

Geriatrics-Competent Care Webinar Series

An Introduction to Geriatrics-Competent Care

August 20, 2014



Introduction to Geriatrics-Competent Care

A Discussion of Universal Competencies that are Fundamental to Quality Geriatrics Care, Across Disciplines and Care Settings

This webinar is supported through the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) to ensure beneficiaries enrolled in Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. To support providers in their efforts to deliver more integrated, coordinated care to Medicare-Medicaid enrollees, MMCO is developing technical assistance and actionable tools based on successful innovations and care models, such as this webinar series. To learn more about current efforts and resources, visit [Resources for Integrated Care \(www.resourcesforintegratedcare.com\)](http://www.resourcesforintegratedcare.com) for more details.



Platform Overview

- Microphones are muted
- Need the slides?
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- Slides not advancing?
 - Press F5
- Need Closed Captioning?
 - See the “cc” icon (bottom of screen)
- Have a Question?
 - Click the Question & Answer icon (bottom of screen)
 - Engage the Operator through the phone line
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Overview

- This is the first session of a two-part webinar series titled "Geriatrics-Competent Care."
- Each session will be interactive (e.g., polls and interactive chat functions), with 60 minutes of presenter-led discussion, followed by 15 minutes of presenter and participant discussions.
- Video replay and slide presentation will be available after each session at:
www.resourcesforintegratedcare.com

Introductions

■ Gregg Warshaw, Moderator

Martha Betty Semmons Professor of Geriatric Medicine
Professor of Family and Community Medicine
University of Cincinnati College of Medicine



■ Kyle Allen

Vice President for Clinical Integration
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■ W. June Simmons

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Topics Covered

- What's Unique About Older Adult Care
- Prevention
- Risk of Care Transitions
- Safe Medication Use for Older Adults
- Understanding Geriatric Syndromes
- Social Services and Supports in Geriatrics-Competent Care

Getting to Know Our Audience

Poll Question #1 – Which of the following best describes your professional area?

- Healthcare Administration
- Medicine/Nursing/Physician Assistant
- Pharmacy
- Social Work
- Advocacy
- Other

Poll Question #2 – What is your primary role?

- Administrator
- Clinician
- Educator
- Researcher
- Consumer Advocate
- Other

Poll Question #3 -- In what setting do you work?

- Community Health Center / Federally Qualified Health Center
- Home Care
- Long-term Care Facility
- Managed Care Organization
- Consumer Organization
- Other

What's Unique About Older Adult Care?

Diversity Among Older Adults

There is considerable diversity among older adults:

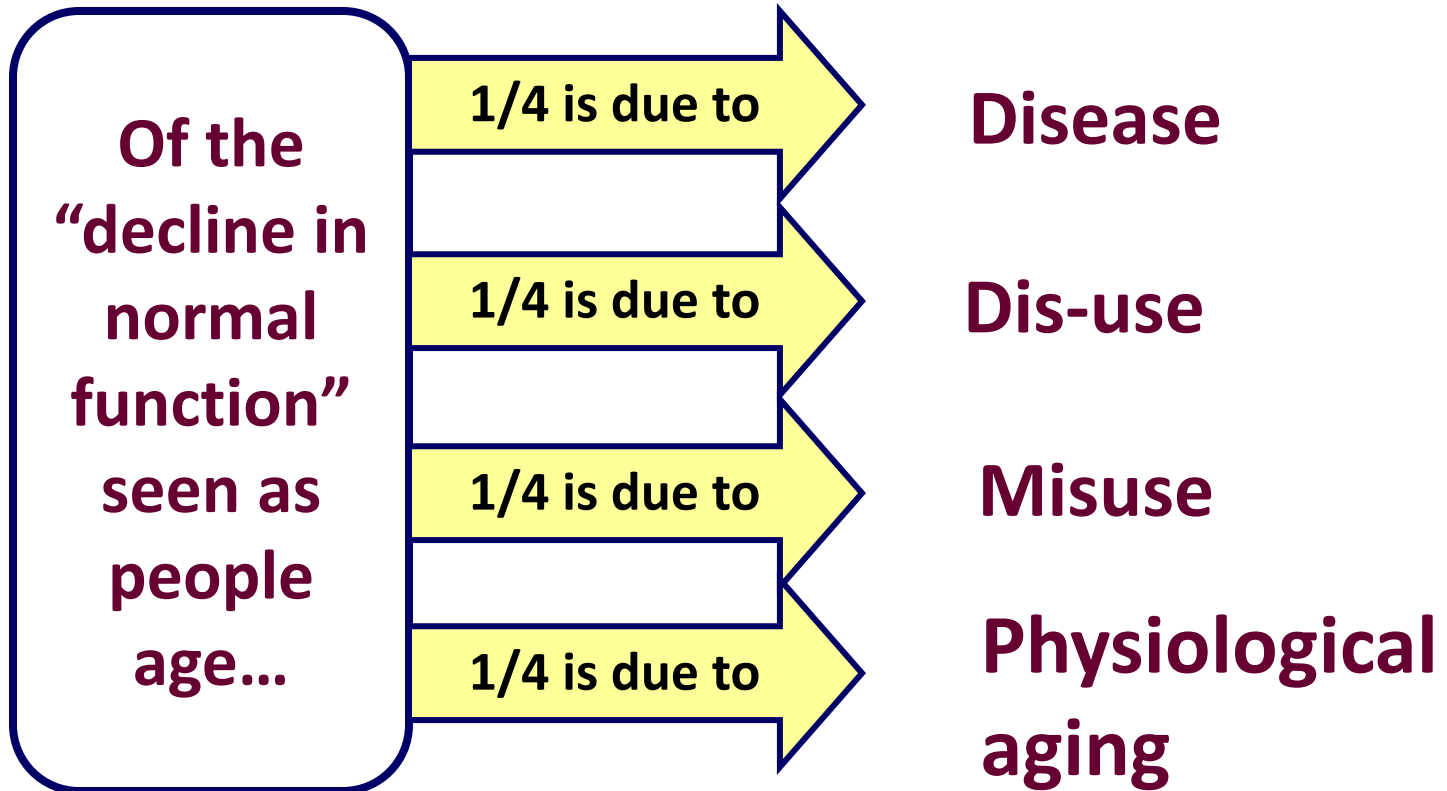
- ▶ Physiological
- ▶ Functional
- ▶ Cultural

Individualized care, rather than protocol-based care, is especially important for older people.

Aging

- is not a disease
- occurs at different rates
 - ▶ among individuals
 - ▶ within individuals
- does not generally cause symptoms

The Rule of Fourths



Case Study

- An 83-year-old woman comes to the office for an examination. She has recently returned to her home after a motor vehicle accident that resulted in injuries, a hospital stay complicated by pneumonia, and a nursing-home stay.
- She is greatly changed since her last office visit: she has lost a lot of weight, moves slowly, and is unable to rise from her chair without using her arms.
- She previously was an avid golfer and swimmer. She asks what she can do to improve her function now that her injuries have healed.

Case Study

Which of the following is effective in improving function in frail older adults?

- A. Comprehensive geriatric assessment
- B. Protein supplementation
- C. Anabolic steroids (testosterone, dehydroepiandrosterone)
- D. Exercise
- E. Home visits to evaluate function in the home

Function: The Critical Outcome

- **Function**, not diagnosis, is what counts, as multiple chronic diseases are common.
- It is important to identify functional deficits that adversely affect the person's prognosis and quality of life.

Principles of Geriatric Assessment

Goal: Promote wellness, independence

Focus: Function, performance
(gait, balance, transfers)

Scope: Physical, cognitive, psychological,
social domains

Approach: Multidisciplinary

Efficiency: Ability to perform rapid screens to
identify target areas

Success: Maintaining or improving
quality of life

Care Planning

Working with the older adult and their family to determine, based on the patient's goals of care:

- ▶ The right amount of care (not too much, not too little)
- ▶ In the right location (least intensive is usually best)

Slow Medicine

- In geriatric care, acting hastily is more likely to do harm than not acting at all.
- Care decisions need to be paced so that the patient, the family, and the clinician have time to evaluate options before proceeding.

