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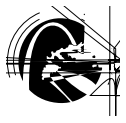
Medicare Annual Wellness Visit: An Underutilized Tool for Healthcare Providers of Older Adults

The population is aging at an exponential rate. Older adults are vulnerable to suffer from multimorbidity and iatrogenesis at higher rates than younger adults. Geriatric providers have specialized training to evaluate and treat geriatric syndromes that can help prevent or amelior
disability, and functional decline. However, there is a growing shortage of healthcare practitioners with an expertise in geriatric care. It is, therefore, important to train other primary care providers to identify early signs of decline and implement strategies to help older adults to age successfully. One strategy is

(continued on page 4)

Congratulations to the physicians in the Department of



lose the revenue for that visit. If it has been established that the visit is a follow-up, the scheduler will need to ascertain if the G0439 code has already been used by another provider within the last 12 months[2].

When the patient has been scheduled for a MAWV, it is recommended that a standardized packet be mailed to the patient with information on what to expect at the MAWV and forms that the patient can complete in advance to save time LQWKHRIFH7KHODWWHU may be partidtla d t048 (a)7.5 (t)-12.9 (i)1 T*[<004C>-14.9 <00510003>-11 .6 (t t)-3.4p03>-11 .6 (0[<004C>-14.9 < be p

1. Vital signs sitting and standing
2. Height, weight, BMI, waist circumference
3. Evaluation of functional status
4. Safety screen
5. Cognitive evaluation
6. Evaluation of mood

The Saint Louis University

ning discussions are an optional part of the MAWV. You MAY bill for CPT codes 99497 and 99498 BUT deductibles and Co-insurance fees must be waived.[6] Some providers and clinics choose to have the patient return for a second advanced care planning visit.

At the MAWV, a FOCUSED exam is performed only as necessary. A physical exam is not a required component of the visit. It is critical that patients understand the purpose of the MAWV in advance of the appointment. The goal is not to manage acute or chronic medical conditions. If a patient wishes to have an acute medical problem addressed, it needs to be clearly explained that this portion of the encounter will be billed separately and the patient may be responsible for co-

There are many similarities between the lifespan of humans and airplanes. Beginning with the design of the airplane followed by its manufacture which mimics the creation of a human from a genetic blue print, followed by their growth. In general, human beings live longer than airplanes – 80 years to about 35 years. However, part of the new composite designs are looking to extend air-IUDPHORQJHYLWDQGWKHPDQLFHWRHQ B52 bombers have been in service for HDUVDQGDUHH[SHFWHGWRÀRU another 25 years.

As in humans, evaluation and maintenance of an airplane is key to its longevity. In airplanes most evaluation of the fuselage is done by non-distractive testing. This includes visual, liquid penetrant, magnetic, ultrasonic, Eddy current and radiographic techniques. These techniques are looking for cracks in the fuselage ZKLFKQHHGWREHÀHGHDUO\

This was a lesson learnt early when 3 of the de Haviland comet jet liners in 1953 and 1954 broke up in the air shortly after takeoff – these incidents became known as the story of the ill-fated comets that crashed like EEDOORÀHDQGZLQJOHVVKHVHLQ cidents lead to a major overhaul of jet aircraft design and also maintenance (equivalent to preventive medicine in humans).

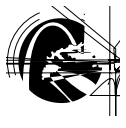
Overall aircraft stress, which leads to metal fatigue and cracks occurs predominantly at take-off and landing. Modern airplanes are built to tolerate 47,500 to 110,000 of these cycles. Aluminum, the most lightweight, malleable metal, has been used to manufacture most airplanes. Recently, composites are being used to replace aluminum. Composites are VWURQJHU[LEOHKDQGOHWHQVLRQZHLJ allow single-piece designs and weigh less than aluminum. All of these are advantages for fuselage design and allow airplanes to carry more passengers.

The major reason for fatigue and cracks in the airplane fuselage is oxidative damage (corrosion). This is also a major reason by humans wear out with aging. In humans satellite cells repair the damage that occurs. In some cases, specialized cell systems, such as those in bone, strengthen and repair areas that are exposed to excess stress or are damaged. The osteocytes are mechanosensors that recognize when excess stress is applied to the bone. They also recognize cracks in the bone. The osteocytes can activate osteoclasts which clear damaged bone and osteoblasts that build new bone. Composite manufacturers are experimenting with ways for cracks in the fuselage to be automatically repaired as they occur. One method is for racks to cause release of epoxy resin and amidoamine which then mix to repair the crack. Microcapsules can release dicyclopentadiene to interact with a ruthenium catalyst as another method to repair cracks.

Problems Faced by Older Humans While Flying

A major problem faced by older SHUVRQV ZKHQ ÀQJ LV SXOPRQDU\ embolism. The decreased air pressure LQ WKH FDELQ ZKLOH ÀQJ LQFUHDV the chance of persons developing clots in their leg veins. Older persons often have sarcopenia (muscle loss) decreasing the ability of the muscles

Geriatric Workforce Enhancement



Hilliard Davis, and St. Louis County Health Department.

