Faculty Present Research at AGS Meeting

Sixteen faculty and students from Duke presented their research at the annual meeting of the American Geriatrics Society in San Antonio, TX, on May 18-20.

C. Colon-Emeric, C. Pieper, K. W. Lyles, J. LaFleur, C. VanHoutven, and R. Adler presented a poster on “The Impact of Osteoporosis Screening on Fracture and Mortality in Older U. S. Men.” They concluded that osteoporosis screening in selected men may be associated with lower fracture rates and mortality, but selection criteria appear to be critical. This poster won best poster award in the epidemiology category.

R. Hall, E. Myers, S. Rosas, A. O’Hare, and C. Colon-Emeric presented a paper on “Choice of Hemodialysis Access in Older Adults: A cost-effectiveness analysis.” They concluded that the cost effectiveness of an arteriovenous fistula placed within the first month of dialysis diminishes with increasing age and lower life-expectancy, and is not the most cost-effective option for those with the most limited life-expectancy.

EDITORIAL
Ageist Euphemisms

“Sticks and stones may break my bones, but words will never hurt me.”

Actually, words can also hurt. This is true even if the words are not intentionally harmful. For example, euphemisms about old age are often used to cover up the negative connotations of the term “old.” Here is an alphabetical list of such terms and sayings along with their negative meanings.

- **Act your age:** when said to an old person, this means do not do any “youthful” things, such as loud singing, wearing bright clothes, showing off your body, getting tattoos, being sexy, or doing anything adventurous or “undignified.”
- **Can’t cut the mustard:** unable to function well, impaired, handicapped.
- **Geezer:** an odd or eccentric old man.
- **I’m not as young as I was:** not as strong, flexible, vigorous, or able as I was.
- **Of a certain age:** of an old age.
- **Old fogey:** senile, ugly.
- **Old maid:** an unattractive unmarried old woman.
- **Old hat:** out of date, trite.
- **Old school:** old-fashioned or conservative. Sometimes may be positive term.
- **Old wives tale:** a silly story, gossip, or superstitious belief.
- **Over the hill:** past one’s prime, declining abilities, frail, senile, or senescent.
- **Senior moment:** a moment when you can’t remember a name or word.
- **Showing signs of aging:** deteriorating, becoming senile or senescent, or showing negative changes such as impaired vision, hearing, memory, or wrinkles.
- **Spinster:** same as old maid.
- **Too old for that:** too senile or frail or impaired to do something.
- **You don’t look that old:** meant as a compliment but actually has ageist connotations because it implies “You don’t look as decrepit or impaired as most people your age.”

Since all these terms tend to reinforce negative ageism, it is best to avoid them.

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For seniors, these vital tips can help you age well*

**By Steven Petrow**

Even at age 70 or older, the choices you make about exercise, eating and your health remain important — and at this point in life, it’s worth taking a second look. As Miriam C. Morey, an expert on aging at Duke University, put it, seniors “need to reset your thinking in terms of what you’ve been doing and what you want to do in the future.”

We need to transition into thinking about mobility, how to augment or enhance it. Here are some questions to ask yourself — or your doctor — and simple measures to adopt to maximize your chances of aging well. From an exercise point, ask:

- Are my legs strong enough?
- Can I get out of my chair without using my hand to help?

**Do a simple test:** Put your arms across your chest and see if you can get out of the chair without using your arms.

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on “The Perioperative Optimization of Senior Health (POSH) Program at the Durham VA: A Specialty Care Education Center of Excellence.” They concluded that in its first year the POSH program provided care for over 200 veterans and rich experiences for learners from 8 different professions.

K. T. Hobbs, B. Hammill, G. Preminger, M. Lipkin, K. Schmader, and C. Scales presented a paper on “Increasing Utilization of Care for Urinary Stone Disease in Older Adults.” They concluded that health care utilization for USD is growing rapidly among older adults, and faster than among any other age group.

S. R. Macdonald, R. Sloane, M. Heflin, and S. Lagoo-Deenadyalan presented a paper on “Perioperative Optimization of Senior Health (POSH) Reduced Postsurgical Complications in High Risk Older Adults.” They concluded that perioperative collaborative care between geriatrics, anesthesia, and general surgery is beneficial.

