Presenter's Bio

Heather Schickedanz, MD

Dr. Heather Schickedanz is a family physician-geriatrician originally from Long Beach, California.

She completed her undergraduate education at UC Berkeley and medical training at UCSF, then joined the UCLA faculty in 2014. There, she helped develop and implement workforce education for inter-professional teams caring for older adults and persons with dementia.

Dr. Schickedanz joined the Los Angeles County Department of Health Services in 2015, and currently serves as the Chair of the Department of Family Medicine at Harbor-UCLA Medical Center.

She is the founder and Co-Chair of the LA County Health Agency Geriatrics Workgroup, and serves on several Los Angeles county committees and task forces to improve health equity and wellness for older adults.

Her work includes primary care leadership, family medicine and geriatrics research, clinical care, and teaching.

She is a proud mom of two and married to a Pediatrician.

IMPROVING THE HEALTH OF DIVERSE OLDER ADULTS

GERIATRICS IN PRIMARY CARE

JUNE 10, 2023 L.A. CARE GERIATRIC CARE CONFERENCE IN COLLABORATION WITH ALZHEIMER'S LOS ANGELES

HILTON SAN GABRIEL, CA 91776

DIRECTLY PROVIDED CME / CE ACTIVITY

BY L.A. CARE HEALTH PLAN

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CHAIR, HARBOR-UCLA FAMILY MEDICINE
CO-CHAIR, LA COUNTY GERIATRICS WORKGROUP
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Harbor-UCLA FAMILY MEDICINE

Health Services LOS ANGELES COUNTY

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The following CME Planners and CME Faculty do not have any financial relationships with ineligible companies in the past 24 months:

- Leilanie Mercurio, L.A. Care PCE Program Manager, CME Planner.
- Jennifer Schlesinger, MPH, CHES, Alzheimer's Los Angeles Vice President, Healthcare Services & Professional Training, CME Planner.
- Alicia Villegas, LCSW, Alzheimer's Los Angeles Director of Healthcare Client Services, CME Planner.
- Heather Schickedanz, MD, Chair, Harbor-UCLA Family Medicine; Co-Chair, Los Angeles County Geriatrics Work Group; and Assistant Professor, UCLA David Geffen School of Medicine; CME Faculty.

An Ineligible company is any entity whose primary business is producing, market-ing, selling, re-selling, or distributing healthcare products used by or on patients.

Commercial support was not received for this CME/CE activity.

Welcome!

- Introduction
- Aging in Los Angeles
- The Geriatric 5M’s Framework
- Resources
- Q&A

Medi-Cal Expansion

Good News!

Starting May 1, 2022, **all people 50 and older** who are eligible can get **"Full-Scope" Medi-Cal**. **Immigration status does not matter**.

"Full-scope" Medi-Cal is FREE health insurance that covers all types of care including: doctor's visits, specialist appointments, dental, vision, prescription drugs, in-home care, transportation to appointments, and more!

I am 50 or older (or will be in May). How do I enroll?

- If you already have "Emergency" Medi-Cal, you will automatically get "Full-Scope" Medi-Cal on May 1, 2022.
- If you don't already have "Emergency" Medi-Cal, you should enroll now so that you can automatically get "Full-Scope" in May. Contact your clinic or the groups below.

Remember!

- My Health LA is not insurance. Medi-Cal is.
- Getting "Full-Scope" Medi-Cal **will not** affect the immigration status of you or your family.

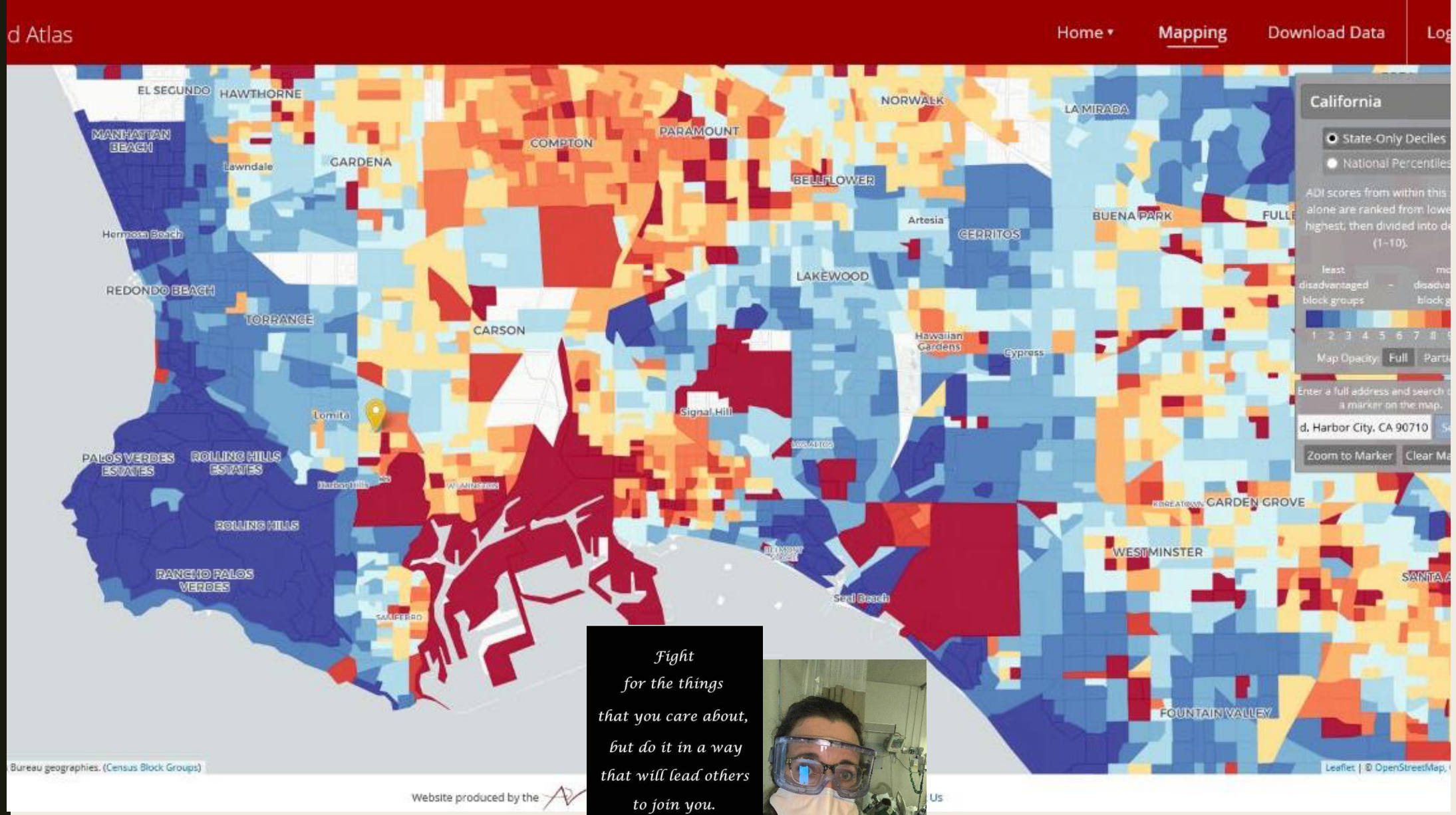
The only possible exception is if you are going to use Medi-Cal to pay for long-term nursing home care. You can talk to a BAILA lawyer to learn more.

In Los Angeles County, the Community Health Outreach Initiative (CHOI) (https://bit.ly/3ppVUnt) and the BAILA Network (www.bailanetwork.org or 1-888-624-4752) can answer your questions and help you enroll!

BAILA Benefits Access for Immigrants Los Angeles

Learning Objectives

1. Describe the "Geriatric Five (5) M's" framework for care of older adults.
2. Identify evidence-based tools for primary care providers to assess older adults' cognitive health, falls risk, medication risk, and advance care plans.
3. Recognize the impact of social determinants of health and health care disparities on diverse older adults, within the context of the 5 M's framework.
4. List at least three (3) community-based resources that can help primary care clinic teams support diverse older adults.



Fight
for the things
that you care about,
but do it in a way
that will lead others
to join you.

Ruth Bader Ginsburg

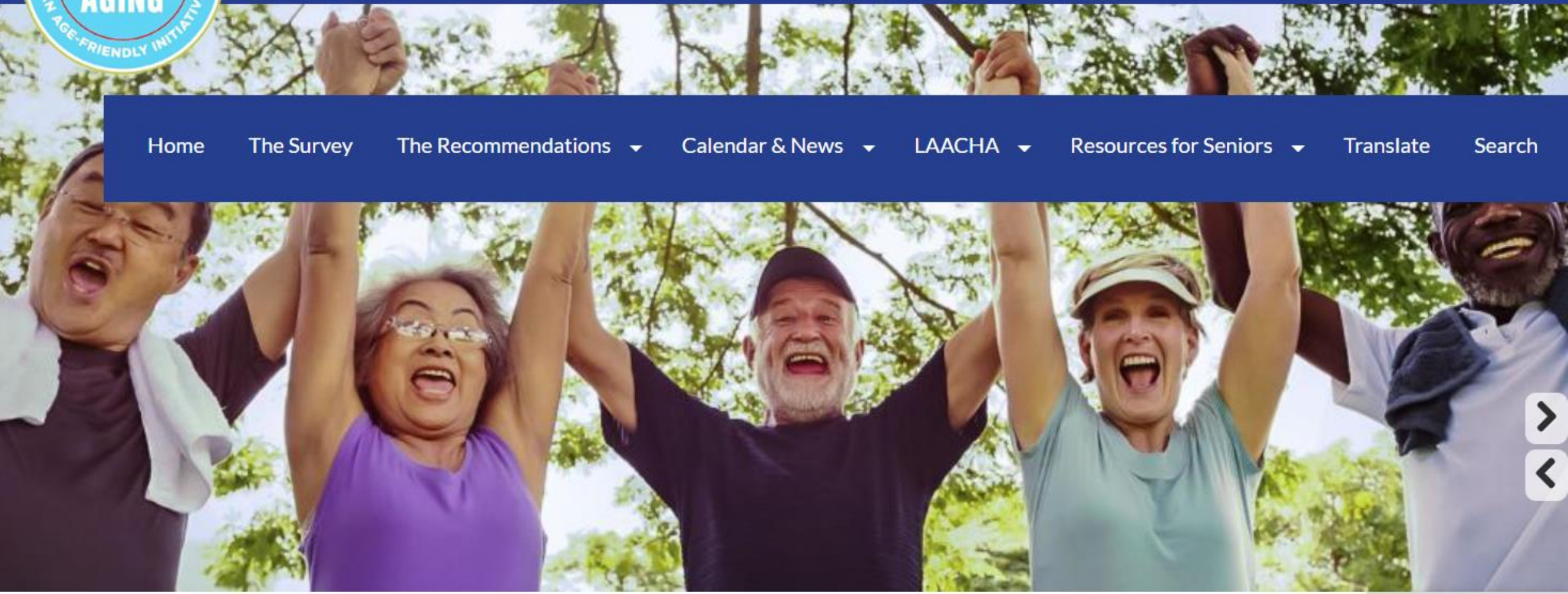
https://www.purposefulagingla.com

LOS ANGELES

! Update on coronavirus | 311 City Services | LA City Directory

PURPOSEFUL AGING
LOS ANGELES
AN AGE-FRIENDLY INITIATIVE

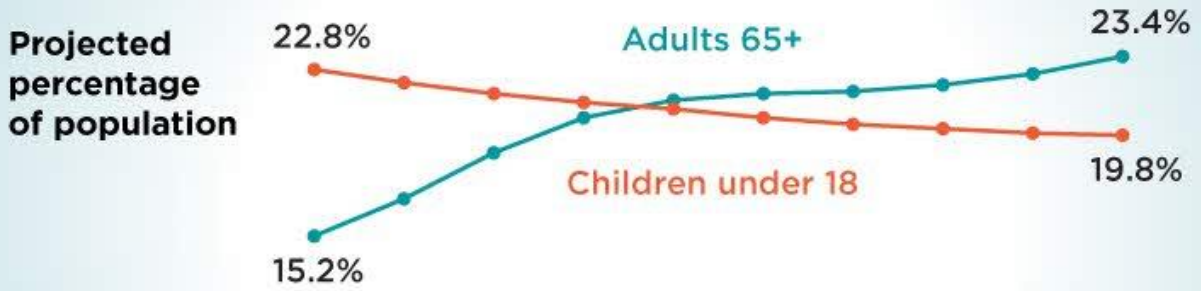
Home | The Survey | The Recommendations | Calendar & News | LAACHA | Resources for Seniors | Translate | Search



An Aging Nation

Projected Number of Children and Older Adults

For the First Time in U.S. History Older Adults Are Projected to Outnumber Children by 2034



Note: 2016 data are estimates not projections.

United States® Census Bureau

U.S. Department of Commerce
U.S. CENSUS BUREAU
census.gov

Source: National Population Projections, 2017
www.census.gov/programs-surveys/popproj.html

