

Aging SUCCESSFULLY



Spring 2017
Vol. XXVI, No. 1

Medicare Annual Wellness Visit: An Underutilized Tool for Healthcare Providers of Older Adults

By Milta O. Little, DO, CMD

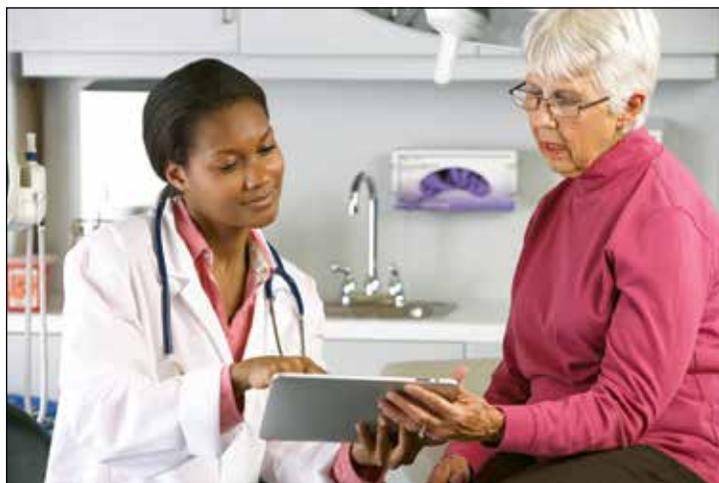
The population is aging at an exponential rate. Older adults are vulnerable to suffer from multimorbidity and iatrogenesis at higher rates than younger adults. Geriatric providers have specialized training to evaluate and treat geriatric syndromes that can help prevent or ameliorate frailty, sarcopenia, disability, and functional decline. However, there is a growing shortage of healthcare practitioners with an expertise in geriatric care. It is, therefore, important to train other primary care providers to identify early signs of decline and implement strategies to help older adults to age successfully. One strategy is to leverage the Welcome to Medicare and Medicare Annual Wellness Visits (MAWV). These visits were

designed with the intent to provide aggressive, safe, and effective primary and secondary prevention strategies for older adults. These visits are reimbursed at higher rates than the standard follow-up visit and are billed using the codes G0438 for the initial Welcome to Medicare visit (average reimbursement \$172.00, payable only once per lifetime) and G0439 for the subsequent MAWV (average reimbursement \$111.00, payable every 12 months).

There are three components to the MAWV:

- 1) healthcare risk assessment (or as we know it in the geriatrics world: the geriatric assessment)
- 2) provider consultation
- 3) personalized prevention plan.

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SLU Geriatricians Recognized as BEST DOCTORS 2016

Congratulations to the physicians in the Department of Internal Medicine who were recognized as Best Doctors. This year Saint Louis University has more than 170 SLUCare physicians recognized by Saint Louis Magazine as best doctors of 2016. Geriatricians honored include:



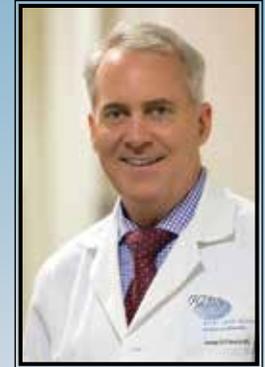
Dr. John E. Morley



Dr. Gerald Mahon



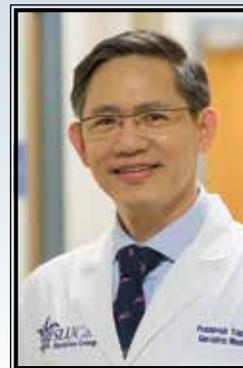
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EDITORIAL

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The Need to Educate Health Professionals in Care of Older Persons

Health care is complicated and, in no place is this more so than in the care of older persons. Besides often having multimorbidities, older persons often have specific geriatric syndromes, *e.g.*, frailty, sarcopenia, anorexia of aging, and cognitive dysfunction, which alter the presentation of diseases and also require to be managed individually.

The problem created by the uniqueness of older persons is compounded by a shortage of geriatricians and allied health professionals with specialist training in gerontology. At present, there is one geriatrician for every 2,546 persons over the age of 60 years. By 2030, there will only be 1 for every 4,254! Compounding this is that geriatricians are the lowest paid physicians, making fewer and fewer physicians enthused about becoming geriatricians.

To overcome this deficit, it is essential that primary care health professionals receive increased training in the approach to the care of older persons. Many physicians and other health professionals received minimal training in gerontology during their education. In an attempt to overcome this deficit, the Bureau of Health Professionals at the Department of Health and Human Services has provided interprofessional training in geriatrics through the Geriatric Education Centers and, more recently, the Geriatric Workforce Education Program (GWEP). These programs provided and are providing a minimal amount

of training to equip health care professionals with tools to care for older persons.

Besides an extensive interprofessional training program, we, at Saint Louis University, have developed the Rapid Geriatric Assessment (RGA) tool (see page 5) to enable health professionals to assess older persons for geriatric syndromes and completion of advance directives. In Missouri, over 5,000 older persons have been screened for these syndromes by an interprofessional workforce, resulting in the finding that over 20% of older Missourians have at least one of these syndromes that is not being treated appropriately.

In Perry County, Missouri, this educational effort has led to widespread screening and the development of a special exercise program for those with sarcopenia and cognitive stimulation therapy for persons with moderate Alzheimer's. We look forward to continued funding for these important education events, so that our older citizens can get optimal cost-effective care as they journey through their third age.



John E. Morley, MB, BCh

Dr. Morley offers a daily geriatric nugget via Twitter. Follow him @meddocslu.



John E. Morley

Medicare Annual Wellness Visit

(continued from page 1)

Table 1. Medicare Wellness Visit		
Task	How to Do	Completed By
Schedule Patient	Follow scripts	Call Center Schedulers with assistance from Office Manager
Determine Eligibility	Ask when last completed Check with Medicare Contractor	Call Center Schedulers with assistance from Office Manager
Information Package	Mail	Call Center Schedulers with assistance from Office Manager
Verify Computer Information	Medication List Family History Patient History Social History Immunizations List of Physicians	Medical Assistant and Nurse
Update New Content	Vital signs sitting/standing Height, weight, BMI Rapid Geriatric Assessment (RGA) Patient Health Questionnaire (PHQ-2) Do you smoke? Do you drink alcohol? Home safety Do you have sex? Last colonoscopy/mammogram	CPN, RN, MA
Summary of Visit	Lifestyle interventions Personalized prevention plan	MD/DO/NP/PA
Billing	Diagnosis code V70.0; Initial Annual Wellness Visit G0438; Subsequent Annual Wellness Visit G0439	Office Manager



Medicare Annual Wellness Visit

(continued from page 4)

Short, validated tools that can be used by any member of the health-care team can be incorporated into a standardized protocol to quickly identify geriatric syndromes and other risks to health and wellness. In this article, I outline an algorithm (Figure 1, see page 16) and specific provider task list (Table 1, see page 4) that can be adopted by clinics and healthcare systems to efficiently integrate the MAWV into the provider workflow.

A clinic wishing to take advantage of this Medicare benefit will first need to establish a protocol for scheduling patients. Typically, this phase is handled by the call center schedulers with support from the clinic manager. When making appointments for the MAWV, it is important to use scripts to guide the schedulers and patients. There are sample scripts available¹ but each clinic or system should tailor the script to their unique needs and patient populations. The first step is to determine eligibility. One does this in two ways:

- 1) Electronically using 270/271 inquiries through the practice management software. This route is better for batch inquiries, for example, if a clinic would like to offer this service to a large group of existing patients.
- 2) Through the online provider service portal offered by the Medicare administrative contractor, which is better for infrequent inquiries, such as when a single patient calls requesting a MAWV. It is critical to determine if the patient has had the initial visit billed at any point in his lifetime because this code can only be used once and if the bill is rejected, the clinic will

Figure 2



Saint Louis University

Rapid Geriatric Assessment*

*There is no copyright on these screening tools and they may be incorporated into the Electronic Health Record without permission and at no cost.

ID#: _____ Sex: _____ Age: _____ Primary Care Provider Y / N

Ethnicity (circle): African/Am Asian Caucasian Hispanic Non-Hispanic



The Simple "FRAIL" Questionnaire Screening Tool

Fatigue: Are you fatigued?
Resistance: Cannot walk up one flight of stairs?
Aerobic: Cannot walk one block?
Illnesses: Do you have more than 5 illnesses?
Loss of weight: Have you lost more than 5% of your weight in the last 6 months?

Scoring: 3 or greater = frailty; 1 or 2 = prefrail

From Morley JE, Vellas B, Abellan van Kan G, et al. J Am Med Dir Assoc 2013;14:392-397.

Total FRAIL Score: _____

SARC-F Screen for Sarcopenia (Loss of Muscle)

Component	Question
Strength	How much difficulty do you have in lifting and carrying 10 pounds? Scoring: None = 0 Some = 1 A lot or unable = 2
Assistance in Walking	How much difficulty do you have walking across a room? Scoring: None = 0 Some = 1 A lot, use aids or unable = 2
Rise from a Chair	How much difficulty do you have transferring from a chair or bed? Scoring: None = 0 Some = 1 A lot or unable without help = 2
Climb stairs	How much difficulty do you have climbing a flight of ten stairs? Scoring: None = 0 Some = 1 A lot or unable = 2
Falls	How many times have you fallen in the last year? Scoring: None = 0 1-3 Falls = 1 4 or more falls = 2

Total score of 4 or more indicates Sarcopenia

From Malmstrom TK, Morley JE. J Frailty and Aging 2013;2:55-6.

Total SARC-F Score: _____

SNAQ (Simplified Nutritional Assessment Questionnaire)

<p>My appetite is</p> <p>a. very poor b. poor c. average d. good e. very good</p> <p>When I eat</p> <p>a. I feel full after eating only a few mouthfuls b. I feel full after eating about a third of a meal c. I feel full after eating over half a meal d. I feel full after eating most of the meal e. I hardly ever feel full</p>	<p>Food tastes</p> <p>a. very bad b. bad c. average d. good e. very good</p> <p>Normally I eat</p> <p>a. Less than one meal a day b. One meal a day c. Two meals a day d. Three meals a day e. More than three meals a day</p>
--	--

Scoring: a=1, b=2, c=3, d=4, e=5.
A score ≤14 indicates significant risk of at least 5% weight loss within 6 months.

From Wilson et al. Am J Clin Nutr 2005;82:1074-81.

Total SNAQ Score: _____

Rapid Cognitive Screen (RCS)

1. Please remember these five objects. I will ask you what they are later.
[Read each object to patient using approx. 1 second intervals.]
Apple Pen Tie House Car
2. [Give patient pencil and the blank sheet with clock face.] **This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.**
[2 pts/hr markers ok; 2 pts/time correct]
3. **What were the five objects I asked you to remember?**
[1 pt/ea]
4. **I'm going to tell you a story. Please listen carefully because afterwards, I'm going to ask you about it.**

Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then topped work and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.
What state did she live in? [1 pt]

SCORING

8-10..... Normal
 6-7..... Mild Cognitive Impairment
 0-5..... Dementia

From Malmstrom TK, Voss VB, Cruz-Cliver DM et al J Nutr Health Aging 2015;19:741-744.

