OPEN LETTER

# The 12 Ds of geriatric medical-psychiatry: A new format for geriatric case presentation [version 1; peer review: 1 approved, 1 approved with reservations]

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## Abstract

**Background:** We present a new format for geriatric case presentation called the 12 Ds of Geriatric Medical-Psychiatry that facilitates an integrated discussion of both the physical and mental health issues that pertain to any geriatric patient. The format can be used to replace or to complement traditional medical model case presentation and can also be used as a teaching aid to provide the parameters for a holistic view of the geriatric patient.
**Methods**: We developed the 12 Ds of Geriatric Medical-Psychiatry for case presentation by modifying the SBAR (situation, background, assessment, recommendations) with 12 clinical considerations that apply to any geriatric patient.
Following implementation of the 12 Ds of Geriatric Medical-Psychiatry case presentation in our integrated team of geriatric medicine and psychiatry healthcare providers, we successfully used the 12 Ds model to present more than 180 patients and found the model easy to use and well received by learners and colleagues.
**Conclusion:** The 12 Ds of Geriatric Medical-Psychiatry provides a comprehensive format to discuss the pertinent issues facing geriatric patients. When used in an SBAR format, it appears to be an efficient means for integrated case presentation and/or can be used as a tool for teaching and understanding a holistic view of complex geriatric cases.

## Keywords

geriatric psychiatry, collaborative care, care management, integrated care, mental health

**Open Peer Review**

**Approval Status** ✓ ?

| | 1 | 2 |
|---|---|---|
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Any reports and responses or comments on the article can be found at the end of the article.

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**Author roles: Shulman R**: Conceptualization, Investigation, Methodology, Supervision, Validation, Visualization, Writing – Original Draft Preparation, Writing – Review & Editing; **Arora R**: Conceptualization, Investigation, Methodology, Project Administration, Validation, Visualization, Writing – Original Draft Preparation; **Ali A**: Data Curation, Project Administration, Writing – Review & Editing; **Versloot J**: Supervision, Writing – Original Draft Preparation, Writing – Review & Editing

**Competing interests:** No competing interests were disclosed.

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## Introduction

With increasing age, multi-morbidities that include both mental and physical health problems become more prevalent. Traditionally the health care system is organized according to disease categories which can result in fragmented care across multiple health care providers (Geist *et al.*, 2020; Stange *et al.*, 2010). New and innovative integrated care models, such as collaborative care, are promising solutions to provide optimal care to people suffering from multi-morbidities that include both mental and physical health problem. Collaborative care models are designed to support primary care providers in integrating care for patients with both mental and physical health problems. The model emphasises the care intersections among different health conditions, the need for care coordination and the different roles of the health care professionals from various disciplines (Woltmann *et al.*, 2012). Adopting collaborative care models often requires healthcare professionals to change the way they work which can form a barrier to adoption (Janse *et al.,* 2016; Lipschitz *et al.,* 2017).

### Collaborative Care Project

The Medical Psychiatry Alliance (MPA) - Trillium Health Partners (THP) Seniors Outpatient Community Collaborative Care Project was developed to create a model of *integrated* geriatric medicine and geriatric psychiatry collaborative *care* for seniors aged 65 and over with at least one chronic physical condition impacting function and co-occurring symptoms of depression or anxiety (Geist *et al.,* 2020). The project was implemented as an outpatient service at THP, a large community teaching hospital (University of Toronto) in Mississauga, Ontario. The project underwent an evaluative study that was approved by the THP Research Ethics Board as reported in our publication describing the collaborative care model. (Shulman *et al.,* 2021)

In our collaborative care model, care managers (CMs) who may either be a nurse, social worker, or occupational therapist, provided holistic care with initial and follow-up assessments based on treat to target rating scales. A central part of the care model is structured case reviews (SCR) where the CMs present cases to a geriatrician and geriatric psychiatrist. Recommendations from the SCR are communicated by the CMs to the primary care provider (PCP). The patient in this care model does not meet directly with the specialist physicians therefore a concise but holistic presentation of the patient during the case reviews becomes instrumental to the success of the program.

