The Best of the

CALTCM Summit for Excellence

2019 Fall Summit

October 19, 2019

UC Davis
Betty Irene Moore Hall
2570 48th Street
Room BIMH 1800
Sacramento, CA 95817

About CALTCM

The California Association of Long Term Care Medicine (CALTCM) is the professional organization for California physicians, medical directors, nurses, pharmacists, administrators, and other professionals working in long-term care. We are positioned at the forefront of statewide efforts to advocate quality patient healthcare, provide long-term care education, and influence policy. CALTCM is the state chapter of AMDA: The Society for Post-Acute and Long-Term Care Medicine (formerly the American Medical Directors Association (AMDA)).

Program Overview

CALTCM is pleased to host the 2019 Fall Summit, The Best of the 2019 CALTCM Summit for Excellence. This event has been designed to engage and benefit direct care practitioners, all members of the interdisciplinary team and administrative leadership. This event will help you stay current on best practices to be the driver of quality, patient safety and person-centered care, featuring hot topics in PALTC and two "In The Trenches" sessions, giving participants the opportunity to individualize their experience by choosing from a variety of sessions to fit their education needs.

Target Audience

Physicians, advanced practice nurses, geriatric psychiatrists, pharmacists, nurses (DON/RN/LVN/DSD), administrators, physician assistants, rehabilitation specialists, social services designees, and other members of the interdisciplinary team who care for patients/residents in the PA/LTC setting.

Learning Objectives

By participation in the conference, participants will have the ability to:

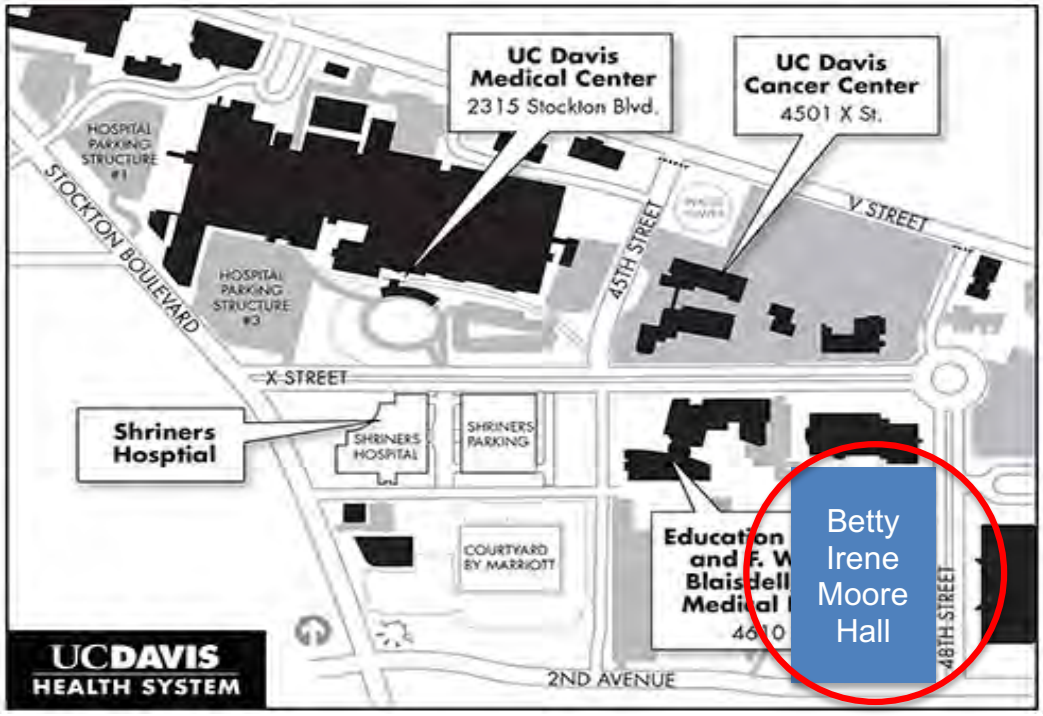
1. Explain the basic structure of the Patient-Derived Payment Model (PDPM).
2. Discuss the current and emerging Policy, Regulatory and Legislative issues facing post-acute and long-term care.
3. Identify strategies for monitoring and treating side effects of Parkinson's Disease drugs, and managing the psychological and cognitive manifestations of Parkinson's Disease.
4. Define best practices to improve resident centered care using current and anticipatory care models.
5. Cite advances in Telehealth.

Conference Location & Information

The conference will be held on the first floor of the Betty Irene Moore Hall.

Location:

UC Davis, Betty Irene Moore Hall, Room BIMH 1800
2570 48th Street, Sacramento, CA 95817
Parking: Reserved, pre-paid, parking available for registered attendees in LOT 17.



Continuing Education Information

Participants are required to sign in at the registration desk. The post event evaluations will be emailed to participants, evaluations MUST be completed to receive continuing education credit. The submission deadline is November 19, 2019. If you prefer a hardcopy of the evaluation and credit request, please visit the registration desk to request a copy or call (888) 332-3299.

Exhibits

Please take every opportunity to visit each exhibitor. Their contributions and participation at our conference is essential to our growth and sustainability.

Program Accreditation Statement

Continuing Medical Education (CME)
California Association of Long Term Care Medicine is accredited by the Institute for Medical Quality/California Medical Association (IMQ/CMA) to provide continuing medical education for physicians.

California Association of Long Term Care Medicine designates this Live activity for a maximum of **4.5 AMA PRA Category 1 Credit(s)™**. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This credit may also be applied to the CMA Certification in Continuing Medical Education.

This course complies with Assembly Bill 1195 Continuing Education: Cultural and Linguistic Competency.

American Board of Post-Acute and Long-Term Care Medicine (ABPLM)
This live activity has been pre-approved by the American Board of Post-Acute and Long-Term Care Medicine (ABPLM) for a total of **3.5 management hours and 1.0 clinical hour** toward certification as a Certified Medical Director (CMD) in post-acute and long-term care medicine. The CMD program is administered by the ABPLM. Each physician should claim only those hours of credit spent on the activity.

Board of Registered Nursing (BRN)
The California Association of Long Term Care Medicine (CALTCM) is a provider approved by the California Board of Registered Nursing (Provider #CEP-16690). This activity has been approved for up to **4.5 contact hours**.

Nursing Home Administrators Program (NHAP)
This activity has been approved by the Nursing Home Administrator Program for up to **5.0 hours of NHAP credit.** Course approval number: 1797005-7332/P

This course meets multiple requirements of the California Business and professions Codes 2190–2196.5 for physician CME, including cultural competency and geriatric credits.

Education Committee

Chair

Michelle Eslami, MD, FACP, CMD

Committee

- Patricia Bach, PsyD, RN
- Debra Bakerjian, PhD, APRN, FAAN, FAANP
- Diane Chau, MD
- Heather D'Adamo, MD
- Michelle Eslami, MD, CMD
- Rebecca Ferrini, MD, MPH, CMD
- Janice Hoffman, Pharm.D, PhD, CGP, FASCP
- Barbara Hulz
- Patricia Lau, MPA
- Vanessa Mandal, MD
- James Michail, MD
- Ron Ordona, DNP, FNP-BC
- Gabriela Sauder, MD
- Rajneet Sekhon, MD, CMD, HMDC
- Karl Steinberg, MD, CMD, HMDC
- Michael Wasserman, MD, CMD
- Deborah Wolff-Baker, MSN, FNP-BC

Program Faculty & Biographies

Debra Bakerjian PhD, FNP, FAAN, FAANP, FGSA
Senior Director for NP/PA Clinical Education and Practice; Associate Adjunct Professor, Betty Irene Moore School of Nursing, UC Davis, Sacramento, CA

Debra Bakerjian is associate clinical professor, at the Betty Irene Moore School of Nursing at UC Davis. She has over 25 years of nursing homes practice experience and has served as a consultant to many nursing homes, providing expert help in quality of care, quality improvement and patient safety. Dr. Bakerjian teaches geriatrics, quality improvement, and patient safety at UC Davis and mentors doctoral students, visiting scholars, masters leadership, nurse practitioner, and physician assistant students. Bakerjian earned a Doctor of Philosophy in Health Policy and Gerontology in 2006 and a Master in Science of Nursing in 1992, both from UC San Francisco School of Nursing. Her doctoral study, "Utilization of Nurse Practitioners in Nursing Homes: A Comparison with Physicians," received the 2006 Dissertation of the Year Award at UC San Francisco. Bakerjian earned a Family Nurse Practitioner and Physician Assistant certificate from the UC Davis School of Medicine in 1989. Bakerjian is active in both state and national organizations associated with the care of older adults. She is the Immediate Past-President of the California Association of Long Term Care Medicine and has been a member of CALTCM and AMDA since 2001, where she serves on the governance, transitions of care, and innovations committees. She was one of first nurses to serve on the steering committee for Advancing Excellence in American Nursing Homes' and is currently on the National Quality Forum's Common Formats standing committee. She is a member of the Health Sciences Executive Committee of the Gerontological Society of America. She is a past president of the Gerontological Advanced Practice Nurses Association and past chair of the GAPNA Foundation. Dr. Bakerjian is a Fellow of both the American Association of Nurse Practitioners, the American Academy in Nursing and the Gerontological Society of America.

Flora Y. Bessey, Pharm.D., BCGP
Consultant Pharmacist, Milpitas, CA

Flora Bessey received her Doctor of Pharmacy Degree from Midwestern University in 2000. In 2002 she attained certification as a geriatric pharmacist from the Commission for Certification of Geriatric Pharmacists. She currently works in the San Francisco Bay Area as a self-employed long-term care pharmacist consultant. Dr. Bessey is actively involved in the California Association of Long Term Care Medicine (CALTCM) and is executive editor of their e-newsletter, the CALTCM Wave.

Jason Close, BS, RRT
Product Manager, Dignity Health Telemedicine Network, Sacramento, CA

Jason is the Director for the Dignity Health Telemedicine Network. He is responsible for the leadership, strategy and business development, day-to-day operations, and program implementations of the DHTN telehealth services. In 6 years, Jason helped to advance the DHTN from 15 Partner Sites to more than 40 Partner Sites. The DHTN provides Telehealth services in the acute, non-acute, and home settings, and approximately 40,000 consults annually.

Jason has undergraduate degrees in Psychology and Respiratory Therapy. He is currently licensed as a Respiratory Care Practitioner in California. Before his current position, he served as the Clinical Specialist and Interim Manager of the Cardiopulmonary Department at Mercy San Juan Medical Center in Carmichael, California. A father of three, Jason spends most his free time with his family. And if the opportunity arises, he enjoys motorcycling through California's gold country and coastal mountain ranges.

