HOMR as Prospective Trigger- Feasibility

- Specific threshold
  - Sens 59%, Spec 90%
  - LR+ 5.9, LR- 0.46
  - Site #1- 19 pts/d (15.8% of admissions)
  - Site #2- 7 pts/d (12.2% of admissions)
- Qualitative
  - Some enthusiasm from staff, minimal concern from patients
  - NO EMAILS!

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HOMR as Prospective Trigger- Feasibility

Group or Variable	Phase 1 (no notification)	Phase 2 (notification)	P value for difference
Age, mean (SD)	83.8 (7.9)	83.0 (7.8)	0.3[a]
Length of Stay, median (IQR)	5 (6)	6 (7)	0.8[b]
"No CPR" order on admission, n (%)	79 (40%)	75 (38%)	0.7[c]
Proportion with PC consult or documented early GOC discussion			
Site 1 - integrated notification, n (%)	20 (20)	35 (35)	***0.02***[c]
Site 2 - email notification, n (%)	53 (53)	45 (45)	0.26 [c]

- 89% Survived to hospital discharge
- 227/401 patients admitted (56.8%) with frailty-related condition
- 94/401 patients admitted (23.5%) chronic organ failure condition
- 80/401 patients admitted (20%) with cancer-related condition

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Qualitative Results

- Some physicians found prompts helpful, others expressed concerns of redundancy/frequency
  - *“As long as it’s not mandated, I think it’s a very good thing to have a reminder.”*
  - *[The notifications] would be most useful if they gave me information that I wasn’t already aware of. [...] And I suppose if there was a patient who I didn’t really think was at significantly high risk, and then, you know, this score tells me that they have a very high risk of dying in some short period, that might alter my approach.*

- Patients and family hoped mHOMR would prompt more communication with physicians
  - *“Notifications might benefit those who were less vocal in advocating for themselves.”*

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HOMR as Prospective Trigger- PC Needs

- Surveyed pts identified by HOMR tool
  - Severe Symptoms (ESAS Score >6)
  - Desire to speak to MD about ACP (ACP Engagement Tool)
- Comparison of different HOMR thresholds
  - HOMR >0.21 (Sens 59%, Spec 90%)
  - HOMR >0.10 (Sens 83%, Spec 77%)

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HOMR as Prospective Trigger- PC Needs

- 76% agreed to complete questionnaire
  - 91% patients, 9% family/SDM
- 10 week enrollment on general internal medicine ward:
  - HOMR threshold >0.10 flagged 22.6% of admissions
  - HOMR threshold >0.21 flagged 8.5% of admissions

Illness Trajectory	HOMR >0.10 (n=201)	HOMR >0.21 (n=75)
Cancer	73 (36%)	18 (24%)
Organ Failure	64 (37%)	30 (40%)
Frailty	40 (20%)	26 (35%)
Other	14 (7%)	1 (1%)

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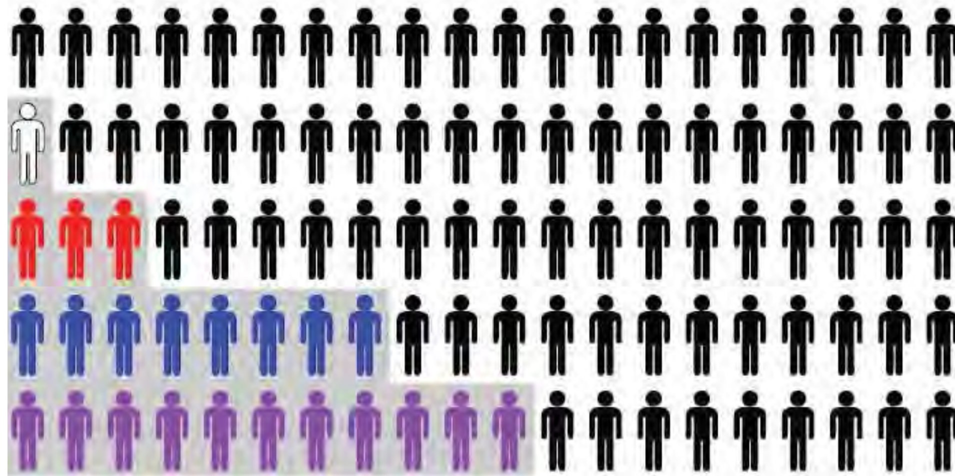
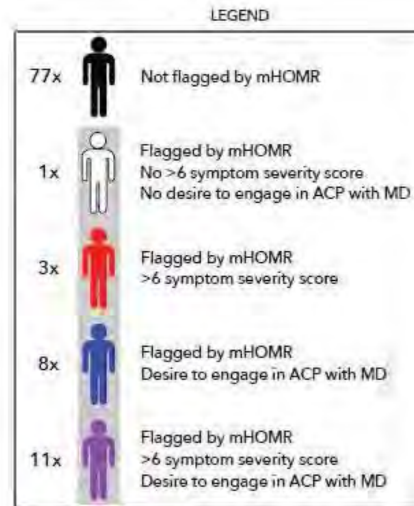
HOMR as Prospective Trigger- PC Needs

