



PMDA

Pennsylvania's Association for Long Term Care Medicine



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Official Pennsylvania Chapter of
American Medical Directors Association



President's Message

Spring Training in Tampa

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



The amazing weather and warm hospitality of Tampa that was savored at AMDA's annual conference further enhanced the energy and enthusiasm of our kindred medical directors from home and around the nation. The symposium, which was

called "Spring Training for a Winning Team," appeared to be enjoyed by all those attending.

Although it was very hard to resist the beautiful Florida climate and harbor scenery, the many interesting clinical and medical direction topics that were presented drew us all into the convention center. The sessions included many interesting topics, as well as more of the new case-based interactive format that was introduced at last year's symposium in Long Beach, Calif.

The Keynote Address on Friday morning featured Dr. Rick Brinkman, a well-known author and speaker. Dr. Brinkman amused us as he imparted tactics on how to enhance our ability to communicate with difficult people. We laughed as he described their behavior in colorful terms such as a Tank, Grenade, Whiner, Know-it all or Sniper.

After describing the types of communicators, Dr. Brinkman continued to describe how communication is 55 percent nonverbal, 38 percent based on tone, and only 7 percent based on content. He discussed how conscious communicators are aware when a mismatch occurs between their message of content and tone, and that the message of tone will "crush"

any words said. When discussing forms of communication, he reminded us that e-mail only allows 7 percent of the communication that occurs in person, and, therefore, must be carefully crafted, because its limitations can make it easily misunderstood.

PMDA's state chapter meeting was held on Friday night and hosted more than 50 members. Board officers, committee chairs, AMDA staff, Foundation Futures members and geriatric fellows present were introduced. Subsequently, attendees reviewed the activities of PMDA leadership. The discussion that ensued during our chapter meeting illustrates how our organization continues to thrive and effect positive change in long-term care within our state and increasingly at the national level.

With the support of our active membership, PMDA continues to hold its place as one of the largest, most successful and dynamic

continued on page 2

Inside This Issue

- Renal Decline Impacts Drug Selection and Dosing in the Elderly 3
- AMDA Conference Provides Venue for Learning, Networking..... 4
- National Healthcare Decisions Day .4
- Model Programs and Policies Swap Session: TB Testing Protocol 5
- Welcome New Members 6
- What's Happening in Harrisburg? Update on PA OA/LTL..... 7
- End of Life Updates 8

President's Message

continued from page 1

state chapters in AMDA. Our state chapter continues to have the most CMDs of any in the country, with very visible leadership positions in AMDA. PMDA also continues to pursue many new initiatives that will serve our members practicing in long-term care facilities.

Committees continue to be the backbone of PMDA, where initiatives are pursued. The Public Policy Committee, under the guidance of Dr. David Nace, explores issues that relate to interface of government, provider groups, professionals, and LTC residents. In 2010, the committee promoted 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.

Comments were sent in conjunction with AMDA to our national legislators on LTC issues, such as DEA regulations. It was recommended that nursing home physicians be able to use the nurse in their facilities as their agent. The DEA's current recommendations on schedule II's were discussed and the need for them to be refined in order to improve their practicality.

Dr. Nace also discussed the new regulations that no longer require Pennsylvania NPs to have their orders or notes co-signed. On one hand, Dr. Nace did not recommend the zoster vaccine in our nursing home population, but on the other hand the great importance of vaccinating staff and residents with the flu vaccine was discussed. He reminded us that when giving nursing facility residents the flu vaccine it is not necessary to obtain permission or perform education.

Dr. Nace is working with Dr. Judith Black, who continues to actively champion the POLST. The POLST is a portable, highly visible medical order that gives patients more control over their end-of-life care. PMDA, through its leadership, pushed the legislation that led Pennsylvania to adopt the POLST and continue to work tirelessly with other PMDA members on its use throughout the state.

Through our Strategic Partnership Committee, under the guidance of its chair, Dr. Gary Bernett, and the hard work of our members, we continue to work with other organizations such as PADONA, PANPHA and PHCA to increase our success in Harrisburg as a long-term care organization.

Because of the strides that the Membership Committee Chair, Dr. Thomas Lawrence, has made to increase our strength, he was asked at the state chapters presidents meeting to advise other state chapters on how to expand their membership.

