

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

June 8, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear PTAC Committee:

I write to offer my support for the Intensive Care Management Skilled Nursing Facility Alternative Payment Model proposed by Avera Health Senior Care eLong Term Care (eLTC). If this model is approved, it will support a telehealth-based, geriatrician-led team approach to care for the elderly. This model uses two-way telehealth to increase access for elderly patients in rural areas.

It is my understanding that Avera's successful eLTC program serves as the basis for this proposal, due to its proven ability to provide both high-quality elder care and lower health care costs.

This model has potential to expand access to trained geriatricians and improve the quality of care delivered to elderly patients. In addition, the proposed model will adopt best practices in the industry and support the local workforce. Having implemented telehealth in more than 330 locations, Avera Health is well positioned to advance this proposal.

I encourage your strongest consideration of this proposal. Thank you for your time and attention to this matter.

Sincerely,



Collin C. Peterson
Member of Congress

DISTRICT OFFICES



June 5, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Public Comment – Intensive Care Management Skilled Nursing Facility Alternative Payment Model

To Whom It May Concern:

Hello, I am pleased to share this letter of support on behalf of the South Dakota Association of Healthcare Organizations (SDAHO) in strong support of the proposed Intensive Care Management Skilled Nursing Facility Alternative Payment Model submitted by Avera Health Senior Care eLong Term Care (eLTC).

Avera's eLTC program represents the foundation of this proposal. Developed in 2014, Avera eLTC has achieved outstanding results, improving care for residents of acute care and long term care facilities and reducing healthcare costs through the use of two-way telehealth services.

If approved and implemented, the proposed model will provide payment for organizations delivering geriatrician-led interdisciplinary care via two-way audio/visual telehealth. This will greatly benefit elderly patients who will gain access to the expertise of a board-certified geriatrician and geriatric team.

The proposed model certainly keeps with the mission and vision of SDAHO to "advance healthy communities through a unified voice across the health care continuum and envisioning communities throughout South Dakota where all residents reach their highest potential for health." We believe the proposed alternative model is consistent with these high standards.

Thank you for your consideration.

Warm regards,

A handwritten signature in black ink that reads "S.A. Duke".

Scott A. Duke
President/CEO

United States Senate

WASHINGTON, DC 20510
June 7, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Technical Advisory Committee:

I write to request your full consideration for the application submitted by Avera Health Senior Care eLong Term Care (eLTC) for the Intensive Care Management Skilled Nursing Facility Alternative Payment Model.

Avera Health is a regional partnership for health professionals, which shares support services to provide care to more than 330 locations in over 100 communities. The partnership proposes a new physician-focused payment model that leverages a board-certified geriatrician's expertise across geography, population, and clinical teams using an interactive telecommunications system for encounters. The model was designed based on the successful Avera eCARE Senior Care eLong Term Care program funded by The Center for Medicare and Medicaid Innovation.

The proposed model will provide a method of payment for organizations utilizing two-way telehealth technology to establish geriatrician-led teams providing elder care in various settings. It will greatly expand access to the services provided by board-certified geriatricians, improve the quality of health care delivered to a growing elderly population in various settings, adopts best practices, and support the local workforce.

Avera Health seeks to implement this innovative solution to positively impact patients through more timely and appropriate care, increasing quality of life and satisfaction. Facilities will also benefit from this proposal through increased quality of care, less workforce turnover, and difficulty recruiting new employees.

Thank you for your consideration of this application.

Sincerely,



Deb Fischer
United States Senator

Lincoln Office
440 North 8th Street
Suite 120
Lincoln, NE 68508
(402) 441-4600
(402) 476-8753 (Fax)

Omaha Office
11819 Miracle Hills Drive
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(402) 391-3411
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(308) 630-2321 (Fax)

Kearney Office
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Kearney, NE 68847
(308) 234-2361
(308) 234-3684 (Fax)

Norfolk Office
Post Office Box 1021
Norfolk, NE 68702
(402) 200-8816

From: Victoria Walker
To: [PTAC \(OS/ASPE\)](#)
Subject: Public Comment - Intensive Care Management in Skilled Nursing Facility Alternative Payment Model
Date: Thursday, September 21, 2017 9:17:02 AM

Skilled nursing facilities care for many of our most complex and vulnerable members of society, and yet are often under-resourced by the medical community, with no likelihood of increased workforce numbers in the foreseeable future. This unique approach to augmenting care allows an interdisciplinary team of healthcare professionals to support the onsite team in delivering care that is tailored to the complexities of this population. This approach has been proven to improve outcomes and decrease costs. Creating a sustainable funding mechanism that will enable this approach to be widely operationalized is the next crucial step in making this support available to post acute and long term care residents and staff in communities across the country.

Thank you for your consideration.

Victoria Walker MD, CMD, FFAFP
Chief Medical and Quality Officer
The Evangelical Lutheran Good Samaritan Society
2014-16 APSA Congressional Health and Aging Policy Fellow
605-362-3314 (Office) 605-214-7301 (mobile)

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The Evangelical Lutheran Good Samaritan Society.

From: Lynne Hunter <Lynne.Hunter@avera.org>
Sent: Wednesday, September 27, 2017 3:16 PM
To: PTAC (OS/ASPE)
Subject: Public Comment-Intensive Care Management in Skilled Nursing Facility Alternative Payment Model

PTAC
U.S. Department of Health and Human Services

I am writing in support of the Intensive Care Management SNF Alternative Payment Model. As a 29 year employee of Avera in the social work field working in the areas on oncology, palliative care and hospice, I see the impact this model can have not only in reduced costs but also in patient care. Despite the best efforts of medical staff, I have seen our geriatric population in SNF end up in the acute hospital setting, receiving aggressive care and then having a discussion about goals of care once this care is implemented. I have seen hospice and palliative care services underutilized and the challenges of skilled nursing facilities in providing care in such a challenging setting. Often a trip to the hospital is the only option a stressed and understaffed SNF has to help a resident. Avera's eCare services will provide an invaluable resource in reducing this trend. Avera's eCare system historically has a proven track record of success in the hospital settings in rural areas that have utilized the service and this program will be the next layer of services needed. The model of care is a win win situation for all involved as it will improve quality of care for the residents, it will provide support and resources for the SNF and it will reduce costs. Thank you for the opportunity for public comment on this vital program.

