SHOULD MY PATIENT GO TO THE ICU – PREDICTING VALUE-BASED OUTCOMES IN ELDERLY PATIENTS?

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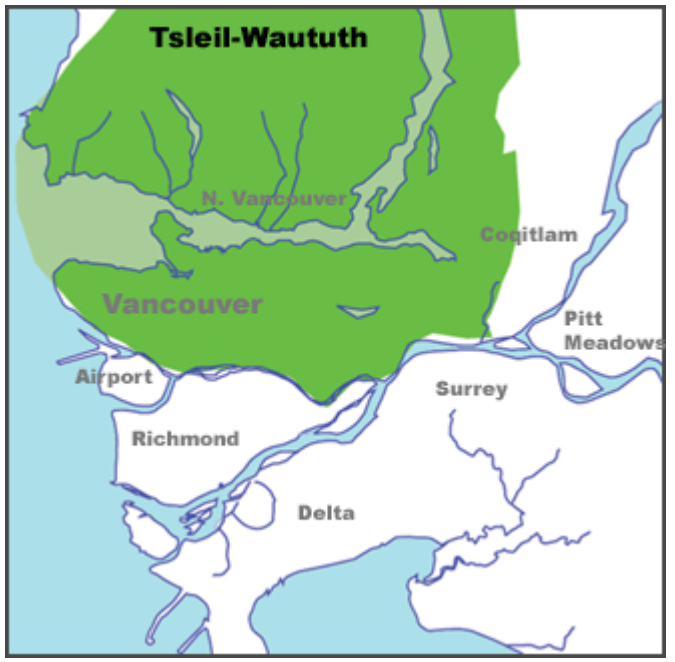
LAND ACKNOWLEDGEMENT

We would like to acknowledge that we are delivering this workshop on the traditional territories of the Musqueam, Squamish and Tsleil-Waututh peoples.



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FACULTY/PRESENTER DISCLOSURE

FACULTY: RUTH MACREDMOND

RELATIONSHIPS WITH FINANCIAL INTERESTS:

GRANTS/RESEARCH SUPPORT: OPERATING GRANT PHC FOUNDATION

SPEAKERS BUREAU/HONORARIA: NONE

CONSULTING FEES: NONE

PATENTS: NONE

POTENTIAL FOR CONFLICT OF INTEREST: NONE

LEARNING OBJECTIVES

1. UNDERSTAND PREDICTORS OF ICU MORTALITY WRT AGE, COMORBIDITIES AND FRAILTY.
2. REVIEW OTHER OUTCOMES IMPORTANT TO PATIENTS – FUNCTION, DISABILITY, INDEPENDENT LIVING
3. IMPROVE SERIOUS ILLNESS CONVERSATIONS IN STRUCTURALLY VULNERABLE PATIENTS – TIPS FOR BETTER ENGAGEMENT

OUTLINE

- BACKGROUND (LIMITATIONS OF THE DATA)
- FRAILTY AND CRITICAL CARE
- SURVIVAL AFTER CARDIAC ARREST
- ICU OUTCOMES – MORTALITY, DISABILITY, QOL, DISCHARGE DISPOSITION
- ACP IN STRUCTURALLY VULNERABLE PATIENTS

BACKGROUND

Population is aging

- 2050: 16% world population >65, 25% Europe and N.America
- 2050: number of persons > 80 will triple

United nations: World Population Ageing 2020 Highlights

Technological imperative

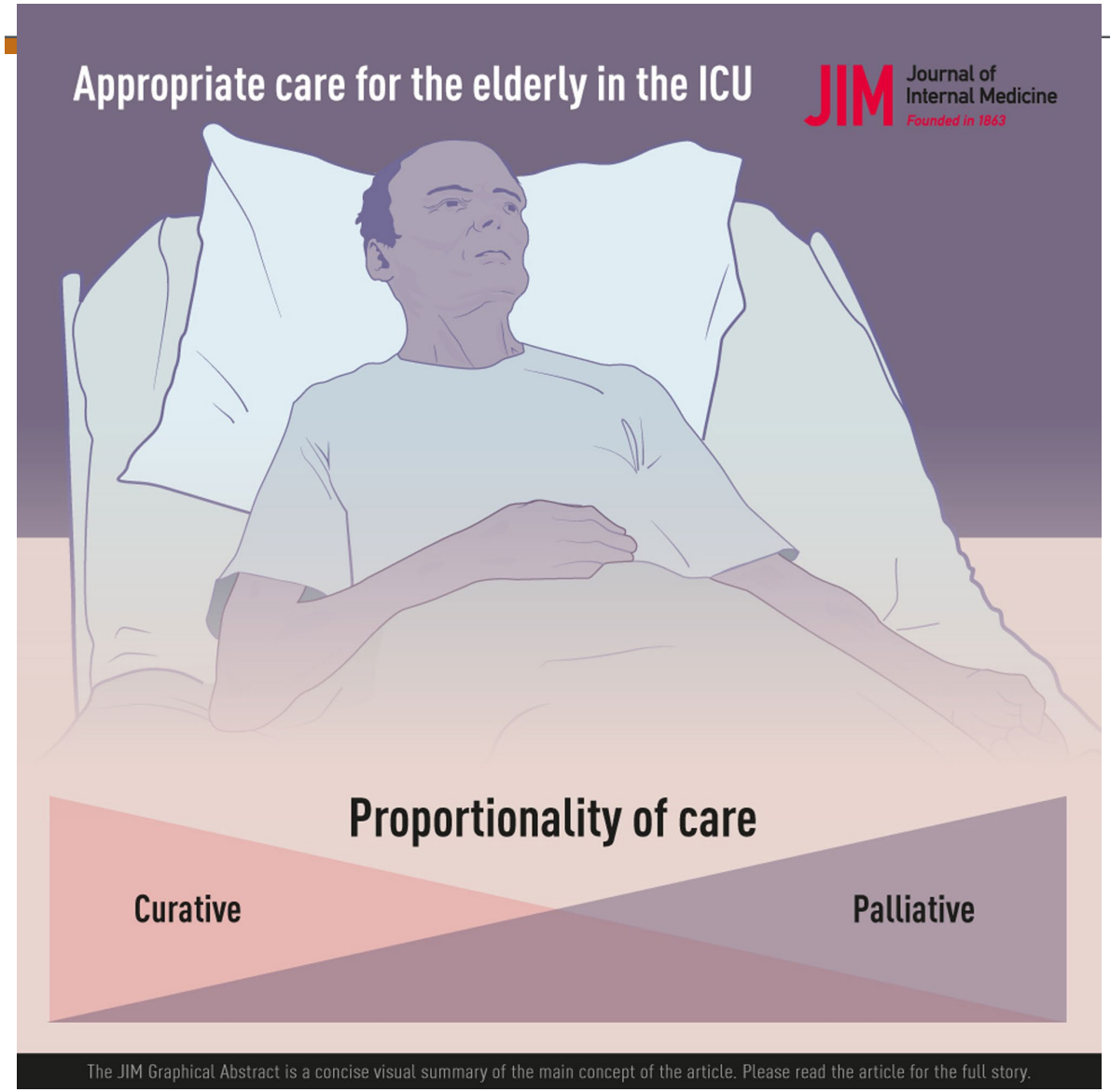
Resource limitation – distributive justice/triage

CONSEQUENCES OF INAPPROPRIATE CARE IN THE ICU

1. Violation of basic ethical values
2. Patient and family suffering
3. Moral distress, avoidance behavior
4. Compassion fatigue, burnout

Causes and consequence of disproportionate care in Intensive Care Medicine *Kompanje et al*

Curr Opin Crit Care. 2013 Dec;19(6):630-5.

