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Aging with Grace

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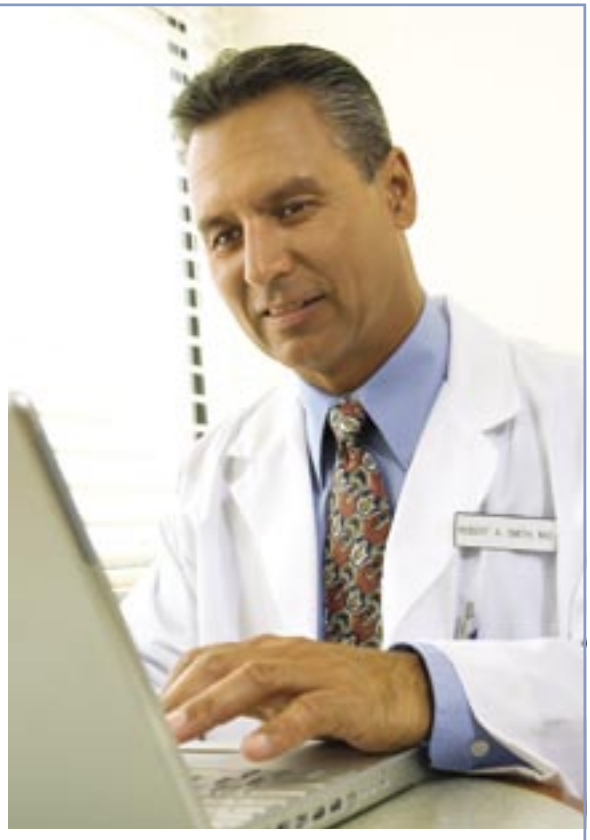

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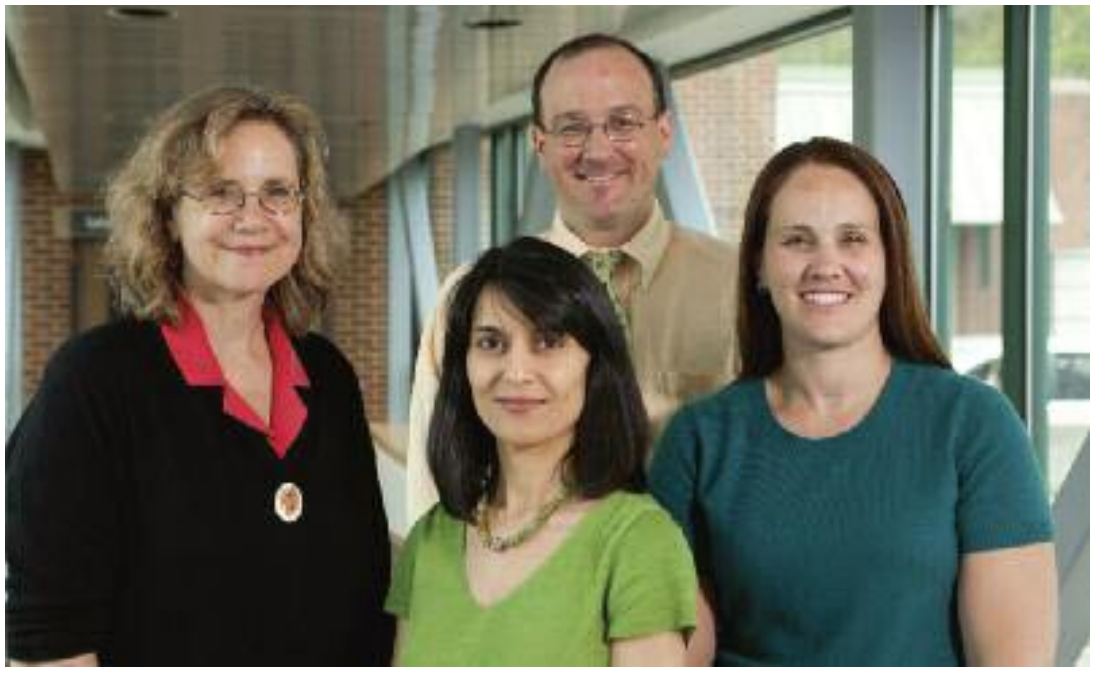

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Jane Lochrie, MD

The number of elderly patients in the United States is rapidly increasing. The over sixtyfive population has increased by a factor of eleven during the 20th century and by the year 2030 it is estimated that one out of every five Americans will be a senior citizen. Seventy-nine percent of patients over the age of seventy have at least one chronic disease; moreover, thirty percent of senior citizens have three or more chronic diseases. Eighty percent of older adults take at least one prescription medication. Over ninety percent of elderly people who need assistance with their activities of daily living rely on family for this care. This issue of Worcester Medicine explores some innovative methods that we who deliver care to our elderly population in Worcester should consider.

The first article describes the "Writer's Roundtable" at Eisenberg Assisted Living. Dr. Lucia Knoles, a Professor of English at Assumption College, has the residents there preserving their history with weekly writing assignments, giving them a new reason to live. Dr. Knowles writes a heart-wrenching letter to her father about how she perceives her father's life in an assisted living facility.

Dr. Mills describes the HomeRun Program, a joint venture between the Reliant Medical Group (formerly the Fallon Clinic) and the Fallon Community Health Plan. This novel program has hired two geriatric nurse practitioners to make home visits to elderly patients who are unable to come into their physicians' office for care. This program has been so successful both financially and clinically that there are now plans to significantly expand the HomeRun program to include the entire Worcester County.

The Worcester PACE Program via Summit ElderCare, provides coordinated, comprehensive care to older adults who are eligible for nursing home placement and allows them to remain in the community. Once the patient is enrolled, the PACE program becomes the sole source of all the participants' medical, social and insurance needs. The program, sponsored by the Fallon Community Health Plan, has been so successful that it has opened four sites since its inception in 1995 under the direction of Dr. David Wilner.

Dr. Gurwitz, who has been a frequent contributor to Worcester Medicine and is well-known in the field of patient safety and quality improvement, debunks several myths concerning medication-related risk in the geriatric population.

And finally, we have included a Point/Counterpoint on the Massachusetts Death with Dignity Act that will likely be a ballot question in 2012. Dr. Angell, who has written on this subject extensively, has offered insight into why she supports the bill. I have stepped out of my role as editor with John Smithhisler to give the opposing view.

Jane Lochrie, MD

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An Introduction to an Introduction

Joel H. Popkin, MD

Joel H. Popkin, MD

Dr. Lucia Knoles is a renowned Professor of English at Assumption College where, more than a decade ago, she co-directed the first faculty development seminar on teaching, learning, and technology. Ultimately she provided the vision for Assumption's Instructional Technology Center. Among so many other notable achievements, Lucia has served in a variety of posts, including Chair of the English Department, Assistant Dean of Studies, and Assistant to the Provost and Assistant Dean of Faculty. This year she received the "Michael O'Shea Award for Excellence in Teaching."

