Geriatricians and the Management of Long-term Conditions

Long term conditions are the main reasons for multiple pathology, and multiple pathology is the main explanation for the non-specific presentations of disease that typify geriatric medicine – such as the geriatric conditions or geriatric giants of immobility, instability and intellectual impairment.

Long term conditions are managed principally in primary care settings, yet much acute hospital work can be seen as episodes of exacerbations of long term conditions rather than de novo acute, self limiting conditions. Hospital care and community care are part of the same process of managing long term conditions.

Secondary care services are able to develop specialist areas of expertise, for example, in stroke, Parkinson's disease and in falls. This expertise is required both for those who are acutely unwell and also for those in the stable phases of their long term conditions.

It follows that promoting community geriatricians in support of this process is required, including

- training of geriatricians for this role
- supporting the CPD for geriatricians in this role
- taking a lead on the multi-disciplinary education and training of staff involved in these services and
- identifying the R&D needs in this process

Policy developments strengthening primary care provide the specialty of geriatric medicine an opportunity to review and strengthen its partnership with primary care. The Department of Health has promulgated a three level model for the management of long term conditions: self management, disease management and case management for those with complex and multiple conditions. It is this latter group that geriatricians have most to offer, backed up by the evidence-based practice of comprehensive geriatric assessment.

The BGS Primary and Continuing Care SIG offer a model of care for frail older people, and this is intended to be useful for the effective implementation of services for such people, including case management (Figure 1).

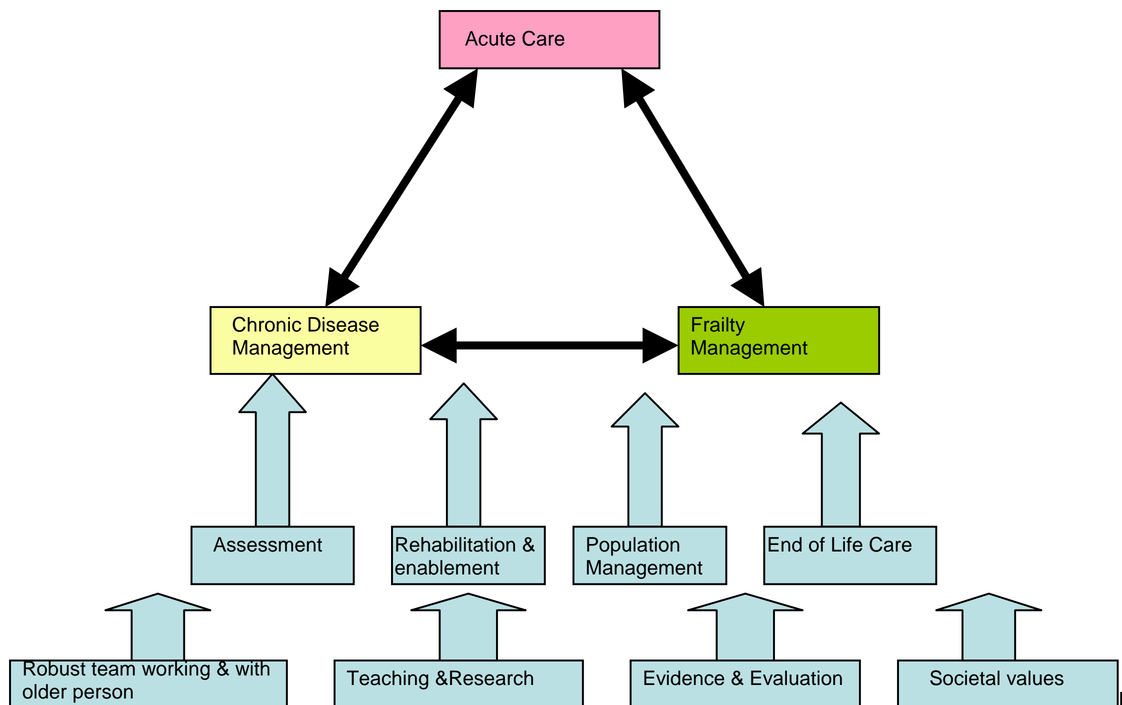

Figure 1

Fundamental to any system managing long term conditions is the requirement of the patient to access appropriate types of treatment, delivered in a flexible and collaborative fashion wherever the patient lives. These should include:

- Acute treatment
- Comprehensive assessment and review
- Rehabilitation and re-enablement
- Palliative care and end of life care

Elements that underpin sound service implementation include teaching, training, governance and research.

