"If Only Someone Had Warned Us"

How to recognize pre-terminal patients and the potential harms caused by continuing traditional care.

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Disclosures

- National Hospice and Palliative Care Organization (NHPCO)
- Coalition for the Advancement of Palliative Care (CAPC)
- MCE CME for Primary Care
- Family Medicine Education Consortium (FMEC)
- Goldblatt IT Systems



Cardiac Case Study



Chief Complaint

86 Year old female comes in to see you for passing out after picking something up off the ground while walking her poodle in the backyard. She has stable substernal discomfort with exertion as well. She is occasionally light headed.



History of Present Illness

Known AS for 10 years; now with dyspnea walking across a room with a cane and ankle edema. Has a FWW but "never uses it". Feels generally more fatigued, weaker and has lost 12 pounds over the last year due to change in appetite. Work up for weight loss was unrevealing. Denies palpitations. 2 stents placed 7 years earlier for CAD. H/O DM, Htn, CAD, a-fib and mild diastolic failure. She also is being treated for gout, moderate osteoarthritis pain and depression.

She has a BMI of 21. She is generally inactive and rarely gets out because she is "not up to it." She states she hasn't had the energy she used to for years. Does not smoke or drink.



Description - Continued

She has lived with her daughter and son-in-law for 2 years. Both work. Does not drive, cook or pay bills. She is mildly demented with a MMSE of 22, 6 months ago. Her family states that she is just a little forgetful. She wears glasses (20/100 without) and hearing aids (when she remembers). Daughter states she needs more help since she is losing her strength.

Previous Surgical History

- TAH
- Lap chole
- ORIF with stage 3 heel ulcer (resolved) and delirium



Medication Table

ASA	325mg	Oxybutynin 5mg bid
Atorvastatin	10mg	Paxil 20mg
Metoprolol	50mg bid	Flexeril 10 mg qhs
Lisinopril	20mg	Hydrocodone 5/325 tid prn
Digoxin	0.250mg	Ibuprofen 600mg tid
Metformin	500 bid	Tylenol PM
Allopurinol	300mg	MVI
Furosemide	20mg	Potassium ER 20meq
Aricept	5mg qd	Pantoprazole 40mg



Vitals

Vitals: BP 100/50, HR 52, RR 16, Temp 97.8

Alert and oriented but easily distracted. No JVD at 90 degrees. Heart is irregular with a 2/6 SEM at the RSB, Lungs are CTA with diminished AE. Abd is soft, NT and NABS. No HJR. No focal neuro deficit. +1 bilateral ankle/le edema.

CXR - Poor inspiration but NED

ECHO - Mod Severe AS, diastolic failure, mild decrease in LVF.

EKG; a fib with HR 54



Lab Data

Abnormal for hemoglobin 11.2, total chol 110 (was 150 the previous year)/ LDL 43 (was 65), pro-BNP 537, albumin 3.3, BUN 24/Cr 0.7, hgbA1c 6.0



A Decision is made to consider surgery after an angiogram is obtained.

Before you proceed... Here are some questions to ask.



Up to Date: Physiology and Goals of Care for the Pre-terminal Populations are Not the Same as a Younger and Healthier Geriatric Patient



Hoefer, Daniel, M.D.



Identifiers of a Pre-terminal patient:

Weight loss (Wallace, JAGS 1995) – 2 year follow up No loss 11% Involuntary loss 28% Voluntary loss 36%

Heel ulcer (Malik, JAMDA 2013) – 1 year
Stage 1 or 2, 55%
Stage 3 or 4, 70%
All stages without vascular intervention 68%
All stages with vascular intervention 59%

Delirium (multiple articles) 30% at 3 mo. to 78% at 34 mo.

Biomarkers (Verdery 1991 J of Gerontology)

84% 1 year mortality for patients with low cholesterol (<160) plus low albumin and hemoglobin versus 7% if none were low. For stable custodial patients.







Other Risk Factors for this patient:

- Cognitive Decline
- Depression
- Social Isolation
- Polypharmacy



What is this patient's biggest concern?

