

Maine's Initiatives in Geriatric Medical Care:

Commentary from the Front Lines

by Cliff Singer and Roger Renfrew

Cliff Singer and Roger Renfrew write from their perspectives as medical practitioners and leaders in geriatric medicine to examine issues affecting health care and outcomes for older adults in Maine. Focusing on the acute and primary care systems, they highlight issues and policy recommendations they think are most urgent or helpful.

This is a time of creative innovation in the health care of older adults. In this article, we offer commentary on some of the many health care initiatives at the national and state level. We are not policy experts. We are two people with decades of experience in the medical care of older adults. We write with a deep and intimate knowledge of how policy affects the patients and families we serve. We write also from the perspective of our leadership roles in elder care both within our medical centers and within the Dirigo-Maine Geriatric Society, our state chapter of the American Geriatric Society, the primary medical organization with a singular focus on improving the health care of older adults. Our aim is to highlight critical issues affecting health outcomes of older adults in Maine's hospitals and clinics as we perceive them from the bedside and not the boardroom. Our focus will be on the acute and primary care systems, since long-term care is covered elsewhere in this issue. At the end of the article, we highlight the issues and policy recommendations we think are most urgent or helpful.

CURRENT STATUS OF HEALTH CARE OF OLDER ADULTS IN MAINE

In many ways, we are doing a good job. National surveys indicate that residents of Maine enjoy good health relative to citizens in other states. This is likely as much due to our demography, active lifestyles, and natural environment as anything else, but access to good medical care plays a role. We are blessed with excellent hospitals. Maine's hospitals consistently achieve high marks for safety and quality (<http://www.themha.org/>). We have integrated health care networks that are newly dedicated to primary care, emphasizing better health,

disease prevention, and integrated, multidisciplinary care of older adults with complex chronic conditions. We also have a high proportion of health care providers who have deep roots in their communities and intimate knowledge of the people they serve.

But we are also a state with special challenges. Our population is older than most and older adults need more medical care. Nationally, 23 percent of people over 75 years of age had 10 or more physician office visits in the last 12 months, compared to 14 percent of people aged 45 to 64 (Blackwell, Lucas, and Clarke 2014; Schiller et al. 2014). Seventy-one percent of older adults have hypertension (high blood pressure), 49 percent have been diagnosed with arthritis, 31 percent heart disease, 25 percent cancer, and 21 percent diabetes. Eighty percent of Mainers over 65 years of age take at least one medication prescribed for chronic health problems (MDHHS 2012).

As in much of rural America, Maine's health care infrastructure is comprised of a network of small hospitals, primary care clinics, and nursing homes. Maine hospitals receive high ratings for quality compared to national standards, but struggle financially because of high levels of uncompensated care and below-cost reimbursement for higher than average proportions of MaineCare (Medicaid) and Medicare patients. Maine hospitals lost money in 2014, with an aggregate operating margin of -0.3 percent (loss). According to the Maine Hospital Association, this operating loss was due to lower inpatient-bed use (good), higher taxes, and reduction in Medicaid and Medicare reimbursement rates. Medicaid reimbursement for inpatient care is 28 percent below cost (MHA 2014). Maine's hospitals face extreme financial pressure from non-Medicare-reimbursed care. Maine's

uninsured and MaineCare populations are greater than national averages, and the uncompensated care provided by the state's hospitals doubled from 2006 to 2013 (MHA 2014).

Financial survival is especially challenging for small rural hospitals, which have even higher percentages of MaineCare and Medicare patients and fewer options for highly reimbursed surgeries and subspecialty procedures. These low margins mean our smaller hospitals will fall behind in investment in new technologies, facilities, staff recruitment, and training to meet the needs of our growing geriatric population. Hospital, clinic, and nursing home closures in rural Maine are a special threat to seniors and their family caregivers (Bailey 2009). Increasingly, Maine's small local facilities are joining the major hospital networks, resulting in improved access to specialists and integrated care, but a loss of autonomy and local control.

