A Tale of Two Seniors

A Person-Centred Approach to Assessment & Management of Seniors

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Land Acknowledgement

In the spirit of reconciliation, we acknowledge that we live, work and play on the traditional territories of the Blackfoot Confederacy (Siksika, Kainai, Piikani), the Tsuut'ina, the Îyâxe Nakoda Nations, the Métis Nation (Region 3), and all people who make their homes in the Treaty 7 region of Southern Alberta.

Disclosures

- None

Objectives

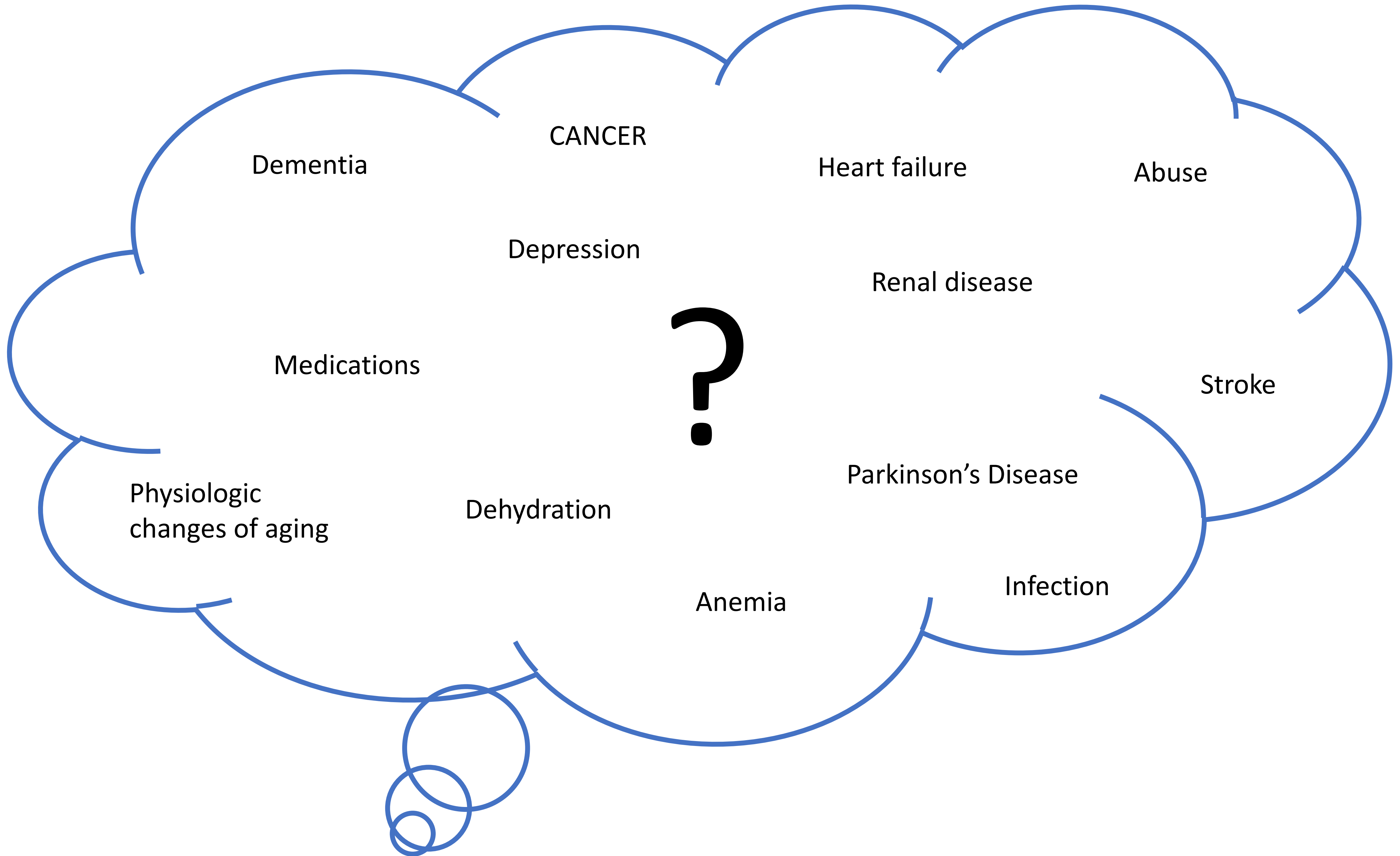
- Share my approach to seniors who present with **undifferentiated issues** and **medical complexity** in the office setting
- Appreciate the benefit of **individual patient context, function and goals** to inform your screening and management of seniors
- Increase awareness of **clinical resources** to support your care of seniors