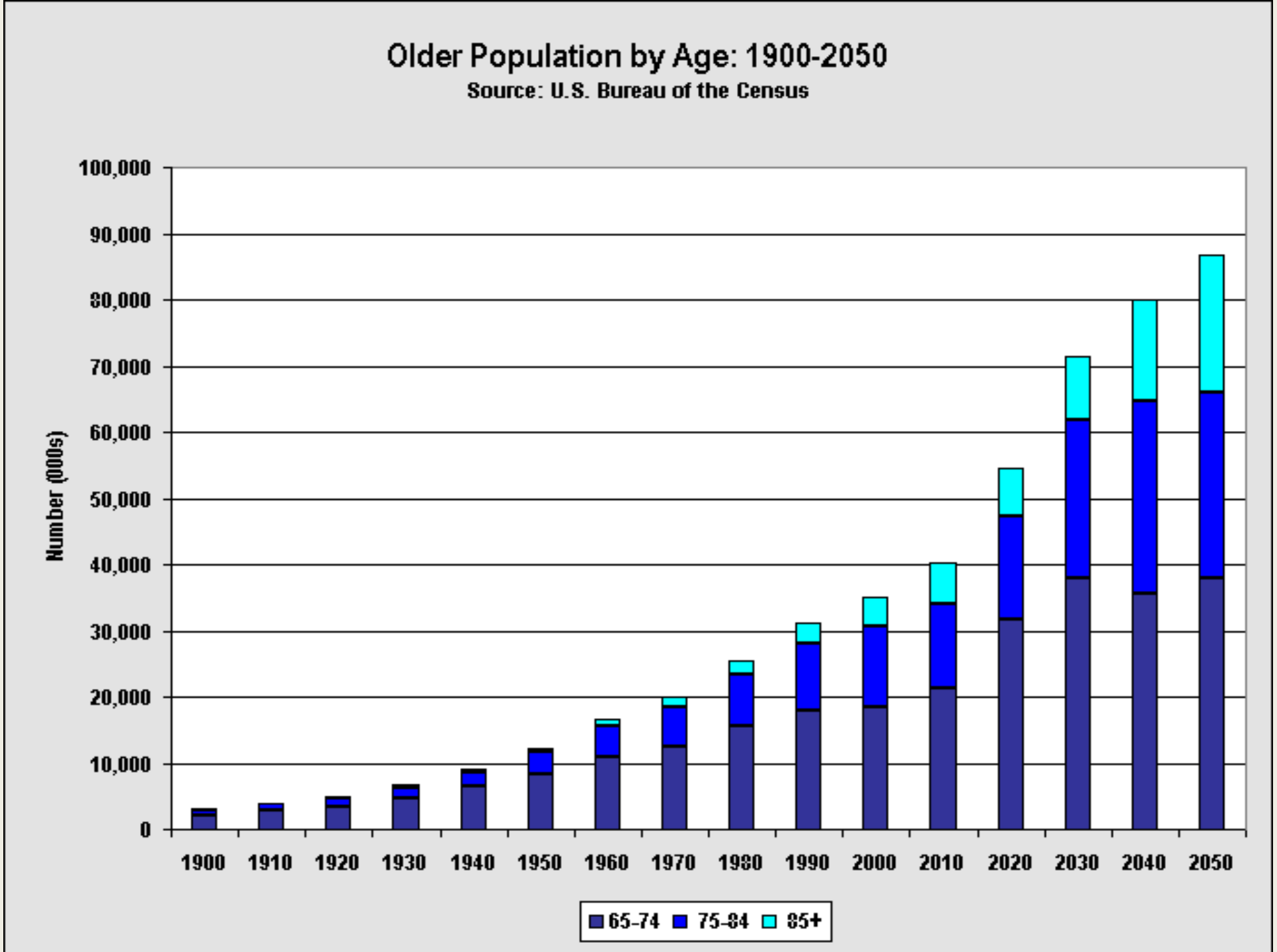
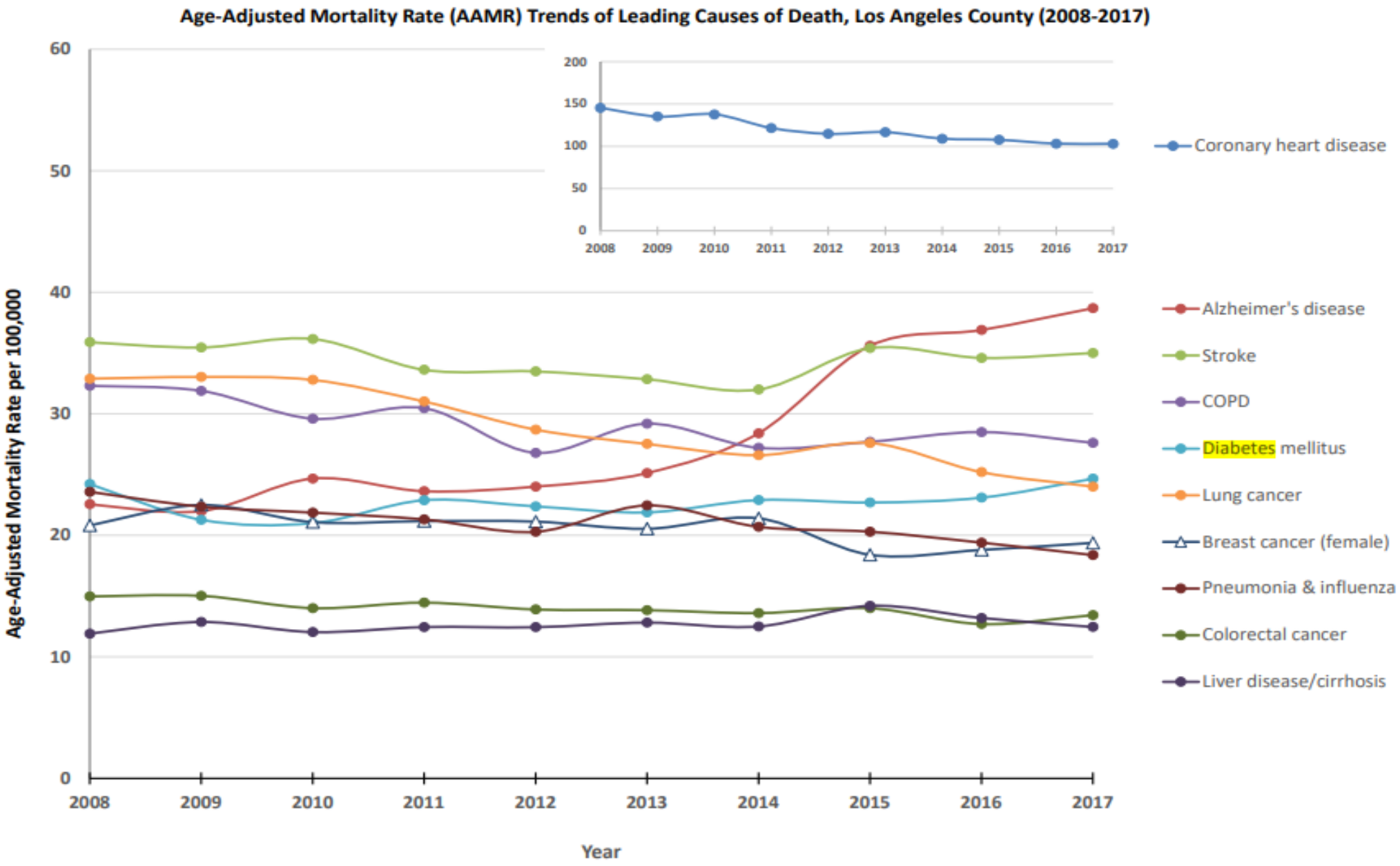

Older Population by Age: 1900-2050
Source: U.S. Bureau of the Census
Number (000s)
100,000
90,000
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
1900
1910
1920
1930
1940
1950
1960
1970
1980
1990
2000
2010
2020
2030
2040
2050
65-74
75-84
85+

FIGURE D-1: TRENDS IN LEADING CAUSES OF DEATH, LOS ANGELES COUNTY 2008-2017



Patterns of Mortality in Los Angeles County, 2008-2017

Let's Geriatricize!

Normal Aging

Geriatric Assessment: An Office-Based Approach

Paul E. Tatum III, MD, MSPH, University of Missouri, Columbia, Missouri
Shaida Talebreza, MD, University of Utah School of Medicine, Salt Lake City, Utah
Jeanette S. Ross, MD, University of Texas Health Science Center, San Antonio, Texas

Family physicians should be proficient in geriatric assessment because, as society ages, older adults will constitute an increasing proportion of patients. Geriatric assessment evaluates medical, social, and environmental factors that influence overall well-being, and addresses functional status, fall risk, medication review, nutrition, vision, hearing, cognition, mood, and toileting. The Medicare Annual Wellness Visit includes the key elements of geriatric assessment performed by family physicians. Comprehensive geriatric assessment can lead to early recognition of problems that impair quality of life by identifying areas for focused intervention, but a rolling geriatric assessment over several visits can also effectively identify subtle or hidden problems. Assessment should be tailored to patient goals of care and life expectancy. By asking patients and families to self-assess risks using precompleted forms, and by using trained office staff to complete validated assessment tools, family physicians can maximize efficiency by focusing on identified problems. Fall risk can be assessed with a single screening question: "Have you fallen in the past year?" The Beers, STOPP (screening tool of older persons' prescriptions), and START (screening tool to alert doctors to right treatment) criteria are helpful resources for reviewing the appropriateness of medications in older adults. Screening for depression is recommended when depression care supports are available; this can be performed with a brief two-item screen, the Patient Health Questionnaire-2. Older adults should be screened for unintentional weight loss and malnutrition. Although rates of hearing loss and vision loss increase with age, there is insufficient evidence to recommend screening in asymptomatic individuals. The U.S. Preventive Services Task Force advises clinicians to assess cognition when there is suspicion of impairment. Urinary incontinence can impair patients' quality of life, and it can be assessed with a two-question screening tool. Immunizations and advance care planning are also important components of the geriatric assessment. (*Am Fam Physician*. 2018;97(12):776-784. Copyright © 2018 American Academy of Family Physicians.)

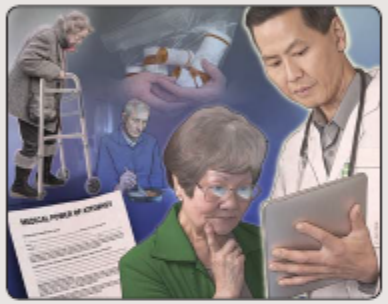


Illustration by Catherine Delphia

Older adults with complex chronic conditions will be an increasing proportion of family physicians' patient population. In 2015, patients older than 65 years accounted for 31% of all U.S. office visits, and that proportion will grow.[1] Since 2013, every day 10,000 baby boomers turn 65 years of age and enter Medicare.[2] By 2030, the population older than 65 years will double to 72 million (20% of the total U.S. population).[2] Individuals are living longer, with multiple chronic illnesses, making them vulnerable to disability and diminished quality of life. Although 95% of older patients with complex needs have regular access to care, 58% struggle to navigate the system, and 62% are stressed about their ability to afford housing, utilities, or meals.[3] Geriatric assessment, which evaluates medical problems; cognitive, affective, and functional abilities; and social and environmental factors, can identify these unrecognized needs to improve the well-being of older adults.

Additional content at https://www.aafp.org/afp/2018/0615/p776.html.

CME This clinical content conforms to AAFP criteria for continuing medical education (CME). See CME Quiz on page 774.

Author disclosure: No relevant financial affiliations.

Evidence Base for Comprehensive Geriatric Assessment

Most of the literature supporting geriatric assessment models involves specialized geriatric team-based assessment. Comprehensive geriatric assessment is a systematic

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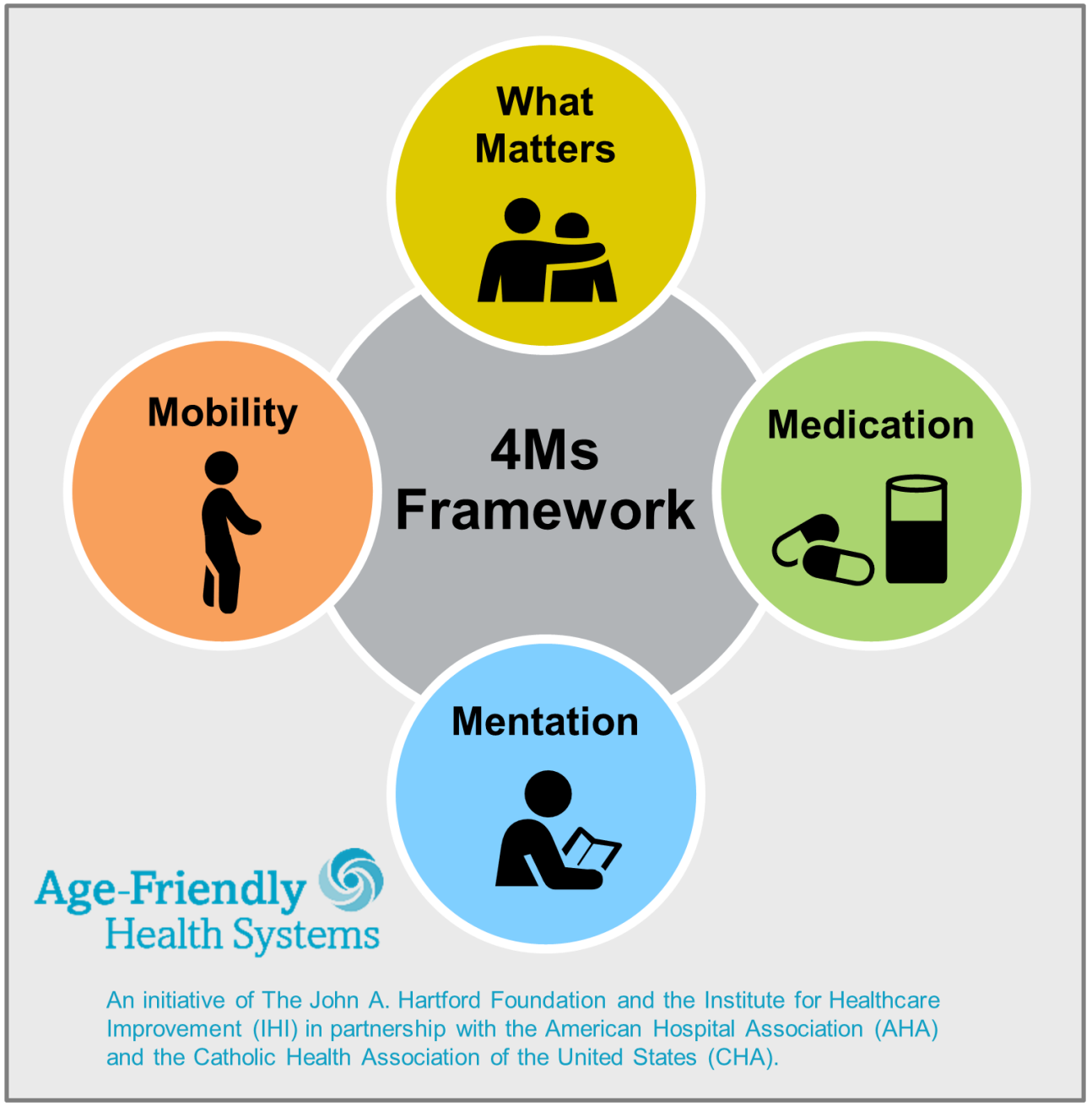


What Matters

Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication

If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

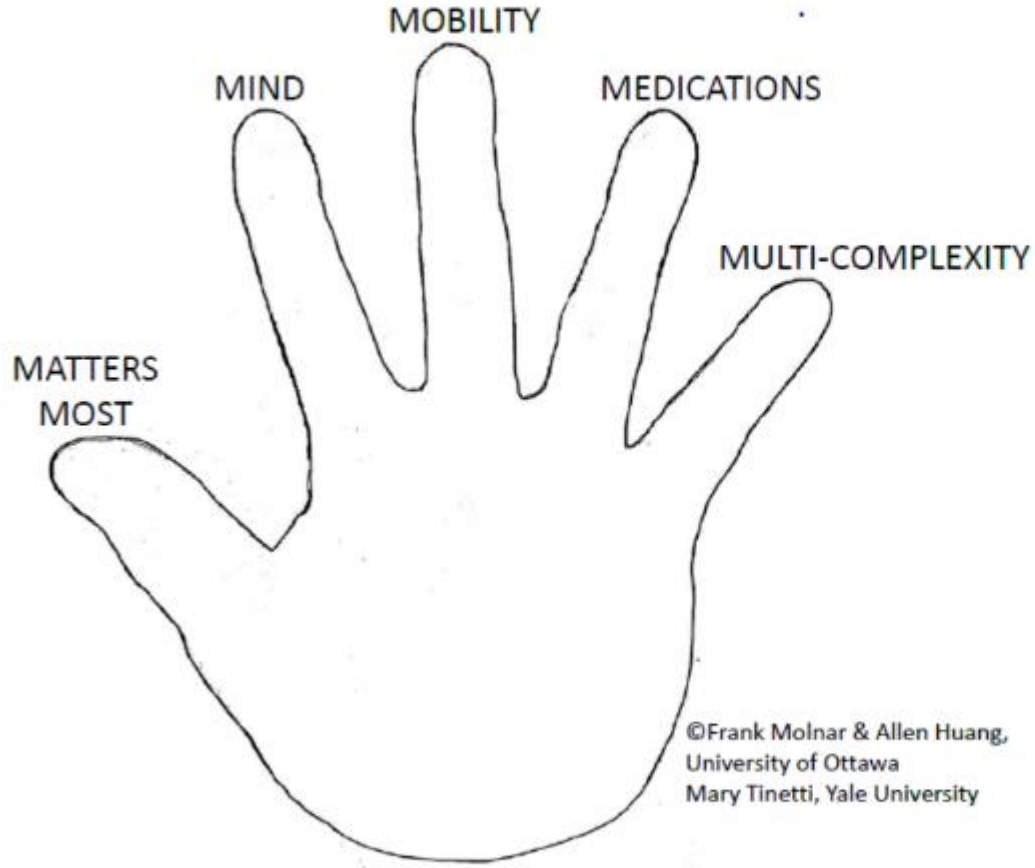
Mentation

Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility

Ensure that older adults move safely every day in order to maintain function and do What Matters.