Total RCS Score: _____

Advance Directive

Do you have an advance directive? Y/N

Revised 8/15/2016

Medicare Annual Wellness Visit

(continued from page 5)

lose the revenue for that visit. If it has been established that the visit is a follow-up, the scheduler will need to ascertain if the G0439 code has already been used by another provider within the last 12 months².

When the patient has been scheduled for a MAWV, it is recommended that a standardized packet be mailed to the patient with information on what to expect at the MAWV and forms that the patient can complete in advance to save time in the office. The latter may be particularly important for new patients to the clinic as existing patients will already have much of the information available in the chart for the providers to review and update.

The patients should be asked in advance to bring in the following information:

- Medical, surgery, and family history. Having this information readily available will help to more quickly input and review it in the clinical chart.
- Full medication list, including over-the-counter and supplement medications
- List of healthcare providers and durable medical equipment suppliers
- Immunization record

- Record of screening tests (colonoscopy, mammogram, abdominal US, DEXA, chest CT, etc.)

When the patient arrives for her or his appointment, a member of the team will perform the standardized MAWV assessment, which serves as the basis for the individualized recommendations that will be given by the physician or advanced prac-

itioner. This portion can be done by anyone under direct (in house, not in room) supervision of physician or advanced practitioner. I recommend the use of a medical assistant, licensed practical nurse, or registered nurse for this purpose. There are required elements of the MAWV that MUST be incorporated into this assessment.^{3,4} These are:

Figure 3. FRAIL-Nursing Home Scale

	0	1	2
Energy	Good/Excellent	Fair	Poor
Transferring	Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable.	Needs help in moving from bed to chair or requires complete transfer	Needs help in moving from bed to chair or requires complete transfer & KATZ score <3
Mobility	Goes out	Able to get out of bed/ chair but does not go out	Bed or chair bound
Continence	Exercises complete self-control over urination and defecation	Is partially or totally incontinent of bowel or bladder	Is partially or totally incontinent of bowel or bladder & KATZ score <3
Weight Loss (last 3 months)	No weight loss.	1-3 kg (between 2.2 and 6.6 lbs) or does not know	>3 kg (6.6 lbs)
Feeding	Gets food from plate into mouth without help. Preparation of food may be done by another person.	Needs partial or total help with feeding or requires parenteral feeding	Needs partial or total help with feeding or requires parenteral feeding & KATZ score <3
Dressing	Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	Needs help with dressing self or needs to be completely dressed.	Needs help with dressing self or needs to be completely dressed & KATZ score <3..
Total Score 0-14: 0-1 non frail, 2-5 frail, 6-14 severely frail			



Medicare Annual Wellness Visit

(continued from page 6)

1. Vital signs sitting and standing
2. Height, weight, BMI, waist circumference
3. Evaluation of functional status
4. Safety screen
5. Cognitive evaluation
6. Evaluation of mood

The Saint Louis University Rapid Geriatric Assessment (RGA, Figure 2, see page 5) combines several brief, reliable, validated tools that provide early detection of common geriatric problems, track changes over time, and has nearly all the elements required for the MAWV. Educational materials to train on the use of the RGA can be found on the Gateway GEC website: aging.slu.edu. In addition to the elements of the RGA, I recommend screening for depression using the PHQ-2 and asking the following additional safety questions:

1. Do you smoke?
2. How many alcoholic beverages do you drink a week?
3. Do you feel safe at home?
4. Do you have sex?
5. Have you had accidents or gotten lost while driving?

Once the assessment portion of the visit is completed, the patient is given his personalized prevention plan.^{3,4} This is the only part that MUST be done by a physician (MD/DO), advanced practitioner (NP/PA), or licensed healthcare provider (e.g., pharmacist, health educator, or registered dietician) under direct (in clinic) supervision of the physician⁵. This person reviews all the data collected from the patient and at the assessment, creates a risk factor list, creates an age-appropriate screening schedule (see Table 2), and gives personalized health advice and a written prevention plan (PPPS). Advanced care plan-

Table 2. Recommended Screening Tests

SCREENING	RECOMMENDATION	RECOMMENDING BODY
Colorectal cancer screening	Yearly FOBT, 5 years sigmoidoscopy, 10 year colonoscopy age 50-75	USPSTF More specific recommendations by ACS*.
Annual mammography	Yearly age 45-55 Biennially age 55-75	ACS USPSTF
Bone density determination	Every 2 years DEXA women >65; men and younger women if high risk	USPSTF National Osteoporosis Foundation
Annual low-dose CT Chest for lung cancer	Age 55 to 80 years with 30 pack-year smoking history, currently smoke or quit <15 yr	USPSTF
Abdominal ultrasound for Abdominal Aortic Aneurism	One time only Male, age 65-70, history of smoking	USPSTF
Prostate cancer screening	Age 40-50 high risk Age 50+ DRE+PSA	ACS
	Recommend AGAINST	USPSTF
Hepatitis C and HIV	1-time screening for HCV infection to adults born between 1945 and 1965. HIV screening if high risk	USPSTF
Hearing and Vision	Depends on comorbidities	USPSTF

FOBT = fecal occult blood testing
 USPSTF = United States Preventative Services Task Force
 ACS = American Cancer Society
 DEXA = dual energy x-ray absorptiometry
 DRE = digital rectal exam
 PSA = Prostate Specific Antigen
 *<https://www.cancer.org/cancer/colon-rectal-cancer/detection-diagnosis-staging/acs-recommendations.html>

Medicare Annual Wellness Visit

(continued from page 7)

ning discussions are an optional part of the MAWV. You MAY bill for CPT codes 99497 and 99498 BUT deductibles and Co-insurance fees must be waived.⁶ Some providers and clinics choose to have the patient return for a second advanced care planning visit.

At the MAWV, a FOCUSED exam is performed only as necessary. A physical exam is not a required component of the visit. It is critical that patients understand the purpose of the MAWV in advance of the appointment. The goal is not to manage acute or chronic medical conditions. If a patient wishes to have an acute medical problem addressed, it needs to be clearly explained that this portion of the encounter will be billed separately and the patient may be responsible for co-pays or other deductibles.

Although the MAWV was not originally designed for non-clinic settings, we have successfully incorporated these visits into our nursing home population with the assistance of the facility staff to identify eligible patients. The RGA was modified in this setting to include the FRAIL-Nursing Home (FRAIL-NH) scale (see Figure 3 on page 6), which was validated to identify people at high risk of mortality, functional decline, falls, and hospitalizations over 6-12 months.⁷⁻⁹

Completing MAWVs in the nursing home setting can help medical providers and facilities ensure compliance with vaccinations (a 5-star requirement), begin advance directive discussions with caregivers, and identify residents who would most likely benefit from hospice end-of-life care. A toolkit was created to assist nursing home providers to complete MAWVs, meeting all requirements (Figure 4).

In conclusion, the MAWV is an important tool for general practice providers to increase revenue and adequately evaluate for and treat geriatric syndromes to improve outcomes for older adults. Currently underutilized, algorithms and tools exist to help practices to efficiently incorporate MAWV into their workflow. Visit aging.slu.edu for more information and video.



Resource List

1. Cuenca AE. Making Medical Wellness Visits Work in Practice. *Fam Pract Manag*. 2012 Sep-Oct;19(5):11-16. <http://www.aafp.org/fpm/2012/0900/p11.pdf>
2. How to Bill Medicare's Annual Wellness Visit (AWV). <https://www.acponline.org/practice-resources/business-resources/payment/medicare/how-to-bill-medicares-annual-wellness-visit-awv>
3. The ABCs of the Annual Wellness Visit (AWV). [Figure 4. SLU Annual Medicare Wellness Visit](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-

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SLU Annual Medicare Wellness Visit
 Nursing Home _____

Name _____ DOB ____/____/____ Date ____/____/____

Vital Signs: Ht _____ Wt _____ BP ____/____/____ Pulse _____ RR _____

Vaccinations: Influenza Y/N ____/____/____ Pneumococcus Y/N ____/____/____ Prevnar Y/N ____/____/____ Tetanus Y/N ____/____/____	Date Hepatitis B Y/N ____/____/____ Herpes Zoster Y/N ____/____/____ PPD Y/N ____/____/____
---	---

Active Diseases:	Medications:
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____
6. _____	6. _____
7. _____	7. _____
	8. _____
	9. _____
	10. _____
	11. _____
	12. _____
	13. _____
	14. _____

PHQ 9 _____	Hearing Impaired Y/N _____	9. _____
FRAIL _____	Cerumen Impacted Y/N _____	10. _____
FRAIL NH _____	Vision Impaired Y/N _____	11. _____
Pain Score _____	Falls Y/N _____	12. _____
SARC-F _____	Smoking Y/N _____	13. _____
SNAQ _____	Weight Loss Y/N _____	14. _____
RCS _____	Advance Directive Y/N _____	

A Scale to Identify Frailty in the Nursing Home - FRAIL NH Scale

	0	1	2
Fatigue	No	Yes	PHQ-9 ≥ 10
Resistance (Transfer)	Independent Transfer	Set Up	Physical Help
Ambulation	Independent	Assistive Device	Not Able
Incontinence	None	Bladder	Bowel
Loss of Weight	None	≥ 5% in 3 mo.	≥ 10% in 6 mo.
Nutritional Approach	Regular Diet	Mechanically Altered	Feeding Tube
Help with Dressing	Independent	Set Up	Physical Help
TOTAL			0-14

Assessment: Patient had annual wellness visit. Agree with findings. Pt is cognitively intact/ impaired, not frail, not falling, not disabled. Pt and/or family counseled.

Recommendations: _____

Signature _____ G0439

Network-MLN/MLNProducts/downloads/AWV_chart_ICN905706.pdf

4. Medicare Learning Network. Annual Wellness Visit (AWV), Including Personalized Prevention Plan Services (PPPS). 2011. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7079.pdf>
5. Frequently Asked Questions from the March 28, 2012 Medicare Preventive Services National Provider Call: The Initial Preventive Physical Exam and the Annual Wellness Visit. <https://www.cms.gov/outreach-and-education/outreach/npc/downloads/ippe-awv-faqs.pdf>
6. Medicare Learning Network. Advance Care Planning (ACP) as an Optional Element of an Annual Wellness Visit (AWV). 2015. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9271.pdf>
7. Kaehr E, et al. FRAIL-NH Predicts Outcomes in Long-Term Care. *J Am Med Direc Assoc* 2015; 17(3):826
8. Kaehr E, et al. Frailty in Nursing Homes: The FRAIL-NH Scale. *J Am Med Direc Assoc* 2014; 16(2):87-89
9. Luo H, et al. Predicting Adverse Health Outcomes in Nursing Homes: A 9-Year Longitudinal Study and Development of the FRAIL-Minimum Data Set (MDS) Quick Screening Tool. *J Am Med Direc Assoc* 2015; 16(12): 1042-47.

Aerogerontology: Comparing Human and Airplane Aging

By John E. Morley, M.B., B.Ch.



There are many similarities between the lifespan of humans and airplanes. Beginning with the design of the airplane followed by its manufacture which mimics the creation of a human from a genetic blue print, followed by their growth. In general, human beings live longer than airplanes – 80 years to about 35 years. However, part of the new composite designs are looking to extend airframe longevity and the magnificent B52 bombers have been in service for 60 years and are expected to fly for another 25 years.