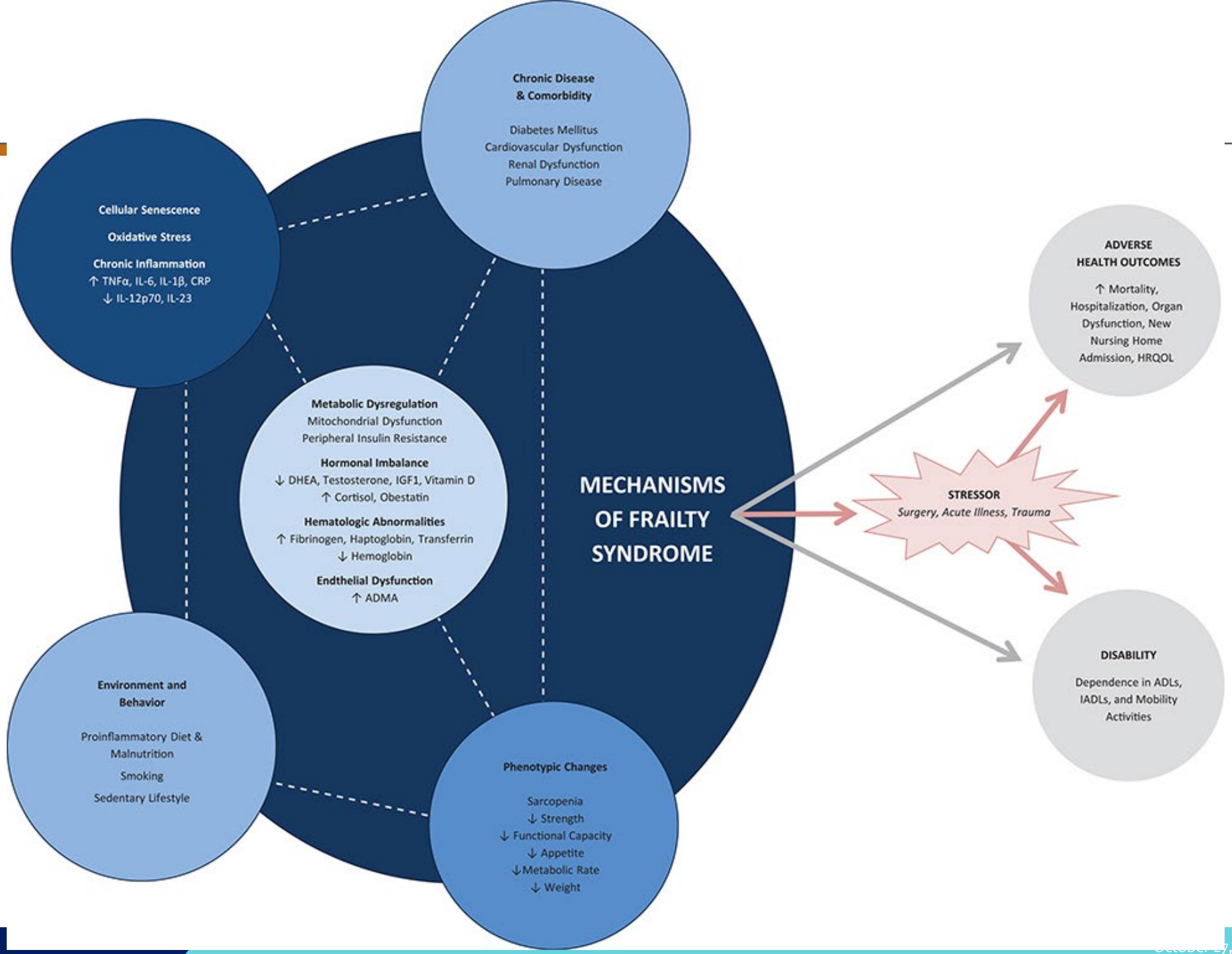


"When is too much too much and too little too little?"

FRAILTY

Component	Description
State of vulnerability	Acute or chronic stressors elicit a maladaptive response disproportionate to the degree of insult.
Multifactorial etiology	Complex biological processes interact through network effects involving multisystem dysregulation and the age-associated accumulation of molecular, cellular, and tissue damage.
Heterogeneous presentation	Multiple points of entry and dynamic, nonlinear disease progression produce variability in observed characteristics in those affected.
Clinically measurable	Operationalized measurement tools are able to provide a diagnosis of frailty, although a gold standard is notably absent.
Increased risk of adverse outcomes	Patients are subject to increased rates of adverse outcomes including functional decline, decreased quality of life, increased health care utilization, and mortality.

De Biasio JC, Mittel AM, Mueller AL, Ferrante LE, Kim DH, Shaefi S**. Frailty in Critical Care Medicine: A Review.** Anesth Analg. 2020 Jun;130(6):1462-1473.


Chronic Disease & Comorbidity
Diabetes Mellitus
Cardiovascular Dysfunction
Renal Dysfunction
Pulmonary Disease
Cellular Senescence
Oxidative Stress
Chronic Inflammation
↑ TNFα, IL-6, IL-1β, CRP
↓ IL-12p70, IL-23
Metabolic Dysregulation
Mitochondrial Dysfunction
Peripheral Insulin Resistance
Hormonal Imbalance
↓ DHEA, Testosterone, IGF1, Vitamin D
↑ Cortisol, Obestatin
Hematologic Abnormalities
↑ Fibrinogen, Haptoglobin, Transferrin
↓ Hemoglobin
Endthelial Dysfunction
↑ ADMA
MECHANISMS OF FRAILTY SYNDROME
Environment and Behavior
Proinflammatory Diet & Malnutrition
Smoking
Sedentary Lifestyle
Phenotypic Changes
Sarcopenia
↓ Strength
↓ Functional Capacity
↓ Appetite
↓Metabolic Rate
↓ Weight
ADVERSE HEALTH OUTCOMES
↑ Mortality, Hospitalization, Organ Dysfunction, New Nursing Home Admission, HRQOL
STRESSOR
Surgery, Acute Illness, Trauma
DISABILITY
Dependence in ADLs, IADLs, and Mobility Activities

Clinical Frailty Scale*

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 Managing Well – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 Vulnerable – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 Mildly Frail – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with **all outside activities** and with **keeping house.** Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9 Terminally Ill - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

LIMITATIONS OF THE DATA

- Selection Bias: Studies likely omit many frail patients with “no ICU” orders
- Treatment Bias: Include ICU admissions with limitations in care – intubation/CPR/dialysis
- Frail patients more likely admitted with higher severity of illness
- Retrospective observational studies

AGE AND CARDIAC ARREST OUTCOME

IHCA: 29 studies

Survival 18.7% (70-79), 15.4% (80-89), 11.6% (90+)

(high rates of functional decline in survivors)

OHCA: 14 studies

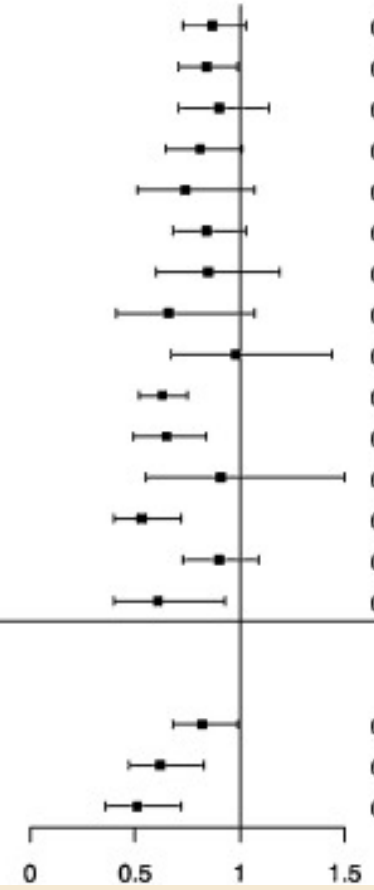
Survival 4.1% age > 70 - less with increasing age

Zanders R, Druwé P, Van Den Noortgate N, Piers R. **The outcome of in- and out-hospital cardiopulmonary arrest in the older population: a scoping review.** Eur Geriatr Med. 2021 Aug;12(4):695-723.

COMORBIDITY AND SURVIVAL IN OHCA

30–day survival, all patients

Comorbidity*	Proportion	Adjusted OR	Lower CI	Upper CI	p–value
Myocardial infarction	24.4	0.87	0.73	1.03	0.098
Congestive heart failure	28.8	0.84	0.71	0.99	0.041
Peripheral vascular disease	11.4	0.90	0.71	1.14	0.378
Cerebrovascular disease	14.3	0.81	0.65	1.01	0.059
Dementia	6.2	0.74	0.51	1.07	0.107
Chronic pulmonary disease	18.8	0.84	0.68	1.03	0.088
Connective tissue disorder/Rheumatic	5.4	0.85	0.60	1.19	0.338
Peptic ulcer disease	3.0	0.66	0.41	1.07	0.094
Mild liver disease	2.9	0.98	0.67	1.44	0.916
Diabetes without complications	22.7	0.63	0.52	0.75	<0.0001
Diabetes with complications	9.5	0.65	0.49	0.84	0.001
Paraplegia/Hemiplegia	2.4	0.91	0.55	1.50	0.706
Renal disease	9.6	0.53	0.40	0.72	<0.0001
Cancer	17.2	0.90	0.73	1.09	0.277
Metastatic carcinoma	4.4	0.61	0.40	0.93	0.021
Charlson comorbidity index					
0–2	62.6				
3–4 (vs. 0–2)	20.7	0.82	0.68	0.99	0.041
5–6 (vs. 0–2)	10.1	0.62	0.47	0.83	0.001
>6 (vs. 0–2)	6.6	0.51	0.36	0.72	0.0002



Hirlekar G, Jonsson M, Karlsson T, Hollenberg J, Albertsson P, Herlitz J. **Comorbidity and survival in out-of-hospital cardiac arrest.** Resuscitation. 2018 Dec;133:118-123. doi: 10.1016/j.resuscitation.2018.10.006.

