The Public Policy Update during the virtual Annual Conference of AMDA – The Society for Post-Acute and Long-Term Care Medicine addressed several developments, challenges, and changes, but one theme was consistent: the Society is working hard to advocate for its members and their patients.

Leaders and staff have ensured that the Society and members of our profession have a place at the table and are involved in policy setting and decision-making on the federal, state, and local levels. Not surprisingly, much of the session focused on COVID-related issues, including the Society’s advocacy priorities relating to the pandemic response and temporary crisis-specific regulatory changes.

Optimism, Empowerment Among the Chaos

Opening the program on an optimistic note, Alex Bardakh, MPP, PLC, the Society’s director of public policy and advocacy, said, “This is not an easy time, but we are all trying to respond the best we can. We are working to advocate for you, to make sure you have the tools and resources you need, and to connect you with others. You are not alone in this.” Noting that college basketball and March Madness is usually a part of early spring, Mr. Bardakh quoted the late North Carolina State Coach Jim Valvano, who said, “To me there are three things everyone should do every day. Number one is laugh. Number two is think ... Number three, you should have your emotions move you to tears.”

Mr. Bardakh said, “I go through many emotions reading the [Centers for Medicare & Medicaid Services] regulations that go out almost hourly every day,” giving his audience “a sense of the chronology” of developments and changes. He said, “Lots is happening on state and local levels, and we’ve been doing more work state by state and helping to connect members with decision-makers.” He added, “If you feel like you are alone and have no resources, let us know.”

On the federal level CMS released an interim final rule which included waivers on telehealth and changes regarding patient transfers, nursing aide training, and laboratory tests.

Telehealth Takes Center Stage

“Issues regarding telehealth care came to a head with the COVID crisis,” Mr. Bardakh noted. The Society has been working on expanding reimbursements for telehealth services, and he observed that CMS’s temporary waivers address some of these issues. In addition to waiving the one-a-month limitation on skilled nursing facility subsequent care visits (99307–99310) billed via telehealth, it added initial nursing facility and discharge visits to the list of approved telehealth services (99304–99306, 99315, 99316), added assisted living and home health codes to the approved telehealth visits, and added payment for phone-only evaluation codes (99441–99443). For all telehealth visits, the modifier “95” must be included with the regular CPT code. CMS also has waived the established patient requirements and relaxed Health Insurance Portability and Accountability Act (HIPAA) requirements to allow the use of more common technologies such as Skype.

Mr. Bardakh emphasized key language from the CMS guidance on Medicare telehealth: “CMS is waiving the requirement in 42 CFR 483.30 for physicians, [nurse practitioners, and physician assistants] to perform in-person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options.”

Telehealth visits require the same documentation as in-person exams. That means the practitioner “must document a review of the resident’s total program of care, including the resident’s current condition, progress, and problems in maintaining or improving their physical, mental, and psychosocial well-being and decisions about the continued appropriateness of the resident’s current medical regimen.”

Mr. Bardakh offered a few suggestions for regulatory visits:

- If the resident is stable, consider “doorway” visits for subsequent visits.
- Make sure regulatory visits are compliant with the required frequency.
- Document all visits.
- Ensure notes are compliant with the required content as per CMS.

Operational Challenges

David Nace, MD, MPH, CMD, 2020–2021 AMDA president, talked about the challenges of balancing accepting residents (either new or returning) from the hospital, preventing the spread of the virus, and cohorting/isolating those who are sick, symptomatic, and at high risk. He noted that the Society has been working closely with CMS and other federal and state agencies to manage admissions in a way that protects residents and staff alike.

Nursing homes are expected to admit patients coming or returning from acute care hospitals and COVID-19 positive residents also have been established successfully in pandemic hotbeds such as New York. Dr. Nace observed, “This is a positive step that creates the potential for alternate care sites.”

Dr. Nace referred to CMS’s guidance as of April 3, which said, “To avoid transmission within nursing homes, facilities should use separate staffing teams for residents to the best of their ability.” If a facility transfers residents to a different location for cohorting/isolation, the transferring facility doesn’t need to issue a formal discharge and should bill Medicare normally for each day of care.

