Partnering for Excellence in the Care of the Seriously Ill

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No relevant financial disclosures

Learning Objectives

1. Describe similarities and differences between Hospice & Palliative Care
2. Discuss strategies for partnering with palliative care providers to meet the needs of the seriously ill patient and family

Rehab & Palliative Specialists Share:

- Interdisciplinary
- Comprehensive Care
- Value caregivers
- Complex patients
- Improve Quality of Life
- Maximize Function

UNDERSTANDING HOSPICE & PALLIATIVE CARE

Pal·li·ate

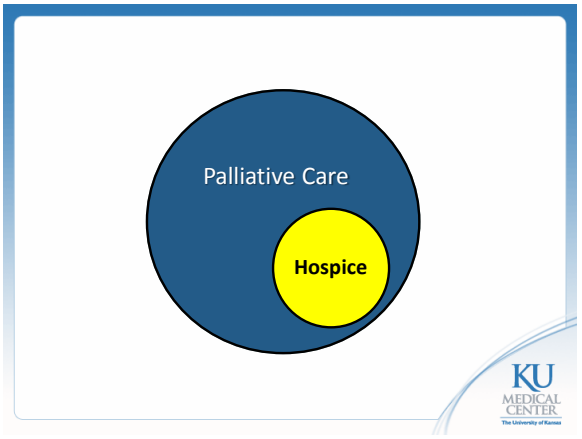
Latin, *palliāre*
To cover up

Latin, *pallium*
A cloak

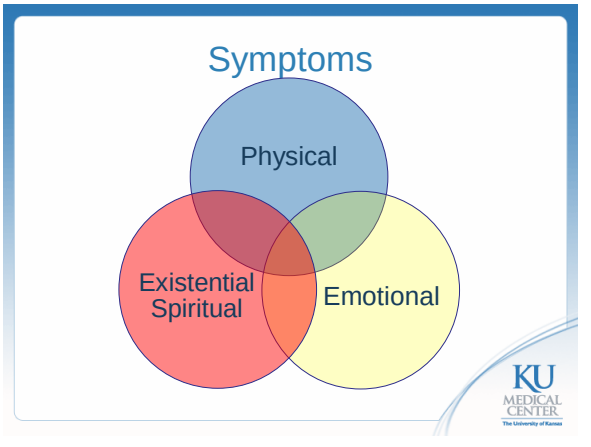
To relieve or lessen without curing; alleviate

The World Health Organization's Definition of Palliative Care

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.



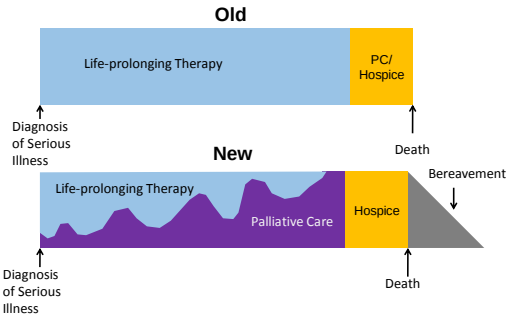
	Palliative Care	Hospice
When	Anywhere in illness trajectory	Prognosis < 6 MONTHS
Where	Usually in hospital, some outpatient programs	Goes to patient (Hospice is not a place)
Goals of Care	Variable	Comfort Directed Usually avoiding hospitalization
Availability	Depends on individual program	Planned visits 24/7 on-call
Team Members*	Depends on individual program	Nurses, physicians, volunteers, chaplains, social workers, bereavement coordinators
Levels of Care	Primary Secondary Tertiary	Routine Continuous Care General Inpatient Respite