TABLE I. Charlson Comorbidity Index*

Score	Condition
1	Myocardial infarction (history, not ECG changes only)
	Congestive heart failure
	Peripheral vascular disease (includes aortic aneurysm ≥6 cm)
	Cerebrovascular disease: CVA with mild or no residua or TIA
	Dementia
	Chronic pulmonary disease
	Connective tissue disease
	Peptic ulcer disease
	Mild liver disease (without portal hypertension, includes chronic hepatitis)
	Diabetes without end-organ damage (excludes diet-controlled alone)
2	Hemiplegia
	Moderate or several renal disease
	Diabetes with end-organ damage (retinopathy, neuropathy, nephropathy, or brittle diabetes)
	Tumour without metastases (exclude if >5 years from diagnosis)
	Leukaemia (acute or chronic)
	Lymphoma
3	Moderate or severe liver disease
6	Metastatic solid tumour
	AIDS (not just HIV-positive)

Abbreviations: AIDS = acquired immunodeficiency syndrome; CVA = cerebrovascular accident; ECG = electrocardiogram; HIV = human immunodeficiency virus; TIA = transient ischaemic attack

* For each decade >40 years of age, a score of 1 is added to the above score

CCI	10 year survival
3	77
4	53
5	21
6	2
7	0

COMORBIDITY -OHCA

Table 3
Thirty-day survival in different CCI groups.
Data presented as number survived (%).
* Ordered CCI group were used in p-value calculation

Survival at 30 days	CCI 0–2	CCI 3–4	CCI 5–6	CCI > 6	p-value *
All patients	1200 (16.0)	260 (10.5)	86 (7.1)	52 (6.6)	<0.0001
Patients found in ventricular fibrillation	841 (35.0)	173 (27.0)	53 (20.2)	31 (19.4)	<0.0001
Patients with another initial arrhythmia	243 (5.0)	55 (3.1)	23 (2.5)	17 (2.8)	<0.0001

FRAILTY AND CARDIAC ARREST OUTCOME

Resusc Plus. 2022 Jul 1;11:100266.

Outcomes in adults living with frailty receiving cardiopulmonary resuscitation: A systematic review and meta-analysis

Joseph Hamlyn [1], Charlotte Lowry [1], Thomas A Jackson [1 2], Carly Welch [1 2]

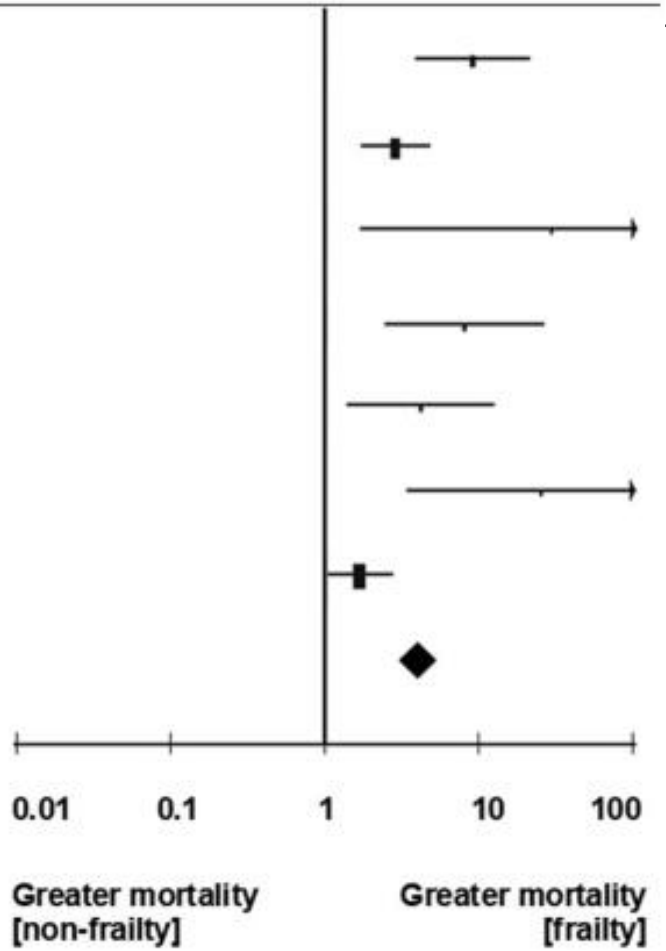
8 studies, 2017 patients

7 IHCA, 1 OHCA

Study	Non-frailty Events, total (n/N)	Frailty Events, total (n/N)	Weight	Odds ratio Fixed [95% CI]
Fernando, 2019	242/353	118/124	11.1%	9.02 [3.85, 21.11]
Hu, 2021	88/143	149/181	31.6%	2.91 [1.75, 4.84]
Ibitoye, 2020	37/50	40/40	0.7%	29.16 [1.67, 507.86]
Smith, 2018	235/316	69/72	6.6%	7.93 [2.43, 25.88]
Thomas, 2021	31/50	34/39	6.3%	4.17 [1.39, 12.51]
Wharton, 2019	84/123	55/56	1.7%	25.54 [3.41, 191.31]
Xu, 2020	169/202	329/368	42.0%	1.65 [1.00, 2.71]
Total (95%)	**886/1237**	**794/880**	**100%**	**4.05 [3.05, 5.36]**

Heterogeneity: $Chi^2 = 23.76$, df = 6 (P = 0.0006); $I^2 = 75\%$

Test for overall effect: Z = 9.71 (P < 0.00001)



Mortality : OR 3.56 for CFS >4
Increased mortality with increased frailty
Overall mortality CFS >4 – 90.2%
One study: no patients with CFS > 4 survived.

IN HOSPITAL CARDIAC ARREST

. Age Ageing 2021 Jan 8;50(1):147-152.
Frailty status predicts futility of cardiopulmonary resuscitation in older adults
Sarah E Ibitoye [1], Sadie Rawlinson [2], Andrew Cavanagh [3], Victoria Phillips [2], David J H Shipway [4]

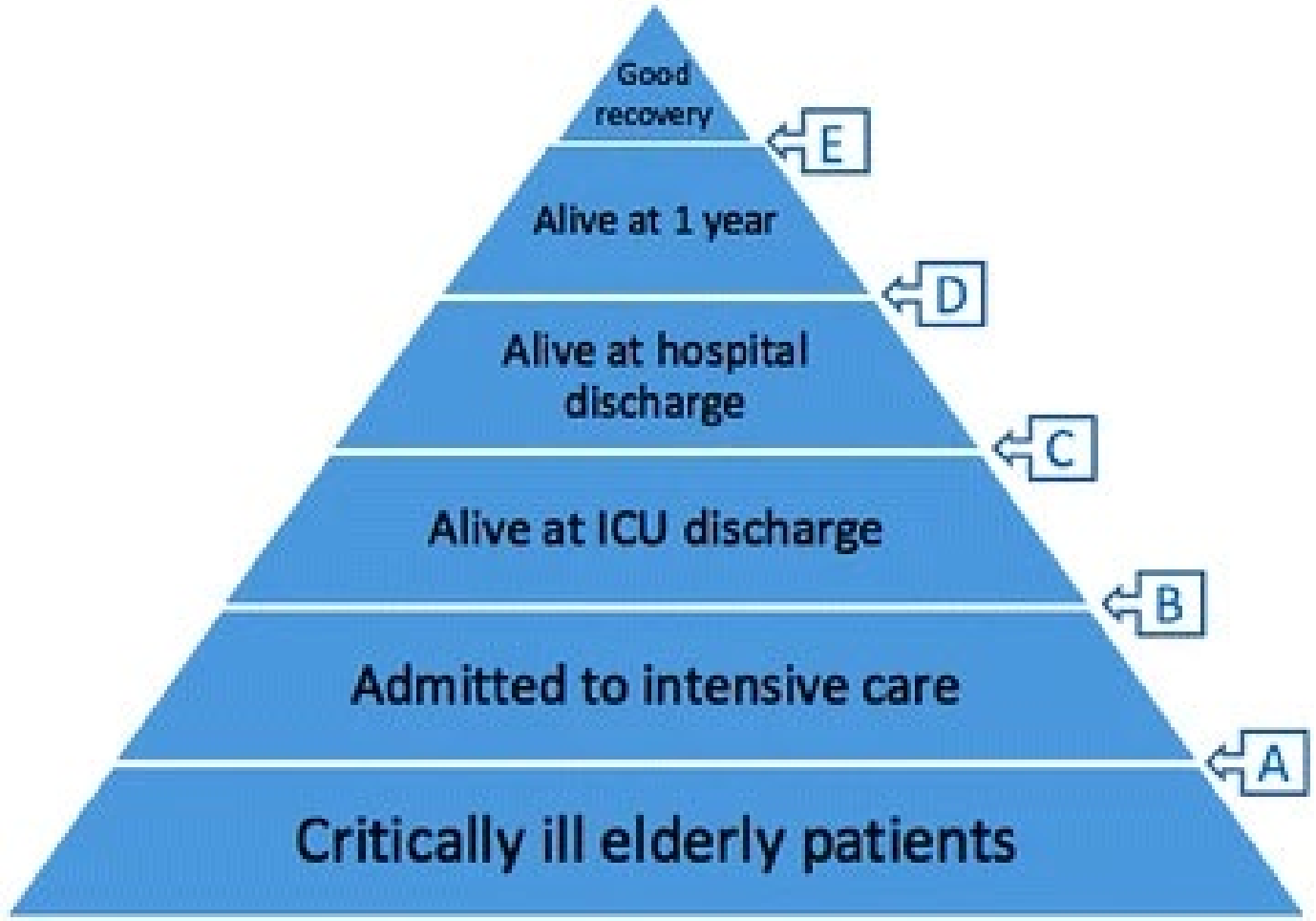
- Retrospective chart review, UK, 90 patients over age 60
- Survival to hospital discharge: 26% of non-frail (CFS <= 4) no survivors in frail cohort

- Jonsson H., Piscator E., Israelsson J., Lilja G., Djärv T.:
- **Is frailty associated with long-term survival, neurological function and patient-reported outcomes after in-hospital cardiac arrest? A Swedish cohort study.** Resuscitation 2022;
- 232 patients > 65 who survived at minimum 30 days; 6 month survival 92 vs 74, 3 year survival 74 vs 22
- Frailty was associated with increased depression and worse general health

SHOULD WE RECOMMEND CPR TO OLDER PATIENTS?

