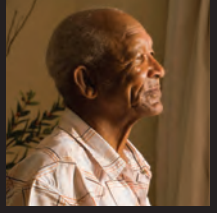
PMDA

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

Spring 2015



Administrative Office
777 East Park Drive; P. O. Box 8820
Harrisburg, PA 17105-8820
Phone: 717-558-7868
Fax: 717-558-7841
pmda@pamedsoc.org
www.pamda.org

Official Pennsylvania Chapter of
American Medical Directors Association

President's Message

You Don't Have to Do That!

by Leon Kraybill, MD, CMD
leonkraybill@gmail.com

Our efforts to improve the quality of long-term care often lead us to try to work harder, complete more tasks, and get more done. We exhort ourselves and our colleagues to ramp up our efforts. While these are honorable aspirations, our energy and motivation often dwindle by the end of the day.

Another way to look at quality is to avoid those tasks and efforts that are unnecessary, unproven, or futile. Sometimes we need to do less, say no, and recommend not doing treatments. While it sometimes appears easier on in the short term to agree with every request, the long-term results often make more work for us. Here are some ways to potentially lighten your workload and improve quality:

1. **Do not obtain a urine culture unless there are clear signs and symptoms that localize to the urinary tract.** Do not order a UA for "smelly" or "dark-colored" urine. Establish a protocol with your facility that requires identification of symptoms (dysuria, frequency, urgency, or signs of infection without other explanation) before a UA is requested. Encourage fluids and monitor over several shifts in borderline situations.
2. **Do not obtain a follow-up urine culture following treatment for a UTI if there are no persistent urinary symptoms**.
3. **Do not place an indwelling urinary catheter to manage urinary incontinence (appropriate reasons may be acute retention/ outlet obstruction, healing of deep sacral wounds, or comfort at end of life)**.
4. **Do not obtain screening tests for breast, colorectal, or prostate cancer if life expectancy is < 10 years**.
5. **Do not obtain a C. difficile toxin test to confirm a "cure" if bowel symptoms have been resolved**.
6. **Do not recommend aggressive interventional care, emergency room assessment, or hospital admission in a frail resident just because they are declining**. These decisions require an understanding of the resident's goals of care and the potential benefit/risk of the assessment. Establish the code status, POLST wishes, and advanced directives early in the admission process in order to help guide your subsequent decisions.

continued on page 3

Inside This Issue

Don't Miss the PMDA Regional Meeting Registration Deadline!

Looking for long-term care educational opportunities for you? PMDA's Regional Meetings offer convenient, localized, and focused opportunities for your professional development.

by Daniel Haimowitz, MD, CMD, FACP
Chair, PMDA Regional Meeting Committee
geridocl@comcast.net

The next presentation in our series of statewide regional meetings will be held on **May 13, 2015**. The topic will be **"Stop Healthcare-Associated Infections: How the PA Patient Safety Authority (PPSA) and PMDA Can Work Together"**. The interactive teleconference will be held from 6:30 pm to 8:00 pm at four different sites: the Boyd-Horrox Funeral Home in Norristown, the Mennonite Home in Lancaster, the Rose View Center in Williamsport, and the Cumberland Woods Village in Allison Park, PA. This subject was recognized as a key issue during a meeting of the PA Patient Safety Authority's Long-Term Care subgroup that PMDA members Dr. Ken Brubaker and Dr. Dan Haimowitz attend.

Infection control is becoming an increasingly important topic, related both to clinical (UTIs, C. diff, Norovirus, influenza, etc.) and administrative (QAPI, nursing home meeting function, reporting to the state and public) concerns. There are opportunities for improvement in implementing infection control best practices at leadership, physician, clinical, and support staff levels. This presentation will describe the use of practical tools to incorporate infection control strategies into a facility's clinical workflow.

Attendees will learn about the Patient Safety Reporting System (PSRS), how it can be used for QAPI, what nursing home staff have to do in order to meet PSRS requirements, and how all members of the Interdisciplinary Team can work together to prevent healthcare-associated infections. The PPSA has practical tools

that healthcare practitioners may be unaware of that can help focus on issues, target problems, and find solutions. This will be a presentation of interest to medical directors, attending physicians, nurse practitioners, administrators, and DONs.

Leading the discussion at the teleconference on May 13 will be Sharon Bradley, RN, Senior Infection Prevention Analyst for the PPSA. She is a board-certified infection prevention specialist with experience as a clinician, educator, and DON. Co-presenting will be Mike Doering, the executive director of the PPSA, along with Dr. Brubaker. We hope you will be able to attend!

Registration Information

To register, you can either call 717-531-6483 and reference course #J5764-15-Z; email ContinuingEd@hmc.psu.edu; mail to Registrar, Penn State Hershey Continuing Education G220, P. O. Box 851, Hershey, PA 17033; or register online at http://www.pamda.org. **Registration is FREE, and CME/CMD/NHA credit is available.**

We would like to thank the facilitators at each site for their assistance: Dr. Dan Haimowitz (Chair), Dr. Dave Fuchs, Dr. Dilip Elangbam, and Dr. Dan Steiner. If anyone has interest in helping develop regional meetings at other sites, particularly Lehigh Valley, Erie and Wilkes-Barre/Scranton, please contact any one of us, or Bonnie Bixler, our staff at Penn State Hershey at (717) 531-6483. There are many benefits of having an active regional meeting, and any site with interest is encouraged to become involved.

