

# PMDA

# news

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The official publication of PMDA, Pennsylvania's Association for Long-Term Care Medicine

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## President's Message

# Transitions

by Thomas E. Lawrence, MD, CMD; lawrencet@mlhs.org; (484) 427-8000



In recent weeks I have had two experiences that have opened my eyes to the changing nature of transitions in care within the long-term care arena. Last week I received a call from a local cardiologist who was transferring a patient out of the hospital to

my service at a local nursing facility and he wanted to give me sign out on her case. It was the first such call that I have received from a hospital physician in a long time. The resident proved to be clinically complex and it was a much appreciated call that helped me with the resident's continuing medical care at our nursing home.

The second unusual event involved a nursing home resident who was transferred to the hospital emergency room twice in the same weekend for intractable bleeding from a temporary dialysis catheter. The ER at the same local hospital had just implemented an electronic medical record system and within hours of the visit the nursing facility had copies of the EMR progress notes complete with triage summaries, full physician notes, medication reconciliation, and a depression and suicide screen and fall risk assessment. For many years, one of the great black holes in health care has been the nursing home resident (often with dementia) in the ER. To have EMR progress notes available from ER represents a huge step forward.

My observation over recent years has been that transitional care in the long-term care setting

has been slowly but steadily improving. Most of my nursing facilities now receive a copy of the complete hospital record at the time of admission, often including the discharge day physician progress note and an interim discharge summary. However, good transitional care has not yet come to all nursing facilities.

Poor transitional care for elders is an important national quality improvement objective in many settings. Evidence has shown poor transitions increase the risk of re-hospitalization and medication errors. The American Medical Directors Association has been especially concerned about problems in transitional care, and, in March 2009, issued a White Paper entitled "Improving Care Transitions from the Nursing Facility to a Community-Based Setting" ([http://www.amda.com/governance/whitepapers/transitions\\_of\\_care.cfm](http://www.amda.com/governance/whitepapers/transitions_of_care.cfm)). The

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# “Please Be My Doctor Kevorkian!”

by David E. Fuchs, MD, CMD; defuchs@comcast.net; (717) 898-2900

If it has not happened to you already, someday you will certainly receive a request from a nursing home resident to help end his or her life. Physician Assisted Suicide (PAS) seems like a viable option to some. The many losses sustained by our frail elderly, including loss of independence, loved ones, and the ability to do things that previously brought pleasure, may bring them to conclude that death is preferred over continuing to live. What should be your response? I have found that a three-step approach changes this difficult situation into one of benefit to both patient and physician.

First, *decline to honor the request*. You are ethically and legally bound to do so. One of the primary tenets of Medical Ethics is nonmaleficence, to do no harm. Assisting a patient to cause their death certainly does them harm. PAS is illegal in Pennsylvania and in 48 other states. Only Oregon state law permits it, and there are many steps to comply with that law. So many, in fact, that only 341 people have died under this law in the 11 years it has been in effect—less than 0.03% of all deaths in Oregon during that time.

You must be clear to your patients that you cannot help them end their life. I remind them that Dr. Kevorkian went to prison, and so would I if I honored their request.

Second, you must avoid the pressing compulsion to leave the room and *assess your patient for depression*. Depression is a common, treatable illness that affects at least 40% of nursing home residents. Suicidal thoughts are usually a sign of depression. Question your resident about sleep disturbance, appetite change, weight loss, and anhedonia. The Geriatric Depression Scale is a quick, easy and objective way to diagnose depression. Consider antidepressant medication or psychiatric consultation. Beneficence, to do some good, is the ethical tenet you will be honoring with this approach.

Third, *engage in a theological discussion*. Regardless of your own religious beliefs, listen to your patients describe how they view the end of life. Older people are far more religious than the young, and they realize their time on earth is limited. They usually have pondered the afterlife, and for many it holds a greater value than their present condition on earth. Allowing them to express their feelings may assist them in finding a reason for their continued living. It will bring you closer and create a more effective doctor-patient relationship.

“What purpose do you think God has for you now on this earth?” is a question I often ask in this situation. Surprisingly, this sometimes prompts them to see that their life still has value, usually in terms of some family relationships. Many will say they will do God’s will, and you may comment that it is not for doctors or patients to determine the time of death, but rather a higher power that many call “God.” Most facilities have a chaplain who can offer spiritual counseling to continue the discussion that you begin. If the physician validates this discussion by initiating it, it will assume a greater importance in the eyes of the patient.