D. C. Parker, K. Hall, M. Morey, and R. Sloane presented a paper on “Sedentary Behavior is Associated with Elevations in Pro-Inflammatory Biomarkers.” They concluded that increased time spent in bouts of sedentary behavior is associated with changes in pro-inflammatory biomarkers.

C. Scales, M. Greiner, L. Curtis, B. Hamill, D. Peterson, C. Amundsen, M. Heflin, and K. Schmader presented a paper on “Variations in Care Intensity for Overactive Bladder Symptoms among Medicare Beneficiaries.” They concluded that downstream OAB treatment costs vary by both patient and provider characteristics, and particularly by provider specialty, even after controlling for presence of incontinence.

K. Schmader et al. presented a paper on “Make CME Matter: A national skills workshop may impact practice change for patients with chronic wounds." They concluded that national workshops allow for expert consultation and hands-on skill-building. This may impact practice change.

M. Sharda, E. Matoon, L. Matters, S. R. Macdonald, T. Thomas, J. M. Prewitt, M. Gao, B. Worley, and H. White presented a poster on “Project CALM: Confusion Avoidance Led by Music.” They concluded that patients report a positive effect on mood and pain. This poster won a “best poster” award.

M. Toles, C. Colon-Emeric, M. Naylor, J. Asafu-Adjei, and I. Hanson presented a paper on “Pilot-Testing Connect-Home: Transitional Care in Skilled Nursing Facilities.” They concluded that Connect Home is feasible, acceptable to staff and patients, and improves preparedness for discharge.

K. E. Zietlow, S. R. Macdonald, R. Sloane, and M. Heflin presented a paper on “Comparative Outcomes of Patients with and without Cognitive Impairment within a Comprehensive Perioperative Assessment Program.” They concluded that patients with and without cognitive impairment who participated in a perioperative collaborative multidisciplinary care program had similar outcomes.

X. Zuo, A. Luciano, C. Pieper, and H. Cohen presented a paper on “Exploring the Relationship between Inflammatory Markers and Metabolic Intermediates in Older Adults.” They concluded that there is an age-associated interplay between inflammatory and metabolic markers demonstrating close linear associations.
A major focus of my research has been transitions of care involving the emergency department (ED). My research interests were initially sparked during my year as Chief Resident at Stanford, when I practiced in the general medicine clinic, on the inpatient medicine wards and in the emergency department (ED). Working in all three of these settings gave me a unique appreciation for the perils patients face as they move throughout the health care system.

I frequently saw patients in my own clinic with new problems following an ED visit due to misunderstanding of discharge instructions, such as how to take their medications. I saw patients on the wards who had been treated and discharged from the ED in preceding weeks, but failed to follow up with their primary care provider for further management and subsequently required inpatient admission. However, I also had first-hand knowledge of the challenges facing ED staff in caring for patients who were being discharged. Providing information was difficult; patients were acutely ill or injured and often exhausted after a lengthy ED evaluation. Formulating a follow-up plan was often a formidable task, particularly after business hours in the busy and chaotic clinical environment that is ubiquitous in EDs. When I came to Duke to begin fellowship training in Geriatrics, I continued my work in the ED and began seeing patients in Geriatrics clinic. The problems resulting from the discontinuity in service from the ED to the primary care clinic were the same, but magnified in an older frail population. It was these clinical observations that led me to focus my research efforts on care transitions.

Together with collaborators in the Division of Geriatrics and the Aging Center, as well as the Geriatrics, Research, Education, and Clinical Center (GRECC) and Health Services Research Center of Innovation (COIN) at the Durham VA, I have conducted a number of studies examining the frequency and predictors of adverse health outcomes in older adults discharged from the ED. We conducted the first studies using national samples in both Medicare and VA populations to demonstrate the high rates of return visits after ED discharge. In a national sample of Medicare beneficiaries, we found that nearly 1 in 3 older adults return to the ED, are hospitalized, admitted to a nursing home or die within 90 days of discharge from the ED. This work also helped to establish the relationship between ED visits for chronic conditions and risk of return, and contributed to untangling the relationship between frailty and adverse outcomes. Frailty is strongly associated with subsequent hospitalization, but not repeat outpatient ED use, highlighting the unique nature of this particular type of health care utilization.

