A SELECTION OF TEN CURRENT READINGS ON TOPICS RELATED TO MANAGING COMPLEX PATIENTS IN FAMILY MEDICINE SETTINGS

some available as free full-text and some requiring payment

Selection of readings made by A/Prof Goh Lee Gan

READING 1 – WHOLE-PERSON MODEL OF CARE: IN COMPLEX CHRONIC ILLNESS IN LATE LIFE

Shippee ND, Shippee TP, Mobley PD, Fernstrom KM, Britt HR. Effect of a whole-person model of care on patient experience in patients with complex chronic illness in late life. Am J Hosp Palliat Care. 2017 Jan 1:1 049909117690710. [Epub ahead of print] PubMed PMID: 28133973.

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Author information:
Shippee ND,[1] Shippee TP,[1] Mobley PD,[2] Fernstrom KM,[2] Britt HR.[2]

[1] Division of Health Policy and Management, University of Minnesota School of Public Health, Minneapolis, MN, USA. [2] Division of Applied Research, Allina Health, Minneapolis, MN, USA.

ABSTRACT

BACKGROUND: Patients with serious chronic illness are at a greater risk of depersonalized, overmedicalized care as they move into later life. Existing intervention research on person-focused care for persons in this transitional period is limited.

OBJECTIVE: To test the effects of LifeCourse, a team-based, whole-person intervention emphasizing listening to and knowing patients, on patient experience at 6 months.

DESIGN: This is a quasi-experimental study with patients allocated to LifeCourse and comparison groups based on 2 geographic locations. Robust change-score regression models adjusted for baseline differences and confounding.

SETTING/PARTICIPANTS: Patients (113 intervention, 99 comparison in analyses) were individuals with heart failure or other serious chronic illness, cancer, or dementia who had visits to hospitals at a large multipractice health system in the United States Midwest.

MEASUREMENTS: Primary outcome was 6-month change in patient experience measured via a novel, validated 21-item patient experience tool developed specifically for this intervention. Covariates included demographics, comorbidity score, and primary diagnosis.

RESULTS: At 6 months, LifeCourse was associated with a moderate improvement in overall patient experience versus usual care. Individual domain subscales for care team, communication, and patient goals were not individually significant but trended positively in the direction of effect.

CONCLUSION: Person-focused, team-based interventions can improve patient experience with care at a stage fraught with overmedicalization and many care needs. Improvement in patient experience in LifeCourse represents the sum effect of small improvements across different domains/aspects of care such as relationships with and work by the care team.

READING 2 – COMPREHENSIVE GERIATRIC ASSESSMENT: RECOGNITION OF IDENTIFIED GERIATRIC CONDITIONS

van Rijn M, Suijker JJ, Bol W, Hoff E, Ter Riet G, de Rooij SE, et al. Comprehensive geriatric assessment: recognition of identified geriatric conditions by community-dwelling older persons. Age Ageing. 2016 Nov;45:894–9. PubMed PMID: 27614077.

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Author information:
van Rijn M(1,)(1), Suijker JJ,[2] Bol W,[1] Hoff E,[1] Ter Riet G,[2] de Rooij SE,[1,3] et al.

[1] Department of Internal Medicine, Section of Geriatric Medicine, Academic Medical Center, Amsterdam, The Netherlands. [2] Department of General Practice, Academic Medical Center, Amsterdam, The Netherlands. [3] University Center for Geriatric Medicine, University Medical Center Groningen, Groningen, The Netherlands. 4 ACHIEVE Centre of Expertise, Faculty of Health, Amsterdam University of Applied Sciences, Amsterdam, The Netherlands.

ABSTRACT

OBJECTIVES: To study (i) the prevalence of geriatric conditions in community-dwelling older persons at increased risk of functional decline; and (ii) the extent to which older persons recognise comprehensive geriatric assessment (CGA)-identified conditions as relevant problems.

METHODS: Trained registered nurses conducted a CGA in 934 out of 1209 older persons at increased risk of functional decline participating in the intervention arm of a randomised trial in the Netherlands. After screening for 32 geriatric conditions, participants were asked which of the identified geriatric conditions they recognised as relevant problems.

RESULTS: At baseline, the median age of participants was 82.9 years (interquartile range (IQR) 77.3–87.3 years). The median number of identified geriatric conditions per participant was 8 (IQR 6-11). The median number of geriatric conditions that were recognised was 1 (IQR 0-2). Functional dependency and (increased risk of) alcohol and drug dependency were the most commonly identified conditions. Pain was the most widely recognised problem.

