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

FMDA Conference a Growing Success

By Ian Cordes, Executive Director, Florida Medical Directors Association

There is so much that the Florida Medical Directors Association (FMDA) would like to share with you about its annual conference. FMDA has come a long way since its early days, and we are very proud of our progress.

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

For example, FMDA's 15th annual meeting in 2006 was very unique in that, for the very first time, the conference had its own permanent name: "Best Practices in the Geriatrics Continuum." We plan to reuse it year-after-year, and we also have a striking new custom-designed logo and Web site to match.

Best Care Practices in the Geriatrics Continuum 2006 (from left): AAHCP Past-President Dr. George Taler, AAHCP Executive Director Connie Row, FMDA President Dr. Carl Suchar, FGS President Dr. Sandhya Nemade, AMDA President Dr. Steven Levenson, FMDA IAB Co-Chair Dr. Malcolm Fraser, FL-ASCP President Dr. Toni Harrison, and ASCP President Robert Miller.

One reason we chose a permanent name is because we continue to draw attendees from all over the country. In addition, this annual conference is joint-sponsored by the Florida Medical Directors Association and the American Medical Directors Association in conjunction with the Florida Chapter of the American Society of Consultant Pharmacists, and in collaboration with the American Academy of Home Care Physicians and the Florida Geriatrics Society. This is a powerful alliance that gets stronger every year.

Over the years, we've added more educational sessions and more CME/CE intensive educational programming. Not long ago, we hosted weekend conferences where one could earn up to 12 CMEs. Those days are gone. In 2006, the total offering was nearly 30.0 CME hours.

In addition to CMEs provided for physicians and PAs,

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View photos from the 2006 Best Care Practices conference on page 19.

President's Letter

To all the members, associates and friends of FMDA, thanks for all your hard work in 2006, taking care of the most frail and elderly of patients in Florida. The mission of FMDA remains to assist you in staying up-to-date regarding the latest medical and regulatory information in order that we may all achieve the goal of delivering outstanding and efficient care.

Our 2006 yearly conference, "Best Care Practices in the Geriatrics Continuum," initiated a new direction with a growing multidisciplinary approach. I have directed our CME committee to look for new and innovative approaches to improve our yearly program with new formats and interactive learning programs. They are working hard to meet these goals. In addition, I have asked our membership committee to expand our Town Meeting programs in order to bring the FMDA leadership to as many areas around the state as possible.

Working together with other organizations involved in long-term care for our mutual benefit of achieving common goals is critical for continued success on a statewide basis and will be a priority for FMDA over the next year.

The economic stability of FMDA also remains a priority for our future. Thanks to the work of our past leaders, we are financially sound. To continue to grow, we are looking at both traditional and new innovative business relations to keep our organization strong for years to come.

Keep up all the excellent and compassionate care you are providing.

Looking forward to seeing you all in person at our next Town Meeting or at the Best Care Practices in the Geriatrics Continuum conference in Orlando, Oct. 26–28, 2007.

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

Carl Suchar, DO, CMD
President

An Invitation to Get Involved in FMDA

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

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

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

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

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

FMDA Announces Dr. Le as First Futures Program Award Winner

Florida Medical Directors Association (FMDA) President Carl Suchar, DO, CMD, is pleased to announce that Dr. Boa An Andy Gia Le, MD, was the first recipient of its Futures Program at the "Best Care Practices in the Geriatrics Continuum 2006" conference at Disney's *Contemporary Resort* in Orlando. In addition to being provided with complimentary conference registration, free membership for one year, and numerous other benefits, Dr. Le was awarded an educational grant in the amount of $1,000.

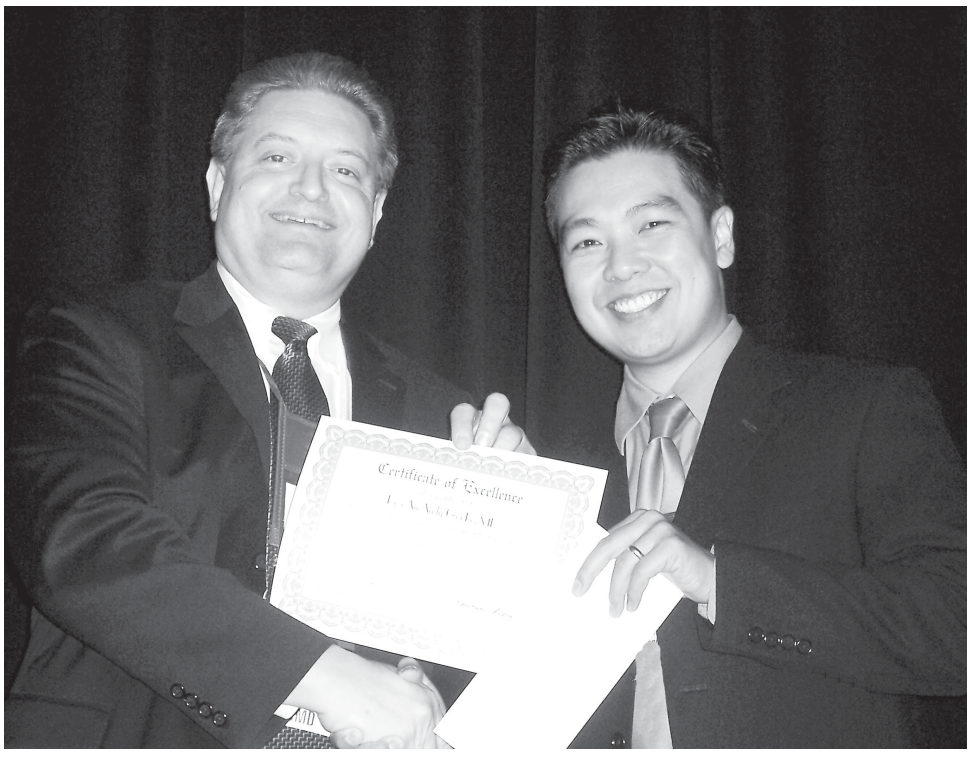
Dr. Le is a fellow in geriatrics at Florida Hospital Family Medicine in Orlando. He completed his residency at In His Image Family Medicine Residency in Tulsa, OK, where he also received his ministry ordination as well. Dr. Le completed his medical degree at Ross University School in Dominica, West Indies, and is licensed in both Florida and Oklahoma. In 2006, Dr. Le was also an American Medical Directors Association Foundation Futures recipient.

Vice President Dr. John Potomski chaired the review committee for the Futures Program and was very pleased with the outcome. In addition to being a past president of FMDA, he is also a former chairman of the board.

"The Futures Program was intended to promote physician practice in long-term care and geriatrics. We are very pleased with Dr. Le's commitment to quality care of the elderly and congratulate him for his past efforts and look forward to his commitment to improving the quality of life and health care for Florida seniors," Potomski said.

The FMDA Futures Selection Committee ranked each applicant according to his or her essay, poster submission, and credentials. This unique program is open to residents and fellows in geriatrics, family practice, and internal medicine with an interest in practicing in long-term care and geriatrics.

For more information concerning the Futures Program, please call Ian Cordes, executive director, at **ian.cordes@fmda.org**, or call the business office at **(561) 659-5581**.