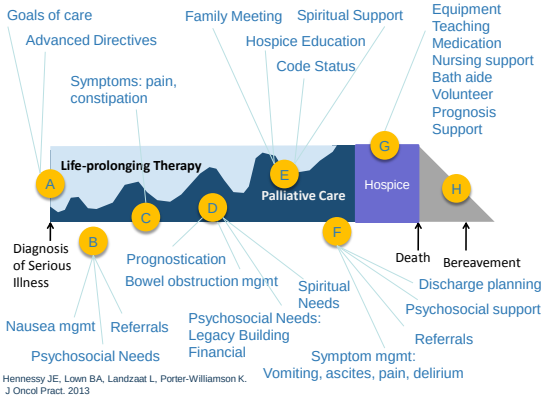


Possible Reasons for consulting Palliative Care

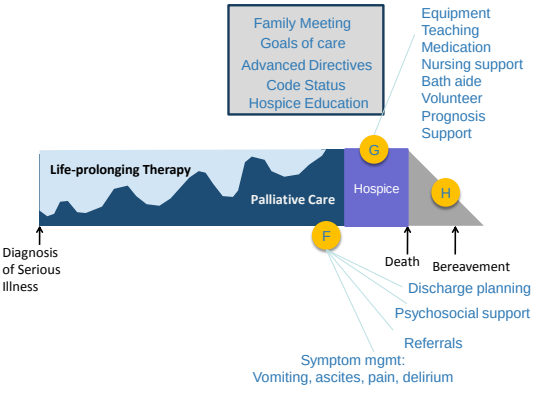
- Symptom management
- Disposition Planning
- Recurrent admissions
- Patient coping
- New diagnosis or prognosis
- Clarifying Goals of Care
- "Difficult" Patient/Family
- Communication Issues
- Psychosocial support
- Specific Decision Making Help and/or capacity
- Hospice Education/Planning
- Actively Dying Patient

Old vs. New Models of Palliative Care

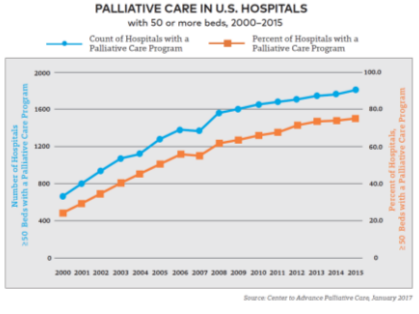




Hennessy JE, Lown BA, Landzaat L, Porter-Williamson K. J Oncol Pract. 2013



Palliative Care is Growing



Palliative Care Teams Vary A LOT

- Who is on the team can vary
- Workflows vary
- Access varies: M-F or 24/7
- Services vary: ACP/Symptoms/Hospice ed
- Who they care for: Peds/Adults/Both
- Institutional Culture
- Where they see patients: inpt/outpt

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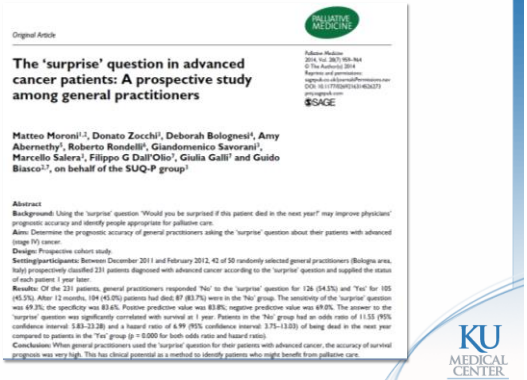
Advantages

- improved QOL (ASCO)
- improved symptom burden (ASCO)
- patient satisfaction (ASCO)
- reduced caregiver distress (Wright)
- more appropriate referral and use of hospice (Greer)
- reduced use of futile intensive care (Wright)
- survival benefit in 1 study of NSCLCA (Temel)
- lower heathcare costs (Zhang)
- no trials to date have demonstrated harm to patients and caregivers, or excessive costs, from early involvement of palliative care (ASCO)

WHO IS APPROPRIATE?



Original Article

The 'surprise' question in advanced cancer patients: A prospective study among general practitioners

Palliative Medicine

SAGE

Matteo Moroni[1,2], Donato Zocchi[1], Deborah Bolognesi[4], Amy Abernethy[3], Roberto Rondelli[4], Giandomenico Savorani[1], Marcello Salera[1], Filippo G Dall'Olio[1], Giulia Galli[1] and Guido Biasco[1,2], on behalf of the SUQ-P group[1]

Abstract

Background: Using the 'surprise' question 'Would you be surprised if this patient died in the next year?' may improve physicians' prognostic accuracy and identify people appropriate for palliative care.

