PMDA

Pennsylvania's Association for Long Term Care Medicine

Summer 2014



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Official Pennsylvania Chapter of
American Medical Directors Association

President's Message

Quality and Professionalism

by Leon Kraybill, MD, CMD
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Quality in long-term care is a multifaceted endeavor that requires the collaboration of the entire interdisciplinary team. Long-term care practitioners follow practical and concrete measures to encourage quality service. However, these tangible efforts can only come to full fruition when professionalism is understood, prioritized, and demonstrated throughout the entire long-term care facility.

Professionalism is more than the technical ability to make a diagnosis, prescribe a medication, or create a treatment plan. It requires an understanding of ourselves, our tasks, and our role in the organization. It calls for an understanding of our individual gifts and limitations. It thrives in an atmosphere of vision and inspiration, compassionate feedback, and gentle accountability. Professionalism needs a balance between the big picture and the immediate needs of the moment. It grows only with repeated education, mentoring, and encouragement and requires personal ownership, concern for the larger good, and willingness to go the second mile.

Professionalism is essential for the leaders of a long-term care facility, but can and should be developed in everyone. It is expected from the medical director, attending physician, administrator and DON, but must be cultivated in all employees. I am often inspired by the professionalism that I see in an aide or housekeeping staff member as they complete their daily "mundane" tasks with pride and joy and compassion.

Here are some ways to cultivate professionalism in your organization:

1. **Make professionalism a part of your organizational mission and hiring standards**. Leaders must be able to articulate and exemplify a culture of professionalism. Hire new staff on the basis of professionalism and incorporate it into annual training efforts. Annual reviews should assess and give feedback in this area. Distribute the AMDA LTC physician core competencies to your doctors and mentor their growth.
2. **Empower facility champions**. One or several individuals should be identified to evaluate, lead, and teach professionalism within the long term care facility. They are tasked with the ongoing responsibility of monitoring and cultivating professionalism.
3. **Encourage lifelong learning**. Get your AMDA CMD, attend a leadership or geriatric care course, reeducate yourself on a geriatric topic and share it with your colleagues. Encourage additional training or leadership in your coworkers, give a presentation at a family support group, or explain to your nurse why you chose a specific treatment.

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Inside This Issue

PMDA Public Policy Update: Crisis Averted with Act 122!

by Zachary Simpson, MD, CMD and David A. Nace, MD, MPH, CMD, Co-Chairs, PMDA Public Policy Committee
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In December 2013, Governor Corbett signed Senate Bill 1042 into legislation as Act 122 of 2013. Act 122 updated the Clinical Lab Act of 1951. The intent of the updates was to ensure that out-of-state laboratory companies follow similar business practices as in-state companies, and to prevent non-competitive business practices.

Unfortunately, ***as originally interpreted***, as of September 15, 2014, Act 122 would also have prevented laboratory companies from providing phlebotomy services to healthcare facilities, including nursing facilities. Laboratories began sending notices to nursing homes in June 2014, notifying them of the intent to discontinue provision of phlebotomy services.

PMDA notified the PA Bureau of Laboratories (PA BOL) that implementation of Act 122, in September as planned, would jeopardize the safe and timely care of the Commonwealth's 81,000 nursing home residents. In particular, it would have resulted in increased transfers of nursing home residents to acute care facilities and outside laboratories in order to provide medically necessary/critical laboratory services. Transfer of nursing residents for phlebotomy services would have inconvenienced residents and resulted in increased healthcare costs, reduced quality of care, overburdened acute care facilities, and increased unnecessary hospital admissions.

