

PMDA

news

Volume 15, Number 3 (Issue 40)
Fall 2008

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

President
Thomas E. Lawrence, MD
West Chester

President Elect
Pamela Fenstermacher, MD, CMD, FAAFP
Jenkintown

Immediate Past President
J. Kenneth Brubaker, MD, CMD, FACP
Elizabethtown

Treasurer
Daniel R. Steiner, MD, CMD
Oakmont

Secretary
Gary B. Bennett, MD, CMD
Haverford

Board of Directors

Judith S. Black, MD, MHA
Pittsburgh

Louis C. DeMaria, Jr., MD, CMD
Medford

David Fuchs, MD, CMD
Lancaster

Leon Kraybill, MD, CMD
Lancaster

Barbara Reall, MBA, MSN, CRNP
Ambler

Neelofer Sohail, MD
Lancaster

John Wilson, DO, MBA, CMD
Hatboro

Newsletter Editors
David E. Fuchs, MD
Lancaster

Neelofer Sohail, MD
Lancaster

Administrative Office
777 East Park Drive; P. O. Box 8820
Harrisburg, PA 17105-8820
Phone: 717-558-7868
Fax: 717-558-7841
pmda@pamedsoc.org
www.pamda.org

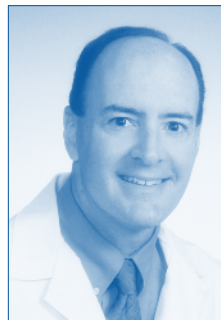
Executive Director
Maria B. Elias

Official Pennsylvania Chapter of
American Medical Directors Association

President's Message

What's In a Name?

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



At PMDA's Annual Business Meeting at the Annual Symposium on October 24th, our membership voted to officially change the name of our organization from the *Pennsylvania Medical Directors Association* to *PMDA/Pennsylvania's*

Association for Long-Term Care Medicine. This change was the culmination of several years of deliberation by PMDA leadership. For many years, our Board of Directors has discussed the changing nature of LTC in Pennsylvania, and how our organization can best rise to the challenge of being the leader in LTC medicine within the State.

Our new name *PMDA/Pennsylvania's Association for Long-Term Care Medicine* has been PMDA's tagline on our website, newsletter, membership materials, and our stationary for over 5 years. The name change reflects two important directions for our organization. First, PMDA has grown to assume a role as the standard bearer for LTC Medicine within the State of Pennsylvania. For sixteen years, we have provided educational programs that have not been limited to focusing on the administrative role of the Medical Director, but that have dealt primarily with health care delivery and clinical medicine within this setting. Secondly, our membership has expanded and evolved in recent years to include not just Medical Directors, but attending physicians and many non-physician professionals including nurse practitioners, nurses, pharmacist, and administrators. Although most of our members are physicians, and most of those are LTC Medical Directors,

we have a more diverse membership than ever before and this adds to our strength and our ability to serve the residents we care for.

Although the vote was clear in changing our organization's name, it was not unanimous. There were concerns about the change, including the questions will PMDA no longer be a primarily physicians professional association, and will we be able to maintain our identity as a State affiliate of AMDA? The PMDA Board is committed to resolving these concerns, and assuring our membership that we will be able to move forward without concern that our new name will hinder our programming and service to members in any way. Indeed, the last year has proven that our organization is more vital than it has ever been in the areas of education and public policy and advocacy. Long-term care in Pennsylvania is changing and *PMDA/Pennsylvania's Association for Long-Term Care Medicine* is better positioned than it has ever been to provide the vision and leadership to move forward into this exciting and evolving arena. ■

Inside This Issue

- Annual Symposium in "Chocolate Land" a Huge Success!!2
- AMDA Board Update.....2
- TB Bacteria: Striving for Zero Tolerance3
- Leading the Good "LIFE"3
- Obstructive Sleep Apnea in the Elderly4
- Public Policy Committee Update5



PMDA 1992 - 2007

15 Years of Excellence in Long-Term Care Medicine

Annual PMDA Symposium in “Chocolate Land” a huge success!!

by Neelofer Sohail, MD, nesohail@lancastringeneral.com, (717) 544-3022

The 16th PMDA Annual educational symposium was held at the Hershey Convention center on October 24, 2008. The attendance was up from the previous years and included an increase in the number of fellows and nurse practitioners.

