

MINNESOTA **MEDICINE**

JANUARY 2013

In the
comfort
of **home**

Why it's better to
care for frail elders
where they live. PAGE 24

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Caring for patients
with dementia and
comorbidities PAGE 41



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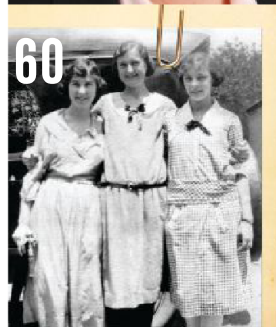
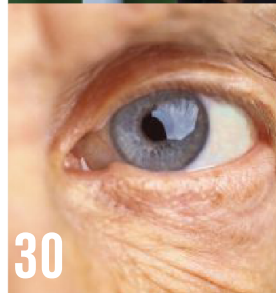
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A patient's final gift.

BY CHARLES BRANSFORD, M.D.

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CONTACT US

Minnesota Medicine

1300 Godward Street, Suite 2500
Minneapolis, MN 55413

PHONE: 612-378-1875 or 800-DIAL-MMA

EMAIL: mm@mnmed.org

WEB: minnesotamedicine.com

OWNER AND PUBLISHER

Minnesota Medical Association

EDITOR IN CHIEF

Charles R. Meyer, M.D.

EDITORS

Carmen Peota

Kim Kiser

PHYSICIAN ADVOCATE WRITER

Dan Hauser

ART DIRECTOR

Kathryn Fors

MMA COMMUNICATIONS DIRECTOR

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CIRCULATION / WEB CONTENT

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Charles R. Meyer, M.D., Editor in Chief

Our health care delivery system is at its most fallible when it confronts the medical problems of the elderly.

The final chapters

The biography of the last three years of my late father-in-law's life reads like a textbook for geriatricians. The story begins with a vital 87-year-old rushing down the stairs to answer the door, missing a step, falling and tearing his quadriceps tendon. Following surgical repair and a full-length leg cast, his next chapter involved a move to a local transitional care unit. Living 400 miles away, we attempted to follow his progress by speaking to him on the phone and searching for staff at the TCU who could give us an update. When he started talking gibberish and the nursing staff didn't seem to acknowledge the change, we traveled to Chicago to see for ourselves. We found a confused Stanley with a large buttock ulcer above his cast. A phone call to his primary care doctor led to his admission to the hospital, where just weeks earlier he had worked as a volunteer in the emergency room.

The next months saw a set of illness dominos falling in turn—MRSA wound and blood infection, urinary tract infection and *Clostridium difficile* (*C. diff*) colitis. Despite these setbacks, he rallied and worked his way up the health care facilities ladder—hospital to acute care rehab, acute care rehab to a different TCU, and then a move to a Minnesota TCU where we could more closely follow his progress. Yet more dominos were to fall—recurrent *C. diff*, aspiration pneumonia, a TURP to relieve obstruction and stop the urinary tract infections, and deep vein thrombosis. After a stay at his fourth TCU, he finally came home to live with us and then, miraculously, he became well enough to settle into an apartment at a nearby senior residence.

For the next three years, he enjoyed the camaraderie of his new circle of friends, getting to know his two great-grandchildren and entertaining all he met with his earthy wit. Yet these years were blemished by a few more falls and worsening of his asthma. His final chapter entailed more falls, decline of his lung function and a final episode of aspiration. He had made his DNR opinions clear long ago, so when his breathing became dire he asked for his family and a chaplain. We were at his bedside to see his last breath.

The motifs in this tale are familiar to anyone who has cared for the elderly. Falls are the dread disease of the aged, as difficult to prevent as the common cold and as deadly as a virulent cancer. Frailty can be a creeping ailment or it can accelerate with the onslaught of any disease. Infectious disease is an opportunistic bully, hitting the elderly when they're down. Multiple diseases in an older patient don't add to their problems, they multiply them.

Concerned family or friends are irreplaceable cogs in the care of seniors. DNR decisions made before dying breaths ease the dilemmas of the final days. Our health care delivery system is at its most fallible when it confronts the medical problems of the elderly.

Tales such as Stanley's hold lessons for all medical practitioners, and I learned a lot of medicine caring for my father-in-law. Instead of seeing a patient for 15 minutes in the exam room, I saw his final days unfold hour by hour. It was an education and a privilege. **MM**

Charles Meyer can be reached at meyer073@umn.edu.

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Physicians need to speak out about gun control

I am writing this six days after the horrific killings in Connecticut. Because of my past involvement in forensic pathology, I have a very clear mental picture of what happened to those children and adults. Can any rational adult argue that there is a cogent reason why guns created only for the purpose of killing many people in a short time are legal?

Do not let misguided arguments about personal rights take precedence over the rights of children to attend school without becoming homicide victims. Picture your favorite first grader in the morgue with multiple gunshot wounds and then think what message you want to convey to lawmakers. Please, fellow physicians, speak out boldly as advocates for gun control.

LISA LUND, M.D.
NORTH CENTRAL PATHOLOGY, P.A.
ST. CLOUD

Editor's response

The Minnesota Medical Association has a number of policies related to firearms. They are listed in the MMA's policy compendium, which is online. Go to www.mnmed.org and look under Publications for "MMA Policy." The document is a searchable PDF.

Physicians wishing to dialogue about this and other issues may do so on these pages or on the MMA's Facebook page.

What's on your mind?

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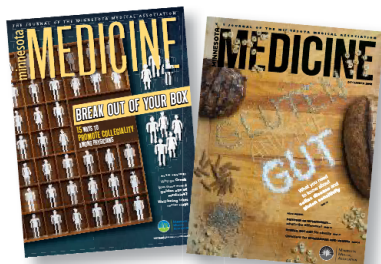
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No, it's not a recording device

BY KIM KISER

Vicki Anderson, an audiologist with HealthPartners, was struck by a story told to her by one of her patients. The woman wore hearing aids and a device that looked like an iPod around her neck. During a visit to her doctor, he noticed the device and asked the woman if she was taping their visit. She explained that the device was a Bluetooth streamer that works with her hearing aids.

“It made me think that if one physician thinks people coming in with these technologies is recording them, others may be as well,” Anderson says.

Technology is changing the hearing aid industry in a number of ways. Devices that didn't exist just a few years ago are now commonplace. Some of these include:

- **Hearing aids that look like hands-free devices for cell phones.** These digital aids use Bluetooth technology, fit in and around the ear much like a wireless earbud headset and come in a variety of colors.

- **Bluetooth streamers.** These devices, which look like an iPod or recorder, deliver audio signals directly to a digital hearing aid, allowing wearers to use audio devices such as cell phones and MP3 players without hurting their ears. They also can use the streamer to control volume and activate rear-facing microphones.

- **Remote or “partner” microphones.** Worn by a companion, these 2-inch-long wireless mics clip to the lapel. They enhance the signal going to the hearing aid and improve hearing in a noisy environment, Anderson says.

- **Hearing aids with extended microphones.** These are less common than the other devices. The mic sticks up above an over-the-ear hearing aid like an antenna, which improves the signal-to-noise ratio for wearers.



A Bluetooth streamer.

Image courtesy of Oticon



A hearing aid that looks like an earbud headset.

PHOTO COURTESY OF OTICON

In the future, hearing aids may not even reside in the ear. A team from the University of Colorado has designed a dress that is also a hearing aid. Microphones in its bodice determine the frequencies and amplitude of incoming sound.



Cost of care

Four out of five people will need some form of care as they age. The average cost of care is now \$48,000 per year. Of course, that cost depends greatly on the type of support needed.

The following are average annual costs in Minnesota.

Care center

Single room = \$85,534

Shared room = \$76,716

Assisted living

\$37,632

Home health

\$57,772 (assuming 44 hours per week)

Source: Genworth 2012



Staying upright

Minnesota has the fifth highest death rate due to falls in the United States—nearly twice the rate of the rest of the country. Surprisingly, our icy winters aren't to blame. The Minnesota Department of Health says there's no seasonal variation in the rate of unintentional falls.

More than 86 percent of those deaths occur among adults age 65 and older. In 2009, older adults experienced more than 29,900 falls, leading to 639 fatalities and estimated medical costs of more than \$255 million. That same year, falls were the No. 1 cause of death from unintentional injury, surpassing car accidents.

A 2012 Cochrane review of 159 randomized trials of fall prevention interventions found the following reduced the rate of or risk for falls:

- A risk assessment with specific interventions targeting a person's risks
- Exercise programs that include balance and strength training; Tai chi was found to be especially effective
- Use of pacemakers in patients with carotid sinus hypersensitivity, which causes a sudden change in heart rate and blood pressure
- Cataract surgery for women when their first eye is affected

- Gradual withdrawal of psychotropic drugs including those that help with sleep, reduce anxiety and treat depression

- Medication reviews involving primary care physicians and patients
- Use of anti-slip devices on shoes in icy conditions.

The review also found

- Taking vitamin D supplements did not appear to reduce falls in most elders but may be effective in those who had low levels before treatment
- Patient education alone was not effective for preventing falls.

Sources: Minnesota Department of Health; Gillespie LD, Robertson MC, Gillespie WJ, Sherrington C, Gates S, Clemson LM, Lamb SE. Interventions for preventing falls in older people living in the community. Cochrane Database of Systematic Reviews 2012, Issue 9. Art. No.: CD007146. DOI: 10.1002/14651858.CD007146.pub3.

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Naomi Woychick, co-director of the HAIL lab, shows Edith Boller some of the technology being developed.

PHOTO COURTESY OF MAYO CLINIC

A study space for aging in place

Mayo's HAIL lab takes research into the home.

BY JEANNE METTNER

On the fourth floor of Charter House, a retirement community in Rochester, two unassuming apartments stand vacant; but they are not for rent. Each unit has a bedroom, den, living room and kitchen. Each is fully equipped and regularly receives visitors who treat it like home—but no one ever stays overnight.

The apartments are a major component of Mayo Clinic's 4,000-square-foot Healthy Aging and Independent Living (HAIL) lab. Created in September 2011 in collaboration with Charter House, the Mayo Clinic Center for Innovation, and Mayo's Robert and Arlene Kogod Center on Aging, the lab is a simulated environment for aging in place—allowing seniors to live independently at home as long as possible. In addition to the mock living areas, it has a conference room with a one-way mirror for observation and a workspace for investigators. State-of-the-art monitoring and audio equipment allow researchers to observe study participants, many of whom are Charter House residents who spend a few hours at a time testing various innovations. “The monitoring equipment allows us to watch how individuals interact with different technologies, services and devices,” says Nathan LeBrasseur, Ph.D., co-director of the lab.

The lab's work encompasses three themes: optimizing transitions (such as from hospital to home or from being married to widowed), facilitating better caregiver support and education, and improving seniors' living environments. Researchers are looking for ways seniors can extend their “healthspan”—that is, the number of years they are living an active and vital life. “The challenge is that most older individuals have two or more chronic condi-

tions and take multiple medications; 60 percent are physically inactive; 50 percent have difficulty climbing stairs, walking a quarter of a mile or lifting a 10-pound object; 38 percent are obese, so there is a lot working against us in terms of the demographic that wants to remain independent,” LeBrasseur says. “Addressing those issues demands a great deal of innovation and creative thinking.”

Researchers from Mayo and other institutions are using the lab in a number of ways. One group is exploring the use of “exergaming” technology to increase physical activity. Designers are looking at ways to adapt today's gaming systems so they better suit older fingers, eyes and minds. Another completed a study that used a tablet computer that was connected wirelessly to a blood pressure cuff. The device measures the user's blood pressure, provides education about the condition and medication used to control it, and allows users to communicate with a health coach from home using a Skype-like application.

“What we're ultimately looking for are innovative, transformative interventions for promoting healthy aging and independent living, not only throughout our immediate community but throughout the country,” LeBrasseur notes, adding that the lab and the work being conducted there is getting attention from throughout the United States. “We're only at the beginning of that process, so in my estimation, we can really only grow from here.”



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Left to right: J. Milo Meland, M.D., Lyla Pagels, R.N., and Steve Laxdal, M.D., are among the dozens who have undergone six hours of training to become Honoring Choices ambassadors.

PHOTOS COURTESY OF HONORING CHOICES MINNESOTA

Cultivating conversations

Honoring Choices Minnesota
helps families plan for the end of life.

BY TROUT LOWEN

When is your life no longer worth living?” As Lisa thought about the question, her dark eyes turned inward in concentration. After a few minutes she replied decisively, “When I can no longer drink champagne and eat chocolate pudding.”

Although her answer may seem frivolous to some, it said volumes about what she valued in life—freedom, cognition, the pleasure of eating and drinking, self-determination—and how she

wanted me, her designated medical decision maker, to help her through the process of dying. When she translated her wishes to an advance care directive and shared it with her physicians and the hospice staff, it also helped them to guide her treatment.

Diagnosed with stage 4 melanoma in 2006, Lisa died at home in the fall of 2011. There was no ambulance. There was no effort to resuscitate her. Her pain was well-controlled by medication.

Two days before she died, she sipped one last glass of champagne surrounded by close friends and family.

Without an advance care directive spelling out her wishes, however, Lisa's life might have ended differently. According to the Centers for Disease Control and Prevention, nearly 70 percent of all Americans die in a hospital, nursing home or long-term care facility—even though seven out of 10 say they would prefer to die at home.

Honoring Choices Minnesota is working to change that. The community-based initiative led by the Twin Cities Medical Society encourages individuals, families, health care professionals and community leaders to talk about end-of-life planning and the importance of completing an advance care directive long before there's a need.

Honoring Choices Minnesota is also working with health care organizations in the Twin Cities to develop and implement advance care planning programs. Since its inception in 2008, Honoring Choices Minnesota has partnered with 21 hospitals representing all six of the major health care systems in the metro area to implement the Respecting Choices model for advance care planning pioneered by Gundersen Lutheran Health System of La Crosse, Wisconsin. In contrast to the traditional one-size-fits-all approach of advance care directives, Respecting Choices tailors advance care planning to an individual's age and health status and focuses on values, goals, and religious or cultural beliefs rather than specific medical procedures. "It's essentially a conversation between family members about what one's beliefs and values are," says Kent Wilson, M.D., medical director of Honoring Choices Minnesota, "so that at a time when a person can't make his or her own decisions, those people who will have to make decisions have an understanding of what those wishes are, and the basis on which those wishes were made and the values behind them so they can be properly honored."

The Respecting Choices model has worked remarkably well in La Crosse County, Wilson says, where it was introduced in the early 1990s. Ninety percent of adults who died in that county in 2008 had an advance care directive, and 99 percent of those directives were included in the patient's health record. In virtually all cases, the medical care the patient received was consistent with the directive.

Honoring Choices Minnesota uses the training, principles and overall methodology of Respecting Choices but has Minnesota-specific governance, health care directive forms and patient education materials, Wilson says.

Early planning

When first planning the initiative in 2008, the Twin Cities Medical Society brought together a group of 27 representatives from health plans, hospitals and health care systems for a presentation on the Respecting Choices model. All of them saw value in it, Wilson says, and they all agreed not to compete over the issue, to use the same training and materials, and to devote real resources to making advance care planning happen.

For most of the next three years, Honoring Choices Minnesota worked with health care and community partners to develop a training program and teach a cadre of facilitators (nurses, clergy and community members) to help patients and families with the process of creating an advance care directive.

Health care provider organizations have begun to develop systems to ensure those directives are accessible, Wilson says. In addition, participating providers have agreed to something called the "Five Promises," which calls for them to initiate a conversation with patients about advance care planning, usually during an annual exam; have facilitators available who can help with planning; make sure plans are clear; maintain and retrieve plans; and appropriately follow those plans when called to do so.

Some of those promises are still a work in progress. Ensuring that information is available throughout and across health systems is particularly challenging, Wilson says, but virtually all health systems in the Twin Cities have begun to incorporate the Respecting Choices model to some extent. Early on, providers tended to target patients with cancer and renal failure, the frail elderly, and others who were likely to need an advance care directive soon. Some systems are now expanding their efforts to primary care settings.

Tom von Sternberg, M.D., associate medical director for geriatric programs, hospice and home care for HealthPartners, says he is already seeing changes. "Honoring Choices has improved the ability of physicians to have patients and families engage in a conversation that results in decisions that really reflect the values of that patient," he says. It also provides physicians with clear, concise documents that outline what patients want and don't want that follow them through the health care system. "Access to this information when a patient is hospitalized is extremely important," he says.



Hmong elders at an Honoring Choices presentation in St. Paul last year.

Public response

How are patients responding to this new emphasis on end-of-life planning? Scott McRae, director of spiritual care for Park Nicollet Health Services, says their first reaction is often fear. They want to know why they're being asked about their values, and if something's wrong. But once they understand the process, he says, patients are eager to talk. Eighty percent of patients in Park Nicollet's pilot program agreed to have a conversation about creating a health care directive. "Patients are hungry to be heard about their health care wishes and values," McRae says.

In 2011, Honoring Choices Minnesota began shifting its efforts toward public engagement. It launched a website and made patient education materials available online, including a health care directive translated into five languages. It set up a multicultural advisory committee and produced the first in a series of documentaries on end-of-life decision making in partnership with Twin Cities Public Television (TPT). In 2012, the organization also launched an ambassador training program to expand its community outreach and established a task force to develop a continuing medical education curriculum for physicians.

