Rounding@IOWA: General Inpatient Hospice Care (GIP)

Transcript

[Upbeat theme music plays]

Dr. Clancy

Welcome to Rounding@IOWA, a continuing medical education podcast developed by and for healthcare teams. I'm your host, Dr. Gerry Clancy, Senior Associate Dean of External Affairs for the Carver College of Medicine at the University of Iowa. Today, we'll delve into general inpatient hospice care, or sometimes referred to as GIP. Our objectives include, first, we'd like our participants to have an up-to-date foundation of knowledge around when general inpatient hospice should be considered regarding level of care. And second, we hope our participants can recognize the actions that they can take to ease suffering using general inpatient hospice care. To address this pressing issue, we're delighted to have two esteemed guests, Dr. Michelle Weckmann and Dr. John Wilde. Dr. Michelle Weckmann, who has been on Rounding@IOWA before, is a hospice and palliative medicine physician in Iowa City with over 20 years of experience in that medical field. She has served the Iowa City Hospice for 20 years and as the medical director of the Iowa City Hospice for the past three years. She graduated from the Medical College of Wisconsin in 2000. She served as an associate professor here at the University of Iowa in the Departments of Family Medicine and Psychiatry for many years. She was the program director for the Combined Psychiatry and Family Medicine Residency Program. And she's now a professor emeritus here at the University of Iowa. Dr. John Wilde is an assistant professor of internal medicine and serves as the program director for the Hospice and Palliative Medicine Fellowship at the University of Iowa. He graduated from medical school from the Western University of Health Sciences in Pomona, California. He completed residency in internal medicine through the Community Memorial Hospital System in Ventura, California. He then came to the University of Iowa for fellowship in the hospice and palliative care program, as well as earning his MBA from the Tippie College of Business, also here at the University of Iowa. So Michelle and John, welcome again to Rounding@IOWA.

Dr. Wilde

Thanks for having us.

Dr. Weckmann

It's great to be here.

Dr. Clancy

Great. So let's get started with an opening question that I ask pretty much of everybody. I just provided our listeners with a brief official description of your educational background and your current titles, but could you tell us what drew you to this work? And let's start with Michelle.

Dr. Weckmann

So I've actually been interested in this work since I was a medical student. I was a medical student way back when we still let our patients smoke while they were in the hospital. My first clinical rotation was a hem-onc rotation. And my job was to take a young 30-something-year-old woman who had metastatic liver cancer down to smoke multiple times a day, actually. Got to know her pretty well. She was having intractable pain. And all of the team, the team, what they kept doing is throwing opioids at her. So we got her to the point where she was somnolent but still in pain. And the issue was not that we were treating physical pain, but that we were trying to treat psychological pain, existential pain. She had three young children at home. And we just weren't getting anywhere. Nobody was addressing the actual source of her pain. While on that rotation, Dr. David Wiseman came in from the hospice or from the palliative medicine team and did a goals of care conversation with a different patient. He named the elephant in the room, which was that patient was dying from cancer. And I watched this happen and said, wow, why is nobody talking to the patient that I am knowing so well in this way? And that's when I decided that this is what I wanted to do. I wanted to help, actually at that point, I wanted to help physicians be better at doing compassionate truth-telling. And it's more throughout the years to doing palliative care at the U and now mostly hospice work.

Dr. Clancy

Great, great. So I think a lot of us, it's a particular story that gets us started as well. Yeah. John, how about you? Is there a story that got you started into this type of work?

Dr. Wilde

Well, it's interesting. I think it's a compilation of several stories. I think I could recall several different times where as an internal medicine resident, I was, you know, running busily from one patient to another, feeling like I didn't ever have enough time to really convey what's happening to patients. It felt like it was easier to prolong someone's suffering than it was to sit down and have a meaningful conversation about their goals, their wishes, and ensuring

that as we're navigating next steps, that we're ensuring that the person behind the patient has been respected. And slowly but surely, I feel like I was kind of being torn apart inside, that there was a part of me saying, you know, you went a medicine to care for people, and all you're doing is just being a cog in a wheel, perpetuating the algorithm from patient to patient to patient. And when I had an opportunity to rotate with one of my dear colleagues at Community Memorial Hospital, in palliative medicine, it was almost like a breath of fresh air. We were restoring humanity in healthcare. And I knew from that point forward, as I was going to other rotations, all I wanted to do was go back to palliative medicine and and build those relationships with people. And so from that point onward, I've dedicated my life to this work.

Dr. Clancy

Well, we're glad both of you are doing it. And I can definitely attest that as my career has progressed, my respect and my admiration for palliative care and this work that you do is just greater and greater. Yeah, it's so important, the work that you do. So in doing this work, what does a work week look like? And John, let's start with you. What a work week might entail. And I'm sure it's a lot of things.

Dr. Wilde

Well, it just, I guess it depends on the week, but most of the time, right now I'm primarily doing inpatient work. I did have an outpatient clinic for some time. Since I've taken on the palliative care directorship role, I have not been able to go and fulfill my outpatient clinic duties anymore. But generally speaking, I do inpatient work where I'm seeing inpatient consults, rounding in every unit in the hospital and caring for everybody wherever they're at, trying to align people's wishes with the treatment plans, assisting people in the end-of-life process, or providing meaningful symptom management, be it in cancer patients or otherwise. I tend to go and have a team of learners around me as we're discussing things, and it's a great time. So I love my work here at the University of Iowa.

Dr. Clancy

Michelle, how about you? You have a different work set up. What's a work week look like for you?

Dr. Weckmann

So I'm still involved with resident education in the sense that I still staff the psychiatry residents in their outpatient clinic three mornings a week. The rest of my time is hospice physician, hospice medical director work. Two mornings a week I attend our interdisciplinary team meetings, which is a Medicare requirement, and all hospices need to

do this. I'm working closely with my nurses on a daily basis, helping manage symptoms, troubleshoot things that are going on, filling prescriptions. I do home visits on occasion, and I also work with learners. I've got the hospice and palliative medicine fellows, and then I've got a number of residents, occasionally medical students who rotate here with us.

