Elder Justice Interdisciplinary Team
Established in Chattanooga
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As a part of Mayor Andy Berke’s initiative with the Family Justice Center, an Elder Justice Interdisciplinary Team was recently established. One of the charges of this group was to present an aging forum where both professionals and elders could come together to learn about issues facing Chattanooga’s aging demographic.

According to the U.S. Census Bureau, 42.8% of Hamilton County’s citizens as of 2014 are 55 and older. Knowing this the interdisciplinary team along with the Southeast Tennessee Area Agency on Aging and Disabilities picked the theme “It Take A Village” to highlight the growing need for multifaceted resources to assist and inspire planning baby boomers, seniors, caregivers and professionals in the field of geriatrics.

The keynote speaker for the event was Amy Bouleware, Elder Care Planning Manager for Chambliss, Bahner and Stophel law firm. She spoke about how Chattanooga is rapidly becoming one of the best places to age successfully. Other session topics included the power of self-care, navigating Medicare, legal issues facing elders, and how to identify and prevent elder abuse. The April 1, 2016 event at Concord Baptist Church was attended by more than 100 people.

Elderhood Express was developed to disseminate evidence-based information to community agencies in the Chattanooga area who are intimately involved with the care of our population who are “outgrowing their youth.” Many newsletters and publications focus on childhood and adulthood, but it is rare to find one solely aimed at issues experienced in “elderhood.” Article selections will be chosen from a variety of disciplines. We will also provide listings of geriatric-focused community events as available.
Hospital Mobility: Evidence based guidance  
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Current projections for the growth of the aging population applied to the currently known hospitalization rate of 32% for older adults indicates that by the year 2030 there could be approximately 23 million older adults hospitalized.¹ Under our current health care system, this number of older adults would overwhelm the available hospital beds in the United States.² The solution is not to build more hospital beds but to improve the quality of care and prevention of illness. In the early 1980’s the concept of functional disability in the elderly was described, and recommendations for prevention was documented.³ Today as the impact of the number of older adults continues to rise we have the tools and processes to reduce this effect. One area to consider is a preventable functional decline, as a primary result of hospitalization.

Functional decline is described as a loss of ability to perform one or more activities of daily living. These activities include transfers from bed to chair, ambulation, toileting, bowel and bladder control, feeding, dressing and bathing. The data demonstrates that functional decline, associated with a change of prior living situation, has been linked to low mobility while hospitalized.⁴ Low mobility is a term used to distinguish the amount of movement out of bed which refers to bed to chair activities. Whereas ambulation is considered medium to high mobility depending on the frequency of ambulation.⁵ Low mobility is a result of many factors related to the hospitalized patient such as perception of illness, symptoms, co-morbidities and perception of availability of staff to assist. Also, treatments such as IV’s, orders for bed rest, medication and other devices contribute to low mobility. There are many barriers to mobility for the older adult admitted to an acute hospital.⁶ These barriers include the patient, treatment, institution, attitudes of staff, expectations of who is responsible, equipment, illness severity, comorbid conditions, symptoms, and delirium.⁶

An area that has contributed to low mobility in the hospital is the October 2008 Centers for Medicare and Medicaid Services (CMS) announcement that falls were listed as a “never event” condition. ⁷ This listing has encouraged many caregivers and manufacturers to respond by implementing programs and devices, such as bed and chair alarms, that decreased the chance of falls. Inadvertently, these devices and programs have discouraged
Evidence-Based Guidance for Providers, Healthcare Professionals, Caregivers, and Patients

Guidance for providers and health care professionals:
- Bed rest orders should only be reserved for those patients whose medical condition will deteriorate if they are mobilized. 12
- Bed rest should NOT be utilized as a “fall prevention” strategy. 8
- Low mobility contributes to pneumonia, urinary incontinence, skin breakdown, falls, delirium. 12,13
- Low to intermediate mobility can predict whether a patient will experience death in the two years post discharge from the hospital. 4
- Advocate for acute care units for the elderly or the components of such to minimize your patients functional decline and other adverse outcomes. 14,15,16

