Government of **Western Australia**
South Metropolitan Health Service
Fiona Stanley Fremantle Hospitals Group

‘Service for Older Adults in Cardiology’

SOAC

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Clinical Lead SOAC

South Metropolitan Health Service respectfully acknowledges the past and present traditional owners of this land on which we are meeting, the Noongar people. It is a privilege to be standing on Noongar country.

We also acknowledge that the Aboriginal population in the South Metropolitan Health Service is diverse and includes Aboriginal people from many communities across Australia.

We also acknowledge the contributions of Aboriginal and non-Aboriginal Australians to the health and wellbeing of all people in this country we all live on and share together.

Understanding Aging In Older Adults

Chronological age

- Linear passage of time

Biological age

- Pathophysiological changes over time

A New Beginning

- Expansion of In-reach Services
  - ED Gold – Aug 2024
  - Oncology-Geriatrics ‘GRACE’ – Aug 2024
  - Cardiology-Geriatrics ‘SOAC’ – Aug 2024
  - OASIS Plus – Vascular / General Surgery / Burns - Nov 2024

Cardio-Geriatric Service
A Natural Collaboration Of 2 Specialties

Cardiovascular disease (CVD)→ leading cause of mortality & morbidity in older adults.[1]

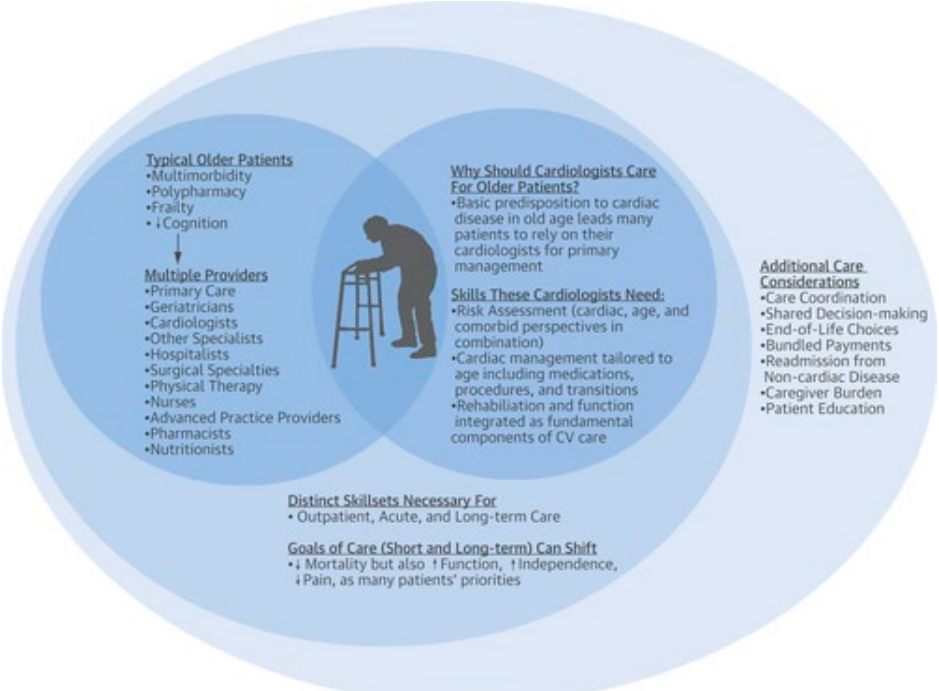
Demographic shift:

- Aging population – older/longevity
- Increasing prevalence of clinical & subclinical CVD

Increased survival - disease developed at younger age

- Incident disease mediated by pathophysiological risks with aging.

‘Geriatric Cardiologist’ – A Novel Approach



Susan P. Bell et al. *JACC* 2015; 66:1286-1299.

Bell, S.P. et al. J Am Coll Cardiol. 2015; 66(11):1286-99.

