Patient Priority–Directed Decision Making and Care for Older Adults with Multiple Chronic Conditions

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KEYWORDS

• Multiple chronic conditions • Fragmented and burdensome care • Patient priorities • Patient's health outcome goals and care preferences • Patient priority–directed care • Current care planning

KEY POINTS

- A majority of older adults have multiple chronic conditions. They receive care that is fragmented, of unclear benefit, burdensome, potentially harmful, and not always focused on what matters most to them.
- One cause of this poor-quality care is that each clinician caring for patients with multiple chronic conditions concentrates on managing different conditions and monitoring different disease-specific outcomes.
- One approach to improving care for patients with multiple chronic conditions is for clinicians to refocus care from treating individual diseases in isolation to achieving patients' specific health priorities, that is, a move from disease-based to patient priority–directed care.
- With patient priority–directed care, all clinicians integrate their care to help meet patients' specific, actionable, and achievable health outcome goals within the context of their care preferences.

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THE PROBLEM

A majority of older adults with cardiovascular diseases have multiple other chronic conditions.[1,2] Individuals with multiple chronic conditions are the major users of health care and are cared for by multiple clinicians.[3–5] The problems inherent in a siloed disease-based approach to decision making for persons with multiple chronic conditions is exemplified by Mrs Smith's experience.

Mrs. Smith is an 83-year-old woman with hypertension, prior myocardial infarction, atrial fibrillation, heart failure, diabetes, depression, peptic ulcer disease, and end-stage kidney disease. She currently takes 15 doses of 11 medications each day.

Over 10 days, Mrs. Smith has her scheduled appointments with her primary care provider, cardiologist, endocrinologist, nephrologist, and psychiatrist. She complains to each of them of tiredness, decreased appetite, and weakness. She also reports feeling burdened by the multiple medications (which she thinks cause some of her symptoms), restricted diet, multiple health care visits, and frequent blood tests. Each of her clinicians, following state-of-the-art, evidence-based guideline recommendations, offers conflicting advice to increase, decrease, or stop the same medications. Her endocrinologist suggests that she start insulin, which would require more blood sugar monitoring and daily shots. Her nephrologist tells her she will have to start hemodialysis soon and needs to undergo placement of an arteriovenous fistula. After these health care visits, Mrs. Smith is still tired and weak but also frustrated that none of her clinicians addressed her concerns and confused by the many additional and conflicting recommendations. Her clinicians are frustrated because Mrs. Smith has not been adherent to her medication or diet regimens and is reluctant to follow the recommendations to start insulin or initiate hemodialysis. The clinicians are also frustrated that other clinicians have changed medications they prescribed. They are not sure how best to communicate with each other and no one seems to take overall responsibility for Mrs. Smith's care.

Care Is Fragmented and Lacking in Accountability

Medicare patients, on average, see 2 primary care providers and 5 specialists a year.[6] A primary care provider whose practice consists of 30% Medicare patients with 4 or more chronic conditions must coordinate with 86 other providers in 36 practices.[7] These clinicians focus on subsets of a patient's diseases, tracking different disease-specific outcomes.[8] Accountability is unclear when there are multiple providers.[8] Primary care providers, specialists, and patients often do not understand each other's roles and responsibilities, which are not usually made explicit.[8,9]

Care Is of Unclear Benefit and Potential Harm

Older adults, in general, and those with multiple and complex conditions, in particular, are excluded from most randomized clinical trials (RCTs), including cardiovascular trials.[10,11] Older adults with multiple conditions may not accrue the same benefit from many treatments and interventions as healthier participants in RCTs.[12,13] As a result, existing disease guidelines may not apply to this large population of patients.[14,15] The dearth of valid evidence means individuals receive many treatments that are of unclear benefit.[16] Furthermore, these treatments may be harmful. Up to 20% of older adults receive at least 1 guideline-recommended medication, including several cardiovascular medications, that may adversely affect coexisting conditions.[17]