A Practical Approach to Geriatric Failure to Thrive

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Table of Contents

I. Introduction of History .................................................................57
II. Definition of Failure to Thrive .....................................................57
   A. Impaired Physical Function ....................................................57
   B. Impaired Cognitive Function ................................................58
   C. Depression .............................................................................58
   D. Malnutrition .........................................................................58
III. Case Study .................................................................................59
IV. Practical Solutions .......................................................................60
V. Conclusion ..................................................................................62
I. Introduction of History

The terminology Failure to thrive for geriatric patients began some thirty years ago as a borrowed terminology used to describe developmental delays in pediatric patients. There are numerous times that the definition has been both underutilized and over-utilized. There has been confusion and very little education provided to medical professionals to facilitate a better understanding of this syndrome. It is important to note that failure to thrive is meant to be a specific diagnostic entity as opposed to a “wastebasket” term meant to define patients with decline when diagnostic studies are inconclusive. Part of the reluctance of physicians to utilize the diagnosis is not only failure to know the diagnostic criteria but fear of appearing intellectually lazy. Also the terminology failure to thrive carries a negative connotation that many do not wish to embrace. Other terms such as “the dwindles” don’t help in the understanding of the syndrome.

Many of you are familiar with the famous quotation from Supreme Court justice Potter Stewart in 1964 when asked to define public obscenity or hard-core pornography. He stated, “I shall not today attempt further to define the kinds of material I understand to be embraced within that shorthand description, and perhaps I could never succeed in intelligibly doing so, but I know it when I see it.” Most medical professionals have this same approach when it comes to diagnosing what constitutes failure to thrive in the geriatric population. They clearly see it everyday in their long-term care practice but may only use the term rarely or occasionally. Typically the term is reserved as a qualifying diagnosis for Hospice or Palliative care.

I will attempt in this discussion to help educate you in the definition of this condition and its prevalence. I will also endeavor to explain a practical approach to the workup, treatment, and care of these patients. It is vitally important that we aggressively determine which of these patients can be reversed and which would be better served with a Palliative plan of care. If we can do a better job of this definition, we can target our care more appropriately to those who would benefit and limit the amount of futile care, which is all too common. A proper plan of care based on the reality of a patient’s condition as well as thorough communication with patients and families is vitally important in achieving more satisfying outcomes and can only help in the Medico-Legal realm.

II. Definition of Failure to Thrive

A. Impaired Physical Function

The first diagnostic criteria for failure to thrive would seem obvious, but let’s attempt to clarify this concept. One straightforward evaluation known as the “Up & Go Test” is a performance measure which can be easily performed. The patient is asked to rise from a sitting position, walk 10 feet, turn, and return to the chair to sit. Patients who complete the test in less than 20 seconds are generally independent for basic transfers. Patients who take more than 30 seconds to complete the test tend to be more dependant and certainly at increased risk for falls. Patients who clearly cannot complete or even attempt this exercise should be considered for the diagnosis of failure to thrive. In addition, evaluation of the patient’s ability to perform Activities of Daily Living (ADL’s) reveals further evidence of the diagnosis. Up to 28 percent of community-dwelling geriatric patients have difficulty with some aspects of these measurable activities. In nursing home settings the percentage varies but in my experience the number approaches 90 percent. It is important that these patients be screened for contributory issues to physical disability such as medications, visual problems, muscular, and neurological disorders.
In many instances in the long-term care setting this workup has already occurred in the outpatient or hospital setting, so it is important to obtain lab reports, medical consultations, radiographs, and other data to clarify whether further workup is indicated. The list of diseases and conditions which can cause diminished physical function are numerous and include: cancers, chronic lung disease, chronic renal failure, liver disease, diabetes, hip fractures, congestive heart failure, recurrent UTI’s, pneumonia, stroke, malnutrition, depression, dementia, malabsorption, and other less common diagnoses.

Patients on certain medications are also at risk for side effects, which can contribute to physical decline. Pain medication, anti-seizure drugs, beta-blockers, diuretics, steroids, antidepressants, and other agents may cause undesired side effects leading to worsening physical decline. In addition, any patient on more than four prescription drugs is at higher risk for adverse effects.

