Renzo ROZZINI

Geriatric Research Group (Brescia, Italy)
Poco tempo per vedere la città di Obama (recentemente vista); pulita e curata. Interventi artistici coraggiosi. Ritorno. La primavera a Chicago è appena iniziata. Taxi 45 dollars. Problemi con il volo di rientro. A casa.
Elderly patients affected by cancer and dementia do not die only because of cancer.

Renzo ROZZINI, Intissar SLEIMAN, Stefano BOFFELLI, Marco TRABUCCHI*.

Department of Internal Medicine and Geriatrics, (Poliambulanza Hospital, Brescia, Italy) and *Geriatric Research Group (Brescia, Italy)
Elderly patients affected by cancer and dementia do not die only because of cancer.

The incidence of both dementia and cancer increases with age. For those aged 65 years and older, the prevalence of dementia is about 1 in 10.

Approximately 4.5 million Americans have Alzheimer dementia, and the number is projected to triple by the year 2050.

Similarly, for those aged 60 to 79 years, the probability of developing invasive cancer is 1 in 3 for men and 1 in 4 for women.

Thus, the probability of co-occurrence of both dementia and cancer in the same patient rises with increasing age.

Cognitive impairment may interfere with the diagnosis and treatment of older patients with cancer. When these diseases co-occur their independent impact in determining prognosis is not clear.
Elderly patients affected by cancer and dementia do not die only because of cancer

We would like to explore this issue presenting data obtained in a population of 2843 older persons, consecutively discharged from a Geriatric Ward (Poliambulanza Hospital, Brescia, Italy) during a 30 month period.

Patients were divided into four groups:
(a) patients without dementia and without cancer (n=2138)
(b) patients with cancer but without dementia (n=234)
(c) patients with dementia but without cancer (n=416)
(d) patients with cancer and with dementia (n=55)
Elderly patients affected by cancer and dementia do not die only because of cancer.

The diagnosis of dementia was performed according to the DSM IV criteria; patients included were those with a degree of dementia moderate to severe and requiring continuous assistance.

The clinical stage of cancer, obtained by physical and radiologic examination and endoscopy, included patients with metastasized cancer.

Among the 289 patients 94 had lung, 74 gastroenteric, liver and pancreas, 48 renal and genitourinary, and 28 hematologic malignancies.

Three months mortality was the outcome measure of our analysis.
Elderly patients affected by cancer and dementia do not die only because of cancer.

The mean age was $78 \pm 8.1$; patients with dementia were significantly older than those without dementia ($82.9 \pm 7.7$ vs $77.7 \pm 7.9$).

Three month survival was 94.2%, 81.2%, 77.9%, and 69.1% respectively in groups (a), (b), (c) and (d) suggesting that dementia significantly increases the mortality of cancer patients (+12.1%, a value comparable with that induced by cancer in patients not affected by dementia, i.e. +13%).
Elderly patients affected by cancer and dementia do not die only because of cancer

Mortality rate of hospitalized elderly patients according to presence/absence of severe dementia and cancer
Results induce important evaluations on clinical and ethical grounds, particularly on the appropriateness of cancer chemotherapy in old patients with a coexisting dementia. We may summarize the interpretation of the data with the statement that “cancer patients affected by dementia do not die only because of cancer”. All decisional procedures regarding treatments should derive from this statement.
Prognostic Value of Newly Recognized Hyperglycemia and Diabetes in Elderly Hospitalized Patients with Heart Failure

Intissar SLEIMAN, Renzo ROZZINI, Stefano BOFFELLI, Piera BARBISONI, Marco TRABUCCHI*. Department of Internal Medicine and Geriatrics, (Poliambulanza Hospital, Brescia, Italy) and *Geriatric Research Group (Brescia, Italy)
Purpose of the study:

Heart failure (HF) is a major public health problem, frequently associated with a poor prognosis. In recent years, an array of options has been identified to treat patients with HF. Many of these options, such as implantable defibrillators and biventricular pacemakers, are invasive and expensive procedures. However, the extent to which these interventions should be applied to elderly patients with HF is unknown, in part because clinically useful markers to predict short-term prognosis are not available. In this framework the predictive role of diabetes is controversial and few data describe the importance of newly recognized hyperglycemia.

We studied the factors associated with 3-month mortality, in particular the role of diabetes and newly recognized hyperglycemia in a cohort of hospitalized elderly patients with HF.
Methods:

Three hundred forty-eight patients with AHF (mean age = 78.9 ± 8.0 years) admitted consecutively to Geriatric Ward Unit of the Poliambulanza General Hospital (Brescia, Italy) from May 2006 to May 2008 were studied.

204 patients with normal glycemic value, 104 with diabetes and 39 with newly recognized hyperglycemia (fasting blood glucose = 126 mg/dl) have been considered.

Age, gender, NYHA Classes, left ventricular ejection fraction, Acute Physiology Score (APACHE II-APS), comorbid conditions, serum albumin, serum urea, serum cholesterol, fasting serum glucose, drugs, mental and functional status, and length of stay were recorded.
### Characteristics of 340 Hospitalized Elderly Patients with Heart Failure According to their Glycemic Status

