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

24TH ANNUAL PMDA SYMPOSIUM

Who should attend?

Medical Directors and Long-Term Care Health Professionals, Physical Medicine, Rehabilitation Professionals, Geriatricians, NPs, PAs, Registered Nurses, Family Physicians & Nursing Home Administrators

FRIDAY, OCTOBER 14, 2016

THE HOTEL HERSHEY | 100 Hotel Road, Hershey, PA 17033

PennState College of Medicine

A continuing education service of Penn State College of Medicine
OBJECTIVES

- Differentiate and diagnose several types of dementia; use non-pharmacologic and pharmacologic treatment approaches; and consider facility physical design strategies to improve quality of living for patients with dementia in long term care settings
- Discuss alternative payment models and strategies to reduce costs and improve care through telemedicine
- Utilize assistive devices in LTC settings even when PT/OT is not involved in the patient’s care
- Review current public policy issues and current professional practice issues related to PA and LTC
- Develop strategies to better manage demanding patients and families in the PA/LTC setting
- Monitor and improve patient outcomes through antibiotic stewardship and reducing the number of lab tests, diagnostic testing, and medications when appropriate
- Identify indicators for pain that may be applied to the evaluation and management of quality of care for the elderly and review the QAPI process for patients with pain

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Sorting out Cognitive Impairment

October 14th, 2016

Miguel Paniagua, MD, FACP
Medical Advisor, Test Development Services
National Board of Medical Examiners
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Learning Objectives
• Given a series of cases, the participant will distinguish between delirium, dementia, and depression
• The participant will sort a series of terms (phrases) related to a cause of cognitive impairment into the appropriate categories and explain their rationale

Card Sorting Exercise
• Interactive and cooperative
• Participants in small groups test their knowledge of three causes of cognitive impairment in elders
• Elements of presentation, diagnosis, and/or treatment that may be closely related or controversial

Ground Rules
• Approximately 15 minutes to sort cards into the “best fit” column
• Can use “?” category if the group collectively cannot decide
• Think aloud as you are sorting the cards
• Many items may fit in more than one column. Reason out loud to each other why you are putting your cards where you have chosen
• Each has a characteristic that may fit equally well in more than one category

Epilogue
• Some cards more controversial than others
• Expert ratings
  – Geriatricians, geriatric psychiatrists
  – Little consensus
  – <1/4 agreed to a degree of 75% concordance or greater
• Performance not reliably dependent on profession nor level (trainee vs. faculty)
Facilitators Guide: The “Three D’s” Card-Sorting Exercise

Developed by:
Miguel Paniagua, MD

Consulting contributors:
Maria H. van Zuilen, Ph.D., Roland J. Pua, M.D., Michael J. Mintzer, M.D., Ivan Silver, M.D.

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Date of Release:
November, 2005

<table>
<thead>
<tr>
<th>Subsequent Revision</th>
<th>Date or Frequency of Revision</th>
</tr>
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<tr>
<td>Addition of other later contributing authors</td>
<td>October 2006</td>
</tr>
<tr>
<td>Addition of card item expert ratings and evidence guide</td>
<td>October 2006</td>
</tr>
<tr>
<td>Enhancement of card template</td>
<td>October 2006</td>
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</table>
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Resource Description
The “Three D’s” Card Sorting Exercise is a 30-45 minute interactive small group activity primarily designed to assess medical learners’ ability to distinguish between aspects of dementia, depression, and delirium. Each learner is given a set of cards with symptoms, diagnostic tools, or other terms related to one or more of these geriatric syndromes, and asked to place them in one of the syndrome categories. As a group, learners discuss their rationale and the available evidence base for placing cards in a certain category. Much of the group discussion typically centers on areas where these diagnostic entities overlap and those elements about which there is uncertainty and/or controversy. This educational modality is also an excellent teaching tool and it promotes peer teaching and self-directed learning. The facilitator is present to encourage discussion among the participants and to correct any misconceptions that may be voiced.

Learning objectives
1. The learner will distinguish between aspects of dementia, depression, and delirium (by sorting cards with descriptive terms and phrases into the “best fit” diagnostic category).
2. The learner will explain the rationale for placing cards into a diagnostic category.

Intended Audience
This interactive gaming activity is intended for third or fourth year medical students, physician assistant or nurse practitioner students, and primary care or psychiatry interns. This activity is not intended for those who already have extensive knowledge and experience in the assessment and management of cognitive impairment in older adults. The ideal number of participants is between 3 to 8 people.

Prerequisites
Before participating in this activity, the learner should have completed at least one family medicine, internal medicine, geriatrics or psychiatry clerkship/rotation. The learner should have basic knowledge of the definitions of delirium, dementia, and depression and their respective presentations clinically.

Instructor qualifications and responsibilities
The instructor should be at senior resident, fellow or attending level in a primary care specialty or psychiatry, or equivalent in nursing or physician assistant training. Some experience in small-group facilitation would be beneficial. Previous experience with these syndromes in a clinical setting is recommended.

Required Resources
You will require a room that can comfortably fit all participants and the facilitator (up to 10 people). A large square or rectangular table or tables that in total are at least 15 feet in length (approximately 4.5 meters) to accommodate up to 15 to 20 cards (4.25 x 7 inches or 10.5 x 18 cm) in each column. No chairs are necessary, as you want the participants to be standing, walking, and interacting with each other and the material. The game cards and table tents should be printed on heavy stock paper or cardboard or on paper that can be laminated (see appendix).

Procedures for Implementation
There are 4 categories— Dementia, Delirium, Depression and a “?” category printed on large cards (see PDF attachment), which should be folded in two into tents, and placed on the table in a row at one end. Be certain to provide enough space in each column on the table to easily display the cards placed there by the participants (see diagram). Similarly, leave enough room on all sides for participants to pass easily around the table. There are multiple key...
characteristics for each of the three categories. These are present on the cards and randomly assigned in relatively equal stacks to each participant.

- First, introduce the group to the format and objectives of the session (5 minutes). Explain that this is an opportunity to physically interact with the concept of cognitive impairment. They will have approximately 15-30 minutes to sort their cards into the “best fit” column.

- Give an equal pile of cards to each member of a small group of learners. Each participant must then sort their cards into the appropriate category of dementia, delirium or depression (or a “?” category if the group collectively cannot decide).

- Ask the participants to think aloud as they are sorting the cards. Explain that many of the items may fit in more than one column, but they should reason out loud to each other why they are putting their cards where they have chosen.

- Each card has a characteristic written on it that may more accurately describe one of the categories than the others. Or that may fit equally well in more than one category.

- Some cards will invoke some controversy in category placement thereby prompting discussion and intra-participant teaching. Thus, the participants have a chance not only to associate cards with categories but to learn from one another and teach one another with facilitator observation.

- Encourage them to challenge each other on the category placement of each card. The facilitator should be non-directive in his facilitation, only to be used as a resource for technical issues at this point. The facilitator may take notes during the session of the errors, omissions and controversies in the participants’ discussion.

- After the students have gone as far as they can, the facilitator then gives the group feedback starting with the group’s correct responses, then addressing the errors and omissions and associated explanations. The facilitator may use the evidence and expert rating guide (separate file) to guide the feedback session.

- Facilitator observation of the student reasoning and group process and is paramount in achieving the stated objectives, thereby facilitating formative feedback during the activity.
Evaluation
Evaluation of this activity has been ongoing at the University of Miami Miller School of Medicine (UMMSM) Geriatrics II rotation (See Appendix A). In the past year, 72 fourth-year students at UMMSM participated in this activity. On a 5 point Likert scale (1 = strongly disagree and 5 = strongly agree), the majority of the student participants felt the objectives of the card sorting session were clearly specified (4.3), understood the activity (4.3) and were able to participate actively (4.4). In a self-reported pre- and post-activity survey, the majority of participants felt their ability to distinguish between dementia, delirium and depression was improved after this activity compared to prior (3.7 to 4.5). Furthermore, the majority felt their ability to distinguish between the tools to screen or diagnose dementia, delirium and depression was improved after this activity compared to prior (3.6 to 4.3).

Expert ratings of card items

A panel of faculty in geriatric psychiatry and medicine were asked to rate each card item (using a 0-3-point scale) on how well it applied to dementia, delirium, and depression. Some examples are displayed in figure above. As expected, experts rated many of the card items having some degree of applicability to more than one of these syndromes. These data will help facilitators in the group discussion by reassuring the students that even the “experts” could come to no consensus on most items.

Competency Assessment
After completing the activity, a cohort of students (N=26) were given six case scenarios and asked to determine whether the patients had dementia, delirium, or depression. The assessment was also given to a comparison group of medical students (N=19) who completed the first geriatrics clerkship but who had not yet participated in the card-sorting activity. Students who completed the activity answered significantly more items correctly than students who did not (mean = 5.88 vs. 5.36; t = 2.703, p = 0.013, non-equal variances).

Relationship to Other Materials
This activity could be used as a “stand alone” activity or complement a traditional teaching session on cognitive impairment in the elderly as an applied knowledge activity. This could also be used in conjunction with an online tutorial or module that covers dementia, delirium and depression in the elderly.
Extension Activities
If there are 10 or more participants, consider using two simultaneous games, essentially doubling the set up described. It would be useful (though not required) to then have additional facilitators to debrief the activity. Furthermore, if more than one game is running at once, the facilitator may choose to then utilize the participants in the debriefing as follows:

- Have half of each participating group switch tables with another group
- Ask the “consultant” group of participants to critique the card placement of the original group, and suggest changes (if indicated) and explain their rationale
- After “consultant” group has competed their critique, then debrief the activity as previously described

Lessons Learned
Since the intention of the game is to mirror the ambiguous presentations of cognitive impairment in the elderly, many of the items were meant to be applicable to two or more categories. This would obligate the participants to reason out loud their choices to the group. This caused much concern in the development team especially when discussion of assessment was introduced. Therefore, the items have been revised from previous versions for clarity and to avoid redundancy.

List of References (utilized in creation of game)

References used in Developing this Guide

Citation
Appendix A - Evaluation Form
Card Sorting Activity

Facilitator: ______________________

Participant: ___ Medical Student (MS-___) ___Resident (Level/Specialty)___________
___ Other (Specify)________________

Please rate the following:
The objectives of the session were clearly specified

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I understood what I was supposed to do during the activity (i.e., the rules of the game were clearly specified).</td>
<td>Strongly Agree</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I was able to participate when I wanted to.</td>
<td>Strongly Agree</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Please indicate how well the learning objectives for the session were met:
Distinguish between aspects of dementia, depression, and delirium (by sorting cards with descriptive terms and phrases into the "best fit" diagnostic category).

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explain the rationale for placing cards into a diagnostic category.</td>
<td>Strongly Agree</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

How was the length of the session?

The length of the session was (check one): ____too long          ____about right          ____too short

Please rate yourself on the following items: (1) retrospectively as you were before participating in this exercise, and (2) as you are currently.

