4 days before her death



S etting:	Getting started
P erception:	What does the person know?
I nvitation:	How much does the person want to know?
K nowledge:	Share information.
E motion:	Respond to the person's feelings.
S ubsequent:	Planning and follow-up.

**Comprehensive
IDT Assessment
Structure and Process:
Open-ended questions
using SPIKES Protocol**



Buckman, R.(1992). How to break bad news: A guide for health care professionals. Baltimore, MD: The Johns Hopkins University Press.

Comprehensive Assessment

Stated and observed needs & concerns

Person's knowledge of disease

- What can you tell me about your illness/disease?
- How does your illness affect your daily activities?
- What symptoms bother you the most?
- What concerns you the most?
- How much of your day do you spend resting? Is it more or less than 50%? Has it changed recently?
- Has anyone talked with you about what to expect?
- How have your religious or spiritual beliefs been affected by your illness?
- Many people wonder about the meaning of all this - do you?
- Do you have a sense of how much time is left? Is this something you would like to talk about?



Medical College of Wisconsin (n.d.). Communication phrases in palliative care.

13

13

Incorporating Goals of Care

#WhatMattersMost

Who will speak for you if there is a time when you cannot speak for yourself?

What is important for you to live life well, until the end? Have you told your Patient Advocate?

- Who, or what, is your source of hope and strength?
- How are decisions about quality of life made in your family?
- Who would be important to include in discussions about your care?

What are you expecting as your illness progresses? If your current condition worsens, what are your goals?

- What are your fears?
- Are there any tradeoffs you are willing to make?
- LATER: What would a good day look like?

Gwande (2014)



Ultimate Goal: Align the person's care to their values and preferences!

14

14

Care of the Patient Nearing the End of Life

Clinical and Functional Assessment Tools



15

15

Managing Pain & Symptoms

Identifying Serious Illness/Hospice Care Needs

- For ongoing patients, conduct regular symptom assessment and success in controlling troubling symptoms
- Initiate steps for symptom management when person is in distress
 - Pain
 - Breathing: shortness of breath/dyspnea/air hunger/respiratory distress
 - Nausea/vomiting
 - Bowel management
 - Appetite
 - Fatigue
 - Sleep
 - Emotional/Psychosocial Distress
 - Spiritual Distress



16

16

Pain & Symptom Management

Decision aids for referral to Specialty Palliative Care

- Karnofsky Performance Status Scale http://www.npcrc.org/files/news/karnofsky_performance_scale.pdf
- Palliative Performance Scale <https://eprognosis.ucsf.edu/ppp.php>
- Edmonton Symptom Assessment Scale <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5337174/>
- Respiratory Distress Observation Scale[©]
<https://www.floridahospices.org/archives/Press%20Releases/Forum%20links/Meg%20Campbell%20Article.pdf>
- Heart Failure: Partnering in Your Treatment (American Heart Assn, 2019) <https://www.heart.org/en/health-topics/heart-failure/what-is-heart-failure/classes-of-heart-failure>
- End-Stage Renal Disease (ESRD). https://www.kidney.org/kidneydisease/siemens_hcp_quickreference
- FICA Spiritual Assessment Tool[©] <https://smhs.gwu.edu/spirituality-health/sites/spirituality-health/files/FICA-Tool-PDF-ADA.pdf>



17

17

Symptom Assessment

Edmonton Symptom Assessment Scale
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5337174/>
 Hui & Bruera (2017)

Date: _____ Time: _____

Please circle the number that best describes your average symptom over the past 24 hours:

No Pain	0 1 2 3 4 5 6 7 8 9 10	Worst Pain
No Fatigue	0 1 2 3 4 5 6 7 8 9 10	Worst Fatigue
No Nausea	0 1 2 3 4 5 6 7 8 9 10	Worst Nausea
No Depressed	0 1 2 3 4 5 6 7 8 9 10	Worst Depression
Not Anxious	0 1 2 3 4 5 6 7 8 9 10	Worst Anxiety
No Drowsiness	0 1 2 3 4 5 6 7 8 9 10	Worst Drowsiness
No Shortness of Breath	0 1 2 3 4 5 6 7 8 9 10	Worst Shortness of Breath
Best Appetite	0 1 2 3 4 5 6 7 8 9 10	Worst Possible
Best Feeling or Well Being	0 1 2 3 4 5 6 7 8 9 10	Worst Feeling of Well Being
Best Sleep	0 1 2 3 4 5 6 7 8 9 10	Worst Sleep

Completed by: Patient Family

Assessed by (Signature/Credentials/ID#/ Date/ Time) _____
 Print / Stamp Name: _____



18

18

Symptom Assessment

Karnofsky Performance Scale

http://www.nprc.org/files/news/karnofsky_performance_scale.pdf

Karnofsky & Burchenal (1949).



KARNOFSKY PERFORMANCE STATUS SCALE DEFINITIONS RATING (%)

CRITERIA

Able to carry on normal activity and to work; no special care needed.	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.
Unable to work; able to live at home and care for most personal needs; varying amount of assistance needed.	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.
Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly.	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

Symptom Assessment

Palliative Performance Scale

<https://eprognosis.ucsf.edu/pps.php>

Lee, Smith, & Widera (nd)



ePrognosis

HOME ABOUT CALCULATORS CANCER SCREENING DECISION AIDS COMMUNICATION

Palliative Performance Scale

- Population: Outpatients with advanced cancer
- Outcome: Median Survival in days
- Scroll to the bottom for more detailed information

Risk Calculator

1. How ambulatory is this patient?

2. What is the patient's daily level of activity? Is there any evidence of disease?

3. How much self-care assistance does this patient require?

4. How much oral intake does this patient have?

5. What is this patient's level of consciousness?

Your best guess of median survival in days

- The Palliative Performance Scale (PPS) has been shown to be both valid and useful for a broad range of palliative care patients: those with advanced cancer diagnoses or life-threatening non-cancer diagnoses in clinics, hospitals, or hospices.
 - The PPS scale¹ was developed in 119 palliative care patients at home (73% with PPS rating between 40-70%) and 213 patients admitted to a hospice unit (83% with PPS ratings between 20-50% on admission) in Victoria, British Columbia.
 - Prognostic estimates for outpatients with advanced cancer were externally validated in a study² of 1,655 adults from an outpatient Oncology Palliative Care Clinic in Toronto, Ontario, Canada between April 2007 and February 2010 (median age of 65 years, 51% female, 91% of patients had died at time of analysis).
 - Discrimination: This risk calculator indicates modest predictive performance (c-statistic=0.63) using the PPS.
- poor
 moderate
 good
 very good
 excellent
- 50% 66% 70% 80% 90%
- Calibration: Calibration was not assessed.
 - Citations:
 - 1 Anderson F, Downing GM, Hill J, Caserio L, Lorch N. Palliative Performance scale (PPS): a new tool. *J Pall Care*. 2011; 5-11
 - 2 Jing RW, Carleton VB, Swain N, Banerjee S, Mal E, Kaya E, Ruder G, Bryson J, Bidley JZ, Lo LW, Zimmermann C. Simple Prognostic Model for patients with advanced cancer based on performance status. *J Clin Oncol*. 2014; 30(5): 335-341.

