Geriatric Palliative Care

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DISCLOSURES

I do not have anything to disclose.

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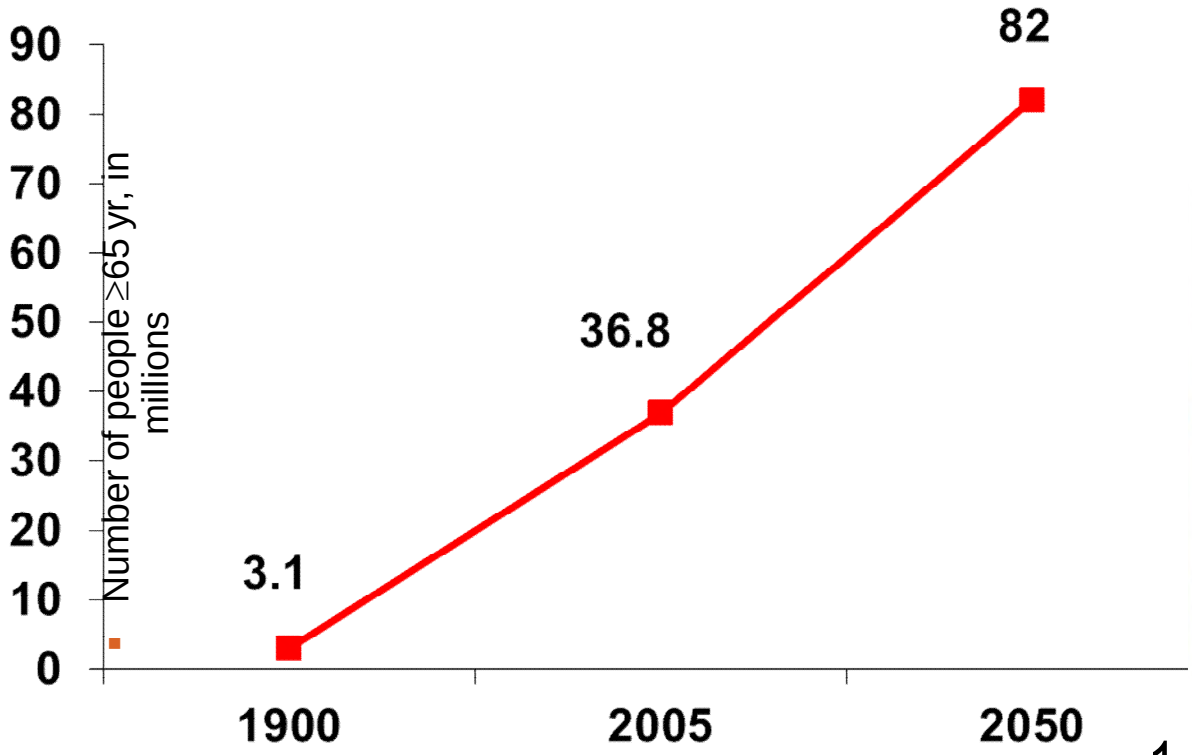
Objective

- Illustrate the synergies across geriatric and palliative medicine
- Learn the 5 M's of geriatric medicine
- Apply geriatric principles to a palliative case

AGING OF THE US POPULATION



Aged 50–64 (young–old)
65–79 (middle–old)
80 and older (old–old) (increase by 300%)

The minority older adult population in the US 20.7% in 2012 to 39.1% in 2050.

1.5-2 million older LGBT Americans and by 2030 2-6 million

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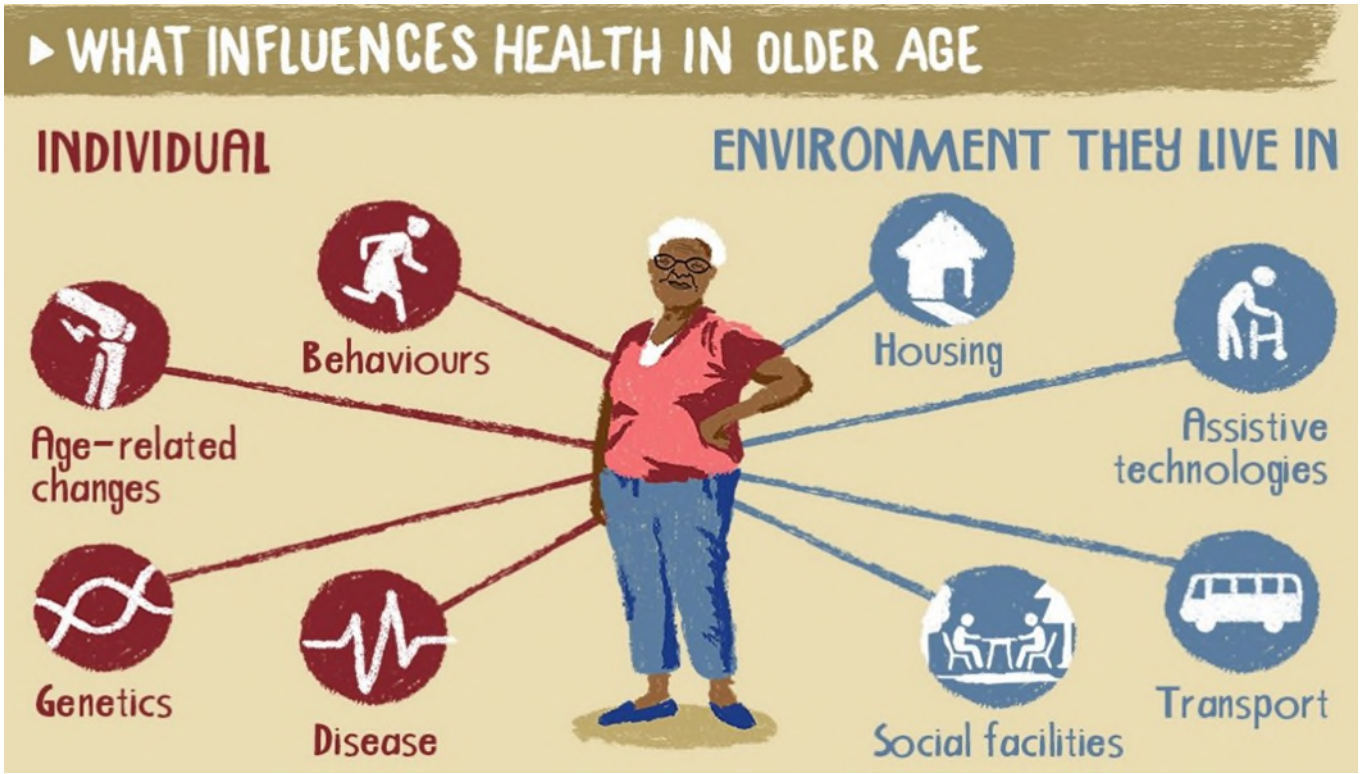
SOCIAL DETERMINANTS OF HEALTH



Heterogeneity

World Health Organization

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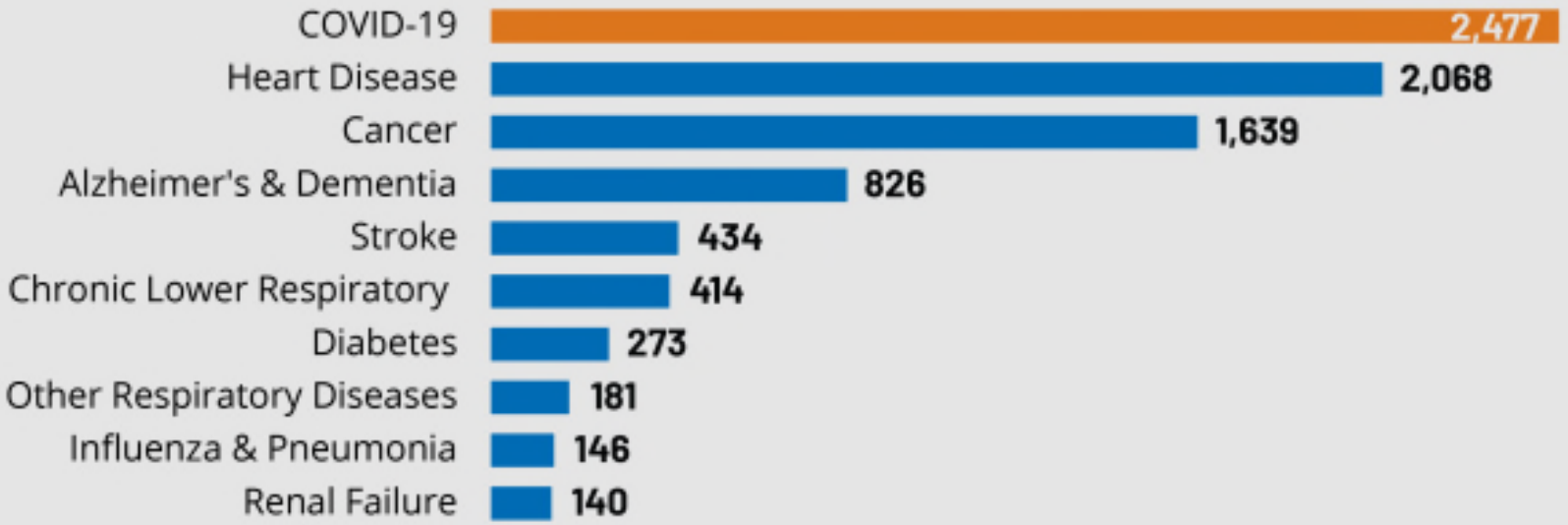
COVID-19 is the Number One Cause of Death in the U.S. in Early 2021

