Key Issues in the care of older patients with cancer

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Key issues

- Defining characteristics of older patients
- Problems of multiple physicians and sites of care
- Potential solutions

Geriatric patient

- 80 year old woman, lives with daughter
- Comorbidities: hypertension, diabetes, atrial fibrillation, mild osteoarthritis, osteopenia
- Mild-moderate cognitive impairment:
  - knows family, pleasant and interactive
  - goes to church and family gatherings
  - unsteady gait, has had several non-injurious falls
  - supervised ADL's, unable to do IADL's
- CLL

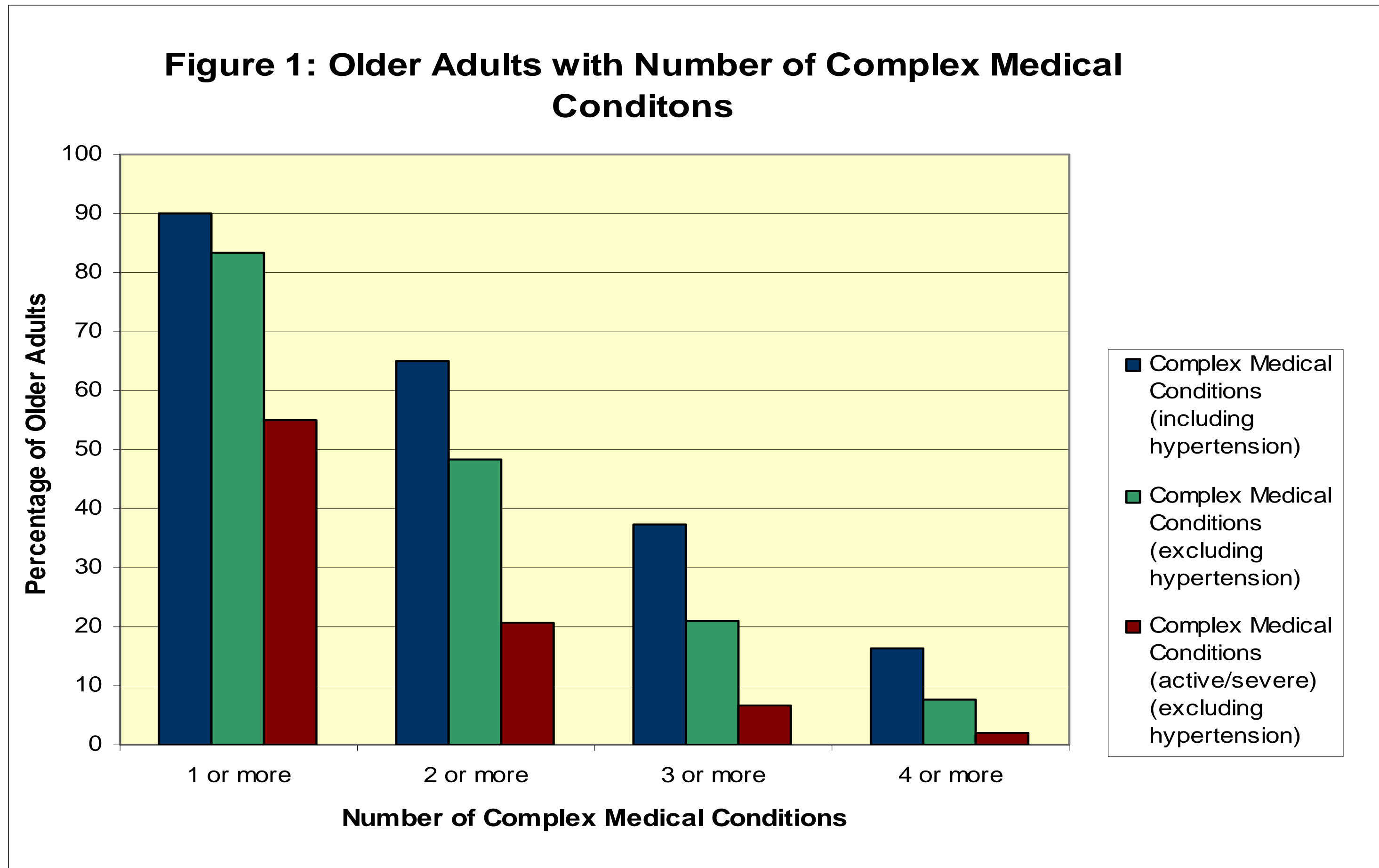
Evidence-based polypharmacy

- 1986
  - Digoxin
  - HCTZ
  - Tylenol
  - 12 U lente insulin

- 2006
  - Metforman
  - Glypizide
  - Rosiglitizone
  - HCTZ
  - Metoprolol
  - Lisinopril
  - Amlodipine
  - Lipitor
  - Aricept
  - Namenda
  - Ibuprofen
  - Protonix
  - Actonel
  - Ca/vitD
  - Coumadin

