End-of-Life Care

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Disclosures

- Dr O’Donnell and Dr Guerry do not have any financial disclosures

Objectives

- Outline advance care planning strategies at the end of life
- Describe best practices for deprescribing at the end of life
- Discuss how and when to refer patients to hospice
- Review symptom management at the end of life

Advance Care Planning at EOL

Advance Health-Care Directives:

- Are suitable for any adult at any age.
- Are not necessarily done in the context of actual end-of-life circumstances.
- Are generally not done in consultation with a medical professional.
- Must be converted into a medical order to be effective.

DMOST (POLST):

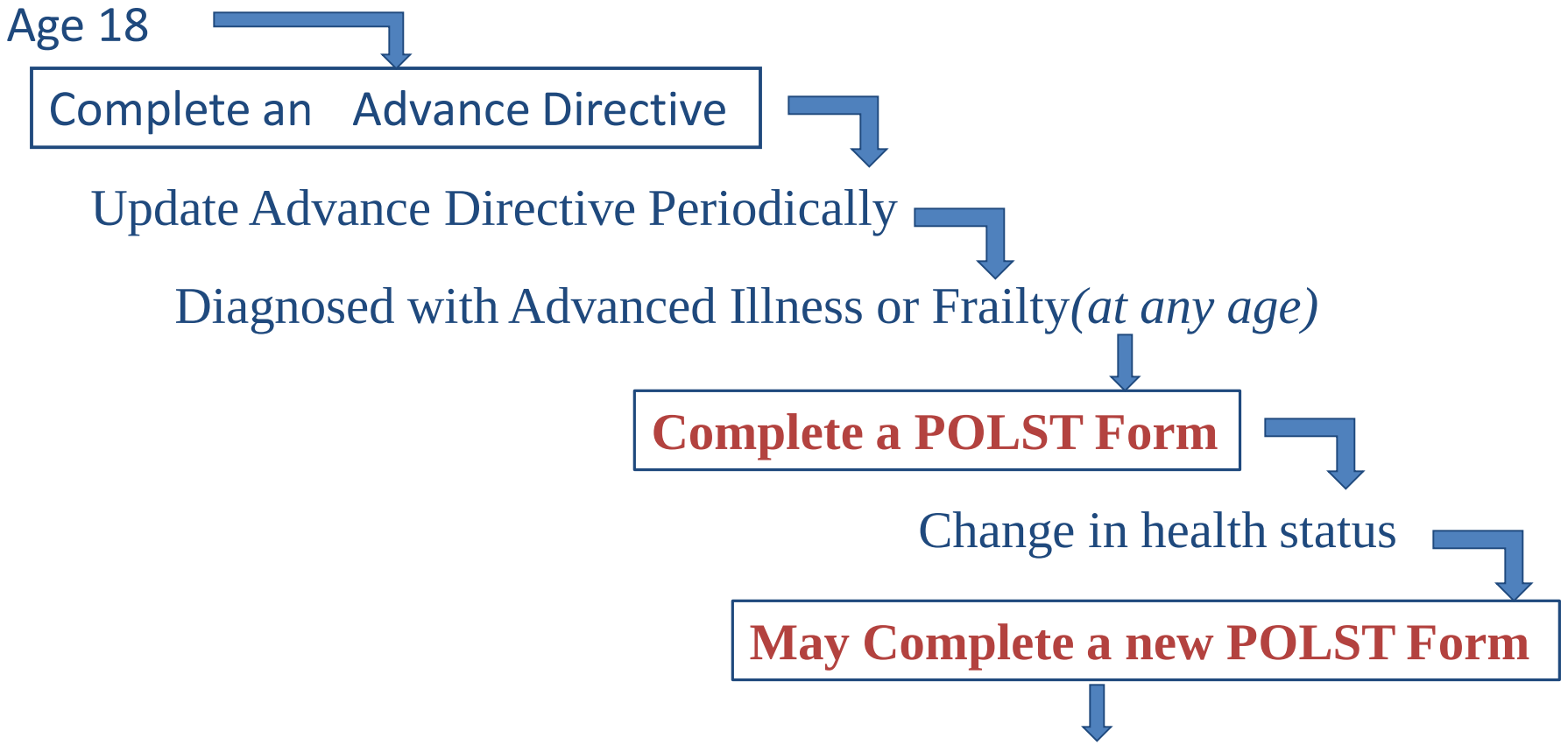
- Is appropriate ONLY for patients living with serious illness or frailty whose health-care practitioner would not be surprised if they died within the next year.
- Is a voluntary conversation with a trained provider which results in the completion of a form recording care preferences. The form is an actionable medical order which is modifiable, portable among various settings, and stays with the patient.

DMOST

Delaware Medical Orders For Scope Of Treatment

Citation: Hickman SE, Nelson CA, Moss AH, et al. Use of the Physician Orders for Life-Sustaining Treatment (POLST) paradigm program in the hospice setting. *J Palliat Med*. 2009;12(2):133–141.

How Advance Directives and DMOST/POLST Work Together



The 8 Step DMOST Protocol

1) Prepare for the discussion
2) Begin with what the patient and family know
   -can be completed by a decision maker if pt not decisional
   -must be signed in person
3) Provide any new information about the patient's medical condition and value from the medical team's perspective
4) Try to reconcile differences in terms of prognosis, goals, hopes and expectations
5) Respond empathically
6) Use DMOST to guide choices and finalize patient/family wishes
7) Complete and sign DMOST
8) Review and revise periodically

DMOST
Delaware Medical Orders For Scope Of Treatment

*adapted with permission from the work of Patricia Bomba, MD and Compassionandsupport.org

DELAWARE MEDICAL ORDERS FOR SCOPE OF TREATMENT (DMOST)

- FIRST, follow the orders below. THEN contact physician/or other health-care practitioner for further orders, if indicated.
- The DMOST form is voluntary and is to be used by patient with serious illness or frailty whose practitioner would not be surprised if they died by next year.
- Any section not completed requires providing the patient with the full treatment described in that section.
- Always provide comfort measure, regardless of the level of treatment chosen.
- The Patient or the Authorized Representative has been given a plain-language explanation of the DMOST form.
- The DMOST form must accompany the patient at all times. It is valid in every health care setting in Delaware.

