Slow Medicine and Community Nursing: Building a Foundation for Community-based Eldercare

Dr. Dennis McCullough

Dartmouth Centers for Health and Aging

Hanover, NH USA

Presenter has nothing to disclose with regard to commercial relationships.

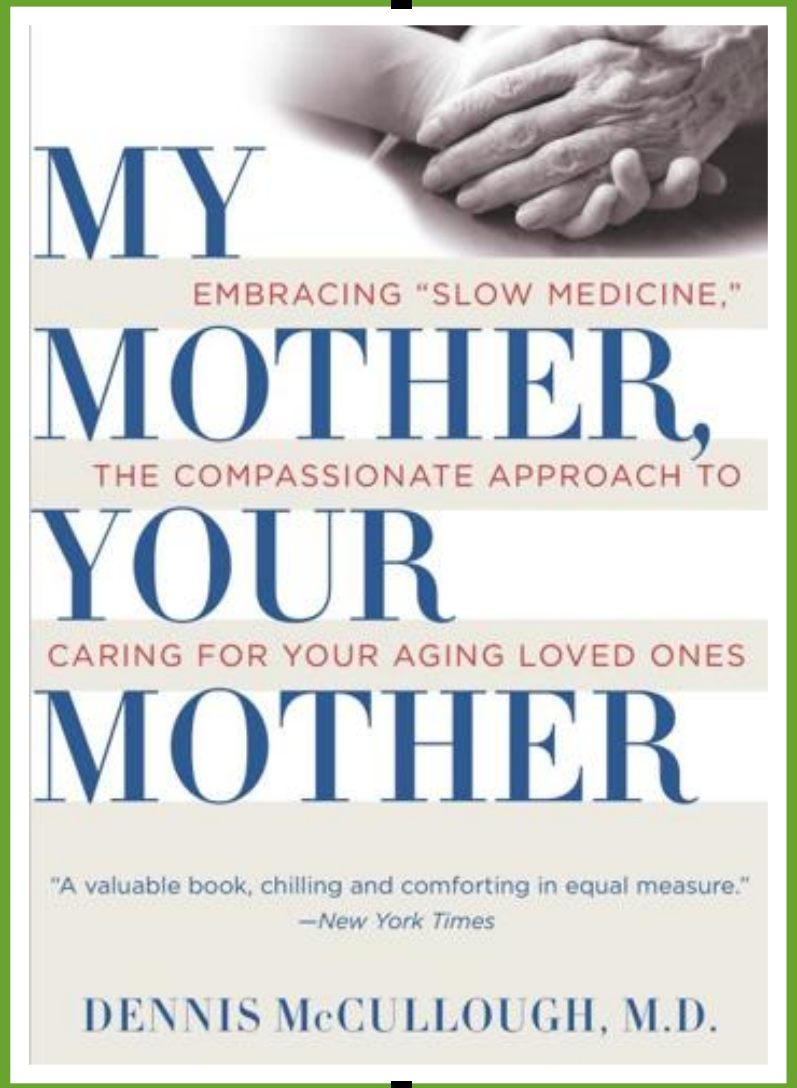
Canaries in a Coal Mine

Photo courtesy Mine Safety and Health Administration
U.S. Department of Labor

ITALY, SLOW FOOD, AND CARLO PETRINI: THE SOURCE OF THE "SLOW" METAPHOR

"The quest for *slowness*, which begins as a simple rebellion against the impoverishment of taste in our lives, makes it possible to rediscover taste."
(Carlo Petrini)

DR. ALBERTO DOLARA
“INVITATION TO A ‘SLOW MEDICINE’”
2002



My Mother, Your Mother:

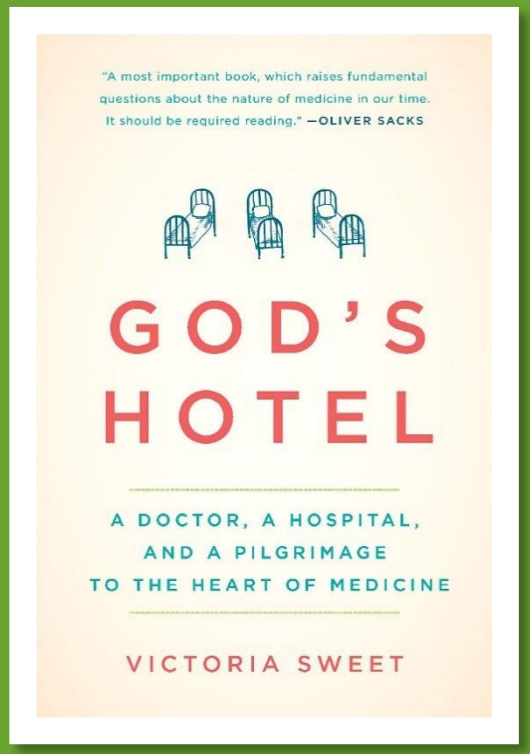
Embracing "Slow Medicine", the Compassionate Approach to Caring for Your Aging Loved Ones

Dennis McCullough, M.D.

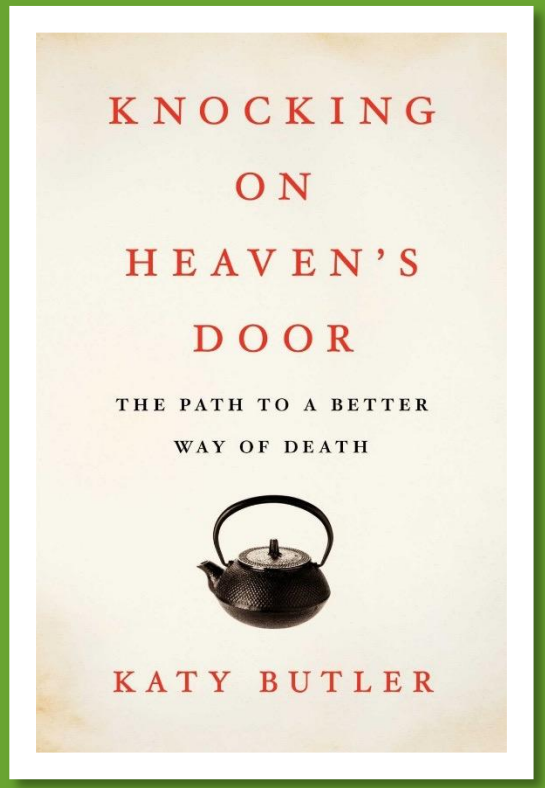
2008

www.MyMotherYourMother.com

SLOW MEDICINE(S) IN THE USA



Sweet, Victoria, M.D.,
God's Hotel: a Doctor, a Hospital, and a Pilgrimage to the Heart of Medicine,
New York: Riverhead Books, 2012
UNDERSTANDING COMPLEX CLINICAL SITUATIONS AND HEALING VIA SLOW MEDICINE



Butler, Katy,
Knocking on Heaven's Door: Our Parents, their Doctors and a Better Way of Death,
New York: Simon and Schuster, 2013.
SLOW MEDICINE AT THE END OF LIFE; HOSTS A SLOW MEDICINE FACEBOOK PAGE

Bauer, Ladd, M.D.,
History of Slow Medicine website—BROAD VIEW

Pieter Cohen MD and Michael Hochman, MD, MPH, Cambridge MA Health Alliance
EVIDENCE-BASED MEDICINE —UPDATES IN SLOW MEDICINE (FACEBOOK),

Complementary and Alternative Medicine using
“Slow Medicine” as new (alternative) term

Other Reform Movements (USA)

"Choosing Wisely"

"Right Care"—The Lown Institute

Roots of Slow Medicine for Elders

Kendal-at-Hanover

Geriatric Team Practice

Family-oriented care

Community-Oriented Primary Care (COPC)

The Dartmouth Atlas research

(hospice, palliative care)

Why Slow Medicine for Elders?

