PMDA

Pennsylvania's Association for Long Term Care Medicine

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Official Pennsylvania Chapter of
American Medical Directors Association

President's Message

Pennsylvania LIFE

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

As the medical director of Genesis Health Care's LIFE (Living Independently For Elders) at Home program for the past six months, I frequently have found myself explaining our program to other professionals. Although LIFE at Home is one of 13 PACE programs in Pennsylvania, I have found that the clinicians I encounter are usually unfamiliar with PACE programs.

A PACE program, or "Program of All-Inclusive Care for the Elderly," is a "capitated benefit authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing," as per the CMS website. In an effort to look at a more cost-effective and creative way to fund long-term care for the upcoming generation of baby boomers, CMS (then HCFA) developed the PACE demonstration project in the late 1980s.

The PACE project is modeled on the system of acute and long-term care services developed by On Lok Senior Health Services in San Francisco, Calif. Presently, Pennsylvania has more PACE programs than any other state. Of the 29 other states that have programs, Massachusetts and New York come in tied for second with six programs.

On Lok began in 1971 as one of the country's first senior day health centers, taking care of older adults in San Francisco where caregivers were strongly committed to keeping elders in their homes. The founders of On Lok soon realized how fragmented the care for their elderly was. Within four years, On Lok began to create a more holistic health care plan that included in-home support services. It subsequently added primary care services and finally case management of acute and chronic health services to its program.

In 1979, Medicare funded a demonstration of its model of long-term care through On Lok Senior Health services. The model featured an interdisciplinary team (IDT), which included physicians, nurses, physical and occupational therapists, social workers, dietitians, health workers and drivers. This IDT formulated and coordinated care plans like those seen in long-term care facilities and provided all medical care and social services for the program's members. In 1997, the BBA established the PACE model of care as a permanent entity within the Medicare

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Focus Continues on Transitions of Care Process Improvement in Capital Area

by Sarah Yazdi Noorbaksh MD, CMD; snoorbaksh@messiahvillage.org; (717) 697-4666

In October 2009, the 17th Annual PMDA Symposium focused on "Transitions of Care: The National Perspective," as James Lett II, MD, CMD, reminded us that "the greatest barrier to patient safety and safety culture is the inherent fragmentation of the U.S. system of care."[1] Many of us were energized as a result of the debates at the symposium, and were "revved up and ready to roll" to make Transitions of Care (TOC) flawless in our facilities.

In the Harrisburg area, a plan grew after I met with Mr. Ed Wargo, director of facility relations for Highmark/Blue Shield, during one of the breaks at the 2009 meeting. Over the following year we met to come up with plans, and then met once with a small group of interested individuals from the community at Messiah Village CCRC, where I am medical director, and worked slowly toward the goal of bringing local hospitals and nursing facilities together to tackle the issues.

The first meeting of the TOC Forum was slated for September 29, 2010, at the Highmark offices. I am pleased to report that there was an outpouring of interest, with representation present from hospitalists, social workers, administrators, nurses, information systems, and admissions personnel from Holy Spirit Hospital, Harrisburg Hospital, Carlisle Hospital, as well as a number of area nursing homes and CCRCs. Dr. Judith Black, medical director for Highmark in Pittsburgh, reviewed TOC efforts in the Pittsburgh area and research and auditing methods to track outcomes of our efforts. From the debate it was apparent that this is an issue that is at the heart of our ability to provide quality health care to seniors in a manner that promotes excellence in outcomes of patient safety.

Over the following year, this group committed to meeting again, this time in two teams. The first would focus on the issues surrounding medication reconciliation while the second looked at documentation tools, including transfer forms and other medical records, in order to enhance uniformity and improve overall communication between sites of care.

In this first meeting of the forum, relationships developed that gave me hope that we can break down the barriers between silos of care, and forge interdisciplinary teams that cut across brick and mortar institutions and work together to provide quality, affordable care for the vulnerable elderly populations we serve.

