

# PMDA

# news

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

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Official Pennsylvania Chapter of  
American Medical Directors Association



## President's Message

# PMDA Seeks Innovation to Meet Future Challenges

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



As the new president of PMDA, I have been able to begin to fully appreciate how PMDA continues to be an organization that is not only thriving and effecting positive change within our state, but also helping improve long-term care at the national level.

Not only do we continue to be recognized as one of the largest, most successful and dynamic state chapters, with the most CMDs of any state, our organization also has many members who are actively involved throughout our national organization, AMDA. PMDA continues to pursue new initiatives in response to the rising professionalism of our members who serve in long-term care facilities in Pennsylvania.

Our committees continue to be the backbone of PMDA, pursuing aggressive agendas.

The public policy committee, under the guidance of Drs. David Nace and Tom Lawrence, continues to explore issues that relate to interface of government, provider groups, professionals and LTC residents. The committee continuously promotes advocacy dealing with clinical, administrative and regulatory issues of critical importance to our organization's primary objective of improving the quality of care for LTC residents in Pennsylvania.

As an organization we continue to highlight PMDA's position on topics that are important to our members, such as DEA regulations and Never Events in the LTC setting, to our

Pennsylvania Legislators. Through our strategic partnership committee, under the guidance of chair Gary Bennett, MD, we are working with other organizations such as PADONA, PANPHA and PHCA to increase our success in Harrisburg as a long-term care organization as well as increase our membership.

The membership committee, under the leadership of Dr. Lawrence, is working to expand our membership. The PMDA board is assisting him by investigating and developing new services, such as the list serve, in order to meet the growing needs of an increasingly diverse group of LTC professionals. Expanding our membership continues to be an important goal as it increases the effectiveness of our organization, and we continue to look at creative ways to achieve this goal through increased partnering with AMDA.

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# Reporting Consultation Services in the Nursing Home to Medicare: Revisions to Payment Policy

by Paula Bonino, MD, MPE, FACP; paula.bonino@highmarkmedicare.com, (412) 544-1931

By now, you are aware that the Centers for Medicare and Medicaid Services (CMS) changed payment policy regarding consultation services. Effective January 1, 2010, CPT consultation codes (99241-99245 and 99251-99255) are no longer recognized for Medicare Part B payment.

Clinicians are to code patient evaluation and management (E/M) visits with E/M codes that represent *where* the visit occurs, and that identify the *complexity* of the visit performed.

Highmark Medicare Services, the MAC contractor for the J12 region (Pennsylvania, New Jersey, Maryland, Delaware and the District of Columbia), maintains Local Coverage Determination (LCD), L27496, Evaluation and Management Services Provided in a Nursing Facility, which was updated due

to these changes. L27496 is available at: <https://www.highmarkmedicare.com/policy/mac-ab/l27496-r5.html>

As per LCD L27496, “initial nursing facility care includes all evaluation and management services performed by the same physician or group done in conjunction with that admission when performed on the same date as the admission or readmission. The nursing facility care level of service reported by the admitting physician should include the services related to the admission he/she provided in the other sites of service as well as in the nursing facility setting.

The initial visit in a Skilled Nursing Facility (SNF) and Nursing Facility (NF) must be performed by the physician except as otherwise permitted (42 C.F.R. 483.40 (c) (4)). The initial visit is defined

as the initial comprehensive assessment visit during which the physician completes a thorough assessment, develops a plan of care and writes or verifies admitting orders for the nursing facility resident. For Survey and Certification requirements, the visit must occur no later than 30 days after admission.”

Also: “Consultative or specialist services are allowed when they address a documented diagnostic or therapeutic question of which the attending physician determines he or she needs the assistance or second opinion of a specialist (by a record review and a physical and/or cognitive examination) to assess the condition.

