Dear Participant,

Thank you for attending the inaugural roundtable meeting of SOS Rx on July 30th. The meeting was an extremely positive first step toward establishing a broad partnership of consumer, patient, physician, pharmacist and caregiver organizations dedicated to making the outpatient use of medications safer. Your participation was much appreciated and we hope you will continue your involvement as we move forward.

The group indicated interest in moving forward with two initiatives:

- An education campaign to achieve consumer actions and system changes that will result in the safer use of medications.
- A consensus building process, which will identify the consumer actions and system changes that hold the most promise for increasing medication safety.

In the coming weeks, workgroups will begin adding definition to these initiatives and we plan to assemble again as an entire group on October 1st. We will be in touch soon regarding details of the next SOS Rx large group meeting.

Attached is a report from the inaugural meeting and a number of documents that will enable us to move forward effectively in a collaborative manner. The attached materials include:

- A meeting report which includes:
    - The SOS Rx purpose statement;
    - A differentiating document, which defines SOS Rx; and
    - A listing of patient safety activities in which organizations that took part in the July 30th meeting are currently engaged
- An SOS Rx sign-on form
- A list of all July 30th meeting attendees
- An editorial authored by Lucinda Main of the American Association of Colleges of Pharmacy, which details a personal experience dealing with the fragmentation in the outpatient system

Thank you again for your participation thus far, and we look forward to working closely with you in the future. Please do not hesitate to call if you have thoughts or questions.

Sincerely,

Linda Golodner
President
National Consumers League

SOS Rx
Senior Outpatient Medication Safety
Inaugural Meeting, July 30th
Meeting Report

The inaugural meeting of Senior Outpatient Safety (SOS) Rx, held July 30th, included 33 participants and observers from 22 organizations. A full list of meeting attendees is attached.

The meeting included introductory remarks from SOS Rx convening organization the National Consumers League and founding sponsor, Express Scripts; a keynote presentation by Dr. David Classen, a recognized expert on patient safety issues and trends; a roundtable conversation about current patient safety initiatives in which each organization is currently engaged (listing attached), and group discussions about initiatives on which the groups hope to collaboratively embark.

Linda Golodner, President and CEO of the National Consumers League set the stage for discussion by highlighting the apparent disconnect between the various parties involved in the medication process as far as when and how to take medications properly. With more drugs coming to market, more people taking medications – OTC, prescriptions and supplements – and seniors disproportionately at risk of or experiencing adverse drug events (ADEs) there is a greater need than ever to address the safe use of medications.

Steve Littlejohn, VP of Public Relations for Express Scripts, noted that Express Scripts' involvement in SOS Rx aims at fulfilling the latter part of their dual company mission: to make prescription drugs more affordable and their use safer. To help make medication use safer, Express Scripts is working with NCL to organize this broad-based group. He said that, because of the growing number of seniors in general, combined with the trend that senior citizens are more likely to be affected by ADEs and other drug safety issues, the initial focus of the coalition will be senior citizens. However, SOS Rx does not intend to be fundamentally limited to the senior population.

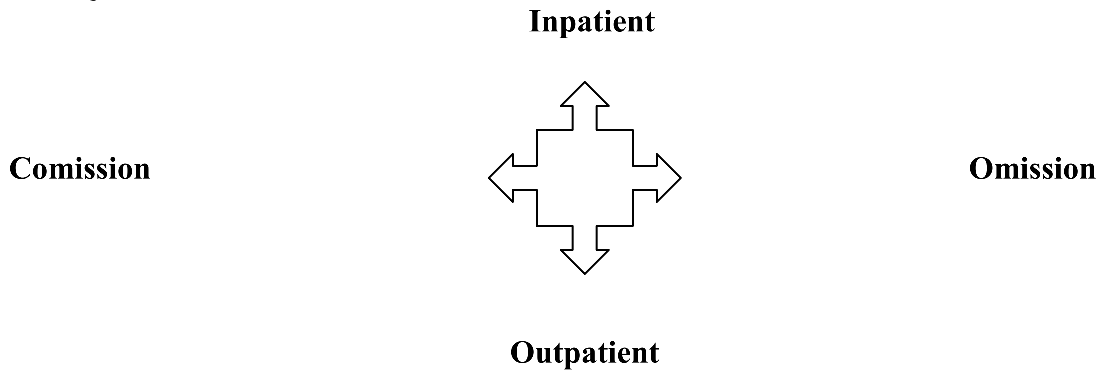
Dr. David Classen, a national authority on patient safety, provided a compelling keynote presentation, entitled "Medication Safety — What's New and What's Next", to the group.

