Newsletter for April 2019

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News from around our organizations and our members:

President Ron Schreiber led the Wisconsin delegation to the AMDA House of Delegates, which also included Paula Hardgrove, Raul Mateo, Curt Hancock and Rex Flygt (pictured below). We considered seven resolutions-two were passed to the Board of Directors, and two were referred to the Board of Directors for analysis and re-direction.

- A19-a white paper on “Stopping eating and drinking by advance directive (SED by AD) in the ALF and PALTC settings” passed. For full text go to https://paltc.org/sites/default/files/A19-WHITE%20PAPER-SED%20AD%20Ethics%20Committee%20White%20Paper%20HOD%20submission.pdf
  This is a very careful review worth your time to read.

- D19-dealt with the studying impact of medical direction on quality outcomes; this was referred to the board

- E19-dealt with two separate issues, 1) recognizing (again) medical director’s compensation is for direction, not referrals to the facility, but also 2) requiring CMS to maintain a list of medical directors. That resolution was divided; both passed, with a lot of moaning and groaning about how little is likely to be accomplished.

- F19-dealt with permitting medical direction by telecommunication technology; this was referred to the board

We again shared a state chapter reception with Minnesota Friday March 8 starting at 6:30 PM; a good time was had by all, mostly.
Irene Hamrick from the UW and a previous WIS-PALTCM officer and director received honorable mention in the poster competition for an article she’s published in JAMDA (see below); she also presented “SNF Five-Star Quality Metrics 101”

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

President Schreiber will be attending the state DQA meeting on Tuesday, April 16th.

Other News-from around our state and our partners:

Our president Ron Schreiber provided this letter in lieu of testimony to the state senate, after testifying before the assembly:
Wisconsin Medical Directors Support Assembly Bill 76 and Senate Bill 103

"Chairman Testin and Members of the Senate Health and Human Services Committee, my name is Dr. Ronald Schreiber, MD, CMD. I am from Appleton and serve as the President of the Wisconsin Society for Post-Acute and Long-Term Care Medicine, also known as the Wisconsin Association of Medical Directors (WAMD). I have been a practicing physician in Wisconsin for more than 25 years. I am Board Certified in Internal Medicine, and am a Certified Medical Director, through the American Medical Directors Association. I serve in the Appleton-Neenah-Menasha area at several skilled nursing facilities."
Thank you for the opportunity to provide written testimony in support of Assembly Bill 76 and Senate Bill 103, which would ensure that the training standards for Certified Nursing Assistants (CNAs) in Wisconsin mirror the federal CNA training standards.

CNAs are a vital component of the post-acute (post-hospital) and long-term care continuum. We as a society must recognize this, and must encourage growth in this field, especially as our population ages at historic rates. Unfortunately, Wisconsin’s shortage of CNAs is worsening over time. We must best prepare for the future to ensure quality care for our aging population.

WAMD recognizes that current state requirements put us at a competitive disadvantage in recruiting CNAs compared to our neighboring states of Minnesota, Iowa, and Michigan, which adhere to federal guidelines. WAMD requests that this be rectified through this important legislation.

The reality is that facilities are largely regulated on the basis of federal regulations. In fact, the Centers for Medicare and Medicaid Services (CMS) just a few years ago went through a significant overhaul of the Requirements of Participation governing facilities participating in the Medicaid program, and the federal CNA training standard of 75 hours was not adjusted in any way. Medical Directors who serve in Wisconsin’s skilled nursing facilities across the state – professionals who ensure that quality care is being delivered to the residents that we serve – believe that putting CNA certification standards in line with the federal government establishes consistency of the standards by which long-term and post-acute care facilities are measured and evaluated.

While some may attempt to make this issue about quality of care, in fact, there is actually very little in the medical literature regarding number of training hours as related to quality measures. What data we do have comes from the CMS website Medicare.gov in terms of nursing home ratings. In Wisconsin, 36% of nursing homes rate as "much above average" (5 star), compared to a range of 36-39% for Minnesota, Iowa, and Michigan. Those ranked "much below average" (1-star) are 9% in Wisconsin, and 5-9% in our bordering states. There is no statistical difference between Wisconsin and our neighbors. Although the five-star rating system does not focus on CNA work exclusively, their level of care and competence certainly affects a facility’s rating. Our neighboring states do not suffer in the CMS star rating as a result of their federally-aligned CNA training.

It is important to note several items about this legislation: the bill does not alter testing/competency requirements – all CNAs have to pass the same test regardless of how many hours are in their training program. All required core competencies for CNAs will be covered following passage of this legislation.
This legislation does not limit the ability of programs to offer CNA training classes with higher hours, which some programs may elect to do; it only affects whether the Department of Health Services is able to require a program to offer training above the federal level.

Thank you for your attention to this matter. I am happy to answer any questions that you may have about WAMD’s support for this important legislation that deserves your support.”

