

PMDA

news

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PMDA 1992 - 2007

15 Years of Excellence in Long-Term Care Medicine

President's Message Geriatric Challenges to Greatness

by J. Kenneth Brubaker, MD, CMD, FACP



This past year my health care system, Lancaster General, encouraged me to read the monograph that accompanied the book *Good to Great* by Jim Collins. This short monograph has re-energized me to be committed to the development of a strong

organizational structure that will enable the Geriatric Department to make a difference in our community both now and in the future. First and foremost, Collins states that if one really wants to improve the care and services to our older adult community, one needs the right kind of staff. This includes not only physicians and nurse practitioners, but nurses, secretaries, office managers, division management, and the CEO of the organization. We all must be deeply passionate about what we do. We all must know why we exist. In other words, we need to be clear about our mission and vision.

Secondly, as geriatric providers we need to clearly understand what our organization can uniquely contribute to the people for whom we care. Of equal importance, we need to be convinced that we provide care in a manner that is better than any other organization in our community. This necessitates that our geriatric team is composed of well-trained staff. All our staff must be highly motivated and make productive contributions through talent, knowledge, skills, and good work habits. While all staff deserve appropriate and adequate pay for their work, staff members

who are working on our geriatric team only because of their high paying salaries may not necessarily be deeply passionate about geriatric care and highly motivated with a strong work ethic.

Finally, while being very passionate about what you do and having the right people on your team, one cannot be successful without having adequate financial resources to carry out your mission. As most geriatric providers know, having adequate financial support is very challenging. CMS has consistently undervalued reimbursement for cognitive services that are very time consuming. This is validated every time one looks at providers' salaries

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Bring Your Family to Historic Gettysburg in October!

by Susan J. Denman, MD, CMD

Join your friends and colleagues at the Wyndham Gettysburg Hotel for the **Pennsylvania Medical Directors Association's 15th Annual Symposium on Friday, October 26, 2007.**

Take this opportunity to update your knowledge, earn CME and CMD credits, visit with our sponsors and exhibitors and participate in the PMDA annual business meeting. We have applied for Nursing CE and Pharmacist credits as well.

Presentations will address pertinent and timely topics such as legal issues in long term care, medication management concerns related to Tags F428 and F329, the oral examination of geriatric patients, treatment of the diabetic nursing home residents and current public

policy concerns. Our distinguished speakers include AMDA's President-Elect Dr. Charles Crecelius and Dr. Naushira Pandya, chair of the panel that wrote the AMDA Clinical Practice Guideline for Managing Diabetes in the Long-Term Care Setting.

A block of rooms has been reserved at the (brand new) Wyndham Gettysburg Hotel, but we expect a large crowd so make your reservations early, before the September 24th



cutoff date. Call **1-866-845-8885** and identify yourself as part of the PMDA group.

Send in your meeting registration brochure or sign up on the PMDA website at www.pamda.org. **See you in October!** ■

PMDA's Mission and Vision were recently revised by the PMDA Board of Directors

PMDA's Organizational Mission:

PMDA, Pennsylvania's Association for Long-Term Care Medicine, is the professional organization of medical practitioners who are committed to the continuous improvement of quality care for Pennsylvanians across the long-term care continuum. PMDA will provide advocacy, education and professional development services for medical directors, physicians, nurse practitioners and other healthcare team members. PMDA advances its mission by outreach with other groups involved in long-term care.

PMDA's Organizational Vision:

PMDA, Pennsylvania's Association for Long-Term Care Medicine, will serve as a state leader in enhancing the healthcare and quality of life for Pennsylvanians across the continuum of long-term care, through the education of medical directors, physicians, nurse practitioners and other healthcare team members.

PMDA History

by Sefi R. Knoble, MD, CMD, FACP

Pennsylvania Medical Directors Association 1992-2007

15 Years of Excellence in Long-Term Care Medicine

This year, the PMDA newsletter is highlighting significant events in the first 15 years of our organization. In this issue we focus on the second five years.