JACC
JOURNAL OF THE AMERICAN COLLEGE OF CARDIOLOGY

- Multimorbidity
- Multiple Providers
- Distinct Skill Sets
  - Outpatient, Acute, long-term care
- Appropriate Goals of care
  - Short term
  - Long term
- Holistic Approach

Future of Geriatric Cardiology

Proposed Care Model & Skillsets:

Cardiologists Caring for Geriatric Patients

Aim: “patient centered care”

Older adults →

- Reduced capacity to tolerate / desire medications
- Higher comorbidity affecting quality of life & survival
- Patient priorities: qualitative, functional objectives
- Management complexities
- Align intervention accordingly

Critical **Care** Gaps

Processes of care

Processes improving transitions:

- Readmission reduction programs

Continuity of cardiovascular care across care settings:

- Geriatric clinic without walls
- Goals of care discussions
- End-of-life care discussions
- Recognition of caregiver burden and crises

Geriatric Cardiology: A New Discipline?

ELSEVIER
JACC: Advances

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Journal Article

Geriatric Cardiology: Coming of Age

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THE JOURNEY OF

GERIATRIC CARDIOLOGY

1947
Framingham Heart Study

1948
Gerontology Branch of the National Heart Institute

1958
Baltimore Longitudinal Study on Aging

1970
Textbook: Management of the Geriatric Patient with Cardiovascular Disease

1972
Bogalusa Heart Study

1974
National Institute on Aging

1985
- Council on Geriatric Cardiology
- Laboratory of Cardiovascular Science (NIA)

1987
18th Bethesda Conference on Geriatric Cardiology

1989
Cardiovascular Health Study

1996
Geriatric Cardiology Education Retreat

1999-2008
Pivotal Research in Cardiology in the Elderly (PRICE) conference series

