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Rebecca Conant, MD (right), Director of UCSF Housecalls Program, visiting her patient Sammie.

## *A Message from the Chief of Geriatrics on "good geriatric care"*

Geriatric medicine crystallizes what is best about medicine, because geriatrics exemplifies what the physician Francis Peabody said over 80 years ago: "The secret of the care of the patient is in caring for the patient."

Medicine has changed a lot in the years since then. No doubt Peabody would cherish the ways scientific medicine has helped many people lead longer and better lives, and he might also caution that modern science should not diminish the human side of medicine.

Geriatrics combines science and humanity in medicine, because its practice is explicitly and unabashedly grounded in respect

and devotion to older patients and their complex human needs. Most geriatricians are drawn to the specialty precisely because the skills it emphasizes have to do with listening carefully, identifying the needs of older patients and their families - and then meeting those needs over time.

Every day, the physicians and staff in the UCSF Division of Geriatrics put this approach into practice through our work as doctors, teachers, and researchers. To illustrate our approach, this issue of our newsletter focuses entirely on what it means to care - truly care - for one's patients.



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## Why Caring Matters

*Hands-on compassion is central to high quality geriatric care*

**J** is an irascible loner, a veteran in his sixties with bipolar disease, diabetes, high cholesterol and Crohn's disease. A long-time resident at the San Francisco Veterans Affairs Medical Center's (SFVAMC) Community Living Center, J's health problems and struggles managing them would previously often land him a room in the adjoining VA Hospital.

Part of the problem was that while many good doctors know how to skillfully treat each of J's health problems, few have the skill set to convince him to actively participate in his own care. Jennifer Morris, MD, is an exception.



Jennifer Morris, MD, (right), prepares dinner with her patients.

One day Dr. Morris – a recent recipient of the Knight Steele Award, an annual award the Division of Geriatrics gives to a health provider who does the most to make a difference for her patients – was waiting for a 6:30 pm meeting that keeps her at the Community Living Center (CLC) late twice a month. Aware that J's anti-psychotic medications, frustration with food choices at the CLC, and inclination to fill the void with fast food exacerbate his food-related health problems, she suggested to him that they start having some home-cooked dinners together. To her surprise, he agreed – and even offered to invite another veteran to join them.

Morris secured a room with a kitchen and then, the day before their first meal together, she and the men decided on a menu. She shopped that night and arrived the next morning with food and utensils. By the second dinner – ground sirloin Shepherd's Pie, cucumbers with vinegar, and coconut cakes – a routine had been established.

“The cucumbers opened a discussion about gardens and preparing vegetables,” says Morris. “When I eat with them I can have a real influence on things like what they eat and portion control...because rather than seeing this as medicine, they see the home-cooked meals as a chance to have and do what they really like. It gives them control over their life.”



Patients Richard Buckner and Gordon Anderson "slice and dice".



Patient Steve Leeper tends to the sauce.

## Why Caring Matters *continued*

### *Human needs yield clinical results*

“In long term care, responding to the human needs of our patients can be every bit as therapeutic as responding to their medical needs,” says Helen Chen, MD, Director of Geriatrics and Extended Care at the VA. “What makes Dr. Morris such a great doctor for our long term care patients is her ability to see past the illnesses and care for them as people.”

In addition to her bi-weekly dinners, Morris voluntarily took on a patient no one else wanted: a homeless wheelchair-bound paranoid schizophrenic with an extensive history in the criminal and mental health systems. She ultimately earned the man’s trust and eased his final days. While working with another veteran, Morris discovered he would sit outside in the cold for hours, waiting for an agency representative who often came late. Morris not only waited with her patient one day and confronted the tardy agency employee, she ultimately wrote a letter on her patient’s behalf – and got results.

“I firmly believe everyone is good - I am fairly naive that way – and while my approach doesn't always work, when it does it's because patients learn that I am here for them, not just for their diabetes or end-stage disease,” says Morris.

