Slow Medicine – An Old Approach to a New Problem

Kenneth Brummel-Smith, MD
Charlotte Edwards Maguire Professor of Geriatrics
Florida State University College of Medicine

Disclosure

- I have no relevant financial relationships with commercial interests to disclose.

Objectives

Participants will be better able to:

- Identify the population who would benefit from "Slow Medicine"
- Differentiate the difference between severity of illness and prognosis
- Describe methods for eliciting a patient's goals and wishes as part of the QAPI
- List the resources needed to promote "Slow Medicine" for at-risk residents

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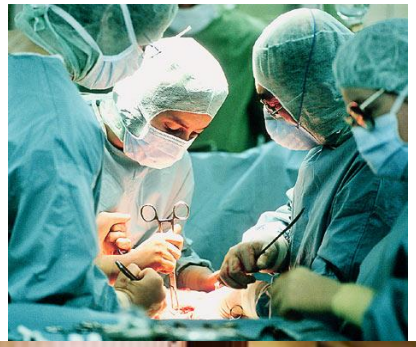
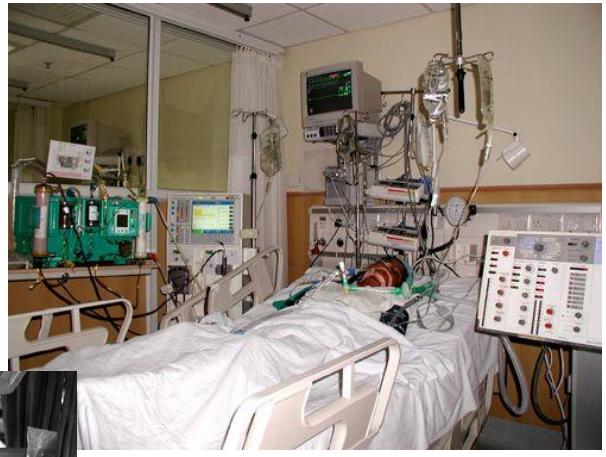
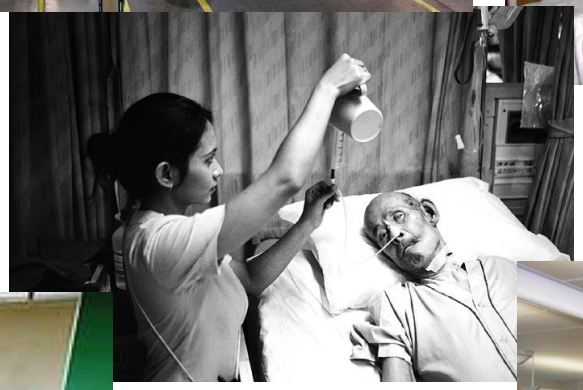
Guiding Principles

- The will of the patient, not the health of the patient, is the ultimate goal of health care.
- As a health care provider, you are one of the most abnormal people on the planet.
- Uncertainty is almost always attended by fear.
- Fear is almost always a factor in decisions in medicine that lead to bad outcomes.

Abnormal People Vs. Normal people







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Populations

- Healthy people and people with acute, time-limited conditions
- People with stable or early chronic conditions
  - Maintain their usual social role and have long life expectancy
- People with serious, progressive, eventually fatal illness
  - Meet the “surprise question” criterion

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Lunney JR JAMA 2005;289:2387-2392

New Terminology Needed

- Hospice – focuses on people in the last 6 months of life
- Palliative care – focuses on symptomatic improvement regardless of health status
- Care for those with Eventually Fatal, Chronic Conditions*
  - PACE, some HMOs (SCAN), Sutter AIM, Home Support, Gunderson Lutheran
  - ACOs(?), Comprehensive Primary Care (?)

