www.fmda.org
Florida Medical Directors Association
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Progress Report
2002 APEX AWARDS FOR PUBLICATION EXCELLENCE
Serving Physicians Practicing in Florida's Postacute Care Continuum

Many Firsts for FMDA

By Ian Cordes, Executive Director, Florida Medical Directors Association

There is so much I'd like to share with you about our upcoming 15th Anniversary Conference, but I don't know where to start.

We have come a long way since the early days of FMDA, and we have a lot to boast about.

With the help and support of the incredibly dedicated volunteer leadership, the Board of Directors has steered our association ahead of the curve. They have tried and succeeded in keeping the association relevant and have enhanced and improved member services over the years.

For example, this year's annual meeting is very unique in that, for the very first time, the conference has a new, permanent name, Best Practices in the Geriatrics Continuum, which we will feature year-after-year, and a striking new custom-designed logo to match. We hope you like the look and the new approach.

We have also assembled our longest, most CME/CE-intensive educational program in FMDA's history. It wasn't that long ago when we hosted weekend conferences where you could earn up to 12 total CMEs. Those days are gone. This year, the total offering is nearly 30.0 hours of CMEs starting on a Thursday morning instead of Friday evening.

FOR THE FIRST TIME EVER...

1. FMDA is hosting an AMDA program as part of a new pre-conference day. The program is their clinical practice guideline implementation workshop. This is as timely as you can get.
2. FMDA is offering the Florida mandatory licensure update courses this year.
3. FMDA is welcoming a speaker from Florida's Teaching Nursing Home Program — in fact, its director.
4. There are not one, but two speakers from Harvard Medical School.
5. FMDA is welcoming members of the American Academy of Home Care Physicians as attendees.
6. FMDA is also welcoming members of the Florida Geriatrics Society as attendees.
7. The president of the National Association of Directors of Nursing Administration in LTC will be a speaker on Saturday morning.
8. FMDA will be awarding its very first FMDA Futures grant.
9. FMDA will be offering CMEs and CEs for all our attendees if they choose to attend the administrator's session, which is co-sponsored by the Florida Chapter of the American College of Health Care Administrators.
10. FMDA is hosting an end-of-life decisions summit for Florida-based stakeholders who would like to promote the use of physician orders for life-sustaining treatment, also known as POLST.
11. FMDA has arranged for Disney to offer the spouses and guests of attendees the opportunity to sign up for two behind-the-scenes tours.

One thing that won't be a first this year is that you will experience a well-organized, high-quality educational conference in a relaxed, friendly, and comfortable atmosphere.

Please join us as we host Best Care Practices in the Geriatrics Continuum, the geriatrics conference of the year!

For more information about this amazing geriatrics medical conference, please call the business office at **(561) 659-5581**, or visit our Website at **www.fmda.org**. You won't be sorry.

INSIDE

For more information on the Best Care Practices conference, go to pages 4–8

President's Letter

To the members, affiliates, and friends of FMDA:

As I reach the one-year mark as your president, I am excited to report on the state of our organization. Our primary mission remains to represent the medical directors of skilled and long-term care nursing facilities throughout Florida. This task can only be accomplished by working together with our allied health care professionals for the common good of all.

With the commitment and hard work of your Board of Directors and multiple committee members, we are indeed fulfilling our mission for you, the members, affiliates, and friends. Ultimately it is our patients and their families who benefit from our association's worthy efforts.

Membership in all categories of FMDA continues to grow. In addition to expanding our involvement in the entire long-term health care continuum, we have established a working relationship with both the American Academy of Home Care Physicians as well as the Florida Geriatrics Society.

With the help of our outstanding Executive Director Ian Cordes and many of our Board members, we have been well represented at many important meetings both in Florida and around the nation.

Constantly changing economic conditions require FMDA to be vigilant in its fiscal operations and to continually work to maintain adequate financial resources to meet our missions.

This year, our new Best Care Practice in the Geriatric Continuum meeting promises to be our biggest and best educational event ever.

Looking forward to seeing you all in person at the Orlando conference.

Sincerely yours and proud of all of you providing long-term care to the elderly,

Carl Suchar DO, CMD
President

An Invitation to Get Involved in FMDA

We invite each member to become more involved in the Florida Medical Directors Association (FMDA) by becoming a volunteer. Numerous opportunities are available to serve for a year, a month, or a day. You can help guide our organization through committees, task forces, and subsections that advise the board of directors, provide advice, facilitate or lead various programs, or even start a new subsection.

Volunteers are the heart of FMDA. Our strength is a result of the time and effort provided by those who volunteer their time and knowledge to serve their colleagues and to further all medical directors in long-term care.

Participating as a volunteer provides a gateway to develop and hone leadership skills, increase professional contacts, and give back to the profession. Let us know what types of volunteer opportunities interest you.

We look forward to your participation in FMDA. Should you have any questions, please contact Ian Cordes, executive director, at (561) 659-5581 or ian.cordes@fmda.org.

FMDA *Progress Report* has a circulation of more than 1,000 physicians, nurse practitioners, directors of nursing, administrators, and other LTC professionals. *Progress Report* is a trademark of FMDA. Co-editors Drs. Rosemary and Ed Lamm welcome letters, original articles, and photos. If you would like to contribute to this newsletter, please e-mail your article to ian.cordes@fmda.org.

Real Dialogue About DNRO Dilemmas in LTC

FMDA was contacted by Florida Health Care Association (FHCA) about this important online discussion. The initial question was posed by **Suyrea Reynolds, NHA,** a knowledgeable and long-time nursing home administrator in the Orlando area. The dialogue shown below is presented in chronological order. Participants included:

Kenneth Brummel-Smith, MD; Charlotte Edwards Maguire Professor and Chair, Department of Geriatrics, Florida State University College of Medicine, Tallahassee

Karen Goldsmith, JD; legal consultant for FHCA

Bruce Robinson, MD; physician consultant to FHCA, and Chief of Geriatrics at Sarasota Memorial Hospital

LuMarie Polivka-West, MS; Senior Director of Quality Credentialing, FHCA

Howard Tuch, MD, CMD; Robert Wood Johnson Health Policy Fellow, National Program Office of The Institute of Medicine, Washington, D.C., and a former director of FMDA.

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1. *Suyrea Reynolds, NHA*

A while back I asked if there was something written about DNR and advance directives: a best practice policy and procedure.

This has come up again. Hospital staff is slamming the SNFs because they "didn't follow the patient's wishes." Example: A patient has a DNR order in the hospital. That order is sent with the patient to the SNF. Within 24 hours the patient codes and the SNF sends him/her to the hospital (because the SNF doctor has yet to see his new admission and the facility has not done the SNF paperwork for DNR).

Is there something that I can give the hospital that details the expectation of the state for SNFs?

2. *Bruce Robinson, MD*

A hospital attending can and does write a Do Not Resuscitate Order (DNRO) whenever in his or her judgment one is justified, and a hospital is expected to follow such an order.

The nursing home is not a hospital, and the state statute for DNR's is in effect. This statute has, in my opinion, never been the only way to define resuscitation status, but is the only way for which there is a guarantee of legal immunity. It is also the only legal mechanism to produce the yellow DNR form that emergency personnel accept as evidence of DNR status. For these reasons, most nursing homes attempt to use the DNR statute to structure all DNR decisions. I do not personally know what position surveyors take regarding DNR orders that do not follow the statute.

Under the DNR statute, a competent individual can sign, and a physician sign to complete the process. A patient incapable of making his/her own decision (most of those who are likely to need one) requires that: 1. one (two optional) physician determines them incapable, and 2. two physicians sign that the patient is end-stage, terminal, or PVS, 3. then a surrogate or proxy can sign the DNR for the patient, and 4. a doctor signs to complete the yellow DNR form. Such a process takes time, and it is easy for it to be incomplete before a decision is needed.

Continued on page 22

Clinical Practice Guidelines "Train the Trainer" Implementation Workshop

Become an AMDA CPG Implementation Trainer

Workshop Date/Time: 9 a.m.–4 p.m., Thursday, Oct. 19, 2006

Place: *Disney's Contemporary* Resort, Orlando, Florida

This interactive workshop will include a general course in the geriatric clinical care process, its importance and impact on care, as well as train you how to assess and evaluate facilities' current processes and protocols; you will learn: • ***How to identify areas for improvement*** • ***How to anticipate and overcome obstacles and barriers*** • ***How to lead and facilitate culture change*** • ***How to evaluate staff knowledge and skills*** • ***How to set up in-service and training schedules*** • ***How to measure the effectiveness of clinical practice guidelines (CPG) implementation*** • ***How to implement CPGs***

Target Audience: Physicians • Consultant Pharmacists • Nurse Practitioners • Nurses • QIO Managers

Space is limited: Registration fee is only **$50** and is accepted on a first-come, first-serve basis. Register now, at the same time you sign-up for the Best Care Practices in the Geriatric Continuum conference.

AMDA gratefully acknowledges Forest Laboratories Inc. for its support of this training project. NOTE: No CME/CPE/CE/CEU contact hours are provided for this workshop.

FMDA & Best Care Practices In The Geriatrics Continuum Thanks You!

October 20-22, 2006 • Orlando, Florida

We wish to thank the following organizations for hosting industry-supported symposia on Friday, October 20, 2006:

BREAKFAST & PRESENTATION
Parkinson's Disease: New & Emerging Therapies
This is an industry-supported symposium supported by an educational grant from ***Teva Neuroscience***.

LUNCHEON & PRESENTATION:
Lessons From the Memory Disorder Clinic
This is an industry-supported symposium supported by an educational grant from ***Forest Pharmaceuticals***.

Evaluation of Urinary Incontinence Treatment Guidelines
This is an industry-supported symposium supported by an educational grant from ***Watson Pharmaceuticals***.

Poster Viewing Schedule

FRIDAY, Oct. 20
4:15–6:45 p.m.

SATURDAY, Oct. 21
7–8 a.m., 9:45–10:15 a.m., 11:30 a.m.–1:30 p.m.

Annual Trade Show

We gratefully acknowledge the support of these exhibitors:

Abbott Laboratories, Alpha Physician Services, Alpharma, Amedisys Home Health Services, American Academy of Home Care Physicians, American Medical Directors Association, Amgen, AstraZeneca, Boehringer Ingelheim, Bristol-Myers Squibb, Eisai, Elsevier, Esprit Pharma, Evercare, FL-ASCP, Florida Geriatrics Society, FMQAI, Forest Pharmaceuticals, GlaxoSmithKline, Great Independence, Healthpoint, Janssen Pharmaceutica, Kinetic Concepts (KCI), Knowles Mobile Diagnostics, Merck & Company, Merck Vaccines Division, Mobile Physician Technologies, Nephron Pharmaceuticals, Novartis Pharmaceuticals, PAR Pharmaceuticals, PartnerCare Health Plan, Pfizer, The Pill Help Company, RADS Mobile X-Ray & Digital Imaging, Salus Behavioral Health, Sanofi-Aventis Pharmaceuticals, Senior Care Pharmacy, Sucampo Pharmaceutical, TAP Pharmaceuticals, Teva Neuroscience, UCB Pharma, Vitas Innovative Hospice Care, Watson Pharma, and Wyeth

FMDA & Best Care Practices In The Geriatrics Continuum Thanks You!

We wish to thank the following organizations for providing support!

GENERAL

Abbott Laboratories *— Name Badge Holders*
Boehringer Ingelheim *— Brief Cases*
Gallagher Daniel Keenan, PA *— Handouts on CD*

FRIDAY, OCT. 20

Abbott Laboratories *— FMDA Board Meeting*
Abbott Laboratories *— Welcome Reception Entertainment*

SATURDAY, OCT. 21

PAR Pharmaceuticals *— Breakfast in Exhibit Hall*
Alpha Physician Services *— Morning Coffee Break*
Forest Laboratories *— Afternoon Coffee Break*
Johnson & Johnson Health Care Systems LTC Group
— President's Wine & Cheese Reception
Boehringer Ingelheim *— Nurse Practitioners' Dinner*
Forest Laboratories and PartnerCare Health Plan
— FMDA Board Meeting

SUNDAY, OCT. 22

Pfizer *— Continental Breakfast*
Evercare *— Post-Conference FMDA Meetings*

FRIDAY, OCT. 20

Basic Training for New Health Care Practitioners and Those New to Long-Term Care
— This program was funded by an educational grant from
Amgen.