Demographics
Fragmentation of Care
Complexity
Uncertainty
Costs

FRAGMENTATION OF CARE:

more and more “-ists”

Special-ists

Hospital-ists

Transition-ists

SNF-ists

LTC-ists

Office-ists

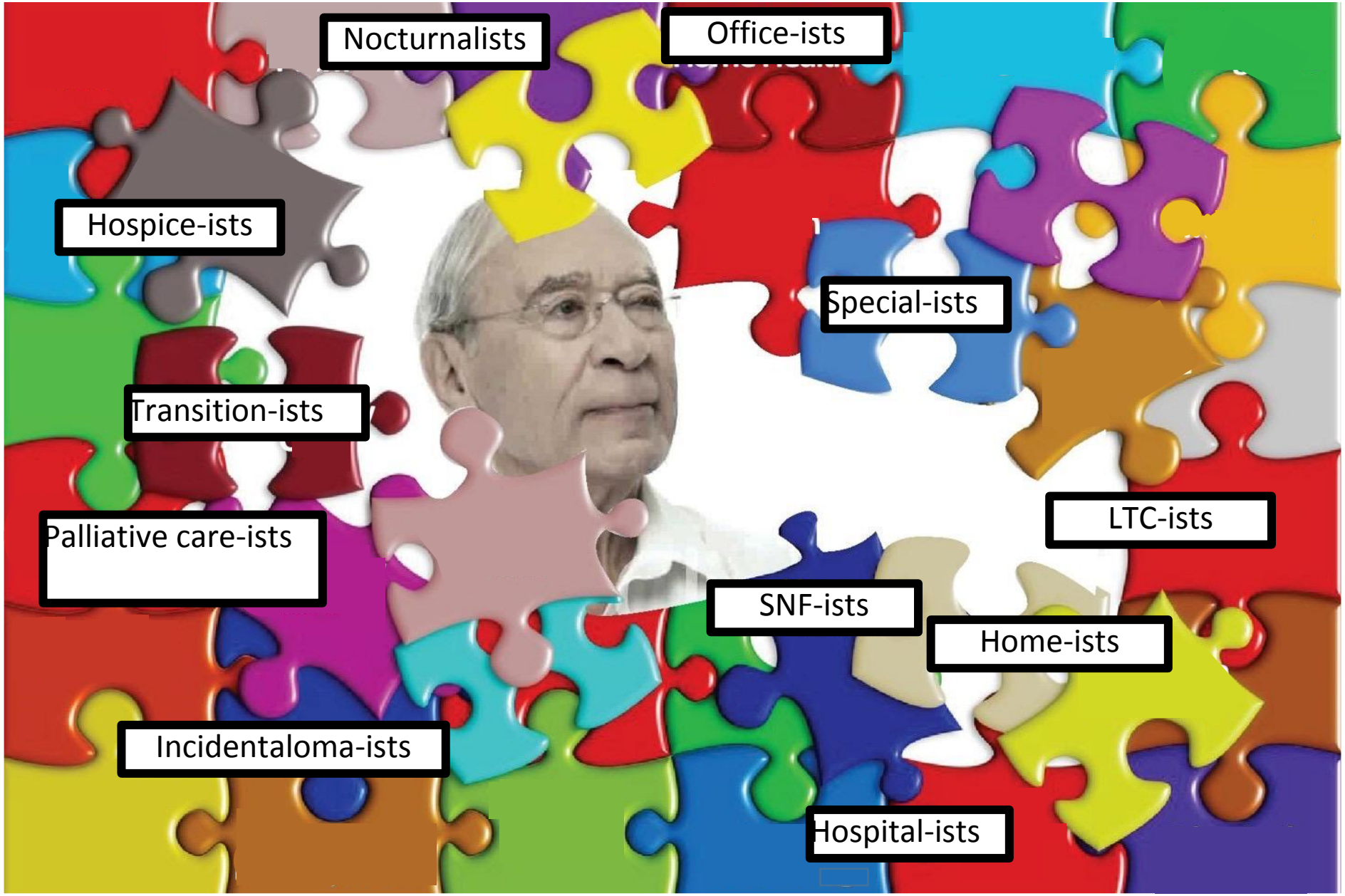
Home-ists

Palliative care-ists

Hospice-ists

Incidentaloma-ists

Nocturnalists


Nocturnalists
Office-ists
Hospice-ists
Special-ists
Transition-ists
LTC-ists
Palliative care-ists
SNF-ists
Home-ists
Incidentaloma-ists
Hospital-ists

Stability

"Everything is just fine, dear."-Mom

Compromise

"Mom's having a little problem."-Dad

Crisis

"I can't believe he's in the hospital"-Sister

Recovery

"She'll be with us for a while"
-Rehabilitation Nurse

Decline

"We can't expect much more."