Unmet PC Need (n=186)	HOMR score 0.10-0.21	HOMR score >0.21	P value for difference
ESAS Symptom score >6 (%)	62	77	**0.03**
Desire to speak to MD about ACP (%)	82	74	NS
Either (%)	**94**	**91**	**NS**

HOMR as Prospective Trigger- PC Needs

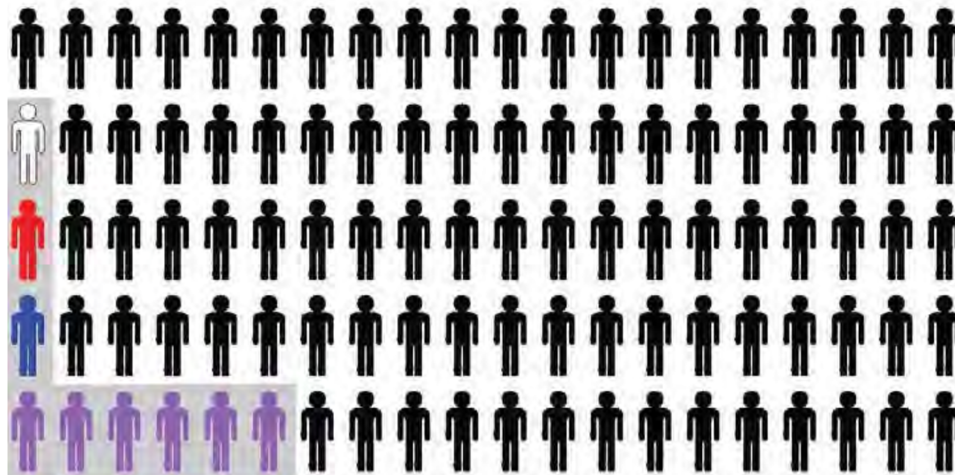
For every 100 admissions to GIM

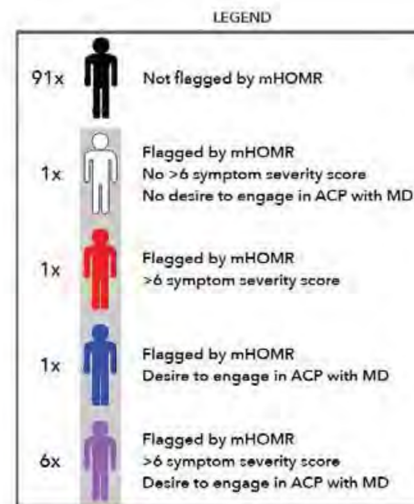




HOMR >0.10

For every 100 admissions to GIM





HOMR >0.21

Open Access | Protocol

BMJ Open

Algorithm for predicting death among older adults in the home care setting: study protocol for the Risk Evaluation for Support: Predictions for Elder-life in the Community Tool (RESPECT)

