Geriatrics and Chronic Disease Care

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Geriatrics as the Model for Chronic Disease

- Chronic disease is THE major issue in health care
- Current organization of health care is inappropriate

Geriatrics = Chronic Care + Gerontology

Core of Geriatrics

- Age-specific syndromes
  - **Falls**
  - **Dementia**
  - **Incontinence**
- Atypical disease presentation
- Management
  - **Multiple, simultaneous, interactive problems**
    - **Medical**
    - **Coordination**

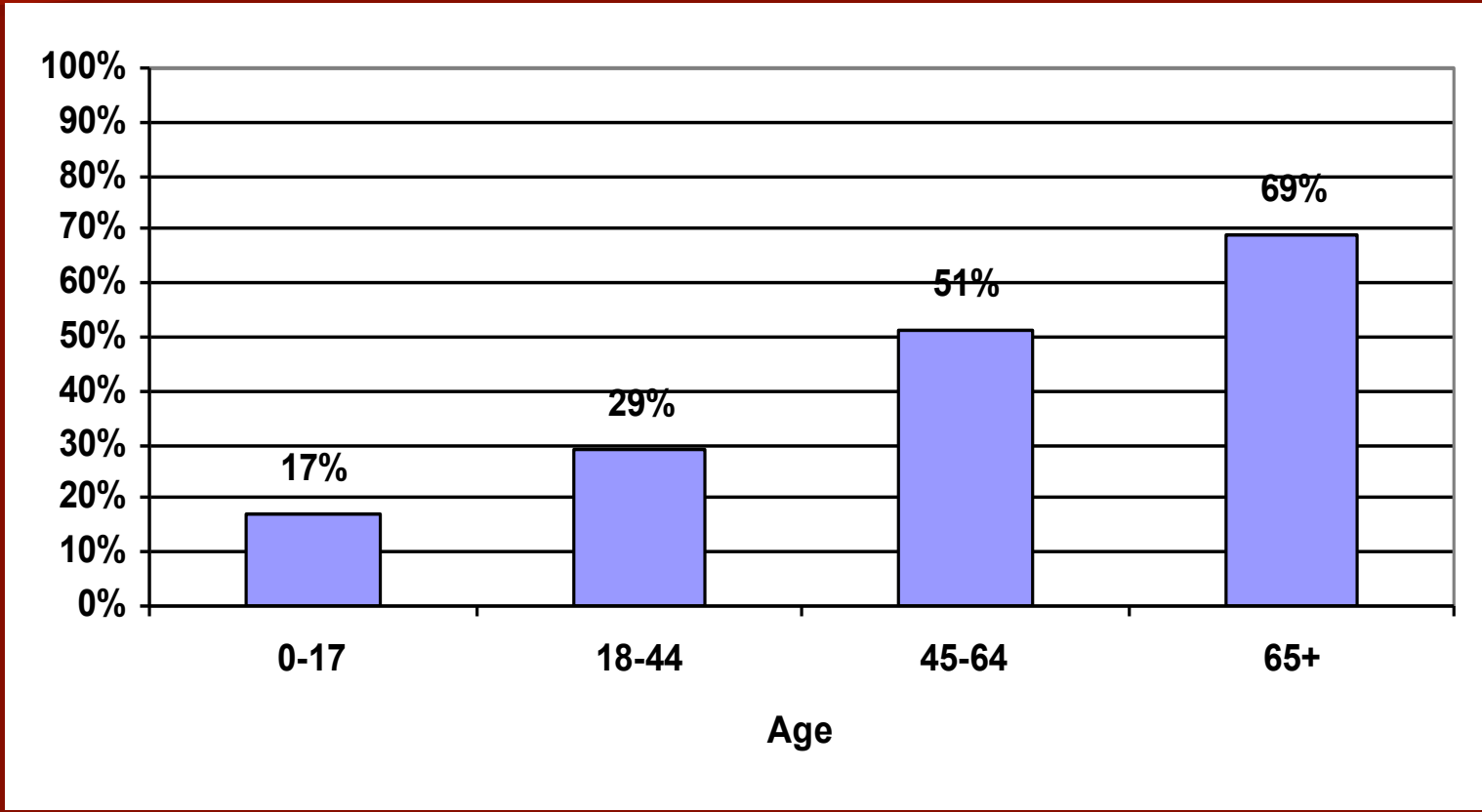
Chronic Disease Epidemiology

- Preventing a chronic disease will increase the absolute number of people with chronic diseases (Boult, 1996)

  Competitive risk

- Prevalence of chronic disease increases with age
- Age-related and aging-associated diseases

Persons With More Than One Chronic Condition



Source:
Hoffman, Catherine, and Rice, Dorothy P. Estimates based on the 1987 National Medical Expenditure Survey. University of California, San Francisco – Institute for Health & Aging, 1995.