-Visiting Nurse

Prelude to Dying

"I sense a change in her spirit."
-Nurse in Long-Term Care


Death
“You’d better come now.”
-Hospice Nurse

Grieving & Legacy

"We did the right things…"

-Brother

Slow Food Principles

Family Recipes, Local Ingredients

Simmering on the Back Burner

Large Table, Long Meals

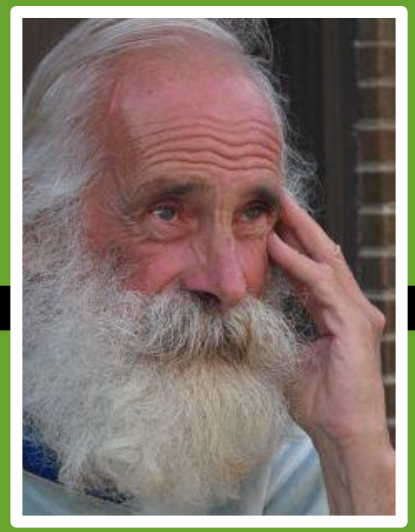
Slow Medicine Principles

Cultural Context and Patient & Family Values

Pacing ALL Eldercare Decisions

Enlarging Support

Sustaining Advocacy



For elders and families, Slow Medicine is a philosophy and a set of practices to improve quality of life and quality of care.

For doctors and other health professionals, Slow Medicine represents an improved way of understanding and guiding elders and their families.

AGS Guiding Principles for Management of Multimorbidity

Patient Preferences

Interpreting the Evidence

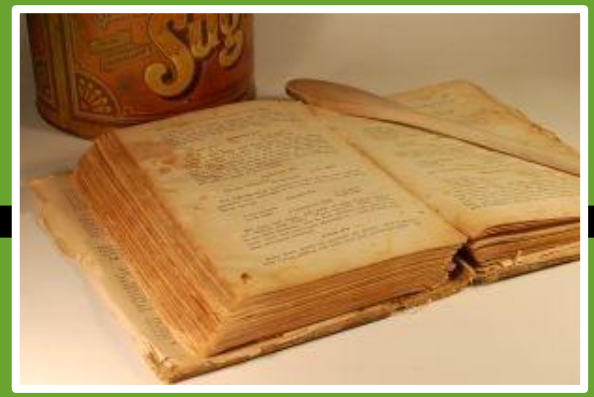
Prognosis

Clinical Feasibility

Optimizing Therapies and Care Plans

Patient Preferences

- A “deeper understanding” of the patient
- “Informing the patient” does not equal “understanding by the patient”
- Eliciting broad preferences is not medical decision-making
- Family, friends deserve involvement
- Preferences change over time (Kleinman)

