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fmda™

Dedicated To Florida Long Term Care Medicine

Progress Report

WINNER 2010 APEX AWARDS FOR PUBLICATION EXCELLENCE

Serving Physicians, Nurse Practitioners, and Physician Assistants Practicing in Florida's Long-Term Care Continuum

President's Letter

The CME/Education Committee, which plans our annual conference, has been extremely busy putting together another outstanding program. I salute Dr. Symeonides, the program director, and Dr. Rhonda Randall, who chairs the Committee, and all the Committee members who worked so diligently throughout the year.

For complete conference information, including a registration form, please see pages 13-16, of this issue. As you can see, there are some excellent educational programs, not to mention a number of exciting sessions on the pre-conference day on Thursday.

In addition, we invite spouses and guests of our attendees to gather and enjoy some of the best entertainment and theme parks in the world. For more information, see page 15.

FMDA hosted a highly successful Town Meeting in Safety Harbor in July. With nearly 70 local physicians, nurse practitioners, and administrators in attendance, we were accompanied by eight vendors who supported us by exhibiting at the event (see page 8).

The day prior to the Town Meeting, we held a strategic planning session. This gave us an opportunity to reflect on FMDA's past, future, and potential to grow in size and in capabilities as an organization — to benefit its members.

Dr. Randall did an outstanding job as the facilitator, and I also want to thank our chairman, Dr. Carl Suchar, for taking such an active lead in ensuring the success of this important meeting. To read an overview of the meeting's results, please refer to the article on page 6.

One of the issues that surfaced was the need to consider establishing a formal leadership training program. By doing so, FMDA would seek to increase the number of members who are ready to assume leadership positions in the association. The ultimate goal would be to enhance leadership capability and the capacity to facilitate the organization's growth. This would also create a pipeline for future leaders. Doesn't this sound interesting to you?

We invite you to read the article from attorney Starlett Miller on page 20. It's about AEDs, DNRs and medical directors. Let me know what your thoughts are on this, as it relates to the effort to enact POLST (physician orders for life sustaining treatments) legislation here in Florida.

While some practitioners in Florida may be ambivalent to POLST, it has been reported that some people are also opposed to the current advance directives and living wills. This may be due to the perception that they perpetuate inefficiency and confusion for the public and health-care personnel. They also have been known to present confusion and unclear specificity as to decisions made by patients in complicated medical conditions and when those health conditions change. Whether patients make concessions for specific treatments in specific circumstances or not, physicians know when most patients have a good prognosis, and therefore may hesitate to follow patients' advance directives if withholding treatment will cause them harm. They do not want to withhold treatment and cause death when this patient may survive and lead a productive and normal life.

On another matter, I urge you to find the time to read AMDA's response to the DEA for CSA revisions that would accommodate our patients who require controlled substances in nursing homes (see page 12). FMDA was a supporting organization for AMDA's comprehensive review and analysis of the challenges we currently face in this area.

We've introduced a new "Ambassador" program that connects FMDA members with first-time attendees in order to enhance their conference experience. If you've already volunteered, you will be receiving some correspondence soon. If you have not signed up yet, please consider volunteering now by calling the business office (see page 7). Let's share some of our southern hospitality.

With the help and guidance of the membership chair, Dr. Carl Suchar, who is also the chairman of the board, we introduced a new way to reach out to our peers. For more details, please see the "Buddy" article on page 10. I am certain that, with an **Apple iPad** as grand prize for the most new-member referrals, we will all have a great time and a lot of competition.

I continue to be very grateful for the fine stewardship provided by our dedicated officers, directors, and staff. It is through their efforts that we push forward to maintain and improve the level of services to our members.

I look forward to seeing you in person at the "Best Care Practices in the Geriatrics Continuum 2010" conference in Orlando, Oct. 28-31, 2010.

Sincerely yours,

Hugh W. Thomas, DO, FAAFP, CMD
President

BCP: Another Outstanding Educational Program

— Register today for 'Best Care Practices in the Geriatrics Continuum 2010'

Dear Friends:

Here is an update on our 19th Annual Conference, "Best Care Practices in the Geriatrics Continuum 2010," to be held on Oct. 28-31, in Orlando.

The educational program is designed to provide a review and update of major geriatric diseases, as well as illnesses and risks found in nursing home patients, residents of assisted living facilities, and seniors living at home. Topics will include a wide range of clinical and administrative talks, including an annual forum with national leaders, including American Medical Directors Association President-elect Karen Leible, MD, CMD; American Society of Consultant Pharmacists President Shelly Spiro, RPh; and American Geriatrics Society Chairman of the Board Cheryl Phillips, MD, CMD.

AMDA will be providing an "optional" advanced Clinical Practice Guidelines (CPG) intensive on diabetes on Thursday, Oct. 28, a preconference day.

Best Care Practices 2010 will host the bi-annual program "Basic Training for New Health Care Practitioners & Those New to Long-Term Care" on its pre-conference day, Thursday, October 28. It will feature such experts as Alejandro Jaen-Vinuales, MD, James A. Haley Veterans Administration Medical Center; Martha Little, PharmD, past chair of FL-ASCP and member of the board of directors of the American Society of Consultant Pharmacists; Cathy Ates, RNC, CDONA/LTC, president of Parthenon Healthcare and immediate past-president of Florida Association Directors of Nursing Administration/LTC; Jo Ann Fisher, FNP-BC, clinical coordinator of Osler Geriatrics and president of the FL Chapter of Gerontological Advance Practice Nurses Association; and Denise Baultrip Cuyjet, president of the Florida Health Care Social Workers Association.

This conference is designed to educate physicians, physician assistants, nurse practitioners, directors of nursing in LTC, registered nurses, senior-care pharmacists, consultant pharmacists, and long-term-care 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.

YOUR GUESTS: Your traveling companions will not be bored. Epcot will be hosting its **International Food & Wine Festival** while you are there. In addition, there is no better place than Orlando to spend Halloween. Universal Studios Orlando is hosting its **Annual Halloween Horror Nights** (**www.halloweenhorror_nights.com/ for more information**). Plus there's the **Halloween Spooktacular** at SeaWorld Orlando. And, if that isn't enough, there's also **Mickey's "Not So Scary Halloween Party for Halloween 2010"** at *Disney's* Magic Kingdom. In addition, my wife, Stacey, has graciously offered to coordinate some of these group outings.

HOTEL RESERVATIONS: This year's conference will be held at the beautiful **Walt Disney World Swan and Dolphin,** 1500 Epcot Resorts Blvd., Lake Buena Vista, FL 32830. Visit the website at **www.Swandolphin.com**/ and see all they have to offer our attendees.

The special group rate is only **$175** single/double occupancy plus a discounted resort fee of **$10 per day**, and **$9 for self-parking** and **$14 for valet parking** per day. To make a reservation, please call **(800) 227-1500** and mention that you are attending the "Florida Medical Directors Association" or "Best Care Practices in the Geriatrics Continuum" conference, or you may also reserve a room online at **www.bestcarepractices.org/venue.html**. To guarantee rate and room availability, you should 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.

Yours truly,

John Symeonides, MD, CMD; Program Director
Best Care Practices in the Geriatrics Continuum 2010

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Front Cover

The beautiful artwork on the front cover is titled "Lighthouse Keepers Home" and was painted by Bruce Landers, a 58-year-old resident at Park Meadows Health and Rehabilitation Center in Gainesville. The artwork was featured in Florida Health Care Association's "Art From the Heart" calendar.

Landers, a quadriplegic, is paralyzed from his chest down, has only half the function of his arms, and has no hand or finger function.

Lander's artwork is a wooden jigsaw puzzle. He painted it, put the jigsaw puzzle back together and glued it on a cardboard backing. He painted this at the VA hospital while bed-ridden and used a hand adaptation on his hand to hold the paint brush.

Park Meadows is a 154-bed skilled-nursing facility managed by Greystone Healthcare Management and is a member of FHCA.

Drs. Pandya and Levy Cherish Their Experiences as Fulbright Scholars in Slovakia

In the waning days of the summer of 2009, Leonard Levy, DPM, MPH, and Naushira Pandya, MD, CMD, traveled to Slovakia to serve as Fulbright senior specialist scholars at Comenius University Faculty of Medicine in Bratislava.

During their Slovakia sojourn, Dr. Levy, professor and associate dean of education, planning, and research, and Dr. Pandya, professor and chair of the Department of Geriatrics, of Nova Southeastern University, had an opportunity to develop collaborative relationships with the medical school in Bratislava to benefit both Comenius University and Nova Southeastern University. Drs. Levy and Pandya are the first NSU-COM faculty members to be named Fulbright specialist scholars.

Dr. Pandya (left) with medical students in Slovakia

Drs. Levy and Pandya are two of more than 400 U.S. faculty and professionals who traveled abroad in 2009 through the Fulbright Specialists Program, which is sponsored by the U.S. Department of State's Bureau of Educational and Cultural Affairs. The Fulbright Specialists Program, created in 2000 to complement the traditional Fulbright Scholar Program, promotes linkages between U.S. academics and professionals and their counterparts at universities abroad. The program is designed to award grants to qualified U.S. faculty and professionals, in select disciplines, to engage in short-term collaborative two- to six-week projects at higher-education institutions in more than 100 countries. International travel costs and an honorarium are funded by the U.S. Department of State Bureau of Educational and Cultural Affairs, while participating host universities cover grantee in-country expenses or provide in-kind services.

Working in Slovakia, a relatively poor nation with a population of about five million people, would prove to be quite an enlightening experience for the two Fulbright specialist scholars. Drs. Levy and Pandya became acquainted with Slovakia's universal health-care system as well as its rigorous system of medical and postgraduate education, and learned about the shockingly low pay — about $18,000 annually — that physicians receive in the government-run system.

Participating in the Fulbright field of interest titled Public/Global Health, they worked independently at Comenius University, although there were several opportunities for them to work together during their stay in Slovakia. "My work there was, of course, focused on geriatrics," said Dr. Pandya, who had an opportunity to attend a reception at the American Embassy in Slovakia, present numerous lectures, and gain valuable exposure to the Slovak eldercare system. "Slovakia actually has a very old tradition in geriatrics that stretches back many years."

Working closely with Daniela Ostatnikova, MD, PhD, vice dean for international relations at Comenius University Faculty of Medicine, Dr. Pandya was put in contact with numerous geriatrics experts, including Vladimir Krcmery, MD, PhD, DrSc, who heads the geriatrics department at a private hospital affiliated with Comenius University that is operated by an order of monks. In addition to providing lectures to the medical students and residents at the hospital, Dr. Pandya was invited to the annual Slovak international geriatrics conference in Tale, where she interacted with many Slovak and international geriatricians and presented a lecture on "Water and Mineral Disorders in the Elderly."

During her time in Slovakia, Dr. Pandya also had a chance to visit many facilities, including several public and private nursing homes as well as the largest hospital system, called Kramare, where she provided informative lectures to medical and speech pathology students as well as residents. What she learned from these experiences was that, despite their cultural differences, the Slovak geriatricians shared quite a bit of commonality with their U.S. counterparts. "I was impressed by the great knowledge and humility of the professors I worked with," said Dr. Pandya, who made brief side trips to Budapest, Hungary, and Prague, Czech Republic. "It was very valuable for me to connect with geriatricians from several countries, and it was reassuring to know we all have the same passionate feelings about geriatrics."

Although Dr. Pandya found their general approaches to geriatric care to be similar, she says she was quite impressed with the lack of clutter and the efficient way patient care was handled in the Slovak facilities she visited. "They actually have a very practical approach to caring for patients," she explained. "I thought the layout of their nursing homes was more conducive to maintaining patient mobility than those in the United States. For example, armchairs were arranged in the corridors so patients could always have a place to sit. As a result, the older patients were much more mobile and much less reliant on wheelchairs. In addition, although the medical personnel had access to the same type of scans and MRIs we have in the United States, they seemed to order them more judiciously and rely heavily on their clinical judgment.

