UC San Diego

UC San Diego Previously Published Works

Title

2016 American Association for Geriatric Psychiatry Annual Meeting Presidential Plenary Address Improving the Mental Health Care of Older Americans Four Essential Ingredients: Technology, Advocacy, Education and You (The Members of the AAGP).

Permalink

<https://escholarship.org/uc/item/1gw559f7>

Journal

The American journal of geriatric psychiatry : official journal of the American Association for Geriatric Psychiatry, 24(7)

ISSN

1064-7481

Author

Sewell, Daniel D

Publication Date

2016-07-01

DOI

10.1016/j.jagp.2016.04.011

Peer reviewed

2016 American Association for Geriatric Psychiatry Annual Meeting

Presidential Plenary Address

Improving the Mental Health Care of Older Americans

Four Essential Ingredients:

Technology, Advocacy, Education and

You (The Members of the AAGP)

Daniel D. Sewell, M.D.

Corresponding Author:
Daniel D. Sewell, M.D.
University of California, San Diego
200 West Arbor Drive
San Diego, CA 92103-8631
Phone: 619-543-3779
Fax: 619-543-7337
Email: dsewell@ucsd.edu

Introduction Including the Two Main Goals of My Remarks

Our tradition as an organization has been for our opening plenary to conclude with some remarks by the incoming president. As I begin my remarks, I want to say first of all what a tremendous honor it is for me to have been given the opportunity to serve as your president for the next 12 months.

I joined the AAGP when I was a geropsychiatry fellow at UC San Diego back in 1990. Since that time, I've had the privilege of listening to many gifted and talented AAGP presidents deliver their plenary addresses. This evening I feel like I've been given both the challenge and the opportunity to walk in the footsteps of giants. To be completely honest, my first goal is not to let this intimidate me.

I've spent the past several months thinking about what I wanted to say to each of you this evening. Ultimately, the content of my talk was informed by my recognition and appreciation of the most important thing I know, unequivocally, we all share in common: improving the mental health care of older adults. Next, I spent some time thinking about what I believe are some of the most essential ingredients that will help us achieve this shared objective. I concluded that there are at least four essential ingredients: technology, advocacy, education, and each of you in this room.

My second goal is to explain my rationale for how I determined that each of these factors was essential, while also inspiring and energizing you to continue the journey we are on to improve the mental health care of older

adults. Margaret Mead is quoted as having said “Never doubt that a small group of thoughtful committed citizens can change the world. Indeed it's the only thing that ever has.”¹ To be clear I believe that, at least as it pertains to improving the mental health of older adults, we, the members of the AAGP, are this small group of thoughtful committed citizens.

Five Key Points

I have five key points tonight. First of all, I'd like to acknowledge that, although we've been using clinical applications of technology for quite some time, we are now on the crest of a new wave of technologies that hold the promise of improving the health and well-being of older individuals, especially those living with mental disorders.

Secondly, in the realm of clinical applications of technology which benefit older adults, we have the opportunity to make significant and meaningful contributions via research education and clinical recommendations. Thirdly, as members of the AAGP we are uniquely qualified to advocate for social and political changes that will benefit the older individuals to whom we have devoted our professional lives. My fourth key point is that we are also uniquely qualified to educate and mentor other healthcare providers who have not received optimal specialized training in geriatric mental health care. And finally, in order to fully realize the potentials of technology, advocacy and education we cannot allow our fears and anxieties to limit us.

Anton Rubaclini said, “If you want to catch your dreams you have to drop your fears.”² Some of you know that I have a couple of fears or

phobias. I have a fear of heights, or more precisely, a fear of falling from high places. I also have a good deal of anxiety about technology. The good news is that, thanks to friends, colleagues and family members like my husband, Jim, I'm learning to conquer both. A number of years ago when the AAGP met in Orlando, Jim and I took some extra time to vacation in the Florida Keys. Somehow, I let him talk me into parasailing. This is a photo of Jim and me parasailing off the coast of Key West. Given that you now know I have a fear of falling from high places, please note the irony of the smiling face looking down on us from the inner surface of our parachute. Obviously, I survived this experience. So, I'm conquering my fear of heights and I'm conquering my anxieties about technology and I'm determined not to let my discomfort with technology limit my ability to provide the best care possible to the older patients for whom I care.