The next and final statewide regional meeting this year will be held on **November 5, 2015** with a focus on **geriatric literature review**. Be sure to mark your calendar, and additional details will be announced as they become available. ■

President's Message
continued from page 1

7. **Do not insert percutaneous feeding tubes in residents with advanced dementia — they do not improve quality of life or prolong life**. In fact, they may worsen symptoms such as fluid overload, diarrhea, abdominal pain, reflux, and risk of aspiration.
8. **Do not prescribe antipsychotic medications for BPSD (behavioral and psychological symptoms of dementia) in residents with dementia without a documented assessment for underlying causes of the behavior**. Develop a checklist of the current symptoms, duration, and the attempted interventions — and request this before you start a new medication.
9. **Do not routinely prescribe lipid-lowering medications in residents with a limited life expectancy**. Statins for residents without heart disease and age 75-85 have little evidence for benefit. Statins in residents > 85 years old have evidence for increased risk of harm.
10. **Do not start blood pressure medication in residents over 60 years old for a blood pressure of < 150/90**.
11. **Do not quickly start anticholinergic bladder medications without careful assessment and close follow-up of gait, confusion, bowels, and urine retention**.
12. **Do not continue any medication for which you cannot provide ready justification or which is not consistent with the resident's goals**.
13. **Do not use sliding scale insulin for long-term diabetes management of individuals in long-term care**. Switch to basal insulin, or basal + rapid acting insulin with meals.
14. **Do not make telephone treatment decisions without adequate information**. Ask for a phone call rather than a fax for any decisions that are not straightforward. If the staff member does not have complete information, ask them to gather this and call you back. Establish an INR flow sheet that holds all of the necessary information. Use the AMDA "Know-it-all before you call" series, or the INTERACT II tools to help your staff prepare for phone calls.
15. **Do not automatically approve a consultant's recommendation just because they are a specialist**. You are a LTC specialist and probably know the resident the best. Consider the suggestion in light of overall goals and quality of life. You are not required to accept the recommendation, but you need to document why you are choosing otherwise.
16. **Do not forget that you are part of a long-term care team**. You don't have to make all the decisions or do all the work. Ask for input from your team, see what they have done, respect their ideas, and teach when possible. Once you have gained their respect and trust, they will usually go out of their way to help you. ■

AMDA Certification Program Updates Name, Mission

The following article was printed with AMDA's permission.

Columbia, MD — The American Medical Directors Certification Program (AMDCP) is now the American Board of Post-Acute and Long-Term Care Medicine (ABPLM). The newly renamed Board remains an affiliate organization of AMDA — The Society for Post-Acute and Long-Term Care Medicine (AMDA), and will continue to administer the Certified Medical Directors (CMD) Program. ABPLM is the only organization to offer certification for medical directors in post-acute and long-term care (PA/LTC) medicine. Current CMD certification and recertification requirements remain the same and are unaffected by the name change.

The name change reflects 2014 changes to the ABPLM's mission, and recognizes the increasing prominence of post-acute care in the long-term care continuum. The ABPLM mission statement is "to recognize and advance physician leadership and excellence in medical direction and medical care throughout the PA/LTC continuum via certification, thereby enhancing quality of care." In 2013, AMDA finalized a set of attending physician competencies, with an evidence-based framework for the unique set of knowledge and skills necessary to facilitate quality outcomes in PA/LTC. An educational curriculum to support these competencies is currently being developed. Inspired by this, the ABPLM is exploring the creation of an additional certification program for attending physicians as another avenue to enhance quality of care in PA/LTC settings.

ABPLM Chair Thomas Edmondson, MD, CMD, AGSF, FACP, commented on the name change echoing other changes within the organization saying, "The Board feels that the new name honors our mission of promoting the professional development of attending physicians in the PA/LTC setting, and at the same time, the critical contributions of medical directors in facilities." ■

An Invitation from the PMDA Annual Symposium Co-Chairs

by Firas Saidi, MD, CMD, and Brian Kimmel, MD, CMD
saidif@mlhs.org and kimmels@comcast.net

Members of the Annual Symposium Committee have been hard at work to organize the upcoming symposium to ensure timely coverage of topics relevant to practitioners get covered.

Mark your calendars for October 16-17, 2015! We hope to see you again at the Hershey Lodge in Hershey, PA.

You will see a good mix of clinical and administrative sessions to interest you and help address relevant issues to the LTC practice environment.

The symposium will commence with a presentation. We have decided to focus on the resident with shortness of breath as a frequent complaint indicating a change in condition. We will then shift the discussion to two dynamic speakers to review two of the most common presentations: etiologies and pearls on management and common pitfalls relevant to the clinical case. Those issues will be reviewed by Dr. Jacquie Sutter and Dr. Matthew Wayne (former AMDA president).

Afterwards, a panel will be convened to address any further questions or comments from the audience. We hope to make this very lively discussion. Our experience, as many of you will agree, is that discussions like those tend to enrich the topic even further.

Dr. Susan Levy will address the audience as AMDA's president-elect and give the annual AMDA update. She will discuss relevant issues at the national stage, and ways that AMDA is working to further the goal of improving care within the long term care continuum and beyond as our health care systems continue to evolve.

The afternoon will be filled with talks, including a QAPI on the topic of CHF and how to address that in nursing facilities. This will be helpful to all and everyone involved in providing care at an LTC facility. This is not just a medical director topic. We will also have a speaker address billing issues that are common to the long-term care environment. This will be combined with a talk introducing all of us to the much-dreaded ICD – 10 coding system that will possibly be implemented by October.