“Only one initial specialist service should be reported by each specialist per admission. When ordering specialist services, the following elements need to be considered: a consulting specialist should possess an additional knowledge base and/or skills clearly outside the skill/knowledge base of that primary care attending physician, unless the consultation is for a second opinion; the service requested must be appropriate for the specific individual; the service will affect the resident/patient assessment, diagnosis or care planning or treatment.”

As per CMS’s instructions, the primary physician caring for the patient should use the modifier “-AI,” Principal Physician of Record, with the initial nursing facility care code. This modifier identifies the physician who oversees the patient’s care from other physicians who may be furnishing specialty care.

As per CR 6740, “Physicians shall code patient evaluation and management visits with E/M codes that represent where the visit occurs and that identify the complexity of the visit performed. In the...nursing facility setting, all

## For More Information About Consultation Services, See:

11/25/2009 Federal Register; information on Consultations begins on page 61767: [edocket.access.gpo.gov/2009/pdf/E9-26502.pdf](http://edocket.access.gpo.gov/2009/pdf/E9-26502.pdf)

Medlearn Matters 6740 for Change Request (CR) 6740: [www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf](http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf)

Medlearn Matters SE1010, Questions and Answers on Reporting Physician Consultation Services: [www.cms.hhs.gov/MLNMattersArticles/downloads/SE1010.pdf](http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1010.pdf)

Medlearn Matters 6705 for CR 6705: [www.cms.hhs.gov/MLNMattersArticles/downloads/MM6705.pdf](http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6705.pdf)

CR 6740, Revisions to Consultation Services Payment Policy: [www.cms.hhs.gov/transmittals/downloads/R1875CP.pdf](http://www.cms.hhs.gov/transmittals/downloads/R1875CP.pdf)

CR 6705, Expansion of Medicare Telehealth Services for CY 2010: [www.cms.hhs.gov/transmittals/downloads/R1881CP.pdf](http://www.cms.hhs.gov/transmittals/downloads/R1881CP.pdf)  
[www.cms.hhs.gov/transmittals/downloads/R118BP.pdf](http://www.cms.hhs.gov/transmittals/downloads/R118BP.pdf)

Medicare Claims Processing Manual, Pub. 100-04, Chapter 12: [www.cms.hhs.gov/Manuals/IOM/list.asp](http://www.cms.hhs.gov/Manuals/IOM/list.asp)

E/M documentation guidelines: [www.cms.hhs.gov/MLNEdWebGuide/25\\_EMDOC.asp](http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp)

E&M Coding Guidance: <https://www.highmarkmedicare.com/partb/em/index.html>

Frequently Asked Questions (FAQs) regarding Consultation Services: <https://www.highmarkmedicare.com/faq/partb/pet/lpet-consultations.html>

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# AMDA Event Covers Many Important Topics

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

More than 1,200 long-term care providers journeyed to Long Beach, Calif., on March 11-14 for the American Medical Director Association's (AMDA) 2010 annual symposium.

They gathered to teach and learn, and fine tune their skills in long-term care (LTC). They listened and lectured, praised and argued, ate and laughed, and relished sharing the joys and struggles of LTC.

The annual symposium had a new name, Long Term Medicine 2010, reflecting AMDA's commitment to all members of the long-term care IDT. The attendee roster demonstrated this switch, showing many physicians, nurses, DONs, administrators, pharmacists, social workers and others from the interdisciplinary teams. Many of these people see AMDA as their professional home for LTC issues.

New research data demonstrates the benefits of having an AMDA certified medical director presence in a facility. A July 2009 article from the Journal of the American Medical Directors Association (JAMDA) showed a clear and measurable positive effect on quality if the medical director is a certified medical director.

Paul Katz, new AMDA president, outlined his philosophies and goals for the upcoming year. He anticipates an ever-changing landscape in LTC and proposed ways to respond to these challenges and rewards. He called for further development of LTC competencies, and a curriculum to foster these skills. Further defining a LTC specialty will give credibility to LTC work, and foster additional quality development.

