Palliative Care
SCHOOL OF MEDICINE
UNIVERSITY OF COLORADO
**ANSCHUTZ MEDICAL CAMPUS**
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# Early Outpatient Palliative Care Referral for Ischemic Stroke Survivors

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## Statement of the Problem

Ischemic stroke survivors have significant sequelae[1,2]

Ischemic stroke survivors would benefit from outpatient palliative care (PC)[3]

Inpatient neurology providers are not making referrals

## Purpose/Objectives

- Purpose: Increase outpatient PC referrals for ischemic stroke survivors and caregivers
- Objectives:
  - Educate inpatient stroke providers regarding PC
  - Develop supportive PC tools for providers

## Background & Literature Review

- Research on PC is focused on acute (hospitalized) and end-of-life care for ischemic stroke survivors
- There is no guidance on early initiation of outpatient PC for ischemic stroke survivors

## Acknowledgements/References

Mentor: Maurice Scott, MD
Thank you to:
Anita Anderson
Regina Fink, PhD, APRN, AOCN, CHPN, FAAN

References:
1. Creutzfeldt CJ, Holloway RG, Walker M. Symptomatic and palliative care for stroke survivors. *J Gen Intern Med.* 2012;27(7):853-860.
2. Dy SM, Feldman DR. Palliative care and rehabilitation for stroke survivors: Managing symptoms and burden, maximizing function. *J Gen Intern Med.* 2012;27(7):760-762.
3. Braun LT, Grady KL, Kutner JS, et al. Palliative care and cardiovascular disease and stroke: A policy statement from the American Heart Association/American Stroke Association. *Circulation.* 2016;134(11):e198-225.

## Methods

- UCHealth inpatient ischemic stroke providers were educated via PowerPoint presentation on the scope, indications, benefits, and availability of PC
- PC provider support included an algorithmic pathway, sample script, and Epic SmartPhrase in the electronic health record along with PC pocket cards
- Records were reviewed pre/post intervention and a one-way ANOVA was conducted

**Post-Stroke Neuro Palliative Care Referral**

* This is for Outpatient referrals to **Neurology** Palliative Care Clinic
**If the issue(s) is/are better addressed prior to discharge, then consult the inpatient Palliative Care Team** (303-266-7629 or see Amion.com)

Use **AgileMD "Palliative Care" Pathway** for guidance:
Epic patient chart: DHM Pathways Tab

**Does patient or family have any of the following needs/issues?**

- Physical symptom management (current or anticipated) including pain, weakness, neuro-related movement disorders, vision changes, fatigue, etc.
- Psychological symptoms including depression, anxiety, grief
- Uncertain or unclear goals of care
- Help matching goals to next steps
- Assistance with advance care planning
- Uncertainty regarding prognosis
- Cognitive issues such as confusion, memory loss, behavioral changes
- Spiritual, social or psychological distress
- Reduced quality of life
- Rapid decline in function
- Assistance with transitions of care (e.g. SNF, LTC)
- Discussions regarding hospice and end-of-life care
- Limited family or social support
- Caregiver and/or patient support
- Multiple hospitalizations
- Insufficient fluid/calorie intake
- Patient or family request

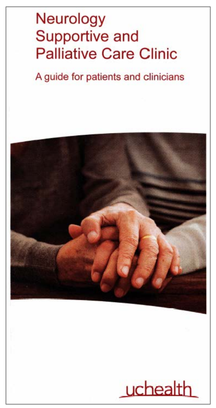
**Approaching patient and/or family to discuss Palliative Care**
**Sample Script**:
This is/has been a serious illness / life changing event / difficult admission. Things often look different when you get home than they did before this illness / diagnosis / admission. I would like to discuss additional support for you and/or your family after discharge.

