Presents

Advanced Care Planning: The Patients' Priorities Care Model

Speaker:

Suvi Neukam

AARP Oregon

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(Oregon Psychiatric Acces Line)
OPAL-K for kids and OPAL-A for adults

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ADVANCED CARE PLANNING:

THE PATIENT PRIORITIES CARE MODEL

Suvi Neukam, DO

Assistant Professor

Geriatrician, OHSU

June 2022

DISCLOSURES

None

OBJECTIVES

1. Define the model of Patient Priorities Care
2. List the benefits for patients and providers of this model
3. Identify components of a Patient-Priorities-Aligned exploratory conversation
4. Review ways to document care planning conversations

MEET GUS || 88 YO MALE

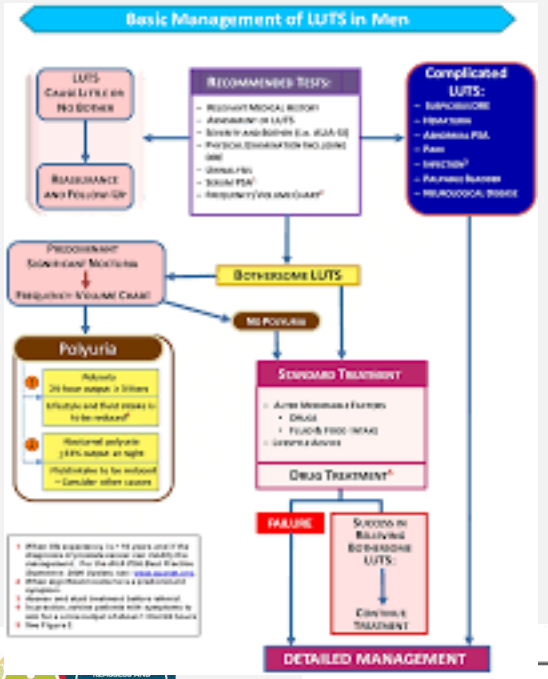
PMHx

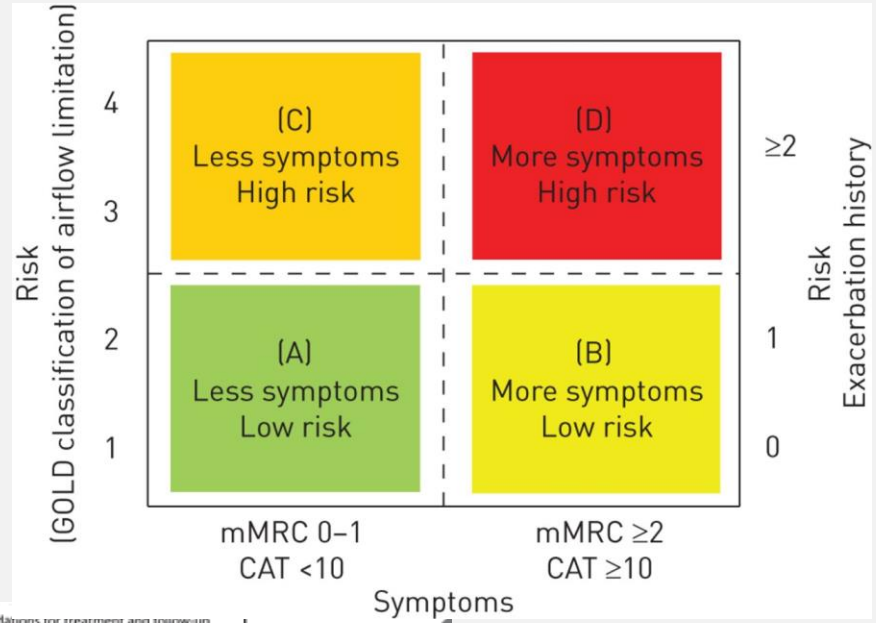
- Remote MI (1995)
- HTN
- HFrEF
- CKD 3
- Vascular Dementia
- COPD
- OA
- DM (A1c 7.2%)
- Hypothyroidism
- Hx of Falls
- BPH

