

A Framework for Shared Decision Making in Geriatrics and its Application to Advance Care Planning

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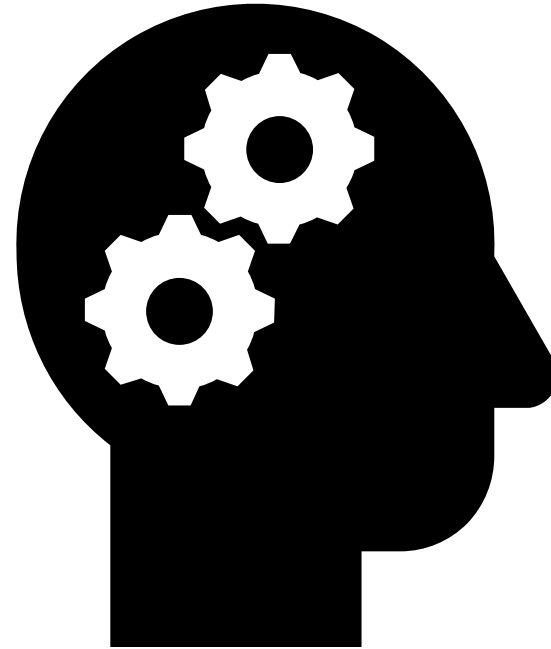
Yale SCHOOL OF MEDICINE

Decision Making and the Older Patient

Narrower window between benefits and harms



Variability in prioritization of benefits and harms



Examples



CHADS-VASC
HASBLED



Establishing Benefits and Harms



Epidemiologic studies

- Can be difficult to identify existing datasets
- May require primary data collection

Examples:

- Outcomes associated with different treatment options for a common condition
- Requires statistical methods for propensity adjustment

Table 3. Effect of Treatment Site on Immediate and 2-Month Outcomes of Patients with Pneumonia, Stratified by Respiratory Rate

	Hospital Treatment (%)	LTCF treatment (%)	<i>p</i> Value
Among patients with respiratory rate ≥ 40 (n=46):			
Immediate death from pneumonia	3/30 (10)	6/16 (38)	.047
Death at 2 months	9/22 (41)	3/6 (50)	1.0
Functional decline at 2 months	4/17 (24)	3/6 (50)	.318
Death or functional decline at 2 months	13/26 (50)	6/9 (67)	.460
Among patients with respiratory rate < 40 (n=266):			
Immediate death from pneumonia	5/36 (14)	26/230 (11)	.585
Death at 2 months	6/19 (32)	25/158 (16)	.108
Functional decline at 2 months	12/25 (48)	44/177 (25)	.029
Death or functional decline at 2 months	18/31 (58)	69/202 (34)	.016

