Geriatric Care and Transitions of Care for Older Adults

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The following CME planners and CME faculty do not have relevant financial relationships with ineligible companies in the past 24 months.

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An ineligible company is any entity whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

Commercial support was not received for this CME/CE activity.

Learning Objectives

At the completion of the activity, learners can:

1. Summarize the 4 M's of Geriatrics: Mobility, Medications, Mind, and What Matters and how they apply to the quality of care of older adults.
2. Identify at least two (2) methods for assessing delirium in older adults.
3. Distinguish between different types of Advance Care Planning documents and how they apply to "What Matters" for the care of older adults.
4. Describe at least two (2) health system challenges to medication reconciliation in older adults and how to ensure safe transitions of care.

AGEING and HEALTH

▶ EVERY OLDER PERSON IS DIFFERENT

Some have the level of functioning of a 30 year old.

Some require full time assistance for basic everyday tasks.

Health is crucial to how we experience older age.

#yearsahead

AGEING and HEALTH

WHAT INFLUENCES HEALTH IN OLDER AGE

INDIVIDUAL		ENVIRONMENT THEY LIVE IN	
	Behaviours		Housing
	Age-related changes		Assistive technologies
	Genetics		Transport
	Disease		Social facilities

#yearsahead

What Matters

Mobility

4Ms Framework

Medication

Mentation

Age-Friendly Health Systems

An initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA).

For related work, this graphic may be used in its entirety without requesting permission.
Graphic files and guidance at ihi.org/AgeFriendly

What Matters

Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication

If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation

Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility

Ensure that older adults move safely every day in order to maintain function and do What Matters.

Ms. W

91-year old widowed community-dwelling female. Lives alone. Uses a rollator. On home oxygen. Chronic arthritic pain in shoulders and knees. Recent difficulty with memory and thinking. Receives meals delivered to her home. Has a visiting nurse once a month. Chronic lower extremity edema. Essential tremor of head and hands. Uses adult briefs.

Goal is to remain in her home. Daughter is her chosen health care decision-maker.

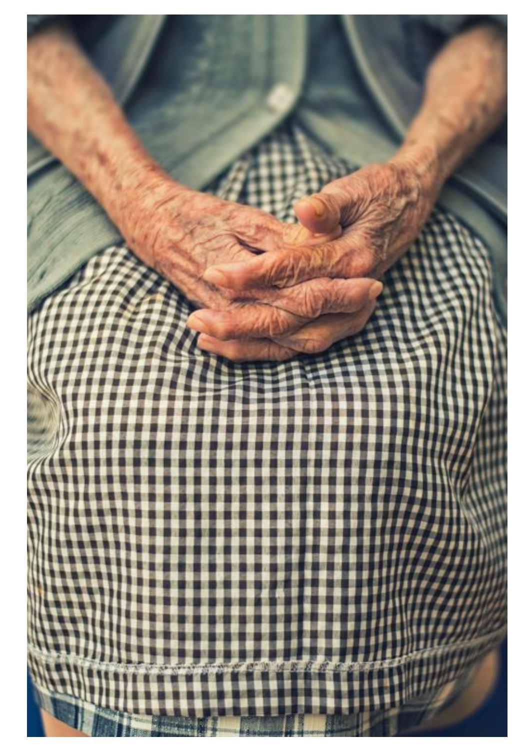
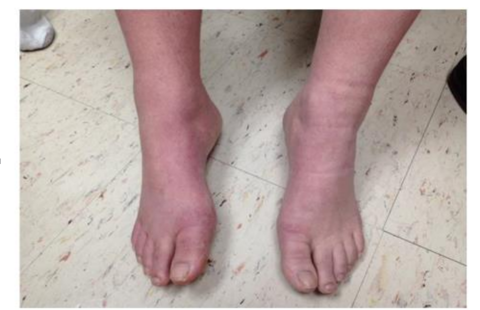


Photo by Danie Franco on Unsplash

Initial In-home Assessment with Ms. W



Denies falls. Endorses fear of falling and unsteady gait.

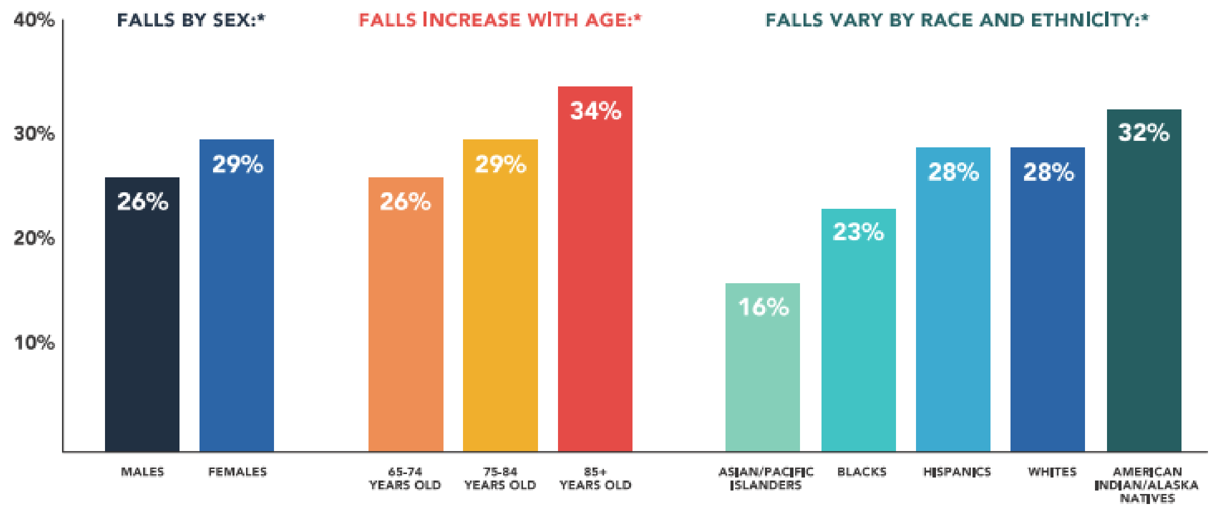
Difficulty rising from a chair – rocks and takes multiple attempts.

Oxygen tubing snakes throughout the house.

Wears no shoes or loose slippers due to lower extremity swelling.

Medication list: ASA 81mg, Fish Oil, KCl, Primidone 100mg BID, Propranolol 50mg BID, Glipizide 2.5mg ER, Gabapentin 300mg twice daily, HCTZ 50mg, Oxybutynin 10mg ER, Diltiazem 240mg, Calcium 600mg, Vitamin D 400 IU, Vitamin B complex

4 M's: Mobility: Falls Assessment



Mobility: STEADI Questions

Three key questions for patients:

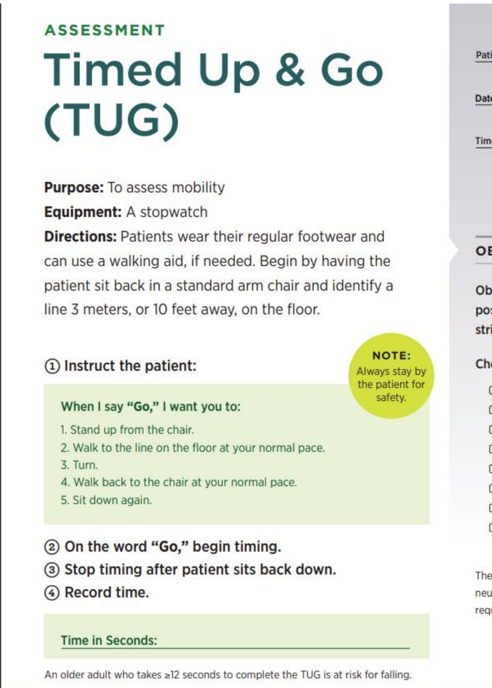
1) Feels unsteady when standing or walking?