Of course no PMDA annual symposium is complete without Dr. David Nace giving all of us his updates on public policy in our great Commonwealth. Additionally, Saturday will showcase Dr. Ken Brubaker, who will be speaking about medical director's role in LTC and what should be expected of him or her. Dr. Neelofer Sohail and Jane Miller, CRNP, will review the physician/nurse practitioner or physician assistant collaboration and what a successful relationship should look like, as well as any pitfalls that all attendees will need to be aware of.

Continuing with the theme of the patient with shortness of breath, Dr. Stanley Siegel will discuss palliative care options and end-of-life care. Similarly, many of you see older residents in retirement communities and nursing homes who are anemic. Dr. Andy Chapman from Jefferson medical school will talk to us about reasonable evaluation options to diagnose and manage those residents. He will also touch on a few other hematologic diseases common in the geriatric population.

Saturday afternoon will include discussions of the elder abuse from an ethical and legal standpoint. This very important topic will be addressed by Dr. Duncan McLean and David Hoffman, Esq. This year we will have a session to discuss top articles in the field of geriatrics and LTC practice. We are hoping to make this a tradition and keep it going for years to come, as the research is exponentially expanding in our field.

We will close by having a roundtable/ panel discussion to review most common controversial issues that face providers in our field of work. These topics were chosen from the PMDA listserv, which has been enriched by participation from members throughout our state. These are sure to be very interesting to anyone working in any capacity in the LTC field.

We are very excited about this year's symposium, and we encourage you to bring a friend or a colleague along. We all share the goal of improving the care of seniors in this field and are confident that this educational weekend will assist all of you to further that cause.

See you in Hershey in October! ■

Welcome New Members

PMDA welcomes the following individuals who have become PMDA members since November 4, 2014:

Brian Hines – Financial Voyages - LTC Industry Partner

Kawita Vichare, MD

Dissemination of Value Based Health Care Delivery

by Thomas Lawrence, MD, CMD
lawrencet@mlhs.org

AMDA's Annual Conference, *Quality on Track in Long-term Care*, was held March 19-22 in Louisville, Kentucky. Again this year, one dominant theme of the conference was the impact of new models of care arising out of the Affordable Care Act (ACA). The emerging revolution in American health care that includes accountable care organizations (ACO) and bundled payment programs has considerable impact on the delivery of care in long-term care settings. The single fact that consistently formed the framework of the discussions at AMDA, and an important driver of alternative payment models, is that 50% of all post-acute care (PAC) spending occurs within skilled nursing facilities.

A session entitled *Preparing for Alternative Payment Structures: Bundled Payments in Post-Acute Care* presented a description of the overall structure of bundled payment initiatives in the long-term care setting. The "operating headwinds" were described as reduced government and private payer reimbursement and the need for reduced length of stay. A shifting payor mix was profiled from the current dominant Medicare fee for service structure with a smaller percentage of managed care organization (MCO) revenue to a future payor mix and a growing percentage of managed care payments, a shrinking minority of fee for service payments, and a growing mix of ACO and bundled payments programs that are both hospital and health system based, as well as those programs that are implemented by other PAC providers.

The speakers pointed out that a clinical redesign strategy must accompany the change in payor source and also must include care coordination and population health capabilities that are able to shift across care settings along the PAC spectrum. This will include an expanded role for home health initiatives as a centralized site of care. The various models of bundled payment programs were described, the two most common of which are the Model 2 retrospective acute care hospital stay plus the PAC stay, and the Model 3 retrospective PAC stay only.

How reform in this arena will evolve was discussed in the context of two individual reform timelines. The first is a delivery system reform which results in transformation of setting specific treatment silos into integrated care coordination and then to the broader goal of population health improvement. The second is a payment system reform transitioning from fee for service to pay for performance (e.g. bundled payments) to global pay for value/risk models. These two processes of reform are paced differently but must be intimately linked in order for these changes to succeed.

Kindred Healthcare described their experience with the Model 3 program in the Cleveland market, which includes a three armed strategy including: (1) continuing the care that is passed on to them (usually from the hospital setting), including utilizing PAC physician leadership; (2) managing care transitions effectively with IT support and disease-specific clinical pathways; and (3) adjusting to new payment systems embracing ACO participation and bundled payment projects. Attention to physician practice patterns including encouraging weekly follow-up visits in addition to urgent visits is considered critical to the success of this model. In addition, special attention is paid to optimizing medication utilization and laboratory and diagnostic services; this is considered very important and received special effort and attention.

Four keys to success in LTC facility bundled payments programs were highlighted by the presenters. First was successful partnering between hospitals and PAC partners, including nursing facilities and home health care providers. Second was comprehensive care redesign components including emergency department engagement, care map implementation, rehab fast tracking, advance care planning initiatives (including POLST), and QAPI programming. Third was a nurse navigator coordinating care management over the 90-day episode of care and being responsible for patient engagement and advocacy. The fourth and final key to success was using IT to monitor episodes and provide dashboards for key quality metrics.

