PMDA
Pennsylvania's Association for Long Term Care Medicine

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Official Pennsylvania Chapter of
American Medical Directors Association

## President's Message

# The Pursuit of Quality and Life Balance

by Leon Kraybill, MD, CMD

Quality - degree of excellence, a distinguishing attribute, superiority in something, the perception of the degree to which the service meets the customer's expectations.

Quality assurance - the activity of checking services to make sure that they are good.

We throw these terms around with ease, seeking to present our efforts in a holiday wrap of intrigue and promise. We dutifully attend our meetings, prepare our reports, submit to the scrutiny of our regulators, and meet the needs of our customers and families. And, if honest, most of us consider ourselves and our facilities to be above average. We often succeed on an individual and institutional level. We give our heart and soul to our work, putting in long hours and emotional energy. We ponder and agonize and rethink for the third time. We grab some food and sleep and start all over. We give of ourselves, our time, our compassion, and our life energy.

And it's hard work…the demands are myriad and seemingly unsatisfiable. We return to work inspired by a lecture or presentation, only to find that our inspiration dissipates into immediate needs and crises. We set the strategy and course for new direction, only to find our resources and options change in the next week. We put in the extra time to finish a needed project, but often at the expense of our personal and emotional health.

Undoubtedly, it's rewarding work. We all know the moments of success that renew our energy: the smile on the face of a resident, a wink as you pass by a room, the appreciation of the family member who finally understands, the peacefulness of a painful situation finally managed, the coordination of resources that allow care to continue, the successful discharge to home, the staff member who responds with insight and compassion to dementia behavior, the recognition of a unique trait, or the successful navigation and delivery to the end of life.

The essence of life and death are often distilled into one day or even one hour of our long-term care experience, day after day. Many of us find it to be our life mission, with an almost addictive attraction to dealing with people when the pretenses and less important things of life are peeled away.

So how do we pursue and maintain a quality of care that is head and shoulders above our national norm? How do we inspire ourselves, and then our staff members and facilities to share this mission? How do we encourage daily giving of ourselves without depleting our energy and inspiration? How can we make this a team effort, not only of the people in our specific building but also of our colleagues across the state of Pennsylvania?

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## Inside This Issue

# Update from the PA Office of Aging/Long Term Living

by J. Kenneth Brubaker, MD, CMD

One of the most significant events that occurred in the PA Department of Aging over the past nine months was the development of the Pennsylvania State Plan on Alzheimer's disease and Related Disorders (ADRD). This plan was created through a 26-member planning committee that included a number of public hearings throughout Pennsylvania. There were three PMDA members that took time out of their busy schedules to give testimony on the dire need for more training in the field of geriatrics.

Seven recommendations were made to Governor Corbett by the Pennsylvania Alzheimer's Disease Planning Committee. They include the following:

1. Improve awareness, knowledge, and sense of urgency about medical, social, and financial implications of Alzheimer's disease and related disorders across the Commonwealth.
2. Due to the magnitude of the ADRD epidemic, identify and, where possible, expand financial resources to implement this plan through federal, state, foundation, private, and other innovative funding mechanisms and partnerships.
3. Promote brain health and cognitive fitness across the lifecycle from birth onward.
4. Provide a comprehensive continuum of ethical care and support that responds to social and cultural diversity, with services and supports ranging from early detection and diagnosis through end-of-life care.
5. Enhance support for family and non-professional caregivers and those living with ADRD.
6. Build and retain a competent, knowledgeable, ethical, and caring workforce.
7. Promote and support novel and ongoing research to find better and effective cures, treatments, and prevention strategies for ADRD.

On a different note, the Preventable Serious Adverse Events (PSAE) plan continues to limp along, requiring final approval internally before being sent to CMS for approval. Many of you have already heard about the recent OIG report released in early March 2014. This report suggests that many of the serious adverse events within the nursing home settings are preventable. Once again, there will be a push to engage the state surveyors to solve the problem of reduction of preventable events. While our state surveyors may improve the reduction of some preventable events, I believe an equally important contributing problem is the lack of available providers to evaluate frail residents within 24 to 36 hours of a sudden change of condition. Finally, nursing home management teams must recognize that most individual failures are due to systems failures. I frequently observe, when reviewing cases from the attorney general's office and from Adult Protective Services, that management's "fixing" the problem of a preventable event was done by firing staff but failing to fix the system that was a major contributor of the staff error.

I have included the key pieces of the ACT 1 legislation that was passed by PA legislators in 2009. Hopefully, this will help you and your nursing facilities prepare for the eventual PSAE program.

