PALTmed Texas Geriatrics Enews Letter:

November 2024

A Big Welcome to our New Board Members!

Michael Krol, MD, CMD has rotated up to President of PALTmed Texas. Other new board members are: President Elect: Cassie Huynh, MD, CMD and Vice President: Neeta Nayak, MD, CMD. New Directors are: Aruna Joysula, MD; Sarah Ross, DO; and Janet Lieto, DO. A big thank you to Chidinma Aniemeke, MD, CMD for her two years of service as president and to Directors Teresa Albright, MD, CMD, Melissa Miller, MSN, APRN, and Megan Walker, MD who have stepped down.

TGS elected Hennie Garza, RPh and Ezenwa Onyeman, MD as new Directors. A big thank you to Neela Patel, MD who rotated off after serving for nine years on the board.

Inside this issue:

TMDA is now PALTmed Texas

In keeping up with our national chapter, and with approval of our members, TMDA has changed their dba to PALTmed Texas.

HSC Health Selected to Test Medicare Dementia Care GUIDE Model

HSC Health has been selected by the Centers for Medicare & Medicaid Services (CMS) to participate in a new Medicare alternative payment model designed to support people living with dementia and their caregivers. Under CMS' Guiding an Improved Dementia Experience (GUIDE) Model, HSC Health will be one of almost 400 participants building Dementia Care Programs (DCPs) across the country, working to increase care coordination and improve access to services and supports, including respite care, for people living with dementia and their caregivers.

Launched on July 1, 2024, the GUIDE Model will test a new payment approach for key supportive services furnished to people living with dementia, including: comprehensive, person-centered assessments and care plans; care coordination; 24/7 access to an interdisciplinary care team member or help line; and certain respite services to support caregivers. People with dementia and their caregivers will have the assistance and support of a Care Navigator to help them access clinical and non-clinical services such as meals and transportation through community-based organizations.

HSC Health participation in the GUIDE Model will help people living with dementia and their caregivers have access to education and support, such as training programs on best practices for caring for a loved one living with dementia. The GUIDE Model also provides respite services for certain people, enabling caregivers to take temporary breaks from their caregiving responsibilities. Respite is being tested under the GUIDE Model to assess its effect on helping caregivers continue to care for their loved ones at home, preventing or delaying the need for facility care.

For more information on CMS' GUIDE Model, please visit:
https://www.cms.gov/priorities/innovation/innovation-models/guide.

TGS/TMDA Annual Conference 2024: Geriatrics Through the Grapevine

Our 35th annual conference was held in person August 9-11 2024 at the Hilton DFW Lakes Executive Conference Center in Grapevine, Texas. Attendees received up to 16.5 hours of AANP, ABIM-MOC, CME, CMD, 15.50 hours of AAFP, and up to 2 hours of ethics credit. It was great to meet in person to network and learn something new. A wide variety of topics were presented including: wound care, trafficking of older adults, insomnia, delirium, osteoporosis, advanced care planning, resilience, medical liability reform, heart failure management, ageism, cognitive assessment for intellectual/developmental disorders, and medicinal uses of honey. Dr. Robert Parker gave the keynote address on *What I Learned as an Expert Witness.* TGS and TMDA had their annual business meeting and prize drawings. Kent Davis, MD and Jennifer Heffernan, MD won complimentary registration to the 2025 conference.

We had a great turn out of students, fellows, and residents who attended. JPS Health Network and Texas A&M University Medical School hosted geriatric fellowship recruiting tables on Saturday. Below are some photos from the conference from Charles Miller, MD, CMD our resident photographer. We hope to see you at the 2025 conference August 1-3 in Austin at the Hotel Viata.

For more info check out our conference website: **TGS/TMDA Annual Conference**

General Session

Exhibit Hall

Renee Flores, MD
TGS President

Chidinma Aniemeke, MD,
President of TMDA

Dr. Gnanasekaran

Ferhart Ozturk, PhD

Robert Parker, MD Keynote Speaker

Feeding Tubes – To Place or Not to Place? by Neeta Nayak, MD, CMD

First published in PULSE magazine on 9/4/2024

Sometimes I have to pinch myself. Is this really my twenty-fifth year of practice as a palliative care physician? My head is full of memories of caring for hundreds of patients as they navigate their final days of life.

I think of the first patient I placed on hospice in my first week of practice as a newly minted attending. At eighty-eight years old, Mrs. C. had been perfectly functional and even driving herself. But now she arrived at rehab after a sudden massive stroke. Her daughters were holding out hope for improvement. She was unable to maintain nutrition due to dysphagia (difficulty swallowing) and a feeding tube was placed in the hospital. Her oldest said, "We were told this was temporary, and the tube could be removed anytime."

We moved Mrs. C. into intensive rehabilitation. She made minor progress, but a month later was still unable to walk, talk or eat.