A considerable number of frail complex older people suffering from long term conditions live in care homes and in some areas account for a disproportionate number of admissions to acute hospitals. A case management system such as has been demonstrated to be effective in the United States could be used in the United Kingdom.

The role of the geriatrician should include:

- Participation in the management of older people with multiple long-term conditions, as well as common conditions in older people affecting their function such as Parkinson's disease
- Providing advice at times of transition, recognising the limitations of active intervention and the importance of palliation
- Providing specialist clinical support to primary care in the management of frail older people especially at the time of a health crisis
- Providing professional support for assessment processes used on older people, in particular the assessment for NHS continuing healthcare and NHS funded nursing care
- Leadership of clinical governance arrangements for services outside the hospital.
- Nurturing the multidisciplinary team in the primary care sector, including teaching
- Leading and facilitating the R&D in services for long term conditions

Preface
This document was first prepared for the BGS in 2005 by a working party of the BGS Primary and Continuing Care SIG working party comprising Dr Jackie Morris, Dr John Gladman, Dr Ian Donald, Dr Willie Primrose, Dr Finbarr Martin, Dr Clive Bowman, Dr Gordon Campbell, Dr Chris Turnbull, Dr Chris Foote, Dr Tony Luxton, Dr Eileen Burns, Dr Elizabeth Raw, Dr Amanda Thompsell and Mr Richard Lynham. It was prepared in the light of the UK's NHS growing policy interest in long term conditions, and aimed to contribute by clarifying the role of geriatricians, particularly in the management of older people with multiple and complex conditions.

It is BGS policy to revise its documents periodically, in the light of new evidence and to maintain relevance to developments in health policy. This document was therefore extensively revised by the BGS Primary and Continuing Care SIG in 2009, with particular contributions by Professor John Gladman, Dr Ian Donald, Dr Willie Primrose and Dr Chris Turnbull.

1 Background

Long term conditions are the main cause of multiple pathology, and multiple pathology is the main explanation for the non-specific presentations of disease that typify geriatric medicine – such as the geriatric conditions or geriatric giants of immobility, instability and intellectual impairment.

Long term conditions are managed principally in primary care settings, yet much acute hospital work in the developed world can be seen as episodes of exacerbations of long term conditions rather than de novo acute, self limiting conditions. Hospital care and community care are part of the same process of managing long term conditions.

Secondary care services are able to develop specialist areas of expertise, for example, in stroke, Parkinson's disease and in falls. This expertise is required both for those who are acutely unwell and also for those in the stable phases of their long term conditions.

It follows that promoting community geriatricians in support of this process is required.

2 The BGS integrated model

The Department of Health uses a three level model to describe long term condition management [1]. The first level is self management of long term conditions, and this requires people with long term conditions to know about their condition, and to be empowered regarding their treatment. An example might be in ensuring that a person with insulin dependent diabetes can monitor and adjust their treatment as needed. The next level is disease management, where disease-related services support specific aspects of long term management. Taking diabetes as an example again, this might include routine screening for nephropathy, hypertension and retinopathy. The third level is case management, and is suggested for people with complex, multiple needs. In England, community matrons have been widely implemented to attempt this. Whilst case management per se has a mixed evidence base for effectiveness, and the English

community matron service is as yet unproven, it is reasonable to assume that case management (using community matrons or some other means) can deliver the principles of comprehensive geriatric assessment – a well established and evidence based approach to older people with complex needs [2].

The BGS believes that a particularly important role that geriatricians must play in long term condition management is in contributing to the management of vulnerable older people with complex needs wherever they are – be it in hospitals, in intermediate care settings, in care homes, or those who are on community matrons' caseloads. The BGS uses an integrated model of care encompassing health and social care systems to understand the underlying processes necessary to do this effectively (Figure 1).