Michelle Eslami, MD, FACP, CMD
Chief Medical Officer, Rockport Healthcare Services; Professor of Medicine; Associate Chief of Post-Acute and Long-Term Care Services, Division of Geriatrics, David Geffen School of Medicine at UCLA, Los Angeles, CA

Michelle Eslami, MD, FACP, CMD, is chief medical officer (CMO) of Rockport Healthcare Services. Eslami joined Rockport Healthcare Services in July 2018 after 23 years at UCLA, where she was a Clinical Professor of Medicine and Associate Chief of post-acute and long-term care services in the Division of Geriatrics.

Rockport Healthcare Services is one of California's largest nursing home administrative services companies serving almost 10,000 residents and patients across 70 skilled nursing facilities (SNFs). As CMO, Eslami is responsible for the quality of medical care provided at the SNFs, which includes ongoing collaboration with the medical directors of each facility to ensure they are each delivering person-centered care. Her current projects include improving on best practices related to resident admissions and readmissions, emergency department usage and residents' safe discharge back home into their communities.

During her career as a UCLA faculty member, she was recognized with numerous teaching and mentorship awards. The American Geriatrics Society, of which Eslami is a long-standing member, named her Geriatrician of the Year in 2009. She continues to be passionate about providing holistic care to older adults and treating each patient with dignity.

David Farrell, MSW, LNHA
Senior Director, The Green House Project, Berkeley, CA

David Farrell, M.S.W., L.N.H.A., is a licensed nursing home administrator who has spent his entire career in the long-term care profession. He started as a certified nursing assistant in order to earn extra money while attending college. That experience inspired him to pursue a master's degree in Social Work with a concentration in Gerontology and Administration from Boston College. In the 30 years he served as a nursing home administrator and regional director of operations, David consistently implemented patient-centered care using quality improvement practices. He is a published author of numerous articles and the co-author of two books on healthcare leadership which have received widespread acclaim. Currently, David is the Vice President for Subacute Services for Telecare Corporation.

Robert Gibson, PhD, JD
Senior Clinical Psychologist; Edgemoor DPSNF, Santee, CA

Robert Gibson, Ph.D., J.D., is the psychologist at Edgemoor DP SNF, a 192 bed skilled nursing facility run by the County of San Diego. He is also licensed as an attorney. In addition to provision of psychological services and evaluations, Dr. Gibson has focused on a range of subjects including surrogate decision-making, assessment of decision-making capacity, the interplay between resident rights and the facility's duty of care, younger adults, and the management of criminals in long-term care.

Ashkan Javaheri, MD, CMD
Geriatrician, Mercy Medical Group – Dignity Health Medical Foundation; Head of the Geriatric Division, Assistant Clinical Professor, UC Davis School of Medicine, Sacramento, CA.

Dr. Javaheri is a geriatrician with Mercy Medical Group- Dignity Health Medical Foundation in Sacramento, CA. He is the head of the geriatric division and assistant clinical professor at UC Davis School of Medicine. His work is primarily at skilled nursing facilities, memory care clinic, supervising house call providers, and tele medicine.

Jay Luxenberg, MD
Chief Medical Officer, On Lok; Program Faculty Geriatric Care and Outcomes, Clinical Professor, Department of Medicine, UCSF, San Francisco, CA

Dr. Jay Luxenberg is an internist and geriatrician who has practiced in San Francisco since completing training in 1987. He has served as Chief Medical Officer at On Lok since 2011. On Lok is the original PACE program – Program for All-Inclusive Care for the Elderly. It offers comprehensive health care for more than 1450 frail elderly persons in San Francisco, Fremont and San Jose, California, all of whom are eligible to live in a nursing home. Until June 2011 he served as Chief Medical Officer at the Jewish Home, San Francisco, a 430-bed skilled nursing facility with an acute geropsychiatric hospital unit. He is Clinical Professor, School of Medicine, University of California, San Francisco. He teaches at U.C.S.F., U.C. Berkeley and Stanford. He had a private practice of geriatric medicine from 1987-1996.

After completing a fellowship in geriatric medicine, he spent 1984-87 as a Medical Staff Fellow in the Section on Brain Aging and Dementia, Laboratory of Neurosciences, at the National Institute on Aging, National Institutes of Health in Bethesda, MD. He served on the Board of Directors, including a term as Treasurer, of the International Psychogeriatrics Association. He served on the Board of Directors of On Lok prior to employment there. He is currently President of the Board of Directors of Mount Zion Health Fund. He has published many research papers, reviews and book chapters. His most recent book is "Residential Care - Your Role in the Health Care Team". He has published four Cochrane Database Systemic Reviews (Haloperidol for agitation in dementia, Valproate preparations for agitation in dementia, Antipsychotics for delirium, and Benzodiazepines for delirium). He is editor of the California Association of Long Term Care Medicine newsletter "The Wave". He serves on the Editorial Board of the Journal of the American Medical Directors Association (JAMDA). He is a Fellow of the American Geriatrics Society and the American College of Physicians.

Vanessa J. Mandal, MD, MS, CMD
Post-Acute Care and Geriatric Consultation, Mercy Medical Group; Assistant Professor, Internal Medicine Program, UC Davis School of Medicine

Graduate Hahnemann University School of Medicine, Philadelphia Pennsylvania. Elected Internal Medicine Residency and Geriatric Fellowship – Montefiore Medical Center, a Pioneer ACO in the Bronx. Focus on addressing the psychosocial determinants of health through house call visits. She has had a 17-year career as an Internist and Geriatrician spans academic practice in NY, ambulatory practice Texas, and full time practice in post-acute setting in California. Dr. Mandal completed her Masters in Healthcare Administration and Inter-professional Leadership at UCSF in 2016 and continues in leadership roles in Greater Sacramento:

- Medical Director, HCR Manor Care- initiated QAPI on reducing inappropriate benzodiazepine and high risk medication use. Facility had ZERO medication deficiency in 2017 survey.
- Recipient of California Association of Health Services at Home (CAHSAH), Physician of the Year Award in 2015 for work as Medical Director of Eskaton Home Health Services.
- Dignity Health Physician Leadership Program, Health Services Advisory Group (HSAG) – improving care coordination between Dignity Health Hospitals in Greater Sacramento and post-acute facilities. Spearhead palliative care efforts in skilled nursing facility.
- Education Committee CALTCM

Karl E. Steinberg, MD, CMD, HMDC
Chief Medical Officer, Mariner Health Care; Emeritus Editor, Caring for the Ages; Chair, President-Elect and Public Policy Committee, AMDA; President & CEO, Stone Mountain Medical Associates, Inc.

Dr. Karl Steinberg is an experienced clinician with over 20 years in practice in San Diego County. He is a geriatrician and board-certified family physician with a subspecialty certification in hospice and palliative medicine. Dr. Steinberg got his undergraduate degree in biochemistry and molecular biology from Harvard in 1980, then taught high school in New York City for three years. He attended medical school at The Ohio State University, graduating in 1987, then completed his family medicine residency at UCSD (San Diego) in 1990. Dr. Steinberg is the Emeritus Editor-in-Chief of *Caring for the Ages*, serves on AMDA's board of directors and is incoming chair of AMDA's Public Policy Committee, and chair of the Coalition for Compassionate Care of California. Dr. Steinberg has been a hospice and nursing home medical director since 1995 and is probably best known for taking his dogs on rounds with him on most days.

Indira Subramanian, MD
Director, SouthWest PADRECC VA Parkinson Disease Center of Excellence; Health Sciences Full Clinical Professor, Department of Neurology, UCLA

Dr. Indu Subramanian received her medical degree in 1996 from the University of Toronto, Canada. She interned for a year in San Diego Mercy Hospital before joining the UCLA Neurology Residency Program. Dr. Subramanian received her Movement Disorder Fellowship training at UCLA. Upon completing her two-year fellowship training, Dr. Subramanian has stayed on and is now a Clinical Professor at UCLA in the Dept of Neurology. She established the movement disorder clinic at the West Los Angeles Veterans Administration and has assumed the position of the Director of the South West PADRECC (Parkinson Disease Research, Education and Clinical Care). She has developed an interest in complementary and alternative medicine with a special interest in Yoga and Mindfulness. She underwent a 200 hour yoga teacher training in 2015 with Annie Carpenter and is currently studying to be a mindfulness instructor to teach MBSR under the direction of J.G.Serpa. She is designing a yoga teacher training program for yoga instructors who are interested in working with PD patients. She is also boarded in Integrative Medicine.

Kerry Weiner, MD, MPH
Chief Clinical Officer, Care ConnectMD

Dr. Weiner has over 20 years' experience as a physician leader and executive at the national level specializing in developing and managing physician multispecialty medical groups. He has particular expertise in care redesign to meet value-based reimbursement strategies. Kerry is currently working with CareconnectMD, a large PAC medical group in California, creating a special needs ACO devoted to long term care special needs patients. He served as CMO of IPC Healthcare from 2011 - 2017, where he led the clinical functions of a national medical group with over 1300 acute hospitalists, 800 post- acute and 200 behavior health providers. He was a leading advocate for participation in the CMS BPCI pilot, an APM based on episodic payments. (IPC was acquired by TEAMhealth in 2015). Previously, Dr. Weiner served as CMO and Sr. VP of Lakeside Community Health Care for 26 years where he was also cofounder. He grew the organization to a 140 provider medical group with PCP, hospitalists and 14 sub-specialties. The group cared for FFS patients and managed care patients. In addition, Dr. Weiner was responsible for the care in Lakeside IPA with 2200 providers. The combined company managed risk contracts for 250,000 patients.

Dr. Weiner received his medical degree, master's in public health and bachelor's degree from the University of California, Los Angeles. Dr. Weiner is an active member of the SHM (Society for Hospitalist Medicine) Public Policy Committee and the AMDA Post-Acute and Long Term Care Society Public Policy Committee.

Faculty and Planner Disclosures

It is the policy of California Association of Long Term Care Medicine (CALTCM) to ensure balance, independence, objectivity, and scientific rigor in all of its sponsored educational programs. All faculty participating in any activities which are designated for *AMA PRA Category 1 Credit(s)™* are expected to disclose to the audience **any** real or apparent conflict(s) of interest that may have a direct bearing on the subject matter of the CME activity. This pertains to relationships with pharmaceutical companies, biomedical device manufacturers, or other corporations whose products or services are related to the subject matter of the presentation topic. The intent of this policy is not to prevent a speaker with a potential conflict of interest from making a presentation. It is merely intended that any potential conflict should be identified openly so that the listeners may form their own judgments about the presentation with the full disclosure of the facts. It remains for the audience to determine whether the speakers' outside interests may reflect a possible bias in either the exposition or the conclusions presented.

The following faculty and planners have indicated any affiliation with organizations which have interests related to the content of this conference. This is pointed out to you so that you may form your own judgments about the presentations with full disclosure of the facts. All conflicts of interest have been resolved in accordance with the ACCME's Standards for Commercial Support.

