Electronic Personal Health Records: Solution to a Looming Crisis

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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 through a system of eight hospitals and 18 family health centers. We are eager to assist physicians, nurses, therapists, social workers, other clinical healthcare providers and caregivers in improving the care of the oldest and frailest members of society.

In this issue, we consider the impact of medical informatics on healthcare. Innovations in how we exchange health information and enhance access to care through technology are becoming increasingly important to ensure that care is coordinated and integrated across all elements of the complex healthcare system. Such needs have served as the momentum behind adopting the use of integrated electronic health records. All physicians and other providers throughout the Cleveland Clinic health system share medical information including Emergency Department visits, office notes from primary care providers and specialists, laboratory values, and other test results. Providers outside Cleveland Clinic can access DrConnect to maintain continuity of care among private physician offices, non-Cleveland Clinic hospitals and post-acute care facilities. Through MyChart, patients and designated caregivers can access test results, schedule appointments and communicate with physicians.

Neil Mehta, MD, contributes an article that gives us insight into the impact of medical informatics on the ability of patients to make the most of their doctor visits. David Longworth, MD, Chairman of Cleveland Clinic’s Medicine Institute, helps us see geriatrics in light of the changes we anticipate as we shift toward accountable care. Susan Williams, MD, discusses how clinicians can help their elderly patients strike a balance in their nutrition between what they need for disease management and what they want to maintain their desired quality of life. Finally, Margery Gass, MD, helps us understand female sexuality and quality-of-life issues our older women typically face.

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 exceptional geriatricians who have an interest in patient care, education and program development. Feel free to contact me about these opportunities, or peruse our website for more information: clevelandclinic.org/geriatricmedicine.

Please do not hesitate to contact me with any questions, concerns or suggestions on how we might improve our services to you and your patients in the future at 216.444.6801 or rapporb@ccf.org.

We look forward to continuing our partnership with you.

Kind regards,

Barbara Messinger-Rapport, MD, PhD
Director, Center for Geriatric Medicine
Cleveland Clinic Medicine Institute
Geriatricians have an important role to play in this era of healthcare reform because of their skill in managing the medically complex and frail elderly, who are high utilizers of healthcare resources. This brief discussion highlights the ongoing evolution in care delivery and payment models, and the vital role of geriatricians.

The Patient Protection and Affordable Care Act (PPACA), passed by Congress in March 2010, changed the landscape in healthcare in the United States and set the stage for the formation of accountable care organizations (ACOs). Release of the proposed rule for ACOs by the Centers for Medicare & Medicaid Services (CMS) in March 2011 was met with widespread opposition across the country from physicians, hospitals and healthcare systems. Fundamental tenets of the proposed rules were perceived as overly prescriptive, too regulatory, cumbersome to administrate and unfair with regard to the proposed retrospective assignment of patients to providers. To its credit, CMS incorporated the feedback and released a significantly modified final rule in October 2011 governing the formation of ACOs. Although potentially threatened in the courts and in the upcoming election, the PPACA has the potential to transform the delivery of healthcare in the United States, and many primary care physicians, specialists, hospitals and healthcare systems are positioning themselves to compete, survive and thrive in a new world. Geriatricians should be no exception.

Medical Home (PCMH) began to gain traction only a decade ago when it was resurrected and ultimately endorsed over several years by a number of professional societies. In 2002, seven Family Medicine organizations released the Future of Family Medicine project, which among other things called for the creation of a medical home for every patient. The American College of Physicians called for an “advanced medical home” in 2005, and in 2006, IBM and a number

Key Points:

- Geriatricians have a critical role to play in this era of healthcare reform because of their unique skills in effectively managing medically complex and frail elderly patients.
- Patient-centered medical homes are making good on their promise to deliver high-quality care at lower cost.
- Accountable care organizations are gaining acceptance across the country and represent a payment model that rewards higher-quality care at lower cost with shared savings.
of partner organizations created the Patient-Centered Primary Care Collaborative to promote the model. In 2008, The National Committee for Quality Assurance (NCQA) released its Physician Practice Connections® Patient-Centered Medical Home Recognition Program, which defined essential elements for PCMH recognition. These elements were updated in January 2011 to further emphasize patient-centeredness and to align with governmental initiatives in the areas of quality, patient safety and the use of health-information technology.