- OHCA
  - NO
- IHCA
  - Low CFS, Cardiac diagnosis/history – maybe
  - Frail, non-cardiac admission - no

OUTCOMES IN CRITICALLY ILL ELDERLY PATIENTS



FRAILTY IS ASSOCIATED WITH:

- Increased ICU mortality
- Increased ICU length of stay
- Increased hospital and long term mortality
- Increased burden of disability at 6 months
- Increased admission to nursing home

De Biasio JC, Mittel AM, Mueller AL, Ferrante LE, Kim DH, Shaefi S. Frailty in Critical Care Medicine: A Review. Anesth Analg. 2020 Jun;130(6):1462-1473.

OUTCOMES IN VERY OLD PATIENTS

24 ICUs in Canada, 1671 patients

ICU mortality 22%, Hospital mortality 35%

Patients with frailty - higher hospital mortality, less likely to be discharged to home (33%)

26% of survivors returned to previous function

Heyland, Daren MD, MSc[1]; Canadian Critical Care Trials Group and the Canadian Researchers at the End of Life Network. **The Very Elderly Admitted to ICU: A Quality Finish?***. Critical Care Medicine: July 2015 - Volume 43 - Issue 7 - p 1352-1360

OUTCOMES IN VERY OLD PATIENTS

311 ICUs in 21 European countries

5021 patients, median age 84, 48% women

ICU mortality 22%, 30 day mortality 32.6%

Frailty increased mortality HR 1.54

Unplanned admissions: 30-day mortality 40%

Flaatten H, De Lange DW, Morandi A, Andersen FH, Artigas A, Bertolini G, Boumendil A, Cecconi M, Christensen S, Faraldi L, Fjølner J, Jung C, Marsh B, Moreno R, Oeyen S, Öhman CA, Pinto BB, Soliman IW, Szczeklik W, Valentin A, Watson X, Zaferidis T, Guidet B; VIP1 study group. **The impact of frailty on ICU and 30-day mortality and the level of care in very elderly patients (≥ 80 years).** Intensive Care Med. 2017 Dec;43(12):1820-1828.

GERIATRIC SYNDROMES – VIP-2 STUDY

3920 patients 80+yo, 242 ICUs Europe

Frailty – CFS >4, Cognitive impairment – IQCODE >=3.5, disability – ADL <5

ICU mortality 29%, Hospital mortality 39%

Predictors of mortality: Age (1.02 per year), ICU admission diagnosis, SOFA and CFS (1.1 per point).

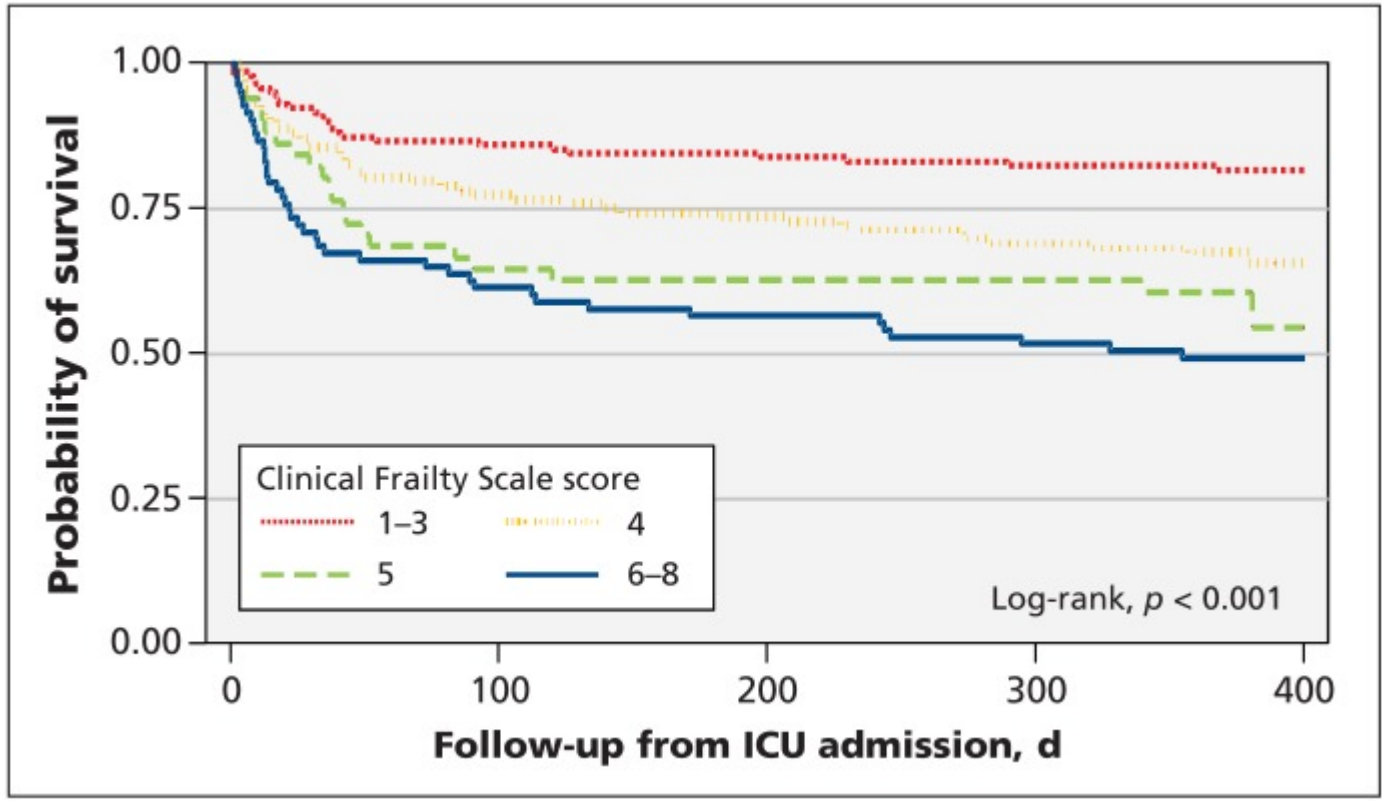
Guidet B, de Lange DW, Boumendil A, Leaver S, Watson X, Boulanger C, Szczeklik W, Artigas A, Morandi A, Andersen F, Zafeiridis T, Jung C, Moreno R, Walther S, Oeyen S, Schefold JC, Cecconi M, Marsh B, Joannidis M, Nalapko Y, Elhadi M, Fjølner J, Flaatten H; **VIP2 study group**. **The contribution of frailty, cognition, activity of daily life and comorbidities on outcome in acutely admitted patients over 80 years in European ICUs: the VIP2 study**. Intensive Care Med. 2020 Jan;46(1):57-69.

FRAILTY – SHORT- AND LONG-TERM OUTCOMES

421 adults >50y0 in 6 hospitals in Alberta

Frailty – CFS >4

Prevalence of frailty – 32%



Bagshaw SM, Stelfox HT, McDermid RC, Rolfson DB, Tsuyuki RT, Baig N, Artiuch B, Ibrahim Q, Stollery DE, Rokosh E, Majumdar SR. **Association between frailty and short- and long-term outcomes among critically ill patients: a multicentre prospective cohort study.** CMAJ. 2014 Feb 4;186(2):E95-102.

Clinical outcomes, by frailty status

Outcome	Group; no. (%)of patients*		Association, OR (95% CI) or difference in medians (*p* value†)
	Frail *n* = 138	Not frail *n* = 283	
Adverse event‡	54 (39.1)	83 (29.3)	1.54 (1.01–2.37)
Death			
In ICU	16 (11.6)	27 (9.5)	1.37 (0.72–2.62)
In hospital	44 (31.9)	45 (15.9)	1.81 (1.09–3.01)
Duration of stay, d, median (IQR)			
In ICU	7 (4–13)	6 (3–10)	1 d (0.02)
In hospital	30 (10–64)	18 (10–40)	12 d (0.02)
Discharge disposition§	*n* = 91	*n* = 235	
Home, living independently	20 (22.0)	104 (44.3)	0.35 (0.20–0.61)
Home, living with help	33 (36.3)	58 (24.7)	1.67 (1.00–2.81)
Other¶	38 (41.8)	73 (31.1)	1.51 (0.92–2.48)
Discharged newly dependent**	24 (70.6)	96 (51.6)	2.25 (1.03–4.89)
Hospital readmission§	51 (56.0)	92 (39.1)	1.98 (1.22–3.23)