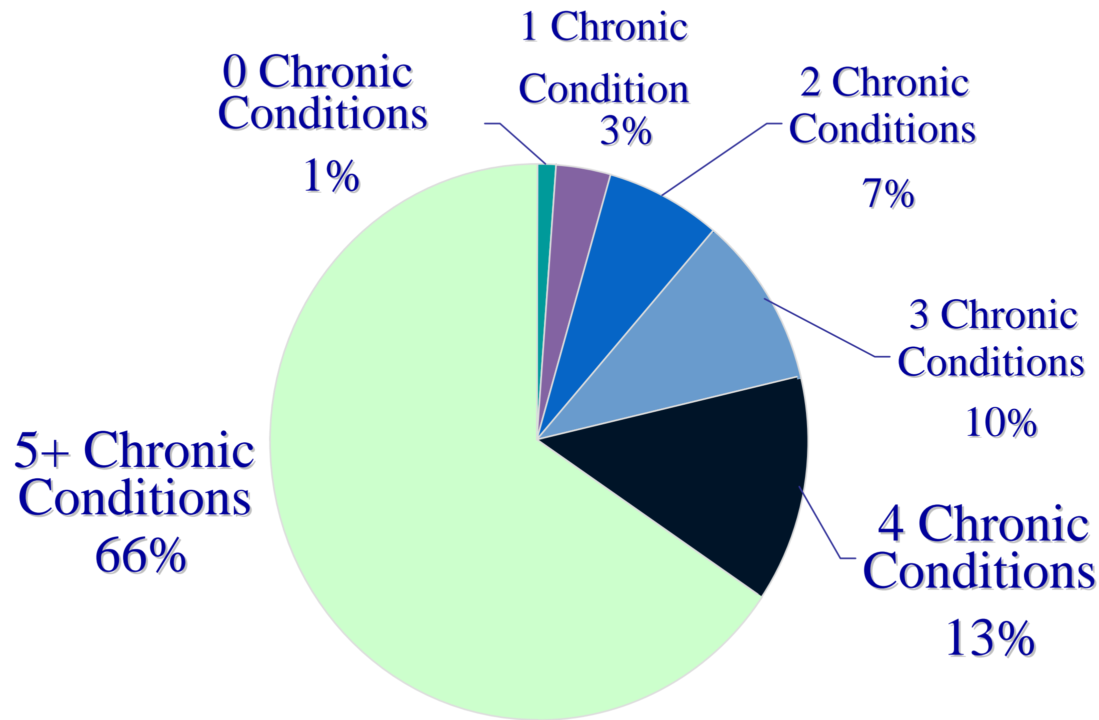
Older adults have multiple comorbid diseases

Data from HRS, people aged 65 and older



Cigolle et al, 2005, JAGS

Most Medicare Expenditures Are for People with Multiple Conditions



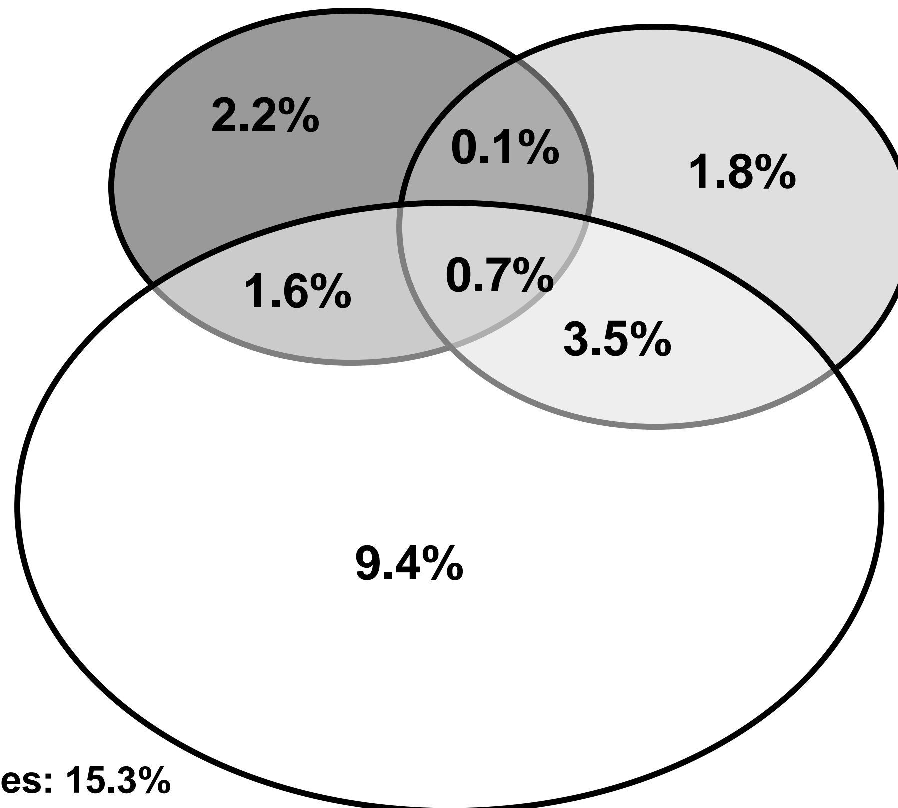
Percent of Medicare Expenditures by Number of Chronic Conditions