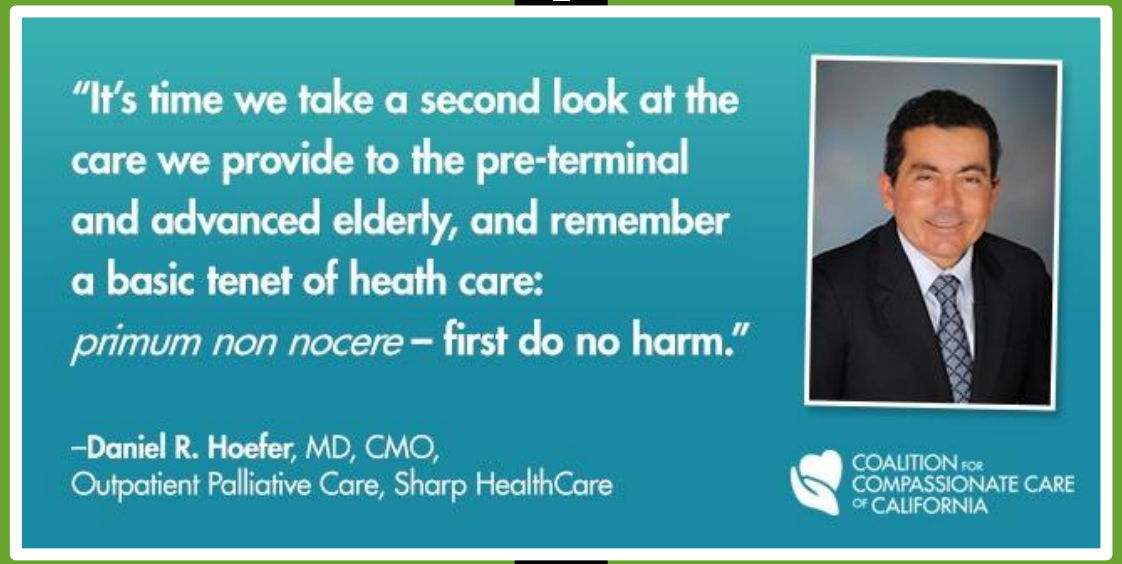


Evidence

- Much of care of chronically ill and frail is an “evidence-free zone”
- Clinical practice guidelines often in conflict

Prognosis

- An under-developed clinical skill
- A “springboard” to deeper discussions
- Dr. Daniel Hoefer, Sharp, California
  - use prognostication tools
  - hold all clinicians to a “Fifth Category” --SOAPP, not SOAP
  - How about a “Prognostic Batting Average”?



Clinical Feasibility

- Treatment complexity
- Treatment burden
- “Looks fine on paper, but impossible for elder, family, caregivers”

Optimizing Therapies and Care Plans

- “Promise medications”
- Polypharmacy
- Conflict resolution: doctors (not) talking to doctors
- Requires years of attention

Embedding Slow Medicine within Fast Medicine

Incorporate **GERONTOLOGY**, not just GERIATRICS

De-emphasize EFFICIENCY--focus on **SLOWED CLINICAL PROCESS**

Attend to **INDIVIDUAL** within CIRCLE OF CONCERN

“Side Effects” of Slow Medicine

- More control resides with elders and families
- Wider range of choices offered
- Humanistic caring
- Cost reductions

Challenges for Medical Systems

- Our future success resides in knowing how to better care for the chronically ill and frail.
- Embracing this task leads to more experienced clinicians and nuanced advising for elders.

- EOL and Late Life costs undermine our care systems
- 80% of people die after age 65
  - 20% at age 65-75
  - 30% at age 75-85
  - 20% after age

Upper Valley Community Nursing Project

Dennis McCullough, MD
Laurie Harding, MS, RN
ReThink Health 2014

What Is The Problem?

In the Health Care System:

Gaps in care for frail and chronically ill older people

Lack of connection between patient, family, health and medical care providers – we need “better glue”

