

PMDA

news

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President's Message

Just Pick Up the Phone

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



At last month's PMDA Annual Symposium in Hershey, I was inspired by the example of one of the day's speakers, who when asked how he handled a particular problem said he just picked up the phone and made a call to a key person and it fostered

solution building.

In the job of nursing facility Medical Director there are innumerable opportunities to affect successful problem solving by simply making a phone call—administrative telemedicine. In an era of rapidly expanding technology in health care, the low-tech option of making a call is an often overlooked but critically important intervention.

The importance of telemedicine in Long-Term Care (LTC) practice is well established and grounded in the reality that most LTC practitioners are present in the facility for a very limited amount of time; for most, this amounts to no more than a few hours each week. This pattern includes most LTC Medical Directors, who are usually part time in their position, and who also have a limited presence in the facility.

As Medical Director of multiple nursing facilities, it is commonplace for me to receive calls from the facility Director of Nursing (DON) about urgent issues regarding a wide range of topics, and it is equally common that I may place a call out to them. These calls commonly involve such issues as infection

control policy and practice, medical staff issues, pharmacy problems and concerns and miscellaneous resident care issues.

As the complexity of nursing facility care continues to increase, the working collaboration of the Medical Director and DON has expanded beyond the limited hours of Medical Director's rounds within the facility.

The role of administrative telemedicine for the Medical Director has broadened as the clinical complexity of LTC medicine has expanded. Higher resident acuity has resulted in a greater requirement for oversight of the medical staff by the Medical Director.

At least weekly I am called upon by one of my facilities to address a problem with a specific attending physician. Whereas in the

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Update on H1N1

By David A Nace, MD, MPH, naceda@upmc.edu; (412) 692-2360

Since April 2009, a new influenza A virus has predominated influenza activity worldwide. Initially labeled the swine flu, 2009 H1N1 is now a household moniker, if not an uninvited guest.

In the U.S., seasonal influenza activity typically begins in the fall, peaks around the winter months, and then gradually fades away by June. The figure below illustrates influenza activity for the current season. With the emergence of 2009 H1N1 in April, we saw an initial wave of activity followed by persistent low level influenza-like illness (ILI) activity over the summer, and now a second wave of activity that has yet not peaked. Below is the picture of a pandemic.

So how is this pandemic shaping up so far? Typical of past influenza pandemics, this one also appears to be impacting younger individuals more than the elderly. Not only is the incidence of 2009 H1N1 more frequent in younger adults, but hospitalizations and mortality are also more frequent in those less than 60 years. In the past two months alone, we have seen more hospitalizations among those less than 65 years than in most entire flu seasons.

Likewise, 90 percent of the mortality so far is in this younger population. Surveillance data from the Pennsylvania Department of Health reveals almost no ILI activity in long-term care (LTC) residents through September. While mortality from 2009 H1N1 remains low, it is still worrisome that roughly 1/3 of all deaths have occurred in otherwise healthy individuals.

What is the status of the 2009 H1N1 vaccine?

In early October, the government released the initial supplies of the 2009 H1N1 monovalent vaccine for use in certain priority groups. Vaccine supply so far has been limited, but is starting to pick up gradually.

As of Oct. 30, 27 million doses were on hand for shipment. The amount of available 2009 H1N1 vaccine will continue to increase over time, but

ACIP H1N1 Vaccination Recommendations for Priority Groups

Priority Group	Vaccine Type
Pregnant women	Injection
Caregivers of infants <6 months old	LAIV* or Injection
Children and young adults aged 6 months to 24 years	LAIV* or Injection
Persons aged 25-64 years who have medical conditions that put them at risk	Injection
Health care/emergency medical service workers	LAIV* or Injection

* 2 years to 49 years with no underlying medical condition and not pregnant can receive LAIV (Live, Attenuated, Intranasal Vaccine) or injection; children 6 months to 23 months can receive injection only.



