PACE Care Pathways

Initiatives to Apply Contemporary Guidelines
to Participant Goals

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Financial Disclosure Statement

• Dr. Ryan has no relevant financial relationships to disclose
There were MANY Guidelines

ACP, ACS, NCI, NIH, AMA, ACC, AHA, AUA, ACOG, IOM, CTF & USPSTF

US Preventative Services Task Force

- Evidence based
- Frequent updates
- Factor in net benefit, quality of evidence

- From 1984 to 1989, the task force's stated purpose was to "develop recommendations for primary care clinicians on the appropriate content of periodic health examinations"
Improving Preventive Care for ALL

- Late 1990’s increasing # guidelines, confusion in Geriatrics . . .

Q: Did physicians have time to do this well?
   - Isn’t treating acute problems enough?

- What is the Evidence of benefit for Older Adults?

- Was AGE a poor criteria for decision making?
Challenges in Applying Guidelines by AGE to Very Old

- Older adults are **not often represented** in clinical trials and are more **heterogenous** than younger adults; and

- Important **outcomes** may not be measured and reported in ways conducive to evidence synthesis and interpretation.

- Many geriatric disorders have Multiple RISK factors, interventions, and expected outcomes;
What should you know about functional life expectancy?

How can we use this information in caring for our participant and their families?

If your life expectancy at 70 years old is 18 additional years . . .

What is your life expectancy at 80 years old?

a) 8 years
b) 10 years
c) 14 years
d) 18 years

How does LE change if you are not in “average” health?
Three Tiers of Prevention

• **Primary Prevention:**
  – Prevent the Disease

• **Secondary Prevention:**
  – Screen and PREVENT the complications

• **Tertiary Prevention:**
  – Find the complications early and
  – PREVENT the Disability
Prevention for Older Adults

The Need to Prioritize

- Competing demands for limited time
- More Tertiary prevention issues
  - (CHD, Diabetes, COPD)
- Long-term benefits reduced by competing mortality
- Greater risks of interventions
- Importance of Quality of Life
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<td>Medications review</td>
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<td>Reviewer</td>
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<td>-- Rectal exam</td>
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<td>Reviewer</td>
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<td></td>
<td>Ryan</td>
<td>Ryan</td>
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<td>-- Stool occult Blood</td>
<td>6/5</td>
<td>Friedman</td>
<td>Reviewer</td>
<td></td>
<td></td>
<td>Ryan</td>
<td>Ryan</td>
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<tr>
<td>-- Flexible</td>
<td>6/5</td>
<td>Friedman</td>
<td>Reviewer</td>
<td></td>
<td></td>
<td>Ryan</td>
<td>Ryan</td>
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Health Capacity

Risk Factors
- Obesity
- Tobacco and alcohol
- Environmental
- Hypertension
- Rapid weight gain/loss
- Hyperglycemia
- Hip fracture
- Stroke
- CHF
- COPD
- Incontinence
- Dementia
- Caregiver burnout
- IADL/ADL decline

Cumulative, inter-related risk factors require ongoing, coordinated care interventions.

Adapted from, “The Glide Path”
Kyle R. Allen, DO
Medical Director, Post-Acute and Senior Services
Summa Health System
Prevention in PACE: Role of GuidePaths (early 2000’s)

• Instead of using chronological age to guide decision-making, life expectancy and functional status have been used to create four categories of older patients:

• 1) Robust older people: life expectancy > 5 years and functionally independent
• 2) Frail older people: life expectancy of < 5 years and significant functional impairment
• 3) Moderately demented older people: life expectancy from 2 to 10 years and may or may not be functionally impaired
• 4) End-of-life older people: usually a life expectancy of < 2 years.

Role of GuidePaths

• Overlap between categories may exist, functional status may fluctuate, and predicting life expectancy may be challenging, but compared with age alone, functional capacity in older persons has been found to be a good predictor of mortality and overall health status.

• The recommendations allow for decisions to be made on a “graded” rather than an “all-or-nothing” basis and allow for better patient involvement in decision-making. The four levels are:
Four levels of recommendations

• DO
  ▪ Discuss

• Consider
  ▪ Don’t Do
### Geriatric Screening and Preventive Care

#### Table 12.1 (continued)\(^a\)

<table>
<thead>
<tr>
<th>Item</th>
<th>Robust elderly</th>
<th>Frail</th>
<th>Moderately demented</th>
<th>End of life</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Life expectancy &gt;5 years and functionally independent</td>
<td>Life expectancy &lt;5 years or significant functional impairment</td>
<td>Life expectancy 2–10 years</td>
<td>Life expectancy &lt;2 years and functionally non-independent</td>
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<tr>
<td>Osteoporosis</td>
<td>Do at least once; consider every 2 years</td>
<td>Do at least once every 2 years</td>
<td>Do at least once</td>
<td>****</td>
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<tr>
<td>Cholesterol screening</td>
<td>Consider screening for patients aged 65–75 years if they have additional risk factors (e.g. smoking, diabetes, hypertension)</td>
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<td>****</td>
<td>****</td>
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<tr>
<td>TSH</td>
<td>Do every 2 years</td>
<td>Do every 2 years</td>
<td>Do every 3 years</td>
<td>Consider if symptomatic</td>
</tr>
<tr>
<td>Fasting blood glucose</td>
<td>Do if symptomatic or every 3 years if the patient has risk factors</td>
<td>Do if symptomatic or every 3 years if the patient has risk factors</td>
<td>Consider if symptomatic</td>
<td>Consider if symptomatic</td>
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</tbody>
</table>

