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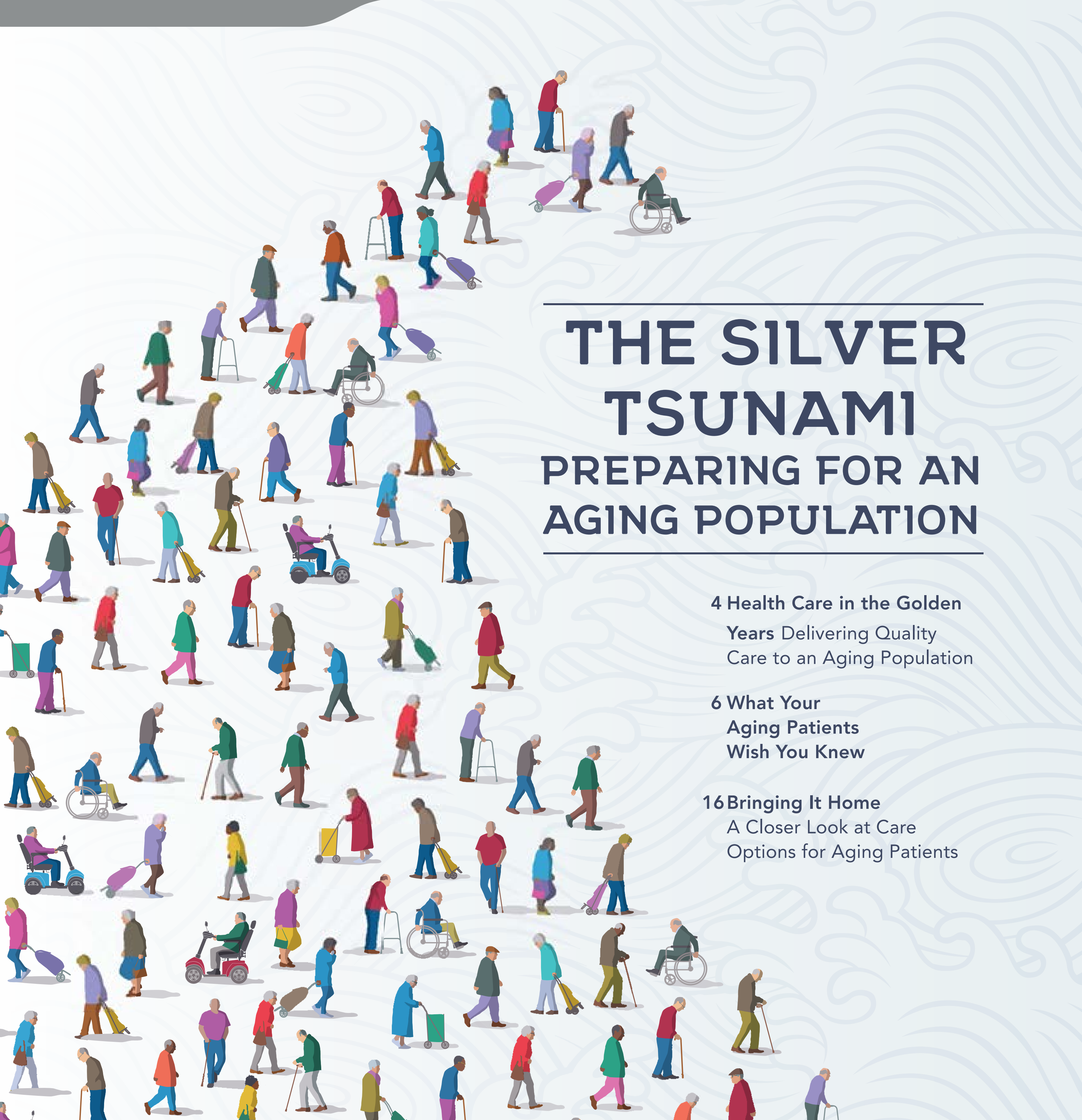

THE SILVER TSUNAMI

PREPARING FOR AN AGING POPULATION

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Delivering Care to an Aging Population

With the "silver tsunami" well on its way to landfall, America's health institutions are preparing like never before to care for an aging population.

The U.S. Census Bureau reports that by the year 2050, approximately 50 million people age 75 or older will be living in the United States. Approximately 80 percent of these older adults will have at least one chronic disease, and 77 percent will have at least two. To provide effective patient-centered care for this population, we need to work now to develop systems and infrastructures that will be both sustainable and in line with individual patient goals.

A critical factor in designing holistic care models for aging, chronically ill patients will be the effective use of interdisciplinary care teams—within practices and across organizations—that offer a broad array of expertise, with all members providing integrated care to the patient. To encourage the development of such integrated team-based systems, it is necessary to move from payment models that compensate for the volume of care provided to those that compensate for the value of care.

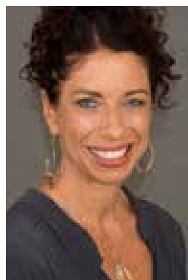
Technology advancements will continue to improve our ability to bring diagnostic and therapeutic interventions into communities and homes. Tools such as patient portals and electronic health records have paved the way for high-level communication and coordination of services, also allowing the quick relay of information to geographically dispersed caregivers, family, and support systems.

New technology, combined with the increasing patient preference to age in place, means that home-based medical care will continue to gain traction across the U.S., even though no governmental payment system yet exists to make it a sustainable model of care. Demonstration projects such as Independence at Home, and studies like Hospital-at-Home, show that when medical care is delivered in the home, there is potential for high-quality care, a better patient and caregiver experience, and cost savings.

To sustain quality care, we need to build capacity for a sufficient clinical and nonclinical workforce specifically qualified to provide this care. This includes the role of the homecare worker, which is projected to be the largest single health-care occupation by 2030.

Lastly, clinicians will need to ask the right questions to discover patients' goals for care. Doing so will help guide all decision-making to ensure that care is aligned with what is most important to patients throughout the natural course of their lives.

Working in interdisciplinary teams, focusing on our patients' values, and developing systems to provide the right care—in the right place, at the right time—will put our patients first, mitigate costly and unwanted interventions, and allow us to develop a system that delivers the best possible health care to our aging population.



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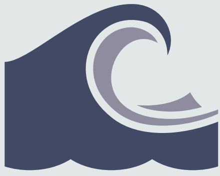

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HEALTH CARE IN THE GOLDEN YEARS

Delivering Quality Care to an Aging Population

As the owner and director of Northwest Geriatrics, a practice near Seattle, John Addison, MD, FACP, treats mostly elderly patients with one or more chronic conditions. During his medical career spanning over three decades, Addison has acquired enough information on geriatric medicine to fill a textbook or two. But he'd need to carve out time to write it—no easy feat, since demand for his practice's services continues to grow.

Addison isn't alone. Many providers treating Baby Boomers, adults born between 1946 and 1964, find that business is booming. Per the World Health Organization (WHO), today's adults are less likely to die from infections or accidents, and more likely to see their golden years, which means more adults will require health care well into their 80s and beyond.

In its Global Health and Aging Report, the WHO predicts that the global population of adults over 65 will nearly triple between 2010 and 2050, ushering in a dramatic shift in national and global demographics. By 2030, all Boomers will reach 65. Soon after, people over retirement age will outnumber youth for the first time in U.S. history. The US Census Bureau reports that by 2035, 78.0 million Americans will be older than 65, compared to 76.4 million younger than 18. Per the WHO, the population of older adults is expected to significantly outnumber children by 2050.

Though demand for senior-centered health care is swelling, the real "boom" is just beginning. The oldest Boomers, born in the 1940s, are now reaching their 70s, with another decade or so before they reach the so-called "frail elderly" stage of life. The National Institutes of Health (NIH) predicts that by 2030, the population of the "oldest old," born before 1946, will reach 9 million.

That means that providers like Addison caring for the oldest among us—our parents, neighbors, teachers, and someday, our peers—must manage increasing patient panels while preparing for even bigger challenges down the road. Meeting this burgeoning demand will require significant societal shifts in the way geriatric health care is defined, directed, and delivered.

THE ACCESS ISSUE

Access to health care is one of the top issues facing today's older patients, and disparities in access to care will continue to grow, says Robert L. Urata, M.D., a family-medicine physician in Juneau, Alaska. As a family physician in a remote, rural clinic, Urata cares for patients throughout their lifespan and serves as volunteer director for Hospice and Homecare of Juneau. He sees patients struggle with access to care in a remote region where specialists are few and transportation challenges abound; Juneau is not completely accessible by car, and air travel provides vital connections to specialist care. While some of Urata's older patients can afford to travel by plane for chemotherapy or surgery, others are place-bound.

Transportation presents a barrier to care for patients living in regions far less remote than Alaska. Today, 3.6 million patients miss or delay needed medical appointments because of transportation problems, per a report in *The Gerontologist*.

Financial constraints create another barrier to care, even with Medicare coverage. The Commonwealth Fund reports that nearly 20 percent of today's seniors do not seek care for an acute medical problem because of financial constraints. Medicare reimbursement rates make it hard for primary-care providers to make ends meet, says Urata, so patients using Medicare consistently report that they can't find a primary-care physician or get an appointment to see a provider within a reasonable timeframe.

The nation's severe shortage of primary-care physicians further restricts access to care. Per the Kaiser Family Foundation, more than half of the country's primary-care needs go unmet. As the population of older adults continues to swell, burgeoning patient panels will strain health-care resources.

This problem is particularly acute in rural communities, where the gap between primary-care needs and available providers can exceed 80 percent, says Katie Smith Sloan, president and CEO of LeadingAge, an education and advocacy organization based in Washington D.C.

"The rural population is older than the population at large, and there are fewer health-care providers in those communities," says Smith Sloan. "Not just physicians, but therapists, mental-health professionals, social workers, and caregivers. It becomes very hard to provide the high-quality care older people deserve."

VIRTUAL REALITY

Sorting through the financial, demographic, and social issues impacting seniors' access to care is undeniably complex, and solutions aren't simple. But advances in telemedicine—care delivered through a video chat or a voice call on a computer or a mobile device—may hold promise, enabling place-bound seniors to receive health care without leaving their home, and enabling doctors to treat more patients without spending precious time out of the office.

