

# Caring *for the Ages*

A Monthly Newspaper for Long-Term Care Practitioners

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## Art and Music Programs Prove Their Worth

BY SHARON WORCESTER

NASHVILLE, TN – Two studies presented at AMDA Long Term Care Medicine—2014 showed that music and art programs can be well-received in the long-term care setting and can measurably improve the quality of life for residents.

One study showed that long-term care residents participating in a medical student-driven music- and art-activities program experienced improvements in pain, depression, and cognition. The other suggested how an art program can enrich the lives of people with dementia. Both studies were presented in the poster session at the meeting, and the authors discussed their findings with CARING FOR THE AGES.

Rebecca King-Tucker, MD, CMD, author of the study involving patients with dementia, noted that activity choices tend to be limited in the long-term care setting, especially for residents with dementia, who can experience significant decline in function and worsening of depressive and behavioral symptoms. Unfortunately, these declines get worse when these residents aren’t challenged with diverse activities.

Florence Y. Ling said that since pain, depression, and cognitive decline can go unrecognized and undertreated in nursing homes, exploring and supporting complementary avenues to enhance resident quality of life is particularly important. “Our purpose was to bring music- and art-based interventions to improve overall quality of life for residents at a local long-term care facility,” she said of her study.



COURTESY DR. KING-TUCKER

In the front row, residents of the Golden Living Center facility in Greenville, NC, show their creations. Behind them (left to right) are Rebecca King-Tucker, MD, CMD, art teacher Elizabeth Waters, Maria Knupp, RN, GNP, FNP, and activities director Terry Edwards.

Participating residents attended two four-session cycles of participatory music or visual arts activities. Each session lasted 30 minutes and was led by medical students and premedical students from the University of Texas at San Antonio. Each cycle included a showcase session to provide a musical celebration and to highlight participants’ artwork.

Preprogram and postprogram surveys of all participants showed that Wong-Baker Faces Pain Rating Scale scores dropped an average of one level among people in the music program. No change occurred in those in the art program, Ms. Ling said.

Depression, as measured by the Geriatric Depression Scale, decreased by 1 point among people participating in the music program and by 1.5 points in those in the art program. However, postprogram scores still fell within the depression range, she noted.

As for cognition, there was no change on the Mini-Cog test among people participating in the music program, but there was recall improvement among those in the art program. Both programs were well-received by the residents, and the findings suggest that they were associated

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## And So, DSM-5 Manual Says Goodbye to ‘Dementia’

BY BRUCE JANCIN

ORLANDO – This month, the hallowed term “dementia” is supposed to be tossed onto the scrapheap of discarded psychiatric nomenclature, replaced by “major neurocognitive disorder.”

When the latest version of the Diagnostic and Statistical

Manual (DSM-5) was released in May 2013, the American Psychiatric Association gave a year’s grace period for the world to absorb the changes before they take effect. “Dementia” was replaced in the DSM-5 because the term was deemed stigmatizing; the rough translation from the Latin roots is

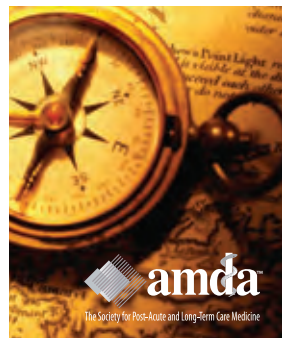
“loss of mind.” Acknowledging that old habits die hard, however, the DSM-5 also states that use of the term is not precluded “where that term is standard.”

The old DSM-IV category of delirium, dementia, and amnesic and other cognitive disorders has been replaced in the DSM-5 by the neurocognitive-disorders

category. Major and mild neurocognitive disorders from Alzheimer’s disease are included under this new category. At the annual meeting of the American Association for Geriatric Psychiatry, W. Vaughn McCall, MD, and George T. Grossberg, MD, highlighted the changes.