Faculty and Planners	Role	Affiliation / Financial Interest	Name of Organization
Patricia Bach, PsyD, RN	Faculty/ Planner	None	
Deb Bakerjian, PhD, APRN, FAAN, FAANP	Faculty/ Planner	None	
Flora Bessey, PharmD, BCGP	Faculty/ Planner	Speaker Honoraria Spouse is employed by Eli Lilly	Acadia Pharmaceutical Eli Lilly
Diane Chau, MD	Planner	None	
Jason Close, BS, RRT	Faculty	None	
Heather D'Adamo, MD	Planner	None	
Michelle Eslami, MD, CMD, FACP	Faculty / Planner	None	
David Farrell, MSW, LNHA	Faculty	None	
Rebecca Ferrini, MD, MPH, CMD	Faculty/ Planner	None	

Robert Gibson, PhD, J.D.	Faculty	None	
Janice Hoffman, PharmD, EdD, APh, BCGP, FASCP	Faculty/ Planner	None	
Hulz, Barbara	Planner	None	
Ashkan Javaheri, MD	Faculty/ Planner	None	
Mary Kasem, MD	Planner	None	
Patricia Lau, MPA	Planner	None	
Magda Lenartowicz, MD	Planner	None	
Ro Linscheid, NHA	Planner	None	
Jay Luxenberg, MD	Faculty	None	
Vanessa Mandal, MD, MS, CMD	Faculty/ Planner	None	
James Michail, MD	Planner	None	
Ron Ordona, DNP, FNP-BC	Planner	None	
Gabriela Sauder, MD	Planner	None	
Rajneet Sekhon, MD, CMD, HMDC	Planner	None	
Karl Steinberg, MD, CMD, HMDC	Faculty/ Planner	None	
Indira Subramanian, MD	Faculty	Consulting Fee, Consultant	Acadia
Michael Wasserman, MD, CMD	Planner	Editorial Board, Honoraria	Merck Manual
Kerry Weiner, MD, MPH	Faculty	None	
Deborah Wolff-Baker	Planner	None	

Special Acknowledgements

CALTCM would like to extend our gratitude to:

Accommodations

UC Davis Betty Irene Moore Hall

2019 Fall Summit Donor

SCAN Health Plan and Independence at Home, a SCAN Community Service

2019 Fall Summit Exhibitors

Acadia Pharmaceuticals

Advanced Home Health and Hospice

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Program Agenda

7:45 AM	**Registration & Exhibits Open**
8:30 AM	**Welcome & Introductions**
8:35 AM	**PDPM Regulatory Update**; Kerry Weiner, MD, MPH
9:15 AM	**PDPM: Panel Discussion; Panel:** Kerry Weiner, MD, MPH, Michelle Eslami, MD, FACP, CMD, and Debra Bakerjian, Ph.D., APRN, FAAN, FAANP
9:35 AM	**Public Policy Update;** Karl Steinberg, MD, CMD, HMDC
10:05 AM	**Break**
10:20 AM	**Managing Parkinson's in the SNF;** Indira Subramanian, MD
10:50 AM	**Telehealth;** Jason Close, BS, RRT
11:20 AM	**Trauma Informed Care;** Robert Gibson, PhD, JD
11:50 AM	**Break**
12:05 PM	**Overview: "In the Trenches" Session**
12:10 PM	**"In the Trenches" Breakout Session: Round 1** • **The Joy of Medicine: Avoiding Burnout**; Ashkan Javaheri, MD, CMD • **Medical Apps and Technology**; Jay Luxenberg, MD • **POLST and Palliative Care**; Karl Steinberg, MD, CMD, HMDC • **How to be Competitive with Medicare Advantage**; Vanessa Mandal, MD, MS, CMD • **Avoiding Medical Related Citations**; Flora Y. Bessey, Pharm.D., BCGP • **Antibiotic Stewardship**; Michelle Eslami, MD, FACP, CMD • **Staff Retention**; David Farrell, MSW, LNHA
12:40 PM	**"In the Trenches" Breakout Session: Round 2** • **The Joy of Medicine: Avoiding Burnout**; Ashkan Javaheri, MD, CMD • **Medical Apps and Technology**; Jay Luxenberg, MD • **POLST and Palliative Care**; Karl Steinberg, MD, CMD, HMDC • **How to be Competitive with Medicare Advantage**; Vanessa Mandal, MD, MS, CMD • **Avoiding Medical Related Citations**; Flora Y. Bessey, Pharm.D., BCGP • **Antibiotic Stewardship**; Michelle Eslami, MD, FACP, CMD • **Staff Retention**; David Farrell, MSW, LNHA
1:10 PM	**Closing Pearls**
1:30 PM	**Adjourn**

PDPM Regulatory Update
A Revolution in PALTC

Kerry Weiner, MD

2019

Disclosure Statement

Dr. Kerry Weiner, MD has no relevant financial relationships with commercial interests to disclose.

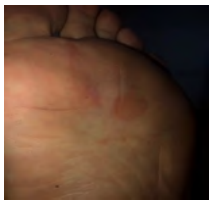
2019

Learning Objectives

- Identify strategies for developing a practice to meet current and future payment structure demands.
- Discuss the impact of healthcare reform initiatives on PALTC practitioners - exclusion from APMs.
- Explain the basic structure of the Patient-Derived Payment Model.

2019

Dr. Wasserman in Rehab



2019

Patient-Driven Payment Model (PDPM)

2019

Care Follows Finance: Therapy Services Drove SNF Spending Growth

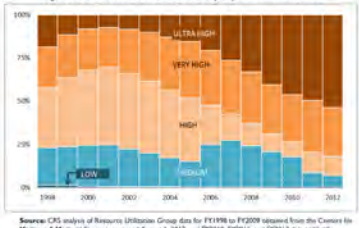
Counting the Minutes

Medicare pays nursing homes daily rates for stays based in part on how much therapy they provide. Average 2013 Medicare rate per day:

- **Ultra high** 720+ minutes per week: $559
- **Very high** 500-719: $445
- **High** 325-499: $383
- **Medium** 150-324: $341
- **Low** 45-149: $325
- **Non therapy**: $337

Source: WSJ analysis of Medicare claims data
THE WALL STREET JOURNAL.

Figure 5. Distribution of Covered SNF Days, by Rehabilitation RUG



Source: CRS analysis of Resource Utilization Group data for FY1998 to FY2009 released from the Centers for Medicare & Medicaid Services, prepared August 1, 2012, and FY2010, FY2011, and FY2012 data publically available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Spotlight.html

Game Changing Differences

- RUG IV
  - 80% dependent on Level/ hours of therapy
  - 10% dependent on ADLs
  - 10% dependent on geographic location
  - Total MDS items: 20
- PDPM:
  - Driven by primary clinical diagnosis + co-morbidities based on ICD-10 codes
  - Modified by cognitive, functional status assessments
  - Modified by LOS
  - Total MDS items: 161

2019

Drivers of Patient Outcomes? Chicken vs. Egg

- Minutes of therapy?
- Nursing needs?
- Actuarial weighting?
- Coding & documenting?
- SNF Infrastructure?
- Physician Burnout?

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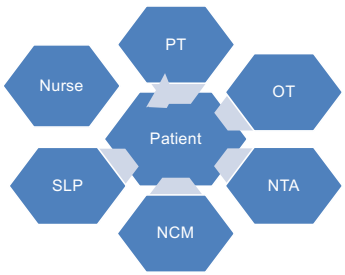
PDPM Care Compensation Factors



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Clinician's Impact in PDPM

- Payment linked to patient condition(s) on admission
- New category, NTA (non-therapy ancillary), depends on patient co-morbidities and therapy
- Modify payment during stay if acuity changes significantly
  - Reimbursement decreases over time unless there are material changes in condition.

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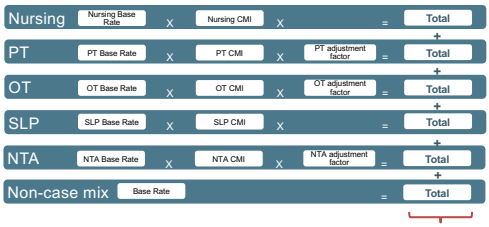
PDPM Payment



2019

Variable Per Diem Adjustment Factor:

- OT, PT: Fixed Rate that decreases weekly after 20 days
  - 1-20 days = 1.0 x $
  - 21-27 days = 0.98 x $ and drops by .02 every week thereafter (91 days = 0.78)
- NTA : New category, heavily front loaded
  - 1-3 days = 3.0 x $
  - 4-100 days = 1.0 x $
- IPA (Interim Payment Assessment): For significant change in condition
  - Cover additional costs for "treating in place"

2019

Admission Note Documentation is Essential

- Establish Primary Admitting Diagnosis
  - May be different than inpatient diagnosis.
- Note surgery during proceeding inpatient stay
- Use specific codes (not general codes)
- Codes must justify SNF care
- Provider documentation must match NH coding
- Complete within first 5 days

2019

PDPM Primary Diagnosis Clinical Categories based on Physician Documented ICD-10 codes

Surgical Categories

- MJR or Spinal
- Other Ortho Surgical
- Non- Ortho Surgical
- Non- Surgical Ortho

Medical Categories

- Medical Management
- Acute Infections
- Cancer
- Pulmonary
- CV and Coagulations
- Acute Neurologic

2019

NTA: Non Therapy Ancillary Cost Calculation

- Primary diagnosis drives base $
- + Weighted Co-morbidities & Extensive services (50 items)
- Payment front loaded: First 3 days = 3x $

2019

Non-Therapy Ancillary Conditions/Services

Condition/Extensive Service	Points
HIV/AIDS	8
Parenteral IV Feeding: Level High	7
Special Treatments/Programs: Intravenous Medication Post-admit Code	5
Special Treatments/Programs: Ventilator Post-admit Code	4
Parenteral IV feeding: Level Low	3
Lung Transplant Status	3
Special Treatments/Programs: Transfusion Post-admit Code	2
Major Organ Transplant Status, Except Lung	2
Active Diagnoses: Multiple Sclerosis Code	2
Opportunistic Infections	2
Active Diagnoses: Asthma COPD Chronic Lung Disease Code	2
Bone/Joint/Muscle Infections/Necrosis - Except: Aseptic Necrosis of Bone	2
Chronic Myeloid Leukemia	2
Wound Infection Code	2
Active Diagnoses: Diabetes Mellitus (DM) Code	2
Endocarditis	1
Immune Disorders	1
End-Stage Liver Disease	1
Other Foot Skin Problems: Diabetic Foot Ulcer Code	1
Narcolepsy and Cataplexy	1
Cystic Fibrosis	1
Special Treatments/Programs: Tracheostomy Post-admit Code	1
Active Diagnoses: Multi-Drug Resistant Organism (MDRO) Code	1
Special Treatments/Programs: Isolation Post-admit Code	1
Specified Hereditary Metabolic/Immune Disorders	1

