Strategies in Establishing Patient Centered Pain Management Goals

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CME Statements

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Disclosures

No Relevant Financial Relationships
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No Conflicts of Interest

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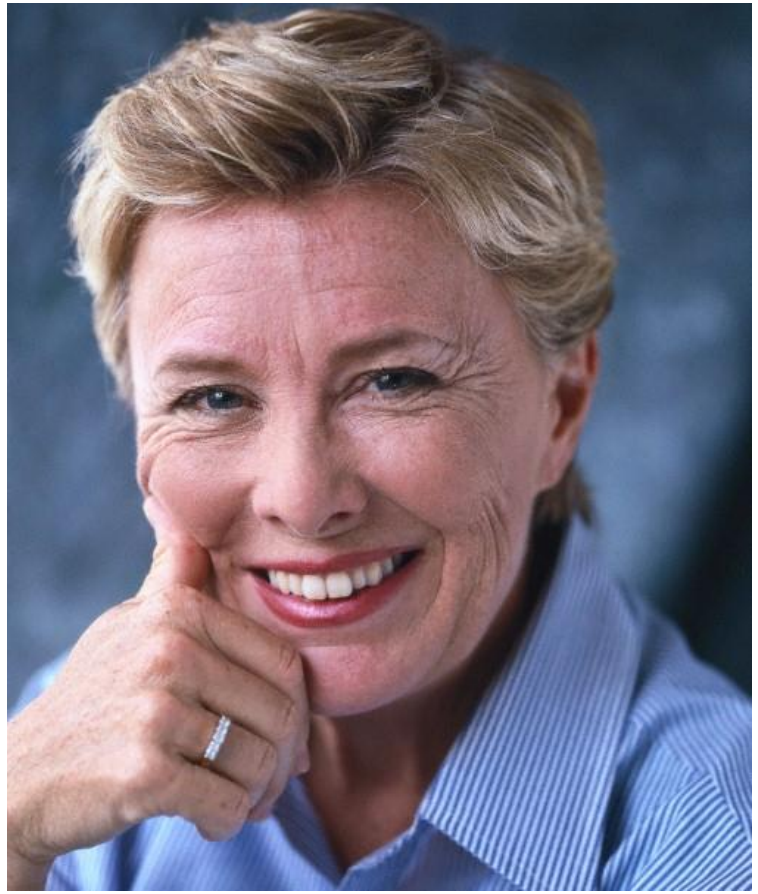
Learning Objectives

- 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

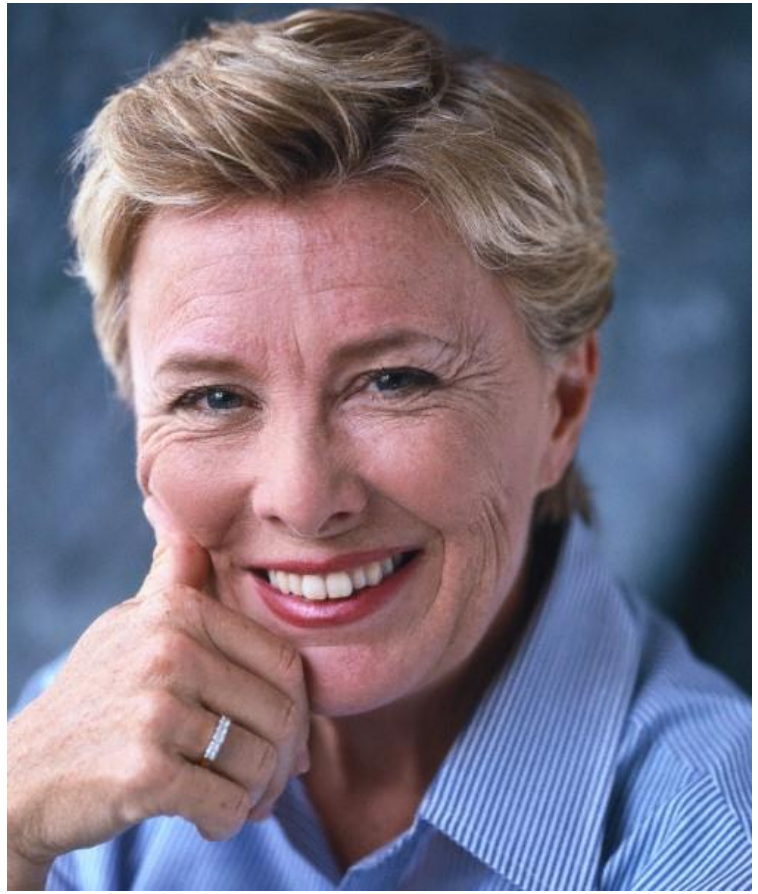
Case: In clinic, Judy 69 y/o Widow

- 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:

