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 & colesvevalam. 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
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

- 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

177 related guidelines found on NGC

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

- 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 planning
- 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

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?
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

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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

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**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.

**HDL Cholesterol**
45 mg/dL

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**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
- Meglinitides
- SGLT2s
- Smoking Cessation
- ASA

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**Risk Time Period**
10 years

- 32.4% No event
- 67.6% Total with an event
- 0.0% Number who benefit from treatment
- ∞ Number needed to treat
- 21.7% Baseline events using baseline factors alone
- 45.9% Additional events “caused” by risk factors

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**Benefit Estimate Details**
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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