Working with a broad coalition of stakeholders, including the Hospital Association of Pennsylvania (HAP), Leading Age PA, PA Association of County Affiliated Homes (PACAH), PA Health Care Association (PHCA), Pennsylvania Medical Society (PAMED), Pennsylvania Association of Pathologists (PAP), and the UPMC Health System, PMDA was able to assist in the PA BOL's revision of the interpretation of Act 122. **We are very relieved to report that nursing facilities may continue to contract with laboratories for phlebotomy services**. The PA BOL has also clarified that **Act 122 will not apply to other long-term care facilities such as personal care or assisted living facilities** (as they are not considered healthcare facilities under PA Healthcare Facility Act). **In addition to the other stakeholder organizations for their support, PMDA wishes to thank the PA BOL for their understanding of the significance of our concerns and willingness to work towards an appropriate solution that ensures timely access to important clinical care services**.

Both sets of clarifications from the PA Department of Health regarding Act 122 are posted on the PMDA website. ■

President's Message

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4. **Inspire others with your passion**. Talk about the special skills and rewards in the care of older individuals, explain why you enjoy doing what you do, be proud of personal and facility accomplishments, articulate a mission of improved care, and recognize and praise excellence in others.

5. **Establish an atmosphere of inquiry** (rather than blame, criticism, or scapegoating). Expect opportunities for improvement and change. Use them as moments to identify system problems, chances to teach, and examples of how to prevent future harm.

6. **Encourage self reflection and improvement** - Start by acknowledging personal errors and room for improvement, praise self assessment, seek improvement rather than blame, and welcome suggestions.

7. **Prioritize communication skills**. Talk before you blame, ask before you conclude, inquire if the message received is what you intended, repeat important messages in several different ways, and communicate regularly with residents and families.

8. **Emphasize the importance of the team**. Everyone should leave their egos at home and recognize that they are now part of a team that will work for the common good of long-term care residents. Authority figures who demonstrate selfless servant leadership are powerful role models and inspire others to similar behavior.

Here are some sample questions to help start the discussion about professionalism and quality in your long-term care facility:

- How do we constructively reflect on individual performance to encourage professionalism and growth?
- How do we review organizational culture and systems to provide the best care?
- How do we invite input from everyone in the facility?
- How do we teach ourselves to improve our skills and knowledge?
- Are we using our resources to fullest advantage?
- How can we improve communication with ourselves, as well as our residents, families, and peers?

An institutional culture that encourages professionalism will inevitably result in improved quality of care. As leaders, we must understand and emulate this characteristic. As we inspire others to convey professionalism, we improve their lives and accomplish the mission of our facilities. ■

New POLST Train-the-Trainer Curriculum

by Marian Kemp, RN, BSBA and Judith S. Black, MD, MHA
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The use of POLST continues to expand in Pennsylvania and currently there is some use in at least 70 percent of Pennsylvania's counties. This has prompted some physicians and organizations to consider if there is a need to increase training offered on the POLST process. Consequently, the Pennsylvania POLST Consortium of the Coalition for Quality at the End of Life (CQEL) has developed a POLST Train-the-Trainer curriculum.

The focus of the course is the development of skills needed to facilitate the discussion of goals of care for individuals with advanced illness or serious health conditions, are medically frail, or those of advanced age and wishing to define their preferences for care.

The course consists of a 2.5 hour online prerequisite and upon completion, enrollees are eligible to participate in the 5.5 hour in-person course. This program has been approval for CME credits from the Center for Continuing Education in the Health Sciences at the University of Pittsburgh. Nurses can also use these CME credits for licensing renewal. Marywood University has approved the awarding of CEUs for Social Workers, Marriage & Family Therapists and Professional Counselors.

If you are interested in presenting the program in your organization or region, **all required materials will be provided at no cost**. For additional information, contact the POLST Coordinator at PAPOLST@verizon.net. ■

Bylaws Changes Proposed for Vote at October Annual Membership Meeting

by David E. Fuchs, MD, CMD
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At the May PMDA Board of Directors meeting, the Board approved the creation of a new seat on the Board to increase the number of Licensed Advanced Practitioners on the Board from one to two. The number of at large physicians on the Board (6) will not change. The Board felt that with the increasing number of Nurse Practitioners in PMDA's membership, and with the increasing role that Licensed Advanced Practitioners play in delivering long term care, a second seat on the Board is appropriate.