Lynne Hunter

Lynne Hunter, MSW, CSW-PIP, OSW-C
Oncology Social Worker
Avera Medical Oncology and Hematology
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605-322-3005
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lynne.hunter@avera.org





September 26, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Assistant Secretary of Planning and Evaluation Office of Health Policy
200 Independence Ave S.W.
Washington, D.C. 20201

Via: PTAC@hhs.gov

RE: Public Comment—Intensive Care Management in Skilled Nursing Facility Alternative Payment Model

Dear Committee Members,

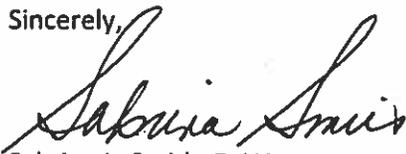
I am writing on behalf of the American Telemedicine Association (ATA) to express our support for the Intensive Care Management in Skilled Nursing Facility Alternative Payment Model. ATA is a non-profit association based in Washington DC with a membership network of more than 10,000 industry leaders and healthcare professionals. We are a leading telehealth association helping to transform healthcare by improving the quality, equity and affordability of healthcare throughout the world.

We support Avera Health's proposal, Intensive Care Management in Skilled Nursing Facility Alternative Payment Model, and applaud its use of telehealth technology to bring patient-centered, quality care to seniors in nursing facilities. Avera has demonstrated that well-integrated telehealth services can positively influence outcomes and health care cost, and has put forward a compelling model to align payment incentives across Medicare providers.

The proposal draws on the broad evidence base for cost-effective telehealth services. It allows physicians to work with any telehealth technology that meets industry and regulatory standards, with no reliance on proprietary technology. Because of this, we see the model as broadly applicable to Medicare beneficiaries and geriatric practices across the nation.

We thank you for the opportunity to comment and for your consideration in reviewing the proposal.

Sincerely,


Sabrina L. Smith, DrHA
Interim Chief Executive Officer

From: Mary Maertens
To: [PTAC \(OS/ASPE\)](#)
Subject: Comments - Avera Health eLTC proposal
Date: Monday, October 02, 2017 7:24:06 PM

Please find the following points in support of the PTAC proposal recently submitted.

Use of eLTC provides the following benefits for Facility/Staff:

- Helps with quality outcomes
- Helps reduce transfers (ED and rehospitalization)
- Helps improve VBP outcomes
- Helps with Nursing Home Compare outcomes
- Financially: shows signs of ROI in many different ways
- Financially: this model would allow costs to be incurred by the payer receiving the largest benefit from our services (Medicare) rather than the site – remember as you word this there is ROI for the site too, so choose wording carefully
- Has been proven to help with recruitment and retention

The Resident:

- Access to a geriatrician and geriatric care team
- Around the clock immediate responses
- Avoids delay of care
- Alleviates the burden of transfers which are undue hardships on the residents and their families
- Quality of life
- Coordination of care

And The Local Physicians:

- Alleviates phone calls, faxes, etc. that they do not have time for
- Alleviates time spent after hours taking call
- Helps lower burnout rates
- Helps with coordination of care

I urge the adoption of this proposal. Our facility and residents have enjoyed the benefits above and reduced costs for CMS due to readmissions and transfers to higher cost settings.

Please contact me for further information.

Mary Maertens
Regional President and CEO

Thanks, Mary

Sent from my iPad

October 3, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

SUBJECT: PUBLIC COMMENT - Intensive Care Management Skilled Nursing Facility Alternative Payment Model

Dear Committee Members:

I am writing on behalf of [The Evangelical Lutheran Good Samaritan Society](#) (the Society) to express our organization's strong support for the proposal offered by Avera Health's Intensive Care Management Skilled Nursing Facility Alternative Payment Model associated with its Senior Care eLongTermCare program, also called eLTC.

The Society has skilled nursing facilities throughout the country and is the nation's largest not-for-profit provider of long-term care services. We have partnered with Avera Health in their eLTC program since its inception. As a partner with Avera, we have experienced numerous benefits of the Alternative Payment Model – which has included lower costs, more effective response to patients' needs in our rural SNFs, as well as an improvement in quality outcomes and reduced readmission rates among our participating facilities.

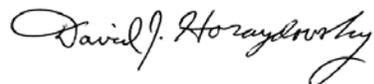
In addition to demonstrated reduction of costs and increase in quality, we also believe that refinement of the model's application will show continued improvement in our customer/patient and staff satisfaction scores which, in sum, addresses all aspects of the CMS's Triple Aim objectives.

Thus, we are proponents of and offer our strong support for Avera's Alternative Payment Model proposal.

Should you have any questions related of the Society's support and recommendation, please contact Dr. Victoria Walker, as follows:

Victoria Walker MD, CMD, FAAFP
Chief Medical and Quality Officer
The Evangelical Lutheran Good Samaritan Society
2014-16 APSA Congressional Health and Aging Policy Fellow
605-362-3314 (office) / 605-214-7301 (mobile)
Vwalker3@good-sam.com

Sincerely,



David J. Horazdovsky
President and CEO

October 4, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Angela Tejada
Assistant Secretary for Planning and Evaluation Office of Health Policy
US Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Intensive Care Management in Skilled Nursing Facility Alternative Payment Model

Dear Ms. Tejada:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) submits the following comments to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) regarding the Intensive Care Management in Skilled Nursing Facility (SNF) Alternative Payment Model (APM) submitted by Avera Health (Avera). APTA respectfully requests that the model include other eligible professionals whose services are deemed integral to the APM, including physical therapists. Our organization's goal is to foster advancements in physical therapist practice, research, and education. The mission of APTA is to further the profession's role in the prevention, diagnosis, and treatment of movement dysfunctions and the enhancement of the physical health and functional abilities of members of the public.

The physical therapy model of practice as delineated in the *Guide to Physical Therapist Practice* is patient-centered, incorporating patients' needs and goals across a continuum of care. Physical therapists serve an important role in patient safety and patient care transitions, and can help reduce readmissions by providing recommendations for the most appropriate level of care to the health care team prior to and during care transitions. They also integrate essential elements of evaluation and management with a patient-centered focus based on the best available evidence to optimize outcomes. Physical therapists provide various interventions with the goals of improving muscle performance, activity, and participation, and promoting physical activity to avoid subsequent impairments, activity limitations, and/or participation restrictions.

While APTA is a vested partner with the Department of Health and Human Services (HHS) in the objective of tying Medicare payment to quality (rather than quantity) through APMs, we are dismayed that participation of rehabilitation providers such as physical therapists are severely underrepresented in these initiatives. We strongly believe that the success of APMs in improving the quality of care and decreasing costs depends on the collective efforts of all health care

providers throughout the health care spectrum, including physical therapists, home health agencies, rehabilitation agencies, inpatient rehabilitation facilities, SNFs, and other provider types. The true potential to reduce costs and improve the health of individuals and populations will not be fully realized until HHS takes meaningful steps to include physical therapists and other rehabilitation providers within APMs.