Print Patient's Name (last, first, middle) _____ Date of Birth ___/___/___ last four digits of SSN _____

A **Goals of Care** (see reverse for instructions. This section does not constitute a medical order.)

B **Cardiopulmonary Resuscitation (CPR)**

Patient has no pulse and/or is not breathing

☐ Attempt resuscitation/CPR. ☐ Do not attempt resuscitation/DNAR.

C

Medical Interventions: *Patient is breathing and/or has a pulse.*

☐ **Full Treatment**: Use all appropriate medical and surgical interventions, including intubation and mechanical ventilation in an intensive care setting, if indicated to support life. Transfer to a hospital, if necessary.

☐ **Limited Treatment**: Use appropriate medical treatment, such as antibiotics and IV fluids, as indicated. May use oxygen and noninvasive positive airway pressure. Generally avoid intensive care.

- ☐ Transfer to hospital for medical interventions.
- ☐ Transfer to hospital only if comfort needs cannot be met in current setting.

☐ **Treatment of Symptoms Only/Comfort Measures:** Use any medications, including pain medication, by any route, positioning, wound care, and other measures to keep clean, warm, dry, and comfortable. Use oxygen, suctioning, and manual treatment of airway obstruction as needed for comfort.
Use antibiotics only to promote comfort. Transfer only if comfort needs cannot be met in current setting.

☐ **Other Orders**:_____

D **Artificially Administered Fluids and Nutrition:** *Always offer food/fluids by mouth if feasible and desired.*

☐ Long-term artificial nutrition
☐ Defined trial period of artificial nutrition: Length of trial: _____ Goal: _____
☐ No artificial nutrition ☐ hydration only ☐ none (check one box)

E

Orders Discussed With: ☐ Patient _____ ph.# _____
Printed Name & phone number

☐ Guardian ☐ Surrogate (per DE Surrogacy Statute)
☐ Other ☐ Agent under healthcare POA/or AHCD _____
☐ Parent of a minor Signature

_____ _____ _____ _____
Print Name of Authorized Representative Relation to Patient Address Phone #

If I lose capacity, my Authorized Representative may not change or void this DMOST _____
Patient Signature

F

SIGNATURES: Patient/Authorized Representative/Parent (mandatory) *I have discussed this information with my Physician / APRN / PA*

_____
Signature Date

If authorized representative signs, the medical record must document that a physician has determined the patient's incapacity & the authorized representative's authority, in accordance with DE law.