Case 1: Mrs. B

- 89 year-old retired nurse and widow, lives alone in an independent seniors condo with supportive family in town and activities in her building, no financial issues
- On ASA 81mg and ramipril 5mg because of a query stroke in the past; work-up all negative, fully recovered, declined statin, BP well controlled, no cognitive issues; also takes Vit D and Calcium and fish oil
- No other medical issues, non-smoker, glass of wine at family dinners, vaccinated
- Recently stopped driving in dark (decreased confidence with vision), otherwise functionally independent, no Home Care, daily walks when sidewalks clear
- See her for driver’s medicals, med refills, odd worry about minor issues (e.g. rash)

Case 1: Mrs. B

- Comes to you with complaint of no energy for a few weeks, getting worse
- Not feeling myself; something’s just not right; lost my energy

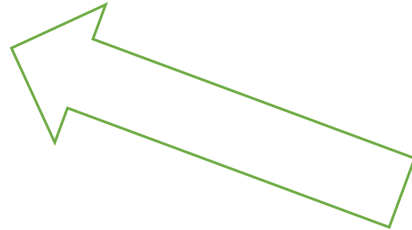


Dementia
CANCER
Heart failure
Abuse
Depression
Renal disease
Medications
?
Stroke
Physiologic
changes of aging
Dehydration
Parkinson’s Disease
Infection
Anemia

Good Questions	Better Questions
How is your sleep? Are you getting enough? Yes	Has your sleep **changed** at all? Yes- more broken at night, needs to nap in daytime Sometimes an ache in the back, sometimes nocturia Pain? Not pain- it's an ache- back, lower abdomen, vaginal
Are you eating and drinking enough? Yes	Are you eating/drinking **less/more** than usual? Less- but that's because I'm less active lately Flood in building- programs cancelled Can't outside because ice Can't stand for as long to cook- back gets "tired" Family is out of town on vacation
Any new medications or OTC? No	What OTC products are you using? Ibuprofen daily for a couple weeks
Any Pain? No	Has anything changed in your life recently? Has anything changed in your daily routine?

Case 1: Mrs. B

- “Pain” (back, abdomen, vaginal)
- Less intake
- Les active
- Taking NSAID



- Review of Systems- focus on a change from baseline
- Function/Routine
- Social history

Physical Exam

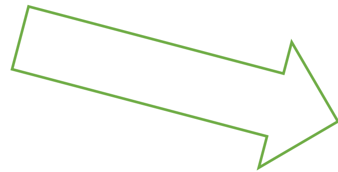
- Vitals: BP a bit soft
- Midline thoraco-lumbar pain, can self-transfer, gait normal
- Abdomen soft- generalized mild lower abdo discomfort, no guarding, ?fecal loading

DON'T STOP THERE!!!

