

SOCIETÀ ITALIANA
DI GERONTOLOGIA
E GERIATRIA

64 CONGRESSO NAZIONALE SIGG

Continuità di affetti, continuità di cure

ROMA, 27/30 NOVEMBRE 2019 - AUDITORIUM DELLA TECNICA

Quali principi per la gestione delle cure nella persona con Multimorbilità?

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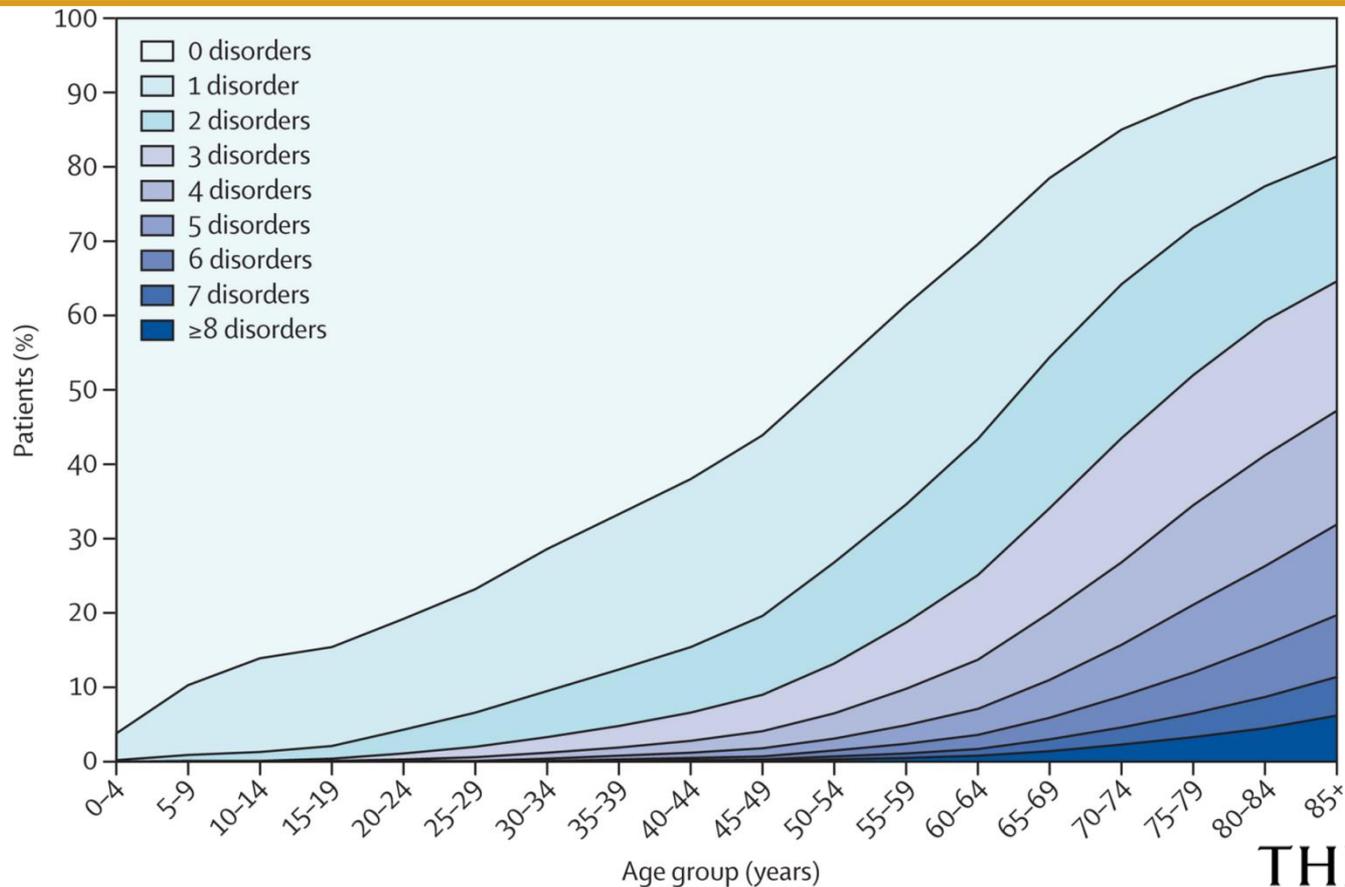


Di cosa parliamo...

