Section 3: HEALTHCARE SYSTEMS

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CARE OF THE ELDERLY PATIENT

Patients age 65 years or older represent over 30% of acute care hospitalizations and 50% of hospital expenditures. The hospitalized elder is at risk for a multitude of poor outcomes, which may include increased mortality, prolonged length of stay, high rates of readmission, skilled nursing facility placement, and delirium and functional decline. These outcomes have significant medical, psychosocial, and economic impact on individual patients and families as well as on the healthcare system in general. In addition to disease-based management, care of the elderly must be approached within a specific psychosocial and functional context. Hospitalists engage in a collaborative, multidisciplinary approach to the care of elderly patients that begins at the time of hospital admission and continues through all care transitions. Hospitalists can lead initiatives that improve the care of elderly patients.

KNOWLEDGE

Hospitalists should be able to:

- Describe the complications related to hospitalization in the elderly.
- Describe the environmental or iatrogenic factors that may contribute to complications in the hospitalized elderly.
- List medications with potential to cause adverse drug reactions in the elderly.
- Describe interventions that can decrease rates of poor outcomes in the hospitalized elderly.
- Explain the key elements of the discharge planning process and options for post-acute care.
- Describe the multiple options for transition from the acute care hospital that can assist patients in regaining functional capacity.
- List patient-specific risk factors for complications in the hospitalized elderly.

SKILLS

Hospitalists should be able to:

- Perform a thorough history and physical examination to identify patient risk factors for complications during hospitalization.
- Perform a brief cognitive and functional assessment of the elderly patient.
- Use active measures to prevent, identify, evaluate and treat pressure ulcers.
- Formulate multidisciplinary care plans for the prevention of delirium, falls, and functional decline.
- Provide non-pharmacologic alternatives for the management of agitation, insomnia, and delirium.
- Prescribe medications for the behavioral symptoms of delirium or dementia that cannot be controlled with non-pharmacologic management.
- Perform a social assessment of the patient's living conditions/support systems and understand how that impacts the patient's health and care plan.
- Formulate safe multidisciplinary plans for care transitions for elderly patients with complex discharge needs.
- Incorporate unique characteristics of elderly patients into the development of therapeutic plans.
- Recognize signs of potential elder abuse.

ATTITUDES

Hospitalists should be able to:

- Appreciate the complications and potential adverse effects associated with polypharmacy.
- Educate patients and families about individual measures and community resources that can reduce potential complications after discharge.
- Appreciate the risks and complications associated with restraint use.
- Appreciate the concept of transitional care.
- Participate actively in multidisciplinary team meetings to formulate coordinated care plans for acute hospitalization and care transitions.
- Promote a team approach to the care of the hospitalized elder, which may include physicians, nurses, pharmacists, social workers, and rehabilitation services.
- Appreciate the medical, psychosocial and economic impact of hospitalization on elderly patients and their families.

- Establish and maintain an open dialogue with patients and families regarding care goals and limitations, palliative care, and end of life issues, including living wills.
- Connect elderly patients with social services early in the hospital course to provide institutional support, which may include referral for insurance and drug benefits, transportation, mental health services and substance abuse services.
- Communicate effectively with primary care physicians and other post-acute care providers to promote safe, coordinated care transitions.
- Lead, coordinate or participate in multidisciplinary hospital initiatives to develop prevention programs and standardized treatment algorithms for elder outcomes such as delirium, falls, functional decline, and pressure ulcers.
- Lead, coordinate or participate in hospital initiatives to improve care transitions and reduce poor discharge outcomes in the elderly.
- Lead, coordinate or participate in patient safety initiatives to reduce common elder complications in the hospital.