To date, after several committee meetings, we are finalizing a uniform transfer document that we hope will be adopted by nursing facilities when sending residents to the emergency department. Emergency physicians were instrumental in helping us streamline the information they need, and our next step is to find ways to help as many facilities use the universal form as possible. New projects are now on the agenda, including discharge from hospital form review, medication reconciliation process review, and, of course, the POLST.

Other groups have also kept the ball rolling. The Holy Spirit Hospitalist group held an evening dinner meeting last winter that was well attended by nursing home representatives and physicians to discuss Transitions in Care. There have been a number of efforts across the region in York, Reading, Lancaster and Lehigh Valley, and interest by the local Office of Aging in research on this very important process. The Philadelphia Regional Meeting group organized a multi-site teleconferenced dinner meeting in eastern Pennsylvania last fall to discuss Transitions in Care issues.

As with so many things in life, I have learned that the process is far more important than the content or the final form or tool that might be developed. The spark that was lit at the annual meeting two years ago has led to enhanced networking of teams across our area. Face-to-face interactions occurred with colleagues from other silos of care who only "knew" each other through barely legible handwriting, and who now feel that they can make personal calls more frequently to clarify orders or history. Intra-disciplinary teams from each facility, including social services, admissions, discharge planners, EMS services, emergency room physicians, hospitalists, and attendings now have a sense that they are part of one team, and understand each other's regulatory boundaries and frustrations in the transitions of patients across the care continuum.

Only good can come of this for the people we serve. ■

1. Stephen Shortell, PhD, MBA, MHA and Sare Singer PhD, MBA JAMA, January 30, 2008

Welcome New Members

PMDA welcomes the following new member to the Association:

Active Members

Susan Beidler, CRNP
Diane DeAngelo, CRNP
Lynn Engler, CRNP
Susanne Lane-Sandt, CRNP
Shawn Lisowski, CRNP
Allyson Miller, CRNP
Louise Murray, CRNP
Michele Riep, CRNP
Craig Ronco, CRNP
Michelle Strychalski, CRNP
Melissa Tucker, CRNP

CMS Face-To-Face Encounters for Home Health Certification

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

On April 1, 2011, the Centers for Medicare and Medicaid Services (CMS) began enforcement of new rules for face-to-face (FTF) encounters for home care and hospice certification (https://www.cms.gov/HomeHealthPPS/Downloads/f2f_listserv.pdf; http://www.cms.gov/center/hha.asp). This new regulation was mandated by the Patient Protection and Affordable Care Act, and is intended to ensure that the physician who is certifying home care and recertifying Hospice services actually saw the patient. This additional requirement is intended to assure that the physician's order is based on current knowledge of the patient's condition – seeing the patient is a provision not previously included in Home Health Plan of Care Certification requirements.

The new rules for home health require that the FTF encounter take place within 90 days prior to, or 30 days after the start of services. If the FTF encounter does not take place and is documented within the 30-day window, the provider agency will not be permitted to bill for services provided. There are no exceptions to this provision. A FTF encounter performed and documented 31 days after the start of services will disallow home health agency billing.

CMS has allowed certain accommodations to make compliance with the rule easier. Firstly, a four-month window was provided to accomplish the FTF visit – a relatively long period of clinical care. In addition, CMS has allowed other treating physicians other than the patient's primary care physician to fulfill the FTF requirement. The most common scenario will be a hospitalist who will not be following the patient in the home but who saw him or her in the hospital and completes the FTF encounter, certifies the patient for home care, and signs off on the initial orders. The hospitalist will then be allowed to "hand off" the care to his or her community-based physician.

Other allowances under the rule permit a non-physician practitioner to perform the FTF encounter, but only the certifying physician can document the clinical findings that are required. Documentation that is required includes the date of the FTF encounter, and the elements of the physician narrative include:

- clinical findings that support that the encounter was related to the primary reason for home care,
- clinical need for home health services,

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President's Message
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program and gave states the option to provide PACE services to Medicaid beneficiaries.