Physician / APRN / PA

_____
Signature Date Time

_____
Print Name

_____
Print Address

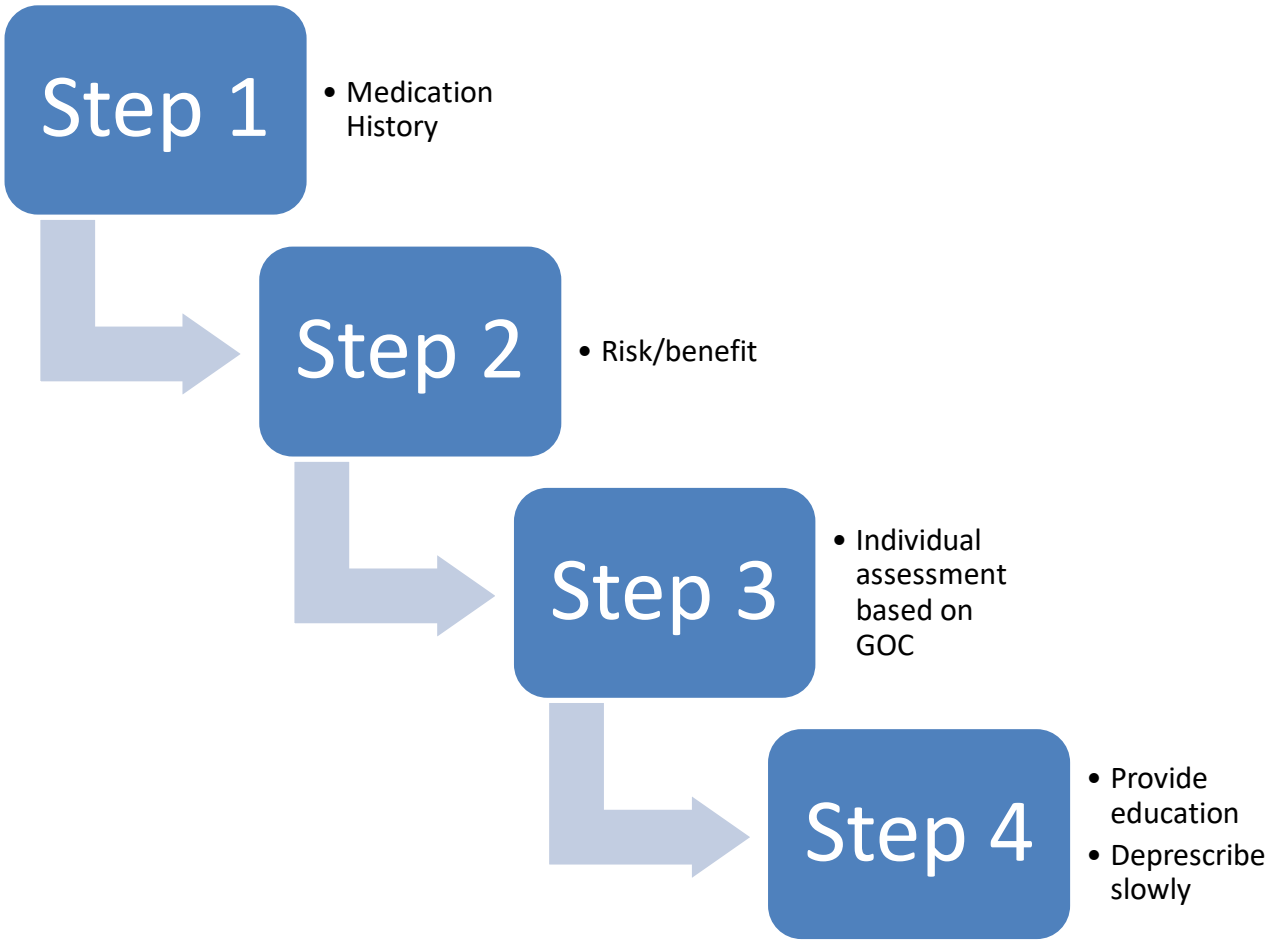
_____
License Number Phone #

Deprescribing at End of Life

Barriers

- Uncertainty regarding ongoing benefits of medications
- Psychological: Reluctance from patients to change medications
- Concern regarding stopping medication initiated by other specialists
- Patient or provider perception of abandonment
- Patient or provider discomfort with discussing life expectancy

Approach to Deprescribing



Journal of the American Geriatrics Society, Volume: 67, Issue: 1, Pages: 172-180, First published: 13 October 2018, DOI: (10.1111/jgs.15616)

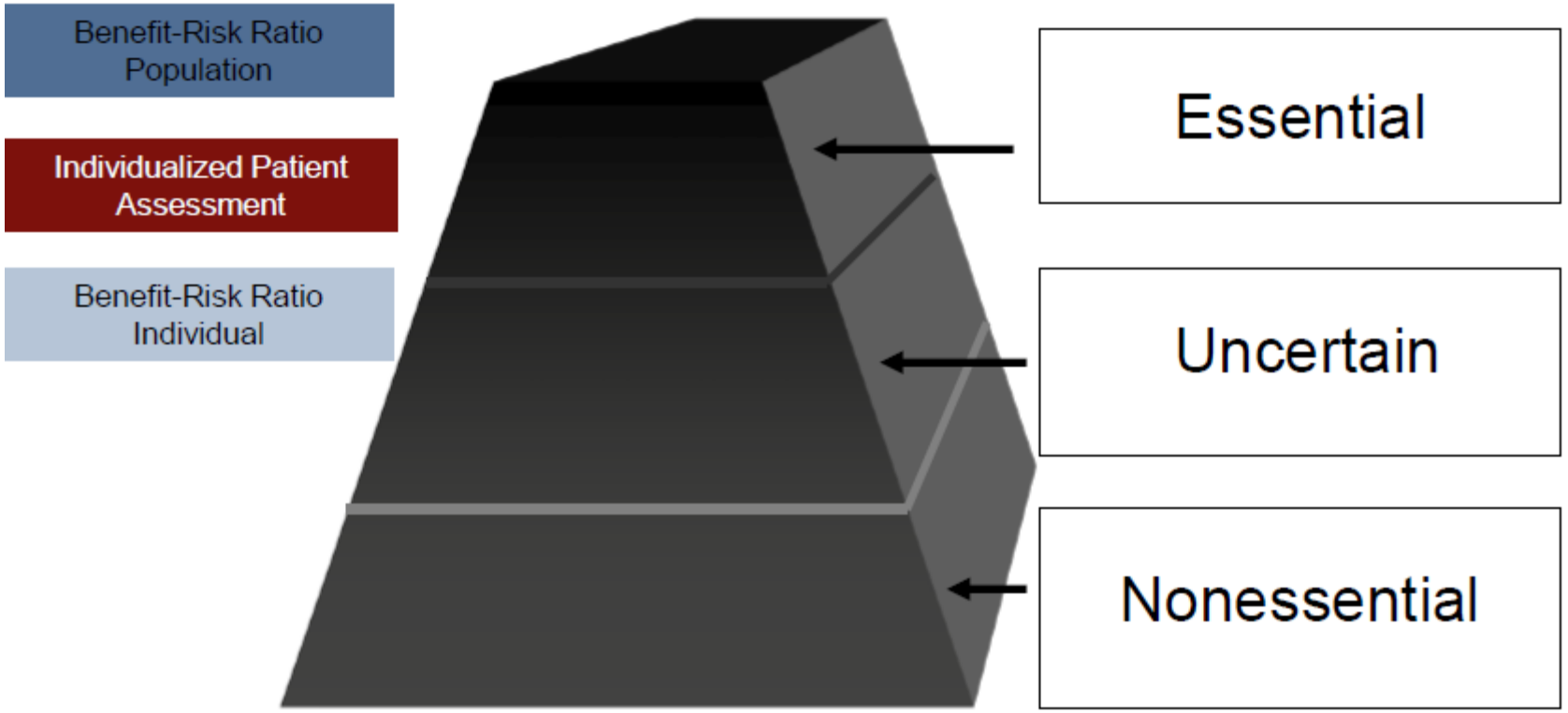
Common Meds to Stop

- Statins
- Vitamins/Supplements
- Antihypertensives
- Gastric protection
- Oral hypoglycemics

