Necessary Steps: How Health Care Fails Older Patients, And How It Can Be Done Better

A chance meeting between an octogenarian and a geriatrician shows how the US health system focuses on medical care at the expense of older adults' well-being.

BY LOUISE ARONSON

The clinic was in a dilapidated old building located down the hill from a recently renovated hospital, yet the entryway retained a worn grandeur. Tapering, semicircular walls extended like welcoming arms from either side of the sliding glass doors, and a half moon of sidewalk stretched to the quiet side street.

That’s where I first saw her. She stood at the curb with her cane propped on her walker squinting toward the nearby boulevard. It must have been about 4:30 in the afternoon then, as I’d asked for the last appointment of the day with the podiatrist doing my pre-op for a minor foot surgery and I was about to be late. The woman was clearly well into her eighties, with a confident demeanor and clothes and hair that revealed an attention to appearance and at least a middle-class existence. She had a cell phone in one hand and seemed to be waiting for a ride.

This was just before Christmas, so when I came back out after 5:00, night had fallen. But for her tan winter coat and bright scarf, I might have missed her standing in the shadows leaning against the curved wall. She still held the cell phone, but now her shoulders were slumped and her hair disheveled by the increasingly cold evening breeze.

I hesitated. On one side of San Francisco, my elderly mother needed computer help. On the other, our dog needed a walk, dinner had to be cooked, and several hours of patient notes and work e-mails required my attention.

I asked if she was OK. When she answered “Yes,” I waited. She looked at the ground, lips pursed, and shook her head. “No,” she said. “My ride didn’t come, and I have this thing on my phone that calls a cab but it sends them to my apartment. I don’t know how to get them here, and I can’t reach my friend.”

She showed me her phone. The battery was now dead. I called for a taxi with my phone and helped her forward to the curb. She was tired and cold by then and suddenly seemed frail.

We chatted as we waited. Her name was Eva, and she owned a small business downtown—or she had. She was in the process of retiring, having been unable to do much work in recent months because of illnesses. She’d been hospitalized twice in the past year, she said. Nothing catastrophic, yet somehow the second stay had dismantled her life. Things had never quite gotten back to normal since then.

The geriatrician in me noted that she had some trouble hearing, even more difficulty seeing, arthritic fingers, and an antalgic gait that favored her right side. But her brain was sharp, and she had a terrific sense of humor.

Finally, the cab arrived. The driver watched as I helped Eva off the curb,
an awkward, slow process because of her cold-stiffened joints, the walker, and our bags. As I turned to open the backseat door, he sped away without his passenger. I stared, dumbfounded, and pulled out my phone to call the company and complain. Eva was more sanguine.

“It happens all the time,” she said. Just then, a taxi from another company turned the corner. He slowed down for my outstretched hand but saw Eva and screeched off into the night.

“Damn,” she muttered.

**Doing The Right Thing**

It didn’t take a rocket scientist—or even a geriatrian—to figure out why taxis didn’t want to pick up Eva. Doctors and medical practices often invoke the same reasoning: The old move too slowly, making efficiency impossible. And more often than not, there are complications.

“I’ll give you a ride,” I said, having refrained from making the offer until then at least in part because of that uniquely American quandary: What if something happens to her and her relatives sue?

Her face lit up. “Oh no,” she said. “I couldn’t let you do that.”

It took almost as long to maneuver her into my front seat as it did to get across town. She directed me to an apartment complex on the steep slope of one of San Francisco’s trademark hills. Twin rows of stacked apartments, separated by an expanse of shrubs and trees, rose up the incline like terraced fields, their landings connected by flights of steep, poorly lit steps. As it turned out, Eva lived toward the top. Before we started up, she handed me her keys and pointed, explaining that she needed to exchange her going-out walker and cane for her primary care doctor and several of her specialists.