Dr. Clancy

So let's begin with our main topic. For a clinician early in practice or a clinician being developed, which you both do, what's the single most important thing to understand about inpatient hospice care in a general hospital setting?

Dr. Wilde

I think that the most important thing to consider when it comes to inpatient hospice care is that this is a designation intended for people whose symptoms could not be controlled outside the hospital setting. We'll talk a little bit later about the differences between hospice and comfort care and so on. But I think that's the big thing is that this is hospice level of care, but hospital level of symptom needs. I think that's probably the most simplistic way to go and describe it. Michelle, do you have anything to add to that?

Dr. Weckmann

I guess I would also add one misconception is that when somebody is enrolled in hospice, it sometimes is taken as do not treat or do not evaluate. And particularly at an inpatient, a GIP level of care, that's not accurate. We are often doing tests and evaluating and we are aggressively managing symptoms.

Dr. Clancy

So let me ask a similar question just in a different way. So when we say general inpatient hospice, what problem is this level of care meant to solve?

Dr. Weckmann

So I'll start. This is an acute problem. Typically, it's one of symptom management or symptom control. And these are problems that cannot be managed in the home setting, even with aggressive hospice support.

Dr. Clancy

Got it. Got it. And Michelle, you've touched on this, but are there common misunderstandings you hear from particularly trainees about hospice in the hospital setting?

Dr. Weckmann

Oftentimes we hear when somebody is enrolled in hospice, the thought is that it's about giving up or it's about stopping all treatments or it's only indicated for the final hours of life. Hospice is a lot more than that.

Dr. Wilde

And if I just might add something, a common misunderstanding I hear from trainees when it comes to hospice in the hospital is that most people feel that just because they are comfort care, that somehow they're also hospice. And while that is a possibility, to be designated a hospice patient in the hospital setting, you need to meet the GIP criteria. In other words, your symptoms need to progress to the point where we cannot control it in any other capacity other than in the hospital.

Dr. Clancy

So let's look at maybe some clinical examples. Do you have a clinical vignette that illustrates when GIP is a clear fit?

Dr. Weckmann

So let's start with a home patient that we recently had admitted GIP. This was a gentleman with metastatic cancer who developed an acute vomiting syndrome. He was unable to keep any medications down. The hospice team had been out multiple times. We'd cycled through multiple anti-emetics, including something called a DMD suppository. That's a compounded suppository with dexamethasone, metoclopramide, and diphenhydramine. When that didn't work and he couldn't keep his pain medications down and his pain was escalating, we approached them with the idea of coming in for a GIP admission, specifically to manage that nausea and vomiting and ensure that he was able to get his pain medications that he needed. And so he came in, we diagnosed a partial small bowel obstruction, put him on bowel rest, did IV fluids, used IV meds, and I think he was in for three days before we were able to get him back home comfortable again.

Dr. Clancy

Great, great. Good.

Dr. Wilde

I have another one if you'd like. This is kind of an inpatient perspective. So I recently had a case where we were working very hard to get a young woman home. She had ovarian cancer that was metastatic through her spine and her abdomen and peritoneum. And we tried a lot of different ways to go and get her symptoms well controlled to get her home as

her wishes to die there with the support of hospice. Unfortunately, her symptoms continued to progress. She had a bowel obstruction. She had terrible cancer-related pain and required high levels of patient-controlled analgesia, PCA, which eventually turned into nurse-controlled analgesia. We eventually enrolled her in hospice here at the hospital, where after several weeks of being here, ultimately succumbed to her illness. and died here in the hospital. And all the while we were supporting her, both the team here as a palliative care service, in addition to having the hospice services, nursing services that were applied. And it was the best of a hard situation.

Dr. Clancy

Yeah, absolutely. So let's move on to some definitions and hopefully we can prevent some confusion. How would you explain the difference between palliative care, hospice care, and comfort care to new physicians, to medical students and residents.

Dr. Wilde

I think the most simplistic way to describe it is I think palliative care is what you might consider to be the live well team. We're here to go and meet you where you're at in your whatever illness that you may have, a serious illness. And we wear two hats. One hat is that we're symptom management specialists. And the other hat that we wear is that we help to align what is important to you with the treatment plan that you're seeking. And so kind of help navigate through the complexity of illness. I think hospice care, and Michelle can go and speak more to this, I feel like this is more of the die well team. Their whole process is, you're in the final chapter of your life. They're there to support you to ensure that the final chapter is the best one they can make it. Whereas palliative care might be in an ongoing while, let's say you're getting cancer treatment, we're here to go and make sure that cancer treatment goes as best as it can. Where comfort-focused care, this is purely at the end of life, maybe here in the hospital, but you're not quite at the point where you're ready to go home with hospice and you don't meet GIP criteria quite yet.

Dr. Clancy

So in hospital workflow, what's the practical difference between inpatient hospice and inpatient palliative consults?

Dr. Wilde

That's a great question. I'll take this one. I think that the inpatient palliative consults is this could be for a lot of different reasons, for goals of care, generally speaking of, I have a serious illness, we need to figure out what to do here. It could be symptom management outside of an end-of-life process. And so there's a lot of things that we do as a palliative

care consultants that are outside of kind of an inpatient hospice situation or even comfort care. And so inpatient hospice, we tend to get involved before inpatient hospice is utilized, but inpatient hospice is really intended for those patients who are meeting the threshold of GIP criteria after we've already gotten involved from a palliative care. So I'd say that's a subset of what we do in palliative medicine here in the hospital. And we get the added benefits of our esteemed colleagues with hospice to join us in our quest of ensuring patients are comfortable throughout the last few days to weeks of their life.

Dr. Clancy

So sometimes I hear the term hospice has been elected. What does that mean clinically and what changes about the care plan once hospice is declared or elected by the patient?