Highlights from the presentation include:

- Media are increasingly covering medical errors and safety mistakes.
- Because of this increased exposure, people do not feel the system is safe.
- E-prescribing holds great promise to make the system safer.
- There is a need to audit where e-prescribing is implemented to ensure its proper use.
- Thus far, most of the focus of patient safety efforts has been on the inpatient setting and the commission of errors. Now, errors of omission and commission in

both inpatient and outpatient settings are gaining increased attention. He described the four-quadrant view of patient safety issues:

Four Quadrant View



In questions following Dr. Classen's presentation, he noted trends and issues in patient safety such as: e-prescribing—while it has a positive impact on patient safety for inpatient settings, only a few hospitals currently use e-prescribing for outpatient clinics. In terms of safety alerts, researchers have discovered settings where alerts have been turned off to save time. Additionally, existing systems typically are unable to share data due to the technological difficulties in combining inpatient and outpatient records.

Through the roundtable conversation about each organization's patient safety initiatives and the subsequent discussion about initiatives in which SOS Rx members might engage together, it became clear that the collaborative approach holds considerable promise. Many of the groups have addressed consumer drug safety or senior patient safety through brochures or other educational programs. They agreed, however, that collaboration offers the opportunity to leverage diverse but related interests, areas of expertise and outreach networks.

The group then discussed the mission/purpose of SOS Rx. The group agreed a precise focus is essential to make progress and achieve results. Therefore, the coalition should focus on increasing the safe use of medications in the outpatient setting (medications being defined as over-the-counter, dietary supplements and prescription products), and initially focus on the senior population as being most at risk. A campaign-style approach was strongly recommended, employing skilled and targeted use of media, advertising, the Internet and other communications channels as well as possibly a celebrity spokesperson. This campaign will be aimed at achieving consumer actions and system changes that will result in the safer use of medications. The action agenda consensus-building process will identify and prioritize consumer actions and system changes that hold the greatest potential for increased safe use of medications. As a result of this discussion, the group arrived at the attached purpose statement (Addendum 1) and differentiating paper (Addendum 2).

To further develop thinking and plans for the education campaign and action-agenda consensus building process, workgroups were formed. These workgroups will meet

between now and the next meeting on October 1st, and will report the results of their work at that meeting.

Attendees also discussed the roles of SOS Rx participating organizations. For example, review messages and materials for accuracy, collaboratively develop new materials; help determine the scope of the campaign; be included in e-mail alerts and list serves, conduct events/meetings at their local chapters and share relevant materials with other members of the coalition. The next SOS Rx meeting will be October 1st, 2003.

Addendum 1:

Purpose/Mission Statement

The purpose of SOS Rx is to make the outpatient use of medicines safer. Our voice is national and our actions evidence-based. SOS Rx will focus on campaign-style education/information initiatives aimed at securing consumer actions and system changes that enhance the safe outpatient use of medications. Participating organizations signify support and commitment to work together to assure the safe outpatient use of medications for all consumers and patients, with initial focus on safe use by senior citizens.

