SAGE Open Nursing
Volume 10: 1–5

DOI: 10.1177/23779608241274209
journals.sagepub.com/home/son

Aging With Grace: The Quest for Integrated, Compassionate Care for Older Adults

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Abstract

Introduction: This Practice Update discusses the potential for implementation of the 4M model for care of older adults in Israel, to complement the medical-centric model that exists today. The older adult population in Israel is increasing. However, efficient and sufficient care that takes patient's wishes into consideration is lacking.

Purpose: Care of older adults, particularly palliative patients, is complex and requires multidisciplinary efforts. There are numerous challenges to caring for older adults. These include fragmentation of care, unclear boundaries between palliative and geriatric care, and the preservation of patient autonomy, indicating a need to adopt new care frameworks.

Conclusion: The authors suggest implementing the 4M model as a new care framework in addition to the current medical-centric model. This framework considers important care aspects during discussions of care: what matters to the patient, medication, mentation, and mobility. Implementation of this model can promote better-integrated care, thus improving the quality of life for older adults.

Keywords

well-being, COVID-19, nurses, mental health, resilience

Received 13 December 2023; Revised 23 June 2024; accepted 13 July 2024

Introduction

Over the last century, life expectancy has nearly doubled, leading to a rise in the global population of older adults (aged 65 and above) (Dzau et al., 2019). In 2023, Israel's older adult population constituted 12% of the total population. This statistic is projected to rise to 15% by 2040, underscoring the pressing need to ensure this demographic receives quality healthcare (Shnoor & Cohen, 2021). Advanced age significantly increases the risk of chronic diseases and other health issues, leading to increased use of already-limited healthcare resources (Atella et al., 2019).

Effective care for older adult patients necessitates a holistic, value-based approach to care (Fulmer et al., 2021). Both palliative care providers and geriatricians provide care to a large portion of this demographic. Advancing palliative and geriatric services is crucial not only for enhancing the caliber of patient care and ensuring service continuity but also as a cornerstone for the utilization of medical technologies and resources (Fisher-Reif et al., 2016).

In Israel, the field of palliative care is relatively new. The implementation of palliative care into the healthcare system was outlined in a 2009 Ministry of Health Director-General's circular. This circular described how hospitals, long-term care facilities, and health maintenance organizations must develop a palliative care service for their patients within four years, and train dedicated staff. Staff must include a physician, a nurse, a psychologist, and a social worker (Israeli, 2009). However, implementation of palliative services in general, and geriatric hospitals, has been inconsistent and insufficient (Bentur et al., 2015). Currently, while Israel has introduced a national plan for palliative care (Fisher-Reif et al., 2016), it is still an emerging field and the majority of palliative services are given to cancer patients (Shaulov et al., 2019).

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Review of the Topic

Challenges in the Provision of Care to Older Adults in Israel

Interplay Between Geriatrics and Palliative Care. Globally, there is a complex interplay between geriatrics and palliative care, including in Israel. Visser et al. (2021) identified three themes that describe the working practices of each specialty in relation to the other. The first are the unclear boundaries between the two specialties regarding goals of care and the target patient population. This has led to blurred boundaries and an unclear sense of what geriatricians and palliative care specialists can and cannot do within the framework of their specialty (Visser et al., 2021; Voumard et al., 2018).

The second theme is the uncertainty regarding the placement of older adults within the current healthcare framework. Since many older adults suffer from multimorbidities, healthcare providers may find it challenging to treat an older adult in a single framework (Oksavik et al., 2021). Third, communication gaps between healthcare providers are commonplace and there are collaboration challenges regarding advance directives, symptoms management, and end-of-life care (Visser et al., 2021).

In Israel, this complex interplay is evident in the manner in which palliative care is administered among older adult patients. A report conducted by Myers-JDC-Brookdale Research Institute found that palliative care is administered differently in different geriatric hospitals. In some geriatric hospitals, palliative care is provided in all hospital departments; in others, it is provided only in complex nursing departments. Some hospitals will only provide palliative care based on the recommendations of a palliative care committee (Bentur et al., 2015). A portion of the healthcare providers interviewed for this report stated that the Director-General's circular from 2009 did not contain clear instructions as to how the institutions were to develop and operate a palliative care service within the four-year framework (Bentur et al., 2015). Furthermore, while the Ministry of Health has decreed that palliative care services fall under the national insurance law (whereby all Israeli citizens have basic universal healthcare insurance), the law does not detail the eligibility criteria, who can refer a patient for palliative care, or what care a patient is eligible to receive (Bentur et al., 2012).