As specified in ACT 1, a PSAE event must meet all of the following criteria:

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## President's Message

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These are the questions I ask of myself and PMDA as I began a two-year presidency. How can we articulate a better understanding of long-term care quality? How can we encourage accomplishment of this quality without burning ourselves out? How can we share our individual successes, resulting in improved resources for everyone? What are the resources and tools available within our facilities, but not broadly known? How can we relinquish our "silo view" and understand the broader needs of everyone?

I have no easy answer or universally successful scheme. I have ideas that have worked within my facilities but they may not work everywhere, and I suspect there are many even better ideas in place elsewhere.

Several starting points include:

- The interdisciplinary team – doctors (and everyone) should shed their ego as they enter a long-term care facility. Care is given by everyone, and each role is important. I play an important role as physician, but only as a colleague of 10 other people who also have important roles. Once everyone understands and learns this, we can truly get down to dealing with what is important. Respect is earned by valuing a colleague's role, not by trumpeting your own.
- Online resources – there are increasing numbers of great websites and institutions and agencies who provide tools and programs and recommendations for best care. Let's know and utilize the resources that are out there.
- Share our successes - there are many similar situations and scenarios that we all deal with on a regular basis. Let's not "reinvent the wheel" in each of our facilities for each new situation. I'll be happy to give extra time on my particular problem and then share it with you, if I can get the recommendations and solutions from my colleagues around the state on 10 other difficult problems.
- Self-care and knowing our own limits - none of us can do everything, nor should we try. Once we give up on doing it all, it is actually easier to request and accept the assistance of others.
- Telling our stories of learning and mission - many of us do long-term care work because of our love of connection and story and interaction. Stories inspire us more than inspirational speeches. Sometimes what we learn from a situation is more important than whether it was a failure or success. Let's share our stories of inspiration and how we have grown – and see them as water and fertilizer for our continued excellence.

My newsletter columns will pursue these issues during my presidency. I welcome your ideas, suggestions and stories of how we can further this area. Send your thoughts to my email: lskraybi@lghealth.org. ■

# AMDA 2014 Highlights: the Emergence of the ACO

by Thomas Lawrence, MD, CMD

AMDA's Annual Conference—Creating Harmony in Long Term Care—was held February 27 through March 2, 2014 in Nashville, Tennessee. One of the dominant and innovative themes of the conference was the impact and interface of affordable care organizations (ACO) and long term care practice. Several sessions covered aspects of care delivery and the transformation of care that the ACO brings to American medicine. One recurrent theme of the sessions focused on the healthcare Triple Aim Initiative (Institute for Healthcare Improvement,) which is the simultaneous pursuit of three dimensions: improving the patient experience of care, improving the health of populations, and reducing the cost of healthcare.

Dr. Verna Sellers and David Adams from Centra Health in Virginia presented a session addressing the innovative aspects of ACOs as a new delivery model of care within the context of the Affordable Care Act. A new set of core competencies that was described includes physician-hospital integration, care coordination and management capability, information systems sophistication, service distribution effectiveness, strong cost structure management, successful payer relationships and contracting, and brand identity development. A dynamic shift in risk was described which involves switching financial risk from payers to providers. This principle anticipates care transformation as it transitions from fee-for-service to pay-for-performance arrangements and bundled payments to global capitation.

In a large session, Montefiore Medical Center in the Bronx, New York City presented The Changing Imperative of Healthcare: Lessons from Montefiore's Pioneer ACO. Dr. Amy Ehrlich described the setting—an urban community with a large elderly population of very high ethnic diversity who are relatively impoverished with a very high medical morbidity. The health system consists of four hospitals with more than 90,000 annual admissions. The ACO program began in January 2012 and has been one of the top priorities of the health system. The ACO consists of 23,000 Medicare beneficiaries and primary care physicians that are both ACO-employed and community-based. Initiatives that are part of the ACO include care management, emergency department case management, transitional care programs, nursing facility initiatives, medical home visit programs, and clinical pathways for a number of acute and chronic conditions including heart failure, chest pain, and back pain. The program also includes use of geriatric hospitalists and consultation services for both geriatrics and palliative care.

