Integrating Goals of Care Discussions into Routine Care

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Objectives

- Define the difference between goal-directed care and guideline-directed care

- Describe patient characteristics which make goal-directed care imperative

- Describe the process for assessing patient goals

- Describe barriers to goal-directed care

Patient Cases

- Mrs. B – 94 yrs old; painful, swollen, red right calf. No other symptoms.

- Mrs. S – 72 yr old, atrial fibrillation, hypertension, high cholesterol. Diltiazem & dabigatran; thiazide & lisinopril; simvastatin & colesevelam. Complains of muscle aches requiring regular acetaminophen. Has stopped exercising and is gaining weight.

Your Recommendations?

Guidelines

- DVT - Treat patients with warfarin and unfractionated heparin (UFH) or low-molecular-weight heparin (LMWH) for at least 5 days and discontinue heparin when the INR has stabilized between 2 and 3. **A**

- Lipids - Screen all men older than 35 and all women older than 45 for lipid disorders. **A**

- Statins reduce overall mortality in primary and secondary prevention of CAD. **A**

Essential Evidence + 2012

Why Guidelines?

- Variation in practice
- Failure to integrate new knowledge
- Move from "expert opinion" to evidence
- Accountability
- Standardization

Standardizing Care

- Clinical Practice Guidelines (CPG)
- Care Pathways
- Glidepaths (GeriMed)
- Disease Management programs
- Quality standards (ACOVE)
- Incentives
  - Productivity
  - Quality – Pay For Performance (P4P)

Heart Failure Guidelines

177 related guidelines found on NGC

- 21 recommendations regarding assessment
  - One referred to ADL
- 22 recommendations regarding risk reduction
- 17 recommendations regarding treatment
  - One referred to exercise training
- One referred to end-of-life care

ACC/AHA Guideline on Heart Failure, 2001

AMDA HF Guidelines

- Decide whether to work up
  - Based on patient factors and goals
- Decide whether to control risk factors
- Incorporate patient's or surrogate's wishes
- Evaluate effect of co-morbid conditions
- Management of end-of-life care

AMDA Heart Failure Guidelines, 2002

Diabetes Guidelines

247 guidelines found on NGC

- Specific recommendations on carbohydrate, fat, and protein intake (28)

- Specific recommendations on Tx of HTN, lipids, glycemic levels, and renal problems (13)

- Two recommendations on older adults

- One recommendation of exercise

- None discussed when to stop meds

ADA, 2001, republished 2003, Diabetes

AGS Diabetes Guidelines

- Individualized care planing
- Attention to geriatric syndromes
  - Falls, depression, cognition, incontinence
- Managing co-morbid conditions
- Pain
- Balancing patient values
- Life expectancy

AGS Guidelines for Improving Care in Older Persons, *JAGS* 2003;51:S265

Multiple Conditions & CPG

- Hypothetical patient - COPD, diabetes, osteoporosis, hypertension, osteoarthritis

- Majority failed to address comorbid conditions, EOL care, QOL, patient preferences, short- and long-term goals

- 13 meds in 21 doses per day, PCP + 6 specialists, frequent ADE, medication cost $411 per month

Boyd CM, *J Amer Geriatr Soc* 2003;