DISCLAIMER

The information provided on ePrognosis is designed to complement, not replace, the relationship between a patient and his/her own medical providers. ePrognosis was created with the support of the Division of Geriatrics at the University of California San Francisco. However, its content is strictly the work of its authors and has no affiliation with any organization or institution. This web site does not accept advertisements. If you reproduce the material on the website please cite appropriately. For feedback and questions regarding the site please email: [si Lee, MD \[e:lee@ucsf.edu\]](mailto:si Lee, MD [e:lee@ucsf.edu]), [Alex Smith, MD \[a:smith@ucsf.edu\]](mailto:Alex Smith, MD [a:smith@ucsf.edu]) or [Eric Widera, MD \[e:widera@ucsf.edu\]](mailto:Eric Widera, MD [e:widera@ucsf.edu]).

Symptom Assessment

New York Heart Association (NYHA) Functional Classification

<https://www.heart.org/en/health-topics/heart-failure/what-is-heart-failure/classes-of-heart-failure>

Dolgin, Fox, Gorlin & Levin (1994)



Class	Patient Symptoms
I	No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea (shortness of breath).
II	Slight limitation of physical activity. Comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea (shortness of breath).
III	Marked limitation of physical activity. Comfortable at rest. Less than ordinary activity causes fatigue, palpitation, or dyspnea.
IV	Unable to carry on any physical activity without discomfort. Symptoms of heart failure at rest. If any physical activity is undertaken, discomfort increases.
Class	Objective Assessment
A	No objective evidence of cardiovascular disease. No symptoms and no limitation in ordinary physical activity.
B	Objective evidence of minimal cardiovascular disease. Mild symptoms and slight limitation during ordinary activity. Comfortable at rest.
C	Objective evidence of moderately severe cardiovascular disease. Marked limitation in activity due to symptoms, even during less-than-ordinary activity. Comfortable only at rest.
D	Objective evidence of severe cardiovascular disease. Severe limitations. Experiences symptoms even while at rest.

For Example:

- A patient with minimal or no symptoms but a large pressure gradient across the aortic valve or severe obstruction of the left main coronary artery is classified:
 - o **Function Capacity I, Objective Assessment D**
- A patient with severe anginal syndrome but angiographically normal coronary arteries is classified:
 - o **Function Capacity IV, Objective Assessment A**

Hospice Criteria

Ross, Sanchez-Reilly & Healy (2018), Page 1

https://cdn.ymaws.com/www.nmncp.org/resource/resmgr/2018_annual_conf_presentations_handouts/6_johnson/Hospice_Card_JSRRSSRJM_H20.pdf



NEUROLOGIC DISEASE

(Criteria are very similar for chronic degenerative conditions such as A.L.S., Parkinson's, Muscular Dystrophy, Myasthenia Gravis or Multiple Sclerosis)
The patient must meet at least one of the following criteria (I or 2A or 2B):

- Critically impaired breathing capacity, with all: Dyspnea at rest. Vital capacity < 30%. Need O₂ at rest. patient refuses artificial ventilation
OR
- Rapid disease progression with either A or B below:
Progression from:
Independent ambulation to wheelchair or bed-bound status normal to barely intelligible or unintelligible speech normal to pureed diet
independence in most ADLs to needing major assistance in all ADLs
AND
A. Critical nutritional impairment demonstrated by all of the following in the preceding 12 months:
Oral intake of nutrients and fluids insufficient to sustain life
Continuing weight loss
Dehydration or hypovolemia
Absence of artificial feeding methods
OR
B. Life-threatening complications in the past 12 months as demonstrated by ≥1:
Recurrent aspiration pneumonia, Pyelonephritis, Sepsis, Recurrent fever, Stage 3 or 4 pressure ulcers)

RENAL FAILURE

- The patient has 1, 2, and 3.
- The pt is not seeking dialysis or renal transplant
 - creatinine clearance* is < 10 cc/min (<15 for diabetics)
AND
 - Serum creatinine > 8.0 mg/dl (> 6.0 mg/dl for diabetics)
- Supporting documentation for chronic renal failure includes: Uremia, Oliguria (urine output < 400 cc in 24 hours), Intractable hyperkalemia (> 7.0), Uremic pericarditis, Hepatorenal syndrome, Intractable fluid overload.
- Supporting documentation for acute renal failure includes: Mechanical ventilation, Malignancy (other organ system) Chronic lung disease, Advanced cardiac disease, Advanced

STROKE OR COMA

- The patient has both 1 and 2.
- Poor functional status PPS* ≤ 40%
AND
 - Poor nutritional status with inability to maintain sufficient fluid and calorie intake with ≥1 of the following:
≥ 10% weight loss in past 6 months
≥ 7.5% weight loss in past 3 months
Serum albumin < 2.5 gm/dl
- Current history of pulmonary aspiration without effective response to speech therapy interventions to improve dysphagia and decrease aspiration events
- Supporting documentation includes:
Coma (any etiology) with 3 of the following on the 3rd day of coma:
Absent verbal response
Absent withdrawal response to pain
Serum creatinine > 1.5 mg/dl



- REFERENCES:**
- Centers for Medicare & Medicaid services, HHS § 418.22 Certification of terminal illness. <https://www.gpo.gov/fdsys/pkg/CFR-2011-titles42-vol32/pdf/CFR-2011-titles42-vol32-sec418-22.pdf>. Accessed 4/12/18
 - Medicare Program: FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements <https://www.federalregister.gov/documents/2017/08/04/2017-16294/medicare-program-fy-2018-hospice-wage-index-and-payment-rate-update-and-hospice-quality-reporting>. Accessed 4/12/2018
 - Anderson F, Downing GM, Hill J. Palliative Performance Scale (PPS): a new tool. J Palliat Care. 1996; 12(1): 5-11.
 - Morita T, Tsunoda J, Inoue S, et al. Validity of the Palliative Performance Scale from a survival perspective. J Pain Symp Manage. 1999; 18(1):2-3.
 - Virk K, Glare P. Validation of the Palliative Performance Scale for inpatients admitted to a palliative care unit in Sydney, Australia. J Pain Symp Manage. 2002; 23(6):456-7.
 - Mewis J, Kim A, Flanagan J. Palliative performance scale and survival among outpatients with advanced cancer. Supportive Care in Cancer 2015; 23:4: 913-918.