Preventive geriatrics Gerald M. Mahon1, Joseph H. Flaherty1,2 and Suzanne M. Mahon3 in Principles and Practice of Geriatric Medicine, Fifth Edition. Edited by Alan J. Sinclair, John E. Morley and Bruno Vellas. © 2012 John Wiley & Sons, Ltd. Published 2012 by John Wiley & Sons, Ltd
Life Expectancy varies

Figure - Upper, middle, and lower quartiles of life expectancy for women at selected ages are shown here.

(From Walter LC, Covinsky KE. JAMA. 2001.)
Prevention in PACE: Three Guide paths

Longevity, Function, and Comfort

• Used to guide *prevention* discussions

Q: Exclusive or overlapping?
Q: Static, Progressive or bidirectional?

*Should we apply these categories beyond prevention?*
Glidepath ??
Glidepath ??

Longevity

Acute Illness

Function

Comfort ??
## Preventative Care 2014

<table>
<thead>
<tr>
<th>Test</th>
<th>Longevity</th>
<th>Functional</th>
<th>Comfort Care</th>
<th>Interval/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prostate Cancer Screening (PSA)</td>
<td>Consider if LE ≥ 10 yrs and age 55-69</td>
<td>Consider if LE &gt; 10 yrs and age 55-69</td>
<td>N</td>
<td>Every 2 years</td>
</tr>
<tr>
<td>Breast Cancer Screening (Mammography)</td>
<td>Yes if LE ≥ 5 yrs, age 55-75</td>
<td>Consider</td>
<td>N</td>
<td>Every 2 years</td>
</tr>
<tr>
<td>Lung Cancer Screening</td>
<td>Yes, age 55-80, 30 pack/year history of smoking and current smoker or quit within 15 yrs (may stop at 15 yrs of smoking cessation or LE ≤ 5 yrs)</td>
<td>N</td>
<td>N</td>
<td>Annual low-dose CT scan (age 55-80) *No if participant has a health problem that limits life expectancy or is unwilling to have curative surgery.</td>
</tr>
<tr>
<td>Lipids Screening</td>
<td>Y</td>
<td>Consider</td>
<td>N</td>
<td>Initially then every 5 years if initial is at goal; quarterly if not at goal; annually if being treated</td>
</tr>
</tbody>
</table>
Terms and labels
Why do we use labels?

Frailty

• Do you recognize frailty?

• What is the importance of identifying frailty in the hospital setting?
Determinates of Hospitalization Outcome

Baseline Frailty

Hospitalization Outcome

Acute illness

Hazards of the Hospitalization

Podrazik PM, Whelan CT. Med Clin N Am 2008
Geriatricians ID frailty features

At least 50% of Geriatricians cited each of the following characteristics associated w/frailty

- Under nutrition
- Functional dependence
- Prolonged bedrest
- Pressure sores
- Generalized weakness
- Aged >90
- Wt loss
- Anorexia
- Fear of falling
- Dementia
- Hip fracture
- Delirium
- Confusion
- Going outdoors infrequently
- Polypharmacy

American Geriatric Society
10 things all clinicians and patients should do

1. Don’t recommend percutaneous feeding tubes in patients with advanced dementia; instead offer oral assisted feeding.
2. Don’t use antipsychotics as the first choice to treat behavioral and psychological symptoms of dementia.
3. Avoid using medications other than metformin to achieve hemoglobin A1c<7.5% in most older adults; moderate control is generally better.
4. Don’t use benzodiazepines or other sedative-hypnotics in older adults as first choice for insomnia, agitation or delirium.
5. Don’t use antimicrobials to treat bacteriuria in older adults unless specific urinary tract symptoms are present.
6. Don’t prescribe cholinesterase inhibitors for dementia without periodic assessment for perceived cognitive benefits and adverse gastrointestinal effects.
7. Don’t recommend screening for breast, colorectal, prostate or lung cancer without considering life expectancy and the risks of testing, overdiagnosis and overtreatment.
8. Avoid using prescription appetite stimulants or high-calorie supplements for treatment of anorexia or cachexia in older adults; instead, optimize social supports, discontinue medications that may interfere with eating, provide appealing food and feeding assistance, and clarify patient goals and expectations.
9. Don’t prescribe a medication without conducting a drug regimen review.
10. Don’t use physical restraints to manage behavioral symptoms of hospitalized older adults with delirium.
RISKS FOR HAZARDS OF HOSPITALIZATION *

- Restraints
- Unfamiliar Environment
- Sensory Deprivation
- Immobility
- Isolation
- Incontinence
- Polypharmacy
- Insomnia
- Malnutrition/N.P.O.

