Module: Triggers

Learning Objectives

Attitudes	• Appreciate the importance of early and ongoing assessment of palliative care needs. • Recognize the value of interdisciplinary collaboration needed to provide comprehensive care to patients with life-limiting or life-threatening conditions.
Knowledge	• Demonstrate the role of primary and specalist palliative care in meeting the needs of patients and families. • Demonstrate knowledge of how to perform early and daily assessments for palliative care needs.
Skills	• Demonstrate knowledge of the multiple areas of needs that patients may have that can be provided by a multidisciplinary team. • Recognize unmet patient needs and facilitate discussions with appropriate team members or facilitate specialist palliative care consultation. • Implement admission and daily assessment protocols to identify triggers for inderdisciplanary or specialist palliative care involvement.

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Teaching Outline

Surgical patients with serious illness may have needs that can be met by palliative-care oriented treatment. "Triggers" or specific criteria can be used at various points both at and during admission to assess when and what type of palliative care is most appropriate and may assist in closing those gaps. This module will describe various trigger types for non-specialist "primary" palliative care delivery and specialist palliative care consultation and provide guidance on implementation.

Palliative Care Triggers

1. Definitions: Specialist versus Primary Palliative Care

    - Specialist palliative care refers to palliative care provided by clinicians who have specialized training and often delivered by a multi-disciplinary group that includes representatives from specialties such as social work/ care management, spiritual care and others
    - Primary palliative care refers to palliative care provided by a treating clinician as part of their management strategy without involvement of other consultants
    - Specialist palliative care services are not sufficiently available to meet all the palliative care needs of surgical patients.
    - While specialist palliative care triggers can be useful, some studies suggest needs-based triggers for primary palliative care can provide more patient and family-focused interventions.[1,]

2. Primary Palliative Care (non-specialist Palliative Care) Triggers

    - The ACS TQIP (Trauma Quality Improvement Program) Palliative Care Best Practices Guidelines[5] has goals and timelines for palliative care assessment as they relate to triggers for palliative care. Triggers form part of a high-quality system to meet the following goals:

        i. Within 24 hours of admission: identify the health care proxy, obtain advance directives documents, perform a prognostication assessment, provide emotional and informational support for the family and patient, address urgent and focused advance care planning and decision-making needs, and screen for further palliative care needs

        ii. Within 72 hours of admission: hold a family meeting, have a Goals of Care Conversation for advanced care planning.

- Assessing unmet needs can help provide multidisciplinary care for patients who do not meet the criteria for specialist palliative care or help to deliver care in systems that lack clinicians with palliative care training, offering an alternative or supplement to specialist consultation.

    i. Chaplains can provide spiritual support to patients and their loved ones

    ii. Social workers can aid in alleviating psychosocial, developmental, relational, and financial stressors

    iii. Nurses can address specific patient comfort needs

    iv. Primary team providers can provide primary palliative care such as initial symptom management, "goals of care conversations" addressing health care decision-making, and code status discussions.

3. Specialist Palliative Care Triggers

- Unmet needs assessments can be used as triggers to prompt involvement of the appropriate interdisciplinary team members, additional conversations on daily rounds, or, if necessary, specialist palliative care consultation.

- Various tools exist which evaluate patient needs based on a variety of criteria such as symptoms, baseline functional status, quality of life, prognosis, and medical history.

- One such tool as developed with the Consensus Report from the Center to Advance Palliative Care[2] from the Journal of Palliative Medicine can be used to assess needs at time of admission:

    Patient has 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 • Frequent admissions (e.g., more than one admission for same condition within several months) • Admission prompted by difficult-to-control physical or psychological symptoms (e.g., moderate-to-severe symptom intensity for more than 24–48 hours) • Complex care requirements (e.g., functional dependency; complex home support for ventilator/antibiotics/feedings) • Decline in function, feeding intolerance, or unintended decline in weight (e.g., failure to thrive)
Secondary Criteria:[b] • Admission from long-term care facility or medical foster home • Elderly patient, cognitively impaired, with acute hip fracture • Metastatic or locally advanced incurable cancer • Chronic home oxygen use • Out-of-hospital cardiac arrest • Current or past hospice program enrollee

- Limited social support (e.g., family stress, chronic mental illness)
- No history of completing an advance care planning discussion/document

[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.