2) Worries about falling?

3) Has fallen in past year? » If YES ask, “How many times?” “Were you injured?”

→ Any “yes” answer indicates fall risk

Mobility: Timed Up and Go (TUG)



ASSESSMENT

Timed Up & Go (TUG)

Purpose: To assess mobility

Equipment: A stopwatch

Directions: Patients wear their regular footwear and can use a walking aid, if needed. Begin by having the patient sit back in a standard arm chair and identify a line 3 meters, or 10 feet away, on the floor.

① Instruct the patient:

NOTE: Always stay by the patient for safety.

When I say "Go," I want you to:

1. Stand up from the chair.
2. Walk to the line on the floor at your normal pace.
3. Turn.
4. Walk back to the chair at your normal pace.
5. Sit down again.

② On the word "Go," begin timing.

③ Stop timing after patient sits back down.

④ Record time.

Time in Seconds: ______

An older adult who takes $\geq$12 seconds to complete the TUG is at risk for falling.

Patient ______

Date ______

Time ______ ☐ AM ☐ PM

OBSERVATIONS

Observe the patient's postural stability, gait, stride length, and sway.

Check all that apply:

- ☐ Slow tentative pace
- ☐ Loss of balance
- ☐ Short strides
- ☐ Little or no arm swing
- ☐ Steadying self on walls
- ☐ Shuffling
- ☐ En bloc turning
- ☐ Not using assistive device properly

These changes may signify neurological problems that require further evaluation.

- Falling is common, but not a normal part of aging
- Functional testing helps to risk-stratify
- Timed Up & Go
- Four Stage Balance Testing
- 30 second chair stand

Mobility: Four stage balance test

Narrow based stance

Semi-tandem stance

Full tandem stance

One foot stance

Instructions to the patient:

1. Stand with your feet side by side. **Time:** ________ **seconds**
2. Place the instep of one foot so it is touching the big toe of the other foot. **Time:** ________ **seconds**
3. Place one foot in front of the other, heel touching toe. **Time:** ________ **seconds**
4. Stand on one foot. **Time:** ________ **seconds**

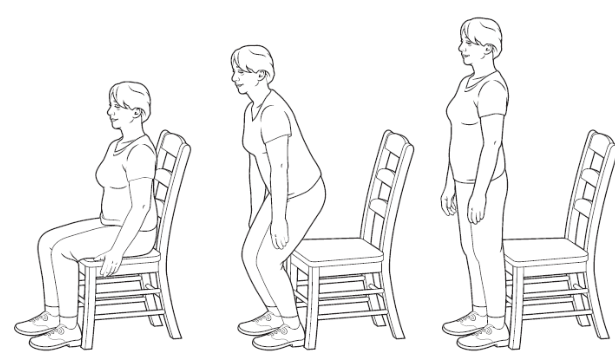
An older adult who cannot hold the tandem stance for at least 10 seconds is at increased risk of falling.

Walker

Cane

Exercise classes

Mobility: Chair Rise Exercise



Chair Rise Exercise

- Assesses quadriceps strength
- Stratify compared to age / gender
- Timed for 30 seconds
- Count number of chair stands

Chair Stand Test (Women)

Percentile rank	60–64	65–69	70–74	75–79	80–84	85–89	90–94
95	21	19	19	19	18	17	16
90	20	18	18	17	17	15	15
85	19	17	17	16	16	14	13
80	18	16	16	16	15	14	12
75	17	16	15	15	14	13	11
70	17	15	15	14	13	12	11
65	16	15	14	14	13	12	10
60	16	14	14	13	12	11	9
55	15	14	13	13	12	11	9
50	15	14	13	12	11	10	8
45	14	13	12	12	11	10	7
40	14	13	12	12	10	9	7
35	13	12	11	11	10	9	6
30	12	12	11	11	9	8	5
25	12	11	10	10	9	8	4
20	11	11	10	9	8	7	4
15	10	10	9	9	7	6	3
10	9	9	8	8	6	5	1
5	8	8	7	6	4	4	0

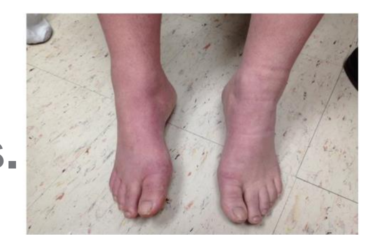
Adapted from Rikli & Jones 1999.

Chair Stand Test (Men)

Percentile rank	60–64	65–69	70–74	75–79	80–84	85–89	90–94
95	23	23	21	21	19	19	16
90	22	21	20	20	17	17	15
85	21	20	19	18	16	16	14
80	20	19	18	18	16	15	13
75	19	18	17	17	15	14	12
70	19	18	17	16	14	13	12
65	18	17	16	16	14	13	11
60	17	16	16	15	13	12	11
55	17	16	15	15	13	12	10
50	16	15	14	14	12	11	10
45	16	15	14	13	12	11	9
40	15	14	13	13	11	10	9
35	15	13	13	12	11	9	8
30	14	13	12	12	10	9	8
25	14	12	12	11	10	8	7
20	13	11	11	10	9	7	7
15	12	11	10	10	8	6	6
10	11	9	9	8	7	5	5
5	9	8	8	7	6	4	3

Adapted from Rikli & Jones 1999.

