



# PMDA

## Pennsylvania's Association for Long Term Care Medicine



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### President's Message

## Person-Directed Care

by Pamela A Fenstemacher, MD; pfenstemacher@gmail.com; (215) 481-2738



In the late 1920s, William H. Berger saw an unmet need and, after his death in 1929, his mansion was renovated so that six elderly women would have a home in which to live. More than 80 years later, after three further renovations with accompanying name

changes, Phoebe Wyncote has come full circle as it strives again to be the person-directed home from which it began.

Person-directed care, also known by other acronyms such as resident or patient-centered care, is a philosophy that has caught the attention of many groups ranging from the advocacy group Pioneer Network, to the Centers for Medicare and Medicaid Services (CMS) and AMDA. AMDA's white paper on person-directed care defines it as a "philosophy that encourages both older adults and their caregivers to express choice and practice self-determination in meaningful ways at every level of daily life. Values that are essential to this philosophy include choice, dignity, respect, self-determination and purposeful living."

Although these values are at the core of desirable medical care and are embraced by many medical providers, a variety of current practices in the Long-Term Care (LTC) setting conflict with these principles. From the beginning of residents' days when they awake followed throughout the day by how they take their medications, the food they eat and the activities in which they participate, they commonly follow a schedule that is determined by staff convenience.

The food consumed by residents at these frequently inflexible meal times is often based on a diet that was modified without their input. Even care plans created for the residents focus on their medical problems or the facility routines instead of focusing on who the individual resident is, and what are his or her wishes, likes and dislikes.

For more than a decade, alternative approaches to nursing home care have been evolving and becoming more prevalent as demonstrated by the Eden Alternative, Green House Project, as well as the Planetree and Wellspring Models, in an attempt to better meet the needs of this population. During this time, as we Baby Boomers approach and begin to reach our retirement, there

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# Public Policy Updates

by David A. Nace, MD, MPH, Chair Public Policy Committee; [nacede@upmc.edu](mailto:nacede@upmc.edu); (412) 692-2360

## DEA Reconsiders Its Policy

Over the summer, the Drug Enforcement Administration (DEA) requested information on questions concerning how controlled substances are prescribed and administered in nursing homes. PMDA worked closely with AMDA in crafting a detailed response to this request. The 14-page response was submitted in August 2010.

After receiving almost 500 responses to the request, the DEA issued a statement of policy on October 6, 2010, in the Federal Register (<http://edocket.access.gpo.gov/2010/pdf/2010-25136.pdf>). This change in policy would allow nursing facility nurses to be the agent of the prescriber when clinicians are prescribing Schedule III-V medications, thus allowing nursing facility nurses to contact the pharmacy on behalf of the clinician. The new policy would require the physician to establish an agreement with each nurse acting as their agent, and would not apply to Schedule II medications.

PMDA is working with AMDA to request the DEA extend its policy to include Schedule II medications. In a recent survey, half of AMDA members reported prescribing Schedule II medications daily. Thus the change in DEA policy still fails to ensure pain is adequately, promptly, and safely treated in nursing facility residents.

PMDA has signed an AMDA letter to the DEA concerning Schedule II medications. Both the PMDA response to the DEA and the AMDA letter to the DEA concerning Schedule II medications are available on the PMDA website ([www.pamda.org](http://www.pamda.org)).

## Eliminating Myths about F 334—

### Influenza and Pneumococcal Immunizations

Several members have reported difficulties with surveyor interpretations of F 334—Influenza and Pneumococcal Immunization Programs. Facilities report being advised of information not required under this federal licensure regulation. The three most common misconceptions reported are:

- 1) Written consent forms are required for influenza vaccination – **FALSE**.

F 334 does not require written consent, nor does the CDC, other state or federal regulations or any professional organization. Written consent forms are deterrents to effective immunization programs and should never be encouraged. Use of written consent forms for influenza would not be considered standard of care. Influenza immunization remains one of the safest medical treatments available and the most effective means of preventing influenza.

- 2) Physician orders are required for influenza vaccination – **FALSE**. F 334 does not require a specific physician order. In 2003, CMS authorized the use of standing order programs. Under such programs, influenza and pneumococcal immunizations may be given without a physician order as long as the facility has a standing order policy approved by the medical director. Go green, save a tree, eliminate unnecessary work, and prevent influenza!
- 3) Family members should sign a form stating they received education on the influenza vaccine – **FALSE**. F 334 in no way requires this. Facilities are required to provide education, which must include the Vaccine Information Statement (VIS). The VIS may simply be given to residents or be mailed to proxy decision makers. No signatures are required.

PMDA was involved in the development of F 334 and Dr. David Nace provided the surveyor training on this F tag in October 2009. PMDA re-verified the information provided above with CMS in September 2010.