We who serve you on the PMDA Board realize how important it is for PMDA membership to be of value. During the state chapter meeting in Tampa, we discussed how the list serve and newly renovated website could meet the growing needs of an increasingly diverse group of LTC professionals. As we continue to strive to expand our membership and, therefore, the effectiveness of our organization, we look for creative ways to achieve this goal. We encourage you to apprise PMDA leadership about how we can best meet your needs as well as join us in our effort to recruit new members.

Dr. Kraybill has been laboring to enrich our website with an amazing array of resources and links that are exclusively available to PMDA members. "I encourage you to share information like forms, educational materials and links," said Dr. Kraybill, Webmaster of www.pamda.org. "The website is only as valuable as the information that it contains."

Also available on the website is PMDA's newsletter, which educates PMDA members about a variety of topics. The newsletter welcomes articles and input. If you interested in contributing please contact Dr. Sohail or Dr. Fuchs.

Our Annual Symposium Committee, under the direction of Drs. Susan Denman and John Mast, is once again working tirelessly to put together a successful educational program where we will continue to expand our knowledge base, hone our clinical skills and have the opportunity to solve practical clinical and administrative problems with peers.

In October 2010, our 18th Annual Symposium was held in conjunction with our hospice brethren. The symposium saw a record number of attendees in the Land of Chocolate, where we also found some new members.

I am very pleased to announce that the 2011 Symposium has been expanded to a day and a half for our increased enrichment. The Annual Symposium Committee is finalizing the planning for our newly lengthened symposia, which will be held in Hershey on Oct. 21-22. Details about the symposium will be reported on the PMDA website.

The Regional Meetings Committee, headed by Drs. Sarah Noorbaksh and Dan Haimowitz, is working toward a statewide meeting of all the regional groups in the future. Dr. Haimowitz held an educational program using videoconferencing at several locations in northeast Pennsylvania in May 2010, which also provided networking opportunities for our members.

PMDA is looking toward using technology to link statewide meetings in the future as our sophistication and technology improves. In the meantime, the Philadelphia Regional Meeting continues to have a strong showing of its members who continue to enjoy networking and educational enrichment under the strong leadership of Dr. Haimowitz.

At our PMDA state chapter meeting in Tampa, Dr. Ken Brubaker, PMDA Board member and Chief Medical Director of the Pennsylvania Office of Aging and Long Term Living, discussed the PSAE. The Chair of the House of Delegates (HOD), our own Dan Haimowitz, discussed 2011 resolutions at the end of the meeting before it was adjourned.

AMDA leadership and staff emphasized at the state presidents meeting that they are enthusiastically looking for stronger, new and creative ways to partner with and help further develop State Chapters. Both AMDA and state chapters hope to increase the number of people who are both AMDA and State Chapter members. The state chapter presidents commented that they would like to have more interaction with AMDA, as well as a means to

continued on page 3

President's Message

continued from page 2

continue to increase the interaction and partnering between the state chapters. Examples of this include sharing strategies to increase membership and having small states combine annual symposia.

At the AMDA HOD, Pennsylvania's 15 delegates discussed 11 resolutions that ranged from white papers on such topics as "The Nursing Home Medical Director as Leader and Manager," "Medical Director Training" and "The Role of the Medical Director in Quality Assurance and Process Improvement in LTC" to resolutions on using the title of physician, evidence based survey requirements, and pursuing DEA legislation in federal courts.

The white papers were extremely well received, as opposed to the later resolutions that were turned down by the HOD. Resolutions that dealt with Accountable Care Organizations, addressing an expected increase in LTC continuum residents with criminal correctional histories, and an international membership for AMDA were approved with enthusiasm.

Although the resolution for mandatory immunizations for LTC workers created a passionate debate, it was passed by a very wide margin. The results of the elections were announced at the end of the HOD and we learned that our new AMDA Vice President is Jonathan Evans. Ken Brubaker, newly retired as the representative from the States' Presidents Council to AMDA's Board, was elected Treasurer of the AMDA board. PMDA delegates were thrilled to see that happen. David Nace was asked to join AMDA's Public Policy Committee as well.

