

geriatric medicine gerontology Report

NEWS FOR THOSE WHO CARE FOR AND ABOUT OLDER ADULTS

UC Establishes Student Chapter of American Geriatrics Society

Fourteen University of Cincinnati (UC) medical students representing all grades have joined to launch a Student Chapter of the American Geriatrics Society (AGS). Timothy Lewis, MD, clinical instructor in the Department of Internal Medicine is the chapter advisor. The Student Leadership Council includes Libby Beiter UC II, Shawana Klinesteker UC I, Darcy Laurey UC II and Gwen Roesel UC IV.

The mission of the chapter is to interest physicians-in-training, no matter their specialty choice, 1) to encourage curriculum development in geriatrics, 2) to offer educational programs in geriatrics and, 3) to promote service learning projects in community facilities serving older people. This mission is in keeping with the national AGS.

An initiation dinner meeting was held on January 19, 2003 in the Faculty Conference Center in the Medical Sciences Building. A short business meeting was followed by a program about older people who are successfully living long lives. Key note speaker was Dr. Jean Rothenberg, founder of the Cincinnati Speech and Hearing Center. Because of her long life and how she has chosen to live, despite numerous blips in the road on her way to the age of 94, Dr. Rothenberg was chosen to speak to students about "Successful Aging". One of her greatest successes was to face her hearing loss with unrelenting determina-

tion not to be handicapped by it.

In her early 20's Dr. Rothenberg discovered that she was hard of hearing. This was at a time when very little was known about hearing deficits. During her discussion with the students, Jean, as she prefers to be addressed, chronicled her journey to not only learn everything she could about hearing loss but to also do all that was possible to overcome any problems that her hearing loss presented. As a result of her personal resolve and insights she ultimately gathered a group of Cincinnatians together to establish what is now known as the Cincinnati Speech and Hearing Center.

Jean also counseled the students to "do"! Jean declares that her long and satisfying life is directly related to her basic personality which does not allow her sit around and dream about something she thinks is a good idea or something that she wants to do. She does it! This philosophy is what she believes has been the driving force behind her ability to age successfully and continue to be active. Jean also believes that, despite numerous health problems, she has faced all her problems while "refusing to view herself as a victim". By the end of their discussion the students all agreed that the most important message they got from their discussion with Jean Rothenberg was that the main ingredients of successful aging

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The Christ Hospital Assumes Sponsorship of Geriatric Evaluation Center and Center for Alzheimer's Care

Commitment to clinical care, education and research in geriatrics remains unchanged

In 1987, The University Hospital in cooperation with the University of Cincinnati Department of Family Medicine initiated the Geriatric Evaluation Center (GEC). Since its inception, the services it offers have been highly valuable to the community. The success of the GEC is largely attributable to its location at Maple Knoll Village (MKV), a nationally accredited continuing-care retirement community in north Cincinnati. The GEC provides outpatient interdisciplinary medical and social

assessments. The Center's intention is to assist older persons and their family members cope with the expected adjustments of normal aging and concerns about daily problems. In 2000 the GEC program was expanded to offer primary care to patients with memory loss in the University Center for Alzheimer's Care. Both services share the same faculty and staff at the MKV site.

For appointment information:

Geriatric Evaluation Center
(513) 782-2730

Center for Alzheimer's Care
(513) 782-2731

Continuing as the only Health Alliance outpatient geriatric-specific clinical service, the Geriatric Evaluation Center and the Center for Alzheimer's Care are now offered under the aegis of The Christ Hospital. This transition administratively began in September 2001. Both clinical services maintain the same structure and faculty/staff at the MKV site but the name on the door and publicity will reflect The Christ Hospital. The Christ Hospital and the Geriatric Evaluation Center and the Center for Alzheimer's Care remain committed to inter-related missions that emphasize clinical care, education and research in geriatrics. ■

Student Chapter

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are to face all that life has to offer, good or bad, with determination to succeed, to be flexible and to stay interested in the world around you. One of the students noted that she learned that with a "positive" attitude old age does not have to be "negative"—it can be a very exciting and rewarding time of life.