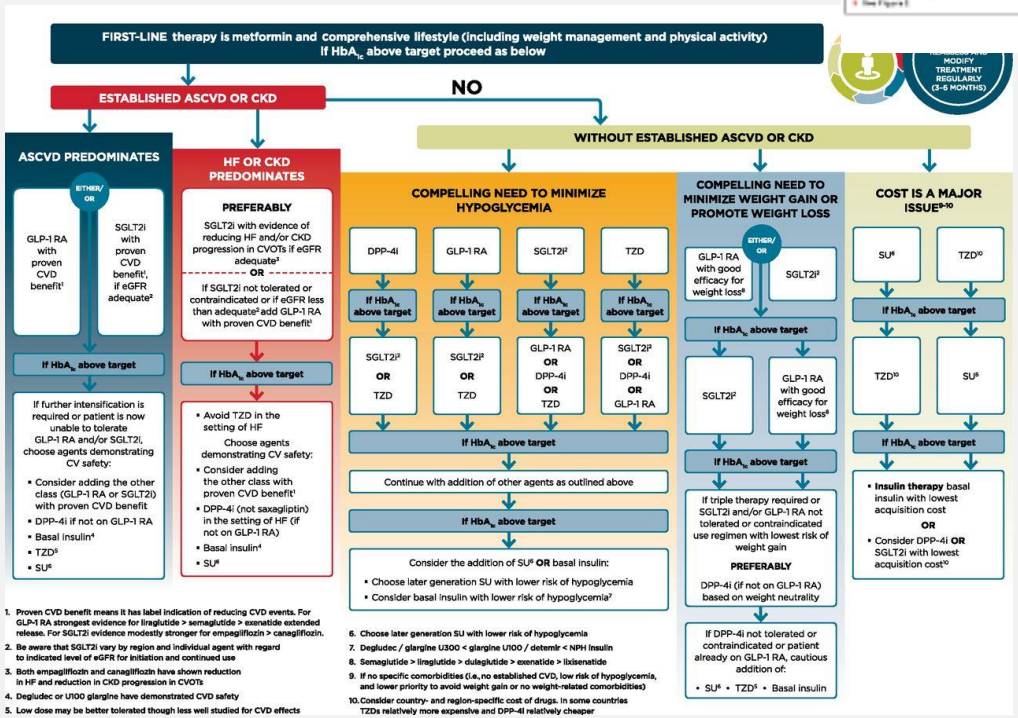
Rx

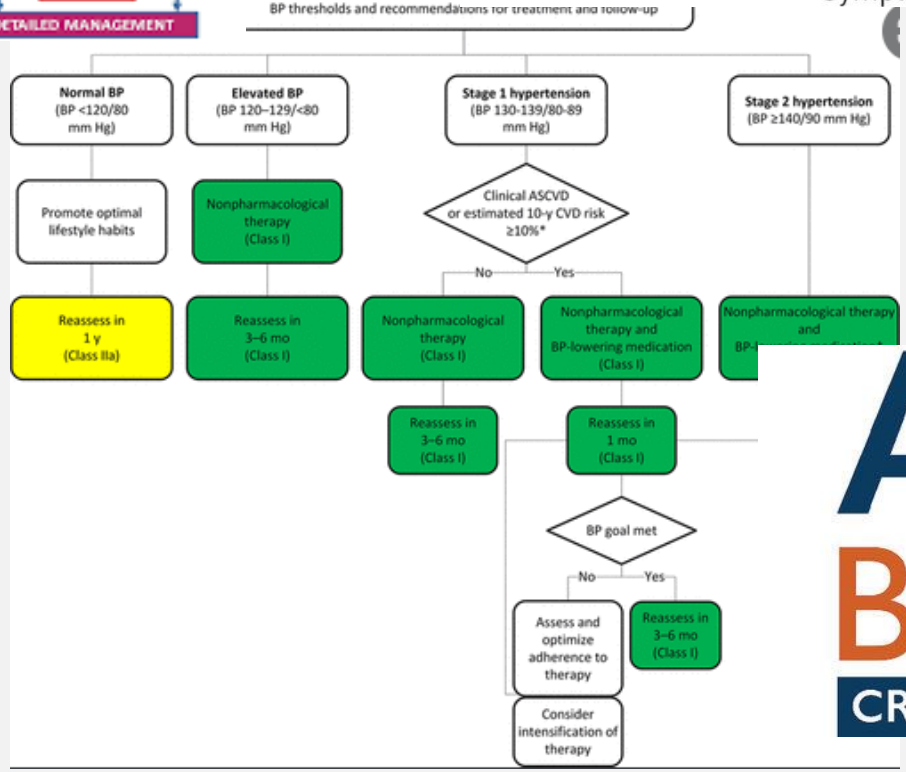
- ASA
- Metoprolol
- Amlodipine
- Lasix
- Donepezil
- Albuterol
- Tiotropium
- Simvastatin
- Lidocaine gel
- APAP PRN
- Metformin
- Glargine
- Levothyroxine
- Gabapentin
- Tamsulosin

KDIGO









AGS BEERS CRITERIA® 2019

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- Albuterol
- Tiotropium
- Simvastatin
- Lidocaine gel
- APAP PRN
- Metformin
- Glargine
- Levothyroxine
- Gabapentin
- Tamsulosin

❑ Gus' Daily To-Do:

- ❑ Weigh himself
- ❑ Check BP
- ❑ Check CBG
- ❑ Take morning Rx (some on an empty stomach)
- ❑ Remember to take medicines that don't fit in the pill box (ex. Insulin, inhalers…)
- ❑ Drink 64 oz of water
- ❑ Do leg pumps before standing and use walker
- ❑ Do exercises
- ❑ Remember to walk
- ❑ Urinate every hour
- ❑ Take PM medications
- ❑ Elevate legs for 30 min before bed, then pee

IS THERE A BETTER WAY?