CPG Problems

- Conceptual: problem of focus
  - Disease - not the person-centered
  - Disease - not function-oriented
  - Specialty - not primary care
  - Outcomes valued by the Patient?
- Input:
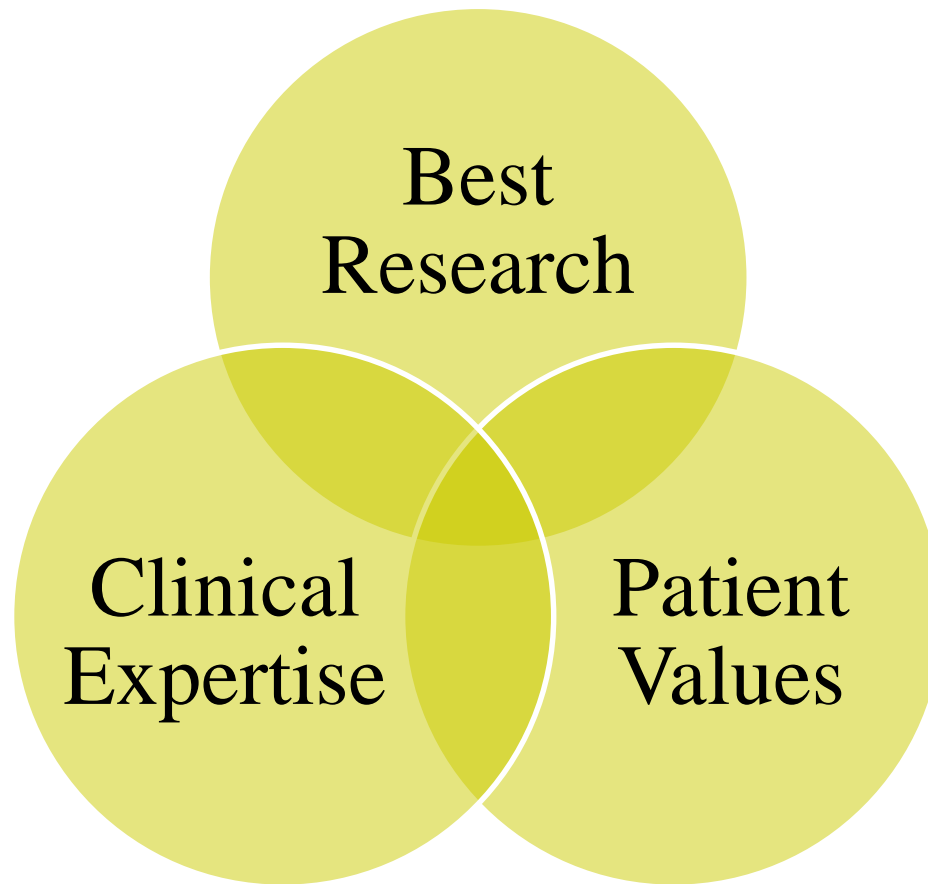 - Advocacy oriented
  - Funding?

Concern: Not focused on MY patient

CPG Problems

- Ethical issues
  - commercial conflicts of interest
  - short-term vs long-term goals
  - "halo effect" - become a surrogate marker of quality
- Cultural problems
  - Rarely studied in minority cultures (or elders)
- Risk: Further erosion of trust of the profession

Evidence Based Medicine

Circles are varying in size and dynamic

What Are Goals and Benefits?

- Outcomes that are intrinsically valuable to the patient
  - Patient- or person-centered
- Benefits are determined by the patient, not the health care system

Goals of Care

- Cure illness
- Prevent death
- Prevent disability
- Relieve suffering
- Increase function

- Promote health
- Prevent transmission
- Increased quality of life
- Increased control
- A good death

Shared decision making
Changes as person ages
Changes as disease progresses

Treatment Targets

- Related to goals
- Goal = general
  - E.g., prevent strokes
- Target = measurable outcome
  - BP<150/90
- Positive targets (to reach)
- Negative targets (to avoid)

What is "Patient-Centered?"

- ☐ IOM - care that is respectful of and responsive to individual patient preferences, needs, and values

- ☐ AHRQ - Patients become active participants in their own care and receive services designed to focus on their individual needs and preferences, in addition to advice and counsel from health professionals.

Practicing Goal-Directed Care

- Ask patients about their goals
- Educate patients about the difference between symptom treatments and prevention treatments
- Use motivational interviewing techniques
  - Explore ambivalence
- Practice "minimally disruptive medicine"

Sample Goal Questions

- What do you care about most in your life?

- What is the most enjoyable (or valuable) part of your life?

- What is most worth living for?

- How important is it for you to live long?

- What would make life less (or not) worth living?

- What do you worry about not being able to do?

- If you had 6 months to live, what would you do differently?

- For all: Why?

Waters D, Pain Physician 2006;9:353

Talking About Goals at EOL

- What is most important in your life now?

- What experiences have you had with serious illness?

- Which fits your values?
  - Treat intensively even if it means suffering to try to extend life
  - Use medical treatments but stop if you are suffering, even if it means a shorter life
  - Use all measures to promote comfort, even if it means a shorter life

- Can you imagine a health situation that would be worse than death?

- Have you changed your mind about what is important over time?

ACP Decisions (modified), 2015

Two Types of Treatments

- Symptom
  - Time period is NOW
  - Patient experiences the benefit
- Prevention
  - Time period is years from now (average 5-7)
  - The benefit (if any) is NOT experiencing something

When Do We Stop Treatments?

