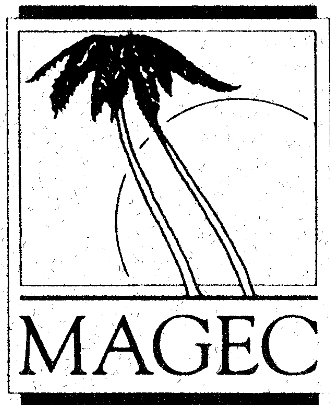

MAGEC MESSENGER

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Influenza immunization in a large Hispanic group of frail, homebound elderly

by Kamal Hamdan, MD, CPUR; Adam G. Golden, MD; Mary Brooks, RN; Michael Silverman, MD

In Florida and nationwide, the majority of functionally and cognitively impaired frail elderly live at home, rather than in a nursing home. The population of frail, homebound elderly is difficult to study because these people are often geographically and functionally isolated from studies based in medical centers. Eldercare is a managed care plan designed to care for this large and poorly served population.

Influenza is a significant cause of mortality and morbidity in the frail elderly population. Approximately 85 percent of the 10,000 yearly deaths due to influenza are in persons over the age of 65, and the case-fatality rate among nursing home residents is approximately 30 percent. The influenza vaccine provides 50 to 80 percent protection in the frail elderly population. The use of the vaccine in the elderly is associated with a 48 to 57 percent decrease in hospitalization rates for pneumonia and influenza and a 27 to 30 percent reduction in total mortality. The cost-effectiveness of the vaccine has also been demonstrated.

Currently, the United States Preventive Services Task Force (USPSTF), the American College of Physicians, and the American Academy of Family Physicians all recommend annual influenza vaccinations for every individual over 65. The only contraindications for vaccination are an allergy to eggs and an acute febrile illness (Wool, Jonas, Lawrence, 1996). Despite the goal of the U.S. Public Health Service for a 60 percent annual immunization rate in the elderly, studies indicate that vaccination rates may be lower. Vaccination rates in the ethnic minority populations are not well studied. Examination of poor immunization rates have revealed that compliance is dependent on the education and behavior of both physician and patient.

To determine compliance with USPSTF guidelines regarding yearly vaccinations for influenza, we collected data in our group of frail elderly patients in 1997. We studied the most common reasons for not receiving a yearly influenza vaccination.

Eldercare serves the frail elderly as an alternative to regular Medicaid benefits and is funded by Medicaid as a prepaid health plan. The goal of this plan is to maintain the frail elderly clients in their home environments at no cost to any member. Eldercare manages long-term services for 3,400 culturally diverse clients (80 percent Hispanic). All clients must meet Florida Medicaid financial eligibility and must demonstrate sufficient impairment in functional status (need assistance for three or more activities of daily living) to qualigy for nusing home placement under the Medicaid program.

The managed care service does not control the medical aspects of care, although clients receive a number of benefits from the plan, including personal care, home management, home health supplies, nutritional supplements, and care management. The medical components provided include physician, hospital, X-ray, laboratory, and, nursing services, and prescribed drugs.

The data regarding compliance with yearly vaccinations for 1997 were collected for a large sample of our population. All information was collected by the case managers. Patient charts were reviewed and phone interviews were conducted with the clients and/ or their caregivers. Faxes were sent to physicians' offices to confirm vaccinations. If a client did not receive an influenza vaccination, the reasons were recorded.

Of the 643 clients interviewed, 39 percent received influenza vaccinations. The reasons for the lack of compliance with immunization guidelines are:

•Afraid of side-effects
•Never heard of these vaccinations
•Does not need ("never had a cold")
•Vaccine not available
•Client unable to get to doctor
•Physician advised against vaccination because of "side effects"
•Physician did not believe in flu vaccination

Immunization rates were disturbingly low n a frail high-risk group of geriatric, predominantly Hispanic clients. Whether this low rate of immunization resulted in an increase in deleterious effects in this population should be examined. Both client and physician behavior appeared to contribute to the low rate.

These findings have initiated a bilingual intervention, including nurse visits. phone contact, and printed educational material to increase vaccination rates. The effectiveness of these strategies will be monitored in 1999, following intervention. Given the large expected increase in both the frail, homebound elderly and the Hispanic geriatric populations, the results of these interventions may represent an important step in improving the quality of care to this underserved population.