It’s an approach that the UCSF Division of Geriatrics hopes sets a standard for others – not because it’s the “nice” thing to do, but because it works. What follows are stories of other UCSF geriatricians making a difference through caring. ■

## Putting the Home into Nursing Homes

Every Monday and Friday, a cramped meeting room at the Community Living Center (CLC) struggles to accommodate seven wheelchair-bound veterans, a geropsychologist, a social worker, and a recreational therapist. In addition to their physical disabilities, many of the veterans suffer from mental health challenges that range from post-traumatic stress disorder and bipolar disorder to depression and substance abuse.

Part of a pilot program that creates “neighborhoods” within the CLC, this group of vets lives near each other, sees the same staff consistently, and attends a variety of events together from classes to community outings. Geropsychologist Elizabeth Sutherland and social worker Pam Low have championed these “neighborhoods” because the support they provide helps residents break through an institutional mentality that encourages dependency. “Self-reliance has real therapeutic value,” says Low. “It helps the residents create their own coping mechanisms and alternative therapies.”

Vincent, grey-haired and pony-tailed with an impish sense of humor, likes the changes.



Elizabeth Sutherland and Pamela Low meet with CLC residents Donnie Ruth, Gordon Anderson, Michael Wong and James Dupery.

“I’ve been here seven and a half years, and I didn’t know until we started this group we had taxi scrip (taxi voucher) ...it makes it a lot easier to get out of this place,” he says, the night after attending a Madonna concert.

“For one veteran in our group, the barbecue we did was his first time out of the CLC in four years,” says Low. “Now he has asked for a pass home to see his dying father and another to join his family for Thanksgiving.” The neighborhood approach also seems to help some veterans talk through their problems.

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## Putting the Home into Nursing Homes *continued*

“I spilled my guts last week,” says Jeff, another member of the group. “That’s something I wouldn’t dare do unless I know I’m in good company.”

The neighborhoods are part of the Veterans Administration’s “Cultural Transformation” movement, which aims to make VA nursing homes around the country more, well, “homelike.” That movement was a major impetus for changing the name of the San Francisco Veterans Affairs Medical Center (SFVAMC) Nursing Home Care Unit to the Community Living Center. “The name change signals to staff and residents that this is not just a clinical facility, but a home where veterans live,” says Medical Director Anna Chang, MD.

Some changes are physical: new floors and furniture and the addition of a library, a computer center, and small gardens. Others are clinical, including an approach to treatment driven by what the vets themselves determine their therapeutic goals to be.

Still other proposed changes are atmospheric. For example there are discussions underway to consider replacing today’s more regimented, institutional-type meals with monthly family dinners, continental breakfasts, and short-order cooks. In addition, Low chairs a committee that is exploring how to bring in a pet cat or two.

But Chang, Low, Sutherland, and nursing manager Candy Crider – who have led the cultural transformation movement at the SFVAMC – recognize that change is never easy or fast. To bring everyone on board, they have led a series of meetings and presentations for both staff and residents.

“For staff sometimes it’s as simple as doing an exercise that asks them to imagine three things they would like to have if they broke their hip and were facing an extended stay here... because the shift has to be at the level of the heart, not just the mind,” says Sutherland.

“What’s encouraging is there is emerging evidence – including at this facility – that this type of change yields improved clinical and functional results,” says Chang. ■



Anna Chang, MD, Medical Director, Community Living Center, SFVAMC

## A Nurse Changes the Face of Hospital Care at UCSF

“Hospitals are skilled at treating acute illnesses, but they have done less well addressing older patients’ functional needs,” says geriatrician Ken Covinsky, MD, who notes that this has been a concern of many faculty members in the UCSF Division of Geriatrics. “Our work has shown that older people often leave the hospital more disabled than when they entered and hospitals really need to address the impact this has on patient independence.”