Dr. John Potomski (left), Vice President, Florida Medical Directors Association, presents Dr. Le with a Certificate of Excellence in recognition of his FMDA Futures Program award.

Aging Resource Centers: A New Concept

By Edwin R. Lamm, MD, FACS, CMD

The Department of Elder Affairs, through the Area Agencies on Aging, is planning to establish regional Aging Resource Centers (ARC) to assist elders and their families in accessing publicly funded long-term care services for elders.

These include services provided by community and other public assistance programs. The ARC will expedite the Medicaid eligibility determination process for applicants of home and community-based services to the most frail applicants, and clarify the specific roles and responsibilities of each party.

The 2004 Florida Legislature amended Chapter 430 Florida Statues, requiring that the current system of public provision of home and community-based services for older persons with dementias be replaced with one based on the concept of Aging Resource Centers. The intent is to provide services in a person's best interest while reducing the use of and cost of nursing home care.

The purposes of an ARC are to enhance ease of access and utilization of aging and long-term care services, reduce system fragmentation, and offer a supported decision-making process for consumers. It will provide multiple access points to the long-term care network, that flow through one established entity with wide community recognition.

The ARC will work closely with CARES, which provides federally mandated pre-admission screening for nursing home applicants, provides client assessments to identify long-term care needs, establishes level of care, and recommends the least restrictive and most appropriate placement under authority of Title XIX of the Social Security Act as well as the Florida Statutes and Administration Code.

Aging Resource Centers functions include access; information and referral; screening; triaging; eligibility determination; long-term care options; counseling and choice counseling; fiscal control which includes wait-list management and care plan review; and quality assurance.

I am a member of the Board of Directors of West Central Florida Area Agency on Aging and have been asked to function as medical consultant to the ARC.

Note: Edwin Lamm, MD, FACS, CMD, and his wife, Rosemarie Lamm, ARNP, PhD, are co-editors of FMDA *Progress Report*

FMDA Donates to New Endowment to Promote Advanced Practice Nursing in Long-Term Care

— CFP Physicians Group starts an educational scholarship program with UCF School of Nursing

CFP Physicians Group, located in Casselberry, Florida — a suburb of Orlando, has created an advanced practice nursing endowed scholarship with the University of Central Florida School of Nursing, which will become the College of Nursing in July 2007. The purpose of this endowment is to advance training programs for ARNPs interested in geriatric health care. The program began in January 2007 with a generous five-year foundation endowment from CFP.

Dr. Steven Selznick, president of CFP, stated, "CFP has been involved with caring for patients in Orlando area nursing homes since 1983, and its physicians were one of the first members of Florida Medical Directors Association.

"Over the years, CFP has brought many physicians and midlevel providers to the annual FMDA meetings," Dr. Selznick added. "Currently, Dr. Hugh Thomas serves on the FMDA Board of Directors. CFP Physicians serves as medical director to 13 area nursing homes and together with nurse practitioners and physicians assistants, provide care to more than 1,000 nursing home residents."

The group has recognized the need for more specialty trained ARNPs providing services to the elderly population. Many ARNP programs focus their training in the outpatient or hospital setting. CFP's desire is to provide ARNP students with an earlier exposure to the exciting and challenging long-term care (LTC) environment during their practicum training.

"With early patient discharges from hospitals to skilled nursing facilities (SNFs), it is imperative that we have individuals experienced in LTC needs as well as understanding the federal regulations governing nursing facilities," Dr. Selznick said. "As the first-generation baby boomers reach Medicare age along with the increase in managed care organizations, SNFs will play a significant part in both acute care and chronic long-term care medicine. As the geriatric population's needs increase, so must the quality of care. Education and training is the first step to ensure the future of this growing health care sector."

Dr. Malcolm Fraser, Chair, FMDA Industry Advisory Board (from left); Joyce Henckler, Assistant Vice President for Major Gifts, Office of University Development, UCF; Dr. Steve Selznick, President, CFP Physicians Group; FMDA Dr. President Carl Suchar; and Dr. Victor Gambone, Immediate Past-President, FMDA

FMDA President Carl Suchar is proud to announce that FMDA had made a one-time donation to this endowment and was very supportive of Dr. Selznick's efforts to promote LTC.

"CFP Physicians has had the foresight to recognize the need to promote training and education in the long-term care continuum," said Dr. Suchar, "and our organization is fully supportive of this effort. As a result, FMDA has donated $2,500 to this endowment."

Anyone wishing to make a donation may do so by sending your tax-deductible contributions to:

UCF Foundation [a 501(c)(3), non-profit corporation]
12424 Research Parkway, Suite 140
Orlando, FL 32826-3257

Please designate your payment to the CFP Physicians Group Advanced Practice Nursing Endowed Scholarship – CHPA 000129.

For more information, contact UCF at **(407) 882-1220**.

Pensacola Hosts FMDA Town Meeting

By Hugh Thomas, DO, CMD; Membership Chair

Another FMDA Town Meeting was held in Pensacola on Jan. 19, 2007. There were almost 40 attendees present to hear Dana Saffel, PharmD, discuss F-Tag 329 and its implications in long-term care.

F-Tag 329 deals with unnecessary drugs. Specifically, this tag involves excessive doses, excessive duration, adequate indications, adequate monitoring and adverse consequences. Dr. Saffel's presentation was very informative and was just an example of the education and services FMDA brings to its members across the state.

The Town Meeting dinner was sponsored by Abbott Laboratories along with meeting co-sponsor American Health Associates, an independent laboratory servicing private physician's offices as well as nursing facilities.

Earlier in the day, the CME/Education Committee met for several hours developing this year's annual symposium. The Board of Directors met after that for a regular business meeting.

Our next Town Meeting will be held in June at a date and location that will be determined. We encourage all of our members, and those interested in joining, to attend these enjoyable Town Meeting dinners.

Hugh Thomas, DO, CMD
Chair, Membership Committee

FMDA member Dr. Michael Foley (from left); Duane Gallagher, chair, Florida's Board of Nursing Home Administrators; and Bonnie Cruz, the new president of the Florida Association Directors of Nursing Administration/LTC

FMDA President Dr. Carl Suchar, from left, with Michel DeRousse with Abbott Laboratories, the Town Meeting dinner sponsor, and Dr. Hugh Thomas, Chair, FMDA Membership Committee

Jim Jackson, Director, Business Development (from left); Debbie Martin, President; and Chris Gregg, Account Executive — all with American Health Associates — are joined by FMDA President Dr. Carl Suchar (second from the left).

LTC Leadership Council Forms

Four national organizations representing the key professions — administrators, directors of nursing, medical directors and consultant pharmacists — that provide leadership in long-term care and with roles that are defined by regulation, have joined to deliver a consistent message on behalf of their members through a new coalition, the Long Term Care Professional Leadership Council ("the Council").

The Council includes representation from the American College of Health Care Administrators (ACHCA), American Medical Directors Association (AMDA), American Society of Consultant Pharmacists (ASCP), and National Association Directors of Nursing Administration /Long-Term Care (NADONA).