Source: Partnership for Solutions, Medicare Standard Analytic File, 1999.

Proportions of adults aged 65 years and older with complex medical conditions, cognitive impairment, and ADL/IADL dependencies

≥3 Complex Medical Conditions: 4.6%
(active/severe, excluding HTN and cognitive impairment)

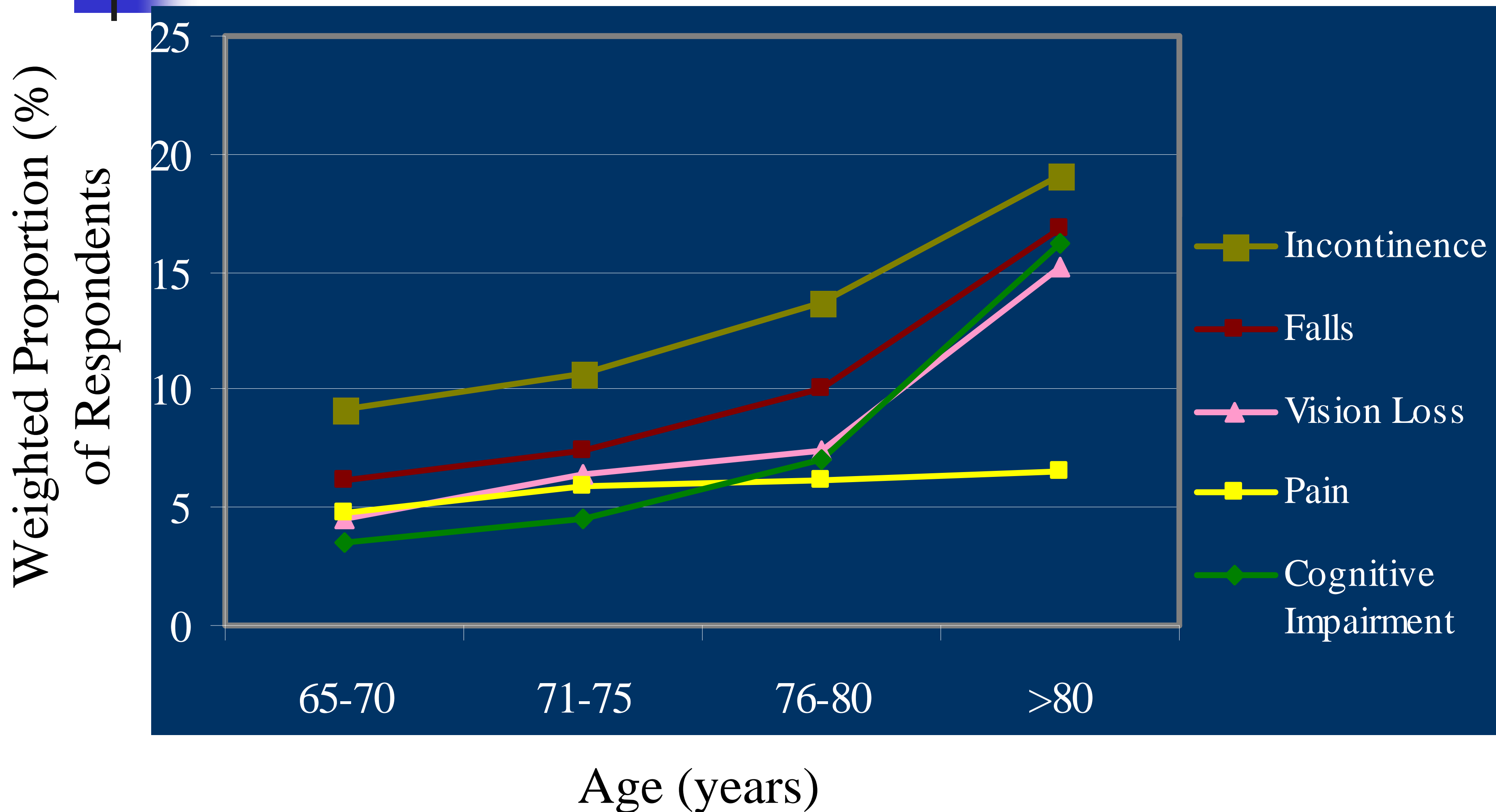
Cognitive Impairment: 6.1%