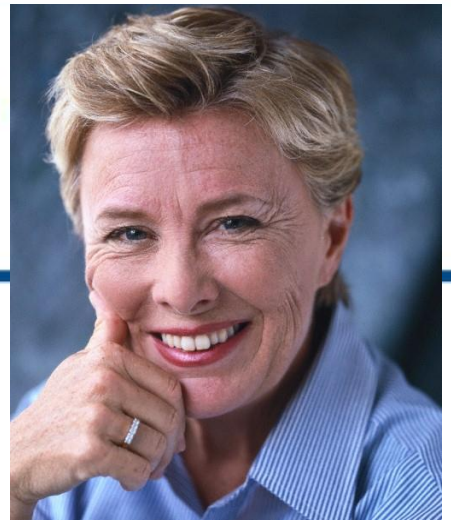
1. Nonsteroidal anti-inflammatory drugs (NSAIDs)
   - E.g.: naproxen and coxibs, and related agents like acetaminophen
2. Antidepressants (e.g. amitriptyline, duloxetine)
3. Anticonvulsants (e.g. pregabalin, carbamazepine)
4. Opioids (e.g. morphine)

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.

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Shared decision-making

A definition.

(*Shared Decision Making*. Coulter, Collins. Kings Fund, July 2011)

*"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."

Old vs New

Patient says:	Doctor responds	
	Paternalism	Shared Decision Making
"I hate this exercise plan."	"Then try walking after dinner every night with your husband for 10 minutes	"What do you hate about it? What would help you do better at it?"
"I don't think I can quit smoking."	"Smoking is the leading cause of preventable death ..."	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?

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

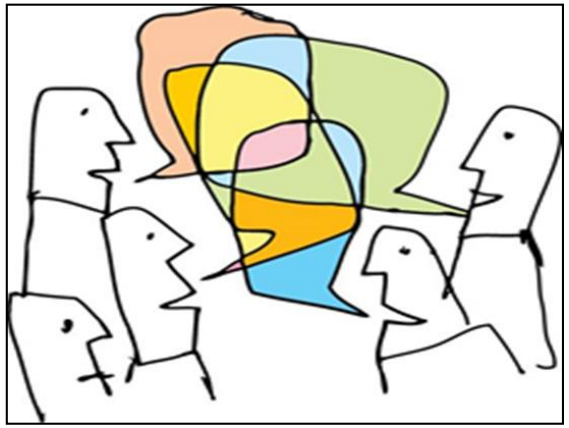
Case: Judy 69 y/o Widow
Main communication strategies

- 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



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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

MM 3 2013 Page 1 of 2

Maryland Medical Orders for Life-Sustaining Treatment (MOLST)

Patient's Last Name, First, Middle Initial	Date of Birth	☐ Male ☐ Female

This form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation and other life-sustaining treatment options for a specific patient. It is valid in all health care facilities and programs throughout Maryland. This order form shall be kept with other active medical orders in the patient's medical record. The physician, nurse practitioner (NP), or physician assistant (PA) must accurately and legibly complete the form and then sign and date it. The physician, NP, or PA shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 do not apply, leave them blank. A copy or the original of every completed MOLST form must be given to the patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.

CERTIFICATION FOR THE BASIS OF THESE ORDERS: Mark any and all that apply.

I hereby certify that these orders are entered as a result of a discussion with and the informed consent of:

_____ the patient; or
_____ the patient's health care agent as named in the patient's advance directive; or
_____ the patient's guardian of the person as per the authority granted by a court order; or
_____ the patient's surrogate as per the authority granted by the Heath Care Decisions Act; or
_____ if the patient is a minor, the patient's legal guardian or another legally authorized adult.

Or, I hereby certify that these orders are based on:

_____ instructions in the patient's advance directive; or
_____ other legal authority in accordance with all provisions of the Health Care Decisions Act. All supporting documentation must be contained in the patient's medical records.

_____ Mark this line if the patient or authorized decision maker declines to discuss or is unable to make a decision about these treatments. **The patient's or authorized decision maker's participation in the preparation of the MOLST form is always voluntary.** If the patient or authorized decision maker has not limited care, except as otherwise provided by law, CPR will be attempted and other treatments will be given.