<table>
<thead>
<tr>
<th>Patients</th>
<th>Without History of Diabetes and Normal Glycemic Values</th>
<th>With History of Diabetes</th>
<th>Without History of Diabetes and Abnormal Glucose Values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean ± SD n=204</td>
<td>Mean ± SD n=101</td>
<td>Mean ± SD N=35</td>
</tr>
<tr>
<td>Age, Years</td>
<td>79.2 (± 8.0)</td>
<td>78.9 (± 8.3)</td>
<td>77.6 (± 7.7)</td>
</tr>
<tr>
<td>Gender (male), n (%)</td>
<td>80 (39.2 %)</td>
<td>37 (36.6 %)</td>
<td>19 (54.3%)</td>
</tr>
<tr>
<td>MMSE score (0-30)</td>
<td>25.3 (± 5.4)</td>
<td>24.6 (± 4.8)</td>
<td>23.6 (± 6.1)</td>
</tr>
<tr>
<td>Preadmission Barthel Index (0-100)</td>
<td>90.7 (± 16.5)</td>
<td>85.7 (± 22.4)</td>
<td>83.6 (± 22.9)</td>
</tr>
<tr>
<td>Charlson Index (0-33)</td>
<td>4.8 (± 1.3)</td>
<td>5.0 (± 1.5)</td>
<td>5.1 (± 1.5)</td>
</tr>
<tr>
<td>APS Score (0-33)</td>
<td>2.7 (± 3.1)</td>
<td>3.2 (± 3.3)</td>
<td>3.5 (± 3.8)</td>
</tr>
<tr>
<td>Left Ventricular Ejection Fraction*</td>
<td>58.9 (± 19.9)</td>
<td>59.3 (± 19.3)</td>
<td>57.7 (± 19.5)</td>
</tr>
<tr>
<td>Serum-Glycemia (mg/dl)</td>
<td>92.8 (± 13.3)</td>
<td>133.1 (± 51.2)</td>
<td>143.9 (± 17.2)</td>
</tr>
<tr>
<td>Serum-Cholesterol (mg/dl)</td>
<td>193.0 (± 51.1)</td>
<td>186.4 (± 52.2)</td>
<td>191.9 (± 42.2)</td>
</tr>
<tr>
<td>Serum-Albumin (g/dl)</td>
<td>4.0 (± 0.7)</td>
<td>3.8 (± 0.6)</td>
<td>3.8 (± 0.5)</td>
</tr>
<tr>
<td>Serum-Creatinine (mg/dl)</td>
<td>1.1 (± 0.7)</td>
<td>1.3 (± 0.8)</td>
<td>1.2 (± 1.0)</td>
</tr>
<tr>
<td>Serum-Urea (mg/dl)</td>
<td>25.8 (± 11.4)</td>
<td>28.8 (± 13.1)</td>
<td>26.7 (± 10.6)</td>
</tr>
<tr>
<td>Sodium (mmol/l)</td>
<td>138.5 (± 4.6)</td>
<td>137.6 (± 5.2)</td>
<td>137.0 (± 4.5)</td>
</tr>
<tr>
<td>Troponin I, ng/ ml</td>
<td>0.39 (± 1.34)</td>
<td>0.40 (± 1.32)</td>
<td>0.42 (± 1.35)</td>
</tr>
<tr>
<td>Heart Rate, beats/min</td>
<td>85 (± 19.0)</td>
<td>83 (± 18.0)</td>
<td>98 (± 21.0)</td>
</tr>
<tr>
<td>Systolic blood pressure, mm Hg</td>
<td>153 (± 35)</td>
<td>159 (± 38)</td>
<td>157 (± 37)</td>
</tr>
<tr>
<td>NYHA † Class III-IV n (%)</td>
<td>123 (60.3)</td>
<td>63 (62.4)</td>
<td>25 (71.4)</td>
</tr>
<tr>
<td>Comorbidity</td>
<td>Anemia‡, n (%)</td>
<td>86 (42.2)</td>
<td>42 (41.6)</td>
</tr>
<tr>
<td>Hypertension, n (%)</td>
<td>190 (93.0)</td>
<td>94 (93.0)</td>
<td>30 (85.7)</td>
</tr>
<tr>
<td>Previous Myocardial Infarction, n (%)</td>
<td>129 (63.0)</td>
<td>68 (67.3)</td>
<td>25 (71.4)</td>
</tr>
<tr>
<td>Valve Disease n (%)</td>
<td>18 (8.8)</td>
<td>11 (10.9)</td>
<td>4 (11.4)</td>
</tr>
<tr>
<td>Atrial Fibrillation n (%)</td>
<td>67 (32.8)</td>
<td>39 (38.6)</td>
<td>8 (22.9)</td>
</tr>
<tr>
<td>COPD n (%)</td>
<td>31 (15.2)</td>
<td>12 (11.9)</td>
<td>6 (17.1)</td>
</tr>
<tr>
<td>Number of Drugs at Admission</td>
<td>5.4 (± 2.3)</td>
<td>6.5 (± 3.0)</td>
<td>6.6 (± 2.6)</td>
</tr>
<tr>
<td>Length of Stay in Hospital (days)</td>
<td>6.0 (± 2.6)</td>
<td>7.1 (± 4.3)</td>
<td>6.5 (± 4.1)</td>
</tr>
</tbody>
</table>

* = p ≤ 0.05; † = p ≤ 0.01; ‡ = p ≤ 0.001
Factors Associated with 3 Month Mortality in a Group of 340 Elderly Patients with Heart Failure According to Glycemic Status

<table>
<thead>
<tr>
<th></th>
<th>N/events</th>
<th>Unadjusted</th>
<th>Adjusted*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate to Severe Dementia (MMSE&lt;18)</td>
<td>121/16</td>
<td>3.4 (1.3-8.7)</td>
<td>3.1 (1.2-7.8)</td>
</tr>
<tr>
<td>Acute Physiology Score† (&gt; 4)</td>
<td>78/11</td>
<td>3.8 (1.7-8.4)</td>
<td>1.8 (1.1-7.4)</td>
</tr>
<tr>
<td>Without history of Diabetes and normal glycemic value</td>
<td>204/11</td>
<td>1.0-Ref</td>
<td>1.0-Ref</td>
</tr>
<tr>
<td>With history of Diabetes</td>
<td>101/10</td>
<td>1.8 (0.8-4.1)</td>
<td>1.4 (0.5-4.4)</td>
</tr>
<tr>
<td>Without history of Diabetes and abnormal glucose value</td>
<td>35/7</td>
<td>3.6 (1.4-9.3)</td>
<td>2.7 (1.0-9.4)</td>
</tr>
</tbody>
</table>

Univariate analysis and multiple logistic regressions were applied to identify factors statistically associated with 3 month mortality.

* Variables associated to 3 month mortality and not entered in multivariate Cox proportional hazards model were: age (80+), gender, number of drugs, hyponatraemia, serum albumin, and left ventricular ejection fraction
Results:

Diabetes and newly recognized hyperglycemia are common in this population; in fact, the prevalence were 29.7 % and 10.3 % respectively.

The 3-month mortality was 8.2% in the total group, and 5.4% (11 patients), 9.9 % (10 patients) and 20 % (7 patients ) in normal glycemic, diabetic and in newly recognized hyperglycemia groups respectively.

Predictors of mortality in the bivariate analysis were age (>80 years), APS (> 4), S-albumin (<3.5 g/dl), hyponatraemia (<135 mmol/l), MMSE (<18), number of drugs, higher heart rate and newly recognized hyperglycemia.

In multivariate logistic regression analysis, after controlling for confounding, APS (>4) = OR 2.8 (95 % CI, 1.1-7.4), MMSE (<18) = OR 3.1 (95 % CI, 1.2-7.8), and newly recognized hyperglycemia = OR 2.7 (95 % CI, 1.0-9.4) were independent factors associated with 3-month mortality.
Conclusions:

In elderly patients with HF, newly recognized hyperglycemia, elevated APS and dementia predict short-term mortality.

These results may enable clinicians to better advise patients about prognosis, thus tailoring the management of HF, excluding more aggressive interventions, and allowing considerations for palliative care.
SPECIAL INTEREST GROUPS

7:30 – 9:00 A.M.