**B. Impaired Cognitive Function**

There are several methods for evaluating a patient’s cognitive function. It is important to note the baseline level and determine whether the patient has had a rapid decline versus a more chronic picture. The acuteness of the process can help distinguish between true failure to thrive and dementia. Typically patients with failure to thrive have a more acute or sub-acute decline.

There are several brief tests, which should be performed to establish baseline cognitive function. The most commonly used is the MMSE, a 30-item exam that takes 10-15 minutes to complete. A simpler test is the clock drawing test, in which a patient is simply asked to draw an analog clock representing a specific time. Credit is given as one point each for drawing the clock circle, correct placement of all numbers, and hands on the clock in the proper time. This test is much quicker but is limited to patients with the proper dexterity with handwriting. As with physical decline, many of the same medications can worsen cognitive function. Polypharmacy may also have the effect of contributing to cognitive decline.

**C. Depression**

Depression is a significant component of the Geriatric failure to thrive syndrome and should be suspected in all of these patients. The short form of the Geriatric Depression Scale is commonly used to screen patients. This test consists of 15 questions answered simply yes or no. Elderly patients have a presentation of depression that is somewhat different than the general population. Some of the usual observations are confusion, memory loss, apathy, decline in personal hygiene, weight loss, poor appetite, and slowness of both thinking and movement. Many of these patients have experienced multiple losses including death of a spouse or friend, loss of mobility, financial stresses, and loss of independence. Some of these patients have a history of depression as well. Where possible, it is helpful to identify whether the depression is primary or a reaction to the patient's circumstances. Certainly any patient scoring 5 or greater on the Geriatric Depression Scale should be referred to a psychiatrist and/or mental health team to assess and treat, possibly with medication.

**D. Malnutrition**

The final category in the assessment of Geriatric Failure to Thrive is malnutrition. Usually this factor is the easiest to quantify. It is important to know that malnutrition is an independent predictor of mortality in older patients. All admissions to long-term care facilities require assessment of body weight, weight trend, and daily caloric intake. The patient should also be evaluated for barriers to oral intake including poorly fitting dentures, oral pathology, and difficulty swallowing. Many times these assessments have been performed in the hospital setting prior to a long-term care admission, but should be repeated.
Monitoring of lab data to quantify malnutrition is commonly used. Four markers of malnutrition in the elderly are: prealbumin, albumin, hypocholesterolemia, and total lymphocyte count. While the albumin level is most commonly used, prealbumin has a slight advantage in specificity, having a shorter half-life. It is important to note that neither of these markers has been scientifically linked specifically to malnutrition. Rather, they are independent markers of morbidity and mortality, and typically reflect more about prognosis than they do nutrition. Similarly, low serum cholesterol levels have been found to be an independent predictor of short-term mortality. Total lymphocyte count is sometimes utilized in this setting but has limited acceptance and more predictive of short-term morbidity and mortality.

III. Case Study

J.R. is an 89yo WF who resided at an assisted living facility when she was found unresponsive and taken to her local hospital. At the time of admission she had multiple medical problems including CHF, CRF, ASHD S/P CABG, type 2 DM, severed PVD with recent history of angioplasty of L superficial femoral artery, and chronic bronchitis. She was on multiple medications, including Lasix, Lanoxin, Lisinopril, Lipitor, Plavix, ASA, Norvasc, Spiriva inhaler, Singular, Megace, and had recently been placed on Aricept by her primary physician due to suspected mild dementia.

In the E.R. she was found to have suffered a left intertrochanteric hip fracture from a fall probably due to a TIA. She was admitted and after Orthopedic consultation was taken to surgery for fixation. Post operatively she suffered from fluid overload, bilateral pleural effusions and probable pneumonia. She spent 12 days in acute care for medical stabilization after which she was transferred to a hospital based SNF.

At the time of admission to the SNF she was noted to be dependant for all activities of daily living. She required two therapists to get up to standing position and was able to walk 8 feet with maximum assistance of 2 people. On her third day on the SNF, her left leg became acutely swollen and diagnostic ultrasound revealed a DVT of the L popliteal vein. The patient was converted to more aggressive anti-coagulation regimen with a Heparin/Coumadin bridge and therapy was withheld for 5 days.