≥1 ADL or IADL Dependencies: 15.3%

Health and Retirement Survey:

Weighted Proportion of Respondents with Geriatric Conditions

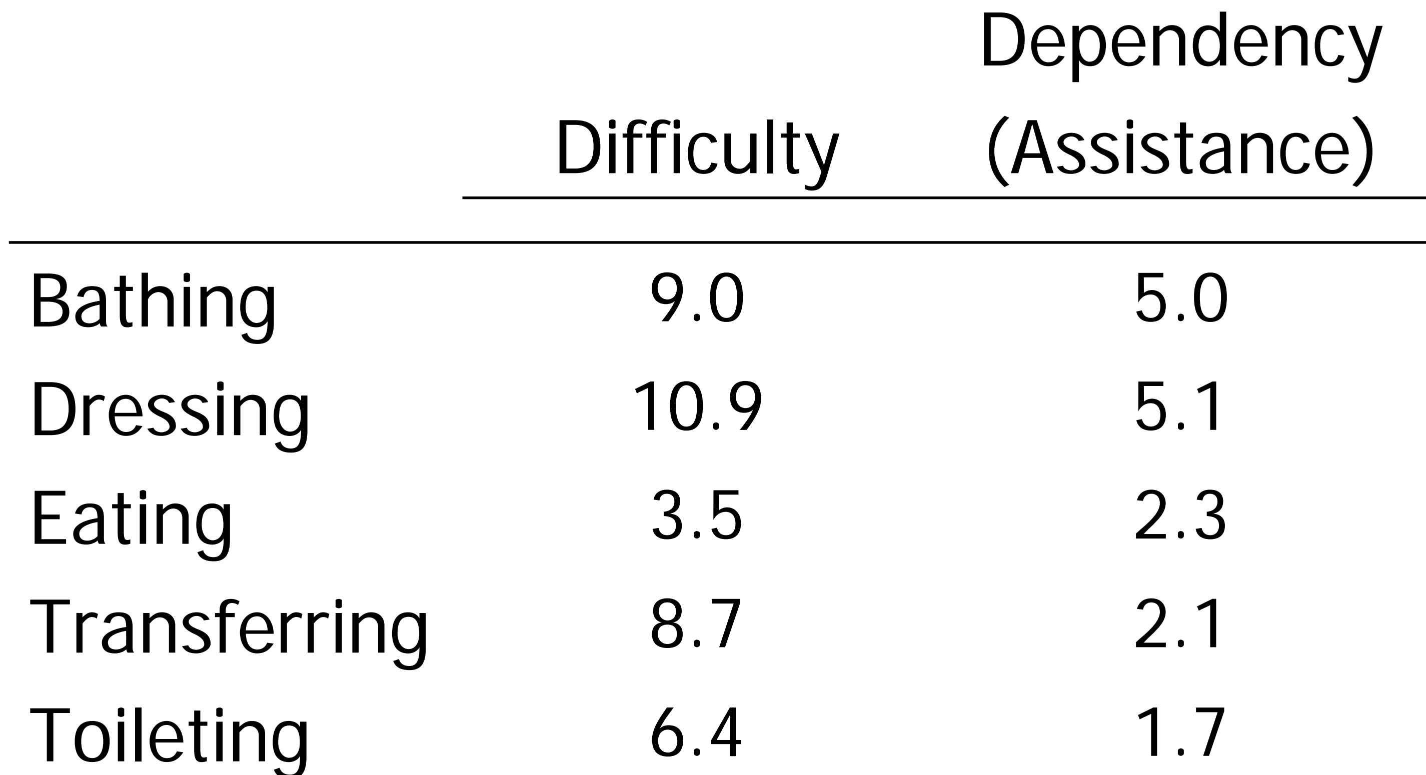


Importance of Disability

- Up to 60% of older patients have difficulty with vigorous activities.
- 66% of functional difficulties are unrecognized by primary care physicians.