## An Archaic Regulation Bites the Dust: Physicians No Longer Must Countersign CRNP Orders and Notes

After many years of discussion with the PA Department of Health (DOH), we've finally been heard! In July 2010, the DOH submitted a proposal to IRRC to eliminate 211.7(c), the requirement that all CRNP orders, notes and notations must be countersigned by a physician within seven days.

Following Act 48 of 2007, this regulation simply made no sense, reduced efficiency of care, and failed to improve patient safety. The final policy change was published in the October 2, 2010, PA Bulletin and is available on our website. Thanks to all who participated in the Request for Exemption Campaign, which helped make this possible!

## Long Awaited PA POLST Version Approved

Following Act 169 of 2006, the PA DOH began development of a Pennsylvania version of the POLST form. The PA version (Pennsylvania Orders for Life Sustaining Treatment) is now available and will be posted on the PMDA website ([www.pamda.org](http://www.pamda.org)). The POLST directives may be recognized and followed by EMS teams simply by contacting medic command. The form will be published in Pulsar Pink with 110# weight paper (in case you are ever asked on Jeopardy!).

## 'Never Events' Changes Name and Is Released for Comment

The PA Department of Public Welfare (DPW) released a proposed list of Preventable Serious Adverse Events (PSAE), formally termed never events, for nursing facilities in the October 16, 2010 PA Bulletin. The notice also prohibits facilities from knowingly billing the MA program for events on the list. To meet the criteria of PSAE, all four of the following criteria must be met:

- 1) The event was preventable.
- 2) The event was serious.
- 3) The event was within the control of the nursing facility.
- 4) The event is the result of an error or other system failure within the nursing facility.

DPW accepted comments on the notice through November 16, 2010. PMDA members were strongly encouraged to read and comment on the list, which can be found at <http://www.pabulletin.com/secure/data/vol40/40-42/1975.html> or by link on our website. ■

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# Pennsylvania POLST Education Planned for Early 2011

by David A. Nace, MD, MPH; [nacede@upmc.edu](mailto:nacede@upmc.edu); (412) 692-2360

Michael Huff, Acting Secretary for the Pennsylvania Department of Health (DOH), approved the Pennsylvania Orders for Life-Sustaining Treatment form in late October. The Department of Health will make the form, along with printing instructions, available on the DOH website.

Anticipating the finalization of the POLST form, a coalition of interested long-term and palliative care physicians, insurers, health care providers, and professional and trade associations have collectively

planned a series of introductory educational webinars for January 2011. The webinars will provide a foundational understanding of Pennsylvania's advance directive law and how physician orders for life-sustaining treatment can support care decisions at the end of life.

Health care providers will also have an opportunity to hear how hospitals, nursing homes and communities have come together to implement physician orders for life-sustaining treatment in their facilities. Following these introductory webinars,

expert faculty will conduct regional face-to-face sessions to assist those interested in implementing the Pennsylvania Orders for Life-Sustaining Treatment in their communities.

For more information about the project or to volunteer your involvement, please contact Sharon Muscatell, director, quality and accreditation services at the Hospital & Healthsystem Association of Pennsylvania (HAP) at [smuscatell@haponline.org](mailto:smuscatell@haponline.org) or (717) 561-5347. ■

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## PMDA's Annual Symposium Exceeds Expectations!

by Susan Denman, MD, CMD, FACP; [susan\\_j\\_denman@uhc.com](mailto:susan_j_denman@uhc.com); (215) 902-9009

The PMDA 18th Annual Symposium on Friday, October 15, in Hershey Pennsylvania was attended by 150 participants, our largest group ever! Once again, the audience was treated to a comprehensive program with excellent speakers of national renown.

The morning session about End-of-Life Care in the Long-Term Care environment was created by the Symposium Committee in conjunction with the Pennsylvania Hospice Network, and the afternoon program included key regulatory updates and clinical topics pertinent to the LTC clinician. Most of the enthusiastic audience stayed for the entire day – a tribute to the value of this educational experience and networking opportunity.

Symposium topics in the morning program included:

- identifying prognostic factors in advanced illnesses and improving communication skills with patients and families who face end-of-life decisions;
- integrating palliative care concepts into the LTC setting and improving

the collaboration between hospice and nursing facility palliative care teams; and

- discussing dementia as a terminal illness.

The lunch program included AMDA updates from Dr. Karen Leible, AMDA president-elect, as well as a tour of the new and improved PMDA website by PMDA board member Dr. Leon Kraybill.

The afternoon program combined clinical and regulatory topics, including:

- the implications of F-tag 441 regarding infection control and outbreak identification;
- understanding the role of the medical director during outbreaks of C. diff or norovirus;
- managing diabetes in the nursing home resident;
- clarifying common misunderstandings regarding regulatory requirements, “never events” and LTC clinical protocols; and

- explaining the role of the medical director in the LTC survey process.