Following in the footsteps of Pennsylvania's own J. Kenneth Brubaker, MD, Robert Schreiber, MD, CMD, of Roslindale, Mass., was named as the 2010 "Medical Director of the Year." Like Dr. Brubaker, in 2008, Dr. Schreiber was selected from more than 30 medical director nominees across the country for his excellence in long-term care and efforts to improve the care of his residents.

Sixty-four young physicians enrolled in the Futures Program and received a full day of introduction to long-term care clinical and administrative issues. This program is repeated annually and can be a significant professional and personal starting point for LTC work.

PMDA fully supported the attendance of three Futures attendees this year. PMDA suggests that each of its members encourage residents or fellows to consider attendance in future years.

Poster presentations outlined a variety of new research, treatments and theories. Several Pennsylvania facilities and PMDA members presented their projects. Out of 74 submissions, the best poster award went to one entitled "Are they stubborn or are they sick?" This study looked at rejection of care, and sought to evaluate why this occurred, focusing on modifiable changes.

AMDA national leaders discussed the top public policy issues. These include FDA interpretation of class II narcotic prescriptions, health care reform, liability reform, transitions of care, never events, LTC billing codes and cooperation with LTC advanced practice nurses.

The new MDS 3.0 tool is scheduled to start in the fall of 2010. Several lectures introduced this new tool and discussed its use. Other presenters helped attendees understand the CMS five star LTC facility rating system.

Keynote speakers talked about the secrets of a long life, artful images of geriatrics and practical communication strategies for long term care professionals.

Dan Buettner, *New York Times* and *National Geographic* writer, has traveled around the globe to discover and explore "Blue Zones," hotspots of human health and vitality. He and his team have studied the common denominators that may contribute to extraordinary longevity.

His scientifically based research found several common themes in these areas of

longevity: individuals are important in the community, the diet is plant-based, individuals are connected rather than isolated, retirement is deemphasized, and there are ritualized ways for stress reduction.

Several new features attracted attendees. Focused workshops on common medical problems, wound care and infection control used case studies to discuss a team-based approach. A "model programs and policies swap session" offered a stage for IDT teams to discuss their innovative programs on depression support, fall investigations, staff retention, management of sex offenders and reducing the use of psychotropic medications.

The 2010 AMDA symposium provided a plethora of academic knowledge, practical clinical tips, public policy information and social connection with long-term-care colleagues from across the country. For many attendees, it provides a reminder of their LTC mission, and a recharge of new ideas and energy.

Get out your calendar and put Tampa, Fla., on your schedule for the March 24-27, 2011 symposium. ■

## Welcome New Members

PMDA welcomes the following new member to the Association:

### Individual Members (Physicians)

Lee A. Cowen, DO

Namrata V. Haldipur

### Affiliate Members

Margaret A. Degler, CRNP

# Symposium Experience Educates Providers on LTC Challenges

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

The 2010 Annual AMDA Symposium enjoyed another successful educational event with a near record number of attendees. In addition to the many elective presentations, there were more opportunities to participate in interactive seminars where colleagues could network with their peers.

An added session included an opportunity to share model programs and swap successful policies and procedures. This year's symposium did an excellent job of creating experiences where LTC providers could utilize the successes of others rather than having to create a "new wheel" to solve their Long-Term Care (LTC) challenges.

Foremost on the minds of all AMDA attendees were their continuing concerns related to the DEA "curve ball" thrown to us. The AMDA leadership that includes physicians and AMDA staff continues to put a lot of energy into achieving a permanent fix for the unfortunate and unnecessary suffering placed upon our residents throughout the entire country, all because the Drug Enforcement Administration (DEA) will not allow the

LTC nurse to serve as an "agent" like is done in the hospital setting.

In order to build our case, AMDA continues to request your help by providing anecdotal situations where the present DEA requirements have delayed the expected care for our residents suffering with pain. We also can help AMDA by contacting our Washington legislators and educating them of the need to change the law/regulations ASAP.

