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Collaborative Healthcare Delivery

Long Term & Aged Care Environments

Objectives

- Review the opportunities for improved care for seniors and those with chronic complex/serious advanced illness.
- Identify strategies to provide care for those needing increased levels of care
- Educate regarding care requirements in different settings and approaches to reimbursement

What is the magnitude of this population?

www.cdc.gov/features/agingandhealth/state_of_aging_and_health_in_america_2013.pdf

- The growth in the number and proportion of older adults is unprecedented in the history of the United States.
- Two factors—
  - longer life spans
  - aging baby boomers
- The population of Americans aged 65 years or older will double during the next 25 years to about 72 million.
- By 2030, older adults will account for roughly 20% of the U.S. population.

Chronic Conditions

- During the past century, a major shift occurred in the leading causes of death for all age groups, including older adults,
  - from infectious diseases and acute illnesses to
  - chronic diseases and degenerative illnesses.
- More than a quarter of all Americans and two out of every three older Americans have multiple chronic conditions
- Treatment for this population accounts for 66% of the country's health care budget.

Chronic conditions

- More than 25% of Americans but 67% of older Americans have multiple chronic conditions.
- Treatment accounts for 66% of the health care budget.
- People with chronic disease may also have other health problems such as which make the situation worse!
  - Substance abuse
  - Mental illness
  - Dementia
  - Developmental disabilities

Mobility impairment

- Mobility is fundamental to everyday life and central to an understanding of health and well-being among older populations.
  - Impaired mobility is associated with a variety of adverse health outcomes
- By changing physical environments and creating unique integrated interventions across various disciplines, we can improve mobility for older adults.
- Transportation is a HUGE issue!!!!

How can we help these folks?

- Interdisciplinary team provides early detection of problems with early and effective interventions
- Functional assessments are used to assess risk
- Interdisciplinary team provides access to primary care, prevention and chronic disease management
- Comprehensive care addresses nonmedical contributors to hospital and ED use (food, safe housing, socialization and activities)

— Atul Gawande, *Being Mortal: Medicine and What Matters in the End*

- Several years ago, researchers at the University of Minnesota identified 568 men and women over the age of seventy who were living independently but were at high risk of becoming disabled because of chronic health problems, recent illness, or cognitive changes. With their permission, the researchers randomly assigned half of them to see a team of geriatric nurses and doctors—a team dedicated to the art and science of managing old age. The others were asked to see their usual physician, who was notified of their high-risk status. Within eighteen months, 10 percent of the patients in both groups had died. But the patients who had seen a geriatrics team were a quarter less likely to become disabled and half as likely to develop depression. They were 40 percent less likely to require home health services. These were stunning results. If scientists came up with a device—call it an automatic defrailer—that wouldn't extend your life but would slash the likelihood you'd end up in a nursing home or miserable with depression, we'd be clamoring for it. We wouldn't care if doctors had to open up your chest and plug the thing into your heart. We'd have pink-ribbon campaigns to get one for every person over seventy-five. Congress would be holding hearings demanding to know why forty-year-olds couldn't get them installed. Medical students would be jockeying to become defrailulation specialists, and Wall Street would be bidding up company stock prices. Instead, it was just geriatrics. The geriatric teams weren't doing lung biopsies or back surgery or insertion of automatic defrailers. What they did was to simplify medications. They saw that arthritis was controlled. They made sure toenails were trimmed and meals were square. They looked for worrisome signs of isolation and had a social worker check that the patient's home was safe. How do we reward this kind of work? Chad Boult, the geriatrician who was the lead investigator of the University of Minnesota study, can tell you. **A few months after he published the results, demonstrating how much better people's lives were with specialized geriatric care, the university closed the division of geriatrics."**