Team Care

Inter-professional team care is essential to providing optimal care for older adults.

Prevention

Prevention

- Immunizations and screening tests that are recommended for older adults based on their remaining life expectancy and cognitive status.
- Additional preventive activities and services that are potentially beneficial for older adults.

Iatrogenic Illness

- Frail older adults have limited physiologic reserve.
- Illness caused by medical interventions is one of the most common yet preventable medical problems of older people.
- The risk/benefit of diagnostic tests and treatments must be reviewed carefully in order to avoid iatrogenic illness.

Physical Activity

- Emphasize advantages: promotes mobility, ↓ rates of heart disease & osteoporosis
- Recommend a program that balances exercise for:
 - ▶ Flexibility (e.g., stretching)
 - ▶ Endurance (e.g., walking, cycling)
 - ▶ Strength (e.g., weight training)
 - ▶ Balance (e.g., Tai Chi, dance)

Annual Wellness Exam

- New Medicare benefit created by the Affordable Care Act
- Designed to address:
 - ▶ geriatric assessment
 - ▶ medication management
 - ▶ Injury prevention

Risk of Care Transitions

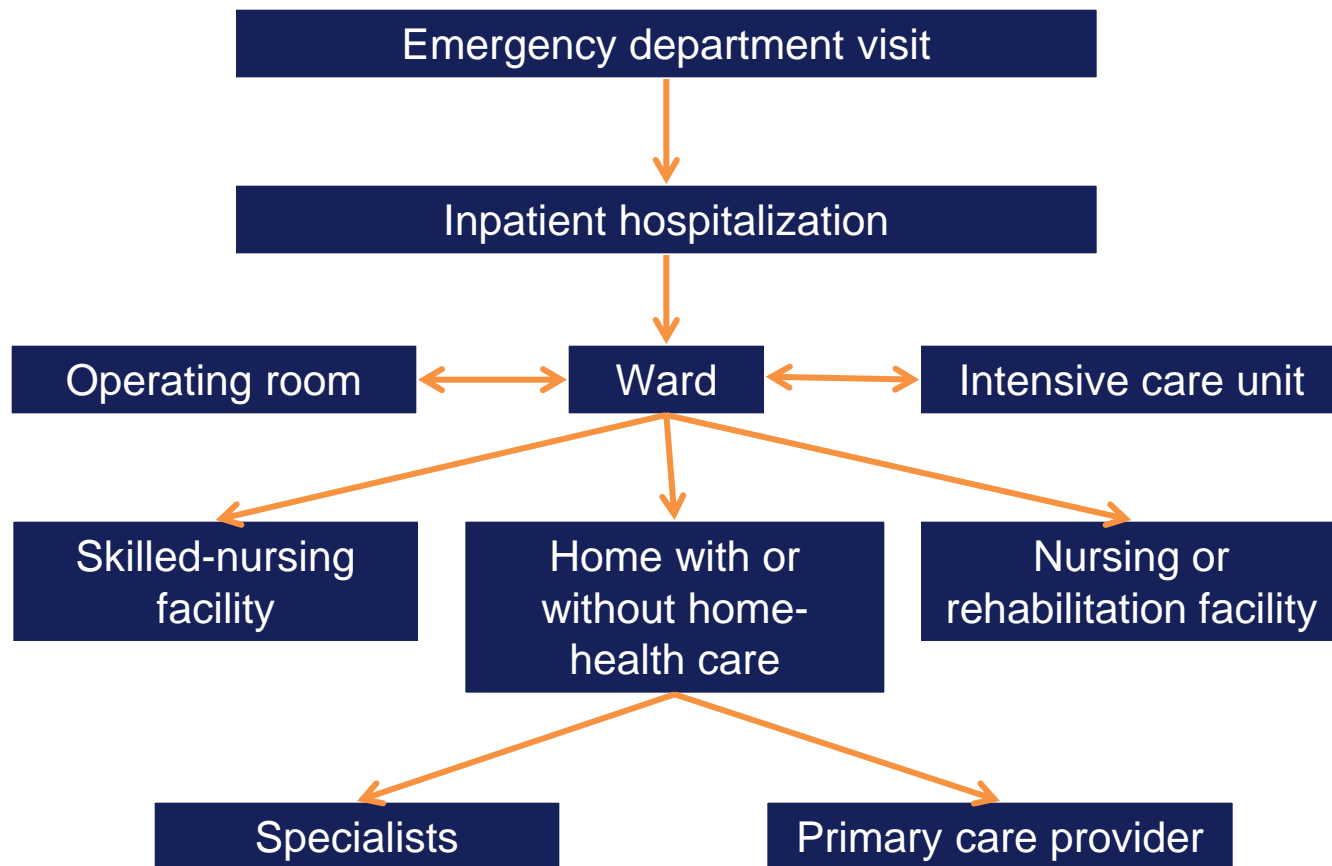
Care Transitions

Transitions of care from one provider or setting to another can lead to:

- ▶ misunderstandings of diagnoses and plans
- ▶ medication discrepancies
- ▶ confusion on the part of patients and families

Many older adults have limited physiologic reserves and are at risk of bad outcomes during poorly handled transitions.

Common Care Transitions



Safe Medication Use for Older Adults

Medication Safety Challenges

- Effective drug treatments for chronic illnesses have expanded, and many older people have multiple chronic illnesses.
- Adverse drug reactions and drug-drug/drug-disease interactions increase as the number of prescribed medications increases.
- Adherence to complex, multiple drug regimens is difficult: poor vision, poor memory, limited funds, etc.

Gaps in Our Understanding of Medication Use in Older Adults

- Safety and effectiveness of any given medication is not well studied in the aged.
- Multiple concomitant medications adversely affect the safety and effectiveness of individual medications.
- Multiple medical problems can adversely affect the outcomes of pharmacotherapy.