FRAILTY - MORTALITY, DISABILITY AND COGNITIVE IMPAIRMENT

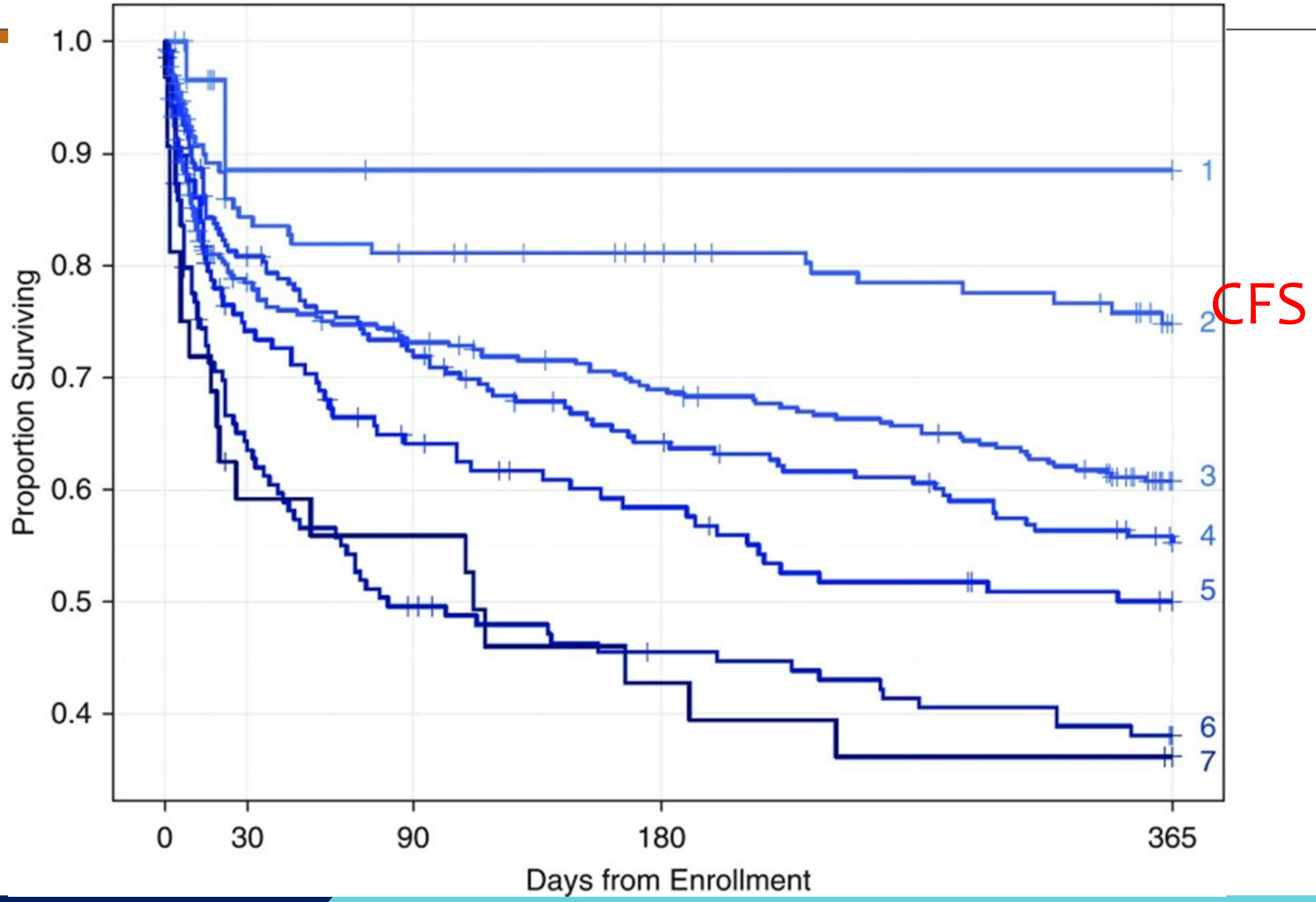
1040 patients, 5 US centres, Median age 62, median CFS 3

Higher CFS (75th percentile) had 50% greater risk of death at one year vs lower CFS (25th percentile)

Effect of frailty was independent of age

Brummel NE, …..Ely EW. Frailty and Subsequent Disability and Mortality among Patients with Critical Illness. Am J Respir Crit Care Med. 2017 Jul 1;196(1):64-72.

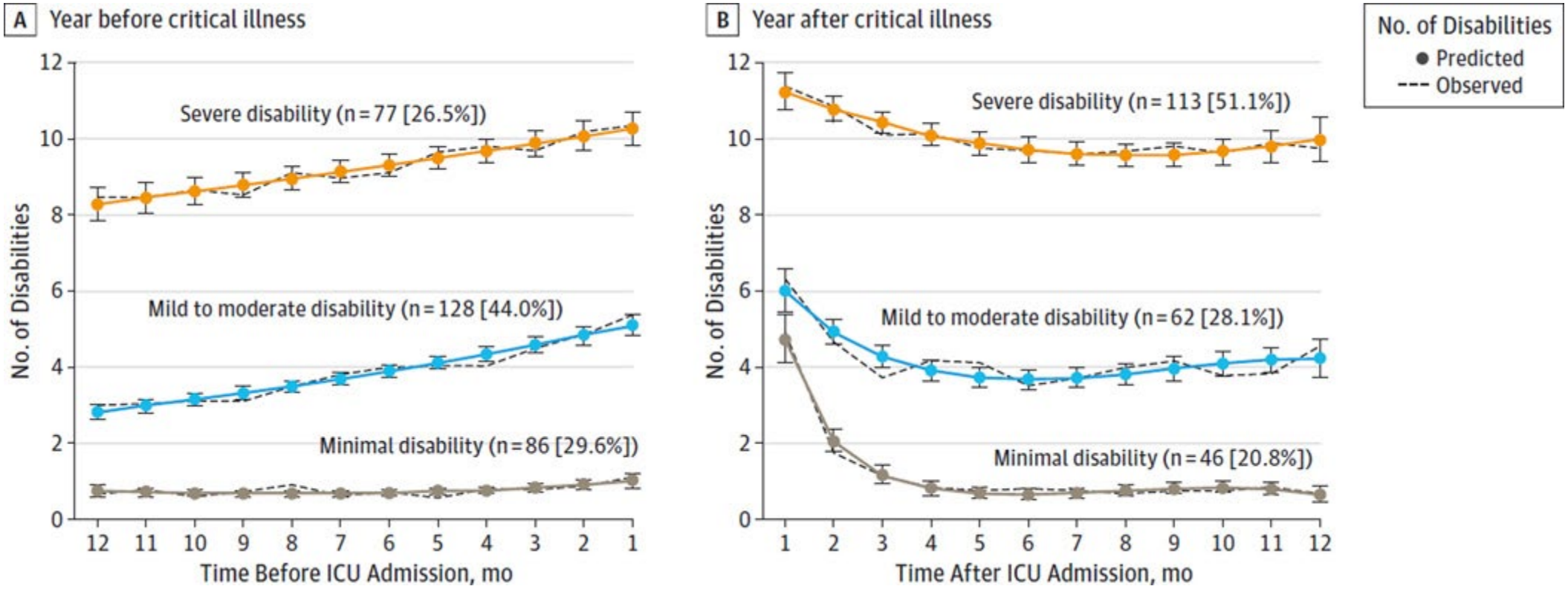
FRAILTY PREDICTS SURVIVAL



FRAILTY PREDICTS DISABILITY AND REDUCED QOL

	3 Months		12 Months	
	Point Estimate* (95% CI)	*P* Value	Point Estimate* (95% CI)	*P* Value
Mortality‡	1.4 (1.1 to 1.8)	0.01	1.5 (1.2 to 1.8)	<0.001
IADL disability‡	1.2 (1.0 to 1.4)	0.04	1.3 (1.1 to 1.6)	0.002
BADL disability§	1.1 (0.9 to 1.3)	0.23	1.1 (0.9 to 1.4)	0.10
RBANS score‖	−0.6 (−1.7 to 0.4)	0.42	−0.2 (−1.6 to 1.2)	0.12
SF-36 Physical Component¶	−2.1 (−3.0 to −1.1)	<0.001	−1.9 (−2.9 to −0.8)	<0.001
SF-36 Mental Component¶	0.5 (−0.9 to 2.0)	0.08	−0.5 (−2.0 to 1.0)	0.16