Dr. Weckmann

I can jump in with that one. So when somebody is elected to enroll in hospice, it typically means they have come to some sort of acceptance to the fact that they have a terminal prognosis. And the changes really depend on what their goals of care are, right? We certainly have some people who are in hospice that we're still doing some labs, we're still doing some tests, sometimes we're doing blood transfusions, depending on what those goals of care are. And so it's really very individual. If I were to generalize, I would say that when somebody has elected hospice, and again, accepted that they have a terminal condition, typically we are changing the focus away from disease modifying treatment to symptom management almost exclusively.

Dr. Wilde

And I would just add that very frequently when this happens in the hospital setting, people have recognized that they've been treading water within the hospital setting for some time. They've attempted to go and get all the treatments set with a curative intent and ultimately realized there's not a lot we can do here. And so rather than, the phrase I like to say is rather than adding days to your life, we add life back to your days. And that's a time when we can pursue hospice care.

Dr. Clancy

That's a great kind of teaching moment there as far as phraseology. And then let's talk a little bit more about specific ways you can approach this and actually what words you use. What language do you recommend clinicians avoid? Because it can create fear or misunderstanding as you begin to talk about moving to this level of care and what language works well? What are some of your greatest hits?

Dr. Wilde

I can tell you one of palliative care's biggest pet peeves is when people say withdrawal of care. That to me implies that what I do doesn't matter, that I don't care anymore. So you could withdraw a ventilator, you can withdraw like a dialysis, but we don't withdraw care. And so I had a great esteemed colleague, Dr. James Ray, who was a pharmacist, who as a fellow, I was using that phrase that is very common in healthcare, withdrawal of care. And he took me aside and essentially said, listen, your job is going to be that of syntax. It's important to go and make sure that how you say things reflects what you mean. So withdrawal of care is almost like a—he referred a paper to me, it's Better Words for Better Deaths, during which in that paper he says that withdrawal of care would be an excellent name for a common medical mistake. So we gotta be cautious about what we're utilizing there.

Dr. Weckmann

I agree entirely with John. I often talk about transitioning goals of care. So we are transitioning from a ventilator to a comfort-oriented approach. Related to that, some other things, I suppose, my soapbox is when we say, I know how you feel. I don't know about you, but I know John has had the experience. I mean, I've been yelled at by patients and family members for saying that. It's a really quick way to learn, okay, let's rephrase that. And typically it is, I don't understand, I mean, I can't know how you're feeling in this moment. which you can then follow up with, in my experience with other families who are in this situation, they tell me they feel angry, they feel scared, they feel whatever that emotion might be.

Dr. Wilde

Exactly. And if you want to be as simplistic, you could simply say, I can't even imagine what you're going through, right? I mean, if you don't feel like you have the emotional capacity to go and really empathize and find those deeper emotions they may be feeling, a simple phrase like that is great. I will also add, the big pet peeve as well is nothing that you could do or giving up language. To me, that really bothers me because again, it implies that what we do is somehow less meaningful. And that's not true at all. What we're doing is shifting priorities from, again, attempting to prolong things to not prolong things. One of my patients once shared, the spouse of a patient, she says, in reference to her husband, I want to do what we can to prolong his life, not prolong his death. And so when we're approaching care, I think that's an important nuance that we need to be aware of, is that we have done so many marvelous things in prolonging life in healthcare, but we've also extended the dying process. It's important for us to go and recognize the difference and then advocate for the patients and let them know what we're doing.

Dr. Clancy

Yeah, really good advice from both of you. It's really, I like that focus on how important syntax is.And when I know I'm going to have a difficult conversation with the patient, I will purposely prepare my resident or my med student and say, watch how I try to ease into this. And most of the time it goes okay. Yeah. So let's still talk about some specifics. and give our listeners really kind of the things to be watchful for. What are the most common symptom-driven reasons patients need GIP level of care? In your experiences, when is it time to make that move?

Dr. Wilde

All right, I'll go. I think that there's a difference, I think, between my answer as a primarily inpatient provider compared to Dr. Weckman, who's primarily a hospice provider. And so I think from my perspective, I see probably the vast majority of patients, it's regarding to pain and discomfort, typically requiring high doses of PCAs. Though we do also see this in your compassion extubation cases where people have profound levels of dyspnea. Again, we're requiring high levels of PCAs or nurse controlled analgesia—NCAs as well. At times we'll see other major symptoms like profound agitation, terminal agitation, recalcitrant nausea, sometimes even recurrent seizures and things like that. So these are probably the most common symptoms that I see on an inpatient level that would necessitate a general inpatient level of care.

Dr. Weckmann

Same thing from a hospice home setting. I am going to add dyspnea, right? Intractable dyspnea. Sometimes we need to bring patients in for that. Occasionally weakness or recurrent falls. And sometimes that's to sort of figure out what's causing the falls so that we can put an intervention in place and send them back home. Sometimes it's because we need to then look at placement. And on a rare occasion, I would say sometimes bleeding. And I can think of a specific home patient. This was a woman in her 60s with a metastatic breast cancer that wasn't treated. She had a large fungating lesion and developed an arterial bleed from that lesion at home. And I offered GIP to this patient because there was no way that—pressure bandages weren't working. I couldn't ligate it in the home. She ended up declining GIP and chose instead to let it bleed. And so then we in the home did continuous home care and medications to sort of facilitate her death from that bleed, but it would have been an appropriate GIP admission.

Dr. Clancy

Sure. So when you both are on rounds, are there some yellow flags that trigger in your mind that it's time to have the hospice GIP conversation? What do you look for? What's, when does the bell go off in your head?

Dr. Wilde

Yeah, I think that, I think there's probably 2 answers to this. One is we have an initiative here in the hospital where if somebody is known that they're intubated in the ICU, and it is known now that they're going to be pursuing comfort-focused care with a compassionate extubation, we can enroll somebody in GIP hospice before that. Two is there's an expectation that the patient will likely develop symptoms consistent with a GIP level of care, and so this is what we call the GIP initiative. I'm sure that if you're at the University of Iowa, you've heard of this. And so I would just encourage, as we are approaching that possibility, to ensure that we are getting our social workers involved early, because there are prior authorizations that are needed sometimes, insurance checks. We need to make sure that Iowa Donor Network is available and know that they are or not being considered for donation and so on. So I would just encourage that as kind of an early, early kind of yellow flag. Outside of that, what I would just emphasize is that again, this is, GIP is a symptom-driven measure here in the hospital. So if you're finding that there's high levels of symptom needs and people are pursuing comfort care, that would be a GIP-able patient.