HHS, including the Centers for Medicare and Medicaid Services (CMS) and PTAC, is leading the federal government's transition from fee-for-service to value-based care. Given the influence of PTAC on the development of future Medicare and Medicaid payment models, we encourage the committee to consider the benefits and clinical value that physical therapists, among other provider types, can bring to current and future APMs. To truly accelerate the adoption and use of Medicare and Medicaid APMs, HHS, as well as CMS and PTAC, must undertake a stronger effort to promote payment models that are accessible to all providers, including physical therapists. Therefore, we strongly recommend that PTAC use its influence to encourage the development of APMs that incorporate providers who do not currently have access to an APM, including physical therapists, occupational therapists, and speech-language pathologists.

Avera's Proposal

Avera has proposed an APM that is designed to benefit SNF patients directly by increasing physician engagement and enhancing access to providers when care is necessary. The APM strives to achieve the triple aim of health care by preventing avoidable escalation of illness for residents. This is accomplished by providing for 24/7 access to a geriatrician-led care team through telemedicine, the delivery of geriatric care management and management of care transitions, and the mentoring and training of long-term care staff to improve early identification of resident change in health status. The APM is based on evidence-based care management practices delivered by a geriatric multidisciplinary team—the Geriatric Care Team. The Geriatric Care Team is led by a geriatrician and comprises multiple clinical disciplines in order to *more effectively manage the whole health of the patient*. This includes gerontology-trained or certified advanced care practice providers, pharmacists, social workers, nurses, and behavioral health practitioners. The model is intended to serve all types of residents.

The following comments focus on the narrow composition of the Geriatric Care Team. We thank PTAC for its consideration of APTA's feedback on the proposed SNF APM.

APTA Recommendations

While APTA appreciates the overall intent of Avera's proposal and supports any model that is designed to proactively and holistically care for nursing facility residents, we believe the APM must be more inclusive of medically necessary services. For Avera's APM to truly deliver higher-value care and promote coordination and interdisciplinary teamwork, we strongly encourage that PTAC require Avera to modify its proposal to include a physical therapist on the Geriatric Care Team. As currently proposed, we believe the model will fail to truly accomplish its delineated goals, which include preventing unnecessary hospitalizations and improving the overall health of geriatric patients.

We acknowledge that the proposal indicates the Geriatric Care Team may extend to other specialty care areas. However, if Avera's goal is to enhance the effective care management of a patient, it would be judicious to include a physical therapist on the team. At a minimum, Avera should demonstrate that the APM has the appropriate referral relationships in place to give SNF residents access to physical therapy services to ensure patients achieve the highest level of function as their conditions will allow.

Geriatric Care Team Must Include a Physical Therapist

To expand upon the confines of the initial screening of each patient upon admission, we recommend that a physical therapist be included within the SNF APM's care team. Although the model is designed to enhance health care quality and decrease beneficiary cost of care through earlier intervention and proactive care management, the model does a disservice to SNF residents by excluding physical therapists from the Geriatric Care Team. Physical therapists assess patients individually to determine the risk factors for falling, such as loss of mobility, loss of balance, weakness, incoordination, ambulation problems, home environment dangers, and decreased confidence. Physical therapists also create specialized programs to address those risks and then guide the person through the program. Additionally, they work to promote, maintain, and restore physical function within a patient's neuromuscular, musculoskeletal, integumentary, and cardiopulmonary systems.

The rationale behind the proposed composition of the Geriatric Care Team is unclear, given that the outcome and quality metrics mirror the Nursing Home Compare and Value-Based Purchasing programs, and the monitored measures include the percentage of short-stay residents who made improvements in *function*; percentage of short-stay residents who were successfully *discharged to the community*; and percentage of short-stay residents who self-report moderate to severe *pain*.

Physical Therapists are Essential to Monitoring and Improving Patient Function

As shown in the clinical vignette below, physical therapists who serve on a SNF care team can identify interventions that will improve patient mobility and promote patients' safe return to the home. We urge PTAC to consider this example as demonstrative of the value that physical therapists could add to the care team in the proposed SNF APM.

After a 70-year-old patient is admitted to a SNF with pain and limited mobility, she is identified to be at risk for falls. After furnishing a physical therapy evaluation, the therapist develops a plan of care to help the patient meet her goals to return home, based on the patient's social and medical history, current level of physical function, and aspects of the patient's home that may present further risks to the patient. The plan of care includes physical interventions that can improve the patient's reduced body functions to increase activity and physical impairments for a safe return to the home. After seeing the patient daily for 2 weeks, the therapists teaches the patient how to perform an exercise program to decrease pain, build strength, and improve endurance. The physical therapist also works with the SNF team to identify a plan to promote integumentary healing and safe mobility to see that the patient is able to return home.

Physical Therapists Provide Chronic Pain Management

Physical therapists play an important role in managing acute or chronic pain by administering treatments that include strengthening and flexibility exercises, manual therapy, posture awareness, and body mechanics instruction. Physical therapists offer an alternative to opioids and other pharmacologics for long-term pain management by helping patients improve their function and range of motion, while also helping patients learn to understand the underlying causes of their pain. We appreciate that the model includes a pharmacist who can review medication lists for polypharmacy and appropriateness; however, excluding therapy professionals from the care team effectively serves to reinforce the idea that only pharmaceutical options are available for the treatment of pain, which will continue to encourage the over-utilization of opioids to treat pain. Physical therapists are uniquely qualified to recommend treatments for pain that are not prescription-based.

Physical Therapy Leads to Improved Function for Patients with Cognitive Impairments

Physical therapists also have significant responsibility in caring for patients with cognitive impairments, developing and implementing comprehensive therapy programs for this population. Dementia or cognitive impairments are highly prevalent within SNF residents, and these conditions often denote a patient's need for the continuous delivery of physical therapy to maintain mobility or function. Frequently, patients with any type or level (mild to severe) of cognitive impairment require therapy interventions throughout the day. Physical therapists also are often involved with care management and critical decision-making with the patient's family/caregivers about the most appropriate "next level of care" for patients with cognitive impairments. Including a physical therapist on the Geriatric Care Team will help ensure that patients receive the care they need at the right time in the right setting, and that they are empowered to stay in the community after discharge.

Physical Therapy Services are Effectively Furnished via Telehealth

APTA supports telerehabilitation as a means to reduce spending, improve health and wellbeing, and enhance communication between patients and their providers.

