Caring for our Aging Population: A Primary Care Challenge

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Keys for Health Center Success
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Reality of the 21st century

- No other force is likely to shape the future of national economic health, public finances, and national policies as the irreversible rate at which the world’s population is growing older. – Standard & Poor's “Global Aging 2010: An Irreversible Truth”
The Growing Number of Older Adults

• 2013: 35 Million people 65 years old or older - 16% of our population
• 2030: 72 Million people – 20% of our population
• Nearly 8000 people turn 65 every day!
• People 75 and older use 3-4 Xs more hospital days than people 45-55 years old
• 25% of Medicare patients are readmitted to hospitals within 30 days
• People 85 and older spend about 5X more on healthcare than people 45-55 years old
Challenges

• Typically older people are sicker with higher acuity and more co-morbidities
• Hospitalizations have longer LOS
• Older adults often lose both cognitive and physical function during hospitalization
• Older adults are more susceptible to “never events”
• Changes on medication regimens often result in delirium and cognitive decline
• Fee for service structure
More Challenges

• Healthcare costs are soaring
  – 17.6 % of our GDP last year
  – 1.5 – 2 Xs more than any other country
  – USA ranks 20th in life expectancy
  – 7th in mortality in cancer
    • A detection issue
    • #1 in treatment after diagnosis
• Our health care system’s attention is on acute disease focused episodes
Selected Risk Indicators for Americans age 65+

- 32% are obese
- 10% are smokers; 55% of men and 31% of women are former smokers
- Average time spent watching TV is 4.1 hours per day
- 1 in 4 has at least 1 limitation in bathing, dressing, eating, walking or using the toilet
- 1 in 4 has diabetes

Source: US Administration on Aging
1 in 8 Americans 65+ has Alzheimer’s disease

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<tr>
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<th>NOW</th>
<th>2050</th>
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<tr>
<td>Number diagnosed (in millions)</td>
<td>5.2</td>
<td>13.2</td>
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<tr>
<td>Health care spending (in Billions)</td>
<td>183</td>
<td>1,100</td>
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<td>% of GDP</td>
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<td>3</td>
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Source: Alzheimer’s Association and Goldman Sachs
Workforce Issues

- Very few providers are trained in geriatrics.
- The IOM report (2007) “Retooling for an Aging America” was a call for action underscoring that our health care system is not ready to meet the pending crisis when we look at the demographics of older adults, their health status, long-term needs and challenges of caring for this unique population.
Physicians

- ~650,000 – very few in primary care and less than 2%/year choose this specialty
- Most primary care physicians have no background in geriatrics
- < 7,000 certified in geriatrics
- ~1,500 certified in geriatric psychiatry
- Most all programs require some exposure to geriatrics
- < 3% of medical students choose a geriatric elective
Projection of Geriatricians
Geriatric Workforce Policy Studies (2009)

Geriatricians (in Thousands) vs. Population 75+ years (in Millions)

- 2010: 6.8K Geriatricians, 19M Population 75+
- 2020: 6.3K Geriatricians, 23M Population 75+
- 2030: 6K Geriatricians, 34M Population 75+
- 2040: 5.4K Geriatricians, 45M Population 75+
- 2050: 5.4K Geriatricians, 49M Population 75+
Geriatricians/10K people 75+ years
Nurse Practitioners

- A vital source of primary care for older adults
- 255,000 APNs: <5000 prepared in geriatrics
- 40 research studies show that patient outcomes from NPs in primary care are comparable to those of MDs
- NPs cover about 80-90% of the services physicians provide
- In 2010 Obama announced an increase in funding for RN managed primary care clinics, many of which are FQHCs
- Scope of practice issues
Never before have we had so much to do and so little time to do it.