Average Daily Deaths in the United States from COVID-19 (February 2021) and Other Leading Causes (2020)



KFF Analysis of CDC Mortality Data

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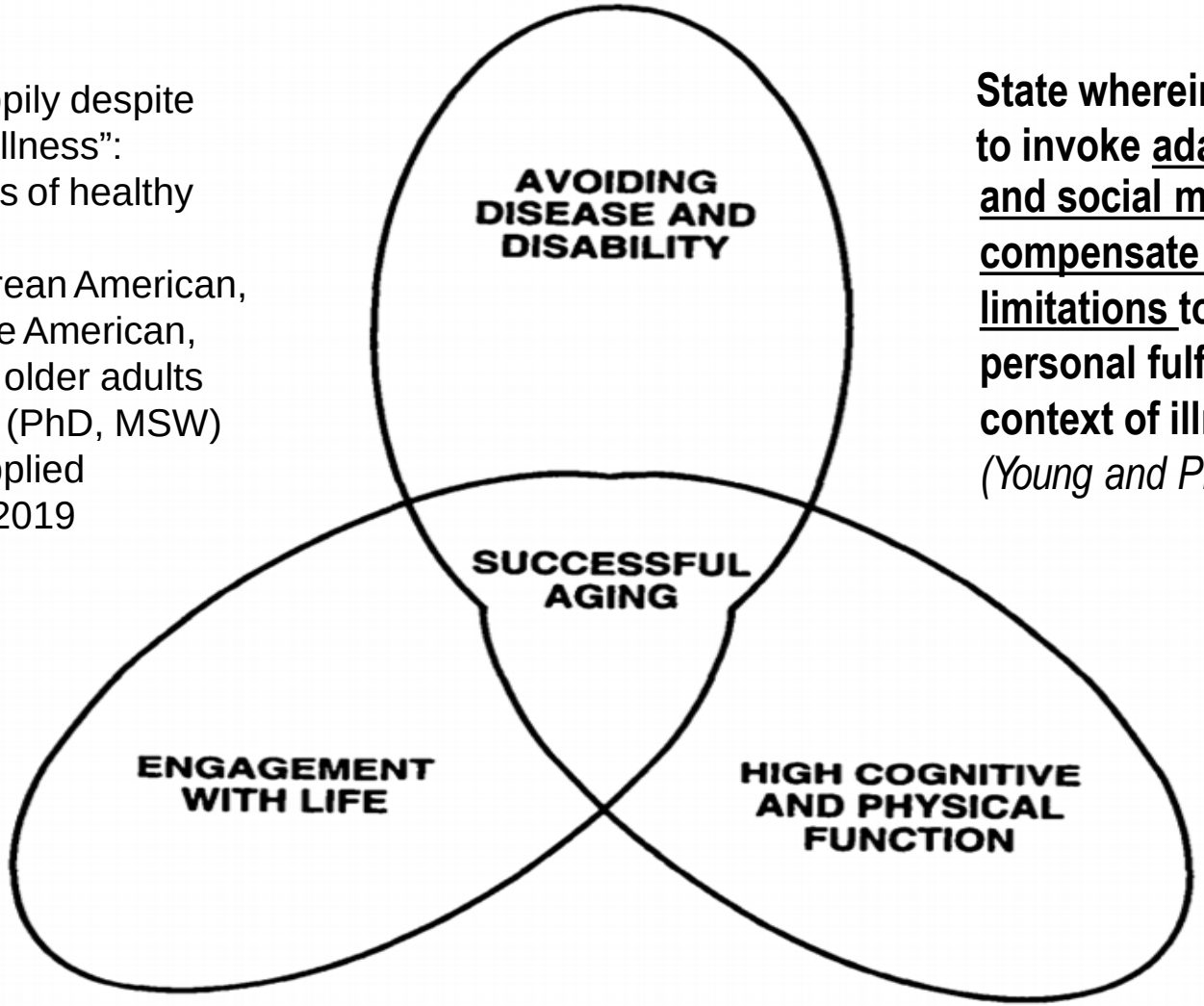
MODEL FOR SUCCESSFUL AGING

"Living happily despite having an illness": Perceptions of healthy aging among Korean American, Vietnamese American, and Latino older adults
H. Nguyen (PhD, MSW)
Nursing Applied Research 2019



State wherein an individual is able to invoke adaptive psychological and social mechanisms to compensate for physiological limitations to achieve a sense of personal fulfillment, even in the context of illness and disability.
(Young and Phelan 2009)

65-74: 89% report no disability

85+: 40% report no disability

Rowe, John W; Kahn, Robert L (1997). "Successful Aging". The Gerontologist. 37 (4): 433–440.

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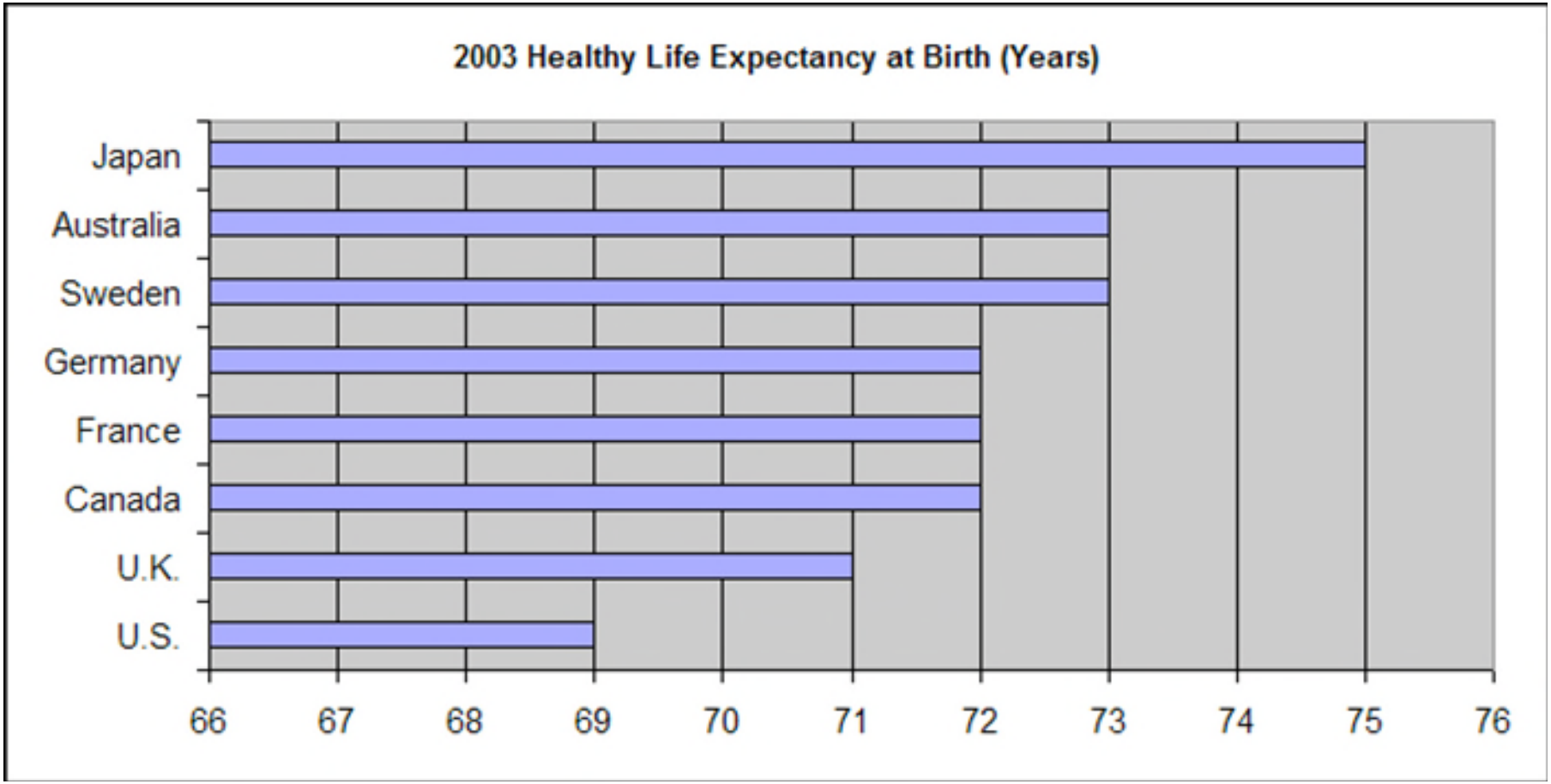
MORBIDITY COMPRESSION