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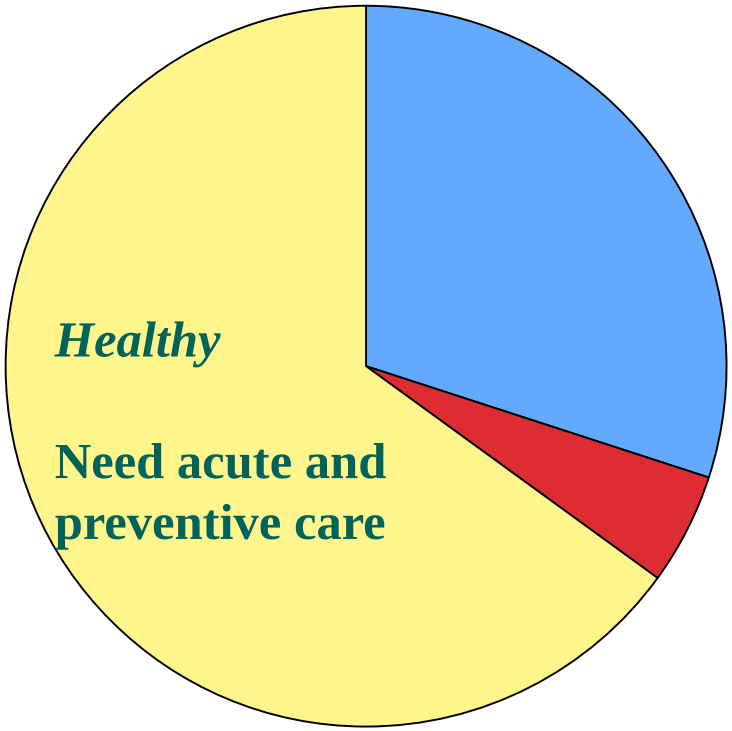
*Joanne Lynn, Sick to Death, 2004

A Century to Get Into Problems

	1900	2010
Age at death	46	80
Top causes	Infection Accidents Childbirth	Cancer Organ system failure Stroke Dementia
Disability	Not much	2 - 4 years before death
Financing	Private, modest	Public (Medicaid and Medicare) Substantial (83% in Medicare, ½ of women in Medicaid