### Structured Case Reviews (SCR)

Good communication is key to the success of collaborative care. SCRs are essential part of the collaboration in an integrated care team to foster effective communication. We realized that healthcare workers from different disciplines would benefit from a common means to discuss cases. One commonly used framework to ensure effective communication during patent care is the SBAR (situation, background, assessment, recommendations) where the presenter conveys the overall "story" of the patients using the structure from the SBAR (Shahid & Thomas, 2018). Although, the SBAR framework promotes collaboration through effective communication, it is not specifically designed to capture both mental and physical health problems as they present itself in older adults. Additionally, since the CM within a collaborative care model plays the central role in the care coordination and management it is often this role that performs the case presentation. However, CMs often lack formal training or education in traditional medical-model case presentation for which the order of issues presented can differ between mental health and physical health models. To overcome these challenges, we developed a new format for case presentation based on modifying the SBAR framework of communication using a novel clinical approach we named the 12 Ds of Geriatric Medical-Psychiatry.

## Methods

### The 12 Ds of Geriatric Medical-Psychiatry

The 12 Ds of Geriatric Medical-Psychiatry was developed by extrapolating on the concept of the SBAR, the 3 Ds (Arnold, 2004; Dharia *et al.*, 2011; Edwards, 2003; Milisen *et al.*, 2006) and 4 Ds (Insel & Badger, 2002) of geriatric psychiatry. Alternate approaches to conceptualizing the geriatric patient considered included the Geriatric 4 Ms (Molnar, 2016) and 5 Ms (Molnar *et al.*, 2017).

The case presentation model including the 12 Ds as part of a case review is presented as follows:

Situation: includes referral source, reason for referral, and patient's expectations.

Background: includes age, gender, language spoken, marital status, and living arrangements.

Assessment: described using the 12 Ds of Geriatric Medical-Psychiatry. The 12 Ds for case presentation are described in Table 1 and a schematic representation of the 12 Ds can be found in Figure 1.

Recommendations: for investigations, pharmacological and non-pharmacological treatment suggestions to patient and PCP.

We successfully used the 12 Ds model to present more than 180 patients and found the model easy to use and well received by learners and colleagues. All verbal and written reports to our referring PCPs utilized the 12 Ds case format presentation rather than the traditional format of case reporting and we did not receive one complaint or criticism.

## Discussion

The 12 Ds of Geriatric Medical-Psychiatry appears to be an efficient means for case presentation and is particularly suitable for integrated collaborative care for seniors by interdisciplinary teams. In our experience, the 12 Ds of Geriatric Medical-Psychiatry can be applied to discussion of any geriatric patient, not only those with depression/anxiety and physical

**Table 1. 12 Ds of Geriatric Medical-Psychiatry.**

| | |
|---|---|
| 1. **D**ementia or any cognitive changes | Cognitive screening such as with the MoCA (Nasreddine *et al.*, 2005) or RUDAS (Storey, *et al.*, 2004) would be reported and any subjective and/or informant description of a decline in cognition or function. |
| 2. **D**epression/anxiety-demoralization | Mood and anxiety screening such as with the PHQ-9 (Kroenke & Spitzer, 2002) and GAD-7 (Spitzer *et al.*, 2006) would be reported and screening for suicide risk assessment with the C-SSRS (Posner *et al.*, 2011). Report any subjective and/or informant description of mood and anxiety symptoms. Determine if symptoms correspond to early-life recurrent depression or late-life onset depression which commonly correlates with a depression-executive dysfunction syndrome (Alexopoulos, 2005). Report the mental status examination findings regarding affect, mood and thought content. Be aware those without major depressive disorder but with chronic physical illness may nonetheless suffer demoralization and tiredness of life leading to desire for death (van Wijngaarden *et al.*, 2014). |
| 3. **D**elirium (subsyndromal) | Report any concerns about possible cognitive disruption consistent with subsyndromal delirium (Cole *et al.*, 2003) from reversible factors. If warranted, assess patient using the CAM (Inouye *et al.*, 1990) or via caregiver interview using the Sour Seven Delirium Detection Questionnaire for Caregivers (Shulman *et al.*, 2016). |
| 4. **D**isabling medical illness | Report the medical history resulting in physical limitation in activities of daily living (ADLs) and/or restriction in participation in social activities. Describe any enduring physical condition that reduces the individual's well-being. |
| 5. **D**rugs-including drinking (alcohol) & dope (cannabis) | Report prescriptions, over the counter and homeopathic products, and any substance use and allergies. Report previously trialed and/or discontinued psychotropics including the duration of treatment and reasons for discontinuation. Focus on inappropriately prescribed medications for seniors utilizing the Updated Beers Criteria for use of medications in older adults (American Geriatrics Society, 2015). |
| 6. **D**isconnection/disengagement (social health) | Report patient's social support network. Social risk factors for depression and anxiety symptoms include social isolation, lack of social support systems, destitution, lower socioeconomic status, and limited access to a healthy diet, medications and/or transportation (Egbert, 1996). |
| 7. **D**elusions | As described in the DSM-5 (Schizophrenia Spectrum and Other Psychotic Disorders) (American Psychiatric Association, 2013) delusions are fixed beliefs that are not amenable to change in light of conflicting evidence. |
| 8. **D**ecision-making capacity | The patient's ability to consent to healthcare decisions is discussed. Document if a Power of Attorney for Personal Care has been completed or alternatively who is the substitute decision maker (SDM). |
| 9. **D**ischarge planning | The plan of care includes planning for appropriate disposition and referral if needed. |
| 10. **D**econditioning | Functional screening such as with the WHODAS 2.0 (Garin *et al.*, 2010) is reported or alternatively describe any decline or improvement in function as needed. |
| 11. **D**riving | Due to mandatory reporting laws in many jurisdictions such as in Ontario, we suggest any geriatrics assessment requires consideration if a condition exists that may impair driving. |
| 12. **D**eath | Suicide risk is covered in depression/anxiety-demoralization. Death here refers to dealing with mortality issues in the self or others. |