As in humans, evaluation and maintenance of an airplane is key to its longevity. In airplanes most evaluation of the fuselage is done by non-distractive testing. This includes visual, liquid penetrant, magnetic, ultrasonic, Eddy current and radiographic techniques. These techniques are looking for cracks in the fuselage which need to be fixed early.

This was a lesson learnt early when 3 of the de Havilland comet jet liners in 1953 and 1954 broke up in the air shortly after takeoff – these incidents became known as the story of the ill-fated comets that crashed like “a ball of fire and wingless.” These incidents lead to a major overhaul of jet aircraft design and also maintenance

(equivalent to preventive medicine in humans).

Overall aircraft stress, which leads to metal fatigue and cracks occurs predominantly at take-off and landing. Modern airplanes are built to tolerate 47,500 to 110,000 of these cycles. Aluminum, the most lightweight, malleable metal, has been used to manufacture most airplanes. Recently, composites are being used to replace aluminum. Composites are strong, flexible, handle tension well, allow single-piece designs and weigh less than aluminum. All of these are advantages for fuselage design and allow airplanes to carry more passengers.

The major reason for fatigue and cracks in the airplane fuselage is oxidative damage (corrosion). This is also a major reason by humans wear out with aging. In humans satellite cells repair the damage that occurs. In some cases, specialized cell systems, such as those in bone, strengthen and repair areas that are exposed to excess stress or are damaged. The osteocytes are mechanosensors that recognize when excess stress is applied to the bone. They also recognize cracks in the bone. The osteocytes can activate osteoclasts which clear damaged bone and osteoblasts that build new

bone. Composite manufacturers are experimenting with ways for cracks in the fuselage to be automatically repaired as they occur. One method is for racks to cause release of epoxy resin and amidoamine which then mix to repair the crack. Microcapsules can release dicyclopentadiene to interact with a ruthenium catalyst as another method to repair cracks.

Problems Faced by Older Humans While Flying

A major problem faced by older persons when flying is pulmonary embolism. The decreased air pressure in the cabin while flying increases the chance of persons developing clots in their leg veins. Older persons often have sarcopenia (muscle loss) decreasing the ability of the muscles to pump blood through the legs. This is further aggravated by the cramped space in airplanes limiting leg movement. Varicose veins and increased coagulability in older persons further increase the chances of forming blood clots.

Fortunately, as increased composite use occurs, this will allow increased cabin air pressure.

The reduced air pressure with lower oxygen saturations and the ex-

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Aerogerontology

(continued from page 9)

pansion of gas in the body can make persons with lung and heart disorders more likely to run into trouble on long trips. Sharing bacteria and virus in the cramped quarters of a plane is more common and older persons who may have a reduced immune system are more likely to get sick. The uncomfortable seats in planes can aggravate pain from osteoarthritis. During turbulence an elderly passenger walking to the bathroom has an increased risk of falls. Jet lag can be a major problem for some older persons who already have sleep disturbances.

Pilot Fatigue

Pilot error is the cause of over three quarters of disastrous aviation accidents. Pilots aged 60 years need

10 x more light in the cockpit than at 45. Fatigue is a major problem. This is particularly a problem in pi-



lots with sleep apnea, which is now screened for in the pilot medical exam. Over age 65 there is a measurable decrease in reaction time and decision making. Finally, psychological disorders such as depression can cause pilots to make major

errors as occurred recently on the German Wings Flight.

Conclusion

A new field in aviation industry is developing. This is the design of planes to decrease or fix aging damage of the plane, but also to redesign planes to decrease the risks to the increasingly more aging passengers.

This field is called aerogerontology, and we can expect it to blossom over the next decade. I was fortunate to attend the first meeting on this subject between Airbus experts and gerontologists in Toulouse last year.

Dr. Morley previously posted this article on LinkedIn <https://www.linkedin.com/in/dr-john-morley-b55a584a/>.

Nursing Home Research International Working Group
October 13-14-15, 2017 - St. Louis, USA

October 13-14-15, 2017 • St. Louis, USA

Meeting place: **Saint Louis University Learning Resources Center**
3545 Vista Ave., St. Louis, MO 63104 USA

For oral communication and poster
Call for abstracts: deadline June 26, 2017

www.nursing-home-research.com





Geriatric Workforce Enhancement Program Announces 2017 Geriatric Leadership Scholars

The Geriatric Workforce Enhancement Program (GWEP) provides the opportunity for three faculty each year to be selected from colleges and universities across Missouri to participate in the Geriatric Leadership Scholars Program. This GWEP initiative is aimed at developing competent gerontology faculty who have the skills to teach and assess students and is key to improving future care for older adults. To develop healthcare faculty with expertise in geriatrics and gerontology, the Geriatric Leadership Scholars Program provides support for three health care faculty to enhance their geriatric knowledge and skills. Scholars participate in and lead GWEP education events. Each of the Scholars are paired with a Gateway GEC Faculty Mentor who works with the Scholar throughout the year to address teaching, research, and program development issues.

THE 2017 GERIATRIC LEADERSHIP SCHOLARS INCLUDE:



Devita Tarell Stallings, Ph.D., MSN, RN, Saint Louis University School of Nursing

Devita Tarell Stallings, Ph.D., MSN, RN, is an Assistant Professor in the Saint Louis University School of

Nursing. A member of the nursing faculty since 2013, Dr. Stallings's research focuses on helping adults reduce cardiovascular health disparities by understanding and improving exercise, diet, and medication adherence self-management behaviors. Dr. Stallings' experiences in emergency department nursing have guided her interest in public health nursing in which she can work to address health care needs of vulnerable populations. She was recently recognized for her work with the American Heart Association Multicultural Health Initiative.

Devita Tarell Stallings, Ph.D., MSN, RN



Angela Sanford, M.D., Saint Louis University School of Medicine Division of Geriatrics

Angela Sanford, M.D., is an Assistant Professor of Internal Medicine at the Saint Louis University School of Medicine in the Division of Geriatrics. Dr. Sanford is engaged in research examining hip fractures in older adults. Her clinical practice includes caring for older adults in the hospital, outpatient, and nursing home settings.

Angela Sanford, M.D.



Jamie Koerner, PharmD., BCPS University of Missouri—Kansas City School of Pharmacy at MU

Jamie Koerner, PharmD., BCPS, is a Clinical Assistant Professor in the School of Pharmacy at University of Missouri-Kansas City a satellite program at University of Missouri (Columbia campus). Dr. Koerner's work includes serving as a member of an interprofessional Senior Assessment/ Geriatric Evaluation (SAGE) Clinic in

Jamie Koerner, PharmD, BCPS

Columbia where she assesses the appropriateness and safety of the patient's medications.



Geriatric Workforce Enhancement Program: A Year of Innovations

In July 2015, the Gateway Geriatric Education Center (GEC) was awarded federal funding from the Health Resources and Services Administration through the Geriatric Workforce Enhancement Program

iversity, Kirksville and Washington University, St. Louis), community health systems (Perry County Memorial Hospital, Perryville; SSM Health; Myrtle Hilliard Davis Health Center and St. Louis County Health Depart-

ment, St. Louis), Northside Youth and Senior Services, St. Louis; Health Resource Center, St. Louis; Alzheimer's Association, St. Louis; and four Area Health Education Centers (East Central, Southeast, Southwest, and Northeast regions).
frailty, sarcopenia, nutritional, and caregiver well-being assessment, our GWEP has developed a multi-faceted approach that creates pathways to assessment and intervention in common geriatric syndromes. Two initiatives are underway that not only enable students and practitioners to gain competence in assessing and treating older adults, but are also providing services for older adults and their families in the community.

First publicized in the 2016 issue of this newsletter, the Rapid Geriatric Assessment (RGA) (See pg.5) which provides data for the older adult and primary care provider with validated assessment of frailty, sarcopenia, nutritional needs, and cognitive status has now been administered over 5,000 times throughout Missouri in community-based health screening events, in residential communities, out-patient settings, in-patient acute care settings, and an event at the Missouri State Fair. The RGA has also been integrated into the health records systems of several area organizations, including a number of departments within the SLUCare system, Perry County Memorial Hospital, Myrtle

(GWEP) to provide interprofessional education and training for students, faculty, and practitioners in caring for older adults and their family and care networks. Now in the second of three years of funding, the Saint Louis University GWEP team, in collaboration with our community and university partners, have made significant process toward the goals of improving geriatric care in Missouri. Several of our initiatives are described in detail within this issue of Aging Successfully with our progress toward fully implementing our innovative initiatives are highlighted here.

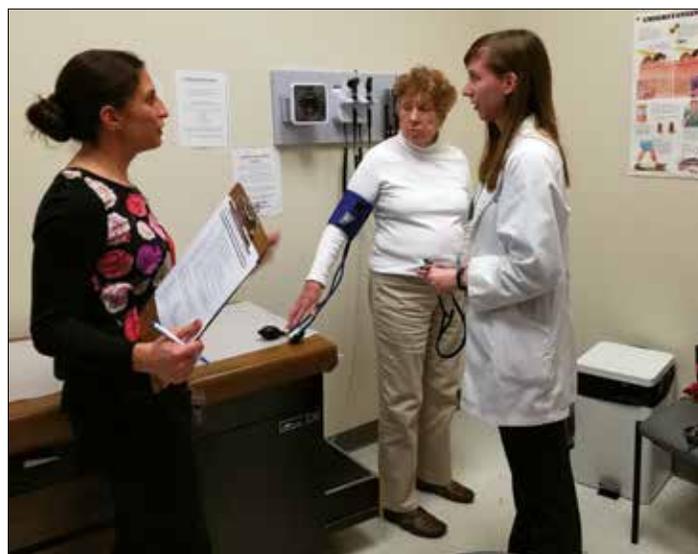
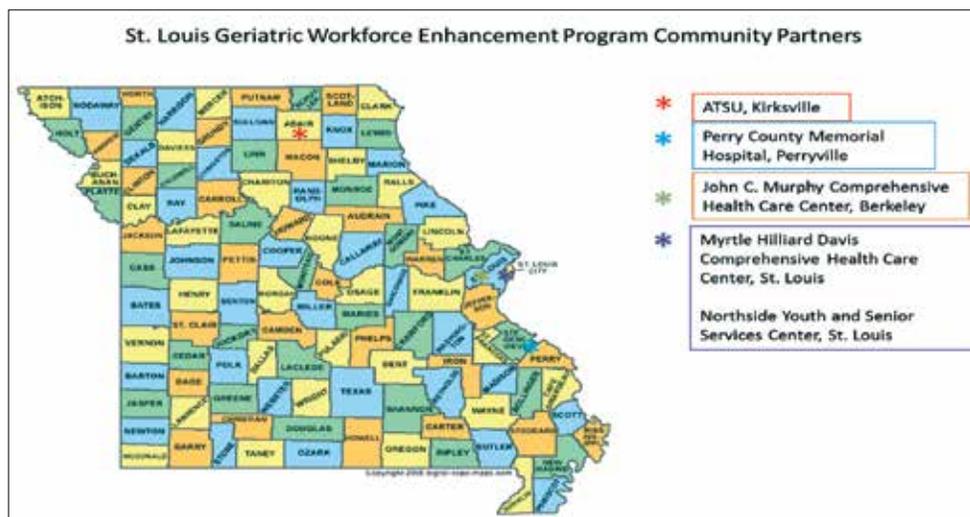
Our success in working for improved health and social service care for older adults in primary care settings is possible only through the efforts of our community and university partners that are located throughout Missouri. As indicated in the map inset, GWEP's partners include universities (A.T. Still Uni-

ment, St. Louis), Northside Youth and Senior Services, St. Louis; Health Resource Center, St. Louis; Alzheimer's Association, St. Louis; and four Area Health Education Centers (East Central, Southeast, Southwest, and Northeast regions).

