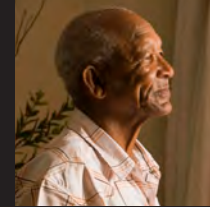


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The Pennsylvania Society for Post-Acute and Long-Term Care Medicine



Fall 2014

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President's Message

LTC Quality: Repetition of the Common

by Leon Kraybill, MD, CMD
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While innovative and creative new programs are sometimes necessary, it is the thorough and consistent repetition of our daily tasks that truly influences quality. Many of our daily tasks can be seen as repetitious and mundane, but it is the unique story of the

individual in front of us which makes our work intriguing and life-giving. This editorial reviews common tasks that can elevate our work to extraordinary quality.

From a cynical perspective, LTC work often involves individuals with declining health, admitted from home or hospital, and often on a treatment regimen prescribed by other providers. They require intervention when there is a crisis, and chart closure at the end of life.

From a proactive and inspired perspective, LTC work is the amazing repeated opportunity to meet individuals with varied and intriguing life histories, and to have the privilege of being involved with their care during the final chapter of their life. It is the opportunity to lead medical, social, and psychological care tailored to the immediate needs of the individual. It is the chance to provide dignity by allowing for understanding of health conditions, managing symptoms, and communicating honestly.

We can best complete these daily tasks if we pay attention to the "mundane" details of care, and use routines that carry us through the necessary steps with each resident.

• **The admission exam** sets the tone for the entire admission. This is the moment to

spend some extra time interviewing the resident and family, looking at office records, researching hospital treatments, and outlining the big picture. Which conditions will alter the patient's health in the near future, and which are less immediately relevant? What problems have not yet been identified? What conditions have been forgotten? A thorough problem list is the only way that I can manage all of this information (see the PMDA website for a sample problem list – www.pamda.org/forms-and-templates).

- **Cognitive function** affects the resident's ability to understand their current conditions, participate in the treatment plan, and make decisions for their future care. If you do not test cognitive function, you will miss impairment in many individuals. Cognitive testing should be part of the admission exam.

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Halloween at PMDA 2014

by John Mast, MD, CMD
jjmast@lghealth.org



PMDA 2014 started early and ended late. Thursday evening started the meeting with a reception for the early arrivers. Friday morning, Timothy Smith, MD, started the conference with horror stories of

more regarding institutionalization of the mentally ill. Using this backdrop, he banished our fears regarding competency and commitment. The 302 process was reviewed, which can be used to commit individuals that are or have been a clear danger to themselves or others within a prior 30-day period. He also discussed the difference between competency and capacity determinations. Providers only determine situation-specific capacity.

Dr. Smith also cleared the cobwebs that surround the mystery of when to stop and start dementia medications. They help only about 5% (on average) for those suffering from SDAT. Anticholinesterase inhibitors should be stopped if there is associated nausea, vomiting, diarrhea, anorexia, gastric symptoms, or other side effects. Bradycardia, syncope, and hip fracture are other risks. Memantine's tolerability is greatly affected by renal failure and side effects include dizziness, headache, confusion, somnolence. No consistent benefits with behaviors with the cholinesterase inhibitors or memantine, and they should not be used for people with mild cognitive impairment. Dr. Smith advised to use memantine or donepezil, but not both.

Ronald C. Goren, MD, scared us all with carbapenem resistant Klebsiella pneumoniae horror stories. He reviewed the bugaboo of foul-smelling urine and distributed an article with educational posters that we can use to educate our staff in our facilities. He said we should treat a UTI only if the resident is septic or if the patient has clear persistent dysuria, hematuria, retention, tachycardia, fever, or

diaphoresis. Dysuria is the most reliable symptom of a UTI.

Naushira Pandya, MD, CMD, clarified hypercalcemia, the management of which is essential for our skeleton. The most common causes of hypercalcemia are increased absorption from bone and adsorption from diet, as well as malignancy. Dr. Pandya also discussed realistic goal-oriented SNF diabetes care. Goals for the LTC resident are different from the worried well. She advised us to control blood pressure to under 150/90 for those over 75 years of age and functionally dependent. AMDA AIC goals are 7-8%, but under 8.5% is acceptable if residents are very complex or have a poor prognosis. Other goals include avoiding all hypoglycemias under 70 and avoiding pre-meal hyperglycemias over 200. A primary benefit of this level of diabetic control is fewer infections and reduced use of antibiotics.

J. Kenneth Brubaker, MD, CMD, reviewed the NFCE (Nursing Facility Eligibility Tool). Aging in place at home is the increasing trend, even when individuals have needs that could put them in the nursing home. Long term care at home is the growth area in the long term care continuum!