LIFE providers receive monthly Medicare and Medicaid capitation payments for each eligible enrollee. Medicare eligible participants who are not eligible for Medicaid pay monthly premiums equal to the Medicaid capitation amount, but no deductibles, coinsurance, or other type of Medicare or Medicaid cost-sharing applies. LIFE providers must assume full financial risk for participants' care without limits on amount, duration, or scope of services. PACE programs provide social and medical services primarily in an adult day health center, supplemented by in-home and referral services in accordance with the participant's needs.

The PACE service package must include all Medicare and Medicaid covered services, and other services determined necessary by the interdisciplinary team for the care of the PACE participant. On enrollment, the PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees.

CMS designed the PACE model "to address the needs of long-term care clients, providers, and payers." Because the financing of PACE programs is capitated, providers can creatively deliver services that participants need rather than be limited to those reimbursable under the traditional Medicare and Medicaid fee-for-service system. Examples include caregiver support, adult day care and assistance with finances, as well as a variety of support services in the home (meals, personal care and housekeeping).

A nursing home eligible individual who is 55 or older is first assessed by the IDT prior to enrollment in the PACE program, at which time a plan of care is developed. After the individualized care plan is developed, a comprehensive service package is formulated that allows the participant to receive services that are designed to facilitate the participant living in his or her home and avoiding institutionalization.

All PACE programs have a medical director who is an integral part of the program, and responsible for the programs quality of medical care, and is also frequently involved in the direct medical care of the participants. A PACE program's physician is often paired with an advanced practitioner and functions as an integral part of the IDT and a closely involved clinician. These clinicians provide comprehensive geriatric medical care and insight into the participant's medical conditions and functional deficits.

This allows the IDT to better care for the impaired individual and optimizes his or her function within the community because the physician works with the IDT, the participant and his or her caregivers in order to help create a participant's individualized plan of care that delivers the appropriate integrated services to that participant. These services also include consultants, acute care and nursing facility services when necessary. ■

When Your Patient Has a Physician in the Family

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

When one of my elderly relatives suffers an acute change in condition, as a geriatrician I am often summoned to offer an opinion about his or her care, or even to speak with the attending physician. Although this may be comforting for the patient, it poses some difficulty for the attending physician. The attending must be certain not to violate HIPAA as the physician in the family is not a treating physician and permission from the patient or POA must be obtained prior to such dialogue.

The attending physician may feel threatened or annoyed by the call from a physician in the family. Is the patient not pleased with his or her care? Am I going to be subjected to second guessing? As the attending physician, it is useful to put your ego aside and be gracious in discussing the case amidst an air of collaboration with the family member. As the physician family member, a similar attitude is vital if anything good is to result from the conversation.

I once called my uncle's physician at his request. I began by thanking him for taking such good care of my dear relative. Then I politely asked if he had considered PMR in his differential diagnosis. Indeed he had not, and when the Sed Rate came back extremely high, he was grateful for my providing an insight that had not occurred to him. Had I begun the conversation in a confrontational manner, I doubt my uncle's care would have benefitted from my intervention.

I had a resident in skilled nursing who had a physician son. He would call the nurse several days a week and inquire about his mother's condition. He would then suggest changes in her medication or recommend specific blood tests to the nurse to be relayed to me, the attending physician. She developed CHF and he requested an ACE inhibitor be started, not realizing that she became orthostatic and hypotensive on low dose lisinopril in the recent past. He did not approve of Depakote being used for behavioral symptoms of dementia, even though it was the first drug we tried that reduced her constant, distressing exit-seeking behavior. He was clearly attempting to write orders for his mother's care, even though he was not her attending physician.