Major Considerations in Safe Medication Use for Older Adults

- One clinician on the patient's health care team must take responsibility for all the medications prescribed by all providers.
- Regular review of all medications – prescribed and over-the-counter – with the goal of trying to reduce medication use as much as possible.

General Approaches to Medication Use in Older Adults

- Consider non-pharmacological approaches first .
- Start low, go slow. Evaluate thoroughly.
- Caution with medications new to the market.
- Annual medication reconciliation, including over-the-counter, vitamins, supplements, herbal or other remedies.
- Keep possible medication side effects in mind at all times.

Before Prescribing a New Drug, Consider:

- Is this medication necessary?
- What are the therapeutic end points?
- Do the benefits outweigh the risks?
- Is it used to treat effects of another drug?
- Could 1 drug be used to treat 2 conditions?
- Could it interact with diseases, other drugs?
- Does patient know what it's for, how to take it, and what adverse side effects to look for?

Understanding Geriatric Syndromes

Understanding Geriatric Syndromes

- Accumulation of multi-system deficits is responsible for the existence of geriatric syndromes.
- Geriatric syndromes are typically multi-factorial.
- Rare in younger people and common in older adults.

Understanding Geriatric Syndromes

- More than 50% of older adults have 3 or more chronic diseases.
- Multiple chronic illnesses are associated with increased rates of death, disability, adverse effects, institutionalization, use of healthcare resources, and impaired quality of life.
- Older adults with multiple geriatric syndromes are heterogeneous in terms of illness severity, functional status, prognosis, personal priorities, and risk of adverse events.

Most Significant Geriatric Syndromes

- Falls
- Gait and balance problems
- Dizziness
- Weakness
- Frailty
- Incontinence
- Confusion

Falls: One of most common geriatric syndromes

- Annual incidence of falls is close to 60% among those with history of falls.
- Complications of falls are the leading cause of death from injury in people aged ≥ 65 .
- Most falls are not associated with syncope.
- Falls literature usually excludes falls associated with loss of consciousness.

