The Public Policy Update at AMDA—The Society for Post-Acute and Long-Term Care Medicine’s Annual Conference has always been a popular and powerful program. It reflects back on what the organization and its members have accomplished, and it looks ahead to potential challenges, actions, initiatives, and solutions. It’s always inspiring, but this year more so than ever. “Look around you. The people you see are the reason we’re standing here today,” said Alex Bardakh, MPP, CAE, the Society’s director of public policy and advocacy. “In March of 2020, instead of folding, you banded together, becoming extraordinary advocates for your patients, your communities, and your families. You created policies that took care of your communities. That was real advocacy.”

Growing the Grassroots
“We do direct lobbying. We visit Capitol Hill regularly—whether it’s in person or via Zoom. We are talking to all of the federal agencies,” said Mr. Bardakh. “We also do grassroot lobbying—meaning all of you. We have asked you to participate in the process, and you have stepped up.” He talked about the Society’s many other activities on the national stage, including our participation in the American Medical Association (AMA) House of Delegates, “where we bring our specialty to the table.”

Pointing to more than a dozen associations and other stakeholders that the Society often partners with, Mr. Bardakh said, “We must move the needle together for the sake of all our patients.” He also recognized the importance of the Society’s state chapters and their work, as well as that of the State Advocacy Task Force.

COVID did not stop federal policy development, and Michele Bellantoni, MD, CMD, associate director, post-acute and long-term care at Johns Hopkins Bayview Medical Center, said, “During the pandemic, AMDA has not been on mute.” For instance, she noted that Drs. Chuck Crecelius, MD, and Bob Zorowitz, MD, MBA, CMD, represented the Society on the AMA’s Evaluation and Management Workgroup (formed by the AMA Current Procedural Terminology (CPT) Editorial Panel and Relative Value Scale Update Committee (RUC)).

Elsewhere, Dr. Bellantoni said, “We averted another cut to Medicare Part B physician payment, including nursing home codes.” The Merit-Based Incentive Payment System (MIPS) is automatically exempted for this year, she observed. However, the future of the program remains in doubt. She added, “Value-based medicine is important and will continue in some capacity.”

Biden Plan: The Good, Not-So-Good, and Missing Pieces
“There are some good things, some bad, and some things that are glaringly missing” in the Biden-Harris administration’s plan, Mr. Bardakh observed. The good are recommendations for single occupancy rooms, full-time infection preventionists, career pathways for frontline staff, and ownership transparency. “These are all things we have advocated for in the past two years,” he said.

The bad, he suggested, is that there are too many sticks and not enough carrots. “The continuing bashing of nursing homes as if this is somehow the bad sector of health care and that COVID is somehow a nursing home problem and not a health care problem is wrong. We all know it, and the entire country should know it,” Mr. Bardakh said.

“It seems like we continue to enforce the survey process as it is and we continue to build a Jenga piece without building a foundation.” That, said Mr. Bardakh, goes to what is missing in the administration’s plan. He observed, “There was not one single mention of IT [information technology] infrastructure.” He added, “We have to ensure we have interoperability and can work with our hospital partners and the entire health care sector.” There also wasn’t a single mention of the medical director, he said, stressing that these practitioners made such a tremendous difference and played such an important role during the pandemic.

As far as the timeline for the administration’s nursing home reform plan, Mr. Bardakh noted that there is no interim final rule for implementation and it likely will involve a step-by-step process with some elements moving faster than others. Nonetheless, he said, “We need to advocate for this now. Every opportunity we have to comment and to be at the table, we will.”

Information Technology Needs Attention ASAP
Although the Biden-Harris plan didn’t address health IT, this doesn’t mean that there hasn’t been any action on this area. Society President Suzanne Gillespie, MD, RD, CMD, pointed to the Office of the National Coordinator for Health Information Technology (ONC) Final Rule Implementing the 21st Century CURES Act, a sweeping rule that passed a year ago with provisions on interoperability standards, data blocking, and patient access.

“Where we are at the table for tech issues,” Dr. Gillespie stressed. For instance, the Society is involved with the Post-Acute Care Interoperability (PACIO) Project, “a collaborative effort to advance interoperable health data exchange between post-acute care and other providers, patients, and key stakeholders across health care and to promote health data exchange” (http://pacioproject.org/).