Carla Graf is among those leading the fight. A clinical nurse specialist in geriatrics and UCSF School of Nursing doctoral student, Graf is the centerpiece of the UCSF Medical Center’s Geriatric Resource Nursing model, one of a few such models that have emerged to help hospitals better address the specialized needs that often arise with older patients. As the “geriatric resource” Graf fills multiple roles in an effort to minimize potential complications from being hospitalized and get patients discharged in a way that gives them the most reasonable control over their own life.

“Few have done more than Carla Graf to improve care for the elderly in San Francisco,” says Seth Landefeld, MD and Chief of the Division of Geriatrics.

One of Graf's roles is to consult on geriatric syndromes that range from delirium and dementia to bedsores and incontinence. Another role is to train providers to work more effectively with older patients. A third role is working with nursing leaders to revise policies and procedures so that they reflect current, evidence-based practice. "I advocate from the perspective of how to apply these policies to the older patient and older family members – and we are fortunate that the hospital administration, especially the chief nursing officer, recognizes the contributions of clinical nurse specialists in this way," says Graf. Finally, the UCSF School of Nursing and the hospital also encourage Graf's research efforts, which have included identifying patients who may benefit from a geriatrician/geriatric nurse practitioner home visit after hospital discharge, and evaluating how well the hospital does with recognizing delirium in older patients.



Carla Graf, PhD(c), MS, RN, CNS-BC, (right) Geriatric Clinical Nurse Specialist and Rose Moore, MS, RN, GNP (left) assistant patient care manager of the Medicine unit.

complications of illness for elders," says Graf. "For example, when older adults are hospitalized for pneumonia, the pneumonia may be better in three to four days, but after spending three days lying in bed, the patient can't walk," Graf continues. "If they can't walk, they can't go home because they won't be able to get groceries or prescriptions filled, cook, bathe or shower. That's why everyone working with geriatric patients needs to understand how to assess cognition, hearing and vision, mobility, pain, sleep patterns, bowel and bladder continence – and how to put a plan in place to maintain function."

Such care, however, requires more training, more patience, and more resources than are typically available. "Things as simple as toileting may take more time and possibly the help of more than one caregiver," says Graf. "So does communication, respect, encouragement, smiling, and making eye contact. These all go a long way toward getting patients to do what they need to do to get better."

That, in turn, requires providers who genuinely want to work with older patients. "Geriatrics is fascinating and complex work, but you have to love it," says Graf. "The best patient care begins with positive regard – focusing on the person's abilities, on what they can do, and not the things they can no longer do independently. And you just can't fake that type of regard." ■

“The best patient care begins with positive regard – focusing on the person’s abilities, on what they can do, and not the things they can no longer do independently. And you just can’t fake that type of regard.”

–Carla Graf, PhD(c), MS, RN, CNS-BC

Graf says that part of the challenge with geriatric hospital care is that despite a baseline physical and functional assessment when patients enter, the follow-up on the functional piece often gets lost. "This happens either because there is no clear sense of ownership or because staff is not fully aware of how to address the functional



Carla Graf, RN, Clinical Nurse Specialist (center) confers with staff in the Medicine unit at 14 Long Hospital

## Home Visits Foster Connections and Independence

If one of geriatrics' primary goals is to keep older adults independent as long as possible, then home visits by providers must play a prominent role. The San Francisco Veterans Administration Medical Center's (SFVAMC) Home-Based Primary Care program provides comprehensive care for complex patients who are functionally limited. The program enables some 200 patients who might otherwise wind up at a skilled nursing facility to continue living at home.

Each patient receives an individualized care plan, implemented at their home by an interdisciplinary team that includes a physician, nurse practitioner, nurse, social worker, nutritionist, geropsychiatrist, geropsychologist, pharmacist, and administrative assistant. "We see patients as often as medically indicated, sometimes as much as weekly," says Program Administrator Fred Contreras, NP.

