

THE WHOLE PICTURE

Addressing The Needs Of Seniors

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Occupation

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Focus

Health care delivery and economics

Funding

ADA Clinical Research Award

Seniors face different challenges in managing their diabetes than their younger counterparts. They may have physical disabilities, other health conditions that must be treated, or memory impairment. Those who live on fixed incomes often face financial barriers to care. Any of these challenges may hinder a senior's ability to care for his or her diabetes.

"We can't treat people who are 80 the same way we treat people who are 40," says Medha Munshi, MD, director of



Addressing financial challenges and multiple health conditions may go a long way toward preserving the quality of life for seniors with diabetes, says Medha Munshi, MD.

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[research profile]

the geriatric program at the Joslin Diabetes Center, instructor at Harvard Medical School, and gerontologist with Beth Israel Deaconess Medical Center in Boston. “Their needs are different. Their bodies are different and respond differently to treatment. You have to look at their whole picture, not just the diabetes.”

Munshi and her team of researchers have devised a program they hope will address “the whole picture.” Using funds from an American Diabetes Association Clinical Research Award, they’re studying the program’s effectiveness in overcoming barriers to diabetes care in a population of seniors.

A Mixed Population

Munshi’s study will involve 100 people older than 70 who have either type 1 or type 2 diabetes and have A1C levels of 8 percent or more. (The A1C measures blood glucose control over 3 months. Seven percent is considered good control.) The researchers will assess each participant’s health (including diabetes control), physical ability and

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function, and social and economic background.

Next the participants will be separated into two groups. One group, the control group, will receive diabetes care from a health care team at the Joslin Clinic. These participants will also receive 4 hours of general diabetes education from a research nurse.

The other group, the program group, will receive the same care. However, they will also have more in-depth meetings with Joslin health care providers who specialize in geriatric medicine. These specialists will assess the participants’ age-specific problems and address each participant’s own particular needs.

“This is a very heterogeneous population,” Munshi says. “At 75, some will be playing tennis every day, others will need a wheelchair. Some are active and independent, others need

care-giving. Some live alone, others don’t.”

The team will help participants in the program group find and connect with community resources as the necessity arises. For example, if a participant has a history of falling, the team may help make arrangements for a home care nurse to visit or for the participant to receive physical therapy.

After 6 months, the program will end. “At that point, we’ve identified [the program group’s] needs and barriers and have enough support systems set up so they can maintain their care on their own,” says Munshi.

The team will reassess all participants’ health, physical ability, and social and economic backgrounds, and then repeat the assessments 6 months later. At study’s end, the team will compare results between the two groups.

Beyond A1C

Munshi anticipates that participants in the care group will fare better than those in the control group because of the individualized attention they receive. “We’re looking primarily at A1C, to see if their blood glucose goes down and whether they can maintain it,” she says.

However, there’s more to it than that, she says. Independence is a primary goal for many seniors. “Most of the time when you ask older people what they want, they want to remain functional,” she says.

Therefore, the team will compare physical functionality between the two groups. “We’ll ask them about their activities of daily living like bathing, [using the toilet], and meal preparation, and we’ll assess their walking.”

Munshi hopes the program will help participants and care providers alike learn to balance the need for good control with other aspects of a senior’s health care.

“In older age, the basic general concept is do the best you can,” she says. “That’s not to say [seniors] don’t need [good glucose] control, but there are things that have to be considered first.”

One of the biggest concerns for seniors with diabetes is low blood glucose, she says. “Even a mild episode of low blood glucose can be dangerous. A person can feel dizzy, fall, break a hip, and end up in

a nursing home. Then we’ve defeated the whole purpose of treating diabetes. The risk from the treatment should never outweigh the risk of the disease.”

She adds that sometimes this is hard for a health professional focused solely on diabetes treatment to see, which is why the program addresses so many facets of senior life.

“It’s overwhelming,” she says. “When I talk to other doctors, they can’t [cover all the details] they’re supposed to in the limited time they get with their patients as it is, so we hope to identify the most common challenges and barriers to care and provide intervention for them. Then we can make that part of routine care for our elderly patients.”

In the long run, she says such care would not only help preserve the quality of life for many seniors, but it would also be more economical for patients and care providers: She anticipates that program participants will have fewer emergency room visits and will be more likely to keep doctor’s appointments.

That has important implications for health care as a large segment of the population heads toward retirement.

“Right now 1 in 5 patients is older than 65, and that’s only going to increase,” Munshi says. “Unless we learn how to take care of them differently, we may face a lot of problems.”