Falls Assessment

- **Ask all older adults** about falls in past year
- **Single fall:** check for balance or gait disturbance
- **Recurrent falls or gait or balance disturbance:**
 - ▶ Obtain relevant medical history, physical exam, cognitive and functional assessment
 - ▶ Determine multifactorial falls risk (see next slide)

Factors Affecting Fall Risk

- History of falls
- Medications
- Visual acuity
- Gait, balance, and mobility
- Muscle strength
- Neurologic impairments
- Heart rate and rhythm
- Postural hypotension
- Feet and footwear
- Environmental hazards

Falls Treatment

- Most favorable results with health screening followed by targeted interventions
- Aim to reduce intrinsic and environmental risk factors
- Interdisciplinary approach to falls prevention is most efficacious

Social Services and Supports in Geriatrics-Competent Care

Bringing medicine, families and community-based services together



Social Services and Supports in Geriatrics-Competent Care

- The focus is on modifiable risk factors at home
- Resources available – there are many community-based agencies serving elders
- Social workers are “eyes and ears” to identify risks and unmet needs and facilitate access to:
 - ▶ Social services, public benefits and home care, food, transportation and caregiver support
 - ▶ Evidence-based programs for individuals and caregivers aimed at enhanced self-management

Psychosocial and Environmental Assessment

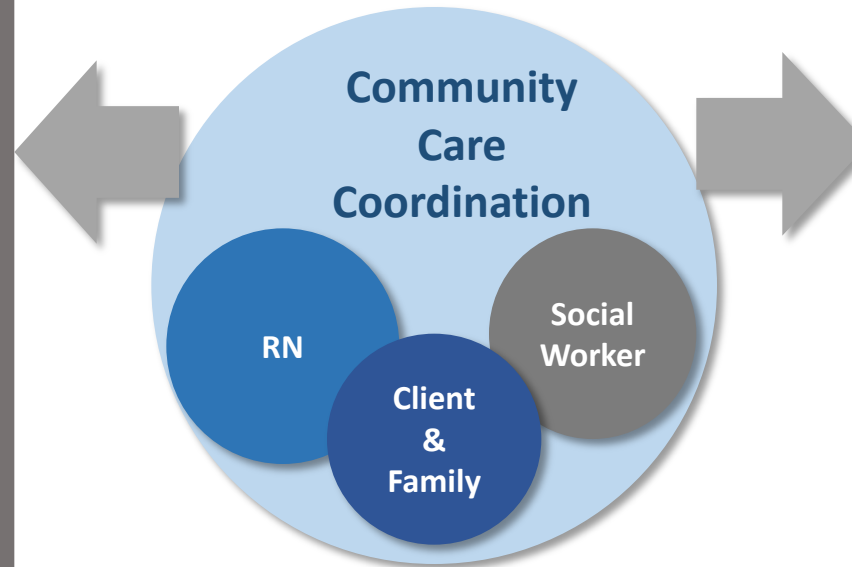
- Functional assessment (ADL/IADL)
- Fall risk – Medications, lighting, trip hazards
- Screening for depression (PHQ 2/9) and cognitive impairment (Mini Mental Status)
- Home safety/cleanliness/maintenance
- Identification of barriers to compliance with treatment plan
- Evidence of problems (e.g., alcohol bottles, odors, moldy food)
- Social support & services – Both patient and formal/informal caregivers; abuse indicators

Current MSSP Services Model: (can be adapted for Duals as CMS rules change)

Purchased Services

(Credentialed Vendors)

- Safety devices, e.g., grab bars, w/c ramps, alarms
- Home handyman
- Emergency response systems
- In-home psychotherapy
- Emergency support (housing, meals, care)
- Assisted transportation
- Home maker (personal care /chore) and respite services
- Replace furniture /appliances for safety/sanitary reasons
- Heavy cleaning
- Home-delivered meals – short term
- Medication management (HomeMeds)
- Special needs required to maintain independence



Referred Services

- AAA
- IHSS
- Community Based Adult Services (formerly Adult Day Health Center)
- Regional Center
- Independent Living Centers
- Home Health
- In-Home Palliative Care
- Hospice
- DME
- Families / Caregivers Support Programs
- Senior Center Programs
- Evidence-based Health Impacting Self-Care programs
- Long-term home-delivered meals
- Housing Options
- Communication Services
- Legal Services
- HICAP
- Ombudsman
- Benefits Enrollment for services (ie food stamps)
- Money management
- Transportation
- Utilities
- Volunteer services

Why Focus on Community Partnerships for Social Services?