Addendum 2: SOS Rx Defined and Differentiated

Focus: Outpatient
(Not Inpatient)

Emphasis: Most at risk populations -- initially, seniors.
(*Not* low risk populations)

Objective: Increase safe use of medicines/reduce harm from unsafe use
(Not surgical, radiological, laboratory, diagnostic, etc. errors)

Scope: Includes over the counter, supplements and prescriptions
(Not prescription drugs alone)

Target: Consumer actions and system changes for safer use
(Not discovery, approval, formulation, manufacture or counterfeit)

Activity: Education and communication initiatives
(Not research, standard, protocols, measures, monitoring, etc.)

Strategy: Campaigns
(*Not* another brochure)

Members: "Everyone around the table"
(*Not* just consumers, industry, or health professionals, etc.)

Notes

- The consensus action agenda process (November 9-11) will identify and rank order consumer actions and system changes. Starting point will be JAMA, NEJM on ambulatory medication safety. (See summary prepared for inaugural meeting)
- Rank ordering will take place on three dimensions: (1) Impact on increasing safe use of medicines/reducing harm from unsafe use, (2) Time to accomplish, (3) Resources needed to accomplish
- The campaign style education/communication initiatives will target achievement of these actions and changes will be targeted by participating organizations and beyond.
- Information sharing between/collecting information from participating organizations will support these initiatives.

Addendum 3: Brief Overview of Individual Organizations' Activities/Efforts Surrounding Patient Safety

Academy of Managed Care Pharmacy - Marissa Schlaifer

- Stressed patients need to ask their doctors questions to prevent medical errors of commission and omission
- Currently, pharmacists are overloaded with misinformation about drug-drug interactions
- Dedicated to establishing standards for drug interaction information
- RFP out to research institutions

Agency for Healthcare Research and Quality - Chunliu Zahn

- Involved in a variety of patient safety activities and grants
- Have done research on medications that are not appropriate for the elderly
- Currently doing research on drug interactions in elderly outpatients

Alliance for Aging Research - Debbie Zeldow

- Focus on the misuse of medication in the elderly
- 1998 report, "When Medicine Hurts Instead of Helps"
- Patient materials include a section on medication safety

American Academy of Family Physicians - Debbie Graham

- Professional organization for family physicians
- Conduct CME programs on patient safety.
- Has more than 200 family physicians who participate in research studies in the National Research Network
- Network clinics and residency programs participated in studies on medical errors, filing anonymous reports on the Internet and on paper. Current study involves laboratory and diagnostic imaging testing process errors
- In a group of studies about medical errors in family medicine, the error reported most often was ordering medications
- AAFP will convene the first National Ambulatory Research and Education Conference on Patient Safety in Chicago, September 18-19, 2003

American Association of Colleges of Pharmacy - Will Lang, Lucinda Maine

- Represents 89 colleges of pharmacies.
- Not about establishing curriculum; are about enhancing pharmacy education.
- Participate in many organizations, like this one, to identify emerging trends that pharmacy students need to focus on in health care delivery
- Geriatric special interest group represents AACP's collective involvement with geriatric care
- Geriatric services are of professional and personal interest to Lucinda

American Geriatrics Society - Sue Emmers

- 9,000 geriatricians worldwide

- Focus on monitoring drug use and coordination and re-imbursement with health care organizations
- Views issues from a policy perspective

American Medical Association - Deborah Cohen

- One of the founding members of the National Patient Safety Foundation
- Very involved in patient safety legislation
- Focuses on all of the various issues from drug importation to direct-to-consumer advertising

American Pharmacists Association Foundation – Bill Ellis

- Work in conjunction with the ISMP to promote safety messages
- Publish the Medical Safety Self Assessment for Community and Ambulatory Pharmacy
- Conducts medication use pilot projects in community settings that utilize point-of-care testing in a collaborative practice model that involves patients, physicians, pharmacists, other health care professionals, and employers

American Society of Health-System Pharmacists - Kacey Thompson

- Help more than 30,000 people make better use of their medications
- Interdisciplinary collaborations – using team-based models
- View pharmacists as crucial health care providers
- Established a hard copy and Internet resource, www.safemedication.com, providing accurate and trusted drug information to the public, free of charge.