NOTE: a better version of this graphic can be found at <http://www.cdc.gov/media/transcripts/2009/pdf/t103009-supplement.pdf>

providers should continue to expect shortages in the short term.

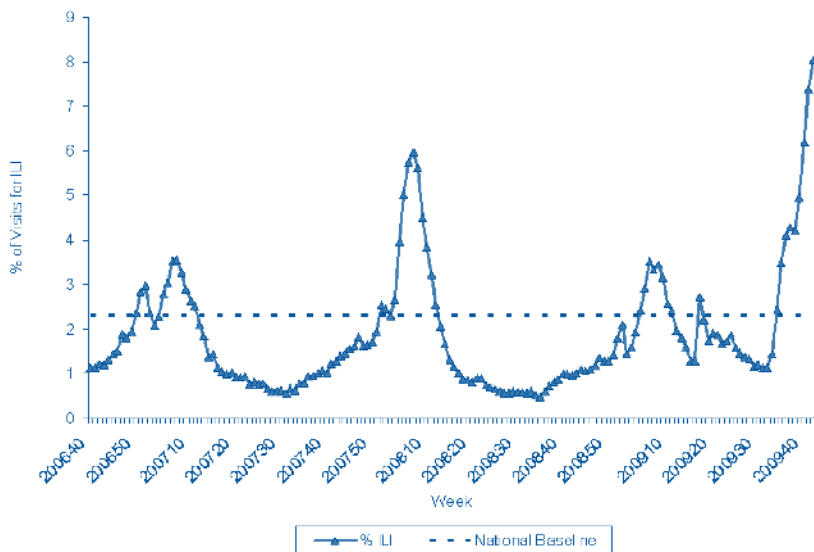
Who are the priority groups? The table above lists the priority groups for the vaccine. Individuals in these groups should be given the 2009 H1N1 vaccine as it becomes available. Individuals not included in these groups should not receive the vaccine at this time.

Why are older adults and LTC residents not on the priority list? The reason that older adults are not on the 2009 H1N1 priority list, even if they have underlying chronic medical conditions, relates to the unique epidemiology of 2009 H1N1.

Like past pandemics, this strain of influenza has had little impact on older adults so far. It has been postulated that older adults may have some distant immunity from the disease. A study from MMWR in May 2009 supports this idea showing more than 33 percent of adults 60 years of age and older had cross-reactive antibodies against 2009 H1N1 (MMWR 2009;58(19):521-24). Targeting the more susceptible populations in the table above clearly makes sense.

Is the vaccine safe? This question has been the focal point of much discussion. Skeptics have raised concerns that this is a new vaccine with an unproven safety record and that it was raced through the production process without the usual

Percentage of Visits for Influenza-like Illness (ILI) Reported by the U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet), Weekly National Summary, October 1, 2006 - October 24, 2009.



NOTE: a better version of this graphic can be found at <http://www.cdc.gov/flu/weekly/>

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AMDA Board Update

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

The AMDA Board continues to be very engaged in a number of important issues that significantly impact each of us as we care for patients in nursing homes. The effectiveness of the Board is closely related to the AMDA staff that has been collaborating with other organizations of similar interest in serving the frail older adults in our communities.

Recently, the AMDA Board and staff have been dealing with an unexpected “curve ball.” This occurred when the DEA decided to enforce its interpretation of the regulations relating to Schedule II drugs.

Many clinicians could not believe that the DEA was more interested in enforcing its interpretations of the regulations than having concern for the quality of resident care. However, all nursing home physicians have been forced into a prescribing system that prevents the timely administration of Schedule II drugs to residents.

Originally, the AMDA staff was hoping to meet with DEA staff members to educate them about the similarities between nursing home care and hospital care. To treat the nursing home nurse any differently actually reduces the

quality of resident care, especially as it relates to pain management in previously hospitalized residents.

The AMDA staff has made very little progress in convincing the DEA that its well-intentioned efforts of interpreting the regulations have frustrated nursing home staff and providers. We all have observed our patients suffering more rather than less by the DEA’s decision.