The proposed new wording for **Article VI, Section 2**, would be as follows, with changes in **bold** and the deleted wording in {brackets:}

> The Board of Directors shall consist of six (6) at large physician members and the Immediate Past President, the President, the President-Elect and the Secretary and Treasurer. {One} **Two** additional {position is} **positions are** reserved for a non-physician, a licensed advanced practitioner (nurse practitioner, physician assistant or clinical nurse specialist.)

Additionally, AMDA has changed their name this year to be more inclusive of all facets of the long term care continuum: "AMDA, The Society for Post-Acute and Long-Term Care Medicine." Given our intimate relationship with our national partner, the PMDA Board proposes that PMDA, Pennsylvania's Association for Long-Term Care Medicine, be renamed "PMDA, The Pennsylvania Society for Post-Acute and Long-Term Care Medicine."

Therefore, a second proposed bylaws change will be voted upon at the October Annual Business Meeting as follows, with new wording in **bold** and deleted wording in {brackets:}

Article I

Section 1. Name: This Association shall be known as the **"The Pennsylvania Society for Post-Acute and Long-Term Care Medicine,"** {Pennsylvania's Association for Long-Term Care Medicine} hereinafter referred to as PMDA.

Comments and questions regarding these proposed changes are welcomed. ■

Don't Forget to Register for the 2014 Annual Symposium!

by John Mast, MD, CMD, Co-Chair, PMDA Annual Symposium Committee
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Register today at http://www.pamda.org

The 2014 Annual Symposium will be held this Halloween at Hershey, from Friday, October 31 through Saturday, November 1. To kick off the weekend, join us Thursday evening for a new networking reception at 6:30pm; drinks and light refreshments will be provided. Friday will mainly consist of clinically relevant presentations and Saturday's program will provide attendees the knowledge base necessary to be an accountable care organization survivor.

Have research you'd like to share? Don't forget to submit your abstract for consideration for the popular poster display! Posters may be on any subject related to the long term care continuum including clinical care, medical direction, quality improvement or transitions of care but are not limited to these categories. We encourage posters that showcase programs that have improved quality of care or display innovative forms used in nursing facilities. Encore presentations of posters displayed at other meetings are allowed. Abstracts consisting of no more than 500 words summarizing the poster should be submitted on the PMDA website (http://www.pamda.org/) **no later than 5:00pm on September 12, 2014.**

2014 Annual Symposium presentation highlights include:

- Dementia, decision-making capacity, and the 302 process
- Infectious disease
- Hypercalcemia
- Level of care determination
- Diabetes care for the elderly
- Governor's Commission update
- CMS update
- New nursing facility quality measures and patient satisfaction
- How providers succeed in the accountable care environment
- Lancaster County ACO program success story
- Key elements of a successful home visit
- Bundled care and the skilled nursing facility

New this year: Ask-the-Expert Roundtable Discussions! Explore current hot topics in LTC through case studies and problem-based discussions. Scheduled Ask-the-Expert discussion topics include antipsychotics, interdisciplinary teams, PACE/LIFE, personal care/assisted living, Medicaid managed LTC services, advanced practice collaborations, ACOs and bundled care, POLST, teaching in residency programs, and dealing with difficult attendings. Join your colleagues for lively and engaging interaction!

We hope to see you at Hershey for Halloween! Be sure to share this symposium update with colleagues and administrators in your hospital and long-term care setting—the sessions will be instructive to all as we prepare for the changing healthcare environment. ■

We Honor Veterans

By Sarah Noorbaksh, MD, CMD
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It is said that we learn something new every day. I, like most long-term care or hospice professionals, was not aware that one in four of the people who die in the United States each year are veterans! I spoke with a colleague, Hospice Social Worker Fred Anderson, about the ***We Honor Vets*** program he spearheads at our agency and how it can support the efforts of long-term care providers in accessing services for the veterans for whom they care. He explained that the program began as a partnership between the NHPCO and the VA when they recognized that many veterans were dying in the community and not on VA campuses. The question then became how to improve end-of-life care for veterans, and they came up with the We Honor Vets campaign with the goal of creating a system to educate community hospice providers. The program is now beginning to branch out to other services like nursing homes, funeral homes, and other places that may come into contact with veterans and older adults. He recommends that professionals begin by going to www.wehonorvets.org to familiarize themselves with the basics of the program.