SATURDAY, OCT. 21

The Importance of Understanding Quality Measures & Quality Indicators
— This program was funded by an educational grant from
PartnerCare Health Plan.

Struggling with Polypharmacy: Using Patient Examples to Make a Difference
— This program was funded by educational grant from
Abbott Laboratories.

2006 Annual Program Description

This program is designed to provide a review and update of major geriatric diseases, illnesses, and risks found in nursing home patients, residents of assisted living facilities, and seniors living at home. Topics include stroke evaluation and prevention, falls prevention, polypharmacy, geriatric dermatology, understanding Quality Measures and Quality Indicators in SNFs, pain management and symptom control, disaster preparedness, and geriatric orthopaedics. The program also includes a session on how to start a home care medicine practice, a presentation on new Medicare coding issues, and a special general session on regulatory and legislative issues facing practitioners in long-term care and home care. In an effort to reach out to new practitioners and those new to long-term care, a three-hour basic training program is being presented again this year.

Target Audience

This conference is designed to educate physicians, senior care pharmacists, consultant pharmacists, physician assistants, nurse practitioners, directors of nursing in LTC, registered nurses, and nursing home administrators, as well as geriatricians, primary care and home care physicians, physicians considering becoming long-term care or home care medical directors, and others with an interest in geriatrics and its continuum of care. The faculty includes national and regional authorities in the fields of medical direction, senior care pharmacology, as well as long-term care and geriatric medicine.

Best Care Practices
In The Geriatrics Continuum
October 20-22, 2006 • Orlando, Florida

2006 Conference Agenda

Pre-Conference: THURSDAY, OCT. 19, 2006

8 a.m.–7 p.m. REGISTRATION: ***Disney's Contemporary*** **Resort**

9 a.m.–4 p.m. **AMDA's CPG "Train the Trainer" Implementation Workshop**

FLORIDA MANDATORY LICENSURE UPDATE COURSES

1–2 p.m. **Domestic Violence**

2:15–4:15 p.m. **Preventing Medical Errors**

4:30–5:30 p.m. **HIV/AIDS Update**

FRIDAY, OCT. 20, 2006

7:30 a.m.–7 p.m. REGISTRATION: ***Disney's Contemporary*** **Resort**

8–9:30 a.m. ISS BREAKFAST & PRESENTATION
Parkinson's Disease: New & Emerging Therapies
— Theresa A. Zesiewicz, MD; Associate Professor of Neurology and Associate Professor of Pharmacology and Molecular Therapeutics, University of South Florida
This is an industry-supported symposium.

9:45–10:45 a.m. **Technological Advances in Falls Prevention in the Elderly**
— Bernard A. Roos, MD; Division and Institute Director, and Chester Cassel Endowed Chair for Research in Gerontology, University of Miami School of Medicine; Director, Florida's Teaching Nursing Home Program

11 a.m.–12 p.m. **Starting a Home Care Medicine Practice**
— George A. Taler, MD; Director, Long-Term Care, Department of Medicine, Washington Hospital Center; Past-President, American Academy of Home Care Physicians
— Constance Row, MPA, P/M Cert. HCA; Executive Director, American Academy of Home Care Physicians

12–2 p.m. ISS LUNCHEON & PRESENTATION
Lessons From the Memory Disorder Clinic
— Lori Daiello, PharmD; President, Pharmacotherapy Solutions
— Marc Agronin, MD; Director of Mental Health Services, Miami Jewish Home & Hospital for the Aged
This is an industry-supported symposium.

1–4 p.m. **BASIC TRAINING FOR NEW HEALTH CARE PRACTITIONERS AND THOSE NEW TO LONG-TERM CARE:**
A primer for physicians, consultant pharmacists, and nurse practitioners wishing to learn about the nuances of practicing in the long-term care continuum
— Alejandro Jaen-Vinuales, MD; Assistant Professor, University of South Florida College of Medicine, Division of Geriatric Medicine, Tampa
— Naushira Pandya, MD, CMD; Associate Professor; Chair, Department of Geriatrics, Nova Southeastern University, Fort Lauderdale
— Martha Little, PharmD; Past President, FL-ASCP; member of the Board of Directors of the American Society of Consultant Pharmacists
— Joan Burritt, GNP; and **JoAnn Fisher, ARNP;** Osler Geriatrics, Melbourne
— Cathy Ates, RNC, CDONA/LTC; President, Parthenon Healthcare, Pensacola; President, Florida Association Directors of Nursing Administration
— David P. Sylvester, NHA; Senior VP, Health Central Hospital and Facility, Winter Garden, Fla.; President, Florida Health Care Association

2:15–4:15 p.m. **ISS: Evaluation of Urinary Incontinence Treatment Guidelines**
— David A. Smith, MD, CMD; Professor of Family Medicine, Texas A&M University; Immediate Past-President, American Medical Directors Association (AMDA); member of Editorial Advisory boards of Annual of Long-Term Care, JAMDA, and Geriatric Times Website.
This is an industry-supported symposium.

4:15–5:15 p.m. **New Medicare Coding for Physicians, Office Managers & Others: Getting Paid**
— Dennis Stone, MD, CMD; Corporate Medical Director, Integritas; Chief Medical Officer Home Quality Management; Past President, AMDA
— George A. Taler, MD; Director, Long-Term Care, Department of Medicine, Washington Hospital Center; Past-President, American Academy of Home Care Physicians

5:15–6:45 p.m. WELCOME RECEPTION & ENTERTAINMENT IN EXHIBIT HALL

7–9 p.m. DINNER & PRESENTATION: **The Nuances of Stroke Evaluation & Treatment**
— Galen V. Henderson, MD; Assistant Professor of Neurology, Harvard Medical School; Chief of the Division of Critical Care & Emergency Neurology, Brigham and Women's Hospital, Boston

SATURDAY, OCT. 21, 2006

7 a.m.–5 p.m. REGISTRATION: ***Disney's Contemporary*** **Resort**

7–8 a.m. CONTINENTAL BREAKFAST IN EXHIBIT HALL
POSTER PRESENTATIONS VIEWING

8–9:45 a.m. **Annual Regulatory & Legislative Update**
— Steve Levenson, MD, CMD; President, American Medical Directors Association
— Robert Miller, RPh; President, American Society of Consultant Pharmacists (ASCP)
— Sherrie Dornberger, RNC, CDONA; President, National Association of Directors of Nursing Administrators/LTC
— George A. Taler, MD; Past-President, American Academy of Home Care Physicians

9:45–10:15 a.m. COFFEE BREAK IN EXHIBIT HALL
POSTER PRESENTATIONS VIEWING

10:15–11:30 a.m. **Annual Regulatory & Legislative Update** INTERACTIVE PANEL DISCUSSION **(continued)**

11:30 a.m. ANNUAL LUNCHEON IN EXHIBIT HALL

2006 Conference Agenda

1:30–2:30 p.m. **The Importance of Understanding Quality Measures & Quality Indicators**
— Steve Levenson, MD, CMD; President, AMDA

2:40–4:10 p.m. **Struggling with Polypharmacy: Using Patient Examples to Make a Difference**
— Richard Ackermann, MD; Professor of Family Medicine and Founding Director, Division of Geriatrics, Mercer University School of Medicine, Macon, GA
— Richard Marasco, BS Pharm; President, seniorpharm.com, Valdosta, GA; Past-President, Florida Chapter, ASCP

4:20–5:20 p.m. **Geriatric Dermatology: Aging Skin Changes & Aging Related Dermatoses**
— Neil A. Fenske, MD, FACP; Professor of Dermatology and Pathology; Chairman, Department of Dermatology and Cutaneous Surgery, University of South Florida College of Medicine, Tampa

3–5 p.m. **BREAKOUT SESSION**
Aligning Leadership for Organizational Improvement
— Marianna K. Grachek, RN, MS, NHA; CEO, American College of Health Care Administrators
— Brian Robare, CNHA, CALA; President, Florida Chapter, American College of Health Care Administrators

Breakout Session

6:30–7:30 p.m. PRESIDENTS' WINE & CHEESE RECEPTION

7:30–9:30 p.m. CONSULTANT PHARMACISTS: Members-only dinner meeting

SUNDAY, OCT. 22, 2006

7:15–8 a.m. BREAKFAST

8–9:30 a.m. **Common Pain & Symptom Management Challenges in the Postacute Care Continuum**
— Howard Tuch, MD, CMD; Robert Wood Johnson Health Policy Fellow, National Program Office of The Institute of Medicine, Washington, D.C.

9:30–10 a.m. FMDA MEMBERSHIP MEETING

10–11:30 a.m. **When Disaster Strikes . . . An Interdisciplinary Approach to Complete Preparedness**
— Charlie A. Cefalu, MD, MS; Professor and Chief, Section of Geriatric Medicine, Louisiana State University School of Medicine; Medical Director, Geriatric Medicine Program, Medical Center of Louisiana, New Orleans
— Robin Bleier, RN, CDONA/LTC, LHRM; President, RB Health Partners; FADONA 2nd VP; Chair, Florida Health Care Association's Disaster Preparedness Committee; Member, American Health Care Association's Life Safety & Disaster Planning Committee

11:30–11:40 a.m. PRETZEL BREAK

11:40–12:40 p.m. **Hot Topics in Geriatric Orthopaedics**
— Henry J. Mankin, MD; Chief of Orthopaedic Services, Massachusetts General Hospital; Edith M. Ashley Professor of Orthopaedics, Harvard Medical School, Boston

12:40 p.m. END OF CONFERENCE: Door prizes, etc.

POLST Post-Conference Forum

2–4 p.m. **Strategies for Improving End-of-Life Decisions: Promoting Physician Orders for Life-Sustaining Treatment**
Moderator— Kenneth Brummel-Smith, MD; Professor and Chair, Department of Geriatrics, Florida State University, College of Medicine, Tallahassee

— This session does not provide continuing education credits and is not open to the public. Registrants to the Best Care Practices conference may attend, but due to limited space, please RSVP to the FMDA business office.

* The meeting agenda for Best Care Practices in the Geriatrics Continuum is subject to change.

Win an Apple iPod nano or *FREE* Annual Program Registration!

FMDA wants you, a current FMDA member, to win its Membership Contest. The rules are very easy. Just recommend as many new members to FMDA as possible between now and Oct. 21, and you could win.

Grand Prize: One lucky FMDA member, with the most new member referrals, will win either one ***Free*** registration to FMDA's Annual Conference (a $224 value) or an Apple iPod nano — it's the winner's choice.

Also, any member referring two (2) new members or more will received one year free membership to FMDA.

The contest deadline is Saturday, Oct. 21, so act today by going to **www.fmda.org/membership.html**, download the new membership brochure, and e-mail it to all your physician, PA, and nurse practitioner friends and colleagues. Or, call the business office at **(561) 659-5581** for help and support.

The lucky winners will be announced on Sunday, Oct. 22 during FMDA's 15th Annual Program, titled, Best Care Practices in the Geriatrics Continuum, at *Disney's Contemporary* Resort in Orlando, and you do not have to be present to win.

*(You must be named on the membership application as the referring member.)

REGISTRATION FORM

Yes! I would like to register now!