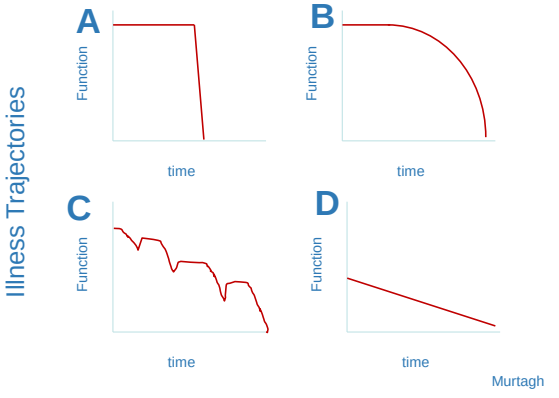
Aim: Determine the prognostic accuracy of general practitioners asking the 'surprise' question about their patients with advanced (stage IV) cancer.

Design: Prospective cohort study.

Setting/participants: Between December 2011 and February 2012, 42 of 50 randomly selected general practitioners (Bologna area, Italy) prospectively classified 231 patients diagnosed with advanced cancer according to the 'surprise' question and supplied the status of each patient 1 year later.

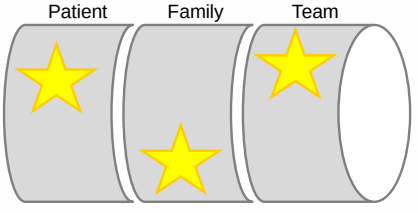
Results: Of the 231 patients, general practitioners responded 'No' to the 'surprise' question for 126 (54.5%) and 'Yes' for 105 (45.5%). After 12 months, 104 (45.0%) patients had died; 87 (83.7%) were in the 'No' group. The sensitivity of the 'surprise' question was 69.3%; the specificity was 83.6%. Positive predictive value was 83.8%; negative predictive value was 69.0%. The answer to the 'surprise' question was significantly correlated with survival at 1 year. Patients in the 'No' group had an odds ratio of 11.55 (95% confidence interval: 5.83–23.28) and a hazard ratio of 6.99 (95% confidence interval: 3.75–13.03) of being dead in the next year compared to patients in the 'Yes' group ($p = 0.000$ for both odds ratio and hazard ratio).

Conclusion: When general practitioners used the 'surprise' question for their patients with advanced cancer, the accuracy of survival prognosis was very high. This has clinical potential as a method to identify patients who might benefit from palliative care.

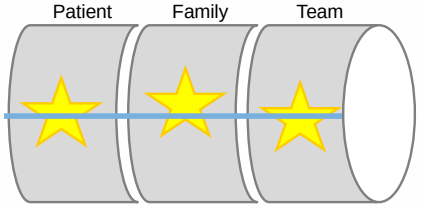


MATCHING RESOURCES TO FIT THE GOALS OF CARE

Goals of Care



Goals of Care



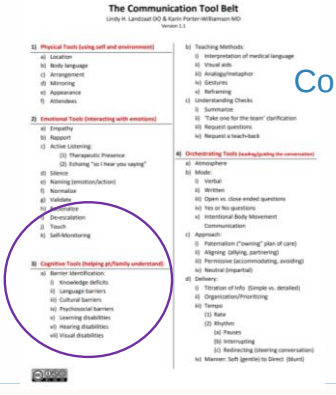
What do "Goals of Care" mean?

Patient/Family	Provider/System
• What do you **HOPE** that the treatment will achieve? – Cure – Better function – Reaching a milestone – Comfort – Help others	• What are we **DOING**? What is the focus of the medical plan?" – Save/rescue – Optimize function – Extend life – Manage symptoms

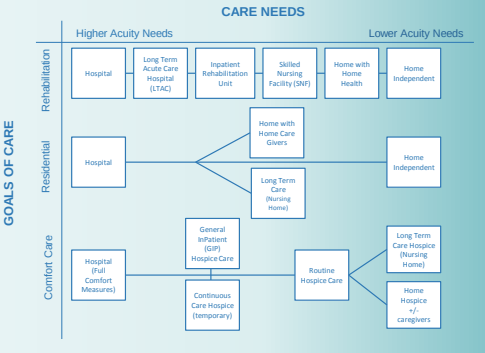
Exploring Impacts of Serious Illness

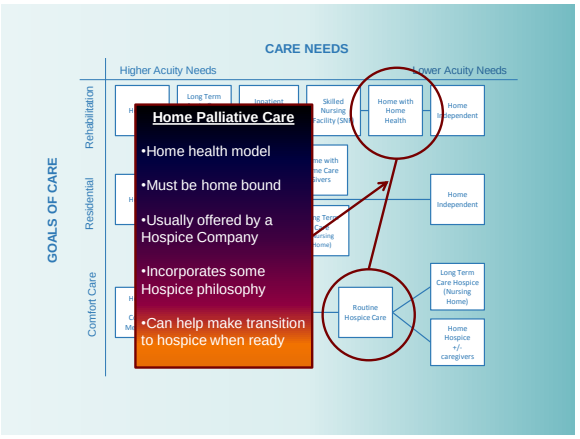
- What's you're understanding of your condition?
- What are you hoping for?
- What gives you strength in dealing with illness?
- How have you dealt with tough times before?
- What's most important to you right now?

