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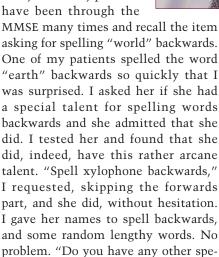


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# The woman who could spell backwards

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My routine initial evaluation for every patient includes a reduced mental status exam. One item is a request to spell the word, "earth" forwards and backwards, a slight modification of the question on the standard Mini-Mental State Examination (MMSE). I do this because it is likely that many patients



cial or unusual talents?" I asked. "No." And, as best I've discovered over the next few years, she did not.

This has led me to wonder about highly focused, unusual talents that people may have that may go unrecognized, or, if present, either unexploited or unable to be exploited. Aleksandr R. Luria, the famous Soviet neuropsychologist of the 1930s, wrote a wonderful monograph, The Mind of a Mnemonist, about a Russian man with a perfect memory. He made his living impressing audiences with his unfailing ability to remember virtually everything. He was not apparently gifted in other areas, not



creative, not brilliant. Luria kept detailed notes on their interactions during his laboratory visits and later would ask questions. "What color tie was I wearing at our meeting 17 years ago on March 23, 1928, and what were the headlines in the newspaper?" The man never erred. In the theater where he performed, an assistant would ask the

audience to mention a number, and they would be written on a board in the order in which the audience spoke. After one or two hundred numbers they would be spoken to him once, after which he would repeat the list.

Obviously a good memory is better than a bad one. There is no field of endeavor where there is a downside to an enhanced memory. It is easy to see that certain types of memory better serve certain activities than others. Mozart's ability to recall music obviously served his extraordinary talents. Chessmasters' memories for whole games serve the obvious need of helping to choose a strategy or the next move. One can never know what sorts of special talents we or our family members may have if they never get the chance to exploit it. How would a poor, uneducated person in the third world know that they can repeat music that is a thousand notes long after hearing it only once, if the person never is exposed to the situation? How many people are asked to spell a word forwards and backwards? I assume it is a pretty rare request. How many readers have tested themselves spelling a word backwards?

This leads back to an important

question. Why did I ask her to spell the word backwards? This is a standard test of "working memory," which is a concept to describe the tasks involved in remembering the word and manipulating it while not forgetting it, thus "working" with it, without losing it. It is analogous to rotating a geometric shape in one's mind to see what it looks like from different perspectives. But, interestingly, my patient seems to be no better at this than the average person who couldn't spell xylophone backwards after several hours of trials.

I have not subjected my patient to formal neuropsychological testing to determine if there are hidden talents, perhaps even unknown to herself. The patient is herself unaware of any other special abilities, and I've seen none. So, what does this tell us about special talents? I think it tells us that we can't recognize them unless the patient tells us. It tells us that the capabilities may exist in isolation, without any hint of brilliance or special talent. It tells us that testing may overlook particularly isolated but extraordinary talents, and that memory, like most human thought endeavors, can be extraordinarily focused, without generalizability. Memory, intelligence, and talent work best when united, but may exist in isolation. .

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# Woonsocket teens TEACH community health

ERIC J. CHOW, MD, MS, MPH; JACKIE HSIEH, MD; LAURA ALLISON WOODS; JUNE JIAO; MARGRET CHANG, MD

IN AN INTERVIEW, MELINDA GATES once remarked about innovations in the developing world that "when you let people participate in the design process you find that they often have ingenious ideas about what would really help them."1 These words are at the heart of successful community health programs around the world aimed at bringing change to those who need it the most. But we do not need to look too far to recognize that these same principles apply to communities here at home. Early in 2014, we created Teens Empowered to Advocate for Community Health (TEACH), a partnership organization to inspire the next generation of youth to enact change in their own communities by empowering them with the basic principles of public health.

With a seed grant from the American Academy of Pediatrics Community Access to Child Health (CATCH), we sought to teach public health as an afterschool curriculum with a goal of inspiring teens to be agents of change. At first, we met with many potential partners before serendipitously initiating the program at Woonsocket High School. Woonsocket proved to be a perfect place to start as a city of 40,000 people, rich with diversity and character, but still faced with many risk factors for poor health outcomes. And the high school students turned out to be motivated and engaged to initiate change from within.

Our partnership with community

organizations like Riverzedge Arts was the first key to the launch of our program. Riverzedge Arts is an organization that had connections with Woonsocket High School in offering after-school courses for credit through a program called Expanded Learning Opportunities (ELO). Karen Barbosa, the ELO director of Riverzedge, and Liz Holohan, the ELO Woonsocket Coordinator, were vital to helping us to understand how to integrate our goals into a classroom curriculum. Furthermore, we brought in enthusiastic medical and public health students from Brown University to help deliver these topics into an interactive community-driven way.

Courses then took effect through an integrative approach. Nutrition is now taught in the grocery store as a scavenger hunt to build a nutritious meal. LGBT health and advocacy issues are introduced during a field trip to the local YouthPride, Inc. center. First line cardiopulmonary resuscitation and emergency medicine skills are taught at the Lifespan Medical Simulation Center. Sexual health is taught as a jeopardy game, where students team up and answer questions. Students learn reproductive anatomy by engaging in hands-on modeling activity. During the second semester, students are taught basic research skills and prompted to ask one fundamental question: what do the students perceive as public health issues in their community? And what projects

can they design to bring about change?