Copies of the symposium Power Point presentations will be posted on the PMDA website for those who missed the meeting.

The PMDA Annual Symposium provides a perfect opportunity to learn about the latest clinical and regulatory updates, attend the annual business meeting over lunch and network with colleagues while earning CME and CMD credits. ■

### SAVE THE DATE

The PMDA 19th Annual Symposium will be held at the Hershey Lodge on October 21, 2011.

We encourage all PMDA members to attend.

# DPW Issues Proposed Bulletin Identifying Preventable Serious Adverse Events for Nursing Facilities

by Paula G. Sanders, Esq.; [psanders@postschell.com](mailto:psanders@postschell.com); (717) 612-6027

On October 16, 2010, the Pennsylvania Department of Public Welfare (DPW) published the long-awaited proposed bulletin<sup>1</sup> that identifies Preventable Serious Adverse Events (PSAEs) for nursing facilities. Under the Preventable Serious Adverse Events Act (Act 1),<sup>2</sup> a health care provider [all types] may not *knowingly* seek payment from a health payer or patient for a PSAE or for any services required to correct or treat the problem created by a PSAE when that event occurred under his or her control.

Act 1 delegated the question of what constitutes a PSAE in a nursing facility to DPW. The Act directed DPW to issue a bulletin with a 30-day comment period and to address those comments before releasing a final bulletin. When the final bulletin is issued, which is anticipated to occur in the next three months, nursing homes will be prohibited from knowingly seeking payment from residents or the Medicaid program for a PSAE as defined in the bulletin.

Pennsylvania is one of the first states in the country to implement a non-payment policy for nursing home “never events” or PSAEs. It is also one of the first states to apply this type of policy on a prospective basis—if a nursing home knows that a PSAE has occurred in its facility, it may not knowingly seek payment. If it discovers that payment has *unknowingly been sought* for a PSAE or services required to correct or treat the problem, it must immediately notify the health payer or patient and refund payment within 30 days of discovery or receipt of payment, whichever is later. Although the bulletin only addresses payment provisions under the Medicaid program, there is a high

probability that it will become a model for other payers.

A cursory review of the proposed bulletin highlights many of the challenges involved with applying a never event payment policy to nursing homes, and underscores the important role physicians will play in helping their facilities determine if certain events were truly within the nursing home’s ability to prevent.

Unlike acute care hospitals, nursing homes typically treat patients with chronic, as opposed to acute and episodic, illnesses. Due to their extended stays and multiple co-morbidities, an event that might otherwise appear to be a PSAE may be caused by an underlying medical condition that, if properly documented, would show that the event was not preventable. The Pennsylvania Medicaid program reimburses participating nursing homes under a complex case mix payment system, making it difficult, if not impossible, to quantify the true cost of a PSAE. One of the more troubling provisions of the bulletin, perhaps, is that in cases where a resident’s case mix index remains high after a PSAE, DPW will not accept a medical director’s or attending physician’s determination that a resident’s condition is no longer the result of a PSAE, but instead will require facilities to petition the DPW to review the clinical decisions before a payment restriction may be lifted.

Facilities should convene a PSAE committee consisting of physicians, clinical, front line, administrative and billing staff to review the bulletin and prepare for its implementation. Medical directors should engage in the process

and provide guidance on how to identify whether an event was preventable, as well as whether a resident’s change in condition is related to a PSAE. The deadline to submit comments to the DPW was November 15, 2010.<sup>3</sup>

## What is a PSAE?

In order for an event to be a PSAE, it must occur in the nursing facility, the following four conditions must be satisfied *and* the event has to be one that has been identified by the DPW as a PSAE. The four conditions are:

1. The event was preventable. To be preventable, the event could have been anticipated and prepared for, but, nonetheless, occurred because of an error or other system failure; *and*
2. The event was serious. The event is serious if the event subsequently results in death or loss of body part, disfigurement, disability or loss of bodily function lasting more than seven days or still present at the time of discharge from a nursing facility; *and*
3. The event was within the control of the nursing facility. Control means that the nursing facility had the power to avoid the error or other system failure; *and*
4. The event is the result of an error or other system failure within the nursing facility.

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<sup>1</sup> The proposed bulletin can be accessed at <http://www.pabulletin.com/secure/data/vol40/40-42/1975.html>

<sup>2</sup> The Preventable Serious Adverse Events Act, Act of June 10, 2009, P.L. 1, No. 1, codified at 35 P.S. §§ 449.91—449.97 (“Act 1”), passed unanimously on June 8, 2009 and was signed by Governor Ed Rendell on June 9, 2009.

