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OHIO VALLEY APPALACHIA REGIONAL GERIATRIC EDUCATION CENTER

Arleen Johnson, Ph.D., Director OVAR/Geriatric Education Center

Stanford GEC and OVAR/GEC Convene ASA Peer Group on Emergency Preparedness and Aging

Melen McBride, Associate Director, Stanford GEC, and Arleen Johnson, Director, OVAR/GEC, convened a Peer Group Session on *Emergency Preparedness and Older Adults: Issues for Training, Services and Research* on March 16 at the Joint Conference of the NCOA/ASA held in Anaheim CA. The new peer group was attended by 13 health care providers and administrators from AZ, CA, FL, KY, MA, OR,TX, and UT, representing Area Agencies on Aging, nutrition programs, Foster Grandparents programs, caregiver ministry, senior housing, emergency preparedness agencies, council on aging, Office of Aging Services, adult services, Veterans Administration Hospital, homecare attendant programs, and Geriatric Education Centers. Issues discussed included rapid needs assessment forms, identifying elders at high risk, confidentiality, state/county preparedness plans in urban and rural areas, awareness campaigns through neighborhood watch and other community education models, communication and collaboration strategies, securing agency files, high risk registries, and resources. The group was interested in (a) being included in a distribution listserv for further networking; (b) ASA establishing a formal Emergency Preparedness for Aging Interest/Peer Group, and (c) ASA offering training for certification in geriatric emergency preparedness and response with the result being the establishment of an ASA registry of trained ASA members who could be called upon to provide emergency support across the US. Dr. McBride presented these ideas to ASA staff and they were well received.
JD/ASA/ASA 2006 Peer Group BTEPA minutes

MOUNTAIN STATE GERIATRICS EDUCATION CENTER

Interdisciplinary Faculty Committee Produces Geriatrics Competencies

Health professions educators in West Virginia will have available to them a list of professional competencies for use in developing educational programs to prepare faculty, students, and practitioners in the community regarding care of older adults.

During the past several months, the MSGEC Interdisciplinary Faculty Committee (IFC) has been preparing a list of geriatrics related educational competencies. The IFC plans to distribute the competencies in upcoming months to health professionals in education programs in the state as guides for curriculum development and practice experiences.

Utilizing consultation related to competency-based education provided by Dr. Jamie Shumway, curriculum coordinator for the WVU School of Medicine, this group prepared a final draft of the competencies including sub-objectives. During this process, members reviewed professional literature regarding competency-based education in health professions and each discipline. Leadership within the IFC was provided by Dr. Barbara Nunley and Dr. Mark Newbrough who prepared drafts of competency materials and to Dr. David Elliott, Dr. Richard Meckstroth, and Dr. Brenda Wamsley who facilitated the review meetings.

For information about the geriatrics competencies, contact Sara Jane Gainor at the MSGEC office 304-293-2526.

What is Geriatrics?

"Senility is a state of physiological valetudinarianism. It requires special study, not as a pathological condition of maturity, but as an entity entirely apart from maturity." I.L. Nascher

With the advent of the aging of the baby boomers, the field of geriatrics represents one of the most exciting in modern medicine. Geriatricians are physicians who focus on the care of the aging population. Unlike many other physicians who have a high proportion of older patients in their practice, geriatricians place a high premium on improving the function of older persons and not just on treating diseases as they occur. Geriatricians are also aware of new advances that occur in longevity research and in minimizing the ravages of aging. However, unlike the anti-aging industry, the geriatrician avoids offering a dizzying array of hormones and supplements, most of which are risky and of unproven benefit. Geriatricians are specialists who can work closely with primary care physicians to improve our quality of life as we age.

The term *geriatrics* was coined by Ignatz Nascher, a New York physician, in the early part of the twentieth century. At about the same time, the term *gerontology*, which refers to the study of aging, was created by the Nobel Prize winner, Elie Metchnikoff. It has been suggested that *geratology* is a more appropriate term to describe the study of aging individuals.

As already pointed out, geriatrics focuses on the maintenance of function. Function at its simplest level is the ability to get in and out of bed, wash, dress, feed, and toilet oneself. Dr. David Thomas and his colleagues at Saint Louis University showed that the absence of the ability to perform any of these very simple tasks was highly predictive as to whether an older person will die in the hospital or go to the nursing home (1). At the next highest level of function is the ability of a person to shop, prepare meals, look after personal finances, take medications, and use the telephone. It is a combination of these two sets of functions that determines the ability of a person to live at home without help.