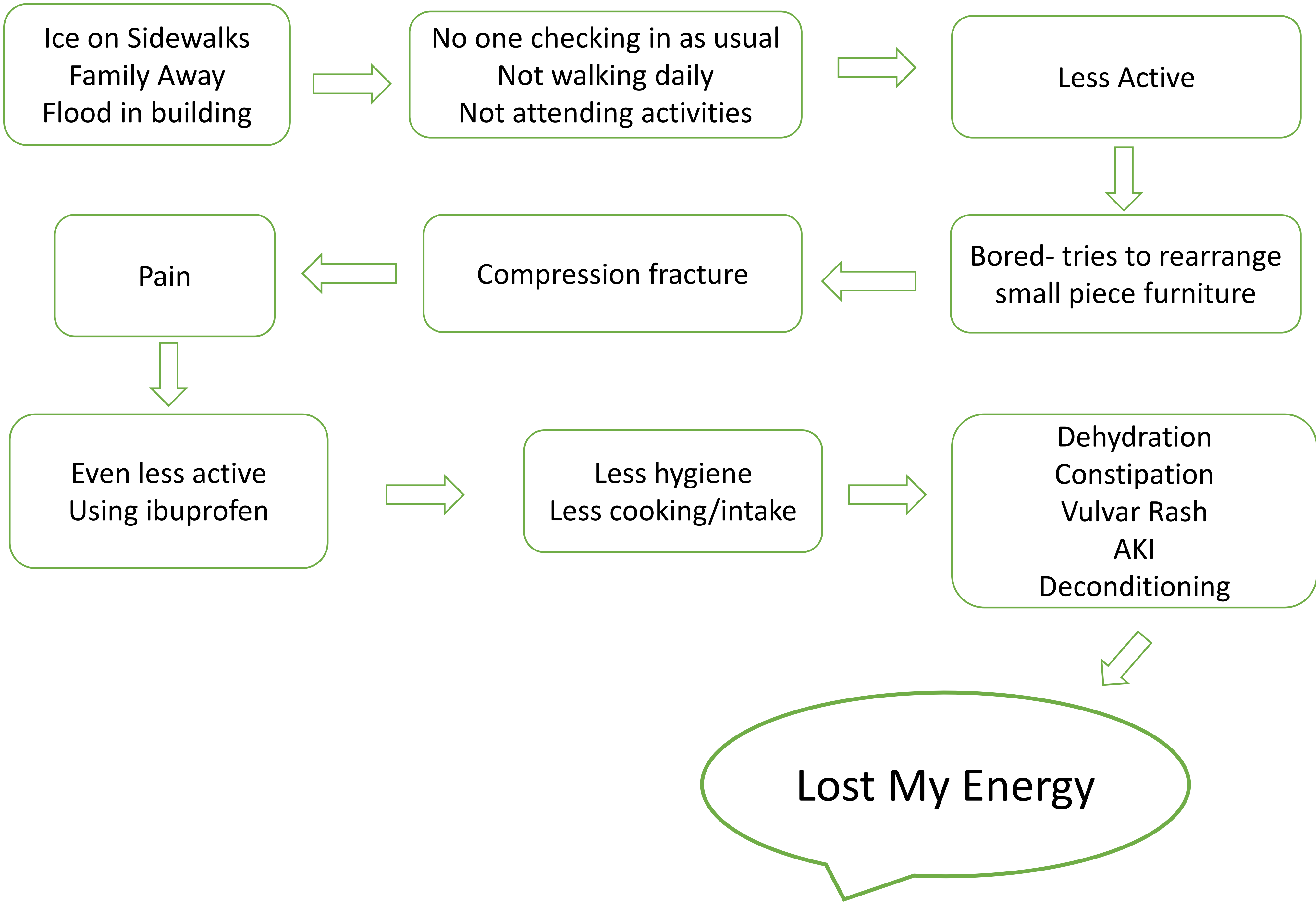
- Vaginal inspection- vulvar dermatitis, ?yeast

Case 1: Mrs. B

- Less intake
- Less active
- Taking NSAID
- ?Dehydration
- ?Constipation
- Back pain nyd
- Vulvar rash



Labs, xray (no need for urine!)
Fluids, PEG
Stop nsaid, hold ACE-I
Start acetaminophen
Topical steroid+antifungal
Short-term support and monitoring


Ice on Sidewalks
Family Away
Flood in building
No one checking in as usual
Not walking daily
Not attending activities
Less Active
Bored- tries to rearrange
small piece furniture
Compression fracture
Pain
Even less active
Using ibuprofen
Less hygiene
Less cooking/intake
Dehydration
Constipation
Vulvar Rash
AKI
Deconditioning
Lost My Energy

Key Points: Vague Presentation

- Often a multifactorial etiology
- ROS is good but remember to focus on changes
  - e.g. “decreased intake”
- Functional review (change from baseline) is key
  - e.g. “pain” vs. change in daily functioning
- Don’t forget about social history to help assess for changes, triggers and identify supportive needs
- We change a lot as we age- don’t forget the physical exam
- Use your clinical support resources to closely monitor response to treatment and interventions
- Don’t assume a vaguely unwell senior has a UTI

Asymptomatic Bacteriuria

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1. **Don't use antimicrobials to treat bacteriuria in older adults unless specific urinary tract symptoms are present.**

Why?