DISCLAIMER: The Hospice Criteria Card authors have made every effort to provide information that is accurate and complete. The information contained herein is provided "as is" and without warranty of any kind. The contributors to this card disclaim responsibility for any errors or omissions or for results obtained from the use of information contained herein.

Hospice Criteria Card

Hospice is a program designed to care for the dying & their special needs. All hospice programs should include:
(a) Control of pain and other symptoms through medication, environmental adjustment and education.
(b) Psychosocial support for both the patient and family, including all phases from diagnosis through bereavement.
(c) Medical services commensurate with patient needs.
(d) Interdisciplinary Team (IDT) approach to patient care, patient/and family support, and education.
(e) Integration into existing facilities where possible.
(f) Specially trained personnel with expertise in care of the dying and their families.

Hospice Eligibility Criteria
In order to be eligible to select hospice care under Medicare, an individual must be—(a) Entitled to Part A of Medicare; and (b) Certified as being terminally ill in accordance with § 418.22.

Duration of hospice care coverage—Election periods:
(1) An initial 90-day period;
(2) A subsequent 90-day period; or
(3) An unlimited number of subsequent 60-day periods.*

Hospice Face-To-Face (FTF) encounter Must include documentation that a hospice physician or a hospice nurse practitioner had a FTF encounter with the patient. This encounter is used to gather clinical findings to determine continued eligibility for hospice care. The FTF must occur within 30 days calendar prior to the start of the "3rd benefit period and every subsequent recertification period.

Hospice Levels of Care
Routine Home Care (RHC): Core services of hospice interdisciplinary team provided at patient's home (place of residence)
Continuous Home Care (CHC): Intended to support patient and their caregivers through brief periods of crisis. CHC provides care for 8-24 hours a day. 250% of care must be primarily provided by an LPN or RN. Home health aid or homemaker services can be used to cover the needs.

Inpatient Respite Care (IRC): short term care to provide relief to family/ primary caregiver. Limited to 5 consecutive days
General Inpatient Care (GIP): care provided in acute hospital or other setting with intensive nursing & other support outside of the home. For management of uncontrolled distressing physical symptoms (e.g. uncontrolled pain, respiratory distress, etc.) or psychosocial problems (e.g. unsafe home or imminent death when family can't cope at home)

Hospice Principal Diagnosis
Identify the condition that is the main contributor to the person's terminal prognosis. Non-specific diagnoses such as Debility or Adult Failure to Thrive (AFTT) may no longer be listed as a principal terminal diagnosis. Debility and AFTT can and should be listed as secondary (related) conditions to support prognosis if indicated.

Hospice Criteria

Ross, Sanchez-Reilly & Healy (2018), Page 2

https://cdn.ymaws.com/www.nmnp.org/resource/resmgr/2018_annual_conf_presentations_handouts/6_johnson/Hospice_Card_JSRRSSRJM_H_20.pdf



Terminal illness: GENERAL (non-specific)
Terminal condition not attributed to a single specific illness.

AND
Rapid decline over past 3-6 months as evidenced by:
Progression of disease evidenced by sx, signs & test results
Decline in PPS to ≤ 50%
Involuntary weight loss >10% and/or Albumin <2.5 (helpful)

CANCER
Patient meets ALL of the following:
1. Clinical findings of malignancy with widespread, aggressive or progressive disease as evidenced by increasing symptoms worsening lab values and/or evidence of metastatic disease
2. Palliative performance Scale (PPS) ≤ 70%
3. Refuses further life-prolonging therapy OR continues to decline in spite of definitive therapy

Supporting documentation includes:
Hypercalcemia > 12
Cachexia or weight loss of 5% in past 3 months
Recurrent disease after surgery/radiation/chemotherapy
Signs and sx of advanced disease (e.g. nausea, requirement for transfusions, malignant ascites or pleural effusion, etc.)

Functional Assessment Scale (FAST) for Alzheimer's Type Dementia

1	No difficulty either subjectively or objectively.
2	Completion of ongoing location of objects.
3	Subjective work difficulties.
4	Decreased job functioning evident to co-workers. Difficulty in traveling to new locations. Decreased organizational capacity.
5	Decreased ability to perform complex task, (e.g., planning dinner for guests, handling personal finances e.g. forgetting to pay bills, etc.)
6	Requires assistance in choosing proper clothing to wear for the day, season or occasion, (e.g. pt may wear the same clothing repeatedly, unless supervised)
7	Occasionally or more frequently over the past weeks, * for the following: A) Improperly putting on clothes without assistance or cueing B) Unable to bathe properly (not able to choose proper water temp)
8	Inability to handle mechanics of toileting (e.g., forget to flush the toilet, does not wipe properly or properly dispose of toilet tissue)
9	Urinary incontinence
10	Fecal incontinence
11	A) Ability to speak limited to approximately ≤ 8 intelligible different words in the course of an average day or in the course of an intensive interview B) Speech ability is limited to the use of a single intelligible word in an average day or in the course of an intensive interview C) Ambulatory ability is lost (cannot walk without personal assistance) D) Cannot sit up without assistance (e.g., the individual will fall over if there are not lateral restraints on the chair) E) Loss of ability to smile F) Loss of ability to hold up head independently

* Scored primarily on information obtained from a knowledgeable informant.

Palliative Performance Scale (PPS)

%	Ambulation	Activity Level Evidence of Disease	Self-Care		Intake		Level of Consciousness		Estimated Median Survival in Days	
			Self-Care	Intake	Level of Consciousness	Estimated Median Survival in Days				
100	Full	Normal (No Disease)	Full	Normal	Full	Normal	Full	NA	NA	108
90	Full	Normal (Some Disease)	Full	Normal	Full	Normal	Full	NA	NA	108
80	Full	Normal with (Self) Some Disease	Full	Normal or Reduced	Full	Normal or Reduced	Full	NA	NA	108
70	Reduced	Can't do normal job/work/Some Disease	Full	Normal or Reduced	Full	Normal or Reduced	Full	145	145	108
60	Reduced	Can't do hobbies/housework/Significant Disease	Occasional Assistance Needed	Normal or Reduced	Full or Confusion	Normal or Reduced	Full or Confusion	29	4	4
50	Majorly Reduced	Can't do any work/Extensive Disease	Consistent Assistance Needed	Normal or Reduced	Full or Confusion	Normal or Reduced	Full or Confusion	32	11	11
40	Majorly Reduced	Can't do any work/Extensive Disease	Major Assistance	Normal or Reduced	Full or Confusion	Normal or Reduced	Full or Confusion	18	3	41
30	Bed Bound	Can't do any work/Extensive Disease	Total Care	Reduced	As above	As above	As above	8	5	5
20	Bed Bound	Can't do any work/Extensive Disease	Total Care	Minimal sig	As above	As above	As above	4	2	6
10	Bed Bound	Can't do any work/Extensive Disease	Total Care	Minimal only	Dimmed or Coma	Dimmed or Coma	Dimmed or Coma	1	1	6
0	Death									

A Survival post admission to an inpatient palliative unit, all diagnoses (Nix 2012). B Days until patient death following admission to an acute hospice unit, diagnoses not specified (Johnson 1996). C Survival post admission to an inpatient palliative unit, cancer patients only (Morita 1996).

