Curing Medicare Synopsis and Outline:

Through stories and data, I describe why I believe the care of our elderly has taken a wrong turn and how Medicare is instigating the very problems it seeks to rectify. Aggressive care has become gospel across the geriatric landscape, as technology and medicines are seen as weapons to cure aging itself, and as the hospital is viewed as a bastion that can magically ameliorate even the most devastating of problems in the elderly. Unfortunately, as those of us who practice medicine well know, and as the data demonstrates, often the least aggressive care given to the very old leads to the most humane and effective results. But, significantly due to Medicare's payment structure and rules, the elderly in our country are given little option but to pursue care that they often do not want. Medicare finances and encourages hospitalization, but pays virtually nothing for palliative and home care. Medicare finances and encourages a specialized and high-tech assault on disease, while its neglect of primary care has left few doctors willing and able to best care for the elderly. In long term care, where the frailest elderly live, Medicare and the regulatory environment push aggression to its zenith, leading to a deluge of testing and hospitalization that has never been shown to improve outcome. All of this is expensive, and much of it is harmful. But even as the ACA and Medicare seek to improve the toxic environment, many doctors and patients believe that geriatric health care is only becoming more burdensome and ineffective under the watch of Medicare's reformers .

My book is unlike others that are on the market. In my study I examine our nation's geriatric health care crisis through the lens of a practicing primary care physician. Few policy makers ask those of us who live and work in the shadow of Medicare what is wrong with geriatric health care delivery and how we think it can be repaired, and yet we have a unique and vital perspective. Using personal experiences and ample evidence, with over 400 references cited, I unearth a culture of hospital-based aggressive care and specialization that has become the modus operandi of Medicare, especially among our oldest citizens and in the very troublesome world of long term care. I explore approaches now being employed by Medicare reformers to fix the system, demonstrating why they do not address the deep rooted problems now plaguing geriatric health care delivery. In the end, I offer straightforward and simple solutions to assure Medicare's solvency through cost-effective, sensible plans that do not restrict patient choice or impact the doctor-patient relationship, leave intact the current fee-for-service model, are simple to institute, and yet strike at the central flaw that underlies Medicare's payment structure and rules. By understanding the reasons that Medicare has pushed geriatric health care in the wrong direction and confronting them directly, we can create a sustainable insurance plan that promotes palliative home-based care for those who want it, and can care for our elderly in the best way possible for many decades to come.

Introduction: My Boss

The introduction uses several stories and data to illustrate the central theme of the book: that elderly people who purse palliative care have a superior quality of life and even extended length of life compared to those who pursue aggressive care, but that Medicare encourages the latter and eschews the former. In this chapter we talk about the history of Medicare and how its initial structure and purpose is not functional in today's world as the population ages, the physician pool becomes more specialized, and medical technology has exploded.

Chapter One: Defining Quality, the Quest for Numerical Perfection

Chapter one elucidates how the prolific use of relative risk/benefit language in relaying medical information is a very confusing and deceptive method of understanding the impact of medicines, tests, and procedures on outcome, especially among the elderly. We then discuss how clinical guidelines called quality indicators, now being used by Medicare reformers to grade doctors and potentially determine physician salary, rely on measuring and fixing numbers as a marker of quality care, although such measurements are a very poor predictor of patient outcome. We explore several medical conditions in which numbers are measured—hypertension, diabetes, high cholesterol, osteoporosis, and others—to see if fixing those numbers conveys health benefit to the elderly. We talk about the use of medication in treating nuisance problems of the elderly, such as in memory loss and incontinence, and determine if this is an effective means of treatment, and how the culture of Medicare, and its quality indicators, encourage their use.

Chapter Two: Defining Thorough, Finding and Fixing Everything

Chapter two explores the popular perception of what constitutes "thorough care," discussing often fallacious assumptions that have permeated into common lore and into the ethos of Medicare itself. Looking for and aggressively treating medical problems, symptoms, and numbers as a way of improving outcome in the elderly is what now defines thorough care. We look at many specific instances of tests and treatments in the elderly and ascertain if they are beneficial. We talk about how Medicare encourages and finances aggressive testing and treatment, while it does not pay for more palliative care that is often more effective and clearly less expensive.

Chapter Three: Specialization, Expectation, and Litigation

Chapter three shows how our society has become more specialized, and how specialized care carves up elderly people into numbers, diseases, and conditions instead of treating them holistically. We talk about the impact of specialization on the health of the elderly and the cost

of such care. We discuss the dearth of primary care doctors and how Medicare's payment schedule encourages specialization and reduces the primary care pool. We then talk about how specialization raises expectations regarding what medical aggression can achieve in reversing disease in the elderly. We end by talking about how malpractice fear buds from raised expectations and leads to more testing and treatment in the name of defensive medicine.

Chapter Four: Hospitals, the Pinnacle of Thorough

Chapter four discusses how the hospital is a typical destination for the elderly both because Medicare encourages hospitalization due to its payment schedule and its rules, and also because there is a prevalent belief that the hospital is the most suitable location for the sickest people. We talk about the risks and benefits of hospitalizing the elderly, focusing on the financial and human costs of the hospital. We then discuss how Medicare essentially requires hospitalization for elderly people who need more extensive care, as it provides no other feasible alternatives.

Chapter Five: Long Term Care, the Unwitting Geriatric ICU

Chapter five look at long term care facilities, such as Assisted Living and Nursing Homes, in which many of the oldest and frailest elderly live. We show that because of regulations and Medicare rules, residents of long term care are subjected to the most aggressive medical care and highest hospital rate among the elderly. We talk about the many forces that lead to that reality, the cost of such care, and the impact of that level of thorough care on the health and quality of long term care residents.

Chapter Six: Curing Medicare

Chapter six summarizes past attempts to improve Medicare, and why they did not succeed. It then delves into current attempts to reform Medicare, both through the ACA and the CMS innovation center, and discusses how they are impacting current practice and outcomes. The chapter elucidates what needs to be done before meaningful reform can be instituted, and then offers several specific ideas for reform based on my own experience and data. The chapter ends with a blueprint for reform that is both pragmatic and achievable.

Afterword: Redefining Thorough

Relaying various patient stories, I discuss how through care can be redefined as helping patients to accommodate to illness rather than trying to cure every symptom of aging and fixing every errant number, staying active and vibrant, and having happiness be a primary focus. We discuss the benefits of a palliative approach in the elderly, and how Medicare could focus its efforts on promoting comfort and dignity rather than often needless aggression.