Dr. Weckmann

I would say from a home setting, because it's slightly different, if my hospice nurse has to go out more than twice in 24 hours, or if they go out and they're with the patient for a prolonged more than two hour period of time, I'm starting to think that there's something going on we can't manage at home. And GIP might be appropriate.

Dr. Clancy

Are there common reasons that someone is referred to GIP but probably shouldn't be, you know just the misunderstandings from whatever treatment team is asking you questions?

Dr. Wilde

It's great you should ask that. You know, Michelle and I were chatting before this, and it is just kind of funny. We've instigated this GIP initiative for the ICUs, and sometimes people don't just die when you extubate them. And so they tend to have a prognosis of, I don't know, days or weeks. And that's a hard conversation to have with somebody. And sometimes even more difficult to justify ongoing GIP status where you tend to like to see a progression of symptoms or an escalation of care needed on a daily basis so that when

Medicare comes in and says, how do you justify this thousands of dollars a day of reimbursement to your service? that we say, yes, because of X, Y, or Z reasons. So I would just, I would say if there's anybody that likely has a prognosis of days or weeks, it's something that we need to be cautious about. And certainly anyone without significant symptoms would not be considered for GIP.

Dr. Weckmann

And just to add to that, the first thing I thought of when I saw this question was placement issues. GIP should not be utilized just because you can't place a patient.

Dr. Clancy

Don't get me started.

[laughter]

Dr. Wilde

The worst is when you get someone involved in GIP and then the hospice has to sign off for some reason. I mean, that just feels bad for everyone.

Dr. Clancy

Yeah, yeah.

Dr. Weckmann

Yeah, I agree.

Dr. Clancy

So again, back to the kind of the training the new resident or the new fellow, walk us through what a new fellow or resident has to do, needs to do when they suspect a patient might need inpatient hospice. What are the mechanics of it? How do they get it started?

Dr. Wilde

I think if you ever have a question at all, I would have a low threshold just to reach out to palliative care, put in a consultation and have them come by and assist you in that decision-making process. Not that palliative care is the ultimate arbiter of whether or not a patient is GIP appropriate or not, but I would say that we know the business well. So I would encourage you to reach out to a palliative care provider first, And then we can help to clarify what has been talked about. We can ensure that the families are aware that they're given choice of various hospice agencies, which I think is very important, and kind of go from there.

Dr. Clancy

Great. So as you both have discussed, you know, when you move to hospice status, a different group of services are available. What do we have to document to support the patient qualifying for this level of care? What needs to be in that chart so that utilization management doesn't come marching down and say, you did it wrong, doctor?

Dr. Wilde

I will just simply say that there needs to be some level of what is the ultimate goal here? Is it comfort-focused care? And then the next thing would be that you have to justify the symptom needs. And so, and the way that I do that in my documentation is ongoing, uncontrolled, or to treat underlying, ongoing, uncontrolled symptoms of pain, dyspnea, X, Y, Z, continue doing these levels of things. So, and usually that's an intravenous medication. It doesn't have to be, but it usually is.

Dr. Weckmann

And I will say that the hospice agency, typically the nurses are also doing documentation to support the GIP level of care. And they may reach out to the individual provider and ask them to add something to their notes to make sure that it meets the Medicare requirements.

Dr. Clancy

Great. So there's a lot of people involved, which is great. Have any advice on how to keep everybody on the same page and make sure that, you know, the primary team, the palliative care team, the hospice team is all working together? You guys have done this for a while now. So how do you get the team all rowing in one direction?

Dr. Wilde

Communication. I mean, that's what it all comes down to that, right? I think that is the key in all of healthcare that is lacking is if we don't communicate, then bad things happen. There's a reason why we've created, SBAR and other things like that is because if we don't communicate, then things fall through the cracks.

Dr. Weckmann

I'll say Epic Secure Chat has been wonderful.

Dr. Clancy

Yeah, I would agree.

Dr. Weckmann

Because it is a way to get everybody on the same conversation, the same page in real time or asynchronous time if you need it. I've seen a huge improvement in how we communicate with Epic Secure Chat.

Dr. Clancy

Great. So, you know, we have a complex patient set of needs, and they're going to be in the hospital for a little bit. And we work in an environment where there is evening and weekends and such. Any specific guidance on that handoff to make sure that you get it right as well as you take the very specific desires from a patient or a family and make sure that it's, again, their wishes are paid attention to? Is it communication again?

Dr. Wilde

It's really communication. And I feel like Michelle and I, we're cheating because our team consists of chaplains and social workers and nurses. And, we work together. And so every single day, I send out a chat to all the members of my team. and just tell them what the plan is every single day regarding all our patients. And then anytime there's an update, we talk about every single patient through Epic Secure Chat. And so if we're not doing that consistently, then bad things happen. And so all I can say is just, it's just good communication. And so I would encourage if you are not in, you know, the cheater role that Michelle and I are where it's already built in, do your best to make yourself a little uncomfortable and reach out to these individuals. I promise you it will pay back in dividends.

Dr. Weckmann

I'm also going to say don't copy-forward your plan in your notes. [group laughter] Right? If you have a goals-of-care conversation, put that very clearly in your assessment and plan. You know, a great assessment is, you know, this is a 98-year-old woman who is general inpatient hospice for management of pain. I believe she has a prognosis of hours to days. She does not want escalation of care, right? And hopefully the person who's coming on, if a crisis happens, will actually go and read your last note and see that.

Dr. Clancy

Yeah, very much so. Let's get into symptom management and some specific areas. You both are seasoned clinicians now. What advice do you have as far as pain crises and what are some of the pitfalls that you see that can be better handled? What advice do you have?

Dr. Wilde

Michelle, you want to start this one off?