Currently, Society members Steven Buslovich, MD, CMD, and Dheeraj Mahajan, MD, CMD, are working on a PACIO project to standardize data flow from setting to setting using new Fast Healthcare Interoperability Resources (FHIR) standards. At the same time, the Society has been discussing efforts to address funding for health IT in PALTIC in meetings with congressional representatives.

Telehealth took center stage during the pandemic, and this technology continues to receive attention. The Public Health Emergency (PHE) 1135 waiver remains in effect, so all telehealth is allowed with no limitations. Telehealth visits are paid at the same rate as in-person visits. Nursing homes can bill per encounter as an originating site using code Q3014.

What will happen after the PHE expires? According to Dr. Gillespie, the Centers for Medicare & Medicaid Services finalized the once every 14 days restrictions on subsequent care nursing home codes (99307–99310). Initial visit codes (99304–99306) weren’t included after the PHE expires. CMS also has added home/domiciliary established patient codes to the telehealth list for the rest of the year. The proposed physician fee schedule released last July doesn’t make any changes to telehealth for nursing home codes.

“AMDA is strongly advocating for an extension of telehealth waivers and removing barriers to telehealth visits,” said Dr. Gillespie. At the same time, the Society’s Telehealth Workgroup is working on use cases around telehealth.

Strategizing Staffing
Unsurprisingly, workforce issues are at the top of the Society’s advocacy agenda. In 2021, the association released an updated position statement advocating for benefits/career ladders and training for direct care workers and continued support for the Geriatric Workforce Enhancement Program and Geriatric Academic Career Awards, among other efforts. The Society has stated repeatedly that staffing and a trained workforce are key to quality care.

Dr. Gillespie stressed that any decisions about staffing need to consider the broader issues, all of which are part of the Society’s position statement on...
A Year in Review: Selected Relevant Research for PALTC Medicine
By Tess Bird, DPhil

The 2022 Annual Conference of AMDA – The Society for Post-Acute and Long-Term Care Medicine featured the annual Year in Review session: a discussion of 12 articles published in the past year that three presenters determined to be important for post-acute and long-term care. A select article from each presenter is summarized below.

**Slowing: A Vascular Geriatric Symptom**


“Slowing: A Vascular Geriatric Symptom?” came out in JAMDA earlier this year with a corresponding editorial. The authors of this cross-sectional study investigated “the interrelation between slowing in walking, thinking, and mood, and their relationship with cerebral small vessel disease (CSVD)” to determine whether “slowing” could be considered a new geriatric syndrome. The researchers defined measures of slowdown around walking, thinking, and mood and rated 566 participants from the Amsterdam Aging Cohort. They also examined brain imaging of these patients for evidence of CSVD. The researchers concluded that “slowing in walking, thinking, and mood are closely related and associated with CSVD.” They also suggest that slowing may be a new phenotype and that slowing is a potential geriatric syndrome.

A JAMDA editorial that accompanied this study (J Am Med Dir Assoc 2022;23:20–22) pointed out that slowing fits some of the criteria for a geriatric syndrome, including that: it is increasingly common with age and multifactorial; it has meaningful clinical consequences; and it is identifiable and measurable. However, slowing may not be distinct from other conditions or syndromes. As Dr. Gammack summarized, “In fact, slowing is found in many, many other physiologic functions — metabolic rate, for example, wound healing is slow, and slowing is a factor in frailty. So is this really a new syndrome, or is this ... a subset of what we might consider to be a frailty phenotype?” There also may be other domains beyond CSVD, she added.

Dr. Gammack’s take-home message is that “slowness is worthy of additional study and conversation. It may end up being a new geriatric syndrome for us, but we need more research on that.”

**Policy**

from previous page


Dr. Gillespie also noted that there is an urgent need to address multiple issues related to staffing. “These are important conversations we need to be at the table for,” she said.

**Looking Ahead With Clear Vision**

So much has happened in the past two years, but the Society and its leadership are looking ahead with optimism and determination. Referring to the Biden-Harris administration’s plans for PALTC, Dr. Gillespie observed, “AMDA has so many roles we can take on during this time.” These include:

- Supporting bold actions, such as single occupancy rooms and full-time infection preventionists.
- Advocating for transparency (including a registry of nursing home medical directors).
- Optimizing PALTC care processes and culture.
- Being the voice to ensure quality and promote the reality that compliance doesn’t necessarily translate into quality.
- Strengthening the PALTC workforce (via efforts such as training requirements for medical directors and training/tools for all practitioners).
- Promoting infrastructure/tool innovation and new models and settings of care.