The Council was formed to foster collaboration to identify and promote comprehensive approaches to defining and meeting quality standards for long-term care facilities and the care of their residents, through efforts that include: Advancing consistent standards, positions, and recommendations pertaining to long-term care; Promoting evidence-based cross-disciplinary protocols for care and for operational issues; Developing and coordinating cross-disciplinary educational programs; Overcoming political, social, and economic obstacles to coordinated, consistent care, instead of fragmentation and excessive competition in long-term care; Establishing accountability for identifying and meeting standards of care; Promoting effective root cause analysis of clinical and operational problems; Identifying and promoting optimal approaches to providing long-term care and services, and; Promoting enlightened discussion about how to advance the quality of services for residents of long-term care facilities.

The Council believes that there is great potential to improve quality in long-term care facilities by consistently using basic proven approaches to managing systems and providing clinical care. Council members are committed to advancing these approaches along with their colleagues in the trade associations, the government, and consumer advocates.

These professions stand apart because they have direct personal responsibility for running nursing homes and for providing and overseeing direct care to all nursing home residents.

Their members make the day-to-day clinical and operational decisions that directly affect the lives of the 1.5 million individuals who live or receive short-term health care services in the nation's nursing homes. Their role is further enhanced by both regulatory mandates and by their own professional standards.

As a council, they intend to identify and promote areas of agreement about common issues and concerns as well as how to attain desired goals. Future plans include outreach to the full spectrum of stakeholders.

Online Guide to State Nursing Home Regulations

Regulatory barriers are often cited for the failure of nursing homes to find ways to increase autonomy and quality-of-life for their residents. For nursing home providers wanting to better comprehend their regulatory challenges, researchers at the University of Minnesota School of Public Health determined that there was no existing repository for existing state regulations and the ways they are applied.

In response, the researchers developed NH Regulations Plus, a searchable Web site designed as a one-stop location to compare the content, changes, and applications of state regulations related to nursing homes. This user-friendly site can be used to find regulations governing facilities in a particular state, investigate a particular topic nationwide, consult federal regulations and related codes, discover what providers are developing to comply with regulations, research state regulations, and more.

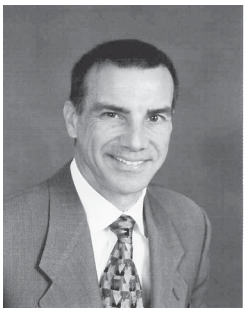
The initiative is part of a 2005 study, "Comparing State Regulations Affecting Nursing Homes: Implications for Culture Change and Resident Autonomy," and is funded by a grant from the Hulda B. and Maurice L. Rothschild Foundation. To access NH Regulations Plus, visit **www.hsr. umn.edu/NHRegsPlus**.

National Commission Hears Testimony

On Jan. 27, the National Commission for Quality Long-Term Care heard testimony from several experts about workforce issues in long-term care. The testimony can be downloaded at the Commission's Web site, where you will also find several informative reports about the current state of affairs in long-term care: **www.qualitylong-termcarecommission.org/reports.html**.

The Difference a "Caring" Care Model Makes for Floridians

By Victor Gambone Jr., MD, FACP, CMD



Health and well-being services for people who need the most care — those who are older, and have long-term or advanced illnesses or disabilities — are often the most fragmented. Traditional Medicare and Medicaid fee-for-service systems were structured primarily to provide acute care, not to meet the needs of people with complex conditions.

This fragmentation often leads to poor health outcomes, is unnecessarily costly, and is draining for both patients and physicians. People with five or more chronic conditions made up just 20 percent of all Medicare beneficiaries in 2004, but accounted for over two-thirds of the program's costs. Additionally, a 2006 Dartmouth Atlas project study[1] — examining the costs associated with caring for chronically ill seniors enrolled in Medicare between 2000 and 2003 — found that up to $40 billion (or nearly a third) of what is spent for their care is potentially unnecessary.

For nearly a decade, Evercare of Florida has been working to reduce this fragmentation by using an innovative care model that provides more, better care that is also cost-effective in both the community and institutional settings.

The Heart of the Evercare Plan — Nurse Practitioners and Care Managers

Evercare integrates medical, health, and social support services to enhance enrollees' access to health care and improve their quality of life. Today, Evercare is serving nearly 13,000 Floridians through an array of Medicare, Medicaid, and private-pay long-term care plans, programs and services. Nationally, Evercare serves more than 120,000 people.

What makes Evercare's care model so unique and effective are nurse practitioners and care managers who coordinate care for the "whole" person, not just their individual conditions.

Claudia Taylor is the daughter of an Evercare enrollee and knows the difference an extra pair of eyes can make. "My mom's quality-of-life improved because someone is watching Grace Taylor, not just that room number. My life has improved, because I can call [her care manager] Linda... Linda helps me… Evercare is a great thing."

Claudia's story illustrates how the Evercare care model works — putting people first. Nurse practitioners and care managers like Linda develop and manage personalized care plans for enrollees that focus on preventive care. They coordinate multiple services for enrollees; facilitate better communication among physicians, institutions, patients and their families; and ensure that all treatments are effectively integrated.

Additionally, Evercare nurse practitioners and care managers help ease the demands on physicians' time by answering questions about treatment plans, medications or medical conditions.

Proven Success

The Evercare care model has been demonstrated to be successful in both the nursing home and community settings. It has been shown to reduce preventable emergency room visits by half and hospitalizations by 45 percent, as well as the incidence of acute episodes in the nursing home[2]. Additionally, Evercare participates in the Florida Nursing Home Diversion Project — which helps elderly Floridians stay in their communities, rather than nursing homes, wherever appropriate — reducing nursing home placements by 70 percent over four years, according to a 2006 Office of Program Policy Analysis & Government Accountability study[3].

Evercare plans have also won fans among physicians, nursing home administrators, enrollees and their families.

Dr. Margaret R., a physician in Evercare's network, says: "I really work as a team with the nurse practitioner, the patient and their families. This team approach helps keep the family more informed and the patient much happier and healthier. It's really unique."

A 2006 survey of physicians found that 91% said they are likely to continue working with Evercare, and 85% said they are more satisfied with Evercare plans than other plans in their practices.[4] "Nurse practitioner assistance is extremely beneficial for me and makes me much more efficient," said one doctor contacted for the survey.

Among nursing home administrators nationally, 92 percent were satisfied with the overall quality of care provided by Evercare plans. They also said that having a nurse practitioner in the facility working with patients was the most important advantage of Evercare.[5]

Evercare's plan for nursing home residents also achieved 97 percent family satisfaction in a 2005 survey of responsible parties, while overall satisfaction of those involved with Evercare's Health & Home Connections and Evercare at Home programs in Florida was 93% and 94% respectively[6].

This vote of confidence underscores the critical role nurse practitioners and care managers play in optimizing the health and well-being of Evercare enrollees.

A New Generation

As the baby-boomer generation ages, the number of people in need of effective, coordinated care will surge. Evercare will grow and evolve to meet their needs in the most appropriate settings, whether living independently in the community, in nursing homes, or in assisted living facilities. But Evercare's commitment to holistic care, putting the patient first and reducing fragmentation, will always remain at the heart of the solution.