FUNCTIONAL TRAJECTORIES AMONG OLDER PERSONS BEFORE AND AFTER CRITICAL ILLNESS

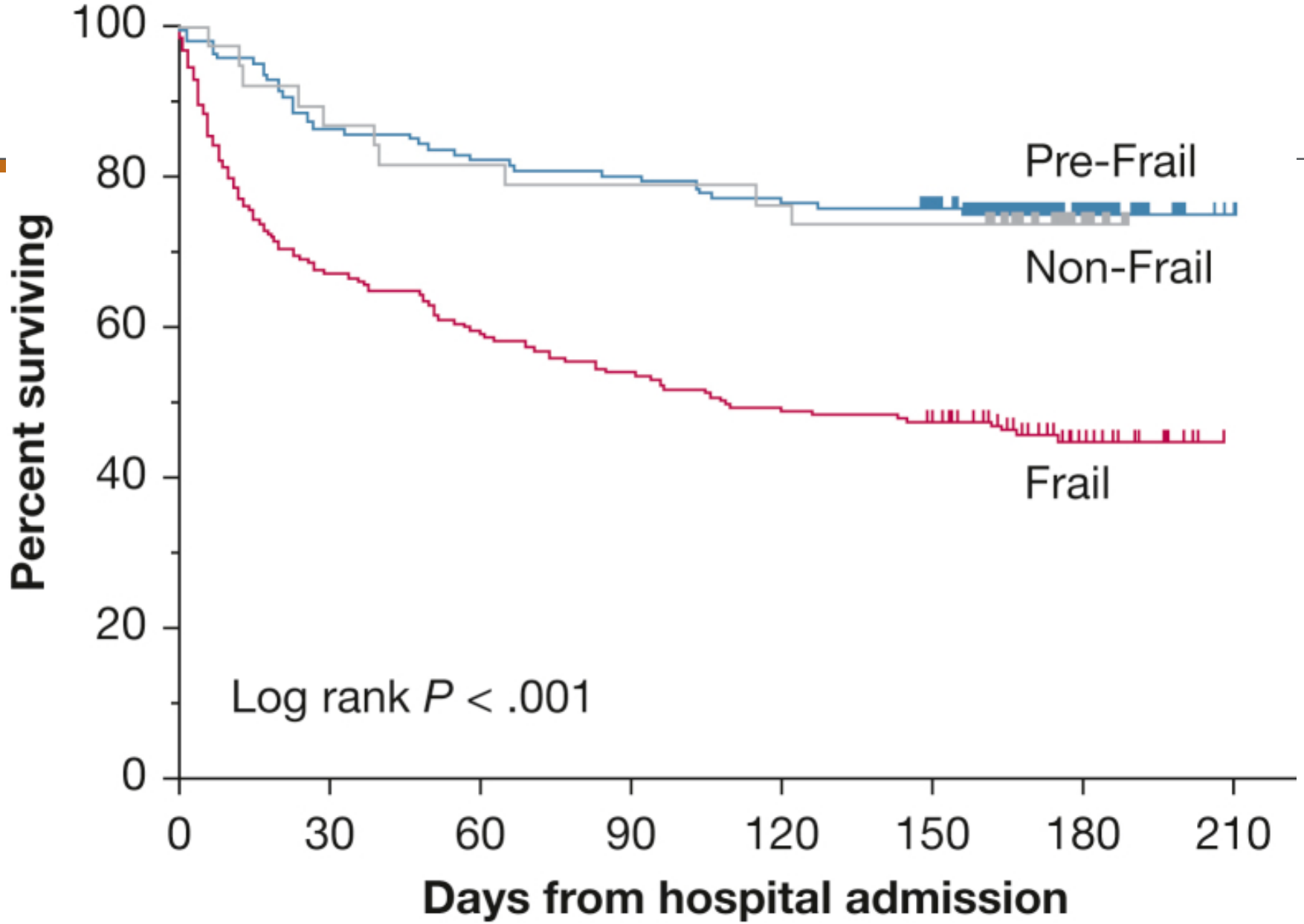


Ferrante LE, Pisani MA, Murphy TE, Gahbauer EA, Leo-Summers LS, Gill TM. **Functional trajectories among older persons before and after critical illness.** JAMA Intern Med. 2015 Apr;175(4):523-9.

Adjusted Probabilities of Transitioning Between the Pre-ICU and Post-ICU Functional Trajectories

	Post-ICU Functional Trajectory (95% CI)			
Pre-ICU Functional Trajectory	Minimal Disability (n = 44)	Mild to Moderate Disability (n = 64)	Severe Disability (n = 113)	Early Death[b] (n = 70)
Minimal disability (n = 86)	0.49 (0.31–0.65)	0.27 (0.16–0.45)	0.13 (0.04–0.19)	0.12 (0.05–0.19)
Mild to moderate disability (n = 128)	0.02 (0.00–0.10)	0.32 (0.23–0.42)	0.40 (0.28–0.49)	0.26 (0.19–0.35)
Severe disability (n = 77)	0.00 (0.00-0.00)	0.00 (0.00–0.07)	0.66 (0.52–0.75)	0.34 (0.23–0.44)

Incident nursing home admission: not frail 23.5%, prefrail 37.7%, frail 58.8%

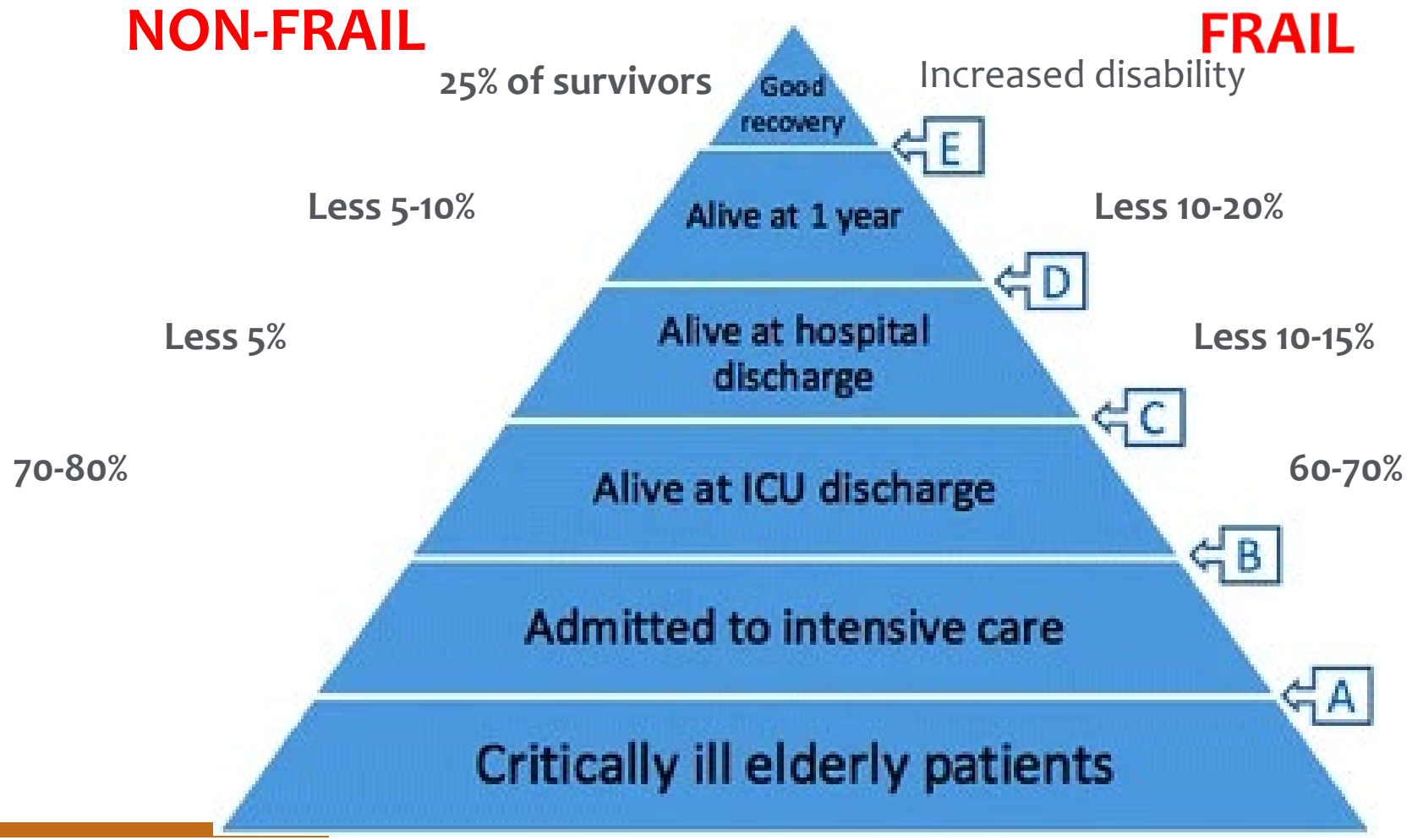

Percent surviving
100
80
60
40
20
0
Pre-Frail
Non-Frail
Frail
Log rank P < .001
0
30
60
90
120
150
180
210
Days from hospital admission

PROLONGED VENTILATION AND TRACHEOSTOMY

- Historical cohort study, 270 patients >70 yo (mean 81 yo)
- ICU mortality 26%, Hospital mortality 46%, Hospital LOS 81 days
- Discharge: Home 6%, all were frail (median CFS 7), tube fed (70%), unable to speak (56%), non-ambulatory (68%)

Lee, T., Tan, Q.L., Sinuff, T. et al. Outcomes of prolonged mechanical ventilation and tracheostomy in critically ill elderly patients: a historical cohort study. Can J Anesth/J Can Anesth 69, 1107–1116 (2022)

OUTCOMES IN CRITICALLY ILL ELDERLY PATIENTS



SHOULD MY ELDERLY PATIENT BE ADMITTED TO ICU?

