Geri-ality

WITH DR. NAZIR

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Online Resources for Advance Care Planning: What's your Plan?

Advance Care Planning (ACP) assures that care is patient-centered and results in improved health, utilization and satisfaction outcomes. Given its significance, CMS now reimburses clinicians for having ACP discussions with their patients. Still many other barriers exist that prevent needed utilization of this service. One of these barriers pertain to patient and family understanding of the complex issues around ACP discussions. The PREPARE website (https://prepareforyourcare.org/) uses a simple 5-step process and instructional videos to overcome this barrier. A recent randomized trial assessed the impact of this website resource. This trial of more than 400 elders resulted in a 25% to 35% increase in documentation of advance directives for patients/ families that utilized the PREPARE website. No clinician or system-level interventions are needed for this user-friendly website. Given that patient literacy and provider availability are significant barriers to high-quality care delivery, this study provides an innovative solution to improve population health. Though not a perfect solution for all populations (e.g. cognitively impaired patients will need help from surrogates) I am very excited to learn more about this resource and facilitate systems for guiding patients/ families to utilize this resource. Appropriate and timely completion of advance directives is a must for succeeding in achieving the Triple Aim of healthcare and I am hopeful that this resource will go a long way in enhancing quality of care for our patients.

Sudore RL, Boscardin J, Feuz MA, McMahan RD, Katen MT, Barnes DE. Effect of the PREPARE Website vs an Easy-to-Read Advance Directive on Advance Care Planning Documentation and Engagement Among Veterans A Randomized Clinical Trial. JAMA Intern Med. 2017;177(8):1102–1109. doi:10.1001/jamainternmed.2017.1607

Promoting Palliation through Smart De-Prescribing

Moderate to Advanced dementia among nursing home patients should prompt clinicians to increase their focus on palliative therapies to minimize burdens of care, both on patients and their caregivers. In 2008, experts in geriatrics and palliative care proposed a list of "never appropriate" medications for advanced dementia patients.[1] Researchers in Sweden reviewed the use of these medications among dementia patients for the last 12 months of their life and offered clinicians great advice.[2] In this retrospective study of more than 120 thousand patients more than half were living in institutions.

The results from this study showed that the prevalence of never medications deceased slightly from 38.6% to 34.7% in the last 12 months, and the prevalence of at least one such medicine was almost 20% during the last 30 days of patient's life. For institutionalized patients more than 30% and 12% were still on anticholinesterase inhibitors (donepezil etc.) and memantine respectively. Lipid lowering medicines were still being prescribed to 8.5% of patients during the last month of life. Interestingly, estrogen use (and other sex hormones) only slightly decreased during the last month of life with a prevalence of almost 10%. Female sex, younger at time of death and being in the community were risk factors for higher use of such medications at the end of life.

This study, like a few others before this one reminds us that de-prescribing has to be on our minds when we provide palliative care for patients with dementia. The role of anti-dementia medications in advanced dementia is questionable and many of these medications come with serious adverse effects and price tags. Similarly use of anti-lipid medications in advanced dementia mostly is not warranted and should be questioned. End of life carries a lot of burden and costs for family and caregivers and it should be our priority to minimize medications with questionable benefits to enhance quality of life.

[1] *Holmes, H.M., Sachs, G.A., Shega, J.W. et al, Integrating palliative medicine into the care of persons with advanced dementia: Identifying appropriate medication use. J Am Geriatr Soc. 2008;56:1306–1311*

[2] *Use of Medications of Questionable Benefit During the Last Year of Life of Older Adults With Dementia Morin, Lucas et al. Journal of the American Medical Directors Association , Volume 18 , Issue 6 , 551.e1 - 551.e7*

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All those Fancy Transitional Care Programs! What's the Evidence?

Healthcare systems are investing in several transitional care new models that range from simple post-discharge phone calls to visits by expert transitional care nurses to patients' homes. What is the real return on investment on these approaches? How many patients have improved outcomes as a result of these efforts?

A recent comprehensive systematic review provides evidence-based answers to the above questions. For this review authors only included randomized controlled trials that aimed to improve care coordination and continuity of care with a visit within 30 days of discharge. Only 92 studies made the final cut.

The results were striking with a reduction in mortality that sustained for 18 months (NNT=14). Similarly, readmission to hospital was significantly lower in transitional care patients and this benefit sustained for 18 months (NNT=9). There were no differences for both groups when it came of quality of life. The most impactful elements of transitional care that improved outcomes were post-discharge phone calls, 24/7 availability of phone call service and the involvement of the pharmacist.

This study is helpful as it validates the value of well-planned proactive transitional care activities for complex patients. Ongoing and meaningful patient contact for many months helps build the communication channels and trust that is needed. Finally, it assures me that with a small Number Needed to Treat (NNT) values, transitional care investments are cost-effective to implement for healthcare systems, both acute and post-acute.

Le Berre, M., Maimon, G., Sourial, N., Guériton, M. and Vedel, I. (2017), Impact of Transitional Care Services for Chronically Ill Older Patients: A Systematic Evidence Review. J Am Geriatr Soc, 65: 1597–1608. doi:10.1

Steps for Cholesterol Management; Cut the Jumbo Mumbo

If you are feeling somewhat overwhelmed by all the new evidence emerging around cholesterol/ lipid management, you are not alone. Recent studies and many subsequent guidelines are causing some confusion around what practitioners need to know and need to do for evidence-based cholesterol management. Well here is some help thanks to a recent JAMA editorial.[1]

The editorial provides recommendations from the most recent ACC/AHA Guidelines that approach cholesterol management from an individualized risk-lowering framework rather than attaining pre-specified LDL and HDL targets for primary and secondary prevention of cardiovascular episodes. The editorial acknowledges shared decision-making as the corner stone of therapy. It also confirms that new trials have all but removed niacin as an option due to lack of benefit.

The editorial shares a 5 step process to make a decision on treatment. Step 1 is to assess patient's risk using approved calculators (e.g. http://tools.acc.org/ascvd-risk-estimator/). Risk is high if it comes to >7.5% over 10 years OR if patient already has atherosclerotic cardiovascular disease OR if patient has diabetes.[1] Step 2 is to encourage a healthful lifestyle (smoking cessation, diet, exercise and weight control). Step 3 is to discuss the role of lipid lowering medications, associated risks and their costs. Step 4 is to start treatment based on patients' goals. For primary prevention, begin low or moderate intensity statin therapy (e.g. pravastatin 20mg/ day) unless patient wants aggressive treatment with high intensity treatment. For secondary prevention and in patients with diabetes, start high-intensity treatment (e.g. Atorvastatin 80 mg/day). Final step entails a close follow up to confirm meeting of goals and assessing medication tolerance.

This editorial will be very helpful to me in my practice around cholesterol management. It provides relatively simple strategy for me to determine individual patient's risk for a cardiac event and then to individualize care by discussing patient goals before selecting the treatment. Lipid management continues to hold great promise in minimizing CVD events and should continue to be a priority in our practices regardless of the setting of care.

[1] *http://circ.ahajournals.org/content/circulationaha/early/2013/11/11/01.cir.0000437738.63853.7a.full.pdf*

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