Express Scripts – Ed Weisbart

- Each year, Express Scripts electronically transmits more than 33 million safety alerts, such as drug-to-drug interactions, on specific patients to their pharmacies
- Even after prescriptions are dispensed, Express Scripts further analyzes claims data to identify potential safety risks and follow up by mailing notifications to physicians—20,524 in 2002
- Among Express Scripts' commercially insured population, the average member receives care from 2.3 doctors and uses 1.3 retail pharmacies. Express Scripts' extensive member database detailing prescription use is stored in a secure computer system to identify some safety risks at the point of care that otherwise may be missed.

GPhA - Christine Simmon

- Focus on the safety and manufacturing of generic drugs.
- Public perception is that generic drugs are not as effective as their brand name counterparts
- Launching a consumer education campaign in October and November to tackle this misconception
- Also conducting a project with the FDA asking the industry to report medical errors, so we will have the largest database of medical errors.

Institute for Safe Medication Practices – Kate Kelly

- Analyze medical errors
- Disseminate that information in newsletters and alerts
- Focus is on outpatient services

Massachusetts Group Insurance Commission - David Czekanski

- Cover 265,000 state employees, retirees and dependents
    - 118,00 over the age of 50; 56,000 of those are 65 and over
- Provide the health insurance, including prescription drug coverage, for this population
- Aim to make information simple and understandable
- Implemented pilot program surrounding alert technology
    - Viagra vs. nitrates Rx's
- First state agency to join Leapfrog Group
- Express Scripts client; mentioned that because PBMs house entire prescription drug history, there are a lot of things they can do to increase safety for those with insurance (i.e., soft and hard edits, disease management programs)

National Consumers League - Rebecca Burkholder

- Provides good health information to consumers so they can make good decisions with their health care providers
- Evaluating "evidence-based medicine" as term that is often used but often misunderstood by consumers.
- Educating consumers about the proper use of OTC painkillers and dietary supplements
- Another focus area is health literacy. (Noted the millions of Americans who read below a fifth grade level and for whom English is a second language)
- Ensure health information is distributed in a comprehensible manner

National Family Caregivers Association – Suzanne Mintz

- Key message is that family caregivers need to be advocates for their loved ones and themselves
    - Empowered family caregivers are more proactive and better able to ensure their loved one's safety
    - Although patient safety has not been a specific message, everything we are about leads to it
- Developed a curriculum surrounding effectively communicating with health care professionals, targeting caregivers.
- Conducing training workshops for session leaders, to enable leaders to conduct local sessions
- Educational pamphlets and newsletters specifically teach family caregivers how to function proactively within the healthcare system
- Also on the board of the National Patient Safety Foundation

National Farmers Union – Clint Monchuk

- Not directly involved in patient safety
- Noted opportunities to learn from other industries

National Health Council – Jennifer Haslip

- Focus mainly on chronic conditions.
- Provide brochures and PSAs aimed at putting patients first.
- Empower patients to ask their physicians questions about their medication regimens
- Currently planning a co-branded initiative with United Health Group featuring advertisements in magazines targeting women.
- Also focus on assessing and enhancing health literacy

National Patient Safety Foundation - Lou Diamond

- Sponsors a national congress and research activities
- Under an AHRQ grant, Web-based education program for health care professionals
- Sponsored the Pharmaceutical Safe Use Project in July 1999, but the organization lost funding and is currently not active
    - As part of the Safe Use Project, convened a two-day consensus conference of the stakeholders where the participants agreed to a prioritized agenda, and activated the next phase of one action step, the development of a public education campaign. One component of this campaign was the development and publication of a brochure entitled "Think It Through."