All of those efforts are showing some success. In 2012, Honoring Choices Minnesota trained 39 community ambassadors and hosted 95 presentations. It has also trained more than 900 facilitators who counsel families about end-of-life planning. The program's health care directive has been downloaded more than 14,000 times. In addition, TPT and the Twin Cities Medical Society received a special regional Emmy Award, the "Making a Difference Award," for their work on the Honoring Choices documentaries. More than 700 video clips and programs are available for viewing on the Honoring Choices (www.honoringchoices.org) website.

Community engagement is crucial to the program's success, says von Sternberg, because it takes the onus off of physicians who don't have time or perhaps the inclination to have in-depth discussions about advance care planning with patients and their families. Yet, he says, doctors do need to bring up the issue and stress its importance during an annual exam or when there's a change in health status—a conversation that can take place in about five minutes. Patients who need more help can then be referred to a trained facilitator. Once a directive is completed, however, doctors have a responsibility to review it to ensure it's clear, concise and complete, and then make sure it's entered into the medical record, Wilson says.



Honoring Choices Minnesota's assistant medical director Stefan Pomrenke, M.D., M.Div. (left), with Kent Wilson, M.D., medical director and a driving force behind the program. Pomrenke has focused on Honoring Choices' work in faith communities done in partnership with the Minnesota Council of Churches.

Early and often

When is the right time to initiate a conversation about end-of-life planning? Earlier than you might think, Wilson says. Ideally, everyone should have an advance care directive starting at age 18. Those directives should be updated every 10 years or whenever there's a significant change in health status. Why so early? Wilson points out that the two U.S. Supreme Court cases that essentially defined the right to privacy and end-of-life decision making involved young adults, 25-year-old Nancy Cruzan, who was severely injured in a car crash, and 21-year-old Karen Ann Quinlan, who lived for years in a persistent vegetative state after a drug overdose.

"Our objective is that 100 percent of very young adults should have a well-thought-out, properly executed health care directive," Wilson says. "So we've got a lot of work to do." **MM**

Trout Lowen is a Minneapolis writer.

To have an Honoring Choices Minnesota ambassador speak to your group, contact Barbara Greene at 612-623-2899 or bgreene@metrodoctors.com.

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When geriatrician George Schoephoerster, M.D., works with the families of people with dementia, he knows exactly what they are going through. He saw his wife, Jeanie, experience the stress, constant worry and heartache of caring for her mother as the condition ate away at her health in the early 2000s.

Jeanie first helped her mother move from Iowa to a St. Cloud assisted living facility, eventually relocating her to the Schoephoerster home when she could no longer live safely on her own. Then, as an only child, Jeanie cared for her mother 24/7 while also tending to the couple's two teenaged children. Because her mother would wake constantly, Jeanie would get only two to three hours of sleep every night. She had no time to take a break, exercise or see friends.

Caring FOR THE caregiver

Their well-being is critical to that of the patient.

BY SUZY FRISCH

“She started to develop alopecia, which meant losing most of her hair. It did grow back eventually. But the entire process was so fatiguing and stressful for her,” recalls Schoephoerster, who sees patients primarily in nursing homes for Geriatric Services of Minnesota in St. Cloud. “It was a full-time effort for her, and it was so hard for her to seek help.”

When someone is chronically ill, it often falls to a family member or friend to care for them. In fact, more than 30 million people with acute and chronic illnesses in the United States are currently being supported and cared for by nonmedical personnel, according to the American College of Physicians. About 90 percent of the time, family members serve as the caregiver, looking after the daily and medical needs of a spouse, parent or child out of love and a sense of duty. Yet that sense of duty often leads caregivers to put the patient’s needs far ahead of their own. As a result, the caregiver often bears the brunt of the stress associated with their loved one’s illness, which can be detrimental to their own health.

“Caregiving is a dangerous business. There is good data to show that caregivers are subject to more depression and stress-related illnesses than noncaregivers,” says Robert Kane, M.D., a professor of public health and director of the Center on Aging at the University of Minnesota.

Between 40 and 70 percent of caregivers have clinically significant symptoms of depression, with about one-quarter to one-half of them meeting the diagnostic criteria for major depression, according to research from the Family Caregiver Alliance. In addition, the Commonwealth Fund found caregivers experienced heart attack, heart disease, cancer, diabetes and arthritis at nearly twice the rate of non-caregivers—45 percent versus 24 percent. Sometimes, caregivers even pay the ultimate price: The University of Pittsburgh’s Caregiver Health Effects Study noted that the mortality rate for caregivers is 63 percent higher than the rate for noncaregivers of the same age.

Yet when caregivers are well-cared-for, patients do better. In fact, numerous

studies have shown that when caregivers receive the support and respite they need to effectively tend to their loved one, they can keep that person living independently longer. In one, New York University researcher Mary Mittelman, Dr.P.H., tested a caregiver intervention that has four components: two individual counseling sessions, four family counseling sessions that include the primary caregiver and other family members, ad hoc counseling over the phone to manage crises or changing symptoms, and weekly support groups. She found that caregivers participating in this program kept their spouses out of

nursing homes for about a year and a half longer than those who did not take part in it. The caregivers also had fewer symptoms of depression and were better able to deal with their spouse’s behavior than those in a control group.

University of Minnesota psychologist Joe Gaugler, Ph.D., conducted a follow-up study based on the New York University Caregiver Intervention to see if the same model of support and counseling worked when the caregiver was an adult child caring for a parent with Alzheimer’s disease.

He maintains that “If one supports the family caregiver and helps reduce the

6 WAYS to help caregivers

Caring for chronically ill patients is a delicate balance between keeping them involved in their own care and engaging the caregivers who support them. In 2009, the American College of Physicians released “Family Caregivers, Patients and Physicians: Ethical Guidance to Optimize Relationships,” a guide to improving relationships between patients, caregivers and physicians.

Among its suggestions:

- **Keep interactions focused on the patient and allow the patient to take part in decision-making when appropriate.** Although physicians should view caregivers as partners, they should still keep the patient involved in their care as long as possible.
- **Ensure that the patient, caregiver and other family members share a common and accurate understanding of the patient’s condition and prognosis.** Caregivers report that their most pressing unmet need is clear and consistent information about their loved one’s condition and treatment.
- **Routinely validate the caregiver’s role and be sensitive to commitments the caregiver made to the patient regarding care.** Caregivers feel more supported when the patient’s physician considers them an important team member.
- **Develop care plans for the patient and caregiver that include education, support and social service referrals.**
- **Be alert for signs of caregiver distress and suggest appropriate referrals.**
- **Develop a palliative care plan that helps maximize the patient’s and caregiver’s quality of life and prepares them for what may happen in the future.** The caregiver who is prepared for the final stages of an illness will likely experience less anxiety and depression or complicated grief after the patient dies.

SOURCE: American College of Physicians, www.acponline.org/running_practice/ethics/issues/.../caregivers.pdf

stress and issues they are going through, the overall quality of care for the person with Alzheimer's is improved." Gaugler says this model can work for caregivers of people with other chronic diseases as well.

Many now say that looking out for patients' best interests means physicians should be keeping an eye on their caregivers, too. Kane says physicians should be thinking about how to get caregivers to take as good care of themselves as the person they are caring for.

"It's in the best interest of the person they are caring for to find a way to reduce the burden on the caregiver," says Kane, who wrote the 2011 book *The Good Caregiver*, a guide for people caring for aging loved ones.

Valued resources

Kane says there are a number of things physicians can do to help lighten the caregiver's load. One of the most important is to acknowledge the critical role the caregiver plays in the health of the patient. "We need to recognize them as very valued resources," he says, adding that physicians need to view the caregiver as a key member of the care team. Because they are the ones who are with the patient day in and day out, caregivers see subtle changes that may not be obvious during a clinic visit. They also pick up on clues that their loved one might not be coping well—something a patient may be unwilling to discuss with his doctor.

Caregivers also serve as a hub for information about all of the patient's conditions, medications and treatments. Kane notes that most seniors see eight different doctors, and there may be minimal communication or coordination of care between them. "The physician who thinks they are going to manage the health of a patient without the caregiver is foolish," he says. "It's very important that you talk to



PHOTO COURTESY OF THE SCHOEPHOERSTER FAMILY

The Schoephoerster family in happy times. Jeanie Schoephoerster (lower left) cared for her mother at home.

them and listen to them. It's also very important to respect their observations."

In addition, physicians need to support the caregiver. The starting point may be to simply ask how the caregiver is doing. Schoephoerster recommends that physicians ask whether the caregiver is getting enough sleep, exercising and taking regular breaks, even if he or she isn't their patient.

"Sometimes it's getting the person to have a conversation about the effect of caregiving on themselves," he explains. "It's not providing them care but making sure they are recognized."

Just telling caregivers to take care of themselves may not be enough because they often will still put the patient's needs first, says Michelle Barclay, vice president of program services for the Alzheimer's Association Minnesota-North Dakota. "Caregivers know they need to take care of themselves, but it's like telling people to stop smoking—it's really hard to do," she says. "Instead, the doctor should tell the caregiver that it's best for the patient to do x, y, and z, and that if the caregiver is

stressed or ill that's not good for the patient."

Support beyond the clinic

Gaugler says physicians should also encourage caregivers to tap into community resources as well as their own support networks. He points out that the most effective programs are multidimensional and ongoing.

The Minnesota Association of Area Agencies on Aging (mn4a.org/contact-us) is a good place to start when looking for support. It can connect caregivers

with respite care, adult day care for the patient, support groups and other services such as housekeeping and errand running as well as meals and transportation.

Barclay says when physicians tell caregivers to find a support group, it adds weight to the recommendation and often motivates the caregiver to finally take that step. "Many caregivers have told me that going to a caregiver support group saved their life," Barclay says. "Alzheimer's disease is so stigmatized; they bottle it up and don't talk about it. And then they lose their social support network because friends and family are scared of the disease."

If a physician surmises that a caregiver isn't doing well, it's certainly reasonable to recommend that they see their own doctor, Schoephoerster says. The physician also can suggest holding a family conference to discuss what should happen if the caregiver is no longer able to care for the patient.

Ultimately, though, tending to the best interests of patients means looking out for their caregivers, too. "The caregiver is the biggest ally you've got in this uphill battle with older people with multiple morbidities," Kane says. "You've got to take care of them because they're keeping you from the ultimate disaster." MM

Suzy Frisch is a freelance writer in Apple Valley, Minnesota.

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James Pacala believes geriatricians should be the “go-to” specialists for dealing with the health issues of the frail elderly.



PHOTOS BY KATHRYN FORSS

Geriatrician in chief

James Pacala, M.D., on what physicians should know about caring for older adults.

INTERVIEW BY CARMEN PEOTA

As president of the American Geriatrics Society, James Pacala, M.D., M.S., is familiar with a very scary set of statistics: The number of people older than 65 years in the United States is projected to grow from 40 million today to more than 60 million by 2025. The number of geriatricians we'll need by that year is 25,000 (we currently have 7,000). The outlay of federal dollars for Medicare is expected to jump from \$580 billion today to more than \$1 trillion by then. Given that, you might

think Pacala would be pessimistic about the future. He is anything but: “I’m more of a glass half-full guy,” he says.

Although nature may have something to do with that, Pacala, who also is associate director of the department of family medicine and community health at the University of Minnesota, sees a number of positive signs of change when it comes to caring for our growing geriatric population. He’s a fan of the Center for Medicare and Medicaid Innovation, the entity cre-

ated by the Affordable Care Act to test innovative payment and service delivery models and promote such reforms as care coordination, bundled payments and accountable care organizations. “I see people and departments of public health and politicians recognizing that this [caring for the elderly] is one of the challenges we face as a society. I also see the progress that has been made by colleagues in geriatrics in improving the care of older adults,” he says.

His optimism is evident whether Pacala is talking one on one or presenting before an audience of his peers. He's an enthusiastic evangelist for geriatrics who believes his specialty's moment has come. What geriatricians need to do now, he says, is shift from sounding the alarm about the demographic problems to becoming the "go-to" specialists for solutions. Geriatrics principles, he believes, need to be widely adopted in the new care models that are emerging. We asked him to talk about these principles and what his field has to offer the rest of medicine.

What is the essential challenge of geriatrics?

For the majority of older adults, there gets to be a point when the chronic conditions they have accumulated can no longer be thought of as independent problems—they become interdependent. If you treat one of those conditions, it's likely to have some effect on one of the other conditions. At that point, you as the physician have to start looking at all of the different problems a patient has—both medical and nonmedical. It's a balancing act, requiring complex decision-making.

How do geriatricians do this?

For each treatment, you need to run through a process in concert with the patient to figure out whether that treatment is likely to be beneficial or harmful. The American Geriatrics Society just published a paper, "Patient-Centered Care for Older Adults with Multiple Chronic Conditions," that spells out how to do this.

That document goes through the steps a clinician can take. Doctors, especially geriatricians, have been weighing the benefits and risks of different treatments implicitly their whole professional lives. What this document does is formalize the process.

How does this play out with patients?

Think of a patient who has hypertension, diabetes, osteoarthritis and peripheral neuropathy from diabetes. He used to socialize regularly and take daily walks with his wife; but she died a year ago and his

best friends have moved to Florida; now he rarely gets out, is mostly sedentary and has become quite deconditioned. So he has a combination of medical and nonmedical problems. Given his set of problems, what do you do about his high blood pressure?

For a less-complicated patient, you'd want to lower the blood pressure because you know that doing so reduces the likelihood of stroke and heart attack and lengthens life. But in this case, lowering blood pressure could cause problems. You have a patient with decreased muscle mass and increased joint stiffness, which puts him at increased risk of a fall. Also, he's got peripheral neuropathy in his feet from diabetes, and that makes him more likely to trip or stumble when he goes from one type of floor surface to the next. And if he did fall, he might not be strong enough to catch himself to break the fall. We know that if you administer an antihypertensive to such a complex patient, you'll be increasing his risk of falling if his blood pressure goes too low. So whether his blood pressure should be lowered is much less clear-cut than it might be. And even if you do decide to lower it, how much should you lower it? Should you have a higher target than you would for another patient? These are the kinds of complex decisions you need to work through.

What percentage of older adults are like this patient?

I look at the older adult population as four groups. The first group are the people who are healthy or who have limited chronic disease. They are functionally independent and their medical problems don't have a significant impact on their lives. That's the majority of adults over 65.

The second group is the people with significant chronic illnesses. Their medical conditions may have some impact on their lifestyle and functioning, and they may need assistance with transportation, meals, laundry and things like that. But they're still usually able to maintain their independence.

The third group is what I call the frail or complex or multi-morbid group. These are older adults with multiple chronic diseases



“In geriatrics, we look at the patient across all their organ systems and assess how well they are doing in all domains as well as how they are functioning.”

across multiple organ systems. They usually also have nonmedical stressors related to their environment or caregiving. These are people whose medical conditions have a major impact on their lives. They spend a considerable portion of their day dealing with their conditions. They are very high and frequent users of the medical system in terms of going to see their doctor and being hospitalized. Many are functionally disabled and have difficulty performing basic activities of daily living—dressing, grooming, toileting, etc.

The last group are the people who are in their last months of life. These are people who have a different set of problems. They have advanced chronic diseases, but for them issues like pain control, quality of life and a dignified death have become paramount.

Do all of these groups of people need geriatric care?

Each of those stages presents with different types of problems and warrants a different care approach.

A healthy older person will present to their doctor with acute problems, and the usual care approach will take care of those problems. The second group, the chronically ill, frequently present with flare-ups of one of their chronic illnesses. These people require a chronic disease model of care. That's been well-described in the medical literature. The third group, the frail-complex group, frequently present with geriatric syndromes, problems like falls, incontinence, confusion, weight loss, muscle wasting and delirium. Virtually 100 percent of the time, when a patient presents with a geriatric syndrome, there's not a single cause. These patients require a geriatrics care approach. The fourth group, the dying, present with end-of-life issues, distressing symptoms like pain and shortness of breath, and some profound psychosocial issues as well. They require palliative and/or hospice care.

What sets the geriatric care approach apart from other ways of caring for patients?

The acute-care and even the chronic disease models look at diseases as isolated



Pacala says that although geriatricians often don't get paid for the extra time they spend with patients, they give their specialty high marks for career satisfaction.

entities. In geriatrics, we look at the patient across all their organ systems and assess how well they are doing in all domains as well as how they are functioning. If I as the doctor just treat the medical part and we ignore the other stuff, the patient won't get better. Geriatrics is team-based, proactive, functionally based care. We are trained to recognize and treat geriatric syndromes. We're also trained in chronic disease care and palliative and hospice care. But our real focus is the most complex chronically ill patients, those frail elderly patients.

Isn't it time-consuming to provide care in this way?

Yes. And that affects us financially. One of the problems in geriatrics is that we are mostly a nonprocedural specialty. We mostly perform evaluation and management. In nonprocedural specialties that principally generate revenue through evaluation and management codes, one is better off in terms of compensation if one sees a lot of patients. In geriatrics, we see very complex patients, so we can't

see as many patients as other physicians might. Also, we aren't compensated for a lot of the things we do. I don't get paid for spending an extra 10 minutes in the office explaining why I'm not going to treat an older patient's hypertension as stringently as I might a younger patient's. I also don't get paid for most of the extra time I spend facilitating complex decision-making with patients and their families.

