Inpatient Geriatric Consultations — Not What They Used to Be

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Mild Cognitive Impairment: A Definition and Approach

Sexuality in the Elderly Male: The Clinician’s Role
Geriatric Care Ranked No. 4

Cleveland Clinic has been ranked among America’s top hospitals since U.S. News & World Report began its annual survey of “America’s Best Hospitals” in 1990.

The 2012 survey ranks Cleveland Clinic No. 4 overall. The survey ranks Cleveland Clinic among the nation’s top 10 hospitals in 14 specialty areas, and as the top hospital in three of those areas.

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Staff Listing
Dear Colleagues:

Deciding where to send your patients who need comprehensive geriatric care can be difficult. Our goal in Cleveland Clinic’s Center for Geriatric Medicine is to serve as a central resource for geriatric and gerontological clinical, educational and research activity throughout the Cleveland Clinic health system. Our center coordinates programs and advises and assists clinicians throughout our system of eight hospitals and 18 family health centers. We are eager to assist and educate physicians, nurses, therapists, social workers, other clinical health providers and caregivers in improving the care of the oldest and frailest members of society.

In this issue, we build on our efforts to incorporate geriatric principles into an accountable care model. William Zafirau, MD, is leading our participation in a three-year demonstration project sponsored by the Centers for Medicare & Medicaid Services that seeks to reduce costs by reducing hospital readmissions and improving care coordination. Cleveland Clinic is one of only 16 practices nationwide chosen for this important project. Chris Whinney, MD, recounts his efforts to improve post-acute care via communication between hospitalists and SNFists (doctors who take care of patients in skilled nursing facilities). Quratulain Syed, MD, examines the role of the geriatric inpatient consultation on perceptions about transitions of care.

We collaborate with the Neurological Institute on several initiatives: with Jagan Pillai, MD, on diagnosing and managing mild cognitive impairment; with Ryan Walsh, MD, and Babak Tousi, MD, on Parkinson disease in our patients; and with Patrick Baker, OTR/L, CLVT, on rehabilitative therapy for elders with low vision. Read more about that important work in these pages.

Milton Lakin, MD, considers the impact of sexuality on quality of life for older men. We also look at how “smart” technology in homes can keep people safe and living at home longer with a higher quality of life.

These articles represent a small sample of the work we do every day to help make a real difference in the quality of our patients’ lives.

Over the past few years, Cleveland Clinic has expanded its inpatient, outpatient and post-acute care programs. With growth comes opportunity for recruiting geriatricians who have an interest in patient care, education and program development. Feel free to contact me at 216.444.6801 and/or peruse our website for more information: clevelandclinic.org/geriatricmedicine.

We look forward to continuing our partnership with you. Please don’t hesitate to contact me with any questions, concerns or suggestions on how we might improve our services to you and your patients.

Kind regards,

Barbara Messinger-Rapport, MD, PhD
Director, Center for Geriatric Medicine
Cleveland Clinic Medicine Institute
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Those of us who read Dr. Atul Gawande’s article titled “Big Med,” published in the Aug. 13, 2012, edition of The New Yorker, learned about the shocking experience David Luz had when his 78-year-old mother was admitted to a hospital after an episode of syncope and a fall.

As Luz recounts, his mother stayed in the hospital overnight, underwent an extensive workup and was discharged home the next day without any clear explanation or any proper discharge paperwork or plan. Luz says of the experience: “We didn’t get to go until 6 p.m., with a tired, disabled lady and a long drive home.” In addition, Luz and his mother both struggled to navigate the post-discharge follow-up.

These sentiments are shared by most families who have witnessed a loved one being admitted to a hospital and undergoing a significant yet unexplained physical and cognitive decline in a matter of a few days. Primary care physicians also go through a frustrating ordeal when an older adult patient is admitted to a hospital. They find frustrating the lack of communication from the staff on the inpatient side, especially when the patient is discharged home or to a rehabilitation facility with unclear documentation about the hospital course and post-discharge plan.

Inpatient teams experience an equally difficult situation when trying to communicate with an agitated or lethargic, delirious older adult with multiple medical problems, scant patient history on admission, unavailable records from primary care providers and, frequently, few involved family members. Medical professionals also struggle with avoiding frequent readmissions for chronic diseases, an especially complex and frustrating situation in a country such as ours that is facing a significant shortage of primary care services.

These personal experiences are supported by national and global data about higher readmission rates and the hazards of hospitalizations for older adults, such as polypharmacy, instrumentation, malnutrition and long-term cognitive and functional decline.

A Welcome Shift

The Inpatient Geriatrics Consultation Service at Cleveland Clinic was initiated a few years ago, with both the aforementioned challenges and the medically complex patient population at Cleveland Clinic in mind. Cleveland Clinic provides healthcare services to the Northern Ohio area and is a referral center for complex cases from hospitals throughout the state, as well as neighboring states. The inpatient geriatrics consult team offers consultative services on issues including polypharmacy, gait impairment and falls, cognitive impairment and delirium, elder abuse and neglect, goals of care in patients with multiple comorbidities, and other geriatric syndromes.

Analysis of data from an ongoing research project by the Center for Geriatric Medicine on perceptions of inpatient providers regarding the role of the geriatrics consult service indicates that all the participants in the study survey found the services offered by the consult team helpful and expressed continuing need for assistance with issues involving functional decline, delirium, medical decision-making capacity and discharge planning.

A staff physician, along with an Internal Medicine resident and Geriatrics fellow, make up our consultation team. We follow a systematic approach, with review of overall acute issues and special emphasis on improving nutrition, increasing cognitive and physical activities, reducing polypharmacy, and recommending verbal and nonverbal de-escalation techniques to help providers manage cognitively challenged older adults going through an acute medical or surgical illness.