Research on transitions of care among older adults has traditionally focused on the hospital (inpatient admissions). My research has demonstrated the importance of expanding this focus to include EDs, which provide nearly 10% of all ambulatory care visits to seniors in this country. In addition to previously recognized risk factors including high medical co-morbidity and previous health service

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Also, what is my balance like, because once you reach this age [many] start to lose their balance. Can you stand on one leg? Start practicing. You should think about your strength because that’s one of the most important things about maintaining your independence. Do less cardio and do more things for strength — lower- and upper-body.

*Reprinted from The Washington Post, April 15.*
use, we found that suboptimal medication therapy and poor understanding of ED discharge information are associated with higher risk of return, underscoring the importance of further work to improve the ED to primary care transition. This series of studies led to the design of a nurse telephone support program for high risk older adults discharged from the ED that we are currently testing in a randomized controlled trial.

As a geriatrician and health services researcher, I am keenly interested in translating research findings into meaningful changes in care delivery for older adults. One example of my efforts in this area is the EQUiPPED project. EQUiPPED (Enhancing Quality of Prescribing Practices for Older Adults) is a multi-component interdisciplinary quality improvement program aimed at improving medication safety for older adults in the ED that was based in part on our team’s research. EQUiPPED has now been implemented in 8 VA medical centers across the country; in the first 4 centers completely implementing the program, prescriptions to older adults for potentially inappropriate medications have been reduced by an average of 45%. AHRQ has recently funded a study to implement and evaluate EQUiPPED at Duke, Mt. Sinai and Grady Hospital in Atlanta, Georgia.

Another result of my clinical work and research interest in care transitions has been development and implementation of STRIDE, a supervised walking program for older adults. Older adults who participated in STRIDE at the Durham VA had reduced length of stay and were less likely to be admitted to a nursing home. STRIDE will be implemented and evaluated at an additional 8 VA medical centers across the country via a cluster randomized trial as part of the Function and Independence QUERI program project grant (PI Hastings, IP HX002258) that began in October 2016.

I’m excited about these new opportunities and look forward to continuing to work closely with others in the aging and health services research community toward our shared goal of improving health and health care for seniors.
FREQUENTLY ASKED QUESTIONS*
How can you preserve your memory?

“What was the name of that course you were taking to improve your memory?”
“I can’t remember.”

There really are a bunch of things you can do to preserve and boost your memory:

- **Exercise your brain.** Although the brain is not a muscle, it responds to exercise like a muscle: if you exercise it, it tends to maintain its strength; if you don’t use it much, it tends to wither; memories tend to atrophy. Apparently any kind of challenge to your mind can work as brain exercise: solving puzzles; playing games; memorizing poems and songs; learning a new language; taking or teaching a course; writing; using a computer; reading something mentally challenging; playing a musical instrument; dancing; doing a routine task in a novel way (like using your left hand if you’re right handed, and vice versa).

- **Process information with several senses:** visual, auditory, and touch.

- **Avoid excessive stress.** A little stress may be good to challenge your brain, but too much stress that makes you anxious or depressed is not good.

- **Get plenty of sleep.** Most old people need as much or more sleep as younger people. Short naps during the day are also beneficial.

- **Stay involved with people.** People with larger social networks tend to maintain their mental functions better than isolated people, because social people are more likely to engage in the physical and mental activities which boost brain function.

- **Do volunteer work.** Volunteer work tends to challenge brains with new activities, exercise, and socializing. It also makes you feel useful and valued, which helps prevent depression.

- **Take care of your body.** Your brain is part of your body, so keeping your body healthy through regular exercise, good diet, hygiene, and medical care is essential for brain health.

- **Eat a brain-healthy diet:** lots of fruits and vegetables, whole grains, fish like salmon, tuna, and sardines (rich in omega-3 fatty acids).

*Adapted from Palmore, Older Can Be Bolder, Amazon, 2011.

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SLOGAN FOR THE DAY:
Old age is better than its alternative.
COMING EVENTS


September 8: The 2nd Annual Center for the Study of Aging Retreat will be held at Trent Semans Great Hall. Contact: http://sites.duke.edu/centerforaging/.

March 1–4, 2018: The Association for Gerontology in Higher Education (AGHE) invites the submission of original presentations for its 44th Annual Meeting and Educational Leadership Conference at the Sheraton Atlanta Hotel in Atlanta, GA. Contact: aghe.org/am.