PACE-programs of all inclusive care for the elderly

- PACE (Programs of All-Inclusive Care for the Elderly) is a non-profit health and supportive services program designed to assist seniors who want an alternative to long-term care placement. The mission of PACE is to enable the aging population to live with dignity in their communities. With the PACE program's assistance, participants can remain in the secure surroundings of their own homes and communities while providing family members and caregivers with much needed professional guidance, physical relief and emotional support.
- PACE is sponsored by mostly nonprofit agencies, the Center for Medicaid and Medicare Services (CMS) and the state Department of Health and Hospitals (DHH).
- PACE Baton Rouge takes a team approach to care which revolves around its diverse, multi-skilled team members. Each participant is supervised by a doctor, nurse practitioner, registered nurse, social worker, physical therapist, occupational therapist, registered dietician and others who work together to develop an individual goal and care plan and carefully monitor progress.
- Services include the following:
  - adult day care that offers nursing; physical, occupational and recreational therapies; meals; nutritional counseling; social work and personal care;
  - medical care provided by a PACE physician familiar with the history, needs and preferences of each participant;
  - home health care and personal care;
  - all necessary prescription drugs;
  - social services;
  - medical specialties, such as audiology, dentistry, optometry, podiatry and speech therapy;
  - respite care; and hospital and nursing home care when necessary.
- If you are Medicaid eligible or have Medicare and Medicaid, there is no cost for PACE.
  - If you are eligible for Medicare only, there will be a fee involved.
  - Those without Medicare or Medicaid may pay privately for PACE.
  - PACE participants may be fully and personally liable for the costs of unauthorized or out-of-network services.
- If at any time you are permanently placed in a nursing home, you may be responsible for a portion of the cost of your care.
- There is a PACE program in Baton Rouge (FMOLHS), New Orleans (Catholic Charities) and approval for a program in Lafayette (FMOLHS).

Conclusions and Care Model Implications

- **ALL Medicare Beneficiaries**
  - Re-hospitalizations within 30 days
    - 19.6% among Medicare FFS beneficiaries
      - 22.9% among 65+ dual eligible beneficiaries
  - Potentially avoidable hospitalizations (PAH)
    - 50% of PAH due to 2 conditions: CHF & bacterial pneumonia
    - Account for
      - 1 in 5 Medicare hospitalizations
      - 2 in 5 hospitalizations among dual eligibles
  - Cost of PAH to Medicare ~$20.6 billion (CY2006) [AHRQ, HCUP Statistical Brief #72, 2009]
- **<u>Interdisciplinary</u>, <u>all-inclusive</u> care for frail elders in PACE can reduce:**
  - Hospitalizations by over 40%
  - Potentially avoidable hospitalizations by over 50% in PACE, compared to comparable frail elders receiving HCBS
  - ER rates relative to Nursing Homes; difficult to compare due to lack of benchmarks for duals at NH level of care

Serious advanced illness- not in order of prevalence

- Cancer
- Heart failure
- Lung failure (COPD/emphysema)
- Liver failure
- Kidney failure
- Brain failure which complicates all and is associated with highest risk of worsening prognosis
- Frailty----”dwindles”
- There is “always something we can do to care for you but we are not able to cure you”

Fast criteria vs. age

Relationship between Alzheimer's disease progression and child development 1984 Barry Reisberg
From Alzheimer's Association website "The Stages of Alzheimer's Disease"

12+ years	Hold a job	3 earliest symptoms of AD
8-12 years	Handle simple finances	4 mild AD
5-7 years	Select proper clothing	5 moderate AD
5 years	Put on clothes unaided	6 moderately severe AD
4 years	Shower unaided	6
4 years	Toilet unaided	6
3-4.5 years	Control urine	6
2-3 years	Control bowels	6
15 months	Speak 5-6 words	7 severe AD
12 months	Speak 1 word	7
12 months	Walk	7
6-10 months	Sit up	7
2-4 months	Smile	7
1-3 months	Hold head up	7

Where are the patients needing more help?