We recognized quickly that the high school students were constantly picking up on the public health issues that the city had been facing for years. As an example, according to Rhode Island Kids Count in 2016, greater than 350 births in Woonsocket were to girls between the ages of 15 to 19.2 To assume that students did not understand these facts is a mistake. A student once asked why a daycare at school was not supported so that teen mothers could avoid absenteeism. Another student identified obstacles in accessing contraception education despite teens knowing they could benefit from it. Questions like these became topics of their research projects and proposals for interventions. The topics are often the most prevalent health issues in their communities, such as absenteeism, truancy, student dropout, teenage pregnancy and mental health issues. In turn, through TEACH, the students learn about the public health process and have become motivated to engage with their communities from a grassroots approach. We believe that these teens will take the next step from presenting these ideas to making real change come to life.

Now well into our third year, our organization has matured, our curriculum has been enriched and our students are still persistent with their desire to bring solutions to the problems they identify around them. We have also expanded



across state lines, where medical and nursing students at the University of Massachusetts at Worcester are bringing TEACH to Rockdale Recovery High School. Here, instead of viewing their substance use history as a problem – teens are encouraged to use their experiences as a way to educate medical providers and the public about how to approach adolescent substance use in the local community.

What began as a small group effort to bring public health knowledge to students has, in turn, taught physicians, graduate students and teachers alike that empowering teens can have a lasting and meaningful impact in a community. We believe that our model of public health education and intervention with teens can serve as a model elsewhere to engage the community to enact change. Partnerships and an interdisciplinary team were vital to our success. With help from our partnerships and passionate team members, we hope to bring these teens' "ingenious ideas" to fruition. •

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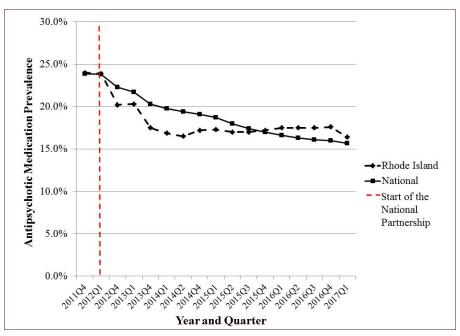
# Antipsychotic Medication Use and Reduction: Unanswered Questions and Policy Implications

DANIEL HARRIS, BA; NELIA SILVA-ODOM, RN, BSN, MBA, MHA; LYNN MCNICOLL, MD

Historically, antipsychotic medications (APMs) have been used to treat mood and behavior dysregulation associated with dementia.1 However, their associations with early mortality and risk of adverse events for adults above the age of 65 (e.g., Parkinsonism and cerebrovascular events, respectively) prompted the Centers of Medicare & Medicaid (CMS) to introduce The National Partnership to Improve Dementia Care in 2012.<sup>2,3</sup> The Partnership incentivizes APM reduction by publically reporting a nursing home's prevalence of APM use and incorporating the prevalence into their quality rating, with fewer APMs indicating better quality.3 Notably, only residents with schizophrenia, Huntington's or Tourette's are excluded from the APM prevalence calculation.3

During the early years of The Partnership, Rhode Island showed promise in reducing APM use among long-stay nursing home residents (24.0% in quarter-4 2011 to 16.5% in quarter-2 2014) (Figure 1).3 However, while the national prevalence of APM use steadily decreased, Rhode Island's progress slowed in quarter-3 2014 and increased to 17.6% in quarter-4 2016.3 In response, the local CMS Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) implemented several educational and skill-building interventions; which, in part, are likely related to the latest reductions in APM use the state.3 However, a recent analysis of resident-, facility- and community-level factors and APM use among Rhode Island nursing homes suggests that dementia may no longer be as strongly associated with APM use.4 Results showed that the prevalence of residents with dementia was negatively associated with APM use after controlling for other resident-level factors. Psychiatric diagnoses and other medications (e.g., antianxiety and antidepressants) were among the strongest factors associated with increased APM use. While additional research is necessary to elucidate these findings, the results lend insight into the success of The Partnership as well as underscore the need to reevaluate its initial aims in the context of a potentially changing nursing home population. More specifically, RI's increased APM prevalence may, in part, be attributed to demographic shifts towards younger nursing home residents, presenting with symptoms

Figure 1. National and Quarterly Rhode Island Prevalence of Antipsychotic Medication Use for Long-Stay Nursing Home Residents



Source: Data were adapted from the Centers for Medicare & Medicaid Services National Partnership to Improve Dementia Care.3,5

Notes: The Partnership began on March 29, 2012. Residents with Huntington's, Tourette's, or Schizophrenia were excluded.3,5

and psychiatric diagnoses warranting

APM use that are unassociated with dementia (e.g., bipolar disorder).

The Partnership was designed to reduce inappropriate APM use among residents with dementia.3 However, new empirical evidence suggests that APM use may no longer be as associated with dementia at the facility level.4 Given these results, and CMS' narrow exclusionary criteria, several questions emerge: Will the risk of a low quality rating motivate nursing homes to discontinue appropriate APMs? Has CMS considered the consequences of eliminating APMs in residents who have clinically justified reasons to use them? For example, under the current initiative, residents with bipolar disorder or using APMs approved for certain diagnoses (e.g., aripiprazole, an atypical antipsychotic, for depression) are at risk of medication discontinuation. Ultimately, how far can APM reduction go and remain safe and stable?<sup>5</sup>

Opportunities for future research include the longitudinal study of changes in the demographic composition of nursing home residents and how those changes are associated with a nursing home's APM use and finances. Policy-level changes may aim to refine the APM quality measure to ensure it is focused on *inappropriate* APM use (e.g., exclude residents less than 65 and/ or with psychiatric diagnoses justifying the use of APMs).

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