In a session entitled *Bridging the Chasm between Provider and Payor*, principles related to collaboration between payor (an MCO) and provider were reviewed. Approaches to payors picking the right SNF partners were discussed, including scorecard grading of SNFs, ensuring systems are in place to guide patients to the right level of care, monitoring performance metrics, and aggressive management of length of stay (LOS). Performance metrics that were promoted include 7- and 30-day re-hospitalization rates, average LOS, timeliness and completeness of discharge planning, and referral rates to partnered home health and durable medical equipment providers. Other characteristics of SNFs that made them more attractive to MCOs were discussed, such as direct to SNF admissions (avoiding 72 hour hospitalization), a patient-centered approach to care, and other innovative initiatives that included a high degree of engagement with leading health systems and area ACOs.

The Impact of Value Based Medicine on Post-Acute and Long-Term Care Medicine, presented by Dr. Charles Crecelius, discussed issues related to ACO and SNF collaboration. The process of patient attribution to an ACO was described; this is determined by the primary care physician who makes the plurality of visits within a calendar year. It was pointed out that SNF visits count as PCP codes for the purpose of attribution. The ACO's

continued on page 7

Additional Resources from the 2015 AMDA Annual Meeting

by Dale K. Hursh, MD, CMD
Guest Author

At AMDA's Annual Meeting, a featured session each year is "This Year in Review for Long-Term Care." During this presentation, twelve articles published in the past year with the potential to impact medical care of elders are critically appraised by four experienced practitioners/educators. This year, the critiques were given by Dulce Cruz, MD, Julie Gammack, MD, CMD, John Morley, MB BCH, and Elizabeth Galik, PhD, CRNP. The session was well attended and generated interesting discussion among the attendees.

The abstracts of four of the articles presented during the 2015 "Year in Review for Long-Term Care" are featured below. Audio content for this session will be accessible via AMDA's online library in the near future, so take advantage of the opportunity to hear these presenters review key geriatric literature of 2014.

Dysken MW, Sano M, Asthana S, et al. "Effect of vitamin E and memantine on functional decline in Alzheimer disease: the TEAM-AD VA cooperative randomized trial". *JAMA* 2014; 311(1):33-44. doi:10.1001/jama.2013.282834.

Importance: Although vitamin E and memantine have been shown to have beneficial effects in moderately severe Alzheimer disease (AD), evidence is limited in mild to moderate AD.

Objective: To determine if vitamin E (alpha tocopherol), memantine, or both slow progression of mild to moderate AD in patients taking an acetylcholinesterase inhibitor.

Design, Setting, and Participants: Double-blind, placebo-controlled, parallel-group, randomized clinical trial involving 613 patients with mild to moderate AD initiated in August 2007 and concluded in September 2012 at 14 Veterans Affairs medical centers.

Interventions: Participants received either 2000 IU/d of alpha tocopherol (n = 152), 20 mg/d of memantine (n = 155), the combination (n = 154), or placebo (n = 152).

Main Outcomes and Measures: Alzheimer's Disease Cooperative Study/Activities of Daily Living (ADCS-ADL) Inventory score (range, 0-78). Secondary outcomes included cognitive, neuropsychiatric, functional, and caregiver measures.

Results: Data from 561 participants were analyzed (alpha tocopherol = 140, memantine = 142, combination = 139, placebo = 140), with 52 excluded because of a lack of any follow-up data. Over the mean (SD) follow-up of 2.27 (1.22) years, ADCS-ADL Inventory scores declined by 3.15 units (95% CI, 0.92 to 5.39; adjusted P = .03) less in the alpha tocopherol group compared with the placebo group. In the memantine group, these scores declined 1.98 units less (95% CI, −0.24 to 4.20; adjusted P = .40) than the placebo group's decline. This change in the alpha tocopherol group translates into a delay in clinical progression of 19% per year compared with placebo or a delay of approximately 6.2 months over the follow-up period. Caregiver time increased least in the alpha tocopherol group. All-cause mortality and safety analyses showed a difference only on the serious adverse event of "infections or infestations," with greater frequencies in the memantine (31 events in 23 participants) and combination groups (44 events in 31 participants) compared with placebo (13 events in 11 participants).

Conclusions and Relevance: Among patients with mild to moderate AD, 2000 IU/d of alpha tocopherol compared with placebo resulted in slower functional decline. There were no significant differences in the groups receiving memantine alone or memantine plus alpha tocopherol. These findings suggest benefit of alpha tocopherol in mild to moderate AD by slowing functional decline and decreasing caregiver burden.

Donoghue OA, Jansen S, Dooley C, et al. "Atrial fibrillation is associated with impaired mobility in community-dwelling older adults". *Journal of the American Medical Directors Assoc* 2014; 15(12): 929-33. doi:10.1016/j.jamda.2014.08.005. Epub 2014 Oct 5.

Objectives: To examine the independent associations between atrial fibrillation (AF) and objectively measured mobility in a nationally representative cohort.

Design: Wave 1 of The Irish Longitudinal Study on Ageing (TILDA), a population-based study assessing health, economic, and social aspects of ageing.

Setting: Community-dwelling adults completed a home-based interview and a center-based health assessment.

Participants: Participants aged 50 years or older, with Mini-Mental State Examination score of 24 or higher, and who completed at least 1 mobility test (n = 4525).

Measurements: Mobility was assessed with the Timed Up-and-Go (TUG) test and usual and dual task gait speed obtained using a 4.88-m GAITRite® mat. AF was diagnosed using a 10-minute surface electrocardiogram recording. Linear regression analyses were performed to compare mobility in participants with and without AF, adjusting for confounders.