- Symptoms
  - It is not providing a clinically important effect
  - Treatment is causing immediate or long-term problems
- Prevention
  - Goal is no longer desired
  - If one was fully informed about the actual benefits and harms one would not take them
  - Symptoms created by treatment are unacceptable

Fostering "Minimally Disruptive Medicine"

- Respect patient preferences
- Share decision making
- Improve communication
- Coordinate care
- Start all meds with lower doses

- Minimize office visits
- Minimize tests
- Minimize procedures
- Minimize the number of pills
- Minimize cost

Communication Skills

- Offer a "menu of options"
- Ask permission
  - Simple question
    - "Would you like to know some things that you could do?"
  - First choice
    - "Which of these options would you like to talk about first?"
  - Prefacing
    - "This may or may not worry you, but…"

Informed Consent

- Our recommendation
  - Risks & benefits
- Alternatives to the recommendation
  - Risks and benefits of those
- What's likely to happen if nothing is done
  - Risks and benefits

Shared Decision Technologies

- Breast cancer treatment – Dartmouth
- Osteoporosis treatment – Providence Health System, Portland
- Patient decision aids – Institute for Healthcare Improvement
- Ottowa Personal Decision Guide
- Bubble choice grids

Agenda "Bubble Sheet" CHF F/U Visit

Diet

Exercise

??

Stress

Medications

Alcohol

??

Smoking

The Absolute CVD Risk/Benefit Calculator

Framingham
Heart attacks + angina/coronary insufficiency + heart failure + strokes + intermittent claudication

QRISK®2-2014
Heart attacks + strokes

ACC/AHA ASCVD
CHD death + nonfatal heart attacks + fatal/nonfatal strokes

Age
70 years

Gender
✔ Male | Female

Smoker
✔ Yes | No

CVD risk is reversed after 5-10 years of no smoking

Diabetes
✔ Yes | No

Systolic Blood Pressure
140 mmHg

Enter present blood pressure regardless of treatment

120 mmHg is used for baseline risk

On treatment for BP
Yes | ✔ No

Click YES if taking blood pressure medication

Total Cholesterol
210 mg/dL

Cholesterol should be prior to drug treatment

116 mg/dL is used for baseline risk.

Click to change to mmol/L.

HDL Cholesterol
45 mg/dL

Relative Benefit: 0%

Benefit often has *nothing* to do with the effect on the surrogate marker. At present, you can only select one intervention at a time.

Physical Activity

Mediterranean Diet vs Low fat

Vitamin/Omega-3 supplements

BP meds (not atenolol/doxazosin)

Low-mod intensity statins

High intensity statins | Fibrates

Niacin | Ezetimibe | Metformin

Sulfonylureas | Insulins

Glitazones | GLPs | DPP-4s

Meglitinides | SGLT2

Smoking Cessation

ASA

Benefit Estimate Details

Risk Time Period

10 years

🙂	**32.4%**	No event	
☹️	**67.6%**	Total with an event	
🙂	**0.0%**	Number who benefit from treatment	
NNT	∞	Number needed to treat	
☹️	**21.7%**	Baseline events using baseline factors alone	
☹️	**45.9%**	Additional events "caused" by risk factors	

A Classic Example

- An older person (70) with risk factors for CVD
  - Smokes (2 PPD), DM (A1C 9.5) , BP 155, cholesterol 230, HDL 45
  - No history of stroke, heart attack or renal disease
- What will lower risk the greatest?

http://chd.bestsciencemedicine.com/calc2.html

Another Example

- Your patient has heart failure, type 2 diabetes, hypertension, osteoporosis, atrial fibrillation, and mild incontinence
  - **And – early Alzheimer's Disease**
- You follow all guidelines – AHA, AGS-DM, JNC8, NOF, AGS-AF, AMDA-incontinence
- AND – you incorporate the principle of the AGS guideline on multimorbidity
- What will your patient be rewarded with?

When is Goal-Directed Care Imperative?

- When the patient wants it
- When the risks of treatment start to equal the benefits of treatment
- When the benefits of treatment are minimal
- When the risks of treatment are high
- When there is much uncertainty
- When the patient is older (>75)

Barriers to Goal-Directed Care

- Medical narcissism
- Time pressures
- Inappropriate quality standards
- Prejudice and racism
- "Trained patients"
- Consumer mentality
  - Direct-to-consumer advertising

Back to Mrs. B and Mrs. S

Changing Health Care

- Measure patient-centeredness as a quality outcome
  - "Is there anything at all that could have been done better today?"
- Vest control in the patient's hands
- Be transparent about science, costs, processes, and errors
  - Apologize
- "Customized standardization"
- Train providers in emotional intelligence

References

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