Frank Byrne, President and CEO of the Pennsylvania LIFE Provider Alliance, and David Nace, MD, MPH, CMD, gave the time-honored public policy update. Mr. Byrne discussed the state government process aimed at supporting aging at home for the skilled eligible. Dr. Nace described PMDA's state-level advocacy efforts and how lab companies may supply phlebotomists (vampires) to SNFs. Medical marijuana is also being evaluated in the legislature, but for oral ingestion only. Dr. Nace detailed the purple haze that surrounds medical marijuana in the nursing facility.

Karen Tritz, Director of the HGS Nursing Facility Division, was the keynote speaker starting Saturday's sessions. She reviewed the difficulties with adverse events

in short stay residents, as well as the development of a surveyor protocol and tool for identifying adverse events. Ms. Tritz mentioned the need to incorporate QAPI principles in the plan of correction, which is a process that often takes longer than the 10-day required response period. She mentioned the requirement for every facility to have a written agreement with each hospice that provides services at your facility, and the common deficit of care coordination between medical providers and hospice providers. The civil money penalty tool is a software tool that increases consistency with the use of this enforcement remedy and will soon be rolled-out nationally. The CMP funds will be reinvested to improve dementia care in SNFs. Ms. Tritz mentioned the problem of physicians deferring to consultant psychiatrists and accordingly not adjusting medications, along with the tendency for psychiatrists to prescribe more medications than the IDT desired. Reduction of medicines and reducing falls are other goals of the OIG.

Richard Stefanacci, DO, MGH, MBA, AGSF, CMD, announced what we all can expect in the future: post acute care and long term care. He reviewed value-based payment systems for the skilled nursing facility and what happens with bundling of care. He mentioned that vaccines of all kinds can be billed separately during the sub-acute stay. Medications for patients on dialysis often should be paid for by the dialysis provider. Dr. Stefanacci discussed how to improve SNF urgent care, to prevent readmissions, and to survive in the upcoming ACO era. He mentioned that hospital admissions are reduced with a "rapid assessment and initial treatment partnership" with local emergency rooms and discussed telemedicine in the SNF, as well as a single lead EKG device that can be attached to your iPhone (AliveECG). Later, Dr. Stefanacci talked about evolving models of health care delivery, predicting

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President's Message

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- **Advance care planning** involves establishing and discussing the expectations for improvement, stability, or decline, and exploring what the individual wishes to accomplish. If you do not have a sense of prognosis or the individual's wishes for care, you can rarely provide quality care. All LTC residents and family should be offered the opportunity to complete a POLST document, which outlines the patient's specific choices regarding future care. Any significant change in health should trigger a review of the individual's goals and current treatments.
- **Regular provider visits** to the resident and facility are vital to good care. Frequent rounding in the facility (weekly or more often) allows you to monitor changes, intervene before crisis, manage at the appropriate moment, and build trust with your staff.
- **Medication review** should occur at each visit, with the perspective of "medication nihilism". If you cannot provide ready justification for any medication, you should consider stopping it. If a medication "time horizon to benefit" is longer than the

prognosis of the resident, you should consider stopping it. If a medication benefit is no longer consistent with the individual's goals, you should consider stopping it.

- **Attention to pain management and comfort** is appropriate at every visit. Ask your patients: "Do you have pain anywhere today? Is there anything that would make you more comfortable?" These are simple questions, but they open the door to significant discussions. Your staff will know which of your residents have pain. We must be the voice for those who are no longer able to describe their symptoms.
- **Open and supportive lines of communication with facility staff** are priceless to fostering quality. These people are your eyes and ears 24/7. If you disrespect them, they can make your life miserable. If you listen, teach, praise, and engage them, they will go out of their way to help you and their residents. Take a little time to connect with them, and you will gain information that you can get nowhere else.

- **Find the unique story of each resident** by following the above steps. Your residents and families will sense your caring and compassion, and your work will find new meaning.

Common tasks are common, but they are also essential to quality care. They are the building blocks for the best care of each resident. When done consistently, they establish an institutional culture of quality care. ■

Halloween at PMDA 2014

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a model that includes patient and community partnership with the hospital provider groups, all sharing risk and benefit for health care cost containment.

