

Aging SUCCESSFULLY



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Perry County Implements Innovative Ideas To Improve Geriatric Care

Funded in 2015 by the Health Services Research Administration, the Saint Louis University Geriatric Workforce Enhancement Program (GWEP) is now in the third year of the project. Specific to an older and aging population, the SLU GWEP has been engaged

in an interprofessional, strategic initiative to strengthen collaborative approaches to improve care of older adults provided by health and social service professionals. Goals of the major GWEP initiatives include: 1) identify the prevalence of older adults who are experiencing

geriatric syndromes and developing a systems approach to early identification and access to care for older adults, specifically in the areas of cognitive function, frailty, sarcopenia, and anorexia; 2) enhance community partnerships to promote
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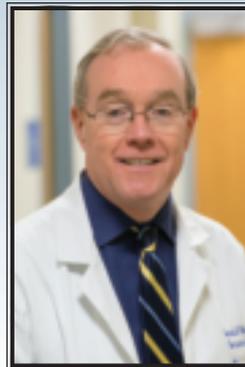
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SLU Geriatricians Recognized as Best Doctors 2017

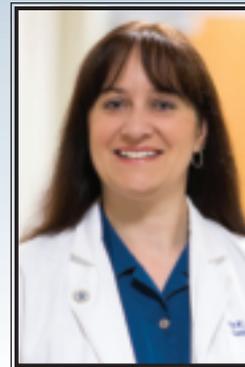
Congratulations to the physicians in the Department of Internal Medicine who were recognized as Best Doctors. This year Saint Louis University has more than 170 SLUCare physicians recognized by Saint Louis Magazine as best doctors of 2017. Geriatricians honored include:



Dr. John E. Morley



Dr. Gerald Mahon



Dr. Julie A. Gammack



Dr. Milta O. Little

SLU Geriatrics is always on the move. Keep up with us!

Find us on facebook.com/GatewayGEC

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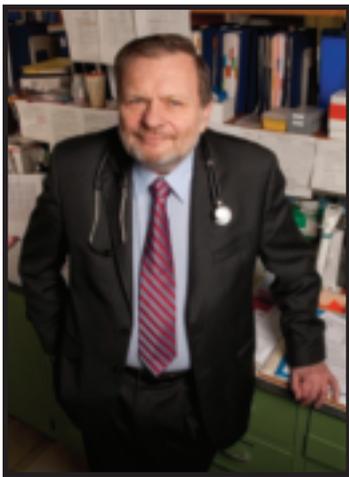
<http://www.youtube.com/c/GatewayGeriatricEducationCenterstl>

EDITORIAL

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Developing a Preventive Program to Maintain Intrinsic Capacity with Aging

Intrinsic capacity is defined by the World Health Organization as a combination of a person's physical and mental capacities. Intrinsic capacity is a strong predictor of health and wellbeing. Resilience is the ability to adapt to stressors and thus maintain a person's intrinsic capacity.



John E. Morley, MB, BCH

In geriatrics the approach to maintaining intrinsic capacity involves primary, secondary and tertiary prevention. Primary prevention to slow the aging process consists of physical exercise, a Mediterranean diet with

large quantities of extra virgin olive oil, eating fish 2 to 4 times a week, having adequate mental stimulation and socialization, and age appropriate treatment of risk factors for cardiovascular disease and osteoporosis.

Frailty can be considered to be the early loss of resilience. This is the stage when secondary prevention becomes important. The Rapid Geriatric Assessment (RGA) allows screening for frailty (the FRAIL), as well as sarcopenia (SARC-F), anorexia (SNAQ) and cognitive dysfunction (RCS). The program we have developed in Perry County allows computer identification of these geriatric syndromes and an algorithmic pathway for management. For example, the management for frailty is driven by its causes:

Fatigue: Sleep apnea, depression, hypothyroid, hypotension, vitamin B₁₂ deficiency and anemia

Resistance Treat sarcopenia with 6 weeks physical therapy, 1.2g/km leucine enriched protein,

Aerobic 1,000 IU of vitamin D and a lifetime physical exercise program

Illness: Reduce polypharmacy

Loss of weight: Look for treatable causes using the MEALS-ON-WHEELS mnemonic.

Similar algorithms exist for SARC-F and SNAQ positivity.

For persons with cognitive dysfunction, ruling out treatable causes is important:

Drugs, especially anticholinergic

Emotional (depression)

Metabolic problems (B₁₂ deficiency, hypothyroid)

Ear wax removal and hearing amplification

Normal Pressure Hydrocephalus

Tumors and other space occupying lesions

Infections

Atrial fibrillation

Sleep apnea

In addition, lifestyle modifications as shown by the Finnish Geriatric (FINGER) study including Mediterranean diet with extra virgin olive oil, socialization, exercise, and treatment of cardiovascular risk factors should be instituted. Finally, with moderate dementia the person should enter cognitive stimulation therapy (CST), followed by year-long maintenance CST.

The elements of secondary prevention are those that are carried out in our Perry County demonstration program.

Tertiary prevention is the classical geriatric approach to disability reversal as originally demonstrated in the Geriatric Education and Management Unit study described by Larry Rubenstein and his colleagues.

We believe that the program described here, which is a collaboration between primary care health professionals and geriatricians represents the optimal approach to allow countries around the world to optimally decrease possible negative effects from the aging tsunami.

John E. Morley

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Perry County's Innovative Ideas

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screening and outreach education, 3) develop integrated models of clinical practice for screening and improved care of older adults including management and prevention of further decline, and 4) educate the current and future workforce to competently deliver care for older.

The GWEP has collaborated with a number of partners throughout Missouri to enhance the quality



of services provided to older adults. One of our valued partnerships is with Perry County Memorial Hospital. In this newsletter, we highlight their story which emphasizes what one organization can do to change the culture of care for older adults.

The Story of Perry County Memorial Hospital

Perryville, Missouri, in Perry County, is located approximately 80 miles south of St. Louis. The population of Perry County approaches 19,000. Perry County Memorial Hospital (PCMH – People Care More Here) is a rural 25-bed Critical Access Hospital that also provides multiple in-patient, out-patient, primary care, and specialty program services.

PCMH became a collaborative clinical partner site in the SLU GWEP program and has developed as a model of academic-community collaboration and is helping SLU

to develop a template for successful replication and dissemination in establishing and integrating comprehensive geriatric screening and care programs. PCMH has approximately 3,000 patients in their system over the age of 65, 1,008 of those patients (>34%) have received screenings utilizing the SLU-developed Rapid Geriatric Assessment (RGA) since the program was initiated in 2015.