DEMENTIA
The patient has both 1 and 2:
1. Stage 7C or beyond according to the FAST Scale
AND
2. One or more of the following conditions in the 12 months:
Depression
Pyelonephritis
Sepsis
Multiple pressure ulcers (stage 3-4)
Recurrent Fever
Other significant condition that suggests a limited prognosis
Inability to maintain sufficient fluid and calorie intake in the past 6 months (10% weight loss or albumin < 2.5 gm/dl)

HEART DISEASE
The patient has 1 and either 2 or 3.
1. CHF with NYX Class IV symptoms & both:
Significant symptoms at rest
Inability to carry out even minimal physical activity without oxygen or nitrate
2. Patient is optimally treated (ie diuretics, vasodilators, ACEI, or hydralazine and nitrates)
3. The patient has angina pectoris at rest, resistant to standard nitrate therapy, and is either not a candidate for or has declined invasive procedures.

Supporting documentation includes:
EF ≤ 50%, Treatment resistant symptomatic dysrhythmias
h/o cardiac related syncope, CVA 2/2 cardiac embolism
h/o cardiac resuscitation, concomitant HIV disease

HIV/AIDS
The patient has either 1A or 1B and 2 and 3.
1A. CD4+ < 25 cells/ml, OR 1B. Viral load > 100,000
AND
2. At least one (1) : CNS lymphoma, untreated or refractory meningitis (loss of ≥ 35% lean body mass), MAC bacteremia, Progressive multifocal leukoencephalopathy, Systemic lymphoma -visceral KS, Renal failure no HD, Cryptosporidium infection, Refractory toxoplasmosis
AND
3. PPS* of < 50%

LIVER DISEASE
The patient has both 1 and 2.
1. End stage liver disease as demonstrated by A or B & C:
A. PTI > 5 sec
OR
B. INR > 1.5
C. Serum albumin < 2.5 gm / dl
AND
2. One or more of the following conditions:
Refractory Ascites, h/o spontaneous bacterial peritonitis, Hepatorenal syndrome, refractory hepatic encephalopathy, h/o recurrent variceal bleeding

Supporting Documents includes:
Progressive malnutrition, Muscle wasting with decreased strength, Ongoing alcoholism (> 80 gm ethanol/day), Hepato-cellular CA HbsAg positive, Hep. C refractory to treatment

PULMONARY DISEASE
Severe chronic lung disease as documented by 1, 2, and 3.
1. The patient has all of the following:
Disabling dyspnea at rest
Little of h/o response to bronchodilators
Decreased functional capacity (e.g. bed to chair assistance, fatigue and cough)
AND
2. Progression of disease as evidenced by a recent h/o increasing office, home, or ED visits and/or hospitalizations for pulmonary infection and/or respiratory failure.
AND
3. Documentation within the past 3 months ≥1:
Hypoxemia at rest on room air (pO2 < 55 mmHg by ABG) or oxygen saturation < 88%
Hypertension evidenced by CO2 > 50 mmHg
Supporting documentation includes:
COP Pulmonary and right heart failure
Unintentional progressive weight loss


Care of the Patient Nearing the End of Life

Case Study: Ms. V



Ms. V

**History, using
Comprehensive Assessment**



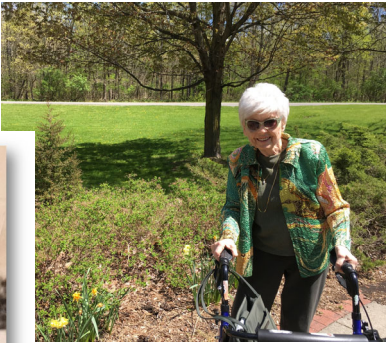

MI-CCSI
Center for Clinical Systems Improvement

Practice
Transformation Institute

25

25

**Physical
Assessment
History**



MI-CCSI
Center for Clinical Systems Improvement

Practice
Transformation Institute

26

26

Psychological & Psychiatric



27

27



Social Family & Relationships



28

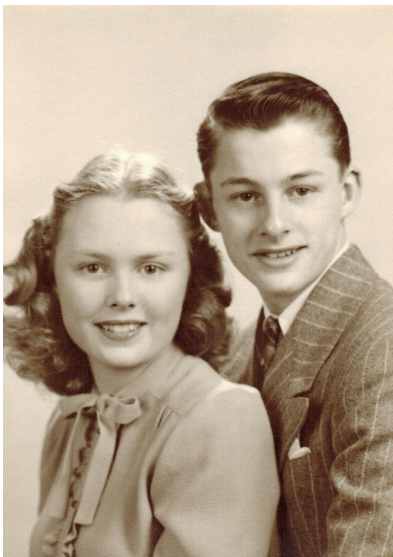


Social Financial



29

29



Spiritual, Religious & Existential



30



Cultural



31

31

Ethics and Law Medical Decision-Making



32

32

Case Study: Ms. V

Poll (Question 1)

You are Ms. V's case manager

Given her history of chronic pain, decreased mobility, and increasing frailty, which assessment tools would you use to help determine her current status?

1. Karnofsky Performance Status Scale
2. Edmonton Symptom Assessment Scale
3. Caregiver Strain Index
4. 1 and 2 only



33

33

Case Study: Ms. V

Scenario (Question 2)

Ms. V's daughter brings her to PCP for check-up

Assessment:

- Recent onset decreased stamina, increased fatigue, some air hunger with exertion
- Hasn't been able to shower without assistance
- Difficulty walking to Community Dining Room without stopping to rest; no energy to cook meals in her complete kitchen, depending more and more on door delivery
- Pain remains at usual levels
- PCP notes there has been a slight increase in Ms. V's heart murmur. All VS remain stable.

