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As Care Teams Cooperate, Silos Topple, Quality Rises

BY JOANNE KALDY
In the post-health care reform world, medical practitioners no longer can work without the input of other disciplines or specialties. The concept of care teams, with the patient at the center, is the new normal.

“Geriatrics always has been open to the interdisciplinary team and the idea that it takes a community to care for older adults. But now, with the rise of the Affordable Care Act and accountable care organizations, the focus on teams by policy-makers and other decision makers is more than lip service,” said Barbara Resnick, PhD, RN, a professor at the University of Maryland School of Nursing in Baltimore and longtime AMDA member.

Reflecting AMDA’s long support for the team approach to care in postacute and long-term care (PA/LTC) facilities, the organization’s House of Delegates in March formalized its commitment to including practitioners beyond medical directors in its programming, policy setting, and planning. At their meeting in Nashville during AMDA LTC Medicine—2014, the AMDA delegates voted to extend full membership to nurse practitioners (NP) and physician assistants (PA) and to change the organization’s name from AMDA – Dedicated to Long Term Care Medicine to AMDA – The Society for Post-Acute and Long-Term Care Medicine.

“Nursing home medicine always has been team-oriented.

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bias and conflict of interest when deci-
sions are made by physicians alone
outweigh the efficiency of unilateral
decision-making. Some jurisdictions
have formalized that viewpoint. New
York State, he noted, authorizes physi-
cians to make decisions for a patient
but requires the concurrence of a sec-
ond physician and sometimes an ethics
consult, depending on the invasiveness
and gravity of the treatment. The
Veterans Health Administration
follows a similar process.

Some nursing homes can’t muster
an internal ethics committee, but can
turn to consultations with a nearby hos-
pital’s ethics committee or a regional
body, such as the committees admin-
istered throughout New Jersey by the
state’s Office of the Ombudsman for
Interstate teams in long-term care
facilities to make medical decisions for
incapacitated individuals with no known
family or friends. California’s statute
was recently challenged, however, in
a lawsuit by an advocacy organization
that the statute is a viola-
tion of due process and has permitted
nursing homes to improperly give resi-
dents psychotropic drugs, place them
in restraints, and end life-sustaining
treatment.

Dr. Gibson said the changes, filed last
October, reflect some isolated instances of facilities’ improper use of the stat-
ute, not a problem with the law itself.
For instance, interdisciplinary teams
may not have been made up correctly,
or facility staff may have made choices
for residents while disregarding avail-
able decision-makers. “If facilities don’t
use the statute in the right way and use it to do the right thing, it’s open to
attack,” he said.

The team-based model works well,
Dr. Gibson said, and can be successful
for many situations, from obtaining con-
sent for admission to a nursing home to a range of decisions, either affirming or
refusing treatment.

Nursing homes are indeed in a quan-
dary, said Colorado’s Dr. Ghahm, but
“certainly there is a precluding interest
for nursing homes to do something”
to enable fair and thoughtful decision-
making for the unbriefed. And, as he
sees it, there are two advantages to collab-
oration: If facilities in a locale or region
all “embrace common mechanisms, and
the ombudsmen are on board, then you’re not legislating, but you’re [changing the culture and]
that’s a different standard,” he said.

In all states, the judicial process for a
health care facility to assume guardianship is slow, cumbersome, expensive, and a
last resort at best, especially for nursing
homes, several sources for this article said.
The problem of the unbriefed weighs on
Dr. Ghahm’s mind, which says something about the extent of it.
Colorado is among the states with the
most flexible default surrogate laws;
the list of potential clinician-appointed
surrogates includes not only close family
members but also friends. A longer list
of potential surrogate categories
should help reduce the number of
unbriefed in the first place.

Like a few other states and jurisdictions,
Colorado also has a program to train
volunteers to serve as court-appointed
guardians for the unbriefed. Yet, while
Dr. Ghahm said that thevol-
teers become highly competent to serve
as surrogates, it is extremely difficult
for nursing homes to recruit enough of
them and sustain their efforts.

Joshua Raymond, MD, MPH, CMD,
immediate past-president of the New
Jersey Medical Directors Association,
said that he has had positive experi-
ences with state-appointed guardians.
“They have advocated for the patient, and they have been reasonable, at the same
time, with end-of-life decisions,” he said.

However, ethics committees have
advantages. Among other things, there
are often long delays in obtaining guardi-
anships, and the process is prohibitively
costly for many nursing home residents.
There appears to be a shift occurring.
Dr. Gibson said, toward recognizing a
“community approach” to substituted
judgment, rather than vesting authority in
one surrogate.

Dr. Pope called ethics committees
“the best middle ground” for making
treatment decisions for unrepresented
patients. As a legal expert, he favors
those that are external to the health care
facility or nursing home.

Independent viewpoints provide a
check on possible biases and conflicts of
interest that clinicians have been shown
to act on, even if not consciously or
deliberately, such as those relating to
to age, race, or financial motives to
undertreat or overtreat. In addition, the
need to explain treatment decisions to
another decision-maker – especially an
outside decision-maker – can prompt
more thorough deliberation and clearer
articulation of risks, benefits, and alter-
natives, Dr. Pope said. The mechanism
being deliberated in Colorado, on the
other hand, involves an internal team
supplemented with an outside ombuds-
man for objectivity.

Dr. Raymond, who is medical director
of The Health Care & Rehabilitation Center in Freehold, NJ, said that either
approach can be helpful. Certainly, he
advised, nursing homes that are part
of larger health care systems should
utilize the professionals and resources
of that system in forming and
maintaining an ethics committee can
be labor intensive. The main point, he
said, is that the “physician should not be
standing alone. You need to have
resources available.

Sometimes, casting a wide net within
one facility is all that is needed, several
sources said. “Most importantly, when
making decisions on behalf of others, we
should get input from as many available
sources as possible,” said Jonathan Evans,
MD, MPH, CMD, adding that “those
who have the most contact with residents
generally have the most knowledge.”

“It is very, very difficult to know exactly what someone else wants – even
if you know that person well,” said Dr.
Evans, AMDA’s immediate past presi-
dent and chief medical officer for Life
Care Centers of America in Cleveland,
Tennessee. He said that numerous
studies have shown that decisions that
individuals say they would make for
themselves under particular circum-
stances do not match decisions that
their designated surrogates would make.
“In general, adults tend to presume that
their parents, for instance, would have
wanted more aggressive care than they
actually do,” he said.

Looking at long-standing religious preferences, previous decisions with
the health care system, past rejections
and acceptances of elective interven-
tions, and other factors can sometimes
yield clues as to what the individual might want, sources said.

“Remember, too, that someone
may be incapacitated in the sense that
they can’t give informed consent, but
they may still be able to discuss, in some
way and at some time, certain prefer-
ences and wishes,” Dr. Gibson noted.

“We need to look for anything that
makes it easy to best execute substituted
judgment,” he said.

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