Finally I called the physician son directly as he was listed as his mother's POA. I explained my rationale for the use of Depakote and how the staff and I felt it was beneficial. I convinced him I had his mother's best interest as my foremost concern. I offered to speak with him anytime he had concerns about his mother's care. Although he still calls the nurses regularly to hear about his mother's condition, his frequent requests for order

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Meaningful Data Could Help Reduce Facility Acquired Infections

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

On June 20, I attended the Pennsylvania Patient Safety Authority (PPSA) meeting as a member of the Pennsylvania Healthcare Associated Infection Advisory Panel. The PPSA has been collecting data related to nursing home acquired infections.

The challenge is trying to get meaningful data that will enable nursing homes to reduce their facility acquired infections and antibiotic resistant organisms. For example, PPSA has noted that the reportable non-catheter urinary tract infections among many nursing facilities runs around 0.16 infections/1,000 resident days while others run between 0.20 to 0.40 infections per 1,000 resident days.

In the two nursing homes that I serve as a medical director, I noticed that one facility had a very low UTI rate but didn't have a specialized infection control nurse while my other facility had a much higher UTI rate and had an infection control nurse. Both facilities have been rated as four stars ever since the nursing home star ratings were established. Is it possible to conclude that facilities that have a special designated infection control nurse could have more UTIs because of more accurate reporting?

Of additional interest is the fact that one of my nursing facilities was running an infection rate of 1.2 infections/1,000 resident days according to the MDS 2.0 criteria. With staff and physician education, we were able to drop the rate to 0.6 infections/1,000 resident days. This lower rate put the facility in the mid-30Th percentile on the MDS 2.0. Yet all of these rates are far above the rates collected by the PPSA. The major difference is in the criteria that the PPSA is using for diagnosing UTIs.

Since PPSA is using criteria that are modeled very closely to McGeer's criteria for UTIs, I believe the data for non-catheter UTIs is more accurate than the data from the MDS 2.0. I will be very eager to see how our present MDS 3.0. data for UTIs will compare with MDS 2.0 data and with PPSA data.

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PMDA's 19th Annual Symposium is Right Around the Corner!

Don't miss the innovative format and expanded educational sessions:

The PMDA Annual Symposium will be at the Hershey Lodge on Friday, October 21, and for the first time will have an additional Saturday morning session on October 22, 2011. The option to attend Friday only is available for a reduced registration fee, but we hope you will be able to stay overnight to take advantage of the full program.

This year's nationally recognized speakers include:

- J. Kenneth Brubaker, MD, CMD, 2009 recipient of AMDA's Medical Director of the Year Award
- Brian M. Duke, Secretary of Aging, Commonwealth of Pennsylvania
- F. Michael Gloth III, MD, FACP, AGSF, Associate Professor of Medicine, Division of Geriatric Medicine and Gerontology, Johns Hopkins School of Medicine
- Coleen Kayden, RPh, Pharmacist, Williams Apothecary, Lancaster, Pennsylvania
- Leon Kraybill, MD, CMD, Medical Director, Health Campus Outpatient Center, Harrisburg Pike, Lancaster, Pennsylvania
- David Nace, MD, PhD, Assistant Professor of Medicine, University of Pittsburgh School of Medicine, University of Pittsburgh Institute on Aging
- Andrew Rosenzweig, MD, FACP, Associate Fellowship Director, Division of Geriatrics, Abington Memorial Hospital, Clinical Assistant Professor of Medicine, Drexel University College of Medicine
- Andrew Rosenzweig, MD, MPH, Chief Clinical Officer, MedOptions, Providence, Rhode Island
- Paula Sanders, Esq., Partner, Post and Schell, Attorneys at Law, Harrisburg, Pennsylvania
- Navin Verma, MD, Assistant Professor Medicine, Division of Nephrology, Penn State College of Medicine, Hershey, Pennsylvania
- Matthew Wayne, MD, CMD, AMDA's President-Elect and Assistant Professor of Medicine at the Case Western Reserve School of Medicine

The Friday morning session will be devoted to managing psychiatric and behavioral conditions. Afternoon topics include the interdisciplinary team process, legal and safety concerns, public policy updates, and reducing re-hospitalizations for heart failure. Saturday morning topics include pain management, Vitamin D, pharmacy updates and the management of chronic kidney disease.