The Society has been staying on top of these issues and has been working closely with other stakeholders. Dr. Nace said, “As an organization, we have taken a great deal of action. We’ve been talking to stakeholders about this issue and what is considered a safe transfer from the hospital to the nursing home. We have a joint position statement with the American Health Care Association, and we have circulated this with the National Governors Association, legislators, and the media. We are holding conversations that will help break down barriers and clear up misconceptions.”

Communicating with families is essential through these efforts, especially because they cannot visit residents in person. Dr. Nace said, “We need to stay in contact with families on a regular basis and share information with them. When you make calls to them, make sure you have the most up-to-date information available.” He noted that there are many resources on the Society’s website that practitioners can use to talk with families and other questions (https://palce.org/COVID-19).

With families unable to visit, the challenges of resident isolation also need to be addressed, said Dr. Nace. “Distancing doesn’t have to be social. When we put people in isolation, there is a higher rate of depression, delirium, and functional decline, and we have to plan to address this.” He urged his audience to help by keeping in touch with isolated older people in their own lives. “One of the most important things you can do is write letters and send postcards. It can really make a difference, I’ve been sending letters to an aunt; it’s been fun,” he said.

The pandemic has highlighted the importance of ensuring that the post-acute and long-term care workforce has the skills necessary to provide care. CMS is waiving the requirement that skilled nursing homes and nursing facilities not employ anyone for longer than four months unless they meet specific certification and training requirements. Dr. Nace said, “Achieving adequate staffing levels may be a concern for SNFs and NFs during this public health emergency. CMS is temporarily waiving these requirements so they don’t present barriers for staffing levels during the duration of this pandemic.” However, he added, “The direct care workforce has been underaddressed nationally for quite a long time. AMDA has taken and continues to take an active interest in this.”

Action on Antipsychotics Continues

“There continues to be congressional attention on how antipsychotics are used in nursing homes,” said Suzanne Gillespie, MD, RD, CMD, 2020–2021 AMDA vice president. Some legislators have expressed concern that the use of these drugs is still too high, and Congress recently sent a letter to community pharmacists seeking more information related to antipsychotic use. She noted that the Society has been and remains very active on this issue and has held meetings on Capitol Hill.

She referred to a proposed rule on as-needed (PRN) antipsychotic use that came out last summer. “AMDA submitted comments on this in September of 2019. We expressed strong support for proposed changes that would treat PRN orders for antipsychotic medications the same as for other psychotropic medications.” She added, “The current requirement limiting use to 14 days and mandating a face-to-face visit before reordering is clearly not consistent with current medical standards of care. This imposes an unnecessary burden on both patients and prescribers, increases the risk of shifting antipsychotic orders from PRN to standing, and potentially delays appropriate patient treatment.” The final rule on this has not yet been released, but Dr. Gillespie assured her audience that they will be hearing more about this.

Elsewhere, Dr. Gillespie mentioned Project PAUSE (Psychoactive Appropriate Use for Safety and Effectiveness), a collaboration with the American Society of Consultant Pharmacists, the Gerontological Society of America, and the Alliance for Aging Research to develop an alternative process measure for appropriate antipsychotic use.

In addition to antipsychotics, Dr. Gillespie highlighted a few other key issues:

- Health information technology (IT)/Interoperability. The Office of the National Coordinator for Health IT’s ‘Cures Act Final Rule’ was released late last year and supports seamless and secure access, exchange, and use of electronic health information.
- Opioid use. There is renewed interest in the opioid epidemic, and a proposed rule addressing this is under discussion. Dr. Gillespie said, “Conversations on this have been continued to next page.
Saying “Hello” to Age-Friendly Health Systems

By Joanne Kaldy

Speaking virtually to her audience at the Annual Conference of AMDA – The Society for Post-Acute and Long-Term Care Medicine, closing keynote speaker and the Society board member Alice Bonner, PhD, APRN, GNP, said, “Keep focusing on things that are positive. We need that more than ever.” In her presentation, “Adventures in Aging During a Difficult Time,” Dr. Bonner shared some stories and personal reflection while talking about the world of Age-Friendly Health Systems.

Talking about the importance of Age-Friendly Health Systems, Dr. Bonner shared current and projected census data. People aged 65 to 75 — many of whom are active in the workforce and community — are currently the largest segment of the older adult population. Soon another segment — frail seniors aged 85 and older — will begin to dominate the older adult population. As the number of those older adults continues to grow and exceeds that of young adults entering the work force, finding a way to care for older adults is imperative. Dr. Bonner said, “Aging is a public health issue. If we don’t figure out how to care for older adults efficiently and effectively, we won’t have funds for other things such as public roads.”