There was an array of presentations to whet everyone’s appetite. Some of the highlights were Wound Care and Nutrition in LTC by Dave Thomas, MD, CMD, who is considered an expert in the field of wound care. Palliative Care by William Smucker, MD, CMD, drew out a variety of issues about end of life care in the nursing home. Phenelle Segal RN, CIC, provided an update on the ACT 52/HAI from the Pennsylvania Patient Safety Advisory

committee and the follow up action plans and its impact on LTC. Paula Sanders, Esq, and Ken Brubaker MD, CMD, FACP, addressed issues pertaining to competency and decision making following assessment of dementia and management of behaviors by Drs. Joan Weinryb and Joel E. Streim. This was followed by a panel discussion on the presentation topics moderated by AMDA President-elect, David Brechtelsbauer, MD, CMD.

Drs. Thomas Lawrence and David Nace provided update on public policy issues with ACT 52, influenza vaccination and the PMDA list serve that was created to help physicians in the community.

During lunch, participants attended the meetings, networked with colleagues and visited the exhibitor booths. During this time, elections were held for board member positions, bylaws were reviewed and changes recorded.

Our special thanks to Drs. Susan Denman and Judith Black for doing such a tremendous job year after year. This is reflected in the quality of the speakers and topics that are reviewed. Also, thanks to all the PMDA staff members that work behind the scenes to get everything working seamlessly.

Mark your calendars and plan to join us for next year’s meeting at the Hershey Lodge on Friday, October 16, 2009. ■

AMDA Board Update

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

Since joining the AMDA Board in March 2008, I am still on a learning curve as I am understanding who and what drives the “engine.” While we have met once at the end of our AMDA meeting this past March, Board members have monthly conference calls and frequent updates. There are a host of activities behind the scenes which includes political activities, fiduciary responsibilities, and educational commitments. I have included below several significant discussions that could

eventually impact many if not all of us sometime in the future.

1. The AMDA Educational Committee reported on a request by a member of the AMDCP (American Medical Director Certification Program) Board for greater access to medical director education by diversifying delivery mechanism for the Core Curriculum. Dr. Chuck Crecelius, president of AMDA, has appointed a task force to consider additional opportunities to provide education on medical direction, including working with corporate members and fellowship programs.
2. AMDA is moving forward in establishing a Board Advisory Group which will be made-up of non-physician providers who are providing significant contributions within the nursing home setting. AMDA’s goal is to get broader input/advice from a more diverse provider group which will enable all of us to improve the quality of care for our residents.

3. The AMDA Board is exploring the development of a White Paper acknowledging the importance and benefits of continuing medical director education. Since the State of Maryland requires medical director education, a recent survey in Maryland demonstrated that both medical directors and administrators valued the additional educational requirements of the medical directors. At least one other state is looking into requiring additional education in medical direction for its medical directors. In the past AMDA has been silent on this topic. Since several states have or are considering moving in the direction of expecting medical directors to participate in on-going continuing education in medical direction, AMDA is considering being more pro-active by developing a White Paper which will look at the value and benefits for medical directors taking advantage of opportunities in medical direction education. ■

Notice to PMDA Members

Previous membership applications should be discarded due to bylaws changes that were approved at the Annual Business meeting on October 24, 2008. Enclosed application should be used for colleagues or membership recruitment purposes.

TB Bacteria: Striving for Zero Tolerance

by Shirley Bushong, BSN, RN, Infection Control Nurse, Conestoga View Nursing & Rehabilitation, SBushong@lrcmail.com, (717) 295-3618

To assure that appropriate TB prevention and control measures are undertaken to protect residents and staff at Conestoga View Nursing & Rehabilitation (CV), Lancaster, PA, CV has incorporated the QuantiFERON—TB Gold Test (QFT-G) into its screening protocol to aid in diagnosing *Mycobacterium tuberculosis* infection. Driven to advance and keep on the frontline of long term healthcare facilities, CV continuously strives for innovations to improve its infection prevention efforts. Dedicated to delivering high quality long term care services to residents, their families, staff and the surrounding community, includes managing the elderly and immunocompromised individuals who host chronically complex, health challenges.