As I would write in an e-mail to my general internist colleague the next morning, getting Eva out of my car and up the forty-nine stairs to her apartment “took nearly an hour because of her grave debility. She is very weak, has audible bone-on-bone arthritis in all major joints, frequent spasms in her left hip, minimal clearance of her right foot and could not move her left foot; I basically had to hoist her.” I had no idea how Eva ever made it up the steps unassisted and couldn’t imagine how long it might take when she did.

We took frequent breaks so Eva could catch her breath and have a reprieve from the pain she felt with every step. During each rest stop, she told me more about her life. She’d had several romances but no children. Most of her friends were also old and ill, so she didn’t see them as much as she’d like. She had lived in the same apartment since the early 1970s, loved it, and would never live anywhere else. She had a blood cancer that hopefully was cured, asthma, some kind of heart problem, and both glaucoma and macular degeneration. After a recent hospitalization for pneumonia, she had been sent to a local nursing home and said she’d rather die than go there again, though she wasn’t at all keen on dying. She hated that she could no longer work and couldn’t understand why people looked forward to retirement.

Forty some minutes after starting our ascent, we arrived at her apartment. Inside, there was a living room crowded with stacks of books, magazines, and mail, and a small cluttered kitchen. It also had what a friend of mine, in reference to her own octogenarian mother, recently referred to as “that old lady smell.”

“Shut the door,” she said suddenly, but not soon enough. A blur of dark fur grazed my leg, and her cat disappeared down the steps into the night.

We both called him. No response. I walked down the steps, calling and looking. Nothing. After ten minutes of searching, there was still no sign of the cat. This wasn’t the first time he’d escaped, but, she informed me, when an indoor cat got out, you never knew whether he’d be back.

I should have stayed longer to look for him, but I went home.

**The Chart Biopsy**

Before I left, Eva gave me permission to access her medical record, contact her primary care doctor, and make recommendations to help improve her function and well-being. What I found in her chart speaks with tragic eloquence to some of the fundamental ways in which our health care system undermines both patients and clinicians.

Logging into the electronic record the next morning at work, I learned that Eva had made thirty visits to our medical center in the previous year. This included nine ophthalmology appointments; five radiology studies; four appointments with her lung doctor; four visits to the incontinence clinic; three appointments with her cancer doctor; two emergency department visits; and one appointment each with her cardiologist, a nurse in the oncology clinic, and her primary care doctor. This tally does not include the appointments she missed because, as is noted in at least two places in her chart, “the taxi never showed up.” Eva also made frequent phone calls to her doctors’ offices and was taking seventeen medications prescribed by at least five physicians.

There are words for patients such as Eva and this pattern of care. On the patient side, the words are: complexity, multimorbidity, and geriatric. On the system side, they include: fragmented, uncoordinated, and expensive. How and why this happens—and it happens far more often than not for all patients, though its impact is far greater on the
Policy Checklist

The issue: Standard, disease-based approaches to health care for older adults lead to high-cost care for elderly patients that often undermines their health and well-being. Training requirements for health professionals must be updated to reflect current demographics and the unique needs of an aging population. Billing codes must allow for adequate reimbursement of individualized, coordinated assessment and management of functional status, medical complexity, prognosis, caregiver effectiveness, and patient goals.

Resources:
GerIPal, http://www.geripal.org

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old, ill, and frail—has at least as much to do with medical training and culture and the economics of medicine in the United States as with the challenges of old age itself.

The notes in Eva’s chart revealed clinicians providing thorough, evidence-based evaluation and treatment of the issue or organ system in which they specialized. Sometimes in medicine we see notes that suggest the doctor doesn’t really know the patient or is just going through the motions, cutting and pasting from past notes. These notes were different. Eva’s doctors and nurses knew her, seemed to care about her, and were applying all of their considerable expertise on her behalf. Unfortunately, their expertise didn’t include any of the skills that would have addressed Eva’s most pressing needs.

Several notes hinted at what I saw as Eva and I made our slow trek up the steps to her apartment. They documented terrible arthritic pain, significant mobility issues, and ongoing transportation problems. One physician commented that Eva “does not walk much in her own apartment but does utilize a walker. Often, however, she is semi chair bound.” Despite these important observations about Eva’s most bothersome medical condition and significant life challenges, none of the clinicians seeing her evaluated her joints and gait, did a functional assessment, treated her pain, or referred her to either a social worker or another clinician who might address these crucial needs.

