Newsletter for January 2020

Kristin Severson, DO, FACOI, CMD, President monkeyboymomma@yahoo.com
Paula Hardgrove, MD, MPH, CMD, President-elect paulahardgrove@gmail.com
Ron Schreiber, MD, CMD, Immediate past-resident 1707ron@gmail.com
Curt Hancock, MD, CMD, Webmaster cwhancock@gmail.com
T Rex Flygt, MD, MA, FACP, CMD, Newsletter Editor Flygt@centurytel.net
Karen Miller, Executive Assistant KarenMiller.Rio@gmail.com
Melissa Montgomery, Executive Assistant melissa.wamd@icloud.com

News—from around our organizations and our members.

Your association has been active—
The board will teleconference Thursday January 23rd—issues to cover include:
• Whether to join membership billing with AMDA;
• How much to contribute to the AMDA foundation futures;
• Finalizing the delegates to the AMDA House;
• Re-enrolling with the Superior Quality Alliance, Metastar’s long-term care collaboration;
• Planning for the 2020 meeting to be held at the Holiday Inn in Pewaukee October 8th and 9th—save the date!
• And

Big news—new member benefit for 2020—

WAMD now has an email discussion listserv address for members:
• This Discussion Email is a new member benefit. If you would like to send questions to the entire membership of WAMD, please send an email to WAMD-Members@mail-list.com
• All Members will receive the email when you send a question to this email address.
• To reply to the discussion email, and answer their question, click REPLY-ALL so everyone can receive your helpful response.
• You can also share and attach documents just as you would a regular email.
• You should have received a welcome email on Dec. 30th. If you have questions about this service, please contact Melissa.WAMD@icloud.com.
Other News—from around our state and our partners.

Join Our Group of Trusted Health Care Quality Improvement Leaders and Innovators!

Why participate?
Joining Superior Health Quality Alliance (Superior Health) provides you access to data-driven, customized support; access to subject matter experts; opportunities to participate in high-quality educational sessions; networking opportunities; and more. There is no cost to your organization to join.

Nursing Home Quality Improvement Collaborative
Superior Health’s Nursing Home Quality Improvement Collaborative expands on years of experience assisting nursing homes with improving the quality of care and the quality of life of those living in nursing homes. Superior Health provides each participating nursing home with regular data reports, education, and training to build capability and expertise. In addition, we can help nursing homes meet regulatory requirements due to experience with the state survey process. We recognize changes in payment models are driving changes in the way work is done—we’re here to help you navigate this structure for your success.

Community Coalitions for Improving Care
Joining our Community Coalitions for Improving Care Initiative provides you with the opportunity to connect with other health care organizations. Together, with the common goal of improving health and care available for all in your community, you will be able to collaborate and share best practices, determine efficiencies as you work together, improve patient satisfaction and possibly accelerate progress toward other requirements. We will supply data to help your group focus on shared areas of improvement and provide relevant national best practices, educational resources, and tools. With this initiative, your organization has the opportunity to improve in various areas including community-based transitions and opioid and other related adverse events.

Visit www.superiorhealthqa.org/join or call 833-821-7472 today!

The Focus of Our Work
Superior Health is powered by eight organizations with proven success driving achievement of Medicare quality improvement program goals. Superior Health will work to improve the quality of health and health care for health care consumers, patients, clinicians, health care organizations, and communities by supporting these five areas:

- Improve nursing home quality focusing on reducing unnecessary resident harm, reducing hospitalizations and increasing a facility’s Five Star Quality Rating.
- Increase quality of care transitions through engagement of community coalitions to reduce unnecessary emergency department visits and increase medication safety.
- Increase chronic disease prevention and self-care for those living with cardiovascular disease, diabetes and chronic kidney disease.
- Increase patient safety including reducing adverse drug events and healthcare-related infections.
- Improve behavioral health and opioid misuse through prevention and access to health services.
From the Trenches—questions about the meaning of PA/LTC life.

Revisiting Comfort Care

Jeffrey Nichols, MD, CMD

Caring for the Ages August 1, 2018 Volume 19, Issue 8, Pages 6–7

Dear Dr. Jeff:
Multiple articles tell us that if we only had quality palliative care services in nursing homes, we would not need (fill in the blank, from physician-assisted suicide to rehospitalizations to statins to hospice referrals). Our facility has been trying to create a program and a policy for comfort care while still complying with regulations from the Centers for Medicare & Medicaid Services. We reached out to the palliative care specialist at the local hospital for advice, but she stated that she had no experience with nursing home care and no suggestions except obtaining advance directives and referring patients to hospice. Can you help?