World Health Organization

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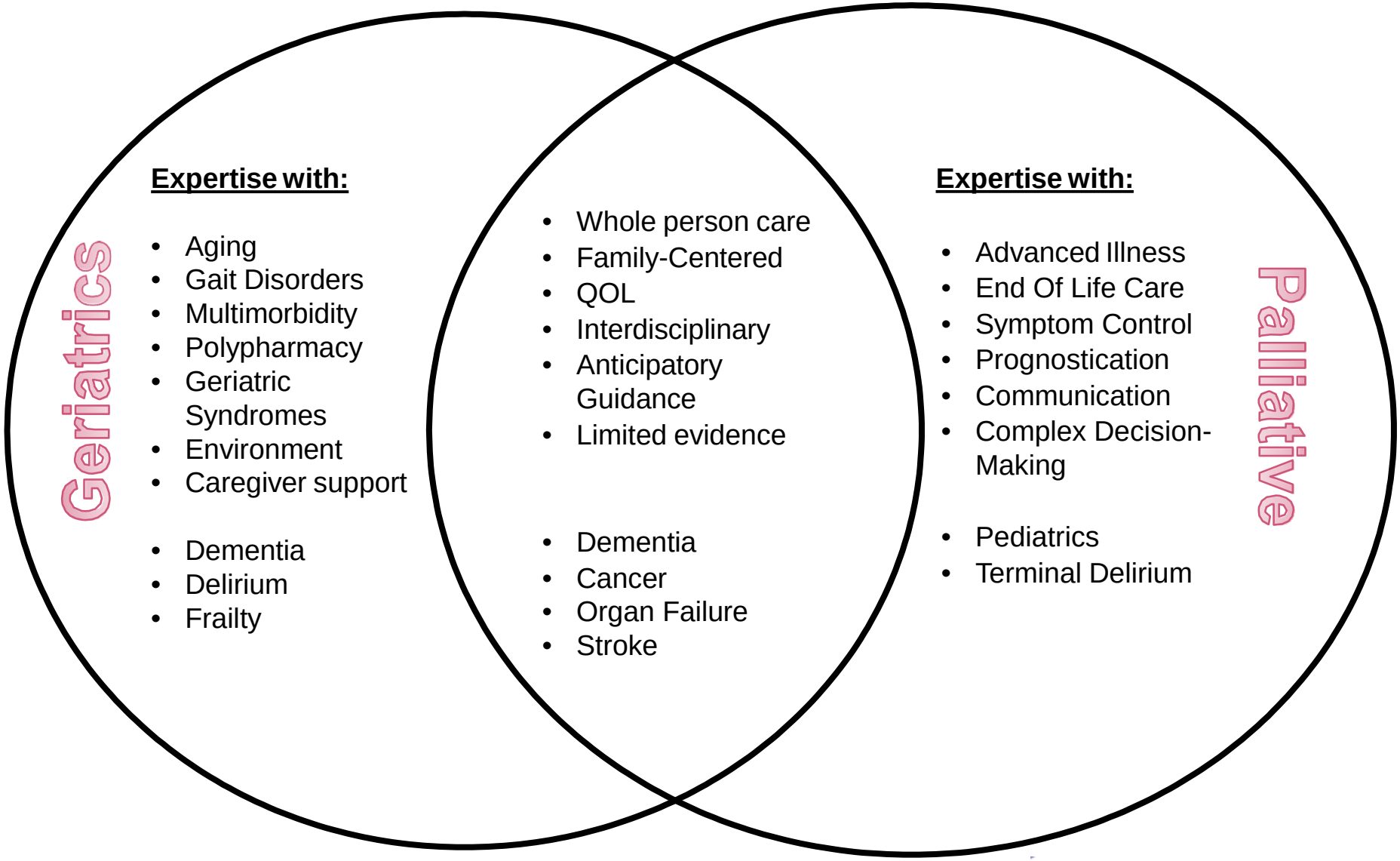
COMPETENCIES ACROSS THE GERIPAL SPECTRUM



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4 M's AGE-FRIENDLY HEALTH SYSTEM + 1 M

MIND (Dementia/Delirium)
Diagnosis, Management, Team-based coordination

MOBILITY
Function, Independence, Fall-Risk, Prevention

MEDICATIONS
Polypharmacy, Deprescribing

MULTIMORBIDITY
Management of heterogeneous older adults with multiple medical problems incorporating preferences, evidence-based medicine, prognosis, feasibility, and optimization (both pharmacologic and non-pharmacologic) to individualize care plans

MATTERS MOST
Values, Priorities, Treatment Goals

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Dementia: Definition DSM IV

MIND

Clinical definition: Three criteria are required for a diagnosis

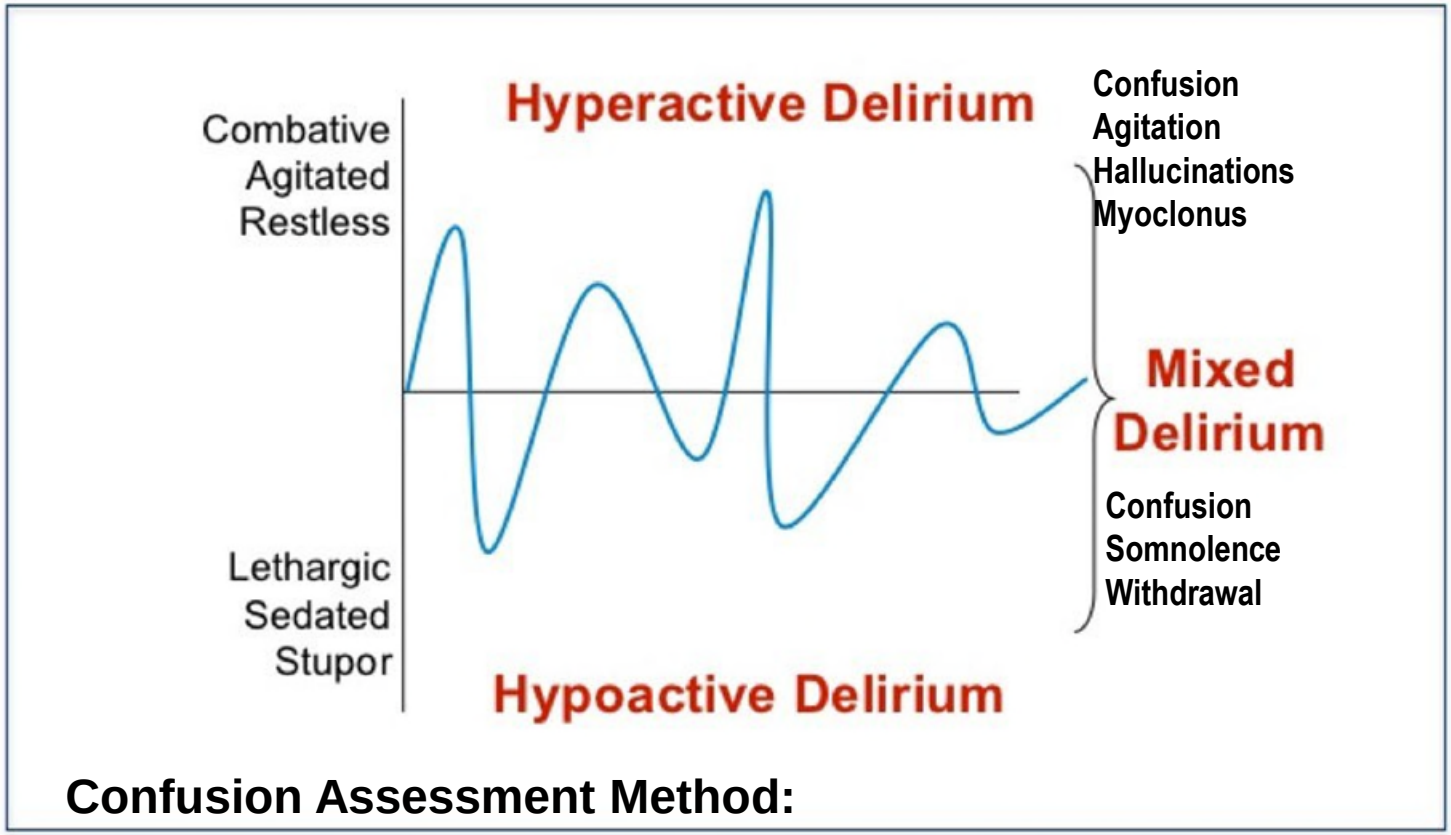
1. A short-term memory deficit that can be demonstrated objectively on cognitive testing
2. At least one other cognitive impairment such as:

Aphasia – difficulty finding the right words or using the wrong words
Executive function impairment – difficulty with planning, judgment, mental flexibility, abstraction, problem-solving, etc.
Agnosia – impaired recognition of people or objects
Apraxia – forgetting how to do simple tasks that were well-learned previously (hobbies; work-related tasks; or activities of daily living, such as cooking, driving a car, using a phone, etc.)