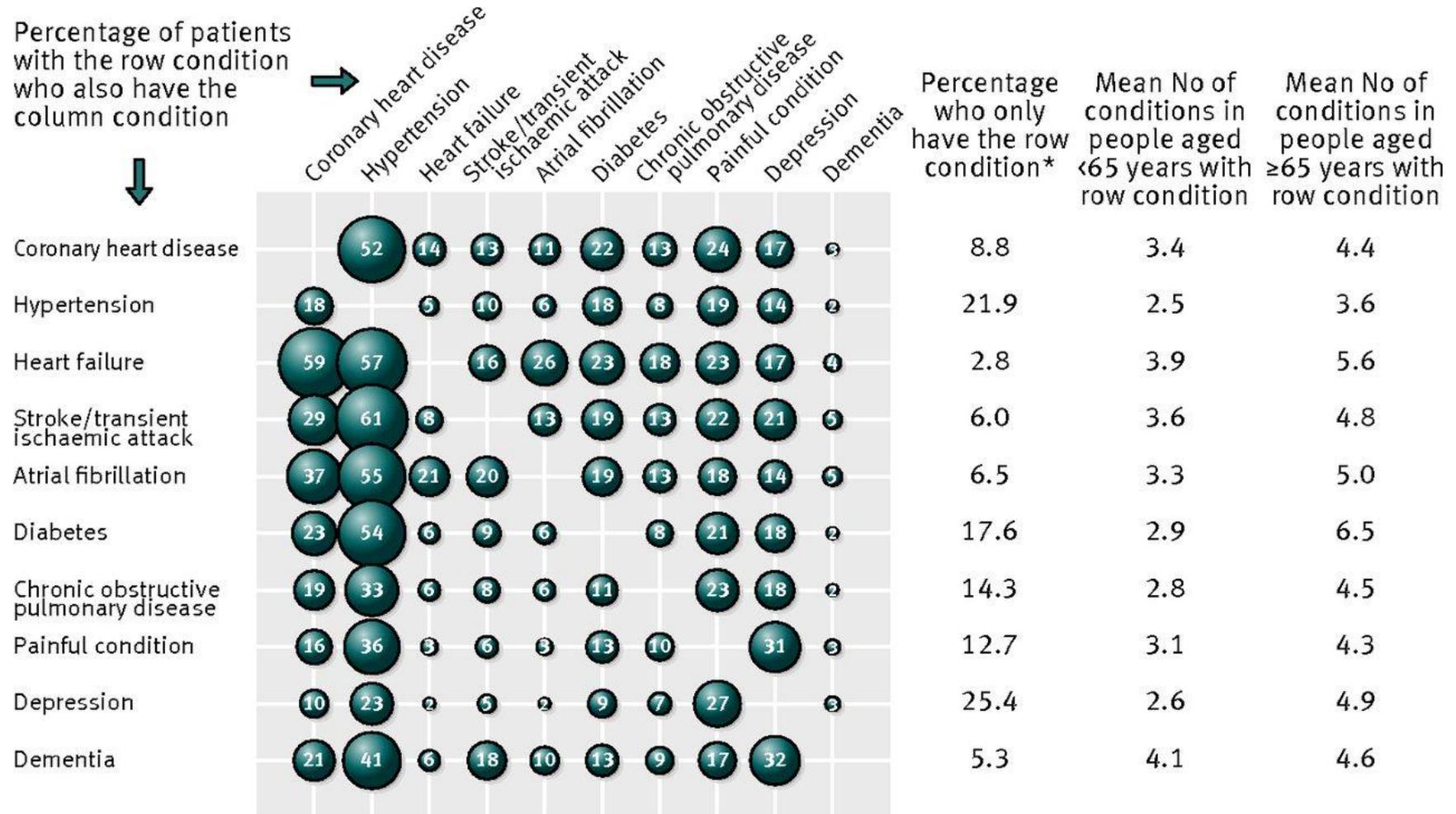
- Multimorbilità

Multimorbidity

Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study

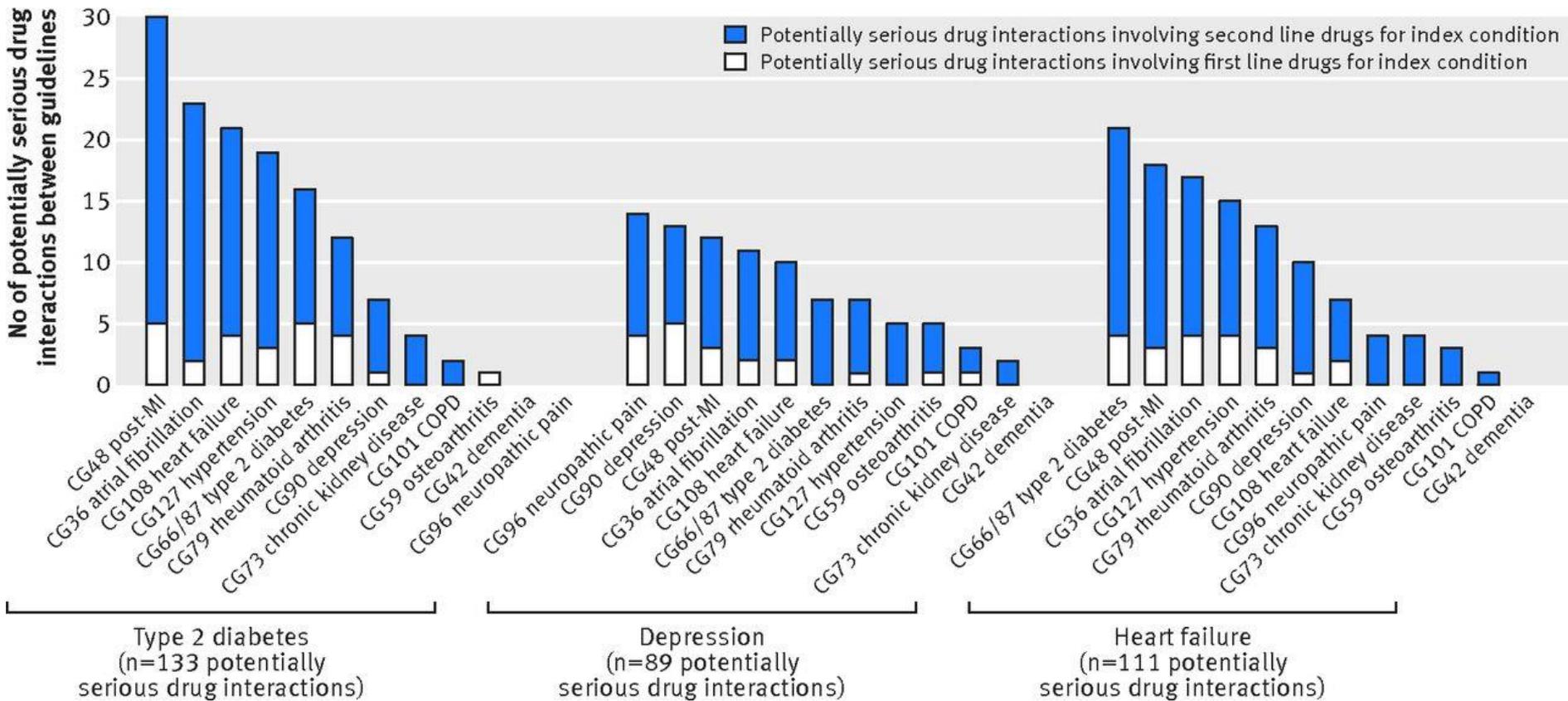


Comorbidity of 10 common conditions



* Percentage who do not have one of 39 other conditions in the full count