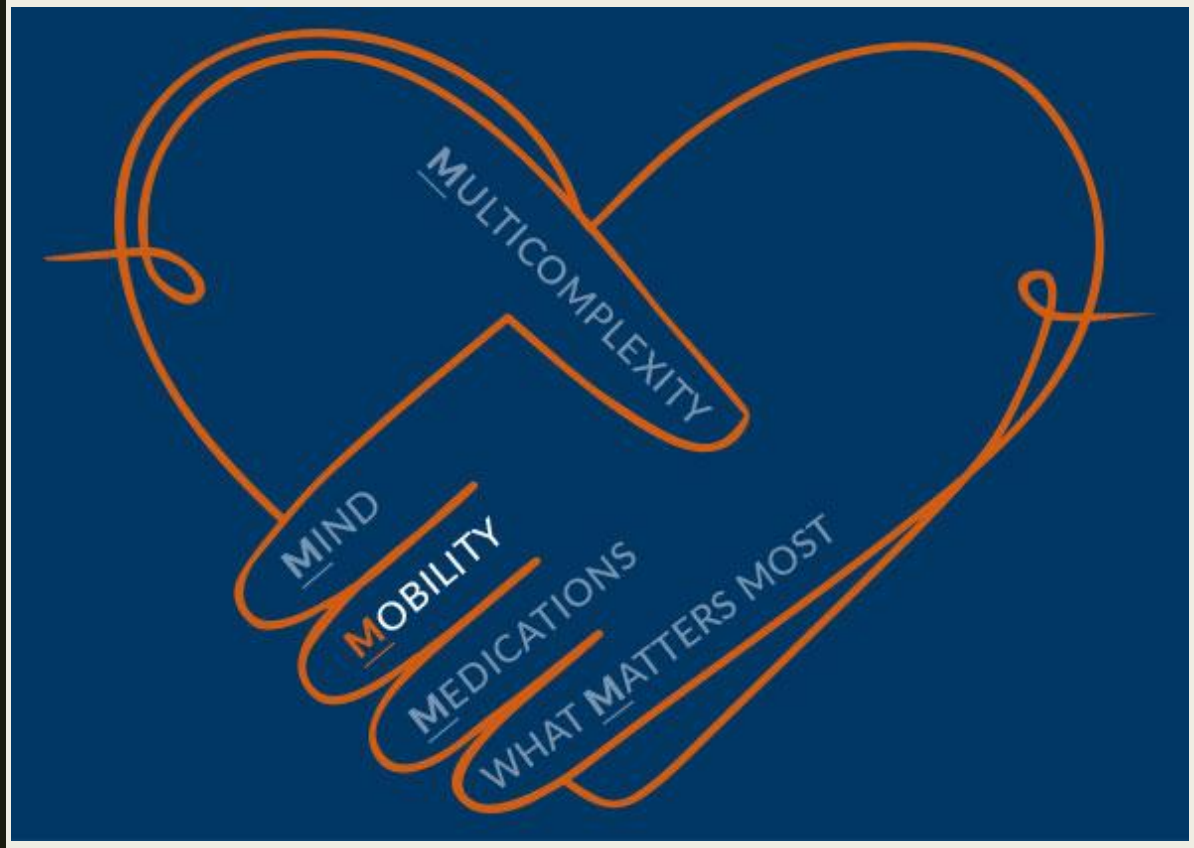
Visual of a hand providing an alternative representation of the GERIATRIC 5Ms© framework



Dr. Frank Molnar

Canadian Geriatrics Society, CME Journal

HIA-TipSheet Geriatric 5Ms.July20_0.pdf (healthinaging.org)



5 M'S GERIATRICS FRAMEWORK

1. Multicomplexity: Social determinants of health, Caregiving, Level of Care, Linguistic and Cultural considerations – we will consider these throughout, and end with a couple of cases.

2. Mind: Cognitive Health, Dementia, Delirium, Depression/Mood

3. Mobility: Functional status, Gait + balance, Fall prevention

4. Medications: Polypharmacy, De-prescribing, Dosing, DDIs-ADE's, Pill burden

5. What Matters Most: Values, Goals of Care, Decision Maker, Advance Care Planning, Advance Directives, POLST.

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Mind: A Brief Cognitive Health Screening

Mini-Cog©

Instructions for Administration & Scoring

ID: _____ Date: _____

Step 1: Three Word Registration

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.[1-5] For repeated administrations, use of an alternative word list is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

Step 2: Clock Drawing

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

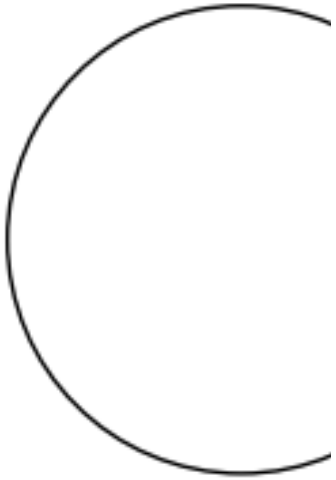
Word List Version: _____ Person's Answers: _____ _____ _____

Scoring

Word Recall: _____ (0-3 points)	1 point for each word spontaneously recalled without cueing.
Clock Draw: _____ (0 or 2 points)	Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored. Inability or refusal to draw a clock (abnormal) = 0 points.
Total Score: _____ (0-5 points)	Total score = Word Recall score + Clock Draw score. A cut point of <3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of <4 is recommended as it may indicate a need for further evaluation of cognitive status.

Clock Drawing

ID: _____



References

1. Borson S, Scanlan JM, Chen PJ et al. The Mini-Cog as a screen f sample. J Am Geriatr Soc 2003;51:1451–1454.
2. Borson S, Scanlan JM, Watanabe J et al. Improving identificatio Geriatr Psychiatry 2006;21: 349–355.
3. Lessig M, Scanlan J et al. Time that tells: Critical clock-drawing Psychogeriatr. 2008 June; 20(3): 459–470.
4. Tsoi K, Chan J et al. Cognitive tests to detect dementia: A syste Intern Med. 2015; 61-69.
5. McCarten J, Anderson P et al. Screening for cognitive impairmer Acceptability and results using different versions of the Mini-Co
6. McCarten J, Anderson P et al. Finding dementia in primary care: project. J Am Geriatr Soc 2012; 60: 210-217.
7. Scanlan J & Borson S. The Mini-Cog: Receiver operating charact Geriatr Psychiatry 2001; 16: 216-222.

AD8 Dementia Screening Interview

Patient ID#: _____
CS ID#: _____
Date: _____

Remember, "Yes, a change" indicates that there has been a change in the last several years caused by cognitive (thinking and memory) problems.	YES, A change	NO, No change	N/A, Don't know
1. Problems with judgment (e.g., problems making decisions, bad financial decisions, problems with thinking)			
2. Less interest in hobbies/activities			
3. Repeats the same things over and over (questions, stories, or statements)			
4. Trouble learning how to use a tool, appliance, or gadget (e.g., VCR, computer, microwave, remote control)			
5. Forgets correct month or year			
6. Trouble handling complicated financial affairs (e.g., balancing checkbook, income taxes, paying bills)			
7. Trouble remembering appointments			
8. **Daily** problems with thinking and/or memory			
TOTAL AD8 SCORE			

Adapted from Galvin JE et al, The AD8, a brief informant interview to detect dementia, Neurology 2005:65:559-564

Mind: A Multicultural Cognitive Assessment

R U D A S

The Rowland Universal Dementia Assessment Scale: A Multicultural Cognitive Assessment Scale.
(Storey, Rowland, Basic, Conforti & Dickson, 2004). International Psychogeriatrics, 16 (1), 13-31

Date: ___/___/___ Patient **Name:** _____

Item		Max Score
Memory 1. (Instructions) I want you to imagine that we are going shopping. Here is a list of grocery items. I would like you to remember the following items which we need to get from the shop. When we get to the shop in about 5 mins. time I will ask you what it is that we have to buy. You must remember the list for me. **Tea, Cooking Oil, Eggs, Soap** Please repeat this list for me (ask person to repeat the list 3 times). (If person did not repeat all four words, repeat the list until the person has learned them and can repeat them, or, up to a maximum of five times.)		
Visuospatial Orientation 2. I am going to ask you to identify/show me different parts of the body. *(Correct = 1)*. Once the person correctly answers 5 parts of this question, do not continue as the maximum score is 5. (1) show me your right foot (2) show me your left hand (3) with your right hand touch your left shoulder (4) with your left hand touch your right ear (5) which is (indicate/point to) my left knee (6) which is (indicate/point to) my right elbow (7) with your right hand indicate/point to my left eye (8) with your left hand indicate/point to my left foot	.....1 .....1 .....1 .....1 .....1 .....1 .....1 1	..../5
Praxis 3. I am going to show you an action/exercise with my hands. I want you to watch me and copy what I do. Copy me when I do this . . . (One hand in fist, the other palm down on table - alternate simultaneously.) Now do it with me: Now I would like you to keep doing this action at this pace until I tell you to stop - approximately 10 seconds. (Demonstrate at moderate walking pace). Score as: *Normal* = 2 *(very few if any errors; self-corrected, progressively better; good maintenance; only very slight lack of synchrony between hands)* *Partially Adequate* = 1 *(noticeable errors with some attempt to self-correct; some attempt at maintenance; poor synchrony)* *Failed* = 0 *(cannot do the task; no maintenance; no attempt whatsoever)*		..../2
Visuoconstructional Drawing 4. Please draw this picture exactly as it looks to you (Show cube on back of page). *(Yes = 1)* Score as: (1) Has person drawn a picture based on a square? (2) Do all internal lines appear in person's drawing?  (3) Do all external lines appear in person's drawing? 	.....1 .....1 1	..../3
Judgment 5. You are standing on the side of a busy street. There is no pedestrian crossing and no traffic lights. Tell me what you would do to get across to the other side of the road **safely**. (If person gives incomplete response that does not address both parts of answer, use prompt: "Is there anything else you would do?") Record exactly what patient says and circle all parts of response which were prompted. .... Score as: Did person indicate that they would look for traffic? *(YES = 2; YES PROMPTED = 1; NO = 0)* Did person make any additional safety proposals? *(YES = 2; YES PROMPTED = 1; NO = 0)*	 .....2 2	..../4

Functional Activities Questionnaire

Administration

Ask informant to rate patient's ability using the following scoring system:

- Dependent = 3
- Requires assistance = 2
- Has difficulty but does by self = 1
- Normal = 0
- Never did [the activity] but could do now = 0
- Never did and would have difficulty now = 1

1.	Writing checks, paying bills, balancing checkbook	
2.	Assembling tax records, business affairs, or papers	
3.	Shopping alone for clothes, household necessities, or groceries	
4.	Playing a game of skill, working on a hobby	
5.	Heating water, making a cup of coffee, turning off stove after use	
6.	Preparing a balanced meal	
7.	Keeping track of current events	
8.	Paying attention to, understanding, discussing TV, book, magazine	
9.	Remembering appointments, family occasions, holidays, medications	
10.	Traveling out of neighborhood, driving, arranging to take buses	
	TOTAL SCORE:	

Evaluation

Sum scores (range 0-30). Cut-point of 9 (dependent in 3 or more activities) is recommended to indicate impaired function and possible cognitive impairment.

Pfeffer, R.I., Kurosaki, T.T., Harrah, C.H. Jr., Chance, J.M., & Filos, S. (1982). Measurement of functional activities in older adults in the community. *Journal of Gerontology, 37*(3), 323-329. Reprinted with permission of Oxford University Press.

Diagnostic criteria for major neurocognitive disorder (dementia)

A. Significant cognitive decline from a previous level of performance based on:

1. Concern of the individual, a knowledgeable informant or the clinician

2. A substantial impairment in cognitive performance by standardized neuropsychological testing or, in its absence, another quantified clinical assessment.