“Major neurocognitive disorder” is a syndrome, which includes what was formerly known as dementia. The distinction between it and the new “mild neurocognitive disorder,” previously known as mild cognitive impairment or

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# Medicare's Pay-Data Dump Frustrates Some Physicians

BY MARY ELLEN SCHNEIDER

For the first time, federal officials have publicly released data on how much Medicare pays individual physicians.

On April 9, the Centers for Medicare & Medicaid Services (CMS) posted searchable files with information on more than 880,000 health care providers, including their specialty, the number of services they provided, what they charged, and what they were paid by Medicare.

Collectively, the data reveal \$77 billion in Medicare Part B payments made in 2012.

The data set also allows the public to search for specific procedures and find out how often they were performed and the variation in payments.

For instance, in 2012, more than 91 million outpatient office visits were billed to Medicare with the CPT code 99213. The average Medicare-allowed amount was \$69.59, with a range of \$12.42 to \$144.56. Chest x-rays were performed more than 17 million times in 2012; the average Medicare-allowed amount was \$8.94, with a range of \$6.52 to \$28.56.

The Medicare-allowed amount for the more than 10 million emergency department visits billed to Medicare in 2012 ranged from \$108.29 to \$231.27, with an average allowed charge of \$167.62.

In the short term, the large-scale data dump has yielded a slew of news stories about outlier physicians who raked in tens of millions from the Medicare program. Medicare officials said they expect that in the long term, the data will help root out fraud and highlight geographic payment variations.

"For too long, this information was not made public," Jonathan Blum, CMS principal deputy administrator, said during a press conference. "We believe the public has a right to know this information. The Medicare program is by and large funded with taxpayer dollars, and

taxpayers have the right to understand what is being paid for and how it's being paid."

Aside from increased transparency, Mr. Blum said the agency is also counting on researchers, journalists, and the public to find patterns of waste or fraud that the agency may have missed.

The data release has left physicians with unanswered questions – most notably how to address errors. CMS officials did not provide physicians a chance to review their data before they were released, and so far, there is no formal mechanism for requesting corrections. The agency is working on setting up an appeals process, but it's not ready yet, said Reid Blackwelder, MD, president of the American Academy of Family Physicians. "It's not an ideal situation at all," he said.

"AMDA supports transparency in Medicare payments to any party accepting such taxpayer-funded monies," said Charles Crecelius, MD, PhD, FACP, CMD, chair of AMDA's Public Policy Committee and a multifacility medical director in St. Louis. "The use of raw data will be confusing to the average person, and the lack of a formal mechanism to request corrections of errors is concerning. AMDA fully supports the use of data by appropriate parties to find and correct Medicare fraud and abuse."

**'AMDA fully supports the use of data by appropriate parties to find and correct Medicare fraud and abuse.'**

For now, physicians can try e-mailing questions or complaints to CMS at MedicareProviderData@cms.hhs.gov.

Another lingering question is how to explain the information to patients.



Jonathan Blum

"Payment data are particularly confusing since various complex factors contribute to their variability," said Norman E. Vinn, DO, president of the American Osteopathic Association. Physicians will be forced to explain to their patients that the CMS data are raw and don't reflect the competency of the physician or the quality of the treatment provided.

But Dr. Blackwelder said that if patients do bring up the data, it could be an opportunity to discuss why certain tests are frequently ordered or how Medicare actually pays physicians. For instance, Dr. Blackwelder said the Medicare charges reflect the cost of services, while the payments from the CMS are usually much lower. "It's a really important issue for patients to be aware of," he said.

While nearly all physician organizations voice their support of greater transparency on health care payments, they also object to the lack of context provided by the CMS.

The American Medical Association released a guide to the media highlighting

the potential for errors in the data, as well as the lack of information about quality. The raw data could also be misleading in any of several ways, the AMA noted.

For instance, since residents, physician assistants, and nurse practitioners sometimes file claims under a physician's National Provider Identifier (NPI) number, the data listed for a particular physician may not accurately portray the services performed by that physician. Also, the data do not account for the patient mix, the demographics of the practice, or drug and supply costs.