Mrs. C. looked miserable, but her family kept hoping for a miracle. Ninety days passed with no measurable improvement. She would need custodial care.

It was the harsh reality of economics that made the daughters agreeable to having a realistic conversation with us. "We were told we could pull the tube at any time. That's why we went with it." "Are we killing mom if we stop feeding?" "But she would never have wanted to live on a tube when the rest of her body is not cooperating."

A few minutes later, again "But will we be killing mom if we stop feeding? Will God ever forgive us?"

And, "I wish we had never agreed to a tube. We made her miserable for nothing. We robbed her of the chance to have a peaceful journey."

It was an emotional conversation as these tend to be. We as medical professionals have to be careful with saying "feeding tubes may be temporary and can be removed at any time" because even though ethically withholding versus withdrawal of feeding maybe theoretically equal, the trauma of making a decision to withdraw is exceedingly painful.

After deliberation, the daughters agreed to hospice. Within days, she had another massive stroke and became unresponsive and regurgitated feeding. The decision to stop was not difficult for the family anymore.

The daughters told us, "Mom made a decision for herself and spared us agony. We are not sure if we could've lived with ourselves had we stopped feeding. She was a wonderful mom even at the end!"

Alzheimer monoclonals from My AGS Online via Sheldon Ball PhD,MD AGS, ACP

The integration of anti-Alzheimer monoclonal antibodies into the standard of care for treatment of Alzheimer's disease has hit a few bumps along the road. NICE, the United Kingdom's National Institute for Clinical/Care Excellence, has rejected donanemab [1] & lecanemab [2,3] due to cost & significant health risks. Now it appears that Eisai & Biogen, makers of lecanemab, had failed to advise trial participants of their risks for amyloid-related imaging abnormality-edema or effusions (ARIA-E) based upon their apoE genotype, data collected in the pre-trial phase of clinical trials. [4] Patients homozygous for apo E4 are > 6 times more likely to experience symptomatic ARIA with edema or effusions (ARIA-E) & 3 times more likely to experience cerebral micro-hemorrhages than those homozygous for apo E3.

Alzheimer's disease < aaushi.info/A15569 > donanemab < aaushi.info/A57023 > Lecanemab < aaushi.info/A57239 > anti-Alzheimer monoclonal antibody < aaushi.info/A57526 > ARIA-E < aaushi.info/A57811 >

References: 1. www.bmj.com/content/387/bmj.q2342 2. https://www.bmj.com/content/386/bmj.q1692
3. www.bmj.com/content/386/bmj.q1853 4. https://www.nytimes.com/2024/10/23/health/alzheimers-drug-brain-bleeding.html

The Inevitability of Reimagining Long-Term Care

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Long-term care has been reimagined for as long as it's been recognized, which in part explains the multitude of options that emerged during the mid-20th century growth of formal long-term care support in the United States and other developed nations.[1] The articles in JAMDA's special issue on Reimagining Long-Term Care propose ways to further reimagine care going forward; this editorial calls the question as to whether we'll ever stop reimagining long-term care, and posits that we won't, for better and for worse. For better, because there's always room for improvement and consumer desires will continue to evolve. For worse, because the absence of a "system" of long-term care virtually ensures different visions between factions and partial progress at best.

On that point, let's correct 2 erroneous beliefs. Long-term care—services delivered over a sustained period of time to persons with cognitive or functional limitations—is not a "continuum" nor a "system." As but a few examples, if it were a continuum, we'd expect the prevalence of functional impairment to be less among persons receiving adult day services than among persons in assisted living, when in fact the percentage of persons with 3 or more limitations in activities of daily living is virtually identical (64% and 61%, respectively).[2,3] Or, we'd expect the percentage of persons with arthritis, diabetes, heart disease, or hypertension to be lower among home health agency users than among assisted living or nursing home residents, which it isn't.[4] And if long-term care were a system—by definition, "a set of things working together as parts of a mechanism or an interconnecting network"[5]—we'd not have the situation in which hospital costs to Medicare and nursing home costs to Medicaid were on a different ledger, or that specific models of care would be needed to improve and reduce transitions across care settings.[6–12] The lack of a system makes long-term care incredibly complex.

Areas in Which to Reimagine Long-Term Care

Attesting to the complexity inherent in long-term care, each article in JAMDA's special issue highlights a different topic, yet every article points to the interrelatedness of all topics. This editorial groups the articles into 5 areas and notes interrelationships among them: workforce; societal issues; models of long-term care; financing, payment, and regulations; and long-term care services.