3. Together, these cognitive deficits must result in **impairment in performance of daily activities, including significant impairment in social or occupational functioning, and must show a progressive decline from previous functioning.**

Delirium Subtypes

MIND



Confusion Assessment Method:

Acute onset and fluctuating course
Inattention **D**isorganized thinking
Altered level of consciousness
If yes to #1 & 2 AND either 3 or 4, then +delirium

Inouye NEJM 1990, Marcantonio NEJM 2017, Fong 2009

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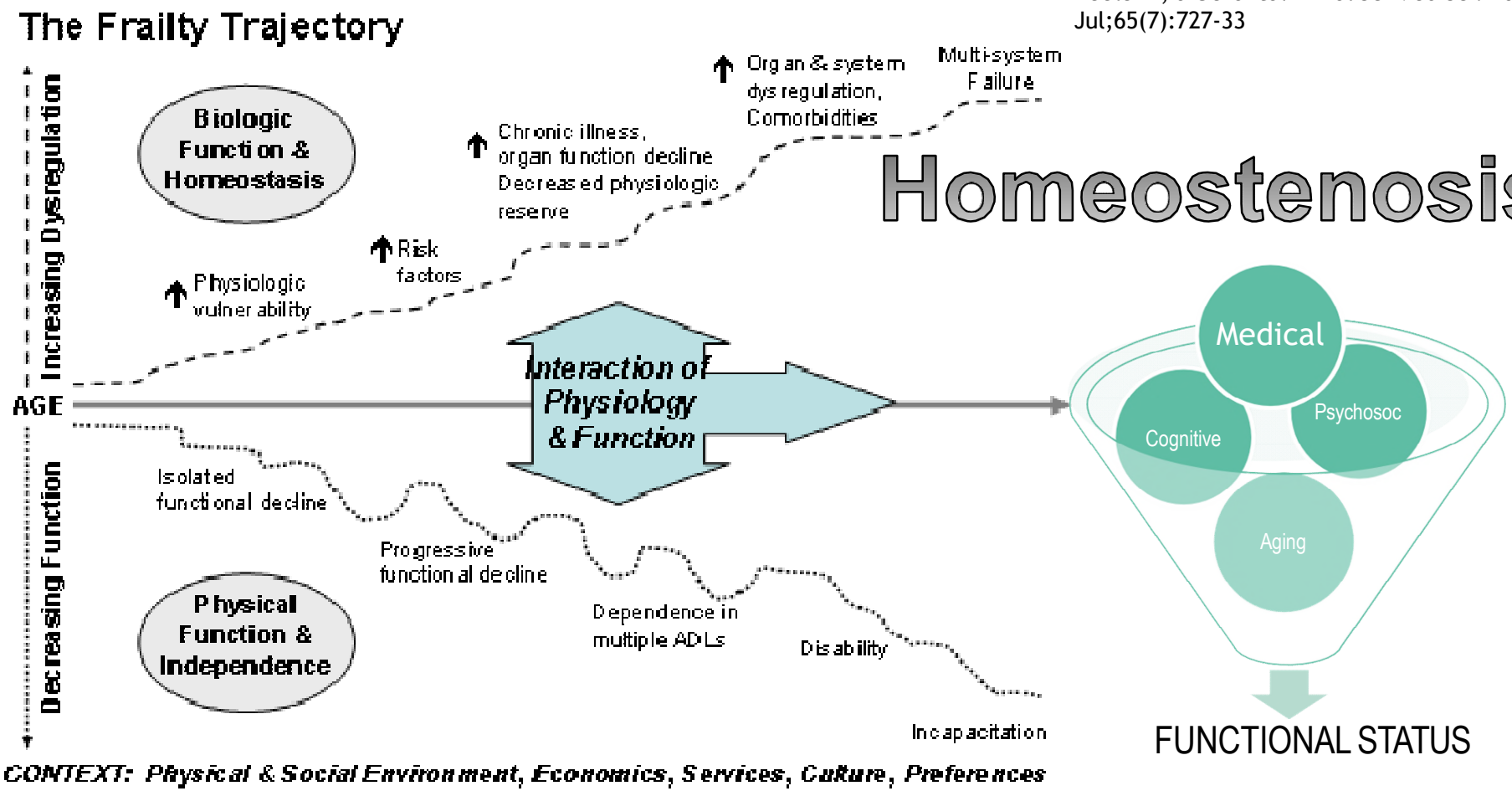
Keeler E, J Gerontol A Biol Sci Med Sci. 2010 Jul;65(7):727-33



Dimension to be evaluated and as an outcome to be improved or maintained

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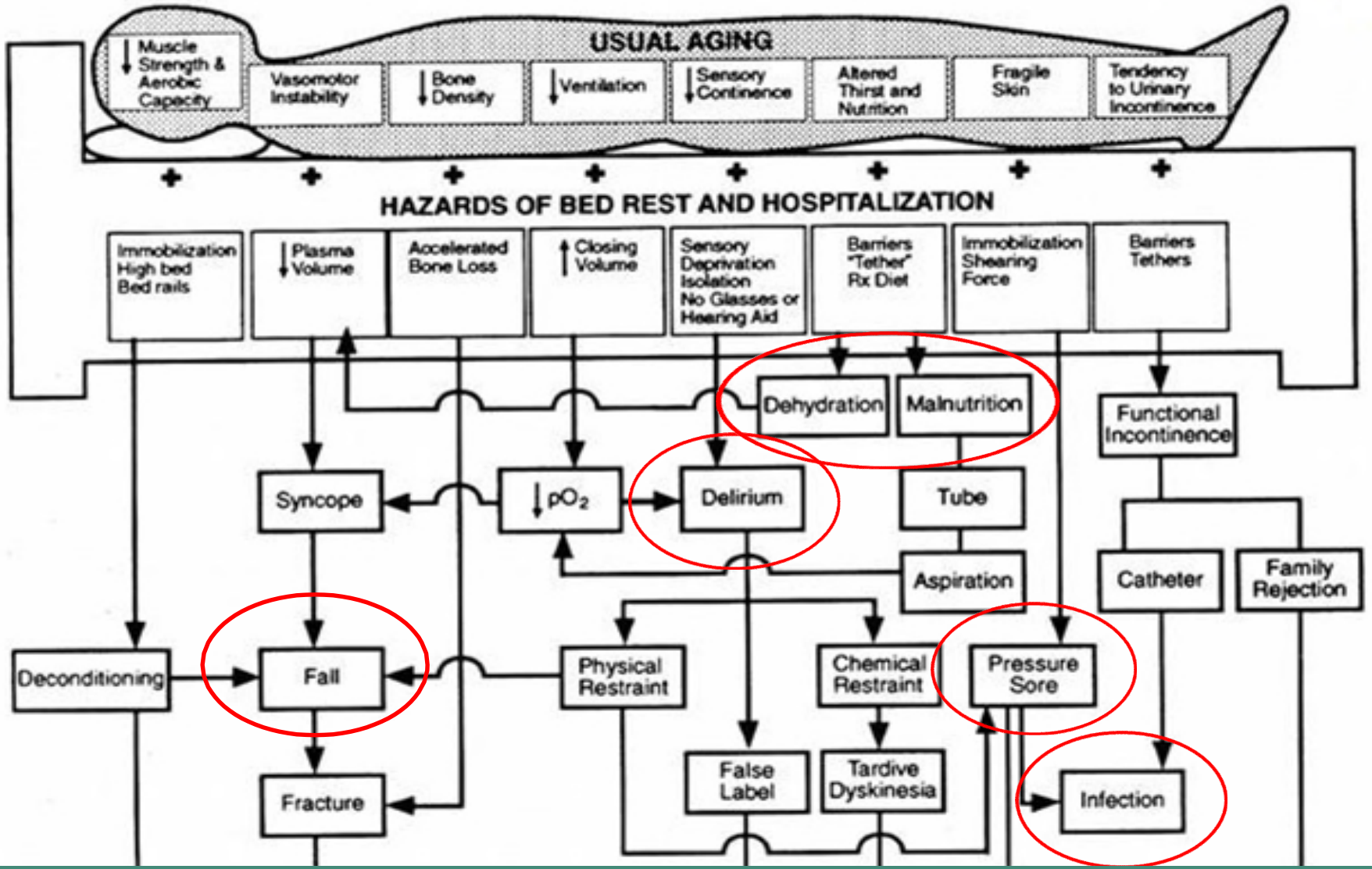
HAZARDS OF HOSPITALIZATION

- 30-40% lose > 1 basic ADL on discharge compared to pre-admission
  - 25-40% remain impaired 3 months later
- 20% readmitted within 30 days

Sager Arch Int Med 1996, Barry JAGS 2011, Jencks NEJM 2009

MOBILITY



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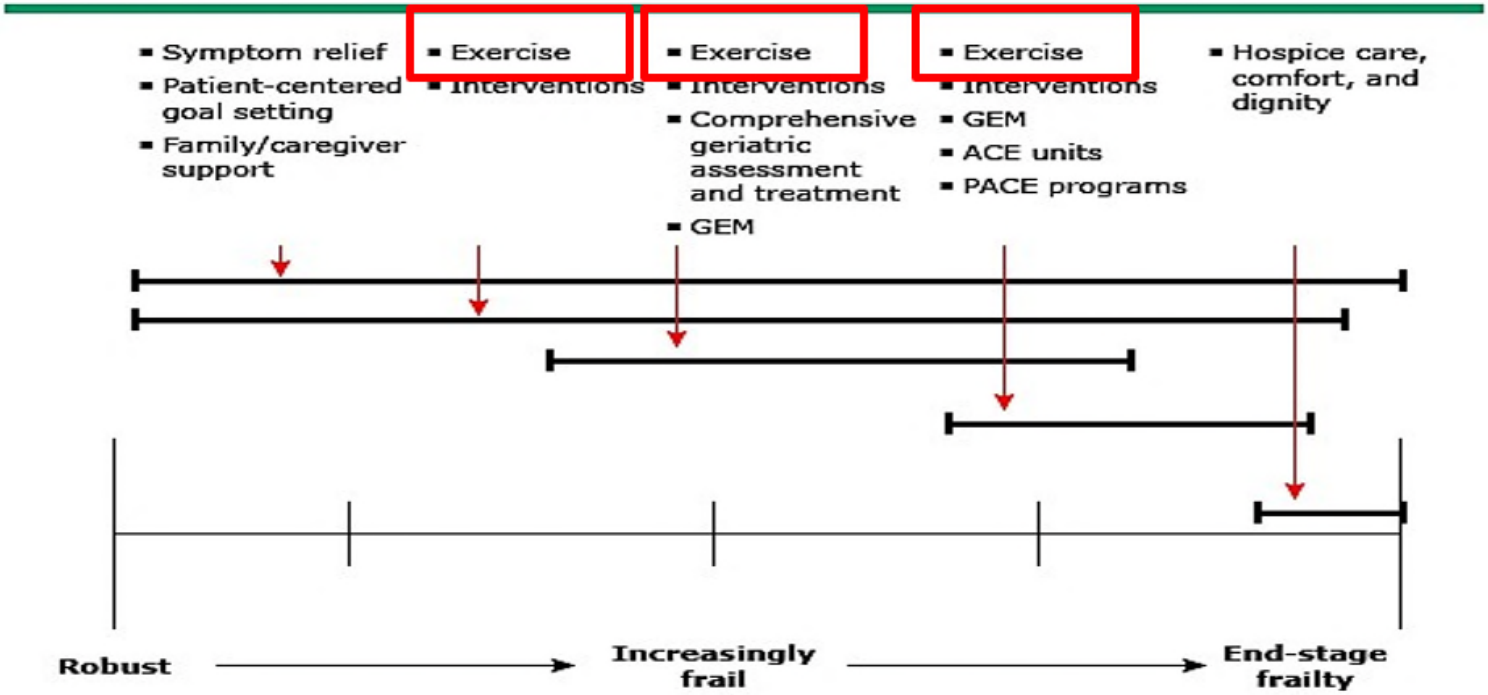
Potential interventions along the spectrum of frailty in older adults

