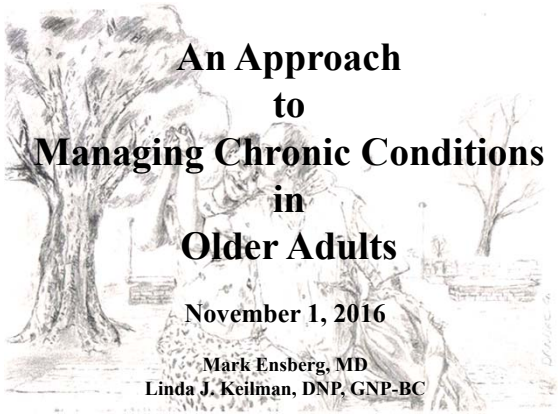

An Approach to Managing Chronic Conditions in Older Adults

November 1, 2016

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OUTCOME:

Case management professionals will be able to identify older adults with health conditions that make self-management difficult, identify strategies to optimally manage care needs & maximize quality of life (QoL)

Who are the Older Adults in the USA ?

Unless otherwise indicated, sources of data are from the U.S. Census Bureau, the National Center for Health Statistics & the Bureau of Labor Statistics; data available from the AoA Profile of Older Americans: 2015

- **46.2 million 65 years & older in 2014** (15%)
  - **This # will double to 98 million by 2060** (21%)
- **1 in 7 adults**
- **Women outnumber men**
- **~ 46% women age 75+ live alone**
- **22% represent racial/ethnic populations**
- **The 85+ population is projected to triple from 6.2 million** (2014) **to 14.6 million in 2040**
- **2.6 million Baby Boomers in 2060; youngest would be 96**
- **2033 = 65+ will outnumber people < 18**

- **9.3 million 65+ are Veterans**
- **High school or higher education = 83.6%**
- **71% live in homes with computers**
- **53,364 centenarians** (2010 Census)
- **# of nursing homes = 15,600** (2014)
  - **~ 5% of 65+**
- **Median yearly income in 2014:**
  - **Females = $17,375**
  - **Males = $31,169**

- **Major sources of income:**
  - **Social Security 84%**
  - **Assets (51%)**
  - **Private pensions (27%)**
  - **Government employee pensions (14%)**
  - **Earnings (28%)**
- **2014 Supplemental Poverty Measure** (SPM)
  - **14.4% older adults** (Federal Poverty Level [FPL])
    - **Most likely due to including medical out-of-pocket expenses in calculations**

- **Married: 70% men; 45% women**
  - **34% older women are widowed**
- **½ million grandparents 65+ had primary responsibility for their grandchildren living with them**
- **Average life expectancy:**
  - **Males = 76.4 years**
  - **Females = 81.2 years**
- **72,197 persons aged 100 or >**
  - **Doubled the 1980 figure (32,144)**

- **1.1 million age 65+ self-identify as lesbian, gay, bisexual or transgender** (LGBT)
  - **By 2060 will exceed 5 million**
- **Key LGBT Disparities:**
  - **↑ risk of social isolation**
  - **Income not commensurate with education**
  - **More lifetime discrimination & victimization**
  - **Limited access to aging, health, support services**
  - **↑ rates physical illness, mental distress & weakened immune system** *(Fredriksen-Goldsen, 2016)*

- **MI in top 14 states with # of individuals 65+**
- **In 2025, 60 years & older**
  - **2,566,831**
    - **24.0% of the state population**
- **In 2025, 85 years & older**
  - **246,421**
    - **2.3 % of the state population**
- **State-wide network of Area Agencies on Aging for every county**
- **Aging & Adult Services Agency** (AASA)

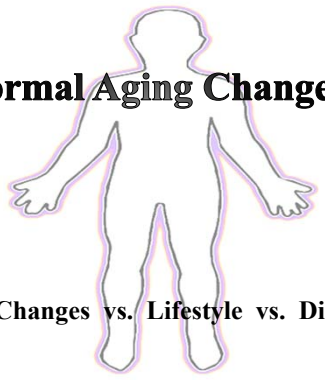
Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	
Medical bills	Playgrounds	Higher education			Quality of care
Support	Walkability				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Heiman & Artiga, 2015