"What really struck me when I toured the various hospitals and nursing homes was how thin the patients' charts were," she added. "There was less outside information, and fewer tests were ordered. I was also surprised to learn that the geriatric fellows in Slovakia stay overnight at the nursing homes, which is something you would never see here. At Kramare Hospital, the doctors' offices and on-call rooms are located in the same ward as the patient rooms, and every doctor's office has a bed. Generally, physicians are assigned nine patients and care for more when they are on call. In contrast, our residents and attending physicians in the United States usually care for 20 to 30 patients at a given time."

As she reflects on her time spent serving as a Fulbright senior specialist scholar, Dr. Pandya is grateful for the opportunity to foster future alliances that have the potential to benefit both universities. "It was a great opportunity to collaborate on interesting projects with my peers in Slovakia," Dr. Pandya stated. "I came away from the experience feeling I had really made a number of good friends. My hope is that we keep a connection going for many years to come."

Stand Up and be Counted

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; offer advice about our information technology needs, 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 volunteer opportunities interest you.

We look forward to your participation in FMDA. Should you have any questions, please contact **Dr. Hugh Thomas**, president (**hwthomas2000@aol.com**), or **Ian Cordes**, executive director, at **(561) 659-5581** or **ian.cordes@fmda.org**.

FMDA Convenes Strategic Planning Meeting

By Matthew Reese, BS; Educational Programming Coordinator, FMDA

On July 16, 2010, FMDA board members met at the Safety Harbor Resort & Spa in Safety Harbor to host its first-ever Strategic Planning Meeting. Dr. Rhonda Randall, FMDA Education/CME committee chair, served as the meeting facilitator. Goals of the meeting were to review the association's organizational values, to fine-tune its mission, and to develop a vision statement that will guide us through the next four years. Put simply, this meeting was a way to determine what our organization intends to do and how we intend to do it.

Dr. Rhonda Randall makes a presentation during the strategic planning meeting.

A mission statement clarifies the fundamental purpose of an organization. Why does FMDA exist, and what are we doing to reach our vision? There was a group consensus that our current mission statement did not fully describe FMDA's core competencies and our identity as an organization. The most important aspect of our organization is making sure that vulnerable people get the highest quality of care. As a result, a new mission statement was developed:

The mission of FMDA is to promote the highest quality care as patients move through the long-term-care continuum. FMDA is dedicated to providing leadership, professional education, and advocacy for the inter-professional team.

More than our previous one, this mission statement encompasses a broader spectrum of care and cohesiveness throughout the continuum of long-term care. By taking a more global view of health care, FMDA can be more entrenched within the senior-care continuum, and have greater collaboration with related groups.

In discussing the broader aspects of the mission statement, Dr. Randall reiterated, "It is important to focus on inter-professionalism and collaboration with our fellow health-care practitioners so that we can provide the highest quality of care for our patients."

From left to right: Dr. John Symeonides, Dr. Steven Selznick, and Dr. Hugh Thomas

Next, the board focused on coining the association's vision statement, which describes its objectives. It is a long-term view of our organization over the next four to 10 years. Features of an effective vision statement include clarity/lack of ambiguity, vivid clear picture, description of bright future, memorable and engaging wording, realistic aspirations, and alignment with organizational values and cultures. With these features in mind, FMDA leadership came up with a vision that accurately describes where FMDA desires to go as an association.

The first sentence of the vision statement makes clear that FMDA is not just a membership society for medical directors but is an association that welcomes any health-care practitioner with an interest in long-term care and geriatrics. A major goal in becoming a model organization is having quality collaborations with other related groups so that individuals are aware of FMDA and what we provide to our members.

"We want FMDA to be a valued resource for health care providers for years to come," added Dr. Carl Suchar, chairman of the board, "When a health-care professional needs advocacy or is looking for quality continuing education, we would like FMDA to be at the forefront."

The Florida Medical Directors Association will reach out to all long-term-care professionals through dissemination of information and access to resources. FMDA will become the premier organization for providing leadership and education for best care practices, evidence-based medicine, regulatory compliance and practice management. FMDA's goal is to become a model organization that collaborates with related organizations and promotes the highest quality of care to patients in the long-term care continuum.

Current successes, weaknesses, opportunities, and threats that face the organization were discussed during the next stage of planning. Known as a SWOT analysis, this vital tool determines potential objectives and goals for the organization. Some concerns fell under Medicare and reimbursement issues and how they will affect physicians in the near future. Health-care reform is also an unknown, as it doesn't truly kick in until 2014. MDS 3.0 remains a hot topic. FMDA must look at future funding sources for our annual Best Care Practices meeting, whether those sources come as product theaters or opportunities for CME online. The boom in ALFs — as opposed to nursing homes — will be a major factor in our future, as ALFs have no medical director. Our members must be educated about care in ALFs, and learn ways to protect themselves from potential lawsuits.

FMDA membership is a great measuring tool of our success as an organization. By boosting membership, we increase the reach of the association, thus creating more opportunities for our members.

The president of FMDA, Dr. Hugh Thomas, was adamant: "FMDA must remain proactive and focus on new and advanced

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A Thorough Evaluation of Weight Loss and Malnutrition in the LTC Setting Must Include an Interdisciplinary Approach

Clinical Pearls

By Jan Cripanuk, ARNP, BC; Jennifer Hawkins ARNP, BC; and Jill Banister, ARNP, BC

Weight loss and malnutrition are common problems in the long-term care (LTC) setting. DiMaria-Ghalili & Amella (as cited in White & Truax, 2007) estimate that 40-85% of residents in LTC facilities are malnourished. This issue leads to numerous complications and increased mortality. Prompt recognition of residents at risk and the implementation of interventions targeting weight loss and malnutrition are essential to promoting the health of our residents. According to the American Geriatrics Society (2009), malnutrition in the LTC setting is defined as a weight loss of 5% of total body mass in the past 30 days or 10% in the past 180 days, or a dietary intake of < 75% of most meals. Residents meeting this definition are at risk and require a thorough and timely interdisciplinary evaluation. The interdisciplinary team consists of the physician/nurse practitioner (NP)/physician assistant (PA); dietitian; speech/occupational/physical therapist; and social worker.

Jill Banister (from left), Jan Cripanuk, and Jennifer Hawkins are nurse practitioners at MorseLife in West Palm Beach.

The physician/NP/PA completes the medical evaluation. This evaluation includes a medical history, physical examination (PE), medication review, and blood work. The medical history focuses on acute and chronic conditions and co-morbidities that may be contributing to the weight loss. The PE includes all major organ systems, specifically targeting the skin, oral, neurological, and gastrointestinal systems, as well as an assessment of psychological issues, visual impairment, and hearing losses. The purpose of the medication review is to identify medications that can cause a decrease in appetite, such as nutritional supplements, anti-infectives, cardiac medications, psychiatric medications, and antineoplastics. The med review will also identify medications causing a malabsorption effect, or an increase in metabolism. Appropriate blood work includes a CBC, BMP, TSH, HgA1c, albumin, prealbumin, transferrin, B12 and cholesterol level.

Complementary to the medical evaluation are the assessments and treatment plans of the remaining interdisciplinary professionals. The nursing professionals are the primary patient advocates who quickly identify the residents at risk of weight loss. The dietitian's expertise in evaluation of the resident's level of malnutrition and required supplementation is critical to the success of the treatment plan. The roles of the various therapists cannot be understated. The speech therapist will identify and treat problems associated with dysphagia. The occupational therapist will recommend special feeding devices if needed. The physical therapist is trained to develop exercise programs for the identified resident in order to stimulate appetite. The social worker is crucial in identifying psychosocial issues contributing to the weight loss. These issues include depression, dementia, response to loss, and environmental changes.

Through the collaboration of the interdisciplinary team, resident outcomes will be greatly improved. The goal is to utilize as many resources as are available in each individual LTC setting in order to improve the prognosis of the residents suffering from weight loss and malnutrition.

References

Beers, M. H., & Berkow, R. (2000). Protein-energy undernutrition. Beers, M. H., & Berkow, R. (Eds.), ***The Merck Manual of Geriatrics***, 3rd ed. (pp. 595-603). Whitehouse Station, NJ: Merck Research Laboratories.

Reuben, D. B.; Herr, K. A.; Pacala, J. T.; Pollock, B. G.; Potter, J. F.; & Semla, T. P. (2008). ***Geriatrics at Your Fingertips***, 10th ed. New York, NY: The American Geriatrics Society.

Vitale, C. A.; Monteleoni, C.; Burke, L.; Frazier-Rios, D.; & Volicer, L. (2009). Strategies for improving care for patients with advanced dementia and eating problems: optimizing care through physician and speech pathologist collaboration. ***Annals of Long-Term Care***, 17, 32-39.

White, B. & Truax, D. (2007). The nurse practitioner in long-term care: guidelines for clinical practice. Sudbury, MA: Jones and Bartlett.

Conference Ambassadors Wanted

If you have some mileage in the business, some successes as well as scars, you have a lot to offer newcomers attending their first annual conference.

So, whether you are a physician, nurse practitioner, physician assistant, director of nursing, or nursing home administrator, please sign up to be an "Ambassador" to newcomers at the upcoming "Best Care Practices in the Geriatrics Continuum 2010" conference. This year's conference will be at Disney's Swan and Dolphin in Lake Buena Vista from Oct. 28-31, 2010.

Being an Ambassador is actually pretty light duty, says FMDA President Hugh Thomas, DO, CMD. Volunteers will be assigned to a newcomer prior to the conference, and will be asked to touch base with that person throughout the conference.

"This is a way to get new people engaged," says Dr. Thomas. Ambassadors will also be asked to follow up with the newcomer after the conference, to find out what value he or she derived from it, and to explore how FMDA can benefit him or her on an ongoing basis.

You can sign up to be an Ambassador when you register for the conference. Watch your e-mail and the mail for the conference brochure and registration form, or call the office at **(561) 659-5581**, or visit **www.bestcare practices.org**.

FMDA News & Updates. . .FMDA News & Updates. . .

Progress Report Wins 2010 APEX Award of Excellence

FMDA, a chapter of the Columbia, MD-based American Medical Directors Association, and a specialty society of the Florida Medical Association has been awarded the APEX 2010 Award of Excellence in the category of Newsletters – Electronic & Web, for FMDA's statewide newsletter *Progress Report*.

APEX 2010 – the 22nd Annual Awards for Publication Excellence – recognized outstanding publications including not only newsletters and magazines, but also annual reports, brochures, and websites.

According to the APEX 2010 judges, "APEX 2010 awards were based on excellence in graphic design, editorial content and the success of the entry in achieving overall communications effectiveness and excellence. Naturally, entries in design categories were judged solely on the basis of their graphic design, and writing entries were evaluated primarily on the basis of editorial quality."

Hugh Thomas, DO, CMD, president of FMDA said, "We have worked diligently to publish a newsletter that is reader-friendly and provides the kind of information we hope our membership finds useful."

Karl Dhana, MD, CMD, the editor of *Progress Report*, had this to add, "As editor, it is very gratifying to be recognized, but it is a team effort, and I would be remiss if I did not thank the rest of the board for their continued support of *Progress Report*."

The APEX Awards for Publication Excellence is an annual competition for writers, editors, publication staffs, and business and nonprofit communicators. It is sponsored by Communications Concepts Inc., publishers of business communication reports for professional communicators.

With more than 3,700 entries, competition was exceptionally intense. Grand Awards were presented to honor outstanding work in 11 major categories, while Awards of Excellence recognized exceptional entries in 127 subcategories.

FMDA Hosts Summer Town Meeting in Safety Harbor

On average, the FMDA board of directors travels around the state at least twice a year to connect with its members and potential new members at the local level. We've had the pleasure of hosting events from Pensacola to Jacksonville, Orlando, Tampa, Sarasota, Fort Myers, West Palm Beach, Miami, St. Petersburg, Coral Gables, Fort Lauderdale, Lake Worth, Tallahassee, and Daytona Beach.

We hosted another memorable Town Meeting & Dinner on July 17 at the Safety Harbor Resort. Earlier in the day, the CME/Education Committee and the board of directors met for regularly scheduled business meetings. Earlier that evening, our Town Meeting was preceded for the first time by a reception with exhibitors who supported this event. The dinner, which followed, was hosted by FMDA, and spouses and guest were invited to attend.