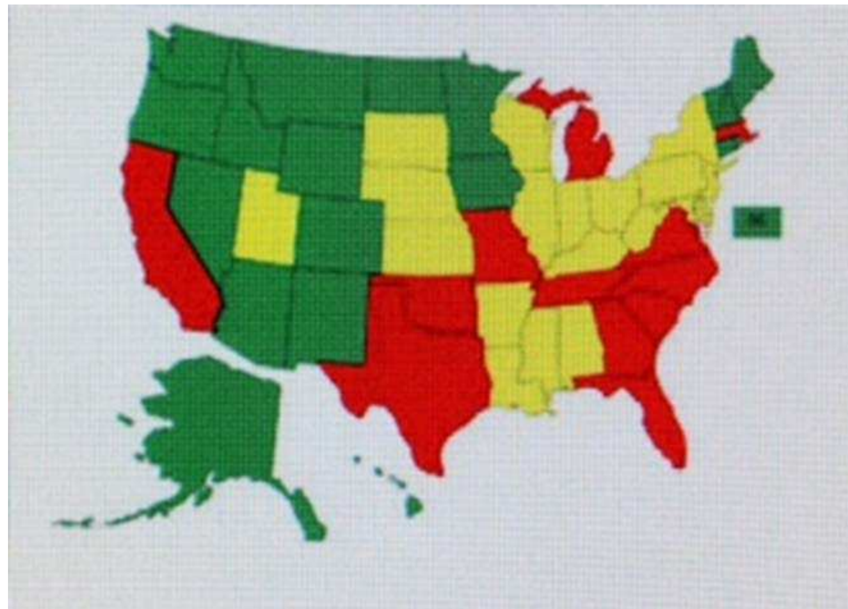
- Who best to help them?
- In what setting?
  - Home (theirs or someone else)
    - Physician office practice
    - Geriatric assessment practice
    - Home visit
  - Grouped housing
    - Physician office practice
    - Geriatric assessment practice
    - Home visit
  - Assisted Living
    - Physician office practice
    - Geriatric assessment practice
    - Home visit
  - Nursing home care
    - NH and Physicians have a duty to provide care for these patients once every 30 days for the first 90 days then once every 60 days thereafter and as often as medically necessary. Every other required visit can be seen by an APP.

Advance Practice Professionals (APP)

- Estimated shortage of 130K physicians by 2025 split between primary and specialty care
- Delivery and payment reforms may change the mix of personnel needed
- All should practice to the "level of their training and license"
- Some states are better than others
- Louisiana is improving????

Nurse Practitioners

- 86% with masters degree 5% with doctorate
- Shorter and less costly training as compared to MD
- Evidence of high quality care and patient satisfaction
- Majority in collaborative team based care
  - 19 states independent, 12 states supervision, 19 regulated collaborative agreement www.aanp.org/legislation-regulation/state-legislation-regulation/state-practice-environment



Nurse Practitioners

- 2010 IOM report called for state legislatures to eliminate historical, regulatory and policy boundaries that prevent NP from practicing to the full extent of their education and training.
- FTC also recommends APRN scope should be a key component of our nation's strategy to deliver effective health care efficiently and to fill gaps in primary care access
- PACE allows NP to function as PCP with waiver and hospice as PCP
- Payment is set at 85% of Medicare allowable
- Salaries 65K-120K
- No co-signature required on note/rx unless practice site requirement
- www.nihcm.org/pdf/Meeting-the-demand-for-primary-care-nurse-practitioners-answer-the-call-John-Iglehart-Expert-Voices-10-2014.pdf

