



THE FLORIDA SOCIETY
FOR POST-ACUTE AND
LONG-TERM
CARE MEDICINE

Progress Report

Serving Physicians, Medical Directors, Advanced Practice Nurses, Pharmacists, Physician Assistants, and Nurse and Nursing Home Administrators Practicing in Florida's Post-Acute and Long-Term Care Continuum

Best Care Practices in the Post-Acute and Long-Term Care Continuum 2018 a Huge Success

— More than 280 post-acute and long-term care practitioners energized at conference.

FMDA – The Florida Society for Post-Acute and Long-Term Care Medicine and President Dr. Rhonda Randall are very pleased with the successful outcome of the organization's 27th Annual Conference, Best Care Practices in the Post-Acute and Long-Term Care Continuum 2018. The exceptional PA/LTC conference provided a high-quality, high-relevance educational and networking experience to more than 280 physicians, advanced practice nurses, pharmacists, physician assistants, nurses, and administrators at Disney's *Grand Floridian* Resort in Orlando.

Dr. Randall was very impressed by the number of high-level presentations and quality speakers this year.

"Playing on the Best Care Practices theme of this year's conference, there is much change in the world of PA/LTC medicine, with a lot of focus on clinical excellence and administrative effectiveness and efficiency," Dr. Randall said.

The CME-Education Committee headed by chair Dr. Shark Bird and Program Director Dr. Angel Tafur did a tremendous job this year — it showed. Our thanks to the excellent faculty whose sessions were all very well received by attendees.

The event kicked off with two pre-conference workshops. The first, an intensive four-hour morning session, was titled Shared Decision-Making in Serious Illness: Honoring Preferences During Clinical Decision-Making. It featured

experts Carole Montgomery, MD, FHM, MHSA, director, Physician Development and Program Improvement, and Linda Briggs, MSN, MA, RN, director, Program Development and Research, both with Respecting Choices®, a division of the Coalition to Transform Advanced Care (C-TAC) Innovations.



Red-Eye Rounds: PA/LTC and Geriatrics Clinical Quandaries session with expert panelists (L-R) Marva Edwards-Marshall, DNP, ARNP-BC; Paul Katz, MD, CMD; Rick Foley, PharmD, CPh, BCGP, FASCP; Naushira Pandya, MD, CMD; and Moderator Angel Tafur, MD, CMD

This was followed by the three-hour Stakeholders Workshop: A Statewide Initiative to Prevent Avoidable Hospital Readmissions. This is part of a three-year initiative spearheaded by FMDA – The Florida Society for Post-Acute and Long-Term Care Medicine in collaboration with the Florida Hospital Association, Health Services Advisory Group (QIO-QIN), Agency for Health Care Administration, Florida College of Emergency Physicians, Florida Health Care Association, Florida Chapter American Society of Consultant Pharmacists, and Florida Association Directors of Nursing Administration/LTC. Expert panelists from acute care, emergency medicine, EMS, and long-term care shared their best practices to a packed crowd.

The highly anticipated National Leaders Forum featured Cari Levy, MD, PhD, CMD, president, AMDA – The Society for Post-Acute and Long-Term Care Medicine; Chad Worz, PharmD, RPh, CEO, American Society of Consultant

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THE FLORIDA SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE

Serving physicians, medical directors, advanced practice nurses, pharmacists, physician assistants, and nursing and nursing home administrators in Florida's post-acute, sub-acute, skilled care, home care, hospice, and assisted living facilities.

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From the President

FMDA: On the Move



FMDA is proud to serve as the premier organization for providing leadership and education for best care practices, evidence-based medicine, regulatory compliance, quality outcomes, and practice management in post-acute and long-term care (PA/LTC) in Florida. We have developed an effective network of related industry and professional groups that collaborate and promotes the highest quality of care for our patients and residents. From housing the Florida POLST Paradigm, to leading the charge to reduce avoidable hospital readmissions, to being a leader in the Florida Partnership to Individualize Dementia Care in Florida Nursing Homes, to joining the new Palliative Care Coalition for Florida, FMDA is out in front of the issues and supporting its members' priorities.

We experienced a major increase in membership numbers in 2016, and that has continued with successful and growing collaborations on important statewide initiatives, a nationally respected Best Care Practices in the PA/LTC Continuum annual conference, and an annual symposium sponsorship with Florida State University's College of Medicine. There is a lot for us to be proud of! Now 573 members strong, including 26 Lifetime members, FMDA is the largest chapter of AMDA in the country. Perhaps, more importantly, we think we are one of AMDA's most active chapters from continued support of the futures program, to service on committees, and in national leadership roles, to engagement



in the House of Delegates. Our society enjoyed a banner year in 2018, and it has been my pleasure to serve as president of FMDA — my medical home.

We offer our gratitude and congratulations to FMDA's 2018 CME-Education Committee for putting on another spectacular annual conference. With growing attendance of 280 and glowing course evaluations, this year's Best Care Practices annual conference held at Disney's *Grand Floridian* was a seamless flow of cutting-edge education, excellent peer-to-peer networking, and an energized Trade Show in the exhibit hall.

I would like to take a moment to thank the generous sponsors of our 27th Annual Conference, whose support is essential to the society's long-term vision. Our sincerest thank you to Bronze Grande Sponsors: Optum and VITAS Healthcare; President's Wine & Cheese Reception: Consulate Health Care; Friday's Welcome Reception in Exhibit Hall and Poster Sessions: Optum; Conference Briefcases: Sun Pharma; Saturday's Continental Breakfast in Exhibit Hall: VITAS Healthcare; FMDA mobile app annual sponsorship: UnitedHealthCare. We also thank the following companies for hosting Product Theaters, including Janssen Pharmaceuticals, Lilly USA, Sun Pharma, and Sunovion Pharmaceuticals.

FMDA has developed and will continue to develop powerful leaders and mentors to improve quality of care and drive better patient outcomes. This energy is the force

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FMDA *Progress Report* has a circulation of more than 4,000 physicians, advanced practice nurses, physician assistants, consultant pharmacists, directors of nursing, administrators, and other PA/LTC professionals. *Progress Report* is a trademark of FMDA. *Progress Report* Editor Elizabeth Hames, DO, CMD, welcomes letters, original articles, and photos. If you would like to contribute to this newsletter, please email your article to ian.cordes@fmda.org.