On Saturday evening, conference goers were treated to dinner at the New York Yankees' George Steinbrenner Stadium, where we were able to rub elbows with the Yankees during their spring training. Many AMDA members showed their batting talent as they participated in a "Home Run Derby" and speed as they flew around the bases. This year's AMDA President's Reception gave us an opportunity to warmly greet Karyn Leible, MD, CMD, as our new president. Having had the good fortune to work closely with Dr. Leible teaching the Core Curriculum in Medical Direction, I am sure that

AMDA will continue to thrive under her leadership.

PMDA's success as a professional organization continues to depend on serving the needs of our members. The field of long-term care is continually changing and growing in order 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.

PMDA leadership is very interested in hearing from our members and learning of your needs. Your views, opinions, ideas and suggestions are critically important to the growth of PMDA. 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. I also invite you to join us. Please contact us if you are interested in becoming involved in your regional meeting, contributing to our website, newsletter or any of our committees. We look forward to hearing from you. ■

Renal Decline Impacts Drug Selection and Dosing in the Elderly

By Don Bastian, RPh, MS, CGP; (610) 751-3942; bastian523@hotmail.com

As a consultant pharmacist, one of my primary goals is to monitor all residents for renal decline and to recommend appropriate, alternative drug selection or dose modification to account for reduced renal function. The geriatric population is a fragile age group from a pharmaceutical perspective because renal function declines with the aging process.

This is particularly important since most drugs and/or drug metabolites have a significant renal mode of elimination. Unfortunately, when most drugs are brought to market, they are tested on healthy young adults when determining effective dosing guidelines.

We need to think of the geriatric resident in the same light we think of the neonate

when considering drug selection and dosing. This involves looking up the patient's weight, age, serum creatinine using a calculator to determine creatinine clearance and referring to the literature dosing guidelines. This is a time consuming process. But it is important when considering the negative consequences of drug overdose, which includes side effects, additional drug therapy, drug therapy failures, increased costs, additional lab tests, resident falls, hospitalizations, morbidity and mortality.

When determining creatinine clearance, it is best to use the Cockcroft-Gault formula, because it takes all the key patient-specific variables into consideration, including gender, age, weight and serum creatinine. Many lab reports of basic and

complete metabolic profiles include a rough calculation of creatinine clearance. However, the lab report calculation is not as accurate or reliable since not all the patient-specific variables are included in the calculation.

Pocket personal computers/smart phone applications are readily available to minimize time constraints by providing quick and easy-to-use programs that apply the Cockcroft-Gault method of determining creatinine clearance and provide easy access to renal dosing guidelines (e.g. Lexi-Comp, Inc. and Clinical Pharmacology).

One final point worth mentioning is that the serum creatinine levels can be very

continued on page 6

AMDA Conference Provides Venue for Learning, Networking

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

“Spring Training for a Winning Team” was the theme for the annual AMDA meeting held recently in Tampa, Fla. I always come back from the AMDA meeting energized with new ideas to improve the quality of care in my skilled nursing facility. The opportunity to meet and discuss common problems with other physicians and allied health professionals who work in nursing homes is most valuable.

The educational sessions count for up to 24 hours of CME provided by national thought leaders. John Morley, MD, and David Thomas, MD, from St. Louis provided an excellent clinical update. Other topics ranged from psychiatric prescribing for dementia residents to a review of common dermatologic problems in the elderly.

Another highlight this year was the number of talks on MDS 3.0, the new methodology facilities must use to assess their residents. MDS 3.0 will involve more direct resident interviews and create more need for medical director input into the care planning process.

Some CME opportunities involved audience participation and small group discussion with colleagues and experts. “Red Eye Rounds” is a popular session where attendees ask questions of experienced medical directors or clinicians beginning with breakfast at 6:30 a.m.

In addition to formal CME, large group sessions provided an update on AMDA advocacy for issues affecting our practice in long term care. AMDA continues to work with the DEA to lighten the current burdensome requirement for written signed prescriptions for schedule II controlled substances in the nursing home.

AMDA has formed a committee to delineate the competencies for physicians who practice in nursing facilities. Although no formal training requirement is being proposed by AMDA, it will be beneficial to understand what skill sets are recommended for practicing in the nursing home and what resources AMDA and PMDA can provide to keep us all at a high level of competency.

Rick Brinkman, best-selling author of “Dealing with Difficult People,” gave a lively talk illustrating techniques to help communicate more effectively with staff in our facilities. An inspirational closing keynote address from David Greenberger focused on our relationships with our demented geriatric residents.