2007
Essentials of Cardiovascular Care for Older Adults geriatric curriculum

2010
ACC Geriatric Cardiology Leadership Council

2011
ACC Geriatric Cardiology Member Section

2014
Clinical Content Collection at ACC Geriatric Cardiology section

2015-21
ACC/AGS/NIA U13 Workshops in Older Adults with CVD

2022
JACC Advances

5 Essential Principles

Older Adults With cardiovascular disease

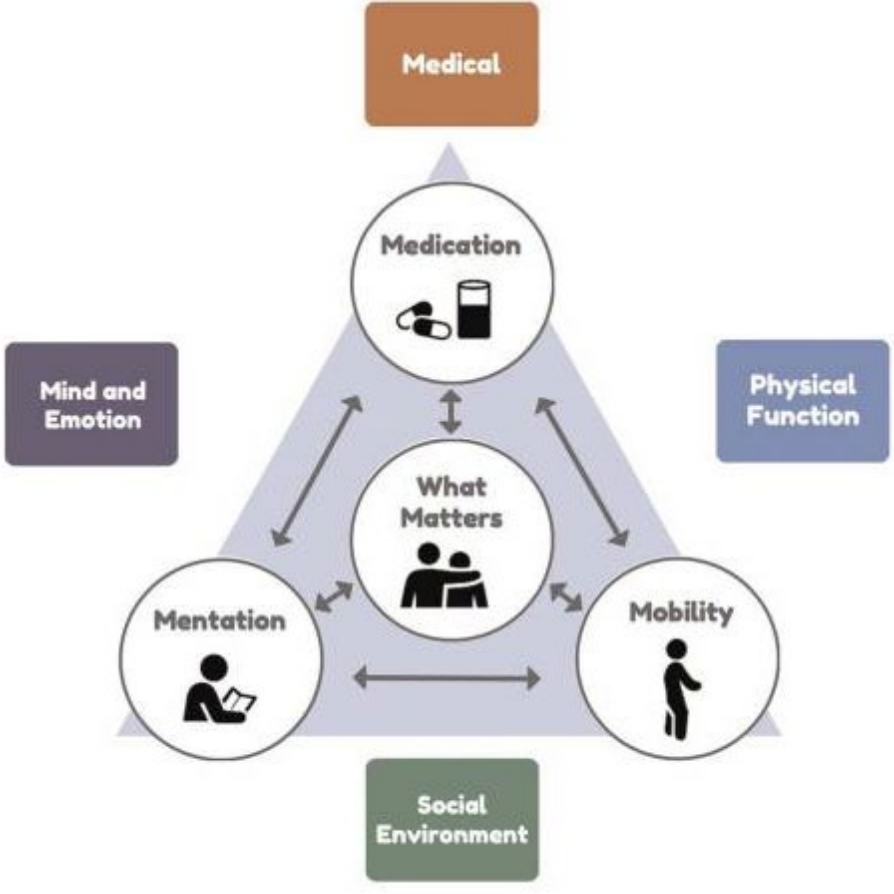
1. Recognize multicomplexity impact

Inclusive decision-making : 3 factors

- Cognition
- Physical function
- Social environmental factors

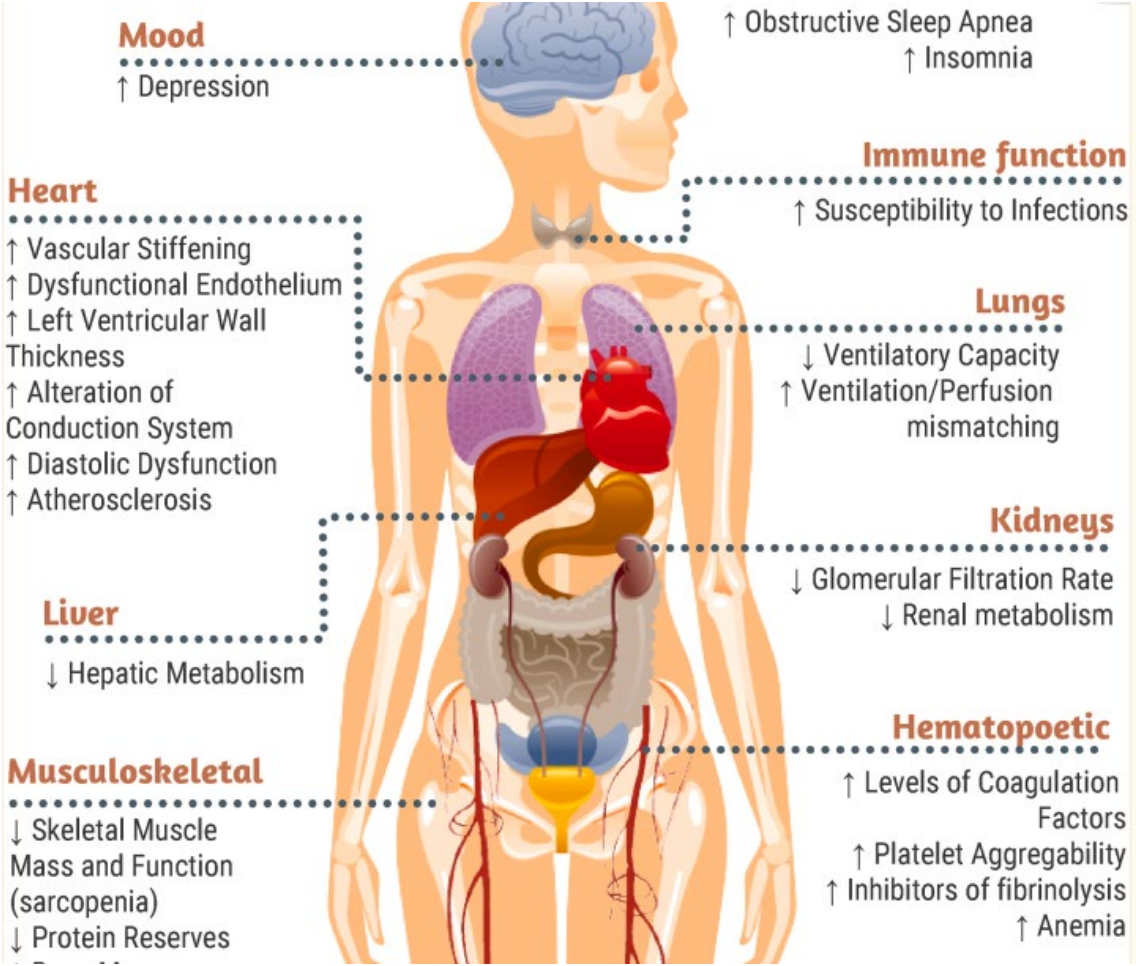
5. Care Plan→ Patient priorities & health goals

CENTRAL ILLUSTRATION: Conceptual Framework for Geriatric Cardiology



Caring For Older Adults With CVD

Physiological Changes With Aging



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.