The SNF APM proposal indicates that telehealth is key to the model's success, as it allows the Geriatric Care Team to serve beneficiaries in many communities while enhancing patient experience and improving the efficiency of the delivery of care. The benefits of telehealth services furnished by therapy professionals has been recognized by both the US Department of Veterans Affairs (VA) and Indian Health Service (IHS). In fact, these 2 agencies recently launched a telehealth program to expand access for American Indian and Alaska Native veterans. The program allows eligible veterans at IHS facilities to be seen and treated by physicians at VA medical centers through the use of technology, including videoconferencing and remote monitoring of vital signs.¹ The VA also uses telerehabilitation to enhance continuity and

¹ To learn more, visit: <https://www.ihs.gov/newsroom/ihs-blog/november2016/indian-health-service-launches-telehealth-program-to-expand-health-care-access-for-native-veterans/>.

coordination of care to help patients transition back to their local communities after being discharged from Department of Defense medical facilities or polytrauma rehabilitation centers.²

Many states permit therapy providers to furnish telehealth services, and they do so safely and effectively. In the SNF setting, telehealth therapy services may make the difference in preventing falls, functional decline, costly emergency room visits, and hospital admissions or readmissions, particularly in rural and underserved areas. We believe that allowing each SNF resident within the APM to have 24/7 access to a physical therapist can potentially have a dramatic impact on improving care and reducing negative consequences and costs of care.

Conclusion

APTA encourages the Administration to more strongly incentivize the inclusion of a broader set of practitioners within APMs such as the proposed SNF APM. In summary, while this model is a well-intentioned effort to improve the health of SNF residents, APTA strongly believes that the inclusion of additional practitioners on the Geriatric Care Team, including physical therapists and other therapy professionals, will lead to improvements in care and patient experience, as well as a decline in health care costs, thereby achieving the triple aim. To better enhance the SNF APM's efforts to deliver high-quality, timely, cost-effective care to residents, we encourage PTAC to recommend that the SNF APM be modified to include additional health care professionals whose services are integral to the success of this APM.

We thank PTAC for the opportunity to comment on the proposed Intensive Care Management in SNF APM. Should you have any questions regarding our comments, please contact Kara Gainer, Director of Regulatory Affairs, at karagainer@apta.org or 703/706-8547.

Thank you for your consideration.

Sincerely,



Sharon L. Dunn PT, PhD
Board-Certified Orthopaedic Clinical Specialist
President

SLD: krg

² To learn more, visit: <https://www.polytrauma.va.gov/Telerehabilitation.asp>



2550 University Avenue West
Suite 350 South
St. Paul, MN 55114-1900

Submitted by Electronic Mail to PTAC@hhs.gov

October 5, 2017

Physician-Focused Payment Model Technical Advisory Committee
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Ave. SW, Washington, DC 20201

Re: Public Comment - Intensive Care Management in Skilled Nursing Facility
Alternative Payment Model

Dear Committee Members:

On behalf of LeadingAge Minnesota, I am writing to express support for the Intensive Care Management in Skilled Nursing Facility Alternative Payment Model proposed by Avera Health. Together with their dedicated employees, LeadingAge Minnesota members serve older adults in all the places they call home, including more than 200 skilled nursing facilities across our state.

Like the successful Avera eLong Term Care program on which it is based, this proactive model supports many important goals, including:

- Increasing access to specialized geriatric expertise, both for residents and facility staff;
- Reducing avoidable emergency department visits and hospitalizations;
- Achieving successful transitions of care;
- Alignment with existing quality measures; and
- Leveraging telemedicine and other health information technology to extend system capacity and enhance care coordination.

Transformation and innovation of care delivery, including the payment and regulatory policies that support it, is a priority for LeadingAge Minnesota, and we believe the Avera model will further the goals of high-quality, person-centered and cost-effective care for the elderly.

Sincerely,

A handwritten signature in black ink, appearing to read "Jonathan W. Lips, J.D.", written in a cursive style.

Jonathan W. Lips, J.D.
Vice President of Legal and Regulatory Affairs

October 5, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Public Comment – Intensive Care Management Skilled Nursing Facility Alternative Payment Model

Dear PTAC Committee:

I am writing to express my support for the Intensive Care Management Skilled Nursing Facility Alternative Payment Model proposed by Avera Health Senior Care eLongTermCare (eLTC). The eLTC program, upon which the payment model is based, has demonstrated that it reduces healthcare costs while improving quality of care for residents in the acute care and long term care setting. As a previous administrator in a rural location with eLTC, I saw first hand how this program increased access to healthcare while improving the wellbeing of residents without having to leave the facility.

The Intensive Care Management Skilled Nursing Facility Alternative Payment Model, if approved by this committee and CMS, will provide a payment mechanism for organizations implementing a telehealth-based, geriatrician-led care team approach to care for the elderly. The model utilizes two-way audio/visual telehealth technology to connect a limited number of geriatricians to a larger population of elderly patients in various settings and locations. The real time access allows these geriatricians access to the resident's medical record, facility nursing staff, and the resident all at the same time to ensure all the information is obtained to provide the care that will provide the best outcome for the resident.

In addition to improving care for elderly residents in both urban and rural settings, the payment model will improve staff satisfaction and workforce development in acute care and long term care setting. The access to physicians 24/7 under this program will help prevent hospitalizations as eLTC supports the nursing staff through acute situations verses sending the resident to the ER, especially, during the night time hours. The eLTC program has also helped the recruitment of staff, as nurses now have a physician that can support them visually 24/7 through acute care situations.

Thank you for your consideration of this model. Feel free to contact me with any further questions.

Respectfully Submitted,



Philip Samuelson, Regional Vice President – South Dakota
The Evangelical Lutheran Good Samaritan Society
psamuels@good-sam.com



AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

Submitted via email to PTAC@HHS.gov

October 6, 2017

Physician-Focused Payment Model Technical
Advisory Committee (PTAC)
c/o U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation,
Office of Health Policy
200 Independence Avenue, SW
Washington, DC 20201

RE: Intensive Care Management in Skilled Nursing Facility Alternative Payment Model

Dear Committee Members:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) on Avera Health's Intensive Care Management in Skilled Nursing Facility (SNF) Alternative Payment Model (APM) proposal. Our comments are specifically related to the following areas:

- Geriatric Care Team;
- Quality Metrics; and
- Restricted Telehealth Reimbursement.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 191,500 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.

Geriatric Care Team

The goal of the Intensive Care Management Physician-Focused APM is to prevent unnecessary emergency department visits and avoidable hospitalizations for Medicare long-term care residents by:

- providing 24/7 access to a geriatrician-led care team through telehealth;
- delivering care management and management of care transitions; and
- mentoring and training long-term care staff to improve early identification of resident change in health status.

The Geriatric Care Team will supplement existing services at the long-term care facility (e.g., SNF) as a wraparound service. Residents will continue to see their attending, primary care provider and be cared for by their nursing facility staff, but will have around the clock access to the Geriatric Care Team who will be able to respond to episodic, emergent issues, and off-hour events.