<table>
<thead>
<tr>
<th>Ability to distinguish between aspects of dementia, depression, and delirium</th>
<th>Before Low</th>
<th>High</th>
<th>Currently Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

I learned something new in this session that I can use in my daily practice.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments (How can we improve this session?)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix B - Peer Feedback Form
The “three D’s” of Cognitive Impairment: An interactive card-sorting exercise

Number of participants: ________________

Participants (check all that apply): ___ Medical Students MS-__________________________
___ Residents (Level/Specialty)__________________________
___ Other (Specify) _______________________

Please rate the following:
The objectives of the activity were clearly specified

Strongly Agree 1 2 3 4 5 Strongly Disagree

The instructions on how to facilitate the activity were clearly specified.

Strongly Agree 1 2 3 4 5 Strongly Disagree

Please indicate, in your opinion, how well the learning objectives for your session were met:

The learner will distinguish between aspects of dementia, depression, and delirium (by sorting cards with descriptive terms and phrases into the “best fit” diagnostic category).

Strongly Agree 1 2 3 4 5 Strongly Disagree

The learner will explain the rationale for placing cards into a diagnostic category.

Strongly Agree 1 2 3 4 5 Strongly Disagree

How was the length of the session?

The length of the session was (check one): ____too long ______about right ____too short

Please specify: _______________________

I will utilize this activity again in the future.

Strongly Agree 1 2 3 4 5 Strongly Disagree

Comments (How can we improve this session?):

Facilitators Guide: The “Three D’s” Card Sorting Exercise
November 2005 (Updated October 2006)
Sorting out Cognitive Impairment

Miguel Paniagua, MD, FACP

mpaniagua@nbme.org

National Board of Medical Examiners

Adjunct Associate Professor, The Perelman School of Medicine, The University of Pennsylvania

Objectives:

- Given a series of cases, the participant will distinguish between delirium, dementia, and depression
- The participant will sort a series of terms (phrases) related to a cause of cognitive impairment into the appropriate categories and explain their rationale

Or http://www.pogoe.org/productid/18805

This activity involves an interactive and cooperative card-sorting exercise that provides an opportunity for participants in a small group to test their knowledge of a group of diagnoses that may have elements of their presentation, diagnosis, and/or treatment that may be closely related or controversial. A good example, illustrated in this activity, is that of cognitive impairment: delirium, depression and dementia. The facilitators guide, cards, and evidence guide is available at the sites above.


Differentiation between a diminished or altered cognitive functioning as a consequence of aging and one resulting from serious health problems is critical in the elderly. An unrecognized cognitive disorder or the worsening of the impairment may hamper the effectiveness and appropriateness of care and treatment; therefore, standardized assessment procedures and systematic monitoring of cognition and behavior are important aspects of the nursing care of older adults. In this article from the nursing literature, current notions for accurate and comprehensive cognitive assessment in older persons are delineated. Further, an overview of epidemiological screening and diagnostic dilemmas of dementia, depression, and delirium are provided.
<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Delirium</th>
<th>Dementia</th>
<th>Depression</th>
<th>Acute Psychosis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Onset</strong></td>
<td>Acute</td>
<td>Progressive</td>
<td>Acute or insidious</td>
<td>Acute</td>
</tr>
<tr>
<td><strong>Course</strong></td>
<td>Waxing &amp; Waning</td>
<td>Unrelenting</td>
<td>Variable</td>
<td>Episodic</td>
</tr>
<tr>
<td><strong>Attention</strong></td>
<td>Impaired</td>
<td>Intact until late in the disease</td>
<td>↓ concentration &amp; attention to details</td>
<td>Variable</td>
</tr>
<tr>
<td><strong>LOC</strong></td>
<td>Altered</td>
<td>Normal until late in the disease</td>
<td>Normal</td>
<td>Normal</td>
</tr>
<tr>
<td><strong>Memory</strong></td>
<td>Impaired commonly</td>
<td>Prominent short- and/or long term memory impairment</td>
<td>Normal, some short term forgetfulness</td>
<td>Usually normal</td>
</tr>
</tbody>
</table>

**Notes:**
## DEPRESSION IS TREATABLE

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Depression</th>
<th>AD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onset</td>
<td>Rapid, relatively short duration</td>
<td>Gradual, long duration</td>
</tr>
<tr>
<td>Mood</td>
<td>Flat or depressed</td>
<td>Apathetic</td>
</tr>
<tr>
<td>Intellectual function</td>
<td>Don't know answers</td>
<td>Confident but inaccurate</td>
</tr>
<tr>
<td>Memory loss</td>
<td>Loss of short and long term</td>
<td>Recent most impaired</td>
</tr>
<tr>
<td>Other</td>
<td>Impaired concentration</td>
<td>Impaired orientation</td>
</tr>
<tr>
<td>Self image</td>
<td>Poor</td>
<td>Normal</td>
</tr>
<tr>
<td>Personal and family history</td>
<td>Depression is more common</td>
<td>Depression is less common</td>
</tr>
</tbody>
</table>

**Notes:**
## DELIRIUM IS DANGEROUS

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Delirium</th>
<th>Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onset</td>
<td>Sudden</td>
<td>Gradual</td>
</tr>
<tr>
<td>Reversibility</td>
<td>Usually reversible</td>
<td>Irreversible and progressive</td>
</tr>
<tr>
<td>Disorientation</td>
<td>Early and profound</td>
<td>Late during the disease</td>
</tr>
<tr>
<td>Consciousness</td>
<td>Clouded/fluctuating</td>
<td>Not affected</td>
</tr>
<tr>
<td>Language</td>
<td>Uses wrong works</td>
<td>Worsen with advanced disease</td>
</tr>
<tr>
<td>Attention span</td>
<td>Short</td>
<td>Not affected</td>
</tr>
<tr>
<td>Speech</td>
<td>Incoherent</td>
<td>Coherent</td>
</tr>
<tr>
<td>Sleep-wake cycle</td>
<td>Hour to hour variability</td>
<td>Day-night reversal</td>
</tr>
<tr>
<td>Psychomotor changes</td>
<td>Markedly hyperactive or hypoactive</td>
<td>Not until late</td>
</tr>
</tbody>
</table>

**Notes:**
Non-Pharmacologic Treatment of Dementia
Heidi White, MD, MHS, MEd, CMD

OBJECTIVES

- To describe novel approaches to improve the lives of older adults with dementia
- To adopt a framework for behavioral management of dementia symptoms
- To facilitate the abilities of the front-line staff to:
  - Recognize each challenging behavior
  - Report challenging behaviors
  - Respond by using behavioral interventions

BACKGROUND

1. 1.4 million residents resided in a nursing home in 2011.
2. 65% had noted cognitive impairment
3. 39% was severe
4. 80-90% of those with dementia develop at least one distressing behavioral symptom over the course of illness.

DRAMATIC DECREASE IN PRESCRIBING OF ANTIPSYCHOTIC DRUGS UNTIL MID/LATE 1990S

Can we accept and plan for neurodiversity?
Non-Pharmacologic Treatment of Dementia
Heidi White, MD, MHS, MEd, CMD

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**MEDICAL DIRECTOR LEADERSHIP**
- Assist nursing home in identifying competent and committed practitioners
- Ensure timely follow up of resident concerns, visits and pharmacy recommendations
- Monthly Behavioral IDT meeting
- Policy on appropriate assessment, prescribing for, and monitoring of dementia related behaviors
- Policy promoting resident choice, individualized plan of care, permanent staffing
- Policies and Procedures for Informed Consent

**CASE-BASED EDUCATIONAL PROGRAM**
- Monthly interdisciplinary case conference (behavior rounds)
- Secured dementia unit in a community-based NH
- Front-line staff chooses a resident to discuss
- Systematic characterization of:
  - the behavior
  - possible antecedents
  - intervention plan

---

**IMPLEMENTATION**
- Feasibility - July 2012
  - Attendance
  - Coverage
  - Efficiency
  - Communication
- Education enhancement – April 2013
  - Resource folders
  - Behavior Team
  - Pocket Card

**ASSESSMENT**
- Acute, subacute, or insidious onset of symptoms
- What exactly is (are) the behavior(s)?
  - Provide a description rather than a label
  - Frequency
  - Intensity
  - Duration
  - Timing

---

**EVALUATION PROCESS**
- History-collateral information (nurse, CNA, family, roommate)
- Physical examination
- Assessment and Plan
  - Interdisciplinary
  - Identify, assess, remove and treat contributing factors
- Follow Up
  - Frequent re-evaluation
  - "Antecedent-Behavior-Consequence" analysis

**WHAT ARE THE CONTRIBUTING FACTORS?**
- Physical
- Psychological
- Environmental
Non-Pharmacologic Treatment of Dementia
Heidi White, MD, MHS, MEd, CMD

- Pain
- Delirium: infection, medications, dehydration
- Nutrition: hunger, frustration
- Elimination (Constipation, urinary retention)
- Sensory Deficits
- Sleep Disturbance
- Cold/Hot

PHYSICAL/ MEDICAL FACTORS

- New surroundings
- Overstimulation (light, noise, activity)
- Under-stimulation
- Institutional routines/ expectations
- Trying to do things too fast
- Lack of prompts for daily activities
- Not understanding language/instructions

ENVIRONMENTAL FACTORS

- Loneliness
- Boredom
- Apprehension, worry, fear
- Autonomy/ privacy
- Loss of intimacy
- Depression
- Anxiety
- Psychosis- hallucinations/ delusions

PSYCHOLOGICAL FACTORS

POCKET CARD: RECOGNITION

POCKET CARD: RESPONDING & REPORTING
**Non-Pharmacologic Treatment of Dementia**
Heidi White, MD, MHS, MEd, CMD

**MAKING LIFE BETTER**

- Individualized Music
- Aromatherapy (lavender oil, lemon balm)
- Massage and Touch
- Pet therapy

**PERSONALIZED MUSIC THERAPY**

- Immersive listening environment provided by headphones
- Individualized playlists tailored to listener’s early life experience and interests
- Safe, inexpensive

**OVERHEARD AT ENO POINTE...**

- “That’s a real great idea you guys have.”
- “The iPods have been a huge help in calming residents during our busiest times.”
- “She’s usually ready to break out of here.”

**RECOMMENDATIONS**

- Keep playlists between 3-5 hours
- Expect to lose 1-3 iPods per year
- Save money on headphones
- Most music overlaps between residents
- Still room for titrating to interests
- Incorporate into workflow
- Speaker (iHome) for dinner group listening experience
- Not everyone likes it everyday!