For those reasons, we're consistently at the very bottom or close to the bottom of the pay scale for physicians. But two studies over the past 15 years have documented that geriatricians rank first or second among all specialties in career satisfaction.

Why is that?

It's because you've got people who are going into it despite the negative incentives in terms of compensation. We're a very committed, fulfilled group of people.

Then why do so few young physicians go into geriatrics?

There are always young people who are interested in it. But one of the unintended consequences of medical training is that

students' attitudes toward older people worsen as they progress through training. Through medical school and residency, virtually every old person a student or resident sees is very sick and very complicated. These patients are more difficult to take care of and they don't get better as quickly as younger patients. If you get a complicated elderly patient admitted to your service, it's a lot of work. It takes more work than a less complicated younger patient. And students and residents never see that same old person living in their home, feeling fine and making important contributions to family and the community. So medical students' attitudes about older people can become negative as they progress through their training.

What attracted you to geriatrics?

Three things. One is that I had a fantastic role model, Dr. T. Franklin Williams, when I was a first-year medical student at the University of Rochester in upstate New York. His vision for caring for older people captured my imagination. Dr. Williams left the following year to become the first director of the National Institute on Aging. The second thing was a sense of social mission. The idea of working with a very vulnerable population resonated with why I became a doctor in the first place.

The third is kind of a funny one. It was a personal challenge. When I was a kid, I found going into nursing homes and interacting with old and frail people to be a frightening experience. There was residual apprehension in college and medical school, and I thought that I should confront it head on, that I should turn this fear into a strength. I liked the idea of challenging myself to do that.

You've said that geriatrics principles need to be more widely integrated into care models and adopted by other specialties. Is this happening?

At the American Geriatrics Society, we have a number of initiatives to do just that. One is the Geriatrics for Specialists Initiative. We're working with other specialty societies to infuse geriatric principles into the work they do. A good example is the recently published guidelines for preoperative assessments for older patients that were jointly developed by the AGS and the American College of Surgeons. This was the result of surgeons and geriatricians getting together. We have another program called CRIT, Chief Resident Immersion Training, where we train chief residents in medicine so they can teach their residents about geriatrics. AGS members have also worked with the John A. Hartford Foundation and the Association of American Medical Colleges to enumerate basic competencies in geriatrics that all medical students should demonstrate. We've been working hard to extend the footprint of geriatrics across all specialties, realizing that there just aren't enough geriatricians to go around, nor will there be in the future. MM

Carmen Peota is managing editor of *Minnesota Medicine*.

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ON THE COVER



In the comfort of home

Why it's better to
care for frail elders
where they live.

BY HOWARD BELL

When Todd Stivland, M.D., was practicing family medicine in Duluth in the early 2000s, he was bothered by what he saw happening to a large number of frail elderly patients. For many, just getting to the clinic was an ordeal.

For Stivland, trying to address all of their medical needs during a brief clinic visit was as much of a challenge. Seeing that this model wasn't working well, he decided to do something about it. In 2006, he moved to Stillwater to start Bluestone Physician Services. Bluestone physicians take care of the frail elderly where they live—in Bluestone's case mostly at assisted living and memory care facilities.

For the first year, Bluestone was just Stivland, his laptop and no paycheck. Now, the company has 70 employees, including six primary care physicians, eight nurse practitioners, 20 nurse care coordinators, a psychiatrist and a neurologist who visit 140 geriatric facilities from the Iowa border to Lake Superior. "Every year since we've started we've doubled our patient volume," Stivland says. "I can't hire doctors fast enough to meet the demand."

Although Stivland's idea took off, it wasn't exactly new. HealthPartners started sending physicians to nursing homes 40 years ago and to assisted living facilities in the late 1990s, according to Tom von Sternberg, M.D., co-director of its geriatrics division. "We learned long ago that physician/nurse practitioner team visits to geriatric facilities is the right thing to do," von Sternberg says. "It's much more efficient and vastly improves the quality of patient care."

Today, all the big metro area health systems and many outside the Twin Cities have physician/nurse practitioner teams that serve geriatric facilities. In the Twin Cities, physicians already care for 50 percent of assisted living residents where they live, according to Mike Spilane, M.D., who co-directs HealthPartners' program with von Sternberg. "And it won't be long before they all are," he says. "When people are demented and immobile, it's unsafe and inefficient to extract them from where they live and plop them in a doctor's office

for a 15-minute visit that's unlikely to contribute anything of value to their quality of life."

A new model of care

The demand for care at geriatric facilities has increased partly because we're living longer and with more chronic conditions and partly because reimbursement models such as Medicare DRG payments encourage early discharge from the hospital with recovery or rehabilitation taking place in the transitional care unit (TCU) section

"We talk about
**goals, not
symptoms.**

We don't talk
about the stroke
in room 12.

We talk about
Edith."

— Nick Schneeman, M.D.



of nursing homes. These units provide a nearly hospital-level of care. Meanwhile, assisted living is becoming more like nursing homes used to be. “You’d be amazed at the level of care assisted living residents need,” Stivland says. “These aren’t people who play golf every week and just need a little help with their meds.”

The role of the physician depends in part on the level of care needed. In TCUs, the onsite physician likely serves as a consultant who keeps the patient’s primary care physician informed and provides them with a detailed discharge summary. In nursing homes and assisted living facilities, the onsite physician likely is the patient’s primary physician.

In nursing homes, the physician may visit patients anywhere from once a week if they are new to the TCU to once every one to two months if they are in the long-

Most of the physicians who make onsite visits don’t have the competing demands of a full-day, high-volume clinic practice. In fact, the 10 physicians at Geriatric Services of Minnesota in Robbinsdale, who with eight nurse practitioners care for 3,000 patients at various facilities and in their homes, don’t see any patients at a clinic. “We have no clinic practice or overhead to worry about,” says Nick Schneeman, M.D., medical director and founder of Geriatric Services. This works especially well when a frail elderly person has a medical crisis. “We can be interrupted anytime, and we’re available on-call 24/7.”

Protocols in place

In addition to being able to focus on the needs of the frail elderly, physicians in geriatric onsite programs are using increasingly standardized protocols that are

including nurses aides, social workers and therapists; discharge planning; and family conferences.

Because protocols encourage communication, visiting doctors connect with patients and their families more frequently and more thoroughly because they have more time to spend with them, Schneeman says. “Our family conferences are the core of our success in lowering costs and improving care,” he explains.

Geriatric Services’ five-step conference starts with storytelling. The family and, when possible, the patient tell their story about the patient’s journey from independence to dependence. “This usually takes about 25 minutes,” Schneeman says. “It’s informative, cathartic and it shows that we care enough to take the time to listen.”

Next, the physician summarizes the story to make sure everyone’s on the same page. In the third step, the physician asks about the goals for care—what would mom want or not want? “We talk about goals, not symptoms,” says Schneeman. “We don’t talk about the stroke in room 12. We talk about Edith.”

In step four, the physician writes an advance care directive based on those goals—or modifies an existing one. In the final step, the physician conducts a medication audit and determines which medications can be stopped or changed and which subspecialists will be needed, based on the patient’s advance care directive and care goals.

Following these protocols accomplishes many good things including use of fewer medications, less unnecessary or undesired care, fewer hospital re-admissions and ER visits and increased patient and family satisfaction. “It’s magical how this time-intensive but simple process drives cost down and satisfaction up,” Schneeman says. “The wrong time to try to do all of this is at the time of a medical event. When you wait until then the usual pathways of care take over.”

“It’s magical how this time-intensive but simple process drives cost down and satisfaction up.”

— Nick Schneeman, M.D.



term care area. Long-term care patients are more apt to be seen if they are new, unstable, have a status change, need a medication review, or need an advance directive, according to von Sternberg.

improving the quality of care. According to von Sternberg, protocols ensure a consistent approach because they spell out who does what, when and how. For example, each physician/nurse practitioner team does previsit planning to decide which patients should be seen that day. There are protocols for medication audits; getting input from all nursing home staff,

Reducing risk, improving outcomes

The focused geriatric teams also help smooth the transitions from hospital to TCU and from TCU to home or wherever the patient is going. “Transitions are difficult,” says Ken Kephart, M.D., medical director for Fairview Senior Services, whose physician/nurse practitioner teams serve 40 facilities across the metro area. “There are so many pieces of information and unclear, contradictory orders for meds and therapies,” he says. “Studies show a greater than 50 percent error rate on every transfer from hospital to TCU. Most are not dangerous, but some may lead to hospital re-admission.” For this reason, onsite teams usually spend more time with TCU patients, as these patients are more likely to be unstable and at high risk for complications and hospital re-admission.

Once care plans are in place and running smoothly, the nurse practitioner takes over primary responsibility for making visits and staying in touch with the family and facility staff, with the physician being involved as needed. “Nurse practitioners spend more time with the patient,” Kephart says, “especially in nursing homes, and they generally do a better job of communicating with families and facility staff. That close communication also helps promote timely use of palliative care and hospice.”

Electronic medical records further enable communication. Von Sternberg says most onsite teams can access their care system’s electronic medical record by using cell-phone enabled laptop computers, making communication even more efficient. Onsite teams also use the electronic medical record to communicate with hospital and specialty clinicians, further improving safety and efficiency.

Stivland says the number of ER and hospital visits has fallen by 50 to 70 percent at the facilities Bluestone physicians visit. “There’s no doubt we’re saving money and increasing quality at transitional care and long-term care facilities,” Schneeman says. “We have a 3 to 7 percent re-admit rate and the national average is 18 to 20 percent.”

THE EVOLUTION OF NURSING HOME MEDICINE

In the 1970s, Madeline Adcock, M.D., a physician at St. Paul-Ramsey Medical Center (now Regions Hospital), was one of a handful of physicians delivering care to frail elderly patients in nursing homes. “At the time, nursing homes were very neglected,” says Patrick Irvine, M.D., an internal medicine physician, who went on to provide such care himself. “Doctors were wary of going into them.”

When residents did need care, instead of seeing physicians onsite in the facilities, they were transported to doctors’ offices and clinics, where they would often wait for hours in wheelchairs and on gurneys before being seen. “It wasn’t good care for anyone,” Irvine says of this model.

When Adcock tried to get her fellow physicians to join her in these visits, many were reluctant. For one thing, it wasn’t efficient for them to visit a nursing home unless they had a large panel of patients there. Also, reimbursement for providing such care was low. So Adcock trained a team of nurse practitioners to work with her.

At first, administrators at nursing homes were reluctant to invite the nurse practitioners in and were concerned about them prescribing, Irvine says. “But those homes that did saw an immense and immediate improvement in the quality of care.” Soon, Adcock and her team were seeing hundreds of patients in nursing homes around the metro area.

Doctors took notice. Irvine became one of the first physicians to join Adcock’s team. “I was lucky to be able to get in on the ground floor of nursing home medicine,” he says. “Back in the ’70s, this was an underserved population, and there was so much we could do for them.”

The model of physician/nurse practitioner teams made sense, too, as they could accommodate more patients in a day. “It made it much more efficient to deliver the services in a facility, and you do a better job,” Irvine says. “You each have skills and relationships that you bring, and that makes for a real synergistic team.”

By the early 1980s, onsite physician/nurse practitioner team visits to nursing homes had proven so effective that two Twin Cities nurse practitioners, Jeannine Bayard and Ruth Ann Jacobson, started a new business based on the model called Evercare.

Evercare became part of United HealthCare in the mid-1990s and expanded into other states, becoming one of the largest providers of onsite nursing home care in the country. Irvine served as its medical director during that time. Meanwhile, the big Twin Cities health care systems saw the value of onsite physician/nurse practitioner team visits and started their own programs. As Minnesota systems embraced the model, Evercare began to lose market share; it ceased operating in the state three years ago. According to Irvine, the organization is still strong elsewhere in the country.

Today, Irvine says, more and more physicians are making a career out of providing onsite care of the frail elderly. “It’s been an evolution of awareness of the need,” he says. “From being totally ignored by medicine 40 years ago, we’ve made great progress.” —H.B.

THE PAYMENT PROBLEM

Although onsite care has been shown to improve quality and reduce costs associated with caring for frail elderly patients, paying for it remains a problem. Traditional fee-for-service payments don't cover the cost of onsite visits and the 24/7 coverage and phone calls needed to do a good job, says Ken Kephart, M.D., medical director for Fairview Senior Services.

Minnesota has a revenue source that is addressing the payment problem. The Minnesota Senior Healthcare Option (MSHO) combines revenue from Medicare and Medicaid into a pool of funds held by health plans, most notably Medica, UCare and Blue Cross and Blue Shield of Minnesota. Patients must be enrolled in both Medicare and Medicaid to be in the program and are referred to as being "dual eligible." The health plans are then free to contract with onsite providers in innovative ways. For example, individuals who are in the MSHO program can be admitted directly to a TCU or skilled nursing unit of a nursing home without the minimum three-day hospital stay required to trigger Medicare coverage.

Nursing homes can get increased payments for MSHO patients who receive costly care that would usually be administered in the hospital such as receiving IV fluids or antibiotics or starting anticoagulants; but the money they receive is still less than the cost of hospitalizing those patients. "It's about aligning payment incentives," says Kephart, "to allow nursing homes to do the right thing—to treat in place without incurring financial hardship."

Whereas fee-for-service Medicare uses a volume-driven compensation formula, MSHO is value-driven, according to Nick Schneeman, M.D., medical director for Geriatric Services of Minnesota. "It allows physicians to slow down, spend more time with patients and families, and do what's right for frail elderly patients. What's right for geriatric patients with complex chronic or late-stage disease is almost always less expensive and more patient-centered."

Even though many nursing home residents do not qualify for MSHO, there are enough patients on MSHO to support value-driven onsite nursing home care for all patients, Schneeman says. "One of the reasons we can make this work," he says, "is because 30 to 40 percent of our nursing home patients are dual eligible through MSHO. If we only saw Medicare fee-for-service patients, our model of care would fall apart."

Schneeman's group has gone a step further and now contracts with health plans to manage the MSHO funds, shifting the responsibility for clinical and financial outcomes to the physicians. Controlling the pool of dollars, according to Schneeman, allows physicians to slow down. "You can't get it right in 15 minutes for an 85-year-old moderately demented person on 15 drugs," he says. Schneeman also says that managing the pool enables him to recruit highly qualified physicians because "we can pay a competitive wage."

Schneeman explains that a robust peer-review process prevents the chance that a physician will withhold care in order to save money. "We tell our docs to treat each patient like they're your mom or dad and you're paying every penny. We provide the same care in the same manner to everyone, and it works. It's similar to fee-for-service primary care clinics that lose money on Medicare and Medicaid patients and make up for it with commercially insured patients. Our physicians don't know who is and who is not insured through MSHO." – H.B.

National studies show patients treated onsite for pneumonia, deep vein thromboses and other common geriatric conditions have the same or better outcomes than those who are being treated in the hospital. "It's simply safer and easier on the patient to do care onsite," Kephart says.

More doctors needed

Finding doctors to do onsite geriatric visits, especially full-time, can be a challenge, Schneeman says, mostly because of misunderstandings about what the job entails. "Geriatrics isn't glamorous," he says. "Many doctors perceive older patients to be complex and burdensome." Schneeman likes to hire mid-career physicians to do onsite visits full-time. "Some of them love old people," he says. "Some of them hate electronic medical records. All of them want to do a better job as a doc than they could in their previous practice." Although the hours aren't much different than in clinic practice, they're more flexible, he says.

Most who try it like it, Spilane says. "Many of our hospitalists spend about 20 percent of their time doing this and they find it can be enjoyable work that provides balance with their other practice," he says. "We don't have physicians leaving our program, partly because we emphasize teamwork. You're never alone."

Onsite geriatric work "is a fabulous way to practice," says John Mielke, M.D., an internist/geriatrician and chief medical officer for Optage House Calls, a division of Presbyterian Homes in the Twin Cities. He and five nurse practitioners visit eight facilities ranging from TCUs to independent living. "Seeing patients where they live might seem inefficient for the doctor," he says, "but it's very efficient in other ways. It helps us sort out the complexities and see the nuances of their environment—why, for example, they might be falling a lot. It's challenging and it's beneficial."

Despite those advantages, attracting young physicians to this line of work remains challenging. Kephart says two things deter medical students from geriatrics: the difficulty of the specialty and its low pay. "Most of our patients," he says,

“have five or more serious chronic diseases and are on 10 or more medications, and they’re slowly getting worse, not better, leading to difficult discussions with patients and families about prognosis and treatment plans.” As for pay, physicians who have completed a geriatric fellowship often get paid the same or less than an internist or family physician who has not done a fellowship.

