Navigating the Aging Journey and our Healthcare System

Providing Team-based Healthcare to the Aging Adult in Montana

By Shawna Yates

Objectives:

- Primer to the 4M's
- Understanding of the aging demographics
- Overview of the Geriatric Assessment
- Introduction to palliative care

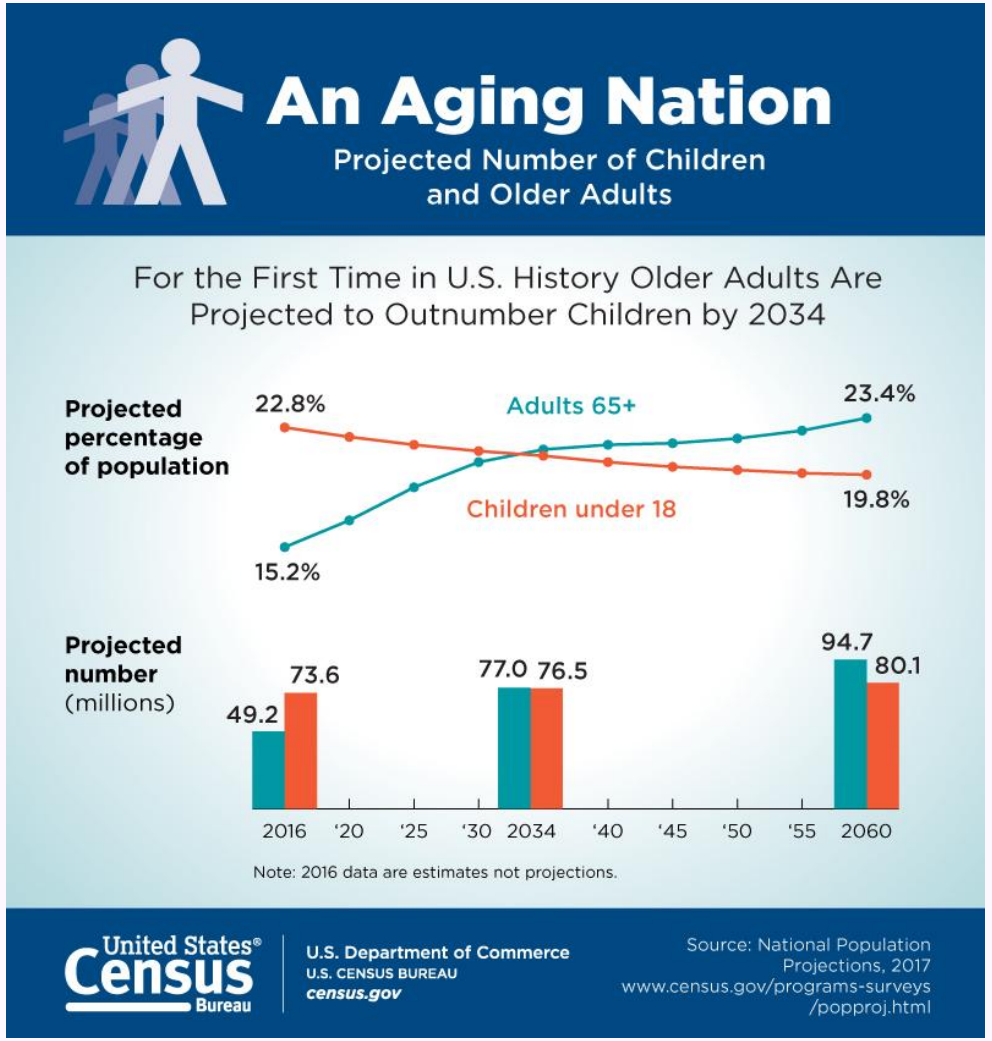
Greying of America

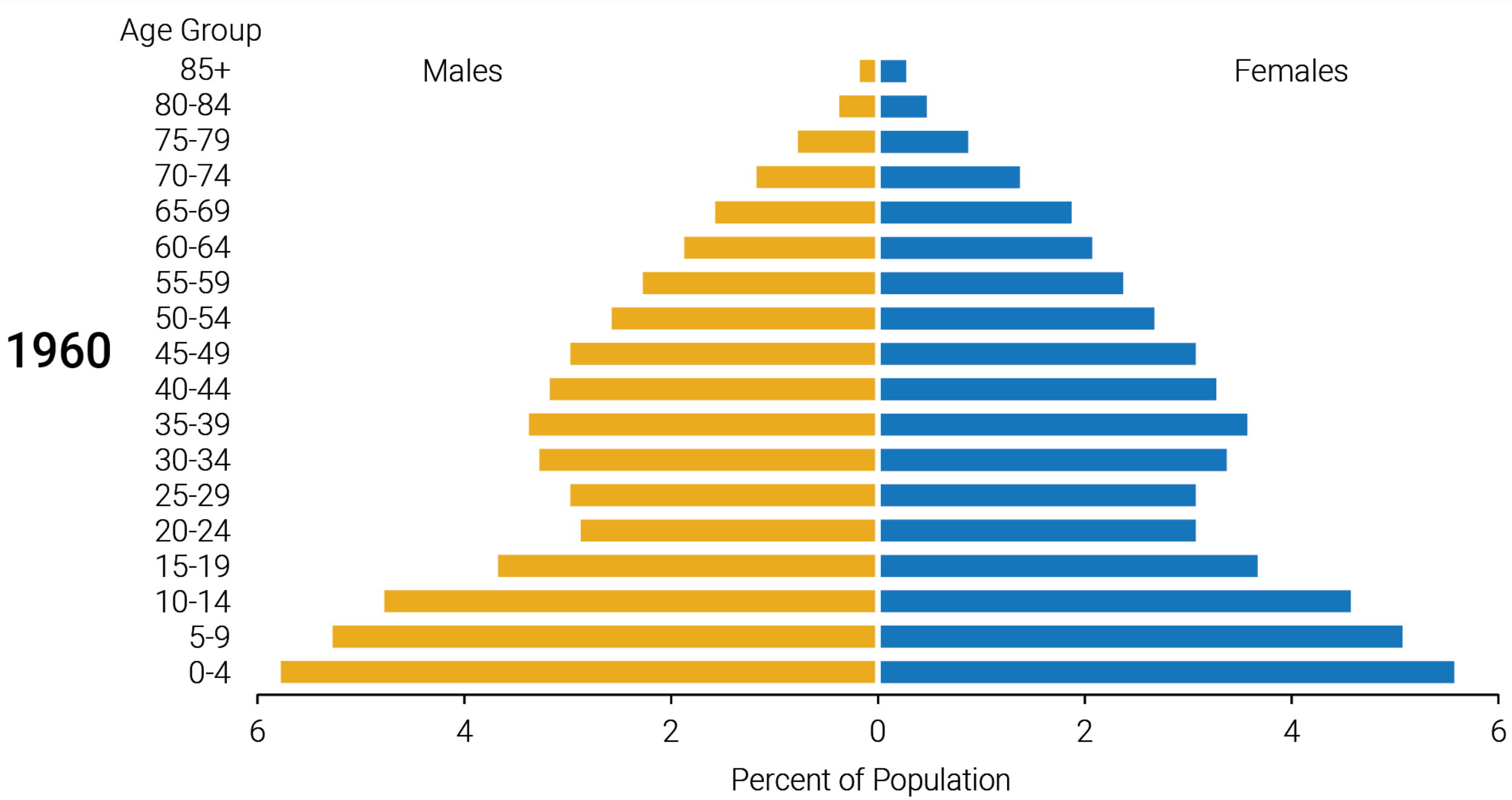
1 in 6 individuals in the US is over the age of 65