Initial Visit with Ms. W



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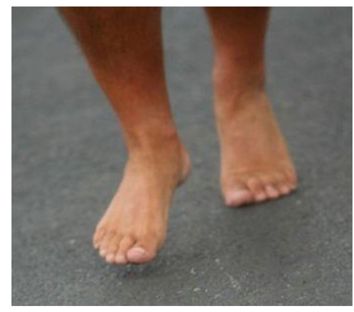
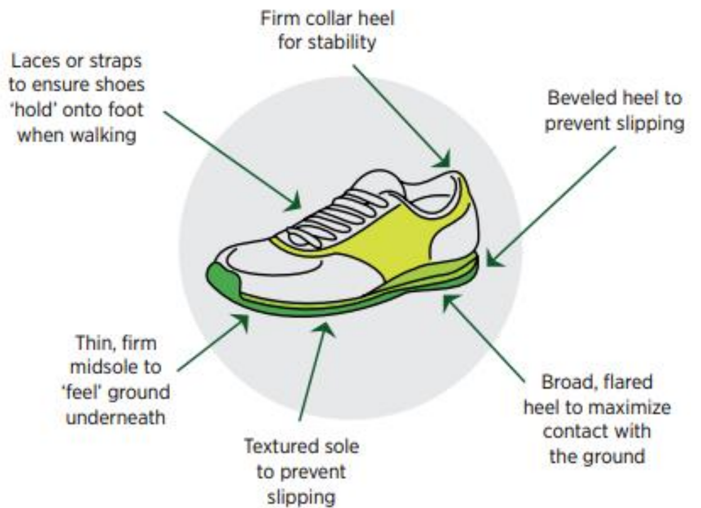
Footwear at time of fall

- ❖ Most common: slippers (22%) walking shoes (17%) and sandals (8%)
- ❖ 75% wore shoes with at least one sub-optimal feature
- ❖ Going barefoot or in stocking feet increased risk of fall: adjusted odds ratio 11.2



Sherrington C, Menz HB. An evaluation of footwear worn at the time of fall-related hip fracture. Age Ageing. 2003 May;32(3):310-4. doi: 10.1093/ageing/32.3.310. PMID: 12720618.

Counsel Your Patients on Footwear



- Firm collar heel for stability
- Beveled heel to prevent slipping
- Broad flared heel to maximize contact with the ground
- Textured Sole to Prevent Slipping
- Foot Problem Risks: foot pain, decreased ankle joint flexibility, reduced calf muscle strength, neuropathy, bunion or toe deformities
- Yellow hospital socks do not decrease risk

Evidence Based Falls Interventions: Home Safety Evaluation

Use this checklist to find and fix hazards in your home.

STAIRS & STEPS (INDOORS & OUTDOORS)

Are there papers, shoes, books, or other objects on the stairs?

- ☐ Always keep objects off the stairs.

Are some steps broken or uneven?

- ☐ Fix loose or uneven steps.

Is there a light and light switch at the top and bottom of the stairs?

- ☐ Have an electrician put in an overhead light and light switch at the top and bottom of the stairs. You can get light switches that glow.

Has a stairway light bulb burned out?

- ☐ Have a friend or family member change the light bulb.

Is the carpet on the steps loose or torn?

- ☐ Make sure the carpet is firmly attached to every step, or remove the carpet and attach non-slip rubber treads to the stairs.

Are the handrails loose or broken? Is there a handrail on only one side of the stairs?

- ☐ Fix loose handrails, or put in new ones. Make sure handrails are on both sides of the stairs, and are as long as the stairs.

FLOORS

When you walk through a room, do you have to walk around furniture?

- ☐ Ask someone to move the furniture so your path is clear.

Do you have throw rugs on the floor?

- ☐ Remove the rugs, or use double-sided tape or a non-slip backing so the rugs won't slip.

Are there papers, shoes, books, or other objects on the floor?

- ☐ Pick up things that are on the floor. Always keep objects off the floor.

Do you have to walk over or around wires or cords (like lamp, telephone, or extension cords)?

- ☐ Coil or tape cords and wires next to the wall so you can't trip over them. If needed, have an electrician put in another outlet.

KITCHEN

Are the things you use often on high shelves?

- ☐ Keep things you use often on the lower shelves (about waist high).

Is your step stool sturdy?

- ☐ If you must use a step stool, get one with a bar to hold on to. Never use a chair as a step stool.

BEDROOMS

Is the light near the bed hard to reach?

- ☐ Place a lamp close to the bed where it's easy to reach.

Is the path from your bed to the bathroom dark?

- ☐ Put in a nightlight so you can see where you're walking. Some nightlights go on by themselves after dark.

BATHROOMS

Is the tub or shower floor slippery?

- ☐ Put a non-slip rubber mat or self-stick strips on the floor of the tub or shower.

Do you need some support when you get in and out of the tub, or up from the toilet?

- ☐ Have grab bars put in next to and inside the tub, and next to the toilet.

- Home health agencies can provide an occupational therapist for a home safety evaluation
- Patients and caregivers can conduct their own home safety evaluation using a checklist

Chase, C. A., Mann, K., Wasek, S., & Arbesman, M. (2012). Systematic review of the effect of home modification and fall prevention programs on falls and the performance of community-dwelling older adults. *The American Journal of Occupational Therapy*, *66*(3), 284-291.

Initial Visit with Ms. W

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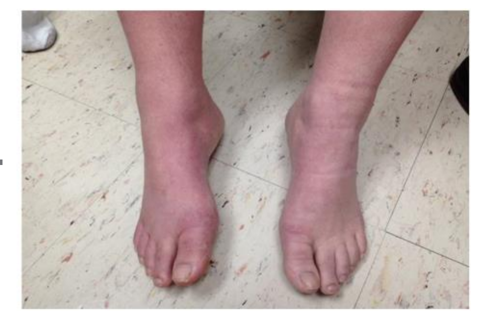

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4 M's: Medications: Falls Risk

Beer's List/Criteria: List of Potentially Inappropriate Medications for Older Adults: Last Update American Geriatrics Society 2023

Medications to avoid with history of falls or fractures	
Anticonvulsants	Diabetic medications (hypoglycemia)
Antipsychotics	
Benzodiazepines	CV/BP meds: alpha-blocker
Sedative hypnotics: Eszopiclone (Lunesta), Zaleplon (Sonata), Zolpidem (Ambien)	Anti-cholinergic medications
TCAs	
SSRIs	
Opioids	

May cause: ataxia, impaired psychomotor function, syncope, falls, impaired cognition

Increased risk in combination

2023 American Geriatrics Society Beers Criteria® Update Expert Panel. (2023). American Geriatrics Society 2023 updated AGS Beers Criteria® for potentially inappropriate medication use in older adults. *Journal of the American Geriatrics Society*, *71*(7), 2052-2081.

4 M's Medications: Polypharmacy

Ms. W's medication list:

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Increased risk of hypoglycemia in older adults: Glipizide 2.5mg ER – switch or eliminate

High Anti-cholinergic burden: Oxybutynin 10 mg ER – switch or eliminate

Anti-Convulsants: Gabapentin, Primidone – assess for effectiveness / eliminate

Decrease polypharmacy (4 or more medications): ASA, Fish Oil, Calcium – consider eliminating

4 M's: Mentation

Prevent, Identify, Treat and Manage: Depression, Dementia and Delirium

- Outpatient: Annual Depression Screening (PHQ-9)
- Outpatient: Dementia Screening (Mini-Cog)
- Inpatient: Delirium Screenings

Interventions known to reduce falls

1) Appropriate footwear

2) Medication Review

3) Vitamin D supplementation: 800-1000 IU daily (AGS & CDC)