Initiatives were developed in collaboration with the five highest volume nursing facilities in the network that included regular meetings with facility medical directors and ACO leadership, joint analysis of readmissions, and shared clinical pathways, including those for diabetes and heart failure. Other innovative programs they developed include a geriatrics hospitalist program, emergency department (ED) navigators, a nursing facility transfusion program, and coordinated palliative care across all care settings. The geriatrics hospitalist program encompasses a teaching service that includes fellows, family practice residents, and medical students. All ACO nursing facility residents who are admitted to the hospital are covered by the geriatrics hospitalist service. This improves both transitions in care and the continuity of care. The ED patient navigator program utilizes a nurse practitioner stationed in the emergency department to assess nursing facility residents who are under evaluation there.

Dr. Michael Bogaisky presented risk factors for hospital readmission among the ACOs nursing home residents. Baseline demographics depicted patients that had very high medical comorbidities and advanced age (averaging over 80 years old.) Patients readmitted to the hospital within 30 days were found to have a mortality rate that was three times those admitted to the hospital for primary admission. Thirty-day readmission rates of the participating nursing homes ranged from 22% to 69%. Dr. Bogaisky also pointed out that the readmission rates for their geriatric hospitalist service was lower by 13%, compared to a group of outpatient geriatricians practicing part-time in the acute care setting. The greatest risk factors for a 30-day readmission were found to be patients with end-stage renal disease and chronic kidney disease, followed by COPD, CHF, and diabetes.

Dr. Sandra Selikson discussed the nursing facility imperative in ACO participation. ACO approaches utilized by the nursing facility to improve care as part of the project include audits of all rehospitalizations, a monthly ACO meeting with nursing facility administrators, a heart failure management protocol, and development of an advanced care unit within the nursing facility, essentially creating a hospital within the facility. The monthly meetings between the ACO and the participating nursing facilities involve representatives from all key nursing facilities including the Administrator, Medical Director, and Director of Nursing. A variety of quality measures are shared and individual cases and problem areas are discussed. Clinical programs and best practices are shared with each other and include utilization of feeding tubes, PICC lines, and outpatient blood transfusion. Shared expectations including seven-days-a-week admissions were agreed upon by all facilities. Efforts to promote advance care planning including identifying residents who might benefit from hospice or palliative care programs rather than rehospitalization for changes in condition are promoted. The heart failure protocol developed for the ACO includes mandatory cardiology consultation and a protocol that optimizes medical management. Through these and other initiatives, a decline in the rehospitalization rate of ACO patients over four years from 25% to 17%, and

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# Government Focus on Quality of Care Highlights Need for Greater Director Involvement in Quality Assurance[1]

by Paula G. Sanders, Esquire[2]

Improving quality and preventing adverse events of care in post-acute settings, including skilled nursing homes (SNFs) and hospices, continues to be a major focus of the Office of Inspector General (OIG), the Centers for Medicare and Medicaid Services (CMS), and the Department of Justice (DOJ.) Recent OIG reports stress lack of sufficient oversight and enforcement as a factor that has contributed to poor care in such settings. Not surprisingly, members of Congress have read the OIG reports, and in an April 2, 2014 letter to CMS, Administrator Marilyn Tavenner and Senators Charles Grassley and Bill Nelson look for changes to the survey and certification process. Taken together, the OIG reports and Congressional inquiry underscore the need for medical directors to become more involved in their organizations' quality assurance programs.

Senator Grassley, Ranking Member of the Senate Committee on the Judiciary, and Senator Nelson, Chair of the Senate Special Committee on Aging, trace their concern about SNF quality of care to two OIG reports, Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries[3], and Medicare Nursing Home Resident Hospitalization Rates Merit Additional Monitoring[4]. Drawing on the findings of these reports, the Senators want to work with CMS "to improve the survey and certification process to improve patient care and to identify problems earlier, so that CMS can work with facilities to address them before they compromise patient care."

It is too early to tell how CMS will respond to the Senators' inquiry about changes to the survey and certification process. We do know, however, that CMS and the Agency for Healthcare Research and Quality (AHRQ) are committed to raising awareness of nursing home safety issues and seeking ways to reduce resident harm using methods similar to those used to promote hospital safety efforts. CMS has advised the OIG that it will instruct state agency surveyors to review nursing home practices for identifying and reducing adverse events.

Now is a good time for medical directors to assume a more proactive role in their organizations related to quality assurance, particularly in those areas that the government has identified as being problematic. According to the OIG Adverse Events report, in Fiscal Year 2011, approximately 22% of Medicare beneficiaries experienced preventable adverse events during their stay at a SNF. The OIG extrapolated that these events cost Medicare about $2.8 billion for hospital treatment for harm caused by SNFs[5]. Of those events, the OIG determined that 59% were clearly or likely preventable: 37% of events were related to medication; 37% of events were related to resident care; and 26% of events were related to infection. The consequences of those events varied in scope with 79% of the adverse events resulting in a prolonged SNF or hospitalization, 14% requiring intervention to sustain the resident's life and 6% contributing to or resulting in the resident's death.