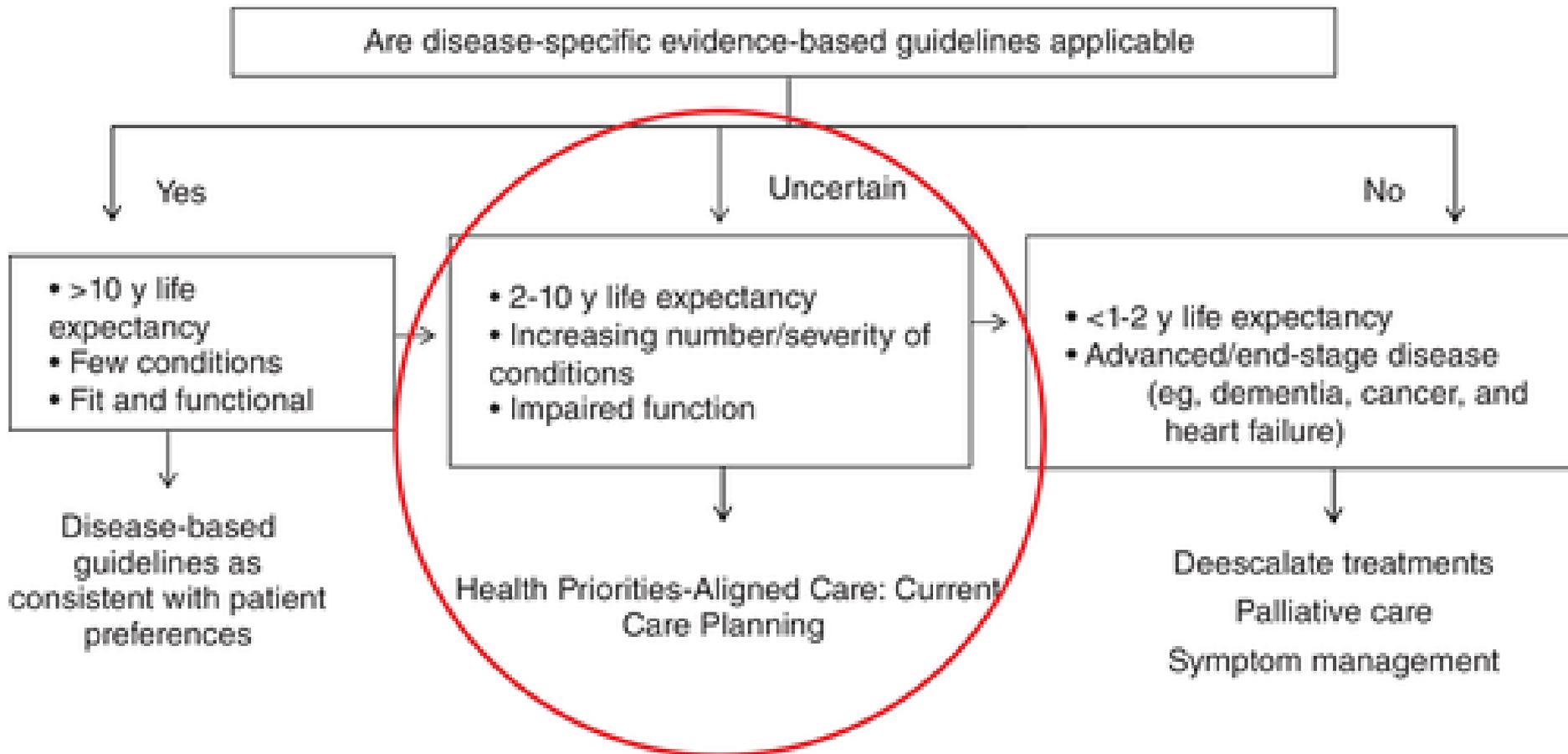
Potentially serious drug-drug interactions between drugs recommended by clinical guidelines for 3 index conditions and drugs recommended by each of other 11 other guidelines



Di cosa parliamo...

