Managing elderly persons with multiple illnesses in primary care

This guide proposes a comprehensive approach centred around caring for the elderly and their multiple diseases. It concerns both patients with loss of autonomy and those without.

Key points

- With increasing life expectancy, the prevalence of chronic illnesses is also increasing on a regular basis. From the age of 75 years, it is very common for people to be suffering from at least two chronic illnesses. Added to the risks of multimorbidity are those associated with polypharmacy and the multiplicity of prescribers.
- Caring for patients with a number of chronic conditions is an ongoing process: identifying patients, informing them, interviewing and assessing them, planning their care, follow-up and treatment adjustments with the patients and their family.
- The most effective approaches combine managing the chronic illnesses with managing their functional, social and psychological problems. They should be prioritised according to the severity of their illnesses and the patients’ own priorities.
- Care is a multidisciplinary affair: it calls for the professionals involved to work together and for standardized key messages to be passed on to the patients.
- It highlights the responsibility of the regular doctor for coordinating the care pathway, organising the interventions by the various parties involved and keeping track of the multiple medications.
- It requires patients to be involved by keeping them informed, by offering them therapeutic education if need be, and by including them in the follow up of treatment decisions.
- Patient monitoring should be intensified at times when the care pathway is at risk of being disrupted, especially after a period of hospitalisation, in order to forestall the risk of an unscheduled readmission.
- When the patient’s situation necessitates a formalised approach involving a number of professionals, Individualised Patient-centred Care should be considered.

What needs to be done

Stages 1, 2 and 4 are common to all multiple-disease patients over the age of 75 years. Stage 3 (PPS) is not routinely applied. A synopsis of the staged approach is presented in Appendix 1.
Stage 1. Identify the elderly with multiple illnesses

**Professionals involved:** Regular doctor in partnership with the pharmacist.

**Nature of the intervention:** identifying persons aged 75 years and over, with at least three chronic illnesses.

**Objective:** To identify a group of patients to whom to offer intensified and multidisciplinary care.

**Method:** Primarily by reference to the patient’s medical file and the Electronic Medical Summary (VSM). Analysis of the medicinal products prescribed (Ameli account), exchanging information with the pharmacist (pharmaceutical record) may also allow illnesses not listed in the patient’s medical file to be identified.

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### Tailoring patient care to the risk profiles

<table>
<thead>
<tr>
<th>Patient profiles</th>
<th>Points to watch</th>
<th>Interventions to be prioritised</th>
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</table>
| **Autonomous patient with a predominant disease and comorbidities** (e.g. heart failure with diabetes and AHT) | Intensify monitoring after a period of hospitalisation  
Manage multiple medications | Organise cooperation with the organ specialist or with the disease consultant  
Educate the patient and his/her family  
Consider a PPS* |
| **Autonomous patient suffering from a number of illnesses together** | Establish priorities between objectives and treatments  
Manage multiple medications | Formalise follow-up of the various specialist opinions  
Educate the patient and his/her family  
Consider a Individualised Patient-centred Care* |
| **Patient with multiple diseases combined with frailty and loss of autonomy, even if early-stage** | Stop loss of autonomy getting worse | Carry out a geriatric assessment of primary or specialist care options  
Organise home help services  
Consider Individualised Patient-centred Care* |
| **Patient with multiple diseases coupled with precarious financial and social circumstances, fuel poverty, etc.** | Reduce factors limiting access to care and quality of life | Draw up a social audit  
Organise social measures  
Propose temporary support for the patient  
Consider Individualised Patient-centred Care* |

* Some elderly patients with multiple illnesses, even if they are autonomous, may need Individualised Patient-centred Care to be arranged if managing their illnesses and treatments proves to be complex, with a high risk of issues with medication.

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### Chronic illnesses to be taken into account

- **Chronic conditions**
- **Chronic illnesses/health problems that are not classed as chronic conditions but require long-term care or involve functional impairment:** arterial hypertension, kidney failure, disabling osteoarthritis

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THE ORIGINAL FRENCH VERSION IS THE LEGALLY BINDING TEXT
Stage 2. Assess the medical problems and the person’s situation

In this stage, a review of the chronic illnesses and their treatments, an assessment of the personal situation, and finding out their priorities and preferences are of equal importance: they need to be carried out concurrently.