Maine's rural demographic makes access to necessary medical, mental health, or dental care challenging for older adults living outside of the few urban centers.

Alzheimer's disease is the leading cause of progressive cognitive decline to dementia in older adults. It affects 13 percent of seniors (> 65 years of age) and 37,000 people in Maine have the disease, a number that is rapidly increasing and beginning to overwhelm our hospitals and long term care systems (MDHHS 2013).

Depression and other mental health disorders are also common in older adults, with major depression affecting from 5 percent to 10 percent of seniors at any given time (Taylor 2014). People with health conditions affecting daily function are at even higher risk of depression. Patients with depression have 50 percent higher health care costs than nondepressed people with comparable levels of medical illness (Unutzer et al. 1997), yet depression is undertreated in seniors (Unutzer et al. 2000).

Maine's rate of alcohol abuse in older adults is higher than national averages, 5.1 percent versus 3.1 percent for those over 65, although these are self-reports.

Overuse of benzodiazepines for anxiety and sleep and opioids for chronic pain continue to contribute to injuries from falls and confusion (MDHHS 2012). Diagnosis and treatment of neurological, cognitive, mental health, and substance-use disorders in old age is especially difficult in Maine given the scarcity of specialists. This means that primary care providers are often left treating these conditions to the best of their abilities.

Maine's rural demographic makes access to necessary medical, mental health, or dental care challenging for older adults living outside of the few urban centers. Driving to specialty care in remote towns is expensive at any time and often hazardous in winter. Military veterans may have even greater distances to drive to get to one of the VA outpatient or hospital facilities.

Many of Maine's older adults live on limited, fixed incomes, making medical co-pays, mental health care, medications, dental care, eye care, or hearing aids out of reach. According to the federal Administration on Aging website (<http://www.aoa.gov/>), older adults averaged out-of-pocket health care expenditures of \$5,069 in 2013, an increase of 35 percent since 2003. Older Americans spent 12.2 percent of their total expenditures on health care, as compared with 7.1 percent among all consumers. These data suggest that the economics of health care hits Maine hard because of the state's older-than-average demographic.

CHALLENGES TO HIGH-QUALITY CARE

Evidence-based Quality Metrics

The National Academy of Science's Institute of Medicine has challenged us to pursue care that is safe and effective. This has led to the development of evidence-based guidelines for many aspects of care issued by specialty societies of physicians, nurses, and other health care providers. These guidelines provide clinical pathways rated by the soundness of the research evidence base and where good evidence is not available, complemented by expert opinion. They have become the standards of practice and increasingly, reimbursement.¹

For providers caring for older adults, there are challenges with many guidelines. Older adults with multiple co-morbidities are often excluded from the studies from which the evidence is derived. This reflects the difficulty of studying a population with high risks of complications and mortality from their underlying conditions. Unfortunately, one cannot assume that research done on

relatively younger patients with a single disease can be translated to this population. In the cases of diabetes and hypertension, applying guidelines for younger adults may lead to increased mortality in older adults. Yet, once guidelines are developed by specialty societies, they may become national measures upon which reimbursement decisions are made by the Center for Medicare and Medicaid Services (CMS) through programs such as Meaningful Use of the Electronic Health Record, Physician Quality Reporting System (PQRS), and Value Based Purchasing.

There has been slow progress at including geriatric-specific indicators into these sets. Of 254 PQRS indicators, 28 may be considered geriatrics-focused. Most of these are specific to a disease or condition, and none address the patient with multiple co-morbid conditions. This is a gap that needs to be addressed, as more than 50 percent of Medicare patients have three or more chronic conditions. At the local system level, there is an advocacy process that is needed to direct limited resources to implementation of these initiatives. There are initiatives that state and federal regulations either require or create incentives for, but there are also, within local institutions, proposals based on recognized local needs and enthusiasms of providers for specific quality initiatives. Pursuing these initiatives often requires buy-in from colleagues to overcome institutional pressure to align initiatives with broader system-level goals that may not always meet the needs of older patients in that community.

