The Complicated Older Patient...Who are you gonna call??

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April 20, 2012

Objectives

- Review demographics
- Differentiate between frail elders and those who exemplify healthy aging
- Discuss when to request a geriatric consultation
- Explore ways geriatricians can assist with complicated patients
Between 2000 and 2010, population > 65 years old increased at rate of 15.1% 
- Total US population increased at rate of 9.7% 
- 40.3 million people > 65 years 
  - 5.3% increase from 2000 (35 million) 
- 13% of total population 
  - Increased from 12.4% in 2000 
- 1.3 million people > 65 live in skilled-nursing facilities (3.1% of population > 65)
Population Changes

- 2050: Projected to be 88.5 million people > 65
- Population will become more ethnically and racially diverse

CHARACTERISTICS OF ELDERLY
Healthy Aging

- Avoiding premature morbidity/mortality
- Monitoring functional health status
- Remaining independent in spite of functional loss and/or illness
- Remaining productive in society
- Maintaining economic resources as long as possible
- Retaining cognitive and creative skills
- Adjusting psychologically to losses and trauma of the aging process

Complicated Patients

- Heterogeneity of health status
- Age related physiologic changes
- Increased incidence of comorbidities
- Atypical presentation of illness
- Increased iatrogenic illness
- Increased need for social support system
- Different goals of care
- Adverse reactions of medications
- Polypharmacy

Frailty

- Predicts mobility and progressive decline in ADL
- Fried Frailty Criteria (FFC):
  - Unintentional weight loss of 4.5 kg in past year
  - Self-reported exhaustion
  - Weakness (decreased grip strength)
  - Slow walking speed
  - Low physical activity
- Comprehensive Geriatric Assessment and intervention improves frailty status and functional status
Atypical Presentation of Disease

- Functional decline caused by infection, CVA, hypoxia, etc.
- Misleading symptoms:
  - Infection with normal WBC, afebrile
- Signs of one disease obscured by another
- No presentation at all:
  - Silent infarct, silent acute abdomen
- No single cause for presenting symptoms → Most symptoms are multifactorial

Iatrogenic Illness

- Common
- 1/3 of hospitalized elderly have problems with iatrogenic side effects
- Adverse drug reactions are the most common complication
- Other complications:
  - Deconditioning
  - Delirium
  - Falls
  - Infection
  - Pressure ulcers

Risk Factors for Medication Complications

- > 6 concurrent chronic illnesses
- > 12 doses of medicine per day
- > 9 meds
- One prior drug reaction
- Low body weight or BMI
- > age 85
- Estimated creatinine clearance of 50 or less
At age 65, 10% have dementia
At age 85, 50% with dementia
2012: 5.2 million people with Alzheimer's
2050: estimated 16 million will have Alzheimer’s
Dementia, delirium, depression → overlapping symptoms → more difficult diagnosis
Often accompanies and complicates chronic conditions

WHEN TO CONSULT A GERIATRICIAN

Reasons to Consult a Geriatrician
• Patients > 65 years old
• Multiple comorbidities
• Psychosocial issues (depression, isolation)
• Geriatric syndromes (dementia, falls, functional disability)
• Previous or high medical utilization
• Possible change in living situation
Geriatric Philosophy

- Functional based focus of care
- Coordinate with interdisciplinary teams
- Tailor treatment plan to individual's needs, considering all aspects of the patient (physical, functional, social, financial, spiritual, psychological, etc)

Geriatric Teams

- Geriatrician/medical director
- Midlevel practitioner
- Social Worker
- Nurse
- Dietician
- Physical therapist
- Occupational therapist
- Speech therapist
- Pharmacist

Settings for Geriatric Consultations

- Inpatient
- Outpatient
- Office Based Primary Care
- Nursing Home
- Home Visits

A geriatric consult on every patient > 65 is not needed or cost effective
Components of Geriatric Consultation

- Functional status
- Fall risk
- Cognition
- Mood
- Polypharmacy
- Social support
- Financial concerns
- Advance care wishes

Components of Geriatric Consultation

- Nutrition/weight change
- Urinary continence
- Sexual function
- Vision/hearing
- Dentition
- Living situation
- Spirituality

Functional Status

- Activities of Daily Living (ADL)
  - Bathing
  - Dressing
  - Toileting
  - Grooming
  - Feeding
  - Transferring
- Instrumental Activities of Daily Living (IADLs)
  - Grocery shopping
  - Driving
  - Telephone
  - Preparing food
  - Taking medications
  - Managing finances
Falls
- History of falls
- Associated events with falls
- Symptoms
- Injuries
- Balance
- Gait assessment

Cognition
- History (from patient and caregivers)
- Memory screen (clock drawing, MMSE, SLUMS)
- Studies to rule out other underlying causes
- Evaluation for depression/mood disturbance
- Referral for formal Neuropsych testing

Mood
- Depression often underdiagnosed and inadequately treated
- Depression may present atypically
- Geriatric Depression Scale (GDS)
- Patient Health Questionnaire-9 (PHQ-9)
Polypharmacy
- Multiple medications prescribed by multiple providers
- Often medications are treating adverse effects of other medications
- Increased risk of drug-drug interactions and adverse events
- Patients should bring medications with them, including OTC and herbals

Social and Financial Issues
- Social support
- Caregivers
- Surrogate decision makers
- Caregiver stress
- Finances

Advance Care Planning
- Living will
- Preferences
- Decision-making capacity
Geriatric Trauma

- Falls and MVA predominant causes
- Delay in recognition of elderly trauma → Increased time in ER → Delay in care
- Geriatric Trauma Team consult
  - Advanced care planning
  - Disposition decisions to promote function
  - Medication changes
  - Decreased inappropriate medications
  - Assisted with pain management
- Chronological age + comorbid disease + moderate injury
  → Overwhelms coping of frail elders
- Death, disability, loss of independence

Geriatric Consultation in Cancer Patients

- Geriatricians detected and described patients’ problems
- Strengths
- Limitations
- Needs for services
- Geriatrician ranks problems
- Tools used:
  - Cumulative Illness Rating Scale—Geriatrics (CIRS-G)
  - Katz Activities of Daily Living Index
  - Lawton Instrumental Activities of Daily Living (I-ADL)
  - Mini Nutritional Assessment
  - Folstein MMSE
  - Clock drawing test
  - Geriatric Depression Scale (GDS)

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Patients who received lower dose intensity treatment

- Higher rate of serious comorbidity and ADL dependence ($p < 0.001$)
- Needed geriatric intervention in two or more areas
- Poor overall condition related to previous geriatric state, NOT cancer

Patients who received higher dose intensity treatment

- Higher rate of ADL-dependence ($p < 0.01$)
- Rates of serious comorbidity and cognitive impairment similar to patients with same dose intensity
- No need for frequent geriatric interventions
- Loss of autonomy due to cancer, NOT geriatric conditions
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References
