PMDA

The Pennsylvania Society for Post-Acute and Long-Term Care Medicine

Summer 2015

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Official Pennsylvania Chapter of
AMDA: The Society for Post-Acute and Long-Term Care Medicine

President's Message

ACP: A Focal Point of Resident Care

by Leon Kraybill, MD, CMD
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A comprehensive **advanced care planning (ACP)** discussion is a culminating moment that demonstrates the best of quality focus in the long-term care setting. A stellar ACP discussion requires numerous elements, empowers resident engagement, builds resident trust, and sets the tone for the entire admission.

There is a growing chorus of voices throughout the country recognizing the importance of ACP discussions. Columnists are writing about ACP on an almost daily basis. CMS is proposing to reimburse providers for this discussion. Insurers are incenting providers. Physicians and nurse practitioners speak passionately. Families and residents are requesting it**.** Hospital systems are giving significant institutional support to ACP documentation. And perhaps, most importantly, families and residents are requesting it. Individuals and families are typically grateful for these honest discussions, usually have fairly clear ideas about their goals, and are eager to have their wishes honored.

Ideal advanced care planning requires all of the following components: provider understanding of the resident's medical condition and prognosis, resident understanding of their health status, a discussion with the resident about his or her goals for future care, honest communication about feasible treatments, translation of healthcare goals into medical orders, and appropriate documentation of these choices.

Standardizing and championing the ACP process in your facility is a relatively easy way to improve quality, and make your facility stand out in the community. A smooth-running program requires the following components:

- A facility champion who articulates the need, inspires the staff, and guides the process
- Facility policy and procedure that outlines a clear method of introducing, discussing, and documenting ACP
- An expectation that discussion of ACP will be offered to and documented for all residents in the facility

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Inside This Issue

TAKE ADVANTAGE OF PMDA MEMBERSHIP

By providing advocacy, education, and professional development services for medical directors, physicians, and other healthcare team members, PMDA is the premiere professional organization committed to the continuous improvement of quality care for Pennsylvanians across the long-term care continuum. PMDA advances its mission by outreach and collaboration with other groups involved in long-term care. Founded in 1992, PMDA is also one of the oldest and largest State Affiliate Chapters of the AMDA: The Society for Post-Acute and Long-Term Care Medicine.

MEDICAL DIRECTORS FORUM

PMDA's medical director members serving in long-term care facilities across the state have access to a **secure email blog** allowing medical directors to post questions to each other regarding a wide range of pertinent post-acute and long-term care issues. **More than 150 physicians use this especially valuable tool** to instantly engage their colleagues for insight into and background resources for any professional questions they may have. The responses are usually quick, thorough, and on point; it is **like having a panel of experts to consult at literally just a mouse click away.**

PUBLIC POLICY

PMDA is one of the few AMDA state chapters that have a functioning and **very active Public Policy Committee** that works diligently to fight for medical directors' positions on a large variety of issues. For example, we were instrumental in working with the Commonwealth to streamline the recent infection control regulations. PMDA has also been able to work as part of a **coalition of long-term care providers** on a wide range of issues that affect the daily practices of all PA post-acute and long-term care practitioners.

REGIONAL MEETINGS

Twice a year, PMDA hosts regional meetings that are **simultaneously broadcast to multiple satellite venues across the state.** Each meeting addresses important issues in the practice of long-term care medicine, uses an informal "iron sharpens iron" approach to peer assisted professional growth, and provides a sounding board for disseminating innovative care in both the clinical and administrative realm.

ANNUAL SYMPOSIUM

Each Fall, PMDA's Education Committee plans and hosts an **outstanding educational program featuring distinguished faculty presenting cutting edge topic reviews of long term care medicine.** The Symposium has consistently grown in attendance and remains our most popular forum for networking. Members receive a discounted registration rate.

OTHER RESOURCES/PUBLICATIONS

PMDA members will enjoy a **newly-redesigned website** that is compatible with all smart phones and tablet devices. Watch your inbox for more information! Also, don't miss the latest issue of ***PMDA News*, provided to members three times per year.** This newsletter features Annual Symposium updates, legal advice, and informational articles. PMDA membership guarantees a complimentary subscription to *PMDA News*.

JOIN/RENEW TODAY AT WWW.PMDA.ORG!