The stereotype of the technophobic senior who shuns computers is, thankfully, disappearing. Providers shouldn't assume that older

(Continued on page 20)

What Your Aging Patients Wish You Knew

If only Suzanne had known. If only she'd known that the first back surgery would lead to more. If only she'd known that the second knee replacement wouldn't go as well as the first. If only she'd known that one of her surgeries would be followed by a stroke.

The knowing would have helped her deal with it better.

Even if she had known all these things, Suzanne says she might not have done anything differently—but the knowing would have helped her deal with it better. While her experiences might not have been predictable, she wishes her doctors had at least considered the possibilities and informed her of them.

"One of the things the doctors might not tell you is that when you have spinal fusion, the discs above and below may also go at some point," Suzanne says. The 74-year-old, who lives in Hood River, Oregon, has since had her entire lumbar spine fused, and had several fusions in her cervical spine as well. "I was in so much pain before that first surgery, I had to do it, but I just wish I'd known that wasn't going to be the only one," she says.

Suzanne ran into the same problem with her knees. This past February, she had a knee replaced. "I did not have to walk with a cane, and I didn't have much pain," she says, "but my knee would give out once in a while. The doctor told me I needed surgery, and that it was bone-on-bone." She'd had her other knee replaced 15 years earlier, and recuperated with no problems—but it did require a revision seven years later. That, she says, should have been a wake-up call that a second knee replacement might not go smoothly, especially given that she was that much older than when she underwent the procedure for the first time.

In fact, it almost couldn't have gone worse. Suzanne had a stroke the day after the surgery. She ended up staying in the hospital for 19 days, instead of the five she'd originally planned for. The stroke caused no paralysis, but resulted in immediate cognitive issues. These resolved before she left the hospital, but she now

can't straighten out her new knee, and walks with a cane. "My doctor thinks that's because of the stroke, but he didn't really explain why, and I'm not sure I agree with that," she says.

The heart of the problem, Suzanne says—and likely most doctors and patients would agree—is that doctors are just too busy to provide the kind of care they and their patients want. "Most doctors have your best interests at heart," she says, "but they have such a patient load—you can tell. My niece is a doctor, and she has to see a new patient every 15 minutes. So they can't take the time they need to with their patients." In her experience, the care patients receive suffers as a result.

LISTEN UP

When it comes to medical treatment, Madeleine has seen—or rather, heard—it all. The 84-year-old Seattle resident retired 12 years ago from a 17-year career as a medical transcriptionist, working on everything from radiology to emergency-room cases.

"I have a lot of empathy for doctors because I heard what they're dealing with on a day-to-day basis," she says. "Not only do they have to see so many patients, but not everyone is a good communicator." That goes for doctors and patients alike, she says, adding, "Some doctors can't put a sentence together… and some patients aren't articulate enough to explain their problems." This leads to a big communication breakdown, in her opinion—which is only compounded when doctors are rushed.

The irony is that despite Madeleine's understanding, medical vocabulary, and ability to communicate well—she even goes to doctor visits with written notes—she currently feels talked-down-to about her own medical problem—lower-back pain,

Talk to me as if I have a brain.

exacerbated by years of using a foot pedal on a transcription machine. "I'm on their side and speak their lingo, so—please, talk to me as if I have a brain," she says.

Madeleine was pleased with her long-time doctor, who recently retired. The same doctor treated Madeleine's mother until she died, so he had a long history with the family. When Madeleine first came to him about her back issue, he was honest, she says. "He told me, 'I hope we can help you.'" She appreciated that he didn't sugarcoat the possibility that he couldn't.

"My back [which suffers from severe stenosis of the lumbar spine and severe arthritis] can't be fixed with surgery, and I wouldn't want to have surgery at my age anyway," she says. "But getting pain relief is a big taboo." Taking over-the-counter pain relievers gave her a bleeding ulcer, and she's still trying to figure out how to manage her pain.

She's not wild about her new doctor, either. "He's hard to understand, and I can understand doctors—that was my job," she says. If he listened to her, "I think we could have a mutually beneficial relationship," she says. "We'll see how this goes, but building a rapport with someone takes years."

They're not off to a great start. When she did some initial routine lab work with him, he never called her back with the results,

(Continued on page 26)

Connecting with Elderly Patients

by David McGrath, CPHRM

Patty could tell that something seemed different about her father Frank. As they walked their favorite trail around the lake, she noticed that he was moving more slowly and seemed to be running out of breath faster than she had remembered. The buttons on his shirt seemed to be slightly strained, as if he had gained weight in his stomach, and he complained about having eaten something that must have disagreed with him.

"Have you seen Dr. Jones recently?" she asked him.

Her father scowled. "I had an appointment last week. But you know how it is with these young kids—in and out, and here's a bunch of pills. I'm just getting old."

Patty frowned. "He prescribed medication? For what?"

"I don't know," Frank said, shrugging his shoulders. "He talks too fast. All those big words. They make no sense." He spied a nearby bench. "Can we sit down for a bit? I'm so tired."

Worried, Patty sat with her father and they watched the ducks without speaking.

A week later, Patty received a call from the hospital. Her father was in the emergency room and appeared to have had a heart attack.

As she drove to the hospital, thoughts swirled in her head. What had gone wrong? Did the doctor miss a diagnosis? Had her father misunderstood the doctor's instructions?

Most importantly, what could have been done to avoid this?

EACH IS UNIQUE

What comes to mind when you think of your elderly patients? You might imagine a fragile person with thin white hair who is hard of hearing. Perhaps their mind has begun to slip and their memory isn't what it once was. Maybe they walk with a cane or a walker. You might think first of the health complaints that become more common as people age—congestive heart failure, osteoporosis, arthritis, and dementia.

Do you bring these images to work with you? You might be inadvertently stereotyping your patients, forcing them to fit a mold they don't necessarily belong in. It's crucial to remember that each patient—including each elderly patient—is different and has different goals, different health concerns, and different needs.

Research has shown that patients who feel like they have a relationship with their health-care provider are less likely to bring a lawsuit if a mistake is made or things go wrong. In today's health-care model, patient satisfaction is absolutely crucial.

Building relationships with your patients—including your elderly patients—can be challenging, but the payoffs are immeasurable, and include improved health outcomes and happier patients.

ADAPT YOUR STYLE

It might be helpful to take a step back and consider what your older patients expect and need most from their health-care providers. Many of these patients grew up with family doctors who provided care for each member of the family and were an active part of the community. They took their time getting to know their patients and may have even made house calls.

Over the years, the medical model has changed considerably. Many providers feel forced into spending less and less time with their patients, and the provider-patient relationship sometimes gets pushed aside because of the limitations imposed by third-party billing and the need to see a large number of patients every day.

But now the pendulum has begun to swing back in the other direction. We're recognizing (again) the value of provider-patient relationships and the importance of taking the time to connect with and understand your patients. For your older patients, it may feel like things are coming back around full circle, and it's important to honor that.

While every elderly person has different needs, there are some concerns that, statistically, are more frequent in the elderly. For instance:

- Only 3% of adults ages 65 and over are considered proficient in health

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We're recognizing (again) the value of provider-patient relationships and the importance of taking the time to connect with and understand your patients.

Delirium in a Hospitalized, Elderly Patient

Delivering Care without Causing This Common Issue

by Viral Shah, MD

CASE STUDY #1

An 82-year-old man came to a hospital for an elective total knee replacement. At home, he had been taking a baby aspirin daily and sublingual nitroglycerin on an as-needed basis. His surgery went without any immediate complications, but his postoperative course was rocky:

DAY 1: The patient received opiates. His post-op order set had orders for PRN morphine, Dilaudid, oxycodone, Vicodin, Percocet, Compazine, Phenergan, Ambien, and Benadryl. He became delirious.

DAY 2: The patient's Foley catheter was removed. He fell and hit his head. A constant observer was placed in his room.

DAY 3: The patient received Ambien and Benadryl. He became combative and took a swing at a staff nurse. The orthopedic surgeon called for internal medicine consultation. The hospitalist discontinued all opiates, Ambien, Phenergan, Benadryl, and Compazine. Only acetaminophen was left on the orders for pain control.

DAY 4: The patient was still combative and therefore could not participate in PT/OT evaluation.

DAY 5: There was some improvement in the patient's mental status, but he was not at baseline.

DAY 6: The patient showed improvement and had his first PT/OT evaluation after surgery.

DAY 7: The constant observer was removed, and the patient fared well without an observer. The patient was back to his baseline—mentally.

DAY 8: The patient left for a rehabilitation facility to pursue further physical therapy.

CASE STUDY #2

A 72-year-old woman was admitted for spine surgery on her neck. After the surgery, she received 25 mg of oxycodone in the next 24 hours to bring her pain level down to 3/10. She started to stutter, became confused, and developed hypoxia. Her family was alarmed and called the nurse. A rapid-response team soon arrived at her bedside. The hospitalist administered Narcan and discontinued oxycodone. The patient improved to her baseline in four to five hours.

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Delirium is associated with a 60% increase in one-year mortality, as well as increased hospital costs.

(Delirium in a Hospitalized Elderly Patient, continued from page 11)

DEFINING AND RECOGNIZING DELIRIUM

In our first case, what could have been a hospitalization of two or three days turned into an eight-day hospitalization. In the second case, a well-intentioned effort led to increased stress for the patient and her family. Both cases involve patient delirium.

Delirium is an acute decline in cognition and attention, and there are two types: hyperactive and hypoactive. The type described in the first case is hyperactive delirium, and the type in the second case is hypoactive delirium.

Health-care providers often fail to recognize hypoactive delirium, which is evidenced by lethargy and somnolence. In fact, in a study at Yale–New Haven Hospital, 65% of physicians and 43% of nurses failed to recognize delirium.[1]

WHY SHOULD WE CARE ABOUT DELIRIUM?