Another Town Meeting is being planned for early 2011 on a date and location to be announced. Stay tuned for more information.

FMDA was joined at the exhibits and Town Meeting dinner with representatives from Oak Manor Senior Living Community in Largo. Executive Director Brad Graham (shown above, third from the left) with his wife (fourth from the left), and key staff members from Oak Manor.

Prescribing Controlled Substances in LTC: Tips for Practicing Clinicians on the Go

Physicians, nursing homes, and pharmacists have been experiencing aggressive enforcement action by agents of the Drug Enforcement Administration (DEA). We in long-term care have had to modify longstanding procedures in an effort to ensure compliance with DEA rules. The changes forced upon us have delayed dispensing of controlled substances to patients who urgently needed them in long-term care facilities.

The American Medical Directors Association, American Academy of Family Physicians, American Academy of Hospice and Palliative Medicine, American Geriatrics Society, American Medical Association, and other organizations are working together to strongly advocate that Congress and the DEA change the rules to allow for the longstanding practice of having nurses act as the physician's agent. Changing laws and regulations is a long and complex process, however, and our patients cannot wait.

A "tip sheet" has been developed to help you comply with current law in a manner that will smooth the way for more expeditious dispensing of the controlled substances you prescribe for your patients. For a copy of this tip sheet, go to **www.fmda.org/advocacy.html**.

Is Your Facility Dog-Friendly?

The American Medical Directors Association (AMDA) is encouraging nursing facilities in Florida to submit photos of dogs for the 2011 AMDA Foundation Caring Canines calendar. AMDA is inviting Florida facilities because its 2011 annual symposium is in Tampa next year, and this would present an excellent press opportunity.

They also hope to find a facility/practitioner who is willing to bring his or her dog to the meeting for a press conference and meet-and-greet with symposium participants.

Details may be found at: **www.amdafoundation.org/content/view/652/1/**. For more information, contact **Joanne Kaldy** with the AMDA Foundation at **(240) 527-9848**.

NSU Receives $2.1 Million Federal Grant to Provide Training to Improve Geriatric Care

Nova Southeastern University recently received a $2.1-million federal grant to provide training to improve care for South Florida's large geriatric population.

The five-year grant will expand training and geriatric education for students, faculty, and health care professionals, with the long-term goal of increasing the number of professionals working in geriatrics.

NSU's medical school, the College of Osteopathic Medicine, received the grant to fund its Florida Coastal Geriatric Resources, Education, and Training Center (GREAT GEC). This center — one of more than 40 GECs in the U.S. — is using the grant from the Health Resources and Services Administration of the U.S. Department of Health and Human Services to provide inter-professional training for health-care professionals and students in geriatrics and eldercare throughout the region. The GEC will work with community-based partners in South Florida and Southwest Florida.

NSU's GREAT GEC was honored this year with the Florida State Surgeon General's Health Innovation, Prevention and Management Award for providing wellness and disease prevention, and for advocating healthy lifestyles.

The GEC grant will create a geriatric faculty development program for NSU faculty who teach geriatrics and will provide health care students with clinical geriatrics training in nursing homes, acute-care hospitals, ambulatory care centers, senior centers and retirement communities.

The new grant also emphasizes research based on geriatric practices used by health-care providers. Naushira Pandya, MD, CMD — NSU's principal investigator for the GEC, and a director of FMDA — will start a project to examine diabetes management and patients' ability to follow guidelines provided by their physicians on personal diabetes care and management.

The grant was submitted through the effort of Cecilia Rokusek, EdD, MS, RD, executive director of education, planning, and research and GREAT GEC executive director.

"This grant is imperative to better the lives of South Florida's elderly population, which is the largest percentage of the total population in the country," Rokusek said. "This grant allows the GEC to expand cutting-edge training programs and evidence-based practice research for students, faculty, and practicing geriatrics professionals."

As Americans continue to age, she said, the percentage of total time provided by physicians and other geriatrics professionals for patient care could increase to 39 percent nationally by 2020. Integrated geriatrics curriculum is critical in helping to meet the growing needs of the population 65 years and older. Florida is helping to the lead the way through programs such as the GEC.

Selznick Appointed Chair of FMDA's Industry Advisory Board

Florida Medical Directors Association President Hugh Thomas, DO, CMD, is pleased to announce that the FMDA board has appointed Steven Selznick, DO, CMD, as the new chairman of its Industry Advisory Board (IAB). He takes over from founding chairman, Dr. Malcolm Fraser, a past-president and former FMDA board chairman, who did an outstanding job of developing this dynamic group.

The IAB was founded in 1999 as a way for the Florida Medical Directors Association and other interested organizations to enhance lines of communication and work together to develop solutions for our common problems. Membership is by invitation only and is limited to a select few industry leaders. Meeting twice a year, participants have provided valuable input into planning the annual program and trade show and in supporting FMDA in other areas of mutual interest.

Steven Selznick, DO, CMD

Dr. Selznick graduated from Vanderbilt University before pursuing his medical degree at the College of Osteopathic Medicine and Surgery in Des Moines, Iowa. Following an internship at Youngstown Osteopathic Hospital in Ohio, he completed his family practice residency in Pensacola and started his medical practice in Casselberry, Fla., in 1983.

Dr. Selznick is certified by the American Board of Family Physicians and American Medical Directors Association (AMDA), and he is a Fellow of the American Academy of Family Physicians. He holds membership in the American Osteopathic Association, FMDA, AMDA, and the Florida Academy of Family Physicians.

Dr. Selznick — a staff member of Florida Hospital, Health Central Hospital, and the University Behavior Center — also serves as medical director for rehabilitation facilities, skilled nursing facilities, and home health agencies. He is on the speaker's bureau for multiple pharmaceutical companies and provides medical-legal consulting to a number of law firms.

"We are very pleased that Steve has made the decision to chair this important committee," said Thomas.

"His unique understanding of our profession and our position within the long-term-care environment makes him the ideal candidate. Dr. Selznick is a terrific ambassador for FMDA," he added.

For more information concerning the Industry Advisory Board, please contact Ian Cordes, executive director of FMDA, at **(561) 659-5581**, or via e-mail at **ian.cordes@fmda.org**.

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FMDA News & Updates
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Thomas Named Life Care's Southeast Division Medical Director of the Year

FMDA congratulates its president, Dr. Hugh Thomas, medical director at Life Care Center of Orlando, because he was named Southeast Division Medical Director of the Year for Life Care Centers of America.

From left to right: Life Care Center President Beecher Hunter; Life Care Center Chairman Forrest L. Preston; FMDA president, Dr. Hugh Thomas; and Life Care corporate medical director, Dr. Kenneth Scott Jr.

The award was given during a ceremony held at the American Medical Directors Association Symposium in Long Beach, Calif. Several other divisional award winners were also honored.

Thomas was chosen for his dedication to the facility's residents over the past seven years. He participates religiously in the facility's performance improvement program. He is an advocate for residents and frequently educates facility associates on health-care topics. In the community, he is active in his practice and in leading smoking cessation classes.

"Dr. Thomas is a steadying influence for the residents and a compassionate and encouraging teammate who helps us move forward in our mission," said Laura Haraburda, executive director.

"Our medical directors play a pivotal role in the care of our residents," said Beecher Hunter, Life Care president, "and we are proud to honor those who stand out in their commitment and their compassion to ensure the health and well-being of those entrusted to them."

Life Care Center of Orlando is one of 23 skilled nursing and rehabilitation facilities in Life Care's Southeast Division.

Founded in 1976, Life Care is a nationwide health-care company. With headquarters in Cleveland, Tenn., Life Care operates more than 220 nursing, subacute and Alzheimer's centers in 28 states.

FMDA Call for Poster Submissions

FMDA is hosting its 7th Annual Poster Session during the Best Care Practices Conference, Oct. 28-31. The first 10 applicants who are accepted by the review committee will receive complimentary registration to the 2010 conference (only one applicant per poster presentation will be considered).

Poster sessions provide an opportunity for practicing physicians, pharmacists, and nurse practitioners to share with colleagues the results of research, best practices, and outcomes. The sessions are visual presentations using diagrams, charts, and figures. Poster presentations may be on any aspect of the following categories: clinical care, pharmacology of medicine, medical education, history of medicine, medical direction, medical care delivery, medical ethics, economics of medicine, and pediatric long-term care — and in any long-term care setting.

All poster abstract proposals must be submitted online on our website at **www.fmda.org**. All submissions that are complete and follow the Criteria for Acceptance of Posters will be considered and reviewed based on the content contained within the proposal.

Submission of a proposal is a commitment by at least one author to be present at the designated times to discuss the information in the poster with symposium participants. We have arranged the schedule so that there is no overlap between educational sessions and poster exhibit times. The primary presenter listed on the proposal will be informed of its status in early October. Guidelines for presentation and preparation of visual material will be sent to the primary presenter upon acceptance.

Authors whose abstracts are accepted for presentation at the symposium will have their abstracts submitted for publication in the *Journal of the American Medical Directors Association* (JAMDA).

To learn more, or to submit a proposal, go to **www.fmda.org**, or call Ian Cordes, FMDA executive director, at **(561) 659-5581**.

Have You Called Your "Buddy"?

The FMDA Membership Committee recently launched its new 2010 Membership Campaign. Our goal is for each current FMDA member (physician, NP, or PA) to personally sign up at least one new member this year.

To accomplish this goal, every current member will be assigned another member "buddy," who is to be contacted and encouraged until that person has signed up a new FMDA member.

Incentives* for both old and new members will include:

1) **Recruiting member** gets 50% off renewal dues and 20% off 2010 conference registration fees as long as the new member attends the 2010 annual conference.
2) **New Member:** If the new recruit has not been a member in the last three years, he or she will receive 50% off FMDA membership dues and 20% off the 2010 annual conference registration fee.
3) If an FMDA member recruits at least two (2) new members, he or she is given a coupon worth 50% off annual dues, plus 40% off 2010 conference registration fees – but both new members must register to attend the conference.

FMDA News & Updates

Continued from the previous page

4) **Door Prizes** – Will be given away at the ***Best Care Practices in the Geriatrics Continuum 2010*** conference:
   a. For all FMDA members who recruited at least one new member.
   b. There will also be separate raffles during the conference for NPs/PAs and physicians who recruit new members.
   c. There will be a separate drawing for most referred new members. You could win an **Apple iPad**!

***Incentives will be issued by Nov. 30, 2010, to all those who are eligible.**

As the leading organization in Florida promoting the multidisciplinary approach to long-term and rehabilitative care at Florida's nursing homes, we hope to reach the highest possible number of physicians, nurse practitioners, and physician assistants. We need everyone's help if we are to succeed.

Thanks for all that you do for Florida's frail and elderly nursing home patients.

A Review of Published Scientific Articles: Part II

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b) *Functional status of elderly adults before and after initiation of dialysis*, by Tamura M. Kurella, K.E. Covinsky et al, was published in the *New England Journal of Medicine* on Oct. 15, 2009. The researchers wanted to determine whether functional status before dialysis is maintained after initiating the treatment in elderly patients with end-stage renal disease.

Using two linked national registries, they identified all 3,702 U.S. nursing-home residents who were starting dialysis between June 1998 and October 2000 and for whom at least one measurement of functional status was available before dialysis began. Functional status was measured by the degree of dependence in seven activities of daily living via MDS-ADL, or the Minimum Data Set-Activities of Daily Living, which has a scale of 0 to 28 points; higher scores indicate greater functional difficulty. In the three months after beginning dialysis, the median MDS-ADL score worsened from 12 to 16, and functional status maintained in only 39% of the residents. By 12 months after beginning dialysis, 58% had died, and pre-dialysis function had been maintained in only 13%.

In a random-effects model, initiation of dialysis was associated with a sharp decline in function, independent of age, sex, race, and functional-status trajectory before dialysis. The decline remained substantial even after adjusting for the presence or absence of accelerated decline during the 3 months before initiation of dialysis. The study concluded that "among nursing home residents with ESRD, the initiation of dialysis is associated with a substantial and sustained decline in functional status."