(Footnotes)

1 "The Care of Patients with Severe Chronic Illness: A Report on the Medicare Program", The Center for the Evaluative Clinical Sciences (CECS) at Dartmouth Medical School, The Dartmouth Atlas Project (John E. Wennberg, MD, MPH, et al), 2006 (www.dartmouthatlas.org)

2 Robert Kane report, University of Minnesota, reported in *Journal of American Geriatrics Society*, October 2003

3 Office of Program Policy Analysis & Government Accountability, 2006

4 *Market Strategies, Inc.*, December 2006

5 *Market Strategies, Inc.*, October 2006

6 *Market Strategies, Inc.*, October 2005 and April 2006

FMDA Now Accepting Applications for 2007 Futures Program

FMDA is pleased to announce that applications are now being accepted for the 2007 FMDA Futures Program.

Participants chosen for the program will receive numerous benefits, including a one-time educational grant in the amount of $1,000 and complimentary registration to the 2007 Best Care Practices conference, October 26-28, 2007 at Disney's *Contemporary Resort* in Orlando.

The FMDA Futures Program is open to residents and fellows in geriatrics, family practice, and internal medicine with an interest in practicing in long-term care and geriatrics. Recipients are required to present scientific posters that 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, and economics of medicine in any long-term care setting.

Applicants may submit an online application at **www.fmda.org/futures.html**. The FMDA Futures Program Selection Committee will rank each applicant according to his or her essay, poster submission, and credentials. The application deadline is Aug. 31, 2007.

For questions, please contact the FMDA business office at **(561) 659-5581**.

New Conference Web Site Under Construction

FMDA is pleased to announce that a new Web site is currently being built at **www.bestcarepractices.org** to better promote all future "Best Care Practices in the Geriatrics Continuum" conferences.

This year's conference will be held October 26–28, 2007, at Disney's *Contemporary Resort* in Orlando.

Please follow our progress as we develop this site into our main Internet access point for all conference-related information dealing with registration, educational programs, poster presentations, trade show, etc.

For more information, please contact the FMDA business office at **(561) 659-5581**.

Brevard County LTC Symposium Held

By JoAnn Fisher, ARNP; NP/PA Ex-Officio Board Member, FMDA

The 17th Annual Brevard County Long-Term Care Symposium, sponsored by the Brevard County Medical Directors Association, was held at the Melbourne Hilton Rialto on Nov. 15, 2006. The event was supported by Eisai, Inc.; KCI, Inc.; and Forest Pharmaceuticals, as well as exhibitors from 24 companies. This was the first year for exhibitor support and was very successful from both the attendees' and exhibitors' feedback. The symposium was attended by more than 400 professionals, including medical directors, physicians, nurse practitioners, DONs, administrators, and various long-term care team members.

John H. Potomski Jr., DO, CMD (left to right); Malcolm Fraser, MD, CMD; David Browning (The Mayberry Deputy); Barbara Czekalska; Dolores and Joseph Twarog.

The master of ceremonies was John H. Potomski Jr., DO, CMD, who has held this event for 17 years. JoAnn Fisher, ARNP, was the chairperson; and Joan Burritt, ARNP, of Geriatric Assessment Services provided nursing attendees with CEs. With the help of Osler Geriatric's fellow nurse practitioners and secretaries, Terry Bryan and Brandon Lee Byrd, the night went very smoothly.

Our guest speakers were Rosemary Laird, MD, whose topic was "Update in Alzheimer's Disease Therapy," Malcolm Fraser, MD, CMD, who presented "Treatment of Depression in the Medicare Part D Environment," and Stathis Poulakidas, MD, who addressed "Current Concepts in Wound Care." All speakers were excellent and very well received by the attendees.

A special surprise this year included entertainment during dinner by David Browning, "The Mayberry Deputy." He also handed out the door prizes at the end of the evening. The very funny "Deputy" has performed for millions of people throughout the United States and Canada, and has also brought a great deal of humor to many nursing home residents over the years.

In a special presentation, Charlie Antoni, of Brevard Wuesthoff Hospice and Palliative Care, received the Heart of Hospice award from the National Hospice and Palliative Care Organization for his Community Outreach Program. He was especially commended for his work with the minority communities as well as the veteran community and for developing the three hour "End-of-Life" continuous education course supported by Brevard Wuesthoff Hospice and Palliative Care.

The recipient of the annual Long-Term Care Achievement Award was Patricia Collins, administrator of Palms Rehab. and Health Care Center. "Tricia" started her career as the nursing home administrator at Medic Home in 1980, following in the footsteps of her mother, Wilma McLeod, who was the administrator of the first nursing home in Brevard County. Having been a "visitor" at the nursing homes during her school years, it is no surprise that she became part of our long-term care team in Brevard.

Susan Waterbury, ARNP, of Osler Geriatrics, received a commendation for attaining advanced certification in October 2006 from the National Board for Certification of Hospice And Palliative Nurses. The board, in association with the Hospice and Palliative Nurses Association, promotes delivery of comprehensive palliative nursing care through the certification of qualified hospice and palliative nurses. These organizations are dedicated to supporting nurses and health care team members as they improve the care of people, their families, and communities facing life-limiting and terminal illness. The advanced practice certification is an honor only obtained by 100 advanced practice nurses nationwide. This certification is in addition to board-certification by the American Nurses Credentialing Center in Family Practice.

Following the program was a hospitality hour sponsored by Dr. Potomski. This provided opportunities to interact with the speakers and for participants to network with each other regarding many long-term care issues. All the participants gave great reviews and are looking forward to the 18th Annual Brevard County Long-Term Care Symposium, which will be held in November 2007.

Cruz Elected FADONA President

During the closing moments of FADONA's 20th Anniversary Convention titled, "Sailing the Sea of Quality," Bonnie Cruz, RN, BSN, MEd, was sworn-in on as the eighth president in FADONA's history. The ceremony was held on Feb. 7, 2007, aboard Carnival's *Sensation*, by National Association of Directors of Nursing Administration President Sherry Dornberger.

Cruz is the director of nursing at the Manor at Blue Water Bay, a 120-bed skilled nursing facility in Niceville, Fla. She has served as FADONA's Region I coordinator since 1999, and had done a great job in supporting the local chapters.

"Bonnie is a natural leader and will continue to promote and develop FADONA as a premier organization designed to provide wonderful networking opportunities and professional development of directors of nursing across the state of Florida," said outgoing president Cathy Ates.

Other newly elected and appointed officers and members include Robin Bleier, 1st vice president; Carmen Shell, 2nd vice-president; Reuben Bowie, treasurer; Susie Jensvold, secretary; Tina Shook, Region I coordinator; and Rick Weber, Region III coordinator.

CMS Revises State Operations Manual

CMS has issued Transmittal R22SOMA, containing revisions to the State Operations Manual (Pub 100-7), Task 5 (Information Gathering) and Sub-Tasks 5A (General Observations of the Facility), 5C (Resident Review), and 5E (Medication Pass and Pharmacy Services) of Appendix P — Survey Protocol for Long-Term Care Facilities.

In addition, Appendix PP — Guidance to Surveyors for Long-Term Care Facilities has the following revisions:

- The regulatory text at Tags F329, F330, and F331 has been combined into Tag F329 (Unnecessary Drugs).
- The regulatory text at Tags F425, F426, and part of the regulatory text at F427 has been combined into Tag F425 (Pharmacy Services).
- The regulatory text at Tags F428, F429, and F430 has been combined into Tag F428 (Drug Regimen Review).
- The regulatory text at Tags F431, F432, and part of the regulatory text at F427 has been combined into Tag 431 (Labeling of Drugs . . .).
- The entire interpretive guidelines for all of the combined tags have been revised as well.