The support provided by the hospital administration and staff has made this collaboration and expansion of the geriatric care program possible. Janice Lundy, BSW, MA, MHA, Director of Social Work & Geriatric Care Management, has been a champion in leading the efforts to increase the services offered to older adults in the Perry County area. With over 27 years' experience in social work, a masters' degree in gerontological studies, and a masters' in healthcare administration. Janice and her colleagues work with SLU faculty and colleagues at PCMH to implement a number of initiatives that have been critical in raising the level of care provided for older patients. Key components of the success of the PCMH model include improved clinical care through integration of the RGA into in-patient and out-patient settings, introduction of Cognitive Stimulation Therapy (CST) for persons with dementia,

the establishment of an exercise and strengthening program, and instituting a protocol for the Medicare Annual Wellness Visit. Highlights of each area are provided here.

Improved Clinical Care

The first initiative in changing the culture of geriatric care was to integrate the RGA into the Electronic Health Record (EHR). Leadership and clinical care teams work together to implement an innovative new model of care to improve in-patient care and outcomes and enhance access to resources for patients in the community. Janice and her team began by focusing on continuing education and professional development sessions across the hospital and clinical care teams to get everyone engaged, clarifying the goal of comprehensive geriatric assessments and use of the RGA to improve care for elderly patients and assure they were getting referral and access to appropriate services to reduce complications during their in-patient care and improve outcomes through engagement in follow-up programs. Two to three education programs are held annually for nursing staff to address aspects of the RGA, delirium prevention, programs that impact fall-risk reduction, and CST. Within three months of the start of the GWEP partnership in 2015, the EHR team has integrated the RGA into the hospital intake process.

The next step was to establish policy for comprehensive screening during in-patient care. PCMH implemented a policy that ALL in-patients at the hospital who are at "high-risk" of developing complications or having difficulty during their stay, AND all patients >65 years of age are screened

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Perry County's Innovative Ideas

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using the RGA. An interprofessional care team completes different aspects of the RGA and triggers additional assessment and care as needed. This starts with the nurse assessing for cognitive impairment, frailty, and sarcopenia. This is followed by the registered dietitian assessment and PT and OT assessments for fall risk and limitations to activities of daily living (ADLs). The next step was to expand integration of comprehensive screening to the out-patient setting with primary care providers (PCPs). The RGA became a standard component of the Medicare Wellness Visit for all

patients over 65 years of age. With the RGA in the EHR, the PCMH team continues to work on integrating the algorithm to interpret the assessment and screening data. At this time, the summary of the four assessments is

done manually to “diagnose” a patient with aspects of geriatric syndromes and to complete orders for coordinated, collaborative care.

Cognivite Stimulation Therapy

The effectiveness of any screening/assessment protocol is to have resources to refer patients to if concerns are identified. The PCMH team has developed two new services to which older patients can be directed if problems of cognition and/or frailty or sarcopenia are detected. Cognitive Stimulation Therapy (CST) is a non-pharmacologic intervention for persons with

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We are going digital! This is our final printed edition of the newsletter. To receive a digital copy of future issues, please send your email address to aging@slu.edu.

Perry County's Innovative Ideas

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dementia. Janice and her colleague, Debbie Hayden, RN, BSN, OTR/L, Director, Occupational Therapy Services, travelled to the U.K. where CST was founded, to become certified to deliver CST and train others. PCMH now offers twelve CST groups each week and consistently their pre- and



post-data collection of participants shows marked improvements in cognition, quality-of-life, and depression. Janice and Debbie have been national and international leaders in the development of CST interventions. They have hosted international visitors from New Zealand, Hong Kong, and Singapore and have provided training in Hong Kong. They are members of the SLU CST Team and will be working to develop the North American CST Training Center to be housed at SLU.

Exercise and Strengthening Program

An area of critical concern for many professionals who care for older adults is ensuring adequate exercise and strengthening to prevent falls, improve strength and function, and contribute to a healthy brain. To address this need, the PCMH team has worked with the physical therapists to create a weekly exercise and strengthening program that has enabled many of the participants to improve their mobility, balance, and strength.

The Outcomes

Here are stories of two of the

Perry County older adults who have benefitted from these new services:

“Wayne” was screened by his primary care physician utilizing the RGA and identified as positive for multiple geriatric syndromes. He was referred for



Wayne

a comprehensive geriatric evaluation and referral services including CST, exercise, home visit with social worker and OT, and a nutritional consult with the registered dietitian. In the last year, Wayne has experienced tremendous improvements including NO falls, INCREASED weight gain, NO visits to the ED, and he is LIVING on his own. In Wayne’s own words, “I feel much stronger and more confident. I’m so glad to still be living in my home.”



Donnie

“Donnie” is a 84-year-old man who received the RGA as part of his annual Medicare Annual Wellness visit. The positive outcomes of the screening resulted

in referral to comprehensive assessment and referrals to the exercise and CST programs. Donnie was doing well, then stopped therapy after a move to new home. After experiencing several falls, PCMH staff were able to build on their prior relationship with him, get him back into CST and the exercise and fall prevention program. This also led to assessment and discussions with his wife in terms of home support and needs for the couple. Increased engagement of both Donnie and his wife in support programs has resulted in overall and specific improvements. Donnie shared these thoughts: “It taught me to walk again. I got a lot of my strength back and was able to get rid of my walker. It has made a really big difference. I love coming to this group and being around the other guys.” Donnie’s wife also shared her perspective: “He is more alert and active. He was sad before and is now much happier. The exercise program has helped both of us tremendously because it has taught me how to keep my strength up as well.”

Systems Level Changes: Culture, Clinical Care, and the Patient Experience

In reflecting on the past three years of innovation, PCMH staff have identified a number of changes in the culture of patient care within their organization:

1. Knowing Prior Patient Status:

Acute care in the hospital focuses on reason for visit and acute needs. The programs integrated with the RGA, the documentation in the electronic health record, and the correlation to ED visits that are in the records, provides a much better picture of the patient’s “prior

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Geriatric Assessment: Seeing the Whole Picture

Melissa Ramel, PhD, MS, MPH, RD, LD, Instructor, Department of Nutrition and Dietetics

A group of clinicians with students in tow, all walk into a clinic on a Thursday afternoon. What do they have in common? They likely have many things in common, but for the purposes of the clinic, they are arriving to provide care for older adults. This interprofessional care team comprised of faculty and students, conducts the Geriatric Assessment Clinic (GAC) at the Health Resources Center (HRC). A pillar of the GAC is the interprofessional approach; thus representatives from medicine, social work, physical therapy, occupational therapy, speech & communications disorders, and nutrition, facilitate each clinic.