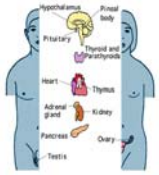
Normal Aging Changes



Normal Changes vs. Lifestyle vs. Disease

- Presbyopia
- Presbycusis
- Cognition
  - More difficult to recall on demand
  - More time required to learn something new
  - Multi-tasking difficult
- Heart slower & larger; vessels stiffer
- Bones shrink in size & density
- ↓ muscle strength, flexibility & muscle mass
- Slower GI transit time
  - Constipation more common

- Atrophy & weakening of bladder muscles
- Prostate enlargement
- Gums recede; ↓ tooth enamel
- Skin thins & loses elasticity; ↓ subcutaneous fatty tissue; ↓ oil production
- Hormone fluctuation
  - Vaginal dryness
  - Flaccidity with erection
- Lowered immune system



NEVER assume that a loss of mental sharpness is just a normal sign of aging!

Chronic Conditions

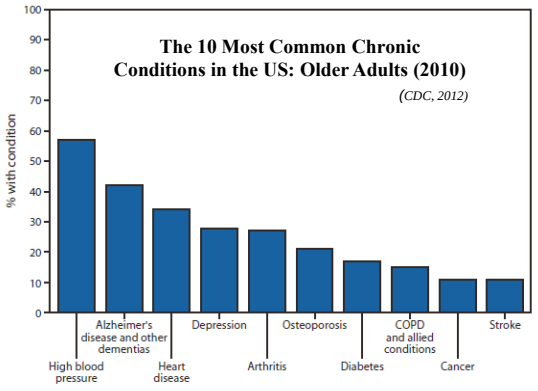
- Complex
- Last, or are expected to last, a year or longer
- Potentially limit what a person can do
- Some may be self-managed
- May require ongoing care
- May cause episodic problems or symptoms that can be controlled with specific interventions

OR

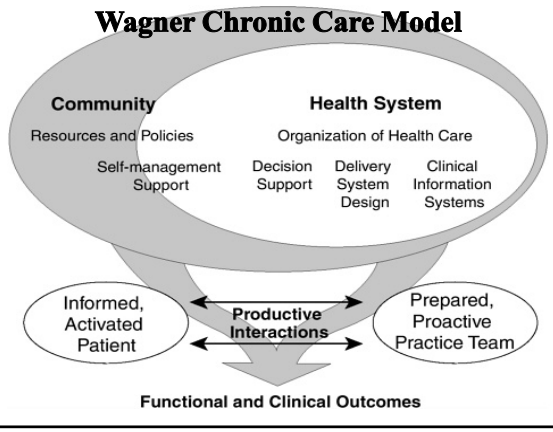
- May severely limit a person's abilities & impact their QoL

- In 2010:
  - ~ 52% of all Americans had at least 1 chronic condition
  - Almost 1/3 (~ 32%) had multiple chronic conditions
  - ~ 35% women vs. ~ 28% men
- Prevalence in co-morbid conditions increases with age
  - ~ 50% of all people aged 45 – 64 years
  - ~ 80% of people 65 & older

Agency for Healthcare Research & Quality (AHRQ), 2014



- ***Healthcare Spending:***
  - **86% for 1 or > chronic conditions**
  - **71% for multiple chronic conditions**
  - **35% is for 8.7% of people with 5 or > chronic conditions**
  - **71 cents of every $1.00 goes to treating people with multiple chronic conditions**
- **The % of healthcare spending for 5 or > chronic conditions increased from 22% in 2006 to 35% in 2010** *(AHRQ, 2014)*



Chronic Disease Self-Management:

- **Techniques to deal with frustration, fatigue, pain & isolation**
- **Appropriate physical activity for maintaining strength, flexibility & endurance**
- **Managing medications**
- **Effective communication techniques**
- **Nutrition**
- **Problem-solving; decision-making**
- **How to evaluate new evidence-based treatments** *(Stanford School of Medicine, 2016)*

- **Arthritis ***
- **Diabetes ***
- **Heart disease**
  - **Hypertension ***
- **Lung disease**
  - **Asthma, chronic bronchitis, emphysema**
- **Parkinson's disease**
- **Cancer**
- **HIV / AIDS**

Administration for Community Living, U.S. Department of Health and Human Services, 7/21/2016. Retrieved from http://www.aoa.gov/AoA_Programs/HPW/ARRA/PPHF.aspx