FRANKLIN D. ROOSEVELT
Primary Care is Special

- The hub of care coordination across the care continuum
- Prevention of transitional care issues
- Diagnoses are often a challenge
  - Undifferentiated
  - Family issues
  - Behavioral health
- Management of chronic diseases
- Prevention of avoidable function loss
Today’s Environment and Primary Care

• Do more with same or less resources
• Growing number of older people AND longevity
  – More chronic disease management
  – More demands to maintain function
• Quality is a challenge to sustain
• What happens when you screen for depression
• Patient engagement
• Quickly changing evidence
• Referral follow up
  – within 3 days – 100%
  – within 7 days – 70%
  – 2-6 weeks – 0%
• Triple Aim – is it realistic?
Affordable Care Act (2010)

• Recognizes that patient should be at the center of care
• Shifts priority from episodic acute care to incentivized comprehensive care across the continuum
• Focuses on chronic disease management
Accountable Care Organizations (ACO)

• ACA initiative
• An organization of providers that agrees to be accountable for the cost, quality and overall health care of a designated group of Medicare beneficiaries
• Those that achieve cost savings will share in those savings
• Those that spend more than they receive are at risk
• Could be network of physicians, or hospitals, or insurers
Patient Centered Medical Homes (PCMH)

- ACA initiative
- Deliver primary care
- Facilitate partnerships between patients, providers and family caregivers
- Coordinates all care
- Outcomes
  - Reduce cost of care, particularly chronic disease management, with best practices
  - Reduce avoidable use of ED
  - Reduce avoidable hospital admissions and readmissions
  - Reduce cost of drugs, and adverse drug events.
Nurse Practitioners and Primary Care

• Nurse practitioners are the future of primary care in this country
• Provide accessible quality care regardless of ability to pay
• Since only <5,000 are prepared in geriatrics we need to increase the capacity of NPs to deliver age sensitive care to this growing number of older adults
Primary Care of Older Adults (PCOA)

• “This project is supported by funds from the Department of Health and Human Services (DHHS), Health Resources and Services Administration, the Bureau of Health Professions (BHPr), Division of Public Health and Interdisciplinary Education (DPHIE)
• Hartford Institute for Geriatric Nursing
• PCOA is online resources to help Primary Care Providers (NPs, MDs and PAs) provide age sensitive care to older adults.
  – Patient focused
  – Interprofessional
  – Evidence based
  – Age specific
• Enhance the capacity of the workforce to provide the care necessary to maintain older adults at their highest level of function
Survey conducted by HIGN

- 148 respondents
- 96% need more knowledge about older adults
- 25% certified in geriatrics
- % of people >65 years old in practice
  - 75% - 68 respondents (46%)
  - 50% - 27 respondents (18%)
  - 25% - 26 respondents (17.5%)
  - <25% - 28 respondents (18.5%)
Topics for First Release

- Health Promotion and Disease Prevention in Older Adults
- Common Screening with Older Adults
- Cancer Screening
- Presentation of Illness in Older Adults
- Dementia (3 Modules)
- End of Life and Palliative Care (2 Modules)
- Chronic Disease Management
- Chronic Pain Management and Osteoarthritis
- Making your Practice Friendly to the Older adult
- Medication Management
The **First** Annual Wellness Visit

- A preventive wellness visit to help plan services
- Health Risk Assessment
  - Have it completed prior to encounter (20 minutes)
  - Demographics, self assessment of health, psychosocial and behavioral risks, ADLs and IADLs
- Medical Family History
  - Medical/surgical issues, medications, family diseases
- Risk of depression
- Functional ability and level of safety
- General assessment of height, weight, BP
- Detection of any cognitive impairment
The **First** Annual Wellness Exam (Cont.)

- Written screening schedule for next 5-10 years
- List of risk factors for which interventions are recommended or underway
- Personalized health advice or referral
  - Community based services
  - Weight loss
  - Physical activity
  - Tobacco use-cessation
  - Fall prevention
  - Nutrition
- Billing code- G0438
- Billing Description- AWV; includes a Personalized Prevention Plan of Service (PPPS), initial visit
- Co-pay is waived
Subsequent Annual Wellness Visit

• Update the same information from the first visit
• Billing code G0439
• Billing Description- AWV; includes a Personalized Prevention Plan of Service (PPPS), subsequent visit
Annual Visit for Older Adults in Primary Care

• Comprehensive health history, including
  – Medications-Prescribed, over the counter, vitamins, laxatives, herbal
  – Functional assessment-ADLs/IADLs
  – Social assessment
  – Advanced directives
  – Review of systems

• Comprehensive physical exam, including mental status and mood assessment

• Use of evidence-based screening and assessment tools

• Assessment and management plan should address: Medical, nursing, psychiatric, functional, social, nutritional, occupational, financial, familial, environmental, and educational issues and needs
Immunizations for Older Adults: Influenza and Pneumococcal Vaccines