At the initiation of geriatrician, Dr. John Morley, the HRC was established in 1994 by Saint Louis University School of Medicine students and physicians. Since its inception, the HRC has expanded in clinic offerings, but the focus remains the

same, a commitment to providing free health care services to the St. Louis community. Although the marketing budget for the GAC is nonexistent, the current advertising efforts through faculty networks in hospitals, community centers, health departments, and aging service agencies have created a regular patient flow. Since the GAC began in February 2017, the interprofessional group that holds clinic one day/month has provided services for over twenty-five older men and women and their care support teams (caretakers/family members).

Older individuals scheduled at the GAC participate in a com-

prehensive, interprofessional experience. Each member of the team completes an in-depth screening of the patient based on her/his needs and areas of concern in the presence

of the other team members, the older adult, and her/his care partners. Saint Louis University faculty lead the clinic; however, students conduct the patient interviews and specified screening tests as clinically indicated. Each discipline is represented in the exam room to ensure a comprehensive environment is maintained.

The health of the caregivers can also

“...the focus remains the same, a commitment to providing free health care services to the St. Louis community”





Geriatric Workforce Enhancement Program Announces 2017-2018 Geriatric Leadership Scholars

Each year the Geriatric Workforce Enhancement Program (GWEP) provides the opportunity for early to mid-stage career faculty to be selected from colleges and universities across Missouri to participate in the Geriatric Leadership Scholars Program.

This GWEP initiative is aimed at developing faculty who have the skills to teach and assess students and conduct research key to improving future care for older adults. To develop 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 is paired with a Gateway GEC Faculty Mentor who works with the Scholar throughout the year to address teaching, research, and program development issues.

THE 2017-2018 GERIATRIC LEADERSHIP SCHOLARS INCLUDE:

Jan Wood, DNP, RN, NP - C, University of Missouri—Kansas City School of Nursing and Health Studies is a Clinical Assistant



Dr. Jan Wood

Professor who teaches courses in the online master's and doctoral nurse practitioner programs. She also maintains a clinical practice as a hospitalist nurse practitioner at Mercy Hospital in Springfield, Missouri. Dr. Wood's nursing career includes roles in bedside nursing, administration, and patient education. A life-long learner, Dr. Wood completed her Doctor of Nursing Practice in 2015. During her time as a Geriatric Leadership Scholar, she has completed training in dementia care and is developing interprofessionally-focused practice strategies for integration into her coursework and clinical practice. Her SLU faculty mentor is Dr. Helen Lach of the School of Nursing.



Dr. Qiang Chen

Qiang Chen, Ph.D., MSW, is an Assistant Professor at Missouri State University Department of Social Work. Dr. Chen completed his MSW and PhD degrees at the State University of New York at Albany and joined the MSU faculty in 2016. While Dr. Chen primarily teaches in the areas of policy, human behavior, and research, his focus during his Geriatric Scholar year is to engage in research focused on staffing issues within residential care facilities. He is working with Dr. Marla Berg-Weger during his Scholar year.



Dr. Melissa Ramel

Melissa Ramel, PhD, MS, MPH, RD, LD, Saint Louis University Doisy College of Allied Health, Department of Nutrition and Dietetics. As a member of her department's faculty since 2011, Dr. Ramel has focused on nutritional issues in older adults in her teaching, presentations, research, and service. She has been instrumental in helping GWEP faculty to launch the new Interprofessional Geriatric Assessment Clinic at the Health Research Center and currently serves as the Clinic Coordinator. Dr. Milta Little is serving as Dr. Ramel's mentor for her Scholar year.

COGNITIVE STIMULATION THERAPY: MAKING A DIFFERENCE IN NORTHEAST MISSOURI

Debbie Blessing, BA, A.T. Still University GWEP Coordinator

The “Greatest Group Ever” is a new Cognitive Stimulation Therapy (CST) group that began February 5, 2018, at St. Andrews Senior Apartments in Kirksville, Missouri. The group is being facilitated by A.T. Still University’s Geriatric Workforce Enhancement Program (ATSU GWEP) Project Coordinator, Debbie Blessing, in partnership with Northeast Regional Medical Center’s occupational therapist, Kathy Krueger, OTR/L. Arielle Willis, BS is also assisting with the group to learn how to integrate CST into her practice.

This lively group of six older adults attend one-hour sessions twice a week for seven weeks and the program content is a fun and stimulating way to build memory, improve recall, and concentration. This is the first CST group, to date, in which exercise has been incorporated into the program. Each session contains a current event or human interest story and the main activities have focused on childhood/family, hidden objects, sound, word association, and categorizing.

Cognitive Stimulation Therapy (CST) is an evidence-based therapy that does not involve medication and is designed for adults with mild to moderate dementia. The

program was developed for group and individual treatment in the United Kingdom by Drs. Aimee Spector and Martin Orell and has been implemented by the SLU GWEP team within a number of sites across Missouri and Illinois.

ATSU’s Aging Studies Project also offers a course in Individual Cognitive Stimulation Therapy (iCST) for first and second-year medical students. Students are required to complete ten hours of training in iCST before they begin making home visits to deliver iCST in one-on-one sessions with an older adult with dementia. Once the students complete their training and orientation, each is assigned a community-based volunteer elder. The elder volunteer agrees to allow student teams of two to visit her/him in the home and complete ten iCST sessions. The session content is very similar to that of the groups and is well-suited for persons who are unable to leave their homes or participate in a group experience.

A.T. Still University’s Area Health Education Centers Program (ATSU AHEC) Office initiated group and individual CST programs in Northeast Missouri in April 2016. For more information about CST, please visit aging.slu.edu and click on “Cognitive Stimulation Therapy.”



Live Discharge from Hospice Care: Preparing Patients and Family Members

*Cara L. Wallace, PhD, LMSW, Saint Louis University School of Social Work, and
Stephanie Wladkowski, PhD, LMSW, ACHP-SW, Eastern
Michigan University School of Social Work*



Hospice care has been shown to improve end-of-life outcomes for those with chronic illness,¹⁻⁴ yet with eligibility limited to a six-month prognosis, the hospice system is not structured to meet long-term needs.⁵ Many patients stabilize, or have a change in terminal prognosis, leading to a ‘live discharge’ from care. Some social workers have referred to this as ‘graduating’ from hospice,⁶ while others refer to these patients as “not dying fast enough,”^{7,8} or “failure to die on time.”⁹ Ultimately they are still dying from chronic illness, just not within the prescribed six-month framework.

With growth in the number of hospice enrollments overall, live discharges for patients are also expected to increase.⁷ In 2015, 16.7% of all discharges from hospice were patients who were discharged alive¹⁰ (nearly 160,000 patients).¹¹ With this growth it is important to understand the impact of a live discharge on patients and their family members, in addition to how to best prepare and support them.