For more information about the UC Student Chapter of the American Geriatrics Society, contact one of the four members of the Student Leadership Council—Libby Beiter, Darcy Laury, Shawna Kleinsteter, Gwen Roesel—or Administrative Coordinator Elizabeth Gothelf at gothel@fammed.uc.edu. Meetings are planned for every other month. Details are published by email to members and others who may be interested in membership. ■

DONATIONS AND REQUESTS

Contributions honoring individuals welcome

The Office of Geriatric Medicine at the University of Cincinnati College of Medicine welcomes contributions to further geriatric education, training and research. If you wish to make a donation in honor of an individual or as a remembrance at the time of death, please indicate this in your correspondence. An appropriate acknowledgment will be sent to the honoree or family in your name.

Contributions are deductible for income tax purposes to the extent allowed by law.

Please direct inquiries to Gregg Warshaw, MD, (513) 584-0650. Donations and bequests can be directed to:

University of Cincinnati
Office of Geriatric Medicine
PO Box 670504
Cincinnati, OH 45267-0504 ■

2002 - 2003 Geriatric Medicine Fellows

*During the 2002–2003 academic year, four physicians are completing a postgraduate fellowship in Geriatric Medicine. Recently the **Report** had the opportunity to talk with two of the fellows about their decision to receive another year of training which qualifies them to take the post competency test in geriatric medicine and become certified as a geriatrician.*

CYNTHIA LUCK, DO, states that she was influenced to enter geriatric medicine by several different positive experiences while working with older people. During her undergraduate years at Grove City College, PA, Dr. Luck worked with a group known as “Lamplighters for the Blind”. This is a program for older people living in their homes who have vision problems. “This was such a rewarding experience that, to this day, I continue to correspond, telephone and visit my “Lamplighter” named Margaret,” says Dr. Luck. She also credits her interest in geriatric medicine to a role model, friend and geriatrician, Tracy Marx, DO, who had a very important and positive impact on her medical training.

Dr. Luck says that she enjoys spending time getting to know her older patients and residents of the nursing home where she works. “It is very gratifying to help them with their medical conditions and make their lives more enjoyable,” she comments. Upon completion of her fellowship, Dr. Luck hopes to become a full time geriatrician when she returns to the Pittsburg, PA, area where her parents, brother and sister-in-law live.

In 1995, Dr. Luck received a Masters Degree from Duquesne University in Pittsburg and in 1999 she completed her medical education at the Ohio University College of Osteopathic Medicine in Athens, OH. Her residency training was at Family Practice–Doctors Hospital Ohio, Columbus.

LALITHA PARAM, MD, spent five years in private practice before deciding to complete a fellowship in geriatric medicine. Dr. Param states that she received the most enjoyment and satisfaction during her practice years when she was taking care of her older patients and in return she felt her older patients appreciated the care she gave them. However, Dr. Param says, she realized that, at times, she did not have all the knowledge and skills necessary

to do the best possible for her older patients. Thus, she was influenced to complete a fellowship so that she could feel more confident about the care she gave her older patients.

Dr. Param says that her geriatric medicine fellowship training at UC is all that she had hoped it would be. “It is a well structured program with exposure to a broad variety of geriatric patients and issues in the community including assisted living, nursing home and in the hospital,” she explains. Dr. Param particularly enjoys Journal Club where the most current literature on geriatric medicine is analyzed and discussed.

In 1991 Dr. Param graduated from Osmania Medical College, Hyderabad, India and completed her residency at Jewish Hospital, Cincinnati, in 1997. Upon completion of her fellowship, Dr. Param plans to practice in the community. Dr. Param is married and has two children, Priyanka, 8 years of age and Anika who is one year old.

The third member of the current fellowship class is **SABA A. ANSARI, MD**, who in 1999 received her medical education at the University of Minnesota Medical School. In 2001, she completed her residency at the UC Department of Internal Medicine.