Successes in the ACO environment were revealed next. Jeffrey M. Hardin, MD, MBA, FACC, reviewed a successful local model of long term community care. He mentioned the need to incorporate palliative care along with conventional care, before an individual gets to hospice. Dementia is a cost multiplier. Those in

the last six months of life and those living in skilled nursing facilities incur the most expenses. He mentioned the importance of prognostication and contingency planning for the frail at risk individuals. Susan Denman, MD, CMD evangelically reviewed the Optum care plus program, which cares for individuals in the SNF, at home, and during transitions of care. Finally, Dr. Brubaker detailed antipsychotic reductions and difficulties treating different behaviors. The group

discussed and agreed with the need for documentation of informed consent when antipsychotic medications were used.

The conference ended with multiple ask-the-expert breakout sessions. It was a great time for all to network with our colleagues, and get charged up to pursue quality improvement at our facilities. ■

Annual Meeting Highlights

PMDA Looks Back and Forward

More than 100 long-term care physicians, nurses, and other experts gathered at the Hershey Lodge in Hershey, PA on October 31-November 1, 2014 for PMDA's Annual Symposium and Annual Meeting. In addition to all of the innovative and captivating educational presentations and sessions described by Dr. Mast, PMDA also honored revered and long-time members and board members, approved an organizational name change (from here on, PMDA is called **PMDA: The Pennsylvania Society for Post-Acute and Long-Term Care Medicine**), and welcomed fresh experience and insight to the Board of Directors. Here are some highlights from the 2014 Annual Business Meeting.



(L-R) Duncan S. MacLean, MD, CMD, accepts the first PMDA Duncan S. MacLean Founder's Award for Distinguished Service from board member Ken Brubaker, MD, CMD.

The PMDA Board of Directors honored Duncan S. MacLean, MD, CMD Emeritus, with the inaugural Duncan S. MacLean Founder's Award for Distinguished Service in recognition of his development and promotion of PMDA.

In his own words, Dr. MacLean has been "taking care of nursing home patients" for a very long time. He joined AMDA in 1990 and was in its charter class of CMD recipients in 1991. Dr. MacLean "helped found the Pennsylvania Medical Directors Association in 1992, and served as its Charter President and Treasurer. In that role, he assisted with negotiating the successful passage of Pennsylvania's nursing home abuse law in 1995," and then served on the PA Attorney General's Medical Legal Board that "oversaw implementation of the abuse law from 1987-2011."

Dr. MacLean "wrote the Policy-of-the-Month" column in *Caring for the Ages* from 2000-2003 and was a frequent presenter on abuse, sexuality in the nursing home, decision-making capability, and risk management" at numerous AMDA symposia. He currently practices at the Lebanon VA Medical Center as a geriatrician and Medical Director for its House Call and Contract Nursing Home programs. Dr. MacLean "likens his career to that of Forrest Gump: being in a lot of right places as history happened."

The Founder's Award recognizes significant contributions to building the organizational strength, image, and mission of PMDA, which is "To promote Medical Direction and Physician Services in long-term care, to enhance the reputation of PMDA, and to advance goals enabling the Association to improve care delivered to patients throughout the long-term care continuum."

Do you know a colleague who should be considered for this award? Contact the PMDA administrative office at (717) 558-7868 or pmda@pamedsoc.org.



(L-R) PMDA President Leon Kraybill, MD, CMD, represents the Board of Directors in acknowledging Gary B. Bennett, MD, CMD, for his years of service as PMDA Secretary and Board Member.

PMDA Board Welcomes New Members

Congratulations to Dilip Elangbam, MD, MBBS, DNB, MRCP, MRCPI, CMD, FACP, from Muncy, PA, who was elected on October 31, 2014 to serve as PMDA Secretary! Dr. Elangbam will assume his new role on January 1, 2015.

Congratulations to Firas Saidi, MD, CMD, from Wynnewood/Philadelphia, PA, who was elected on October 31, 2014 to serve as one of PMDA's directors. Dr. Saidi will also assume his new role on January 1, 2015.

Also, As part of the bylaws changes adopted on October 31, 2014 during the PMDA Annual Business Meeting, one new additional non-physician (licensed advanced practitioner, nurse practitioner, physician assistant, or clinical nurse specialist) seat was created for the PMDA Board of Directors. The additional seat has not yet been filled.