Physician Assistant

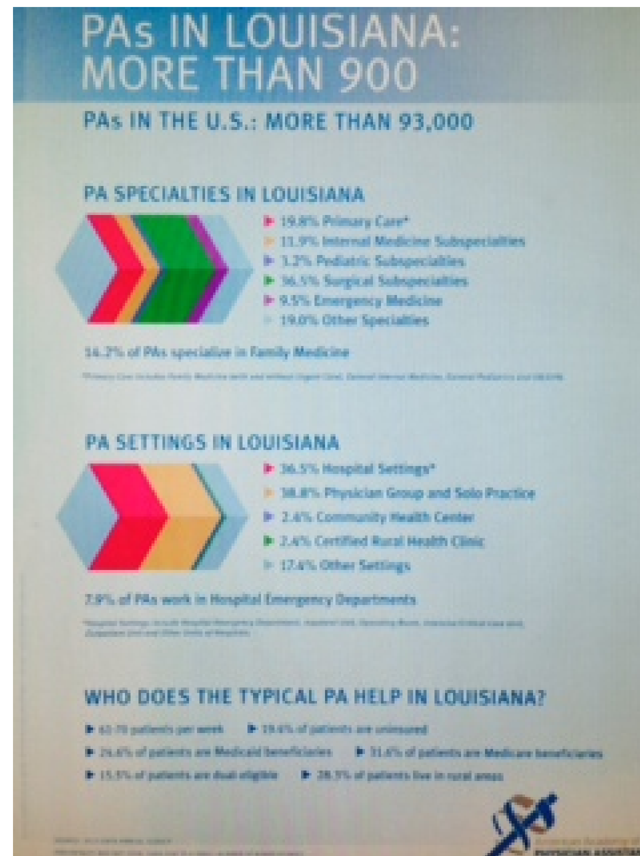
- The physician assistant (PA) profession was founded on the concept of team practice.
- Physician-PA teams enhance coordination and quality of care.
- Similarities in physician and PA training
- Commitment to team practice and the efficiencies created by utilizing the strengths of each professional in the clinical practice setting.
- www.aapa.org/WorkArea/DownloadAsset.aspx?id=2497

Physician Assistant

- PA scope of practice is determined by the team of healthcare providers at the practice and credentialing decisions made by the facility.
- NEW CHANGES:

- PA salaries 70K-120K

Physician Assistant



Home and group housing visits

- No physician requirement
- Patient/family expectations delineated at onset.
- Who is responsible for follow through?
- Type of care which can be provided
  - NO portable CT/MRI!
  - Limited plain x-rays and ultrasounds
  - Labs can be obtained
  - Few procedures can be performed

- Great for patients with a limited intervention or comfort focused plan of care. Also to gain understanding of the family/living situation.
- Who admits the patient if hospitalized?
- How to collaborate with their physician?
- Think it may decrease readmissions---no good data yet!
- Usually no more than 6 patients per day unless grouped together geographically.
- Excellent reimbursement model.

Home visit codes/reimbursement 2014

99341 Problem-Focused Straightforward	$ 53.48
99342 Expanded Problem-Focused Low Complexity	$ 73.57
99343 Detailed Moderate Complexity	$126.90
99344 Comprehensive Moderate Complexity	$176.44
99345 Comprehensive High Complexity	$212.75
99347 Problem-focused Straightforward	$ 53.75
99348 Expanded problem-focused Low complexity	$ 81.49
99349 Detailed Moderate complexity	$123.08
99350 Comprehensive Moderate/high complexity	$171.91

Assisted Living

- No physician requirement
- Facility/Patient/family expectations delineated at onset.
- Who is responsible for follow through?
- Patients considered "independent"-who calls the family? Who gets the medications?
- Type of care which can be provided
  - NO portable CT/MRI!
  - Limited plain xrays and ultrasounds
  - Labs can be obtained
  - Few procedures can be performed
- Great for patients with a limited intervention or comfort focused plan of care. Also to gain understanding of the family/living situation.
- Who admits the patient if hospitalized?
- How to collaborate with their physician?
- Think it may decrease readmissions---no good data yet!
- Can see more patients but must be scheduled otherwise considered soliciting!
- Excellent reimbursement model.