EMMANUEL V. RIVERA, MD, is the fourth member of the current fellowship class. Dr. Rivera received his medical education at the University of Santo Tomas, Manila, Philippines, where he also received a BS in Microbiology in 1984. Dr. Rivera spent two years with the United States Medical Research Unit in Manila before coming to the United States to complete his residency at the Bethesda Family Practice Program–TriHealth Hospital. Before starting his geriatric fellowship program, Dr. Rivera was a Hospitalist/Critical Care Physician at Mercy Franciscan in the Western Hills area of Cincinnati. ■

Geriatric Functional Assessment Focus of Third Year Clerkship Session

As a part of their required rotation in Family Medicine, third year medical students participate in an interactive session learning the components of geriatric functional assessment. This four-hour session was introduced in July 2001 when the UC Department of Family Medicine revised its didactic curriculum to include more student-to-faculty interaction.

In such a session, Gordon Margolin, MD, a member of the geriatric medicine faculty, emphasizes the importance of a functional assessment to a physician developing a plan of care for a frail older patient. Dr. Margolin explains that all physicians are trained to conduct a thorough medical history and physical examination, which are the foundation for an accurate diagnosis. This makes it possible to order appropriate clinical interventions. "However," Dr. Margolin adds, "the majority of physicians are not taught how to gather information about how well the older person can care for himself and whether the living environment is safe and appropriate to the person's functional ability." The quality of an older person's life can be shaped by the physician's acquiring this information and developing a responsive plan.

The session involves an average of 12 students, divided into groups of four, and a preceptor who observes each student conduct a component of the assessment. The exercise takes place at the College of Medicine's Center for Competency and Assessment using standardized patients. Since by the third year most students have experience in conducting a medical history, only a few questions concentrate on past medical history, current health status and medications. Instead, the focus is on concerns such as the ability to use stairs, safety of the home and neighborhood, and proximity to family and neighbors available to "look in" on a regular basis or to help in a crisis.

The functional assessment also involves evaluating how well the person can attend to activities of daily living (ADLs) such as bathing, dressing, toileting, walking, eating and getting in and out of a chair. Instrumental Activities

(IADLs) are appraised as well. IADLs include using the telephone, shopping, preparing meals, doing housework, taking medications, paying bills and managing money. Standard forms are used to assess ADLs and IADLs.

Next, the person's cognitive ability is assessed, scrutinizing both mental status and the possibility of depression. By examining cognitive ability, the physician is determining whether or not appropriate decisions are being made by the patient and whether the person is accurately portraying his ability to function in his or her living arrangement.

At the completion of the interview, the students come together to determine whether they believe the patient can remain living alone, with or without some assistance, or needs regular supervision. A care plan is developed. Then the daughter of the patient is interviewed along with the patient, revealing that the patient has overestimated her abilities and is, in fact, living in a way that the daughter believes is unsafe. This disclosure leads to the development of a new care plan, which faces resistance from the patient. A discussion follows about some of the negotiations that may need to take place between the patient and family with the physician taking the role of mediator.

Following this portion of the session, the students are given information about the warning signs that may signal the need to conduct an all inclusive assessment such as they have just practiced. They learn tips on how to condense a comprehensive evaluation into a time frame that is more realistic for a busy primary care practice and how to collect various components over time which can be used as a baseline when change does occur.

The session concludes with an occupational and physical therapist discussing their respective roles and demonstrating the proper use of adaptive equipment such as canes and walkers and under what circumstances each should be used. Devices to facilitate bathing, toileting, buttoning, tying shoes and putting on socks and hose are also demonstrated. ■

Faculty Hospitalist Practice Benefits Patients, Faculty and Medical Residents

Physicians who emphasize full-time inpatient care in hospitals are growing in number across the country and are known as Hospitalists. By focusing their practice on caring for hospitalized patients, Hospitalists can develop expertise in meeting the unique needs of inpatients.