The key to decreasing the risk of bacterial and disease transmission includes initiating aggressive methods of detection. QFT-G assists clinicians with TB control.

This FDA approved measure detects latent tuberculosis infection and tuberculosis disease by measuring how the immune system reacts to the germs that cause TB.

QFT-G advantages in control practice

- Not affected by persons vaccinated with BCG (individuals immigrating from countries with a high TB prevalence often receive BCG.)
- Does not trigger a boosting response
- Only one blood sample is needed
- Quick turn-around time. Incubation of blood samples is 16-24 hours
- Elimination of subjective reading results
- Elimination of some chest x-rays

A true complexity unfolds into a success story

After receiving the following information, Conestoga View faced the dilemma of making a complex decision:

- An individual with a history of residence in a country of high-prevalence of TB
- Positive PPD
- Positive chest x-ray
- Negative CT scan of the chest

Conestoga View went the extra mile for a definitive answer. Requiring further evaluation ended in a success story for the employee and employer. The results—a negative QFT-G and happy ending (or perhaps happy beginning) for everyone. The QFT-G proved advantageous in expediting the employee's ability to work.

Conclusion

Conestoga View's commitment to infection control involves zero tolerance of TB bacteria. CV supports ongoing research to support and implement comprehensive practices to achieve this end. ■

Leading the Good "LIFE": Programs of All-Inclusive Care for the Elderly in Pennsylvania

by Dorothy Y. Fisher, MD, MGH, CMD, dyfisher@geisinger.edu, (802) 233-3881

Programs of all-inclusive care for the elderly, called PACE in most of the United States, are becoming very popular in Pennsylvania. Here in PA, they are called LIFE (Living Independently for Elders) programs since the acronym PACE has already been taken. Programs of All-Inclusive Care came to Pennsylvania in 1998. The Department of Public Welfare was authorized in the

Governor's fiscal year 1996-1997 budget to implement a long term care managed care demonstration. The administration was looking at new, innovative and cost effective ways of delivering long-term care services to the Commonwealth's frail elderly, which could provide cost savings, as well as allow individuals the option to remain in the community.

This PACE demonstration project was Pennsylvania's first experience in managed care for the nursing facility eligible population. The initial demonstration provided funding to develop ten demonstration sites over three years. Several organizations were in line ready to develop PACE in Pennsylvania.

continued on page 6

Interesting Cases and Ethical Dilemmas

The editors would like you to respond to this call for articles on interesting cases or ethical dilemmas. Perhaps you would like to share a story about a case that was out of the ordinary or particularly challenging? We frequently experience difficulty with end of life issues in long term care as we interact with our patients and their families. Whether it is a clinical or ethical issue that makes the case unique, we are hoping you will put it into about 250 words or less and email it to Neelofer Sohail (nesohail@lancastergeneral.org) or Dave Fuchs (defuchs@comcast.net).

Obstructive Sleep Apnea in the Elderly

by Margaret C. Thomas, MD, mcthomas@lancastergeneral.org, (717) 544-3022

Although even healthy aging is associated with a decrease in the quality of sleep, the importance of sleep to health does not diminish with age. Obstructive sleep apnea (OSA), a disorder of periodic decreases in ventilation during sleep, may further compromise sleep architecture in the elderly. Sleep apnea in general may be due to both peripheral obstruction (commonly known as obstructive apnea), in which no airflow is present with respiratory effort; to centrally mediated absent airflow and respiratory effort (central apnea); and/or to mixed apnea, which starts as a central event but becomes obstructive. This article focuses on obstructive apnea.