<sup>3</sup> Comments should be sent to: Commonwealth of Pennsylvania, Department of Public Welfare/Department of Aging, Office of Long-Term Living, 555 Walnut Street, 5th Floor, Harrisburg, PA 17101-1919, Attention: Yvette Sanchez-Roberts.

**The comments below are from PMDA member Leon Kraybill, MD, submitted on Oct. 29, 2010 to the Department of Public Welfare on Bulletin 35:**

**Attention:** Yvette Sanchez-Roberts

**RE:** Public comment on PA Bulletin 35, Preventable Serious Adverse Events

Dear Office of long-term living:

I am a geriatrician and attending physician at two medium-size Pennsylvania DeFYI Long-Term Care facilities. I am responding to proposed legislation regarding Preventable Serious Adverse Events (PSAEs).

In principle, I agree with the proposed legislation, which seeks to eliminate preventable events, facility negligence, and individual malfeasance. It is always my personal goal, and that of my facilities, to provide stellar care free of personal or corporate error.

I am concerned, however, about some of the specific events that you have listed. In particular, the “fine print” of how you define some of these events will be very important. I am concerned that in some cases, a resident’s inevitable decline and death in a terminal setting could be attributed to facility negligence. I am concerned about the resident who has complications despite facility quality standard-based care. I am concerned that in a population of individuals who are declining and approaching death, this legislation will define success as health, longevity, and lack of decline.

Specifically:

1. **4A - a medication error** – The sheer number of medications administered in my facilities on any month is astounding – thousands and thousands. While my facilities work very hard to eliminate any medication errors, we know that we can never completely eliminate error from the human condition. Appropriate safeguards can’t limit these errors. Administration protocols can improve accuracy. A facility should have an established, thorough, and well thought out approach to this. However, an assumption that an excellent facility never has medication errors is not truly realistic
2. **4E - catheter associated urinary tract infections** – Each of my facilities of 100 and 160 skilled beds have only one or two residents at a time with indwelling urinary catheters. In a few medical situations they are justified. We know that the presence of catheters increases the risk of infection, but sometimes the presence of catheters is preferable to urinary retention or worsening pressure sores or significant resident discomfort. Medical studies show that the colonization rate of these catheters is quite high, at least 25 percent or more. Appropriate catheter care minimizes but does not eliminate the risk of significant infection. It seems unreasonable to assume that any infection associated with indwelling catheter assumes negligence. They should be very rare, but I do not think that they can legitimately be completely prevented. Legislation penalizing such infections will likely result in catheters not being used, even when they may be medically justified. This equally could result in bad outcomes for residents.
3. **4H - an event related to hypoglycemia** – The control of blood sugars is significantly related to illness, food intake, medical decline and other comorbid conditions. We seek to recognize these conditions, anticipate the blood sugar fluctuations, and treat accordingly. However, many brittle diabetics can drop from a normal blood sugar to a comatose state in a matter of hours, with very few other signs to warn of the decline. Some of my patients will fluctuate from extremely high sugars to symptomatically low readings in the same day. While the majority of residents should be able to be maintained in a reasonable blood sugar range, there are some who cannot be regulated and in whom symptomatic high and low blood sugars cannot be prevented.
4. **5B - an event related to a fall** – My facilities spend extensive time, discussion, energy, and effort to prevent falls in our residents. However, our resident population is one which is routinely experiencing clinical decline, gait and balance disturbances, infections, delirium, dementia, and impaired judgment. Short of having 1:1 care, no facility can guarantee that any one resident will never fall or have injury. It is very demoralizing to a facility to provide day after day of above average care, only to be penalized for an event that is not realistically preventable.

In summary, I ask for a reasonable and real-world practical approach to these medical conditions. We should not accept in any situation behavior that is abusive, neglectful, deliberately harmful, lazy, substandard, and uncaring. On the other hand, we should not penalize facilities for the inevitable decline of residents, or when adverse outcomes occur in the setting of compassionate and comprehensive and thorough care.

Sincerely,

Leon S. Kraybill, MD, CMD  
Geriatric Specialist

# AMDA Update

by J. Kenneth Brubaker, MD, CMD, FACP; jkbrubak@masonicvillagespa.org; (717) 361-4011

There continues to be many issues that engages the AMDA board and staff.

Certainly the DEA issue has been on our front burner and continues to receive a lot of energy collaborating with other health care organizations. While it may appear there has been some improvement in defining the nursing home nurse as an “agent,” the recent DEA announcement continues to require many cumbersome hoops to go through. The DEA continues to dig its heels into this issue, which does little to improve the pain management issues for Schedule II medications.

What seems like a very simple solution, namely identifying the nursing home nurse as an “agent” similar to the way the hospital nurses are treated as “agents” with no extra hoops, has taken on a life of itself and continues to create barriers in providing quality health care to the frail older adults within the nursing home community. Stay tuned! This issue may ultimately require legislative action if the DEA continues to create insurmountable barriers to successful treatment of America’s older adults in our communities.