Overwhelmed and confused you!

MULTIPLE CONDITIONS!

Multiple physicians!

Overwhelmed and confused patient!

Conflicting recommendations!

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PATIENT'S PRIORITIES CARE

Model of health care delivery and approach to decision making that focuses on clarifying patients' values and healthcare preferences then aligning health goals accordingly

patient priorities care

PATIENT'S PRIORITIES CARE

Just because we COULD do this for our patient,

doesn't mean we SHOULD do this for our patient.

What do they want?

patient priorities care

Health Outcome Goals

- Health and life outcomes that an individual desires
- SMART goal

(specific, measurable, achievable, relevant, timely)

+

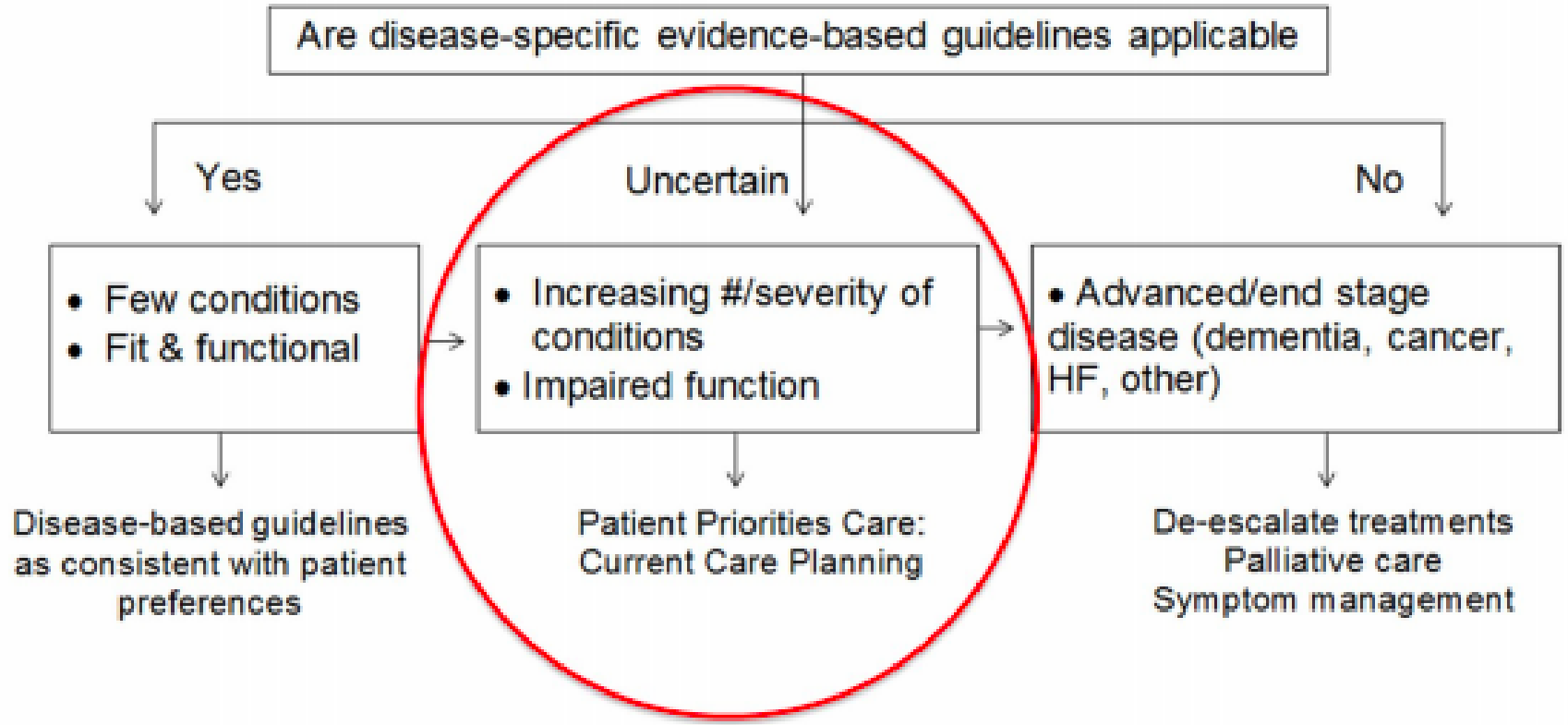
=

Healthcare Preferences

- Healthcare activities the patient is willing or NOT willing to do or receive
- May include medications, self management tasks, health care visits, diagnostic testing, procedures