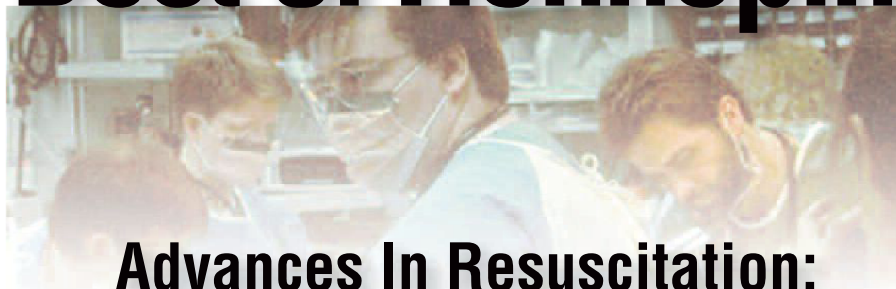
Another issue is the lack of training opportunities. For starters, there’s a shortage of academic geriatricians to teach medical students, residents and practicing physicians, Kephart says. In addition, Minnesota has only four geriatric fellowship slots—two at Mayo and two at Hennepin County Medical Center. “The [University of Minnesota] Academic Health Center has no clinical geriatrics presence or training,” he says.

Kephart would like to see a division of geriatrics established within the departments of medicine and family medicine at the university. Schneeman would like to see a new geriatrics subspecialty in caring for high-risk frail elderly patients but, he says, “Financial drivers to recruit, train and support such physicians just aren’t there.” For now, the only way to find enough physicians to do onsite geriatric visits is to recruit and train primary care physicians who are already practicing.

Overcoming the challenges of caring for the elderly is a work in progress. But despite that, those who provide care in this way are proud of how far they’ve come. “We’ve done a good job of getting providers out where geriatric patients are living,” Kephart says. “At all the health systems, we’re seeing a willingness to do the right thing for our frail elderly.” *MM*

Howard Bel is a medical writer and frequent contributor to *Minnesota Medicine*.

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The eye exam

What the notes in medical charts don't tell you.

BY JONATHAN AVILA

How many more people would she have to tell her story to? “No, no leg pain. No blurry vision or dizziness. No, I was never told I had a heart murmur. For heaven’s sake, can’t you just read my chart? I’ve answered these questions so many times today! I’m tired. Can’t you just come back later?”

Yes, she was tired. Tired and hungry. She hadn’t eaten all day—nobody had let her. And they wouldn’t until I wrote her diet orders in her chart; but I needed to examine her first. To me, she was new and her story fresh. To her, I was the sixth person asking her to relive the scary events that brought her to the hospital that day. I was also the obstacle between her and dinner and rest.

“Mrs. O, I know you’ve told your story to several other people today, but I’d still like to hear it straight from you.” She was not happy about it, but she agreed to be interviewed. Perhaps she figured it was the only way to get rid of me.

“Mrs. O, can you raise your eyebrows for me? Puff your cheeks. Show me your smile. Good. Now follow the tip of my finger with your eyes—don’t move your head. Mrs. O, follow my finger with your eyes. Mrs. O, can you look at my finger? Good, now keep looking at it. Don’t stop looking; follow it with your eyes. Mrs. O, can you please follow my finger with your eyes? Can you look at my finger?”

She kept looking straight at me, ignoring my finger dancing like a frantic bee in front of her face. It wasn’t that she couldn’t see it. And it wasn’t because she couldn’t move her eyes. I had observed her doing that during the interview, as she glanced from her daughters on her left, back to me on her right. “Mrs. O, can you please keep looking at my finger as I move it?”

“Yes, I can.” Again, my finger moved left and right, up and down, and her eyes did not follow it. Those stubborn blue-gray eyes kept looking straight into mine. “Mrs. O, I know you’re tired and hungry, but I need to finish examining you before you can eat and rest. The sooner I’m done, the sooner I’m out of your way. So would you please follow my finger?”

She would not. Regardless of my insistence, she would only respond with that bold, defiant gaze. She understood what I was asking. But her eyes said, “I don’t want to. Make me!” Those eyes that had seen so much of this world, that had witnessed joy and sadness and all the glories and flaws of what it means to be human. They would not move for me.

In her chart, I wrote: “Extraocular movements and convergence not tested due to patient’s difficulty following commands.” I didn’t like that wording. It implied Mrs. O could not understand verbal commands or that she had a defiant behavior disorder. I didn’t even like the word “commands.” It sounded condescending—not to mention quasi-militaristic. Instead, I wanted to write about her gaze. “Per patient’s eyes, patient understood what I was asking her to do, and yet she silently refused to do it even though we both knew she could. If only you could see those eyes, that look.”

Hers was not the only gaze I have wanted to document. Mr. S was transferred to our service from his nursing home because of a urinary tract infection. When I walked in his room, the senior resident instructed me to do only a very brief physical exam and not try to interview him. I put on my stethoscope.

"Mr. S, I am going to listen to your heart," I said loudly after noticing his hearing aid. As soon as my stethoscope touched his chest, he started to sing a Gershwin song. "It's very clear, our love is here to stay. Not for a year, but ever and a day."

"Mr. S, you have a beautiful voice; were you a singer?" The song went on uninterrupted. "Now I'd like to listen to your lungs. Can you take deep, slow breaths through your mouth, please?" Mr. S stopped singing and began making bird sounds. *Queh-queh-queh*. I thought he sounded like a duck quacking; but the senior resident thought he sounded more like a crow, *Queh-queh-queh*. And so Mr. S kept on as I examined his abdomen and extremities.

I found his gaze, not the sounds, to be the most striking feature of that exam. The entire time, Mr. S kept looking straight into my eyes, almost without blinking. His dark brown eyes looked at me as if nothing else mattered. Those eyes saw another world that I could not see, and yet I was part of it. His eyes let me know he wasn't just singing out loud to the wind, ignoring his surroundings. Mr. S was singing for me, making bird sounds for me. It was his way of interacting with me.

Yet the words I had to write in his chart could not express this. "General appearance: alert, not in apparent distress, not oriented, responds inappropriately to the exam." What I really wanted to chart was that Mr. S was lively and fully interactive, if only through his eyes. Those eyes engulfed me and invited me into his world. I was expecting him to get up from the bed and lead me into a dance. But there was no place in the chart where I could document that, where I could write "eyes happy, interactive and lively."

Whereas Mr. S's eyes expressed a happy reality that only existed in his mind, Mr. K's eyes were cognizant of a painful reality. Because of a series of invasive therapies superimposed on a stroke, Mr. K could no longer talk—at least not easily. Yet if you paid close attention, you'd realize his eyes did the talking for him.

I was in Mr. K's room while the palliative care team was discussing end-of-life care with his wife. This was an extremely important decision for Mr. K; and yet no one was including him in the discussion. He couldn't talk or move meaningfully. But his eyes could. They cried. They expressed fear. At one point, they turned to me expressing so much distress I could not decipher any meaning but anguish. Was it despair, frustration or overwhelming sadness? His eyes were deep green like the sea. I wondered whether they had ever cast their gaze on the sea. I wondered whether they would like to do so once more before they closed for the last time.

I would come to meet many more sets of eyes throughout my clerkship rotations. From the curious eyes of the newborn I had just delivered to the dull, fixed eyes of the patient in intensive care, each gaze was unique.

Even though we don't document it in the medical chart, the gaze reveals much. The eyes are more than just a part of the body to evaluate during the exam; they are what guide it. If the eyes look fearful, I provide extra reassurance. If they look away from me, I work harder to gain the patient's trust. If they're warm, our interaction is often interspersed with laughter. If they're tearful, I try to offer comfort and support.

I have searched various textbooks for guidance on how to interpret the gaze. I haven't found any. The patient's gaze is so important; yet we are given no formal instruction about how to make an observation about it. Perhaps, making this observation is simply one of those things that can't be taught—you learn it as you practice it. Perhaps it does not need to be taught—it is just part of human interaction, and we interpret it without realizing it. But there I was, realizing how significant the patient's gaze is and attempting to document what I saw. And yet, I couldn't. The next care team on the floor would read my notes about the physical exam and not know what the patient's gaze told me. **MM**

Jonathan Avila is a fourth-year medical student at the University of Minnesota.

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A FEW MINUTES WITH...

Rep. Erin Murphy, Minnesota's new House Majority Leader

For the first time since 1990, the DFL controls the House, the Senate and the governor's office. Sounds like the making of gridlock-free session, right? Not necessarily. Opinions can vary greatly within the same political party on a number of topics including health care.

In late November, the DFL caucus appointed its leadership for 2013, which included Erin Murphy, a registered nurse and DFL representative from St. Paul, as House Majority Leader. First elected to the House in 2006, Murphy has served on a number of health care committees. As the majority leader, she will be a key player in setting the House's legislative agenda.

The MMA asked Murphy to provide some insight on the 2013 session and how it might affect physicians. Following are excerpts from her comments:

On working together

For the upcoming session, I will join my colleagues to pursue the priorities Minnesotans expressed this past summer and fall—honestly balancing the budget, ensuring our schools are exceptional and reducing property taxes. Minnesotans seek progress rather than a stalemate of ideology. This, too, is the case in health care, and it is time for Minnesota to lead in this field once again.

On the health insurance exchange

We will focus on how best to improve access to high-quality care for Minnesotans and for small businesses as we continue to bend the cost curve. The key to achieving this goal is establishing a



Rep. Erin Murphy, a registered nurse, has been a member of the House of Representatives since 2006.

Minnesota-made health insurance exchange. Now that the Supreme Court has upheld the Affordable Care Act as constitutional, it is critical that we move forward to establish a Minnesota exchange. For many years we have been a leader in health care because we rendered solutions that fit the dynamics of our state. It is my hope that my colleagues on the other side of the aisle will join us in the construction of this tool that will undoubtedly help many Minnesotans and small businesses secure affordable health coverage.

On health and human services and funding for medical education

Health and human services budget has been a continued target for budget balancing. As we work to balance the budget for the future, we will face tough choices. The latest budget forecast again reveals an expected deficit that we must resolve in 2013. As to specifics, we have to assess where we stand. I worry about the loss of funding to support medical education that resulted from the 2011 budget resolution. Minnesota is experiencing a shortage of primary care physicians, and the loss of training funds will only exacerbate that shortage. How we fund MERC [the Medical Education and Research Costs fund] into the future is a question for the Legislature. In addition, to further training, we should consider how to use the current health care workforce most effectively.

On being a health care practitioner and legislative leader

My nursing experience has had an undeniable effect on my work as a legislator. As a registered nurse and a legislator, I have found that the most effective way to resolve problems is to listen. Listening allows you to understand the root of a problem, giving you the best indication of how to solve it. I believe that this is the type of leadership Minnesotans are looking for.



Last fall, Rep. Erin Murphy (left) and other legislators met with members of MEDPAC, the MMA's political action committee, among them Lisa Erickson, M.D., and Janette Strathy, M.D. (pictured).

News briefs

MMA seeks permission to file amicus brief in Avera appeal case

The legal battle between Avera Marshall Medical Center's administration and its medical staff continued in December.

Two weeks after the Avera medical staff, led by Steven Meister, M.D., former chief of staff, and Jane Willett, D.O., chief of staff, filed an appeal with the Minnesota Court of Appeals, the MMA and AMA sought permission to provide an amicus ("friend of the court") brief. They were joined in the request by the American Osteopathic Association, the American Academy of Family Physicians and the Minnesota Academy of Family Physicians.

Meister and Willett's appeal follows in the wake of the September ruling by a Lyon County district judge that said the medical staff bylaws do not constitute a contract between the staff and the hospital, and that the hospital could, in effect, unilaterally change the bylaws, which the hospital had done.

"This continues to be an important case for us," says Robert Meiches, M.D., MMA CEO. "We feel the medical staff needs to maintain a certain amount of autonomy so that the physicians can fulfill their responsibilities in matters of patient care."

The MMA will continue to follow the case.

of Minnesota Duluth Medical School. And one is a physician spouse. So they have a good understanding of the issues that are important to practicing physicians."

MMA watches state budget numbers in terms of health care

The MMA watched with interest in early December as Minnesota's state economist released the budget forecast for the upcoming biennium because projected budget shortfalls could affect health care funding.

The good news is that the state has a \$1.3 billion surplus for the current fiscal year. However, none of that money will go toward health and human services (HHS) programs. Rather, current law stipulates that the surplus be used to partially repay the \$2.4 billion the state borrowed from local school districts to help balance previous budgets.

The bad news is that the state faces a projected \$1.1 billion deficit for the period beginning July 1, 2013, through June 30, 2015. This is in addition to the deficits faced over the last five years.

Within HHS programs, the forecast shows spending was \$196 million lower than projected for fiscal years 2012-2013 and \$185 million lower than estimated for fiscal years 2014-2015. These savings are the result of lower-than-average costs for care provided in the Medical Assistance (MA) program, a downward trend in nursing home caseloads and increased rebates the state receives from pharmaceutical manufacturers.

The forecast is somewhat uncertain when it comes to the MA program, however. The U.S. Supreme Court's ruling on the Affordable Care Act leaves it up to the state to decide whether to expand MA eligibility up to 133 percent of the federal poverty level. This forecast does not include that increase and the matching federal money that would come with it. Also, it puts the federal matching money related to the earlier eligibility expansion to 75 percent of the federal poverty level at risk.

The Centers for Medicare and Medicaid Services has not yet decided whether states will receive 100 percent of the federal money if they decide to expand eligibility to those at something less than 133 percent of the federal poverty level.

"This is another reason why our Legislature needs to adopt the 133 percent expansion soon in 2013," says Dave Renner, MMA director of state and federal legislation.

Task force begins to study opioid abuse

In mid-December, a multi-specialty task force made up of MMA members began meeting to examine the issue of opioid addiction, abuse and diversion. The Prescription Opioid Management Advisory Task Force includes physicians from these specialties:

- ADDICTION/SUBSTANCE ABUSE: Joseph Westermeyer, M.D.
- ANESTHESIA: Mark Eggen, M.D.
- ANESTHESIA/PAIN MEDICINE: David Schultz, M.D.
- EMERGENCY MEDICINE: Christopher Johnson, M.D. and Drew Zinkel, M.D.

DFL selects health committee chairs for 2013 session

With the DFL retaking control of both the House and Senate, there is a new crop of committee chairs. Fortunately, the MMA already has established relationships with each leader.

The following legislators will assume positions related to health care issues:

HOUSE

- HEALTH AND HUMAN SERVICES FINANCE: Rep. Tom Huntley (Duluth)
- HEALTH AND HUMAN SERVICES POLICY: Rep. Tina Liebling (Rochester)

SENATE

- COMMITTEE ON HEALTH, HUMAN SERVICES AND HOUSING: Sen. Kathy Sheran (Mankato)
- COMMITTEE ON FINANCE, HEALTH AND HUMAN SERVICES DIVISION: Sen. Tony Lourey (Kerrick)

"The MMA has worked closely with these chairs for many years," says Dave Renner, MMA director of state and federal legislation. "One is a trained nurse. One is a retired professor at the University



Rep. Tom Huntley



Rep. Tina Liebling



Rep. Tony Lourey

- PAIN MEDICINE: Alfred Anderson, M.D.
- PHYSICAL MEDICINE AND REHABILITATION: Paul Biewen, M.D.
- FAMILY MEDICINE: Keith Stelter, M.D.
- FAMILY MEDICINE/PAIN MEDICINE: William Dicks, M.D.
- HOSPICE AND PALLIATIVE MEDICINE: Donald Grossbach, M.D.
- INTERNAL MEDICINE: Beth Averbeck, M.D.
- OCCUPATIONAL MEDICINE: Beth Baker, M.D.
- ONCOLOGY: Tom Flynn, M.D.
- RESIDENT: Zach Lopater, M.D.
- STUDENT: Yael Smiley

The group's charge is to take a proactive look at the issue from a physician's point of view. The task force is expected to conclude its work by fall 2013.

MMA governance discussion enters new phase

At the Annual Meeting in September, the House of Delegates (HOD) voted to postpone decisions on several governance issues until after further study.

In November, that study phase officially began when the MMA Board of Trustees voted to expand the governance task force, which will consider instituting member-wide voting, creating regular policy councils and changing the structure of future annual meetings.

The new task force will include more members from component medical societies, conduct three to five meetings in the first quarter of 2013, provide an update to the Board of Trustees at its March meeting and give a final report to the Board in May.

This work is in addition to the changes that have already been approved by the HOD. At the Annual Meeting, the body voted to reduce the size of the board from 33 members to 12 to 14. The HOD also voted to change board membership from solely geography-based to competency-based with sensitivity to geographic differences. Plus, the HOD voted in favor of gaining a better understanding of member concerns by holding "listening sessions" throughout the state.

MMA member receives AMA RFS endorsement

Maya Babu, M.D., M.B.A., a neurosurgery resident at the Mayo Clinic and a member of the Minnesota AMA Delegation, has been endorsed by the AMA Resident and Fellow Section (RFS) to run for the RFS seat on the AMA Board. Babu is one of two candidates for the seat.

The election will take place at the AMA Annual Meeting in Chicago in June 2013. If elected, Babu would serve a one-year term as a full voting member of the AMA Board of Trustees.

Running on the theme of "Promoting physician leadership for the future of medicine," Babu has been endorsed by the MMA as well as by the North Central Medical Conference (Iowa, Nebraska, North Dakota, South Dakota and Wisconsin AMA delegations), the American College of Surgeons, the Congress of Neurological Surgeons and the American Association of Neurological Surgeons.



Maya Babu, M.D., M.B.A., testifies at last summer's AMA meeting in Chicago.