Technology

Although I was unable to identify the original source, the following quote has been attributed to Bill Gates: "Never before in history has innovation offered the promise of so much to so many in so short a time."³ There are all sorts of fascinating and wonderful emerging uses of technology. Among these emerging uses of technology are even more amazing ways that we can use technology to communicate among healthcare professionals and the general public through platforms like Twitter. The AAGP's commitment to adopting these new powerful communication technologies is reflected in a number of ways like the recent additions and upgrades to our website which

acknowledge things like Twitter and Facebook and the sessions at our annual meetings with technology themes. As you've heard, this year there are six sessions at our annual meeting with technology themes. In addition, as you've heard, our colleague, Ipsit Vahia, was recently appointed as social media editor of the American Journal of Geriatric Psychiatry (AJGP). This evening, I'm also going to touch on uses of technology that involve clinical assessment, clinical interventions and socioenvironmental enhancements that will benefit the lives of the older people for whom we care.

Uses of Technology to Enhance Clinical Assessment

Although there are a wealth of assessment technologies emerging, tonight I'm going to focus on just one, a less invasive method of home blood glucose monitoring. Currently, as you know, to test blood glucose at home there's no way to avoid a needle, even with the newer continuous glucose monitors. Having a non-invasive device that could lead to less discomfort and could also lead to improved adherence and greater convenience for older patients. Especially for those living with dementia, being able to assess blood sugar levels without a needle stick would be a very desirable innovation. Problem behaviors triggered by needle sticks would be much less common and the ability to correlate blood sugar variations with behavioral changes would be so much easier.

I have a colleague at UC San Diego, Ed Chao, who has begun a study of the effectiveness of a noninvasive glucose sensor in patients with diabetes. This study has been named "The Sensor Study," and here's a bit about how

this sensor works. All of the sensor components are printed on temporary tattoo paper. The sensors are self-adhesive and disposable. By applying a mild electrical current to the epidermis, sodium ions and, in turn, interstitial fluid glucose molecules migrate toward an electrode. An electrochemical sensor that is part of the tattoo detects the electrical charge strength of glucose to measure the glucose level. Here's an image (available upon request) of that tattoo non-invasive glucose monitor. I just think that this is an amazing development on the horizon and I'm really excited to see that research is being done to confirm its effectiveness.

Technology to Improve Clinical Interventions

I'd like to also talk about some technology-based clinical interventions. As some of you may know, for years and years, front-wheeled walkers have required the people who use them to walk hunched over the walker. There's a company in San Diego that has developed what they call "The Life Walker," which allows people who need the assistance of a walker to walk with a walker while remaining upright. What a really remarkable and long-overdue Innovation for these people!

Back in 2010, the AJGP published an article about the use of Wii for older individuals living with subsyndromal depression.⁴ The authors of this study found that 30 minutes of playing Wii 3 times a week for 12 weeks resulted in statistically significant improvements in their subsyndromal depression symptoms. This was such a wonderful study for me to see because it really helped me understand that, even though I have my issues

with technology, there are many older people in our world who are embracing technology and have the potential to benefit from it in all sorts of remarkable ways.

Technologies which Enhance the Environment

Lastly, I want to talk about technologies which enhance the environment and, specifically, I want to tell you a little bit about *smart homes*. I think many of you may know that *smart homes* are homes equipped with lighting, heating and electronic devices that can be controlled remotely by phone or computer, allowing one to make sure that dinner is cooked, the central heating is on, the curtains are drawn and so on. Now, the concept of *smart homes* includes remote patient monitoring for things like blood pressure, glucose, and door openings. The concept also includes medical robotics and telehealth. These emerging uses of technology will allow older adults to maintain their independence and their ability to live at home safely and, in other words, these technologies will help people do what they really want to do which is *age in place*. This is an example of a smart home (image available upon request). The thing I really want to spotlight is the new edition here: the health and fitness room where you could put a tablet computer that you could use to connect with your medical team, monitoring equipment, a medical robot, maybe even a telemedicine system. There are plenty of opportunities to learn about these technologies and, as I mentioned, there are six sessions at this meeting in which technology will be addressed.

Advocacy

I'm going to switch gears here and talk a little bit about one of those other essential ingredients: advocacy. This is a quote from George Bernard Shaw: "People are always blaming their circumstances for what they are. I don't believe in circumstances. The people who get on in this world are the people who get up and look for the circumstances they want and if they can't find them, make them."⁵ It doesn't take special skills and training to become an advocate and I've learned this right in my own backyard. In San Diego, we've confronted a couple of vexing problems. One of them is that the low reimbursement rates we live with from Medi-Cal, which is California's name for Medicaid, has resulted in a nursing home per diem rate for custodial care of patients with dementia, coupled with the CMS 5-Star Quality Rating System, leaving skilled nursing facilities with really little incentive to provide residential care to patients living with dementia. Another problem that we're bumping into are the CMS regulations regarding the use of psychiatric medications in nursing homes. What's happening in our community is that these medicines are sometimes being inappropriately reduced, or just discontinued, even in patients with well documented histories of recurrent major depression, when we know that cessation of antidepressant medication really sets them up to be at high risk for a recurrent episodes of depression. Subsequently, many of these patients then have symptoms that reemerge, they suffer needlessly and often they require rapid hospital readmission.