- Another tool from the same consensus guidelines[2] can be used for daily assessment. Similar to the admission checklist, it has primary and secondary criteria as follows:

Patient has 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
- Difficult-to-control physical or psychological symptoms (e.g., more than one admission for same condition within several months)
- Intensive Care Unit length of stay 7 days
- Lack of Goals of Care clarity and documentation
- Disagreements or uncertainty among the patient, staff, and/or family concerning:
  - major medical treatment decisions
  - resuscitation preferences
  - use of nonoral feeding or hydration

Secondary Criteria:[b]

- Awaiting, or deemed ineligible for, solid-organ transplantation
- Patient/family/surrogate emotional, spiritual, or relational distress
- Patient/family/surrogate request for palliative care/hospice services
- Patient is considered a potential candidate, or medical team is considering seeking consultation, for:
  - feeding tube placement
  - tracheostomy
  - initiation of renal replacement therapy
  - ethics concerns
  - LVAD or AICD placement
  - LTAC hospital or medical foster home disposition
  - bone marrow transplantation (high-risk patients)

[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.

- More specific to surgical patients is the Risk Analysis Index (RAI)[6] which was implemented at the VA. A positive score prompted pre-operative palliative care consultations which were associated with reduced mortality and overall increased palliative care engagement between patients and surgeons.

- The RAI includes age, sex, current living situation, medical history, nutrition, cognitive evaluation, mobility, ability to perform activities of daily living. See bibliography for full details.

- Another needs-assessment to consider is the Palliative Performance Scale[8]:

%	Ambulation	Activity Level Evidence of Disease	Self-Care	Intake	Level of Consciousness	Estimated Median Survival in Days (a)	(b)	(c)
100	Full	Normal *No Disease*	Full	Normal	Full	N/A	N/A	108
90	Full	Normal *Some Disease*	Full	Normal	Full			
80	Full	Normal with Effort *Some Disease*	Full	Normal or Reduced	Full			
70	Reduced	Can't do normal job or work *Some Disease*	Full	As above	Full	145		
60	Reduced	Can't do hobbies or housework *Significant Disease*	Occasional Assistance Needed	As above	Full or Confusion	29	4	
50	Mainly sit/lie	Can't do any work *Extensive Disease*	Considerable Assistance Needed	As above	Full or Confusion	30	11	41
40	Mainly in Bed	As above	Mainly Assistance	As above	Full or Drowsy or Confusion	18	8	
30	Bed Bound	As above	Total Care	Reduced	As above	8	5	
20	Bed Bound	As above	As above	Minimal	As above	4	2	6
10	Bed Bound	As above	As above	Mouth Care Only	Drowsy or Coma	1	1	
0	Death	-	-	-	--			

- While the Palliative Performance Scale (PPS) is often used to predict mortality, it also plays a crucial role in identifying patients who may have significant post-hospitalization needs. In a prospective observational study of trauma survivors >55 years of age, high low pre-Injury PPS ≤70, predicted poor functional outcomes one year after trauma and therefore can be used to identify patients who could benefit from additional post-hospitalization resources.[9]

- In addition to the triggers outlined above for specialist palliative care consultation, we recommend conducting ongoing needs assessments for every patient facing a life-threatening or life-limiting condition. These assessments should encompass the following areas: social support, functional status, psychological well-being, spiritual and existential needs, and financial and legal concerns.

4. Recommendations for Implementation

- Recommend initial admission screening assessment followed by daily assessment by the primary team.

    i. Focus on interdisciplinary care to patients, getting right services involved early, meeting needs earlier.

    ii. Use the correct tool given patient population: daily assessment, pre-operative surgical assessment, multi-disciplinary needs assessment.

    iii. Specialist palliative care consultation should be considered as a part of a needs-based assessment both at and throughout admission.

    iv. Needs assessments should be tailored to the patient population being considered (e.g., patients in the surgical versus medical intensive care unit).

    v. Triggers often focus on needs of the dying (and scales such as PPS can be predictive of mortality); however, triggers may also be appropriately used to identify functional and psychosocial needs for survivors during and after hospitalization.

5. Emerging topics

    i. Artificial intelligence and electronic health record based quantitative calculators like Epic's end of life index may help to identify discrete subpopulations of patients with palliative care needs

    ii. As primary and consultative palliative care in surgery continues to evolve, we increasingly recognize that serious-illness discussions bring both benefit and burden for surgeons. Despite their complexity and emotional intensity, these conversations center on the personal relationship, which is often the most meaningful aspect of medical practice.