Communication Barriers?



Individualization





ARTIFICIAL NUTRITION & HYDRATION THE GOOD, THE BAD, THE UGLY

Benefits of AHN

- Shown to prolong survival in some clinical situations-recovery from stroke, critical illness, MBO, ALS, coma
- Support patients with head & neck cancer during intense chemoradiation
- May help some symptoms, goals, emotional or spiritual needs

Risks of AHN

- Infection
- Thrombosis
- Aspiration with PEG tube feedings
- Pulling on tubes
- Pressure sores from nasal tubes
- Restraint risk
- Head of bed up → pressure sores
- Diarrhea
- Edema (renal failure)
- Bloating

Common Reasons AHN arises

- Dysphagia
- Too Sick!
- Mechanical Obstruction
- Cancer Anorexia Cachexia Syndrome
- Treatment-related sequale
- Fears or concerns related to starvation

Dysphagia

- Your expertise!
- Any reversible causes of the dysphagia?
  - Infections
  - Myasthenia Gravis
- I tell other docs…"Make friends with your speech therapist"
  - They can help prognosticate the swallow
    - Rehab potential
  - Invite SLP to the family meeting

Critical Illness

- Often preventing infection is more important than the nutritional value
- Mucosal lining is thin; presence of nutrients in bowel has protective effect
- Prolonged bowel rest creates risk for systemic sepsis
- If no contradindications, begin enteral feeding within 72 hrs, parenteral not as urgent due to associated risks

IF DYSPHAGIA IS FROM PROGRESSIVE DEMENTIA, BE AWARE OF THE DATA

www.choosingwisely.org

www.choosingwisely.org

Cochrane Database Review

"There is insufficient evidence to suggest that enteral tube feeding is beneficial in patients with advanced dementia. Data are lacking on the adverse effects of this intervention."

Sampson EL, Candy B, Jones L. Enteral tube feeding for older people with advanced dementia. Cochrane Database Syst Rev. 2009 Apr 15;(2)

I want to eat but can't…

OBSTRUCTION

- Consider Goals
- Consider Prognosis
- Is the patient a candidate for:
  - surgery
  - laser ablation
  - radiation
  - stent +/- brachytherapy

I want to eat but can't…

OBSTRUCTION

- If not available, not successful or not effective…
- Especially if patient is hungry and/or goals fit…
- Consider:
  - Gastrostomy tube (PEG)
  - NGT
  - Trial of parenteral hydration
  - hypodermoclysis

Cancer Anorexia-Cachexia Syndrome

- Anorexia = loss of appetite → inadequate calories
- Cachexia = catabolic state → loss of muscle and weight
- Involuntary weight loss
- Tissue Wasting
- Worsening functional status

Cancer & Anorexia

Cytokine release from:
- Tumor itself
- tumor + immune system
- body reacting to tumor

Act peripherally & centrally

Table 1. Cancer cachexia differs from starvation.

Parameter	Cachexia	Starvation
Resting energy expenditure	++	–
Loss of skeletal muscle	++	–
Loss of fat	++	++
Loss of visceral muscle	–	+
Acute-phase response	++	–
Proinflammatory cytokines	++	–
Toxohormones	++	–
Increased liver metabolism	++	–
Liver size	++	––

Abbreviations: +, increased; –, reduced.