**STIMULATION**

- Physical Exercise
- Recordings or video of family
- Snoezelen/Multisensory Therapy

**RHYTHM AND ROUTINE**

- Light therapy
- Bathing Without a Battle
http://www.bathingwithoutabattle.unc.edu/
Non-Pharmacologic Treatment of Dementia
Heidi White, MD, MHS, MEd, CMD

- Community
- Connectedness
- Care

ENVIRONMENT

RESIDENTS WITH BEHAVIORS

<table>
<thead>
<tr>
<th>Month</th>
<th>Total Incidents</th>
<th>Total Alterable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul-12</td>
<td>180</td>
<td>120</td>
</tr>
<tr>
<td>Mar-13</td>
<td>160</td>
<td>100</td>
</tr>
<tr>
<td>Apr-13</td>
<td>140</td>
<td>80</td>
</tr>
<tr>
<td>Aug-13</td>
<td>120</td>
<td>60</td>
</tr>
<tr>
<td>Jan-14</td>
<td>100</td>
<td>40</td>
</tr>
</tbody>
</table>

PERSPECTIVES

- “It made you relate to how that person was acting and how you would want to be treated”
- “Now able to know what behavior they are having”
- “Can get more involved by taking them to see something they like”
- “CNAs now run the floor”
- “It is a great team”
- “Used to be the most difficult unit, now it is one of the best”
- CNAs “feel important”

SUMMARY

- Engaging front-line staff is crucial for person-centered care
- Behavior rounds held on a monthly basis has improved the ability of the front-line staff to recognize, report, and respond to difficult behaviors in persons with dementia
- Ongoing training and reinforcement is needed
- In-facility champion

Acknowledgments

- AMDA Foundation Awards
- Chancellor's Service Fellowship
- Albert Schweitzer Fellowship
- Bass Connections
- Shelley McDonald, DO
- Kelly Murphy
- Daniel Gustz
- Diene Coleman
- Eno Pointe Staff
- Carmella Kroll
- Tung Vu, photos
- Our Residents

Questions?
AMDA Update
Heidi White, MD, MHS, MEd, CMD

Strategic Goals & New Initiatives
24th Annual PMDA Symposium, October 14, 2016

Our Vision:
A world in which all post-acute and long-term care patients and residents receive the highest-quality, compassionate care for optimum health, function, and quality of life.

Our Values:
- We are dedicated above all to quality in PA/LTC processes and outcomes.
- We affirm that a well-trained, collaborative, interprofessional team with physician guidance is best equipped to care for PA/LTC patients.
- We strive to deliver individualized, goal-directed care in all PA/LTC settings of care.
- We are tireless advocates in all venues.
- We are committed to being a credible information resource.
- We are a community – connected to and supportive of each other.

Our Mission:
- We promote and enhance the development of competent, compassionate and committed medical practitioners and leaders to provide goal-centered care across all post-acute and long-term care settings.
- Dedicated to defining and improving quality, we advance through timely professional development, evidence-based guidance and tireless advocacy on behalf of members, patients, and staff.

Domains of Influence

10 Strategic Goals for 2016-17

Domain I
Goal 1. Ensure that the Society is sustainable & well governed

Domain II
Goal 2. Grow the Society’s membership & enhance member value

Domain III
Goal 4. Promote clinical education and competency to optimize system-wide, evidence-based, goal-directed care

Goal 5. Deliver evidence-based clinical guidance for PA/LTC

Goal 6. Leverage technology & innovation to advance PA/LTC
10 Strategic Goals for 2016-17

Domain IV

Goal 1. Advocate for AMDA mission of improved quality, value and patient/resident experience

Goal 2. Improve & strengthen AMDA external relationships

Goal 3. Support optimal patient/resident care through the appropriate definition of quality in PA/LTC

Goal 4. Support the needs of PA/LTC patients, residents and families

An Expanded Focus

• Name change
  • AMDA – The Society for Post-Acute and Long-Term Care Medicine

• New website & domain, logo & branding
  • Consistent with the new, expanded direction for the Society

• Expanded membership
  • NPs and PAs are now “general members” with voting rights and may serve on the AMDA board
  • Help us to recruit attending physicians, NPs and PAs – some 50,000 practice in PA/LTC

A Better Definition of Quality

• Quality in PA/LTC
  • The Board of Directors created a Quality Measures Committee to advance this work
  • We are members of the National Quality Forum and active on their TEPs and Committees
  • We are working actively with CMS on MACRA and MIPS, IMPACT Act implementation of CQMs (Clinical Quality Measures)
  • We launched a “Quality Prescribing” campaign to address medication-related adverse events in the SNF

A New Focus on Assisted Living

• AL Summits took place in 12/2014 and 11/2015 in Columbia, MD
  • All major players in assisted living participated
  • Medical oversight
  • Standards for care of residents
  • Levels of staffing of ALFs and skills required
  • Shape the regulatory environment

  • AL intensives at AMDA 2015 & 2016 Annual Conferences
  • A 3rd summit is scheduled in March 2017 in Phoenix

Support for PA/LTC Physicians

• PA/LTC Physician Competencies
  • Physician Competencies approved by the AMDA board in March 2013
  • Training curriculum development started in 2014
  • First domain launched at our 2016 Annual Meeting in Orlando
  • All five domains complete by December
  • Plans for 2016 & beyond:
    • Education: Development & implementation of online training in 2016 is ongoing
    • ABPLM: Job task analyses for the medical director and attending physician to establish the unique and specialized nature of this practice
    • Two surveys are forthcoming
    • Validation: Research to show the value of the CMD, training and skill

New Directions for Clinical Tools

• Clinical Practice Guidelines improvements:
  • Developing actionable tools, pocket guides
  • New inclusion criteria for National Clearinghouse
  • Conversion to EHR use

• Interactive versions of the Know-it-All series
• Mobile apps
• Embed clinical decision support/order sets into EHRs
• What obstacles to using the CPGs do you see?
Grants – A New Area for the Society

- We have initiated and been invited to participate in a number of federal grants – new activity for us
  - Region 4 CMP grant to develop and implement training in the care of the younger adult, based on our Younger Adult Toolkit
  - AHRQ grant to study effective treatment of UTIs, with University of Pittsburgh
  - Retirement Research Foundation grants continue to support ongoing clinical guidelines revision & dissemination
  - Also validation research
  - To support this work we now have a grants administrator in our Clinical Affairs team

Advocacy: A Landmark Year

- MACRA (post-SGR world)
  - Quality Payment Program (MIPS/APMs)
  - ACOs
  - AMDA submitted comments
  - Exclusions from MIPS Penalties
  - Physician Fee Schedule
  - Advance Care Plan Code
    - Webinar on how to bill and do advance care planning (free recording for members)
  - Complex Chronic Care Management Code
  - POS 31 exemption for ACO attribution
  - New ACO models available
  - Joint Replacement/Cardiology Bundling

- IMPACT Act (data standardization for PA/LTC)
  - Multiple CMS Technical Expert Panels
  - Comments on quality measures
  - Tight timelines
  - Nursing Home RDR Reform – AKA “The Megarule”
  - CMS received over 8,250 comments
  - AMDA’s comments were comprehensive and detailed
  - Many chapters sent in comments in addition to AMDA
  - Final rule due out end of September

Advocacy: Concerns

- Gradual, slow, subtle – but definite: Erosion of the indispensable role of competent clinicians in the nursing home
  - Competent, compassionate and committed physicians/clinicians are needed now more than ever
  - Reflected in our strategic planning survey: clinically complex, frail elders need more involvement from physicians now, not less
  - MIPS/APMs/IMPACT focusing our attention on appropriate quality measures ...
  - But providers and payers are focusing on risk (cost) - need to prove value of dedicated PA/LTC physicians in delivering quality in cost driven system
  - Show your value!!

Society Leaders Go to Capitol Hill in September to Advocate for Medical Directors and PA/LTC Medicine

Your voice is needed!

- Please consider sending us your name to serve on a national committee, task force or workgroup
- Opportunities are plentiful in AMDA, ABPLM, and the AMDA Foundation
- Help shape the future for PA/LTC medical direction and medical practice
- Bring the next generation of practitioners into this setting – be a mentor

Thank You!

Heidi K. White, MD, MHS, MEd, CMD
President-Elect
heidi.white@dm.duke.com
919-660-7516
Alternative Payment Models: Implications for Post-Acute & Long-Term Care

Joe Angelelli, PhD
Senior Advisor, Alternative Payment Models
PAMDA Annual Meeting
October 14, 2016

Outline of Presentation

• National Context of Health Care Payment Learning and Action Network (HCP-LAN)
• MACRA Momentum
• Deeper Dive into Bundled Payments and Shared Savings

National Context

• Health Care Payment Learning & Action Network (HCP-LAN) funded by CMS
  – Guiding Committee
  – Payer Collaborative Workgroup
  – Alternative Payment Model Framework

HCP-LAN Guiding Committee

The Purpose of the LAN is to align private payers and CMS in moving payment from traditional FFS methods to those linked to quality. The goal of the LAN:

In 2016, at least 30% of US health care payments will be linked to APMs. In 2018 at least 50% of US health care payments will be so linked. These payment reforms are expected to demonstrate better outcomes and lower costs for patients.

By sharing information about successful models and encouraging private entities to share their best practices, the LAN will assist in setting a foundation for long-term transformation within the US health care system.
## APM GOALS

**For Payment Reform**

<table>
<thead>
<tr>
<th>Current State</th>
<th>Future State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>Category 1</td>
</tr>
<tr>
<td>Category 2</td>
<td>Category 2</td>
</tr>
<tr>
<td>Category 3</td>
<td>Category 3</td>
</tr>
<tr>
<td>Category 4</td>
<td>Category 4</td>
</tr>
</tbody>
</table>

## MACRA Momentum

**Proposed Timeline of Payments**

<table>
<thead>
<tr>
<th>Year</th>
<th>Physician Fee Schedule</th>
<th>MIPS</th>
<th>OPP in Advanced APM</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>-0.5% each year</td>
<td>+5%</td>
<td>+5% bonus (included in APM)</td>
</tr>
<tr>
<td>2017</td>
<td>-0.5% each year</td>
<td>+5%</td>
<td>+5% bonus (included in APM)</td>
</tr>
<tr>
<td>2018</td>
<td>-0.5% each year</td>
<td>+5%</td>
<td>+5% bonus (included in APM)</td>
</tr>
<tr>
<td>2019</td>
<td>-0.5% each year</td>
<td>+5%</td>
<td>+5% bonus (included in APM)</td>
</tr>
<tr>
<td>2020</td>
<td>-0.5% each year</td>
<td>+5%</td>
<td>+5% bonus (included in APM)</td>
</tr>
<tr>
<td>2021</td>
<td>-0.5% each year</td>
<td>+5%</td>
<td>+5% bonus (included in APM)</td>
</tr>
<tr>
<td>2022</td>
<td>-0.5% each year</td>
<td>+5%</td>
<td>+5% bonus (included in APM)</td>
</tr>
<tr>
<td>2023</td>
<td>-0.5% each year</td>
<td>+5%</td>
<td>+5% bonus (included in APM)</td>
</tr>
<tr>
<td>2024</td>
<td>-0.5% each year</td>
<td>+5%</td>
<td>+5% bonus (included in APM)</td>
</tr>
<tr>
<td>2025</td>
<td>-0.5% each year</td>
<td>+5%</td>
<td>+5% bonus (included in APM)</td>
</tr>
</tbody>
</table>

## MACRA: “VICTORIES FOR PA/LTC PROFESSIONALS”

- Exclude services billed under CPT codes 99304-99318 when the claim includes the POS 31 (SNF, meaning a resident receiving skilled post-acute services) modifier from the definition of primary care services for MIPS under the Resource Use Criteria category.

