Newsletter for May 2019

Ron Schreiber, MD, CMD, president 1707ron@gmail.com
Bob Smith, MD, CMD, immediate past-president rpsmith53@icloud.com
Curt Hancock, MD, CMD, webmaster cwhancock@gmail.com
T Rex Flygt, MD, CMD, newsletter editor Flygt@centurytel.net
Karen Miller, Executive Assistant KarenMiller.Rio@gmail.com

News: from around our organizations and our members:

Your society’s board of directors teleconferenced April 11; issues addressed included:
- The financial report, which is regretfully incomplete for 2018;
- Which CME accreditation entity to use for the educational program at the annual meeting—it’s about money;
- Follow-up on the white paper and resolutions from the AMDA meeting;
- General satisfaction with the jointly-hosted reception at the AMDA meeting;
- Preliminary approval of an AMDA foundation contribution for 2020;
- President Ron S’s testimony in the legislature on the CNA training requirement described in last month’s issue;
- Finalizing the program for our October meeting’s educational program;
- Reviewing the survey on preferences about the October meeting’s educational features;
- The proposed retirement of our dedicated executive assistant!
- Next teleconference Wednesday July 17th at 5:15 PM.

Save the date for our annual meeting October 11-12 2019 at the Radisson in Madison

Save the date for the DQA’s annual FOCUS conference for providers and DQA staff November 20-21 at the Kalahari in Wisconsin Dells. This year’s special session will is “Let’s Talk About It: Topics Too Important to Ignore”
including sexual expression, abuse and resident rights—Teepa Snow will deliver the keynote address “Dementia 360”

Save the date for AMDA’s annual meeting April 2-5 2020 at the Hyatt Regency in Chicago

Other News—from around our state and our partners (in this case, the Wisconsin Quality Coalition of Metastar): Useful “big data” benchmarking information you can’t find anywhere else

This slide shows we are close to our neighbors in antipsychotic use, and decreasing that at a reasonable rate

<table>
<thead>
<tr>
<th>State</th>
<th>Quality Innovation Network</th>
<th>13-Dec</th>
<th>18-Jun</th>
<th>RIR</th>
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<tr>
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October 1, 2017 – September 30, 2018
Goal 15 percent Relative Improvement Rate

This slide is hard to follow, but shows we’re close to our neighbors in reducing antipsychotic use, but will probably never get to zero.
This slide suggests more Wisconsin homes are “above average” than our neighbors; you are probably unfamiliar with this composite score, based on quality indicators, which seems more useful to Metastar than those of us in the business.

### Composite Score

**April 1, 2015 – September 30, 2018**

Cumulative percent of National Nursing Home Quality Care Collaborative (NNHQCC) Homes with score less than or equal to 6.00

**Goal:** 50 percent of NHs

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<th>Wisconsin</th>
<th>Minnesota</th>
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<td></td>
<td>76.3%</td>
<td>64.2%</td>
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And here’s some stuff you didn’t know about Clostridium difficile infection.

**CDI Initiative Baseline Data**

For the time period from January to December 2017

- 1,439,250 resident days
- Infection rate: **0.58 /10,000 resident days**
  - Michigan: 0.71/10,000 resident days
  - Minnesota: 0.97/10,000 resident days
  - National: 0.69/10,000 resident days
  - In comparison, the 2016 rate for hospitalized patients: 7.59/10,000 patient days

**2018**

- Due to lower baseline rate, we set modest goal of five percent reduction of CDI
  - 1,621,171 resident days
  - Infection rate: 0.471 /10,000 resident days
  - 19 percent reduction (exceeded goal)
If you’re interested in getting more information from Metastar, contact jgile@metastar.com for a list of their products and resources; they’re really there to help, and never to punish!

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

We tried to survey the membership as attendings, directors, and non-physician providers, but the response rate for the latter two was too low to report-

- Two-thirds of our responds report certification in family medicine, one-third in internal medicine.
- The median number of visits was between 50 and 100, although the median number of residents on service was 50.
- A super-majority of respondents said their attending physician work was salaried.
- The question on call was not well-phrased; no one reported being paid for taking call.
- Only a bare majority reported being satisfied or very satisfied with their role as an attending.

I need to work the questions out better; let’s do this again in January.

**Other Reviews** - publications from around the world of geriatrics and PA/LTC
THE NEW OLD AGE: Assisted Living—Where There’s Rarely a Doctor in the House

As residents become older and more frail, some facilities are bringing in doctors and nurses instead of relying on 911.

By Paula Span in the New York Times March 29, 2019

The patient moved into a large assisted living facility in Raleigh, N.C., in 2003. She was younger than most residents, just 73, but her daughter thought it a safer option than remaining in her own home.

The woman had been falling so frequently that “she was ending up in the emergency room almost every month,” said Dr. Shohreh Taavoni, the internist who became her primary care physician.

“She didn’t know why she was falling. She didn’t feel dizzy — she’d just find herself on the floor.” At least in a facility, her daughter told Dr. Taavoni, people would be around to help.

As the falls continued, two more in her first three months in assisted living, administrators followed the policy most such communities use: The staff called an ambulance to take the resident to the emergency room.

There, “they would do a CT scan and some blood work,” Dr. Taavoni said. “Everything was O.K., so they’d send her back.”

