



PMDA

Pennsylvania's Association for Long Term Care Medicine



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President's Message

Regulating Assisted Living

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



As of July 31, the Pennsylvania Department of Public Welfare (DPW) will officially announce assisted living regulations. The expected effective date of the final form regulation will be six months later on December 31. Even though a large number

of Assisted Living Residences (ALRs) have been providing a long term care alternative that combines housing and supportive services in the United States, there has been no definition of and were no regulations specific to these facilities in Pennsylvania.

Act 56 of the Pennsylvania General Assembly directed the DPW to develop regulations for ALRs in consultation with industry stakeholders, consumers and other interested parties to ensure accountability and a balance of availability between institutional and home-based and community-based, long term care for adults in need of this care. The DPW feels ALRs should be "designed to allow people to age in place, maintain their independence and exercise decision-making and personal choice."

The proposed regulations were developed to establish the minimum standards of licensure for ALRs that will assist impaired individuals' delay or prevent the need for nursing facility placement. The designers of the regulation wanted to protect consumers' health and safety, privacy and autonomy while balancing providers' concerns related to liability and individual choice.

Facilities that seek to operate as Assisted Living Residences or as dually licensed personal care homes and Assisted Living Residences will be affected by the regulation. The Office of Long Term Living (OLTL) surveyed 1,437 Personal Care Homes (PCHs) in the Commonwealth prior to submitting the final form version of the assisted living regulations. When facilities were asked if they would consider applying for licensure of their personal care facility as an Assisted Living Residence, 262 said they would apply, but more than half of the respondents (461) said they would not consider applying for licensure.

Some facility officials are concerned that they will no longer be able to use the term "assisted living" in any name or written material unless they obtain an ALR license.

Although the new ALR regulations are intended to create "clear differences between

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PMDA's Annual Symposium Promises to be Better Than Ever!

by Susan Denman, MD, CMD, FACP; susan_j_denman@uhc.com; (215) 902-9009

Mark your calendars! PMDA's 18th Annual Symposium is coming to the Hershey Lodge on Friday, October 15.

The theme for the morning session this year is End-of-Life-Care in the Long Term Care Environment. The program was developed by the Symposium Committee in conjunction with the Pennsylvania Hospice Network. The afternoon session will include regulatory updates and clinical topics pertinent to the LTC clinician, including the management of infections and diabetes in the nursing home setting.

Symposium Highlights:

- Identifying prognostic factors in advanced illnesses and improving communication skills with patients and families who are facing end-of-life decisions
- Integrating palliative care concepts into the LTC setting and improving the collaboration between hospice and nursing facility palliative care teams
- Discussing dementia as a terminal illness
- Reviewing the implications of F-Tag 441 regarding infection control and outbreak identification
- Understanding the role of the medical director during outbreaks of C. diff or Norovirus
- Managing Diabetes in the nursing home resident
- Clarifying common misunderstandings regarding regulatory requirements, "never events" and LTC clinical protocols
- Explaining the role of the medical director in the LTC survey process

- Taking a tour of the new and improved PMDA Website
- Visiting with exhibitors, attending the annual PMDA business meeting and networking with your colleagues over lunch

Our Distinguished Speakers:

- **Michael T. Baer, MD**, Medical Director, Bureau of Fee for Service, Office of Medical Assistance Programs, Pennsylvania Department of Welfare
- **Linda Chamberlain**, Supervisor, Pennsylvania Department of Health, Division of Nursing Care Facilities, Harrisburg
- **Dennis Gingrich, MD**, Professor, Family and Community Medicine, Penn State Milton S. Hershey Medical Center, Penn State College of Medicine, Hershey
- **Joan Harrold, MD**, Vice President and Medical Director, Hospice of Lancaster County, Lancaster
- **Barbara Hoffmann, MD, MBA, CMD**, Hershey, Pennsylvania
- **Karyn Leible, RN, MD, CMD**, AMDA's President-elect and Chief Clinical Officer, Pinon Management, Lakewood, Colorado
- **David A Nace, MD, PhD**, Assistant Professor of Medicine, University of Pittsburgh School of Medicine, University of Pittsburgh Institute on Aging, Chief, Medical Affairs, UPMC Senior Communities
- **Phenelle Segal, RN, CIC**, Infection Prevention Analyst, Pennsylvania Patient Safety Authority, Plymouth Meeting, Pennsylvania