"The AMA is disappointed that CMS did not include reasonable safeguards that would help the public understand the limitations of this data," Ardis Dee Hoven, MD, AMA president, said in a statement.

The Medical Group Management Association raised similar concerns. "This release could result in patients making decisions about their care based on faulty assumptions about physicians," Susan Turney, MD, president and CEO of the association, said in a statement. "Claims data are not a proxy for quality, especially when provided in isolation from a single payer."

In the statement, the association said it is also concerned that publishing individual provider information, including their address and NPI number, could leave them vulnerable to fraud.

For decades, the federal government was prohibited from releasing this type of individual payment data. However, in 2013, a federal court lifted the injunction that had barred the government from releasing its database of Medicare physician claims to the public. Since then, CMS has received numerous Freedom of Information Act requests seeking the data.

MARY ELLEN SCHNEIDER is with the New York bureau of IMNG Medical News.



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## Board Room



By Ian L. Cordes, MBA, NHA, FACHCA

# The Value in Experiencing Care and Life Transitions

Two of my relatives, let's call them Aunt Frida and Uncle Frank, are both in their late 80s. After much agonizing, they recently decided to sell their single family home and move into an apartment in an independent living facility. Choosing a unified campus that includes assisted living, skilled nursing, home health care, rehabilitation care, and adult day care, they knowingly positioned themselves at the cutting edge of long-term care.

The couple realized that their declining health had made living in and taking care of a large, single family home – and each other – increasingly challenging. This recognition did not come quickly or easily for either of them. But when it did, they managed to find a beautiful, two-bedroom apartment in their community of choice.

In the course of 3 short months, they accomplished two huge tasks. They selected what little furniture their new smaller “home” could accommodate, and they sold their house, which was quite an accomplishment, especially in the then-current housing climate. Although relieved that they had completed this stage of their journey intact, the most difficult challenge then hit them: deciding which possessions, including a lifetime of cherished mementos, to keep and which to let go before they moved.

One day while I helped them pack their belongings, my uncle broke down and sobbed, saddened by the loss of the life they had built together over 68 years of marriage. In my surprise, I was ill prepared to deal with this outpouring of emotion and felt completely inadequate in my feeble attempt to console him.

However, they mastered this challenge, too, and with precise calculations, but sometimes flawed execution, they transitioned to independent living. There they would enjoy two cooked meals a day, housekeeping services, activities, and scheduled entertainment, as well as excellent medical care at the onsite doctor's clinic.

### A Good Start, But

Their new life began wonderfully and they settled into their new apartment with enthusiasm and a touch of relief. But this was not to last. Within a month, I noticed a rapid decline in Uncle Frank's physical and mental health, and I shared my concerns with his new primary care physician at the clinic. That same week, my uncle fell in his bathroom and was rushed to the hospital.

When I saw him later that day, he was lying in a hospital bed in the corridor

next to the nurse's station so he could be carefully monitored. He was very weak. His speech was slurred and he did not understand where he was or why.

After speaking with the attending physician at the hospital, I learned that my uncle had been taking a mélange of the wrong medications to treat his heart disease, diabetes, thyroid condition, and depression – not to mention a long list of “dietary supplements.”

Then it hit me. Both my aunt and uncle continued to drive after their move and, consequently, they continued to see their old primary care physicians and specialists where they used to live. Now, they had failed to inform the full-time doctor, nurse practitioners, and staff at the clinic in their new community about their routine trips to other medical professionals.

Not surprisingly, they also neglected to tell their new caregivers that they were procuring outside prescriptions for their multiple morbidities. In a short period of time, my uncle had filled two separate prescriptions of differing doses of the same antipsychotic drug, one from a family physician and another from a cardiologist.

After understanding this, I was not shocked to learn that my uncle's fall was a direct result of all the medications he was taking. When I told his new physician that my uncle had multiple prescriptions and that my aunt also was still seeing outside physicians, his response was, “How was that possible?”

The physician had no idea they were both still driving their own cars (this is a serious issue best left for another day). We agreed that the driving needed to be addressed with them, as it was putting the safety of others on the road at risk.