Dr. Weckmann

Sure. I'm going to say that this is going to be fun because Dr. Wilde comes from a palliative care approach. I come from a hospice approach, and they are slightly different sometimes. One of my biggest concerns that I see or pitfalls is that the management is actually not aggressive enough. People are being very cautious and we're not getting symptoms controlled in a quick enough fashion because they're worried about QTC, they're worried about somnolence. And I'm worried about treating that pain and getting that patient comfortable. And the trade-off is often some sedation. And so I have that conversation with the families and patients, and if they're okay with it, then that's fine. If I have somebody in there for pain, I am pretty aggressively managing, if we have a PCA started, managing that PCA to the tune of potentially adjusting and adding a basal or increasing a basal every 12 hours.

Dr. Clancy

Sure. Well, you know, from a executor, family member, much appreciated for both my parents with that approach. So thank you.

Dr. Wilde

I would just add very, very frequently, I hear from nursing staff, hey, regarding using on a PCA is, hey, the patient is uncomfortable. Can we have a basal rate? And while I completely understand the reasoning behind that, if you do the math and you do the reasoning, starting a basal rate is not actually going to get you what you're hoping for, which is better symptom control. And so for me, it's always start by increasing the bolus dose, either by 50 to 100%, depending on if patients are moderate or severe discomfort, respectively. And so, and then you're, if you literally, you can do the math, you can see that you'll have probably a probably 40% higher dose of medicine when you increase the bolus dose compared to just adding a typical basal rate. So I do a lot of education around the hospital between nursing and resident staff about the proper utilization of PCA management. And it's absolutely essential, guys. Increase your bolus first, get the symptoms under control, then the basal can be added in afterwards to ensure that it doesn't have the same reliance on the button as they did before. But if we're talking about patient control, you got to start with a bolus.

Dr. Clancy

Great, great. So another area that can be, you know, frightening and very uncomfortable for both family and patient is dyspnea. How do you approach that?

Dr. Wilde

With opioids. I mean, that's the best thing. So I think that we in the palliative care unit, we don't actually go and monitor oxygen saturation at bedside. Sometimes when people are recently compassionately extubated, you'll still see the O2 monitors and things like that, and that can be distressing—or not—for families. I think that it's, I like to go and treat the patient in front of me rather than the lab values. I can't tell you how often I've been burned by the fact that one day I see somebody who has an oxygen saturation of, say, 68%, and then the next day they're at 89%. And then I felt like, oh, I just gave the family a misperception of timeline based on one erroneous number. So I just try to go and treat the patient that's in front of me with whatever I need to ensure that they're as comfortable as possible.

Dr. Weckmann

I agree completely that opioids are our mainstay for dyspnea, as well as some sort of air blowing past the face, be that oxygen by nasal cannula or a fan. And then don't be afraid of combining benzos if you need to, if they're dyspneic and they're anxious.

Dr. Clancy

Sure, absolutely. Good. One that I get called on sometimes is agitation and delirium. What's your guidance and advice on that? Because that, again, can be very concerning, upsetting to family members.

Dr. Weckmann

So delirium is actually my bread and butter as well. Delirium is the most common reason that a family will request palliative sedation is delirium. It's incredibly distressing. I still look for those common causes and look for reversible causes, even if somebody's I think actively dying, literature actually shows that you can reverse terminal delirium or delirium in the last two weeks of life about 50% of the time. And so looking for the simple things, are they constipated? Do they have urinary retention? Are they hypoxic? And then putting those into the goals of care. So sometimes people have a delirium and families don't want to treat it, right? You may have had someone who was aggressive or demented, and now they're quietly hypoactively delirious. And families are like, you know what? We're okay with this. Let's leave it alone. But even when somebody's dying, I'm still looking for those causes to see if I can reverse that delirium because in general, it's distressing.

Dr. Wilde

Yeah, and I would just add, I think that Michelle, you're the one who taught me this. I think it's when we talk about the distressing components of things when it comes to delirium, be

it hyperactive or hypoactive, essentially what that is, it's a brain failure. It's no different than any other organ dysfunction where, you know, you have kidney failure, have liver failure, so on and so forth. And somehow that feels more justifiable than having a brain failure. But that's ultimately what it comes down to. And having them understand like, oh, this is part of the body shutting down. Okay. Now, we can use medicines to go and help the symptoms of that underlying organ shutting down, but ultimately, this is an irreversible cause most of the time. Now, there's literature that say, yeah, yeah, yeah, yeah . . . [group laughter] But I mean, that's a justification of helping to provide peace to an otherwise distressing situation.

Dr. Clancy

No, I agree. Great, great answers. One that is probably alongside some of these others, the most uncomfortable for the patient is, are the GI symptoms sometimes that come with it. What advice do you have for just terrible nausea and the vomiting that comes with it?

Dr. Wilde

Oh, I mean, I think nausea, this is one of the fun things is being a palliative care doctor is because as a symptom management specialist, I get in the weeds. And so it's important when it comes to nausea that you find what's the reason, the underlying cause of the nausea is it's metabolic. If it's metabolic, then you're going to be better off with a dopamine antagonist, right, within the chemoreceptor trigger zone. If this is going to be something where you're worried about intracranial pressure from things, then you need to give steroids. If they have a mass inside their abdomen, right, then maybe steroids can be probably better for you than doing something like Zofran. Is this chemo related? Then Zofran is gonna be your number one bet for things. So there is no one stop shop when it comes to nausea. Oftentimes people, when they consult me for nausea, it's usually like, well, we tried Zofran and that's about it. And not even realizing that, well, guess what? Zofran caused the constipation that's actually the source of their nausea. So let's go and treat their constipation and then we'll give them Compazine and then it'll assist with their nausea. So I don't know, it's kind of a—I have a big one-page primer that goes into all the different major antiemetics that we utilize. And anyway, be iterative in your approach to nausea.

Dr. Clancy

Absolutely.

Dr. Weckmann

I will just add a couple of pearls here. Haldol combined with dexamethasone will control almost any nausea. If that doesn't work, believe it or not, IV Thorazine, and you can run a continuous infusion at 2 to 3 milligrams an hour. I have never not been able to control nausea with that.