Poor coordination of medical care

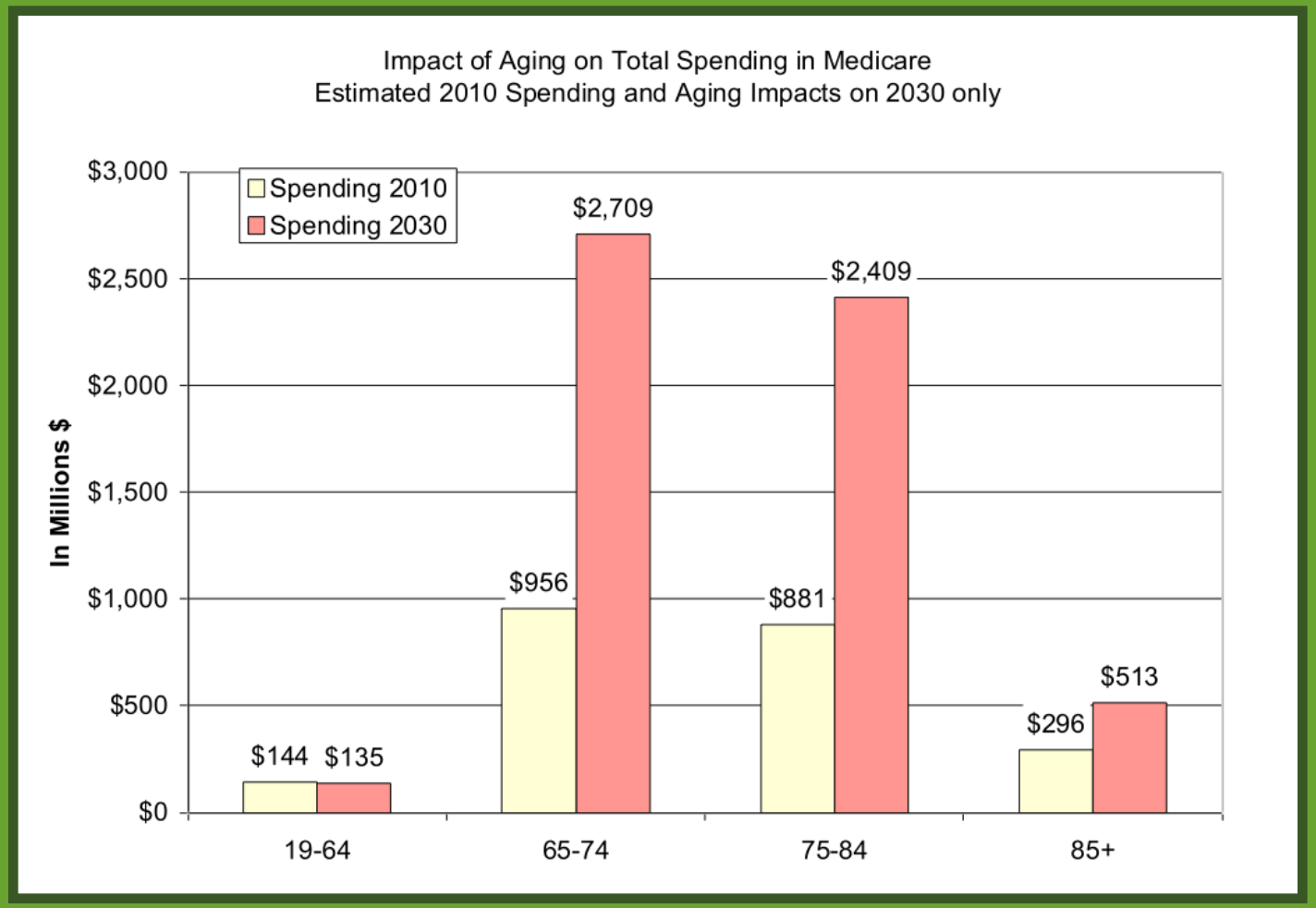
Elder care needs are not consistent with the way care is currently delivered

The Problem is also…

The Aging of the Population

The anticipated cost of health care for elders in the future
if we continue as we are today

Aging has Real Impacts on Medicare…



What We Know:

Successful Programs Are Built On

Relationships
Trust
Continuity (avoids duplication)
Compassion
“Close to Home” Care
24/7/365
(resembles family caregiving)

Source: FMEC 2013

UVCNP

Assisting communities in developing a community-based nursing program that is driven by need - not by reimbursement - and focuses on:

Medical/Social Problem Solving
Surveillance of High-risk individuals
Filling the Care Need Gap
Decreasing the Sense of Isolation
Avoidance of Emergent Care
Volunteer Support
Collaboration with Medical and Human Service Providers

How Does UVCNP Work to Address a Frail/Aging Population?

- Medical care institutions “build out and down” while UVCNP “builds in and up”
- Nurses based in communities, hired by the community, who work with volunteers
- Simple and similar job descriptions: licensed, experienced, familiar with the community and its resources and volunteers
- Focus on relationships and slow medicine approach to care
- Care coordination and intra-community referrals

In our quest for quality in the late years of life, Slow Medicine brings together the best “medical caring” with our age-old traditions of support and caring for elders and their families.

The Race for Quality and Sustainability