Domiciliary codes

99324	$ 53.79
99325	$ 78.48
99326	$135.16
99327	$180.25
99328	$209.21
99334	$ 58.47
99335	$ 91.65
99336	$129.32
99337	$186.80

Nursing home care ICF and SNF

- Nursing home care
    - NH and Physicians have a duty to provide care for these patients once every 30 days for the first 90 days then once every 60 days thereafter and as often as medically necessary. Every other required visit can be seen by an APP.
- Facility/Patient/family expectations delineated at onset.
- Who is responsible for follow through? **Nursing and facility**
- Patients considered dependent….Nursing or MD/NP calls the family with patient permission? Facility responsible to get the medications?
- Type of care which can be provided
    - NO portable CT/MRI!
    - Limited plain xrays and ultrasounds
    - Labs can be obtained
    - Few procedures can be performed
- Goals of care discussions important for long term patients for realistic expectations.
- Who admits the patient if hospitalized?
- How to collaborate with their physician?
- Think it may decrease readmissions---YES it does!!!!
- Can see more patients but need an organized model and database!
- Excellent reimbursement model especially if ACO model.

ICF/SNF codes

- 99304 $ 89.83
- 99305 $128.10
- 99306 $162.48
- 99307 $ 42.84
- 99308 $ 66.12
- 99309 $ 87.07
- 99310 $129.80

National Report Card on Healthy Aging

- Physically unhealthy days per month
- Frequent mental distress
- Oral health: tooth retention
- Disability
- No leisure time physical activity in past month
- Eating fruits and vegetables daily
- Obesity
- Current smoker
- Medication for High blood pressure
- Flu vaccine yearly
- Ever had pneumonia vaccine
- Mammogram in last 2 years
- Colorectal cancer screening
- Up to date on select preventive services
- Fall with injury within past year

Common Story

- 85 year old with moderate to severe dementia who is still able to speak
- Has low grade fever and didn't eat much supper
- Nurse calls on call doc who sends her to ED where she is found to have UTI, admitted and treated with IV fluids and IV antibiotics
- Gets confused during the night, falls out of bed and breaks her hip
- Surgery to repair hip complicated by DVT and pressure ulcer then returns to facility
- More than $10K with resultant increase in debility and decreased life span!
- OR..............
- Assessment according to protocol by nurse who calls doc/NP/PA with good information
- Agreement in advance of same day care with labs ordered in am
- Timely assessment by MD/NP/PA and discussion with family
- Treated in facility with oral antibiotics, increased oral fluids, and care by those who know her and her habits.
- $200
- (Good care for patient but savings accrue to Medicare and costs borne by State or family....money conundrum)

Table 2. Variation in Rates of Burdensome Transitions among 474,829 Patients, According to State.

Criterion for a Burdensome Transition	Overall Rate for All Patients	State with Lowest Rate*	State with Highest Rate*
	%		
Transition 72 hours before death			
To hospice	4.4	Alaska (0)	Nevada (8.0)
From nursing home to acute care hospital	5.8	Vermont (1.1)	Mississippi (12.7)
From hospital to nursing home	2.3	Alaska (0)	Mississippi (3.9)
Lack of continuity in hospitalization			
From nursing home A to hospital to nursing home B in last 90 days	2.7	Alaska (0)	Louisiana (10.9)
Multiple hospital admissions in the last 90 days of life			
≥2 Episodes of pneumonia	2.3	Alaska (0)	Louisiana (6.0)
≥2 Episodes of urinary tract infection	3.9	Vermont (0.1)	Louisiana (11.8)
≥2 Episodes of dehydration	2.7	Alaska (0)	Louisiana (7.6)
≥2 Episodes of septicemia	2.1	Alaska, Idaho, and Wyoming (0)	Louisiana (5.2)
≥3 Hospitalizations for any reason	4.2	Oregon (0.1)	Louisiana (12.2)

* Values in parentheses are state rates.

Interact2.net Interventions to Reduce Acute Care Transfers

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INTERACT

Interventions to Reduce Acute Care Transfers

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What is INTERACT?