Even when initiatives are established, embedding best geriatric practices into primary care is a major challenge. This reflects a payment system that is built on acute visits as opposed to management of complex chronic illnesses and that rewards providers for volume of visits. Many of Maine's primary care practices are small enterprises, without the resources to easily comply with new regulations or meet evolving standards in the care of frail older adults with complex psychosocial and medical needs. Quality metrics may improve the consistency of care provided to patients, but they create an immense strain on practices. For example, the comprehensive provision of preventive services to an average primary care specialist's practice panel is estimated to require 7.4 hours per day (Yarnall et al. 2003).

Individual practices and health systems attempt to meet constantly changing standards. Patient-centered medical homes must meet external standards that can be difficult to implement. This creates a competition for

time and resources between various initiatives. A similar process is occurring in public education and has been labeled initiative fatigue, a term that certainly applies here. "The Law of Initiative Fatigue" states that "when the number of initiatives increases while time, resources, and emotional energy are constant, then each new initiative—no matter how well conceived or well intentioned—will receive fewer minutes, dollars, and ounces of emotional energy than its predecessors" (Reeves 2010).

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This becomes a practical matter in implementation of geriatrics-specific programs. A recent report demonstrated good implementation of screening and evaluation for falls in primary care, but poor implementation of a plan and no notable impact on falls overall in the study population. Because of the complexity of the task and the apparent low yield, the program was discontinued to focus on another initiative instead of working to improve performance (Landis and Gavin 2014). Within health systems and practices, there is a political competition for the time and energy needed to implement initiatives that are otherwise seen as important by the providers. Policies that reward persistence in overcoming the challenges of implementing proactive prevention in eldercare are needed.

Acute Care of Older Adults: "Geriatric-Capable" Hospitals

A visit to an emergency room or hospital by an older adult can be an early sign of pending decline. The care can be highly challenging if the person is frail or has multiple co-morbid conditions. In fact, some older patients are at risk of harm in health care facilities as well as at transitions of care from one setting to another. Thirty to 60 percent of hospitalized elders are discharged with new or increased disability (Hoogerduijn et al. 2007). Many of them either die or have not recovered function, even 12 months after discharge (Boyd et al. 2008).

In all health care environments there is a need for proactive care, which requires providers to think not

only about the acute issues in front of them, but the impact of those problems on other physical, psychological, and social systems. Common concerns in these environments include cognitive function and risk of falls as well as the need to evaluate social support. In the emergency room, both the physical design and culture of care are focused on rapid assessment and stabilization of a presenting symptom and not on the multiple other problems that might lead to rapid failure once sent home. It is not uncommon, for example, for a person with dementia to be discharged from an emergency room with a new medication or care instructions that he is incapable of following.

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Four national organizations have worked together to develop guidelines to help define a geriatric emergency department concept (ACEP 2013). These guidelines address staffing and environment, follow up and transitions of care, education, quality improvement, equipment and supplies, policies, procedures, and protocols. The opportunity is that “the expertise which an ED [emergency department] staff can bring to an encounter with a geriatric patient can meaningfully impact not only a patient’s condition, but can also impact the decision to utilize relatively expensive inpatient admissions, or less expensive outpatient treatments” (ACEP 2013: 2). Furthermore, as the initial site of care for both inpatient and outpatient events, the care provided in the ED has the opportunity to “set the stage” for subsequent care provided.

It is clear though, that this binary approach (inpatient versus outpatient) is driven by rigid reimbursement models and not patient needs. Those needs often demand a range of support and treatment options requiring new reimbursement models for alternatives that are less expensive than hospital admission, but capable of providing professional caregiver support and 24-hour nursing oversight of care. Policies are

needed that encourage health care systems to implement a flexible array of services that are not just hospital or home based.

