What Matters

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I have no disclosures to report.

Objective

At the conclusion of this presentation, participants will be able to describe methods to align care with the older adult’s health outcome goals and care preferences.

The 4Ms Framework

What Matters

Know and align care with each older adult’s specific health outcome goals and care preferences, including, but not limited to, end-of-life care, and access settings of care.

Medication

If medication is necessary, use Age Friendly medication that does not interfere with What Matters, Mobility, Mentation, and Medication across settings of care.

Mentation

Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility

Ensure that older adults move safely every day in order to maintain function and live What Matters.
MTGEC: Age-Friendly Healthcare in the New Normal

Know and align care with each older adult’s specific health outcome goals and care preferences, including but not limited to, end-of-life care, and across settings of care.

Why “Matters Most”, Matters Most

- Older Adults
- Health Systems
- Everyone Else

Patient Priorities Care (PPC)

Framework that aligns healthcare decision-making and care by all clinicians with patients’ own health priorities

- Based on values (matters most)
- Identifying value-based goals and determining what patients are willing and able to do to achieve these outcomes
- Patient preferences are used in decision-making and communication with the patient, caregivers, and other clinicians

For older adults
- Vary in matters most
- Improved communication
- Patients are active partners in healthcare decisions
- Reduces burdensome or unwanted care while increasing desired care

For health systems
- Better patient experience scores & retention
- Avoid unnecessary utilization

For everyone (patients, caregivers, providers, health system)
- Everyone on same page
- Improved relationships
- The basis of everything else
A new approach to care...

- Differs from traditional healthcare → Focuses on the integration of decision-making and care across conditions and healthcare providers that is consistent with each patient’s values and related goals. Focus is not on treating each individual disease in isolation.
- Differs from palliative care → Ideally suited for older adults with multiple comorbidities who are not yet at the end of life. Approach to decision-making that focuses on helping older adults select the best treatments for their individual value and goals.

Glossary: Matters Most

- **Patient Priorities** - The health outcome goals patients most desire within the constraints of their care preferences
- **Values** - The warm and fuzzy things that matter most in our lives that are never fully satisfied
- **Outcome Goals** - Specific desired activities or abilities that can be obtained and completed
- **Care Preferences** - What patients are willing and able (or not willing and able) to do

Priorities provide direction

- **Where do you want to go?**
  - Values are the true north on the compass
  - Goals are stops you want to make along the way
- **Is the journey worth taking?**
  - Care preferences and trade-offs
- **How do we measure success?**
  - Following up on shared goals
  - Unmet goals tell us we have wondered off the path

Do disease-specific evidenced-based guidelines apply?

- **Yes**
  - > 10 years life
  - Few conditions
  - Fit & functional
  - Align disease-based guidelines with patient priorities
- **Uncertain**
  - Shorter life expectancy
  - Increasing #/severity of conditions
  - Impaired function
  - Patient Priorities Care
- **No**
  - < 1-2 years life expectancy
  - Advanced/end stage disease
  - Align symptom management and palliative care with patient priorities
Identifying what matters most

- Not many patients have had this conversation with healthcare providers in the past
- No right or wrong answers
- Really want to know what is important to them so you can partner on appropriate medical care

Do what matters

Translate values into SMART goals

Specific
Meaningful
Realistic
Achievable
Modify over Time
Try it Out: Values or Goals?

- Going to religious services each weekend
  \[\text{GOAL}\]
- Being as independent as possible
  \[\text{VALUE}\]
- Contributing to my community
  \[\text{VALUE}\]
- Getting a new job
  \[\text{GOAL}\]

Helpful and bothersome care

May be first time a provider has asked about how they feel about healthcare tasks, medications, appointments, etc.

- “Which parts of your healthcare are bothersome, difficult to do, or getting in the way of doing?”
- “Which medications seem to help you with your goals and doing what matters most to you?”
Understanding trade-offs

- *Trade-offs*: Balancing the benefits and burdens of healthcare tasks
- Discuss what the patient is willing and able to do

- Does a treatment plan help reach a goal, but require too much effort or create additional symptoms?