health symptoms. Furthermore, the 12 Ds was also well received by medical students as a helpful clinical approach to developing a holistic understanding of the current healthcare issues facing any geriatric patient. We suggest the 12 Ds of Geriatric Medical-Psychiatry could be used as an efficient and effective means for presenting cases and teaching an integrated, holistic approach to understanding complex geriatric cases.

## Practice points

- The 12 Ds of Geriatric Medical-Psychiatry within a modified SBAR framework provides a comprehensive, well

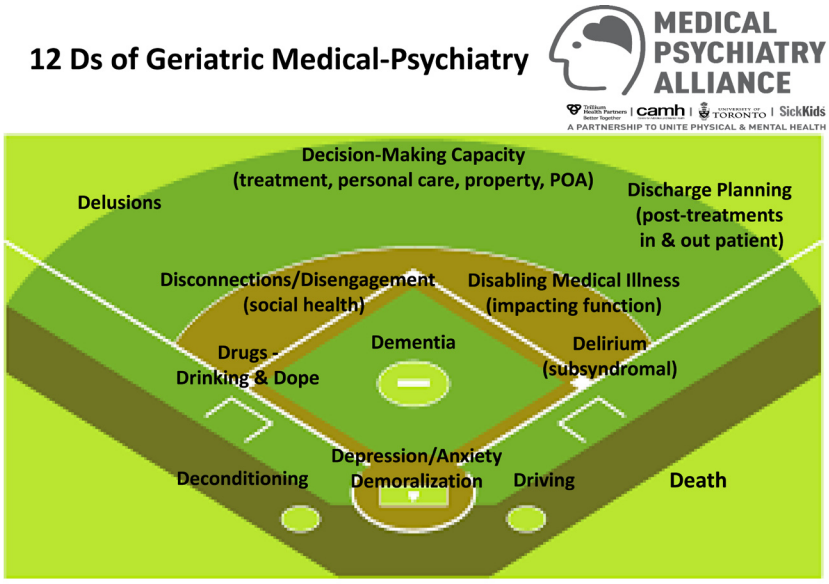


**Figure 1. Schematic of the 12 Ds of Geriatric Medical-Psychiatry presented like a team of players on a baseball field to facilitate easier recall of the clinical concepts.**

organized, and holistic format to discuss the pertinent issues facing geriatric patients.

- The 12 Ds of Geriatric Medical-Psychiatry appears to be an efficient means for case presentation and is particularly suitable for integrated collaborative care for seniors by inter-disciplinary teams.
- In our experience, the 12 Ds was well received by learners as a helpful clinical approach to developing a holistic understanding of the current healthcare issues facing any geriatric patient.

## Author contributions

We confirm that all authors made a significant contribution to the work and the manuscript according to common authorship guidelines.

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# Open Peer Review

## Current Peer Review Status: ✔ ?

**Version 1**

Reviewer Report 25 October 2022

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?

**Steven F. Huege**
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Overall, a well-written and useful letter. A couple of recommendations:

1. In the following two sentences: *"Collaborative care models are designed to support primary care providers in integrating care for patients with both mental and physical health problems. The model emphasises..."* - for consistency, are you referring to a specific model or models more generally?