INTERACT (**Inter**ventions to **R**educe **A**cute **C**are **T**ransfers) is a quality improvement program that focuses on the management of acute change in resident condition. It includes clinical and educational tools and strategies for use in every day practice in long-term care facilities.

INTERACT NIH Evaluation Participants
Click **here** to login if you already have a username

What is the purpose of INTERACT?

INTERACT is a quality improvement program designed to improve the early identification, assessment, documentation, and communication about changes in the status of residents in skilled nursing facilities. The goal of INTERACT is to improve care and reduce the frequency of potentially avoidable transfers to the acute hospital. Such transfers can result in numerous complications of hospitalization, and billions of dollars in unnecessary health care expenditures.

INTERACT Project Team Section
Click **here** to login if you already have a username

Announcements

- INTERACT Version 4.0 Tools for Nursing Homes Now Available! 10/17/2014
- INTERACT Program Tools for Assisted Living Now Available 7/25/2014
- New published review of the INTERACT Program available - see Publications below 3/12/2014
- INTERACT Hospitalization Rate Tracking Tool for 2014 now available 1/5/2014
- INTERACT eCurriculum on Medline University
- Information about the eINTERACT Certification Panel and Process is available at http://www.einteract.info/vendors.html
- Licenses for INTERACT v3.0 for Nursing Homes for EHRs and HIT are now available

Publications Related to INTERACT

- Overview of INTERACT JAMDA 2014
- Measurement of Potentially Preventable Hospitalizations, Long Term Quality Alliance, 2012
- Reducing Unnecessary Hospitalizations - N Engl J Med 2011
- INTERACT Evaluation - J Amer Geriatr Soc 2011
- INTERACT and the EMR Ann LTC 2011
- Avoidable Hospitalizations - J Amer Geriatr Soc 2010
- Avoidable Hospitalizations Editorial - J Amer Geriatr Soc 2010
- INTERACT Pilot Study - J Amer Med Dir Assn 2009
- INTERACT Editorial - J Amer Med Dir Assn 2009

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Assisted Living Series

- Assisted Living Series Set
- Caregivers Communication Guide: Protocols for Change of Condition
- Diabetes Management for the Older Adult
- Medication Management- Part I-Medication Management Manual: Operations Level
- Medication Management- Part II- Assisted Living Management of Medications: A Manual for Caregivers

Clinical Practice Guidelines (CPGs) in the Long Term Care Setting

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  - Subscriptions available as Individual; OR
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- Acute Change of Condition
- Altered Nutritional Status
- Anemia
- Common Infections
- COPD Management
- Dehydration and Fluid Maintenance
- Delirium and Acute Problematic Behavior
- Dementia **Revised 2012**
- Depression
- Diabetes Management
- Falls and Fall Risk
- Gastrointestinal Disorders
- Health Maintenance **Revised 2012**
- Heart Failure
- Osteoporosis and Fracture Prevention
- Pain Management **Revised 2012**
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AMDA ADVOCACY in Action

Choosing Wisely

AMDA Action for Improving Dementia Care in Nursing Homes

Strategies for Reducing Avoidable Hospitalizations of Patients with Serious Advanced Illness

- Additional support and training for facility staff and families
- More medical support for facility staff during late nights and weekends
- Philosophy shift in the appropriateness of hospitalizations
- Better management of transitions of care
- More ongoing advance care planning and discussions among residents, families, physicians and staff of facilities
- Improved capacity of AL facilities to deal with increasing medical needs of residents
- Review of financial incentives

Patients at risk of dying in the next 6 months-“you have to have a plan!”

