Palliative Care Pearls for the Primary Care Practitioner

Brook Calton, MD, MHS
Assistant Professor of Clinical Medicine
Division of Palliative Medicine
University of California, San Francisco

During this hour, we’ll cover:

1. Symptom Management
2. Advance Care Planning
3. How to Get Help

Disclosures
I have no financial disclosures to report.
Ms. Billings

Ms. Billings is a 40 yo woman with colon cancer metastatic to the peritoneum. She is undergoing palliative chemotherapy. She has been taking Acetaminophen (3000 mg/day) for her chronic, cancer-related abdominal pain without relief. She wants to be able to take walk her dog around her neighborhood again but pain is too severe. You decide to start an opioid – which do you choose?

1. Hydrocodone/Acetaminophen 5/325 mg every six hours as needed for pain
2. Fentanyl patch 25 mcg/hr
3. MS Contin 15 mg BID
4. Oxycodone 2.5-5 mg every three hours as needed for pain

Pain Pearls

Take a comprehensive approach

The Bio-Psycho-Social Model

Bio
- Disease-related mechanisms
- Comorbidities

Psycho
- Distress
- Anger
- Fear

Social
- Environmental stressors
- Close personal relationships

The Bio-Psycho-Social Model

Pain Pearls

Take a comprehensive approach

Focus on function!

- ADLs, IADLs
- Hobbies, socialization, exercise
- Concentration, appetite, sleep
- Mood, energy, relationships
- Overall health

Medications
- Medical Cannabis (?)
- Surgery
- Interventional strategies
- Exercise, Sleep
- Acupuncture
- PT/OT
- Palliative radiation (for CA)

Social support
- Limiting other stressors

Opioid Prescribing Principles

PEG Scale

- On a scale of 0-10, over the last week:
  - What has your average pain been? (0-10)
  - How much has your pain interfered with your enjoyment of life? (0-10)
  - How much has your pain interfered with your general activity? (0-10)

Take a comprehensive approach

Focus on function!
A Few Important Details

<table>
<thead>
<tr>
<th>Route</th>
<th>Peak Analgesic Effect</th>
<th>Dosing Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral</td>
<td>60-90 min</td>
<td>Q1-4h</td>
</tr>
<tr>
<td>IV</td>
<td>6-15 min</td>
<td>Q15-30min</td>
</tr>
<tr>
<td>SQ</td>
<td>30 min</td>
<td>Q15-30min</td>
</tr>
</tbody>
</table>

Drug

- Morphine 30 mg
- Hydrocodone 20 mg
- Hydromorphone 7.5 mg
- Hydrocodone 0.5 mg
- Fentanyl See Chart
- Oxycodone 20 mg
- Hydromorphone 1.5 mg
- Oxycodone 10 mg

Safe Opioid Prescribing Pearls

- Start with short-acting as needed medications first.
- Once pain controlled and on stable dosing, can add long-acting to account for short-acting usage.
- Breakthrough dose should be approximately 10% of total daily opioid dose.
- Same risk stratification and opioid monitoring strategies apply for seriously ill.

Opioid Side Effects

- Constipation
- Nausea/vomiting
- Pruritus
- Sedation
- Respiratory depression

Time to Tolerance

- Never
- 7-10 days
- 7-10 days
- 36-72 hrs
- Extremely rare when opioids are dosed appropriately

Ms. Billings (continued)

As you prepare to prescribe Ms. Billings’s oxycodone for the first time, you should do all of the following except:

1. Perform an assessment of Ms. Billings’s opioid misuse/abuse risk
2. Prescribe Docusate
3. Check your state’s prescription drug monitoring program website (PDMP) to check on prior controlled rx prescriptions
4. Prescribe a 7- to 10-day supply of oxycodone rather than a full one month supply
Mr. Chen

Mr. Chen is a 75 yo man with PMH s/f severe COPD using 4L home O2 c/b two hospitalizations this year for COPD exacerbations. He presents to your clinic with ongoing dyspnea both at rest and with activity. After further history and exam, you believe his DOE is from chronic COPD - not an exacerbation of his disease. If you decide to manage with medication, which might you consider?