To complete the picture, we involve family members in cognitive activities for older adults with cognitive impairment. These patients experience significant psychological distress from unfamiliar hospital environments and find it very reassuring to have a family member at their bedside. We also collaborate with
Senior Patient and His Family Find Support and Access to Services and Equipment

A primary concern for aging patients and their families is the ability to preserve independence and maintain quality of life. This holds true for Charles Carter, a lively 96-year-old retired aircraft engine inspector who lives at home with his wife and grandson David, with support from Cleveland Clinic’s Center for Geriatric Medicine.

He was referred to the center after a number of age-related conditions began to take their toll on his body and mind. Now Quratulain Syed, MD, his geriatrician at the Center for Geriatric Medicine, has become the family’s ally, coordinating the services and equipment that Mr. Carter requires to keep him safe and healthy at home.

Streamlined Care

“I really appreciate Dr. Syed,” says David Carter, who is now his grandparents’ live-in caretaker. “She has helped to streamline the number of medications my grandpa was taking, which I believe has helped him to feel better.”

She also has been instrumental in coordinating physical therapy and home care services that Mr. Carter has needed, and she regularly stays in touch with David to keep tabs on Mr. Carter between visits and to offer David her support.

Personalized Service

Mr. Carter was referred to the Center for Geriatric Medicine for evaluation after he began experiencing progressive muscle weakness, gait instability, dizziness and water retention in his legs and feet. He also has a history of hypertension and heart disease, benign prostate hypertrophy, and memory loss — all requiring medication.

Through the Center for Geriatric Medicine, Mr. Carter has received assistance with access to physical therapy at home and to specialized equipment such as a wheelchair, a walker, and grab bars and handrails for his home.

“Going to the geriatric center offers him more individualized care,” David says. “At each visit Dr. Syed goes through the evaluation process a little bit more extensively, asking him questions, watching him walk to check his gait, and she evaluates his strength.”

Together, they then discuss the ongoing plan of care and determine what, if any, additional services Mr. Carter might need.

Now, Mr. Carter manages on two medications, and with some encouragement, he takes walks with his grandson to build and maintain strength. The coordination of care and equipment makes Mr. Carter’s home care less stressful on both him and his family.
According to the 1999 Institute of Medicine report “To Err Is Human,” between 44,000 and 98,000 people die in U.S. hospitals every year of iatrogenic causes. This finding not only has a profound effect on hospitals, it has helped focus attention on transitions of care and on hospital systems. Hospitalists have played a significant role in these processes in most hospitals.

“We still have a lot of opportunities to improve systems of care, especially in transitioning patients from the hospital to the skilled nursing facility (SNF) or to long-term acute care (LTAC) facilities,” says Christopher Whinney, MD, Chairman of the Department of Hospital Medicine at Cleveland Clinic.

The pressure to improve is coming from inside and outside institutions, with the emergence of value-based operations and pay for performance over volume. The Centers for Medicare & Medicaid Services (CMS) is emphasizing metrics of accountability such as achieving core measures, tracking appropriateness of care, meeting readmission targets and assessing patients’ perceptions of the entire experience.

“What patients say will soon affect how we get paid,” says Dr. Whinney.

Readmissions Are Critical

Readmissions may, however, be the true Achilles’ heel. CMS is giving attention to three primary index admission diagnoses: acute myocardial infarction, heart failure and pneumonia. Many of these patients are complex and often require transition to an SNF, where they will continue to require complex coordination of care for multiple medical and surgical comorbidities. Poor or inadequate communication between the hospital and the skilled facility can jeopardize that care.

Physicians who practice in a hospital, especially as trainees, do not necessarily understand what goes on in a skilled facility, says Dr. Whinney. For example, they may not be aware that such facilities are unlikely to have a 24/7 pharmacy or a doctor rounding every day. Most Medicare carriers require a physician certification of skilled needs within 72 hours of admission, and subsequent visits can be as infrequent as once every 30 days.

“So, there is the potential for a great deal of misunderstanding,” says Dr. Whinney. “It’s not so much from the skilled facility doctors, because many of them also round in hospitals; it’s more the dedicated hospital providers and trainees, who may or may not round in skilled facilities, who do not recognize the differences in intensity of care and resources provided for their patients.”

He continues: “We found that between 50 and 60 percent of patients going from Cleveland Clinic to an SNF would ultimately be readmitted here. While one could argue that they were a sicker cohort of patients, there are still several anecdotes about missed communication, missed medications and lost opportunities for collaboration with SNF doctors that could have prevented readmissions.”

With an eye toward fixing this, Cleveland Clinic assembled readmission review teams in 2011 to examine the procedures for patients simply going home, those going home with home health care services put in place, and those going to SNFs.

“We explored what we were telling the facilities and whether or not they were getting the information they needed,” says Dr. Whinney. “We also asked what would make the handoff ideal.”

Adding to the complexity are the Accreditation Council for Graduate Medical Education (ACGME) duty-hour regulations, which were updated in July 2011. Interns can work only 16 consecutive hours on duty, while senior residents can work 24 hours. More frequent care transitions both within and out of the hospital are required, thereby involving more caregivers. Providers need to exert more effort in communication.

“Some people do a great job, and some do not invest in this communication,” he says. “So that’s the challenge: to consistently communicate better for all discharges.”
The First-Ever Long-Term Care Summit

In May, Cleveland Clinic held its first-ever Leaders in Long-Term Care Physicians’ Summit.

The summit brought together hospital-based physicians, whether hospitalists or internists, and SNF physicians (“SNFists”) to discuss ways to improve collaboration and communication.

“We sat down with these facility doctors and asked: If we were to build a plan to ensure perfect hand-off communication, what would it contain? How would we do it? Call? Email? Text? A combination of written and verbal? And, more to the point, what material should we communicate? What do the SNFists need most of all? What belongs in the discharge summary?” explains Dr. Whinney.

To the hospital-based physicians’ surprise, even though they thought they should call every SNF doctor at every patient transition, the SNF doctors don’t always want a call. It depends, they said, on the severity of the patient’s condition. But they do value having a clear means of communicating with the hospital provider so when they are seeing the patient, they have the opportunity to access this provider for a real-time discussion of clinical issues.

