Virginia Long-Term Care Clinician Network Monthly Forum

February 15, 2023

Disclosures

The speakers and presenters for today have no relevant financial conflicts of interest.

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VDH VLIPP Projects

Virginia Long-Term Care Infrastructure Pilot Project (VLIPP) funding will be utilized in nursing homes and long-term care facilities to assist with the ongoing COVID-19 response and to bolster preparedness for emerging infections. The projects are based on identified needs that align with funding objectives

VLIPP Stakeholders:

- Carilion Clinic
- Eastern Virginia Medical School (EVMS)
- Health Quality Innovators (HQI)
- LeadingAge Virginia
- University of Virginia (UVA)
- Virginia Commonwealth University (VCU)
- Virginia Department of Social Services (VDSS)
- Virginia Health Care Association-Virginia Center for Assisted Living (VHCA-VCAL)

https://www.vdh.virginia.gov/haiar/virginia-long-term-care-infrastructure-pilot-projects-vlipp/

Introducing the Network - Share w/ Peers

About the Network: The Virginia Long-Term Care Clinician Network (LTC-CN) brings together medical directors and clinicians practicing in nursing homes, assisted living facilities, and other congregate care settings, such as Program of All-inclusive Care for the Elderly (PACE).

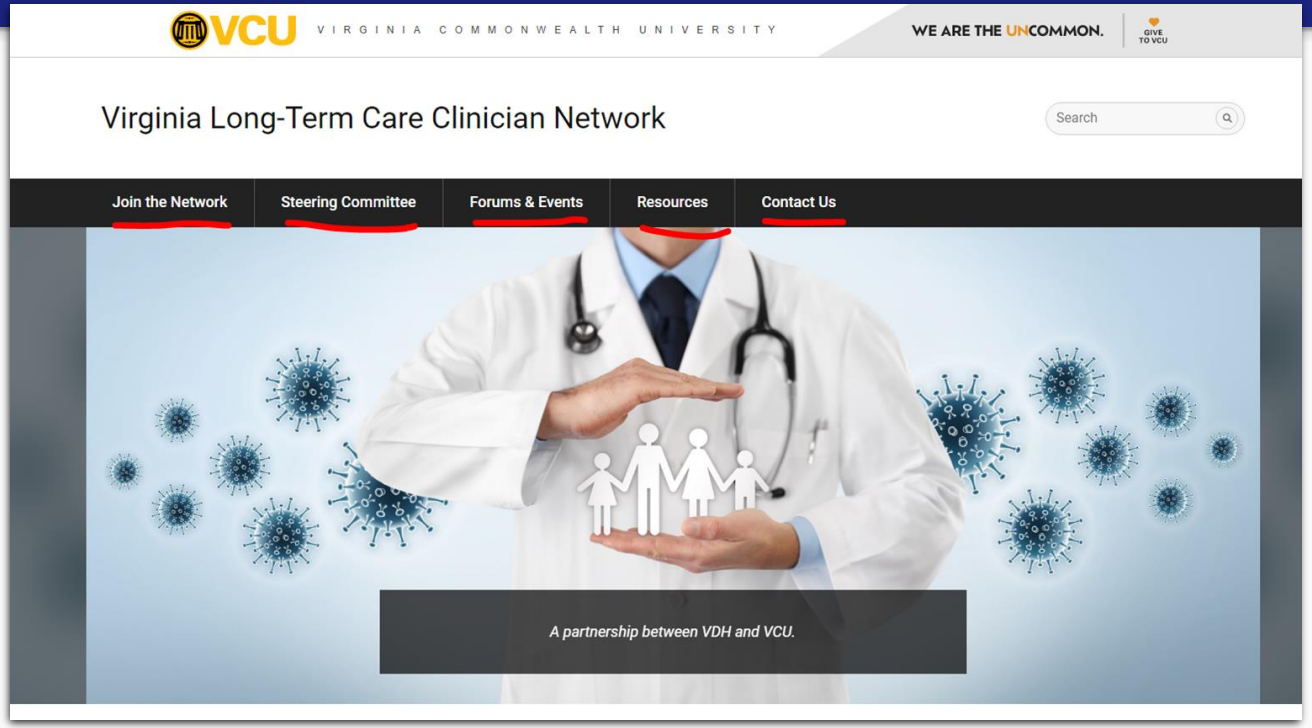
Member Benefits:

- Free peer network fostering open discussion and collaboration
- Monthly newsletter
- Monthly forum (third Wednesday of each month from 4:00-5:00 pm)

Where to find us?

https://ltccn.vcu.edu/

SCAN ME



Who are we?