How much does the patient's cardiac condition really play into her health status?



Do providers want to know what stage of advanced age their patient belongs to?



This patient's risk of developing hospital induced delirium is:

- a. 23%
- b. 33%
- c. 53%
- d. 63%
- e. 83%



Inouye, Sharon, MD, *Risk Factors for Delirium at Discharge*, Arch Intern Med 2007; 167(13)

Incident delirium

Risk Factors:

- 1. Dementia
- 2. Vision worse than 20/70
- 3. Functional Impairment
- 4. High comorbidities
- 5. Any Restraint

0-1 Low 2-3 Intermediate

4-5 High



	Delirium	Death or NH
		Placement
Low risk	4%	15%
Intermediate	18%	39%
High	63%	64%



Table 4. Predictive Model for the Risk of Delirium in Hospitalized Older Patients

Risk factor	Points
Cognitive impairment (inability to think, concentrate, reason, remember, formulate ideas)	1
Elevated blood urea nitrogen/serum creatinine ratio (greater than 18)	1
Severe illness (APACHE score greater than 16, or nurse rating of severe)	1
Vision impairment (corrected near vision worse than 20/70 in both eyes)	1
Interpretation: 0 points = low risk (10% chance of developing 1 or 2 points = intermediate risk (25% chance of developing 3 or 4 points = high risk (80% chance of developing delirium	delirium); delirium); 1).
APACHE = Acute Physiology and Chronic Health Evaluation clincalc.com/lcuMortality/APACHEILaspx).	n (http://

Information from reference 3.

American Academy of Family Physicians August 1. 2014 Volume 90 Number 3



Remember a delirium model for reference



Table 2. Risk Factors for Postoperative Delirium

Age greater than 65 y Cognitive impairment Severe illness or comorbidity burden Hearing or vision impairment Current hip fracture Presence of infection Inadequately controlled pain Depression Alcohol use Sleep deprivation or disturbance Renal insufficiency Anemia Hypoxia or hypercarbia Poor nutrition Dehydration Electrolyte abnormalities (hyper- or hyponatremia) Poor functional status Immobilization or limited mobility Polypharmacy and use of psychotropic medications (benzodiazepines, anticholinergics, antihistamines, antipsychotics) Risk of urinary retention or constipation Presence of urinary catheter Aortic procedures

Adapted from: Chow WB, Rosenthal RA, Merkow RP, et al. Optimal preoperative assessment of the geriatric surgical patient: a best practices guideline from the American College of Surgeons National Surgical Quality Improvement Program and the American Geriatrics Society. J Am Coll Surg 2012;215:453-466.



National Institute for Health and Care Excellence: Risk Factors for Delirium

- 1. Age greater than 65. OR: 3.03
- 2. Chronic cognitive decline or dementia. OR: 6.3
- 3. Poor vision or hearing. OR: 1.7 for hearing
- 4. Severe Illness. OR 3.49
- 5. Infection. OR: 2.96



Marcantonio: Non-cardiac Delirium Risk Postoperative

- 1. Age greater than 70. OR 3.3
- 2. Poor cognitive status. OR 4.2
- 3. Poor functional status. OR2.5
- 4. Self Reported Alcohol abuse. OR 3.3
- 5. Markedly abnormal pre-operative serum sodium, potassium or glucose. OR 3.4
- 6. Non-cardiac thoracic surgery. OR 3.5
- 7. Aortic Aneurysm Surgery. OR 8.3



Delirium – Predisposing Factors



Fig. 1. Age and the probability of transitioning to delirium. The most notable finding related to age was that probability of transitioning to delirium increased dramatically for each year of life after 65 years. Adjusted OR 1.01 (1.00, 1.02) (P = .03). Y-axis = Probability; X-axis = Age in years. (From Pandharipande P, Shintani A, Peterson J, et al. Lorazepam is an independent risk factor for transitioning to delirium in intensive care unit patients. Anesthesiology 2006;104(1):23; with permission.)

Maldonado, JR, Delirium in the Acute Care Setting: Characteristic, Diagnosis and Treatment, Critical Care Clinic 24 (2008); 657-722



Remember important risk factors for delirium when evaluating any patient.