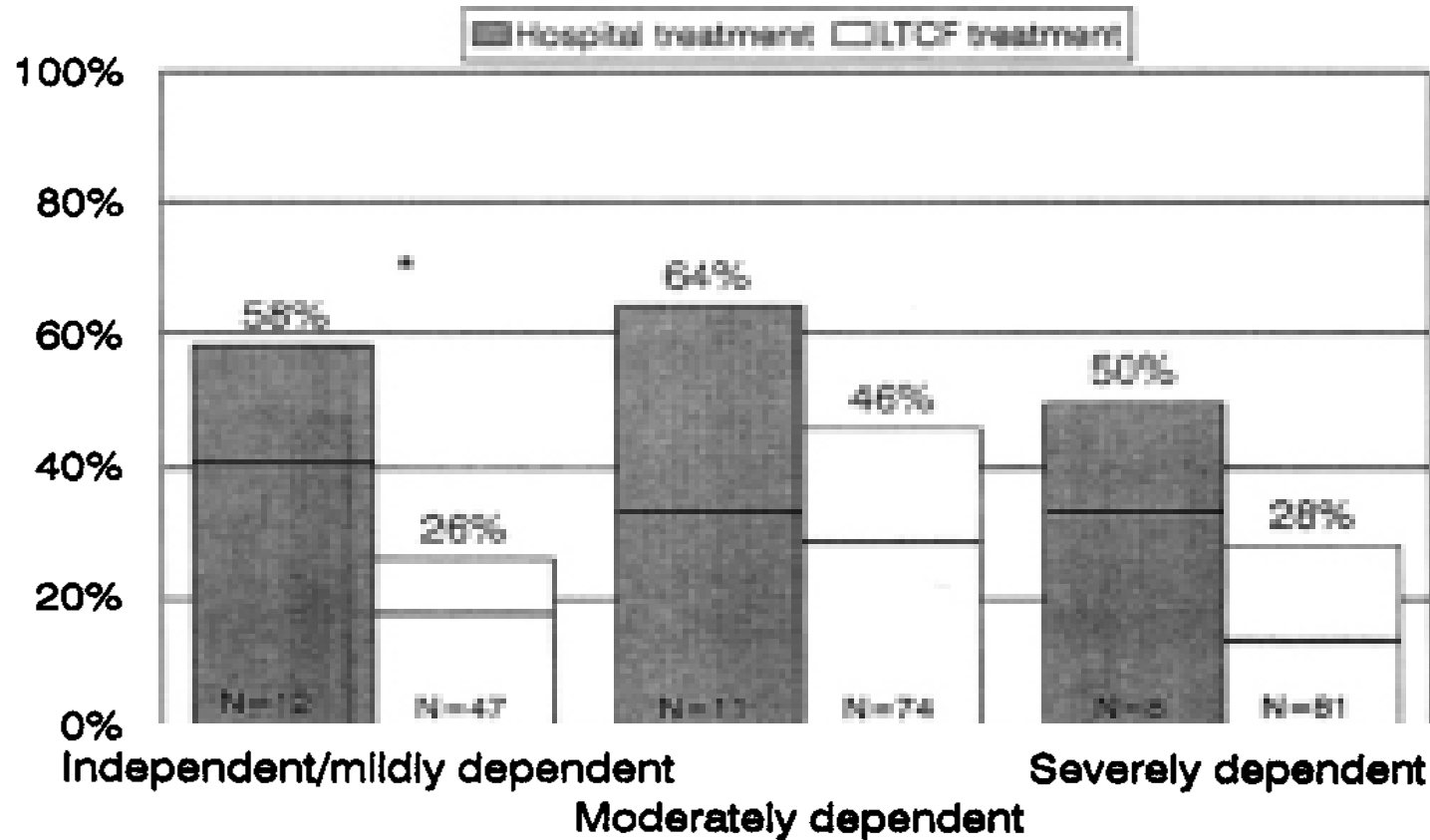
