The University of Toledo
College of Medicine and Life Sciences
Department of Public Health & Preventive Medicine,
Center for Successful Aging,
Center for Continuing Medical Education as well as
The Ohio Geriatrics Society, (OGS) and
Hospice of Northwest Ohio

Present the:

19TH ANNUAL
GERIATRIC MEDICINE SYMPOSIUM:
Palliative Care and the Older Adult

Friday, February 27, 2015
8:00 a.m. - 4:15 p.m.

Hilton Garden Inn
Perrysburg, Ohio
ACKNOWLEDGEMENT
We gratefully acknowledge the following Organizations for their support:

Sanofi

Please be sure to visit the exhibitor booths.
GOLD PATRONS

Addison Heights Health & Rehabilitation Center
Area Office on Aging of Northwest Ohio, Inc.
Gentiva Home Health and Hospice
Heatherdowns Rehab & Residential Care
Hospice of Northwest Ohio
Kingston Healthcare
Oak Leaf Village & the Grove @ Oakleaf Village
Orchard Villa
Ridgewood Manor
Senior Independence Home Health & Hospice
Americare Health Services
Guardian Medical Monitoring, Inc.
Harbor
Heartland of Waterville
HCF Management, Inc.
Lutheran Home Society
Mobile Meals of Northwest Ohio
Ottawa Hills Memorial Park
Otterbein Skilled Nursing & Rehab Neighborhoods
ProHealth Partners
Wellsbrooke Premium Home Health Care
PLANNING COMMITTEE

A special thanks to the members of our planning committee listed below who contributed their time and effort to ensure the success of this program:

Victoria Steiner, PhD
Symposium Director
Public Health and Preventive Medicine
Center for Successful Aging

Murthy Gokula, MD, CMD
Family Medicine

Barbara Hicks, MSN, RN
UT Nursing Alumnus

Cletus Iwuagwu, MD
Geriatric Medicine

Gayle Kamm, PharmD, BCPS
College of Pharmacy

Lisa Keaton, MSW., LSW.
Ruppert Health Center

Barbara Kopp Miller, PhD
Online Education and Learning Ventures
Center for Successful Aging

Deborah Mattin, PhD, MBA, MSN, RN
College of Nursing

Michelle M. Masterson, PT, PhD
College of Health Sciences
Department of Rehabilitation Science
Doctor of Physical Therapy Program

Angele McGrady, PhD, M. Ed, LPCC
Psychiatry, Physiology and Molecular Medicine

A. John McSweeney, JD, PhD, ABPP (CN)
Psychology Department

Barbara J. Messinger-Rapport, MD, PhD, FACP, CMD.
Cleveland Clinic Geriatric Medicine

Katie Perkins, MBA
Hospice of Northwest Ohio

Natalie L. Walkup, MPAS, PA-C
College of Medicine
GUEST FACULTY

Maureen Cervenec, MEd, LPC  
Bereavement Team Coordinator  
Hospice of Northwest Ohio  
Perrysburg, OH

Rabbi Akiva Feinstein  
Spiritual Care Coordinator/Chaplain  
Vinney Hospice of Montefiore  
Beachwood, OH

Thomas S. Lehner, MD, CMD  
CAQ Hospice and Palliative Medicine  
Medical Director- Optum/United Healthcare  
AMDCP (AMDA) Board of Directors  
Honoring Wishes Ohio Task Force  
Clinical Faculty Family Medicine NEOMED  
Cleveland, OH

John F. McGreevey, Jr., MD  
Staff Physician  
Hospice of Northwest Ohio  
Perrysburg, OH

Barbara J. Messinger-Rapport, MD, PhD, CMD, FACP  
Director, Center for Geriatric Medicine, Cleveland Clinic  
Associate Professor, Cleveland Clinic Learner College of Medicine  
Case Western Reserve University  
Cleveland, OH

Todd L. Sobol, MD, CMD, FACP  
Senior Medical Director, Optum Care Plus  
Dayton, OH

THE UNIVERSITY OF TOLEDO FACULTY

Murthy Gokula, MD, CMD  
Associate Professor  
Program Director, Geriatric Fellowship Program  
Department of Family Medicine

Michelle M. Masterson, PT, PhD  
Associate Professor and Director, Physical Therapy Program  
Chair, Department of Rehabilitation Sciences  
College of Health Sciences
DISCLOSURE PAGE

PLANNING COMMITTEE DISCLOSURES
None of our planning committee members have any financial interest or other relationships with any manufacturer of commercial products or service to disclose that would pose a conflict of interest with regards to the content of this activity.

FACULTY DISCLOSURES
None of our faculty has any financial interest or other relationships with any manufacturer of commercial products or service to disclose that would pose a conflict of interest with regards to the content of this activity.

Nursing Credit Disclosure to Learners
The presenters and the planners of this activity have declared that there is no conflict of interest to disclose. All speakers/presenters have signed a statement that says she/he will present information fairly and without bias. This activity is sponsored by the Ohio Geriatric Society. Approved Provider status does not imply endorsement by the provider, ANCC, OBN or ONA of any products displayed in conjunction with an activity.
ACCREDITATION

This activity has been planned and implemented in accordance with the accreditation requirements and polices of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of The University of Toledo and the Ohio Geriatrics Society. The University of Toledo is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The University of Toledo designates this live activity for a maximum of 6.5 AMA PRA Category 1 Credit(s)™. Physicians should claim only credit commensurate with the extent of their participation in the activity.

This Live activity, 19th Annual Geriatric Medicine Symposium: Palliative Care and the Older Adult with the beginning date of 02/27/2015, has been reviewed and is acceptable for up to 6.50 Prescribed credits by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

The University of Toledo Medical Center, Department of Pharmacy is an approved provider of continuing education for pharmacists by the Ohio State Board of Pharmacy. This program has been approved for 0.6 CEU’s. Each pharmacist should claim only those hours of credit that he/she actually spent in the educational activity. Approval# 036-142-15-001-L01

The State of Ohio Counselor, Social Worker and Marriage & Family Therapist Board have approved this activity for 6.5 clock hours of Continuing Professional Education (CPE) for Counselor and Social Workers. Approval Number: MCS021504

The University of Toledo, Psychiatry Department is approved by the Ohio Psychological Association - MCE Program to offer continuing professional education with Provider No. 00P0-340967014. This program has been approved for 6.5 credit hours.

The State of Ohio Board of Executives of Long Term Services & Supports (BELTSS) has approved this program for 6.5 course hours with BELTSS# 043-C-15

This program has been approved by the Ohio Physical Therapy Association (OPTA) for 6.5 hours. Approval Number: 15S0674

This program has been approved by the Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board for 6.5 contact hours. Approval Number: 150271

The University of Toledo, College of Nursing (OH-026 2-1-17) is an approved provider of continuing nursing education by the Ohio Nurses Association (OBN-001-91), an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation. 5.3 Contact Hours of Continuing Nursing Education will be awarded for successful completion. Successful completion requires the learner to: Attend 80% of the session and completion and submission of an evaluation tool.

The AAPA accepts certificates of participation for educational activities certified for Category 1 credit from AOACCME, Prescribe credit from AAFP, and AMA PRA Category 1 credit(s)™ from organizations accredited by ACCME or a recognized state medical society.
For information regarding The University of Toledo, CME Upcoming Events, be sure to visit our website:

cme.utoledo.edu

The UT CME Office is pleased to announce that we have received the ACCME "Accreditation with Commendation" good through 2016.
TO OBTAIN YOUR CME CREDIT

Your CME Program Evaluation and Certificate will be available on Tuesday, March 3, 2015

1. Go to cme.utoledo.edu. (Omit the www/http://)
2. Click on DIRECT LINK TO LOGIN
3. Login:
   - **Username**: lastnamefirstname (no commas, no spaces)
   - **Password**: zip code
   (Your password is your zip code unless you specified another password in your profile)
4. An online forms inbox will appear with your program evaluation to complete.
5. **Complete** your online evaluation; be sure to answer all questions.
6. Click the submit tab.
7. You will be directed to print your certificate.

Hilton Garden Inn Wi-Fi Code: garden2015
19th Annual Geriatric Medicine Symposium:  
Palliative Care and the Older Adult

Friday, February 27, 2015  
Hilton Garden Inn  
Perrysburg, OH

7:30 am  Registration & Continental Breakfast - View Exhibits

8:00-8:15  Welcome  
Christopher Cooper, MD  
Dean of the College of Medicine and Life Sciences

Moderator: Victoria Steiner, Ph.D.

8:15-9:00  When Does it Become Palliative Care?  
Murthy Gokula, MD, CMD

9:00-9:45  Addressing Polypharmacy in Palliative and End of Life Care  
Barbara J. Messinger-Rapport, MD, PhD, CMD, FACP

9:45-10:05  Panel Discussion

10:05-10:20  Break/View Exhibits

Moderator: A. John McSweeny, JD, PhD

10:20-11:05  Advance Directives & Honoring Healthcare Wishes  
Thomas S. Lehner, MD, FAAFP, CMD

11:05-11:50  Ethical and Spiritual Issues at the End of Life: Letting Go of Some Things, Holding On To Others  
Rabbi Akiva Feinstein

11:50-12:10 pm Panel Discussion
19th Annual Geriatric Medicine Symposium:
Palliative Care and the Older Adult
Friday, February 27, 2015
Hilton Garden Inn
Perrysburg, OH

12:10-1:15   Lunch

Moderator: Katie Perkins, MBA

1:15-1:45   Managing Pain in a Palliative Care Setting
John F. McGreevey, Jr., MD

1:45-2:15   Beyond Safety and Symptom Management:
            Interdisciplinary Care Planning that Supports the
            Desires and Goals of the Persons We Serve
Maureen Cervenec, MEd, LPC

2:15-2:45   Meeting the Supportive Needs of Caregivers
Todd L. Sobol, MD, CMD, FACP

2:45-3:05   Panel Discussion

3:05-3:20   Break/View Exhibits

Moderator: Barbara Hicks, MSN, RN

3:20-4:05   The Role Rehabilitation in Palliative Care
Michelle M. Masterson, PT, PhD

4:05-4:15   Panel Discussion

4:15 pm   Adjournment
Objectives:

1. Identify eligible patients for palliative care.

2. Discuss how to deliver bad news.

3. Discuss how to manage multi-morbidity and non-pain symptoms in palliative care.
Welcome

When Does It Become Palliative Care?

Murthy Gokula, MD, CMD
Associate Professor
Program Director (Geriatrics Fellowship)
University of Toledo

Principles of Palliative Care

- Reduce the symptom burden from pain and other distressful symptoms, including the relief of suffering.
- Recognize and address the physical, psycho-emotional, social, and spiritual needs experienced by both the patient and family.
- Provide medical treatment congruent with the wishes, values, preferences, beliefs, and concerns of the patient and family.
- Perform regular clinical assessments, diagnosis, care planning, interventions, monitoring, follow-up, and if possible, anticipation and prevention of distressful symptoms and suffering.
- Care should be patient-centered and family-focused.
- Practitioners and the interdisciplinary team (IDT) must provide seamless transitions in care between institutional, hospital, and home care settings.
Goals of Palliative care for patient & family

• Striving for highest practical quality of life, despite late stage illness
• Autonomy and maintaining dignity
• Relief of distressful symptoms and suffering (social, spiritual)
• Alleviate family burden (psycho-emotional, financial, practical)
• Coming to peace with spiritual issues and relationships

END-OF-LIFE DEMOGRAPHICS IN THE UNITED STATES

• The majority of deaths occur in older adults
• Seriously ill patients spend most of their final months at home, but most deaths occur in the hospital or nursing home
• Location of death varies regionally:
  ➢ Portland: 35% in hospitals
  ➢ New York City: >80% in hospitals

QUALITY OF END OF LIFE IN THE UNITED STATES

• Typical deaths are:
  ➢ Slow
  ➢ Associated with chronic disease in people with comorbidities
  ➢ Marked by ↑ dependency and care needs
• Quality of life during the dying process is often poor because of inadequate treatment of distress; fragmented care; strains on family, support system
• Difficult decisions about use of life-prolonging treatments are commonly necessary
WHAT IS PALLIATIVE CARE?
• Interdisciplinary care that aims to relieve suffering, improve quality of life, optimize function, and assist with decision making for patients with advanced illness and their families
• It is offered simultaneously with all other appropriate medical treatment
• The World Health Organization (WHO) defines palliative care as "applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life."
• The goals of palliative care
  • address patient's needs for communication
  • decisions about treatment
  • relief of distressing symptoms (such as pain from pressure ulcers or arthritis)
  • support for caregivers

How do you know when someone is ready for palliative care?
• Several questions can help determine when palliative care becomes the main focus of care:
  – What options are available for treatment?
  – What does the person living with the illness want?
  – What options are available for palliative care or symptom control?
  – What is the nature and the course of the illness
• Types: Active, Comfort & Urgent palliation

Palliative Care: When?
Models of Palliative Care

- Case management
- Consultation model
- Health or clinical networks
- Integrated care
- Liaison model
- Managed clinical networks (MCNs)
- Pop-up model
- Shared care mode

Attributes of Palliative Care: Canada

- Availability and access to services
- Education for healthcare providers
- Ethical, cultural and spiritual considerations
- Public education and awareness
- Support for family, caregiver and significant others

