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Interview with Dr. Patricia Curtin

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James Ellison: Dr. Curtin, I am pleased that you are going to share with us some thoughts about your work as a geriatrician who treats people with dementia. Can you start by saying a little about yourself?

Dr. Patricia Curtin: Yes, I'm Patricia Curtin, the Section Chief of Geriatric Medicine at ChristianaCare. I am the medical director of two ACE inpatient units in ChristianaCare. ACE stands for Acute Care of the Elderly. One of these is on the Wilmington campus, the other is on the Newark campus. I am also Medical Director of Stonegates Retirement Community and Health Care Center. Finally, I am a board-certified internist and geriatrician who has been in the field of medicine for about 40 years, focusing on geriatrics for the past 22 years.

JE: You've chosen to focus your efforts on the care of older adults, whom many primary care or neurology or palliative care clinicians see in their practices. What is the difference between those providers and a geriatrician?

PC: Great question. Geriatricians usually go through either a family medicine or an internal medicine residency and then acquire additional training during a geriatric fellowship which can take an additional one to three years. Sometimes the final year is devoted to research. I did an internal medicine residency, including a chief resident year and then worked for seven years with the internal medicine faculty at the Medical Center of Delaware, now ChristianaCare. Our medical and nursing leadership saw the increasing numbers of older patients in our health system and felt the need to increase our expertise in the care of the older adult and their special needs. I went back to do a fellowship in geriatrics, which was the best decision I ever made.

JE: Why do you consider it such a good decision?

PC: Well, the way I did it, with seven years of general internal medicine experience, I was then able to focus on what is unique to older patients. I had wonderful mentors at Jefferson, where I attended medical school and my fellowship, and they taught me about the geriatric syndromes and the disorders that affect older adults, like dementia, delirium, falls, pressure ulcers, frailty, and medication issues such as polypharmacy.

JE: How did the fellowship training help you to focus on these conditions?

PC: I think I became more confident in my skills and knowledge in this area. To this day, I remember how I admired the geriatricians from whom I was learning. Even though we were practically the same age, many of them had more experience with older patients and they taught me to be more confident in adding or discontinuing medications and in looking at the patient through the lens of a geriatrician. We know much more about the 40- to 60-year-old patients because they have been studied more (especially in terms of medications, for example) – but the 85-year-old patient requires a different type of clinical judgment and decision-making. Whether it is about falls or frailty, confusion, or medications, we need to consider the effects of age when evaluating treatment goals and plans. Fellowship helped me learn quickly to be able to focus on how age affected the patients' conditions and their care. In the past 22 years, I have continued

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my learning, of course, by reading the literature, attending conferences, being part of geriatric focused organizations, and working with other geriatricians, other colleagues and nursing. I am still learning every day; I'm humbled by what I've learned about how older adults are, and they are very different from younger patients. I also learn a lot from our older patients!

JE: You've mentioned some of the diseases that are different in the older population. What about different vulnerabilities? Are there particular areas where the treatment must be tailored to the vulnerabilities of older adults?

PC: Yes, our older adults are more prone to potential complications such as side effects from medications or treatments, or even from tests. Even a CAT scan with contrast can be damaging to some older patients with renal compromise, where perhaps a 45-year-old might be unharmed. With respect to medications, for example for diabetes or arthritis, the medication options for those diagnoses in a younger patient might be potentially harmful for an older adult. We assess risks and benefits in a different way with older patients. Even though we try to base our treatment decisions on evidence, there are not as many studies for older adults. Even though some older adults may not look their age, their kidneys, livers, brains and hearts are the organs of an older person. We must really keep that in mind. There are changes as we age, and we must take that into account.

JE: Your perspective and the care you take with the treatment of older adults has made you a leader in Delaware. Can you say something about the ACE units that take care of our older adults at ChristianaCare's Wilmington and Christiana hospitals and how they protect the special needs of the older adults?