Dr. Jeff responds:

Confusion regarding the differences between comfort care, palliative care, and hospice care continue throughout organized medicine. This confusion may be worse in long-term care, where the acceptance of the general notion of enhancing patient comfort and forgoing invasive procedures has wide acceptance, but only limited application. Financial pressures to avoid hospital transfers and managed care penetration into long-term care have stimulated further interest in programs seen as reducing expensive interventions, increasingly costly medications, and futile hospitalizations. Even mandatory antibiotic stewardship programs, featured as preventing the development of resistant organisms and antibiotic-related complications, have a simultaneous intention of cost reduction. Indeed, some facilities use their pharmacy antibiotic bills as a measure of program success.

Regardless of motivation, these trends have empowered many practitioners and medical directors in long-term care to develop practices and policies that the many knowledgeable and compassionate professionals in our field have sought for years. Ironically, the dreaded “regs” that are sometimes cited as a barrier actually support many of the care enhancements that good programs would introduce. Some of these regulatory elements date back to the original Federal Nursing Home Reform Act (OBRA ’87) reforms, which attempted to enshrine geriatric best practices into nursing home care. Although the intentions from CMS leadership have not always penetrated to local survey agencies or individual surveyors, most will recognize and support good care, which requires appropriately documented resident choices and resident autonomy.

What Is Comfort Care?

Comfort care is a vague term that suggests many different possibilities. Although some have used comfort care as a synonym for palliative care, the National
Cancer Institute defines it as “care given to improve the quality of life of patients who have a serious or life-threatening disease.” Because nearly all residents of nursing homes, and many in assisted living facilities, have serious diseases that have produced significant functional deficits, this definition would apply to them. The National Institute on Aging website suggests that comfort care has four key elements: attention to physical comfort, mental and emotional needs, spiritual issues, and practical support. These are all mandatory elements of the Minimum Data Set and care planning process in the nursing home. Every long-stay resident and most post-acute residents by this definition should receive comfort care (attention to some needs might need to be arranged after discharge for very short stays).

There is as national shortage of specialists certified in palliative care. They are highly sought-after in acute care settings where the need is critical and their services can be liberating and transformative. The likelihood is that any hospice physician who might consult in your building has little or no formal training in palliative care or expertise in the management of nursing home residents.

Indeed, what resident or family would reject comfort care? Who would voluntarily opt for rough handling, an uncomfortable mattress, nasty food, or unaddressed pain and discomfort while consuming unnecessary or harmful medications, with emotional and spiritual distress ignored or dismissed as a behavioral complication of dementia or a natural consequence of aging? Who would ask to be awakened from a sound sleep at 6 a.m. because morning care is the responsibility of the night shift and must be completed before the next shift arrives at 7 a.m.? Who would want to be denied access to religious activities required by their faith? Or be forced into incontinence because of a lack of assistance getting to the toilet? Some of these deficient practices still occur in a few facilities, but every facility should already be working to completely eliminate them. They are indeed violations of the Requirements of Participation in Medicare and Medicaid.

Again, nursing home admission should put everyone on comfort care. Comfort care should be the standard of care.

Although facility programs designed to increase the prevalence of advance directives may be a worthy endeavor, they will not take you very far down the road to palliative care. The most common advance directive, the Do Not Resuscitate order, is largely an instruction regarding how the body is to be
treated after death. Given that the success rate for cardiopulmonary resuscitation in long-term care is less than 1% in most studies, the decision to avoid resuscitative efforts is essentially the patient saying, “After I die, I wish to be buried next to my beloved wife, to have a simple funeral ceremony with my favorite hymn and “Amazing Grace,” and by the way, I prefer no one break my ribs and stick a tube down my throat prior to embalming.” Advance directives like these may remove the need for time-consuming and strenuous activities by the staff, but they do not really help guide the care of the living. Similarly, designation of a health care proxy simplifies decision-making, but it does not necessarily clarify the decisions to be made or even prevent needless interventions or expensive but futile care processes.

The POLST (Physician Orders for Life Sustaining Treatment) Paradigm form — the name varies from state to state (e.g., MOLST, POST, COLST) — is a more significant step toward palliative care. This medical order allows a resident or health care proxy to make advance decisions on a number of common pre-terminal interventions, such as intubation with mechanical ventilation, feeding tubes, hemodialysis, and antibiotics. The form can be adapted to cover a variety of potential interventions that might require transfer outside the facility customized to the specific individual, such as cancer chemotherapy or blood transfusions, and it allows authorization of time-limited trials of interventions that might prove to be temporary. Thus, a resident might authorize a trial of dialysis to determine whether a decline is related to acute renal failure or another underlying disease, while specifying that if no significant improvement in functional or cognitive status occurs, the dialysis should be terminated.