NCQA defines a PCMH as “a model of care where patients have a direct relationship with a provider who coordinates a cooperative team of healthcare professionals, takes collective responsibility for the care provided to the patient and arranges for appropriate care with other qualified providers as needed.”

To achieve PCMH recognition based on the updated 2011 criteria, practices must possess six essential elements, which are summarized in Table 1.

PCMH 1, Element A: Access during office hours
PCMH 2, Element D: Use data for population management
PCMH 3, Element C: Care management
PCMH 4, Element A: Support self-care process
PCMH 5, Element B: Track referrals and follow-up
PCMH 6, Element C: Implement continuous quality improvement

Table 1: Patient-Centered Medical Home Recognition

Cleveland Clinic has Level 3 NCQA-qualified Patient-Centered Medical Homes at 17 of its 18 Family Health Centers and the main campus Internal Medicine practice. We are studying innovative care models within these medical homes to define which models deliver optimal value to patients and populations.

Accountable Care Organizations

The ACO concept was first articulated in 2006 by Dr. Elliott Fisher, Director of the Center for Health Policy Research at Dartmouth. It constitutes a payment and healthcare delivery model in which providers are held accountable for management of a population of patients with regard to quality and cost, and share in accrued savings if certain quality and cost targets are attained. Success in an ACO world is all about care coordination and the ability to effectively manage the medically complex, high-resource-consuming patients in the population. This vital competency is why highly functioning PCMHs are absolutely essential for an organization to succeed as an ACO. Moreover, in the future, the ability to effectively manage wellness to mitigate the development of chronic diseases in the population will become increasingly important.

Highlights of the final ACO rule released by Center for Medicare & Medicaid Innovation (CMMI) are summarized in Table 2. The program commenced in January 2012. Primary care physicians (PCPs) must be a part
of an ACO and can only participate in a single ACO. A minimum contract period of three years is required. Attributed patients are prospectively assigned, with retrospective verification of participation. The number of quality measures was reduced from 65 to 33 in the final rule, and the requirement for the use of an electronic health record was eliminated. Two shared-savings arrangements are available — one that has no downside risk and limited upside opportunity if cost and quality targets are met, and another that has downside risk but greater upside shared-savings potential. More and more healthcare systems are embracing the concept and are participating or preparing to participate.

What Does This Mean for Geriatrics?

Geriatricians have a vital role to play in this new world of care delivery. While not all medically complex high-resource-consuming patients are elderly, many are. In addition, end-of-life care consumes a disproportionate amount of healthcare dollars, among the elderly. With their unique competencies in prevention and management of the medically complex, frail elderly, geriatricians can contribute — either as PCPs or as consultants in the medical neighborhood — to the cost-effective provision of high-quality care to the growing aging population in this country. Moreover, given the increasing shortage of geriatricians, current practitioners can expand their reach and contribute to the success of PCMHs and ACOs by facilitating the development of care pathways and the education of PCPs about the unique needs of the geriatric population.

<table>
<thead>
<tr>
<th>Table 2: Key Components of the Final CMMI ACO Rule</th>
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<tr>
<td>• PCPs required</td>
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<td>• Three-year minimum contract</td>
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<td>• Prospective patient attribution using plurality-of-care rule</td>
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<td>• Thirty-three quality measures in four domains</td>
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<td>• Electronic health record a quality measure, not mandatory</td>
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<td>• Pay for reporting first year, performance added at year two</td>
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<td>• Two shared-savings options, with and without downside risk</td>
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<td>• Share on first dollar saved in both shared-savings models</td>
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<tr>
<td>• Quarterly reports from CMMI on attributed population</td>
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<td>• Marketing guidelines eased with five-day “file and use” provision</td>
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Dr. David Longworth is Chairman of Cleveland Clinic’s Medicine Institute. He can be reached at 216.445.9085 or longwod@ccf.org.
As the baby boomer generation reaches retirement age and healthcare providers’ ability to treat acute problems improves, we are left with more chronic disease cases in the United States. For example, patients with acute myocardial infarction are more likely to survive today due to improved care. However, these patients are left with problems such as congestive heart failure.