Advance Care Planning: Creating a Climate IRU&ULWLFDO6HOI5HÀ1FWLRQ

Advance care planning (ACP) for end-of-life care has a renewed public interest with the recent popularity of Atul Gawande's best-selling book on end-of-life care,[1] national debates surrounding current death with dignity legislation, and publicity surrounding The Conversation Project,[2] a movement which encourages everyone to have conversations about their end-of-life wishes. Beginning in January 2016, Medicare now reimburses physicians and RWKHU TXDOLÀHG KHDOWK FDUH SURYLGers for voluntary ACP sessions with patients and their families.[3] While these are encouraging signs that, as a culture, we are becoming more comfortable with conversations surrounding end-of-life care, in practice, many providers do not always talk to their patients about ACP, even when opportunities emerge in a clinical visit.[4] When communication does occur, the quality and content of these conversations varies.[5]

Though practitioners overwhelmingly agree on the importance of ACP and preparing for the end of life,[6] the process is fraught with both professco(l)-2.3.5 (t)-16.943s712.417 0 c 0.03s3i12.41p9 (n)0..5 (u)39ih12.4 t436.2 (l)-8. (p)3.3 (a)-4.4 (r)-32.5 (t)-16.9 (a)-11 b-167-22.5 (i)-15 (3)-15

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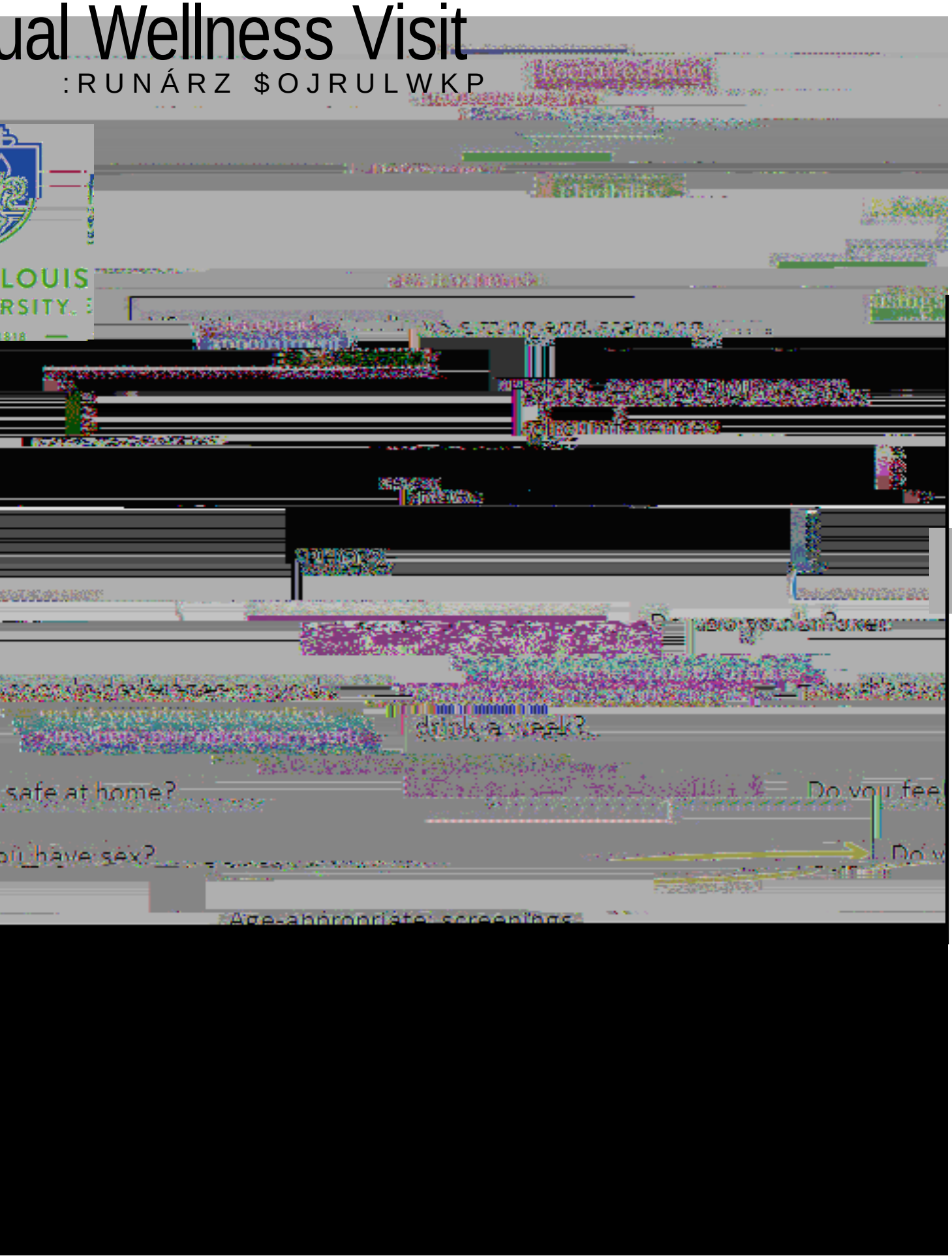


Through the collaborative efforts of multiple academic units and the Gateway Geriatric Education Center, approval was received in October 2016 to offer a new university-wide graduate certificate in interprofessional Gerontology (GIGC). Beginning in Fall 2017, this innovative opportunity will be available to Saint Louis University graduate students and community professionals. The GIGC is a formal academic

Jennifer Ohs, we are examining potential connections between:

1) practitioners' personal and professional history with loss;
2) their own completion of (and communication about) advance directives; and
3) attitudes and current practices surrounding ACP and referrals to hospice and palliative care.

