TMDA ENEWS LETTER MAY 2018

THE TEXAS SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE

tmda

A Message from the President—Jennifer Heffernan, MD

Dear TMDA members,

I hope you were able to attend AMDA: The Society of Post-Acute and Long-Term Care Medicine (The Society) annual conference in Grapevine, TX this past March. Nowhere else do I experience the friendliness of colleagues and excitement of new agendas that The Society has engulfed on. I learned that many of my colleagues who work in the post-acute and nursing home settings also see patients in assisted living facilities and even home visits. I am happy to report The Society has identified this trend and is focusing on providing education to its members and guidance to CMS on how to manage patients in these settings. As we all know, the residents in the assisted living facilities of today are who used to occupy the nursing homes of yesteryear. And patients in nursing homes today are often receiving care that used to only be available in the hospital.

Our Texas/Oklahoma Chapter reception is always one of my favorites at the national conference. It is the perfect opportunity to catch up with colleagues, some who have been with The Society for many, many years and others who are just learning about this amazing organization. We welcomed geriatric fellows, Valerie A. Agena, DO and Tiffany A. Bunag, MD whom TMDA provided scholarships to attend The Society's Future's Program. I remember participating in the Future's Program in 2005 and the positive influence it had on my decision to pursue a career in long-term care.

Each year during the state chapter reception, the Texas members of the House of Delegates (HoD) meet for a lively discussion on who to vote for to fill The Society's Board Member positions and what we think about the proposed resolutions. This year, all of our chosen board nominees won their races!

If you are attending The Society's Annual Conference next March in Atlanta, GA, I highly encourage you to become an HoD member. You don't want to miss the fun!

I look forward to saying "howdy partner" to everyone in San Antonio this August during our 28th annual Texas State Chapter meeting. Don't miss this opportunity to sharpen your long-term care skills and mingle with your fellow Texas long-term care providers and teammates!

Thank you for your dedication to long-term care and TMDA.

Inside this issue:

2018 Events

- TexMed 2018
  May 18-19, 2018
  San Antonio, Texas

- TGS/TMDA Annual Conference
  August 10-12, 2018
  San Antonio, Texas

Remember to pay your 2018 Dues!

Support the Texas Chapter

Members receive a discount to the annual conference!

Renew Online Today!
TMDA Membership Renewal

Use of Robotic Cats to Reduce Falls in Skilled Nursing Facility

Stacey Hamilton MSN, GNP-BC, ACHPN
Chief of Clinical Operations
Austin Geriatric Specialists, PA

We had the good fortune to be able to present our project on using robotic cats to help reduce falls at AMDA in Grapevine, Texas earlier this year. Our project, while not large enough to draw statistical data from, was encouraging in that the trend we saw was a decrease in falls. The average falls per month before the study was 10.7 and the average number during the study months was 6.3. No formal program was designed, but the staff allowed the frequent fallers on the unit to hold the cats on their laps or put a cat on the bed with them during nap time or at night.

We used 5 cats for 30 residents so it is possible that if we had more cats available we would have seen an even larger reduction in falls. The intervention was safe and relatively inexpensive and, since the conclusion of the study, Westminster was so excited about it they have bought more cats and are exploring buying some robotic dogs!

Proposed Resolutions Presented at House of Delegates: AMDA 2018

The proposed resolutions listed below represent a wide variety of important and provocative issues submitted by state chapters from California to Wisconsin.

1. The consultant pharmacist and Centers for Medicare & Medicaid Services Provider Status. **Passed**
2. Enabling attending physicians to waive the three-midnight stay rule for patients receiving care within downside risk-sharing accountable care organizations and advanced bundled payments. **Passed**
3. Waiver of Maintenance of Certification for Board Certification in inactive specialties. **Failed**
4. Need for increasing home care services to assist obese older adults with complex health care needs, age at home and thereby delay or avoid nursing home entry. **Referred to the Board**
5. Proposal to include doctoral level non-physician allied health practitioners as full Society members. **Referred to the Board**
6. Inclusion of bundled payments for care improvement post-acute-only Model 3 in Advanced Bundled Payments for Care Improvement. **Passed**

ask an EXPERT

David A. Smith, MD, CMD
Geriatric Consultants of Central Texas, PA

"I have a cognitively intact patient who has very limited ambulatory abilities secondary to chronic disease, weight and arthritis. She is one of my "frequent fallers" and has fallen 3 times in the past 3 days. She understands that she should call and wait for the CNA to come help her get up to the bathroom but is very impatient. She understands her risk of falling the consequences of fractures or bleeds. However, she insists she can get up and will not ask for help until she is already on the floor. She has also refused physical therapy to help improve strength.
Any recommendations to help us help her reduce her falls and risk for injury?"

Occasionally we encounter patients who, for their own reasons, decline our expert advice or treatments. They are exercising their autonomy (right to have control over their own person) which strains our beneficence (practitioner's duty to do what's right for the patient).

Before directly answering this question, let's be sure about the presented facts. A SLUMS or MMSE, assessment of ability to think in the abstract, an assessment of judgment by examining the patient's understanding of the elements and consequences of their decision and alternatives and assessment for cognitive distortions caused by psychosis, severe depression or other mental illness are needed to be sure that a patient's rejection of medical advice with significant risk for harm is a competent decision.