Babu has been active with both the MMA and the AMA. She serves as the RFS member on the MMA Board of Trustees, is a member of the MEDPAC board of directors, is a delegate to the AMA House of Delegates and serves on the AMA Council on Legislation.

"The Minnesota delegation to the AMA has had the opportunity to watch Maya grow personally and in stature in the AMA," says Raymond Christensen, M.D., chair of the Minnesota delegation. "We are thrilled that Maya has chosen to step forward as a candidate and we solidly support her decision. We have great diversity of specialty in our delegation and as a family physician I am impressed with the inclusiveness with which she approaches this election. It is imperative that we all support her candidacy and utilize every opportunity to discuss her with our colleagues across the country."

Members making a difference

On January 1, MMA member **Daron Gersch**, M.D., took office as mayor of Albany, Minnesota. He will serve a two-year term. Previously, Gersch, who is a family physician at Albany Medical Center, had been on Albany's City Council.

In early November, MMA member **Patrick Zook**, M.D., became the president of the Stearns Benton Medical Society. Zook previously served as North Central Trustee on the MMA Board of Trustees.

Brian Telesz, M.D., an anesthesiology resident at the Mayo Clinic, was the overall winner in the clinical vignette poster category at the AMA's interim meeting in Honolulu in November. His research is titled: "Size Matters: Low Sputum Volume May Impact the Sensitivity of Acid-Fast Smear Results."

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VIEWPOINT

Tackling prescription opioid abuse

The statistics are disheartening. According to the AMA, opioids play a role in 15,000 deaths and account for more than 340,000 emergency department visits each year. From a public health perspective, this is a rapidly growing problem that already accounts for a third as many deaths as highway fatalities, according to the National Highway Traffic Safety Administration.

So, as physicians, what can we do about this? We could point a lot of fingers as to why this is happening, but we feel that the more prudent course is to work to find solutions.

To support this effort, the MMA's Board of Trustees overwhelmingly approved the formation of a Prescription Opioid Management Advisory Task Force (see p. 33 for a list of members). The task force met for the first time in December.

Its goals are to:

- **Raise awareness among Minnesota physicians** about the nature and extent of the problems associated with prescription opioid addiction, abuse and diversion
- **Examine specific strategies for improving physician management of opioid prescribing** (education, use of the Minnesota Prescription Drug Monitoring Program, controlled substance contracts, etc.)
- **Identify and disseminate resources and tools** for opioid prescribing best practices

- **Facilitate MMA participation** in multidisciplinary, communitywide conversations and coalitions aimed at addressing prescription opioid addiction, abuse and diversion.

The group, which includes physicians with expertise in everything from treating substance abuse to occupational medicine to oncology, will continue to meet through 2013.

Physicians, of course, are not the only ones concerned about this problem. Many others are also calling attention to the issue, including business groups, pharmacists, law enforcement agencies and administrators of treatment programs. The MMA has also heard that regulators and lawmakers are considering ideas such as legislating treatment protocols and mandating education—prospects that cause concern.

This is a tricky issue for physicians, as we want to ensure appropriate access to opioids for patients in need of pain relief while protecting the health and safety of our communities. Watch for additional updates about this important work in the coming months.



Dan Maddox, MMA President

PHOTO BY STEVE WEVERKA

“We could point a lot of fingers as to why [opioid abuse] is happening, but we feel that the more prudent course is to work to find solutions.”



Newly elected MMA President Dan Maddox, M.D., receives congratulations from former presidents David Luehr, M.D., (left) and Thomas Stolee, M.D., at the 2012 Annual Meeting last fall.

PHOTO BY STEVE WEWERKA

Q&A WITH MMA PRESIDENT Dan Maddox, M.D.

A few minutes after assuming the role of MMA president at the Annual Meeting last September, Dan Maddox, M.D., did something very un-presidential.

The allergist from the Mayo Clinic climbed up on stage at the Minneapolis Marriott City Center, donned a brown shaggy wig and proceeded to “rock out,” which entailed singing “You Really Got Me” with the hired band.

Sure, it wasn’t standard operating procedure for Maddox but it did demonstrate to the other physicians in attendance that he knew how to unwind. Over the next 12 months, he won’t get many more chances like that, though. The MMA faces a list of weighty priorities – from ensuring that Minnesotans are the healthiest people in the nation to promoting Minnesota as the best place to practice to advancing professionalism in medicine. In other words, he has his hands full.

Shortly after he began his year-long tenure as president, we asked Maddox to provide some insight on the next 12 months.

Why did you want to become president?

I can’t say that the presidency was something that I specifically wanted. I have always felt that serving the medical as-

sociation was an obligation that we all share. When my colleagues in the Zumbro Valley Medical Society asked me to accept the nomination, I was honored. Mostly, I just felt that it was one more capacity for service.

What are your main goals as president of the MMA?

To inspire as many of our colleagues as possible to find the common issues that could unite us, rather than focusing on those things that divide us. To pursue the

goal of a stronger profession—one that really protects the interests of our patients and honors the uniqueness of every patient’s needs. The corporatization of medical care has the potential to undermine both patient choice and professional autonomy, and resistance can only be offered by a strengthened profession.

As you travel around the country, what do you find that sets Minnesota apart from other states in terms of health care and how it’s delivered?

In 2009, Minnesota was still an outlier compared with all other states in terms of the number of physicians who were working in mega-groups and in terms of how tightly organized and how highly competitive the entire medical marketplace was. In the last three years, the rest of the country has moved in the direction led by Minnesota. However, I think we have at least 20 more years of experience with this type of environment compared with our colleagues. So, we can probably offer expertise that they would find valuable.



It’s good to be the president: Dan Maddox, M.D., leads the band in “You Really Got Me” at the Annual Meeting.

PHOTO BY STEVE WEWERKA

You have suggested that each physician make an effort to recruit at least one physician to join the MMA. Was there someone who influenced your decision to join?

I joined the Michigan State Medical Society when I was doing my clinical fellowship at the University of Michigan in 1979.

Although the university did not pay my membership dues, my faculty made it clear that service in the medical association was a given. So naturally when I moved to Minnesota, I joined the MMA immediately (well, as quickly as my license was issued).

What do you say now to physicians who are considering joining the MMA?

I think all you have to do is go over a few examples of some of the very anti-

medical-profession regulatory enactments we've seen in recent years. Plus, point out how important engagement and support of the profession is to success in advocacy. This will help people understand that these issues are common to all our interests.

What does your role at the Mayo Clinic entail?

The lion's share of my time is spent seeing patients with problems that fall within the scope of allergy and clinical immunology. Mayo has been designated a Jeffrey Modell Foundation Center for Immunodeficiency, so we also see patients with primary immunodeficiencies. Of course, we're also involved with teaching medical students, internal medicine residents and the fellows in our allergy fellowship training program.

At a glance

MEDICAL DEGREE:

University of Kentucky, Lexington

RESIDENCIES:

University of Michigan Hospitals, Ann Arbor

FELLOWSHIPS:

Allergy and Immunology, University of Michigan, Ann Arbor

Research, Mayo Graduate School of Medicine, Rochester

CURRENT POSITION:

Consultant in Allergic Diseases at Mayo Clinic in Rochester

MMA in action

Three new staff members have joined the MMA health policy department over the past few months: **Jaime Olson**, manager of continuing education; **Juliana Milhofer**, policy analyst; and **Teresa Knoedler**, policy counsel.

In November, **Dave Renner**, director of state and federal legislation, provided an election wrap-up and legislative preview to Lake Superior Family Physicians, a group of 15 family physicians from the Duluth and Cloquet areas. Renner also attended the Pfizer State Medical Society Leadership Meeting in New York in late November. Each year, Pfizer invites medical society staff from across the country to discuss health care policy issues. The issues discussed at this meeting included health care reform implementation at the state level, administrative simplification efforts, legislation related to the development of biosimilars and academic detailing. Renner also participated in the monthly conference call meeting of the AMA Advocacy Resource Center Executive Committee, of which he is vice-chair. The group discussed state medical society activities related to opioid prescribing and prescription medication abuse.

Eric Dick, manager of state legislative affairs, presented an election analysis and legislative preview to more than 100 University of Minnesota Medical School students in mid-November. Opening with a discussion of the outcome of the 2012 election, Dick shared with the students how the results may affect health care and the MMA's legislative priorities in the 2013 session. In

mid-December, Dick gave a similar presentation at Mayo Medical School in Rochester. Dick also attended the Lake Superior Medical Society's legislative dinner in Duluth in November.

In mid-November, **Brian Strub**, manager of physician outreach, and **Jaime Olson**, manager of continuing education, attended the seventh annual pain conference hosted by MAPS Medical Pain Clinics. Titled "The Pain Epidemic: Equipping Providers for an Escalating Battle," the conference included a variety of physician and other speakers. In late November, Strub and MMA Foundation CEO **Dennis Kelly** attended the Range Medical Society's annual legislative meeting in Grand Rapids. Strub also joined the MMA Medical Student Section leaders at the University of Minnesota, Twin Cities, for a lunch-and-learn discussion on working with medical interpreters in early December. The event was co-sponsored by the Twin Cities Medical Society and the Minnesota Academy of Family Physicians Foundation.

In December, **Olson** represented the MMA at a meeting of the Midwest CME network in Duluth. She also attended the ACCME (Accreditation Council for Continuing Medical Education) State Medical Society conference in Chicago in mid-December.

What the VA can teach us about geriatric care

Organizations wishing to form new care delivery models should look to two long-standing programs for veterans with multiple chronic illnesses.

BY EDWARD R. RATNER, M.D., MELISSA WEST, M.D., KRISTOPHER N. HARTWIG, M.D., AND BRUCE C. MEYER, M.D.

In our state and across the country, pilot projects involving both payers and health care providers (ie, doctors, hospitals and clinics) are underway in a massive effort to transform both the way we deliver and pay for health care. In Minnesota, three health systems were among the first to be named Pioneer Accountable Care Organizations (ACOs) by the Center for Medicare and Medicaid Innovation. In addition, a number of hospitals are experimenting with approaches such as bundling payments for treatment of certain conditions. These projects target patients who consume the most health care and who cost the system the most—the elderly and those with multiple chronic conditions. Although these demonstration projects are important, it should be noted that some “innovative” and very effective models of care already are well-established within the Veterans Affairs (VA) Health Care System.

The VA’s programs deserve consideration for several reasons. First, VA medical centers have long focused on care of exactly the type of patients most important to the success of ACOs and other providers of geriatric care. Second, its business model has parallels with the reform models that the Center for Medicare and Medicaid Innovation is now promoting.¹

Regional VA medical centers’ budgets are based primarily on a case-mix adjusted formula.² In Minneapolis, the 2012 per patient per year amount averaged \$5,500. Physicians are generally employed or provide specialty services for an hourly fee. Typically, when care is provided outside of the VA system, it is paid for on a contractual basis. As a result, there is a strong incentive to deliver care—including nursing home care, home care and hospice services—on site and using salaried staff. This incentive has led the VA to develop a number of clinical models that should now be considered by those seeking to form ACOs and or embark on payment bundling efforts. Two programs that merit further examination are described in this article: the Community Living Center and Home-Based Primary Care, both of which are being used at the Minneapolis VA Medical Center.

The Community Living Center

The Community Living Center (CLC) at the Minneapolis VA Medical Center is an onsite 74-bed, three-unit service that provides transitional care primarily to elderly veterans who require a level of care less than hospitalization but more than can be delivered at home. The CLC provides

an array of services including subacute medical-surgical care, geriatric care including dementia and delirium evaluation, hospice and palliative care, wound care and rehabilitation therapies. A full range of medical therapies (eg, IV antibiotics, total parenteral nutrition and tube feeding) are offered as well.

Most patients admitted to the CLC are transferred from the VA’s medical and surgical units, although they may be admitted directly from outpatient clinics or other facilities. Because the CLC is located in the VA Medical Center, patients and nurses have 24-hour access to the full gamut of hospital resources including evaluations by physicians and radiology, laboratory and subspecialty services. If a patient’s condition changes, he or she can be evaluated immediately and treated, often preventing the need for a higher level of care.

The CLC is surveyed by The Joint Commission and must meet subacute care standards; in addition, the CLC is surveyed by the Long-Term Care Survey and must meet VA nursing home standards. The CLC strives to maintain a home-like environment and offers patients meaningful recreational offerings and choice in everyday activities. Like all Medicare- or Medicaid-certified nursing homes, comprehen-

sive assessments and patient-centered care planning are based on the Minimum Data Set.³ The CLC is staffed primarily by licensed nurses. Patients receive about three hours of nursing or nursing assistant care per day. In addition, the CLC has dedicated physician-nurse practitioner teams, with each MD/NP team caring for a census of about 25 patients. Onsite pharmacists, who specialize in working with geriatric patients, help manage medications; rehabilitation therapists offer services in an adjacent gym.

The CLC has a 10-bed Palliative Integrated Care Unit (PICU) for patients who are between late-stage disease-oriented care and end-of-life care (hospice). Although palliative care can be offered throughout the medical center and at satellite clinics using telehealth technology, care in the PICU makes the most sense for a significant number of veterans with end-stage illness. This group includes those who are in their final days of life and prefer not to be at home, those who require intensive medical management of end-of-life related symptoms (eg, pain, nausea, shortness of breath) and those who require daily hospital-based interventions (eg, radiation therapy) and are unable to travel to and from home. The care teams on this unit include physicians, nurses, social workers and chaplains. The unit also offers complementary therapies including aromatherapy, imagery, massage and energy healing modalities.

The average length of stay for all patients in the CLC is 27 days, exactly the same as for all patients under the Medicare skilled nursing home benefit in community nursing homes in 2008.⁴ For most patients, the goal is discharge home. Home discharges occur about 75% of the time. This compares favorably to the 67% of admissions discharged to home or assisted living from Minnesota nursing facilities.⁵ The 30-day hospital readmission rate for CLC patients averages 11%, about half the re-hospitalization rate of short-stay nursing home patients in community nursing homes in Minnesota.⁶ About 20 patients are admitted to the PICU per month. Of these, about 60% die on the unit and 25%

are discharged home, with the others being discharged to community nursing homes.

Why is this model of care worth considering now? The CLC approach eliminates the barriers and delays associated with transfer from a hospital to a nursing facility (eg, family decision-making about choice of home, staff time required to find an available bed, arranging transportation), which permits earlier focus on the patient's rehabilitation or comfort and better clinical outcomes for patients (as seen by reduced need for readmission to hospital-level care). It also makes good use of excess hospital resources. Some hospitals may have unused licensed nursing home beds, as hospital-based transitional care units were common when Medicare reimbursed post-acute care on a cost basis. In addition, because many Minnesota health systems now employ the physicians and nurse practitioners who provide nursing home care, bringing those teams to hospital-based units would not be difficult. For those reasons, offering in-hospital subacute, postacute and palliative care is worth considering outside the VA system.

Home-Based Primary Care

A second program that should be looked at is the VA's Home-Based Primary Care (HBPC) program, the goal of which is to deliver services at a patient's home to prevent the need for hospitalization or admission to a nursing home, and to keep the veteran living independently as long as possible. It is available through VA medical centers and a growing number of satellite clinics.

Like the CLC, it is staffed by an interdisciplinary team composed of a physician or nurse practitioner, an RN case manager, a social worker, a pharmacist, a dietician, a psychologist and a recreational therapist.

The Minneapolis HBPC program currently serves about 185 veterans with heart failure, COPD, dementia and other debilitating or chronic conditions. Typically, a nurse case manager visits the patient weekly to monthly for medication set up and monitoring, nursing assessments and care coordination. Visits by a physician or

nurse practitioner take place at least yearly or as needed. Social workers, recreational therapists, psychologists and other professionals visit periodically or as needed. The interdisciplinary team meets weekly to coordinate care, reviewing each veteran's case every 90 days or as needed. Unlike Medicare-certified home-care agencies, HBPC does not provide home-based physical therapy, although an occupational therapist does perform environmental and functional assessments.

Nationally, HBPC enrollment for fiscal year 2007 was associated with a 59% reduction in hospital bed days, an 89% reduction in nursing home bed days and a combined reduction of 78% in total inpatient days. Enrollment in HBPC also was associated with a 21% reduction in 30-day hospital readmission rates. The mean total cost of care per patient per year to the VA dropped 24%, from \$38,000 to \$29,000.⁷ The high staff-to-patient ratio required for such care is impossible with Medicare's fee-for-service reimbursement model but could be possible under ACO-like structures and reimbursement systems where care is bundled.

Summary

The innovation now being demanded by Medicare is creating new opportunities for health care organizations to redesign how they deliver care for elderly people. For many years, the VA Health System has experimented with ways to deliver care more effectively and efficiently. Hospital-based postacute and palliative care and home-based primary care are two examples of successful approaches that non-VA providers should be looking at as they move away from fee-for-service reimbursement and invent new care-delivery models. **MM**

Edward Ratner is an associate professor of medicine at the University of Minnesota, where he leads geriatrics education for medical students and others. He also directs the Home Care Program for the Minneapolis Veterans Affairs Health Care System Spinal Cord Injury program. Melissa West is the medical director of the Minneapolis VA's Community Living Center. Kristopher Hartwig is the medical director of the Minneapolis VA's Hospice Palliative Care program. Bruce Meyer is the

medical director of Home and Community Care at the Minneapolis VA and a member of the hospice and palliative care team.