Initial analysis of nearly 180 health care practitioners (physicians, nurse practitioners, RNs, social workers and others) demonstrates strong correlations between a person's history of loss (both professionally and personally), completion and communication about one's own directives, and his/her attitudes and practices in professional ACP. Our experiences are inexplicitly connected with how we practice.

Though many of us respectively received training on separating our beliefs, emotions, and experiences from professional practice, we have less understanding and practice with acknowledging the connections between them, or how to handle the inevitable impact of the personal on the professional. In a text examining emotional and countertransference responses in palliative and end-of-life care,[13] clinician Renee Katz posits the following:

LQÀXHQFHG E\ RXU SDWLHQWV DQG

LPSDFWHG DQG LQÀXHQFHG E\ XV

More than likely, each of us is concerned about assisting our patients with planning for their end-of-life care though many barriers remain. Perhaps the place to start is not just in having the conversations within our own lives, but also in exploring how our own experiences and emotions shape our practices and preferences, both personally and professionally. Maybe it is within this critical self-UHÀHFWLRQ ZKHUH ZH FDQ ¿QG P HDQ ingful connection to the stories of our patients, and perhaps then we can engage in more effective advance care planning for all of us.

References

1. Gawande, A. Being mortal: medicine and what matters in the end. New York: Macmillan Books; 2014.
2. The Conversation Project. In collaboration with the Institute for Healthcare Improvement. Retrieved from http://theconversationproject.org/; 2017.
3. Kaiser Family Foundation. 10 FAQs: Medicare's role in end-of-life care. Retrieved

Interprofessional Teamwork Improves Care for Older Adults

Students from Saint Louis University, Washington University, A.T. Still University, and Maryville University participated in the 2nd Interprofessional Case Competition. Teams wer

Navigating through the challenges of the healthcare system is a daunting task for any first time caregiver. Just
LQJWDVNIRUD\ UVWWLPHFDUHJLYHU-XVW
ask Stacey. As a daughter of a newly diagnosed mother (Judy) with dementia and tending to her recovery from shoulder surgery, Stacey's life became complicated quickly, all while having her only child leaving for college soon. Throughout the initial appointments with her mother's primary care physician, Stacey was offered little support, services, or resources. When a social worker was brought into one of these appointments, Stacey wanted the professional to hear her concerns about the future of the caregiving process. Instead, the social worker provided psychoeducation-focused information to the family about what signs and symptoms to look for in dementia during the following months. Judy was later referred to a geriatrician from a different clinic. This provider wanted Judy on a higher dose of Aricept, but never communicated this information to her primary care doctor or medical team. Stacey was not only confused as to the direction of her mother's care, but had no information that can help manage her life as both a daughter and caregiver.

Stacey is not an outlier in the struggles that dementia caregivers endure. Dementia caregivers are often
VHHQDV WKH KLGGHQ SDWLHQWV LQRXU
healthcare system, as 8.9 <00480003> 781(h)8.9-h <0056n8-13 (h0a8.98.9 <29.4 <0T0 1 Tf0)7.4510003>-1294510
simn(a)-713 (g)-10 (i)16d (c)3.5 (a)1.1 (s p)3 (r)4.9-3ogleave)C(Sm)@I–I!AuqD'Udñ–šREi'§ZV%£C796GB§Q)–' .@I)Q

that families should speak with

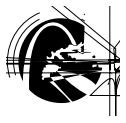
WHAT YOU CAN DO TO SLOW AGING

Human beings tend to peak in their function at 30 years and then decline in every function at th
of ½ to 1% per year. Thus, preventing aging starts at a young age. While the pearls of aging su
fully described here are aimed at persons 60 and older, most of them are equally valid at all ag

WHAT YOU CAN DO TO SLOW AGING

Individual Cognitive Stimulation Therapy: A Personalized Dementia Treatment

The number of individuals devel-



UCL team created iCST with the intention of making a difference in the lives of people with dementia and their caregivers. Seeking to not only improve cognitive abilities but also quality of life, iCST was also intended to recognize value and personhood and reduce the long periods of inactivity often common for individuals with dementia.

iCST Key features

iCST has various key features that distinguish it from group CST as well as other non-pharmacological interventions. Most distinctively, iCST is delivered one-on-one with the same facilitator and participant as a means of cognitive stimulation and relationship building. iCST is appropriate for individuals with dementia whose caregivers wish to deepen their relationship, ‹ • † ‹ ˜ ‹ † — ƒ Ž • ™ Š ‘ • ƒ › „ ‡ • ‡ Ð ‹ – ˆ ” ‘ • one-on-one attention, and persons who do not wish to participate

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