Age and Disease

Age-related Diseases

- ✓ **Rheumatoid arthritis**
- ✓ **Acute lymphocytic leukemia**
- ✓ **Multiple sclerosis**

Aging-associated Diseases

- ✓ **Ischemic heart disease**
- ✓ **Cancer**
- ✓ **Stroke**
- ✓ **Dementia**

Goals of Chronic Disease Care

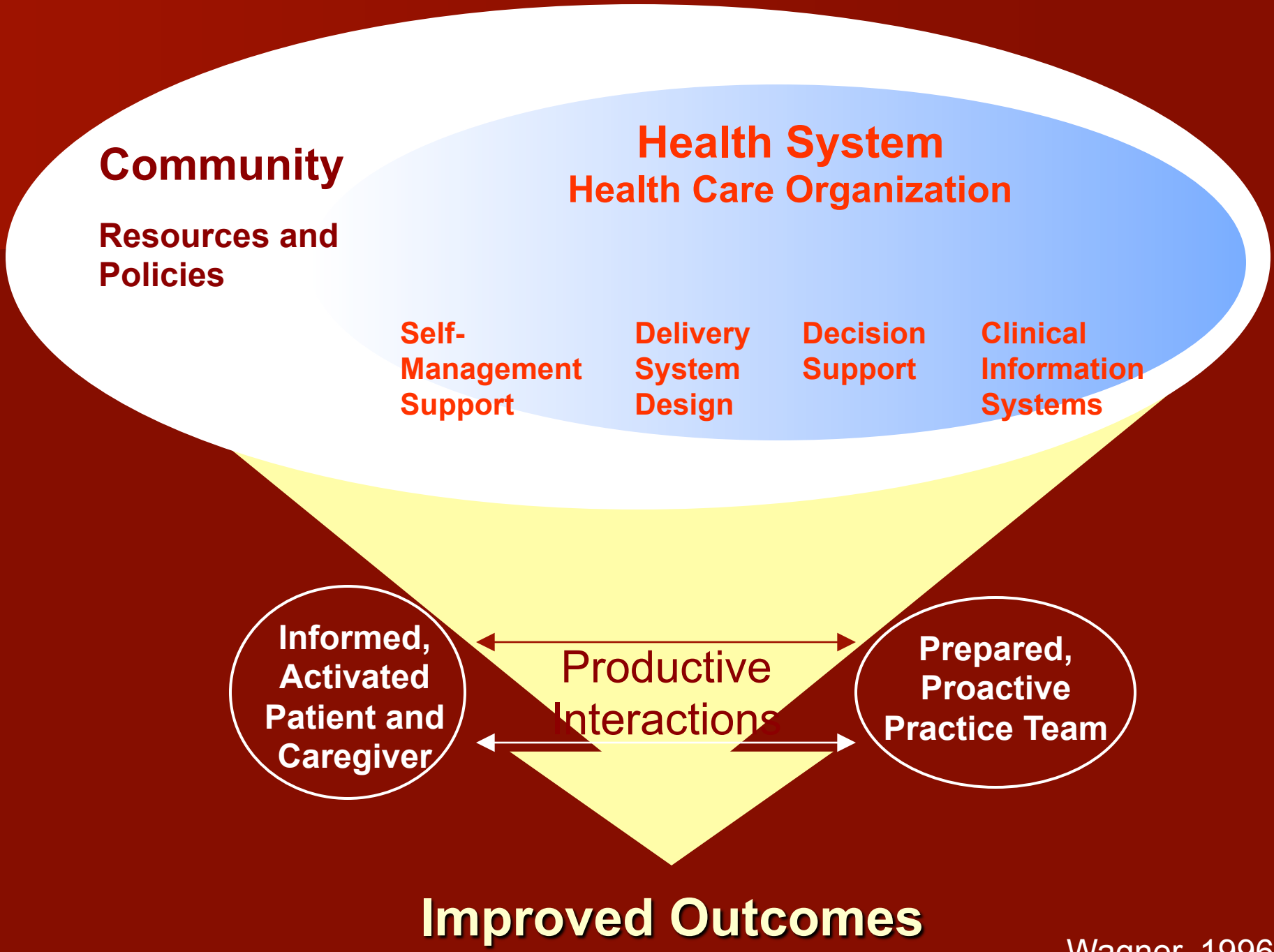
1. Manage the disease as well as possible to reduce the extent and frequency of exacerbations.
2. Minimize the transition from impairment to disability, and from disability to handicap.
3. Encourage patient to play an active role in managing his/her disease but avoid allowing the disease to become the dominant force in the person's life.

More Goals

4. Provide care in a culturally sensitive manner.
6. Integrate medical care with other aspects of life without medicalizing those aspects.

