TMDA ENEWS LETTER October 2018

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

tmda

Members Elect new TMDA Board at Annual Meeting

The 2018 TGS/TMDA Annual Meeting: *Mission of Elder Care* was held August 10-12 at the Omni La Colonnade in San Antonio, Texas. 24 speakers provided 17 hours of CME; CMD; AAFP; AANP credit; and 1 hour of Ethics credit. There were 124 registered to attend. Dr. Kendra Belfi, our Keynote Speaker, talked on the Value of the Texas MOST (POLST) for patient's nearing the end of life. During the TMDA business meeting, the new board of directors was elected (see page 5), Jennifer Heffernan, MD gave an update on the House of Delegates meeting from the March AMDA meeting and Milton Shaw, MD provided an update on our financial status. Dr. J. Lesly Bright won the prize drawing of an Amazon Echo Show. This was Dr. Heffernan's last year as President and our incoming President, Dr. Laura Garcia, presented her with a plaque to commemorate her term of service. Thank you Dr. Heffernan and welcome Dr. Garcia!

The 2019 annual meeting will be August 9-11 in Galveston We hope to see you there.

Thank you
Maggie Hayden
Executive Director, TMDA

Inside this issue:

State Survey Finding

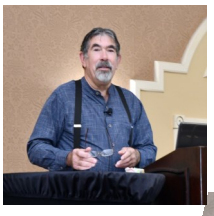
There was a recent finding by the state surveyors regarding use of insulin pens.

The surveyors determined that the nurses were not priming the insulin pens prior to each use


Dr. Fry


Dr. Bright wins a prize!


Dr. Belfi, Keynote


Dr. Smith


Dr. Soch


Dr. Taffett


Saturday Reception


Dr. Schillerstrom


Rev. Williams


Dr. Kvale

ask an EXPERT

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

I have an 84 y/o female with advanced dementia who is bed-bound with severe contractures in both lower extremities. Patient had been stable and on am rounds by the nurse was found to have pain and swelling in her knee and hip. X-ray found unilateral subcaptial hip fracture and distal femoral fracture. Patient had no history of osteoporosis nor history of fall or trauma. On my exam, she had no signs of trauma, showing no bruising or appearing afraid of the exam. She is minimally verbal and not able to express how her leg feels other than affirming pain.

Her MPOA did not want to send her to the hospital for further imaging or evaluation. How do you properly evaluate a patient who has a fracture of unknown origin and how do we report this to the state?

You have told us that your Resident had no history of osteoporosis but an eighty-four year old female, bed-bound with severe contractures has likely been relatively immobile and non-weight bearing for long enough to have high suspicion for poor bone density. If Caucasian, not obese, a past smoker, a history of sedentary lifestyle, prior steroid use, prolonged PPI use or phenytoin use then our suspicion should increase. Many or most of our Residents lack history of osteoporosis (even if prior radiographs had a report of the incidental finding of osteopenia).

You shared with us that x-rays showed fractures but not if osteopenia was reported by the radiologist. If he/she specifically commented that there is normal bone density then you may, in fact, have a case in which your Resident was intentionally or unintentionally mishandled and an investigation should begin. If the radiologist was silent on this issue then you should urgently request a second reading with comment on this issue.

If, as I suspect, the radiologist can opine that there is severe osteopenia then this most likely represents a case of minimum trauma fracture. The term occult fracture is to be avoided here as it means a fracture not visible on x-ray in the acute phase but is apparent later. Almost all minimum trauma fractures will generate allegations of malpractice and/or regulatory scrutiny even though this clinical problem is well described in the medical literature and is not uncommon. Kane, et. al. reported these fractures occur with an incidence of 0.84 per 100 Residents annually.

Your history of absence of other signs of trauma (bruising, guarding during examination) is excellent contributory evidence against mishandling or abuse though bleeding at the fracture and the later "surfacing" of a deep bruise might be possible without significant trauma from the exterior. The color of a bruise can help us estimate the time that blood has been extravasated into tissues and should be carefully observed and recorded.

Unless you lead a charmed life, you should anticipate family or their lawyer or a surveyor making accusations.

Good chart documentation could include a copy of one or more publications from a referenced journal concerning this condition. A search of the term, minimum trauma fractures, brings up "Minimum trauma fractures: lifting the specter of misconduct by identifying risk fractures and planning for prevention." Hommel E, Ghazi A, White H. JAMDA. 2012;13(2):180-6.

