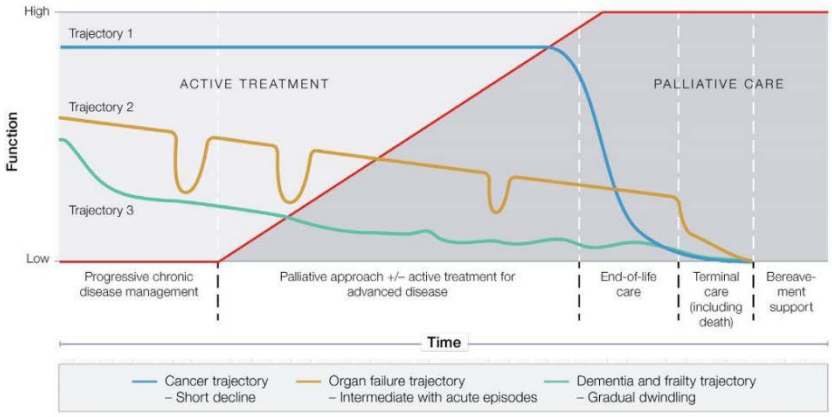
Identify patients & clinical scenarios where an EOL discussion is appropriate

Context: There is a disconnect between the care patients would like to receive at the end of life and the care they receive. Seventy percent of Americans would prefer to die at home, but only 30% do.

Current: Hospitalists are on the frontlines of providing care to seriously ill patients and frequently care for patients nearing the end of life. Often, goals of care are not discussed during acute care hospitalization.

Cutting edge: Palliative care is appropriate earlier earlier in patients' illness trajectories and poor prognosis should be identified based on such factors as readmission and declining functional status. Hospitalists should be skilled in delivering primary palliative care, including prognostication and serious illness conversations to ensure goal-concordant care.



Never-Words	Alternative
There's nothing else we can do	Therapy X has been ineffective in controlling the cancer, but we still have the chance to focus on treatments that will improve your symptoms and, hopefully, your quality of life.
She will not get better	I'm worried she won't get better.
Withdrawing care	We can shift our focus to his comfort rather than persisting with the current treatment, which isn't working."
Do you want us to do everything?	Let's discuss the available options if the situation gets worse.
What would he want?	If he could hear all of this, what might he think?

Formulate strategies for approaching an EOL discussion

Context: Serious illness conversations are a procedure which can and should be learned.

Current: Several frameworks for serious illness conversations exist.

Cutting edge: Sharing prognosis does not take away hope. Words matter poorly done conversations lead to misunderstanding and breakdowns in trust. One example of a tool to help improve conversations: https://www.ariadnelabs.org/wp-content/uploads/2023/05/Serious-Illness-Conversation-Guide.2023-05-18.pdf

Recognize and manage symptoms at the end of life

Context: EOL care includes providing symptomatic relief by identifying, assessing, and treating pain and other distressing physical signs and symptoms, along with the emotional, social, and spiritual support tailored to the needs and wishes of the individual and their loved ones.

Current: For patients with prognosis in the months range, make medication changes based on gestalt.

Cutting edge: Deprescribe non-essential medications based on prognosis. Do not hesitate to use start short acting opioids in opioid naïve patients and titrate up as tolerated. Start treatment of pain and dyspnea with patients at the very end of life (hours to days) with as needed bolus treatment rather than an opioid infusion.

Example Medications	Recommendation (Consider deprescribing….)	Agreement
ACE-inhibitors or ARBs	If for primary prevention of diabetic nephropathy	93.6%
Beta-blockers	Taper if prescribed for mild-moderate HTN	90%
DOACs	If high risk bleeding or if uncontrolled HTN	100%
Insulins	Change fast-acting or mealtime insulins to simpler regimen if irregular intake, lower long acting doses if clinical deterioration	86.7%, 90.9%
PPIs	If prescribed for an ulcer/esophagitis or no clear history of GI bleed, GERD, NSAIDs or steroids	88.6%

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