Why is this a Problem?

Those who work in hospice know that a person may be discharged alive for many reasons, including relocation outside the hospice service area, seeking a curative form of treatment, or safety concerns with the plan of care, such as disruptive, abusive, or uncooperative be-

havior. However, most live discharges occur because the patient’s condition has improved or stabilized, and they no longer meet hospice eligibility criteria.¹⁰ Initially, it makes sense to consider this in a positive light, as the patient’s condition has stabilized. However, many concerns arise during a live discharge from hospice that merit attention.

First, patients discharged from hospice lose access to important services and resources.^{7,12} One question many physicians ask in determining prognosis is “Would I be surprised if this patient died in 6 months following the current illness trajectory?” While this is enough to certify a patient for hospice care, that trajectory often changes once a patient receives hospice services.¹³ Patients begin receiving care in their homes

Live Discharge

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without having to get out for doctor's appointments, tests, or procedures. Pain and symptom management can help patients enjoy better quality of life. Under the Hospice Medicare Benefit, the cost of medications to manage pain and symptoms related to their diagnosis is covered and often delivered directly to the home, along with needed medical supplies or equipment. Hospice services make sick people *feel* better and can actually extend life.¹³ Medicare scrutiny of these patients once they outlive the 6-month prognosis makes it difficult to recertify for hospice care when stabilized symptoms are documented. The patient remains terminally ill based on their diagnosis; however, due to lack of clear prognosis criteria, agencies are unable to demonstrate to Medicare that the patient remains appropriate for ongoing hospice care, resulting in a live discharge.

The full scope of hospice care services available to patients and caregivers include nurse and physician care; physical, occupational, or speech therapy; social services; certified nursing aide services; durable medical equipment and supplies; counseling; and short-term inpatient services. Additionally, care is available around the clock, is provided wherever the patient lives, and is focused on symptom management. The patient and family are recognized as the unit of care (instead of just the patient) and the interdisciplinary team treats the whole person (instead of just the illness). Other qualities noted are the inclusion of volunteers, the availability of services regardless of ability to pay, and bereavement services.¹⁴ When a patient no longer qualifies for services, provided equipment must be removed from the home, the cost of supplies and medications are no longer provided, and interdisciplinary team visits stop. **Upon discharge, many patients return to previous providers outside the home, have less follow-up and support, and may decline in condition and quality of life.**^{7,8,12,15-17}

Although patients' prognoses have changed, they still require substantial care and often struggle to process feelings of abandonment and uncertainty.⁸ Further, an increased burden is placed on primary caregivers who may be unprepared for this transition.^{7,8,12} Far from a best-practice model, social workers across agencies report great variability in how live discharges are managed; there are no standardized protocols.⁶ Finally, social workers report great difficulty trying to replicate the support provided by hospice, and availability of resources is often dependent upon location or financial availability of the patient and caregiver.⁶

Practice Implications

When hospice is supposed to be an "end"-of-life service, how can we approach the live discharge process to help caregivers navigate another care transition? As you approach live discharges within your own agency, consider some of the following tips:

Take a complete inventory of the services you are providing. What needs to be replaced? What cannot be replicated? What resources are available for meeting needs and how long will it take to get these services in place? Additionally, consider which patients are vulnerable to needing the most help. Recent research suggests that patients who are ineligible to be transitioned to another service (i.e. home health or palliative care within the home) or those within rural areas may be particularly vulnerable due to lack of resources and services.⁶

Name the live discharge as a transition. By providing caregivers with a picture of end-of-life care as an ongoing process, we can normalize feelings of loss, including sadness, anxiety, and self-doubt. Recognizing the role of policy in the services we provide and how that impacts the patients and families you care for is also particularly important in identifying your voice as their potential advocate. Social workers also found it helpful to empower patients to appeal the live discharge decision with Medicare, if for nothing else as a mechanism of feedback about the disappointment and challenges associated with having to leave hospice care.⁶ Finally, assessing and validating the caregiver's strengths is an important point in approaching this transition. Helping patients and caregivers recognize other transitions they have experienced during the disease process and how they coped can be a powerful tool in empowering them to manage this change in care.

Validate and identify the complex ambiguity in ending hospice services without the anticipated outcome of death. It can feel confusing to have a loved one deemed "terminal" one day and "not terminal" the next. Caregivers may feel unsure or ambivalent about the change, not wishing for the patient to die, but questioning how long they can continue to be caregiver. "We understand that a live discharge may bring up unclear or conflicting feelings," may be helpful to hear.

Overall, more research is needed to fully understand outcomes following a live discharge from hospice care and to identify best processes for how to approach this critical transition to optimize positive outcomes. How-

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Live Discharge

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ever, recognizing the challenges with live discharge and finding ways to empower patients and their caregivers throughout the process is one place clinicians can start in making a difference during this difficult transition in care.

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Dancing with the STARFs

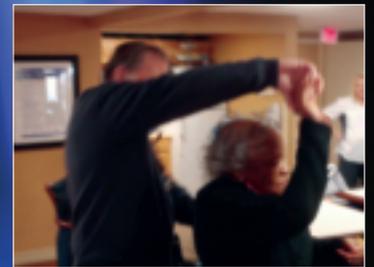


At NHC Maryland Heights, we have introduced an exciting new program which taking off from Dancing with the Stars is called “Dancing with the STARFs.” As pointed out previously, I love to dance with my patients.



Jeff Lorraine, the director of nursing, and the only person I have met who can compete with me for a lack of dancing talent, led off the dancing with a great deal of reluctance. But as can be seen the residents thought he was terrific.

Of course I also had to dance! And while my inability to “twist again like we did last summer,” with some effort, I could eventually convince one or two residents to dance with me.



Fortunately, some of the staff had real dancing talent resulting in a fun filled half hour.

This article was originally published on February 6, 2018, on LinkedIn. Find it at goo.gl/92eNkM.

Interprofessional Geriatric Team Training

Helen W. Lach, PhD, RN, GCNS-BC, and Milta O. Little, DO



A recent review published by Fox and colleagues¹ explored teaching methods for improving teamwork skills among health professions students. They identified over 30 studies that have been conducted in this area. Many involved experiences where teams of students come together for activities, such as our SLU Interprofessional Geriatric Case Competition. Their findings were that most activities improved the student's perceptions toward interprofessional collaboration and practice. They note that many studies varied widely in methods and rigor and additional research is needed in this area.