Potential role of interdisciplinary case management

Article taken from CPUR Notes, October - 1999. Permission to reprint granted by Dr. Michael Silverman of the GRECC - Miami VAMC.

Surgeon General Urges Professionals to Stay Aware of Seniors' Mental Health

Those who work with older people need to look for mental illness in seniors, because primary care physicians often miss mental illness in their elderly patients. Seniors are often misdiagnosed or undemeated for mental disorders in primary care settings, the U.S. surgeon general indicates in a new 500-page report on the status of mental health research and treatment.

Eight to 20 percent of older adults in the community and up to 37 percent in primary care settings suffer from depressive symptoms. Treatment can be successful, with response rates between 60 and 80 percent, but improvement generally takes longer than in younger adults.

Seniors are more likely than other people to have comorbid disorders and social problems that reduce treatment effectiveness, the report notes. Primary care practitioners need to be a critical link in identifying and addressing mental disorders in older adults, it states.

Depression in older people is hard to disentangle from the many other disorders that affect older people, and its symptoms are somewhat different than younger adults, the report said.

Depression in older adults not only causes distress and suffering but also leads to impairments in physical, mental and social functioning. Despite being associated with excess morbidity and mortality, depression often goes undiagnosed.

Findings on Older Adults

Important life tasks remain for individuals as they age. Older individuals continue to learn and contribute to the society, in spite of physiological changes due to aging and increasing health problems, the report concludes.

Continued intellectual, social and physical activity throughout the life cycle are important for maintaining mental health in late life.

Stressful life events, such as declining health and/or the loss of mates, family members or friends, often increase with age. However, persistent bereavement or serious depression is not "normal" and should be treated.

Normal aging is not characterized by mental or cognitive disorders. Mental or substance use disorders that occur alone or co-occur with other problems should be recognized and treated as illnesses.

Disability due to mental illness in individuals over 65 years old will become a major public health problem as the population ages. In particular, dementia, depression and schizophrenia, among other conditions, will all present special problems in this age group. Dementia produces significant dependency and is a leading contributor to the need for costly long-term care in the last years of life. Depression contributes to the high rates of suicide among males in this population. Schizophrenia continues to be disabling despite recovery of function by some individuals in mid- to late life.

There are effective interventions for most mental disorders experienced by older persons (for example, depression and anxiety) and many emotional conditions, such as bereavement.

Older individuals can benefit from the advances in psychotherapy, medication and other treatment interventions for mental disorders used for younger adults when these interventions are modified for age and health status.

Treating older adults with mental disorders accrues other benefits to overall health by improving the interest and ability of individuals to care far themselves and follow their primary care provider's directions and advice, particularly about taking medications.

Barriers to access exist in the organization and financing of services for aging citizens. There are specific problems with Medicare, Medicaid, nursing homes and managed care.

The report, *Mental Health: A Report of the Surgeon General* is online at http: //www.surgeongeneral.gov.

A print copy is available as
Stock No. 017-024-01653-5
from the Superintendent of Documents,
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Article take from Aging Research & Training News, January 2000, Vol. 23 No. 1.

Clinton Proposes Grants to Aid Assisted Living Conversions

President Clinton is proposing to offer $100 million in competitive grants to qualified low-income elderly housing projects willing to convert some or all of their units to assisted living. The plan also would expand access to home- and community-based care through Medicaid by no longer requiring states to obtain a federal waiver in order to provide services outside of a nursing home setting. The White House released details of the President's long-term care initiative in January.

In addition, the plan would provide a $3,000 tax credit for people with longterm care needs and their family caregivers. The initiative would triple the $1,000 Clinton proposed last year. The proposal, which will be included in Clinton's fiscal year 2001 budget request, would cost $8.8 billion over five years and $26.6 billion over 10 years. The credit would be available to people of all ages with three or more limits in their activities of daily living.

The credit, which would be phased in over five years, would start at $1,000 in 2001 and increase in $500 increments until the full credit is available beginning in 2005. According to details released by the White House, the credit would be phased out beginning at $110,000 for couples and $75,000 for umharried taxpayers. To be eligible for the credit, the individual with long-term care needs must have three or more limitations in activities of daily living or a comparable cognitive impairment. The administration estimates that the credit could provide financial relief to about 2 million Americans, including 1.2 million elderly, more than 500,000 nonelderly and 250,000 children.