Definitions for Diagnosis

Apnea is defined as the cessation of airflow lasting ≥ 10 seconds. Hypopnea is ≥ 10 seconds of a 50-90% decrease in airflow and $\geq 4\%$ drop in oxyhemoglobin saturation. The apnea-hypopnea index (AHI) is the apneas and hypopneas per hour of sleep. Diagnosis of mild OSA obtains when there is an AHI of 5-14; moderate is an AHI of 15-29; and severe is an AHI of ≥ 30 . CMS recognizes mild OSA as an indication for treatment only if there are clinical symptoms of insomnia, mood disorder, excessive daytime drowsiness, impaired cognition, hypertension, ischemic heart disease, or prior stroke. However, if the patient has an AHI of 15 or more, symptoms are not required for treatment.

Epidemiology

The laboratory prevalence of OSA increases with age, with studies reporting a prevalence of between 37-62% in those aged 60 or greater. Associations with OSA in the elderly include obesity, diabetes, chronic renal failure, coronary disease, hypothyroidism, and CVA, and are more common in older patients and may explain part of the prevalence. For every 10 kg of weight, the odds ratio for obstructive apnea doubles. Other risk factors are the anatomic and physiologic changes of aging, including increased laxity of the tissues of the upper and lower airways. Although male sex is a risk factor for

diagnosis in middle age, the prevalence in postmenopausal women approaches that of men. Alcohol is another important risk factor. The increased overall laboratory prevalence of sleep apnea is due to both obstructive and central apnea. However, when defined strictly according to clinical criteria such as the CMS, the prevalence declines with age and the significance of only mild OSA is unclear.

Morbidity and Mortality

Mild OSA may cause cognitive impairment in presence of excessive daytime sleepiness. OSA is also associated with overall poor health, greater limitations in IADLs, depression, and decreased performance on the MMSE over time. Severe OSA has also been associated with impaired attention, memory, executive function, and planning. Studies have also demonstrated an association with falls, fractures, and delirium. Severe OSA with an AHI ≥ 30 increases the risk of CVA, with an odds ratio of 2.52. Mortality has also been studied. Increased mortality rates have not been seen in men, but a study of 233 nursing home patients found an association between AHI and increased mortality in women.

Clinical Manifestations

Laboratory diagnosis requires clinical correlation before determining whether to treat, unless the AHI is ≥ 15 . Some of the signs and symptoms of OSA that clinicians encounter in the young (such as insomnia, nonrestful sleep, excessive daytime somnolence, and nocturia) may be the same in elders. However, such typical symptoms of OSA such as loud snoring, high BMI, and large neck may not be detected in the elderly due to lack of a spouse and lower BMIs or some weight loss with age. In addition, signs and symptoms of OSA in elders are often attributed to aging itself or to other comorbidities.

Treatment

Persons suspected of having OSA should be referred to a sleep lab for evaluation. Although there has been conflicting evidence about tolerability of continuous

positive airway pressure (CPAP) in the elderly, do not assume that your patient will not tolerate it. It has been shown in several studies to be generally well tolerated by the elderly, even in the mildly to moderately cognitively impaired. Up to 70% of older persons may obtain CPAP compliance of 6.5 hours nightly for 6.5 nights per week. CPAP has also been demonstrated to lessen daytime sleepiness, improve some measures of cognitive function (attention, psychomotor speed, executive functioning, recall), and to decrease nocturia in older adults. The mask must fit; if there is any snoring at all with the mask on, it does not fit correctly. The patient should be followed up in 1 week after starting CPAP. Both oral and nasal appliances may be used. Goals of therapy should be periodically reassessed relative to daytime sleepiness, mood, cognitive function, hypertension, and physical function.

Recommendations/Bottom Line

Despite the increased prevalence of OSA in the elderly, it is often not diagnosed. Elderly patients with OSA may not have traditional risk factors or physiognomy. Nevertheless, clinicians should continue to have a high index of suspicion for OSA in their older patients. More research is needed to better understand the significance of OSA, especially in long-term care residents. Less cumbersome methods of diagnosing OSA are currently being studied and will greatly aid diagnosis in the nursing home setting in the future. ■

