Newsletter for February 2019

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News from around our organizations and our members:

Your board teleconferenced Wednesday January 16 at 5 PM:

- The financial position of the organization remains sound, although running a little shop like ours remains challenging. In particular, we are again investigating the cost of maintaining CME accreditation, preferring to do our own thing if it's practical. The purchase of other contracted services is always a potential issue as well.
- The membership of the organization remains sound, although we obviously compete for loyalty with a number of others. The best way for us to grow is your recommendation to other LTC professionals.
- Brian Purtell has accepted appointment to our board representing WHCA/WiCAL (succeeding Cliff Woolever).
- President Ron has been invited to a resumed schedule of Provider-Advocates-DQA meetings in Madison.
- While the structure and content of our 2018 annual meeting is set, and the program will start being shown in a couple months, the board decided it was time to poll the membership as a whole on preferences for how the meeting is done. Survey links to that and the other semi-annual surveys are below.

Event Website: https://paltc.org/annual-conference
President Ron Schreiber will lead the Wisconsin delegation to the AMDA House of Delegates, which will also include Paula Hardgrove, Raul Mateo, Curt Hancock and Rex Flygt.

We will again share a state chapter reception with Minnesota Friday March 1; RSVP optional, but President Ron would like to know who’s coming.

And, of course, save the date for our annual meeting October 11-12 at the Radisson in Madison!

**Other News**- from around our state and our partners:

All members who are medical directors should take this survey-
- [https://www.surveymonkey.com/r/FWV9PVX](https://www.surveymonkey.com/r/FWV9PVX)

All physician members who attend patients should take this survey-
- [https://www.surveymonkey.com/r/FJQZKTC](https://www.surveymonkey.com/r/FJQZKTC)

All non-physician providers who attend patients should take this survey-
- [https://www.surveymonkey.com/r/F73HS78](https://www.surveymonkey.com/r/F73HS78)

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

International Dysphagia Diet Standardization Initiative (IDDSI) is Coming

Bureau of Education Services and Technology

What is IDDSI?

The International Dysphagia Diet Standardization Initiative (IDDSI) is a global standard with terminology and definitions to describe texture modified foods and thickened liquids used for individuals with dysphagia of all ages, in all care settings, and for all cultures. The overriding goal of IDDSI is around **patient safety**.

Complications IDDSI Addresses

Multiple labels and definitions cause confusion. Think about locations you’ve visited and even the labels and definitions that you’ve used to describe food textures and thickened liquids. Often, because labels for dysphagia diets have varied so greatly, an individual who is transferred from an acute care hospital to a long-term care facility, which may be across the street, needs to be reassessed because the dysphagia diet terms are different in the two facilities.

One commercial product is not the same as another commercial product. IDDSI examined many samples and recipes from manufacturers and the products varied significantly. This causes great confusion for caregivers and individuals with dysphagia.

**IDDSI Launch Date**

In December, the Academy of Nutrition and Dietetics and the American Speech-Language-Hearing Association (ASHA) announced their support of May 1, 2019, as the official launch date for IDDSI implementation in the U.S. Keep in mind that this is the “launch date.” The rumor mill has begun and is indicating this to be the complete implementation date for IDDSI, which is **not** the case. The Academy and ASHA recognize that IDDSI implementation will take time and effort and are fully committed to supporting their members through the transition. Members are encouraged to frequently check Eat Right PRO and ASHA for additional educational opportunities and resources.

**Additional Resources**

Everyone is encouraged to go to the official website for IDDSI and explore all of the resources. There are presentations available to help raise awareness and educate staff in your facility about IDDSI. You can sign up to be kept informed of future IDDSI developments under the “Contact Us” tab.

If you have any additional questions, please contact: Vickie Bergquist, MS, RDN, CD, at 414-313-9557 or by email.

**References**

Academy of Nutrition and Dietetics – Start Date for U.S. Implementation of IDDSI Announced

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**Other Reviews** - publications from around the world of geriatrics and PA/LTC
In the Nursing Home, Empty Beds and Quiet Halls
Fewer patients are winding up in nursing homes, and hundreds of the facilities are closing each year.
By Paula Span in the New York Times 28 September 2018

• For more than 40 years, Morningside Ministries operated a nursing home in San Antonio, caring for as many as 113 elderly residents. The facility, called Chandler Estate, added a small independent living building in the 1980s and an even smaller assisted living center in the 90s, all on the same four-acre campus.

• The whole complex stands empty now. Like many skilled nursing facilities in recent years, Chandler Estate had seen its occupancy rate drop.

• “Every year, it seemed a little worse,” said Patrick Crump, chief executive of the nonprofit organization, supported by several Protestant groups. “We were running at about 80 percent.”

• Staff at the Chandler Estate took pride in its five-star rating on Medicare’s Nursing Home Compare website. But by the time the board of directors decided it had to close the property, only 80 of its beds were occupied, about 70 percent.

• Revenue from independent and assisted living couldn’t compensate for the losses incurred by the nursing home.

• In February, the last resident was moved out. Morningside Ministries operates two other retirement communities in the San Antonio area; they took in the independent living and assisted living residents and about 30 nursing home patients, absorbing most of the staff as well.

• But more than 40 older people had to relocate to other nursing facilities or move out of town closer to family, and 30 staff members lost their jobs.

• “There was some real sadness, tears, frustration,” Mr. Crump said. “It’s hard knowing you won’t be providing services to those older folks.”