- Asymptomatic bacteriuria is common in the elderly but not associated with adverse outcomes
- Antimicrobial treatment can cause harms and
- Can cause failure to consider other causes of change in condition

ChoosingWiselyCanada.org (Geriatrics, last updated 2020; Long Term Care, last updated 2021)

Patient Handout

Antibiotics for Urinary Tract Infections in Older People

When you need them and when you don't.

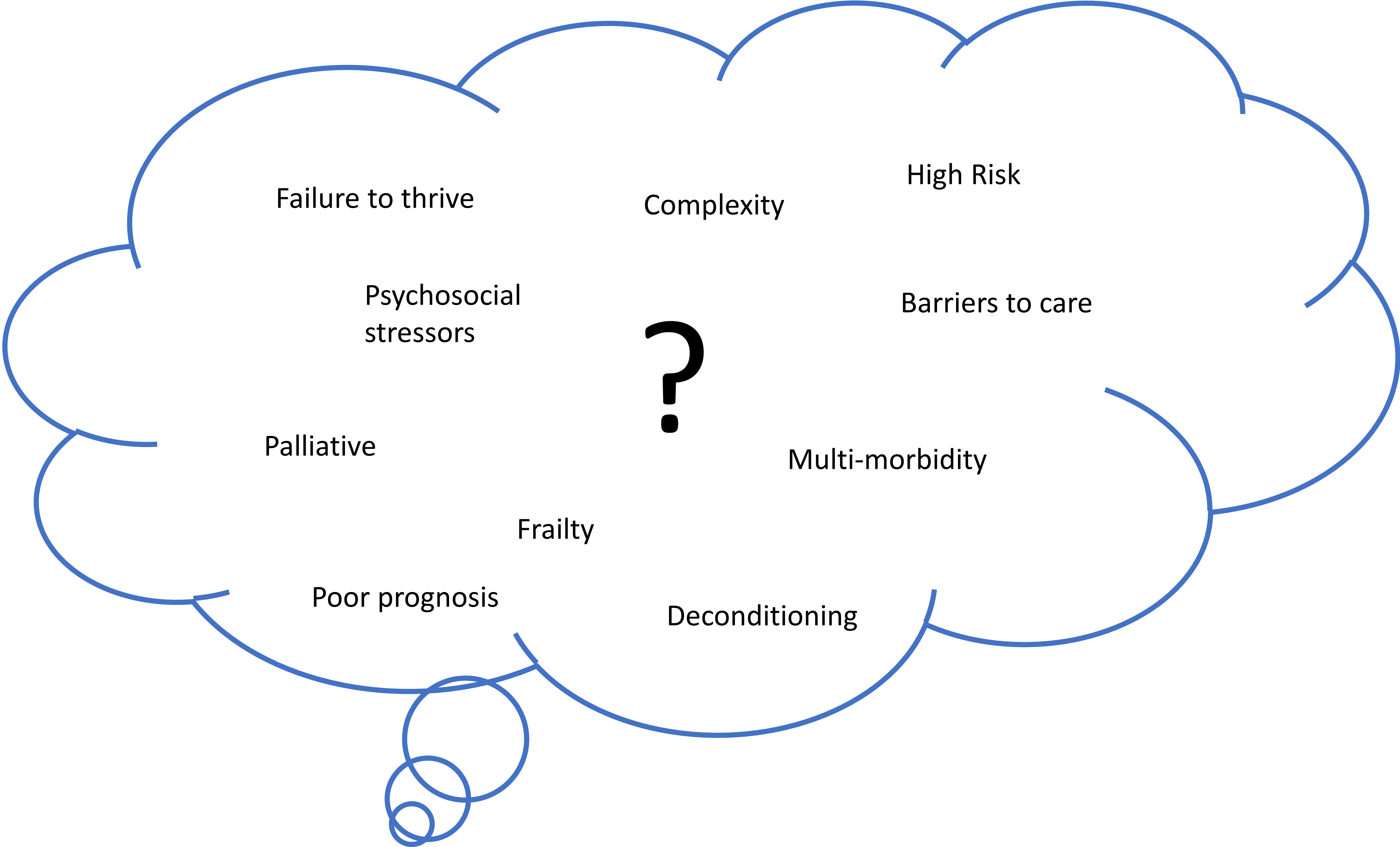
Download PDF

Case 2: Mr. F- Complex Comorbidity

- 73 year-old retired immigrant from eastern Europe, lives at home with wife (who has her own issues), no children, low income
- History:
  - DM2 (last A1C 9.2%, no hypoglycemic episodes)
  - Retinopathy, nephropathy (eGFR 30’s, stable), neuropathy
  - HTN (150’s baseline sBP)
  - CAD (MI w cabgx2)
  - CHF (peripheral edema, reuses old tubi-grip)
  - Afib (rate control and anticoag)
  - LUTS but no BPH or specific etiology found
  - Obesity, OSA untreated (can’t tolerate CPAP)
  - Mobility- uses cane, should use a walker; sob less than ½ block; no falls- yet
  - No cognitive issues, non-smoker, no substances, mood good

Case 2: Mr. F

- 14 medications, 3 vitamins, many OTC's at home, poor med compliance, adjusts or stops insulin or other meds intermittently
- 3 admissions in 3 years (CHF x2, covid pneumonia)
- Many specialists, poor follow-up
- Good follow-up at clinic; give him a written plan each visit, but follow-through is poor


Failure to thrive
Complexity
High Risk
Psychosocial stressors
?
Barriers to care
Palliative
Multi-morbidity
Frailty
Poor prognosis
Deconditioning

Approach to Mr. F (Complex Comorbidity)

- Understanding:
  - Social context and barriers to care
  - Functional status
  - He needs to understand his issues and prognosis (to best level he can)
  - You need to understand his goals and what he can/is willing/able to do
- Based on his individual context:
  - Manage acute issues
  - Manage chronic diseases