It would seem ideal for a thorough discharge summary to accompany the patient, but oddly enough, that is not required by Medicare. CMS allows a 30-day window to complete the summary; in practice, however, if a summary is not completed soon after discharge, it loses its relevance and benefit in effectively facilitating a care transition from one venue to another.

Accordingly, another of the initiatives that Dr. Whinney has championed is that internal medicine providers at Cleveland Clinic prepare a discharge summary on the day of discharge.

It would also seem intuitive that the hospital-based doctor should pick up a phone and call the SNF doctor upon a patient’s discharge to that facility, but the SNFists again said no. The SNF doctor may simply not be ready to absorb the information or may not be with the patient at the time. The ideal time to communicate is when the SNF doctor has had the chance to read the records and is looking at the patient.

“Accordingly, we decided that a better approach would be to let the SNF doctor initiate the contact,” says Dr. Whinney. “These doctors are now given a list of contact options so that they may reach the discharging physician when they are ready to initiate that contact, and by the contact method that they find most appropriate.”

The volume of data can be daunting, and that too is being reviewed.

“We send stacks of information to the SNFs on paper, with a lot of duplicated information. It needs to be distilled to the key things they need,” says Dr. Whinney.

Cleveland Clinic’s DrConnect service provides any doctor real-time HIPAA-compliant access to patient medical records from Cleveland Clinic.

“So now they can look up the information they need without going through an inch-thick stack of paper,” says Dr. Whinney.

Dr. Whinney and his colleagues were very encouraged by the summit and felt that great lessons were learned with respect to future opportunities for clearer collaboration and development of best practices in care transitions. There is still a long way to go in terms of changing the culture of care expectations and communication, he says.

“But in the dawning era of value-based operations, the incentives are there to make this culture change happen and to provide world-class care to patients leaving the hospital setting,” he concludes.

For more information, contact Christopher Whinney, MD, at 216.445.8383 or whinnec@ccf.org.
Diagnosis

Early signs of Parkinson’s include a resting asymmetric tremor, bradykinesia, asymmetric dyskinesia, postural instability and rigidity. Since there are no blood or laboratory tests available to diagnose the disease, diagnosis depends on a rigorous neurological examination and comprehensive history. Recognizing prodromal symptoms can aid in diagnosis: loss of the sense of smell two to four years prior to onset, joint pain, depressive symptoms, and constipation and, six to eight years prior to diagnosis, an REM sleep disturbance in which patients act out their dreams.

Consulting a movement disorders specialist can aid diagnosis and treatment, especially if the patient has bilateral, atypical PD. “It’s important to team up with a movement disorders specialist from the start,” says Ryan Walsh, MD, PhD, a movement disorders specialist at Cleveland Clinic Lou Ruvo Center for Brain Health. “There are many decisions to be made concerning the course of treatment; it’s critical to prescribe the right medications at the right time for the right reasons.”

Medications Overview

The selection of medications is based on the patient’s predominant symptoms and, especially in the senior population, the patient’s comorbidities. Some medications that work well in younger patients cause significant side effects in older patients. “Matching medications to patients is not a trivial decision. One size doesn’t fit all,” says Dr. Walsh.

The current standard of care is “continuous dopaminergic therapy, which reduces chances of motor complications and improves medication ‘on’ time,” advises Babak Tousi, MD, a movement disorders specialist at Cleveland Clinic’s Neurological Institute.

Six classes of medications are used to treat Parkinson’s disease:

- **Dopamine replacement therapy** – the most effective drug for Parkinson’s is levodopa. To reduce side effects, which can include nausea and lowered blood pressure, it is combined with carbidopa. However, levodopa/carbidopa can cause long-term side effects, including dyskinesias, especially if the drug is started too early or...
at too high a dose. So, it is best not to use levodopa early in the disease, unless other medications aren’t effective. Levodopa/carbidopa is available in a controlled release form and is in clinical trials in the U.S. as an intestinal gel infusion. It can be used for advanced PD patients.

- **Dopamine agonists (DAs)** – are often the first drugs used to treat the disease. However, they may cause confusion and compulsive behavior, especially in the senior population, and must be used with caution.

- **MAO inhibitors** – increase dopamine levels in the brain and are used in the early stages of the disease. In seniors with cognitive impairment, however, these drugs should be used cautiously.

- **COMT inhibitors** – allow more levodopa to reach the brain; a new form of levodopa/carbidopa includes the COMT inhibitor.

- **Anticholinergics** – increase dopamine in the brain and are most effective for young patients with a dominant tremor. They are not recommended for use in senior patients.

- **Amantadine** – an antiviral medication that works well for tremors and dyskinesias but can cause confusion and must be used cautiously in the elderly.

Neuropsychiatric complications, such as hallucinations and delusions, can be the most challenging complications of Parkinson’s or its treatment, says Dr. Tousi. First, metabolic causes or infections should be ruled out; then the medications that are least effective in controlling Parkinson’s and affect cognition should be stopped. If none of these approaches works, antipsychotic medications such as quetiapine can be used as the last step.

**Exercise and Physical Therapy**

Nonpharmaceutical treatments, such as exercise and physical therapy, have an important role in treating Parkinson’s and are supported in the medical literature. Symptoms such as postural stability that cannot be addressed by medication do respond to physical therapy.

Cleveland Clinic Biomedical Engineer Jay Alberts, PhD, looked at the effects of “forced exercise” on Parkinson’s disease patients. He found that patients who pedaled a stationary bicycle at a rate 30 percent faster than their preferred rate had improved motor scores (up 35 percent) compared with no improvement in patients who pedaled at their voluntary rate.

**Research/Clinical Trials**

More than 100 PD clinical trials (including eight being conducted at Cleveland Clinic) are currently in progress. They are investigating all aspects of PD, from slowing disease progression to addressing neurotransmitters. Cleveland Clinic sites in Cleveland; Lakewood, Ohio; Las Vegas and Florida have formed a consortium to facilitate trials and address investigator-initiated research. Scientific research is looking at disease development and genes that predispose or protect. Cleveland Clinic is a participant in the Parkinson’s Progression Markers Initiative (www.ppmi-info.org), which aims to identify one or more biomarkers of Parkinson’s disease progression.