• At least the organization has the cold comfort of knowing that nursing homes across the country are grappling with the same problem.

• The most recent quarterly survey from the National Investment Center for Seniors Housing and Care reported that nearly one nursing home bed in five now goes unused.

• Occupancy has reached 81.7 percent, the lowest level since the research organization began tracking this data in 2011, when it was nearly 87 percent.

• “It’s a significant drop,” said Bill Kauffman, senior principal at the center. “The industry as a whole is under pressure, and some operators are having difficulty.”

• Such national statistics mask considerable local differences.

• “The best facilities still have 100 percent occupancy and waiting lists — that’s how you know they’re good,” said Nicholas Castle, a health policy researcher at the University of Pittsburgh.

• But in 2015, the National Center for Health Statistics reported that more than a third of beds were empty in some states, including Illinois, Iowa, Nebraska, Oklahoma and Utah. Texas wasn’t far behind.

• Nationally, “200 to 300 nursing homes close each year,” Dr. Castle said. The number of residents keeps shrinking, too, from 1.48 million in 2000 to 1.36 million in 2015, according to federal data.
Given an aging population, you’d think nursing homes would be coping with the opposite problem — surging demand for their services.

But they also face growing financial strains and regulatory requirements intended to control costs, Mr. Kauffman pointed out.

Under the Affordable Care Act, for instance, hospitals face financial penalties for readmissions, and some have responded by designating patients as “under observation,” rather than admitting them as inpatients. After discharge, Medicare won’t cover skilled nursing care for these patients.

(Generally, Medicare pays for short-term rehabilitative care in nursing homes following a hospital stay; however, Medicaid, administered by the states, covers long-term care.)

Moreover, “certain surgeries are migrating from inpatient to outpatient surgical centers,” Mr. Kauffman said. Medicare won’t cover skilled nursing for those patients, either.

The growth of Medicare Advantage plans, which now cover a third of Medicare beneficiaries, also plays a role.

“They have a keen interest in lowering costs, so maybe they divert people from skilled nursing to home care,” Mr. Kauffman said. “If you do go to a nursing facility, instead of a 30-day stay, maybe the plan wants the patient out in 17 days.”

At the same time, nursing homes face stiffening competition. As their operators sometimes say themselves, they’re selling a product nobody wants to buy.

“You have increased alternatives, like assisted living, and other ways for people to stay at home,” said Ruth Katz, senior vice president of public policy at Leading Age, which represents nonprofit senior service providers. “When people find community alternatives, they use them whenever possible.”

Federal policy has helped propel this shift. For years, advocates protested that Medicaid covered care in nursing homes but not in the places people much preferred to live. Congress paid attention and passed legislation in 2005.

Thirty years ago, 90 percent of Medicaid dollars for long-term care flowed to institutions and only 10 percent to home- and community-based services. Now, the proportions have flipped, and nursing homes get only 43 percent of Medicaid’s long-term care expenditures.

A report from the federal Government Accountability Office earlier this year pointed out, for example, that Medicaid covers assisted living for 330,000 people. A demonstration program called Money Follows the Person has moved more than 75,000 residents out of nursing homes and back into community settings.

It’s good news for consumers — but not so good for nursing homes. The 31 largest metropolitan markets have 13,586 fewer nursing home beds now than in late 2005, the investment center reports.

This could prove a temporary crisis. When the baby boomers enter their 80s and need residential care, occupancy could pick up again.

Even now, nursing homes can turn a profit with lower occupancy by attracting more patients for short-term rehab. Medicare reimburses for those stays at higher rates than Medicaid pays for long-term care. (About 80 percent of American nursing homes are for-profit.)
Facilities are bracing for some tough years ahead, nonetheless. In casting about for additional revenue, they're trying tactics like opening pharmacies and home care agencies, and accepting sicker patients, including those on ventilators, at higher reimbursement rates.

They're experimenting with 12-hour staff shifts, allowing them to hire fewer employees but offer more flexible schedules. Some may convert shared rooms to private ones, a popular move with residents.

Whether emptier and fewer nursing homes benefit older adults and their families remains an open question. On the plus side, people have more choices when they need help, a long-sought goal, said Robyn Grant, director of public policy and advocacy for the National Consumer Voice for Quality Long-Term Care.

“You no longer have to go to a nursing home because it's the only game in town,” she said.

But what about those who already live in nursing homes, or will move in over the coming years, because they need the round-the-clock supervision no other kind of facility offers?

“From what I've observed, as occupancy goes down, so will staff levels,” Ms. Grant said. With most nursing home staffs already stretched too thin, that could hurt.

Despite extensive federal regulations, including new rules adopted in the waning months of the Obama administration, nursing homes have no federal minimum staffing requirements (though some states have requirements).

“You can cut with impunity,” Ms. Grant said, and with financial pressures mounting, she worries that facilities will.

So families with relatives in nursing homes might want to pay particular attention. If occupancy falls, maybe your loved one gets a private room. Or maybe the call button takes even longer to answer.

The new federal rules require more accurate staffing information posted on Nursing Home Compare, using time-cards rather than facilities' self-reports. That's one way families can keep tabs on how empty beds may affect care.

“Monitor the data,” was Ms. Grant's recommendation. “Talk to staff and residents. Definitely keep an eye out.”

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

Wis-PALTCM: The Wisconsin Association of Medical Directors

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