- Multimorbidità
- Linee guida American Geriatrics Society

Decision Making for Older Adults With Multiple Chronic Conditions: American Geriatrics Society Guiding Principles



AGS guiding principles

Elicit and incorporate patient (and family/caregiver) preferences into medical decision making.

Recognize the limitations of the evidence base, and interpret and apply the medical literature specifically for this population.

Frame clinical management decisions within the context of harms, burdens, benefits, and prognosis (eg, remaining life expectancy, functional status, and quality of life).

Consider treatment complexity and feasibility when making clinical management decisions.

Use strategies for choosing therapies that optimize benefit, minimize harm, and enhance quality of life.

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The NEW ENGLAND JOURNAL *of* MEDICINE

Goal-Oriented Patient Care — An Alternative Health Outcomes Paradigm

David B. Reuben, M.D., and Mary E. Tinetti, M.D.

... focus on a patient's **individual health goals** within or across a variety of dimensions (e.g., symptoms; physical functional status, including mobility; and social and role functions) and determine how well these goals are being met...

Goal oriented care

1. Individually desired rather than universally applied health states;
2. It simplifies decision making for patients with multiple conditions by focusing on outcomes that span conditions and aligning treatments toward common goals
3. It prompts patients to articulate which health states are important to them and their relative priority

Goal oriented care

Comparison of Traditional Disease-Specific and Goal-Oriented Outcomes.*

Measurement Domain	Examples of Diseases	Traditional Outcomes	Goal-Oriented Outcomes
Survival	Cancer, heart failure	Overall, disease-specific, and disease-free survival	None if survival not a high-priority goal; survival until personal milestones are met (e.g., grandchild's wedding)
Biomarkers	Diabetes, COPD	Change in indicators of disease activity (e.g., glycated hemoglobin level, CRP level, and pulmonary-function tests)	None (not a meaningful outcome observed or felt by patient)
Signs and symptoms	Heart failure, COPD, arthritis	Inventory of disease-specific signs and symptoms (e.g., dyspnea, edema, and back pain)	Symptoms that have been identified as important by the patient (e.g., control of dyspnea or pain sufficient to perform an activity such as bowling or walking grandchild to school)
Functional status, including mobility	Cancer, heart failure, COPD	Usually none or disease-specific (e.g., Karnofsky score, NYHA functional classification, and 6-minute walk test)	Ability to complete or compensate for inability to complete specific tasks identified as important by the patient (e.g., ability to get dressed without help)

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

Intervention: Patient priorities care, an approach to decision-making that includes patients' identifying their health priorities (ie, specific health outcome goals and health care preferences) and clinicians aligning their decision-making to achieve these health priorities.

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

Results: Compared with UC patients, PPC patients were more likely to have medications stopped (OR, 2.05; 95% CI, 1.43-2.95) and less likely to have self-management tasks (OR, 0.59; 95% CI, 0.41-0.84) and diagnostic tests (OR, 0.22; 95% CI, 0.12-0.40) ordered.

Conclusions: This study's findings suggest that aligning care with patients' priorities may improve outcomes for patients with multiple chronic conditions.

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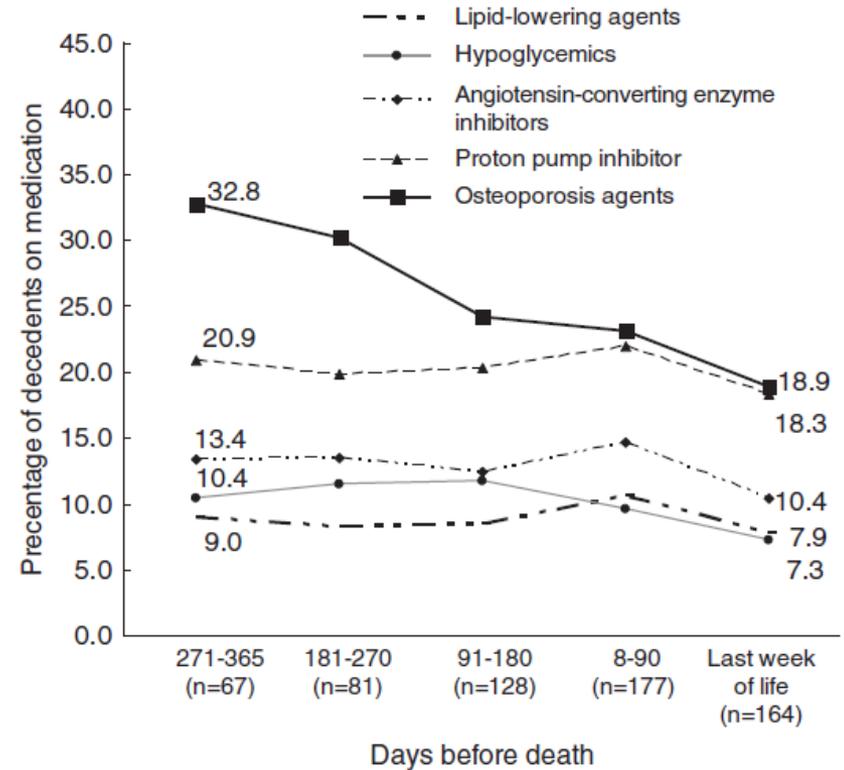
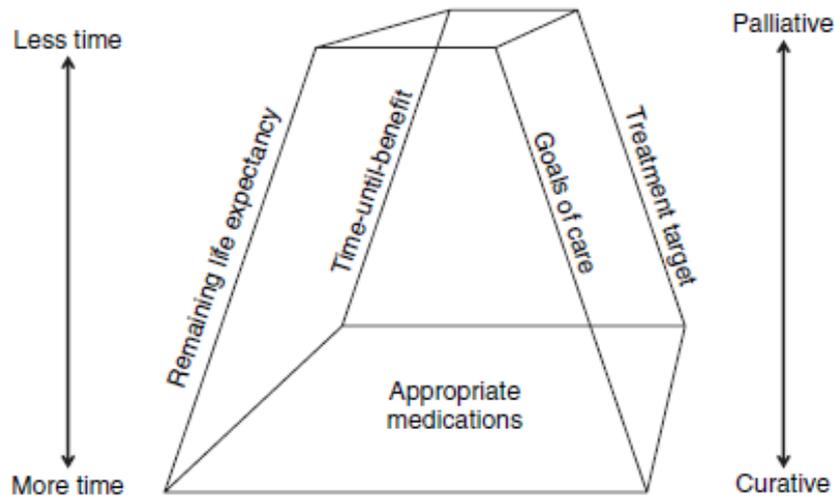
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Life expectancy