1

CPR (RESUSCITATION) STATUS: EMS providers must follow the *Maryland Medical Protocols for EMS Providers*.

_____ **Attempt CPR:** If cardiac and/or pulmonary arrest occurs, attempt cardiopulmonary resuscitation (CPR). This will include any and all medical efforts that are indicated during arrest, including artificial ventilation and efforts to restore and/or stabilize cardiopulmonary function.

[If the patient or authorized decision maker does not or cannot make any selection regarding CPR status, mark this option. Exceptions: If a valid advance directive declines CPR, CPR is medically ineffective, or there is some other legal basis for not attempting CPR, mark one of the "No CPR" options below.]

No CPR, Option A, Comprehensive Efforts to Prevent Arrest: Prior to arrest, administer all medications needed to stabilize the patient. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.

_____ **Option A-1, Intubate:** Comprehensive efforts may include intubation and artificial ventilation.

_____ **Option A-2, Do Not Intubate (DNI):** Comprehensive efforts may include limited ventilatory support by CPAP or BiPAP, but do not intubate.

_____ **No CPR, Option B, Palliative and Supportive Care:** Prior to arrest, provide passive oxygen for comfort and control any external bleeding. Prior to arrest, provide medications for pain relief as needed, but no other medications. Do not intubate or use CPAP or BiPAP. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.

SIGNATURE OF PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT (Signature and date are required to validate order)

Practitioner's Signature	Print Practitioner's Name	
Maryland License #	Phone Number	Date

"Orders" but do not allow for description or caveat.

Do not define "Quality of Life" (QOL)

Values & Goals Assessment Tools

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- "The Magic Questions"
  - *Greatest fear? What brings you joy?*
  - *What do you still hope to achieve?*
- "Values History Form", University of New Mexico
  - http://www.abbylawoffices.com/values-history.pdf
- The Conversation Project
  - https://theconversationproject.org/

All define ***living***, or discuss QOL

Joan Rivers' Living Will:

"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

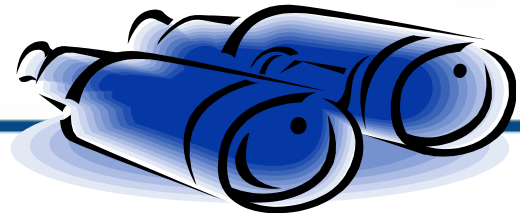
Case: Edna, living in LTC Goals Unknown

- 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

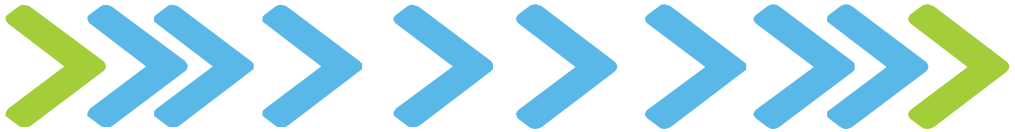
Case: Edna, living in LTC
Goals Unknown

- 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

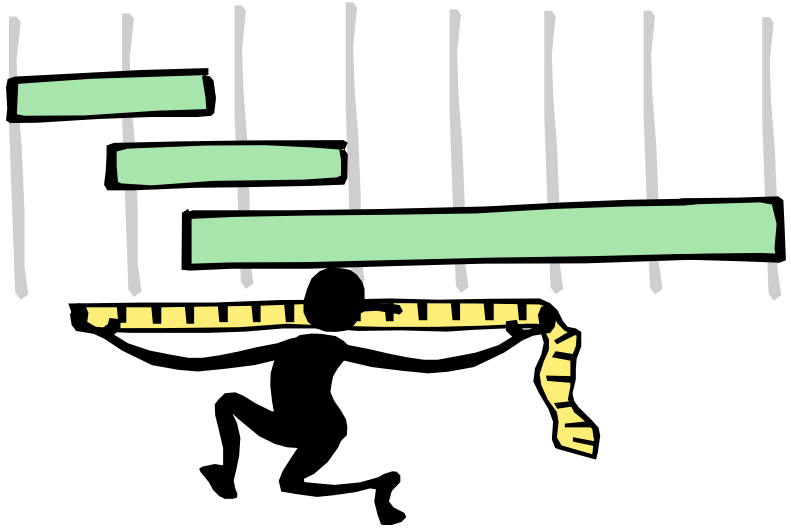
Is decision making different for patients with dementia?



- 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*



MILD → MODERATE → SEVERE



Shared Decision Making
Clinician & Patient as Equals

Paternalism vs Autonomy
vs Shared Decision Making

Information is key
to informed consent

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

Do you know patients Goals?