I felt proud to be from Pennsylvania throughout the conference. PMDA is one of the largest state chapters in AMDA and has more Certified Medical Directors (CMD) than any other state. Numerous Pennsylvanians served as educational speakers, including Drs. Pam Fenstermacher, David Nace, Dale Hursh, Ken Brubaker and Dan Haimowitz.

Our state chapter meeting was attended by over 50 of our membership. The energy in the room was palpable as we held lively discussion on topics such as POLST and the controversy surrounding requiring influenza vaccination of all staff in skilled nursing facilities. Ideas for expanding the utility of our website were presented.

The House of Delegates meeting, chaired by our own Dan Haimowitz, MD, approved white papers on the tasks and functions of the medical director and passed resolutions dealing with our role in Accountable Care Organizations and mandating influenza vaccination for staff in nursing homes. Additionally the House voted to extend AMDA membership to include international representation.

There was also time for pleasure and fellowship. The pharmaceutical industry sponsored numerous product theaters featuring newer agents like Prolia and Aricept 23mg. The final evening event was a trip to the Yankees’ George Steinbrenner Baseball Stadium in Tampa, where some members ran the bases and other members contributed \$50 to the AMDA Foundation for the chance to take five swings in a “home run derby.”

If you have never been to the annual March AMDA meeting, I encourage you to join the rest of us from Pennsylvania in San Antonio March 8-11, 2012. You will come home smarter, strengthened, and eager to return to your work in long term care. ■

National Healthcare Decisions Day

The National Healthcare Decisions Day (NHDD) Initiative is a collaborative effort of national, state and community organizations committed to ensuring that all adults with decision-making capacity in the United States have the information and opportunity to communicate and document their health care decisions. NHDD occurred this year on April 16.

The time is appropriate to think about how health care professionals and patients may access a document to begin the advance care planning (ACP) process. A recommended directive for use by residents throughout Pennsylvania is the Health Care Power of Attorney and Living Will Form that has the endorsements of both the Allegheny County Medical Society and the Allegheny County

Bar Association. This form can be accessed from the home page of the bar association’s website, <http://www.acba.org/> where it can be downloaded or purchased.

All adults can benefit from thinking about what their health care choices would be if they become unable to speak for themselves. Raising awareness about the importance of advance care planning can occur on NHDD – and throughout the year. ■

Model Programs and Policies Swap Session: TB Testing Protocol

By Dale K. Hursh, MD, CMD; dkhursh@lghealth.org; (717) 544-3022

A recent offering at AMDA's Annual Conference is the Model Programs and Policies Swap Session. This session provides a forum for interdisciplinary teams to share innovative programs and policies with AMDA attendees. Presenters share the specific challenges faced in their facilities, the solutions, as well as barriers overcome. At this year's conference held in Tampa, Fla., I had the opportunity to share the tuberculosis (TB) testing protocol of Landis Homes, Lititz, Pa., where I serve as Medical Director.

Within the past several years, facility noted our TB policy to be out of date. Two different situations brought this issue to light. First, we had a new CNA who had a positive tuberculin skin test (TST). This individual was born outside the U.S. and may have had the BCG vaccine, though this was not completely certain and unable to be verified.

The other cause for our reevaluating our TB policy was related to the Pennsylvania law enacted in 2007 known as Act 52, or the Health Care Associated Infection Prevention and Control Act. This law required health care facilities, nursing homes included, to implement a mandatory internal infection control plan and required mandatory reporting of health care-associated infections. To maintain compliance with this law, we revised our infection control plan and looked more closely at our TB prevention program.

Once our facility recognized that TB policy needed revised, we reviewed applicable sources and focused on the CDC's Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health Care Settings, 2005. The Director of Quality Improvement and Risk Management and I studied the guidelines and revised and updated our policy and procedure accordingly.

The purpose of the 2005 CDC guidelines on TB was to replace the previous 1994 guidelines, in large part due to the changing epidemiology of TB. The 2005

guidelines also were expanded to include non-traditional settings, including nursing homes, and more guidance was provided for this setting.

