Palliative and Therapeutic Harmonization: Optimal care meets appropriate spending

June 12, 2013
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The Summit:
Creating system change through innovation
PATH is a work in progress. Preliminary results are encouraging.

The Journey
1. Understand
   • Dementia
   • Co-morbid disease
   • Frailty
2. Communicate
3. Empower

The Mountain: Why PATH, Why Now?

PATH
Palliative and Therapeutic Harmonization
Aligning Care with Prognosis in Frailty

Paige Moorhouse MD, MPH & Laurie Mallory MD
Geriatric Update Feb 23, 2013
PATH

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Aligning Care with Prognosis in Frailty

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The Mountain: Why PATH, Why Now?

- Population aging
- Unprecedented levels of frailty
- Increasing reliance upon technically advanced, highly specialized algorithms
- New focus on inappropriate

YET:
- Frailty can be addressed by current models of health care
- Limitations of evidence-based medicine

A dangerous cycle threatens sustainable health care

Frailty

Health Crisis
• Population aging
• Unprecedented levels of frailty
• Increasing reliance upon technically advanced, highly specialized algorithms
• New focus on appropriateness

YET...
• Frailty not addressed by current models of health care
• Limitations of evidence-based medicine
A dangerous cycle threatens sustainable health care

Incomplete Recovery

Frailty

Health Crisis

WHAT’S DRIVING THIS?
- Medical advances
- Failure to coordinate complex care
- Treating one thing at once
- Epidemic of assessment

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WHAT'S DRIVING THIS?

• Medical advances
• Specialized mandates ("silos") that foster:
  – Indiscriminate application of guidelines
  – Inefficiency in multidisciplinary teams
    • Epidemic of assessment
    • Failure to co-ordinate complex care
    • Treating one thing at once
• Narrow focus to decision making
• Unsustainable use of resources
Re-assessing team-based care
Innovation

We sought to create a model of care where:

• Teams are able to collaboratively assemble the "big picture" of each person’s health story
• Frailty is at the forefront of evidence-informed decision making
• Patients and families feel empowered by information
• We make optimal use of resources
The Journey

1. Understand
   - Dementia
   - Co-morbid disease

2. Communicate

3. Empower
1. Understand

- Dementia
- Co-morbid disease
- Frailty

The key to appropriate care planning
The PLAN Tool

- Shift emphasis from assessment to planning as endpoint
- Acknowledges dynamic impact of frailty on decision-making
- Focus on appropriateness of care
- Helps change the culture of "doing nothing"
  - Choosing against an intervention doesn’t mean choosing against care

PLanning for Appropriateness Now
Dementia
Frailty:
The key to appropriate care planning
Frailty can be measured

Frailty predicts outcomes

Understanding frailty is critical to care planning
2. Communicate
PATH model differs from traditional PC model

• Increased emphasis on providing information
• Introduce frailty and its impact on prognosis
• When appropriate, acknowledge the "last chapter of life"
• Bond with families
  • Navigate and guide
3. Empower
<table>
<thead>
<tr>
<th>1</th>
<th>Understand</th>
<th>Standardized process and tool for assembling the health trajectory and frailty</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>&quot;What is this patient’s story?&quot;</td>
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<tr>
<td>2</td>
<td>Communicate</td>
<td>Approach to evidence-informed discussion of frailty and prognosis</td>
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<td>&quot;Did you know?&quot;</td>
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<td>3</td>
<td>Empower</td>
<td>Build skills in decision maker for current and future decisions</td>
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<td>&quot;What information do I need to make a decision?&quot;</td>
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The Journey

3. Empower

2. Communicate

1. Understand
  - Dementia
  - Co-morbid disease
  - Frailty

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Preliminary results are encouraging
PATH: Health Services

Decision Outcomes for Scheduled Treatments

- Cardiac Surgery: n = 53
- Other Surgery: n = 11
- Hemodialysis: n = 10
- Other Procedure: n = 3