Lynn J, Sick to Death, 2004

Health Status of the Population



Chronic Illness consistent with usual role –

Need acute and preventive care, and education about the future

Chronic, progressive, eventually fatal illness

Needs: Different services and priorities. Excellent caregivers

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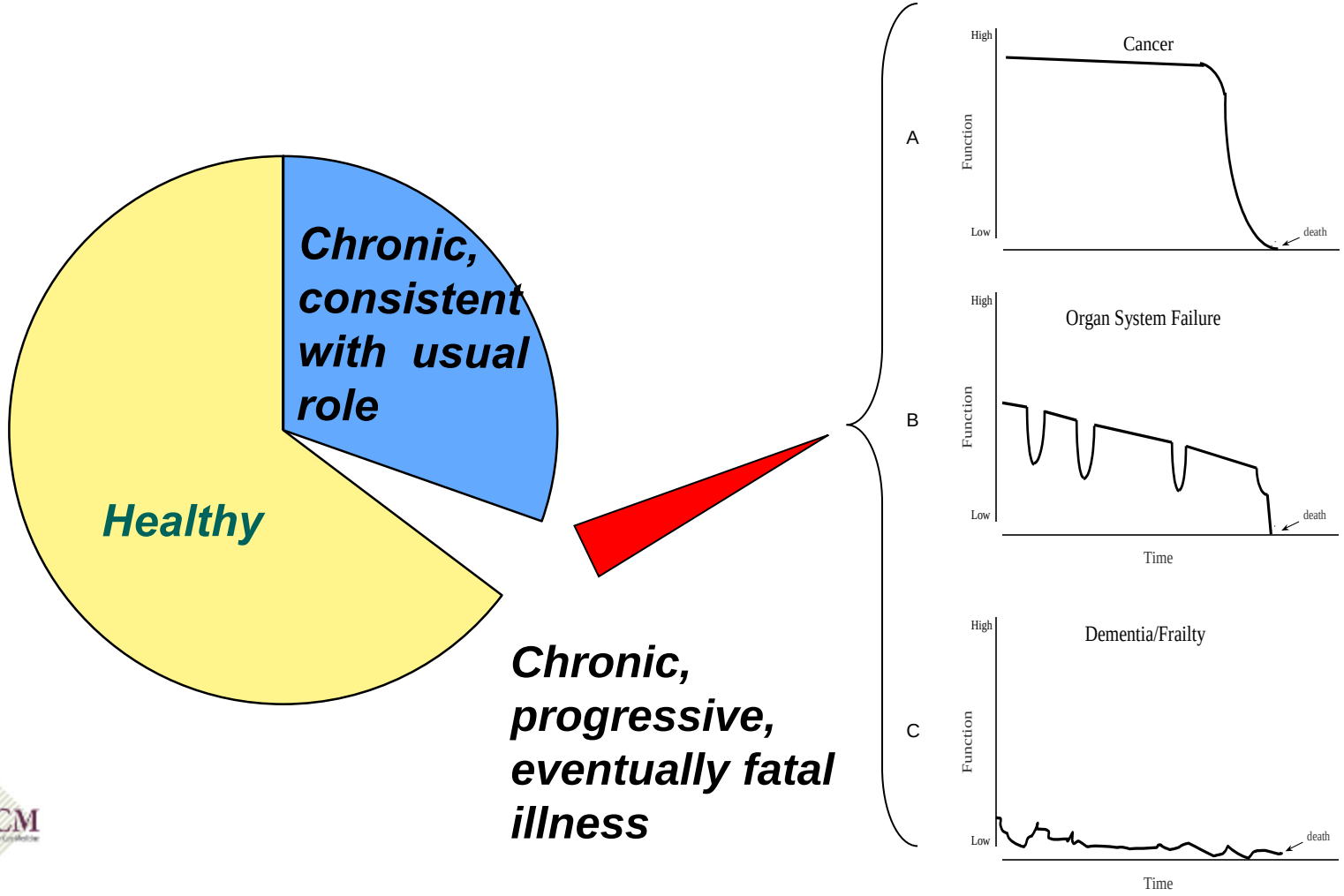
Lynn J, Sick to Death, 2004