The good news is that the AMDA staff recently received an unexpected call from a member of Senator Max Baucus’ staff. Baucus is the Chair of the Senate Finance
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IHI Trigger Tool

by Steven M. Handler, MD; handler@pitt.edu; (412) 692-2360

Adverse Drug Events (ADEs) are defined by the Institute of Medicine (IOM) as, “injuries resulting from a medical intervention related to a drug.”¹ ADEs are a common cause of morbidity and mortality in the nursing home (NH) setting, and are associated with 93,000 deaths a year and in as much as \$4 billion of excess healthcare expenditures.²⁻⁴

Despite the frequency and potential impact of ADEs, current methods of detection that primarily rely on comprehensive manual chart review leads to a significant number of events that remain undetected. Over the past decade, the Institute of Healthcare Improvement (IHI) helped develop the trigger tool

methodology, which greatly simplifies the chart review process by allowing rapid and systematic examination of charts to extract relevant data for the detection of potential ADEs.

The technique, which requires minimal training, appears to increase the rate of ADE detection 50-fold from traditional reporting methods.⁵

Researchers at the University of Pittsburgh lead by Dr. Steven M. Handler, developed an IHI-endorsed⁶ trigger tool based on the results of a study to develop a consensus list of agreed upon laboratory, pharmacy, and Minimum Data Set triggers to expand the use of the trigger tool methodology to the NH setting.⁷

The triggers themselves represent specific events, including the results of certain laboratory studies (e.g., supratherapeutic serum medication concentrations, such as digoxin level), ordering of certain medications (e.g., antidotes, such as naloxone), and change in clinical status or new sign or symptom (e.g., drug-induced fall). The authors suggest that this tool be incorporated into the consultant pharmacist medication regimen review process.

Please see the enclosed insert for a copy of the IHI-endorsed trigger tool. For more detailed instructions on how to use the tool, please visit the IHI website or contact Dr. Handler (handler@pitt.edu). ■

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PMDA Symposium Focuses on Transition in Care Topics

by Neelofer Sohail, MD, NESohail@LancasterGeneral.org; (717) 544-3022

Safe transitions was the mantra at the 17th Annual PMDA Symposium held at the Hershey Lodge and Convention Center in Hershey on Friday, Oct. 16. The event drew 127 attendees.

After Gary Bernett, MD, CMD, started the day with housekeeping items and introductions, the stage was taken by James E. Lett, MD, CMD, who is very intimately involved at the CMS level in developing the protocol for safe transfers. He talked about definitions of care transitions and the inadequacies of the current system.

Dr. Lett was followed by the University of Pittsburgh's Robert Palmer MD, MPH, who discussed the models and complications of acute hospital care in the elderly. He was able to provide some practical information on the care of the geriatric patient in a hospital without a special unit for geriatrics.

Cheryl Phillips, MD, CMD, chief medical officer of the On Lok program in California, talked about the practical approach to managing care transitions. She focused on SNF-ER transfers and appropriate communication that could help in such transfers. One of the toughest and most common problems, medication management during transfers, was taken on by Steven Handler MD, MS, CMD. He was also able to provide a variety of practical tools and suggestions.

This time the lunch had two breakout sessions, the PMDA business meeting and the LIFE/PACE meeting that was moderated by Daniel Haimowitz, MD, CMD, and led by Dorothy Fisher, MD, of the Geisenger program in Scranton and Dr. Phillips. The LIFE meeting provided the support that a lot of providers are looking for, as Pennsylvania becomes the hub of the new LIFE/PACE programs.

The afternoon sessions started off with a talk on the nursing home as a new specialty practice by Paul Katz, MD, CMD, from the University of Rochester (N.Y.). He was followed by Alex Makris, MD, CMD, who talked about the

management of influenza and rotovirus breakouts in LTC.