“We need strong voices; we need broad communities. Part of the beautiful thing about AMDA is how we bring together people from all walks of life. That is the secret sauce of our community,” she said.

**Welcoming You to the Table**

All of the speakers stressed the significance of members’ involvement in advocacy. They urged the audience to share stories with them about how policy and legislative issues are affecting them, their residents, and their facilities. If you would like more information on how you can be involved, go to https://paltc.org and look for the Policy Snapshot in the Society’s Weekly Roundup e-News for legislative, regulatory, and other policy updates.

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Senior contributing writer Joanne Kaldy is a freelance writer in New Orleans.

**Aducanumab for Alzheimer’s Disease**


One of the Alzheimer’s disease drugs, aducanumab, has stirred considerable controversy this year. Although the clinical trials have yet to be published, Dr. Sanford presented data from the clinicaltrials.gov website.

Aducanumab is an IgG1 antibody beta monomonal antibody specific for the amyloid beta oligomers and fibrils implicated in Alzheimer’s disease. Two identical phase 3 double-blind, placebo-controlled, randomized controlled trials were designed to determine the efficacy of this medication for “slowing cognitive and functional impairment”, the ENGAGE trial (https://clinicaltrials.gov/ct2/show/NCT02477800) and the EMERGE trial (https://clinicaltrials.gov/ct2/show/NCT02484547). Dr. Sanford noted that these studies were both terminated after the interim analysis met futility criteria at 1.5 years; the planned period was 3.5 years.

Dr. Sanford then explained that, while it is unclear why, the U.S. Food and Drug Administration (FDA) reevaluated these data and “found that there was conflicting efficacy between the two trials.” She noted, “The ENGAGE study did not meet the primary end point reduction relative to placebo, and no statistically valid conclusions could be made for the secondary end points. The EMERGE study did, however, reach statistical significance.”

Dr. Sanford said that although the FDA generally prefers two well-controlled trials that demonstrate efficacy for drug approval, they can approve a drug based on one trial. She added, “The FDA collaborated closely with the study sponsor, Biogen, to reevaluate the data from all phases, which is unusual and which some speculate may have influenced their objectivity.”

The trials enrolled 1,653 (ENGAGE) and 1,643 (EMERGE) participants. Using a monthly intravenous infusion, the trials compared a low dose versus a high dose of aducanumab versus a placebo. The primary outcome was a change from baseline in the Clinical Dementia Rating Sum of Boxes (CDR-SB) at 78 weeks. There was no statistically significant change in the ENGAGE trial; in the EMERGE trial, statistical significance was only reached for the primary outcome in the high-dose group.

The adverse events were significant. Although there was a low mortality rate, amyloid-related imaging abnormalities (ARIA) — or brain scans showing vasogenic edema and microhemorrhages — were high at 41% to 42% in the low-dose group for both studies, and at 53% in the high-dose group for both studies. The placebo group only showed 9% ARIA for both studies.

Dr. Sanford further explained that an FDA advisory committee had to vote on whether the EMERGE study alone provided enough evidence supporting the efficacy of aducanumab for the treatment of Alzheimer’s disease. One member voted yes, eight no, and two were uncertain. However, on June 7, 2021, the FDA approved aducanumab — a decision that has contributed to the controversy surrounding this drug.

The Society has published a position statement on aducanumab (J Am Med Dir Assoc 2021;22:1777; https://bit.ly/3uH94PR). The statement cites a number of concerns, including lack of efficacy, potential for dangerous side effects, high cost (~$50,000 per year), and potential for providing false hope.

**Doll Therapy for Behavioral and Psychological Symptoms of Dementia**


Her first study was a randomized controlled trial on the use of doll therapy to treat agitation in dementia patients. She noted that doll therapy is based on the principles of attachment theory: “Which basically means that as humans, when we have needs, or when we feel particularly vulnerable, we crave that physical closeness with other people. Dolls may actually be used as a translational object where people with dementia may be able to — when their BPSD [behavioral and psychological symptoms of dementia] is an attachment request — they may be able to translate that into a caregiving role towards what they perceive as a baby.”

The researchers were interested in the reduction of BPSD and caregiver burden over the primary outcome and reduction of delirium as a secondary outcome. They included participants with moderate to severe dementia and moderate to severe agitation who were able and willing to interact with dolls and did not have a mournful or negative parental experience in their past.

After exclusions, 26 participants were enrolled in doll therapy and 26