ACUTE HOSPITAL CARE
ROOM: Columbian
CHAIR: Robert M. Palmer, MD, MPH
The mission of the Acute Hospital Care Special Interest Group is to improve the outcomes of hospitalization of elderly patients through improvements in clinical care, dissemination of research findings and promotion of health professional education. Innovative approaches to acute hospital care are discussed at AGS meetings. The SIG meeting is open to all AGS participants.

LONG-TERM CARE
ROOM: Buckingham
CHAIRS: Deborah W. Robin, MD & Jean K. Pals, RN,BC, BSN
The SIG on Long-Term Care (SIG on LTC) is a resource and active voice to the AGS, the public, healthcare practitioners, policy makers and educational centers regarding issues on the availability, delivery, quality and regulation of LTC in the US. All members of the SIG on LTC are urged to attend as well as other interested AGS members who wish to join.
PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

ROOM: Columbian
CHAIR: Melinda Lee, MD
This session is aimed at those who are in the early phase of PACE (Program for All-Inclusive Care of the Elderly) development, may be considering the establishment of a PACE program, or have an interest in the provision of primary care within PACE. This comprehensive, fully integrated model provides community-based care for the frail elderly. We encourage anyone with questions to come and explore why this model has become so successful.

REHABILITATION

ROOM: Gold Coast
CHAIR: Neil Nusbaum, MD, JD
The Rehabilitation Special Interest Group has focused on topics of particular interest to those addressing the rehabilitative needs of frail older adults.

Program of All-Inclusive Care for the Elderly (PACE)

PACE is unique. It is an optional benefit under both Medicare and Medicaid that focuses entirely on older people, who are frail enough to meet their State's standards for nursing home care. It features comprehensive medical and social services that can be provided at an adult day health center, home, and/or inpatient facilities. For most patients, the comprehensive service package permits them to continue living at home while receiving services, rather than be institutionalized. A team of doctors, nurses and other health professionals assess participant needs, develop care plans, and deliver all services which are integrated into a complete health care plan. PACE is available only in States which have chosen to offer PACE under Medicaid.
STATE-OF-THE-ART CLINICAL UPDATES SESSION – PART I

ROOM: Grand C-F
CME/ NURSING CONTACT HOURS: 1.5
CME/CEU SESSION CODE: 3013
MODERATOR: Bruce R. Troen, MD
These sessions will present cutting-edge clinical material, and offer pragmatic advice on how to put this information into practice.
LEARNING OBJECTIVES: (1) discuss the recognition, etiology, prevention, and management of delirium; 2) review the pathobiology, clinical presentations and recent advances in the diagnosis of dementia; (3) describe the scientific rationale and use of currently approved as well as emerging treatments for dementia; 4) prioritize major risk factors for morbidity and mortality in older patients with Type 2 Diabetes Mellitus, 5) individualize therapeutic targets for patient based on functional status and comorbidities; 6) achieve safe glycemic control in frail, older adults.

12:30 – 12:45 P.M.  Hitting the Sweet Spot: Individual Therapeutic Targets for Older Diabetics
                         Samuel C. Durso, MD, MBA

12:45 – 1:00 P.M.  Delirium in Older Persons: Clinical Pearls
                         Sharon K. Inouye, MD, MPH

1:00 – 1:15 P.M.  Osteoarthritis
                         Najia Shakoor, MD

1:15 – 1:30 P.M.  Cutting Edge Strategies for the Diagnosis and Treatment of Dementia
                         Sanjay Asthana, MD, FRCP(C)

1:30 – 1:45 P.M.  Hearing Impairment: Improving Communication with and for Patients
                         Priscilla F. Bade, MD, CMD

2:15 – 2:45 P.M.  State-of-the-art Clinical Updates SESSION – PART II

ROOM: Grand C-F
CME/ NURSING CONTACT HOURS: 1.5
CME/CEU SESSION CODE: 3022
These sessions will present cutting-edge clinical material, and offer pragmatic advice on how to put this information into practice.
LEARNING OBJECTIVES: (1) discuss new research on what is effective for senior fall prevention; (2) incorporate life expectancy in recommendations around screening and prevention; (3) describe new recommendations regarding colon and prostate cancer screening; and (4) describe how to counsel older adults about prevention and geriatric health issues.

2:15 – 2:30 P.M.  Prostate Disease
                         Lisa Granville, MD

2:30 – 2:45 P.M.  Prevention: One Size Does Not Fit All
                         Mara A. Schonberg, MD

2:45 – 3:00 P.M.  Preventing Falls: What Works?
                         Lawrence Rubenstein, MD

3:00 – 3:15 P.M.  Immobility/Mobility Problems
                         Barbara Resnick, PhD, CRNP, FAAN, AANP

3:15 – 3:30 P.M.  Parkinson’s Disease/Evaluation and Treatment of Tremor
                         Janice Knoefel, MD
WHICH GERIATRIC PATIENTS SHOULD BE TREATED FOR OSTEOPOROSIS: ASSESSING RISK AND USING COST EFFECTIVE OSTEOPOROSIS TREATMENT THRESHOLDS

ROOM: Grand B
CME/ NURSING CONTACT HOURS: 1.5
CME/CEU SESSION CODE: 3018
ACPE PROGRAM #203-999-09-041-L01-P
PHARMACY CONTACT HOURS: 1.5
MODERATOR: Douglas P. Kiel, MD, MPH

Developed by the Osteoporosis and Metabolic Bone Diseases Special Interest Group.

This symposium will present information about the derivation and practical application of the FRAX fracture assessment tool to enable attendees to apply this in their practice. It will also focus on the appropriate thresholds for osteoporosis treatment in older patients. The symposium will feature extended time for interaction with speakers.

LEARNING OBJECTIVES: (1) discuss the basis for the FRAX fracture risk assessment tool; (2) describe the FRAX tool and use it in clinical practice; and (3) discuss the National Osteoporosis Foundation cost-effectiveness threshold for treatment of osteoporosis.

Understanding and Using the FRAX Tool From the World Health Organization to Assess the Risk of Fracture
Robert Lindsay, MB, ChB, PhD, FRCP

Cost-effectiveness Osteoporosis Treatment Thresholds: The United States Perspective
Anna N. Tosteson, ScD
WHICH PATIENTS BENEFIT THE MOST FROM A GERIATRICIAN’S CARE?
DEFINING GERIATRICS TO FORGE COALITIONS AND GAIN LEVERAGE

ROOM: Columbus 1-L
CME/ NURSING CONTACT HOURS: 1.5
CME/CEU SESSION CODE: 2021
MODERATOR: Gregg A. Warshaw, MD

This session will continue the discussion of the October 2008 Journal of the American Geriatrics Society symposium on the role of geriatricians in clinical practice. In this symposium a survey of the academic directors of US geriatrics program resulted in a consensus that geriatricians should focus clinical efforts on the care of the most frail and vulnerable older adults. The accompanying articles, editorial, and commentary commented on this strategy. In this session, results of a recent survey of AGS members to assess their views on this topic will be presented, and then two geriatricians will debate the value of bringing focus to the role of geriatricians in clinical practice. Time will be available for attendees to participate in the discussion.