- Intramuscular Influenza vaccine annually, starting October and ending February
- Pneumococcal vaccine once after the age of 65 with a revaccination after 5 years
- Tetanus-diphtheria toxoid (Td) as a booster shot every ten years
- Herpes zoster (shingles) has decreased the incidence of herpes zoster and postherpetic neuralgia by 51% and 67% respectively
Screening Recommendations

• **Breast**- : Mammography every 1-2 years for women with >5 years remaining life expectancy up to age 85 years (longer if healthy and functional and patient feels will benefit).

• **Cervical**-: No testing for those >65 if had adequate prior screening and are not otherwise at high risk for cervical cancer. Women with a history of human papillomavirus (HPV) should continue annual testing.
Screenings (cont.)

- **Colon**: To screen for cancer: FOBT yearly or Fecal Immunochemical Test yearly;
  - **To screen for polyps and cancer**: Flexible sigmoidoscopy every 5 years (if positive, do colonoscopy) OR colonoscopy every 10 years starting at age 50; OR double contrast barium enema every 5 years (if positive, do colonoscopy); OR CT colonography every 5 years (if positive, do colonoscopy)
  - There is no upper age limit to stop screening

- **Prostate**: Yearly digital rectal exam (DRE) as part of yearly physical
Geriatric Syndromes*

- Not a specific disease
- Refer to one symptom or a complexity of symptoms with high prevalence in geriatrics
- Often result from multiple diseases and multiple risk factors
- Broad category of signs and symptoms prevalent in the older adult population
- Have more than one cause
- Limit Activities of Daily Living or Instrumental Activities of Daily Living
- Reduce quality of Life

Geriatric Syndromes*

- Difficulty Walking
- Functional decline
- Falling
- Dizziness, syncope
- Hearing problems
- Vision problems
- Urinary incontinence

Geriatric Syndromes * Continued

- Frailty
- Pressure Ulcers
- Delirium
- Dementia
- Eating and feeding difficulties
- Sleep disturbances
- Slowed cognitive processing
- Pain

*The American Geriatrics Society, [http://www.americangeriatrics.org](http://www.americangeriatrics.org)
Geriatric syndromes primarily refers to one symptom or a complex of symptoms (e.g. falls, delirium) that result from multiple disease and risk factors.

Impossible to know or predict all of the multiple etiological and pathogenetic pathways of selected geriatric syndromes.

Geriatric syndromes can stem from disease, iatrogenesis and frailty.
Medication Use in Older Adults

- Medications can lead to geriatric syndromes
- Medications must be considered as the source for an abrupt change in condition
  - abrupt change in mental status
  - weight loss
  - dehydration
  - agitation or restlessness
  - anorexia
  - urinary retention
  - decline in functional status
  - daytime sleepiness
  - falls
- Newly added medications are the usual culprit; however, polypharmacy, drug-drug interactions, or drug-disease interactions must also be considered.
Medication Use in Older Adults (Cont.)

• BEST TOOL: The American Geriatrics Society Updated Beers Criteria (AGS, 2012) includes three main categories:
  1. Potentially inappropriate medications and classes to avoid in older adults
  2. Potentially inappropriate medications and classes to avoid in older adults with certain diseases and syndromes that the drugs listed can exacerbate
  3. Medications to be used with caution in older adults
AGS Updated Beers Criteria

Other Important AGS 2012 Beers Criteria Resources


• Based on the AGS Geriatrics Review Syllabus (GRS): A Core Curriculum in Geriatric Medicine, 7th Edition, the GRS Teaching Slides Website includes downloadable slide presentations in Microsoft® PowerPoint® on the AGS Beers Criteria 2012. The Beers Criteria Teaching Slides are available at: http://teachingslides.americangeriatrics.org/sample.asp

• For more information, please visit the AGS Beers Criteria 2012 Clinical Practice Website at: http://www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/2012
Managing Polypharmacy

- **Reduce the dose**: "Start Low and Go Slow," or give the lowest possible dose when starting a medication and slow upward titration to obtain clinical benefit; many ADEs are dose-related

- **Discontinue unnecessary therapy**: Prescribers are often reluctant to stop medications, especially if they did not initiate the treatment. This practice increases the risk for an adverse event.