Such ping-ponging occurs commonly in the nation’s nearly 30,000 assisted living facilities, a catchall category that includes everything from small family-operated homes to campuses owned by national chains.

It’s an expensive, disruptive response to problems that often could be handled in the building, if health care professionals were more available to assess residents and provide treatment when needed.

But most assisted living facilities have no doctors on site or on call; only about half have nurses on staff or on call. Thus, many symptoms trigger a trip to an outside doctor or, in too many cases, an ambulance ride, perhaps followed by a hospital stay.

Twenty years after the initial boom in assisted living — which now houses more than 800,000 people — that approach may be shifting.

Early on, assisted living companies planned to serve fairly healthy retirees, offering meals, social activities and freedom from home maintenance and housekeeping — the so-called hospitality model.

But from the start, the assisted living population was older and sicker than expected. Now, most residents are over age 85, according to government data. About two-thirds need help with bathing, half with dressing, 20 percent with eating.
Like most older Americans, they also generally contend with chronic illnesses and take long lists of prescription drugs — and more than 80 percent need help taking them correctly.

Moreover, “these places became the primary residential setting for people with dementia,” said Sheryl Zimmerman, an expert on assisted living at the University of North Carolina at Chapel Hill.

About 70 percent of residents have some degree of cognitive impairment, her studies have found. So residents can find it difficult to coordinate medical appointments and tests, and to travel to offices and labs, even when facilities provide a van.

“The assisted living industry has to recognize that the model of residents going out to see their own doctors hasn’t worked for a long time,” said Christopher Laxton, executive director of AMDA, a society that represents health care professionals in nursing homes and assisted living.

His recent editorial in McKnight’s Senior Living, an industry publication, was pointedly headlined: “It’s time we integrate medical care into assisted living.” AMDA is considering developing model agreements.

“There has to be more attention to medical and mental health care in assisted living,” Dr. Zimmerman agreed. “Does everyone who falls really need to go to an emergency department?”

Lindsay Schwartz, an executive at the National Center for Assisted Living, a trade association, said in an email that “assisted living has certainly expanded its role in providing medical care over the years by adding nursing staff and partnering with other health care providers, among other ways.”

But persuading most operators to provide medical care likely won’t happen without a fight. They’ve built their marketing strategies on looking and feeling different from the dreaded nursing home, and they object to “medicalizing” their communities.

“They don’t want the liability,” said Dr. Alan Kronhaus, an internist who, with Dr. Taavoni (they are married), started a practice called Doctors Making Housecalls in 2002.

The facilities also “live in mortal fear of bringing down heavy-handed federal regulation,” he said. That can happen when Medicare and Medicaid, which cover most residents’ health care, get involved.

Doctors Making Housecalls provides one example of how assisted living can offer medical care. The practice dispatches 120 clinicians — 60 doctors, plus nurse-practitioners, physician assistants and social workers — to about 400 assisted living facilities in North Carolina.

“We see patients often, at length and in detail, to keep them on an even keel,” Dr. Kronhaus said. By contracting with labs, imaging companies and pharmacies, the
practice can provide most of the medical care for more than 8,000 residents, on site and around the clock.

Working with a local emergency medical service, he and his colleagues reported in a 2017 study that the practice could reduce emergency room transfers by two-thirds.

The Lott Assisted Living Residence in Manhattan, on the other hand, relies on a single geriatrician, Dr. Alec Pruchnicki, to provide medical care for most of its 127 or so residents.

If they’re feeling sick, a family member calls or the resident just knocks on the door of “Dr. P’s” basement office. “Sometimes it’s just a cold — chicken soup,” Dr. Pruchnicki said. “But this winter we had a few cases of flu and pneumonia, things you need to treat.”

Nearby Mount Sinai Hospital employs him and provides emergency services when needed. Often, they’re not. In 2005, Dr. Pruchnicki reported at medical conferences, he decreased hospitalizations by a third. “I can’t be in the only place in the country where this would work,” he said.

Spending time in emergency rooms and hospitals often takes a toll on residents, even if their ailments can be treated. They get exposed to infections and develop delirium; they lose strength from days spent in bed.

Perhaps that contributes to short stays in assisted living. Adult children often see these facilities as their parents’ final homes, but residents stay just 27 months on average, after which many move on to nursing homes.

Adding doctors to assisted living could also cause problems, advocates acknowledge; in particular, it might increase the already high fees facilities charge.

But something has clearly got to give. “There can be health care in assisted living without making it feel like a nursing home,” Dr. Zimmerman said.

Family members tell of frightened and confused residents arriving unaccompanied at emergency rooms, unable to give clear accounts of their problems. Dr. Kronhaus recalls a resident with dementia taken to the local E.R. by ambulance; discharged, she was sent home by taxi. The address she gave the driver was her former home, where neighbors spotted her and called the police.

By contrast, the North Carolina woman with a history of falls is doing well.

Dr. Taavoni discovered that her hypertension medications were causing such low blood pressure that she fainted. Reducing the dose and discontinuing a diuretic, Dr. Taavoni also weaned the patient off an anti-anxiety drug she suspected was causing problems, substituting a low dose of an antidepressant instead.

The falls and the related emergency room visits stopped. Doctors Making Housecalls is still caring for her, and for most of the neighbors in her assisted living facility.
**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
www.wamd.org 5329 Fayette Ave., Madison, WI 53713