- **Joan Teno, MD, MS**, Associate Director, Center for Gerontology & Health Care Research, Professor, Community Health and Medicine, Brown Medical School, Providence, Rhode Island
- **Deborah Way, MD, CMD**, Living Independently for Elders, School of Nursing, University of Pennsylvania, Philadelphia
- **Gordon J. Wood, MD**, Section of Palliative Care and Medical Ethics, Institute to Enhance Palliative Care, University of Pittsburgh

The PMDA Annual Symposium provides a perfect opportunity to learn about the latest clinical and regulatory updates, attend the annual business meeting over lunch and network with colleagues.

Attendees will qualify for 6.5 hours of CME, including 1.5 hours of patient safety/risk management education and 3.25 hours in management education for CMD recertification. Bring your family and enjoy the park as well!

The Hershey Lodge has made a block of rooms available to PMDA Symposium attendees and exhibitors. Make your reservation by calling (717) 533-3311 and identifying yourself as part of the PMDA group. The deadline is August 29, 2010. But don't wait—availability is limited.

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! ■

18TH PMDA ANNUAL SYMPOSIUM

OCTOBER 15, 2010 • J4105-11-Z

Register Online: www.pennstatehershey.org/web/ce/home/programs/pmda

Register online, by fax, or by mail. If you do not receive a confirmation from Penn State within two weeks, call 717-531-6483 to confirm. Late registrations are accepted only if space is available. Please provide both daytime and evening phone numbers so we can contact you should last-minute changes occur.

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The fees for this program are (check one):

	Early Registration (postmarked on or before 9/16/10)	Late Registration (postmarked after 9/16/10)
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Nonmember physician	<input type="checkbox"/> \$155/person	<input type="checkbox"/> \$170/person
Nonmember resident*, fellow*, or other health-care professional	<input type="checkbox"/> \$85/person	<input type="checkbox"/> \$100/person
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The Epidemic of Inappropriate Treatment of Asymptomatic Bacteriuria in Nursing Facilities

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

The April release of the Pennsylvania Patient Safety Authority's 2009 Annual Report defined new information about the epidemiology of infections in the nursing home setting.¹

Previous surveys that have examined the prevalence of infections in American nursing facilities consistently found that urinary tract infections (UTI) are the most common type of infection followed by respiratory infections.²

The data reported in the Pennsylvania Patient Safety Authority (PSA) report have shown an inverse pattern with regard to these two common types of infections; respiratory infections were found to be more common than UTIs. Of the more than 16,000 nursing home infections reported to the PSA only 18.2 percent were symptomatic UTIs.

The PSA reporting criteria for UTIs were modified from the McGeer criteria that have been used as a tool in infection surveillance for years. The number of UTIs that met the PSA criteria for symptomatic UTIs in 2009 proved to be far fewer than nursing facility providers anticipated. An informal survey of a group of PMDA members who serve as nursing facility medical directors indicated that of all residents in their nursing facilities who were treated with antibiotics for presumed UTI, only a minority (perhaps in the 20-25 percent range) met PSA criteria. Among the larger percentage of cases that do not meet criteria for symptomatic UTI, the leading explanation for the phenomenon is that many of these cases are actually asymptomatic bacteriuria.

Asymptomatic bacteriuria is a condition defined as isolation of a quantitatively significant count of bacteria from an appropriately collected specimen in the absence of symptoms that localize to the urinary tract, suggesting an active infection.³ The following facts about asymptomatic bacteriuria have been well established as evidence based in the medical literature:

- Asymptomatic bacteriuria is extremely common in the LTC setting, being found in up to 50 percent of nursing facility residents;
- It is often associated with pyuria, and the presence of pyuria is not considered indicative of infection;
- It is not a marker for future symptomatic infections;
- Treatment of asymptomatic bacteriuria does not prevent future infections and does not improve survival;
- Treatment is associated with increased adverse drug reactions and other negative effects such as *C. difficile* infection and emergence of resistant organisms;
- Treatment results in recurrence and reinfection with organisms demonstrating increasing antibiotic resistance;
- Direct and indirect costs of care are also driven up by the inappropriate treatment of asymptomatic bacteriuria.