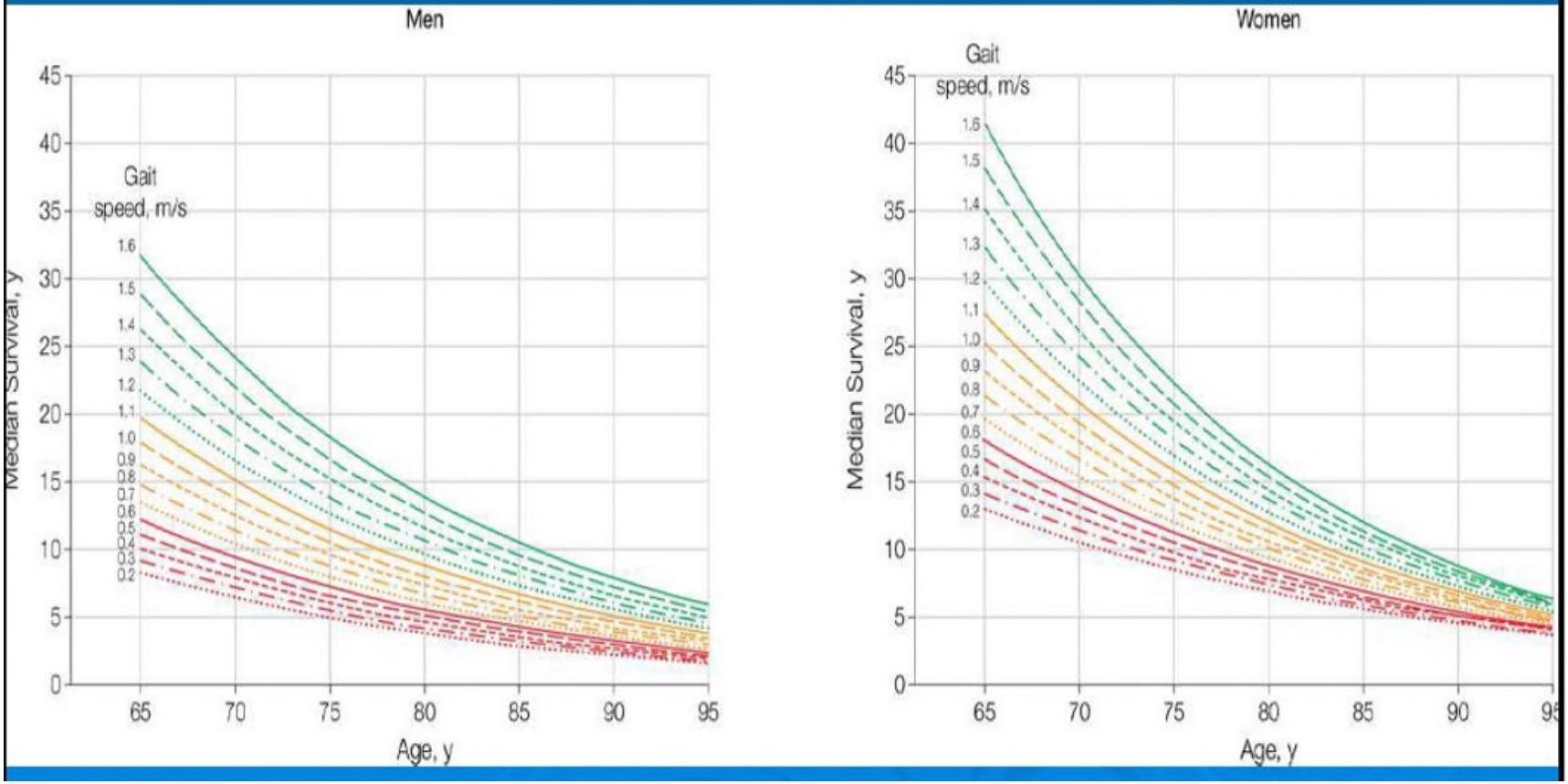


ACE unit: Acute Care for Elders unit; GEM: Geriatric Evaluation and Management; PACE: Program for All-Inclusive Care of the Elderly.

Morrison, Geriatric Palliative Care, 2003

Predicted Median Life Expectancy by Age and Gait Speed

Instructions: Walk 4 m (13 ft) at usual pace



Studenski JAMA 2011

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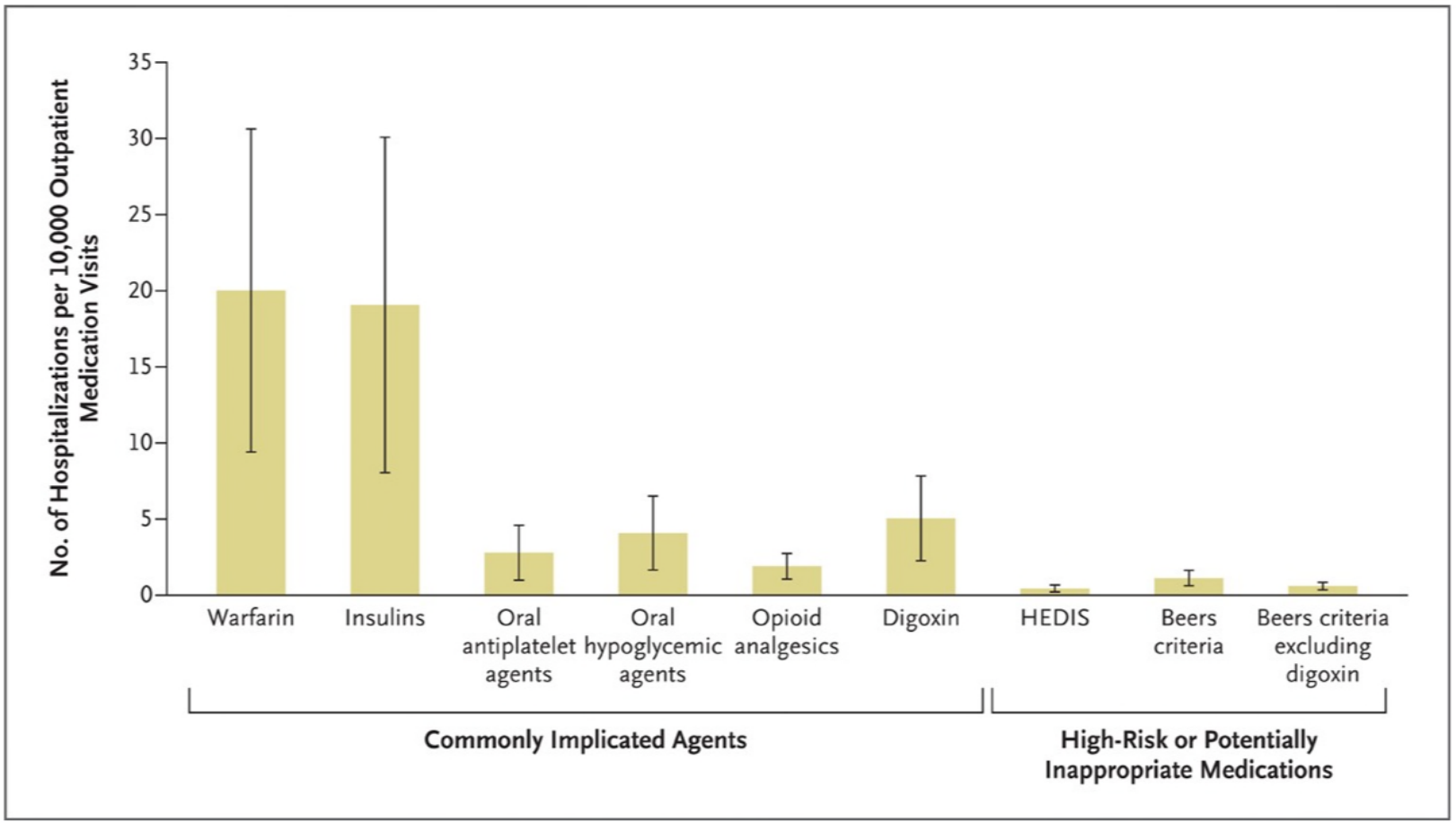
MOBILITY