In the hospital setting, a number of intervention strategies have been tried to improve outcomes and decrease risk of adverse events such as falls and confusion. Multidisciplinary team care, which incorporates geriatrics expertise, can reduce delirium and result in shorter lengths of stay. Specific units designed for older adults (ACE: acute care for elderly) can improve functional status and increase discharges back to home, versus to nursing home, while decreasing mortality (Counsell et al. 2000). Use of standardized protocols leads to more appropriate prescribing, less functional decline, more discharges to home, and recognition of acute confusional states (delirium). These units may have minimal or no effect on length of stay, readmission rate, or mortality, but these may not be the best metrics of quality for frail patients for whom comfort and quality of life are the defining factors for care.

Perhaps the most interesting work in this arena is in the Canadian province of Ontario, which has developed a provincial initiative on senior-friendly hospitals. The elements of this program include the physical environment, implementing evidenced-based processes of care, the emotional and behavioral environment, review of ethics in clinical care and research and organizational support for high-quality geriatric care. At present we have pieces in Maine’s hospitals that work quite well, but there remains a lot to learn about what works best and how to implement this work into day-to-day care.

According to the Institute of Medicine’s Principles of Care (IOM 2008: 76):

- The health needs of the older population need to be addressed comprehensively.
- Services need to be provided efficiently.
- Older persons need to be active partners in their own care.

In an extensive review of published results from 15 models, Boulton and colleagues found that care models based on IOM principles can improve outcomes of interdisciplinary primary care, transitions of care between health care settings or home, providing acute care in patients’ homes, nurse-physician teams for residents of nursing homes, and geriatric care in hospitals (Boulton et

al. 2009). They conclude that “policy makers and health-care leaders should consider including these 15 models of health care in plans to reform the U.S. healthcare system. The Centers for Medicare and Medicaid Services would need new statutory flexibility to pay for care by the nurses, social workers, pharmacists, and physicians who staff these promising models” (Boult et al. 2009). We agree. It is often said that “geriatrics is a team sport” and reimbursement models are needed to provide maximum flexibility in both the care setting and in multidisciplinary care delivery. Medicare’s new chronic care management (CCM) payment program is certainly a step in the right direction. Under the new program, Medicare could reimburse primary care practices about \$40 per month per person for such things as medication management and care coordination for patients who have two or more chronic medical conditions.

Dementia in Primary Care

Cognitive decline to dementia shows increasing prevalence that doubles every decade after the age of 65, achieving 59 percent in people 80 to 89 years old (Plassman et al. 2007). Alzheimer’s disease is the most common cause of dementia in older adults. It is a terminal illness with a long debilitating course. Its impact on the management of other chronic illnesses is significant. As such, it serves as a model for the challenges we face in providing care to an aging population.

Nationwide, and in Maine, there is a shortage of specialty care for persons with dementia. Over 80 percent of the care of older adults occurs in primary care practices. This is quite likely higher in rural states such as Maine. Nationally, one-half of persons with dementia in primary care practices are unrecognized. When they are diagnosed, more than one-half have moderate or late-stage disease. This pattern is true for other geriatrics syndromes such as falls and incontinence. This reflects the difficulty of caring for patients with multiple chronic illnesses and in complex social situations, and the need to address preventive services in a model developed around acute care needs.

There is no simple solution to this problem. Minnesota and Ontario have taken on the challenge at a state and province level. Large health systems such as the VA have attempted to support primary care in the care of these patients. Academic institutions have had success in controlled circumstances, but less success when attempting to spread their work into community-based

practice. The effectiveness of these models is based on indicators of care that should be accomplished. In reality, these are aspirational even in academic geriatrics practices. Models vary from a single practitioner accomplishing the necessary work over several visits to use of a team-based approach.

Team-based approaches vary significantly. One model is to embed a nurse practitioner into a practice with specific responsibility for dementia care for clinic patients. Another model is to use care managers to aid with the coordination of care. More extensive models involve outreach programs that support primary care in the home. Ontario has developed specific training and support for primary care clinics with a primary care specialist within the practice running a memory clinic.

In general, these approaches lead to improved quality and to reduced behavioral symptoms and caregiver distress. There is not yet clear indication of decreases in cost for care with these approaches; thus, sustainability is a major challenge (Callahan et al. 2006; *The Lancet Neurology* 2013).