Plan:

- Remain in Independent Living and use resources as necessary (meal delivery, housekeeping assistance, pace self/take rest intervals, continue home-based palliative care for pain management).
- After the appointment Ms. V states to her daughter, "I wonder if my cancer is back?"



34

34

Case Study: Ms. V

Poll (Question 2)

You are Ms. V's care manager

Which response is most therapeutic?

1. "I am sure it's not cancer. You have been under stress. Let's focus on positive thoughts."
2. "It sounds like you are concerned about a cancer recurrence. What concerns you most?"
3. "What makes you think your present difficulties are related to cancer?"
4. "Is this something you want to discuss with your doctor?"



35

35

Case Study: Ms. V

Scenario

- Ms. V works an afternoon rest period into her day and asks her housekeeper to come weekly vs. every other week
- She continues with meal delivery and limits her excursions out of her apartment
- Ms. V mentions to her daughter that a local DME vendor, while servicing her walker, tells Ms. V he can get her a good deal on a used electric wheelchair.
- Ms. V's daughter is concerned her mother will lose more strength if she uses a power chair
- She is also concerned use of the chair could force her mom to Assisted Living
- Ms. V has always stressed a strong need to be independent



36

36

Case Study: Ms. V

Poll (Question 3)

Ms. V and her daughter call you, the care manager, for an opinion. You would respond:

1. "If she can get a good deal on a power chair, this might better conserve her energy for tasks in her home."
2. "Avoid this vendor; it sounds like he is trying to bill you for unnecessary equipment."
3. "Let's make an appointment for you to come in and talk to your doctor."
4. You ask Ms. V the Karnofsky Performance Scale questions over the phone and compare them to previous scores. You note the score has dropped. "It looks as though you may be experiencing a decline in function. May I schedule an appointment for you and your daughter to visit with the doctor?"



37

37

Case Study: Ms. V Scenario



38

Case Study: Ms. V

Poll (Question 4)

Ms. V chooses to be admitted to further assess the situation.

What question(s) would you recommend for Ms. V?

1. "What do you understand about your condition?"
2. "What do you hope for right now?"
3. "Do you want to start hospice services?"
4. 1 and 2



39

39

Discharge Planning

Karnofsky Scale 40
 Palliative Performance Scale
 40%
 NYHA Class 3C
 worst case 44 days,
 most likely 51 days,
 best case 60 days



40

Discussion

Discharge Planning

While in Rehab, Ms. V's daughter wants to approach her mother about the need for Assisted Living (AL) vs. returning to Independent Living (IL)

What questions or recommendations could help Ms. V and/or her daughter make the decision on IL vs. AL?



41

41

Disposition decision: Assisted Living

Assessment and Plan

Subjective:

- Ms. V is pleasantly surprised with the AL unit
- She is determined to be able to attend activities in the day room and attend Sunday services in the Chapel
- She would also like to eat in the dining room

Objective:

- Ms. V is fatigued and slightly SOB walking from bedroom to living room; she is unable to walk outside of her room
- She remains cheerful, states "I just need to get my strength back so I can do the other activities."



42

42

Disposition decision: Assisted Living

Poll (Question 5)

As her care manager, you would ask Ms. V:

1. "What can you tell me about your disease?"
2. "Has anyone talked with you about what to expect?"
3. "What matters most to you right now?"
4. "Many people wonder about the meaning of all of this (e.g., fatigue, limited ADLs and stamina). Is that something you wonder about?"
5. All of the above



43

43

Decisions

- Ms. V understands her "time is limited"
- Daughter recommends they consider hospice for additional support to her mother and the AL staff, as she is requiring increased personal care due to SOB and fatigue
- Daughter calls the PCP and requests a hospice consult from their preferred hospice service

True or False:

The PCP can act as the primary physician for Mrs. V's non-hospice needs while she on hospice service

- True
- False



44

Patient-Centric Hospice Plan of Care

- Ms. V's PCP will remain Physician of Record for issues not related to hospice admission criteria;
- Hospice NP will manage orders for issues directly related to admission criteria
 - Hospice RN will visit 1-2x/week to assess pain and functional status
 - Pain will be managed at acceptable level, with consideration for Morphine Sulfate Extended Release (MSER) equianalgesia. Potential crisis aversion plan will be formulated for when Ms. V can no longer swallow. Transition plan will include route/dosage change from MSER tabs to MS Instant Release (oral or rectal as indicated)
- Oxygen at 2 lpm as needed for air hunger and during activity
- Hospice CNA will visit 3 days/week for personal care



45

45

Patient-Centric Hospice Plan of Care

- Hospice volunteer will visit 1 day/week to help Ms. V with holiday cards and social stimulation
- Ms. V will access spiritual support from her CCRC's Chaplain, who is known to her
- Hospice social worker will provide support to Ms. V and her daughter for financial and emotional support concerns



46

46

Document the Person-Centric Plan

Michigan Physician Order for Scope of Treatment (MI-POST)

https://www.michigan.gov/mdhhs/0,5885,7-339-73970_5093_28508_76849-488836-,00.html

Prevents or manages crisis intervention



The screenshot shows the MDHHS website with a search bar at the top. The navigation menu includes: Assistance Programs, Adult & Children's Services, Safety & Injury Prevention, Keeping Michigan Healthy, Doing Business with MDHHS, and Inside MDHHS. The 'Inside MDHHS' menu is expanded, showing: Budget & Finance, Office of Inspector General, Careers With MDHHS, Community & Volunteer Opportunities, County Offices, Equal Employment Opportunity, Executive Staff Bios, Reports & Statistics - Health Services, Hotlines, Legal, MDHHS Audit, Newsroom, and Policy and Planning. The main content area is titled 'MI-POST' and describes it as an optional, 1 page, 2-sided medical order. It lists related content such as Michigan EMS, Coronavirus Disease (COVID-19) Response, and Michigan Regional Poison Control Center.

47

47

MI-POST Form

MICHIGAN PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (MI-POST)
Michigan Department Health and Human Services

HPAA permits disclosure of MI-POST to other Health Care Professionals as necessary. This MI-POST form is void if Patient Information or Section D are blank. Leaving blank any section of the medical orders (Sections A or B) does not void the form and interpreted as full treatment for that section.

PATIENT INFORMATION
Patient Name (last, first, middle initial)
Date of Birth (mm/dd/yyyy) Date Form Prepared (mm/dd/yyyy)

Diagnosis supporting use of MI-POST
This form is a Physician Order sheet based on the medical conditions and decisions of the person identified on this form. Paper copies, facsimiles and digital images are valid and should be followed as if an original copy. This form is for adults with an advanced illness. It is not for healthy adults.