Prevalence (%) of ADL Difficulty and Dependency-- Individual Tasks

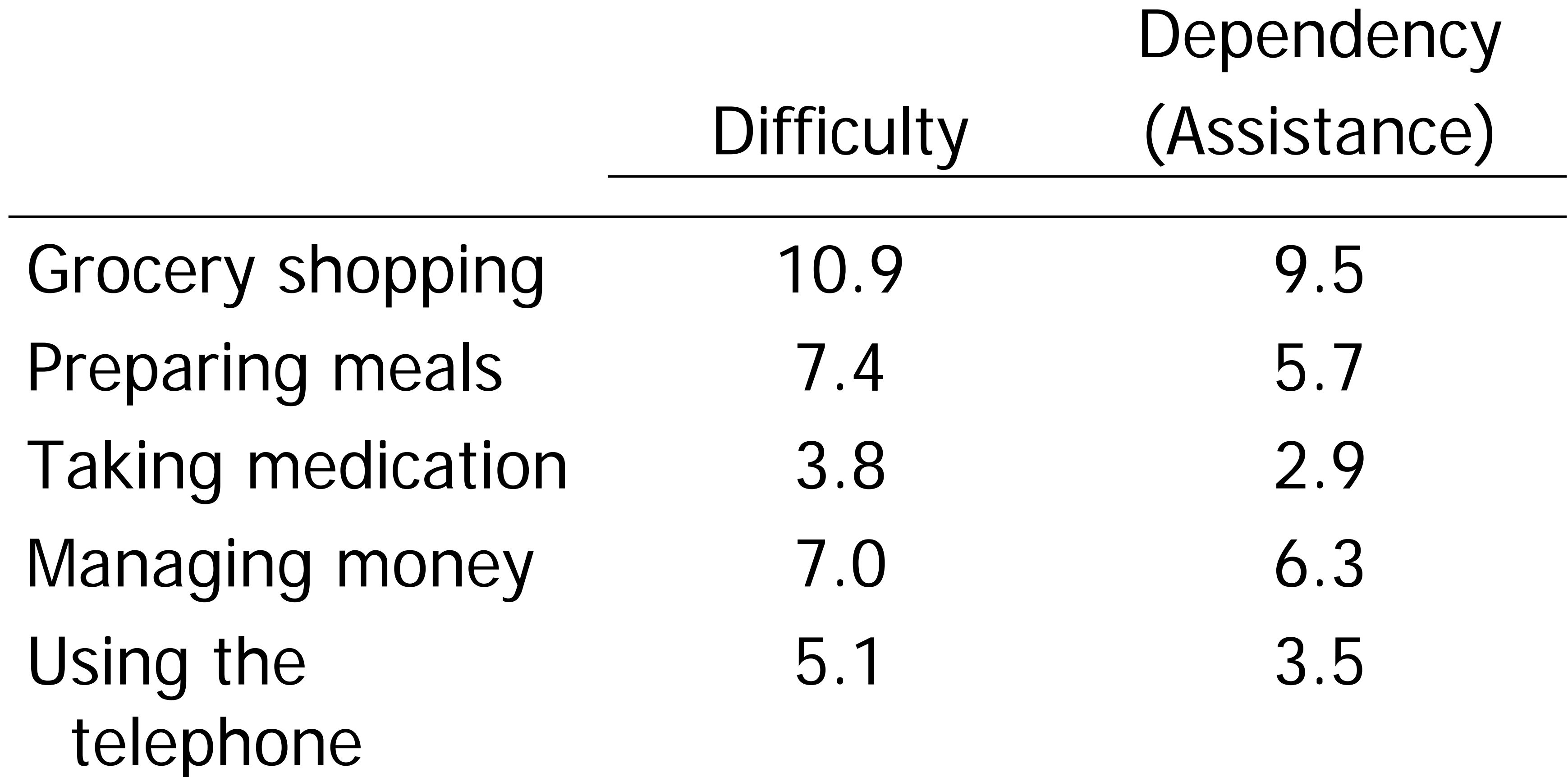
HRS: people 65 and older



	Difficulty	Dependency (Assistance)
Bathing	9.0	5.0
Dressing	10.9	5.1
Eating	3.5	2.3
Transferring	8.7	2.1
Toileting	6.4	1.7

Prevalence (%) of IADL Difficulty and Dependency-- Individual Tasks

HRS: people 65 and older



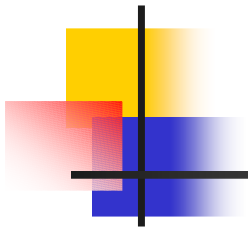
	Difficulty	Dependency (Assistance)
Grocery shopping	10.9	9.5
Preparing meals	7.4	5.7
Taking medication	3.8	2.9
Managing money	7.0	6.3
Using the telephone	5.1	3.5