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Dementia-related psychiatric symptoms often lead to crisis situations in which patients are left sitting in emergency departments because of a lack of safe discharge options. Family caregivers or nursing home staff may no longer be able to provide care to a paranoid, aggressive, or wandering person. There is a severe shortage of psychiatric beds and psychiatric units may consider these patients medical and beyond their expertise or abilities. Hospital medical units consider them psychiatric and unless an acute medical problem is identified (e.g., pneumonia, stroke, or urinary tract infection), Medicare reimbursement for the admission will be denied. Beyond that, acute medical inpatient services are not safe places for people with dementia who may be ambulatory, disoriented, and intermittently aggressive. Therapeutic crisis respite beds are urgently needed for such situations, where people with dementia can be safely supervised and treated until they are safe to either

return home or go to an appropriate memory care facility. Successful efforts to shorten or delete the “3 overnight” requirement for discharge to a skilled facility, and recognition of crisis dementia care as a skilled care need would improve care and possibly reduce costs.

Many critical aspects of dementia care, including direct patient assessment in the home setting and caregiver support and education, can be performed via telemedicine. Transporting a person with dementia to a clinic appointment, often to a specialist in a distant town, can be challenging and expensive. The vagaries of Maine's winter weather adds a burden on family caregivers who are already barely coping. Videoconferencing and office visits via telemedicine provide effective, safe, and cost-effective (especially for the patient) alternatives, yet are not reimbursed by Medicare in two Maine counties considered urban by the Centers of Medicare and Medicaid (Cumberland and Penobscot). Transportation, even within a town, can be trying for our patients, and we look forward to the day when this regulatory policy is changed.

Health care institutions are already finding it difficult to fill vacancies from retiring nurses, physicians, and other health care workers with special skills and decades of knowledge and experience.

Geriatric Care Workforce

According to the Administration on Aging, the U.S. population aged 65 and over will exceed 70 million by 2030, twice as many as in 2000. In 2030, one in four Mainers will be over 65. Maine's population of the *oldest old* (i.e., >85) grew by 58 percent during the 10-year period of 1999 to 2009. This strong trend is continuing, placing special burdens on our systems of care. When older Mainers become patients, as they routinely do, they deserve the best care from a health care workforce that is well trained in geriatric medicine. Maine's seniors with complex, age-related diseases and functional limitations may be challenged to find medical providers and institutions with the type of specialized knowledge, skills, and facilities that meet

current standards for state-of-the-art geriatric medicine. Without recruiting from out of state and out of country, we will be hard-pressed to meet the need. Health care institutions are already finding it difficult to fill vacancies from retiring nurses, physicians, and other health care workers with special skills and decades of knowledge and experience. Workforce policy experts estimate the United States will need 13,522,000 health care providers by 2030, versus the 9,994,000 workers we had in 2005 (Mather 2007). This is occurring at a time when many providers have been reaching retirement age and many Americans have been reaching an age at which they need more medical and nursing care.

According to data in the IOM report, less than 1 percent of registered nurses, 4 percent of social workers, and 1 percent of physician assistants identify as specialists in the care of older adults (IOM 2008). There is a particularly acute shortage of primary care geriatricians (internal medicine or family medicine physicians with extra training in geriatric medicine). By 2030, it is estimated that there will only be 7,750 primary care geriatricians, far short of the estimated need of 36,000 (IOM 2008).

Geriatric psychiatry faces a more dire shortage. There are only about 1,600 psychiatrists certified in geriatrics in the United States, one for every 11,372 older Americans. The shortfall will only be made up if we improve the training of generalists in geriatric medicine, including not just general internists and family medicine specialists, but general psychiatrists, family nurse practitioners, psychiatric mental health nurse practitioners, and primary care physician assistants.

The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services recently awarded \$35.7 million dollars to 44 organizations in 29 states to support geriatric education for health care providers (up to \$850K per awardee). The University of New England and the University of Maine each led efforts to submit ambitious grant proposals. Unfortunately, neither proposal was funded this round.

