Objectives

• Understand the importance of prognostication
• Gain a different perspective on quantity of life vs. quality of life
• Know four points to build a framework of care
• Practice complex reflection
Core idea

- Build rapport
- Gather information

Framework

- Identify patient
- Estimate prognosis
- Define goal
  - Value
- Plan of care
  - “Strong opinions, lightly held”
Quantity vs Quality

- Quantity
  - Fear of abandonment
  - Fear of unknown
- Quality
  - Fear of pain

Value = Quality / Cost
Mrs. C. is an 85-year-old widowed homemaker with Alzheimer’s disease who was recently admitted to a nursing home following a hip fracture three months ago. That event was complicated by delirium and a congestive heart failure (CHF) exacerbation. Her ejection fraction showed moderate systolic dysfunction (35%). She also has hypertension, osteoporosis, and asymptomatic coronary artery disease. Although no longer able to walk, she has fairly preserved language skills and can assist with transfers and most activities of daily living. She does not have the capacity to discuss most of the medical treatment decisions, and defers to her daughter as her surrogate. She has lost 20 lbs. over the last two years (10 lb. in the last year) and weighs 174 lbs. Her daughter thinks her mother is nearing the end of life and asks whether her mother is eligible for hospice.

Your next step in management is:

1. Refer to hospice
2. Prescribe an appetite stimulant
3. Review the POLST form
4. Discuss prognosis
5. Remind daughter, only one problem per visit


An 89-year-old male nursing home resident with a 10-year history of Alzheimer’s disease presents with a temperature of 37.8°C, a productive cough, and a respiratory rate of 24 breaths per minute. Nurses report that for the past 6 months he has been coughing at breakfast and having trouble swallowing. He has profound memory deficits, no longer recognizes his daughter (who is his health care proxy), is bed bound, is able to mumble a couple of words, and is unable to perform any activities of daily living.

Your next step in management is:

1. Refer to hospice
2. Start oral antibiotics
3. Review the POLST form
4. Discuss prognosis
5. Send to emergency department

### Primary hospice diagnosis, no. (%)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>National hospice</th>
<th>SCPMG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>10,883 (33.4%)</td>
<td>3,177 (52.5%)</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>3,656 (11.2%)</td>
<td>672 (11.1%)</td>
</tr>
<tr>
<td>Cerebrovascular</td>
<td>2,878 (8.8%)</td>
<td>145 (2.4%)</td>
</tr>
<tr>
<td>Dementia</td>
<td>6,721 (20.6%)</td>
<td>569 (9.4%)</td>
</tr>
</tbody>
</table>


SCPMG internal data

---

### Invalid Principal Diagnosis (August 22, 2014)

- Dementia, unspecified, with behavioral disturbance
- Vascular dementia
- Frontal lobe syndrome
- Debility
- Failure to thrive

Valid Principal Diagnosis

- Alzheimer’s dementia
- Lewy body dementia
- Parkinson’s dementia

Alzheimer’s Hospice Guideline

<table>
<thead>
<tr>
<th>FAST 7 or above</th>
<th>Aspiration pneumonia or</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to walk without assist</td>
<td>Pyelonephritis or</td>
</tr>
<tr>
<td>Unable to dress without assist</td>
<td>Sepsis or</td>
</tr>
<tr>
<td>Urinary and fecal incontinence</td>
<td>Multiple ulcers or</td>
</tr>
<tr>
<td>No meaningful conversation; &lt; 6 words</td>
<td>Recurrent fever after antibiotics or</td>
</tr>
<tr>
<td><strong>PLUS within 12 months</strong></td>
<td>&gt;10% wt loss, serum albumin &lt; 2.5 g/dl</td>
</tr>
</tbody>
</table>

Local Coverage Determination (LCD) for HOSPICE - Determining Terminal Status (L25678)
### Functional Assessment Staging (FAST)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Check highest consecutive level of disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>7a</td>
<td>Speaks less than 6 intelligible words</td>
</tr>
<tr>
<td>7b</td>
<td>Single intelligible word</td>
</tr>
<tr>
<td>7c</td>
<td>Ambulatory ability lost*</td>
</tr>
<tr>
<td>7d</td>
<td>Cannot sit up without assistance</td>
</tr>
<tr>
<td>7e</td>
<td>Loss of ability to smile</td>
</tr>
</tbody>
</table>