References

- Avidan AY. Sleep and Neurologic Problems in the Elderly. *Sleep Med Clin* 2006; 1: 273-292.
- Gammack JK, ed. Sleep in Elderly Patients. *Clinics in Geriatric Medicine* 2008; 24(1): 1-180.
- Kamel NS. Insomnia in the Elderly: Cause, Approach, and Treatment. *Am J Med* 2006; 119(6): 463-469.
- Shochat T and Pillar G. Sleep Apnoea in the Older Adult. *Drugs Aging* 2003; 20: 551-560.
- Stone KL and Redline S. Sleep-Related Breathing Disorders in the Elderly. *Sleep Med Clin* 2006; 1: 247-262.
- Vaz Fragoso CA and Gill TM. Sleep Complaints in Community-Living Older Persons: A Multifactorial Geriatric Syndrome. *JAGS* 2007; 55: 1853-1866.

Public Policy Committee Update

by Thomas Lawrence, MD, CMD, tomlawrence@comcast.net, (484) 427-8000; and David Nace, MD, MPH, naceda@upmc.edu, (412) 692-2360, Public Policy Committee Co-Chairs

At the annual meeting on October 24, 2008, PMDA presented an overview of public policy items impacting long-term care. Several important issues at the state and national levels were discussed. The following is a brief summary of some of these issues along with recent updates. A copy of the annual symposium presentations have been posted on the PMDA website for more details. Members are also welcome to contact PMDA at pmda@pamedsoc.org for additional details or clarifications. Members are also welcome to access the NEW PMDA Medical Directors Forum Listserve by requesting listing through the PMDA e-mail address.

Act 52

By now, Act 52 should be a household name for nursing facilities in the Commonwealth. Passed in July 2007, Act 52 attempts to improve infection control practices in all healthcare settings, particularly through attention to healthcare associated infections (HAI). The following are some common questions asked about recent developments in Act 52.

What is a Healthcare Associated Infection?

The Patient Safety Authority (PSA) finalized and published its definitions of HAI for nursing facilities in the September 20th, 2008 PA Bulletin (www.pabulletin.com). HAI are all infections in nursing facility residents that were not present or developing at the time of admission to the nursing facility.

Beginning on April 1, 2009, nursing facilities will be required to electronically report all cases of the following HAI:

- Urinary tract infections associated with the use of a urinary catheter
- Urinary tract infections not associated with the use of a urinary catheter
- Lower respiratory tract infections
- Influenza-like illness
- Skin and soft tissue infections (cellulitis, IV site infections, burns, vascular and diabetic ulcer infections,

device associated infections, pressure ulcer infections)

- Gastrointestinal tract infections
- Intra-abdominal infections (peritonitis and abscesses)
- Meningitis
- Viral hepatitis
- Osteomyelitis
- Primary blood stream infections.

How do I know what to do?

The PSA will be hosting training sessions across the state beginning in January 2009. Additionally, there will be web-based training sessions for those who cannot travel to the regional meetings. The PSA has identified PMDA as a partner in announcing these training sessions and information is to be posted on our website as it becomes available. Additionally, the PSA has announced the availability of training grants for facilities. These grants may be used to offset the costs of preparing for Act 52. Training plans may address the identification, reporting, or prevention of HAI. Nursing facilities interested should download the application from the PSA website and submit the application by the deadline of November 26, 2008 (www.psa.state.pa.us/psa/site/default.asp).

Do I have to notify patients about HAI?

The PSA stipulates that nursing facilities must provide **written notification of all HAI to the resident or responsible party within 7 days of occurrence**. While not a requirement for nursing facilities under the MCARE Act or Act 52, the PSA has added this requirement in its September PA Bulletin release. PMDA has serious concerns about such reporting and has worked with other provider organizations across the state in a group letter requesting removal of this requirement. Nursing facilities have a significant portion of their patients who request limited or no interventions consistent with their end of life wishes. In such situations, infections including HAI, are a natural process of the dying process. Provision of written

notification in these circumstances holds no evidence based value for improving care.

What information must I share with healthcare workers?

Act 52 requires nursing facilities to forward the infection control portion of each PSA Advisory to all of their staff, **including physicians**. The advisories may be found at the PSA website listed above. Click the link in the left hand column entitled "Advisories and Related Resources."