President's Message

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- Honoring of a resident's ACP wishes during all acute changes or permanent decline
- Facility charts with a dedicated and consistent location to document ACP wishes
- Medical orders that are placed on the charts of residents who elect to limit future interventions (i.e. DNR, no hospitalization, no feeding tubes). POLST is a tried-and-proven method for this. And,
- A process to ensure that documentation of a resident's ACP wishes will accompany them to outside specialists, the emergency room, or a hospital.

Different members of the interdisciplinary team should be involved in accomplishing ACP. The admissions team should quickly acquire prior ACP documents and make them accessible. They can also introduce concepts of code status and POLST. Social work can introduce and facilitate discussion about goals of care. Nursing can use ACP choices to guide treatment choices and alert the provider to previously established goals. Providers are often in the best position to discuss medical conditions and prognosis, and finalize medical care orders. The resident's choices for care will be fully honored only when the entire team uses the ACP wishes as a framework for ongoing decisions.

CMS has recently recommended provider reimbursement for ACP discussions, starting in 2016. This would be a CPT code, separately payable, with designated RVUs. It appears that it could be billed in addition to E/M services. More details are available at: http://federalregister.gov/a/2015-16875.

Advanced care planning is a starting and ending point for quality care in your facility. Initiation or expansion of these efforts can reap immediate benefits in your facility. Discuss it with your providers. Bend the ear of your administrator. Inspire your DON. Lead your colleagues. Explain to your staff. And always, always consider it with your residents. ■

The 2015 Annual Symposium: What to Expect This Year

By Brian B. Kimmel, DO, CMD, and Firas Saidi, MD, CMD
Symposium Co-Chairs
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We listened to our members and you got your wish. This year's **23rd Annual PMDA Symposium** will not fall on Halloween weekend. Plan your schedules to attend a quality educational conference event **October 16 and 17 (Friday and Saturday).** This year, in keeping with the "New World Order", topics will cover a wide variety sure to interest the diverse audience that we came to expect at PMDA. **Categories will run the gamut of medical direction, clinical programs, and government updates, as well as exposure to the ICD-10.** Members of the interdisciplinary team will find multiple selections during the two day program to meet your needs.

Friday the 16th will start with a case discussion on "Change in Condition." This will be consistent with PMDA concerns regarding post-acute care in long-term centers. Next there will be lectures on two subjects: COPD CHF, with case studies and a Q&A session to follow. After that, we switch gears and enjoy an AMDA update on national trends with an opportunity to find out what's new and coming up at the national stage.

After lunch we will address QAPI and how it can work for you. Midafternoon, the hot item is ICD-10 codes and billing issues. This will surely be a talk to plan to attend. We will finish the day with our annual PMDA public policy update. This is always a dynamic hour. No matter what you do in the long term care setting, there will be something in that discussion that will affect your residents, patients, and your facility.

On Saturday we will gain insight on what to expect of our medical directors. The topic will be "The Positive Impact of the Nurse Practitioners in LTC" and the discussion will be an opportunity to enhance a working relationship to extend quality care to all levels. Please plan to attend. We will then jump right back to a clinical theme on Palliative Care in Advanced COPD and CHF and will follow this with a topic not done in years: "Hematologic Disorders in Post-Acute and LTC Settings". We will finish the morning with discussion on Elder Abuse, a Clinical Legal Perspective. It should be very informative.

After lunch on Saturday there will be two new twists to the program. First, we'll learn the top five articles that could make a difference in our practice, and we will finish the conference with a panel of PA/LTC experts discussing a variety of hot topics that are frequently raised or discussed on PMDA's members-only list serve. This session will feature several experts in the field and the panel to handle a potpourri of topics that you will most likely encounter at your facilities at one point or another. It's a chance to whatever the issue is you can have an in person multi panel discussion and response opportunity.

Remember, our conference is not only an educational event, but also the opportunity to share, interact, and bond network with medical professionals throughout the entire state of Pennsylvania! Opportunities for educational credits will be offered. Come to Hershey in October to enjoy a couple of days of education as well as sharing a Hershey's chocolate bar with a colleague. ■

A detailed Symposium agenda is included on the following pages.