- Christian Bergman, MD - Principal Investigator
- Bert Waters, PhD - Project Director
- Laura Finch, MS, GNP, RN - Clinical Coordinator
- Kim Ivey, MS - Communications / Administration
- Jenni Mathews - Survey Data & Evaluations Specialist
- Kristin MacDonald, MS, RD - Newsletter & Content Editor

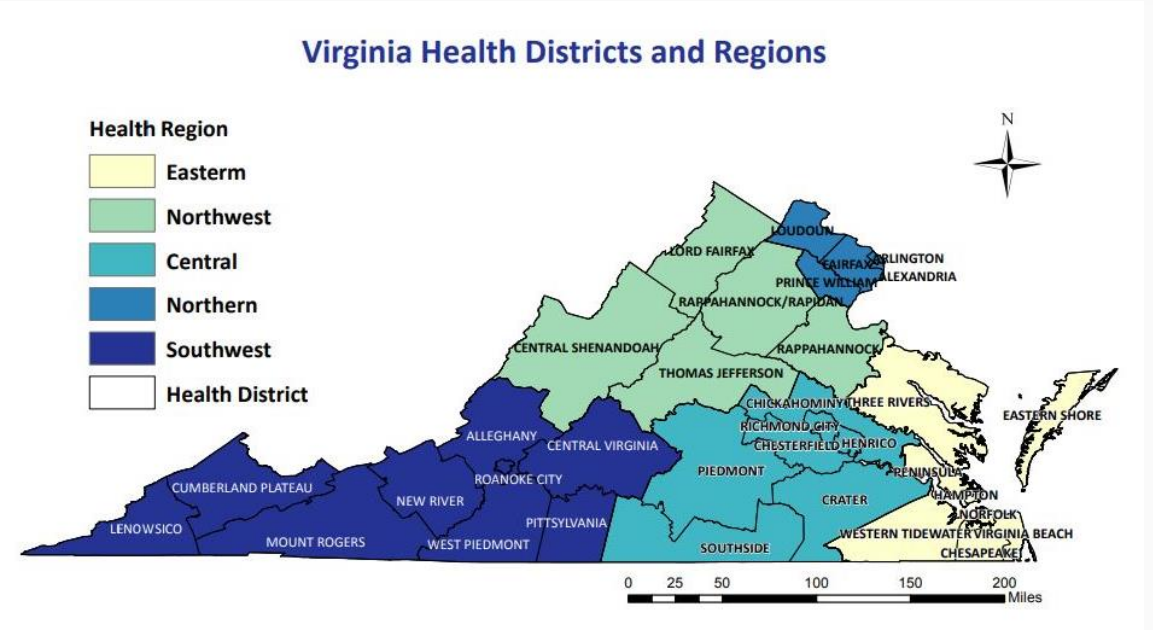
Who are you?

Please use the Chat box to share:

- **Name**
- **Role**
- **Location in Virginia (city or region)**

Steering Committee Structure

- 2 representatives (MD, NP/PA) from each of the Virginia Health Planning Regions
- Monthly meetings to provide guidance to project



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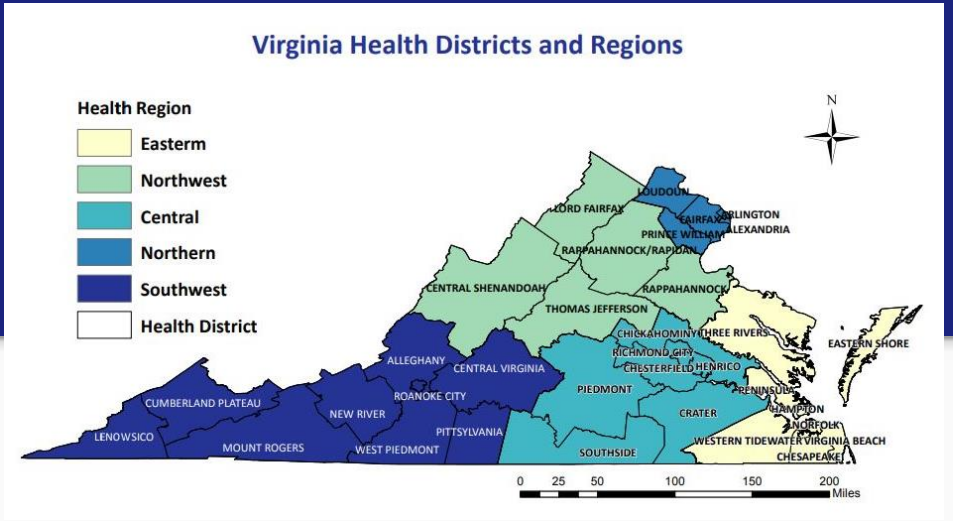
Steering Committee



Eastern Region: Rob Walters, MD & Mary Mallory, NP

Northwestern Region: Jonathan Winter, MD

Central Region: William Reed, MD & Tangela Crawley-Hardy, NP

Southwest Region: Katherine Coffey-Vega, MD & Jamie Smith, NP

Northern Region: Noelle Pierson, NP

Statewide: Shawlawn Freeman-Hicks, NP

Monthly Forum - Every 3rd Wednesday, 4-5 PM

A 60-minute Zoom session to connect with long-term care clinicians around the state. We will continue to integrate COVID-19 topics in our discussion, but will also expand the topics and encourage robust discussions around other areas of interest pertinent to long-term care such as:

- Infection Control Practices (enhanced barrier precautions, etc.)
- Clinical topics (falls, antipsychotic use, antibiotic stewardship, etc.)
- Vaccinations (influenza, pneumonia, COVID-19, shingles)
- State and Federal Legislative Updates
- Advance Care Planning and Capacity Determination
- QAPI and sample PIP charters