According to the proposal, the Geriatric Care Team should consist of multiple clinical disciplines in order to effectively manage the whole health of the patient. **ASHA agrees with this**

approach, but is surprised that the proposal does not specifically include rehabilitative therapy services, such as speech-language pathology, as integral to this model given the importance of swallowing assessment and treatment for this patient population. We offer the following scenario to illustrate our point:

A patient is admitted on a Saturday morning to a SNF on a regular diet and thin liquids. Nursing staff quickly notice that the patient is coughing a lot on his lunch and would like a speech-language pathology evaluation to determine the safest diet/liquid consistency. Unfortunately, most SNFs do not have speech-language pathologists on call on weekends. In this scenario, having a speech-language pathologist available via telepractice for this consult would expedite services for the patient and enhance quality of care.

ASHA requests that Avera Health clarify the projected length (i.e., start and end date) of the Intensive Care Management Physician-Focused APM. While we understand that this model will serve as a wraparound service, we seek further clarification about whether ongoing care for residents will run in perpetuity or have a defined end date. Finally, adoption of this model by nursing facility staff is a key determinant of its success. Therefore, ASHA suggests that this model include detailed strategies and measurement for extensive nursing facility staff engagement and participation. For example, at a minimum, ongoing, timely and effective coordination, communication and information sharing between the Geriatric Care Team and nursing facility staff are necessary to prevent gaps in care management and transitions.

Quality Metrics

Avera Health is proposing that the Geriatric Care Team's performance be evaluated, in part, on their ability to monitor patient outcomes on 13 quality measures. Of the 13 quality measures, roughly 1/3 address functional outcomes. **It is unclear how this model can adequately measure functional outcomes if therapy providers are not included in the Geriatric Care Team.** In addition, many SNF patients have a functional deficit; therefore, failure to include therapy services is a major disservice to these patients.

None of the proposed quality measures evaluate services related to cognition that are provided by speech-language pathologists. At a minimum, a cognition assessment should include problem-solving, memory, and attention. The Care-C Tool includes these items. We have provided the specific items in Appendix A for PTAC's reference. To ensure items associated with cognitive function are only completed when necessary based on patient presentation, the Geriatric Care Team should consider using a screening tool, such as the Montreal Cognitive Assessment (MoCA) or a similar screening tool, to determine the need for these services. If the results of the screening tool indicate that the patient needs cognitive treatment, then the suggested items from the CARE-C would be completed. The CARE-C elements are appropriate outcome measures that meet the purpose of the Improving Medicare Post-Acute Care Transformation Act; they would provide an indication of treatment outcomes, which screeners or intake items do not.

We recognize that it is critically important to capture information on patients who have swallowing and altered diet needs, and items from the CARE-C can provide useful information

as a basis for capturing swallow information. An assessment should describe: 1) the patient's usual ability with swallowing regular food (solids and liquids swallowed safely without supervision and without modified food or liquid consistency); 2) modified food consistency/supervision (patient requires modified food or liquid consistency and/or needs supervision during eating for safety); and 3) tube/parental feeding.

Restricted Telehealth Reimbursement

ASHA requests that Medicare payment policies applied to physicians, such as telehealth services, also be extended to all therapy providers, including speech-language pathology, occupational therapy, and physical therapy. Currently, speech-language pathologists are not recognized as telehealth providers under Medicare. Waiver of the telehealth restrictions would allow comprehensive, coordinated care provided by speech-language pathologists when telehealth is the preferred option for the patient and clinician. Continually growing evidence for the effectiveness of telehealth services demonstrates the potential for Medicare beneficiaries to remotely access medically necessary services. In addition, 18 states and the District of Columbia have laws and regulations, definitions, or policies related to the use of telehealth for audiologists and speech-language pathologists.*

Speech-language pathologists have demonstrated the capability to provide effective care through telehealth technologies for more than a decade in various settings. Telehealth venues include medical centers, rehabilitation hospitals, community health centers, outpatient clinics, universities, clients'/patients' homes, and residential health care facilities. There are no inherent limits to where telehealth can be implemented as long as the services comply with national, state, institutional, and professional regulations and policies. Telehealth is being used in the assessment and treatment of a wide range of disorders, including articulation disorders, autism, dysarthria, fluency disorders, language and cognitive disorders, dysphagia, and voice disorders.

In closing, ASHA:

- believes that interprofessional practice is necessary to safely address the complex and emergent needs of long-term care residents.
- requests that the Intensive Care Management Physician-Focused APM, if approved, be revised to include rehabilitative services, including speech-language pathology.

Thank you for the opportunity to provide comments on Avera Health's Intensive Care Management in Skilled Nursing Facility Alternative Payment Model proposal. If you or your staff have any questions, please contact Daneen Grooms, MHSA, ASHA's director of health reform analysis and advocacy, at dgrooms@asha.org.

Sincerely,



Gail J. Richard, PhD, CCC-SLP
2017 ASHA President

Appendix A

ADMISSION – CARE C – SECTION III: Provider Information

III. Provider Information (cont.)					
H.5a Cognitive Status Answer only if you answered "Yes" to H.5 "Does the patient have any problems with memory, attention, problem solving, planning, organizing or judgment?" and if you have the skills, knowledge, or training, to provide a response; otherwise, leave this section blank.					
H.5b Please describe the patient's problems with: <ul style="list-style-type: none"> • Memory • Attention • Problem Solving • Planning • Organizing • Judgment 	<input type="checkbox"/> Mildly impaired: Demonstrates some difficulty with one or more of these cognitive abilities. <input type="checkbox"/> Moderately impaired: Demonstrates marked difficulty with one or more of these cognitive abilities. <input type="checkbox"/> Severely impaired: Demonstrates extreme difficulty with one or more of these cognitive abilities.				
H.6a Problem Solving Answer only if you answered "Yes" to H.6 "Does the patient have any problems with memory, attention, problem solving, planning, organizing or judgment?" and if you have the skills, knowledge, or training, to provide a response; otherwise, leave this section blank.					
The patient solves: Simple Problems: Following basic schedules; requesting assistance; using a call bell; identifying basic wants/needs; preparing a simple cold meal Complex problems: Working on a computer; managing personal, medical, and financial affairs; preparing a complex hot meal; grocery shopping; route finding and map reading		Simple Problems		Complex Problems	
		H.6b Without Assistance	H.6c With Assistance	H.6d Without Assistance	H.6e With Assistance
Never or Rarely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sometimes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Usually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Always	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Level of Assistance:</u> Without Assistance: Patient performance without cueing, assistive device, or other compensatory augmentative intervention With Assistance: Patient performance with cueing, assistive device, or other compensatory augmentative intervention					
<u>Frequency of problem solving:</u> Never or Rarely: Less than 20% of the time Sometimes: Between 20% and 49% of the time Usually: Between 50% and 79% of the time Always: At least 80% of the time					



A Passionate Voice for Compassionate Care

October 6, 2017

Physician-Focused Payment Model Technical Advisory Committee
Office of the Assistant Secretary for Planning and Evaluation
Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Attn: Angela Tejada at PTAC@hhs.gov

Re: Public Comment on Intensive Care Management in Skilled Nursing Facility Alternative Payment Model by Avera Health

Dear Committee Members:

On behalf of the Catholic Health Association of the United States (CHA), the national leadership organization of more than 2,000 Catholic health care systems, hospitals, long-term care facilities, sponsors, and related organizations, I am writing to express our strong support for the Intensive Care Management in Skilled Nursing Facility Alternative Payment Model proposal submitted by Avera Health.