2015 PMDA Symposium Agenda

Thursday, October 15

6:30pm – 7:30pm	Networking Reception

Friday, October 16

7:50am	Welcome – *Leon Kraybill, MD, CMD*
8:00am	Change of Condition: The 2:00am Phone Call: A Case-Based Discussion *Firas Saidi, MD, CMD*
	Chronic Obstructive Pulmonary Disease (COPD) *Jacquie Stutter, DO, FCCP*
	Congestive Heart Failure (CHF) *Matthew Wayne, MD, CMD*
9:40am	Break/Exhibits/Posters
10:10am	Q&A of Morning Presenters, joined by: *Susan M. Levy, MD, CMD, AGSF* *Heather Zinzella Cox, MD, CMD, FAAHPM*
10:40am	AMDA Update: National Trends in Post-Acute and Long-Term Care Medicine *Susan M. Levy, MD, CMD, AGSF*
11:00am	Annual Business Meeting/Election
11:30am	Lunch
12:30pm	Coffee/Dessert – Exhibit Hall
1:00pm	Making QAPI Work for You *Matthew Wayne, MD, CMD*
1:45pm	LTC-Specific ICD-10 Codes and Related Billing Issues *Linda Benner, CPC, CPMA, CASCC, COBGC*
2:45pm	Break/Exhibits/Posters
3:00pm	Q&A of ICD-10 and Related Billing Issues
3:30pm	Public Policy Update: Trends in PA *David A. Nace, MD, MPH, CMD*
4:30pm	Adjournment

Saturday, October 17, 2015

7:50am	Moderator Welcome and Introductions
8:00am	What Should I Expect From My Medical Director? *J. Kenneth Brubaker, MD, CMD*
8:45am	The Positive Impact of Nurse Practitioners in LTC *Neelofer Sohail, MD, CMD* *Jane Miller, NP, MSN, CRNP*
9:15am	Break/Exhibits
9:30am	Palliative Care in Advanced COPD and CH *Stanton Segal, MD*
10:30am	Common Hematologic Disorders in the Post-Acute and LTC Settings *Andrew E. Chapman, DO, FACP*
11:30am	Elder Abuse: Clinical and Legal Perspectives *Duncan MacLean, MD, CMD* *Dave Hoffman, MD, Esq.*
12:15pm	Lunch
1:15pm	Top Five Articles That Could Make a Difference in Your LTC Practice *David A. Nace, MD, MPH, CMD*
1:45pm	LTC Forum: Panel Discussion on Hot Topics Moderator: *Tom Lawrence, MD, CMD* Panelists: *Gary B. Bernett, MD, CMD* *Neelofer Sohail, MD, CMD* *Terry Ballentine, MS, ANP-BC, CRNP* *David A. Nace, MD, MPH, CMD*
2:30pm	Adjournment

Welcome New Members

PMDA welcomes the following individuals who have become PMDA members:

Thomas Braide, MD
Patrick Gilhool, DO, CMD
Clinton Holumzer, MD
Raffi Megerian, MD
Deanna Ziemba

PMDA Formally Addresses CRNP Scope of Practice

At the May PMDA Board meeting, Board members discussed recently proposed legislation to expand the autonomous practice of nurse practitioners (CRNPs) in Pennsylvania. The Board reviewed a recent member poll on this proposal, invited input from a CRNP Board member, and discussed the specific role of CRNPs in the long term care setting. **The board felt that the currently proposed legislation had limited pertinence to the practice of CRNPs in long-term care, and elected not to take a formal position on this legislation.**

PMDA has and will continue to welcome and support CRNPs as part of the LTC team. CRNPs reflect 20% of PMDA membership, will have two (2) voting PMDA Board seats this fall upon completion of the annual election, and are welcome to participate at all committee levels. A recent poll of PMDA members revealed mixed opinions on the proposed legislation.

CRNPs are currently legally allowed to practice in PA after they have established and signed a formal supervisory relationship agreement with a collaborative physician. Approximately 20 states currently allow autonomous CRNP practice and do not require a formalized collaborative physician agreement. A CRNP in these states can set up a practice and see patients independently.

There is currently a shortage of LTC providers in parts of the US, and CRNPs help to fill this void. There have been difficulties in parts of PA to find providers that will oversee CRNPs who wish to work in LTC.

The proposed Pennsylvania legislation (HB 765) would allow CRNPs to "practice as licensed independent practitioners within the particular clinical specialty area or population focus in which they hold current certification from a national certification program that required the passing of a national certifying examination."

Current CMS guidelines for LTC skilled care require a physician to perform and bill for a skilled admission exam, as well as every other required regulatory visit. Nurse practitioners can see residents for acute issues at any time, and alternate regulatory visits with the physician. Thus, physician collaboration is mandated by federal statutes.