Patient's Health Priorities

Figure 1: Decision-making and care of older adults with multiple chronic



Blaum C, Rosen J, Naik AD, Smith C, Dindo L, Vo L, et al. Feasibility of implementing patient priorities care for patients with multiple chronic conditions. J Am Geriatr Soc. 2018; doi: 10.1111/jgs.15465

"UNCERTAIN" PATIENTS

a. Multiple Chronic Conditions (e.g. presence of ≥3 active health problems)
b. >10 medications
c. > 1 hospitalization over the past year
d. > 2 emergency department visits over the past year
e. Seen by >2 specialists (excluding gynecology, ophthalmology) over the past year

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BENEFITS

Patients

- Reduces burdensome and unwanted care
- Validates autonomy
- Empowers patient in their own care
- Improved communication

Physicians

- More efficient care plans
- Increased compliance
- Easier care integration
- Improved communication

Tinetti JAMA October 2019

Feder et al. JAGS July 2019

JAMA Internal Medicine | Original Investigation

Association of Patient Priorities–Aligned Decision-Making With Patient Outcomes and Ambulatory Health Care Burden Among Older Adults With Multiple Chronic Conditions

A Nonrandomized Clinical Trial

Mary E. Tinetti, MD; Aanand D. Naik, MD; Lilian Dindo, PhD; Darce M. Costello, EdD, MPH, MBA; Jessica Esterson, MPH; Mary Geda, BN, MSN, RN; Jonathan Rosen, MD; Kizzy Hernandez-Bigos, BA; Cynthia Daisy Smith, MD; Gregory M. Ouellet, MD; Gina Kang, MD; Yungah Lee, MD; Caroline Blaum, MD

Table 2. Baseline Follow-up Differences in Patient-Reported Outcomes Among Older Adults With MCCs Receiving PPC or UC

	Least Squares Mean (SE)[a]		Baseline − Follow-up[b]	
Patient-Reported Outcome	Patient Priorities Care	Usual Care	Difference (SE)	*P* Value
Treatment Burden Questionnaire	−12.4 (4.0)	−7.4 (4.0)	−5.0 (2.0)	.01
O-PACIC	−0.2 (0.2)	0.1 (0.2)	−0.06 (0.1)	.60
CollaboRATE	−1.2 (5.3)	2.9 (5.2)	−4.1 (2.8)	.14

Tinetti JAMA October 2019

Table 3. Changes in Ambulatory Health Care Use in Older Adults With MCCs Receiving PPC or UC

Health Care Use Category	Bivariate Analysis			Multivariable Analysis, Odds Ratio (95% CI)[c]
	Weighted %[a]		Odds Ratio (95% CI)[b]	
	PPC (n = 163)	Usual Care (n = 203)		
Weighted No.	357	362		
Medications				
Any medication				
Added	65.0	58.9	1.15 (0.83-1.58)	0.93 (0.63-1.39)
Stopped	52.0	33.8	2.00 (1.47-2.72)	2.05 (1.43-2.95)
Cardiovascular medication[d]				
Added	20.8	15.7	1.33 (0.90-1.96)	1.07 (0.69-1.67)
Stopped	25.9	8.9	3.42 (2.20-5.30)	3.43 (2.10-5.60)
Psychotropic medication[e]				
Added	18.7	11.2	1.73 (1.13-2.65)	1.67 (1.02-2.72)
Stopped	11.0	7.0	1.57 (0.92-2.65)	1.66 (0.92-3.01)
Diagnostic/laboratory tests[f]				
Any ordered	80.8	86.4	0.33 (0.20-0.57)	0.22 (0.12-0.40)
Any avoided[g]	5.0	3.6	1.37 (0.66-2.86)	1.33 (0.62-2.85)
Referrals/consults[h]				
Any ordered	48.9	44.4	1.09 (0.81-1.49)	1.02 (0.72-1.43)
Any avoided[g]	5.5	2.6	2.08 (0.94-4.62)	1.87 (0.80-4.36)
Procedures[i]				
Any scheduled	29.2	21.5	1.41 (1.00-2.00)	1.37 (0.95-1.98)
Any avoided[g]	12.3	7.1	1.75 (1.04-2.93)	1.49 (0.86-2.57)
Self-management tasks[j]				
Any added	57.5	62.1	0.71 (0.52-0.97)	0.59 (0.41-0.84)
Any stopped	6.4	8.6	0.69 (0.39-1.22)	0.58 (0.31-1.11)