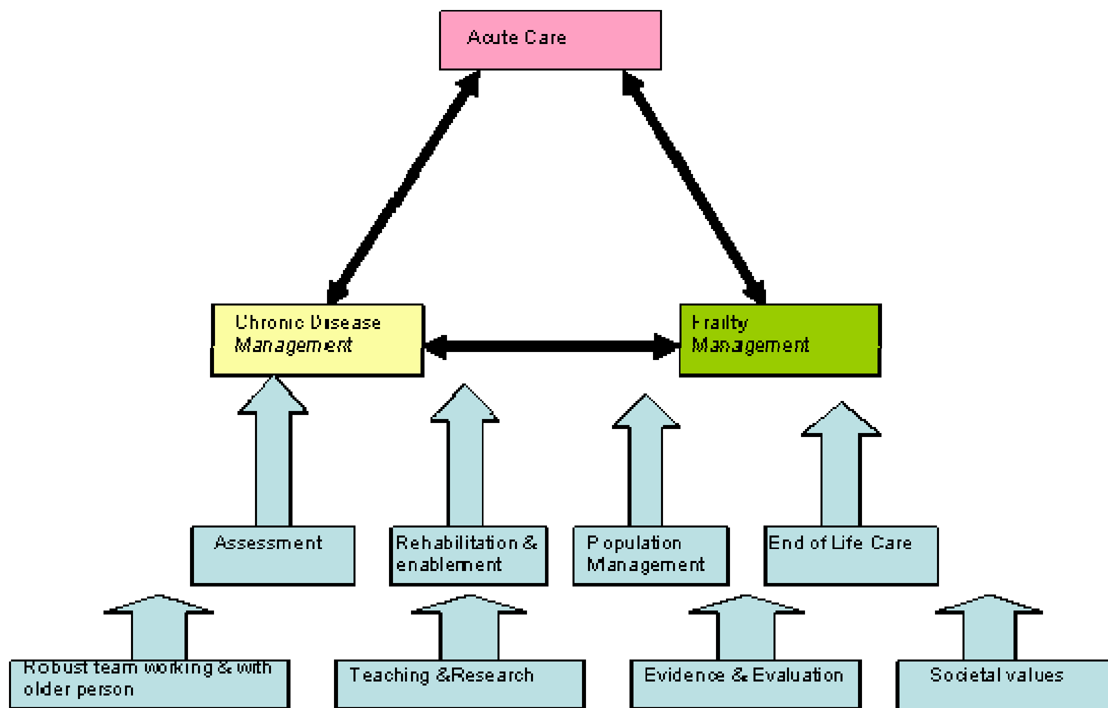

Figure 1

Fundamental to any system managing long term conditions is the requirement of the patient to access appropriate types of treatment, as shown in the model, delivered in a flexible and collaborative fashion wherever the patient lives. These should include:

- Acute treatment of exacerbations of their conditions
- Comprehensive assessment at whatever point they come into contact with services
- Rehabilitation and re-enablement
- Palliative care and end of life care

Figure 1 helps to illustrate the role of the geriatrician. Considering the blue boxes in the lower part of the figure:

- Departments of geriatric medicine provide a valuable multidisciplinary skill resource, and experience in a variety of team work models. Community geriatricians can help develop team working in community settings, not least by contributing a secondary care perspective to other settings (such as intermediate or primary care).

- Many geriatricians are trained in research and teaching, have collaborations with local, national and international colleagues, and hence can take a significant role in teaching and research. Teaching is a crucial aspect of team development. Research is now a core NHS role, and has advantages in terms of staff development, recruitment and retention.
- There is a potential problem of quality assurance and service monitoring in the care of vulnerable elderly people. For example death or institutionalisation rates may not be good indicators of success of services. Disease specific indicators (such as the proportion of hypertensive people achieving normotension, or people with diabetes achieving low levels of glycosylated haemoglobin) may not be helpful. Sector specific indicators (such as length of stay) do not capture the patients' overall experiences if they have multiple transitions between services and sectors. Community geriatricians, by virtue of their familiarity with the evidence base relevant to vulnerable older people and their cross-cutting role, can help in this process.
- It is a tenet of geriatric medicine that frail older people may present to any health, social or other sector with a non-specific problem that is usually due to a combination of acute and chronic health conditions. Those trained in the specialty of geriatric medicine have specific expertise in establishing the contributions of these health conditions. It is important that those who present to a social worker with a propensity to fall, for example, can be comprehensively assessed by health professionals including geriatricians where needed.
- Rehabilitation is a multidisciplinary process, and most of the barriers to rehabilitation or recovery are medical or have medical contributions (e.g. pain, depression, constipation, cardiac failure, COPD, or iatrogenic conditions). Geriatricians, or in some settings GPs with special training, are needed to ensure that these barriers are overcome and hence that rehabilitation services and teams work effectively.
- End of life care, including both planning for it, the delivery of palliative care and also terminal care, are inevitable and essential aspects of the management of those with multiple and complex conditions. Geriatricians have great expertise in these aspects of care by virtue of their training and every day experience.