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EARN CME CREDIT**Using Dementia as the Organizing Principle when Caring for Patients with Dementia and Comorbidities**

Date of release: January 2013

Estimated time of completion:
30 minutes

Educational objectives:

- 1) To understand the way dementia can affect a patient's other chronic conditions
- 2) To learn to organize a patient's care around their dementia, rather than their other chronic conditions

Target audience: primary care physicians

Authors: Alan Lazaroff, M.D., internal medicine and geriatrics specialist, Denver, Colorado; Lynne Morishita, G.N.P., M.S.N., geriatrics health consultant; George Schoepfoerster, M.D., geriatrician, Geriatric Services of Minnesota, St. Cloud; Teresa McCarthy, M.D., M.S., C.M.D., geriatrician, University of Minnesota

Disclosures: Faculty have indicated they have no relationship which, in the context of their presentations, could be perceived as a potential conflict of interest.

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Using Dementia as the Organizing Principle when Caring for Patients with Dementia and Comorbidities

BY ALAN LAZAROFF, M.D., LYNNE MORISHITA, G.N.P., M.S.N., GEORGE SCHOEPHOERSTER, M.D., AND TERESA MCCARTHY, M.D., M.S., C.M.D.

Most patients with dementia have other chronic health concerns as well. Because dementia affects every aspect of a patient's life, its consequences need to be considered in each care decision, including the treatment of comorbid illnesses. In this article, we present a framework for organizing the care of such patients around their dementia, rather than around their other conditions.

The aging of America will inevitably result in a significant increase in the prevalence of dementia. It is estimated that dementia affects one in eight people older than 65 years in the United States. That number is projected to increase by 50% by 2030.^{1,2} The most important risk factor for cognitive impairment is increasing age. Up to 50% of people older than 85 years of age have significant cognitive impairment.^{1,2} And the number of people living to age 85 and beyond is increasing at the fastest rate of any age group.³ This means physicians and other primary care providers will see many more patients with dementia in their practices in the future.

Most people with dementia have other health concerns as well. Ninety-five percent of Medicare beneficiaries with dementia have at least one co-existing chronic medical condition, and most have more than one.⁴ As of 2004, 26% of Medicare beneficiaries age 65 or older with dementia also had coronary heart disease; 23% also had diabetes; 16% also had congestive heart failure; 13% also had cancer; and 8% also had Parkinson's dis-

ease.⁵ Such patients are more likely to be hospitalized than those without dementia; they also have longer hospital stays, as dementia influences both outcomes and utilization patterns.⁶ In addition, the cost of care for people with chronic conditions is much higher if dementia is also present.⁵ Total 2004 health care payments for patients with dementia were three times the amount for those without dementia.⁵ Unfortunately, the additional spending does not always lead to better medical outcomes, nor does it achieve the patient's goals for care.

Because most primary care providers have little training or experience caring for cognitively impaired individuals, they often treat dementia as just one of many comorbidities, and one for which medical treatment options are limited. However, the reality is that dementia is a chronic, progressive, debilitating and ultimately fatal condition that affects every aspect of a patient's life; its consequences need to be considered in every care decision, including the treatment of comorbid illnesses. In this article, we present an approach

for achieving optimal outcomes in adults with cognitive impairment—organizing primary care around their dementia rather than around their comorbidities.

Organizing Care around Dementia

Dementia causes impairment in memory, information processing and judgment. Persons with the condition have variable-but-diminished ability to:

- understand information about their disease and treatment
- report changes in their health status
- follow instructions regarding medication and other treatments
- remember follow-up appointments and arrange to get to these appointments
- judge whether or not they need help or medical care.

Dementia has a profound effect on a patient's ability to participate in his or her own care that must be accounted for in the clinician's treatment plan. Thinking of the patient as *a person with dementia who has multiple comorbidities* is more effective than thinking of the patient as *a person with diabetes, osteoporosis and hypertension who also has dementia*. Therefore, the presence of dementia often is the most important thing to know about a patient when making decisions about his or her health care.

The Role of the Care Partner

Because dementia gradually degrades a person's ability to participate in his or her own medical care, good care requires the assistance of a care partner (in the early stages) or caregiver (later on as disability increases) who will bring the patient to appointments, participate in the visit, oversee or supervise medication adherence, and serve as a source of information about the patient's progress. Identifying and developing a working relationship with a care partner or caregiver (often a family member) is essential to caring for a person with dementia. Physicians and other primary care providers should stress the importance of the caregiver and insist that he or she attend all office visits. They also should offer them ongoing support and look for clues that might suggest that the

support the patient is receiving at home may be inadequate or that the caregiver is overburdened (Table 1).

The Goals of Primary Care

Pharmacotherapy for dementia may provide modest symptom relief, but it is not yet possible to prevent or reverse the progression of most forms of the disease. Therefore, caring for a person with dementia should not focus on its cure or even its modification. The health care team does, however, play a very important role in reducing the suffering that accompanies the disease, reducing the negative impact on both the patient's health and quality of life as well as that of his or her family, and optimizing the management of any comorbid conditions. Quality of life is addressed by maximizing a person's functional independence, ensuring that he or she has adequate support, effectively managing any behavioral issues that may arise, emphasizing safety, and encouraging socialization and community engagement to the extent that the person is comfortable with it and enjoys it. Having dementia puts one at increased risk for complications that can arise from poor adherence to medication regimens, lack of recognition of adverse drug reactions, falls, delirium and preventable hospitalizations (Table 2).⁷ Effectively addressing these risks is the mark of high-quality care of a person with dementia.

Monitoring and Adjusting Goals and Treatment

Because dementia is almost always progressive, ongoing monitoring and modification of care goals and treatments will be necessary. Early in the course of the disease, problems with memory predominate but are often dismissed by family members as the result of fatigue or inattention. As the disease progresses, other cognitive functions are affected, including reasoning, language and visual-spatial abilities. Patients experience increasing difficulty with performing instrumental activities of daily living (shopping, laundry, navigating transportation, taking medications properly, cooking, cleaning, using the tele-

phone and managing money). Later, they become unable to perform basic activities of daily living (bathing, dressing, grooming, using the toilet, walking and eating).⁸ In the final stages of the disease, profound neurological disability is present, not unlike that seen in the end stages of multiple sclerosis or Parkinson's disease. Because dementia is a dynamic process, patients' impairments evolve with the disease and must be considered accordingly. Both the diagnosis of dementia and the current and projected impact of the disease must inform decisions over time.

TABLE 1

Signs of Inadequate Patient Support or an Overburdened Caregiver

- Poor medication adherence
- Weight loss
- Falls
- Wandering and being found by neighbors or police
- Missing appointments
- Decreased attention to hygiene and grooming
- Unhelpful visits to urgent care/emergency room

TABLE 2

Preventing Unnecessary Hospitalizations

- Provide access to a care team member 24/7
- Develop an acute care plan for potential emergencies that is based on shared decision-making and is accessible to on-call providers 24/7
- Facilitate adherence to a medication regimen for treating co-existing conditions
- Ensure follow-up with a primary care provider soon after a hospital discharge
- Ensure that the patient and caregiver know what symptoms and signs to report after a hospital discharge

Case Study

Your morning is interrupted by a call from the emergency room. Your patient, Eunice M., was found by her niece, disheveled and confused. She is being admitted with heart failure and “altered mental status.” Eunice and her husband have been your patients for years, but Mr. M. died suddenly of a stroke a month ago.

Eunice has a history of heart failure, hypothyroidism and osteoarthritis. About a year ago she was diagnosed with mild dementia. Her medical problems have been easily managed and well-controlled. She and her husband had always appeared to be doing fine; he often spoke about their active social life. Eunice is not someone you expected to need hospital admission. What went wrong?

When her husband died, Eunice lost the critical support he provided and was unable to administer her medications because of her cognitive impairment. That led to her heart failure and a potentially preventable hospitalization. Avoiding such situations in the future will involve changing your approach and using her dementia as the organizing principle for her care.

The first step in doing so is finding a care partner. When Eunice came to the office for a follow-up visit after being discharged, she was accompanied by her niece, who is close to Eunice and wants to help.

The niece has been staying at Eunice’s house since she was discharged from the hospital. She indicated that she found several unopened bottles of prescription medications in a kitchen drawer. She also said Eunice’s appetite has improved compared with before the hospitalization and that she is “better than she has been in a while.” Such observations are important to the care team.

By serving as her care partner, Eunice’s niece can continue providing her aunt’s health care providers with accurate information and ensure follow-through with recommendations and monitoring.

Next, an assessment of Eunice’s functional and cognitive abilities will determine the level of support she will need to remain in her home. Assistance with medication management would be beneficial and can be arranged with the niece or a home health provider. A thorough medication review is warranted. The goal is to simplify the regimen where possible. In addition, adult day care, engaging a professional care coordinator or respite care should be considered, as they could help alleviate the stress associated with caregiving for her niece.

Eunice should be as involved as possible in determining the goals of her care. Discussions with her and her niece about advance directives, preventive measures and health crisis management should occur as soon as possible and be documented. These should be reviewed and updated regularly and with any significant change in Eunice’s health status. Financial matters should be considered while Eunice is capable of participating in these discussions. Eunice and her niece may need legal advice as well.

Finally, as Eunice’s primary care physician, you will need to take into account her wishes, the trajectory of her disease and the impact of her dementia on any comorbid illnesses. This will maximize her ability to remain as independent as possible and minimize her risk of preventable adverse events and diminished quality of life.

Key Points in the Care of the Person with Dementia

- Let everyone know that dementia is present
- Be aware that preserving function, maximizing quality of life and helping patients identify and meet goals are the key to good care
- Engaging a care partner is critical for managing dementia and any comorbidities
- Minimize caregiver burden through education and support
- Develop a care plan for potential emergencies
- Assess acute clinical changes that may not be part of the patient’s dementia
- Be aware that the chaos of acute hospital care increases the risk of delirium

TABLE 3

Suggested Clinic Visit Checklist

- Medications
- Activities of daily living
- Cognition
- Mood/behaviors
- Adherence to treatment
- New symptoms
- Falls
- ER visits/hospitalizations
- Caregiver fatigue

TABLE 4

Enhancing Safety in the Patient with Dementia

- Assess the patient or care partner's comfort level with taking risks (eg, for the patient getting lost, leaving burners on)
- Refer for home safety evaluation
- Have the care partner remove scatter rugs and clutter that can cause falls
- Have the care partner plug nightlights in areas with poorly lit walking pathways
- Have the phone pre-dialed with emergency contacts and make sure the patient knows how to use it

TABLE 5

Weighing Treatment Risks, Burdens and Benefits

- Consider whether the treatment itself adds an unreasonable "hassle factor"
- Consider whether treatment results in clinical improvement or reduced suffering
- Consider the benefits of preventive measures and treating co-morbidities as dementia progresses and life expectancy decreases

Patients should be seen regularly, perhaps every three to six months. This allows the clinician to:

- monitor the progression of cognitive and functional impairment and adapt the goals and treatment plan
- look for adverse effects of medications and poor adherence to the medication regimen, signs of acute intercurrent problems and the exacerbation of chronic disease
- check on how the caregiver is coping (Table 3).

Considering Independence and Safety

For a person with dementia, daily life poses an increased risk of adverse events such as falls, becoming lost, car accidents, financial exploitation and accidental drug overdoses. The primary care provider who counsels the family regarding the optimal balance of safety and independence, based on an understanding of these risks in the context of the patient's (or care partner's) preferences, renders an invaluable service (Table 4). Assessment by an occupational therapist or another member of the health care team can help determine what the patient is capable of doing independently with the help of aids and with which activities the patient needs assistance. An environmental assessment performed by a care manager, occupational therapist or nurse from a home care agency can identify modifications that can be made to a home to reduce a person's risk of falling and wandering off. A visit to the home often provides a wealth of insight into the needs of both the patient and family.

Weighing Treatment Options

Dementia alters the benefit/burden equation for treating comorbid illness in several ways. First, it reduces life expectancy,⁹ making some prevention activities a lower priority. For example, a patient with comorbid diabetes may not live long enough for tight glucose control to reduce microvascular complications, and the goal of longer survival may be tempered by the reduced quality of life from cognitive impairment and functional dependency.

Given this understanding, patients and their caregivers may choose to forego or reduce the intensity of interventions that might otherwise be recommended for comorbidities such as diabetes, hyperlipidemia or hypertension.

As dementia progresses, standard treatment options carry an increased risk of adverse outcomes. For example, in a patient with advancing dementia, hypotension may become a greater immediate risk than the consequences of hypertension; in such cases it may be appropriate to gradually increase the blood pressure target. In a patient with diabetes and worsening cognitive impairment, control targets may be relaxed, as the danger of hypoglycemia may outweigh any benefit from tight control. The risks of treatment with drugs such as warfarin (bleeding) or alendronate (esophagitis) increase substantially in the patient who may be unable to take medication competently, making the case against their use unless safe administration can be assured. The care plan for the patient should not place unreasonable expectations on the patient or caregiver; instead, treatment should be adapted to what can be reasonably accomplished (Table 5).

Prescribing for the Patient with Dementia

Perhaps the single best way to positively affect cognition in a patient with dementia is careful and attentive management of his or her drug regimen (Table 6). Good prescribing practice for the patient with dementia requires paying special attention to both the patient's adherence to drug regimens and susceptibility to adverse effects of certain drugs. A patient with dementia cannot be relied on to self-report adherence to a medication regimen. In addition, the likelihood of an adverse drug reaction rises sharply with the number of drugs and doses taken.¹⁰ For those reasons, the medication regimen should be simplified as much as possible. Depending on the severity of cognitive impairment, techniques such as using pill minders or other dispensing aids; having caregivers count pills, supervise refills or actually dispense the medication in person; and limiting pa-

Care Partner and Caregiver Issues

Caring for a demented person is stressful and difficult. Spousal caregivers are usually elderly and may be in poor health themselves. Adult children have competing demands of work and family. Those with dementia gradually lose the capacity to accurately assess their own needs and can misinterpret the helpful efforts of others as interference with their autonomy.

The demands on the caregiver can be unrelenting. Verbal or physical aggression, incessant repetition of what the caregiver said and shadowing (following the caregiver wherever she goes) can be difficult to tolerate. But remaining at home and delaying or avoiding institutional placement is an important goal for most older people. Interventions that improve caregiver well-being are available and often can delay nursing home placement.¹

Caregivers need help successfully managing these life-altering responsibilities. The Alzheimer's Association, the Area Agencies on Aging and Minnesota's Senior Linkage Line (800-333-2433) along with other community-based organizations offer care consultation, education, training and support for caregivers. Such services can reduce caregiver stress and help the caregiver manage the patient's behavioral issues to optimize their ability to function safely and independently. Caregivers can get respite by having their loved one participate in adult day care, by creating a plan that divides responsibilities among several family members or by having their loved one do respite stays in an assisted living facility or nursing home.

Caregivers of people with dementia sometimes neglect their own health needs and, as a result, are at increased risk of depression and illness. If the caregiver shares a primary care doctor with the person with dementia, the physician will be aware of this and will be able to assist the entire family in dealing with the stresses of caring for their loved one. If the caregiver has a different physician, it is appropriate to observe the caregiver's demeanor and remind her of the importance of continuing to care for her own health, while she serves as caregiver.

One approach that can be effective in supporting caregivers is to provide them with direct contact information for a designated health care team member who knows the patient's care goals and plan, and who is readily available and can bypass the usual procedure for dealing with incoming telephone calls. Ideally, the designated team member will have a relationship

with the patient and caregiver before a crisis occurs, paving the way for effective communication in difficult situations.

Caregivers dealing with a crisis often feel overwhelmed and may need urgent support to regain their footing. Prompt attention in such situations can avert unhelpful ER visits and the cascade of unproductive tests and treatment that can sometimes follow. Increasingly, with models such as the patient-centered medical home, nurses and/or social workers who serve as care managers will become an important resource to both the patient, their caregiver and the medical provider in addressing the many psychosocial issues that arise.

Acknowledging the difficulty of the caregiver's work and the benefit it brings to their loved one is important, as the caregiver may feel isolated and unappreciated even by other family members. Such acknowledgement seems to be particularly powerful when it comes directly from the physician.

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Preventing Care Partner and Caregiver Burden

- Hold a family meeting to identify patient goals and plan care
- Offer direct contact with a staff person who is aware of the patient/family's goals and care plan
- Provide information on resources such as the Senior Linkage Line and Alzheimer's Association that offer education, caregiver support, help with behavioral issues and respite care

tient access to large quantities of pills may need to be considered.

Drugs with strong anticholinergic properties (including first-generation antihistamines, tricyclic antidepressants and drugs for overactive bladder), sedative hypnotics and other drugs that act on the central nervous system are likely to produce delirium and other CNS-related side effects such as dizziness and balance problems that can lead to falls. Such side effects can be difficult to distinguish from the underlying neurological disease.

The American Geriatrics Society recently updated *Beers Criteria for Potentially Inappropriate Medication Use in Older Adults*, an outstanding evidence-based reference for minimizing adverse drug events. It recommends avoiding use of selected medications in specified situations because of the high incidence of adverse effects in older adults. It also recommends that patients with dementia avoid anticholinergics, benzodiazepines and antipsychotic drugs.