LEARNING OBJECTIVES: (1) describe the AGS members’ views on the proposal to limit the clinical focus of geriatricians; (2) list three arguments in favor of targeting geriatricians’ clinical practice on the frail older adult; and (3) list three arguments in favor of geriatricians maintaining a pluralistic clinical focus that addresses the needs of the well and frail older adult.

RESULTS OF THE ADGAP AND AGS SURVEYS
Elizabeth Bragg, PhD

Arguments in Favor of the Advantages to Geriatrics to Narrow our Clinical Focus to the Most Vulnerable Older Adults
Kenneth Brummel-Smith, MD

Arguments Against Geriatrics Narrowing our Clinical Focus; Advocates for a Pluralistic Discipline that Includes the Healthy and Less Impaired Elderly
Robert M. Palmer, MD, MPH

Questions and Discussion with the Audience
Observations and Path Forward
William J. Hall, MD
CONTROVERSIES IN GERIATRIC CARDIOLOGY

ROOM: Grand B
CME/NURSING CONTACT HOURS: 1.5
CME/CEU SESSION CODE: 0211
ACPE PROGRAM #203-999-09-047-L01-P
PHARMACY CONTACT HOURS: 1.5
MODERATOR: Michael W. Rich, MD
This session will use a protagonist/antagonist format to debate 2 controversial issues in the management of cardiovascular disease in older adults: the role of cardiologists vs. PCPs in the management of older adults with heart failure, and the use warfarin in the management of older adults with atrial fibrillation.

LEARNING OBJECTIVES: (1) describe the rationale for referring all older adults with heart failure to the care of a cardiologist; (2) describe the limitations and pitfalls of referring older adults with heart failure for cardiology consultation; (3) discuss the rationale for the aggressive use of warfarin in the treatment of older adults with atrial fibrillation; and (4) discuss the limitations and potential adverse consequences of warfarin therapy in older adults with atrial fibrillation.

All Older Adults with Heart Failure Should be Referred to a Cardiologist: Protagonist Perspective
Marc A. Silver, MD

All Older Adults with Heart Failure Should be Referred to a Cardiologist: Antagonist Perspective
John E. Morley, MD

Warfarin is Indicated in all Older Adults with Atrial Fibrillation: Protagonist Perspective
Susan J. Zieman, MD

Warfarin is Indicated in all Older Adults with Atrial Fibrillation: Antagonist Perspective
Sean Jeffery, PharmD
SPECIAL INTEREST GROUPS

12:30 – 2:00 P.M.

CANCER AND AGING

ROOM: Buckingham
CO-CHAIRS: Arash Naeim, MD, PhD, & Arti Hurria, MD
The Cancer and Aging Special Interest Group is an interdisciplinary assemblage of geriatric, gerontologic, and oncologic professionals whose collective mission is to: (1) promote multidisciplinary-centered cancer prevention, assessment, and management of older adults; (2) promote education and training in geriatric oncology concepts; (3) promote research in geriatric oncology; (4) facilitate linkages among those organizations and institutions which serve or focus upon geriatric and/or oncologic causes; and (5) champion and advocate for those elders and their families who are impacted by cancer.
NEEDS OF OLDER GAY AND LESBIAN, BISEXUAL AND TRANSGENDER PERSONS

ROOM: Haymarket
CHAIR: David O. Staats, MD
Geriatrics has not yet fully considered the needs of older gay and lesbian, bisexual and transgender persons. This interest group intends to initiate a more formal analysis and observation of these needs. This SIG meeting is open to all AGS participants.

6:30 – 8:00 P.M.

DISASTER PLANNING AND PREPAREDNESS

ROOM: Gold Coast
CHAIR: Charles A. Cefalu, MD, MS
This new SIG will provide up-to-date, accurate, and useful information as well as guidance to all geriatric healthcare professionals regarding disaster planning and preparedness. It is open to health professionals who work with older adults in all geriatric health care sites, including acute, long term care, rehabilitation, and home settings.
ADULT VACCINATION IN 2009

ROOM: Regency C
CME/ NURSING CONTACT HOURS: 2.0
CME/CEU SESSION CODE: 3027
MODERATOR: Suzanne F. Bradley, MD

Supported by an educational grant from Merck & Co., Inc.

The Adult Vaccination in 2009 symposium will focus on vaccination issues that are unique to the older adult population. The panel will discuss aging and the immune system in terms of vaccine responsiveness, benefits and risks of the pneumococcal and zoster vaccines, and successful delivery of vaccines to older adults.

LEARNING OBJECTIVES: (1) describe how aging affects the immune system with regards to vaccine responsiveness and methods to improve immune responsiveness; (2) discuss the latest evidence for the uses, benefits and risks of vaccines in older adults and (3) describe practical tips for the successful delivery of vaccines to older adults.

Immune Senescence and Vaccine Response:
Understanding What We Are Up Against
Janet McElhaney, MD

Update on Zoster Vaccine and Pneumococcal Vaccine for Older Adults
Suzanne F. Bradley, MD

Secrets to Delivering Vaccines to Your Older Patients
Amy H. Lyons, RN, MS, CIC
Infections

SYMPOSIA

7:30 – 9:00 A.M.

ANDREW WEINBERG SERIES:
INFECTION DISEASE IN LONG-TERM CARE

ROOM: Grand A
CME/ NURSING CONTACT HOURS: 1.5
CME/CEU SESSION CODE: 0101
ACPE PROGRAM #203-999-09-042-L01-P
PHARMACY CONTACT HOURS: 1.5
MODERATOR: Jean K. Pals, RN, BC, BSN

The AGS will join AMDA in honoring Dr. Andrew Weinberg’s work as a liaison between AMDA and AGS. The AGS and AMDA will each be offering a symposium at their meetings as part of the Weinberg Series. This session will focus on infection control of Clostridium difficile, methicillin-resistant Staphylococcus aureus (MRSA) and influenza in the long-term care setting.

LEARNING OBJECTIVES: (1) discuss infection control of Clostridium difficile, MrSA and influenza in the long-term care setting.