❒	Paid-up **FMDA**, **FL-ASCP**, **AAHCP**, and/or **FGS** members **(Full registration*)**	$224
❒	New/renewing **FMDA** members **(Full registration)** **(includes $45 for annual dues for Regular and Professional Affiliate members)**	$269
❒	Non-member physicians **(Full registration)**	$294
❒	Non-member consultant pharmacists **(Full registration)**	$294
❒	Unlicensed registrants **(Full registration)**	$369
❒	Nurse Practitioners, Physician Assistants, and RNs members of **FMDA** **(Full registration)**	$129
❒	Nurse Practitioners, Physician Assistants, and RNs **(Full registration for new/renewing FMDA members)**	$174
❒	Nurse Practitioners, Physician Assistants, and RNs **(Full registration for non-members)**	$199
❒	**Physicians:** fellows, interns, and residents in geriatrics, family practice, and internal medicine ... **(Full registration)**	$75
❒	**Students:** PAs, NPs, nurses, pharmacists, and NHA/ALF administrators **(Full registration)**	$75
❒	**"Friday Registration"** (includes all sessions and Trade Show, but does not include dinner-presentation)	$75
❒	Medicare Billing seminar for physicians and office managers. Includes name badge for Trade Show & Welcome Reception	$25
❒	**Pre-conference:** AMDA's CPG "Train the Trainer" Implementation Workshop on Thursday, Oct. 19 **(no CEs)**	$50
❒	**Pre-conference:** All 3 Florida mandatory licensure update courses on Thursday, Oct. 19 **(approved for CEs)**	$25
❒	Nursing Home and ALF Administrators **(Full registration)**	$175
❒	Nursing Home and ALF Administrators **("Saturday Only")**	$110
❒	**Guests:** Friday evening dinner presentation (**spouses and guests)**	$45 per person
❒	**Guests:** Saturday **FL-ASCP** Dinner Meeting (**spouses and guests)**	$45 per person

***FULL REGISTRATION: Fees include attendance at all educational sessions, receptions, planned meals, and Trade Show admission, from Oct. 20 to Oct. 22. The pre-conference sessions on Thursday, Oct. 19, are not included, and are extra.**

RSVPs for Friday, Saturday, & Sunday (agenda subject to change)

1. Friday Luncheon & Seminar: ____ **Yes**, I will attend; ____ **No**, I will not; **2. Friday Afternoon:** ____ **Yes**, I will attend; ____**No**, I will not;

3. Friday's Basic Training for Practitioners: ____ **Yes**, I will attend; ____**No**, I will not; **4. Friday Evening Dinner** (spouse/guests are extra): ____ **Yes**, I will attend; ___ **No**, I will not; Spouse's /Guest's name: _____; ____ vegetarian request; **5. All Day Saturday:** ____ **Yes**, I will attend; ____**No**, I will not; **6. FL-ASCP Membership Dinner** (spouse/guests are extra)**:** ____ **Yes**, I will attend; ____ **No**, I will not; Spouse's /Guest's name: _____; **7. Nurse Practitioners Saturday Dinner Presentation** ____ **Yes**, I will attend; ____ **No**, I will not; and **8. Sunday General Sessions:** ____ **Yes**, I will attend; ____ **No**, I will not; **9. POLST:** ____ **Yes**, I would like to attend.

NOTE: Due to space limitations, planned conference meals are only provided to registrants and exhibitors.

Name: _____ **Title:** _____ **License #**_____ **State**___

Facility Name/Affiliation: _____

Mailing Address: _____

City: _____ **State/Zip:** _____ **Phone:** _____

Fax: _____ **E-mail:**_____ **Amount enclosed: $**_____

There will be a $50 administration fee for all written cancellation requests received on or prior to Oct. 6, 2006. There will be no refunds after Oct. 6, 2006.

Please make check payable to **FMDA** and mail to:

200 Butler Street, Suite 305, West Palm Beach, FL 33407

(561) 659-5581 • Fax: (561) 659-1291 • www.fmda.org • E-mail: ian.cordes@fmda.org

Disney's Contemporary Resort

FMDA has reserved a block of rooms at *Disney's Contemporary* Resort, located at 4600 N. World Drive, Lake Buena Vista, FL 32830. The special group rate is **$175** single/double occupancy. To make a reservation, please call **(407) 824-3869** and mention you are attending the Florida Medical Directors Association, or Best Care Practices in the Geriatrics Continuum conference.

To guarantee rate and room availability, you must make your reservations as soon as possible. This special group rate will be applicable three (3) days prior to and three (3) days following the main program dates, subject to availability. Free self-parking is available.

FMDA is a not-for-profit corporation. Its federal tax identification number is 59-3079300.

Managing Pandemic Considerations

By Robin A. Bleier, RN, LHRM, FACDONA

The world has become a different place. Disasters caused by mother nature, terrorism, or other means of man-made circumstances require us to rethink our clinical risk-management practices and approaches to ensure that we are proactive whenever possible. Planning, practice, drills are key to keeping us disaster flexible, ready to care for our residents and guide our staff.

Severe Acute Respiratory Syndrome

The 2003 pandemic of severe acute respiratory syndrome (SARS) demonstrated how quickly human respiratory viruses can spread, especially in a world of modern air travel. Disease spread will likely be even faster during an influenza pandemic because a typical influenza virus has a shorter average incubation period (typically 2 days vs. 7–10 days for SARS-associated coronavirus [SARS-CoV]) and is more efficiently transmitted from person to person.

Influenza Pandemic

If an influenza pandemic begins outside the United States, public health authorities might screen inbound travelers from affected areas to decrease disease importation into the United States. If a pandemic begins in or spreads to the United States, health authorities might screen outbound passengers to decrease exportation of disease. Early in a pandemic, state and local health departments might also implement domestic travel-related measures to slow disease spread within the United States.

Because some persons infected with influenza will still be in the incubation period, shedding virus asymptomatically, or have mild symptoms, it will not be possible to identify and isolate all arriving infected or ill passengers and quarantine their fellow passengers. Moreover, if an ill passenger is identified after leaving the airport, it might not be possible to identify all travel contacts within the incubation period for influenza. Nevertheless — depending on the situation — these activities might slow the spread early in a pandemic, allowing additional time for implementation of other response measures such as vaccination.

So we should make sure we understand and plan for the small percent we might be able to control.

Once a pandemic is underway, exit screening of travelers from affected areas ("source control") is likely to be more efficient than entry screening to identify ill travelers. Early in a pandemic, this intervention may decrease disease introductions into the U.S. Later, however, as pandemic disease spreads in communities, ongoing indigenous transmission will likely exceed new introductions and, therefore, federal authorities might modify or discontinue this strategy. Voluntary limitations on travel during a pandemic alert and pandemic, as persons decide to limit their own personal risk by canceling nonessential trips, will also decrease the amount of disease spread. Limiting or canceling travel of U.S. residents and others from affected countries will depend on the properties of the pandemic virus that emerges, and will be informed by the facts on the ground at the time of emergence.

Travel within the United States

§ If the level of influenza transmission in a U.S. area is high and if most other areas have not yet been affected, HHS and state and local health authorities might decide to recommend limiting or canceling nonessential travel to that area or to implement increased disease surveillance measures.

§ Other containment measures and travel restrictions to slow disease spread within the United States that might be considered include:

§ Distributing travel health alert notices on domestic flights,

§ Isolating ill arriving passengers on domestic flights and quarantining passengers and crew, following protocols developed for international flights,

§ Closing mass transit systems (e.g., buses and subways; etc.), and

§ Closing interstate bus and train routes.

Avian Flu

The World Health Organization (WHO) had logged just 132 cases of the disease at the end of November 2006, but the victims' high mortality rate has sparked widespread anxiety. In a global pandemic, WHO estimates the disease could take 7.5 million lives in less than three months. But whatever the disease's ultimate impact, it (coupled with the devastation wrought by Hurricane Katrina) has served to turn corporate attention to the potential problem of staff decimation due to any number of environmental factors.

Related economic consequences of a flu pandemic could be huge. Illness and worker absenteeism would contribute to economic disruption, WHO says, and thanks to global business ties, an outbreak in one region could strangle businesses on the other side of the planet. Missing staff could affect operations of essential services like utilities and transportation. A World Bank estimate puts the worldwide cost of a serious flu pandemic at around $800 billion.

While a flu epidemic might not materialize at all, even a limited

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Marasco Receives First ASCP Senior Care Pharmacist Award

Richard Marasco, BS Pharm, CGP, FASCP, past-president of the Florida Chapter of the American Society of Consultant Pharmacists (ASCP), was recently awarded ASCP's Senior Care Pharmacist Award at its 28th Midyear Conference & Exhibition in Las Vegas, by ASCP President Robert Miller.

"Rich applied his outstanding clinical knowledge of geriatric pharmacotherapy to improve the quality of life for his senior patients wherever they reside," said ASCP's Miller. "Matching his outstanding record as a clinician is his success as an independent entrepreneur," Miller added.

Marasco is one of the country's first board-certified geriatrics pharmacists and served on the ASCP Board of Directors. He was also instrumental in the success of the joint annual meetings shared by FL-ASCP and FMDA.

Medicare Quality Improvement Organization for Florida Embarking on the 8th Scope of Work

FMQAI, the Medicare Quality Improvement Organization (QIO) for Florida, has embarked on its next contract cycle of work (the 8th Scope of Work). FMQAI is again working with Medicare providers in the following care areas: nursing home, home health, hospital, physician practice, and beneficiary protection and rights: reviews of quality of care complaints and appeals of discharge or service termination.

Partnerships and collaborations are vital to FMQAI's work as the Medicare QIO. Our collaboration with FMDA has contributed to the success achieved during our previous contract cycle, and will play an important role as we move forward.

Overview of the Nursing Home Quality Initiative in Florida:

FMQAI has implemented a quality improvement model for facilitating systems change in Florida's nursing homes. The model incorporates basic elements of sound quality improvement process development:

- Identifying quality improvement goals
- Measuring performance against the goals
- Developing a corrective action plan and implementing the appropriate systems change
- Re-measuring performance
- Continuing the cycle until the desired effect is obtained

FMQAI provides technical assistance to all nursing homes in the state. In addition, FMQAI offers intensive technical assistance to 15% of the nursing homes that volunteered to participate in an extensive training program. This program consists of monthly onsite visits for instruction in creating an environment for culture change. FMQAI works with the nursing homes' multidisciplinary teams to adopt quality leadership as a new way of doing business, using the Institute for Healthcare Improvement model for accelerating improvement.

For more information, go to **www.fmqai.com**, or call **(866) 800-8767**, and ask for the NHQI team.

National Provider Identifier (NPI) Number

On May 1, 2006, the Centers for Medicare & Medicaid Services (CMS) introduced the revised CMS 855 Medicare provider enrollment applications. As part of the revised enrollment process, initial enrollees and existing enrollees making changes to their enrollment information must include their NPI number and a copy of the National Plan and Provider Enumeration System (NPPES) NPI notification with the enrollment application. No initial application can be approved and no updates to existing enrollment information can be made without this NPI information. All health care providers and suppliers who bill Medicare are required to obtain their NPI in advance of enrolling in or changing their Medicare enrollment data. If you are an individual or sole proprietor who furnishes health care, you are eligible for one and only one NPI. If you are an individual who is a health care provider and who is incorporated, you may need to obtain an NPI for yourself and an NPI for your corporation or LLC. If you are an organization that furnishes health care, you may determine that you have components, called "subparts," that need their own NPI.

For additional information about the NPI, please go to **www.cms.hhs.gov/NationalProvIdentStad**. If you have not yet obtained your NPI number, CMS encourages you to do so soon even if you are not enrolling or making a change to your Medicare enrollment information. A sheet designed to provide basic information about the NPI, including the three different ways to apply for your NPI, is available at **www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/EnrollmentSheet_WWWWH.pdf**. Whatever method you use to obtain your NPI, be sure to keep this information, share it with your health care partners, and update your information with NPPES whenever any of the information used to get your NPI changes.

Starting May 23, 2007, the NPI will replace all of your existing provider numbers that you use to bill Medicare, Medicaid, and other health care payers.