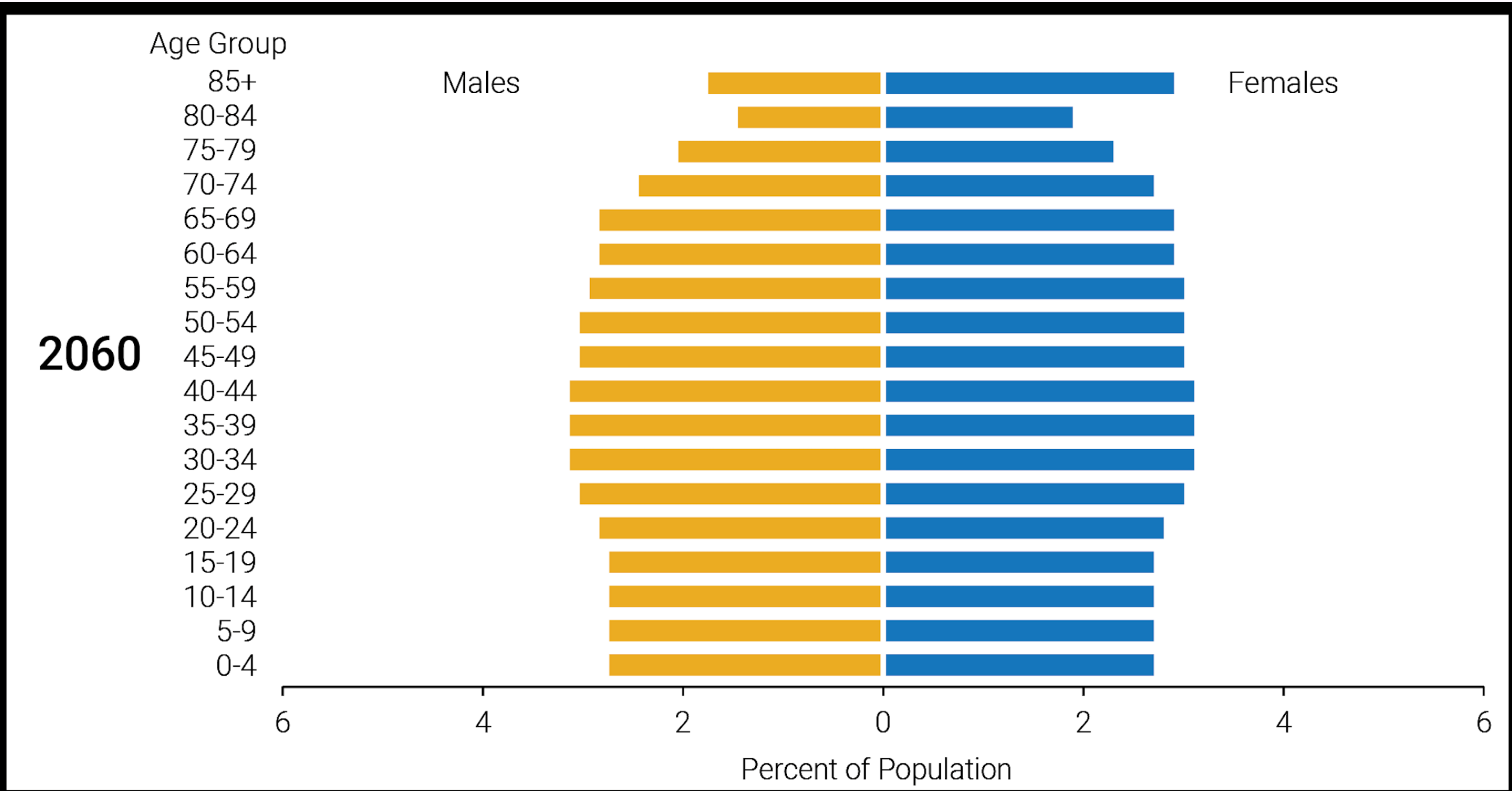
The 2030 Milestone: By 2030, all baby boomers will be older than 65, expanding this group to 74 million people.

