# Integrating Quality Palliative and End-of-Life Care into the Geriatric Assessment

## Opportunities and Challenges

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**KEYWORDS**

- Palliative care • End-of-life care • Prognosis • Disease trajectories
- Symptom management

**KEY POINTS**

- The comprehensive geriatric assessment is greatly enhanced by integration of ongoing palliative and end-of-life care assessments and care.
- Advance care planning and discussions about advanced illness management and dying can improve end-of-life care outcomes.
- Common disease trajectories are evident that indicate a limited life expectancy and the need for palliative care.
- Common physiologic and physical changes are evident, which can be used to improve palliative and end-of-life symptom management.
- Anticipation and management of the common physical, psychosocial, and spiritual symptoms experienced at the end of life are vital to a quality death for older adults.

## INTRODUCTION

Traditionally, health care providers have had difficulty discussing nonaggressive options of care with their patients because it is often associated with giving up. In particular, physicians may believe in the value of palliative care but still hesitate to bring up the subject with their patients, fearing that it will destroy their hope or imply a lack of commitment to treatment.[1,2] This circumstance commonly results in unnecessary, nontherapeutic, expensive treatments and decreased quality of life.[3] It is imperative that the ongoing assessment of older adults includes the appropriate and timely consideration, then completion, of transitioning from conventional curative care treatments to a palliative or comfort care model of care. These care transitions should

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focus on improving quality of life through shared decision-making between patients, their families when appropriate, and health care providers.[4] In general, there needs to be greater recognition and implementation of palliative care to improve older adult patients' quality of life and their deaths through symptom control and follow-through on their health care choices.

Palliative care is frequently perceived as an end-of-life measure, an option only when curative or life-prolonging therapy is no longer beneficial. This perception is false in that palliative care, including symptom management, psychosocial counseling, and discussion about treatment goals and expectations, should be incorporated into the routine assessment and primary care of older adults beginning at the time of any new diagnosis, particularly for patients with aggressive disease or high symptom burden. It can be the main focus of care or offered concurrently with life-prolonging medical treatment.[5]

## SCOPE AND DEFINITION OF PALLIATIVE AND END-OF-LIFE CARE

Palliative care, at its best, provides excellent symptom management and exceptional patient, family, intraprofessional, and interprofessional communication regarding illness, hopes, goals, and expectations for treatment over time, toward the goal of creating a patient-centered plan of care.[6] An interprofessional team care approach is optimal to achieve the aims of relieving suffering, improving the quality of life, optimizing function, and assisting with decision-making for patients with advanced illness and their families.[7,8] This approach is effective for providing comprehensive, proactive assessments and monitoring with advanced symptom management and counseling. Further, it allows for coordination with community services to furnish medical equipment, meals, transportation, caregiving, and other services needed to improve overall quality of life and wellness.

Through shared decision-making, older adult patients can receive relief of their physical and emotional suffering as well as preventing unnecessary hospitalizations, medications, and treatments. A primary goal for these patients is an improved quality of life, the highest practicable functional status, and greater satisfaction with their health care, while also reducing the total costs of care.[3]

The goals of palliative and end-of-life care are 4-fold: (1) advanced symptom management at home or the least restrictive environment, care coordination with community service providers, and an interprofessional approach to complex quality-of-life issues; (2) facilitated shared decision-making by and between the patients, their families when appropriate, and their physician through development of innovative standardized tools for each party; (3) quality-of-life focused treatment choices with a decrease or elimination of multiple inpatient and outpatient services; and (4) a seamless continuum of community-based supportive care until the end of life. Palliative care is best offered in the last 2 years of life, if not initially from the time of any new life-limiting diagnosis. End-of-life care aims to relieve suffering and improve quality of life for patients with advanced illness and their families in the last days of life.[7,8]

Providing outstanding palliative and end-of-life care is not merely practical but imperative for older adult patients. It enhances quality of care when added to the work done by the health care team caring for older adults. The successful integration of palliative care into routine geriatric assessment should result in fewer deaths in a hospital setting, longer hospice lengths of stay, less futile treatments in the last weeks of life, and higher satisfaction levels for patients and families.