- Improve health care for adults with chronic conditions through *comprehensive, coordinated, and continuous expert and evidence-based services*
- Add in-home assessment/coordination of supportive social services to medical care
 - ▶ Enhance impact of medical care
 - ▶ Improve health outcomes
- ACA and Duals plans provide opportunity for shared cost savings for LTSS

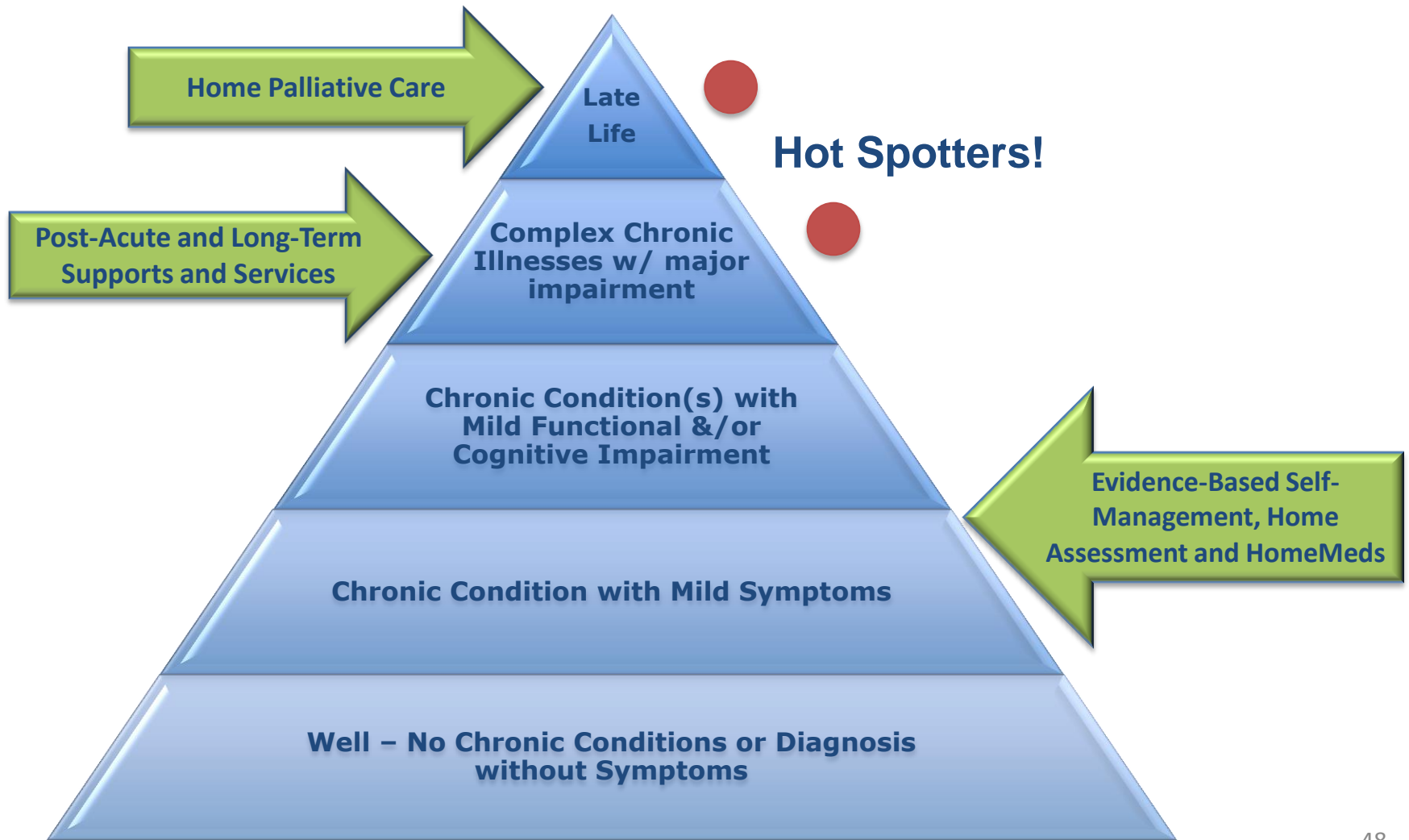
Health Care + Social Services = Better Health and Continued Independence