MEDICAL ORDERS

Section A - Cardiopulmonary Resuscitation (CPR)
Person has no pulse and is not breathing.
 Attempt Resuscitation/CPR (Must choose Full Treatment in Section B).
 DO NOT attempt Resuscitation/CPR (DNR/No CPR, allow Natural Death).
Valid DNR on file?
 Yes, date of DNR
 No

Section B - Medical Interventions
Person has pulse and/or is breathing.
 Comfort-Focused Treatment - primary goal of maximizing comfort. See MDHS-5837 for further details on medical interventions.
 Selective Treatment - primary goal of treating medical conditions while avoiding burdensome measures. See MDHS-5837 for further details on medical interventions.
 Full Treatment - primary goal of prolonging life by all medically effective means. See MDHS-5837 for further details on medical interventions.

Section C - Additional Orders (optional)
Medical orders for whether or when to start, withhold, or stop a specific treatment. Treatments may include but are not limited to dialysis, medically assisted provisions of nutrition, long-term life-support, medications, and blood products.

Section D - Signature of Attending Health Professional
My signature below indicated that these orders are medically appropriate given the patient's current medical condition, reflect to the best of my knowledge the patient's goals for care, and that the patient (or the patient representative) has received the information sheet.

Print Name Date
Signature Phone Number

Send form with patient whenever transferred or discharged.

MDHS-5836 (Rev. 4-21) 1

Patient Last Name Patient First Name

Print Name of Collaborating Physician Phone Number

Section E - Signature of Patient or Patient Representative
My signature indicates I have discussed, understand and voluntarily consent to the medical orders on this MI-POST form. I acknowledge that if I am signing as the patient's representative, these decisions are consistent with the patient's wishes to the best of my knowledge.
 Patient Patient Advocate/Durable Power of Attorney of Health Care (DPOAHC)
 Court-Appointed Guardian

Print Name Date
Signature Date

Information of Legally Authorized Representative
Complete this section if this MI-POST form was signed by a Patient Advocate/DPOAHC or Court-Appointed Guardian.

Address Phone Number Alternate Phone Number

Section F - Individual Assisting with Completion of MI-POST Form
Print Preparer's Name Title Date
Preparer's Signature Organization Phone Number

Section G - To Reaffirm or Revoke This Form
This MI-POST form can be reaffirmed or revoked at any time, verbally or in writing. See MDHS-5837 for further details on reaffirmation or revocation. If a new form is not completed, full treatment and resuscitation will be provided.

Reaffirmation 1
Healthcare Provider Name/ Collaborative Physician (if applicable)
Patient/Representative Name
Healthcare Provider Signature Patient/Representative Signature Reaffirmation Date

Send form with Patient whenever transferred or discharged.
HPAA permits disclosure of MI-POST to other Health Care Professionals as necessary.

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, gender identification or expression, sexual orientation, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

MDHS-5836 (Rev. 4-21) 2



48

48

MI-POST Patient & Family Information Sheet

This form *must* be filled out and attached to the MI-POST form!

See the MI-POST FAQ sheet for complete information

MICHIGAN PHYSICIAN ORDER FOR SCOPE OF TREATMENT (MI-POST) PATIENT AND FAMILY INFORMATION SHEET
Michigan Department of Health and Human Services

What is an MI-POST?

- An optional, two-page, two-sided medical order with a person's wishes for care in a crisis.
- A part of the advance care planning process that includes choices about Cardiopulmonary Resuscitation (CPR), critical care, and other wanted care.
- A form that guides care only if the person cannot tell others what to do at that time.
- A completed form is signed by the patient/patient representative and the physician, nurse practitioner, or physician's assistant that gives medical advice and suggestions.
- A patient representative may fill out an MI-POST for the person if they are not able to make healthcare choice due to illness or injury.

Who has an MI-POST?

- Any fully-abled adult or an adult with a serious illness like heart failure that has advanced and is near its treatment.
- An adult (or patient representative such as a Patient Advocate or court-appointed Guardian) that talks to a healthcare provider to learn about their choices for care and what they might mean for them.

Where can a MI-POST be found?

- A blank MI-POST can be found in care setting, including a provider's office, a health care facility or agency, or online.
- Completed forms belong to the person and are kept with the person wherever they live.
- Copies of the form can be given to family, friends, hospitals, and any other places the person wants for the original stay with the person.

When can a MI-POST be changed?

- The form can be changed at any time by the person or the patient representative, verbally or in writing.
- If any of the following has occurred, the form must be revoked or reaffirmed by the patient or patient representative and the Attending Health Professional within the time frame indicated from the time the event occurred, or the form will be considered VOID:
 - One year from the date since the form was last signed or reaffirmed.
 - 30 days from a change in the patient's Attending Health Professional or change in the patient's level of care, or care setting; or any unexpected change in the patient's medical condition.

How do I reaffirm or revoke a MI-POST?

- Reaffirming the MI-POST form indicates there are no changes and requires signature with date of reaffirmation on the second page of the form. The form provides space for one reaffirmation. If another reaffirmation is needed, a new MI-POST form should be completed.
- Revocation of this MI-POST form is required if treatment changes are desired. A new MI-POST form should be completed to reflect treatment changes. With "revoked" over the signatures of the patient or patient representative, and the signature(s) of the Attending Health Professional, in Section A, B, C, or D, and date the revocation.
- Write "VOID" diagonally on both sides in large letters and dark ink.
- Tell the Attending Health Professional, patient, patient representative, and care setting.

What do the types of medical interventions mean?

- Comfort-Focused Treatment** - primary goal of maximizing comfort.
- Relieve pain and suffering through medication by any route, positioning, would care and other measures. Use oxygen, manual suction treatment of airway obstruction and non-invasive

MDHHS-5837 (Rev. 2-21) 1

respiratory assistance as needed for comfort. Food and water provided by mouth as tolerated. May involve transportation to the hospital if comfort needs can't be met in current location.

- Selective Treatment** - primary goal of treating medical conditions while avoiding burdensome measures. In addition to care described in comfort-focused treatment, use IV fluid therapies, cardiac monitoring including cardioversion, and non-invasive airway support (CPAP, BiPAP) as indicated. DO NOT use advanced invasive airway interventions or mechanical ventilation. May involve transportation to the hospital. Generally, avoid intensive care.
- Full Treatment** - primary goal of prolonging life by all medically effective means. In addition to care described in selective treatment, use intubation, advanced invasive airway interventions, mechanical ventilation, cardioversion and other advanced interventions as medically indicated. Likely to involve transportation to the hospital. May include intensive care.