Clostridium Difficile
  Michael E. Maddens, MD, CMD

Methicillin-resistant Staphylococcus Aureus (MRSA)
  Chesley Richards, MD, MPH

Influenza
  Christie DeBruhl, PharmD
Infections

PNEUMONIA ACROSS SITES OF CARE

ROOM: Grand B
CME/ NURSING CONTACT HOURS: 1.5
CME/CEU SESSION CODE: 0206
ACPE PROGRAM #203-999-09-046-L01-P
PHARMACY CONTACT HOURS: 1.5
MODERATORS: Kevin P. High, MD, MS & Suzanne F. Bradley, MD

This session will focus on treating pneumonia in acute, long-term care and outpatient settings.

LEARNING OBJECTIVES: (1) describe a rational approach to the treatment of older patients with healthcare-associated pneumonia when the concern for antibiotic-resistant bacteria is high; (2) describe the overall scope of pneumonia in nursing homes as a clinical and public health problem; (3) identify modifiable risk factors for nursing home acquired pneumonia; (4) become informed about evolving evidenced based strategies for prevention; (5) review the diagnostic, therapeutic, and preventive considerations in managing older adults with pneumonia in the outpatient setting.

Managing Healthcare-Associated Pneumonia in Older Adults: Implications of Antimicrobial Resistance
Stephen Weber, MD

Pneumonia in Long Term Care Residents: Can We Prevent It?
Vincent J. Quagliarello, MD

Prevention and Treatment of Community-Acquired Pneumonia in Older Adults
Mark Loeb, MD, MSc
THE ROLE OF QUALITY DENTAL/ ORAL HYGIENE IN THE FRAIL AND NURSING HOME ELDERLY POPULATION— PREVENTION OF LOCAL, REGIONAL AND SYSTEMIC MANIFESTATIONS OF ORAL DISEASE

ROOM: Grand B
CME/NURSING CONTACT HOURS: 1.5
CME/CEU SESSION CODE: 0113
MODERATOR: Charles A. Cefalu, MD, MS

Developed by COSAR.

This symposium will provide the participant with the essential components of a quality dental/oral hygiene program for frail elders in the nursing home utilizing an interdisciplinary team approach to care.

LEARNING OBJECTIVES: (1) discuss the specific components of a quality dental/oral hygiene program for frail and nursing home elders; (2) discuss the specific role of the dental hygienist in the frail and nursing home elderly resident and the collaborative approach and roles of the affiliated dentistry service, speech therapist, nurse aide and nursing and attending physician/Medical Director; (3) discuss quality outcomes associated with good dental/oral hygiene care for frail and nursing home elderly and local, regional, and systemic complications of unmet needs; and (4) discuss reimbursement issues for quality dental/oral hygiene in the frail and nursing home elderly specifically for the oral hygienist, dental services and dental appliances.

Implementation of and Coordination of a Collaborative and Interdisciplinary Dental Hygiene Program for Frail and LTC Elderly—The Basic Components
Barbara J. Smith, PhD, RDH, MPH

The Role of the Nurse Aide and Nursing in the Provision of Quality Oral Hygiene in Frail and Nursing Home Elderly
Barbara Resnick, PhD, CRNP, FAAN, AANP

Manifestations of Regional and Systemic Disease as a Consequence of Inadequate Oral/Dental Hygiene in Frail and Nursing Home Elderly
Kenneth Shay, DDS, MS
CONSTRUCTING QUALITY INDICATORS
FOR THE CARE OF OLDER PATIENTS
VISITING EMERGENCY DEPARTMENTS (II)

ROOM: Gold Coast
CME/ NURSING CONTACT HOURS: 2.0
CME/CEU SESSION CODE: 0109
MODERATOR: Douglas K. Miller, MD

Developed by the Society for Academic Emergency Medicine's Geriatric Interest Group.

This session will provide attendees with information and skills to create consensus about quality indicators for emergency care of older patients.

LEARNING OBJECTIVES: (1) describe an approach to developing and measuring quality indicators in emergency department care; (2) discuss important quality indicators and their measurement for three specific issues: screening and prevention, medication use, and functional assessment; and (3) identify areas where geriatricians and emergency physicians can cooperate to improve care associated with screening and prevention, medication use, and functional assessment in the ED.

The Rationale, Development and Use of Quality Indicators to Improve the Emergency Care of Older Adults
Neil S. Wenger, MD

Proposed Quality Indicators for Prevention and Screening of Older Emergency Department Patients
Christopher Carpenter, MD

Proposed Quality Indicators for Medication Prescription in Older ED Visitors
Kennon Heard, MD

Proposed Quality Indicators for Functional Assessment of Older ED Visitors
Kirk Stiffler, MD
PREDICTION, PROGRESSION, AND OUTCOMES OF CHRONIC KIDNEY DISEASE IN OLDER ADULTS

ROOM: Grand A
CME/NURSING CONTACT HOURS: 1.5
CME/CEU SESSION CODE: 0112
MODERATOR: Jocelyn E. Wiggins, MA, BM, BCh, MRCP
This program focuses on the clinical care of older patients with chronic kidney disease (CKD) not yet requiring renal replacement therapy and managed predominantly in geriatrics and primary care practices.
LEARNING OBJECTIVES: (1) describe the advantages and limitations of current approaches to evaluating renal function in older adults, and recognize their clinical applications in the diagnosis and management of chronic kidney disease (CKD) in older patients; (2) review current approaches to (a) evaluating the older patient with newly recognized CKD (what studies to perform, when to refer), (b) identifying risk factors for progression of CKD with a focus on co-occurring conditions (e.g., diabetes, hypertension, acute kidney injury); and (3) explore current approaches to managing complications of CKD (e.g., atherosclerosis, osteodystrophy, anemia, cognitive impairment).

Assessing Renal Function in the Aging Kidney:
Problems and Practical Approaches
Michael G. Shlipak, MD, MPH

“Pre-clinical” and Clinical CKD: Evaluation, Natural History and Risk Factor Management
Jeff D. Williamson, MD, MHS

Managing Complications of CKD
Sanjeevkumar R. Patel, MD, MS
OPTIMIZING MEDICATION THERAPY IN
CLINICALLY COMPLEX ELDERS: EVIDENCE,
CONCEPTS, AND FUTURE DIRECTIONS

ROOM: Grand A
CME/ NURSING CONTACT HOURS: 1.5
CME/CEU SESSION CODE: 0119
ACPE PROGRAM #203-999-09-043 -LO1-P
PHARMACY CONTACT HOURS: 1.5
MODERATOR: Joseph Agostini, MD

Developed by the Polypharmacy Special Interest Group.

The overall goal of this program is to present evidence and strategies to improve key components of outpatient medication therapy in clinically complex elders, including medication adherence, effectiveness, and safety, and to tie together these disparate elements into a conceptual framework for prescribing and a roadmap for future research.