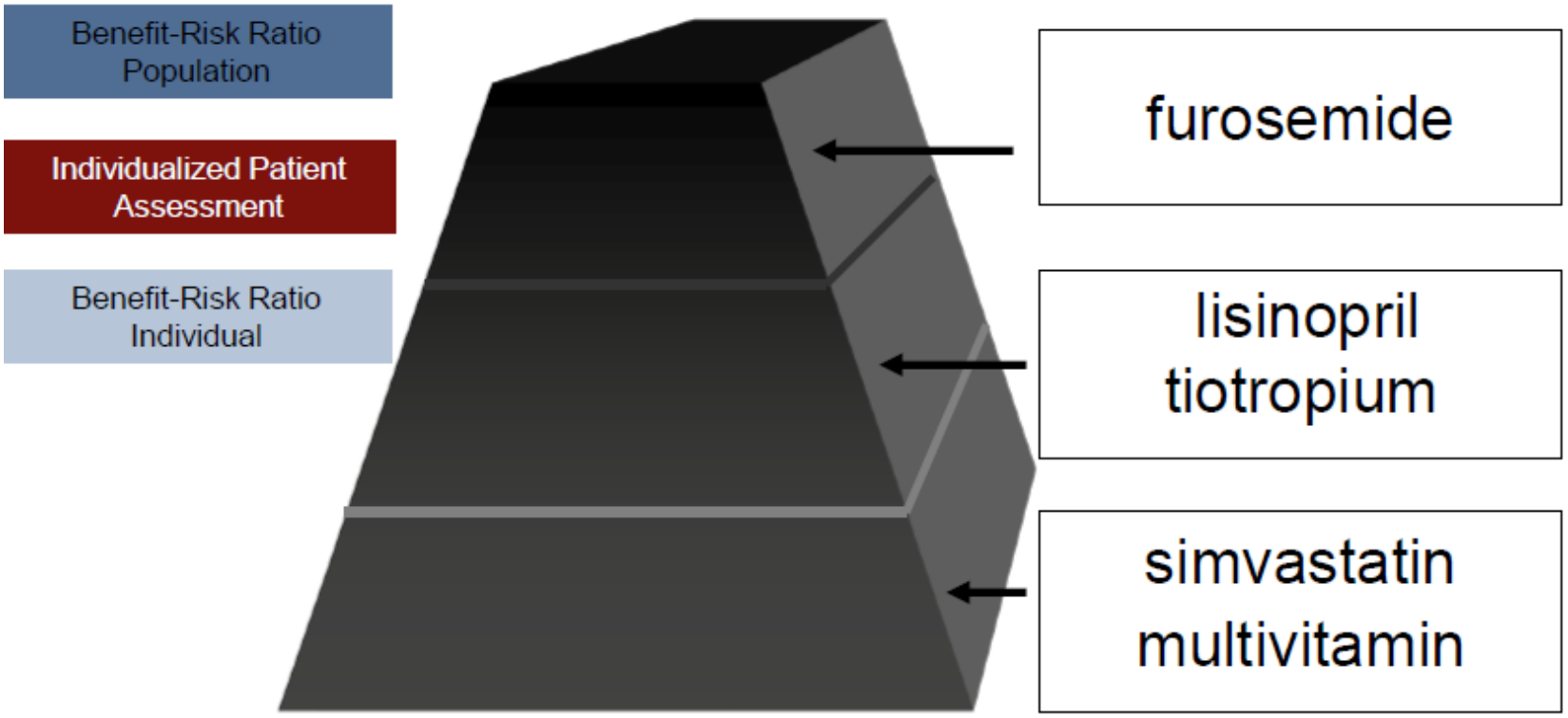
Case of FG

- FG is a 72-year-old man admitted to hospice for metastatic lung cancer
- Other past medical history
  - Heart failure
  - Emphysema
  - Hypertension
  - Coronary artery disease
- Medications include the following:
  - Furosemide
  - Lisinopril
  - Tiotropium
  - Simvastatin
  - Multivitamin

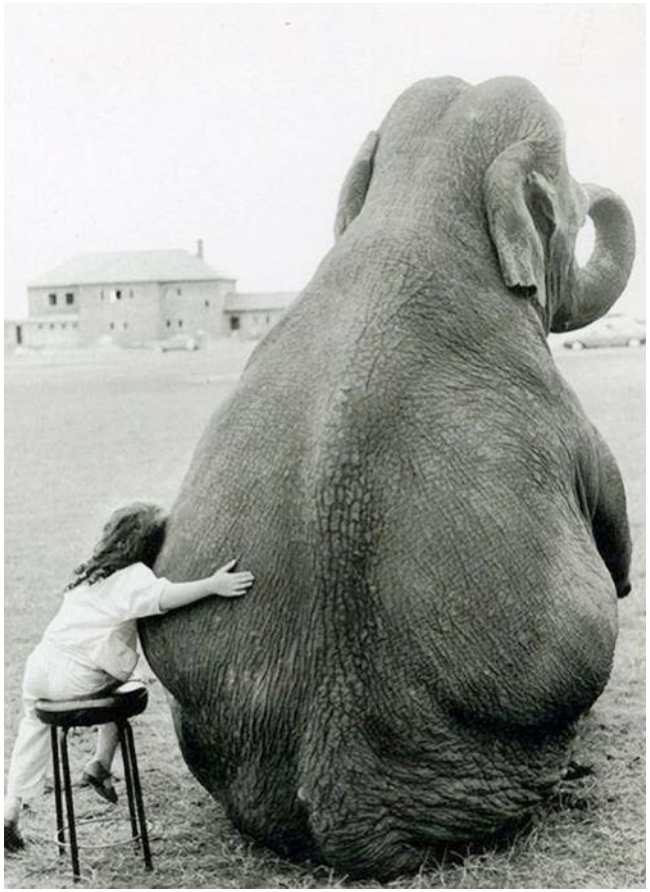
Case of FG


Benefit-Risk Ratio Population
Individualized Patient Assessment
Benefit-Risk Ratio Individual
Essential
Uncertain
Nonessential

Case of FG


Benefit-Risk Ratio Population
Individualized Patient Assessment
Benefit-Risk Ratio Individual
furosemide
lisinopril
tiotropium
simvastatin
multivitamin

When to Refer to Hospice



Who should I refer to Hospice?

- Prognosis of six months or less
- The Surprise Question
  - Would you be surprised if your patient died in the next year
    - Sensitive in ESRD and CA populations
    - May be a good trigger, to think about ACP and more deeply about prognosis.

J Palliat Med. 2017 Jul;20(7):729-735. doi: 10.1089/jpm.2016.0403. Epub 2017 Feb 16.

Using the Surprise Question To Identify Those with Unmet Palliative Care Needs in Emergency and Inpatient Settings: What Do Clinicians Think?

Haydar SA[1], Almeder L[2], Michalakes L[3], Han PKJ[4], Strout TD[1].