Although this date is still a long time away, you should begin sharing this information with Medicare, other payers, and your other health care partners in order to make the transition to NPI as smooth as possible. For more information about the revised provider enrollment process, please contact your Medicare contractor or go to **www.cms.hhs.gov/MedicareProviderSupEnroll**.

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AMA Launches New Prescribing Data Restriction Program

The American Medical Association (AMA) recognizes that the inappropriate use of prescribing data is a growing concern among physicians. In response, the AMA has launched a new Web-based Prescribing Data Restriction Program (PDRP), which will address physicians' concerns about inappropriate use of prescribing information by pharmaceutical sales representatives, while ensuring these data continue to be available for evidence-based medicine and research.

While the AMA does not collect or distribute physician prescription data of any kind, it does offer individual physicians a voice in how their prescription data is to be used and accessed. The PDRP allows physicians to make informed decisions about whether they want to deny all pharmaceutical sales representatives access to their prescribing habits. Physicians can also register a complaint against specific companies or representatives who use prescribing data inappropriately.

The AMA's efforts to empower physicians will keep prescribing data available for the benefit of evidence-based medicine and quality patient care while discouraging pharmaceutical representatives from using these data to pressure physicians to prescribe a particular drug. The program took effect July 1, and physicians can register via the AMA Website now. Visit **www.ama-assn.org/ama/pub/category/12054.html** to learn more about the PDRP.

Get Involved in Reinstating Federal Funding for Title VII

During the Annual Symposium in March in Dallas, the AMDA House of Delegates passed a resolution supporting the reinstatement of funding for Title VII, specifically its provisions on geriatric education centers, geriatric training for physicians, dentists, and behavioral health/mental health professionals, and geriatric academic career awards. Funding in the amount of $31.5 million for these programs was cut out of the 2006 federal budget. Unless Congress votes otherwise, the funding will not appear in the 2007 budget. Because Title VII is the only federal funding for programs that train providers for underserved populations, it is imperative that we get physicians involved in advocating their members of Congress to request that Title VII be reinstated in the 2007 budget.

Get involved now. It is very important to contact your member of Congress to restore Title VII funding. There are two things you can do:

Visit the American Geriatrics Society (AGS) Website at **www.americangeriatrics.org/advocacy** to learn more about Title VII, and what they can do to restore funding to these vital geriatric programs.

AGS has also established a Webpage (**http://ga1.org/campaign/TitleVII**) with information on Title VII and a sample letter that may be edited and e-mailed directly from the Website to their representatives.

It is vital that Title VII funding be reinstated. Restoration of this funding will help ensure that there will still be training programs for health care workers that provide them with the skills needed to serve the elderly population.

If you have any questions, please feel free to contact Matt McBride at the AMDA office at **(410) 740-9743**, or **mmcbride@amda.com**.

Long-Term Care Physicians Experience Difficulties in Prescribing Selected Drugs for Patients in Medicare Part D

According to a June report from AMDA, physicians who care for frail elderly patients in long-term care settings are running into significant problems in obtaining appropriate medications for their patients since the implementation of the Medicare Prescription Drug Benefit. In some instances, these problems have resulted in patients getting ineffective medications, getting medications late, or not getting medications at all.

According to the survey of long-term care physicians,

• 70% of respondents indicated that they are frequently or very frequently having trouble obtaining drugs for their patients due to drug plan requirements for prior authorization for drugs that are on drug plans' formulary (approved list of drugs). These are drugs that are theoretically covered under the Medicare drug program, but in practice may not be available because of hurdles set up by drug plans.

• It is particularly difficult to obtain coverage for some drugs, such as those for patients with Alzheimer's disease. Over 23% indicated problems obtaining drugs for Alzheimer's disease, primarily because of requirements for prior authorization. There is potentially significant impact on nursing facility patients who might benefit from these medications, as more than 40% have dementia.

• 55% of respondents reported frequent or very frequent problems with requests for exceptions for drugs they feel their patients need that are not on drug plan formularies. Numerous physicians have reported that some drugs on the formularies are inappropriate for use in frail elderly patients, or are drugs that other CMS guidelines for long-term care facilities either recommend not be used or be used only with great caution.

Long-term care physicians also report other significant administrative problems that present obstacles to obtaining medically necessary drugs. Each drug plan is allowed to develop its own procedures for drug approvals, exceptions, and appeals, and physicians have to deal with many different drug plans for each nursing facility. Cumbersome administrative processes and requirements for personal telephone calls from physicians are the norm, and telephone waiting times of 25 to 45 minutes per call are common.

• 52% of respondents are spending more than 4 hours per week working with drug plans and pharmacies to obtain medically necessary medications for their patients. Of those, 13% reported spending 8 hours or more per week. Medicare does not compensate physicians for this additional time. One member noted, "I am

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spending a lot of time on prior authorizations, sometimes 14 a day, and some alternative drugs are the cheap ones which, cause harm. I have had patients on (the drugs I prescribe) for years and have already tried the viable alternatives." Another told us, "Many patients are being forced to change their medications, even after years of success." And another physician reports that "Almost anything non-generic has become a problem."

• The Centers for Medicare and Medicaid Services (CMS) has made some efforts to streamline Part D administration, and has recently asked drug plans to use a common form for exceptions. However, only 17.5% indicated that the majority of drug plans that covered their patients were using this common coverage determination form.

Typically each nursing facility patient resident today has six to 10 active medical problems and takes nine or more prescription drugs. Considerable care must be taken with any changes in drugs to minimize potential adverse outcomes. AMDA is very concerned that the impediments to medically appropriate medications that many of our members are now experiencing will result in increased adverse drug reactions, as well as an increase in adverse interactions between drugs and patients' other medical conditions.

According to AMDA President Steven Levenson, MD, CMD, "Although PDP concerns about cost and indications are understandable, clinical considerations (appropriateness, safety, and possible adverse consequences) must take precedence. While PDPs may look at individual drugs, the prudent LTC physician must consider each drug in the context of the entire regimen, including possible interactions and adverse consequences. In geriatric patients, a limited viewpoint often leads to serious complications that harm the patient and cost much more (in hospitalization, remedial interventions, etc.) than the amount that is saved initially."

"It is imperative that Medicare drug plan procedures and forms be standardized and dramatically streamlined," stated Lorraine Tarnove, AMDA executive director. "The many dedicated long-term care physicians cannot be expected to sustain the current level of effort required to try to persuade drug plans to approve the medications their patients need. Generally, our members recognize that drug plans can help many of their patients financially, but they consider the program's current procedures to be very problematic."

F Tag Updates from AMDA

Activities

According to CMS' training materials, the intent of the activities Tag is that this particular regulation mandates that the facility consider each resident's varying interests, so that the mere development of a program is not sufficient for compliance. A facility cannot just place residents into any available activities. Instead, the facility must individualize activities according to each resident's interests, in order to enhance well-being.

For various reasons including physical condition and cognitive losses, residents may be unable to pursue prior interests unless the facility makes efforts to provide adaptations or assistance. And, in order to enhance well-being, the facility should realize that residents can also develop new interests. For example, many older individuals have not worked with a computer, but more facilities are helping residents learn to use computers, making equipment available, and teaching residents about the Internet and e-mailing.

Psychosocial Outcomes

The purpose of the Psychosocial Outcome Severity Guide is to help surveyors determine the severity of psychosocial outcomes resulting from the identified noncompliance at a specific F tag. The guide is used to determine the severity of a deficiency in any regulatory grouping (e.g., quality of care, quality of life) that resulted in a negative psychosocial outcome. This guide is not intended to replace the current scope and severity grid. It is to be used in conjunction with the scope and severity grid to determine the severity of outcomes to each resident involved in a deficiency that has resulted in a psychosocial outcome.

Quality Assurance

The revised guidance for long-term care surveyors regarding Quality Assurance and Assessment (QAA) condenses Tags F520 and F521 into one tag. The revisions clarify the QAA committee functions, i.e., committee composition and frequency of meetings, identification of quality deficiencies, development of action plans, and implementation of action plans and correction of identified quality deficiencies. The investigative protocol explains the objectives and procedures surveyors will need for their investigation. The deficiency categorization provides severity guidance for the determination of the correct level of severity of outcome to residents from deficiencies found at Tag F520. The implementation date for all of these Tags was June 1, 2006. As with the last set of issuances, CMS is allowing time for surveyors to train for the new guidance before it is implemented. The CMS Web-link to locate the revisions is located at **www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage**.

AMDA Comments on Draft Nutritional Status Guidance

"It is heartening to see [the Nutritional Status] guidelines incorporate newer scientific evidence for the management of the devastating nutritional problems in long-term care residents," said AMDA in a letter praising draft revised Guidance to Surveyors of Long-Term Care Facilities for the current tag, F325 Nutritional Status.

"The document actually is so well constructed as to be both a useful guide for a QI process, as well as a fair instruction set for surveyors in approaching this problem," the association adds.

AMDA member George Taler, MD, CMD, served on the expert panel that drafted the guidance. Dr. Taler chaired the AMDA clinical practice guideline committee on "Altered Nutritional States," which was published in spring 2002.

Comments on the guidance were submitted in mid-May, and CMS expects to issue the final guidance in fall 2006.

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The guidance references **www.amda.com** as a Website resource and AMDA's Altered Nutritional Status Clinical Practice Guidelines for recommended interventions to improve nutritional status, assess nutritional risk, and prevent malnutrition. In their comments, AMDA stated their appreciation of the emphasis on the role of the treating physician and the medical director in compliance with the Tag. "We view this as a positive move by CMS, and we appreciate the recognition of the hard work of our physician members," said AMDA.

AMDA Supports AGS Joint Statement on End-of-Life Care

Earlier this year, AMDA officially endorsed an American Geriatrics Society joint position statement on the elements that constitute quality services for patients receiving end-of-life care. Titled Access to High Quality End-of-Life Care in Nursing Homes, the joint statement had been reviewed, and edits proposed, by a special AMDA work group comprised of physicians who practice in end-of-life care.

The joint statement expressed six specific positions:

1. Nursing homes have an obligation to provide high-quality end-of-life care to all residents;
2. Nursing homes may ensure that their residents receive high-quality end-of-life care by developing internal palliative care programs and/or by contracting with community hospice programs;
3. When nursing homes rely on community hospice programs, they should ensure that hospice is available to residents for whom it is appropriate;
4. When nursing homes choose to contract with community hospice programs, they should ensure that hospice agency services are tailored to meet the unique needs of patients who most often die with dementia and other chronic degenerative diseases;
5. Quality standards in nursing homes should emphasize the importance of providing access to high-quality palliative and end-of-life care; and
6. Existing payment systems should be modified to promote hospice access for appropriate residents.

Also endorsing Access to High Quality End-of-Life Care in Nursing Homes were the American Academy of Hospice and Palliative Medicine and the National Hospice and Palliative Care Organization.

To read the entire joint statement, visit the AMDA Website at **www.amda.com/library/governance/resolutions/hospice_access.htm**.

Your Help is Needed to Remove the SGR

AMDA and the American Medical Association needs your help to continue the effort to repeal the Sustainable Growth Rate (SGR) and enact legislation to ward off a physician payment cut in 2007. The SGR is the formula used to determine the annual Medicare budget through the previous year's gross domestic product, and it is what is responsible for the continued decline in Medicare reimbursement. If the SGR is not repealed, and legislation not enacted to prevent a payment cut, physician payment will be reduced 5% in 2007.

AMDA and the AMA ask you to contact your representatives in Congress and tell them how important it is that your reimbursement is not cut by 5%. Inform your members of Congress that reduced reimbursement will require you to scale back the services you provide to Medicare patients and that legislation is needed now that recognizes the Medicare Payment Advisory Commission's recommendation of a 2.8% payment increase for 2007. Remind them that the SGR is at fault for these annual Medicare payment reductions, and the only solution is to replace the SGR methodology with a formula that can reflect the increases in physician practice costs.