Infection Control Interpretive Guidelines (F tags 441-445)

CMS continues its work on revising the nursing facility interpretive guidelines for infection control. This project started in January 2007. This September, CMS released a working draft to stakeholder organizations, including AMDA. CMS is now in the process of reviewing and responding to comments submitted. A date for implementation of the new guidelines is not certain at this point. The guidelines will attempt to reduced tags 441-445 into 2 primary tags, 441 (Infection Control & Infection Control Program) and 444 (Hand Hygiene). PMDA has participated on the expert panel revising the guidelines.

60% or Bust!

Health and Human Services Wants Healthcare Workers to Get the Flu Shot!

Healthcare worker (HCW) influenza immunization has emerged as a cornerstone practice to reducing the impact of influenza in older adults.

continued on page 7

American Medical Directors Association Certification Program (AMDPC) Spring 2008 CMD's

Ashith Mally, MD, McMurray, PA
Sarah Y. Noorbaksh, MD, CMD, Mechanicsburg, PA
Jeffrey H. Perlson, DO, CMD, Southampton, PA

Leading the Good “LIFE”

continued from page 3

State staff assigned to the project set out to make necessary system modifications, coordinate and educate appropriate agencies, set rates for the program, and begin development of any state specific program requirements.

After several years of development on the part of the developing organizations, as well as the Department, the program became operational with two LIFE providers in Philadelphia County in October 1998. A third program followed in Allegheny County in March 1999. Since that time, an additional eight organizations stepped forward to implement the LIFE model in various parts of the state (personal communication, Cindy Proper).

The State of Pennsylvania Department of Public Welfare, Office of Long-Term Care Living has announced an effort to make LIFE programs available throughout the state of PA. Currently, LIFE programs exist in all but 22 markets across the state. LIFE programs provide all needed medical and social services to seniors who qualify for nursing home care but have a desire to continue to live in the community. The Pennsylvania LIFE Expansion Project is a project of the Commonwealth of Pennsylvania Department of Public Welfare, Office of Long-Term Care Living administered by the National PACE Association. The goal of the project is to greatly expand the availability of LIFE programs to seniors in Pennsylvania with long-term care needs, by assisting health care providers that may be interested in developing LIFE programs as a line of business.

Currently, 13 LIFE providers operating 21 day health centers serve approximately 1,500 participants in 15 counties. Program expansion is already underway, and will bring the total to 15 providers serving 45 counties. The goal of this project is to make the LIFE program available to Pennsylvanians in the remaining 22 unserved markets (www.palife.org).

History of PACE

PACE traces its roots to San Francisco in the early 1970's. The Asian community there was unhappy with the long-term care options for their seniors. Most were on

Medicaid, and thus were forced to accept nursing home placement often far from their families. This was due to the scarcity of open beds due to the CON process. To fix this problem, a program was developed called On Lok, which means “place of peace and happiness” in Cantonese. This program started with an adult day health center where elders could receive a hot meal, health and social services and supervision during the day. Eventually, the program grew to include home health and support services, primary care and case management. The program provided all the health needs for the individual elder, as well as adult day services for elder socialization to enable their children to work. This was all within a culturally sensitive model. This was an important point, since many immigrants did not speak English, thus placement outside their community meant an inability to communicate effectively. The program eventually applied to become a Medicare provider, and is now run with capitated fees from Medicare and Medicaid (www.onlok.org). The model was well-received by Medicare, and was designated a permanent Medicare program under the Balanced Budget Act of 1997. CMS has since supported widespread development of this model (Gross et al.).

Clients Served

PACE serves individuals that are 55 years and older, certified by their state to need nursing home care, and able to live safely in the community at the time of enrollment. The individual must have Medicare and usually Medicaid, although the person may choose to private pay if they do not meet financial eligibility for Medicaid.