Maine is competing with many other states to recruit needed health care professionals. Neither the outstanding quality of life in Maine, nor its natural beauty, has historically been enough to win recruitment competitions. Our best success in meeting our needs for an expanded geriatric-capable health care workforce will come through establishing excellent training programs, providing competitive salaries and incentives for repaying student loans, and above all, supporting all

health care workers to do work they can take pride in. High morale is the best recruiting tool of all.

INITIATIVES IN MAINE TO IMPROVE CARE

To paraphrase our opening sentence, these are exciting times in geriatric health care. Many promising initiatives are underway at both the national and local levels to address some of the issues that we've covered in the previous sections.

Maine's State Plan for Aging

In 2012, Maine's Department of Health and Human Services' (MDHHS) Office of Aging and Disability Services (OADS), in accordance with the federal Older Americans Act of 1965, published a plan outlining goals, objectives, strategies, and performance measures to guide state-coordinated activities for the well-being of Maine's seniors. The plan was meant as a guide for the development and coordination of statewide projects for health, housing, social, and nutritional services, as developed by each of the five regional Area Agencies on Aging in Maine. The plan will be revised in 2016 and will continue to serve as a road map for improving the well-being and independence of Maine's seniors.

State Plan for Alzheimer's Disease and Related Dementias in Maine

In 2012, another collaborative effort, this time the state chapter of the Alzheimer's Association and MDHHS, issued a road map to improve the diagnosis and treatment of people with dementia and their families. A HRSA-funded grant to MDHHS in 2013 is helping efforts to meet some of the goals laid out in the state plan to improve the diagnosis and community care of persons with cognitive impairment and dementia in Maine.

Maine Council on Aging

In 2011, a coalition of organizations providing a wide range of services to older adults formed the Maine Council on Aging (MCOA) to advocate for improved social services and health care for Maine's seniors. MCOA promotes an ambitious legislative agenda that seeks to improve community-based care and support direct caregivers. MCOA has organized a workgroup that focuses on issues of health and wellbeing and advocates for state and national policies to support evidence-based health care reform. The Health and Wellness

Workgroup has proposed seven initiatives for priority action and 16 long-term goals to address policy issues, improve integrated geriatric primary care, and direct workforce education. (MCOA 2015).

State Innovation Model

The State Innovation Model (SIM) grant (\$33 million) provides resources to primary care practices for the integration of physical and behavioral health care through the development of integrated teams.² The SIM grant acknowledges the critical importance of mental health in the overall health of communities and the need to integrate what have been two systems of care. The *behavioral health home* and the integration of mental health professionals in the primary care office are two results. Another important part of the project is the training of health care providers in diabetes prevention, care of persons with developmental disabilities, and improving long-term care and transitions of care between levels of service.

Maine Health Access Foundation

The Maine Health Access Foundation (MeHAF) is a private, nonprofit foundation that promotes access to health care for the underserved and improvements in quality of care for everyone by supporting innovative projects. They have supported several major projects through grant programs: Thriving in Place (brings health care providers and community service providers together to keep people with complex physical and behavioral health care needs at home rather than in institutions), integrated care (behavioral health homes, integrating physical and mental health care), promoting projects in payment reform for improving quality of outcomes, and health information technology (Maine's HealthInfoNet system) to improve coordination of care among providers. (See Boober [2015] and Bradney [2015], this issue, for discussion of Thriving in Place.)

Maine Quality Counts

Maine Quality Counts (MQC) is a private, nonprofit agency managing large grants and contracts that aim to transform health and health care in Maine by facilitating collaborative projects that meet pressing needs. By working with all players in health care, MQC is engaged in many of the major efforts in Maine to improve chronic care through innovative, interdisciplinary, comprehensive care models.