### Another Surprise

I contacted the executive director of their facility to see whether my relatives had advance directives on file at the facility. Surprisingly, she said no. I could not imagine my uncle, who spent most of his professional life operating nursing homes and assisted living facilities, not appreciating the need to have a signed advance directive executed when they were in good health.

Trying to drill down deeper and better understand this, I called their attorney and asked him if he had a living will or health care surrogate form on file for either my aunt or uncle. I explained that my uncle was in the hospital and that we could not determine whether any existed.

The surprising answer here, too, was no. The attorney said he would prepare

a set for me to present to my aunt and uncle. In the meantime, I shared my concern with my cousin, who happens to be a registered nurse working in home health care. In response, she brought a set of her own documents for them to sign in Uncle Frank's room at the hospital.

With my uncle not in the best medical or mental health and my aunt distraught, I didn't think it was appropriate to present these forms to them. But my cousin was determined. As she explained the forms she was holding, my uncle became agitated. Uncle Frank repeatedly stated that his attorney was the executor of his estate and would make those decisions when necessary.

**Despite my having more than 30 years in long-term care, none of my training ever prepared me to deal with my own aging relatives.**

Clearly, my uncle did not have the capacity to evaluate his advance directive options and did not understand the difference between an estate and a living will or the appointment of a health care surrogate. Suffice it to say that my cousin backed off and, 5 months later, we have not presented forms to either relative because their health continues to decline and it has become increasingly difficult to explain advance directives and living wills in any meaningful way they can understand. I am hopeful that I will have an opportunity to accomplish this, but I have my doubts.

Back at the hospital, it took 5 days to stabilize Uncle Frank's medications so that he could be discharged to the rehab center on the campus where he lived. He was given great care there, but he was angry and didn't know why he couldn't go home. In just 3 days, he discharged himself against medical advice and went home to his apartment just one building away.

He requested that the rehab center arrange for continued outpatient rehab care, which went on for a few more weeks. While I was initially shocked at my uncle discharging himself, I came to understand completely why he wanted to live at home – mainly to make sure my aunt was not alone.

A few months have passed since this crisis and Aunt Frida and Uncle Frank are making the best of it. My cousin visits them once a week to sort out Uncle

Frank's medications and make sure he takes the prescribed dose of the correct medication at the right time. This has helped immensely.


I worry about their health and well-being and am highly concerned that they continue to drive. The last time their eldest son was in town, he tried to take his dad's car keys from him, but with steam coming out of Uncle Frank's ears, his son retreated to the position that his father not drive at night.

### Now I Know

I have been a licensed nursing home administrator since 1985 and have been the executive director of the Florida chapter of AMDA since 1999. After all that has transpired with my aunt and uncle, I feel like I'm part of a case study from one of our annual conferences – you know, the one with multiple morbidities, frailty, care transitions, ethical dilemmas, polypharmacy, antipsychotics, advance directives, depression, doctor shopping, and on and on.

Despite my having more than 30 years in long-term care, none of my training ever prepared me to deal with my own aging relatives. In retrospect, I can't stop thinking about the avalanche of frail seniors and their families, all over the country, who are dealing with similar personal stories within our health care system.

There is one thing I am sure about. Now that I am more aware of what medical directors, attending physicians, nurse practitioners, and nursing home staff are challenged with by their patients, their relatives, and sometimes each other, I have a newfound appreciation and admiration for what you have to cope with – day in, day out.

By the way, did I tell you what my uncle did 2 years ago? After having paid sizeable long-term care insurance premiums for more than 15 years, he got into a dispute with the insurance carrier over a claim. He responded in anger by not paying any more premiums, knowing that the company would cancel his insurance. And it did, just when he was about to need it the most. Does this sound familiar to anyone? 

MR. CORDES is president of Corecare Associates of West Palm Beach, FL, where he consults with long-term care companies and manages the Florida Medical Directors Association and several other Florida-based health care associations. “Board Room” is an occasional series of articles by members of the CARING FOR THE AGES Editorial Advisory Board.