Thomas Lawrence, MD, and David Nace, MD, CMD, provided the public policy update, focusing on never events in nursing homes and the steps PMDA is taking to clarify the issues surrounding them. Also, Dr. Nace provided some clarity on the controversial CII prescriptions in LTC. He also talked about the seasonal flu and the H1N1 vaccine. He stressed the need for the vaccination of the seasonal flu for the health care workers as well as patients and the use of the declination form, which is available on the following website: www.immunize.org/catg.d/p4068.pdf.

The conference ended with a presentation from Gregory Raab, MD, from Penn State Hershey Bone and Joint Institute. Dr. Raab talked about post acute care and anticoagulation issues after surgery. As usual the pharmaceutical companies provided their products and information for the participants during the breaks. The providers networked with old friends or formed new friendships. ■



Paul Katz, MD, CMD, from the University of Rochester (N.Y.), spoke about the nursing home as a new specialty at the 17th Annual PMDA Symposium.



J. Kenneth Brubaker, MD, CMD, left, was recognized for his outstanding service and dedication as a Past President and member of the PMDA Board of Directors. He was presented the award on Oct. 16 at the PMDA Annual Business meeting in Hershey, Pa. Pictured with Dr. Brubaker is Thomas Lawrence, MD, president of PMDA.



Highlights from the PMDA LIFE/PACE Lunch Meeting



President's Message

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past I often resorted to letters or memos to communicate concerns with medical staff members, I am increasingly impressed with how quickly I can resolve the problem with a direct phone call.

Administrative calls placed to others within the LTC arena – including hospital providers, pharmacy and therapy providers, and regulators (such as the regional Department of Health field office—have become commonplace for many Medical Directors also.

Establishing a working relationship with these individuals can result in initiatives to improve the care provided to residents in the facility in a highly efficient way. Many Medical Directors have also developed successful working relationships with their facility corporate offices and also with individuals associated with the provider trade organizations (such as PANPHA and PHCA).

Medical Directors, who also serve in the clinical role as attending physician, have long since learned the value of having a low threshold to place a phone

call to assist in the care of nursing home residents. This has been particularly important in the area of risk management for attending physicians.

It is a good rule of thumb for effective and thorough clinical practice to use telemedicine to keep family members of residents updated with regard to changes in care. This caveat also applies to administrative telemedicine: if you are even contemplating placing a call to initiate and foster communication—do it—just pick up the phone. ■

Update on H1N1

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safety controls. These charges are simply false and demonstrate a more general lack of understanding of influenza vaccines.

First, the flu vaccine is changed each year to match new strains emerging during the preceding season. Therefore, our seasonal flu vaccine is also a new vaccine every year. Considering this, the safety record for the 2009 H1N1 should really reflect the well established safety record of seasonal flu vaccines of the past two decades.

As to the second question of this vaccine being rushed into production, this also is wrong. The vaccine is being produced using the same technology and production controls as all influenza vaccines to date. The manufacturers involved are those experienced in seasonal influenza production.

The FDA has licensed this vaccine using the same standards as all seasonal influenza vaccines. In fact, barring surprises, we anticipate the 2009 H1N1 vaccine to be the seasonal H1N1 component of the 2010-2011 influenza vaccine.

Is it still important to get the seasonal flu vaccine? We expect at this time that seasonal influenza will continue to circulate. So far this season, typing of isolates is revealing 2009 H1N1 in more

than 99 percent of isolates, but it is still early in the seasonal influenza season.

Seasonal influenza remains a threat to older adults and LTC residents and we should not let our guard down against this disease. Facilities are still required to offer vaccine to their residents as supplies hold out. An unexpected early season vaccine shortage has limited supplies so far, but we anticipate seasonal vaccine availability later in the fall.

Are antivirals useful against 2009 H1N1? While there have been a few reports worldwide of antiviral resistance, the vast majority of U.S. isolates tested are showing sensitivity to oseltamivir (99.5 percent) and zanamivir (100 percent). Resistance to amantadine and rimantadine remain at 100 percent and so these agents are not recommended.