Non-Therapy Ancillary Conditions/Services

Condition/Extensive Service	Points
Morbid Obesity	1
Special Treatments/Programs: Radiation Post-admit Code	1
Highest Stage of Unhealed Pressure Ulcer - Stage 4	1
Psoriatic Arthropathy and Systemic Sclerosis	1
Chronic Pancreatitis	1
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	1
Other Foot Skin Problems: Foot Infection Code, Other Open Lesion on Foot Code, Except Diabetic Foot Ulcer Code	1
Complications of Specified Implanted Device or Graft	1
Bladder and Bowel Appliances: Intermittent catheterization	1
Inflammatory Bowel Disease	1
Aseptic Necrosis of Bone	1
Special Treatments/Programs: Suctioning Post-admit Code	1
Cardio-Respiratory Failure and Shock	1
Myelodysplastic Syndromes and Myelofibrosis	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	1
Diabetic Retinopathy - Except : Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	1
Nutritional Approaches While a Resident: Feeding Tube	1
Severe Skin Burn or Condition	1
Intractable Epilepsy	1
Active Diagnoses: Malnutrition Code	1
Disorders of Immunity - Except : RxCC97: Immune Disorders	1
Cirrhosis of Liver	1
Bladder and Bowel Appliances: Ostomy	1
Respiratory Arrest	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	1

SLP: Clinical Category+ …

SLP Payment Factors

- Primary Diagnosis
- Acute Neurologic Condition
- SLP Co-morbidities
- Cognitive impairment
- Swallowing disorder
- Mechanically Altered Diet

SLP Co-morbidities

- CVA, TIA
- Aphasia
- Hemiplegia/ Hemiparesis
- Traumatic Brain Injury
- ALS
- Oral Ca
- Laryngeal CA
- Apraxia
- Dysphagia
- Speech & language Deficits
- Tracheostomy care
- Ventilator

2019

Swallowing Dysfunction and Mechanically Altered Diet

- Swallowing dysfunction matters
- Appropriate therapy?

2019

PT & OT Clinical Categories

PT & OT components use four collapsed clinical categories

PDPM Clinical Categories	PT & OT Clinical Categories
Major Joint Replacement or Spinal Surgery	Major Joint Replacement or Spinal Surgery
Acute Neurologic	Non-Orthopedic Surgery & Acute Neurologic
Non-Orthopedic Surgery	
Non-Surgical Orthopedic/Musculoskeletal	Other Orthopedic
Orthopedic - Surgical Extremities Not Major Joint	
Medical Management	Medical Management
Cancer	
Pulmonary	
Cardiovascular & Coagulations	
Acute Infections	

2019

PT & OT Functional Score: GG Items

Section GG items included in the PT & OT Functional Score:

Section GG Item	Functional Score Range
GG0130A1 – Self-care: Eating	0 – 4
GG0130B1 – Self-care: Oral Hygiene	0 – 4
GG0130C1 – Self-care: Toileting Hygiene	0 – 4
GG0170B1 – Mobility: Sit to Lying	0 – 4 (average of 2 items)
GG0170C1 – Mobility: Lying to Sitting on side of bed	
GG0170D1 – Mobility: Sit to Stand	0 – 4 (average of 3 items)
GG0170E1 – Mobility: Chair/bed-to-chair transfer	
GG0170F1 – Mobility: Toilet Transfer	
GG0170J1 – Mobility: Walk 50 feet with 2 turns	0 – 4 (average of 2 items)
GG0170K1 – Mobility: Walk 150 feet	

2019

Important Nursing Component Changes

- RUG – IV: Therapy / Non-therapy
  - Therapy RUGS weighted 90%: $ based on quantity
  - Non-therapy RUGS: Only 1 weighted RUG

2019

PDPM Nursing Component Modifications

- Uses RUG-IV nursing classification with significant weighting variation:
  - Function score based on Section GG of the MDS 3.0
  - Collapsed functional groups, *decreases* nursing groups from 43 to 25

2019

Case Presentation

81 yo F with COPD admitted to Hospital for SOB and fever. HPI: 10 days at home with cold symptoms, sputum production and fever, weakness, poor appetite, SOB.
PMH: COPD, HTN, Diverticulosis, Mild Dementia

Hospital course: Found to be in respiratory distress, BP 90/60, acidotic and admitted to ICU. Placed on BICAP and treated with IV antibiotics. Improved over 7 days. DC to SNF because of generalized weakness.

Med list: includes Albuterol, Atrovent inhaler and steroid taper, Metformin, Metamucil, Rouvastatin, Benazepril, Bactrim

PE: vitals stable, Oriented x 2, wt. 240, Ht. 5'4"
Lungs: Few wheezes
Hrt: RRR
Ext: Lft ankle ulcer 3cm, tender, red, with mild exudate
Culture: MRSA recovered
Pre –Albumin 9

2019

Primary Diagnosis COPD: Pulmonary - Medical Management
NTA Co-morbidities: Less Obvious Opportunities

1Pt. Cardio-respiratory shock
1Pt. Morbid Obesity
2 pt. Active DM
1 Pt. Multi-drug resistant organism
1 Pt. Diabetic foot ulcer
2 Pt. Wound infection
1 Pt. Malnutrition

9 Pt. Total; increased NTA CMI 0.72 to 2.53 ($77.30/d vs. $199.80/d) = diff. of $1715.00 for 14 day stay; about $250.00 more than PPS

2019

Patient Example : 79 Year Old Man with Femur Fracture

Patient is a 79 year old male with acute diagnosis of **femoral fracture**. He is also recovering from pneumonia. The patient has no cognitive impairment but is **depressed**. The patient needs considerable assistance with activities of daily living.

Category and CMI placement

The primary diagnosis of femur fracture qualifies for placement into "Other Orthopedic category" in SNF. The pts. categories and resultant CMI's adjustments for each of the case-mix adjusted components:

Component	Case-mix group (CMG)	Case-mix index (CMI)
Nursing	CBC2	1.54
PT	TG	1.67
OT	TG	1.64
ST	SD	0.68
NTA	NF	0.72

2019

Daily payment for each component in a 30 day stay

Component	Case-mix group	Case-mix index	Base Rate	Per diem
Nursing	CBC2	1.54	$103.46	$159.33
PT	TG	1.67	$ 59.33	$ 99.08
OT	TG	1.64	$ 55.23	$ 90.58
ST	SA	0.68	$ 22.15	$ 15.06
NTA	NF	0.72	$ 78.05	$56.20
Non case-mix			$ 92.63	$ 92.63
PDPM Base per diem				$512.87
PPS Per Diem – RUG				$631.22

	# of Days	PDPM Per Diem	PDPM Total	PPS Per Diem	PPS Total
Days 1-3	3	$ 625.27	$1,875.80	$631.22	$1,893.66
Days 4-20	17	$ 512.87	$8,718.87	$631.22	$10,730.74
Days 21-27	7	$ 510.89	$3,576.25	$631.22	$4,418.54
Days 28-30	3	$ 507.01	$1,521.03	$631.22	$1,893.66
Total	30	$ 523.06	$15,691.95	$631.22	$18,936.60

2019

Jury is Out on PDPM Therapy Adjustments

- Relationship between functional status and payment is not linear
- Moderate functional decline a/w higher reimbursement
- Focus on most appropriate care?

2019

Impact of PDPM

- Proper ICD-10 coding required
- Proper evaluation and MDS coding required
  - Translation: Providers will be “quarried”
- Case mix of SNF patients will change
- SNF infrastructure needs to change
- The Geriatrics approach to care is NECESSARY!

2019

Important concepts and Diagnoses
APP: Broad River Rehab PDPM Navigator

- ICD 10 coding
  - Major factor in base rate calculation
  - Identify primary dx + co-morbidities
  - Co- morbidities in NTA; SLP
- LOS: first three days
  - 5 day rule
  - NTA 1-3
  - + 20 days
- Diagnoses not to miss

Major changes of condition (Dx and co-morbidities)
Acute neuro conditions
Preceding surgeries in ACH

- Diagnoses not to miss (continued)

HIV / AIDS
Diabetes and complications
COPD/asthma/ fibrosis
Infections: Ortho, resistant organ, opportunistic
Immune def/ connective tissue disorders/IBD
Morbid obesity / malnutrition
Psoriatic arthritis
CML/ myloplastic disease
ESLD/ cirrhosis
Chronic pancreatitis

2019

Public Policy Update:

PALTC, Regulatory and Judicial Update

Karl Steinberg, MD, CMD, HMDC

2019

Disclosure Statement

Karl Steinberg, MD, CMD, HMDC has no relevant financial relationships with commercial interests to disclose.

2019

Learning Objectives

By the end of the session, participants will be able to:

- Explain the national healthcare political landscape and its impact on PALTC
- Recognize the impact of value-based medicine on PALTC clinicians
- Differentiate the PDPM Model from the RUGs system
- Utilize knowledge of California-specific regulatory and judicial developments to improve policies and care

2019

Legislative Priorities

Democratic House/Republican Senate

- **Drug Pricing**
- **Surprise Billing**
- **Nursing Home Quality**

2019

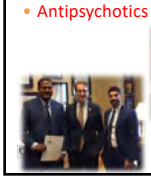
Regulatory Priorities

- Admin Burden Reduction
- Drug Pricing
- Evaluation and Management Coding
- My HealthEData Initiative
- Interoperability

2019

Society on Capitol Hill

- Geriatric Workforce Enhancement Program (GWEP)
- Telehealth
- Medical Director Directory
- Antipsychotics



MACRA Quality Payment Program

2019

41

Quality Payment Program

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program:

2019

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MIPS Year 3 (2019) Final

Performance Category Weights

Year 2 (2018) Final

Performance Category	Performance Category Weight
Quality	50%
Cost	10%
Improvement Activities	15%
Promoting Interoperability	25%

Year 3 (2019) Final

Performance Category	Performance Category Weight
Quality	45%
Cost	15%
Improvement Activities	15%
Promoting Interoperability	25%

2019

43

MIPS Year 3 (2019) Final

Performance Threshold and Payment Adjustments

Year 2 (2018) Final

Final Score 2018	Payment Adjustment 2020
≥70 points	• Positive adjustment greater than 0% • Eligible for additional payment for exceptional performance — minimum of additional 0.5%
15.01-69.99 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
15 points	• Neutral payment adjustment
3.76-14.99	• Negative payment adjustment greater than -5% and less than 0%
0-3.75 points	• Negative payment adjustment of -5%

Year 3 (2019) Final

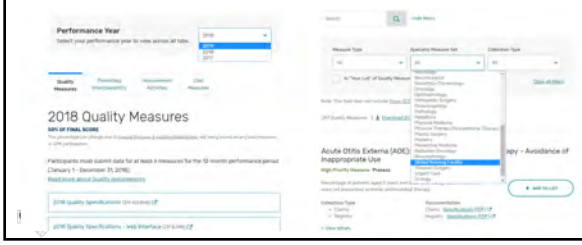
Final Score 2019	Payment Adjustment 2021
≥75 points	• Positive adjustment greater than 0% • Eligible for additional payment for exceptional performance — minimum of additional 0.5%
30.01-74.99 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
30 points	• Neutral payment adjustment
7.51-29.99	• Negative payment adjustment greater than -7% and less than 0%
0-7.5 points	• Negative payment adjustment of -7%

2019

Specialty Measure Sets

Clinicians and groups can choose to submit a specialty or subspecialty measure set. In doing so, they must submit data on at least 6 measures within that set. If the set contains fewer than 6 measures, the clinician or group should submit each measure in the set.