Such arrangements require providers attuned to more than a patient's primary diagnoses. "When you are in someone's home, you can't ignore the other aspects of their lives," says Medical Director Sandra Moody, MD. "Maybe a patient is about to be evicted; maybe they are not eating or there are safety issues, such as someone in the household owning a gun."

"And because caregivers need respite, we often support the caregiver as much as the patient," says Contreras.

Despite these complexities, many believe home-based primary care can and should be a more readily available option for the rapidly growing population of older adults outside the VA. The SFVAMC has calculated that the success of its home-based program in averting hospitalizations and nursing home placements reduced the total cost per patient per year by 24 percent. Yet outside of the VA, home visit programs usually require financial support in addition to insurance reimbursement.

The much-lauded UCSF Housecalls program is an example of a home visit program that must depend on philanthropy to survive. "UCSF Housecalls allows me to provide the best possible medical care to our frail elders," says Rebecca Conant, MD, Director of the Housecalls program. "Seeing someone at home and taking the time to coordinate care improves satisfaction and helps people achieve their goals. However, our medical



Sandra Moody, MD, Medical Director, SFVAMC Home Based-Primary Care

reimbursement system does not recognize the value of this time and skill. It's only through the generosity of our donors that we can provide care regardless of the ability to pay."

"These types of policy and care delivery constraints seriously affect our ability to provide the types of care older patients need," says Dr. Kenneth Covinsky, Acting Chief, Division of Geriatrics, who along with Bree Johnston, MD, penned an editorial arguing for Medicare to radically alter the way it pays for care for the elderly. The piece entitled "Envisioning Better Approaches for Dementia Care" appeared in the *Annals of Internal Medicine* in November 2006.

"Our patients illustrate clearly how the scientific and psychosocial sides of medicine are not separate and that good care requires skill in both areas. This is the type of care home visits can foster," says Covinsky. ■



## Palliative Care and Hospice: What Do You Want from the Rest of Your Life?

Eric Widera, MD, Director of the hospice and palliative care programs at the San Francisco Veterans Affairs Medical Center (SFVAMC), lights up when he tells the story of a terminal cancer patient who had worked his entire adult life as a chef. What the man wanted most before he died was to cook again. So Widera and his team brought in heirloom tomatoes and gourmet bread and cheese, and they helped the man cook up and eat a grilled cheese meal.

He was ecstatic. “It had nothing to do with his chemo,” says Widera. “But it helped him achieve something important.”

Trained in both geriatrics and palliative care, Widera believes the two disciplines are both necessary and complementary for the work he does. “Geriatrics highlights improving functional status and quality-of-life – understanding things like dementia and urinary incontinence – while palliative care stresses relief of suffering and how to take care of patients holistically,” he says.

The palliative care program at the SVAMC aims to catch people immediately after they’ve been diagnosed and before hospitalization.

“If we see people earlier, we can help them deal with everything from physical suffering to things like: How can I afford medications? How can I get to chemo? How can I deal with guilt of being a burden and other psychosocial issues?”

In contrast, hospice is for acutely ill patients who physicians expect have less than six months to live. The 10-bed hospice at the SFVAMC, located in the Community Living Center, is staffed by an interdisciplinary team that includes a physician, nurse practitioner, social worker, psychiatrist, psychologist, chaplain, massage therapist, nurses, and a recreation therapist.

“As the physician, I’ve been trained to do symptom management, but the goal of these programs is to relieve all suffering: physical, psychosocial, emotional, spiritual,” says Widera. “To do that, we need the chaplain, the social worker, and the psychiatrist. I learn every day from the team and it changes how I approach patients.”



Eric Widera, MD stands next to the 2008 Palliative Care Remembrance Wreath. Each ribbon represents a patient who has passed away.

“Eric’s passion for improving the well being of patients near the end of life is contagious,” says Dr. Kenneth Covinsky, Acting Chief, Division of Geriatrics.