Lucia also advocates for the residents of the Jewish Health Center in Worcester, having created a series of literature classes for the aged, and more recently a blossoming "Writers' Roundtable" which includes my 100 year old mother, Mollie Galub ~ a devout Lucia fan. Since Mollie became Lucia's student, she has felt compelled to write continuously, and we had to end up sharply paring down her notes that follow about what Lucia has meant to her. But I'll have her talk about that.

Dr. Lucia Knoles and the Writers' Roundtable ~ a Student's Perspective

Mollie P. Galub, a resident at Eisenberg Assisted Living

Mollie P. Galub

I was a busy wife, mother, and teacher. Looking back, it is hard to imagine how it all got done. But this existence was so wrapped in love and my sense of duty that I did it happily, in giving joy to the most important people in my world. Any sacrifices on my part have been well repaid by the total love of my children, who grew up almost too soon. There were heartaches along the way, of course – the loss of two caring husbands and the utter sense of loneliness and despair those tragic deaths wrought. A needed coping step was going back to school at the New School for Social Research, where I learned well beyond what a master's program at Columbia had taught me decades earlier about research and giving talks on scholarly topics. Then, a couple of years ago, when wintering in Florida, some bug got hold of me, causing some lung and heart damage. With Death stalking around my bed, my children literally saved my life, transforming it by pushing me at age 98½ to move up to the Eisenberg Assisted Living Residence in Worcester, where I now reside.

Eisenberg is a wonderful facility, with a deeply caring staff, a warm and comforting environment, and delicious food. A truly remarkable feature has been the visits of Professor Lucia Knoles from Assumption College. Lucia has created a challenging "Writers' Roundtable" that has made us all ~ including her father ~ pick up pen and paper. (Maybe in a few more years I'll figure out how to peck on a keyboard.) She immediately had us pour out stories and memories, keeping us on our toes with weekly assignments. It's like being in school again, but a lot more fun. She's told us to forget about grammar and punctuation and instead bare our souls ~ to write from the heart as if we're talking with someone. We each read our papers aloud. What amazing life stories emerge! My cup often runneth over.

Lucia inspires many young people, of course, and she has had them directly interacting with us elders, which inspires us in turn. Life is good again. In fact, it is fabulous! In the transition I didn't die or go crazy, in part because I am busy again, including writing and giving advice from an old crow who just turned 100 to get off that chair and head towards new adventures. My professor and friend Lucia Knoles has the wings of an angel.

A Letter to My Father about the Meaning of Life

Reflections on Aging, Assisted Living, and Autobiography Writing

Dr. Lucia Knoles

Dr. Lucia Knoles

Dear Dad,

You've said you're bored, and my lawyer-brother can't understand why. He thinks it sounds great to be able to watch films, take trips to ice-cream shops, and play games instead of having to work late over legal papers. It's hard for him to understand your frustrations because he doesn't have enough time and you have too much.

When you say you are bored, I think you mean that none of the activities at your assisted living residence give you the sense of purpose you once earned by running a trucking company, building a home, and being a husband and father. Clearly, you're not the only one who feels this way. I notice your fellow residents walk around clutching the yellow schedule of activities for the week. "We try hard to fill up the time," one person explains.

I suspect we all need "something to do" and something more ~ a sense of purpose. I notice that two of the people who seem most contented in your residence use their talents to contribute to your community: one plays the piano for people after dinner, the other researches subjects that interest her and gives lectures to the other residents.

You also say you're lonely, Dad. No wonder. You're a man in a sea of women, a Catholic in a kosher building, a red-state guy among a bunch of blue-staters. Remember the first time you played in the regular Sunday afternoon poker game? You came back and grumped, "That was just a bunch of old ladies bickering." None of the well-dressed ladies sitting around the table looked or talked like the teamsters, cops, and businessmen who used to be part of your regular poker game back home.

But that can't be all of it because even the women at your residence suffer bouts of loneliness. People miss the friends who really KNEW them back in their old neighborhoods and workplaces. They miss the husbands and wives who have died. One woman admits to me that she cries at night when alone in her apartment remembering her husband,and concludes, gesturing around her, "What we have in common is loss."

So when you ask me, "What is the meaning of life, after all?" I know you are trying to make sense of the repeated losses of your own recent life.

It's a bad time to ask me. I've been thinking about loss too. For a year and a half I've watched you struggle to adjust to the calamities of age and the limitations of life in an assisted living residence. I've watched mom be swept away by Alzheimer's and die in a nursing home.

Who am I to answer your question? Not a philosopher, psychiatrist, or priest ~ just an English teacher. So I thought perhaps by teaching an autobiography-writing course in your residence, I would give people one more thing to occupy them, perhaps something more. And now seven months later, I'm beginning to understand what that "more" is.

My plan was simple. We would meet once a week to read aloud from published autobiographies, talk about writing, and share what we had written since the previous class. One morning each week I would have "office hours" to help people with their writing ~ which sometimes meant transcribing their stories on my laptop while they spoke.

Do you remember how we worried when only one or two people showed up at the first sessions of our "Writers' Roundtable?" Now we need three roundtables to accommodate all the people who want to share their stories.

I think that the Roundtable gives participants a sense that they are using time rather than using it up. Writing in the privacy of their own apartments or discussing their stories in class engages people's

minds and allows them to produce something they can be proud of. I was struck by the transformation of our class members as they came before the public as authors for the first time the night we held our reading for residents, family members, and friends. Everyone was dressed up. Cheeks were flushed, eyes were bright, deep seriousness was periodically punctuated with excited laughing. One teenage boy said to me, "I've never seen my grandmother like this. She's not like this when she comes to our house for dinner." The explanation? As one class member later wrote about that night: "I'd thought I was a cast-off. I found out that I'm a writer."

And I think you and your classmates have begun to understand that even if you feel lonely, you're not really alone. Everyone listened carefully the day you read aloud your piece called "Solitude," beginning: "A person can walk down 42nd street in New York and still be alone. Although I live in close contact with other people, I feel that the days of my life are ticking away in a lonely private environment of solitude." There was silence until you came to the end, where you described mom being taken to the nursing home, and concluded: "Now she is gone. I get up at night and I think she is still there. But she's not. I'm alone."