— This review is based on a presentation that was held during the American Medical Directors Association LTC Medicine 2010 conference. Presenters included Barbara J. Messinger-Rapport, MD, PhD, CMD; John Morley, MB, BCh; Julie Gammack, MD, CMD; and Mary Patt Rapp, PhD, RN.

FMDA Convenes Strategic Planning Meeting

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membership initiatives to remain competitive. There are a lot of professional medical societies out there to choose from, so how can we stand out from the rest?"

Social networking sites, such as Facebook, provide opportunities through which FMDA could advertise its services. Use of new technology — such as online software for our members, web-conferencing, and online networking — could boost our recognition and reputation as a state medical society. The further FMDA can extend its reach within the senior-care spectrum, the more beneficial we can be as a state medical society to our members, and the greater effect we can have on health care as a whole.

One of our larger challenges is the development of new leaders within the organization. Every four years, there is turnover in FMDA leadership, and we could benefit from focused leadership training and mentorship. By providing leadership advocacy to our members, we create a pipeline of emerging leaders to guide our association to its goals.

"Future FMDA leaders would most certainly benefit from participation in leadership training exercises," said Dr. Suchar. "As a model organization, we need effective leadership that can guide us to our goals and pave the way for future leaders."

FMDA leadership identified the following priority areas and overall goals for our strategic plan: 1) Increase value to our members by becoming a primary source for education, resources and services; 2) Foster engagement and development of the association's leadership; 3) Implement established governance processes; 4) Expand and strengthen relationships with strategic partners; 5) Develop use of new information technology that allows for FMDA's growth and sustainability.

It is the intention that every one of these goals follows the SMART acronym: Specific, Measurable, Attainable, Relevant, and Time-bound.

These five goals provide a foundation for FMDA to measure itself in the years to come. Which of these goals is most important to the organization? How do we remain on task? To answer these questions, it is important that we encourage team-building exercises and volunteer events that keep us focused on our goals. A strategic planning meeting should probably occur every two years and incorporate a select group of FMDA leaders to drive facilitation. It is the board's intention that a basic meeting like the one in Safety Harbor will lay the framework for future strategic planning meetings.

Now that FMDA has the basics, a longer program could be held over a full day with other programming, or over the course of two days. Regardless of its time frame, the meeting should remain focused and fresh while incorporating SMART goals.

FMDA *Progress Report* has a circulation of more than 1,000 physicians, physician assistants, nurse practitioners, directors of nursing, administrators and other LTC professionals. *Progress Report* is a trademark of FMDA. Editor Karl Dhana, MD, CMD, welcomes letters, original articles and photos. If you would like to contribute to this newsletter, please e-mail your article to ian.cordes@fmda.org.

FMDA Supports AMDA Response to DEA for CSA Revisions to Accommodate LTC Residents

By Ian Cordes, MBA, NHA; Executive Director, FMDA

As you may know, FMDA has been following the impact of the enforcement policies of the DEA with regard to nursing homes and controlled substances.

The Drug Enforcement Administration (DEA) issued a notice in the Federal Register, this summer, requesting the public's feedback on whether the agency should revise existing regulations in order to make it easier for residents in long-term care facilities (LTCFs) to gain access to controlled-substance medications (read the June 29 *Federal Register Notice* here: **http://edocket.access.gpo.gov/2010/pdf/2010-15757.pdf**. DEA was specifically seeking comments from practitioners, pharmacists, LTCFs, nurses, residents and families of residents in long-term care.

Representatives from all aspects of LTC have long requested relief from the wait experienced by patients denied timely access to narcotic pain medications due to DEA regulations that are not compatible with the long-term care practice model. DEA's request for comment presented stakeholders with an opportunity to seek changes to the Controlled Substances Act (CSA) that would allow for the LTC nurse to be recognized as the agent of the prescribing physician and to allow chart orders to be recognized as valid prescriptions for controlled substance medications.

All comments were due no later than midnight on August 30, 2010.

FMDA was a supporting organization for the comprehensive response presented by AMDA on Aug. 29, 2010. The entire document may be seen at **www.fmda.org/advocacy.html**.

Here is an excerpt:

"As the clinical leader, the physician works in consultation with nurses and the interdisciplinary team to determine appropriate services and programs for a nursing facility resident to ensure that these are consistent with the person's diagnoses, condition, prognosis, and wishes. This team approach to care has been in existence for approximately 30 years in the long-term care setting.

Nurses in the nursing facility do not act independently — rather, they serve as the direct agent for the physician, providing important clinical information and responding to the physician's questions. Only then do they transcribe the physician's verbal order. This is a critical point, as the nurse is able to assess patients' pain and, in turn, can furnish the information to allow the physician — not the nurse — to order appropriate drugs and services. (This is no different from the way such prescribing frequently occurs at acute-care hospitals all over the nation — the nurse contacts the physician, and the physician gives the order by phone.)"

This final excerpt highlights our challenges:

"Several changes in regulation have been proposed, but each is a lengthy, time-consuming solution. This is an urgent problem for which an urgent solution is long overdue. Ninety-one percent of AMDA members surveyed reported that their facility has experienced delays in obtaining controlled-substance medications for residents. Seventy-one percent surveyed said that the delays apply to all schedules. Due to this inability to receive medications in a timely manner, 24 percent responded that their facility has had to send residents to the hospital to receive controlled-substances medications."

Questions for the Medical Director

Question: How often is the attending physician required to see the resident in a skilled nursing facility (SNF)?

Answer: The timing of physician visits is based on the admission date of the resident. Visits will be made within the first 30 days, and then at 30-day intervals up until 90 days after the admission date. Visits will then be at 60-day intervals. Permitting up to 10 days slippage of a due date will not affect the next due date. At the option of the state, required visits in SNFs after the initial visit may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist who is not an employee of the facility but who is working in collaboration with a physician.

Reference: Guidance to Surveyors PP 665-669 (F387, F390)

~ Volunteers Needed Now ~

FMDA is looking for one or more volunteers to help us revive the Medicare-focused *Coding Corner* feature article for the award-winning *Progress Report* newsletter.

FMDA Job Fair

FMDA's first job fair will be held on Friday, Oct. 29, 2010, during its 19th annual conference and trade show. Attendees will be able to network with health care recruiters and learn about new and interesting opportunities.

Technology Guru Needed

FMDA is looking for a technology guru to advise its board about new and interesting applications that would support and enhance member services.

C O N F E R E N C E A L E R T

ADVANCED CPG INTENSIVE:
Implementing AMDA's Diabetes Management in the Long-Term Care Setting Clinical Practice Guideline

1-5 p.m., Thursday, Oct. 28, 2010
Walt Disney World Swan, Lake Buena Vista, Fla.

DIABETES MANAGEMENT CPG: Staff and practitioners in the LTC setting commonly face challenges in managing frail elders with diabetes. The prevalence of diabetes has increased worldwide over the past two decades, and the prevalence of type 2 diabetes increases with age. Individuals with undiagnosed type 2 diabetes are at increased risk for coronary heart disease and stroke, and they are more likely to have dyslipidemia, hypertension, obesity, and microalbuminuria. Diabetes is an independent predictor of LTC facility placement in the elderly. LTC-facility residents with diabetes are a vulnerable group, often taking multiple medications and experiencing frequent infections and high rates of cardiovascular complications, dehydration, hospitalizations, hyperosmolar states, and physical and cognitive disability. The prevalence of functional disability and multiple co-morbid conditions in the LTC population increases the complexity of diabetes management. Hyperglycemia impairs cognition and, when untreated, may contribute to further functional decline in patients with dementia. Additionally, hyperglycemia decreases pain thresholds, impairs vision, impedes wound healing, and may increase the risk for falls. Once diagnosed, many patients still do not get the necessary care to prevent complications. Given the increasing prevalence of diabetes and the high associated costs, an intensive educational program is essential to improve guideline adherence and mitigate physician and patient barriers to optimal care.

OVERVIEW: This program will start with an explanation of the medical care process and its relationship to risk management. The rest of the program will walk the attendee step by step through the newly updated AMDA "Diabetes Management in the Long-Term-Care Setting" clinical practice guideline. Participants will come away with a greater understanding of how to manage the frail diabetic patient and the common co-morbid complications that accompany diabetes.

TARGET AUDIENCE: **Physicians • PAs • Pharmacists • Nurse Practitioners • Nurses • QIO Managers • Directors of Nursing • Long-Term Care Administrators**

SPACE IS LIMITED: Registration fee is only **$75** 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 2010"** conference.

Hotel Reservations: *Walt Disney World Swan & Dolphin*

HOTEL RESERVATIONS: FMDA has reserved a block of rooms at the **Walt Disney World Swan**. The group rate is **$175** single/double occupancy plus a discounted resort fee of $10 per day, plus discounted parking at $9 for self and $14 for valet.

To make a reservation, please call **(800) 227-1500** and mention you are attending the Florida Medical Directors Association's Best Care Practices conference. To guarantee rate and room availability, you must make your reservations before the hotel is sold out. This special group rate will be applicable three (3) days prior to and three (3) days following the main program dates, subject to availability. You may also reserve your hotel room at www.bestcare practices.org/venue.html.

Handouts

The registration fee includes a complimentary CD that contains all handouts provided to us by the speakers. You will receive this CD when you register on site. In addition, these same handouts will be available at www.bestcare practices.org, so you may print them without charge before you get to the conference. If you prefer, for an extra charge of **$35**, you may order a set of handouts when you pre-register, and they will be ready for you when you arrive at the conference. However, please be aware that we cannot ensure the availability of every PowerPoint presentation or handout for every session.

In Appreciation of Their Support

BRONZE-LEVEL GRAND SUPPORTERS: *American Health Associates, Evercare* and *Vitas Innovative Hospice*

FMDA, FL-ASCP, ACHCA, AALTCN, & FGS gratefully acknowledge support for this conference with exhibit fees from the following companies: Abbott Laboratories ✧ American Health Associates ✧ Amgen ✧ Astellas Pharma ✧ Bayer Healthcare Pharmaceuticals ✧ Centocer Ortho Biotech ✧ Cotler Health Care & Development ✧ Eli Lilly & Company ✧ Elsevier ✧ Florida Clinical Laboratory ✧ Florida Chapter of GAPNA ✧ Forest Pharmaceuticals ✧ GlaxoSmithKline ✧ Haven Hospice ✧ Iroko Pharmaceuticals ✧ Merck ✧ MobilexUSA ✧ NADONA/LTC ✧ Novartis ✧ Pfizer ✧ Sanofi-Aventis ✧ Strativa ✧ Sucampo ✧ Vitas Innovative Hospice ✧

2010 Conference Agenda

Optional PRE-CONFERENCE DAY: THURSDAY, OCT. 28, 2010

8 a.m.–7 p.m. *Registration & Information:* **Walt Disney World Swan**

9 a.m.–4:30 p.m. ***American Association for Long Term Care Nursing***
6.0 hours *A Day-long Prep. Course for "Culture Change" Nurse Coordinator Certification Program* **(101)**
~ ***Charlotte Eliopoulos RN, MPH, PhD****; Executive Director, AALTCN*

11:15 a.m.-12:45 p.m. ***Lunch on your own***

1-5 p.m. ***American Medical Directors Association*** *4.0 hours*
Advanced "Clinical Practice Guideline" Intensive on Diabetes **(102)**
~ ***Jacqueline Vance, RNC;*** Director of Clinical Affairs, American Medical Directors Association

~ ***Albert Riddle, MD, CMD;*** president of Riddle Medical Group and Medicare D Assist; and member of AMDA's Clinical Practice Guidelines Committee
— This session is supported by an educational grant from **sanofi aventis**.

1-4 p.m. *Basic Training for New Health Care Practitioners & Those New to Long-Term Care* **(103)** *3.0 hours*

There are separate registration fees for these pre-conference sessions. See page 7 for sign-up options.