B. The cognitive deficits interfere with independence in everyday activities

C. The cognitive deficits do not occur exclusively in the context of a delirium.

D. The cognitive deficits are not better explained by another mental disorder.

Specify:

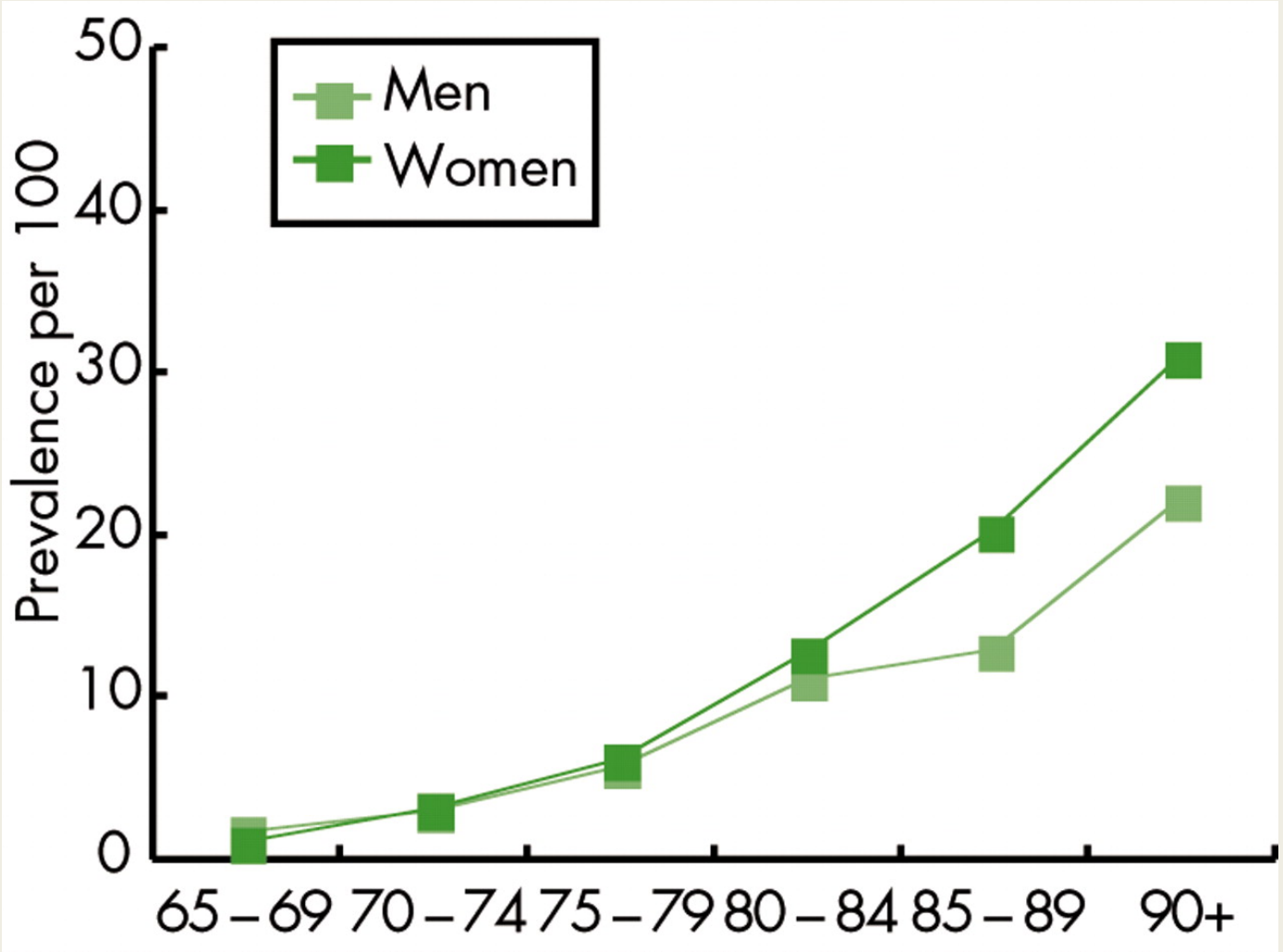
- Without behavioral disturbance:
- With behavioral disturbance (specify disturbance)

Estimated Number and Percent Change in People 65+ with AD by Race/Ethnicity in LAC, 2019 and 2040[2]			
Race/Ethnicity	**2019**	**2040**	**% Change**
Non-Latino White/Caucasian	72,055	142,764	98%
Asian American/ Pacific Islander	31,245	68,225	118%
Black/African American	13,962	35,341	153%
Other	2,173	6,072	179%
Latino	47,422	152,980	223%

Estimated Number of People Age 55+ with Alzheimer's Disease by Race in Los Angeles County

RACE	2019	2025	2040
White/Caucasian American, Non-Latino/a/x	75,600	93,037	145,609
Latino/a/x American	51,537	70,676	158,654
Black/ African American	14,921	19,844	36,150
Asian American/Pacific Islander	35,952	41,354	69,825
Native American	414	462	985
Multirace	1,920	2,574	5,309
TOTAL	**182,363**	**229,972**	**418,572**

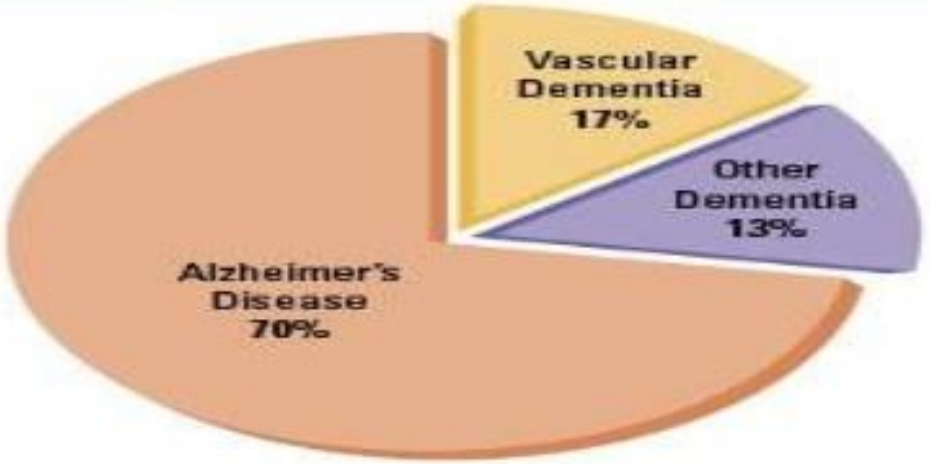
Pooled prevalence of dementia by sex.



W M van der Flier, and P Scheltens J Neurol Neurosurg Psychiatry 2005;76:v2-v7

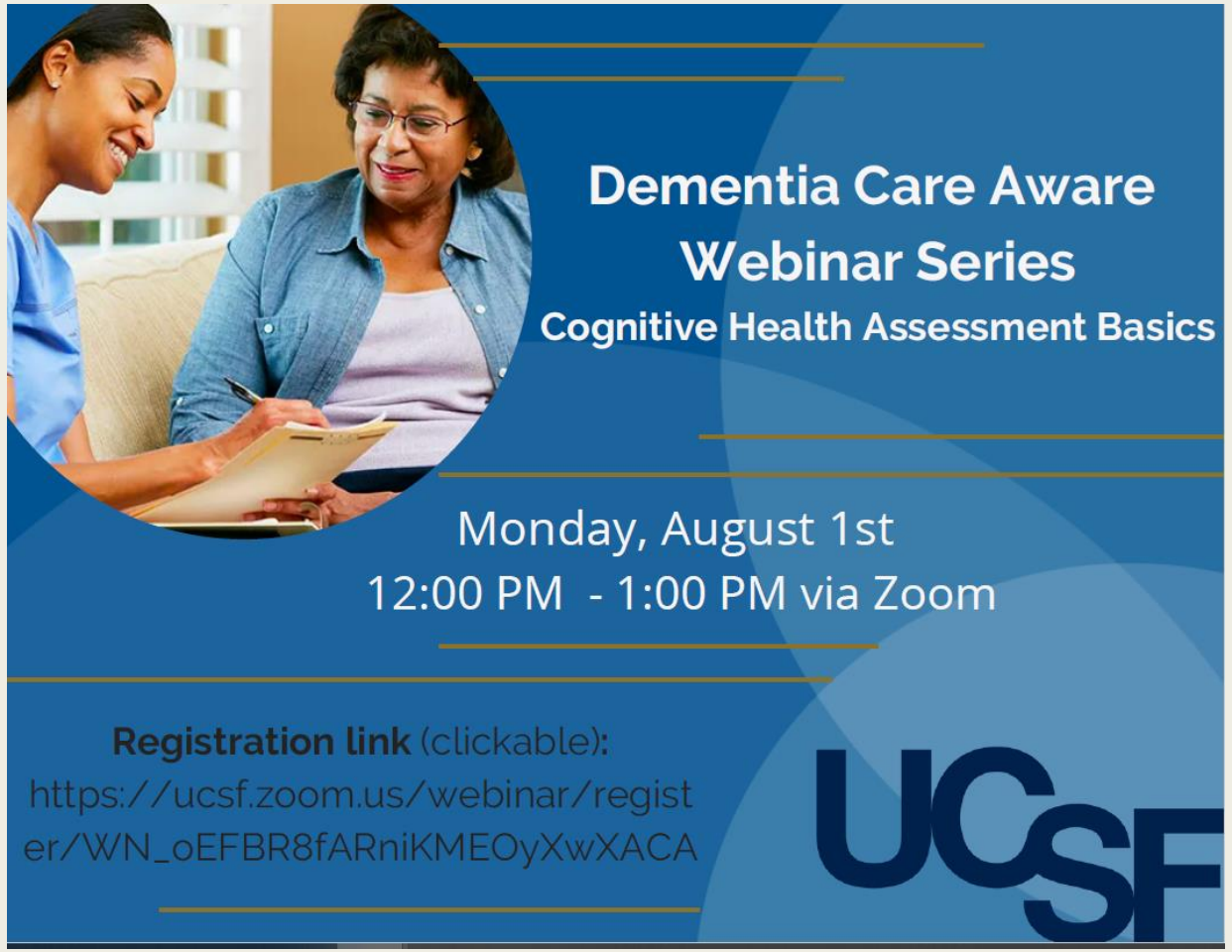
JNNP

Overall Situation:	USA DATA
Alzheimer's disease	70 %
Vascular Dementia	15-20%
Lewy Body	10-15 %



Source: Plassman, BL; Langa, KM; Fisher, GG; Heeringa, SG; Weir, DR; Ofstedal, MB, et al. "Prevalence of Dementia in the United States: The Aging

FREE dementia care training is available!



https://ucsf.zoom.us/webinar/register/WN_oEFBR8fARniKMEOyXwXACA

Dementia Care Aware **GOALS**

Through the Cognitive Health Assessment*, training, and practice support for providers:

- *Dementia Care Aware will rapidly improve the ability of primary care teams serving Medi-Cal beneficiaries to **detect dementia** and create a stage-appropriate care plan.*
- *Tailor training and resources to Medi-Cal beneficiaries' needs.*
- ***Improve care and quality of life** for people living in dementia, especially those who are higher risk and from communities that have historically experienced **disparities**.*

*In accordance with SB 48, benefit is accessible to patient 65 and older with Medi-Cal only and from trained providers.

Medications:

Avoiding PolypHARMacy

1. Complete Meds History and Reconciliation

2. Identify meds on the Beer's List

3. Recognize the Prescribing Cascade and Deprescribe

From THE AMERICAN GERIATRICS SOCIETY

A POCKET GUIDE TO THE 2019 AGS BEERS CRITERIA®

This guide has been developed as a tool to assist healthcare providers in improving medication safety in older adults. The role of this guide is to *inform* clinical decision-making, research, training, quality measures and regulations concerning the prescribing of medications for older adults to improve safety and quality of care. It is based on *The 2019 AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults.*

Originally conceived of in 1991 by the late Mark Beers, MD, a geriatrician, the Beers Criteria catalogues medications that cause side effects in older adults due to the physiologic changes of aging. In 2011, the AGS sponsored its first update of the criteria, assembling a team of experts and using an enhanced, evidence-based methodology. Since 2011, the AGS has been the steward of the criteria and has produced updates using an evidence-based methodology and rating each Criterion (quality of evidence and strength of evidence) using the American College of Physicians' Guideline Grading System, which is based on the GRADE scheme developed by Guyatt et al.

The full document, along with accompanying resources, can be found in its entirety online at geriatricscareonline.org.

INTENDED USE

The goal of this guide is to improve care of older adults by reducing their exposure to Potentially Inappropriate Medications (PIMs).

- This should be viewed as a guideline for identifying medications for which the risks of their use in older adults outweigh the benefits.
- These criteria are not meant to be applied in a punitive manner.
- This list is not meant to supersede clinical judgment or an individual patient's values and needs. Prescribing and managing disease conditions should be individualized and involve shared decision-making.
- These criteria also underscore the importance of using a team approach to prescribing and the use of non-pharmacological approaches and of having economic and organizational incentives for this type of model.
- A companion piece that addresses the best way for patients, providers, and health systems to use (and not use) the AGS Beers Criteria® was also developed. The document can be found on geriatricscareonline.org.

The criteria are not applicable in all circumstances (i.e. patients receiving palliative and hospice care). If a provider is not able to find an alternative and chooses to continue to use a drug on this list in an individual patient, designation of the medication as potentially inappropriate can serve as a reminder for close monitoring so that adverse drug effects can be incorporated into the electronic health record and prevented or detected early.

AGS THE AMERICAN GERIATRICS SOCIETY
Geriatrics Health Professionals.
Leading change. Improving care for older adults.

TABLE 1. 2019 American Geriatrics Society Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults

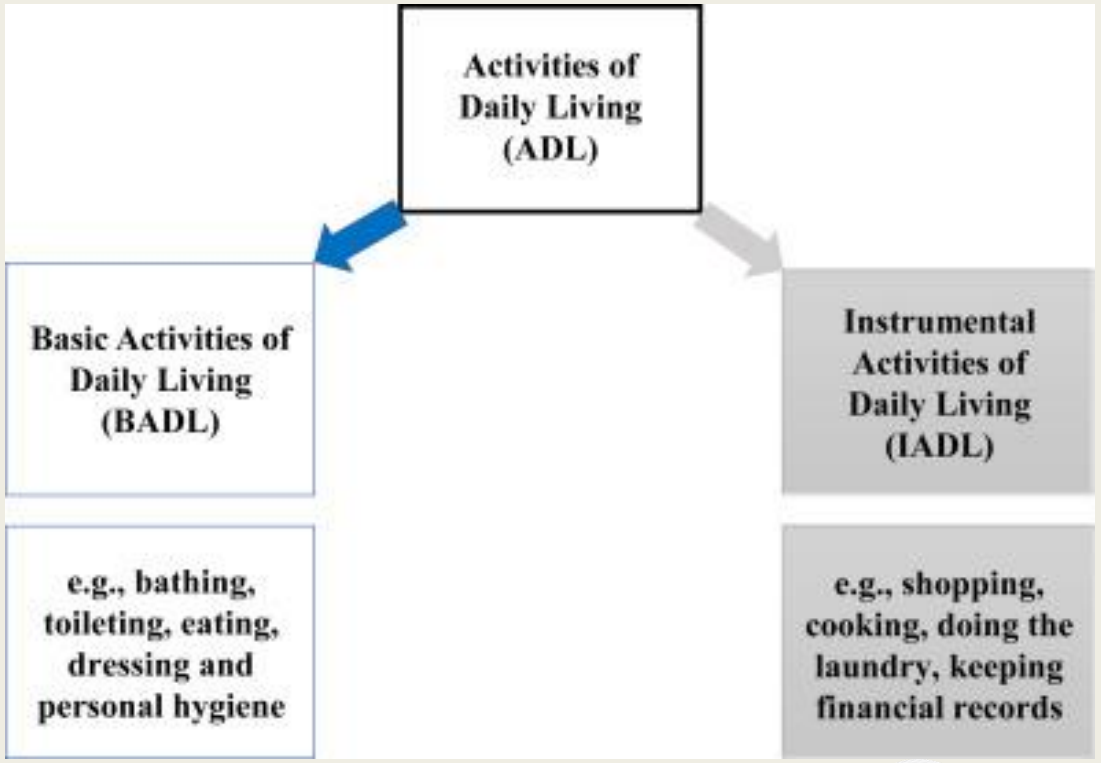
Organ System, Therapeutic Category, Drug(s)	***Recommendation,*** Rationale, *Quality of Evidence (QE), Strength of Recommendation (SR)*
*Anticholinergics **	
First-generation antihistamines: ■ Brompheniramine ■ Carbinoxamine ■ Chlorpheniramine ■ Clemastine ■ Cyproheptadine ■ Dexbrompheniramine ■ Dexchlorpheniramine ■ Dimenhydrinate ■ Diphenhydramine (oral) ■ Doxylamine ■ Hydroxyzine ■ Meclizine ■ Promethazine ■ Pyrilamine ■ Triprolidine	***Avoid*** Highly anticholinergic; clearance reduced with advanced age, and tolerance develops when used as hypnotic; risk of confusion, dry mouth, constipation, and other anticholinergic effects or toxicity Use of diphenhydramine in situations such as acute treatment of severe allergic reaction may be appropriate *QE = Moderate; SR = Strong*
Antiparkinsonian agents ■ Benztropine (oral) ■ Trihexyphenidyl	***Avoid*** Not recommended for prevention of extrapyramidal symptoms with antipsychotics; more effective agents available for treatment of Parkinson disease *QE = Moderate; SR = Strong*
Antispasmodics: ■ Atropine (excludes ophthalmic) ■ Belladonna alkaloids ■ Clidinium-Chlordiazepoxide ■ Dicyclomine ■ Homatropine (excludes ophthalmic) ■ Hyoscyamine ■ Methscopolamine ■ Propantheline ■ Scopolamine	***Avoid*** Highly anticholinergic, uncertain effectiveness *QE = Moderate; SR = Strong*
Antithrombotics	
■ Dipyridamole, oral short-acting (does not apply to the extended-release combination with aspirin)	***Avoid*** Rationale: May cause orthostatic hypotension; more effective alternatives available; IV form acceptable for use in cardiac stress testing *QE = Moderate; SR = Strong*