The proposal is based upon Avera's innovative eLong Term Care program, which was the recipient of a Centers for Medicare and Medicaid Innovation Health Care Innovation Award Round 2 (HCIA2) grant in 2014 and resulted in both improved quality of care and reduced costs.

Our nation is grappling with how to provide the best care for frail elders with multiple complex conditions in a cost-effective way. We need to develop new solutions for addressing the challenges of caring for residents in long-term care. Ensuring nursing home residents have ready access to timely geriatric care can protect and enhance their health status and avoid unnecessary utilization of health care resources. The Intensive Care Management in Skilled Nursing Facility Alternative Payment Model offers a way forward for providers and patients across the country.

In the proposed model, a multidisciplinary geriatric specialist team led by a board-certified geriatrician uses two-way telemedicine technology to work alongside primary care physicians and facility staff members. Around-the-clock access to geriatric care management and care-transition management will improve care for medically complex elderly nursing facility residents and prevent avoidable health deterioration, complications and hospital admissions. Addressing

Physician-Focused Payment Model Technical Advisory Committee
October 6, 2017
Page 2 of 2

potential health issues early on in the post-acute setting will yield savings for Medicare through the avoidance of unnecessary hospital admissions and readmissions and through the improved health status of beneficiaries.

The model includes financial incentives to improve outcomes and quality and to reduce the total cost of care. Future payments are conditioned upon meeting quality goals based on NQF-endorsed measures and CMS metrics using existing Medicare quality measurement programs. The proposed model can be used in urban or rural settings and gives patients the right to opt out at any time.

Thank you for your consideration of the Intensive Care Management in Skilled Nursing Facility Alternative Payment Model proposed by Avera Health. I urge you to submit to the Secretary a positive recommendation to make this model available to our nation's most vulnerable elderly and those who care for them.

Sincerely,

A handwritten signature in cursive script that reads "Sr. Carol Keehan". The signature is written in black ink and is positioned above the typed name and title.

Sr. Carol Keehan, DC
President and CEO

Submitted electronically via PTAC@hhs.gov

October 6, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dr. David Basel
Vice President of Clinical Quality
212 East 1 1st Street, Suite 412
Sioux Falls, SD 57104

Re: Intensive Care Management in Skilled Nursing Facility Alternative Payment Model

Dear Committee Members:

The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 213,000 occupational therapists, occupational therapy assistants, and students of occupational therapy. The science-driven, evidence-based practice of occupational therapy enables people of all ages to live life to its fullest by promoting participation in daily occupations or activities. In so doing, growth, development and overall functional abilities are enhanced and the effects associated with illness, injuries, and disability, are minimized. We appreciate the opportunity to provide feedback on the Intensive Care Management in Skilled Nursing Facility Alternative Payment Model (hereinafter “the Model”) proposal for PTAC. AOTA appreciates and supports the benefits associated with APMs that are intended to more efficiently and more effectively address the challenges affecting nursing home residents regarding accessing timely and quality care.

I. Composition of the Geriatric Care Team

The Model proposes that it is aimed at addressing 1) limited access to timely physician care for high-risk residents; 2) shortage of geriatricians to meet the medical needs of growing population of elderly Americans; and skill gaps in the capabilities of nursing home staff to address the increasing acuity of residents. Despite the fact that skilled therapists are trained to fill in these needed gaps, the proposal for the Model appears to exclusively omit any of the therapy services (OT, PT, or SLP) provided in SNFs, from the geriatric care team. Occupational therapists should be a recognized provider in the “Geriatric Care Team” as the services that occupational therapists provide can facilitate the care team in reaching the Model’s overarching goal of preventing avoidable escalation of illness for residents; resulting in better quality, better patient experience, and lower costs.

In addition to the primary geriatrician the proposal notes that the “Geriatric Care Team” *should*, but is not required to “consist of multiple clinical disciplines in order to more effectively manage the whole health of the patient. The proposal includes coordination with behavioral health specialists, social workers, and pharmacists and *may* extend to other specialty care areas as needed.” AOTA would request clarification from Avera Health on whether this is intended to keep the model flexible in terms of patient choice and providers who are included in the Model and additionally whether this Model’s focus is outside the scope of the standard rehabilitation that occurs in a SNF since, the proposal appears to explicitly omit any mention of the therapy practitioners who are regularly included as part of an interdisciplinary team in a SNF, and additionally reimbursed by Medicare, namely an occupational therapist, physical therapist, and speech-language pathologist.

II. Geriatric Care Management Services

AOTA would like to strongly emphasize the role of occupational therapy practitioners and encourage the use of their services in the Model as they are clinically trained to provide many of the geriatric care management services listed in this proposal to high risk patients.

- Medication Management in Coordination with the PCP

Occupational therapists consider the physical, cognitive, and psychosocial issues related to performance and function, which are critical areas affecting the ability to manage medication routines. Occupational therapists play an important role in improving patient safety by enhancing medication management. Medication non-adherence, especially in patients with chronic conditions, results in higher hospitalization rates, poorer outcomes, and dramatically increased health care costs. In fact, studies have shown that between 50-70% of older adults fail to take medications according to physician instructions – resulting in an estimated 3 million older adults being admitted to skilled nursing facilities each year and causing as many as 125,000 deaths annually.¹

Medication management is different from medication reconciliation and reviewing medications to eliminate duplications and contraindications. As leading experts in the development of habit and routines, occupational therapy practitioners play a pivotal role in helping patients develop medication management routines based on their desired activities. Working with occupational therapy practitioners to establish daily routines aimed at significantly improving medication compliance have proven to increase overall health and functional status, decrease risk of falls, improve cognition, and increase driver safety for older adults.²

Studies in this area indicate that medication habits need to be individually developed to promote realistic integration into existing life routines. This finding is consistent with client-centered

¹ Wertheimer, A., & Santella, T. (2003). Medication compliance research: Still so far to go. *Journal of Applied Research*, 3, 1–9.

