PUBLIC POLICY
Alex Bardakh, MPP

What Pains PALTC Clinicians the Most?

On a recent call with the Centers for Medicare & Medicaid Services (CMS), one of the CMS officials asked the leadership of AMDA — The Society for Post-Acute and Long-Term Care Medicine a very broad question: What pains post-acute and long-term care (PALTC) clinicians the most? What are they most concerned about? Without skipping a beat, Society’s leaders answered with their own question: Well, how much time do you have? Of course, thinking about this more seriously, there are myriad concerns one could pick. What is your answer if you had to pick one thing?

From a public policy standpoint, the most common response the Society receives when asking about what pains clinicians the most is lack of respect — both from peers and financially — for the work they do and the people they take care of. In the rapid movement from volume to value, that type of respect means recognition that the work PALTC clinicians are doing is making a substantial difference toward improving quality of care and helping achieve the savings everyone is so focused on. Some PALTC clinicians have had success with value-based models. We know from experience with the Bundled Payment for Care Initiative (BPCI) Models 2 and 3 that post-acute care has played a key role in the model’s success (“Bundled Payments for Care Improvement [BPCI] Initiative,” https://innovation.cms.gov/initiatives/bundled-payments/). We also know that the seven-site CMS demonstrations on reducing readmissions for the long-stay population have shown significant results on all measures of value (“Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents,” https://innovation.cms.gov/initiatives/rahnfr/).

Will New Models Show Promise?
Despite the evidence of success, CMS did not continue the post-acute model of BPCI in the Advanced BPCI, and the funding for the seven-site demonstration is set to run out in 2020 — with no clear plan for scaling. The most recent announcement from the Department of Health and Human Services (DHHS) alongside the Centers for Medicare & Medicaid Innovation (CMMI) for new models excludes PALTC in the nursing facility as well (“CMS Announces New Opportunities to Test Innovative Integrated Care Models for Dually Eligible Individuals,” Apr. 24, 2019; https://go.cms.gov/2YTMuS0).

The first new model, called Primary Care First, builds on previous ones such as Comprehensive Primary Care Plus (CPC+), and Independence at Home. The second, Direct Care Contracting, builds on experience in the Medicare Shared Saving Program (MSSP). Neither of the previous models were designed for the PALTC population, and neither are these new opportunities. For those taking care of seriously ill patients outside an institutional setting there is an advanced illness track that hopes to incentivize clinicians to take care of the most vulnerable population. According to CMS, the model is designed to achieve better outcomes by “increasing patient access to advanced primary care services, and has elements specifically designed to support practices caring for patients with complex chronic needs or serious illness.”

So the question is, Why are these models seemingly leaving out an important sector of PALTC? CMS has the data on the number of lives and subsequent dollars PALTC clinicians have been responsible for saving. CMS also must see the opportunity that exists in this sector. Yet, when asked, the most common answer we receive is that they are, of course, focused on quality of care in nursing facilities — just look at the recent congressional hearings on nursing home oversight, or the blog post from CMS administrator Seema Verma about additional regulatory oversight.

In a world that is moving toward incentive-driven payment models, why does CMS believe that the answer to the nursing home problem is more oversight — especially given that this is already the most regulated part of health care?

CMS has indicated that its first goal is to address gaps in care — finding care for those who have seemingly “fallen through the cracks.” This is evident in their focus on new primary care Current Procedural Terminology (CPT) codes for care coordination that cover 30 days of follow-ups and patient-centered care. But the question is whether these decisions by CMS are continuing to perpetuate a problem of segmentation rather than supporting a cohesive care–coordinated system where each sector of health care has an equal opportunity to succeed. Nursing facilities and the clinicians who practice in them are not in control of quality data on the number of lives and subsector of PALTC? CMS has the incentive-driven payment models, why does CMS believe that the answer to the nursing home problem is more oversight — especially given that this is already the most regulated part of health care?

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We Are PALTC
Jean Harpel, MSN, RN, GCNS, CPASRM

Scheduled Preventive Maintenance

When I am on site for a visit, I talk to communities about the importance of having a schedule to conduct preventive maintenance on various pieces of equipment throughout the organization. Recently I experienced this process firsthand as I boarded a plane. First, the plane had been delayed by weather; then, as we passengers were buckling in, I heard the grounds crew tell the captain those very words: “scheduled preventive maintenance” followed by “it was not done, so this flight is now canceled.”

Weather delays I can understand, but preventive maintenance? As we all deplaned and got in line to try to find alternative flights, I couldn’t help but wonder why this had happened. Similarly, I’ve thought about incidents that have made the papers recently — such as a wheelchair transport lift dumping a resident off the back of a van, and a broken sling sending a resident plummeting to the ground. Was a lack of a preventive maintenance schedule to blame?