Preservation of Patient Autonomy. Advance directives (ADs) provide patients with the right to accept or decline various medical treatments and make informed decisions about their care, thereby safeguarding their autonomy within healthcare settings (House et al., 2023). With a global increase in the prevalence of multiple chronic conditions among older adults (McNabney et al., 2022; Porteri, 2018), they are more susceptible to hospital admissions, re-hospitalizations, and iatrogenic complications (Boersma et al., 2020; Rodrigues et al., 2021).

In 2005, Israel passed the "Dying Patient" act, recognizing people's right to make their own end-of-life decisions and enable them to be part of the decision-making process. The composition of the law was challenging due to the conflict between Israelis' religious beliefs and the wish not to have patients suffer from aggressive medical treatment, which may prolong life, but would be fraught with pain (Werner et al., 2022). However, even once the law was passed, it was not widely implemented and the number of older adults who have signed an AD is relatively low (Shvartzman et al., 2015; Zigdon & Nissanholtz-Gannot, 2020). Factors contributing to this relatively low rate of signed ADs include perceived clashes with religious views both among Jews and Muslims, lack of public education about the law and the options it provides, and healthcare professionals' hesitancy or lack of training in discussing and facilitating the creation of AD with patients (Zigdon & Nissanholtz-Gannot, 2020).

Fragmentation of Care. Current healthcare systems frequently struggle with fragmentation of care, which can negatively affect vulnerable populations, such as older adults, and exacerbate economic inefficiencies in the healthcare system (Levi & Davidovitch, 2022). For example, this occurs among individuals with chronic diseases who might encounter limited or repetitive services from practitioners, and often face gaps during transitions between healthcare institutions (Doty et al., 2020). The consequences of fragmented care are particularly dire for older adults given their need for a comprehensive, coordinated strategy to treat their multifaceted medical and psychosocial requirements (Kaltenborn et al., 2021; McNabney et al., 2022). An example of the impact of care fragmentation is the increased likelihood of hospital readmissions among older patients, or the provision of overlapping or conflicting treatments contributing to patient confusion, costs, and adverse health outcomes (Kaltenborn et al., 2021; McNabney et al., 2022).

In Israel, there is fragmentation of care for frail older adults. As part of the Universal Healthcare Law, the individual's health maintenance organization is responsible for continuity of care. This is meant to prevent the individual from being passed from institution to institution while receiving different aspects of care throughout the care process. However, due to opposition from the Ministry of the Treasury and other issues, this concept has yet to be implemented (Clarfield et al., 2010). This opposition primarily stems from issues related to resource allocation, lack of infrastructure, resistance from some healthcare providers or institutions, and lack of consensus on the best approaches to operationalize continuity of care (Assor & Greenberg, 2022; Levi & Davidovitch, 2022).

Given the presented evidence, the authors propose that integrating the Age-Friendly Health Systems initiative, which is designed for older adults in all care environments, would substantially enhance Israel's healthcare framework for older adults. This initiative should be incorporated into

both educational curricula and clinical rounds, as well as into practice, both in hospitals and in the community (Fulmer et al., 2018; Institute for Healthcare Improvement, 2019).

Integrating Care: The 4M Model. In 2019, the American Hospital Association's Health Research and Educational Trust, in collaboration with the Institute for Healthcare Improvement and the Catholic Health Association of the United States, introduced a pioneering framework to enhance care for older adults. This framework became known as the 4M model (Dzau et al., 2019; Fulmer et al., 2021; Institute for Healthcare Improvement, 2019; Mate et al., 2021). The 4M model guides the care of older adults and makes complex care processes more manageable. The 4Ms include the following: what matters, medication, mentation, and mobility.

What matters emphasizes the understanding and respect of individual patient care goals during times of health, illness, and end-of-care processes. Taking the patient's values and beliefs into consideration can improve health outcomes (Mate et al., 2021). Medication entails the adherence to Beers Criteria to curtail and manage polypharmacy and ensure medications align with the patient's priorities. Furthermore, the use of medication should not come at the expense of other care aspects—mentation, mobility, and what matters (Mate et al., 2021). Mentation encapsulates efforts to prevent, alleviate, and treat the three "D"s: depression, delirium, and dementia based on evidence-based guidelines. Finally, mobility means ensuring that patients in all settings are able to maintain a degree of mobility (Dzau et al., 2019; Fulmer et al., 2021; Institute for Healthcare Improvement, 2019; Mate et al., 2021).