4) Multifactorial: Including home safety evaluation*

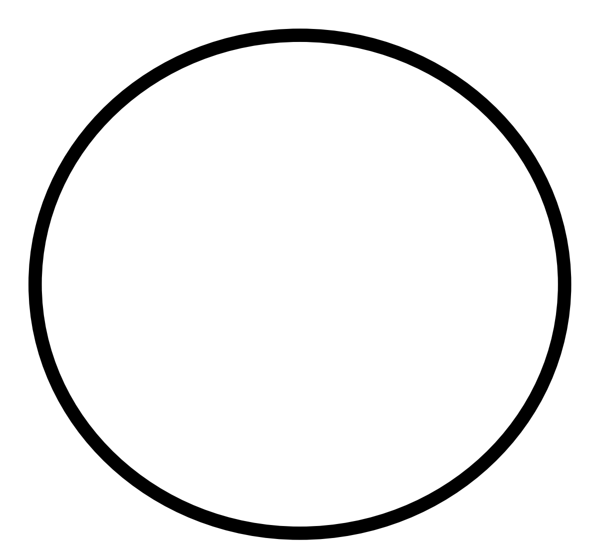
5) Exercise programs that include muscle strengthening and balance training**

*Endorsed in latest USPSTF Recommendations – Grade B** & Grade C**

Mini-Cog

1) Instruct the patient to listen carefully and repeat the following:

Banana Sunrise Chair



2) Draw a clock

3) Ask the patient to repeat the three words

Scoring: 0 words recalled: Positive screen
3 words recalled: Negative screen
1-2 words recalled + Normal clock: Negative Screen
1-2 words recalled + Abnormal clock: Positive Screen

Dementia and Visual Perception

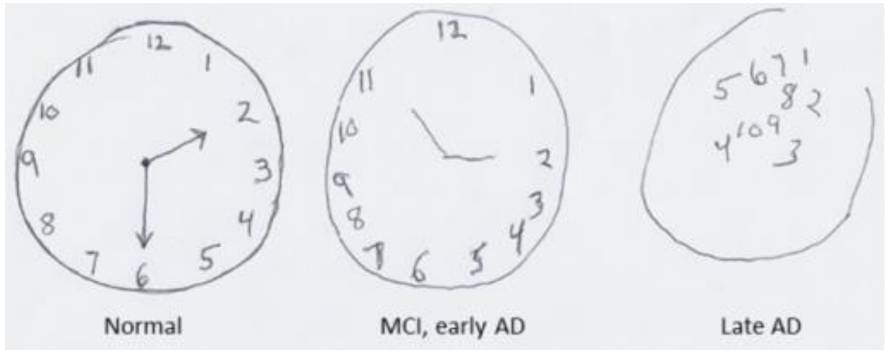
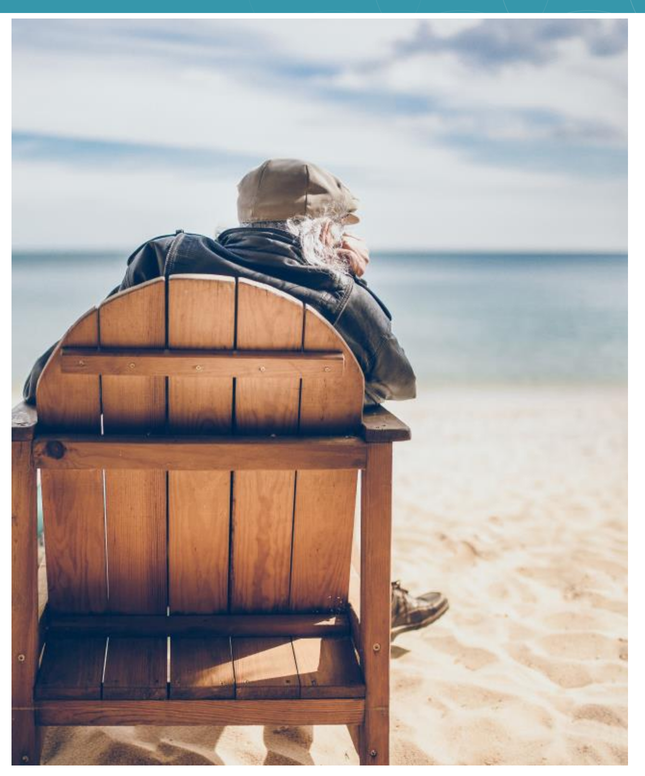


Figure 4: The progressive deterioration of pattern processing ability in a subject as they progress from mild cognitive impairment (MCI) to severe Alzheimer's disease (AD). In this clock drawing task the subject is asked to draw a clock with the hours and showing the time 2:30. When the person has MCI/early AD the numbers for the hours on the clock are drawn in proper order, but during the time it took to draw the clock the subject forgot that he/she had been asked to show the time 2:30. In the case of the patient with late-stage AD, the drawing bears little resemblance to a clock.

Mattson MP. Superior pattern processing is the essence of the evolved human brain. Front Neurosci. 2014 Aug 22;8:265. doi: 10.3389/fnins.2014.00265. PMID: 25202234; PMCID: PMC4141622.

Dementia - Prevalence



Age range	% affected
65-74	5%
75-84	15-25%
85 and older	36-50%

Kramarow EA. Diagnosed Dementia in Adults Age 65 and Older:United States, 2022. Natl Health Stat Report. 2024 Jun;(203):1-9. PMID: 38912900.

4Ms: What Matters

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Goal is to remain in her home. Daughter is her chosen health care decision-maker.

Photo by Mosoianu Bogdan on Unsplash

Why do Advance Care Planning?

- More likely to receive care that they want
- Receive fewer non-beneficial medical treatments
- Report better quality of life
- Improves Patient and Family Satisfaction
- Reduces stress, anxiety, and depression in surviving relatives

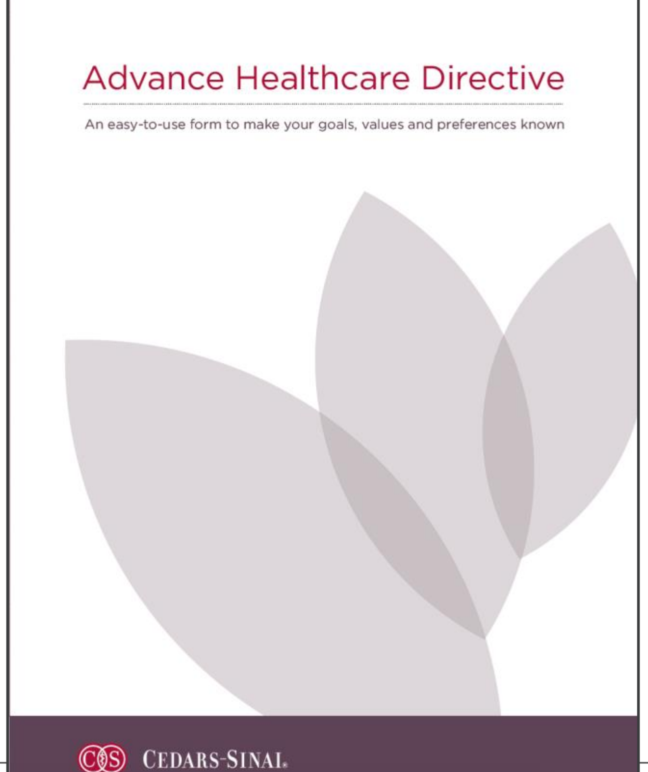
Why do Advance Care Planning?