How to Refer to Hospice

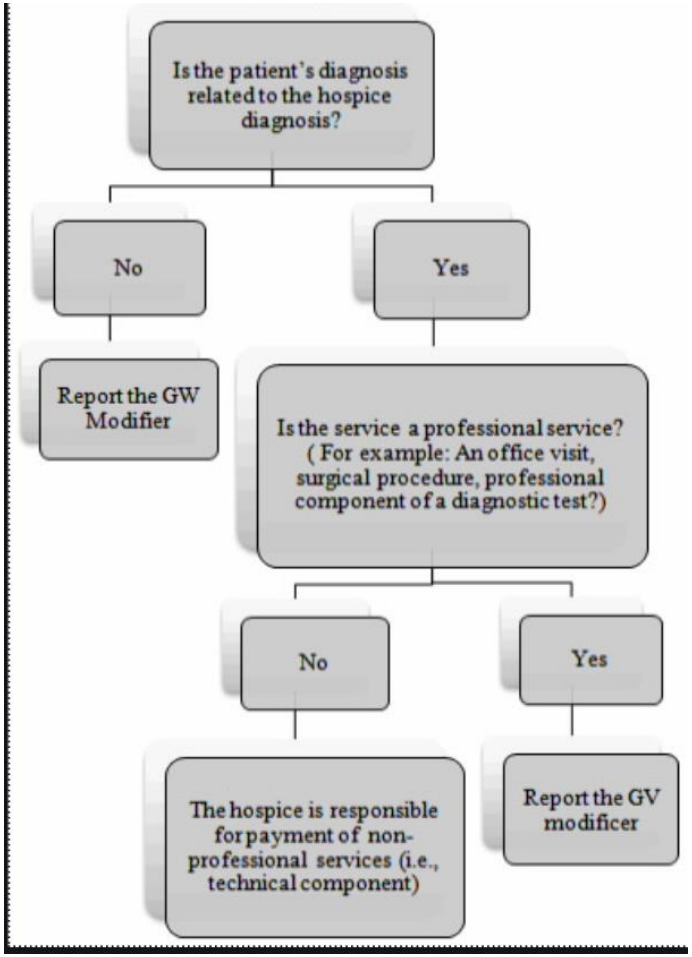
- Physician's order
- Medical certification x 2 physicians – hospice medical director and pt's physician
  - Patient can choose attending physician -who they identify as the most significant individual delivering the medical care- can be MD, DO, NP, or PA.
- Patient election – instead of typical Medicare
  - Waive all rights to Medicare payment for services related to terminal illness and related conditions unless provided/arranged by hospice
  - Medicare pays for covered benefits unrelated to terminal prognosis

Can I see my patient while they are on hospice?

- Can stay attending physician
- Reimbursement codes while on hospice
  - GV modifier- Dx related to hospice dx and a professional service offered. Attending physician not employed or paid under arrangement by the patient's hospice provider
  - GW modifier- Service not related to the hospice patient's terminal condition

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1321.pdf

Can I see my patient when they are on hospice?



https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00003600

Symptom Management at the End of Life

Disclaimer

- Will not go into assessment and full differential diagnosis of symptom etiology

- Diagnosis comes first. Get the history. Figure out the cause. Then treat appropriately

Pain

- Verbal and non verbal assessment
- Mod- severe pain--opioids first line
- Respiratory depression concern
- Don’t forget the bowels!

Supportive Therapy for Dyspnea

- Lower room temperature
- Fan/air circulation
- Avoid strong odors, fumes and smoke
- Positioning
- Manage anxiety
  - Counseling
  - Relaxation
  - Identify situational components
  - Breathing techniques
  - Occupation/music therapy
  - Guided imagery, hypnosis
- Reduce exertion

Dyspnea- Medication Management

- Effects- modulate the perception of dyspnea by binding to opioid receptors, may also have a vasodilatory effect
- Morphine most commonly used
- Dosing:
  - Opioid naive: morphine 10-15mg oral /2-4mg IV
  - When acute and severe– parental is the route of choice every 10-20min until relief
  - Nebulized opioids in RCT have not shown benefit
- Anxiolytics

Benefits and Burdens of NPPV as a Palliative Intervention

Benefits

- Treatment of potentially reversible illness without intubation in pts both ‘full code’ and DNI
- May postpone death short time to achieve short term goal
- When combined with opiates may relieve dyspnea
- Provide temp relief while other measures are initiated

Burdens

- Potential to medically prolong the dying process
- May be uncomfortable in itself
- Added burden of decision making (having to wdl LST)
- Technology may prevent communication and intimacy at EOL

Anorexia/Cachexia

- What medication works
- What does the patient want?
- Artificial nutrition and IVF
- Family support

Medications

- Megaestrol Acetate
- Corticosteroids
- Cannabinoids
  - Dronabinol
  - Cannabis

Feeding Tubes and Advanced Dementia

Choosing Wisely®

An initiative of the ABIM Foundation

American Academy of Hospice and Palliative Medicine

aahpm

AMERICAN ACADEMY OF HOSPICE AND PALLIATIVE MEDICINE

Five Things Physicians and Patients Should Question

1

Don't recommend percutaneous feeding tubes in patients with advanced dementia; instead, offer oral assisted feeding.