The top three boxes of Figure 1 illustrate that acute care is not divorced from long term condition management. An episode of acute care might be evidence of a failure of long term condition management, but more often it might be simply an inevitable event that signifies a need to alter the long term condition management plan. Such episodes of acute care need to be delivered mindful of the long term management plan already in place, and insights obtained from such acute admissions need to be absorbed into the future long term condition management plan.

The top three boxes of Figure 1 also indicate that some patients may need disease management at some points in time and frailty management (an example of which in England would be case management by community matrons) at others. The breadth of training of geriatricians enables them to support both processes at the same time – for example in providing complex COPD or CCF management advice when and where needed.

The arrows between the top three boxes in Figure 1 illustrate that the patients move from sector to sector, and this Figure does not describe the myriad services and sectors that these patients encounter. It is at points of transition that errors and new problems emerge, and by working across sectors community geriatricians are uniquely positioned to ensure smooth flow of information over transitions.

3 Long term conditions - care homes

The population management approach referred to in the above model reminds us that in most UK Primary Care Trusts, or similar units of health care responsibility, a considerable proportion of the people with long term conditions are in care homes, around 4-5% of people aged over 65 years reside in such settings in the UK. In some areas, residents of care homes account for large disproportionate numbers of hospital admissions. In many parts of the UK the usual models of primary care provision do not make it easy to deliver high quality care to residents of care homes, particularly in areas where there is a high density of homes or when many practices have responsibility for different residents of the same home. It is recognised that the management of long-term conditions in care homes separately and care is subject to a different set of standards and regulations.

Some people in care homes or other long term care settings are fully NHS funded and support by NHS continuing healthcare, although only a minority. Even in these people, their primary medical care tends to be delivered by general practitioners and not geriatricians (or other specifically trained physicians such as in other countries).

There is no reason why residents of care homes should not benefit from high quality case management services. Indeed, the models of case management from the USA that have recently been tried in the UK were mainly based in nursing homes [3]. However, there are approaches other than case management. In the first decade of this century there has been the development of novel models of health care for the care home sector, given the absence of firm evidence for the superiority of one model over another and the population management perspective to complex long term conditions. These have been briefly described in a recent commentary [4].

One example of an innovative development in Chester le Street Newcastle is outlined below and illustrates that active organisation of services in primary care can create the service structure that is capable of delivering the core processes of high quality care to care home residents. This is not an approach that can necessarily be replicated elsewhere, but it is an illustration of what can be achieved with innovative thought. The Castlegarth Practice, Durham and Chester le Street Primary Care Trust was established to provide proactive care solely to the frail elderly residents of residential and nursing homes in Durham and Chester le Street. The practice was staffed by two full time nurse practitioners who case managed 100 patients each in several different nursing homes. Medical support to the nurse practitioners was provided by GPs. Geriatric medical input was provided by a GPwSI in geriatric medicine for four sessions per week. The practice targeted key areas specifically relevant to this patient group. For example a local Quality and Outcome framework for the new GP contract incorporated falls assessment and future areas included palliative care, tissue viability and continence. The style of practice was proactive, rather than reactive care: this is likely to be both efficient as well as effective. The practice liaised monthly with the secondary care geriatric medical department, as well as forged links with occupational therapy OT, physiotherapy, dieticians, the continence team, and tissue viability services. Practice staff worked closely with the staff in the care homes and there was an ongoing educational programme. An example of the service in practice is an elderly lady in a residential home with cognitive impairment who, over a few weeks became more agitated and had sustained several falls resulting in numerous trips to the Emergency Department in the preceding weeks. Home review with comprehensive geriatric assessment by assessment by the team revealed two unrecognised diagnoses: a large postural hypotension (a treatable condition that commonly causes falls and blackouts) and thyrotoxicosis

(another easily treated condition, due to an over active thyroid gland which caused many of her symptoms). After treatment she was less agitated had no further falls.