The OIG's Compendium of Priority Recommendations[6], released in March 2014, is a good resource to review for understanding how the OIG would like CMS to improve the survey and certification process and the quality of care provided by SNFs. Citing a prior report that found that Medicare paid approximately $5.1 billion for a sample of 2009 stays in which SNFs did not meet quality-of-care requirements, the OIG identified significant problems with inappropriate care planning and discharge planning. Specifically, the OIG found that for 37% of stays, SNFs did not develop care plans that met requirements or did not provide services in accordance with care plans. For 31% of stays, SNFs did not meet discharge planning requirements. Other areas of poor quality care related to wound care, medication management, and therapy. Areas of special concern for the OIG also include inadequate resident monitoring, failure or delay of necessary care, and atypical antipsychotic drug use.

In neither the Adverse Events nor the Resident Hospitalization reports did the OIG consider whether the alleged problems they found were episodic or systemic. Regardless of this shortcoming, by focusing on data within their own facilities, medical directors can help administration analyze patterns and trends. Working within the privileged environment of their Quality Assurance and Assessment Committee, medical directors can assume a leadership role in conducting root causes analyses of identified risk areas. Beginning this process now will better position the SNF for the increased scrutiny that is guaranteed to follow in the aftermath of the recent OIG reports on quality of care.

Although CMS has yet to issue regulations clarifying the parameters of an effective Quality Assurance and Performance Improvement (QAPI) Program, based on these reports and recommendations, CMS is likely to require that the QAPI Program address the reduction of preventable adverse events in SNFs. In fact, CMS guidance on QAPI states that QAPI incorporates the existing Quality Assessment and Assurance regulation which requires facilities to track, investigate and try to prevent adverse events. CMS has also indicated that when nursing facilities promote a systematic, comprehensive, data-driven approach to care, this very well may prevent adverse events from occurring.

As the person responsible for the implementation of resident care policies within the SNF, medical directors are integral to detecting and preventing adverse events. To date, many SNFs have failed to take full advantage of the value that medical directors can bring to their quality assurance endeavors. The recent OIG reports and the Congressional letter to CMS should serve as a wake-up call to all SNFs to engage their medical directors in a more integrated and thoughtful approach to quality assurance. ■

1. This article does not offer specific legal advice, nor does it create an attorney-client relationship. You should not reach any legal conclusions based on the information contained in this article without first seeking the advice of counsel.
2. Ms. Sanders is a Principal and Chair of the national health law practice of Post & Schell, P.C. She may be reached at psanders@postschell.com and 717-612-6027
3. OIG, *Adverse Events in Skilled* Nursing *Facilities: National Incidence Among Medicare Beneficiaries*, OEI-06-11-00370 (Feb. 2014)
4. OIG, *Medicare Home* Resident *Hospitalization Rates Merit Additional Monitoring*, OEI-06-11-00370 (Feb. 2014)
5. The sample consisted of only 653 beneficiaries who had SNF stays of 65 days or less.
6. OIG, Compendium *of Priority Reecommendations,* (March 2014). *See also*, OIG 2014 Workplan and OIG 2014-2018 Strategic Plan.

# The 2014 PMDA Annual Symposium: A Preview

by John Mast, MD, CMD, Co-Chair, PMDA Annual Symposium Committee

During the annual symposium, long term care will get another educational boost this Halloween at Hershey. Friday will consist mainly of clinically relevant presentations. Saturday will give attendees the knowledge to be an accountable care organization survivor.

Friday morning, Tim Smith will discuss dementia, decision-making capacity, and the 302 process. He'll also give a separate lecture about when to start and stop dementia medications. Later in the morning of Halloween, we'll have appropriately frightening lectures on infectious disease by Ron Goren, and Hypercalcemia by Naushira Pandya.

After lunch, Ken Brubaker will give a presentation on level of care determination, and Naushira Pandya will give an update regarding diabetes care for the elderly. At the end of the day, Dave Nace will present the time-honored public policy update and Frank Byrne will give a governor's commission update.

Medicine is changing; at times it is a frightening, like a graveyard at night during Halloween. However, armed with appropriate knowledge and skills, we can succeed and thrive during this paradigm change. Finally, providers can be reimbursed for doing quality work that improves outcomes! Saturday's sessions will inform. Important lessons from ACO success stories can be extrapolated to each of our long term care settings.