All the people around the tables knew what you were talking about; they've all gone through the same thing. The woman who talks about her own nighttime loneliness wiped tears away from her eyes and laughed, saying, "That's why we keep inviting you to play poker, Joe!" (And I've noticed you've been dropping in on the game more since she said that.) I think that sharing your autobiographies has made it possible to see that what connects you is more important than what sets you apart from one another. This class has convinced me that Steinbeck was right when he wrote:

We are lonesome animals. We spend all of our life trying to be less lonesome. One of our ancient methods is to tell a story begging the listener to say-and to feel- 'Yes, that is the way it is, or at least that is the way I feel it.' You're not as alone as you thought.

I'm not sure what you and I expected when we started this course ~ perhaps funny stories about the model T or warm reminiscences of Gramps ~ but I've been surprised by the number of pieces that reveal people in their eighties and nineties still struggling to make sense of their lives. I should have known angst isn't just for adolescents. One woman writes about her sense of abandonment as a young girl when her mother suddenly died. Two more write about fathers who never expressed love or approval. And you, of course, write about Mom. Shortly after Mom died, you began reading a new piece aloud to the class: "While Bridget was fixing Sunday dinner she called a fork a spoon and I immediately realized that our lives had just changed forever." Mom was one of the most formidably competent women I have ever known, and in your story you tell of watching as the incredible woman you had married was gradually replaced by a series of childlike characters who danced unreservedly in front of strangers, kicked nurses who tried to give her injections, and fell out of her chair in her enthusiasm playing kickball. Rather than fall headfirst down into the hole of loss, you write of loving the precious time you had with "the dancer, the snuggler, the smiling patient, the kickball player and the special friend to others that we had not met before." Although I'd once worried that mom's Alzheimer's behavior would embarrass you, I realized that wouldn't happen the day towards the end when you pointed, smiling, towards mom cuddling a blonde-haired baby doll and said, "Now you know how beautifully you were held when you were a baby." And so it didn't surprise me when you concluded your essay:

I . . . now believe that the bottom line of her story is that whether the unfortunate person is a loved one or friend or patient they deserve our respect and above all our love. By giving them those things we are not only improving their lives but also our own, not only enhancing their human dignity but enhancing our own as well.

Throughout the years of mom's long illness, we felt like victims of fate with little control over our destinies. Now, in your writing, you seem to be taking control of the story of your life. You are choosing its meaning.

Dad, I don't think life is like a math question that has a right answer. Instead, I think we need to find some sense of purpose, a sense of belonging to a community, and a way of finding meaning in the events of our life. I think that's what you've been doing in the autobiography course, and I think the other students have too. Do you know how I answer when people ask me how you're doing? I say you're capable of occasional bouts of happiness. And I know that in a time of grief, walking each week into that room of bright, eager, and caring people and listening to them share the stories of their lives has brought me a sense of purpose, community, and meaning. For which I'm profoundly grateful.

Your loving daughter,
Lucia

"Home Is Where the Heart Is…"

Charles S. Mills, MD, FACP

Charles S. Mills, MD, FACP

In an era in which there is pressure on medical systems and providers to be ever more productive, the thought of a return to a home visit format for doctor visits would seem illogical. Yet, Fallon Clinic (Reliant Medical Group) and the Fallon Community Health Plan formulated just such thinking into a plan of action.

Starting in 2008 and coming to fruition in 2009, the health plan, under the leadership of its CMO, Dr. Elizabeth Malko, M.D., and the clinic, under the guidance of its quality/management medical director, Michael Kelleher, M.D., formulated a system to address issues of care deficiencies in the Fallon Senior Plan population.

A feeling existed that somewhere within the global population of elderly enrollees there likely was a population of patients who were getting sicker while unable to access care sufficiently early on in their decline. Such a situation could be projected to increase institutional needs/risks. Therefore, to address this premise, the HomeRun program was created. This program's focus was on patients with a frequent number of hospitalizations and ER visits. Concurrently, patients who met these criteria and also seemed to lack consistent follow up with their PCPs defined a secondary population boundary.

In conjunction with the home care support structure of the VNA CareNet, a team was formulated with two geriatric NPs going into the homes of patients identified as eligible for the program. These NPs would work directly with the patients' PCP and also with the guidance/support of Dr. Charles S. Mills, M.D. from the department of geriatrics at Fallon Clinic. The patients' PCPs were encouraged to give their feedback both for the enrollment of other patients and as to whether the patients identified by data search were appropriate from their perspective. This collaboration and involvement of the PCP was critical to the buy-in and acceptance of the patient for the program.

Due to the constraints of staffing volume, the program was limited to an initial enrollment of 150 patients. The geographic locale for the program had to be kept fairly tight to limit time loss in travel. Given these conditions, the patients had to reside within Worcester city limits or the contiguous towns.

The program has not only been successful financially but it has also created opportunities of insight relative to the care of this population of frail elderly patients. First, the premises of inclusion that were initially applied have been amended a couple of times over the past two years. Specifically, risk modeling tools such as the DXCG scores used to predict the likelihood of a patient increasing risk for future utilization did not correlate well with the experience of the providers going into the homes. The team came to recognize that the patients most appropriate for the program more often than not were those who were suggested directly by their PCPs.

Once a patient was considered, his or her chart was reviewed for all pertinent medical risk and particularly for signs of functional change and/or decline. The PCPs' sense of their patients' need was most often confirmed at the time of visit.

The program also acts as an adjunct to the PCPs' voice and directives to their patient. But these conversations, when placed into the context of a patient's home, are received differently. The capacity to engage in concrete discussions of additional care support needs in the home, the possible need for out-of-home support programs such as Summit Elder Service Plan or adult day healthcare, or the need for honest assessment of end-of-life needs such as hospice care are all elements of care enhancement that lead to reduce risks.

Equally important to these conversations is the skilled vision of the providers going into the home. The notes from these providers reflecting the reality of the settings in which patients live can help the

PCP better understand the limits of care directives given in the pristine setting of a routine office visit. The patient's capacity to create the image of stability and functionality at the time of an office visit often dissolves once an NP or MD is actually witness to his/her status in the home.

Finally, the program's HomeRun Club, a monthly meeting at Summit Elder Service Plan's site on Grafton Street, adds an additional therapeutic benefit for enrollees. Many home visit programs have included an out-of-home component to this model of care. Some of these have patients attending a routine physical therapy group session. Some were structured simply for added socialization. In the case of HomeRun, a monthly program of topic presentations (e.g. elder scams, pharmacy issues, seasonal vaccination updates, etc.), a light meal and transportation to and from the site has been successfully implemented.

Although the majority of the HomeRun patients do not attend, on average 20-30 patients come routinely. Those who attend do enjoy the fellowship of the new friendships that they develop along with the bonds formed with the HomeRun staff. The program is managed by a social worker, Brenda Geron, under the care management department of FCHP.

As a result of the success witnessed to date in this program, there are active efforts to expand it to the whole of Worcester County. Presently, we are recruiting new geriatric NP and physician time to allow for such growth.