Delirium is common among hospitalized patients, and the incidence rate for new-onset delirium after a hospitalization may be 25–60%.[2] The highest incidence rate of 50–60% is often seen with hip-fracture patients.[3]

Once present, delirium may be challenging to treat. It may last for days to weeks before completely clearing up. It increases the length of stay at the hospital, the risk of complications, and the probability of discharge to a nursing home instead of to the patient's home. Delirium also increases the risk of death in a hospital by 10 times.[4]

Delirium is associated with a 60% increase in one-year mortality, as well as increased hospital costs.[5] In fact, according to one study, total annual costs attributable to delirium were $16,000–$64,000 per patient.[6]

WHAT CAUSES DELIRIUM?

Medications are the number-one cause of delirium. Other common causes include infection, metabolic disturbances, and catheter tubes.

Sedatives, narcotics, and anticholinergic medications present the highest risk of causing delirium. The number of medications being taken at once also matters. The relative risk of causing delirium increases from 2.7 to 13.7 percent when the number of prescription medications taken increases from three to more than six.[7] Several medications (e.g., furosemide, ranitidine, digoxin, nifedipine, and isosorbide) have partial anticholinergic activity and can contribute to delirium.[8]

Studies that influence which clinical practice guidelines are developed for treatment of chronic diseases rarely include elderly patients. Yet within this group, medication compliance starts to deteriorate at four medications per day. Polypharmacy increases the risk of side effects, and more drugs tend to be prescribed to treat the side effects of other drugs—a phenomenon known as the "prescribing cascade." Take, for example, allopurinol, which is prescribed to treat hydrochlorothiazide-caused hyperuricemia and gout. The therapeutic benefit of simultaneous use of an anticholinergic medication (tolterodine) with a cholinesterase inhibitor (donepezil) is questionable, yet it is not uncommon to see both medications on an elderly patient's medication list.

WHAT IS THE PROPER TREATMENT OF DELIRIUM?

The best strategy is prevention. Once delirium is present, use "social restraints" by keeping an observer or a family member in the room with the patient. Absent a clear medical need, avoid physical restraints. Most importantly, absent a clear medical need, avoid all benzodiazepines—they appear to make delirious patients calm, but they only prolong and worsen the delirium itself. (The only exception is delirium due to benzodiazepine withdrawal.) Understand the medications that are on the Beers list of inappropriate medications (published by the American Geriatrics Society) for elderly patients and the potential impact of prescribing a medication on that list.

Avoid or remove Foley catheters, absent a clear medical need. Minimize sensory interruptions. Make hearing aids and prescription glasses available.

With a combative patient, consider using haloperidol. If you use it, assess the patient for side effects such as akathisia and extrapyramidal effects. If the patient has Parkinson's disease or another extrapyramidal syndrome, use quetiapine, 25–100 mg once or twice daily.

Effective pain management after a fracture or joint/long-bone surgery is essential. Pain management starts with expectation management. Pharmacotherapy is just a part of an overall comprehensive pain-management plan, and opiates are just a part of pharmacotherapy.

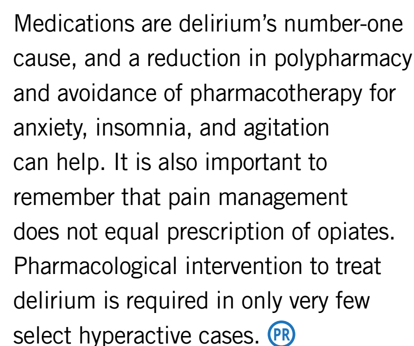
In a randomized controlled trial, a pain protocol reduced delirium by one-third. In this protocol, 1 gm of scheduled acetaminophen was used four times a day while patients were awake. Doses were withheld during the night, in order to allow the patients to sleep without disturbances. Low-dose morphine was used subcutaneously or intravenously for early-stage pain, and low-dose oxycodone was used for later-stage pain. A stool softener was always prescribed along with any opiate use.[9] Another study, based on data from the Denver VA Medical Center, used hot and cold pads, massages, and relaxation therapy to aid pain management.[10]

WHAT CAN WE DO NEXT?

Other hospitals (Yale, University of Pittsburgh Medical Center) have successfully implemented programs to reduce delirium. One such program is the Hospital Elder Life Program (HELP). They offer all resources at no cost, including manuals that describe everything it takes to start and sustain a HELP plan. Use of HELP has demonstrated lower hospital costs, reduced length of hospital stay, and lower costs per survival day at the one-year follow-up. It has also shown a reduction in hospital falls, catheter use, pressure ulcers, and delirium.

CONCLUSION

Delirium adversely affects many of our elderly hospitalized patients. Prevention is the best strategy for treating delirium. Medications are delirium's number-one cause, and a reduction in polypharmacy and avoidance of pharmacotherapy for anxiety, insomnia, and agitation can help. It is also important to remember that pain management does not equal prescription of opiates. Pharmacological intervention to treat delirium is required in only very few select hyperactive cases. PR



Dr. Viral Shah, MD is an internal medicine specialist at MultiCare Health System in Tacoma, WA, and has been practicing for 13 years.

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POLST
THE FORM YOU NEED TO KNOW

THE WAY CHARLES ULTIMATELY PASSED WASN'T HOW HE'D WANTED TO GO.

A 90-year-old resident of Longview, Washington, diagnosed with Parkinson's Disease, Charles signed a "do-not-resuscitate" (DNAR) order. Yet when his heart stopped beating during surgery to repair a fractured hip, doctors performed compressions hard enough to crack his sternum. He was placed in the ICU, connected to a breathing machine and feeding tube, and kept in a coma-like state—against the wishes he had previously expressed in writing. Charles spent the next six weeks living in severe pain before he passed.[1]

Charles's case highlights the benefits, and limitations, of a document known as a "physician orders for life-sustaining treatment" form, or POLST form, in Oregon and Washington. (It's known by different but similar names in other states.)

POLST VARIATIONS BY STATE

POLST forms and guidance vary by state. In addition, the name and acronym used for POLST programs may also differ slightly. For more information on state-specific programs, visit their respective websites:

Alaska (MOLST—Medical Orders for Life-Sustaining Treatment)
Currently under the auspices of the Alaska Pioneer Homes
www.dhss.alaska.gov/daph/Pages/default.aspx

Idaho (POST—Physician Orders for Scope of Treatment)
www.idqol.org

Oregon (POLST—Physician Orders for Life-Sustaining Treatment)
www.oregonpolst.org

Washington (POLST—Physician Orders for Life-Sustaining Treatment)
www.wsma.org/POLST

Wyoming (POLST—Provider Orders for Life-Sustaining Treatment)
www.wyomed.org/wyopolst

ABOUT POLST

While patients often have advance directives that express their personal philosophies about future care, a POLST form is a medical order for the specific medical treatments patients want if a medical emergency happens today. POLST forms are appropriate for individuals with a serious illness or advanced frailty near the end of life.[2]

POLST forms were first developed in Oregon in the 1990s. While all states are now adopting the form to some degree, "There is significant state variability in their adoption," says Dr. Susan Tolle, M.D., Director of the Center of Ethics in Healthcare at Oregon Health and Science University (OHSU) and Chair of The Oregon POLST Coalition. "Some states have very mature POLST programs and widespread use of the forms, and other states are still developing a program." Ideally, Tolle adds, POLST forms should be readily available for those who want them and are nearing the end of life.

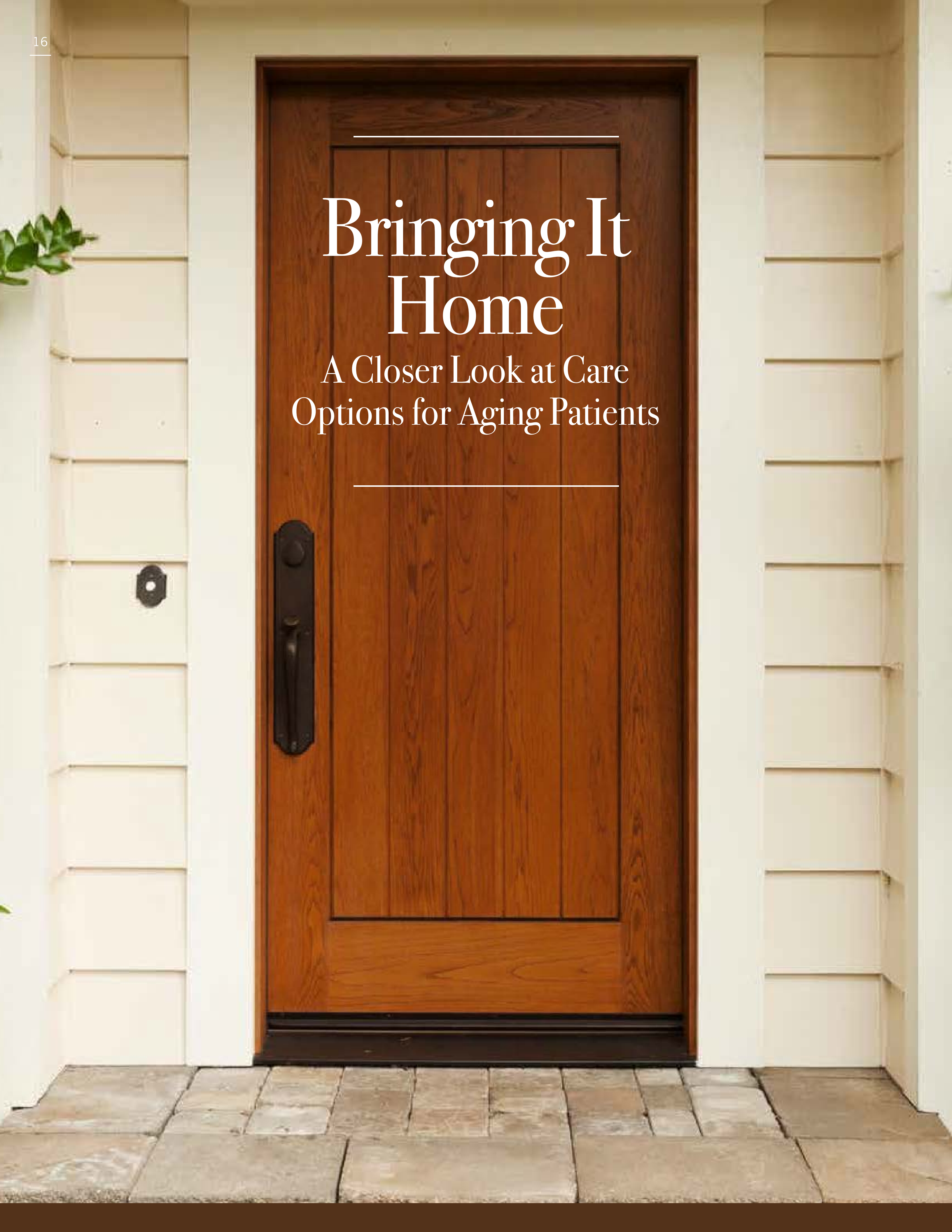
POLST forms and advance directives work together. Considered a legal document, advance directives enable patients to indicate their general wishes about treatment and to appoint a surrogate. However, these directives need be turned into action with medical orders to ensure that patient wishes are honored by emergency medical personnel.