The PMDA Symposium keeps you up to date with the latest clinical and regulatory issues. You'll have an opportunity to participate in the PMDA Annual Business Meeting over lunch and to network with your colleagues. Bring your family to enjoy the park as well!

Attendees will qualify for up to nine hours of CME and several hours of CMD clinical and management credits. Nursing attendees will receive a certificate of attendance toward their continuing education as required by the Board of Nursing.

The Hershey Lodge has made a block of rooms available to PMDA Symposium attendees and exhibitors. Make your reservation by calling (717) 533-3311 or (800) 533-3131 and identifying yourself as part of the PMDA group. Rooms are available on a first-come, first-served basis, so book your reservations ASAP but no later than September 19, 2011.

Register online at www.pennstatehershey.org/web/ce/home/programs/pmda . For more information, call (717) 531-6483 or email:ContinuingEd@hmc.psu.edu.

See you in Hershey! ■

CMS Face-To-Face Encounter for Home Health Certification

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- certification that the patient is homebound.

It is important to remember that Medicare's policy on being confined to home does not mean that the patient is unable to leave the home. As the CMS FTF Questions and Answers website states: "the condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving home would require a considerable and taxing effort. **If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment."**

The CMS website also provides the following sample physician FTF encounter narrative as an example: "The patient is temporarily homebound secondary to status post total knee replacement and currently walker dependent with painful ambulation. PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decompensation or adverse events from the new COPD medical regimen."

Most home health agencies have developed their own forms for documentation of the required elements. Although there is some variability in the forms, most home health FTF encounter forms include the following elements: date of FTF encounter, the medical condition which is the primary reason for home care services, the clinical findings that support the services, justification of homebound status, and the physician name, signature, and date.

Many agencies have provided "cheat sheets" for guidance that include lists of Medicare approved conditions, services, and phrases that describe and justify the homebound status of patients. However, the rule does preclude home health agencies from completing or drafting the required elements of the documentation for the certifying physician. A sample documentation guide is posted on the PMDA website: http://www.pamda.org.

"If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment."

PMDA members have voiced a wide range of concerns and frustration with the additional work involved in completing the FTF encounter documentation. While most PMDA member physicians have stated that a qualifying FTF visit is usually made in the course of providing routine attending physician services to nursing facility residents, most also report that the added work of completing the documentation requirements is very burdensome.

Some physicians have indicated that they have been routinely asked to complete the FTF encounter form prior to the patient being discharged from the nursing home. This practice is not a requirement of the rule as the FTF encounter and/or its documentation can be completed after the start of service. The documentation can be completed up to 30 days after the start of services. Indeed, most of our members who have responded to questions have stated that the forms are faxed to their office for completion after the home care services have begun.

Some physicians have said it is challenging to find the required clinical information in their office when they are completing the form. Others have reported that the home care agencies often provide a clinical summary that details the clinical conditions and services to be provided for that patient (such as the home health referral intake summary form) along with the FTF form that is faxed to their office. Physicians have stated it is fairly easy to confirm the date of a qualifying FTF encounter by checking their billing records.

Some PMDA physicians have indicated a sense of duty in completing the forms as refusal may create a barrier to needed services for their patients transitioning from the nursing facility to the home setting. Others have voiced a strong sense that they cannot afford to provide the time needed to perform yet another unpaid service for patients, and that it is just not possible in their current practice model. Despite the burden, it appears likely that if the nursing home physician fails to perform this task it may introduce potential problems in the transition in care.