After two weeks on the skilled unit, she had made modest gains, requiring moderate assistance with most ADL’s. She was transferred to a community SNF for continuing efforts to return her to independent living. Her admission assessment revealed two stage II areas on the sacrum. In addition both heels were noted as boggy and purplish in color and categorized as unstageable. During her first week her nutrition intake was marginal and nutrition supplements were added. Megace could not be used due to recent thrombosis.

The staff also noted worsening behavioral issues with the patient refusing nursing care at times. She was placed on an air-loss mattress but was inconsistent in allowing the staff to turn her. She became more agitated at times, becoming aggressive at times with the staff. Mental health services saw the patient and placed her on medical therapy. Based on cognitive assessments she was diagnosed with moderately severe dementia. She was also felt to be moderately depressed, and was placed on anti-depressant medication.

Rehab services saw the patient but noted very limited progress due to physical and mental decline. Due to ongoing failure of PT + OT she was discharged from rehab services after 2 weeks. She was seen by ST due to nutritional concerns and cognitive dysphasia. She was noted to be at moderate risk for aspiration.

After nearly 4 weeks at the community nursing home, she developed a fever of 103 and transferred to the ER where a diagnosis of sepsis was made. She was noted on admission to the hospital to have one sacral ulcer staged at 4 and continued unstageable heels. On admission her albumin was 1.8 and prealbumin was 11.3. BUN and creatinine were 63 and 2.7 respectively. The patient was hospitalized for 3 weeks with IV antibiotics, fluids, and wound care being provided. A PEG tube was placed during the first week of hospitalization.
The patient was discharged to another nursing home from the hospital where she lived another 3 weeks until her death. The original nursing home was sued, claiming multiple failures and violations of the standard of care.

In examining this case in hindsight, there were clear indicators of severe failure to thrive in this patient on admission to the first community facility. The patient's physical decline was clearly apparent from initial PT and OT assessments, which indicated complete dependence for all ADLs. Her cognitive decline was well documented by the mental health team and consultant Psychiatrist. Finally nutritional compromise was not only obvious to the dietician at the nursing home, but also documented by the hospital nutritionist prior to her admission. In fact, her albumin was 1.9 and her prealbumin was 13.2 just days prior to her admission to the community nursing home. The nursing staff at the hospital prior to admission had also noted behavioral and cognitive issues.

IV. Practical Solutions

It is extremely important to take a practical commonsense approach when dealing with these patients. The first hurdle is to consider the diagnostic entity as a real disease process worthy of equal consideration with other chronic diseases. Many in the medical community think of failure to thrive as a diagnosis to utilize when a patient is declining but there is confusion as to why. They may also be slow to use the diagnosis for fear of appearing intellectually lazy. Some may also feel the wording of failure to thrive has a negative connotation, implying that the medical community has “given up” on the patient.

Clearly there is diagnostic and prognostic value in the diagnosis of failure to thrive. First, the workup is thorough and methodical in evaluating each component of the condition. The diagnosis should not be made unless investigations into each of the four categories have taken place. A comprehensive physical and cognitive assessment should be performed on admission. Involvement of nursing, PT, OT and ST is central to this workup. In addition, screening for depression will hopefully identify those at higher risk so mental health involvement can commence. Nutritional consultation will help identify those at highest risk and consider interventions.

Of most importance is that the goal should be practical. We should be attempting aggressively to identify those patients that can be reversed and those who would be better served using a palliative care plan. We should be striving to identify these patients and get them on their appropriate care plan as soon as feasible.

The following approach is a practical way of utilizing the certification periods for the purpose of making the decision of rehabilitative vs. palliative care when a patient is admitted to a skilled nursing facility and multiple co-morbidities exist.

Physical screening by PT and OT ideally will occur in the first 48 hours after admission. Functional capacity is also to be assessed by nursing. A baseline level of functioning is established and compared to baseline to see if trends are apparent. Assessment of cognitive function and depression screening ideally occur within this time frame. These along with nutritional screening give a baseline snapshot of the patient’s functional capacity. It is at this point during the admission process that the patient and family should be involved in the process to establish expectations, taking into account factors such as advance directives, cultural barriers, educational barriers, or any other factors that keep the patient and family on a different page than the nursing home staff. Open communication at this point is crucial to a healthy partnership and can significantly reduce the risk of litigation. Often, the patient has already executed an advance directive, which can help, but even in its absence, it is important for the nursing home staff to understand the specific expectations of the
patient and family. Sometimes expectation equals reality, and sometimes is doesn’t. The earlier this can be defined, the better.