Our social worker for the UC San Diego Senior Behavioral Health inpatient unit, Sarah Bieber, decided that she could do something about these problems. You see her pictured here. She takes a lot of ribbing in that she is no relation to Justin, but she actually kind of looks like him. Sarah decided that she should collect information about four representative cases that reflected the two problems that I previously described to you and then she coordinated a meeting of key stakeholders and experts including skilled nursing facility administrators and the UC San Diego Director of Government and Community Affairs, Aaron Byzack. We met with Aaron Byzack and we had an amazingly productive meeting during which he taught us about advocacy, in much the same way that Ilse Weichers and Paul Kirwin could teach you about advocacy at a session at this year's annual meeting. Aaron suggested that we have a second meeting and at that meeting we should come prepared with the essential ingredients for an effective advocacy effort. He said we need to get the history down. We needed to describe in clear simple language what were the events and decisions that had led us to these current problems. He wanted us to really get clear on what is happening now in terms of the current status of the problems. He taught us how important it is that, when we advocate for change, we have to have what he called "the ask." So we're now going to meet with Aaron a second time with this information and at this meeting we will be developing an advocacy plan with goals, strategies and tactics. We will also be identifying

potential partners that can help us in our advocacy efforts, as well as timetables to achieve very important specific goals.

Issues Ripe for Advocacy

There are so many issues right now that are ripe for advocacy. I want to acknowledge Ilse Weichers, again, for her efforts these past couple of weeks bringing to our attention the Mental Health Reform Act and the need for us to get in touch with elected officials involved with this legislation so that we can add to the legislation something that was, unfortunately, omitted: loan forgiveness for clinicians interested in geriatric clinical training. Interestingly, this legislation did provide monies for those committed to training in Child and Adolescent Psychiatry but, unfortunately, we were not included in this legislation. We have hope, however, that the campaign that Ilse is helping us lead will actually allow us to add that language to the bill. I also want to share that today, one of our own, Paul Kirwin, actually traveled to Capitol Hill to be a part of this effort to get language added to the bill so that those committed to training in geriatric fields like geriatric psychiatry could also benefit from loan forgiveness and other forms of financial support.

There are several other issues ripe for advocacy including the FDA's proposal to reclassify ECT devices from class 3 to class 2. This is very significant because it will really help make ECT much more accessible, especially to those older patients you sometimes don't respond well to antidepressant medications. It will also take away some of the stigma that's now still impacting individuals who have been referred to ECT treatment. I

also want to mention that there is discussion now about the need to develop competency testing for older physicians. This is a very difficult topic but I think we are the ones most qualified to help come to a reasonable decision about how to handle this challenge.

There are opportunities at the annual meeting to learn about advocacy including the AAGP public policy caucus meeting on Saturday. In addition, Ilse and Paul will be doing a session on Saturday called “Policy and Advocacy 101.” There will also be another session on Sunday regarding advocacy. This session will be focused on the upcoming election, which I know most of you have probably been paying close attention to, thanks to certain people who are getting a lot of media coverage right now as they run for office.

Education

The AAGP Scholars Program

The last area I want to speak about is education and mentoring. I have included here a quote which has been attributed to Winston Churchill but which may actually be a poetic paraphrase of a longer and well-confirmed quote of Churchill: “We make a living by what we get but we make a life by what we give.”⁶ The AAGP Scholars Program is such a remarkable program. It has been described as our “Crown Jewel.” This program would not be possible except for the generous donations to the Geriatric Mental health Foundation and, as you know, most of these donations come from our own membership. Because of the generosity of our membership, I'm sure many of you in this room included, this year the scholars fund has brought 37

talented residents and medical students from across the country to our annual meeting. In addition, I want to highlight that four of our 2015 Honors Scholars are returning this year and will be presenting the academic projects that they completed during their participation in the Scholars Program in 2015. So please make note that on Saturday from 1:30 to 3 p.m. in the Georgetown West meeting room you can listen to these individuals speak about what they did as Honors Scholars. I also want to acknowledge the two leaders of this program, Michelle Conroy and Laura Marrone, for really continuing forward this tremendous program that we all are so grateful to have. I know that there are lot of names on this slide but this slide represents our future, so I'm going to pause just for a minute so that you can take in some of these names and appreciate that they come from all over the country. This slide has the ten AAGP General Scholars. These individuals are medical students.