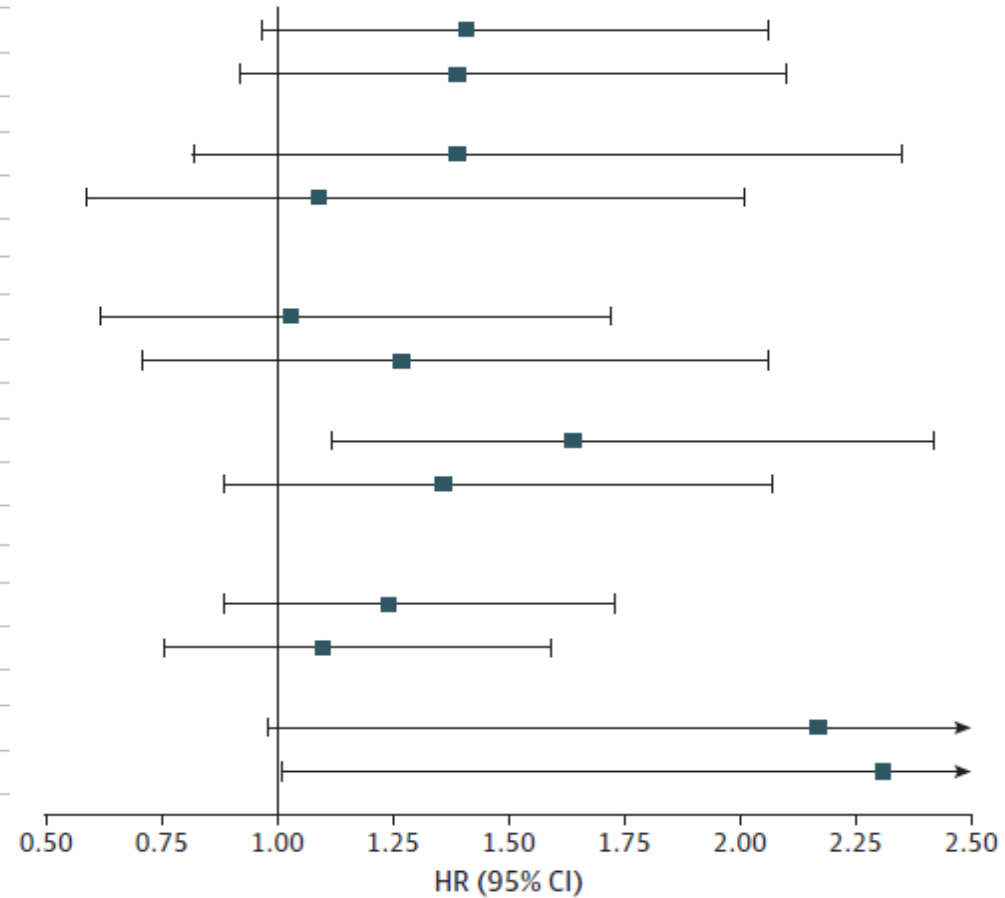