² Classen, S., Mann, W., Wu, S., & Tomita, M. R. (2004). Relationship of number of medications to functional status, health, and quality of life for the frail home-based older adult. *OTJR: Occupation, Participation and Health*, 24, 151–160; Lococo, K. H., & Staplin, L. (2006). Literature review of polypharmacy and older drivers: Identifying strategies to collect drug usage and driving functioning among older drivers (Grant DTNH22-02-D-85121). Washington, DC: National Highway Traffic Safety Administration.

practice. Evidence also strongly suggests that patients need and would significantly benefit from skilled intervention, whether it is assisting in developing cues, arranging for equipment, assessing the environment, or arranging for monthly refills. These findings substantiate occupational therapy practitioners' role in developing specific, individualized, concrete plans for integrating medications into daily routines, thus increasing the patient's odds of adherence exponentially. Addressing medication habits and routines is especially important to prepare patients for the home setting, where they may be more independent than they would be in an institutional setting.

- Behavioral Health Support, Including Addressing Medications, Behaviors, and Crises

Occupational therapy practitioners address the psychological and social aspects of human performance as they influence health, well-being, and participation in occupations. Occupational therapy offers distinct contributions to mental health services by recognizing and emphasizing the complex interplay among client variables, activity demands, and the environment and context in which the participation takes place. Occupational therapy practitioners are skilled in analyzing, adapting, or modifying the task or environment to support goal attainment and optimal engagement in occupation so that clients can develop and maintain healthy ways of living. Occupational therapy practitioners collaborate with clients to determine what is currently important and meaningful and what he or she wants or needs to do. Together, they identify factors that may be barriers or supports to healthy participation in desired and necessary daily occupations (AOTA Official Statement: Mental Health Promotion, Prevention, and Intervention in Occupational Therapy Practice).

- Cognitive Function and Mental Status Assessment

Despite the omission of this critical element of a patient's health from this particular proposal, AOTA has long had a strong interest in cognitive function, and the profession of occupational therapy has a core responsibility for evaluating and treating patients with cognitive impairments as they relate to their ability to succeed at life tasks. Even mild impairments in cognition can significantly affect a person's ability to function and perform daily life activities and thus must be evaluated and addressed if PAC quality is to be achieved.

Cognition refers to information-processing functions carried out by the brain that include, attention, memory, executive functions (i.e., planning, problem solving, self-monitoring, self-awareness) and a range of other abilities. Rather than attempt to isolate specific cognitive functions, occupational therapy practitioners administer assessments and provide interventions that focus on functional cognition as it relates to the performance and successful completion of everyday life activities. Attention to these issues relate directly to achievement of optimum health and success of the SNF stay in preparing the patient for next levels of care and life.

- Transitional Care Follow-up with Patients after SNF/NF Discharge within 72 Hours

AOTA supports the recognized importance of transitional care follow-up as a major function of the Geriatric Care Team, but emphasizes that an occupational therapist must be included in order to perform a thorough discharge assessment in order to plan for the patient's next transition. The

patient-centered focus of the care plan and discharge planning processes is part of the foundation of occupational therapy and how occupational therapists assess, treat, and consider discharge and transitions as part of the assessment of a patient's functional, psychosocial and cognitive status on an ongoing basis. AOTA strongly supports the involvement of the patient in determining his/her goal(s) of care and discharge planning, as well as taking into account realistic caregiver support after discharge.

We believe that the intentional involvement of occupational therapy in transition planning would result in more appropriate and informed choices that meet the patient's needs.

III. Potentially Avoidable Hospitalizations and Proposed Quality Metrics

A key concern raised in this proposal centers around the patient's access to appropriate care. The quality measures proposed by this model are an indication that value is placed on measuring the outcomes of occupational therapy and other therapeutic services. This is clearly indicated by the fact that the Model identifies key quality measures for monitoring, that relate directly to the care that therapy professional provide, however the Model does not include therapy professionals to provide care to the identified high risk SNF patients. By allowing other professions who are included in the Model to "monitor" therapy-centric quality measures, and get reimbursed for submitting these measures, this APM diminishes the unique contribution and distinct services of each of the therapy professions.

The use of occupational therapy is important to assuring the Model can meet the quality metrics set forth. Occupational therapy practitioners can meet patients' needs relating to falls prevention, activities of daily living (ADLs), such as self-care, and instrumental activities of daily living (IADLs). Research has shown that patients' unmet ADL needs result in hospital readmissions³, thus, we are concerned that such a payment approach will limit access to occupational therapy services and the patient's ability to have their ADL/IADL needs met before discharge. In addition, hospital readmissions (for example, those due to falls), would have significant implications for quality payment. Therapy is a critical part of patient care in SNFs, particularly in relation to key quality measures set forth under this APM, and it must be appropriately provided to those who would benefit from therapy to improve or maintain optimal function.

IV. Areas Requiring Additional Clarification

AOTA applauds Avera Health in bringing forth this proposal as a means of addressing some of the challenges associated with nursing home patients and potentially avoidable hospitalizations in hospitals. With that being said, we found there were some areas that Avera Health could provide further information and/or clarification, specifically:

- Whether standard therapy services (occupational therapy, physical therapy and speech-language pathology) that occur in a SNF fall outside of this model?

³ Rogers, A. T., Bai, G., Lavin, R. A., & Anderson, G. F. (2016, September 2). Higher hospital spending on occupational therapy is associated with lower readmission rates. *Medical Care Research and Review*, 1–19. <https://doi.org/10.1177/1077558716666981>

- Whether there is flexibility to include other professionals in the Geriatric Care Team, and is that only to the extent of the geriatrician's discretion?
- Is the Medicare payment the same regardless of whether the patient is in a Part A stay or Part B stay (long-stay resident)?
- Does the payment change if the patient is private pay but eligible for Medicare?
- Does the payment change if the patient is only receiving Medicaid?

* * *

Thank you for the opportunity to comment on the Intensive Care Management in Skilled Nursing Facility Alternative Payment Model proposal for PTAC. AOTA looks forward to a continuing dialogue with CMS and external health care entities on APMs that are intended to more efficiently and more effectively address the challenges affecting nursing home residents regarding accessing timely and quality care.

Sincerely,

A handwritten signature in black ink, appearing to read "Ashley Delosh". The signature is written in a cursive, flowing style.

Ashley Delosh, JD
Regulatory Analyst

Public Comment - Intensive Care Management in Skilled Nursing Facility Alternative Payment Model

Monday, October 09, 2017
2:16 PM

Subject	Public Comment - Intensive Care Management in Skilled Nursing Facility Alternative Payment Model
From	Brechtelsbauer, David
To	PTAC (OS/ASPE)
Sent	Friday, October 06, 2017 11:36 PM

I am a recently retired family physician & geriatrician and faculty member at the Sanford School of Medicine at the University of South Dakota. This comment is in support of the proposal by Avera Health, [Intensive Care Management in Skilled Nursing Facility Alternative Payment Model](#). The focus of my practice and teaching since becoming certified in Geriatric Medicine in 1986 has been geriatrics. A particular area of interest has been post-acute and long-term care medicine.