1998 to 2002 were years of growth for PMDA. Attendance at the Annual Symposium grew to over 100 participants. Members and officers became increasingly active, representing PMDA in a variety of organizations including the Pennsylvania Restraint Reduction Initiative, PANPHA, PHCA, the Pennsylvania Culture Change Coalition and the Pittsburgh End of Life Collaborative. Major issues addressed by the Public Policy Committee included TB Regulations, LPN Verbal Orders, the 48-Hour Countersignature, Assisted Living Regulations and Survey Consistency. PMDA was increasingly recognized by outside agencies and organizations as a

key source of information and education in long-term care practice and regulation.

PMDA Presidents, 1998-2002:

- 1) Louis DeMaria, 1998
- 2) Mario Cornacchione, 1999
- 3) Margaret Kush, 2000
- 4) Daniel Haimowitz, 2001
- 5) Glenn Panzer, 2002

Milestones in the Second Five Years:

June, 1998: The first Regional Educational Symposium was held in Plymouth Meeting. Participants discussed The Management and Assessment of Chronic Pain in the LTC Resident.

June, 1998: Final rules regulating PA nursing facilities included key provisions recommended by PMDA regarding routine laboratory testing, inclusion of CDC guidelines on TB and the requirement that medical directors of PA nursing facilities have a PA medical license.

March 1999: AMDA House of Delegates passes PMDA CPR resolution. ■

Clostridium Difficile Associated Disease (CDAD) in the Nursing Home

by Phenelle Segal, RN CIC, Infection Control Consulting Services, LLC

Clostridium difficile, most commonly known as *C. diff*, is an anaerobic spore-forming bacillus that causes diarrhea and colitis. It continues to evolve as a formidable pathogen in the long-term care setting. Emerging resistant strains are being seen with increased frequency across North America and several countries in Europe. These strains produce toxins that are responsible for toxic megacolon and have resulted in cases of sepsis and death.

Traditionally, *C. diff* was confined to a population of institutionalized persons who had been treated with antibiotics and subsequently developed “antibiotic associated colitis.” Of concern recently is the emergence of this disease in “nontraditional hosts” (otherwise healthy, non institutionalized persons residing in the community, some without antimicrobial exposure). However, the majority of cases are still being seen in institutionalized patients that have a history of antibiotic exposure.

The strain BI/NAP1 has contributed to several outbreaks worldwide. Virulence characteristics associated with the BI/NAP1 strain include increased toxin production (TcdA and TcdB), the presence of a binary toxin, altered antimicrobial resistance patterns (fluoroquinolones) and increased capacity of the organism to sporulate. *C. diff* also has a TcdC gene which is a downstream negative regulatory gene that controls the expression of TcdA and TcdB. These distinct genotypical strains of *C. diff* have the propensity to hypersporulate and cause major outbreaks. In addition, increasing resistance to Metronidazole (the antibiotic treatment of choice) is occurring at an alarming rate.

Risk Factors

Immunity and Age:

Inadequate mounting of the immune system, older age and co-morbidities requiring hospitalization are risk factors.

Antibiotic Usage:

Most antimicrobials are implicated in the acquisition of CDAD; however, some agents pose a greater risk than others (cephalosporins, extended-spectrum penicillins and clindamycin). Risk may also be augmented by extended duration of use.

Gastric Acid Suppression and Use of PPIs:

Despite earlier studies and thinking, there is no conclusive evidence to support that these agents are a risk factor. Research studies are ongoing.

Environmental Factors:

C. diff is highly contagious and easily spread via contaminated hands and the environment. Lack of hand washing is a factor, as is the shift from traditional soap and water based hand washing to the use of alcohol-based hand hygiene products. While the alcohol based hand hygiene products are excellent for general use in Infection Control, they are not effective for eradication of *C. diff* due to its spore-producing characteristic. Traditional institutional cleaning products are not effective on inanimate surfaces, therefore additional expense is required to prepare and handle 10% sodium hypochlorite (bleach) solutions or to purchase commercially prepared bleach products. Patients need isolation precautions, which further add to the financial burden of this disease.