Learning Objectives: (1) describe and apply evidence-based approaches to minimize harm and maximize benefit of medication use in elders with multiple comorbidities; (2) develop a conceptual approach for integrating harms and benefits of prescribing for elders with multiple comorbidities; and (3) identify current gaps in knowledge and key avenues for future research into safe and effective prescribing for elders with multiple comorbidities.

Adherence in Elders with Complex Medication Regimens
Steven M. Handler, MD, MS

Effectiveness of Pharmacotherapy in Elders with Multiple Comorbidities
Lillian C. Min, MD

Adverse Drug Events and Drug Safety and in Elders with Complex Medication Regimens
Joseph T. Hanlon, PharmD, MS

Panel Discussion
INDUSTRY-SUPPORTED
SYMPOSIUM (DINNER SERVED)
6:30 – 9:00 P.M.

A MULTIDISCIPLINARY APPROACH
TO MANAGEMENT OF CHRONIC
CONSTIPATION IN OLDER ADULTS: CASE
STUDIES FOR OPTIMAL TREATMENT

ROOM: Regency Ballroom D
CME/ NURSING CONTACT HOURS: 2.0
CME/CEU SESSION CODE: 0126
ACPE PROGRAM #203-999-09-045-L01-P
PHARMACY CONTACT HOURS: 2.0
MODERATOR: Eric G. Tangalos, MD

Supported by an educational grant from Sucampo Pharmaceuticals,
Inc. and Takeda Pharmaceuticals North America, Inc.

This session will present ways to tailor management strategies and treatment plans for the various etiologies of chronic constipation often encountered among older individuals, including medication-related causes.

LEARNING OBJECTIVES: (1) describe ways to tailor multidisciplinary management strategies and treatment plans for the various etiologies of chronic constipation often encountered among older adults, including medication-related causes; (2) define key culturally based challenges in treating older adults with chronic constipation; (3) describe strategies and tools to improve communication regarding chronic constipation with patients from diverse cultural and/or socioeconomic backgrounds; and (4) evaluate the use of current and new therapeutic strategies in the management of patients with chronic constipation.

Case 1: Diagnosis and Management
Brooks D. Cash, MD

Patient Sensitivity and Cultural Competence
Eric G. Tangalos, MD

Case 1 Conclusion and Case 2: Complications
Mario Cornacchione, DO, CMD
SATURDAY, MAY 2

7:00 A.M. — 1:30 P.M.

CONTROVERSIES AT THE CROSSROADS OF PERIOPERATIVE CARE

THE EIGHTH ANNUAL MEETING OF THE SECTION FOR ENHANCING GERIATRIC UNDERSTANDING AND EXPERTISE AMONG SURGICAL AND MEDICAL SPECIALISTS (SEGUE)*

ROOM: Regency C
CME/ NURSING CONTACT HOURS: 3.5
CME/CEU SESSION CODE: 0201
There is no additional fee to attend this session. Seating for the meeting is on a first-come, first-served basis. Developed and supported by The John A. Hartford Foundation supported Geriatrics-for-Specialists project, Increasing Geriatrics Expertise in Surgical and Related Medical Specialties

LEARNING OBJECTIVES: (1) consider the role of the geriatrician in optimizing preoperative assessment and impact on post operative outcomes in the older patient; (2) discuss the geriatric specific issues of post operative delirium, end of life and functional assessment in the setting of indicated surgery in the older patient; and (3) discuss the issues involved in deciding whether surgical or more conservative approaches should be utilized in the management of back pain and coronary artery disease in the older patient.

7:00 A.M. Continental Breakfast
7:30 A.M. Welcome and Introductions
Joseph Cleveland, MD
University of Colorado Health Sciences Center

7:45 A.M. Cross Cutting Challenges in Perioperative Care
“Do Geriatric Principles Matter in Perioperative Care?”
MODERATOR: Holly Richter, PhD, MD
University of Alabama at Birmingham

PRESENTERS:

SURGICAL SPECIALTIES PERSPECTIVES:

Functional Assessment:
Alan Dardik, MD, PhD
Department of Surgery, Yale University

Post-operative Delirium:
Deborah J. Culley, MD
Department of Anesthesiology, Harvard Medical School

End-of-life:
Sandhya A. Lagoo-Deenadayalan, MD, PhD
Department of Surgery, Duke University

Geriatrician/Generalist Perspective:
Peter Pompei, MD, Stanford University

9:15 A.M. Break
9:30 A.M. Point/Counterpoint
MODERATOR: Allen Settel, MD
Case School of Medicine

Spine Surgery vs. Physical Medicine & Rehabilitation for Low Back Pain in Elders

SURGERY:
Simon Mears, MD, MPD
Department of Orthopaedic Surgery,
Johns Hopkins University

PHYSICAL MEDICINE & REHABILITATION, NON-SURGICAL MEASURES:
Jonathan F. Bean, MD, MS, MPH
Department of Physical Rehabilitation and Medicine, Harvard Medical School

10:00 A.M. Coronary Artery Bypass (CAB) vs. Percutaneous Coronary Intervention (PCI) for Elders with Coronary Artery Disease

CAB: David Fullerton, MD
Division of Cardiothoracic Surgery,
University of Colorado

PCI: Joseph Cleveland, MD
Division of Cardiothoracic Surgery,
University of Colorado

10:30 A.M. Break
10:45 A.M. An Acorn, a Fish, and the Journey of a Thousand Miles: Geriatrics Specialty Education at the Crossroads
Andrew G. Lee MD, Chair of Ophthalmology
The Methodist Hospital, The Texas Medical Center, Houston, Texas

11:45 A.M. Lunch and the Dennis W. Jahngien & T. Franklin Williams Career

*Formerly known as the Section for Surgical and Related Medical Specialties
SURGICAL COMPLICATIONS AND IMPROVED POST OPERATIVE CARE IN GERIATRIC PATIENTS

ROOM: Grand A
CME/ NURSING CONTACT HOURS: 1.5
CME/CEU SESSION CODE: 0218
MODERATOR: Michi Yukawa, MD, MPH

As more older patients (in their 80s and 90s) are undergoing surgery, clinicians who care for geriatric patients need to be aware of surgical complications and their presentation and occurrence specific to geriatric patients and possible preventive managements. Therefore, this program will review the four common surgical complications (weight loss/malnutrition, wound healing/infection, cognitive decline, and functional decline) and new innovative methods to prevent these complications.

LEARNING OBJECTIVES: (1) describe the risk factors and interventions for malnutrition and post-operative weight loss in the older surgical patients; (2) describe changes in post surgical wound healing in middle age and older adults and discuss potential interventions for improving healing; (3) identify the causes for cognitive dysfunction post operatively and describe potential preventive management; and (4) explain the causes for functional decline after surgery and discuss potential preventive methods.