Another item that received a good deal of discussion at the AMDA Symposium related to the idea of developing core competencies for LTC providers. While geriatric fellowship programs have developed LTC core competencies, no organization that is engaged in caring for the nursing home population has defined expectations and skills of their primary care providers.

Many attendees voiced enthusiastic support for AMDA to provide leadership in the development of core competencies. However, the greater challenge will be determining how a LTC attending will learn the expected knowledge and how the

attending will be recognized for his/her knowledge.

While much work needs to be done, priority should be given first to developing the core competencies. AMDA will expect much input from its members as well as other stake holders involved in nursing home care. Stay tuned to this important issue!

Finally, the most important news for Pennsylvania members is that our Dan Haimowitz, MD, was nominated and elected to the AMDA Board. Congratulations Dan!!! His tireless energy and passionate enthusiasm for his patients and AMDA is a welcomed addition.

Having completed my second of three years serving on the AMDA Board, I continue to be impressed with the quality of the AMDA staff under the excellent leadership of Lorraine Tarnove. I also have appreciated my fellow AMDA Board members who volunteer many hours working for an organization that is strongly committed to member education and quality care for our LTC residents. ■

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## New MDS Tool Found to Produce More Efficient Assessment

by Dale K. Hursh MD; dkhursh@lancastergeneral.org; (717) 544-3022

During the AMDA Annual Symposium, an informative talk presented during Saturday's general session by Debra Saliba, MD, MPH, highlighted the new MDS (Minimum Data Set) 3.0. This is set to be implemented in community nursing homes in October 2010.

Dr. Saliba presented data from a national trial, which found that improvements

incorporated in MDS 3.0 produced a more efficient assessment and better quality information was obtained in less time. MDS 3.0 has shown improved accuracy and reliability in a national trial of more than 4,500 nursing home residents.

In addition, the updated tool includes resident voice as well as improved clinical

relevance. Despite the fact that MDS 3.0 is 38 pages in length, the national study shows the average time for completion was 45 percent less than the average time for MDS 2.0.

The final MDS 3.0 form and instruction manual are available on the CMS website at <http://www.cms.gov> (search "MDS 3.0"). ■

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# Please Stop Giving My Mother That Medication!

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

As a physician, you presume that your license gives you the authority to prescribe the medication you feel is right for your long-term care resident. Unfortunately, there are many obstacles that interfere with your authority and legal duty to prescribe appropriately. We have all experienced the difficulty of formularies and “prior authorization,” but what happens when the family members decide to get involved with medication decisions?

In some cases, the family may appropriately alert you to an unnecessary medication, such as a statin in a 95-year-old woman with advanced dementia. But more often than not, the family wants to reduce the pill burden by eliminating medications that they feel do not offer much benefit, or even add a medication that they read might be helpful.

If the resident has decision-making capacity, it is inappropriate for a family member to attempt to influence your prescribing decisions. Unfortunately, many will still try to do so. In these situations it is best to comply with HIPAA by requesting the resident’s permission before speaking with the family member.

I have been surprised at times to learn how the resident perceives their children as “meddling” and requests that I do not speak with them. Others want to foster open communication and request that I make the contact.

If the resident lacks decision-making capacity, it is helpful if one family

member has Durable Power of Attorney. You can then be certain that they have the right to register their opinion.

Many times you are bombarded with input from multiple family members. In this setting, it is best to ask the family to appoint one representative to communicate with you. Alternatively, you may need to schedule a family meeting at the facility to discuss differences of opinion.

New reimbursement interpretations assist us here, as “time spent on the nursing floor” can be added to the face-to-face time with the resident to yield a higher billing code for services performed that day.

Recently a daughter asked me to prescribe an herbal supplement for her mother’s dementia that she read was being studied by a large research university. When I explained that there was no proven medical benefit at this time, the daughter requested I “give it a try anyway.”