1. Start 25 mcg/hr Fentanyl patch
2. 25 mcg Fentanyl with 2mL saline via neb 4x /day prn SOB
3. Start Lorazepam 0.25mg PO BID prn SOB
4. Start Morphine liquid 20 mg/mL 2-4mg PO q6h prn SOB

Dyspnea: A Vicious Cycle

Constipation Pearls
Better to stay ahead...
Activity and hydration key...and challenging
Fiber/psyllium can be problematic
Something from below if > 4 days

Opioid-Induced Constipation
• Avoid Docusate
• Start with Senna, then add Miralax, Lactulose, etc
• Consider Methylnatrexone for opioid-induced, laxative-refractory constipation

Tarumi Y. J Pain Symptom Management, 2013
Dyspnea – Role of Oxygen

Effect of palliative oxygen versus room air in relief of breathlessness in patients with refractory dyspnea: a double-blind, randomized controlled trial.

Bourn J, Lancet 2010;376(9743):784-93

Dyspnea Pearls

• Treat the underlying cause
  • Pleural effusion, PE, PNA, ascites
• Medication education
• Positioning
• Pacing
• Breath training
• Fan and/or fresh air
• Pulmonary rehab
• Acupuncture in COPD

Bausewein C. Cochrane Database Syst Rev. 2008(2):CD005623

Medications for Dyspnea

• Opioids first-line
  • Multifactorial mechanism of action
  • Low dose safe and likely effective
  • Anecdotal but no sufficient evidence for inhaled opioids
  • Benzos as adjunct if anxiety

Advance Care Planning
**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

**Unique Opportunity in Primary Care**

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

**Strengths**
- Confidentiality
- Duration
- Trust
- Ability to coordinate across settings
- Unique ability to have those 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

**Benefits of ACP**

- Patients who have advance care planning or EOL conversations with their provider are:
  - Less likely to:
  - More likely to:
    - Receive outpatient hospice and be referred to hospice earlier (Zhang et al. 2009, Wright et al. 2008)
    - Have their wishes known and followed (Detering et al. 2010; Houbin 2014)
    - Have caregivers who are satisfied with the quality of their loved one’s 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

Gludemans et al. (2015) Fam Practice

ACP Best Practices in a Busy Practice

<table>
<thead>
<tr>
<th>Separate Visit</th>
<th>Pre-Work</th>
<th>Identify Surrogate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire warning shot</td>
<td>Assign pre-work (a.k.a. prepareforyourcare.org)</td>
<td>“Is there anyone you trust to make medical decisions? Who would make those choices if it’s not you?” “Have you talked about your wishes with your doctors? What medical care are you sure you do not want?”</td>
</tr>
</tbody>
</table>

For me, the biggest barrier 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!

www.prepareforyourcare.org
ACP - Documentation
• Include on problem list; be specific
• Health systems streamlining EMR ACP documentation
• Ideally, complete advance directive and medical order (for patients with less than 1y prognosis; in states where available)

ACP - Billing
• ACP CPT codes
  • “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/yr

Defining Specialty-Level Palliative Care
• Palliative Care focuses on:
  • Team-Based care
  • Symptom management
  • Excellent communication
  • Comprehensive care
  • Bio-psycho-social-spiritual
  • Family
  • Continuity
• Palliative Care is NOT:
  • For older adults only
  • End of Life Care
  • Hospice Care
When Should I Consult Palliative Care?

1. At time of diagnosis of a serious illness
2. At time of change of illness
3. At time of illness crisis
4. When cued by patient or family
5. Any of the above

What to Say

- Palliative Care is:
  - “Specialized medical care for people with serious illness”
  - “An extra layer of support”
  - “A team that focuses on quality of life and works with me to help you feel as good as you can for as long as possible”

Finally, Always Remember...

“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.” - Torrie Fields

“People will forget what you said, people will forget what you did, but people will never forget how you made them feel.” - Maya Angelou

“Say something empathic and then just shut up!” - James Tulsky MD