Tinetti JAMA October 2019

Table 2. Perceived Benefits of Patient Health Priorities Identification Process

Benefit	Exemplar quotes
Knowledge or insight into patients' health and healthcare	
Learning to ask questions	"It's somebody who could help me to find out how to get help for something, to listen." (P5)
Gaining knowledge of care options	"The [PHPI] process just did not seem as perfunctory as when you go do the doctor. [The facilitator] wanted to know more in detail how does that affect you and what would you like to change." (P161)
Reinforcement of the patient-clinician relationship	"Well, it got me to realize that the doctor's office and my own doctor are truly interested in my health." (P182)
Patient activation	
New perspectives of health and healthcare, goals, and objectives	"I found it interesting. It was helpful. It helped me sit down and really think about things, vs just kind of reacting day to day. It helped me refocus my thoughts and really kind of verbalize my priorities." (P184)
Assertiveness and confidence	"Cuz it's changed my assertiveness, where I used to keep it to myself. I think it's given me more confidence in living alone at my age." (P142)
Motivation for change	"She suggested maybe a nutritionist to talk to about the weight and stuff like that, which I have been going to. I needed the push, I guess, to ask to go see one." (P9)
Communication	
With family	"To be more open with my girls, because they are really holding my life in their hands, because they do know that I have a living will. And I do want it respected." (P142)
With clinicians	"Well, it's taught me to speak up, because I am the type of person that, you know, 'Oh, well, it's minor, I will not mention it.'" (P161)

Journal of the American Geriatrics Society

Feder et al. JAGS July 2019

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HOW IS THIS ACCOMPLISHED?

EXPLORING VALUES

- Introduce
- What Matters?
- Concerns and Fears
- Goals and Preferences
- Summarize

EXPLORING VALUES

Introduce	**V** inVest the patient
What Matters?	**A** Assess what matters
Concerns and Fears	**L** things Loathed & Limitations
Goals and Preferences	**U** what do "U" want?
Summarize	**E** End the conversation


(active)
LISTENING
(patient)
LIGHTS UP
The 4 "Ls"
(validating)
LANGUAGE
LET GO
(of your agenda)

V: INVEST THE PATIENT

V
inVest the patient

A
Assess what matters

L
things Loathed & Limitations

U
what do "U" want?

E
End the conversation

"I know we have worked together for quite a while and I know some about what matters to you. But I want to understand better how your health and your healthcare influences your day to day life. The more I know about this, the better we can work towards a plan of care that is right for you."

A: **A**SSESS WHAT MATTERS

V
inVest the patient

A
Assess what matters

L
things Loathed & Limitations

U
what do "U" want?

E
End the conversation

"What matters most to you?"

- **Connecting** (friends, family, spirituality, community)
- **Enjoying life** (recreation, hobbies, growth, learning, production)
- **Functioning** (independent living, IADLs/ADLs)
- **Managing health** (quality and length of life, symptom control)

L: THINGS **L**OATHED & **L**IMITATIONS

V
inVest the patient

A
Assess what matters

L
things Loathed & Limitations

U
what do "U" want?

E
End the conversation

"What concerns you most when you think about your health and healthcare?"

"What fears and worries do you have about your health as you think about the future?"

U: WHAT DO "U" WANT

V
inVest the patient

A
Assess what matters

L
things Loathed & Limitations

U
what do "U" want?

E
End the conversation

"What would you most like help with in your day to day life from your health care team?"

"What health problem or parts of your healthcare do you think is making it more difficult to (fill in the goal)?"

"What abilities are so critical to your life you can't imagine living without"

"If you became sicker how much would you be willing to go through to accomplish x?"

E: END THE CONVERSATION

V
inVest the patient

A
Assess what matters

L
things Loathed & Limitations

U
what do "U" want?

E
End the conversation

- Summarize what you have heard
- Allow the patient the opportunity to correct misunderstandings
- Thank them for openly participating in the conversation
- Introduce next steps

BACK TO GUS…

What Matters?

”My wife. Always, my wife”
“We can talk about everything or nothing. It’s all perfect”

Concerns and Fears

”What if I can’t take care of my wife?”
Chemotherapy- “no one should wither and die!”

Goals and Preferences

“I cannot be failed by my own two legs”
“If it’s a means to an end, I could go to therapy”
“But long term, my head will always rest next to Betty’s”

What Matters

Spending quality time with wife

S Specific

M Measurable

A Achievable

R Relevant

T Time-Bound

INSTEAD OF THIS:

"I am going to exercise more!"

TRY THIS:

"I will walk outdoors for 15 minutes on Mondays, Wednesdays and Fridays. Anywhere is fine if I am out and about but probably up and down my street".