### Alzheimer’s Hospice Guideline

- Not evidenced based
- Common for patients that don’t meet guideline to die within 6 months


*Note: The asterisk (*) indicates a potential clinical significance or note of caution.*
Mitchell / Advanced Dementia Prognostic Tool (ADEPT)

• [https://eprognosis.ucsf.edu/mitchell.php](https://eprognosis.ucsf.edu/mitchell.php)

1. Has your patient been admitted to the nursing home in the past 90 days? Yes
2. How old is your patient? 85-89
3. What is the sex of your patient? Female
4. Does your patient have shortness of breath? No
5. Does your patient have at least one pressure ulcer that is greater than or equal to Stage 2? No
6. Is your patient totally dependent for all Activities of Daily Living, including feeding, toileting, and dressing? No
7. Is your patient bedbound most of the day? No
8. Does your patient have insufficient oral intake? Defined as not consuming almost all fluids in previous 2 days or at least 25% of fluid intake at most meals? Yes
9. Does your patient have bowel incontinence? No
10. Is your patient's BMP less than 16.5? No
11. Has your patient experienced recent weight loss? Defined as more than 5% body weight in prior 30 days or more than 20% in prior 180 days? Yes
12. Does your patient have congestive heart failure? Yes

Your predicted 6-month mortality: Risk of 6-month mortality: 28%

<table>
<thead>
<tr>
<th>Ability to predict 6 month mortality</th>
<th>LCD</th>
<th>ADEPT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.55</td>
<td>0.67</td>
</tr>
</tbody>
</table>

Prognostic clues

- Median survival for NH home patients was 1.3 years
- End stage dementia with pneumonia 53% 6-month mortality
- End stage dementia with hip-fracture 55% 6 month mortality

Morrison RS, Siu AL: Survival in end stage dementia following acute illness. JAMA 2000;284:47-52

Discussing prognosis

ADAPT

Ask
What have the doctors told you?

Discover
Is it ok to talk about the future? What plans do you have?

Anticipate ambivalence
Talking about the future can be scary

Provide info
From my knowledge of the situation, this is what we’re looking at...

Track emotion
I wish I had better news...
A 78-year-old male living at home with a 10-year history of Alzheimer’s disease presents with weakness. Daughter (who is health care proxy) reports for 6 months he has been coughing at breakfast and having trouble swallowing. He has lost 10# in 4 months (>10% wt loss). He used to walk up to 25 ft with a walker now he one person assist to walk 10 ft. He has profound memory deficits, no longer recognizes his daughter, is able to mumble a couple of words, and is unable to perform any activities of daily living.

His daughter understands his prognosis is poor and states that he wouldn’t want an attempted resuscitation if his heart stopped but she is asking if tube feeding would extend his life.

Your next step in management is:

1. Refer to hospice
2. Recommend tube feedings
3. Review the POLST form
4. Send to emergency department
5. Offer comfort care

Clinical course of advanced dementia

- **Eating problems (86%)**
- Febrile episodes (53%)
- Pneumonia (41%)
- Last 3 months of life (40.7%) burdensome intervention
- Mortality after 18 months (54.8%) N=323
Tube feeding

Advanced dementia, requiring assistance with feeds

| N=36492 | Median survival 177 days |
| TF 1957 (5.4%) | Insertion at 1 month | Insertion at 4 months |
| No change in length of survival |


Tube feeding

- Age and serum albumin related to 30d mortality
- Dementia and presence of PEG-related complications not related to 30d mortality
- High-calorie supplements, oral feedings help gain weight. No survival difference


Tube feeding

- No conclusive evidence of prolonging survival
- No conclusive evidence of improving quality of life,
- It may actually increase the risk of developing pneumonia due to inhaling small quantities of the feed and even death.