- Frequent Emergency Room visits and/or hospitalizations over the last 6 months
- Semi-comatose state
- Minimal oral intake (or receiving continuous IV hydration or tube feeding)
- Inability or difficulty with taking oral medicines
- Major decline in functional status with no identified reversible cause
- Mottling of extremities
- Primary diagnosis of metastatic cancer
- Primary diagnosis of advanced dementia
- Existing DNR order

Lack of Advance Care Planning

- Discussion about advance care planning
- Updating care plans as medical needs change
- Documenting these in a clear way and informing all who might be involved
- Use of LaPOST (Louisiana Physician Order for Scope of Treatment)
- NEVER, NEVER, NEVER say "do you want us to do everything!"

Maxine's Living Will

New Living Will

I, ___________________________, being of sound mind and body, do not wish to be kept alive indefinitely by artificial means. Under no circumstances should my fate be put in the hands of pinhead politicians who couldn't pass ninth-grade biology if their lives depended on it, or lawyers/ doctors interested in simply running up the bills. If a reasonable amount of time passes and I fail to ask for at least one of the following:

Glass of wine ______ Margarita ______ Martini ______ Cold Beer ______ Chicken fried steak and cream gravy ______ Mexican food ______ French fries ______ Pizza ______ Bowl of ice cream ______ a cup of coffee ______ Chocolate ______ Sex_______,

It should be presumed that I won't ever get better. When such a determination is reached, I hereby instruct my appointed person and attending physicians to pull the plug, reel in the tubes and call it a day.

Signed

____

The LaPOST Program

- Helps health care professionals discuss and develop treatment plans that reflect patient end of life wishes.
- Results in the completion of the LaPOST form.
- The LaPOST form is an easily identifiable document that translates a patient's end of life wishes and goals of care into a physician order which transfers with the patient across care settings (hospital to home to nursing home to hospice)
- Helps physicians, nurses, health care facilities and emergency personnel honor patient wishes regarding life-sustaining or emergency treatments.
- Is voluntary
- Is neither for nor against treatment
- Is complementary with Advance Directives
- LaPOST is generally for patients with health conditions that are life limiting. Physicians should consider consulting with the patient about completing a LaPOST form if the patients:
  - Wants to avoid or receive life-sustaining treatment.
  - Resides in a long-term care facility or requires long-term care services.
  - Might die within the next year.

Summary

- Lots of issues
- Coordination of care is necessary
- Payment soon to be tied to better outcomes
- It is the kind of care we want for our own parents
- Communication is key!

Bibliography

- Ouslander JG, Berenson RA. Reducing Unnecessary Hospitalizations of Nursing Home Residents. N Engl J Med 2011: 365;13: 1165-67
- Ouslander JG, Lamb G, Tappen R, et al. Interventions to reduce hospitalizations from nursing homes: evaluation of the INTERACT II collaborative quality improvement project. J Am Geriatr Soc 2011; 59: 745-53
- Mor V, Intrator O, Feng Z, Grabowski DC. The revolving door of rehospitalization from skilled nursing facilities. Health Aff (Millwood) 20120; 29:57-64
- Chattopadhyay A, Bindman AB. Linking a comprehensive payment model to comprehensive care of frail elderly patients. JAMA 2010:304;17: 1948-49
- Dosa David Should I Hospitalize My Resident with Nursing Home Acquired Pneumonia J Am Med Dir Assoc 2005; 6:327-333
- Kane RL Finding the Right Level of Posthospital Care JAMA 2011;305(3):284-293
- Teno JM et al Churning: The Association between Health Care Transitions and Feeding Tube Insertion for Nursing Home Residents with Advanced Cognitive Impairment JPM 2009; 12 (4) 359-362
- Gozalo P et al End of Life Transitions among Nursing Home Residents with Cognitive Issues N Engl J Med 365:13 1212-1221
- Katz PR et al Nursing Home Physician Specialists Ann Intern Med. 2009;150:411-413
- AGS 2012 Beers Criteria Update Expert Panel. AGS Updated Beers Criteria for potential inappropriate medication use in older adults. JAGS 2012: 1-16
- Byock I. The Best Care Possible Avery Press 2012