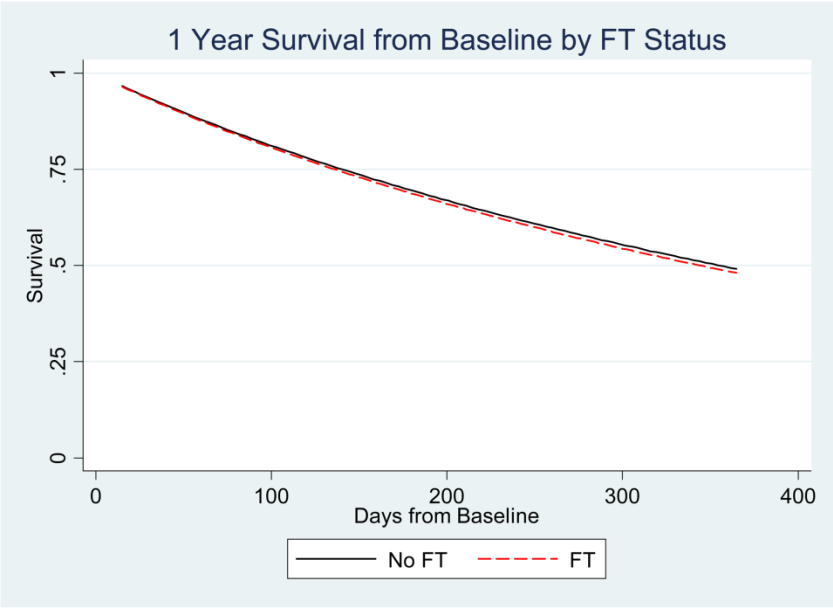
In advanced dementia, studies have found feeding tubes do not result in improved survival, prevention of aspiration pneumonia, or improved healing of pressure ulcers. Feeding tube use in such patients has actually been associated with pressure ulcer development, use of physical and pharmacological restraints, and patient distress about the tube itself. Assistance with oral feeding is an evidence-based approach to provide nutrition for patients with advanced dementia and feeding problems; in the final phase of this disease, assisted feeding may focus on comfort and human interaction more than nutritional goals.

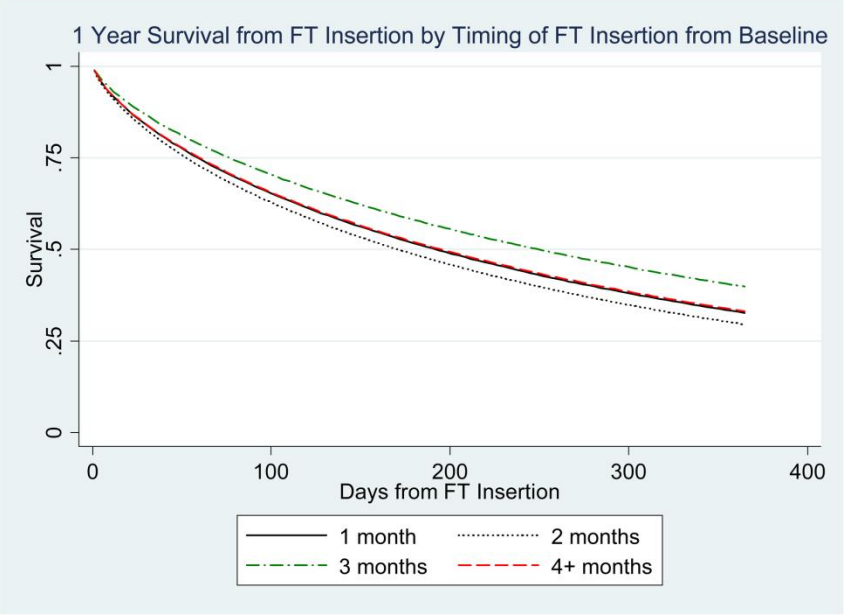
Feeding Tubes and Advanced Dementia

J Am Geriatr Soc. 2012 October ; 60(10): 1918–1921. doi:10.1111/j.1532-5415.2012.04148.x.

Does Feeding Tube Insertion and its Timing Improve Survival?

Joan M. Teno, M.D., M.S.[*], Pedro L. Gozalo, Ph.D.[*], Susan L. Mitchell, M.D., M.P.H.[†], Sylvia Kuo, Ph.D.[*], Ramona L. Rhodes, M.D., M.P.H.[‡], Julie P.W. Bynum, M.D., M.P.H.[§], and Vincent Mor, Ph.D.[*]





Tube Feeding and EOL

Monroe County Medical Society Community-wide Guidelines

Benefits/Burdens of Tube Feeding/PEG Placement for Adults

	Dysphagic Stroke (Patients with previous good quality of life, high functional status[1] and minimal co-morbidities)	**Dysphagic Stroke** (Patients with decreased level of consciousness, multiple co-morbidities, poor functional status[1] prior to CVA)	**Neurodegenerative Disease [e.g., Amyotrophic Lateral Sclerosis (ALS)]**	**Persistent Vegetative State (PVS)**	**Frailty** (Patients with multiple co-morbidities, poor functional status, failure to thrive and pressure ulcers[2])	**Advanced Dementia** (Patients needing help with daily care, having trouble communicating, and/or incontinent)	**Advanced Cancer** (Excludes patients with early stage esophageal & oral cancer)	**Advanced Organ Failure** (Patients with CHF, renal or liver failure, COPD, anorexia-cachexia syndrome)
Prolongs Life	*Likely*	*Likely in the short term* Not likely in the long term	*Likely*	*Likely*	Not Likely	Not Likely	Not Likely	Not Likely
Improves Quality of Life and/or Functional Status	up to 25% regain swallowing capabilities	Not Likely	Uncertain	Not Likely	Not Likely	Not Likely	Not Likely	Not Likely
Enables Potentially Curative Therapy/Reverses the Disease Process	Not Likely	Not Likely	Not Likely	Not Likely	Not Likely	Not Likely	Not Likely	Not Likely

This grid reflects only certain conditions. Some examples of other conditions where direct enteral feeding would be indicated include radical neck dissections, esophageal stenosis and motility diseases, post intra-thoracic esophageal surgery and safer nutrition when the alternative would be parenteral hyperalimentation.