Because POLST is a medical order, it would require a specific override by the decision-maker and the physician, which dramatically improves the likelihood of compliance with the resident’s wishes and decreases the rate of inappropriate hospital transfers. Most of the interventions that might be rejected would require hospital transfer and often occur with an urgency that prevents careful thought and discussion. These forms require physician signature and generally require medical explanation regarding their nature and relevance for the particular patient, so they require physician and team input. This is the sort of advance care planning that is reimbursable under the Medicare billing codes and it should be encouraged. POLST is not palliative care per se, particularly as patients and proxies may still choose a variety of uncomfortable interventions with minimal
probability of benefit, but it does help seriously ill people get the kinds of treatment they want and avoid getting treatments they don’t want.

Unfortunately, formal palliative care training often excludes significant exposure to nursing home residents, except when they are transferred back into acute care. I was on the faculty of one otherwise excellent program where the total exposure was one half-day at our facility.

Palliative Care Essential
There is a national shortage of specialists certified in palliative care. They are highly sought-after in acute care settings where the need is critical and their services can be liberating and transformative.

The palliative care needs for nursing home residents are real, but could and should be adequately addressed in high-quality long-term care. Although there are many excellent practitioners certified in palliative care who work in nursing homes, they are predominantly nursing home physicians who have been grandfathered into the field. Although insufficient for board eligibility in palliative care, many geriatric fellowships now include significant palliative care components in their curriculum and rotations; in fact, there are combined palliative and geriatric fellowships.

With the tremendous growth of the hospice industry (more than two-thirds of American hospices are for-profit), the likelihood is that any hospice physician who might consult in your building has little or no formal training in palliative care or expertise in the management of nursing home residents. Although hospice does offer many potential benefits to your residents, and particularly to their families, do not expect that a hospice contract will necessarily provide much assistance to your proposed program.

The likelihood is that any hospice physician who might consult in your building has little or no formal training in palliative care or expertise in the management of nursing home residents.

Knowledge Gap
Twenty-five years ago, when I was asked to be the acting medical director for the hospice that was affiliated with the hospital and nursing home where I worked at that time, I decided to seek board certification from what was then the American Board of Hospice and Palliative Medicine. As I read the review materials for the
examination, I was astounded to discover that they sought to teach these presumed specialists a variety of topics that are probably already quite familiar to most of the readers of this article: basic medical ethics, the need to treat pain, the principles of team-based care, listening to the patient and the family, basic pressure ulcer management, the concept of delirium, and the use of laxatives, particularly for patients also receiving narcotics. What was new largely concerned hospice eligibility, certification, and mandatory minimum services.

After two recertifications from the American Board of Internal Medicine, I have learned more about pain relief through aggressive invasive procedures and about the needs of dying children and their families, but the additional knowledge and insight I have gained regarding nursing home palliative care has come from my colleagues, JAMDA and other geriatrics journals, and presentations at the Society national conferences. The Core Curriculum materials and Clinical Practice Guideline are an excellent place to begin.

Palliative care is care provided to manage symptoms, rather than cure illness or prolong life. Residents are “on palliative care” when they or their proxy determine the goals of care and prioritizes symptom management over other possible goals. And palliative care can be given in conjunction with what is often considered traditional “curative” care. Aligning the plan of care with the goals of care is much more than simply creating a list of interventions that might or might not be done. It requires a comprehensive review of the medication list, but also all the elements of the care plan. Does a floor ambulation program enhance the resident’s independence or simply aggravate sore knees and hips? Does a low-salt diet decrease the enjoyment of meals or help to limit the symptoms of congestive heart failure? Could more be done for a resident who has apathy or mild depression that isn’t sufficient to “trigger” on the Major Depression Rating Scale?

Most of the functional deficits and nursing needs that necessitate long-term placement are aspects of diseases that can’t be cured and whose natural history is largely beyond the control of modern medicine. Whether the underlying diseases are cognitive, neurologic, cardiac, pulmonary, or endocrine, good palliative care is often the best care that an excellent geriatric team can provide. A palliative care program helps to focus on the residents’ goals, and our own — both what we do and why we do it.
How to Write Email with Military Precision

A few tips on how to craft emails to quickly and clearly relay messages and avoid miscommunication.