The San Diego County Alzheimer's Project

There are a couple of other education efforts that I want to spotlight. I want to tell you a little bit about something really special that's happening in San Diego County. It's really quite a remarkable situation that we are experiencing. Thanks to the leadership of our San Diego County Board of Supervisors, and with support from the San Diego County Medical Society, we have launched something called the San Diego County Alzheimer's Project. What's remarkable about this effort is that somehow representatives of these very competitive health systems have come

together, along with other organizations like Alzheimer's San Diego, and also caregivers, to work on solutions to help our county address the growing needs of individuals and patients impacted by Alzheimer's and other forms of dementia. It has been so heartwarming to be in a conference room with these other folks who, historically, we would have friction with and we would compete with, and yet we are working together on this common cause in a very remarkable way. We are aware that in San Diego County alone there are currently 60,000 individuals being impacted by some form of dementia and this number is expected to rise to 94,000 by the year 2030. So thanks to Dianne Jacob and Ron Roberts, in 2014 the Alzheimer's Project was launched and it was organized into three different sections: one focused on cure, one focused on care and one focused on clinical issues.

The participants in this effort represent neurologist, psychiatrist, geriatricians and also members of various caregiver communities and provider organizations. We are really outnumbered. We've studied the ratio of primary care providers in our county versus specialists and we're outnumbered about 3 to 1. I think these ratios are pretty much replicated across the country. It's very clear that specialists will not really be the ones most likely to care for people and family members impacted by Alzheimer's. When we asked our primary care colleagues if they're engaged in caring for people with dementia, 77% of the family practice and internal medicine clinicians who responded to our survey said yes we do care for people impacted by dementia and their families. Our survey also revealed that

they're really not very well prepared to do this. Perhaps the most important information on this slide (table included on this slide available upon request) is that among family practice and internal medicine doctors in San Diego County, 80% of them said that they were not at all aware of available resources or only aware of a few resources.

So we've been busy over the past two years identifying best practices for screening evaluations and disease management of Alzheimer's disease and related dementias. We've come up with recommendations on standards of practice. We have developed tools for use by primary care practitioners. We have organized and launched pilot studies in various health systems and we're developing teaching tools for dissemination of information to clinicians, particular the primary care providers throughout our county. I'm proud to say that our efforts led us to the "DICE" approach for the assessment and treatment of patients impacted by behavioral and psychological signs and symptoms of dementia.⁷ I think many of you realize that this model was developed by members of our own organization, including Helen Kales and Constantine Lyketsos. The "DICE" model is the model that we are now going to be presenting to our primary care colleagues. I also want to spotlight that this effort has included a number of AAGP members. Our colleague, Steve Koh, a graduate of the fellowship program in geriatric psychiatry at UC San Diego, has been chairing the subcommittee on providing education and I have been serving as the chair of the disease management subcommittee.

Other Noteworthy Educational Efforts

There are a number of other important educational efforts under way to educate people who need to learn more about how to provide high quality, effective geriatric mental health care. Some of you may be aware that yesterday in the evening we had a three-hour meeting jointly sponsored by the Hartford Foundation, the American Federation for Aging Research and the AAGP. The focus of our meeting was to begin the process of developing a mini fellowship program that we will be able to bring to communities and providers wherever it is needed so that we can get these people up to speed and help them learn what we know so well, but they have not yet had a chance to learn.

There's also an effort underway in which we have partnered with the APA. Without getting into too many of the details here, CMS has created an initiative called Transforming Clinical Practice and the APA has been identified as a Support and Alignment Network. Specially, the APA has agreed to train 3500 psychiatrist throughout the country on the collaborative care model. Now we know about collaborative care. That's what we do for a living. We practice on a daily basis interprofessional care. So the APA wisely turned to us and said "we need someone from the AAGP to help us." I'm so proud to say that Joel Streim has volunteered to represent us in this effort and I want to thank Joel for this.

Many of you are also aware of the Geriatric Workforce Enhancement Program (GWEP). This program has been modified recently, but the good news is that the funding stream continues. In July of 2015, through the

GWEP pathway, 35 million dollars were awarded to 44 different organizations in 29 states to support quality health care for older Americans. Many of us are involved in this effort and, if you're not, then explore whether there is a GWEP program in your area and, if there is, volunteer to help. There will be a session at our annual meeting about the Geriatric Workforce Enhancement Program led by Sandra Swantek, Lisa Boyle, Elizabeth Santos and Joel Streim. If you're curious to learn more about GWEP, and to figure out whether there is a GWEP awardee in your neck of the woods, please consider attending this session.