Not all risk factors are equal





It is important to recognize who might develop delirium because delirium is associated with all of the following long term consequences except:

- 1. Delirium is only associated with short term but not long term consequences
- 2. Higher mortality
- 3. Longer lengths of stay
- 4. Higher rates of Readmissions
- 5. Permanent functional decline
- 6. Permanent Cognitive decline
- 7. Higher rates of institutionalization







Study	Number of people with delirium/ total population	Population characteristics						Prognosis
		mean age	females %	dementia %	nursing home patients, %	comorbidity	ADL impairment	mortality/time
Levkoff et al. [4]	144/325	82	67	24	30	NR	NR	26.4%/6 months
Francis et al. [18]	50/229	78	60	0	0	high	NR	39%/2 years
O'Keeffe and Lavan [5]	95/226	82	60	30	20	Charlson 2.1	high	31%/6 months
Inouye et al. [6]	87/727	79	60	19	4	high	medium	30%/3 months
McCusker et al. [8]	243	30%	60	NR	NR	Charlson 2.3	high	42%/1 year
	compared with 118 nondelirious	>85 years					-	
Present study	106/425	66% >85 years	75	60	40	Charlson 2.3	high	35%/1 year, 59%/2 years

Table 4. Population characteristics and prognosis of patients with delirium in various studies





Reminder:

Mortality with hospital induced delirium is about 30% at three months to 80% at three years.



NEJM Cognitive Decline Post Cardiac procedure 2012

- 60 years of age or older
- Statistically significant decrease in MMSE scores at 12 months for status post operative cardiac procedures p < 0.001
- 31% vs. 20% : delirious vs. non delirious patients
 p = 0.055

Saczynski, Jane, PhD, et Al. *Cognitive trajectories after post operative delirium* 2012, NEJM 367(1):30-39



Wacker, Priscilla, et al, *Post-Operative Delirium is Associated with Poor Cognitive Outcomes and Dementia*, Dement Geriatri Cogn Disord 2006; 21:221-27

Is delirium the precursor for dementia?

For this study – no pre-existing cognitive, hearing or visual deficit known Hip or Knee replacement

Fracture – 60% developed delirium Elective Repair – 24.6% developed delirium.

5 year prospective Study

Results: Patients who developed delirium were 1050% (10.5 times) more likely to have developed dementia than those who did not.



Study	N	Population	Study design	Follow-up period	Delirium measure	Cognitive outcome measure	Findings
Koponen and Riekkinen, 1989	70	Geriatric psychiatric hospitalized patients	Prospective	l year	Clinical Rating	D-Test ²	Cognitive deterioration associated with delirium observed in 36% of patients at 1-year follow-up
Francis and Kapor, 1992	229	General hospitalized medical patients	Descriptive	2 years	Chart review, clinical interview, MMSE	Modified Telephone MMSE	Decline in MMSE scores in patients with delirium compared to controls
Rockwood, 1999	203	General hospitalized medical patients	Prospective	3 years	DRS, ^b MMSE, ^c Clinical Judgment, CIRS ^d	MMSE, Blessed Dementia Rating Scale, Gero-psychiatric Interview	Delirium was associated with increased dementia at follow-up
Dolan et al., 2000	682	Hip replacement surgery	Prospective	2 years	Chart review, proxy interviews using a modified version of the CAM	MMSE	Patients with delirium were more likely to have cognitive impairments at 2-year follow-up
Rahkonen et al., 2000	51	Community-dwelling elderly hospitalized for acute delirium	Prospective	2 years	DSM-Criteria	Neuropsychological battery	Patients had higher than expected dementia incidence rates over 2 years
McCusker et al., 2001	315	Medical patients	Prospective	l year	CAM ^e	MMSE	Patients with delirium had lower MMSE scores at 1-year follow-up compared to controls
Katz et al., 2001	102	Residential care patients	Prospective	l year	Clinical evaluations	MMSE, Buschke Selective Reminding Tests, Stroop Test, Verbal Vigilance	Patients who develop delirium within the context of a medical illness demonstrated greater cognitive decline
Rahkonen et al., 2001	199	Community-dwelling patients	Prospective	3 years	Surrogate interviews, clinical interviews, chart review	MMSE, ADL, ^e IADL, ^g Chart Review	Increased risk for new diagnosis of dementia among "oldest old"
Jackson et al., 2003	34	Medical ICU patients	Prospective	6 months	CAM-ICU ^k	Comprehensive neuropsychological battery	No significant association between delirium duration and cognitive outcomes