Equally significant were the problems that no one mentioned. No physician commented on the number of doctors Eva had or visits she made, both of which might reasonably raise questions about fragmented care and the need for care coordination. Nor did any of her clinicians address her use of a very long list of medications, a situation known as “polypharmacy” and associated with adverse drug reactions and bad outcomes including falls, hospitalization, and death. Finally, and particularly remarkable for a woman in her eighties with multiple medical problems and no immediate family, no one documented her life priorities and goals of care, or who she would want to make medical decisions on her behalf if she were unable to do so herself.

Over My Dead Body
After exchanging e-mails with her doctor, I called Eva to tell her what to expect. She wasn’t nearly as concerned about her medical care as I was. She liked her doctors and, as is the case for many people, seemed to take for granted that each body part required its own specialist. It also became clear that her medical visits served an important social purpose. When I mentioned that she could get her toenails trimmed by a home visit podiatrist instead of making bimonthly trips to the clinic where we had met, she exclaimed, “But I’ve been going there for years. And they’re so nice to me!”

I tried to take a casual, conversational tone for my next question and asked whether she’d ever considered moving. I was thinking that a building on flatter terrain, without stairs, and closer to shops would offer her greater independence. Assisted living, if she could afford it, would provide those advantages plus cleaning services, meals, and a built-in social network.

“The only way I’m leaving here,” she said, “is feet first.”

I didn’t press her. As is often the case, Eva’s choices made her life more difficult. Yet it was also true that the apartment had been her home for decades, and anywhere she moved would be many times the cost of her 1970s-era, rent-controlled apartment. Like the vast majority of older adults, what Eva wanted most was someone who would help her maximize her health and function so she could continue in the life and home she’d created for herself.

Before hanging up, I asked if I could put her on the wait list for our geriatrics practice. I explained that if she agreed, she would get a new doctor who would take a different approach to her care. The geriatrician would manage her diseases as her previous doctors had, but he or she also would begin by establishing Eva’s life and health priorities, address her function and transportation challenges, review her medications and appointments to see if all were truly neces-
sary, and be available by phone or to make a home visit if she got sick to try and prevent hospitalizations.

Eva was silent for a moment. Then she said, “That sounds too good to be true!”

**What Good Health Care Looks Like**

I know most of Eva’s doctors. Each one is compassionate, smart, and dedicated. Indeed, her diseases were largely under good control. Yet Eva’s health was declining, she was missing appointments, and she was less and less able to care for herself and her apartment. Several of her clinicians recognized this, but none took action. This was not because of personal or professional failings. Most physicians would have taken the same approach to Eva’s care as these doctors did. Their actions—and inaction—were the inevitable result of their medical training and our medical system’s sometimes myopic focus on medicine at the expense of health.

Medical education prioritizes the same specialties today as it did a century ago, when the average age of death was forty-seven and when tuberculosis and childbirth were among the leading killers. People in their eighth, ninth, and tenth decades are as different, physiologically and socially, from middle-aged adults as children are, yet all medical students learn pediatrics and adult medicine, but there are no universal requirements for geriatrics training. This makes no sense demographically or medically. There are forty-eight times more octogenarians now than there were in the first half of the last century, and older patients are the age group most likely to be harmed by medical care. The hospitalization in which Eva’s pneumonia was cured, but her life “ruined” by hospital and nursing home time without adequate or appropriate exercise, provides a typical example of how usual adult care fails older patients. To rectify this situation, two things need to change. First, the groups charged with accreditation of medical schools and residency training programs—the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education, respectively—must mandate training in geriatrics for all medical students and for residents in all specialties where doctors routinely provide care to older adults. Importantly, such training cannot merely consist of providing standard adult care to patients over a certain age. Nor can it be narrowly focused on conditions known as geriatrics syndromes, such as dementia and falls. Instead, trainees must be required to attain competence in the unique approach to care that distinguishes geriatrics as a specialty: individualized, coordinated, team-based care that prioritizes patients’ goals, function, and quality of life. Given that the principal source of funding for residency and fellowship training is the Medicare trust funds, it should be relatively straightforward for policy makers to insist on links between graduate medical education payments and training that benefits the Medicare population.