What Matters

Spending quality time with wife

Health Goal

Bring Betty out to dinner once every week

What Matters

Spending quality time with wife

Health Goal

Bring Betty out to dinner once every week

ACHIEVABLE

What Matters

Spending quality time with wife

Health Goal

Bring Betty out to dinner or lunch once every week or cook a fancy dinner for her at home

BARRIERS TO GOALS

"Now that we know your health goal, let's explore the symptoms or health problems that are most bothersome or most interfering with your ability to successfully achieve this goal."

What Matters

"What is holding you back from living according to what matters most to you?"

"What would make it easier to feel connected to what is most important?"

"You have shared before that *[pt-specific goal]* is very important to you. What makes this difficult to do more regularly?"

Mentation

"Do you feel your mood has affected your ability to reach your goal? Are worries or low spirits getting in the way?"

"It can be so overwhelming to keep track of everything going on. Have you felt that your memory or attention has made it harder for you to reach your goals?"

Mobility

"I know that [ex- *staying active and independent*] is important to you, so I would like to talk about how you are getting around the home. Has your mobility, balance or falling made reaching your goals harder?"

"Before you described some activities and daily functioning that was important to you. What makes it hardest to do these activities on a more regular basis?"

Medications
(and More!)

"You shared that feeling strong is important to you. Do you think there are any medicines you take that make you feel particularly weak or shaky?"

"I know us doctors have been keeping you busy recently. Can you tell me how doing these things (labs, imaging, doctors visits) makes you feel? Do you think it is impacting your ability to meet your goals?

MATTERS: he feels like the more time he spends at his own doctor's appointments, the less time he has with Betty

MENTATION: he has been feeling overwhelmed and not sure if cognition is deteriorating or if he is just too tired and distracted to remember things

MOBILITY: he needs to be strong enough to take care of himself and his wife. No falls but feeling less steady on his feet and worries about this.

MEDICATIONS: he wants to avoid medicines that me him feel dizzy (he knows he can't fall!) or foggy (it is a great fear that he will mismanage his wife's medicines)

"Your priority is to improve (SYMPTOM)
so that you can (HEALTH OUTCOME GOAL).

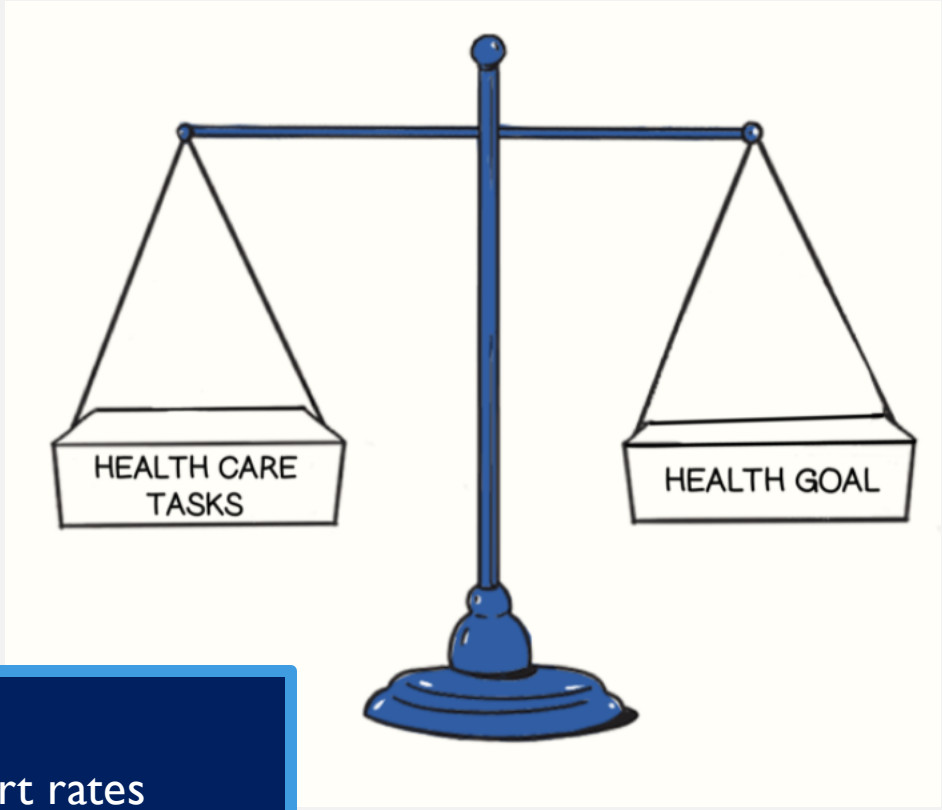
Let's discuss changes to your healthcare
that can help you do that."