Each year for the past three years, the Geriatric Workforce Enhancement Program has sponsored an interprofessional team experience for students at Saint Louis University and other local

universities. The experience is designed as a Case Competition. Students are assigned to teams with a variety of disciplines represented and are given a complex case involving a geriatric patient situation. Student teams are directed to review the case, analyze the problems and possible solutions, and develop a plan of care for the patient/family. Students then present their care plan as a team to a panel of inter-university faculty judges and are scored. The cases are developed to meet several requirements:

- Represent a particular type of patient issue (chronic disease, end-of-life, or transitions in care)
- Have complex medical needs requiring a health care team
- Problems represent common geriatric scenarios that

health professionals encounter in practice

- The input and collaboration of a variety of disciplines will enrich the patient's care
- Have problems that require decisions by the patient and/or family, guided by suggestions from the health care team
- Have interesting features such as difficult family dynamics, cognitive impairment issues, or mental health concerns.

These components of the cases are important because we want students to be exposed to interesting geriatric content. We focus especially on common problems they are likely to see in their practice, such as dementia. We also want them to

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Interprofessional Geriatric Team Training

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appreciate that the aging population requires extra knowledge and expertise to address their problems. Students may consider geriatric patients easy and not amenable to interventions. They may not appreciate the interplay of medical and psychosocial problems that are so complex in older adults. Cases also need to have problems that are informed by a variety of professional disciplines. We want students to see how valuable the lens of different disciplines can be to solving complex patient problems. We often get comments about how students learned how much other disciplines have to contribute to the patients.

Student presentations are evaluated based on the Interprofessional Education Collaborative (IPEC) guidelines for collaborative team work: working together with positive team practices regarding values/ethics, respect for different

roles and responsibilities, and communicating well. Students, mentors, and judges have evaluated the experiences very highly. Scores are generally at a high level for teams while, at the same time, judges are examining the strengths and weaknesses of the teams using the four main IPEC competencies, to determine additional resources we can provide to help students have a strong interprofessional experience. We are willing to share our materials and information, the web site is noted below.

The following provide resources on interprofessional training, geriatric team training, and/or case studies for interprofessional activities.

- POGOe: the Portal of Geriatrics Online Education (cases, examples for a variety of sources) - <https://www.pogoe.org/>
- TeamSTEPPS Implementation Guide - Agency for Healthcare Research and Quality - <http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/instructor/essentials/implguide.html>

- National Center for Interprofessional Practice and Education - <https://nexusipe.org/>
- Interprofessional Education Collaborative - <https://ipecolaborative.org/>
- World Health Organization Framework for Action on Interprofessional Education and Collaborative Practice - http://www.who.int/hrh/resources/framework_action/en/
- Geriatric Interdisciplinary Team Training. Hartford Institute for Geriatric Nursing. Interprofessional Education and Practice Books (IPEP books) - <https://consultgeri.org/education-training/e-learning-resources/interprofessional-education-and-practice-ipep-ebooks>
- Advancing Care Excellence for Seniors (ACES) - National League for Nursing (<http://www.nln.org/professional-development-programs/teaching-resources/ace-s/unfolding-cases>)

For additional information about interprofessional practice or the SLU Interprofessional Geriatric Case Competition, please contact Dr. Helen Lach by email at helen.lach@slu.edu.

1. Fox, Onders, Hermansen-Kobulnicky, Nguyen, Myran, Linn, Hornecker. Teaching interprofessional teamwork skills to health professional students: A scoping review. *J Interp Care* 2018, 32(2), 127-135.



Exercise and Strengthening Training Program Now Available

Jill FitzGerald, PT, DPT, GCS, CSCS, CEEAA, and Kelly Hawthorne, PT, DPT, GCS, CEEAA, Department of Physical Therapy

As we know, the number of older adults (over 65 years of age) will almost double between 2005 and 2030.¹ By 2030, 20% of the United States population will be older adults; those over 85 years of age are the fastest growing segment of that category.² Knowing this population is quickly growing, all of us in the health and social service professions, must focus on the physical changes related to age and implement strategies to assist our older adult population in maintaining an optimal quality of life.

Of particular concern is muscle weakness in older adults. Muscle weakness occurs at a rate of 1-5% annually after the age of 30.³ Muscle mass is lost at a rate of 4-6% per decade, starting at 40 for women and 60 for men.⁴ Sarcopenia, the loss of muscle mass and strength, effects 5-13% for adults aged 60-70 years with increasing statistics aged 80 or above.⁵⁻⁶ Despite the reasons for sarcopenia, (*i.e.*, decreased ability within the muscle to contract secondary to increased fat, inactivity, and denervation), we, as health professionals must address our concerns with our patients. Studies have shown that not only does a strength-based exercise program promote strength gains and func-

tional independence, such a program also improves joint integrity, bone density, confidence, pain, and sleep.⁷⁻⁸

As part of the Geriatric Workforce Enhancement Program, we identified the need for a training curriculum that is easily translated into practice within community-based organizations and facilities. In an effort to develop a comprehensive community-based strengthening program for older adults, we began with an established program, Growing Stronger.⁸ From there, we made additions to the program targeting specific muscle groups linked to falls, frailty, and normal balance strategies for the older adult. These additions included exercises focused on posture, core musculature, pelvic floor, hip musculature and single leg stance.

In accordance with the American Physical Therapy Association Academy of Geriatric Physical Therapy's Exercise Recommendation for Older Adults,¹⁰ we developed three tiers for each exercise, including low, moderate, and high variations allowing each participant to exercise with the proper intensity. In collaboration with the students in the Program of Physical Therapy at Saint Louis

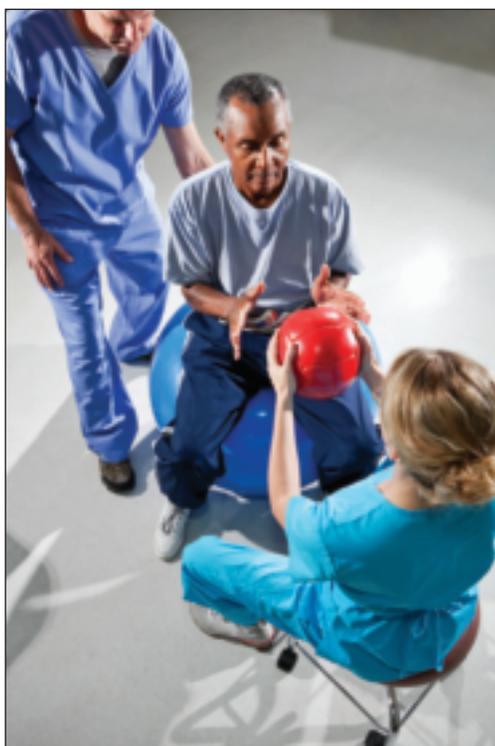
University and the original authors of Growing Stronger, we produced module-based training videos for community integration. An implementation training program for community leaders has been developed to promote the adoption and integration of this program. The comprehensive training includes:

- information for starting a community program
- screening participants, benefits of the program
- developing leadership skills
- tracking the program including participant assessments, proper progression, precautions, safety measures
- copies of the exercise videos.