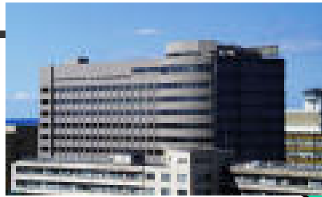
Defining characteristics of older patients

- Multiple comorbidities (chronic diseases)
- Polypharmacy
- Geriatric conditions
  - Functional impairment/disability
  - Gait disorders and falls
  - Sensory impairment (vision, hearing)
  - Chronic pain
  - Depression
  - Incontinence
- Cognitive impairment

- Physiological vulnerability
- Adverse medication events
- Delirium with hospitalization or medications
- Personal care needs
- Inability to comply with self-management

Older patients experience complex care

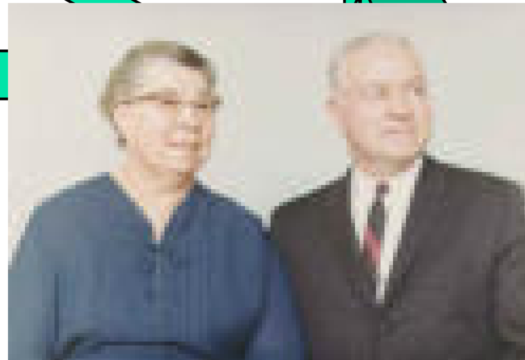




Hospital

Disease Management

Pharmacy



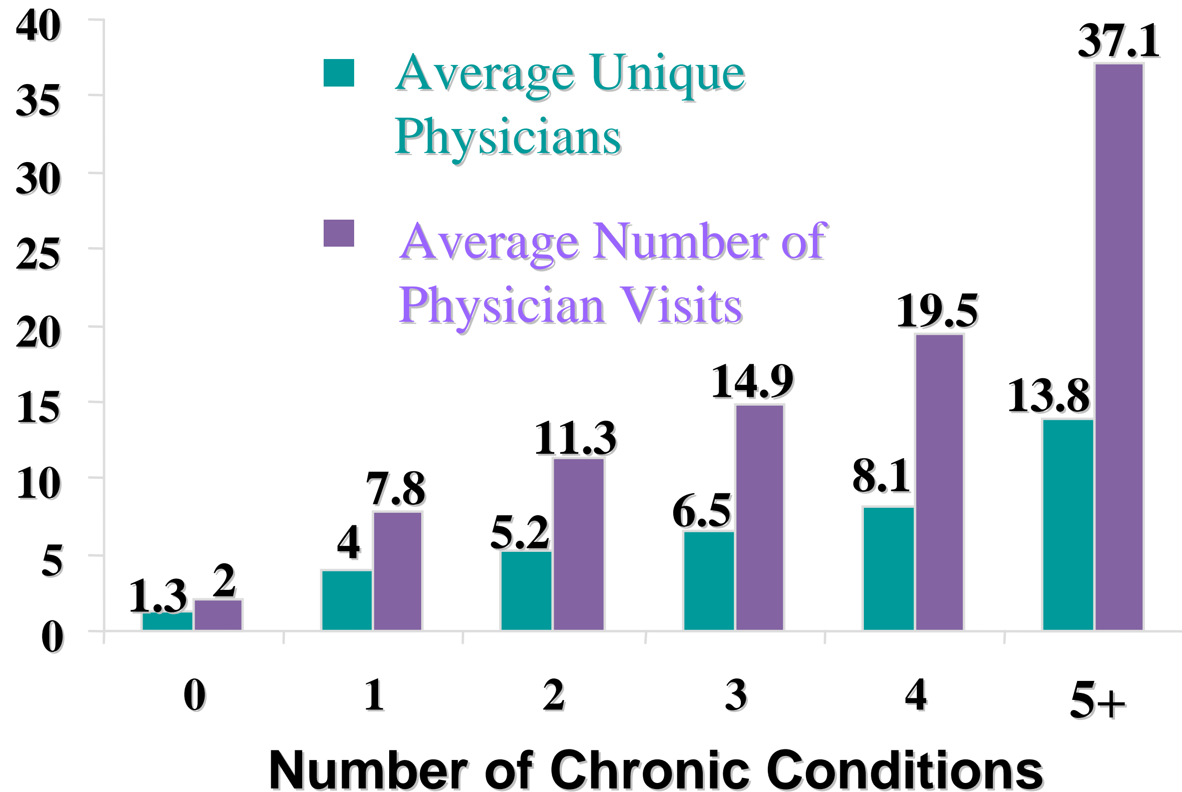
Family Caregiver

Home Care

Physicians

Nursing Home

Elderly With Multiple Conditions See Multiple Physicians



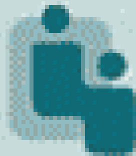
Source: Partnership for Solutions, Medicare Standard Analytic File, 1999.

