Welcome to Today's Faculty:

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- Connie serves as a consultant to the Hospice and Palliative Nurses Association (HPNA) and ANCC Accredited Provider Unit Lead Nurse Planner, a consultant to the Center to Advance Palliative Care, Palliative Nurse Practitioner at the North Shore Medical Center in Massachusetts, and Co-Director of the Palliative APP Externship
- Committee work includes: the American Hospital Association Circle of Life Award Selection Committee and chairs the MA Comprehensive Cancer and Control Network Palliative Workgroup Care
- National Work includes: Editor of the 3rd, 4th, 5th and 6th editions *of Palliative Nursing Scope and Standards*, Editor of the 2nd and 3rd editions of the National Consensus Project for Quality Palliative Care *Clinical Practice Guidelines*, Co-Editor of *Advanced Practice Palliative Nursing*, and palliative care content expert on the Measurement Applications Partnership (MAP) Post-Acute Care/Long Term Care; Clinical; and Patient and Family Care Workgroups, Past President and board member of HPNA.
- She is a Cambia Health Foundation Sojourns Leadership Scholar, Fellow of the American Academy of Nursing, and Fellow of Palliative Care Nursing

Reflections of Advanced Practice Palliative Nursing Across the US

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Call to Action – Nurses Lead and Transform Palliative Care

American Nurses Association and Hospice and Palliative Nurses Association 2017

- All nurses (LPNs/LVNs/RNs/APRNs) practice palliative care – from a few skills up to specialty practice
- Nurses are the largest segment of health care and can directly impact access to palliative care.
- Nurses should actively engage in designing new palliative care programs, improving educational services, developing policy, and appropriately crafting regulatory and legislative language to address access, safety, quality, and payment reform for palliative care services.

ASCO 2018

Along with the role of the oncologist trained in palliative care, an advanced practice nurse (APN) could play an important role in building and maintaining an interdisciplinary network of care, necessary for the management of complex palliative situations.

The APN is a vital member of the interdisciplinary team and a key player who collaboratively integrates palliative practices throughout the patient's disease course by promoting QOL and reducing fragmented delivery of care. APNs could spearhead the development, implementation, and evaluation of palliative care services.

TABLE 4. PERCENTAGE OF PATIENTS BY PRINCIPAL DIAGNOSIS

Principal Diagnosis	Percentage
Cancer	27.2 %
Cardiac and Circulatory	18.7 %
Dementia	18.0 %
Respiratory	11.0 %
Stroke	9.5 %
Other	15.6 %

NHPCO 2018 Facts and Figures

National Hospice and Palliative Care Organization

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer

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ABSTRACT

BACKGROUND

Patients with metastatic non–small-cell lung cancer have a substantial symptom burden and may receive aggressive care at the end of life. We examined the effect of introducing palliative care early after diagnosis on patient-reported outcomes and end-of-life care among ambulatory patients with newly diagnosed disease.

METHODS

We randomly assigned patients with newly diagnosed metastatic non–small-cell lung cancer to receive either early palliative care integrated with standard oncologic care or standard oncologic care alone. Quality of life and mood were assessed at baseline and at 12 weeks with the use of the Functional Assessment of Cancer Therapy–Lung (FACT-L) scale and the Hospital Anxiety and Depression Scale, respectively. The primary outcome was the change in the quality of life at 12 weeks. Data on end-of-life care were collected from electronic medical records.

RESULTS

Of the 151 patients who underwent randomization, 27 died by 12 weeks and 107 (86% of the remaining patients) completed assessments. Patients assigned to early palliative care had a better quality of life than did patients assigned to standard care (mean score on the FACT-L scale [in which scores range from 0 to 136, with higher scores indicating better quality of life], 98.0 vs. 91.5; P=0.03). In addition, fewer patients in the palliative care group than in the standard care group had depressive symptoms (16% vs. 38%, P=0.01). Despite the fact that fewer patients in the early palliative care group than in the standard care group received aggressive end-of-life care (33% vs. 54%, P=0.05), median survival was longer among patients receiving early palliative care (11.6 months vs. 8.9 months, P=0.02).

Temel Study 2010
Culture change within Palliative Care

- Improved QOL
- Less depression
- Less “aggressive EOL care”
  - Chemotherapy not given within 14 days of death
  - Earlier and longer enrollment in hospice
- Improved survival
  - Less depression
  - Improved quality of life
- Increased documentation of resuscitation preferences

Study now replicated in various cancers such as GI, sarcoma and other diseases such as heart failure, neurological disorders, and pulmonary disease.

Randomized Controlled Trials

Temel NEJM 2010:

- Outpatient PC for late-stage NSCLC patients
- less aggressive death
- Improved: survival, quality of life, depressive symptoms

Bakitas JAMA 2009:

- Psychoeducational sessions advanced cancer
- Improved: quality of life, depressive symptoms

Brumley JAGS 2007:

- Home-based PC for home-bound pts with Ca, CHF, COPD
- Improved: satisfaction, at-home deaths, fewer ED visits and hospitalizations

Palliative Care vs. Hospice

Palliative Criteria

- The surprise question – Would you be surprised if patient died within 12-24 months?
- Serious or life-threatening illness which
- Encompasses patients of all ages, diagnostic categories, living with a persistent or recurring medical condition that adversely affects their daily functioning or will predictably reduce life expectancy
- Covered under insurances by specialty symptom management

Hospice Criteria

- Terminal illness with prognosis of six months or less, if the disease runs its normal course
- Certified by a physician and hospice physician
- To receive care focusing on comfort and quality of life rather than curative
- Covered under Medicare Part A, Medicaid, or commercial insurance

Where do APRNs provide palliative care?