A request for PAS, though difficult for physicians, can open the door to treatment of depression and an improved quality of life for the nursing home resident. By declining to do harm, you may turn the tables and actually do some good. ■

## Never Events Bill Signed Into Law

Reprinted from the PANPHA website

On June 10 Governor Rendell signed into law Act 1 of 2009. Known as the Preventable Serious Adverse Events Act, this statute applies to health care facilities and its medical staff—NOT Personal Care Homes and Assisted Living Facilities—and prevents any health care provider from seeking payment for a preventable serious adverse event or for any services required to correct or treat the problem created by a preventable serious adverse event that occurs under its control. If a health care provider unknowingly requests payment for a preventable serious adverse event, that provider must notify the payor and provide a refund within 30 days of discovery.

While this Act does apply to nursing homes, we do not yet know how “serious adverse events” will be defined in this setting. PANPHA was successful in persuading the administration that the identified list of “serious adverse events” was not applicable to the long-term care setting. Accordingly, the statute charges the Department of Public Welfare with issuing a bulletin that will outline a nursing home specific list of “serious adverse events” that will trigger the ban on seeking payment. Prior to publication of this nursing home bulletin, the Department is mandated to consult with long-term care stakeholders and hold open meetings to develop the list of nursing home specific events. The bulletin will be subject to public comment, and the Department is required to address all comments upon final publication.

PANPHA will naturally be at the negotiating table during the development of the Department’s bulletin. Members will be kept apprised of developments as we move forward, and we will send alerts if and when grassroots advocacy is needed.

If you have any questions regarding this Act, please contact either Mark Miller at [mark@panpha.org](mailto:mark@panpha.org) or Nick Luciano at [nick@panpha.org](mailto:nick@panpha.org). ■

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# Physicians Orders For Life Sustaining Treatment (POLST)

by Greg Lyon-Loftus PhD, MD, CMD; greg.lyonloftus@gmail.com; (717) 749-3181

Advanced Directives developed as a public response to changes in dying that were most clearly precipitated by the development of CPR. As CPR advanced, interventions became more invasive – intubation, mechanical ventilation, IV fluids and pressors, even intracardiac injection. And soon, no one died in the hospital without some “code” or “resuscitation” effort. And more people died in hospital with tubes and restraints, and slowly, and at great cost.

In the 1970s, social unrest with these outcomes developed, and the 1990 Patient Self-Determination Act required that all hospitals receiving Hill-Burton funds “inquire” of patients and “educate” their communities about Advanced Directives. Various states offered “Living Will” formats for patient wishes to be expressed. Gradually these became adopted by the legal profession, and were incorporated into estate planning documents. And the concept of Power of Attorney for Health Care was added similar to the POA for financial matters. (The efficacy of such documents varied widely. They generally

said: “If I am in a *terminal state or permanently unconscious*” then I choose or decline items from a list of treatment options.)

Advanced Directives were intended to communicate to physicians the patient’s preferences. However, their availability in times of crisis was often limited, and they did not actually carry any authority. A physician’s orders were required to implement them. Further, each time a patient changed institutions a new set of physician orders were needed, authorized by a physician credentialed in the current location and not applicable during transport.

The legal status of Advanced Directives in Pennsylvania was clarified by ACT 169 (2006), among other things, the act:

- Totally and helpfully rewrites and updates Pennsylvania’s Living Will statute;
- Provides more expansive Health Care Power of Attorney provisions;

- Contains a set of rules to designate a statutory health care representative in the event that an individual does not already have a guardian or agent under a Health Care Power of Attorney or Living Will; and
- Reenacts the provisions for out-of-hospital DNR (do not resuscitate) orders, and changed language of “terminal state” to “end stage medical condition.”

## Health care agents and representatives

A health care agent may be given authority as broad as the patient would have if competent. In contrast to Living Wills, health care agents are not restricted to end-of-life decision-making. Although health care agents generally are given authority only when the patient is incompetent, a health care power of attorney may vest an agent with authority even when the patient is competent.

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# Formation and Proper Use of Facility Ethics Committees

by Maryann C. Galietta, MD; mgred@comcast.net; (215) 493-0556

Having served on a formal ethics committee in a skilled nursing facility for 10 years, several insights come to mind that may help others maximize the benefits of their committees or assist those with committees in the formative stages. Also, in having assisted with many educational efforts on ethical issues and in answering questions in various formats, similar pitfalls and roadblocks often become apparent. During all these experiences, the most frequent shortcoming was the rush to “hurry up and solve a problem” or bring some insight to an ethical dilemma, or offer some kind of an answer. A properly

formed ethics committee should always be advisory. Possible solutions may be offered, but the actual end decision and the work of implementing that reverts back to those involved in the dilemma.