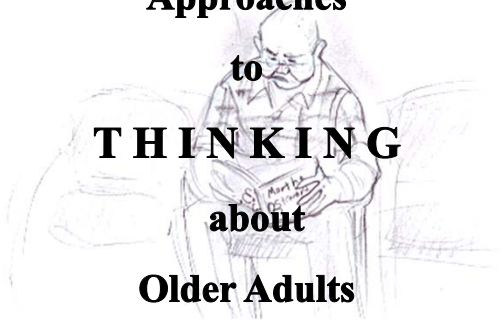
Approaches

to

T H I N K I N G

about

Older Adults



Age Cohorts:

- **65 – 74 years**
  - **Baby Boomers; the Woodstock Generation**
- **75 – 84 years**
  - **Present with a lot of opportunity to maintain function & QoL**
- **85 & older**
  - **Oldest old**
  - **Fastest growing segment of older adults**

Functional Assessment: 6 Key Areas

- **Cognition** (memory, thinking, decision-making)
- **Physical** (strength & endurance; gait, balance, falls, ADLs)
- **Psychological** (mood & personality; anxiety, depression)
- **Spiritual** (beliefs, values, meaning & purpose)
- **Social** (isolation, caregiver issues, network, community)
- **Home environment** (type of structure; assets & barriers)

3 Groups of Older Adults with Differing Care Needs

1. **Vigorous & Relatively Healthy**
2. **Medically Complex**
3. **More Frail & Moving Toward the End-of-Life**

Group 1: Vigorous & Relatively Healthy

- **Continuing to work (or play)**
- **Independent in Instrumental Activities of Daily Living (IADLs) -** *or minimally dependent in 1 IADL*
  - **Ability to use phone; shopping; food preparation; housekeeping; laundry; transportation; take own meds; finances**
- **Cognitively intact**
- **Fewer than 3 chronic conditions**

- **Living life as usual & aging in place**
- **Independent or may start requiring minimal assistance with home** *(housework, yard work, laundry, etc.)*
- **Basically independent in Activities of Daily Living (ADLs)**
  - **Bathing**
  - **Dressing**
  - **Toileting**
  - **Transferring**
  - **Eating**

Hierarchy of personal care skills

Role of the Case Manager:

- **Know the person's story**
  - **Life goals**
  - **Bucket list**
- **Teach/educate**
- **Empower**
- **Advance care planning**
  - **Living document**
  - **Frequent updates & conversations**
- **Goal: safe at home; continue usual life pattern**

Care Coordination:

- **T E A M**
- **Interprofessional**
- **Integrated**
- **Holistic**
- **Innovative**
- **Informed**
- **Person & family-centered**
- **Ongoing communication**
- **Improves quality** → ***Outcomes***
- **Reduces health care costs** → ***Outcomes***

Group 2: Medically Complex

- **3 or > chronic illness**
- **Difficulty with IADLs (2 or >)**
- **Possible:**
  - **Memory impairment**
  - **Difficulty with gait, falls or ADLs**
  - **Depression**
  - **Spiritual distress**
  - **Lack of caregiver support**
- **Less than adequate home environment**
- **Inadequate nutrition**

- **Look for unrecognized IADL impairment**
  - **Remember the 5 reasons for impaired IADLs**
  - **Use brief screens of functional status**
    - **3-Item Recall**
    - **Clock Drawing**
    - **Timed Up & Go**
    - **PHQ-2**
  - **Durable Power of Attorney for Health** (DPOA)
  - **Living arrangements**

- **Optimal living at home requires "a fit" between the persons:**
  - **Functional capabilities**
  - **Support at home**
    - **ADL, IADL, medications, treatments**
  - **Characteristics of the home**
- **Utilize community resources**
- **Arrange for further evaluation or referral as necessary**

- **Increasing # of falls &/or injuries**
  - **1 out of 5 falls results in a serious injury**
  - **2.8 million older adults treated in ED yearly**
  - **> 800,000 hospitalized r/t fall injury**
  - **Falls are most common cause of traumatic brain injuries** (TBI)
  - **$31 billion annually** *(CDC, 9/20/2016)*
  - **Fear of falling leads to less activity leading to social isolation, weakness, depression & increases chances of falling**

Medi-CARE for Falls

Medi – cation

Beers Criteria

C hronic diseases that predispose

A cute illness and acute orthostasis

R ehab (activity) Related Factors

E nvironmental Factors

Role of the Case Manager:

- Emphasis on function & QoL
  - Moving from partial assistance to dependent
- Identify red flags for self-management difficulties
  - History, physical assessment, observation
- Issues with:
  - Nutrition, urinary incontinence (UI), depression, dementia, inadequate caregiver support, transportation, mental health issues, accumulated grief/loss/bereavement

- Care management challenges:
  - Discuss with older adult
    - Bio/psycho/social/spiritual/environmental barriers to managing life & chronic condition symptoms
- Support & encouragement; instill hope
- Use of community resources
- Broaden support network
  - Family, friends, church, gatekeepers *(mail, paper, UPS, utilities)*, neighbors, chore person, local office on aging, home care, etc.

Group 3: Frail, Palliative & End-of-Life Care

- Overall poor health status
- Moderate to severe cognitive impairment
- > 5 chronic conditions
  - Dependent in 2 or > ADLs
  - Functional decline
  - Poor nutrition
  - Intractable symptoms
- Living in long-term care facility

Role of the Case Manager:

- GOALS = comfort & QoL
- Medication review
  - Do better on less
  - Stop medicine - often improve
- Simplify treatments
- At high risk for:
  - Iatrogenic problems
  - Emergency Department/Urgent Care visits
  - Risk of hospitalization
- Friday night plan
- Criteria for Hospice care

Case Management

Guiding Principles:

- Person-led *(patient/client/member/resident/consumer)*
  - Attitudes, beliefs, values, life goals, culture, environment, preferences, faith/spirituality
- Case-manager facilitated
  - Therapeutic relationship
    - Based on trust & mutual respect
    - Goal/outcome directed
      - Plan of care
  - Empowerment
  - Individualized person-centered care focus

- **Behavioral change approach:**
  - **Assess**
  - **Advise**
  - **Agree**
  - **Assist**
  - **Arrange**

  5 A's

  - **Readiness for change**
- **Family participation**
  - **Roles & relationships**
  - **Home life**
  - **Circumstances** *(Registered Nurses' Association of Ontario, 2010)*

Motivational Interviewing

Definitions:

- **A directive, client-centered counseling style for eliciting behavior change by helping clients to explore & resolve ambivalence** *(Rollnick & Miller, 1995, p. 325)*
- **Method for encouraging people to make behavioral changes to improve health outcomes** *(Lundahl et al., 2013)*
- **A collaborative conversation style for strengthening a person's own motivation & commitment to change** *(Miller & Rollnick, 2013)*

Principles:

- **Expressing empathy**
  - *Nonjudgmental; non-confrontational; non-adversarial; showing warmth & caring*
- **Supporting self-efficacy**
  - *Promote self-awareness; embrace client autonomy; positive praise; encourage choices*
- **Indicating/developing discrepancy**
  - *Assist person to develop goals; help to compare/contrast present to hoped for future; evoke reasons for & against change*

- **Rolling with resistance** *(allow exploration of perceived barriers without challenging, maintain client-centered focus, encourage examination of new ideas)*
- **Utilizing concepts of:**

  - **Reflective/empathic/intentional listening**
  - **A directive approach**
  - **Collaboration**
  - **Evocation of motivation**
  - **Patient autonomy**

Key Communication Skills & Strategies:

- **Using open-ended questions**
- **Affirming**
- **Reflecting**
- **Summarizing for clarification**
- **Assessing readiness for change**
- **Providing individualized information & advice with the person's permission**
- **Instilling hope & optimism**

What are <u>YOU</u> Going to Do?

- **Engage the person**
- **Ask permission to discuss**
- **Listen reflectively** *(make a guess about what the person means)*
- **Assess readiness/importance/confidence**
- **Ask open ended questions** *(opening a door)*
- **Use <u>AND</u> versus BUT statements**
- **Give affirmation** *(accentuate the positive)*
- **Summary** *(collecting, linking, transitional)*

- ***MI <u>may</u> potentially:***
  - **Improve the ability to sleep better**
  - **Increase physical activity**
  - **Improve energy level**
  - **Decrease social isolation**
  - **Improve self-worth & self-esteem**
  - **Prevent suicidal thoughts**
  - **Improve nutrition**
  - **Improve adherence toward self-care**
  - **Instill hope**

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