TABLE 6

Preventing Medication Problems

- **Adverse drug reactions** Stop meds that are not indicated or do not provide benefit
- **Poor medication adherence** Minimize the number of medications; provide medication set up and effective reminders for patient and care partner; simplify the regimen
- **Increased cognitive impairment** Avoid anticholinergics, benzodiazepines, H-2 antagonists, zolpidem and antipsychotics, both chronically and prn

Source: *Beers Criteria for Potentially Inappropriate Medication Use in Older Adults*. Available at: www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/2012.

Recognizing Acute Illness

Recognizing and treating acute illness in a person with dementia may be challenging because of the absence of typical clues. In patients with significant cognitive impairment, acute changes in health status often present as increased confusion, falls, loss of appetite or dehydration. The relationship between these presentations and the underlying cause (eg, pneumonia presenting as increased confusion without respiratory symptoms) may not be obvious.

Because Alzheimer's disease typically manifests as a *slow steady* decline in cognitive abilities, any *sudden* increase in confusion should prompt an evaluation to identify an underlying acute cause. Medications, infection, constipation, urine retention, pain, myocardial ischemia, dehydration, sleep deprivation and dental disease can be common causes of delirium or acute mental status changes in patients with Alzheimer's disease.

Conclusion

Dementia is a progressive condition that has profound consequences for every aspect of life. Although it may be the least "treatable" of a person's chronic medical problems, understanding how dementia affects all other conditions is the key to providing excellent care. Organizing care around dementia makes it possible to avert medical crises precipitated by the patient's reduced capacity for self-care, thereby improving an individual's health and quality of life while decreasing spending on care that is ineffective or even harmful. **MM**

Alan Lazaroff practices internal medicine and geriatrics in Denver, Colorado. Lynne Morishita is a geriatrics health care consultant. George Schoephoerster is a geriatrician with Geriatric Services of Minnesota in St. Cloud. Teresa McCarthy is a geriatrician at the University of Minnesota.

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Empowering Older Adults to Manage Chronic Conditions and Reduce their Risk for Falls

BY JEAN K. WOOD

Chronic diseases and falls are among the major causes of death and disability among people age 65 and older. Often, they can be managed or, in the case of falls, prevented. Studies have shown that programs that teach people to manage their conditions or risk factors can reduce the chance of complications or poor outcomes that can affect their quality of life and independence. This article reminds physicians that older adults should be encouraged to engage in preventing disease and injury and describes two programs that have been shown to help older adults do this: A Matter of Balance for fall prevention and Living Well with Chronic Conditions.

Chronic illnesses and falls are among the major causes of death and disability among older adults. More than 80% of older adults have at least one chronic condition and 50% have at least two.¹ Each year, one in three persons age 65 and older falls.^{2,3} In 2009, older adults in Minnesota experienced more than 29,900 falls, resulting in 639 fatalities.⁴

Both chronic diseases and falls can be costly. According to the National Council on Aging, direct health care expenditures associated with chronic conditions totaled more than \$262 billion in 2009. That same year, the costs associated with fall-related injuries exceeded \$19 billion for persons age 65 and older. More devastating is the toll chronic illnesses and falls can take on a person's quality of life and ability to live independently.

Older people can do a number of things to prevent or limit the effects of chronic disease or reduce their risk of falling, among them eating healthfully and exercising. Physicians can play an important role in getting them to make lifestyle changes. Whether it's simply reminding patients that moving their body everyday will make them feel better or encouraging

them to eat well, nudges from a physician more than anything else motivate patients to take steps to age well.

Engaging Older Patients

In Minnesota, only 25% of adults age 65 years and older and 23.1% of adults ages 55 to 64 years consume five or more fruits and vegetables per day.⁵ Older adults as well as younger adults need to be reminded that this is optimal. When working with older adults, physicians should emphasize the importance of eating a variety of foods from all food groups so that they get the nutrients their aging bodies need. They also can emphasize that a proper diet can prevent such problems as heart disease, stroke, high blood pressure, type 2 diabetes and bone loss and can help keep muscles, bones, organs and other body parts strong, which is important to fall prevention. A healthful diet also boosts immunity and helps keep the mind sharp.

Patients also should be reminded that any physical activity that gets them breathing harder and using their muscles is beneficial for both preventing disease and reducing their risk of falling. The Centers for Disease Control and Prevention (CDC)

recommends that healthy adults age 65 years and older engage in 150 minutes of moderate-to-intense aerobic exercise every week as well as strength training that works the muscles in the legs, hips, back, abdomen, chest, shoulders and arms at least twice a week.⁶ The CDC describes moderate to intense physical activity as that which allows one to talk but not sing while engaged in it.

But just encouraging patients to eat a healthful diet and exercise may not be enough. In some cases, referral to evidence-based health promotion programs that address underlying issues that prevent older adults from making changes that would reduce their risk for falls or complications from chronic illnesses can make a difference. Here, we describe two such programs, A Matter of Balance and Living Well with Chronic Conditions.

A Matter of Balance

Poor muscle tone, decreased bone mass, loss of balance and reduced flexibility caused by lack of exercise are major contributors to a person's risk of falling. Having a fear of falling adds another dimension to the risk, as people often let their

fears limit their physical activities, which can lead to them to become even more deconditioned. A Matter of Balance: Managing Concerns about Falls is a program designed to reduce participants' fear of falling and increase their level of activity as well as their confidence. The program consists of eight sessions taught by trained coaches. Participants meet weekly or twice weekly for two hours. During those sessions, they

- Set realistic goals for staying active
- Learn how to stay safe at home
- Complete exercises to increase strength and balance
- Learn how to identify and control the fear of falling.

A Matter of Balance can make a difference. In 1998, a randomized controlled trial showed that individuals who took part in A Matter of Balance reported increased levels of activity ($P < .05$) and greater mobility control ($P < .05$) immediately afterward as compared with control subjects.⁷ A follow-up study showed that when the program was implemented in a community setting and led by trained volunteers participants' results were comparable to those from the randomized controlled trial.⁸

Living Well with Chronic Conditions

Living Well with Chronic Conditions (Minnesota's name for the Stanford Chronic Disease Self-Management Program) is a group workshop designed to enable participants to build confidence in managing chronic conditions such as heart disease, diabetes, and arthritis and maintaining their health. The workshop takes place over six weeks with one 2.5-hour class per week. Classes are facilitated by a pair of trained lay leaders and are held at a variety of sites including senior centers, senior residences, continuum of care campuses, community centers, clinics, hospitals and churches.

During the six-week workshop, participants receive information about their condition and learn practical skills for managing their pain and fatigue, eating healthfully, increasing their physical activity, making informed treatment choices,

and talking with their doctors and families about their health concerns. They develop these skills by focusing on three major areas that are essential to self-management: action planning, problem solving and decision making.

Randomized controlled trials and follow-up studies conducted over the last 10 to 15 years have shown the chronic disease management approach to be effective. In one study, outcomes associated with six months of participation included the following:

- Increased ability to exercise
- Better coping strategies and symptom management
- Better communication with physicians
- More energy and less fatigue
- Decreased disability
- Fewer physician visits and hospitalizations.⁹

A follow up study found that after one year, participants saw these effects:

- Significant improvements in energy, health status, participation in social activities and self-efficacy
- Less fatigue or health distress
- Fewer emergency room visits
- No decline in activity or functioning, even though there was a slight increase in disability after one year.

After two years they saw:

- No further increase in disability
- Reduced health distress
- Fewer visits to physicians and emergency rooms
- Increased self-efficacy.¹⁰

Conclusion

For older adults, prevention is critical to avoiding the consequences of chronic conditions and falls. By encouraging patients to take steps to manage their health, physicians can help them avoid these problems and remain active and independent as long as possible. Evidence-based programs such as A Matter of Balance and Living Well with Chronic Conditions offer guidance for patients living with or at risk for these conditions. **MM**

Jean Wood is executive director of the Minnesota Board on Aging and director of the

Aging and Adult Services Division, Minnesota Department of Human Services.

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Physicians can learn more about **A Matter of Balance and Living Well with Chronic Conditions** at mnhealthyaging.org or by calling the Senior LinkAge Line (800-333-2433).

SENIORS AND DRIVING

Three Stories, Three Outcomes

BY KATHY WOODS RAKOWCZYK, OTR/L, CDRS

Physicians who care for older patients may find themselves being asked to make a judgment about whether a person is able to continue driving. Discussing this topic is rarely easy for the physician or the patient. One option for physicians who find themselves in this situation is referring the patient for an evaluation by a driver rehabilitation specialist. This article describes what this entails and how such an evaluation might help clarify whether a patient can safely remain behind the wheel.

For many older adults, driving means independence and being able to participate in social, medical, religious, work or volunteer activities. But there may come a time when a person's ability to drive safely needs to be addressed. Because safe driving requires integration of the visual, physical, mental and cognitive systems, each of which may be affected by aging, disease, medication or traumatic injury, driving ability tends to decline with age. Statistics show that older drivers have more accidents per mile driven than the rest of the driving population and that their accidents often are related to inattention or slowed visual processing speed. Equally concerning is that the rate of fatalities increases with age: Because our bodies become more fragile as we get older, we become less able to withstand the forces involved in a vehicle crash.

Having an accident, getting lost or experiencing a health problem may prompt an older adult or a family member to become concerned about driving performance. In some cases, the family member may turn to their loved one's physician for help and advice. In Minnesota, physicians are encouraged, but not required, to report patients who have medical conditions that may have an impact on their ability to drive safely to the Minnesota Department of Public Safety's (DPS) Medical Unit. Physicians who report a patient in good

faith have immunity from legal repercussion; and the identity of the reporting physician will remain confidential unless a court subpoenas the DPS records. When reporting a patient, the physician need only disclose the patient's name, date of birth, home address, and a brief statement such as "I, as his physician, recommend this person's driving privileges be revoked" or "I have concerns regarding this person's driving safety."

Individuals reported to DPS are notified of this in writing. They usually have 30 days to comply with the requests in the letter, one of which may be to obtain a statement about their fitness to drive from a physician. A physician who does not feel qualified to make a judgment about a patient's ability to drive may recommend that the individual have a driving assessment.

During a driving assessment, the driver's abilities are evaluated by a driver rehabilitation specialist, often a health care professional (such as an occupational therapist), and/or a driving instructor who has been trained to plan, develop, coordinate and implement driver rehabilitation services for people with disabilities or who are aging.

The driver rehabilitation specialist will typically complete a three-hour comprehensive assessment that begins with a client interview. The driver, and sometimes a family member, may be asked about the

driver's health, medications, functional abilities, current driving habits and the reason for the assessment.

After the interview, an occupational therapist performs clinical testing to assess the person's visual, physical and cognitive skills. During that assessment, the driver's visual acuity, peripheral vision, color recognition, depth and visual perception, visual tracking ability and contrast sensitivity will be evaluated. If the driver does not meet Minnesota vision standards (acuity and peripheral vision) for driving, he or she is referred to an optometrist or ophthalmologist for an eye exam. If that vision specialist documents that the driver meets state vision standards, the driver may return to complete the driving assessment. If the driver does not meet the state's vision standards, then he or she is ineligible to continue driving.

The driver's physical abilities, including upper and lower body coordination, strength, range of motion, endurance, reaction time and ability to turn to look around are also evaluated. If an individual's mobility is impaired, his or her potential to drive with adaptive equipment will be assessed. For example, someone with right hemiparesis from a stroke may be able to drive using a left-foot accelerator pedal and a spinner knob on the steering wheel. Such equipment modifications might be contraindicated if there is

concern about the person's ability to learn new tasks.

Cognition testing includes assessment of a person's insight into his or her functional abilities, ability to divide their attention, information processing speed, memory, orientation and problem-solving skills.

The behind-the-wheel assessment is done using a vehicle outfitted with safety equipment including an evaluator brake. During the on-the-road portion, the driver rehabilitation specialist assesses the driver's ability to apply the rules of the road, their awareness of their environment and their physical ability to control the vehicle. The driver rehabilitation specialist may provide instruction on safe driving to see if the person being tested can improve his or her driving and retain new information.

After the drive, the driver rehabilitation specialist reviews the findings, identifies concerns and makes recommendations.

Among the options:

- Return to or continue driving with no restrictions
- Return to or continue driving with restrictions such as no night driving, no rush hour driving, driving familiar routes only, driving only a certain distance from home or no freeway driving
- Complete lessons to further determine driving safety
- Complete lessons to train a driver to use adaptive equipment
- Refer for therapy
- Cease driving.

If the driver rehabilitation specialist recommends that a person stop driving, information about alternative transportation such as Metro Mobility or other services available in their area is provided. These resources, as well as family and community support, are critical to helping a person adjust to the change in lifestyle and remain as involved in their usual activities as possible.

Three Cases

The following examples illustrate how the process works for individuals who have different needs and problems.

A Great Resource for Physicians

The American Medical Association (AMA) has an excellent resource for physicians: AMA Physician's Guide to Assessing and Counseling Older Drivers. The guide is online at: www.ama-assn.org/ama/pub/physician-resources/public-health/promoting-healthy-lifestyles/geriatric-health/older-driver-safety/assessing-counseling-older-drivers.page.

E.K., an 85-year-old retired researcher, was referred by his physician for a driving assessment after he received a letter from the State of Minnesota requesting a physician's statement about his fitness for driving. A good Samaritan had reported that E.K. had fallen asleep at a traffic light. During his assessment, he admitted he was exhausted that day because he was caring for his wife who had been ill. He said he hoped to continue driving familiar routes, including freeways and downtown, but that he already avoided night driving.

Vision testing revealed that he met the state's standards for driving in terms of peripheral vision and visual acuity but that he had difficulty with binocular fusion, depth perception and contrast sensitivity. He scored within functional limits for sign recognition, judgment, problem solving, visual perception, short-term memory, orientation, map reading and for the physical skills used in driving. He scored in the low- to moderate-risk category on a visual divided attention task in which he was asked to discriminate between two objects in the central field of view while simultaneously identifying the location of an object in the peripheral vision. Drivers use this skill when they have to discriminate between a red or green light and notice a pedestrian on the side of the road.

During testing, E.K.'s processing speed varied and he had difficulty with situations requiring divided attention. He remained alert and attentive throughout clinical testing and did not appear drowsy. During the on-the-road assessment, E.K. applied the rules of the road and was aware of his environment. A slight delay was noted in his identification of traffic control at various intersections especially on unfamiliar routes.

The driver rehabilitation specialist recommended that E.K. be allowed to continue driving familiar routes only during the day time, and that he avoid freeways as well as driving in bad weather and during rush hour. The specialist also discussed the effect fatigue can have on driving safety and alternatives to driving including contacting a family member for assistance or using alternative transportation. E.K. was receptive to the feedback and is expected to comply with the recommendations.

Seventy-six-year-old G.W. was referred for a driving assessment by his physician after his wife had expressed concerns. G.W. had been involved in an accident. He totaled his vehicle and took out a stop sign as he tried to avoid hitting a deer. After the accident, G.W. drove home—about 30 miles—without his prescription eyeglasses, which he needs to meet state vision standards. The accident occurred in the early morning when it was still dark. It was also raining. He did not contact the police.

G.W.'s medical history includes two strokes about 10 years ago, resulting in decreased mobility in his right foot as well as speech changes. Family members also reported potential for cognitive impairment. After his strokes, G.W. stopped driving for a period on his physician's recommendation. Then, he switched physicians and his new doctor gave him the OK to return to driving. Family members refuse to ride with G.W.

G.W. reported that he sometimes uses his left foot on the gas pedal because of the impaired mobility in his right leg. His insight was poor in terms of recalling events leading to the driving assessment, and he seemed to lack appreciation for the accident and his actions.

G.W. met the state's vision requirements for driving, but his binocular fusion and depth perception were impaired. He had impaired contrast sensitivity as well. Testing revealed poor sign recognition, difficulty with visual perception and slowed processing. He also scored in the high-risk category on a cognitive divided attention task but within functional limits for problem solving.

During the on-the-road assessment, the evaluator intervened several times to prevent potential accidents because of G.W.'s high-risk driving behaviors. Twice at two-way stop-sign-controlled intersections, the driving evaluator applied the brake when G.W. failed to yield to cross traffic that was not required to stop. Because of challenges with divided attention, his visual scanning was limited, resulting in him missing important traffic signs. He lacked awareness of the risk when he approached utility vehicles parked on the side of the road, and he did not shift his path of travel away from the workers. Depth perception issues were also noted. G.W. used his left foot to brake a couple of times. This is a concern because it can slow reaction time and increase a driver's risk of hitting the wrong pedal.

The driver rehabilitation specialist recommended that G.W. cease driving. G.W. declined to sign a consent form allowing release of the report to his physician and instead said he would provide a copy to his doctor. The evaluator was concerned that he would not comply with the recommendation. Family members were present (G.W. had given consent for this) to hear the recommendation and were provided with information about alternative transportation options. They also were encouraged to follow up with G.W.'s health care team.