- MIPS-eligible clinicians (no longer ‘eligible professionals’) who lack control over the EHR technology in their practice locations (e.g., surgeons using ambulatory surgery centers or a physician treating patients in a nursing home who does not have any other vested interest in the facility, and may have no influence or control over the health IT decisions of that facility) would need to submit an application demonstrating that a majority, 50 percent or more, of their outpatient encounters occur in locations where they have no control over the health IT decision of the facility, and request their advancing care information performance category score be reweighted to zero.
**Episode Based Payment (Bundle) Definition**

- **A fixed dollar amount** that covers a set of services for a defined period of time.

- Payment is typically administered on a FFS basis with **retrospective reconciliation** to an episode budget. But there are examples of prospective (“bundled”) payment in use.

- Most often providers share in savings generated (“shared savings”), but are sometimes held accountable for losses too (“shared risk”).

- Quality is typically a component of payment – either influencing gain/loss distribution, or as a separate bonus.
### UPMC Programs in the APM Framework

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>Fee-for-service</td>
</tr>
<tr>
<td>Category 2</td>
<td>Pay for reporting</td>
</tr>
<tr>
<td>Category 3</td>
<td>Rewards for performance</td>
</tr>
<tr>
<td>Category 4</td>
<td>Comprehensive Population-based Payment</td>
</tr>
</tbody>
</table>

#### Health Plan’s proportion spend in upside-only shared savings or episodic (bundled) alternative payment models in 2015

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Medicare</th>
<th>Commercial</th>
<th>Medicaid</th>
<th>Rocky Mountain Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>UPMC</td>
<td>52%</td>
<td>44%</td>
<td>37%</td>
<td>73%</td>
</tr>
<tr>
<td>Humana</td>
<td></td>
<td>51%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anthem</td>
<td></td>
<td>40%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td></td>
<td></td>
<td>37%</td>
<td></td>
</tr>
<tr>
<td>Rocky Mountain</td>
<td></td>
<td></td>
<td></td>
<td>73%</td>
</tr>
</tbody>
</table>

In October, the CMS-funded Health Care Payment Learning & Action Network (HCP-LAN) will release results of national benchmarking survey.

---

### UPMC Health Plan Average Eligible Members for Shared Savings Participation

<table>
<thead>
<tr>
<th>Product</th>
<th>Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial (ASO &amp; FI)</td>
<td>444,420</td>
</tr>
<tr>
<td>Medicare</td>
<td>133,331</td>
</tr>
<tr>
<td>SNP</td>
<td>21,386</td>
</tr>
<tr>
<td>Medicaid</td>
<td>387,201</td>
</tr>
<tr>
<td>Commercial Exchange</td>
<td>116,324</td>
</tr>
</tbody>
</table>
Shared Savings Structure

- Health Plan is paid a percentage of premium for administrative services.
- Spend for all services included in pool except pharmacy (part D)
- Monthly cost reconciliation with practice
  - Revenue minus Cost = Shared Savings
- Strict quality standards must be achieved before any annual Shared Savings payouts are made. Current metrics are based on CMS STARS rankings and HEDIS scores

UPMC. Insurance Services Division.

Shared Savings Model – Quality Measures

- Breast Cancer Screening (process)
- Colorectal Screening (process)
- Osteoporosis Management in Women (process)
- Diabetes Care: Eye Exam (process)
- Diabetes Care: Kidney Disease Monitoring (process)
- Rheumatoid Arthritis Management (process)
- Plan All-Cause Readmissions (outcome)
- High Risk Medication (process)
- Part D Adherence for Oral Diabetes Medication (outcome)
- Part D Adherence for Hypertension Medications (outcome)
- Part D Adherence for Cholesterol Medications (outcome)
- Statin Therapy for Patient with Diabetes (Display Measure) (process)

Key Success Factors

- Highly engaged physicians/strong physician leadership
- Aligned incentives
- Well-defined network management
- Accurate practice membership rosters
- Individualized Education on HCC and CMS STARS optimization


UPMC Health Plan Medicare/SNP Medical Expense Ratio
Shared Savings Program v. Rest of Network 2011 - 2015

Key Success Factors, con’t

- Strong Medical Management and Clinical Information to support physicians and population management
- Accurate coding and documentation
- Actionable and reliable data and information
- It’s all about the data
Looking Ahead: Using Telemedicine To Reduce Costs And Improve Care

Steven M. Handler MD, PhD, CMD
Associate Professor, Division of Geriatric Medicine and Biomedical Informatics; CMIO, UPMC Community Provider Services

Disclosure

• I am the Chief Medical and Innovation Officer for Curavi Health
• I do not own any equity interests in Curavi Health, nor do I have any options or other interests that are convertible into equity interests in Curavi Health

Potentially Avoidable Hospitalizations (PAHs)

• CMS defines PAHs as hospitalizations that could have been avoided because the condition could have been prevented or treated outside of an inpatient hospital setting

• Approx. 25% of all hospitalizations are considered PAHs

• Have an ALOS of 6.1 days and an estimated cost of $8 billion ($11,255/admission) to CMS (Centers for Medicare and Medicaid)

Most Common PAHs

Six conditions responsible for 80% of PAHs:
- Pneumonia (32.8%)
- UTI (14.2%)
- CHF (11.6%)
- Dehydration (10.3%)
- Skin Ulcers, cellulitis (4.9%)
- COPD / Asthma (6.5%)

Complete List of PAH Diagnoses?

- Acute Renal Failure (AKI)
- Altered mental status
- Anemia
- Asthma
- C. Difficile infection
- Cellulitis
- CHF (congestive heart failure)
- Constipation/Impaction
- COPD
- Diarrhea/Gastroenteritis

- Failure to thrive
- Falls and Trauma
- HTN (hypertension)
- Pneumonia/Bronchitis
- Nutritional deficiency
- Poor glycemic control
- Psychosis
- Seizures
- Skin Ulcers
- UTI (urinary tract infections)


The range in rates across the states was considerable, with more than a threefold difference across states.

Disproportionate # of PAHs Come from NHs

- 16% of Medicare/Medicaid beneficiaries were in a NH, yet comprised 45% of all PAHs
- Most common setting where PAHs originate from are NHs
- PAHs from NHs are often multifactorial

Programs Designed to Reduce PAHs

1. **Evercare** (Optum™ Care Plus) model that uses NPs and Care Managers reduced hospital admissions by 47% and emergency department use by 49% (Kane et al., 2004)

2. **Medicare Advantage** partnerships to waive 3-day qualifying hospital stay necessary for Part A benefit and treat in place

3. **INTERACT** QI program reduced hospital admissions between 17-24% (Ouslander et al, 2011)

Core Programatic Elements of RAVEN

1. Facility-based Nurse Practitioners/Enhanced Care Nurses

2. INTERACT tools to reduce avoidable hospital admission

3. Individualized educational program/simulation

4. Enhanced medication management, monitoring, and pharmacy engagement

5. Use of telemedicine to enable remote clinical assessment, and facilitate communication.
Technological Sophistication of NHs

- Approx. 60% of NHs have an EMR
- Majority use a fax for meds, labs, radiology, recaps

What is Telemedicine?

- Telemedicine is defined as the use of telecommunication and information technologies in order to provide clinical healthcare at a distance.
- Types of telemedicine:
  1. Interactive services (synchronous)
  2. Store-and-forward (asynchronous)
  3. Remote monitoring (self-monitoring)

Evidence-Base for Telemedicine in NHs

- Edirippulige et al., conducted a systematic review which provides evidence for feasibility and stakeholder satisfaction in using telemedicine in NHs across clinical specialties
  - J Telem Telecare, 2013
- Grabowski et al., showed that an after-hours physician-based telemedicine program can reduce hospitalization by 9.7% and yield $151K cost savings to Medicare/NH/yr.
  - Health Aff, 2014

Perceptions of Telemedicine for PAHs

- Surveyed 435 physicians and nurse practitioners who attended the 2015 AMDA - The Society for Post-Acute and Long-Term Care Medicine Annual Conference
- Survey components:
  - Case vignette showing how telemedicine could be used to manage acute changes of condition in NHs
  - Perceived benefits and concerns about the use of telemedicine in NHs
  - Attributes of a successful telemedicine program
  - Demographic information

Perceptions and Attributes of Telemedicine

<table>
<thead>
<tr>
<th>Statement</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Telemedicine may help manage existing patient care...</td>
<td>425</td>
<td>1.99</td>
<td>1.80</td>
</tr>
<tr>
<td>2. Telemedicine was adequate to address existing patient care...</td>
<td>422</td>
<td>2.15</td>
<td>1.90</td>
</tr>
<tr>
<td>3. Telemedicine was improved to address patient care...</td>
<td>423</td>
<td>2.19</td>
<td>1.90</td>
</tr>
<tr>
<td>4. Telemedicine may help avoid unneeded transfers to the emergency department hospital...</td>
<td>425</td>
<td>2.45</td>
<td>1.18</td>
</tr>
<tr>
<td>5. Telemedicine may improve access to appropriate medical care...</td>
<td>426</td>
<td>2.50</td>
<td>1.17</td>
</tr>
<tr>
<td>6. Telemedicine may improve clinical communication...</td>
<td>425</td>
<td>2.80</td>
<td>1.19</td>
</tr>
</tbody>
</table>

*Responses expressed on a 5-point Likert scale, ranging from “strongly agree” to “strongly disagree,” with lower scores indicating stronger agreement.

Email telemedicine survey items:

<table>
<thead>
<tr>
<th>Statement</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ability to deliver the expert medical advice, diagnoses, or consultation to a patient...</td>
<td>426</td>
<td>3.25</td>
<td>0.99</td>
</tr>
<tr>
<td>2. Ability to send the patient's medical history, lab results, or diagnostic or treatment options to the requesting clinician...</td>
<td>423</td>
<td>4.35</td>
<td>0.44</td>
</tr>
<tr>
<td>3. Ability to follow up or provide ongoing medical care remotely or at a distance...</td>
<td>422</td>
<td>4.35</td>
<td>0.45</td>
</tr>
<tr>
<td>4. The telemedicine equipment was specific designed for use in nursing homes...</td>
<td>423</td>
<td>4.15</td>
<td>0.66</td>
</tr>
<tr>
<td>5. The telemedicine equipment was specific designed for use in nursing homes...</td>
<td>426</td>
<td>2.19</td>
<td>1.90</td>
</tr>
<tr>
<td>6. The telemedicine equipment was specific designed for use in nursing homes...</td>
<td>426</td>
<td>4.15</td>
<td>0.66</td>
</tr>
</tbody>
</table>

*Responses expressed on a 5-point Likert scale, ranging from “extremely important” to “not very important,” with lower scores indicating more importance.
Summary: Using Telemedicine for PAHs

- Highly positive and strongly-held beliefs of the value of telemedicine for managing PAHs in the NH setting
- Suggests that there is potentially unmet demand for telemedicine and that NHs may be receptive to appropriately designed solutions
- Need to focus on the sociotechnical aspects of implementation and continued use of telemedicine to ensure its continued use through a highly structured change mgmt. process
- Limitations include self-selected sample and potential biases in the respondent population