If one reads the mission statements or by laws of standing committees, or the stated purpose of an ethics committee in written academic material, there may be some variation in context, but the core charges are always the same, namely: education; policy review and development; and confidential case review. The greatest benefit and usage of a committee in a facility or a region is to prioritize the

usage of time to those charges in the order stated. Too often there is an urgency to hear a case or offer a solution when the committee itself is not properly grounded or educated in the principles of ethics and intricacies of the law. Such case reviews then turn into an exchange of opinion rooted in emotion and personal experience of the members, rather than a consensus based on sound ethical judgment guided by the expertise of different disciplines.

Education must be first and foremost if a committee is to reach its full potential.

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## Formation and Proper Use of Facility Ethics Committees

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Besides bringing their individual expertise based on their profession or standing in the community, committee members have a responsibility to educate themselves and enrich their appreciation and perspective outside their own field of expertise. The committee has a communal responsibility to educate themselves as a committee and grow in their ability to function as a committee. If committee members are to advise on any matters that could not be solved through the usual channels, it follows that they should be able to offer more insight than what was already in the mix. As the committee becomes more mature, educational efforts should be extended beyond the committee to staff, residents, families, and the community at large.

There is often a common thread to many of the dilemmas that present themselves in a facility that would prompt an ethics committee to review policy or work on the development of a new policy. This is an area where committees are not used to full potential and benefit. There tends to be a

facility-based fear about engaging in that type of discussion or action. The benefit that a committee can affect by examining certain policies and advising on potential changes for improvement should not pose a threat to a facility, but rather open a dialogue that could only serve to benefit it and those in its care.

By turning attention to these two primary charges, it follows that whatever cases are brought to the committee for review will be true ethical dilemmas that could not be solved through normal dialogue with the physician, nursing staff, social service, and administration. It is not the role of an ethics committee to directly assist with decision making in a facility because that facility does not have proper procedures in place to allow for sound medical decision processes for all residents. For example, if a resident is competent, or has an appointed health care representative; and if the physician has explained the diagnosis and possible treatment options; and if staff and social service have been available to answer any questions about the specifics of those options; and if administration approves either option since there is no violation of policy — a

case review by the ethics committee is not necessary. This is the type of sound medical decision making that goes on all the time.

Review by the ethics committee would be appropriate if the health care representative appeared to be selecting an option that was not in keeping with the resident's previously stated wishes or the resident's presently stated wishes especially if the resident's capacity comes into question. Review might also be appropriate if the resident or health care representative was demanding an option that the physician had discussed and was not advising as a reasonable course of action.

In summary, an ethics committee can be of the most service to a facility and those in its care if it stays true to its mission and maintains humility as a committee to serve and facilitate. It should always remain neutral and unbiased, and not become an instrument of the facility. The committee must step up to the plate and become the quiet conscience of a facility while guarding against any self-indulging pride or power. ■

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## President's Message

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paper describes the current challenges involving the transition of residents from the nursing home back to home and community settings. A number of recommendations for improving care in this area are proposed in the white paper. Priorities include: establishing a system for medication reconciliation with the previous out-patient regimen; identifying the primary care physician (PCP) responsible for carrying out follow-up care; and establishing avenues of communication for clinical care regarding medical issues that have transpired and priorities for follow-up care.

Transitional care has been an area of interest for PMDA, and this year's Annual Symposium has a concentration during the morning session on Transitions in Care that will cover ground-breaking material presented by a group of national experts. In addition, in the coming months PMDA will be initiating a Transitional Care Best Practices initiative that will focus on sharing best practice models among our members and their facilities. The first areas of focus will include: guidelines for the process of NH discharge transitional medical care, medication reconciliation at discharge, and follow-up communication with PCP's. We will be encouraging our members to share their ideas for best practice in these areas

and to share policies and procedures and appropriate forms that they have developed to serve this purpose. It is our hope that many of our members will participate by forwarding their ideas, policies, procedures, and forms to the PMDA office for inclusion in the Transitional Care Best Practices project. Selected sample materials that exemplify excellence in practice will be posted on the PMDA website. Our pooled expertise will prove to be an invaluable asset to Pennsylvania nursing home residents and care teams. Please send your ideas and sample documents to [pmda@pamedsoc.org](mailto:pmda@pamedsoc.org). Thank you. ■

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# AMDA Board Update

by J. Kenneth Brubaker, MD, CMD; [jnbrubak@lancastringeneral.org](mailto:jnbrubak@lancastringeneral.org); (717) 361-4011