CONCLUSION: CGA identified many geriatric conditions, of which few were recognised as a problem by the person involved. Further study is needed to better understand how older persons interact with identified geriatric conditions, in terms of perceived relevance. This may yield a more efficient CGA and further improve a patient-centred approach.

READING 3 – MULTIMORBIDITY IN PEOPLE WITH CHRONIC KIDNEY DISEASE: IMPLICATIONS FOR TREATMENT BURDEN AND OUTCOMES

Fraser SD, Taal MW. Multimorbidity in people with chronic kidney disease: implications for outcomes and treatment. Curr Opin Nephrol Hypertens. 2016;25:465–72. PubMed PMID: 27490909.

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Author information:
Fraser SD,1 Taal MW.

[1] (a) Academic Unit of Primary Care and Population Sciences, Faculty of Medicine, University of Southampton, Southampton, Hampshire SO16 6YD (b) Division of Medical Sciences and Graduate-Entry Medicine, University of Nottingham (c) Department of Renal Medicine, Royal Derby Hospital, Derby, UK.

ABSTRACT

PURPOSE OF REVIEW: With ageing populations, the prevalence of multimorbidity is increasing. This review discusses recent developments in the understanding of multimorbidity in the context of chronic kidney disease (CKD). It explores the associated treatment burden and the implications for key outcomes and patient care.

RECENT FINDINGS: Comorbidity and polypharmacy are common in CKD, even at early stages, and are associated with significant treatment burden. Both 'concordant' and 'discordant' comorbidities have a negative impact on mortality, cardiovascular disease, hospitalisation and length of stay. In addition, quality of life is influenced by many factors beyond CKD, including comorbidities and certain medications. Several factors may reduce treatment burden for people with CKD, though research on this is at an early stage. Although patient activation is desirable to support self-management amongst people with multimorbidity, there are significant challenges that impact patient capacity amongst elderly populations with complex needs.

SUMMARY: Comorbidities are common in CKD and have important implications for patients, clinicians and health services.

READING 4 – CLINICAL FRAILTY SCALE

Gregorevic KJ, Hubbard RE, Lim WK, Katz B. The clinical frailty scale predicts functional decline and mortality when used by junior medical staff: a prospective cohort study. BMC Geriatr. 2016;16:117. PubMed PMID: 27250650; PubMed Central PMCID: PMC4890513.

doi: 10.1186/s12877-016-0292-4.[Free Full Text]

Author information:
Gregorevic KJ,[1,2] Hubbard RE,[3] Lim WK,[4, 5] Katz B.[6,4,7]

[1]Department of Aged Care, Northern Hospital, 185 Cooper St, Epping, Vic, 3076, Australia. kgregorevic@student.unimelb.edu.au. [2] North West Academic Centre, University of Melbourne, Melbourne, Australia. kgregorevic@student.unimelb.edu.au. [3] Geriatric Medicine Deputy Director, Centre for Research in Geriatric Medicine, The University of Queensland, Brisbane, Australia. [4] University of Melbourne, Melbourne, Australia. [5] Northern Hospital, Epping, Australia. [6] Geriatric Medicine, St Vincent's Hospital, Melbourne, Australia. 7 La Trobe University, Melbourne, Australia.

ABSTRACT

BACKGROUND: Increasing frailty is associated with risk of mortality and functional decline in hospitalised older adults, but there is no consensus on the best screening method for use by non-geriatricians. The objective of this study is to determine whether the clinical frailty scale (CFS) can be used to identify patient baseline frailty status in the acute general medical setting when used by junior medical staff using information obtained on routine clinical assessment.

METHODS: This was a prospective cohort study in an acute general medical unit. All patients aged 65 and over admitted to a general medical unit during August and September 2013 were eligible for the study. CFS score at baseline was documented by a member of the treating medical team. Demographic information and outcomes were obtained from medical records. The primary outcomes were functional decline and death within three months.

RESULTS: Frailty was assessed in 95 percent of 179 eligible patients. 45 percent of patients experienced functional decline and 11 percent died within three months. 40 percent of patients were classified as vulnerable/mildly frail, and 41 percent were moderately to severely frail. When patients in residential care were excluded, increasing frailty was associated with functional decline ($p = 0.011$). Increasing frailty was associated with increasing mortality within three months ($p = 0.012$).