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ABSTRACT

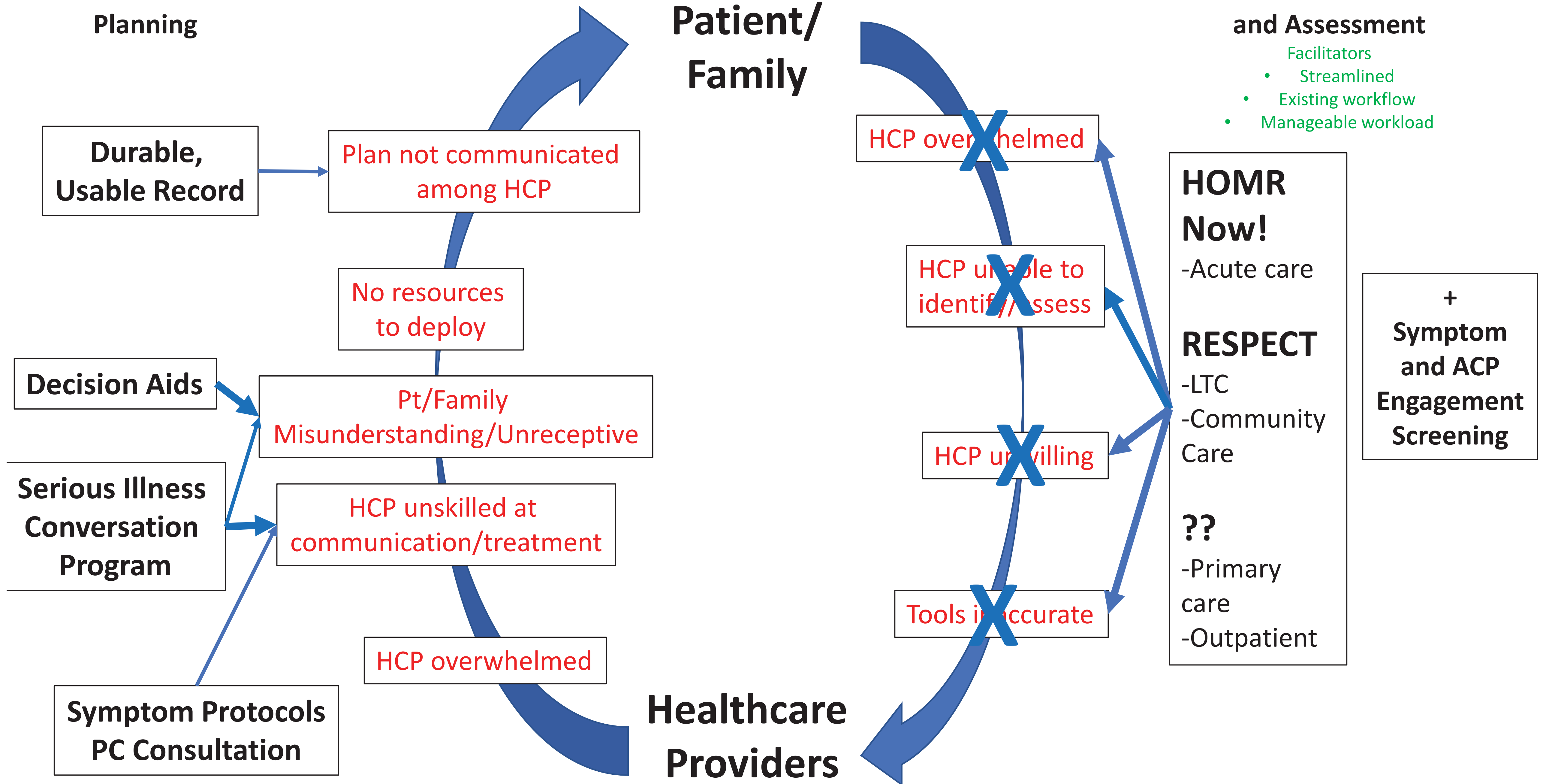
Introduction: Older adults living in the community often have multiple, chronic conditions and functional impairments. A challenge for healthcare providers working in the community is the lack of a predictive tool that can be applied to the broad spectrum of mortality risks observed and may be used to inform care planning.

Objective: To predict survival time for older adults in the home care setting. The final mortality risk

Strengths and limitations of this study

- Risk Evaluation for Support: Predictions for Elder-life in the Community Tool (RESPECT) will be developed using a large, routinely collected, population-level home care data set in Ontario, Canada (over 1.3 million home care assessment records between 2007 and 2014).
- RESPECT will improve the identification of people who are and are not near the end of life

Gratitude to Amy Hsu


Action and Planning
Patient/ Family
Identification and Assessment
Facilitators
Streamlined
Existing workflow
Manageable workload
Durable, Usable Record
Plan not communicated among HCP
HCP overwhelmed
HOMR Now!
-Acute care
No resources to deploy
HCP unable to identify/assess
Decision Aids
Pt/Family Misunderstanding/Unreceptive
RESPECT
-LTC
-Community Care
+ Symptom and ACP Engagement Screening
Serious Illness Conversation Program
HCP unskilled at communication/treatment
HCP unwilling
??
-Primary care
-Outpatient
Tools inaccurate
HCP overwhelmed
Symptom Protocols PC Consultation
Healthcare Providers

Key points

- No “magic bullet”
- No assessment/planning system will address certain barriers
  - Patient/family resistance
  - Lack of resources
  - HCPs too overwhelmed to act

HOMR- Conclusion

- Feasible and acceptable
- Identifies a small # of patients with high burden of unmet needs
- Preferentially identifies neglected groups (e.g. frail)
- Versatile- can adjust sensitivity based on capacity
- Possibly effective for changing care
  - Utility if connected to specific intervention- results pending
- Future direction
  - QI tool to drive specific interventions

Questions?

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Post-webinar survey

Survey will pop up on your screen after webinar

- **Feedback on how to improve webinar series**

Project contact

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Next webinar

http://www.cfn-nce.ca/news-and-events-overview/webinars/

- **Wednesday, February 6, 2019 at 12 noon ET**

  Cardiac Surgery among the Frail and Elderly Towards Optimal Decision Making – CFN-funded Frailty Measures Implementation Grant Program – Greg Hirsch, Nova Scotia Health Authority

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