By 2050, the percentage of those over 65 will be 22%

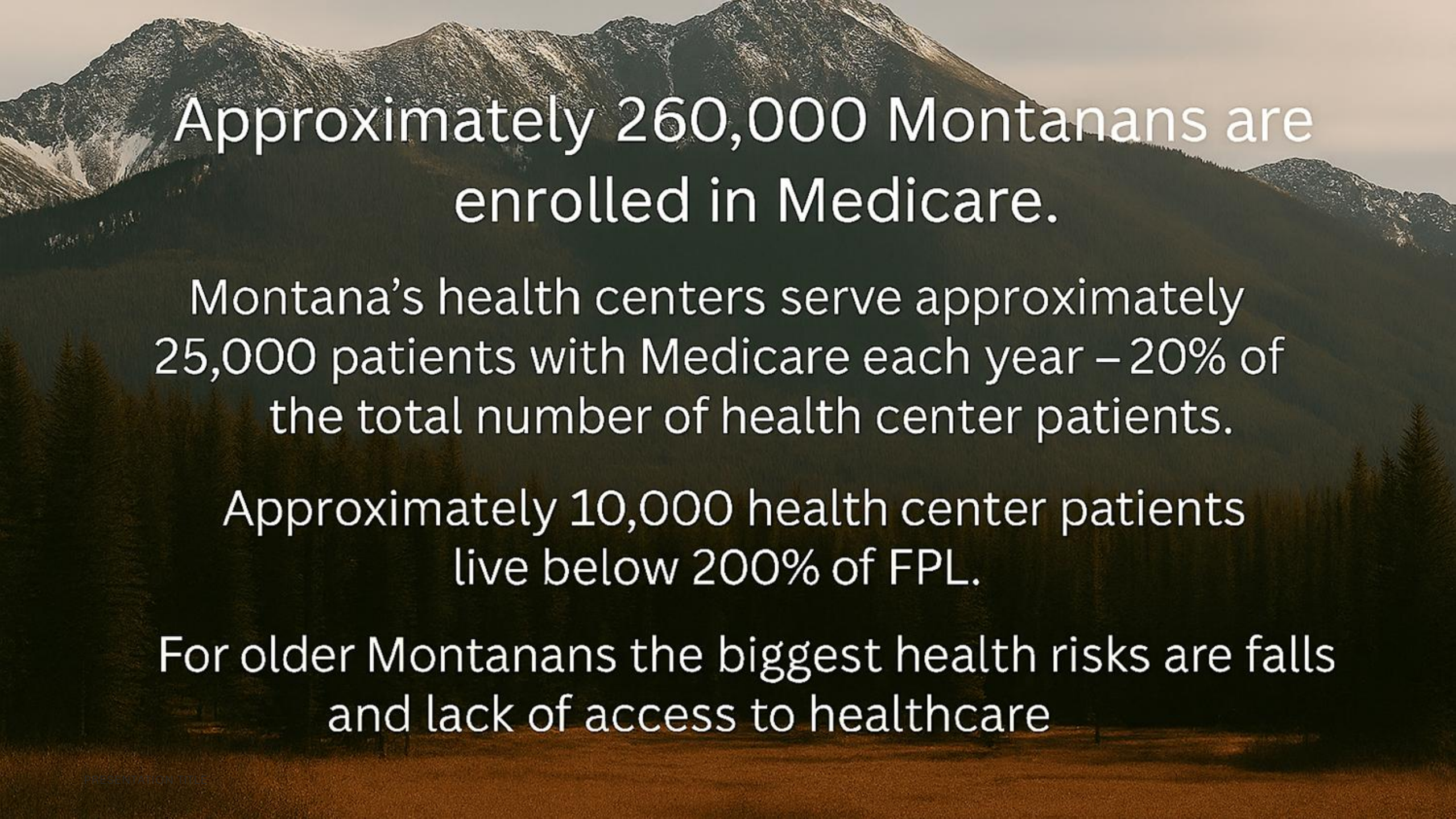
Longevity: The 85-plus population is expected to jump from 1.9% in 2010 to 4.3% by 2050.