Recognizing Residents at high risk for osteoporotic fractures associated with falls or with ordinary care and care planning these would be far beyond the standard of care and be state of the art (but I bet you wish you'd done it). None of my charts have this but you may have scared me into it!

I'd make a self report to DADS of a significant injury but try to pre-empt criticism by diagnosing severe osteopenia and minimum trauma fractures and include the absence of external signs of trauma as well as relevant literature, just as you do in your charting. If you are treated unfairly, let TMDA know.

Bedside Manners
A Senior PsychCare Guide to Better Patient Communication

Submitted by Leo Borrell, MD

"I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug."
-Louise Lasagna

Introduction

In my opinion good bedside manners are the ultimate tool that a doctor has. They don't just make a doctor likeable but also transform the person into an effective and compassionate healer.

I know that it is very important to listen to what the patient has to say. Give them time to explain to me what they have been experiencing. This makes them feel cared for and special. This is how I expect to be treated by my doctor and so I give the same treatment to my patients!

It is very important to Smile and Make Eye Contact, this reassures the patient that you are really listening. One should not spend the limited time of the appointment viewing a computer screen or chart while they are trying to explain medical problems. It is unlikely that a patient's condition will improve if they believe the doctor does not care. Their trust on the doctor is what solves half the problem.

We are partners in the health care experience. Patients must feel comfortable asking questions. "Basic things make a difference in patient outcomes…" says Leonard S. Feldman, Assistant Professor of Medicine at John's Hopkins University School of Medicine. "These are things that matter to patients and are relatively easy to do."

In today's era, when the world has become a global village, people have to work on their attitudes. But there is one thing that hasn't changed at all, the art of medicine. The doctor has the power to either dispel your fears and to make you feel relieved, or feed your anxieties and fears.

"The secret to the care of the patient is in caring for the patient." The profession demands that all doctors have bedside manners and that they should be compassionate, supportive and humane. Good bedside manners can help doctors look likeable, but they also help to make a doctor become an effective healer. Most schools, in the race to prove their worth, forget that the world need is not more doctors, but more good doctors. Unfortunately, some professors and lecturers don't practice medicine and are laboratory scientists. Unintentionally, they transfer the lack of manners to their students. The doctors with impeccable communication skills are likely to do better at their jobs.

"Communication is the most important medical procedure that anyone in healthcare can do," says Maysel Kemp White, PhD, president and CEO of Healthcare Quality and Communication Improvement.

"Healthcare's focus on physical disease and bio-medicine is unbalanced. We need to pay much more attention to emotional, psychological, and spiritual wellbeing and the huge importance of healing relationships.

-Dr Robin Youngson

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The issue is to practice communication techniques. "Choose one new skill, and practice it consciously for five weeks" Kemp White says. "It will become part of who you are."

Jerome Groopman wrote, "The entire compassionate dimension of medicine, which is really key to the profession and which is so gratifying – all of that is threatened, severely threatened…"

87% of physicians who report erosion in enthusiasm for medicine (58% of 2,608 surveyed initially in the US) attribute this loss to the inhibition of empathic care (Zugar, 2004; Shanafelt, 2009). "What's in jeopardy in medicine – is the human connection between doctor and patient." The ancient Greeks were adamant "we should approach the patient with moderate steps – gazing calmly at the sick bed…"

To read the rest of this article please click HERE

AMDA INFO

Upcoming Webinar

October 24 (7:00pm-8:30pm Eastern)
Wound Care: Maximizing Quality While Controlling Cost
Speaker: Jeffrey M. Levine, MD

Webinar Fees:
AMDA Members: Free!
Non-Members: $99 (Not an AMDA member, join today!)

AMDA On-The-Go

Podcast Series

Episode 15: Optimistic Project

Episode 14: Management of LTC Residents with Diabetes

View All Episodes

2019 Save the Date

AMDA Annual Conference
March 7-10, 2019
Atlanta, Georgia
https://paltc.org/annual-conference

TexMed 2019
May 17-18, 2019
Dallas, Texas
https://www.texmed.org/TexMed/

AGS 2019
May 2-4, 2019
Portland, Oregon
http://meeting.americangeriatrics.org/

TGS/TMDA Annual Conference
August 9-11, 2019
Galveston, Texas
http://tgstmdaconference.org/

Meet the 2018-2019 TMDA Board of Directors

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