Karen Tritz, CMS Director of the Nursing Facility Division, will give us a CMS update. New nursing facility quality measures and patient satisfaction measures will be presented. Alice Bonner will discuss how providers succeed in the upcoming accountable care environment and a successful pilot ACO program from Lancaster County will be highlighted by Jeff Hardin. Key elements of a successful home visit program will be reviewed by Susan Denman from Optum. The morning presenters will have a panel discussion at the end of the morning sessions.

After lunch on Saturday, we will have a presentation regarding bundled care and the skilled nursing facility. Saturday afternoon before the meeting is adjourned, we will have round table discussions where you can "ask the expert."Look for the symposium brochure for topics!

We hope to see you at Hershey for Halloween! Be sure to share this symposium update with colleagues and administrators in your hospital and long term care setting—the sessions will be instructive to all as we gird up for the changing healthcare environment. ■

# PMDA Hosts Twice-Annual Regional Meetings

by Daniel Haimowitz, MD, CMD, FACP, Chair, Regional Meeting Committee

Since 2013, PMDA has presented twice-annual statewide regional meetings. In addition to providing an educational opportunity, these meetings provide extra value, which includes the ability to network with colleagues, stay up to date with current issues in the long-term care arena on a state and national level, and the ability to receive CMD credit. This year, the PMDA Regional Meeting Committee and the Program Committee have become more aligned, with Bonnie Bixler, the Assistant Director Penn State College of Medicine, Continuing Education, providing better organizational structure and improved coordination of educational offerings through PMDA.

We are currently organizing two statewide programs for 2014. The first will be held on **May 22, 2014** at six locations via WebEx webinar. The topic is "Helping Your Facilities Prevent Falls: Your Role as Medical Director in Falls Prevention." The speaker is Barbara Resnick, PhD, RN, CRNP, FAAN, FAANP. Dr. Resnick is Past President of the American Geriatrics Society, a member of the AMDA Foundation Board, and a nationally-recognized expert in fall prevention techniques. The presentation is geared not only towards medical directors, but will also be of great use to attending physicians and nursing home leadership and staff. Issues to be discussed include:

- Why this topic is important for the medical director
- What should the ideal role of the medical director be regarding fall reduction?
- What should the DON/NHA say to/expect from the medical director?
- Are there in-services available for the medical director to present to staff?
- Is there a "best" standardized form for facilities to use, both in fall reporting and for fall data analysis?
- How best should the information from a falls committee get to the medical director?
- How can/should the medical director work with attendings about education and fall reduction?
- Can/should a falls reduction program incorporate medication reduction overall?

With the new organizational format, this free event will provide not only CMD credit, but also CME and NHA credit. At the meeting, there will also be an update on current PMDA activities and committee work. Regional meeting location information is as follows:

**Southeast Region** - Crossroads Hospice
523 Plymouth Rd., Suite 225
Plymouth Meeting, PA 19462
Facilitator: Dan Haimowitz, MD, CMD

**Southcentral Region** - Mennonite Home
Juniata Room
1520 Harrisburg Pike
Lancaster, PA 17601
Facilitator: Leon Kraybill, MD

**Williamsport** - Rose View Center
1201 Rural Ave.
Williamsport, PA 17701
Facilitator: Dilip Elangbam, MD

**Erie County Medical Society Building**
1438 W 38th St.
Erie, PA 16508
Facilitator: Craig Johnston, DO

**Lehigh Valley** - Cedarbrook Nursing Home
350 S. Cedarbrook Rd.
Allentown, PA 18104
Facilitator: Catherine Glew, MD

**Pittsburgh** - UPMC Passavant Hospital
Assembly Hall, 9100 Babcock Blvd.
McCandless, PA 15237
Facilitator: Dan Steiner MD

**For online meeting registration, visit http://www.pamda.org/pmda-regional-meetings.**

Our second statewide regional meeting is scheduled for **November 19, 2014**. The topic will be pain management in long-term care. Please mark your calendars now! All are welcome to attend, so RSVP and invite your staff and colleagues to attend as well. The hard work and efforts of the facilitators is greatly appreciated—they are available to answer any questions you may have. There is also an opportunity for exhibitors to attend the events. If you have any leads, please direct them to the exhibitor information at http://www.pamda.org/pmda-regional-meetings. ■

## Update from the PA Office of Aging/ Long Term Living

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1. The event was preventable. To be preventable, the event could have been anticipated and prepared for, but, nonetheless, occurred because of an error or other systems failure.