Ronald Schreiber, MD, CMD
President, Wisconsin Association of Medical Directors

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

“Things I thought I heard at AMDA”

o Have you looked at the New York “algorithm for the unbefriended”? —an estimated 3 to 4 percent of long-stay residents have no proxy decision-maker.

o Autonomy is the experience of authorship of behavior, not simply the experience of noninterference.

o How much do you understand about the new PDPM (patient driven payment model), including the role in non-case mix basal rate, and front end load?

o PDPM will replace payment therapy with payment management of complexity as the touchstone of post-acute medicine. The biggest thing that’s happened since the BBA of 1997, which led to the last big wave of bankruptcies in long-term care.

o AMDA is working on a marijuana clinical practice guideline; they say they’re not, but you know they must be.

o There is a lot of congressional interest in resolving the surprising billing complications of observation; the solution to the three-night rule might get bundled into that, but don’t hold your breath.

o Probably regretfully, the nursing home quality measures are not physician quality measures.

o No one gets participation trophies in long-term care. Do we need a state medical director of the year award, or a young medical director of the year award?

o What would you say to this: “This is why I came to post-acute/long-term care… This is why I stay…."

o I can’t—we can.

o After adequate compensation, professional satisfaction is about autonomy, mastery, and purpose—which is why PA/LTC providers tend to stay in the business.
Providers really don’t want to be paid for call: They want no meaningless call.

Adequate nurse triage upgrades the work done by provider…. Strong nurse triage can stop 80% of calls and organize work more productively.

Why do you need to be notified for the sake of notification along? The bar should be at notification that asks you to do something.

Recruitment Retention Productivity

Telemedicine is among the interventions that probably reduce readmissions, although deployment of the Interact tools is better-evidenced.

Do you have online access to the AMDA guidelines? Why not?

Do you know how to evaluate and treat the Krumholz post-hospital syndrome?

Heart failure increases the risk of readmission by 50%, but furosemide will not fix two of the three conditions the HFpEF (heart failure with preserved ejection fraction) patient will be readmitted for.

In other words, since HFpEF really isn’t a “heart” problem, you have to manage the complications (including complications of therapy) and the comorbid conditions.

Thirty-day readmission is now the key quality indicator (“it’s about the economy, stupid”); functional capacity and percent discharge home should be.

Do you know what’s in section GG of the MDS?

Do you have the provider resilience app on your phone? What’s the equivalent, in self-maintenance, to singing happy birthday while hand washing?

Working with your specialty society can help prevent “lone ranger” isolation at work.

The real touchstone about “avoidability”, suggests Crecelius, is not the nature and scope of the intervention at the change in condition, but identifying and treatment what is reversible before the change in condition.

The PA/LTC workforce is small and aging. Nurture it. --Of the 37 certified medical directors in Wisconsin, more than half plan to reduce or discontinue practice in the next five years; this parallels, of course, other reports that a similar proportion of Wisconsin physicians plan to cut back on clinic time or duties due to the more and more burdensome “administrative load” on the same timeline.

Speaking of administrative load, coding has become more and more complex, although there are proposals on the table to make things simpler to bill (even if service is more complicated). For more info, go to https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlngeninfo/index.html.

Nursing home physicians remain relatively immune from professional liability claims, but not so facilities.
If you haven’t read the AMDA white paper on “SED by AD” (Stopping eating and drinking by advance directive), do so (citation above)

Silos continue to harden and separate and the hospital remains best funded silo.

Only the long-term care medical director is looking beyond the door, realizing we care for populations and not sites of service.

Should a provider-provider handoff at the transition of care be a quality measure?

Firm touch pharmacy review reduces high impact medication errors at the transition of care.

There is plenty of consternation with the electronic medical record nationwide. You are not alone.

Here’s a script for you: “I’m not sure I understand what you’re saying: Do the SBAR and I’ll call you back…”

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

Transitioning from Insulin to DDP-4 Inhibitors for Type 2 Diabetes
by I. Hamrick, MD, M. Goblirsch, BS; and W.-J. Tuan, MS (University of Wisconsin)

“Introduction: Dipeptidyl-peptidase 4 (DPP-4) inhibitors are a relatively new treatment regimen for Type II Diabetes Mellitus (T2DM) and are associated with less hypoglycemia than insulin. There are no published data regarding the effects of these drugs on insulin therapy. This case series presents findings from a cohort of older adults on insulin who received DPP-4 treatment with the intention of discontinuing insulin, if possible. Using data from electronic health records, we reviewed all residents in nursing homes with T2DM who were on insulin and started on DPP-4 inhibitors. We tapered insulin dosages when finger stick blood glucose levels were <200mg/dL and noted when insulin treatment was stopped altogether. …

Conclusion: More than half (59%) of patients were able to transition off insulin therapy onto DPP-4 inhibitors with subsequent improvement in weight by 4.1 pounds and HgA1c by 1%. These findings suggest that DPP-4 inhibitors provide a new care option in the treatment of Type II Diabetes Mellitus in older nursing home patients and can be used to transition patients off insulin therapy. Because it may take several months, patience and close monitoring is required to succeed. This report provides a starting point for larger studies to confirm our findings and develop a protocol for transitioning patients.”

For full text go to https://doi.org/10.1016/J.JAMDA.2019.01.054

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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