CONCLUSIONS: A high proportion of eligible patients had the frailty measure completed, demonstrating the acceptability of the CFS to clinicians. Despite lack of training for medical staff, increasing frailty was correlated with functional decline and mortality supporting the validity of the CFS as a frailty screening tool for clinicians.

READING 5 – SYSTEM MANAGEMENT: PREVENTION OF POTENTIALLY INAPPROPRIATE PRESCRIBING

Moriarty F, Bennett K, Cahir C, Kenny RA, Fahey T. Potentially inappropriate prescribing according to STOPP and START and adverse outcomes in community-dwelling older people: a prospective cohort study. Br J Clin Pharmacol. 2016;82:849–57. PubMed PMID: 27136457; PubMed Central PMCID: PMC5338119.

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Author information:
Moriarty F,[1] Bennett K,[2] Cahir C,[2] Kenny RA,[3] Fahey T.[1]

[1] HRB Centre for Primary Care Research, Department of General Practice, Royal College of Surgeons in Ireland, Dublin. [2] Division of Population Health Sciences, Royal College of Surgeons in Ireland, Dublin. [3] The Irish Longitudinal Study on Ageing, Trinity College Dublin, Dublin, Ireland.

ABSTRACT

AIMS: This study aims to determine if potentially inappropriate prescribing (PIP) is associated with increased healthcare utilisation, functional decline and reduced quality of life (QoL) in a community-dwelling older cohort.
METHOD: This prospective cohort study included participants aged ≥65 years from The Irish Longitudinal Study on Ageing (TILDA) with linked administrative pharmacy claims data who were followed up after 2 years. PIP was defined by the Screening Tool for Older Persons Prescriptions (STOPP) and Screening Tool to Alert doctors to Right Treatment (START). The association with number of emergency department (ED) visits and GP visits reported over 12 months was analysed using multivariate negative binomial regression adjusting for confounders. Marginal structural models investigated the presence of time-dependent confounding.
RESULTS: Of participants followed up (n = 1753), PIP was detected in 57 percent by STOPP and 41.8 percent by START, 21.7 percent reported an ED visit and 96.1 percent visited a GP (median 4, IQR 2.5-6). Those with any STOPP criterion had higher rates of ED visits [adjusted incident rate ratio (IRR) 1.30, 95% confidence interval (CI) 1.02, 1.66] and GP visits (IRR 1.15, 95%CI 1.06, 1.24). Patients with two or more START criteria had significantly more ED visits (IRR 1.45, 95%CI 1.03, 2.04) and GP visits (IRR 1.13, 95%CI 1.01, 1.27) than people with no criteria. Adjusting for time-dependent confounding did not affect the findings.
CONCLUSIONS: Both STOPP and START were independently associated with increased healthcare utilisation and START was also related to functional decline and QoL. Optimizing prescribing to reduce PIP may provide an improvement in patient outcomes.

READING 6 –PRIMARY CARE: CARING FOR HIGH-NEEDS, HIGH-COST POPULATIONS

Hochman M, Asch SM. Disruptive Models in Primary Care: Caring for High-Needs, High-Cost Populations. J Gen Intern Med. 2017 Apr;32(4):392-397. PubMed PMID: 28243870; PubMed Central PMCID: PMC5377887.

doi: 10.1007/s11606-016-3945-2. [Free Full Text]

Author information:
Hochman M,[1] Asch SM.[2,3]

[1] The Gehr Family Center for Implementation Science, Keck School of Medicine, University of Southern California, 2020 Zonal Ave., IRD 320, Los Angeles, CA, 90033, USA. mhochman@med.usc.edu. [2] Stanford University School of Medicine, Stanford, CA, USA. [3] The VA Palo Alto Health Care System, Menlo Park, CA, USA.

ABSTRACT

Starfield and colleagues have suggested four overarching attributes of good primary care: "first-contact access for each need; long-term person- (not disease) focused care; comprehensive care for most health needs; and coordinated care when it must be sought elsewhere."

As this series is on reinventing primary care highlights, there is a compelling need for new care delivery models that would advance these objectives. This need is particularly urgent for high-needs, high-cost (HNHC) populations.

By definition, HNHC patients require extensive attention and consume a disproportionate share of resources, and as a result they strain traditional office-based primary care practices.

In this essay, we offer a clinical vignette highlighting the challenges of caring for HNHC populations. We then describe two categories of primary care-based approaches for managing HNHC populations: complex case management, and specialized clinics focused on HNHC patients.