PMDA Regional Meetings Offer Innovative and Engaging Member Benefits

by Daniel Haimowitz, MD, CMD, FACP, Chair, PMDA Regional Meeting Committee
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The latest PMDA statewide regional meeting was held on November 19, 2014 with the topic of pain management. Entitled "Not the Standard Pain Talk," the presentation was led by speakers

Sue Mullaney, MS, APRN, GNP-BC and Laura McNamara, APRN-BC, ANP, GNP, ACHPN, CWCN-AP, both nurse practitioners with expertise in palliative and hospice care. The broadcast webinar was held in five different sites across Pennsylvania (SouthEast, Lehigh Valley, SouthCentral, Williamsport and Pittsburgh). Dr. Leon Kraybill discussed a number of issues related to PMDA prior to the lecture. Bonnie Bixler from Penn State College of Medicine, Continuing Education was thanked for her continued assistance in helping to set up the regional meetings, as were the facilitators at each site. These high-quality programs would not be possible without the hard work of each of these volunteers—Dilip Elangbam (Williamsport), Dave Fuchs

(SouthCentral), Catherine Glew (Lehigh Valley), Dan Haimowitz (SouthEast) and Dan Steiner/Tafoi Kamara (Pittsburgh).

Let's review four issues in this article regarding the regional meetings: 1) the benefits of attendance, 2) PMDA as an interdisciplinary organization, 3) opportunities for meetings at two other sites, and 4) potential for additional benefit from regional meetings.

It has been discussed in the past, and bears repeating, that there are multiple benefits from attending regional meetings, both at the statewide and regional (currently only held in the SE) levels. Outside of the annual PMDA Symposium, there are limited talks devoted solely to LTC. This is the opportunity to not only receive education, but also to network with colleagues, learn about developments in LTC at regional, state and national levels, bring up new concerns, get advice and assistance, identify topics for state-level advocacy and/or AMDA House of Delegate resolutions, hear what other organizations are focused on, become aware of job opportunities, and much more. There is also the availability of CMD credits, along with CME

credits. Very frequently, long-term care practitioners function within our own silos. It's a rare chance to be amongst others who empathize and can identify with the issues that we all struggle with.

Interestingly, the Pain Talk was led by two nurse practitioners. That is very much in keeping with PMDA's philosophy of inclusiveness. PMDA was one of the first AMDA affiliates to include nurse practitioners on their Board. PMDA also adopted a bylaws change at the last Annual Symposium to change their tag line to The Society for Post-Acute and Long-Term Care Medicine, which is consistent with AMDA. The purpose of this action is to acknowledge the role of nurse practitioners and physician assistants in LTC. PMDA is even more inclusive, though: all members of the IDT are welcome to attend regional meetings and to become PMDA members. Please encourage your administrator, DON, attending physicians, and others to join PMDA, and invite them to our regional meetings.

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PMDA Regional Meetings Offer Benefits

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For the previous statewide meetings, one of the regional sites was Erie. PMDA was generously helped by Craig Johnston and the Erie Medical Society. Unfortunately, this area was unable to participate in the November 2014 meeting. PMDA is very eager to continue working with this region in the future. If you have any interest, or know of someone who might be interested in becoming involved, please contact Bonnie Bixler at 717-531-6483, or email her at bbixler1@hmc.psu.edu. The planning committee for the regional meetings has developed expertise in running these meetings with Bonnie's able assistance, and the amount of time required by the facilitators has been very manageable. Another opportunity identified during the Annual Symposium is for the Scranton/Wilkes Barre area.

The regional committee team will be reaching out to involved medical directors in that area for 2015, but please contact Bonnie Bixler as above if you would like to become involved. Any of the other regional facilitators would be happy to speak to interested parties to give their experience with running the meetings.

As the experience with having regional meetings continues, the planning committee is extremely interested in getting feedback. Topics for future meetings are always welcome. We have discussed developing coordination of topics between the regional meetings and the Annual Symposium. There is also an opportunity to use the statewide regional meeting forum as an opportunity to engage and involve PMDA members

in current issues (in other words, mini-“membership meetings” at intervals between PMDA Annual Symposia). Your input is important, valuable, and essential, and benefits everyone. We look forward to hearing from you, and seeing you at the regional meeting events. ■

Welcome New Members

PMDA welcomes the following new members to the Association:
(Effective July 17, 2014 to November 4, 2014)