- <30% of patients with end-stage medical diagnoses discuss their goals and preferences with a physician
- Conversations occur late in the course of illness, little time to meaningfully act on preferences
- Conversations focus on medical procedures rather than patient's values and priorities
- Documentation of conversations hard to find in medical record

Detering, K. M., Hancock, A. D., Reade, M. C., & Silvester, W. (2010). The impact of advance care planning on end of life care in elderly patients: randomised controlled trial. *Bmj*, *340*, c1345.

Advance Healthcare Directives

- Appoints a Healthcare agent/Durable Power of Attorney for Healthcare (DPOA)
- Provides space to share your values & preferences
- Must be notarized or signed in front of two witnesses



Help Center

Ask a question

Log In Create Account

- Creating an Account
- Friending
- Your Home Page
- Messaging
- Photos
- Videos
- Pages
- Groups
- Events
- Payments
- Apps
- Facebook Mobile and Desktop Apps
- Accessibility

What is a legacy contact and what can they do?

Share Article

A legacy contact is someone you choose to look after your account if it's memorialized. Once your account is memorialized, your legacy contact will have the option to do things like:

- Write a pinned post for your profile (example: to share a final message on your behalf or provide information about a memorial service).
  - Note: If your timeline and tagging settings don't allow anyone other than you to post on your timeline, your legacy contact won't be able to add a pinned post to your profile once it's memorialized
- Respond to new friend requests (example: old friends or family members who weren't yet on Facebook)
- Update your profile picture and cover photo
- Request the removal of your account

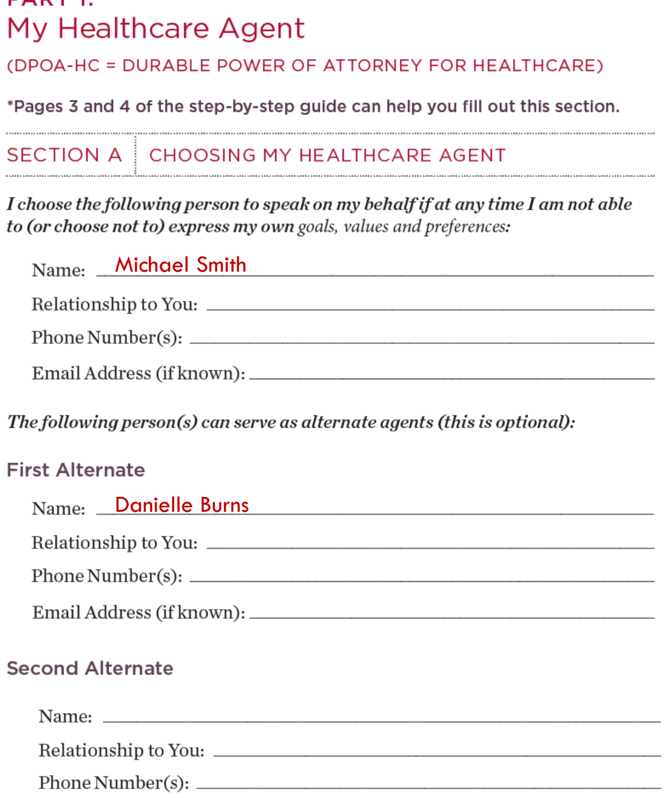
You also have the option to allow your legacy contact to download a copy of what you've shared on Facebook, and we may add additional capabilities for legacy contacts in the future.

Your legacy contact can't:

- Log into your account
- Remove or change past posts, photos and other things shared on your timeline
- Read your messages
- Remove any of your friends or make new friend requests
- Add a new legacy contact to your account

Learn more about memorialization and how to add a legacy contact to your account

My Healthcare Agent
(Part 1)



PART 1:
My Healthcare Agent
(DPOA-HC = DURABLE POWER OF ATTORNEY FOR HEALTHCARE)

*Pages 3 and 4 of the step-by-step guide can help you fill out this section.

SECTION A | CHOOSING MY HEALTHCARE AGENT

I choose the following person to speak on my behalf if at any time I am not able to (or choose not to) express my own goals, values and preferences:

Name: Michael Smith
Relationship to You: ____
Phone Number(s): ____
Email Address (if known): ____

The following person(s) can serve as alternate agents (this is optional):

First Alternate

Name: Danielle Burns
Relationship to You: ____
Phone Number(s): ____
Email Address (if known): ____

Second Alternate

Name: ____
Relationship to You: ____
Phone Number(s): ____
Email Address (if known): ____

4

Advance Healthcare Directive: My Healthcare Agent (Part 1)

Important Considerations:

- Must be at least 18 years old
- Does not need to live near you, as long as they are available
- Cannot be a licensed medical professional who is actively giving you medical care
- Should be trusted to honor your wishes, able to make choices that are not always easy, and willing to act as your agent
- Other: Who would the medical teams turn to by default if your Directive was not completed?
- CA uses "closest to you," ethical hierarchy: spouse, adult children, parents if they are alive, and then siblings

My Healthcare Agent (Part 1, Section B)

Part 1 (continued)

SECTION B	WHEN WOULD I LIKE MY HEALTHCARE AGENT TO BEGIN REPRESENTING ME?

- For help with filling out this section, please refer to page 5 of the Step-by-Step Guide.

Please complete the sentence below by initialing either option 1 or option 2:

I would like my healthcare agent to begin participating in decisionmaking about my healthcare...

Option 1

...only when my physician determines that I am unable to express my own goals, values and preferences.

MTS

(Initial Here)

Option 2

...from this time forward, even if I am still able to speak for myself.

____

(Initial Here)

Goals Drive Care

- “How much does your family know about your priorities and wishes?”
- “What are your most important goals if your health situation worsens?”
- “What are your biggest fears and worries about the future with your health?”
- “What gives you strength as you think about the future with your illness?”
- “What abilities are so critical to your life that you can’t imagine living without them?”
- “If you become sicker, how much are you willing to go through for the possibility of gaining more time?”

My Healthcare Goals, Values & Preferences

PART 2:
My Healthcare Goals, Values and Preferences

SECTION A | QUALITY OF LIFE

This section allows you to share what quality of life you would find acceptable. This information will help your medical team better understand who you are and what is most important to you. This can be a challenging topic---it can make you think about questions such as "what makes my life worth living?", "what do I value most about my mental and physical health?" and "what would I not want to live without?

*Pages 6-9 of the step-by-step guide can help you fill out this section.

My life would be worth living and therefore I would want my life to be prolonged as long as possible, under the following circumstances:

All circumstances — even if it means only the basic functioning of my organs (heart, lungs, kidneys etc.) with or without machines and indepedent of quality of life.

OR

All circumstances, unless I would NEVER recover the ability to:

Physical & Bodily Considerations (e.g. live without being permanently attached to life support machines, be able to walk):

Be able to walk.

Cognitive Considerations (e.g. be concious, know where I am, be able to think clearly):

Know where I am.