1960
Age Group
Males
Females
85+
80-84
75-79
70-74
65-69
60-64
55-59
50-54
45-49
40-44
35-39
30-34
25-29
20-24
15-19
10-14
5-9
0-4
6
4
2
0
2
4
6
Percent of Population


2060
Age Group
85+
80-84
75-79
70-74
65-69
60-64
55-59
50-54
45-49
40-44
35-39
30-34
25-29
20-24
15-19
10-14
5-9
0-4
Males
Females
6
4
2
0
2
4
6
Percent of Population


Montana
Oldest State in the West
Approximately 21% of Montana residents are 65+
By 2030 it is anticipated 32% of Montana residents will be 65+.


Approximately 260,000 Montanans are enrolled in Medicare.
Montana's health centers serve approximately 25,000 patients with Medicare each year – 20% of the total number of health center patients.
Approximately 10,000 health center patients live below 200% of FPL.
For older Montanans the biggest health risks are falls and lack of access to healthcare

Challenges to the changing demographics

ECONOMIC AND SOCIAL IMPACTS

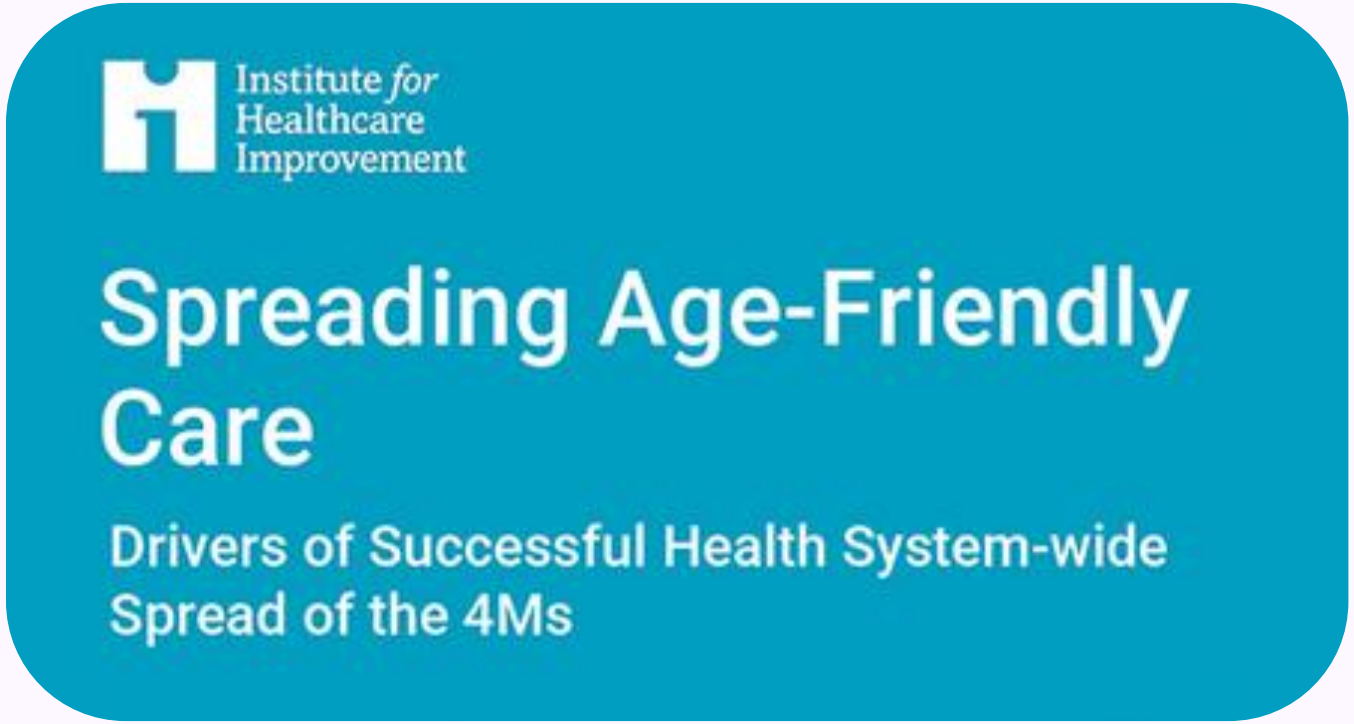
- Workforce shortage
- Dependency ratios
- Fiscal Instability
- Family Changes
- Caregiver Gap