The AMDA staff, board members, and many other volunteer physicians serving on numerous committees continue to put lots of energy into keeping pace with the rapidly unfolding events that are happening nationally and state wide. Foremost on the AMDA agenda is communicating with the DEA and more recently with the FDA. The purpose is to educate both agencies how DEA's interpretation and enforcement of the regulations are creating a complex system for physicians prescribing schedule II pain medications in a timely manner. AMDA has already received many calls and e-mails from its members regarding the recently enforced requirements in several states. Physicians are finding these prescribing requirements cumbersome. The requirements frequently affect the quality of care for pain management. If anyone experiences or hears about situations where the recent DEA enforcement has actually caused harm (Yes, unnecessary pain and suffering!!!), please forward your information to AMA's executive director, Kathleen Wilson ([kwilson@amda.com](mailto:kwilson@amda.com)). The staff wants to collect as many stories as possible to share with the DEA and FDA.

AMDA also has brought the DEA issue to the attention of the American Medical Association's (AMA) House of Delegates. The AMDA resolution passed and it is now AMA policy "That our American Medical Association urge the U.S. Drug Enforcement Agency to amend its regulations to recognize nursing staff as agents of the prescriber/physician in long term care facilities."

On a different note, the AMDA Board recently discussed the grassroots Assisted Living initiative that our own beloved Dan Haimowitz is spearheading. Those of us that have seen patients in free standing AL facilities have recognized the need for improving the medical care to the AL residents. Many of the AL residents could easily meet the requirements for skilled care but choose not to because of the increased costs. The AMDA Board is interested in supporting and encouraging AMDA members who work in AL by developing an effective communication network. This network will enable AMDA members to share common problems and solutions relating to issues that are unique to the AL environment. If there is growing

interest and support among our members, eventually a core group of AL physicians can become a subsection in AMDA.

Finally, the AMDA Board continues to work at developing and maintaining acceptable standards related to funding our future educational programs. The AMDA Board also wants to be very circumspect in preventing any potential conflict of interest by board members and all others who are volunteering in AMDA. In our December 2009 AMDA Board meeting, we will be looking more closely at the recently published article in JAMA entitled "Professional Medical Associations and Their Relationships with Industry." This article specifically addresses the activities of individuals and medical associations that should be avoided in order to eliminate any conflict of interest when planning educational programs.

My membership and activities on the AMDA Board is very challenging and rewarding. Our AMDA organization continues to put a lot of energy into improving the quality of patient care and improving provider satisfaction working with the frail older adults in the LTC setting. ■

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## Physicians Orders For Life Sustaining Treatment (POLST)

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When duly authorized, a health care agent generally may direct the provision, continuation, withholding, or withdrawal of all forms of medical care from the patient.

Act 169 does not impose a requirement that the patient be permanently unconscious or have an end-stage medical condition for a health care agent to direct the withholding or withdrawal of health care necessary to preserve the patient's life.

Generally speaking, a health care representative may make health care decisions for an incompetent adult patient who has no controlling Living Will, health care power of attorney, or guardian of the person.

Unless a patient designated otherwise, the patient's health care representative will be determined by a statutory list that generally gives priority in the following order:

- spouse and adult child who is not the child of the spouse
- adult child
- parent

- adult sibling
- adult grandchild
- close friend

As in the case of a health care agent, a health care representative generally may direct the provision, continuation, withholding, or withdrawal of medical care, including life-sustaining medical care.

In contrast to a health care agent, a health care representative may direct the withholding or withdrawal of care necessary to preserve life only when the patient is permanently unconscious or has an end-stage medical condition.

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# Welcome New Members

PMDA welcomes the following new member to the Association:

## Individual Members (Physicians)

Thomas Keller, MD

Cynthia Rosenberg, MD

Robert Scott, MD

E. Louis Czechowski, RPh

## American Medical Directors Association Certification Program (AMDCP) Spring 2009 CMD's

Domenick J. Brasile, DO, CMD, Erie, PA  
Thomas V. Brislin, DO, CMD, Allentown, PA  
Catherine M. Glew, MD, CMD, Allentown, PA  
Daniel K. Grob, MD, CMD, Pittsburgh, PA  
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Ashith Mally, MD, CMD, McMurray, PA  
Thomas Mextorf, DO, CMD, FAAFP, MHA, Hollidaysburg, PA  
Susan M. Moyer, MD, CMD, Elkins Park, PA  
Sarah Y. Noorbaksh, MD, CMD, Mechanicsburg, PA  
Leslie T. Pallone, DO, CMD, Beaver, PA  
Jeffrey H. Perlson, DO, CMD, Southampton, PA  
Gubbi Ranganath, MD, CMD, Shenandoah, PA  
David J. Sherwood, MD, CMD, Landenberg, PA  
Gursharan Singh, MD, CMD, Mahanoy City, PA  
Robert V. Smith, MD, CMD, Philadelphia, PA  
Adam Sohnen, MD, CMD, Pittsburgh, PA

## Physicians Orders For Life Sustaining Treatment (POLST)

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However, in most situations in which it is appropriate to direct the withholding or withdraw life-preserving medical care, the patient will be considered to be permanently unconscious or to have an end-stage medical condition.