2. The event was serious. The event is serious if the event subsequently results in death or loss of body part, disfigurement, disability, or loss of bodily function lasting more than seven days or still present at the time of discharge from a nursing facility.

3. The event was within the control of the nursing facility. Control means that the nursing facility had the power to avoid the error or other system failure.

4. The event is the result of an error or other system failure within the nursing facility. ■

**AMDA 2014 Highlights**
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most recently heading toward 12%, was achieved.

The final element of the Montefiore ACO presentation was a discussion by Dr. Roy Goldberg about palliative care initiatives in the long-term care setting. This program includes a screening of all ACO patients admitted to a participating nursing facility for palliative care symptoms and needs. A multidisciplinary hospice and palliative care team was created to optimize on-site evaluation of potential cases. This effort focuses on residents with advanced life-limiting illness including severe dementia, COPD, congestive heart failure, cancer, other advanced CNS conditons, and other advanced diseases, including pulmonary hypertension and coronary artery disease. It was found that about 55% of their facility residents were deemed appropriate for palliative care consultation. They reported increased identification of unmet palliative care needs and also an increased number of hospice referrals with implementation of this program.

Dr. Ken Brubaker and Dr. Vicki Gilmore from Masonic Village in Elizabethtown, Pennsylvania presented issues in positioning nursing facility organizations for the ACO environment. They outlined five steps that nursing facilities can take to optimize their position in preparation for ACO participation. These were: (1) avoiding hospitalizations and re-hospitalizations (including a focus on prevention of infections and optimizing antibiotic use); (2) optimizing staffing and controlling staff turnover; (3) medical staff organization (including consistent physician coverage, staff geriatricians, and a closed-staff model); (4) clinical process enhancements with intensive quality monitoring (addressing areas such as expanded nursing assessment, optimal medication utilization, and aggressive advance care planning); and (5) partnering with health systems. The importance of sharing both clinical and quality data was highlighted as critical to the success of ACO partnering.

All of the sessions emphasized the need for providers at different levels of care to work together in promoting collaboration and network partnering, attention and commitment to quality improvement, and the need to embrace innovation and new models of care. In addition, it is realized that while many of these approaches are outside of traditional market considerations such as payer coverage and revenue generation, they are the keys to successful ACO planning and operation. ■

# Who's Paying for This, Anyway?

by Deborah Way, MD, CMD and Sarah Noorbaksh, MD, CMD

On March 10th of this year, CMS issued the "Final Guidance on Part D Payment for Drugs for Beneficiaries Enrolled in Hospice." The authors of this article intend to present exact wording from this document (in italics) and refer the reader to the complete document. However, we also provide some editorializing and welcome readers to comment on the PMDA members list serve.

*Hospice is responsible for covering all drugs or biologics for the palliation and management of the terminal and related conditions. Therefore drugs and biologics covered under Medicare Part A per-diem payment to a hospice program are excluded from coverage under Part D.*

***Drugs Covered under the Hospice Benefit***
*The hospice plan of care must include all services necessary for palliation and management of the terminal illness and related conditions.*

***Drugs Covered under Part D for a Beneficiary Who Has Elected Hospice***
*For prescription drugs to be covered under Part D when the enrollee has elected hospice, the drug must be for treatment of a condition that is completely unrelated to the terminal illness or related conditions.* ***We expect drugs covered under Part D for hospice beneficiaries will be unusual and exceptional circumstances.*** *(Bold added by authors.)*

The memorandum continues (and this bold/face is provided by CMS:) ***Therefore, the sponsor should place beneficiary-level prior authorization (PA) requirements on all drugs for beneficiaries who have elected hospice to determine whether the drugs are coverable under Part D.***

***Drugs that are a Beneficiary Liability***
*There may also be some drugs that were for the treatment of the terminal illness and/or related conditions prior the hospice election that will be discontinued upon hospice election as it has been determined by the hospice interdisciplinary group, after discussions with the hospice patient and family, that those medications may no longer be effective in the intended treatment, and/or may be causing additional negative symptoms in the individual. These medications* ***would not be covered under the Medicare hospice benefit****, as they would not be reasonable and necessary for the palliation of pain and/or symptom management. If a beneficiary still chooses to have these medications filled throughout his or her pharmacy, the* ***costs of these medications would then become a beneficiary liability for payment and not covered by Part D.***

We believe that this new rule from CMS is intended to decrease the cost of medications for the patient who has elected hospice care. We agree that the standard of care should be to review patients' care plans for medical appropriateness. However, the actuality is that this new guideline forces patients who are already in crisis due to advanced illness to choose care that may not be medically appropriate. Frequently, a patient who arrives at the question "Is

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HOSPICE the right choice for me?" has spent a great deal of time worrying about blood pressure, salt intake, blood glucose measurements, and cholesterol. Mandating a choice between hospice care and a statin, to put it simply, may tip the patient to continuing care that may not be in alignment with goals of care.