HEALTH AND WELLBEING

- Chronic Disease
- Cognitive Decline
- Healthcare Costs
- Current Environmental Barriers

Age-Friendly Health Systems

The Institute for Healthcare Improvement (IHI), in partnership with The John A. Hartford Foundation, officially launched the Age-Friendly Health Systems initiative and the 4Ms framework (What Matters, Medication, Mentation, Mobility) in 2017. The framework was developed to improve care for older adults by focusing on evidence-based practices, do not harm, and align with What Matters to the older adult and their family care partners.



In 2017, Drs Molnar, Huang and Tinetti launched the 5Ms

TABLE 1

GERIATRIC 5Ms

Mind	Mentation
	Dementia
	Delirium
	Depression
Mobility	Impaired gait and balance
	Fall injury prevention
Medications	Polypharmacy
	De-prescribing
	Optimal prescribing
	Adverse medication effects and medication burden
Multi-complexity	Multi-morbidity
	Complex bio-psycho-social situations
Matters most	Each individual's own meaningful health outcome goals and care preferences

Reprinted with permission from Molnar F, Huang A, Tinetti M; Canadian Geriatrics Society. Update: the public launch of the geriatric 5Ms. April 28, 2017. Accessed April 25, 2024. https://static1.squarespace.com/static/63599251a953f80dd1922762/t/653a987fa1ed661104970e49/1698338943784/UPDATE+-THE+PUBLIC+LAUNCH+OF+THE+GERIATRIC+5MS.pdf

- What **M**atters most (to you): planning the care you want for your future
- Your **M**obility: balance and walking
- Your **M**ind and memory
- Your **M**edicines

Case Presentation

Lena is a 94 year old hispanic female, widowed and living in her own home of 70 years. She is hard of hearing, requires a walker to get around her home and rarely leaves her familiar surroundings. She lives alone with occasional check ins from her niece and nephew. Her vision is changing and she can no longer read or write or watch TV. Her finances are limited and she lives on $900 in social security monthly. Her past medical history includes OA, macular degeneration, HTN, and urinary incontinence.

She takes a fall in her home and lies on the ground until her family comes upon her at which time she is rushed by ambulance to the hospital.

What do we need to consider in this scenario if we are an Age-Friendly Healthcare System?

Lena: Goals of Care and Patient Centered

Scenario 1:

She travels to hospital to find a fracture of her hip

Meds: pain management, maybe anxiety control, BP meds, anesthesia

Mobility: she will be bed bound, require surgery, and then rehab to regain her new level of function

Mind: will she have delirium, how will she navigate the new place and faces, how will her hearing impairment affect her care, can she make medical decisions, will she lose the will to live and develop depression and anxiety

What Matters: POA, have these conversation been relayed, if she says no to SNF or surgery what are her options

Mulitcomplexity: will she need a foley to prevent skin breakdown and urinary retention, will her BP spike and place her at risk of CVA, will anesthesia impact her cognition,

Scenario 2:

Her POA calls the clinic and an urgent ref is placed for Hospice

What Matters: Ahead of time goals of care conversations included her desire to die at home and undergo no heroics of the health care system

Meds: Pain management can be initiated and monitor BP for optimal control

Mobility: She may not walk again, she may be chair bound and require new levels of assistance to stay in her home