Older Women's League - Laurie Young

- 57 Chapters
- National at-large membership
- Focus on all issues affecting women in midlife and aging
- Publish helpful information about health care issues targeted to our membership, including:
    - Guide to OTC medications
    - Prevention and treatment of osteoporosis

Massachusetts Coalition for the Prevention of Medical Errors - Paula Griswold

- Develop educational programs, specifically focused on CPOE
- Focus on e-prescribing and identifying errors that occur as part of the systemic process.
- Developed a communications piece aimed at consumers identifying tips for physician visits.
- Part of the collaborative initiative assessing clinical conductivity of managed care clients.

National Chronic Care Consortium - Richard Bringewatt

- Two-thirds of Medicare costs stem from chronic care patients who utilize multiple doctors, drugs, pharmacies, etc.
- Focus on finance, administration and delivery of care.
- There are systemic problems with our system that is not designed to comply with chronic care patients

National Council on the Aging – Not present during the discussion

UnitedHealth Group - Michael Anderson

- Efforts are directed toward patients
- Provide patients with tools to enhance their safety
- Through partnership with AARP:
    - Support AARP's Wise Use of Medications Campaign
    - Encourage AARP members to take an active role in their health care by providing practical tips for partnering with their doctor and pharmacist to optimize medication safety
- Partner with Express Scripts to administer the AARP Pharmacy Services discount card programs, which alert dispensing pharmacists of potential drug interactions and other problems
- Stress the importance of:
    - Annual prescription reviews
    - Understanding therapy goals
    - Good communications surrounding prescription regimens

Addendum 4: Organizations To Be Contacted for SOS Rx Involvement

- American Society of Consultant Pharmacists
- American Nursing Association
- Pharmaceutical companies
- Insurance companies
- CMS
- FDA
- American Public Health Association
- National Medical Association
- Allied Health Professionals
- American Benefit Council
- Employers
- Organized labor
- Hispanic Consumer Group
- American Medical Group Association
- Medical Group Management Association
- National Senior Medicare Committee

SOS RX
SIGN-ON FORM

Name of Company/Association/Organization: ___________________________________

Name of Key Contact: ____

Address: ____

Phone: ____

Fax: ____

E-mail: ____

- ❑ The above-named organization agrees to support the following purpose of SOS Rx.

Purpose Statement

The purpose of SOS Rx is to make the outpatient use of medicines safer. Our voice is national and our actions evidence-based. SOS Rx will focus on campaign-style education/information initiatives aimed at securing consumer actions and system changes that enhance the safe outpatient use of medications. Participating organizations signify support and commitment to work together to assure the safe outpatient use of medications for all consumers and patients, with initial focus on safe use by senior citizens.

We are interested in participating in the following capacity:

- ❑ Education campaign workgroup
- ❑ Consensus building workgroup
- ❑ Advisory Committee

*Note: SOS Rx will not use the name of your organization in any capacity without prior authorization.