Like all end-of-life decisions, the interpretation of what is needed for comfort and what is medically necessary can be an Escher diagram of complex scenarios and must be individually tailored for each patient. When, for example, would anticoagulation be medically necessary for a hospice patient with cancer, and recent PE or DVT or stroke or MI? If a patient with end stage COPD is on expensive immune modulators for painful RA, are these to be covered by hospice, or are they related to pain management?

The best we can do as medical providers is to continue to "do the right thing." We must understand the following questions: "What are the patient's goals of care?" "How can we guide our patients and their families?" "What is the best vehicle to achieve the goals of care?" And above all, the process we use and the documentation in the patient's records must be exquisitely detailed.

We must review all of the patient's diagnoses and their medications along with the history of the illness which led them to require hospice care. We must review how each comorbidity affects the hospice diagnosis. We must then justify each medication and treatment to ensure that the individual patient receives the care that is best for them. All of this places an increased burden of time on providers, many of whom just want to take care of the patient.

In addition, for many patients entering hospice care, there are several providers involved in care who may have differing opinions with regard to what is necessary, or may prescribe to the patient without the knowledge of the hospice medical director. Ultimately, the new guidance leaves the final decision to the hospice physician. This makes communication and cooperation between practitioners on a timely basis even more important when end of life care is being anticipated.

The complete title of this report is "Part D Payment for Drugs for Beneficiaries Enrolled in Hospice - Final 2014 Guidance. March 10, 2014." ■

# When the POA Wants to Borrow Your License

by David E. Fuchs, MD, CMD

When caring for frail, elderly patients, a third party, the Durable Medical Power of Attorney (POA) is part of the physician-patient relationship. Although both the physician and the POA feel they have the patient's best interest at heart, there are times when they disagree. Handling these conflicts is an important skill for the long term care clinician to master.

Recently, I received a fax from a facility expressing concern that a resident was suffering from an increase in anxiety. I recommended increasing her Zoloft dosage. The next day I received a fax indicating the POA did not agree to the dosing change. I spoke with the POA, who explained to me that she read about Zoloft on the internet and learned it was an antidepressant, and that her mother was not at all depressed. I carefully explained the anxiolytic properties of SSRI antidepressants, and how Zoloft has an FDA-approved indication for the treatment of anxiety. I am sure she subsequently Googled to check that my assertion and opinion were correct.

A younger physician might find it astounding that someone with no medical background would question the wisdom of a physician with experience and credentials in long term care. But in fact, this is a common scenario. Lay people often feel impotent in their desire to help their loved ones, and becoming a POA may empower them to flex their muscles and try to take control in an arena for which they are poorly equipped or educated. It is helpful to validate the POA's position, and then explain why, in your opinion, an alternative treatment plan would be more likely to achieve the goals of care upon which you have both previously agreed.

Recently, a patient with congestive heart failure treated with morphine with the support of Hospice developed increased shortness of breath, substantial weight gain, and increased need for oxygen. I ordered a diuretic, which was refused by the POA. When I called to explain my reasoning, the POA indicated that she did not want any definitive treatment for the CHF as it might prolong her father's life. I explained how uncomfortable hypoxia is, and that an arrhythmia or renal failure would surely take his life soon, whether I added some diuretic (along with more morphine) for comfort or not.

Even your nursing staff may fall into the trap of simply wanting to satisfy the POA's wishes without seeking a clearly thought-out medical decision. Once, I received a fax from a nurse regarding a new admission to my care. She stated that the POA wanted her mother's benzodiazepine discontinued immediately. This unfortunate woman came under my care from a physician who had been treating her for years with benzos. Immediate cessation would cause significant withdrawal symptoms, possibly even death. Clearly a trial of a slow taper was in order, but had I reflexively acquiesced to the POA's wishes, I may have done serious harm to my patient.