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We wish to thank the following organizations for their support:

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Editor's Corner

Focus on Advance Directives

By Elizabeth Hames, DO, CMD; Assistant Professor, Department of Geriatrics, NSU-COM; Associate Program Director, Geriatric Medicine Fellowship – Aventura Hospital; Editor, *Progress Report*

National Healthcare Decision Day (NHDD) 2019 is to be held in April. The goal of the annual event is to educate and empower the public and providers about the importance of advance care planning.



- NHDD encourages patients to express their wishes and for providers and facilities to respect those wishes.

- NHDD is a 50-state independent, but coordinated annual initiative of The Conversation Project to provide clear information on health care decision-making to patients and providers/facilities through dissemination of simple, free, and uniform tools to guide the process.

- NHDD is supported by a national media and public education campaign.

- NHDD is inclusive and brings together individuals from the health care/legal/religious sectors to work on a common project.

- NHDD helps patients understand that advance health care decision-making includes much more than living wills; it focuses on communication and choosing an advocate.

I recently noted in Dartmouth Atlas of Healthcare that several regions in Florida (predominantly southeastern and central) ranked among the most aggressive in the nation for care in the last six months of life — in terms of number of inpatient hospital days, ICU admissions, and inpatient spending for Medicare enrollees — which peaked for the state at over \$22,000 per person in Miami.

In a retrospective unpublished study I did in 2017, with

one of our geriatric fellows, Ovidiu Ghita, DO, we examined a hospital district in Florida and found that 78 percent of patients enrolled into hospice during a 12-month period were admitted to hospice during the last three days of life.

The national average is 35 percent of patients enrolled in their last three days. Further study is needed quickly to understand the driving factors and form potential action plans to change these alarming statistics within our state. Advanced care planning and open communication are most certainly central in this goal.

A Fall 2017 article by Blanca Miller, RN, PhD, published by the American Nurses Association, gave a nice description of the evolution of the concept of patient self-determination.

In the 1960s, Luis Kutner, founder of Amnesty International, first suggested that individuals should write down their choices for medical treatment. In 1972, the Euthanasia Society of America created the first form for a living will — which was not a legal document at that time. In 1976, the Karen Quinlan case (the first right-to-die case in the U.S.) provoked much interest in patient self-determination. The public

disagreement surrounding the case led to the Natural Death Act, passed in California in 1976. Soon, other states followed during the 1970s and '80s — currently all 50 states have some form of living will and advance directive laws. The Supreme Court acknowledged the right to die, but left the right to set standards under state control.

There is currently no uniformity in state laws regarding advance directives, and a wide variation in designations, terminology, treatments that individuals can refuse, and requirements for those persons serving as surrogate decision-makers. Certain states (including Oregon, California, Montana, Washington, and Vermont) have laws that allow patients to accelerate death. Generally, if state laws are more prescriptive than CMS regulations, then the state laws need to be followed.

In 1990, Congress passed the Patient Self-Determination Act (PSDA), which required patients to receive information about advance directives and their right to accept or refuse medical treatment. The final version of the PSDA required

Further study is needed quickly to understand the driving factors and form potential action plans to change these alarming statistics within our state.

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Thank You!

We wish to thank the following organizations for hosting these Product Theaters during our 2018 Annual Conference:

Thursday, Oct. 11

PRODUCT THEATER LUNCHEON

***COPD in the Long-Term Care Setting:
A Case-Based Discussion of Nebulized Therapy***

— Sponsored by **Sunovion Pharmaceuticals**

Thursday, Oct. 11

PRODUCT THEATER DINNER

***New Advancements in the Treatment of laBCC
Long-Term Clinical Data***

— Sponsored by **Sun Pharma**

Friday, Oct. 12

PRODUCT THEATER LUNCHEON

***Evidence-Based Approach to Reducing Stroke Risk
in Non-Valvular Atrial Fibrillation***

— Sponsored by **Janssen Pharmaceuticals**

Friday, Oct. 12

PRODUCT THEATER DINNER

Trulicity® (dulaglutide injection) Product Theater

— Sponsored by **Lilly USA, LLC**

Saturday, Oct. 13

PRODUCT THEATER LUNCHEON

***A Look at Seizures in Long-Term Care –
Highlighting a Treatment Option for Partial Onset Seizures***

— Sponsored by **Sunovion Pharmaceuticals**

How to Complete a Bulk Patient Search on E-FORCSE[®], Florida Prescription Drug Monitoring Program

By Karl Dhana, MD, CMD; Senior Vice President Affairs, MorseLife Health System, West Palm Beach



Here is a step-by-step outline on how to complete a bulk patient search on E-FORCSE (the database for controlled substances).



1. Have your staff generate a list of patients using Excel (FORMAT: column A: first name; column B: last name; column C: DOB). If your EMR has the capability to generate a list with the above info you can also use the EMR to generate the info for you. I can provide details on how to do this in SigmaCARE.
2. Save the above demographics as an Excel spread sheet.
3. Go to E-Forcse website and log-in.
4. Click on "Menu" then "Bulk Patient Search."
5. Click on "File Upload."
6. Next click on "View Sample File."
7. A new window will open asking you for permission to open the spreadsheet downloaded from E-FORCSE.
8. Go ahead and open this spreadsheet; it will be blank except for the titles of the columns.
9. Go to your spreadsheet that has your census info/ demographics (Steps 1 & 2); highlight all the info (first name, last name, DOB) and press Control+C (copy).
10. Then go to the sample file downloaded form E-FORCSE; click on row 2 (below the titles) and paste the info you highlighted into the newly downloaded sample file from E-FORCSE.
11. You should now have all your demographic info in the sample file downloaded. This may appear tedious but by using the sample file that E-FORCSE uses it guarantees that the Excel spreadsheet is the correct format. There are a ton of Excel spreadsheet formats and the website will only take a specific type.
12. Next, save this file with a unique name (e.g., MHC Oct 15).
13. You will have to accept some popup window warnings regarding the format; just click OK and accept.
14. Go back to E-FORSCE and click "Choose File."
15. A window will pop up; locate the file you saved in step 12 above (i.e., MHC Oct 15 2018).
16. Click "Validate Format" – this step allows you to check for errors before running the report.
17. Wait a few seconds and a popup window will open asking your permission to download an Excel spreadsheet with comments on your data. It's important to realize that "errors" will appear at the end of every entry in the spreadsheet; you will need to expand the "errors" column to see if there is an actual error.
18. One of the common errors is suffix; in my experience the spreadsheet doesn't handle special characters ", Jr" or " ' " very well, so go ahead and delete them. Don't

worry, the patient will be found.