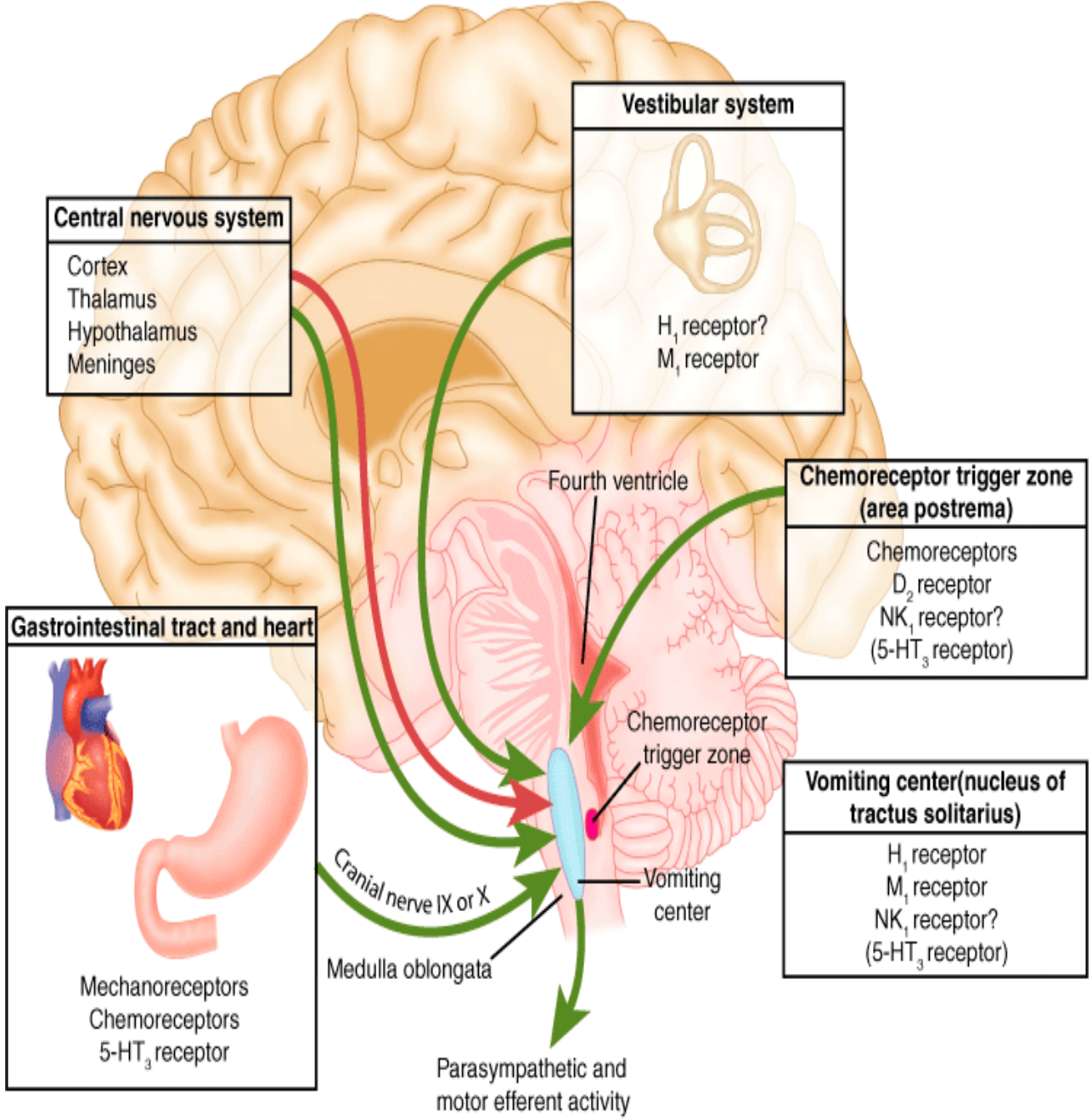
https://molst.org/wp-content/uploads/2018/07/Complete-tool-kit-for-feeding-tubes.pdf

Feeding in Advanced Dementia or EOL

- Liberalize diet
- Careful hand-feeding
- Socialization at meal time
- Eating problems and weight loss are expected parts of late stages of disease
  - Important anticipatory counseling

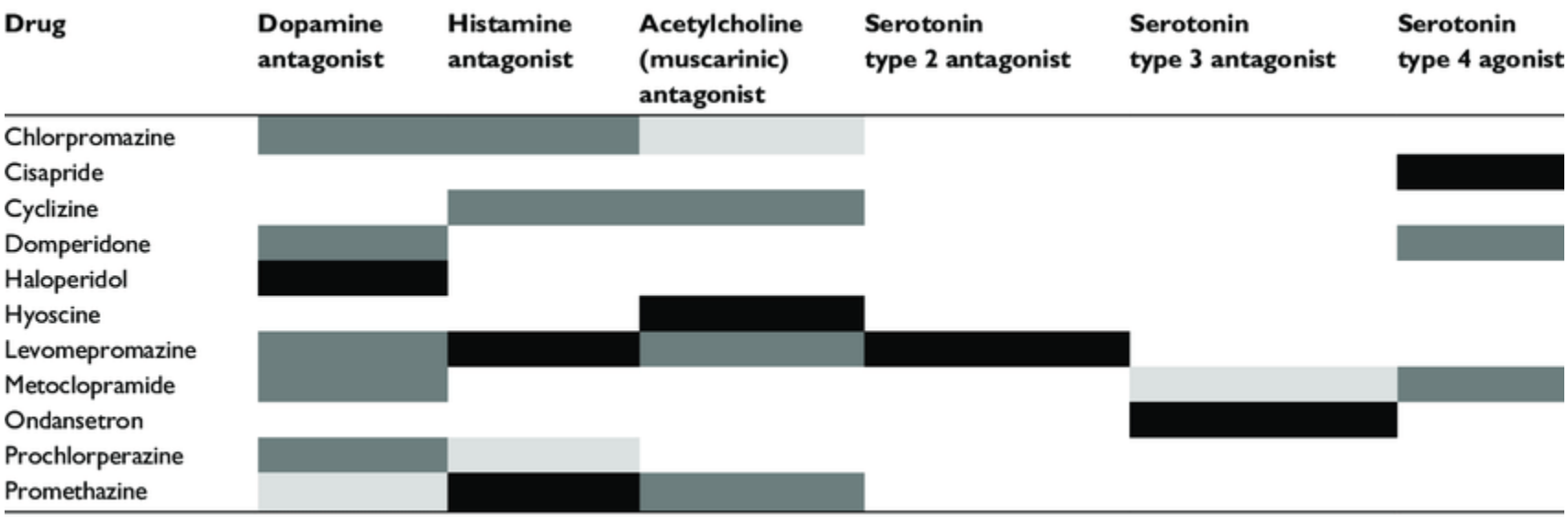
Nausea/Vomiting

- Pathophysiology
- Patient assessment
- Treatment



Source: Katzung BG, Masters SB, Trevor AJ: *Basic & Clinical Pharmacology, 11th Edition*: http://www.accessmedicine.com

Nausea/Vomiting



Notes: Black, high affinity for receptor; dark gray, moderate affinity; light gray, low affinity; white, no known affinity.