Tools: Palliative Care Readiness

- Primary Care
  - Karnofsky Scale
  - Palliative performance scale
  - Mortality Risk Index Score
  - FAST Scale, Dementia Prognostic Index,
- Cardiology: Seattle Heart Failure Model
- Oncology: Intra-hospital Cancer Mortality Risk Model or the Cancer Prognostic Scale, ECOG Performance Status Scale
- Nephrology: Charlson Comorbidity Index
- Critical Care the Acute Physiology and Chronic Health Evaluation II (APACHE II),
  - www.eprognosis.org
- McGill Quality of Life questionnaire
  - http://www.adjuvantonline.com
Tools: Palliative Care Readiness

- http://www.melanomaprosnosis.org/
- http://www.prostatecalculator.org/
- http://eurology.surgery.duke.edu/Aspx/PredictionModel\NomogramsModel.aspx
- http://www.lifemath.net/cancer/
- http://urology.ucsf.edu/patientGuides/uroOncPt_Assess.html#capra
- http://urology.ucsf.edu/patientGuides/uroOncPt_Assess.html#capra
- http://oto2.wustl.edu/clinepi/prog.html

Tools: Palliative Care Readiness

- http://urology.jhu.edu/prostate/hanTables.php
- http://skynet.ohsu.edu/nomograms/
- http://www.predictcancer.org/
- http://www.mskcc.org/cancer-care/prediction-tools
- http://nomogram.org/
- http://www.mayoclinic.com/calcs/

General Criteria for palliative care consultation

**Presence of a Serious, Chronic illness**
- Declining ability to complete activities of daily living
- Weight loss
- Multiple hospitalizations
- Difficult to control physical or emotional symptoms related to serious medical illness
- Patient, family or physician uncertainty regarding prognosis
- Patient, family or physician uncertainty regarding goals of care
- Patient or family requests for futile care
- DNR order conflicts
- Use of tube feeding or TPN in cognitively impaired or seriously ill patients
- Limited social support and a serious illness (e.g., homeless, chronic mental illness)
- Patient, family or physician request for information regarding hospice appropriateness
- Patient or family psychological or spiritual distress
Intensive Care Unit Criteria

- Admission from a nursing home in the setting of one or more chronic life-limiting conditions (e.g., dementia)
- Two or more ICU admissions within the same hospitalization
- Prolonged or difficult ventilator withdrawal
- Multi-organ failure
- Consideration of ventilator withdrawal with expected death
- Metastatic cancer
- Anoxic encephalopathy
- Consideration of patient transfer to a long-term ventilator facility
- Family distress impairing surrogate decision making

Triggering criteria: ICU

- Includes baseline patient characteristics (e.g., pre-existing functional dependence, age >80 yrs, advanced-stage malignancy)
- Selected acute diagnoses (e.g., global cerebral ischemia after cardiac arrest, prolonged dysfunction of multiple organs)
- Healthcare use criteria (e.g., specified duration of ICU treatment, referral for tracheotomy or gastrostomy, decision to forgo life-sustaining therapy such as renal replacement)
- For pediatric ICUs, extreme prematurity, severe traumatic brain injury, and Trisomy 13 are illustrative trigger criteria
- For some ICUs, the trigger is the judgment of the critical care physician that a poor outcome is likely or the failure of initial ICU efforts to address palliative care needs of the patient or family.

Benefits of integrating palliative care ICU

- ↓ Intensive care unit/hospital length of stay
- ↓ Use of nonbeneficial treatments
- ↓ Duration of mechanical ventilation
- ↑ Family satisfaction/comprehension
- ↑ Family anxiety/depression, posttraumatic stress disorder
- ↓ Conflict over goals of care
- ↓ Time from poor prognosis to comfort-focused goals
- ↑ Symptom assessment/patient comfort
- ↓ decreased; ↑ increased.
**ICU Communication Bundle**

- By ICU day 1
  - Identify medical decision maker
  - Address advance directive status
  - Address resuscitation status
  - Distribute family information leaflet
  - Assess pain regularly
  - Manage pain optimally
- By ICU day 3
  - Offer social work (emotional/practical) support
  - Offer spiritual support
- By ICU day 5
  - Conduct interdisciplinary family meeting

**Emergency Room Criteria**

- Multiple recent prior hospitalizations with same symptoms/problems
- Long-term-care patient with Do Not Resuscitate (DNR) and/or Comfort Care (CC) orders
- Patient previously enrolled in a home or residential hospice program
- Patient/caregiver/physician desires hospice but has not been referred
- Consideration of ICU admission and or mechanical ventilation in a patient
  - with metastatic cancer and declining function
  - with moderate to severe dementia
  - with one or more chronic diseases and poor functional status at baseline

**Oncology Criteria**

- Metastatic or locally advanced cancer progressing despite systemic treatments with or without weight loss and functional decline; Karnofsky < 50 or ECOG > 3
- Progressive brain metastases following radiation
- New spinal cord compression or neoplastic meningitis
- Malignant hypercalcemia
- Progressive pleural/peritoneal or pericardial effusions
- Failure of first – or second-line chemotherapy
- Multiple painful bone metastases
- Consideration of interventional pain management procedures
- Severe prolonged pancytopenia in the setting of an untreatable hematological problem (e.g., relapsed leukemia)
• When does primary care turn into palliative care?

Symptom assessment & management

- Assessment of patients with advanced illness is often challenging due to patient cognitive impairment, fatigue and comorbidities.
- Determine intensity, pattern, aggravating/alleviating factors, location, associated symptoms and effect on function and cognition.
- Determine if symptom is acute, chronic or intermittent.
- Review previous and current treatment for the symptom.
- Perform appropriate, symptom-focused physical exam.
- Ascertain, if possible, the likely pathophysiology underlying the symptom.
- Consider medications as a cause.
- Identify reversible causes.
- Try to utilize the least invasive diagnostic testing to minimize patient pain, discomfort or suffering.
- Initiate treatment based on primary illness, phase of illness, prognosis, comorbidities, patient/family preferences.
- Consider complementary and alternative therapies especially if requested by family and patients.

Symptoms in advanced illness

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Cancer (%)</th>
<th>Non-cancer (%)</th>
<th>Cancer, AIDS, COPD, heart &amp; renal disease (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatigue</td>
<td>72.74</td>
<td>76</td>
<td>32-90</td>
</tr>
<tr>
<td>Pain</td>
<td>71.74</td>
<td>67</td>
<td>34-96</td>
</tr>
<tr>
<td>Lack of energy</td>
<td>69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weakness</td>
<td>60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appetite Loss</td>
<td>53.70</td>
<td>55</td>
<td></td>
</tr>
<tr>
<td>Breathlessness</td>
<td>36</td>
<td>36</td>
<td>60-95</td>
</tr>
<tr>
<td>Anxiety/Depression</td>
<td>40</td>
<td>57</td>
<td></td>
</tr>
</tbody>
</table>
### System assessment scales

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Assessment scales to consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anorexia</td>
<td>Functional assessment anorexia/cachexia therapy scale</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Hamilton anxiety rating scale (HAM-A)</td>
</tr>
<tr>
<td>Cognitive</td>
<td>Mini-Neuro, COGNISTAT</td>
</tr>
<tr>
<td>Constipation</td>
<td>Modified constipation assessment scale, Patone assessment of constipation tool</td>
</tr>
<tr>
<td>Delirium</td>
<td>Confusion assessment method (CAM), Delirium rating scale</td>
</tr>
<tr>
<td>Depression</td>
<td>Beck depression inventory, Short form geriatric depression scale, Zung depression scale, Cornell scale for depression in dementia, CES-D Geriatric chart form</td>
</tr>
<tr>
<td>Dyspnea</td>
<td>Numerical analog scale (0‐10), Visual analog scale (VAS)</td>
</tr>
<tr>
<td>Fatigue</td>
<td>NAS, VAS, Fatigue symptom inventory</td>
</tr>
<tr>
<td>Insomnia</td>
<td>VAS</td>
</tr>
<tr>
<td>Pain</td>
<td>Numerical analog scale (VAS), visual analog scale (VAS), verbal description scale, Wong Baker FACE scale, Brief pain inventory (BPI)</td>
</tr>
<tr>
<td>Spiritual pain</td>
<td>FICA spiritual assessment tool</td>
</tr>
</tbody>
</table>

### Please remember...

**Goals of care can change over time**

### The GSF Prognostic Indicator Guidance :UK for GPs

- **The Surprise Question:** ‘Would you be surprised if this patient were to die in the next few months, weeks, days’?
- General indicators of decline - deterioration, increasing need or choice for no further active care.
- Specific clinical indicators related to certain conditions.
Palliative Care in Nursing Homes (NHs)

- People living in NHs expected to double to more than 3 million by 2030
- More than 40% of adults will die in NHs
- NHS falling short on delivering the high quality care their residents deserve
  - Limited resources
  - Over worked and undertrained frontline staff
  - beleaguered leadership
Palliative Care in Nursing Homes (NHs)

- Common Issues
  - Inadequate pain
  - Pressure ulcers
  - Use of physical and chemical restraints
  - Feeding tubes
  - Little attention to advance care planning
  - Hospice referrals made too late or not at all
  - Repeated avoidable hospitalizations
  - Hospitalizations and other adverse events poor communication of new care plans.

Palliative Care in Nursing Homes (NHs)

- 3 different models of care in NHs
- Engagement of outside palliative care consultants
- Advantages:
  - Available for all nursing home residents
  - No additional costs to the nursing home
    (palliative care consultants bill Medicare part B fee-for-service)
- Disadvantages
  - Variable existence
  - Non-availability of such services in all areas.

Palliative Care in Nursing Homes (NHs)

- Second model: NH of employ its own palliative care team and train front-line staff in palliative care, knowledge, and skills
- Very popular model with many advantages
  - Daily contact between clinicians and nursing home residents
  - Helps to promote care aligned with patient's goals and preferences
  - Timely response to clinical changes.
  - Examples of this model include the Comfort Matters approach developed in Phoenix, AZ
  - Green House and Eden Alternative nursing home models.
  - Requires resources to invest in staff training
  - Hiring of (scarce) specialist level palliative care professionals.
Palliative Care in Nursing Homes (NHs)

- The third model: partnerships between hospice agencies and nursing homes in the same communities.
- Increased rapidly in the last 10 years
- Few concerns like placing the hospice at risk of government accusations of fraud and abuse.
- Nursing homes with higher hospice penetration tend also to have better palliative care practices (such as access to opioid analgesics) for all residents, whether on hospice or not.
  - Due to greater staff awareness
    - techniques for pain and symptom management
    - addressing emotional and spiritual needs.

Palliative Care in Nursing Homes (NHs)

- Significant barriers:
  - Regulatory hurdles created by quality measures for nursing homes
  - Economic incentives promote frequent hospitalizations.
  - Residents returning from a 3 day hospitalization of three days or more are eligible for the more generous Skilled Medicare Benefit.
  - Medicare policies delay hospice referrals for dying residents, as the Skilled Medicare Benefit pays for a resident’s room and board in the facility, while the Medicare Hospice Benefit does not.
  - Lack of training among all clinicians in addition
  - Inadequate staffing levels in most facilities.
  - Under resourced, understaffed and high turnover because the work is difficult, poorly paid, lacks a career ladder, and requires demanding paperwork and regulatory compliance.
  - Chronic shortage of staff with any palliative care training,
    - Failure to assess and manage common symptoms such as pain and shortness of breath.

STEPS IN COMMUNICATING BAD NEWS

A systematic approach to delivering bad news can improve the physician’s, patient’s, and family’s ability to cope with the situation and plan for the future

- Prepare
- Establish the patient’s understanding
- Learn how much the patient wants to know
- Deliver the information
- Respond to the patient’s feelings
- Organize a plan and follow-up procedure
PREPARING TO DELIVER BAD NEWS

• Plan what will be discussed
• Ensure that all medical facts and confirmations are available
• Choose an appropriate, comfortable setting
• Deliver the news in person, privately
• Allow time for discussion
• Minimize interruptions

ESTABLISH THE PATIENT’S UNDERSTANDING

Ask questions such as:
• “What do you understand about your illness?”
• “When you first had symptom X, what did you think it might be?”
• “What have other doctors told you about your condition or procedures that you have had?”

HOW MUCH DOES THE PATIENT WANT TO KNOW?

Make no assumptions; remember that:
• Patients have the right to be told the truth but also to decline to learn unwanted information
• A patient may not want to know full details
• A patient may wish to have a family member informed instead
DELIVERING BAD NEWS

- Use a sensitive, straightforward manner
- Avoid technical language or euphemisms
- Check for understanding and clarify difficult concepts
- Use phrasing that sends a “warning shot” to prepare the patient, for example:
  “Mr. X, I feel bad to have to tell you this, but the growth turns out to be cancer.”

