Nova Southeastern University College of Osteopathic Medicine

GEC Channel

Volume 2, Number 1 | Published by the Florida Coastal Geriatric Resources, Education, and Training Center (GREAT GEC) | Spring 2009

Project Director's Message

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As we continue our many educational activities and prepare for our Second Annual Interdisciplinary Geriatrics Symposium, I have come to realize that although geriatrics may be a household name for many, it may not be as obvious to others. This is true not only of the lay public, but also of some health professionals. Indeed, some of our patients have been slightly offended that they are in the care of geriatricians (I don't think I'm that bad!), whereas others have sought us through diligent research and are delighted to finally visit us in our clinic.

It has been very gratifying when the middle-aged "children" of our patients schedule an appointment for a geriatrics consultation or even to transfer their care to us. These individuals realize the value of healthy aging, reducing risk factors that may in turn prevent or ameliorate existing medical problems, maintaining functional activity level, as well as psychosocial wellbeing. I would call that preventive geriatrics, although this is not a professionally accepted term yet.

So what is geriatrics? And why is it different from the practice of medicine in many other specialties that also treat older adults? The University of Miami Miller School of Medicine at Florida Atlantic University and the Institute of Quality Aging at Boca Raton Community Hospital have kindly shared the BIG 10 Basics in Geriatrics with the GREAT GEC. They are as follows:

1. ***Aging is not a disease.*** Aging occurs at different rates in individuals and, by itself, does not cause symptoms. However, it does increase susceptibility to many diseases and reduces physiologic reserve (homeostenosis).

2. ***Medical conditions in geriatric patients are commonly chronic, multiple, and multifactorial.*** This makes management complex and challenging, particularly when acute illnesses are superimposed on chronic conditions and treatment because any one condition may influence or even worsen another condition.

3. ***Reversible and treatable conditions are often under-diagnosed and undertreated in geriatric patients.*** Older individuals, caregivers, and health professionals mistakenly attribute many symptoms to "old age," and many conditions present atypically. Geriatric syndromes such as delirium, gait instability and falls, urinary incontinence, pain, insomnia, sensory impairment, frailty, and malnutrition are common and require systematic screening and cause identification.

4. ***Functional ability and quality of life are critical outcomes in the geriatric population.*** These factors are also critical in determining living situation, and even small changes (e.g., the ability to transfer) can make a crucial difference for quality of life of older patients and caregivers. Standard assessment tools to measure basic and instrumental activities of daily living are available.

5. ***Social history, social supports, and patient preferences are essential aspects of caring for geriatric patients.*** Examples include ethnicity, education, occupation, family relationships, spirituality, and resources. Living circumstances are critical in managing geriatrics as is caregiver availability, health, and resources.

6. ***Geriatric care is multidisciplinary.*** Respect, collaboration, and communication among health professional disciplines are essential in the care of geriatric patients and their caregivers. Multiple professionals acting as an interdisciplinary team can play a vital role (e.g., nursing, rehabilitation therapists, dieticians, pharmacists, social workers, clergy).

7. ***Cognitive and affective disorders are prevalent and commonly undiagnosed at early stages.*** Common causes of cognitive impairment include delirium, Alzheimer's disease, multi-infarct, and other forms of dementia. Depression and anxiety disorders are often undiagnosed. Screening tools for delirium, dementia, and depression should be used routinely.

8. ***Iatrogenic illnesses are common and many are preventable.*** Polypharmacy, adverse drug reactions, drug-disease reactions, drug-drug interactions, and inappropriate medication use are common. Hospitalization can be hazardous to older individuals and may be associated with complications such as falls, delirium, pressure ulcers, nosocomial infections, immobility, deconditioning, and functional decline. These can be serious and life-threatening.

9. ***Geriatric care is provided in a variety of settings ranging from home to long-term care institutions.*** Specific definitions and criteria exist for admission to these settings, and funding for care varies and depends on many factors. The need for improved communication and coordination and of transitions between care settings to avoid medical errors, patient injuries, and unnecessary health care utilization is being increasingly recognized.

10. ***Ethical issues and end-of-life care are critical aspects of the practice of geriatrics.*** Principles of palliative care and end-of-life care are essential for providing good care. Hence, advance directives can be critical in preventing ethical dilemmas and futile care.

Positive Aging Is Not Just a Trend!

Cecilia Rokusek, Ed.D., R.D., GREAT GEC Executive Director

Spring is here, and what an appropriate time to think about "positive aging." One can say that positive aging is the "in thing" to talk about. I would say it is the right thing to talk about no matter what your age is. In the January/February 2009 commentary section of the *Positive Aging Newsletter*, the authors defined the period of what I refer to as adult aging as "an unprecedented period of human enrichment." This was such a powerful statement. Aging is a process that in the most accurate of all debates begins when we are born. This is why I so enjoyed the movie the *Curious Case of Benjamin Button*, because it provides a forum for discussion about the human life cycle and the aging process. In using this birth parameter for the life cycle and aging, the challenge exists for all of us in the health, social science, and education arenas to foster and cultivate an appreciation for the aging process. We must focus on developing and building good health and resilience that will enable us to deal with, and in some cases overcome, the challenges of what we used to call "growing old."