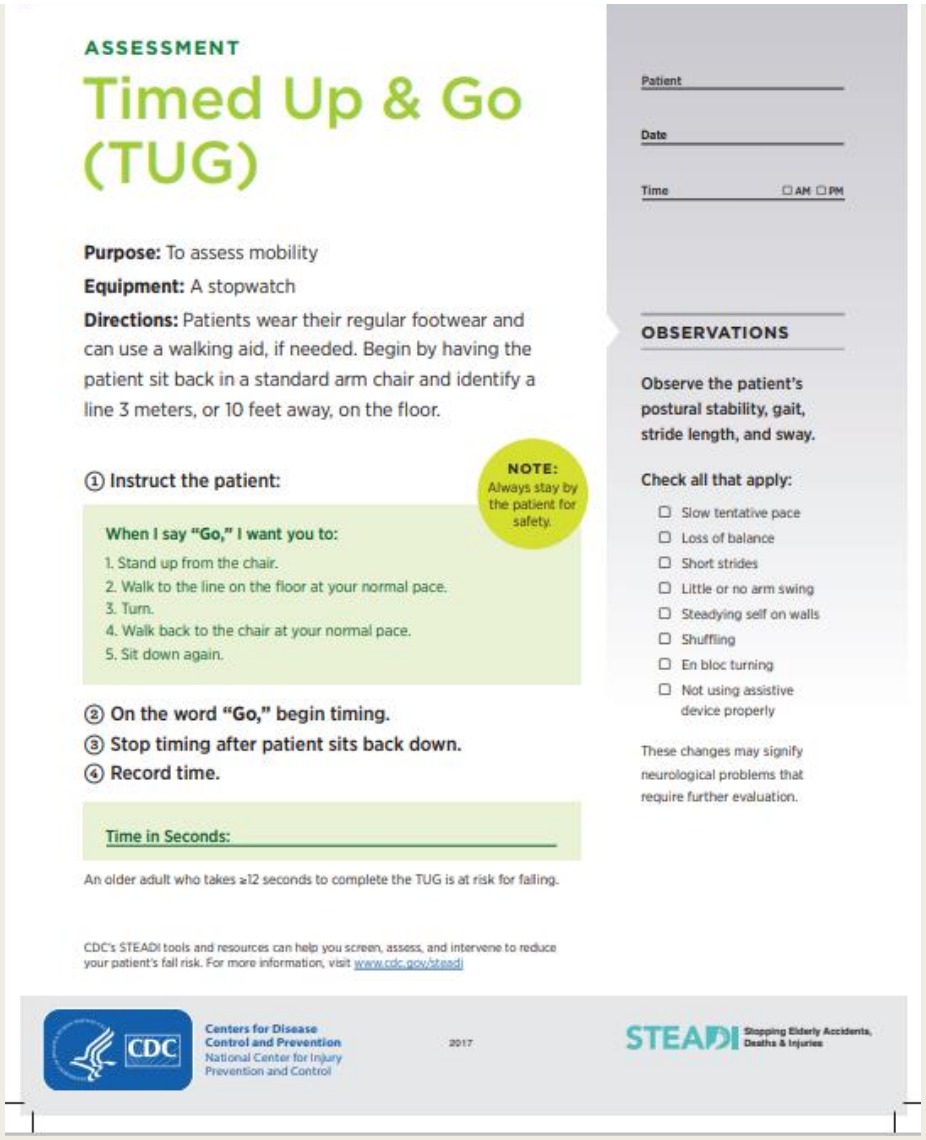
*See also criterion on highly anticholinergic antidepressants

CNS=central nervous system; NSAIDs=nonsteroidal anti-inflammatory drugs; SIADH, syndrome of inappropriate antidiuretic hormone.

Table 1 *(continued on page 3)*

Mobility:
Functional status, Falls





ASSESSMENT

Timed Up & Go (TUG)

Patient

Date

Time ☐ AM ☐ PM

Purpose: To assess mobility

Equipment: A stopwatch

Directions: Patients wear their regular footwear and can use a walking aid, if needed. Begin by having the patient sit back in a standard arm chair and identify a line 3 meters, or 10 feet away, on the floor.

① Instruct the patient:

NOTE: Always stay by the patient for safety.

When I say "Go," I want you to:

1. Stand up from the chair.
2. Walk to the line on the floor at your normal pace.
3. Turn.
4. Walk back to the chair at your normal pace.
5. Sit down again.

② On the word "Go," begin timing.

③ Stop timing after patient sits back down.

④ Record time.

Time in Seconds: _____

An older adult who takes ≥12 seconds to complete the TUG is at risk for falling.

CDC's STEADI tools and resources can help you screen, assess, and intervene to reduce your patient's fall risk. For more information, visit www.cdc.gov/steadi

OBSERVATIONS

Observe the patient's postural stability, gait, stride length, and sway.

Check all that apply:

- ☐ Slow tentative pace
- ☐ Loss of balance
- ☐ Short strides
- ☐ Little or no arm swing
- ☐ Steadying self on walls
- ☐ Shuffling
- ☐ En bloc turning
- ☐ Not using assistive device properly

These changes may signify neurological problems that require further evaluation.

CDC Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

2017

STEADI Stopping Elderly Accidents, Deaths & Injuries

MH

START HERE

1 SCREEN for fall risk yearly, or any time patient presents with an acute fall.

Available Fall Risk Screening Tools:

- **Stay Independent: a 12-question tool** [at risk if score ≥ 4]
  - **Important:** If score < 4, ask if patient fell in the past year (If **YES** → patient is at risk)
- **Three key questions** for patients [at risk if **YES** to any question]
  - Feels unsteady when standing or walking?
  - Worries about falling?
  - Has fallen in past year?
    - » If **YES** ask, "How many times?" "Were you injured?"

SCREENED NOT AT RISK

PREVENT future risk by recommending effective prevention strategies.

- Educate patient on fall prevention
- Assess vitamin D intake
  - If deficient, recommend daily vitamin D supplement
- Refer to community exercise or fall prevention program
- Reassess yearly, or any time patient presents with an acute fall

SCREENED AT RISK

2 ASSESS patient's modifiable risk factors and fall history.

Common ways to assess fall risk factors are listed below:

Evaluate gait, strength, & balance

Common assessments:

- Timed Up & Go
- 30-Second Chair Stand
- 4-Stage Balance Test

Identify medications that increase fall risk

(e.g., Beers Criteria)

Ask about potential home hazards

(e.g., throw rugs, slippery tub floor)

Measure orthostatic blood pressure

(Lying and standing positions)

Check visual acuity

Common assessment tool:

- Snellen eye test

Assess feet/footwear

3 INTERVENE to reduce identified risk factors using effective strategies.

Reduce identified fall risk

- Discuss patient and provider health goals
- Develop an individualized patient care plan (see below)

Below are common interventions used to reduce fall risk:

Poor gait, strength, & balance observed

- Refer for physical therapy
- Refer to evidence-based exercise or fall prevention program (e.g., Tai Chi)

Medication(s) likely to increase fall risk

- Optimize medications by stopping, switching, or reducing dosage of medications that increase fall risk

Home hazards likely

- Refer to occupational therapist to evaluate home safety

Orthostatic hypotension observed

- Stop, switch, or reduce the dose of medications that increase fall risk
- Educate about importance of exercises (e.g., foot pumps)
- Establish appropriate blood pressure goal
- Encourage adequate hydration
- Consider compression stockings

Visual impairment observed

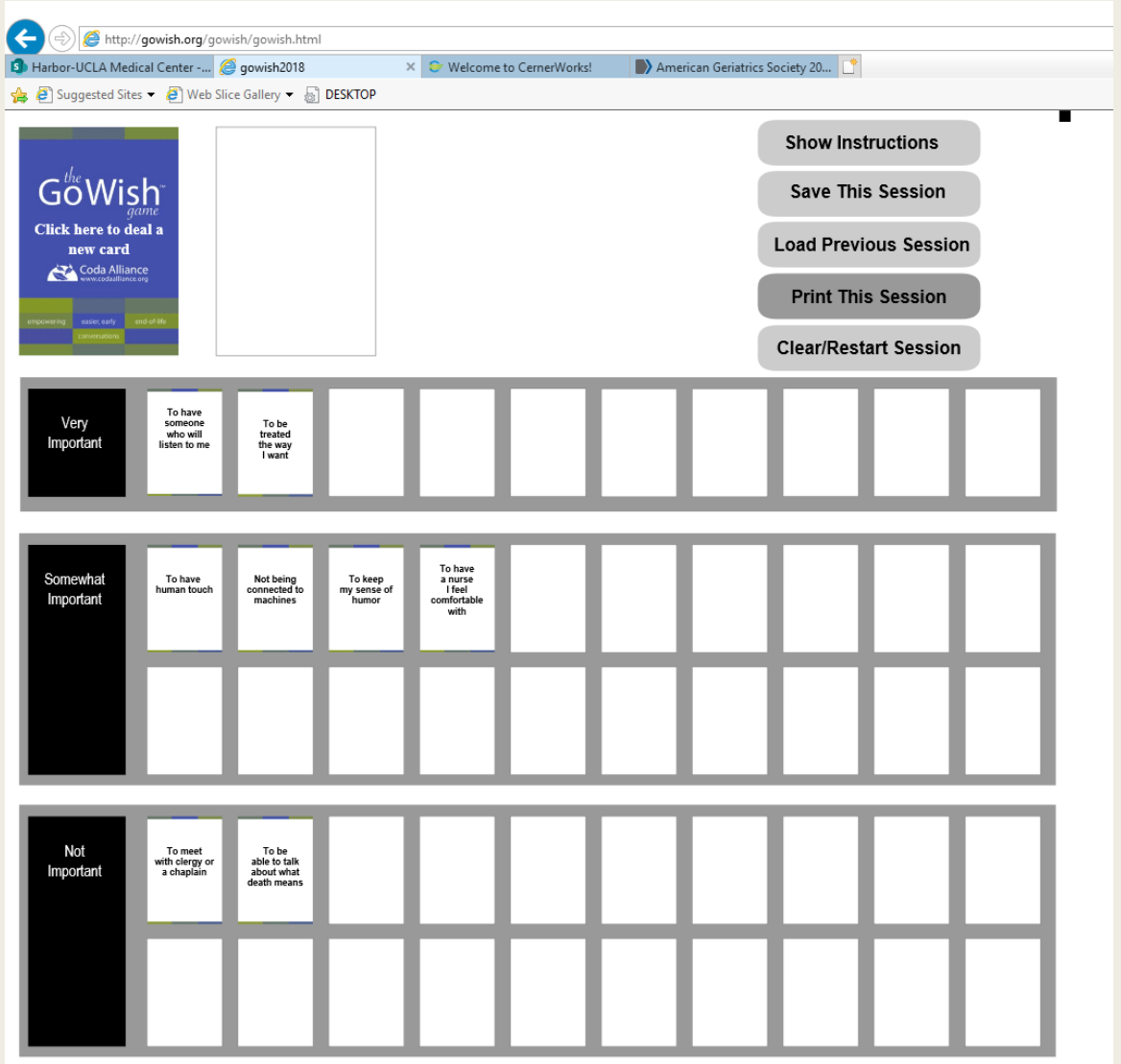
- Refer to ophthalmologist/optometrist
- Stop, switch, or reduce the dose of medication affecting vision (e.g., anticholinergics)
- Consider benefits of cataract surgery
- Provide education on depth perception and single vs. multifocal lenses

Feet/footwear issues identified

- Provide education on shoe fit, traction, insoles, and heel height
- Refer to podiatrist

Matters Most: Aligning care with values

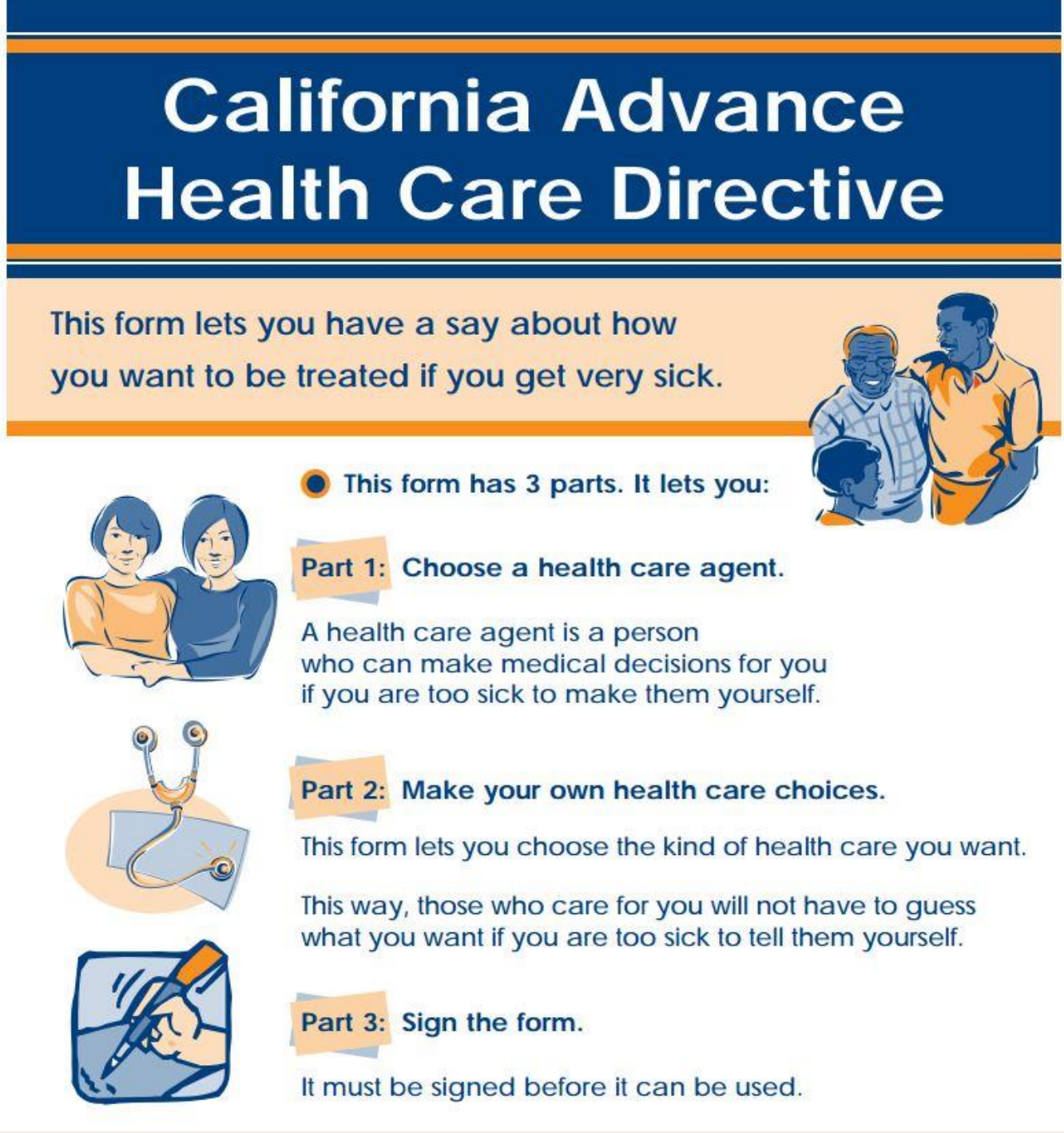
- Decades ago, most people died at home but today most Americans die in hospitals or nursing homes.
- More than one out of four older Americans face questions about medical treatment near the end of life but are not capable of making those decisions.
- There are patient- and clinician-barriers to these conversations.
- Implicit bias and cultural factors must be identified and addressed in order to promote trust.