The division of General Internal Medicine in the UC Department of Internal Medicine initiated a faculty Hospitalist service at The University Hospital in November 2001. It is staffed by Drs. Sean Miller, Tim Lewis, and Allen Bryant. This service cares for patients hospitalized on a general internal medicine ward service that is currently not staffed with resident physicians or medical students.

The faculty Hospitalist service was initially developed with two main objectives: 1) to ease the work-load on the resident-covered ward teams to insure that residents do not exceed Accreditation Council for Graduate Medical Education-mandated admission caps and 2) to free up more time to focus on resident and student education. Thus far, the faculty Hospitalist service has focused on caring for patients who are admitted in the evenings via the UC Emergency Department by a night-float resident who comes in to relieve the on-call day-time ward team. In the future, the division is considering expanding the Hospitalist service so that physicians in the academic center or perhaps the greater Cincinnati community could refer their patients to the service (i.e., during the day).

According to Dr. Lewis, there are several advantages to having a regular onsite internal medicine faculty presence in the hospital. "The faculty Hospitalists are available to supervise resident procedures, act as positive

inpatient role models, communicate with patients and their families, and manage any urgent medical problems that may arise during the day," he explains. Dr. Lewis further notes that, thanks to the presence of the Hospitalist service, the ward team admissions have been reduced. In addition, faculty and resident satisfaction is improving because there is more time available for resident and medical student education. Hospitalists have the opportunity to learn to be very efficient at managing hospitalized patients since they attend on the in-patient wards four months per year compared to the non-Hospitalist faculty who typically attend inpatient services two months per year. Their daily hospital presence also gives Hospitalists ample opportunities to stay proficient with invasive procedures typical of the inpatient setting.

The physicians staffing the UC faculty Hospitalist service also recognize the limitations to a hospital-based practice. One salient, but not insurmountable issue is discontinuity in patient care between the outpatient and inpatient settings. Unlike a primary care doctor, a Hospitalist typically has no prior relationship with the patient he or she cares for in the hospital. This

lack of patient-physician continuity between health care settings, if not handled carefully, can undermine patient satisfaction and the quality of medical care. This crucial issue mandates vigilant attention to the shared responsibility of effective communication between Hospitalists and primary care physicians. The UC Hospitalists are tackling this problem very seriously and are striving to excel at communication that demonstrates a commitment to keeping both the primary care physicians

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UC Faculty Hospitalists

Dr. Allen Bryant completed his residency at UC and joined the faculty after five years in private practice as an internist. He was the chief of medicine at Dearborn County Hospital (Indiana) and the head of its intensive care unit from 2000 to 2002.

Dr. Tim Lewis completed a residency at UC in 2001 and joined the Hospitalist service in July 2002 after completing a geriatric medicine fellowship at UC. He is a member of the UC geriatric medicine teaching faculty.

Dr. Sean Miller completed his internal medicine residency in 2001 at UC. He is also the medical director for the internal medicine inpatient ward on 7 North West at The University Hospital. ■

FROM THE DIRECTOR: The Practice of Geriatric Medicine

Geriatric Medicine

Although the practice of geriatric medicine includes preventive medicine and the diagnosis and treatment of reversible diseases, it is dominated by the challenge of caring for patients with chronic illness. The geriatrician's goal in managing chronic illness is to maximize the older adult's productivity, well being, and happiness. To achieve these goals, the delivery of quality, cost-effective medical services to older adults is critical. Accomplishing these goals will require continuous broad education and research initiatives that reach every medical student, resident, fellow, and practicing physician.

Physicians certified in geriatric medicine and geriatric psychiatry are leading this effort, but leadership, expertise, and commitment is required from all medical and surgical specialties and other health care disciplines. The certain dramatic growth in the number of older adults during the coming decades and the increasing cost of new, effective medical and surgical treatments add urgency to this challenge. In addition, the delivery of medical services to older adults occurs not only in the familiar office and hospital settings, but also in the home, retirement home, rest home/assisted living facilities, nursing home, and hospice settings. Effective medical care for older adults in all settings requires that physicians work cooperatively with practitioners representing many health care disciplines, such as nursing, social work, and the various therapies.