Couch M, et al "Cancer Cachexia Syndrome in Head and Neck Cancer Patients: Part 1. Diagnosis, Impact on Quality of Life and Survival and Treatment" Head and Neck 2007; 401-11

Geriatric Anorexia or Cachexia

8 **Avoid using prescription appetite stimulants or high-calorie supplements for treatment of anorexia or cachexia in older adults; instead, optimize social supports, discontinue medications that may interfere with eating, provide appealing food and feeding assistance, and clarify patient goals and expectations.**

Unintentional weight loss is a common problem for medically ill or frail elderly. Although high-calorie supplements increase weight in older people, there is no evidence that they affect other important clinical outcomes, such as quality of life, mood, functional status or survival. Use of megestrol acetate results in minimal improvements in appetite and weight gain, no improvement in quality of life or survival, and increased risk of thrombotic events, fluid retention and death. In patients who take megestrol acetate, one in 12 will have an increase in weight and one in 23 will have an adverse event leading to death. The 2012 AGS Beers criteria lists megestrol acetate and cyproheptadine as medications to avoid in older adults. Systematic reviews of cannabinoids, dietary polyunsaturated fatty acids (DHA and EPA), thalidomide and anabolic steroids, have not identified adequate evidence for the efficacy and safety of these agents for weight gain. Mirtazapine is likely to cause weight gain or increased appetite when used to treat depression, but there is little evidence to support its use to promote appetite and weight gain in the absence of depression.

Choosing Wisely
An initiative of the ABIM Foundation

AGS Geriatrics Healthcare Professionals
Leading Change. Improving Care for Older Adults.

HEAD AND NECK TREATMENT

Cochrane Database Review

"There is not sufficient evidence to determine the optimal method of enteral feeding for patients with head and neck cancer receiving radiotherapy and / or chemoradiotherapy. Further trials of the two methods of enteral feeding, incorporating larger sample sizes, are required."

Nugent B, Lewis S, O'Sullivan. Artificial tube feeding methods for use with patients with head and neck cancer who are receiving treatment with radiotherapy, chemotherapy or both JM, 2013

Swallow Exercises

- Before, During, or After Head and Neck treatments?
- Cochrane Review reported no evidence for improvement in swallow for patients undergoing head and neck treatments; need more high quality studies.

Perry A, Lee S, Cotton S, Kennedy C, Swallowing exercises for affecting swallowing after treatment in people with advanced-stage head and neck cancers 2016.

OUTPATIENT PALLIATIVE HEAD AND NECK CLINIC

ALSO WORTH KNOWING ABOUT

Gastrostomy Tubes

PEG isn't a brand or specific type of tube.
For feeding or venting?

How Placed	Technique	Location of Placement	Abbreviation
Percutaneous	Endoscopically	Gastrostomy	PEG
Percutaneous	Endoscopically	JeJunostomy	PEJ
Percutaneous	Radiographically	Gastrostomy	PRG
Surgically		Gastrostomy	G-tube

G tubes, sizes

French (3 times diameter in mm)	
French Gauge	Diameter
16	5.33 mm
18	6 mm
20	6.67 mm
24	8 mm
28	9.33 mm

Hypodermoclysis

- Subcutaneously administered fluids
- Rate of 20 - 125 mL/h
- NS or isotonic dextrose most commonly
- Small catheters
- Sites: R/L scapular, Upper lateral arm, Lateral thighs, anterior thighs, upper abdominal wall, dorsal aspect of upper arms

Hypodermoclysis

- Metanalysis: 8 (1 USA, 3 Europe, 3 Canada, 1 Asia)
- Geriatric patients
- Duration of treatment 4-21 HDC
- Safety: safety profile of HDC comparable to IV
- Efficacy: equally effective
- Site Changes: similar, 2 days
- Infusion related Agitation: better with HDC (37 vs 80%)
- Nursing feasibility: nurse rating the same,
  - Nursing Time required: 2.4 min HDC vis 6.1 IV
- Cost: IV supplies 4x greater than for HDC supplies

Remington R, Hultman T, JAGS, 2007 55: 2051-55

When might Hypodermoclysis be indicated?

Maybe, if goals fit +

- Intractable Nausea
- Symptomatic dehydration, can't do ORT
- Trial in delirium/altered mental status changes
- Weakness/malaise
- Opioid induced neurotoxicity/myoclonus
- Overwhelming need to try

Not indicated

- Goals are aggressive & IVF needed fast
- Dry mouth
- Hypervolemic, pulmonary edema, dyspnea
- Only prolonging dying
- When surrogate for untreated family anxiety

Proctolysis (Rectal Hydration)