- **Attempt a trial of nonpharmacological interventions and treatments** prior to requesting medication for new symptoms.

- **Recommend safer drugs**: Avoid drugs that are likely to be associated with adverse outcomes (review Beers Criteria, AGS website)

- **Optimize drug regimen**. When prescribing medications, the focus should be on risk versus benefit where the expected health benefit (e.g., relief of agitation in dementia with psychosis) exceeds the expected negative consequences (e.g., morbidity and mortality from falls that result in hip fracture)
Managing Polypharmacy (cont.)

- **Initiation of new medication:** Assess risk factors for ADRs, potential drug–disease and drug–drug interactions, and correct dosages

- **Avoid the prescribing cascade:** Avoid the prescribing cascade by first considering any new symptom as being an adverse effect of a current medication prior to adding a new medication.

- **Avoid inappropriate medications.** Review criteria for potential inappropriate medications, drug–disease interactions, and potential drug–drug interactions (**Beers Criteria**)

- **Employ nonpharmacological approaches** for symptoms (e.g., therapeutic activity kit for agitation)
Presentation of illness in older adults includes:
- vague presentation of illness
- altered presentation of illness
- non-presentation of illness
# Classic Signs and Symptoms of Presentation of Illness in Older Adults

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<thead>
<tr>
<th>Signs and Symptoms</th>
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<tr>
<td>• Delirium/Acute Confusion</td>
<td>• Functional decline</td>
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<tr>
<td>• Failure to eat or drink (for example, anorexia)</td>
<td>• Reduced mobility</td>
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<td>• Failure to develop a temperature or fever in light of leukocytosis</td>
<td>• Generalized weakness</td>
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<td>• Lack of pain with a disease known to cause pain (such as gastric ulcer disease)</td>
<td>• Falling</td>
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<td>• Fatigue</td>
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<td>• Urinary Incontinence</td>
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Common Diseases with Altered Presentation in Older Adults

- Infections
- Cardiac disease
- Diabetes
- Thyroid disease
- Gastrointestinal disease
- Depression
Common Infections and their Presentation in Older Adults

• Pneumonia-Assess for increased respiratory rate, decreased appetite, change in mental status, change in function
• Urinary Tract Infections-Assess for new onset urinary incontinence, urinary frequency, change in mental status, change in function
• Cellulitis and other skin infections-Assess skin and feet, including between toes each visit
• Note: Older adults may not present with fever or increased white blood cell count as is typical in younger adults with infections
Cardiac disease: Congestive Heart Failure (CHF)

- Increased incidence with age. Median age 75 years.
- Leading cause of hospitalization and rehospitalization in older adults
- Major cause of disability in older adults
- Major cause of decreased quality of life
- Risk for transitional care issues
- Annual expenditure exceeds $10 billion
Congestive Heart Failure: Assessment in Older Adults

- Classic signs in younger adults, such as $S_3$ gallop, increased jugular venous pressure, and tachycardia may not be present in older adults
- Baseline may already include lower extremity edema
- Decreased appetite may be first sign of worsening disease
- Weight gain
- Increased respiratory rate
- Shortness of breath
- Change in sleep pattern
- Confusion/Delirium
- Anxiety
- Fatigue
Cardiac disease: Acute Coronary Syndromes

• Of the approximate 1.2 million myocardial infarctions annually in the U.S., 2/3 occur in those ≥65 years old, 44% in those ≥75 years old

• Mortality after acute myocardial infarction (MI) increases with age
  – 80% MI deaths occur in those ≥65 years old
  – 60% MI deaths occur in those ≥75 years old

GNRS, 2011
Acute Coronary Syndromes: Assessment in Older Adults

- Classic symptoms in young adults, such as chest pain and diaphoresis may not be present in older adults
- Sudden onset dyspnea is most common initial symptom
- Confusion/Delirium
- Dizziness
- Syncope
- Anxiety
Diabetes Mellitus

- Prevalence 15%-20% among those ≥65 years old
- 10 year reduction in life expectancy
- Two-fold increased rate of MI, stroke, kidney failure in older adults with diabetes
- Risk of blindness increased 40% in older adults with diabetes
- Increased mobility and disability issues in older adults with diabetes