AFTER DELIVERING BAD NEWS

- Respond to feelings
  - Use active listening
  - Encourage expression of emotion
  - Acknowledge the patient’s emotions
- Organize a plan and follow-up
  - Address patient’s concerns in immediate plan
  - Set an appointment for a follow-up visit
  - Discuss additional tests, referrals, sources of support
  - Provide information on how you can be reached with additional questions

SPIKES TOOL

- S – Setting
  - Arrange for some privacy
  - Involve significant others
  - Sit down
  - Make connection and establish rapport with the patient
  - Manage time constraints and interruptions.
- P – Perception of condition/seriousness
  - Determine what the patient knows about the medical condition or what he suspects.
  - Listen to the patient’s level of comprehension
  - Accept denial but do not confront at this stage.
- I – Invitation from the patient to give information
  - Ask patient if s/he wishes to know the details of the medical condition and/or treatment
  - Accept patient’s right not to know
  - Offer to answer questions later if s/he wishes.
SPIKES TOOL

K – Knowledge: giving medical facts
- Use language intelligible to patient
- Consider education level, socio-cultural background, current emotional state
- Give information in small chunks
- Check whether the patient understood what you said
- Give any positive aspects first e.g.: Cancer has not spread to lymph nodes, highly responsive to therapy, treatment available locally etc.
- Give facts accurately about treatment options, prognosis, costs etc.

E - Explore emotions and sympathize
- Prepare to give an empathetic response:
  - Identify emotion expressed by the patient (sadness, silence, shock etc.)
  - Identify cause/source of emotion
  - Give the patient time to express his or her feelings, then respond in a way that demonstrates you have recognized connection between 1 and 2.

S – Strategy and summary
- Close the interview
- Ask whether they want to clarify something else
- Offer agenda for the next meeting e.g.: I will speak to you again when we have the opinion of cancer specialist.

PALLIATION OF NON-PAIN SYMPTOMS

- Constipation
- Nausea and vomiting
- Diarrhea
- Bowel obstruction
- Anorexia and cachexia
- Delirium
- Depression
- Dyspnea
- Cough
- Loud respiration

CONSTIPATION

- Common for terminally ill patients
- Caused by opioids, immobility, poor fluid intake
- Treatment:
  - Prophylactic laxatives: stool softener & bowel stimulant (docusate sodium & senna or bisacodyl)
  - If ineffective, add osmotic laxative (sorbitol, lactulose, polyethylene glycol)
  - If no bowel movement in 4 days, consider enema
  - If impaction occurs: disimpact manually or with enemas before starting laxative therapy
NAUSEA AND VOMITING

- Key facts
  - Occur in 40% to 70% of patients with advanced cancer
  - May be caused by disease or its treatment

- Select antiemetic agent on the basis of:
  - Likely cause
  - Pathway mediating the symptoms
  - Neurotransmitters involved

EMESIS CAUSED BY DRUGS & TOXINS

- Common causes
  - Drugs: opioids, digoxin
  - Biochemical disorders: hypercalcemia, uremia
  - Toxins: tumor-produced peptides, infection, radiotherapy, abnormal metabolites

  Pathway
  - Chemoreceptor trigger zone in vomiting center
  - Dopamine, serotonin, histamine acetylcholine receptors

- Treatments
  - Dopamine antagonists (eg, haloperidol)
  - Prokinetic agents (eg, metoclopramide)
  - Serotoninergic antagonists (eg, ondansetron, granisetron)

EMESIS ORIGINATING IN THE GUT

- Common causes
  - Gastric irritation, gastric distension, liver capsule stretch
  - Opioid stasis, constipation, tumors, peritoneal inflammation
  - Upper bowel, genitourinary, biliary stasis

- Pathway
  - Gut
  - Receptors: serotonin, histamine receptor type 1

- Treatments
  - Motility agents for stasis (eg, metoclopramide)
  - Serotonin antagonists, antihistamines
EMESIS OF OTHER ORIGINS

• Vestibular apparatus
  ➢ Receptors: muscarine, acetylcholine, histamine receptor type 1
  ➢ Common causes: drugs (aspirin, opioids), motion sickness (Ménière's disease, labyrinthitis), local tumors (acoustic neuroma, brain tumors, bone metastases to base of skull)
  ➢ Treatment: scopolamine, hydrobromide, meclizine

• Cerebral cortex
  ➢ Common cause: raised intracranial pressure
  ➢ Treatment: dexamethasone

DIARRHEA

• Affects 7%–10% of patients with cancer being admitted to hospice
• Consider fecal impaction presenting as watery diarrhea in immobile older patients on opioids
• Review medications for excessive laxative therapy

MALIGNANT BOWEL OBSTRUCTION EPIDEMIOLOGY

• Up to 50% of patients with ovarian and GI cancers have malignant bowel obstruction
• Patients diagnosed with malignant bowel obstruction have a median survival of 3 months
• High symptom burden with nausea, vomiting, colic, and abdominal pain
### MALIGNANT BOWEL OBSTRUCTION TREATMENT

- Evaluation and management depends on functional status, goals of care, expected survival
- Treatment options:
  - Surgical: limited evidence for benefits in terms of quality of life at the end of life
  - Endoscopic techniques: stents, best used for single point of obstruction
  - Medical management: mainstay of treatment (combination therapy with opioids, antispasmodics medications, antiemetic medication, antisecretory agents, corticosteroids)

### ANOREXIA AND CACHEXIA

- Loss of appetite is almost universal among terminally ill patients
- Anorexia in actively dying patients who do not wish to eat should not be treated
- Symptoms of dry mouth should be treated
- Appetite stimulants (eg, corticosteroids) may benefit patients in early stages
- Encourage patients to eat whatever is most appealing, without dietary restrictions

### DELIRIUM

- Common and distressing for both terminally ill patients and their families
- Identify potentially reversible causes (infection, impaction, uncontrolled pain, urinary retention, hypoxia)
- Use low doses of nonsedating antipsychotic
- Actively dying, nonambulatory patients may benefit from sedating antipsychotic
- Avoid benzodiazepines
DEPRESSION

- Under-recognized and undertreated in the terminally ill
- Vegetative symptoms (insomnia, anorexia, weight change) may not be reliable because of underlying illness
- Be alert for mood change, loss of interest, suicidal ideation
- Treat aggressively: antidepressants, psychiatric consultation, cognitive-behavioral therapy are appropriate

DYSPNEA

- Assessment
  - Patient self-report is the only reliable measure
  - Respiratory rate and lab tests often do not correlate
- Management
  - Treat underlying cause, but do not delay symptom management
  - Use O₂ if saturation < 90% but use cautiously with patients who retain CO₂
  - Use fan, open window to stimulate 5th cranial (trigeminal) nerve & reduce dyspnea
  - Benzodiazepines control anxiety but not dyspnea
  - Opioids reduce respiratory drive, dyspnea

COUGH

- Causes
  - Production of excess fluids
  - Inhalation of foreign material
  - Stimulation of irritant receptors in the airway
- Management
  - Treat underlying cause
  - Add opioids if underlying disease not resolvable
    - Dextromethorphan: few sedative effects
    - Codeine, hydrocodone elixirs
    - Methadone syrup for longer duration of action
    - Nebulized anesthetic for irritated pharynx of local infection or malignancy
LOUD RESPIRATION

• The inability to clear secretions from the oropharynx, resulting in loud or "rattling" respirations
• Caused by secretions oscillating up and down during inspiration and expiration
• Treatment:
  ➢ Family education prior to its occurrence
  ➢ Postural drainage, positioning, and suctioning
  ➢ Anticholinergics
    • Hyoscine (scopolamine patch) every 72 hours
    • Hyoscyamine 0.125 sublingually
    • Glycopyrrolate 0.2 mg SC every 8 hours

SUMMARY

• Palliative care aims to relieve suffering, improve quality of life, optimize function, and assist with decision making for patients with advanced illness and their families
• Palliative care is offered simultaneously with all other appropriate medical treatment
• Communicating bad news requires preparation, sensitivity to patient's understanding and needs, and an organized plan and follow-up

SUMMARY

• Pain should be assessed in all patients, and adequate treatment may combine drugs with nonpharmacologic interventions
• Clinicians should watch for and treat other symptoms: constipation, nausea & vomiting, diarrhea, anorexia & cachexia, depression, delirium, dyspnea, and cough
Resources on palliative care:

- For information on the development of palliative care teams, visit the Center to Advance Palliative Care at www.capc.org.
- For the National Consensus Project (NCP) Guidelines, go to www.nationalconsensusproject.org.
- For the National Quality Forum (NQF), National Framework and Preferred Practices for Palliative and Hospice Care Quality, go to www.qualityforum.org.
- http://getpalliativecare.org/
- North West Ohio Hospice Palliative care program: Sincere
Addressing Polypharmacy in Palliative & End of Life Care

Barbara J. Messinger-Rapport, MD, PhD, CMD, FACP

Objectives:

2. Consider symptoms as possible drug side effects.
3. Reassess disease management needs based on life expectancy, performance, and possible drug side effects.
Addressing polypharmacy in palliative and end of life care

February 27, 2015
BJ Messinger-Rapport, MD
Cleveland Clinic

After this presentation, learner will be able to

1. Consider life expectancy and performance in assessing a patient
2. Consider symptoms as possible drug side effects
3. Reassess disease management needs based on life expectancy, performance, and possible drug side effects.

A Century of Change

<table>
<thead>
<tr>
<th></th>
<th>1900</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Expectancy</td>
<td>49 years</td>
<td>77 years</td>
</tr>
<tr>
<td>Usual Place of Death</td>
<td>Home</td>
<td>Hospital</td>
</tr>
<tr>
<td>Most Medical Expenses</td>
<td>Family</td>
<td>Medicare</td>
</tr>
<tr>
<td>Disability before Death</td>
<td>Minimal</td>
<td>2 years, on average</td>
</tr>
</tbody>
</table>

Function and Age:

Life expectancy by age

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>70</td>
<td>35</td>
<td>30</td>
</tr>
<tr>
<td>80</td>
<td>25</td>
<td>20</td>
</tr>
<tr>
<td>90</td>
<td>15</td>
<td>10</td>
</tr>
</tbody>
</table>

Minimal debility at EOL
Major trauma; Overwhelming Infection; Advanced Cancer

Gradual step decline
Acute on chronic disease; Progressive inflammatory disease or cancer

May not have time/need for “transitions”
Long period of debility at end of life

<table>
<thead>
<tr>
<th>Time</th>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Dementia / Frailty

May have: multiple transitions. Certainly need: advance care planning


In Loving Memory
Jack LaLanne (1914-2011)

"In my mind, nothing on this earth is more addictive than refined sugar."

—from the book, Sugar Shock, by ConEine Robertson

(Headed during a phone interview.)
**JH:** Triathlete in his 60's
62 looks even better than 37!

Mexican Artist Rufino Tamayo
Art at 30 and 90 years of age

**PREDICTORS OF DEATH:**
**NONAGENARIANS**

- **Male:**
  - ↓ ADL HR 1.62
  - ↓ BMI HR 1.43
  - ↓ MMSE HR 1.30

- **Female:**
  - ↓ CVD HR 1.7
  - ↓ ADL HR 1.61
  - ↓ MMSE HR 1.42
  - ↓ BMI HR 1.26
  - ↓ hand-grip HR 1.14

Non-predictors: Obesity, diabetes, smoking.

Nybo JAGS 2003
Frailty- prevalence

Prevalence of Frailty
- Age < 30: 2%
- Age ≥ 65: 22.4%
- Age ≥ 85: 43.7%

Frailty as a syndrome

Frail is at least 3 of the following:
- Reduced activity
- Slowing of mobility
- Weight loss
- Diminished handgrip strength
- Exhaustion

None: Robust
1 or 2: pre-frail

Clinical Frailty Scale®

1. Very Fit: People who are robust, active, energetic and motivated. They are among the fittest for their age.
2. Well: People who have no active disease syndrome but are less fit than category 1. They often exercise or are very active occasionally e.g. weekly.
3. Managing well: People whose medical problems are well controlled, but are not regularly active beyond routine walking.
4. Vulnerable: While not dependent on others for daily help, often report symptoms or limitations. A common complaint is being "tired out", and/ or being tired during the day.
5. Mildly frail: These people often have minor signs of slowing, and need help with high order ADLs (shaving, transportation, heavy housework, mobility). Typically will fully progressively impair over about 6 months.
6. Moderately frail: People need help with all ADLs and may need minimal assistance during (sitting) with dressing.

7. Severely frail: Completely dependent for personal care, often without basic (physical or cognitive). Even to they seem stable and not at high risk of dying within ~6 months.
8. Very Severely frail: Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.
9. Terminally ill: Approaching the end of life. This category applies to people with a life expectancy <6 months who are not otherwise medically frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of recent events, though still remembering the event itself, repeating the same questions, and social withdrawal. In moderate dementia, recent memory is very impaired even though the person can remember their past life events well. They can do personal care with prompting. In severe dementia, they cannot do personal care without help.
Frailty Predicts Mortality, Institutionalization

CSHA Clinical Frailty Scale
Rockwood. CMAJ. 2005

Frailty predicts other outcomes (e.g. emergency surgery)


Chronic disease management

• ↑ prevalence chronic disease with age
• Each disease requires medication
  - HTN, HPL, CAD, DM, HF, AF
• Treatment saves lives and morbidity
  BUT
• When a person is sufficiently frail
  - Burden treatment (i.e. side effect) > benefit
  - Treatment becomes polypharmacy
Definition of polypharmacy

• No consensus definition
• Hanlon. *Amer J of Geri Pharm.* 2007
  - the use of multiple medications, and/or
  - the administration of more medications than are clinically indicated
• Bushardt. *Clin Interv Aging.* 2008
  - PIM (potentially inappropriate drug), or
  - 6+ concomitant medications

Thief! Patient #1

• 80 years old in 1992
• Retired colonel, USAF
• Chronic renal disease
• 100% functional (CFS 2)
• Prescription (now OTC) Cimetidine
  - Peptic ulcer
• THEN: Theft, lost car, lawyer!!