To view the transmittal, go to **www.cms.hhs.gov/transmittals/downloads/R22SOMA.pdf**.

Source: AMDA

AARP Public Policy Institute Announces New Publications

The AARP Public Policy Institute is pleased to announce the release of the following new publications. All are available online, and original copies may be requested by e-mailing **ppi@aarp.org** or by calling **(202) 434-3890**.

1. ***Quality Assurance for Long-Term Care: The Experiences of England, Australia, Germany and Japan*** (#2007-05) by Joshua M. Wiener, PhD; RTI International; Jane Tilly, PhD; Anna Howe, PhD; Colleen Doyle, PhD; Alison Evans Cuellar, PhD; John Campbell, PhD; and Naoki Ikegami, MD, PhD (89 pages).

www.aarp.org/research/longtermcare/quality/2007_05_ltc.html

This paper examines the long-term care quality assurance systems in England, Australia, Germany, and Japan. The approaches taken in the four countries and the United States represent a range of financing and delivery systems and use a variety of strategies to assure the quality of long-term care services. Without systematic cross-country quantitative data, it is impossible to make judgments about which quality assurance system is best or which aspect of quality assurance is most effective in improving care. Nonetheless, the United States and other countries can fruitfully learn from the quality initiatives undertaken in each nation. Contact **Don Redfoot** at **(406) 652-7155** for more information.

2. ***Work and Well-being Among the Self-Employed at Older Ages*** (#2007-04) by Julie Zissimopoulos and Lynn A. Karoly, RAND Corporation (100 pages).

www.aarp.org/research/work/employment/2007_04_work.html

This paper addresses some of the patterns of self-employment at older ages, including: (1) the characteristics of older self-employed workers and the nature of their jobs; (2) transitions in and out of self-employment at older ages; and (3) the wealth accumulation and portfolio diversification of older self-employed workers. Contact **Sara Rix** at **(202) 434-2416** for more information.

3. ***Mandatory Employer Pensions in Ireland, Germany, and The United Kingdom*** (#2007-03) by Sophie Korczyk, Ph.D. (30 pages).

www.aarp.org/research/financial/pensions/2007_03_pension.html

This paper provides a very timely description of the experiences of Ireland, Germany, and the United Kingdom in the operation of their new mandatory pension plans and how the features of those plans compare with features of 401(k) plans, providing lessons for expanding pension coverage in the United States. Contact **John Gist** at **(202) 434-3872**, for more information.

CMS Recognizes Joint Commission Accreditation for Durable Medical Equipment, Prosthetics, Orthotics and Supplies

If you are a supplier of durable medical equipment, or contract with a company that provides this service to your facility, this information pertains to you. The Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS) has granted the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) deeming authority to accredit durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) as provided by the Medicare Modernization Act of 2003.

The CMS designation means that DMEPOS suppliers accredited by the Joint Commission are "deemed" as meeting Medicare requirements, which include the recently published Quality Standards. CMS found that the Joint Commission's standards for DMEPOS are equal to, or more stringent than, the Medicare Part B quality standards.

The Joint Commission began evaluating home medical equipment suppliers in 1988 as part of its Home Care Accreditation and today evaluates approximately 1,400 home medical equipment suppliers. Joint Commission accreditation provides an assessment of a supplier's compliance with state-of-the-art standards that have been specifically adapted to the special services offered by these organizations, in addition to the CMS Quality Standards. The survey is performance-focused and emphasizes the results home medical equipment suppliers should achieve, instead of the specific method used.

The primary home medical equipment services accredited under the Joint Commission's Home Care Accreditation Program are:

- Durable medical equipment — hospital beds, wheelchairs, and lift chairs
- Oxygen delivery systems — CPAP, Bi-PAP, ventilators
- Diabetic supplies
- Ambulatory aids — canes, crutches, walkers, etc.
- Orthotics and prosthetics

For more information about Joint Commission Home Care Accreditation, visit the Joint Commission Web site at **www.jointcom mission.org**, or contact **Maryanne Popovich** at **(630) 792-5742**, or **mpopovich@jcaho.org**.

Hospice Care: An Integral Part of LTC

By Jeffrey M. Behrens, MD, FACP, CMD, CHCQM; Secretary/Treasurer, FMDA

Within most long-term care (LTC) facilities, one can find a variety of patients, including short-term or "subacute" patients recovering from a recent hospitalization or surgery, or for wound care or I.V. antibiotic therapy. In addition, many patients are long-term patients who reside in the nursing home essentially for custodial care. Within this group is a category of patients who are entering the final chapters of their lives and are appropriate for end-of-life or hospice care. Recently, there has been an increase in the numbers of patients residing in LTC facilities who are receiving hospice services.

Although hospices have existed since the Middle Ages, the recent hospice movement started in England in 1967, pioneered by nurse-turned-physician Dame Cicey Saunders. The first United States hospice started in Connecticut in 1974 and now there are thousands of hospices in this country.

All hospices offer four levels of care: routine (home) care, in-patient care, continuous (crisis) care, and respite care. Although routine care is considered home care, the definition of home is where the patient resides; even if this means a LTC facility. Many of our custodial care patients can and will remain in their own beds in the LTC facility when they are enrolled in hospice.

In-patient care is often provided in a free-standing hospice facility but can also be provided in a "contract bed" within the LTC facility. The only requirement is for patients to meet certain "in-patient" criteria. If they meet these criteria, they can be cared for in the LTC facility, and the LTC facility will be reimbursed at a higher rate. The LTC staff provides the care; and the hospice nurses, physicians, CNAs, chaplains, and social workers provide additional care.

Continuous or "crisis" care is provided when a routine home care patient is having a medical crisis, such as increasing pain, shortness of breath, impending death, etc., and additional care is required. The patient may remain in the LTC facility, and the hospice provides hospice personnel 24/7 as required.

Respite care is available for any community hospice patient who needs a place to stay for up to five days when their family and caregivers need a "respite" to allow them time to refuel their batteries. This too can be provided in a LTC facility.

Hospices provide expert care in the relief of symptoms that accompany the dying process, some of which include physical pain, spiritual & emotional pain, depression, shortness of breath, nausea, vomiting, coughing, diarrhea, and constipation, just to mention a few. Hospice physicians are specially trained in the medical aspects of these symptoms, and they work with an interdisciplinary team of professionals including nurses, CNAs, chaplains, social workers, grief counselors and volunteers. Any physician who works in a nursing home should be familiar with interdisciplinary teams. We work with them all the time.

Hospice care can and should be considered for any patient with an estimated life expectancy of 6 months or less. These conditions are NOT limited to cancer. Patients with other life-limiting conditions should be considered. These other conditions include: heart disease, pulmonary disease, dementia, liver disease, renal disease, stroke and coma, ALS, AIDS, and general debility or failure to thrive.