Risk Factors and Interventions for Malnutrition and Post-Op Weight Loss in the Older Surgical Patient
Rose A. DiMaria-Ghalili, PhD, RN, CNSN

Post Surgical Wound Healing and Surgical Site Infection in Middle Aged and Older Adults: Implications for Practice
JoAnne D. Whitney, PhD, RN, CWCN, FAAN

Post Operative Cognitive Dysfunction in Older Patient
Jeffrey H. Silverstein, MD

Natural History and Determinants of Postoperative Functional Recovery in Older Adults and Implications for Interventions to Improve Recovery
Valerie A. Lawrence, MD
HOSPITAL ELDER LIFE PROGRAM (HELP)

ROOM: Haymarket
CHAIR: Sharon K. Inouye, MD, MPH
The Hospital Elder Life Program (HELP) is an innovative model of hospital care designed to prevent delirium and functional decline and to improve overall quality of hospital care for older persons. The mission and goal of this SIG is to allow all current and potentially interested HELP sites to come together to discuss successes and challenges in the implementation process. A new HELP website (funded by the National Library of Medicine) was implemented to try to meet the needs of HELP sites nationally and internationally. At this SIG, we will discuss the progress on our HELP collaborative paper, as well as the latest updates on the website. We hope to gain feedback on both projects. All current HELP sites, and anyone interested in learning more about HELP are encouraged to participate. You need not have an active HELP site to participate, just an interest in improving hospital care for older persons.
The Hospital Elder Life Program:
Background and Overview

Sharon K. Inouye, M.D., M.P.H.
Professor of Medicine at Harvard Medical School

Director of the Aging Brain Center (ABC) at Hebrew Senior Life, Milton and Shirley F. Levy Family Chair in Alzheimer’s Disease
HOSPITALIZATION OF OLDER PATIENTS

EPIDEMIOLOGY

• 35% of U.S. population aged ≥ 65 years is hospitalized each year.
• Account for nearly 50% of inpatient days.

IMPACT

• Hospitalization often represents a pivotal event in the life of an older person.
• Loss of function and independence represent frequent and unfortunate outcomes.
WHY IS HOSPITALIZATION HAZARDOUS?

- Acute illness
- Older, vulnerable patient
- Precipitating factors for adverse events
  - (a) Preventable
  - (b) Nonpreventable
POTENTIAL PRECIPITATING FACTORS

For average older person:

> 200 chance or decision nodes/day where adverse events might occur in hospital.
RISKS OF IATROGENIC COMPLICATIONS

• Rates of iatrogenic complications in older hospitalized patients 29-38%

• Increased risk of complications in older patients 3 – 5 fold

## COMPLICATIONS OF HOSPITALIZATION

![Flowchart diagram]

### Categories of Complications

<table>
<thead>
<tr>
<th>Category</th>
<th>Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delirium</td>
<td>25-60%</td>
</tr>
<tr>
<td>Functional decline</td>
<td>34-50%</td>
</tr>
<tr>
<td>Adverse drug events</td>
<td>54%</td>
</tr>
<tr>
<td>Operative complications</td>
<td>52%</td>
</tr>
<tr>
<td>Diagnostic or therapeutic mishaps</td>
<td>31%</td>
</tr>
<tr>
<td>Nosocomial infections</td>
<td>17%</td>
</tr>
<tr>
<td>Physical injury/falls</td>
<td>15%</td>
</tr>
<tr>
<td>Pressure sores</td>
<td>10%</td>
</tr>
<tr>
<td>Pulmonary embolism</td>
<td>3%</td>
</tr>
</tbody>
</table>
THE HOSPITAL ELDER LIFE PROGRAM (HELP)

A Model of Care to Prevent Delirium and Functional Decline in Hospitalized Older Patients

HOSPITAL ELDER LIFE PROGRAM

GOALS

An innovative approach to improving hospital care for older patients, with primary goals of:

- Maintaining physical and cognitive functioning throughout hospitalization
- Maximizing independence at discharge
- Assisting with the transition from hospital to home
- Preventing unplanned readmission
UNIQUE ASPECTS OF HELP

• Hospital-wide focus; geriatric unit is not required
• Provision of skilled staff and trained volunteers to carry out interventions
• Use of practical interventions directed at 6 known risk factors for cognitive and functional decline
• Targeting of program towards appropriate patients
• Standard quality assurance procedures
## ELDER LIFE PROGRAM INTERVENTIONS

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Impairment</td>
<td>Reality orientation</td>
</tr>
<tr>
<td></td>
<td>Therapeutic Activities Program</td>
</tr>
<tr>
<td>Vision/Hearing Impairment</td>
<td>Vision/Hearing Aids</td>
</tr>
<tr>
<td></td>
<td>Adaptive Equipment</td>
</tr>
<tr>
<td>Immobilization</td>
<td>Early Mobilization</td>
</tr>
<tr>
<td></td>
<td>Minimizing immobilizing equipment</td>
</tr>
<tr>
<td>Psychoactive Medication Use</td>
<td>Nonpharmacologic approaches to sleep/anxiety</td>
</tr>
<tr>
<td></td>
<td>Restricted use of sleeping medications</td>
</tr>
<tr>
<td>Dehydration</td>
<td>Early recognition</td>
</tr>
<tr>
<td></td>
<td>Volume repletion</td>
</tr>
<tr>
<td>Sleep Deprivation</td>
<td>Noise reduction strategies</td>
</tr>
<tr>
<td></td>
<td>Sleep enhancement program</td>
</tr>
</tbody>
</table>
OTHER HOSPITAL ELDER LIFE PROGRAM
INTERVENTIONS

• Geriatric nursing assessment and intervention
• Interdisciplinary rounds
• Geriatrician consultation
• Interdisciplinary consultation
• Provider education program
• Community linkages and telephone follow-up
INTERVENTION PROCESS

• **Screening**: all patients $\geq 70$ years are screened
• **Inclusion**: as inclusive as possible, must have at least one risk factor for cognitive/functional decline
• **Exclusion**: minimized, mainly inability to participate in interventions
• **Assignment**: after screening, patients assigned to interventions based on their risk factors by Elder Life Specialists. Individualized menu of interventions
• **Adherence**: completion of all interventions tracked daily by Elder Life Specialists
HELP: INCLUSION CRITERIA

• Age 70 years and older
• At least one risk factor for cognitive or functional decline:
  (a) cognitive impairment-MMSE<24
  (b) mobility or ADL impairment
  (c) dehydration-BUN/Cr ratio ≥18
  (d) vision impairment
  (e) hearing impairment
• Able to communicate verbally or in writing
HELP: EXCLUSION CRITERIA