So in a world of "new and better," it's nice to see that something "tried and true" can be rediscovered. It's also affirming to know that the PCPs' senses are still reliable barometers of their patients' needs. And, at least in the case of the HomeRun program, it's rewarding to be able to assist the doctor in improving some of their patients' risks.

Charles S. Mills, MD, FACP, is Director, Post-Acute Care Reliant Medical Group and Director, HomeRun Program, Department of Geriatrics.

holy trinity

Death With Dignity: It's Time

Marcia Angell, MD

Marcia Angell, MD

Probably most physicians have seen terminally ill patients who, despite excellent palliative care, find their suffering no longer bearable and ask their physicians for medication to bring about an earlier, more peaceful death. These are heartbreaking cases. Although nearly all pain can be relieved, some cannot, and other symptoms, such as breathlessness, nausea and weakness, are even more difficult to control. The realization that the situation can only grow worse adds to the suffering. Worst of all, according to data from Oregon, is the loss of autonomy and dignity that such patients feel.

Many compassionate physicians would like very much to help such patients hasten their deaths, but worry about possible liability. That is the reason for the Massachusetts Death with Dignity Act, which is likely to be on the 2012 ballot. The proposal is the same as the Oregon Death with Dignity law that has been in effect for 14 years. It enables mentally competent adults who have an incurable disease that their physicians believe will cause death within six months to request drugs to end their lives if and when they choose. To make certain the request is well-considered, it must be made twice, separated by at least 15 days, and two witnesses have to agree that it is the patient's wish. Most important, the medication is swallowed, not injected, so the decision is clearly voluntary.

If the ballot initiative is successful, it will become law in Massachusetts. How has it worked in Oregon? Since the Oregon law was implemented in 1997, assisted dying has been used sparingly and exactly as intended. It has accounted for 525 deaths, only 0.2 percent of total deaths in Oregon in the most recent year. Most patients were suffering from cancer, and most were relatively well-educated and well-insured. Notably, over 90 percent were receiving hospice care. About a third did not use the medication they were prescribed, but simply kept it on hand in case they eventually did want to use it. It provided peace of mind.

There will be intense opposition to the Massachusetts ballot initiative, and much of it will be not only overheated, but misleading, so it's important to clarify several key points.

First, this is not a debate about life vs. death. All of the patients concerned will be close to death; the debate is about the manner of death.

Second, the Act does not require physicians to provide medication to patients who request it if they do not wish to do so. It simply provides one more choice for both physicians and patients as they deal with terminal illness. In the great majority of cases, both physicians and patients find palliative care sufficient. Assisted dying would be reserved for those cases in which both physician and patient agree that it is not. It would be a choice, not a requirement.

Third, the evidence from Oregon and Washington (where assisted dying has been legal for almost three years) is that, far from undermining palliative care, the availability of assisted dying has improved access to good palliative care. Assisted dying and palliative care are no more mutually exclusive than medical treatment of heart failure and heart transplantation; one is used when the other fails.

Fourth, opponents will protest that patients who request an earlier death may simply be depressed, and should be referred for psychiatric help. But good studies from Oregon show that depression is no more common in patients who request assisted dying than in other terminally ill patients. Moreover, it is extremely difficult to diagnose depression in dying patients, since the symptoms overlap with those of terminal illness, and in any case, there are few good studies of whether it can be successfully treated in this context. If

physicians believe that depression is distorting a patient's judgment, they need not comply with the request, but can offer a referral for psychiatric care.

Despite the strong opposition, I am convinced that the Death with Dignity Act will support Massachusetts physicians in practicing compassionate medicine. They will be able to fulfill more completely their two most important obligations to their patients: first, to respect their patients' autonomy, and second, to relieve suffering. Before assisting a patient's death, physicians should be certain that it will fulfill both these obligations. Physicians should not honor a request for assisted dying if the patient is not suffering from an incurable disease, nor should they hasten death if the patient does not request it. But where both conditions are met, assisted dying is simply good medicine, just as it is good medicine to withdraw unwanted life-sustaining treatment, such as dialysis or a ventilator.

Arguments against the Death with Dignity Act seem to stem from the paternalistic notion that terminally ill patients can't be trusted to know what they want. But patients do not have to be protected from themselves. They are the ones to say when their suffering has become intolerable, and physicians should be able to stand with them without fear of retribution. Death is hard enough without being forced to endure protracted agony.

Dr. Marcia Angell is senior lecturer in social medicine at Harvard Medical School and former editor-in-chief of the New England Journal of Medicine.

Primum, Non Nocere

Jane Lochrie, MD and John Smithhisler

Jane Lochrie, MD

John Smithhisler

Primum, non nocre (First, do no harm) is one of the fundamental principles of medical ethics and is taught to all medical students around the world. This basic precept of the medical profession is being threatened by the initiative petition for the Massachusetts Death with Dignity Act that will authorize Massachusetts physicians to provide lethal dosages of medication to certain patients with a terminal illness at their request. The proponents claim that the Act will ensure choice, safeguards, and the compassionate end of suffering. But it is fair to ask if this claim is true.

Patients are most vulnerable at the end of life. These seriously ill patients are not only suffering from physical pain but are often overwhelmed by fear, isolation, loss of independence and thoughts of being a burden to their families. This psychological suffering often leads to thoughts of suicide and requests for physician-assisted suicide. The factor most commonly cited in the request for physician-assisted suicide is not intractable pain; the concern is rather about lack of control, being a burden to others, being unable to care for oneself, and fear of severe pain in the future.[1]

Physician-assisted suicide is not the answer to this dilemma. The American College of Physicians published a position paper that states, "After carefully considering all the arguments, the ACP-ASIM is opposed to the legalization of physician-assisted suicide, even in limited circumstances. Legalization would undermine the patient-physician relationship and the trust necessary to sustain it; and endanger the value our society places on life, especially on the lives of the disabled, incompetent and vulnerable individuals."[2]

It is the responsibility of every physician to optimize the health and well-being of his/her patients and to alleviate pain and suffering. Palliative care is now a recognized subspecialty by the American Board of Medical Subspecialties. Most academic medical centers and many other hospitals have palliative care and hospice consultation services. The multidisciplinary approach of palliative care can address the pain and suffering of all patients. In particular, all pain can be treated.[3] Despite attempts by proponents to speak as if physician-assisted suicide is a part of palliative care, it is completely contrary to palliative care. Physician-assisted suicide is lethal, not symptom-relieving; its trajectory is away from life-affirming palliative care and toward ending life.

Is it compassionate care to leave these patients to their suicidal impulses or vulnerable to the potential self-serving motives of those who may benefit from their deaths? The petition does not require psychiatric evaluation in every case either at the time of the request or at the time of ingestion of the medication. Patients who are clinically depressed may nevertheless be cleared by physicians if in the subjective opinion of the physician the patient does not have impaired judgment. The physician is only required to "inform" the patient about palliative care and hospice, but this leaves such wide latitude of interpretation that many patients will not receive appropriate palliative care from which they would benefit.