Combine this with a decreasing pool of primary care physicians who can manage multiple chronic diseases effectively, and we are looking at a huge healthcare crisis.

The answer lies with patients. Patients with chronic diseases need to take ownership of their conditions. They need to monitor various measures such as blood sugar that indicate the quality of control over their conditions. They need to ensure that they are in sync with their providers regarding appointments, changes in medications, laboratory test results and planned changes in care.

One way to empower patients is through the use of personal health record (PHR) portals that allow them to view their electronic medical record (EMR) in a secure online space.

There is a general assumption that older adults may have problems using technology. In 2001, Marc Prensky, an author of books on digital learning, coined the term “digital natives.” This refers to the millennial generation that grew up surrounded by technology. Those born earlier he labeled “digital immigrants,” or people who retain an “accent” even after adapting to the use of technology. In Prensky’s view, older adults remain fundamentally different in their interaction with technology.

Subsequently, however, this view has been questioned. In 2011, David White, a U.K. researcher in an e-learning research and development group at the University of Oxford, wrote that the digital behavior is better categorized on a spectrum ranging from “digital residents” to “digital visitors” and is not based on gender or age. He notes that these designations are not necessarily dependent on technical skills but rather on personal choice. Thus, we should not assume that our older patients would not use PHR portals. Even David White’s digital visitors use technology to perform specific tasks, such as booking airline tickets, even though they may not “live” in the digital space by participating in social networking, for example.

Multiple Benefits of PHR Portals

PHR portals have many features that can help to empower the patient with chronic disease:

**VIEWING THE EMR.** Patients can see their laboratory results, along with trends and associations. They can be linked to reference websites that help them learn to interpret the results. They can review their medication lists, allergies and letters from providers.

**MESSAGING.** Providers can send private secure messages to their patients. They can remind patients to call back with blood pressure readings, for example. Depending on physician preference and the policies of the institution, physicians can allow patients to reply to their messages from within the PHR. Providers can also attach notes to test results before releasing them to the patient.

**APPOINTMENTS.** Patients can see upcoming appointments and request appointments with various providers.

**HEALTH MAINTENANCE REMINDERS AND ALERTS.** Patients with diabetes, for example, can see that they are due for an annual dilated retinal exam or for six-month blood work.

**UPLOAD PERSONAL HEALTH DATA.** Many monitoring devices, such as glucometers, can automatically upload results to PHRs such as Cleveland Clinic’s MyChart via services such as Microsoft HealthVault. The results can then be shared with the provider.

**CAREGIVER ACCESS.** PHRs may be shared with caregivers at home, which is especially helpful for elderly patients who may have cognitive disorders or who lack computer or Web access.
The fact that Grace Montgomery, of Warrensville Heights, Ohio, has developed hypertension, type 2 diabetes and hypercholesterolemia at age 71 is not surprising. The fact that she manages these conditions quite well using an electronic health record may, however, surprise some physicians.

Neil Mehta, MD, — Associate Professor of Medicine and Director of Education Technology at Cleveland Clinic Lerner College of Medicine — is not one of them. Mrs. Montgomery is a longtime patient of Dr. Mehta, an internist who is also Director of Cleveland Clinic’s Center for Online Medical Education and Training. He encouraged her to start using MyChart, Cleveland Clinic’s online personal health maintenance tool, six years ago.

A Memory Aid
“I really appreciate MyChart now that I am older and my memory is not what it used to be,” says Mrs. Montgomery. “Before, Dr. Mehta would discuss the findings from a procedure or test and I would forget some of it before I got home.” Now, she can easily review his summary online.