- Alternative ONLY when other resources are not available
- A 22 French nasogastric catheter can be inserted approximately 40 cm into the rectum.
- The patient can be positioned as for any rectal procedure.
- Tap water can be used, and the rectal infusion increased from 100 ml to a maximum of 400 ml per hour, unless fluid leakage occurs before the maximum volume is achieved.
- The majority of patients can successfully tolerate this approach at a volume of 100 to 200 ml per hour

http://www.mypcnow.org Fast Fact 134 Robin Fainsinger MD

DEALING WITH EMOTIONS

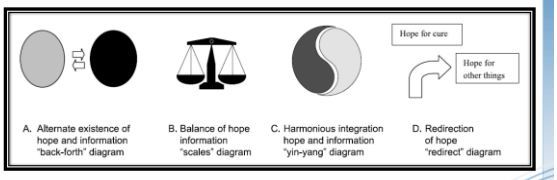
Emotional Aspects of Eating

- **Nurturing**
- **Socialization**
- **Routines**
- **Pleasure**
- **History**
- **Healing when ill**

When you're feeling stuck

- Are the goals aligned?
  - Unrealistic goals?
    - Understanding of illness
    - Trust
    - Maladaptive coping
    - Caregiver issues
    - Need to witness a treatment or therapy?

Conceptual Models of Hope



Curtis 2008

Wish/Worry statements

- Words matter
- Avoid linking statements with "but", it negates whatever you said first.
- "I wish that David will get strong enough for chemo too. I worry that may not be the case. Is that something you've allowed yourself to consider as well?"

Comfort Care for Terminally Ill Patients

The Appropriate Use of Nutrition and Hydration

Robert M. McCann, MD; William J. Hall, MD; Annmarie Groth-Juncker, MD

Objective.—To determine the frequency of symptoms of hunger and thirst in a group of terminally ill patients and determine whether these symptoms could be palliated without forced feeding, forced hydration, or parenteral alimentation.

Design.—Prospective evaluation of consecutively admitted terminally ill patients treated in a comfort care unit.

Setting.—Ten-bed comfort care unit in a 471-bed long-term care facility.

Participants.—Mentally aware, competent patients with terminal illnesses monitored from time of admission to time of death while residing in the comfort care unit.

Main Outcome Measures.—Symptoms of hunger, thirst, and dry mouth were recorded, and the amounts and types of food and fluids necessary to relieve these symptoms were documented. The subjective level of comfort was assessed longitudinally in all patients.

Results.—Of the 32 patients monitored during the 12 months of study, 20 patients (63%) never experienced any hunger, while 11 patients (34%) had symptoms only initially. Similarly, 20 patients (62%) experienced either no thirst or thirst only initially during their terminal illness. In all patients, symptoms of hunger, thirst, and dry mouth could be alleviated, usually with small amounts of food, fluids, and/or by the application of ice chips and lubrication to the lips. Comfort care included use of narcotics for relief of pain or shortness of breath in 94% of patients.

Conclusions.—In this series, patients terminally ill with cancer generally did not experience hunger and those who did needed only small amounts of food for alleviation. Complaints of thirst and dry mouth were relieved with mouth care and sips of liquids far less than that needed to prevent dehydration. Food and fluid administration beyond the specific requests of patients may play a minimal role in providing comfort to terminally ill patients.

JAMA. 1994;272:1263-1266

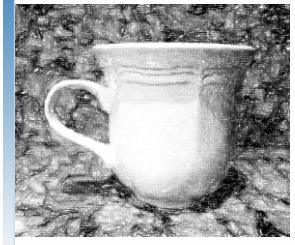
METHODS

Setting

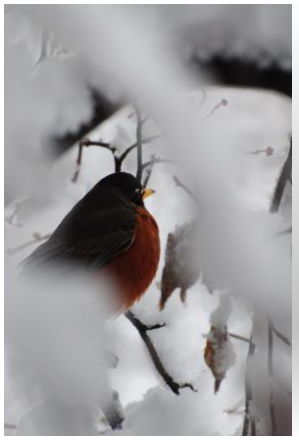
The study was carried out in a comfort care unit at St. John's Home, a 471-bed, community-based long-term care facility in Rochester, NY, from April 1990 to April 1991. Patients were eligible for admission to the 10-bed comfort care unit if they were certified by their primary care physician as terminally ill, which implies a life expectancy of 6 months or less, and if they wished comfort care. The patient's pertinent medical history was reviewed before admission by a staff physician to verify that the patient had a terminal illness and was functionally in need of skilled nursing care. All patients had specific care guidelines outlined based on their wishes with specific reference made to cardiopulmonary resuscitation, artificial nutrition and hydration, and the use of antibiotics.