Workforce

Today, one of the topics most requiring reimagination is the long-term care workforce. We didn't need COVID-19 to highlight historic issues related to burnout, understaffing, and the low regard bestowed on the long-term care workforce, but it certainly did that.[13] In this issue of JAMDA, the article focusing on transforming direct care notes that the recent unprecedented federal and state attention on long-term care makes the time ripe for a national direct care workforce strategy, which could perhaps be incorporated into federal funding and accountability mechanisms.[14] Beyond nursing assistants, there is need to revisit the availability of nurses, whose capacity could be augmented by employing foreign-educated nurses, albeit requiring an eye toward equity and necessary preceptorship.[15] Going one step further, another article stresses that the future includes a more decisive role for nurse practitioners but notes that changes are needed to restrictive practice acts and that better differentiation is needed between their responsibilities and those of physicians.[16] The role of physicians is also reimagined in an article on assisted living, proposing structured medical care led by a medical director, while also noting related controversies such as implications for continuity of care.[17]

Reimagining the long-term care workforce would not be complete without addressing technology and families; the critical role of both came to the forefront during the pandemic. A pragmatic innovation presents ex-

periences using a robotic device to enhance provider presence in nursing homes; it limited staff burden but has cost implications if it is to be routinely incorporated into care going forward.[18] Regarding families, evidence recommends that residential long-term care embrace a more family-centric perspective, including involving families when developing organizational governance policies.[19] There is also a need to maintain focus on respite for family who provide care at home, embracing new models borne out of COVID-19 such as supervision of care recipients by offsite respite providers via an interactive computer screen.[20] Both articles envision a more empowered role for families, recognizing their critical role especially in light of staffing shortages.

Societal Issues

Three articles speak to societal issues inherent in long-term care that require attention. A special article addressing systemic racism presents 7 recommendations to address racial and ethnic disparities in long-term care based on existing evidence, addressing topics ranging from needs of family caregivers, to redesigning pay for performance programs, to culture change.[21] In a different context, culture change is addressed in an editorial stressing the need to build trust in post-acute and long-term care, tasking medical care providers to help the field move away from a fear-based work culture.[22] In yet a different context, a special article goes beyond the concept of a "safety culture" to a "just culture" and provides guidance for organizations to focus not only on outcomes but also on behavioral choices; in so doing, changes are needed both to the culture of the long-term care setting and to the survey process.[23]

Models of Long-Term Care

There is much to reimagine based on international models of long-term care, as described in 7 articles in JAMDA's special issue. Four articles provide broad recommendations or emerging models of long-term care. One is a World Health Organization global expert consensus report recommending 50 broad-reaching long-term care services.[24] Another describes Costa Rica's new national long-term care service program that is expected to inform the efforts of other middle-income countries.[25] A third article describes a Dutch network to treat residents with any of 7 rare conditions for whom there is a need to improve care, collaboration, and competencies (eg, Huntington disease, Korsakoff syndrome, mental and physical multimorbidity),[26] and a fourth article describes the Netherlands' efforts to address the needs of persons with young-onset dementia.[27] In addition, 3 evidence-based international articles speak to collaborative models that have promise for the future: a generalist-specialist collaboration with elderly care physicians embedded in primary care[28] and 2 types of collaboration between long-term care settings and hospitals.[29,30]

Three articles address the future of 2 consequential models of care in the United States—post-acute care and assisted living. An editorial questions whether a nursing home can and should provide both post-acute and long-term care, based on the challenges of providing optimal care to very different populations, disparities in care, and a shrinking market.[31] A special article speaks to tensions that have affected the very fabric of assisted living, noting that today's assisted living is not as intended and must be reimagined, suggesting numerous potential solutions to move toward that future.[32] A third article describes a quality improvement collaborative that could serve as a model to guide assisted living moving forward.[33]

Financing, Payment, and Regulation

Although explicit or implicit in virtually every article related to workforce, societal issues, models, and services, 2 articles in JAMDA's special issue focus squarely on financing, payment, and regulation. The first addresses the current patchwork, variability, and insufficiency of funding, and the resulting barriers to care, quality, equity, and efficient allocation of resources; in reimagining, it envisions a new federal long-term care benefit and its essential features, as well as related tradeoffs and challenges.[34] In a different vein, a nationwide study provides a new vision for regulations related to architectural design, calling for more single-occupancy rooms and more spacious living areas after finding associations between residential density and COVID-19 cases and deaths.[35] COVID-19 will abate with time, but concern regarding infection transmission in long-term care will be never-ending.