  - Approach screening, preventive care

Note:
- This is not a CGA
- See often
- Use your resources

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Functional Assessment

- Mobility/falls
- Continence
- Home management (cooking, cleaning, shopping, laundry)
- Medication mgt
- Transportation
- Hobbies
- Finances

Mr. F's Social & Functional Status

- Financial stress, can't afford medications every month, has to take wife to many medical apts and attend to her needs, can't get out for coffee with friend
- Is completing own IADLs but with concerns
  - hygiene marginal
  - using continence products
  - diet poor (quick, salty, unhealthy food)
  - home environment cluttered and needs a deep clean
  - poor med compliance despite blister packs
  - Is driving
- Home care can't go in…bed bugs

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Mr. F: Goals and Advance Care Planning

- Wants quality of life over quantity; would accept short hospital stay if could be back to baseline but no surgery or cancer tx; wouldn’t want to live at a level much below his current status; M1 GoC
- Forgets to take meds when out and too expensive, wants BID dosing only
- Would like legs (discomfort from swelling) and breathing to improve
- Wants to be able to meet friend for coffee once a week
- Would move to a facility with supports if wife could accompany, was affordable and had help with move

Advance Care Planning Tips

Goals of Care:

- Use the individual's context and not the form to guide discussion

Personal Directive:

- No lawyer needed; use the form on AB OPGT website; use health care team to support completing this; keep a copy on the chart

Enduring Power of Attorney:

- Best created with legal guidance; affordable option through Kerby Centre

Advance Care Planning Goals of Care | Alberta Health Services

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  - **Manage chronic diseases**
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Screening & Prevention