The idea of living and aging positively reflects a holistic approach to living. It means we do not so much look at our individual age in actual years but rather in how we feel and how we think. The new middle age in America is now being defined as those between the ages of 50-70 years old. This baby boomer age group feels and acts younger than peer groups of that age did 30 years ago. In many countries around the world, even modern-day western and central Europe, this is not the case. The United States is setting the standard for positive aging. This new view of aging positively has huge implications for those of us in the delivery of care to that age group, which is why we need to reexamine how we interact with and treat those individuals who are 50 years and older.

The *2004 Reinventing Retirement Symposium Report* published by the Harvard School of Public Health and the Met Life Foundation helped to bring awareness to stereotypical labels we use for society's maturing population. The report stated conclusively that, "The current language of aging is obsolete and may be an impediment to change." Society uses many stereotypical terms and actions that categorize people, most especially mature adults. We continue to use terms that categorize and label such as retiree, going into retirement, or senior citizen. An invitation and membership to AARP is NOT a sign of growing old. When I got my membership invitation two months before my 50th birthday, I was thrilled because I saw it is an opportunity to save money at hotels and restaurants—it was like a reward card!

Positive aging is a state of mind that should be with us throughout life. It is a mindset that also influences how young people view people older than they are. It may even be a factor for young adults in their decision to pursue or not pursue a career in gerontology. As a society, I believe we must focus more on this issue of healthy and positive aging and strive to build resilience in the life process of aging. This is a HUGE challenge because it involves changes in attitudes and actions in "how we do business" not only in health care but in all areas of daily living from housing to banking. This change in attitude and action needs to come from each of us. It is not something government can do—our legislators are actually having a difficult time even defining what it means to be an older person and when to collect benefits for money invested with them for a pension, or should I say a supplemental funding source for a mature lifestyle?

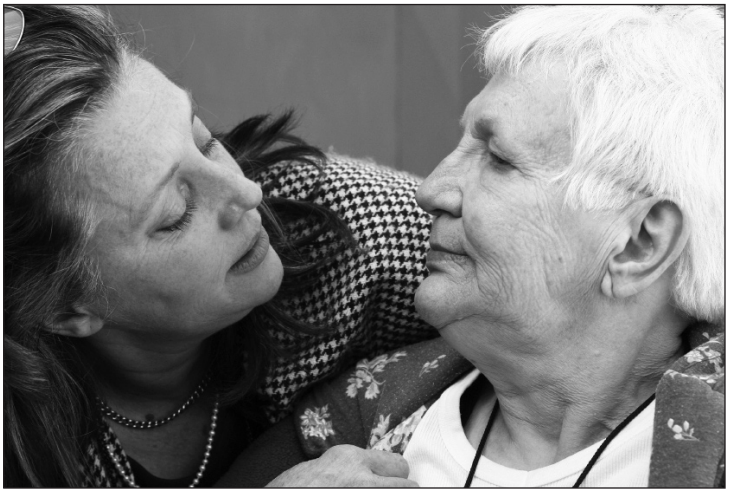
In the book *Choices and Changes – A Positive Aging Guide to Life Planning*, author G. Richard Ambrosius describes the field of positive aging and combines it with the most recent research to help readers develop a detailed road map for getting the most from "life's second half." The focus on gaining and passing on wisdom as we mature is a must-do for everyone. The book emphasizes prevention and positive planning that can actually negate the need for many health care expenses as compared to negative age-related planning that often emphasizes retirement and detachment from a normal active lifestyle. Ambrosius "embraces" positive aging as a period in the second half of our lives that opens doorways to an exciting and productive life. A positive aging attitude, as noted in so much of the literature, is one of the best indicators to successful, healthy, and positive aging. Two of my favorite sections in the book are "Rethinking Retirement" and "Personal Growth and Life Enrichment."

So what can be done? Some countries, like New Zealand, have adapted *Positive Ageing Policy 2004-2008*. This policy document focused on creating a positive aging society that included health, financial security, independence, self-fulfillment, community attitudes, personal safety and security, and the physical environment. Emphasis was on both mature and young generations to help shape attitudes, expectations, and actions regarding aging and mature citizens. Policy is certainly a way that we can gain some attention nationally, but it will take time. We can start NOW…with some attitude changes.

Let's start by celebrating birthdays as a celebration of life. Birthdays should be viewed as a time when we are becoming wiser, more confident, more secure, and BETTER overall...just like a fine wine.

Community Emergency Preparedness for the Elderly

By Jessica De Leon, Ph.D., GREAT GEC Associate Executive Director



Natural and manmade disasters impact all people, but they have been particularly harmful for the elderly. Of the more than 1,200 people that died as a result of Hurricane Katrina in 2005, more than 74 percent were over age 60 and 50 percent were over age 75. Of the 35 people who died in Harris County, Texas, as a result of Hurricane Rita, 64 percent were over age 60 (*Dyer et al, n.d.)*. The differential effects of disasters on the elderly are not just a U.S. phenomenon. In the 1995 Hanshin earthquake in Japan, more than half of the fatalities were among people over 60, and the death rate of people 80 years and over was six times higher than that of those under age 50 *(Tanida 1996)*.