19. IMPORTANT: Any changes should be made to your file (e.g., MHC Oct 2018) and then saved.
20. Repeat the "Validate Format" until there are no errors (Step 16).
21. Once there are no errors, enter a Group Name in the field on E-FORCSE (e.g., MHC Oct 2018) – I use the entity and the date so in the future it is easy for me to know which entity and what date that database represents, e.g., MHC Oct 15 2018 means MorseLife Health Center Oct. 15, 2018.
22. After entering the name, click on "Search"; depending on the size of your file it may take a little while before all the data is pulled.
23. To access your data click on the tab "Bulk Patient History."
24. You will see a list of all the bulk searches you have done. If you labeled them clearly it should be rather easy to find the facility and date you are looking for.
25. To view a specific patient in that report you can click on the name of the report and then scroll through the list to find your patient. I do not recommend finding your data this way.
26. An easier way to find your patient is to click on "Menu" then "Request History."
27. Click on "Advanced Options."
28. Enter a few letters of the last name of the patient you are searching in the "Last Name" field and hit enter.
29. Then click "Search."
30. A list of all patients with that last name will appear. You can easily click on the patient name and then click on "View" to actually see the data and report.

Side note: the presenter of the CME course at FMDA stated that once the bulk search was done it would satisfy the requirement of us checking the database. I tried to explain that you don't actually see the data when you do the bulk search but he states once the search was completed we are covered. I would still check the patient data since it is so easy to find the info once you have completed the bulk data search. I also have my nurse (my designee in E-FORCSE) print the e-FORCSE data and attach it to a script whenever there is a request for a refill or new controlled substance. The E-FORCSE data is then shredded and not entered in the chart. This eliminates the need for you to log on and pull up the data.

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THE SOCIETY
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FMDA News From Around the State

Lifetime Members

Dr. David LeVine, chair of the Membership Committee, and the officers and directors of FMDA welcome its newest Lifetime members: FMDA Past President **Dr. Malcolm Fraser** and FMDA director and CME-Education Committee Chair **Dr. Shark Bird**. Dr. LeVine invites you to join the growing group of lifetime members:

Owen A. Barrow, MD; Ian Levy Chua, MD; Marigel Constantiner, RPh; Moustafa Eldick, MD; Ronald Garry, MD; F. Michael Gloth III, MD, CMD; Jackie Hagman, ARNP; Dr. Leonard Hock; Gregory James, DO, CMD; Bernard Jasmin, MD, CMD; Dr. Matthew Nesetti; Dr. William La Corte; Dr. Pedro Morales; John Pirrello, MD; John Potomski, DO, CMD; Brian Robare, CNHA; George Sabates, MD, CMD; Katherine Stanley; Richard Stefanacci, DO, CMD; Carl Suchar, DO, CMD; John Symeonides, MD, CMD; Angel Tafur, MD, CMD; Lauren Tafur, ARNP; and Hugh Thomas, DO, CMD

FMDA offers two-year, three-year, and lifetime memberships, and we encourage new and renewing members to join at one of these levels. For more information about membership, please contact **Jordan Fernandes, Member Services Manager**, at (561) 689-6321.

Vohra Endowment Match

FMDA thanks Dr. Shark Bird for joining FMDA as a Lifetime member and then asking his employer, Vohra Wound Care, to match his contribution with a matching donation to FMDA, a 501(c)(3) charitable organization. Thanks very much!

Journal Club

The Journal Club is a learner-based community seeking to improve health care and health through enhanced care in the PA/LTC continuum. It is a forum where people who care can meet, share, learn, and create change.

FMDA's Journal Club helps its members stay current with the latest evidence-based clinical information relevant to PA/LTC medicine. Journal Club participants share in reviewing articles that are interesting, provide relevant takeaways, and highlight best practices. It has developed into a very effective way to gain new knowledge.

Chaired by **Dr. Diane Sanders-Cepeda**, each Journal Club meeting is scheduled for 30 minutes, once a month, via conference call, and is hosted by rotating club members with staff assistance. During these meetings, the group critically analyze recent literature using evidence-based medicine principles, including: patient preferences, clinician expertise, and scientific findings, each weighted equally. We quickly review two to three papers



and present highlights and takeaways in a concise, high-yield manner, and discussion is encouraged. We look forward to your interest and participation.

The next scheduled meeting is at **12:30 p.m., Jan. 29, 2019**.

POLST Workgroup Moving Forward

FMDA has been the home of Physician Orders for Life-Sustaining Treatment (POLST) Paradigm in the state of Florida since December 2017.

Chaired by **Dr. Leonard Hock**, the purpose of this POLST workgroup is to develop effective strategies for statewide



educational programs, securing grants, fundraising, developing educational and promotional tools, soliciting letters of support from stakeholder groups, lobbying to pass a POLST law in the Florida legislature, developing a coalition of stakeholders, and developing an overall coordinated strategy.

General information about POLST and future POLST events throughout the country may be found on the national POLST Paradigm website at <http://polst.org/>.

Additional information about POLST may be found in this AARP article at <http://www.aarp.org/health/doctors-hospitals/info-04-2011/polst-04-11.html>.

Florida POLST launched a new website at www.POLSTFL.org, where you can find a copy of the Florida POLST form.

If you would like to support Florida POLST, please call or email our executive director, Ian Cordes, at (561) 689-6321, or ian.cordes@fmda.org.

Progress Report Newsletter Is Digital

We have transitioned to a digital-only edition and we are asking our members if they prefer that a printed version be mailed to them instead of a digital version via email. Please send your request for a printed newsletter to **Ian Cordes** at ian.cordes@fmda.org.

Call for Articles for Progress Report

FMDA is currently accepting articles for future issues of its award-winning publication, *Progress Report*. If you would like to submit an article or get more information, please contact **Ian Cordes** at ian.cordes@fmda.org.

FMDA Activities at AMDA Conference

In addition to organizing the Florida Delegation and participating at AMDA's House of Delegates, FMDA invites its member to attend a FMDA Board Meeting from 11:30 a.m. to 1 p.m., Friday, March 8, 2019, in Atlanta, GA.

In addition, FMDA is hosting the Florida Chapter Reception from 6:30 to 7 p.m., on Friday, March 8.