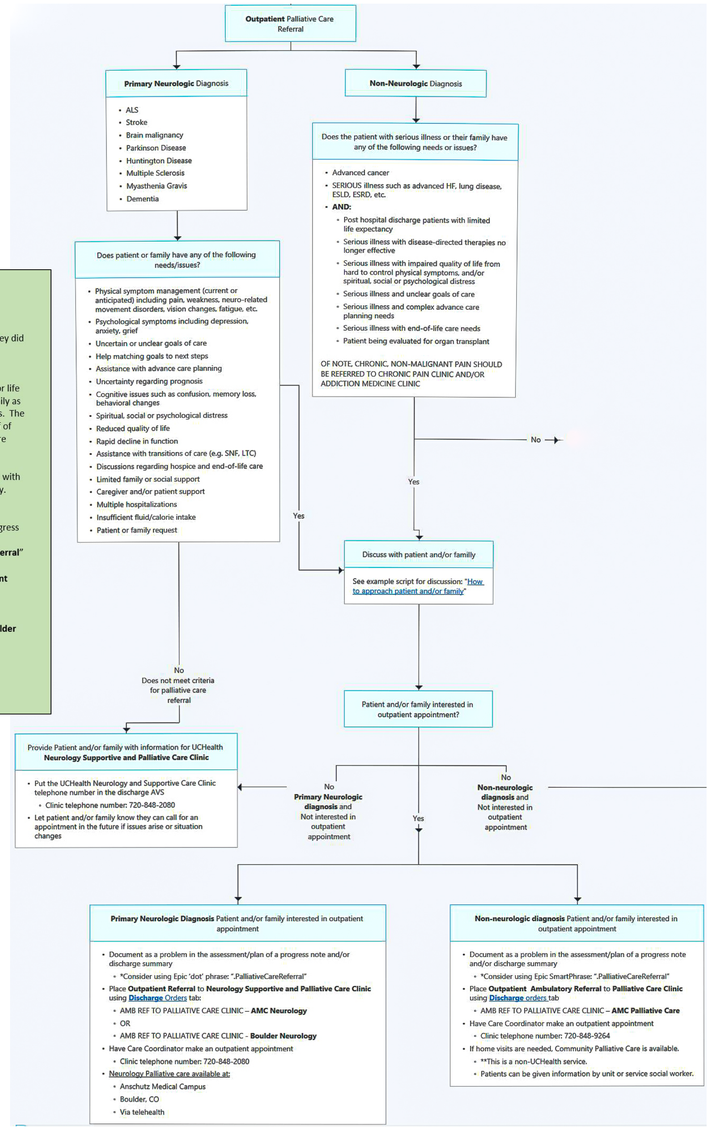
Palliative care is specialized care for people with serious illnesses or life changing events. This is a team who can support you and your family as you go forward / adjust to changes and/or help with the next steps. The focus will be on understanding your illness / disease process, relief of symptoms, effective communication, and support for making future decisions and lifestyle adjustments.

The palliative care team can provide an additional layer of support with focus on maintaining the best quality of life for you and your family.

**If Patient and/or family are interested**:

- Document as a problem in the assessment/plan of a progress note or discharge summary
  - *Can use Epic 'dot' phrase: "**.PalliativeCareReferral**"
- Place **Outpatient** Referral to Neurology Supportive and Palliative Care Clinic using **Discharge** Orders or **Outpatient** Orders:
  - AMB REF TO PALLIATIVE CARE CLINIC – **AMC Neurology**
  - OR AMB REF TO PALLIATIVE CARE CLINIC - **Boulder Neurology**
- Have Care Coordinator make an appointment
  - Clinic telephone number: 720-848-2080

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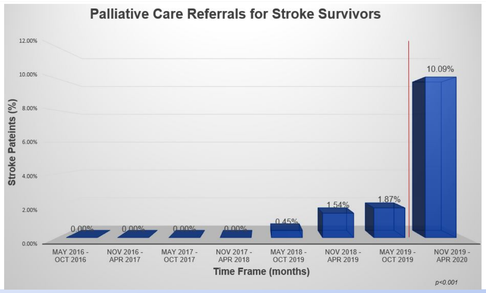
## Findings




Average referrals over six months increased from 1.87% pre-intervention to 10.09% post-intervention ($p<0.001$)

## Conclusions

- Education can increase referrals to outpatient PC
- Providers needed frequent encouragement and reminders to consider PC referral
- No outpatient stroke PC referral criteria exists
- Barriers to referral include misunderstanding of PC, provider discomfort with difficult conversations, and limited time allowed with patients to discuss PC

## Future Directions

- Effective interventions to educate providers to change practice still need to be determined
- Incorporation of PC training early into ongoing continuing education might be beneficial
- Developing specific PC referral criteria for stroke survivors post hospitalization should be explored

## Limitations

- Documentation was lacking to evaluate if a referral was declined by the patient or caregiver
- Referrals were not placed if uninsured or if insurance was provided by Kaiser, VA, or prison system
- Results likely affected by COVID-19 pandemic
- Designed for a single institution and may not be reproducible