This patient is "refusing" Physical Therapy which might be a red flag for some such problem with mental capacity. She's too impatient to wait for staff to answer her call bell. Is this because we're giving her Lasix? Alternatively, her questionable choices may be consistent with her personality, value system and her health beliefs. Competent people can legally and ethically exercise bad judgment and we all know folks who have exercised this right repeatedly, all their lives! Such a person must shoulder the responsibility for their own decisions, however (the ethical principle of justice).

We work for the patient and our duty is to assist them in obtaining the best possible outcome in the context of their healthcare choices. To throw up one's hands and "let the chips fall where they may" given a patient's non-compliance or non-adherence is abandonment.

Assuming this patient is mentally capacitated and you've documented this and the patient's decision carefully (as a medical malpractice risk management tactic), the practitioner needs to offer other interventions to mitigate the dangers that this patient has chosen to accept. Hipsters, helmet, non-slip and well-fitting foot gear, assessment for and treatment of osteopenia should be offered and if declined, then document. A medication review for drugs that increase risk of falling or of injury with falling should be done and a risk/benefit ratio determined in light of patient generated risks. Document, Document, Document!

Excessive duration of PPIs, steroids and phenytoin come to mind as drugs that cause osteopenia and likely tip the risk/benefit ratio in the direction of de-prescribing. Anti-hypertensives and many other drugs can cause orthostasis. Many psychoactives increase fall risk by several mechanisms. Anticholinergics can cause delirium or worsen dementia, so decrease safety awareness. The list goes on and on.

When patients make choices like this one or, similarly, choose to eat regular consistency diet when best medical advice is for a modified diet, it is prudent to meet with the patient and family and to formally exercise a Negotiated Risk Contract. This instrument documents patient choice against medical advice in a non-pejorative way albeit clarifying the patient has chosen to accept the risks.

Advanced Payment Models and SNFs- Caught between Scylla and Charybdis?

Liam Fry, MD

As we hear more and more about alternate payment models and new Medicare initiatives , the question becomes what is our role as nursing facility medical directors and attending physicians and practitioners? More and more both the skilled nursing facility as well as the practitioner groups are being asked to participate in Accountable Care Organizations (ACO), Bundle Payment Care Initiatives (BPCI), CCJR, and Managed Medicare (MA) taking some form of risk. I strongly suspect that each and every one of us has already been affected somehow by one if not more of these programs. It raises significant questions both regarding patient safety as well as changes in nursing facility reimbursement and bottom line which ultimately has the potential to affect all nursing home patients. These programs (ACO, BPCI, CCJR, MA plans) all have as one of their goals to reduce the spend in post-acute care. One of the main ways they intend to do this is by decreasing length of stay in SNFs as well as trying to discharge more patients home for home rehabilitation as opposed to facility-based rehabilitation. As practitioners caring for the SNF patients, there is increased external pressure from the insurance company or the BPCI initiator or the ACO to discharge soon. At the same time, the nursing facility continues to be paid on a per diem rate so every day you push the patient to go home earlier is lost potential revenue for the facility. The answer of course is "to just focus on what is best for the patient". However, that is not always an easy task. The data that we have actually argues that the more hours per day of therapy a patient can get, the better the outcomes. This would push us to want inpatient rehab for all our patients. So are we being unethical in allowing almost none to go to IPR and to shorten the LOS at SNF - i.e. the "number of hours". The short answer is probably both yes and no. Health care has changed a lot in 5 years – PCPs are more accountable, home health agencies are more aggressive in providing early needed care, etc. It is likely that newer data will show that this trend of getting patients home faster is not bad – and likely better – for some patients. While insurers and BPCI initiators will come to us with "data" such as Milliman data, as we know well, our patients – frail geriatric patients – frequently don't fit into those categories all that well. That is where our role will become so much more critical and the decision about when to discharge becomes much more challenging. We will need to discharge patients who are appropriate to go home, perhaps even incurring the wrath of the nursing facility; and we will need to advocate for those patients who need to stay, incurring the wrath of the insurance company or initiator. We can look at this as being "caught in the middle" or we can look at ourselves as being leaders to both groups, forging a path through the changing healthcare landscape with patient care as the driver.

AMDA Needs Your Assistance!

AMDA has been tasked with identifying medical directors of nursing homes in CA, FL, SD and TX. The Health Resources and Services Administration (HRSA) has funded a grant to survey nursing home medical directors about medical staff organization in US nursing homes. The medical directors will be asked to describe medical staff structure and organization using a nursing home medical staff organizational (NHMSO) survey tool. We have developed a form for Attending Physicians and Medical Directors to complete. Click HERE to access the survey. Thank you in advance from AMDA

TGS/TMDA Annual Conference

Join TGS and TMDA August 10-12, 2018 for our 28th Annual Conference. This three day event offers a wide range of topics geared toward the health and well-being of the elderly. CME/CMD, AAFP, and AANP approval is pending.

Topics Include:
Wound Care, Journal Club, Team STEPPS, Decisional Capacity Assessments, Models of Palliative Care Delivery, Texas Tort Battles, Gerontechnology, Medicare Choices Models, Controlled Substances in the LTC Setting, Antibiotic Stewardship, Geriatric Trauma, Reduce Readmissions and more!

Check out our new conference website for registration and hotel information!

TGS/TMDA Conference Website

Meet the 2017-2018 TMDA Board of Directors

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