

Complex Care: Treating an Older Patient with Multiple Comorbidities

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Case scenarios are written to express typical situations that family physicians may encounter; authors remain anonymous. Please send scenarios to Caroline Wellbery, MD, at afpjournal@aafp.org. Materials are edited to retain confidentiality.

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Case Scenario

A 74-year-old Latino patient with a history of hypertension, diabetes mellitus, dyslipidemia, multivessel coronary and peripheral arterial diseases, and chronic osteomyelitis was recently discharged from our hospital after undergoing several toe amputations. His hospital course was complicated by contrast-induced nephropathy that required hemodialysis; heparin-induced thrombocytopenia; lower extremity cellulitis; and significant functional decline.

One week after discharge, he presented to the geriatrics clinic for follow-up about his pain and mobility. He wanted to know if he could obtain a motorized wheelchair. He appeared to have moderate leg pain, apparently because he never filled his discharge prescription for oxycodone (Roxicodone). He did not remember his medications or their dosages, and had not brought his pill bottles with him. He was unsure about when and where to follow up with his multiple subspecialists. How can I best treat this patient with multiple chronic conditions? How should I address his limited health literacy?

Commentary

Although there are guidelines for management of single chronic illnesses, the evidence base for management of multiple comorbidities is lacking. The American Geriatrics Society described a clinical approach to managing patients with multiple comorbidities in 2012.¹ A summary of the American Geriatrics Society expert opinion is available at <http://www.americangeriatrics.org/files/documents/MultimorbidityPocketCardPrintable.pdf>.

The challenge of managing multiple comorbidities can be compounded by limited health literacy, which is more common in older persons, poor persons, and certain minorities, such as Latinos.² For a typical older patient, medical care has become more complex, comprising multiple steps with crucial exchanges of information.³ Most physicians have between 15 and 30 minutes for a follow-up visit, which is often insufficient to address many or all comorbidities effectively. The following management strategy attempts to address clinical and system-based challenges. Additionally, applying an approach based on the acronym PACE can help physicians to pace themselves during visits with these patients (*Table 1*).

Table 1. A Practical Approach to Treating Older Patients with Comorbidities

- P** Prioritize what you want to accomplish during this office visit
- A** Ask patients for their concerns, goals, values, and preferences for a plan of action
- C** Communicate in simple language, avoid jargon, and elicit understanding
 - Collaborate with the interdisciplinary care team
 - Coordinate care with caregiver and/or family
- E** Employ an evidence-based approach in creating a management plan

PRIORITIZE

Prioritizing involves identifying concerns that need attention during this visit and those that can wait until the next visit. Focus on problems that may lead to the greatest morbidity, and possibly mortality, in the next days or weeks. A discussion of the patient's agenda, as well as your own, at the beginning of the visit will help to create a realistic framework of the items that will be addressed in the time available. The patient in this case scenario is mainly ►

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concerned about the toe amputation, the pain in the leg, and getting a motorized wheelchair for ambulation. At the beginning of the visit, create a pain management plan, discuss wound care, and follow up on his kidney function and cell counts. At the end of the visit, it would be beneficial to alert a social worker to assist the patient with procuring durable medical equipment.

COMMUNICATE EFFECTIVELY

Good communication is key when interacting with older patients who have comorbidities. There are several components to facilitating effective communication with this population.

Active Listening. Start by asking the patient for his or her most pressing concerns. It is appropriate to probe for general and specific goals and values, as well as any preference for a particular plan of action. The ask-tell-ask and teach-back methods can elicit the patient's understanding of key medical concepts or recommendations.⁴ Avoid medical jargon, and use concrete and direct words rather than abstract terminology.

Interpreter Services. Nonverbal communication is best gauged by someone who is well versed in the patient's culture. Check whether your institution provides language interpreters, and schedule them for visits as needed. Another option is a phone interpreter service. Family members should not be used as proxy history providers or interpreters.

Reinforcement. Visual aids can clarify and reinforce comprehension of key medical issues. For example, decision aids for diabetes management are available for teaching patients about their medications' benefits, adverse effects, and dosages.⁵ Electronic medical records can create individualized visit summaries that include instructions and educational materials.

APPLY EVIDENCE-BASED MEDICINE

Employing a patient-specific, evidence-based approach helps balance the benefits and harms of diagnostic or therapeutic interventions. Reviewing current practice recommendations and calculating the absolute risk reduction and the number needed to treat will guide management decisions. Prognostication in patients with many chronic conditions, although imperfect, may help prioritize decisions based on the patient's life expectancy. This patient has a five-year mortality risk of roughly 69% and a 10-year mortality risk of roughly 93% based on Schonberg and Lee indices, respectively.⁶

COLLABORATE

An interdisciplinary care team can help manage a complicated case. A social worker, nurse practitioner, or registered nurse, if available, is often able to meet with the

patient or family at more frequent intervals to assist with health education, chronic care management, and psychosocial counseling.

In my practice, the social worker assists with determining insurance coverage and payment sources, and the medical assistant orders supplies from our durable medical equipment vendor. In the absence of a social worker, another member of your practice can visit the Medicare website (<http://www.medicare.gov>) to find a list of covered medical equipment vendors in your area.

INVOLVE THE CAREGIVER OR FAMILY

With the patient's permission, reach out to a caregiver or responsible family member and give him or her a few tasks to complete and report back to you at a specified date. This person could be asked to obtain immunization or procedure records from other physicians or clinics or to report on the patient's response to a new medication in a week's time.

MANAGE PRE- AND POSTVISIT FACTORS

Alert your front-desk staff and administrative assistant to any special needs of particularly worrisome patients. Such patients may benefit from a personal phone call the day before the appointment (rather than an automated call) reminding them to bring their medication bottles to the visit and clarifying the date, time, and location. At the end of the visit, the patient should have an easy-to-understand follow-up schedule to take home. Some physicians may feel comfortable sharing their cell phone number so the patient can bypass the delay and frustration that may be associated with an answering service.

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