Several key points of the 2005 guidelines are noteworthy. First, every health care setting should have a TB infection control plan that is part of an overall infection control program. As part of that plan, each setting is advised to have a three-level hierarchy of controls:

1. administrative controls – these involve setting and implementing policy and procedures and ensure testing of health care workers (HCW);
2. environmental controls – those means used to prevent spread and reduce concentration of droplet nuclei; and
3. respiratory protection controls – ways of further reducing risk of exposure and include things such as use of personal protective equipment and cough etiquette procedures.

The specific details of the TB infection control plan will differ depending on the type of health care setting and on whether patients with suspected or confirmed TB are expected to be encountered there or transferred to another health care setting.

And this brings us to another key point of the CDC guidelines – TB risk assessment. This risk assessment is the initial and ongoing evaluation process used to determine the potential for transmission of TB, and this should be done regardless of whether or not a setting expects to encounter patients with TB. This risk assessment is what determines the types of administrative, environmental and respiratory protection controls that are needed and also helps in the ongoing QI process of the TB prevention program in the facility.

A third point of importance concerns TB risk classification. This is performed as part of the risk assessment to determine the need for and frequency of HCW testing. Settings are classified as low

risk, medium risk and potential ongoing transmission. Low risk settings are those where TB disease is not expected to be encountered and exposure is unlikely. Medium risk classification is where employees will or will possibly be exposed to persons with tuberculosis. The third class, potential ongoing transmission, is a temporary classification for a setting with evidence of person-to-person transmission of TB.

How often HCW are tested for TB depends on the risk classification for that setting. A final pertinent aspect of the 2005 CDC guidelines concerns the use of the blood assay for Mycobacterium tuberculosis or BAMT. The BAMT can be used as a screening test in place of the TST.

With this background on the issue that our facility faced and an understanding of the recommended guidelines, I'll share our solution. We updated our TB policy. The initial TB risk assessment was performed, and we established a policy of ongoing, annual risk assessments. We also included the use of the BAMT as an acceptable screening measure. Based on our risk assessment, we classified as low risk, so we eliminated our previous requirement for serial TST for staff members and instead implemented an annual TB symptom screen, a questionnaire completed each year by staff.

In terms of barriers encountered to develop this program, the time factor was the biggest. As with most major program changes, this took time to tear apart the previous policy, research and study the current guidelines, and develop the new policy. Collaboration among administrative staff helped to lessen this burden. Another barrier was and continues to be the change in established routine and the staff reeducation required for a shift in protocol. In-services and educational sessions are means used to communicate the policy and procedure changes to the interdisciplinary team.

continued on page 6

Renal Decline

continued from page 3

misleading in the elderly. For example, in a 90-year-old female who weighs 98 pounds and has a serum creatinine of 1.0 mg/dl, the calculated creatinine clearance is 26.27 ml/min. The decreased muscle mass in the elderly accounts for the misleading conclusions one could make if only looking at serum creatinine. A serum creatinine of 1.0 mg/dl could mean significant renal compromise in the elderly.

I recently conducted a simple retrospective review of all medical records on a 60-bed unit of a long term care facility to determine the percentage of drugs typically used in the elderly population that require renal impairment dosing. My review identified 65.9 percent or 56 of 85 drugs in use on the unit have renal dosing guidelines according to two reference sources (Lexi-Comp & Clinical Pharmacology). The percentage of drugs that were dose adjusted according to patient specific renal compromise would be interesting to study but was beyond the scope of this review. Of the 34.1 percent of the drugs that do not have renal dosing guidelines, in over 50 percent of these drugs, the literature stated that “specific guidelines are not available; it appears that no dosage adjustments are needed” (Clinical Pharmacology). This statement suggests that the majority of drugs without renal dosing guidelines have not been adequately studied or renal dosing information is unknown.

According to the renal dosing literature, drug dosages should be lowered or the

dosing interval extended based on a specified range of creatinine clearance. In some cases, the drug should be avoided or is contraindicated at certain levels of decreased creatinine clearance. For example, sulfamethoxazole-trimethoprim (Bactrim/Bactrim-DS) dose should be reduced by 50 percent if CrCl 15–30 ml/min and if CrCl < 15 ml/min, then use is not recommended by the manufacturer (Clinical Pharmacology). Another example of a commonly used antibiotic is nitrofurantoin (Macrobid), which is contraindicated when CrCl <60ml/min.