Interactive, Social & Community Considerations (e.g. communicate in some way with other people, live outside of a healthcare facility):

Live outside of a healthcare facility.

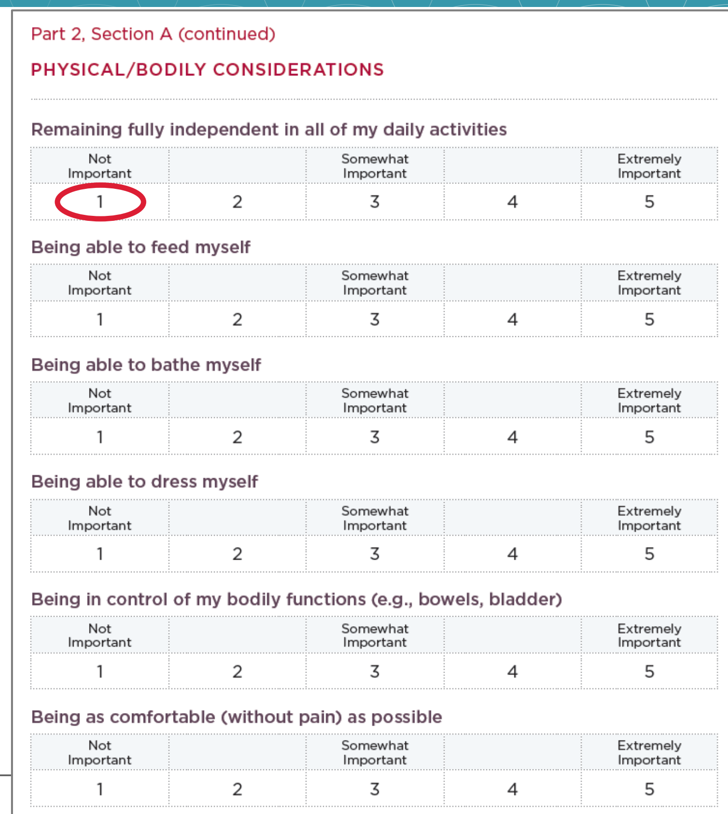
OR

I am not sure

If you would like to share additional details, please use page 8 or the extra pages provided at the end of this document.

My Healthcare Goals, Values & Preferences:

- Important questions to consider:
  - What makes my life worth living?
  - What do I value most about my mental & physical life?
  - What could I not live without?


Part 2, Section A (continued)

PHYSICAL/BODILY CONSIDERATIONS

Remaining fully independent in all of my daily activities

Not Important		Somewhat Important		Extremely Important
1	2	3	4	5

Being able to feed myself

Not Important		Somewhat Important		Extremely Important
1	2	3	4	5

Being able to bathe myself

Not Important		Somewhat Important		Extremely Important
1	2	3	4	5

Being able to dress myself

Not Important		Somewhat Important		Extremely Important
1	2	3	4	5

Being in control of my bodily functions (e.g., bowels, bladder)

Not Important		Somewhat Important		Extremely Important
1	2	3	4	5

Being as comfortable (without pain) as possible

Not Important		Somewhat Important		Extremely Important
1	2	3	4	5

https://www.cedars-sinai.org/programs/support-services/services/healthcare-ethics/advance-directives.html

My Healthcare Goals, Values & Preferences

Part 2 (continued)

SECTION B | SCOPE OF TREATMENT

Some people have ideas about which treatments they would be willing to receive and which ones they would not accept under any circumstances. This section is designed to help you communicate your preferences. If you do not have any specific ideas or preferences about treatment options, select the first option below. If you do have specific preferences, please write them in the space provided under the second option. If you are not sure, select the last option.

***Pages 10-11 of the step-by-step guide can help you fill out this section.**

If my physician believes that I have a reasonable change of recovering to the Quality of Life I stated in Part 2A (on the previous page),
I would be willing to undergo the following:

- ALL procedures, treatments and interventions offered by my healthcare team.

OR

- All procedures, treatments and interventions offered by my healthcare team, EXCEPT:
  Being placed on a breathing machine.

OR

- I am not sure

If you would like to share additional details, please use page 8 or the extra pages provided at the end of this document.

Closing the Conversation

"I've heard you say that ___ is really important to you. Keeping that in mind, and what we know about your illness, I recommend that we ___. This will help us make sure that your treatment plans reflect what's important to you."

"How does this plan seem to you?"

Signing My Advance Healthcare Directive

PART 6:
Signing My Advance Healthcare Directive

***Page 14 of the step-by-step guide will help you fill out this Part.**

In order to make this document legal and valid, you must sign below. Your signature must be witnessed by either a **notary public** (Option 1, see page 13) or in the presence of **two witnesses** (Option 2, see page 14):

Name (Print):

____

Signature:

____

Date of Signature:

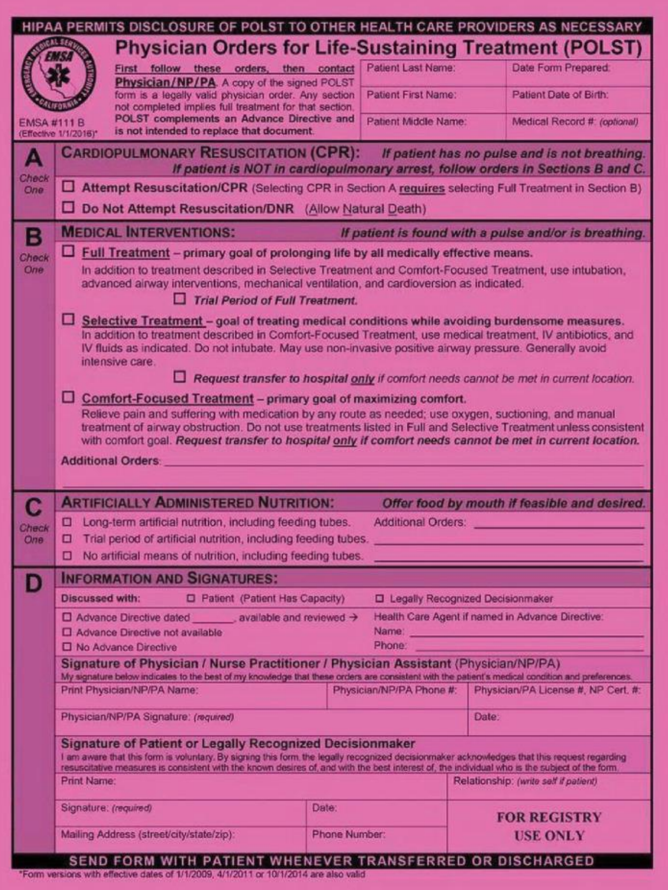
____

You must sign in the presence of two witnesses or a **notary public.**

POLST Forms

Would you be surprised if the patient died in the next year?

Does your patient have specific wishes against resuscitation or intubation?



HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B (Effective 1/1/2016)*

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A Check One — **CARDIOPULMONARY RESUSCITATION (CPR):** *If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A requires selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B Check One — **MEDICAL INTERVENTIONS:** *If patient is found with a pulse and/or is breathing.*

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
☐ *Trial Period of Full Treatment.*

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
☐ *Request transfer to hospital only if comfort needs cannot be met in current location.*

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. *Request transfer to hospital only if comfort needs cannot be met in current location.*

Additional Orders: ______

C Check One — **ARTIFICIALLY ADMINISTERED NUTRITION:** *Offer food by mouth if feasible and desired.*

☐ Long-term artificial nutrition, including feeding tubes.
☐ Trial period of artificial nutrition, including feeding tubes.
☐ No artificial means of nutrition, including feeding tubes.

Additional Orders: ______

D — **INFORMATION AND SIGNATURES:**

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated ______, available and reviewed →
☐ Advance Directive not available
☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: ______
Phone: ______

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*	Date:	FOR REGISTRY USE ONLY
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011 or 10/1/2014 are also valid

Transitions of Care: Home to Hospital

- Ms. W falls and her Apple Watch alerts her daughter and paramedics
- Transferred to the hospital for assessment
- Ms. W has a pelvic fracture
- In the hospital her daughter notes that she is confused

4M's: Delirium

- Disturbance in ATTENTION
- SHORT period of time (usually hours to days)
- Change from baseline
- ADDITIONAL disturbance in cognition (memory deficit, disorientation, language, visuospatial ability, or perception)
- NOT better explained by another preexisting, evolving or established neurocognitive disorder and NOT caused by a medical condition, substance intoxication or withdrawal, or medication side effect.

4M's: Delirium

	Dementia	Delirium
Onset	Insidious	Acute
Course	Constant	Fluctuating
Attention	Generally Preserved	Disordered
Alertness	Generally Preserved	Disordered
Hallucinations	Generally Absent	Often present
Movement/Restlessness	Generally Absent	Often present

Delirium: Diagnosis

History from collateral sources

Observation

DSM-V criteria

Often undiagnosed (hypoactive form often overlooked; fluctuating nature make diagnosis difficult when only brief time spent with patient)

Nursing documentation of confusion

Delirium – Risk Factors

Dementia or Cognitive Impairment

Advanced Age

Hearing impairment

Visual impairment

Hospitalization/Surgery

Physical restraints

Foley catheter

>3 new medications

Elie M, Cole MG, Primeau FJ, Bellavance F. Delirium risk factors in elderly hospitalized patients. J Gen Intern Med. 1998 Mar;13(3):204-12. doi: 10.1046/j.1525-1497.1998.00047.x. PMID: 9541379; PMCID: PMC1496920.

Delirium is DEADLY

- Up to 50% of older adults (65 years and up) in the hospital
- Delirium in ICU → x2-4 more likely to die
- Delirium in ER → 70% increased risk of death in 6 months
- Delirium in Nursing home → x5 increased risk of death in 6 months
- Cognitive impairment increased risk of delirium x2-4

Kiely DK, Marcantonio ER, Inouye SK, Shaffer ML, Bergmann MA, Yang FM, Fearing MA, Jones RN. Persistent delirium predicts greater mortality. J Am Geriatr Soc. 2009 Jan;57(1):55-61. doi: 10.1111/j.1532-5415.2008.02092.x. PMID: 19170790; PMCID: PMC2744464.

Delirium: Incidence in Hospital

General Medical Admission:	11-42%
CABG:	33%
Bilateral Total Knee Replacement:	40%
Hip fracture:	43-61%

Al Farsi RS, Al Alawi AM, Al Huraizi AR, Al-Saadi T, Al-Hamadani N, Al Zeedy K, Al-Maqbali JS. Delirium in Medically Hospitalized Patients: Prevalence, Recognition and Risk Factors: A Prospective Cohort Study. J Clin Med. 2023 Jun 7;12(12):3897. doi: 10.3390/jcm12123897. PMID: 37373591; PMCID: PMC10299512.

Medications that cause delirium

Anticholinergics

Anti-inflammatory agents (prednisone)

Benzodiazepines

Cardiovascular (digoxin, diuretics)

Delirium causes

Medications

Infections: Respiratory, skin, urinary

Metabolic disorders: Dehydration, Electrolyte imbalance, Hypoglycemia, Hypoxia

Cardiovascular: Arrhythmia (Atrial Fibrillation), heart failure, MI

Neurologic: CNS infections, head trauma, seizures, stroke, TIA

Fecal impaction/Constipation

Other: Urinary retention; Pain; Immobility

Testing for Delirium: 2 simple options

1) Months of the Year Backwards (93% sensitivity; 84% specificity administered by medical residents in the ER)

Ask them to state the months of the year forwards starting with January

Ask them to state the months of the year backwards starting with December

Fail = Couldn’t make it to July backwards

2) Days of the Week Backwards (should be able to complete full week)

Marra A, Jackson JC, Ely EW, Graves AJ, Schnelle JF, Dittus RS, Wilson A, Han JH. Focusing on Inattention: The Diagnostic Accuracy of Brief Measures of Inattention for Detecting Delirium. J Hosp Med. 2018 Aug 1;13(8):551-557. doi: 10.12788/jhm.2943. Epub 2018 Mar 26. PMID: 29578552; PMCID: PMC6502509.

Prognosis

- Weeks or months to resolve

- Waxing and Waning mental status continue as patient improves but there will be a general trend toward improvement

- Persistent Symptoms
  At discharge: 44.7%
  1 month: 32.8%
  3 months: 25.6%
  6 months: 21%

Preventing Delirium

Orientation protocol, Stimulating activities, Family at bedside

Facilitate good sleep: Noise reduction, warm milk/herbal tea, music, melatonin 0.5 mg

Early mobilization

Sensory Aids: Visual aids (Glasses); Hearing aids

Identify and treat medical conditions

Encourage hydration

Delirium: Treatment

- Treat the underlying physiologic disturbance.
- Family and caregiver presence first line
- Correct Sensory Deficits (Pocket Talker, Glasses)
- Promote normal sleep & Prevent dehydration
- Use soft restraints or mitts only when necessary to provide needed care (e.g., to prevent IV removal)
- Pharmacological therapy if significant agitation or aggression

Challenges to Assessment of Mentation in Transitions of Care

- Lack of understanding of older adult's baseline function → Misdiagnosis
- Assume older adult has dementia (miss delirium diagnosis)
- Failure to assess educational status and language barriers → misdiagnosis of cognitive impairment
- Failure to address sensory barriers (hearing aids, glasses)

Challenges to Medication Reconciliation in Transitions of Care

- Inaccurate medication list on admission
- Prescriptions from multiple prescribers not using the same health record
- Medications left on medication list, despite no longer taking
- Hospital medications changed to hospital formulary (statin) and both medications taken upon discharge
- Discharge from hospital to skilled nursing facility to home without records available

Solutions to Medication Reconciliation in Transitions of Care

- Obtain medication lists from family / patient
- Review available pharmacy records
- Discuss medications with family / patient to ensure adherence (team member can assist)
- Close the loop – timely provision of discharge summaries to SNF / PCP

Challenges to "What Matters" in Transitions of Care

- Ms. W would like to remain at home
- Discussion with daughter – ok with short term rehab stay to return home
- Returns home after 3 weeks with caregiver in place for medication supervision and assistance with bathing and dressing
- Follow-up with PCP within 7 days of discharge
- Frequent follow-ups – every month, then 2 months – reassess goals/status

4 M's for Caring for the Older Adult

- **Mentation:** Prevent, Identify, Treat and Manage Dementia, Depression, and Delirium across settings of care
- **Mobility:** Ensure that older adults move safely every day in order to maintain function and do What Matters
- **Medications:** Use Age-Friendly medication; Avoid Polypharmacy
- **What Matters:** Align care with goals, values, and preferences

Frequently Asked Questions (FAQs)

1. What are some differences between an Advance Directive document and a Physician Orders for Life-Sustaining Treatment (POLST) form?