Monthly Forum Structure, 60 min

Introduction - 2 minutes

Updates - 5 minutes

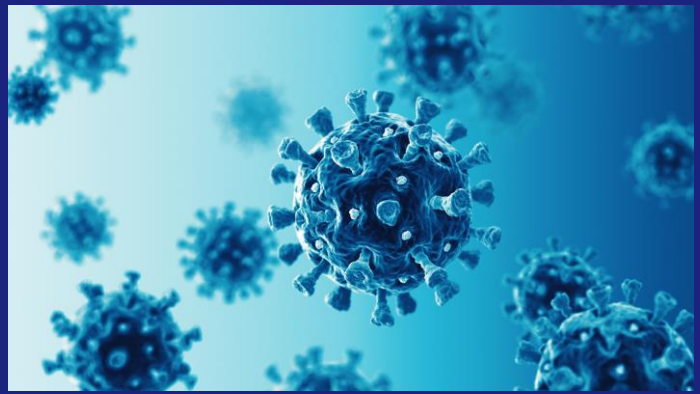
Featured Monthly Topic - 15-20 minutes

Open Discussion - 15-20 minutes

Feedback - 5 minutes

Updates

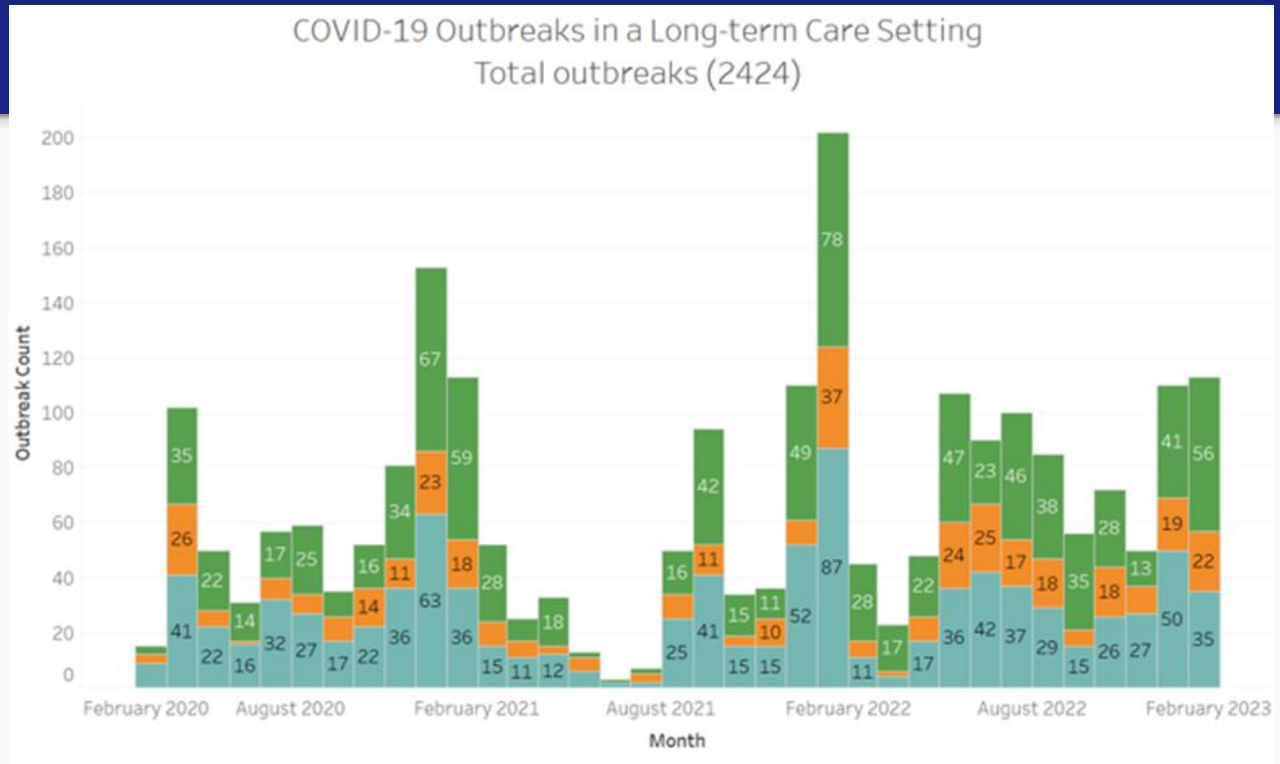
COVID-19:
Data, Treatment, Vaccines



Data

January 2023
reported outbreaks:

- 35 from NHs
- 56 from ALs
- 22 from MultiCare



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Data

Current state of COVID-19 in Virginia - for the week ending 02/11/2023:

- 1382 new hospital admissions
- 4 deaths
- Both represent a 4-week downward trend

Virginia Department of Health (VDH) COVID-19 Dashboards

VDH Dashboard Snapshot

COVID-Like Illness (CLI)

The percentage of all emergency department (ED) and urgent care (UC) visits, that are for COVID-like symptoms, can signal how much COVID-19 there is in a community.