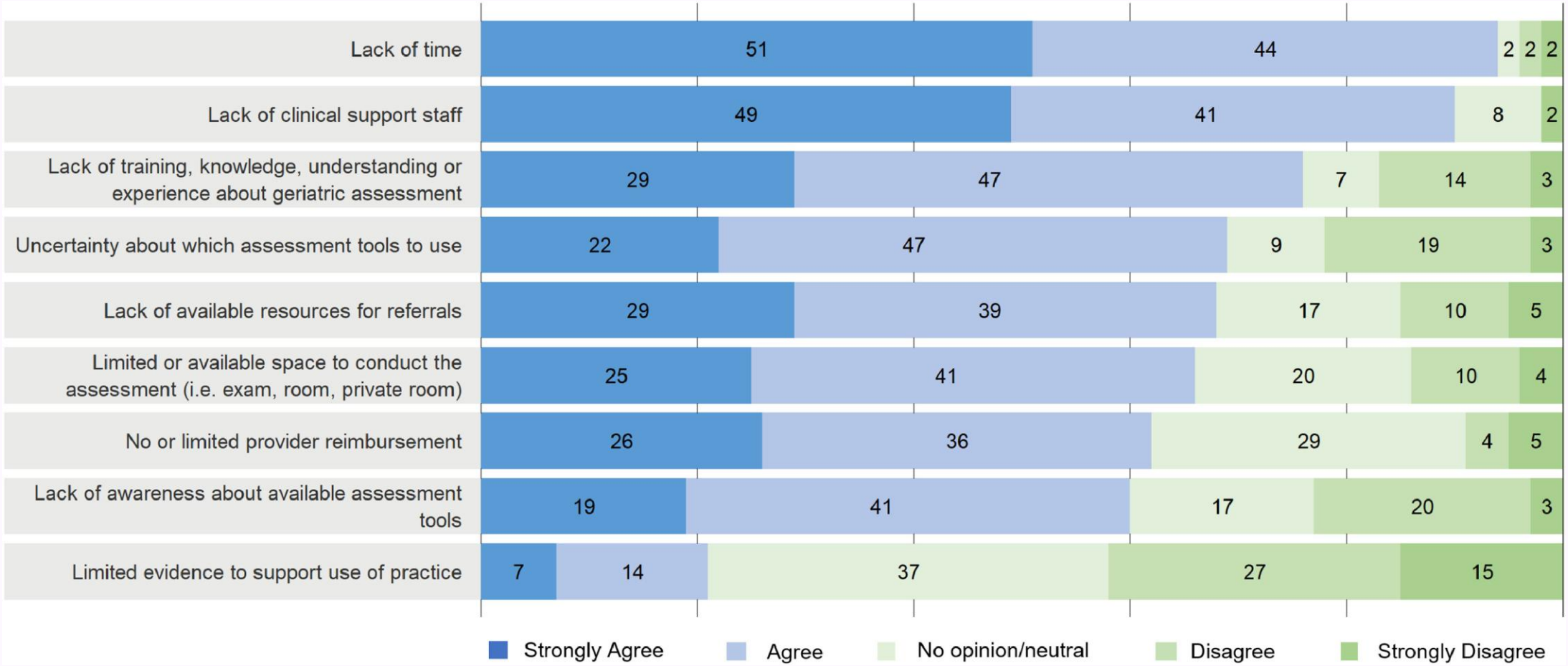
Mind: She may develop more fear and anxiety of falling again and the toll of her pain and complications of hip fracture may lead to no nutritional intake and death