Another very important topic in health care has to do with encouraging more people to join the workforce that is needed in caring for the rapidly growing population of frail older adults. Recently, the Institute of Medicine (IOM) issued a new report urging policies that promote more independence for advanced-practice nurses (APNs) in order to solve the physician shortages.

Those physicians with advanced geriatric training also acknowledge the dire need for expanding an adequately trained workforce in geriatrics. However, the issue is much greater than training more APNs in geriatrics and promoting more independence of APNs. While the Patient Protection and Affordable Care Act (PPACA) passed this past March does include the establishment of a National Health Care Workforce Commission, establishes grants to provide training opportunities for direct care staff working with frail older adults, and creates grants for more geriatric training in medical schools, health care reform has not effectively dealt with the inequities of reimbursement among all specialties and the increasing cost of medical education

that forces many debt-ridden students into higher reimbursement specialties.

Finally, one of the areas of AMDA’s interest has to do with developing core competencies for providers engaged in caring for frail older adults. This interest is as a result of geriatric trained providers and a number of nursing home organizations requesting guidelines for expected knowledge and care of residents in a nursing home, LIFE care, and Waiver Program.

Dr. Matt Wayne, our future AMDA president, is leading a committee in the development of core competences. A lot of thought and planning has gone into this process. There will be future opportunities for input by AMDA members and members of associations related to Long-Term Care. It is important to get it “right,” since it will become the standard of expected care in our specialty.

Finally, AMDA is always looking for enthusiastic and passionate geriatric providers who are interested in serving on committees. Please feel free to contact Dr. Dan Haimowitz, a fellow AMDA Board member, or me if you are interested in helping. ■

## President’s Message

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has been an increasing groundswell of professionals who care for the frail elderly and advocacy groups, such as the Pioneer Network, promoting person-directed care in the Long-Term Care setting.

In response to this desire for change of culture in nursing facilities, CMS revised the *State Operations Manual, Appendix PP—Guidance to Surveyors for Long Term Care Facilities* in April 2009. CMS changed the interpretive guidelines as they relate to several federal tags that focus on quality of life and environment, especially F-Tag 242 (Self-Determination

and Participation) that now includes the statement:

*“Residents have the right to have a choice over their schedules, consistent with their interests, assessments, and plans of care. Choice over “schedules” includes (but is not limited to) choices over the schedules that are important to the resident, such as daily waking, eating, bathing, and the time for going to bed at night. Residents have the right to choose health care schedules consistent with their interests and preferences, and the facility should gather this information in order to be proactive in assisting residents to fulfill their choices.”*

“AMDA supports the philosophy of person-directed care and believes that

it can promote improved quality of life for long term care residents.” AMDA’s white paper on person-directed care does express concern that “while promoting resident choice and dignity is essential, approaches that focus only on these psychosocial issues while ignoring the resident’s complex medical needs invite poor outcomes.”

Many are concerned that vulnerable residents may be at greater risk for:

- developing pressure ulcers if they are allowed to stay in one position in bed for too long or may have problematic loss of diabetic control;

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# Review of *Clostridium difficile* Guidelines 2010 Update

By Dale K. Hursh, MD; [dkhursh@lancastringeneral.org](mailto:dkhursh@lancastringeneral.org); (717) 544-3022

This year marks 15 years since publication of the Society of Healthcare Epidemiology of America (SHEA) position paper on *Clostridium difficile* infection (CDI). It also marks eight years since SHEA issued a position paper on CDI with information specifically for Long-Term Care settings. Since the release of these two papers, there have been changes in the epidemiology and treatment of this infection. To provide current guidance, a joint expert panel appointed by SHEA and the Infectious Diseases Society

of American (IDSA) developed and published an update this year in the May issue of *Infection Control and Hospital Epidemiology*.

The 2010 clinical practice guidelines for CDI in adults included information on the definition of CDI, the changing epidemiology, important diagnostic considerations, and recommendations for infection control and environmental management of the pathogen as well as treatment. The recommendations were based on best available evidence and

practices as determined by the expert panel, and the process used to develop the guidelines included a systematic weighting of the quality of the evidence and the strength of each recommendation.