Second, we must have billing codes and appropriate reimbursement for care that improves the health and lives of older adults. Currently, many critical geriatric interventions are either unfunded or funded at such low rates that growing numbers of doctors will not see Medicare patients. For example, a clinician who implemented evidence-based recommendations, such as design of an individualized exercise program or multifactorial intervention, to reduce Eva’s recurrent falls—the fifth leading killer of older adults—could not easily or straightforwardly bill for that work. Nor could the clinician bill straightforwardly for assessment and management of Eva’s functional status, multimorbidity, goals of care, or caregiver needs and caregiver effectiveness. Moreover, there would be no reimbursement for phone calls with Eva to assess response to treatment changes or to troubleshoot her challenges. While Medicare’s new Chronic Care Management policy enables billing for time spent communicating with her caregivers, physical therapist, and social worker, the clinician would receive just $41 per month, regardless of how many calls and how much time was required. A system for both services and coordination based on time and with levels of payment that increased with increasing time required would encourage clinicians to provide the care a patient needs instead of providing inadequate care in artificially limited time frames.

**A Happy Ending**

Eleven months after I met her, Eva finally made it off the geriatrics practice wait list. During her first visit, the geriatrician elicited Eva’s health and life priorities and documented the name and contact information of her health care proxy. Because she listed arthritis and pain as her biggest problems, she received steroid injections in her two most painful joints and a pain medication safe in older adults. As her specialists had noted on her recent visits to them, her blood pressure was quite high. It turned out Eva wasn’t taking several medications because she hadn’t been able to get to the pharmacy for them. She was taking a medication known to worsen incontinence, another shown to benefit middle-age patients but not those older than age eighty, and a few that might no longer be necessary. The geriatrician adjusted the timing of her medications so the schedule was simpler and less burdensome, and arranged for home delivery from the pharmacy.

Eva’s geriatrician also learned that on days when Eva couldn’t manage her stairs at all, getting to the medical center was outrageously costly. She had to pay three dollars per step to be carried first down and later back up the steps to her apartment. Since there were forty-nine steps, this meant $147 each way or $300 per appointment, not including the fare for the ride itself. Fortunately, she didn’t need to visit the medical center nearly as often as she had been. The geriatrician could treat her incontinence, stable lung disease, and other chronic conditions, and could monitor her for cancer recurrence, during home visits. Other members of the team—in this case, a nurse, physical therapist, and social worker—helped align Eva’s self-management...
skills, activities, and home environment with her goals. The only specialist Eva still needed was the eye doctor. Equally important, with the money she saved on transportation, Eva could hire more help at home.

Helping an older adult find a caregiver, delineating the caregiver’s tasks, monitoring the caregiver’s work with the older adult, and ensuring the caregiver’s own well-being are not traditional medical tasks. They are, however, among the most important interventions to ensure the well-being and safety of frail older adults. Once in place, Eva’s caregiver picked up medications, assisted with cooking and exercise, and cleaned the apartment. She also provided Eva with much-needed social interaction and foot care.

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Nearly three years later, Eva is looking forward to her ninetieth birthday. She is frailer than when I first met her, but all her primary goals have been met: She has remained out of the hospital, out of nursing homes, and in her beloved apartment with her cat, who did eventually come home. Those who argue that health care consists primarily of prescriptions and procedures, or treatment of body parts and diseases, have created a system that prioritizes medicine to the detriment of patient health. It’s time we took a broader view of health care—one that puts the well-being of patients first and trains and rewards clinicians who work with patients, caregivers, and other health professionals to achieve that goal.

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