New For 2019 – SNF Specialty Set Identified



19

45

Advanced APMs

Clinicians and practices can:

- Receive **greater rewards** for taking on some risk related to patient outcomes.

"So what?" - It is important to understand that the Quality Payment Program does not change the design of any particular APM. Instead, it creates **extra incentives** for a sufficient degree of participation in Advanced APMs.

2019

APMs

- New models: Primary Care First/Direct Contracting Announced
  - Details forthcoming
  - Not for PALTC institutional setting
- No dedicated model for PALTC practitioners
- Society working with AAHPM on end-of-life MACRA funded quality measures
- AMDA meeting with CMMI to discuss PALTC focused AAPMs

2019

QPP: What to Expect in 2019

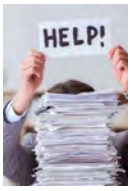
- Majority still in MIPS
- Must "meaningfully" participate to avoid penalty
- SNF-specific list of measures available
- Post-acute facility-based option in the works but not available yet
- Check with your practice where you stand
- Society webinar with CMS staff

2019

Evaluation and Management Coding

2019

CMS Rework of Evaluation and Management Coding



- 2019 Physician Fee Schedule proposed rule proposed significant changes to **Office-Based** E&M Coding Documentation and Billing Requirements
- 2019 Physician Fee Schedule Proposed Rule Implements Changes taking effect in 2021
- Changes to CCM/TCM Coding
- New codes for single condition
- Remote patient monitoring codes
- **No current proposals for institutional primary care codes including SNF E&M but possible in the future**

2019

Antipsychotics

2019

Antipsychotics

- Continued focus on Improving Dementia Care in Nursing Homes
- Troubling reports of false schizophrenia diagnosis to improve 5-Star Ratings
- Society developed a workgroup to address concerns
- Support for changes to PRN in CMS Proposed Rule (awaiting final rule)
- AMA Resolution from AAGP: "RESOLVED, That our AMA ask Centers for Medicare and Medicaid Services (CMS) to discontinue the use of antipsychotic medication as a factor contributing to the Nursing Home Compare rankings, unless the data utilized is limited to medically inappropriate administration of these medications."
- Meetings with House Ways and Means Committee


Congressional leader fears false diagnosing; wants more scrutiny of nursing homes' antipsychotic use

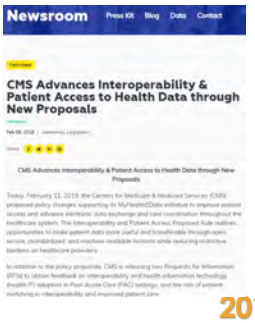
2019

Health IT

2019

CMS/ONC Rule on Data Sharing

- Published Feb 11, 2019
- Implements 21st Century Cures Legislation
- Data exchange as Hospital CoP
- Rules on data blocking
- Two Requests for Information (RFIs) to obtain feedback on interoperability and health information technology adoption in PAC


Newsroom Press Kit Blog Data Contact

CMS Advances Interoperability & Patient Access to Health Data through New Proposals

2019

Telehealth

2019

Telehealth

- Legislative effort to provide reimbursement for telehealth services in PALTC
- Remove once a month restriction on using SNF subsequent care codes via telehealth
  - Passed BoD resolution
  - Adopted by AMA House of Delegates
- Use of newly established G codes for telehealth – viable in SNF?

2019

New Society Resources

2019

Requirements of Participation

2019

Phase 3 RoPs, effective 11/28/19

1. Quality Assurance and Performance Improvement

- Develop, implement, and maintain effective comprehensive, data-driven QAPI program that focuses on systems of care, outcomes of care and quality of life.
- Mandatory training within QAPI on infection prevention and control program (IPCP), educating staff on written standards, policies, and procedures for each program.

2. Person-Centered Care Planning, Baseline Care Plan

- Develop baseline care plan within 48 hours of admission
- IDT: Include CNA, dietary, social worker. AND Resident/resident rep.
- DC planning, follow-up care documentation

2019

Phase 3 RoPs, effective 11/28/19

3. Trauma-Informed Care

- Appropriate staffing, competencies, necessary behavioral health care services/resources
- Based on facility assessment

4. Infection Control

- Formal IPCP, including Infection Preventionist, who must be on QA&A Committee

5. Compliance & Ethics Program

- Facility must have established written compliance and ethics standards to reduce violations, abuse, neglect.

6. Physical Environment

- No more than 2 residents to a room (new rooms), call light at bedside, bathrooms with sink, shower and toilet, smoking policies

2019

Phase 3 RoPs, effective 11/28/19

7. **Training Requirements**
   - Communication, abuse/neglect/exploitation, resident rights, QAPI, Compliance & Ethics, ICPC, CNAs get 12 hours on dementia annually
   - Behavioral health, and specific target areas based on facility assessment
8. **Dietary**
   - Required certification/education levels, competencies
   - Accommodation of preferred mealtimes, …and much more

2019

CMS Proposed Rule Delaying Ph.3

(7/15/19)

CMS proposes to delay the implementation of certain phase 3 QAPI and compliance and ethics related requirements that are directly impacted by the proposed changes in the regulation to one year following the effective date of this proposed rule, if finalized, to avoid confusion and promote transparency

- **Resident Rights:** CMS propose to revise this provision to remove the language indicating that facilities must ensure that residents remain informed and would instead specify that residents be informed of only their primary care physician's information at admission, with any change of such information, and upon the resident's request.
- **Facility Assessments**: Reduce the frequency that LTC facilities are required to conduct a facility assessment to every two years.
- **Ethics & Compliance:** Proposed revisions include removing the requirements for a compliance officer and compliance liaison as well as revising the requirements for reviewing the program from annually to biennially.
- **Food & Nutrition:** Increase flexibility by providing that those who have performed as the director of food and nutrition services for a minimum of two years by allowing them to continue doing so without obtaining additional certification. Newly hired directors of food and nutrition services or those with less than two years of experience would need to complete, at a minimum, a course in food safety and management.

2019

CMS Proposed Rule Delaying Ph.3

(7/15/19) - *Continued*

- **QAPI:** Allow facilities greater flexibility in tailoring their Quality Assurance Program Improvement (QAPI) program to the specific needs of their individual facility by eliminating prescriptive requirements. It would retain introductory regulatory text that requires a facility's QAPI program to be ongoing and comprehensive and to address the full range of care and services, but it would remove detailed regulatory requirements that set forth how a program meets those objectives.
- **IDR:** Update Informal Dispute Resolution (and independent process) by adding timeframes on process, and increased provider transparency.
- **Pharmacy Services:** Remove the existing requirement that PRN prescriptions for anti-psychotics cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This proposed revision would increase flexibility by allowing each facility to allow for PRN orders of all psychotropic medications to be extended beyond 14 days if the attending physician or prescribing practitioner believes it appropriate and documents his or her rationale in the resident's medical record and indicates the duration for the PRN order.
- **Infection control:** The rule would remove the requirement that each nursing home's infection preventionist work at least part-time at the facility. Instead, an infection preventionist would merely need to have "sufficient time at the facility to meet the objectives" of the infection prevention program.

2019

AMDA Submitted Comments

Support antipsychotic PRN similar to other psychotropic medications
Support changes to remove requirement to alert ombudsman on every discharge and transfer
Support more flexibility in QAPI regs
Support changes around infection control

AMDA letter: https://paltc.org/publications/society-amda-comments-participation-requirements-ltc-facilities

2019

SNF Payment - A Little on PDPM

2019

What is the Patient Driven Payment Model (PDPM)?

Began October 1st, 2019

Represents a marked improvement over the RUG-IV model for the following reasons:

- Improves payment accuracy and appropriateness by focusing on the patient, rather than the volume of services provided.
  - Improves targeting of resources to patients with varying therapy needs based on discipline (PT, OT, SLP)
  - Nursing Case-Mix now separated into a Nursing component and a Non-Therapy Ancillary (NTA) component
- Significantly reduces administrative burden on providers.
  - MDS data from the 5-day assessment is used to calculate five Case-Mix Index (CMI) clinically adjusted components
- Improves SNF payments to currently underserved beneficiaries without increasing total Medicare payments.
  - More accurately compensate for levels of care
  - Likely to see higher reimbursement for higher acuity patients

2019

Key Points

- System will finally reimburse for medically complex patients
- Accurate and thorough physician/NP/PA coding is critical to telling CMS who we actually take care of in PALTC
  - Facility reimbursement
  - Clinician reimbursement (remember MACRA here – care complexity)
- Progress notes / problem lists must include diagnoses and preferably the actual ICD-10 codes.

2019

www.paltc.org/pdpm

- Webinars
- White Papers
- CMS Resources
- Society Forum

2019

SNF Value-Based Purchasing Program (VBP) and Quality Reporting Program (QRP)

2019

SNF VBP

- Skilled Nursing Facility 30-Day All-Cause Readmission Measure
- The Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) is used in the SNF VBP Program. The SNFRM estimates the risk-standardized rate of unplanned readmissions within 30 days for:
- People with fee-for-service Medicare who were inpatients at PPS, critical access, or psychiatric hospitals.
- Any cause of condition
- SNFs earns a SNF VBP Performance score (0 to 100) and ranking which is calculated based on that SNF's performance on the measure. The SNF VBP performance score is equal to the higher of the achievement score and improvement score.
- SNFs are awarded points for achievement on a 0-100-point scale and improvement on a 0-90-point scale, based on how their performance compares to national benchmarks and thresholds.