Health of Older Adults

In 2000, the number of adults age 65 and over numbered 35 million, about one in every eight Americans. By 2030 the number of older Americans will have doubled to 70 million. In 1999, 6.3% of adults age 65 and over reported at least one limitation in Activities of Daily Living, and 12.4% reported at least one limitation in Instrumental Activities of Daily Living.

Utilization and Cost of Services

Although the health and physical functioning of older adults appears to be improving, there remains a concern that the rapid growth of the oldest age groups will have a major impact on health care costs. The Centers for Medicare and



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Medicaid Services recently released a report on U.S. health care expenditures for 2000. After a decade of stability, health care spending grew to \$1.3 trillion in 2000—up nearly 7% from 1999, the fastest acceleration in 12 years. These expenditures represented 13.2% of the U.S. gross domestic product. In 2000, Medicare spending rose 5.6 % to \$224.4 billion. In 2000, nursing home and home health total expenditures also rose, after several years of stable or declining rates. In 1997 Medicare and Medicaid combined were the source of payment for 68% of institutional care.

Federal efforts to control the rate of growth of these expenditures has centered on complex formulas that control payments to providers and the less successful application of managed care principles to Medicare. Medicaid payments for older adults have also risen significantly during the past 20 years. Medicare reimbursement is the single most influential force shaping medical practice in the U.S., accounting for 26.7% of physician income in 2000.

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In 1999, 25% of office visits to physicians in the U.S. were made by adults age 65 or over (192.2 million visits). This represented 592 visits per 100 persons age 65 or older, as compared to 283 visits per 100 persons of all ages. Forty-six percent of office visits made by older adults were to family physicians or general internists; 54% were made to other medical specialists. Over the past decade, the trend has been for a larger percentage of ambulatory office visits to occur in non-primary care specialists' offices.

Current Number and Distribution of Practicing Geriatricians and Geriatric Psychiatrists

Currently the national average number of geriatricians is 5.5 per 10,000 population over 75 (individual state rates range from 2.2-15.9) and there are 1.4 geriatric psychiatrists per 10,000

population over 75 (individual state rates range from 0.2-4.12). The total number of Certificates of Added Qualifications awarded from 1988 through 2001 includes: 9907 American Board of Internal Medicine/American Board of Family Practice (ABIM/ABFP) certificates, 2508 American Board of Psychiatry and Neurology certificates and 503 American Osteopathic Boards of Internal Medicine and Family Practice certificates. The end of the initially available practice pathway accounts for the decline in examinees from allopathic family medicine and internal medicine since 1994 and from psychiatry since 1996.

Geriatric medicine and psychiatry Certificates of Added Qualifications are valid for ten years, with re-certification required. Re-certification in osteopathic geriatric medicine does not begin until October 2002. The number of candidates seeking to become re-certified has been low. In 2001 the ABIM conducted a review of re-certification in geriatric medicine. Approximately 42% of those in geriatric medicine have returned for re-certification. Preliminary analysis of the ABFP diplomates found a 50% recertification rate for the 1988 cohort. Although ABIM/ABFP diplomates from the 1988 and 1990 examinations may still apply for re-certification, it appears that a significant decrease in the number of certified geriatricians will occur over the coming decade, despite the continued growth of fellowship training pro-

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grams. It is estimated that from 1998 through 2004 there will be a 34% reduction (from 9,256 to 6,127) of ABIM/ABFP certified geriatricians in the U.S.

Implications

The aging of the U.S. population will have a major impact on the practice of medicine and future health care costs. Current cost containment strategies are inadequate to address this demographic trend. The principles of geriatric medicine practice developed over the past 50 years, if widely applied to the care of older Americans, provide an opportunity to deliver quality, cost-effective care for the well elderly and for older adults with chronic illness. In addition, investment in research that leads to substantial advances in the prevention and treatment of the diseases that result in the greatest functional loss among the old is essential.

