



circumstances in which life sustaining or restoring measures may be withheld or even withdrawn. Traditionally, advance directives have included a living will and health care power of attorney. The living will often addresses situations in which the patient has a terminal illness, persistent vegetative state, or progressive neurologic condition and can include explicit directions for care management including withdrawal or withholding of specific measures, including artificial nutrition and hydration. Living wills are ideally paired with a companion document, the health care power of attorney, which designates the person's preferred decision maker, or proxy, in the event of an incapacitating illness. For patients who have not created a health care power of attorney, typically the spouse or other first-degree relative is the default decision maker. If no proxy is designated and no next of kin is available, guardianship may be obtained. Guardianship is a legal proceeding whereby the court appoints a surrogate decision maker. The physician's responsibility includes determination of a person's capacity for independent decision making in the event of altered sensorium or progressive cognitive impairment. This involves an assessment of his or her ability to understand the situation, ask questions, weigh options and render an opinion and, in certain situations, may require a full geriatric or neuropsychological assessment. Traditional advance directives, particularly the living will, have been criticized as having limited utility in conveying specific preferences. Recently, more detailed forms have emerged to record very specific preferences and limits for measures such as hydration, nutrition, hospitalization, and resuscitation. Examples include the Medical Orders for Scope of Treatment (MOST) and Physician's Orders for Life Sustaining Treatment (POLST) forms. Of course, effective completion and application of any of these forms should include a goals of care conversation conducted with the primary care provider ideally involving family caregivers. In addition, as preferences change over time depending on health status, health care providers should encourage older adults to revisit and renew their advance directives on an annual basis.

● HIGH-RISK CIRCUMSTANCES

The Hospitalized Patient

Millions of older adults are hospitalized in the United States each year for a variety of acute illnesses and elective procedures. Fortunately, in the United States, Medicare Part A covers much of the cost associated with acute care, including hospitalization and follow-up rehabilitation. While in the hospital, however, older adults are vulnerable to myriad complications related to both their compromised health state and problems inherent to the acute care environment itself. As noted previously, delirium afflicts hospitalized elders at a very high rate and increases risk of prolonged hospital stays, nursing home admission, and death. Hospitalized older adults also experience the effects of immobilization, with loss of muscle strength and deconditioning. Acutely, these factors increase the risk of falls and impair function and ability to provide self-care. In addition, poor oral intake may result in malnutrition, and illness-related fluid losses cause dehydration. As a result, hypotension and protein-calorie malnutrition are common problems. Immobility and malnutrition both predispose the acutely ill patient to the development of pressure

wounds, which can develop in under 2 hours. All these problems worsen in the presence of delirium or depressed mood. Environmental factors also contribute to problems, including tethers such as catheters and intravenous lines (which increase risk of falls), noisy wards, and frequent tests and procedures that further disrupt diurnal rhythms and sleep. Up to one third of hospitalized older adults experience a decline in their ability to perform ADLs in the course of their hospitalization. Patients who experience declines in function during hospitalization have higher rates of rehospitalization, prolonged institutionalization, and mortality after discharge, and many (41%) never return to their preadmission level of function. To combat these problems, some hospitals have created specialized inpatient geriatric care units, often termed *acute care for elders (ACE) units*. These units incorporate adaptations in the physical environment and specially trained staff to provide safe, patient-centered care designed to maximize restoration of function and prevent common complications of hospitalization. In randomized trials, ACE units and their consultative counterpart, the Mobile ACE (or MACE), have reduced lengths of stay, improved care transitions, and lowered readmissions. Likewise, geriatric evaluation and management (GEM) units (described later) offer specialized, team-based post-acute care with an emphasis on rehabilitation and return to prior level of function.

Care Transitions

As noted previously, older adults experience high rates of complications during acute illness and require prolonged periods of time to recover. For this reason, management in the post-acute period represents a critical and complex time in their care. Specifically, older adults with acute illness often find themselves transferred among different care settings and providers. Nearly one quarter of hospitalized older adults are discharged to skilled nursing facilities, and another 12% are discharged with home health care. Of those discharged to skilled facilities, about one fifth will return to the hospital within 30 days. Transitions in care represent high-risk episodes, and evidence shows that patients and caregivers frequently experience miscommunication, medication errors, and missed essential laboratory tests or appointments during this period. Recent trials have demonstrated a reduction in rehospitalization through a structured discharge and transition plan that includes medication reconciliation before and after discharge, careful planning for laboratory and appointment follow-up, communication with patients and caregivers about expectations and preferences, and specific coaching for patients and caregivers in symptom management and care. More information on care management in transitions is available at www.caretransitions.org.

● SYSTEMS OF CARE

Ambulatory and Home Care

The majority of care for older adults occurs in the outpatient setting. Much of the cost of this care, including visit fees, laboratory tests, x-ray studies, and vaccinations, is covered under Medicare Part B, for which patients pay a monthly premium. Outpatient visits may occur with the physician, physician assistant, nurse practitioner, or clinical nurse specialists, depending on the nature