PATIENT-CENTERED, GOALS-BASED GERIATRIC CARE

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(T Fried and M Tinetti AJM 2004)
DISCLOSURES

• No conflicts of interest
DIFFERENT APPROACHES: DISEASE-ORIENTED VS. INTEGRATED, INDIVIDUALLY TAILORED
DISEASE-ORIENTED MODEL

- Developed late 19\textsuperscript{th}, early 20\textsuperscript{th} Centuries
- Life expectancy mid-40s
- Era of acute illness: recovery or death
DISEASE-ORIENTED MODEL, cont.

- Patient presents with chief complaint
- History and physical exam
- Labs and other studies
- Differential diagnosis
- More labs and studies
- Diagnosis → Treatment
PROBLEMS WITH THE DISEASE-ORIENTED MODEL

• **UNDERTREATMENT**
  – Reluctance to treat symptoms if single etiology is not found
    • Depression not meeting DSM criteria
    • Chronic dizziness
    • Chronic pain
  – Non-physiologic causes/risk factors not recognized
    • Coronary disease $\rightarrow$ drugs, cardiac cath
PROBLEMS WITH THE DISEASE-ORIENTED MODEL, cont.

• OVERTREATMENT
  – Clinical guidelines, medical culture, other influences may demand multiple treatments
  – Resulting polypharmacy and other iatrogenic risk
  – Example: a patient with DM, heart failure, CAD, hypertension, osteoporosis “requires” 15 medications
PROBLEMS WITH THE DISEASE-ORIENTED MODEL, cont.

• MISTREATMENT
  – Results from focus on disease-specific outcomes instead of patient preferences
  – Example: 90-yr community-dwelling woman admitted for pneumonia
    • One week of hospitalization ➔ improved O2 saturation and reduced WBC count
    • Unfortunately discharged to SNF
21st CENTURY AMERICAN HEALTH CARE

- Life expectancy 74 years
- Clinical encounters for patients with multiple, chronic illnesses
CURRENT ERA, cont.

- Unclear linkages between pathology and clinical manifestations
- Complex biological / non-biological interplay
- Survival may require burdensome interventions, in less desirable health states
INTEGRATED, INDIVIDUALLY-TAILORED (IIT MODEL)

- Patient presents with complaint(s)
- Evaluate the 3 T’s
- TROUBLE: How does it trouble you? (Physical, psychological, social)
- TRADEOFFS: Potentially conflicting goals (Survival, function/independence, comfort)
- TEARS: Psychological and social context
INTEGRATED, INDIVIDUALLY-TAILORED, cont.

- Propose and negotiate interdisciplinary treatment plan after knowledge of 3 T’s is acquired
COMPARE AND CONTRAST: FOCUS OF CLINICAL DECISIONS?

- DISEASE MODEL: The disease! (Its diagnosis and treatment)
- IIT: patient priorities and preferences
CAUSE OF HEALTH CONDITIONS?

- **DISEASE MODEL:** The disease! (“Pathology”)
- **IIT:** Interplay of genetic, environmental, psychosocial factors
TARGET OF TREATMENT

• DISEASE MODEL: The disease!
• IIT: Modifiable factors contributing to the health conditions that affect patient goals
SYMPTOMS AND IMPAIRMENTS

- **DISEASE MODEL**: Best addressed by treating the disease!
- **IIT**: These ARE the primary foci of treatment (whether or not they can be attributed to disease)
CLINICAL OUTCOMES TO TRACK

- DISEASE MODEL: determined by the disease: HbA1c, BP, mortality
- IIT: determined by individual patient goals: energy, appetite, gait, survival, independence
PRIMARY FOCUS

- DISEASE MODEL: survival
- IIT: several competing goals, perhaps including survival
CASE 1: MRS. C HAS HYPERTENSION

- 88 yo woman followed by general internist in highly-rated staff model HMO
- PMH: DM 2 (last A1c 7.8), htn, knee OA, macular degeneration
- MEDS: glipizide 5 qd; MVI; acetaminophen 650 tid; lisinopril 20 qd; ASA 81 qd; ibuprofen prn
CASE 1, cont.

- **SH:** Retired history teacher, widow, active as volunteer docent at Victorian mansion. No smoking, one glass of wine most evenings.
- **PE:** Lying 168/78 76 Standing 148/72 Well-dressed and –groomed, thin but spry, requires two tries to arise w/o arms, gait otherwise normal.
- **LABS:** CBC normal Cr 1.2
- **ECG** → LVH
CASE 1, cont.