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2019

SNF QRP Assessment-Based Quality Measures

NQF Measure ID	Measure Title	Data Collection Timeframe	Data Submission Deadline
NQF #0674	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	01/01/17-12/31/17	May 15, 2018
NQF #0678	Percent of Patients or Residents with Pressure Ulcers that are New or Worsened	01/01/17-12/31/17	May 15, 2018
NQF #2631	Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function	01/01/17-12/31/17	May 15, 2018

SNF QRP claims-based measures

Measure	Data Source
Discharge to Community- Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)	Medicare FFS claims
Potentially Preventable 30-Days Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)	Medicare FFS claims
Medicare Spending Per Beneficiary – Post-Acute Care (PAC) Skilled Nursing Facility Measure	Medicare FFS claims

CALTC

2019

California Update

- Staffing minimum requirement (3.5/2.4)
  - Workforce shortage is significant
- CANHR v. Chapman/Smith (Epple, 1418.8)
- Transfer/discharge
- New attack on MICRA (ballot measure)

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2019

California Update

- SB 305: Medical Cannabis for Terminally Ill in Healthcare Facilities (passed, awaiting signature)
- AB 714: Offering Naloxone to certain patients receiving Rx for opioids/benzos
  - Amended to include waiver for terminally ill
- New Section S Language on CA MDS: *"**POLST** is only appropriate for patients who are seriously ill or nearing end of life. **POLST** is never mandatory and should not be required as a condition to admission."*

2019

Managing Parkinson's in the SNF

Indira Subramanian, MD
Clinical Professor, UCLA Neurology/WLA
VA/PADRECC Director

2019

Disclosure Statement

Dr. Indira Subramanian, MD has disclosed that she is a consultant for Acadia Pharmaceuticals and receives a consultant fee for her services.

2019

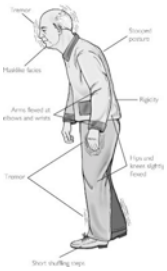
Learning Objectives

- Updates in Parkinson's medications.
- Strategies for monitoring and treating side effects of PD drugs.
- Managing the psychological and cognitive manifestations of PD.
- The IDT and managing the motor manifestations - Environmental safety, nutrition and physical therapy for PD LTC residents.

2019

Parkinsonism

- Parkinsonism is a clinical syndrome characterized by:
  - **T**remor at rest
  - **R**igidity
  - **A**kinesia/bradykinesia
  - **P**ostural instability
- "TRAP"



2019

Geriatric Population

- More likely other systemic disease, malnutrition, polypharmacy, decreased tolerability of drugs
- Also increased comorbidity of other neurological disease : Alzheimer's, Strokes, NPH, subdural hematomas

2019

Diagnosing PD in Elderly

- Clinical diagnosis of 2/3 of bradykinesia, rigidity and tremor
- Impairment of postural reflexes should be used only adjunctively
- Therapeutic response to Levodopa trial also very helpful

2019

PD May Be Over and Under Diagnosed in the Elderly

- Overdiagnosis (due to overlap with normal aging) may lead to unnecessary therapy with resultant side effects/$$
- Underdiagnosis may lead to avoidable disability and poor quality of life
- Surveys indicate that 40-50% of patients in the community and 25% in institutions may be undiagnosed

2019

Pathophysiology of PD

- Loss of Dopaminergic cells within the Substantia Nigra pars compacta (SNpc)
- Lewy bodies - Comprised of α-synuclein protein aggregates
- Pathology also found in other areas of the brain and the peripheral nervous system

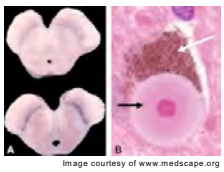
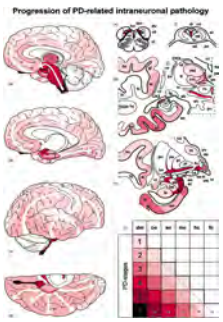


Image courtesy of www.medscape.org

2019



Braak et al.
Neurobiol Aging
2003

2019

Non-Motor Symptoms of PD

- **Sleep** - REM sleep behavior disorder, fragmented sleep, altered sleep/wake cycle, daytime fatigue
- **Autonomic** - Orthostatic hypotension, bladder problems, constipation, erectile dysfunction, seborrhea, sweating, sialorrhea
- **Psych** - Depression, anxiety, apathy, inability to make decisions
- **Cognitive** - Bradyphrenia, "tip of the tongue" phenomenon, dementia (later)
- **Sensory/Pain** - Shoulder pain, paresthesias

2019

Differential Diagnosis of Parkinsonism

- **Idiopathic Parkinson's Disease**
- Parkinson Plus syndromes/Atypical Parkinsonism
  - Dementia with Lewy Bodies
  - Multiple System Atrophy
  - Progressive Supranuclear Palsy
  - Corticobasal Syndrome
- Secondary causes of parkinsonism
  - Drug-induced
  - Vascular
  - Normal pressure hydrocephalus

2019

Secondary Parkinsonism

- Medication-induced
  - Dopamine blockers: neuroleptics, metoclopramide
- Vascular parkinsonism
  - Characterized by lower>upper extremity involvement
- Normal Pressure Hydrocephalus
  - Triad of gait changes (magnetic gait), incontinence, dementia
- Toxins
  - MPTP, CO, manganese
- Trauma (dementia pugilistica)

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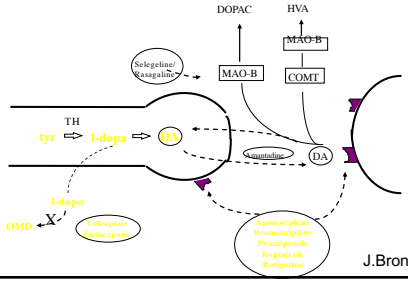
Drugs For Parkinson Disease



J.Bronstein

CALTCM 2019

Parkinson's Disease Treatment

- Non-pharmacologic treatment
  - Exercise/mind-body approaches like yoga/mindfullnes
  - Nutrition – fiber, hydration
  - Education and Support
- Pharmacologic treatment is symptomatic
- Needs to be individualized. Considerations:
  - Age
  - Symptoms and Severity
  - Comorbidities
  - Cost

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Levodopa

- Most effective treatment for PD
- Short half-life - Must be taken at least 3 times/day
- Protein interferes with absorption (amino acid transporter)
- Side effects: nausea, orthostatic hypotension, and hallucinations
- Long-term risk of dyskinesias and motor fluctuations, especially in younger patients
- **First choice for older or more advanced patients**

2019

Sinemet Regular

- Should be given at least TID
- Peripheral side effects include nausea, vomit, orthostatic hypotension
- These can be reduced by increasing amount of carbidopa
- Central side effects include somnolence, later dyskinesias, hallucinations
- Start 25/100 tid and titrate to symptoms, 75-150 of carbidopa total/day
- Be mindful of protein interaction on tube fed patients (run tube feeds at night away from sinemet or will not get absorbed)

2019

Sinemet CR

- Usually given at bedtime for wearing off over night
- Has 70-80% bio-availability of Reg sinemet
- Goal is to avoid pulsatile administration
- Lacks the “kick” of Sinemet R (quick onset)
- Can clog up G-tubes so better to switch to IR sinemet

2019

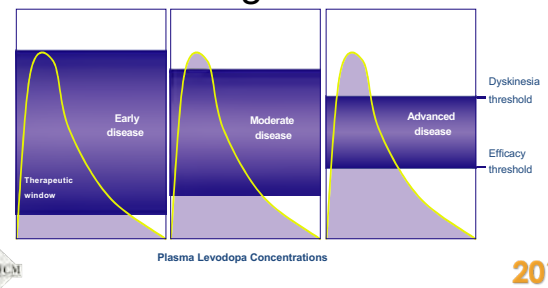
Initial Therapy: The Elderly Patient

- Shorter treatment horizon
- Lower risk of long-term complications
- Higher likelihood of other medical problems

- Levodopa: well tolerated, effective
- Use other medications cautiously due to side effects (cognitive and other)
- Avoid sedating medications

2019

Late PD Changes



2019

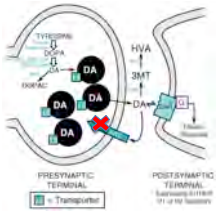
Management of Motor Fluctuations

- Goal is to decrease fluctuations of levodopa levels
- Reduce levodopa dose/increase dose frequency
- Add MAO-B or COMT inhibitor for wearing off
- Add amantadine for dyskinesias (be careful in elderly)
- Newer levodopa formulations
- Surgical: DBS

2019

COMT Inhibitors

- Entacapone, Tolcapone
- Add to levodopa to help with wearing off
- Side effects: diarrhea and nausea. Turns urine orange (not dangerous)
- Tolcapone can rarely cause fulminant hepatic failure



A. Keener 2016 2019

Entacapone (COMTAN)

- COMTAN (200 mg tablet) is given with each administration of carbidopa/levodopa, up to 8 times daily
- Also in combined formulation with C/L called Stalevo (in 50, 75,100, 125,150, 200 strengths)- stalevo now available in generic

2019

Non-Motor PD Symptoms

- **Psychiatric**
  - Dementia
  - Hallucinations
  - Delirium
  - Mood Disturbance
    - Depression
    - Agitation
    - Anxiety and Panic Attacks
- **Autonomic**
  - Orthostatic Hypotension
  - Constipation
  - Urinary problems
  - Sexual problems
  - Sweating and Thermoregulation
- **Sleep Disorders**
  - Insomnia
  - Sleep Fragmentation
  - Parasomnias
  - Restless Legs Syndrome
  - PLMS
  - Excessive daytime sleepiness
  - Sleep attacks
- **Sensory**
  - Pain
  - Paresthesias
  - Altered sensation
  - Restless legs

2019

Hallucinations, Psychosis

- Management: Antipsychotics:
  - Quetiapine- low dose at night largely
  - Clozapine (agranulocytosis:frequent blood monitoring)
  - Avoid typical antipsychotics (haloperidol, risperidone).
  - **New agent Pimavanserin for PD Psychosis – 5 HT2A inverse agonist; Does not block dopamine receptor**

  Cholinesterase Inhibitors:
  - donepezil (po) and rivastigmine (patch) some anecdotal evidence to support; do not worsen PD except tremor
  - PD med down-titration may be necessary

2019

Falls

- Multifactorial:
  - Postural instability
  - Freezing
  - Orthostatic hypotension
- Management:
  - PT eval for fall prevention training
  - Home safety eval
  - **U-step walker** is a great walker for PD patients
  - Has a laser light for freezing, basket and seat

2019

Orthostatic Hypotension

- Nonpharmacologic-management (preferred)
  - Compression stockings or abdominal band
  - Hydration, dietary salt intake
  - Avoidance of rapid postural changes
- Medications (only for those refractory to non-pharmacologic management):
  - Alpha adrenergic agonists (midodrine)
  - Volume expanders (florinef)
  - Norepinephrine prodrug (Droxidopa)
  - **Patients with PD are also prone to supine hypertension, and must be monitored closely if they are being treated with the above medications**
- Adjustments to dopaminergic medication

2019

PD Treatments: Others

- Amantadine: mild symptomatic benefit early in disease, primarily used as adjunct to decrease Levodopa-induced dyskinesias
  - Side effects: anticholinergic, also can cause confusion and hallucinations, livedo reticularis
- Surgical: Deep Brain Stimulation