A total of 71 patients had a total of 77 procedures scheduled at the time of PATH consultation.
# PATH: Appropriateness

<table>
<thead>
<tr>
<th>Baseline Measure</th>
<th>OR (95% CI) Controlled for age</th>
<th>P Value</th>
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</thead>
<tbody>
<tr>
<td>Frailty (Clinical Frailty Scale)</td>
<td>3.41 (1.39 - 8.33)</td>
<td>&lt;0.005</td>
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<tr>
<td>Dementia Stage (FAST)</td>
<td>1.66 (1.05 - 2.65)</td>
<td>0.03</td>
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<tr>
<td>Ranked Invasiveness of procedure</td>
<td>1.0 (0.37 - 1.40)</td>
<td>NS</td>
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**Multivariate analysis:** Controlling for baseline age and frailty, procedure invasiveness showed a trend towards association with decision to proceed (OR 0.5, 0.2 - 1.0).
Our Partners

Clinical Care

Primary Care:
- Central East LHIN GAIN Teams
- Seniors' Community Health Team (SSRH)
- Dalhousie Refresher Course

Tertiary Care:
- Pre-surgical Screening Program
- Renal PATH

Long Term Care:
- RK MacDonald (GASHA)
- Southwest LHIN Woodingford Lodges
- LTC Network (CIHR grant 1-97553)

Academia:
- Dalhousie Academic Detailing Service

Research Trainees:
- MAHTS Candidate: Qualitative study of CG experience
- MAHTS Candidate: HTN Guidelines in LTC
- Nursing PhD Candidate: PATH in LTC

Research and Education

Government collaborations:
- Nova Scotia Department of Health and Wellness
- Continuing Care Nova Scotia
- Drug Evaluation Service of Nova Scotia

Media:
- Thoughtcast: Interview Podcast #181
- Dr. Tek, April, 2012
- Palliative Care Network: Community Media Watch, 27 December, 2012

Awards:
- Accreditation Canada Leading Practice
- Capital District Gold Quality Award
- IPAC Leadership Award: Deloitte

Policy
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<td>Guide to decision making</td>
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<td>• Narrative knowledge translation tools on dementia, frailty</td>
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<td>• Guide to death at home/hospital</td>
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<td>• Framing Questions</td>
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<td><a href="http://www.pathclinic.ca">www.pathclinic.ca</a></td>
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Treating Hypertension in Long Term Care

Start Treatment
Consider starting treatment if a HBP is moderately high (160/100 mmHg or above) or if tolerated.

Stop Treatment
Antihypertensives can be discontinued if treating HBP is less than 130/< 80 mmHg and urine protein is normal.

In general, use non-pharmacological interventions.

Education
• Assessment tools
  - teams and individuals
• Training programs
• Evidence-informed treatment guidelines and widgets
Treating Hypertension in Long Term Care

Start Treatment

Consider starting treatment when SBP is 160 mmHg or higher
Use seated blood pressure (not supine) to make treatment decisions

• Aim for sitting SBP to be 140 to 160 mmHg if no orthostasis or other adverse effects.
• In the very frail with short life expectancy, a target SBP of 160 to 180 mmHg is reasonable.
• In general, use no more than 2 medications.

Stop Treatment

Anti-hypertensives can be tapered and discontinued if sitting SBP is less than 140 mmHg.

Before discontinuation, consider if the medications are treating additional conditions such as rate control for atrial fibrillation or symptomatic control of heart failure.