The AMDA CPG Program offers CME/CMD/CE credits.

Culture Change Course offers CME/CMD/CE credits.

Basic Training Course for New Practitioners and Those New to LTC

~ ***Alejandro Jaen-Vinuales, MD;*** attending physician, Geriatrics and Extended Care Service, James A. Haley VA Medical Center, Tampa

~ ***Martha Little, PharmD;*** past chair, FL-ASCP; member of the Board of Directors of the American Society of Consultant Pharmacists

~ ***Cathy Ates, RNC, CDONA/LTC;*** president, Parthenon Healthcare; immediate past-president, FADONA

~ ***Jo Ann Fisher, FNP-BC;*** clinical coordinator, Osler Geriatrics, Melbourne, Fla.; president, Florida Chapter of GAPNA

~ ***Denise F. Baultrip-Cuyjet, BA;*** corporate director of social services, Senior Care Group; president, Florida Health Care Social Workers Association

7-8:30 p.m. ***Product Theater Dinner*** *(non-CME/CPE/CE)* **(104)**
The Challenges of Treating Depression in Older Adults
~ ***Adam Sky, MD;*** assistant clinical professor, St. Louis University School of Medicine

— This program is sponsored by and the speaker is presenting on behalf of **Lilly USA, LLC**. It is being presented consistent with FDA guidelines and is not approved for continuing education credit. Dinner will be provided for attendees of this program.

FRIDAY, OCTOBER 29, 2010

8:30-10 a.m. ***Breakfast & Presentation*** **(105)** *1.0 hour*
Managing Infectious Diseases in LTC
~ ***Gregory J. Gahm, MD, MS;*** associate clinical professor of medicine, Department of Geriatric Medicine, University of Colorado Health Sciences Center; medical director of Ovations/EverCare Colorado; vice-president, Colorado Medical Director's Association

10:15-11:15 a.m. *Gastrointestinal Disorders in the Elderly* **(106)** *1.0 hour*
~ ***Vijayalakshmi S. Pratha, MD, CPI;*** medical director, Clinical Applications Laboratory, San Diego, Calif.

10:15-11:15 a.m. ***Florida-ASCP Breakout Session I*** *(approved for all)*
Policy Update for Healthcare Professionals **(107)** *1.0 hour*
~ ***Brad Kile, PhD;*** Executive Director, FL-ASCP

11:30 a.m.-1 p.m. ***Product Theater Lunch*** *(non-CME/CPE/CE)*
Alzheimer's Disease & the Long-Term Care Resident **(108)**
~ ***James E. Race, MD;*** RJE Clinical Research, Dallas, TX
— This program is sponsored by and the speaker is presenting on behalf of **Eisai Inc.** and **Pfizer Inc.**

1-2:30 p.m. ***Trade Show*** *and* ***Job Fair***

2:30-4 p.m. ***Florida-ASCP Breakout Session II*** *(approved for all)*
The Pharmacists' Role in Treating Restless Leg Syndrome **(109)** *1.5 hours*
~ ***Irene Malaty, MD;*** Assistant Professor, Department of Neurology at University of Florida; Medical Director of National Parkinson Foundation Center of Excellence; Director of Tourette Syndrome Clinic
— This session is supported by an educational grant from **UCB Pharma**.

2:30-4 p.m. *Common & Uncommon Skin Conditions in the Elderly* **(110)** *1.5 hours*
~ ***Inna Sheyner, MD, CMD***; associate professor of medicine, Dept. of Medicine, Division of Geriatrics, University of South Florida College of Medicine, Tampa; medical director, NHCU, James A. Haley VA Hospital, Tampa

4:15-5:15 p.m. *Screening for Cancer in the Elderly* **(111)** *1.0 hour*
~ ***Lodovico Balducci, MD;*** program leader, Senior Adult Oncology Program, H. Lee Moffitt Cancer Center, Tampa; professor of oncology and medicine, Dept. of Oncologic Sciences, University of South Florida College of Medicine

5:15-7:15 p.m. ***Welcome Reception & Entertainment in Exhibit Hall***

7:30-9 p.m. ***Dinner & Presentation:*** *Pain Management and the American Geriatrics Society's Guidelines* **(112)** *1.0 hour*
~ ***Cheryl L. Phillips, MD, AGSF, CMD;*** *chief medical officer of On Lok Lifeways in San Francisco, and chair of the American Geriatrics Society*

SATURDAY, OCTOBER 30, 2010

8-9 a.m. ***Continental Breakfast in Exhibit Hall***

9-10:30 a.m. *National Leadership Council: Future Directions* **(113)** *1.5 hours*
American Medical Directors Association *(AMDA)*
~ ***President-Elect*** **Karyn P. Leible, *MD, CMD,***
chief clinical officer, Pinon Management, Lakewood, CO

American Society of Consultant Pharmacists *(ASCP)*
~ ***President*** **Rachelle "Shelly" Spiro, *RPh, FASCP,***
president of Spiro Consulting

American Geriatrics Society *(AGS)*
~ ***Board Chair Cheryl L. Phillips, MD, AGSF, CMD,***
chief medical officer of On Lok Lifeways in San Francisco

10:45-11:45 a.m. *Care Transitions: Patient Safety First* **(114)** *1.0 hour*
~ ***James E. Lett II, MD, CMD;*** Serves in the clinical oversight unit of California Prison Health Care Services; was president of AMDA from 2003-2004; and president of Florida Medical Directors Association from 1991-1993

~ ***Cathy Ates, RNC, CDONA/LTC;*** *president, Parthenon Healthcare; immediate past-president, Florida Association Directors of Nursing Administration/LTC (FADONA); FADONA representative and co-chair of FADONA/FHA/AHCA Transitions Collaborative Project*

Best Care Practices in the Geriatrics Continuum 2010

2010 Conference Agenda

~ ***Denise R. Remus, PhD, RN;*** *chief quality officer for BayCare Health System in Clearwater, Fla.; Florida Hospital Association representative and co-chair of FADONA/FHA/AHCA Transitions Collaborative Project*

10:45-11:45 a.m. ***ACHCA Breakout Session I*** *(CEUs approved for NHAs only)*
ACHCA Professional Certification Review **(115)** ***1.0 hour***
~ ***Sharon Colling, CNHA, CALA, CSW, Fellow;*** *administrator of Belle Terrace and executive director of Ridgeview Towers assisted living facility, both located in Nebraska; vice-president of the Nebraska Health Care Association*

11:45-12:45 a.m. ***Break in Exhibit Hall***

12:45-2:15 p.m. ***Luncheon-Presentation & Annual Awards***
Osteoarthritis, Osteoporosis, & Other Metabolic Bone Diseases in Older Adults **(116)** ***1.0 hour***
~ ***F. Michael Gloth III, MD, FACP, AGSF, CMD;*** associate professor of medicine, Division of Geriatric Medicine and Gerontology, The Johns Hopkins University School of Medicine, Baltimore, MD; adjunct associate professor in Medicine, University of Maryland School of Medicine; corporate medical director and senior vice-president of medical affairs, Mid-Atlantic Health Care

2:15-3:15 p.m. ***Management & Treatment of Chronic Obstructive Pulmonary Disease in LTC*** **(117)** ***1.0 hour***
~ ***Gary H. Greenspan, MD;*** medical co-director, Respiratory Therapy Department, Mease Hospital, Dunedin and Countryside

3:30-4:30 p.m. ***Challenges & Opportunities Presented by National Health Reform Initiatives*** **(118)** ***1.0 hour***
~ ***Brad Kile, PhD;*** Executive Director, FL-ASCP

3:30-5:30 p.m. ***ACHCA Breakout Session II*** *(CEUs approved for NHAs only)*
ACHCA Professional Certification Review **(119)** ***2.0 hours***
~ ***Sharon Colling, CNHA, CALA, CSW, Fellow;*** administrator of Belle Terrace and executive director of Ridgeview Towers assisted living facility, both located in Nebraska; vice-president of the Nebraska Health Care Association

Activies for Spouses and Guests

If you have a spouse, guests, or children traveling with you, volunteers are organizing some fun outings for them. Your traveling companions will not be bored one bit. From shopping at the *Mall at Millenia* and outlet malls, to enjoying spa treatments, and the world-famous theme parks, there is so much to choose. Epcot is hosting its *International Food & Wine Festival*. In addition, there is no better place than Orlando to spend Halloween. Universal Studios Orlando is hosting its *19th Annual Halloween Horror Nights* (go to **www.halloweenhorrornights.com**). Plus, there's the *Halloween Spooktacular at SeaWorld Orlando*. If that wasn't enough, there's also Mickey's *"Not So Scary Halloween Party for Halloween 2010"* at Disney's Magic Kingdom. Specially-priced Walt Disney World® Theme Park Tickets for attendees and guests are available online at **www.bestcarepractices.org/attendees.html**. For more information about joining other conference guests, please contact **Stacy Symeonides** at **(561) 659-5581**.

4:40-5:40 p.m. ***Differential Diagnosis of Movement Disorders in the Geriatric Population*** **(120)** ***1.0 hour***
~ ***Ramón Luis Rodríguez, MD;*** assistant professor of neurology; director of clinical services for the Movement Disorders Center; director, Tyler's Hope Center for Comprehensive Dystonia Care; co-director, Movement Disorders Clinical Trials Center, University of Florida McKnight Brain Institute

5:30-6:30 p.m. ***ACHCA District IV Membership Meeting*** *(no CEUs)*

6:30-7:30 p.m. ***President's Halloween Wine & Cheese Reception***

7:45-9:15 p.m. ***Product Theater*** *(non-CME/CPE/CE)*
Additional Therapeutic Options for Patients with Mixed Dyslipidemia **(121)**
~ ***Babek Alex Vakili, MD, FACC;*** chief of cardiology, Orlando Regional Medical Center – S. Seminole Hospital; director of Cardiac Catheterization Laboratory at Florida Hospital Altamonte
— This program is sponsored by and the speaker is presenting on behalf of **Abbott Laboratories.**

SUNDAY, OCTOBER 31, 2010

7:45-9:15 a.m. ***Breakfast & Presentation:***
Geriatric Cardiology: State of the Science II **(122)** ***1.0 hour***
~ ***Jeanne Y. Wei, MD, PhD;*** executive director, Donald W. Reynolds Institute on Aging; professor and chair, Donald W. Reynolds Department of Geriatrics, University of Arkansas for Medical Sciences (UAMS), Little Rock, AR; and past-president, Society of Geriatric Cardiology, Washington, DC

9:30-11 a.m. ***What Everyone Should Know About the New MDS 3.0 Requirements for Physicians, PAs and NPs*** **(123)** ***1.5 hours***
~ ***AMDA President-Elect* Karyn P. Leible, *MD, CMD;*** chief clinical officer, Pinon Management, Lakewood, CO
~ ***Christopher Masterson, RN, RAC-CT, BSHA, WCC;*** senior vice-president of clinical operations, Greystone Health Care Management

11:10-11:30 a.m. ***Break & FMDA Membership Meeting***

11:30 a.m.-12:30 p.m. ***Dehydration in the Elderly: Detection, Diagnosis Impact, & Treatment*** **(124)** ***1.0 hour***
~ ***David R. Thomas, MD, FACP, AGSF, GSAF, CMD;*** professor of internal medicine, Division of Geriatrics/Gerontology; St. Louis University School of Medicine Division of Geriatrics/Gerontology, St. Louis, MO

12:30 p.m. ***END OF CONFERENCE:***
Announcements, Door Prizes, etc.

11:15 a.m.-12:45 p.m. ***ACHCA Breakout Session III***
The Business Advantages of Academic & Provider Partnerships in the Aging Services Field **(125)** ***1.5 hour***
~ ***Douglas Olson, NHA, MBA, PhD, FACHCA;*** associate professor at the University of Wisconsin – Eau Claire; director of the Center for Health Administration and Aging Services Excellence
This session is approved for administrator CEUs only.