**Definition:** Diagnosis should be based on a combination of clinical and laboratory findings. A case of CDI is defined by the presence of symptoms (usually diarrhea) and either a stool test positive for *C. difficile* toxins or toxigenic *C. difficile*, or colonoscopic or histopathologic

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## DPW Issues Proposed Bulletin Identifying Preventable Serious Adverse Events for Nursing Facilities *continued from page 4*

There are six categories of PSAE events. They are listed below:

### 1. Surgical Events

- Surgery performed on the wrong body part
- Wrong surgical procedure performed on a resident
- Surgery performed on the wrong resident
- Unintended retention of a foreign object in a resident after surgery or other procedure

### 2. Product or Device Events

- An event associated with the use of contaminated drugs, devices or biologics provided by the nursing facility
- An event associated with the use or function of a device in resident care in which the device is used for functions other than as intended
- An intravascular air embolism that occurs while being cared for in a nursing facility

### 3. Resident Protection Events

- Resident suicide or attempted suicide

- Resident elopement (disappearance for more than four hours)

### 4. Care Management Events

- A medication error (such as errors involving the wrong drug, wrong dose, wrong resident, wrong time, wrong rate, wrong preparation, or wrong route of administration)
- Severe allergic reaction
- A hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products
- Stage 3 or 4 pressure ulcers acquired after admission to the nursing facility
- Catheter-associated urinary tract infection
- An event related to spinal manipulative therapy
- Vascular catheter-associated infection
- An event related to hyper- or hypoglycemia (diabetic ketoacidosis, nonketotic hyperosmolar coma, diabetic coma, hypoglycemic coma) the onset of which occurs while the resident is being cared for in a nursing facility

### 5. Environmental Events

- A burn incurred from any source while being cared for in a nursing facility

- An event related to a fall (fractures/dislocations/crush injuries/intracranial injuries/burns) while being cared for in a nursing facility
- An electric shock while being cared for in a nursing facility
- Any incident in which a line designated for oxygen or other gas to be delivered to a resident contains the wrong gas or is contaminated by toxic substances
- An event associated with the use of restraints or bedrails while being cared for in a nursing facility

### 6. Criminal Events and Unlawful Activities

- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider
- Abduction of a resident
- Sexual assault on a resident
- A physical assault (that is battery) ■

For more information on how a PSAE can be identified and how non-payment amounts can be calculated, visit the PMDA website at [www.pmda.org](http://www.pmda.org).

## Review of *Clostridium difficile* Guidelines 2010 Update

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findings revealing pseudomembranous colitis. While many patients have a history of antibiotic treatment in the eight weeks preceding illness, recent antibiotic use is not part of the definition due to cases of CDI occurring in the absence of antimicrobial use.

**Epidemiology:** The guidelines provided recommendations for how CDI surveillance data should be collected and reported. Available standardized case definitions for surveillance of infection should be used, and these are:

1. health care facility onset, health care facility-associated CDI;
2. community-onset, health care facility-associated CDI; and
3. community-associated CDI.

At a minimum, all inpatient health care facilities should conduct surveillance for health care facility-onset and health care facility-associated CDI in order to identify outbreaks and monitor patient safety. The rate of health care-associated CDI should be expressed as the number of cases per 10,000 patient-days.

The changing epidemiology of CDI was highlighted in the guidelines with available data showing increases in overall incidence, particularly in those ages 65 and older, as well as in disease severity. Other notable epidemiologic changes mentioned include its occurrence in populations previously felt to be low risk and emergence of NAP1/BI/027, a more virulent strain.

**Diagnosis:** Testing for the organism should only be done on unformed, diarrheal stool unless ileus is suspected. Stool testing of asymptomatic individuals is not advised, and this includes tests of cure. When diagnostic testing for CDI is available, it should be used and empiric treatment without diagnosis is considered inappropriate.

Regarding testing methods, stool culture is recognized as the most sensitive but not clinically practical due to slow turnaround time. Enzyme immunoassay (EIA) testing for *C. difficile* toxin A and B is rapid though less sensitive and for this reason considered by the expert panel to be a suboptimal alternative approach for diagnosis.

Toxin testing is most important clinically, though limited by its decreased sensitivity. The guidelines included a potential solution to this involving a two-step testing method to improve sensitivity. A final acceptable testing option noted is polymerase chain reaction (PCR) testing. This appears to be rapid, sensitive and specific, but more data are needed before routine use can be recommended.

**Infection control and prevention:** Health care workers and visitors should wear gowns and gloves on entry to the room of patients with CDI. Additionally, compliance with hand hygiene is emphasized. When outbreaks or increased CDI rates are noted, visitors and health care workers should wash hands with soap and water after contact with infected patients.

The guidelines noted the resistance of *C. difficile* spores to killing by alcohol-based hand antiseptics. Patients with CDI should be accommodated with a private room with contact precautions. When private rooms are not available, an acceptable alternative is to cohort infected patients and provide dedicated toilets for each.

Identification of asymptomatic carriers is not advised, nor is treatment. In terms of environmental cleaning and disinfection, use of chlorine-containing cleaning agents is recommended. Also important to prevention is minimizing the frequency and duration of antimicrobial therapy as well as the number of antibiotics prescribed.