The current Pennsylvania proposal relates to autonomous CRNP practice in an outpatient setting. **The PMDA Board felt that the proposed changes were outside of PMDA's LTC focus, would not alter CRNP practice in LTC, and thus did not take a formal position.** The Board welcomes ongoing discussions about expanding the role of CRNPs in LTC, strengthening the CRNP-physician relationship, and meeting the needs of Pennsylvania LTC residents. ■

POLST Train-the-Trainer Curriculum Now Available

By Marian Kemp
Pennsylvania POLST Coordinator
Coalition for Quality at the End of Life (CQEL)

From the year 2000 until recently, much effort was dedicated in Pennsylvania to creating an awareness of the Physician's Orders for Life-Sustaining Treatment (POLST). With the POLST now being widely used in Pennsylvania, communication is centered on improving the quality of use and helping to assure effective POLST conversations. However, when engaging in a POLST goals of care conversation, it is important that providers have the skill and are comfortable in a situation that involves such a sensitive topic.

Among POLST champions, there was recognition a few years ago that many facilities lacked staff who could appropriately lead such a discussion. Under the auspices of the Coalition for Quality at the End-of-life (CQEL), the Pennsylvania POLST Consortium was formed. At a meeting in 2013, the group determined a training program should be developed that would offer a consistent curriculum and could be presented across the state. The 8.0 hour credit course was launched successfully in the Spring of 2014. To date, it has been presented in eleven locations and 550 individuals have participated. At least three sessions are planned for Fall 2015.

The course is designed for anyone who completes, signs, and/or educates others on POLST, including physicians, CRNPs, nurses, social workers, and other healthcare professionals. The goal is that they would then go back to their place of work and become the POLST Champion and trainer in their location.

All materials required to present the course are made available to presenting partners at no cost. Organizations that have presented the course to date have utilized community practitioners with knowledge and experience in POLST as faculty. Attendees of the course have commented that in addition to content, it has been beneficial to have faculty share some of their professional experience. Feedback on the program from presenters and participants has been very positive.

If you would be interesting in presenting the program in your organization or region, or if you are interested in further information, contact the POLST Coordinator at PAPOLST@verizon.net. ■

University of Pittsburgh, AMDA, and University of Wisconsin Team Up to Improve Treatment of UTI, Reduce Unnecessary Antibiotic Use, and Combat Antimicrobial Resistance

By David A. Nace, MD, MPH, CMD
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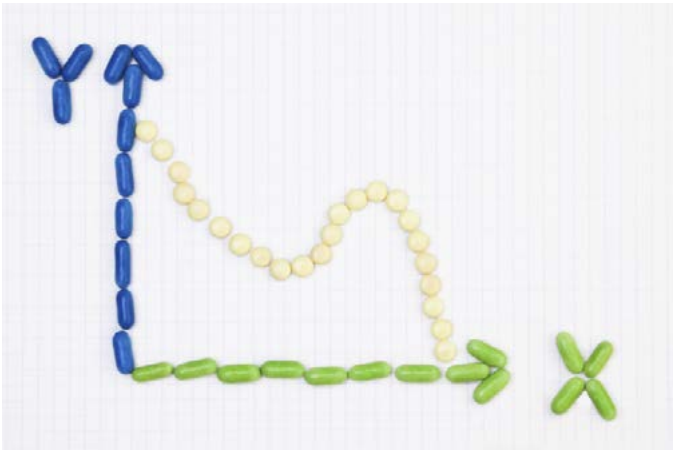

The University of Pittsburgh, School of Medicine will be leading a $1.5 million national trial to examine methods to reduce unnecessary use of antibiotics in post-acute and long-term care (PA/LTC) facilities.

The three-year study funded by the US Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ) will update guidelines and develop/disseminate tools to help PA/LTC facilities better manage urinary tract infections (UTI) which are commonly misdiagnosed and incorrectly treated. PMDA member David A. Nace, MD, CMD, serves as the principal investigator on the grant.

Nationally and globally, antimicrobial resistance is a top public health threat. Ninety years after the discovery of penicillin, growing resistance to all classes of antibiotics threatens to return medicine to the pre-penicillin era. Inappropriate antibiotic use in both the agricultural and healthcare industries is the primary cause. Traditionally, clinicians depend upon the development of new classes of antibiotics when resistance rates increase. Unfortunately, there has been a progressive decline in the development of new antibiotics, starting in the 1980s.[1] This means it is critical that clinicians engage in efforts to improve antibiotic use - so called antimicrobial stewardship programs.