I asked Mr. Anderson to explain what it takes for a hospice, for example, to become a ***We Honor Vets Partner***. For hospice providers, there are four levels to complete after signing a commitment letter:

- Level 1: Provide education to staff and volunteers and develop a system to identify veterans
- Level 2: Build organizational capacity to provide quality care to veterans
- Level 3: Develop and strengthen relationships with VA medical centers in the area and with veterans organizations, and
- Level 4: Increase access and improve quality of care for veterans in the community.

I posed the question of how We Honor Vets has tangibly benefitted veterans as opposed to a time before it was in place. Mr. Anderson explained that as we started as a campaign partner, one area of focus for our organization was that of "Honor and Recognition." The website provides templates for printing certificates, and we have given certificates at the bedside and conducted pinning ceremonies around the holidays. Our organization felt that this is particularly helpful for our Vietnam veterans, who often reflect that their homecoming was very difficult, with veterans asked to not wear their uniforms upon homecoming and being in spit on, as one veteran recalled. We often talk about the differences in the experience of the WWII culture vs. the Vietnam era culture, and now the Afghanistan and Iraq war cultures; we must tailor end-of-life spiritual and psychological support to the particular culturally-unique aspects of each of these wars.

Our organization also helps with benefits, which help the veteran and the provider maximize assistance available. The VA healthcare benefit is excellent in that it provides payments for hospital care, medications, home health care, and hospice care. So when we have a patient that comes to us with no insurance, the first question we ask is if that patient is a veteran. There may be a form of payment the veteran can access. When we meet with patients that don't have benefits but acknowledge they are veterans, we are often able to get them "service connected," in some cases to a hospice benefit with access to the inpatient unit. A local example is the Lebanon VA facility, which has also provided for payment to a contracted nursing facility. We have been able to take patients who are fearful of going to a nursing home due to costs, have them approved for healthcare, and in turn approved for the hospice benefit, which then allowed coverage for a VA-supported stay at a contracted nursing facility. The community hospice remains the hospice provider at the facility. There are also a few pension-type benefits, including aide and attendants, and homebound care. This may help the veteran or spouse with monthly payments for extra help in the home or assisted living.

Since the We Honor Vets campaign started, an outline of Best Practices for Partners in the program has been published. One such practice is the collection of history. Often the most traumatic events and memories of war, conflict, or trauma come out at end of life, and it is helpful to us to learn from the VA what these experiences might be. The Vet to Vet program is another best practice. Often the veteran will share what they won't admit to anyone else, and if shared with us, social workers and spiritual support can help some veterans with difficulty seeking forgiveness at end of life. Another best practice is belonging to a Hospice-VA partnership in order to access care at the VA more efficiently. And finally, there is patient and family evaluation survey data that may be collected by CMS for quality assessment. ■

Welcome New Members

PMDA welcomes the following new members to the Association:
(Effective April 28, 2014 - July 17, 2014)

Patricia S. Bauwin, RN
Amy M. Corcoran, MD
Ira M. Thal, MD

PMDA Regional Meeting Update

by Daniel Haimowitz, MD, CMD, FACP
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PMDA continues to host twice-yearly statewide regional meetings. The most recent meeting was held via teleconference on May 30 2014 at six different locations, including Plymouth Meeting, Lancaster, Williamsport, Erie, Allentown, and McCandless. Featuring guest speaker Barbara Resnick, PhD, RN, CRNP, FAAN, FAANP, the meeting theme was "Helping Your Facility Prevent Avoidable Falls: Your Role as Medical Director in Falls Prevention." More than 90 Pennsylvania healthcare professionals registered to attend the presentation. Not only was there value from the education, but CMD, CME, and NHA credits were offered as well.