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

- American Geriatrics Society Expert Panel on the Care of Older Adults with Multimorbidity. Guiding principles for the care of older adults with multimorbidity: an approach for clinicians. J Am Geriatr Soc. 2012;60(10):E1–E25.
- 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.

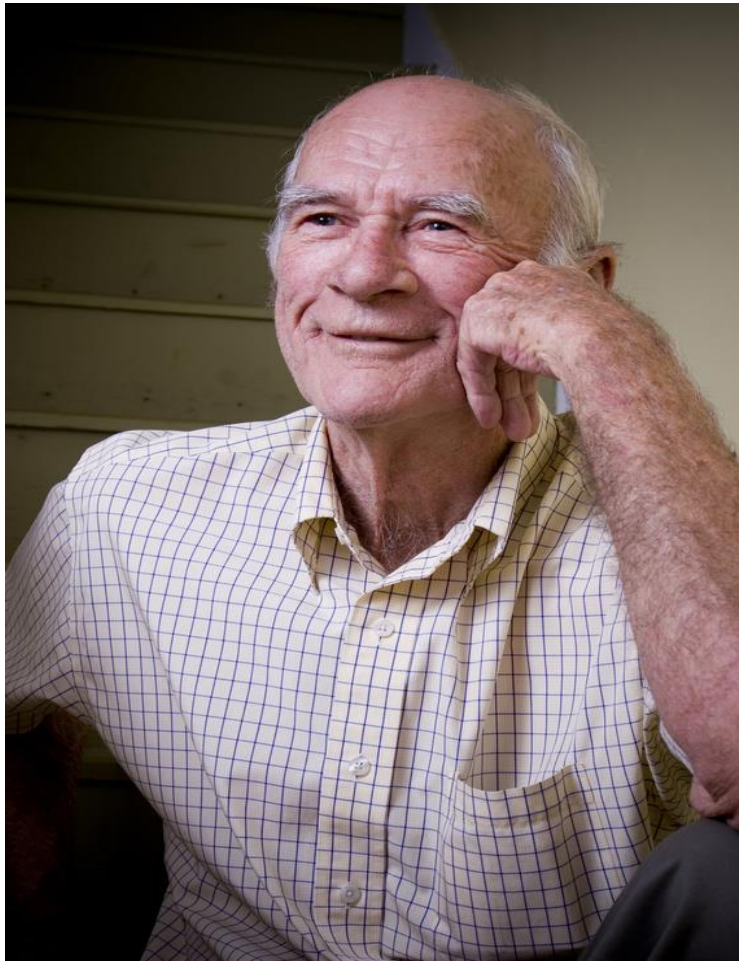
5 Guiding Principles for the Care of Older Adults with Multimorbidity:

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

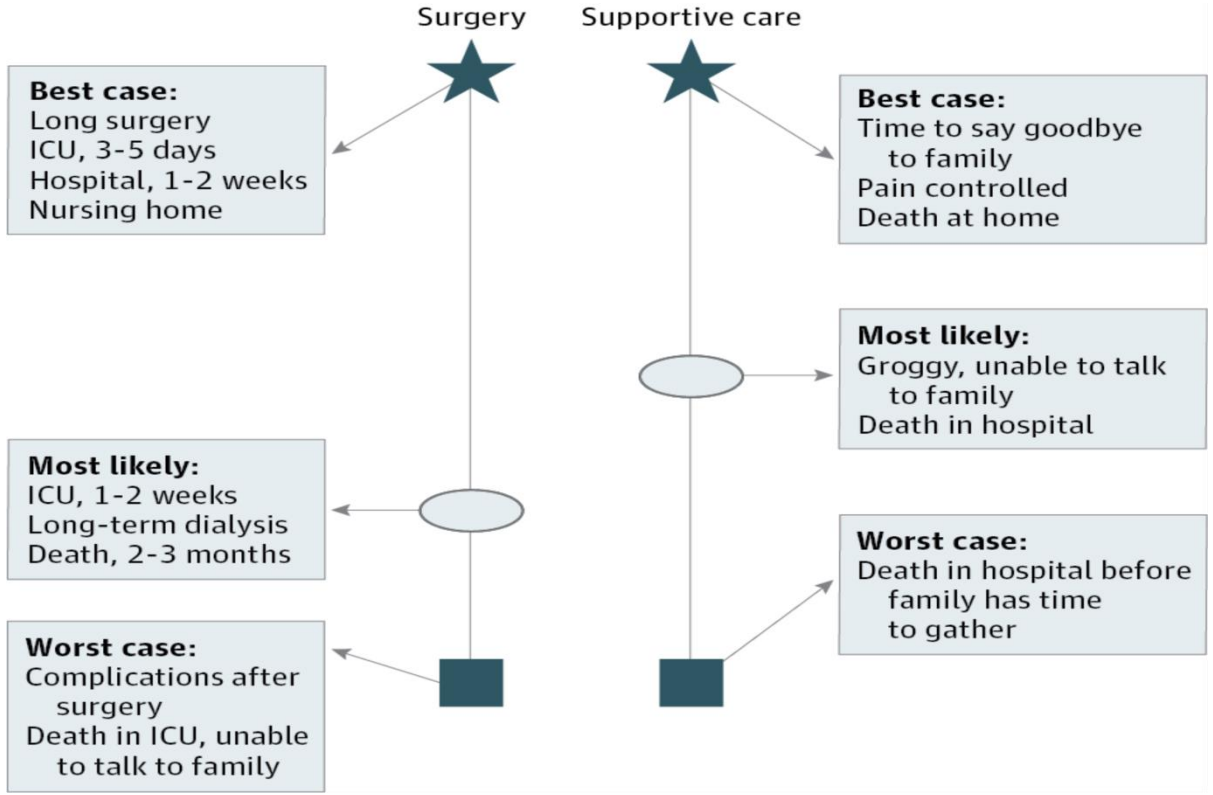
- 81 y/o M with early Parkinson's Disease, CAD s/p CABG, and COPD on home oxygen
- Fall with hip fracture