- ^aD-Test = D-Test is the full title. elsewhere.
- ^bDRS = Delirium Rating Scale.
- ^cMini-Mental State Exam.
- ^dCumulative Illness Rating Scale.
- ^eCAM = Confusion Assessment Method.
- fADL = Activities of Daily Living.
- ^gIADL = Instrumental Activities of Daily Living.
- ^hCAM-ICU = Confusion Assessment for the Intensive Care Unit.















George, James, et al, *Causes and Prognosis of Delirium in Elderly Patients Admitted to a District General Hospital*, Age and Ageing 1997; 26: 423-27

1 year risk - OR	
Mortality	2.30
Institutionalization	4.53
Readmission	2.05


Marcantonio, Edward, MD, SM, et al, *Delirium Is Independently Associated* with Poor Functional Recovery After Hip Fracture, JAGS, 2000; 48(6)

Delirium occurred in 52 of 126 patients After adjusting for risk factors delirium was associated with poor functional outcomes at 1 mo

ADL decline OR - 2.6 Decrease in ambulatory ability OR - 2.6 Death or Nursing Home Placement OR - 3.0

< 50% of patients returned to their pre-fracture level of function. Followed for 6 months.



Reminder: What Patients Care About

Terri R Fried MD, et al, Understanding the Treatment Preferences of Seriously III Patients, NEJM 2002; 346: 1061-66

For advanced illness patients, 74.4% and 88.8%, of patients would forgo treatment if the treatment burden was low but the probability of severe functional impairment or cognitive impairment was high.

This compares to 98.7% of patients who would want treatment in the treatment burden was low and they were more likely to return to their previous level of function.

Mortality was not the major determinant in patient choice.

n=279

Patients' had no cognitive or functional deficits in this study.



Salkeld, G et al, *Quality of life related to fear of falling and hip fractures in older women: a time trade off study,* BMJ 2000; 320(7231): 341-46

Of women surveyed (>74 year of age) 80% would rather be dead than experience the loss of independence and quality of life that results from a bad hip fracture and subsequent admission to a nursing home.



This patient has an anticholinergic burden score of:

- 1. 0
- 2. 3
- 3. 6
- 4. 9
- 5. >12
- 6. What is an anticholinergic burden score?
- ...and why do we care?



Delirium is directly related to the number of medicines prescribed and the number of drug-drug interactions.

Drug Class or Variable	Reference(s)	Relative Risk of Delirium
Type/class of drug		
Sedative-hypnotic drugs	29-31	3.0-11.7
Narcotics	30-33	2.5-2.7
Anticholinergic drugs	29, 33, 34	4.5-11.7
Any psychoactive drug	35	3.9
Number of drugs		
≥2 psychoactive drugs	18	4.5
Adding >3 drugs in	18	4.0
24 hours		
2-3 drugs	27	2.7
4–5 drugs		9.3
≥6 drugs		13.7

Table 2. The Association of Medications with Delirium

Inouye, Sharon K, et al, *Delirium: A Symptom of How Hospital Care is Failing Older Persons and a Window to Improve Quality of Hospital Care,* Am J Med 1999; 106: 565-73



The most important medication issues associated with hospital induced delirium are polypharmacy and anticholinergic medications.