Cleveland Clinic’s full list of clinical trials can be found at clevelandclinic.org/clinicaltrials.

“It’s a really exciting time in Parkinson’s disease research,” says Dr. Walsh. “There is more basic scientific research that is increasing understanding of what is driving disease development and progression. I’m hopeful that there will be more compounds that can help slow disease progression.”

Ryan Walsh, MD, (left) can be contacted at 702.483.6000. Babak Tousi, MD, (right) can be reached at 216.636.9467 or babak.tousi@ccf.org.
Boot Up MISTY for Me: New Technology Platform Enables Independence

Designed to maximize the independence of senior citizens and to give families peace of mind, MISTY is a technology platform with the capacity to shape the future of geriatric healthcare. Beginning in fall 2012, Cleveland Clinic will test this groundbreaking technology through a clinical trial that will focus on developing a strong triangular relationship among patient, caregiver and healthcare provider.

The MISTY program runs on a state-of-the-art HP TouchSmart television, which will be provided to research participants for their in-home use throughout the course of the trial. The user-friendly touch screen will allow participants to monitor their health, manage their medications, connect with their family and engage with their physician on a regular basis. The highly interactive nature of the program creates an unprecedented live feedback system, ensuring that there is no disconnect between any two links of the healthcare triangle.

If you know of a patient who might be interested in participating in this or any of the clinical trials and research studies at Cleveland Clinic Lou Ruvo Center for Brain Health, please contact us at 702.659.0850.
Recognition of mild cognitive impairment (MCI) has become pertinent clinically with our increasing awareness of early cognitive changes in neurodegenerative disorders, particularly Alzheimer disease. MCI is thought to represent an intermediate state of cognitive function between the changes seen in normal aging and those fulfilling the criteria for dementia.

The estimated prevalence of MCI in population-based studies ranges from 10 to 20 percent in persons older than 65. The incidence of dementia in people with MCI at 5 to 10 percent in community-based populations is significantly higher than the general incidence of dementia, which is estimated at 1 percent of the population of the U.S. But it should be kept in mind that even as MCI is often regarded as a precursor to dementia, there is significant room for reversal of MCI to normal cognition — up to 25 to 30 percent improvement is noted in some studies.

Issues in Clinical Evaluation of MCI

Clinical history in patients with MCI often suggests a progressive decline in cognition and difficulty in performing with ease some tasks they were proficient in previously. MCI subjects, in contrast to people meeting the criteria for dementia, are relatively independent in their ability to complete activities of daily living (ADLs) and most instrumental activities of daily living (IADLs). Use of instruments such as the Functional Activities Questionnaire (FAQ), which can be administered in an office setting and characterizes impairment in function consistent with dementia, can be useful to distinguish between MCI and dementia. Additional office-based cognitive tests or more formal neuropsychological testing is necessary to corroborate the history of cognitive decline. Scores on an office cognitive test such as the Mini-Mental State Exam are often insensitive to early impairment; more useful measures include the Short Test of Mental Status and the Montreal Cognitive Assessment (MoCA). Minimum or maximum cutoff scores in these tests, though often useful rules of thumb, are not perfect for a diagnosis of MCI, as different etiologies and domains of cognitive impairment are noted under the broad rubric of MCI.

In the amnestic subtype of MCI, episodic memory impairment (e.g., the inability to learn and retain new information) is the prominent problem, with other cognitive domains such as judgment, language and visuospatial skills being relatively preserved and the ability to perform functional activities being relatively intact. In the non-amnestic subtype of MCI, memory is relatively preserved compared with the other cognitive domains of attention, language or visuospatial skills. About two-thirds of all patients with amnestic MCI harbor the pathological features of Alzheimer disease and develop the clinical syndrome of Alzheimer dementia within five years, whereas the remaining one-third have nonprogressive or very slowly progressive causes of cognitive impairment (e.g., depression or age-related cognitive impairment). Neuropsychological testing may be helpful to distinguish particular subtypes of MCI from normal aging, but such testing is not routinely needed to make the clinical diagnosis of MCI. Significant family history of Alzheimer’s dementia and the presence of genetic risk factors also suggest that diagnosed MCI is more likely to progress to Alzheimer’s dementia.

MCI in Older Old Persons

Among older old persons (age > 80) the diagnosis of MCI is more challenging. Elderly populations are more likely to have multiple factors contributing to functional disability, including joint and muscle weakness, poor eyesight and hearing, poor nutrition, and failure to thrive, all of which contribute to impairment in the performance of ADLs and IADLs. It is important to take these factors into consideration when making the distinction between cognitive changes meeting the criteria for MCI or dementia in this population.

We also now recognize that the nature of dementia pathology is often different in different ages of onset. The association between the pathological features of Alzheimer’s disease and dementia is stronger in younger old persons than in older old persons, with mixed etiologies being prominent in dementia of the older age group. Differing etiologies of dementia could have different time
courses of progression and degrees of severity of cognitive
domains affected and functional capabilities curtailed.

Though amnestic MCI commonly precedes Alzheimer’s
dementia in general, among subjects over the age of 80 the
common etiologies of dementia are slightly different, thus
hindering the ability to make what seemingly should be
straightforward clinical assumptions about amnestic MCI
invariably leading to Alzheimer’s dementia. Other amnestic
syndromes, including hippocampal sclerosis and argyro-
philic grain disease, are noted more often in these older old
persons and need to be considered in addition to Alzheimer
disease as older old persons with these syndromes are often
cognitively less impaired than later stages of Alzheimer’s
dementia. Additional investigations are often meaningful
and may be pursued if the patient has no other significant
medical comorbidty influencing life expectancy, and the
patient and his or her family would like to know the pos-
sible course of future cognitive changes.