Five Percent of the Population



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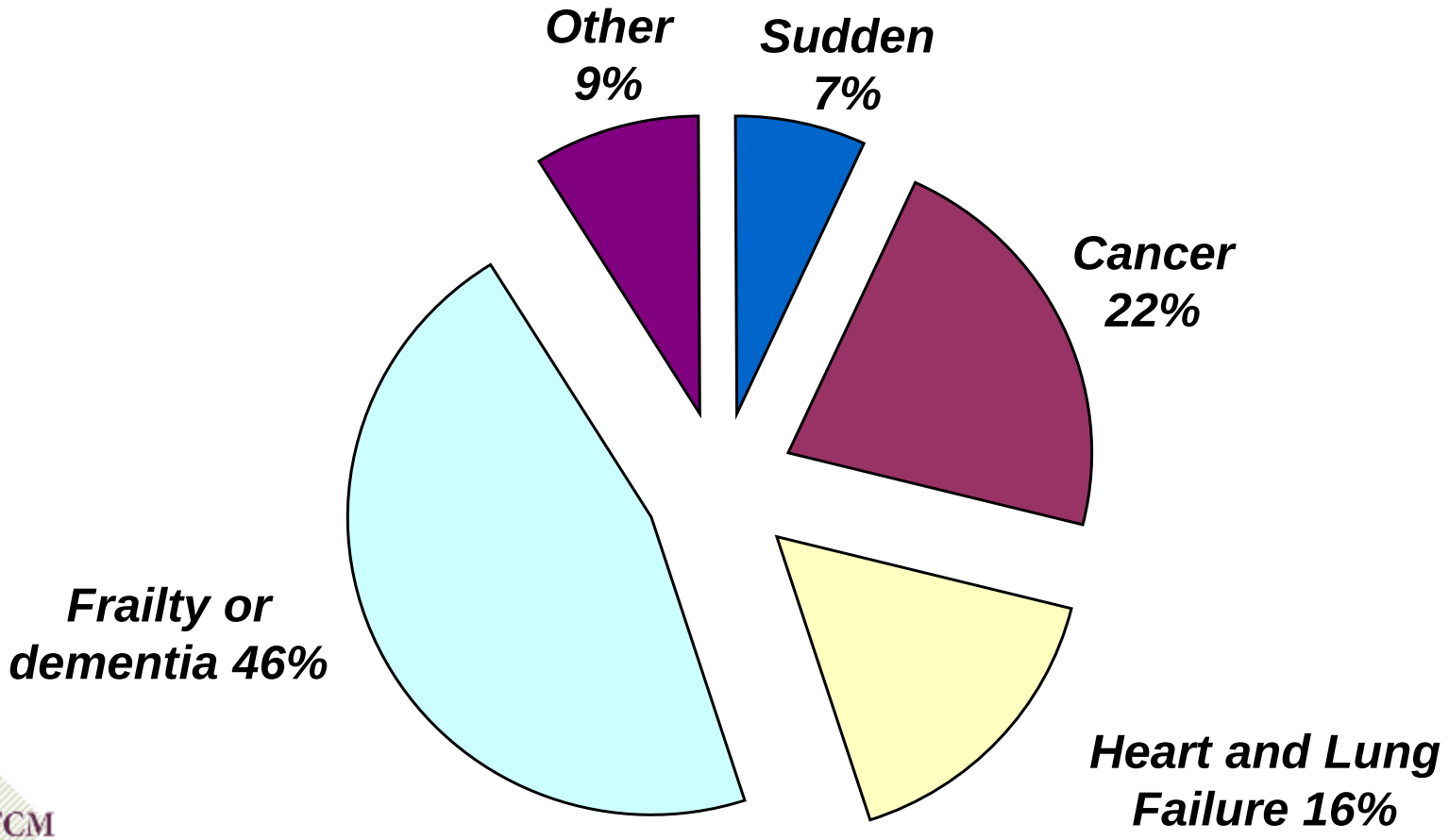
Medicare Decedents



93% of patients have “expected deaths”

Severity vs. Prognosis

- Severity
  - Traditional: severity framed in physiologic terms (FEV1, EF) or functional deficits or age
  - New model – framed in patient's perceived quality of life or goals
- Prognosis
  - Traditional: computed based upon above factors
  - New model: chances that interventions will achieve patient goals

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ePrognosis

Estimating Prognosis for Elders

Home | Calculators | About | How We Sort | How to Use | FAQ | Feedback | Links | GeriPal

Each bubble represents a prognosis calculator. Click on a bubble to view the calculator.

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What Is Needed To Help People with Eventually Fatal Chronic Conditions(EFCC)?

- "Deep" advance care planning
- A committed, capable team
- A system with options
- Caregiver education and support
- Proper financing
- Respect for patient decision-making

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“Deep” Advance Care Planning

- Occurs early in the course
- Repeated and graduated over time
  - Responsive to change
- Foundation –understanding of and respect for the patient’s goals and wishes
- Courageous – willing to modify standard clinical guidelines and quality measures
- Contemplative – based on reflection

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3- Step Process

- Understand the patient's goals and wishes
  - Make sure the caregivers understand and accept them
- Complete advance care documents
  - Name and educate a surrogate
- Complete a POLST for when the "surprise question" applies

