Managing Complexity in Older Patients with CKD

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The increasing number of adults surviving to older ages has led to increasing incidence and prevalence of those diseases common among older adults, including CKD (1). CKD in older persons rarely occurs in isolation and is frequently concomitant with those diseases that contribute to CKD development, including diabetes, hypertension, and heart disease (2). Because of its prevalence among older adults, CKD also occurs alongside other conditions common in older persons, including arthritis, depression, cognitive impairment, chronic obstructive pulmonary disease, and osteoporosis (3,4). The significant burden of comorbidity experienced by older adults with CKD likely contributes to the high degree of frailty and decreased functional status also found among older adults with CKD (5,6). In this milieu of multiple chronic conditions requiring complicated medication regimens and dietary/lifestyle recommendations, with high potential for drug-drug and drug-disease interactions, it is not surprising that older adults with CKD may struggle with adherence and engagement in their CKD management (3,7).

The importance of CKD within a roster of other medical problems may vary from one individual to another. A person’s context—the overall combination of medical, social, and financial circumstances affecting that person’s health—may influence the relative importance of CKD for a given individual (8). Older adults with CKD are less likely to progress to require dialysis compared with their younger peers with similar levels of kidney dysfunction (9). Moreover, symptoms often seen in adults with CKD may be nondisease specific, such as fatigue or lack of energy, and thus, may be under-recognized (10). For these reasons, among older adults with CKD and multiple chronic conditions, CKD may not always be a dominant condition—a disease that requires so much attention that its importance overtakes that of other medical problems—and as such, CKD management strategies may not always be prioritized by patients who are already struggling with complex regimens of care (11). All of these factors may contribute to challenges and variability in patient self-management of CKD.

In this issue of the Clinical Journal of the American Society of Nephrology, Bowling et al. (12) have highlighted specific challenges encountered by older adults attempting CKD self-care. They recruited an older population (mean age of 75.1 years old) of predominantly men (>95% men) who are veterans within a Veterans Affairs renal clinic. The identified population was representative of older men with CKD in its comorbidity, with high prevalence of hypertension (90%), arthritis (73.3%), diabetes (66.7%), and heart failure (23.3%), and its complex medication regimens (average of 12.5 medications per patient). The vast majority (73.3%) of the identified population had mild to moderate CKD (stage 3: eGFR=30–59 ml/min per 1.73 m²), consistent with patterns of CKD stage among older adults (13). With recognition of the varied trajectories experienced by older adults with CKD, these authors specifically identified and targeted focus groups around three kidney disease trajectories within their study population (stable, linear decline, and nonlinear) (14).

Using data derived from focus group interviews of this representative population, Bowling et al. (12) identified complexity as an overarching driver behind many of the challenges faced by these individuals in their efforts toward CKD self-management. In recent years, the idea of complexity in medicine has evolved from a simple concept requiring a single disease to one requiring a combination of diseases and conditions. Complexity in medicine is defined as the interactions among multiple conditions and an individual’s response to these conditions. Complexity in medicine has been shown to decrease quality of care, increase healthcare costs, and increase patient morbidity and mortality (15).

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second patient’s care likely feels more complex, with multiple barriers to care driven largely by social and health system factors. It is of note that Grant et al. (17) focused on provider perspectives of complexity. Bowling et al. (12) importantly shed light on the patient’s own perspective of complexity. The patient population examined by Bowling et al. (12) exemplified a broader idea of complexity. The patients interviewed voiced challenges related to CKD self-management particularly around keeping up with multiple treatment regimens for different conditions and in adjusting to different dietary requirements despite financial constraints and differing social norms.

The older adults with CKD who were interviewed by Bowling et al. (12) also described a lack of a cohesive plan or support from nephrologists with other care providers as they worked to understand and incorporate medication and lifestyle changes related to their CKD into their overall health regimen. Patient concerns regarding poor communication between providers were strengthened by sometimes conflicting medical regimens recommended by different specialists. These experiences are consistent with the continued disease-specific approach to care within nephrology and across medical specialties (18,19). Thus, it is not surprising that disease-specific guidelines and quality metrics for medical specialties may foster fragmented disease-specific care without adequate consideration of potential disease-treatment or disease-disease interactions, which may occur within complicated treatment plans for multiple conditions (3).

Both of the above hypothetical patients would benefit from shifting from a disease-specific to a goal-directed approach to care. The idea of goal-directed care has developed as an alternative to the traditional disease-based approach to medicine (20). Incorporation of shared decision making to understand patient goals and health care priorities has the potential to support better integration of care across specialties by providing patient-specific (as opposed to disease-specific) goals, which all members of a patient’s health care team can work toward together. Many different conditions share similar general health domains, such as patient functional status, symptom burden, and patient survival (21). Use of patient-specific goals of care across providers and settings may also lead to fewer conflicting therapy regimens. Challenges in implementing a goal-directed approach to care may include provider inexperience or discomfort in eliciting patient goals as well as uncertainty about how to incorporate this style of care into a health care system that does not yet place value on broader, nondisease-specific metrics. Strategies have been developed to promote productive patient-provider interactions to help translate values and desired health care goals into goals for care that are reasonable, attainable, and measurable (22). Providers can then work to design a treatment strategy to achieve those goals, while imposing the smallest possible treatment burden. Incorporation of a minimally disruptive approach to care for older adults with CKD may help provide the greatest benefit from health care for this complex population with multiple chronic conditions (23).

Almost all of the study participants in this paper were men. In the population interviewed by Bowling et al. (12), one half of the included patients were married, and most indicated a relatively high level of social support (median score of 20, ranging from five to 25, with 25 being the most support), suggesting a strong possibility of at least some caregiver involvement, but input from caregivers about CKD or other aspects of health care management was not reported. The role that caregivers play in care delivery and coordination is an essential part of optimizing and individualizing care for older adults with health care complexity and multimorbidity. Patients with poor self-rated health and low health care literacy, which describe a significant proportion of the population examined in this study, are also more likely to have caregivers accompany them to appointments (24). Caregivers for older adults, including family members, friends, and companions, are on the front lines of patient complexity and yet, are often not specifically included in patient care planning or communication about changes in care routines (25). Exploration of input and perceptions from caregivers for older adults with CKD could provide valuable insight into the challenges that these individuals may face as they work to integrate CKD care into their overall health care regimen. Future work should include the perspectives of older women with CKD as well as older adults with CKD who have less social support.

This study by Bowling et al. (12) shines an important light on patient perceptions and individual challenges experienced by older adults with complex medical care and multiple chronic conditions as they work to incorporate CKD management into their overall health care strategy. The ability of nephrologists and other care providers to explore how CKD may fit in the overall context of the care of an older adult with multiple chronic conditions and the role that CKD self-management may play toward achieving broader, patient-specific health care goals will help to foster a more cohesive, integrated, and patient-centric management strategy for this important and growing patient population.

Disclosures
None.

References


Published online ahead of print. Publication date available at www.cjasn.org.