Strategies in Establishing Patient Centered Pain Management Goals

Danielle Doberman, MD, MPH, HMDC
Medical Director, Palliative Medicine, Johns Hopkins Hospital
CME Statements

• Nurses: This session has been approved for 0.5 contact hours. Hospice & Palliative Care Network of Maryland is an approved provider of continuing nursing education by the Maryland Nurses Association, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation.
  – Note: MNA/ANCC does not endorse or approve any commercial products.

• Social Workers: The Maryland Board of Social Work Examiners certifies that this program meets the criteria for 0.5 credit hours of Category I continuing education for social workers in Maryland.
Disclosures

No Relevant Financial Relationships with Commercial Interests

No Conflicts of Interest

Danielle J. Doberman, MD, MPH, HMDC
Learning Objectives

• Determine strategies for developing appropriate pain management goals in older and end-of-life adults
• Define shared decision making
• Discuss the “best-case, worst-case” paradigm for discussing treatment options with patients
Case: In clinic, Judy 69 y/o Widow

- H/o osteoarthritis, cardiomyopathy. EF 30% and depression.
- In clinic for acute on chronic low back pain after helping friend move.
- When seen 2d prior at Urgent Care, given cyclobenzaprine and hydrocodone/acetaminophen and told she had a compression fracture.
Case: In clinic, Judy 69 y/o Widow

- Normally sees your partner.
- Does yoga, swims and sees chiropractor regularly
- States she is fearful of trying either drug given her “weak heart” and “issues with things in the past.”
- Med List: Lisinopril, metoprolol, sertraline, furosemide, multivitamin
4 broad classes of pharmacologic pain relief:

1. Nonsteroidal anti-inflammatory drugs (NSAIDs)
   - E.g.: naproxen and coxibs, and related agents like acetaminophen
2. Antidepressants (e.g. amitriptyline, duloxetine)
3. Anticonvulsants (e.g. pregabalin, carbamazepine)
4. Opioids (e.g. morphine)

Risks and benefits with each
What are your next steps?

- Solicit more information
- Use open ended questions
  - “Tell me more about…”
  - “Take me through your thoughts …”
  - “What was your prior experience…”
- Use when you are not sure what someone is talking about
- Avoid assumptions
Case: Judy 69 y/o Widow

“Tell me more about your concerns…”

• Says cardiologist warned her about certain pain medicines, but she isn’t sure which.
• States she is an active member of A.A. and has been abstinent for 20 years. Questions if any of these medications will impact her sobriety?
• And she misused prescription opioids following a knee replacement in her late 50s.
Shared decision-making
A definition.

“Shared decision making is a **process** in which clinicians and patients **work together** to clarify treatment, management, or self-management goals, sharing information about options and preferred outcomes with the aim of reaching mutual agreement on the best course of action.”

→ Represents shift in the doctor-patient dynamic where control/power is given to/shared with the patient
→ Can be used for current or future decisions. When used for future decisions, we call it “advance care planning.”
<table>
<thead>
<tr>
<th>Patient says:</th>
<th>Doctor responds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paternalism</td>
<td>Shared Decision Making</td>
</tr>
<tr>
<td>&quot;I hate this exercise plan.&quot;</td>
<td>&quot;Then try walking after dinner every night with your husband for 10 minutes&quot;</td>
</tr>
<tr>
<td>&quot;What do you hate about it? What would help you do better at it?&quot;</td>
<td>&quot;I don't think I can quit smoking.&quot;</td>
</tr>
<tr>
<td>Smoking is the leading cause of preventable death ...&quot;</td>
<td>Why do you think that? What has happened in the past when you tried to quit? What concerns you most when you think about trying to quit?</td>
</tr>
</tbody>
</table>
When is it needed?

- Appropriate any time there is more than one reasonable course of action
- For decisions that are ‘preference sensitive’
- Most healthcare decisions are ‘preference sensitive’: consider:
  - Tx that may improve one condition but make another worse
  - Tx that may offer long-term benefits but cause short-term discomfort
  - Multiple medications with benefits and harms that must be balanced
Case: Judy 69 y/o Widow
Main communication strategies

- Summarize and repeat:
  - “I am hearing you say you are concerned that any pain regimen not impact your sobriety; not trigger an addiction, and be safe for your heart? Have I understood correctly?”

ASK – patient’s ideas, feelings, knowledge about the condition, and overall goals and acceptable outcomes
TELL – share needed clinical information
ASK – check understanding or what choice patient selected
Key to Shared Decision Making is: Discussing Goals of Care
“Goals of Care?”
Goals of Care = Patient Values

- Cure disease
- Avoid early death
- Maintain or improve function
- Prolong life
- Avoid pain
- Avoid disability
- Avoid dependence
- Maintain alertness
- Improve life quality
- Stay in control
- Support family

*Goals may change as an illness evolves*
“Orders” but do not allow for description or caveat.

Do not define “Quality of Life” (QOL)
Values & Goals Assessment Tools

• “The Magic Questions”
  – Greatest fear? What brings you joy?
  – What do you still hope to achieve?