Many physicians who care for patients in the LTC setting are not aware that they can continue to see their own patients and bill for services rendered even though the patient is receiving hospice benefits. The truth is that hospices ENCOURAGE the attending physician to continue to treat their own patients. A hospice referral is not a mandate to come off the case. The attending knows the patient the best, is encouraged to work with the hospice personnel, and is actually considered to be part of the interdisciplinary team. The hospice physician will work alongside the attending and act as a consultant with regard to the pain medications and other medications used during the dying process. Of course, if the attending chooses to relinquish the care to the hospice physician, this can be done as well. If the physician continues to treat the patient for the hospice-related diagnosis, he/she simply bills Medicare with a "GV" modifier. If the care rendered is for a non-hospice related condition, the modifier is "GW." Medicare will reimburse the attending at the usual and customary rates as if hospice were not involved.

There is absolutely no reason why an attending physician should stop seeing his/her hospice patients. Who knows, maybe you will be exposed to a branch of medicine that you know very little about and will want to learn more about. If you are very lucky, you may become so interested in the field that you will want to become a full-time hospice physician as I have done.

Jeffrey M. Behrens, MD, FACP, CMD, CHCQM, is secretary/treasurer of FMDA and chairs its Subcommittee on Hospice. He is board-certified in internal medicine, geriatrics, hospice & palliative care, and health care quality management. He is the medical director of VITAS Innovative Hospice of Palm Beach and three nursing homes in the West Palm Beach area.

What is the Difference Between POLST and a Living Will? Does an Individual Need Both?

By W. Daniel Doty, MD, FACC, FAHA; Member, Board of Directors, Project GRACE

The existence of both a living will (advance care plan) and physician orders for life-sustaining treatment (POLST), particularly if both are present in a given individual, may seem confusing and potentially conflicting upon initial comparison. There is a tendency to expect them to be "consistent," that is to state the same restrictions in care on both documents.

However, this may not be appropriate at all. In fact, a well-written living will may be highly restrictive in treatments, whereas POLST orders may specify the patient's desire to accept any or all the treatments rejected in the living will. To understand the differences, it is critical to recognize that (1) a living will (advance directive) is a legal expression of choices made by the *patient*, typically after counseling with a physician or other knowledgeable individual, while POLST orders are a set of written *orders* chosen by the *physician*, after counseling with the patient and/or surrogate(s); (2) advance directives are choices for hypothetical conditions that may or may not occur in the *future*, while POLST orders are written as appropriate for the patient's *current* situation; and (3) advance directives (AD) apply to conditions which, by definition, are irreversible, end-stage, and have *little or no chance of recovery*, while POLST orders, since they are active orders intended for the patient's current state of health, assume that the patient's health will remain fundamentally the same or that illnesses that may arise *will not drastically change the patient's health status or prognosis.*

In other words, POLST orders typically do not apply to new, future conditions that *do* significantly change the patient's health status. Such changes usually require a significant *revision* of previous POLST orders. For example, if an individual's condition seriously worsens, the level of intensity of treatment may need to be reduced, either through discussion with the patient or with the surrogate (should the individual lose decisional capacity).

The one condition in which there *should virtually always be concurrence* between POLST and the AD is when an irreversible condition addressed in the AD *already exists* when POLST orders are written. In this instance, assuming the AD is scenario-specific (addresses both the specific medical condition that the patient has and the possible treatment choices), the POLST orders should be written in accordance with the AD.

An exception to the above clear distinction between the intent of living wills versus POLST is the fact that some living wills (such as that contained within the Project GRACE ACP) do allow "other" choices, which might include "here and now" decisions, similar to POLST. For example, an elderly individual, aware of the extremely low probability of survival of cardiopulmonary arrest, might request that all curative treatments be withheld if he or she develops an incurable condition. In addition, in keeping with advanced age, the individual might *also* write "I do not want cardiopulmonary resuscitation under any circumstances" under "other." The latter is a "here and now" treatment decision similar to that of POLST orders. For this request to be fully implemented, however, the individual should still have a physician's DNR order (POLST or otherwise) written.

Similarly, within the POLST orders, the choice of "other" under the "Medical Interventions" section, allows the possibility for the individual to request that the physician write an order addressing a hypothetical, circumstantial situation (as might be done in a living will), e.g., "I do not want any medical interventions at all, just comfort care, if I develop a permanent state of unconsciousness or an imminently fatal condition."

A reluctance to use an AD or POLST often arises when physicians or patients do not clearly understand the limits of AD and POLST documents. Physicians often fear loss of control of the patient, and patients fear loss of autonomy. A clear recognition of the limits of both ADs and POLST may serve to reassure patients, family, health care providers, and institutions that both POLST and ADs can serve their intended purposes without causing misdirection of care.

One might argue that even in patients who have both POLST orders and an AD, many conditions may arise in which a specific condition and/or treatment choice is not

addressed by either document. This is commonly true. In fact, situations that are not addressed by the AD or by POLST likely represent the *majority* of illnesses encountered by the patient over time. This is to be fully expected, since it is likely that only patients who are elderly or chronically ill will find POLST orders useful (otherwise, no restrictions in life-sustaining orders will be appropriate) and living wills typically apply only to end-stage conditions.

The great majority of treatment choices involve potentially reversible illnesses and must be based upon weighing the burdens versus the benefits of treatment at that time. They cannot be easily anticipated ahead of time and depend upon numerous individual factors involving the individual patient's medical condition and personal values and goals. In other words, the patient and physician must continue to make day-to-day treatment decisions. The patient (or surrogate) is simply exerting his or her right to make some decisions to avoid unwanted treatments in the future for circumstances or medical conditions that already exist in POLST. Through the living will, the patient is exerting his or her right to instruct physicians and surrogate(s) to withhold unwanted treatments for hypothetical, futile medical conditions that may arise in the future. The remaining great majority of health care decisions must be made on an ongoing basis.

Training Modules on Health and Aging

The fields of gerontology and aging studies continue to grow quickly, and educators working in these fields will appreciate this particular set of instructional resources. Developed and maintained by the National Center for Health Statistics (NCHS) and the American Society on Aging (ASA), these modules deal with trends in health care utilization, health-related behaviors, and health care expenditures of the United States population.

Each module has been tested by a variety of professional educators, and currently there are eight modules available on the site. Based on data from the NCHS Data Warehouse on Trends in Health and Aging, the titles include, "Life Expectancy and Mortality," "Trends in Chronic Diseases among Aged Population," and "Disability Trends Among the U.S. Aged Population."

For more information, visit **www.as aging.org/NCHS**.

FMDA Conference a Growing Success

Continued from page 1

our conference also offers contact hours for senior care pharmacists, nurse practitioners, licensed nurses, and nursing home administrators. This format is very unique and has worked very well since we first started it five years ago.

In addition to seminars, we also have poster presentations, and in 2006, we introduced a new FMDA Futures program to encourage physician practice in long-term care and geriatrics.

Attendance at our conference has grown steadily over the years. In 1999, there were approximately 125 attendees. In 2006, there were 382. In 1999, there were 20 vendors exhibiting. In 2006, there were 47 vendors with 49 displays.

One of the great things about being in Florida is that we have some amazing hotels and resorts where we can host our conference. We have just renewed a multi-year agreement with Disney to return to their *Contemporary Resort* — which is right next to the Magic Kingdom. It's an amazing property where the monorail actually runs right through it!

Please join us Oct. 26–28, 2007, as we host "Best Care Practices in the Geriatrics Continuum 2007." For more information about this amazing geriatrics medical conference, please call FMDA at **(561) 659-5581**, visit our Web site at **www.fmda.org**, or e-mail us at **ian.cordes@fmda.org**.

