Palliative Care Pearls:
What Works, What Doesn’t

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First, the bad news---
What Doesn’t Work...

1. Docusate
2. Chemotherapy Near End of Life
3. IV Hydration Near End of Life
4. Oxygen in Non-Hypoxic Patients with Dyspnea

Disclosures

I have no financial disclosures to report.

Docusate for Constipation

- Study: Double-blind RCT
  - 74 patients, 3 inpatient Canadian hospices
  - Randomized to 10 days of:
    - Senna 1-3 tabs/day + docusate 100 mg BID
    - Senna 1-3 tabs/day + placebo BID

Study Results

- Docusate group had marginally larger volume of stool p=0.06; stool consistency was slightly different between groups
- No differences in:
  - Average # of bowel movements/day
  - Patients' perceptions of the difficulty or completeness of defecation
  - Pain
  - Percent of patients requiring additional bowel intervention (74% placebo; 69% docusate))
- Additional issues: tastes horrible, pill burden

Take-Homes

No appreciable benefit of adding Docusate to Senna in hospice patients

- What works for constipation:
  - Always rx laxative with opioid
  - Start with senna, then add Miralax, Lactulose, etc
  - Suppository or enema (avoid Fleet's) if > 3-4 days
  - Consider Methylnatrexone for opioid-induced constipation if above not working

Chemotherapy near End of Life

- Goals of chemotherapy for patients with metastatic cancer:
  1. Live longer
  2. Live better
- Study: Association of chemo in last 6 months of life with caregiver-reported quality of life in last week of life and survival

- ½ of patients were on chemo at enrollment
- Median survival 4 months
- Patients with good functional status were more likely to receive chemo
- Results:
  - No difference in survival
  - Chemo associated with worse QoL for patients with better functional status at baseline

Think twice about whether to support palliative chemotherapy for patients with metastatic cancer who are near the end of life.
IV Hydration Near End of Life

- Significant controversy
- Stopping to eat and drink at end of life is normal
- Associated with edema, effusions and ascites
- Does not reduce thirst
- Requires some sort of access/line

RCT of 129 hospice patients with cancer and mild-moderate dehydration

Intervention:
- 1L NS/day over 4 hours x 4 days
- 100mL NS/day over 4 hours x 4 days

Study Results

- No stat sig difference in:
  - Survival (21 vs 15 d)
  - Symptoms (fatigue, myoclonus, sedation, hallucinations)
  - Quality of Life
- Both groups noted subjective improvement in dehydration symptoms

Typically best to minimize IVF at end of life.

Supplemental Oxygen for Dyspnea In Non-Hypoxic Patients

- Palliative oxygen therapy widely used for dyspnea
- Potential benefits: placebo effect, family feels like “doing something”
- Potential burdens: ties patient down, social stigma, uncomfortable, nosebleeds, fire risk
Supplemental Oxygen Trial

- Study:
  - Double-blind RCT
  - 239 outpatients in US, Australia and UK with lifelimiting illness, refractory dyspnea, and PaO2 > 55mHg
  - Randomized to RA or O2 at 2 LPM x 7 days
    - Instructed to use O2 at least 15 hours/day

Study Results

- No difference between supp O2 vs RA by NC in:
  - Mean AM Breathlessness scores
  - Mean PM Breathlessness scores
  - Quality of Life

Compared with RA NC, oxygen by NC provides no benefit for dyspnea in patients who are not hypoxemic.

What Works for Dyspnea

- Treat the underlying cause
  - Pleural effusion, PE, pna, ascites
- Opioids
  - Low dose, Safe even in COPD
- Position
- Breathing training
- Fan and/or fresh air
- Cold cloth to face
- Acupuncture in COPD

And now, the good news---(Other Things) That Work!

- Palliative Care
- Skilful and Sensitive Communication
- Advance Care Planning
Palliative Care

- Specialized medical care for patients with serious illness and their families
- Focuses on providing relief from the symptoms and stress of a serious illness
- Team-based approach
- No prognostic or treatment limitations
- Hospice is a type of palliative care
  - A Medicare Benefit (Part A)
  - For patients with prognosis less than six months who have chosen to forgo life-prolonging interventions
  - Can be offered at home, SNF, or other residential facility

Old Paradigms of Palliative Care Engagement

- Traditional, delayed advanced care model
- Proactive advanced care model

Current Paradigm of Palliative Care Engagement

- Condition appropriate for palliative care may or may NOT progress to death

Palliative Care Benefits

**Quality Improves**
- Reduction in symptom burden
- Improved quality of life
- Longer length of life
- Increased family satisfaction
- Better family bereavement outcomes
- Care matched to patient centered goals

**Costs Decrease**
- Hospital costs decrease
- Need for hospitalization/ICU decreases
Early Palliative Care Intervention

- **Study:**
  - Non-blinded, RCT (single site)
  - Ambulatory patients with newly diagnosed metastatic NSCLC
  - Immediate PC + onc vs onc
  - Primary outcome: change in QOL at 12 weeks


Study Results

- Baseline characteristics did not differ between groups
- **Intervention group:**
  - Better QOL scores
  - Less depression
  - More documentation of resuscitation preferences
  - Less aggressive care at the end of life
  - Lived two months longer

Skillful and Sensitive Communication

- Patients and families want their providers to:
  - Bring up end of life issues
  - Be available and willing to talk AND listen
  - Provide timely and clear information
  - Encourage questions
- **Patients tend to want:**
  - Prognostic information
  - For bad news to be delivered sensitively
  - Control over the timing of conversation
  - Active participation in decision-making, but desire recommendations

Yet, patients and families report...