Minimum criteria for starting antibiotics in nursing facility residents have been

proposed and include the presence of systemic signs of infection, such as fever or delirium, and the presence of signs or symptoms that localize to the urinary tract, such as dysuria, hematuria, or new urinary incontinence.⁴ Minor, non-specific, and non-localizing signs or symptoms should not be considered an indication to begin empiric treatment with antibiotics.

A common pitfall in the care of nursing home residents is to ascribe abnormal appearing urine—such as cloudy or malodorous urine—as a sign of a UTI. Another common mistake is to attribute non-specific and often subtle changes in residents with dementia, such as confusion, restlessness, or lethargy, in the absence of localizing signs or symptoms to a UTI.

The non-specific, sporadic, fluctuation in behavior seen among nursing home residents with dementia unrelated to any acute illness is a common phenomenon. Confusion over this issue often results in an incomplete nursing assessment being presented to physicians and the resulting clinical pressure to prescribe empiric antibiotics inappropriately.

There is no evidence-based literature that supports the practice of routinely obtaining urine cultures to evaluate residents with dementia who demonstrate changes in behavior or function without more specific signs of infection. One rational approach to assessing possible UTI in residents who are unable to give a history of symptoms involves withholding

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Pennsylvania Patient Safety Authority Update

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

The Healthcare-Associated Infection Advisory Panel (HAI) met with the Patient Safety Authority (PSA) on June 18 for a review and update of the LTC data collected since June 2009.

The PSA has developed and is preparing to pilot evidence based LTC practice assessment tools for facilities to use in identifying barriers to the implementation of best practices at the bedside. The seven categories removed “will” include hand hygiene, environmental infection control, outbreak control, prevention of urinary, respiratory, skin and soft tissue, and GI/resistant organism infections.

Future PSA goals for nursing homes will include the following activities:

1. Identify high and low performers through data analysis
2. Conduct on-site visits to identify best practices
3. Share best practices among facilities
4. Develop best practice tools based on facility visits
5. Implement an automated alert tracker system (for unusual trends) with best practice guidance for nursing homes
6. Continue developing educational programs based on data analysis and onsite reviews
7. Continue publishing advisory articles based on findings
8. Participate in ongoing and future HAI reduction/prevention collaborative
9. Continue assisting facilities with help desk inquires

Dan Haimowitz and I are members of the PSA/HAI Advisory Panel. If anyone has questions or concerns, please e-mail Dan (geridoc1@comcast.net) or me (jkbrubak@lancastergeneral.org). Also, much credit must be given to Phenelle Segal, a PMDA member and an Infection Control LTC consultant who is contracted by PSA to collect HAI information, analyze and develop an effective educational program to reduce HAIs in Pennsylvania nursing homes and hospitals. ■

AMDA Update

by Daniel Haimowitz, MD, FACP, CMD; geridoc1@comcast.net; (215) 943-2222

AMDA continues to be responsive to members’ needs by addressing their most pressing concerns. At the top of this list continues to be the problem with the Drug Enforcement Agency (DEA) not considering the nurse as the agent of the physician in the nursing home. AMDA has presented testimony at a Senate Special Committee on Aging Listening Session about this issue, has met with OmniCare pharmacy and has partnered with other organizations such as the American Medical Association (AMA) and the American Geriatrics Society (AGS).

Recently a Federal Register notice was issued by the DEA entitled “Dispensing of Controlled Substances to Residents at Long Term Care Facilities.” According to the DEA, the solution to the prescription procedure problems long term care facilities are facing is for facilities to obtain licensing from their state Boards of Pharmacy.

This, unfortunately, brings up other issues of paperwork, monitoring and oversight. Comments about the Federal Register notice to the DEA are due by August 30, 2010. The entire notice can be viewed at <http://edocket.access.gpo.gov/2010/pdf/2010-15757.pdf>.

The AMDA Board has been following up on several issues that arose during this year’s Annual Symposium. A hot topic was the passage at the House of Delegates of the PMDA resolution regarding PhRMA. At this point, the Board is awaiting feedback from the AMDA Ethics Committee prior to any further action.