- Cancer, OP, CV, DM
- Cognitive, Mood
- Sensory
- Immunizations

Diabetes Targets: function rather than age

Table 1
Glycemic targets in older people with diabetes

Status	Functionally independent	Functionally dependent	Frail and/or with dementia	End of life
Clinical Frailty Index*	1–3	4–5	6–8	9
A1C target *Low-risk hypoglycemia* (i.e. therapy does **not** include insulin or SU)	≤7.0%	<8.0%	<8.5%	A1C measurement not recommended. Avoid symptomatic hyperglycemia or any hypoglycemia.
A1C target *Higher-risk hypoglycemia* (i.e. therapy includes insulin or SU)		7.1–8.0%	7.1–8.5%	

Diabetes Canada 2018 Clinical Practice Guidelines: Diabetes in Older People; Can J Diab 2018;42;S283

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5 **Avoid using medications known to cause hypoglycemia to achieve hemoglobin A1c <7.5% in many adults age 65 and older; moderate control is generally better.**

Reasonable Glycemic Targets:

- Healthy older adults with long life expectancy: 7.0-7.5%
- Moderate complexity, life expectancy <10 yrs: 7.5-8.0%
- Multiple morbidities, shorter life expectancy: 8.0-8.5%

ChoosingWiselyCanada.org (Geriatrics, last updated 2020)

Blood Pressure Targets

- **Canadian Diabetes Association (Diabetes Canada):**

  Functionally independent, >10 yr life expectancy: <130/80

  Functionally dependent, orthostasis, limited life expectancy: individualize

Diabetes Canada 2018 Clinical Practice Guidelines: Diabetes in Older People; Can J Diab 2018;42;S283

Blood Pressure Targets

- **Canadian Cardiovascular Society (Hypertension Canada):**
  - Risk-based approach to treatment thresholds and targets

Table 5. Blood pressure thresholds for initiation of antihypertensive therapy and treatment targets in adults

Patient population	BP threshold (mm Hg) for initiation of antihypertensive therapy	BP target (mm Hg) for treatment
Low risk (no target organ damage or cardiovascular risk factors)	SBP $\geq$ 160 (Grade A) DBP $\geq$ 100 (Grade A)	SBP $<$ 140 (Grade A) DBP $<$ 90 (Grade A)
High risk of cardiovascular disease*	SBP $\geq$ 130 (Grade B)	SBP $<$ 120 (Grade B)
Diabetes mellitus	SBP $\geq$ 130 (Grade C) DBP $\geq$ 80 (Grade A)	SBP $<$ 130 (Grade C) DBP $<$ 80 (Grade A)
All others	SBP $\geq$ 140 (Grade C) DBP $\geq$ 90 (Grade A)	SBP $<$ 140 (Grade A) DBP $<$ 90 (Grade A)

Hypertension Canada 2020 Guidelines: Can J Cardiol 36 (2020) 596-624

Table 6. Clinical indications defining high-risk adult patients as candidates for intensive management

Clinical indications
Clinical or subclinical cardiovascular disease; or
Chronic kidney disease (nondiabetic nephropathy, proteinuria < 1 g/d, [*]estimated glomerular filtration rate 20-59 mL/min/1.73 m^2); or
Estimated 10-year global cardiovascular risk $\geq 15\%$[†]; or
Age ≥ 75 years
Patients with 1 or more clinical indications should consent to intensive management.

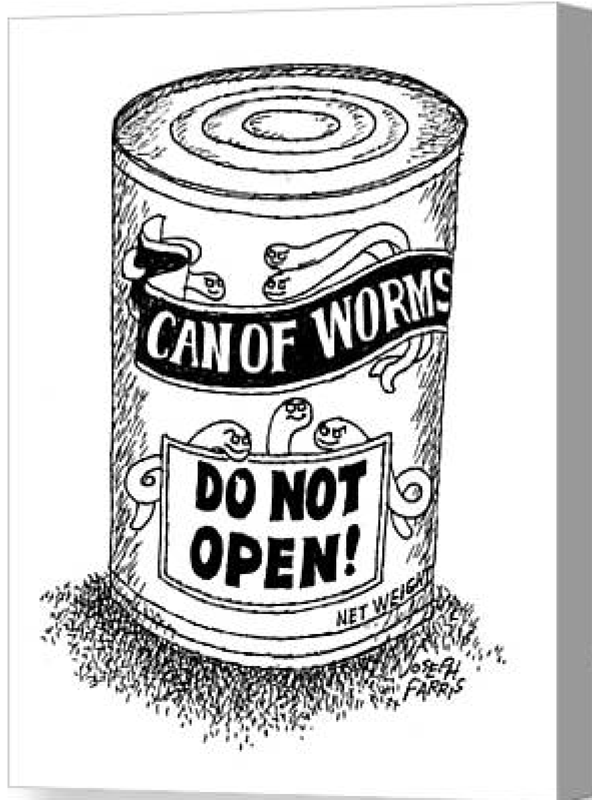
Hypertension Canada 2020 Guidelines:
Can J Cardiol 36 (2020) 596-624