Results from a study in Florida found that the implementation of the 4M model during an annual wellness visit in a group of primary care clinics, had a positive effect on the use of medication, advanced care planning, and performance of fall risk assessments (Tewary et al., 2023a). A dedicated nurse practitioner played a key role in ensuring the 4M model was implemented and that important aspects of care such as fall and cognitive assessments, depression risk, and more, were documented in each patient's chart to ensure optimal follow-up care (Tewary et al., 2023b). Another study implemented the 4M model into annual wellness visits at primary care clinics that were focused on preventative care. This method was utilized instead of the standard problem-related care, whereby preventative measures and chronic conditions were addressed as an aside or not at all (Garbarino et al., 2023).

As noted by the researchers (Tewary et al., 2023b), the success of implementation was dependent on the availability of a dedicated staff member, either a registered nurse or a nurse practitioner. These nurses play a key role in implementing the 4Ms and ensuring that all care aspects are conducted such as risk assessments, conversations regarding care, and medications, are documented, and are made available to the rest of the care team while also freeing up time for other clinicians. This, in turn, can lead to less adverse events, a higher satisfaction of care, and a better quality of life.

In Israel, the integration and quality of geriatric and palliative care are increasingly recognized as critical components of healthcare. The Israeli National Palliative Care Policy of 2009 underscores the country's commitment to ensuring all citizens have access to palliative care (Israeli, 2009). This policy framework aimed at establishing quality care standards and the essential roles of palliative care teams within healthcare facilities, marking a significant advancement in the care of older adults (Dreiher et al., 2020; Even-Zohar et al., 2021).

However, the effective implementation of palliative care and geriatric services faces challenges, including staffing and training gaps, which impact care quality (Assor & Greenberg, 2022; Levi & Davidovitch, 2022). Cultural, religious, and ethical considerations play a significant role in shaping healthcare practices and views on ADs and end-of-life care in Israel. The Dying Patient Law of 2005 illustrates the delicate balance between medical ethics and religious beliefs in the Israeli context. Despite legal frameworks supporting ADs, the uptake remains low, stressing the need for increased awareness and education among healthcare providers and the public (Clarfield et al., 2017; Grove et al., 2022).

The 4M model offers a comprehensive approach to improving care for older adults, aligning with Israel's healthcare objectives. Implementing the 4M framework in Israel could enhance geriatric and palliative care by addressing fragmentation, improving communication among healthcare providers, and ensuring that care delivery is consistent with the patients' needs and the complexities of their conditions (Fulmer et al., 2018; Fulmer et al., 2021; Garbarino et al., 2023).

Conclusions

Care tailored for older adults is grounded in three foundational pillars: commitment to evidence-based practices, causing no harm to older adults in their care environment, and considering the concerns of the family and the broader environment (Institute for Healthcare Improvement, 2019). To truly optimize geriatric care, it is imperative to integrate these components across all geriatric care settings, fostering collaboration between palliative care providers, geriatricians, and nursing staff. Based on previous research, implementation is most successful through the utilization of a dedicated staff member, usually a registered nurse or nurse practitioner, who can oversee the process. This unified approach ensures a consistent care philosophy across various organizations and settings. It is worth noting that the 4Ms would not replace the medical-centric approach common in the Israeli healthcare system, but rather complement it. Integrating the 4M approach into the current medical-centric approach would

shift the focus toward quality of life, especially when disabilities and comorbidities are present.

Future research on geriatric and palliative care in Israel is essential for enhancing care quality and efficacy, particularly through the lens of the 4M model. Future research should explore patient and family engagement in the care process. This would enable policymakers to better understand barriers and facilitators to implement the "What Matters" principle, especially considering Israel's unique cultural, religious, and ethical viewpoints. Future research could also examine the role of technology in supporting the 4M model's implementation and assess the utility of digital health tools in delivering integrated, personalized care to older adults. Another research direction would be to investigate the policy implications of adopting the 4M model to understand how health policies align with the model's objectives. Identifying metrics that reflect patient-centered outcomes, care quality, and system efficiency will be crucial for monitoring the model's impact. Last, a cost-effectiveness analysis of the 4M model would offer valuable insights into the economic benefits of the model's broad adoption.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Ethics Approval Statement

Ethical approval for this study was obtained from the Jerusalem College of Technology Ethics Committee (approval no.: 21_014).

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

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