Optimizing Outcomes For Frail High Risk Seniors Through Specialist-Specialist and Primary Care-Specialist Collaborative Models

RGPsof Ontario
Perioperative Surgical Home For The Frail Elderly

Dr. Daniel McIsaac
The Ottawa Hospital
RGPs of Ontario
PERIOPERATIVE SURGICAL HOME FOR THE FRAIL ELDERLY

Daniel I McIsaac MD, MPH, FRCPC
“…multidisciplinary, team-based approach to patient-centered care that aims to reduce variability, provide continuity…ensure best-practice across the perioperative continuum of care”
▶ No conflicts of interest

▶ Program funding:
  • Canadian Frailty Network
  • University of Ottawa Department of Anesthesiology
  • TOHANO
  • Canadian Anesthesiologists’ Society
  • International Anesthesia Research Society

▶ Collaborators
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  • Hussein Moloo
  • Julie Nantel
  • Janet Squires
  • Monica Taljaard
  • Carl van Walraven
THE PERIOPERATIVE HEALTHCARE SYSTEM

Preoperative  Intraoperative  Postoperative
A COMPLEX SYSTEM

Preoperative

• Diagnosis
• Evaluation
• Decision making
• Care planning
• Optimization

Intraoperative

• Anesthesia
• Surgery
• Pain management
• Acute monitoring

Postoperative

• Pain management
• Recovery/rehabilitation
• Sub-acute monitoring
• Transition to community
• Return of normal function
A COMPLEX SYSTEM

- Diagnosis
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- Anesthesia
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Continuum of Care
PERIOPERATIVE FRAILTY

- Preoperative frailty predicts
  - Mortality
  - Morbidity
  - ICU admission
  - Length of stay
  - Institutional discharge
  - Self reported new disability
SO, YOU’RE NOT SURPRISED
The Association of Frailty with Outcomes and Resource Use After Emergency General Surgery: a Population-Based Cohort Study

Daniel I. McIsaac, Husein Moloo, Gregory L. Bryson, Carl van Walraven

Anesthesia & Analgesia, accepted
2 KEY OUTCOME MESSAGES

1. Early mortality risk
   • Day 1 20-30 times higher
   • Day 3 15-20 times higher
   • Markedly elevated for ~3 months after surgery

2. Loss of independence
   • 30-50% discharged to an institution
     - All community dwelling before surgery
   • 2-6 times increased relative risk
- IDENTIFY
- RISK STRATIFY
- DECISION SUPPORT
- OPTIMIZATION
- ENHANCED CARE PATHWAYS
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• DECREASE VARIATION
• SUPPORT BEST PRACTICE
• RISK RE-STRATIFICATION
Intraoperative

Preoperative

Postoperative

- IDENTIFY
- RISK STRATIFY
- DECISION SUPPORT
- OPTIMIZATION
- ENHANCED CARE PATHWAYS

- DECREASE VARIATION
- SUPPORT BEST PRACTICE
- RISK RE-STRATIFICATION

- MONITOR (pre- and post-discharge)
- ENHANCED RECOVERY
- IMPROVE CONTINUITY AND TRANSITIONS
STRENGTHS
WEAKNESSES
OPPORTUNITIES &
THREATS
Who Is Involved

STRENGTHS
- Multidisciplinary
  - MDs
  - RNs
  - KT/Imp Sci
  - Scientists

WEAKNESSES
- Insufficient patient engagement

OPPORTUNITIES
- People care about frailty
- System and Pt outcomes

THREATS
- Competing priorities
- Who’s patient is this?
Funding Sustainability

**STRENGTHS**
- Growing external/internal research funding

**WEAKNESSES**
- No institutional program funding

**OPPORTUNITIES**
- MOHLTC Innovation funding
- The iron is hot

**THREATS**
- QBPs (procedure, not patient-centered)
**Policy Support**

**STRENGTHS**
- Evidence-based framework and focus
- Best practice guidelines (ACS/AGS/BGS)

**WEAKNESSES**
- No standard hospital or ministry policy

**OPPORTUNITIES**
- Novel area of research
- Emerging team based and comprehensive care models

**THREATS**
- Frailty isn’t woven into healthcare policy-yet
STRENGTHS
- Buy in from clinical leads
- Motivated program lead