What if a section on MI-POST was previously left blank or incomplete?

- If a section was previously blank (Section A, B, or C) and is later completed, follow the procedures for reaffirming.

Why is a MI-POST helpful?

- A completed MI-POST expresses the person's wishes even if they cannot speak.
- How is a MI-POST different from an advance directive?**
 - MI-POST tells what care you give and an advance directive tells who can speak (patient advocate) for the person if they are not able.
 - An advance directive must be witnessed; the patient advocate must accept the role, and may or may not give information about wishes for care.

It is best for anyone with a MI-POST to also fill out a Durable Power of Attorney for Health Care form and talk to the person so that they will be prepared to speak on the person's behalf.

I have reviewed this information before signing a completed MI-POST.

Patient Name	Date of Birth
Patient Representative Name (if needed)	
Signature	Date

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, gender identification or expression, sexual orientation, partner considerations, or a disability or genetic information that is unrelated to the person's eligibility.

MDHHS-5837 (Rev. 2-21) 2



MI-POST Example

MICHIGAN PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (MI-POST)
Michigan Department Health and Human Services

HIPAA permits disclosure of MI-POST to other Health Care Professionals as necessary. This MI-POST form is void if Patient Information or Section D are blank. Leaving blank any section of the medical orders (Sections A or B) does not void the form and interpreted as full treatment for that section.

PATIENT INFORMATION

Patient Name (last, first, middle initial) _____
Date of Birth (mm/dd/yyyy) _____ Date Form Prepared (mm/dd/yyyy) _____

Diagnosis supporting use of MI-POST _____

This form is a Physician Order sheet based on the medical conditions and decisions of the person identified on this form. Paper copies, facsimiles and digital images are valid and should be followed as if an original copy. This form is for adults with an advanced illness. It is not for healthy adults.

MEDICAL ORDERS

Section A - Cardiopulmonary Resuscitation (CPR).
Person has no pulse and is not breathing.

- Attempt Resuscitation/CPR (Must choose Full Treatment in Section B)
- DO NOT attempt Resuscitation/CPR (DNR/No CPR, allow Natural Death)
- Valid DNR on file?
 - Yes, date of DNR _____
 - No

Section B - Medical Interventions
Person has pulse and/or is breathing.

- Comfort-Focused Treatment** - primary goal of maximizing comfort. See MDHHS-5837 for further details on medical interventions.
- Selective Treatment** - primary goal of treating medical conditions while avoiding burdensome measures. See MDHHS-5837 for further details on medical interventions.
- Full Treatment** - primary goal of prolonging life by all medically effective means. See MDHHS-5837 for further details on medical interventions.

Section C - Additional Orders (optional)
Medical orders for whether or when to start, withhold, or stop a specific treatment. Treatments may include but are not limited to dialysis, medically assisted provisions of nutrition, long-term life-support, medications, and blood products.

Section D - Signature of Attending Health Professional
My signature below indicates that these orders are medically appropriate given the patient's current medical condition, reflect to the best of my knowledge the patient's goals for care, and that the patient (or the patient representative) has received the information sheet.

Print Name _____ Date _____
Signature _____ Phone Number _____

Send form with patient whenever transferred or discharged.

MDHHS-5836 (Rev. 4-21) 1

Patient Last Name	Patient First Name
_____	_____

Print Name of Collaborating Physician
Jesse, Jonathan, MD Phone Number _____

Section E - Signature of Patient or Patient Representative
My signature indicates I have discussed, understood and voluntarily consent to the medical orders on this MI-POST form. I acknowledge that if I am signing as the patient's representative, these decisions are consistent with the patient's wishes to the best of my knowledge.

Patient Patient Advocate/Durable Power of Attorney of Health Care (DPOAHC) Court-Appointed Guardian

Print Name
Theresa R. Van _____ Date _____

Signature

Information of Legally Authorized Representative
Complete this section if this MI-POST form was signed by a Patient Advocate/DPOAHC or Court-Appointed Guardian.

Address	Phone Number	Alternate Phone Number
_____	_____	_____

Section F - Individual Assisting with Completion of MI-POST Form

Print Preparer's Name	Title	Date
_____	_____	_____
Preparer's Signature	Organization	Phone Number
_____	_____	_____

Section G - To Reaffirm or Revoke This Form
This MI-POST form can be reaffirmed or revoked at any time, verbally or in writing. If a new form is not completed, full treatment and resuscitation will be provided.

Reaffirmation 1
Healthcare Provider Name/ Collaborative Physician (if applicable)

Patient Representative Name

Healthcare Provider Signature _____ Patient Representative Signature _____ Reaffirmation Date _____

Send form with Patient whenever transferred or discharged.
HIPAA permits disclosure of MI-POST to other Health Care Professionals as necessary.

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, gender identification or expression, sexual orientation, partner considerations, or a disability or genetic information that is unrelated to the person's eligibility.

MDHHS-5836 (Rev. 4-21) 2



Final Days



51

51

Learning Objectives Recap

- Utilize clinical and functional assessment tools that identify a patient's worsening condition and appropriateness for hospice care
- Identify barriers to meeting patient and family needs while honoring their priorities
- Create a plan of care, in the least restrictive environment, that meets the needs of the patient and family while honoring the patient's preferences
- Define the indicators for a referral to a specialty hospice care provider



52

52



53



54



Thank you

Acknowledgements

Development Team

Michigan Center for Clinical Systems Improvement

- Thomas Dahlborg, MSHSM – Executive Director
- Sue Vos, BSN, CCN, RN – Program Director
- Robin Schreur, BS, RN, CCM – Trainer
- Pauline Virro-Nic, MS, MBA, PMP – Project Manager

Practice Transformation Institute

- Virginia Hosbach, MSN, RN – Director of Training and Education
- Harmony Kinkle, BBA – Director of Operations

Sponsor

Blue Cross Blue Shield of Michigan

- Faris Ahmad, MD, MBA – Medical Director, Provider Engagement
- Sharon Kim, MPA – Health Care Manager, Value Partnerships



Acknowledgements

Special thanks to our content development partners

- Mary Beth Billie, DNP, RN-BC, CCM
- Ellen Fink-Samnack, MSW, LCSW, CCM, CCTP, CMHIMP, CRP, DBH-C
- Frances Jackson, PhD, RN, PRP
- Carol F. Robinson, DNP, MS, BSN, RN, CHPN®