**Doing What Matters**

Age-Friendly Health Systems is an initiative of the John A. Hartford Foundation and the Institute for Healthcare Improvement in partnership with the American Hospital Association and the Catholic Health Association of the United States (https://bit.ly/25eD8i4). Dr. Bonner observed, the goal of Age-Friendly Health Systems is to “build a social movement so all care with older adults is age-friendly.” That is, it is guided by an essential set of evidence-based practices, causes no harms, and is consistent with what matters to the older adult and his or her family.

“Age-friendly care is the reliable implementation of a set of evidence-based practice interventions across four core elements, known as the 4Ms, to all older adults in your system,” said Dr. Bonner. These 4Ms are:

- **What Matters:** Know and align care with each older adult’s specific health outcome goals and care preferences including, but not limited to, advance care planning; and cross settings of care.

- **Medication:** If medication is necessary, use age-friendly medications that do not interfere with what matters to the older adult — mobility and mentation — across care settings.

- **Mentation:** Prevent, identify, treat, and manage dementia, depression, and delirium across care settings.

- **Mobility:** Ensure that older adults move safely every day to maintain function and to do what matters.

This is also about person-directed, interdisciplinary, whole-person care for people at every age. Dr. Bonner said, and a focus on community and public health with better integration of health care and community-based organizations/programs and services. It means that health professionals, municipal leaders, aging-program leaders, and others create an efficient, sustainable network that is accessible to all people, regardless of income or geography.

“There are process and outcome measures we developed for hospital and outpatient practices,” said Dr. Bonner. The outcome measures include 30-day readmissions, emergency department visit rates, Consumer Assessment of Healthcare Providers and Systems (CAHPS), lengths of stay, incidence of delirium, and goal-concordant care. The process measures include the presence of high-risk medications or polypharmacy and screenings/documentation for depression, dementia, and delirium. She said that there are efforts underway to look at outcome and process measures for post-acute and long-term care. “We would love your input to ensure that measures developed reflect care in this setting,” she told her audience.

“All 50 states have something happening around Age-Friendly Health Systems,” said Dr. Bonner, and she invited her audience to get involved. “There are a lot of partnerships, and they are really important; we encourage you to work with them.”

For more information or to get involved, Dr. Bonner directed people to go to the Institute for Healthcare Improvement’s site (https://bit.ly/2DFvU1p). She said, “This is our time to be relentless,” revealing a T-shirt bearing that word. She urged everyone to be relentless and stay positive. She said, “We can’t do this alone. We have to do it together. There are lots of things you can do that take time and effort but don’t cost money. Ask your residents and teams what matters and decide together on priorities.”

An Age-Friendly Health System Action Community, a seven-month, free learning community, started on March 25. It’s not too late for members of the Society to get involved in that effort, Dr. Bonner said.

**Creative and Connected**

Dr. Bonner lauded people’s ability to be positive and creative. “This is so hard in the throes of a pandemic, but we need to be creative to keep people’s spirits up. We need to work alongside others, surprise people a little, and do something people didn’t anticipate you would do.” She added, “We can do this. We can find the positive and uncover ways to keep people’s spirits up.”

Moving ahead and toward more Age-Friendly Health Systems, Dr. Bonner said, “it always starts with the residents. How will we enhance their quality of life?” She further observed, “We have to remind ourselves to say ‘thank you’ every time we can.” Making the facility feel like home, like a community, like a family, she said, is a “top priority.” Lean in, Dr. Bonner suggested. “Pick one to two goals, and build on the strengths of your teams, especially people at the point of care.”

Get close based practice interventions across four implementation of a set of evidence-based practices, causes no harms, and is social movement so all care with older adults efficiently and effectively. We need that more than ever.”

In conclusion, she said, “This is so important; we need the courage and commitment of the Society’s members and their heroic efforts to protect their residents, provide quality care, and keep their teams safe in the midst of an unprecedented health care crisis. Dr. Gillespie said, “I want to recognize the work of AMDA members — so many passionate advocates and people doing wonderful work.”

Senior contributing writer Joanne Kaldy is a freelance writer in Harrisburg, PA, and a communications consultant for the Society and other organizations.

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