Many organizations have a software program for preventive maintenance, which spits out a list of to-do’s each day or weekly. Two things come to mind for me when I hear this. First, those lists are only as good as the data entered into the program — was everything that needs preventive maintenance actually entered into the database? Second, how do you ensure that what is on the list is completed in a timely and accurate manner? Where is the follow-up? Who is making sure the job gets done?

Think of this scenario: A group of 15 residents is boarding your transport van for a trip to lunch and a show. Your facilities director sees that the van is scheduled to go to the garage for an annual inspection, oil change, new tires, and lift repair (the hydraulic lift safety latch has been sticking). Would you cancel the outing? Or would you reschedule the preventive maintenance appointment?

Or here’s another scenario: Your therapy pool is due for its weekly dose of chemicals, but the shipment has been delayed and won’t arrive for three more days. Do you cancel the therapy sessions for the next three days? Or do you allow the residents in the pool (after all, it hardly gets used)?

How seriously do you take your preventive maintenance programs? What risks are you taking by not adhering to a strict preventive maintenance program? The scheduling of routine and preventive maintenance is important for a number of reasons:

1. It eliminates unexpected expenses and breakdowns.
2. It keeps costs down because repairs are not being made on an emergency basis.
3. It stops problems before they occur.
4. It results in improved quality and safety conditions for everyone. Ultimately I do understand the reasoning behind canceling my flight. Because of the delays, I arrived home more than 8 hours later than expected — but I arrived safely. At the end of the day, don’t you want your residents to be safe and for your staff to arrive home safely as well?

Ms. Harpel has over 13 years of experience in critical and acute care nursing and is a Geriatric Clinical Nurse Specialist. She is a senior risk management analyst and consultant at ECRI Institute. Since joining ECRI Institute she has focused on providing risk management consulting services and education to not-for-profit aging service providers throughout the U.S. and speaks on fall prevention, dementia care, and other topics.
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dollars from the money they are saving the system.

We know from anecdotal and empirical evidence that taking care of patients is the only true way to achieve the goals of the Triple Aim. Yet with no new models to incentivize this behavior change, PALTC clinicians are left wondering when the next audit will show up for an increased number of visits and how much more money they will have to spend to comply with the Merit-Based Incentive Payment System (MIPS). This is what is creating the gap in care CMS is trying to remove. Although patients have not, in a traditional sense, fallen through the cracks, the lack of incentives to take care of them supports as much of a lack of access to good care as any problem CMS is trying to address. This is unlikely to be solved by the increased regulatory oversight Seema Verma has suggested.

This seems to be an opportune time to discuss these issues with CMS and CMMI and work together to incentivize and coordinate clinician and facility incentives such that everyone is rowing the boat in the same direction. The Society has held discussions and responded to requests for information to create a new facility-based option for MIPS participation, for example. It is also the reason the Society is laser focused on bringing the lack of innovative payment options in PALTC to light.

There are plans to continue to meet with CMS and CMMI to redefine the conversation and work together to come up with innovative solutions that include PALTC clinicians rather than promoting shiny new models that continue to exclude the patient population that Medicare serves. There are Society members who are developing innovative Accountable Care Organization contracts and using technology such as telehealth to succeed in the current value-based environment. We just need to bring those ideas to a broader and bigger scale so that anyone — from the largest to smallest practices — can participate.

Do you have an answer to the question CMS has asked us or thoughts on this topic? Please share on the AMDA forum (paltc.org/forum) and on social media @AMDAPaltc @Caring4theAges #PALTCE.

Mr. Bardakh is director of public policy and advocacy for AMDA – The Society for Post-Acute and Long-Term Care Medicine.

Have a Provocative Poster? Submit Your Proposal Today

Posters are a popular and powerful way to communicate ideas, bring focus to an issue, or spotlight an innovative program or initiative. There is still time to submit an abstract for the poster program at the Society’s 2020 annual conference in Chicago, IL. Go to https://www.abstractscorecard.com/cfp/submit/login.asp?EventKey=ANMPALEI for more information.

The deadline for submission is 12 p.m. EST on November 26, 2019. Not only will you gain from the experience of participating in the program, but hundreds of physicians, other practitioners, and stakeholders will have the opportunity to view your poster and benefit from your findings.

The best posters are clear, concise, and balance their text with strong tables and graphics. Handouts with key points also are useful. Having others view your completed poster and seeking their feedback before submission can help identify the areas that need clarification or questions your viewers may have.

If something is on your and your colleagues’ radar, others likely will be interested in the topic as well. Be assured that Society members welcome your insights and experience — if you have a poster idea, we want to hear from you.

Introducing a

DEMENTIA Care Course

With the support of The John A. Hartford Foundation and GAPNA, the UCLA Alzheimer’s and Dementia Care program developed The Dementia Care Specialist (DCS) Curriculum. This 22-module online curriculum provides a basic knowledge base for Nurse Practitioners who are looking to advance their expertise in caring for patients with dementia.

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