The goals developed for GWEP are ambitious and far-reaching, but successes abound in each of the areas outlined in the original proposal, and are highlighted here:

Interprofessional Geriatric Education

In striving to reach our goal of providing students and practitioners with interprofessional clinical training in dementia,



A Year of Innovations *(continued from page 12)*

Hilliard Davis, and St. Louis County Health Department.

Training students and practitioners on using the RGA has expanded across a number of settings and educational institutions. At Saint Louis University, students from medicine, nursing, occupation, physical, and speech therapies, social work, medical family therapy, and interprofessional education receive training on the RGA along with the opportunity to administer the assessment in a clinical setting. Students from Washington University School of Social Work, A.T. Still University, University of Missouri—Kansas City and St. Louis, and Maryville University have also been introduced to the RGA. In total, 1,999 students have been trained, far exceeding our original goal of 1,100! To learn more about the RGA, visit the GEC website at: aging.slu.edu. For more information on scheduling a training or a screening, send an email to aging@slu.edu.

Our second clinical education initiative, the Interprofessional Geriatric Assessment Clinic (GAC), was launched in February with students and faculty from medicine, occupation, physical, and speech therapies, nutrition and dietetics, and social work collaborating to provide a comprehensive assessment of older adults (age 65 years and older) and their care partner. The GAC is a partnership with the SLU Health Resource Center, a free student-led multi-clinic service. Patients for this new clinic may be self-referred or referred by a health or social service provider. The clinic is held the first Thursday of each month starting at 1:30 p.m. at the HRC, located at 1408 N Kingshighway Blvd., #213, St. Louis, MO 63113. To refer a patient or make an appointment, call Sue Brooks at 314-977-8462.

GWEP interprofessional education initiatives extend beyond the classroom and clinical settings. GWEP faculty have organized two Interprofessional Graduate Geriatric Case Competitions (see article on page. 22) with students and faculty from more than ten different professions and five universities participating in a month-long experience in which students develop an interpro-



fessional plan of care which is then presented to a panel of faculty judges.

The third cohort of GWEP Geriatric Leadership Scholars has now been selected and will begin on July 1, 2017, for a year-long experience. See page 11 to learn about the current cohort of Scholars. Each Scholar is paired with a GWEP faculty mentor to deepen her or his expertise in geriatric research or curricular development, participates in GWEP clinical activities, and shares his or her work with others through presentations. Our Scholars are conducting research in such areas as end-of-life care in nursing facilities around the world, Cognitive Stimulation Therapy, and physical therapy with older adults in the community.

We are pleased to report that the combined efforts of many SLU faculty over a number of years has resulted in the approval of an Interprofessional Graduate Certificate in Gerontology. Launching in Fall 2017, students and professionals from the community can complete the 12-15 credit hour certificate program by selecting courses in medicine, nursing, social work, occupational and physical therapy, nutrition and dietetics, law, health care ethics, medical family therapy, communication sciences and disorders, public health, and communication. For more information on this new program, contact Dr. Cara Wallace at wallacecl@slu.edu.

With the introduction of the Medicare Annual Wellness Visit (MAWV) into primary and geriatric health care, GWEP faculty have responded to a need for professional training. GWEP faculty Drs. John Morley and Milta Little and Nurse Practitioner Patricia Abele have developed a protocol to guide the completion of the MAWV (on pages 16-17).

Specialized Training Programs

While identifying physical and cognitive health concerns in older adults is the first step in competent geriatric care, being able to offer interventions is critical, but often the missing piece of the comprehensive geriatric care plan. GWEP faculty and students have been hard at work in the past year developing

specialized training for professionals to be able offer programming in three areas that can aid older adults in optimizing the aging experience. While all three programs will be presented as workshops at the 28th Annual Summer Geriatric Institute, highlights are presented here:

Cognitive Stimulation Therapy (CST)—GWEP faculty and partners continue to expand the training and delivery of CST, a validated non-pharmacologic intervention for persons with dementia. Over 571 students, faculty, and professionals have participated in CST training. Since introducing CST to the area, Saint Louis University faculty, staff, and students along with community partners at Perry County Memorial Hospital and A.T. Still University have delivered training across the U.S., developed on-line learning modules, introduced a course on Individual CST (iCST)

communication Sciences and Disorders) and Max Zubatsky (Medical Family Therapy) and their graduate students are offering CST groups, while Drs. Marla Berg-Weger and Sue Tebb (School of Social Work) and Dan Stewart, social work doctoral student, are studying the impact of iCST on persons with dementia and their caregivers. To read about iCST, see the story on page 29 and to learn more about CST, visit our CST page at aging.slu.edu. To inquire about training, email aging@slu.edu.

Exercise and Strengthening—GWEP faculty members Kelly Hawthorne and Jill Fitzgerald, Department of Physical Therapy, have developed a training curriculum for exercise and strengthening to prevent falls and sarcopenia that can be offered in community or residential setting. Training is available in-person or on-line at aging.slu.edu.

Caregiver Well-Being and Support—GWEP faculty Dr. Sue Tebb (School of Social Work) and Geriatric Leadership Scholar, Dr. Max Zubatsky (Department of Family & Community Medicine Medical Family Therapy Program) will be debuting at the Summer Geriatric Institute the Caregiver Well-



Being and Support training that utilizes the HRSA-produced Caregiver Training modules. The curriculum provides a session-based approach to facilitating a caregiver support group. To learn more about this new training, see the article on page 23. A training video will soon be available at aging.slu.edu.

Looking Forward to the Future

As this update on GWEP activities conveys, our GWEP team and partners continue to engage our students, faculty, partners, and professionals in education and training to transform the primary health care community. Our goal remains to provide the best possible health and social service care for the oldest members of our society. As we plan for the upcoming year, our focus will be on further integrating the Rapid Geriatric Assessment into the health systems in our region, disseminating the training that has been developed in Cognitive Stimulation Therapy, Exercise and Strengthening, and Caregiver Well-Being and Support, and graduating students who will be well prepared to serve older adults.

To stay current on GWEP initiatives, visit us at aging.slu.edu. You may also check us out on:

- Facebook: <https://www.facebook.com/GatewayGEC/>
- YouTube: <http://www.youtube.com/c/GatewayGeriatricEducationCenterstl>
- Twitter: @GatewayGEC, @drjohnmorley, and @meddocslu
- LinkedIn: Search for Dr. John E. Morley



for medical students, integrated CST into coursework for social work, communication sciences and disorders, and medical family therapy students, and conducted research to examine the applicability of the U.K.-developed intervention within a U.S.-based population. Here at Saint Louis University faculty members Dr. Whitney Postman (Com-

Advance Care Planning: Creating a Climate for Critical Self-Reflection

By Cara Wallace, Ph.D., LMSW

Advance care planning (ACP) for end-of-life care has a renewed public interest with the recent popularity of Atul Gawande's best-selling book on end-of-life care,¹ national debates surrounding current death with dignity legislation, and publicity surrounding The Conversation

of ACP and preparing for the end of life,⁶ the process is fraught with both professional and personal barriers. On the professional side, physicians report barriers such as language or medical interpretation issues, patients' limited health literacy, patients' mistrust of the health care

each of us has a history that tells a story about how and why we chose to pursue the degree and career path we did. Our early experiences on this path contribute to this story and the shaping of an individual to a clinician. Maybe, there are clues within this history that have the power to impact how we interact with patients and families in ACP.

In an autobiography written as he was faced with his own terminality,¹² Dr. Paul Kalanithi recounts many of the professional experiences that taught him about working with patients on the brink between life and death:

"Amid the tragedies and failures, I feared I was losing sight of the singular importance of human relationships, not between patients and their families but between doctor and patient. Technical excellence was not enough. As a resident, my highest ideal was not saving lives—everyone dies eventually—but guiding a patient or family to an understanding of death and illness."

Dr. Kalanithi's reflections allowed him to connect his professional experiences with his personal life, enabling him to be clearer about not only what he wanted in his own healthcare, but also as a skilled clinician, how to communicate with patients and family members about wishes of their own. This reflective process is one that few of us engage in, but that likely has direct relevancy to how we practice direct patient care.

In a current, ongoing study with SLU colleagues, Drs. Dulce Cruz and

(continued on page 21)



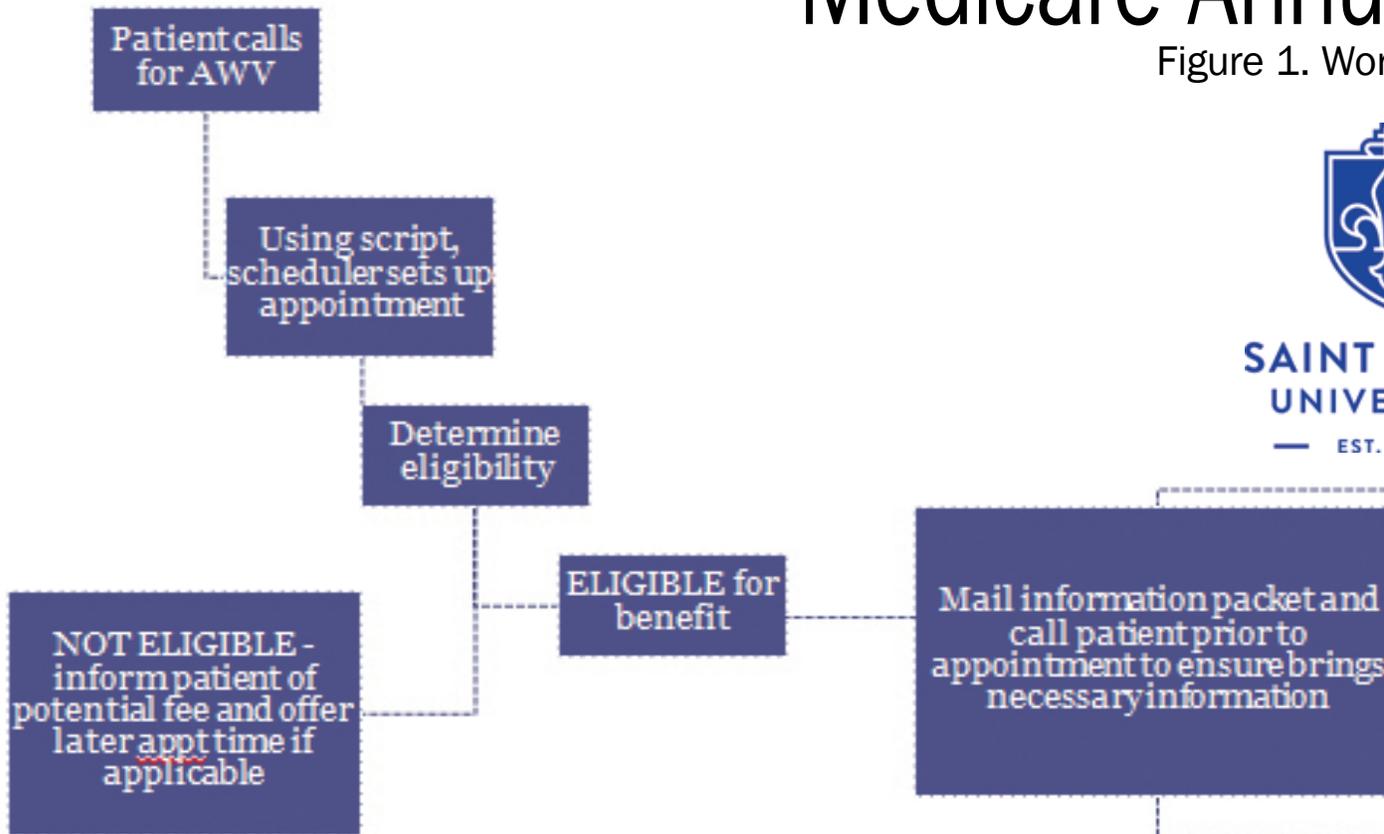
Project,² a movement which encourages everyone to have conversations about their end-of-life wishes. Beginning in January 2016, Medicare now reimburses physicians and other qualified health care providers for voluntary ACP sessions with patients and their families.³ While these are encouraging signs that, as a culture, we are becoming more comfortable with conversations surrounding end-of-life care, in practice, many providers do not always talk to their patients about ACP, even when opportunities emerge in a clinical visit.⁴ When communication does occur, the quality and content of these conversations varies.⁵