Content Evaluators

- | | |
|--|---|
| <ul style="list-style-type: none"> ▪ Ruth Clark, RN, BSN, MPA
<i>Integrated Health Partners</i> ▪ Anthony Clarke, MD – Family Medicine
<i>Health Centers Detroit</i> ▪ Lindsay Gietzen, PhD, MS, PA-C
<i>Oakland University School of Health Sciences</i> ▪ Joanna Krapes, BSN, RN
<i>Blue Cross Blue Shield of Michigan</i> | <ul style="list-style-type: none"> ▪ Ewa Matuszewski, BA
<i>Medical Network One</i> ▪ Rosemary Rojas, MSN, RN
<i>Blue Cross Blue Shield of Michigan</i> ▪ Janet Scovel, MBA, BSN, RN, CCM
<i>Priority Health</i> ▪ David Van Winkle, MD, MBA – Family Medicine ▪ Erin Zimny, MD – Emergency Medicine/Hospice and Palliative Care
<i>Henry Ford Health System</i> |
|--|---|



57

57

Acknowledgements

Special thanks to our video contributors:

Interview and roundtable discussion

- | | |
|--|---|
| <ul style="list-style-type: none"> ▪ Faris Ahmad, MD, MBA
<i>Blue Cross Blue Shield of Michigan</i> ▪ Kathryn D. Bartz
<i>Michigan Community Visiting Nurses Association</i> ▪ Anthony Clarke, MD
<i>Health Centers Detroit</i> ▪ Kim Farrow, MD
<i>Detroit Integrated Health</i> ▪ Elizabeth Haberkorn, MSN, FNP, BC
<i>Judson Center Family Health Clinic</i> | <ul style="list-style-type: none"> ▪ Imam Kamau Ayubbi
<i>Michigan Medicine</i> ▪ Charles Kibirige, MA, MDIV, BCC
<i>Henry Ford Health System</i> ▪ Gregg Stefanek, DO
<i>Dow Family Health Center</i> ▪ Lori Zeman, PhD, LP, ABPP
<i>Beaumont Family Medicine – Sterling Heights</i> ▪ Erin Zimny, MD
<i>Henry Ford Health System</i> |
|--|---|

Video filming and producing

Bureau Detroit

- Julie Banovic
- Anthony Morrow



58

58

Resources

- Anderson F, Downing GM, Hill J, Casorso L, Lerch N. Palliative Performance scale (PPS): a new tool. *J Pall Care*, 12(1): 5-11
- Buckman, R.(1992). *How to break bad news: A guide for health care professionals*. Baltimore, MD: The Johns Hopkins University Press. LANDMARK
- Campbell, M. L., & Templin, T. N. (2015). Intensity cut-points for the Respiratory Distress Observation Scale. *Palliative medicine*, 29(5), 436–442. <https://doi.org/10.1177/0269216314564238>
- Carson, B., & Lewis, G. (2007). *Take the risk: Learning to identify, choose, and live with acceptable risk*. Grand Rapids, MI: Zondervan.
- Center to advance palliative care (CAPC). (2019, January 17). Clinical training recommendations for all clinicians caring for patients with serious illness. In Center to advance palliative care. Retrieved February 1, 2021, from <https://www.capc.org/training/>
- Dolgin, M., Fox, A. C., Gorlin, R., & Levin, R. I. (1994). Criteria Committee: Nomenclature and criteria for diagnosis of diseases of the heart and great vessels. In *New York Heart association* (9th ed.). Boston, MA: Lippincott Williams and Wilkins. Retrieved from <https://www.heart.org/en/health-topics/heart-failure/what-is-heart-failure/classes-of-heart-failure>
- Egan City, K. A., & Labyak, M. J. (2010). Hospice & palliative care for the 21st century: A model for quality end-of-life care. In Ferrell, B. & Coyle, N. (Ed.). *Oxford textbook of palliative nursing*, 3rd edition (pp. 13-52). Oxford University Press.
- Get Palliative Care. (2021). Resources for clinicians. In *GetPalliativeCare.org*. Retrieved February 9, 2021, from <https://getpalliativecare.org/resources/clinicians/>
- Gwande, A. (2014). *Being mortal: Medicine and what matters in the end*. New York, NY: Penguin Random House.
- Hui, D., & Bruera, E. (2017). The Edmonton Symptom Assessment System 25 Years Later: Past, Present, and Future Developments. *Journal of pain and symptom management*, 53(3), 630–643. <https://doi.org/10.1016/j.jpainsymman.2016.10.370>
- Karnofsky, D. A., & Burchenal, J. H. (1949). Evaluation of chemotherapeutic agents. In C. M. MacLeod (Ed.), *The clinical evaluation of chemotherapeutic agents in cancer* (pp. 191-205). New York, NY: Columbia University Press. LANDMARK
- Lee, S., Smith, A., & Widera, E. (nd). Palliative Performance Scale. In University of California San Francisco ePrognosis. Retrieved July 11, 2021, from <https://eprognosis.ucsf.edu/pps.php>



59

59

Resources

- National Palliative Care Research Center. (n.d.). Karnofsky Performance Status Scale. In *npccr.org*. Retrieved March 8, 2021, from http://www.npccr.org/files/news/karnofsky_performance_scale.pdf
- Medical College of Wisconsin (n.d.). Communication phrases in palliative care.
- MiHIN (2020). ACP Resource Guide. Retrieved February 9, 2021 from https://mihin.org/wp-content/uploads/2020/11/Resource-page-D3_10.28.2020-1.pdf
- National Consensus Project for Quality Palliative Care.(2018). *Clinical Practice Guidelines for Quality Palliative Care*. 4th ed., Richmond, National Coalition for Hospice and Palliative Care, 2018, www.nationalcoalitionhpc.org/wp-content/uploads/2018/10/NCHPC-NCPGuidelines_4thED_web_FINAL.pdf. Accessed 5 Mar. 2019.
- National Hospice & Palliative Care Organization. (2019). Palliative care or hospice? The right service at the right time for seriously ill individuals. In NHPCO. Retrieved February 9, 2021, from https://www.nhpco.org/wp-content/uploads/2019/04/PalliativeCare_VS_Hospice.pdf
- Ross, J. S., Sanchez-Reilly, S., & Healy, J. (2018). Hospice criteria card. In *New Mexico nurse practitioner council*. Retrieved July 18, 2021, from https://cdn.ymaws.com/www.nmnpcc.org/resource/resmgr/2018_annual_conf_presentations-handouts/6_johnson/Hospice_Card_JSRSR_JMH_20.pdf
- WHO (1993). Study protocol for the World Health Organization project to develop a Quality-of-Life assessment instrument (WHOQOL) Qual Life Res. 1993;2(2):153–159. doi: [10.1007/BF00435734](https://doi.org/10.1007/BF00435734)



60

60