Medication Table

ASA	325mg		Oxybutynin	5mg bid
Atorvastatin	10mg	[Paxil	20mg
Metoprolol	50mg bid		Flexeril	10 mg qhs
Lisinopril	20mg	l	Hydrocodone	5/325 tid prn
Digoxin	0.250mg		Ibuprofen	600mg tid
Metformin	500 bid	-	Tylenol PM	
Allopurinol	300mg	1	MVI	
Furosemide	20mg		Potassium ER	20meq
Aricept	5mg qd	1	Pantoprazole	40mg



Evidence-Based Advanced Illness Medication List

Nitroglycerin	SL prn	ASA	?
Metoprolol	50mg bid	Allopurinol	?
Lisinopril	10mg	Anti Depressant	?
Tylenol or hydrocodo	one TID (no prn)	Docusate	?



Stopping Statins in the last Year of Life:

- 1. 381 patients
 - a. 189 stopped statins and 191 continued
 - b. 49% Cancer Patients 51% non-CA
 - c. Primary and secondary prevention
 - d. Median time to death
 - i. Off 229 days
 - ii. On 190 days
 - iii. Trend
 - e. Statistically significant improvement in QOL scores off statins
 - f. Less symptoms off statins and \$712 dollars less per patient.

Abernethy AP, Kutner, Blatchford PJ: Managing comorbidities in oncology: A multisite randomized controlled trial of continuing versus discontinuing statins in the setting of life-limiting illness. ASCO Annual Meeting. Abstract LBA9514. Presented June 3, 2014.

2. 84% 1 year mortality for stable custodial nursing level patients for patients with chol <150, low hemoglobin and low albumin (versus 7% if no markers present)

Verdery 1991 J of Gerontology



Side Effects of SSRIs n the Advanced Elderly Falls with Fracture: HR fracture 2.1, OR Falls 2.2 (Arch Int Med 2007, 106:188-940)

Worse risk of fracture than with glucocorticoids or PPIs: 19% of postmenopausal women will fall twice after starting an SSRI per year with a statistically significant increase in fractures (J Bone Miner Res 2012, 27(5): 1186-95)

Upper Gastrointestinal and post-surgical bleeding (J Clin Psych 2010, 71(12); 1565-75): doubles the risk of UGIBs and possible increase bleeding associated with surgical procedures

Hyponatremia: (Ann Pharmacother 2006; 40(9):1618-622



Clinical guidelines for the advanced elderly:

According to the American Geriatric Society, the American College of Cardiologists and multiple endocrinology societies, no advanced age diabetic should have a HgbA1C > 7.0.





Fig. 1. Kaplan-Meier survival curves for excessive polypharmacy (ten or more drugs), polypharmacy (six to nine drugs) and non-polypharmacy (five or fewer drugs) groups in (a) the first phase (n = 601, aged ≥ 75 years) between 1998 and 2002 and (b) the second phase (n = 339, aged ≥ 80 years) between 2003 and 2007.

Jrykka, J, et al, *Polypharmacy Status as an Indicator of Mortality in an Elderly Population*, Drugs and Aging 2009; 26: 1039-48



Using prognostic modeling, this patient's post hospital risk of functional decline is:

- 1. 15%
- 2. 25%
- 3. 35%
- 4. 45%
- 5. 55%



We <u>can</u> identify the at risk population for functional decline and provide statistical information:

Developmental Cohort n=448 Validation cohort n=379

- 3 Risk Factors Identified
 - 1. Increased age
 - 2. Decreased MMSE
 - 3. IADL deficiency

(IADLS – Managing Finances, Taking Meds, Using the phone, Shopping, Transportation deficit, Preparing meals, deficient housework)

Sager, Mark A MD, et al, Hospital Admission Risk Profile (HARP): Identifying Older Patients at Risk of Functional Decline Following Acute Medical Illness, JAGS, 1996;44(3): 251-57



TABLE 3 Scoring of the Risk Profile: Relationship Between Significant Predictor Variables and Loss of ADL Function
for the Development Cohort $(n = 448)$

Patient Characteristic	Parameter Estimate	Risk Score
Age		
<75 (n = 128)	reference	0
75-84 (n = 232)	.668	1
$\geq_{85 (n=87)}$	1.24	2
Abbreviated MMSE *		
15-21 (n = 349)	reference	0
0-14 (n = 99)	.562	1
Preadmission IADL function		
6-7 (n = 210)	reference	0
0-5 (n = 238)	.965	2

* Abbreviated Mini-Mental State Exam, range 0-21.

