



Shifting Gears: Navigating Palliative Care from the Hospital to Home

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30 Years of Impact: Driving the Future of Case Management

Shifting Gears: Navigating Palliative Care from the Hospital to Home

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OBJECTIVES

- Briefly describe what Palliative Care is and the role it can play in pain and symptom management while a patient is admitted and when they are discharged.
- Identify common symptoms in Palliative Care and the main treatment options for pain (non-pharmacologic and pharmacologic)
- Discuss transition from inpatient to outpatient palliative care and key considerations for a smooth transition, including common roadblocks encountered.



CORE MESSAGE

- A referral to palliative care does not guarantee a successful transition between care settings.

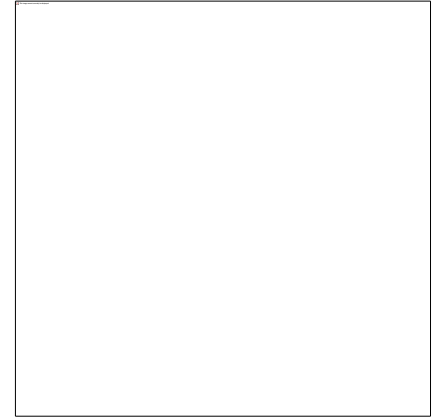
A safe transition requires:

- A team responsible for symptom management
- Medication reconciliation
- Communication between the sending and receiving teams
- Service models that match patient's location and needs
- Confirmation that referral was received/accepted/appropriate
- A contingency plan if symptoms worsen/there is a crisis/need for more support before initial visit.



DISCLOSURES

No disclosures





Panel Introduction

- **Laura Marsh, DO, MPH** (Clinical Assistant Professor, Family Medicine, Hospice and Palliative Medicine)
- **Kayla Sheehan, MD** (Clinical Assistant Professor, Family Medicine, Hospice and Palliative Medicine)
- **Kira Stalhandske, NP** (Nurse Practitioner, Hospice and Palliative Medicine)
- **Rebecca Ritchey, RN** (Care Navigator, Hospice and Palliative Medicine)
- **Amanda Eidemiller, MSW** (Social Work, Hospice and Palliative Medicine)

What is Palliative Care?

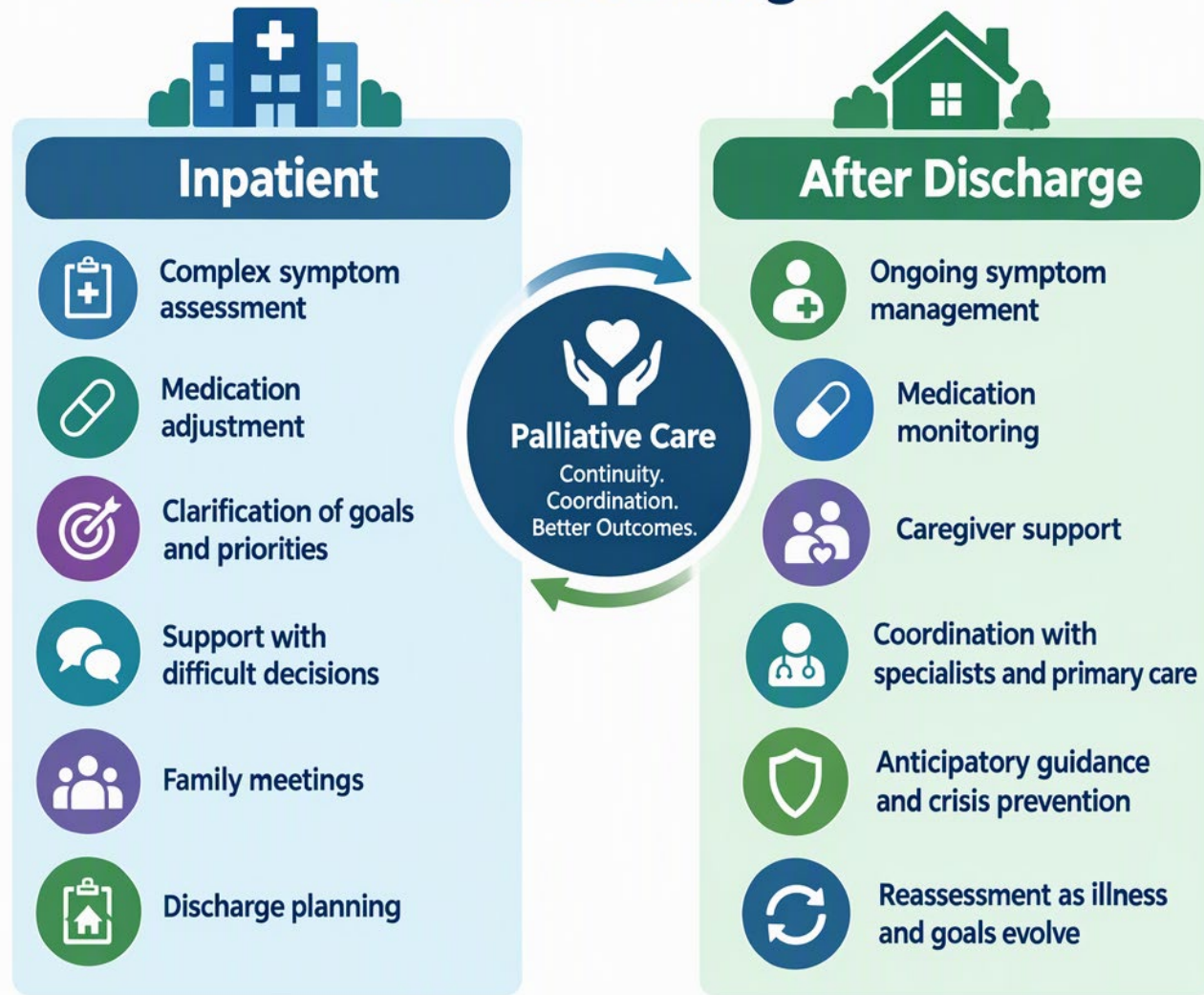
- Specialized care for people living with serious illness
- Focus on symptom relief, quality of life, communication, and support
- Appropriate at any stage of illness
- Can be provided alongside disease-directed or life-prolonging treatment
- Supports patients, care givers, teams