- **Note the person’s main concern (“priority of the moment”)**

**Professional involved:** Treating doctor.

**Nature of the intervention:** Systematically finding out the person’s current priority (and that of the caregivers, with the person’s consent).

**Objective:** To provide care according to the person and his/her needs.

**Method:** Gather information by interviewing.

The “current” priority or priorities relates to symptoms or a symptom, functional problems or illnesses: lumbar pain, difficulties getting about, heart failure, pain, etc. At a certain given time, the person often has a single priority that will not necessarily coincide with the caregivers’ priority, and which will need to be taken into account in whatever action is taken.

- **Review diagnoses and treatments**

**Professionals involved:** Treating doctor, ideally as part of a team or member of a group practice; specialists if necessary; pharmacist, private state-registered nurse or state-registered nurse from a home nursing service.

**Nature of the intervention:** Review the number and stage of development of the various chronic illnesses and the medicines.

**Objective:** To clarify the links between symptoms and illnesses, between the various illnesses, and between treatments and illnesses in order to adjust the treatment strategies.

**Method:**

- **Clarify the diagnosis** for each illness, assess the diagnostic tests, the impact, the prognosis and the factors that could promote decompensation in the presence of intercurrent events. Illnesses are ranked according to their degree of seriousness, their connections, their rate of progression and the treatment options, and their status as a chronic condition is reassessed, or else renewed.

- **Proceed to a review of the prescribed medicinal products** using the prescriptions, the Ameil account (reimbursements history of the past 6 months) or the pharmaceutical record (history of medicines dispensed over the past 4 months), and through the doctor and pharmacist meeting with the patient (and/or the family). A nursing approach can highlight problems in treatment management and thus identify patients who are at iatrogenic risk. Ascertain good compliance and look out for cases of self-medication. With a view to adjusting the doses of the medications, the Cockcroft-Gault equation is used routinely to assess creatinine clearance.

- **Match all the treatments with the illnesses/health problems using the PMSA diagnosis table** (Appendix 2), simplified version of the *Prescribing drugs for the elderly programme (PMSA)*. Give thought to the possibility of using non-medicinal treatment alternatives.

- **Assess the person from the functional, psychological and social points of view**

**Professionals involved:** Treating doctor and local party, if necessary with the aid of geriatric teams performing a role in a hospital setting or as part of a healthcare network/support platform.

**Nature of the intervention:** Multidimensional personal assessment.

**Objective:** To identify problems relating to functional and psychosocial difficulties. Confirm evidence of possible frailty.

**Method:**

A primary care geriatric assessment may be carried out in a number of steps over the course of successive consultations and contact with the patient, and involve a home visit. It may be done quickly if the patient is autonomous and has no social problems. It can be supplemented by a specialist geriatric assessment in the event of difficulties, or multiple or complex problems.

On completion of this assessment, the problems identified by the professionals are prioritised with the aid of the Problem Situations Checklist (Appendix 3). This will subsequently be able to be used for a consultation between professionals.

- **Find out the person’s treatment preferences**

**Professionals involved:** Treating doctor and a primary care team, personal care services.

**Nature of the intervention:** Systematically finding out personal preferences as regards medicinal treatment and non-medicinal alternatives (and those of the carers, with the person’s consent) after explaining the advantages and disadvantages of the various treatment options.

**Objective:** Involve the person in treatment decisions.

**Method:** Gather information by interviewing.

Personal preferences are recorded in the medical file and are included in the diagnosis and treatment review, as well as in the geriatric assessment.

At the end of these assessments, the treatment strategy is reassessed while taking into account the conclusions of the PMSA diagnosis, the results of the patient’s functional and psychosocial assessment, his/her...
treatment preferences, current priority and capacity for managing his/her own illnesses and their treatments.
The updated results of this treatment strategy review are recorded by the treating doctor in the Electronic Medical Summary (VSM), included in the Shared Medical Record (SMR). Where TPEs are involved, with the patient’s consent, the treating doctor gives access to this information to the other carers who are going to be arranging the TPE programme: nurse, pharmacist, physiotherapist.

Stage 3. If necessary, draw up an Individualised Patient-centred Care plan

Professionals involved, with the person’s consent: treating doctor (leader), other local professionals (pharmacist, private state-registered nurse or state-registered nurse from a home nursing service, physiotherapist), social worker, home help professionals, Geriatric expertise (with the aid of support coordination) (cf. How to use Individualised Patient-centred Care).