Services Provided

The PACE provides and pays for care in all settings; even nursing home care, should that eventually become necessary. The PACE health care model is based on the philosophy that it is best for elders with chronic care needs and their families to be served in the community for as long as possible. PACE provides all health care needs including medications, durable medical equipment, therapies, primary, acute and long-term care, labs, hospital and rehabilitation programs. This is similar to an HMO, except that most HMOs have a prescription co-pay, which PACE does

not, and most do not cover durable medical equipment. PACE also covers home care services, including home delivered meals, personal care, homemaker and doctor visits, as well as nursing and therapy in the home. Adult day services are at the hub of the program where many of the services are provided, in addition to affording valuable social contact. The goal of the program is to keep an elder at home and independent as long as it is safely possible. Generally, family is involved, as the program does not cover 24 hour a day care. When this level of care is needed, an individual is usually admitted to a nursing facility. In general, PACE is able to keep 75% of its participants at home (www.npaonline.org).

How PACE is financed

Dual Medicare and Medicaid funding is a special feature of PACE programs. Fees are based on a case mix basis, and are adjusted to account for the severity of illness and frailty of the PACE clientele. This integrated, capitated funding stream allows the program complete autonomy (and creativity) in how it uses dollars for the benefit of the participants. It releases the PACE from requirements to follow the usual guidelines of “covered services,” although a PACE must offer at least all the services offered by Medicare and Medicaid. With PACE, the problem of cost-shifting or substituting one service or setting for another to avoid payment is eliminated. PACE, by receiving a capitated fee from both Medicare and Medicaid, no longer bills either of these two entities. On the contrary, PACE now becomes the payer and is responsible for paying the bill no matter where the elder needs to go. In this way, it is only what is best for the participant that guides the team in their decision-making. Likewise, the PACE physician is paid a salary and thus is not motivated to cut visits short in order to see more patients or limit time spent in less reimbursed interactions. In essence, there are no more worries about RBRV's. The physician is paid to care for these individuals regardless of how long it takes or where the elder is located.

In Pennsylvania, LIFE programs often start with funding from Medicaid (Medical Assistance) only, and any services usually covered by Medicare

continued on page 7

Leading the Good “LIFE”

continued from page 6

are billed to Medicare by the individual providers on a fee-for-service basis. This model is known as “Pre-PACE.” The Pre-PACE is required to demonstrate the same fiscal responsibility with all health services, as though the program were fully capitated. Pre-PACE programs are required to convert to full capitation (PACE) within 2 years.

Types and roles of clinical providers and other health professionals

PACE utilizes an interdisciplinary team consisting of primary care, nursing, PT, OT, dietary, transportation, personal care workers and, most importantly, the PACE participant, to make spending decisions based on the participant’s goals. Each discipline does an independent evaluation of the participant’s care needs. A care plan is developed among the team, including frequency of day center attendance, and is reviewed every 6 months or sooner if needed. Other specialties, such as podiatry, optometry, cardiology, are

utilized when necessary by a referral process. Services such as massage therapy and acupuncture may also be used if they are provided by certified professionals. The team has full discretion over spending decisions and thus, for example, if a participant needs a ramp built for access to their home instead of needing to move, the team can authorize the funds. This flexibility is key to the mission and success of PACE. This flexibility has allowed PACE to deliver services in a cost-effective manner. One needs to remember that PACE is responsible for all the participant’s care needs, including acute and primary care. Studies which compare the cost of PACE to that of traditional nursing home care plus the cost of acute and primary care reveal that PACE saves money for both Medicare (usually at risk for acute and primary care) and Medicaid (usually at risk for long term care) (Bodenheimer, 1999).

One drawback to PACE is that one must give up their own doctor and utilize one of the PACE physicians. This is problematic for some who have a very close

relationship with their doctor. With this in mind, some PACE sites are experimenting with allowing the participant to stay with their primary care doctor upon entering PACE. One of the advantages of utilizing the PACE physician is that he or she is able to follow the PACE participant to any care setting the elder may need to be in such as the home, hospital or nursing facility. It is very difficult to get this level of service from many community physicians. Additionally, utilizing one physician eliminates many of the information gaps that are so problematic in long-term care (Bodenheimer, 1999). ■