Prevention and Treatment

1. Judicious use of antibiotics including length of treatment and types of antimicrobials.
2. A multidisciplinary approach to decreasing overall infections, thereby lessening the need for antimicrobials. This includes reducing the use of invasive devices (e.g. urinary catheters, F-tag 315 in the elderly).
3. Early diagnosis and appropriate antimicrobial treatment protocols including increased usage of oral Vancomycin. Protocols vary and are instituted by the physician according to current standards of practice. Use of probiotics is controversial due to lack of supportive evidence and emergence of fungemia and bacteremia attributed to probiotics.
4. Enhanced Infection Control measures including the following:
 - a. Isolation or cohorting of patients; including the use of personal protective equipment such as gloves and gowns.
 - b. Education of staff on effective hand hygiene practices including hand washing with soap and water when caring for patients infected with *C. diff*.
 - c. Dedicated equipment in patient rooms.
 - d. Effective cleaning and disinfecting of the environment; particularly the rooms and bathrooms of patients infected with *C. diff*. ■

PMDA Public Policy Update

by Thomas E. Lawrence, MD, CMD, and David A. Nace, MD, MPH, Public Policy Committee Co-Chairs

June 2007

Governor Rendell releases his “Prescription for Pennsylvania”

In January 2007, Governor Rendell released his *Prescription for Pennsylvania*. The *Prescription* is a set of strategies that seek to improve health care in Pennsylvania by targeting affordability, access to care, and quality with the ultimate goal of reducing costs. The *Prescription* hopes to improve long term care services primarily by growing home and community services.

Specific details for many areas are not yet available; however, House Bill 700 has been drafted and in March was referred to the House Insurance Committee. The House Democratic Policy Committee held hearings in Harrisburg on 03/29/07 on the bill. PMDA provided input for this hearing through testimony submitted on behalf of the University of Pittsburgh Institute on Aging. One particular item addressed was the role of nurse practitioners and restrictions on their authority to give verbal orders in nursing facilities.

If passed, House Bill 700 would grant nurse practitioners the authority to give oral orders (verbal and telephone orders) in all facilities and situations in which physicians are permitted. PMDA has been actively trying to persuade the state to allow physician extenders the ability to give oral orders and therefore supports the bill’s current language on this issue.

A thorough review of House Bill 700 is currently being conducted by the Public Policy Committee. We will update members on the *Prescription* and House Bill 700 in the fall newsletter; and, at the annual symposium in Gettysburg.

Members are encouraged to review the Governor’s Prescription and House Bill 700 at <http://www.gohcr.state.pa.us/prescription-for-pennsylvania/index.html>.

Members should also forward any thoughts, concerns or comments on the bill to the Public Policy Committee by contacting

Maria Elias at melias@pamedsoc.org or Dr. Nace at naceda@upmc.edu.

POLST Initiative Update

Act 169, the Advance Directive for Healthcare Act of 2006, requires the state to form a task force for the adoption of the POLST or a similar tool. A task force has been established. No word so far on its progress. PMDA will be following this issue closely and supports the statewide adoption of the POLST.

For more information on the POLST, please visit the website www.polst.org or contact the Public Policy and Advocacy Committee.

Drug Regulations Updated (F329 & F428)

The new guidelines for F329 and F428 went into effect in December 2006. The Public Policy Committee has not heard of any survey related concerns from members about the new guidelines. Please forward any questions on the guidelines to the Public Policy Committee.

Public Policy Talking Points

The committee recently developed a list of *Talking Points*. The list is a tool that identifies key PMDA positions and includes background information for each topic area. The list can benefit members in several ways. It provides a quick reference of PMDA positions, helps launch discussions should you meet with local legislators, and can assist you in educating other team members at your long term care facilities. Look for the list to appear on the PMDA website by July 2007 or contact Maria Elias at melias@pamedsoc.org.

Talking Points are available currently for the POLST and Hand Hygiene.