2019

Novel Agents

- Impax formulation- Rytary- has microbeads with coating of levodopa formulation that is combination of long and short acting sinemets-improves wearing off in fluctuating patients, decrease dose frequency
- Duopa- liquid sinemet gel formulation that is administered through pump continuously into duodenum; may be good for advanced PD patients with motor fluctuations that have cognitive problems
- Inbrija- new inhaled levodopa (lacks carbidopa) – for reduction of off episodes

2019

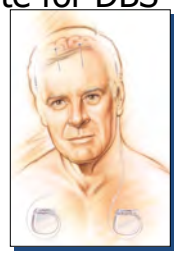
DBS for PD

- Targets: STN & GPi – equally effective for motor symptoms
  - STN – able to decrease medication dose
  - GPi – fewer neuropsychiatric side effects
- ViM thalamus – only treats tremor
- Does not alter disease progression
- Risks: stroke/hemorrhage, infection, stimulation-related side effects
- Can exacerbate mood and cognitive issues

2019

The "Ideal" PD Candidate for DBS

- Age: 40-70
- Symptomatic for 5-10 years or more
- Initial Good Response to L-DOPA
- Marked motor fluctuations
  - Severe dyskinesia
  - Minimal "on-time without dyskinesias"
    - Frequent cycles (q3h or less)
  - Substantial disability during "off-periods"
    - Freezing/Gait Disturbance
- Cognitively Intact/Realistic expectations
- Adequate Social support
  - Access to programming of stimulators



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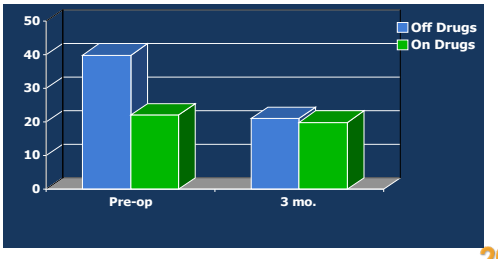
STN DBS Effects on PD Motor Function



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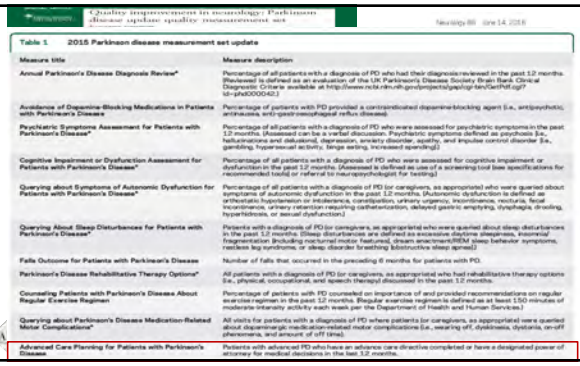


Quality improvement in neurology: Parkinson disease update quality measurement set

Table 1 2015 Parkinson disease measurement set update

Measure title	Measure description
Annual Parkinson's Disease Diagnosis Review*	Percentage of all patients with a diagnosis of PD who had their diagnosis reviewed in the past 12 months. (Reviewed is defined as an evaluation of the UK Parkinson's Disease Society Brain Bank Clinical Diagnostic Criteria available at http://www.ncbi.nlm.nih.gov/projects/gap/cgi-bin/GetPdf.cgi?id=phd000042.)
Avoidance of Dopamine-Blocking Medications in Patients with Parkinson's Disease	Percentage of patients with PD provided a contraindicated dopamine-blocking agent (i.e., antipsychotic, antinausea, anti-gastroesophageal reflux disease)
Psychiatric Symptoms Assessment for Patients with Parkinson's Disease*	Percentage of all patients with a diagnosis of PD who were assessed for psychiatric symptoms in the past 12 months. (Assessed can be a verbal discussion. Psychiatric symptoms defined as psychosis (i.e., hallucinations and delusions), depression, anxiety disorder, apathy, and impulse control disorder (i.e., gambling, hypersexual activity, binge eating, increased spending).)
Cognitive Impairment or Dysfunction Assessment for Patients with Parkinson's Disease*	Percentage of all patients with a diagnosis of PD who were assessed for cognitive impairment or dysfunction in the past 12 months. (Assessed is defined as use of a screening tool (see specifications for recommended tools) or referral to neuropsychologist for testing.)
Querying about Symptoms of Autonomic Dysfunction for Patients with Parkinson's Disease*	Percentage of all patients with a diagnosis of PD (or caregivers, as appropriate) who were queried about symptoms of autonomic dysfunction in the past 12 months. (Autonomic dysfunction is defined as orthostatic hypotension or intolerance, constipation, urinary urgency, incontinence, nocturia, fecal incontinence, urinary retention requiring catheterization, delayed gastric emptying, dysphagia, drooling, hypertidrosis, or sexual dysfunction.)
Querying About Sleep Disturbances for Patients with Parkinson's Disease*	Patients with a diagnosis of PD (or caregivers, as appropriate) who were queried about sleep disturbances in the past 12 months. (Sleep disturbances are defined as excessive daytime sleepiness, insomnia/ fragmentation (including nocturnal motor features), dream enactment/RBM sleep behavior symptoms, restless leg syndrome, or sleep disorder breathing (obstructive sleep apnea))
Falls Outcome for Patients with Parkinson's Disease	Number of falls that occurred in the preceding 6 months for patients with PD.
Parkinson's Disease Rehabilitative Therapy Options*	All patients with a diagnosis of PD (or caregivers, as appropriate) who had rehabilitative therapy options (i.e., physical, occupational, and speech therapy) discussed in the past 12 months.
Counseling Patients with Parkinson's Disease About Regular Exercise Regimen	Percentage of patients with PD counseled on importance of and provided recommendations on regular exercise regimen in the past 12 months. (Regular exercise regimen is defined as at least 150 minutes of moderate intensity activity each week per the Department of Health and Human Services.)
Querying about Parkinson's Disease Medication-Related Motor Complications*	All visits for patients with a diagnosis of PD where patients (or caregivers, as appropriate) were queried about dopaminergic medication-related motor complications (i.e., wearing off, dyskinesia, dystonia, on-off phenomena, and amount of off time).
Advanced Care Planning for Patients with Parkinson's Disease	Patients with advanced PD who have an advance care directive completed or have a designated power of attorney for medical decisions in the last 12 months.

Parkinson's Disease: Prognosis

Major predictors of death within 12 months

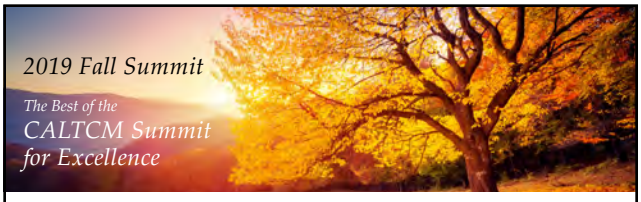
- Weight loss
- Dementia
- Worsening dysphagia and hospitalizations for aspiration events
- Increasing postural instability and falls
- Psychosis
- Decrease of dopaminergic medications due to psychotic side effects

2019

End-of-Life Care

- Dopaminergic therapy should be continued as long as the patient is still taking po medications.
  - In fact, dose requirements often increase at the end-of-life due to reduced GI absorption.
- When cessation of dopaminergic medications is deemed necessary, these should be tapered.
  - Abrupt discontinuation can cause NMS or Dopamine Agonist Withdrawal Syndrome.
  - Taper schedules should be made in consultation with a neurologist when possible.
- Certain medications which are commonly used in the hospice setting have anti-dopaminergic properties and should be avoided.
  - Ex: haloperidol, metoclopramide, and prochlorperazine.
  - Reasonable alternatives include quetiapine for agitation and ondansetron for nausea.

2019



Extending Clinical Services through Telemedicine

Jason Close, BS, RRT

2019

Disclosure Statement

Jason Close, BS, RRT has no relevant financial relationships with commercial interests to disclose.

2019

Learning Objectives

- Understand the basics of telehealth, including the various terminologies used and different modalities.
- Analyze an approach to program or product development for telehealth services.
- Discuss the barriers and challenges facing the delivery of telehealth care in the Post-Acute setting.

2019

Defining Digital Healthcare

- Digital Health
- Virtual Care
- Telehealth
- Telemedicine

2019

2019

Types of Telemedicine

- Asynchronous (Store-and-Forward)
- Remote monitoring
- Synchronous (Real-Time)

2019

The Hub & Spoke

- Originating Site (Spoke)
- Distance Site (Hub)

2019

Telemedicine Myths

- Displace local staff
- Makes patient care easier
- I cannot be compensated

2019

Who we are?

The Dignity Health Telemedicine Network is a centralized telehealth network, that provides telehealth services to increase access, better outcomes, improve the care experience, and decrease total cost of care within the Dignity Health system and 10 additional external clients.

2019

Dignity Health Telemedicine Network

Mission:

Provide timely access to quality care from anywhere

Vision:

One day, remote care and in-person care will become indistinguishable

2019

People | Process | Platform

The **Right Provider**

in the **Right Location**

at the **Right Time**

for the **Right Reason**

using the **Right Technology**

2019

Clinical Program Development

- Understand the request (unveil the need)
- Learn the current state (identify the issues)
- Identify stake holders
- Set the goal
- Define effectiveness
- Define the scope
  - Define the limitations (out of scope)
- Set the timeline

2019

Operationalizing your Program (Facility Level)

- Kick-Off Meeting
- Weekly touch point
- Contracting
- Credentialing
- Policies & Procedures
- Workflow
- Quality Assurance
- Technology
- In-Servicing and Education
- Mocks
- Go-Live

2019

Telehealth in the Subacute and Long-Term Care Environment

2019

The Problem

- Access to care
- Comprehensive care may be episodic
- Coordination of care may be suboptimal
- Unnecessary transfers and admissions

2019

The Solution

- On-demand access to a covering provider (24/7)
- Access to specialty providers

2019

Potential Benefits

- Access to immediate care
- Reduced trips to physician offices and hospitals
- Reduced readmissions
- Increased patient and staff engagement/satisfaction
- Reduced costs
- Time saved
- Reduced “windshield” time
- Improved quality of life
- Improved provider satisfaction

2019

Challenges

- Technology cost adoption
- Compensation for providers
- Lack of Medicare billing (in most areas)
- Multiple provider groups/independent providers covering a single facility

2019

Who can bill?