For more information, please contact the business office at (561) 689-6321.

Best Care Practices in the PA/LTC Continuum 2018

Continued from page 1

Pharmacists; and Valerie K. Sabol, PhD, ACNP-BC, GNP-BC, president, Geriatric Advanced Practice Nurses Association. During the session, which was moderated by FMDA President Dr. Rhonda Randall, leaders were each given an opportunity to present their respective organization's challenges and opportunities. The talk show format provided great speaking points that impact the continuum of PA/LTC in clinical, administrative, and legislative areas.

Some other highlights included excellent clinical and administrative topics in addition to the engaging Red-Eye Rounds: PA/LTC and Geriatrics Clinical Quandaries with an esteemed panel of experts (see the photo on the front cover), and the new two-hour mandatory Opioid Prescribing Controlled Substances course with Joshua Lenchus, DO, RPh, FACP, SFHM.

Another unique program was introduced this year — FMDA Talks: Student Presentations. It highlighted brief presentations of five medical, pharmacy, nursing, and physical therapy students who all did an exemplary job.

We enjoyed perfect weather at the President's Wine & Cheese Reception, which was held outside on the Marina Patio. It was generously sponsored by Consulate Health Care and one of its vice presidents, John Perticone, welcomed all those in attendance. FMDA President Dr. Rhonda Randall also said a few words and then recognized FMDA's 26 Lifetime members.

For the past couple of years, FMDA's Journal Club, under

the leadership of Chair Diane Sanders-Cepeda, DO, CMD, has gathered during the annual conference for a 30-minute in-person meeting not unlike their monthly remote meetings. This year was different. The Journal Club hosted a



General Session on Sunday during Greg Chaires' presentation

one-hour CME/CE Geriatric Literature Review with the following excellent presenters: Elizabeth Hames, DO, CMD, assistant professor, Dept. of Geriatrics, Kiran Patel College of Osteopathic Medicine Nova Southeastern University; Au-Co Nguyen, DO, Geriatric Fellow, Aventura Hospital; Marva Edwards-Marshall, DNP, ARNP, BC, clinical services manager with Optum; and Michelle Lewis, MSN, APRN, FNP-BC, GNP-BC; nurse practitioner, Care Delivery & Management, Optum.

The Recognition Ceremony included the announcement of the best poster presentations with the awarding of certificates and gift cards. This was followed by two special guest speakers, Dr. Joshua Lenchus, president, Florida Osteopathic Medical Association (FOMA); and

Chris Laxton, executive director, AMDA – The Society for Post-Acute and Long-Term Care Medicine.

FMDA President Dr. Rhonda Randall is excited about the growing success of Best Care Practices and the level of support received year after year from collaborating organizations. "As the president of FMDA, I am very grateful



Annual Trade Show

STAND UP AND BE COUNTED

We invite each member to become more involved in FMDA by becoming a volunteer. Numerous opportunities are available to serve for a year, a month, or a day. You can help guide our organization through committees, task forces, and subsections that advise the board of directors, provide advice, facilitate or lead various programs, or even start a new subsection.

Volunteers are the heart of FMDA. Our strength is a result of the time and effort provided by those who volunteer their time and knowledge to serve their colleagues and to further all physicians, medical directors, advanced practices nurses, physician assistants, consultant pharmacists, nurse administrators and administrators in post-acute and long-term care.

Participating as a volunteer provides a gateway to develop and hone leadership skills, increase professional contacts, and give back to the profession. Let us know what types of volunteer opportunities interest you.

We look forward to your participation in FMDA. Should you have any questions, please contact **Ian Cordes**, executive director, at **(561) 689-6321** or **ian.cordes@fmda.org**.



Best Care Practices in the PA/LTC Continuum 2018

Continued from previous page

for our collaboration with numerous post-acute and long-term care health care organizations across the nation,” she said. FMDA looks forward to continuing and growing relationships with other related organizations and medical schools in the state.

“As the president of FMDA, I am very grateful for our collaboration with numerous PA/LTC organizations across the nation.”

— Dr. Rhonda Randall

Best Care Practices in the Geriatrics Continuum 2018 was joint-provided by FMDA – The Florida Society for Post-Acute and Long-Term Care Medicine and AMDA – The Society for Post-Acute and Long-Term Care Medicine, and held in collaboration with the Florida Chapters of Gerontological Advanced Practice Nurses Association, the National Association of Directors of Nursing Administration, and Florida Geriatrics Society.

The conference was designed to educate physicians, nurse practitioners, physician assistants, pharmacists, directors of nursing in LTC, registered nurses, and long-term care administrators, as well as geriatricians, hospice physicians, primary care and home care physicians, physicians considering becoming long-term care or home care medical

FMDA Talks: Student Presentations



From left: Cassandra Vonnies, MS, ARNP, GNP-BC, AOCNP, Doctoral Student of Nursing Services; Samantha Quigley, BS in Biomedical Sciences, Student Pharmacist; Stephanie Mathews-Brashear, MSN, Doctoral Student of Nursing Services; Moderator Shark Bird, MD, CWSP, CMD; Lauren Perrotta, BS in Exercise Science, Doctoral Student of Physical Therapy; and Brennan Ninesling, BS in Biology, BA in Spanish, Second-Year Medical Student

Canadian Attendees Spotlited

In the summer of 2016, Executive Director Ian Cordes (left), received an email from Dr. Perry Rush (center) of Toronto, asking for information about our Best Care Practices Conference.

With a familiar sounding name, Cordes responded that he went to high school with a Perry Rush. Sure enough, it was the same person. Dr. Rush and his wife, Andrea, who is an attorney, both attended our conference in 2016, and returned in 2018.

They have the distinction of being the first Canadian attendees. It's a very small, big world. Cordes and both Perry and Andrea Rush are members of the same high school graduating class in Montreal, Quebec, Canada.



directors, and others with an interest in PA/LTC medicine. The faculty included national and regional authorities in the fields of PA/LTC and geriatric medicine, medical direction, as well as senior care pharmacology.

For more information about next year's Best Care Practices conference, taking place at the Loews Sapphire Falls Resort at Universal Orlando, Oct. 24-27, 2019, please contact FMDA at (561) 689-6321.