Components of Chronic Disease Care

- Patient experience of care
- Care delivery teams
- Organizations within which delivery teams and patients interact
- Regulatory and payment environment


Community
Resources and Policies
Health System
Health Care Organization
Self-Management Support
Delivery System Design
Decision Support
Clinical Information Systems
Informed, Activated Patient and Caregiver
Productive Interactions
Prepared, Proactive Practice Team
Improved Outcomes

Wagner, 1996

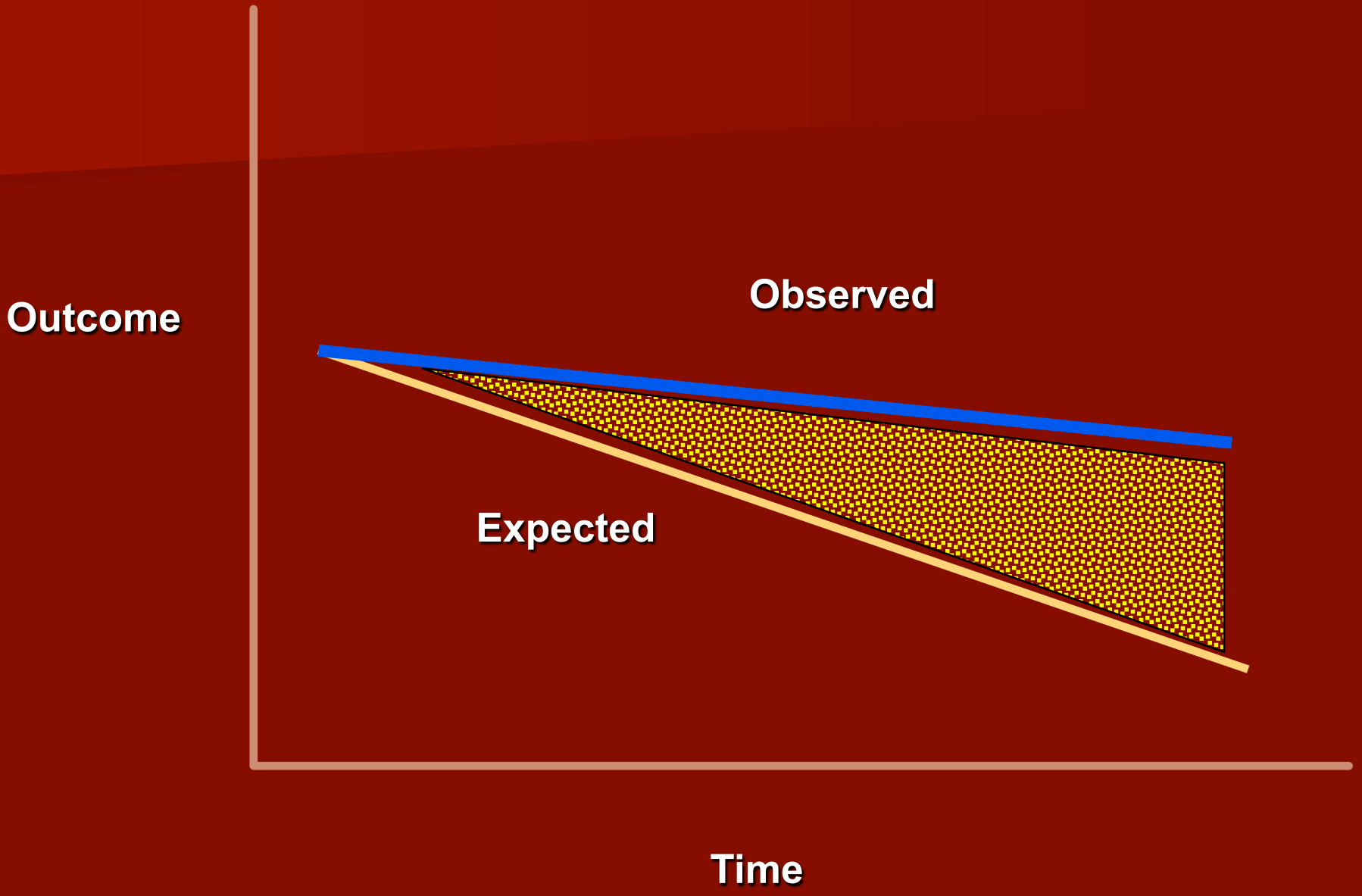
Implications of Chronic Care

New definitions

- **Prevention**
- **Patients' roles**
- **Time**

New approaches

- **Professional roles**
- **Expectations**
- **Information technology**
- **Management**
- **Integrating acute & LTC**


Outcome
Observed
Expected
Time

Evidence of Success

- Increased clinic visits and reorganization associated with fewer hospitalizations and urgent care visits in VA
  - COPD
  - Pneumonia
  - CHF
  - Angina
  - Diabetes
  - Chronic renal failure
  - Depression

Ashton, NEJM, 2003

- Quality care related to better survival among vulnerable older patients

  Higashi, Ann Int Med, 2005

- Self-management programs for diabetes and hypertension improve outcomes

  Chodosh, Ann Int Med, 2005

- Medication adherence reduces hospitalizations for diabetes, hypertension, hypercholesterolemia and CHF

  Sokol, Med. Care, 2005

Models of Chronic Disease Care

- Primary care with specialty referrals
- Primary care from specialists
- Organ systems care by specialists, primary care by GNPs

Meeting the Challenge of Chronic Illness

Robert L. Kane
Reinhard Priester
Annette Totten

Johns Hopkins University Press, 2005