Palliative Performance Scale (PPSv2)
version 2

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity *with* Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

EMERGENCY HOSPITALIZATIONS FOR ADEs



Budnitz NEJM 2011

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DEPRESCRIBING

- Ensure medication list is accurate
- Assess patient's adherence to medications
- Cross-reference medications on list with medical indications

Prepare patient for eventual review of medication at the time of prescription:
- Clarify expectations and outcomes/goals
- Develop time frame/plan for review
- Explain that a change in health status may signal the need for a review

Identify issues related to medications
- Number of medications or uncertainty of indication
- Patient/family concerns
- Adverse effects, such as falls and confusion
- Better options available in specific drug class

Set goal of deprescribing

Communicate plan with patient or substitute decision-maker

Considerations

Identify medication(s) to deprescribe
- Prioritize if more than one identified; factors to consider when prioritizing: adverse drug reactions, patient nonadherence, no clear indication, lack of benefit, use of medication to treat adverse reaction to a drug that can be changed, severity of condition being treated, risk of withdrawal symptoms

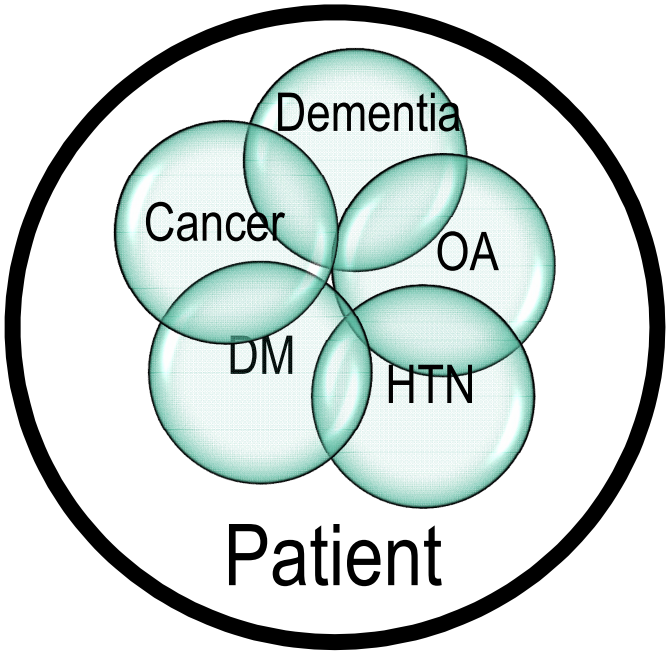
Develop weaning/titration strategy

Monitor, review and support
- Identify adverse effects from discontinuation of medication
- Identify recurrence of original symptoms
- If need to restart, consider best drug in class for older people (e.g., nortryptiline rather than amitryptiline)
- Continue to ask patient to bring in all medications and review whether and how they are being taken

Frank CMAJ-JAMC 2014

AGS GUIDING PRINCIPLES

1. Evidence
2. Prognosis
3. Feasibility
4. Optimization
5. Preferences

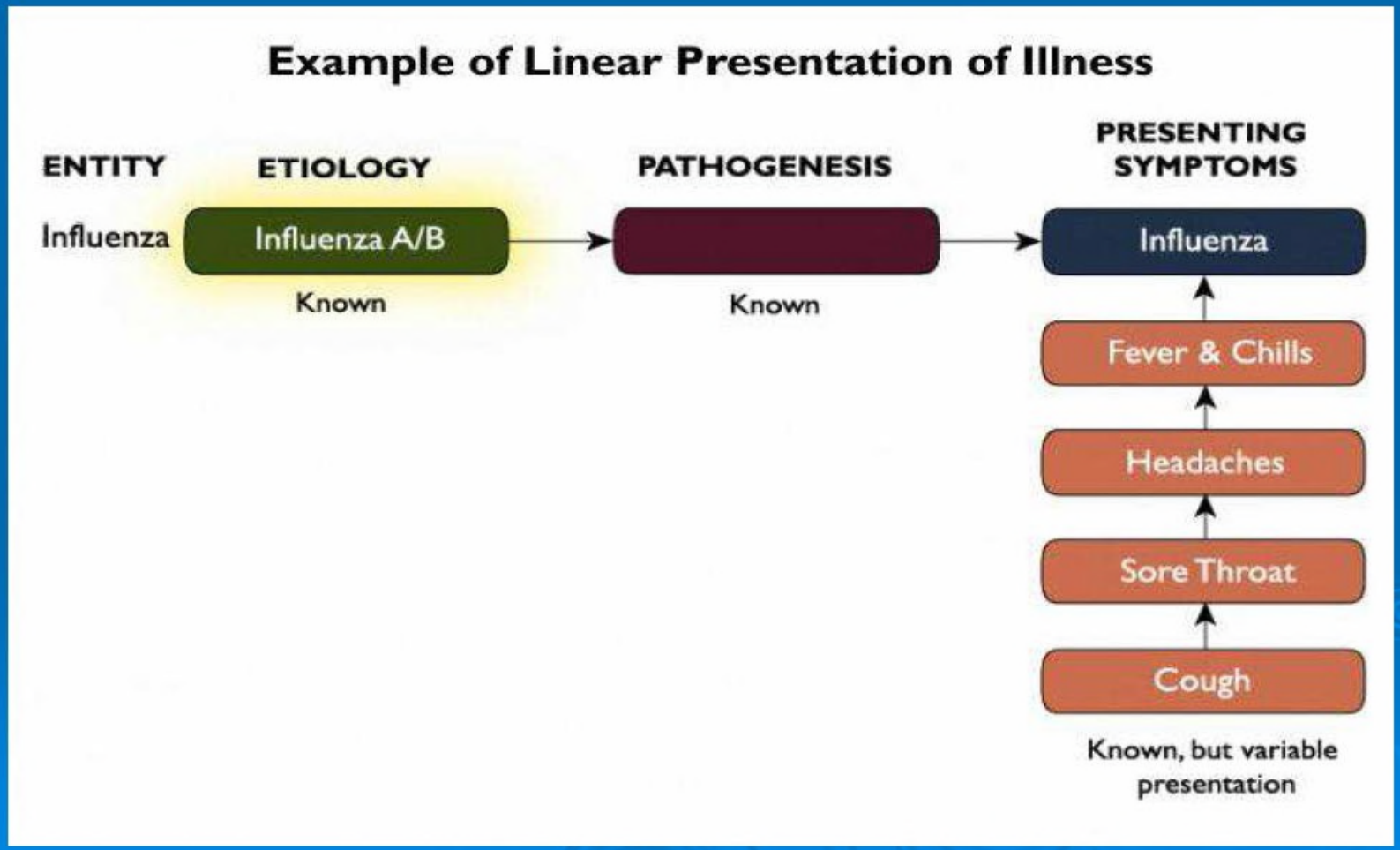


Guiding Principles for the Care of Older Adults with Multimorbidity: An Approach for Clinicians. JAGS;60(10),2012.

MANAGING COMPLEXITY

- Embrace it
- Determine which disease process drives terminality
  - Tell the story
- Understand clinical evidence
- Check for QOL assumptions