Although complex case management programs can be incorporated into or superimposed on the traditional primary care system, such efforts often fail to engage primary care clinicians and HNHC patients, and proven benefits have been modest to date. In contrast, specialized clinics for HNHC populations are more disruptive, as care for HNHC patients must be transferred to a multidisciplinary team that can offer enhanced care coordination and other support. Such specialized clinics may produce more substantial benefits, though rigorous evaluation of these programs is needed.

We conclude by suggesting policy reforms to improve care for HNHC populations.

READING 7 – PRIMARY CARE: PEOPLE WITH DEMENTIA

Dyer SM, Laver K, Pond CD, Cumming RG, Whitehead C, Crotty M. Clinical practice guidelines and principles of care for people with dementia in Australia. Aust Fam Physician. 2016 Dec;45(12):884-889. PubMed PMID: 27903038.

RACGP Website. [Free Full Text]

Author information:
Dyer SM, Laver K, Pond CD, Cumming RG, Whitehead C, Crotty M.

ABSTRACT

BACKGROUND: Dementia is a national health priority in Australia. Most people with dementia are over the age of 65 years, have a number of comorbidities and experience a trajectory of functional decline. General practitioners (GPs) have an important role in the diagnosis and management of people with dementia. The Cognitive Decline Partnership Centre's Clinical practice guidelines and principles of care for people with dementia (Guidelines) was recently approved by the National Health and Medical Research Council (NHMRC).

OBJECTIVE: This article describes the recommendations within the Guidelines that are of greatest relevance to GPs, including those addressing diagnosis, living well, managing behavioural and psychological symptoms, supporting carers, and the palliative approach.

DISCUSSION: The Guidelines synthesise current evidence in dementia care and emphasise: timely diagnosis; encouraging the person with dementia to exercise, eat well and keep doing as much for themselves as possible; supporting and training carers to provide care; and reducing prescription of potentially harmful medications where possible.

READING 8 – TRANSITIONAL CARE: CHRONICALLY ILL OLDER PATIENTS

Le Berre M, Maimon G, Sourial N, Guériton M, Vedel I. Impact of Transitional Care Services for Chronically Ill Older Patients: A Systematic Evidence Review. J Am Geriatr Soc. 2017 Apr 12. PubMed PMID: 28403508.

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Author information:
Le Berre M,[1] Maimon G,[1] Sourial N,[1] Guériton M,[1] Vedel I.[1,2]

[1] Lady Davis Institute of the Jewish General Hospital, Montreal, Québec, Canada.
[2] Department of Family Medicine, McGill University, Montreal, Québec, Canada.

ABSTRACT

Transitions in care from hospital to primary care for older patients with chronic diseases (CD) are complex and lead to increased mortality and service use. In response to these challenges, transitional care (TC) interventions are being widely implemented. They encompass education on self-management, discharge planning, structured follow-up and coordination among the different healthcare professionals.

We conducted a systematic review to determine the effectiveness of interventions targeting transitions from hospital to the primary care setting for chronically ill older patients.. Randomized controlled trials were identified through Medline, CINHAL, PsycInfo, EMBASE (1995-2015). Two independent reviewers performed the study selection, data extraction and assessment of study quality (Cochrane "Risk of Bias"). Risk differences (RD) and number needed to treat (NNT) or mean differences (MD) were calculated using a random-effects model. From 10,234 references, 92 studies were included.

Compared to usual care, significantly better outcomes were observed: a lower mortality at 3 (RD: -0.02 [-0.05, 0.00]; NNT: 50), 6, 12 and 18 months post-discharge, a lower rate of ED visits at 3 months (RD: -0.08 [-0.15, -0.01]; NNT: 13), a lower rate of readmissions at 3 (RD: -0.08 [-0.14, -0.03]; NNT: 7), 6, 12 and 18 months and a lower mean of readmission days at 3 (MD: -1.33; [-2.15, -0.52]), 6, 12 and 18 months. No significant differences were observed in quality of life.

In conclusion, TC improves transitions for older patients and should be included in the reorganization of healthcare services.

READING 9 – NURSING HOME: ROLE IN PREVENTION OF FUNCTIONAL DECLINE

Laffon de Mazières C, Morley JE, Levy C, Agenes F, Barbagallo M, Cesari M, et al. Prevention of functional decline by reframing the role of nursing homes? J Am Med Dir Assoc. 2017;18:105–10. PubMed PMID: 28126135.