National Nursing Home Week Theme and Logo Unveiled

The theme for the 2007 National Nursing Home Week observance is

"Treasure Our Elders"

The celebration will begin on Mother's Day, May 13, and continue through May 19, 2007. For more information, go to **www.ahca.org/news/nr061204.htm**.

Frequently Asked Questions About Recovery Audit Contractors from the Centers for Medicare and Medicaid Services

Here are some recent statistics provided by CMS:
Number of claims with overpayments: 76,458
Number of providers receiving a demand letter: 24,338
Average overpayment ($) per provider: $138

Q. Do recovery audit contractors (RACs) look for underpayments? What happens if they find an underpaid claim?
A. Yes, RACs will identify underpayments as well as overpayments. In situations where a RAC identifies both overpayments and underpayments for a provider, the RACs offset the underpayment from the overpayment. In situations where a RAC identifies an underpayment for which there is no overpayment from which to offset, the RACs will inform the carrier or intermediary, who will proceed with the claim adjustment and payment to the provider. A *MLN Matters* article, SE0617, was released on 04/10/2006 with additional information for providers concerning the identification of an underpayment by a RAC. The *MLN Matters* article can be found at **www.cms.hhs.gov/MLNMattersArticles/download/SE0617.pdf**.

Q. Will the RAC review evaluation and management (E&M) services on physician claims under Part B?
A. At this time, the RAC shall NOT attempt to identify overpayments/underpayments that result from a provider mis-coding the E&M service (e.g., billing for a level 4 visit when the medical record only supports a level 3 visit). However, the RAC MAY attempt to identify overpayments/underpayments arising from:
• E&M services that are not reasonable and necessary,
• Violations of Medicare's global surgery payment rules, even in cases involving E&M services.

Q. How will the RAC choose the health care entity that is to be reviewed for overpayments or underpayments? Will it be a random process?
A. The RACs will use their own proprietary software and systems as well as their knowledge of Medicare rules and regulations to determine what areas to review.

Q. Will the RAC appeal process mirror the regular Medicare appeal process?
A. The Medicare Appeals process will remain the same for physicians under Part B and Part A non-inpatient claims. The only difference under Part A is for the inpatient hospital claims under the Prospective Payment System (PPS). In the current appeals process, the first-level appeal will go to the quality improvement organization (QIO); however, the RAC appeals will go to the Fiscal Intermediary that processed the claim.

Q. How are the RACs paid for finding and recovering overpayments?
A. RACs are paid on a contingency basis (i.e., they retain a portion of the monies recovered) for all accurately identified overpayments.

Q. How long does a provider have to submit medical records when requested by a RAC?
A. Providers must respond within 45 days to a RAC request for medical records. Providers may request an extension at any time prior to the 45th day by contacting the RAC.

Q. Who should providers contact with questions concerning RAC communications?
A. Providers should first attempt to contact the RAC through the customer service line. If that does not answer the provider's questions and/or concerns, then the provider can contact CMS. CMS has set up a special e-mail address for the provider community to use. It is **CMS RecoveryAuditDemo@cms.hhs.gov**.

Q. Will the RACs replace all current review entities?
A. No. Other entities such as Medicare contractors (carriers, durable medical equipment regional carriers, and fiscal intermediaries), program safeguard contractors, Office of Inspector General or quality improvement organizations (QIO) could still review a provider's claims. The RACs will not review a claim that has previously been reviewed by another entity.

Q. If a provider repays or Medicare recoups an alleged overpayment identified by the RAC and the provider later wins an appeal, will CMS reimburse the provider with interest?
A. CMS is required to pay interest when an appeal decision is favorable to the provider. The payment of interest in response to a favorable provider appeal decision is determined by CMS' interpretations of the appeal regulations. These regulations determine the process for all overpayments, not just RAC-identified overpayments.

Q. Under what circumstances will a RAC request medical records in order to determine if an overpayment exists?
A. RACs must use complex review (where medical records ARE involved in the review) in situations where there is a high probability (but not certainty) that the claim contains an overpayment.

Q. How will the RAC determine which claims to review?
A. The RACs will use their own proprietary software and systems as well as their knowledge of Medicare rules and regulations to determine what areas to review.

Q. How are the RACs paid for finding underpayments?
A. RACs are paid on a percentage basis for all underpayments identified and recovered.

Q. Under what circumstances, can a RAC make a finding that an overpayment or underpayment exists without requesting medical records?
A. RACs may use automated review (where NO medical record is involved in the review) ONLY in situations where there is certainty that the claim contains an overpayment. Automated review must:

a) have clear policy that serves as the basis for the overpayment ("clear policy" means a statute, regulation, National Coverage Determination, coverage provision in an interpretive manual, or Local Coverage Determination that specifies the circumstances under which a service will ALWAYS be considered an overpayment);
b) be based on a medically unbelievable service; or

c) occur when no timely response is received in response to a medical record request letter.

Q. Once a provider submits a medical record, who reviews it — the regular carrier/intermediary or the RAC?
A. The RAC.

Q. What is the name and contact information for each RAC?
A. Providers may contact customer service representatives by telephoning HealthData Insights (Florida only) at **(866) 360-2507**.

Q. Will the timing for appeals by the Medicare contractors be the same for the RACs?
A. Yes. The timeframe for filing an appeal remains the same.

Q. Whose claims will be reviewed under the RAC demonstration program?
A. Physicians, providers and suppliers who submit claims to Medicare.

Q. Why is CMS using recovery audit contractors?
A. Section 306 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) required CMS to complete a demonstration project to demonstrate the use of recovery audit contractors in identifying underpayments and overpayments and recouping overpayments under the Medicare program for services for which payment is made under part A or B of title XVIII of the Social Security Act.

Dementia Guidelines and End-of-Life Issues

The American College of Health Care Administrators (ACHCA), along with other industry stakeholders, is working with the Alzheimer's Association on its Dementia Care Practice Recommendations for End-of-Life Care. Designed for assisted living residences and nursing facilities, the care practice recommendations will be based on the latest evidence in dementia care research and the experience of care experts.

The Alzheimer's Association will sponsor two literature reviews to support practice recommendations — one review will focus on end-of-life care for people with dementia in residential care settings, while the other review will pertain to care provided in assisted living centers and nursing homes as well as public policy barriers to delivering that care. The recommendations also seek to incorporate religious and cultural traditions that affect end-of-life treatment decisions.

FMDA Membership Application

There are three classes of dues-paying FMDA members. **A. Regular Membership:** Every medical director or attending physician of a long-term care medical facility or organization in the state of Florida and neighboring states shall be eligible for Regular membership in FMDA. Members in this classification shall be entitled to a vote, shall be eligible to be a member of the Board of Directors and to hold office. **B. Affiliate members:** Composed of two categories, they may be any individual or organization in the medical, regulatory or political field of long-term care that wishes to promote the affairs of FMDA. An Affiliate member shall have all FMDA privileges except shall not be eligible to vote nor hold office. The two categories are: **1. Professional Affiliate members.** This category is comprised of physician assistants and advanced registered nurse practitioners. Professional Affiliate members may be appointed by the Board of Directors to serve on FMDA committees, and **2. Organizational Affiliate members.** Includes vendors, other professionals, and organizations. **C. Allied Health Professional Relations Committee:** Health care practitioners who provide essential services to patients in the postacute setting are eligible to join, including dental professionals, podiatrists, opticians, psychiatrists, senior care pharmacists, psychologists, etc. Committee members are non-voting, and may be appointed by the Board of Directors to serve on other FMDA committees.