The majority of eligible patients had diagnoses of cancer or stroke. Patients were admitted from hospital units and home. Although no strict age limit was defined, most patients were older than 60 years.

Consider…



- Offering favorite foods in small amounts
- Flavoring ice chips
- Soaking oral swabs w/ favorite beverage
- Is mouth moist? Swab?
- Is the presentation pleasing?
- Is the setting appealing?



Comforting without food

- Music
- Reading
- Therapeutic Touch, Massage
- Reminiscing or Story Telling
- Being a Quiet presence
- Providing Oral Care

BUT AM I STARVING HIM?

Coaching

- Prepare family for what is normal and expected at end of life
- Remind family of the underlying cause
- Prepare family for what the plan will be if:
  - Pt is hungry or thirty
  - Not awake

Landzaat, Sinclair. Principles and Practice of Hospital Medicine.

Scripting

- "Many family members worry about this. What we know is:
  - Dying patients almost universally lose their appetite; his dying is a result of the cancer
  - Remember the last time you had the flu?
  - The body does not process food & drink the same at this stage of illness
  - A failing body typically starts to shift fluids to the wrong places; that can add discomfort

Landzaat, Sinclair. Principles and Practice of Hospital Medicine.

Scripting

- If he becomes alert enough and wants something, we're happy to start with sips and bites of whatever sounds good and see how that goes
- If he is not awake, it's not safe to put food in his mouth. We will continue to provide oral care for comfort.

Landzaat, Sinclair. Principles and Practice of Hospital Medicine.

Support for caregivers

- Identifying what people "do" not just labeled relationships
- Reassess frequently
  - "What are you most worried about?"
  - "How are things going?"
  - "What is/isn't working?"
  - "What would make this easier?"
  - Who can you talk to when you're feeling stressed?"

Supporting caregivers

- Family meeting
- Encourage them to see own provider
- May need counselor/support group
- Palliative Care intervention
- Partner with Social Work
- Partner with Spiritual Care

Caring for our patients and ourselves

- Work as a team
- Maintain Perspective
- Rotation of duties
- Respect Boundaries
- Recognize caregiving fatigue
- Advocate for team resources

TIPS FOR WORKING WITH DOCS

First…

- Be aware of preconceived notions about palliative care; these can skew behaviors and attitudes towards pts
- It may seem counterintuitive, but Palliative Care is actually about **LIVING**
- Must be engaged early enough for patient and family to benefit
  (i.e. the last 24 hours of life is too late)

Appreciate KUMC SLP experts who share:

- Prognosis of swallowing
  - Explain the motor/cognitive/practical constraints
- Ability of pt to meet caloric requirements
- The "safest swallow"
  - Consistency of fluids and solids
  - Facilitative maneuvers for successful swallowing
- Recs for aggressive vs comfort goals

SLP & Palliative Care

- This information guides shared decision making:
  - PEG or not
  - Trial of small bore feeding tube (Dobhoff/Corpak)?
  - Stay NPO
  - Comfort feeding: spend what limited time there is, enjoying the safest consistency of food and drink

SLP & Palliative Care

- Patient & family informed of risks and benefits
- Patient maintains control over this aspect of their QOL
- Still want to try to make it as comfortable as possible
  - Sharing maneuvers, tips, coaching for family may still be indicated
- Some patients can not eat very comfortably
  - Autotitrate, how and what they eat
  - Might need a PEG:
    - » to help palliate hunger
    - » to receive comfort directed medication

Tips for Collaboration

- We're interested in your rehab prognosis
- Don't presume PC reason is always "end-of-life"
- We advocate for short stay rehab when clear, realistic goals, need your help
- Some hospices contract with rehab specialists
- Helpful for us to "see" pt doing therpies
- Don't automatically sign off when goals switch to hospice

Example:

RECOMMENDATIONS: Pending GOC. Spoke with pt's primary team, pt and wife (via phone call) re: recommendations. F/u with family will be required.

Aggressive goals of care

1. NPO. Continue source of short term non-oral nutrition. Return of safe swallow function likely largely dependent on recovery from other medical conditions. Do not anticipate pt will safely progress to p.o. Diet w/in next 2-3 weeks; therefore, source of long term non-oral nutrition may need to be considered pending pt's overall goals of care.
2. Ice chip protocol (3-5/hour, stop if coughing & re-attempt later, upright)
3. Ongoing speech therapy for dysphagia management.