As specific medical orders, on the other hand, POLST forms can be found in electronic medical records, accessed by all health-care personnel, and listed in a state registry. In efforts led by Dr. Tolle, Oregon has been instrumental in making POLST forms accessible in patient medical records with a single click.[3] Technology integration is critical, according to Dr. Tolle. "We are encouraging a one-click immediate access, separate from advance directives, so health-care professionals see it immediately when they open a patient chart," she says. "In a growing number of Oregon hospitals, patient records display a 'POLST YES' or 'POLST NO' on the header, so the document is not buried with other correspondence. This ensures that in a crisis, health-care professionals are far more likely to find it and follow its instructions."

WHEN TO FILL OUT A POLST

It's not accurate to say that all elderly patients need POLST forms. According to the National POLST Paradigm, POLST

(Continued on page 25)



Bringing It Home

A Closer Look at Care Options for Aging Patients

HOME-BASED MEDICAL CARE: BACK TO THE FUTURE

"We're harkening back to the true 'Marcus Welby' model."

Dr. Pamela R. Miner, Medical Director of Housecall Providers in Portland, Oregon, is shaping the future of health care by keeping an eye on the past. Serving an increasingly elderly population whose members prefer to maintain control over their care and surroundings, Housecall Providers offers home-based medical care that's proving to be beneficial for patients, families, and even payers.

"We fill the need for people who are in their home and unable to leave, except for very costly ER visits or ambulance rides, to get to the medical care they need in a crisis," says Dr. Miner. "They may not be completely homebound, but there may be other reasons they struggle to get into a clinic setting."

Housecall Providers brings a multitude of primary-care services directly to the patient. "Home-based medical practices diagnose and treat chronic medical conditions, and we can often prevent avoidable hospitalizations or other complications," says Dr. Miner. "Technological advances mean that providers can now offer EKGs, ultrasound, X-rays, IV treatments, and other vital services. For a chronically ill person with limited energy, getting to and from a doctor's office might be so taxing that it is all that they can do that day."

WHAT'S BEST FOR THE INCREASINGLY HOMEBOUND PATIENT?

In their model, Housecall Providers serves as the primary-care provider for its patients. Miner admits that it's often difficult for clinic-based physicians to give up the responsibility for care when they've established a long-term relationship with their patients. "We're saying to our partners in the community, 'If you struggle to make good medical recommendations for your patients because you haven't seen them for some time, we will go to them.' We're often approached by caseworkers, hospital social-work teams, patients, and families who recognize that trips to the hospital or other appointments are becoming burdensome. They're reaching out to us and asking us to take over their care or their loved one's care."

"Think of a patient with increasing dementia: the thought of trying to get them into the car, and the stress and the anxiety they experience when moving and traveling in unfamiliar environments ."

DR. PAMELA R. MINER,
MEDICAL DIRECTOR,
HOUSECALL PROVIDERS

"Think of a patient with increasing dementia: the thought of trying to get them into the car, and the stress and the anxiety they experience when moving and traveling in unfamiliar environments," she adds. "When we're able to visit them in an assisted-living facility or private home, the patient and family feel like they're getting good quality care. Plus, they're maximizing quality of life for their loved one each day, knowing time may be growing short."

With America's rapidly aging population, approximately two million people are homebound. Dr. Miner says that only 15 percent of those are getting home-based medical care, so the opportunity for physicians to work within this model is enormous.

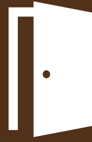
"This type of care allows you to take your training and best practices in diagnosis and treatment, and put the patient's needs at the center of how you build a care plan," she says. "You get to think critically about each and every intervention or step that might affect their complex medical conditions. It provides an extremely stimulating opportunity for physicians. For those who like medicine for its high-touch, high-communication, patient-centered focus, it's extremely rewarding."

REIMBURSEMENT: PROVING THE EFFICACY OF THE MODEL

Contrary to what some might think, Dr. Miner knows that the advantages of home-based medical care have economic benefits as well. "Medicare's fee-for-service schedule only covers around 50 percent of the costs associated with delivering this kind of care," she says. "We're building a case to be reimbursed on a value-based structure."

Housecall Providers is currently participating in the multi-year demonstration from the Centers for Medicaid and Medicare Services Innovation called Independence at

(Continued on page 18)



“You can connect with your patients on a different level, because it takes skill to go into someone else’s home–after all, it’s their territory.”

ALYSSA GOODRICH, CLINICAL MANAGER, SPOKANE, WA

(Bringing it Home, continued from page 17)

Home. The project seeks to provide metrics surrounding home-based primary-care services. In its second year, Housecall providers showed a 26 percent savings in patient-health costs over a control group that did not receive home-based primary care—a savings of $830 per patient every month.

“If we can convince the marketplace and payers to understand the value of what we do, some of our reimbursement challenges will slide away and it will become easier to attract high-quality clinicians to this environment,” Miner continues. “In order to be sustainable and to expand care for an aging population, home-based medical practices need new reimbursement models, different than the old fee-for-service.”

HOME-BASED CARE TO SUPPORT PRIMARY CARE

Still other providers specialize in delivering home-based nursing care and related services often ordered by primary-care physicians for their patients. Alyssa Goodrich, a clinical manager providing home-based care in Spokane, Washington, says that with hospital stays getting shorter, she and her team are able to help elderly patients with items such as wound care, catheter care, and various therapies.

“We have many skilled clinicians including nurses, physical therapists, occupational therapists, speech therapists, and even medical social workers,” she says. She agrees that providing in-home care is particularly rewarding for any clinician: “You can connect with your patients on a different level, because it takes skill to go into someone else’s home—after all, it’s their territory,” she says. “You have to make them feel comfortable and confident in what you can provide for them.”

Yet there can be a disconnect in the coordination of these services—which is why it’s crucial for the ordering physicians to let their patients know specific details. Says Goodrich, “Sometimes patients believe they’re getting an in-home caregiver to do basic household chores, and that’s not the case.” In such instances, it’s important that the ordering physicians—and their patients—understand exactly what services those providers are delivering.

HOSPICE: A DELICATE CONVERSATION

“Hospice care is much more familiar to people than it has been in the past. It’s not as scary a word as it used to be,” says Kim Ransier, Executive Director

of Hospice of North Idaho. "One thing we're also noticing is that people are calling us and getting referred to us later in their illness than they were 20 or 30 years ago. That's largely due to the advent of so many new treatments, and more education on the part of the consumer to try and seek out treatment options." According to Ransier, the average length of hospice care nationally is approximately 60 days. At Hospice of North Idaho, it's about 40 days.

One common misconception is that hospice care is only for elderly patients and their families to think about. "We have a 25-year-old right now who was diagnosed with leukemia six months ago and now only has a few days to live," says Ransier. "We had a meeting with his family only just yesterday. While he had been referred to all sorts of specialists during treatment, at no time did anyone say his disease could end his life. No one told him or his family during these months that hospice could be an eventual possibility."

BRINGING FAMILIES TOGETHER AT CRITICAL TIMES

All families need to be prepared when treatments are no longer effective and a loved one is facing hospice care. "One of the biggest challenges we face are the late referrals," says Ransier. "We like to work with families and provide time for them to process what's happening. But when we have someone for five days, the family doesn't have time to adjust or visit and say goodbyes."

On a positive note, technology and connectivity have helped families better navigate hospice issues. "We've coordinated family conversations over Skype," Ransier continues.

(Continued on page 35)

MORE RESOURCES

FOR END-OF-LIFE DISCUSSIONS

BOOKS

Being Mortal by Atul Gawande

The Conversation: A Revolutionary Plan for End-of-Life Care by Angelo Volandes

Dying Well: Our Journey of Love and Loss by Susan Ducharme Hoben

VIDEO

Being Mortal: A PBS Frontline Report
www.pbs.org/video/frontline-being-mortal

PUBLICATIONS

Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life (2015)
https://bit.ly/2NWgiao

WEBSITES

The Conversation Project
www.theconversationproject.org

The Center to Advance Palliative Care™
www.capc.org

National Hospice and Palliative Care Organization
www.nhpco.org

(Healthcare in the Golden Years, continued from page 5)

patients are less tech-savvy than their younger counterparts, says Ralph A. Rossi MD, MPH, a primary-care physician at Seattle's Polyclinic. "Among my older patients there's a wide range of comfort with technology; we have an electronic patient portal that some older patients have embraced."

Per new research, many of today's older patients are far from technophobic. A 2018 report in *International Journal of Emergency Medicine* shows that virtual-medicine acceptance and utilization rates are high among people over 65, and satisfaction rates are consistent with those of younger patients. A systematic review in the *Journal of Telemedicine and Telecare* found that virtual health care promotes independence and helps seniors better understand health-care information.

Advances in technology are helping address some barriers to care, says Smith Sloan. "This is a fast-growing area, ranging from telemedicine—important particularly in rural settings, or where older adults can't easily travel to a doctor's office—and the efficient exchange of relevant health information electronically to addressing the needs of people living with dementia or preventing social isolation," she says.