The proponents claim that physician-assisted suicide should be allowed because physician-assisted suicide and withdrawing or withholding life-sustaining treatment that is disproportionate are equivalent. In fact, these actions are radically different. Physician-assisted suicide utilizes a directly lethal agent; palliative medicine removes disproportionate treatment but continues care that is appropriate for the condition of the patient. Physician-assisted suicide is designed to end the patient, not the suffering; palliative medicine supports the patient.

The most significant challenge confronting health care today is financial. In this era of health care reform, it is up to us to make hospice and palliative care the standard of care for every patient who requires it. Unfortunately, it is less expensive to end a life than to provide the appropriate end of life care. There is every reason to believe that the knowledge and use of palliative care will suffer

over time wherever physician-assisted suicide becomes legal, as is shown in the case of the Netherlands and in Oregon.[4] Significantly, there is no requirement in this petition for the attending or consulting physician to be knowledgeable about palliative care or to make a palliative care referral.

Physicians will also be swept up in a process that only gives the illusion of freedom, choice, and safeguards. For example, there is only a vague mention that patients have an "appreciation of the relevant facts." However, there are no criteria for determining capacity, nothing that takes account of the ebb and flow of patient capacity, and no requirement to ascertain capacity at the time of ingestion. Physicians will be required to give a prognosis of an incurable and irreversible terminal disease that will likely take the person's life within six months, but this timeframe does not need to be an assessment based on treatment. Patients whom physicians determine are depressed may nevertheless be cleared. Physicians are required only to recommend that the patient notify next of kin and to advise about the importance of having another person present at the time of ingestion, and no physician is required to be present when the drug is ingested.

These barriers to genuine informed choice, together with the other deficient safeguards in the petition, set both physician and patient on a path that diminishes opportunities for appropriate palliative care and weakens a patient's ability to reverse the course toward suicide. Physicians ought not be caught in the middle of this ill-advised petition but instead should remain single-minded in what they do best ~ provide appropriate nurture and care to life.

Jane Lochrie, MD is the Program Director for the Internal Medicine Residency Program at St. Vincent Hospital.

John Smithhisler is the former President and CEO at St. Vincent Hospital.

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Summit ElderCare

Part of the Program of All-Inclusive Care of the Elderly (PACE)

David Wilner, MD

David Wilner, MD

Older adults often fear placement in nursing homes and overwhelmingly tell us that they want to stay at home and "age in place." But as we accumulate chronic illnesses and start to need help with our activities and independent activities of daily living, it becomes hard to maintain independence and to coordinate all one's care needs. The doctor can evaluate and prescribe for medical issues, but what about the psycho-social needs and coordination of the insurance benefits? A number of programs are available, but eventually the selection of which program and the coordination of programs becomes increasingly challenging for patients and their families as they seek to avoid nursing home placement.

Many of us are hearing about or waiting for newer models of care ~ such as Patient Centered Medical Homes and Accountable Care Organizations ~ to be developed with the anticipation and hope that as these models of care are developed, they will improve the coordination and effectiveness of care for populations of patients. However, there currently exists a successful, viable, and effective program that coordinates the medical, psycho-social, and insurance needs of older adults; it is called the Program of All Inclusive Care for the Elderly (PACE). In Central Massachusetts, the PACE program is Summit ElderCare.

This CMS program, active in Massachusetts since 1991 and in Worcester since 1995, was initially locally known as Elder Service Plan and currently as Summit ElderCare. It provides a coordinated, comprehensive care program to help older adults at risk of nursing home placement remain in the community. By combining medical care, social care, and insurance into one program, it allows one team of geriatric professional staff to concentrate on one set of participants. Summit ElderCare is Central Massachusetts' PACE program with 4 sites: on East Mountain Street and Grafton Street in Worcester, in Leominster, and in Charlton. It is a program sponsored by Fallon Community Health Plan that is open to anyone currently receiving Medicare benefits who chooses PACE as his/her Medicare benefit and who meets the following three criteria:

- Is at least 55 years old
- Lives in the PACE service area (which in Central Massachusetts is currently all of Worcester County plus Marlborough and Hudson)
- Is certified as eligible for nursing home care by the relevant Massachusetts Aging Service Access Point (ASAP)
- Is determined to be safe to live in the community with services and support after the initial evaluation by the PACE Interdisciplinary Team (IDT)

Once enrolled, the PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees and the IDT coordinates and arranges the provision of all needed care.

Summit ElderCare, as part of the Program of All-Inclusive Care for the Elderly, is a capitated benefit authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. The program is modeled on the system of acute and long-term care services developed by On Lok Senior Health Services in San Francisco, California. The model was tested through CMS (then HCFA) demonstration projects that began in the mid-1980s. The PACE model was developed to address the needs of long-term care clients, providers, and payers. For most participants, the comprehensive service package permits them to continue living at home while receiving services rather than be institutionalized. Capitated financing allows providers to deliver all services participants need rather than be limited to those reimbursable under the Medicare and Medicaid fee-for-service systems.

The Balanced Budget Act established the PACE model of care as a permanent entity within the Medicare program and Massachusetts Executive Office of Elder Affairs encouraged Massachusetts non-for-profit organizations to provide PACE services to Medicaid beneficiaries as a state option.

At Summit ElderCare, an interdisciplinary team consisting of professional and paraprofessional staff assesses participants' needs, develops care plans, and delivers all services (including acute care services and, when necessary, nursing facility services) which are integrated for a seamless provision of total care. PACE programs provide social and medical services primarily in an adult day health center, supplemented by in-home and referral services in accordance with the participants' needs. The PACE service package includes all Medicare and Medicaid covered services, plus other services determined necessary by the interdisciplinary team for the care of the PACE participant.

The PACE organization receives monthly Medicare and Medicaid capitation payments for each eligible enrollee. Medicare eligible participants who are not eligible for Medicaid pay monthly premiums equal to the Medicaid capitation amount, but no deductibles, coinsurance, or other type of Medicare or Medicaid cost-sharing applies.

PACE was one of three programs researchers identified as models of long term care that are effective, efficient and less expensive than traditional long term care in a study whose findings appeared in the November 3, 2010 issue of the Journal of the American Medical Association (JAMA).

Summit ElderCare currently provides care for almost 900 older adults and is successful in helping most of them to remain living in their own homes or other community settings. Its medical staff of 8 geriatricians and 6 nurse practitioners have expertise in providing primary medical care for older adults, including management of multiple chronic conditions, palliative care, and end-of-life care. Other team members using their expertise in the older population include social workers, physical and occupational therapists, activity therapists, transportation coordinators, home care nurses and home health aides, nurses and medical office assistants, and business staff.