Upon identification of a community leader, a two to four-hour training session is encouraged to ensure proper usage of the materials and understanding of the program. Overall, the goal is to integrate this community-delivered, strength-based exercise program into established service sites for older adults. Promoting a routine strength based exercise program in the community is necessary to combat sarcopenia and encourage good quality of life.

For more information regarding this community-based strength training program, contact Dr. Fitzgerald at Saint Louis University Program in Physical Therapy, (314) 977-8505 or jill.fitzgerald@health.slu.edu.

(see page 18 for the citations referenced in this article)



Morley Receives Two Awards

John Morley presented the keynote address “Precision (P4) Medicine as the Future of Geriatric Medicine” at the Congress of the German Society for Geriatric Medicine in September 2017, in Frankfurt, where he was also presented with the Lifetime Achievement Award from the German Society for Geriatric Medicine.



Dr. Morley

At the 2018 annual conference, The Society for Post-Acute and Long-Term Care Medicine honored Dr. Morley with the inaugural John Morley Award in recognition of his many years of leadership and service to geriatric care.

GEC Hosts International Nursing Home Research Conference

In partnership with the International Association of Gerontology and Geriatrics Nursing Home Research



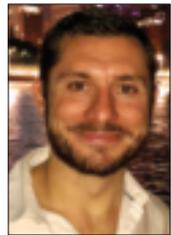
Social Work Faculty members attend conference

International Working Group, the Geriatric Education Center hosted the 2017 conference October 13-15, 2017, at Saint Louis University. The conference provided a venue for interprofessional dissemination of research being conducted in nursing home settings around the globe. The gathering was attended by 114 researchers, representing 13 countries. Conference highlights included innovative use of technology, non-pharmacologic interventions for patients with dementia, prevention of hospitalizations, and interprofessional practice within residential settings.



Dr. Joseph Ouslander and Dr. Christopher Lien, two of the international attendees at the Research Poster Session

International Scholar Visits Division of Geriatric Medicine



Dr. Fougère

Dr. Bertrand Fougère is serving as a yearlong visiting professor in the Division of Geriatric Medicine. Specializing in geriatric medicine, longterm and post-acute care, Dr. Fougère practices at Toulouse University Hospital, France. He completed medical school and internship at Poitiers University and a fellowship at Lille University, all in France. His current research interests focus on the prevention of disability in older adults and early detection of frailty and cognitive decline in primary care.

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Division of Geriatric Medicine Welcomes Three New Fellows

Mandissa A. Sealey, M.D., is completing a geriatric fellowship. Sealey attended medical school at the University of Guyana Faculty of Health Sciences, Guyana, and went on to residency in internal medicine at the Brooklyn Hospital, New York. After completion of her fellowship, Dr. Sealey will be working as a primary care out-patient physician with a focus on geriatric patients in Fleming, Kentucky. She focuses her current research on hip fractures and arthritis.



Dr. Sealey



Dr. Simmons

Cameron B. Simmons, Jr., M.D., is completing a palliative care fellowship. He completed medical school at Louisiana State University School of Medicine, New Orleans, and his residency in family medicine at CMC Elizabeth Family Medicine Program. Upon completion of his one-year fellowship, Dr. Simmons, will be joining the SLU Palliative Care faculty. His research interests are focused on early initiatives in palliative care.

Sukesh Manthri, M.D., is completing a palliative care fellowship at SLU. Manthri, a graduate of Prathima Institute of Medical Sciences, completed his internal medicine residency at Southern Illinois University School of Medicine. Dr. Manthri has accepted a fellowship at East Tennessee State University to complete a medical oncology fellowship. His research interests include pain and symptom management, biomarkers, genomics, lung neoplasms, and medical oncology.



Dr. Manthri



Is there a Good Death?

By John E. Morley, MB, BCh

One day as I was leaving the nursing home at 7:30 at night, a 94 year old resident called out as I walked by her door: “Dr. Morley can you please come here.” Being late for dinner I walked on pretending I hadn’t heard her. As I walked past a number of other rooms my conscience told me that I cannot do it. So I turned around and went back to her room.

“What is the problem Mrs. X,” I asked.

“Can you come and sit with me because I am going to die shortly.”

“That’s nonsense, you are very healthy” I replied.

Nevertheless, I sat beside the bed and took her hand. For the next half hour, we talked about her life and my life, and then she said, “It’s time now.”

Her hand slipped out of mine and she was silent. There was a feeling of warmth in the room and then I thought I saw a blinding light fly out of the window. I felt more at peace than I ever had.

I had no need to look. My patient had completed her life’s journey and I could imagine her now in a beautiful garden full of celestial light.



I knew I had experienced a good death.

Unfortunately in my long career I have rarely had the good fortune to experience “the good death.” Often death occurs without preplanning as physicians fight to save the un-saveable. Nearly 40% of persons in Missouri do not have an advance directive.

The other problem with experiencing the “good death” is it is rare that relatives accept that it was time for their loved one to finish their journey on this earth. While the only certainty on this earth is that once we are born we will die. It is extremely difficult for most of us to accept the appropriateness of death.

As I have been fortunate to be present at a perfect death I know that “the good death” can occur. However, rarely can this be accepted by family. It is important that we all contemplate how we will die well and especially that our loved ones accept we have a good death.

This article was originally published on Dr. Morley’s LinkedIn page.



The Whole Picture

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be a concern for many in the aging population. Individuals who accompany the patient are also screened for their well-being and provided a space to discuss concerns they may have about the patient.

Through a partnership with the Alzheimer's Association, a social worker from this agency is available at each clinic to provide further consultation, resources, and care.

At the completion of the clinic, the attending physician, along with a small group of students and/or faculty, will revisit the patient and caregiver to discuss results of the screening tests and provide take-home recommendations for further care and follow-up.

This innovative approach allows for students to gain experience with patient interaction and rapport building, gain an understanding and appreciation for other members of the healthcare team, and build their own discipline specific skills. While students may feel somewhat uncomfortable with the process at the beginning of the clinic, by the end the students (and faculty) appreciate the innovative approach. The clinic does not uncover all underlying concerns for the patients, but the interprofessional team is able to identify priorities that can provide the patients with a plan for next steps in the management of their health care.

Over the past year, it is apparent that a majority of patients provided care at the GAC are already integrated into a network of providers. However, the care is segmented, nonspecific, and can often be confusing for the older adult and care partners. This clinic can address those gaps as the comprehensive screening is uniquely tailored for the geriatric population. Although, the GAC is not designed to provide ongoing care, we can help the older adults and their families organize their health plan moving forward and to achieve their goals for aging successfully.