An interesting comment asked during a general session regarded the role of women physicians in long term care. Several articles about this topic are in the works, which may be timed for publication to coincide with the inauguration of AMDA’s next president, Karyn Leible.

Speaking of presidents, current AMDA president Paul Katz has accepted a new position in Toronto. This will not affect any of his AMDA duties, but may give him an interesting perspective on such things as international membership!

Committee work remains vital to the mission of the organization. AMDA members were asked to fill out surveys regarding nursing facility services CPT codes 99315 and 99316. Expect to see a somewhat lengthy membership survey soon. Please fill it out, as the information is vital to AMDA to be able to truly represent and advocate for our members (and, for full disclosure, please note that I am chairman of the Membership Committee).

Public Policy has also been involved with a paper regarding the supervision and collaboration between attending physicians and advanced practices nurses. The plan, after input from the Board and

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President's Message

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PCHs and ALRs relating to the kinds of service offered to the residents, the physical site requirements for individual living units and the conditions for licensure," many interested stakeholders are concerned that the regulations do not clearly distinguish between PCHs and ALRs.

The DPW has attempted to clarify the distinction between the two types of facilities. Many people felt that the statutory language in Act 56, which allows PCHs to "assist residents in obtaining health care services," and the new regulation's statement that ALRs be "required to provide supplemental health care services" are indistinct. According to the DPW, a PCH does not have to assist a resident in securing health care but an ALR does.

The ALR is distinguished from the PCH in that it has the opportunity to seek Medicaid funding, while a PCH cannot. The PCH regulation states "Commonwealth law prohibits a PCH from housing and serving residents whose care needs would qualify them for nursing facility care."

In the final regulations DPW clarified that any adult who requires the services of a licensed long term care nursing facility may reside in the ALR, "if the needs of the potential resident can be met by the ALR, the appropriate supplemental health care services are provided to the resident and the design, construction, staffing and operation of the ALR allow for a safe emergency evacuation."

Furthermore, DPW may grant a waiver that would allow some services traditionally offered in a skilled nursing facility to be offered by the ALR so its residents may "age in place." Included in the 12 conditions are ventilator dependency, stage III and IV decubiti, continuous intravenous fluids, and nasogastric tubes.

The assisted living regulations may limit the number of current and newly planned PCHs applying for the ALR licensure because of increased costs, paperwork (such as a required assessments, support plans and resident handbook) and structural requirements. New costs that will be incurred by facilities that apply for the ALR licensure include the additional yearly fee required for licensure (decreased to \$300/home, with an additional \$75/bed plus \$150 for special care designation), the cost of increased staff (mandatory RN and dietitian) and the increased cost of building requirements of new facility structures.

Existing facilities may not be able to operate as assisted living facilities because they do not meet the new regulations structural (kitchen access and a bathroom in each living unit) or size requirements (160 square feet/single, 210 square feet/double). However, the survey completed by the DPW estimated that only 9 percent of facilities surveyed currently have living units with bathrooms that will not meet the size requirements.

Examples of the increased paperwork required in the ALR initial assessment of the residents includes a preliminary support plan, final support plan and certification that the needs of a potential resident can be met by the ALR's provided services. The initial assessment and preliminary support plan needs to be completed within 30 days prior to admission unless the resident is being admitted from the hospital, has nowhere else to live or is in an abusive situation. If he or she fits into those areas, it can be completed up to 15 days after admission.

The final support plan should be completed by 30 days following admission. The paperwork needs to be completed by an administrator, RN or in conjunction with an RN, by an LPN.

The definition of a "living unit" differs between PCH and ALR. PCH can have up to four residents living in one bedroom. In an ALR, each resident must have

his/her own "living unit." "Under no circumstances may a resident be required to share a living unit in an ALR," but a resident may do so if they consent in writing. A living unit in an ALR must contain a "... private bathroom, living and bedroom space, kitchen capacity (which may mean electrical outlets to have small appliances such as a microwave and refrigerator), closets and adequate space for storage and a door with a lock (except where a lock or appliances in a unit under special care designation would pose a risk or be unsafe)." The regulations were crafted so that the resident would have a private place to relax, entertain and prepare meals if they so choose.