For more information on Summit ElderCare and the Program of All Inclusive Care for the Elderly, see www.summiteldercare.org and its related links.

David Wilner, MD, is a Geriatrician and Medical Director of Summit ElderCare.

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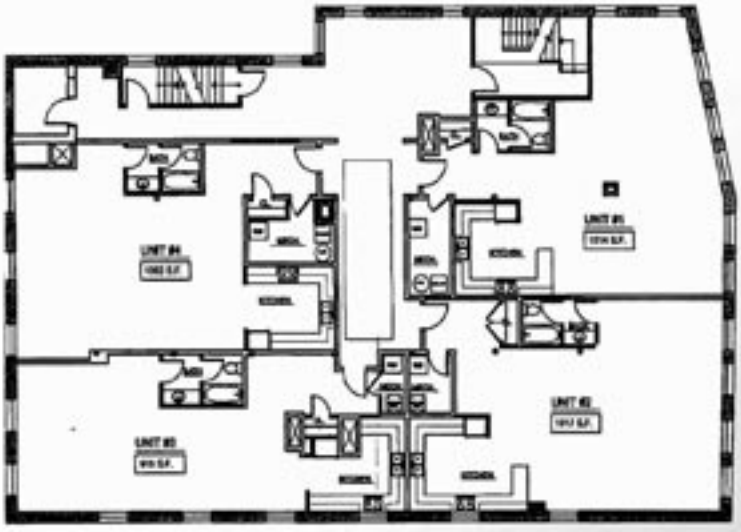

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Improving Medication Safety in Older Adults: Beliefs and Myths

Jerry H. Gurwitz, MD

Jerry H. Gurwitz, MD

"It is much easier to write upon a disease than upon a remedy. The former is in the hands of nature and a faithful observer with an eye of tolerable judgment cannot fail to delineate a likeness. The latter will ever be subject to the whim, the inaccuracies, and the blunder of mankind." William Withering (1741 – 1799)

While William Withering wrote these words over two centuries ago, his quote continues to capture the way in which medications are often used in our older patients. There are multiple factors that place the elderly at special risk for adverse drug effects. Older patients often have multiple co-existing illnesses leading to the use of complex drug regimens. Polypharmacy can lead to redundant drug effects and increased risk of serious drug-drug interactions. Adverse drug effects are often non-specific and go unrecognized in older patients. In addition, there are a number of pharmacologic changes that occur with aging, potentially increasing risk. Finally, errors in medication management leading to near-misses, close calls, and preventable drug-related injuries occur frequently in older patients.

While the issue of medication safety in older adults is an ongoing concern, there exist a number of widely held but misleading beliefs relevant to the use of medications in the elderly. A careful examination of these beliefs may encourage new ways of approaching the problem of medication-related risk in the growing geriatric patient population.

Belief 1: Knowing geriatric pharmacology means you know geriatric pharmacotherapy.

Substantial age-related pharmacologic changes theoretically increase the risk of adverse drug effects in older patients. These pharmacologic changes include altered pharmacokinetics (what the body does to the drug) and pharmacodynamics (what that drug does to the body). The half-life of many drugs, particularly those that are very lipid soluble, increases markedly with advancing age, a pharmacokinetic change with aging. In addition, with advancing age, we become more sensitive to the effects of many types of medications (e.g., benzodiazepines, opioids, and warfarin), a pharmacodynamic change that occurs independent of any pharmacokinetic changes. For these reasons, it has been dogma in the care of geriatric patients that prescribing shorter half-life medications reduces the risk of adverse effects. For example, in the case of benzodiazepines, shorter half-life agents (e.g., lorazepam) might be considered safer to prescribe to older patients than longer half-life agents (e.g., diazepam). However, a study published in the Archives of Internal Medicine in 2004 by Wagner and colleagues challenged that assumption, finding that the risk of hip fracture in older patients was not reduced among patients prescribed shorter half-life benzodiazepines relative to longer half-life agents. Risk was increased with use of any benzodiazepine and was especially high during the first two weeks after starting therapy. The take away message from this study is that all sedatives must be used cautiously in any older patient and the prescriber should be especially vigilant during the initial period after starting a sedating agent. Furthermore, the pharmacokinetic characteristics of a drug cannot be relied on to ensure safe prescribing in older patients.

Belief 2: Although older adults may frequently experience adverse drug events, generally they are not preventable.

Numerous studies have examined the occurrence of adverse drug events (drug-related injuries) in older patients across all settings of care. For example, a study conducted by the Meyers Primary Care Institute that focused on the ambulatory setting found that adverse drug events occurred at a rate of 50 per year for every 1000 persons

age 65 and older. More than a quarter of these events were considered preventable, as they were associated with one or more errors in prescribing, dispensing, monitoring, and patient adherence. If the findings of this study are generalized to the population of all Medicare enrollees, then nearly two million drug-related injuries occur per year. In addition, estimates based on this study suggest that there may be in excess of 180,000 life-threatening or fatal adverse drug events in the Medicare population, of which more than half may be preventable.

Belief 3: If we could eliminate use of inappropriate "bad drugs," we could eliminate most drug-related problems in older adults.

Patient safety and quality improvement efforts relevant to improving medication safety in older adults commonly focus on discouraging use of a limited list of "high risk" medications. One such list of these medications is commonly referred to as the "Beers criteria," named for Dr. Mark Beers, a geriatrician who developed the original version of the list in 1991. Since that time, the list has been modified numerous times, and an updated version is due to be released by the American Geriatrics Society in 2012. Unfortunately, many studies have demonstrated that most adverse drug events in older patients are not associated with drugs included in the Beers criteria. For example, a national study of older patients presenting to emergency departments for visits relating to medication use found that less than 4% of all visits were associated with Beers criteria drugs. The medications most commonly associated with hospitalizations following emergency departments visits by older patients were warfarin, insulin, oral antiplatelet agents, and oral hypoglycemic medications; few hospitalizations result from drugs that are typically designated inappropriate in the elderly. It is essential that health care providers be vigilant with regard to use of all medications in older patients. Improved management of anticoagulant, antiplatelet, and antidiabetic medications may provide the best opportunity to improve drug safety in this vulnerable population.

Belief 4: Technology is the answer to all our problems.