Michele Boornazian, DO, CMD

Thomas Braide, MD

John Bruder, MD

Grace Cordts, MD

Michelle Cuttino, CRNP

Darryl Guistwite, MD

Elizabeth Handte, CRNP

Kenneth Harm, Jr., MD

Christine Herb, MD

Robert Howse, Jr., MD

Ruxandra Jadic, MD

Jatin Kyada, MD

Michael Leser, MD

Kimberly Manganaro, MD

Lilian Ogujiofor, CRNP

Vikas Passi, MD

Thulasingam Ravindramurthy, MD, CMD, FACP

Ashley Ritter, CRNP

Brandon Roda, CRNP

Kelly Rucker, CRNP

Barbara Seward, CRNP

Thomas Shultz, MD

Joel Tumberello, CRNP

Maria Urick, CRNP

Deanna Ziembra

Help Your Facilities Prepare for New Focused Surveys

By Paula G. Sanders¹, Esquire and Laura M. Weeden, Esquire
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Medical directors, attending physicians, and advanced practice nurses should use the next few months to re-familiarize themselves with the Minimum Data Set, Version 3.0 (MDS), and the impact that progress notes and documentation of active diagnoses may have on their long term care facilities' compliance with federal and state requirements. The Centers for Medicare and Medicaid Services (CMS) recently announced the roll-out of a new survey protocol whereby long term care facilities will be surveyed for compliance with MDS requirements and staffing levels (Focus Survey). This new nationwide initiative results from the success of a limited MDS/Staffing-Focused Survey five-state pilot project.²

Although CMS has not released all of the findings from the pilot program, CMS has reported that the piloted survey protocol enabled surveyors to review the assessment process in greater depth than during the annual surveys. This "deeper dive" into the MDS and corresponding records enhanced surveyors' ability to identify errors and deficiencies related to MDS coding and resident care. According to CMS, surveyors identified and cited deficiencies in twenty-four of the twenty-five (96 percent) surveys that were conducted during the pilot. Findings from the pilot included inaccurate staging and documentation of pressure ulcers, lack of knowledge regarding the classification of antipsychotic drugs, and poor coding regarding use of restraints.

We expect that another area of scrutiny will be on whether the MDS accurately reflects active diagnoses that are supported by the medical record. According to Section I of the CMS RAI Version 3.0 Manual (RAI Manual), an active diagnosis is one that has been diagnosed by a medical professional within the past sixty days and is "active" within the seven-day look-back period of

the MDS completion. Active diagnoses have a direct relationship to the resident's functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the look-back period. Medical professionals can help their facilities improve the accuracy of diagnoses coding by ensuring that they provide comprehensive documentation about current and active diagnoses. Consider, for example, that the RAI Manual identifies the following as potential sources of information about active diagnoses:

- Transfer documents
- Physician progress notes
- Recent history and physical
- Recent discharge summaries
- Nursing assessments
- Nursing care plans
- Medication sheets
- Doctor's orders
- Consults
- Official diagnostic reports.

Facilities across the country will need to prepare for the increased attention that surveyors will be paying to MDS accuracy. The new Focused Surveys will last two days, and will assess MDS coding practices in relation to resident care, as well as staffing levels. The Focused Surveys will look for consistency in the MDS, care plans and medical records and are anticipated to be much more detailed than the utilization management reviews (UMRs) conducted by the Pennsylvania Department of Public Welfare.³ CMS will be providing mandatory training to all state survey agency (SA) staff conducting reviews, as well as one manager or trainer within the SA, before starting the MDS Focused Surveys. In Pennsylvania, the Focused Surveys will be conducted by the Department of Health. Look for Focused Surveys to begin shortly after the new year.

These new surveys will supplement, but not replace, a nursing home's standard survey cycle. If a deficiency is found during the MDS focused survey, however, the nursing home will be cited. Depending on the nature and severity of the cited deficiency, enforcement actions and sanctions may follow. CMS has not yet announced if the results of the Focused Surveys will be made public.

Origins of the MDS Focused Surveys

CMS developed MDS focused surveys in response to a number of reports by the Office of Inspector General (OIG) that found that nursing facility assessments were often capturing inaccurate information that was not supported by the medical record. For example, in 2013, the OIG published a report in which it found that "SNFs reported inaccurate information, which was not supported or consistent with the medical record, on at least one MDS item for 47 percent of claims."⁴

Similarly, in a 2012 report entitled *Nursing Facility Assessments and Care Plans for Residents Receiving Atypical Antipsychotic Drugs*, the OIG found assessment errors are common in nursing homes, particularly for residents receiving antipsychotic drugs.⁵ This report found that 99 percent of records reviewed failed to meet one or more federal requirements for resident assessments. For example, many medical records lacked evidence of involvement by a professional who was qualified in the relevant care area to conduct a comprehensive assessment, such as a mental health professional. In 46 percent of records, the RN was solely responsible for conducting the resident assessment, even though the residents may have had mental health conditions that needed to be assessed by qualified health

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Help Your Facilities Prepare

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professionals. As a result of these findings, the OIG recommended that CMS consider modifying its survey process in order to improve detection of noncompliance with federal requirements for assessments of residents receiving atypical antipsychotic drugs.