- Identify/Address Social Determinants of Health:
 - ▶ Functional status, personal choices in everyday life
 - ▶ Isolation, family structure/issues, caregiver needs
 - ▶ Environment – home safety, neighborhood
 - ▶ Economics – affordability, access
- Community Based Organizations have:
 - ▶ Time to probe, trust, different authority
 - ▶ Cultural/linguistic competence
 - ▶ Lower-cost staff & infrastructure
 - ▶ High-impact, evidence-based programs

Expanding Supports for Aging Well

- There is an expanding deployment of social workers to identify challenges and threats to aging well at home for complex patients.
- Evidence-based community programs have been established for patient activation to address lifestyle change – especially to manage risks like diabetes progressing, heart disease and falls.
- Pro-active care is emerging – focus on the whole person.

Targeted Patient Population Management with Increasing Disease/Disability



Targeting for Social Services: Focus on Concentration of Risk

- Functional limitation
- Dementia
- Frailty
- Serious illness(es)
- Hospital/Emergency room use

Home and Community-Based Services are High-Value

- Improves quality
 - ▶ Staying home is concordant with people's goals
- Reduces spending
 - ▶ Based on 25 state reports, costs of home and community-based LTC services less than 1/3rd the cost of nursing home care

Services Targeted to Individual Needs

Evidence-based Self-Management

Independent w/
chronic condition

HomeMeds,
Stanford Chronic
Disease Self-
Management
(Diabetes, Pain,
Spanish versions)

Short-term In-Home Services

At risk for
deterioration &
high utilization

Care transition
coaching
Risk screening
Psychosocial evaluation
Service coordination

Long-term Services & Supports

Frail/disabled

Service coordination,
Purchase of services
(meals, respite,
transport, chores)

Some Evidence-Based Programs



SELF-MANAGEMENT

- Chronic Disease Self-Management
- Tomando Control de su Salud
- Chronic Pain Self-Management
- Diabetes Self-Management Program

PHYSICAL ACTIVITY

- Enhanced Fitness & Enhanced Wellness
- Healthy Moves
- Arthritis Foundation Walk With Ease Program

MEDICATION MANAGEMENT

- HomeMeds

FALL RISK REDUCTION

- Stepping On
- Tai Chi Moving for Better Balance
- Matter of Balance

DEPRESSION MANAGEMENT

- Healthy Ideas
- PEARLS

CAREGIVER PROGRAMS

- Powerful Tools for Caregivers
- Savvy Caregiver

Home Assessment Improves Medication Safety

- Home visit by nurse or social worker
 - ▶ Collect comprehensive medication information
 - ▶ Assess for possible adverse effects & discrepancies
 - ▶ Screen through software to find potential problems
- Pharmacist review & resolve problems, educate
- Supporting resources are valuable to assure effective use of meds gathered in home visits
- Emerging Models:
 - ▶ Targeted home visits for high-risk patients
 - ▶ Add to care transitions, self-management programs
caregiver support, etc.
 - ▶ Part of comprehensive fall prevention initiative

Post-Acute Social Work Home Coaching

- Compared to patients who met referral criteria but did not receive the home visit
 - ▶ 12.8% lower rate of ED use
 - ▶ 22% lower rate of readmissions
- Medication Issues Identified and Recommendations Made by PharmD: 63%
- Other issues identified (e.g., PHQ-9, caregiver or financial need): 54%
- Falls risks identified – 77%

To Achieve the Triple Aim: Better Care, Better Health, Lower Cost

- Apply Principles of Geriatrics-Competent Care
- Form Partnerships of Health Care Providers, Home and Community-Based Providers, Consumers and Advocates

Questions



Survey

Thank you for joining our webinar.

Please take a moment and complete a brief survey on the quality of the webinar.