– The agenda for "Best Care Practices in the Geriatrics Continuum 2010" *is subject to change without notice. Credit hours are subject to change with the schedule. Credit hours for administrators vary from what's shown. Call FMDA for details.*

Best Care Practices in the Geriatrics Continuum 2010

www.bestcarepractices.org

2010 Registration Form

REGISTRATION FORM

Yes, I would like to register now!

Registration — Choose one only!

❒ Paid-up **FMDA**, **FL-ASCP**, **ACHCA, AALTCN**, and/or **FGS** members **(Full registration*)**	**$295**
❒ New/renewing **FMDA** members **(Full registration*)** **(includes $65 for annual dues for Regular and Professional Affiliate members)**	**$360**
❒ Non-member physicians **(Full registration*)**	**$415**
❒ Non-member consultant pharmacists **(Full registration*)**	**$415**
❒ Non-member Nursing Home and ALF Administrators **(Full registration*)**	**$415**
❒ Non-member Nurse Practitioners, Physician Assistants, and RNs **(Full registration*)**	**$415**
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Optional Events

❒ **Pre-conference** (10/28): **AMDA's Advanced Clinical Practice Guidelines Workshop**	**$75**
❒ **Pre-conference** (10/28): **Basic Training Course for New Health Care Providers and Those New to LTC**	**$75**
❒ **Pre-conference** (10/28): **'Culture Change' Nurse Coordinator Certification Program: AALTCN Daylong Prep Course**	**$75**
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***FULL REGISTRATION:** **Fees include attendance at all educational sessions, receptions, planned meals, and trade show admission, from Friday, Oct. 29, through Sunday, Oct. 31, 2010. Sessions on Thursday, Oct. 28, are extra.**

Please RSVP for the Following Sessions (agenda subject to change)

1. MEMBERS: I am a member of ___FMDA, ___FL-ASCP, ___FGS, ___ACHCA, or ___AALTCN. 2. Thursday's non-CE Product Theater Dinner: ____ Yes,* I will attend; ___ **No**, I will not; **3. Friday's non-CE Product Theater Luncheon: ____ Yes,*** I will attend; ___ **No**, I will not; **4. Friday's CME/CPE/CE Dinner Program: ____ Yes**, I will attend; ___ **No**, I will not; **5. Presidents' Wine & Cheese Reception on Saturday: ____ Yes**, I will attend; ____ **No**, I will not; **6. Saturday's non-CE Product Theater Dinner: ____ Yes,*** I will attend; ____ **No**, I will not. **7. Sunday's CME/CPE/CE Breakfast-presentation: ____ Yes**, I will attend; ____ **No**, I will not. **8.** ____ Yes, I would like to make a special meal request, so please contact me. **9. New FMDA members:** What is the name of the FMDA member who referred you? _____ **10. ____ Yes,** I am a 1st-time attendee. **11.** Would you like to volunteer to be a conference **"Ambassador"?** Volunteers will each be assigned to a newcomer prior to the conference, and will be asked to touch base with that person throughout the conference. Ambassadors will also be asked to follow up with the newcomer after the conference, to find out what value he or she derived from it, and to explore how FMDA can benefit him or her on an ongoing basis. ___ **Yes!** **12. NOTE: Due to space limitations, planned conference meals are provided only to registrants.** ****Confirm your participation by signing up when you arrive at the conference – first come, first served – as space is limited.***

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Family Communication: Never More Important or Complex

Family communication not only is key to a patient's comfort and care, but good communication can also prevent conflicts and save time and trouble. One national survey indicates that medical directors have limited communication with family members. Only 15% of respondents said they have daily family communications, and 35% said they have weekly interactions. While 90% said they use the telephone to communicate with families, 59% said they utilize formal in-person meetings, and 60% use informal personal meetings. A small percentage also employ fax and e-mail communications and family-night programs. There are ways for physicians to make the best use of their limited time and access to technology to communicate effectively with families and prevent misunderstandings or conflicts.

"You're going to have a problem if you go in to discuss a DNR for Dad if the family hasn't yet accepted that he is terminally ill."

"Situations often escalate into conflict because of differences in agendas. The team has one idea about what should be done and presents this information without learning about the family's needs and concerns," says Daniel Bluestein, MD, CMD, a multi-facility medical director in Virginia and AMDA Communications Committee chair. He adds, "You need to find out what's going on with the family — their fears and concerns. You're going to have a problem if you go in to discuss a DNR for Dad if the family hasn't yet accepted that he is terminally ill."

Being observant can help the physician detect red flags of a looming conflict, says Dr. Bluestein. If someone is getting angry or frustrated, the person may get restless and avoid eye contact. Body language becomes more closed off — arms cross and posture is stiffer. Dr. Bluestein suggests that the physician's own feelings can be indicators of pending trouble. "If you find a conversation frustrating or tense, the other person probably isn't happy either. If you sense that a conversation is escalating into a conflict or confrontation, it's best to back off and get a neutral party involved instead of charging forward," he says, adding, "Make sure there is a documentation trail about what happens during a conversation."

While technology offers increased opportunities for family communication, it also presents challenges for physicians and staff. "If you or your staff use e-mail to communicate with family members or others, it is important to stress privacy and accuracy," says Dr. Bluestein. "Make sure you have e-mail addresses right. Don't just depend on an institutional directory. It's easier than you think to send information to the wrong person." He suggests thinking twice before committing something to writing and not sending messages when you are irritated or frustrated. "Twitters, e-mails, and text messages can come back to haunt a provider if they are sent in anger or something is distorted or can be misinterpreted."

Dr. Bluestein urges caution about e-mail as a way to communicate with family members. "Unless I know someone very well, I generally don't make e-mail available. Especially if you are talking about something potentially emotionally charged, there really is no substitute for face-to-face communication."

The way you talk to family makes a big difference, says Dr. Bluestein. "A call just to touch base often genuinely surprises and touches people. Families usually appreciate someone taking time to reach out to them." This goes a long way toward avoiding problems and preventing surprises that can evolve into complaints and lawsuits.

Gone are the days when families just accept the physician as an authority figure, says Dr. Bluestein. He explains, "We're starting to see generations of seniors and adult children who grew up questioning authority and thinking for themselves. We need to enlist them as partners. This calls for a strategy to build alliances with families any way you can. Listening to them, involving them, and getting their stories are immensely important."

AMDA's Consumers Corner (www.amda.com/consumers/index.cfm) *offers information, questions, and tools that physicians can use to educate families about key issues and to encourage open conversations.*

A Review of Published Scientific Articles: Part II

A recent AMDA presentation during its Long-Term Care Medicine 2010 presented a dozen articles published in the past year about medical practice and processes in the care of frail elders. All articles were chosen and critically appraised by experienced, multidisciplinary practitioners and educators to identify updated treatments, diagnosis methods, and care management of acute or chronic disease. The categories below summarize those presentations. This is the second of a two-part series of articles.

III. NURSING HOME

a) *Using video images to improve the accuracy of surrogate decision-making: A randomized controlled trial*, by A.E. Volandes et al, was published in the *Journal of the American Medical Directors Association*, Oct. 2009. When elderly patients are unable to make end-of-life decisions, doctors turn to surrogate decision-makers, whose knowledge of patient desires often is poor. Volandes' group wanted to compare the concordance, or agreement, of preferences in care goals among patients and their surrogates after 1) listening only to a verbal description of advanced dementia or 2) viewing a video decision support tool of the disease after hearing the verbal description. Care choices included life-prolonging care (CPR, mechanical ventilation), limited care (hospitalization, antibiotics, but not CPR), and comfort care only to relieve symptoms.

At two geriatrics clinics in Boston between Sept. 2007 and May 2008, 14 pairs of patients 65+ and their surrogates were randomly assigned — 6 to "verbal narrative" and 8 to "video after verbal narrative" — to determine whether goals chosen by the patient in case of eventual dementia would be the same as the surrogate's prediction. Among the pairs using verbal narrative, only 33% were in agreement — only two surrogates correctly predicted what their loved one would want if in a state of advanced dementia. The eight pairs using the video tool, however, ended with 100% agreement.

b) H.J.M. Cools et al studied *Benefits of increasing the dose of influenza vaccine in residents of long-term care facilities: A randomized placebo-controlled trial*, published in the *Journal of Medical Virology*, May 2009. Theorizing that increased vaccine doses and mid-season boosting may increase the proportion of LTC residents having immunity from influenza, the Cools group in 1997-1998 studied 815 residents in 14 LTC facilities.

After pre-vaccination titers, residents were randomly assigned to receive 15 or 30 microg of inactivated influenza vaccine, followed by a 15-microg booster or a placebo booster at Day 84. Seroresponses were reanalyzed by hemagglutination-inhibition. Forty percent of participants had pre-vaccination titers > or = 40. At Day 25 post-vaccination, this increased to 66.3% after a 15-microg dose vs. 73.3% after a 30-microg dose. Participants receiving a "30" dose followed by a "15" booster showed more protective titers, compared to those receiving only a 15-microg dose. Differences were most apparent in participants with low pre-vaccination titers. Booster vaccination after an initial "15" dose did not increase the protective rate. The group concluded that doubling the dose of influenza vaccine increased protection-related responses among LTC residents, especially those with low pre-vaccination titers.

c) *Prazosin for the treatment of behavioral symptoms in patients with Alzheimer's disease with agitation and aggression*, by L.Y. Wang et al, appeared in the *American Journal of Geriatric Psychiatry* in Sept. 2009. Agitation and aggression often seen in Alzheimer's patients are major causes of patient distress, caregiver burdens, and institutionalization. Adhering to the theory that these patients have enhanced behavioral responses to central nervous system norepinephrine (NE) release, Wang's group tried Prazosin — a nonsedating generic medication used for hypertension and benign prostatic hypertrophy — to antagonize NE effects at brain postsynaptic alpha-1 adrenoreceptors.

The group concluded that doubling the dose of influenza vaccine increased protection-related responses among LTC residents, especially those with low pre-vaccination titers.

b) Cools study

In a double-blind, placebo-controlled, parallel group study in a university AD center and a nursing home in Seattle, 22 participants (mean age: 80.6 +/- 11.2) were randomly assigned: 11 received placebo, and 11 received Prazosin. Each was measured with the Brief Psychiatric Rating Scale (BPRS) and Neuropsychiatric Inventory (NPI) at weeks 1, 2, 4, 6, and 8; the Clinical Global Impression of Change (CGIC) was done at week 8. Adverse effects and blood pressure changes were similar in both groups, but patients on Prazosin had greater behavioral improvements than those on placebo.

d) *The clinical course of advanced dementia*, by S.L. Mitchell et al, was published in the *New England Journal of Medicine* on Oct. 15, 2009. Dementia, a leading cause of death in the U.S., is under-recognized as a terminal illness; and Mitchell's group wanted to spotlight the clinical course of nursing-home residents with advanced dementia.

The group followed 323 such residents and their health-care proxies for 18 months in 22 nursing homes. Collected data characterized the residents' survival, clinical complications, symptoms, and treatments and determined the proxies' understanding of the residents' prognosis and expected clinical complications. Over the18 months, 54.8% of the residents died. The study found that pneumonia (41.1%), a febrile episode (52.6%), and an eating problem (85.8%) were frequent complications that were associated with high 6-month mortality rates. Distressing symptoms (dyspnea, 46.7%; pain, 39.7%) and burdensome interventions such as ER visits, IVs, tube feedings were also common. In the last 3 months of life, 40.7% of residents underwent at least one burdensome intervention. The study concluded that patients with

health-care proxies who understand the prognosis and clinical course are likely to receive less aggressive care near the end-of-life.