New ADMA Toolkit For Anticoagulation

AMDA recently created a new toolkit, *Antithrombotic Therapy in the LTC Setting*. This toolkit nicely reviews and summarizes the complex recommendations for DVT prophylaxis. PMDA supports the use of this toolkit in promoting patient safety.

Of note, a recent study by Jerry Gurwitz and colleagues in the *American Journal of Medicine* highlights the dangers of

anticoagulant use in nursing facilities. In this study of 25 nursing homes in Connecticut, warfarin was associated with 720 adverse events over the course of one year. Eleven percent of these (82 events) were serious and 2% (13 events) were life threatening or fatal. (*Gurwitz JH, et al. The safety of warfarin therapy in the nursing home setting. American Journal of Medicine. 20007;120:539-544.*)

More information on the toolkit is available at www.amda.com.

Contacting the Public Policy and Advocacy Committee

—If you have any questions, comments, concerns, or want to share any experiences about any of the issues discussed above, please contact us at www.pamda.org. ■

Welcome New Members

PMDA welcomes the following new members to the Association

Individual Members (Physicians)

Yogindra S. Balhara, MD
Thomas V. Brislin, DO
Michelle L. Ecker, MD
Barry M. Fabius, MD
John M. Goetz, MD
Kathleen A. Kreider, MD
William D. Loretan, DO
William J. McGrath, DO
John S. Parry, MD
Stanely J. Savinese, DO
Bernard S. Zoranski, DO

Individual Members (NPs or PAs)

Carla M. Donkus, CRNP

LTC Industry Partner

Timothy A. Molnar

Affiliate Members

Arlene S. Postupak, NHA

Nurse Practitioner Regulations: How Does Pennsylvania Rank?

by Sefi R. Knoble, MD, CMD, FACP

A recent article in *The American Journal for Nurse Practitioners* surveyed nurse practitioner regulations in all 50 states and the District of Columbia. An expert panel assessed three domains of the regulatory climate: consumer access, reimbursement and prescribing ability.

Primary findings included a wide variation in regulations from state to state suggesting that these practices are not evidence-based, have no basis in patient safety and in many cases seem arbitrary.

Each state was given a score of up to a maximum of 100 points (30 total possible

points for Legal Capacity; 40 total possible points for NP Patients' Access to Services and 30 total possible points for NP Patients' Access to Prescriptions). Each domain had several individual issues that were assessed (e.g. up to 10 points for professional autonomy; up to 4 points for the ability to be granted hospital privileges; up to 8 points for prescriptive authority). The highest ranking state was Arizona, with 100 points; the lowest was Alabama, with 35 points. Pennsylvania came in 19th place, with 78 points and received a "Grade C." There were equal deficits in all three domains.

Please see the PMDA Public Policy Update in this issue for additional details on our efforts to encourage the PA Legislature to allow Nurse Practitioners to give verbal orders in the nursing home setting. In addition to the reference below, the findings of this panel can also be reviewed at www.webnp.net/ajnp.html. ■

Lugo NR, O'Grady ET, Hodnicki DR, Hanson CM. Ranking state NP regulation: practice environment and consumer healthcare choices. *Am J Nurse Pract.* 2007;11(4):8-23.

NPUAP Updated Pressure Ulcer Staging System

by Sefi R. Knoble, MD, CMD, FACP

The National Pressure Ulcer Advisory Panel has updated the definitions of and staging system for pressure ulcers based on current research and expert opinion. The new system replaces the original system first published in 1989. In addition to new definitions for each stage, Deep Tissue Injury (DTI) and Unstageable have been added as distinct stages. The new definitions for stages are quoted below. Complete information and expanded definitions can be found at www.npuap.org.

Pressure Ulcer Definition

A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated.

Pressure Ulcer Stages

Suspected Deep Tissue Injury:

Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Stage I:

Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

Stage II:

Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound

bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

Stage III:

Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

Stage IV:

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

Unstageable:

Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. ■

CMS Proposes Increased Physician Work Values for Nursing Facility Codes

Provided by the AMDA

The American Medical Directors Association (AMDA) applauds the Centers for Medicare and Medicaid Services (CMS) today for its proposal to increase physician work relative value units (RVUs) for the Nursing Facility code family. CMS issued the proposed new RVUs in the proposed rule *Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for Calendar Year 2008*. If approved in the final rule due out later this Fall, physicians will see the new reimbursement rates starting on January 1, 2008.