What can be done in your community to protect elders before, during, and after disaster events? The challenges faced by the elderly in past disasters have provided solutions that can be incorporated into planning efforts to meet the needs of the elderly in your community.

Establish identification and tracking systems: An identification and tracking system is needed for elderly, frail elderly, and disabled elderly so they can be quickly located after an event. After the terrorist attacks in New York City on September 11, 2001, only elderly and disabled individuals who had contacted a social service agency prior to the event were on the list of special-needs victims being used by emergency rescue personnel *(O'Brien 2003)*.

Identification ideas include Internet tracking, bar-coded ID bracelets, and city-wide/neighborhood maps that illustrate high concentrations of elderly residents. Electronic tracking systems could be adapted to include medical records, medication lists, etc., so this information is immediately available to emergency and medical personnel.

Improve sheltering of elderly, frail elderly, and disabled elderly: The elderly would benefit from the establishment of separate shelters that are designed, staffed, and equipped to meet the special needs of this population. These shelters could also include security personnel to establish a safer environment than regular public shelters where the elderly and frail elderly are easy victims for scams, theft, violence, and abuse. Registration procedures are also needed to identify the elderly upon entering shelters and to aid reunification with family members. Among some elderly New Orleans evacuees, family members could not locate their elderly relatives for weeks after the storm due to the lack of a registration/tracking system in Texas' Astrodome where thousands had been sent *(Dyer et al, n.d.)*.

Tracking the subsequent movements of the elderly is also needed after evacuees leave shelters so their whereabouts are constantly updated and current, correct information is available to family, health care providers, social service workers, and others. Furthermore, tracking elderly evacuees after they leave shelters can aid in assuring these individuals are housed in facilities that are safe, secure, and can provide the health and social care they need. Some elderly victims of Hurricane Katrina were returned to shelters because they were placed in housing facilities that could not provide the assistance the elderly evacuees needed *(Dyer et al, n.d.)*.

Involve gerontological/aging specialists in planning efforts: Specialists in the elderly (e.g., geriatricians, geriatric nurses, social workers, etc.) should be involved in disaster planning at every level. Their expertise can inform planners of specific needs the elderly will have, and thereby reduce some of the problems and challenges seen in the past. Experts and professionals in geriatrics can also train others to better serve elderly disaster victims.

Involve the elderly in disaster planning, exercises, and drills: Involving seniors in disaster planning, exercises, and drills will illustrate potential areas of difficulty, point out needs that would otherwise be overlooked, and address these issues prior to an actual event. Input from the "experts"—the elderly themselves—especially those that have experienced disaster events or have special needs, could prove invaluable to truly addressing the needs of this population.

Involve community organizations and resources in planning: Local, existent social service organizations and resources should be involved in disaster planning so the knowledge, expertise, and resources of the local community are incorporated into planning. This can facilitate a rapid and efficient response after an event that takes full advantage of local resources and personnel.

Specialized teams, tools, and instruments: Professionals working with elderly Hurricane Katrina evacuees from New Orleans found many of them were not receiving

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the medical care they needed. This was particularly problematic for those without family members present to advocate for them. To address the needs of these vulnerable evacuees, the professionals created a team and developed a screening tool to assess the needs of the frail elderly and triage those with the greatest needs, i.e., SWiFT, Seniors Without Families Triage *(Dyer et al, n.d.)*. Teams and instruments such as these that are created specifically for elderly and frail elderly in disaster situations should be part of future planning and response.

Include social service needs in response efforts: Although physical health and wellbeing are the first priorities after a disaster event, long-term social services and needs, such as finding future housing and assistance obtaining disaster relief funds, must also be a priority. These services can facilitate a return to normalcy and independence and reduce the stress associated with facing an unknown future. Provisions for critical social services in the "red zone" of disasters are also needed. After 9/11, social service personnel and home health aides lacked official authorization to enter the disaster zone, and therefore could not provide essential services *(O'Brien 2003)*.

Conclusion

Research on past disasters has shown that the characteristics of the elderly make them more vulnerable in emergency situations. Seniors in the United States and internationally are more negatively impacted by these events and often comprise the majority of injured and dead. However, analysis of past disasters and emergency events also has illustrated areas needing improvement to alleviate the mistakes and challenges of the past. Careful planning can make senior citizens safer before, during, and after disasters and emergency events, and therefore must be a priority for individuals, communities, the nation, and the world.

For more information on disaster preparedness for the elderly and other vulnerable groups, please contact Nova Southeastern University's Center for Bioterrorism and All-Hazards Preparedness at (954) 262-1850 and visit its Web site at *www.nova.edu/allhazards* for free online training on all-hazards preparedness and response.

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The *GEC Channel* is published through the NSU-COM Florida Coastal Geriatric Resources, Education, and Training Center (GREAT GEC).

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