13.0 percent of ED/UC visits were CLI in the week ending 02/11/2023

9.7% points lower than the previous week ending 02/04/2023

4 week trend in CLI

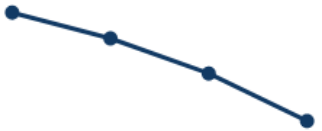
Cases by Date of Illness

While many cases are no longer reported due to at-home testing, the overall trends of reported cases can still be valuable.

6,205 cases in the week ending 2/11/2023

7,915 cases in the week ending 2/04/2023

4 week trend in Cases



VDH Dashboard Snapshot

COVID-19-Associated Hospital Admissions

COVID-19 hospital admissions indicate the severity of disease in the community and the impact on the health care system.

1,382 new hospital admissions in the week ending 02/11/2023

4% points lower than the previous week ending 02/04/2023

4 week trend in Hospital Admissions

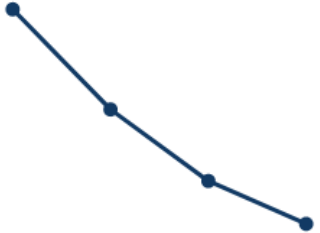
COVID-19-Associated Deaths

Trends in reported deaths help us to understand the severity of COVID-19 and its impact on the community. Death data is subject to delays. Learn more from the *How does VDH Count COVID-19 Associated Deaths?* blog post.

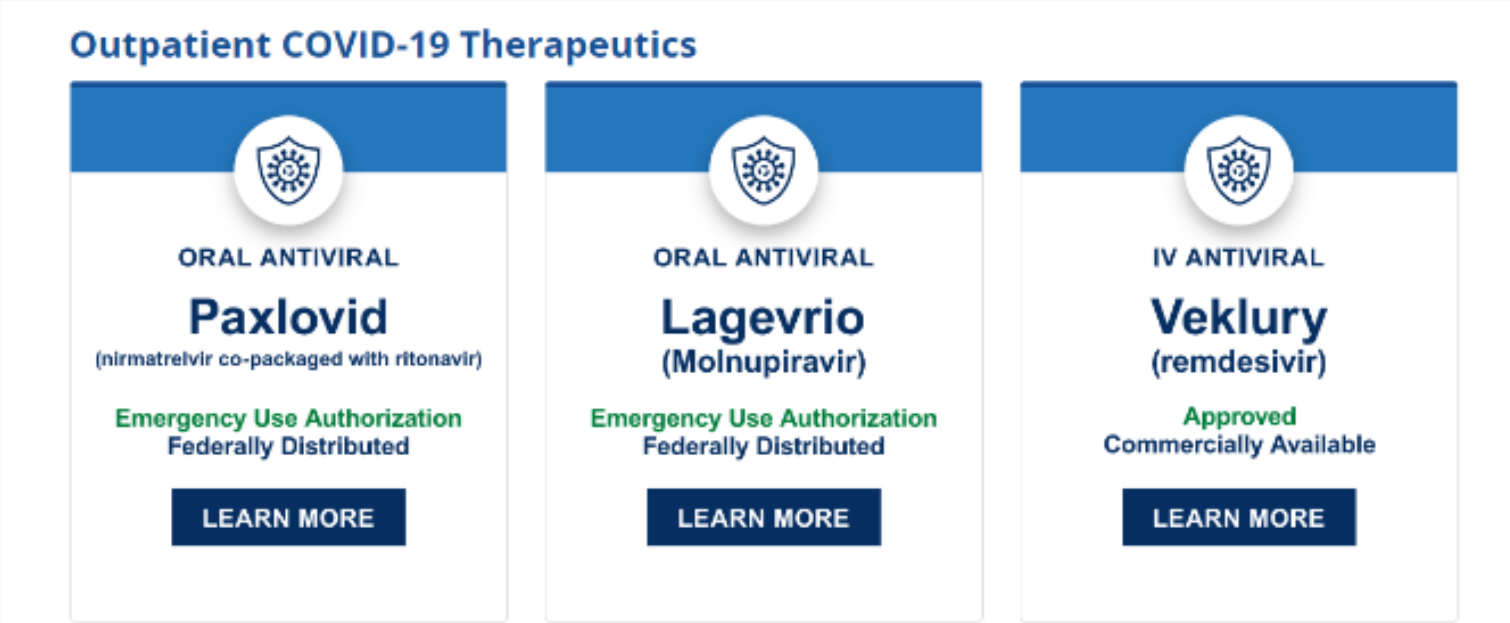
4 deaths in the week ending 2/11/2023

7 deaths in the week ending 2/04/2023

4 week trend in Deaths



Current Therapeutics



ASPR - COVID-19 Treatments: Key Messages for Long-Term Care Facilities

Bivalent Booster

- CDC reports bivalent booster found to be effective against latest variants
- Recommended for adults: one bivalent mRNA booster dose two months after any primary series or previous monovalent boosters
- COVID-19 vaccine safety signal for persons aged 65+:
    - Current data suggests ischemic stroke after receiving Pfizer COVID-19 Bivalent Vaccine is very unlikely to be a true clinical risk

***Read more COVID-19 updates in our first edition of the LTC-CN newsletter!**

Featured Monthly Topic:

2023 AMA CPT Coding Changes

Monthly topic - AMA CPT codes

AMA Coding Changes Overview

Time-based Billing

History, Review of Systems, Physical Exam

Medical Decision Making (MDM) Review

Case Studies with Discussion

Guiding Principles: E/M Workgroup & CPT® Editorial Panel

The CPT/RUC Workgroup on E/M expanded the scope of their work to include the other E/M families of services to reduce the burden of having two separate sets of E/M Guidelines in the CPT code set.