GNRS, 2011
Diabetes Mellitus (continued)

• Classic symptoms in young adults, such as polyuria, polydipsia, and polyphagia may not be present in older adults

• More common symptoms in older adults:
  – Confusion/Delirium
  – Dehydration
  – Urinary incontinence
  – Weight loss
Thyroid Disease

- Classic symptoms of hypothyroidism in young adults, such as fatigue, dry skin, decreased skin turgor, constipation may not be present in older adults
- Classic symptoms of hyperthyroidism in young adults, such as tremor, tachycardia, goiter, heat intolerance, increased perspiration may not be present in older adults
- Presentation in older adults
  - Hypothyroidism may present with no symptoms, confusion or vague complaints that cannot be attributed to anything else
  - Hyperthyroidism may present with confusion, atrial fibrillation, weight loss, muscle weakness
- Thyroid Stimulating Hormone (TSH) is best to screen for thyroid disease in older adults

GNRS, 2011
Hypothyroidism in Older Adults with Dementia

• Treatment for hypothyroidism rarely helps return to normal cognitive ability

• Treatment often improves cognition, functional ability, and mood

GNRS, 2011
Gastrointestinal Disease

- Gastrointestinal (GI) bleeding in older adults may present as abdominal cramping, generalized pain, dehydration
- Typical presentation of GI obstruction in young adults, such as firm and tender abdomen, may present as abdominal cramping, vague complaints, dehydration, diarrhea
- Appendicitis is more common in young adults, but often misdiagnosed in older adults, thereby increasing morbidity and mortality
Depression

• Prevalence of minor depressive disorder in 8%-40% older adults in primary care
• Prevalence of major depressive disorder in 6%-10% older adults in primary care
• Complaints of sadness and depression not common in older adults
• Common presentation in older adults: decrease in function and activity level, fatigue, vague complaints, somatic complaints, “I don’t know” responses to questions

GNRS, 2011
Screening for Depression in Primary Care

• Review risk factors for depression on the Medicare Annual Wellness Visit

• Use an evidence-based screening tool to screen for depression during the Annual Physical Exam (Example: Geriatric Depression Scale: Short or Long Form)

• Collaborate with interprofessional team members to provide individualized management and treatment of depression
Dementia

• 3 modules available on the Hartford Institute website now
  http://www.hartfordign.org/practice/dementia_primarycare/

• **Module 1**- Mild Cognitive Impairment and Alzheimer's Disease: Evidence-based Care Guide for Primary Care Providers
• **Module 2**- Collaborative Care Approach to Memory Disorders in Primary Care
• **Module 3**- Patient Self-Management Resources- Fact and Question Sheets
  • Fact Sheet 1- Alzheimer's Disease- AD
  • Fact Sheet 2- Mild Cognitive Impairment (MCI)
  • Fact Sheet 3- Family Member of an Older Adult Diagnosed with Alzheimer's Disease-AD
  • Fact Sheet 4- Family Member of an Older Adult Diagnosed with Advanced Alzheimer’s Disease –AD
Older Adults with Dementia and Chronic Illness

- With dementia comes other co-morbidities
- Almost 95 percent of persons with dementia have at least one other chronic condition

- 30% Coronary Artery
- 28% Congestive Heart Failure
- 21% Diabetes
- 17% Chronic obstructive pulmonary disease
Assessment of Cognitive Impairment

The Try This:® General and Dementia Assessment Series (www.ConsultGeriRN.org/resources) evidence-based tools to measure cognitive impairment and depression include:

- Brief Evaluation of Executive Dysfunction
- The Mini-Cog (dementia)
- The Montreal Cognitive Assessment (MoCA) (mild cognitive impairment)
- Recognition of Dementia is Hospitalized Older Adults
- The Confusion Assessment Method (CAM) (delirium)
- Assessing and Managing Delirium in Persons with Dementia (delirium superimposed on dementia)
- The Geriatric Depression Scale
Summary

• Call to action
• Time is now
• Chronic disease management
• Care coordination
• Patient/family centered
• Prevention and wellness
• Interprofessional care team
• A care system that is seamless with a value for the quality of life and highest potential for every patient.