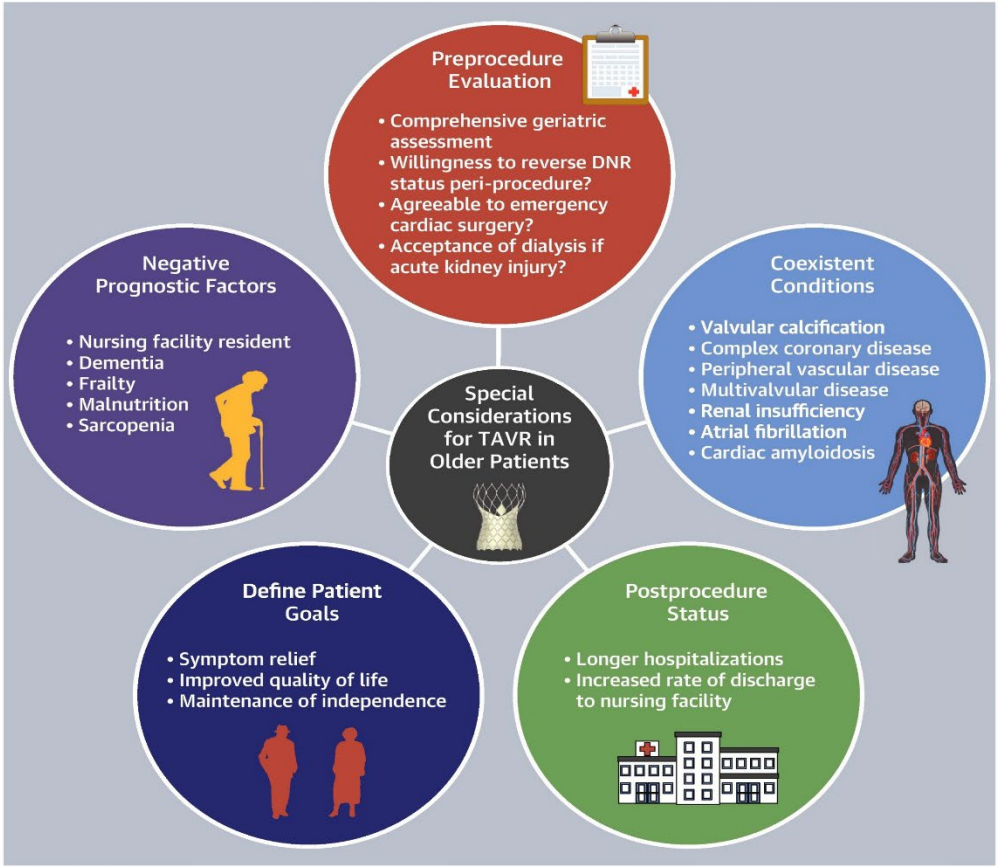
In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