Implementation of an antibiotic stewardship program is encouraged. Use of probiotics is not recommended for primary *C. difficile* prevention as limited data exist to support this, and there are potential risks for inducing bacteremia or fungemia from the probiotic.

**Treatment:** Effort should be made to stop the causative antimicrobial agent as soon as possible. When severe or complicated CDI is suspected, empiric treatment is recommended without delay. If the stool toxin assay is negative, treatment decisions should be individualized. Because they can obscure symptoms and precipitate toxic megacolon, antiperistaltic agents should be avoided.

Metronidazole is the drug of choice for an initial episode of mild-to-moderate CDI at a dose of 500 mg orally three times per day for 10 to 14 days. Vancomycin is the agent of choice in an initial episode of severe CDI and is dosed at 125 mg orally four times per day for 10 to 14 days. The regimen of choice in cases of severe, complicated CDI is vancomycin given orally with or without IV metronidazole. Colectomy should be considered for severely ill patients.

# SAVE THE DATE:

## State Chapter Reception

PMDA will hold a chapter reception for members at the AMDA Annual Meeting in Tampa, Fla. The reception will take place from 6-7:30 p.m. on Friday, March 25. More details will follow.

For more info on AMDA's Annual Meeting, which runs from March 24-27, visit <http://ltcmedicine.com/default.aspx>.

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# New PMDA Website Provides Added Resource for Members

by Leon S. Kraybill, MD, CMD, [leon@kraybill.net](mailto:leon@kraybill.net); (717) 544-3022

PMDA on the Web, PMDA's newly updated website with many new features, became available during the 2010 PMDA Annual Symposium. You can visit the site at our previous address, [www.pmda.org](http://www.pmda.org). The site complements the resources that PMDA offers to Long-Term Care facilities and the professionals who provide care in this arena.

Updates on PMDA public policy are provided. Links to current LTC are listed, as well as regulations that are being considered. Current issues in LTC are available, such as information on recent DEA rulings on prescribing controlled meds in LTC.

PMDA on the Web users can access information on PMDA membership and benefits, previous PMDA symposia, and links to LTC CME. Educational opportunities for providers and facilities are available, along with extensive links to geriatric resources. Resources are provided for personal care, provider responsibilities and AMDA clinical practice guidelines. Links for facility comparison are also listed.

A section on LTC clinical issues includes pages on dementia and evaluation, pain management, transitions of care and infectious diseases. A variety of forms and templates can be downloaded and used in any facility. A policy and procedure section will become a place to peruse documents that facilities have used to manage their clinical situations. These forms are offered to PMDA members for use, and improvement of quality care.

Future developments will include a discussion board for PMDA members to discuss and seek input on LTC concerns.



An employment section will allow individuals or facilities to advertise LTC employment opportunities.

PMDA seeks to make this site the one-stop website address that keeps its members up to date, provides resources for quality LTC, outlines potential templates for LTC use, and serves as a vehicle for sharing the joys and struggles of LTC. PMDA welcomes your suggestions for improvement of this site, and seeks your submissions of templates, policy and procedures, or any other beneficial information.

Please send your suggestions to the webmaster, Leon Kraybill, [leon@kraybill.net](mailto:leon@kraybill.net). ■

## Welcome New Members

PMDA welcomes the following new member to the Association:

### Active Members

Nancy Chudoff, CRNP  
Erin Concannon-Fink, DO  
Gerald Gibbons, MD  
Charles Givens, MD, FAAFP  
Tatyana Kemarskaya, MD  
Ashith Mally, MD  
Gregory Mokrynski, MD  
Adaora Okoli-Umeweni, MD  
Robert Potter, Jr., MD  
Bernard Proy, MD  
Russell Rentler, MD  
Bruce Silver, MD  
Heidi Singer, CRNP

Evan Switala, PA  
James Tricarico, DO  
Joel Yeager, MD  
LuAnne Yeager, MD

### Affiliate Members

Vicki Gillmore, RN  
David Johnson  
Susanne Kelly, RN  
Lisa Sherwood  
Jean Yarnall

### LTC Industry Partner Member

Ryan Dougherty

## President's Message

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- increased blood pressure if allowed to eat indiscriminately or if given higher risk pain medicines based on their insistence may have bad outcomes.

Realizing that the basis of good geriatric care is the attempt to balance residents' complex medical needs while trying to maintain their personal choice and quality of life, AMDA believes that a "blanket or rote approach" will not suffice. Individualized care that should seek to understand the entire person—the medical, functional and psychosocial aspects of the resident—was recommended.

Furthermore, it was recommended that the interdisciplinary team should consider both the potential effects of proposed interventions on the resident as well as its effect on a disease, as seen with diets to treat diabetes and hypertension that have only modest benefit and can cause weight loss in the frail elderly.