Dr. Wilde

They're usually asleep at that point in time too, right? But that's. . .

[laughter]

Dr. Weckmann

Not always. . .

[laughter]

Dr. Clancy

They are, they are, and it controls the delirium too. Yeah. How about the secretions? You know, you need definitely the help of the team on this one, but what's the best way to coach the team on dealing and working through secretions.

Dr. Wilde

This is fun because Michelle and I actually come with two different perspectives on this. We were talking beforehand. So I mean, the prevailing thought for years was we got to do what we can to prevent the death rattle. I hate that term. I call it terminal secretions because death rattle just seems so aggressively descriptive. And so I prefer to call it the terminal secretions. Recent literature does no longer supports the utilization of anticholinergic drugs such as atropine, glycopyrrolate, those kind of things. And so we don't provide them. In fact, some of the literature even conveys that it causes dry mouth, it causes halitosis. The secretions that do exist become more sticky and more difficult to control. So we do a lot of education of the family members that I say, look, this is similar to snoring. If you are aware of it, then you would stop it like snoring, right? It bothers everyone around you, but it doesn't bother the patient. And the best thing we can do is actually prevention. And so things that I tell ICU staff is if we have any inkling that we're pursuing something like comfort-focused care, then let's stop maintenance fluids. The more fluids that you have, the excess fluids you have, the worse those terminal secretions are going to be. And so previous literature recommended that you start with glycopyrrolate pre-extubation. I don't know if that's still supported, but that being said, it is very difficult to be a loved one or someone caring for somebody in the realm of seeing somebody with terminal

secretions. So I'm going to turn the time over to Michelle and just let her kind of say her piece.

Dr. Weckmann

I thought you were going to steal my thunder there. I agree entirely with everything that John said. But it's really hard to be sitting at that bedside, especially when you're at home and you're alone and not have anything to do. So we do still use, I only use glycopyrrolate because it's the one that doesn't cross the blood-brain barrier, so it's less likely to cause delirium. Yes, it can cause the dry mouth and the stickier secretions. But we do teach families how to position. They aren't always able to because of physical limitations. Our nurses will go out and assist with positioning, but sometimes they just need something to do because they're so distressed by the sound that's coming out of those patients, by those terminal secretions. And then we do use glycopyrrolate. Anecdotally, there are times that it's helpful, or at least family members tell us it's helpful.

Dr. Clancy

Sure, sure.

Dr. Weckmann

So we confuse support hospice and palliative medicine fellows.

[laughter]

Dr. Clancy

You guys are keeping it very civil. Great job.

[laughter]

Dr. Clancy

If the audience could only see your faces, yeah, that's right. So I'm a frequent de-prescriber. So what's your framework for de-prescribing in the inpatient hospice setting?

Dr. Wilde

Michelle, I'm going to let you go.

Dr. Weckmann

So it's all goals of care, right? Most of what I do is based on goals of care. We sometimes have patients and families who are just not ready to get rid of those chronic maintenance medications that we know are no longer serving their purpose, right? Atorvastatin. If

somebody is in the dying process, atorvastatin does not make any difference anymore. We can provide education. But if it's providing that patient or family comfort and they're able to still swallow, I don't fight it. Yep. And that's not about all, it's not a hill I choose to die out.

Dr. Wilde

It's hilarious because when I was a fellow, I remember being in our IDT discussions where you're discussing all the patients on the census. And I remember just keep on saying, There's patients on aspirin and statin, this patient, blah, blah, blah, blah, blah. And I remember going to one of these houses and talking to this 80 some old year old lady. She looks at me, she said, I have been on aspirin for the last 40 years. I'm gonna die on aspirin. And I said, okay, you know what? That's fine. You know, and yeah, pick your battles. I will say, you know, when it comes to just de-prescribing, do what's right. You know, if you feel that this is not going to be contributing to someone's comfort. I don't know anyone who's like, you know, that Lipitor really just made me feel so good, you know, or that Lisinopril or whatever. It just, if it doesn't make them feel any better, but it does well for the mind, keep it. If it doesn't do anything at all and they don't care to have it, get rid of it.

Dr. Clancy

Good. So Michelle, you opened the door. Let's talk about goals of care. And again, you're both seasoned clinicians. Again, kind of specifics, what are some of your opening lines when introducing hospice in the hospital setting and selling it in a way that it's, this is the right time and this will be helpful?

Dr. Weckmann

So I am gonna pull out what I call the Ann Broderick method.

Dr. Clancy

Oh, I know Ann, yes.

Dr. Weckmann

Yeah, lots of us know Ann. Watching her do a number of these conversations, when she was bringing up hospice, she would never refer to it initially by name, but what she would say is, what if I told you that there was a service who would come into your house, with nurses and social workers and chaplains, and they would give you the durable medical equipment you needed, and they would cover your medications, and they would make sure you were comfortable and your symptoms were well managed. And I told you this was free. And you know, everybody would be like, that sounds like a great service.

Dr. Wilde

Pick me! Pick me! Yes, please.

Dr. Weckmann

And she'd go, the name of that service is hospice.

Dr. Wilde

Oh no, no, no. I don't want hospice. That's scary.

Dr. Weckmann

[laughter] Exactly. And then I would follow up with, tell me what your concerns are about hospice. What have you heard? What have you experienced? But introducing it without calling it by its name sometimes helps.

Dr. Wilde

I do very similarly. I think what we do is I try to go and establish what's important to patients, what their ultimate wishes are, and then aligning with that. Hospice is not the forefront of the conversation. It's the aftermath of a deep conversation, which ultimately leads to, it sounds like we're at a point now where we're trying to go and focus on comfort. The best way I know to make that happen, to keep them from having to come back to the hospital and things like that is with the support of hospice. So aligning treatments with goals is how we do it.

Dr. Clancy

And, you know, you both are experienced enough, you know, doing this for so many years, and I'm sure you're ready for it, but when the family says, so you're saying we're giving up, How do you, what's your comeback that keeps the conversation where it needs to be as far as goals of care?