For more information about the GAC, please visit aging.slu.edu and watch the brief video, <https://youtu.be/9ZoJZwE4If8>. To make a referral to the GAC, please telephone 314-977-8462.

“...the interprofessional team is able to identify priorities that can provide the patients with a plan for next steps in the management of their health care.”



AGING SUCCESSFULLY
is going
DIGITAL!

This is our final printed edition of the **Aging SUCCESSFULLY** newsletter.

To receive a digital copy of future issues, please send your email address to aging@slu.edu.

Exercise Program

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The Nursing Home with *the MOSTEST*

For the last 25 years Saint Louis University's Geriatrics program has worked closely with NHC Maryland Heights to develop and study a variety of activities aimed at improving the quality of life of residents in nursing homes.

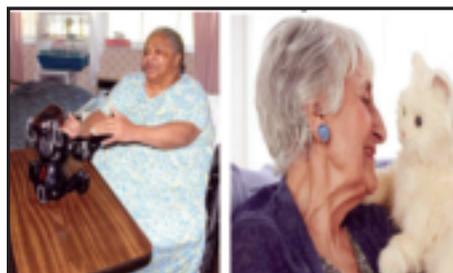
Our first initiative was to develop a small farm between two wings of the nursing home. The original occupants were a donkey, a chicken and 2 goats. The goats did not last long as they jumped over the fence and ate the garden furniture leading to their banishment from the nursing home.



ley to come and eat it. I quietly left the nursing home feeling somewhat embarrassed. Fortunately, the donkey kicked the chicken, which was very beloved by the residents. To protect the chicken the "Resident's Council" ordered the donkey to be expelled from the nursing home. The upside of this is I didn't have to be called an "ass" anymore!

Other animals we have had include a Llama, 2 alpacas, sheep (including the fattest sheep I have ever seen), many chickens, ducks, miniature goats and a Shetland pony. Indoor cockatiels have been very popular with the residents. At present we have visiting cats that come and interact with the residents on a monthly basis.

One of our experiments was to compare the popularity of a dog to AIBO, a robotic dog. In the end it



seemed that residents with dementia liked the robot just as much as a real dog! At present we have 4 Hasbro



cats in the nursing home on the Special Needs (dementia) Unit. These are very popular.

Exercise: Over the years we have developed many exercise programs. In one study of residents with behavioral problems, we found that the exercise program dramatically reduced difficult behaviors. Recently, we have introduced bingo with exercise (Bingocize) which is popular as long as it does not shorten the time for playing bingo!

Cognitive Stimulation Therapy (CST): CST is a program for persons with moderate dementia. Each session starts with remembering

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One evening when I was visiting residents in the nursing home late, I heard a nurse calling, "Dr. Morley, come here quickly!" While I was surprised the nurse knew I was in the nursing home, I rushed outside to help with the emergency. Imagine my surprise when I saw the nurse with a carrot in her hand calling to the donkey by the name of Dr. Mor-

Perry County's Innovative Ideas

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status” – what, how, and why that status may have changed (better or worse)

2. Language and bias towards patients:

There used to be a tendency to label patients as “old and confused”. This program has changed awareness and language to be more inclusive, descriptive, and correlated to aspects of actionable items for care and prevention, such as

a. Use of terms like “geriatric syndrome”, “frailty cascade”, “mild cognitive impairment”, “delirium prevention”

b. There are now systems of screening and referral that empower clinical staff to be able to address these patient needs and have systematic mechanisms to get them screened and into the case or support services they need

c. Care teams are discussing patients in language that promotes care and action, vs. just labeling

3. Continuous Quality Improvement and Professional Development:

regular continuing education and professional development in-service 2-3 times per year regarding some aspect of the RGA, screening, care, and referrals for older adult patients

4. Capacity Building (as result of partnership with the SLU Geriatric Program and GWEP):

building robust CST and exercise and strengthening programs, developing leadership skills and national/international reputations as experts in CST, and conducting research on the impact of the CST and exercise programs are just a few of the achievements that have enhanced the capacities of PCMH staff.

5. Quality Improvement: Not to stand still, the PCMH community looks for ways to improve the quality of services. For example, PCMH staff regularly engage in the activities of improvement and using team discussions to identify areas that could work or flow well. The workflow process in the primary care office using the RGA in the EHR was not working so the physician and team discussed the issue and re-conceptualized the process and flow, resulting in a new model which improved the outcomes when applied.

6. Community Engagement: As a result of the expanded perspective on geriatric patients, PCMH has developed local partnerships to include: 1) County Health Department: PCMH Team provided training for the Department of Public Health staff nurses; including the RGA training, screening and referral programs; 2) Nutrition programs: PCMH is in discussion now with the goal of linking the home visit van/meal program with RGA screening (food services provided by County Senior Tax Commission). Prior relationship and existing referral system with the meals on wheels program; the agency needed a van, the trade was the new van plus the addition of a person who could complete the RGA screens on the van. For the future, develop a new program that included home-based screening with RGA and care; 3) Transportation Program: (Paid through the County Senior Tax Commission and County Services for Medicaid Services). The hospital transportation program is used to get patients to programs

and appointments with PT, OT, CST; and 4) Perryville Community Center (MO Area Agency on Aging partner): PCMH provides talks on geriatric wellness, cognitive function, frailty, fall risk, weight management and signs community members up for RGA screening at the clinic

“The RGA is very beneficial to us in helping to detect functional and cognitive decline early in older adults, allowing for early interventions. It provides a platform to discuss other concerns and an opportunity for patient and family education. The geriatric team approach to care of the older adult is essential.”

- Theresa Lipe, MSN, FNP



Theresa Lipe



Dr. Schabbling

“The Comprehensive Geriatric Assessment Program has been a valuable tool in my practice. It allows me a way to screen patients at risk for future problems that might occur. With a multidisciplinary approach my patients are evaluated for polypharmacy, generalized weakness and frailty, and memory loss. Programs designed to improve or stabilize cognitive deficits and a physical therapy program allowed my patients to stay at home safely for a longer period of time.”