Signed: ____

Date: ____

*****Please return via fax to (202) 835-0747, attention Linda Golodner*****

Attending Organizations	Attendee(s)	Address	E-mail
Academy of Managed Care Pharmacy	Marissa Schlaifer Director of Pharmacy Affairs	100 North Pitt St. Suite 400, Alexandria, VA	mschlaifer@amcp.org; (703) 683-8416 x303
AHRQ	Chunliu Zhan	2101 East Jefferson Street Rockville, MD 20852	czhan@ahrq.gov; 301-427-1225
Alliance for Aging Research	Sarah Claassen and Debbie Zeldow	2021 K Street, NW Suite 305 Washington, DC 20006	claassen@agingresearch.org; dzeldo@agingresearch.com; 202/293-2856
American Academy of Family Physicians	Debbie Graham, Senior Research Associate in the AAFP National Research Network	11400 Tomahawk Creek Pkwy Leawood, KS 66211	dgraham@aafp.org; phone: 800-274-2237 x 3176
American Association of Colleges of Pharmacy (AACP)	Will Lang, Director of Government Affairs	1426 Prince St. Alexandria, VA 22314	wlang@aacp.org; 703-739-2330
American Association of Colleges of Pharmacy (AACP)	Lucinda Maine, Executive Vice President or Will Lang, AACP Director of Government Affairs	1426 Prince St. Alexandria, VA 22314	lmaine@aacp.org; 703-739-2330
American Geriatrics Society	Susan Emmer	Empire State Building 350 5th Avenue Suite 801 New York, NY 10118	Emmerconsulting@aol.com; 301-320-3873
American Medical Association	Debra Cohn, Washington Counsel	515 N. State Street Chicago, IL 60610	debra_cohn@ama-assn.org; 202-789-7400
American Pharmacists Association Foundation	Bill Ellis, Executive Director	2215 Constitution Avenue, NW Washington, DC 20037	wellis@aphanet.org; 202-429-7565
American Society of Health-System Pharmacists	Kasey Thompson - Director of Patient Safety	7272 Wisconsin Avenue Bethesda, MD 20814	kthompson@ashp.org; 301-657-3000, 1270
Express Scripts	Ed Weisbart, Vice President of Medical Affairs	13900 Riverport Drive, Maryland Heights, MO 63043	EWeisbart@express-scripts.com, 800-332-5455
GPhA	Christine Simmon Vice President of Policy and Public Affairs	2300 Clarendon Blvd. Suite 400 Arlington, VA 22201	Christine@gphaonline.org; Direct line: (703) 647-2494
GPhA	Gordon Johnston, VP of Regulatory Affairs	2300 Clarendon Blvd. Suite 400 Arlington, VA 22201	gordon@gphaonline.org; Direct line: (703) 647-2496
Institute for Safe Medication Practices	Kate Kelly , Pharm.D., Publications	1801 Byberry Rd Huntington Valley, PA 19006	kkelly@ismp.org; 215-947-7797
Massachusetts Coalition for the Prevention of Medical Errors	Paula Griswold, Executive Director	5 New England Executive Park Burlington, MA 01803-5096	pgriswold@mhalink.org; 781-272-8000 x152
National Chronic Care Consortium	President and CEO Richard J. Bringewatt	801 Pennsylvania Avenue Suite 245 Washington, D.C. 20004	rbringewatt@nccconline.org ; 202-624-1516

Attending Organizations	Attendee(s)	Address	E-mail
National Consumers League	Linda Golodner, President and CEO	1701 K Street, N.W., Suite 1200 Washington, D.C. 20006	lindag@nclnet.org; (202) 835-3323, 118
National Consumers League	Rebecca Burkholder (Program Associate)	1701 K Street, N.W., Suite 1200 Washington, D.C. 20006	rebeccab@nclnet.org; 717-394-4925
National Council on Aging	Chuck Mondin, Program director, United Seniors Health Council	409 Third St, SW Suite 200 Washington, DC 20024	chuck.mondin@ncoa.org; 202-479-6973
National Family Caregivers Association	Suzanne Mintz	10400 Connecticut Avenue #500 Kensington, MD 20895-3944	suzanne@nfcacares.org; 301-942-2302
National Farmer's Union	Clint Monchuk	400 North Capitol St. NW Suite 790 Washington, DC 20001	nfu1@nfudc.org; phone - 202-314-3193
National Health Council	Jennifer Haslip	1730 M Street NW Suite 500 Washington, DC 20036	jhaslip@nhcouncil.org; 202-785-3910
National Patient Safety Foundation	Louis Diamond, board member; Vice President and Medical Director of The MEDSTAT Group	515 N. State St. Chicago, IL 60610	louis_diamond@medstat.com
Older Women's League	Laurie Young, Executive Director	1750 New York Avenue, NW Suite 350 Washington, DC 20006	lyoung@owl-national.org; 202-628-0444
United Health Group	Mike Anderson	9900 Bren Road East, MN008-T500 Minnetonka MN 55343	mjanderson@uhc.com; 952-936-3112
Massachusetts Group Insurance Commission	David Czekanski	PO Box 8747 19 Staniford Street Boston, MA 02114-8747	David.Czekanski@GIC.STATE.MA.US; phone--617.727.2310x3035 fax: 617.227.2681
Observers	**Attendee(s)**	**Address**	**E-mail**
Express Scripts	Steve Littlejohn, Vice President of Public Relations	13900 Riverport Drive, Maryland Heights, MO 63043	314-702-7556; slittlejohn@express-scripts.com
Express Scripts	Larry Zarin, Vice President of Brand & Corporate Development	13900 Riverport Drive, Maryland Heights, MO 63043	314-702-7600, lzarin@express-scripts.com
Express Scripts	Brenda Motheral, Vice President, Outcomes Research	13900 Riverport Drive, Maryland Heights, MO 63043	800-332-5455, bmotheral@express-scripts.com
Hill & Knowlton	Marilyn Castaldi	466 Lexington Ave., New York, NY 10017	212.885.0383; mcastaldi@express-scripts.com
Hill & Knowlton	Lee Lynch	600 New Hampshire Avenue, Suite 601, Washington, DC 20037	202-944-5186, llynch@hillandknowlton.com
Hill & Knowlton	Ingrid Sheriff	600 New Hampshire Avenue, Suite 601, Washington, DC 20037	202-944-1933; isheriff@hillandknowlton.com
Hill & Knowlton	Ellie Kline	600 New Hampshire Avenue, Suite 601, Washington, DC 20037	202-944-5193; ekline@hillandknowlton.com