Figure 2. Proportion of patients with mild pneumonia treated in the hospital (gray bars) and in the long-term care facility (white bars) who had a functional decline or death in the 2 months after their pneumonia. The line within each bar marks the proportion of patients who had functional decline (below the line) and who died (above the line). * $P = .04$ for the difference in proportions.

Figure. Serious Fall Injury Events Among Relevant Subgroups According to Antihypertensive Intensity in Older Adults With Hypertension

Character	HR (95% CI)
Age	
<85 y (n = 3918)	
Moderate intensity	1.41 (0.97-2.06)
High intensity	1.39 (0.92-2.10)
≥85 y (n = 1206)	
Moderate intensity	1.39 (0.82-2.35)
High intensity	1.09 (0.59-2.01)
Sex	
Women (n = 3156)	
Moderate intensity	1.03 (0.62-1.72)
High intensity	1.27 (0.71-2.06)
Men (n = 1968)	
Moderate intensity	1.64 (1.12-2.42)
High intensity	1.36 (0.89-2.07)
Fall in past year	
No (n = 4621)	
Moderate intensity	1.24 (0.89-1.73)
High intensity	1.10 (0.76-1.59)
Yes (n = 503)	
Moderate intensity	2.17 (0.98-4.80)
High intensity	2.31 (1.01-5.29)



Two Approaches to Individualized DM

START WITH THE DECISION

Discrete decisions

- Surgical interventions

Outline the options and their benefits and harms

Assess the benefits and harms in the context of a person's preferences

START WITH THE PREFERENCES

“What matters most”

- Specific goal
- Prioritization among common outcomes

Choose a care plan that is most likely to achieve desired goals/outcomes

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Decision aids

<https://anticoagulationdecisionaid.mayoclinic.org/>

Gist



Working Backward from Outcomes

What is your health outcome goal?

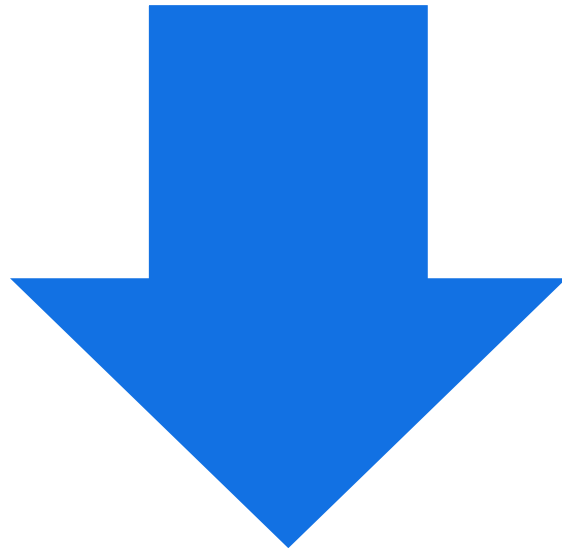
What healthcare activities are you willing to do to achieve that goal?