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What Palliative Care Contributes Across Settings



Common Symptoms

- Pain (focus of today's talk)
- Nausea/Vomiting
- Anxiety/Agitation
- Constipation
- Cough, pruritus, secretions...

TYPES OF PAIN

NOCICEPTIVE

Somatic

- bones, joints
- connective tissues
- muscles
- sharp
- dull & aching
- can localize site
- may be worse with movement
(*"incident pain"*)

Visceral

- Organs – heart, liver, pancreas, gut, etc.
- may be crampy, or dull & aching
- referred pain
- difficult to localize

NEUROPATHIC

- difficult to describe; not a typical "pain"
- numb; burning; tingling; crawling; stabbing; etc
- allodynia
- consider it as a possible element of any difficult pain syndrome

Symptom framework

- Reversible causes
- Severity and **functional impact**
- Patient goals and tradeoffs
- Nonpharmacologic interventions
- Pharmacologic options
- Monitoring requirements
- Plan: who will reassess and when

Addressing Symptoms

Examples of Treatment Approaches

Symptom	Nonpharmacologic approaches	Pharmacologic categories
 Pain	- Positioning, heat or cold when appropriate - Physical or occupational therapy - Assistive devices - Relaxation, spiritual support	- Acetaminophen - Anti-inflammatory medication when appropriate - Opioids - Adjuvant analgesics
 Dyspnea	- Positioning - Fan or airflow - Pacing - Breathing techniques - Treatment of underlying cause	- Opioids in selected patients - Bronchodilators - Diuretics - Oxygen when indicated
 Nausea	- Small meals - Trigger avoidance - Hydration strategies	Antiemetic selected according to likely cause
 Constipation	- Mobility - Hydration when appropriate - Toileting routine	Stimulant and osmotic laxatives; prophylaxis when opioids are used
 Anxiety or distress	- Reassurance - Counseling - Relaxation - Chaplaincy - Caregiver support	Medication when clinically appropriate and consistent with goals
 Delirium	- Reorientation - Sleep support - Sensory aids - Familiar presence	Treat reversible causes; symptom-directed medication when needed

Better comfort  Better days

Care Coordination Considerations for Opioids:

- Transitioning from hospital to hospice with PCA requires long-term IV access, identification of hospice facility (that accepts PCA), set up plan (in the hospital for transit vs upon return home).
- Buprenorphine and methadone may have restricted use in certain facilities (i.e not able to continue/dispense)
- Request that primary teams supply 30 days of controlled substances to bridge to OP establish care visit and avoid readmission/ED presentation

Ketamine (N-methyl-D-aspartate (NMDA) receptor antagonist)

- Opioid sparing effects at low subanesthetic doses
- Higher doses for general anesthesia
- Multiple routes IV, Oral, Buccal and Intranasal.
- Care Coordination:
 - May require compounding pharmacy
 - Restricted/Limited use in facility settings
 - Generally not covered by insurance

Case Example



- Patient with a left ventricular assist device and complex serious illness
- Prolonged hospitalization following implantable cardioverter-defibrillator discharge, concern for infection, and a right femoral neck fracture
 - Not a surgical candidate; persistent fracture-related pain
 - Inpatient palliative care engaged for pain management. Started PCA, rotated to oral pain regimen
- Discharged to SAR with an outpatient palliative-care referral
- A second referral was placed by the OP specialty clinic
- Patient remained in rehabilitation, where the outpatient clinic model did not match the patient's location
- Family later contacted palliative care because pain remained inadequately managed
- A video visit was scheduled even though medication management depended on coordination with the rehabilitation clinician
- Repeated attempts to contact the facility prescriber were unsuccessful
- The team redirected the referral to a community palliative-care service who was able to see the patient at the facility.
- The new service initiated care within 48 hours



Where did the transition fail?



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What should have happened?

- Before discharge?
- On arrival to rehabilitation?
- When symptoms persisted/worsened?
- When the plan is not working?



Who does what?



Inpatient palliative-care team

- Define the active symptom problems
- Document treatment response and medication rationale
- Identify anticipated complications
- Recommend an interim plan
- Communicate directly with the receiving clinician when complexity is high



Case management or care coordination

- Match the referral to the actual destination and service area
- Verify insurance, eligibility, and acceptance
- Determine whether the service can see patients in skilled nursing or rehabilitation
- Confirm appointment timing and transportation or technology needs
- Close the referral loop



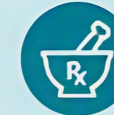
Nursing

- Document symptom trajectory and functional impact
- Assess patient and caregiver understanding
- Identify medication-access and administration barriers
- Provide clear escalation instructions



Social work

- Assess caregiver capacity, finances, transportation, housing, and psychosocial needs
- Address goals, coping, and support systems
- Help identify community resources



Pharmacy

- Reconcile medications
- Identify interactions, duplications, and renal or hepatic considerations
- Confirm formulary coverage and access
- Clarify opioid and controlled-substance logistics
- Recommend monitoring and bowel regimens



Receiving facility or community team

- Acknowledge and review the handoff
- Confirm the responsible prescriber
- Reassess symptoms after arrival
- Communicate changes and unresolved concerns
- Ensure after-hours coverage or escalation instructions

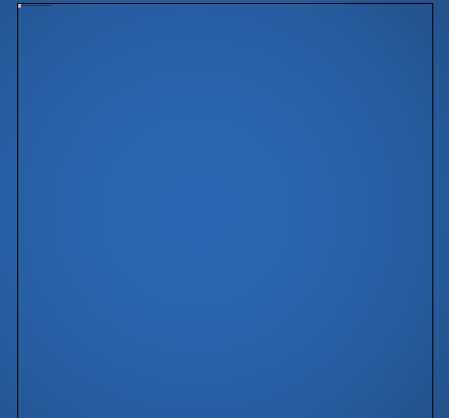


Patient and family

- Share priorities and acceptable tradeoffs
- Identify the preferred contact person
- Understand who to call for symptoms
- Receive written instructions without being made responsible for repairing system failures

Take-aways:

- Palliative care can accompany disease-directed treatment across settings.
- Symptom treatment must be clinically appropriate and feasible in the next setting.
- A placed referral is not a completed transition.
- Complex transitions require explicit ownership, direct communication, and closed-loop follow-up.
- Case managers and care coordinators are central to matching the patient's needs and location with the right service model.



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THANK YOU!

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THANK YOU!

PRESENTER

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