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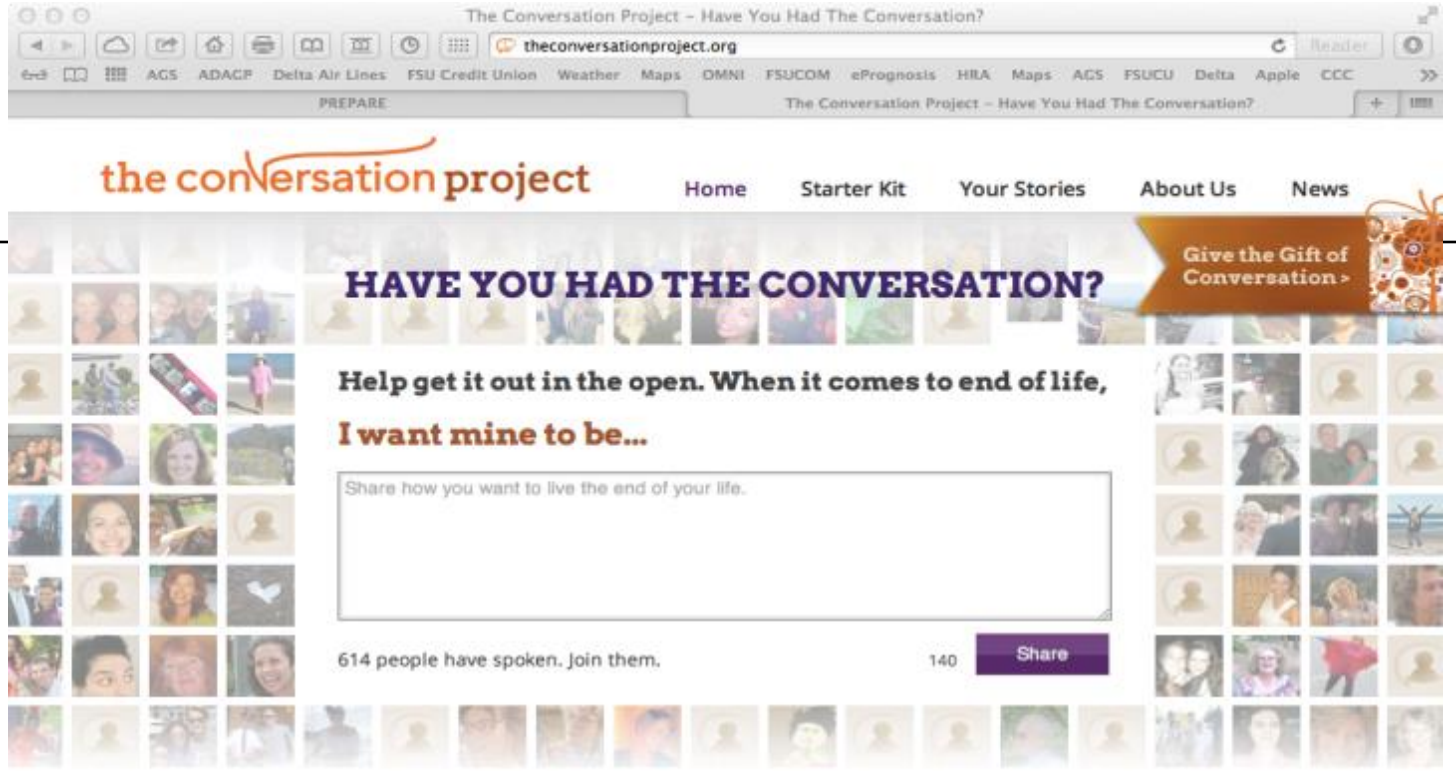

WHAT
it's all about

Hear from co-founder Ellen Goodman about what The Conversation Project is, what we're asking people to do and why she got involved.

WHY
it's important

60% of people say that making sure their family is not burdened by tough decisions is "extremely important"

56% have not communicated their end-of-life wishes

One conversation can make all the difference.

Source: Survey of Californians by the California HealthCare Foundation (2012)

HOW
to get started

Explore our Starter Kit for tools and tips to help you have the conversation.

EXPLORE STARTER KIT

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Understanding Goals & Wishes

- What is most important in your life?
- What experiences have you had with serious illness?
- Can you imagine a health situation that would be worse than death?
- How do you balance quality of life with medical care?
- Have you changed your mind about what is important over time?