The White House recently responded by issuing an executive order and creating the National Action Plan for Combating Antibiotic-Resistant Bacteria. A key component of the plan is the development of antimicrobial stewardship plans in all healthcare settings, including nursing facilities.[2] This grant, ***Improving Outcomes of Urinary Tract Infection in LTC Facilities: The IOU Study***, directly addresses this need by seeking to improve the management of urinary tract infection (UTI).

Suspected UTI is the most common infection encountered in nursing facilities and the most frequent reason for antibiotic use. Unfortunately, up to two thirds of antibiotic courses directed at UTI are not indicated. In addition to antimicrobial resistance, inappropriate antibiotic use in nursing homes places residents at an increased risk of adverse drug events, Clostridium difficile infection, and increased healthcare costs.[3] What is particularly worrisome is the fact that residents appear to be at risk of adverse drug events even if they haven't directly received antibiotics. Simply residing in a home with a high rate of antibiotic use increases an individual's risk.[4]

The *IOU Study* will enroll 40 nursing homes in four states, including North Carolina, Pennsylvania, Texas, and Wisconsin. Half will receive the intervention during the testing phase, while the other half will serve as controls. At the end of the testing period, the control homes will have access to the intervention. Ultimately, with AMDA's assistance, the intervention will be offered to all nursing facilities. Outcomes to be measured will include measures of antimicrobial use, rate of appropriate and inappropriate treatment of UTI, measures of antimicrobial resistance and rate of adverse events.

The project team hopes to recruit interested nursing facilities in Pennsylvania for the study. More information will be available later in the year. ■

REFERENCES:

1. Spellberg B, Guidos R, Gilbert D, et al. The epidemic of antibiotic-resistant infections: A call to action for the medical community from the Infectious Diseases Society of America. *Clin Infect Dis*. (2008) 46 (2):155-164.

2. White House. National Action Plan for Combating Antibiotic-Resistant Bacteria. March 2015. https://www.whitehouse.gov/sites/default/files/docs/national_action_plan_for_combating_antibotic-resistant_bacteria.pdf (accessed 07-27-2015)

3. Nace DA, Drinka PJ, Crnich CJ. Clinical uncertainties in the approach to long term care residents with possible urinary tract infection. *J Am Med Dir Assoc.* 2014;15:133-139.

4. Daneman N, Bronskill SE, Gruneir A, et al. Variability in antibiotic use across nursing homes and the risk of antibiotic-related adverse outcomes for individual residents. *JAMA Intern Med* (Published online June 29, 2015) doi:10.1001/jamainternmed.2015.2770.

Choppy Waters Ahead for Managed Long-Term Services and Support

By Dr. Reshma Shah
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By mid-to-end 2016, major changes will occur (what a stockbroker may call a volatile market) in PA in the management of long-term services and support (MLTSS) for dual-eligible participants. The Governor has directed the Departments of Human Services and Aging to increase opportunities for older Pennsylvanians and individuals with physical disabilities to remain in their home. As a result, based on research conducted by the University of Pittsburgh, MLTSS enrollment will become mandatory for adults receiving Medicaid long-term care services and dual eligible participants over the age of 21 years. These changes do not apply to individuals with intellectual disabilities.

Currently in Pennsylvania, the MLTSS target population consists of 318,000 dual eligible adults without long-term services and support (LTSS) needs, and 104,000 with LTSS needs. There are also 25,000 participants who are either nursing facility clinically eligible (non-dual) or adults in the Act 150 program. It has been shown that this target population is amongst the poorest and sickest of the entire Medicare population.

In order to explain the changes, let's consider the fictional Mr. Smith. Mr. Smith is a dual eligible community dweller who, up until now, is not registered with a service. When the enrollment period begins, sometime in the middle of 2016, Mr. Smith will initially undergo a standardized assessment to assess his individual needs and identify the service plan that will best suit him. The aim, as per the Depts. of Human Services and Aging, is to ensure this process is patient-centered, self-directed when possible, and includes transitions between settings so that quality outcomes are assured.