Advance Care Planning and the Advance Directive

Provides patients opportunity to:

- Consider and document what matters most for their care; align care with goals.
- Designate and communicate with a surrogate decision maker.
- Provide guidance on their own health care in the case that they are unable to speak for themselves.



California Advance Health Care Directive

This form lets you have a say about how you want to be treated if you get very sick.

This form has 3 parts. It lets you:

Part 1: Choose a health care agent.

A health care agent is a person who can make medical decisions for you if you are too sick to make them yourself.

Part 2: Make your own health care choices.

This form lets you choose the kind of health care you want.

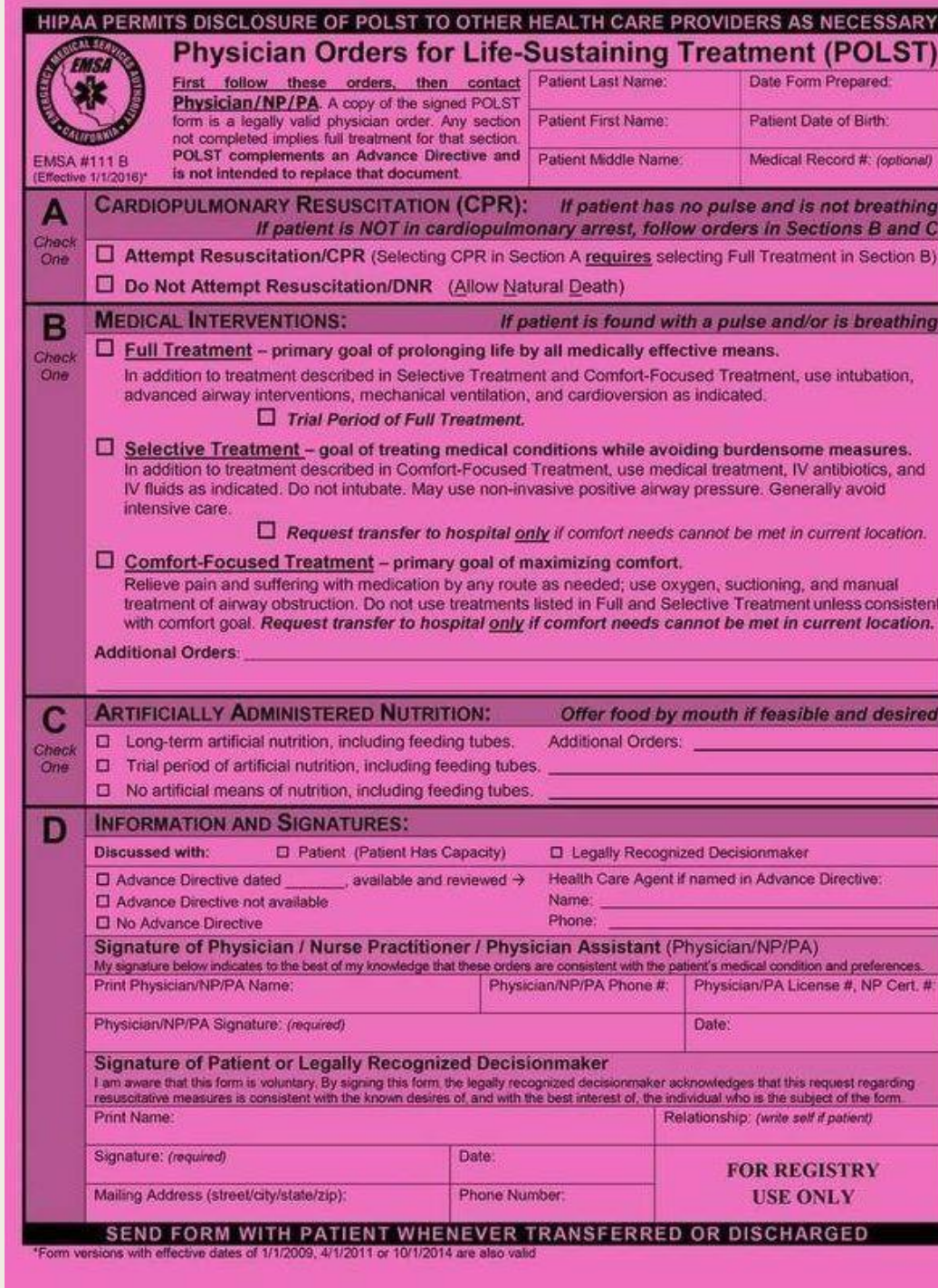
This way, those who care for you will not have to guess what you want if you are too sick to tell them yourself.

Part 3: Sign the form.

It must be signed before it can be used.

POLST and Code Status

- POLST is *recommended* when "provider would not be surprised if patient died within a year."
- Complete for any patient who wishes "allow natural death" (a.k.a. do not resuscitate).
- Readdress at care transitions, clinical changes, or per patient preference.
- ACP, Advance Directive, POLST/Code Status should be documented.



HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

EMSA #111 B (Effective 1/1/2016)*

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.

Patient Last Name: | Date Form Prepared:
Patient First Name: | Patient Date of Birth:
Patient Middle Name: | Medical Record #: (optional)

A Check One — CARDIOPULMONARY RESUSCITATION (CPR): *If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C*

- ☐ Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B)
- ☐ Do Not Attempt Resuscitation/DNR (Allow Natural Death)

B Check One — MEDICAL INTERVENTIONS: *If patient is found with a pulse and/or is breathing*

- ☐ Full Treatment – primary goal of prolonging life by all medically effective means. In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
  - ☐ *Trial Period of Full Treatment.*
- ☐ Selective Treatment – goal of treating medical conditions while avoiding burdensome measures. In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
  - ☐ *Request transfer to hospital only if comfort needs cannot be met in current location.*
- ☐ Comfort-Focused Treatment – primary goal of maximizing comfort. Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. *Request transfer to hospital only if comfort needs cannot be met in current location.*

Additional Orders: _____

C Check One — ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired*

- ☐ Long-term artificial nutrition, including feeding tubes.
- ☐ Trial period of artificial nutrition, including feeding tubes.
- ☐ No artificial means of nutrition, including feeding tubes.

Additional Orders: _____

D — INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

- ☐ Advance Directive dated _____, available and reviewed →
- ☐ Advance Directive not available
- ☐ No Advance Directive

Health Care Agent if named in Advance Directive: Name: _____ Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name: | Physician/NP/PA Phone #: | Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: *(required)* | Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name: | Relationship: *(write self if patient)*
Signature: *(required)* | Date:
Mailing Address (street/city/state/zip): | Phone Number:

FOR REGISTRY USE ONLY

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011 or 10/1/2014 are also valid

Learning Objectives

1. Describe the "Geriatric Five (5) M's" framework for care of older adults.
2. Identify evidence-based tools for primary care providers to assess older adults' cognitive health, falls risk, medication risk, and advance care plans.
3. Recognize the impact of social determinants of health and health care disparities on diverse older adults, within the context of the 5 M's framework.
4. List at least 3 community-based resources that can help primary care clinic teams support diverse older adults.

Multicomplexity:

Listening to our Patients' Voices

A Tale of Two (New) Patients

Sra. A: 68F DM2 (A1c=9.4), CAD, HLD, HTN, obesity, osteoarthritis, depression, MCI, PDR, falls.

Mr. B: 72M DM2 (A1c=10.2), CKD4, BPH, UI, CAD, AF (on anticoag), HFrEF, HLD, HTN, HOH, falls.

Quiz: Which is greater?

A. The seating capacity at SoFi stadium

B. The number of Angelenos over 65 years old with DM2

Quiz: Which is greater?

A. The seating capacity at SoFi stadium

=70,240 (100,240 expanded for Super Bowl)

B. The number of Angelenos over 65 years old with DM2

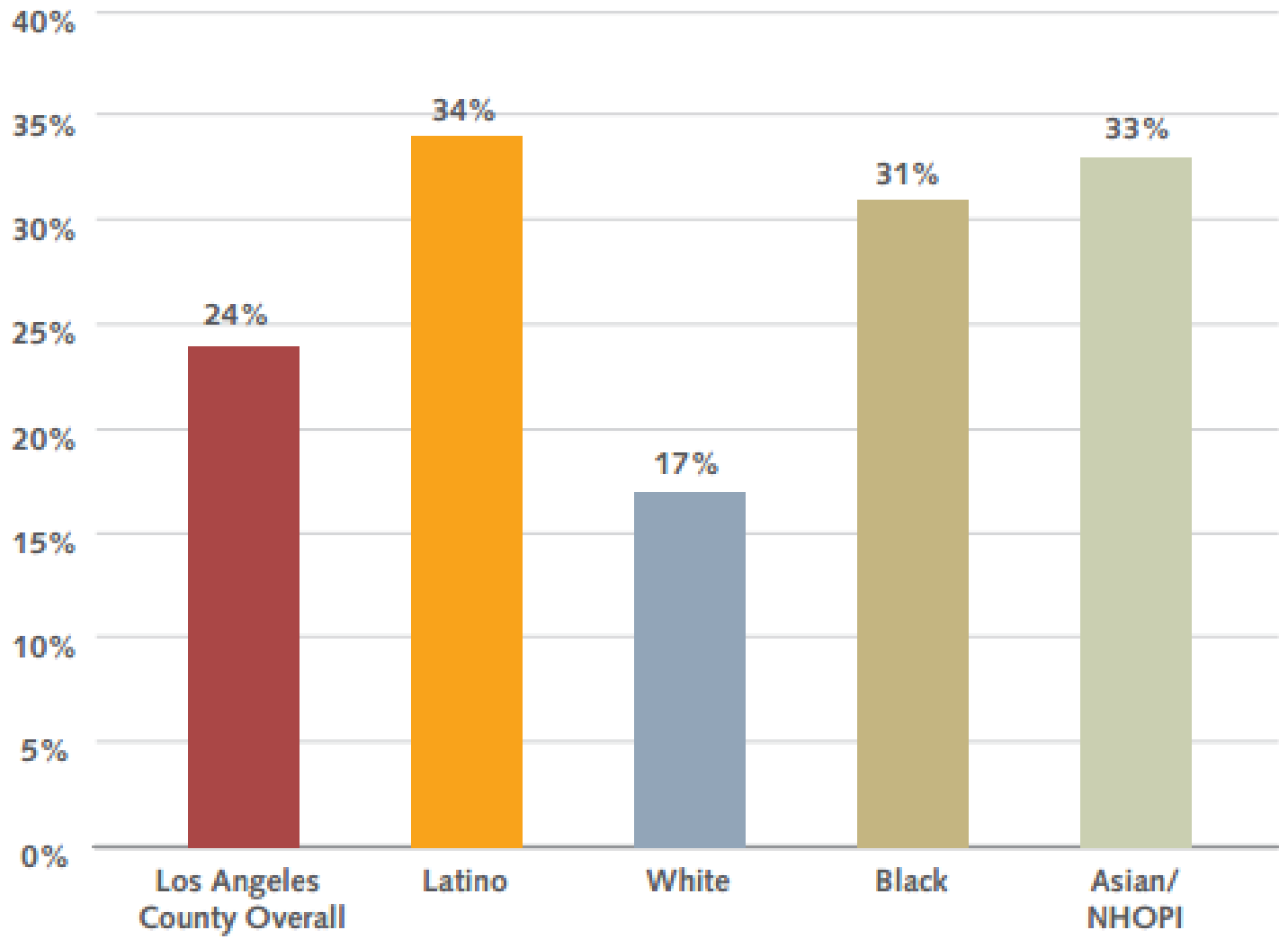
= 306,000

Los Angeles County Health Survey, 2018.