In sum, although we've been using clinical applications of technology for quite some time, we are now on the crest of a new wave of technologies that I believe hold the promise of improving the health and well-being of older individuals, especially those impacted by mental disorders. In the realm of clinical applications of technology which would benefit older adults, we have the opportunity to make significant and meaningful contributions via research, education and clinical recommendations. We are also uniquely qualified to advocate for social and political changes that will benefit the older individuals to whom we have devoted our professional lives. We also are uniquely qualified to educate and mentor health care providers who have not yet received optimal specialized training in geriatric mental health. In order to fully realize the potentials of technology, advocacy and education, we cannot allow fears and anxieties to limit us. In essence, our calling, our

challenge, our charge is to, as Gandhi has been widely, albeit, somewhat inaccurately paraphrased: “Be the change you wish to see in the world.”⁸

Acknowledgments

I'd like to end with some acknowledgements. Abraham Lincoln is believed to have said “I'm a success today because I had a friend who believed in me, but I didn't have the heart to let him down.”⁹ I feel so lucky that I've not had just one friend but I've had a loving family, many friends and many colleagues who have believed in me and, because of this, I have never had the heart to let them down. I want to acknowledge my team back in San Diego. This is a photograph of some of the folks I work with in our Senior Behavioral Health Program at our holiday party back in December. You may see some familiar faces. I want to acknowledge the UC San Diego Division of Geriatric Psychiatry. I consider these individuals my professional family and some of you may know that I consider Dilip and Sonali Jeste my professional parents. I want to acknowledge my AAGP family. I also want to acknowledge my personal family, my partner Jim, and his sisters Donna and Janet, who are with me for the meeting this year. Thank you so much. And most of all, I want to acknowledge my husband, Jim, shown here with our puppy dog, Katie, back in 2015 in Carlsbad, CA. Thank you so much. Thank you.

References

1. According to the Institute for Intercultural Studies website (intercultural studies.org): “Although the Institute has received many inquiries about this famous admonition by Margaret Mead, we have been unable to locate when and where it was first cited, becoming a motto for many organizations and movements. We believe it probably came into circulation through a newspaper report of something said spontaneously and informally. We know, however, that it was firmly rooted in her professional work and that it reflected a conviction that she expressed often, in different contexts and phrasings. Mead’s fullest exploration of cultural transmission and of the place of small groups in cultural change and innovation was in *Continuities in Cultural Evolution*, first published in 1964.”
2. [www.best**quotes**4ever.com/authors/**anton-rubaclini-quotes**](http://www.bestquotes4ever.com/authors/anton-rubaclini-quotes)
3. http://www.huffingtonpost.com/fomin/whos-disrupting-whom-an-o_b_9310438.html
4. Rosenberg D, Depp CA, Vahia IV, et al.: Exergames for subsyndromal depression in older adults: a pilot study of a novel intervention. *Am J of Geriatr Psych* 2010;18:221-226
5. Shaw GB: *Misalliance, the Dark Lady of the Sonnets, and Fanny's First Play. With a Treatise on Parents and Children*. London: Constable and Co, 1914

6. According to The Churchill Centre and Museum at the War Rooms

London, here is what Churchill actually said in Scotland, 1908: "What is the use of living, if it be not to strive for noble causes and to make this muddled world a better place for those who will live in it after we are gone? How else can we put ourselves in harmonious relation with the great verities and consolations of the infinite and the eternal? And I avow my faith that we are marching towards better days. Humanity will not be cast down. We are going on swinging bravely forward along the grand high road and already behind the distant mountains is the promise of the sun."

7. Kales HC, Gitlin LN, Lyketsos CG and the Detroit Expert Panel on

Assessment and Management of the Neuropsychiatric Symptoms of Dementia: Management of Neuropsychiatric Symptoms of Dementia in Clinical Settings: Recommendations from a multidisciplinary panel. J Am Geriatric Soc 2014; 62:762-769

8. Morton B. Falser Words Were Never Spoken. The Opinion Pages. The

New York Times; August 29, 2011. "Gandhi's words have been tweaked a little too in recent years . . . Sure enough, it turns out there is no reliable documentary evidence for the quotation. The closest verifiable remark we have from Gandhi is this: "If we could change ourselves, the tendencies in the world would also change. As a man changes his own nature, so does the attitude of the world change towards him. ... We need not wait to see what others do."

9. http://thinkexist.com/quotes/abraham_lincoln/