It has been pointed out that CMS does reimburse physicians for completion of the Medicare home care certification and issuing initial orders and review of the plan of care using billing code G0180. It is apparent that many PMDA members who routinely perform these required services and their documentation do not bill for their work. Although the FTF encounter is not billable separately, it is part of the overall initial home care certification process and submitting billing for the work of home health certification may help reimburse for the effort spent in this time consuming process. ■

When Your Patient Has a Physician in the Family

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changes through the nursing staff declined after that conversation.

My most disappointing experience with a physician family member occurred when a patient with multiple sclerosis and stroke was dying under Hospice care. I made a special trip to the facility at the end of my office hours to meet with the daughter and the Hospice nurse. We all agreed that our patient was actively dying and supportive morphine was the best course.

An hour later I received a phone call from the nurse that the daughter insisted that her mother be transported immediately to the ER "to be sure we had not overlooked something treatable." After a traumatic transfer, her mother died within minutes of arriving in the ER. I learned thereafter that the daughter's husband, a physician, having not seen the patient nor spoken with me or the nurses, had strongly encouraged his wife to get her mother to a hospital for a second opinion. His action increased the suffering of the patient and family and interfered with a comfortable death in the skilled nursing facility. As the attending physician, I felt extremely disrespected by my colleague.

Physician family members who have any concern about the care of their relative should avoid passive-aggressive behavior and contact the attending physician directly, ensuring HIPAA compliance. They should politely ask for information about the case and start from the belief that the attending physician has more information than do they, and has the patient's best interest at heart. This can establish a collaborative relationship that will permit polite, informative, useful dialogue to occur. Then travesties such as the one mentioned above can be avoided, and better care for our patient and loved one can result. ■

Meaningful Data Could Help Reduce Facility Acquired Infections

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As you can see, we are collecting a lot of data. But one can become confused to know what to do with that data. I have become interested in seeing how many of my colleagues are treating UTIs that don't meet the PPSA's criteria for non-catheter UTIs. Interestingly, some of my colleagues are treating more residents for UTIs that don't meet the stricter PPSA criteria than those residents who meet McGeer's criteria.

Even more intriguing is the fact that the same provider has demonstrated significant practice variation among three resident units (the same provider sees all of the residents in each units). For example, in one unit I have observed the same number of residents being treated for UTIs diagnosed by McGeer's criteria as those who have not met McGeer's criteria. On another floor there have been two to three times more residents treated for UTIs who didn't meet McGeer's criteria as those UTIs that have met McGeer's. This would suggest that the staff is driving the potential over-use of antibiotics instead of the physicians/CRNPs.

Since I have been observing that physicians and CRNPs are using a lot of antibiotics that may not be necessary, I have become as interested in collecting data of antibiotic use that doesn't meet the PPSA criteria as those that do. At Masonic Village, we are beginning to collect the following data: the number of antibiotics ordered per 1,000 residents/mo (this includes oral, IV, and IM but excludes topical) and the number of antibiotic days/1,000 residents/mo. This data will tell me not only how many antibiotics have been ordered every month on each unit but also how many days residents are receiving antibiotics/1,000 residents/mo.

Since Masonic Village has one physician seeing all of the residents on each floor, it will be easier to look at physician practice patterns as it relates to prescribing antibiotics. Taking this information and developing a running control chart, I will have an opportunity to look at normal and special cause variations that could exist in each of the providers' practices. If collecting this data can give me more insight into practice patterns, there is a better opportunity to look at special cause variation that could be helpful in reducing the use of inappropriate antibiotics among the frail elderly population. Hopefully, the reduction of antibiotic use will cut down in the c-diff infections, MDROs, VREs, and MRSAs within our facility. ■

Visit the PMDA Online

PMDA's website, www.pamda.org, continues to be an important resource of LTC information. It is frequently updated with best practice information and legislative news that affects every PMDA member. Be sure to check out the recently added face-to-face certification form, which can be found on our home page.

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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
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