Number of independent instrumental activities of daily living before admission.



Risk of long term functional decline

	Development	Validation
Low (0-1)	17%	19%
Intermediate (2-3)	28%	31%
High (4-5)	56%	55%



This patient has how many characteristics of geriatric Frailty Syndrome? And why should we care?

- 1. 1:5
- 2. 2:5
- 3. 5:5
- 4. 3:8
- 5. 6:8



Adapted by the American Geriatric Society

Frailty has a Phenotype: Requires 3 or more of 5 clinical features

- 1. Loss of strength
- 2. Weight loss (unintended)
- 3. Low activity level/increased sleeping
- 4. Poor endurance or easily fatigued
- 5. Slowed performance/unsteady gait



Frailty As A Predictor of Surgical Outcomes

LOS for Major Procedures

No Frailty	4.2 days
Intermediate	6.2 days
Frail	7.7 days

Surgical Complications Major Procedures

No Frailty	19.5%
Intermediate	33.7%
Frail	43.5%

Martin A Makary, MD, MPH, Am Coll Surg. 2010 Jun;210(6):901-8. doi: 10.1016



Discharge Disposition (Assisted Living or SNF)

Minor Procedure

No Frailty	0.8%
Intermediate	0%
Frail	17.4%

Major Procedure

No Frailty	2.9%
Intermediate	12.2%
Frail	42.1%



Katherine Lee, MD, Et al, The Impact of Frailty on Long-Term Patient-Oriented Outcomes after Emergency General Surgery: A Retrospective Cohort Study. JAGS Vol 68, Issue 5.



Figure 1

One-year survival among older emergency general surgery patients separated by frailty group.



This patient's risk of "Hospital Associated Disability (HAD)" is:

- 1. 53%
- 2. 63%
- 3. 73%
- 4. 83%
- 5. What is HAD?...and why should we care?



"Hospital-Associated Disability"

- Defined as loss of 1 ADL needed to live independently without assistance
- Occurs in 30% of persons over age 70 frail patients have higher risk
- Occurs even if the illness is successfully treated and has no direct relationship to the illness
- Less than 50% of patients with HAD have recovered to pre-illness levels at 1 year

"Hospital-Associated Disability", 2011 Covinsky, K E, et al, JAMA 306(16):1782



Prognosis with HAD:

- 41% died at 1 year
- 29% Remained disabled
- 30% returned to pre-illness levels



Predictive Model for Developing Hospital Associated Disability (HAD)

Risk Factors:

- 1. Decubitus Ulcer RR-2.7
- 2. Cognitive Impairment RR-1.7
- 3. Functional Impairment RR-1.8
- 4. Low Social Activity Level RR-2.4



Total Risk Factors Probability of Developing HAD (Validation Cohort)

0	6%
1 – 2	29%
3 – 4	83%

Inouye, Sharon MD, MPH, et al, A Predictive Index For Functional Decline in Hospitalized Elderly Medical Patients, 1993 Journal of Intern Med :645-652



National Surgical Quality Improvement Program (NSQIP)

Preoperative evaluation 2012, 2016 and 2020 guidelines ACS and AGS

- MiniCog/MMSE on every patient going for surgery age 70 or older
- Geriatric frailty on every patient age 70 or older

Should also provide serial follow-up at 1 month, 6 months, 1 year and 2 years.



Palliative Preoperative Screen: (Always discussed in the context of the type of surgery or intervention.)

- 1. TUGT of > or = to 15 seconds
- MMSE of less than 25 or ANY documented cognitive disturbance (e.g MCI, previous delirium episode)
- 3. Alcohol or drug use
- Polypharmacy (Greater than 10 medications, including any OTC and vitamins = 1 point)
- 5. ACB score of 3 or greater or any benzodiazepine use
- 6. Multiple comorbidities
- 7. Age greater than 70
- 8. ADL deficiency
- 9. IADL deficiency

Any single factor, aside from age, should trigger a trained pre-operative palliative consultation.