I then explained that the potential adverse effects were also unknown and potentially dangerous, and she understood my reluctance to honor her request.

Often the issue is expense. Sometimes family members are diligently trying to manage limited resources, but we must be on guard for family members who would do anything, including denying appropriate medication, to preserve assets that they might inherit.

It is often helpful to explain to the family what you perceive the benefit of

the medication might be. Perhaps their mother’s quality of life would decline rapidly if the expensive cholinesterase inhibitor were discontinued.

Some family members feel they have sufficient knowledge to offer skilled counsel to the physician. The family member may be a physician, a pharmacist or may simply be quoting something they read on the Internet. Ascertaining the source of their information and their professional background often permits a more collaborative dialogue instead of a confrontational one.

If a disagreement cannot be resolved, it may help to explain that you are legally bound to prescribe what you feel is in the resident’s best interest. Abruptly stopping medication like beta blockers in residents with known heart disease is certainly not advisable, and may even represent malpractice, even if a family member demands such action.

It may be helpful to enlist the medical director of your facility (or another attending physician if you are the medical director) to speak with the family when, despite your best efforts, the family cannot appreciate the peril of discontinuing certain medications.

Family communication can enhance everyone’s comfort level with your medication decisions. Be careful to be certain you have the right to speak with the family member, and remember that you alone have the ultimate legal responsibility for what you choose to prescribe. ■

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## Reporting Consultation Services in the Nursing Home to Medicare: Revisions to Payment Policy

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physicians (and qualified non-physician practitioners where permitted) who perform an initial evaluation may bill the... nursing facility care codes (99304-99306).”

Per LCD L27496: “Coverage for subsequent nursing facility care for evaluation of specific medical conditions will be considered reasonable and necessary if they would require the skill of a physician or non-physician practitioner (i.e., nurse practitioner, physician assistant, where permitted by

state licensure) to evaluate the patient in a face-to-face contact.”

As per CR6740, for consultation services: “Follow-up visits in the facility setting shall be billed as...subsequent nursing facility care visits.” These are represented by codes 99307-99310. Also: “All physicians and qualified non-physician practitioners shall follow the E/M documentation guidelines for all E/M services.” ■

## President's Message

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One example is our newly updated and expanded website. Under the leadership of Leon Kraybill, MD, the PMDA website is being further redesigned to meet our members' needs and has new administrative assistance from our parent organization, AMDA. Among other things available on the website is the *News*, PMDA's newsletter that under the guidance of Neelofer Sohail, MD, continues to enhance communication and education of the PMDA membership.

Our annual symposium committee, under the direction of Drs. Susan Denman and Judith Black, works tirelessly to put together a successful educational program each year that allows participants to expand their knowledge base and hone clinical skills, as well as provide the opportunity to solve practical clinical and administrative problems with peers.

Our 17th Annual Symposium held in Hershey in October 2009 was successful and well attended. The committee has completed planning for the 2010 symposium that will be held in Hershey on October 15.

The regional meetings initiative headed by Drs. Sarah Noorbaksh and Dan Haimowitz aims to plan another statewide meeting of all the regional groups in the future. Dr. Haimowitz is working on videoconferencing at several locations in northeast Pennsylvania in May, which will provide an educational program as well as networking opportunities for our members. In Pittsburgh, Dr. Nace had a record turnout this year at his regional meeting. Regional meetings continue to allow our membership to share information and ideas on a regular basis outside of our two annual gatherings.

Once again, March was a big month for our organization. At the AMDA Annual Symposium in Long Beach, Calif., we had 40 members present at our state chapter meeting and reception. PMDA board members and committee chairs present were introduced and the activities of the committees were discussed.

Ken Brubaker, MD, a past-president of PMDA and a current representative from the state's president's council to AMDA's board also discussed the current activities of AMDA and the board. The resolutions PMDA sent to the House of Delegates were discussed as well.