Mrs. Montgomery uses MyChart to refill her prescriptions for antihypertensive and lipid-lowering medications. She controls her diabetes with diet and exercise, and MyChart helps her see trends in her glucose and HbA1c levels over time. “I can see where I am today compared with where I was two years ago,” she says. “I can click on ‘chart’ and input the dates for either glucose or A1c and see whether the levels have gone up or down.”

Prompt Test Results
A few days before each visit, Dr. Mehta schedules her blood work. “What I like most about MyChart is that lab results are available so promptly,” says Mrs. Montgomery. If blood is drawn at 8 a.m, results are available to her within hours as opposed to days.

When she doesn’t understand something, Mrs. Montgomery makes a note to ask Dr. Mehta. “Dr. Mehta is very thorough and patient. He always takes time to answer each question to my satisfaction,” she says. “He goes over all my test results. We talk about my concerns and what concerns him. Then, together, we plan a course of action.”

Mrs. Montgomery schedules follow-up appointments using MyChart. She also relies on the online reminders to schedule health maintenance and preventive screenings.
Looking at this list of benefits, it seems that we have a solution to help empower our patients and to provide continuity of care instead of 20-minute office visits six months apart.

But will physicians and patients use this? Can it really work? These are the early days of PHR portals and there are concerns.

Physicians worry about getting inundated with questions about abnormal test results, such as HDL cholesterol levels being higher than normal or mean platelet volumes being abnormal. They may also be concerned about unreimbursed care provided through PHR portal messaging. As we move to models of care such as primary care medical homes and accountable care organizations, such concerns will be less of an issue.

Patients have concern about the privacy and security of their health information. In a recent survey of adults visiting a primary care practice, 76 percent expressed an interest in using PHR portals. Their prior experience using the Internet to manage their healthcare, perceptions about the potential benefits of PHR portals and college education were independently associated with potential PHR portal use.

In a 2007 online poll of more than 2,000 adults reported in the Wall Street Journal, 91 percent of respondents felt that patients should have access to their own EMRs. Sixty percent felt that the benefits of such access would outweigh the security and privacy risks.

**PHR Portals Produce Results**

There is early data that PHR portals do make a difference, according to a 2008 study reported in the Archives of Internal Medicine. In the randomized study of 11 primary care practices that had enrolled 244 patients with diabetes, those who were seen at practices using PHR portals were more likely to have their diabetes medication regimens adjusted than those who were not, which could potentially lead to improved control of their blood sugar.

Another randomized study reported in the Archives of Internal Medicine in 2006 enrolled 750 community-dwelling seniors who had been admitted to the hospital with one of 11 conditions that predicted a high likelihood of readmission. The patients (or home caregivers) in the intervention group were trained to use a patient-centered EMR. Those patients had fewer readmissions and lower mean hospital costs.

As we move toward primary care medical homes and accountable care organizations, we can leverage practice-linked patient health records to improve the care of our older patients and to manage costs.

**Dr. Mehta** is an Associate Professor of Medicine and Director of Education Technology at Cleveland Clinic Lerner College of Medicine, and Director of the Center for Online Medical Education and Training. As a physician in the Medicine Institute, he is particularly interested in the management of patients with chronic disease or multiple complex problems. To reach Dr. Mehta, call 216.445.6512 or email mehtan@ccf.org.

For references, please email the editor.
Good nutrition is important to promote and maintain good health, but it becomes of particular importance in our eldest community-dwelling patients. Aging may be associated with diminished appetite, inadequate protein intake and, in the very old, inappropriately decreased caloric intake and weight loss.

Lean muscle mass is lost at the rate of approximately 1 percent per year after 30 years of age. Muscle fibers decrease in size and number as we age. Sarcopenia is a gradual, pathological loss of skeletal muscle mass greater than is seen with aging alone. It affects 50 percent of people over the age of 80 and is associated with a high rate of disability and healthcare expenditure. A person does not have to be underweight to be sarcopenic. Sarcopenia can exist in the obese elderly, and their outcomes are particularly poor.