Guidance for patients and families:
- You should question your healthcare provider if your family member who is in a hospital stays in the bed or only gets up to the chair. 17
- You (caregiver) should inquire about how you can be a part of your family members mobility plan while in the hospital
- You (patient) should expect to be out of bed and walking as soon as your medical status allows

movement and has created an environment of low mobility, which is shown to increase falls and other more severe outcomes, such as death in the two years after discharge, for the hospitalized older adults. 8

Studies have indicated that all of the caregivers for older adults can play a role in improving mobility while hospitalized. 9,10,11 Provider orders that encourage mobility, nursing staff who contribute by mobilizing all patients unless contraindicated and referrals to Physical and Occupational Therapy when there is medical necessity all contribute to decreasing the impact of hospitalization on mobility.

Focus on mobility can improve a patient’s functional status, discharge to the previous living environment and overall survival post hospital stay. Also, patients and families understanding and involvement in mobility improve overall outcomes. Mobility is considered to be an important aspect of hospital care secondary to its impact on longer term survival. 4,5 Since the importance of mobility is established; the health care community can begin to understand the overall need to make mobility a priority. 5

While the need for health care will increase as our population continues to age it is prudent for our system to implement programs to eliminate preventable complications from hospitalization. These programs have already begun in areas such as preventing catheter-associated urinary tract infections and central line-associated infections. We should utilize the lessons learned from these as well as other quality improvement initiatives to provide health care that improves outcomes. Research has shown
how mobility impairments have evolved and in some ways how we can intervene to reverse the declines associated with hospitalization. As presented above, judicious use of bed rest, reduced use of tethers, appropriate referrals to therapy and family and caregiver education are all important in reducing hospital-associated functional decline.

References

8. Sinha SK, Detsky AS. Measure, promote and reward mobility to prevent falls in older patients. JAMA. December 2012; 308; 24: 2573-2574.
Informal Caregivers: Their Significant but Challenging Place in Society

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Informal caregiving is defined as the unpaid care by family/friends to those with a chronic illness or disability. The Family Caregiver Alliance estimates over that there are over 4 million caregivers providing care to frail and/or cognitively impaired individuals. The estimated economic value of the care provided by informal caregivers is more $234 billion dollars (National Health Policy Forum, 2013). Without informal caregivers, the long-term care budget would skyrocket. Also, because of informal caregivers, elders are able to “age in place”. This term refers to the ability of elders to remain in the comfort of their own home, in their familiar communities and in the presence of the familiar faces of those who love and care for them rather than transitioning to a long-term care facility.

Caregiving, especially for those with caring for Alzheimer's Disease caregivers, is especially challenging and can impact every aspect of the lives of informal caregivers. Many times, caregiver burden is the result. Caregiver burden is multi-faceted involving the physical, psychological and financial hardships experienced by the informal caregiver. In many instances, caregivers can become socially isolated, experience loss of freedom and become physically worn out (Cyburn, Stones, Hadjistavropoulos, & Tukko, 2000); Vitaliano, Russo, Young, Teri & Maiuro, 1991). Many caregivers experience medical complications along with the exacerbation of already diagnosed chronic illnesses as a result of their caregiving responsibilities (Shulz, et al, 1999). Factors such as being female and Caucasian, the functional dependence of the care recipient and limited
disease-related knowledge are influences in caregiver burden. Other factors such as resilience, increased disease-related knowledge and use of formal services are shown to be instrumental in decreasing informal caregiver burden (Scott, 2013).
Understanding that unaddressed caregiver burden can have damaging effects on informal caregivers. The following are practical but effective principles that can be used to intervene with and support informal caregivers in order to decrease caregiver burden:

- Use of formal services (case management, assessment, referrals, advocacy)
- Application of a strengths/resilience-based assessment to identify the caregiver’s coping and mastery skills
- Encourage the caregiver to tap into personal resilience qualities such as internal locus of control, tolerance to develop competence in caregiving responsibilities.
- Use the multi-faceted assessment to identify, build and encourage the utilization of a social support network
- Provide informal caregiver with disease specific information to improve health literacy for improved outcomes
- Encourage participation in support/education group meetings
- Use of respite services to increase opportunity for social interaction and outlets.