Poster Presentations



Dr. Michael Gloth, chair of the Poster Review Committee (right); FMDA President Dr. Rhonda Randall (left); poster sessions sponsor Optum represented by Brian Kidd (second from left), Director of Clinical Operations at Optum North Florida; and Dr. Robert Kaplan, chairman of the Board of FMDA and Medical Director at Optum North Florida (second from right), recognize poster presenters (center, from left) third-year medical students and co-presenters John Wang and Milee Patel, who were the runners-up, and Dr. Sarah Syed. Dr. David LeVine (not pictured) was honored for the best poster presentation.

Photo Highlights from the 2018 Annual Conference

National Leaders Forum

National Leaders Forum (from left) was moderated by FMDA President Dr. Rhonda Randall and featured GAPNA President Valerie K. Sabol, PhD, ACNP-BC, GNP-BC; AMDA President Cari Levy, MD, PhD, CMD; and ASCP CEO Chad Worz, PharmD, RPh.



Dr. David LeVine (left) was honored for best poster presentation by Dr. Robert Kaplan, chairman of the Board of FMDA and Medical Director at Optum North Florida.



2018 Silent Auction in the Exhibit Hall

President's Wine & Cheese Reception — Sponsored by Consulate Healthcare



Beat the Code Blues! CPT Coding in the SNF II

By Robert A. Zorowitz, MD, MBA, CMD; Senior Medical Director, Optum, New York
Dr. Zorowitz replies to unanswered attendee questions from his session at the annual conference.



At the coding session, there were some questions that I'm not sure I answered definitively. Here are the paraphrased questions and answers:



Q: Is it possible to report 99358-99359 Prolonged Service Without Direct Patient Contact (i.e., non-face-to-face) if performed the day before an E&M service?

A: Yes. If the typical time for the E&M service is exceeded and both services meet minimum time requirements, 99358/99359 could be reported, even if performed prior to the E&M visit. For example, a patient calls the office with a complaint, speaks with the physician. The physician instructs the patient to come to the office the next day and proceeds to review recently received hospital and consultant records. Between the phone encounter and records review, the physician spends 31 minutes. The next day, the patient comes to the office. The physician performs 99214, exceeding the typical 25 minutes indicated in the code descriptor. The physician could report both 99214 and 99358. Documentation should describe not only the services provided, but also the duration of each service (I would recommend documenting time in, time out, and total duration), in case the notes are ever audited. NOTE: If the patient were not to subsequently come for an appointment and an E&M visit was not performed, 99358 could not be reported.

If it is possible to communicate with the attendees at the session, they may appreciate getting this further info. If not, I understand.

Q. What is the difference between 99336 vs 99337 for ALF codes.

A. 99336 is defined as moderate complexity whereas the 99337 is defined as moderate to high complexity.

Q. CCM visits: All information seems to indicate a calendar month vs. 30 days. Am I reading correctly that the 20 minutes of time needed should occur Aug. 1-31 vs. Aug. 3-Sept. 3?

A. Yes, the code descriptors explicitly indicate that services should be reported based on a calendar month, not 30 days. This was done to prevent any confusion from the payer.

Q. I had previously heard that only one provider in a practice could bill CCMs for all patients; however, as I read the guidelines it sounds like only one provider can bill the CCM per month per patient vs. one provider of all CCMs in a practice?

A. Only one provider can bill CCM per month per patient. The code does not really address multi-provider practices, so multiple providers could bill the CCM code for their respective patients, as long as all requirements of the code are met.

FMDA's Dynamic Mission & Vision Statements

Mission – Describes the fundamental purpose of an organization, why it exists, and what it does to reach its vision.

The mission of FMDA – The Society for Post-Acute and Long-Term Care Medicine is to promote the highest quality care as patients transition through the post-acute and long-term care continuum. FMDA is dedicated to providing leadership, professional education, and advocacy for the inter-professional team.

Vision – Describes the desired future state of an organization in terms of its objectives. It is a long-term view.

FMDA – The Florida Society for Post-Acute and Long-Term Care Medicine will provide professional leadership to disseminate information and provide access to resources and experts.

FMDA will further advance as the professional hub for education on best care practices, evidence-based medicine, regulatory compliance, and practice management.

FMDA will continue to be the model organization that collaborates with related organizations to promote the highest quality patient care and outcomes in the post-acute and long-term care continuum.

Innovative LTC Solutions to Address Our Needs

Richard G. Stefanacci, DO, MGH, MBA, AGSF, CMD; Lifetime Member, FMDA

For many of us, our childhoods were filled with Saturday morning cartoons watched on one of three channels on a television firmly planted in our living rooms. One popular cartoon at that time was *The Jetsons*. In one episode, little Elroy is attempting to get out of school by pretending he's sick. His mother calls on their physician, who makes a televisist. This non-in-person visit was depicted some 50 years — a half-century — ago and now it's a regular part of our work in LTC.

www.youtube.com/watch?v=WP2y_bpnZDw

But while *The Jetsons* was certainly interesting in how innovation was used, in today's environment investments in innovation both in terms of dollars and time require a clear appreciation for what can be delivered. LTC innovation has the ability to improve occupancy and payments based on clinical and financial outcomes. The clinical outcomes would come in the form of quality measures and resident/caregivers' quality of life, while the financial outcomes would come from reductions in total cost of care, primarily through fewer emergency room visits and hospitalizations.

The financial models that focus on this need to improve the value LTC providers delivery are several and growing. These include Accountable Care Organizations, Bundled Payments, and Readmission Penalties. The Centers for Medicare and Medicaid Services (CMS) describes Accountable Care Organizations (ACOs) as groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high-quality care to the Medicare patients they serve.

Coordinated care helps ensure that patients, especially the chronically ill, get the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.

The Bundled Payments for Care Improvement (BPCI) initiative comprises four broadly defined models of care, which link payments for the multiple services beneficiaries receive during an episode of care. Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care. Bundled



payment models are growing in use as private physicians utilize the services of sophisticated bundled payment managers to assist them in functions typically requiring large health systems. Today, individual physicians can engage successfully in bundled payments. This is expanding the application.

The Hospital Readmission Reduction Program (HRRP), which financially penalizes hospitals with relatively high rates of Medicare readmissions, is currently focused on readmissions occurring after initial hospitalizations for selected conditions — namely, myocardial infarction, congestive heart failure, pneumonia, chronic obstructive pulmonary disease (COPD), elective hip or knee replacement, and coronary artery bypass graft (CABG).

All of these models depend on LTC providers reducing the total cost of care by decreasing emergency room visits and hospitalizations through innovative ways of improving care. Following are a few examples of innovative solutions to consider for your LTC practice.