And, Covinsky argues, it is providers who understand patients in the context of their entire lives who are at the heart of exemplary geriatric care. Attentiveness – Morris’s home-cooked meals (pg. 2), culture change at the VA (pg. 3), Graf’s patience and positive regard (pg. 4), the team-based home visits of Home-Based Primary Care and Housecalls (pg. 6), and the approach of Widera and his team in hospice and palliative care – is the key to successful outcomes with older patients.

“In medicine, we tend to focus on the diagnosis and the medical treatments, but we don’t really focus on the life,” says Widera. “What are people’s hopes for the life they have left? What’s important to do? And how can we make it happen?” ■

### Hospice and Palliative Medicine

UCSF is now offering an ACGME accredited one-year clinical fellowship in Hospice and Palliative Medicine. The first fellows will be starting in July of 2009. The fellowship’s educational goal is to train physicians in the care of patients with life-threatening illness by supporting the best quality of life throughout the course of an illness, and by managing factors that contribute to the suffering of the patient and the patient’s family.

For more information please visit:

<http://hospsrvr.ucsf.edu/fellowship/pallmed.html>

# Selected Publications, Honors, Awards, and Grants in Aging

## Awards

**Will Gordon**, a second year medical student mentored by **Michael Steinman, MD**, received the award for best poster presentation at the Bay Area Clinical Research Symposium.

**Jennifer Morris, MD**, received the Knight Steel Award. This award is made to a physician or student at UCSF who has made an exceptional contribution by "making things work" for a patient.

**Edgar Pierluissi, MD**, has received an Early Stage Investigator Award from the S.D. Bechtel, Jr. Foundation. With the support of the foundation, Dr. Pierluissi will focus his efforts on researching risk factors for Alzheimer's disease, with the goal of advancing understanding and prevention of the disease.

**Michael Steinman, MD, Victor Valcour, MD, and Douglas White, MD, MAS** are recipients of the 2008 Paul B. Beeson Career Development Awards in Aging Research.

**Rebecca Sudore, MD**, was awarded a career development award from the Health Services Research and Development Service of the Department of Veterans Affairs.

## Grants

**Rebecca Conant, MD** received a grant from the Callison Foundation for core support of the Housecalls program.

**Seth Landefeld, MD, Helen Chen, MD, and Louise Walter, MD**, will design and edit a new series in JAMA, "Care of the Aging: From Evidence to Action."

**Alexander Smith, MD**, was awarded a Supplement Award Grant from the National Institute on Aging.

**Victor Valcour, MD**, received an R01 Grant from the National Institutes of Health for a project titled: "Peripheral Reservoir of HIV DNA in Monocytes Pivotal to Cognition in HIV."

**Eric Widera, MD**, recently received a competitive grant from the Veterans Affairs Medical Center (VAMC) to develop a program to expand palliative care services to the outpatient setting.

## Publications

**Covinsky KE**, Lin F, Bittner V, Hlatky MA, Knight SJ, Vittinghoff E. Health-related quality of life following coronary artery bypass graft surgery in post-menopausal women. *J Gen Intern Med.* 2008;23 (9):1429-34. Epub 2008 Jun 24.

**Landefeld C, Steinman M.** The Neurontin Legacy — Marketing through Misinformation and Manipulation. *N Engl J Med.* 2009;8;360(2):103-6.

**Lee SJ**, Go AS, **Lindquist K**, Bertenthal D, **Covinsky KE.** Chronic conditions and mortality among the oldest old. *Am J Public Health.* 2008;98(7):1209-14. Epub 2008 May 29.

**Smith A**, Earle C, McCarthy E. Racial and Ethnic Differences in End-of-Life Care in Fee-for-Service Medicare Beneficiaries with Advanced Cancer. *Journal of the American Geriatrics Society.* 2008;57 (1): 153 – 158. Epub 2008 Nov 25.

# Newsletter on Aging

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