The AMA has a Website that assists patients with getting involved in protecting their access to Medicare services, **www.protectpatientsnow.org**.

For further information, contact Matt McBride in the AMDA Government Affairs Department at **(410) 992-3112**.

Safe Supervision Bill Signed into Law

On Tuesday, June 20, 2006, Gov. Jeb Bush signed HB 699, the Safe Supervision bill, into law. This bill, effective July 1, 2006, sets new standards for physician supervision of nurse practitioners and physicians assistants and does away with redundant CME requirements for physicians.

The bill limits the number of satellite offices that a physician can supervise: four (4) for primary care; two (2) for specialty care; and two (2), eventually phasing to one, for offices offering primarily dermatologic care, including those offices offering primarily aesthetic skin care services. It also limits who may supervise a satellite office offering primarily dermatologic care. Physicians who supervise a satellite office offering dermatologic care will now have to be board-eligible or board-certified dermatologists or plastic surgeons.

The bill requires that a physician who supervises any satellite offices must post in each of the offices a current schedule of the regular hours that the physician is present in that office, and the hours that the office is open when the physician is not present.

The bill exempts most supervised institutional settings, such as hospitals, rural health clinics, nursing homes, and medical student and resident training.

Safe Supervision Bill Revealed

Below is some information about the supervision portion of the bill:

The Bill Does NOT:

- § Change current law regarding who may supervise an ARNP or PA;
- § Change current law regarding what services an ARNP or PA may provide;
- § Change current law regarding who may perform hair removal;
- § Change current law regarding who may utilize a laser;
- § Change current law regarding who may perform dermatologic

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services, including aesthetic skin care services; and
§ Change current law regarding what services a physician may offer in his or her primary place of practice.

The Bill DOES:

§ Limit the number of offices providing ARNP or PA services that one MD or DO can supervise;
§ Limit who can supervise a satellite office providing primarily skin care services; and
§ Limit the distance a supervising physician can be from an office providing primarily skin care services.

This bill language is the result of an agreement between several organizations that represent doctors, nurses, and PAs and addresses primarily physicians who supervise ARNPs and PAs in medical offices other than the physician's primary practice location.

Web-based Measurement Tool for States Released

HHS's Agency for Healthcare Research and Quality (AHRQ) has released a new interactive Web-based tool for states with access to measures and tables of the National Health Quality Report (NHQR) from each state's perspective. It includes:

- State ranking tables on 15 representative measures of health care quality from 179 measures in the 2005 NHQR;
- Summary measures of quality of types of care (prevention, acute, chronic) and settings of care (hospital, ambulatory, nursing home, and home health);
- Comparisons of each state's summary measures relative to the region or nation;
- Performance meters that show state performance relative to the region or nation; and
- Data tables for each state's summary measures that show the NHQR detailed measures and numbers behind the performance meters.

Go to **www.qualitytools.ahrq.gov/quality report/2005/state** to view the Snapshot tool. The 2005 National Healthcare Quality Report and a 2005 National Healthcare Disparities Report are available online at **www.qualitytools.ahrq.gov**, by calling **(800) 358-9295**, or by e-mailing **ahrqpubs@ahrq.gov**.

AHRQ will partner with four states in 2006 to develop a complementary guide to the State Snapshot Web tool that will help states use the information from the tool for priority setting and quality improvement.

Legislative Happenings: Are These Annual Trends?

During the 2006 Florida Legislative Session multiple pieces of legislation relevant to the practice of medicine were defeated:

- Language in SJR 1918 that would have allowed the repeal of Amendment 3 from the Constitution, with transfer to statute. This would have allowed the measure to be challenged in court as unconstitutional. Voters overwhelmingly passed Amendment 3 in 2004 and thereby limited attorney contingency fees in medical liability cases. The result has been a significant stabilization of the medical liability insurance market.
- SB 2678, which would have provided for the licensure of naturopaths in Florida, was killed by a vote of 7-2 in the Senate Health Care Committee.
- HB 485, by Rep. Farkas, would have allowed ARNPs to prescribe controlled substances.
- SB 570 by Sen. Bennett included a proposal for pharmacists to administer flu shots to patients moved forward in the Senate but was stopped in the House.
- A proposal by Rep. Flores (HB 881) that would have allowed foreign-trained physicians to practice as physicians in Florida without completion of an ACGME residency was killed in the House Committee on Colleges and Universities.
- Proposals that would have made it more difficult for a physician to self-insure, SB 271 by Sen. Jones and HB 565 by Rep. Farkas, were never heard in committee.
- A well-intentioned anti-fraud measure that would have required most physician offices to become licensed and regulated as a clinic did not move forward.
- A proposal was defeated that would have required licensure for hearing interpreters, increasing the cost to physicians and decreasing their availability, making it even more difficult to comply with the ADA requirement to provide an interpreter.

What Passed:

- Gov. Jeb Bush signed the bill doing away with joint and several liability in Florida (HB 145/SB 2006). Passage of this bill was a joint effort between the FMA and the business community, and was strongly opposed by the trial bar.
- There was language passed in the budget bill that provides for the Department of Health to compile physician workforce data. This will help to provide necessary information for proponents of medical liability reform and is an important piece of artillery in the tort battle.

Changes to CME Requirements

On June 20, 2006, Gov. Bush signed HB 699 (Sen. Peaden and Rep. Negron) into law. It took effect on July 1. This article includes a summary of the portions of the bill regarding CME requirements.

The new law provides that physicians (MDs and DOs) will now only be required to complete one (1) credit in HIV/AIDS — this must be done prior to the first renewal of the license, but once the physician has taken one (1) credit, he or she does not ever have to take it again. Most Florida physicians have already met this requirement, and will not need to take the course again.

The new law provides that physicians (MDs and DOs) will now only be required to complete two (2) credits in domestic violence every third biennial renewal, beginning with renewals following July 1, 2006.

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The HIV/AIDs and domestic violence courses will no longer be required prior to initial licensure. For initial licensure, the only requirement will be two (2) credits in prevention of medical errors. The biennial requirement for prevention of medical errors also remains the same — MDs and DOs must complete two (2) credits during each two-year licensure cycle.

End-of-life and palliative care courses can no longer be used in lieu of the HIV/AIDS course or domestic violence course.

Below is a summary of Florida CME requirements for MDs only, effective July 1, 2006:

Initial licensure:
Two (2) credits in prevention of medical errors

First renewal:
One (1) credit in HIV/AIDS
Two (2) credits in prevention of medical errors

Every renewal thereafter:
40 credit hours of CME including two (2) credits in prevention of medical errors

In addition, every third renewal:
Two (2) credits in Domestic Violence.

MDs renewing on Jan. 31, 2007 will be required to complete two (2) credits of domestic violence before renewal in 2011.

MDs renewing on Jan. 31, 2008, will be required to complete two (2) credits of domestic violence before renewal in 2012.

New Law Passed Requiring Practitioners to Identify Their Licensure to Patients

HB 587 by Rep. Galvano was signed by the Gov. Bush on June 13 and took effect on July 1, 2006.

The new law requires that all licensees identify to patients the type of license under which they practice. This requirement can be met via a nametag (Nancy Smith, RN), in writing, or orally (I am Nancy Smith, a registered nurse).

Advertisements must also clearly identify the type of license the practitioner holds ("Thomas Jones, Optometrist" or "Thomas Jones, MD," instead of "Dr. Thomas Jones").

Information on Medicare Part B Electronic Remittance Advice

Electronic remittance advice (ERA) provides claims payment/denial information for automated posting to patient accounts. You can end manual posting, and free your office staff for more important tasks if your software vendor provides the ability to configure your system to automatically update your accounts receivable or patient billing system. Review your office processes and ask these questions:

• How much time does our office spend in manually posting information received on the hard copy Medicare Remittance Advice/Notice (MRA/MRN)?

• Could our office staff use this time more effectively?

If ERA/ERN could benefit you, contact your software support vendor for more information. Go to **www.floridamedicare.com/edi_getstarted_Electronic%20Data%20Request%20(EDR)%20Form.pdf** for additional information with application form and completion instructions.

CMS Announces Proposed Changes to Physician Fee Schedule Methodology

— Increased payments based on time spent with patients

CMS issued a notice proposing changes to the Medicare Physician Fee Schedule (MPFS) that will improve the accuracy of payments to physicians for the services they furnish to Medicare beneficiaries. The proposed notice includes substantial increases for "evaluation and management" services, that is, time and effort that physicians spend with patients in evaluating their condition, and advising and assisting them in managing their health. The changes reflect the recommendations of the Relative Value Update Committee (RUC) of the American Medical Association.

The notice appeared in the June 29 Federal Register. CMS responses to public comments on the proposals in this notice will be combined with those for the upcoming MPFS notice of proposed rulemaking in a final MPFS rule scheduled for publication this fall. If adopted, the RVU revisions in this proposed notice would be fully implemented for services to Medicare beneficiaries on or after Jan. 1, 2007, while the practice expense revisions would be phased in over a four-year period. To view the announcement, go to **www.cms.hhs.gov/apps/media/pressrelease.asp?Counter=1887**.

To view the display copy of the proposed notice (CMS-1512-PN), go to **www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?**

Medicare Standard Paper Remittance No Longer Mailed if You Have ERA

Effective June 1, 2006, the standard paper remittance (SPR) received through the mail is no longer available to providers/suppliers 45 days after being set up to receive the electronic remittance advice (ERA), whether the ERA is received directly or through a billing agent, clearing house, or other entity representing a provider/supplier.

In response to the provider/supplier communities continued need for SPRs, the Centers for Medicare & Medicaid Services (CMS) has developed free software called Medicare Remit Easy Print (MREP) that gives providers/suppliers a tool to read and print a remittance advice (RA) from the HIPAA compliant Health Care Claim Payment/Advice (835) file.

The MREP software was designed to incorporate new functionality to save providers/suppliers time and money. The paper output generated by MREP is similar to the SPR format. CMS has

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worked with other payers to ensure their acceptance of the SPR generated by the MREP software for coordination of benefit claims submission. Additionally, CMS has worked with clearinghouses to assure similar software is available to read and print an electronic remittance advice (ERA) for those providers/suppliers that utilize clearinghouse services. For further information regarding MREP software, please go to **www.florida medicare.comedi_get started_edepl.asp**.

New Medication Therapy Management Certification Program Developed

The American Society of Consultant Pharmacists (ASCP) and the American Pharmacists Association (APhA) will launch an educational tool to prepare pharmacists to deliver Medication Therapy Management (MTM) services. This ACPE*-accredited certificate program will debut in January 2007.

The Medication Therapy Management Certificate Program is designed to enhance pharmacists' knowledge and skills in working with medically-complex patients to identify and resolve medication therapy problems. Among American seniors, who take more medications than any other age group, the risks of medication-related problems are greatly magnified. Goals of the educational project are to improve public health through improved medication use, to provide the training necessary for community pharmacists to perform MTM for patients of all ages, and to motivate increased numbers of community pharmacists to establish MTM services in their practices.

Coursework will include self-study and live components. The content will include practical applications and case study; be applicable to working with patients in all age groups, but also include components tailored for working with senior patients; and provide guidance for practice implementation regardless of payer source.

You may visit ASCP's Website at **www.ascp.com**, or APhA's Website at **www.aphanet.org**. For more information, contact Marlene Bloom (ASCP) at **(703) 739-1316, ext. 136**.

*The Accreditation Council for Pharmacy Education (ACPE) is the national agency for the accreditation of professional degree programs in pharmacy and providers of continuing pharmacy education.

Medicare Physician Pay Cuts Deeper than Projected

The Medicare physician payment rule recently released predicts a payment cut of 5.1 percent for 2007, highlighting the need for Congress to fix the deeply flawed Medicare physician payment system.