With the increasing use of electronic health records that have the potential to include clinical decision support relevant to medication prescribing, there has been an expectation that the risk of drug-related injuries, especially for older patients, can be substantially reduced through these technologies. While many studies have demonstrated that the quality of prescribing can be improved by providing clinical decision support embedded within a computerized order entry system, few if any studies have shown that the risk of drug-related injuries can be reduced by use of these systems alone. To some extent, this is attributable to the limits of these technologies, including their limited ability to integrate important clinical information into clinical decision support, and "alert burden" to the prescriber due to the generation of an overwhelming number of warnings. While improvements in these systems will inevitably come over time, a broader mix of interventions to reduce medication errors and preventable adverse drug events in older patients should be considered. Improving communication among health care professionals, including physicians, nurses, and pharmacists, as well as between the primary care physician and specialists, is of paramount importance. In addition, we must find better approaches for engaging our older patients as active participants in their medical care, as they are the direct beneficiaries of the care we provide, and the ones who assume the ultimate risks of the treatments we prescribe.

Recommended readings:

1. Wagner AK, Zhang F, Soumerai SB, Walker AM, Gurwitz JH, Glynn RJ, Ross-Degnan D. Benzodiazepine use and hip fractures in the elderly: Who is at greatest risk? Arch Intern Med 2004;164:1567-1572.

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3. Budnitz DS, Shehab N, Kegler SR, Richards CL. Medication use leading to emergency department visits for adverse drug events in older adults. Ann Intern Med 2007;147:755-765.

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Dr. Gurwitz is Executive Director of the Meyers Primary Care Institute, a joint endeavor of Fallon Community Health Plan, University of Massachusetts Medical School, and Reliant Medical Group. He also serves as Chief of the Division of Geriatric Medicine at University of Massachusetts Medical School.

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Worcester District Medical Society's Spoken History Project: Elliott M. Marcus, MD

Anthony Esposito, MD

Anthony Esposito, MD

In 1995, Elliott Marcus and other area physicians were interviewed by students from the University of Massachusetts Medical School (UMMS) for the Spoken History Project. The interviews were videotaped and, in some cases, transcribed; video recordings and transcribed interviews are available through the WDMS. At the time of his interview, Elliott was the Chief of the Department of Neurology at Saint Vincent Hospital, a Professor of Neurology at UMMS, and a practicing neurologist; as colleagues and readers of Worcester Medicine know, Elliott passed in July 2011.

Elliott's Spoken History Project interview is a treasure. With sparkling eyes, mischievous smiles, and baritone pronouncements, he offers comment on a host of transitions he observed during his career. For example, Elliot catalogues the technological advances in neurology, such as the disappearance of the pneumoencephalogram as a diagnostic tool and the ascension of the MRI, and he explains the scarcity of clinical neurologists outside of Boston and other metropolitan centers until the 1960s. His observations on how shifting reimbursement models have influenced the doctor-patient relationship and the ratio of medical generalists to specialists are provocative; his comments on the impact of budgetary constraints spawned by the Vietnam War and President Johnson's Great Society on medical research are informative.

What is most engaging about Elliot's interview, however, is the story of his becoming a distinguished clinician, educator and scientist. "I was interested in science," he reflects. "I had gone to Yale as an undergraduate, and I was an intensive major in psychology. The idea of seeing how the mind worked, of seeing how the nervous system worked, appealed to me. I was going to go into psychiatry [here he smiles amusedly]…but in my last year at Yale, I had a seminar by a man named Frank Beach who was teaching psychobiology. Frank Beach was actually teaching neurosciences, but they had not coined the name yet, and what he was talking about was the biologic approach to understanding behavior.

I came to medical school [at Tufts] and was interested in pursuing projects in the area of psychiatric research…[what] I found was C. Wesley Watson, a new guy in the neurology department who was interested in the things I was interested in, like the biologic basis of behavior…I studied with him as a medical student and eventually, I became his Sherlock Holmes. C. Wesley Watson was interested in studying epilepsy and that's how I got interested in studying epilepsy…Most of my career was related to research in epilepsy and teaching of neurosciences..."

And for those considering a career in medicine, Elliott offers timeless advice: "I certainly would advise people to go into medicine in spite of the many, many challenges. You have to look beyond all of the various hassles…you have to look at the many opportunities. Medicine is one of the few professions where you can go in and you can do multiple possible things. What specific advice do I have? First, avoid debt so that you can keep your options open….Second, don't go into an area just because you think it is going to give you high remuneration…There are things in the world and in life other than medicine. You should be broadly educated and you should enjoy doing those things you enjoy doing."

Apt advice indeed from a man whose interests were as broad as the seas he sailed and whose pleasure in scholarly pursuits was as scintillating as the setting sun off the starboard bow.

Provider Price "Reform"

Peter J. Martin, Esq.

Peter Martin, Esq.

A 2010 Massachusetts statute created the Special Commission on Provider Price Reform tasked with the job of investigating "the rising cost of health care insurance and the impact of reimbursement rates paid by health insurers to providers." Last month, the Special Commission issued a report containing six recommendations that may be reflected in proposed legislation with significant impact on the health care provider community.

The Special Commission started with two premises: first, that health care provider price disparities are due to providers' market leverage, not quality of care or other factors, and second, that a reduction in these price variations will generate overall health care system savings. The first conclusion is based on a 2010 Attorney General study that found that price variation is not related to quality of care, sickness of the population served or the complexity of the services, or whether the provider is an academic teaching or research facility. The latter conclusion is based on a DHCFP study from earlier this year which stated that if price disparities were limited to within a range from the 20th to the 80th percentile of payments for inpatient hospital and physician and professional services, total savings would approximate $267 million.

While one can quibble with the diagnosis ~ some hospitals participating in discussions with the Special Commission pointed to low reimbursements by federal health care programs, overcapacity of inpatient beds, and fee-for-service payments as more fundamental issues ~ the Special Commission's recommendations derive directly from that characterization of the problem.

The most startling recommendation, described as "near-term" by the Special Commission, was that an independent panel within DHCFP evaluates whether a provider should be paid more than the "market-based median" for a given service based on the quality of the service provided. If the provider loses before this panel, it must accept the lower of that market-based median price or the price paid by the insurer to the provider in its last contract. The Special Commission proposed that this process would apply to fee-for-service, global and alternative payment arrangements. This short-term mechanism would last only until the legislature determines that price variation reflects meaningful differences in quality, or other acceptable factors for variation.

Another recommendation does not assume that quality is the only acceptable reason for price differences. That recommendation is that an independent body conducts an analysis to identify acceptable and unacceptable factors for variation and then calculate the maximum reasonable adjustment to an insurer's median rate for services for each acceptable factor. The Special Commission identified quality, stand-by services, care coordination, and community-based services provided by allied health professionals as being potentially acceptable factors for variation; it stated that market power and advertising expenditures "may be among the unacceptable factors." Once the acceptable factors and their quantifiable adjustments are identified, the next step would be to use that information in a strategy designed to reduce price variation.