Results: In this sample (mean age 62.3 years; range 51–89), overall prevalence of AF was 3.1%, increasing to 6.7% in the over 70s (11.8% men; 2.8% women). In multivariate analysis, AF was independently associated with slower TUG (0.37; 95% confidence interval [CI] 0.07–0.71; P = .043) and slower usual gait speed (−3.59; 95% CI −7.05 to −0.12; P = .030). There was a significant age*AF interaction effect for usual gait speed (−0.480, 95% CI −0.907 to −0.053, P = .028). Adults with AF walked 3.77 cm/s more slowly than adults without AF at age 70, declining by 4.8 cm/s for each additional decade.

Conclusion: AF is independently associated with lower usual gait speed in community-dwelling adults and this effect is magnified in those aged 70 and older. This may place them at increased risk of falls, hospitalization, cognitive decline, and mortality, as well as stroke and heart failure. Early recognition and treatment of

Additional Resources AMDA Meeting

continued from page 6

AF is vital to improve physical function and reduce this risk.

Sardar P, Chatterjee S, Chaudhari S, et al. "New oral anticoagulants in elderly adults: evidence from a meta-analysis of randomized trials". *Journal of the American Geriatric Society* 2014; 62:857-864. doi:10.1111/jgs.12799. Epub 2014 May 1.

Objectives: To evaluate the efficacy and safety of new oral anticoagulants (NOACs) in elderly adults.

Design: Meta-analyses of randomized clinical trials (RCTs).

Setting: PubMed, Cochrane Library, EMBASE, Web of Science, and CINAHL databases were searched from January 1, 2001, through March 30, 2013.

Participants: Elderly population (≥75) in RCTs comparing NOACs (rivaroxaban, apixaban, and dabigatran) with conventional therapy.

Measurements: Two authors reviewed the trials, and odds ratios (ORs) were calculated using a random effects model.

Results: Ten RCTs included 25,031 elderly participants. Risk of major or clinically relevant bleeding was not significantly different between NOACs and conventional therapy in elderly adults (OR = 1.02, 95% confidence interval = 0.73–1.43). Similar results were observed when comparing NOACs and pharmacologically active agents. In atrial fibrillation (AF) trials, NOACs were more effective than conventional therapy in prevention of stroke or systemic embolism in an elderly population with AF. In non-AF trials, NOACs also had a significantly lower risk of venous thromboembolism (VTE) or VTE-related death than conventional therapy in elderly adults. Analysis for individual NOACs showed that the NOAC was noninferior or more effective than conventional therapy for efficacy and safety outcomes.

Conclusion: In participants of clinical trials aged 75 and older, NOACs did not cause excess bleeding and were associated with equal or greater efficacy than conventional therapy.

Herrick JE, Bliwise DL, Puri S, et al. "Strength training and light physical activity reduces the apnea-hypopnea index in institutionalized older adults". *Journal of the American Medical Directors Association* 2014; 15(11): 844-846. doi:10.1016/j.jamda.2014.08.006. Epub 2014 Oct 5.

Objectives: To determine the effect of seven weeks of resistance training and walking on the apnea-hypopnea index (AHI) in institutionalized older adults compared with a usual care control group.

Design: Secondary analysis of data from a randomized controlled trial.

Setting: Ten nursing and three assisted living facilities in Arkansas.

Participants: Institutionalized older adults.

Interventions: Exercise group (EG) performed supervised resistance training to arm and hip extensors on 3 days a week with additional 2 days a week of light walking. Usual care group (UC) participated in the usual activities provided within their living facility.

Measurements: Two nights of polysomnography before and following 7-week intervention.

Results: Adjusted means in the EG group showed a decrease in AHI from 20.2 (SD ±1.3) at baseline to 16.7 (SD ±0.9) at 7 weeks. Absolute strength gains were not associated with improved AHI.

Conclusion: Supervised resistance training and light walking reduced the severity of obstructive sleep apnea in institutionalized older adults. ■

Dissemination of Value

continued from page 5

impact on LTC practice has forced SNFs to track performance parameters such as re-hospitalizations, length of stay, CMS quality measures and star rating, and their capacity to implement special clinical programs, such as CHF, COPD, and orthopedic programs.

In a session entitled *Nursing Homes and Accountable Care Organizations: How to Divide the Pie*, the experience of a Pioneer ACO was presented. One additional practice that was identified as optimal was providing a "warm handoff" with every transition in care, including at the time of discharge from SNF. Some characteristics of preferred SNFs included facilities with a four-star rating for staffing, holding admission meetings with family ("inclusion") within 7 days of admission, ACO care coordinators attending SNF weekly admission meetings, and using Interact program tools to review all hospital transfers. It was noted that expanded attention to advanced care planning and promoting discussion of the goals of care is instrumental to optimizing transitions to palliative care. Rapid response to acute changes in condition of SNF residents was another indicator of high functioning facilities. In addition, it was emphasized that even facilities that are "low quality" based on ACO determinations will still need to be providers, as some patients may be hard to place for conditions such as behavioral health challenges.

Taking the aggregate opinions of the various expert presenters, a monthly ACO/SNF report should report the following quality metrics: 30-day hospital readmission rates, 30-day hospice referral and mortality rates, average length of stay, ER and outpatient hospital utilization patterns, PAC related metrics, and PAC discharge settings (e.g. home health). In addition, it was recommended that the quality of PAC and hospital leadership relationships should be continuously evaluated.