Services at the Bedside

Much of the available innovation involves increasing care at the bedside, whether that bedside is in an LTC facility or in the community. Several of these opportunities are emerging from our smartphones. These devices now have the ability to do everything from a single lead EKG to an ultrasound and inner ear exam. Before this innovation the use of these diagnostic tools often required patients being transported to a hospital or specialist clinic. But now these tools can be used right at the patient's bedside, speeding time of diagnosis and eliminating the burden of transporting a patient.

Similar benefits can be realized through the use of eConsults — These are electronic consults with specialists. Like the smartphone tools, eConsults can increase the speed of diagnosis at the bedside. Imagine a referral report in the chart from a dermatologist within 24 hours of simply sending a photo of the lesion. It's the high-tech way of doing the informal telephone consults that we have been employing for years with our colleagues to get an answer to a clinical question. This formal process provides the specialist the chart, specific question, and related information, all without having the patient leave their room.

With an increased focus on cardiac care coming as a result of readmission penalties for congestive heart failure and MI,

One thing is for sure: Our future will be very interesting. Just look at *The Jetsons*, which can now be viewed from our Dick Tracy-like wristwatches.

LTC providers are raising their scope of cardiac care. Two innovations in this area are the use of remote telemetry monitoring and cardiac vests. Gone are the days when telemetry patients required monitoring by in-facility nurses staring at a bank of monitors 24/7. Instead, these patients can be monitored by a team far outside the facility. These allow facilities to manage telemetry patients in a most efficient and effective manner. Another piece of cardiac innovation is a wearable vest that can assess a patient's volume status in a non-invasive manner. This provides recommendations on the use of diuretic far in advance of weight gain, leg edema, or shortness of breath.

Another group of innovations is bringing other services normally only available in hospitals and other specialized settings. Services such as paramedic delivered acute care, and hospital at home services allow hospital-level care to be provided at the bedside. In addition, dialysis and blood transfusions are being brought into facilities by teams equipped to provide these services bedside in any facility and leave without any impact on facility or staff.

All of these services can be provided not only in LTC facilities but in our patients' homes. This is a need increasingly falling on LTC providers as they become responsive to care transitions to the home as well as delivering LTC in the community. A primary need of many older adults to remain safe at home is medication management. Innovative devices in this area ensure that older adults take their medications correctly through prompts and electronic delivery. This can assure that PRN/as needed medications are only provided within the appropriate timeframe, preventing a patient from taking several sleeping pills because they forgot they already took it. In addition, medications such as Warfarin that may require a dose being held because of an elevated PT/INR now can be securely managed by LTC providers remotely, ensuring that changes will be applied without relying on a patient or caregiver remembering. All of this is managed by the LTC provider, allowing older adults to remain safe in the community.

Communication and Beyond

The need to provide timely information to all members of the care team, including primary care providers, nursing staff, specialist, and families, is increasingly critical. Several innovations provide secure texting and messaging to increase communication among all parties — between nursing staff and providers or the entire team and the family — improving access to information and better managing outcomes.

Of course, communication needs go beyond these and includes the very real need to interface with our emergency and urgent care colleagues, who often fail to appreciate the LTC facility's scope of care. With the growth of urgent care centers, LTC residents can receive a rapid assessment and initial treatment (RA+IT) and then go back to the facility to complete that treatment. This innovative approach requires the receiving team to be knowledgeable and fully engaged in this process. If you are attempting this process with your

local emergency department and they are not fully aware, they will default to admitting that resident. The success of the RA+IT program is based on improved communication.

Safety

Several innovative solutions are now available to address major safety concerns in LTC — falls, elopement, wounds, and staff welfare. These include such devices as fall belts filled with air bags that can sense a traumatic fall, activate and provide a cushion to an otherwise traumatic hit to the floor. There are combination hockey pants, which have been proven effective, but which no one wants to wear, and car air bags.

Other innovative devices on the safety front for LTC patients include monitors to prevent elopement and others that sense increased and prolonged pressure to move a patient in an effort to prevent pressure lesions.

But our staff also is in need of safety assistance, especially while lifting patients. Japan has invented a nurse robot that can lift and move patients safely, avoiding harm or injury to patient or staff. Robots are replacing nurses and pets too. Several versions of robotic pets are available to provide companionship, thus lowering anxiety and the use of sedative medications.

The Future

If we look not to our textbooks and journals for answers to where the future innovation will take us, perhaps it's a world of self-driving cars and artificial intelligence. Although, it doesn't appear that either will take place for another 50 years. For us in LTC, the key will be incorporating innovation in our practices when and where the model will support it, in such a way that the financial and administrative costs will not outweigh the benefit.

This future will allow LTC to secure their facilities on those very important preferred provider lists while also offering LTC services outside of the facility, in homes and other settings. One of these settings may be all those garages that are suddenly emptied as a result of personal cars being replaced by innovative cars on demand — which will free older adults from driving and open space for loved ones to live near their families. One thing is for sure: Our future will be very interesting. Just look at *The Jetsons*, which can now be viewed from our Dick Tracy-like wristwatches.

Richard G. Stefanacci, DO, MGh, MBA, AGSF, CMD; Adjunct Assistant Professor, Jefferson College of Population Health, Thomas Jefferson University; Clinical Professor, Department of Geriatrics & Gerontology, Rowan University – School of Osteopathic Medicine; Board Member, American Society of Consultant Pharmacists Foundation; Lifetime Member, FMDA



Cybersecurity Must Be Part of Every Health Care Professional's Job

By Craig Musgrave, CIO, The Doctors Company

On May 12, 2017, the world's biggest ransomware attack nearly crippled Britain's public health system and forced doctors to turn patients away. The WannaCry worm, which experts believe to have come from U.S. National Security Agency (NSA) hacking tools released by Wikileaks, spread quickly to companies and critical infrastructure worldwide. A White House homeland security adviser said that more than 300,000 computers across 150 countries were hit. One cyber risk modeling firm put the total economic damage at \$8 billion. Since the attack occurred, security researchers have already identified a new strain of malware that could be much more dangerous.

We will see more cyber-attacks like WannaCry in the months and years to come. They are increasing in frequency and sophistication. But they are also preventable.

Typically, health care organizations use sophisticated encrypted software to manage and protect patient data. Does the existence of these

more sophisticated platforms mean that there is no risk to the medical practice or to the hospital? The answer, unfortunately, is no.