There are many causes of declining function in old age, but in general, these can be divided into four major areas, namely cognitive problems, frailty, nutritional problems, and iatrogenesis. All of these occur on a backdrop of inadequate social support.

Bernard Isaacs, a British geriatrician, created the concept of the Giants of Geriatrics. These are a set of conditions that are common and treatable in older persons and often poorly treated by general physicians. These conditions are also known as the I's of Geriatrics and have been expanded from the original four to ten.

The common cognitive problems associated with aging are delirium, dementia, and depression. All of these are commonly missed by both family members and physicians. In a study of African Americans, we showed that the majority of elderly persons with depression were not being treated (2). Depression is a highly treatable condition and its presence is associated with poor outcomes in persons suffering from a myocardial infarction. It is also associated with poor rehabilitation outcomes. Delirium has multiple treatable causes and when appropriately treated, as has been done at our hospitals with the creation of a 4-bed Delirium Unit directed by a geriatrician, has excellent outcomes (3).

Frailty occurs as age-related physiological decline interacts with disease to place the older person at risk of functional decline when exposed to an additional stress. Frailty has a number of causes including decline in executive function, visual problems, nutritional problems, polypharmacy, balance problems, many diseases, congestive heart failure, diabetes, osteoporosis (fractures), sarcopenia (age-related loss of muscle mass), decline in endurance (VO_2 max), and pain resulting in limitation of mobility.

Weight loss in older persons is a serious concern. There are five major causes of weight loss in older persons – protein energy undernutrition, dehydration, malabsorption, sarcopenia, and cachexia. Older persons develop a physiological anorexia of aging which places them at risk for developing severe anorexia when they become sick (4). The major reversible cause of anorexia in older persons is depression.

The thirst drive often functions poorly as we age, placing older persons at major risk for developing dehydration. Older persons need at least 4 to 8 glasses of fluid each day. Vitamin deficiencies, caused by malabsorption, have been associated with the development of cognitive impairment. All older persons need a calcium and Vitamin D supplement to prevent osteoporosis and hip fractures.

Unfortunately, iatrogenesis is extremely common as we age. All too often, an older patient has a Foley catheter inserted into the bladder during hospitalization and it is left in place when s/he returns home. This is a major cause of urinary tract infection, septicemia, and death in older persons. Foley catheters also represent a one-point restraint, hindering mobility in older persons. The available evidence suggests that physical restraints, which are still widely used in hospitals, increase injuries and can be associated with death. Nevertheless, this form of elder abuse remains in common practice.

Older persons are commonly allowed to languish in bed developing contractures and impaired mobility. The development of Acute Care for Elderly (ACE) Units is beginning to reverse this trend. The altered metabolism of drugs that occurs with aging can lead to older persons receiving too high a dose of a drug. Older persons also tend to take large numbers of medications (poly phar macy), increasing the opportunity for drug-drug i nt e r a c t io n s . The appropriate management of medications in an older person is a cornerstone of the geriatric approach.

Geriatrics is an interdisciplinary field. This field recognizes and places high value on the skills of all health professionals. Because of the multiple problems that many older persons have, there is a need for more time to fully address their needs and this is more efficiently done in an interdisciplinary team setting. Teamwork has been proven to enhance the medical outcomes of the older person.

The efficaciousness of the geriatric assessment and management approach has been demonstrated in multiple studies and summarized in a meta-analysis (5). Very few medical subspecialties have as much data demonstrating their effectiveness as does geriatrics.

As geriatrics moves into the 21st century, geriatricians are taking on new roles. While geriatrics is classically a “high touch” field, geriatricians are also keeping abreast of the remarkable achievements in assistive devices and prostheses being developed. An example of this is the development of the “smart houses” that allow older persons to live longer at home alone. Geriatricians are also becoming experts on “antiaging” approaches and are among the best persons to ask about whether these are “hype” or reality. Unfortunately, much of the time, the answer will be that these are unproven, and unlikely to be proven, approaches. However, following an appropriate preventive and health promotion program will not only add life to your years, but most probably, also add years to your life.

WHEN SHOULD A GERIATRICIAN BE CONSULTED?