Dr. Wilde

Reframing is so much of what we do, you guys. It's, I think this, instead of you're giving up, it's no, we're not giving up. We're just providing rational, logical care here. We're doing everything, we're being very aggressive in making sure that we're providing life to those days rather than days of this life.

Dr. Weckmann

Yeah, we're changing the goals from disease cure to symptom management.

Dr. Clancy

Yeah, good. And how about, sometimes different members of the family are going to be torn on this and sometimes the treatment team as well, different or different parts of the treatment teams. How do you manage some of that conflict?

Dr. Weckmann

I was going to say, I keep bringing the patient back into the room, whether the patient is in that room or not. So, you know, what has your dad told you in the past? Or sometimes it's as frank as saying, we are going to turn this conversation now to talk about your dad. This conversation is about your dad. And just sort of keeping that patient in the center of the conversation and what those patient goals are.

Dr. Wilde

I agree. And I kind of refer to this book. For those who can't see the video, it's Master Communication with Seriously Ill Patients. This was written by Anthony Back and Robert Arnold and James Tulsky. Really phenomenal resources here talking about conflict. And I think that, again, it's emphasizing, recognizing that two people can be coming at the same problem with two different angles with the same exact emotion. They both care about this person. and just naming that in the room and letting it air out and then encouraging giving each other grace through this difficult time. Sometimes conflict can happen for so many different reasons. And I would just, I could give an hour long lecture on conflict. So I won't go into deeper detail, but I think again, it's focusing on the patient. I would agree with Michelle.

Dr. Weckmann

I just want to throw one more thing is grief. Grief makes people do things they would not normally do, and naming that can sometimes be really helpful. These actions are coming out of grief sometimes, not the person themselves.

Dr. Clancy

So any guidance on when the patient moves into a state of lacking capacity and again, working with families on who's the decision maker?

Dr. Wilde

So when a patient lacks capacity and we have to figure out who the decision maker is, or is that your question?

Dr. Clancy

Yeah, they oftentimes call the psychiatrist, and have us declare that the person does not have capacity, but then what?

Dr. Wilde

Right. I mean, I think that this is a medical-legal concern and it goes back . . . I'm assuming, of determining who would be the next legal next of kin and durable power of attorney. And here in the state of Iowa, obviously we have the hierarchy of so on and so forth. But where I struggle is where when those people who are named as those medical decision makers who are clearly not electing to pursue what the patient otherwise would want. That's a big challenge. because you have to keep on bringing the, you have to continue to bring the patient back in. If Gerald were here in the room with us, what would Gerald. . .

Dr. Clancy

It's Gerard, by the way.

[laughter]

Dr. Wilde

No, not Gerry. I'm just, you know, if patient X were in the room with us now, how would they, how would they respond having understood what we're talking about today? And that's the best thing I can do. But even at that point in time, sometimes people, I've had people say to me so many times, I know that they would say this and they would hate me for saying this, but I cannot let my loved one go. And at that point in time, I say, you know what? Why don't we take a break? You know, we'll hit this back later.

Dr. Weckmann

I would say one of the biggest problems that I face is when a patient does not have capacity, but the healthcare power of attorney keeps deferring to what the patient is saying or says they want. When they don't actually understand the fact that they are terminally ill or dying. And so that can create sometimes some interesting conflict.

Dr. Clancy

Sure. This one hits, this next question actually hits a little bit too close to home because we actually had an issue about this where hospice was in place, but we had not had the code and the DNR conversation that needed to be had. So how do you circle back and make sure that code status and hospice or state are aligned.

Dr. Weckmann

Okay, I'm going to jump in and say they don't need to be aligned. Some patients need to be coded. Some patients need to die in the hospital. Some families need that. And so you can be a full code and still be on hospice services. From my standpoint, I make sure the patient and the family understand what that means. So it typically means they won't die at home. It may mean that they get CPR completed, they may get ribs broken. I don't scare them when I'm having these conversations, but we talk about the fact that their death will probably be medicalized and it won't occur at home. And comfort may not be the chief focus at that time. But some patients and families need this. They need to die in the ICU with all of the bells and whistles.

Dr. Wilde

Go down swinging, right?

Dr. Clancy

We did everything we could.

Dr. Wilde

Yeah, exactly. And for some, that's ethically how the framework of their life is. I find it so fascinating because I think hospital-wide, and I don't think that's unique to this institution, we're so obsessed with code status. So obsessed with code status, and for good reason. But I can't tell you how often I get a consult saying, hey, can you, this is an 87 year old, can you make them DNR? And that is not my role. And I can tell you that when I approach code status conversations, rarely is it, do I go in with the intent to go and actually change code status. My goal is to talk to them about what their wishes would be. And then after we've determined value systems, then I align those patients, their goals with that treatment. And so I say, hey, you never want to be on a ventilator again. Okay, great. I'm so grateful that you said that with me. Because of that, we're not going to be doing full, we're not going to do a code status here because it will invariably lead to you needing a ventilator. You know, that's an informed assent model, just so, you know, for those who are in the business.

Dr. Clancy

The nuances of the code is really important. Absolutely. Yep, very much so. We did a, I think, one of our most meaningful podcasts with Dr. Schmidt on the getting DNR right. Yeah, it was really, yeah, he changed the way I think about things. Yeah. What are some of the common non-beneficial traps that once they enter into this, the hospice category that we forget about that sometimes we can remove? And what I'm getting at is sometimes, you know, they keep on getting poked for labs and things like that. Are there other things that

that just you need to pay attention to because the routine of the hospital is there and it needs to be stopped?