When should antivirals be considered for 2009 H1N1? Antiviral treatment should be initiated for all hospitalized patients with ILI. Clinicians should not wait for test results before initiating antiviral therapy, and should initiate antiviral treatment regardless of the duration of illness.

In such critically ill patients, the CDC notes some benefit to patients even when treatment is initiated beyond the traditional 48 hour window. In general, otherwise health outpatients with uncomplicated illness should not be treated as most will recover uneventfully.

Consideration can be given to those outpatients with suspected or confirmed

2009 H1N1 who are deemed at high risk for complications. Included in this group are: children younger than 2 years old; adults 65 years and older; pregnant women; and persons with chronic medical illnesses.

What about hospitalized patients who can't take oral medications? Peramivir is an investigational antiviral agent that is available for intravenous use under an Emergency Use Authorization (EUA) issued by the FDA. Peramivir will be available through the CDC for critically ill hospitalized patients who are either unable to take oral medications, or who have been deemed to fail oral treatment.

Study data on the efficacy of peramivir are limited at this time. Peramivir is not indicated for outpatient treatment at this time. For more information on this agent, contact the CDC at 1-800-CDC-INFO (1-800-232-4636).

Questions? The CDC website (www.cdc.gov/flu) provides up-to-date information on influenza activity, vaccine and antiviral questions. You may also contact us at PMDA about influenza related questions or concerns at pmda@pamedsoc.org.

Disclosure: Dr. David A. Nace is Director of Influenza Programs, University of Pittsburgh Institute on Aging, the AMDA representative to the National Influenza Vaccine Summit, and an advisory member to the PA ILI Net. Dr. Nace has no financial conflicts of interest to report. ■

AMDA Board Update

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Committee. This Committee requested help in clarifying the precise wording in the Senate Bill that addresses the issue defining the nursing home nurse as an “agent.”

Our AMDA staff member, Kathy Wilson, has been very helpful in drafting the correct language for the Senate health care bill. Hopefully, the Senate bill will significantly influence the final reform legislation coming out of Washington. Stay tuned!

Another topic that is receiving attention by the AMDA staff and Board has to do with weighing the pros and cons of supporting a “specialist” concept for those who are dedicating their careers in long-term care. Is there value in recognizing and encouraging specialists in nursing home care similar to what the medical

profession is doing in hospital care with the hospitalist concept?

Paul Katz, MD, CMD, who is the Director of the Geriatric Program at the University of Rochester, has been giving leadership to this new nursing home specialist concept.

Very likely you will be hearing a lot more about this idea in the future. If the nursing home specialist does eventually develop into a subspecialty of geriatrics, one of the most important benefits will be the need to develop a “core competency.”

An example of a core competency need is found in the admitting H & P. I have personally observed admission histories and physicals range from “accepting the H & P” from the hospital records (most of which are very inadequate for a frail older adult) to a five-page comprehensive H & P that includes depression screening,

cognitive screening, ADL history, decision-making ability, and DNR status.

With the opportunity for future debate exploring the pros and cons of a nursing home “specialist,” hopefully we will be able to more accurately define what it is that is required by nursing home providers that will raise the bar of quality care for our frail older adults.

Serving on the AMDA Board for 18 months has been a very rewarding experience. The AMDA Board has very committed members who are dedicated to improving the quality of geriatric care, especially for the frail older adults living in nursing homes.

I would strongly encourage my Pennsylvania colleagues to accept an opportunity to serve on the AMDA Board if asked by the nominating committee in the future. ■

Welcome New Members

PMDA welcomes the following new member to the Association:

Individual Members

Tracy Birbeck, CRNP

Vance Good, MD

Affiliate Members

Arpama Edala, MD

Olga Schweiker, MD



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A New PMDA website is under construction.

We are trying to update the site with new and useful resources for our long term providers. The new website will also be easy to navigate. Until the new site is launched in 2010, please continue to visit www.pamda.org. Please stay tuned.