- Coma
- Severe aphasia
- Intubated on ventilator
- Terminal condition
- Combative or dangerous behavior
- Severe psychotic disorder
- Severe dementia (e.g., unable to communicate)
- Respiratory isolation (e.g., tuberculosis)
- Discharge within 48 hours of admission
- Refusal by patient, family, or physician
- Other (i.e., cannot participate in interventions)
QUALITY ASSURANCE PROCEDURES

Key to the program’s effectiveness

Procedures include:
• Daily review of intervention adherence
• Monthly Elder Life Program Working Group
• Monthly Program Director meeting with individual staff
• Twice yearly staff performance checks – with paired standardization
• Quarterly volunteer performance assessment – with competency based checklists
• Patient-Family Survey
VOLUNTEERS

- **Unique role:** Hands-on
- **Selection criteria:** Responsibility, caring, and respect for older persons.
- **Commitment:** Minimum of one 4 hour shift/week for 6 months
- **Training:** Intensive, 16 hours didactic group, followed by 16 hours one-on-one training with patients
- **Quality checks:** Quarterly competency-based checklists
- **Volunteer retention:** Daily staff communication, quarterly educational/support session, monthly newsletter, and incentive awards
# Yale Delirium Prevention Trial Results

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Intervention Group (N=426)</th>
<th>Usual Care Group (N=426)</th>
<th>Matched OR (CI) or p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incident delirium, n (%)</td>
<td>42 (9.9%)</td>
<td>64 (15.0%)</td>
<td>.60 (.39-.92)</td>
</tr>
<tr>
<td>Total delirium days</td>
<td>105</td>
<td>161</td>
<td>p=.02</td>
</tr>
<tr>
<td>No. delirium episodes</td>
<td>62</td>
<td>90</td>
<td>p=.03</td>
</tr>
<tr>
<td>Delirium severity score</td>
<td>3.9</td>
<td>3.5</td>
<td>p=.25</td>
</tr>
<tr>
<td>Recurrence rate</td>
<td>13 (31.0%)</td>
<td>17 (26.6%)</td>
<td>p=.62</td>
</tr>
</tbody>
</table>

HELP: RESULTS
(N = 1716 admissions of 1507 patients)

ADHERENCE
Adherence Rate, patient-days, n (%)

<table>
<thead>
<tr>
<th>Complete</th>
<th>Partial</th>
<th>Non-adherence</th>
<th>Total # days assigned</th>
</tr>
</thead>
<tbody>
<tr>
<td>23,152 (62%)</td>
<td>10,036 (27%)</td>
<td>3,943 (11%)</td>
<td>37,131</td>
</tr>
</tbody>
</table>

FUNCTIONAL OUTCOMES

<table>
<thead>
<tr>
<th>Outcome Description</th>
<th>HELP</th>
<th>Medical Literature</th>
<th>Delirium Prevention Trial Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMSE decline by ≥ 2 pts, admission to discharge</td>
<td>8%</td>
<td>14-56 %</td>
<td>26%</td>
</tr>
<tr>
<td>ADL decline by ≥ 2 pts, admission to discharge</td>
<td>14%</td>
<td>34-50%</td>
<td>33%</td>
</tr>
</tbody>
</table>

HELP PROGRAM BENEFITS

- Innovative program, prevents decline in older patients
- Ethical, high face validity
- Quality improvement, better outcomes/patient satisfaction
- Cost-effective
- Creation of center of excellence in geriatric care
- Volunteer base: human element and community linkage
- Enhanced public relations
- Provision of nursing education and support; improved nursing job satisfaction and retention
- Educational site for geriatric care
- Training site for nurse’s aides and sitters
- Prepares hospitals to cope with our aging society
THE CHALLENGE

1. Changes are difficult:
   • Although commonsensical, these interventions do not occur consistently.
   • Requires system-wide changes in our approach to older persons.

2. Examples of needed changes:
   • Routine cognitive and functional assessment on hospital admission
   • Monitoring mental status as a “vital sign”
   • Enhanced geriatric expertise (RN and MD) at the bedside
   • Widespread provider education
   • Case management services
ENSURING PATIENT SAFETY

“Errors can be prevented by designing systems that make it hard for people to do the wrong thing and easy for people to do the right thing.”

-- To Err is Human, Institute of Medicine 2000

The goal for all of us is to create systems that make it easy to do the right thing in the care of older persons.
OVERVIEW - The Hospital Elder Life Program is an innovative model designed to improve the hospital experience of older patients. Often times, hospitalization for an older person means a decline in physical and mental abilities, making it difficult to recover from illness and return to their previous level of functioning. The primary goal of the Hospital Elder Life Program is to maintain the cognitive and physical functioning of the older hospitalized adult with volunteers carrying out four volunteer interventions.
FEEDING- For older patients, maintaining good nutrition is essential not only to fighting infection and healing, but can also help prevent confusion. Volunteers encourage adequate intake and provide companionship, social contact and stimulation during meals.
MOBILIZATION - Bed rest interferes with the function of major body organs and can lead to generalized deconditioning. The Early Mobilization Program aims to keep older patients physically moving while they are in the hospital. Those patients able to walk receive assistance three times a day, and those unable to walk receive coaching to complete simple exercise movements three times daily.
DAILY VISITOR - It is quite common for older adults who show no signs of confusion at home to become disoriented and forgetful in the hospital. The primary goal of the Daily Visitor Program is to prevent confusion from developing by using Orienting Communication to provide the patient with information that they need to stay mentally aware of reality.
THERAPEUTIC RECREATION - Recreational or leisure activity provides a balance to refresh the spirit and regain the energy spent during hours at "work" of treatment and recovery. Therapeutic activity programs are designed for patients to experience pleasant activities which boost self-esteem, encourage socialization, and provide mental stimulation, all of which prevent mental deterioration and lead to a faster recovery.
VOLUNTEERS - Volunteers play a central role in this program, by carrying out program interventions directly at the bedside. This program gives volunteers a level of patient contact and responsibility that is unique amongst hospital programs. Volunteers help to create a friendly hospital environment by providing sympathetic support, encouragement and companionship to older patients and their families.
La locuzione latina, tradotta letteralmente, significa *la Grecia, conquistata [dai Romani], conquistò il feroce vincitore*. (Orazio, Epist. Il, 1, 156).

La locuzione prosegue con **et artes intulit agresti Latio**: *e le arti portò nel Lazio agreste*.

Roma conquistò la Grecia con le armi, ma questa con le sue lettere ed arti riuscì ad incivilire il feroce conquistatore, rozzo e incolto. La locuzione si cita per esaltare la potenza ed efficacia delle belle lettere, dell'arte, degli studi nella civilizzazione dei popoli.

**Graecia capta ferum victorem cepit**

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