Tips on acting on what Matters Most

- Use patient’s priorities to guide care decisions
  - “There are several things we could do, but knowing what matters most to you, I suggest we…”

- Use patient’s priorities (not just diseases) in communicating, making decisions, assessing benefit

- Document how patient’s priorities have been used to guide care so that this knowledge can be incorporated by other providers

Case Study: Mrs. B

- Mrs. B is a 75-year-old woman with multiple chronic conditions including Atrial Fibrillation, Diabetes, Hypertension, Arthritis.
- She often presents to her PCP, endocrinologist, pulmonologist, or cardiologist with varying symptoms including fatigue, pain, dyspnea, and urinary frequency.
- Dr. T, her PCP, is not sure how to balance her competing conditions and symptoms. She is also uncertain if some of her treatments are helping Mrs. B, and wonders if some may be causing more burden and harm than benefit.

Personalized Values for Mrs. B

- **I want to…**
  - Spend time with family, watching grandchildren (Connection)
  - Volunteer at the library (Enjoyment)
  - Be able to lift items with her hands and walk (Functioning)
What questions you would ask Mrs. B to help her verbalize a health outcome goal?

**RECAP:** 75 y/o female
- **PMH** – Afib, CAD, Depression, DM2, GERD, Recurrent GI Bleed, Hypertension, OSA, Arthritis
- Symptoms: fatigue, pain, dyspnea, and urinary frequency
- Fatigue has multiple possible causes but no one clear etiology. She has not been adherent to CPAP
- Two admissions for heart failure in the past year, one for an upper gastrointestinal bleed

I want to:
- Spend time caring for my grandchildren
- Volunteer in the community, especially in the library

Health Goals for Mrs. B

I want to...

- **Goal 1** - Watch grandchildren after school 2-3 times weekly
- **Goal 2** - Volunteer in library, handling books, two times weekly

Trade-offs

- Review the Mrs. B example
- Formalize which clinical interventions she is willing and able to do and which she wants to avoid:
  - Medications
  - Self-care or at-home health care tasks
  - Tests, treatments, and procedures
  - Health care visits

PPC for Mrs. B

Using her priorities as focus of decision-making

**Outcome goals:** Watch grandchildren after school 2-3 times weekly; Volunteer in library, handling books, two times weekly

Healthcare preferences:

- **Willing and able to do:** Exercise, physical therapy, laboratory tests & imaging; some medications better tolerated & more helpful than others

- **Burdensome care:** Multiple medications daily, CPAP, hospitalizations

- **One thing (most important):** To be less tired so that she can continue to watch her grandchildren.
Talking with clinicians
Goal: Promote a partnership between patient and health care team

Encourage the patient to:
- Ask questions
- Be honest: not sharing may lead to unwanted treatments that don’t support goals
- Voice values, goals, and preferences

Consider patient-specific barriers to open communication
- Embarrassment
- Deference
- Health Literacy
- Time

Identify and reconcile sources of differing recommendations

Mrs. B
Current Concern: Fatigue
PCP
Cause: Metoprolol
Solution: Stop
Cardiologist
Cause: Heart failure
Solution: Continue Metoprolol

Align decision-making among clinicians when there are conflicting recommendations

Steps:
- Acknowledge uncertainty & that there is often no one best answer
- Decide based on patient priorities not just disease-based tradeoffs
- Identify and reconcile sources of differing recommendations
- Brainstorm alternatives until you arrive at a compromise solution

Responding to life or health changes (optional)

Acknowledge that health priorities may change. Discuss that priorities can be re-visited when an anticipated or experienced change significantly impacts health, functioning, or life expectancy (e.g. surgery, death of a spouse, etc.)

"Don’t worry, I know that your health priorities may change. We will check in regularly about them. Knowing what matters to you helps me recommend the best care for you at every point. We will work together to see what works best for you."