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

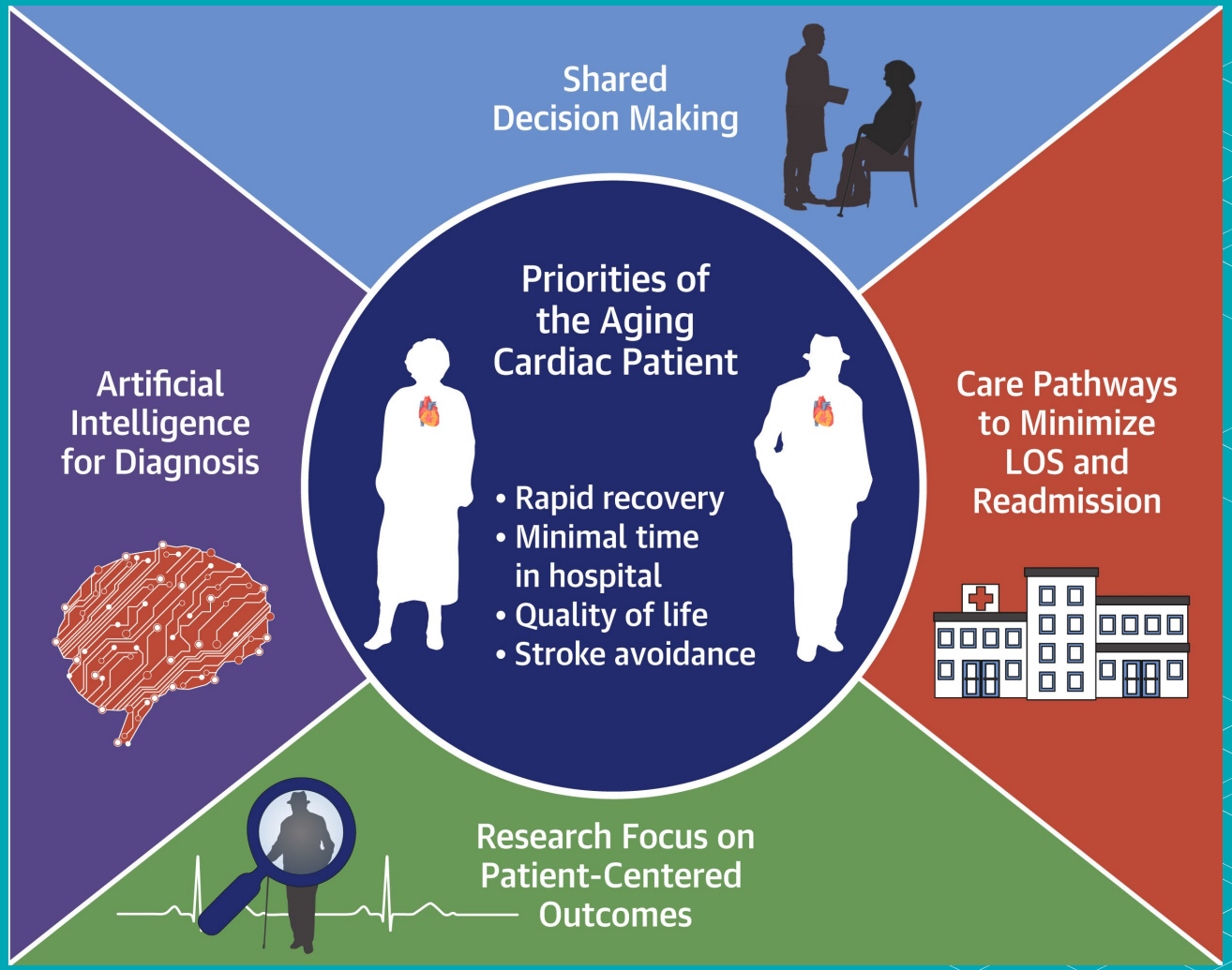
* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

DALHOUSIE UNIVERSITY
Inspiring Minds

CENTRAL ILLUSTRATION: Special Considerations for TAVR in the Older Adult Population



Damluji AA, et al. J Am Coll Cardiol Intv. 2024;17(8):961-978.


Shared Decision Making
Artificial Intelligence for Diagnosis
Priorities of the Aging Cardiac Patient
• Rapid recovery
• Minimal time in hospital
• Quality of life
• Stroke avoidance
Care Pathways to Minimize LOS and Readmission
Research Focus on Patient-Centered Outcomes

SOAC: The Service

- On site Geriatrician & Registrar
- In reach SOAC: 3 days
  - Tue/Wed/Fri: Coronary Care Unit & 4D Ward
- Referral pathway
  - e referral> FSH> Geriatric Medicine> Medical
  - Registrar pager 28713 Mon-Fri 9am-5pm
- Referral reason:
  - Rehabilitation – hospital wide
  - Discharge planning – hospital wide
  - Comprehensive geriatric assessment – CGA specific to SOAC
  - Geriatric syndromes - specific to SOAC
  - Prehabilitation – work in progress
    - Virtual LifeFit SurgFit Prehabilitation Education Program (health.wa.gov.au)