Therapeutic concentrations of nitrofurantoin are not attained in the urine of patients with CrCl <60ml/min (lexi-Comp). This fact will explain many therapeutic failures when nitrofurantoin is used to treat urinary tract infections in residents with significant renal compromise. Metformin (Glucophage) is contraindicated in the presence of renal dysfunction defined as a serum creatinine > 1.5mg/dl in males, or > 1.4mg/dl in females.

Clinically, it has been recommended that metformin be avoided in patients with CrCl <60-70ml/min (Lexi-Comp). The manufacturer states: “Use metformin with caution in the elderly; less than 3 percent of patients in clinical trials were \geq 75 years of age. Metformin is substantially excreted by the kidney and the risk of adverse reactions (including lactic acidosis) is greater in patients with reduced renal function. Because aging is associated with renal function decline, care should be taken with dose selection

and titration. Monitor renal function regularly. Unless renal function is normal, do not use metformin in those patients \geq 80 years of age.” (Manufacturer Package Insert).

One of the most commonly used drugs in the elderly is acetaminophen (Tylenol). Acetaminophen is considered a very safe analgesic/antipyretic in the elderly when dosed appropriately. Every pharmacist and physician is well aware that the total daily maximum acetaminophen dose is 4 g from all sources. However, how many health care providers are aware that acetaminophen should be dose adjusted when CrCl 10-50 ml/min.: administer every six hours; CrCl <10ml/min.: administer every eight hours (metabolites accumulate) (Lexi-Comp)? This is interesting because almost all routine Tylenol orders in long term care facilities are dosed every four to six hours.

The above examples are a small sampling from the literature that demonstrates how renal compromise can significantly impact drug selection, dosing and, ultimately patient safety. Even when the serum creatinine is reported to be within “normal limits” and the lab report stated that the projected creatinine clearance is >60 ml/min., use caution, calculate the actual creatinine clearance, check the literature for renal dosing guidelines and monitor the resident for drug efficacy and side effects.

Don Bastian, RPh, MS, CGP, is a Board Certified Geriatric Pharmacist and President, DB Pharmacy Consultants LLC, Wescosville, PA ■

Welcome New Members

PMDA welcomes the following new member to the Association:

Active Members

Dean Quimby, MD
Judith Bailey, CRNP
Robert Furia, MD
Concepto Flores, MD
Teresa Gallagher, CRNP

Richard Satriale, MD
Phillip Boccagno, MD
Danielle Snyderman, MD
Maria Urick, CRNP

Affiliate Members

Kristen Demshock, RN

Model Programs

continued from page 5

In conclusion, in terms of results and lessons learned, we now have an updated policy reflecting current national standards regarding preventing of TB transmission. We instituted the annual TB risk assessment, require less frequent TB testing of our staff, and use the BAMT as an alternate testing method. Hopefully, in looking at our experience with TB screening, you will learn something that will enable you to improve the TB prevention programs in your facilities. ■

What's Happening in Harrisburg? Update on PA OA/LTL

By J. Kenneth Brubaker, MD, CMD, c-jbrubake@state.pa.us; (717) 772-2540

I have been working as the Chief Medical Director of the Pennsylvania Office of Aging and Long Term Living (PA OA/LTL) for six months. It has been an interesting learning curve as I am getting more comfortable with the numerous bureaucratic acronyms and departments within OA/LTL. I have enjoyed getting acquainted with the staff and have appreciated their passion, knowledge and commitment in serving the aging community in Pennsylvania.

While my role as the Chief Medical Director continues to be defined on a weekly basis, I have been spending a significant amount of my time evaluating appropriate levels of care for Pennsylvania's older adults. In addition, I have been expanding my reviews for levels of care among those individuals between the ages of 21 to 59 who have similar needs as the frail older adults.

Determining levels of care can be very challenging. I have observed that physicians frequently have differing opinions regarding nursing home eligibility of residents. Some physicians make levels of care determinations based

primarily on disease states with limited consideration given to other factors such as activities of daily living and instruments of activities of daily living (ADLs/IADLs).

As a reminder to my colleagues, the level of function is more important in assessing levels of care than the diagnoses. When diagnoses impact levels of care, it is usually among persons with chronic unstable medical conditions such as diabetes, COPD, and/or heart disease. In these unstable conditions, one usually observes frequent emergency room visits and/or hospitalizations.