References

- Bodenheimer, Thomas. 1999. Long Term Care for Frail Elderly People- The On Lok Model. *N Engl J Med*, 341:1324-132
- Gross, D.L., H. Temkin-Grener, S. Kunitz & D.B. Mukamel. 2004. The growing pains of integrated health care for the elderly: lessons from the expansion of PACE. *The Milbank Quarterly*, 82, 257-282.
- Proper, Cindy. Personal communication
www.npaonline.org
www.palife.org

Public Policy Committee Update

continued from page 5

Immunizing HCW against influenza is both a personal and patient safety priority. Health and Human Services (HHS) has established a HCW influenza immunization target of 60% for its Healthy People 2010 goal. This target is based on evidence showing a reduction in mortality among nursing home residents when staff immunizations reach this estimated level.

PMDA not only supports this goal, but believes all healthcare workers including physicians have a moral responsibility to their residents to get the flu shot. For more information and tools, please visit the HHS website at www.hhs.gov/ophsp/programs/initiatives/vacctoolkit/index.html or the CDC website at www.cdc.gov. Also, don’t forget to take advantage of National Influenza Immunization Week which is December 8-14, 2008.

Assisted Living Residences Draft Regulations

PMDA provided written comments to the Department of Public Welfare

in September on the draft regulations for Assisted Living. Our organization objected to the mandatory use of Automatic External Defibrillators in the LTC setting due to the unproven efficacy of this treatment in this setting. We advocated for a more liberal policy for completion of the physician medical evaluation that is required to allow residents to be admitted to Assisted Living Residences in a more timely fashion. PMDA also supports a more liberal policy for requesting exemption to the excluded medical conditions that are part of the regulations. These changes will allow for greater continuity of medical care that AL residents will receive.

The Public Policy Committee encourages participation by any members who would like to serve in this exciting and important area for our organization, and we welcome responses from our membership to the issues we have raised and continue to pursue. As always, please forward your questions and comments to Dr. Nace or Dr. Lawrence through the PMDA office by e-mail at pmda@pamedsoc.org. ■

Welcome New Members

PMDA welcomes the following new members to the Association:

Individual Members (Physicians)

Dorothy Y Fisher, MD
Larry J. Plundo, DO
Andrew B. Rosenzweig, MD
Frederick L. Teribury, Jr., MD
James E. Xanthopoulos, DO

Individual Members (NPs or PAs)

Cindy L. Wolf, CRNP

Individual Members (LTC—Industry Partner)

Cori Payton Axe
Donna Oswald

Affiliate Members

Behzad Doratotaj, MD ■



PMDA 1992 - 2007

15 Years of Excellence in Long-Term Care Medicine

777 East Park Drive
PO Box 8820
Harrisburg, PA 17105-8820

PSRT STD
U.S. POSTAGE
PAID
HARRISBURG, PA
PERMIT 922

Dr. Knoble honored at PMDA Symposium

Sefi R. Knoble, MD, FACP, was recognized at the 2008 Annual Symposium for her years of dedicated service to PMDA. A practicing geriatrician in Philadelphia, Dr. Knoble earned her medical degree at Albany Medical College in New York, and did her residency in Internal Medicine at Fairview University Medical Center.

Dr. Knoble has served as an active PMDA Board member, during which time she helped grow the Annual Symposium into the outstanding educational experience it is today. Her tenure as PMDA President in 2004-2005 was marked by an increase in membership and stature of our organization. She has published research on the effectiveness of home-based interventions for adults with severe disabilities and is a noted speaker at medical conferences. We are grateful that



PMDA President, Dr. Tom Lawrence, presents plaque to Dr. Sefi Knoble in recognition of her outstanding service and dedication to the organization as a past president, newsletter editor and board member.

Dr. Knoble has utilized her many talents to further the mission of PMDA. ■

Anyone interested in learning more about serving on the PA Attorney General's Advisory Board for Elder Abuse/Neglect, please email Ken Brubaker, jkbrubak@lancastergeneral.org. The attorney general's office would like to get more geriatricians on the Advisory Board. This is an excellent opportunity to help PA improve the care of our frail older adults, many of whom have no one to serve as their advocates.

PMDA 2009 Annual Symposium • Friday, October 16, 2009, The Hershey Lodge