Trade-Offs



Life extension

Disease prevention



“Work” of healthcare

Medication adverse effects/drug-disease interactions

- Impairment of function

Decision making in serious illness

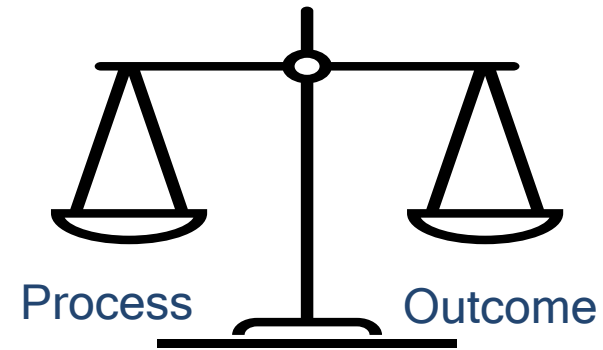
Without trade-offs



Do you want us to resuscitate you?

- Broken ribs, pounding on chest

With trade-offs



Willingness to Undergo Life-Sustaining Treatment

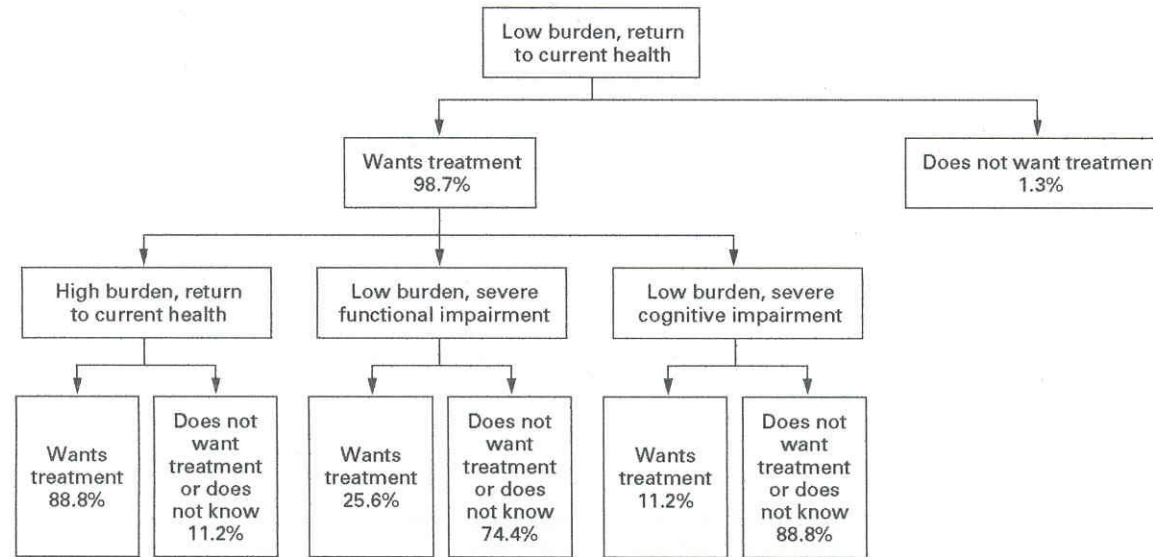
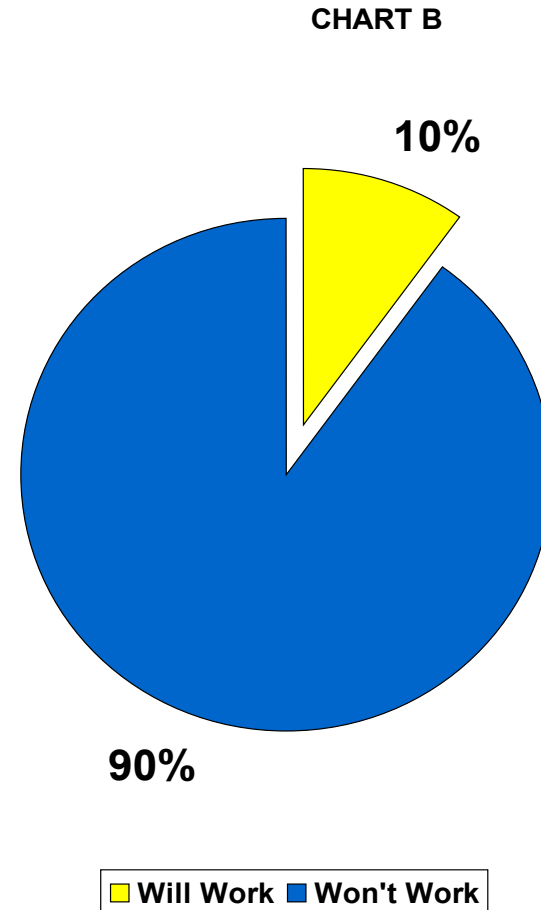
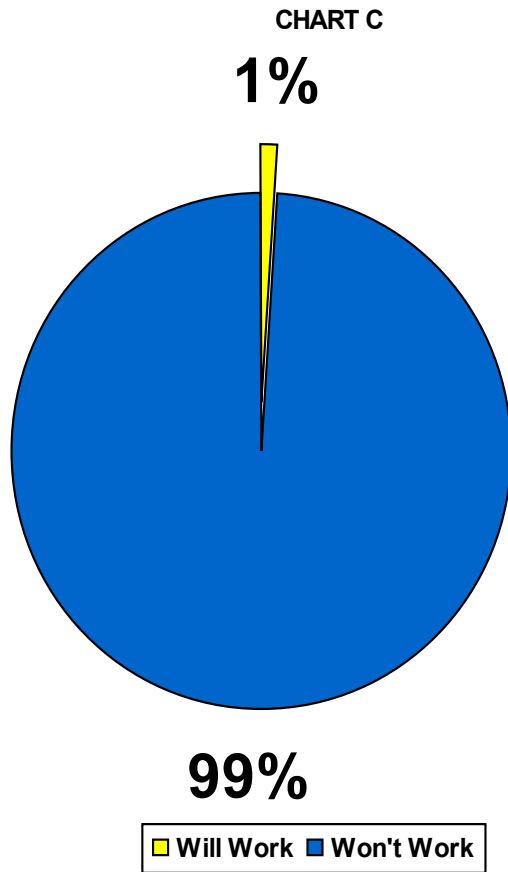