- Home - with consultation by advanced practice registered nurse and physician visits
- Skilled Facilities - with consultation by advanced practice registered nurse and physician visits
- Hospitals - by interprofessional teams
- Outpatient/Ambulatory Care- by interprofessional teams
- Other settings - prisons, shelters, adult and pediatric day care centers, group homes

SNAP SHOT of APRNs Providing Palliative Care

- The Palliative Care APRN Externship - a Pilot
  - Site Implementation
  - Based on pilot from 2014 -2016
  - 48 APRNS from around the country (VA, MT, CA, MA, NY, WI, AL, NJ)
- The Palliative Care APRN Externship - A National Model. Cambia Healthcare Foundation Sojourns Scholar Project of C Dahlin.
  - National Implementation
  - 2018 - present
  - 5 sites in the US - 32 APRNS - Mixed Practice
- Mixed Practice - Primary and Specialty
- 50 hour immersion course with didactic and clinical

Palliative Care per ASCO 2018

ASCO AMERICAN SOCIETY OF CLINICAL ONCOLOGY

Recommendation 1.1 Basic (Primary Health Care): Palliative care needs should be addressed in the community or at the primary health care center. These needs may be addressed by primary health care providers, nurses, community health workers, volunteers, and/or clinical officers.

Recommendation 1.2 Limited (District): In addition to provision of palliative care in the community and at primary health care centers, outpatient palliative care services should be established. When a counselor is not available, psychosocial and spiritual needs may be addressed by team members trained in basic palliative care.

Recommendation 1.3 Enhanced (Regional): In addition to the community-based and outpatient palliative care services available at the limited level, inpatient consultation services should be available to hospitalized patients with palliative care needs. Consultation services should be provided by an interdisciplinary team, including (but not limited to) a physician, nurse, counselor, and pharmacist. Mental health and spiritual services may be added to the team when possible.

Recommendation 1.4 Maximal (National): In addition to the palliative care services available at the enhanced level, dedicated inpatient palliative care beds should be established, staffed with trained professionals.

APRN Palliative Care Practice Across the Country – Primary Palliative Care

Primary Palliative Care –

Providing Pain and Symptom Management - Communication Across the Trajectory

Access to Resources

- Hospitals
  - Hospitalists
- Veteran's Administration
- Residential
  - Home – Independence at Home, Primary Care
- Long term care
  - Skilled facilities, assisted living
- Clinics
  - Primary Care
  - Geriatric
  - Specialty Clinics – Heart Failure, Pulmonary, Neurology, Chronic Disease Clinic

APRN Palliative Care Practice Across the Country – Specialty Palliative Care

Specialty Palliative Care –

Providing Complex Pain and Symptom Management

Difficult Discussions Across the Trajectory

Access to Resources

- Clinics
  - Palliative Care Clinics
- Hospitals
  - Community
  - Rural
- Dedicated Units in Facilities
- Hospices
- Home Health Agencies
- Group Practices

Best Practices

- Documentation
  - Including prompts for templates
    - ACP, Pain and Symptom s Assessment (ESAS), Spiritual Care (FICA)
- Communication
  - Template to Ask and Document Goals of Care
- Symptom Management
  - Methadone in the hospital
  - Opioids for shortness of breath in advanced CHF and COPD
- Using appropriate assessment tools for the right populations
  - Clinics
    - Advance Directives such as 5 Wishes or the like
  - Nursing Home
    - CAM to assess delirium in patients with dementia
    - PAINAD to assess pain in patients with dementia

Challenges to APRN Palliative Care Practice

- Education
  - Pawlow, Dahlin, Doherty, and Ersek (2017) found that 75% of Specialty Palliative Care APRNs did not receive enough palliative care education in graduate programs
  - Lack of palliative nursing specialty graduate nursing programs
- Training
  - Clinical experiences with exposure to upstream palliative care and hospice
  - APRN preceptors, particularly specialty palliative APRNs
- Scope of Practice
  - State - Limitations of prescribing or advanced work in state regulations
  - Organizations - Limitations of bylaws or culture

Opportunities

- NPs the fastest growing segment of health care
- Best in the Community Arena
  - More ability for APRN leadership outside of academic medical centers
  - Clinic, Home/Residential, Long Term Care
  - Non-traditional sites - Group Homes, Senior Centers, Community Centers, Adult and Pediatric Day Care Centers

Considerations to Practice

- Can integrate palliative principles into any practice
- Understand current environment of organization and match your strengths to them which usually include issues of patients with serious illness such as 30 day readmissions, ED admissions and hospital admissions
- Match palliative care to patient quality and satisfaction

Final Thoughts

BE BOLD and CREATIVE WHERE EVER YOU PRACTICE

- *"How very little can be done under the spirit of fear." -Florence Nightingale*

- *"The door that nobody else will go in at, seems always to swing open widely for me." -Clara Barton*

Palliative APRN Education and Training

- HPNA
  - Education
    - Graduate Faculty Council – Consensus Education Content for School of Nursing who provide APRN specialty palliative care graduate education
    - Fellowship Council – Standards for Palliative APRN fellowships
  - Opportunities
    - Leadership Training – 1) Intensive Workshop 2) One year Mentored Program
  - Resources
    - Dahlin et al. APRN Onboarding Guide – coming soon
    - Moreines L. Root M, Dahlin C. The APRN Core Curriculum – coming soon
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Resources

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