Fernandez, H. and Callahan, K
Levels of Care

- Curative care
- Comfort care
- Palliative care
- End-of-life care
- Longevity care
- Functional care
Descriptions of Palliative Care

1. “Care beyond cure”
2. “Low technology and high touch”
3. “Adding life to days not just days to Life”
4. Palliative care means never saying “there is nothing we can do” but saying “there is always something we can do”
As Illness Progresses…
An Increasing Emphasis on Palliation
Three Levels of Care in PACE

- Developed as a tool to facilitate discussions with participate and families
- Based on clinical research models describing patient preferences, communication styles and decision making around transitions of care.
- Three levels presented along a continuum, with patients describing where they believe their preference are and how they expect it might change in the future

Longevity  Functional  Comfort
Level of Care:  Longevity

Participant expresses a preference for life-prolonging treatment.

A participant with a goal of longevity typically desires unrestricted use of medically-indicated treatments, including CPR, invasive procedures, life-sustaining treatments (ACLS, surgery, ventilator support, dialysis, IV fluids and tube feedings) and is willing to try to follow recommended medication dietary and intervention regimens.
Level of Care: Functional

Participant’s main goal is to maintain function.

Participant makes individualized choices to limit some invasive procedures that are not consistent with that goal. Limited procedures may include CPR, mechanical ventilation, and other life-sustaining treatments. This participant may choose to modify adherence to diet and medication recommendations.
Level of Care: Comfort

Participant desires treatments aimed at providing comfort only. Treatment choices focus on relieving pain and other symptoms and limiting invasive, life-sustaining treatments such as CPR, mechanical ventilation, dialysis, surgery, and perhaps hospitalization.
Two Questions about Levels of Care

• Where along this continuum do you see yourself today & WHY?

Longevity           Functional           Comfort

What next? Do you think you will stay with this focus? What do you think would have to happen to cause you to reevaluate?
Care Management Model in PACE

Interdisciplinary Care

PACE Pathway
- Longevity
- Functional
- Comfort
- 13 month grief care

Time
- Increased monitoring and interventions
- EOL care
- Advance Care Planning and Goals of Care
- Death

Curative focus
Palliative focus
Bereavement
Whose guidelines should we be following, anyways?

- Proliferation of guidelines
- "Eminence" based versus evidence based
- Internal versus external
  - Ability to tailor to resources
  - Time consuming to develop
  - Need for ongoing updates
Reframing Person-Centered Care

From “what is the matter with you”

To “what matters to you”
Person Centered Requirements

Patients/families
- Patient preferences
- Patient perspective
- Cultural norms
- Family of origin
- Fears
- Goals
- Expectations

Health Care Staff
- Recognition of complexity of illness
- Progression of illnesses
- Options / likelihoods
- Regular reassessment
- Prognosis
- Coordination
Patient centered care

- Patient preferences
- Patient perspective
- Cultural norms
- Family of origin
- Fears
- Goals
- Expectations

- Time
- Listening > talking
- Writing & repeating
- More time
What are you afraid of?

- Missing life?
- Dying too soon?
- Being judged by others?
- Losing control?
- Not being asked?
- Unfinished business?
- Pain?
- Gasping for breath?
- Death?
Recommendations for patients / Families

• Be clear
  – what information you want?
  – How you want information?
  – Who do you want part of the discussion

• Choose a proxy
  – Talk to that person
  – Bring them along

• Hope for the best and prepare for the worst
The BEST doctors are consistently over optimistic at Prognosticating . . .

So how can we get better?

• “Would you be surprised if your patient died in the next 6 months”?
• “Are the visits with doctors and nurses becoming more frequent without clear end point?”
• “What are the patients goals ?”

Consider Offering a Palliative Care focus
Skills to Improve Palliative and Comfort care

Educate staff:
- Symptom recognition
- Attitudes
- Fears
- Structure pathways while preserving choices
  - improve consistency

Train staff:
- Assessment skills (RN)
- Monitoring skills (LPN)
- IF A then B
- When to ask for help
Myth: Palliative care = “no more treatment”

We assess the values & goals of a patient, designing care around them
Skills to Improve Palliative and Comfort care

Educate **patients:**
- Symptom recognition
- Attitudes
- Fears
- Structure plans while preserving choices

Train **families**
- Monitoring skills
- IF A then B
- When to ask for help
WE'RE TO SPEND MORE TIME ENGAGING WITH PATIENTS ON A MORE COMPASSIONATE ‘HUMAN’ LEVEL...AND HERE ARE THE GUIDELINES ON HOW TO DO IT!
Questions?
Thank You