Though a minority (perhaps 1 in 100) undergo aging with
virtually no cognitive decline and are regarded as aging
successfully, most people experience cognitive decline
as part of the aging process. Normal cognitive decline
in the elderly can be consistently distinguished from
pathological decline by comparing a patient’s cognitive
performance to general population norms; in contrast,
such distinctions are not always possible by demonstrat-
ing a buildup of neurodegenerative pathology in the
brain by Amyloid PET or other AD specific tests. This is
important because some people with normal cognition
can exhibit changes related to Alzheimer’s disease and
vascular pathology and still function normally according
to age-appropriate standards. This could possibly be
related to their higher cognitive reserve.

Evaluation and Management
To evaluate for MCI in the elderly, I would recommend
a neurological examination, including an assessment
of mental status, MoCA, FAQ and screening for depres-
sion. Neuropsychological testing may be appropriate,
particularly if there is concern regarding the degree of
impairment relative to the cognitive changes of aging.
for the patient’s age, education and physical status. A medication review to minimize the role of anticholinergics, antipsychotics, benzodiazepines and other cognitive depressants is important. An MRI scan is suggested to rule out other conditions that might explain memory loss (e.g., stroke, tumor or hydrocephalus); the results might also show changes (e.g., significant generalized atrophy or more focal hippocampal atrophy and/or vascular changes) suggesting etiologies that would evoke greater concern about a progression toward dementia.

Also, blood tests should be performed to rule out nutritional deficiencies including folate and multiple B vitamin deficiencies, especially if the patient is living alone or has significant caregiver issues affecting the patient’s food intake. Checking thyroid function and cardiac status and ruling out infections pertinent to the patient’s history are also important. Physical and occupational therapy evaluations are usually recommended to assess the patient’s safety in living alone and ability to handle medication dosing independently; they also enable the implementation of fall precautions if the patient’s history warrants them. At Cleveland Clinic, we also offer cognitive rehabilitation to help patients overcome the early functional difficulties of forgetfulness.

A discussion with the patient’s family, if available, is critical. That discussion should include the rationale and need for pursuing further investigations to better understand the etiology of the patient’s cognitive decline better. This information might be useful for the family in making financial decisions and arranging future care for the patient. The patient should be encouraged to undertake aerobic exercise, intellectually stimulating pastimes and social activities, given that these might be beneficial and pose little risk.

I would recommend a clinical re-evaluation in six months to evaluate any worsening, to determine whether further investigation into the etiology is needed and to start medications if there is progression to dementia.

Given the negative results of medication trials thus far in MCI, I would explain the costs and potential side effects of pharmacotherapy and take the patient’s needs into consideration when prescribing any medication.

Jagan A. Pillai, MD, PhD, is a brain health specialist with interests in diagnosis and treatment of cognitive changes resulting from neurodegenerative diseases. He can be reached at 216.636.9467 or pillaij@ccf.org.
Home-based primary care teams at Cleveland Clinic have joined a three-year national effort to improve health outcomes and reduce expenditures for Medicare beneficiaries with chronic medical conditions. In April, Cleveland Clinic Home Care Services was among 16 practices chosen from 130 applicants to participate in the Independence at Home Demonstration of the Centers for Medicare & Medicaid Services (CMS).

“Medicare uses demonstration projects to help determine if it should change its benefits or the way it reimburses providers,” says William Zafirau, MD, Medical Director of Cleveland Clinic at Home. It administers four models of care that are included in the demonstration: hospital at home, physician house calls, transitional care and chronic disease self-management. CMS is studying innovations such as these as part of the Affordable Care Act.

“Medicare was founded in 1965 to take care of acute illness. Now, more and more, older people are not dying of acute illness but are living longer with chronic disease,” Dr. Zafirau says.

To participate in the Independence at Home Demonstration, Medicare beneficiaries must have at least two chronic conditions, need assistance with at least two activities of daily living, and have had nonelective hospitalization and rehabilitation (skilled nursing stay, inpatient rehabilitation, home care or outpatient care) within the past 12 months.

Hospital at Home
Hospital-at-home programs help people go home from the hospital earlier or stay at home instead of being hospitalized. According to Dr. Zafirau, this model was developed in Europe, and the first U.S. trial was published in 2004 by researchers at Johns Hopkins University. They found that home care for individuals with heart failure, chronic obstructive pulmonary disease or pneumonia could cost less and produce similar outcomes when compared with hospitalization.

Cleveland Clinic at Home launched its “Go Right Home” program in 2008 in collaboration with the Orthopaedic & Rheumatologic Institute. Individuals who undergo total hip or knee replacement now get an immediate postoperative evaluation, and many go home for physical therapy instead of to a rehabilitation facility. “This program benefits patients — who prefer to be home — and has shortened the average hospital stay for hip and knee replacement by one day, from about three days to two days,” Dr. Zafirau reports.

Physician House Calls
House calls make sense for home-bound, chronically ill older patients who otherwise would see doctors only in the hospital or emergency department, Dr. Zafirau says. Cleveland Clinic’s Medical Care at Home program comprises four physicians and two nurse practitioners who make house calls, along with physi-
cians in palliative and hospice care. Medical Care at Home was launched in 2008 and now follows approximately 500 patients.

Typical house calls are 45 minutes. “We go through the person’s problems, discuss medications, provide education and talk about goals of care,” Dr. Zafirau says. Services include in-home laboratory tests, radiography and ultrasound, as well as skilled nursing, physical therapy, occupational therapy, and speech therapy.

Some people are visited every two to three months and others every other week, based on medical necessity. “We can avoid some hospital admissions by combining physician access with skilled nursing in people’s homes,” explains Dr. Zafirau. He notes that studies of physician house call programs have shown reductions of 30 to 50 percent in hospitalization rates and 20 to 35 percent in overall costs for this population.

Transitional Care

Miscommunication, adverse events and rehospitalization are risks whenever a patient moves from hospital to home or a nursing facility. “With transitional care, community medical professionals will know what care and medications were provided in the hospital and what’s expected after discharge,” Dr. Zafirau explains.