The ALR regulations also have further provisions relating to special care units that serve individuals with Alzheimer's disease, dementia and acquired brain injury—the only place where specialized care can be provided for these conditions. "The distinction between ALRs and PCHs is that ALRs are a long term care alternative that allows individuals to age in place, maintain independence and exercise decision-making and personal choice."

PCHs are facilities that have residents "who require assistance or supervision with tasks of daily living, such as dressing, bathing, diet, and financial management." It is the responsibilities of PCHs to assess residents on an ongoing basis. And if any resident is in need of a higher level of care, it is up to PCHs to develop a timely plan for placement.

Some other concerns expressed about the new regulations include the fact that not enough training is required for administrators and that an expedited appeals process was not available for discharge or transfer. Praise was expressed for the ALR regulations' inclusion of resident rights.

For more information on ALR regulations, visit www.irrc.state.pa.us/Regulations/RegInfo.cfm?IRRCNo=2712. ■

The Epidemic of Inappropriate Treatment of Asymptomatic Bacteriuria in Nursing Facilities

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empiric antibiotic therapy and monitoring the resident over the course of 24 to 48 hours for emerging specific signs of infection while awaiting urine culture results. If no specific or localizing signs develop, or if the resident's non-specific signs resolve or improve, no treatment is indicated.

In light of the growing problem of antibiotic-resistant organisms in the LTC

setting, curtailing the inappropriate use of antibiotics should be a primary goal of the facility's infection control program. As Dr. Paul Drinka of the University of Wisconsin has written, "the use of popular antibiotics in nursing homes can be compared to a soldier with a limited number of bullets being overrun by the enemy. Don't waste your time shooting at shadows."⁴ The nursing facility medical director can play a pivotal role as champion in educating the nursing and medical staff in this area and in promoting the appropriate use of antibiotics. ■

AMDA Update

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other organizations, is to publish this as a journal article, which would allow for editorials and further comments from the broader community. The CMD board has reconfirmed its policy about providing CMD credits for small groups at the state level.

There have been a few organizational changes within AMDA. Kris Holtman, who was responsible for State Chapters, has retired. She will be missed. With the current economic situation and pharmaceutical and private research dollars being very tight, the AMDA Foundation will be focusing on the programs that mean the most to the AMDA members—the Futures program, the Wall of Caring, the Pfizer and Evercare awards, and another edition of the very successful Canine Calendar

(in the initial calendar, my own beloved pooch was "Mr. July 2011").

State chapters can be a driving force for AMDA, and all PMDA members are strongly encouraged to become AMDA members. Involvement in AMDA committee work is also recommended (but please be aware that the president of AMDA needs to make the assignments for members of all AMDA committees).

Finally, and somewhat selfishly as chair of the AMDA House of Delegates, don't forget that it's always a good time to be working on resolutions for the House of Delegates! If there's an issue that bothers you, or you think needs more attention at the national level, write it down and start to think about how it could be presented as a resolution. I would be happy to help you with its development, as would the AMDA staff. ■

Welcome New Members

PMDA welcomes the following new member to the Association:

Individual Members (Physicians)

Olga Schweiker, MD

Michael Yao, MD

Joel Nystrom, MD

Domenick Brasile, DO

Michael Weed, MD

Affiliate Members

Ann Marie Sommer, CRNP

Christopher Vargo, CRNP

Joan Weaver, CRNP

Victoria Edelman, CRNP

Debora Brooks-Wilson, CRNP

Randi Johnson, CRNP

Melynda Dohl, CRNP

Jennifer Ceglia, CRNP

Lisa Hengen, CRNP

Nadjie Joseph, CRNP

Terry Ballentine, CRNP

Sarah Beam, CRNP

LTC Industry Partner Member

Timothy Molnar

CLASSIFIED

Genesis Physician Services has an opportunity for a **part-time Medical Director** at Rose View Center, a 123 bed sub-acute & long-term care facility, located in Williamsport, PA. Experience as a Medical Director in a long-term care facility and Gerontology certification preferred, but not required. GPS offers competitive stipend commensurate with experience plus generous annual bonus program. For more information, contact Rena Mack, Recruitment Manager, at 1-800-597-7601 or Rena.Mack@genesishcc.com.



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