2020 Canadian Hypertension Guidelines

- "Patient selection for intensive management is recommended and caution should be taken in certain high-risk groups"
  - institutionalized elderly individuals (limited or no evidence)
  - Unwilling or unable to adhere to multiple medications (contraindication)
  - Unable to measure BP accurately (contraindication)
  - Standing SBP <110 (contraindication)
  - No mention of frailty, limited life expectancy, dementia
- "...encourage the use of clinical judgement and shared decision-making when identifying BP targets to ensure feasibility in the patient's broader clinical, social, and economic context"

Hypertension Canada 2020 Guidelines: Can J Cardiol 36 (2020) 596-624

Frailty and Life Expectancy



Clinical Frailty Scale:
Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ. 2005;173(5):489–95

ePrognosis.ucsf.edu

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Clinical Support Resources (Team)

- Specialized Assessments: Function, Falls, Cognition, Driving, Capacity
- Home Care
  - Functional support and assessment (OT, PT), falls, wounds, eye drops, monitoring, placement, SW, dementia care team, specialized chronic disease teams
  - Geriatric Consult Team (CGA)
- PCN
  - SW, Geriatric RN, Geriatric Assessment and Support clinic (CGA)
- Carewest Day Hospital
- Carewest Comprehensive Communicty Care (C3)
- Falls Prevention Clinic
- Senior’s Health Clinic (CGA)
- Specialist Link: Geriatric Medicine
- Regional Capacity Assessment Team (RCAT)
- Community Accessible Rehab (CAR)

Approach to Mr. F based on his context

Acute Issues	ST: Bed bug treatment, medication affordability MT: Support functioning and move to more supportive living situation
Chronic Diseases/Issues	ST: Once med compliance supported and monitoring in place: BP reduction, A1C around 8.0% Med review w focus on (BG, BP, fluid), BID dosing; non-pharma edema mgt LT: reassess LUTS, reassess tx goals
Prevention, Screening	ST: Immunizations, Falls prevention- environmental assessment MT: Ophtho LT: Annual cognitive screen
Resources and f/u	SW- bed bugs, med payment (Pharmacist also), cleaning, MoW Home Care- med admin, bath support, placement, emergency alert, weights/BP/BG, dietician Diabetes nurse Visit min q monthly then aim for q3 months Consider C3 Program if doesn't want to move

Approach to Mrs. B

Social Context and Goals	Well supported M1; wants to pass at home but would accept hospital stay for uncomplicated, reversible issue Seeing family most important; continue social/exercise in building
Function	Recent change due to compression #, now back to baseline- independent
Acute issues	Osteoporosis mgt, falls prevention
Chronic disease mgt	BP in 130's- does not want to be more aggressive; check standing BP Wants to cont ASA, ACE-I
Screening/ Prevention	Immunizations, optometry Mobility- walking, exercise classes Maintain socialization
Resources & Follow-up	Environmental assessment for falls prevention Visit q~6 mo; if no concerns- reassess function

Summary:

- When assessing a vague presentation in elderly focus your review on a change from baseline (and don't fall into the UTI trap)
- Understanding patient context, goals and functional status will:
  - Aid in assessment of vague and complex presentations in seniors
  - Inform management
  - Guide screening and preventive care
- Use clinical resources to assist you with assessment, management, support and monitoring

“It is much more important to know what sort of a patient has a disease than what sort of a disease a patient has.”

~William Osler