- Physicians
- Nurse practitioners (NPs)
- Physician assistants (PAs)
- Nurse-midwives
- Clinical nurse specialists (CNSs)
- Certified registered nurse anesthetists
- Clinical psychologists (CPs) and clinical socialworkers (CSWs)
- Registered dietitians and nutrition professional

2019

Billing Opportunities – Synchronous Telehealth

- Originating sites bill the Q3014 facility fee
- Initial nursing facility care services are done in-person
- Subsequent nursing facility care services are considered "federally-mandated" visits, and are limited to 1 visit every 30 days
  - 99307 to 99310
- Inpatient follow-up consultation codes can be billed as utilized
  - G0406 to G0408

2019

Billing Opportunities – Synchronous Telehealth

Code	Description	Time/Duration	PFS National Pricing
99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving	10 mins @ pt bed/floor/unit	$44.69
99308		15 mins @ pt bed/floor/unit	$69.92
99309		25 mins @ pt bed/floor/unit	$92.98
99310		35 mins @ pt bed/floor/unit	$137.67
G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth	15 mins	$39.28
G0407	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth	25 mins	$73.16
G0408	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth	35 mins	$105.23
Q3014	Telehealth originating site facility fee	n/a	n/a

2019

Billing Opportunities – Asynchronous Telehealth

Code	Description	Time/Duration	PFS National Pricing
99446	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional	5-10 mins	$18.38
99447		11-20 mins	$36.40
99448		21-30 mins	$54.78
99449		31+ mins	$72.80
99451	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional	5+ mins	$37.48
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional	30 mins	$37.48

Summary

- Patients need access to care
- Staff need access to expertise
- Facilities need to reduce cost
- Telemedicine offers an opportunity

2019

Trauma Informed Care in LTC

Robert M. Gibson, Ph.D., J.D.
Edgemoor DPSNF

2019

Disclosure Statement

Robert Gibson, PhD, JD, has no relevant financial relationships with commercial interests to disclose.

2019

Learning Objectives

- Understand key regulatory issues related to trauma informed care (TIC) in LTC.
- Demonstrate knowledge of TIC principles.
- Apply principles of TIC in the case of an LTC resident.
- Assess TIC in the context of policy and procedure.

2019

What is Trauma?

- Individual trauma results from an **event**, series of events, or set of circumstances that is **experienced** by an individual as physically or emotionally harmful or life threatening and that has lasting adverse **effects** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, July 2014

- Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) …..ways….

DSM V 2013

2019

Trauma informed care in SNF—mandated, although undefined.

F699; §483.25(m) Trauma-informed care
The facility **must** ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with **professional standards of practice** and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.

Note: at this time, the State Operations Manual provides no guidance.

As a phase 3 requirement, this will be implemented beginning November 28, 2019

2019

Other Relevant Ftags

- F742 - Based on the comprehensive assessment, the facility **must** ensure that—A resident who … has a history of trauma and/or post-traumatic stress disorder, **receives appropriate treatment**…
- F659 - Comprehensive Care Plans (**must**) "Be provided by **qualified persons**…(and) "Be culturally-competent and trauma–informed."
- F740 - Behavioral health services **must** be provided.
- F741 - The facility **must have sufficient staff** who provide **direct services** to residents with the appropriate competencies…to meet the behavioral health needs…(of) residents with a history of trauma and/or post-traumatic stress disorder.

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2019

What does compliance look like?

- Screening? – directly asking can be traumatic! But need comprehensive and ongoing assessment.
- Care planning—identify trauma, co-morbidities, manifestations, triggers, and strategies to eliminate or mitigate triggers.
- Staffing—who is qualified?
- Policies and procedures
- Clinical Documentation
- Education

F850 Social worker

- *Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is:*
- *§483.70(p)(1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and*
- *§483.70(p)(2) One year of supervised social work experience in a health care setting working directly with individuals.*
- Does this meet the standards of "qualified persons" or "professional standards of practice" for treating trauma?
  - Maybe…make sure they have specific, relevant training and time to provide treatment.
  - May raise issue of scope of practice. As therapy, does this require a licensed practitioner?
  - Are they "qualified persons" per F659?

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2019

Is a new competency for nursing staff mandated?

- F741 "…must have sufficient staff who provide direct services to residents with the appropriate competencies…to meet the behavioral health needs…(of) residents with a history of trauma and/or post-traumatic stress disorder." Competencies include, but are not limited to:
  - Communication and interpersonal skills;
  - Promoting residents' independence;
  - Respecting residents' rights;
  - Caring for the residents' environment;
  - Mental health and social service needs; and
  - Care of cognitively impaired residents.
- In phase three, under §483.95(i) (F949), behavioral health, **formalized training programs must be completed and documented** for all staff that support and provide care for residents that have behavioral health needs.

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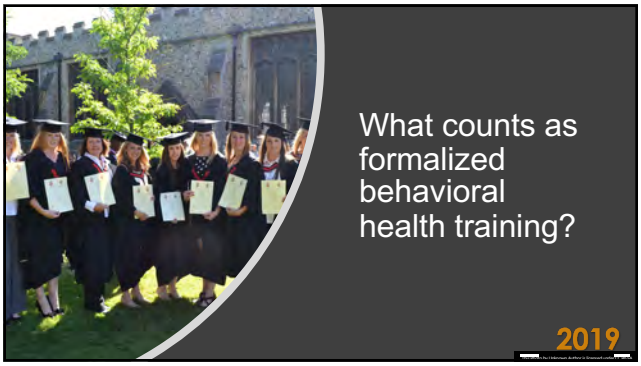

What counts as formalized behavioral health training?

2019

SAMHSA SUGGESTS: SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH—but no one tells HOW we do this in nursing home.

1. Safety
2. Trustworthiness and Transparency
3. Peer Support
4. Collaboration and Mutuality
   Note F553 The right (of the resident) to participate in the development and implementation of his or her person-centered plan of care
5. Empowerment, Voice and Choice
6. Cultural, Historical, and Gender Issues

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2019

Goals and values of TIC are oriented to protect and support the survivor of trauma

Shift from "What's wrong with you?" to "What happened to you?"

2019

But…

How do we manage "what happened to them" when it leads to harmful behaviors?

How do we protect the resident and also other residents and staff from harmful behaviors affecting them?

2019

Trauma is often associated with borderline personality disorder, PTSD, substance use, mental illness and poor relationships….

Traits of these may include:

- Irritable behavior and angry outbursts, often involving verbal or physical aggression
- A pattern of unstable and intense interpersonal relationships characterized by extremes of idealization and devaluation, i.e., splitting.
- Impulsivity
- Recurrent suicidal behavior
- Intense or prolonged psychological distress and/or marked physiological reactions to exposure to internal or external cues (triggers)
- Persistent negative beliefs and cognitive distortions, e.g., "no one can be trusted"
- Affective instability, e.g., intense episodic dysphoria, irritability or anxiety
- Transient, stress-related paranoid ideation or severe dissociative symptoms

Diagnostic and statistical manual of mental disorders (5th ed.)

2019

Julie

- Julie is a 52-year-old female admitted from a local hospital after being attacked in the community. She had been in a previous SNF that "doesn't have any beds." She is morbidly obese and quadriplegic, but over time regains significant function of her arms/hands and obtains a power wheelchair to facilitate her discharge. She tells you she experienced sexual abuse as a child and her mother did not protect her. Her mother's calls trigger many negative emotions, as do many other things leading to threats to harm herself or episodes of screaming and accusations. She has made so many reports of staff abuse that staff are frightened to care for her.
- After obtaining the power wheelchair, there is growing conflict between her and her peers as she is able to engage more with others. She lacks social skills and overreacts to perceived slights, with severe anxiety, rage, threats to leave AMA, threats of suicide and calling 911 on several occasions. Julie will only accept very low doses of psychotropic medications and it it is not clear they improve her behavior.
- Julie begins to bully peers with hurtful comments and intrusive behavior. Residents make abuse complaints against her and she retaliates with more bullying behavior, following others around and harassing them and disrupting activities and the milieu generally. She speaks of the unfairness of her treatment and how she is the victim of persecution, although those observing the situation feel she is the perpetrator.
- Julie is very convincing and evokes a great deal of sympathy. She describes being "the victim" of others "trying to make me look bad" or to "make me lose my powerchair." She is believable until a very different picture is presented by multiple peers and staff.

CALTCM

2019

Discussion: How do we treat Julie in a trauma informed manner?

- What happened to you?
- TIC
  1. Safety
  2. Trustworthiness and Transparency
  3. Peer Support
  4. Collaboration and Mutuality
  5. Empowerment, Voice and Choice
  6. Cultural, Historical, and Gender Issues

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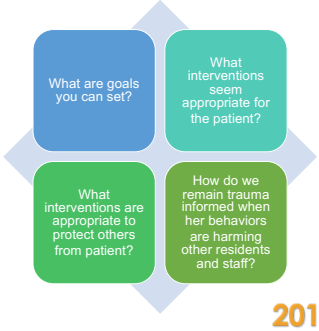
2019

How to care plan



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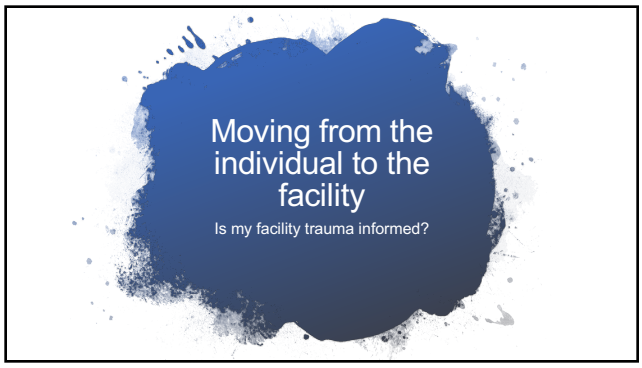


There are trauma informed assessment tools for observing and evaluating a facility

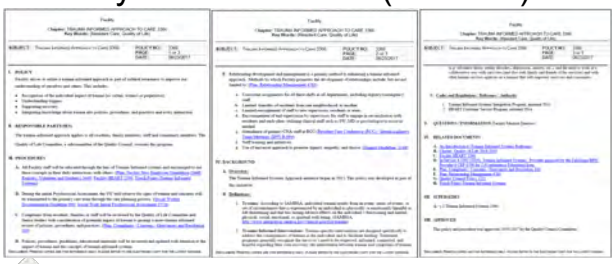
https://alamedacountytraumainformedcare.org/trauma-informed-agencies/developing-a-trauma-informed-agency/

Sample questions for an audit

- Does the décor in facility environments reflect the colors, textiles, and images of cultural/ethnic populations served by the program?
- Are Trauma informed evidence-based or emerging best practices utilized?
- Are hiring practices, policies and procedures, contracts, etc. trauma informed?
- Does staff communicate in ways that promote dependability and foster trust?
- Is the staff role, scope, and availability clearly communicated to consumers?

CALTCM 2019

Policy and Procedure (handout)



2019

Discussion: Does P&P appear to support trauma informed care?

TIC principles

- Safety
- Trustworthiness and Transparency
- Peer Support
- Collaboration and Mutuality
- Empowerment, Voice and Choice
- Cultural, Historical, and Gender Issues

Practicalities

- Screening
- Care planning—identify trauma, co-morbidities, manifestations, triggers, and strategies to eliminate or mitigate triggers.
- Staffing—who is qualified?
- Policies and procedures
- Clinical Documentation
- Education

2019

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2019