The increase in values is the result of four years of work by AMDA to obtain new and revised nursing facility codes through the Current Procedural Terminology (CPT) process followed by a campaign to seek new work values for the revised 2006 Nursing Facility code family. AMDA, who also developed the original Nursing Facility code set back in 1991, conducted a survey of physicians that perform the service and presented the results to the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) in February 2007. "Physicians who practice in nursing homes reported that the work caring for the nursing home patient was similar to that provided for a hospital patient. Our survey respondents agreed saying the nursing home population is a distillation of the hospital discharges with more medical complexity," said Dennis Stone, MD, MBA, CMD, AMDA's Advisor to the RUC. After a protracted process, the RUC sent its final recommendations to CMS significantly increasing the relative values of most of the Nursing Facility codes.

"The impact of these RUC recommendations is enormous," said Alva "Buzz" Baker, MD, CMD, AMDA President. "Payments for the physician work associated with nursing facility services (codes 99304-99306, 99307-99310, and 99318) could increase by more than \$196 million in 2008." The table below shows the impact of the work RVU changes for each of the codes.

AMDA was joined in the effort to obtain appropriate physician work values by the American College of Physicians, American Geriatrics Society (AGS), American Academy of Family Physicians (AAFP), and the American Academy of Home Care Physicians (AAHCP).

"AMDA did a commendable job in presenting this information and we were grateful to work with them on this issue," said David C. Dale, MD, FACP, president of the American College of Physicians. "These increases in value are a testament to the extraordinary level of work required of physicians that work in nursing facilities. This increase in value should help to make work in the nursing home as attractive as work in other settings." Meghan Gerety, MD, past president of the American Geriatrics Society agrees: "The AGS strongly supported the values recommended by AMDA for the nursing facility care codes. We were pleased to support AMDA in the effort to fairly capture the work of physicians."

Additionally, with the acceptance of the time data presented with the codes 99304-99306, 99307-99310, and 99318 submitted for approval to the RUC, the CPT Editorial Panel refined the descriptors to include the typical times associated with these services. As a result, prolonged services provided in nursing facilities will become eligible for additional payments when the time requirements for the prolonged services codes 99354-99357 are met. There is no change in the nursing facility discharge codes 99315-16. AMDA will be revising its *Guide to CPT® Coding, Reimbursement and Documentation for Long Term Care* to include times.

AMDA's efforts were led by Dennis Stone, MD, CMD, MBA, and Charles Crecelius, MD, PhD, CMD, AMDA's Advisor and Alternate Advisor to the American Medical Association's Relative Value Scale Update Committee (RUC); Past President Eric Tangalos, MD, FACP, AGSF, CMS; and AMDA Director of Government Affairs Kathleen Wilson, PhD; with the assistance of AMDA's RVS Committee members Arthur Snow MD, CMD; Leonard Gelman MD, CMD; David MacRae MD, CMD; Robert A. Zorowitz, MD, MBA, CMD; and George Taler, MD.

AMDA is a 5,400-member national professional association committed to continuous improvement of quality patient care by providing education, advocacy, information, and professional development for medical directors, attending physicians, and other professionals in the long term care continuum. Visit AMDA at www.amda.com.