Figure 2. Treatment Preferences According to the Burden and Outcome of Treatment.

Conveying Likelihoods



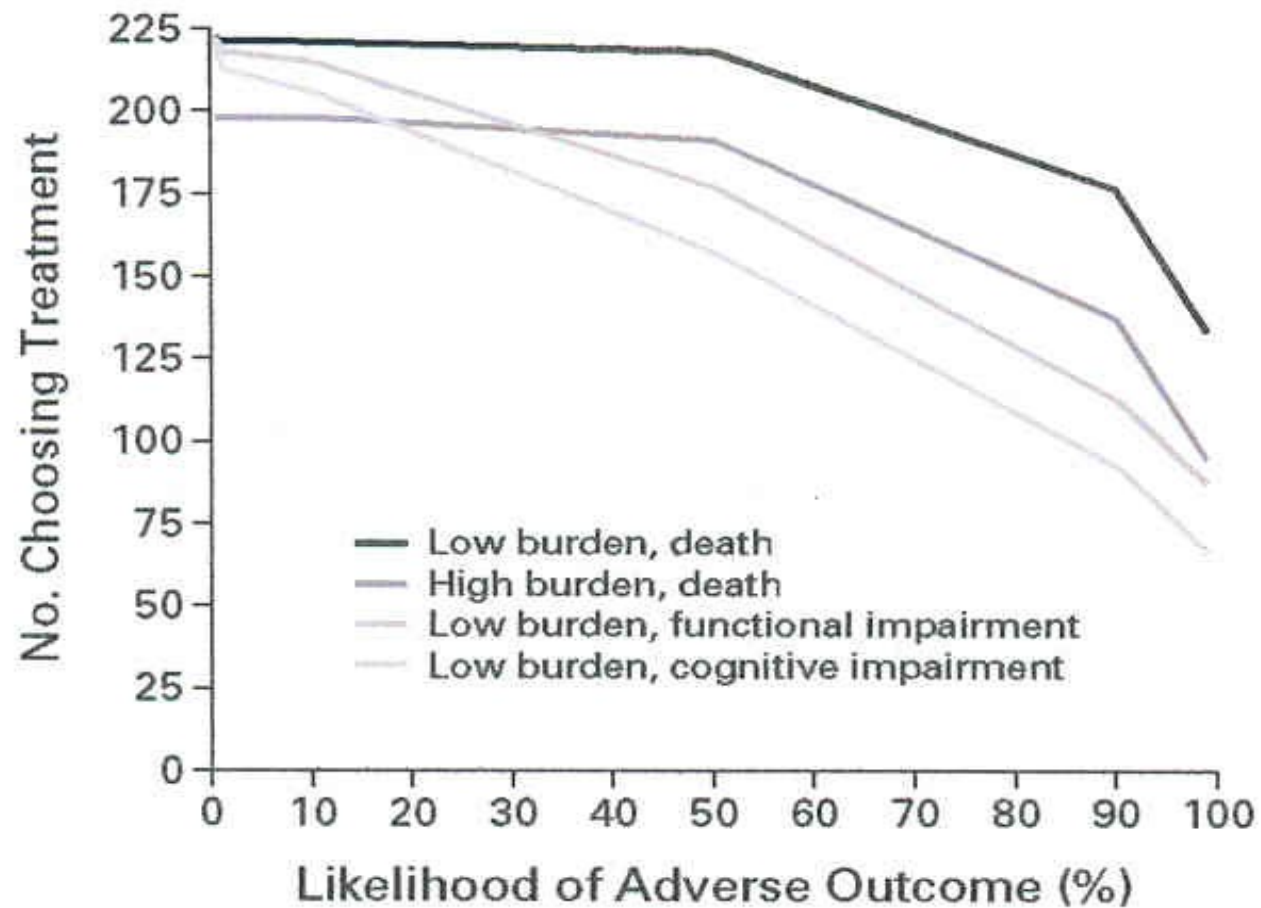


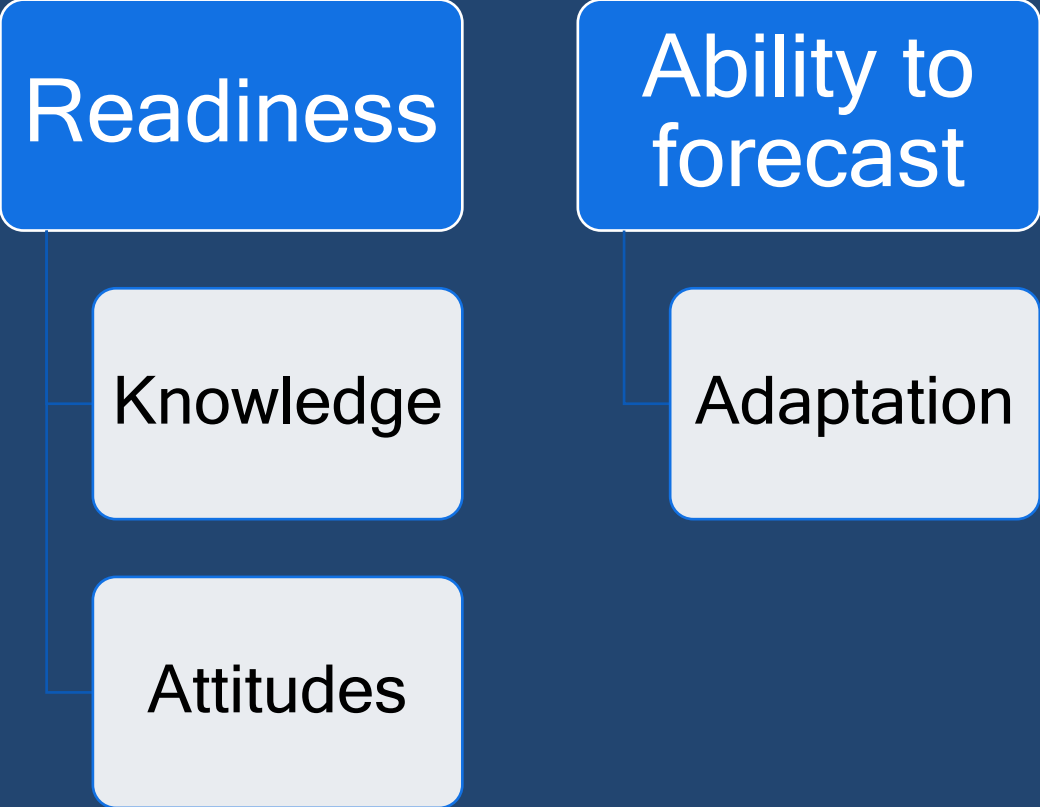
Figure 3. Treatment Preferences According to the Burden of Treatment and the Likelihood of an Adverse Outcome.