Linear Disease Presentation

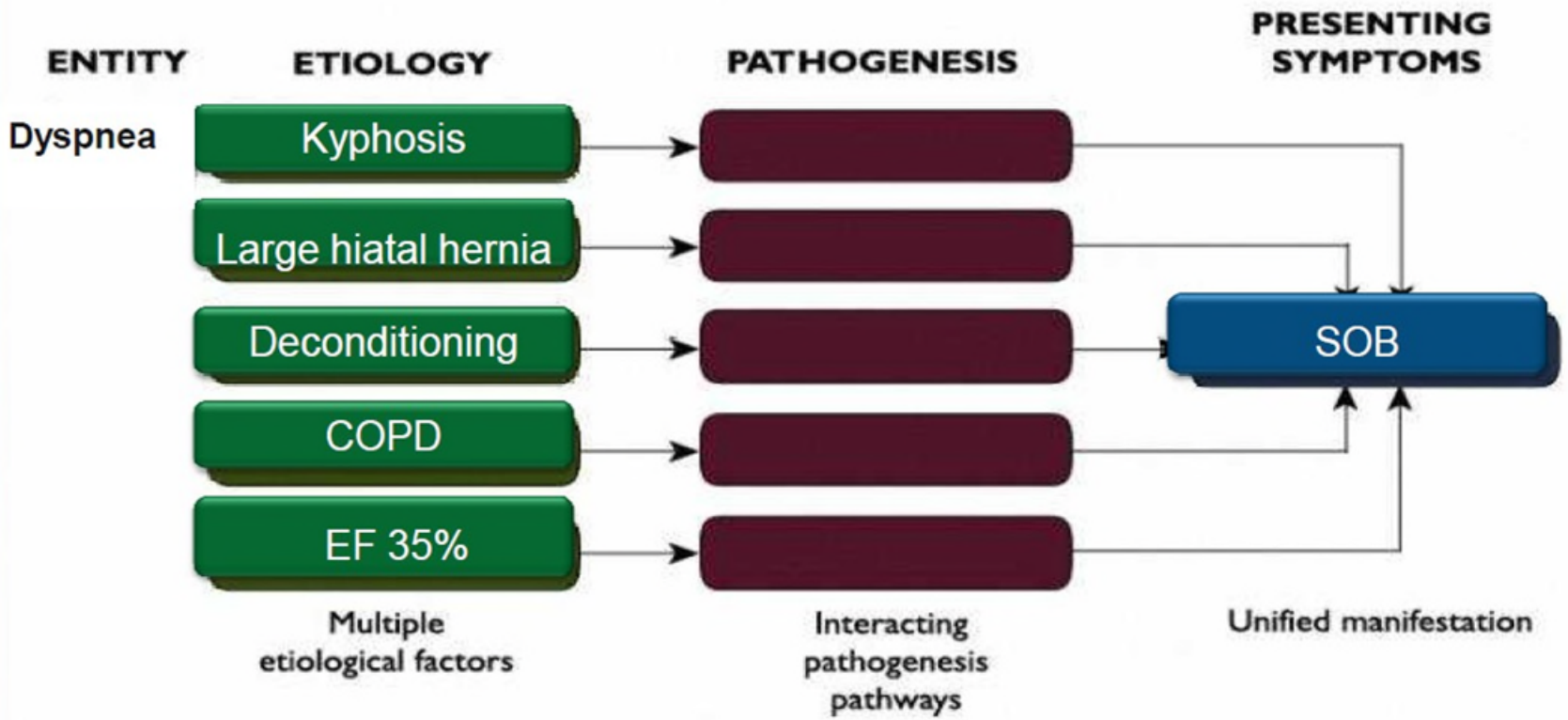


Multifactorial Etiologies:

SOB

MULTIMORBIDITY

What are some other causes triggered by serious illness?



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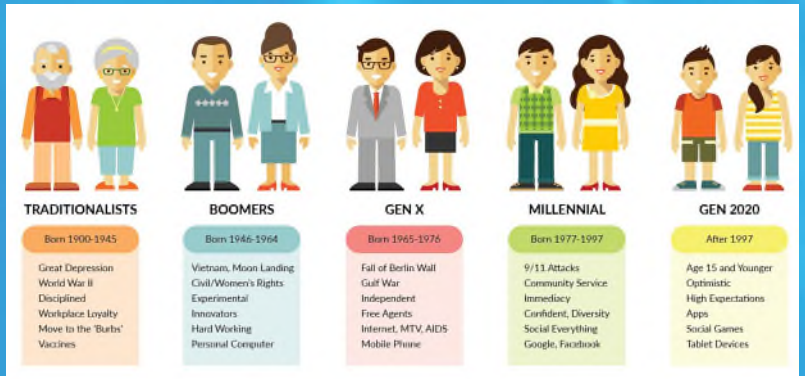
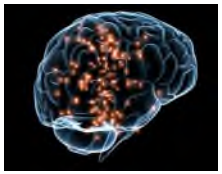
ADDRESSING CULTURE WITH INTENTIONAL CURIOSITY



- **A**ge and cohort effects
- **D**egree of physical ability
- **D**egree of cognitive ability
- **R**eligion
- **E**thnicity and race
- **S**ocioeconomic status
- **S**exual orientation and gender identity
- **I**ndividualistic life experiences (including trauma, level of acculturation) – Trauma Informed Care
- **N**ational origin – Immigrant, Refugee,
- **G**ender role expectations – Family structure



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Hays. Addressing Cultural Complexities in Practice, 2nd Ed: Assessment, Diagnosis, and Therapy, 2008

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Dimensions of Geriatric Assessment

(with a focus on Social Determinants of Health)

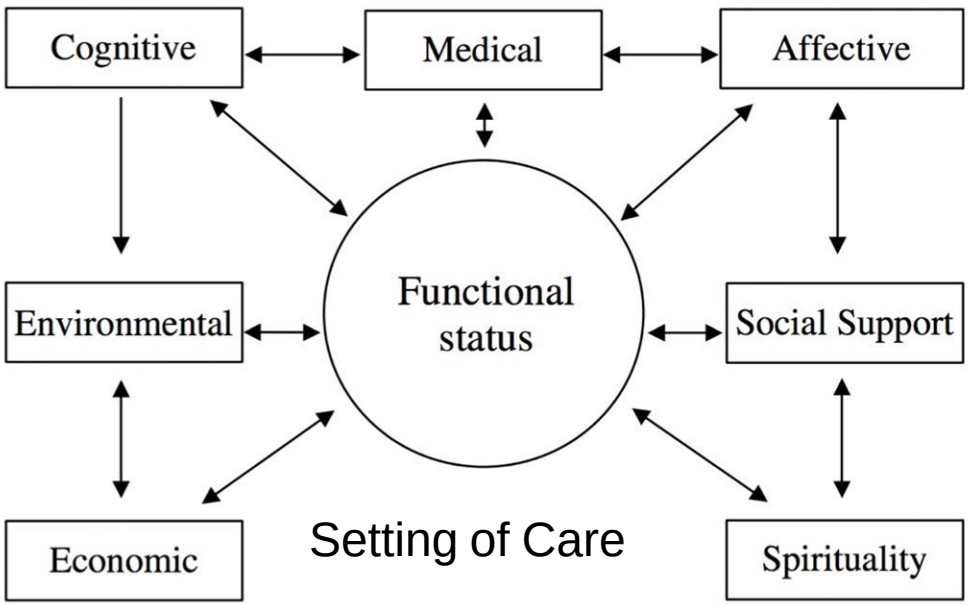

Fig 1. Interacting dimensions of geriatric assessment.

Icahn School of Medicine at Mount Sinai

Rosen SL and Reuben DB. Geriatric Assessment Tools. Mt Sinai J Med. 78:489–497, 2011

Mr. R 80 yo Referred To Palliative Clinic With A New Lung Mass

- Diabetes BMI 26
- Arthritis
- MCI
- Depression
- Heart failure
- OP
- CAD s/p MI
- OA
- Dyslipidemia
- GERD
- Cataract
- Gout
- Psoriasis
- Vit B12 deficiency

Mr. R's Medications

- Citalopram
- Pantoprazole
- Alendronate
- Acetaminophen
- Allopurinol
- Glipizide
- Aricept
- Carvedilol
- Cyanocobalmin
- Candesartan
- Lovastatin
- ASA
- Vitamin D

After Your Visit

- Citalopram – d/c low Na
- Pantoprazole – d/c no indication
- Alendronate – d/c time to benefit
- Acetaminophen – check dose
- Allopurinol – check uric acid
- Glipizide – check A1c
- Aricept- confirm indication
- Metoprolol – check VS
- Cyanocobalamin – check B12
- Lovastatin – check ldl
- ASA – check risk factors
- Vitamin D - keep

Applying the 'Evidence'

- **UNCERTAIN**

Likelihood of Benefit

- Magnitude of Effect
- Time to Benefit
- Life Expectancy
- Other Tx options
- Ability to 'adhere'

- **UNCERTAIN**

Likelihood of Harms

- From Screening
- From Treatment
- Patient burden

Patient Preferences

Societal Concerns

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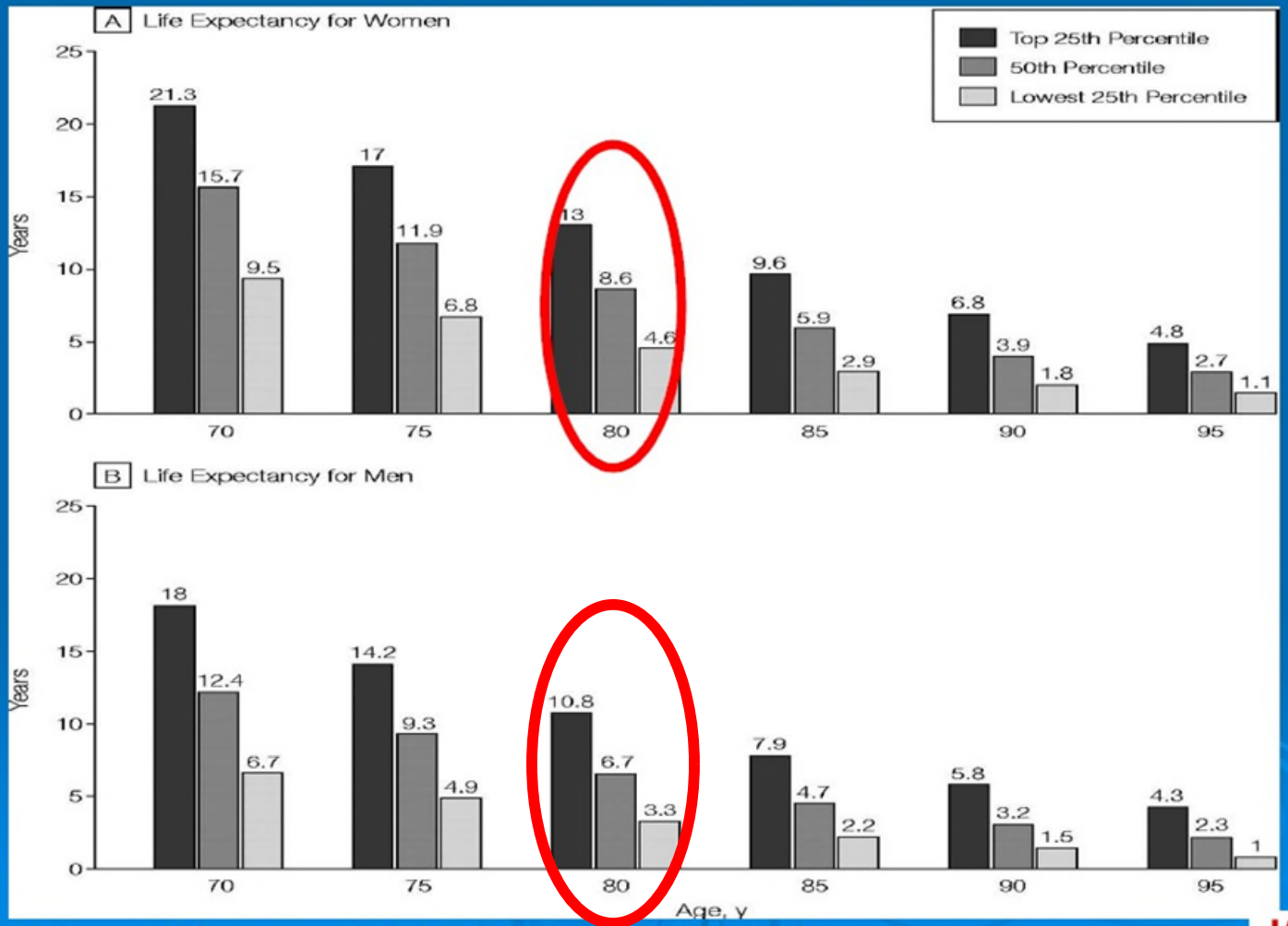
Upper, Middle, and Lower Quartiles of Life Expectancy