Federal Health Care Reform

Current efforts at health care reform are ultimately going to be judged on whether they improved access to care, improved quality, and lowered costs. An accountable care organization (ACO) accepts responsibility for providing care to a community or population for a fixed cost, sharing risk with the payer, in this case, either Medicare or MaineCare. The Affordable Care Act (ACA) has cut Medicare reimbursement of hospitals to help pay for Medicaid expansion, which Maine has not done. The financial squeeze affects our hospitals' abilities to provide for the growing needs of seniors with acute medical, surgical, and psychiatric needs. On the flip side, the ACA has provided competitive grants for creative pilot programs to test new models of care, some of which are being piloted in Maine:

1. **Patient-centered Medical Home (PCMH)**—A team of health professionals, consisting of primary care providers, case managers, and mental health providers, working together to meet patient-focused outcomes of improved health.
2. **Population-based Care**—Communities of people defined in advance who undergo screening and health assessments to prevent and treat chronic health conditions. Treatment and tracking of outcomes is performed by the care teams using measurable outcomes and evidence-based algorithms of care.
3. **Accountable Care Organizations**—Developed as a way to improve the coordination of care between hospitals, primary care, and community services; health care systems relying on population-based care to reduce costs and improve quality, sharing risks of expenses with payer (Medicare).
4. **Community Care Transitions Program**—Provides resources for community agencies to coordinate transitions of care (home to hospital, hospital to nursing home, nursing home to home) to reduce errors and help maintain continuity of care.
5. **Bundled Payment for Care Improvement Model 2**—Links payment for multiple services during an episode of illness with certain key performance measures for quality.
6. **Medicare Care Choices Model**—Provides for the integration of palliative care services and primary care practices.

There were federal programs to model and provide interdisciplinary, comprehensive, proactive care for frail elders with complex physical, mental, and social needs before the ACA. Program for All-Inclusive Care for the Elderly (PACE) programs provide comprehensive medical and social care to frail older adults, most of whom are dually eligible for Medicaid (MaineCare) and Medicare. By combining revenue streams from Medicare and Medicaid with a high level of flexibility, PACE programs are able to support people at home for longer periods of time. Maine's effort to develop a PACE program is currently on hold. We need to overcome challenges in developing PACE programs in rural areas and small cities, but we are hopeful PACE programs will be part of our mix of services in the future.

SUMMARY

This article has described a few of the most challenging issues we confront on a daily basis as we care for older patients. Some of these problems call for action on a federal level. Some are actually the results of well-intentioned reform efforts, whereas others may be addressed by on-going initiatives. Policy initiatives at the national level to reform health care have led to many promising efforts at the state level, and we are fortunate to have many people engaged in creative efforts to improve proactive, preventive, and comprehensive care. We strongly endorse these efforts and the policy priorities put forward by MCOA in the "Health and Wellbeing" section of their annual report (2015). There are many competing priorities in health care for seniors, but we close by creating our own "wish list" of both federal and state-level policy reforms:

Federal

- Policies should reward persistence in overcoming the challenges of implementing proactive elder-care. Culture change takes time.
- Policies are needed that encourage health care systems to implement a flexible array of services that are not just hospital or home-based.
- Reimbursement models are needed to provide maximum flexibility in both the care setting

and professional discipline of care delivery. Interdisciplinary care can be cost effective with better outcomes.

- Therapeutic crisis respite beds are urgently needed where people with dementia can be safely supervised and treated until they are safe to either return home or go to an appropriate memory care facility.
- Shorten or delete the “3 overnight” requirement for discharge to a skilled facility, and recognize crisis dementia care as a skilled care need. This would improve care and possibly reduce costs.
- Reimburse videoconferencing and office visits via telemedicine in Cumberland and Penobscot counties.

Federal and State

- Support excellent training programs, provide competitive salaries and incentives for student loan repayment, and above all, support health care workers to do work they can take pride in.

State

- Improve access to high-quality dementia care day programs and assisted living. 

ENDNOTES

1. More information about the guidelines is available at <http://www.iom.edu/Reports/2011/Clinical-Practice-Guidelines-We-Can-Trust>
2. More information about the SIM program is available at <http://www.maine.gov/dhhs/sim/index.shtml>

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