Care delivery complexity

- No accountable and/or primary care physician
- Patient and family may deny or not realize vulnerability of patient
- Patient may be unable to follow plan of care
- Patient may have multiple hospital admissions

Chronic care delivery models

- Chronic care model
- Transitional Care
- Care Coordination
- Disease Management
- Medical Home



improving
chronic
illness care

Chronic Care Model

Community

Health System

Self-Management Support

Delivery System Design

Decision Support

Clinical Information Systems

Informed, Activated Patient

Productive Interactions

Prepared Practice Team

Improved Outcomes

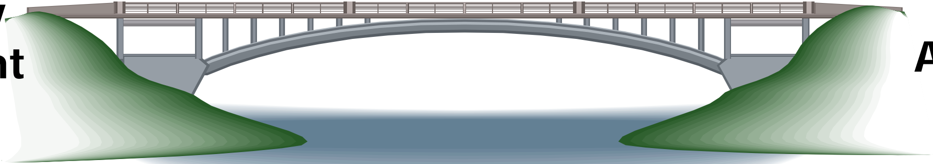
Chronic care model

- Lots of information on web
- May not work in Medicare
  - Vulnerable, multiple comorbidities
- Geriatrics has been involved in development
- Evolving – patient safety

Coordinating Care

transitions

Emergency Department

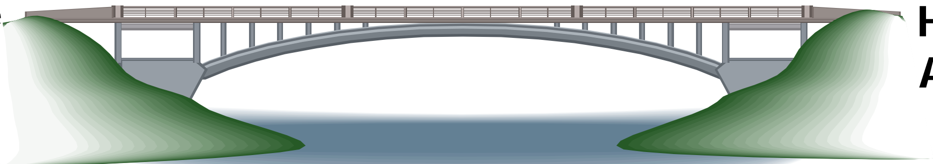


Home or Assisted Living

Hospital

Home, Assisted Living Nursing Home or Palliative Care

Sub-acute nursing home



Home or Assisted Living

Transition Interventions

- Post transition contact
- Pharmacist-facilitated discharge
- Discharge coordination
- Clinic rapid access
- Visiting Nurses
- Palliative Care consults
- Disease management
- Nursing home service
- ED: CHOICES

"Medical Home" Interventions

- Continuing care clinic
- Complex care coordination
- Disease management
- Palliative care – out patient
- Long-term care: home care and nursing home

Transitional Care Interventions

- Post discharge/post ED calls
- Pharmacist coordinated discharge
- Nursing home coordination service: geriatrics consult service and nursing home physician
- Visiting nurse partnering with physician
- Rapid clinic access post discharge: transitional care clinic

Transitional Care: post discharge short-term care coordination

Problem	Example	Consequence
Appointments	Timely appointment not made Patient unaware of appointment	Health deteriorates Missed appointment Readmitted
Contact Information	Discharge destination unknown	Unable to contact patient
Discharge counseling	Patient confused about medications Patient confused about tests	Does not take medications Does not go to tests Readmitted
Social	Lacks transportation Cannot afford medications	Misses appointment Does not take medications Readmitted
Home care	Visiting nurse not available	Health deteriorates Readmitted

Care Coordination

- System Level
  - Financial model, provider incentives
  - Structures: multispecialty practices, teams
  - Electronic medical record
  - Data systems: reports and feedback
- Service delivery level
  - Transitional care
  - Complex care management
  - Disease management
  - Team care
  - Patient self-management support