What is immediately clear from these sessions at AMDA examining the ongoing revolution in health care that has been launched by the ACA, is that, to improve costs and optimize outcomes in the PAC setting, the length of stay must be reduced in tandem with improvement in care coordination across time and location. These steps are critical in meeting the "triple aim" of health care in the post-acute and long-term care setting. ■

LIFE from the Outside

by Dr. Reshma Shah
Guest Author

"LIFE, NOW, you need to contact Dr. Pam. You will love it there" said my husband, the dental student, as he walked in the door. "Who?! What?! Where?" I thought. As I would soon come to learn, LIFE (Living Independently for the Elderly) is one of the friendliest places in healthcare, but more importantly, extremely mission driven to provide the best for its members.

As a physician, having practiced medicine in the United Kingdom (UK) after graduating from a London medical school, I experienced a real change of pace upon moving to Philadelphia a little over two years ago to join my husband here. Shortly after settling into life in this pleasing city, I craved clinical experience and began looking for opportunities. Luckily, I interviewed with Dr. Fenstemacher, the Chief Medical Director of LIFE, leading me to begin working on a variety of research projects involving much interaction with staff and the members. I would not hesitate to say that my experience here at this center has been the best of my career. You may be surprised. An urban center? Yes!

Upon first hearing about LIFE, I was intrigued. Apparently, here was a place where members can attend as often as they wish Monday to Friday, and in addition to social activities can partake of adjunct services including podiatry, optometry, audiology, and dentistry. Crucially, they also have their primary care needs met by the medical, nursing, and social care staff working at LIFE. Could this magical place exist? In my time here at LIFE I have come to see that tremendous staff and the drive they posses makes this a reality greatly benefiting the members and by extension the community.

LIFE is a Program of All-Inclusive Care for the Elderly (PACE), and this particular center is based in the heart of urban West Philadelphia, serving a member population of approximately 400 with a dramatic skew to female and African-American. The

center, although independent, is operated by the University of Pennsylvania School of Nursing, which provides a mutually beneficial experience to both parties. With the nursing and medical students rotating through every month, guest speakers making regular appearances, and ample opportunities for research, all clinical staff find it easier to stay current with their practice. The philosophy of LIFE, which is reiterated scrupulously during all meetings to improve member care, is to provide much needed support which enables the elderly to remain living in their own homes. These frail elders would otherwise have required immediate nursing home placement, so their involvement with the LIFE program enables them to continue living with their families and continue their close ties in the community.

Long-term care in the UK, to a large degree, consists of a maximum of four short home help calls a day to frail seniors who remain in their homes. These visits focus on bathing, feeding, and other activities of daily living. Once the elder requires much more assistance with transfers or care that takes longer than the calls, the patient is typically transferred to a nursing home. Medical care continues to be coordinated by their local family physician, and even minor emergencies generally land the patient in hospital, which carries a large risk of transfer to a nursing home and inability to ever go back to their own home.

Here at LIFE, the risk that the elder does not get to return to their own home after an acute admission is somewhat mitigated by the strong ties that have been established with local short-stay skilled nursing facilities and rehabilitation centers, as well as home help aides providing as many calls as the member may require. I saw this firsthand during a hospital visit with the transitions manager, Nurse Draper. We noticed a member's low affect post-amputation surgery and she arranged for a psychiatrist visit. Following this encounter, we then visited one of the rehabilitation centers to wrangle a bed, and due to this personalized care, the patient is on her way to learning to live without her leg with the hope that she could go back home. This is just one example of the dedication to the LIFE mission.

All the staff here are inspiring, from the transportation team to the administration department. I was particularly taken with the multitude of tasks conducted in a single day by Dr. Fenstemacher. She juggles managing the budget, writing and reviewing policies, providing medical oversight for the nurse practitioners if required, rounding on nursing home patients, and especially running down to attend to emergencies that arise in the center. In addition, she is intimately involved in training the next generation of medical directors through AMDA's Core Curriculum.

The support I have personally received from everyone here at the LIFE center far surpasses any that I have experienced at any point in my career. I now understand why everyone is truly happy to come to work and members are overwhelmingly positive in their praise. ■

Nursing Home Compare Five Star Ratings Changes

The following article was published with permission from AMDA's Health Policy Advisor.

The Centers for Medicare & Medicaid Services (CMS) recently announced changes to the Nursing Home Compare Five Star rating system during a skilled nursing facility open door forum call. Changes include adjustments to the scoring methodology of the rating system to account for several trends CMS has encountered over the last few years. The impact of this change may cause many nursing homes to see a drop in their star rating. Participants on the call asked CMS to provide information explaining how the new system impacts the quality score if they see a drop and why it may have occurred.

CMS will complete the following actions:

- ***Add 2 Quality Measures (QMs):*** for antipsychotic medication use in nursing homes to the 5-Star calculations. One measure is for short-stay residents when a nursing home begins use of antipsychotics for people without diagnoses of schizophrenia, Huntington's disease, or Tourette syndrome, and a second measure reflects continued use of such medications for long-stay nursing home residents without diagnoses of schizophrenia, Huntington's disease, or Tourette syndrome.
- ***Raise Performance Expectations:*** by raising the standards for nursing homes to achieve a high rating on all publicly reported measures in the Quality Measures category on the website.
- ***Adjust Staffing Algorithms:*** to more accurately reflect staffing levels. Nursing homes must earn 4-stars on either the individual Registered Nurse (RN) only or the staffing categories to receive 4-stars on the Overall staffing rating and can have no less than a 3-star rating on any of those dimensions.
- ***Expand Targeted Surveys:*** a plan for State Survey Agencies to conduct specialized, onsite surveys of a sample of nursing homes across the U.S. that assess adequacy of resident assessments and the accuracy of information reported to CMS that is used in calculating quality measures used in the rating system. A report on the results of the pilot surveys completed in 2014 in five states is available at: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html.