Heart Care at Home, launched in 2010, has become standard practice for cardiac patients at the main campus Heart & Vascular Institute. Nurse practitioners meet patients before discharge, then follow their home care for 30 days. Medication reconciliation accounts for approximately half of the time spent on transitional care, according to Dr. Zafirau.

“We also provide remote care for many cardiac patients, using wireless home
monitors. They weigh themselves and take vital signs and can ask questions about symptoms. A nurse monitors the transmissions daily and contacts the patient if there's a problem," Dr. Zafirau says.

More than 2,100 patients have participated in Heart Care at Home, and the 30-day readmission rate has gone down from 30 to 23 percent, he reports.

**Chronic Disease Self-Management**

Cleveland Clinic bundles chronic disease self-management within Heart Care at Home, Medical Care at Home and physician house calls, explains Dr. Zafirau. An individual with heart failure, for example, is instructed on what to expect from medications and the importance of reporting symptoms or weight fluctuations. An individual with diabetes learns how medications work and how to avoid hypo- and hyperglycemia and what to do if either occurs, he says.

“We also help people eat in healthier ways,” Dr. Zafirau concludes. “The goal is to make patients active participants in managing their chronic diseases, which can reduce visits to the emergency department or hospitalization, for months or years to come.”

How to Refer Patients to Cleveland Clinic at Home Programs

Cleveland Clinic at Home programs help people with illnesses or injuries recover in their homes, when possible, rather than in the hospital. Services include nursing care, infusions, respiratory therapy, behavioral services, physical therapy and occupational therapy. Physician referral is required, and referrals are accepted 24 hours a day, seven days a week by phone at 216.444.4663 or 800.263.0430. Ohio counties served are Ashtabula, Columbiana, Cuyahoga, Erie, Geauga, Huron, Lake, Lorain, Mahoning, Medina, Portage, Stark, Summit and Trumbull.

Physicians who refer patients to Cleveland Clinic at Home programs can monitor their patients’ progress online. Users of Epic or MyPractice can follow patients through the electronic medical record. Others can use a complimentary secure website known as DrConnect. For more information, email drconnect@ccf.org or call 877.224.7367.

For references, please email the editor.
Interest in sexual activity tends to decline with age, but doctors should not assume that men in their 70s and 80s are not sexually active, according to Milton M. Lakin, MD, an internist with Cleveland Clinic’s Glickman Urological & Kidney Institute. He cites a survey of 3,005 community-living adults that was published in 2007 that provides a glimpse into the bedrooms of older Americans.

In that survey, the percentage of men and women who reported being sexually active declined from 73 percent for those 57 to 64 years of age, to 53 percent for ages 65 to 74, and to 26 percent for ages 75 to 85. Among the active 75- to 85-year-olds, however, 54 percent reported having sex two or three times per month and 23 percent once a week.

“Men were significantly more likely to be sexually active and to be in a marital or other intimate relationship,” says Dr. Lakin, who studies and treats male sexual dysfunction. “Men also appeared to be more satisfied with their sexual lives.” Women were much more likely to report sex as not pleasurable. Similarly, 35 percent of women vs. 13 percent of men rated sex as “not at all important,” perhaps because fewer older women are in intimate relationships, he adds.

“Sex appears to be a greater preoccupation for men in these age groups than for women. And, as a group, men find sex more satisfying, even if they have some degree of sexual dysfunction,” Dr. Lakin says.

Erectile dysfunction (ED) is the most common male sexual difficulty. The 2007 survey found an ED prevalence of 37 percent in men ages 57 to 85. Other studies have detected higher rates. The Massachusetts Male Aging Study found an overall 52 percent prevalence of some degree of ED in men ages 40 to 70. “At age 40 it was approximately 40 percent, at age 50 it was 50 percent, and so on,” Dr. Lakin says.

Other sexual complaints of older men include decreased desire and difficulty achieving climax, according to Dr. Lakin. “Ejaculation and climax are two separate issues,” he explains. “Expulsion of semen takes place in the genital organ, and the sensation of orgasm is a central nervous system event. For example, a man who has had his prostate and seminal organs removed doesn’t ejaculate, but he can still achieve a climax.”

Educating men about sexual physiology can be difficult, however, because of men’s reticence to discuss sex with their doctors. Nearly two-thirds of male respondents to the 2007 survey reported that since age 50 they had never discussed sex with a doctor.

“Most men are dealing with possible sexual dysfunction, not just in later years but throughout life,” Dr. Lakin says. “During office visits, it’s very reasonable to ask men about issues related to their sex life: Are you having a problem with desire? Are you having problems having an erection? Are there difficulties or pain with ejaculation? Are you experiencing pleasure with an orgasm?”

Causes of ED mirror the risk factors for coronary artery disease — diabetes,
hypertension, hypercholesterolemia and cigarette smoking. “About 50 percent of men with diabetes have erectile problems, and it’s probably closer to 70 percent above age 55,” Dr. Lakin says.

Radical prostatectomy and other prostate cancer treatments cause ED for many men, according to Dr. Lakin. Medications, including selective serotonin reuptake inhibitor antidepressants and thiazide diuretics, have ED as a side effect.

Testosterone levels decline with age and may be a factor in ED, but this issue is complicated, he says. “Low amounts of hormone are necessary for adequate erections, but we don’t know the amount needed, how effective testosterone supplementation is or the long-term effects.”

Testosterone supplementation may help men who are hormonally deficient. Some clinicians define this as testosterone levels < 300 ng/dL, but Dr. Lakin prefers a more cautious threshold in the 200 ng/dL range. Clinical symptoms such as decreased libido, decreased erection quality and absence of morning erections also would be present, he explains.

For the primary care work-up of ED, Dr. Lakin recommends three hormone studies — testosterone, prolactin and thyroid stimulating hormone — along with a sexual history. If the problem is ED, he recommends a trial with one of the phosphodiesterase-5 (PDE-5) inhibitors. “Consider referral to a urologist if medication is ineffective, the patient is dissatisfied or the ED is complicated,” he recommends.