- Mark B. Schabbling, MD

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Perry County's Innovative Ideas

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Looking Toward the Future: The MODEL for Replication and Dissemination

SLU and PCMH hope to develop a template of the Perryville Model and travel to other regions of the state to discuss and provide trainings on systems change and sustainable integration of the RGA and Services for Older Adults. The essence of the model for replication includes:

1. Developing and building upon the interests of an organizational champion
2. Utilize the Five Key Principles for Effective Team-Based Care (outlined by Mitchell et.al. in an IOM Roundtable Paper: Shared Goals, Clear Roles, Mutual Trust, Effective Communication, and Measurable Outcomes):
 - a. Establish a clear, shared goal across the unit/team: Develop a better way to care for elderly patients
 - b. Identify clear roles to create a system of screening, and care across in-patient, out-patient, and prevention services
 - c. Mutual Trust - collaboratively build a system that supports professional development, education, clinical care/services, and community engagement

- d. Effective Communication – documentation in the EHR, team meetings, overcoming barriers, focus on participatory approach
 - e. Measurable Outcomes – systems of tracking overall model, individual areas of documentation and reporting, and QI measures to build a learning organization and culture of safety and improvement
3. Focus on Systems Change and ongoing QI Model of Improvement
 4. Education System – of the current and future workforce
 5. Clinical Care System – screening, care, documentation, and programs to improve outcomes
 6. Community Engagement System – establishing and developing community partnerships with the goal of mutual benefit and collaboration to improve care to the older adult population and build sustainable resources for Community Based Agencies to strengthen services to their target community.

PCMH has shown that organization-wide change is possible when there is commitment. We, at SLU, are grateful for the opportunity to collaborate with this forward-thinking health system whose staff are willing to change the way they provide services for their community.

Thank you to David Pole, Ph.D., Director, Center for Interprofessional Education & Research, Assistant Professor, Family and Community Medicine, for providing information for this profile on Perry County Memorial Hospital.

"The care of older adults in this community is a priority for the hospital. I am very pleased the hospital has been able to support these geriatric programs that have greatly enhanced the health and lives of our most vulnerable community members."

- Patrick Carron, CEO



SERVICES

Services of the Division of Geriatric Medicine include clinics in the following areas:

- Aging and Developmental Disabilities • Bone Metabolism
- Falls: Assessment/Prevention •
- Geriatric Assessment •
- Geriatric Diabetes •
- Medication Reduction •
- Menopause •
- Nutrition • Podiatry •
- Rheumatology •
- Sexual Dysfunction •
- Urinary Incontinence •

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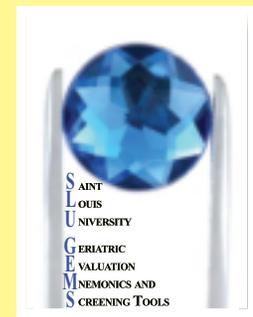
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(at Saint Louis University)

or **314-977-9601**

(at Des Peres Hospital's Medical Arts Pavillion)

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Interprofessional Graduate Certificate in Gerontology Now Offered at Saint Louis University

With an emphasis on developing competencies in interprofessional care of older adults, highlights of the certificate include:

- 15 credit-hours which include interprofessional and experiential/practicum opportunities
- Designed for post-baccalaureate students, current graduate students, and professionals currently working with older adults, including: dietitians and nutritionists, health care workers, occupational therapists, physical therapists, speech-language pathologists, nurses, nurse practitioners, social workers, and more.
- Opportunity to take courses across the university with a focus on:
 - Foundational competencies (frameworks for understanding human aging; biological, social, and psychological aspects of aging; humanities and aging; research and critical thinking)
 - Interactional competencies (attitudes and perspectives, ethics and professional standards, communication with and on behalf of older persons, interdisciplinary and community collaboration)
 - Contextual competencies (well-being, health and mental health; social health; and policy)



For more information, contact Cara L. Wallace, PhD, LMSW, Gerontology Certificate Coordinator at Cara.wallace@slu.edu or call 314-977-2746.

the MOSTEST (continued from page 19)

the group name and singing a song. The participants then discuss something that was popular in the past and how this has changed over their lifetime. For example, show them a model of



a Model-T Ford and talk about how cars replaced the horse and carriage and then show them pictures of cars from the 1930s and ask what their parents paid for their car (answer = \$690), then ask what cars cost today. Then show a picture of a modern Lamborghini (I like the ones of them being used as Italian police cars). Then read a clipping of a self-driving Google car and ask: “Who would have thought that?”

We showed that a combination of CST and an exercise program mark-

edly improved memory in nursing home residents.

Therapeutic Horticulture: We have a program where interacting with plants is used to improve residents’ body, mind and spirit. There is

a special emphasis on smelling heavenly scented flowers and spicy herbs. This program is run in conjunction with the Missouri Botanical Garden.

Dance Therapy: I have consistently danced with my patients. We are in the process of setting up a “Dancing with the STARFs (Staff)” program (see associated article on page 12).

Snoezelen Room: This stimulatory room with music and flashing lights can calm

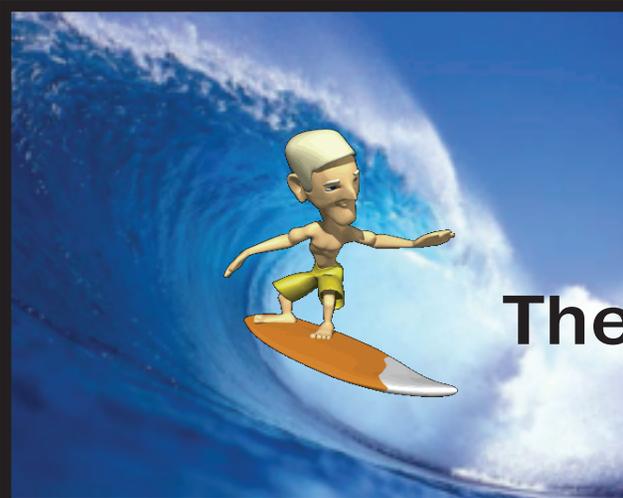
persons with agitated behaviors.

In conclusion, activities are a key to improving quality of life in the nursing home. NHC Maryland Heights together with Saint Louis University has developed a number of exciting activities which have been shown to enhance the enjoyment of living in a nursing home.

This article was originally published on Dr. Morley’s LinkedIn page.



**29th Annual Saint Louis University
Summer Geriatric Institute
Saint Louis University, St. Louis, MO
June 4 – 6, 2018**



The Aging Tsunami is Upon Us

The Division of Geriatric Medicine at Saint Louis University School of Medicine and the Gateway Geriatric Education Center are pleased to present the 29th Annual Saint Louis University Summer Geriatric Institute.

In addition to the 2-day Summer Institute, an optional training on Cognitive Stimulation Therapy (CST) will take place on June 6, 2018.

For full details and registration go to:

<https://slu.cloud-cme.com/summer>



CST

Cognitive Stimulation Therapy Training

Wednesday, June 6, 2018, 7:30 a.m. - 4:30 p.m.

Saint Louis University

**For additional details including course objectives and to register, visit
<https://slu.cloud-cme.com/summer>**



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