Prior to the presentation, PMDA President Leon Kraybill, MD discussed many of the advantages of PMDA membership, such as collegiality, education, a statewide LTC voice, and public policy updates. He stressed that PMDA membership includes more than medical directors and physicians. Dr. Kraybill also spoke about the upcoming Annual Symposium, the new poster presentation at the Symposium, the opportunity to nominate a PMDA Medical Director of the Year, PMDA committees, and the medical director listserve.

The timely presentation engendered lively discussion at the regional sites. One of Dr. Resnick's points, a "Myth Buster," was that there are no available studies demonstrating the utility of performing regular neurochecks in LTC settings following a fall, and there is no regulatory requirement to do so. She recommended that medical directors take the lead and advise their facilities to "prevent this waste of time." A follow-up discussion on the PMDA listserve asked for input from fellow medical directors, since while there is no evidence that neuro checks remain a standard of care. Included in this request was a sample facility neurological assessment record. The goal of the listserve was solicitation of advice "as we all strive to work smarter not harder."

The facilitators at each site were thanked for their help in arranging the webinar, and also for their ongoing participation on the Regional Meeting Committee. Volunteers from each region are welcome to join the committee. There is a particular need for assistance of members from the Erie area. For those who were unable to attend, a copy of the slides is available on the PMDA website at www.pmda.org under PMDA Regional Meetings.

The Southeast region continues to have local meetings. The next one is scheduled for September 18. The next statewide regional meeting will be held on November 19, with the topic of Pain Management in LTC. As information becomes available, it will be relayed via email announcements and posted on the PMDA website. Please mark your calendars, and encourage your colleagues to attend. ■

PAMED Speciality Leadership Cabinet Update

by Leon Kraybill, MD, CMD
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I attended the PAMED Specialty Leadership Cabinet meetings on February 4 and May 20. Many of the discussed issues are not specifically applicable to geriatrics but apply to physicians and our medicolegal environment.

Discussion highlights at each meeting include:

February 4, 2014

- Healthy PA – The Cabinet reviewed components of the proposed Corbett plan.
- Physician Apology – Legislation was signed in October 2013 preventing most physician apologies from being used against them in a medical liability suit.
- CRNP Independent Practice – PAMED opposes this concept.
- Physician Assistant Countersignatures – The necessity of a countersignature is 100% during first 12 months, but relaxed thereafter.

May 20, 2014

- Opioid Prescribing Guidelines - A PAMED workgroup collaborated with the state to release a four-page set of guidelines recognizing the appropriate use of opioids, but only inappropriate settings, and after discussion of risks and benefits. The workgroup recommended that the use of the guidelines be voluntary and not mandatory. The guidelines do not specifically address opioid use in LTC, nor the current prescription fiasco. They can be accessed at http://www.pamedsoc.org/opioidguidelines.
- Maintenance of Certification Difficulties - Many physicians feel that the current certification process is not working well and has little evidence to show improved physician care. The process is expensive, time-consuming, anxiety-raising, and risks loss of privileges. No formal SLC recommendations were made at the meeting.
- Controlled Substance Database – This legislation will likely be enacted.
- Primary Health Care Loan Repayment Program – This program would help medical students with loan repayment in exchange for commitment to serve in a medically-underserved area.
- Corbett Healthy Pennsylvania Program – The plan includes proposed expanded access for 500,000 DPW on insured individuals and expected to be approved by CMS.

PAMED Lifeguard Program – PAMED offers an assessment and mentoring program for impaired physicians or physicians in transition. Gather more information by visiting www.LifeGuardProgram.com or calling 717–909–2590. ■

Register Today!

2014 PMDA Annual Education Symposium

Friday, October 31st - Saturday, November 1st

The Hershey Lodge
325 University Drive
Hershey, PA 17033

Visit **www.pamda.org** for registration and exhibition information.

We hope to see you there!

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