Telemedicine for NH Specialty Consultations

- The goal of this study was to determine the perceived utility of providing specialty telemedicine in NHs
- Surveyed 522 physicians and nurse practitioners who attended the 2016 AMDA - The Society for Post-Acute and Long-Term Care Medicine Annual Conference
- Top 5 specialties that physicians and APPs would refer to:
  - Derm > Geri psych > ID > Neuro > Cards
- Top 5 Statements of agreement:
  - Fill an existing service gap > Improve timeliness of resident care > Increase access to appropriate care > Decrease ED/hosp > Increase overall quality of care

RAVEN Telemedicine Team and Approach

- Ashley Boots, CRNP
- Christa Bartos, RN, PhD
- Julie George, RN
- Telemedicine Support Group
- Community Provider Services IT
- Facility engagement
- Facility and telemedicine readiness
- Facility telemedicine training

Stop and Watch Early Warning Tool

If you have identified a change while caring for or observing a resident, please circle the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

STOP
- Seems different than usual
- Temperature 103°F
- Talks or communicates less
- Overall needs more help
- Generalized weakness
- Pain new or worsening
- Participated less in activities

AND
- Ate less
- No bowel movement in 3 days or diarrhea
- Drank less
- Weight change
- Agitated or nervous more than usual
- Tired, weak, confused, or drowsy

WATCH
- Change in skin color or condition
- Left foot warm with warm hand
- Help with walking, transferring, toileting more than usual

Traditional Telephonic Clinical Case

- Chris Bartos is an 86 yo female (new resident) transferred to Jane St NH following a recent hospitalization for a UTI with sepsis
- Resident has a PMHx of diabetes, hypertension, osteoarthritis, Alzheimer’s disease and malnutrition
- Resident has indicated FULL TREATMENT on her POLST form and would like antibiotics if life can be prolonged
- Family wants to send her out because they believe that the hospital can take care of sick patients better

RAVEN Reduce Avoidable Hospitalizations using Evidence-based interventions for Nursing facilities in Western Pennsylvania

How can we do this differently?
**“Telly” the Telemedicine Cart**

- HP All-in-one PC
- Washable keyboard/mouse
- Pan/tilt/zoom camera
- HD Web camera
- Speakerphone
- Bluetooth stethoscope
- Digital otoscope
- 12-lead PC-Based EKG
- Portable Doppler ultrasound
- Teleconference/med software
- Wireless gateway (Verizon/ATT LTE)

**RAVEN Telemedicine Results**

- 18 RAVEN Partner NHs
- CRNP-based model; 6 hrs./day; long-stay residents (>100 days) only
- Completed 148 telemedicine and 1,690 telephonic-only consultations since 2/14

<table>
<thead>
<tr>
<th>Percentage of hospital transfers avoided:</th>
<th>Sep 2014 – July 31, 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telemedicine consults (69 of 117)*</td>
<td>59.0%</td>
</tr>
<tr>
<td>Telephonic-only consults (199 of 1,690)</td>
<td>11.8%</td>
</tr>
</tbody>
</table>

**Post-Consult Telemedicine Survey**

<table>
<thead>
<tr>
<th>I was able to see the resident and/or images on the screen without delay, cloddiness, or interruption in video quality.</th>
<th>strongly disagree</th>
<th>disagree</th>
<th>neutral</th>
<th>agree</th>
<th>strongly agree</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was able to hear the RN/resident without delay, cloddiness, or interruption in sound quality.</td>
<td>11</td>
<td>13</td>
<td>4</td>
<td>32</td>
<td>67</td>
<td>117</td>
</tr>
<tr>
<td>The resident seemed comfortable communicating during the Telemedicine consult.</td>
<td>11</td>
<td>15</td>
<td>10</td>
<td>30</td>
<td>51</td>
<td>117</td>
</tr>
<tr>
<td>The nurse seemed comfortable communicating during the Telemedicine consult.</td>
<td>3</td>
<td>1</td>
<td>26</td>
<td>31</td>
<td>62</td>
<td>117</td>
</tr>
<tr>
<td>I was able to obtain an adequate history of present illness, past medical history, and review of symptoms.</td>
<td>3</td>
<td>2</td>
<td>9</td>
<td>32</td>
<td>76</td>
<td>117</td>
</tr>
<tr>
<td>I was able to complete an adequate physical exam.</td>
<td>4</td>
<td>2</td>
<td>11</td>
<td>35</td>
<td>64</td>
<td>117</td>
</tr>
</tbody>
</table>

**Potentially avoidable conditions present:**

<table>
<thead>
<tr>
<th>Value</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute confusion, delirium, altered mental status</td>
<td>15.9%</td>
<td>16</td>
</tr>
<tr>
<td>Agitation, psychosis, depression</td>
<td>4.2%</td>
<td>5</td>
</tr>
<tr>
<td>Cellulitis, skin breakdown</td>
<td>21.6%</td>
<td>25</td>
</tr>
<tr>
<td>CHF</td>
<td>15.9%</td>
<td>13</td>
</tr>
<tr>
<td>Constipation</td>
<td>1.7%</td>
<td>2</td>
</tr>
<tr>
<td>COPD</td>
<td>6.7%</td>
<td>8</td>
</tr>
<tr>
<td>Delirium</td>
<td>11.8%</td>
<td>14</td>
</tr>
<tr>
<td>Diarrhea, C diff, pseudomembranous</td>
<td>5.2%</td>
<td>7</td>
</tr>
<tr>
<td>Failure to thrive</td>
<td>2.0%</td>
<td>3</td>
</tr>
<tr>
<td>Falls and or trauma</td>
<td>4.2%</td>
<td>5</td>
</tr>
<tr>
<td>Glycemic control</td>
<td>5.9%</td>
<td>7</td>
</tr>
<tr>
<td>Hypothyroidism</td>
<td>2.5%</td>
<td>3</td>
</tr>
<tr>
<td>Pneumonia or bronchitis</td>
<td>21.9%</td>
<td>26</td>
</tr>
<tr>
<td>Urinary Tract infection</td>
<td>10.5%</td>
<td>13</td>
</tr>
<tr>
<td>Other</td>
<td>10.7%</td>
<td>12</td>
</tr>
<tr>
<td>None of the above</td>
<td>25.8%</td>
<td>34</td>
</tr>
<tr>
<td>Total</td>
<td>110</td>
<td></td>
</tr>
</tbody>
</table>

**RAVEN Telemedicine Results (Cont.)**

<table>
<thead>
<tr>
<th>The Telemedicine cart allowed me to provide appropriate care.</th>
<th>strongly disagree</th>
<th>disagree</th>
<th>neutral</th>
<th>agree</th>
<th>strongly agree</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Telemedicine consult helped avoid the need for a face-to-face visit by a NP or physician.</td>
<td>12</td>
<td>9</td>
<td>11</td>
<td>35</td>
<td>94</td>
<td>117</td>
</tr>
<tr>
<td>The use of Telemedicine is an appropriate and effective use of my skillset and time.</td>
<td>7.7%</td>
<td>4.3%</td>
<td>10.3%</td>
<td>30.8%</td>
<td>47.0%</td>
<td>117</td>
</tr>
<tr>
<td>Overall, I was comfortable and satisfied using the Telemedicine cart.</td>
<td>8</td>
<td>6</td>
<td>9</td>
<td>23</td>
<td>71</td>
<td>117</td>
</tr>
<tr>
<td>Overall, I found the technology effective in the medical management of this resident.</td>
<td>9.4%</td>
<td>8.0%</td>
<td>8.0%</td>
<td>19.7%</td>
<td>53.8%</td>
<td>117</td>
</tr>
<tr>
<td>The Telemedicine consult helped to avoid resident transfer to the hospital/ED.</td>
<td>4.2%</td>
<td>12.0%</td>
<td>24.6%</td>
<td>19.7%</td>
<td>36.2%</td>
<td>117</td>
</tr>
</tbody>
</table>
Lessons Learned

- Facility physician and administration support is critical for success
- Telemedicine is not just a technology change, but also a culture change for NH staff (sociotechnical aspects)
- Consistent connectivity is crucial for successful consultations
- Keep everything as simple and intuitive as possible
- No individual user IDs and passwords
- Ongoing education and support – refreshers provide repetition and keep NH staff aware

RAVEN Phase 1 Interim Results

- Net savings to CMS of over $5 million (first 3 yrs. of data)

Table 2: Effect of ECCP intervention on probability of any utilization outcome: Multivariate regression results, 2011-2014, Pennsylvania

<table>
<thead>
<tr>
<th>Probability of having at least one:</th>
<th>Mean, 2012 (percent)</th>
<th>Effect (percentage points)</th>
<th>p-value</th>
<th>Effect (% of mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-cause hospitalization</td>
<td>31.0</td>
<td>-6.8</td>
<td>0.001</td>
<td>-21.9%</td>
</tr>
<tr>
<td>Potentially avoidable hospitalization</td>
<td>15.2</td>
<td>-3.7</td>
<td>0.030</td>
<td>-24.3%</td>
</tr>
<tr>
<td>All-cause ED visit</td>
<td>22.3</td>
<td>-3.1</td>
<td>0.144</td>
<td>-13.9%</td>
</tr>
<tr>
<td>Potentially avoidable ED visit</td>
<td>7.6</td>
<td>-3.1</td>
<td>0.001</td>
<td>-40.8%</td>
</tr>
</tbody>
</table>

RAVEN Phase II

We have been funded to test the effects of providing a payment model to the current and additional ~15 NHs and practitioners for the treatment of qualifying medical conditions.

1. Payments to a SNF under Medicare Part B for the treatment of qualifying conditions.
2. Increased practitioner payments under Medicare Part B for the treatment of conditions onsite at the LTC facility.
3. Practitioner payments under Medicare Part B for care coordination and caregiver engagement for beneficiaries in a SNF or NF stay.

Proposed Skilled Nursing Facilities for Phase Two

Telemedicine in UPMC NHs and Curavi

- 6 UPMC NHs (~700 beds)
- Geriatrician-based model; 6 hrs./day; whole-house model
- Completed 98 telemedicine and 38 telephone consultations Since 3/15

Percentage of hospital transfers avoided: cumulative totals reflect Mar 2015 – April 2016

<table>
<thead>
<tr>
<th>Type of Consult</th>
<th>Percentage</th>
<th>Avoided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telemedicine</td>
<td>39 of 98</td>
<td>40.0%</td>
</tr>
<tr>
<td>After-Hours Telephone Consults</td>
<td>6 of 38</td>
<td>16.0%</td>
</tr>
</tbody>
</table>

Thanks to Kambria Ernst, RN, MSN
### Anecdotes

- **NP:** “We can do a lot at these facilities...Sometimes patients get sent out during the night and I get frustrated because we could have safely managed the resident.”
- **Nurses:** “This is going to be very useful. Sometimes it is just really hard to describe a resident’s condition on the telephone.”
- **DON:** “I see this is really great, it is going to let our nurses be nurses.”
- **Residents families:** Aw struck and I think they were shocked. The only question I got was “do we have to pay for this” They were surprised. One lady said “I saw this on Dr. Phil, dial a doctor.”
- **Doctors:** “This is great if it cuts down on the phone calls I get at night.”