## Decision-making by health care agents and representatives

Health care providers are required to provide information to health care agents and representatives to aid them in their decision-making. The various state and federal privacy requirements generally will not restrict what may be disclosed.

Health care agents and representatives generally are required to make decisions for patients based on the patient's express wishes, the patient's preferences and values, and the patient's best interests, in that order of priority.

Modified rules apply to withholding or withdrawal of artificial nutrition and hydration. There is a "rebuttable presumption" that the patient would want

this treatment in the absence of the patient specifically stating otherwise in writing. Generally speaking, the presumption may be overcome if the patient clearly expressed wishes to the contrary or it is clear from the patient's preferences and values that the patient would not want the artificial nutrition and hydration." (source Pennsylvania Medical Society bulletin Facts on Act 169, Advance Directives, 8/08)

The applicability of advanced directives was facilitated by ACT 169, however, the ongoing difficulties with availability of the patient's documented wishes continues to be a problem. With each location or institution change, the attending physician must re-record the conversation with the patient or agent and then convert that into a coherent set of physician orders.

The POLST form was developed to improve the consistency with which a patient's preferences could be implemented by structuring those preferences into a standardized set of physician orders that could be followed in any location, and to identify those orders in a widely recognized format.

With leadership from Dr. Judith Black, POLST was implemented in the Pittsburgh

area and is now spreading, with various other locales in the process of developing community action programs.

The POLST has special significance for PMDA members because it helps us to structure the discussion of End-Of-Life Care, and create a document that protects the patient's preferences during transitions through various institutions, including EMS transport.

Information about the POLST and conducting family discussions about End-Of-Life Care is available at [www.polst.org](http://www.polst.org). ■



**AMDA 2010  
Annual Symposium**  
March 11-14, 2010  
Long Beach, CA

# Register Now For PMDA Fall Annual Symposium

PMDA's 17th Annual Symposium will be held Friday, October 16, 2009 at The Hershey Lodge and Convention Center in Hershey, PA. Attendees will qualify for six hours of CME and fulfill 6 hours of CMD recertification. The seminar is open to Medical Directors, Attending Physicians, Nursing Home Administrators, Directors of Nursing and Allied Health Professionals working in long term care.

The morning session will revolve around the hot topic of Transitions in Care, featuring talks on the National Perspective, Acute Hospital Care of the Elderly, Practical Approaches to the Management of Transitions between the ER and SNF, and Medication Management.

Debate regarding a Specialty for Long Term Care Medicine will be shared by AMDA President-Elect Paul Katz, MD, CMD. Infectious Disease Outbreaks in the Nursing Home, Public Policy Update, and Anticoagulation Management following Joint Replacement will be covered in the afternoon. PMDA's Annual Membership Meeting will be held over lunch.

The following faculty from across the nation will be featured:

**Steven Handler, MD, MS, CMD**, Asst. Professor of Biomedical Informatics, Division of Geriatric Medicine, University of Pittsburgh.

**Thomas Lawrence, MD**, President of PMDA.

**James Lett II, MD, CMD**, Chairman, AMDA CPG Working Group for Care Transitions in the Long Term Care Continuum.

**Alex Makris, MD, CMD**, Corporate Medical Director, Seniors Management North, New Jersey.

**David Nace, MD, MPH**, Asst. Professor of Medicine, University of Pittsburgh School of Medicine.

**Robert Palmer, MD, MPH**, Visiting Professor of Medicine, Division of Geriatric Medicine, University of Pittsburgh.

**Cheryl Phillips, MD, CMD**, Chief Medical Officer, OnLok, Inc., San Francisco, CA.

**Gregory Raab, MD**, Asst. Professor of Orthopedics and Rehabilitation, Penn State Hershey Bone and Joint Institute, Hershey, PA.

Register now online at <http://www.hmc.psu.edu/ce/PMDA2009/>



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*Pennsylvania's Association for Long-Term Care Medicine*

# **17TH ANNUAL SYMPOSIUM**

• **Friday, October 16, 2009** •

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*Hotel reservation deadline is September 15, 2009*

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