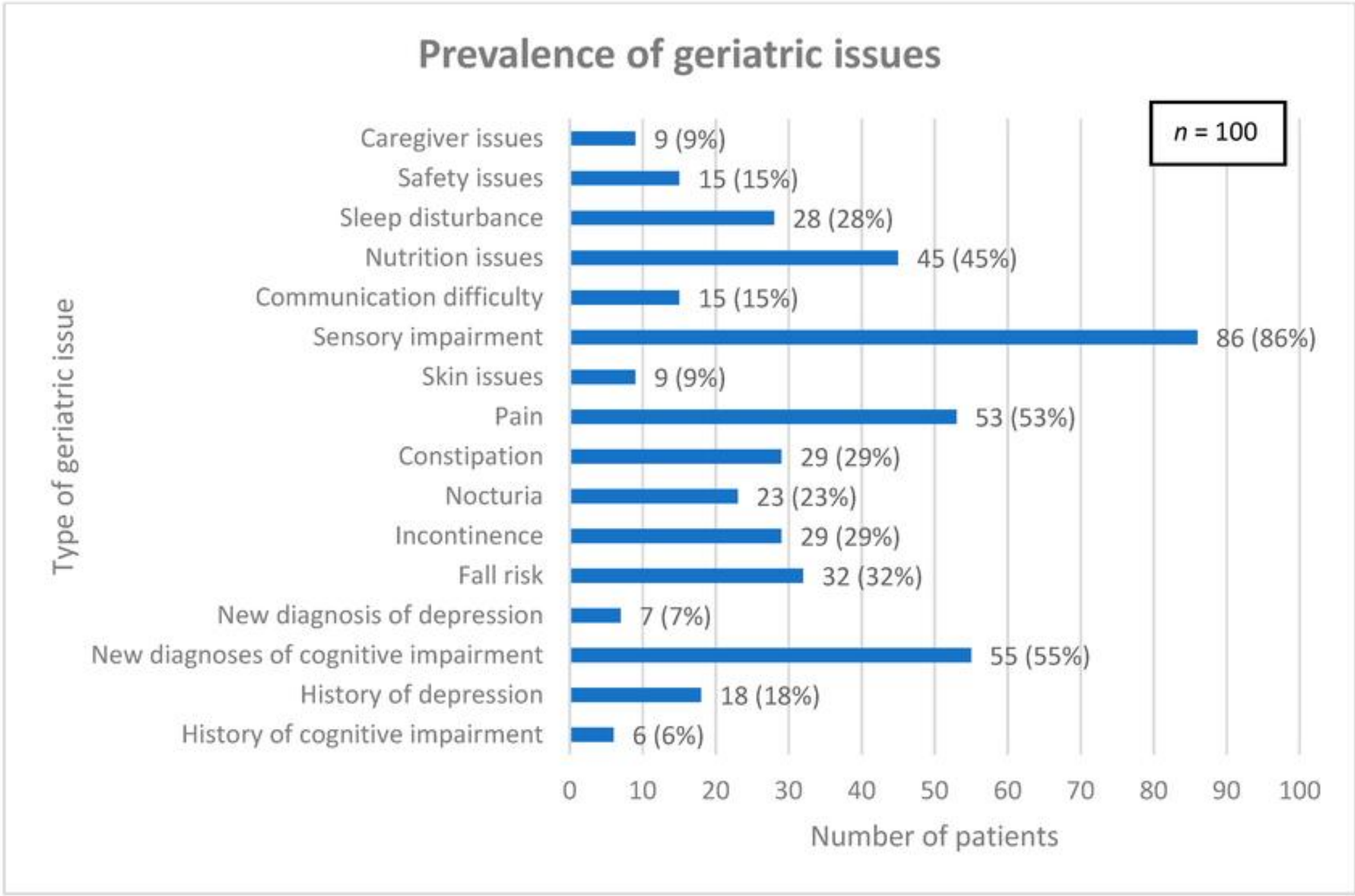
Mulitcomplexity: She will need DME and in home monitoring to make her comfortable and determine her level of care through this healing timeframe, she may never be able to live alone again

Geriatric Assessment

1. Medical History
2. Social history and social support
3. Functional history – IADLs ADLs
4. Nutrition
5. Sleep
6. Sensory – Vision, hearing, mouth, etc
7. Polypharmacy and substance use
8. Cognitive and Psychological/Spiritual assessment
9. Mobility and Environmental Assessment
10. End of Life wishes and Goals of Care

Barriers to providing comprehensive geriatric assessment




Prevalence of geriatric issues
n = 100
Type of geriatric issue
Caregiver issues
9 (9%)
Safety issues
15 (15%)
Sleep disturbance
28 (28%)
Nutrition issues
45 (45%)
Communication difficulty
15 (15%)
Sensory impairment
86 (86%)
Skin issues
9 (9%)
Pain
53 (53%)
Constipation
29 (29%)
Nocturia
23 (23%)
Incontinence
29 (29%)
Fall risk
32 (32%)
New diagnosis of depression
7 (7%)
New diagnoses of cognitive impairment
55 (55%)
History of depression
18 (18%)
History of cognitive impairment
6 (6%)
0
10
20
30
40
50
60
70
80
90
100
Number of patients

Dr. Yates – What does my practice look like

- Hospice and Palliative Care Certificate in addition to Board Certified Family Medicine for 19 years
- Medical Director of 2 hospice teams in Butte
- Direct Patient Care at Blacktail Health 0.5 FTE
- Panel size – 300
- Patients seen on average 4.7 times a year
- Team includes NP, RN, MA, BH and shared care manager and clinical pharmacist
- We provide off-site visits in the nursing homes and assisted living centers as well to patient home.
- New patients are over the age of 80 or living with dementia
- We provide CCM to all patients interested in participating
- Help lead the Value Based care work especially for Medicare – RN lead MWV