I have had the opportunity to work with Avera's e-LTC geriatrician-led interdisciplinary care team while it was supported by the CMMI grant. I have interacted in the capacity of nursing home medical director, and as faculty supervisor for family medicine resident physicians and geriatric medicine fellows when they have been caring for residents in post-acute and long-term care venues. I have also had the opportunity to sit in with providers as they participated in telemedicine visits and have been involved in the training of e-LTC team members.

I strongly endorse this program and would urge thoughtful consideration of the proposed payment model. The easy access to e-LTC is valued by nursing facilities and is reassuring to post-acute patients and long-term care residents. Nursing home staff feel supported and every visit provides the opportunity for relevant staff development in addition to timely and quality patient/resident care. The outcomes described in the proposal speak for themselves.

Sincerely,

D. A. Brechtelsbauer MD, CMD
Emeritus Faculty – Sioux Falls Family Medicine Residency
Associate Professor, Sanford School of Medicine University of South Dakota
Past President, AMDA – The Society of Post-Acute and Long-Term Care Medicine

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Comments on the application of Avera Health titled "Intensive Care Management in Skilled Nursing Facility Alternative Payment Model"

Monday, October 09, 2017
2:21 PM

Subject	Comments on the application of Avera Health titled "Intensive Care Management in Skilled Nursing Facility Alternative Payment Model"
From	Sandvik, David
To	PTAC (OS/ASPE)
Sent	Friday, October 06, 2017 11:58 PM

I fully support the application of Avera Health with the above title. As a practicing geriatrician for over 26 years and a general internist for another nine years, I understand the difficulties of obtaining excellent patient outcomes in nursing home practice. I and collaborators published evidence that accurate communication during patient transfers from the hospital to skilled nursing home resulted in the lowest patient rehospitalization rates published at the time. As a fellow in the Geriatrics Fellowship of the University of South Dakota Sanford School of Medicine, under my Program Directorship, Dr. Oluma Bushen, the geriatrician responsible for the design of the Avera Health demonstration grant concentrated on the transfer information available for new admissions to skilled care and other nursing home units, thereby decreasing readmission rates. In rural both rural and urban nursing homes in South Dakota, patient transfers from hospitals to skilled nursing home units might occur on a Friday evening, at times missing vital information such as medication lists, hospitalization summaries, even dietary orders. Transferring physicians and primary care physicians were often unavailable until Monday morning and nursing home staff were at a loss as to necessary care to provide the patient in the interval. The availability of a geriatric care team 24/7 can provide support for patient care at those difficult moments.

The same lack of care direction often occurs at other intervals in nursing home care, such as during nighttime hours when the easiest solution for a nursing home attending primary care physician is the order to send a nursing home patient to the emergency room for evaluation. Evaluation of options from that point on shows minimal alternatives to patient hospitalization with transport back to the nursing home often unavailable during nighttime hours. Preventive care in the nursing home often could prevent these transfers and hospital admissions as shown by the data outlined in this application.

Finally, the change in nursing home culture shown in the demonstration project is invaluable. The changes are part of nursing home Medical Direction activities. But expertise in medical direction is difficult to find outside of geriatricians and certified medical directors under AMDA, the Society of Post-Acute and Long-Term Care, particularly in rural areas.

So, the proposal listed above has the effects of facilitating nursing home admissions, particularly those from hospitals, both for skilled short-stay and long-term care residents; appropriate in-facility care of patients with medical or social conditions which might evolve into avoidable hospitalizations; and improvement of overall facility care in areas of medical direction. All these activities lead to fewer avoidable hospitalizations and emergency room visits and significant financial savings to the Medicare system. This is a unique intervention leading to improved quality of care and should be reimbursed.

David Sandvik, MD, MACP, CMD

Professor Emeritus
University of South Dakota Sanford School of Medicine

Sandvik D, Bade P. A hospital-to-nursing home transfer process associated with low hospital readmission rates while targeting quality of care, patient safety, and convenience: a 20-year perspective. *J Am Med Dir Assoc* 2013;14:367-374.

Congress of the United States
Washington, DC 20515

October 6, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Members of the Physician-Focused Payment Model Technical Advisory Committee:

Avera Health provides access to high-quality, comprehensive health care services in our home state of South Dakota, as well as Minnesota, Iowa, Nebraska, and North Dakota. With a footprint of 72,000 square miles spanning 86 counties, Avera continues to innovate and further improve health care access for all South Dakotans through its focus on quality, outcomes, and advancements in technology.

We understand that Avera Health has submitted a proposal under your consideration for its Intensive Care Management Skilled Nursing Facility Alternative Payment Model. Avera has shared that this proposal is based off of its eLong Term Care Program funded by a Center for Medicare and Medicaid Innovation grant. As you assess the merits of this model, we respectfully ask that you give Avera's application full and fair consideration.

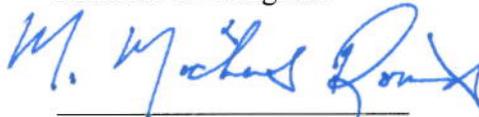
Sincerely,



JOHN THUNE
United States Senator



KRISTI NOEM
Member of Congress



M. MICHAEL ROUNDS
United States Senator



3708 W. Brooks Place • Sioux Falls, SD 57106 • (605) 361-2281

October 4, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Letter of Support for Intensive Care Management Skilled Nursing Facility Alternative Payment Model Proposed by Avera Health Senior Care eLong Term Care (eLTC)

Dear PTAC Committee:

On behalf of the South Dakota Association of Healthcare Organizations, this letter is to express support for the Intensive Care Management Skilled Nursing Facility Alternative Payment Model proposed by Avera Health Senior Care eLongTermCare (eLTC). The eLTC program, upon which the payment model is based, has demonstrated that it reduces healthcare costs while improving quality of care for residents in the acute care and long term care setting.

The Intensive Care Management Skilled Nursing Facility Alternative Payment Model, if approved by this committee and CMS, will provide a payment mechanism for organizations implementing a telehealth-based, geriatrician-led care team approach to care for the elderly. The model utilizes two-way audio/visual telehealth technology to connect a limited number of geriatricians to a larger population of elderly patients in various settings and locations.

In addition to improving care for elderly residents in both urban and rural settings, the payment model will improve staff satisfaction and workforce development in acute care and long term care setting.

Thank you for your consideration of this model.

Sincerely,

A handwritten signature in black ink, appearing to read 'S.A. Duke'.

Scott A. Duke
President/CEO