In the late 1990s, U.S. health care providers began to prescribe opioid pain relievers in increasing amounts after pharmaceutical companies assured them that patients would not become addicted. These opioid prescribing practices led to widespread misuse of both prescription and nonprescription opioids, and the ensuing realization among the medical community that these medications were indeed addictive. In 2017, the U.S. Department of Health and Human Services (HHS) declared a public health emergency and announced a strategy to combat the opioid epidemic ("What Is the U.S. Opioid Epidemic?" Sept. 4, 2019; http://bit.ly/2uQnlNR).

In October 2019, HHS published guidelines for appropriate dosage reduction or discontinuation of long-term opioid analgesics, which provide advice to clinicians who are considering making a change to a patient’s opioid dosage ("Guide for Clinicians," Oct. 2019; http://bit.ly/2su87gI). The Comprehensive Addiction and Recovery Act (CARA) of 2016 included provisions that give Medicare Part D plans important new tools to use in 2019 to address opioid overutilization. To execute this law, the Centers for Medicare & Medicaid Services (CMS) passed a

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Tapering Recommendations for Benzodiazepines
By Jeanne Manzi, PharmD, BCGP, FASCP

A mid the opioid crisis in the United States, another class of psychoactive medications — benzodiazepines — is often used inappropriately and should be considered for deprescribing. In tapering these medications, safe practices must be adopted and nonpharmacological alternatives should be considered, when appropriate.

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Helping EHRs Talk to Each Other
By Joanne Kaldy

I nteroperability is the holy grail of health information technology (HIT) and electronic health records (EHRs). While it’s still not a reality for most practitioners, it’s getting closer. Attendees at the 2020 Annual Conference of AMDA – The Society for Post-Acute and Long-Term Care Medicine in Chicago will hear about where we are, where we need to go, and how to get there.

"If Only These Systems Could Talk: Addressing the Cross-Setting Electronic Health Record Interoperability Dilemma" on Saturday, April 4, brings together industry leaders to discuss the current status, challenges, barriers, and future of EHR interoperability and the path to a fully integrated health information exchange (HIE) model.

Until recently, post-acute and long-term care has been far off the radar of policy-makers and others. As a result, said Dheeraj Mahajan, MD, FACP, CMD, president/CEO of CIMPAR, SC, in Oak Park, IL, the session’s chair, there was no money to build systems, no robust clinical information, and poor adoption by physicians. As we move from fee-for-service to value-based care, the silos of information that don’t talk

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Join the only medical specialty society representing practitioners working in the various post-acute and long-term care settings.

Visit paltc.org/membership to learn more!
More than ever, physicians and other practitioners are using and embracing electronic health records (EHRs) and other technology, but they still see these systems as far from perfect. At the same time, some of these concerns are shared by patients and families as they become more tech savvy.

According to a report from Stanford Medicine, 81% of primary care practitioners (PCPs) believe that EHRs have led to improved care and are "somewhat" satisfied with their current system. Most (70%) say EHRs have improved over the last five years. However, 40% say that there are more challenges with EHRs than benefits.

Among other findings from the study:

• 49% of office-based PCPs think that using an EHR actually detracts from their clinical effectiveness
• 71% agree that EHRs greatly contribute to physician burnout
• 8% say the primary value of their EHR is clinically related

Over half of practitioners (59%) think that EHRs need a complete overhaul. Specifically, 72% think that improving the user interface of EHRs could best address the challenges in the immediate future. Elsewhere, 67% think that solving interoperability deficiencies should be the top priority for EHRs in the next decade, and 43% want better predictive analytics to support disease diagnosis, prevention, and population health management. Nine of 10 physicians want EHRs to be more intuitive and responsive.

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By Joanne Kaldy

Make the Most of EHR

• Future-proof your practice. The ability to coordinate care instantly and seamlessly via the internet is an emerging giant in the field of medicine and of tantamount importance to the future of health care. Keep ahead of the curve by leveraging your EHR to grow the percentage of patients whose clinical information is shared electronically across care settings.

• Think about your notes beyond what they mean clinically. For practitioners receiving Medicare reimbursements, the Centers for Medicare & Medicaid Services treat progress notes like itemized bills. The notes entered into your EHR today not only need to convey important medical information about patients to other medical staff but also should document the accurate and complete information requested by Medicare.