Figure 30

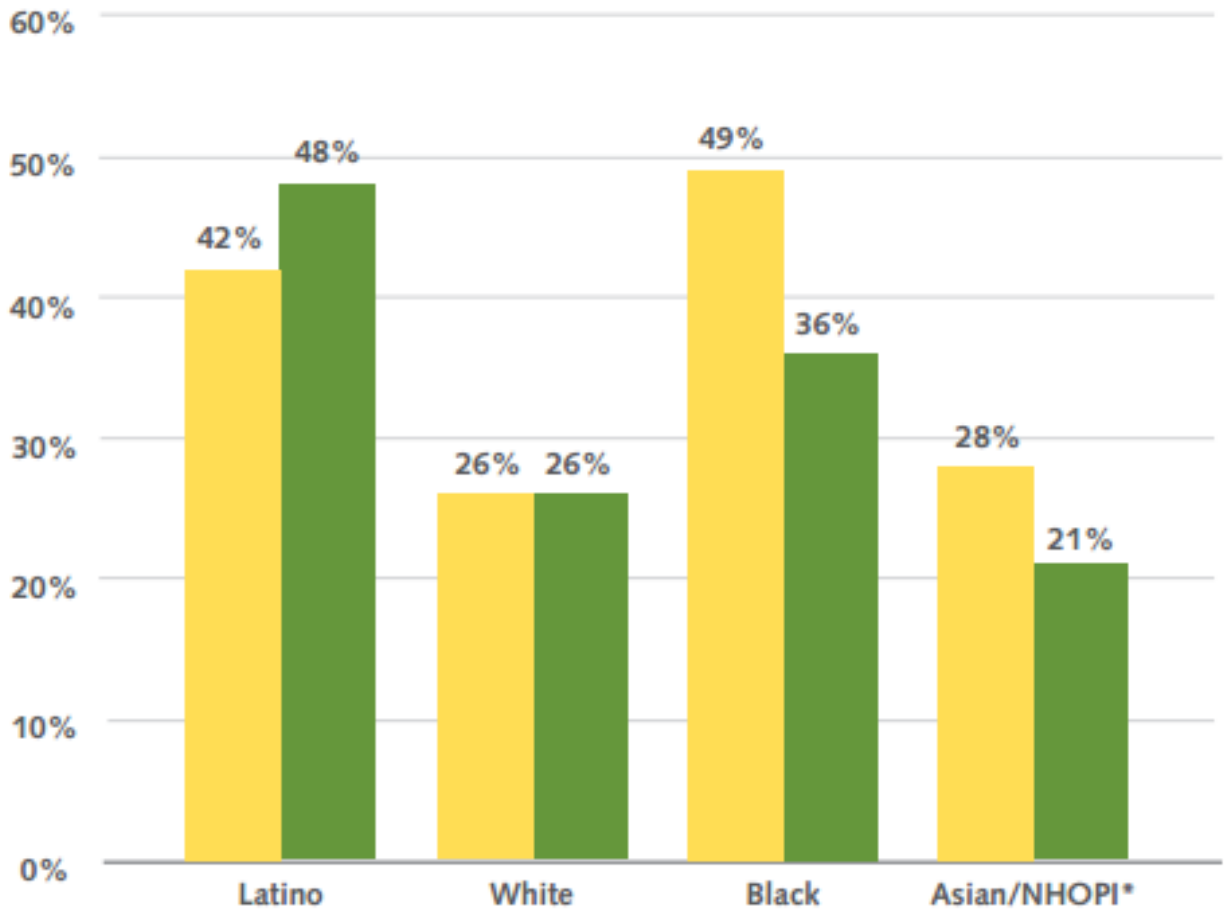
Percentage

Prevalence of Diabetes Overall and by Race/Ethnicity for Ages 65 and Older, Los Angeles County 2011



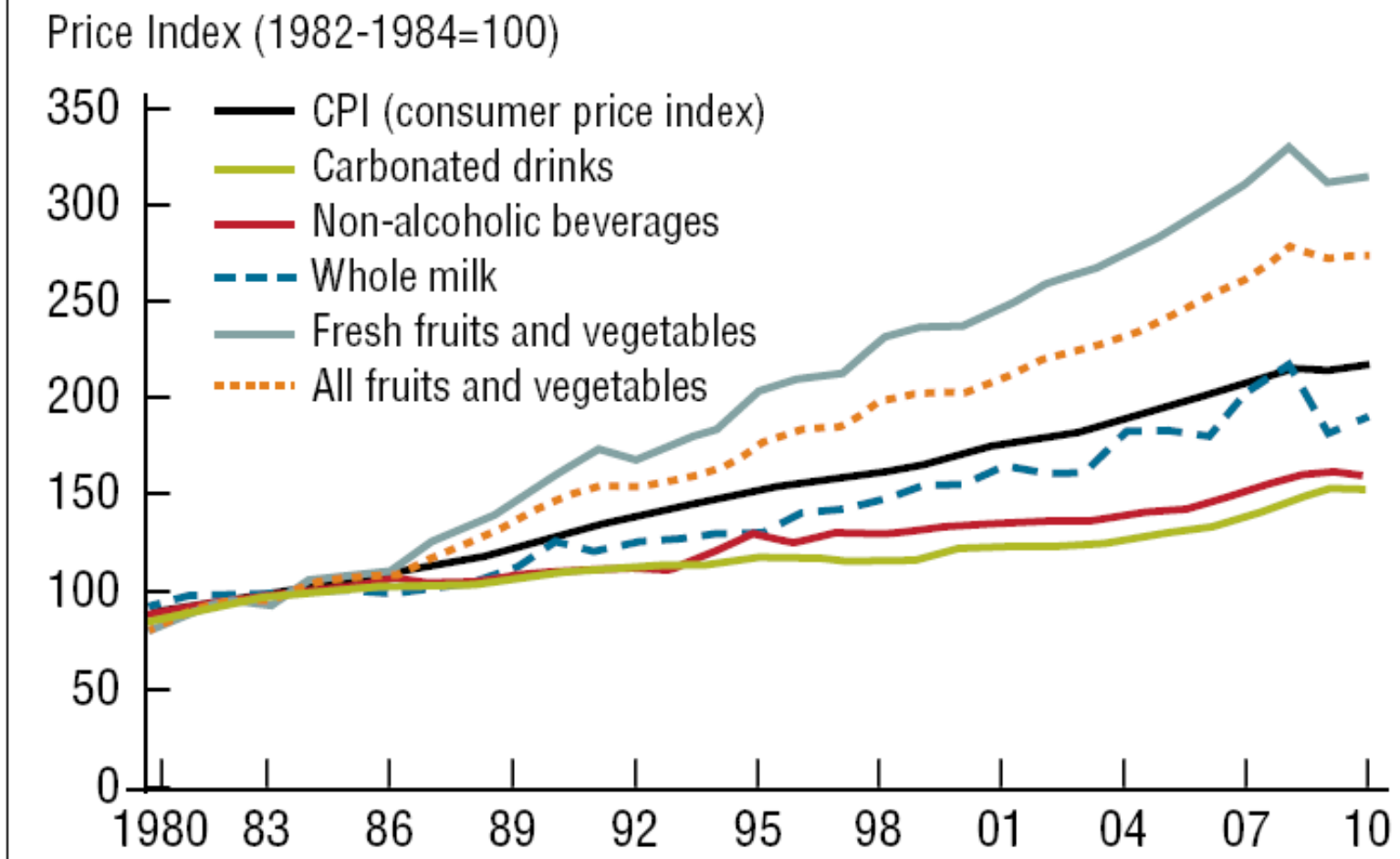
Note: NHOPI = Native Hawaiian or Other Pacific Islanders.
Source: 2011 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health.

Figure 40 Consumption of at Least One Soda or Sugar Sweetened Drink per Day for Children & Adults by Race/Ethnicity, Los Angeles County 2011



*The estimate for Asian/NHOPI adults is statistically unstable.
Note: NHOPI = Native Hawaiian or Other Pacific Islanders.
Source: 2011 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health.

Figure 2.7 **Price Indexes for Selected Foods and Beverages, 1980-2010**



Notes: Prices for each group are annual average prices for all urban consumers. All fruits and vegetables include fresh, canned, and frozen. Base period 1982-84=100.

Source: National Health and Nutrition Examination Survey data, 2003-2006.

What is Racial Justice?

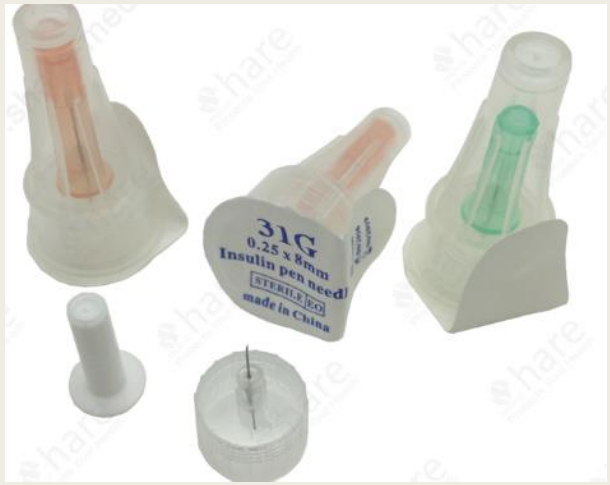
Racial justice is the systematic fair treatment of people of all races, resulting in equitable opportunities and outcomes for all. Racial justice — or racial equity — goes beyond "anti-racism." It is not just the absence of discrimination and inequities, but also the presence of deliberate systems and supports to achieve and sustain racial equity through proactive and preventative measures. ***(Racial Justice in Education, 2018)***

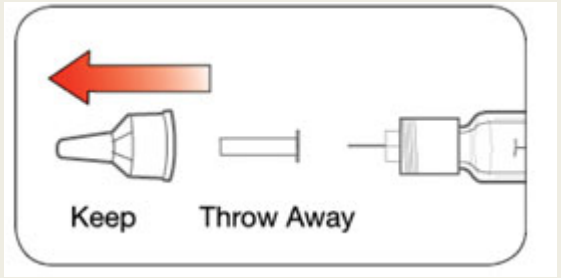
Table 1

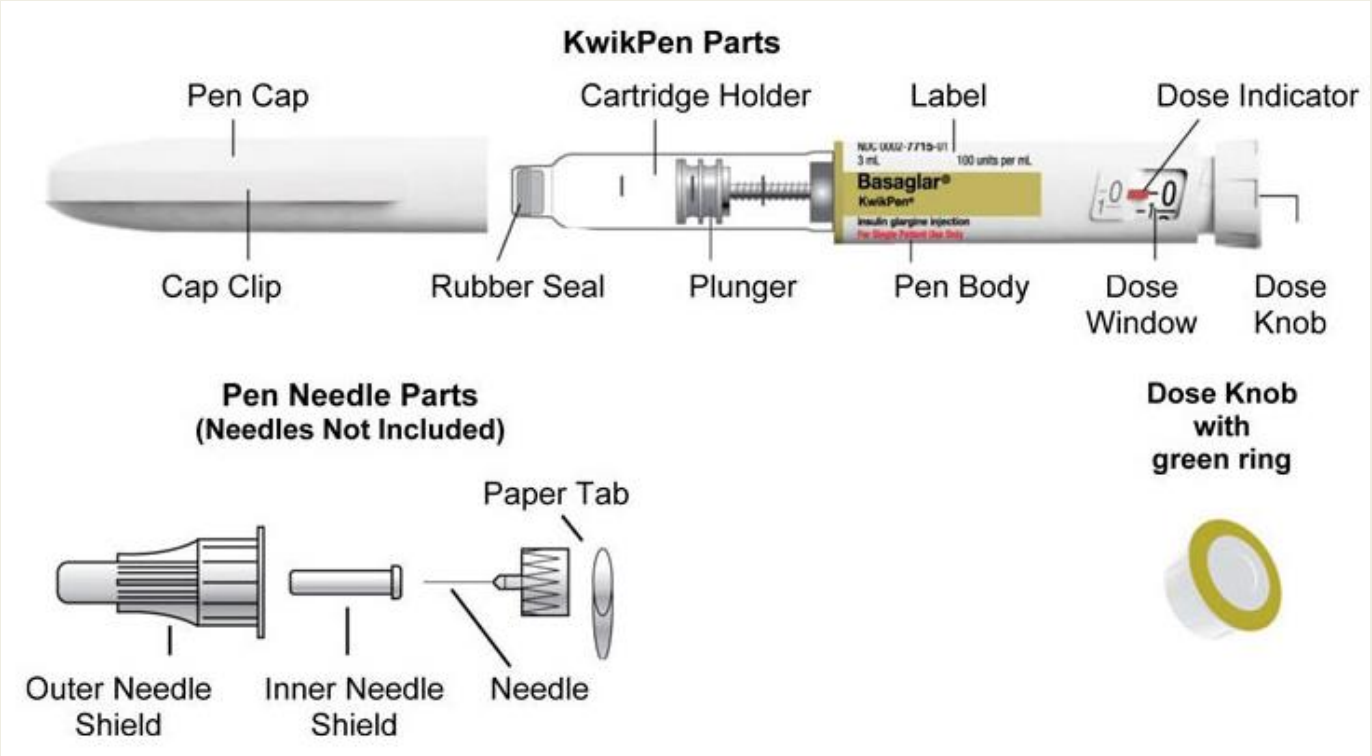
Elements of a Multicultural Geriatric Assessment.

Multicultural Assessment	Domain	Suggested Assessment Tools or Approach	Future Directions
1.	Baseline Preventive Care	Determine prior access to medical care, vaccination status, cancer screening history	Develop consensus guidelines on approach to vaccination assessment, cancer screening in older adult immigrant populations
2.	Chronic Conditions	Determine if diagnosis was delayed and address sequelae of untreated illness	
3.	Language	Determine literacy level and preferred language	
4.	Communication Barriers	Screen for cognitive, hearing, and visual impairment	Develop hearing loss screening assessment that can be used with an interpreter
5.	Health Literacy	Determine education level, print literacy, use teach-back method	Enhance low-literacy patient education in multiple languages. Develop and validate training for Community Health Workers (CHWs) on health coaching in older adult immigrant populations.
6.	Acculturation Level	Assess self-reported health	Conduct longitudinal studies of self-reported health in older adult immigrants and correlate with health outcomes

Diabetes care in older adults: sensory impairment, health literacy, falls…insulin?







Addressing Older Adults with Diabetes in Primary Care…

Sra. A: 68F DM2 (A1c=9.4), CAD, HLD, HTN, obesity, osteoarthritis, depression, MCI, PDR, falls.

Mr. B: 72M DM2 (A1c=10.2), CKD4, BPH, UI, CAD, AF (on anticoag), HFrEF, HLD, HTN, HOH, falls.

With a Culturally-responsive, Age-Friendly Approach

- Understand the patient's perspective, caregiver/family situation
- Identify social factors, address barriers to Racial Justice/Health Equity
- Apply the Geriatric 5M's framework

The Geriatrics 5Ms*

Multicomplexity	Geriatrics healthcare professionals[1] focus on these 4Ms...	When caring for older adults, all health professionals should consider...
Multicomplexity describes the whole person, typically an older adult, living with multiple chronic conditions, advanced illness, and/or with complicated biopsychosocial needs.	Mind	■ Mentation ■ Dementia ■ Delirium ■ Depression
	Mobility	■ Amount of mobility; function ■ Impaired gait and balance ■ Fall injury prevention
	Medications	■ Polypharmacy; deprescribing ■ Optimal prescribing ■ Adverse medication effects and medication burden
	What Matters Most	■ Each individual's own meaningful health outcome goals and care preferences

[1]Geriatrics health professionals are pioneers in advanced-illness care for older individuals, with a focus on championing interprofessional teams, eliciting personal care goals, and treating older people as whole persons.

*Adapted by the American Geriatrics Society (AGS) with permission from "The public launch of the Geriatric 5Ms" [on-line] by F. Molnar and available from the Canadian Geriatrics Society (CGS) at http://canadiangeriatrics.ca/2017/04/update-the-public-launch-of-the-geriatric-5ms/ Accessed July 14, 2020.

Sra. A is Span-Speaking, immigrant. Difficulty reading pill bottles and scared to inject insulin. Lonely; got lost trying to 'return home to Mexico.'

Mr. B is the IHSS caregiver for his wife with moderate dementia. Frustrated by frequent urination at night and falls. Wants to stay well enough to care for his wife at home. Worries about their future.