Long-Term Care Services

Four articles speak about the type of services provided in residential long-term care. Consistent with the point above, a letter stresses the ongoing need to focus on infection control,[36] and another calls to focus more closely on relocations within long-term care.[37] Two special articles delve more deeply into care itself. One addresses recommendations for nutrition care and mealtimes, identifying which recommendations are most feasible and the related need for funding, policy, and practice standards.[38] The second equates high-quality nursing home care with palliative care, also noting the critical role of payment policies and regulations.[39]

Research to Reimagine Long-Term Care

All of the articles in JAMDA's special issue on reimagining long-term care draw on literature and research to support their recommended vision for the future. That said, virtually every article also speaks to the need for additional research to guide implementation and examine outcomes, including but not limited to determining the impact of wage increases, training, and models of staff supervision[14]; considering how best to implement a "just culture"[23]; developing and implementing new models of assisted living and related regulatory requirements, financial incentives, and access[32]; examining the costs associated with federal long-term care policy[34]; and developing valid and reliable measures to evaluate the quality of and set benchmarks for palliative care.[39]

Why It's Inevitable That We'll Forever Be Reimagining Long-Term Care

More than 30 years ago, Bob and Rosalie Kane wrote, "Given that our present long-term care is faulted on the grounds of both quality and cost (public and private), little will be lost by trying a new approach."[40] (p628) That statement remains true today. The articles included in the special issue of JAMDA make clear that reimagining long-term care implicates complex interrelationships between the workforce, societal issues, models of long-term care, financing, payment, regulations, and services. On the one hand, those interrelationships make it challenging to effect change; on the other hand, change in one area can have a domino effect in improving outcomes as long as none of the dominoes impede progress.

Everyone wants long-term care to be reimagined toward a better future, but like so many other issues affecting the world, achieving that change is politicized. For the foreseeable future, it may be best to consider that the reimagined future set forth in the special issue of JAMDA is an aspirational future. And, when changes are effected, they will likely be incremental, given the lack of an existing system of long-term care.

Perhaps the more fundamental reason that we'll forever be reimagining long-term care is that care and outcomes can never be optimal regardless our best efforts. Ultimately, care recipients face significant physical and/or cognitive challenges, have often lost their closest partner owing to death, and may have complex conditions and symptoms with limited life expectancy. Given these realities of the population served, how can we not want to reimagine the impossible? And so, we'll forever be swimming upstream against a current of disability and loneliness, wanting to achieve what cannot be fully achieved and striving to create a system that better merges science, caring, and resources.

Within the next few months, the National Academies of Sciences, Engineering, and Medicine is expected to release recommendations to improve the quality of nursing home care, presumably with relevance to other long-term care settings. It is hoped that their report and the articles in the special issue of JAMDA combine with the renewed national focus on the future of long-term care to spur constructive change.

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Click **HERE** for the original article and a list of the references.

PATIENT.

She was an elderly female with advanced dementia, minimally verbal now, needing continuous redirection, and having severe, difficult to manage agitation/aggression at home.

I held my patient's hands and redirected her gently, over and over, so that her daughter could tell me what was happening, without the interruption of redirecting her mother, yet again. The daughter was frustrated, because so much has been tried and failed, so many doctors consulted, and I was just a new face to tell the story to, yet again. She feared her concerns about her mother, my patient, would fall flat and futile, yet again.

My hands were always cold in medical settings. While I held her hands, my sweet patient began rubbing my hands and arms softly but purposefully, I think to warm me up. I smiled at her from behind my mask, smiling as hard with my eyes as with my face so she would know. Her own eyes moistened and crinkled in recognition of the smile. Suddenly, my patient embraced me from her wheelchair and held me close. Her daughter burst into tears at the sudden affection her mother showed me.

This moment was a glimmer of how my patient was before dementia, and also who she still is inside. But to her daughter, it may have been the first time a doctor had seen her mom for who she is and was. Not just an elderly agitated woman, but a PERSON.

A loving and whole person.

Grandmother, mother, daughter, wife, sister, more.

PERSON.

By Dr. Julia Hiner

FUTURES PROGRAM

The Futures Program is designed to expose fellows, residents, advanced practitioners, and allied health professionals to the numerous career opportunities available in PALTC medicine. In addition to PALTmed membership, participants receive the following benefits:

- Admission to the Futures Program on March 13
- Attendance at all sessions during the PALTC25 Annual Conference
- Access to resources provided through Futures Connect, the year-long online program that offers platforms for networking, discussions about topics of clinical interest, and open discussions with PALTC leaders

Deadline to apply is November 18, 2024.

Learn More & Apply

Who is credited with coining the term "geriatrics" and in what year?

The first person to email the correct response to will win a $25 gift card to Starbucks!

Email your answer to Maggie@texasgeriatrics.org

Winner based on date/time stamp of Ms. Hayden's inbox!

This is the same as Spring 2024 as no one answered it.

2025 Save the Date

PALTmed25
March 14-15, 2025
Charlotte, North Carolina
paltc25

AGS Annual Scientific Meeting
May 8-10, 2025
Chicago, Illinois
AGS Annual Meeting

TexMed
May 8-10, 2025
San Antonio Texas
Texmed2025

PALTmed Texas Geriatrics
Annual Conference
August 1-3, 2025
Austin, Texas
TGS/TMDA Conference

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