Collaboration Spans Disciplines

Abuse *from page 1*

woman who was living with her son in southern Orange County. When he arrived at the residence with a social worker from adult protective services, no one answered the door, so they called the sheriff's department to gain entry.

Once inside, they found the woman lying on a urine-soaked mattress in a dark room littered with dog feces.

"She was very confused," recalled Dr. Liao, who is an internist at the UCI Medical Center.

A neighbor called the son at work to let him know what had transpired. When the son arrived at the house, the sheriff's deputy instructed him to bring his mother to the medical center's geropsychiatry unit for evaluation and treatment. Once she was there, "she improved significantly and she was eventually placed into a nice assisted living facility," Dr. Liao said.

When officials from the office of the Orange County public administrator/public guardian looked further into the woman's case, they discovered that that son and another son had been taking money from their mother and neglecting her.

The case is "a good example of collaboration between adult protective services, the medical community, law enforcement, and the public guardian, where everybody contributed to this lady's safety and improved her quality of life, and protected her finances from future abuse," Dr. Liao said.

Meeting face to face with colleagues from a wide range of disciplines also saves time.

"Now we all know each other," Dr. Mosqueda noted. "A few weeks ago, there was a case involving an elderly patient [who] came into an emergency room in southern Orange County and a police detective was called. He was able to call me and say, 'This might be abuse. Is there something I should ask these doctors to order in terms of lab tests?' "

One way physicians can be proactive about elder abuse and neglect, she said, is to ask pointed questions during every routine office visit with elderly patients, such as: Are you afraid of anybody? Is anybody stealing from you? Is anybody hurting you?

Dr. Mosqueda makes it a point to ask caregivers of her patients with dementia if they're hurting the person with dementia.

"I'll say something like, 'Boy, your mom's a handful. Are you ever getting to a point where you hit her or you're worried that you're going to hit her?' People will answer that question."

Telltale signs of physical abuse include explanations for an injury that don't match the clinical presentation.

"For example, if you see somebody who has bruising on their chest, abdomen, or their neck and they say it was from a simple fall where they tripped and slipped. Those don't commonly tend to be places where you're going to get bruises," Dr. Mosqueda said. "It's rare to fall and bruise your neck."

She also advises being vigilant about checking for pressure sores.

"Sometimes we'll see people for an office visit who are very debilitated, and we don't get them undressed," she said.

"It's hard to get them on an exam table, and so we never look at their sacrum or their buttocks to see if there's a pressure sore there.

"I've seen multiple cases where the pressure sore was probably there at the time of the office visit, but nobody looked for it. Neglect is a type of abuse, so when a patient comes in and has particularly poor grooming or hygiene, we have to ask, what's going on?"

One way to be proactive about elder abuse or neglect is to ask pointed questions, such as: Are you afraid of anybody? Is anybody stealing from you? Hurting you?

The center receives funding from Orange County, private foundations, and public and private research grants.

"Our center really involves research and education, so at any one time, we have quite a few grants going to help support the work that we're doing," Dr. Mosqueda said.

One research project led to the formation of a countywide death review team, which partners with the coroner's office to study cases of suspicious deaths among elderly in the area.

"Elder abuse is complex and multifaceted," observed Dr. Liao. The center "is a really good example of how you can tackle something so complex and multifaceted with an interdisciplinary collaboration to address one of our most difficult problems in our society."

The center has been instrumental in helping "cases move along or be resolved—cases that in the past probably would have stagnated and gone either nowhere, or would have gone so slowly that it would have frustrated everybody," he noted.

Meanwhile, Dr. Mosqueda said, other counties in California have launched their own programs modeled after Orange County's Elder Abuse Forensic Center.

In the coming years, "I hope we'll have a better understanding about what we can do toward prevention and mobilization of community resources to catch abuse at earlier stages," she said.

"I'd like to see our center provide victim services and services for families as well. If we can do some early identification, maybe we can help prevent some of these [cases of abuse] from occurring." ■

TALK BACK

What problems have you seen in recognizing and responding to elder abuse and neglect?

Weigh in at www.familypracticenews.com
We look forward to hearing from you!