Sampson EL, Candy B, Jones L. Enteral tube feeding for older people with advanced dementia. Cochrane Database Syst Rev 2009

Discussing tube feedings

<table>
<thead>
<tr>
<th>PAUSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pause</td>
</tr>
<tr>
<td>Ask</td>
</tr>
<tr>
<td>Understand</td>
</tr>
<tr>
<td>Suggest</td>
</tr>
<tr>
<td>Empathy</td>
</tr>
</tbody>
</table>

VitalTalk 2017
60th Annual Raymond M. Kay, MD Internal Medicine Symposium
A 78-year-old male living at nursing home with a 10-year history of Alzheimer’s disease presents with weakness. Daughter (who is health care proxy) reports for 6 months he has been coughing at breakfast and having trouble swallowing. He has lost 10# in 4 months (>10% wt loss). He used to walk up to 25 ft with a walker now he one person assist to walk 10 ft. He has profound memory deficits, no longer recognizes his daughter, is able to mumble a couple of words, and is unable to perform any activities of daily living.

His daughter understands his prognosis is poor and states that he wouldn’t want an attempted resuscitation if his heart stopped but she is asking if antibiotics be helpful

Your next step in management is:

1. Refer to hospice
2. Offer antibiotics
3. Review the POLST form
4. Send to emergency department
5. Offer comfort care

Clinical course of advanced dementia

• Eating problems (86%)
• Febrile episodes (53%)
• Pneumonia (41%)
• Last 3 months of life (40.7%) burdensome intervention
• Mortality after 18 months (54.8%) N=323

Antibiotics

• 12-months 2/3 of patients have suspected infection
  • 72% treated with antimicrobials
  • 94.8% wanted “comfort”
  • 37.8% received counseling


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Antibiotics

• Primary outcome: survival vs symptom management

• Suspected pneumonia N = 225
  • 91% received antibiotics
  • all that received antibiotics improved survival
  • all that received antibiotics had worse symptoms


60th Annual Raymond M. Kay, MD Internal Medicine Symposium
Words matter

<table>
<thead>
<tr>
<th>Phrases to avoid</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stop</td>
<td>“What are your goals”</td>
</tr>
<tr>
<td>Stop</td>
<td>“It’s time for hospice”</td>
</tr>
<tr>
<td>Stop</td>
<td>“Do you want comfort care”</td>
</tr>
<tr>
<td>Stop</td>
<td>“He’ll probably die on the table”</td>
</tr>
<tr>
<td>Stop</td>
<td>“There’s nothing more we can do”</td>
</tr>
</tbody>
</table>

http://www.geripal.org/201003/maintaining-relationships-stop-using_09.html

Value

- What’s most important to you?
- What’s the most difficult for you?

Children JW1, Back AL1, Tulsky JA1, Arnold RMJ REMAP: A Framework for Goals of Care Conversations. Oncol Pract. 2017 Apr 26
An 89-year-old male receiving hospice support at home for Alzheimer’s disease presents with tachycardia and dark concentrated urine. His son understands his prognosis is poor and hope patient can remain home. He was started on oral antibiotics for presumed urinary tract infection but he has not improved.

The patient reaches in the air and and tries to climb out of bed.

The resident you’re working gives report and asks if he should prescribe risperidone or haloperidol.

Your next step in management is:

1. Smile, your resident isn’t recommending lorazepam
2. Suggest risperidone
3. Suggest haloperidol
4. Suggest lorazepam
5. Suggest non-pharmacological therapy
risperidone vs haloperidol

- Double-blind, parallel-arm, randomized clinical trial
- Oral risperidone vs. haloperidol vs. placebo
- Administered every 12 hours for 72 hours based on symptoms
- Supportive care
- Midazolam for severe distress or safety

## haloperidol + lorazepam

<table>
<thead>
<tr>
<th>RASS change</th>
<th>lorazepam + haloperidol</th>
<th>Placebo + haloperidol</th>
<th>Difference</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 30 min</td>
<td>-3.62</td>
<td>-1.62</td>
<td>-2.00</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>0 to 8 hours</td>
<td>-4.12</td>
<td>-2.27</td>
<td>-1.85</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>


### Polypharmacy

- 1 in 4 older patients hospitalized for medication related problems
- 30 - 50% of hospitalizations potentially reversible
- 18% of deaths attributable to Adverse drug reaction
- 44% of patients discharged with unnecessary drug

Drivers of polypharmacy

- Disease specific guidelines
- Guideline derived quality indicators, performance incentives
- Sensitivity of age discrimination
- Focus on treating acute disease
- Adverse drug effect seen as new disease


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Tool for identifying and discontinuing potentially inappropriate drugs.