### Why We Should Care: The CMS Regulatory and Reimbursement Landscape

![CMS Regulatory and Reimbursement Landscape](image)

### Telemedicine and NH Strategy

![Telemedicine Strategy](image)

### Implications for NH/Payor/Provider/Family

- **Lower cost** of care by providing it in the NHs rather than the ED or hospital which can reduce the number of PAHs and lowers readmission rates
- **Maintain NH census stabilization and referral relationships** with hospitals
- **Reduction of pending CMS payment penalties for PAHs** (value-based purchasing initiative) and alignment with other alternative payment models (bundled payments, ACOs)

### Barriers to Telemedicine in NHs

- **Physician licensure**
- **Physician credentialing**
- **Establishment of physician-resident relationship**
- **Lack of belief in the value or potential of the technology**
- **Limited information technology infrastructure/connectivity in NH**
- **Administrative support/buy-in**
- **High staff turnover**
- **Reimbursement**
How Can You Do Telemedicine in the NH?

- Communicate the value of telemedicine to your residents and their families
- Work with the NH to ensure facility engagement, facility and telemedicine readiness, and facility telemedicine training
- Use HIPAA-compliant and secure telemedicine software and hardware (Guidance from CMS; Appendix C)
- Ensure you have notified your malpractice insurer
- Confirm that NH has notified the Dept. of Health

How do I get Reimbursed (Part 1)?

- Determine if your NH is an authorized (rural non-MSA) originating site: [http://tinyurl.com/HRSAcheck](http://tinyurl.com/HRSAcheck)
- For medical necessity, use the Subsequent Nursing Facility Care CPT E&M codes 99307-10 and include the “GT” modifier (via interactive audio and video telecommunications system)
- Ensure that your H&P meets all requirements for that particular CPT E&M code and is documented in the NH medical record
- Limited to 1 visit per the same resident every 30 days

How do I get Reimbursed (Part 2)?

- For advance care planning (ACP) services, use CPT E&M codes 99497 (first 30 min.) and 99498 (each addl. 30 min.) (starting January 2017)
- Include the “GT” modifier (via interactive audio and video telecommunications system)
- Ensure that your H&P meets all requirements for that particular CPT E&M code and is documented in the NH medical record
- There is no limits on the number of times ACP can be reported for a given beneficiary in a given time period

How Does your NH Get Reimbursed?

- Determine if your NH is an authorized (rural non-MSA) originating site: [http://tinyurl.com/HRSAcheck](http://tinyurl.com/HRSAcheck)
- HCPCS code Q3014, Telehealth originating site facility fee
  - Can be billed for Short-term and LTC Medicare Beneficiaries
  - The NH bills the MAC for the originating site facility fee, which is a separately billable Part B payment = revenue in addition to the daily RUGs rate for skilled residents
  - Managed care companies can reimburse NHs for code Q3014 for all products if they elect to do so
Assistive Devices for the non PT/OT

October 14th, 2016

Miguel Paniagua, MD, FACP
Medical Advisor, Test Development Services
National Board of Medical Examiners
Adjunct Associate Professor of Medicine
University of Pennsylvania Perelman School of Medicine

Learning Objectives
- Define gait, mobility, transfer, assistive device
- List assistive devices in order of those providing the most to least stability
- List indications, advantages and disadvantages of ambulation assistive devices
- Select appropriate assistive devices for patients with specific ambulation problems and medical conditions

Definitions
- Gait – Using legs from an upright posture to move across a distance
- Mobility – Voluntary change of position
- Transfer – Shift of core body weight from one surface to another
- Assistive device – Equipment to overcome impairment of one or more functions critical to Activities of Daily Living

EPIDEMIOLOGY
- Gait disorders – 20% of elders
- Devices frequently used – 25% up to age 80; 50% of those over 80
- Most commonly used – Canes > Walkers > Wheelchairs

Gait Change as a “medical alert”
- Gait changes are often the first sign of a medical problem
- Virtually any disease process can alter gait by altering sensory, motor or neurologic function
- DO NOT ignore altered gait!

What are the benefits of assistive devices?
- Longer maintenance of function
- Improved confidence level and feeling of safety
- Decreased caregiver burden
- Better quality of life
Criteria for Selection

Level of Stability Provided
- Parallel bars
- Walker
- Axillary crutches
- Forearm crutches
- Two canes
- One cane

Criteria for Selection

Required Coordination
- Forearm crutches
- Axillary crutches
- Two canes
- One cane
- Walker
- Parallel bars

Key points

- Assistive devices for ambulation (AD) improve balance and stability during ambulation
- Increased base of support and stability, improve balance, unload weight, and facilitate propulsive forces of ambulation
- Safe usability is the focus in selection, education, and training for use of devices

Complications of use of assistive devices for ambulation?

- Cumulative Repetitive Stress injuries to Upper Extremities
- Accidents
  - Improper device, incorrect use, equipment failure
- Increased energy requirement
- Reduced walking speed for most devices

Key points

- Devices need to be tailored to patient’s
  - Physical and cognitive status
  - Level of stability and off-loading desired
  - Ambulation requirements

- Complications of AD use/misuse of for ambulation can be very serious

Summary

- Balance and Gait disorders
  - Are common
  - Linked to quality of life
  - Can be a sign of underlying pathology

- Assistive devices are useful if properly prescribed & used

- The specific fitting and training for AD use should be done with input from the Physical Medicine and Rehabilitation Team
Assistive Devices for the Non-Therapist: An Interactive Session
Miguel Paniagua, MD, FACP

Assistive Device Cases

- Straight cane
- Offset cane
- Crutches
- Quad Cane
- Standard walker
- 2-wheeled walker
- 3-wheeled walker
- 4-wheeled walker

Match your cases with the proper device

Straight Cane?

<table>
<thead>
<tr>
<th>Straight Cane</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 79 y/o male with mild dizziness caused by Meniere’s disease</td>
</tr>
<tr>
<td>A 66 y/o male diabetic with mild balance problems and numbness of his legs</td>
</tr>
<tr>
<td>A 69 y/o female with peripheral neuropathy and occasional interstices</td>
</tr>
<tr>
<td>A 80 y/o male with poor vision due to bilateral cataracts</td>
</tr>
<tr>
<td>A 70 y/o female with decreased peripheral vision due to glaucoma falling more often</td>
</tr>
</tbody>
</table>

Offset Cane?

<table>
<thead>
<tr>
<th>Offset Cane</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 68 y/o female with moderate pain from arthritis in her right knee and hip</td>
</tr>
<tr>
<td>A 72 y/o woman with mild LLE weakness after a traumatic injury</td>
</tr>
<tr>
<td>A 62 y/o man with mild pain from a right knee strain</td>
</tr>
</tbody>
</table>

Crutches?

<table>
<thead>
<tr>
<th>Crutches</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 63 y/o female who fractured her left ankle while playing tennis</td>
</tr>
<tr>
<td>A 65 y/o male with a recent RLE distal femur fracture from skiing, who is otherwise healthy</td>
</tr>
</tbody>
</table>

Standard Walker?

<table>
<thead>
<tr>
<th>Standard Walker</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 79 y/o male with a recent bilateral knee replacement and normal upper extremity strength</td>
</tr>
<tr>
<td>A 75 y/o female with bilateral knee osteoarthritis and good upper extremity strength</td>
</tr>
</tbody>
</table>

2-Wheeled Walker?

<table>
<thead>
<tr>
<th>2-Wheeled Walker</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 69 y/o male with vertebrobasilar ataxia who loses his balance a lot</td>
</tr>
<tr>
<td>A 62 y/o active male with psoriatic arthritis affecting the knees and wrists bilaterally</td>
</tr>
<tr>
<td>A 68 y/o female with early Parkinson's disease who has been using a cane but has been falling more often</td>
</tr>
<tr>
<td>An 88 y/o previously active male with trouble standing after a 1-month hospital stay for pneumonia</td>
</tr>
<tr>
<td>A 79 y/o woman with resting tremor, shuffling gait and difficulty turning while walking</td>
</tr>
</tbody>
</table>
Assistive Devices for the Non-Therapist: An Interactive Session
Miguel Paniagua, MD, FACP

3-Wheeled Walker?

<table>
<thead>
<tr>
<th>3-Wheeled Walker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three-wheeled walkers do not provide a good base of support and they fold easily. Because of their instability, they pose a safety risk.</td>
</tr>
</tbody>
</table>

4-Wheeled Walker?

<table>
<thead>
<tr>
<th>4-Wheeled Walker</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 66 y/o male with severe mitral regurgitation who feels exhausted all the time</td>
</tr>
<tr>
<td>A 71 y/o male with end-stage pulmonary hypertension weakness who cannot go to the mailbox without getting SOT</td>
</tr>
<tr>
<td>A 76 y/o female with mild dementia &amp; severe COPD who complains of always being tired</td>
</tr>
<tr>
<td>A 88 y/o woman with severe class IV CHF</td>
</tr>
</tbody>
</table>

??????

<table>
<thead>
<tr>
<th>86 y/o man with hemiparesis from CVA</th>
</tr>
</thead>
<tbody>
<tr>
<td>This man needs a weight-bearing device so a cane is incorrect. With hemiparesis, a walker cannot be used - he has unilateral arm weakness. A hemiplegic or quad care might be possible but neither is a choice. A wheelchair might be required.</td>
</tr>
</tbody>
</table>
Assistive Devices for the non-PT/OT

Miguel Paniagua, MD, FACP
mpaniagua@nbme.org

Learning objectives:
Attendees will:
• Define gait, mobility, transfer, assistive device.
• List assistive devices in order of those providing the most to least stability
• List indications, advantages, and disadvantages of assistive devices.
• Select the appropriate assistive device for a series of geriatric patients with given problems or medical conditions

Instructional Activity:
• This case-based session is designed to apply basic information learned from the online “Assistive Devices in the Elderly” training module and the medical conditions common in the geriatric patients who need and use them. (See reference)
• This interactive teaching activity uses a card sorting format: students use several cards with patient scenarios and are asked to match these with the appropriate assistive device.
• The session includes facilitator feedback and, time allowing, an extension activity for identifying proper and improper use of assistive devices
• This activity is NOT intended to teach students how to prescribe an assistive device because as physicians, you will be able to draw on the expertise of other disciplines to complete a more formal evaluation. However, we do want you to be able to recognize when a patient may benefit from an assistive device and when they may be using an inappropriate assistive device.