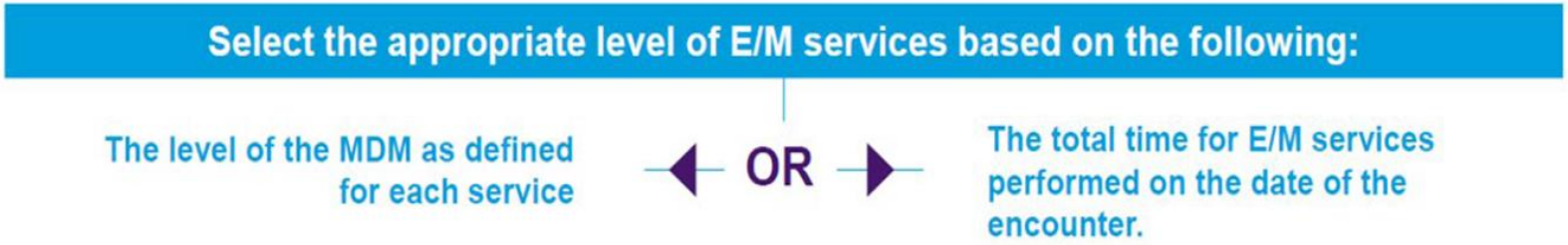
The Workgroup continued their work by following their existing **guiding principles** related to the group's ongoing work product:

- To decrease administrative burden of documentation and coding, and align CPT and CMS whenever possible
- To decrease the need for audits
- To decrease unnecessary documentation in the medical record that is not needed for patient care
- To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties

From 8/9/2022 Webinar, Prestesater L, Levy, B, Hollmann P. "E/M 2023: Advancing Landmark Revisions Across More Settings of Care," downloaded on 10/2/2022 from https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management

Revision of the Remaining E&M Services

- Nursing Facility Services
- Home and Residence Services
- Hospital Inpatient and Observation Services



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AMA CPT 2023 E&M Tables

Initial Nursing Facility Care

Patient: New or Established			
Code	**99304**	**99305**	**99306**
REQUIRED ELEMENTS			
Medically Appropriate History and/or Examination	X	X	X
Medical Decision Making Level			
Straightforward or Low	X		
Moderate		X	
High			X
OR			
Total Time (On Date of the Encounter)			
Minutes	25	35	45

Subsequent Nursing Facility Care

Patient: New or Established				
Code	**99307**	**99308**	**99309**	**99310**
REQUIRED ELEMENTS				
Medically Appropriate History and/or Examination	X	X	X	X
Medical Decision Making Level				
Straightforward	X			
Low		X		
Moderate			X	
High				X
OR				
Total Time (On Date of the Encounter)				
Minutes	10	15	30	45

Of note: The E&M Table is property of the AMA CPT 2023 Manual

Role of History/Exam

Of note, the “nature and extent of the history and/or physical examination are determined by the treating physician…”

Not an element in selection of the level of E/M code

Think about medical-legal risk in documentation.

Billing based on Time

Time is “total time on the date of the encounter”

Includes F2F and non-F2F

Includes: preparing to see patient, obtaining/reviewing separately obtained history (waiting room ipad), perform exam, counseling / education, ordering meds/tests/procedures, referring/communicating with others, documentation, interpretation of results, care coordination)

Best practice (time in-out and list of what was done)

Billing based on MDM

4 levels of MDM

- Straightforward, low, moderate, high

3 elements of MDM

- Number and Complexity of Problems
- Amount and/or Complexity of Data Reviewed and Analyzed
- Risk of Complications and/or Morbidity/Mortality of Patient Management

Medical Decision Making 2023 (must have 2 of 3 elements to bill at certain level)

Level of MDM	Problems/Complexity	Data review	Risk
Straightforward	Minimal	Min/None	Minimal
Low	Low	Limited	Low
Moderate	Moderate	Moderate	Moderate
High	High	Extensive	High

Table 1: Levels of Medical Decision Making (MDM)

	▶Elements of Medical Decision Making		
Level of MDM (Based on 2 out of 3 Elements of MDM)	**Number and Complexity of Problems Addressed at the Encounter**	**Amount and/or Complexity of Data to Be Reviewed and Analyzed** ***Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.***	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
Straightforward	**Minimal** ■ **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
Low	**Low** ■ **2** or more self-limited or minor problems; **or** ■ **1** stable, chronic illness; **or** ■ **1** acute, uncomplicated illness or injury; **or** ■ **1** stable, acute illness; **or** ■ **1** acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**Limited** *(Must meet the requirements of at least 1 out of 2 categories)* **Category 1: Tests and documents** ■ **Any combination of 2 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test* **or** **Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	**Low risk of morbidity from additional diagnostic testing or treatment**