• Remember that good data entry enables a focus on patient care. Timely, accurate, and robust data entry into your EHR lets the business-minded people in your practice do what they do best and frees the practitioners to focus on providing the best patient care possible.

EHRs Talk to each other become more problematic. The 21st Century Cures Act was the first major step toward governmental intervention to promote interoperability," said Dr. Mahajan. This bill, passed in 2016, was designed to bring medical product and technology innovations and advances to patients who need them faster and more efficiently (U.S. Food and Drugs Administration, March 2018, http://bit.ly/37jKlxw).

"This move forward is essential because there is no room in new models of care for communication information gap that result in adverse events or other problems that increase costs and negatively impact outcomes. There is a need for longitudinal records that enable practitioners to see what has happened as the patient moves from setting to setting," said Dr. Mahajan.

The consequences of systems that don’t share information go beyond finances. They can be devastating, even deadly. Dr. Mahajan said, "I tell the story about a patient who within three months went from living independently to moving through three hospitals and two nursing homes in five different systems." He added that her living will, do-not-resuscitate order, and other data weren’t transferred to the emergency department, where she was resuscitated and ultimately intubated. She suffered and was denied a peaceful death because her information didn’t travel with her to the next site of care.

"This was my motivation to drive forward. We need to make as practice managers is protecting patient information and the organization," said Dr. Swenson. He added, "One appeal of a good EHR is a two-step verification process. That ensures that if a laptop or other device is lost or stolen, we wouldn’t have to worry about patient information being accessed.”

Increasingly, he suggested, cybersecurity is part of orientation for new providers. "We address HIPAA and cybersecurity in the first week, and we continue to provide updates on these issues over time as new developments or security threats arise," he said.

Patients and Cyber Concerns
As stories about health system and organization cyber breaches make headlines, patients and their families are becoming more aware of security issues. At the same time, patient-generated health data from wearable and remote devices present new opportunities for security problems.

In one study from the Harvard T.H. Chan School of Public Health, a third of patients surveyed said they are "very concerned" that an unauthorized individual or entity will be able to access their private data, and 26% said they are

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EHRs should be the top priority for EHRs in the near future. Elsewhere, 67% think improving the user interface of EHRs

Thin Line Between Love and Hate
A love-hate relationship with EHRs isn’t uncommon for practitioners, but there are some who love their information technology. What kind of system wins practitioners’ affections? It’s one that involves physicians and other practitioners in its design, is easily integrated into their workflow, enables access to information without multiple clicks or searches, and frees them for direct patient care, said Darren Swenson, MD, the CEO and president of US Post Acute Care in Tacoma, WA. Features such as a voice-to-text interface also are popular. This enables practitioners to focus on their conversation with the patient and lets the system record necessary information. "Rather than searching for a field, you just say the field. Some even have medical libraries built into the application to help ensure accuracy," said Dustin Baker, security manager and privacy officer at GPM, Inc., in Asheville, NC.

Cybersecurity: Going From Scary to Safe
While the Stanford poll didn’t address practitioners’ concerns about privacy, this is an issue on everyone’s minds. They’ve either read about security breaches that have affected others, or they’ve personally experienced a breach. "One of the most important decisions we have to make as practice managers is protecting patient information and the organization," said Dr. Swenson. He added, "One appeal of a good EHR is a two-step verification process. That ensures that if a laptop or other device is lost or stolen, we wouldn’t have to worry about patient information being accessed.”

Dr. Swenson stressed, “Protecting patient data should be at the top of our list. These individuals should expect us to protect their information at all costs.”

PALTc practitioners should start to prepare for conversations about patient data protection, which will become commonplace in the near future.

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"Protecting patient data should be at the top of our list. These individuals should expect us to protect their information at all costs.”

Senior contributing writer Joanne Kaldy is a freelance writer in Harrisburg, PA, and a communications consultant for the Society and other organizations.

Annual Conference Sessions
Other sessions at the conference to address EHR and technology-related issues include:

• Electronic Medical Records and Computerized Physician Order Entry in LTC: Friend or Foe (Friday, April 3)
• Tools of the Trade: A Practical User Guide From Apps to Data Analytics (Friday, April 3)
• An Advanced Care Unit: Using Telemetry and Continuous Vital Sign Monitoring to Reduce 30-Day Hospital Readmissions (Saturday, April 4)
• Expert Consensus on the Use of Telemedicine in the Roles, Tasks, and Functions of the PALTc Medical Director (Saturday, April 4)