Package Insert: cimetidine

The following adverse events were observed during the clinical trial programmes:

- **Body as a whole:** Common: headache
- **Gastrointestinal:** Common: diarrhoea, constipation
- **Nervous system:** Common: dizziness, drowsiness, tiredness
- **Dermatological:** Common: rash

Confusional states, reversible within a few days of withdrawing cimetidine, have been reported rarely, usually in elderly or ill patients such as those with renal insufficiency or organic brain...
2014: Failure to thrive; hip fracture: Case study #2

- 85 yo, living with dtr, multiple doctors
- Constipation, poor intake, weight loss
- Edema, nocturia 5 times at night
- Recent fall at night, hip fracture
- PMH:
  - CAD (no stent), HTN, anemia, GERD

Current Medications
Case Study #2

Before hip fracture
- ASA 325 mg
- Plavix 75 mg daily
- Iron 325 mg tid
- Prilosec 40 mg twice daily
- Norvasc 10 mg
- Lasix 40 mg

Case #3

- 85 yo, living with dtr, multiple doctors
- Diarrhea, incontinence (urine, stool), poor intake, weight loss
- Progressive weakness, disability
- Falls (esp walking to bathroom)
- Dtr frustrated due to hygiene issues
- PMH:
  - HTN, DM, CAD, mild-mod dementia
Medications: Case #3

• ASA 81 mg
• Atorvastatin 80 mg daily
• Metformin 1000 mg bid
• Donepezil 10 mg daily

Prescription drug use in 2010

Source: NHANES. Figure 20 in www.cdc.gov/nchs/data/hus/hus13.pdf

Percent of community dwelling adults 65+ years taking prescription medication

Source: www.cdc.gov/nchs/data/hus/hus13.pdf
Older adults take multiple medications

Problems with polypharmacy

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Adverse Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constipation</td>
<td>Abdominal pain</td>
</tr>
<tr>
<td>Anorexia</td>
<td>Weight loss</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Fecal incontinence</td>
</tr>
<tr>
<td>Urinary frequency</td>
<td>Urinary incontinence</td>
</tr>
<tr>
<td>Edema</td>
<td>Leg pain; nocturia</td>
</tr>
<tr>
<td>Bleeding</td>
<td>Stroke, transfusion</td>
</tr>
<tr>
<td>Vision changes</td>
<td>Inability perform ADL</td>
</tr>
<tr>
<td>Balance</td>
<td>Fall, accidents</td>
</tr>
<tr>
<td>Confusion</td>
<td>Fracture</td>
</tr>
<tr>
<td>Loss bone density</td>
<td></td>
</tr>
</tbody>
</table>

Side effects & commonly prescribed drugs

- Common side effects
- Commonly prescribed drugs
  - Used for disease management
- Not inclusive
- In general, not include drugs for:
  - Bacterial infection, HIV, cancer
### Constipation

- Supplements: Iron, Calcium, Antacids
- Calcium Channel Blockers
  - Verapamil > amlodipine, felodipine
- Anti-muscarinics (over-active bladder)
- Antipsychotics: olanzapine; quetiapine
- Clonidine
- Sucralfate, cholestyramine
- Bromocriptine

### Anorexia

**Consider dose relationship**

- **Diabetes**: metformin
- **Dementia**: cholinesterase inhibitors
  - Donepezil, rivastigmine, galantamine
- **Depression**: venlafaxine, bupropion
- **Epilepsy**: Topiramate, lacosamide
- **Parkinson’s**: Carbidopa/ Levodopa
- **Cardiac**: Amiodarone
- **COPD**: Theophylline
- **Stimulants (methylphenididine)**

### Diarrhea

- **Diabetes**: metformin
- **Dementia**: cholinesterase inhibitors
  - Donepezil, rivastigmine, galantamine
- **Depression**: sertraline
- **GERD**: Proton Pump Inhibitors, H₂-blockers
- **Sleep**: Herbal teas
- **Misc**: Lithium, digoxin, sildenafil
# Urinary Frequency/ Incontinence

- High-dose diuretics
- Nocturnal UI: (next slide)
  - Drugs associated with edema
- Stress UI in women: alpha blockers
  - Terazosin, doxazosin, prazosin
- Cholinesterase inhibitors
  (controversial) Gill 2005
- Most anti-depressive agents
  (particularly SSRI) Movig 2002.

## Edema

- CCB: dose related
  - Dihydropyridines: Nifedipine, Felodipine, amlodipine
  - Less so: Diltiazem, verapamil
- Antipsychotics: NOT dose-related
  - Olanzapine, Quetiapine
- DM: thiazolidinediones
- Vit B deficiency (B1, B5, B6)
- Fludrocortisone, hormone therapy, steroids, testosterone
- Depression: MAO inhibitors; TCA’s

## Bleeding

<table>
<thead>
<tr>
<th>Prescribed</th>
<th>Supplement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin</td>
<td>Vitamin E</td>
</tr>
<tr>
<td>Clopidogrel</td>
<td>Ginkgo biloba</td>
</tr>
<tr>
<td>SSRI (sertraline, citalopram, etc)</td>
<td>Garlic (large amts)</td>
</tr>
<tr>
<td>SNRI (venlafaxine, duloxetine, etc)</td>
<td>Ginger (not dried)</td>
</tr>
<tr>
<td>NSAIDs (less with cox-2 inhibitor)</td>
<td>Ginseng (Asian)</td>
</tr>
<tr>
<td>Steroids (prednisone)</td>
<td>Feverfew</td>
</tr>
<tr>
<td></td>
<td>Saw Palmetto</td>
</tr>
<tr>
<td></td>
<td>Willow bark</td>
</tr>
</tbody>
</table>
Adverse effects of medications on vision

• Digoxin and/or amiodarone:
  - blurred or yellow vision
• Anticholinergics (bowel, bladder)
  - Double vision
  - Reduced accommodation
  - Increased intra-ocular pressure
• Hydroxychloroquine: color perception, visual accommodation

Drugs and balance (inner ear issues)

• Antibiotics:
  - Gentamycin
  - Tobramycin
  - Azithromax, erythromycin, clarithromycin
• Cancer therapy
  - Nitrogen mustards
  - Vincristine

Drugs and balance (NOT inner ear)

• Amiodarone
• Anti-depressants (new and old)
• Anti-anxiety medications
• Pain medications (esp early on)
• Dextromethorphan (cough suppressant)
• Sleep aides
  - Prescription
  - OTC “PM” medications
Confusion

• ↓ ability to make new memories:
  - Benzodiazepines (valium)
  - Anticholinergics, anti-muscarinics (oxybutinin)
  - Antihistamines
• ↓ brain processing speed
  - anti-epileptic meds (not dilantin)
• ↓ Concentration: older depression meds
• ↑ Delusions, hallucinations
  - Older antidepressives
  - Older antihistamines (benadryl)
  - Parkinson medications (also compulsions)

Medications that accelerate loss of bone mass

Phenytoin, barbiturates
Aromatase inhibitors
Cyclosporine A; Tacrolimus
Glucocorticoids
Gonadotropin releasing hormone
Lithium
Medroxyprogesterone acetate (Depo-Provera®)
Methotrexate
Proton pump inhibitors
Selective serotonin reuptake inhibitors (SSRIs)
Thiazolidinediones (Rosiglitazone, Pioglitazone)
Thyroid hormones in excess
Heparin, Low molecular weight heparin

Live long and prosper?
Problems with Antioxidants?

• Low serum β carotene, selenium, vitamin E
  - Associated with debility, mortality
• Supplementation antioxidants
  - Bjelakovic, JAMA. 2007
  - ↑ mortality w/ β carotene, Vitamins A,E
• Hip fracture risk with Vitamin A
Antipsychotics for Dementia Behavior

• Examples:
  - Aripiprazole (abilify)
  - Olanzepine (zyprexa)
  - Risperidone (risperdal)
  - Quetiapine (seroquel)

• Potential adverse effects:
  - Ineffective
  - Movement disorder
  - Falls
  - Lower respiratory infection
  - Lower bone density
  - Constipation, weight gain, edema

Bradycardia

• Calcium channel blockers
• Beta Blockers
• Glaucoma eyedrop (eg timolol)
• Syncope; pacemaker placement(?)
  - Cholinesterase inhibitors (Gill 2009)

Back to my patients
Case #1

• 80 years old in 1992
• Retired colonel, USAF
• Queried patient and wife
  - Cimetidine: prescribed once daily
  - Taking twice daily
• Confusion resolved w/dose reduction
• Drug eventually replaced by ranitidine
Case #2: Constipation, anorexia, edema

- Replace norvasc (edema) by Ace-I; ARB; even thiazide
  - Lasix no longer needed
- Stop plavix (no stent)
  - Reduce ASA to 81 mg daily or M, W, Fr
- Titrate PPI off
  - (trial low dose H2-blocker?)
- Lower iron immediately to one daily
  - Probably be able to stop the iron if no PPI

Case #3: Diarrhea, incontinence, weakness

- Weakness:
  - Reduce atorvastatin to 10-20 mg/d*
- Diarrhea:
  - Reduce or stop metformin
  - Reduce or stop donepezil
- Urinary incontinence:
  - Reduce or stop donepezil

Supported by 2013 ACC/AHA Cholesterol guidelines

Symptoms and Meds

- Any questions?
Reducing polypharmacy requires

1. Tool to identify polypharmacy
2. Point-of-care drug app
3. Rapid Computation of Cr Cl or eGFR
1. Tools to identify geriatric polypharmacy

- “Beers” criteria (handout)
  - Fick. Arch Int Med. 2003
- STOPP & START. O’Mahony.2010
- ARMOR (nursing homes)
- POM (primary care)

Prescribing Optimization Method
6-question POM

- Undertreatment present? Should we add a med?
- Adherence?
- Can we withdraw a med?
- Adverse effects present?
- Interactions likely?
- Adjust dose, frequency, or form?

2. Medication “apps”

- Free:
  - Epocrates
  - Medscape
- Subscription:
  - www.lexi.com
  - www.factsandcomparisons.com
  - www.micromedex.com
3. Estimating renal function: CrCl or eGFR

**Medscape:**
- Reference...calculator...renal...
  - Cockcroft-Gault

**Epocrates:**
- Calculators:
  - Cockcroft-Gault
  - GFR (MDRD)

---

**Cockcroft Gault**

\[
\text{CreatClear} = \text{Sex} \times \frac{(140 - \text{Age})}{\text{SerumCreat}} \times \frac{\text{Weight}}{72}
\]

- Assumes stable Cr (steady state)
- C-G may underestimate CrCl in elders
- Package inserts of some drugs to use either actual body weight (e.g., daptomycin, dofetilide) or ideal body weight (e.g., adefovir, tenofovir) in the CG equation
Objectives:

1. Present the dilemma clinician’s face when discussing life plans at the end of life with a patient.

2. Identify different approaches to having the life planning discussion at the End of Life.

3. Review MOLST/POLST Paradigm, where are we in Ohio.
**Advance Directives & Honoring Healthcare Wishes**

Thomas S Lehner, MD, FAAFP, CMD
Medical Director
Optum
Complex Population Management
Cleveland, Ohio

---

**Objectives**

1. Present the dilemma clinicians face when discussing life plans at the end of life with a patient

2. Identify different approaches to having the life planning discussion at the End of Life.

3. Review MOLST/POLST Paradigm, where are we in Ohio.

---

**Dying in America**

“I think many years ago an advanced civilization intervened with us genetically and gave us just enough intelligence to develop dangerous technology but not enough to use it wisely. Then they sat back to watch the fun. Kind of like a human zoo. And you know something? They’re definitely getting their money’s worth.”

*George Carlin*
Dying in America

- Historical Perspective (Last 50 years)
  - Physiological event vs a process
  - Death is viewed as a failure, a disease itself
  - "The enemy"
- Current Changing Perspectives
  - Quality of care with life-threatening illness is increasingly recognized as an ethical obligation of health care providers
  - Treat at all costs changing to effective / efficient care

---

Dying in America

- When families talk about letting their loved ones die "naturally," they often mean "in their sleep" - not from a treatable illness such as a stroke, cancer or an infection.
- Choosing to let a loved one pass away by not treating an illness ... feels too complicit to some
- Conversely, choosing treatment that will cause a patient further suffering ... somehow feels like taking care of them.
- While it's easy to empathize with these family members' wishes, what they don't appreciate is that very few elderly patients are lucky enough to die in their sleep.
- Everyone dies of something ... "nobody gets out of here alive"

---

"The sick person is at a point where what he wants most from people is not love, but an appreciative grasp of his situation."

- Joy Williams in State of Grace
“IN SEARCH OF A GOOD DEATH”

- Pain & Symptom Management
- Clear Decision Making
- Preparation for Death
- Completion
- Contributing to Others
- Affirmation of the Whole Person


“Avoiding a Bad Death”

- Poor Symptom Control
- Patient / Family Stress
- Moving from Crisis to Crisis
- Inadequate Preparation
- Drained Resources
- Emotional & Spiritual Isolation
In The Beginning...