Of note: Table 1 is property of the AMA CPT 2023 Manual

Moderate	**Moderate** ■ **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** ■ **2** or more stable, chronic illnesses; **or** ■ **1** undiagnosed new problem with uncertain prognosis; **or** ■ **1** acute illness with systemic symptoms; **or** ■ **1** acute, complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** ■ **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** ■ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** ■ Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* ■ Prescription drug management ■ Decision regarding minor surgery with identified patient or procedure risk factors ■ Decision regarding elective major surgery without identified patient or procedure risk factors ■ Diagnosis or treatment significantly limited by social determinants of health

Elements of Medical Decision Making

Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to Be Reviewed and Analyzed ***Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.***	Risk of Complications and/or Morbidity or Mortality of Patient Management
High	**High** ■ **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; **or** ■ **1** acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents or independent historian(s)** ■ **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** ■ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** ■ Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* ■ Drug therapy requiring intensive monitoring for toxicity ■ Decision regarding elective major surgery with identified patient or procedure risk factors ■ Decision regarding emergency major surgery ■ Decision regarding hospitalization or escalation of hospital-level care ■ Decision not to resuscitate or to de-escalate care because of poor prognosis ■ Parenteral controlled substances◀

Of note: Table 1 is property of the AMA CPT 2023 Manual

Definitions - Moderate Complexity

Please see full CPT Manual

Medical necessity - document in CC section.

Chronic illness with exacerbation, progression, or side effects of treatment: a chronic Illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attn to treatment for side effects.

Definitions - Moderate Complexity

Please see full CPT Manual

Acute illness with systemic symptoms: an illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as: fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms.

Definitions - High Complexity

Please see full CPT Manual

Chronic Illness with severe exacerbation, progression, or side effects of treatment: the SEVERE exacerbation or progression of a chronic illness or severe side effects of treatments that have significant risk of morbidity and may require escalation in level of care.

Definitions - High Complexity

Please see full CPT Manual

Acute or chronic illness or injury that poses a threat to life or bodily function: an acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment.

Definitions - High Risk

Please see full CPT Manual

Drug therapy requiring intensive monitoring for toxicity: does not include glucose levels during insulin therapy or annual electrolytes/renal function for someone on diuretic. **Would include:** BMP for AKI, accuchecks for suspected hypoglycemia

Case 1 - New admission

HPI: 72 year old female with a h/o progressive dementia, HTN, DM, and COPD who was hospitalized for 3 weeks due to a fall resulting in a left hip fracture. Now being admitted to SNF for PT/OT. Admitted yesterday. Has pain on movement of left hip.

PE: left hip dressing c/d/I, no signs of erythema or drainage, left hip ROM limited by pain, alert and oriented to self only, tells me she is in the hospital and that its Saturday (actual day is Monday).

AP: 1) Hip fracture, now s/p left hip ORIF, increasing pain, reviewed orders and hospital records, increase oxycodone from 2.5 q6 to q4. 2) Delirium superimposed on dementia, unstable, possibly related to hospitalization vs medications, unclear background, spoke to daughter on phone for 15 minutes, obtained background information regarding decreased functional status, usually more alert/oriented than currently, last labs were 4 days ago, will check CBC, BMP, 3) Hypertension, continue losartan 50, reviewed labs in hospital, possible AKI, will follow up on BMP, goal SBP < 140, currently BP 160, not controlled, possible exacerbated by pain. 4) Diabetes, stable, not currently on medications, 5) COPD, stable, on room air

Time: 35 minutes

Case 1 - New admission

HPI: 72 year old female with a h/o progressive dementia, HTN, DM, and COPD who was hospitalized for 3 weeks due to a fall resulting in a left hip fracture. Now being admitted to SNF for PT/OT. Admitted yesterday. Has pain on movement of left hip.

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Time: 35 minutes

POLL: How would you bill this?

Case 1 Discussion

Level of MDM (2/3)	Problems/Complexity	Data review	Risk
Straightforward	Minimal	Min/None	Minimal
Low	Low	Limited	Low
Moderate	Moderate	Moderate	Moderate
High	High	Extensive	High

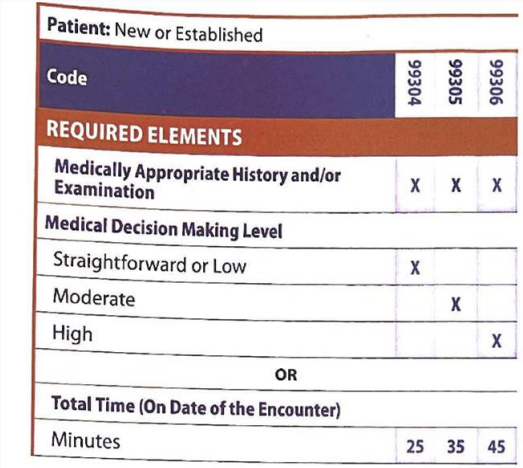
Time Based: 99305, 35 minutes

MDM Based: 99305 vs. 99306

- Problem: potentially Moderate/High due to “1 undiagnosed program with uncertain prognosis” vs. “1 acute or chronic illness that poses a threat to life/bodily function”