When prescribing PDE-5 inhibitors, Dr. Lakin usually starts with the lowest recommended dose for men of any age. He tells patients the drug may take one to two hours, depending on which medication the patient is prescribed, to be fully absorbed, “and it won’t work without foreplay or other sexual stimulation.” He also discusses potential side effects: headache, flushing, nasal congestion, heartburn, backache and visual effects. PDE-5 inhibitors are contraindicated in patients using nitrates for heart disease.

Dr. Lakin participated in research at Cleveland Clinic on PDE-5 inhibitors’ effectiveness in men with ED caused by radical prostatectomy. “Patients have a better chance of responding to these medications if both neurovascular bundles are spared. If the cancer is extensive and both nerves are taken, the likelihood of response is almost nil. But even if both nerve bundles are spared, a large number of patients may not respond, and recovery may take one to two years for those who do,” he says.

PDE-5 inhibitors are effective in 60 to 70 percent of men, generally those with mild to moderate ED, according to Dr. Lakin. When medication is ineffective, other options for motivated patients include vacuum restriction devices, penile injections or penile prosthetic devices. Dr. Lakin notes, however, that drugs and devices are not the only routes to satisfying sexual lives.

“A lot of men are unaware they can achieve the sense of orgasm without a firm erection. We’ll discuss other ways to enhance sensitivity and achieve satisfaction,” he says. For more information about the male sexual response, he suggests reading The New Male Sexuality by Bernie Zilbergeld, PhD.

Dr. Lakin served as Section Head of Medical Urology at Cleveland Clinic Glickman Urological & Kidney Institute from 1995 to 2009. His specialty interest is the evaluation of male sexual dysfunction. He is a retired staff consultant and practices at Cleveland Clinic’s Richard E. Jacobs Health Center in Avon, Ohio. Dr. Lakin can be reached at lakinm@ccf.org or 440.695.4000.

For references, please email the editor.
Low-Vision Therapy Improves Quality of Life for Elderly Patients

By Patrick Baker, MHS, OTR/L, CLVT

This morning, as healthcare workers, we woke up, turned off our alarm and went about our usual routines in preparation for our day’s activities. Many of us got family members ready for the day and fixed some breakfast and a beverage, gathered our last-minute things together and got in our car to go begin our busy day.

Tomorrow, try doing this with opaque tape over a pair of glasses, or wear sunglasses or a blindfold. For many older adults, this is representative of how they function with some form of vision loss.

According to the 1995 Lighthouse National survey on Vision Loss, the following can be said about the visual acuity of the elderly:

“Self-reported vision impairment is greater than estimated previously, with 15 percent of 45-64-year-olds, 17 percent of those aged 65-74 years, and more than one-fourth (26 percent) of elders 75 years and older classified as visually impaired, and half report that a vision problem interferes with their daily lives. Furthermore, there is pervasive fear of blindness among older adults and limited knowledge about age-related vision loss.”

In addition, other studies report that an estimated 163,000 Americans ages 20-44 and 174,000 individuals ages 45-64 are legally blind. Legally blind is considered acuity of worse than 20/200 or field of view of less than 5 percent.

The leading causes of vision loss in older adults are cataracts, glaucoma, diabetic retinopathy and macular degeneration. All those conditions are treatable, but even with treatment, many patients are left with some visual impairment. Their “best corrected” vision (usually by way of glasses) may not be sufficient for independent daily function.

Stroke and traumatic brain injuries often have a visual impairment component. While the person’s sight is not affected, meaning that their eyes function, the ability of the brain to comprehend or accurately “visualize” what the eyes see is affected. These injuries can also lead to significant loss of visual field or loss of attention to the affected side.

Once ophthalmologists or optometrists have completed their work, patients still must function to the best of their ability with the vision they have. Specially trained therapists, either an occupational therapist (OT) or certified low-vision therapist (CLVT), are frequently able to assist patients with visual deficits to maximize their remaining vision in order to enable them to be as independent as possible in their daily lives.

At Cleveland Clinic, the therapist is both an OT and a CLVT. As a CLVT, the therapist can assess a person’s functionality from a visual standpoint, but also will assess how this ability integrates with the person’s overall func-
tion from an OT standpoint. For example, he or she might assess how a patient with recent vision loss can function with comorbidities such as Parkinson’s, arthritis or other chronic disease.

Therapy revolves around five key components: lighting, contrast, magnification, organization and counseling.

LIGHTING — This component may include special types of lights, “daylight” light bulbs, focused lighting, appropriate lamps, or ceiling or counter lighting. It may also include special sunglasses to reduce brightness and glare. Use of the right light for the situation can make a huge difference.

CONTRAST — Attempting to eat chicken and mashed potatoes from a white plate sitting on a white tablecloth and using a clear water glass can be difficult and embarrassing for a visually impaired person. Finding medications on a light countertop can be impossible. Newsprint is gray type on gray paper vs. the black lettering on white paper found in magazines, which are easier to read. Carpet, tile, baseboards, rugs, newspapers and furniture can blend together if they are a similar color, especially when coupled with deficient lighting. Therapists can educate family and patients about the use of contrast throughout the home to improve independence.

MAGNIFICATION — Whether it is over-the-counter glasses or a several-thousand-dollar closed-circuit television system, all magnifiers work the same way; magnification makes the object appear bigger and closer but reduces visual field. Most persons requiring more magnification than glasses can provide need several approaches to meet the needs of different situations. One would not use a CCTV to read labels at the store, nor use a pocket magnifier to read a book. Finding the right magnification and using the appropriate device for the task is key to success.

ORGANIZATION — The therapist can work with the patient AND family to develop an organization plan for each area of the home so that everyone knows where everything should go. That way, items encountered and used in a patient’s daily life can be organized in the best way possible, avoiding mishaps such as opening the wrong can or package because the patient is no longer able to read labels.