Nature of the intervention: Plan the healthcare activities and aids in complex situations.

Objective: To anticipate problems as far as possible and deal with them in a clinically and organisationally appropriate manner (individually, in face-to-face consultations; collectively for a concerted group approach, if that is what is required).

Method: Use of a questionnaire to assist in deciding on initiating an Individualised Patient-centred Care (PPS) approach. In this questionnaire, the presence of criteria over and above the multiple diseases (severe illness, combination with social problems, etc.) is an additional incentive to set up a Individualised Patient-centred Care. Ultimately, the decision depends on the clinical judgement of the treating doctor.

- If the need to set up Individualised Patient-centred Care is confirmed, local professionals consult with each other with the aid of the problem situations checklist. An action plan is then put forward embodying consistent messages addressed to the patient (e.g. diet and VKAs, low-salt diet and heart failure, etc.).

- Setting up the Individualised Patient-centred Care also involves appointing a care consultant charged with monitoring the efficacy of the planned actions.

- If the situation of the person with multiple illnesses does not call for Individualised Patient-centred Care, with the person’s consent the doctor will use secure messaging to share with the parties concerned information useful for caring for that person. The planned interventions are entered by the treating doctor, with a follow-up date, in the medical file.

Stage 4. Arranging for a follow-up and reassessments

Professionals involved: Treating doctor, ideally as part of a team or in a peer group; organ specialists if necessary; pharmacist, if need be; private state-registered nurse or state-registered nurse from a home nursing service.

Nature of the intervention: Follow-up and reassessment of the diagnoses and treatments.

Objective: Ensure consistent medical follow-up for more than one prescriber.

Method: Monitoring diagnostic and treatment optimisations over time, reassessing treatment objectives, controlling iatrogenic risk in relation to polypharmacy and self-medicating, arranging follow-up by a number of specialists (consultations, additional examinations), ensuring safe transfers, reconsidering priorities with the patient in the event of a new health problem arising.

Regular monitoring (PMSA diagnosis at least once a year), to be intensified at times when the care pathway is at risk of being disrupted (decompensation, transfers between primary care centre and hospital and vice versa, new illness, change in family, etc.).

HAS publications cited in this guide

This guide links in with other HAS publications to do with care pathways for managing elderly patients with multiple diseases: dealing with frailty, managing drug prescribing, therapeutic patient education, communicating with and consulting healthcare professionals, discharge planning:

- Caring for the frail elderly in an outpatient basis
- Checklist of problem situations
- Programme for Prescribing drugs for the elderly (PMSA)
- Improving the quality and safety of drug prescribing for the elderly
- Electronic Medical Summary
- Individualized Patient-centred Care
- TPE PAERPA (elderly persons at risk of loss of autonomy) Multimorbidity – Polypharmacy reference framework
- Reducing the risk of avoidable hospital readmissions among the elderly
- Checklist for hospital discharges > 24 h

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What you need to know

Chosen definition of multimorbidity

This guide concerns elderly persons aged 75 years and over, with at least three chronic diseases.

Patients with severe disease in the terminal phase are not eligible for this approach.

Epidemiology

57% of persons aged 75 years and over and with at least one chronic condition, 40% have at least two chronic conditions, 3.6% at least three, and 0.8% at least four.

Impact

Multimorbidity in the elderly may be combined with:

- increased social and psychological vulnerability;
- loss of autonomy, impaired quality of life, depression, sensory deficits.

It complicates the practice of healthcare professionals and impacts the organisation of care due to:

- diagnostic uncertainty. The diagnoses of chronic diseases are sometimes insufficiently substantiated, with the risk of treating only the symptoms (Appendix 4);
- polypharmacy (on average between 8 and 10 medications), increasing the risk of drug interactions, poor compliance, adverse events, and partly-avoidable hospital admissions;
- the risks that come with multiple prescribers:
  - fragmentation of care, and mixed signals;
  - stress and break-ups during scheduled and unscheduled healthcare transitions;
  - addition of dedicated guidelines for each disease;
- increased use of resources and increased costs connected with the drug consumption and hospital admissions.