Though practitioners overwhelmingly agree on the importance

system, and a lack of understanding about patients' cultural or religious beliefs surrounding death, dying and decision-making.⁷ Other reported barriers include lack of knowledge about available services, lack of training, and lack of standardized criteria for referrals.^{8,9} On the personal side, even physicians do not have formal conversations about their own ACP with their own providers and families,¹⁰ citing lack of time as a primary reason for why communication and completion have not occurred.¹¹

As a provider, you can perhaps see yourself within these barriers and you already recognize ACP as a potential area for improvement in working with patients. For others, maybe this is less on your radar. Yet,





Dark blue: call center schedulers with assistance from office manager

Teal: MA/LPN/RN

Light blue: MD/DO/NP/PA

Orange: office manager

Upon rooming patient, perform assessment (see box insert)

Physician, NP or PA review all the data, create screening schedule, risk factor list, and gives personalized health advice and holds advance directives discussion. FOCUSED exam only as necessary



Annual Wellness Visit

Workflow Algorithm



LOUISIANA STATE UNIVERSITY
1818

Recruit existing patients for AWW

Determine Eligibility

Call patients using script to schedule appointment

VS sitting and standing

Height, weight, BMI, waist circumference

RGA

PHQ-2

Do you smoke?

How many alcoholic beverages do you drink a week?

Do you feel safe at home?

Do you have sex?

Age-appropriate screenings

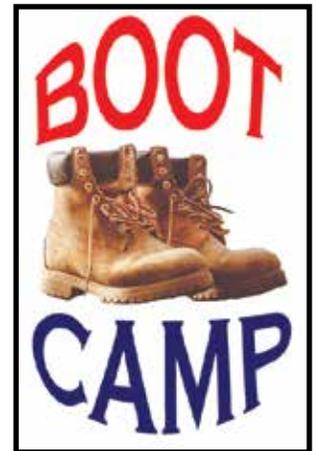
MA or Nurse inputs or updates Med/Sx/Famhx, medication list, list of providers and medical suppliers, immunization record

Bill: Diagnosis code V70.0; Initial Annual Wellness Visit G0438; Subsequent Annual Wellness Visit G0439



The Division of Geriatric Medicine along with SSM and SLUH, invited Diane Meier, M.D., FACP, Director of the Center to Advance Palliative Care to present a state-of-the-art presentation entitled: **Meeting the Needs of Older Adults with Senior Illness: Challenges and Opportunities in the Age of Health Care Reform.**

On October 29, 2016, the Division of Geriatric Medicine held its annual Geriatrics Boot Camp Educational series for residents and physicians. There were 12 attendees from Family and Internal Medicine programs from Saint Louis University, St. Mary's Health Center, University of Illinois - Belleville, and University of Illinois - Springfield. Presenters included **Drs. Milta Little, John Morley, Angela Sanford, and Miriam Rodin.**



For information contact Sue Brooks 314-977-8462.

CONGRATULATIONS

to our Division of Geriatrics faculty on a number of accomplishments and honors:

Drs. Dulce M. Cruz-Oliver and Milta O. Little have been promoted to Associate Professor of Medicine.

Congratulations also to **Dr. Dulce M. Cruz-Oliver** on her appointment as a Fellow in the American Geriatrics Society and being named as one of 50 physicians to receive the designation of Fellow of the American Academy of Hospice and Palliative Medicine (FAAHPM).



Dr. Cruz-Oliver

The 2016 Caris Healthcare Leadership Development Institute meeting was held on October 18, 2016 in Murfreesboro, Tennessee. **Milta Little, D.O.**, serves as the medical director for the St. Louis office which was named the 2016 West Region Office of the Year.



Dr. Little

Edited by **John E. Morley, MB, BCH**, and managed by **Valerie Tanner**, the Journal of the Medical Directors Association is now ranked Second Among Geriatrics/Gerontology Journals, having become the second most cited journal in Thomson Reuters' Geriatrics/Gerontology category.



Dr. Morley



Dr. Berg-Weger

Marla Berg-Weger, Ph.D., LCSW, Professor of Social Work and Executive Director, Gateway Geriatric Education Center, has been elected to serve a 3-year term as the Chair-Elect/Chair of Social Research and Public Policy, one of the 4 sections of Gerontological Society of America which has 5500+ members.



Dr. Rodin

Miriam B. Rodin, M.D., Ph.D., has been appointed Deputy Editor of the *Journal of the American Geriatrics Society*.



SLU Launches New Graduate Interprofessional Gerontology Certificate Program

By Cara Wallace, Ph.D., LMSW

Through the collaborative efforts of multiple academic units and the Gateway Geriatric Education Center, approval was received in October 2016 to offer a new university-wide Graduate Certificate in Interprofessional Gerontology (GIGC). Beginning in Fall 2017, this innovative opportunity will be available to Saint Louis University graduate students and community professionals. The GIGC is a formal academic award (as defined by the U.S. Department of Education) conferred by the University upon the successful completion of all requirements. This certificate is for post-baccalaureate students across disciplines who wish to pursue a gerontology-related career. The GIGC consists of 12 credit hours, attendance at SLU's Geriatric Education Center Summer Institute, and a discipline-specific practicum with older adults. For community members not currently enrolled in an active degree program, the practicum can be waived with gerontology-related practice experiences.

The GIGC builds upon courses already offered at SLU across a number of departments allowing students to take elective coursework outside of their own academic program. The goal is for students to achieve an interdisciplinary education alongside peers from various fields which they will encounter in the workforce. The following SLU programs and departments are currently involved and/or supportive of the GIGC program:

- Albert Gnaegi Center for Health Care Ethics
- College for Public Health and Social Justice
- Department of Communication

- Department of Communication Sciences and Disorders
- Department of Health Management and Policy
- Department of Family and Community Medicine; Medical Family Therapy Program
- Department of Nutrition and Dietetics
- Department of Occupational Science and Occupational Therapy
- Department of Physical Therapy and Athletic Training
- Division of Geriatrics, School of Medicine, Gateway Geriatric Education Center
- School of Law
- School of Nursing
- School of Social Work

The certificate program will aid in addressing the increasing need for health and social service professionals to care for our older adult population. U.S. Census data indicates older adults currently comprise 14.1% of the population, a number that will increase to 27%

by 2050.¹ As the population of older adults increases, so does their projected longevity, racial/ethnic diversity, rates of poverty, potential for being childless and/or single, and number of chronic illnesses. In 2011, the CDC reports that 80% of all older adults had at least one documented disability or chronic illness and half had two or more.² At least one chronic illness is reported by 95% of older Missourians, while 80% experience at least

two and 65% have at least three.³ Each of the above factors has the potential to increase older adults' risk for compromised health and impact older adults' quality of life and ability to age-in-place, thus prompting the need for competent, person-centered health and social care providers.

With the passage of the Affordable Care Act,⁴ care coordination and interdisciplinary care teams were identified as important to improving health outcomes, preventing hospitalizations, and reducing the cost of care for older adults. This certificate program will train individuals to be part of such teams. The certificate curriculum is designed using the Association for Gerontology in Higher Educa-



tion's (AGHE) Gerontology Competencies for Undergraduate & Graduate Education as a guide. AGHE is a well-established organization consisting of experts in aging throughout the US, Canada, and abroad, whose goals are to: "1) advance gerontology and geriatrics education in academic institutions; and 2) provide leadership and sup-

(continued on page 20)



GIGC Program

(continued from page 17)

port of gerontology and geriatrics education faculty and students at education institutions.”⁵

Employment of gerontology-related health care workers are all projected to grow faster than the average across all occupations. See the chart above for projected growth in select occupations.

Each of these identified professions need workers trained in gerontology, as highlighted by the Department of Labor Statistics. “Healthcare social workers will continue to be needed to help aging populations and their families adjust to new treatments, medications, and lifestyles,”⁶ and “occupational therapists...help senior citizens maintain their independence” and are also needed in healthcare settings to assist with patients with chronic conditions.⁷ Similarly, physical therapists will be needed to care for adults who are remaining more active later in life. Older adults are now also “more likely to experience heart attacks, strokes, and mobility-related injuries that require...rehabilitation.”⁹ These same health conditions will also contribute to speech or language impairments requiring speech-language pathologists.¹⁰ “Psychologists will also be needed to provide services to an aging population, helping people deal with the mental and physical changes that happen as they grow older.”⁸ The

growth of an aging population will also “increase the need for dietitians and nutritionists in nursing homes” in addition to baby-boomers looking for ways to stay healthy creating “more demand for dietetic services.”¹¹ Finally, registered nurses will be at the forefront of caring for older adults who “typically have more medical problems than

younger people.”¹²

The GIGC directly aligns with SLU’s Jesuit tradition and mission. Older adults are a vulnerable population in great need of coordinated services and care. With the shortage of healthcare workers identified to fill the workforce in this area,⁶⁻¹² Jesuits’ mission to help “where the need is

Projected Growth From 2014-2024

Healthcare Social Workers ⁶	19%
Occupational Therapists ⁷	27%
Psychologists ⁸	34%
Physical Therapists ⁹	34%
Speech-Language Pathologists ¹⁰	21%
Dieticians and Nutritionists ¹¹	16%
Nurse Practitioners ¹²	16%

greatest” is particularly relevant. The holistic, interdisciplinary approach of the certificate program also aligns with a focus on “the whole person.”