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VIEWPOINTS

An Experience with Medicare: What's Missing?

Lucinda L. Maine, PhD
Executive Vice President, American Association of Colleges of Pharmacy

I approach this writing assignment with significant trepidation. My subject, "What is missing from our health financing and delivery system?" is one about which volumes have been written and great minds have pondered ceaselessly. It is my motivation for writing this now that gives me pause. I am writing after the experience of assisting my almost 85-year-old stepfather through his last 90 days as a Medicare beneficiary. At the end he lost his race with old age and chronic illness. That part was inevitable. What he and our family experienced should not be.

His death is not the story here. It is the dysfunction that pervades acute and chronic health care that demands attention. I am not a litigious person, but I am a problem-solver. In the brief exposure to acute, chronic and long-term care embodied in my family's experience I found several very important lessons.

The most poignant lesson was learning that what I was experiencing is not unique among my peers. Many, even in our small community of educators, are dealing with parents aging, often at a distance. As a society we are struggling to produce quality in a system that was never designed to do what we are asking of it. Instead it was assembled in piecemeal fashion. Medicare alone is now a cobbled together system with over 300,000 pages of federal regulations that don't collectively add up to a quality program.

Succinctly, the lessons are related to quality and coordination of health services, the absence of "care" in the health care system and poor decision-making attributable to health financing and bad policy. The final lesson hits closer to home and is one we are only too well aware of – Medicare beneficiaries suffer dramatically from a lack of coordinated pharmaceutical care.

The intelligent men and women at the Institute of Medicine are right! Our health delivery system is fraught with errors and the quality chasm is deep and dirty. My father experienced a "hand off" from his primary care physician to a junior partner at a most vulnerable period of time. That occurred with no explanation to my stepfather or his family. Problems were exacerbated because the communication between my father's physicians was so poor – even though they work in the same practice.

Further, there was no coordination of care between the primary physician and the specialists, even when my stepfather was admitted for cardiac care in the hospital next door to his cardiologist's office where regular warfarin monitoring was performed. Sixty days into the saga, while still an inpatient in skilled care, a phone message from the cardiologist's office sought an explanation for why my father had not been in for warfarin monitoring lately.

Every transition – from home to the ICU, ICU to acute in-patient ward, hospital to skilled rehabilitation facility, and finally to home – presented a new opportunity to make a mistake. Unfortunately, but not surprisingly, no one missed even one such opportunity. Case in point, one would imagine that an elderly diabetic patient should have insulin or related therapy ordered, along with appropriate dietary restrictions, no matter what level of institutional care. My father transitioned to the rehabilitation facility from the hospital without those orders!