Interdependent 5-point care plan

- Establish precise diagnoses for all the chronic diseases together, in order to avoid simply treating the symptoms and pointless prescribing.
- Optimise the treatments.
- Assess and take on board the subject's personal background: functional, psychological and social.
- Involve the patient, with his/her consent: and if necessary his/her family (person of trust), as active partners:
  - they must be kept informed;
  - find out their current priority (symptom or disease) and their preferences as regards the approach to dealing with the diseases;
  - Suggest a course of therapeutic education that covers multimorbidity, if the doctor/pharmacist/nurse (if a nurse makes home visits) think that the patient will benefit from it.
  - Decide whether or not to set up Individualised Patient-centred Care. Individualised Patient-centred Care may be considered when a disease is at an advanced stage, is complicated by comorbidities or because it is combined with healthcare and social problems. The treating doctor must decide whether he feels a concerted and formalised group approach would give the patient added value.

What to avoid

- Treating symptoms without an accurate diagnosis, or without prioritising the diseases and treatments.
- Focusing on one disease.
- Fragmenting healthcare delivery into a series of uncoordinated specialist interventions, at the risk of sending out mixed signals and stacking up treatments.
- Not involving the person and his/her family.
- Not listening to the advice and warnings of professionals attending to the subject at home (whether healthcare professionals or not).
- Neglecting the four main risk factors for hospitalisation: falls, polypharmacy, malnutrition, depression.
- Neglecting to intensify monitoring after a period in hospital in order to prevent unscheduled readmission. (checklist for planning a forthcoming discharge).
- Ignoring the warning signs of decompensation of diseases and/or treatments, and situations at risk of being destabilised (summer heat, moving house, loss of caregiver, etc.).
- Ignoring social factors: quality of the habitat/loneliness/financial resources.
Conditions to be met

- **Train the professionals**
  - in the specificities of geriatric multimorbidity, (cascade and Bouchon 1+2+3 scheme) (cf. Annex 4 and OMAGE portfolio to come);
  - in how to optimise drug prescribing;
  - to carry out a geriatric assessment as a first step;
  - in PTE, especially as regards the three main hospitalisation risks: hospital admission, depression, falls;
  - in collaborative working and monitoring involving more than one professional (Individualised Patient-centred Care);
  - to watch out for stress in carers and for the risk of mistreatment/abuse.

- **Develop the organisational structure of primary healthcare**
  - Make the means of exchanging and sharing information between professionals accessible: secure healthcare messaging, shared medical records (DMP),
  - Systematise the tracking of target patients in the practice software of general practitioners,
  - Improve cooperation between primary and specialist healthcare teams in the health regions:
    - locally establish multidisciplinary protocols for managing multimorbid elderly patients,
    - assist the various parties involved to recognise each other and in defining their respective areas of responsibility,
    - develop exchanges in advance of a specialty consultation in order to clarify the needs.

Monitoring criteria

- Number of persons for whom the protocol is used/number of elderly persons with at least three chronic conditions in the patient list.

- Assessment of the results of care and of recourse to care by elderly persons with at least three diseases or chronic health problems: satisfaction of professionals and patients – prevention of loss of autonomy – number of unscheduled hospital admissions or readmissions in the year.

Examples of projects carried out or ongoing

- As part of the PAERPA trials, a Decree from 2 December 2013 established an exception mechanism by authorising healthcare professionals and professionals working in the social and welfare fields to exchange medical, social and administrative information relating to the elderly,

- Development of the shared medical record targeting chronic diseases and older people,

- OMAGE portfolio (to come): aimed at the nursing profession to standardise key messages from an educational perspective,


- **Drug Prescription Guidelines adapted for the elderly (SFGG – CNP de gériatrie) [French Society of Geriatrics and Gerontology – French National Professional Council for Geriatrics],**

- Guide du Collège de médecine générale « Pourquoi et comment enregistrer la situation sociale d’un patient adulte en médecine générale ?
Appendix 1. Summary of the approach

Identifying the patients

75 years and over
At least three chronic diseases

Assess the medical problems and the person’s situation
- Find out what that person’s current priority is
- Give details of the diagnoses and optimise the treatments

PMSA diagnoses
- Functional, psychological and social assessment

Consultation checklist
- Find out the person’s treatment preferences

Reassessing the treatment strategy: medicinal and non-medicinal treatment, with the person’s consent