Impact of CMS Proposed Work RVUs on Medicare Payments for NF Services

Code	Descriptor	Current Work RVU (2007)	Proposed Work RVU	Proposed CMS Percent Increase	Number Visits 2005	Total \$ Impact of Proposed Work RVU in 2008*	Total \$ Impact Proposed Work RVU in 2008* if 10% decrease in Conversion Factor
99304	NF care, initial	1.20	1.61	40.8%	66,194	\$1,028,521	\$925,670
99305	NF care, initial	1.61	2.30	42.9%	596,972	\$15,610,385	\$14,049,367
99306	NF care, initial	2.01	3.00	49.3%	1,253,854	\$47,042,753	\$42,338,539
99307	NF care, subs	0.60	.76	26.7%	5,290,304	\$32,078,287	\$28,870,501
99308	NF care, subs	1.00	1.16	16.0%	9,942,870	\$60,289,587	\$54,260,707
99309	NF care, subs	1.42	1.55	9.2%	2,170,882	\$10,695,230	\$9,625,721
99310	NF care, subs	1.77	2.35	32.8%	1,168,937	\$25,693,878	\$23,124,524
99318	Annual NF	1.20	1.71	42.5%	198,581	\$3,838,119	\$3,454,312

*Excludes potential budget neutrality adjustments of the work RVUs by CMS in the final rule.

Joint Commission... Did You Know?

by Sefi R. Knoble, MD, CMD, FACP

JCAHO (The Joint Commission on Accreditation for Healthcare Organizations) IS NO MORE! The Joint Commission, as it is now known, recently launched a "new brand identity." It also has a new tagline: "Helping Health Care Organizations Help Patients." The new website name is www.jointcommission.org. There has been no change in Joint Commission activities. Despite their best effort; however, plenty of people will be saying "Jayco" for a long time to come. At the website, they ask that if anybody has questions or suggestions regarding the name change to contact the organization at Brand@jointcommission.org. ■

President's Message

continued from page 1

by specialties. Not-for-profit organizations frequent state that "if one has no margin, one has no mission." This is equally true in the specialty of geriatrics. To be successful in geriatrics in the future, I believe we need to reevaluate how we go about developing and maintaining a strong financial base in order to provide excellent geriatric care in our communities. In order to develop a strong financial geriatric service line we may need to look at how other successful not-for-profit institutions maintain financial stability and continue to successfully carry out their mission. One such successful not-for-profit institution is the Masonic Villages of Pennsylvania. They have recognized the importance of maintaining a significant endowment in order to carry out their mission. We are all aware that many successful educational institutions have found endowments to be the key to maintaining success.

My challenge to all of our PMDA members is to provide leadership by moving geriatric care from "Good to Great" in your communities. Geriatricians need to be committed to educating our colleagues in all subspecialties who provide geriatric care and the lay community. I believe through education and our role modeling quality geriatric clinical care, we will elevate the standard of care in our communities. Thomas Beeman, President and CEO of the Lancaster General Health System has stated, "Health care is a community concern and must be solved by the community." I believe this is right on the mark when it comes to improving geriatric services in our communities. We cannot wait for "Washington" to solve our problems. The solution begins with the passions of those who want to make a difference in geriatric care and geriatric education. Margaret Mead stated, "Never believe that a few caring people cannot change the world. For indeed, that's all who ever have." ■



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**2005 Family Satisfaction Survey, Market Strategies, Inc., Oct. 2005.

***2004, Nursing Home Staff Satisfaction Research, Strategic Resource Partners, LLC, Dec. 2004. The Evercare clinical model is a primary component of Evercare health plans, Medicare Advantage plans offered by United HealthCare Insurance Company or its affiliated corporate entities. ©2006 United HealthCare Services, Inc.



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Make Your Reservations Early!!**

A limited block of rooms is being held at the brand new Wyndham Gettysburg Hotel for the 2007 PMDA Annual Meeting attendees and exhibitors. Please be sure to make your room reservations ASAP to insure room availability, even before the cutoff date. Reservations may be made by calling 1-866-845-8885. Identify yourself as part of the PMDA group and you will immediately receive your confirmation.

PMDA's 2007 Annual Meeting

Mark Your Calendars & Make Reservations Now!

Highlighted topics will be presented such as...

- ◆ Legal Issues in Long-term Care
- ◆ Medication Transition Management:
Reconciliation Tools
- ◆ Medication Regimen Review (Tag F428)
- ◆ Unnecessary Medications (Tag F329)
- ◆ Oral Examination in Geriatric Patients
- ◆ Update on Diabetes Management
- ◆ Public Policy Discussion

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