- Data: Moderate – reviewed prior hospital notes, labs, assessment of delirium requiring input from an independent historian (daughter)

- Risk: Moderate or High due to prescription drug monitoring and due to drug therapy requiring intensive monitoring for toxicity (oxycodone in setting of delirium), losartan in setting of possible AKI



Patient: New or Established			
Code	99304	99305	99306
REQUIRED ELEMENTS			
Medically Appropriate History and/or Examination	X	X	X
Medical Decision Making Level			
Straightforward or Low	X		
Moderate		X	
High			X
OR			
Total Time (On Date of the Encounter)			
Minutes	25	35	45

Case 2 - New admission

HPI: 87 year old male with a history of advanced CHF (EF 15%), HTN, DM, COPD who was hospitalized for 2 weeks due to acute heart failure exacerbation. Hospital course was complicated by delirium and a fall with a decline in physical strength. Daughter is present at beside and reports that this is his 6 hospitalization in the last year. His wife passed away 1.5 years ago and he has not been able to maintain his function at home, has been forgetting to take his medications. He is seen at bedside, currently oriented to self but appears withdrawn, answers in short one-two sentences.

PE: Alert, withdrawn, oriented to self only, mutters that he is in the hospital. +b/l LE edema, pitting, wearing NC oxygen, some basilar crackles but hard to hear as he does not want to sit up, abd soft, NT/ND, pulse regular.

A/P: 1) Acute on chronic CHF exacerbation, appears stable currently on Lasix 40 daily, ordered BMP for next week, 2) Depression, new problem, suspected depression after talking to daughter and evaluating patient, will need to obtain collateral history and review prior PCP records. 3) HTN, stable on lisinipril, metoprolol ,4) DM, not currently on insulin, used to be on metformin, ok to continue to hold for now, 5) COPD stable

Time: 50 minutes

Case 2 - New admission

HPI: 87 year old male with a history of advanced CHF (EF 15%), HTN, DM, COPD who was hospitalized for 2 weeks due to acute heart failure exacerbation. Hospital course was complicated by delirium and a fall with a decline in physical strength. Daughter is present at beside and reports that this is his 6 hospitalization in the last year. His wife passed away 1.5 years ago and he has not been able to maintain his function at home, has been forgetting to take his medications. He is seen at bedside, currently oriented to self but appears withdrawn, answers in short one-two sentences.

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Time: 50 minutes

POLL: How would you bill this?

Case 2 Discussion

Level of MDM (2/3)	Problems/Complexity	Data review	Risk
Straightforward	Minimal	Min/None	Minimal
Low	Low	Limited	Low
Moderate	Moderate	Moderate	Moderate
High	High	Extensive	High

Time Based: 99306, 50 minutes

MDM Based: 99305 vs. 99306

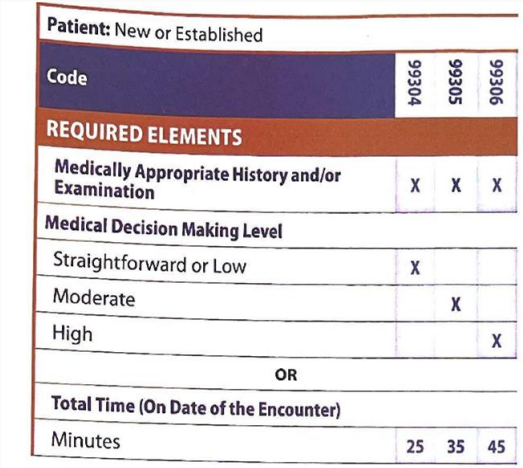
Time: Spent 5 minutes reviewing chart, 10 minutes examining patient, 25 minutes talking to daughter outside the room, and 10 minutes reviewing and updating orders. Total time: 50 minutes. **Review statement with compliance on what you need to specify.**

MDM Based: probably only 99305

- Problem: Moderate (1 or more chronic illness with exacerbation) and 1 undiagnosed new problem.

- Data: Moderate (reviewed notes from hospital, test results in hospital, and ordered a BMP). Did not independently interpret test or discuss management with another provider

- Risk: Moderate due to prescription drug management and treatment significantly limited by social determinants of health.



Patient: New or Established			
Code	99304	99305	99306
REQUIRED ELEMENTS			
Medically Appropriate History and/or Examination	X	X	X
Medical Decision Making Level			
Straightforward or Low	X		
Moderate		X	
High			X
OR			
Total Time (On Date of the Encounter)			
Minutes	25	35	45

Case 2 Discussion

Of note, if you had discussed goals of care and your conversation with the family was about decision not to escalate care, risk would be increased to High and if you believe that his CHF exacerbation is a chronic illness that poses a threat to life, problem could be increased to High which would yield a 99306. Alternatively, you can document by time as done here.

Case 3 - Follow Up

CC: knee pain

HPI: Has knee pain, been a chronic problem, but has flared up over the past week, resident states "it's because of the cold weather". Denies falls or injuries. States Tylenol alleviates the pain and wants it scheduled "for a few days".