1. Accurately ascertain all current drug use
   - 'brevet paper bag' medication reconciliation

2. Identify patients at risk of, or suffering, ADR
   - at risk: citi-medications advanced age (>75 years)
     - high-risk medications
     - assess for current, past or highly likely future toxicity

3. Estimate life expectancy
   - clinical prognostication tools or lifepro calculators

4. Define overall care goals
   - consider current functional status and quality of life with
     - preference to estimated life expectancy

5. Verify current indications for ongoing treatments
   - perform diagnosis-medication reconciliation
   - confirm diagnostic labels against formal diagnostic criteria
   - arrange for each confirmed diagnosis, drug appropriateness

6. Determine need for disease-specific preventive medications
   - estimate clinical impact and time to future treatment benefit
   - compare this estimate with expected lifespan

7. Determine absolute benefit-harm thresholds of medications
   - reconcile estimates of absolute benefit and harm using prediction
     - tools: (see http://www.mccabe.com)

8. Review the relative utility of individual drugs
   - rank drugs according to the relative utility from high to low based on
     - predicted benefit, harm, administration and monitoring burden

9. Identify drugs to be discontinued and seek patient consent
   - record drugs for discontinuation with patient preferences

10. Develop and implement drug discontinuation plan with close monitoring
Deprescribing

• Pubmed “deprescribing” -> 219 items
• 2007 - 2013 -> 17 items
• 2014 - 2017 -> 202 items

Identifying and discontinuing drugs when harms outweigh benefit
• Patient centered but with inherent uncertainties
• Shared decision making
• May be misconstrued as limiting therapy

Scott IA et al, Reducing inappropriate polypharmacy: the process of deprescribing. JAMA Intern Med. 2015 May;175(5):827-34
Process of deprescribing

• Is the patient actually taking the drug
• Does the drug fit with the patient’s circumstances
• Does the benefit outweigh the potential harm
• May be misconstrued as limiting therapy

Scott IA et al, Reducing inappropriate polypharmacy: the process of deprescribing. JAMA Intern Med. 2015 May;175(5):827-34

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Barriers of deprescribing

• Fragmented care, incomplete information
• Stopping a medicine that is in a clinical guideline
• Uncertainty of future
• Emotional connection

Scott IA et al, Reducing inappropriate polypharmacy: the process of deprescribing. JAMA Intern Med. 2015 May;175(5):827-34
Medicines patient’s like

• Warfarin
• Insulins
• Anti-platelet agents
• Oral hypoglycemic
• Opioids
• Antibiotics

Most common hospitalization for adverse drug event

• Warfarin
• Insulins
• Anti-platelet agents
• Oral hypoglycemic
• Opioids
• Antibiotics

Warfarin

• CHADS2
  • https://www.mdcalc.com/chads2-score-atrial-fibrillation-stroke-risk

• HAS-BLED
  • https://www.mdcalc.com/has-bled-score-major-bleeding-risk

Transitions

<table>
<thead>
<tr>
<th>REMAP</th>
<th>Reframe</th>
<th>“Given this information....”</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Emotion</td>
<td>“I can see you’re concerned...”, “Tell me more...”</td>
</tr>
<tr>
<td></td>
<td>Map future</td>
<td>“Given this, what’s important...” “What are your concerns in the future...”</td>
</tr>
<tr>
<td></td>
<td>Align</td>
<td>“It sounds like this is what’s important...”</td>
</tr>
<tr>
<td></td>
<td>Plan</td>
<td>“This is what we can do...”</td>
</tr>
</tbody>
</table>
Core idea

• Build rapport
• Gather information

Framework

• Identify patient
• Estimate prognosis
• Define goal
  • Value
• Plan of care
  • “Strong opinions, lightly held”
Questions:
earl.b.quijada@kp.org
Twitter: @equijada