Newsletter for January 2019

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News from around our organizations and our members:

Your board will teleconference Wednesday January 16 at 5 PM; agenda items to Karen and President Ron now, please.

Save the Date: 2019 WAMD Annual Conference October 11-12, Radisson Hotel, Madison. The CME committee is working on another great line-up of topics and speakers. Thanks for all the suggestions.

We also need additional persons for the Wisconsin delegation at the House of Delegates at the AMDA meeting in March; express interest in involvement to Ron now, please.

Speak of AMDA-Atlanta, we will share a state chapter reception with Minnesota Friday, March 8; responses optional, but Ron would like to know who’s coming.

ANNUAL CONFERENCE
March 7 – 10, 2019
Hyatt Regency Atlanta

Event Website: https://paltc.org/annual-conference

Other News from around our state and our partners:

New opioid guidelines arrive not a moment too soon
Following my C-section earlier this year, I was fortunate to be able to access heavy-duty pain medication. Until we discovered my pain pump wasn’t working.

That was unfortunate, but luckily I was young(ish), in good health(ish) and had a new baby. But as AMDA – The Society for Post-Acute and Long-Term Care (PALT) Medicine President Cari Levy, M.D., Ph.D., recounts, many nursing home professionals have stories of people they’ve cared for who couldn’t access pain medication.

"Everybody has one of those in their brains, where the resident was suffering," she told me Thursday following the announcement of new guidelines from AMDA. “We had to get prescriptions faxed, and it was a weekend and there were all of these hurdles. That’s so unnecessary. That’s a lot of what drives the motion around it.

AMDA has two main goals with its new policies: One, “provide access to opioids when indicated to relieve suffering and to improve or maintain function” and two, “Promote opioid tapering, discontinuation and avoidance of opioids when the above goals are not achievable, to prevent adverse events, dependence and diversion.”

While it’s always been challenging to make sure nursing home residents receive the right amount of pain medication, the opioid epidemic has resulted in some states cracking down to a point that paralyzes effective pain management. Providers have to balance the responsibility to prevent theft of medications with making sure residents are not in pain.

“The epidemic of opioid addiction has affected every sector. That’s the most difficult thing,” said AMDA Executive Director Chris Laxton. “One of the federal responses to the opioid epidemic has been to restrict them. That has resulted in some of our residents who have been well managed to not get access to pain meds when they have needed them.”

He noted that states vary tremendously on rules, which can make it difficult for a national organization to give blanket guidelines.

“We would really like to see a more consistent approach from state to state,” he said.

Of course, how states manage opioids can often depend on how badly hit citizens have been by opioid addiction. In communities devastated by overdoses, it would follow that a clampdown on the drugs would result in perhaps overcorrection in nursing homes.

“Opioids are poorly understood,” Laxton said. “When people say, ‘We can’t ever use opioids,’ that’s not an appropriate approach to take.”

At the same time, AMDA and other organizations know drug diversion happens across all settings. Staffers have to be screened appropriately, and a “team-based” approach is needed to managing cases.

“Pain management is the poster child for team-based care,” Laxton says.

When discussing when opioids are appropriate, clinicians should look at side effects, Levy notes. For example, a resident may be very constipated, or immobile from the opioids. That might mean tapering the drug.

It all can feel like a lot to take in, which is why medical directors should appreciate AMDA’s work on the guidelines. There is no magic switch to better opioid management, but we can move forward.
• “I don’t think it will ever be possible to prevent 100 percent [of diversions], but we can do a better job,” Laxton said.
• On behalf of those coming out of surgery pressing their pain pump, we thank every provider who agrees.
If the hyperlink doesn’t open, go to https://paltc.org/opioids%20in%20nursing%20homes

From the Trenches- questions about the meaning of PA/LTC life

From time to time we survey the membership about medical director and attending physician practices. This is the sample list of questions for polling by Survey Monkey—reply to Karen Miller or myself if you have other questions that are yearning for answers, and we'll get it out in January.

For medical directors-
• CME? Yes or No
• # of buildings
• # of residents
• Hourly rate ($)
• Travel time/month?
• Call time/month?
• Paid for call?
• Satisfied?