Holmes, Clin Pharmacol Ther 2009

Tija et al, J Am Geriatr Soc 2010

Treatment of non dementia illness in patients with dementia

Problems	Consequences	Responses
Cognition and language	Decreased decision-making capacity Increased caregiver burden Increased risk of diagnostic procedures Adherence problems Difficulty reporting adverse effects Difficulty titrating medicines based on reporting by patient	Consider altered risk-benefit ratio balancing safety and autonomy Adjust communication strategies
Decreased life expectancy	Decreased potential benefit	Consider altered risk-benefit ratio Reserve therapy/screening for those with sufficient life expectancy to realize benefit
Exclusion from studies	Increased uncertainty about effects of therapy in this group	Policy changes to include patients with dementia in appropriate studies

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Concerns about older persons' ability to adhere to complex medication regimens

Concern	Representative Quotation
Historical evidence of inability to adhere	Also I factor in adherence to even a basic treatment. If they cannot manage a basic treatment, the one I am giving them, <u>I am not going to complicate it further by adding something to get to the goal range.</u>
Difficulty understanding medications	<u>Whenever [patients] are confused about what medications they are on that suggests a problem.</u> When they can not tell you what the medications either by name or description, and they are confused about when they are supposed to take them
Availability of social support	Often what you are doing is assessing someone's personality and their abilities to integrate complicated information and goals and <u>if you have a patient who is limited you are obviously not going to push the meds nearly as hard unless there is somebody else in the picture who can administer them.</u> I look at their functioning as a whole and also whether or not they live alone, their support system, have help.

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Avoid un-necessary drugs

Herbal medications

If you are thinking about or already using an herbal medication

- ① Discuss use of the herbal medication with your doctor



DOES IT HAVE A PROVEN BENEFIT?
WILL IT INTERACT WITH OTHER MEDICATIONS I AM TAKING?
WHAT ARE POSSIBLE SIDE EFFECTS?

- ② Do not use in children or if you are pregnant



- ③ Watch for possible side effects



nausea allergic reactions
vomiting rashes
diarrhea asthma
fatigue headaches
dizziness dry mouth

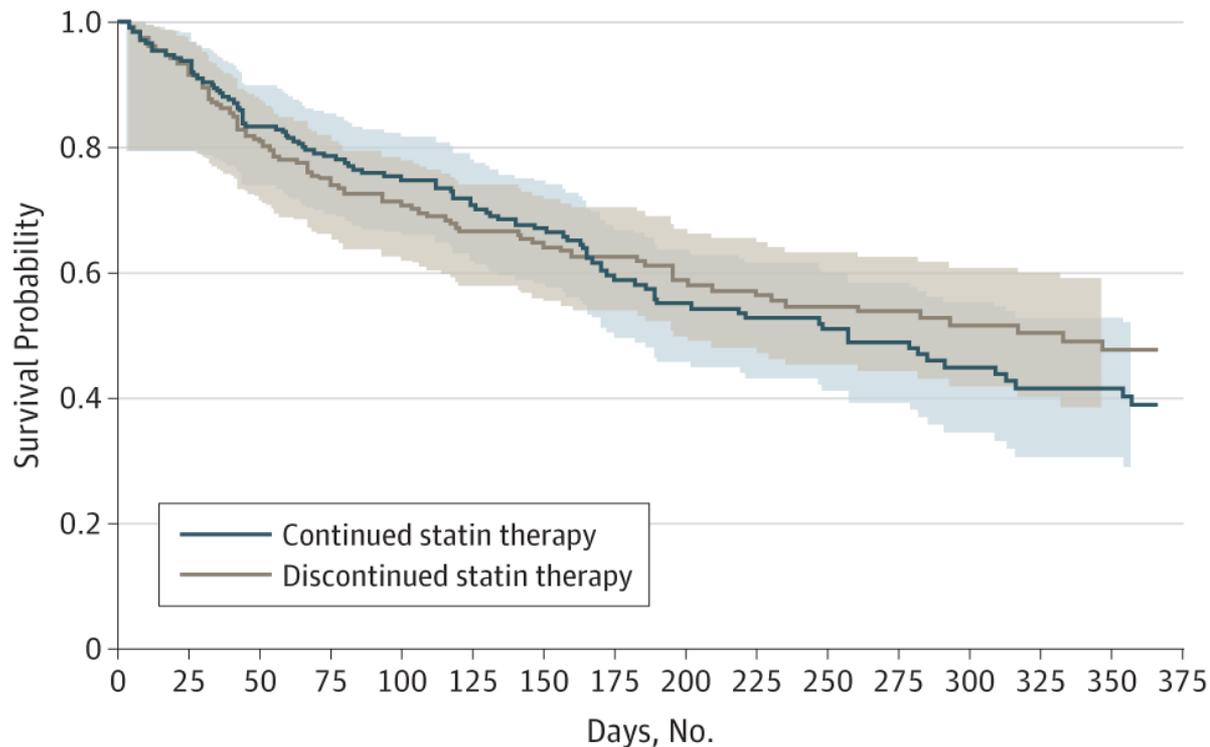
Herbal meds:

- Not regulated
- No proofs of safety and efficacy
- Contamination
- Concentration (?)
- Side effects

Onder G et al. JACC 2017

Onder G et al. JAMA 2016

Safety and Benefit of Discontinuing Statins in Advanced, Life-Limiting Illness

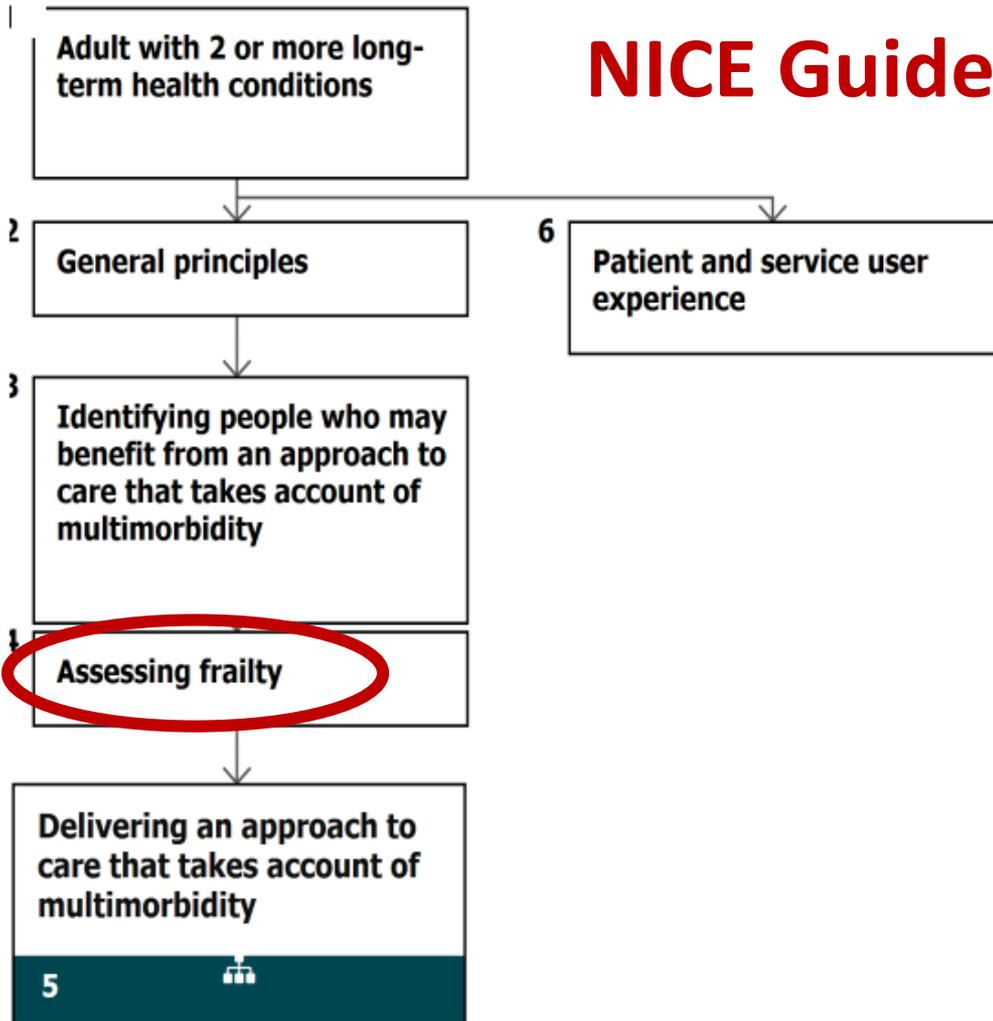


Total QOL was better for the group discontinuing statin therapy ($p = .04$). Few participants experienced cardiovascular events. Mean cost savings were \$3.37 per day and \$716 per patient.

Di cosa parliamo...