- **Not enough:**
  - Contact with physician: 78%
  - Emotional support (pt): 51%
  - Info re: dying process: 50%
  - Emotional support (family): 38%
  - Help with pain/dyspnea: 19%
- **And a lack of:**
  - Coordination
  - Access
  - Anticipatory Guidance
  - Assurance

Teno et al. JAMA 2004;291:80-93
In general...

- We spend a lot of time talking
- But sometimes, not enough
- We interrupt a lot
- We miss emotional cues
- We lack education and confidence

Audience Poll

The biggest barrier for me in having conversations about serious illness/end-of-life with my patients is:

1. Knowledge (of how to have the conversation)
2. Time
3. Money (I can’t or don’t know how to bill)
4. Personal Discomfort - Fear of Taking Away Hope or Damaging the Relationship
5. None, this stuff is easy

Unique Opportunity in Primary Care

- Systematic review of 126 articles: 77 directly addressed primary care, 26 addressed specific populations, 23 addressed general topics

**Strengths**
- Continuity
- Duration
- Trust
- Ability to coordinate across settings
- Unique ability to have these in an iterative manner

**Weaknesses**
- Deficits in knowledge, skills, and attitudes
- Discomfort with prognostication
- Lack of clarity about the appropriate timing and initiation of conversations

Key Communication Tools

- Asking for Permission
Key Communication Tools

- Ask for Permission
- Respond to Emotion

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<tr>
<th>Name</th>
<th>Practice</th>
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<tr>
<td>&quot;It sounds like you’re frustrated.&quot;</td>
<td>&quot;I feel like life is spiraling out of control&quot;</td>
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<tr>
<td>&quot;It must be hard going through this alone.&quot;</td>
<td>&quot;Say something empathic and then just shut up.&quot;</td>
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<td>&quot;I am so impressed by your commitment to your mother.&quot;</td>
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<td>&quot;I’ll be with you through all this.&quot;</td>
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<td>&quot;Tell me more.&quot;</td>
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Utilize Silence

- Practice: "I feel like life is spiraling out of control"
- Utilize Silence
  - "Say something empathic and then just shut up."

Improving Communication

- VitalTalk (www.vitaltalk.org)

Improving Communication (cont.)

- Readings
  - Eprognosis (ucsf.eprognosis.edu)
**Advance Care Planning**

- An **ongoing process** of discussing care preferences and making care plans between patients *(and their caregivers)* and providers
- Should include discussion of person’s priorities, beliefs, and values **AND** prognostic information
- May or may not lead to completion of advance directive
- Both physicians and patients think it’s important

**Benefits of ACP**

- Patients who have advance care planning or EOL conversations with their provider are:
  - More likely to received outpatient hospice and be referred to hospice earlier *(Zhang et al. 2009, Wright et al. 2008)*
  - More likely to have their interventions known and followed *(Detring et al. 2010, Houbin 2014)*
  - Family members are more likely to be satisfied with the quality of death *(Detring et al. 2010)*

**Audience Poll**

In my practice, I aim to have advance care planning conversations with:

1. None of my patients
2. All my patients over 65 years old
3. My patients who are terminally ill
4. Both 2 and 3
5. All my patients regardless of age
ACP Practices in Primary Care

- Systematic review of 10 studies (5 US) among PCPs providing care for patients living in the community or an assisted living
- ACP most frequently done with patients with cancer, Alzheimer’s dementia, or other terminal illness
- Of patients who died of non-sudden deaths, one-third had ACP
- Provider-reported ACP rates higher than patient-reported ones
- Lack of systematic approach; hard to judge when to initiate
- Patients want to discuss, even if healthy; feel it is responsibility of provider to bring up

Glaudemans et al. (2015) Fam Practice

ACP Documentation

- Include on problem list; be specific
- Many health systems working on streamlined EMR ACP documentation processes
- When patient preferences clear, complete advance directive and medical order (for patients with less than 1y prognosis; in states where available)

ACP Billing

- ACP CPT codes NEW in 2016
  - “ACP includes the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional”
  - 99497: first 30 min F2F (wRVU 2.40; $85.99)
  - 99498: each additional 30 min F2F (wRVU 2.09; $74.99)
  - Include pertinent diagnoses; can bill more than once
- Medicare Annual Wellness Visit (AWV)

ACP Tools

www.prepareforyourcare.org
Miscellaneous PC Pearls

- “Easier to stay ahead of [insert symptom], than catch up”
- Symptom management and ACP are PROCESSES
- "Patients (and families) aren’t always looking to be "fixed," often they just want someone to listen to them, validate them, and bear witness to their story."

Summary

- What doesn’t work...
  - Docusate
  - Chemotherapy Near End of Life
  - IV Hydration Near End of life
  - Oxygen for Non-Hypoxic Patients
- What works!
  - Palliative Care
  - Skillful and sensitive communication
  - Advance Care Planning