CHALLENGES FOR CLINICAL PRACTICE IN OLDER PEOPLE:

HOW COMPREHENSIVE GERIATRIC ASSESSMENT (CGA) SHOULD WORK

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Overview

• Case
• Best of five questions
• Sarcopenia and frailty
• Introduce CGA
83♀ admitted acutely. Found in chair with uneaten food around her and a fridge which was almost empty. She was getting meals on wheels. It was evident that she was not going upstairs and sleeping in her settee. She had a commode next to her which was being emptied by her twice daily informal carers. Not compliant with oral nutritional supplements. Not seen outdoors for a few months. She has been treated for minor UTIs recently.

Appeared kempt. Alert and orientated but low in mood. Very thin with low muscle bulk. Transpires she had lost 6 kg in the last 4 months. It was difficult for her to stand and transfer from bed to chair without assistance. There was no neurology. She had dysuria and a positive urine dip to leucocytes. MSU - fully sensitive E.coli and was commenced on trimethoprim. Once week after admission, she was able to stand with assistance and take 3 small steps before fatiguing.

Her medications include, furosemide 40mg od, Ramipril 2.5mg od, aspirin 75mg od, senna, solifenacin 5mg od, amitriptyline 10 mg nocte, metformin 500mg bd, paracetamol 500mg bd, ferrous fumarate 210mg od, ranitidine 150mg bd
• The most likely unifying diagnosis is
  A. Urinary tract infection
  B. Sarcopenia
  C. Sarcopenia and progressive frailty
  D. Malnutrition
  E. Depression and anxiety

• The most important aspect of management is
  A. Physiotherapy
  B. Treat her UTI, physiotherapy and discharge planning including rehabilitation
  C. Comprehensive Geriatric Assessment and intervention
  D. High protein diet and rehabilitation
  E. Resistance exercise programme, rehabilitation

• What aspects of her presentation/illness will have the most impact on her discharge.
  A. Physical weakness
  B. Social isolation
  C. Combined physical, social and psychological components of her illness/presentation
  D. Treatment of her urine infection
  E. Medication review
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Sarcopenia
Loss of muscle mass and strength and impaired physical function with age \(^1\)

After 50 years of age
- Loss of mass 1-2%/yr
- Loss of strength 1.5-3%/yr
- Sedentary > active
- Men > women

"I'll be back"  "oh my back"

\(^1\) European consensus on definition and diagnosis: Report of the EWGSOP, July 2010
How do older people present?

- Non specific fatigue
- Falls
- Delirium
- Weight loss and malnutrition
- Fluctuating disability
- Polypharmacy
- Social isolation
- Incontinence
- From a care home
- With a fragility fracture
Frailty spectrum

- Increased physiologic vulnerability
- Fully developed frailty
- Physical independence
- Begin of decline
- Disability
- Institutionalization
- Death

Challenges for clinical practice in older people

• Older persons needs are more complex
• Often have coexistent functional, psychological and social needs
• Lead to atypical presentations that can often be misunderstood
• Often requires different approach to care

• How do we manage and deliver exemplary care?
Comprehensive geriatric assessment for older adults admitted to hospital: meta-analysis of randomised controlled trials

Graham Ellis consultant geriatrician and honorary senior clinical lecturer, Martin A Whitehead consultant geriatrician, David Robinson consultant geriatrician, Desmond O’Neill associate professor of gerontology, Peter Langhorne professor of stroke care
Comprehensive geriatric assessment (CGA)

- Cornerstone of modern geriatric care
- Multidimensional interdisciplinary diagnostic process
- To determine medical, psychological & functional capability
- To develop coordinated & integrated care plan for long term treatment & follow up

Ellis BMJ 2011
CGA

- 22 trials, 10 315 patients, 6 countries (Ellis 2011)

- Patients admitted to hospital and who underwent CGA
  - More likely to be alive and in their own homes at 6-12 months follow up
  - OR 1.16 (favouring intervention) P=0.003 NNT 33 at 12/12 follow up compared to those who received general medical care
  - Patients less likely to be living in residential care OR 0.78, P<0.008
  - ‘Ward based CGA’ as opposed to team based better
  - Patients less likely to die or experience deterioration OR 0.76, P=0.001
  - Patients experienced better cognition
• CGA vs usual care
  – CGA with intervention reduces frailty burden and improves mobility. Home based PT and exercise with a multicomponent approach, psychological support and social support improves physical function and mobility (BMC Medicine 2013 11 65 evidence 1b)
The effect of patients being on a “ward”

• Dedicated wards have can devote time and focused care to older people
• Ward staff can foster development of greater skills and expertise
• Working in close proximity to a specialized group allows more efficient and effective multidisciplinary team working
• Mobile teams find difficulty to modify behaviors of other professionals involved in patient care and for them to follow recommendations
• Wards have protocols for the care and management of key conditions relevant for the older person
Comprehensive Geriatric Assessment

Screen

- Living on own?
- Involuntary weight loss?
- Tiredness/fatiguability?
- Mobility difficulties
- Memory impairment
- Slowness in walking

Comprehensive Geriatric Assessment

- Physical
- Functional
- Medical
- Nutritional
- Cognitive
- Social
- Environmental
- Anticipatory
CGA – how should it work?

• Most important aspect about CGA
  – Patient centred and what the patient wants
Patient Admitted to AMU. Identified as multiple admissions

If known to Virtual Ward:
Contact Community Health Team + collateral Hx from Patient or NoK

If not known to Virtual Ward:
Collateral Hx from Patient or NoK

• Living on own?
• Involuntary weight loss?
• Tiredness/fatiguability?
• Mobility difficulties
• Memory impairment
• Slow walk speed

Admitted upstream

Commence gathering key components of CGA, Identify Problems, Set Plan

Communicate with Community Health Colleagues
Follow up visit 4 weeks from Discharge
Adjust Plan if necessary

Continue Dialogue with Virtual Ward & GP
Adjust plan as needed

Patient D/C to usual residence

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