- High risk surgery from cardiac and respiratory standpoint
- Consider “best-case/worst-case/most-likely” paradigm



From: **A Framework to Improve Surgeon Communication in High-Stakes Surgical DecisionsBest Case/Worst Case**

JAMA Surg. 2017;152(6):531-538. doi:10.1001/jamasurg.2016.5674



Informed Consent to Surgical Outcomes, not just to Surgery Itself

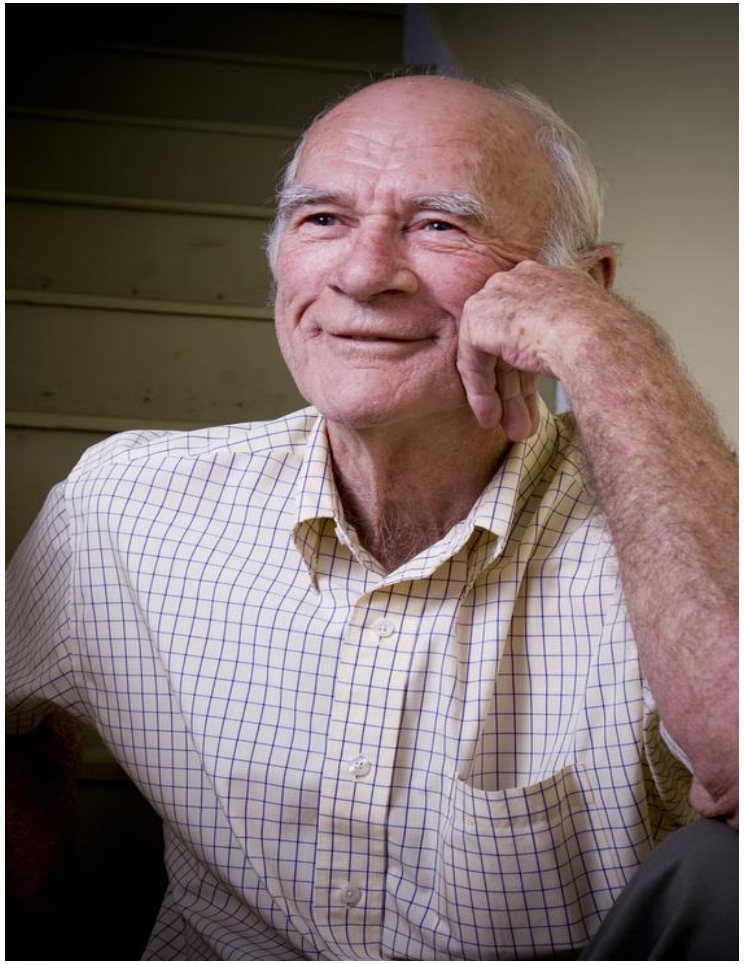
Figure Legend:

Best Case/Worst Case Graphic AidExample 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?

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