For decades, security experts have been saying that one of the best ways to protect yourself from a malware infection or security breach is to keep your software up to date. Running outdated versions compromises your system. Microsoft released a patch in March 2017 that addressed the NSA exploits. But many organizations forgot or overlooked the patch and were left vulnerable.

The health care industry generally uses older hardware and outdated software, which makes these organizations extremely vulnerable. According to the Verizon 2017 Data Breach Investigations Report, ransomware accounted for 72 percent of the malware attacks on the health care industry. And a 2016 study from IBM and Ponemon Institute noted that breaches in the U.S. health care field cost \$6.2 billion each year and approximately 90 percent of hospitals have reported a breach in the past two years.

Just this year, The New Jersey Diamond Institute for Fertility and Menopause reported that a breach exposed the health information of 14,633 patients. The Harrisburg Gastroenterology breach revealed 93,323 patient records. The cancer center Singh and Arora Oncology Hematology notified 22,000 patients of a breach. It doesn't end there, as

experts project that health care will be the most targeted sector, with new sophisticated attacks emerging.

Every organization, and especially health care organizations, must make cybersecurity a fundamental part of their business. But how do they do that? Here are my top five tips for hospitals and medical practices:

Update your software. Make it a regular habit. Turn on auto-updaters — both Microsoft and Apple provide this option.

Provide employee awareness training. According to cybersecurity research firm Mandiant, phishing emails, which trick people into clicking on a link, account for 95 percent of successful breaches and have a 90 percent success rate.

Institute a training program for staff at all levels and go over the basics, such as don't open emails from senders you don't know and don't run unknown USBs.

Leverage IT application whitelisting and layer your security. Health care systems are fragmented in their management of systems and

data. Their ability to patch legacy systems and employ cybersecurity staff varies enormously. Therefore, application whitelisting is essential. Rather than blacklisting known malicious software, an application whitelist prevents the launching of any executable program (known or unknown) that does not have explicit authorization. This, in combination with strong firewalls and network segmentation tools like micro-segmentation, provides stronger security.

Get cyber insurance. According to Beazley, an insurer offering cyber policies, health care accounts for 55 percent of the incidents they have handled in 2017. With health care data breaches on the rise, cyber liability insurance can help you recover faster in terms of financial coverage and remediation. A HIPAA violation of a breach of unencrypted personal health data can run into the millions of dollars.

Back up your data. Make sure you are backing up your data regularly, either to servers or to the cloud, and that you can restore it easily. WannaCry malware threatened to delete crucial files unless ransoms were paid. If files were backed up, losing the data wouldn't have been a concern to those who were attacked.

Recent cyberattacks have been devastating. Cybersecurity is no longer just an IT issue. Every employee and every organization needs do their part. It is imperative that we all make cybersecurity part of our job. Because now, it is.

Every organization, and especially health care organizations, need to make cybersecurity a fundamental part of their business.

From the President*Continued from page 2*

behind our society and we will use this momentum to engage industry thought-leaders as we move forward. To that end, I would like to introduce you to the following committee chairs:

Education: Dr. Shark Bird, Chair; and Dr. Angel Tafur, Vice Chair and Program Director; **Annual Conference Presentations & Poster Presentations Review:** Dr. F. Michael Gloth; **FMDA's Quality Advocacy Coalition (FQAC):** Co-Chairs Dr. Steve Selznick and Dr. Rick Foley; **Fundraising:** Educational Grants, Sponsorships, and Donations — **VACANT;** **Government/Legislative Affairs:** Dr. John Potomski, Chair Emeritus; **Journal Club:** Dr. Diane Sanders-Cepeda; **Membership Development:** Dr. David LeVine; **Newsletter/Communications:** Dr. Elizabeth Hames, Editor, *Progress Report*; **Physicians Orders for Life-Sustaining Treatment (POLST):** Dr. Leonard Hock; **Technology Readiness:** Dr. Alfonso Gonzalez-Rodriguez

Special Interest Groups (SIGs): **Hospice Section:** Dr. Leonard Hock, Chair Emeritus; **Assisted Living SIG:** Dr. John Symeonides; **Rehab. Medicine SIG** — **VACANT;** **Hospital Medicine** — **VACANT;** **Home Care:** Dr. Gabriel Nuriel

There is a growing need to solve common challenges or break barriers with strategic industry partners. Through collaboration with other like-minded organizations, FMDA's Quality Advocacy Coalition, ably co-chaired by Dr. Steven Selznick and Dr. Rick Foley, launched a statewide quality initiative in 2016. The initiative has been led by FMDA, Florida's Agency for Health Care Administration, Health Services Advisory Group, FL Chapter American Society of Consultant Pharmacists, Florida Hospital Association, Florida Health Care Association, Florida College of Emergency Physicians, risk managers, hospitals, hospital systems, nursing home providers, to name a few stakeholder groups.

The purpose of this initiative is to achieve a measurable statewide reduction in unnecessary acute episodes and their associated burdens on patients and families. While many readmissions are necessary, a lot are avoidable. We have a sizable opportunity for improvement because most other states have lower readmission rates than Florida. In fact, Florida ranks at or near the bottom of all states and territories.

We believe the challenges facing health care in Florida require this statewide concerted effort to help achieve the triple-aim of improving population health, patient care experience, and affordability of care. We believe the goals are attainable if we work together to produce significant improvements by targeting avoidable readmissions.

In addition to reaching out to last year's House and Senate sponsors of POLST legislation, we recently met with lobbyists in Tallahassee. We are being told that it is still possible to get a bill passed in 2019, and that we may not have to wait until 2020, or beyond. Unless we take steps to support POLST legislation in Florida, there are no guarantees that POLST will be honored when it is needed the most. As the home of

Florida POLST, we need your help and support to educate and promote the virtues of POLST to Floridians, as follows:

1. Explain that a POLST form is not an advance directive, but it is a physician's order that ensures EMS and other healthcare professionals provide care consistent with a person's wishes.

2. Describe POLST as a portable, actionable medical order that helps ensure patient treatment wishes are known and honored and helps prevent initiation of unwanted extraordinary treatment.

3. Indicate that it should never be mandatory to complete a POLST form.

4. Illustrate that the process of completing a POLST form involves informed, shared decision-making between patients and health care professionals.