Another recommendation acknowledges that "a focus on price variation alone would not address other cost sources such as service mix and service volume changes." Consequently, the Special Commission recommended that "cost containment benchmarks" be adopted together with goals for the increased use of global payments or other alternative reimbursement mechanisms. If these alternative payment or cost containment milestones are not met, unspecified "state action" would take place.

Other Special Commission recommendations focused on increasing the transparency of provider prices and providing consumers "real-time calculations of expected member out-of-pocket costs" for common health care services. Still others related to monitoring provider consolidations and anti-competitive behavior as well as contracting practices that require insurers to include all locations of a provider system in a contract or pay all such locations the same prices.

While these recommendations did not include the use of straightforward rate setting, it is clear the Special Commission did not choose to adopt a market-based strategy using transparency of information, and its recommendations de-emphasized strategies focused on tiered or select provider networks. The Special Commission noted that "the majority of stakeholders" it convened to consider the issue favored strategies of price transparency, consumer incentives in the form of tiered and select provider networks, and the use of acceptable factors for price variation. Despite this feedback, the work of the Special Commission, based upon its initial characterization of the problem as stemming from price variation rather than market failure, will apparently lead to legislative proposals that would create one or more expert panels to establish acceptable factors for variation and evaluate deviations from median prices on a case-by-case basis.

Providers who may have thought that integrating into larger systems would be the best strategy for survival in a world of global payments may want to consider how these recommendations, if enacted into legislation, affect that strategy. Is the number of covered lives as important as being able to make a case for higher quality outcomes that justify higher reimbursements? Perhaps focusing on underserved populations or maximizing the use of allied health professionals is better than seeking higher volumes of "high value" procedural services. Once again, health care providers must await a new round of regulatory action to determine how best to navigate this new landscape of provider price "reform."

Peter J. Martin, Esquire, is a partner in the Worcester office of Bowditch & Dewey, LLP, whose practice concentrates on health care and non-profit law.

WDMS Remembers Its Colleagues

Elton R. Yasuna, MD
1915-2011

Elton Ralph was a dedicated ophthalmologist who practiced in Worcester for more than a half century. In later years, he delighted in being termed a "Renaissance man." Long hours in his office were the usual workday. He did not shirk civic duty, serving for six years on the Worcester School Committee, even running for state office and serving as President of the Worcester District Medical Society (1980-1).

Medical service ran in his blood: his father, brother, cousin and finally son were all physicians. His competitive nature extended to the tennis court and beyond. He and his wife Mildred (Penny) collected the work of American painters and glass artisans. His family collections were widely exhibited in museums and were finally donated in part to the Worcester Art Museum and as a memorial to the Cape Cod Museum, among others.

In his early days, he published several significant papers in his specialty. Later, he was a member of the clinical faculty of the University of Massachusetts Medical School. The style and quality of his professional service was a model practice.

Farewell, Elton; you really were a Renaissance man.

Roy R. Singer, MD

Maxwell Edward Gould, MD
1914-2010

Shortly after Dr. Gould settled in Worcester as a young primary care physician, his career was interrupted by a call for military service in World War II. While fulfilling his obligations to the United States Army, he was further trained in anesthesiology. He served with distinction in India and China, attaining the rank of Major. Upon return to Worcester, he practiced primary care and anesthesiology, an unusual combination of disciplines by today's standards, but at that time, it reflected broader interests and overlap of specialties.

Max had a very warm, friendly, and unhurried persona. His voice was strong and he was very physically fit. He engaged in regular formal exercise and athletics with colleagues at the gymnasium and
by this example, promoted wellness and illness prevention.

Dr. Gould's career spanned three generations. His kindness touched many in Central Massachusetts.

He was a fifty-year member of the Worcester District Medical Society, a member of the medical staff of four of the then six hospitals in Worcester, and he found time to become involved in the outreach of many service organizations.

Dr. Maxwell E. Gould died on August 1, 2010 at the age of ninety-six.

Leonard J. Morse, MD

orange salon

University of Massachusetts Medical Society honors UMMS faculty physicians who gave their time and service to the community and to the Massachusetts Medical Society and the Worcester District Medical Society.

Luanne E. Thorndyke, MD, F.A.C.P.

On Dec. 19, the Office of Faculty Affairs at the University of Massachusetts Medical School (UMMS) sponsored a luncheon to celebrate the service contribution of the 137 UMMS faculty, residents and student who give their time and service in leadership roles for the benefit of the Massachusetts Medical Society (MMS) and Worcester District Medical Society (WDMS).

The president of each of the societies is currently a UMMS faculty member. Over the past two years, 10 of our faculty have been presented with the societies' most prestigious awards; eight are officers (including the current Presidents of each society) and four are past Presidents. Our faculty, residents and students serve as members of a total of 53 committees (30 committees within the MMS and 23 within the WDMS). The medical school was pleased to have the administrative leaders of each of the societies attend the recognition event: Corinne Broderick, Executive Vice President of the Massachusetts Medical Society, and Joyce Cariglia, Executive Director of the Worcester District Medical Society.

Ten UMMS faculty received prestigious awards from either the Massachusetts Medical Society or Worcester District Medical Society in 2011 and 2010. One faculty member, Lynda Young, MD, received awards from both societies in 2011. Dr. Young is the 2011-2012 President of the MMS and received the 2011 WDMS Career Achievement Award. Michael Hirsch, MD, is the current President of the WDMS and 2010 recipient of the MMS's Henry Ingersoll Bowditch Award for Excellence in Public Health. Additional UMMS faculty receiving awards in 2010 or 2011 are:

- Michele Pugnaire, MD, the 2011 MMS Grant V. Rodkey, MD Award for Significant Contributions to Medical Students
- Joseph DiFranza, MD, the 2011 MMS Henry Ingersoll Bowditch Award for Excellence in Public Health
- William Lavelle, MD, the 2011 Award for Distinguished Service to the MMS
- Arthur Pappas, MD, the 2011 MMS 2011 Lifetime Achievement Award
- Hugh Silk, MD, the 2011 WDMS 21st A. Jane Fitzpatrick Community Service Award
- James Broadhurst, MD, 2010 WDMS Community Clinician of the Year Award
- Joel Popkin, MD, 2011 WDMS Community Clinician of the Year Award
- Dennis Dimitri, MD, 2010 WDMS Career Achievement Award
- Oscar E. Starobin, MD, the 2010 MMS Grant V. Rodkey, MD Award for Significant Contributions to Medical Students

It is also important to note the service of 45 UMMS residents and students, 22 of whom received awards in 2010 and 2011.

The UMMS is very proud of the service of its faculty, residents and students and looks forward to continued work with the MMS and WDMS.

Luanne E. Thorndyke, MD, F.A.C.P., is Vice Provost for Faculty Affairs at University of Massachusetts Medical School.

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