But technology may present yet another barrier for seniors. Some patients in remote areas may not have access to the high-speed Internet necessary for a video chat, or even reliable phone service, notes Urata. Complex electronic portals that aren't user-friendly for seniors, like a chat interface with very small text or spotty audio, further discourage seniors from using these portals; the *Journal of Telemedicine and Telecare* reports that complexity is a top telemedicine complaint for seniors.

One solution to the access problem is remarkably low-tech, says John Addison of Northwest Geriatrics. The good old-fashioned home visit, with health-care workers bringing health care to aging patients, can work well for practitioners and patients, providing high-quality care and reducing emergency-room visits for patients who can't get to the doctor on their own. The trick for providers is making the economics of home visits work, says Addison. Clinicians with lower operating costs can make this model work, but for some, home visits aren't economically viable.

> "Today, we have the ability to share health information across a team of providers like never before, so we can work together with specialists in a really coordinated way."
>
> JOHN ADDISON, MD, FACP

THE POLYPHARMACY PROBLEM

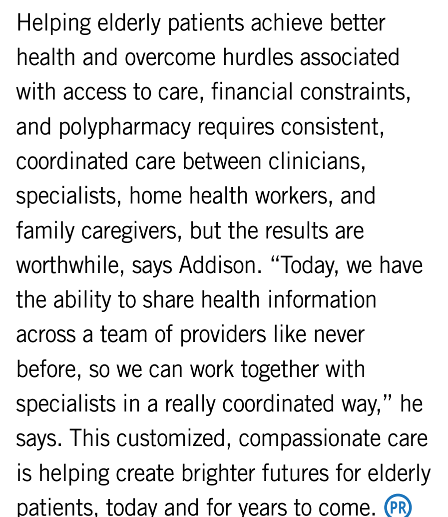
Providing high-quality care to aging adults means treating a growing list of invisible disabilities facing the elderly, from mental illness to sleep disorders to osteoporosis, says Addison. "Often we'll treat the acute issue—like the fracture that results from the osteoporosis—and only afterward begin to address the underlying invisible illness," he says.

Because many invisible ailments are side effects of medications taken for other conditions, polypharmacy is a growing problem for seniors, says Smith Sloan. Polypharmacy, defined as taking multiple prescription medications concurrently, impacts millions of elderly patients: half of today's older adults take five or more medications. Multiple studies link polypharmacy to an increase in adverse health outcomes like falls, hospitalization, and death.

Polypharmacy may compound another problem facing the elderly—that of persistently high rates of depression and suicide. A new study from the University of Illinois at Chicago reports that a third of U.S. adults may unknowingly take prescription medications that increase the risk of depression and suicide. The elderly have the highest rates of suicide, with few programs in place for prevention, per a systematic review published in *Crisis*.

Here again, the solution may lie in simplification. The growing trend of "deprescribing," or helping patients reduce the number of medications they take, can help eliminate some problems associated with polypharmacy, says Addison. "We often find patients taking twice as many medications as they need, and we can cut the number of prescriptions in half quite safely," he says.

Bob Urata also works to "deprescribe" when possible. This means taking care to avoid beginning medicines unless they're necessary, and working across care teams to avoid unwanted medication interactions. "We try not to start our elderly patients on medications unless they really need them," he says. "Using medicines correctly and judiciously helps patients treat the problems they have without creating new ones."



Helping elderly patients achieve better health and overcome hurdles associated with access to care, financial constraints, and polypharmacy requires consistent, coordinated care between clinicians, specialists, home health workers, and family caregivers, but the results are worthwhile, says Addison. "Today, we have the ability to share health information across a team of providers like never before, so we can work together with specialists in a really coordinated way," he says. This customized, compassionate care is helping create brighter futures for elderly patients, today and for years to come.

What Matters in the End: Q&A with Dr. Bob Urata

Valley Medical Care, Juneau, Alaska

Q: What are the trends you've seen in family medicine over the 38 years you've been practicing, in regard to senior patients?

A: I've delivered babies who have grown up; now I'm caring for their children. Some of my early patients who were in their 60s are now in their 90s. And they're not dying—it's actually fascinating! I'm a family-medicine doctor, but as my patients have aged, by default I've become more attuned to the unique health needs of seniors. So I eventually obtained qualifications in geriatrics and hospice and palliative medicine.

Q: What are your observations about how providers care for seniors?

A: Coming out of medical school, we're geared to save lives. We want to take action that solves problems and makes patients healthier. However, not all our elderly patients are up for the rigor we were trained to apply. It's hard for us to slow down, hold back, and not offer every possible treatment. Those of us caring for the elderly are increasingly thinking about balancing quality of life with medical care.

Working with cultural differences is somewhat common, and having interpretation is key. Usually a family member interprets, but that is not recommended, though often preferred by the patient. We can use phone interpreters, but some are not good, so it can be tricky. Also, here in Juneau, doctors do home visits to elderly and hospice patients and one can get a better idea of their culture.

Q: What do you do differently with your more senior patients?

A: I've found it's important not to just rush in with all kinds of tests right away. On the one hand, if you find something concerning, you do want to treat it like it's urgent. But if you find something—like a possible tumor—you have to consider, "What should we do?" Not all patients want to know the test results. If something requires treatment, is the treatment worth it for the patient in the long run? I try to work with the patient to weigh the risks and benefits, understanding all the potential side effects.

Q: What do you make of the wave of Baby Boomers hitting their elderly years?

A: They've always liked having a lot of control…and now they want to control how they die, too! In all seriousness, we're now living in an era in which assisted suicide has been legalized in several states, for patients who have a terminal illness but want to have some control over the situation. That generation has had a hand in some of the shifts that we are only just starting to see. While the older Boomers often want me to decide on the best treatment, I see more of them desire shared decision-making. My typical younger Boomer patients search the Internet and ask many detailed questions, including treatment side effects and effectiveness. There is an increasing interest in natural, over-the-counter products—so it's important to be aware of their use and drug interactions.

Q: Do you have any guidance on caring for seniors?

A: From their youth through their senior years, our goal is to help our patients have a nice long life. But once the end is in sight, it's important to support them in having a nice death, too. As you consider every possible treatment, also consider whether such treatment would just make the patient miserable at the end of life. It's important for the patient, as well as for their loved ones, to feel dignity at the close of a life. As care providers, we play a critical role in helping to preserve the quality of our patients' final days. PR

Dr. Urata received his undergraduate degree in Biology from Northwestern University and his medical degree from the University of Washington. He is board certified in Family Medicine with added qualification in Geriatrics and Hospice and Palliative Medicine. He currently practices at Valley Medical Care in Juneau, Alaska, and is the volunteer director at Hospice and Homecare of Juneau.

ONLINE CME

Polypharmacy in the Elderly: Managing Multiple Medications in the Senior Population

Best suited for: *Physicians and practitioners of all specialties who treat patients over the age of 65.*

The prevalence of many chronic conditions increases with age, and so does the number of medications prescribed to manage them. The conundrum for the prescribing physician is that the over-65 population is less likely than younger patients to obtain the same therapeutic benefit from drugs, and more likely to be affected by adverse drug events. These adverse events include delirium, falls, fractures, GI bleeding, cognitive decline, and hospital and nursing-home admissions.

Older patients benefit significantly when the number of medications they take is reduced. This monograph will assist the physician in reviewing the elderly patient's medication list and identifying medications that may be reduced in dose, replaced with an alternative, or discontinued altogether. It will present risk-management strategies based on the 2012 updated Beers Criteria for Potentially Inappropriate Medications (PIMS), a literature review of new findings on additional classes of drugs that should be reconsidered, and several tools for medication review.

www.phyins.com/polypharmacy

Polypharmacy in the Elderly: What Nurses Should Know About Managing Multiple Medications in the Older Adult

Best suited for: *All nurses, including RNs and LPNs, and any other healthcare personnel involved in geriatric care.*

Nurses can become better equipped to help reduce the risks associated with polypharmacy in the elderly population by understanding how aging affects a patient's ability to metabolize drugs, the types of drugs that cause the most problems in older patients, how to assess for drug-related problems, and how to intervene.

This monograph will assist nurses in reviewing and reconciling elderly patients' medication lists and in utilizing tools such as the 2012 updated Beers Criteria for Potentially Inappropriate Medications (PIMS).

www.phyins.com/polypharmacynurses

Nursing-home Patients: Risk Management in Long-term Care

Best suited for: *Physicians of all specialties and mid-level providers who care for long-term-care patients—especially those physicians and providers who are not based in a nursing home but who oversee care from their office practices.*

Nursing-home patients today are older, sicker, and frailer than ever before. Multiple chronic conditions and reduced mobility and cognition put them at risk for polypharmacy problems, falls, malnutrition, and pressure ulcers. Primary-care physicians who are not based in a nursing home have the added disadvantage of practicing remote medicine. If end-of-life wishes have not been discussed, elderly patients are at increased risk for aggressive and futile care in their final weeks and months of life. These situations create pain and anguish for patient and their families, and increased liability risk for physicians.

This online activity seeks to arm the physician with specific strategies and resources that will assist in making the care of nursing-home patients a reasonable and manageable risk.

www.phyins.com/LTcare

End-of-Life Communications: Two Models

Best suited for: *Physicians of all specialties who may be caring for a patient at the end of his or her life.*

End-of-life conversations are difficult for physicians, and are often avoided or postponed as a result. For the dying patient, this avoidance contributes to a dynamic in which their family develops unrealistic expectations, and the hospital defaults to aggressive or futile care in order to meet them. This scenario often ends with the patient's death in an Intensive Care Unit, and persistent anguish for the family afterward. Many malpractice claims have resulted from this confluence of events.

This online video activity features the contributions of a medical-malpractice defense attorney and three practicing physicians: a psychiatrist, an internist in palliative care, and a critical-care pulmonologist. They present a model for physicians to carry out end-of-life communications in the hospital setting—first, for the physician in private practice; and second, for hospital-employed physicians, describing how palliative-care service can be integrated with the ICU. Specific techniques are presented that have been shown to help avoid creating unrealistic expectations, promote symptom control, allow patients to die at peace, and spare their families the anguish of seeing their loved one suffer.

www.phyins.com/endoflife

AAOS Guidelines, OA Knee: RM Review

Best suited for: *Orthopedists. All other interested health-care practitioners are also welcome to participate.*

In April of 2013, the American Academy of Orthopedic Surgery (AAOS) issued revised guidelines on the treatment of osteoarthritis (OA) of the knee. This monograph will provide a brief summary of the new AAOS recommendations and supporting evidence, interwoven with a risk-management perspective on clinical practice guidelines. Are these guidelines the new standard of care? Or are they cookbook medicine? What is the likelihood that following them will improve patient outcomes?