According to the treating doctor’s judgement:
- Individualised Patient-centred Care introductory questionnaire
- Individualised Patient-centred Care

Follow-up and reassessments

Regular PMSA diagnoses follow-up, at least once a year, to be intensified at times when the care pathway is at risk of being disrupted
## Appendix 2. PMSA diagnosis table

<table>
<thead>
<tr>
<th>Diseases/Health problems</th>
<th>Diagnostic tests?</th>
<th>Diagnosis optimisation? Yes/No</th>
<th>Treatments and non-medication alternatives</th>
<th>Treatment optimisation? Yes/No</th>
<th>Comments</th>
</tr>
</thead>
</table>

The procedure for completion of the PMSA diagnostics table by, respectively, general practitioners and hospital doctors, were explained in 2 slide presentations accompanying this guide.
<table>
<thead>
<tr>
<th>Problems</th>
<th>Follow-up</th>
<th>Problems</th>
<th>Follow-up</th>
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</thead>
<tbody>
<tr>
<td>Drug-related problems</td>
<td>Initiation</td>
<td>Insecurity</td>
<td>Initiation</td>
</tr>
<tr>
<td>- medical accident</td>
<td>Update 1</td>
<td>- financial circumstances</td>
<td>Update 1</td>
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<tr>
<td>- self-medication at risk</td>
<td>Update 2</td>
<td>- living conditions</td>
<td>Update 2</td>
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<tr>
<td>- serious iatrogenic risk from taking treatments (diuretics, psychotropic agents, antithrombotic agents, hypoglycaemic agents)</td>
<td></td>
<td>- fuel poverty</td>
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<tr>
<td>- compliance problem / generics</td>
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<tr>
<td>- personal adjustment to treatments (VKAs, diuretics, hypoglycaemic agents)</td>
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<tr>
<td>Organising follow-up</td>
<td></td>
<td>Inability to perform routine activities of daily living</td>
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<tr>
<td>- transporting carers home</td>
<td></td>
<td>- personal care/hygiene</td>
<td></td>
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<tr>
<td>- more than one participant</td>
<td></td>
<td>- dressing</td>
<td></td>
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<tr>
<td>- numerous or complex diagnostic investigations and/or therapeutic procedures</td>
<td></td>
<td>- going to the lavatory</td>
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<tr>
<td>Mobility problems</td>
<td></td>
<td>- continence</td>
<td></td>
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<tr>
<td>- risk of falling</td>
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<td>- mobility</td>
<td></td>
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<tr>
<td>- fall(s)</td>
<td></td>
<td>- feeding</td>
<td></td>
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<tr>
<td>- post-fall anxiety</td>
<td>Difficulties looking after oneself</td>
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<tr>
<td>- mobility problems at home</td>
<td>- difficulties using the telephone</td>
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<td>- mobility problems outdoors</td>
<td>- difficulties with taking medicines oneself</td>
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<tr>
<td>Loneliness</td>
<td>- difficulties with travelling by oneself</td>
<td></td>
<td></td>
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<tr>
<td>- lack of a close family or social network</td>
<td>- difficulties with managing one’s budget</td>
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<tr>
<td>- geographic isolation</td>
<td></td>
<td>- refuses help and carers</td>
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<tr>
<td>- feels lonely</td>
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<tr>
<td>- cultural isolation</td>
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<td></td>
</tr>
<tr>
<td>Mood disturbances</td>
<td>Disturbed coherence / orientation</td>
<td>Carer: physical or mental exhaustion, risk of abuse</td>
<td></td>
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</tbody>
</table>

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Appendix 4. Clinical specificities of elderly persons over the age of 75 years

“Cascading decompensation of diseases”. (Example: depression followed by malnutrition with sarcopenia fall with fracture).

Functional decompensation of an organ (JP Bouchon’s 1+(2)+3 theory), under the influence of an intercurrent event. The effects of ageing (1) gradually reduce functional reserves, without ever themselves alone entailing decompensation. Superimposed chronic conditions (2) adversely affect functions. Decompensation factors (3) are often multiple and combined in one and the same patient: acute medical conditions, iatrogenic disease and psychological stress. The doctor and the patient need to identify these situations which are at risk from decompensation and define the warning signs.

By way of illustration, clinical cases can be accessed using this link and in the portfolio documentation (to come).