This is the only organization in the state devoted to physicians, physician assistants and nurse practitioners of all specialities practicing in hospital-based, skilled nursing units through subacute care to traditional long-term care. To become a member of FMDA, please complete the following and mail to the address below:

❒ **Yes! I would like to join FMDA.** Enclosed is a check for **$65** for annual dues for **Regular, Professional Affiliate members,** and **Allied Health Professional Relations Committee.** Dues for **Organizational Affiliate members** are **$145** per year.

Name: _____ **Title:** _____

Facility Name/Affiliation: _____

Organization's Name: _____

The mailing address below is for _____ the facility, or _____ my regular office address.

Mailing Address: _____ **City:** _____ **State/ZIP:** _____ **County:** _____

Phone: _____ **Fax:** _____ **E-mail:** _____

Please make check payable to FMDA and mail to: 200 Butler Street, Suite 305 • West Palm Beach, FL 33407

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

Please share this with a colleague who would benefit from membership in FMDA!

News Briefs . . . News Briefs . . . News Briefs . . .

Advancing Excellence in America's Nursing Home Campaign

More than 1,000 nursing homes have already joined the Advancing Excellence in America's Nursing Homes campaign. For facilities already engaged in Quality First and the Nursing Home Quality Initiative (NHQI) or other quality improvement programs, participating in the campaign provides added recognition for what they are already doing to improve the quality of life for residents and staff.

To learn more, visit **www.nhqu alitycampaign.org**.

Flu Vaccine Ordering Information

Several companies are offering Flu Vaccine for the 2007–2008 seasons:

FFF is a company that allows you to choose your delivery dates. For more information, visit **www.my fluvaccine.com**.

Sanofi Pasteur is accepting new orders for Fluzone vaccine in all product presentations. Providers should call 1-800-VACCINE (1-800-822-2463) to place an order for immediate shipment.

GSK is offering the influenza vaccine Fluarix to customers to order online, through a new Web site at **www.GSKvaccinesdirect.com**.

Please note: FMDA does not endorse one manufacturer or distributor over another, but would like to make sure that all members have the tools to keep their residents and staff healthy.

MedPAC Recommendations for 2008

On January 9, 2007, the Medicare Payment Advisory Commission (MedPAC) met to vote on recommendations for updating the major Medicare payment systems. Noted here is information relative to skilled nursing facilities (SNFs).

PAYMENT UPDATE RECOMMENDATIONS

Congress should eliminate the update to payment rates for skilled nursing facility services for fiscal year 2008. MedPAC estimates that this recommendation will reduce Medicare spending by $250 million to $750 million in 2008 and by $1 billion to $5 billion over five years. No effect on providers' ability to furnish care to Medicare beneficiaries is expected.

INDICATORS OF PAYMENT ADEQUACY

Overall supply: stable.
- Volume of services: increasing.
- Access to care: good, but certain beneficiaries may experience delays.
- Quality: declining, as measured by rehospitalizations and community discharge.
- Access to capital: good.

ESTIMATED SNF PROFIT MARGIN IN 2005 (freestanding providers)

- Overall: 13%
- Urban: 12%
- Rural: 15%
- Hospital-based: -85% (loss)

PROJECTED SNF PROFIT MARGIN IN 2007

- Overall: 11%

OTHER ISSUES

The estimated market basket update is 3.1%

Large negative margins in hospital-based SNF (-85% in 2005) appear to be related to allocation of overhead, higher cost structures, different patient mix, and larger number of residents in extensive service RUG categories.

Hospitals have SNF for a number of reasons: reduce inpatient length of stay, can't place resident in freestanding SNF, and additional payment for episode.

While hospital-based SNFs have large negative margins on average, reimbursement for the patient's episode overall (inpatient & SNF stay) are generally covering their direct costs on average.

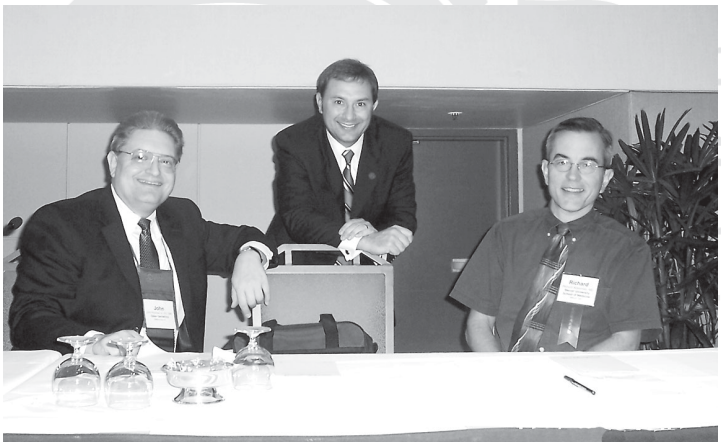
COMMISSIONER COMMENTS

Commissioners requested additional analysis to examine why rehospitalization rates have been increasing and any differences between hospital-based and freestanding SNFs. Commission staff reported that a consultant is preparing a report on this and other issues. The report will be available in Spring 2007. A written transcript of the staff briefings and commissioner discussions is posted on the MedPAC Web site at **www.MedPAC.gov**.

Highlights from the 2006 Best Care Practices in the Geriatrics Continuum Conference

Dr. Akila Balasubramanian (from left), Dr. Carl Suchar, Dr. Victor Gambone and Dr. Hugh Thomas

AAHCP Executive Director Connie Row (from left) with moderator and FMDA Board member JoAnn Fisher, ARNP, and AAHCP's Dr. George Taler



FMDA Vice-President Dr. John H. Potomski Jr., (from left); with speakers Richard Marasco and Dr. Richard Ackermann

FMDA Membership Meeting: Dr. Carl Suchar (from left) delivers his annual report as Secretary/Treasurer Dr. Jeffrey Behrens; Chairman of the Board Dr. Morris Kutner; and Director Dr. Daniel Fortier, look on.

AAHCP Board member and session moderator Kathy Kemle, PA, (from left), with speakers Dr. George Taler and Dr. Dennis Stone

AMDA President Dr. Steve Levenson (left), with FMDA President Dr. Carl Suchar

Seventh Annual IAB Meeting Held in Tampa

On Feb. 20, a group of dedicated industry insiders who sit on FMDA's 2007 Industry Advisory Board (IAB) gathered in Tampa to discuss the challenges faced by health care practitioners and industry providers. The IAB is co-chaired by FMDA Past-President and former Chairman of the Board Dr. Malcolm Fraser and David Reis with Boehringer Ingelheim. Participants represented such organizations as: Amgen, Boehringer Ingelheim, Eisai, Forest Laboratories, GlaxoSmithKline, Humana, Merck Vaccine Division, National Conference Gerontological Nurse Practitioners, Novartis, PAR Pharmaceuticals, Teva Neuroscience, and Watson Pharma

FMDA's *Progress Report* ***Spring 2007***

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