"Seniors who rely on Medicare and the physicians who care for them are stuck wondering if 2007 will be the year access to care erodes as we wait for congressional action to stop the Medicare payment cuts," said AMA Board Chair Cecil B. Wilson, MD.

Dr. Wilson pointed out that Medicare has expanded the treatments it covers more than 90 times since 1999, yet under the current Medicare payment system physicians are penalized with lower payments per service the more care they provide. In fact, Medicare currently reimburses physicians about the same in 2006 as it did in 2001.

Without congressional intervention, Medicare physician payments will be slashed 37 percent over the next nine years, as practice costs increase 22 percent. Nearly half, 45 percent, of physicians tell the AMA the cuts will force them to either decrease or stop taking new Medicare patients. To keep providing high quality care to patients, Medicare must provide appropriate payments to the doctors who provide that care.

The new rule also imposes cuts on imaging services.

"As advances in imaging technology increase the ability to provide quality, targeted care, more patients and physicians rely on these services," said Dr. Wilson. "It is important to look not just to the increase in use of such services, but to their ability to provide patients with healthier outcomes, such as using CT scans and MRIs to pinpoint and stage various types of cancer. Medicare must differentiate between appropriate and inappropriate imaging use and tailor its policies so that appropriate use is not punished."

All physicians and medical students are encouraged to call their U.S. representative and senators about this critical issue. Tell them to take action before the October adjournment to stop the 5.1 percent cut in Medicare physician payments for 2007 and provide a positive update that reflects practice costs, as recommended by the Medicare Payment Advisory Commission. Explain that if Congress doesn't act, the cuts will reduce access to health care for America's seniors.

Call **(800) 833-6354** to be connected with your members of Congress.

Fraser to Chair Allied Health Professionals Relations Committee

FMDA President Carl Suchar, DO, CMD, is pleased to announce that Malcolm Fraser, MD, CMD, has been appointed to head the Allied Health Professionals Relations Committee. Members of this new FMDA group will comprise dental professionals, podiatrists, opticians, psychiatrists, psychologists, etc. The Committee's mission will be to improve dialogue among related health care practitioners and promote networking to enhance the quality of life of the patients and residents in the postacute care continuum.

Malcolm Fraser has been in private practice in St. Petersburg, Fla., since 1980. He is board-certified in family practice and geriatric medicine and is also a certified medical director. He continues to practice clinical medicine in St. Petersburg.

In 1990 he founded Bay Geriatrics/Synergy Health Solutions, which provides consultative services in postacute care. In 1999 he was appointed Florida regional medical director of Health Essentials of Louisville, KY, and sat on its medical advisory board. He also

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served as a corporate medical director for Beverly Enterprises from 1994 to 1996.

Fraser served as president of the Florida Medical Directors Association from 1994 to 1997, and as chairman of its board of directors from 1997 to 2001. Currently, he is chairman of FMDA's Industry Advisory Board.

As founding partner of Consortium Concepts of Akron, Ohio, Fraser has lectured extensively on different aspects of geriatrics including managed care, dementia and capacity, risk management, current trends, medical-legal aspects, and Medicare reimbursement. Most recently, he lectured at the 22nd Annual Review of Geriatric Medicine at Harvard Medical School in Boston.

Since 1992 he has represented the Florida Academy of Family Physicians on the Florida Medicare Carrier Advisory Committee. He has handled many practical situations involving physician reimbursement, and has served on numerous other committees involving both Medicare and legislative issues. He has written/contributed to numerous articles and projects about different aspects of geriatrics and postacute care.

"We are very pleased that Malcolm has decided to chair this important new committee," Suchar said. "His unique understanding of our profession and the postacute care environment makes him the perfect candidate. He has always been the consummate ambassador for FMDA," he added.

For more information concerning the Allied Health Professionals Relations Committee and its first planned meeting, please contact Ian Cordes, executive director, FMDA at **(561) 659-5581**, or via e-mail at **icordes@fmda.org**.

Consumer Reports Tackles Nursing Home Care

In the September 2006 issue of ***Consumer Reports*** there is an article on nursing homes. AMDA has issued a response to this article at **www.amda.com/news/releases/2006/090106.cfm**.

In anticipation of local media inquiries, AMDA has also put together some talking points at **www.amda.com/members/news/nursing_homes_talkingpoints.cfm**.

The ***Consumer Reports*** article can be found at **www.consumerreports.org/cro/health-fitness/nursing-home-guide/0608_nursing-home-guide.htm**.

Know Your Reporting Requirements for Civil Claims

Florida law requires physicians to report any claim or action for damages for personal injury alleged to have been caused by error, omission, or negligence in the performance of professional services as well as any claim relating to an alleged failure to obtain consent once the claim is closed, even if there was no payout of the claim. Most physicians' insurers take care of this reporting requirement for them.

If this has not been done on your behalf, you should send the closed claim report to the Florida Office of Insurance Regulation located at 200 East Gaines Street, Tallahassee, FL 32399, or call **(850) 413-3140**. It is a good idea to retain for your records proof that the report was filed.

Here are two statutes outlining this requirement

Liability statutes:

456.049. Health care practitioners; reports on professional liability claims and actions

Any practitioner of medicine licensed pursuant to the provisions of chapter 458, practitioner of osteopathic medicine licensed pursuant to the provisions of chapter 459, podiatric physician licensed pursuant to the provisions of chapter 461, or dentist licensed pursuant to the provisions of chapter 466 shall report to the Office of Insurance Regulation any claim or action for damages for personal injury alleged to have been caused by error, omission, or negligence in the performance of such licensee's professional services or based on a claimed performance of professional services without consent pursuant to s. 627.912

627.912. Professional liability claims and actions; reports by insurers and health care providers

(1) (a) Each self-insurer authorized under s. 627.357 and each commercial self-insurance fund authorized under s. 624.462, authorized insurer, surplus lines insurer, risk retention group, and joint underwriting association providing professional liability insurance to a practitioner of medicine licensed under chapter 458, to a practitioner of osteopathic medicine licensed under chapter 459, to a podiatric physician licensed under chapter 461, to a dentist licensed under chapter 466, to a hospital licensed under chapter 395, to a crisis stabilization unit licensed under part IV of chapter 394, to a health maintenance organization certificated under part I of chapter 641, to clinics included in chapter 390, or to an ambulatory surgical center as defined in s. 395.002, and each insurer providing professional liability insurance to a member of The Florida Bar shall report to the office any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of such insured's professional services or based on a claimed performance of professional services without consent, if the claim resulted in: 1.A final judgment in any amount. 2.A settlement in any amount. 3.A final disposition of a medical malpractice claim resulting in no indemnity payment on behalf of the insured.

(b) Each health care practitioner and health care facility listed in paragraph (a) must report any claim or action for damages as described in paragraph (a), if the claim is not otherwise required to be reported by an insurer or other insuring entity. Reports under this subsection shall be filed with the office no later than 30 days following the occurrence of any event listed in paragraph (a).

(2) The reports required by subsection (1) shall contain:

(a) The name, address, health care provider professional license number, and specialty coverage of the insured.

(b) The insured's policy number.

(c) The date of the occurrence which created the claim.

(d) The date the claim was reported to the insurer or self-insurer.

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(e) The name and address of the injured person. This information is confidential and exempt from the provisions of s. 119.07(1), and must not be disclosed by the office without the injured person's consent, except for disclosure by the office to the Department of Health. This information may be used by the office for purposes of identifying multiple or duplicate claims arising out of the same occurrence.

(f) The date of suit, if filed.

(g) The injured person's age and sex.

(h) The total number, names, and health care provider professional license numbers of all defendants involved in the claim.

(i) The date and amount of judgment or settlement, if any, including the itemization of the verdict.

(j) In the case of a settlement, such information as the office may require with regard to the injured person's incurred and anticipated medical expense, wage loss, and other expenses.

(k) The loss adjustment expense paid to defense counsel, and all other allocated loss adjustment expense paid.

(l) The date and reason for final disposition, if no judgment or settlement.

(m) A summary of the occurrence which created the claim, which shall include: 1.The name of the institution, if any, and the location within the institution at which the injury occurred. 2.The final diagnosis for which treatment was sought or rendered, including the patient's actual condition. 3.A description of the misdiagnosis made, if any, of the patient's actual condition. 4.The operation, diagnostic, or treatment procedure causing the injury. 5.A description of the principal injury giving rise to the claim. 6.The safety management steps that have been taken by the insured to make similar occurrences or injuries less likely in the future.

(n) Any other information required by the commission, by rule, to assist the office in its analysis and evaluation of the nature, causes, location, cost, and damages involved in professional liability cases.

(3) The office shall provide the Department of Health with electronic access to all information received under this section related to persons licensed under chapter 458, chapter 459, chapter 461, or chapter 466. The Department of Health shall review each report and determine whether any of the incidents that resulted in the claim potentially involved conduct by the licensee that is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply.

CMS Claim Form Being Revised

The claim form CMS-1500 (12/90) is being revised to accommodate the reporting of the National Provider Identifier (NPI) and will then be named CMS-1500 (08/05). The following timeline outlines the schedule for using the revised CMS-1500 claim form:

Oct. 1: Health plans, clearinghouses, and other information support vendors should be ready to handle and accept the revised CMS-1500 (08/05) claim form.

Oct. 1, 2006 - Jan. 31, 2007: Providers can use either the current CMS-1500 (12/90) version or the revised CMS-1500 (8/05) version of the claim form.

Feb. 1, 2007: The current CMS-1500 (12/90) version of the claim form is discontinued; only the revised CMS-1500 (08/05) form is to be used. All rebilling of claims should use the revised CMS-1500 (08/05) form from this date forward, even though earlier submissions may have been on the current CMS-1500 (12/90) claim form.

Hold Placed on Medicare Payments

Medicare will put a hold on Medicare payments for all claims (e.g., initial claims, adjustment claims, and Medicare Secondary Payer claims) for the last nine days of the Federal fiscal year, i.e., Sept. 22–30, 2006.

Providers need to be aware of these payment delays, which are mandated by section 5203 of the Deficit Reduction Act (DRA) of 2006. Accelerated payments using normal procedures will be considered. No interest will be accrued or paid, and no late penalty will be paid to an entity or individual for any delay in a payment by reason of this one-time hold on payments. All claims held as a result of this one-time policy that would have otherwise been paid on one of these nine days are supposed be paid on Oct. 2. This policy applies only to claims subject to payment. It does not apply to full denials and no-pay claims. It also does not apply to periodic interim payments, home health request for anticipated payments, cost reports settlements, and other non-claim payments. Additionally, Medicare contractors will continue to apply the 14-day electronic claim payment floor and the 29-day paper claim payment floor.

On a case-by-case basis, Medicare FIs, RHHIs, or carriers may make adjustments, after Oct. 1, for extenuating circumstances raised by a provider. Payments will not be staggered, and no advance payments during the nine-day hold will be allowed. CR5047 is the official instruction issued to your carrier regarding changes mentioned in this article. CR5047 may be found by going to **www.cms.hhs.gov/Transmittals/downloads/R944CP.pdf**. Please refer to your local carrier if you have questions about this issue.

Internet Prescribing for Patients is Prohibited

Many physicians know that the Florida Board of Medicine passed a rule in 2003 that prohibits Internet prescribing. But some don't realize that the rule doesn't just affect doctors who work for Internet pharmacies.

The rule requires a physician to complete a history and physical examination on a patient prior to prescribing any drug. The only exceptions are as follows: (1) true emergencies requiring immediate administration of medication, and (2) consults with another physician, or on-call or cross-coverage situations. Although newly available technology might allow a physician to access the patient's records via the Internet or communicate with patients via e-mail, the requirements of the Board of Medicine remain the same.

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FMA Files Court Challenge Against Board of Pharmacy

In mid-August, the Florida Medical Association filed a challenge at the Division of Administrative Hearings to block a rule proposed by the Board of Pharmacy that would allow a pharmacist to alter a prescription written by a physician. The rule would allow the pharmacist to change the drug prescribed without first consulting with the physician.