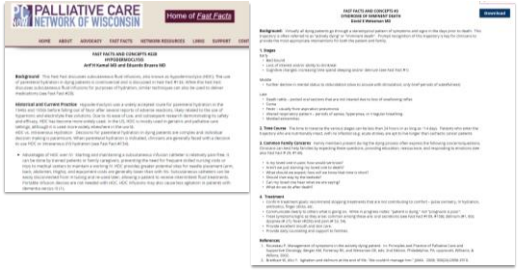
Palliative goals of care/palliative management of dysphagia:

1. Thin liquids w/ thinned purees solids w/ know risk of aspiration.
2. Following swallow strategies may maximize pt comfort when providing p.o.: small bites & drinks; slow rate of intake; alternation of liquids & solids
3. Ongoing speech therapy to focus on pt and family education re: safe swallow strategies, etc.

Free Resource on Palliative Care: Fast Facts

Palliative Care Fast Facts

www.mypcnow.org



Summary

Describe similarities and differences between Hospice & Palliative Care

Discuss strategies for partnering to meet the needs of the seriously ill

- Know your resources
- Surprise Question
- Goals of Care
- Don't prematurely sign off
- Consider leaving comfort feedings recs

References

- Quill, TE and RG Holloway. "Evidence, Preferences, Recommendations—Finding the Right Balance in Patient Care." New England Journal of Medicine. 366;18. May 3, 2012. 1653-1655.
- Von Gunten, C. "Secondary and Tertiary Palliative Care in US Hospitals". JAMA Feb 20, 2002. vol 287, No 7. 875-881
- Morrison, RS and Diane Meier. "Palliative Care" NEJM. 350;25. June 17, 2004. 2582-2590.
- Mitka, M. "Cancer Experts Recommend Introducing Palliative Care at Time of Diagnosis". JAMA March 28, 2012. Vol 307, No 12. 1241-2.
- The SUPPORT Principal Investigators. "A controlled trial to improve care for seriously ill hospitalized patients. The study to understand prognoses and preferences for outcomes and risks of treatments (SUPPORT)". JAMA. 1995 Nov 22-29;274(20):1591-8.
- Butterfield, S. "Caring is Hard Work: Programs seek to address 'compassion fatigue". ACP Hospitalist. May 2012; 21-23.
- "palliate". Dictionary.com. *Collins English Dictionary - Complete & Unabridged 10th Edition*. HarperCollins Publishers. http://dictionary.reference.com/browse/palliate (accessed: June 15, 2012).
- Cassell, Eric J. "The Nature of Suffering and the Goals of Medicine" Second ed. 2004.
- Palliative care Fast Facts. www.mypcnow.org. Editor Sean Marks.

References

- Curtis, JR, et al. Swallowing exercises for affecting swallowing after treatment in people with advanced-stage head and neck cancers. JPM 11 (4) 610-20. 2008.
- Seres, D. "Nutritional Support in Critically ill patients: An overview." UpToDate. 6.16.17
- Landzaat, Sinclair. Care of the Imminently Dying, Chapter 217. Principles and Practice of Hospital Medicine, 2nd ed. McGraw Hill. 2017
- Center to Advance Palliative Care. State grad ratings. https://reportcard.capc.org September 2017, Access to Palliative Care Graph, Jan 2017
- Moroni, et al. "The Surprise Question in Advanced cancer Patients: A prospective study among general practioners." Palliative Medicine 2014. Vol 28 (7) 959-64.
- McCann, RM. Et al. Comfort Care for Terminally Ill Patients. JAMA 1994. 272: 1263-1266.
- Couch M, et al "Cancer Cachexia Syndrome in Head and Neck Cancer Patients: Part 1. Diagnosis, Impact on Quality of Life and Survival and Treatment" Head and Neck 2007; 401-11
- Remington R and T Hultman. "Hypodermoclysis to Treat Dehydraiton: A Review of the Evidence." Journal of American Geriatric Society. 2007. 55: 2051-2055
- Landzaat, L and K Porter-Williamson. Communication Toolbelt. Online. http://www.kumc.edu/Documents/palliative/The%20Communications%20Tool%20Belt.pdf