Dr. Wilde

This is a challenging question. I think it's always a challenging question because oftentimes the things that we start with are given by the time that someone's considering hospice or end-of-life care preceded what we have. So for example, someone has a tracheostomy or they have a PEG tube and then the discussion happens, well, what do we do with this now? And so that becomes a big challenge. At the same token, you can't blame people for doing these things, understanding that tracheostomy improves people's infection rates and likelihood of having physical therapy and so on and so forth. It's good, but we have to be mindful of somebody's ultimate prognosis when it comes to starting any of these initiatives. And so those are some of the quote unquote traps. I give a lecture to my fellows called tube traps. And we got to be cautious about the instigation of these things. And I kind of mentioned the maintenance fluids before, as it might seem like you're doing good things, but in reality, you might be making it so terminal secretions are made worse. I don't know, Michelle, what do you think about this? This is kind of more up your alley in some ways, too.

Dr. Weckmann

So vitals, vitals at 4 a.m. or midnight drives me crazy. If you've got someone who's more alert, they need to sleep. And so changing that vital frequencies to, BID of patient awake or even Q day or not at all. Antibiotics, I think, imaging, things of that nature, those all depend on goals of care. There are times that I might have somebody who's GIP, not actively dying, who I think has a pneumonia. So antibiotics would be appropriate, or a trial of antibiotics if it's consistent with goals of care. Somebody who's in final days or final hours, running another dose of IV antibiotic isn't going to change anything and may, as John already mentioned, make symptoms worse because we're giving them fluids that their body doesn't know how to process anymore.

Dr. Wilde

Right. I mean, I often listen to patients and families, especially this is like for tube feeds, right? Why can't, you're gonna starve my loved one to death? What do you mean? And they don't realize by signing up for ongoing tube feeds, it's like their gut is shutting down. So not only are they on increased likelihood of not being accepting of those tube feeds, so they're gonna puke it up and aspirate it, but also anything that gets past your, you know, into your small intestines and beyond, it's going to reduce, it's going to result in significant gas formation because all the bacteria is just having a heyday of all this extra sugar. And so we're actually making things worse, not better. And so hearing them out, hearing concerns,

then conveying, you know, while I hear you, I'm concerned that this might actually result in worsening X, Y, or Z and just being cautious about that.

Dr. Clancy

Great. All right. One last question before we have the lightning round, which is new to Rounding@IOWA. So how about planning for discharge? So it's, you've mentioned at the start, these hospitalizations sometimes are just three or four days. What needs to happen for discharge back to home?

Dr. Weckmann

So I'm going to say from the hospice standpoint, you have to have the conversation at the beginning of GIP especially if this is a hospitalized patient who then moves into GIP that if symptoms stabilize and are managed, we have to discharge from the hospital. They can't remain on hospice GIP in the hospital if symptoms are controlled. That, in my opinion, needs to happen at time of admission to hospice. And social work needs to get involved at time of admission. And those conversations need to be ongoing.

Dr. Clancy

John, anything?

Dr. Wilde

I completely agree. I think expectation setting is the key here. Anytime that we do a GIP conversion pre extubation, I always say, we're going to start here in the hospital. We're going to see how things go. And then we will work to getting them closer to home. If we don't say that last phrase, then people come at it like, what? What do you mean? We're going home? I thought we were going to die here. Everything's going to be fine. And that we need to make sure that we're, you know, there's reasons to be in the hospital if you're sick. There's reasons to be in the hospital if you're dying.

Dr. Clancy

All right. Wonderful, wonderful detailed answers. Now, you have to give short answers. All right, so it's lightning round. A phrase you use in hospice conversations.

Dr. Weckmann

The focus of hospice is on living, not dying.

Dr. Clancy

Great. John?

Dr. Wilde

I think I just repeat what I said before is add more life to your days instead of days to your life.

Dr. Clancy

I like it. Great. A phrase you never use.

Dr. Weckmann

A patient just passed on or expired. Use the D word. A patient died.

Dr. Wilde

Agreed. I'll add another euphemism: gone. I was once with a resident who told a family member the patient's gone, and they said, well, where'd they go? And they looked awkward, like, “Jesus?” [laughter] And so it just is awkward. So use died. I would also add withdrawal care. Never use withdrawal care.

Dr. Clancy

Great. A clinical sign you watch closely in symptom crisis.

Dr. Weckmann

Non-verbals. All of those.

Dr. Wilde

100%. Use your Abbey pain scores, your respiratory distress observation score, your MOPAT. These are non-verbal scales to determine pain and dyspnea. Essential.

Dr. Clancy

Great. A myth about pain control that you want to bust.

Dr. Weckmann

Opioids are not addictive if they're being used to treat physical pain or dyspnea.

Dr. Wilde

And also opioids don't kill people when done correctly, right? So if you're doing an end of life care, doesn't mean that I caused your loved one's death by using opioids.

Dr. Clancy

Right. How about a resource you recommend for clinicians? And John, you showed a book just a little while ago.

Dr. Wilde

Oh, we have so many things. I think one that both Michelle and I agree on is Fast Facts. Fast Facts is a repository of, I think, 500 plus different palliative care specific things. It's a website, it's an app. And it goes into fairly good detail backed by literature about why we manage things the way we do.

Dr. Weckmann

There are one-page sheets written at a resident level. And so I often hand out the fast facts on how to do a successful extubation.

Dr. Clancy

Great. That's a great one. All right. So as we close, what are some of the take-home points you'd like to leave with our listeners? You guys have been so good. John, let's start with you. Take-home points?

Dr. Wilde

My take-home points would just be all of these things require conversation. Once we understand, you know, the purpose of a goals of care is aligning goals with treatments. Anything else is considered to be a just informed consent. And so once we know their goals, then everything else falls into place. That includes general inpatient hospice. General inpatient hospice is intended for those who have poorly controlled symptoms that necessitate a hospitalization, and we're here to support them during the end of life, final chapter of their life.

Dr. Clancy

So. Great.

Dr. Weckmann

I'm going to agree entirely with what John said, and I will just add the piece that patients can't adequately tell us their goals if they don't know what their true prognosis is.

Dr. Clancy

Yeah. Yes. Good. Great, great, great. Have the hard conversations. Yep. To both of you, thank you so much for joining us and for your great work on these really highly complex

end-of-life issues. And thanks for taking care of families and patients during these very difficult times, but really with a great amount of dignity that you do.

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