• Isn’t it interesting that at the start of life, we are surrounded by our loved ones.
• Each need is fulfilled.
• We are provided every comfort.
...In the End

- Do you think we deserve as much care at life's end as we received at life's beginning?
- How many die alone, in pain, unfulfilled?
- In too many situations, the contrast is quite different...

Think for a moment about the end of your life...

- Pain free?
- Supported by loved ones?
- At home?

Unfortunately, the reality is that most people die:

- In pain
- Alone
- In hospital

What Do People Believe?

- Health professionals should initiate these discussions
- Most are willing to discuss issues about end-of-life care
- They want assistance talking with loved ones and physicians about end of life care
A treatment may be beneficial if it is.....

- Effective in prolonging "quality" life
- Effective in restoring/ maintaining function
- Promotes goals/values of patient
- Consistent with religious/cultural beliefs
- Provides effective symptom management

A treatment may be considered burdensome if it results in...

- More or intolerable pain
- Damage to body image or function
- Psychological harm
- Unacceptable cost for the patient
- No meaningful effect on the situation

Prolonging Life or Prolonging Death?

- Continuing treatment when it provides little or no benefit or chance of survival may:
  - Prolong dying and cause suffering
  - Cause pain and discomfort
  - Decrease meaningful time spent with loved ones
  - Lead to dependence on artificial means to live
**Stewardship of Limited Resources**

- One fourth of total Medicare budget is spent on patients during the last year of their lives – Hogan, C., et.al. *Health Affairs*, 20 (4), 188-195.
- “Slow medicine” concept - sometimes, less is more.

---

**Barriers to the Discussion/Planning**

- Avoidance of the subject
- Lack of professional skill, training, and confidence
- Perceived lack of time
- Lack of reimbursement
- Belief it is not possible
- Not sure what to say/how to say it
- “Cure” vs everything else – treatment?

---

**Why should people plan ahead?**

- Most of us will die in the care of health professionals
- Up to 50% of persons cannot make their own decisions when they are near death
- In uncertain situations, aggressive care is often the norm
- Health care professionals and family members won’t know preferences without discussion.
Four Commons Expressions

- "No Heroics"
- "Don't keep me alive if I am a vegetable"
- "Don't keep me alive on machines"
- "If I am terminal, let me go"

When facing serious illness, it may be helpful to consider....

- What might the 'story' of the rest of my life be like? (medically)
- What are the best outcomes reasonably hoped for?
- What are the worst outcomes we may have to deal with?
- How can we plan ahead for anticipated problems? (See Handbook for Mortals, J. Lynn, MD)

Do Not Resuscitate – DNR in Ohio

A source of confusion
Ohio's Two-Tiered DNR

- DNR- Comfort Care
- DNR- Comfort Care Arrest

WITHHELD VS. WITHDRAWN

- With DNR-CC, CPR (and any "component of CPR") are withheld from the point of the order being written.
- With DNR-CC Arrest, if a "component of CPR" has been initiated as a part of medical treatment, it is withdrawn at the point of arrest.

HB 588/SB 347- OHIO MOLST

- **What is a MOLST?**
  - MOLST is a process. The MOLST is not just a form but a conversation, it is designed to improve the quality of care people receive at the end of life by turning a patient's goals and preferences for care into medical orders. MOLST is based on communication between the patient (or other legally designated medical decision-maker) and health care professionals that ensures that patients understand the decisions they are making.

- **What do the letters M.O.L.S.T stand for?**
  - MOLST stands for Medical Orders for Life-Sustaining Treatment.
**HB 588/SB 347 - OHIO MOLST**

**Who can complete and sign a MOLST form?**
- Many people may be involved in helping a patient clarify goals of care. A health care professional, social worker, nurse, or chaplain commonly may assist in the education and transcription of a MOLST form in collaboration with the patient or surrogate to reflect the goals of care. A valid MOLST form must be signed, dated with contact information for the signing medical practitioner, who is either a physician, nurse practitioner or physician’s assistant.

**Can completion of the MOLST form be mandated to better understand patient wishes?**
- Use of the MOLST form is voluntary and can be revoked once completed. Under the proposed legislation, the MOLST must also be signed by the patient or surrogate in order to be valid.

---

**How does a MOLST help patients?**
- Completion of a MOLST turns the wishes of patients into actionable medical orders that are portable from one care setting to another. A MOLST ensures that patients understand the decisions they are making by encouraging discussions between the patient or other legally designated medical decision-maker and health care professionals.

**How does a MOLST help healthcare professionals?**
- It assists health care professionals in discussing and developing treatment plans that reflect the patient’s wishes and helps physicians, nurses, health care facilities, emergency personnel and first responders honor that patient’s wishes.

---

**What happens to current DNRs in Ohio if this legislation is passed?**
- The DNR Protocol in Ohio that consists of DNR Comfort Care and DNR Comfort Care Arrest will be replaced by the MOLST, i.e. use of the current Protocol would end. However, DNR orders written for patients before the enactment of MOLST would still be honored. Efforts will be made to have all individuals who currently have a DNRCC or DNRCC Arrest form update their wishes using the MOLST.

**Can healthcare professionals and patients use the MOLST form in Ohio, if this legislation isn’t enacted?**
- A MOLST program requires collaboration and involvement from health care, ethics and legal professionals, hospitals, long term care, hospice, and emergency medical services. Currently there is no legal requirement that medical professionals and medical facilities honor a MOLST form.
HB 588/SB 347- OHIO MOLST

- Does a MOLST form replace traditional Advance Directives like the Living Will and Healthcare Power of Attorney documents?
  - No. Traditional Advance Directives are recommended for all adults in order to appoint a surrogate and assure that their values are expressed. When available, any and all Advance Directives should accompany a MOLST form as together they may help in identifying the surrogate decision maker and may identify the patient’s values. However, these documents are not required for the MOLST to be valid. The most recently completed document would be the guide in decision-making regarding care.

- What is the difference between a DNR and MOLST?
  - The DNR only specifies care related to cardiopulmonary resuscitation (CPR). MOLST will include a section that will specify a person’s preferences regarding resuscitation plus other sections that address a variety of healthcare wishes.
CONTACT INFORMATION

Thomas S Lehner MD FAAFP CMD
Optum/United Healthcare
1001 Lakeside Ave
Suite 1000
Cleveland, OH 44114
thomas_lehner@optum.com
Ethical and Spiritual Issues at the End of Life:
Letting Go of Some Thing’s,
Holding onto Others

Rabbi Akiva Feinstein

Objectives:
1. Compare Secular Medical Ethics to Jewish and Other Religion-bound Ethics Systems.
2. Provide specific examples of the distinctions and similarities in these two approaches.
3. Provide suggestions for better communication when religion is part of the decision making process.
4. Discuss a new way of looking at providing ethical palliative care via “Dignity in Care”.
Some Things, Holding Onto Others

Rabbi Akiva Feinstein
Vinney Hospice and Palliative Care of Montefiore
Beachwood, OH
afeinstein@montefiorecare.org

Overview

1) Compare Secular Medical Ethics to Jewish and Other Religion-bound Ethics Systems
2) Provide specific examples of the distinctions and similarities in these two approaches
3) Suggestions for better communication when religion is part of the decision making process
4) A new way of looking at providing ethical palliative care via “Dignity in Care”
Medical Ethics – Historical Background

• Early expression in the form of laws, decrees, and oaths – prepared by and for physicians.
  ○ Code of Hammurabi
  ○ Early Greek writers like Hippocrates
• No shortage of religious approaches as well
• Medical organizations began writing their own codes in later 19th century
  ○ AMA – 1847, British Medical Assoc., and WHO
• Modern medical ethics evolved separately focusing on the rights of the patient

General Ethical Principles and Theories

• How to best recognize ethical dilemmas and provide tools for their resolution
• Measures human conduct, determining normative behavior
• All about values
  ○ Defines the good, a subjective assessment of what something is worth relative to what one must give up for it

Ethical Dilemmas

• Two or more alternative actions, each of which is good, yield conflicting outcomes
• Or an action that does good to one, but causes harm to another
Ethics Asks …

• **1) What Should Be Done**
  • Not what one *ordinarily does*
  • Not what one *could*

• **2) What is the proper course of action?**

A wise person is not the one who knows how to choose good from bad, but he who chooses the lesser of the two evils.
4 Planes of Evaluation

- The desire, intent
- The ethical principle, theory of value
- The method
- The consequences

Not agreed upon which apply, some or all.

Ethics vs. Religion & Law

- Latter provide definitive and absolute rulings while ethics does not decide absolutely, but rather focuses and clarifies questions and issues, and presents options for resolving dilemmas

Ethical Schools of Thought

- Plato & Stoics – validity of moral cognition is absolute and objective, applying to all people in all places and all times.
- Sophists and Skeptic – one can never prove a universal ethical law or value and that all are relative to place and time.
- Intermediate view – Pythagoras – certain values and norms exist for certain populations but may vary due to external circumstances
Modern Ethics

These basic differences of opinion remain unresolved especially given the diversity of human views and societies and case for innate universal seems to be weaker.

Modern Ethics – Validation

So what is the means of validation? Emotions.

- Emotions: joy = good, sadness = bad (Hume, Spinoza)
- Emotions and social habits are the sources for the validity of ethics

Modern Ethics – Validation

Absolute Values

- Do not change from society to society or from time to time
- Factual – empirical, intuitive, metaphysical – religious
- Rejects “modern ethics” concept of relative values (Kant)
Further Utilitarian Theory Divisions
- Is an action that brings the most beneficial results for the most people (society) truly good (Hume and Bentham)?
- Is an action that brings the most good for the individual (Nietzsche, Epicurus, Spinoza)?

Today the conflict remains...
- In lieu of the adoption of a specific philosophical system, our “society” has moved to a pragmatic application of principles rather than values as the basis for ethical discussion in medicine
- 4 Key Principles that we are so familiar with
Autonomy
- Freedom from outside pressure or control
- Cannot be exercised by the young, retarded, or psychotic
- Not to be respected if will harm others
- Considered by some as the most important, yet by others as only one of several other important principles
- Physician’s own autonomy?

Non-maleficence
- Previously simply, “above all do no harm,” but nowadays “strive to do not harm” in light of current medical approach of hi-tech, risk inherent situations

Beneficience & Justice
- Not good enough to do no harm, must be sure to do good
- Justice
  - Equality - Distributive justice
  - Marxism vs. Liberalism
Modern Medical Ethics

- Merger of thinking of various disciplines, including behavioral sciences, biomedical sciences, philosophy, religion and law
- New technologies leads to specialty in its own right
- Paternalism to autonomy
- More caregivers with their own discipline specific focus and values
- Society at large

3 Views of Medical Ethics

- Classic Hippocratic view
  - Paternalism, do no harm, professionalism
- Religious Views like Judaism
- Modern View
  - Autonomy is prominent, 4 key ethical principles, multidisciplinary approach, and other factors
Jewish Medical Ethics

- Background
- Importance of all life events, including dying
- Infinite value of life combined with pragmatism of situation

Secular vs. Jewish Ethics Definitions

<table>
<thead>
<tr>
<th>Value</th>
<th>Secular Medical Ethics</th>
<th>Jewish Medical Ethics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autonomy</td>
<td>The patient’s right to choose among available alternatives.</td>
<td>Autonomy is voluntary, limited to being consistent with Jewish law.</td>
</tr>
<tr>
<td></td>
<td>Autonomy in health care today is determined by the dominant ethical value.</td>
<td></td>
</tr>
<tr>
<td>Beneficence</td>
<td>Physicians provide care that is of benefit to the patient.</td>
<td>Physicians are obligated to heal and benefit patients.</td>
</tr>
<tr>
<td></td>
<td>Patients are obligated to seek beneficial treatment.</td>
<td></td>
</tr>
<tr>
<td>Nonmaleficence</td>
<td>Physicians avoid providing care that is harmful.</td>
<td>Physicians avoid providing care that is harmful.</td>
</tr>
<tr>
<td></td>
<td>This principle is considered secondary to beneficence and not always adhered to since many beneficial treatments may also cause harm.</td>
<td></td>
</tr>
<tr>
<td>Justice</td>
<td>Providing care that is good for the society as a whole, as opposed to focusing on a specific individual.</td>
<td>Societal good is defined by Jewish law.</td>
</tr>
<tr>
<td></td>
<td>Fair allocation of limited health care resources.</td>
<td>Future priority is on a first-come, first-served basis.</td>
</tr>
</tbody>
</table>

Jewish Medical Ethics and End-of-Life Care

BARRY M. KINZBRUNNER, M.D., Journal
# Medical Ethics

## JEWISH MEDICAL ETHICS

<table>
<thead>
<tr>
<th>Issue</th>
<th>Jewish Law</th>
</tr>
</thead>
<tbody>
<tr>
<td>Terminal illness to Jewish law</td>
<td>Twelve intractable illnesses resulting in a limited life expectancy, typically 3 years or less.</td>
</tr>
<tr>
<td>Suicide, assisted suicide and euthanasia</td>
<td>Good; actively dying, typically last 2 days of life is forbidden.</td>
</tr>
<tr>
<td>Refusal of medical treatment</td>
<td>Treatment may be refused if ineffective, futile, or may cause suffering or significant complications.</td>
</tr>
<tr>
<td>Withholding and withdrawing treatment</td>
<td>Withholding: Permitted if treatment will only delay dying process and/or will not provide relief of pain and suffering.</td>
</tr>
<tr>
<td>Withdrawing: It is forbidden to withdraw life support and other direct life prolonging interventions.</td>
<td></td>
</tr>
<tr>
<td>Removing “impediments to death” are permitted.</td>
<td></td>
</tr>
<tr>
<td>Informed consent and truth-telling</td>
<td>Informed consent must be provided in a sensitive and thoughtful manner.</td>
</tr>
<tr>
<td>Truth may be withheld from patients if it is believed that the knowledge will be harmful to the patient.</td>
<td></td>
</tr>
<tr>
<td>Pain and suffering</td>
<td>It is an obligation to treat physical pain as well as emotional pain and suffering. In the face of intractable pain and suffering, other treatments may be withheld and improvements to death may be removed.</td>
</tr>
</tbody>
</table>

---

**Jewish Medical Ethics and End-of-Life Care**


---

**Cardiopulmonary resuscitation (CPR)**

CPR may be withheld.