Journey to Age-Friendly

Mobility issues of the clinic

Coordination of care in SNF and ALF

Dementia Care training for staff

Pharmacy led projects around high-risk BEERs list prescribing

Home Visits

Standard screening of cognition and mood

Advanced care planning conversation and documentation

Continuity of Care

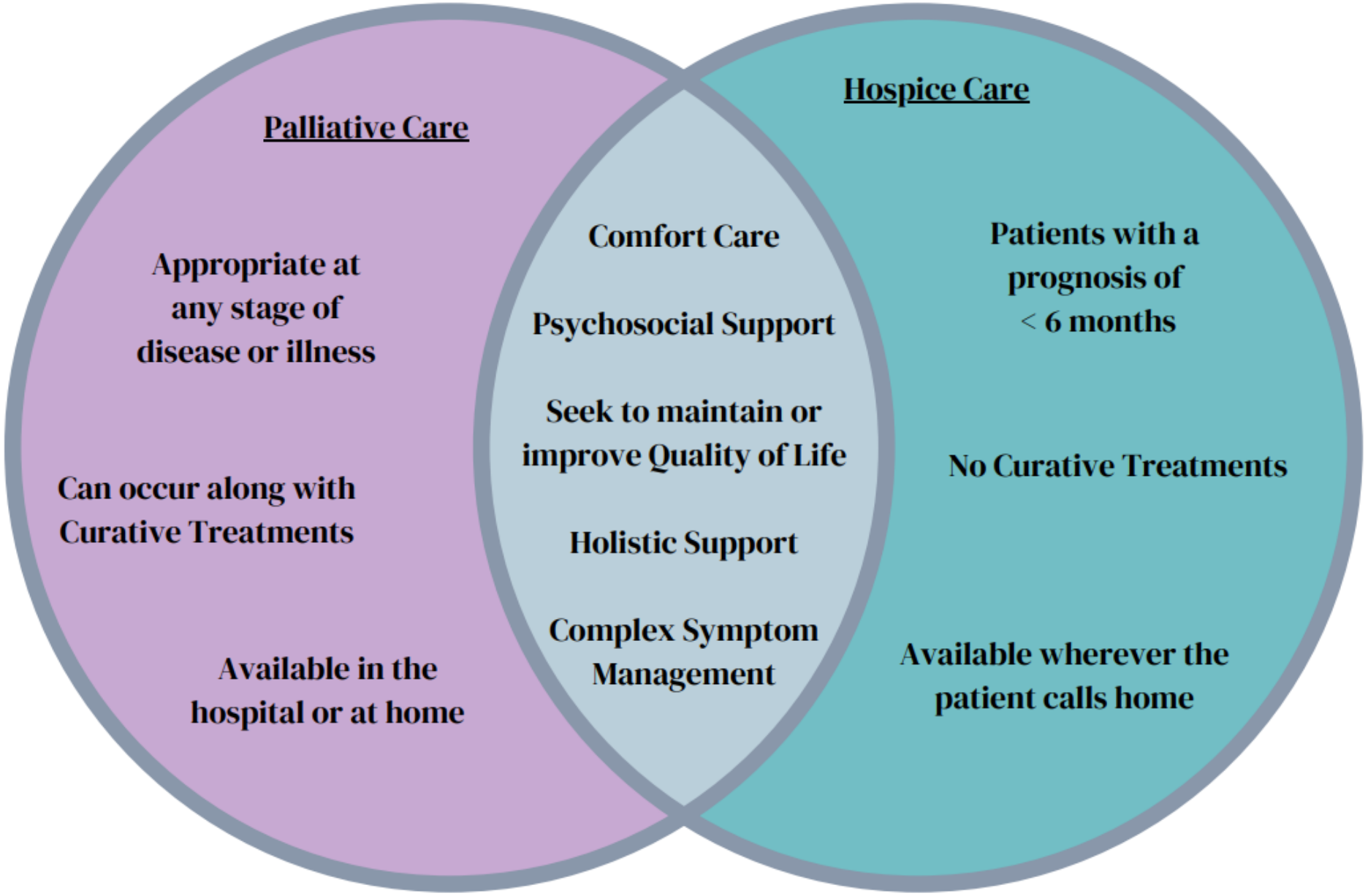
Palliative care

Palliative care is specialized medical care for people living with a serious illness, focusing on providing relief from symptoms, pain, and stress to improve quality of life for both the patient and family. It is provided by an interdisciplinary team, suitable at any age or stage of illness, and can be given alongside curative treatment.

Goal:

- Improved quality of life
- Reduced emotional distress
- Management of symptoms including pain
- Deprescribing

PACE - Program for All-inclusive Care for the Elderly


Palliative Care
Appropriate at any stage of disease or illness
Can occur along with Curative Treatments
Available in the hospital or at home
Comfort Care
Psychosocial Support
Seek to maintain or improve Quality of Life
Holistic Support
Complex Symptom Management
Hospice Care
Patients with a prognosis of < 6 months
No Curative Treatments
Available wherever the patient calls home

Tidbits for Care of the Older Adult

1. What don't I know (ask) Think Geri Assessment
2. Stigma is high – Aging is a bitch
3. Partner with patients and families
4. Goals of Care
5. Physiology changes with age
6. See patients with severe illness frequently
7. Deprescribe
8. Assess for cognitive change
9. Ask the hard questions: sexually active, substance use, end of life concerns, etc
10. Please treat pain

Questions???

Please contact me anytime at

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