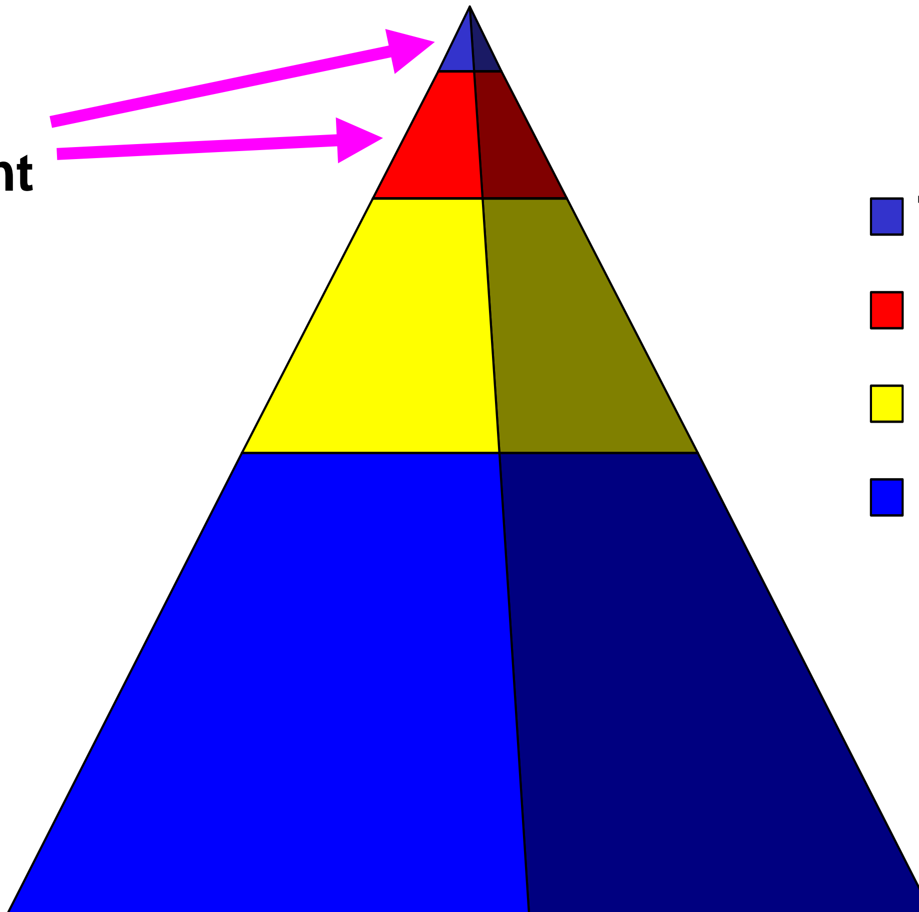
What can care coordination do?

- Improve communication among multiple providers
  - EMR, teams, care management
- Improve patient understanding, compliance, self-management, interaction with health system, access to needed services
  - Teams, care coordinator, nurse educator, telemedicine
- Prevent waste, decrease overuse, misuse, underuse?

Challenges of Chronic Disease

Multiple Levels to address

Disease management



Drivers for Disease Management in Chronic Care

- High cost of chronic disease
- Desire to shift care management tasks out of the primary care office
- Application of *Best Practice* and evidence-based protocols
- Focus on prevention of exacerbation… anticipating problems rather than reacting to crises (secondary and tertiary prevention)
- Relies on improved illness management to improve outcomes and decrease costs

Disease Management Process: Key Elements

- Pt-Team Collaboratively Identify Problems
- Set Patient-Centered Priorities
- Establish Realistic Goals of Care
- Set Measurable Treatment Objectives
- Create Self-Management Strategies
- Provide Training and Support
- Provide Active and Sustained Follow-up

Von Korff M. Ann Intern Med 1997;127:1097 (modified)

Problems with Disease Management (DM) in the Medicare population

- Multiple co-morbidities, patients therefore often assigned to multiple DM programs
- Lack of coordination or communication between DM programs and primary providers
- Interventions often separate from clinical management
- Some disease management programs are “off the shelf” or outsourced

Medical Home

- Idea from pediatrics; picked up by general medicine
- Primary, continuing care for complex patients
- Would provide accountable, coordinated care
- Incorporates team approach: nursing, social work, health educators
- How would reimbursement work?

Medical Home

- Elements of “medical home”
  - continuity
  - access (medical, financial, transportation)
  - Communication (with patient, family, other providers)
  - intercurrent care
  - self-management support
  - 24/7 availability
  - physician accountability

"Medical Home" Interventions

- Longitudinal primary care
- Geriatric primary care
- Complex care coordination
  - Central vs. site-based
  - Special clinical groups:
    - Vulnerable elderly
    - *Dual eligibles/ mental health and social problems*
    - *ESRD/transplant*
    - *Dominant single disease*
- Primary care in the home – Housecalls program
- Advanced-disease management (palliative care)

University of Michigan Example: Turner Geriatric Clinic Care

- Medical home for vulnerable/frail elderly
- Primary care teams
- Collaborative practice with NPs, social work and pharmacist
- Increased intercurrent care and patient/caregiver self-management support
- Provides transitional care, urgent care and palliative care
- Quality review and health maintenance facilitated by nursing