FINDING THE BALANCE

SELF TASKS
- ❑ Weights
- ❑ Blood pressures
- ❑ Special diet
- ❑ Blood sugars
- ❑ Exercise
- ❑ CPAP

VISIT TASKS
- ❑ Primary Care
- ❑ Specialists
- ❑ Therapies
- ❑ Counselors

SYSTEM TASKS
- ❑ Blood work
- ❑ X-rays
- ❑ CT/MR
- ❑ Invasive Procedures
- ❑ Surgery
- ❑ Chemotherapy
- ❑ Radiation
- ❑ Dialysis



1) STOP Gabapentin
2) Home blood pressure and heart rates
3) STOP metoprolol and amlodipine as able

Identify Core Values

Construct SMART outcome goals

Communicate Goals with Clinician

Align treatment plan with values & goals

"*You need* (TEST OR TREATMENT) *because of your* (DISEASE)"

"*I'm recommending (*STARTING, CONTINUING, OR STOPPING TREATMENT*) because it will help you achieve* (PATIENT'S GOAL) *and is consistent with (*PATIENT'S CARE PREFERENCE*)."*

*"I'm recommending we **slowly reduce your gabapentin** because it may be contributing to your **mental fogginess** and I know that **feeling cognitively sharp is important to you**, especially when you need to be witty for those candle lit dinner conversations with Betty!"*

*"I know you already have a lot on your plate, but would you be **willing to check your blood pressure** every day for a week or so if it might make it possible for us to safely **stop one of your blood pressure medications** that could be making you dizzy? I know **it is important for you to not fall and stay as functionally independent as possible** so that you can care for Betty and enjoy quality time with her"*

Identify Core Values

Construct SMART outcome goals

Communicate Goals with Clinician

Align treatment plan with values & goals

Fine. I'll use that cuff, but not forever!

I never liked the gabapentin anyway. Go ahead and stop it.

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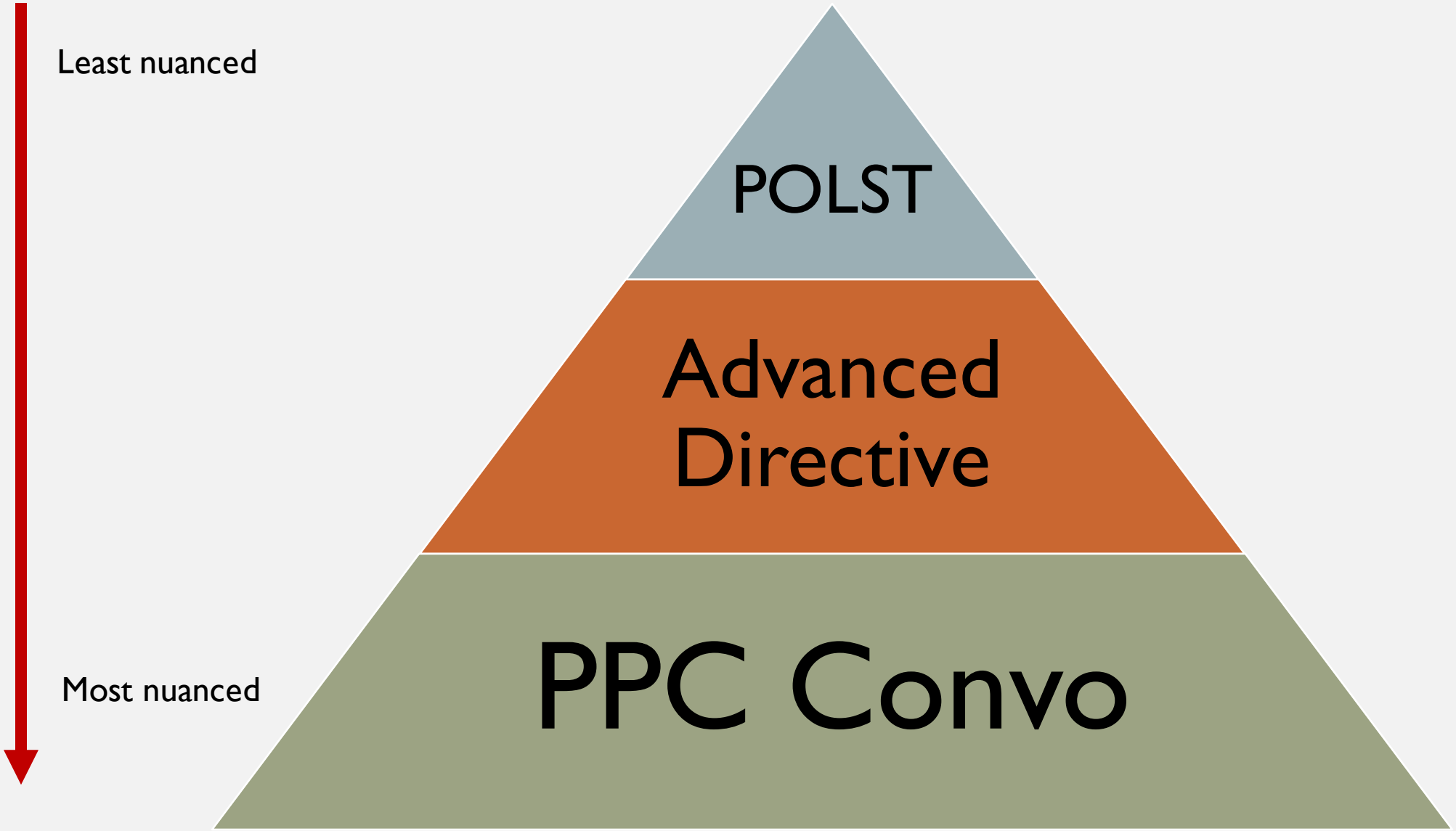
PLUG FOR PROSE DOCUMENTATION