For attending physicians-
• Certification?
• # of visits/month?
• # residents on service in a month?
• Paid salary, FFS, or blend?
• Travel time/month?
• Frequency of night call?
• Paid for call?
• Satisfied?

For NPs-
• Certified
• %FTE?
• # visits/FTE/month
• # residents on service/FTE/month
• Travel time/FTE/month
• Frequency of night call?
• Satisfied?

Other Reviews-publications from around the world of geriatrics and PA/LTC:

The Illness Is Bad Enough. The Hospital May Be Even Worse.
The elderly are particularly vulnerable to “post-hospital syndrome,” some experts believe, and that may be why so many patients return.
By Paula Span in the *New York Times* 3 August 2018

- When she moved from Michigan to be near her daughter in Cary, N.C., Bernadine Lewandowski insisted on renting an apartment five minutes away.
- Her daughter, Dona Jones, would have welcomed her mother into her own home, but “she’s always been very independent,” Ms. Jones said.
- Like most people in their 80s, Ms. Lewandowski contended with several chronic illnesses and took medication for osteoporosis, heart failure and pulmonary disease. Increasingly forgetful, she had been diagnosed with mild cognitive impairment. She used a cane for support as she walked around her apartment complex.
- Still, “she was trucking along just fine,” said her geriatrician, Dr. Maureen Dale. “Minor health issues here and there, but she was taking good care of herself.”
- But last September, Ms. Lewandowski entered a hospital after a compression fracture of her vertebra caused pain too intense to be managed at home. Over four days, she used nasal oxygen to help her breathe and received intravenous morphine for pain relief, later graduating to oxycodone tablets.
- Even after her discharge, the stress and disruptions of hospitalization — interrupted sleep, weight loss, mild delirium, deconditioning caused by days in bed — left her disoriented and weakened, a vulnerable state some researchers call “post-hospital syndrome.”
- They believe it underlies the stubbornly high rate of hospital readmissions among older patients. In 2016, about 18 percent of discharged Medicare beneficiaries returned to the hospital within 30 days, according to the federal Centers for Medicare and Medicaid Services.
- Ms. Lewandowski, for example, was back within three weeks. She had developed a pulmonary embolism, a blood clot in her lungs, probably resulting from inactivity. The clot exacerbated her heart failure, causing fluid buildup in her lungs and increased swelling in her legs. She also suffered another compression fracture.
- “These hospitalizations can lead to big life changes,” Dr. Dale said. Having grown too frail to live alone, Ms. Lewandowski, now 84, moved in with her daughter.
- Dr. Harlan Krumholz, a cardiologist at Yale University, coined the phrase “post-hospital syndrome” in a *New England Journal of Medicine* article in 2013.
- As Medicare began penalizing hospitals for 30-day readmissions under the Affordable Care Act, he looked at the national data and noticed that most readmissions involved conditions seemingly unrelated to the initial diagnoses.
- Patients came in with heart failure or pneumonia, were treated and discharged, then returned with internal bleeding or injuries from a fall.
- “Our general approach in a hospital is, all hands on deck to deal with the problem people come in with,” Dr. Krumholz said. “All the other discomforts are seen as a minor inconvenience.”
- He has argued instead that discharge marks the start of a 60- to 90-day period of increased vulnerability to a range of other health problems, stemming from the stress of hospitalization itself.
- “This is more than inconvenience,” he said. “This is toxic. It’s detrimental to people’s recovery.”
- Any hospital patient, or hovering family member, knows those stresses: Disrupted sleep, as staff draw blood and take vital signs at 4 a.m. A distorted sense of day and night. Unappetizing meals often served at inopportune times.
- Reduced muscle mass and poor balance following even a few days in bed. New prescriptions with unpredictable consequences. Shared rooms. Delirium. Pain.
“It affects your hormones, your metabolism, your immune system,” Dr. Krumholz said. “All these things have widespread effects,” leaving people depleted and less able to stave off other health threats.

The ripple effects vary considerably.

Researchers at Yale followed discharged Medicare patients after hospitalizations for heart failure, heart attacks and pneumonia.

Readmissions for gastrointestinal bleeding and anemia, they found, peaked four to 10 days after discharge. The risk of trauma from falls or other accidents, on the other hand, remained elevated for three to five weeks.