F.D., a 76-year-old retired mechanic, suffered a traumatic brain injury nine months prior to presenting for a driving assessment. Two months after his initial brain injury, F.D. was hospitalized for a subdural brain bleed. After both the injury and the subsequent bleed, he participated in inpatient and outpatient occupational, physical and speech therapy. F.D. denied

any residual deficits from the brain injury. His wife, however, reported that he had slower processing speed and decreased receptive language skills. He had also elected to stop his therapies. He received approval from his physician to drive in a parking lot with a family member but wanted to return to unrestricted driving. He was referred for a driving assessment.

In testing, F.D. met vision standards for driving. His physical ability to operate a motor vehicle was sufficient; however, his gas-to-brake reaction time was slower compared with that of other men in his age group. The driving evaluator needed to repeat directions because F.D. had difficulty comprehending them. He also had significant trouble recognizing signs, solving problems, and performing a divided-attention task. He also exhibited slowed processing, impaired short-term memory, poor concentration, vision problems and inability to complete a map-reading task.

During the on-the-road assessment, the evaluator needed to use the brake when F.D. did not yield to cross traffic at an intersection. In addition, he turned the car very slowly. At one intersection, when the left-turn arrow turned green, he proceeded through the intersection so slowly that the light turned red before he cleared it. F.D.'s ability to manage speed during turns did not improve following feedback from the evaluator. Several times he crossed the center line into the oncoming traffic lane and slowed when there was no need. The evaluator needed to cue him that he was driving on the shoulder of the road instead of in the actual lane and intervened to avoid hitting a curb on a right turn. Overall, F.D. lacked insight about his driving and any safety issues it might be causing.

The driver rehabilitation specialist advised F.D. not to drive at this time. He recommended that F.D. and his spouse follow up with his health care team to determine if he could restart therapy. Then, if his abilities improved, he could be reassessed for a return to driving. In the meantime, alternative transportation options were discussed.

Discussion

These case studies illustrate the fact that aging drivers are not all alike and that age alone does not define one's ability to drive safely. Rather, a person's vision, cognition, physical abilities and insight are the critical factors to consider in determining driving safety.

If a physician feels a patient is unsafe to drive, the physician may report that person to the Minnesota DPS or recommend an evaluation by a driver rehabilitation specialist who can provide an objective assessment of the patient's abilities.

In some cases, such as that of G.W., the evaluation may indicate that the person should stop driving altogether. In others, it may mean that they need to restrict their driving to familiar places and daylight hours or that they need to fit their car with adaptive devices. In the case of F.D., for example, a therapeutic intervention might allow him one day to return to driving.

Transitioning to being a nondriver can be life-changing. Older individuals may be afraid to try using alternative forms of transportation and may discontinue doing activities they used to enjoy. Persons who are told they can no longer drive may feel angry, fearful and frustrated and may experience depression as a result. Physicians are encouraged to offer assistance to patients who experience negative feelings after they cease driving.

Physicians often are asked to make determinations about whether an older patient should continue driving. These are not always easy decisions to make, and conversations with patients or their family members about driving can be difficult. Enlisting the help of a driver rehabilitation specialist, who can help quantify driving ability and skill, can be helpful. The goal in all cases is to make sure that the patient and the public remain safe. ■■■

Kathy Woods Rakowczyk is an occupational therapist, certified driver rehabilitation specialist and licensed driving instructor at Courage Center.

Facilitating Care Transitions for Older Adults

BY JEAN K. WOOD

Successful transitions between care settings can reduce the chance of complications for older adults with complex health conditions. Ensuring good transitions involves not only executing a well-thought-out medical plan but also referring patients to support services in the community and attending to the needs and well-being of their caregivers. This article describes why these factors are so important and how physicians can use Minnesota resources to improve care transitions.

Chronic conditions affect people of all ages, but the extent of their impact differs dramatically across the lifespan. Overall, the conditions that are most common among older adults require more care, are more disabling and are more difficult to treat than the conditions that are more common among younger people.¹

The number of older adults with such conditions will continue to grow as the population ages. Between 2005 and 2030, the number of people age 65 years and older in Minnesota will more than double (from 620,000 to 1.3 million). The number of those age 85 and older will nearly double as well, rising to 163,000.² More than 80% of older adults have at least one chronic condition, and 50% have at least two.³ More than two-thirds of health care spending goes toward treating such conditions, and among older adults, almost 95% of health care expenditures are for chronic illnesses.⁴ Some of the cost understandably stems from the need for the continuous management of these conditions; however, a portion also arises from complications experienced during care transitions.

Care transitions are critical junctures in older patients' lives. In a 2003 article pub-

lished in the *Journal of the American Geriatrics Society*, the University of Colorado's Eric Coleman, M.D., M.P.H., pointed out that poorly executed care transitions result in a multitude of adverse effects that have wide-ranging consequences for both patients and their caregivers.⁵ He noted that the care process can break down at a number of points, including during the preparation of the patient and caregiver, during medication reconciliation, during transport of the patient and during follow-up visits.⁵ A breakdown at any point can lead to medication errors, lack of compliance with the care plan, or an avoidable hospital admission or readmission.

What can we do to ensure that patient care does not break down during care transitions? Research has shown that two factors are critical to how well a patient fares during a care transition: 1) connecting the patient to health-related support services that are available in their home community and 2) providing support for the family member who serves as the primary caregiver and actively involving them in the discharge process.⁶

The Role of Health-Related Supports

Providing assistance with transportation, meals, medications, housekeeping and other daily needs often enables an older adult to better make the transition from hospital to home, regardless of whether they have had an acute illness or are managing a chronic disease.⁷ Such health-related supports are also important over the long haul as they reduce the risk of hospitalization and complications when age and chronic disease combine to increase frailty.⁸ Examples of supports include the following:

- Assistance with Medicare Part D or other prescription drug payment issues, as well as with medication management
- Delivery of meals, including those that meet special dietary needs or personal preferences, to support adequate nutrition
- Transportation to ensure that older adults are able to follow through on referrals and access community services
- Help with chores, homemaker services and home modifications to create an accessible and safe environment

- Self-management programs that teach older adults to better manage their chronic conditions
- Evidence-based interventions that help older adults reduce their risk for falls.

Most of these services are available on a sliding-fee scale. Services are offered by publicly subsidized, private and volunteer providers. As of October 1, 2012, Minnesota law requires that all state-certified health care homes and hospitals refer at-risk older adults to the Senior LinkAge Line to receive care plan follow-up and connection to health-related supports (see “Connecting to Health-Related Support Services”). To learn more about the referral protocol that is being implemented statewide visit www.mnaging.org/en/Advisor/LTCCE.aspx.

The Role of Family Caregivers in Care Transitions

Family caregivers are especially important during care transitions. In Minnesota, family caregivers provide 92% of the support needed by older adults.⁹ This includes complex nursing care, cognitive support and care management. In 2006, an estimated 610,000 caregivers were living in Minnesota, comprising approximately 16% of the adult population.¹⁰ The average caregiver is a 50-year-old woman caring for her 77-year-old mother who has a long-term physical condition. She is likely to be working in a paid job (55% of cases) and has been caregiving for an average of four years.

Family caregivers play a significant role in providing support to and managing the health status and care of their loved ones. According to a nationally representative survey of family caregivers by the AARP Public Policy Institute and the United Hospital Fund:

- 46% of family caregivers perform medical/nursing tasks for care recipients with multiple chronic physical and cognitive conditions
- 78% of family caregivers manage multiple medications on behalf of the care recipient
- 53% of family caregivers frequently serve as care coordinators.¹¹

For those reasons, ongoing communication with and involvement of the family caregiver is critical to successful transitions.

Support for the caregiver is also important. Caregivers providing 21 or more hours of care per week are more likely to report worsening health than those providing 20 or fewer hours of care per week. Caregivers providing 21 or more hours of care weekly also are more likely to be older than 60 years of age, female, retired, involved in caring for longer periods of time, living with the person they care for, and slightly more likely to have a physical limitation than those providing less care. Longer periods of care are also associated with greater levels of stress and a higher prevalence of depression.¹²

Respite services can provide a caregiver with a much needed break. In addition, evidence-based education programs such as Powerful Tools for Caregivers can equip caregivers with the skills they need to help their loved one manage chronic illnesses. During a one-on-one consultation with a caregiver, a physician or other expert can focus on the needs of the caregiver and help the caregiver take action to maintain his or her own health. Such support is especially helpful for persons supporting a loved one with Alzheimer’s disease or another form of dementia. **MM**

Jean Wood is the executive director of the Minnesota Board on Aging and director of the Aging and Adult Services Division, Minnesota Department of Human Services.

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Connecting to Health-Related Support Services

The Minnesota Board on Aging oversees a statewide network of agencies that provide an array of social services for older adults and their family caregivers. Information about these services can be accessed either online (www.minnesotahelp.info) or through the Senior LinkAge Line, the Minnesota Board on Aging’s free information and assistance service (800-333-2433).

Senior LinkAge Line staff will be able to help physicians, family members or older adults themselves locate services in the patient’s neighborhood and help create a plan for use of in-home supports. In addition, they can connect overwhelmed family caregivers with respite care, support groups and caregiver consultants.

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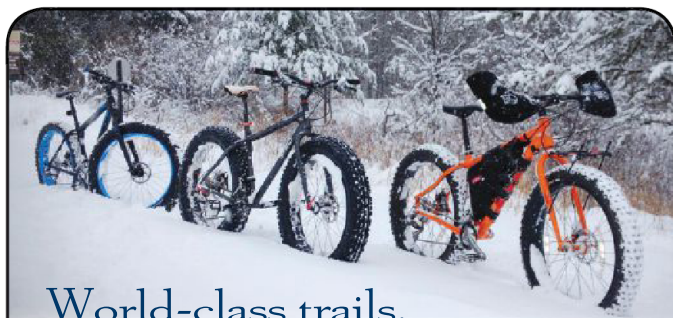
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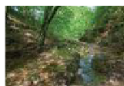
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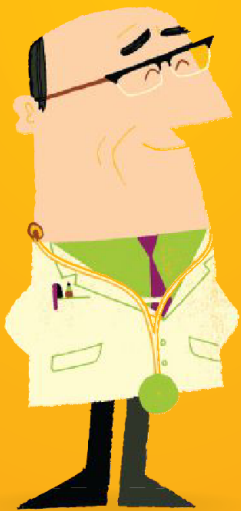
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DollyBelle

A patient's final gift.

BY CHARLES BRANSFORD, M.D.

You knew immediately by her name that she was from another era. Along with the likes of Verna, MayBelle, Verona and Alvena May, her name has slipped into the memory banks of history. Height well under 5 feet, shockingly white short hair, weight less than 90 pounds, and Coke-bottle glasses describe her physical appearance; but it is her spirit that I remember best. She was so comfortable with who she was. She didn't need to pretend about anything. We sat in her hospital room on what turned out to be the last night of her life reminiscing about Stillwater—particularly about the hospital and the old-time doctors.

DollyBelle was born in the original Lakeview Hospital when it, along with a nursing residence, was located on the banks of Lily Lake. She lived just down the shoreline. She remembered being 16 years old at a time when cars were a novelty, refrigeration was a remarkable invention, and when the life of a teen revolved around the hard work needed to keep the farm going and the crystal radio set that connected her with the outside world. On clear Saturday nights she could get stations from as far away as Iowa. She remembered sleepovers with her best friends; they cuddled together on the porch under candlelight listening to the likes of *The Shadow*—“Who knows what evil lurks within the hearts of men—The shadow knows.” On Sundays, you rested because you had no other choice—everything was closed. DollyBelle read, and she read, and she read. Life was simpler, slower, but it was not easier.

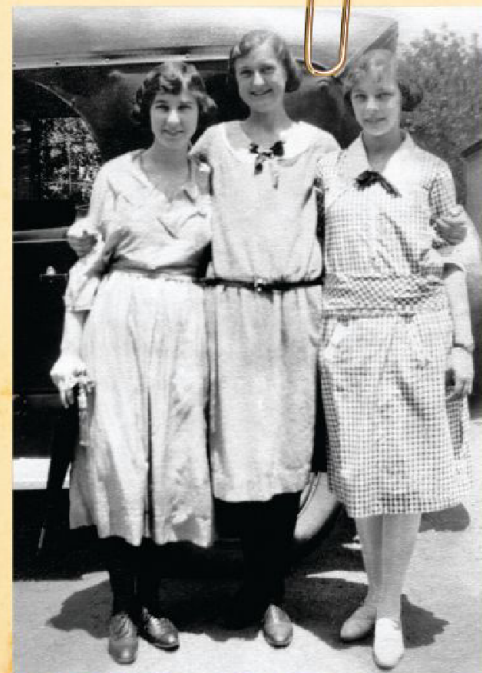
DollyBelle laughed as she described one late summer evening. She was sleeping

on the porch because of the heat listening to the sounds of crickets, bullfrogs and whip-poor-wills along with the gentle lapping of waves along the lake's shore when she was startled by a young woman's screams. Initially, she thought someone was being murdered; she quickly realized it was a woman in labor. With no air conditioning, the hospital had no choice but to keep its windows open on hot summer nights. The screams continued until Dr. Henry VonMeyer arrived.

DollyBelle said Dr. VonMeyer had a powerful presence. Known for his beautiful singing voice, he would “hypnotize” his laboring patients and they would have no memory of the pain of labor. He also did “sleep therapy.” He would hospitalize an exhausted or depressed patient and put him or her to sleep for several days with morphine and hyosine, before waking him up refreshed and cured.

That night, Dr. VonMeyer's operatic aria drowned out the young woman's screams. Then, after a sudden quiet, Dolly heard the distinct slap of a hand on the baby's butt followed by a reassuring cry. She remembered falling asleep with a sense of peace and waking up the following morning with the resolve that she would not get pregnant until she was good and ready! Birth control at its best.

I had met DollyBelle 10 years earlier. I was working in the ER when she presented with her first heart attack. She had no risk factors—she was female, she exercised vigorously, her weight was normal and she was a nonsmoker. I was surprised and very worried as she had a large anterior MI. But she didn't seem worried. She had no fear of



death. I remember her telling me, “Young man, I haven't a care in the world. I know that my Lord will take care of me, and if it's time for me to go then, so be it. It's OK to do everything you can for me, but don't think about any special machines or ventilators for me, I don't need them.”

DollyBelle was so certain and composed. All that mattered, she told me, was being able to continue her work as a deacon, bringing communion and comfort to the “shut-ins” in her church. They were her flock, and life was worth living only if she could find a way to continue ministering to them.

DollyBelle survived that heart attack and a second one and lived 10 more years, serving as a deacon until one last heart attack brought her to our hospital. My final evening with her would never have happened if, by chance, I hadn't noticed her chart while waiting impatiently for lab results on another case. My surly mood turned joyful in her presence.

Good things can happen anytime, anywhere. They are usually gifts that we never could have expected. Having an open heart and open mind often lead us to joy. That night, they led me to DollyBelle. **MM**

Charles Bransford is an internal medicine physician with Stillwater Medical Group.

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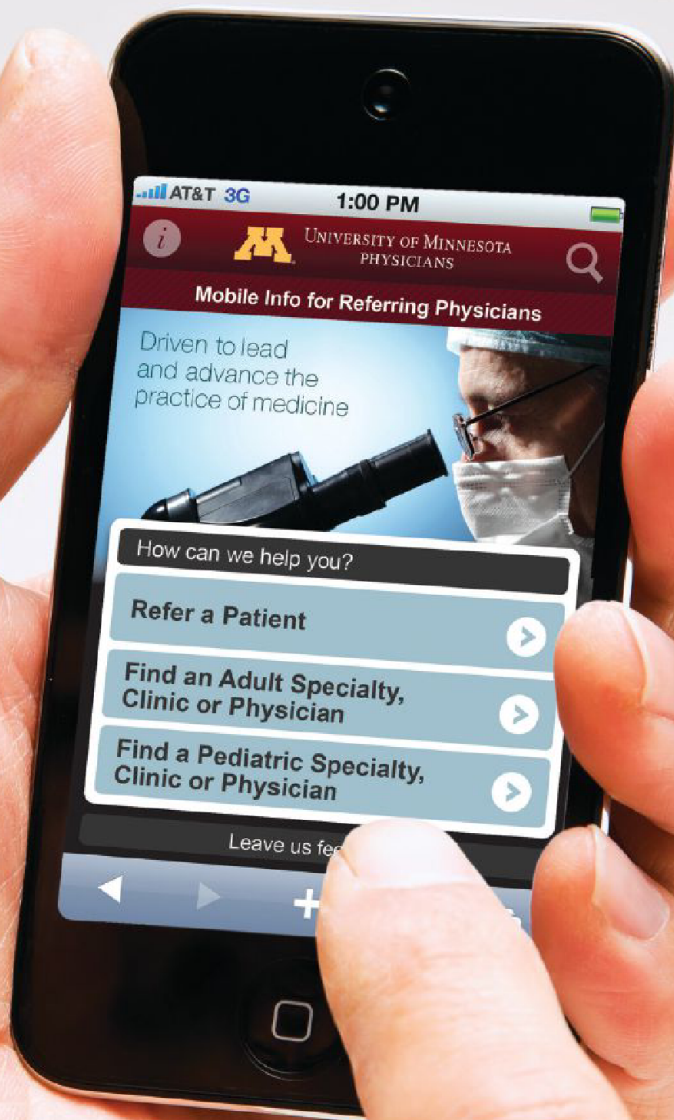
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