Answer: Advance Directives express wishes for care during critical illness and end of life and may also designate a surrogate decision maker. They must be notarized or signed by two witnesses to be legal documents. POLST forms or Physician Orders for Life Sustaining Treatment forms delineate the preferences for or against resuscitation, intensive care, and hospitalization as well as feeding tubes. They require a physician signature in addition to signature of the patient and or their surrogate decision maker. They are valid both whether the patient is in or outside the hospital.

Frequently Asked Questions (FAQs)

2. What are some barriers to medication reconciliation accuracy during transitions of care?

Answer: Clinical staff may assume that the medications in the medical record accurately represent what the patient is currently taking. Patients and their surrogates may not include vitamins or supplements in their medication lists. Patients and caregivers may have limited health literacy and not have awareness of the doses and purposes of their medications. Prescribers from different health systems may be unaware of each other's prescriptions. Prescriptions from multiple sub-specialists in different health systems may not be visible to the person caring for the patient.

Frequently Asked Questions (FAQs)

3. What is the primary characteristic of delirium in an older adult and how can it be quickly assessed?

Answer: Delirium is a deficit of attention. A quick assessment of the ability of a patient to attend can be performed by having the patient state the months of the year in backwards order. If a patient has a lower educational status, an alternative assessment of attention would be having them state the days of the week in backwards order.

Frequently Asked Questions (FAQs)

4. What are the 4 M's of Geriatrics and what is one key assessment for each?

Answer: The 4 M's of Geriatrics are Mobility, Medications, Mind, and What Matters. Mobility can be assessed using a 4-stage balance test to assess for the need for assistive devices.

Medications and specifically polypharmacy (taking 4 or more medications) can put older adults at risk for adverse events due to medication side effects. A full review of medications, their possible side effects, and their necessity helps decrease the risk of falls and hospitalization for older adults.

Mind refers to both mood and memory. A brief memory screen for the outpatient setting is the Mini-Cog exam; while in-patient older adults should be screened for delirium by assessing attention.

What Matters means address an older adult's goals, values, and preferences. Establishing who the preferred surrogate decision maker is for an older adult is a key first step in providing person-centered care.

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Kiely DK, Marcantonio ER, Inouye SK, Shaffer ML, Bergmann MA, Yang FM, Fearing MA, Jones RN. Persistent delirium predicts greater mortality. J Am Geriatr Soc. 2009 Jan;57(1):55-61. doi: 10.1111/j.1532-5415.2008.02092.x. PMID: 19170790; PMCID: PMC2744464.

Al Farsi RS, Al Alawi AM, Al Huraizi AR, Al-Saadi T, Al-Hamadani N, Al Zeedy K, Al-Maqbali JS. Delirium in Medically Hospitalized Patients: Prevalence, Recognition and Risk Factors: A Prospective Cohort Study. J Clin Med. 2023 Jun 7;12(12):3897. doi: 10.3390/jcm12123897. PMID: 37373591; PMCID: PMC10299512.

Resources:

STEADI: Older Adult Fall Prevention: https://www.cdc.gov/steadi/patient-resources/index.html

- Falls Prevention Tools and Hand Outs

Rec ConnectLA: https://www.laparks.org/virtualrecreation

- Free Virtual Live Stream Fitness Classes

NIA YouTube Channel: https://www.youtube.com/playlist?list=PLmk21KJuZUM6_Gy9jxzF9sTO_6u_tYCOm

- Free YouTube WorkOuts for Older Adults

National Institute on Aging: Go4Life YouTube Channel

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National Institute On Aging SUBSCRIBE

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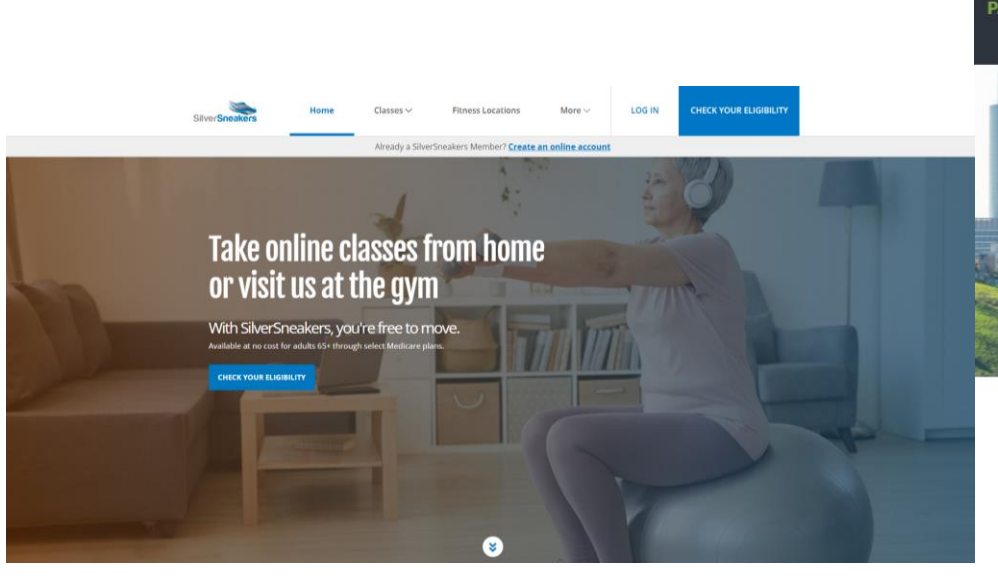
4. 10:08 — 4 Lower Body Strength Exercises for Older Adults from Go4Life — National Institute On Aging
5. 14:55 — 6 Upper Body Strength Exercises for Older Adults from Go4Life — National Institute On Aging
6. 15:30 — 15-minute Sample Workout for Older Adults from Go4Life — National Institute On Aging
7. 10:06 — 10-minute Sample Workout for Older Adults from Go4Life — National Institute On Aging

Refer to other virtual offerings & services: Silver Sneakers, Rec ConnectLA



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Visit often as we will continue to add content and new resources each week! We'd love for you to share your virtual park experience at #RecConnectLA. Stay connected, follow us on Facebook, Instagram, TikTok, and Twitter @RecConnectLA

Here is a selection of online videos and resources prepared by your talented recreation professional team!

Thank you!

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BlueSky: @AllisonMaysMD