Start with summary of the change, probe on how goals and/or preferences have changed

"It sounds like (unrealistic or no longer achievable goal) is very important to you. Let’s talk about other ways that you can do what’s important to you."
MTGEC: Age-Friendly Healthcare in the New Normal

Value: Relationship with wife
Goal: To take a thirty minute walk each morning with wife.
Barriers: Too tired to enjoy going on walk so skipping most days. Notes poor sleep with difficulty falling and staying asleep.
Burden: Too burdensome: Would like to minimize medications. Has declined CPAP for sleep apnea in the past.

Cutting back on caffeine before bed
Trial of melatonin
CPAP

Non-randomized clinical trial
• Primary care practice
• Cardiology consultants
• Hartford, Connecticut
• Non academic, Non VA
• >350 older adult participants
• Identified priorities (n=163)
• Usual care (n=203)

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

what we know so far...

Patient priorities aligned care is effective
Compared with usual care, PPC is associated with...

Focus on patient's goals ➔ Unwanted care ➔ Treatment burden
✓ Medications stopped (2-3x less)
✓ Tests ordered (~30% fewer)
✓ Self-management added (30% fewer)

Modest Time Commitment
✓ Health Priorities Identification: 20-30 minutes
✓ PCP: Few minutes over few visits, then no time difference (+ ~3 hours training over 1.5 years)

Patient priorities aligned care is feasible
Modest IT Requirements

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Patients and Clinicians like PPC

Clinicians like

- Focused visits
- Enables consensus between PCP and specialists
- Improves relationships

Patients like

- Enhanced communication (family & clinicians)
- Facilitation more personal than typical encounters
- More knowledge re their health & healthcare tasks and how they align with priorities
- Could identify goals and make changes

My Experience with PPC...

Feasibility of Clinicians Aligning Health Care with Patient Priorities in Geriatrics Ambulatory Clinic

Aims:
1) Assess the feasibility of identifying patient priorities in the EHR
2) Compare clinicians’ recommendations for patients who did and who did not have their priorities identified

Setting: Michael E. DeBakey VA Medical Center geriatric outpatient clinic from 02/2018-01/2019

Study population: Patients with three or more chronic conditions presenting for routine visits


Results- Identification patient priorities

- All facilitator notes included at least one patient value and documentation of helpful/bothersome care
- All but two facilitator notes recorded a specific patient goal
- PCPs incorporated PPC into their notes more consistently over time, often including a linkage to treatment decisions
- No patients in the usual care group had documentation of PPC, although they received care from the same clinicians

Table 1. Characteristics of the Study Population by Treatment Group

<table>
<thead>
<tr>
<th>Demographics</th>
<th>PPC (n = 35)</th>
<th>UC (n = 35)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y, mean (SD)</td>
<td>83.7 (4.62)</td>
<td>87.5 (5.63)</td>
<td>.29</td>
</tr>
<tr>
<td>Male sex, N (%)</td>
<td>34 (97)</td>
<td>38 (97)</td>
<td>1</td>
</tr>
<tr>
<td>Race, N (%)</td>
<td>15 (43)</td>
<td>21 (61)</td>
<td>.54</td>
</tr>
<tr>
<td>White, non-Hispanic</td>
<td>6 (17)</td>
<td>3 (8)</td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>14 (40)</td>
<td>11 (31)</td>
<td></td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>6 (17)</td>
<td>3 (8)</td>
<td></td>
</tr>
<tr>
<td>Current medications, mean (SD)</td>
<td>17.7 (6.4)</td>
<td>14.6 (5.5)</td>
<td>.10</td>
</tr>
<tr>
<td>Active problems, mean (SD)</td>
<td>15.3 (7.6)</td>
<td>19.3 (8.3)</td>
<td>.39</td>
</tr>
<tr>
<td>Independence in ADLs&lt;sup&gt;2&lt;/sup&gt;, N (%)</td>
<td>34 (97)</td>
<td>31 (86.1)</td>
<td>.24</td>
</tr>
<tr>
<td>Independence in IADLs&lt;sup&gt;3&lt;/sup&gt;, N (%)</td>
<td>23 (65.7)</td>
<td>20 (72.2)</td>
<td>.40</td>
</tr>
<tr>
<td>Hospitalization in past 6 mo.&lt;sup&gt;4&lt;/sup&gt;, N (%)</td>
<td>5 (14.3)</td>
<td>4 (11.1)</td>
<td>.40</td>
</tr>
<tr>
<td>Hospitalization in past year&lt;sup&gt;5&lt;/sup&gt;, N (%)</td>
<td>4 (11.4)</td>
<td>6 (17.1)</td>
<td>.75</td>
</tr>
</tbody>
</table>