The OIG's report spurred CMS to issue a May 2013 memorandum that provides clarification to state surveyors regarding the use of psychopharmacological medications in nursing homes and adjusts the survey process to ensure that there is an adequate emphasis on residents with dementia who are receiving antipsychotic medications.⁶ CMS' memo reiterates the government's perception that nursing homes utilize psychopharmacological medications in an attempt to address behaviors without first assessing whether there is a medical, physical, functional, or other cause of the behaviors.

CMS' concern with nursing homes' ability to care for persons with behavioral issues is also captured in the Medicare Recovery Auditor's (RA) review of SNFs treating patients with psychiatric conditions.

According to Performant Recovery, the RA for Region A,

Patients with only a psychiatric condition who are transferred from a psychiatric hospital to a participating SNF are likely to receive only non-covered care. Also, patients whose primary condition/needs are psychiatric in nature often require considerably more specialized, sophisticated nursing techniques and physician attention than is available in most participating SNFs. (SNFs primarily engaged in treating psychiatric disorders are precluded by law from participating in Medicare.)

Likewise, the National Government Services, Inc. medical policy for SNF services for psychiatric patients states that "[i]t is expected that SNF placement for psychiatric patients would rarely be reasonable and necessary."

Establish Teams and Prepare Facility Staff

The increased scrutiny of MDS coding practices and supportive documentation,

as well as the RAs' focus on SNFs providing care to psychiatric patients, should give medical directors and other professionals pause when reviewing residents' assessments and care plans. The use of a Psychiatric/Mood Disorder diagnosis to support the prescription of antipsychotic medications should be carefully documented and appropriately care planned. The national decrease in the use of antipsychotic medications has not resulted in a decrease in the government's interest in this area.

Long-term care facilities should be establishing teams that include the medical director, physicians and nurses, as well as other staff members whose work has a direct impact on the MDS to identify areas for potential improvement. These collaborative teams should ensure that everyone in the facility understands the importance of consistency in the resident assessments and the interrelationship of the MDS, care plan, care delivery and medical record. ■

References

1. Ms. Sanders is a Principal and Chair of the Health Law Practice of Post & Schell, P.C. She may be reached at PSanders@postschell.com and 717-612-6027. Ms. Weeden is an Associate at Post & Schell, P.C.
2. "Nationwide Expansion of Minimum Data Set (MDS) Focused Survey," *Centers for Medicare and Medicaid Services, S&C: 15-06-NH* (Oct. 31, 2014).
3. The UMR audits monitor the accuracy and appropriateness of payments to determine the necessity of continual stay of residents.
4. OIG, *Skilled Nursing Facilities Often Fail To Meet Care Planning and Discharge Planning Requirements*, OEI-02-09-00201 (Feb. 2013)
5. OIG, *Nursing Facility Assessments and Care Plans for Residents Receiving Atypical Antipsychotic Drugs*, OEI-07-08-00151 (July 2012).
6. "Advanced Copy: Dementia Care in Nursing Homes: Clarification to Appendix P State Operations Manual 9SOM) and Appendix PP in the SOM for F309 - Quality of Care and F329 - Unnecessary Drigs," *Centers for Medicare and Medicaid Services, S&C: 13-35-NH* (May 24, 2013)

We Honor Veterans, *Continued...*

by Sarah Noorbaksh, MD
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Today is Veterans Day, an appropriate time to look at how we care for elderly veterans whether in home settings, long term care, or hospice. Like most long-term care or hospice professionals, I was not aware that one in four of the people who die in the United States each year is a veteran. I spoke with a former colleague, Hospice Social Worker Fred Anderson, about the “*We Honor Vets*” program that he spearheads at a local hospice agency, and we discussed how this VA program supports the efforts of long-term care providers in accessing VA services. He explained that the program began as a partnership between the NHPCO and the VA when they recognized that many veterans were dying in the community, and not on VA campuses. The question then became how to improve end of life care for veterans. The “*We Honor Vets*” campaign was the result of this partnership, with the goal of creating a system to educate community hospice providers and provide guidelines for accessing services. This is now beginning to branch out to other services like nursing homes, funeral homes, and locations that may come into contact with veterans and older adults. Mr. Anderson recommends that professionals begin by going to www.wehonorvets.org to familiarize themselves with the basics of the program.

I asked Mr. Anderson to explain what it takes for a hospice, for example, to become a *We Honor Vets Partner*. For hospice providers, there are four levels to complete after signing a commitment letter, and simply described, these progress from Level 1: Providing education to their staff and volunteers and developing a system to identify veterans, to Level 2: Building organizational capacity to provide quality care to Veterans, to Level 3: Developing and strengthening relationships with VA medical centers in the area and with Veterans organizations, and finally to Level 4: Increasing access and improving quality of care for Veterans in the community.