$P < 0.001$ for each comparison with scenario 1 (a low-burden treatment with an adverse outcome of death).

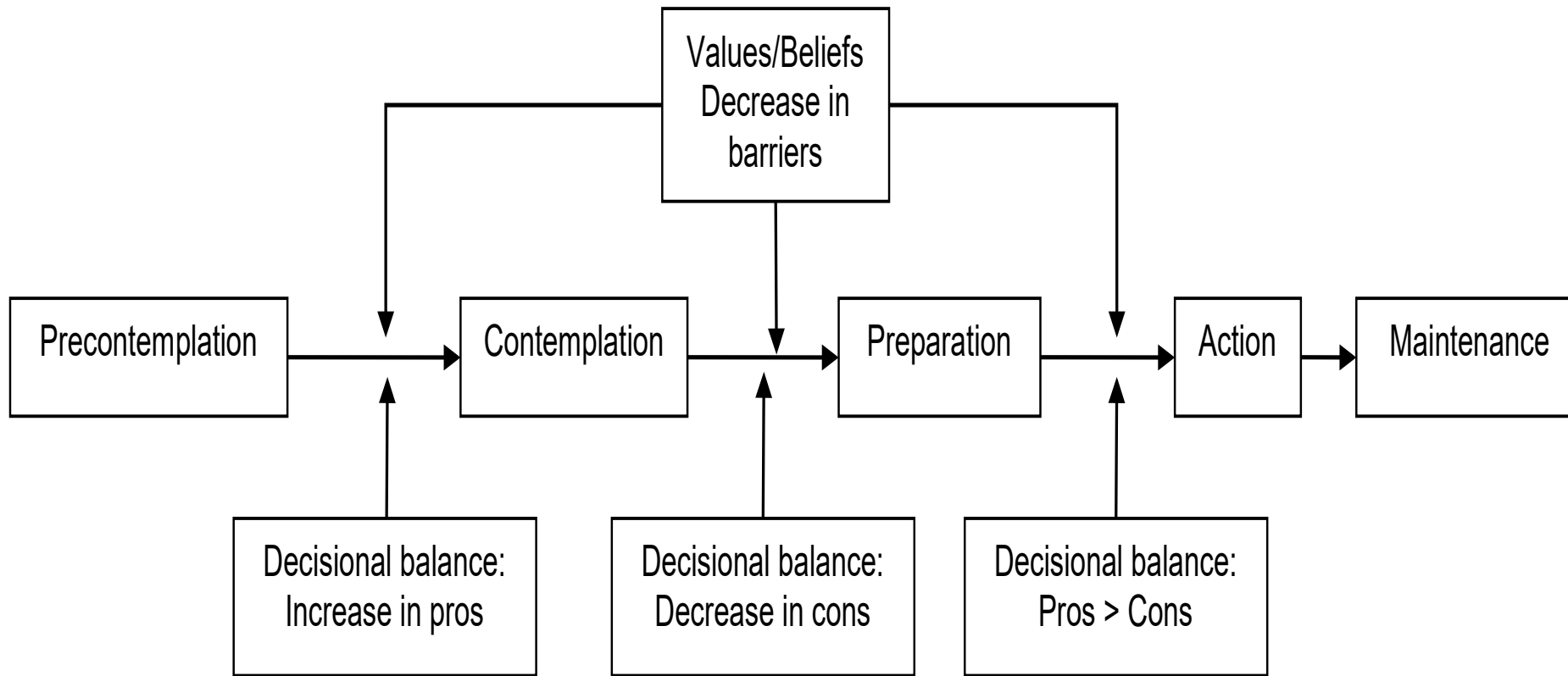
Work accompanied by an editorial:

“The study suggests that discussions of advance care planning should shift from whether patients would accept or reject specific treatments to what they consider acceptable in terms of ... the probability of a successful outcome.”