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Pre/Post Test

Questions

1. What distinguishes specialist palliative care from primary (non-specialist) palliative care?
2. What is the "surprise question" when evaluating a patient for palliative care needs, and how is it applied?
3. Provide at least three examples of interdisciplinary team members and how they might provide primary palliative care.

Answers

1. Specialist palliative care refers to palliative care provided by providers who have specialized training; primary palliative care can be provided by any health care professional.
2. A "No" answer to the "surprise question" indicates that you would not be surprised if the patient were to die within 12 months or before adulthood. The surprise question has modest predictive value for identifying patients at risk of near-term mortality. In terms of its utility as a criterion for palliative care consultation, it is most helpful as an indicator of unmet palliative care needs when incorporated into a broader assessment.
3. Chaplains can provide spiritual support to patients and their loved ones; social workers can aid in alleviating psychosocial, developmental, relational, and financial stressors; nurses can address specific patient comfort needs. Any team member can begin a conversation regarding goals of care by asking questions to learn about a patient's strengths, hopes, fears and worries.

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Case 1

Ms. Garcia, a 79-year-old woman with severe COPD on 2L NC at baseline and chronic steroid use, is admitted to the hospital after a fall from standing with a cervical spine fracture requiring an Aspen cervical collar for several weeks and a hip fracture requiring operative intervention. Her daughter expresses concern that over the last few years, she has had frequent hospitalizations with worsening shortness of breath, weight loss, and reduced ability to care for herself at home.

Questions/Answers

1. What palliative care needs might Ms. Garcia have based on screening criteria at admission?

    - Based on the history provided, there are likely several unmet needs in this scenario:

        i. Frequent admissions are a global indicator that patient would likely require specialist or primary palliative care during admission to elicit goals of care given the escalation of presentations (shortness of breath, now fall from standing with traumatic injury).

        ii. She meets several other primary criteria such as functional dependency and unintended decline in weight (e.g failure to thrive).

        iii. She additionally meets several secondary criteria including chronic home oxygen use and acute hip fracture in the elderly.

2. The patient is recovering postoperatively from her hip surgery, but given the cervical collar, Ms. Garcia is having a hard time swallowing. Speech pathology has determined that she is a high aspiration risk and seems to be aspirating her secretions while sleeping. Her daughter would still like to pursue all avenues to get her mother back living on her own at home. What daily assessment criteria might indicate more palliative care needs than had previously been identified?

    - Ms. Garcia might require nonoral feeding or hydration now that the cervical collar is impairing swallowing. She is triggering secondary criteria for possible feeding tube placement that may indicate unmet palliative care needs.

    - Additionally, specialist palliative care consultation may be warranted as there may be misunderstanding of what Ms. Garcia's eventual prognosis is given her baseline functional status, failure to thrive independently, and frequency of readmission. In conjunction with her new aspiration risk secondary to the cervical collar, specialist

palliative care may help addressing her various needs at this time given the complexity of the patient's situation.

3. After the decision is made to focus on optimizing Ms. Garcia's comfort, her daughter seems distressed. What additional daily assessment criteria might she be meeting and how could you address these?

- Multidisciplinary needs include social work support for navigating the financial and emotional burden of repeat hospitalizations and chaplain support for spiritual and existential distress.

- Additionally, the team should assess on a daily basis what additional care needs the patient may have that may be addressed for enhanced comfort. These include both physical and psychosocial symptoms of the imminently dying. For example:
    - Pain due to immobility and underlying fractures responsive to oral or intravenous acetaminophen
    - Dyspnea, which generally responds to cessation of nonobligate fluids and opioid therapy as well as nonpharmacologic interventions such as increased air flow and creative arts interventions, as well as anticipatory guidance for the daughter regarding changes in respiratory patterns toward the end of life
    - Xerostomia (dry mouth), which should be managed with meticulous oral care and oral mucosal emollients, an intervention in which many caregivers find comfort in direct participation
    - Excessive oropharyngeal secretions, preventable with glycopyrrolate or alternative anticholinergic medications if they appear bothersome to the patient; also important to provide neutral family and caregiver education and anticipatory guidance around this topic while avoiding charged terms such as "death rattle"
    - Delirium and agitation, manageable with both pharmacologic (antipsychotic or antipsychotic + benzodiazepine regimens) and nonpharmacologic (reorientation, reassurance, and environmental) interventions as well as anticipatory guidance
    - Anxiety, manageable both pharmacologically and non-pharmacologically

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