Available gerontology-focused courses are matched to identified AGHE competencies and students are required to complete a course within each of the following three competency areas: Foundational Competencies to All Fields of Gerontology, Interactional Competencies Across Fields of Gerontology, and Contextual Competencies Across Fields of Gerontology (Well-being, Health and Mental Health; Social Health; and Policy). Students are allowed to take these courses as they fit into their schedules as long as they complete the curriculum grid and take courses from at least two different departments in completing the certificate program. This enhances students’ opportunities to learn from interdisciplinary perspectives.

In order to demonstrate achievement of learning outcomes, students will work with their advisors to link

chosen course assignments (papers, projects, exams, etc.) to each outcome. These assignments will be culled into a final portfolio which will be submitted upon completion of the certificate. The portfolio will be assessed by the student’s academic advisor and the Gerontology Certificate Coordinator (GCC), using a standard program rubric. GIGC learning outcomes include the following:

1. Utilize gerontological frameworks to examine human development and aging.
2. Relate psychological theories and science to understanding adaptation, stability and change in aging.
3. Identify comprehensive and meaningful concepts, definitions and measures for well-being of older adults and their families.
4. Engage, through effective communication with older persons, their families and the community, in personal and public issues in aging.
5. Employ knowledge of older persons’ strengths and adaptations to maximize well-being, health and mental health

To learn more about this new program, contact Cara Wallace, GIGC Coordinator, at 314-977-2746 or wallacecl@slu.edu.

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Advanced Care Planning

(continued from page 15)

Jennifer Ohs, we are examining potential connections between:

- 1) practitioners' personal and professional history with loss;
- 2) their own completion of (and communication about) advance directives; and
- 3) attitudes and current practices surrounding ACP and referrals to hospice and palliative care.

Initial analysis of nearly 180 health care practitioners (physicians, nurse practitioners, RNs, social workers and others) demonstrates strong correlations between a person's history of loss (both professionally and personally), completion and communication about one's own directives, and his/her attitudes and practices in professional ACP. Our experiences are inexplicitly connected with how we practice.

Though many of us respectively received training on separating our beliefs, emotions, and experiences from professional practice, we have less understanding and practice with acknowledging the connections between them, or how to handle the inevitable impact of the personal on the professional. In a text examining emotional and countertransference responses in palliative and end-of-life care,¹³ clinician Renee Katz posits the following:

"We propose that our professional work...is extremely personal in nature, that we are profoundly influenced by our patients and their families as much as they are impacted and influenced by us, and that our emotional responses do impact the clinical moment—whether we want them to or not, whether we are aware or not, whether we can admit it or not."

More than likely, each of us is concerned about assisting our patients with planning for their end-of-life care though many barriers remain.



Perhaps the place to start is not just in having the conversations within our own lives, but also in exploring how our own experiences and emotions shape our practices and preferences, both personally and professionally. Maybe it is within this critical self-reflection where we can find meaningful connection to the stories of our patients, and perhaps then we can engage in more effective advance care planning for all of us.

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Interprofessional Teamwork Improves Care for Older Adults

By Helen Lach, Ph.D., RN, RNL, FGSA, FAAN

Students from Saint Louis University, Washington University, A.T. Still University, and Maryville University participated in the 2nd Interprofessional Case Competition. Teams were charged with developing a plan of care for a complex geriatric patient which was then presented to a panel of faculty judges from multiple universities and professions. Nearly 100 students in nine disciplines participated in this innovative program, based on a model developed at A.T. Still University, Kirksville, Missouri.

As interprofessional practice is the hallmark of geriatric care, enabling students to participate in an experiential learning opportunity such as the Competition is critical to their future practice. Many older adults have complex problems best approached with interprofessional expertise. Most health professionals do not learn about the expertise of other team members as each is educated separately, learning the methods and professional terminology of their discipline. Ideally, health professionals begin learning to work together during their educational experiences to gain comfort as they move into practice.

As the focus of our GEC is to strengthen knowledge of interprofessional geriatric care, the Interprofessional Geriatric Case Competition provides a forum for students to learn about aging in a team experience to build skills for practice. The case competition design is based on the Interprofessional Education Collaborative² core competencies for interprofessional teamwork:

- 1) Work with individuals of other professions to maintain a climate of mutual respect and shared values;
- 2) Use the knowledge of one's own role and that of other professions to appropriately assess and address the healthcare needs of patients and to promote and advance the health of populations;
- 3) Communicate with patients, families, communities and professionals in health and other fields in a responsive and responsible manner that supports a team approach to the promotion and maintenance of health and the prevention and treatment of disease; and
- 4) Apply relationship-building values and the principles of

team dynamics to perform effectively in different team roles to plan, deliver, and evaluate patient/population-centered care and population health programs and policies that are safe, timely, efficient, effective, and equitable.

In reflecting on the team simulation, students reported feeling positive about being submerged in a team, gaining insights into other professionals, advocating for patients and families, and of the respect and communication shown. All students said they would recommend the experience. Look for the 3rd Geriatric Case Competition in fall of 2017, open to any health professions students in the region. For more information, contact aging@slu.edu.

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The Hidden Patient in Integrated Care

Addressing the Health Concerns of Dementia Caregivers

By Max Zubatsky, Ph.D. and Susan Tebb, Ph.D.

Navigating through the challenges of the healthcare system is a daunting task for a first-time caregiver. Just ask Stacey. As a daughter of a newly diagnosed mother (Judy) with dementia and tending to her recovery from shoulder surgery, Stacey's life became complicated quickly, all while having her only child leaving for college soon. Throughout the initial appointments with her mother's primary care physician, Stacey was offered little support, services, or resources. When a social worker was brought into one of these appointments, Stacey wanted the professional to hear her concerns about the future of the caregiving process. Instead, the social worker provided psychoeducation-focused information to the family about what signs and symptoms to look for in dementia during the following months. Judy was later referred to a geriatrician from a different clinic. This provider wanted Judy on a higher dose of Aricept, but never communicated this information to her primary care doctor or medical team. Stacey was not only confused as to the direction of her mother's care, but had no information that can help manage her life as both a daughter and caregiver.

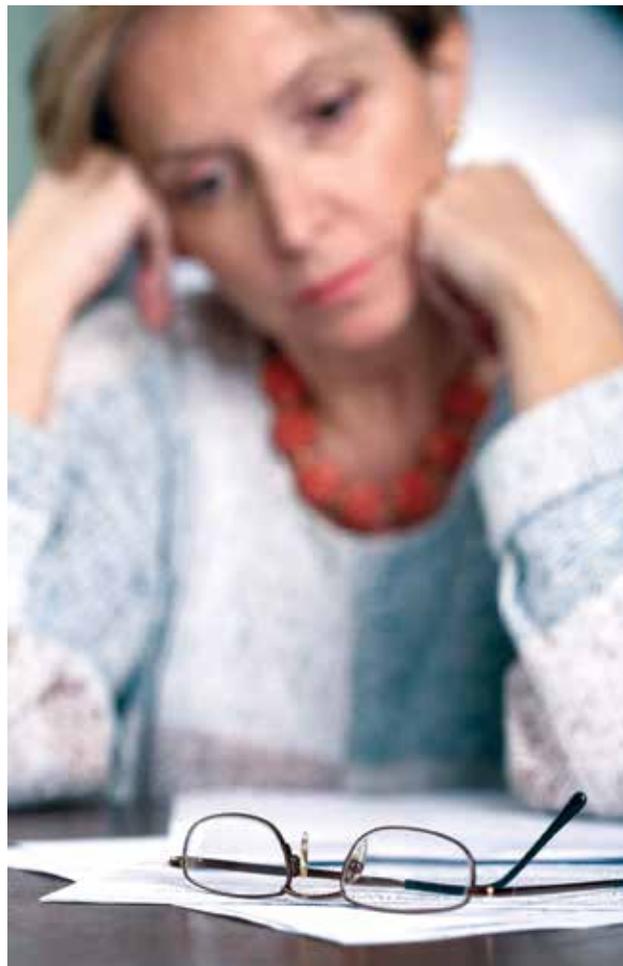
Stacey is not an outlier in the struggles that dementia caregivers endure. Dementia caregivers are often seen as the "hidden patients" in our healthcare system, as they are at risk for increased emotional, psychological and physiological problems over time.¹ Given that a large proportion of patients with dementia are first detected in primary care,² the referral options and strategies after the diagnosis are often disjointed.³ Families who are not part of the care process

may continually see loved ones re-admitted to the hospital multiple times for preventable reasons. Furthermore, behavioral health and other social service entities are not brought into the treatment process until it is too late. As a result, finding effective methods for managing the behavioral and psychological symptoms of caregivers is a public health and economic priority.⁴

The evidence for an integrated, family-centered approach to dementia care is essential for a number of reasons:

1) A wide range of overlapping conditions often present with dementia. Healthcare providers need to assess further for other biopsychosocial issues that often present in this population. Physicians and behavioral health professionals often overlook the family caregiver(s) and systemic problems that exist around dementia (e.g., communication, boundaries of outside family, and aiding daily physical activity). Many patients often go undiagnosed with depression months after a diagnosis, where caregivers may assume that isolation or flat mood might be signs of just the dementia.

2) Most dementia diagnoses are incurable, and thus debilitating on the family as a whole. Because Alzheimer's disease and other dementias are progressive disorders, family members must continually prepare



for increased services and needs of the care-recipient. Conversations with caregivers and support systems must be continual as their loved ones progress through certain dementia stages. Families must also communicate as to who is involved in the caregiving team, whether in-town or long-distance. All family members should also have a list of providers included on the patient's care team.

3) Many individuals with dementia require consistent monitoring over time for safety issues. As symptoms of dementia progress, issues such as driving, fall risk and daily eating become concerns

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Hidden Patient *(continued from page 21)*

that families should speak with healthcare providers about. Patients who lack consistency in attending healthcare appointments often have greater risk of safety and fall issues. Many caregivers are unaware of the resources on safety available from the Alzheimer's Association, AARP, and other organizations and websites that provide resources for aging.

4) As the disease progresses, the compounding physical and mental health issues of caregivers leads to increased risk of earlier mortality. Caregivers are often overlooked in the initial appointments after a diagnosis of dementia is made. If not caught early, areas such as depression, anxiety, insomnia, pain, and weight problems of the caregiver often exacerbate over time. Providers must be aware that caregivers often do not come forward with their health complications, sacrificing their needs for the sake of their loved one's condition and therefore healthcare providers must ask about them.

5) Advances of treatment for dementia may improve survival, but also increase length of care and time needed to provide resources. As older adults have an increased risk for chronic health issues, they are also living longer. Caregivers of persons with dementia often need to be prepared for the "long haul" in the time and resources set aside for their loved one. Additionally, caregivers must weigh the options of living situations throughout the course of the disease and what transition of care options will entail emotionally and financially.

Those who work with caregivers and families of individuals with dementia often struggle with specific interventions to address the strains and burdens of the disease. The following are models and approaches

that may help guide healthcare providers in offering more formalized integrated care services to caregivers.

Telephone-Assisted Programs

The challenges of effectively coordinating services for families of dementia in primary care are well known. Traditional dementia intervention programs for families have often been staff intensive and require a significant amount of time to see members face-to-face. To address the barriers and access to care issues for caregivers, a collaborative care management intervention has been piloted to offer support to individuals over the phone.⁵ An assigned care manager is the direct link to the caregiver, care recipient, PCP and resource team, offering resource options to these areas while receiving continual feedback. This model produces positive outcomes for caregivers regarding access to care options, follow-up communication with professionals and community links to resources. Although the model was established through the Veterans Administration, this streamline of communication and direct resources can apply to a number of sites where providers see older adults.