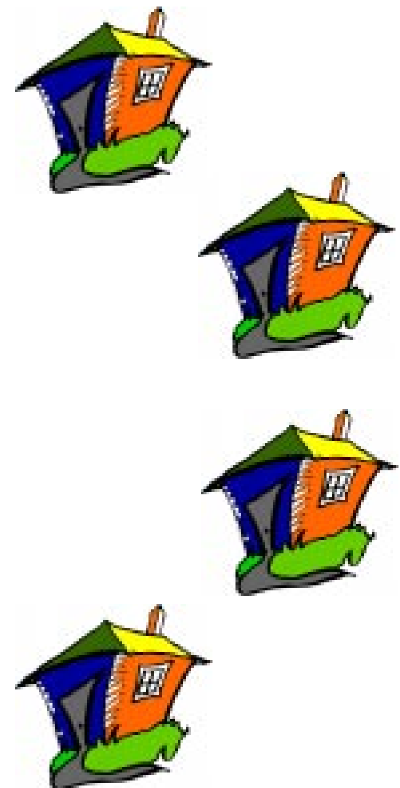
The remainder of the package would provide funding for services that support family caregivers of older persons.

The initiative also would establish a $1.25-billion nationwide support program for family caregivers-offering respite care, information about community- and facility-based long-term care options, and counseling.

Clinton and senior administration officials said they were optimistic that a significant healthcare package could be enacted this year because of the public demand for reform. "These proposals are a significant investment in the health of Americans, another step toward giving every American access to quality healthcare," Clinton said.

A senior administration official also defended Clinton's choice of tax credits over tax deductions in the plans because of the latter's regressive nature. Clinton said that the tax credit "is exactly the right way to go" for long-term care "because there are so many different kinds of long-term care options ... that are appropriate for different families given different circumstances." The president's proposed healthcare initiatives would be funded by the anticipated non-Social Security surplus, according to administration officials.

In response to the plan, John Rother, legislative director for the American Association of Retired Persons, said, the proposal "could be a big first step to help people who sacrifice a lot and provide the bulk of the care. This supports people in doing the right thing and taking care of their families."



Article take from the Assisted Living Executive Report (ALER), February, 2000, Vol. 4 No.3.

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CALENDAR OF CME/CEU EVENTS

Mark Your 2000 Calendar! Contact MAGEC for more information at (305) 243-6270

August 21-24, 2000
FCOA 2000 - The Conference
CME/CEU hours: 6 for administration, nutrition, nursing, occupational therapy, physical therapy and social work,
Location: Tampa Marriott Waterside Hotel, Tampa, FL
Call (850) 222-8877 for information.

September, 2000
Please be advised that the following Intensive Geriatric Training Part B: Discipline Sessions will be offered soon:

Long Term Administration	09/00
Physical Therapy	09/00
Psychology	09/00

Call (305) 243-6270 for information.

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MAGEC is seeking those interested in being trained in an exciting program entitled the ***Adult Health & Development Program***.

This is an intergenerational health promotion and rehabilitation program designed to positively affect the health and well-being of institutionalized and non-institutionalized older adults.

Dr. Daniel Leviton of the University of Maryland will lead the day-long "Directors Training" workshop on August 24, 2000

Please contact MAGEC at (305) 243-6270 for further information.

Visit our website at www.magec.org

CE PROGRAM DESCRIPTION

FCOA 2000 - The Conference
August 21-24, 2000 - Tampa, FL

The Florida Council on Aging is known for its great training conferences, featuring a comprehensive program of workshop topics and outstanding trainers. At **FCOA 2000 - The Conference**, you will attend great training sessions and enjoy networking opportunities with other professionals in aging from across the state and nation.

This year's conference kicks-off with an opening panel sponsored by the Winter Park Health Foundation. National experts Fernando Torres-Gil and Robyn Stone will present *Sneak Preview - Tomorrow's Senior Services.* On Tuesday, Joyce Cohen will give an energetic and challenging keynote at the FPL/FCOA Quality Senior Living Awards Lucheon. On Thursday, Dr. Gema Hernandez, Secretary of the Florida Department of Elder Affairs, will give the State of the State Address.

In partnership with MAGEC, continuing education credits have been approved for all concurrent workshops, two Leadership Academies and two pre-conference intensives. A broad array of topics will be presented, including clinical issues, research and policy updates, administrative and management topics, service delivery innovations, marketing, minority aging, and more. New this year are academy workshops with invited faculty from across the nation.

For more information, or to receive a brochure, please call FCOA at (850) 222-8877.