Resistance strength training is the most potent stimulus for muscle growth in adults, but ongoing studies suggest that adequate dietary protein plus resistance strength training may be most beneficial. Current nutritional recommendations for the management of sarcopenia include a balanced protein diet to prevent and reverse sarcopenia as part of a multimodal therapeutic approach.

Good nutrition promotes a sense of well-being and helps maintain muscle mass and strength, thereby preventing the debilitating consequences of frailty, falls, fractures and other problems.

The RDIs: What They Are — and Are Not

The Reference Daily Intake or Recommended Daily Intake (RDI) is the daily intake level of a nutrient considered sufficient to meet the requirements of 99 percent of healthy individuals in every demographic in the United States. These data are useful when considering the needs of a population but provide little guidance when providers are faced with a frail elder during an office visit.

Food Pyramids for Older Adults

Not long after the USDA Food Guide Pyramid was introduced, researchers at Tufts University published a modified pyramid for older adults. This version (Figure 1) emphasizes the importance of adequate fluid intake, nutrient-dense food choices and daily physical activity. It also includes canned and dried fruits and frozen vegetables that are often easy to prepare, less expensive and easy to keep on hand due to their longer shelf life.
Another tool is the Mediterranean food pyramid (Figure 2). The Mediterranean diet emphasizes exercise and daily grains, fruits, vegetables, olive oil, low-fat dairy choices, and fish and poultry several times per week, and de-emphasizes red meat and sweets. The Mediterranean diet has been associated with better cardiovascular outcomes and a lower risk of Parkinson’s disease and Alzheimer’s disease.

Pearls and Pitfalls of Restrictive Diets in Older Adults
I am often consulted to see an elderly patient for “unexplained weight loss” when, in fact, the patient had been instructed over time to cut back on salt, avoid sugar, and reduce cholesterol and animal fats. Restrictive diets (otherwise known as MNT, or medical nutritional therapy) can prove beneficial in disease management; however, the risks for nutritional deficiencies and sarcopenia must be balanced with any potential benefit of dietary manipulation.

A recent review published in Clinical Nutrition noted that, in general, data on outcomes of MNT in older persons are scarce. The authors conclude that restrictive diets seem less effective with regard to morbidity, quality of life and mortality. They recommend that the focus shift toward providing a highly palatable diet with adequate nutritional intake rich in macro- and micronutrients based on the increased risk for older individuals to become malnourished.

Addressing Diabetes and Obesity in the Elderly
Nutritional management of patients with diabetes presents unique challenges in this population. The most important question should really be, What is the overall treatment goal? For example, is your patient a robust 80-year-old woman living alone, exercising and driving, or is she living in a nursing home and experiencing frequent falls and hypoglycemic episodes?
An HbA1c of 8 percent may be too high for your active 80-year-old, but it may be acceptable for the frail nursing home resident who may not be able to detect symptoms of hypoglycemia. In the latter, the risk of further nutritional restrictions, including suboptimal nutrition and symptomatic hypoglycemia, outweigh any potential clinical benefit.

Similarly, the treatment of obesity in this population presents unique challenges and must be approached with due caution. The presence of obesity should never be a presumed marker for adequate nutrition status insofar as many obese individuals are clinically malnourished (as seen in biochemical indices such as prealbumin, which may be a far more sensitive marker for protein status than albumin, calcium, vitamin D and others). Imposing dietary restrictions without a full assessment that includes a dry (i.e., nonedematous) weight and laboratory workup can further provoke underlying deficiencies as well as overall morbidity.

Promoting gradual weight loss in the appropriate, willing elderly patient can be accomplished safely without compromising nutritional status. Effective strategies include avoiding calorie-rich beverages, limiting sweets, cutting back on snack foods, and emphasizing balanced meals, adequate hydration daily and exercise as appropriate.

The ‘Dwindles’
We’ve all seen her: the small-framed, elderly, kyphotic widow who either lives alone or is alone during the day when her caregiver is working and continues to gradually lose weight despite recommendations to eat more and drink nutritional supplements.