WEAKNESSES
- Silos
- Acute hospital-transition gap

OPPORTUNITIES
- Evaluation hotbed
- Built into hospital data systems

THREATS
- Competing interests
**STRENGTHS**

- Pt-oriented focus

**WEAKNESSES**

- No Shared Decision Making integrated to date

**OPPORTUNITIES**

- Ottawa-Decision making leadership

**THREATS**

- High prevalence of frailty
Patient Selection

STRENGTHS

• High prevalence of frailty
• Poor patient-centered outcomes

WEAKNESSES

• High-prevalence of frailty (40-50%)

OPPORTUNITIES

• Data to establish criteria

THREATS

• Resources needed to support some interventions for high risk frail elders
AGS Person-Centred Care

S - STRENGTHS
• Patient centered outcomes and processes
• Infrastructure for information flows

W - WEAKNESSES
• Co-ordination a work in progress
• How to ‘force’ care plan and goal review

O - OPPORTUNITIES
• Inter-professional team engaged
• KT/Imp Sci experts from day 1

T - THREATS
• Who’s patient is this?
• Outcome overload
FACILITATORS-A SUMMARY

• Everyone seems to ‘get’ frailty
  – Surgeons, other MDs, patients, …
• People are eager to get on board
• Research funders are engaged
• Momentum
  – For our local project
  – For improved care of frail and older patients generally
  – Comprehensive care models
CHALLENGES-A SUMMARY

• How do YOU define frailty?
  – How frail do you need to be for focused intervention

• $  
  – Continued research funding  
  – Institutional funds for long-term implementation

• Competing interests of collaborators
• Patient engagement
• Massive variations in care
• Designing a process for a continuum of care currently built in silos
THANK YOU
WHO IS INVOLVED

STRENGTHS
Multidisciplinary
Anesthesiologists
Geriatricians
Surgeons
Family Physicians
Scientists
Methodologists
Nurse Specialists
KT/Implementation
Science
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WEAKNESSES
Pt engagement
Just starting
Complexities
Competing interests
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- Pt engagement
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- Complexities
- Competing interests

### OPPORTUNITIES
#### PEOPLE CARE
- Frailty makes sense
- Pt engagement
- The iron is hot
- Outcomes speak
- PROMs
- KT approach
- Theory guided
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### THREATS
- Engagement
- Competing priorities
- Who’s Pt is it?
- The silos again
SUSTAINABLE FUNDING

STRENGTHS

External
Consistent & growing
x 3 years

Internal
Research funding
# SUSTAINABLE FUNDING

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OPPORTUNITIES
Innovation funding
Translation to clinical care
Pt engagement
We’re working on it
SPOR
Population dynamics
Ageing population

THREATS
If the research $ dries up
Increased challenge
Clinical budgets
QBPs
Decreased global budgets
LOCUS OF CONTROL

STRENGTHS
Buy in from clinical leads

Motivated leader
I guess that’s me
LOCUS OF CONTROL

STRENGTHS
Buy in from clinical leads
Motivated leader
I guess that’s me

WEAKNESSES
The silos
Shared patients
Surgeon,
Anesthesiologist,
+/- Geriatrician
No SDM
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WEAKNESSES
The silos
Shared patients
Surgeon, Anesthesiologist, +/- Geriatrician
No SDM
Too in-hospital

OPPORTUNITIES
SDM
Ottawa PtDA research group
Momentum of continuum of care
Emerging concept in perioperative care
Team buy in

THREATS
Loss of momentum
Increased challenge
Transitional care