According to FMA, this is a serious threat to the safety of Florida patients and contravenes every tenet of good patient care. The FMA has spoken out against this rule since it was first proposed two years ago, and will continue to utilize all of its means to ensure that it does not go into effect. We will keep you informed as the case proceeds.

DOH Currently Auditing Disciplinary History and Medical Malpractice Claims Information

The Florida Department of Health is currently auditing the disciplinary history and medical malpractice claims information self-reported by physicians in their Practitioner Profiles against the data reported to the National Practitioner Data Bank.

Florida statutes require all profiled health care practitioners to update any change to their profile information within 15 days of an occurrence.

Any medical malpractice changes should be faxed to **(850) 487-3284**. If you have any questions regarding your online account/ user ID and password, or about updating your profile, you can contact a DOH licensure services specialist at **(850) 488-0595**, Ext. 3.

MANAGING PANDEMIC CONSIDERATIONS

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occurrence could damage local economies. The 2003 SARS outbreak in Toronto was responsible for about four dozen deaths in a population of 2.5 million, but it temporarily devastated the city's economy. Hotel vacancy rates rose to 70 percent after WHO issued a travel warning, and other tourism and convention businesses also suffered. Asians, thought by some to be SARS carriers, saw their businesses shunned, and thousands of the city's citizens were quarantined for 10-day periods.

And even hype brings its own collateral damage, irrespective of a disease's material impact. "How much of your workforce uses mass transit to get to work?" Keating says. "If you look at Toronto with SARS, there was a significant drop in how many people would use mass transit. You have areas of public assembly. If you're the Chicago Bears and you're asking people to come to a football game, or you just do business in a mall or a business park, people are going to be less likely to come to work. The physical configuration of your office space can make a difference. If you're working in a cubicles setting and there's a bird flu scare, people are going to be less likely to come to work."

In any epidemic, the most vulnerable organizations will be those with extensive international supply chains, those that rely on international travel, and those that expose workers to many potential carriers of the virus (retail outfits, for example). Organizations will need strategies to deal with high absenteeism, Keating says. "A lot of people think, 'We'll just have people work from home.' The reality is, if they're not already doing that today, they probably can't do it in an emergency."

Companies should also consider compliance requirements in any strategy related to staff disruption. Some regulations require separation of duties and careful security vetting for managers of sensitive functions. If a lot of key staff is taken out of the office, companies may be forced to suspend compliance in order to keep functioning. How long are you going to declare that the rules are set aside? How are you going to document what you're doing during the emergency? How are you going to document renormalization once the crisis is past?

I think we can all agree that communication is critical. Employees need to know what the plans are in case of a disaster, and they need to know before disaster strikes — otherwise the message will lack credibility. Managers should communicate these plans to executives and board members, too, and stay in touch with local and regional public health agencies, in order ensure that corporate disaster-recovery plans will work within the broader civic context.

Business continuity planners make careful estimates of the actual risk to their organizations and resign themselves to the fact that, if there is flu pandemic, much of what happens will be out of their control. Clearly a large percent of what's going on we may have little to no control over, so we should make sure we understand and plan for the small percent we might be able to control.

Some important Websites are:

www.hhs.gov/pandemicflu/plan/sup9.html

www.hhs.gov/pandemicflu/plan/pdf/S09.pdf

Robin Bleier is a clinical risk consultant for RB Health Partners, Inc. She is the 2nd Vice President of FADONA, chair of the FHCA Disaster Committee, a member of the Quality Foundation, and a member of the American Health Care Association Life Safety & Disaster Committee. She can be reached at **(727) 786-3032**, or **robinbleier@yahoo.com**.

Caring for Florida's Seniors

—Why does Florida need a "Senior Investment Strategy"?

The following proposal is endorsed by: AARP Florida, Alzheimer's Association-Florida Chapters, Clearinghouse on Human Services, Community Care for the Elderly Coalition, Florida Association of Area Agencies on Aging, Florida Association of Aging Services Providers, and Florida Council on Aging. This has not been evaluated by FMDA or its Board, however, your comments are welcome.

The elder population of Florida impacts Florida's state government profoundly. Florida's retirement industry generates more revenue than any other industry except tourism. Special needs, however, accompany Florida's elder population. Although the state has a capable aging service network, Florida can significantly improve the lives of its seniors and get "more bang for its buck" by adopting this Senior Investment Strategy.

In addition to separate advocacy initiatives for other programs and issues affecting seniors, such as mobility options, emergency preparedness, affordable housing, and others, the organizations listed below unite specifically to endorse and to promote the state's adoption of this Senior Investment Strategy.

What is the Senior Investment Strategy?

To offer seniors, including those on Medicaid, meaningful and unimpeded community CHOICES among:

- Non-profit and local government community-based providers;
- Programs for which they are eligible;
- Services within those programs; and
- Community-based long-term care.

How Does Florida Implement the Senior Investment Strategy?

- Enhance resources for the community-based long-term care, including nursing home diversion (NHD). Nursing home diversion is a voluntary managed care program that costs Florida less than nursing home care, yet meets the state's goal to provide long-term care in the least restrictive setting. Florida should expand this program and involve more non-profit and local government providers; it is a better investment than Florida Senior Care.
- Repeal Florida Senior Care (FSC). Florida Senior Care forces seniors into managed care plans, debilitates the non-profit aging network, and reduces local charitable contributions and volunteerism. Frail seniors should not be forced into for-profit HMOs to receive needed services.
- Require statewide and full implementation of aging resource centers (ARC). ARCs will establish for seniors a one-stop process to access all services under Florida's future aging service network. Services and care will flow to seniors with needs regardless of the door through which seniors first access the network.

Area Agencies on Aging have submitted ARC transition plans to DOEA. This investment strategy will require DOEA to have implementing rules in place. Even though the Legislature created ARCs in 2004, and despite the requirement within Florida statutes for agencies to enact rules within 180 days of the effective date of legislation, DOEA has not adopted the required implementing rules.

- Enhance resources committed to the Community Care for the Elderly (CCE), and Alzheimer's Disease Initiative (ADI) programs. These non-Medicaid programs divert frail elders from more expensive nursing home and hospital care. These programs have provided Florida and its seniors extraordinary value for the funds invested in them. CCE alone saves Florida nearly $500 million annually in nursing home costs. However, for the last six state fiscal years, the Legislature has not significantly increased funding for the CCE or ADI programs.

FACTS About Florida's Seniors

17% of Florida's population is 65+ (2.8 million persons)

- **Retirees spend $37 billion+ annually.**
- **20% of older Floridians live alone.**
- **8% of older Floridians have self-care limitations.**
- **7.9% of older Floridians live in poverty.**
- **10.3% of older Floridians live in rural areas.**

AARP Public Policy Institute Announces New Publications

The AARP Public Policy Institute is pleased to make available the following new publications on long-term care, economic security, and livable communities. Please use the links below to access the documents in PDF. Original copies of all are available by request, at e-mail: **ppi@aarp.org** or by telephone at the numbers listed below.

Pulling Together: Administrative and Budget Consolidation of State Long-Term Care Services (#2006–05, 27 pages) by Wendy Fox-Grage, Barbara Coleman, and Dann Milne. **www.aarp.org/research/longtermcare/programfunding/2006_05_state_ltc.html**. A two-page In Brief (INB #117) is also available at: **www.aarp.org/research/longtermcareprogramfunding/inb117_state_ltc.html**.

The delivery of publicly-funded long-term care services differs considerably from state to state. Currently, in most states, long-term care functions and operations are dispersed throughout state government. This often results in confusion for consumers as they try to deal with a variety of programs and procedures scattered throughout many different state agencies. To ease this process, many state officials are exploring several strategies, one of which includes the consolidation of long-term care programs, policies, and budgets within one state agency.

This paper examines the consolidated agency approach, describes how several states accomplished consolidation, and provides a checklist of steps toward consolidation for state policymakers considering a move toward such a model. For more information, contact Wendy Fox-Grage at **(202) 434-3867**.

Home Care Quality: Emerging State Strategies to Deliver Person-Centered Services (#2006–07, 32 pages), by Donna Folkemer, National Conference of State Legislatures, and Barbara Coleman. **www.aarp.org/research/health/carequality2006_07_hcc.html**. A two-page brief (INB #119) is also available at: **www.aarp.org/research/health/carequality/inb119_hcc.html**.

Millions of older Americans receive publicly-funded personal care services in their homes to help them with daily activities that they cannot carry out themselves. The heavy reliance on Medicaid to fund services for persons with disabilities has led federal and state governments to devote increased attention to the quality of care being provided. Yet, the public agencies funding these services often find it difficult to assess and monitor the home care provided in homes by numerous workers and family caregivers. The paper examines the efforts of three states (South Carolina, Washington, and Wisconsin) to improve home care quality by using a more person-centered approach. For more information, contact Enid Kassner at **(202) 434-3863**.

Public Funding and Support of Assistive Technologies for Persons with Disabilities (#2006-04, 72 pages) by Marc P. Freiman, AARP Public Policy Institute, and William C. Mann, Jessica Johnson, Shin-yi Lin, Catherine Locklear, University of Florida, Rehabilitation Engineering Research Center on Aging. **www.aarp.org/research/longtermcareprogramfunding/2006_04_assist.html**.

A two-page brief (INB #115) is also available at: **www.aarp.org/research/longtermcare/programfunding/inb115_assist.html**.

Government funding of the range of assistive technologies is a patchwork, the overall effect of which is incomplete and irregular. Medicare and Medicaid coverage is limited because these are health care programs that generally require substantiation of medical necessity, rather than an improvement in functioning, in order to fund assistive technologies. In addition to providing detail on Medicare and Medicaid coverage, this report also: presents coverage information for several other programs; discusses regulatory efforts; and takes a look at the degree to which private sector programs fill the gaps in government funding of assistive technologies. For more information, contact Marc Freiman at **(202) 434-3893**.

Ahead of the Curve: Emerging Trends and Practices in Family Caregiver Support (#2006-09, 55 pages) by Lynn Friss Feinberg, Kari Wolkwitz & Cara Goldstein, Family Garegiver Alliance. **www.aarp.org/research/longtermcare/resources/2006_09_caregiver.html**. A two-page brief (INB #120) is also available at: **www.aarp.org/research/longtermcare/resources/inb120_caregiver.html**.

Caregiver programs and supports are located in every state in the nation. Some of these programs and supportive services have been in existence for decades, but most are relatively new or are newly expanded, thanks in part to federal funding from the national Family Caregiver Support Program, enacted in 2000. This paper highlights three cutting-edge trends in supporting family caregivers: (1) assessment of caregivers' own needs; (2) consumer direction in family caregiver support services; and (3) collaborations on caregiving between the aging network and health care providers. For more information, call Wendy Fox-Grage at **(202) 434-3867**.

Income, Poverty, and Health Insurance in the United States in 2004 (Fact Sheet #123, 2 pages) by Ke Bin Wu. **www.aarp.org/research/assistance/lowincome/income_poverty.html**

Using data from the U.S. Census Bureau's Current Population Surveys, this series of fact sheets reports on the income, poverty, and health insurance status of Americans of all ages. For more information, call Ke Bin Wu at **(202) 434-3878**.

To view other AARP publications on topics of importance to midlife and older Americans, please visit their Web page at www.aarp.org/ppi. Copies of all publications are available by a request to e-mail: ppi@aarp.org, or by calling (202) 434-3840.

REAL DIALOGUE ABOUT DNRO DILEMMAS IN LTC
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In my own facility, when the appropriate decision is clear, I will write a DNR order to be used while the paperwork is completed. I choose to accept responsibility for this. I don't know how a survey team would view this if the question was called, but the other choice is inappropriate resuscitation for lack of paperwork.