- Multimorbilità
- Linee guida American Geriatrics Society
- Linee guida NICE

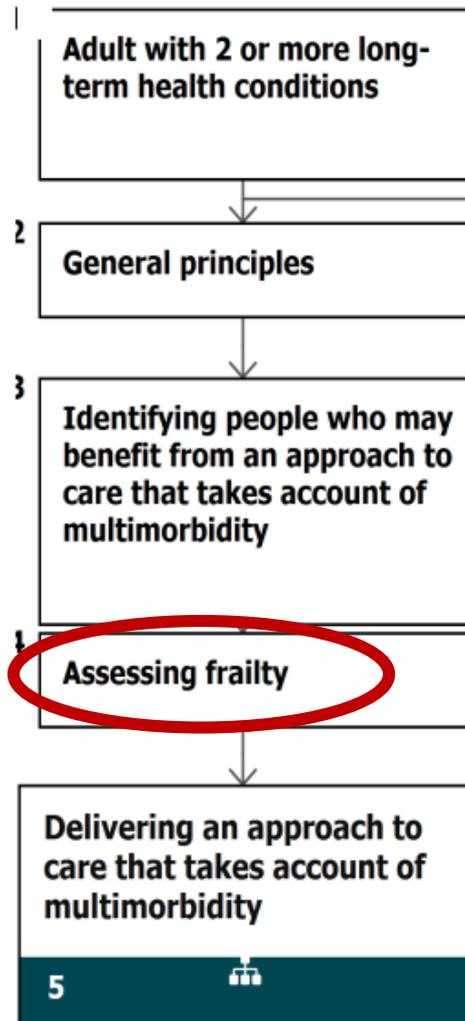
NICE Guidelines Multimorbidity



Treatment of chronic diseases in frailty?

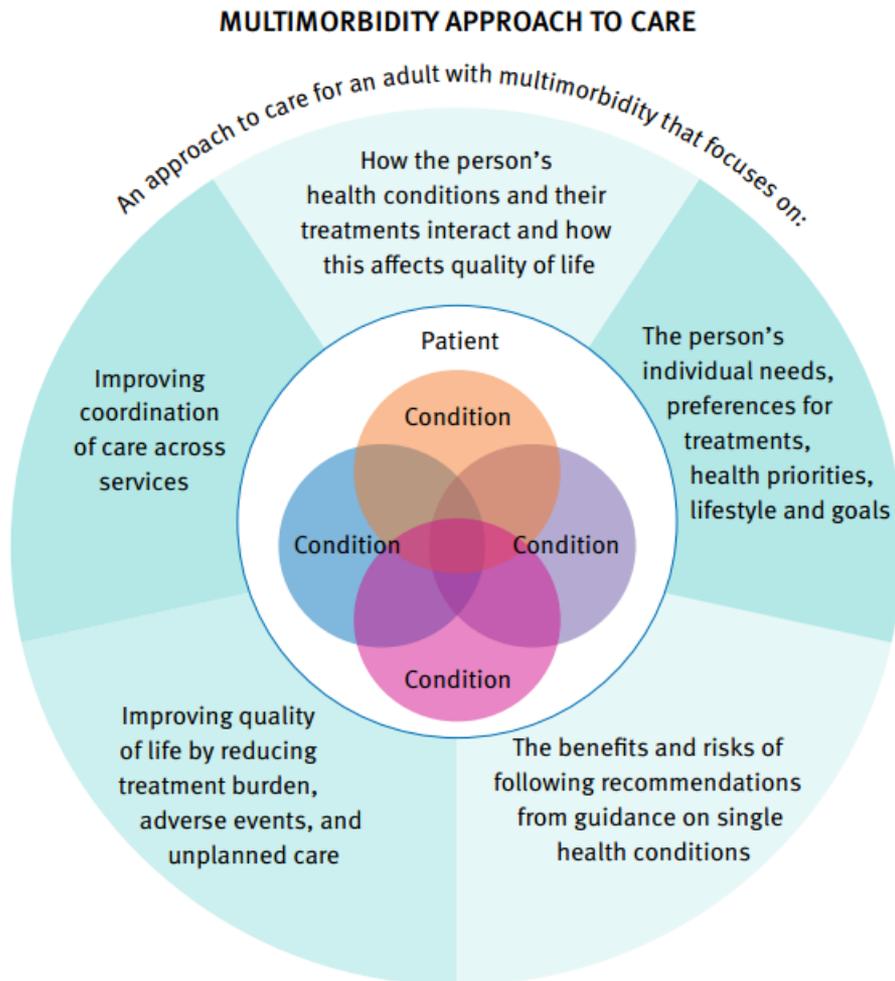
Problem	Consequences	Potential solutions
Exclusion of frail persons from studies	Uncertainties about the efficacy and safety of treatment in frail persons	<ul style="list-style-type: none">• Inclusion of frail patients in RCTs• Evidence from observational studies
Reduced life expectancy in frail persons	Reduced/absent beneficial effects	<ul style="list-style-type: none">• Assess life expectancy• Evaluate risk-benefit ratio of treatments
Increased susceptibility to iatrogenic events	Higher rate of adverse drug events	<ul style="list-style-type: none">• Periodic therapeutic review• Focus treatment on specific goals
Functional deficits associated with frailty	Poor medication adherence; Medication errors	<ul style="list-style-type: none">• Assess the capacity to self-manage meds• Focus treatment on health priorities• Adjust communication strategies• Use of tools to improve adherence• Reduce number medications

NICE Guidelines Multimorbidity



- Discuss the purpose of an approach to care that takes account of MM
- Establish disease and treatment burden
- Establish patient goals, values and priorities
- Review medicines and other treatments taking into account evidence of likely benefits and harms
- Agree an individualised management plan with the person

NICE guideline - Multimorbidity



1.5.1 - Focus on the person's **individual needs, preferences for treatments, health priorities, lifestyle and goals**

1.6.3 - Establish disease burden by **talking to people** about how their health problems affect their day-to-day life.