The symposium "Golden Opportunities: Long Term Care Medicine—2010" was enjoyed by the many who attended, despite the seasonally cool weather for California. Many interesting clinical and medical direction topics were presented, including sessions using a new case-based interactive format that was well received by all.

On Saturday evening, conference goers were treated to dinner and gaming at the Gameworks in Long Beach. This year's AMDA President's Reception, gave us an opportunity to warmly greet Dr. Paul R. Katz as our new president. Members enjoyed gaming that ranged from bowling to virtual reality racing cars at the Indy 500.

The final general session meeting on Sunday, March 14, began with the Anne-Marie Filkin lecture on humanism in medicine. The lecture was provided by Jeffrey M Levine, MD, CMD, with the title "Humanistic Medicine, Geriatrics and Art."

Dr. Levine treated us to poignantly beautiful photographs along with a rich lecture that wove the three themes together and posed questions about our current society and its medical system, which is increasingly struggling to care

for its ever-growing population of frail elders.

PMDA had a strong turnout of more than 70 members despite the distance and the many PMDA/AMDA regulars and board members who were unable to make the meeting this year. At the AMDA House of Delegates Meeting on March 13, our state sponsored three of the resolutions that were presented, highlighting the hard work, vision and leadership of our organization.

All three of the resolutions that Pennsylvania sponsored were passed: Never-events, Recognition as the "Nurse as Agent" of the prescriber in Long Term Care settings, and a resolution on PHRMA regulations. Resolutions were also passed on liability reform, Transitions of Care, as well as a white paper on "The Role of the Medical Director in Person Centered Care."

The resolution effort was spearheaded by Dr. Dan Haimowitz, who was also elected to the chair of the House of Delegates during the meeting—congratulations Dan!

PMDA's success as a professional association continues to depend on developing innovative approaches that serve our members. Innovation in our professional field is desperately needed to continue to meet the challenges of caring for an increasing number of frail and impaired elders who, along with their caregivers, increasingly value choice, self-determination and purposeful living in every long-term care setting.

We are very interested in hearing from our members and learning new ways to meet their needs. Your views, opinions, ideas and suggestions are critically important to the growth of PMDA and I invite you to contact us by phone or e-mail to let us know how we can best help you grow in our dynamic and evolving profession. ■



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PMDA, Pennsylvania's Association for Long-Term Care Medicine  
Cordially invites you to attend a unique educational event for an  
Interactive Webinar

*“Senior Care Perspectives on Diabetes Management”*

**Naushira Pandya, MD**

Author: American Medical Director Association (AMDA)  
Clinical Practice Guidelines  
Diabetes Management in the Long Term Care Setting

The event will take place on

***May 20, 2010 at 6:30 pm***

It will be held at three locations:

***Blue Grillhouse***  
4431 Easton Avenue  
Bethlehem, PA

***Bellatori***  
321 S. Bellevue Ave  
Langhorne, PA

***Doubletree Hotel***  
640 W. Germantown Pk  
Plymouth Meeting, PA

Sponsored by sanofi-aventis.

Space will be limited, if you would like to attend please RSVP to:  
Judy Basler at 1-800-321-0855, Ext: 96091  
or e-mail at [judith.basler@sanofi-aventis.com](mailto:judith.basler@sanofi-aventis.com)

*In accordance with PhRMA code and company policy, spouses and or guests  
are not permitted to attend*



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**PMDA**

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

# **18TH ANNUAL SYMPOSIUM**

• **Friday, October 15, 2010** •

**Hershey Lodge, Hershey, Pennsylvania**

*Hotel reservation deadline is September 15, 2010*



A continuing education service of  
Penn State College of Medicine

#### MORNING THEME

*End-of-Life Management  
in the Long-Term Care Setting:  
The Intersection Between  
Geriatrics and Palliative Care*

#### For More Information

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