• “Values History Form”, University of New Mexico

• The Conversation Project
  – https://theconversationproject.org/

All define **living**, or discuss QOL
"She had written in specifically that she was to be able to go onstage. For an hour. And be funny.” – Melissa Rivers

"She wasn't going to be happy wheeled in to sit in the sun, you know? It was an amazing gift to give me, knowing exactly how she wanted her life to be. Not that it's ever an easy decision, but I knew I was making the right one."
Case: Judy 69 y/o Widow

Goals:
• Rx must not impact sobriety, risk addiction, and be safe for her heart
• Wishes to avoid pain, but will trade this for alertness
• Functional outcome: patient must be able to drive herself to pick up grandson at elementary school and babysit
Case: Edna, living in LTC
Goals Unknown

• 95 y/o F  PMHx: COPD, CKD, advanced dementia, and osteoporosis
  – Hip fracture 3 months ago
  – Dysphagia now requiring puree & thickened liquids

• In last 12 mo, Hospitalized 5x
  – 2 UTIs
  – 2 Pneumonias
  – Hip repair

©Danielle J. Doberman, MD, MPH
Case: Edna, living in LTC
Goals Unknown

• Doesn’t recognize daughter
• Total care except can self-feed with a spoon only
• Has become increasingly resistant to care & transfers in last month
  – No response to non-pharmacologic tx
• Daughter worried pain Rx will “worsen dementia” by “dulling Mom’s mind”
• No restrictions on treatment; Full code
Is decision making different for patients with dementia?

- Does decision making differ by disease stage?
  - → Capacity?
- What does the long view hold?
- “Aggressive medical treatments may feel like torture to an individual who is in unfamiliar surroundings and does not understand the intentions of the care providers.” – Alz Assoc

©Danielle J. Doberman, MD, MPH
Shared Decision Making
Clinician & Patient as Equals

Information is key to informed consent

Does the patient/family know the prognosis?
The typical disease course?
Treatment alternatives?
What is unknown?

Paternalism vs Autonomy
vs Shared Decision Making

Do you know patients Goals?

©Danielle J. Doberman, MD, MPH
Case: Edna, living in LTC
Goals Unknown

• What are Edna’s goals?
• Would her daughter’s goals differ if she understood:
  – Prognosis for functional recovery?
  – Maintenance of cognition?
  – Expected course for dementia?
• Multimorbidity, but with Dementia as predominant
Shared Decision Making and Multimorbidity


• Approach to the evaluation and management of the older adult with multimorbidity.

• 5 Guiding Principles
Inquire about the patient's primary concern (and that of family and friends, if applicable) and any additional objectives for visit.

Conduct a complete review of care plan for person with multimorbidity.
OR
Focus on specific aspect of care for person with multimorbidity.

What are the current medical conditions and interventions?
Is there adherence to and comfort with treatment plan?

Consider patient preferences.

Is relevant evidence available regarding important outcomes?
Consider prognosis.

Consider *interactions* within and among treatments and conditions.

Weigh *benefits* and *harms* of components of the treatment plan.

*Communicate* and *decide* for or against implementation or continuation of intervention/treatment.

*Reassess* at selected intervals: for benefit, feasibility, adherence, alignment with preferences.
5 Guiding Principles for the Care of Older Adults with Multimorbidity:

1. Patient Preferences Domain
2. Interpreting the Evidence Domain
3. Prognosis Domain
   - Ex: Preserve function, Remaining life expectancy, Quality of life, Risk of another event (e.g. stroke, MI, etc)
4. Clinical Feasibility Domain
   - Ex: will patient die from a comorbidity before gaining benefit from proposed treatment? Interactions b/w multiple conditions and Rxs
5. Optimizing Therapies and Care Plans Domain
Case: Joe
Urgent, hospital-based case

- 81 y/o M with early Parkinson's Disease, CAD s/p CABG, and COPD on home oxygen
- Fall with hip fracture
- High risk surgery from cardiac and respiratory standpoint
- Consider “best-case/worst-case/most-likely” paradigm
Informed Consent to Surgical Outcomes, not just to Surgery Itself

Figure Legend:

Best Case/Worst Case Graphic Aid: Example of a Best Case/Worst Case graphic aid that the surgeon would create and use during a decision-making discussion for an older patient with a serious surgical problem. The box represents the worst case scenario, the star represents the best case scenario, and the oval indicates the most likely outcome.
Case: Joe  
Urgent, hospital-based case

• Goals:
  1. Preserve cognition
  2. Preserve independence
     • no long-term vent, or institutionalization
  3. Preserve ambulation
  4. Will trade discomfort for above

• Decision to pursue surgery
Challenges in care of Elderly

- Older adults are heterogeneous in severity of disease, goals of care, functional status, prognosis, risk of adverse events, and priorities for treatment outcomes.
- Greater than 50% have multimorbidity – more than 3 diseases – while most treatment guidelines address a single illness.
- Shared decision making allows a patient and their provider to reach mutually agreeable outcomes.
Questions?

Danielle J. Doberman, MD, MPH, HMDC
doberman@jhmi.edu