5. Explain that the shared decision-making conversation involves the patient discussing his/her values, beliefs, and goals for care, and the health care professional presents the patient's diagnosis, prognosis, and treatment alternatives, including the benefits and burdens of life-sustaining treatment.

6. Recommend that only patients with serious illnesses or frailty should have a completed POLST form.

7. Explain that a POLST form requires that "ordinary" measures to improve the patient's comfort, and food and fluid by mouth as tolerated, always be provided.

8. Discuss how POLST requires health care professionals be trained to conduct informed shared decision-making discussions with patients and families so that POLST forms are completed properly.

9. Emphasize that POLST is about how you want to live for the rest of your life.

If you don't already know, our 28th Annual Conference is going to be held Oct. 24-27, 2019, at Loews Sapphire Falls Resort at Universal Orlando – a very exciting new venue for us. We know our attendees are cost conscious and not only did this recently completed venue offer the best value for 2019, but we are certain you will really enjoy the convenient water taxis that will shuttle you comfortably to City Walk, Islands of Adventure, and Universal Studios Orlando from the Sapphire Falls Resort. See their video highlights on our website. Our Education Committee is already hard at work building another exceptional conference from the ground up for professionals in the PA/LTC continuum and we are accepting submissions for posters and proposals for educational sessions.

Our members are invited and encouraged to get involved, become energized, and stay connected to the society. Not a member yet? Please join today at www.fmda.org.

Respectfully yours,



Rhonda L. Randall, DO
President

Editor's Corner: Focus on Advance Directives*Continued from page 4*

health care facilities to provide patients with information about advance directives upon admission, and to track if a directive had been executed. States were required to create written laws and information about advance directives. To date, data has shown that while facility documentation about advance directives has increased, the completion of advance directives has not.

In June 2016, The Personalize Your Care Act 2.0 was introduced in the House (see below for summary of bill). The Act includes 10 sections, including funding and development of models of care that promote high quality for patients near the end of life through a Demonstration

Project — “a new Medicare model that provides concurrent care choices in addition to hospice care; a functional assessment of the individual; in-home services and supports; 24/7 emergency supports; and promotes the early use of palliative care services.” The need for portability of advance directives is addressed, as are the need for increasing public awareness, education, and training for advance care planning. This proposed legislation makes explicit mention of POLST (Physician Orders for Life-Sustaining Treatment) as an integral part of advance care planning. It also requires inclusion of advance directives and POLST forms in facility electronic health records to improve accessibility of these documents.

Personalize Your Care Act 2.0

This bill amends Title XVIII (Medicare) of the Social Security Act to establish several new programs and requirements related to end-of-life care and advance care planning.

The bill establishes a demonstration program to test the use of advanced illness management and early use of palliative care under Medicare.

The Department of Health and Human Services (HHS) must make grants to eligible entities for the purpose of developing, expanding, and enhancing programs for orders for life-sustaining treatment.

The Centers for Medicare & Medicaid Services (CMS) shall adopt standards for electronic health records with respect to providing one-click access to specified advance care planning documentation.

Under Medicare, an advance directive shall be portable across state lines and may be presumed valid regardless of where it was executed. In the absence of a validly executed advance directive, any authentic expression of a person's wishes with regard to health care shall be honored.

The Government Accountability Office must study and report on the portability, electronic storage, use, and barriers to use of advance directives.

The bill applies specified quality measures to end-of-life care under Medicare.

CMS must report annually on specified information related to Medicare decedents.

HHS shall award grants to increase public awareness of advance care planning. In addition, HHS shall award grants to eligible entities for the development and implementation of training and education programs related to advance care planning, hospice care, and palliative care.

HHS must establish an advisory committee on advance care planning.

FMDA is involved in POLST legislation and has become Florida's home and clearing house for POLST-related questions and information — <https://polstfl.org>. FMDA supports patient-centered models of care near the end of life, and continues to advocate and move this initiative forward. FMDA welcomes involvement from all of its members. Join a committee — help spread the word!

Mission Statement
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Vision
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What do practitioners see as valuable? They can find clinical talks anywhere, but should they come to Best Care Practices for career guidance information, regulatory, and administrative talks? Why should physicians, NPs, pharmacists, PAs, nurse administrators, and nursing home administrators join FMDA and attend our conference? Answer = Career Competitive Advancement. What topics or burning questions would you like to see featured at future educational programs? Become a member today!

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Benefits of Membership

- Award-winning statewide newsletter, *Progress Report*
- Association website: www.fmda.org
- Nationally recognized annual conference, Best Care Practices in the Post-Acute and Long-Term Care Continuum (PA/LTC)
- Dedicated conference website: www.bestcarepractices.org
- Annual update on Medicare billing
- Discounted member registration fee for annual conference
- Convenient, online annual conference registration
- Networking with other PA/LTC practitioners statewide
- Networking and partnering with other post-acute trade and professional associations
- Advocacy in Tallahassee on behalf of the members of FMDA
- Advocacy in AMDA's House of Delegates
- Advocacy in Florida Medical Association's House of Delegates
- Liaise with Florida Osteopathic Medical Association
- Home of Florida POLST
- Free FMDA mobile app for iPhone and Android devices
- Support statewide initiatives to improve patient care and quality of life
- Join FMDA Quality Advocacy Coalition's statewide initiative to reduce avoidable hospital readmissions



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Members receive our award-winning statewide newsletter: *Progress Report*

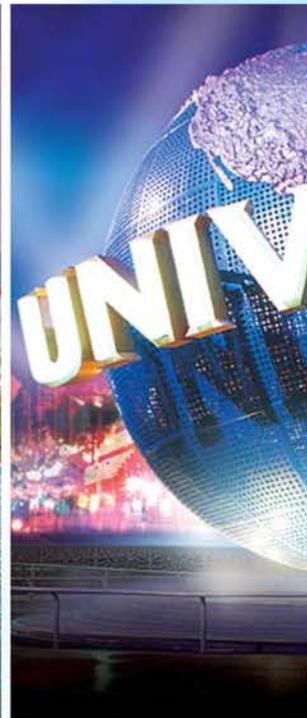


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Best Care Practices in the Post-Acute & Long-Term Care Continuum 2019 is FMDA - the Florida Society for Post-Acute and Long-Term Medicine's 28th Annual Conference, held in collaboration with Florida Chapters of Gerontological Advanced Practice Nurses Association, National Association Directors of Nursing Administration and Florida Geriatrics Society.



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