REACH I and II Projects

Along with the physical burdens of dementia come the challenges of individuals remaining in their homes longer and improving the safety of their living environment. REACH (Resources for Enhancing Alzheimer's Caregivers Health) provides caregivers one-to-one counseling and education about ways to manage their loved ones living situation. Care specialists at clinics and organizations develop a personalized approach to find solutions for caregivers around depression, caregiver stress, home safety and social support services in

times of crisis. The REACH-II project is a modified version of the original approach, designed to promote active problem solving skills and reduce a sense of burden in caregivers. In addition to the REACH interventions, providers offer a series of in-home and telephone sessions that tailor the specific needs of the caregiver and the stage of disease of their loved one.⁶

The Scott and White Family Caregiver Program

Although patients with dementia receive adequate care in hospitals and inpatient settings, the lack of continuity between providers and families upon discharge is concerning. Even in primary care settings, caregivers receive little information after dementia diagnosis is received. The Scott and White Family Caregiver Program (FCP)^{7,8} addressed this area of concern, where patients with dementia and their families are identified through both electronic medical records and primary care provider referral sources. The program was adapted from the REACH-II program, but can be applied to a number of healthcare settings. A set of developmental activities were offered to caregivers and families by the staff and would be the first point of contact for any referral sources. These activities included a Caregiver's Notebook (series of nine sections for caregivers to read) and a Family Profile (tailored to address the risks/needs of the family in caring for the patient).

Saint Louis University (SLU) and the Gateway Geriatric Education Center (GEC) also offer a number of valuable resources for caregivers and healthcare professionals alike. The Caregiver Tools and Education section on the GEC website (<http://aging.slu.edu/index.php?page=caregiver-tools-education>) now offers a series of

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caregiver videos, covering topics such as practice strategies for professionals, end of life decision-making and caregiver stress in the Latino population. This site also includes a training manual for facilitators looking to start a dementia caregiver support group.

Professionals can even download a copy of the Rapid Caregiver Well-Being Scale.⁹ Additionally, a new Memory Clinic is now available for individuals, caregivers and family members to receive comprehensive services at SLU.

On Monday mornings, the Center for Counseling and Family Therapy at SLU will provide therapy services, caregiver groups, cognitive stimulation therapy and free geriatric screenings. For more information on SLU-based resources, visit aging.slu.edu.

Caregiver stress has now become a population health issue, where an estimated 43 million Americans are now caring for someone with a chronic illness or disability.¹⁰ Policymakers, funders

and researchers will need to see the greater role that family caregivers provide and recognize their value. The short-term investments we make to provide services and support to caregivers at any stage will produce long term health benefits.



As healthcare looks to shift into an integrated care model, providers need to remember to integrate family members and patients into the healthcare team for the treatment process of disease and illness.

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WHAT YOU CAN DO TO SLOW AGING



By John E. Morley, M.B., B.Ch.

Human beings tend to peak in their function at 30 years and then decline in every function at the rate of ½ to 1% per year. Thus, preventing aging starts at a young age. While the pearls of aging successfully described here are aimed at persons 60 and older, most of them are equally valid at all ages.

In the last decade there has been an increased awareness of the importance of Person-Centered Care. Most older persons have a number of diseases (co-morbidities) and geriatric syndromes which put them at risk for polypharmacy and can modulate the approach to treatment. Your physician needs to be aware of these interactions and work with you to create an optimal quality of life for years. Many geriatric syndromes have easily treatable causes, e.g., frailty – sleep apnea, hypothyroid, depression, hypotension, and vitamin B₁₂ deficiency; anorexia of aging – depression, medications, nosocomial infections, endocrine disorders, celiac or pancreatic disease, and gallstones; cognitive dysfunction – sleep apnea, atrial fibrillation, depression, anticholinergic drugs, endocrine disorders, hearing and vision problems, and infections. All these geriatric syndromes are responsive to lifestyle changes. In the case of recognizing hypotension and which blood pressure to treat in most persons, ambulatory (home) blood pressure should be obtained. At Saint Louis University we have developed the RAPID GERIATRIC ASSESSMENT which health

professionals can use to rapidly identify early onset of geriatric syndromes (aging.slu.edu).

The lifestyle interventions most appropriate are exercise and a Mediterranean type diet. Exercise clearly decreases cardiovascular disease, improves muscle function preventing diabetes, sarcopenia, and frailty, and may positively influence cognitive function. The exercise component should include resistance and balance exercises as well as aerobic exercises. Exercise becomes even more important when an older person has mobility impairment or multiple hospitalizations.

The optimum diet for an older person is five helpings of fruit and vegetables (one could be replaced by nuts). The secret ingredient in fruit is the polyphenols which my group has recently shown are potent memory enhancers. Similarly, extra virgin olive oil (up to 1 liter a week) decreases cardiovascular disease and enhances memory. Besides eating salads a vegetarian dish of fish paella (the great Catalan dish) is an excellent way to get sufficient vegetables. I always double the suggested amount of olive

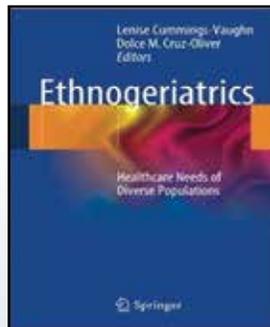
oil to the online recipes for paella. In addition, one should have fatty fish (salmon, tuna) at least 2 to 4 times a week. Fish contains the healthy omega-3 fatty acids, eicosapentanoic and docosahexanoic acid. One or two glasses of alcohol a night will do no harm (unless you are an alcoholic) and may be beneficial. A recipe for making a martini with olive oil is available online. Other olive oil based cocktails are Alligator Alley, Basil Exposition, Oliveto, and Phaedon.

The best way to get vitamin D is to spend about 30 minutes each day in the sun. If you cannot do this, take no more than 1,000 IU of vitamin D daily. Higher doses may cause problems for some persons. Do not measure your vitamin D as the measurement is useless without knowing your vitamin D binding protein. Remember that taking a multivitamin does no good and may do some harm. Get your vitamins from fruits.

It is important to remember that in older persons weight loss is often bad. There are many reasons for this, but a major one is that loss of weight leads not only to a loss of fat, but also muscle and bone increasing the older

New Edition of Ethnogeriatrics Textbook Published

Ethnogeriatrics: Healthcare Needs of Diverse Populations, Lenise Cummings-Vaughn, M.D., and Dulce M. Cruz-Oliver, M.D., (eds), Springer: Switzerland, 2017. Contributors from Saint Louis University Division of Geriatric Medicine include: **Dulce M. Cruz-Oliver, M.D.** "Impact of Immigration: Disease Exposure and Health Maintenance" (with co-author Sandra Sanchez-Reilly, M.D.) and "Hospice/Palliative Care: Concepts of Disease and Dying"; **Milta O. Little, D.O.** "Policy: Impact on Delivery and Access; and **Miriam B. Rodin, M.D.** "How to Study Ethnogeriatrics from the Global to the Local."



WHAT YOU CAN DO TO SLOW AGING

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person's vulnerability to hip fractures and sarcopenia.

Other ways to slow aging are to maintain socialization and brain activity, have appropriate vaccinations (Note: a new shingles vaccine should be available this year and it appears much better than the present one), and undergo screenings where appropriate, e.g., ultrasound for males who smoked to look for an abdominal

aortic aneurysm, colonoscopy, mammogram, etc.

Finally, at least for persons with diabetes, there is emerging evidence that METFORMIN (a \$2 a month drug) may improve memory (see our letter to JAMDA - Liccini, *et al.* Metformin Use and Cognitive Dysfunction Among Patients with Diabetes Mellitus. *J Am Med Dir Assoc* 2016 Nov 1;17(11) 1063-5. doi: 10.1016/j.jamda.2016.08.026.) and may decrease mortality.

For more on how to extend your life you can go to the World Health Organization's "Good health adds life to years" (www.who.int/world-health-day/2012). This publication focuses on how to maintain your INTRINSIC CAPACITY as you age.

This article was previously posted on LinkedIn <https://www.linkedin.com/in/dr-john-morley-b55a584a/>



Lucy Hamm, Oldest Person in St. Louis. Photo provided by St. Louis Public Radio. For complete story, visit: <http://news.stlpublicradio.org/post/curious-louis-who-oldest-person-st-louis#stream/0>

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Robotics and Aging in Place

By John E. Morley, M.B., B.Ch.

For all of us aging in the 21st century we can be almost guaranteed of a robot in our future. The rapid advance in robotic technology and the desire of baby boomers to stay at home rather than to go to an assisted living or nursing home will increase the momentum to making home a safe place for the disabled and the cognitively impaired. Telemedicine is already here and for most of us it will clearly become the method of choice for a physician visit.

For those of us who cannot get out of bed, “Reba the Nurse” – a bear-like robot – is almost ready for prime time. She can safely whisk us out of bed and into a wheelchair or chair. Mobile toilets that can be summoned to the bedside by the patient will help to provide dignity and timely toileting. Japan has developed a toilet that can be worn by persons in bed and will evacuate feces and urine and wash and dry the patient’s bottom. Perhaps the most exciting invention is the “Smart Care Bed” which allows changing sheets without moving the patient, provides massage for the patient to prevent pressure ulcers, has a toilet/bidet system to allow toileting in bed and can be engineered to allow a bath to be part of the bed.

For feeding individuals, “My Spoon” is already in existence. A variety of entertainment robots such as “Aibo the dog” and “Paro the seal” have been shown to improve quality of life. Exercise robots to lead exercise sessions in nursing homes are also in existence. The Wii represents another robotic exercise system.

A variety of electronic detection devices exist that can monitor how long a person spends in bed, whether

they use the toilet or refrigerator, if they fall, if they have a change in walking speed or if they leave the house (and track them if they do). This approach has been used by Marilyn Rantz and team at Tiger Place in Missouri to develop the ability of older persons to be successfully monitored without having an intrusive individual checking up on them.

A number of robotic devices are being developed for rehabilitation, which reduce the need for one-on-one assistance from a physical therapist. The most exciting of these is the exoskeletons which can allow persons with paraplegia to walk.

Companionable is an EU research project that has created a mobile robot to act as a companion for older persons living at home. Besides providing companionship it monitors falls, can make emergency calls, provide reminders such as to take their medicine, store and make available objects such as keys, play cognitive stimulation games and act as a video communication with health care professionals, family and friends. The robot can also monitor physiological signs.