The implementation of Act 1 continues to be a significant concern among LTC providers and nursing home administrators. The Pa OA/LTL will be responding to more than 300 concerns submitted to OA/LTL in reference to the notices by the Department of Welfare regarding the Preventable Serious Adverse Events (PSAEs) in nonpublic and county nursing facilities. I found many of the concerns submitted to be reasonable and insightful as our department reviewed them in great detail. If I was asked to respond to the notices posted

last fall, I would have expressed the same kinds of concerns as my colleagues and other LTC providers.

I am often asked: what do I need to do in preparation for the Preventable Serious Adverse Events program? I believe the most likely events that will be reviewed as potential PSAEs will be third and fourth stage pressure wounds and fractures secondary to falls. Therefore, nursing facilities need to utilize best practices in wound care and in identifying fall risks with appropriate care planning for prevention.

As an administrator, director of nursing, and medical director, your major concern should be having the assurances that all staff follows the established care plans for residents at risk for pressure wounds and falls. At the same time, we all recognize that following our care plans will not always prevent falls with fractures or stage 3/4 pressure wounds and, therefore, will not be considered a PSAE.

If anyone has questions regarding PSAEs or determinations of levels of care, please feel free to e-mail your concerns. (c-jbrubake@state.pa.us). ■



PMDA

Pennsylvania's Association for Long-Term Care Medicine

19TH ANNUAL SYMPOSIUM

• Friday & Saturday, October 21–22, 2011 •

Friday, October 21, 8:00 a.m.–5:00 p.m. • Saturday, October 22, 8:00 a.m.–12:00 noon

Location: Hershey Lodge, Hershey, Pennsylvania

Hotel reservation deadline is September 19, 2011

For More Information

- Call: 717-531-6483
- E-mail: ContinuingEd@hmc.psu.edu
- Web: www.pennstatehershey.org/web/ce/home/programs/pmda

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End of Life Updates

Update on PA Orders for Life-Sustaining Treatment

POLST is “Pennsylvania Orders for Life-Sustaining Treatment.” The POLST program is designed to improve the quality of care people receive at the end of life by turning patient goals and preferences for care into medical orders.

In October 2010, the acting Department of Health Secretary approved the Pennsylvania Orders for Life-Sustaining Treatment (POLST) form for use in the state. This followed the recommendations of the Patient Life-Sustaining Wishes (PLSW) Advisory Committee that convened as mandated by Pennsylvania Act 169 of 2006. The committee was asked to examine the advisability and possible adoption of a standardized form such as POLST. Representatives of AMDA provided significant input into the form that the secretary approved.

In January, notification was received from the National POLST Paradigm Task Force that Pennsylvania now meets specific program requirements and is recognized as

an endorsed program. While POLST is used in many states, only 10 states have received endorsement. Information on POLST can be found at the following websites:

- www.aging.pitt.edu/professionals/resources.htm or
- www.health.state.pa.us/; click on “Quick Links” in the middle of the screen

Highmark Medicare Advantage Advanced Illness Services Program

Often when patients are diagnosed with life-limiting illness, they may not have continuing access to a palliative care team that can provide supportive services as their condition progresses. On January 1, 2011, Highmark launched a new program called Advanced Illness Services (AIS) to help close this gap. AIS is available to Medicare Advantage members enrolled in the SecurityBlue HMO and FreedomBlue PPO. This is for members who reside in Pennsylvania and West Virginia.

AIS offers up to 10 consultative/supportive visits by physicians, nurses, social workers or home health aides to members with

progressive life-limiting illness for whom it would be no surprise if they died within one year. The focus of AIS is to provide emotional support, facilitate decision-making related to care, coordinate services and assist with advanced care planning.

Patients may continue to receive curative and other covered services that are available through their health plan while enrolled in the program. They are not required to be homebound or meet skilled level of care criteria to be eligible for services. Services – which can be received within the home, a health care facility, or assisted living facility – are provided by specially trained teams in the employ of Medicare certified hospice providers. This can facilitate a relatively seamless transition to hospice if that becomes a patient’s choice.

Further information on AIS is available at <https://www.highmark.com/health/pdfs/ais-q-a.pdf> or a Provider Relations Representative. Physicians or other health care providers who would like to refer patients to the program can call (800) 596-9443. Hours of operation are 8:30 a.m. to 4:30 p.m. ■