Walter and Covinsky JAMA 2001; 285:2750-2756

JAMA

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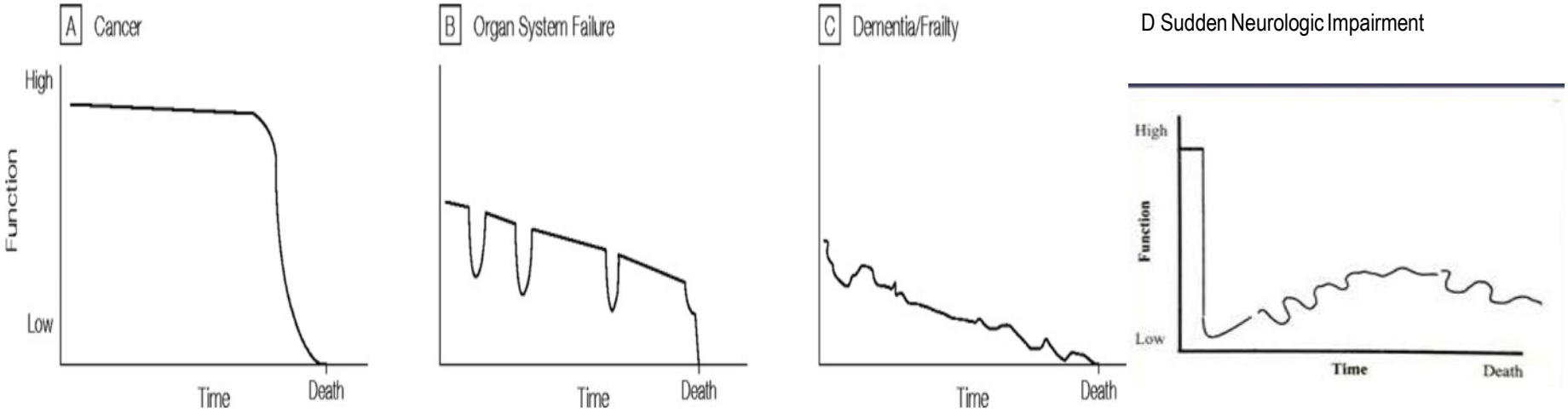
General Trajectories of Function and Well-being Over Time in Eventually Fatal Chronic Illnesses

Prognostication- Navigating Uncertainty



Best case, worse case and anticipatory guidance

Reframing and restaging a "Trial"

43

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Lynn, Serving patients who may die soon and their families. The role of hospice and other services. JAMA 2001.

Eprognosis Calculators

Where is your patient?

Living in the Community

15 month mortality

- Mazzaglia Index

➢ 2 year mortality

- Carey 2 Year Index

➢ 3 year mortality

- Carey 3 Year Index

➢ 4 year mortality

- Lee Index

➢ 5 year mortality

- Schonberg Index

Living in a Nursing Home

6 month mortality

- Porock 6 Month Minimum Data Set Mortality Risk Index - Revised

➢ 1 year mortality

- Flacker 1 Year Newly Admitted Revised Index
- Flacker 1 Year Long Stay Revised Index

Hospitalized

1 year mortality on discharge

- Levine Index
- Walter Index

➢ 1 Year mortality on admission

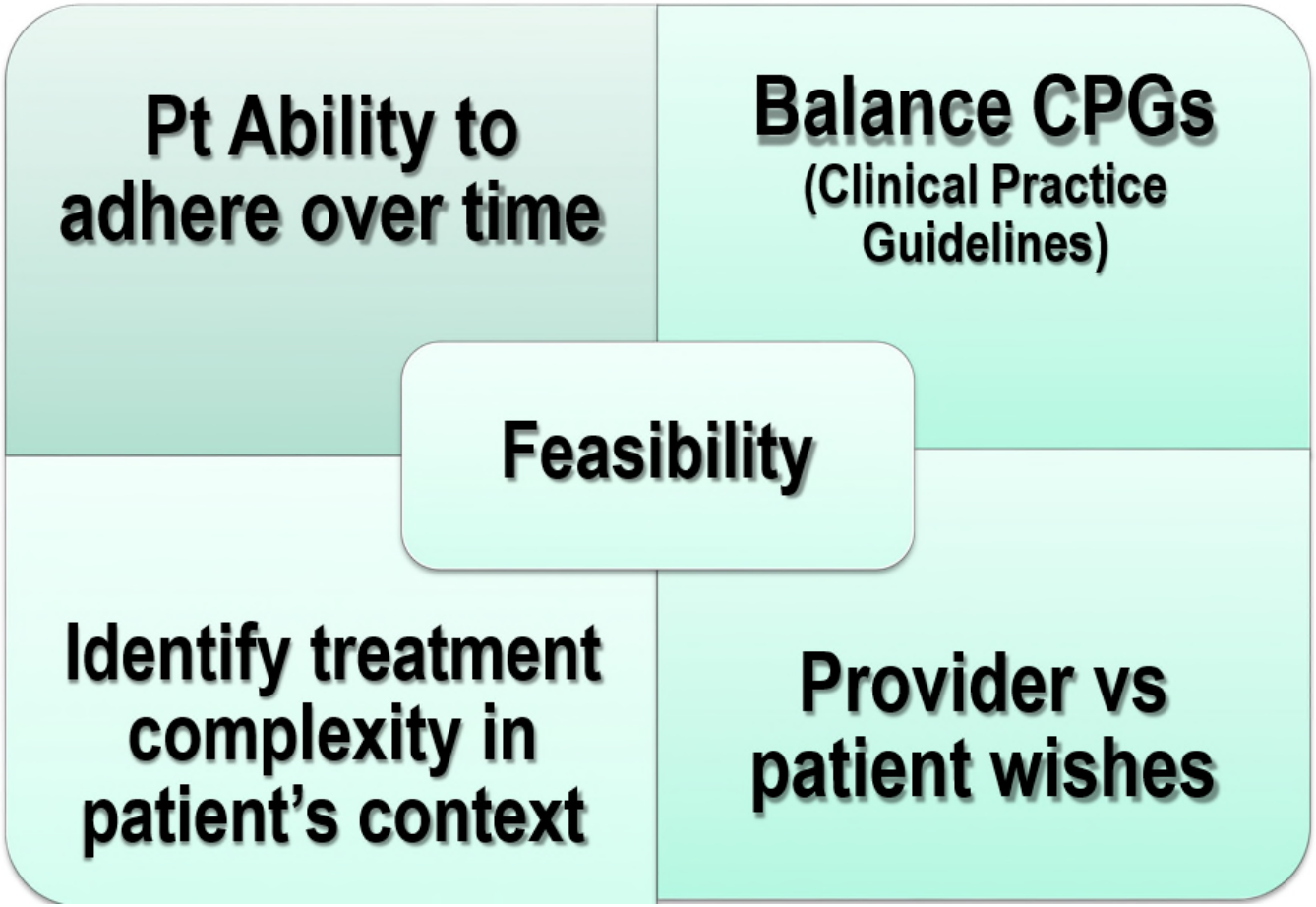
- Di Bari 1 Year Silver Code
- Fischer 1 Year CARING Index
- Inouye 1 Year Index
- Pilotto Index 1 Year and 1 Month Modified Index
- Teno 1 Year Help Model

➢ 2 Year mortality

- Dramé Index

www.ePrognosis.org

Shared Decision Making With Mr. Rodriguez



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Optimization

1. Minimize Harm
2. Maximize Benefit
3. Enhance Quality of Life

Caregiver training
Exercise
Sleep Hygiene
Adaptive equipment

IDT team is critical

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IN SUMMARY

- Geriatric and Palliative principles are rooted in person-centered care

- Clinical themes are synergistic
- Values & priorities matter
- Know the evidence
- Be curious
- Remember the 5 M's

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