4 Long term conditions – high standards, working with primary care

The differing patterns of long-term conditions prevalence, their different settings (in care homes or private residences; urban and rural), the different ethnic mix of population, and differences in organisation of primary care across the UK mean that service structures cannot be the same. The lack of an identical service structure should not be used as an excuse for poor standards of care. The BGS model illustrates the core processes that all services need to demonstrate, but knowledge of this alone does not assure that the standards of care will be high.

The Royal Colleges of Physicians and General Practitioners [5] identified key ingredients to successful implementation, which included:

- Clinical leadership
- Communication - trust and team working
- Close working across the Primary / Secondary care interface
- Patient involvement
- Shared records
- Use of clinical governance

These are the same ingredients which create successful networking, and success in our central processes of acute care, chronic disease management, and frailty management.

Delivering high quality care for people with long term conditions necessarily requires a partnership between geriatricians and primary care physicians. The BGS and RCGP have considered this and provided guidance in another Best Practice document [6].

5 Long term conditions – examples of the provision of community geriatricians

This paper has already argued that geriatricians are necessary to the successful management of older patients with complex long term conditions, and hence the implementation of case management. A community geriatrician will typically work across community and hospital settings, providing expertise in acute and chronic care. A geriatrician will contribute usefully to the assessment process, by providing an adequate diagnosis, particularly in complex settings when illness presents non-specifically or when iatrogenic problems are suspected. The geriatrician's understanding of prognosis in frail older people is useful in planning care at the end of life. The geriatrician can work with case managers and the teams that support them (such as intermediate care teams) to identify and treat the medical barriers to rehabilitation. Geriatricians can complement teams, help train staff and maintain their on-going development, help in assuring standards and help in developing the research and development agenda.

From our experience we advise that there should be at least one identified geriatrician linked to each locality (in England and Wales, a Primary Care Trust) to support the local network of case management. Such arrangements are now in place in many parts of the UK – examples include Leeds and Nottingham.

For example, Leeds has a history of high hospital usage and the hope was that intermediate care might allow a cohort of patients to avoid hospital admission. However, early indicators showed a lack of impact on hospital activity. An experimental secondment by one geriatrician facilitated as well as prevented hospital admissions, with

many patients requiring specialist medical support. The intermediate care team welcomed the geriatrician's role, enabling them to manage patients who would otherwise have been admitted. The local GPs were also very positive about the role, indicating also a willing to support patients in the community with the additional input of the community consultant. Each of the 5 PCTs in Leeds agreed to fund a 0.5 WTE consultant geriatrician to work part-time in the acute trust and part time in the community. The role of the community geriatrician is to support all aspects of intermediate care. With the advent of chronic disease management nurses they also are developing a close working relationship to support these staff. Future targets are comprehensive geriatric assessment of all older people considering a move into long term care and meeting the health needs of residents of nursing homes more effectively.

Another example is in Nottingham, where there were concerns about the safe implementation of intermediate care and the effective implementation of case management by community matrons. Again, an experimental 0.5 WTE secondment by a geriatrician to support matrons, intermediate care teams, and the GPs of fragile older people who "can't come, won't come, or shouldn't come" to the clinic or hospital was undertaken. As in Leeds there was a positive response from GPs and primary care services, and a joint commissioning process between the two PCTs and the acute Trust has secured 3 further full time posts each of which has a 0.5 WTE community commitment. There is now a NIHR research programme grant in Nottingham, two work streams of which involve developing and testing models of comprehensive and co-ordinated specialist care in the community.

6 Long term conditions, conclusions

The role of the geriatrician should include:

- Providing investigation, diagnosis and management for older people with several long-term conditions.
- Providing advice at times of transition, recognising the limitations of active intervention and the importance of palliation.
- Providing specialist advice for conditions that are common in older people but not everyday conditions for general practitioners, e.g. Parkinsonism
- Providing professional support for assessment processes used on older people, in particular for NHS continuing healthcare and for NHS funded nursing care [7].
- Leadership to clinical governance arrangements for services outside the hospital, with support from primary care physicians and social services.
- Nurturing the multidisciplinary team, contributing to service development and training.

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