Mr. Smith will then be assigned to a vendor who will be responsible for providing physical, behavioral, and LTSS and ensure smooth coordination between entities. In order to provide this level of care, vendors will be required to contract with an adequate number of qualified, credentialed providers and to provide this care in the least restrictive setting, such as Mr. Smith's own home and community. If any issues arise, Mr. Smith will have access to a grievance and appeals process. The Departments have also announced that the payment structure will be performance based and there will be an overarching quality evaluation component.

The best way to ensure the MLTSS framework for Pennsylvania is successful is to establish and use a universal eligibility determination tool. This tool would allow for expedited, clear, long-term care eligibility determinations and immediate access to care that is administered by a conflict-free counsellor. Implementation of the framework may pose unanticipated problems, which could be devastating. A possible resolution would be to have a regional approach that would allow for course correction and fine tuning safeguarding overall success. For the sake of transparency, all involved parties, including individuals, families and state policy makers, should have access to outcome and quality performance data that is assessed by a common set of metrics. For example, Mr. Smith and his family could compare the falls data between local vendors which will allow him to make accurate value comparisons in deciding where to enroll.

The goals of the new MLTSS structure and those of Living Independently for Elders (LIFE) organizations run parallel. LIFE organizations are Programs of All-Inclusive Care for the Elderly (PACE) which provide acute, primary, and long-term care services to over 5,000 frail older adults across 34 counties in Pennsylvania. Through effective partnerships with families, LIFE organizations allow over 90% of the nursing home eligible older adults they serve to remain living in the community. Success has been proven by disenrollment rates below 3% and satisfaction rates of up to 88%. Considering the efficacy of this program, LIFE needs to be maintained as a distinct enrollment option. LIFE as a vendor will ensure that the core agenda of the Governor's mission in managing LTSS in the community is upheld by continuing to provide high-quality, all-encompassing care.

LIFE programs, using funds allocated by fixed capitated payments from both Medicare and Medicaid, provide all Medicaid funded services, including nursing facility care, if required. In fact, this is accomplished for less than 60% of Medicaid funded nursing facility costs. And not only nursing facility costs, social support (including bed-bug control (!), air conditioning, etc.), hospitalizations, primary care, nutrition, home care and chaplaincy, amongst other services, are provided to the enrolled older adults. One major advantage of utilizing LIFE programs over Health Plan Based Managed Care options is the interdisciplinary team model (IDT) that drives all patient care at LIFE programs. Not only does every member have a case manager, but the IDT meets weekly with and communicates daily. The IDT is skilled in primary care medicine and rehabilitation (Physical, Occupations, Recreational therapy), which all go towards tailoring the care to the needs of the frail elders and their families. This approach ensures holistic care of the enrollee, guaranteeing a great model for patient- and family-centered care.

It is hoped that the state will work with local services, such as LIFE and the Pennsylvania Association of LIFE Providers (PALPA) during the implementation of the new framework for delivery of MLTSS services. LIFE programs are and should remain an integral part of the fabric of the care providers for frail older adults within the State of Pennsylvania. ■

Special thanks to Dr. Pamela Fenstemacher, Chief Medical Officer, LIFE – University of Pennsylvania.

REFERENCE:

Dept of Human Services, Dept of Aging. (June 2015). Managed Long-Term Services and Supports (MLTSS) Discussion Document. Harrisburg: Commonwealth of Pennsylvania.

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AMDA Core Curriculum Session Offered Near You This Fall!

November 5-8: Part II Live, Philadelphia, PA
For more info, visit www.amda.com/education/core/index.cfm.

The AMDA Core Curriculum on Medical Direction (Core Curriculum) guides participants through 22 critical areas of long-term care management. Each topic builds on information shared and interactive exercises of the topics that precede to create a comprehensive and cohesive picture of medical direction in long term care. The Core Curriculum is presented in two parts, each reflecting elements of adult-learning practices. Part I of the Core Curriculum is a prerequisite for attending Part II. Part I of the Core Curriculum is only offered online, and Part II is only offered live.

Core Curriculum Program Options

Please note: If you have taken Part I only online or live, we strongly encourage you to complete Part II live in November. You have just three opportunities to complete Part II in its current format; either the Philadelphia offering in 2015, the Indianapolis offering July 2016, or the fall 2016 offering, which is yet to be confirmed. You must complete the course no later than 2016. Beginning in 2017, there will be changes to the course structure, order, and content, which will make it difficult to complete the program in its current format. Contact AMDA's Professional Development department at education@amda.com with any questions.