Geriatricians limit their practice to older adults, and thus receive the majority of their compensation from Medicare. Many of the time-intensive services geriatricians provide to older adults and their families are not adequately reimbursed. The growing gap between Medicare reimbursement and the actual costs of delivering medical service seriously affects the willingness of young physicians to consider a career in geriatric medicine. ■

Hospitalist Service

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and themselves "in the loop."

To ameliorate patients' sense of fragmented healthcare, the Hospitalists at UC find it helpful when primary care doctors make a visit or call to check on patients during their hospital stay. This can help to reassure patients that the Hospitalist and the primary care physician are communicating and working in a coordinated fashion in support of their best care. The Hospitalists at UC are committed to reciprocating these efforts by effecting timely communications regarding all patient admissions, important updates, and discharge plans to primary care physicians both inside and outside the UC system.

According to Dr. Lewis, the faculty who staff the Hospitalist Service believe that they are ideally situated to be champions of quality improvement in the in-patient realm at The University Hospital. As they build expertise with the workings of the hospital system, they hope to discover opportunities to make significant system improvements that will favorably affect patient care. Additionally, the division of General Internal Medicine recognizes the importance of ongoing health outcomes research to assess the impact of increased reliance on Hospitalists, and data are being gathered for analysis.

Questions about the internal medicine faculty Hospitalist program can be directed to Drs. Miller, Lewis, or Bryant at 558-7581. ■

Faculty and Staff Notes

Steve Bartz, MD, RPh, Assistant Professor of Clinical Family Medicine in the UC Department of Family Medicine, has been appointed Medical Director of University Family Physicians—University Pointe. In this capacity, Dr. Bartz is involved in all aspects of the practice including budget, personnel, marketing, purchasing and suite design but, first and foremost, patient care. Dr. Bartz earned his medical degree from UC in 1995, completed his residency in Family Medicine and a fellowship in Geriatric Medicine with the UC Department of Family Medicine. Dr. Bartz is also a registered pharmacist. *For more information about services available at University Pointe, call 513-475-8264.*

Timothy Lewis, MD, a 2001 graduate of the UC Geriatric Fellowship Program, was appointed Instructor of Clinical Medicine in the Department of General Internal Medicine. Dr. Lewis serves as a Hospitalist at The University Hospital and as a Preceptor in the General Medicine Internal Medicine Clinic. He serves as the medical advisor of the UC Student Chapter of the American Geriatrics Society. In fall 2001, he led a workshop at the statewide conference sponsored by the Consortium of Ohio Geriatric Academic Programs. To prepare to participate in clinical investigations relevant to general internal medicine and the care of older adults,

he participated in the "Clinical Effectiveness Program" sponsored by Harvard School of Public Health. Dr. Lewis will return in summer 2003 to complete the program with a concentration in clinical epidemiology.

Arvind Modawal, MD, MPH, MRCGP, Associate Professor in the division of Geriatrics of the UC Department of Family Medicine, was awarded honorary fellowship in the Geriatric Society of India in November 2002. At the convocation, Dr. Modawal presented a guest lecture and served as chair of a session. Dr. Modawal was recently appointed Medical Director of Bridgeway Pointe Assisted Living and The Harbor, a Alzheimer's disease and dementia unit on the Drake Center campus. Dr. Modawal is also the new co-Medical Director for Evercare Ohio—Cincinnati, a nursing home HMO. He published in the winter 2002 issue of *Ohio Family Physician* which focused on geriatric issues. Active in balance and falls research, he continues with 'Ergonomic Aspects of Older Workers Balance' in collaboration with the UC Bio-mechanics-Ergonomics Research laboratory.

Irene Moore, MSW, ACSW, Director, Alliance Geriatric Medicine, has written a reference for the *McMillan Encyclopedia of Aging*, entitled Geriatric Assessment Unit, published 2002. ■

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