Nutritional supplements are expensive, and when taken in place of a meal item, do not increase total daily calories. Weight loss in this individual is likely multifactorial. Decline in taste perception may make food less palatable. Impaired salivary flow and poor dentition may make it difficult to masticate. Persons with dementia, depression, chronic pain, heart failure and constipation may also have a suppressed appetite or simply not recognize hunger signals.

Finally, the psychosocial aspects have to be considered. Older adults eat more in the presence of families and in any group environment. A brightly lit environment with pleasing smells, and pleasant background sounds and companionship promotes a healthy appetite.

If your elderly patient has “the dwindles,” first evaluate medications and the dietary advice you have given her. Can you reduce the pharmacologic burden and loosen the dietary restrictions? Then address the need for companionship during the day — if a family member can visit for lunch or take her out or if she can go to a senior center for lunch, she will likely eat much more in that setting than she would alone at home.

Summary
Good nutrition is an essential component of good health and independent living into and throughout the elder years. Recommended dietary interventions should focus on nutritional adequacy, recognizing that dietary restrictions that are effective in younger populations have limited efficacy with regard to quality of life, morbidity and mortality in the elderly. The modified food pyramid and Mediterranean food pyramid provide recommendations for balanced nutrition and are likely to be palatable. Sarcopenia remains a concern in this population. Adequate dietary protein intake (possibly 1.0 to 1.5 g/kg/day in those without significant renal disease) and strength-training exercises are equal partners in the prevention and treatment of muscle loss. Adequate vitamin D (at least 800 to 1,000 units daily) is associated with reduced risks of fall and fracture. There is no evidence for empiric supplementation of other vitamins and minerals through supplements; such supplementation should be guided by clinical and biochemical assessment.

Dr. Susan Williams is a staff member in Cleveland Clinic’s Department of Internal Medicine who specializes in medical bariatrics and bone and mineral metabolism, and sees patients in the Endocrinology Calcium Clinic. Physicians may reach Dr. Williams at 216.445.8542 or at willias9@ccf.org.
Many older women wish to continue sexual activity after menopause. Clinicians can help by being attentive to their health concerns.

“Medical problems, menopause and lack of a partner are three factors that can interfere with women’s sexual function and enjoyment in later life. And because older women might be too embarrassed to bring up sexual problems, clinicians can help by starting the conversation,” states Margery Gass, MD. Dr. Gass, a consultant for Cleveland Clinic’s Center for Specialized Women’s Health, is Executive Director of the North American Menopause Society (NAMS).

She suggests opening with nonthreatening statements such as “Many of my patients have concerns about sexual function as they get older. Do you have any concerns you would like to discuss?” Dr. Gass adds that “if a woman is menopausal, find out if she values maintaining a capacity for sexual function, because that may require being proactive.”

Analyzing Causal Factors
In analyzing data from the Women’s Health Initiative hormone therapy trials, Dr. Gass and colleagues found that women aged 50 to 79 years reported less sexual activity if they were overweight, reported their health as poor to fair, or had a history of myocardial infarction or arthritis. Those not in an intimate relationship were more likely to report no sexual activity in the past year.

“The most common sexual function change women notice at menopause is a decrease in vaginal lubrication,” says Dr. Gass. Many women maintain sexual activity through menopause without a problem. However, some women experience vaginal dryness that may lead to dyspareunia. “Women are not likely to be interested in engaging in intercourse if they are experiencing pain with it,” she says. Discontinuation of sexual intercourse may lead to vaginal stenosis and, ultimately, the inability to have intercourse.

Dr. Gass believes vaginal estrogen treatment should be considered if vaginal dryness is not corrected with lubricants or moisturizers and the woman wishes to be sexually active. Topical treatment can take the form of vaginal creams, tablets or a ring. “These effectively restore vaginal mucosa to a premenopausal state in most cases,” she reports. Two important exceptions are vulvar pain syndromes and vaginal stenosis, for which referral is indicated.