Residents with dysphagia were also discussed because they present a comparable challenge by being at increased risk for choking and aspiration pneumonia. Unfortunately, thickening the liquids of residents with swallowing dysfunction is of questionable value in reducing these risks and can increase their risk of dehydration and malnutrition.

Proper person-directed care requires an effective interdisciplinary team that can consider the risks and benefits of potential interventions, effectively discuss these issues with residents and/or their family/POA, and develop and monitor an individualized plan of care. Furthermore, given the often complex medical needs of nursing home residents, person-directed care highlights the critical role of the medical director in leading the interdisciplinary team.

Because AMDA feels so strongly that the medical director is essential in promoting individualized quality care, in 2007, with financial support from the Commonwealth Fund, AMDA formed an advisory panel with the Pioneer Network and CMS to develop person-directed care competencies for medical directors.

AMDA's 1991 *Medical Director: Role and Responsibilities as Leader and Manager-Functions and Associated Tasks* document has eight medical director functions and associated tasks that have served to define the role of the medical director in the nursing home and helped to shape the educational content of the current Core Curriculum on Medical Direction in Long-Term Care. This task force used a similar methodology to define the role of the medical director and develop a set of competencies for the medical director in facilitating person-centered care.

Twenty-five of AMDA's medical directors with experience in both the clinical care and medical direction of nursing homes that

practice person-directed care took an initial list of 40 competency statements for person-directed care and helped consolidate them to six. The task force believed that there should be a ninth function statement added to the original eight that defines the medical director's role in person-directed care, and that the six competency statements would serve as the associated tasks for this function statement.

"Function 9: Person-Directed Care—the medical director will support and promote person-directed care." The six task statements suggest that the competent medical director should:

- provide oversight to clinical and administrative staff to help maintain and continuously improve the quality of care;
- encourage active resident participation in and promote the incorporation of resident preferences and goals into the development of an individualized plan of care;
- help develop, implement and review policies and procedures that ensure residents are offered choices that promote comfort and dignity;
- collaborate with the interdisciplinary team (IDT), the family and allied services within and outside the organization to encourage planning, implementing and evaluating clinical services to maximize resident choice, quality of life and quality of care;
- educate physicians and other medical professionals on maintaining clinical standards in the context of individualized care;
- collaborate with nursing home leadership to create a person-directed care environment while maintaining standards of care.

In addition to adopting the ninth function of the medical director and its six associated tasks, AMDA is developing education based on these competency statements that will enable medical directors to support and promote person-directed care in the Long-Term Care setting.

"Person-directed care promotes resident choice and self-determination in ways that are meaningful to the resident. It has been a key component of geriatric medicine for decades. The interdisciplinary team and the medical director have essential roles both in facilitating this process as well as in monitoring it for desired outcomes. Medical directors and clinicians should help nursing home administration and staff understand how to provide person-directed care while maintaining clinical excellence. To ensure success, nursing home leadership must support these efforts. In addition, regulations and related surveyor guidance should permit the flexibility to individualize care."

— *The Role of the Medical Director in Person-Directed Care*, AMDA White Paper 2010. ■

## Review of Clostridium difficile Guidelines 2010 Update

*continued from page 8*

Recommendations for treatment of recurrences were also included in the guidelines. First, recurrences should be treated with the same regimen as the initial episode, but they should be stratified by disease severity as for the initial episode, i.e., mild-to-moderate illness, severe, or severe complicated. Metronidazole should not be used beyond the first recurrence or for prolonged therapy due to potential for cumulative neurotoxicity.

Second or later recurrences should be managed with vancomycin using a tapered and/or pulse regimen. An example of a tapering regimen included in the guidelines is as follows: after completion of the usual regimen of vancomycin 125 mg orally four times a day for 10 to 14 days, vancomycin is then administered at 125 mg orally twice a day for 7 days, then 125 mg orally once daily for seven days, then 125 mg orally every two or three days for two to eight weeks.

The guidelines acknowledge the challenge of managing patients who fail the tapering treatment or who experience further relapse. Regarding probiotics in recurrent CDI, studies are inconclusive. No recommendations were made regarding CDI prevention in patients who require continued antimicrobial therapy for an underlying infection.

**Revision dates:** At annual intervals, SHEA and IDSA will determine the need for revisions to the guidelines on the basis of examination of current literature and the likelihood that any new data will have an impact on the recommendations.

**Summary:** *Clostridium difficile* is a common cause of infectious diarrhea in health care settings, and the epidemiology of CDI has changed dramatically in the past several years. Hopefully, by implementing the recommendations of the 2010 updated practice guidelines for CDI in adults, we can stem the tide of this burgeoning disease. ■

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