By now it might be obvious that the traditional term "health care system" has been replaced in this viewpoint with "health delivery system". That word choice is very intentional. The second very clear lesson we learned is that no one is paid by Medicare to *care*. Ironically, the very day this viewpoint was written the news arrives via e-mail that the chief actuary of the Medicare program estimates that premiums for Medicare beneficiaries will rise 12.4% next year. This represents the largest increase in 11 years. Additionally, the fees paid to doctors who treat Medicare patients will be cut approximately 4.2% next year. Our nation's seniors will pay more and their clinicians will get less. Can we really expect to see improvements in the quality of care and coordination of services with further negative payment incentives such as these?

Lest the reader think the entire system was totally broken, there was an exception to the "no care" rule in the care provided by his home care team. When eligibility for skilled care ended, return to independent living was the only choice my fairly headstrong stepfather was willing to entertain, despite concerns for safety held by all of his formal and informal caregivers. However, 75 days of institutional services had stripped this diabetic of his confidence in monitoring his daily blood sugars and administering insulin. This plus poor ambulation left him frail and dependent upon home care for "safe" independent living.

Despite the fact that Medicare does not consider medication-related management needs a reasonable basis for home nursing visits, the visiting nurse agency understood how vulnerable my step-father was in general, and specifically in diabetes management. This was affirmed by poorly managed insulin therapy that produced a swing in blood glucose from over 400 to under 50 mg/dL over 12 hours. The visiting nurses' concern for my father's welfare overrode their concerns about Medicare fraud and abuse for making inappropriate numbers of visits. They bent as many rules as necessary to render compassionate care for their patient right to the end of life. The fact that they had to do this underscores how poorly our health system functions in delivering needed care to needy persons.

Everyone is aware of how fragile our Medicare system has become. As more of us approach the time when we look to it as one source of primary health coverage, we have reason to be concerned about its viability. My experience certainly did not provide a brilliant new insight on the penultimate fixes that will be required to sustain America's promise to its seniors, but one thing is crystal clear. Medicare, and its sister program Medicaid, were never intended to address the long-term care needs of our population.

From a public policy perspective, that is one issue that must be honestly addressed before the 60 to 70 million "boomers" begin to enter their eighth and ninth decades of life.

Then there is the issue of prescription drugs. Overlook for the moment that Medicare pays to diagnose illness -- in my father's case with two extremely expensive trips to the intensive care unit of the community hospital – but does virtually nothing to treat illness once diagnosed. The missteps in medication therapy management over the multi-institutional 90-day drama in health mismanagement were numerous and consequential and ultimately contributed to his death. Notwithstanding that my father had two pharmacists in the family who weighed in on multiple occasions with pointed questions and recommendations related to drug therapy.

In retrospect two relatively simple "fixes" could have played important parts in improving the quality of medication management and, as a result, improved care overall. Those are an accessible record of current medications and a therapeutic plan developed with significant pharmacist input and oversight.

No one, and especially not the primary care physician, was able to produce an accurate record of medications used by my stepfather at the point of initial entry into the hospital. If asked, his community pharmacist probably could have, but of course she wasn't asked. Missed orders, attempts to treat agitation with the wrong antipsychotics, and poor insulin management were among the incidents we encountered, and the errors occurred at every level of care. Further, the deference, or inaction, by one physician when confronted with a medication problem associated with care that had been delegated to a specialist was frightening. In the end, both problems with insulin management and a failure to maintain diuretic therapy accelerated my father's final days.

The Institute of Medicine has just issued a report that suggests that health professionals of the future produced by our schools and colleges must be patient-centered, team-oriented and prepared to deliver evidence-based care supported by informatics and the tools of continuous quality improvement. All I can say is, "we better hurry."