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To cite this article: Deanne T. Kashiwagi (2020): Geriatric inpatient care: what should hospital clinicians know?, Hospital Practice, DOI: 10.1080/21548331.2020.1723354

To link to this article: https://doi.org/10.1080/21548331.2020.1723354
Geriatric inpatient care: what should hospital clinicians know?

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ARTICLE HISTORY Received 6 November 2019; Accepted 27 January 2020

KEYWORDS Geriatric; hospitalist; geriatric assessment; inpatient

In 2015, when the world’s population was estimated at 7.3 billion people, 8.5 percent (617.1 million) were aged 65 years and older [1]. This number is projected to increase more than 60 percent by 2030, when there will be an estimated 1 billion people over 65 years worldwide [1]. In the United States, the number of people older than 65 years has grown from 3.1 million in 1900, to 35 million in 2000, to 49.2 million in 2016 as estimated by the US Census [2]. Increased health care utilization, including hospitalization, is expected as this population continues to age.

In 2017, 15.3% of Americans aged 65 years and older were admitted at least once in the prior year [3]. Admission to the hospital amplifies the physiology of aging and older patients are at risk for adverse events during hospitalization [4]. The hazards of hospitalization for elderly patients have long been recognized and include polypharmacy [5], the risks of geriatric syndromes such as falls and delirium, and the potential for subsequent functional decline [4,6]. This functional decline due to hospitalization is common, with more than half of the oldest old (>85 years) patients experiencing a decline in their pre-illness abilities [7], and predisposes patients to higher post-discharge mortality, dependency, and institutionalization [6,8].

To address these potential adverse effects of hospitalization, several strategies and models of care have emerged to prevent geriatric syndromes and functional decline. Some programs focus on prevention of specific geriatric syndromes, such as the Hospital Elder Life Program (HELP), which personalizes interventions that focus specifically on delirium [9]. Broader approaches to inpatient geriatric care include the Comprehensive Geriatric Assessment (CGA) which is a systematic, interdisciplinary assessment of older patients in the domains of functional status, physical performance and falls, comorbid medical conditions, depression, social activity and support, nutritional status, and cognition [10–12]. The CGA is a patient-centered assessment that helps coordinate interdisciplinary treatment planning and allows detection of geriatric syndromes, or their risk factors specific to each patient [10]. Similarly, the 5Ms (mind, mobility, medications, multicomplexity, and matters most to me), has been proposed as a contemporary mnemonic to organize geriatric assessment, favored for including ‘matters most to me’ as its own item of assessment, reinforcing the importance of a patient-centered approach [13].

Units such as Acute Care for the Elder (ACE) units [14] and geriatric evaluation and management units (GEMU) [15] have evolved to provide patient-centered care for older patients through all phases of a hospital admission and during the post-acute setting. ACE units, where caregivers specializing in geriatric care are concentrated in the same physical space, help facilitate the CGA and integrated care planning for older patients throughout their acute-care admission [14,16]. Although there are competing demands on clinicians’ time and energy in the hospital which makes it difficult to sustain the effort that multidisciplinary care requires, ACE units have demonstrated shorter lengths of stay, lower cost of hospitalization, and fewer discharges to nursing homes [17]. Despite the proven benefits of these models of care, not all hospitals have access to this level of specialized geriatric care [16]. It is important, therefore, that all inpatient care team members are cognizant of the nuances of caring for older patients, although there may be a lack of training in the care of older patients, particularly among hospitalists [18].

The options for care have increased for older patients in recent years. For instance, older adults now undergo interventions such as surgeries that may not have been offered to them in the past. It is estimated that as a result of an aging population, there will be a 30% increased demand for vascular surgeons and an 18% increased demand for both neurosurgeons and general surgeons [19]. Similarly, as the population ages, older patients are being offered therapies for cancer that may not have been offered or available to them in the past. By 2030 approximately 70% of all patients with cancer will be aged 65 years or older [20]. With the option of such interventions as surgery and chemotherapy being offered to patients of increasingly advanced age, the scope of geriatric care is expanding. In these specific clinical situations, it is important for inpatient clinicians to not only acknowledge the typical risks of admission, but also to understand the physiology of aging and how specific interventions, such as anesthesia and chemotherapy, put patients at further risk. To mitigate the additional risks of procedures and treatments, CGA has been integrated into perioperative and cancer care of older patients [21,22].

Caring for the world’s aging population raises additional considerations for inpatient practitioners. Older patients not only have more numerous, common co-morbidities such as diabetes mellitus and hypertension, but also carry diagnoses that may be perceived as uncommon in this patient population, such as substance use disorders [23,24]. By 2020, it is estimated that 5.9 million Americans aged 50 years and older will have a substance use disorder [25], yet
treatment of substance use disorders aren’t well-studied in this population [24]. These atypical diagnoses must be recognized and addressed in order to improve patients’ outcomes. Detection can be more difficult compared to younger patients as older patients with substance use disorders may present with different symptoms [26], and screening tools may use variables or activities that are not relevant in older patients, such as driving or work performance [26]. Similarly, treatment modalities may not be as effective in older adults and may need to be adapted to suit their stage in life [26]. Adjustments for stage in life are also important for older patients who choose palliative care, which may translate differently in this population than a younger one. Older patients have different patterns of symptoms compared to younger patients [27], and awareness of this is important to optimally address their needs. Further, older patients may more often require discussions around withholding or withdrawing life-sustaining support than a younger patient population [28].

Older patients are a unique population to care for in the hospital. The physiologic changes of aging must be accounted for when caring for older adults, and a heightened awareness of geriatric syndromes must be maintained in order to detect and treat these early, or prevent them altogether. Further, an understanding of the spectrum of treatment options now available to older patients, such as chemotherapy and surgery which may not have been as readily offered in the past, is needed in order to mitigate the risk of adverse effects of these interventions. Despite the availability of more treatment options for patients for multiple diagnoses, their goals of care and palliation of symptoms, if comfort is prioritized, should be kept forefront in their management. A first step in improving the care of older inpatients is educating clinicians who can lead efforts to systematize hospital approaches to care. They may then optimize care of older patients by leading integrated care teams that are versed in the physiology of aging, can recognize geriatric syndromes, and can diagnose, treat, and preferably prevent the potential adverse effects of hospitalization.

Declaration of interest

The contents of the paper and the opinions expressed within are those of the author, and it was the decision of the author to submit the manuscript for publication.

Peer reviewers on this manuscript have no relevant financial or other relationships to disclose.

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