<sup>1</sup>All patients were entered care to see by primary care providers between the patient priorities care (PPC) and usual care (UC) groups.
<sup>2</sup>Activities ADLs, activities of daily living; IADLs, instrumental activities of daily living; SD, standard deviation.
<sup>3</sup>Medical outcomes included medical conditions, measures of the patients’ health status, and use of healthcare services.
<sup>4</sup>Medical outcomes included medical conditions, measures of the patients’ health status, and use of healthcare services.
<sup>5</sup>Moments were taken as a unique identifier, 0 not independent.
<sup>6</sup>Moments in years, with one added to the count for each individual hospital stay.
Results- Care recommendations

Table 2: Differences in Documented Changes to Care Following Clinic Visit with Primary Care Provider by Study Group

<table>
<thead>
<tr>
<th>Changes in recommended care</th>
<th>UC (n = 20)</th>
<th>FPC (n = 20)</th>
<th>Mean difference (FPC minus UC)</th>
<th>Cohen's d</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of medications added</td>
<td>.94 (1.19)</td>
<td>.43 (0.50)</td>
<td>- .51*</td>
<td>.50</td>
</tr>
<tr>
<td>No. of medications stopped</td>
<td>.94 (1.30)</td>
<td>.77 (1.14)</td>
<td>-.17</td>
<td>.47</td>
</tr>
<tr>
<td>No. of referrals or consultations added</td>
<td>.94 (1.28)</td>
<td>1.83 (1.04)</td>
<td>-.89*</td>
<td>.85</td>
</tr>
<tr>
<td>No. of referrals or consultations avoided</td>
<td>0 (0.26)</td>
<td>0 (0.26)</td>
<td>0</td>
<td>.44</td>
</tr>
<tr>
<td>No. of referrals to community services and supports</td>
<td>.94 (1.24)</td>
<td>.41 (0.69)</td>
<td>- .26*</td>
<td>.54</td>
</tr>
<tr>
<td>No. of self-management activities added</td>
<td>.94 (1.31)</td>
<td>.91 (0.70)</td>
<td>-.03</td>
<td>.31</td>
</tr>
<tr>
<td>Total no. of changes to care</td>
<td>2.86 (1.65)</td>
<td>4.06 (2.30)</td>
<td>1.2*</td>
<td>.57</td>
</tr>
</tbody>
</table>

* p < .05. P-values were determined using Wilcoxon-Mann-Whitney test.

Matters Most:
- Mission, Aspiration, Purpose (connection, enjoying life, managing health, functioning);
- SMART Goal 1:
  - Care preferences (willing and able, not willing and able to do);
  - Helpful care:
    - Burdensome care and tradeoffs:
      - Treatment plan:
        - Progress toward goal;

Conclusions

- Matters most informs the other M’s, serving as the foundation for age-friendly care
- Matters most goes beyond traditional advance directive conversations
- Patient Priorities Care provides a framework for identifying matters most (value), setting related SMART goals, and evaluating helpful and burdensome medical care
- Patient Priorities Care helps to focus and simplify care for complex older adults living in complex times

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