Once the decision has been made initially to proceed on a rehabilitation vs. a palliative approach, it is imperative to use the first 14 days of certification to assess the patient’s progress. The physician/Medical Director plays a vital role in judging the reversibility of the patient’s medical conditions. Factors that are usually reversible at this point should be identified. The physician should address Polypharmacy. This is usually the area of most benefit in reversing failure to thrive. Nutritional interventions such as appetite stimulants may be beneficial. Antidepressants, if indicated, should be started as soon as possible as their effects may take 2-3 weeks to be seen. Any chronic medical conditions that are either over or under treated would ideally be addressed in this first 2 weeks.

At the end of each 2-week period, a complete reassessment of the treatment plan is in order. From a broad perspective, is the patient objectively declining, plateauing, or improving? A patient showing improvement should have continued aggressive rehabilitation treatment. The patient who has hit a plateau presents the biggest therapeutic dilemma. By Medicare guidelines, patients who plateau no longer qualify for PT & OT services. Any degree of functional improvement can, however, qualify the resident for further rehab. IF the patient declines, it is at this point that a full discussion of palliative care is indicated. Palliative care is not, as many have described, “giving up on a patient,” but rather creating a care plan based on compassion, realism, dignity, and the hope of symptom management. If reversible causes of failure to thrive have been addressed at this point, consultation with Hospice and Palliative professionals would be indicated.

Significant barriers to this approach certainly do exist and all parties involved have their blind spots. First, many patients and families are reluctant to forego the most aggressive interventions and continue to expect miracles from modern medicine. There is always one more medicine or intervention which can restore them to a healthier state. Unfortunately in the frail elderly, these “miracle cures” often do more harm than good. As evidenced in the case example, modern medical technology was of little use to the patient.

We must also address the barriers to a more practical approach in long-term care facilities. There are significant financial incentives to facilities to keep patients qualified under skilled care benefits. Certainly under Medicare compensation guidelines, the most aggressive approaches are rewarded. In addition, it is in the human nature of the care providers in nursing homes to want to improve the functional capacity of patients.

From the perspective of physicians and Medical Directors in long-term care, there are also barriers to palliative care in patients with failure to thrive. We, too, want to see patients show functional improvement. It is different to admit that we are out of “magic bullets.” It is also not easy to confront realities and limitations of interventions when patients and families expect us to “care.” These discussions, while difficult, are imperative in obtaining the appropriate plan of care for our patients and avoiding futile care. Physicians may also be concerned about the certification process for Hospice, fearing that certifying a patient for Hospice with non-cancer diagnoses opens them to governmental scrutiny. It is true that there are specific criteria for Hospice admission under the diagnosis of Failure to Thrive. Specifically, a patient must have a BMI of less than 22 to utilize this diagnosis. There are, however, other options for physicians to consider in patients with a BMI of greater than 22. Generalized debility is another term used to describe multifactorial decline. In order to meet this criteria, the patient must show significant functional decline, be mostly dependant for all ADL’s, and have objective supporting criteria for admission such as albumin <2.5 and multiple hospitalizations. The attending physician and Hospice Medical Director must both certify that the patient has a prognosis of less than 6 months if the disease takes its normal course.
V. Conclusion

While acknowledging the problems that exist in treating our patients with this condition, I believe that we also have an opportunity. We hear so much in the arena of medico legal education on the importance of documentation. While no one will deny the importance of good documentation, I would submit that communication is even more important. We must listen to our patients and their families to the best of our ability and discover where they are. While medical training will allow us to determine the extent of their diseases, we must endeavor to hear their expectations. We also owe them the truth, and to the best of our ability, see how our prognosis matches theirs. I have been struck by how many times in my career they seem relieved that they are finally being heard and that their expectations weren't really that unreasonable. Many seem relieved that they are being told the truth and not receiving false hope. Obviously the manner in which we communicate is of utmost importance. Whether a palliative or aggressive plan of care is chosen, patients and families must know that we will not abandon them. Compassion and honesty should be our focus, and guide all of our decisions.