**Artificial nutritional support and hydration**

Generally must be provided as food and fluids are considered basic care. This should be done in a way as to ensure minimal pain and discomfort.

**Antibiotics**

Generally should be provided as infection is considered a tragedy; however, they may be withheld if they only delay the dying process and/or do not provide relief of pain and suffering.

**Surgery, chemotherapy, radiation therapy**

May be refused or withheld if they only delay the dying process and/or do not provide relief of pain and suffering.

**Mechanical ventilator**

May be withheld, but once initiated may not be actively discontinued.

**Advance directives**

Durable power of attorney and/or living will may be used. The patient’s wishes should be included as a part of the discussion. Medical decisions are compatible with Jewish law.

---

**Jewish Medical Ethics and End-of-Life Care**

A Religion of Life

• Strategies to bridge the gap between Orthodox families, rabbis, and medical staff
• Specialized advanced directives

Ethics: Beyond What We DO
But Rather HOW WE DO IT
Kindness, humanity and respect

Dignity Explained

- “Dignity in Care” provides practical ideas and tools to support a culture of compassion and respect throughout the health care system.
- Dignity in Care is based on 15 years of study by Dr. Harvey Max Chochinov and the Manitoba Palliative Care Research Unit, in collaboration with progressive researchers from Australia, England and the United States.

Benefits of Dignity

They have found that:

- People working in health care can have a huge influence on the dignity of those who use health care services, which in turn can improve the patient experience and increase satisfaction with health care.
- Good communication is an essential ingredient for providing the best quality of health care and patient safety.
• When people use health care services, their sense of dignity is affected by many common factors. One of the most important is how they see themselves, which is affected by how they believe they are seen by others. Considering that so much anxiety is connected to illness, it's easy to understand why people working in health care can have such a strong impact on the dignity of the people they interact with every day. Whether they realize it or not, they are often the 'mirror' by which patients and their families judge their own status within the system.
• People working in health care have a natural desire to be helpful and supportive. Their challenge is to understand all of the differing factors that may affect an individual's sense of dignity, and how they can address these factors as they go about their daily work.

The ABCDs of Dignity
• The ABCDs examine how attitudes may affect actions, and how people can take conscious steps to adjust those attitudes and behaviours. They follow the familiar A-B-C pattern that many disciplines use as the foundation for basic learning.
• Just as all ER staff know the ABCs of emergency response (Airway, Breathing, Circulation), everyone working in health care can remember the ABCDs of Dignity in Care:
  • Attitude
  • Behaviour
  • Compassion
  • Dialogue

The Patient Dignity Question (PDQ)
What do I need to know about you as a person to give you the best care possible?
The Patient Dignity Inventory (PDI)

- The PDI is designed to give clinicians a broad overview or "snapshot" of how someone in their care is doing at any point in time.
- Using a simple questionnaire, patients are asked to rate their current condition on the basis of 25 different indicators. Each question is based on empirical research into the most common factors influencing people's personal sense of dignity.

Concern on a five-point scale, with 1 representing "not a problem" and 5 representing "an overwhelming problem."

1. I feel like I have lost control over my life.
2. I feel I have no control over my body.
3. I feel I am out of control over my mind.
4. I feel I am not in control over my life.
5. I feel my life is out of control.
6. I feel I have no control over my body.
7. I feel I am out of control over my mind.
8. I feel I am not in control over my life.
9. I feel my life is out of control.
10. I feel I have no control over my body.
11. I feel I am out of control over my mind.
12. I feel I am not in control over my life.
13. I feel my life is out of control.
14. I feel I have no control over my body.
15. I feel I am out of control over my mind.
16. I feel I am not in control over my life.
17. I feel my life is out of control.
18. I feel I have no control over my body.
19. I feel I am out of control over my mind.
20. I feel I am not in control over my life.
21. I feel my life is out of control.
22. I feel I have no control over my body.
23. I feel I am out of control over my mind.
24. I feel I am not in control over my life.
25. I feel my life is out of control.
Research and Implementation

- Provable?
- Dignity is really in the eye of the beholder
- Spiritual care performed by all
- Victor Frankl – Man’s Search for Meaning

Wrapping Up

Secular Ethics
Jewish Medical Ethics
How we do ethics?
Dignity In Care Model
Managing Pain in a Palliative Care Setting

John F. McGreevey, Jr., MD

Objectives:

1. Discuss how to recognize patterns of pain.
2. Discuss how to assess pain.
3. Discuss the problems of chronic pain.
Managing Pain in a Palliative Care Setting

John McGreevey, MD
Hospice of Northwest Ohio

Key Points
- Recognizing Patterns of Pain
- Assessing Pain
- The Problem of Chronic Pain
- Approaches to Treatment

What Kind of Pain?
- Nocioceptive pain
  - Telling you that something is wrong.
- Non-nocioceptive
  - Relates to dysfunction of the pain system.
- Cancer pain is often of more than one type.
What Kind of Pain is It?

- Somatic Pain
  - Described as aching, deep pain
  - Example - musculoskeletal (bone mets), soft tissue pain, inflammatory pain

What Kind of Pain is It?

- Visceral Pain
  - Cramping, tightness, pressure
  - May radiate
  - Organ related - Mixed pattern
    - Distension of viscus (Biliary colic, bowel related, urinary tract related)
    - Inflammation (peritonitis) -
      - Pleural, pericardial, meningeal ?
    - Ischemic (angina)

What Kind of Pain is It?

- Neuropathic Pain
  - Burning, shooting, radiating pain
  - May be associated with sensory sx. (paresthesia, numbness, hyperalgesia)
  - Can be to direct nerve root involvement (spine mets), systemic/toxic effect (chemotherapy, diabetes) or chronic changes.
Pain Assessment - Key Points

- Simple scales with regular use are helpful.
  - Visual analog, 1-10 scale, mild moderate severe
  - May help with goal setting.
- Scales should be completed by the patient.
- Many factors may influence pain.
  - Psychosocial and spiritual pain.
  - Gyn. cancers and body image.
  - Meanings of pain.
  - Impact of pain.
  - Reactions to pain.

Spiritual Dimensions of Pain

- Forgiveness Issues
- Relationship Issues
  - Loss of Meaning
  - Loss of Hope

From Groves and Klauser – The American Book of Living and Dying

Pain Assessment

- Is this a new pain or new pattern of pain?
- Is this an acceleration of pain?
- Is this a pain that was previously controlled?
- Do we know the cause of this pain?
Spiritual Dimensions of Pain

- Forgiveness Issues
- Relationship Issues
  - Loss of Meaning
  - Loss of Hope

From Groves and Klauser – *The American Book of Living and Dying*

Recognizing Pain in the Uncommunicative Patient

- Most useful observations:
  - Facial expressions - frowning, grimacing
  - Vocalizations - crying out, moaning
  - Other signs
    - Labored breathing
    - Rigid, knees pulled up
    - Inability to be consoled

Pain Assessment - Dispelling Misconceptions

- Severe pain does not necessarily affect vital signs.
- Not everyone in pain shows outward signs or expresses pain.
- Avoid thinking “They shouldn’t be in that much pain.”
- Patients in severe pain can fall asleep.
Opioids in Pain Management

- Start with short acting easily titrated medication. Morphine is best in most situations.
- Typical breakthrough dose is 10% of total daily dose.
- Titrate scheduled dose by 25-50% depending on situation.
- Watch the acetaminophen dose (Vicodin, Percocet)

Addressing opioid fears

- Realistically discuss side effects and responses to side effects.
- Opioids do not hasten death and they don’t mean death is near.
- Explain the differences between dependence, pseudoaddiction and addiction.

Equianalgesic Doses - Opioid Switching

- 30 mg of oral morphine equals
  - 130 mg. of oral codeine
  - 30 mg. of oral hydrocodone
  - 20-30 mg. of oral oxycodone
  - 7.5 mg of hydromorphone (Dilaudid)
  - 10 mg. of parenteral morphine
  - 1.5 mg. of parenteral hydromorphone
- Reference – www.ohiopaininitiative.org
Equianalgesic Doses - Opioid Switching

- An easy approximation for fentanyl patches is that a 25 mcg. patch delivers about 50 mg morphine equivalent per day.
- When switching from a med that a person has been on for a while, cross-tolerance may be incomplete. Therefore, reduce the dose by 1/3 and titrate from there.

Unique drugs - Methadone

- Advantages
  - Neuropathic pain
  - Lower abuse potential
  - Use in neurotoxicity
  - Use in renal failure
- Disadvantages
  - Unusual kinetics - delayed effects
  - Slow titration q4-5 days.
  - Drug interactions

Adverse effects of opioids

- Nausea
  - Is it the disease?
  - How severe is it?
  - Is the patient constipated?
  - Consider a switch
Opioid Induced Constipation

- Stay ahead of it.
- Start with a natural stimulant with stool softener, e.g. Senekot S (senna with docusate).
- Can use high doses but watch for cramping.
- Second choice Bisacodyl po or suppository.
- Osmotics are good if fluid intake is adequate. Caution with saline laxatives and enemas.
- Use a suppository or possibly an enema if three days without a bowel movement.

Additional opioid side effects

- Sedation and CNS changes
- Respiratory depression
- Myoclonus
- Opioid neurotoxicity
- Pruritis vs. allergy

Pain Management Adjuvants - Somatic Pain

- NSAIDS
  - Especially good for bone and inflammatory pain
  - Significant side effects
    - Cardiac, renal, GI
- Corticosteroids
  - antiinflammatory not analgesic
  - appetite stimulation
  - Efficacy for neuropathic pain
  - Lots of side effects
- Bisphosphonates - Bone mets
  - Main value is in preventing fractures.
Pain Management adjuvants

- Anticonvulsants for neuropathic pain
  - gabapentin 300-3600 mg./day or pregabalin 50 - 300 mg./day
  - renal dosing required
  - side effects sleepiness, visual disturbance, gait disturbance
  - additional anticonvulsants - dilantin, valproic acid, carbamazepine, clonazepam

Pain Management adjuvants

- Antidepressants for neuropathic pain
  - SSRI’s not effective
  - Tricyclics well studied. Consider nortriptyline or desipramine - better side effect profile.
  - Newer drugs venlafaxine and duloxetine are also effective
  - Emerging role for mirtazepine.

Additional therapies

- Physical therapy, massage therapy
- Relaxation, meditation, guided imagery
- Music therapy, art therapy
- Radiation therapy
- Radiofrequency ablation
- Acupuncture, TENS units
When things aren’t working

- Review the meaning of the pain - Consider spiritual pain.
  - Disease may rob or give meaning.
- Is the drug being taken?
  - Diversion, fear of drug.
- Is the drug being absorbed and delivered?
- Is neurotoxicity an issue.
- Has the disease process changed?
  - Obstruction, spinal cord compression, peritonitis, bleed.

Why is Chronic Pain Different?

- Chronic pain may be unrelated to the pathology that originally produced it.
  - The pain becomes the disease instead of the symptom.
- Patients may have had adversarial relationships in the health care system.
- There are no signs to support the presence of pain.
- There may be secondary gain to the pain.
- Treatment approach is different.

Efficacy of Opioids for Chronic Pain

- Most suggest efficacy at improving pain (about 40%) but not eliminating pain.
  - Important for goal setting
- Neuropathic pain responds to opioids.
- Some studies suggest improvement in function.
- Side effects are an issue but manageable to most patients.
- Long term data is limited.
Treating Pain in Older Adults

- Scheduled meds may work better for patients in long term care and difficulty reporting symptoms.
- Goals and outcomes vary for acute and chronic pain.
- Remember non-pharmacological therapies.

Treating Pain in Older Adults

- Frequently underlying musculoskeletal and neuropathic pain
- Aggravated by mobility and positioning issues
- May present with agitation.
  - Need to rule out acute processes when appropriate.
  - May need a trial of analgesics.

Questions ?
Beyond Safety and Symptom Management: Interdisciplinary Care Planning that Supports the Desires and Goals of the Persons We Serve

Maureen Cervenec, MEd, LPC

Objectives:
1. Identify practices that can inhibit an adequate assessment of client desires and goals.
2. Discuss methods for interdisciplinary collaboration that can enhance a primary focus on the desires and goals of the person we serve.
Beyond Safety and Symptom Management

Interdisciplinary Care Planning that Supports the Desires and Goals of the Persons We Serve

Maureen Cervenec LPC
Hospice of Northwest Ohio
February 27, 2015

Objectives

• Identify practices that can inhibit an adequate assessment of client desires and goals

• Discuss methods for interdisciplinary collaboration that can enhance a primary focus on the desires and goals of the persons we serve.