POLICY & PRACTICE

Nursing Home Fees to Increase

The Centers for Medicare and Medicaid Services has proposed increasing the work relative value units—and therefore the physician fees—for services provided in the nursing home setting. If the increase is included when CMS publishes its final fee schedule on Nov. 1, physicians will see new reimbursement rates beginning on Jan. 1, 2008. Under CMS' proposal, fees for nursing home visits would increase 9%-50%, depending on the service. The changes come after 4 years of work by the American Medical Directors Association and other physician groups aimed at persuading CMS that the work involved in caring for a nursing home patient is similar to the work involved in caring for a hospital patient. "Because patients are moved from more intense settings much more quickly than in the past, patients in nursing facilities are often in very serious condition as they are cared for by their physician," said Dr. David Dale, president of the American College of Physicians in a statement. "These work values are a reflection of this extraordinary responsibility."

CMS Releases Medicaid Rule

CMS has unveiled a new method of setting limits on what the federal government will reimburse state Medicaid agencies for prescription drug payments. As part of the new regulation, states will be required to collect information from physicians about prescription drugs administered in their offices so that the state can collect any rebates offered by drug manufacturers on those products. The final rule will take effect Oct. 1. The regulation is expected to save states and the federal government $8.4 billion over the next 5 years, but even with the change, the Medicaid program still is expected to spend $140 billion for drugs over the same time period. The change is in part a reaction to a series of reports showing that Medicaid payments to pharmacies for generic drugs were much higher than what pharmacies actually were paying for the drugs. Pharmacies, the reports showed, made the most profit on those generic drugs with the highest markup, creating an incentive to dispense those drugs.

Joint Commission Announces Goals

The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations) will require health care institutions to take specific actions to reduce the risks of patient harm associated with the use of anticoagulant therapy as part of its 2008 National Patient Safety Goals. The new requirement—which applies to hospitals, ambulatory care and office-based surgery settings, and home care and long-term care organizations—addresses a widely acknowledged safety problem with anticoagulant therapy, the accrediting organization said. The 2008 safety goals also include a new requirement that addresses the recognition of and response to unexpected deterioration in a patient's condition. Under this requirement, hospitals must select a suitable method for enabling caregivers to directly request and obtain assistance from specially trained individuals if and when a patient's condition worsens. Full implementation of both requirements is targeted for January 2009.

Americans Buy Drugs Overseas

More than 5 million Americans adults, or more than 2% of the U.S. population, have recently purchased prescription drugs from another country, such as Canada or Mexico, according to a survey by the Pharmaceutical Research and Manufacturers of America. The vast majority of consumer importers said they were looking for the best price for medicines, but about half decided to buy their drugs in another country because they didn't have a physician's prescription for the drugs they wanted, the survey found. Importers were more likely to be under age 35 years, be Hispanic, live in a southern border state, and to spend more out-of-pocket money on prescription drugs than do nonimporters, PhRMA reported. Most of the drugs imported were to treat chronic ailments. PhRMA President and CEO Billy Tauzin said in a statement that importation increases a patient's risk of being exposed to "dangerous counterfeit medicines."

HHS Expands Vaccine Capacity

The Department of Health and Human Services has awarded two contracts to expand the domestic influenza vaccine manufacturing capacity that could be used in the event of a potential influenza pandemic. The 5-year contracts were awarded to Sanofi Pasteur ($77.4 million) and MedImmune Inc. ($55.1 million). The contracts provide funding for renovation of manufacturing facilities and for manufacturing operations for 2 years, with options for an additional 3 years of operations. Upon completion, these facilities will expand domestic pandemic vaccine manufacturing capacity by 16%, according to HHS. In addition, the facilities will expand vaccine availability for the national stockpile.

Patients Want to Shake Hands

Most patients want physicians to shake their hands when they first meet, but only about half want their first names used in greetings, according to a report in the Archives of Internal Medicine. The authors surveyed adults and also analyzed videotapes of new patient visits. They found physicians and patients shook hands in four out of five visits, but that physicians didn't mention names at all in about half the visits. "Given the diversity of opinion regarding the use of names, coupled with national patient safety recommendations concerning patient identification, we suggest that physicians initially use patients' first and last names and introduce themselves using their own first and last names," the authors wrote.

—Jane Anderson