PC: Back in 2001, we started out with a more global approach to improving the care of the older patients in our health system. We called it the WISH program (We Improve Senior Health), which still exists today. Partnering with our nursing colleagues and experts, we trained health caregivers in all disciplines to care better for older adults throughout our hospitals, through an evidence-based educational program that was based on the NICHE program (Nurses Improving Care for Health System Elders) out of NYU and the John Hartford Foundation. For the first few years, our approach was to develop Senior Health Resource Team members, health caregivers with increased awareness and knowledge of geriatric care needs, on various patient care units. However, after a few years, we wanted to show that we could make an even greater impact if we had all staff trained in geriatrics on one unit. We opened our first ACE unit in 2004 at Christiana Hospital, a 39-bed unit, using the concept and the name (ACE) that had been developed by the Cleveland Clinic where the first ACE unit opened in 1989. We showed improved outcomes, not only defined by length of stay, but also reduced readmissions, fewer falls, fewer complications, less polypharmacy, and reduced costs. Due to this initial success, in 2007 we opened the second ACE unit at Wilmington Hospital. I have been the Medical Director at Christiana since 2004, and in 2014, I also became the medical director at Wilmington Hospital's ACE unit. Between these two units, we take care of about 4000 patients a year, with the average age of the patients being 82 years old. It's wonderful! But we have thousands of older adults throughout our health system, so we continue to train our providers in the WISH program too. We continue to show these improved outcomes, including significant cost savings and improved patient flow.

JE: You're spreading the geriatrician's perspective to non-geriatric units as well.

PC: Yes, that's important to us. We still have work to do, because we're learning all the time about how we can do things better. We have found that if you have a lot of caregivers trained in

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geriatrics on a unit as Senior Health Resource team members, the care is more coordinated, and really has the focus on the older adults' needs, even when they're mixed in with younger patients. Because of this work, we have been recognized as a NICHE Exemplar program for many years,

A more recent innovation came recently from the IHI (Institute for Healthcare Improvement). We were one of the first 100 hospitals to join this initiative, the Age Friendly Health System (AFHS) program. In this initiative, the focus is on the "Four M's": What Matters Most to the patient - that's key - Mobility, Mentation, and Medications. If we focus on those M's to identify what is important to the patient, it organizes our approach to their care, no matter where they are in our health system, inpatient, or outpatient. The Age Friendly project has provided a new framework and a renewed approach to taking care of older adults. We have also attained Exemplar status in that program.

JE: Can you say something about the geriatrician's role in treating dementia in Delaware?

PC: Sure. Geriatricians treat many patients with dementia. We also have been dedicated to improving the care of patients with dementia in Delaware in various ways. We are often asked to share our expertise with groups or task forces such as the State Plan for Alzheimer's Disease. I was part of that Steering Committee as well as the Implementation committee. I was honored and thrilled to be part of those groups, where we worked with the Alzheimer's Association and the State, as I represented ChristianaCare. At that time, President Obama had mandated that each state develop a plan and we were able to go beyond our walls at ChristianaCare and really work with our state and community partners. I know the State Plan is discussed in detail in one of the other articles in this issue of the DJPH. We're still seeing the benefits of the State Plan, for example, in the excellent website dedicated to dementia care, and in the growth of the Swank Center for Memory Care and Geriatric Consultation, which was developed at ChristianaCare to provide the state with an important resource for families and patients with dementia.

JE: How valuable! Now, I've heard you say, several times, that we can never have all the geriatricians that we need in Delaware. But geriatricians do bring a special value to a healthcare system. And I wonder what opportunities you've seen for Delaware's geriatricians to influence care in additional ways that we haven't yet discussed. Do you have any other comments about it?

PC: Yes, with the increasing aging population, there will never be enough geriatricians, in America and around the world, so we must do the best we can. I've mentioned the WISH clinical education program, the ACE units, and the Age Friendly Health System 4Ms initiative. All of those can provide training and experience to providers who haven't gone through a geriatric medicine fellowship and then they become multipliers of expertise or geriatric ambassadors to help us care for older patients. In addition, we teach geriatrics to residents and students. Most residency programs require some formal geriatric training, especially in Internal Medicine and Family Medicine. It's still important to have a core group of geriatric experts, so we're fortunate to have several geriatricians at ChristianaCare. Each does something a little bit different, and that has really helped us expand our reach to the outpatient world, to the retirement communities and nursing homes, to memory care units, to a memory center and geriatric consultation, fall prevention programs, to the primary care practices, and then also on the inpatient side. We're not everywhere, but there are eight or nine of us and we occupy important positions. Also, we work well with each other and we tap each other for expert consultation and collaboration. We also work with our other specialists, internists, family medicine doctors, and other colleagues – and they can reach us for consultation and advice. Even though we may not be able to see every

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patient ourselves, we can help our colleagues keep geriatric care principles in mind as they manage their older patients. We have also played a key role with the creation of care management guidelines and order sets with a focus on best practice for patients. For example, we have guidelines and orders sets for ~~a~~ fall prevention, delirium, skin integrity, and constipation. That way, we are arming the providers with tools to improve their care of older adults.

JE: Thank you for all that you've done to improve the care of older adults and for spreading the perspective of geriatric medicine throughout our provider community to enhance the care of older adults in general. And thank you for sharing your perspective with us today.