From a risk-management standpoint, it is recommended that orthopedists be familiar with the guidelines of their specialty society, and that these guidelines be neither dismissed out of hand nor embraced uncritically. We will suggest ways for orthopedists to weigh the strength of the AAOS evidence and treatment recommendations so as to take them into account in their clinical decision-making.

www.phyins.com/OA-knee

Diagnostic Error and Stroke

Best suited for: *Physicians of all specialties who care for patients who may be at risk of stroke. Other health-care practitioners are welcome to participate.*

800,000 Americans are diagnosed with stroke every year. Despite a steep decline in mortality since the 1960s, stroke is still the country's third leading cause of death, and it remains the leading cause of serious disability.

Stroke is an unfolding event with many different presentations. There is a significant rate of delayed diagnosis of stroke in patients presenting to the ED, and as neurologist David Newman-Toker explains, "Time is brain." Newman-Toker will discuss the cognitive factors and types of presentations that contribute to delayed diagnosis, and will present practical ways to reduce diagnostic error in stroke.

www.phyins.com/stroke

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ONLINE CME

Nephrology and Palliative Care: Discussing End-of-life Issues

Best suited for: *Nephrologists, nephrology fellows, and advanced practitioners who work with dialysis patients.*

One of the toughest clinical questions for practicing nephrologists to answer is, "Will my chronic kidney disease (CKD) patient benefit from dialysis?" In the best-case scenario, a physician should not need to make this judgment alone. Initiating or forgoing dialysis should be a joint decision with the patient after a discussion of the risks and benefits of dialysis vs. non-dialysis management. However, multiple sources confirm nephrologists find conversations about the various treatment pathways associated with advanced CKD challenging. In addition, talking with patients about poor prognoses and end-of-life issues is difficult, and many physicians, including nephrologists, would like to develop more skills in this area.

www.phyins.com/CKD

Withholding Life-sustaining Treatment: An Ethical Paradox?

Best suited for: *Practicing and resident physicians of all specialties and other health-care providers who are likely to treat patients at or near the end of life.*

CMS is allowing reimbursement for health-care providers who have stand-alone discussions with patients about their health-care options near the end of life, including life-sustaining treatment. Lack of reimbursement has likely represented one barrier to these important discussions. Another obstacle has been lack of knowledge on the right way to guide patients as they approach the end of their lives and need to make decisions about the type of care they want or need. There are several ethical issues that arise in this decision-making process that can be difficult to resolve. As a result, some physicians, as well as their patients, simply choose to avoid the topic altogether or give it short shrift. Fortunately, guidelines such as those set forth by the Hastings Center, which are discussed in this monograph, help address these issues and promote effective and productive dialogue at a time when some argue it is needed most.

www.phyins.com/ethicalparadox

Prostate Cancer: Screening, Biopsy, and Management

Best suited for: *Urologists.*

When it comes to the screening and diagnosis of prostate cancer, we're still in the "Good, the Bad, and the Ugly" of the Wild West. The "good" is that 50% fewer men are dying of prostate cancer. The "bad" is that we face a pandemic of over-diagnosis and over-treatment. And the "ugly?" Unfounded screening and treatment patterns promoted within urology, primary care, and even the U.S. Preventive Services Task Force.

In this 1.25-hour webinar, Dr. Scott Eggener walks you through the landscape of PSA, pointing out the components of smart screening that will minimize over-detection. He demonstrates best practices related to novel bio markers through case examples, including what you need to discuss with your newly-diagnosed patients. Finally, he reviews medico-legal considerations and strategies for active surveillance that encompass transition to inactive surveillance. The webinar concludes with a short Q&A highlighting important issues, featuring Dr. Ernest Sussman, Vice President of Risk Management at SCRUBS Risk Retention Group.

www.phyins.com/prostateCME

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> "We need to be sure it's filled out appropriately. If a patient is living life's last chapter, and if they have a deep desire not to spend it in intensive care, then they need to make a plan that is recorded as medical orders. Otherwise, the default is the hospital."
>
> SUSAN TOLLE, M.D., DIRECTOR OF THE CENTER OF ETHICS IN HEALTHCARE, OREGON HEALTH AND SCIENCE UNIVERSITY (OHSU)

(POLST, continued from page 15)

forms are recommended for patients who are seriously ill or frail (at any age) and whom health-care professionals believe may die within one year. In fact, a study conducted in Oregon determined that more than half of POLST forms were completed within the final two months of life.[4]

And there's a risk in filling out the POLST form too early. According to Tolle, "At times, health-care professionals are filling out POLST forms with patients when they are not POLST-appropriate. These people are healthy, so they would indicate on the forms that they want full treatment. As a result of the wrong timing, a few patients have had unexpected consequences, such as being denied life insurance when they are still in good health. They should have an advance directive, of course, but wait until they're sicker to complete a POLST form."

THE CONTROVERSY SURROUNDING POLST

POLST forms have been gaining acceptance across the country. However, the idea of POLST is controversial in some circles. In 2013, the Catholic Medical Association published a paper raising concerns about the moral and ethical issues associated with POLST, suggesting that its use "advances the idea that disability and dysfunction can reduce the value of a person's life," which is seen as a contrast to the values of Catholic health care.[5]

In 2016, the *Journal of the American Medical Association* (JAMA) published a paper whose authors argued that standing physician orders on a POLST form "may actually curtail patient-centered decision making when applied more broadly. Standing physician orders that dictate future treatment decisions are appropriate only if preferences are stable over time and across foreseeable clinical contexts."[6]

Tolle counters that a POLST form, used correctly, truly reflects the patient's wishes. "We need to be sure it's filled out appropriately. If a patient is living life's last chapter, and if they have a deep desire not to spend it in intensive care, then they need to make a plan that is recorded as medical orders. Otherwise, the default

(Continued on page 31)

(What Your Aging Patients..., continued from page 6)

even though he said he would. She wasn't happy about it, but she's trying to cut him some slack. "He's taking over this huge practice, and he's probably really stressed," she says. "I finally called and got the results from one of his physician's assistants."

DANGEROUS INDIFFERENCE

Hurried care and poor communication results in more than just annoyed, dissatisfied patients—it can jeopardize their lives.

Sharon, a 71-year-old in Spokane, Washington, had been in good health for most of her life. The care she received from doctors when she gave birth to her six children was excellent. "Obstetricians always treated me like a person, with respect," she says.

Sharon, too, was exposed to the medical profession through her career, as a technician who took care of ventilators in the respiratory department of a hospital. Which was a good thing, because when she had a medical emergency 10 years ago while at work, she was able to walk herself down to the ER. Her blood pressure skyrocketed to 200 in 20 minutes, and she almost had a stroke. She later learned she was having a "thyroid storm," which is a life-threatening complication of Grave's disease, with which she was later diagnosed. But at the time, the ER doctors put her on medication to treat high blood pressure, and sent her home.

It took months before she was correctly diagnosed, and along the way her records were mixed up with those of another patient who had Hashimoto's disease, an autoimmune disorder that destroys the thyroid gland. At one point, a doctor thought she might have kidney cancer.

Once your hair turns gray, you're invisible. You're one of those old people.

Finally, a friend of Sharon's, who was a cardiac nurse—someone who took the time to listen to her and observe her symptoms—decided that something was amiss. Sharon was experiencing temperature sensitivity, a racing heart, and pressure behind the eyes so severe they protruded. Her friend brought her to a new doctor, who correctly diagnosed her.

Still, it took another two years of monthly visits, blood work, and side effects before Sharon was put on the correct medication. She's been in remission for the past four years, but goes to her doctor for yearly visits. "I'm seeing a wonderful doctor now," she says. "She takes that extra time to talk to me like I'm a person, not just someone you're pushing through the system."

RESPECT YOUR ELDERS

Joni is a 77-year-old former neurology nurse in Boise, Idaho. "I would love to complain about my care, but I'm not the easiest to deal with," she says. "I give doctors a hard time, or else they think they're gods. They don't give you credit for knowing anything, not at all. Once your hair turns gray, you're invisible. You're one of those old people."

But, as she says, "This is my life we're talking about," so she speaks up—loud and clear—about the care she wants for her undifferentiated connective-tissue disease, an autoimmune disorder in which the body mistakenly attacks its own tissues.

"I had a really hard time with the first doctor I saw," she says. "But I don't think I would have liked him in any facet

of life. I needed more info, and I was shell-shocked from the diagnosis." Joni left that doctor for another, whom she thinks is wonderful.

In her experience, she's found that younger doctors give better care to older

They're so into technology that it distances them from people.

patients. "That kid right out of medical school—he's still a wide-open book," she says, "open-minded and much more attentive." But the danger is, she says,

they're too open to patient suggestions: "You drop a hint about what might be wrong or what kind of treatment you want, and they run with it."

Sharon agrees with Joni about the generational issues surrounding medical care. "Doctors can be very condescending to older patients," she says. "It's like they think we're confused because we're older—so they give you a pat on the head and tell you to do as you're told. And I always followed doctor's orders, did exactly what they said. I should have been more aggressive about getting second opinions." Sharon, too, has appreciated the eagerness of younger doctors. "They always know the latest thing and want to try it," she says.

Just remember: we're old, we're not dead.

Madeleine, on the other hand, has experienced the downside of youth in doctors. "They're so into technology that it distances them from people," she says. She once watched an older doctor show a younger doctor how to hand-write a prescription because the computers were down. "Young doctors don't even know how patient care used to be," she says. "I could teach them some things."

CRUCIAL SUPPORT

Joni's a tough cookie, but she believes strongly in relying on friends and family to be medical advocates. "I think every patient, whether they go into the hospital or are hit with a blockbuster—should be advised to not go to the complex appointment alone, because they're only going to hear every fifth word. And they should be choosy about whom they pick to go with them. It's got to be someone who loves you, but isn't controlling and will follow your wishes, and keeps you calm."