Palliative Care Consultations

Usually in response to:

• Physical symptoms that are difficult to control

• Functional limitations
Provider Focus

• Symptom management

• Support optimal functioning within the limits of the disease process

• Safety

Symptom Focused Treatment

• May be sufficient

• However, frequently does not touch the deeper levels of suffering that can accompany a chronic debilitating or terminal condition

Thoughtful consideration for the human who is experiencing the symptoms
The Interdisciplinary Focus

- Physician and / or Nurse practitioner
- Nurse
- Social Worker
- Spiritual Caregiver
- Others

each discipline looks through a slightly different lens

“How are you within?”

Dame Cicely Saunders
What Else Hurts?

What else is contributing to the patient’s DIS-EASE

• Practical support with problem solving
  - Insurance questions / anxieties
  - Navigating the healthcare system
  - Information / education related to disease process
  - Community resources
  - Family or caregiver concerns

What Else Hurts? cont.

• Emotional concerns, fear, anger, depression related to disease process, prognosis, quality of life, relationship strain

• Spiritual concerns or deeper questions related to making meaning of their life circumstance – forgiveness, hope, relatedness.

How are you within?
Quality of Life

- Patient goals / desires
- Optimal functioning given the limitations of the condition
- What gives meaning to the individual?

Tragic Gap

The distance between what is and what could be

(Parker Palmer)

Without Exploring the Gaps

- Resignation / Cynicism
- Unrealistic Optimism/Denial
Who Am I Now?

- Grief / loss
- Disability – What is my contribution?
- Loss of independence
- Impact to relationships
- Future plans disrupted
- Fear of being a burden
- Opportunities for growth and development

The IDT needs to be skilled with facilitating clarifying conversations

_to the degree that the patient desires_ –

- We invite the patient to explore his / her goals, desires, values, life meaning
- Resist the desire to rescue the patient from her reality
- Support the possibility for optimal wellness and personal growth

Goals of Care

- Result from effective assessment
- Understanding patient desires
- Collaborative conversation with patient, and amongst IDT members
- Patient driven
- Creative interventions
Relationships of Integrity

- Facing the tough questions
- Engaging and empowering the patient
- Skill and courage in our conversations
- Interdisciplinary care planning - communication, mutual respect

References

Meeting the Supportive Needs of Caregivers

Todd L. Sobol, MD, CMD, FACP

Objectives:

1. Develop an understanding of the Caregivers perspective.
2. Identify and assess caregivers strain.
3. Develop intervention strategies.
Meeting the Supportive Needs of Caregivers

Todd Sobol, MD, CMD, FACP
Senior Medical Director
Optum CarePlus

Disclosures- Dr. Todd Sobol
• Dr. Sobol has no disclosures at this time.

Objectives
• Develop an Understanding of the Caregiver Perspective
• Identification and Assessment of Caregiver Strain
• Develop Intervention Strategies
Introduction

• By the year 2030, an estimated 20 percent of the U.S. population will be 65 years or older.¹
• Gains in life expectancy accompanied by longer periods of disability²
• Providing care for disabled older adults erodes the physical and psychological health of Caregivers, “The Hidden Patient”³

². Finkel, 1992
³. Anheshensel et al, 1995; Fengler et al, 1979

Introduction

• 80-85 percent of persons with dementia are cared for by family members in their homes¹
• Most caregivers are older spouses or middle-aged grown up children¹
• Caring for someone with dementia is associated with a higher level of stress than caring for someone with functional impairment from another type of chronic illness²


Introduction

• Persons with Alzheimer's disease required an average of 70 hours of care per week, with 62 of those hours provided by the primary caregiver²
• Nursing Home admission does not necessarily improve caregiver well being²
• Depression research in Caregivers focuses on depressive symptoms rather than clinical depression³

Patient Case Presentation

• David is a 75 year old man who came for an evaluation. His chief complaint is forgetfulness
• 3 years of memory problems, worse in the past 8 months
• Asks questions repeatedly
• Trouble remembering details about an event
• During the past 8 months, David has frequently been getting lost

Functional Assessment

• Difficulty with household chores but can cook with the microwave
• Cannot balance his checkbook
• Frequently gets lost while driving near home
• Attends to personal hygiene and dresses himself daily
• David received screening laboratory tests, a head CT scan, and neuropsychiatric testing, and a diagnosis of mild dementia of Alzheimer’s type was made.

Education

• Steps to consider for David’s wife, who is his primary caregiver:
  a.) Provide her with education on AD and support resources available to her
  b.) Discuss David’s treatment options, disease trajectory and provide realistic expectations for his outcome
  c.) Develop a good therapeutic alliance to improve David’s outcome and treatment adherence
  d.) Who will support the caregiver?
Behavioral Problems Associated With Dementia That Cause Stress in Caregivers

- Psychosis
- Agitation
- Aggression
- Depression
- Anxiety
- Insomnia
- Wandering
- Disinhibition

“How much of a mental, emotional, physical and financial strain is it on you to either provide the help directly or to arrange for help to be provided for your spouse or parent?”

Caregivers in United States

- Definition- Anyone who provides assistance to someone else who is incapacitated and needs help.
- Informal Caregivers: Unpaid individuals eg. Family members and friends who provide care
- Formal Caregivers: Volunteers or paid individuals associated with a service system
### Who Are the Caregivers?

- Most of the patients live at home and are cared for by family and friends.
- 60% are women
- 51% are over 50 years of age
- 37% are the sole providers
- 57% are children of the patient
- 6%-23% are spouses
- Remainder are close family members or friends

### Changing Family and Social Structure

- Longer Lifespan
- Treating patients with Multiple disabilities
- Increase female employment
- Decline in two parent family and migration of children has increased number of placements in LTC facilities.
- Influences of Cultural Constructs and Values regarding Caregiving

### 2015 Ohio Medicaid Financial Standards for Long Term Care

- The Medicaid program helps pay for long term care (nursing home, assisted living, or in-home care) for many seniors. The Medicaid rules allow the patient and the patient's spouse to keep certain amounts of their savings and certain amounts from their monthly income. As of January 2015, Ohio's Medicaid program allows the following amounts:
  - Savings patient can keep: $1,500
  - Savings spouse at home can keep: $23,844 - $119,220
  - Monthly income patient can keep: $50
  - Monthly income allowance for spouse: $1,967 - $2,981
  - Monthly housing allowance for spouse at home: $590
  - Monthly utility allowance for spouse at home: $498
  - What Medicaid pays nursing homes each month: $6,327
  - Limit on equity in home: $552,000
Family Reactions to Stress of Caregiving

- **Denial**
  - Initial response that nothing is wrong; false hopes of cure for patient
- **Over involvement**
  - Attempts to compensate for illness
- **Anger**
  - Attempts at compensation have failed and burden takes its toll
- **Guilt**
  - Often when patient can no longer be cared for at home
- **Acceptance**
  - Comes from a full understanding of the disease and its effect on the family

Signs and Symptoms of Caregiver Stress

- Denial
- Social withdrawal
- Depression
- Sleeplessness
- Lack of concentration
- Anger
- Anxiety
- Exhaustion
- Irritability
- Health Problems
- Delay Self Care

STRESS ~ BURNOUT
Consequences of Stress/ Burnout

- People who were depressed had health expenditures 70% > average.
- People who were stressed had health expenditures 46% > average.
- Comparison:
  - Diabetes 35% > average
  - Obesity 21% > average
  - Smokers 20% > average

Potential Consequences of Burnout:
- Substance abuse
- Depression
- Loss of significant relationships
- Lack of enjoyment in life


Burnout: Key Elements

- Emotional Exhaustion
- Withdrawal
- Low Self-esteem
- Depersonalization and Detachment
- Ineffectiveness

Ineffective Burnout Strategies

- Working harder and harder and harder
- Isolation from family and friends
- Blaming oneself for lack of improvement
- Drinking and Drugs
Physician Distress

- 30-50% Experience Burnout Over Career
- 1.5% of Physicians Develop Drug Addiction
- 8-10% of Physicians are Alcoholic
- High Incidence of Anxiety and Depression
- 200 Physician Suicides per Year

Drivers for Physician Burnout

- Manage Emotionally Difficult Patient Decisions
- Tendency to Over-Commit
  - Try to Meet Patient and Family Needs
  - Programs Grow Beyond Staffing
- Physicians have Difficulty Setting Limits
- Provider Strengths may also be Their Vulnerabilities

Strategies for Managing Stress

- Take Time Away from Work
- Work Smart
  - Determine What Parts of Workday Provide Limited Return on Time Invested
  - Write Concise Notes
- Address One Task at a Time
  - Turn off the Beeper/Cell Phone When Interviewing Patients
- Delegate
### Family Care: Outcomes

#### Psychosocial
- Burden
- Depression
- Anxiety
- Decrease self-efficacy
- Poorer subjective well-being & QOL

#### Physiological
- Increased Stress
- Hormone
- Dysregulated immune function
- Cardiovascular reactivity
- Impaired metabolic function

---

### Family Care: Outcomes

- **Health Behaviors**
  - Poor Diet
  - Reduced Exercise
  - Lack of Sleep
  - Lack of Activity

- **General Health**
  - Poor self-reported health
  - Increased symptom reports
  - Increased medication use
  - Increased service utilization
  - Mortality

---

### Influence of Caregiving on Lifestyle and Psychosocial Risk Factors Among Family Members...

- **Aggarwal et al., 2008**

- The purpose of this study was to determine the prevalence and predictors of caregiver strain and evaluate the association between caregiving and cardiovascular disease lifestyle and psychosocial risk factors among family members.

- Participants in the NHLBI Family Intervention Trial for Heart Health who completed a 6-mth follow-up were included in the analysis.
  - N=263
  - Mean age: 50 years
  - Female: 67%
  - Non-white: 29%
• Measures: Caregiver Strain Index, Beck Depression Inventory, Behavioral Risk Factor Survey, MEDFICTS dietary assessment tool
• The results showed that mean caregiver strain scores were significantly higher among those with depressive symptoms and low social support.
• Caregivers may be at increased risk themselves for CVD morbidity and mortality compared to non-caregivers due to suboptimal lifestyle and psychosocial factors.

Caregiving as a Risk Factor for Mortality: Results
• 56% reported having “Caregiver strain”
• Overall 103 (12.5%) died at 4 years
• Likelihood of dying
  - 1.4 times greater in those not helping with their disabled spouse
  - 1.2 times greater in those helping a disabled spouse but not reporting any strain with the caregiving
  - 1.6 times greater in those helping a disabled spouse but reporting strain with the caregiving
• Being a caregiver with mental or emotional strain is indeed a risk factor for earlier death


Spousal Caregivers of Patients with Alzheimer’s Disease Show Longitudinal Increases in Plasma Level of Tissue-Type Plasminogen Activator Antigen
Mausbach et al., 2007

• The objective of this study is to determine if caregivers of spouses with AD demonstrate greater increase in tissue plasminogen activator relative to noncaregiving controls. t-PA is associated with the development of CVD.
• Annual in-home assessments of plasma t-PA antigen were collected over 5 years.
• Participants were married, living with their spouses, at least 55 years of age, and free of serious medical conditions (e.g. cancer)
  - N= 185
• Caregivers demonstrated greater increases in t-PA antigen of the 5 year Study compared to noncaregiver controls.
• The accelerated rate of developing a prothrombotic environment including elevated t-PA antigen may provide one mechanism by which caregiving is associated with greater morbidity and mortality and the development of CVD.
Care Receiver’s Impairments

• Strong association between Caregiver outcomes and Care Recipient
  - Presence of Behavioral Problems
  - Level of Physical Impairment
  - Level of Cognitive Impairment
• Care recipient’s physical impairment and behavioral problems strongly related for Spouse Caregiver than Adult Child Caregiver


Caregiver Involvement

• Strong association between Caregiver outcomes and Caregiver involvement
  - Amount of Care Provided
  - Duration of Care giving
    - Wear and Tear
    - Adaptation
    - Traits
  - Caregiver Burden associated with # of Caregiver tasks and level of physical impairment of Caregiver


Caregiver Case Presentation

• Karen is a 55 year old woman living in Ohio with her husband and adult son.
• Karen’s mother was diagnosed with dementia one year ago and her symptoms have been getting increasing worse over the past 6 months.
• Karen’s father is 82 years old and often needs help with his wife. Karen sees it has her responsibility to be the primary caregiver to her ailing mother.
Karen finds herself staying overnight at her parents house many nights a week. She is often exhausted from a night of caretaking, and her performance at work suffers.

As her mother condition continues to rapidly decline, Karen decides to cut back her work schedule to part time hours.

Karen is not sleeping or eating properly. She finds herself feeling lonely and depressed.

Why Family Members Decline Help from Resources?