References


Shulz, R. & Beach, S. Caregiving as a risk factors for mortality. *JAMA.* 1999; 282(23); 2215-2219


The Facts About Delirium
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What is hospital-acquired delirium?
Delirium is a large-scale problem that impacts hospitalized elderly adults from 20% to 50% in general medical-surgical units and from 70% to 80% in intensive care units (Inouye, Westendorp, & Saczynski, 2014). Delirium is defined as an acute confused state that is characterized by compromised cognition, psychomotor disorders, inattention, and a fluctuating course (Eubank & Covinsky, 2014). Delirium can worsen a patient’s prognosis and recovery, prolong their length of stay, increase their chance of needing a long-term care or a transitional facility stay post-hospitalization, and elevate healthcare costs (Godfrey, Smith, Green, Cheater, Inouye, & Young, 2013). According to Leslie, Marcantonio, Zhang, Leo-Summers, & Inouye (2008), delirium costs the United States’ healthcare system greater than $150 billion dollars each year. While the exact susceptibilities for developing delirium are not completely clear, it has been noted that the incidence of delirium is higher in elderly patients, those who are critically ill, those who suffer cognitive impairments, and those who have experienced orthopedic trauma (Inouye & Charpentier, 1996).

Why is mobility related to delirium?
Studies of mobility in hospitalized clients have shown that 72.9-83% of the hospitalization was spent lying in bed, and there was no documented clinical indication for bed rest in 60% of the cases (Brown, Redden, Flood, & Allman, 2009; Callen, Mahoney, Grieves, Wells, & Enloe, 2004). Many adverse physiological changes transpire when patients are retained on bed rest, even as early as the first day. Complications during the first week of bed rest include but are not limited to contractures, skeletal muscle atrophy, pressure sores, sarcopenia 1-3% per day, plasma volume decreases by 8-10%, increased cardiovascular workload, increased heart rate, decreased stroke volume, decreased cardiac output, orthostatic hypotension, insulin resistance, micro-vascular dysfunction, and bone degradation (King, 2012). Additional complications from immobility can include pneumonia, atelectasis, ARDS, urinary stasis / retention, constipation / ileus, depression / anxiety / emotional lability, altered sleep pattern, venous stasis / DVT, and coordination defects (King, 2012). Furthermore, immobility or limited mobility is included as one of the ten clinical factors that are thought to contribute to hospital- acquired delirium (National Institute for Health and Care Excellence, 2010).

In a recent study, less than 10% of hospitals who responded to the survey noted having specific criteria in place to guide the timing of physical therapy interactions with critically ill (Hodgin, Nordon-Craft, McFann, Mealer, & Moss, 2009). Documented barriers to early mobility include lack of specific protocols or policies to address mobility in the ICU setting, fragmented care among the interdisciplinary team, culture of the ICU staff (mobility not seen as a priority intervention and staff perceptions of patients as too ill to mobilize), lack of education on complications of immobility, delirium, and staff resistance to change (Ross & Morris, 2010).

What can be done to reduce hospital-acquired delirium?
This author has worked to change the current practice of hospital-acquired delirium prevention by the employment of an early progressive mobility protocol within her (former) practice site. As previously reflected, delirium can cause many adverse effects on patients’ hospital courses, length of stay, overall outcomes, and discharge dispositions. By exploring the implementation of an early progressive mobility protocol compared to standard care practices to reduce the incidence of delirium in critically-ill patients, it was found that the employment of a mobility protocol was very effective. With statistically significant proportional reductions in the incidence of hospital-acquired delirium with a more than 50% reduction as well as a decrease in bed rest orders on the MINT and MICU nursing units, this author believes that the
research question has been successfully answered in a positive way. It is the hope that the early progressive mobility protocol and algorithm will become a permanent best-practice initiative that will be utilized in a wide-spread manner.

There is still work to be done in the ICU microsystems regarding the culture of mobility, but this was believed by both physical therapy and nursing staff to be a good starting point. Interdisciplinary collaboration seemingly improved as nursing and physical therapy were working together towards the common goal of increased patient mobility. Future studies should be planned to further investigate the efficacy of the interventions and their impact on intensive care patients, as well as to examine nursing’s compliance with documentation regarding the mobility protocol in the electronic medical record.

References