Go Wish Cards

- Developed by the Coda Alliance (CA) in 2006
- 36 cards with short statements people often cite as important at the end of life
- Goal is to stimulate thought and discussion about values
- Geared for wide range of people – from independent to frail or cognitively impaired

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www.gowish.org

Advanced Care Planning

- Future – more interactive websites
  - www.PrepareForYourCare.org
  - www.MyDirectives.com
- Integration into the EHR
  - Meaningful Use standards
- Registries
  - State (Oregon)
  - National?
- Preferred Intensity of Treatment?

POLST

- Adopted in California
- Increasing amounts of evidence of its value
  - Concordance with wishes
  - Enhancement of palliative care
- Controversies developing
  - Who holds the discussion? Training?
  - Requirements for use
  - Who can sign it?

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Medical Decisions in EFCC

- Guided by:
  - Patient wishes and advance directives
  - Evidence-based outcomes valued by the patient
  - A recommendation by an experienced, compassionate team
- Informed by:
  - Recognition of risk
  - Use of prognostic indicators

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Create A High-Performance Org

- Get training!!
  - Calif. Coalition for Compassionate Care
    - http://coalitionccc.org
  - Respecting Choices
    - http://respectingchoices.org/training_certification
- Set performance standards
  - e.g., PACE – 100% completion rate by 2 months
  - E.g., 90% treatment concordant with POLST
- Foster family discussions

What People With EFCC Need

- Relief of medical symptoms
  - Especially pain
- Caregivers who are trained and supported
- Continuity of services and providers
- A safe environment that promotes function
- Help with planning for the future
- Providers who commit to following the patient's wishes
- A quality system that measures these things

Provider Decision-making

- What are this patient's goals?
- Is the treatment I'm considering likely to help the patient reach her goal?
- What harms may come from treatment?
- If we decide not to provide this treatment, what else do I need to do to reduce suffering or enhance quality of life?

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Case Example

- 92 year old woman, living in an SNF dementia care unit
- POLST (discussed with son) – DNR, comfort level of care, no artificial nutrition
- Found unconscious, aide called 911 before checking chart, patient transported to hospital
- Heart rate 220. Treated and HR now 86. Resident is now awake and alert.
- What next?

Slow Medicine Principles

- Understand the person deeply, acknowledging both losses and strengths
- Accept the need for interdependence and promote mutual trust
- Communicate well and with patience
- Make a covenant for steadfast advocacy
- Maintain an attitude of kindness no matter what

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Dennis McCullough, *My Mother, Your Mother*, 2008

Recommended Resources

- *Sick to Death*, Joanne Lynn, Milbank Fund, NY, 2004
- *My Mother, Your Mother: Embracing Slow Medicine*, Dennis McCullough, Harper, NY, 2008
- www.capc.org
- www.polst.org
- www.TheConversationproject.org
- www.PrepareForYourCare.org
- www.MyDirectives.com

CENTER TO ADVANCE PALLIATIVE CARE

Long-Term Care

People are living longer with chronic illness. By 2050, the number of people in the U.S. over the age of 85 is expected to double, to 8.5 million. Palliative care is essential to achieving the goal of excellent and cost-effective care for adults with complex, advanced illness. The following materials are suggested as a starting point for exploring opportunities to provide palliative care services in the long-term care setting.

Citations

Please visit CAPC's Citations page devoted to long-term care for the most up-to-date references on long term care.

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Books/Manuals

Palliative Care Best Practices: A Guide for Long-Term Care and Hospice. A Publication of the Colorado-based Center for Improving Value in Health Care

Palliative Care Best Practices: A Guide for Long-Term Care and Hospice was developed by the Colorado Center for Improving Value in Health Care. The guide is specific to Colorado laws/regulations, but the approach of providing a time-line of important palliative care interventions in the long -term care setting is appropriate for all states.