In the military, a poorly formatted email may be the difference between mission accomplished and mission failure. During my active duty service, I learned how to structure emails to maximize a mission’s chances for success. Since returning from duty, I have applied these lessons to emails that I write for my corporate job, and my missives have consequently become crisper and cleaner, eliciting quicker and higher-quality responses from colleagues and clients. Here are three of the main tips I learned on how to format your emails with military precision:

1. Subjects with keywords. The first thing that your email recipient sees is your name and subject line, so it’s critical that the subject clearly states the purpose of the email, and specifically, what you want them to do with your note. Military personnel use keywords that characterize the nature of the email in the subject. Some of these keywords include:

   - ACTION – Compulsory for the recipient to take some action
   - SIGN – Requires the signature of the recipient
   - INFO – For informational purposes only, and there is no response or action required
   - DECISION – Requires a decision by the recipient
   - REQUEST – Seeks permission or approval by the recipient
   - COORD – Coordination by or with the recipient is needed

The next time you email your direct reports a status update, try using the subject line: INFO – Status Update. And if you need your manager to approve your vacation request, you could write REQUEST – Vacation. If you’re a project manager who requires responses to your weekly implementation report from several people, type ACTION – Weekly Implementation Report. These demarcations might seem obvious or needlessly exclamatory because they are capitalized. But your emails will undoubtedly stand out in your recipient’s inbox, and they won’t have to work out the purpose of your emails. (It also forces you to think about what you really want from someone before you contribute to their inbox clutter.)

2. Bottom Line Up Front (BLUF). Military professionals lead their emails with a short, staccato statement known as the BLUF. (Yes, being the military, there is an acronym for everything.) It declares the purpose of the email and action required. The BLUF should quickly answer the five W’s: who, what, where,
when, and why. An effective BLUF distills the most important information for the reader. Here’s an example BLUF from the *Air Force Handbook*:

**BLUF:** Effective 29 Oct 13, all Air Force Doctrine Documents (AFDDs) have been rescinded and replaced by core doctrine volumes and doctrine annexes.

The BLUF helps readers quickly digest the announcement, decision, and when the new procedures go into effect. The reader doesn’t necessarily want to know all the background information that led to the decision. He or she likely wants to know “how does this email affect me?” and the BLUF should answer this question every time.

For my corporate job, I don’t use the acronym “BLUF” because it would be unclear to recipients, but I have started leading with “Bottom Line” in bold at the start of my notes. Sometimes, I even highlight the bottom line in yellow so that my point is abundantly clear. Here is an example of a BLUF adapted for corporate use:

Subject: INFO – Working from home

Shannon,

**Bottom Line:** We will reduce the number of days that employees can work from home from three to one day per week effective December 1st.

**Background:**

- This is an effort to encourage team morale and foster team collaboration
- All members of the management committee supported this decision

Shannon knows that no response is required because it was marked INFO. She also quickly grasps the information in the email because of the Bottom Line. Because this is a big change in corporate policy, background details are provided to show that the decision is final, supported by management, and intended to result in positive effects for the company.

3. **Be economical.** Military personnel know that short emails are more effective than long ones, so they try to fit all content in one pane, so the recipient doesn’t have to scroll. They also eschew the passive voice because it tends to make sentences longer, or as the Air Force manual puts it, “Besides lengthening and twisting sentences, passive verbs often muddy them.” Instead, use active voice, which puts nouns ahead of verbs, so it’s clear who is doing the action. By using active voice, you are making the “verbs do the work for you.” Instead of, “The factory was bombed by an F18,” military professionals would say, “An F18 bombed the factory.”

Even though short emails are usually more effective, long emails abound, even in the military. If an email requires more explanation, you should list
background information after the BLUF as bullet points so that recipients can quickly grasp your message, like in the above example.

Lastly, to prevent clogging inboxes, military professionals link to attachments rather than attaching files. This will force the recipient to check the website that has the attachment, which will likely provide the most recent version of a file. Also, the site will verify that the recipient has the right security credentials to see the file, and you don’t inadvertently send a file to someone who isn’t permitted to view it.

Here is an email example for corporate use that uses keywords in the subject, bottom line, background bullets, and active voice:

Subject: INFO – Meeting Change

Shannon,

**Bottom Line:** We scheduled the weekly update meeting for Thursday at 2 PM CST to accommodate the CFO’s schedule.

**Background:**

- We searched for other available times, but this is the only time that works, and it’s important that you are on the call, so that you can address your P&L.
- CFO will be in Boston on Thursday meeting at an offsite with the management committee.
- He wants to review the financial report that can be found here (insert link) before the call.

By adopting military email etiquette, you will introduce a kernel of clarity to your correspondence and that of your colleagues and clients.

**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
  - other post-acute and long-term care professionals,
  - various long-term care associations, and
  - 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.

WAMD-The Wisconsin Society of Post-Acute and Long-Term Care Medicine
www.wamd.org
253 Willow Lane
Hartford, WI 53027
P 844-990-WAMD