It depends……

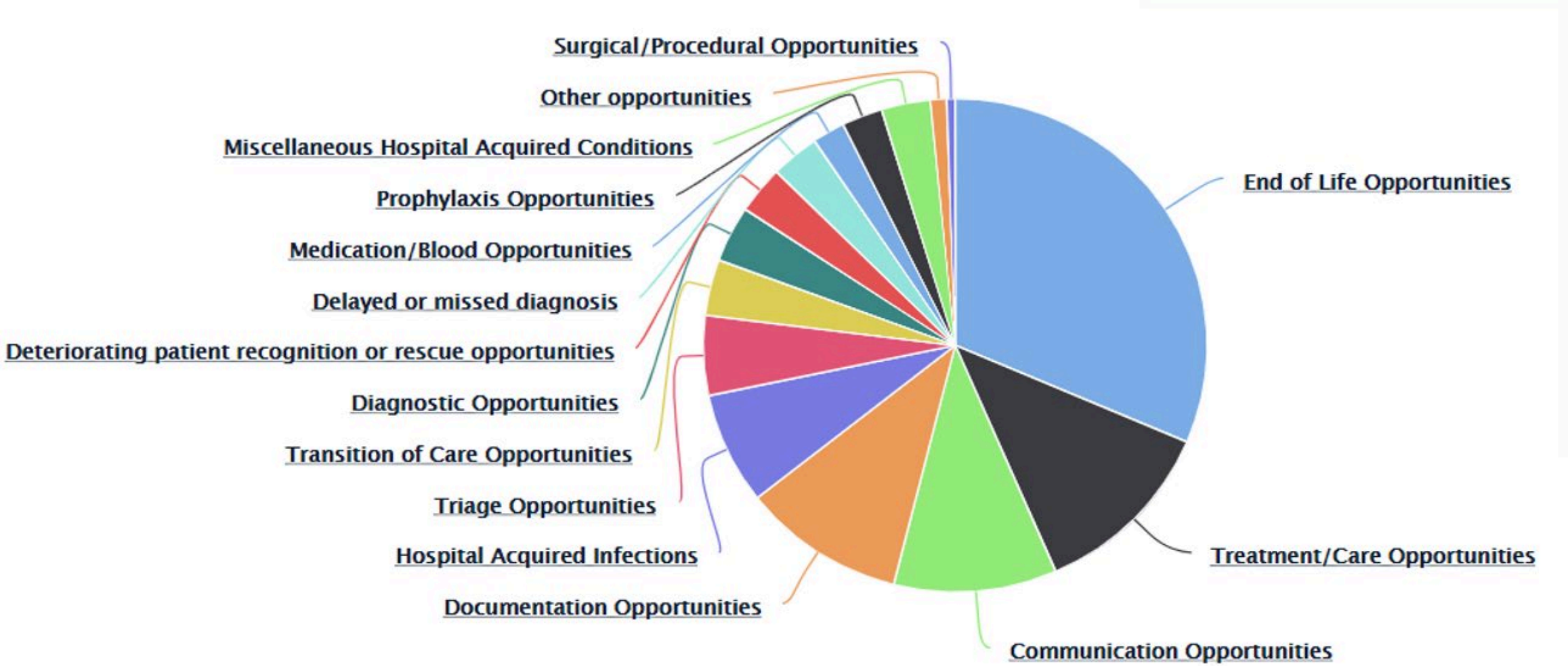
Non-frail patients may have reasonable survival but likely with functional impairment

Frail patients at increased risk of short and long term mortality and increased frailty/reduced QoL

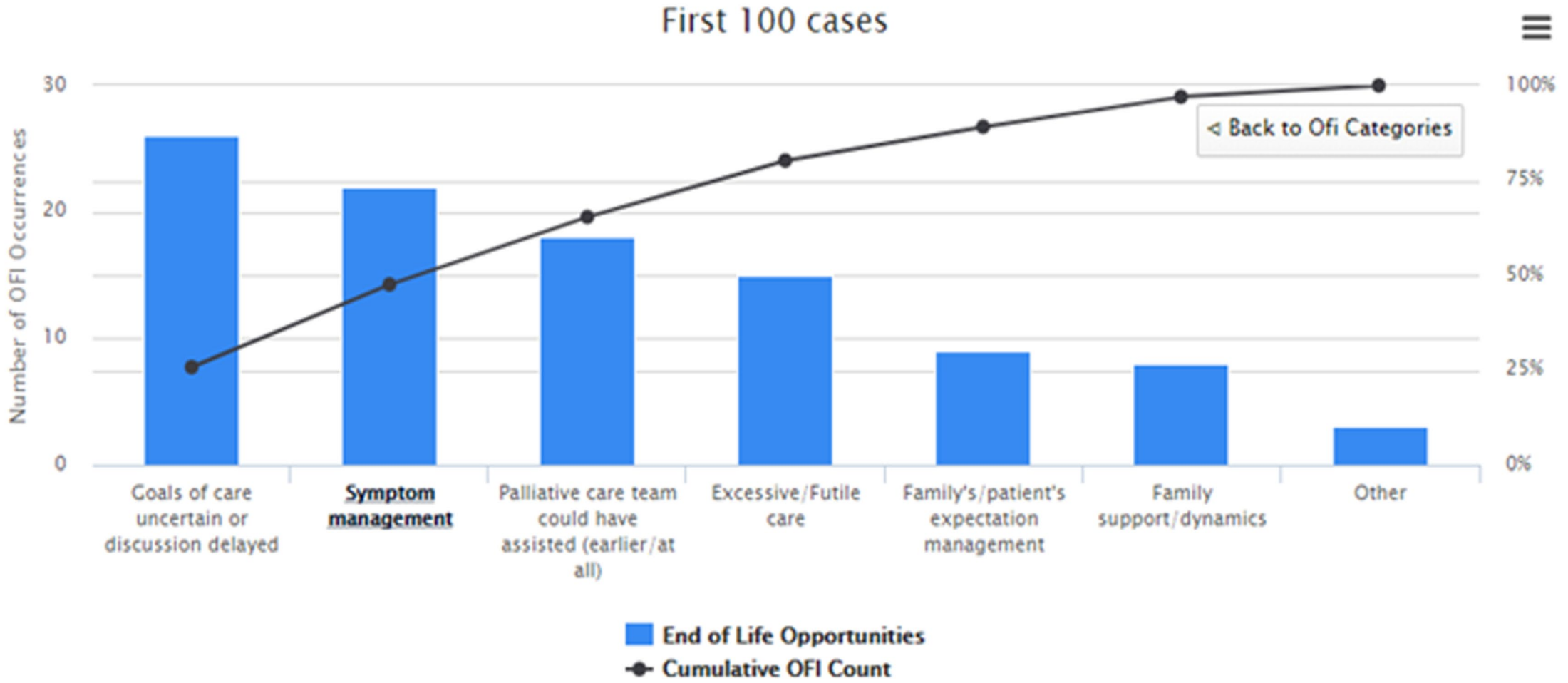
Eliciting patients values/fears/trade-offs critical to making recommendation.

QUESTIONS?

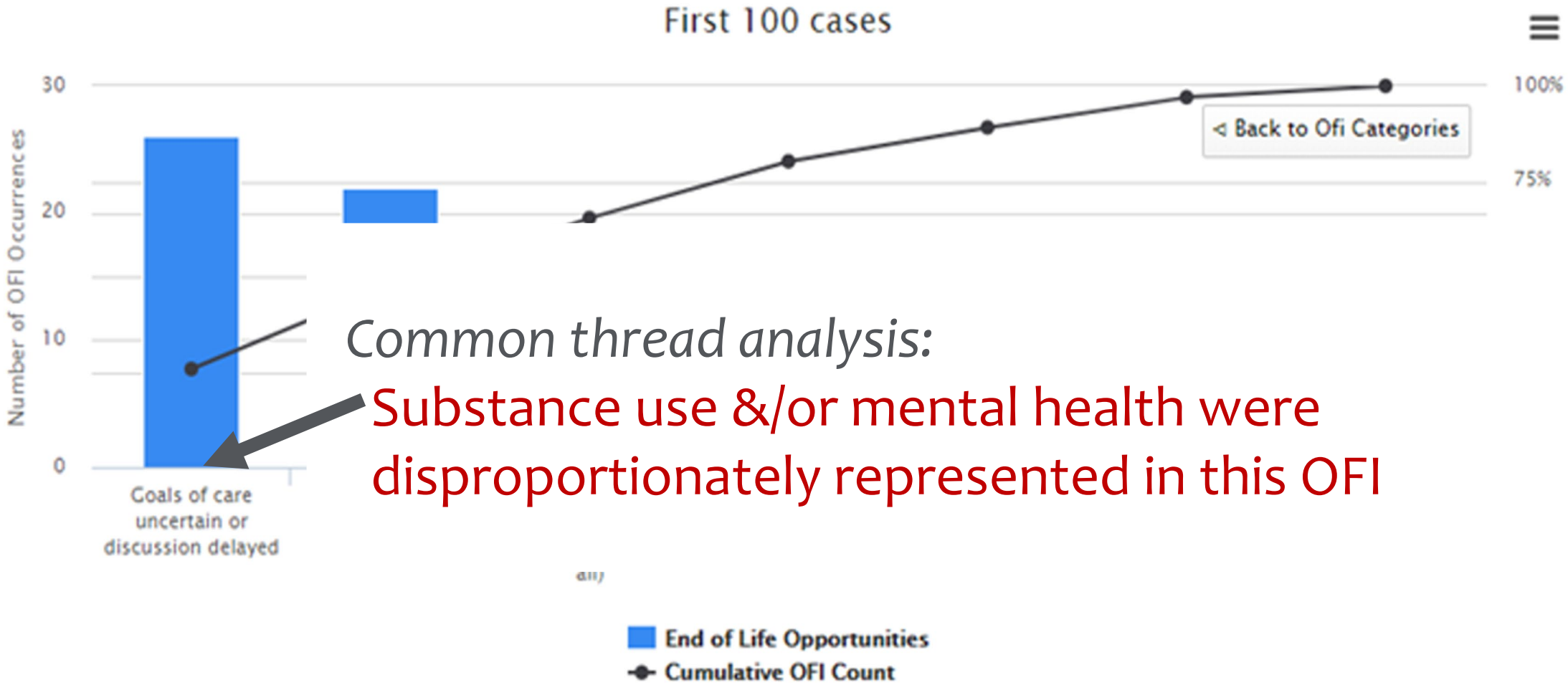
ST PAUL'S HOSPITAL MORTALITY REVIEWS 2019-22 'OPPORTUNITIES FOR IMPROVEMENT' *CATEGORIES*



