An Approach to Managing Chronic Conditions in Older Adults
November 1, 2016
Mark Ensberg, MD
Linda J. Keilman, DNP, GNP-BC

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

Who are the Older Adults in the USA?

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

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

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

Unless otherwise indicated, sources of data are from the U.S. Census Bureau, the National Center for Health Statistics & the Bureau of Labor Statistics; data available from the AoA Profile of Older Americans: 2015
• Married: 70% men; 45% women
  – 34% older women are widowed
• ½ million grandparents 65+ had primary responsibility for their grandchildren living with them
• Average life expectancy:
  – Males = 76.4 years
  – Females = 81.2 years
• 72,197 persons aged 100 or >
  – Doubled the 1980 figure (32,144)

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

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

Social Determinants of Health

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Housing, Transportation, Safety</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social Integration</td>
<td>Health care</td>
</tr>
<tr>
<td>Income</td>
<td>Education</td>
<td>Language</td>
<td>Access to healthy options</td>
<td>Support systems</td>
<td>Coverage, Provider availability</td>
</tr>
<tr>
<td>Expenses</td>
<td>Early childhood education, Parks</td>
<td>Early Childhood education</td>
<td>Social determinant</td>
<td>Community resource</td>
<td>Preventive care, Cultural competency</td>
</tr>
<tr>
<td>Debt</td>
<td>Playgrounds</td>
<td>Vocational training</td>
<td>Discrimination</td>
<td>Services</td>
<td>Quality of care</td>
</tr>
<tr>
<td>Medical Bills</td>
<td>Workability</td>
<td>Higher education</td>
<td>Health status, Functional limitations</td>
<td>Access</td>
<td></td>
</tr>
<tr>
<td>Support</td>
<td></td>
<td>Retirement</td>
<td>Provider availability</td>
<td>Quality of care</td>
<td></td>
</tr>
</tbody>
</table>

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations
Heiman & Arigo, 2015

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

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

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

• Complex
• Last, or are expected to last, a year or longer
• Potentially limit what a person can do
• Some may be self-managed
• May require ongoing care
• May cause episodic problems or symptoms that can be controlled with specific interventions
  **OR**
• May severely limit a person’s abilities & impact their QoL

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

*Agency for Healthcare Research & Quality (AHRQ), 2014*
The 10 Most Common Chronic Conditions in the US: Older Adults (2010)  
(CDC, 2012)

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

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

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

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

Functional Assessment: 6 Key Areas
• Cognition (memory, thinking, decision-making)
• Physical (strength & endurance; gait, balance, falls, ADLs)
• Psychological (mood & personality; anxiety, depression)
• Spiritual (beliefs, values, meaning & purpose)
• Social (isolation, caregiver issues, network, community)
• Home environment (type of structure; assets & barriers)

3 Groups of Older Adults with Differing Care Needs
1. Vigorous & Relatively Healthy
2. Medically Complex
3. More Frail & Moving Toward the End-of-Life

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

Role of the Case Manager:
• Know the person’s story
  – Life goals
  – Bucket list
• Teach/educate
• Empower
• Advance care planning
  – Living document
  – Frequent updates & conversations
• Goal: safe at home; continue usual life pattern
Care Coordination:

- TEAM
- Interprofessional
- Integrated
- Holistic
- Innovative
- Informed
- Person & family-centered
- Ongoing communication
- Improves quality
- Reduces health care costs

Outcomes

Group 2: Medically Complex

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

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

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

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

 Medi-CARE for Falls

Medi – cation

Beers Criteria

C hronic diseases that predispose
A cute illness and acute orthostasis
R ehab (activity) Related Factors
E nvironmental Factors
Role of the Case Manager:

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

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

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

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

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

Guiding Principles:

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

Readiness for change
• Family participation
  – Roles & relationships
  – Home life
  – Circumstances (Registered Nurses’ Association of Ontario, 2010)

Motivational Interviewing

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

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

Key Communication Skills & Strategies:
• Using open-ended questions
• Affirming
• Reflecting
• Summarizing for clarification
• Assessing readiness for change
• Providing individualized information & advice with the person’s permission
• Instilling hope & optimism

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

Utilizing concepts of:
– Reflective/empathic/intentional listening
– A directive approach
– Collaboration
– Evocation of motivation
– Patient autonomy
What are YOU Going to Do?

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

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

References & Resources