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Author information:
Laffon de Mazières C,[1] Morley JE,[2] Levy C,[3] Agenes F,[4] Barbagallo M,[5] Cesari M,[6] et al.

[1] Department of Geriatric Medicine, Gérontopôle, Toulouse University Hospital (CHU de Toulouse), Toulouse, France; Inserm UMR 1027, Toulouse, France. Electronic address: laffondemazieres.c@chu-toulouse.fr. [2] Division of Geriatric Medicine, Saint Louis University School of Medicine, St Louis, MO; Division of Endocrinology, Saint Louis University School of Medicine, St Louis, MO. [3] Denver-Seattle Center of Innovation at the Denver VA Medical Center, Denver, CO; Division of Health Care Policy and Research, University of Colorado School of Medicine, Aurora, CO. [4] Office for Science and Technology, French Consulate in Los Angeles, Embassy of France in the United States, Los Angeles, CA, USA. [5] Geriatric Unit, University of Palermo, Palermo, Italy. 6 Department of Geriatric Medicine, Gérontopôle, Toulouse University Hospital (CHU de Toulouse), Toulouse, France; Inserm UMR 1027, Toulouse, France.

ABSTRACT

Institutionalization is generally a consequence of functional decline driven by physical limitations, cognitive impairments, and/or loss of social supports. At this stage, intervention to reverse functional losses is often too late. To be more effective, geriatric medicine must evolve to intervene at an earlier stage of the disability process.

Could nursing homes (NHs) transform from settings in which many residents dwell to settings in which the NH residents and those living in neighboring communities benefit from staff expertise to enhance quality of life and maintain or slow functional decline?

A task force of clinical researchers met in Toulouse on December 2, 2015, to address some of these challenges: how to prevent or slow functional decline and disabilities for NH residents and how NHs may promote the prevention of functional decline in community-dwelling frail elderly.

The present article reports the main results of the Task Force discussions to generate a new paradigm.

READING 10 – HOME BASED CARE: MANAGING COMPLEX RESPIRATORY PATIENTS

Gillett K, Lippiett K, Astles C, Longstaff J, Orlando R, Lin SX, et al. Managing complex respiratory patients in the community: an evaluation of a pilot integrated respiratory care service. BMJ Open Respir Res. 2016;3:e000145. PubMed PMID: 28074134; PubMed Central PMCID: PMC5174798.

doi: 10.1136/bmjresp-2016-000145. [Free full text

Author information:

Gillett K,[1] Lippiett K,[1] Astles C,[1] Longstaff J,[2] Orlando R,[3] Lin SX,[3] et al.

[1] National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care (CLAHRC) Wessex, Respiratory Theme , Southampton , UK. [2] Wessex Academic Health Sciences Network (AHSN), Portsmouth, UK. [3] National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care (CLAHRC) Wessex, Methodological Hub, Southampton , UK.

ABSTRACT

INTRODUCTION: In the UK, there is significant variation in respiratory care and outcomes. An integrated approach to the management of high-risk respiratory patients, incorporating specialist and primary care teams' expertise, is the basis for new integrated respiratory services designed to reduce this variation; however, this model needs evaluating.

METHODS: To evaluate an integrated service managing high-risk respiratory patients, electronic searches for patients with asthma and chronic obstructive pulmonary disease at risk of poor outcomes were performed in two general practitioner (GP) practices in a local service-development initiative. Patients were reviewed at joint clinics by primary- and secondary-care professionals. GPs also nominated patients for inclusion. Reviews were delivered to best standards of care including assessments of diagnosis, control, spirometry, self-management, education, medication, inhaler technique and smoking cessation support. Follow-up of routine clinical data collected at 9-months postclinic were compared with seasonally matched 9-months prior to integrated review.

RESULTS: 82 patients were identified, 55 attended. 13 (23.6%) had their primary diagnosis changed. In comparison with the seasonally adjusted baseline period, in the 9-month follow-up there was an increase in inhaled corticosteroid prescriptions of 23.3 percent, a reduction in short-acting β2-agonist prescription of 33.3 percent, a reduction in acute respiratory exacerbations of 67.6 percent, in unscheduled GP surgery visits of 53.3 percent and acute respiratory hospital admissions reduced from 3 to 0. Only 4 patients (7.3%) required referral to secondary care. Health economic evaluation showed respiratory-related costs per patient reduced by £231.86.

CONCLUSIONS: Patients with respiratory disease in this region at risk of suboptimal outcomes identified proactively and managed by an integrated team improved outcomes without the need for hospital referral.