Using this model to develop a Geropalliative Anticipatory Standard

Replace the "Annual Physical" with a Palliative Exam every second or third year after age 65



The Benefits of the Geropalliative Physical

- 1. Predicting who is likely to develop hospital-induced delirium
- 2. Identifying who is likely to be institutionalized after hospitalization
- 3. Identifying who will be discharged with psychotropic medications.
- 4. Identifying who will likely develop cognitive and/or functional decline regardless of the outcome of the organ system treated
- 5. Identifying who is at high risk of post hospital mortality
- 6. Identifying who is at high risk of prolonged hospital stay
- 7. Identifying who is at high risk of hospital complications
- 8. Identifying before hospitalization who is at risk of rehospitalization.



Surgical System wide Palliative Consultation and Frailty Screening: Ernst, KF, et al, *Surgical Palliative Care Consultations Over Time in Relationship to System wide Frailty Screening*, 2014 JAMA Surg

33% reduction in 180-day mortality (p<0.001) even after controlling for age, frailty or whether the patient had surgery if the patient receives a (physician led) palliative consultation.



(Circulation. 2012;125:1928-1952.)

© 2012 American Heart Association, Inc. *Circulation* is available at <u>http://circ.ahajournals.org</u> DOI: 10.1161/CIR.0b013e31824f2173

Table 1. Top Ten Things to Know

1. Shared decision making is the process through which clinicians and patients share information with each other and work toward decisions about treatment chosen from medically reasonable options that are aligned with the patients' values, goals, and preferences.

2. For patients with advanced heart failure, shared decision making has become both more challenging and more crucial as duration of disease and treatment options have increased.

3. Difficult discussions now will simplify difficult decisions in the future.

4. Ideally, shared decision making is an iterative process that evolves over time as a patient's disease and quality of life change.

5. Attention to the clinical trajectory is required to calibrate expectations and guide timely decisions, but prognostic uncertainty is inevitable and should be included in discussions with patients and caregivers.

Decision Making in Advanced Heart Failure

A Scientific Statement From the American Heart Association

Endorsed by Heart Failure Society of America, American Association of Heart Failure Nurses, and Society for Medical Decision Making

6. An annual heart failure review with patients should include discussion of current and potential therapies for both anticipated and unanticipated events.

7. Discussions should include outcomes beyond survival, including major adverse events, symptom burden, functional

limitations, loss of independence, quality of life, and obligations for caregivers.

8. As the end of life is anticipated, clinicians should take responsibility for initiating the development of a comprehensive plan for end-oflife care consistent with patient values, preferences, and goals.

9. Assessing and integrating emotional readiness of the patient and family is vital to effective communication.

10. Changes in organizational and reimbursement structures are essential to promote high-quality decision





Figure 2. Prognosis is not only about expectations for survival. There are multiple domains that are of varying importance to individual patients. Adapted from Spilker.³⁸



Balancing risk and benefit in the elderly

When a patient has lost their physiologic reserve decisions regarding care plans must involve Patient centered quality outcomes (PCQMs) vs Organ system directed interventions (OSDIs)

PCQMs

- 1. Worsening Symptoms
- 2. Preventing cognitive decline
- 3. Preventing Functional decline
- 4. Preventing Institutionalization
- 5. Not being an emotional and
- 6. financial burden to the family

Versus

<u>OSDIs</u>

- 1. Improving Symptoms
- 2. Improving Function
- 3. Maintaining Status







Owning the long term and unintended outcomes

We are not only responsible for the acute outcomes of our patients but the long term consequences of that same care.

By using our professional skill of palliative prognostication we can foresee the risks of the unintended consequences of our care. We can then, at the least, offer them an alternative aggressive patient centered pathway.


Conclusion

The new paradigm: Integrating the Outcome goals of the advanced elderly is possible. Prognostication will be mandatory. Regaining this professional tool and the multiple diverse benefits will improve care for this demographic.



Thank you!