Never underestimate the value of your training and experience. You know far more than the POA. You and the POA usually agree on the goals for care. What is needed is for you to explain, in a non-confrontational and non-condescending manner, why you feel your proposed treatment is more likely to benefit the patient. Most times, but not always, you will succeed. After all, you are the one with the license. ■

# The Rewards and Challenges of the Interdisciplinary Team

by Pamela Fenstemacher, MD, CMD

Jenna remembers how her mind frantically raced and her heart pounded in her chest when she was called by the ER in the middle of a critical meeting at work. Her worries had turned instantly towards her family. Was it her mother or one of her young children who was in the ER? Jenna was finally able to reach the ER doctor who informed her that she was needed at the hospital because her elderly mother, Mary, had been rushed there after collapsing in the grocery store with a stroke. Although Jenna is relieved that her mom recovered most of her abilities since her stroke and wants desperately to return home from the rehabilitation center, Mary continues to be somewhat forgetful and anxious because her right-sided weakness has not resolved and she continues to require assistance. Jenna wonders who will help her family. The LIFE program and its IDT are the answer to Jenna's caregiving dilemma.

Studies have shown that the complex healthcare needs of frail older people require an integrated and proactive primary care approach to prevent disability. Interdisciplinary Teams (IDTs) are at the heart of any Program for All inclusive Care of the Elderly (PACE.) The Core features of LIFE at The University of Pennsylvania School of Nursing are those seen in all PACE programs. Funding and provider risk in PACE programs are integrated through capitated Medicare and Medicaid reimbursement. Other core features of PACE programs include targeting nursing home-eligible participants who choose to receive long-term care services in the community, delivering integrated service through adult day care centers, and using interdisciplinary teams for care management.

CMS acknowledges the pivotal role of the IDT in PACE programs and states in its regulations that "the IDT is critical to the success of the PACE program." Our LIFE IDT, like others, consists of nurses, physical and occupational therapists, primary care providers, dietitians, administrators, and social workers with geriatric experience. The care of the IDT, which is aimed at reducing hospitalizations of frail older adults who experience the more adverse effects of hospitalization, is provided as medical intervention and palliative care in the patient's home or at the PACE Center based on the participants' goals of care. The IDT approach involves interactive problem-solving and the exchange of ongoing information about the medical, functional, and psychosocial condition of each participant between team members, contractors, participants and their caregivers in order to create mutual goals for the participant. These goals are then formalized into a Plan of Care (POC). Members at the LIFE program are evaluated at regular intervals and as needed to allow the Team members to develop discipline-specific recommendations before the IDT meets to formulate the patient's individualized POC.

Being a member of an IDT is rewarding, and, at times, a challenge. Because the IDT is frequently engaged in helping families in crisis, it needs to be mindful; not only of the stressors that the patient and the family encounter, but also that other team members are approaching the family's crises from their own point of focus. During the process of deciding how best to care for a participant, Team members need to ensure that the important aspects of their discipline's care are realized and incorporated into the resolution of the crisis. New team members frequently find this aspect of LIFE teamwork the most challenging.

After her assessments, the IDT determines that Mary needs supervision during the day and assistance with her dressing and bathing, as well as reminders to take her medication. Jenna needs to assist her children in the morning and get to work early. Subsequently, the IDT arranges for a home health aide to assist her in the morning until LIFE transportation can pick Mary up and bring her to the Center for socialization, medical care, on-going therapy, meals, and medications. After Jenna arrives home from work, Mary is brought home at night by the Center's transportation. It is a relief for Mary to know that the LIFE program will provide her medications, transportation, hospitalizations, nursing home, or palliative care that she requires, and she will also have the IDT to assist her with her transitions as well. Because the IDT will closely monitor Mary, it will be able to accomplish its goal of improving Mary's function and maintaining her quality of life by allowing her to remain in the community and avoid institutionalization. ■

# New CMDs from Pennslyvania

PMDA would like to congratulate the following Pennsylvania physicians for recently obtaining their CMD certification:

Allan Abramowitz, DO, CMD
Michele L. Boornazian, DO, CMD
Ruxandra O. Jadic, MD, CMD

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# Welcome New Members

PMDA welcomes the following new members to the Association:
(Effective September 4, 2013 - April 17, 2014)

## Active Members

Dawn Beard, CRNP
Laura Brinkley, CRNP
Earl Brinser, DO
Lisa Butz, CRNP
Amy Cassidy, CRNP
Kadesha Collins-Fletcher, MD
Donna Cugini, CRNP
Nancy Dunphy, CRNP
Mark Green, PharmD
Heidi Gros-Cocuzza, CRNP
Kimberly Hashin, MD
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Dana Leshok, CRNP
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