As an example of how this program has tangibly benefitted veterans since his agency began the process, Mr. Anderson explained that the initial area of focus was that of “Honor and Recognition”. The website provides templates for printing service certificates, for example, which can be given at the bedside, or to conduct pinning ceremonies around the holidays. This has been particularly helpful for Vietnam-era veterans who often reflect that their homecoming was very difficult in our culture at the time, and received few recognitions of service. They pay particular attention to the differences in experience of the WWII culture vs. the Vietnam-era culture, and now the Afghanistan and Iraq war cultures, and must tailor end-of-life spiritual and psychological support to the particular culturally unique aspects of those wars.

Another way that the “*We Honor Vets*” program helps is access of benefits, which helps the veteran and the provider maximize assistance available. The VA healthcare benefit is excellent in that it provides payments for hospital care, medications, home health care and hospice care, so when we have a patient that enters hospice with no insurance, the first question asked is if that patient is a veteran, as there may be other routes to obtain coverage for end of life care. When the agency meets with patients that don’t have benefits but acknowledge they are veterans, they are often able to help find out if the care they need is “service connected,” in some cases allowing for a hospice benefit with access to the inpatient unit, or for VA coverage of payments to a contracted nursing facility. The community hospice remains the hospice provider at the contracted facility. There are also pension-type benefits that include aide and attendants, and homebound care that may help the veteran or spouse with monthly payments for extra help in the home or assisted living facility.

Since the campaign, started “*We Honor Vets*” has published an outline of Best Practices for Partners in the program.

One such practice is the collection of history. Often, the most traumatic events and memories of war, conflict, or trauma come out at end of life, and it is helpful to us to learn from the VA what these experiences might be. The Vet to Vet program is another Best Practice. Often, a veteran will share with others what they won’t admit to anyone else, and if shared with us, social workers and spiritual support can help some veterans with difficulty seeking forgiveness for events at war or resolution of trauma at the end of their life. Another of these Best Practice opportunities is belonging to a Hospice-VA partnership in order to access care at the VA more efficiently. And finally, there is the benefit to agencies and nursing homes of increased satisfaction on patient and family evaluation survey data that may be collected by CMS for quality assessment.

With the added focus on care of veterans in the past year, there is greater imperative that all healthcare providers obtain a military service history as part of their initial assessments. As we all seek to de-fragment care and provide the best care in the right place at the right time, the “*We Honor Vets*” program at your area hospice agency can be a useful addition to enhancing the care access and the end-of-life experiences of so many of our patients. ■

Changing PACE

by Pamela A. Fenstemacher, MD, CMD, FAAFP
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For the past forty years, the Program for All Inclusive Care for Elderly (PACE), or Living Independently for Elders (LIFE) in the state of Pennsylvania, has offered a “comprehensive,

fully integrated, provider-based option for those that require nursing home care, the frailest and costliest members of our society”. The PACE program’s philosophy is based upon the belief that living in the community is better for the frail elderly and their families. Nationally, 90 percent of PACE program participants, who are all frail enough to require nursing home care, remain living in the community.

Because of the PACE program’s success, 13 influential United States senators, led by Thomas Carper and Patrick Toomey, recently wrote a letter to Marilyn Tavenner, the Administrator of the Centers for Medicare and Medicaid Services (CMS). The letter stated that they feel PACE is in a unique position to

help CMS with a “larger and more diverse population of individuals” eligible for Medicaid and Medicare. The letter went on to say that the senators believe that PACE should not only continue to care for the frail elderly, but should also help CMS achieve its goals of better care, health, and increased cost-effectiveness for the other dually-eligible as well. The senators’ letter to CMS encourages the Agency to revise the PACE regulations and give PACE programs more “operational flexibility”. The senators feel that the changes they are endorsing would allow PACE programs to use their services to support our seniors more “effectively and efficiently”.

The changes to the PACE regulations proposed by the senators to increase operational flexibility of PACE programs and maintain PACE as a high-quality, cost-effective option to seniors included: offering alternatives of operating a PACE center, allowing PACE organizations to integrate community physicians into the PACE interdisciplinary team (IDT), allowing programs more flexibility in configuring the IDT, and having CMS and state agencies conduct reviews of new PACE provider applications concurrently.

The senators envision using alternatives to the PACE center, such as adult day health centers or senior centers, for participant socialization and interaction with the PACE IDT. These alternatives could possibly prove to be more cost-effective than the PACE center as well. Currently, the regulations proscribe the make-up of the IDT, which is identical for all participants and must include a physician employed by the PACE program as a primary care provider. The senators are proposing that the IDT could be configured based on the participant needs and that physicians, physician assistants, and nurse practitioners in the community should also be allowed to be the team’s primary care providers.