COUNSELING — Therapists can be instrumental in family training for those who have a visually impaired relative or friend, as well as counseling regarding the emotional effects of vision loss. Coping with vision loss can be very overwhelming. Even the word “blind” can have a devastating impact on one’s self-esteem. While family can understand a broken leg because they see the cast, or why their family member is weak after a surgery, it is often hard for a family or caregiver to understand the difficulty of vision loss, because others can’t “see” what is wrong. Helping patients and family/caregivers work through these issues is an important aspect of regaining function after vision loss.

Orthopaedic surgeons often refer patients to therapy after a joint replacement; neurologists refer patients for therapy after a cerebral vascular accident (i.e., stroke) or for a diagnosis of Parkinson’s, multiple sclerosis and other neurological conditions. Ophthalmologists, optometrists, geriatricians and primary care physicians have the option to refer to occupational therapy for vision rehabilitation any patient whose function is impaired on a daily basis due to uncorrectable vision loss.

To access these services, patients or family members may call 216.445.8000 for an appointment, or 216.445.8479 to speak directly with a therapist. A referral from the physician should include a request for a low-vision occupational therapy evaluation and a diagnosis.

For references, please email the editor.
Geriatric Falls Clinic

For elderly patients who have had a fall or fracture, have balance problems, or are at high risk for falls, Cleveland Clinic provides a Geriatric Falls Clinic. At each 90-minute appointment, patients are evaluated for cognition, vision, medical conditions, polypharmacy, physical function and more.

Patients and their referring physicians receive a summary of their visit, outlining any recommendations.

The Geriatric Falls Clinic began in August 2011, and a full report of interventions and outcomes will be published soon. The chart below shows interventions to date.

**Geriatric Falls Clinic: Types of Interventions (to date)**

The most common interventions have been exercise and physical therapy consults (71 percent) and recommended changes in medication (43 percent).

Preliminary reports indicate that 75 percent of patients have not had a fall requiring emergency department assessment or X-ray within three months of their visit to the Geriatric Falls Clinic.

The Geriatric Falls Clinic provides a vital link between patients and services that support and supplement a physician’s care, with the goal of keeping patients safe and independent longer.

For more information about the Geriatric Falls Clinic, visit clevelandclinic.org/geriatricfalls.

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All physicians with appointments in Regional Geriatrics have a joint appointment in the Center for Geriatric Medicine.
Resources for Physicians

**Referring Physician Center and Hotline**
Cleveland Clinic’s Referring Physician Center has established a 24/7 hotline — **855.REFER.123 (855.733.3712)** — to streamline access to our array of medical services. Contact the Referring Physician Hotline for information on our clinical specialties and services, to schedule and confirm patient appointments, for assistance in resolving service-related issues, and to connect with Cleveland Clinic specialists.

**Track Your Patient’s Care Online**
DrConnect is a secure online service providing our physician colleagues with real-time information about the treatment their patients receive at Cleveland Clinic. To receive your next patient report electronically, establish a DrConnect account at clevelandclinic.org/drconnect.

**Physician Directory**
View all Cleveland Clinic staff online at clevelandclinic.org/staff.

**Critical Care Transport Worldwide**
Cleveland Clinic’s critical care transport teams and fleet of vehicles are available to serve patients across the globe.
- To arrange for a critical care transfer, please call 216.448.7000 or toll-free 866.547.1467 (see also clevelandclinic.org/criticalcaretransport).
- For STEMI (ST elevated myocardial infarction), acute stroke, ICH (intracerebral hemorrhage), SAH (subarachnoid hemorrhage) or aortic syndrome transfers, call toll-free 877.379.CODE (2633).

**Outcomes Data**
View clinical Outcomes books from all Cleveland Clinic institutes at clevelandclinic.org/outcomes.

**Clinical Trials**
At any given time, we offer thousands of clinical trials for qualifying patients. For more information, visit clevelandclinic.org/clinicaltrials.

**CME Opportunities: Live and Online**
The Cleveland Clinic Center for Continuing Education’s website offers convenient, complimentary learning opportunities. Visit cfme.org to learn more and use Cleveland Clinic’s myCME portal (available from the site) to manage your CME credits. Web portal available 24/7.

**Executive Education**
Cleveland Clinic has two education programs for healthcare executive leaders — the Executive Visitors’ Program and the two-week Samson Global Leadership Academy immersion program. Visit clevelandclinic.org/executiveeducation.

**Executive Health**
Available in three locations (Cleveland, Florida and Toronto), our Executive Health Program provides active individuals and leaders with a fully integrated, head-to-toe health evaluation by some of the top medical staff in the world. For more information, go to clevelandclinic.org/executivehealth or call toll-free 866.320.1385.

**About Cleveland Clinic**
Cleveland Clinic is an integrated healthcare delivery system with local, national and international reach. At Cleveland Clinic, 2,800 physicians represent 120 medical specialties and subspecialties. We are a main campus, 18 family health centers, eight community hospitals, Cleveland Clinic Florida, Cleveland Clinic Lou Ruvo Center for Brain Health in Las Vegas, Cleveland Clinic Canada, Sheikh Khalifa Medical City and Cleveland Clinic Abu Dhabi.

In 2012, Cleveland Clinic was ranked one of America’s top 4 hospitals in U.S. News & World Report’s annual “America’s Best Hospitals” survey. The survey ranks Cleveland Clinic among the nation’s top 10 hospitals in 14 specialty areas, and as the top hospital in three of those areas.

**Same-Day Appointments**
Cleveland Clinic offers same-day appointments to help your patients get the care that they need, right away. Have your patients call our same-day appointment line, 216.444.CARE (2273), or 800.223.CARE (2272).
Geriatric Medicine Fellowship Offers Diverse Training

Our Geriatric Medicine Fellowship is a 12-month clinical program designed to provide comprehensive training — preparing internists and family physicians to become leaders in geriatric academic settings, nursing homes, outpatient centers and hospitals.

Fellows will benefit from the experience of the Geriatric Medicine interdisciplinary team of clinician-educators dedicated to maintaining patients’ quality of life as they deal with the chronic medical conditions and comorbidities, cognitive issues and frailty that can accompany aging.

For more information, visit clevelandclinic.org/geriatricmedicine.