- Care giving is a privilege
- No one else can do the job as well as you
- Have more time and energy for the task than anyone else
- Feels like shirking your responsibility leading to guilt
- Made a commitment, and making any change would feel like breaking it
- Begun to define yourself solely as a caregiver

Causes of Caregiver Burnout

- Role Confusion
- Unrealistic expectations
- Care-giving is “EASY”
- Lack of Control
- Unreasonable demands
Suggested Screening Questions for Assessing Caregiver Burden in Office

- Do you feel that you are currently under a lot of stress?
- What aspects of your day are the most stressful?
- Have you been feeling down or blue lately?
- Have you been feeling more anxious and irritable lately?
- Do your family and friends visit often?
- Does your family telephone often?
- Do your friends and family watch your relative for you so that you have time for yourself?
- Do you have any outside help?
- Is your relative with dementia having any behaviors, such as wandering, that are difficult to manage?
- What do you do to relieve your stress and tension?

The “Zarit Burden Interview”

- Most widely referenced scale in studies of caregiver burden
- Not designed for use in practice
- Demonstrates the scope of issues to consider when assessing caregiver burden
- 22 questions, 0 to 4 points, high score correlates with higher caregiver burden
- Interpretation of Score:
  - 0 – 21 little or no burden
  - 21 – 40 mild to moderate burden
  - 41 – 60 moderate to severe burden
  - 61 – 88 severe burden

Zarit Burden Interview

- Please circle the response that best describes how you feel.
  - Never
  - Rarely
  - Sometimes
  - Quite Frequently
  - Nearly Always
- **Score:**
  - 0
  - 1
  - 2
  - 3
  - 4
- 1. Do you feel that your relative asks for more help than he/she needs?
- 2. Do you feel that because of the time you spend with your relative that you don't have enough time for yourself?
- 3. Do you feel stressed between caring for your relative and trying to meet other responsibilities for your family or work?
- 4. Do you feel embarrassed over your relative's behaviour?
- 5. Do you feel angry when you are around your relative?
- 6. Do you feel that your relative currently affects our relationships with other family members or friends in a negative way?
- 7. Are you afraid what the future holds for your relative?
- 8. Do you feel your relative is dependent on you?
- 9. Do you feel strained when you are around your relative?
- 10. Do you feel your health has suffered because of your involvement with your relative?
11. Do you feel that you don’t have as much privacy as you would like because of your relative?
12. Do you feel that your social life has suffered because you are caring for your relative?
13. Do you feel uncomfortable about having friends over because of your relative?
14. Do you feel that your relative seems to expect you to take care of him/her as if you were the only one he/she could depend on?
15. Do you feel that you don’t have enough money to take care of your relative in addition to the rest of your expenses?
16. Do you feel that you will be unable to take care of your relative much longer?
17. Do you feel you have lost control of your life since your relative’s illness?
18. Do you wish you could leave the care of your relative to someone else?
19. Do you feel uncertain about what to do about your relative?
20. Do you feel you should be doing more for your relative?
21. Do you feel you could do a better job in caring for your relative?
22. Overall, how burdened do you feel in caring for your relative?

Caring for the Caregivers

- Educate caregivers on disease progression1,2
  - Anticipate what to expect, especially lack of recognition
  - Needs change as stages progress
  - Discuss risk of delirium and plan of treatment
  - Discuss treatment options for end-stage dementia
    - Vegetative stage
    - Ongoing medication use
    - Hospice in the NH

Caring for the Caregivers

- Gentle persuasion
- Be an empathetic physician
- Permission instead of Commands
- Enlist the ill loved one
Caregiver Burnout: Prevention

- Prioritize issues
- Recognize cycles in the adjustment process
- Identify feelings
- Talk with others
- Create a "SPACE" for self
- Share moments
- Find and Embrace Humor
- Seek independence
- Promote competence
- Know yourself: How to cope with change?

Handout for Caregivers: How to Prevent Burnout?

- Find someone you trust -- such as a friend, co-worker, or neighbor -- to talk to about your feelings and frustrations.
- Set realistic goals, accept that you may need help with care giving, and turn to others for help with some tasks.

How To Prevent Burnout?

- Be realistic about your loved one's disease, especially if it is a progressive disease such as Parkinson's or Alzheimer's.
- Don't forget about yourself because you're too busy caring for someone else. Set aside time for yourself, even if it's just an hour or two. Remember, taking care of yourself is not a luxury. It is an absolute necessity for caregivers.
- Talk to a professional. Most therapists, social workers, and clergy members are trained to counsel individuals dealing with a wide range of physical and emotional issues.
How To Prevent Burnout?

• Take advantage of respite care services. Respite care provides a temporary break for caregivers. This can range from a few hours of in-home care to a short stay in a nursing home or assisted living facility.
• Know your limits and do a reality check of your personal situation. Recognize and accept your potential for caregiver burnout.
• Educate yourself. The more you know about the illness, the more effective you will be in caring for the person with the illness.

How To Prevent Burnout?

• Develop new tools for coping. Remember to lighten up and accentuate the positive. Use humor to help deal with everyday stresses.
• Stay healthy by eating right and getting plenty of exercise and sleep.
• Accept your feelings. Having negative feelings -- such as frustration or anger -- about your responsibilities or the person for whom you are caring is normal. It does not mean you are a bad person or a bad caregiver.
• Join a caregiver support group. Sharing your feelings and experiences with others in the same situation can help you manage stress, locate helpful resources, and reduce feelings of frustration and isolation.

Resources for Caregivers

• Private Care Aides
• Home Health Services
• Agency of Aging
• Caregiver Support Services
• Adult Day Centers
• Assisted Living Facilities
• Nursing Homes
• National Organizations
• Local Senior Citizens Centers
• Respite Services
• Church Programs
• Support Groups
Other Resources

- American Association of Homes and Services for the aging
  - www.aahsa.org
- ARCH National Respite Network
  - www.archrespite.org
- Friends' Health Connection
  - www.friendshealthconnection.org
- National Association for Home Care and Hospice
  - www.nahc.org
- National Association of Area Agencies on Aging
  - www.n4a.org
- National Association of Professional Geriatric Care Managers
  - www.caremanager.org
The Role of Rehabilitation In Palliative Care
Michelle M. Masterson, PT, PhD

Objectives

1. Discuss the role of PT and OT in the palliative care setting.
2. Explain the importance of movement and mobility at the end of life.
3. Describe non-pharmacological interventions for pain control.
The Role of Rehabilitation in Palliative Care

Michelle Masterson, PT, PhD
Chair, Department of Rehabilitation Sciences
Director, Doctor of Physical Therapy Program
College of Health Sciences

OBJECTIVES

Discuss the role of PT and OT in the palliative care setting

Explain the importance of movement and mobility at the end of life

Describe non-pharmacological interventions for pain control

REHAB AND PALLIATIVE CARE

Michelle’s Story...

In memory of Roger Clark
AND NOW FOR THE...

“Knowledge” stuff, but first:

- How many PT’s in the audience? OT’s? SLP’s?
- How many PM&R physicians?
- How many of you are currently involved in palliative care?
  - Interdisciplinary or multidisciplinary?
- How many “non-rehab” people consult with/refer to PT? OT? SLP?

WHAT IS PT?

- Physical Therapy...
  - helps individuals maintain, restore, and improve movement, activity, and functioning, thereby enabling optimal performance and enhancing health, well-being, and quality of life.
  - prevents, minimizes, or eliminates impairments of body functions and structure, activity limitations, and participation restrictions.

Therefore, role in palliative care is...
  - 126 hits in CINAHL

WHAT IS OT?

- Occupational Therapy...
  - helps people of all ages participate in the things they want and need to do through the therapeutic use of everyday activities (occupations).
  - helps people function in all of their environments and addresses the physical, psychological, and cognitive aspects of their well-being through engagement in occupation.

Therefore, role in palliative care is...
  - 94 hits in CINAHL
**WHAT IS SLP?**

Speech Language Pathology...
- Helps individuals with speech, language, social-communication, cognitive-communication, and swallowing disorders.
  - Speech disorders = difficulty producing speech sounds correctly or fluently
  - Language disorders = difficulty understanding others or sharing thoughts and feelings
  - Social communication disorders = difficulty with the social use of verbal and nonverbal communication.
  - Cognitive-communication disorders = difficulty organizing thoughts, paying attention, remembering, planning, and/or problem-solving.

Speech Language Pathology also...
- Provides augmentative and alternative communication systems for individuals with severe expressive and/or language comprehension disorders.

Therefore, role in palliative care is...
- xxx hits in CINAHL

**SUPPORTING EVIDENCE**

The Joint Commission “Speak UP”
- Questions to consider about your serious illness and palliative care (just a few):
  - Do you have any symptoms that are bothering you right now?
  - What can we do to make you more comfortable?
  - What gives meaning to your life?
  - How would you like to spend your time among work, school, family, hobbies, and other activities?
SUPPORTING EVIDENCE

**E. Barawid, DO & N. Covarrubias, MD**
Dept. of PM&R, University of CA, Irvine Medical Center

**B. Tribuzio, DO & S. Liao, MD**
Dept. of Palliative Care, University of CA, Irvine Medical Center


---

### IN BARAWID et al.

- 85% of patients with terminal cancer want to walk or move about in a wheelchair
- Poor exercise and nutrition were related to 30% of total cancer deaths
- Significant improvement in feeding independence after OT for patients with end-stage cancer
- Psychological suffering was significantly alleviated by rehabilitation
- Physical activity may be enough to reduce cognitive decline
- 30-40% reduction in risk of hospital admissions and respiratory mortality for those with COPD with consistent physical activity

---

### IN JAVIER & MONTAGNINI

- 56% of patients in palliative care had improved ADL scores within 2 weeks of initiating PT
- Significant improvement in 200 patients with cancer in motor and cognitive function after in-patient rehab
- 28 day exercise program improved fatigue, anxiety, and QOL for patients in hospice
- 6 week structured exercise program improved physical performance, fatigue, and QOL for patients with cancer in hospice and palliative care

"The bottom line… regardless of diagnosis, the goal for all patients receiving palliative care should be to maintain their QOL (quality of dying?) and to maximize their function in accordance with the patient and family’s priorities.”

PT INTERVENTIONS

For movement, mobility, and function:

- Exercise for strength, flexibility, balance, aerobic capacity (endurance)- make it all functional, consider intensity
- Musculo-skeletal-neurologic techniques to facilitate muscle function and length, improve joint motion, reduce muscle spasm and/or hypertonicity- consider effect of therapeutic touch

PT does NOT mean physical torture.
No pain CAN result in gain.

For movement, mobility, and function:

- Teach/assist patient to move as independently as possible (vs. “do for them”)
  - Bed mobility, transfers, standing, walking
  - “Reverse Rehabilitation” (Briggs)
- Teach family how to assist patient
- Evaluate for and instruct in assistive devices and home modification

Barawid et al., 2015; Javier & Montagnini, 2011
OT INTERVENTIONS

- Teach/assist patient in self-care skills (skin, hygiene, dressing, etc.)
- Evaluate physical, emotional, and cognitive abilities and make recommendations to allow participation in important life roles:
  - Energy conservation and managing fatigue
  - Engaging in/modify leisure activities and hobbies
  - Developing coping strategies

AOTA. The role of occupational therapy in end-of-life care. *AJOT* 65(suppl.3):S66-S75; 2011; Javier & Montagnini, 2011; Barawid et al., 2015.

OT INTERVENTIONS

- Therapeutic exercise embedded in meaningful and purposeful occupations
- Evaluate and determine compensatory strategies and adaptive equipment for self-care skills- consider ability to be independence, self-worth/esteem, maintaining a sense of control
- Home/environmental modification
- Family/caregiver education

AOTA, 2011; Javier & Montagnini, 2011; Barawid et al., 2015.

SLP INTERVENTIONS

- Enhance communication, understanding, and decision making ability among patient, family, and health care team
  - Evaluate cognitive processing
  - Evaluate ability to receive and express information
  - Determine the need for augmentative and alternative communication systems
- Optimize function related to oral motor function to improve patient comfort and to promote positive feeding interactions

Barawid et al., 2015; Javier & Montagnini, 2011.
REHAB INTERVENTIONS

**For pain management:**
- Neuro-inhibitory techniques
- Modalities
- Movement (passive and active)
  - ROM within N-M-S limitations (PNF patterns)
- Functional skills
  - ADLs, bed mobility, positioning, posture, transfers, standing, gait
  - Engaging in meaningful occupations and communication
- Environmental modifications

BARRIERS TO REHAB

- Availability of therapists/clients?
- Scheduling? (logistics/coordination with team)
- Who is the team? (Knowledge of each other’s role, knowing when to consult/refer)
- Reimbursement?
- Lack of evidence? (Need for appropriate outcome measures)

OTHER STORIES...

- Coach R who wanted to dance with his daughter at her wedding
- Mr. S who wanted to sit at the dining room table with his family once last time for Thanksgiving dinner
- Mrs. C who wanted to walk to the bathroom by herself
- Mr. J who wanted to be able to get out of bed to the chair by himself in the middle of the night to read his bible
IN SUMMARY

“Loss of independence and role can result in social death prior to biological death.”
(Kaye, P. Notes on Symptom Control in Hospice and Palliative Care. Machiasport, ME: Hospice Education Institute, 2006.)

It takes a TEAM!

- There may be overlap in our skill sets,
- But we must provide what each unique profession can offer to the patient, when appropriate,
- This is patient-centered care!

Thank you!