According to NAMS, data show that progesterone is not required with low-dose vaginal estrogen; however, these studies were of only one year’s duration. Because vaginal estrogen can stimulate the endometrium, women must be counseled to report any bleeding. “Any uterine bleeding needs to be evaluated thoroughly by means of transvaginal ultrasound or endometrial biopsy,” Dr. Gass advises. “The longer someone is using vaginal therapy, the more cautious you should be; both dose and duration of exposure to estrogen play a role in the development of endometrial hyperplasia and endometrial cancer.”

Some clinicians recommend a progesterone challenge test every six to 12 months if low-dose vaginal estrogen is used beyond one year. Bleeding after the 14 days of progesterone therapy requires further investigation. If a woman whose uterus is intact uses standard-dose vaginal estrogen to treat vaginal atrophy and vasomotor symptoms, she needs to add a progesterone either daily or for 14 days each month.

Maintaining Sexual Fitness
“Like staying in shape to play golf or tennis, older men and women need to stay fit to maintain their sexual functionality,” says Dr. Gass. This means avoiding excess weight, controlling cholesterol, and preventing or managing diabetes. Women who don’t have a partner may want to consider maintaining vaginal capacity with a sexual aid that can be purchased discreetly from reputable websites.

Medical conditions also can limit sexual activity. Like men, women with a history of myocardial infarction might fear sexual activity.
Arthritis may cause pain in common intercourse positions. Cancer, chemotherapy or surgery may cause lasting problems. This is where individuals and couples can be creative.

Intimacy Can Take Many Forms
“Some people have not entertained the idea of other forms of intimacy that can achieve orgasm,” says Dr. Gass. It may be helpful to let them know they are not alone, stating, “Some of my patients have found it helpful to try …”

Clinicians who are comfortable with the topic can describe different sexual positions that facilitate intercourse in the face of disabilities. They can encourage couples to consider alternate ways to be intimate, including massages, different kinds of lubricants and sexual toys.

Varied sexual behaviors are not unusual among Americans age 50 and older. The National Survey of Sexual Health and Behavior found that 65 percent of men and 45 percent of women reported a wide variety of sexual activities during the course of the prior year.

However, couples of any age can have differences of opinion. “The human range of desire is very wide, and it’s rare to see a perfectly matched couple,” Dr. Gass says. Thus, many couples have to compromise on frequency and variety in their sex life. A gradual decline in desire for sex is typical with aging. However, for many couples, ongoing sexual activity into their 70s and 80s is a source of meaningful pleasure. Most appreciate physical contact — even just a warm embrace.

Patients seem truly appreciative when a clinician helps them restore or preserve a sexual relationship they value, Dr. Gass concludes.

For more information about hormone therapy products, visit menopause.org/htcharts.pdf.

See “Sexual Health and Menopause” for a general overview of the subjects discussed in this article, which can be found at menopause.org/sex.aspx.

Because older women might be too embarrassed to bring up sexual problems, clinicians can help by starting the conversation.
All physicians with appointments in Regional Geriatrics have a joint appointment in the Center for Geriatric Medicine.
Resources for Physicians

Refering Physician Center and Hotline
Cleveland Clinic’s Refering 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 Refering 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 ccfme.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. Visit ccfme.org.

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.

24/7 Referrals

Refering Physicians Hotline
855.REFER.123 (855.733.3712)

Hospital Transfers
800.553.5056

On the Web at
clevelandclinic.org/refer123

Stay Connected to Cleveland Clinic

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, the Cleveland Clinic Lou Ruvo Center for Brain Health in Las Vegas, Cleveland Clinic Canada, Sheikh Khalifa Medical City and Cleveland Clinic Abu Dhabi.

In 2011, Cleveland Clinic was ranked one of America’s top 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 13 specialty areas, and among the top 2 in four of those areas.
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 2011 survey ranks Cleveland Clinic No. 4 overall in the country. For the 17th consecutive year, cardiac care is No. 1, and 13 specialties are listed among the Top 10.

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’s 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.