1.6.4 - Establish treatment burden by **talking to people** about how treatments for their health problems affect their day-to-day life

1.6.7 - **Encourage people with multimorbidity to clarify what is important to them, including their personal goals, values and priorities.**

Di cosa parliamo...

- Multimorbidità
- Linee guida American Geriatrics Society
- Linee guida NICE
- Linee guida Joint Action CHRODIS

CHRODIS Multimorbidity Care Model

Delivery system design

- Comprehensive assessment
- Coordinated team
- Individualized care plans
- Case manager

Decision support

- Implementation of EBM
- Team training
- Consultation system

Self management

- Tailor Self-management
- Options for self management
- Shared decision making

Clinical information system

- Electronic patients records
- Exchange patients infos
- Uniform coding
- Patient operated technology

Community resources

- Access community resources
- Involvement of social network



CHRODIS Multimorbidity Care Model

16 components identified

For each component:

- Description and aims
- Key characteristics
- Relevance to multimorbidity patients

The model derives from *expert opinion*.

Its applicability should be tested in pilot actions



Implementation – Multimorbidity Care Model

IMPLEMENTATION PROJECTS OF THE WP

1

SITE: Andalucia, SP
SETTING: Primary Care
SCALE: Regional
FOCUS: Individualized Care Plans

2

SITE: Aragon, SP
SETTING: Primary Care
SCALE: Regional
FOCUS: Education, Continuity of Care

3

SITE: Rome, IT
SETTING: Hospital
SCALE: Local
FOCUS: Pts. education, Case Management, Technology, CGA

4

SITE: Vilnius, LT
SETTING: Hospital
SCALE: Regional
FOCUS: CGA, Case Manager, Individualized Care Plans, pts. education

5

SITE: Kaunas, LT
SETTING: Primary Care/Hospital
SCALE: Regional
FOCUS: CGA, Case Manager, Individualized Care Plans

Di cosa parliamo...

- Multimorbilità
- Linee guida American Geriatrics Society
- Linee guida NICE
- Linee guida Joint Action CHRODIS
- Linee Guida Italiane

Società Scientifiche coinvolte

- SIGG
- SIMI
- FADOI
- SIGOT
- SIMG
- SIF
- AGE
- Rete IRCCS Invecchiamento

Quale strumento per parlare di Multimorbilità e Politerapia?

Linee guida ISS – Sistema Nazionale Linee Guida

Per LG potenzialmente pubblicabile nell'SNLG si intende *qualsiasi documento contenente raccomandazioni a contenuto clinico o clinico organizzativo per la pratica professionale connessa all'esecuzione delle prestazioni sanitarie con finalità preventive, diagnostiche, terapeutiche, palliative, riabilitative e di medicina legale sviluppate attraverso un processo sistematico di revisione critica delle evidenze disponibili e che offrano una valutazione chiara dei rischi e dei benefici delle differenti opzioni.*

Research Questions

1. Quali principi sono importanti per la valutazione, prioritizzazione e la gestione delle cure nelle persone con multimorbilità?
2. Quale strumento identifica meglio le persone con multimorbilità a rischio di ricovero ospedaliero non pianificato?
3. Quale strumento identifica meglio le persone con multimorbilità a rischio di una ridotta aspettativa di vita?
4. Quali interventi sono efficaci nel ridurre la politerapia e ottimizzare il trattamento farmacologico?
5. Quali sono l'efficacia clinica e la costo-efficacia della riduzione della politerapia?

Research Questions

6. Quali sono l'efficacia clinica e la costo-efficacia della sospensione del trattamento antiipertensivo?
7. Quali sono l'efficacia clinica e la costo-efficacia della sospensione degli inibitori di pompa protonica?
8. Quali sono l'efficacia clinica e la costo-efficacia della sospensione del trattamento con statine?
9. Quali sono l'efficacia clinica e la costo-efficacia della sospensione del trattamento con ASA o antiaggreganti piastrinici?
10. Quali sono l'efficacia clinica del trattamento con vitamina D?

Research Questions

11. Quali modelli assistenziali migliorano gli outcome nei pazienti con multimorbilità?
12. Quali sono l'efficacia clinica e la costo-efficacia del self-management e di programmi di pazienti esperti per le persone con multimorbilità?
13. Qual è l'efficacia della goal oriented care per le persone con multimorbilità?

Conclusioni

1. Importante nella gestione della MM
l'identificazione della popolazione target
2. Ruolo centrale del paziente (shared decision making)
3. Importanza di valutazione globale delle condizioni del paziente (aspetto cognitivo, sociale, aspettativa di vita, etc.)
4. Linee guida italiane.....