Treating nausea and vomiting in palliative care: A review
Clinical Interventions in Aging 6(1):243-59 · September 2011

Non-pharmacologic therapy

- Alcohol Swab Aromatherapy
- Avoid strong smells or other triggers
- Small, frequent meals
- Limit oral intake during severe episodes
- Relaxation techniques
- Acupuncture and acupressure

Lindblad AJ, Ting R, Harris K. Inhaled isopropyl alcohol for nausea and vomiting in the emergency department. *Can Fam Physician*. 2018;64(8):580.

Oral Symptoms at EOL- Secretions/Xerostomia

Dry

- pilocarpine
- good mouth care, saliva substitutes, swabs, lemon drops, lip balm

Wet

- reassurance
- Positioning
- Medications: atropine, glycopyrrolate, scopolamine, hyoscyamine

Anxiety/Delirium

Anxiety

- Explore statements
- Reassurance

- Complementary therapies
- Pharmacotherapy

Delirium

- Hyper / Hypoactive
- Reorientation, modify environment

- Atypical antipsychotics
- Haloperidol

Comfort Care Kit

- Docusate suppositories
- Prochlorperazine tablets and suppositories
- Oral lorazepam
- Concentrated liquid morphine
- Acetaminophen suppositories
- Haloperidol liquid
- Hyoscyamine tablets

General Pearls

- Not everyone needs a morphine drip
- Work with your hospice team
- Provide anticipatory guidance and education on what dying looks like
- Normalize caregivers feelings
- Don’t forget to offer chaplain involvement

Provider Preferences

J Gen Intern Med. 2012 Oct; 27(10): 1287–1293.
Published online 2012 May 4. doi: 10.1007/s11606-012-2088-3
PMCID: PMC3445687
PMID: 22555775

End-of-Life Care from the Perspective of Primary Care Providers

Maria J. Silveira, MD, MA, MPH[1,2] and Jane Forman, ScD, MHS[1]

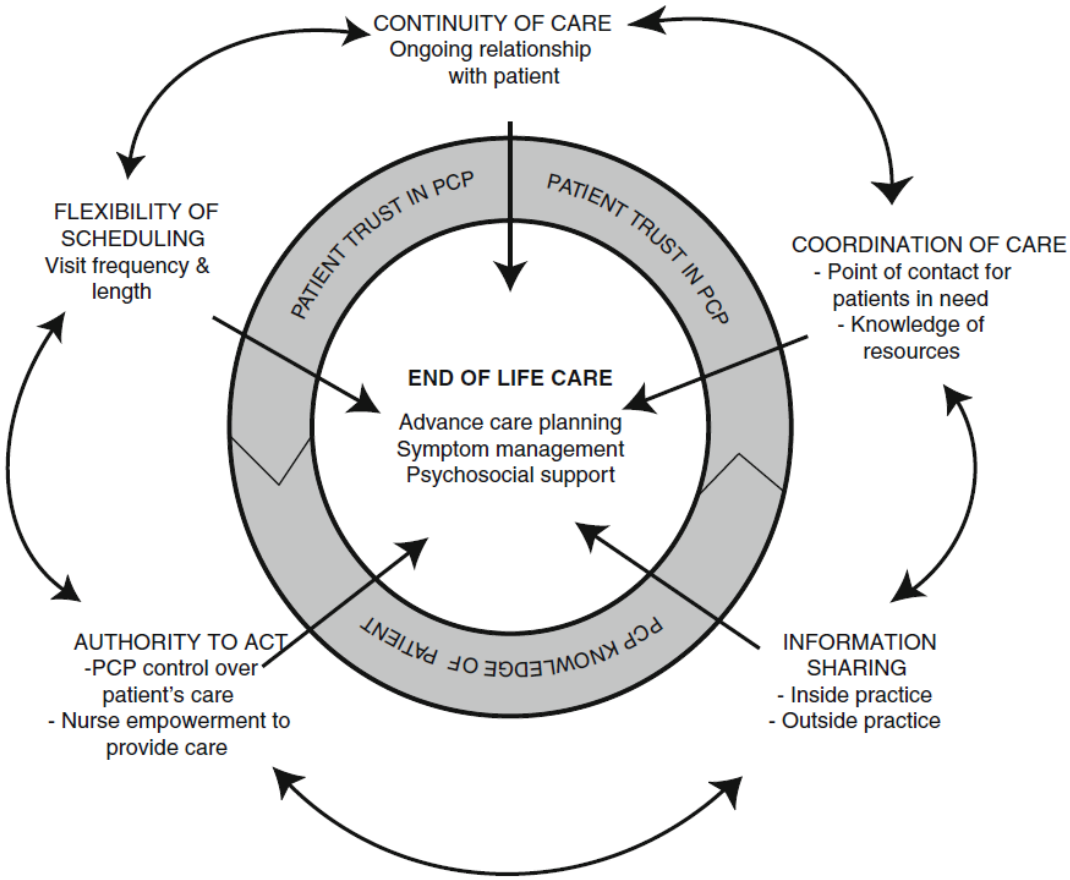


Figure 1. Schematic of themes and interrelationships identified in study.

Thank You!