PE: General: Alert, NAD Respiratory: Normal respiratory effort. Normal to auscultation. Cardiovascular: Irregularly irregular rhythm Gastrointestinal: Abdomen: Soft, nontender, and without masses. Bowel sounds active. Musculoskeletal: Bilateral knees are slightly swollen, has full ROM, no red or warm to the touch, arthritic in nature

A/P: M17.0: Arthritis of both knees Pain not controlled, caution use of PO NSAIDs given takes Eliquis (increased risk of bleeding) so have scheduled acetaminophen 650mg PO TID x10 days (has PRN in place, max dose of 3g/24 hrs).

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A/P: M17.0: Arthritis of both knees Pain not controlled, caution use of PO NSAIDs given takes Eliquis (increased risk of bleeding) so have scheduled acetaminophen 650mg PO TID x10 days (has PRN in place, max dose of 3g/24 hrs).

POLL: How would you bill this?

Case 3 Discussion

Level of MDM (2/3)	Problems/Complexity	Data review	Risk
Straightforward	Minimal	Min/None	Minimal
Low	Low	Limited	Low
Moderate	Moderate	Moderate	Moderate
High	High	Extensive	High

Time Based: not recorded

MDM Based: 99308

Using the elements of the MDM table, this would be a worsening osteoarthritis, which falls “one or more chronic illnesses with exacerbation, progression or side effect of treatment”, no labs, and under the risks “low risk of morbidity from additional dx testing or treatment” for ordering an OTC drug.

Patient: New or Established				
Code	99307	99308	99309	99310
REQUIRED ELEMENTS				
Medically Appropriate History and/or Examination	X	X	X	X
Medical Decision Making Level				
Straightforward	X			
Low		X		
Moderate			X	
High				X
OR				
Total Time (On Date of the Encounter)				
Minutes	10	15	30	45

Case 4 - Follow up

CC: shortness of breath, leg swelling

HPI: 72-year-old female, seen about a month ago by cardiology for chronic diastolic heart failure, afib, and hypertension. She has gained roughly 6 pounds in the past week, staff reported ongoing noncompliance with water restrictions, is already taking Lasix 40 mg twice daily, with 24 hours of progressive shortness of breathing and worsening lower extremity edema. Systolic BPs have been mostly >150 mmHg/30 days, patient states she likes to add salt to foods. Resident requesting to not go to the hospital, 02 saturation has dropped to 87% this morning, staff added 2LNC and is up to 92-93%.

PE: Sitting up in bed, anxious, Neck: Neck supple, Respiratory: Increased respiratory rate, bibasilar crackles, Cardiovascular: RRR, tachy, Edema/Varicosities of Extremities: Symmetric bipedal edema, Gastrointestinal: Abdomen: Soft, nontender, and without masses. Bowel sounds active. Judgment/insight: Appropriate. Alert and oriented x3/3

A/P: I50.31: Acute diastolic heart failure, Resident with severe progression of chronic disease, I10: Uncontrolled hypertension, At risk for end organ damage. Plan: I recommended transport to the ER however resident and family declined. I ordered 5 mg p.o. daily of Zaroxolyn x3 days, will add Aldactone 25mg PO daily (continue Lasix 40mg BID). BMP in the morning to evaluate electrolytes and renal function while on diuretics. I have discontinued the non-di CCB and increased the Lisinopril from 10mg to 20mg PO daily. Nursing staff plan to call cardiology team to make them aware of changes.

Case 4 - Follow up

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POLL: How would you bill this?

Case 4 Discussion

Level of MDM (2/3)	Problems/Complexity	Data review	Risk
Straightforward	Minimal	Min/None	Minimal
Low	Low	Limited	Low
Moderate	Moderate	Moderate	Moderate
High	High	Extensive	High

Time Based: not recorded

MDM Based: 99310

99310 Discussion: Using the MDM table, we would select “decision regarding hospitalization” and “chronic illness with severe exacerbation, progression, or side effect of treatment (1 or more)”. Even though the patient declined ER eval, the decision regarding this counts as much had the patient agreed.

Patient: New or Established				
Code	99307	99308	99309	99310
REQUIRED ELEMENTS				
Medically Appropriate History and/or Examination	X	X	X	X
Medical Decision Making Level				
Straightforward	X			
Low		X		
Moderate			X	
High				X
OR				
Total Time (On Date of the Encounter)				
Minutes	10	15	30	45

Open Forum Discussion

Open Forum Discussion

Waterfall Chat

Instructions: Type in your answer and wait for the countdown to push Enter.

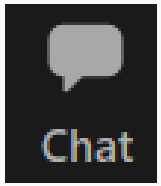
“What is the **number one** issue in Long Term Care right now?”

5, 4, 3, 2, 1…press Enter now!

Open Forum Discussion

Please use the **chat box** or **raise your hand**

if you have a specific topic you wish to discuss.



Thank you for joining the Network!

Next Newsletter - coming to you early March.

Next Monthly Forum - March 15th, 4pm. Scroll down in the Zoom registration confirmation email you received -for a calendar link you can use to update your calendar automatically with the Zoom link for future meetings.

On your way out of Zoom, kindly answer a 3-question feedback survey.

Stay in touch! Email questions and suggestions to ltccn@vcu.edu

Invite your colleagues! They can register at ltccn.vcu.edu