Patient Subacute Catchment

Area Codes – ***No Magic Wand..***

Smart approach:

SOAC e-referral

Suitability for rehab assessed

Cardiology intern calls outreach hospital

Accepting consultant name recorded on digital medical record

Cardiology nurse unit manager to waitlist for Fremantle Hospital (FH) while awaiting other subacute bed

FH rehab discharge coordinator follow up bed status

FSH Older Adult Medical Sub-Speciality In-Reach Service

Inclusion criteria

- All medical subspecialty inpatients >65 yrs or >50 yrs ATSI and of all other ethnicity
- Those with CFS >4, Geriatric Syndromes, multimorbidity, inadequate social support, polypharmacy (>5 medications) and complex discharge needs

Clinical frailty scale

Exclusion criteria

- Patients admitted under shared care with another medical sub-specialty

Key benefits:

- Increased efficiency of patient flow through patients having timely access to general conditioning and geriatrician-led care
- Increased patient & staff satisfaction
- Improved safety & quality of patient care
- Decreased burden on staff to address frail older adult concerns & geriatric syndromes requiring specialist input
- Anticipation of therapeutic complications and strategies aiming to reduce key HAC's eg arrhythmia, delirium, deconditioning

ATSI – Aboriginal and Torres Strait Islander

HACs – Hospital Acquired Complications

FSH Older Adult MEDICAL Sub-Specialty In-Reach Service → SOAC

Enhanced recovery protocols

1

Pre-Treatment

- Comprehensive Geriatric Assessment (CGA) to identify vulnerabilities
- Nutritional optimisation & counselling
- Prehabilitation with personalised exercise programs to improve fitness

2

During

- Optimal management tailored with person-centred care
- Management of therapy-related effects with proactive measures
- Regular monitoring onsite until discharge

3

Post Treatment Phase

- Early mobilisation and physical therapy to maintain strength and function
- Regular follow up assessments to monitor recovery and address complications

FSH Older Adult Medical Sub-Specialty In-Reach Service SOAC

Service Provision

1. Regular Comprehensive Assessments

- Frequent CGA and frailty assessments to tailor patient care plans

2. Standardised Pathways for common conditions

- Delirium Management: Protocols for early identification, prevention and treatment
- Falls Prevention: Comprehensive fall risk assessments and intervention plans
- Pain Management: Standardised pain assessment and multimodal pain management strategies
- Nutritional Support: Protocols for nutritional screening and intervention to prevent malnutrition
- Cognitive assessment
- Disposition planning
- ACAT

3. Stressing the Significance of early mobilisation programs:

- These programs play a vital role in preventing deconditioning and maintaining patient mobility, contributing to their c health and well-being

ACAT – Aged Care Assessment Team

FSH Older Adult Medical Sub-Specialty In-Reach Service SOAC

4. Inpatient Rehabilitation Services at Fremantle Hospital

- Access to physiotherapy, social worker, occupational therapy and speech therapy within the ward

5. Family Involvement

- Engage families in care planning and decision-making processes

6. Regular Multidisciplinary Rounds

- Bi-weekly ward rounds involving the entire care team to discuss patient progress and adjust care plans and attend MDT once weekly (Tuesday) to discuss patient progress and adjust care plans.

MDT – multidisciplinary team

New Frontiers & Horizons

- Geriatricians with skills in acute medicine
- Footprint by invitation to subspecialties at FSH – surgical / medical
- FSFHG → evolution of subspecialty care for older adults
- Collaborative teams
  - tertiary to quaternary geriatric medicine
- Pushing boundaries with new services
- Integrating Outpatient Prehabilitation collaborative models
  - Virtual LifeFit SurgFit Prehabilitation Education Program (health.wa.gov.au)

As we ride the crest of expanding aging demographics Geriatric cardiology is evolving as the appropriate approach for this challenge.

Thank you!

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