Suzanne's two daughters are her advocates. "Eventually the roles reverse" between parent and child, she says. "My oldest daughter is totally against any more surgeries for me." Suzanne, in turn, is the medical advocate for her husband, who suffers from short-term memory loss. She shares her counsel with friends, too. "I tell my friends who are my age: You're not going to be playing golf in six weeks. Sometimes it can take a year to totally recuperate."

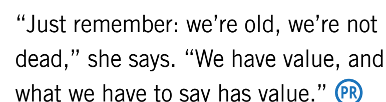
WISDOM OF AGE

"It's hard to weigh the pros and cons of treatment decisions," Suzanne says. "Ultimately you don't know. It would help if doctors would look at your whole history, where you are in life, what kind of shape you're in. They need to see the big picture."

"Focus on me and act like you care," Sharon says. "You can tell who cares and who doesn't, and the ones who care will have a happier patient with a healthier outcome. It's a simple thing."

"Doctors are doing a lot right," Joni says. "They're trying to get people to go to the doctor before it's so bad. They solve many things. They work hard to get people to live healthier, and they are—that part of medicine is amazing."

"Just remember: we're old, we're not dead," she says. "We have value, and what we have to say has value." PR



Denai'ina Wellness Center

A Tribal Home for Wellbeing

The tide is coming in on the Kenai Peninsula in Alaska—or Naqantugheduł in the language of the Kenaitze Indian Tribe, who have historically occupied the area.

The coming tide is the tribe's symbol of the cultural revival it is now experiencing—one that is attracting Alaska Native people to return to this large peninsula off the coast of south-central Alaska, a place the Kenaitze call Yaghanen, or "the good land."

The mission of the tribe is "to assure Kahtnuht'ana Dena'ina (the traditional name of its people) thrive forever." And that of course includes wellness—wellness of the whole person: physical, emotional, social, and spiritual.

Initially, the Kenaitze had operated a small clinic for 35 years. It was always the tribe's plan, however, to fully serve its members' health needs.

Then a big opportunity arose: the tribe earned a highly competitive

Indian Health Service Joint Venture Award in 2011 to cover a wellness center's operational and maintenance costs for the next 20 years.

The tribe's Dena'ina Wellness Center, a 52,000-square-foot facility built in 2014 in the city of Kenai, is a community cornerstone. It provides an array of health services, including medical, dental, and behavioral health care, chemical-dependency assistance, physical therapy, optometry, pharmacy support—even traditional healing, which addresses the natural, emotional, and spiritual elements of health. Traditional healing includes tissue, bone, and joint manipulation; prayer and guided meditation; traditional plant medicine; and traditional foods.

Focused on wellness and primary care, the center employs 157 staff members, including one pediatrician, four dentists, and five nurse practitioners. It contracts with temporary primary-care physicians and is now looking to add one or two full-time primary-care physicians to their staff. (For surgery or specialty care, patients access a hospital 10 miles from Kenai or travel to Anchorage, about 160 miles away.)

The population of Kenai is more than 7,000, and that of the immediate surrounding area is 12,000 and growing. The number of people on the entire peninsula—often called "Alaska's playground" because of strong tourism, especially for hunting and fishing—is about 50,000. There are more than 4,000 Alaska Native and American Indian people who have access to all programs at the Dena'ina Wellness Center, while programs that receive state funding—primarily behavioral health—are open to the entire community.

CARING FOR THE WHOLE PERSON

"Our mission is to provide a culturally appropriate health system, integrated into all services of the tribe, to treat the person as a whole, to look at all the needs of beneficiaries who come to our clinic and make sure their health and wellness needs are met in a way that reflects our values and culture," says Diana Zirul, who serves on the tribal council and is chairperson of the tribe's health board.

According to Zirul, patients at the Dena'ina Wellness Center are called un'ina, "those who come to us," and receive services according to the "Dene' Philosophy of Care," a holistic approach to care that addresses all contributing factors to overall wellbeing.

(Continued on page 30)

Part of nourishing wellness is remembering history and celebrating the natural world, so that too is part of the architecture. Agates inset in the flooring were collected by tribal members.

> "Perhaps the biggest reason the Dena'ina Wellness Center is flourishing is simply that people do better when treated at home."
>
> DIANA ZIRUL, CHAIRPERSON, HEALTH BOARD, KENAITZE INDIAN TRIBE

(Dena'ina Wellness Center, continued from page 29)

This philosophy is reflected even in the design of the building, which has integrated workspaces to allow various care teams to collaborate on treatment plans and customize them to each individual. The facility also features a gym, plus classrooms and a wellness kitchen for educational use.

Part of nourishing wellness is remembering history and celebrating the natural world, so that too is part of the architecture. Century-old Douglas fir planks reclaimed from a Kenai River cannery span much of the interior. The ocean is depicted in blue across the floor near the main entrance. Agates inset in the flooring were collected by tribal members. Dena'ina names are used throughout the facility. Outside the center is a ceremonial space called Raven Plaza, referencing the raven that brought light to the world in a traditional Alaska Native story.

COMMUNITY INTEGRATION

The Kenaitze Indian Tribe even takes integration of medical services beyond the wellness center. The tribe, which is federally recognized as a sovereign, independent nation, delivers a variety of programs and services that it sees as crucial to promoting the wellness of its people and broader community—including a tribal justice system, early-childhood education center, an Elders center, and a social-services program. All are located on the tribe's campus in the Old Town section of Kenai, which was an early Kahtnuht'ana Dena'ina village site.

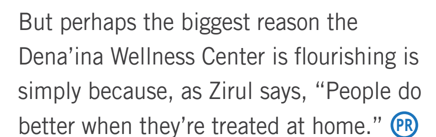
An example of their community integration is the tribe's joint-jurisdictional therapeutic-wellness court, which accepts people—even non–tribal members—who are charged with a substance abuse–related offense. The charged person goes before a tribal and state court judge, sitting side-by-side in Kenaitze's courtroom, for an 18-month program that includes behavioral health and substance-abuse treatment from the Dena'ina Wellness Center. Although this program is new—less than two years old—Zirul says it has been effective and the tribe hopes to expand it.

FULL CIRCLE

While many rural health centers throughout the country struggle with decreasing demand, the Dena'ina Wellness Center isn't among them. Zirul says Kenai is seeing tribal members and others in Alaska move from remote areas to slightly larger ones such as Kenai, which is the rural hub of the peninsula.

"I myself returned here 30 years ago," she says. "People are moving here for the quality of life and to be closer to family." Additionally, she says, the school systems are good, and while the local economy has its ups and downs like any other, the job market is generally healthy.

But perhaps the biggest reason the Dena'ina Wellness Center is flourishing is simply because, as Zirul says, "People do better when they're treated at home." PR



FAST FACTS

CARE PROVIDERS: 1 pediatrician, 5 nurse practitioners, 4 dentists

TOTAL STAFF: 157

BENEFICIARIES: 40,000

FOUNDED: 2014

MEMBER SINCE: 2017

"If you have these conversations with your patients as they become more frail, and stay a bit ahead of the game, it will be a gradual and well informed process for patients and their families."

SUSAN TOLLE, M.D., DIRECTOR OF THE CENTER OF ETHICS IN HEALTHCARE, OREGON HEALTH AND SCIENCE UNIVERSITY (OHSU)

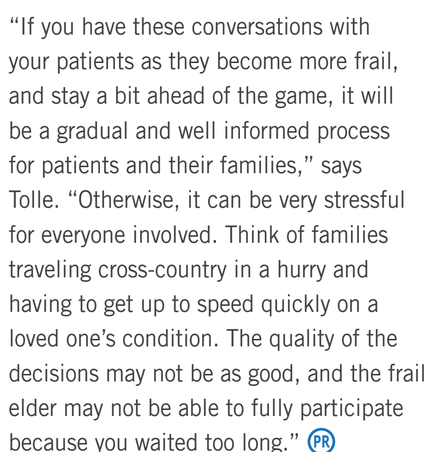
(POLST, continued from page 25)

is the hospital. I want the conversations around POLST to be deep and thoughtful."

HAVING CONVERSATIONS WITH PATIENTS AND THEIR FAMILIES

As with many common medical decisions, primary-care physicians should talk with their sicker patients about advance-care planning and POLST, even if a form isn't completed right away. Ideally, patients would have already set up the legal documents of their advance directives and appointed a surrogate during healthy years (often with the help of a family law professional). Then later, as their health declines, their physician can complete the POLST to provide actionable direction in line with their wishes.

"If you have these conversations with your patients as they become more frail, and stay a bit ahead of the game, it will be a gradual and well informed process for patients and their families," says Tolle. "Otherwise, it can be very stressful for everyone involved. Think of families traveling cross-country in a hurry and having to get up to speed quickly on a loved one's condition. The quality of the decisions may not be as good, and the frail elder may not be able to fully participate because you waited too long." PR



For an overview of POLST that you, your patients, and their families can watch, see "POLST: When Is the Right Time?" on YouTube at: https://bit.ly/2KAIf5C.

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(Connecting with Elderly Patients, continued from page 9)

literacy, according to the National Assessment of Adult Literacy. Research has also connected lower health literacy with poorer physical and mental health.

- 12.7% of adults ages 60 or over report increased confusion or memory loss.

- Approximately half of all adults over the age of 65 report that they have been diagnosed with arthritis.

- Nearly half of Americans aged 65 and over have at least one major eye impairment. Visual impairment often leads to other concerns, including increased risk of fall and fracture, increased risk of depression, difficulty identifying medications, and difficulty participating in daily activities such as bathing and dressing.

- More than 80% of those diagnosed with lung cancer are over the age of 60, and COPD prevalence in those aged 65 and over is estimated at 14.2%.