3. *Kenneth Brummel-Smith, MD*

This is exactly the type of problem that led us on the Oregon (OR) State POLST Task Force to create the POLST and widely educate and disseminate its use to all OR nursing homes.

It has been estimated, based on sampling research, that 88% of nursing home residents in Oregon have a completed POLST form on their chart when they go to the hospital. I don't know if it's been studied what percentage return to the nursing home following an admission with a completed POLST (either the original, unchanged document or a newly completed form based upon clinical changes from the hospitalization), but I know a number of hospitals in Oregon have end-of-life quality improvement initiatives to ensure that the POLST forms are properly transmitted back to the nursing home.

4. *Bruce Robinson, MD*

I just thought of a simple solution to the hospital's complaint. If they would complete the yellow DNR form and send it with the patient, problem solved.

5. *Kenneth Brummel-Smith, MD*

Good point. That is the simplest, and presently only legal way, to ensure that an out-of-the-hospital, unwanted CPR intervention does not take place.

The other issue to consider from a NH "quality measurement" standpoint is how state surveyors look at deaths in the NH. Historically, a death in the NH was seen as a bad mark and a high mortality rate would be likely to be reported as a sign of poor quality. NH were known to transfer residents shortly before death (most CPR attempts in NH residents are unsuccessful with various studies reporting 0% to 3% survival rates) so the resident would most likely die in the hospital and the NH would not get a bad mark.

The whole issue of quality improvement in end-of-life care in NHs has gotten much more (and needed) attention lately in the literature. I don't know the status of Florida NHs and how they are using that literature to the best interests of their residents and the training of their staff. But if a nursing home is attempting to resuscitate patients who have expressed clear wishes they don't want that type of treatment, it says to me there's a significant training need that is unmet.

6. *Karen Goldsmith, JD*

Ken and Bruce raise good points. The problem as I see it regarding transfer from the hospital is that many times a person has a significant episode that brings them to the hospital and does not want to be resuscitated. Then the person gets better and is sent to the nursing home. The nursing home has concerns that are based on the changed condition the person may be reconsidering the DNR. Obviously, a properly filled out yellow DNR form is a good solution. But when there is none, each case has to be considered separately, on its facts.

Dr. Robinson's approach is well thought out and appropriate in my opinion. The bottom line is that the nursing home has the responsibility of determining what the resident's wishes for resuscitation are and should do that as quickly as possible. The yellow form is a legal presumption that the person would not want to be resuscitated so can usually be relied upon, absent other information saying the person changed his mind. Anything else must be reviewed and a decision made at the facility as to the resident's wishes. Wish there was a simple answer. This certainly is something that we could have a lively discussion on.

7. *Suyrea Reynolds, NHA*

I sure do appreciate your thoughts on this subject. The SNFs in this area tell me that the yellow DNR is not all that they need (should the hospital send one. . . which is unlikely). They say the attending physician in the SNF must personally discuss DNR with the resident/family, write a progress note to that effect, and write a DNR order. If the yellow form truly would suffice, I can encourage our team members to make that happen.

As for the yellow form traveling back and forth with the resident to and from the hospital: The hospital does not return the yellow form or advance directive documentation to the nursing home, so the nursing home hesitates to send the original. The hospital will sometimes note the existence of advance directives or DNR on the 3008 (that is another can of worms), but does not send the written documentation.

We hear that this is a problem in many other communities. Thanks for helping us to work our way through this concern.

8. *Bruce Robinson, MD*

There are few physicians who would not issue a DNR order by telephone if a properly completed yellow DNR form was in place. I can support individual discussions, but could not accept delays causing improper care to residents due to same.

I would believe that state law would not recognize the ability of a provider to ignore a properly completed yellow DNR form. I seem to recall something about needing to transfer a patient if a facility is unable to accept such a form. If the nursing home does not agree to accept a properly completed yellow DNR form (with associated incapable and end-stage/terminal forms for proxy signatures) presented by a patient/family, then it is their responsibility to complete whatever internal process they find necessary in a timely fashion, and to take responsibility when they fail to do so. I would complete and send your yellow forms and see how that works out. I would think it will work more often than not.

There are a lot of homes with a lot of individual approaches to such things. Facilities try to err on the side of life, but there is a need for balance.

9. *Karen Goldsmith, JD*

A copy on yellow paper should be honored as well as an original. I disagree that the nursing homes always need something more, although I do encourage them to get a physician's order in the chart as well. However, this is because if you have an order in the place where a nurse expects to find a doctor's order, that is an additional safeguard for the resident's wishes being carried out. If the yellow uniform DNR order is properly completed, it should be honored. Since it requires a finding of a person being at life's end, it is evidence of that person's wishes.

If the person's condition changes such that he is no long terminal, ESC, or PVS, then additional discussion is in order. But those situations should be rare. There is no formula for every situation. We just need to do our best to carry out the person's wishes, and

have a good system for doing that.

10. *Kenneth Brummel-Smith, MD*

Here's the actual text of FL statute 401.45 pertaining to the use of the yellow form:

(3)(a) Resuscitation may be withheld or withdrawn from a patient by an emergency medical technician or paramedic if evidence of an order not to resuscitate by the patient's physician is presented to the emergency medical technician or paramedic. An order not to resuscitate, to be valid, must be on the form adopted by rule of the department. The form must be signed by the patient's physician and by the patient or, if the patient is incapacitated, the patient's health care surrogate or proxy as provided in chapter 765, court-appointed guardian as provided in chapter 744, or attorney in fact under a durable power of attorney as provided in chapter 709. The court-appointed guardian or attorney in fact must have been delegated authority to make health care decisions on behalf of the patient.

(b) Any licensee, physician, medical director, or emergency medical technician or paramedic who acts under the direction of a medical director is not subject to criminal prosecution or civil liability, and has not engaged in negligent or unprofessional conduct, as a result of the withholding or withdrawal of resuscitation from a patient pursuant to this subsection and rules adopted by the department.

— Since most CPR in NH is provided by EMTs, it certainly applies to the NH. Section 3b ensures that physicians are released from liability if they follow a properly executed yellow form. I would counsel your medical directors to educate your attending physicians and make sure your facility's policies cover these issues.

11. *Suyrea Reynolds, NHA*

At issue is whether or not to call 911. If the SNF's nurse finds a resident not breathing, does she or doesn't she call 911 and start CPR? Are you saying that 911 should be called and the yellow form be given to the EMT who then stops CPR (as the SNF will start CPR concurrent with the call to 911)?

In the most recent example, a resident was found not breathing. The yellow form was present, the SNF physician had yet to visit his new admission so there was nothing by the physician in the chart, 911 was called, the yellow form was presented to the EMT, and the patient was transferred to the emergency department at the hospital, where he expired.

The SNF told the hospital staff that since the SNF physician had not written a DNRO nor a progress note re: the discussion with the patient/family, they had no choice but to call 911. It is unclear why, when the EMT was given the yellow form, he/they continued CPR.

12. *Howard Tuch, MD, CMD*

Here is what I usually say to facilities:

1. A properly executed yellow DNR form, when present, is all that is required to withhold CPR in the event of an arrest. It is always wise to complete the form. When a surrogate/proxy signs the form it must be accompanied by certifications of lack of capacity and a qualifying condition (end-stage, terminal, or PVS). This requirement was a bit of an accident. . . the yellow form refers to the surrogacy statutes that require the certifications). A capacitated resident has the right to a DNR even if not determined to be terminally ill.

2. The yellow form was specifically designed to be portable! When present it is all that is required and facility policy, which may and probably should insist on further discussion and documentation, may not insist on CPR in the presence of a completed from despite the absence of this discussion and documentation.

3. The yellow form is only a requirement for EMS and only necessary when EMS is called. This was primarily to protect and clarify the EMS position. However, in the absence of the yellow form there is nothing in statute that prohibits a physician order in the facility medical record for DNR and have it honored. This should be accompanied by proper documentation of an informed decision by resident or surrogate/proxy. A phone order is acceptable if followed by a written order within a reasonable time frame.

Again, this is only a problem if EMS is called. There is no requirement for a certification of terminal illness even when the surrogate makes the DNR decision except when the yellow form is used. A resident can come from the hospital with a DNR order and the NH attending can confirm it as part of the admission orders even without the certifications in place.

This last position may pose some liability risk and I would confirm the order with resident/surrogate, but I would still feel comfortable writing it. Given time, I would also get the yellow form and other certifications in the chart.

13. *LuMarie Polivka-West, MS*

I think we need to develop a joint statement for FHCA, FMDA, and FADONA. Dr. Tuch and I had a similar discussion with the Agency for Health Care Administration a few years back with an informal dispute resolution hearing. Someone from the Agency was involved in that discussion around the responsibility of a nurse to initiate CPR on a nursing home resident whom the nurse determined was dead and there was no DNR or yellow form.

The amazing outcome of all of that was the determination that in Florida statutes, there is no assignment of determining death, except with a medical examiner. So there is no provision in statute or regulation that a nurse may decide that a person "is dead."

Yes, common sense should rule but timing is very important and we know how our documentation in nursing homes may not always reflect reality. I raise this issue at this time because at least the yellow form is a piece of evidence that the resident/patient has participated in a decision-making process not to be resuscitated. But this is a good time to bring all the associations together and develop a statement of concord on the DNR.

14. *Suyrea Reynolds, NHA*

At issue here are patients who have been in acute care forever and we are finally able to discharge them. They leave here with a yellow form and are admitted to the SNF. Within a short time, they are in the emergency department (ED). There have been three such patients in the last month. As the patient is well known to the team members at the hospital, it is noticed when they return to the ED.

The SNFs tell me that they are terrified of doing the wrong thing, so they err on the side of life. FHCA/AHCA detailed guidance is what they tell me is necessary before they will honor the yellow form when the DNRO and progress note are not in the chart.

Yes, I am sure that you wonder if the patient was safely discharged. Most often, it is a patient who has gone back and forth (hospital to SNF) many times, often to different SNFs. The SNF of origin has requested that the family choose another facility generally because the family is difficult to please. The new SNF is aware of the history, so is extremely cautious. Perhaps it is a sign of the times.

Insurance Carriers Should be Prevented From Denying Liability Insurance Coverage to Physicians in Long-Term Care

The following position statement was issued by FMDA and entered into the record during public hearings:

The Florida Medical Directors Association, otherwise known as FMDA, represents the many hundreds of dedicated Florida physicians statewide who treat patients in nursing homes and who also serve as medical directors for those facilities. We wish to highlight the following challenge, which directly impacts the quality of care in Florida's nursing homes.

Problem:

Professional liability carriers in Florida are denying medical malpractice coverage to physicians solely because they provide medical services in nursing homes.

Background:

- More than 70 percent of nursing home residents in Florida are Medicaid beneficiaries.
- Federal and state regulations require every nursing home to have a medical director to manage the administrative duties as well as attending physicians to provide the medical care and oversight.
- Professional liability insurance is a requirement for physicians to practice in this state. In addition, nursing homes require that their physicians carry liability insurance.
- Why are insurance carriers in Florida allowed to discourage well-qualified physicians from caring for Medicaid residents in Florida's nursing homes by denying them coverage?
- As this problem deepens, there will be fewer physicians taking care of a complex and very vulnerable group of patients. . . our frail seniors. This is already an underserved population.
- If the legislature continues to allow this to happen, there will be more expensive emergency room visits, more costly hospitalizations, along with an increase in morbidity and mortality.
- In addition, there will be fewer opportunities to train and mentor physician extenders as well as students and residents in the field of geriatrics. This specialty is desperately needed in the U.S., and in Florida in particular, where our current proportion of elderly is where it is believed the rest of the country will be in 2030.

Solution:

Introduce legislation restricting Florida licensed professional liability carriers from denying coverage to physicians solely because they provide medical services in the long-term care setting. This will open up more opportunities for qualified physicians to support the industry's efforts and our mission — to improve the quality of care and quality of life of our patients.

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