The changes in ratings reflect that CMS raised the bar for performance that should be recognized as high quality and anticipates nursing homes will make quality improvements to achieve these higher standards. However, the changes in the quality measures star ratings released in February do not necessarily indicate a change in the quality of care provided.

Facilities that are concerned about their rating are encouraged to contact CMS to preview their data. If you have questions please contact the AMDA's Public Policy Department at publicpolicy@amda.com.

To read a fact sheet on Nursing Home Compare 3.0, visit http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-02-12-2.html.

To search for nursing homes in local areas, visit http://www.Medicare.gov/nursinghomecompare/search.html.

For more information on the national partnership, visit http://www.CMS.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-19.pdf.

For more information on the Advancing Excellence campaign, visit http://www.nhqualitycampaign.org/news.aspx#17. ■

VA Medical Center Registration Process

By Deborah Way, MD, CMD
PMDA President-Elect
Deborah.way@va.gov

As part of the Philadelphia VA Medical Center, I have heard a great deal of confusion about benefits for veterans. I provide the following as an introduction to what the Philadelphia VA does and some information for providers of veterans in other areas.

The Palliative Care team at PVAMC refers veterans to hospice who have a terminal diagnosis. If the veteran is enrolled in Medicare or has other insurance that will pay, the contracted hospice uses this benefit. If the veteran's insurance has no hospice benefit, or the veteran has no insurance, PVAMC will pay for hospice. In any of these cases, the PVAMC continues to provide and pay for any palliative treatment that is being appropriately offered by PVAMC providers.

Do you care for veterans? Do you want to know if they are entitled to benefits?

Since Hospice and Palliative Care are part of the VHA Standard Medical Benefits Package, all *enrolled veterans* are eligible IF they meet the clinical need for the service. There is NO VA policy that prohibits veterans from receiving VHA care of any kind in addition to Medicare Hospice. The challenges with concurrent care have all been on the Medicare/fiscal intermediary side of the issue. There is a booklet printed by U.S. Department of Veterans Affairs called **Federal Benefits for Veterans, Dependents and Survivors**. Contact your local VAMC to get one!

This is how to get started at Philadelphia VA Medical Center:

What documentation is needed?

- DD214
- Two forms of ID
- Medical Insurance card, if you have one

There are three ways to register: in person, via the internet, or by mail.

In person at PVAMC

- No appointment necessary. Hours of operations are 8:00 am to 4:00 pm.
- VA Medical Center, 3900 Woodland Avenue, Philadelphia, PA 19104.
- Once seated, the process should take about 30 minutes.

By Internet

- Visit www.1010ezmed.gov
- Complete your application and submit. A letter will be sent informing you that your application has been processed.

By Mail

- To obtain an application, google VA Form 10-10EZ. Complete the application and mail to:

  VA Medical Center
  3900 Woodland Avenue
  Philadelphia, PA 19104
  Attention: Registration

Your veteran isn't in the area covered by Philadelphia VA Medical Center? Here are the other VA Medical Centers in Pennsylvania:

Altoona

James E. Van Zandt VA Medical Center (Altoona, PA)
814-943-8164

Coatesville

VA Medical Center (Coatesville, PA) 610-384-7711

Erie

VA Medical Center (Erie, PA)
814-868-8661

Lebanon

VA Medical Center (Lebanon, PA) 717-272-6621

Philadelphia

VA Medical Center
(Philadelphia, PA)

Butler

VA Butler Healthcare (Butler, PA) 724-287-4781

Pittsburgh

VA Pittsburgh Healthcare System, H.J. Heinz Campus (Pittsburgh, PA) 866-482-7488

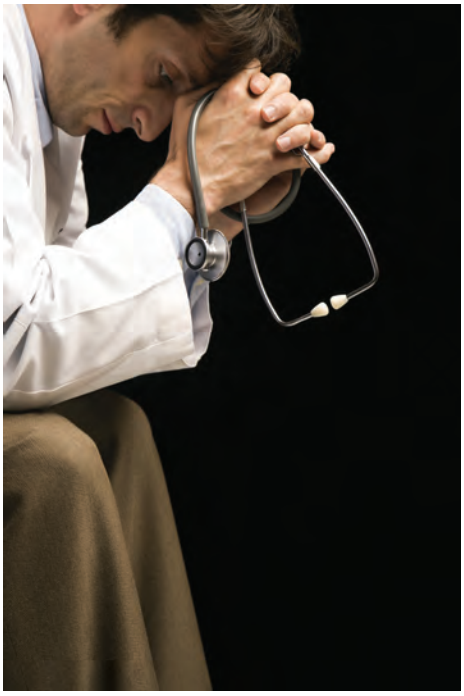
VA Pittsburgh Healthcare System, University Drive Campus (Pittsburgh, PA)
412-688-6000

Wilkes-Barre

VA Medical Center (Wilkes-Barre, PA) 570-824-3521 ■

Coping with Malpractice Litigation

The following content was provided by the Foundation of the Pennsylvania Medical Society. It may be of interest to long-term care practitioners in PA. The Foundation of the Pennsylvania Medical Society is here for physicians during life's most challenging moments.