Key Concepts:
• Use of assistive devices increases with age (25% of those elders up to age 80 and >50% of those over age 80)
• The most heavily used device is a cane (1/3 of all devices compared to walkers and wheelchairs which make up 25 and 10 percent respectively)
• Using assistive devices can help elders maximize their function, decrease dependence on caregivers and increase their own perceived quality-of-life

Definition
• Assistive device: equipment to overcome impairment of one or more functions critical to Activities of Daily Living (ADL’s)

Implications: Gait Change as a Medical Alert
• Gait changes are often the first sign of a medical problem.
• Virtually any disease process can alter gait by altering sensory, motor or neurological function
• Don’t ignore altered gait!
Benefits of assistive devices
- Longer maintenance of function
- Improved confidence level and feeling of safety
- Decreased caregiver burden
- Better quality of life
- For ambulation in various medical conditions
- Improve stability: Lower extremity weakness (stroke, muscle loss, or fracture, disuse)
- Improve balance: Sensory loss (vestibular, posterior column, peripheral, visual)
- Improve coordination: Altered muscle tone (CVA, spasticity, Parkinsonism)
- Alleviate pain: Unloading (arthritis, fracture)
- Improved tolerance during ambulation: allow for rest periods (CAD, CHF, PVD)
- Assistive devices for ambulation (AD) improve balance and stability during ambulation: increase confidence and feeling of safety, increased physical and social activity: reduce residual disability, and decrease caregiver burden
- Mechanism of action: increased base of support and stability, improve balance, unload weight, and facilitate propulsive forces of ambulation

Summary
- Balance and Gait disorders are common in the elderly and one of the greatest detractors to quality of life.
- ADs can aid ambulation, but improper (and even proper use) can lead to problems.
- A basic understanding of gait disorders and clinical conditions associated with them and pros and cons of available assistive devices can help make the appropriate choice to optimize function while limiting safety risks and complications.
- The specific fitting and training for AD use should be done with input from the Physical Medicine and Rehabilitation Team

Glossary
- Gait: propulsive cyclical lower limb motion
- Mobility: voluntary directed (purposeful) change of position (major as opposed to fine movement)
- Transfer: Shift of core body weight from one surface to another
- Rehabilitation: Maintenance and restoration of physical and psychological health necessary for independent living and functional independence
- Disease: Underlying pathologic process or diagnosis noticed at a microscopic level
- Impairment, organ level: Disease progression to a level that affects normal organ function
- Disability: person level, organ impairment that causes restriction in the ability to perform particular activities of daily living (ADL)
- Handicap: societal level, disability that impedes a person from fulfilling social roles
- ADL: activities of self care, six main domains: eating, grooming, dressing upper body, dressing lower body, toileting, bathing
- Orthosis: an external piece of equipment applied to a body part to provide support or stabilize, accommodate deformity, alleviate pain, improve weight/pressure distribution, improve function. i.e. knee brace, ankle-foot orthosis, wrist splint
- Prosthesis: An external piece of equipment that serves as a substitute for a missing body part either for cosmetic (breast prosthesis post-mastectomy) or functional (lower extremity prostheses for amputee) purposes.

Worksheet

The purpose of this activity is for you to learn a few key points about the proper use of assistive devices so you can recognize when a patient is using their device incorrectly and unsafely.

<table>
<thead>
<tr>
<th>Assistive Device</th>
<th>Key Points About Their Use</th>
<th>Common problems/mistakes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straight Cane</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Offset Cane</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crutches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard Walker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two-Wheeled Walker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Three-Wheeled Walker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Four-Wheeled Walker</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Public Policy Update
David A. Nace, MD, MPH, CMD
Zachary Simpson, MD, CMD
naceda@upmc.edu
zsimpson@adi.com
Oct 14, 2016

Conflicts of Interest
Drs. Nace & Simpson have no conflicts of interest directly pertaining to this presentation.

Pennsylvania Focused Policy Items
- PA Prescription Drug Monitoring Program
- PA Electronic Death Registration System (EDRS)
- PA Medical Marijuana Act 16 2016
- PA POLST Legislation

PA Prescription Drug Monitoring Program
- PA PDMP created under Act 191 of 2014
- Database of prescriptions for controlled substance (CS) filled in the state
- Goal is to improve access to a patient's CS prescribing history as well as assisting law enforcement efforts surrounding CS diversion/abuse
- June 24, 2016 - all prescriptions dispensed must be entered within 72 hours
- August 25, 2016 - database live for querying by prescribers

PA Prescription Drug Monitoring Program
- Practitioners protected from liability
- Practitioners may authorize a delegate to perform queries
  - Practitioners are responsible for delegate's actions
  - Practitioners must enter information regarding the query into the medical record
  - "PA PDMP database queried and no issues found", or "PA PDMP database queried, opted not to prescribe CS, discussed findings with patient"
PA Prescription Drug Monitoring Program

**PMDA Actions**
- PMDA supports the PA PDMP
- Provides needed transparency regarding medication histories
- Aug 22, 2016 - telephone call with the PA PDMP Director
- Discussed concerns surrounding use in PA/LTC settings
- Oct 2016 - submitted letter with FAQ and list of unanswered questions
- Awaiting response

My resident is on oxycodone 5 mg TID and I am asked for a new prescription to refill the CS. Do I need to query the PA PDMP?

A. NO - Only new prescriptions or suspicions of abuse/diversion are mandatory queries. This is a continuation of a current Rx

My patient is not responding to the oxycodone and I am increasing the dose to 10 mg TID. Do I need to query the system?

A. NO - this is a continuation of a current prescription

**Pending Issues**
- Documenting timeframe for medical record - we are proposing at the next visit
- Documentation for covering practitioners - we are proposing the covering practitioner notify the primary attending of the results. The primary attending then enters into the medical record at the next visit.
- Issues for both of these are frequent use of oral/telephone orders, lack of EHR access remotely, infrequent onsite present, covering providers not going to a facility

Who can be a delegate in LTC?

Can there be more than one delegate in LTC?

**PA Electronic Death Registration System (EDRS)**
- Requires input of information from several sources
- Providers, facilities, funeral directors, coroners
- EDRS currently in Phase 1
- Funeral homes and coroners
- To be completed till late 2017.
- Phase 2 will involve providers
- Outpatient/hospital may involve provider completing information first, then funeral homes.
- LTC may be different in process as medical records person may end up entering info first > then provider > then funeral home.
**PA Act 16 Medical Marijuana**

- Passed April 17, 2016
- Allows use of “Medical Marijuana” in PA
- Establishes a bureaucracy to implement and oversee the production, distribution, and dispensing of “Medical Marijuana”
- Expected to begin in late 2017 or 2018 (18-24 months following passage)

**PA Act 16 Medical Marijuana**

- Limited to following forms:
  - pill;
  - oil;
  - topical forms, including gel, creams or ointments;
  - a form medically appropriate for administration by vaporization or nebulization, excluding dry leaf or plant form;
  - tincture; and
  - liquid.

**PA Act 16 Medical Marijuana**

- A physician shall:
  - Apply to the department to be registered with the program.
  - Demonstrate to the department by training or expertise that he or she is qualified in treating serious medical conditions.
  - Successfully complete the required four-hour course established by the department.
  - Hold a valid, unexpired, unrevoked, unsuspended Pennsylvania license to practice medicine.
- Physician registrations will become available by the end of the year upon notice in the Pennsylvania Bulletin.

**Does the Medical Marijuana Program Protect Against Federal Prosecution?**

- No. The U.S. Department of Justice (DOJ) has the authority to enforce civil and criminal federal laws relating to marijuana possession and use, regardless of state law. Growing, distributing, and/or possessing marijuana in any capacity, except through a federally-approved research program, is a violation of federal law, and no state or local law provides a legal defense to a violation of federal law.
- In light of current DOJ guidance, however, it may be unlikely that federal authorities would bring civil enforcement actions or criminal investigations and prosecutions against growers/processors, dispensaries, physicians, seriously ill individuals or caregivers as long as they are acting pursuant to the Act. A memorandum from the DOJ, dated August 29, 2013, explains the priorities of federal authorities regarding marijuana possession and use, including state medical marijuana programs.

**LTC Challenges with Medical Marijuana**

- EPA prohibits marijuana
  - CI substance
    - No medical benefit
  - While current administration is not actively enforcing, risk exists because
    - Variability in DEA regional activities
    - Dependent on administration changes
  - NF are federally regulated
  - Federal surveys

**LTC Challenges with Medical Marijuana**

- Storage
  - Cannot store in ebox - ebox owned by pharmacy
  - Cannot store in med cart
  - Cannot store in facility lock box
- Liability due to Inadvertent (or Purposeful) Absorption
  - Oils/topicals
**PMDA Position on Marijuana**

- PMDA opposes legislation that would allow the medical use of cannabis in any form
- PMDA supports the conduct of sound clinical trials evaluating both the risks and benefits of marijuana in well defined conditions
- PMDA opposes the recreational use of marijuana in any form

**PMDA Actions**

- Will be reaching out to PA DOH regarding challenges related to LTC

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**PA POLST Updates**

- Draft legislation developed and finalized winter 2016
  - Create a permanent home and oversight body for POLST
  - Assembles diverse stakeholders around a common understanding and purpose
  - PMDA participation in process
  - Beginning lobbying process

**PA POLST Updates**

- Only 3 states and DC not using POLST at some level
- National POLST website at www.polst.org expanded. Provides information to professionals, the public, and access to PA's site
- POLST 8.0 hours CME course modified. Now known as "POLST Doing It Right!". Goal not to just reach trainers, but anyone who engages in goals of care discussion for those nearing the end of life and for those who provide education on POLST
  - New tools and greater emphasis on having meaningful conversations
- For information on how to bring course to your facility, send inquiry to PAPOLST@verizon.net

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**National Policy Issues**

- CMS Final Conditions of Participation
- Payroll Based Journal (PBJ)
- Advance Care Planning Codes
- Pneumococcal Vaccination Guidance
- 5 Star Updates
- Other AMDA Actions
CMS Final Conditions of Participation

- July 2015, CMS released proposed regulatory reforms for NF - updating the 1987 OBRA based regulations
- Comment period extended to mid October 2015
- AMDA & PMDA both submitted comments
- Numerous areas addressed
- Released scheduled for Sep 2015

Reform of Requirements for Long Term Care Facilities: Centers for Medicare and Medicaid Services. Federal Register / Vol. 80, No. 136 / Thursday, July 16, 2015 / Proposed Rules

CMS Final Conditions of Participation

- Released 9/28/2016
- 713 pages
- Combination of new requirements & reorganization
- Three phase implementation
  - Phase 1 - November 28, 2016
  - Phase 2 - November 28, 2017
  - Phase 3 - November 28, 2019

Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities 10/4/2016

CMS Final Conditions of Participation

- Physician Services -
  - Not included - requirement of face to face visit before acute care transfers
  - Was originally proposed
  - Landslide disapproval
  - Countless valid reasons cited
  - CMS “not to finalize this requirement at this time”
  - Not included - required credentialing section withdrawn

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CMS Final Conditions of Participation

- Physician Services
  - At the time of admission, “a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist must provide orders for the resident’s immediate care and needs”
  - Allow physicians, NP, PA, and CNS to provide admission orders
  - Physicians may delegate authority to write dietary orders
  - Can’t be performed by NP/PA/CNS

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

CMS Final Conditions of Participation

- Medical Director
  - No changes to current section (aside from re-numbering)
  - Changes to Pharmacists Monthly Drug Regimen Review
  - Requires written report to attending, medical director, DON
  - At minimum - resident name, drug, irregularity
  - Must be acted upon by either attending, medical director, DON
  - Attending does not have to agree, but must document reviewed and decision

PMDA – The Pennsylvania Society for Post-Acute and Long-Term Care Medicine
CMS Final Conditions of Participation

- Infection Control
  - Facilities must have an infection prevention and control program (IPCP)
  - Facilities must include an antimicrobial stewardship program
  - Facilities must designate at least 1 Infection Preventionist (IP)
  - May designate more than one person
  - Primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field and can be qualified by education, training, experience or certification

CMS Final Conditions of Participation

- CMS will host a webinar on the Final Rule October 27, 2016
  - AMDA to host Webinar in November (16th ?)