IV. PUBLIC HEALTH

a) *Effects of care coordination on hospitalization, quality of care, and health care expenditures among Medicare beneficiaries: 15 randomized trials* appeared in *JAMA* in Feb. 2009. D. Peikes et al wanted to determine whether care-coordination programs reduced hospitalizations and Medicare expenditures, and improved quality of care for chronically ill Medicare beneficiaries. Eligible fee-for-service Medicare patients — primarily with congestive heart failure, coronary artery disease, and diabetes — volunteered to participate between April 2002 and June 2005 in 15 care-coordination programs, which received a negotiated monthly fee per patient from Medicare. Patients were randomly assigned to treatment or control (usual care) status. Nurses provided patient education and monitoring, mostly by phone, to improve adherence and ability to communicate with physicians. Patients were contacted twice a month on average, but the frequency varied widely. Hospitalizations, costs, and some quality-of-care outcomes were measured with claims data for 18,309 patients (178 to 2657 per program) from patients' enrollment through June 2006. A patient survey 7-12 months after enrollment provided additional quality-of-care measures. Thirteen of the 15 programs showed no significant differences in hospitalization; and none of the 15 programs generated net savings, favorable effects on adherence, or more than a few of the many quality-of-care indicators. The study concluded that "viable care coordination programs without a strong transitional care component are unlikely to yield net Medicare savings," but "programs with substantial in-person contact that target moderate to severe patients can be cost-neutral and improve some aspects of care."

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The study concluded that "among nursing home residents with ESRD, the initiation of dialysis is associated with a substantial and sustained decline in functional status."

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Long-Term Care: DNRs, AEDs, and the Role of the Medical Director

By Starlett M. Miller, Esquire; McCumber, Daniels, Buntz, Hartig & Puig, P.A.

Starlett M. Miller

When long-term care facility staff are faced with a 911 emergency situation, it can be difficult to determine whether a resident has a valid DNR in place before providing life-sustaining medical care. Many facilities use tools such as bracelets or placards in resident rooms to indicate a resident's DNR status; however, many residents refuse or forget to wear their bracelets or are not in their room when emergencies arise. As automated external defibrillators (AEDs) become more commonplace in the long-term care setting (the momentum this trend is gaining is evidenced by the recent passage of House Bill 945 that mandated AEDs in Florida assisted living facilities with 17 or more beds[1]), it is becoming even more critical for facilities to be able to immediately identify whether a resident has a do-not-resuscitate order (DNR) in the event of an emergency situation. AEDs give facilities a greater ability to save lives, but create enormous pressure with regard to staff's response time. For every minute that elapses between an individual's collapse from sudden cardiac arrest[2] and attempted defibrillation, the person's chance of survival decreases by approximately 10-15%. In light of such advances in life-saving technology, it is essential that facilities re-evaluate their policies and procedures to ensure compliance with residents' DNRs in order to promote resident self-determination and reduce the potential for civil liability.

Florida and federal laws dictate that long-term care facilities are required to comply with residents' advance directives. The Patient Self-Determination Act of 1990, which went into effect on December 1, 1991, requires hospitals, nursing homes, home health agencies, and hospice programs receiving federal Medicare and Medicaid funds to create formal procedures that provide written information at admission to patients about end-of-life decision-making and their rights to refuse health-care treatment.[3] The federal act also requires that patients' advance directives are respected.[4] Noncompliance with the Patient Self-Determination Act will result in a loss of Medicare and Medicaid funding.[5]

The Florida Agency for Health Care Administration (AHCA) instituted regulations pursuant to the requirements of the Patient Self-Determination Act. When a resident is admitted to a nursing home, Florida and federal laws require that the resident is provided with a copy of "Health Care Advance Directives — The Patient's Right to Decide," an AHCA publication, or a similar document that substantively describes Florida law regarding advance directives.[6] Incoming residents must also receive a copy of the nursing home's written policies regarding advance directives.[7] Nursing homes may not condition admission or treatment on whether or not the resident has executed or waived an advance directive.[8] If an incoming resident has an advance directive, the nursing home must document the existence of the advance directive(s) in the resident's chart.[9] Where the resident or his family provides the nursing home with a copy of any advance directive(s), the facility must make the advance directive or a copy of the document part of the resident's medical record.[10] Additionally, Florida nursing homes are required to have written policies and procedures that "delineate the nursing home's position with respect to the state law and rules relative to advance directives."[11]

Long-term care facilities must also make sure that any emergency medical technician or paramedic called to the scene of an emergency at the facility is provided with the resources they require by law to honor the resident's DNR. Emergency medical technicians and paramedics have statutory immunity for withholding or withdrawing resuscitation from a patient, but only if presented with a valid DNR that is signed by the patient's physician and the patient or, if the patient is incapacitated, by the patient's health-care surrogate, proxy, court-appointed guardian, or attorney-in-fact.[12] If the DNR has not been signed by the physician, is not on Florida Department of Health Form 1896 that has been printed on yellow, legal-size paper,[13] or otherwise fails to meet the requirements of a valid DNR, emergency medical services must provide resuscitation. Therefore, if a facility does not have the policies and procedures in place to ensure that a resident's DNR is valid and enforceable by emergency medical services, the facility and those individuals responsible for its policies and procedures may be liable for failure to safeguard its residents' end-of-life decisions.

Every nursing home's medical director[14] has statutory and regulatory duties that involve them in the process of ensuring compliance with every resident's DNRs, regardless of whether or not the medical director acts as the attending physician for each individual resident.[15] Medical directors are required to serve on the facility's internal risk management and quality assurance (RMQA) committee[16] and participate at least quarterly with the facility's quality assessment and assurance committee.[17] Although the RMQA committee is the responsibility of the facility administrator,[18] the medical director's role in ensuring that the facility has the tools to ensure residents' advance directives are honored is significant.

A facility's failure to honor a resident's advance directive constitutes an "adverse incident,[19]" which must be reported to AHCA.[20] RMQA committees are required to meet monthly[21] to investigate and analyze the frequency and causes of adverse incidents and create policies and procedures to avoid adverse incidents.[22] The Florida Legislature "encourages" the use of "innovative approaches" that will minimize the risk and severity of adverse incidents.[23] AHCA regulates and reviews the RMQA committee's program as part of its regular license inspection process.[24]

The medical director (in conjunction with the administrator and director of nursing) has an obligation to review each new policy and procedure, annually review all policies and procedures, provide input and make certain they are revised as needed.[25] Because nursing homes' written policies and procedures must address residents' advance directives,[26] the monthly RMQA committee meeting provides medical directors with a statutorily required opportunity to factor recent technological advances and the resulting challenges into the facility's scheme of compliance with residents' DNRs.[27]

The trial bar is beginning to view the rules and regulations governing compliance with residents' advance directives as another opportunity to line their pockets. A recent jury verdict in Florida's first "wrongful prolongation of life" case resulted in a six-digit award to the resident's estate.[28] When Mrs. Neumann was admitted to the nursing home in 1992 with senile dementia and seizure disorder, her granddaughter, Ms. Scheible, presented Mrs. Neumann's living will/advance directive that stated there were to be no life-prolonging treatments or resuscitative measures if Mrs. Neumann had a terminal condition or was in the process of dying.[29] In 1995, facility staff found Mrs. Neumann unresponsive in

her bed; she was breathing, but staff could not obtain her vitals.[30] EMS arrived and intubated Mrs. Neumann and administered dopamine. During EMS transport, Mrs. Neumann attempted to remove the tubing, and EMS applied physical restraints.[31] Mrs. Neumann was extubated two (2) days later pursuant to her DNR and died four (4) days later in the hospital.[32] Ms. Scheible sued the facility for willful disregard of an advance directive under Chapter 765, Florida Statutes, willful disregard of the Patient Self-Determination Act, violation of Mrs. Neumann's nursing home residents' rights, and breach of contract against the facility and Mrs. Neumann's physicians.[33] At trial, the jury found that the facility, but not the physicians, had breached its contract with Mrs. Neumann to honor her advance directives and awarded $150,000 in damages.[34]

While medical directors are not usually named as individual defendants in long-term care lawsuits,[35] there is the potential for this litigation model to shift with an increase in breach-of-contract actions based on a facility's failure to comply with advance directives given the statutory, regulatory and contractual obligations placed upon medical directors with respect to nursing home policies and procedures. Medical directors have contracts with nursing homes that, in most cases, expressly require the medical director's compliance with the statutes and regulations governing medical directors. Under Scheible, facilities have an actionable contractual duty to honor residents' advance directives, thus, there is the potential for breach-of-contract claims against individual medical directors in wrongful prolonging-of-life cases.

Additionally, there have been reports in other states of facilities being investigated and cited by state agencies for failure to comply with residents' advance directives. These results indicate a growing trend of significant administrative and legal exposure for facilities and their administrators, directors of nursing and medical directors in the event a resident is provided life-sustaining medical treatment despite the existence of a valid DNR. There is, of course, also significant exposure if life-sustaining medical treatment is withheld in the absence of a valid DNR. Balancing the two considerations is a challenge from a practical standpoint that is further complicated by the need for adherence to federal and state privacy rules.[36] Generally, facilities risk administrative or legal penalties if a resident's DNR status is made publically available without their consent.

Recommendations

Through innovative policies and procedures that emphasize DNR compliance in light of the increased use of AEDs and privacy concerns, medical directors can help facilities increase their staff's ability to comply with residents' advance directives, maintain residents' privacy, and reduce the likelihood of liability in the event that compliance with advance directives is not possible. The best approach involves: 1) maintaining readily available and current information on each resident's DNR status; 2) obtaining an executed negotiated risk agreement, i.e., prior written release from each resident or their agent for following the resident's wishes; and 3) developing written policies and procedures that will effectuate this approach and ensure that staff are trained on the compliance program.

The task of maintaining readily available and current information on every resident's DNR status begins at the time of each resident's admission to the facility. The administrator and director of nursing, as guided by the medical director and facility policies and procedures formulated with input from the medical director, should make certain that the resident and the resident's family understand their options with respect to advance directives and determine whether the resident already has an advance directive. If the resident does not have a DNR and wishes to implement one, the facility should assist the resident or his agent in executing a valid DNR, have the DNR signed by the medical director (or attending physician if the medical director will not serve as the resident's attending physician), document the existence of the DNR in the chart and place a copy in the resident's chart. If the resident already has a DNR, first, the facility should determine whether that DNR is valid pursuant to Florida law. If it lacks the required form and substance, facility representatives should explain that a different form is required in order for EMS or staff to comply with it and should assist the resident in executing a new, valid DNR, document its existence, and place the original in the chart.

The facility should also develop a system that will allow staff to immediately ascertain a resident's DNR status without blatantly disclosing the resident's end-of-life decision to visitors, contract workers, or vendors. One such example is providing residents with either a red and green rubber bracelet, something akin to the Lance Armstrong "live-strong" bracelet, where a red bracelet means that the resident has a valid DNR and a green bracelet indicates that the resident does not have a DNR. Likewise, placing a discreet sign or other symbol in the room of every resident who has a valid DNR will be a clear indicator to trained staff that the resident does not wish to be resuscitated. Florida law provides that usage of such devices that signify a patient's DNR status is voluntary,[37] which implies that a failure in a facility's DNR identification system, even if due to a resident's failure to wear her bracelet and/or be outside of her room when the emergency occurs, may subject a facility to civil liability for providing resuscitation to a resident with a valid DNR absent an agreement reached with the resident.

Additionally, facilities are encouraged to create back-up systems, such as a DNR Status Log, that staff may immediately check in case the resident

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LTC: DNRs, AEDs, and the Role of the Medical Director

Continued from the previous page

is not wearing the bracelet and is outside of his/her room when an emergency occurs. One staff member should be in charge of creating and updating a book that contains photographs of each resident, his or her name, and DNR status. The facility's policies and procedures with respect to the record should require that the DNR Status Log is kept current and readily available at all times. It should be maintained at the main nurses' station; however, larger facilities should maintain the record at a designated place on each floor or wing. Though an important component of an effective identification system, the DNR Status Log has its drawbacks in that a staff member may not be able to — and probably should not — take the time to check the record before beginning resuscitation on a resident suffering from sudden cardiac arrest.

In order to further reduce the potential for liability in the event of wrongful resuscitation and foster clear communication, facilities should have all residents with DNRs execute a negotiated risk agreement at the time of admission; this is strongly recommended for nursing homes with AEDs on-site. The agreement should explain the facility's policies and procedures with respect to the DNR identification system and explain the difficulties in rapidly identifying a resident's DNR status if, for example, the resident fails to wear the bracelet designating DNR status. The agreement should also contain a waiver and release wherein the incoming resident agrees to utilize the facility's DNR identification system. Each resident should also sign acknowledgment that the resident releases the facility from liability in the event the resident fails to comply with the facility's identification system, and facility staff provides lifesaving measures before the facility can determine the resident's status as having a valid DNR.