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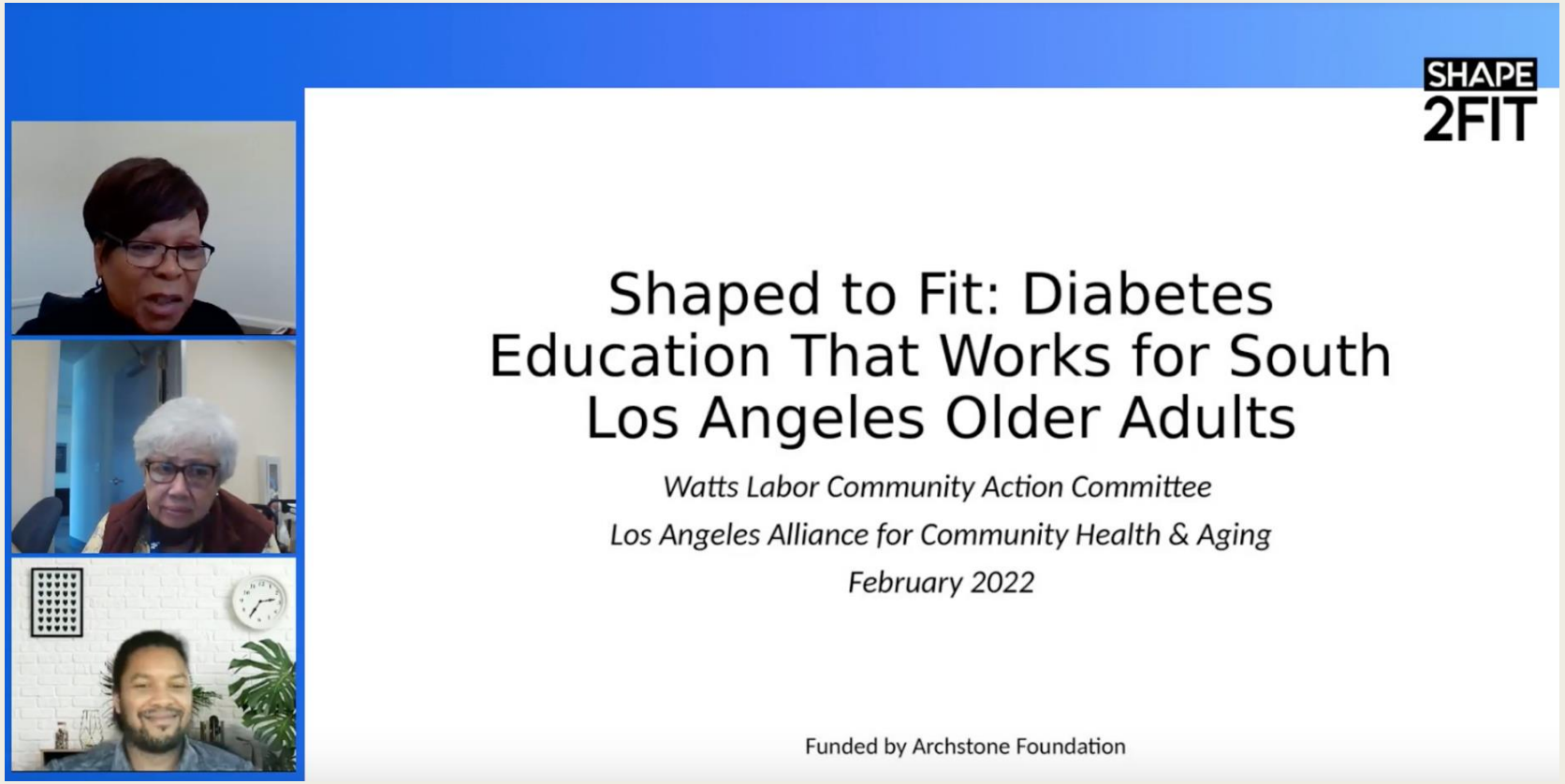
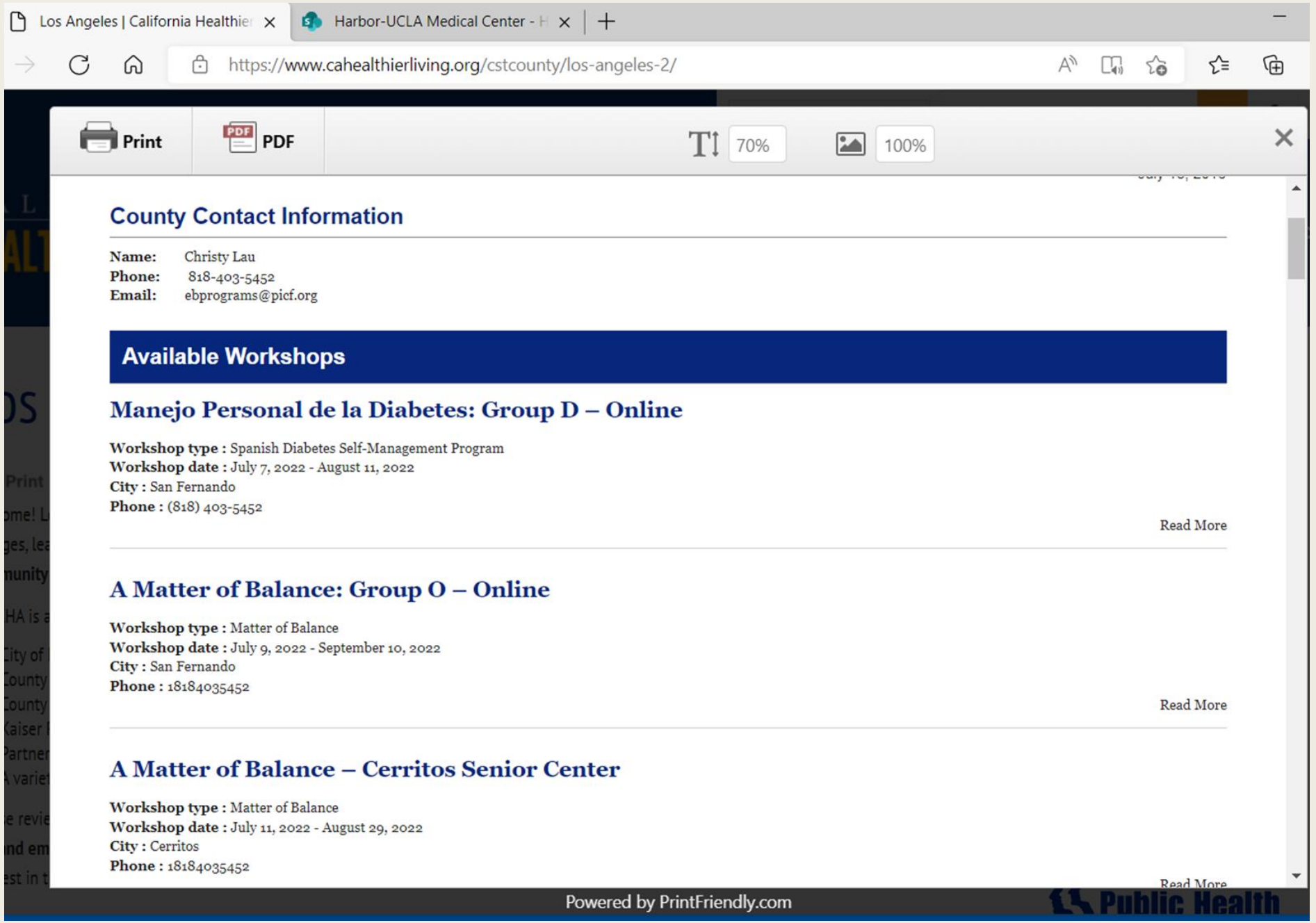
Culturally-adapted, Evidence-Based Diabetes Self-Management Programs



WLCAC
Watts Labor Community Action Committee

Los Angeles Alliance for Community Health & Aging

Health Services
LOS ANGELES COUNTY


Los Angeles | California Healthier
Harbor-UCLA Medical Center - H
https://www.cahealthierliving.org/cstcounty/los-angeles-2/
Print
PDF
70%
100%
County Contact Information
Name: Christy Lau
Phone: 818-403-5452
Email: ebprograms@picf.org
Available Workshops
Manejo Personal de la Diabetes: Group D – Online
Workshop type : Spanish Diabetes Self-Management Program
Workshop date : July 7, 2022 - August 11, 2022
City : San Fernando
Phone : (818) 403-5452
Read More
A Matter of Balance: Group O – Online
Workshop type : Matter of Balance
Workshop date : July 9, 2022 - September 10, 2022
City : San Fernando
Phone : 18184035452
Read More
A Matter of Balance – Cerritos Senior Center
Workshop type : Matter of Balance
Workshop date : July 11, 2022 - August 29, 2022
City : Cerritos
Phone : 18184035452
Read More
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Public Health

CALIFORNIA HEALTHIER LIVING

Find free workshops for wellness!

Your guide to finding health self-management workshops in your community

1 Go to www.cahealthierliving.org

2 Click: Find a Program

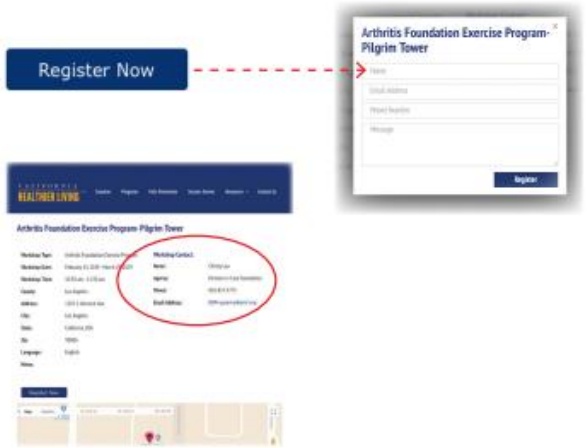
3 Pick a program!

4 Enter your county or zip code and select search radius

5 Select a class, click Register Now

or

call or email the Workshop Contact



Call a 24 hour elder abuse crisis line

California Department of Aging Verified Information

Save

The California State Long-Term Care Ombudsman Program operates a crisis line that receives complaints made by, or on behalf of, individual residents in long-term care facilities.

AVAILABLE
24/7

Elder abuse hotlines

ADA ACCESSIBLE	CITIZENSHIP	AGE	FREE	ELIGIBILITY REQUIREMENTS	STATES
Unknown	**No requirements**	**seniors**	**Yes**	**None**	**California**

WHAT TO DO NEXT

Call 800-231-4024
Call the Crisis Line.

Click to visit link - https://aging.ca.gov/.../
Visit the link to find more information about the program, find services in your area, a
available services.

https://www.dementiacareaware

Harbor-UCLA Medical Center - H

https://www.dementiacareaware.org

UCSF

About Resources Contact Log in

Welcome to Dementia Care Aware!

Dementia Care Aware (DCA) is a state-wide program in California for primary care providers. It provides the information and tools needed for you to successfully administer cognitive health assessments and determine the appropriate next steps for your patients.

Select **Register** to get started. After you register, you'll be automatically enrolled in the free Cognitive Health Assessment eLearning course.

Register

Program

Caregiver Training Videos

Share

THE LACRC

The USC Family Caregiver Support Center, Home of Los
Resource Center, Helps families and communities mast
caring for persons with brain impairing conditions, suc
disease, stroke, Parkinson's disease, traumatic brain i
health issues.

Exploring the Imaginable. Conquering the Journey. Fam
On!

Welcome to the USC Family Caregiver Support Center (USC FCSC). We support family ca
an adult relative or friend (over the age of 18) with one or more of the following tasks:
of bed), making health care decisions, cooking, cleaning, yard work, managing medica
making important decisions, shopping for groceries and other items, legal issues, help
dressing, or providing transportation.

USC Family Caregiver Support C | Harbor-UCLA Medical Center - H

https://www.fcsc.usc.edu

USC | FCSC + LACRC

A Program of the USC Family Caregiver Support Center

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COMMUNITY RESOURCES

The USC Family Caregiver Support Center, home to the Los Angeles Caregiver Resource Center (LACRC) , is part of the California's Caregiver Resource Centers (CRC) system which shares knowledge and resources with family caregivers. This page includes links to family caregiver resources that are part of the CRC system and also to organizations that share our same family caregiver vision. Additionally, it links to fact sheets, tip sheets, and videos that are dedicated to helping family caregivers.

Caregiver Issues & Advice:

Family Caregiver Alliance (FCA)
Resources (PDFs, Videos, Articles, etc.)

Southern Caregiver Resource Center
"Caregiving Corner" Video Series

Getting Help

CareNav
Community Resources
COVID-19 Resources
Nat'l Institute on Aging (NIA) – Enfermedad de Alzheimer
Help for Caregivers – Quick Tip Sheets
Early Signs of Dementia: Recuerdos Olvidados – Forgotten Memories

STAY CONNECTED!

Sign up today to receive our latest news.

Name
Email
Zipcode

Preferred Language
English

I am a (please check all that apply):
- Family Caregiver
- Aging Field Professional
- Other (Interested Community

What will you do differently?

Resources

- Find my citations and links throughout the slides and notes of this presentation.
- More ACP resources:
- CA low literacy AHCD in nine languages http://www.iha4health.org/our-services/advance-directive/
- Five Wishes https://www.agingwithdignity.org/five-wishes
  - *Wish 1: The Person I Want to Make Care Decisions for Me When I Can't*
  - *Wish 2: The Kind of Medical Treatment I Want or Don't Want*
  - *Wish 3: How Comfortable I Want to Be*
  - *Wish 4: How I Want People to Treat Me*
  - *Wish 5: What I Want My Loved Ones to Know*
- PREPARE- website that uses videos and stories to teach people how to identify their values and goals for medical care and to make medical decisions.

  https://www.prepareforyourcare.org/
- The Coalition for Compassionate Care of CA- Helpful phrases in English and Spanish for Providers

  http://coalitionccc.org/wp-content/uploads/2016/01/POLST_Helpful_Phrases_Eng_and_Spanish.pdf

Thank you! Questions?

HEATHER BENNETT SCHICKEDANZ, MD (AKA DR. HEATHER "S-CHICK-E-DANZ!")
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Frequently Asked Questions (FAQs)

1. A Geriatrician:

a. can serve as a primary care physician for older adults

b. can serve as a consulting physician for older adults

c. neither (a) nor (b)

Answer: both (a) and (b)

2. Which of the following would not be considered a "reversible" cause of dementia?

a. vitamin B12 deficiency

b. urinary tract infection

c. osteoporosis

d. substance use disorder

e. major depression

Answer: c

Frequently Asked Questions (FAQs)

3. Your 85-year old patient reports she is taking over-the-counter diphenhydramine (Benadryl) daily for seasonal allergies. Each of the following would be reasonable alternatives to treat seasonal allergy symptoms except:

a. nasal saline rinse

b. chlorpheniramine (AllercChlor)

c. fexofenadine (Allegra)

d. fluticasone (Flonase)

Answer: b

Frequently Asked Questions (FAQs)

4. True or False: Acupuncture is generally a safe, evidence-based, and may be a more culturally-appropriate treatment modality for older adults with conditions such as head and neck pain due to osteoarthritis.

Answer: True

(source: Ask the Expert: Acupuncture | HealthInAging.org