Payroll Based Journal (PBJ)

- You practice at Compliance Meadows, a 160 bed nursing facility in Cambria Co.
  - The facility has implemented several new procedures re PBJ and requests your help.

Payroll Based Journal (PBJ)

- Which of the following statements about PBJ is true:
  - A. Facilities should log all hours that physicians spend each month caring for their patients.
  - B. Facilities should log all hours that NP/PA spend each month caring for their patients.
  - C. Facilities should record the number of administrative hours the medical director works each month.
  - D. Medical directors must log their administrative hours daily.
  - E. Only onsite medical director administrative hours may be counted.
  - F. All of the above
Payroll Based Journal (PBJ)

- Administrative time of medical director is counted
- Clinical time of medical director is not counted
- Onsite and offsite time is counted
- Should be tied back to payroll, invoices, or a contract stipulating hours

- Daily log sheets not required
- Invoices are acceptable
- Monthly summary sheets are acceptable

Advanced Care Planning Codes Update

- October 15 2015, CMS Approved the 2016 Physician Fee Schedule
- 2 ACP codes - 99497 and 99498 were activated
- CMS did not issue a national coverage decision however
- Individual insurers might not approve - nearly all have
- Some insurers waiving co-pay

Both codes require a face-to-face meeting with either the patient, family, or surrogate for “the explanation and discussion of advance directives such as standard forms (with the completion of such forms, when performed), by the physician or other qualified health professional.”

ACP Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Metro Phila Area</th>
<th>Rest of PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>99497</td>
<td>First 30 Minutes</td>
<td>$90.50</td>
<td>$83.85</td>
</tr>
<tr>
<td>99498</td>
<td>Each Additional 30 Minutes</td>
<td>$78.67</td>
<td>$73.28</td>
</tr>
</tbody>
</table>

ACP Code Questions

1. Can the ACP Codes 99497-8 be billed in the nursing home setting?
   - YES - they are not site restricted

2. Can NP/PA use the ACP codes 99497-8?
   - YES - they can be billed by any qualified provider

3. I spent 20 minutes in ACP discussions with the patient and not the full 30 minutes. Can I bill 99497?
   - YES - The CPT® time rule states - “A unit of time is attained when the mid-point is passed.” The 99497 code is used to report the first 30 minutes of face-to-face time. Using the CPT® time rule, if a visit is > 16 minutes and < 31 minutes, then the 99497 code may be billed

ACP Code Questions

4. Can the ACP Codes 99497-8 be billed the same day as another nursing facility Evaluation & Management (EM) code?
   - YES - Both an EM and ACP code can be billed on the same day.
Advanced Care Planning Codes Update

- AMDA Actions
  - Supported inclusion in CMS response letter 2015
  - Sep 6, 2016 letter to CMS, recommending inclusion of 99497-8 on list of approved telehealth services

Pneumococcal Vaccination in PA/LTC

- Pneumococcal pneumonia accounts for 20-60% of community acquired pneumonias (CAP)
- Potentially preventable
- 65+ population remains at high risk
- Vaccination effective >>> even in frail LTC residents
- Pneumococcal vaccination rates still lag

Pneumococcal Vaccination

- 2002 - Standing Orders Programs Approved by CMS
- 2005 - F334 Immunization Requirement
- 2009 - F441 Guidance > Vax Program Assessment
- 2012 - Public Reporting of Vaccination Measures
- 2014 - ACIP/CDC Recommends PCV13
- 2015 - ACIP/CDC Simplifies Intervals
POLICY STATEMENT ON PNEUMOCOCCAL VACCINATION

The Society strongly advocates that Post-Acute and Long-Term Care (PA/LTC) facilities and providers establish and maintain a pneumococcal vaccination program that provides residents with access to current Advisory Committee on Immunization Practices (ACIP) and Centers for Disease Control and Prevention (CDC) recommended pneumococcal vaccinations.

http://www.paltc.org/pneumococcal-vaccination-guidance-paltc-facilities

POLICY STATEMENT ON PNEUMOCOCCAL VACCINATION

Such a program would include a requirement to assess PA/LTC residents for their pneumococcal vaccination status and to administer and document appropriate pneumococcal vaccinations in accordance with current ACIP and CDC guidance, unless the PA/LTC resident declines or has a medical contraindication or allergy.

http://www.paltc.org/pneumococcal-vaccination-guidance-paltc-facilities

POLICY STATEMENT ON PNEUMOCOCCAL VACCINATION

In addition, The Society recommends PA/LTC facilities and providers demonstrate an ongoing commitment to Quality Assessment and Performance Improvement by evaluating and addressing their pneumococcal vaccination programs if vaccine acceptance rates fall below U.S. Department of Health and Human Services goals.

http://www.paltc.org/pneumococcal-vaccination-guidance-paltc-facilities

Case 1 - PPV - Dealing with Uncertainty

- Helen is a new resident admitted to your facility.
- She has advanced dementia.
- Her family is unsure if Helen ever had a pneumonia vaccine.
- You are unable to reach her PCP
Case 1 - PPV - Dealing with Uncertainty
Which action is most appropriate?
A. Give PPSV23 now followed by PCV13 in 1 year
B. Give PCV13 (Prevnar 13) now followed by PPSV23 in 1 year
C. Don’t administer either pneumonia vaccine.

Case 2 - PPV - Before 2014
Which vaccine should she now received?
A. PCV13
B. PPSV23
C. Neither
D. Yellow fever.

Case 2 - PPV - Before 2014
Eleanor is a newly admitted NF resident
She reports having a pneumonia shot at the age of 78 in 2012.
She is unaware of which vaccine it was.

Case 3 - PPV - What is Timely?
What is AMDA’s recommendation on timing of pneumococcal vaccine?
A. Resident assessment & vaccination completed within 7 days
B. Resident assessment completed within 14 days & vaccination completed by first quarterly care conference or discharge, whichever comes first
C. Resident assessment & vaccination completed within 30 days.

Case 3 - PPV - What is Timely?
You are the medical director of Procrastination Acres, a 135 bed facility for retired state politicians in Harrisburg
The administrator asks you how soon after admission should a person be vaccinated.

Pneumococcal References
- General Pneumococcal Vaccination Web Page
- http://www.paltc.org/pneumococcal-vaccination-guidance-paltc-facilities
- Clinical Pneumococcal Vaccination Guidance
- Pneumococcal Coverage Guidance
- http://www.paltc.org/infections-advisory-committee-faq-pneumococcal-vaccination-coverage
Public Policy Update
David Nace, MD, MPH, CMD

Pneumococcal References

- Pneumococcal Assessment Note
- http://www.paltc.org/sites/default/files/Pneumococcal%20Vaccination%20Guidance%20FAQs%202013%202016%20003.pdf
- Society Policy Statement

5-Star Changes

Beginning April 2016, CMS will began publically reporting six new quality measures (QMs) on Nursing Home Compare


4 New Short Stay Measures

Percent of Short Stay Residents

- successfully discharged to the community (Claims-based)
- had an outpatient emergency department visit (Claims-based)
- were re-hospitalized after a nursing home admission (Claims-based)
- made improvements in function (MDS-based)

2 New Long Stay Measures

Percent of Long Stay Residents

- whose ability to move independently worsened (MDS-based)
- received an antianxiety or hypnotic medication (MDS-based)

5-Star Rating Changes

- Beginning in July 2016, five of the six measures will be used in the calculation of 5-Star Quality Rating QM ratings.
  - specificity and appropriate thresholds concerns
- Proposed Benefits
  - Increase the number of short-stay measures
  - Cover important domains not covered by other measures
  - Claims-based measures may be more accurate than MDS-based measures.

Other AMDA Actions

- 3 day stay rule - AMDA has been working with CMS and congress to eliminate the 3 day stay rule.
  - Notice Act August 2016 - requires hospitals to notify patients when they are in observation status ≥24 hours
  - Two Midnight Rule - authorizes physicians to order inpatient status if they believe the patient will stay 2 or more midnights
  - AMDA supporting The Improving Access to Medicare Coverage Act of 2015 (HR 1571/SB43)
    - Counts observation status towards the 3 day stay rule
  - Care Planning Act S 1549 and Personalize Your Care Act HR 5555
    - Makes AC directives portable, establishes quality metrics, supports demonstration projects to test tools/education.

PMDA – The Pennsylvania Society for Post-Acute and Long-Term Care Medicine
Other AMDA Actions

- SNF/NF Subsequent Care Codes & Telehealth
  - Recommendations to CMS to remove once every 30 day limit on number of telehealth visits
  - Particularly an issue in rural areas
- IMPACT Act
  - Continued input to CMS on IMPACT Act
- SNF Value Based Purchasing
  - Continued input to CMS

American Board of Post-Acute and Long-Term Care Medicine (ABPLM)

- Medical Direction - formerly CMD certification
  - All CMD certificate have been moved to ABPLM
  - AMDA conducting a survey regarding format of credentialing process
- PA/LTC Clinical Core Competency Curriculum
  - In development
  - Web education module development underway

The Foundation for PA/LTC Medicine

- Separately incorporated 501(c)(3) organization formed in 1996 to advance the quality of life for persons in post-acute & long-term care (PA/LTC) through inspiring, recognizing and educating future and current health care professionals.

- In 2016, the AMDA Board of Directors mandated the Foundation to be the fundraising vehicle for all the AMDA entities. In addition to changing its name to align with the Society, the Foundation Board restructured and created the Development Committee. Under the guidance of the Board, the committee will be directly responsible for raising funds for the 8 programs to support not only the Foundation’s mission but that of the Society and ABPLM.

- In addition to fundraising, the Foundation will continue its successful programs to recognize and educate future and current health care practitioners:

- The Foundation Futures Program:
  - In order to address the workforce issue in PA/LTC, in 2001, the Foundation created an intensive training experience designed to expose residents, fellows and advanced practitioners to career opportunities in post-acute and long-term care medicine.

- The Foundation Quality Improvement Awards:
  - To encourage the development of innovative projects to make a direct impact on the quality of long-term care.
  - The program has awarded more than $280,000 in research funding.

- The Foundation Quality Improvement & Health Outcome Awards:
  - For "Improving the Quality of Life for Residents Living in Nursing Homes"*
  - Three facilities are awarded $1,000 each for programs developed by the team that demonstrated improved quality of life for their residents.

Visit our website at www.paltc.org for more information.

*To learn more about this opportunity, go to http://paltc.org/infection-prevention-certificate-course.