Mobiserv is another EU project that acts as a social companion; interacts with smart clothes that monitor

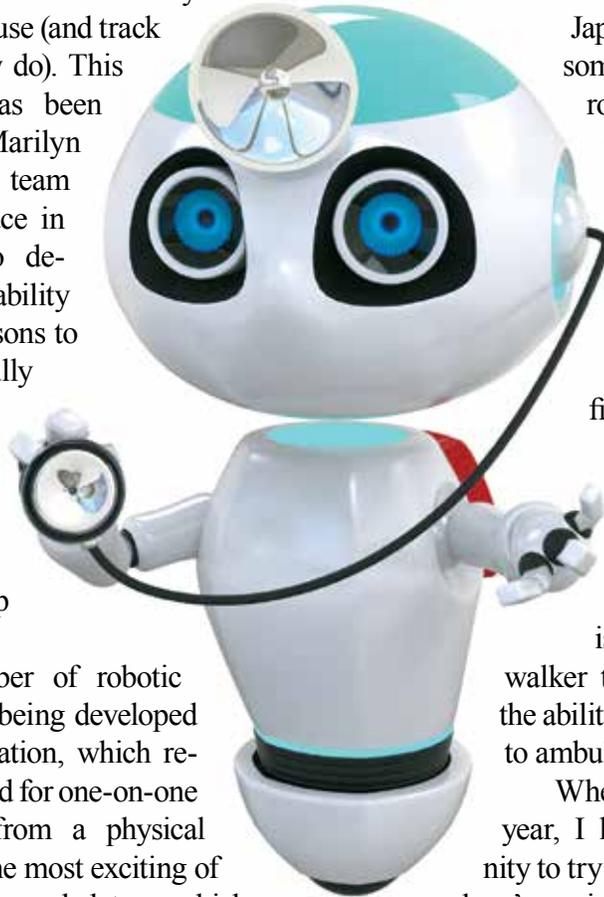
vital signs, falls and sleep patterns; and interacts with a smart home environment.

Japan has developed some humanoid robots, such as ChihiraAico and Pepper, which can respond to humans, show emotions and read to humans. The first set of 1,000 Peppers costing \$1,600 each sold out within the first hour. Encore Smart is an assisted walker that can enhance the ability of older persons to ambulate.

When in Japan last year, I had the opportunity to try out one of Cyberdyne’s assisted limbs. Most incredibly these limbs can move by picking up peripheral electrical impulses when the individual thinks of walking or moving a limb!

We are not yet at the level of the movie “Robot and Frank.” In this movie Frank, a cognitively impaired older person, was given a robot as a companion. Frank, who had spent most of his life robbing banks “convinced” the robot to help him rob a bank! However, companionable and Mobiserv are not that far away. It would appear that it is time that we all accepted that there will be an assistive robot in our future.

Dr. Morley previously posted this article on LinkedIn <https://www.linkedin.com/in/dr-john-morley-b55a584a/>.



Individual Cognitive Stimulation Therapy:

A Personalized Dementia Treatment By Daniel B. Stewart, MSG

The number of individuals developing dementia is rapidly increasing. A progressive and chronic illness in nature, a diagnosis can be devastating and daunting. While a cure remains unknown, health professionals and caregivers continuously seek effective and innovative treatment for persons with dementia. Historically, dementia has been seen and treated through a biomedical lens, changing attitudes towards dementia care have led to increased interest in more holistic forms of treatment. While pharmaceuticals continue to have their place in dementia care, innovative non-pharmacologic treatment options are gaining popularity.

Individual Cognitive Stimulation Therapy (iCST) is a one-on-one non-pharmacologic psychosocial intervention for individuals with dementia. Created by a team of researchers and clinicians at the University College London (UCL), iCST is largely based on Cognitive Stimulation Therapy (CST). Drs. Aimee Spector and Martin Orrell of the University College London created CST in the mid-2000s. Combining the most effective aspects of various non-pharmacologic interventions (e.g., reminiscence therapy, validation therapy, cognitive stimulation), CST was created to provide cognitive and social stimulation within a group setting (5-8 individuals) for persons with mild to moderate dementia. Over the last decade, CST has gained popularity across the United Kingdom and abroad. Along

with its increased utilization, there is an ever-increasing body of evidence regarding CST's effect on cognition and quality of life. In studies from teams in the UK as well as Saint Louis University GEC's own CST research and training team, group CST has shown to improve cognition, decrease depression, and improve overall quality of life. Therefore, building on the success of the group intervention, the UCL research team developed iCST and the subsequent manual, *Making a Difference 3: Individual Cognitive Stimulation Therapy* in 2014. iCST incorporates the principles and the structure of CST, however delivers it within a one-on-one model rooted in a person-centered perspective.

Person-Centered Care

While dementia care has been conceptualized from a medical point

of view and pharmaceutical interventions continue to be a mainstay of treatment, more and more families have expressed interest in non-pharmacologic options to replace or complement pharmaceutical interventions. This interest in non-pharmaceutical interventions for dementia goes hand-in-hand with a paradigm-shifting theory known as person-centered care.

Person-centered care refers to intervention that puts the "person" as the main focus of their care plan rather than the disease or service. Dementia care historically relied on the view of dementia as strictly a biomedical phenomenon. The traditional approach to dementia management involved assessment, diagnosis, and treatment guided by medical interventions and did not consider the personhood of the patient or the impact of the environment and the importance of

interpersonal relationships. In the 1993 seminal article, *Towards a Theory of Personhood in Dementia Care*, social psychologist Tom Kitwood revolutionized dementia care with his application of a "patient-centered" (e.g., "individualized") perspective on dementia care, thus setting the stage for a more holistic approach to dementia care in which not only physical health is promoted but also choice, opinions, and purpose.

Incorporating the principles of person-centered care, along with the most effective elements of non-pharmacologic interventions, the

(continued on page 30)

Table 1. Key Principles of Individual Cognitive Stimulation Therapy

- Mental stimulation**
- Developing new ideas, thoughts, and associations**
- Using orientation in a sensitive manner**
- Focusing on opinions, rather than facts**
- Using reminiscence as an aid to the here and now**
- Providing triggers to support memory**
- Stimulate language and communication**
- Stimulate every day planning ability**
- Using a 'person-centered' approach**
- Offering a choice of activities**
- Enjoyment and fun**
- Maximizing potential**
- Strengthening the relationship by spending quality time together**



UCL team created iCST with the intention of making a difference in the lives of people with dementia and their caregivers. Seeking to not only improve cognitive abilities but also quality of life, iCST was also intended to recognize value and personhood and reduce the long periods of inactivity often common for individuals with dementia.

iCST Key features

iCST has various key features that distinguish it from group CST as well as other non-pharmacological interventions. Most distinctively, iCST is delivered one-on-one with the same facilitator and participant as a means of cognitive stimulation and relationship building. iCST is appropriate for individuals with dementia whose caregivers wish to deepen their relationship, individuals who may benefit from one-on-one attention, and persons who do not wish to participate in a group setting or are no longer appropriate for a group CST intervention. Though iCST was envisioned with a familial caregiver in mind, the intervention is appropriate for paid caregivers as well as professionals to administer. What is important is that the same facilitator and participant can commit to administering the intervention.

Seventy-five sessions have been designed for administration three times a week over a 25-week time period. Ideally, iCST should be administered at the same time and place with each session being approximately 20-30 minutes and following the same structure throughout the 25 weeks. The format includes a welcoming, an opening discussion orientation to time and place, and reading and discussing a news article, followed by the main



Ruth and Rich Fleschner

iCST activity. Each iCST activity is based on a theme that is explicitly described in the manual. Session themes vary from physical games, art discussion, to using money. Within each activity are two levels of activities (level A and level B). Level B presents more cognitive challenge. Regardless of the activities theme, each of the sessions provides an opportunity for active engagement and stimulation.

In order to provide consistency and predictability for the individual with dementia, each iCST session follows the same format. At the outset, the administrator spends five minutes to introduce the session and orient the person to the task at hand. This warm-up can include a light snack, singing a favorite song, or engaging in an active game (such as a ball toss). During this time, the administrator can gauge the participant's alertness and receptivity. After a warm-up, the administrator then implicitly orients the participant to the day, weather, and season. This routine beginning of each session sets the stage for an engaging activity and time well spent.

After the introduction and orientation, the facilitator and participants spend time reading and discussing a current news article which is used

as a means to stimulate conversation, encourage opinion sharing and promote language use. By providing a new piece of information (such as a news article), participants are more inclined to show interest as well as give both facilitator and participant a novel topic to discuss. While "human interest" stories are always a crowd pleaser, Spector and colleague recommend not shying away from more controversial news stories.

When the introduction, orientation, and the news article discussion have been completed, the facilitator introduces the main activity outlined within the *Making a Difference 3* iCST manual. The main activity is structured to engage the participant in ways that pique interest. iCST recognizes that each individual possesses unique ideas, interests, experiences, and abilities that do not disappear with a dementia diagnosis. Though the manual outlines each activity with a set theme and accompanying task, the creators encourage the facilitator to adapt the activity to fit the needs and interests of the participant.

iCST Key Principles

iCST is grounded in many of the same key principles as CST. These key principles are crucial for understanding and administering the intervention. Each principle stems from a variety of different disciplines, theoretical frameworks, and clinical experiences. The creators of iCST find it is essential to understand and follow the thirteen key principles every session in order to successfully implement the intervention. Presented in Table 1, these key principles include ideas such as mental stimulation, encouraging new ideas, thoughts, and associations, using a 'person-centered' approach, and enjoyment and fun.



iCST Benefits

Evidence suggests iCST can improve the relationship between caregiver and care-recipient. Based on research from the University College London, cognitive function and quality of life outcomes have not been shown to significantly improve with iCST. Of note is the fact that these studies utilized familial caregivers who completed less than half of the required sessions. These findings suggest that iCST may be more beneficial when administered by a paid caregiver or a trained professional. Unlike some other non-pharmacologic interventions, iCST does not require a specific educational background or licensure. If an individual has an understanding of dementia and the disease process and a desire to learn about the inter-

vention and the person with dementia, she or he has the tools to be successful.

iCST and CST are evidence-based forms of cognitive stimulation. Person-centered, this non-pharmacologic intervention can provide potential cognitive and emotional benefit while offering a medium to socialize and improve language skills. The facilitator also experiences the benefit of deepening a relationship with the person with dementia as well as recognizing and seeing the person beyond their dementia. Through the use of the iCST manual as well as the GEC Train-the-Trainer iCST video (available at <http://aging.slu.edu/index.php?page=cognitive-stimulation-therapy-cst-project>), caregivers and professionals can learn more about this individualized cognitively stimulation

intervention. For additional information, email aging@slu.edu.

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28th Annual Saint Louis University Summer Geriatric Institute: Teamwork: Caring for the Person, Family, and Professional



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The Division of Geriatric Medicine at Saint Louis University School of Medicine and the Gateway Geriatric Education Center are pleased to present the 28th Annual Saint Louis University Summer Geriatric Institute. This year's event will focus on the team approach to caring for the person including their family, caregivers, and the professionals who provide the care.

Details & Registration available at <https://slu.cloud-cme.com/APH.aspx>



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Aging SUCCESSFULLY

Division of Geriatric Medicine
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This newsletter is a publication of:

Division of Geriatric Medicine
Department of Internal Medicine
Saint Louis University School of Medicine
Gateway Geriatric Education Center of Missouri
(Gateway GEC)

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U1QHP28716 Geriatrics Workforce Enhancement Program for \$843,079. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by the HRSA, HHS, or the U.S. Government.

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Previous issues of *Aging Successfully* may be viewed at <http://aging.slu.edu/agingsuccessfully>.

Some of the photos used in this issue are from www.istockphoto.com.

Moving?

So you won't miss an issue, please send your new email address or mailing address to aging@slu.edu.