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
  - Hydration and activity
  - 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

Prigerson HG. JAMA Oncol 2015; 1(6):778-784
Think twice about whether to support palliative chemotherapy for patients with metastatic cancer who are near the end of life.

**Study Results**

- No improvement in QOL for patients with moderate or poor baseline functional status
- Chemo associated with worse QoL for patients with better functional status at baseline
- No difference in survival (though study not designed for this)

**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, p value 0.83)
  - 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 life-limiting illness, refractory dyspnea, and PaO2 > 55 mHg
  - 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
- Skillful 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
  - Life-prolonging, curative care
  - Hospice care

- Palliative care

Current Paradigm of Palliative Care Engagement

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

- Disease modifying treatment
- Palliative care
- Hospice
- Biological 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

Palliative Care appears beneficial for patients with newly diagnosed metastatic NSCLC.

Access to Palliative Care

www.getpalliativecare.org

CAPC 2015: America's Care of Serious Illness
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

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

**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

Lakin J. JAMA Int Med 2016; 176(9):1380-1387

Key Communication Tools

- Asking for Permission

- Respond to Emotion
  - Name: "It sounds like you're frustrated."
  - Understand: "It must be hard going through this alone."
  - Respect: "I am so impressed by your commitment to your mother."
  - Support: "I'll be with you through all this."
  - Explore: "Tell me more."

  - Practice: "I feel like my life is spiraling out of control"

- Silence as a Tool
  - "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 (Detering et al. 2010; Houbin 2014)
  - Family members are more likely to be satisfied with the quality of death (Detering 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

Glaudermans 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)

[Image: ACP Documentation]

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
  - 99498: each additional 30 min FaF (wRVU 2.09; $74.99)
  - Include pertinent diagnoses; can bill more than once/yr

[Table: ACP Billing]

ACP Tools

- www.prepareforyourcare.org

[Image: ACP Tools]
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
- Great Resource: https://www.capc.org/fast-facts/

THANK YOU

- Brook Calton, MD
- www.geripal.org