Advance Care Planning Notes

Expand All Collapse All

ACP (Advance Care Planning) by Suvi T Neukam, DO at 05/18/21 1730

Date of Service		Author	Author Type	Status
05/18/21 1730	Addend	Suvi T Neukam, DO	Physician	Signed

Advance Care Planning Discussion

We have discussed Advance Care Planning and Goals of Care today with the patient/family and the following is a brief summary of our discussion.

Discussion with Gus today about his care preferences.

Gus is clear that his #1 priority is being able to spend as much good time with wife, Betty, as possible.

"Good Time" is described as "being together" and sharing conversations—making her laugh is his biggest joy in life.

Gus acknowledges that he and Betty are not "spring chickens" anymore and that Betty, in particular, has been needing more help. To this end, his greatest worry is not being able to take care of Betty—he states he needs to make sure he is physically and cognitively strong enough to be her caregiver.

He would like to prioritize treatments/tasks that help him meet these goals and avoid those that compromise his physical strength or cognitive sharpness.

His only "hard stop" is receiving chemotherapy- he is clear he would not ever want this. Otherwise, he would be willing to take medicines or do evaluation (labs, imaging, procedures, even surgery) if it helped him stay strong/sharp and thus be better positioned to care for Betty. He reserves the right to change his mind about this if he feels like the things we are asking him to do is detracting from his time with Betty.

Suvi T Neukam, DO
OHSU PRIMARY CARE AT MARQUAM HILL
3270 Sw Pavilion Loop
Physician's Pavilion, 3rd Floor
Portland, OR 97239-3011
503-494-8562

SUMMARY

- PPC allows us to shift our thinking from what we could do to what we should do
- Both patients and care team members benefit from PPC through improved communication, mutual understanding and greater adherence to care plans
- To practice PPC one must explore the values, goals and preferences of a patient
- If a care planning conversation falls in the forest, but no one hears it…. Document, document, document!

ADDITIONAL RESOURCES

- **Patients' Priorities Care Modules through ACP**:
  - https://ethosce.acponline.org/patient-priorities-care?_ga=2.100024542.1908620252.1559066249-172929199.1558443249
- **Patients Priorities Care Homepage**
  - Conversation guides, modules, FAQs
  - https://patientprioritiescare.org/

ACP
American College of Physicians
Leading Internal Medicine, Improving Lives

patient priorities care

RESOURCES

- Patients Priorities Care Website: https://patientprioritiescare.org/about/
- Blaum CS, Rosen J, Naik AD, et al. Feasibility of Implementing Patient Priorities Care for Patients with Multiple Chronic Conditions Journal of the American Geriatrics Society. 2018;66(10):2009-2016.
- Naik AD, Dindo LN, Van Liew JR, et al. Development of a Clinically-Feasible Process for Identifying Patient Health Priorities Journal of the American Geriatrics Society. 2018;66(10):1872-1879.
- Feder SL, Kiwak E, Costello D, Dindo L, Hernandez-Bigos K, Vo L, Geda M, Blaum C, Tinetti ME, Naik AD. Perspectives of Patients in Identifying Their Values-Based Health Priorities. J Am Geriatr Soc. 2019;
- Tinetti ME, Naik AD, Dindo L, et al. Association of Patient Priorities–Aligned Decision-Making With Patient Outcomes and Ambulatory Health Care Burden Among Older Adults With Multiple Chronic Conditions: A Nonrandomized Clinical Trial. JAMA Intern Med. 2019.
- https://patientprioritiescare.org/wp-content/uploads/2020/04/Patient-Priorities-Care-in-an-Age-Friendly-Health-System-Telehealth-to-Address-COVID-19_PPCJF04172020.pdf

Thank You, Partners!

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