Adapted from Issues in Hypertension 2011, Dalhousie CME Academic Detailing Service, June 2011,
http://cme.medicine.dal.ca/ad_resources.htm
Collaborative Comprehensive Geriatric Assessment

Assessor: ____________________________

Date (YYYY/MM/DD): ____________________ Collaterals: ____________________________

- YO   - M   - F   - ER   - Clinic   - Home   - Inpatient   - Seen urgently

**Current Issue(s):**

- Pain
- Hearing impairment
- Visual impairment
- Current weight __________
- Weight loss __________
- lbs   - kg   - in

### Past Medical History

<table>
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<tr>
<th>Health Concerns</th>
<th>Relevant Information</th>
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### Medications

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<th>Prescribed Medications</th>
<th>Dosage</th>
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### Pertinent details of physical exam

- HR __________
- BP supine __________
- BP standing __________
- RR __________
- Weight __________
- lbs   - kg

- Skin breakdown:  
  - Yes  
  - No

### Diagnostics

<table>
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<th>Test Name</th>
<th>Result</th>
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Framework for Decision Making

- Which health conditions are easily treatable? Which are not?
- How will frailty make treatment risky?
- How can symptoms be safely and effectively managed?
- Will the proposed treatment improve or worsen function, quality of life, or quality of death?
- Will the proposed treatment require care in hospital? If so, for how long?
- Will the approach allow more good quality years, especially at home?
- What can we do to promote comfort and dignity in the time left?
Understanding Frailty

What is frailty?
Frailty is a fragile state of health that makes a person vulnerable to illness and injury. When a person is frail, he or she lacks vitality, strength and resilience to withstand physical and emotional stress.

A person can be frail at any age, but frailty is more common in older people. As they lose muscle mass and bone density, they may feel less stable on their feet and begin to move more slowly. They may feel weak and tired and find that shopping and housework are getting more difficult. Older people who are becoming frail may also find it harder to keep track of the details of their daily lives, as their ability to think and remember declines with the aging of their brains.

When a frail person is injured or sick, he or she is slow to recover and may never regain his or her previous level of health. As more health problems develop over time, the person becomes increasingly frail and requires more and more help from others with the tasks of daily living. Eventually, he or she may require help with personal care and may need to be admitted to a long-term care facility.

How do we recognize and measure frailty?
You can probably picture a frail person quite easily in your mind—you may imagine someone with a slight build, stooped posture, and slow gait. But how do you know what makes this person frail, and what that means to his or her daily function and quality of life? How can you predict how this person will fare in the future?

Researchers at the QEII Health Sciences Centre and Dalhousie University have developed ways to better answer these questions. They have developed a ‘frailty index’ to accurately measure the extent of someone’s frailty.

Simply put, the frailty index counts the number of health issues a person has, and compares this to the number of health issues typically experienced by people the same age. These could be any type of health issue, from heart disease, to osteoporosis, to confusion, to living alone. The key is not the type of health problem but the overall number of problems and their severity. The more health issues a person accumulates, the frailer they become.

Age is only part of the frailty equation
Not everyone will be frail, or as frail as other people their age. There are vast differences in how people age, depending on a wide range of genetic, lifestyle and other factors.

Look at Sandra and Joseph, for example:

Sandra is 82 and suffers from osteoarthritis of the knee, but she continues her habit of walking briskly for 30 minutes each day, in spite of the discomfort in her knees. Although she has macular degeneration, she can still drive and is active in her local gardening club, does her own housework and shopping, and cooks nutritious meals for herself and her husband.

In contrast, Joseph is 74 and being treated for type 2 diabetes, high blood pressure and angina. Nerve damage in his feet from the diabetes makes standing and walking uncomfortable, so Joseph spends most of his time sitting. As a result, he feels unsteady and moves slowly on his feet. He is afraid of falling and gets his daughter to help him to and from appointments and errands. A widower, Joseph relies on hired help to clean house and tends to eat frozen dinners.

Although Sandra is considerably older than Joseph, she is fit and he is frail. Clearly, age is only part of the frailty equation.
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Creating time and space for complex medical decision making
Why Path?

• Quality of Life
• Appropriateness of Care
• Spread
Questions?

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Alternatively, questions can be asked verbally by pressing *1 on your telephone.
Thank you!

Please take a moment to complete a brief survey at: http://www.surveymonkey.com/s/VGT7XS2

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