• Patient and provider motivated to improve blood pressure control
• Wine discontinued: no significant improvement
• Ibuprofen discontinued: BP 158/72
Case 1, cont.

- Lisinopril increased to 30 qd: BP 132/62, with mild orthostatic lightheadedness, aggravated by ambulating and stairs.
- Put to work in gift shop, quits volunteer work 2 months later.
- Doctor “made me age before my time.”
CASE 2: YOU CAN BE TOO THIN

- 77 yo woman presents to ER following third fall in a week. All mechanical, associated with transfers.
- Feels weak, fatigued, no other complaints
- Admitted for “FTT”, ER doctors says “she has cancer somewhere….”
CASE 2, cont.

• PMH: Htn, hand and knee OA, mild diastolic CHF, mild COPD, constipation, anemia, remote smoking history
• MEDS: Furosemide, albuterol/ipratropium, senna, FeSO4
• SH: Widow, lives in mobile home, son visits 1-2 weekends per month, watches soap operas religiously
CASE 2, cont.

- PE: VS normal. Pleasant, elder WF, nl affect, thin (temporal wasting, squared-off shoulders, globally diminished muscle bulk). Heart, lungs, abdom, extremities normal, aside from 1+ edema.
- Requires arms to arise, wide-based slow gait, discontinuous turn, falls into chair.
- Strength 4+/5 globally, other neuro wnl
- MMSE 29, GDS 3
CASE 2, cont.

- LABS: CBC nl Lytes nl BUN 23 Cr 0.8
  Normal LFT, Ca, Mg, Phos Alb 3.3
- CXR hyperinflated, otherwise (-)
- UA → 10 rbc, 3-5 wbc Urine cx (-)
• Additional studies:
  – TSH 3.3  Fasting glucose nl X 2
  – ESR 45
  – Blood cultures X 2 negative
  – Fecal fat (-)
  – Abdominal CT → gallstones without GB inflammation, otherwise unrevealing
  – Urine cytology negative
  – Cystoscopy negative
CASE 2, cont.

• Patient’s NP returns from vacation overseas, visits patient and hospital team
• Patient widowed 18 months previously, son moved out of city around same time, and she hasn’t touched stove since
CASE 2, cont.

- Resolution: Discharged home with PT, Meals on Wheels, Nutritionist follow-up
- Son calls most nights
- Joins church group with frequent pot lucks
- Weight up 20# over 3 months
CASE 3: WHEN THE GOALS ARE A PROBLEM

• 69 yo man referred to Geri Clinic from rural PMD for cognitive assessment
• Several years of forgetting people’s names, concentrating on writing life history. Remembers to pay bills, but not keep up with filing
• +Insomnia, +fatigue, +poor concentration, no suicidal ideations or thoughts of death
CASE 3, cont.

- PMH: Chronic pain (lumbar stenosis, radiculopathy), OA, sober EtOHic, BAD, Alzheimer’s disease, prostate cancer, et al
- Notes: changed physicians when PMDs have been unwilling to treat several reported problems
CASE 3, cont.

- MEDICATIONS: Oxycodeone SR, carisoprodol, celecoxib, tamsulosin, trolterodine, loratadine, B12 inj, donepezil, doxepin, alprazolam q6h, fluoxetine, docusate, ranitidine, guaifenesin, omeprazole, atorvastatin, valerian, pancreatic enzymes, ....
CASE 3, cont.

- SH: Lives alone in ALF with cat, former substance abuse counselor and LPN, never married, assisted his mother in caring for his father with dementia. Receives Meals on Wheels. No EtOH for 27 years.
CASE 3, cont.

- **PE:** Obese, pleasant, alert, interactive, redirectable.
- **MMSE 19/30 (errors: date, floor, serial 7, 0/3 recall)**
- **GDS 7/15**
- **Impairment on Trails B**
- **Examiners concerned about his effort**
CASE 3, cont.

• IMP: ?Drug effect, EtOH history, depression, doubt BAD and AD, investment in patient role
• Recommend: Stop/taper carisoprodol, doxepin, alprazolam, ranitidine, donepezil
• Frequent contact with PMD, Pain Clinic
CASE 3, cont.

- Follow-up: Continued somatic complaints, became constipated after stopping medications
- Medications resumed