

# Improve Frail Elder Care with Expert Clinical Training

“As an Interprofessional team, we can take steps to care for those patients more effectively; to intervene to help them ultimately have better outcomes.”

*Mitchell T. Heflin, MD  
Duke University  
School of Medicine*

## GIVE YOUR CARE TEAM SKILLS TO HELP DECREASE READMISSIONS

Frail and elderly patients have complex needs and the health care team must develop the competencies and cooperation to properly care for them. Some of Duke University's most respected clinicians and researchers developed an integrated program that identifies the risks and special needs of the frail and elderly patients and provides the knowledge and best practices for caring for these medically fragile patients and their families. This program—specially designed for healthcare professionals in the areas of Acute Care, Skilled Nursing, Home Care, and Ambulatory Care—focuses on critical areas of care such as delirium, transition of care, medication, nutrition and shared decision making.



*According to the Administration on Aging-U.S. Department of Health and Human Services, our older population; persons 65 years or older—numbered 44.7 million in 2013. They represented 14.1% of the U.S. population or about one in every seven Americans. By 2040, they are expected to represent nearly 22 percent of the American population and by 2060, there will be about 98 million older persons, more than twice their number in 2013.*

## IMPACT

### Employee Confidence

- Increases confidence of all care team members with respect to frail elder care

### Improved Communication

- Increases collaboration among an ACO or network of providers and encourages consistent communication among caregivers

## FEATURES:

### Delirium

- What you can do to reduce chances the older adult will develop delirium
- Managing the care and identifying behaviors that may indicate delirium

### Medication Management

- Accurate recording and reporting prescription and non-prescription medication use
- Recognizing barriers to adherence with prescribed medications

### Transitions of Care

- Defining care transitions and their importance in optimizing patient care outcomes
- Identifying characteristics that make older adults especially vulnerable during transitions
- Discuss the critical role that each interprofessional team member plays in care transitions
- Applying the National Transitions of Care Coalition (NTOCC) 7 essential interventions to ensure high quality care

### Nutrition

- Identifying and assessing risk factors relevant for poor nutrition
- Using diagnostic aids to confirm poor nutrition
- Assess the effectiveness of the current nutritional plan
- Facilitate communication of the nutrition care plan across care settings

### Shared Decision-Making

- Patient Advocating
- Facilitate difficult conversations with respect to autonomous living and end-of-life care
- Understanding and promoting collaborative decision making

## INITIATIVES AND GOALS SUPPORTED:

- Addressing the needs of the medically complex elderly population
- Decreasing readmissions of frail elders
- Increasing collaboration among an ACO or other network of providers
- Improving CAHPS scores by fostering interprofessional care
- Promoting best practices during transitions of care between healthcare entities

## RECOMMENDED FOR:

- Provider/Prescribers: MD, NP, CNS, PA, PharmD
- Frontline Staff: RN, LPN, CNA
- Allied Health: PT, PTA, OT, COTA, SLP, SW, Recreational Therapist, Respiratory Therapists

Developed by:  Duke University School of Medicine

## SUBJECT MATTER EXPERTS

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## CONTINUING EDUCATION CREDIT

In support of improving patient care, Duke University Health System Clinical Education & Professional Development is accredited by the American Nurses Credentialing Center (ANCC), the Accreditation Council for Pharmacy

Education (ACPE), and the Accreditation Council for Continuing Medical Education (ACCME), to provide continuing education for the healthcare team