Thomas Carper and the other senators “encourage(d) CMS to release a revised PACE regulation and foster a regulatory environment that increases access to the proven, high-quality, cost-effective PACE model”. ■

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2014 AMDA News

by Daniel Haimowitz, MD, CMD, FACP
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PMDA is fortunate to have two members on the AMDA Board, Dr. Ken Brubaker (Treasurer) and myself (Secretary). Both Dr. Brubaker and I are actively involved, and also serve on the Executive Committee and on the AMDA Governance Committee.

The biggest news to come out of the March Annual Meeting was that the House of Delegates (HOD) voted to change the organization's name to AMDA – The Society for Post-Acute and Long-Term Care Medicine. The HOD also voted to expand full membership to nurse practitioners (NPs) and physician assistants (PAs). AMDA's name change reflects the increasing prominence of post-acute care in the long-term care continuum, and the longstanding presence of attending physicians and other practitioners in AMDA's membership in addition to medical directors. NPs and PAs will now be able to participate fully within the structure of the organization, to serve on and chair national committees, to participate in state chapters according to conditions and requirements each chapter chooses to establish, including being Delegates to HOD. At the annual PMDA meeting in October, the Board proposed a name change to stay in line with AMDA. This was presented at the PMDA Annual Business Meeting and passed unanimously.

The AMDA Board monitors and directs all committee work. For the AMDA Public Policy Committee, priorities for the coming year included Regulatory Issues (such as new models of payment, ACO developments, HIT, Meaningful Use and quality measures), as well as improving dementia care in nursing homes and timely access to pain medications. Coalition-building issues included SGR reform, medical liability, payment/RUC, infection control/HAIs, geriatric

workforce, and observation status. Issues to monitor were delivery system reforms (monitor ACOs, nursing readmissions demonstration programs), assisted living, QAPI final rule and implementation, health care reform implementation issues, general practice issues, and support for general physician's issues through the AMA and other coalition efforts. The AMDA Board included the topic patient safety, partly in response to the OIG report on SNF Harms. The AMDA Executive Committee has been having monthly meetings with CMS, which has greatly improved communication between the two organizations.

The issue of defining quality in PA/LTC was the major focus of the AMDA Board's face-to-face meeting in September 2014. The Board felt that quality is central to AMDA's overall mission and is in fact an aspect of everything AMDA does. For this reason, an eighth goal was added to the overall strategic plan regarding quality, making the new goal more broadly focused than just clinical quality measures and focused on the definition of quality in PA/LTC. A white paper detailing these issues will be written and presented at the AMDA HOD meeting in March 2015.

CMS recently convened a meeting regarding the OIG report on Adverse Events in SNFs, where AMDA was invited to attend. In the report, 37% of patient harms were medication-related. In addition, the HHS ODPHP has produced a national plan to combat adverse drug events, focusing on three classes of drugs: anticoagulants, diabetes agents, and opioids. AMDA feels that they should lead this discussion and is reviewing a proposal to develop and implement a "Quality Prescribing" campaign to address this issue, in collaboration with ASCP, AGS, LeadingAge, AHCA, and Consumer Voice, among others.

There were several other important discussions of interest at the September meeting. One involved Assisted Living (AL). There was recognition of the fact

that the AL industry seems to be realizing that AL residents have increasing medical needs and may be more willing to work with physicians to optimally deal with those needs. The AL subcommittee is developing an AMDA member AL survey, prioritizing a list of quality measures in AL, and also holding a meeting with AL providers in December 2014.

Another AMDA issue involved the AMDA Certification Program. Along with a name change to the American Board of Post-Acute and Long-Term Care Medicine, there were involved discussions about requiring an examination for the CMD credential.

As always, AMDA relies on state affiliates to develop HOD resolutions to keep the national organization apprised of important issues, either those already affecting LTC nationally or those occurring on the state level that may have national implications. Dave Fuchs, MD, CMD, will be spearheading PMDA's resolution efforts this year. If you have any suggestions or would like to become involved in crafting resolutions, please contact him at defuchs@comcast.net.

The AMDA Annual Meeting will be held in Louisville, KY on March 19-22, 2015. Information regarding the meeting can be found at www.paltcmedicine.org. Be sure to register, and make your hotel reservations ASAP (the NCAA basketball tournament is being held in Louisville that weekend, so hotel rooms will be at a premium). ■



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