Certainly whenever a person over 70 years of age is deteriorating either functionally or cognitively, s/he should be referred for a full geriatric assessment to see if some simple interventions can reverse or slow the process. Sometime at or near retirement, it is useful to see a geriatrician to check that there are no early problems and to discuss an individualized health promotion plan. Any older person on more than seven medications should have a consultation with a geriatric team. Older persons with memory problems often benefit from consultation with a geriatrician. It could be argued that all persons 70 years and older should have a geriatric consult at least once every five years.

Whether or not one should choose a geriatrician as one’s primary physician depends on the person. Very frail older persons often benefit by having a geriatrician as their primary care physician. In nursing homes, geriatricians and certified medical directors (CMD-AMDA) appear to be more likely to provide state-of-the- art long term care. Many geriatricians are experts in continuous quality improvement, making them ideal medical directors of nursing homes. Finally, many older persons find that geriatricians are kinder and gentler physicians who give them the time they need to discuss their concerns. This discovery may well lead to a geriatrician becoming their primary care physician of choice. However, it needs to be stressed that the majority of older persons are best managed by primary care physicians who utilize the geriatrician as a consultant. When choosing a primary care physician, an older person should ask that physician about the credentials of the geriatricians with whom they work.

CONCLUSION

With the advent of the baby boomers, geriatrics is a field that will grow in stature. The geriatric team represents an important component of the care of every older person, whether healthy or frail. Primary care physicians and subspecialists who fail to see that their older patients have at least one full geriatric assessment every five years are not providing appropriate state-of-the-art care. Geriatrics represents an exciting field of the future. If, as we age, we wish to grow old together and have the best that there is to be, then we all need a geriatrician in our future.

REFERENCES

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3) Flaherty JH, *et al*. *J Am Geriatr Soc* 2003; 51: 1031-5.
4) Morley JE, *et al*. *Am J Clin Nut 2006*; 83: 735-43.
5) Stuck AE, *et al*. *Lancet* 1993; 342:1032-6.

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2006 CALENDAR OF EVENTS

DATE	*EVENT*	*LOCATION*	*CONTACT*
September 11th – 13th, 2006	14th Annual Alzheimer's Association Dementia Care Conference	The Westin Peachtree Plaza Hotel Atlanta, Georgia	Alzheimer's Organization 312-335-5790
September 12, 2006	CGEC Statewide Advisory Meeting	Marina del Rey Marriott Hotel Marina del Rey, CA	Rachel Price (310) 312-0531 rprice@mednet.ucla.edu
September 13th-16th, 2006	23rd Annual Intensive Course in Geriatric Medicine/Geriatric Pharmacy and Board Review	Marina del Rey Marriott Hotel Marina del Rey, CA	Janet L. Adriano (310) 312-0531 jadriano@mednet.ucla.edu
September 15th-16th, 2006	Care of the Elderly	Sitka, AK	Jill Hanson (907) 747-7733 jill.hanson@uas.alaska.edu
September 20th – 21st, 2006	Nutrition & Aging XXI: Advances in Nutrition, Exercise and Aging	Peabody Hotel Little Rock, AR	501-661-7962
October 4th, 2006	Parkinson's Disease: The Team Approach	Sierra Health Services Las Vegas, NV	702-671-6405 lwiley@unr.edu
October 6th, 2006	West Virginia Geriatrics Society Annual Meeting & CE Conference	Charleston Marriott Town Center Charlestown, WV	Mountain State GEC 304-293-2298
October 18th, 2006	18th Annual Colloquium on Aging	Monona Terrace Convention Center Madison, WI	Marty Quimby 608-261-1493
October 25th – 27th, 2006	13 Annual West Virginia Rural Health Conference	Stonewall Resort Roanoke, WV	Mountain State GEC 304-293-2298
November 6th-7th, 2006	Reflecting on 100 Years of Alzheimer's: The Global Impact on Quality of Lives	Crowne Plaza Cleveland City Centre	(216) 368-4945 IAConference@case.edu fpb.case.edu/CFA/announce.shtm
November 16th, 2006	Annual Meeting NAGE and NAGEC	Adam's Mark Hotel Dallas, TX	j.mendez@wayne.edu
November 16th-20th, 2006	The Gerontological Society of America's 59th Annual Scientific Meeting	Adam's Mark Hotel Dallas, TX	www.agingconference.com