2. I would list out 3 and 4 D's, along with Geriatric Ms. Also, I would spell out what SBAR is, even if it is widely known.

3. I would avoid using the word "dope" which has negative connotations.

4. In your discussion, do you have any data, surveys, etc. to back up your claims?

**Is the rationale for the Open Letter provided in sufficient detail?**
Yes

**Does the article adequately reference differing views and opinions?**
Yes

**Are all factual statements correct, and are statements and arguments made adequately supported by citations?**
Yes

**Is the Open Letter written in accessible language?**
Yes

**Where applicable, are recommendations and next steps explained clearly for others to follow?**

Yes

***Competing Interests:*** No competing interests were disclosed.

***Reviewer Expertise:*** Geriatric psychiatry, interprofessional education, Alzheimer's disease

**I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.**

Reviewer Report 26 September 2022

https://doi.org/10.21956/mep.20534.r32566



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The population is rapidly aging worldwide. According to the World Health Organization, the proportion of the world's older adults is estimated to reach about 22% by 2050 (World Health Organization, 2017). Older adults face specific physical and psychological distress. Many are at risk of developing psychiatric and physical conditions, including depressive, anxiety, and neurocognitive disorders, substance use problems, neurological disorders, diabetes mellitus, osteoarthritis, and vision and hearing impairment. Furthermore, older adults are more likely to experience multimorbidity. Older people may experience stressors that are more common in later life, including reduced mobility, chronic pain, and frailty. They are more likely to experience bereavement, a decrease in socioeconomic status upon retirement, or even elder abuse and neglect. All of these stressors can result in social isolation, loneliness, psychological distress, or even physical injuries.

Mental and physical health can impact one another in a bidirectional fashion. For example, older adults with cardiovascular disease have higher rates of depressive disorder compared to healthy ones (Rajan *et al.*, 2020[1]). Additionally, untreated depressive disorder comorbid with cardiovascular disease can negatively affect health outcomes, including an increased risk of premature death (Rajan *et al.*, 2020[1]). The stigma surrounding psychiatric disorders may make older adults reluctant to seek help, contributing to these disorders often being under-recognized. Clinicians must remain vigilant to recognize geriatric syndromes, which can lead not only to psychological consequences, including depression and anxiety syndromes, but also to physical

injuries.

The authors of this paper by Shulman *et al.* (2022) present a very useful rubric for the 12Ds of geriatric psychiatry. Using a baseball metaphor and a well-conceived graphic image, they show how many aspects of geriatric psychiatry are represented by words (in English, anyway) beginning with "D." This includes both *specific illnesses* (e.g., dementia, delirium, depression) as well as other aspects of patient experience that are *not illness-related* (e.g., decision-making capacity, driving, death) that are, nonetheless, often the focus of clinical attention.

The baseball metaphor is pleasing in many ways. The visual representation of the baseball diamond illustrates how multimorbidity is the *rule, not the exception*, in geriatric psychiatry (not to mention, consultation-liaison psychiatry), such that a *"ground ball to the pitcher (dementia), then a throw to the second baseman (disabling medical illness), then another to the first baseman (delirium) for a double play"* succinctly connects critical elements in a common delirium presentation. One must remember that patients' lived experience is an integrated "whole", and not a single "illness episode" and the baseball metaphor captures this succinctly.

The authors further develop their paper using the SBAR (Situation, Background, Assessment, and Recommendations) format as pertains to each identified clinical problem (illness specific as well as non-illness functional limitations), prompting the reader to use a detailed and analytical approach to clinical problem-solving. This encourages the clinician (and other health care personnel) to assess each presenting problem individually, but with a *standard conceptual methodology,* and focuses attention on actionable variables in an integrated fashion. While their model is designed and deployed for geriatric psychiatry, it could be easily applied to consultation-liaison psychiatry and would be especially applicable to complex patients (those patients with excess medical utilization, poor functional outcomes, and co-morbid systemic medical and psychiatric illness).

In summary, the authors present an attractive and relatable rubric that serves to organize clinical concepts, encourages clinicians to think of several simultaneous clinical variables, and provides an attractive and amusing visual and conceptual metaphor. They are to be congratulated on a useful contribution to the clinical-educational literature.

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***Competing Interests:*** No competing interests were disclosed.

***Reviewer Expertise:*** Geriatric Psychiatry, CL Psychiatry

**We confirm that we have read this submission and believe that we have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.**