The phone rings in the middle of the night.

Mark Lopatin, MD, has to decide whether to tell a frail, 79-year-old patient with Parkinson's disease complaining of a fever whether to stay in bed, take Tylenol and drink plenty of fluids, or venture out into the cold night to his local emergency room. The decision should be easy, but Dr. Lopatin, who has dealt with malpractice litigation, says it is not.

Six out of every 10 physicians practicing today have been sued for malpractice at least once, according to the Foundation of the Pennsylvania Medical Society's Physicians' Health Programs (PHP). "The effects of malpractice on the individual should be taken seriously," says Medical Director Jon Shapiro, MD. "As physicians, it represents a major area of stress, because we so often link who we are to what we do."

Kathleen Chancler, a principal in Post & Schell's Professional Liability Practice Group in Philadelphia, agrees. "When a physician is named personally as a defendant in a malpractice suit, it's often a difficult experience for them," she says. "Physicians enter the profession for altruistic reasons, and then find themselves entrenched in an adversarial litigation process that involves lawyers, depositions, and courtrooms, which ultimately takes them away from time with their patients."

According to the PHP, a malpractice suit is business to many lawyers and judges—just part of their jobs. To the physician, a medical liability suit questions his or her professional competence. The outcome of the suit can affect the physician's self-esteem and his or her standing among colleagues and in the community. Judges with numerous cases on the docket and attorneys who participate in multiple malpractice cases can afford a certain detachment, but it contrasts sharply with how the physician is affected.

"If you are facing the litigation process, you can turn to the PHP for information and support," says Dr. Shapiro. "PHP staff are available by telephone to discuss your feelings on the case, refer you to someone who can give you more information about the legal system, and help you gain a better perspective on the claim or suit.

"Adaptive strategies can keep the suit from becoming a catastrophe," Dr. Shapiro adds. "It helps to be able to talk to someone who has endured a common experience to realize you are not alone. That's the benefit of organized medicine."

Dr. Lopatin, like most physicians, has faced malpractice litigation. He said the legal battle was traumatic. "My career and my license were at stake," he says. "Counseling was key to getting through the experience. I've learned that the sun will come up the next day, and it is up to me as to how I will receive it."

Joining PAMED and getting involved with advocacy efforts regarding malpractice reform helped Dr. Lopatin feel like he was taking back some control. His participation as chair of the Montgomery County Medical Legal Committee provided him with further understanding of how the legal system works.

As for Dr. Lopatin's patient who called in the middle of the night? He stayed warm in bed and felt better by morning—a testament to the physician's initial instincts. "I like to use this example when discussing how defensive medicine impacts decision-making, because the patient is actually my father," Dr. Lopatin says. "Had he not been a close relative, I absolutely would have sent the patient to the emergency room."

More work needs to be done to address the political intricacies of malpractice liability in Pennsylvania. "In the meantime, it's important to remember that the PHP can help physicians learn to deal with the anxiety and ultimately survive the pressure by turning the negative stresses of a lawsuit in a positive direction," Dr. Shapiro says.

The Foundation of the Pennsylvania Medical Society provides programs and services for individual physicians and others that improve the well-being of Pennsylvanians and sustain the future of medicine. Visit the Foundation at www.foundationpamedsoc.org. ■

Reprinted with permission from Pennsylvania Physician Magazine (c) 2015.

For counseling or referral service, call the Physicians' Health Programs toll-free at (800) 228-7823 or email php-foundation@pamedsoc.org.

Physicians' Health Programs
a program of
The Foundation of the Pennsylvania Medical Society

Find out what PAMED has done to improve the medical liability environment in Pennsylvania, and what it is doing to continue to bring more tort reform to Pennsylvania at www.pamedsoc.org/medliability.

PMDA
777 East Park Drive
PO Box 8820
Harrisburg, PA 17105-8820

Does Your Smartphone Hold Your Emergency Information?

Long-term care providers regularly have discussions with LTC residents about advance care planning — understanding and planning for future health care changes and decisions. This allows the individual's wishes and goals to be honored, even if they cannot speak for themselves.

Too often we neglect to follow this advice in our own lives, and do not give adequate thought to deciding and documenting our own thoughts and wishes. Thursday, April 16 is **National Healthcare Decision Day** — a time to turn our gaze back on ourselves to make sure we are taking care of ourselves, our loved ones, and our future health.

Here three ways to honor yourself and your health today:

1. Complete a **Health Care Representative** document to designate who will make health care decisions for you if you are incapacitated. This is appropriate for all ages
2. Complete an **Advance Directives Living Will** document — to guide treatment if you have a terminal illness. This is appropriate for all ages, and especially if there are evolving health issue
3. Establish **Emergency contact information** — this serves as a quick reference to contact a designated friend, family member, or other trusted individual in the event of an emergency. Smartphones have the capability of storing your emergency contact information. **In case of emergency** (otherwise known as ICE) contacts can be viewed by first responder personnel even if your phone is locked with a password.

Visit www.pamda.org for instructions on how to enter ICE information on an Apple phone (requires iPhone 6, or older phone updated to new Apple operating system), or Android phone.

Courtesy of ALLSPIRE, a collaboration of six hospital systems in eastern Pennsylvania and New Jersey.