ST PAUL'S HOSPITAL MORTALITY REVIEWS 2019-22 END OF LIFE 'OPPORTUNITIES FOR IMPROVEMENT'



ST PAUL'S HOSPITAL MORTALITY REVIEWS 2019-22 END OF LIFE 'OPPORTUNITIES FOR IMPROVEMENT'



Common thread analysis:

Substance use &/or mental health were disproportionately represented in this OFI


poverty
homelessness
dis(ability)
racism
colonialism
trauma &
violence
mental
illness
stigma
classism
criminalization
of illicit substances
sexism

WHAT IS STRUCTURAL VULNERABILITY?

Structural inequities refers to the systemic disadvantage of one social group compared to other groups. These inequalities are deeply embedded in the fabric of society.

Structural inequities limit peoples ability to achieve and maintain adequate health and well-being.

Bourgois, Holmes, Sue & Quesada, 2017

STRUCTURAL VULNERABILITY

“People experiencing structural vulnerability fall through the cracks [of the health care system], receive care either too late, or not at all, and typically experience less than ideal deaths.”

Stajdhuhar et al, 2019

What tools & resources can we provide to improve Serious Illness Conversations & EOL care for these patients?

Providence HEALTH CARE
How you want to be treated.

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

BC PATIENT SAFETY & QUALITY COUNCIL
Working Together. Accelerating Improvement.

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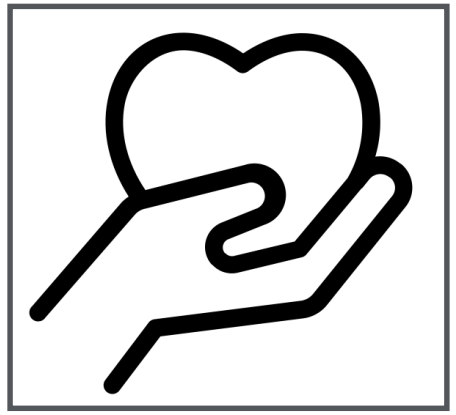
"Is there anyone that you would like included in our conversation, for example...(give options*)"

PAUSE to address any needs / locate supports before resuming.

EMBEDDED PRINCIPLES IN THE SIC FOR STRUCTURALLY VULNERABLE PATIENTS

OUR PIVOTAL ROLE AS HEALTHCARE PROVIDERS



Dzul-Church, 2010
Galvani, 2018

For structurally vulnerable clients living with serious illness, the role of health care provider is *more intimate* and *more significant* than the general population who often have more robust support networks.

Clients experience stigma accessing healthcare and have a lack of positive interactions with health care providers.

Clients cite feeling “unwelcome”, burdensome, and undeserving of care.

PRINCIPLE #1
TRAUMA & VIOLENCE INFORMED CARE

"...because he was institutionalized as a child and abused, he has great fear of being in an institution, even in a hospital… it feels like an institution.

People are in uniform… there is a regimented atmosphere… that provides triggers and he just feels like he can't stay."

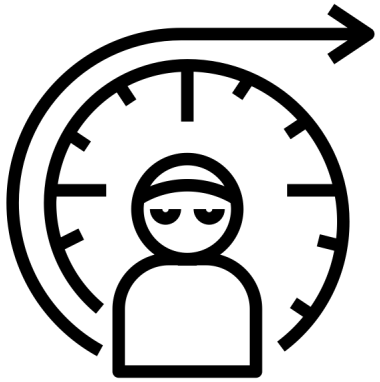
- Participant (Giesbrecht et al., 2018)

PRINCIPLE #2:
SELF AWARENESS & HUMILITY

This is necessary for the provision of trauma informed and culturally safe care for diverse cultures.

Providers must self-reflect if they are *equipped* to engage in a conversation about goals & fears in a trauma informed and culturally safe way. If not, don't do it, seek support & learn

Principle #3
Assess & Address Immediate Concerns



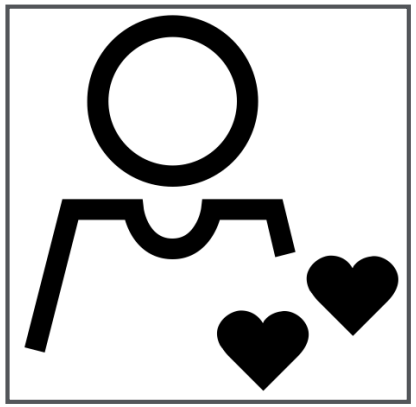
- May have difficulty looking at the future
- Focus may be more on daily survival (food, shelter, withdrawal, safety)

Start by assessing & addressing any immediate concerns

Ebenau et al., 2019
Giesbrecht et al., 2018
Webb, 2020

Principle #4
Focus on Being Relational

- Take time – you can't rush
- Validate & reflect understanding
- Non-judgemental
- Remain present & responsive to emotions
- Respect a need for control
- Be *authentic*



Principle #5
Be Impeccable with Your Word

Make sure to follow through on anything you say you will do

Do not promise things you cannot follow through on, as this will break rapport: If you say you will be back at 5pm, be back at 5pm.

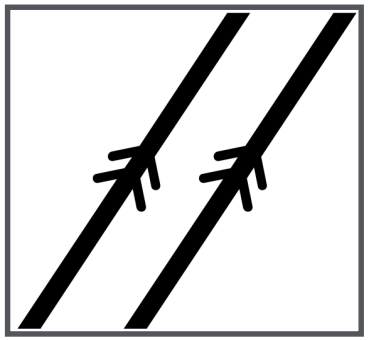
Principle #6
Think Parallel Care Planning

Hope and plan for the best, alongside planning for the worst

Don't frame treatment choices as an either/or decision

Not dependent upon the person being willing to talk about end-of-life.

Encourages planning for multiple approaches at once



Galvani, 2019
Hudson et al, 2016
Shulman et al, 2018

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Wallace Robinson – Lead ACP Providence Healthcare

Kelsey Antineff – Social Work, PHC.

Our Advisory Team who provided essential feedback and guidance throughout the development of this guide:

Barb Eddy (Nurse Practitioner – Downtown Community Health Centre)

Dr. Rose Hatala (Palliative Care)

Wendy Stevens (Peer Navigator – Vancouver Coastal Health)

Dr. Paxton Bach (Addictions Medicine)

Harvey Bosma PhD (Social Work – Palliative Care)

Dr. Stephane Voyer (Internal Medicine)

And the Department of Indigenous Wellness & Reconciliation at Providence Health Care

QUESTIONS?

ACKNOWLEDGEMENTS

Wallace Robinson

Lead – Advance Care Planning

PHC

Kelsey Antineff

IHCA

Prognostic association of frailty with post-arrest outcomes following cardiac arrest: A systematic review and meta-analysis.
Fabrice I. Mowbray, Donna Manlongat, Rebecca H. Correia, John Muscedere, Rachel Couban, Farid Foroutan. Resuscitation June 21, 2021 4 studies, 1134 patients, mean age 71

Frailty a/w 3 fold increased risk of death, reduced odds of discharge to home.

FRAILTY AND PERSISTENT CRITICAL ILLNESS

- Reason for being in the ICU is related to ongoing critical illness

Impact of frailty on persistent critical illness: a population-based cohort study.

Intensive Care Medicine 2022

Jai N. Darvall , Rinaldo Bellomo, Michael Bailey, Paul J. Young, Kenneth Rockwood and David Pilcher

- 269785 patients admitted to ICUs Australia and NZ

Hospital outcome	CFS 1-2	CFS 3-4	CFS 5-6	CFS 7-8
Death, *n* (%)	1834 (2.3)	6767 (4.8)	5390 (13)	2381 (25.6)
Home, *n* (%)	69,154 (87.2)	109,906 (78.7)	25,551 (61.5)	4498 (48.4
Per CI (%)	2205 (2.8)	4419 (3.2)	1739 (4.2)	451 (4.8)

- Mortality of PerCI 30.5% with frailty vs 18% without frailty