While post-hospital syndrome remains a hypothesis for now, research on several fronts may help establish its validity.

Donald Edmondson, a behavioral medicine researcher at Columbia University Medical Center, has pointed out links between the stress levels that heart attack victims report and their likelihood of readmission.

In a meta-analysis, he and his colleagues found that 12 to 16 percent of heart attack patients, most of them older adults, actually develop post-traumatic stress syndrome.

As Dr. Edmondson acknowledged, people experiencing heart attacks have multiple sources of stress, from fear of death to financial worries. But he and his colleagues also have measured the impact of the hospital environment itself. They compared patients (average age: 63) who came to the New York-Presbyterian Hospital emergency room when it was crowded and chaotic (median time in a crowded ER: 11 hours) to those who arrived when it was calmer.

“The more crowded it is when you come in, the more PTSD symptoms you’ll have a month later,” he concluded.

Now the Columbia researchers are following 1,000 E.R. patients with heart attacks, tracking their weight and stress levels and giving each a wearable device to measure physical activity and sleep. The results may help substantiate the effects of post-hospital syndrome.

“We’ve gotten better and better at treating disorders, but we haven’t gotten to the point where we avoid some of the collateral damage to the patient,” Dr. Edmondson said.

Making hospitals less destabilizing, more conducive to healing, seems an achievable goal. Hospitals do it for children, Dr. Krumholz has pointed out.

They could enable older patients, too, to wear their own clothes, get out of bed for walks (even with IV poles), eat enough to maintain their weight. They could assess how many lab tests patients actually need, and whether blood needs to be drawn before dawn.

“We should never wake a sleeping patient unless there’s a compelling reason, and that reason shouldn’t be our own convenience,” Dr. Krumholz said.

But while we’re waiting for hospitals to adopt such policies, we could try a D.I.Y. approach.

Families can bring in favorite foods and help their relatives eat. They can ensure that patients have their hearing aids, dentures, eyeglasses, and walkers or canes to help them stay oriented and mobile.

With a physician’s O.K., they can accompany relatives on short strolls down the corridor to ward off deconditioning, and ask about curtailing wee-hour tests and readings.

“It’s unfair to put families in this position,” Dr. Krumholz said. “It should come from the institution.” But cultural change takes time.
Some hospitals already offer less stressful environments for older patients, including specialized geriatric emergency rooms.

Among those moving in that direction is the University of North Carolina Hospitals Hillsborough Campus, where Bernadine Lewandowski had a private room, as all its geriatrics patients do. She was helped into a chair every day and encouraged to use a walker to reach her bathroom.

The aftereffects proved profound, nonetheless. Already thin, she lost 15 pounds over two months. After her second hospitalization, she began wandering at night, apparently because of a new pain medication, and fell twice in two days. In April, she developed pneumonia, necessitating a third hospital stay.

She’s doing better now, her daughter said. After physical therapy, Ms. Lewandowski can climb the stairs, with someone at her elbow, to her second-floor room. Her weight has stabilized. She enjoys spending time with her family and visiting the hair salon every other week.

But, Ms. Jones said, “We were hoping she’d be with us for a short period and then return to her apartment.” And that never happened.

I try to not get too speculative about the future, but this article [https://www.nejm.org/doi/full/10.1056/NEJMp1808427](https://www.nejm.org/doi/full/10.1056/NEJMp1808427) does outline a potentially different role for the long-term care specialist in the MACRA era of healthcare reform; let me know if you need help getting full text.

**Reflections**
The Wis-PALTCM Mission Statement

It will be the purpose of this organization:

- To promote quality and compassionate medical care for patients of all ages in post-acute and long-term care.
- To establish better communication among physicians serving as medical directors and other providers.
- To promote better communication between medical directors and (a) other post-acute and long-term care professionals, (b) various long-term care associations, and (c) officials of various government agencies.
- To represent medical directors in defining their roles and equitable compensation.
- To serve as a conduit between AMDA and the WAMD membership.
- To conduct continuing education programs, emphasizing the area of geriatrics and post-acute and long-term care.
- To promote a better understanding by the public of issues concerning the post-acute and long-term care facilities and residents.
- To support evidence-based treatments and best practice policies to manage post-acute and long-term care facilities