These concerns may require you to adapt your conversation style. For instance, a patient with low health literacy will require explanations of health conditions and medications, along with explanations of why and how things happen. Jargon will confuse this kind of patient, and many patients may not admit their confusion. A patient with hearing loss may require you to speak louder and more slowly, or to write down instructions clearly (or type them out, if your handwriting is hard to decipher). Patients with confusion or memory loss will also benefit from written instructions, and it may be helpful to ask them to bring someone else along—an adult child, for instance—who can answer your questions more fully and help them remember your instructions. A person with lung disease may speak quietly, be difficult to understand, or become exhausted from a lot of speaking. It's important to be patient with them and allow them to tell their story on their terms.

WAYS TO CONNECT

What other steps can your office take to connect with your elderly patients? You may find that these steps go over well with all of your patients, not just the older ones!

1. **Train your team.** Before you even come into contact with each patient, they will have already met with several members of your team—your front desk, a medical assistant, and perhaps an RN. What impression is your team making? Are they being compassionate towards the needs of your patient, or are their own biases showing? Problems interacting with the team may cause the patient to be less, well, patient—and will make them feel misunderstood before you even begin speaking.

2. **Schedule extra time and avoid interruptions.** Your patient may need more time to tell their story, or you might need more time for explanation and instruction. Either way, allow more time for the appointment, and train your team not to interrupt you when you are with patients. This will help you communicate more effectively and build a solid patient-provider relationship.

3. **Use decision aids such as anatomy models, images, and written instructions.** Make your discussion as memorable as possible by using decision aids to help explain. A model of a mobile joint, an image of the circulatory system, or instructions printed in a larger-size font will go a long way toward increasing patient understanding and improving compliance.

4. **Check your nonverbal communication.** Speaking is only one aspect of communication. What is your body saying to your patients? You might think you're ready to listen to your patients' concerns, but if you are looking at a computer screen, checking the clock on the wall, or sitting in a closed-off position, your patients may pick up on the fact that you are feeling impatient. They may feel like they are bothering you, and will be less likely to share important information as a result.

5. **Document your communication.** Make sure that your chart notes include the communication you had with your patient—everything from the patient's health history to the instructions you gave and the medication you prescribed.

THE MISSED OPPORTUNITY

Let's go back to Patty and Frank. What happened at Frank's appointment with Dr. Jones that could have been done differently?

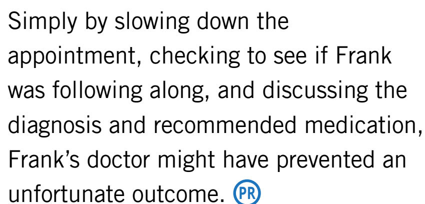
Listen to what Frank had to say:

"You know how it is with these young kids—in and out, and here's a bunch of pills."

It's clear that Dr. Jones missed an opportunity. Frank did not feel valued or listened to. He felt rushed and didn't feel comfortable expressing his discomfort. He was provided with a prescription for medications and didn't understand why he needed them.

"He talks too fast. All those big words. They make no sense."

Dr. Jones likely hit Frank hard with a lot of jargon. Frank may also be having hearing difficulties, but Dr. Jones didn't take a moment to find out. His rapid-fire speech delivery likely frustrated Frank.



Simply by slowing down the appointment, checking to see if Frank was following along, and discussing the diagnosis and recommended medication, Frank's doctor might have prevented an unfortunate outcome. PR

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Trial Results

The following summaries are Physicians Insurance cases that have gone to trial and are public record. In reporting these legal results, it is our goal to inform members about issues that impact health-care professionals. While we share information we think may be informative, we choose not to disclose the names of plaintiffs or defendants when reporting these results.

DELAYED DIAGNOSIS: BREAST CANCER

SPECIALTY: Physician's Assistant and Family Practice

ALLEGATION: The plaintiff was a 28-year-old single woman with two young children who underwent a medical abortion in May of 2014. She was referred from an Emergency Department to the defendant provider on 9/23/14, for complaints of abnormal vaginal bleeding. The physician's exam disclosed a previously undiagnosed right-breast lump. He ordered an ultrasound performed on 9/26/14, which was found to be negative, BI-RADS 1. The patient also underwent a hysteroscopy on 10/2/14, which diagnosed the abnormal bleeding as related to retained products of conception from her March pregnancy.

Radiology sent the patient a letter indicating that her ultrasound results were normal/benign. The letter went on to say that a normal breast ultrasound does not entirely exclude the possibility of breast disease, and requires continued follow-up.

On 10/8/14, the patient called to request consent to return to work. She was reminded of her follow-up appointment on 10/10/14. When she failed to show up, a staff member called within one hour to leave a message requesting that the patient call to schedule a new appointment.

The patient testified that the right-breast lump did not change until a few months after the birth of her third child on 1/1/16. Breast exams performed during her hospitalization for the delivery found no evidence of a right-breast lump. By July of 2016, the patient was diagnosed with a right-breast tumor that involved most of her breast. Despite a negative left-breast exam in July of 2016, by August, she was diagnosed with extensive breast lumps on the left. Her Stage IV breast cancer responded initially to chemotherapy but by trial, her prognosis was poor.

PLAINTIFF ATTORNEY: Steve Haskell, Spokane, WA

PLAINTIFF EXPERTS: Nicholas Fogelson, MD, OBG, Portland, OR, Claire Buchana, MD, Surgical Oncology, Seattle, WA, Randall Patton, MD, Radiology, Olympia, WA

DEFENSE ATTORNEYS: Steve Lamberson, Spokane, WA, Jennifer Moore, Seattle, WA

DEFENSE EXPERTS: Rachel Brem, MD, Breast Imaging/Radiology, Washington, DC, James Brasch, MD, OBG Spokane, WA, Ira Bleiweiss, MD, PTH Phildelphia, PA, Tammy deLamelena, MD, Surgical Oncology, Portland, OR

RESULT: Defense Verdict; Jury Trial

FAILURE TO PERFORM: WRIST SURGERY

SPECIALTY: Orthopedic Surgery

ALLEGATION: On 2/15/14 the patient fell and fractured her wrist while ice skating. Following her fall, she presented to the Emergency Department, where she was referred to an orthopedic surgeon. On 2/21/14 the patient presented to the orthopedic surgeon. After having X-rays taken of the patient's wrist, the surgeon informed her that the best course of action would be for him to perform surgery to repair the fracture. He explained in detail the process for performing an open reduction and internal fixation (ORIF) with the use of a plate and screws, which is the specific procedure he recommended. The patient was resistant to surgery because of the cost, but the surgeon gave her the code for the procedure so she could contact the business office about a payment plan. At the end of the visit on 2/21/14, the patient contacted the business office and received a quote

for the surgery, as well as information regarding payment plans.

On 2/26/14 the patient returned to see the orthopedic surgeon and explained that she wanted him to perform a closed reduction. The defendant surgeon reiterated that closed reductions do not actually improve this type of fracture, and he again urged the patient to consider an ORIF. The patient again resisted the surgeon's recommendation, and she ultimately opted for casting rather than surgery. The patient's cast was removed on 3/28/14 and she was transitioned into a removable brace and advised to follow up as needed.

PLAINTIFF ATTORNEY: Mark Perez, Seattle, WA

PLAINTIFF EXPERT: Jeffrey Holms, MD (ORS), Los Gatos, CA

DEFENSE ATTORNEY: Dylan, Cohon & Lauren Martin, Seattle, WA

DEFENSE EXPERTS: Douglas Hanel, MD (ORS), Seattle, WA, Tristan McGovern, MD (ORS), Port Angeles, WA

RESULT: Defense Verdict; Jury Trial

(Bringing it Home, continued from page 19)

"It especially helps when there are some family members who are local and others who are far away. For example, one might say, 'Dad's in really bad shape, and you should come home.' And another family member replies, 'I just saw him last month and he was fine.' The answer is, 'Well, let's Skype and you can see what he's going through.'"

WHAT PHYSICIANS SHOULD KNOW WHEN DISCUSSING HOSPICE

It's still very difficult for physicians to bring up end-of-life issues, says Ransier. "'How to have the conversation' is something that needs to be taught earlier in medical school and among primary-care physicians," she says, and adds that she thinks it's never too early to begin the discussion. "What we know is that the patients will talk about this. But they often need someone to bring it up. Most of the time, the patient has a long-term relationship with the primary-care doctor. And once the doctor brings it up, patients will respond. Most people still feel that their physicians 'know all,' so it stimulates the conversation and strengthens the relationship."

PALLIATIVE CARE: HIGHLY IMPORTANT AND OFTEN OVERLOOKED

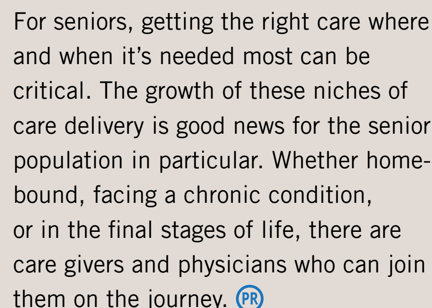
Many patients with chronic conditions such as cancer, congestive heart failure, or Parkinson's experience a range of symptoms and stresses from the treatments they receive. This is where palliative care comes in.

"We talk about palliative care as a wraparound of all the comfort and services patients need while they're navigating chronic illness," says Dr. Miner. "Unlike a hip fracture or cold, these are conditions they'll be managing their entire life. The longer the chronic illness goes on, the less effective our tools are at keeping patients as functional as they want to be. Nurses, social workers, and even spiritual counselors are vital to helping people with the changes they're facing because of the nature of their condition."

At Hospice of North Idaho, more patients receive palliative care at any given time than there are patients in hospice care. "We have a nurse who calls and does a home visit," says Dr. Ransier. "Based on that, she comes up with a plan of care—a call every two weeks, a home visit once a month."

Much like with home-based medical care, the value is clear to see, yet still needs to be quantified. "The challenge is, there is no reimbursement unless the care is provided by a licensed provider like a nurse practitioner or physician," Ransier continues. "We can prevent costly ER visits, and we can connect patients to a lot of social services, which also keeps them out of the hospital."

For seniors, getting the right care where and when it's needed most can be critical. The growth of these niches of care delivery is good news for the senior population in particular. Whether home-bound, facing a chronic condition, or in the final stages of life, there are care givers and physicians who can join them on the journey. PR



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