Other conceptual considerations in ACP



The Trans-Theoretical Model and ACP



STAMP

**SHARING & TALKING
ABOUT MY PREFERENCES**



Your Life, Your Values, Your Choices

Putting Your Health Care House In Order

Participating In Advance Care Planning: Part 1

Yale SCHOOL OF MEDICINE

THE UNIVERSITY OF RHODE ISLAND

All photographs are for illustrative purposes only and the people depicted are models.

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ACP is not for me because...

I'll always be able to make my own decisions.

As you probably know from your own family and friends, when people get very sick, they sometimes can't speak for themselves. You never know when this may happen to you, so you need to have a plan in case it does.

My loved ones already know what kind of treatment I want.

Even if you think your loved ones know what you want, they need to hear it from you. This will make it easier on them down the road. It's also important to fill out the living will and health care proxy forms to remind your loved ones what your wishes are and who is in charge of your care if you are unable to speak for yourself.

The doctors wouldn't use machines on me if I were old and dying.

If you don't have a living will or health care proxy, the doctor is probably going to do everything possible to keep you alive for as long as possible, no matter how old and sick you are.

If I fill out a form, the doctors might take me off life-support sooner than I want.

ACP can help you get all the care you want. You can use the forms and conversation with your loved ones to make sure your wishes regarding treatment are clear.



“We all knew what we had to do.”



Mrs. Kramer is able to rest easy about the difficult decisions she had to make regarding her husband's medical treatment. He had a weak heart with

heart failure and fluid on his lungs. When he became increasingly short of breath, she took him to the emergency room. A doctor there told her and her family that things were not going well and asked if they wanted to put him on a respirator (breathing machine). “We told him no, because my husband and I talked about it all the time and he had said he

didn't want it,” said Mrs. Kramer. Her two daughters-in-law and sons were with her and they supported her decision. Her husband was admitted to a room in the hospital, where he got treatment to make him comfortable. He mostly slept over the next few days, and he died peacefully at the end of the week, with his family by his side.

Even with her preparation, it came as kind of a shock to Mrs. Kramer to have to make the decision and tell the doctors not to use the breathing machine. “It happened so fast,” she said. “I didn't know the doctor who came out to ask me.” But she knew that having talked to her husband and children about this in the past made their ordeal a lot easier. “My sons and daughters-in-law went right along with me,” she said. “We all knew this was what we had to do.”

How ready are you to choose a health care proxy?

I'm thinking about doing this.

Think about who you want to be your health care proxy. Consider all of the people who are close to you. Don't just include family, but also close friends and other important people in your life.

Now think about who could make good decisions for you. This should be someone who:

- Understands your wishes.
- Can separate their feelings from what you want.
- Will be available in an emergency. It is best if this is someone who can talk to your doctors directly.
- Doesn't have their own health problems, so they will be available in the future.

I'm ready to do this.

Once you know who you want as your health care proxy, you need to ask that person. You can say something like:

I would like to talk to you about something very important to me. I need someone who can help my doctors make the best decisions for me if I am in an accident or so sick that I can't make them myself. Would you be willing to do this for me?



STAMP Primary Results

Outcome	Participants Included in the Analysis, n*	Predicted Probability of Completion (95% CI), %†	Risk Difference (95% CI), percentage points‡	Adjusted Risk Difference (95% CI), percentage points‡
Completion of all advance care planning activities			5.9 (1.4 to 10.5)	5.2 (1.6 to 8.8)
Intervention	455	14.1 (11.0 to 17.2)		
Usual care	454	8.2 (4.9 to 11.4)		
Completion of a living will			8.2 (1.4 to 15.0)	6.5 (0.01 to 12.8)
Intervention	347	28.5 (24.5 to 32.6)		
Usual care	334	20.4 (15.0 to 25.7)		
Assignment of a health care agent			13.3 (6.6 to 20.1)	12.2 (2.8 to 21.5)
Intervention	372	32.8 (30.0 to 35.5)		
Usual care	349	19.5 (13.3 to 25.7)		
Communication about quality versus quantity of life			7.0 (−4.7 to 18.8)	2.8 (−7.9 to 13.5)
Intervention	151	61.6 (52.6 to 70.6)		
Usual care	165	54.5 (46.9 to 62.1)		

Take-Home Messages

Key elements of shared decision making:

- Focus on outcomes
- Explication of trade offs
- Meet patients where they are at