The most critical role of a medical director in this process is to establish the policies and procedures necessary to honor residents' end-of-life decisions and protect the facility and its staff from liability. In sum, the policies and procedures should include:

- Making an initial determination about the validity of a resident's DNR (at the time of admission or upon the resident creating a DNR) and any other advance directives;
- Upon the finding of an invalid DNR or other advance directive, providing assistance to determine the resident's wishes and securing valid documentation;
- Documenting all determinations about advance directives in the resident's chart (when the review of advance directives was performed, validity or invalidity of advance directives, when the DNR Status Log was updated with the resident's information);
- Keeping a copy of the advance directive(s) in the resident's chart;
- Incorporating information regarding a resident's advance directive(s) into the Care Plan;
- Adding every resident to the DNR Status Log and keeping the record up-to-date;
- Explaining the DNR compliance plan and negotiated risk agreement to every incoming resident and recommending the execution of the waiver and release to every resident with a DNR; and
- Regularly training staff on all advance directive policies and procedures. In the event the facility elects to have AEDs, the medical director should provide policies and procedures pertaining to the availability and usage of AEDs which ought to include:
- Having AEDs available on every floor or wing of the facility;
- Having easily visible signage on or near the AED to promote awareness in the event a visitor or non-staff member is in the best position to use the AED;
- Providing AED training as part of new staff member orientation and every few months so that all staff are familiar with the particular machine used at their facility and the exact location of all devices;
- Maintaining the devices by designating a specific staff member to check and ensure that the green charge indicator light is illuminated during each shift and that the expiration date has not been reached; and
- Scheduling annual servicing by the manufacturer or AED provider.

For more information on this topic, please contact: Starlett M. Miller, Esquire; McCumber, Daniels, Buntz, Hartig & Puig, P.A., 4830 West Kennedy Blvd., Suite 300, Tampa, Florida 33609. Phone: **(813) 287-2822**, Facsimile: **(813) 287-2833**, and E-mail: **smiller@mccumberdaniels.com.**

An associate at McCumber Daniels, Ms. Miller focuses her practice on professional liability defense, nursing home litigation, medical malpractice defense and complex commercial litigation. In 1998, Ms. Miller graduated cum laude from the Florida State University with a degree in English. She is a 2007 graduate of the Florida State University College of Law. Ms. Miller is licensed to practice in the courts of the states of Florida, Pennsylvania, and New Jersey.

(Footnotes)

[1] By July 1, 2011, ALFs must be in compliance with the statutory changes implemented by HB 945, which passed on June 3, 2010.
[2] 80% of sudden cardiac arrests are caused by ventricular fibrillation for which prompt electrical defibrillation is the *only* effective therapy.
[3] *See* Patient Self-Determination Act of 1990, included in Omnibus Budget Reconciliation Act of 1990, Pub.L. No. 101-508 §§ 4206, 4751, codified at 42 U.S.C.A. §§ 1395cc(a)(1)(Q), 1395mm(c)(8), 1395cc(f); 42 U.S.C.A. §§ 1396a(a)(57), (58), 1396a(w); *see also* 57 Fed. Reg. 8194 (Mar. 6, 1992) (interim final rule); 60 Fed. Reg. 33262 (June 27, 1995) (final rule).
[4] *Id*.
[5] *Id*.
[6] *See* 59A-4.106(1)(a)(3) and (7)(a), Florida Administrative Code.
[7] *See* 59A-4.106(1)(a)(3) and (7)(b), Florida Administrative Code.
[8] *See* 59A-4.106(6), Florida Administrative Code.
[9] *See* 59A-4.106(7)(c), Florida Administrative Code.
[10] *See* 59A-4.106(7)(c), Florida Administrative Code.
[11] *See* 59A-4.106(6), Florida Administrative Code.
[12] *See* § 401.45(3)(a), Florida Statutes.
[13] *See* 64J-2.018(2), Florida Administrative Code.
[14] Appointed in a nursing home pursuant to § 400.141(1)(b), Florida Statutes, and 59A-4.107 and 59A-4.1075, Florida Administrative Code.
[15] Of course, when a medical director is also a resident's attending physician, the medical director must "participate in the development of the comprehensive care plan for the resident." *See* 59A-4.1075(5).
[16] *See* § 400.147, Florida Statutes;
[17] *See* 59A-4.1075(4), Florida Administrative Code; 59A-4.1075(2)(4), Florida Administrative Code.
[18] *See* § 400.147(2), Florida Statutes.
[19] *See* § 400.147(5)(a)(6), Florida Statutes.
[20] *See* § 400.147(8), Florida Statutes.
[21] *See* § 400.147(1)(b) and (e), Florida Statutes.
[22] *See* § 400.147(1)(c), Florida Statutes.
[23] *See* § 400.147(3), Florida Statutes.
[24] *See* § 400.147(11), Florida Statutes.
[25] *See* 59A-4.106(3), Florida Administrative Code; *see also* 59A-4.1075(2)(d), Florida Administrative Code.
[26] *See* 49A-4.106(4)(b), Florida Administrative Code.
[27] *See* § 400.147(1) and (3), Florida Statutes.
[28] *See Scheible v. Joseph L. Morse Geriatric Center,* 988 So.2d 1130 (Fla. 4th DCA 2008).
[29] *Id*. at 1131.
[30] *Id*.
[31] *Id*.
[32] *Id*. at 1132.
[33] *Scheible,* 988 So.2d at 1132. The trial court granted the facility summary judgment on all counts but breach of contract because it found that there was no private cause of action under Chapter 765 regarding advance directives or the Patient Self-Determination Act and that the personal representative did not have a cause of action under Chapter 400 for breach of residents' rights where the violation did not cause the resident's death. The appellate court affirmed the summary judgments and holding that the wrong Mrs. Neumann suffered was a "wrongful prolongation of life," which did not give rise to a cause of action under Chapter 400. *Id*. at 1133; *see also Beverly Enterprises-Fla., Inc. v. Knowles,* 766 So.2d 335 (Fla. 4th DCA 2000).
[34] *Scheible,* 988 So.2d at 1132.
[35] Wilkes & McHugh, P.A., a plaintiffs' firm that has been a major player in long-term care litigation for decades in Florida, generally ceased including medical directors as individual defendants in suits against long-term care facilities years ago due to their typical low policy limits and as a matter of trial strategy. At that time, facilities usually carried substantially larger insurance coverage policies than medical directors. Anecdotally, it can be assumed that Wilkes & McHugh also determined that medical directors were considerably more cooperative as plaintiff's witnesses when they were not individually sued and, accordingly, shifted their litigation model to suing the facility, administrator and director of nursing and attempting to utilize the medical director as a plaintiff's witness.
[36] E.g., Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, Aug. 21, 1996, 110 Stat. 1936.
[37] *See* § 401.45(3)(c), Florida Statutes.

Coalition Opposes CMS Proposal to Require Physician Signatures

Ten major laboratory associations, members of the Clinical Laboratory Coalition (CLC), and the American Hospital Association (AHA) have signed a letter to the CMS administrator, Dr. Donald Berwick, to voice opposition to a Centers for Medicare & Medicaid Services proposal to require a physician's, or qualified non-physician practitioner's (NP's), signature on requisitions for clinical diagnostic laboratory tests paid through Medicare's Part B clinical laboratory fee schedule.

The justification given by CMS for this change in policy is to create a less confusing process that would eliminate any uncertainty over whether a document is a requisition or an order, as signatures would be required on both. The clinical laboratory community feels strongly that requiring a physician's signature on all requisitions for clinical diagnostic laboratory tests is not an effective solution and will lead only to further confusion, a complicated and unnecessary administrative process, and potential harm to patients forced to wait too long for laboratory tests.

The decision that a physician's signature was not the only permissible way to document the ordering of a test came as a result of the November 23, 2001, final rule after a negotiated rulemaking session involving 18 laboratory and health-care organizations, including the American Medical Association (AMA) and CMS. Changing this policy solely on the basis of establishing "a less confusing process" is not enough of a reason to do so. The confusion that exists regarding the difference between "order" and "requisition" is, in part, the result of confusing language in CMS manuals, and can be cleared up without adding the extra and repetitive step of requiring a physician signature on all requisitions.

CLC members signing the letter include the:

American Association of Bioanalysts
American Association for Clinical Chemistry
American Clinical Laboratory Association
American Medical Technologists
American Society for Clinical Laboratory Science
American Society for Clinical Pathology
American Society for Microbiology
Clinical Laboratory Management Association
College of American Pathologists
National Independent Laboratory Association

The American Hospital Association (AHA) also signed the letter, as did two large independent clinical laboratories.

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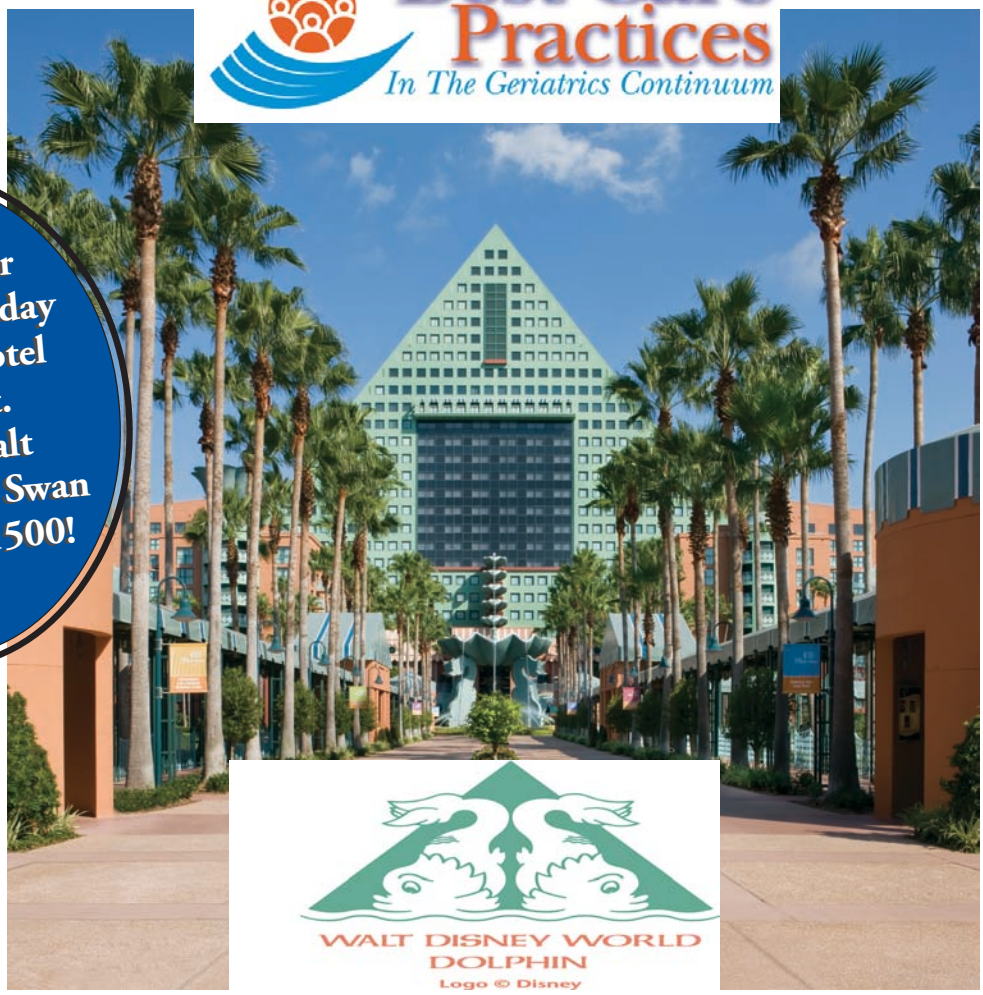

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