

fmda™

Dedicated To Florida Long Term Care Medicine

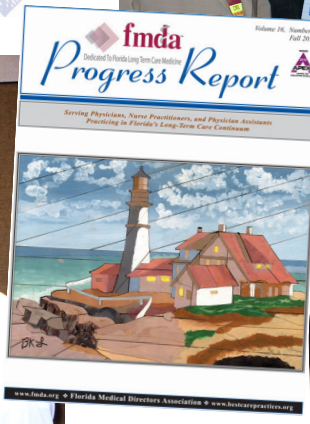
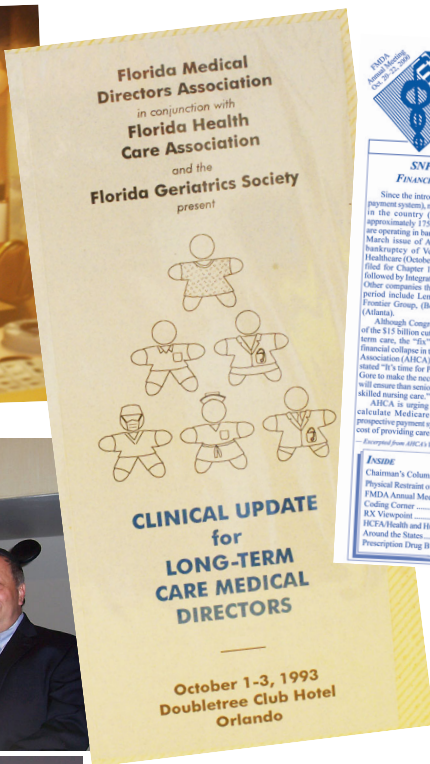
Progress Report

Special 20th Anniversary Edition



*Serving Physicians, Nurse Practitioners, and Physician Assistants
Practicing in Florida's Postacute Care Continuum*

Happy 20th Anniversary FMIDA!





Dedicated To Florida Long Term Care Medicine

Florida Medical Directors Association

Serving medical directors in Florida's postacute, subacute, skilled care and assisted living facilities.

www.fmda.org

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President's Letter

Just in case you hadn't heard, our 20th Annual Conference, Best Care Practices in the Geriatrics Continuum 2011, was a resounding success. We received nothing but glowing feedback, which will be sure to have attendees coming back for years to come.

During the conference we provided our members with the opportunity to join and participate on one or more of FMDA's key committees for 2011-2012. If you were not able to attend, or did not submit your preferences onsite, you are invited to join us in the important work of our association by contacting our business office at (561) 659-5581.

In addition to the election of new officers and directors, and the approval of our revised bylaws (available at www.fmda.org and page 5), the Membership Committee is excited to announce the creation of new member categories and options (see new membership application form on page 13).

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 number of physicians, nurse practitioners, and physician assistants possible. We need all of your help if we are to succeed.



Rep. John Wood

FMDA hosted a Town Meeting and Dinner on January 14 in Palm Beach Gardens. The weekend featured a small trade show and reception along with a dinner program sponsored by Lendbeck. We hosted another successful Town Meeting and welcomed guest moderator Gilda Osborn, administrator of Whitehall Boca Raton. Osborn is president of Florida Health Care Association's District VII and a past president of the Florida Association Directors of Nursing Administration/LTC.

The following morning, we conducted a CME/Education Committee lead by Dr. Robert



Kaplan and a board meeting headed by Chairman of the Board Dr. John Potomski.

I recently had the opportunity to be Physician of the Day during the Legislative Session in Tallahassee for the Florida Medical Association. As you may know, FMDA

is a Specialty Society of FMA. I was shown around the Capitol by Florida Senate President Mike Haridopolis and had the opportunity to discuss our case to exempt SNFs from the requirements of the Pill Mill Bill with a number of elected officials.

Please find the time to learn all you can about the impact of the Pill Mill Bill's controlled substance prescribing requirements on the hospice and nursing home populace. You can start by visiting FMDA's website at <http://fmda.org/advocacy.html>.

As a result of Dr. John Potomski's genuine concern for our members, FMDA jumped into action and worked very hard to add an amendment to exempt nursing homes and hospices from these onerous requirements. We are grateful to all our friends who signed onto our letter of support (see page 19), and especially to the Florida Osteopathic Medical Society, LeadingAge Florida, and the Florida Health Care Association.

I am very thankful 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 our next Town Meeting on June 9 in Tampa, or at the Best Care Practices in the Geriatrics Continuum 2012 conference in Orlando, Oct. 25-28.

If you ever have any questions, please feel free to contact our executive director, Ian Cordes, at (561) 659-5581, or ian.cordes@fmda.org.

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

Sincerely yours,

John G. Symeonides, MD, FAAFP, CMD
President



FMDA President
John Symeonides with
Florida Senate President
Mike Haridopolis

Plans Under Way for Another Outstanding Conference

— Register today for Best Care Practices in the Geriatrics Continuum 2012

Dear Friends:
Here is an update on our 21st Annual Conference, Best Care Practices in the Geriatrics Continuum 2012, to be held Oct. 25-28, in Orlando.

We recently issued a “Call for Presentations,” which has already produced some very interesting proposals for our conference. This process will continue to add a new and dynamic dimension to our conference programming.

We will be providing 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 issues, as well as our annual forum with our national leaders.

At this time, we are developing the educational program to address the most requested topics from last year’s conference. Some of these broad topics include cardiovascular, dermatology, endocrine, gastroenterology, hematologic, and ophthalmology related disorders. Other areas include musculoskeletal, infectious and neurologic diseases, nutritional/hydration disorders, psychiatric disorders and emergencies (including use of the Baker Act), when to discontinue screening procedures and medications, oral health and additional geriatric syndromes (e.g. falls).

Of course, there will be some cutting-edge administrative talks, such as Medicare reimbursement update, ethical dilemmas, Quality Indicators/Quality Measures, advance directives, risk management, physician/consultant pharmacist communication, physician/NP collaboration models, and liability insurance challenges/solutions.

We are very pleased to welcome back all the official liaisons from our collaborating organizations to our CME/Education Committee as well as the University of Florida’s College of Pharmacy, which

will once again provide the CPEs for pharmacists in attendance.

We are working with AMDA again this year to provide another optional intensive on Thursday, Oct. 25, a preconference day. In addition, on that same day we will host the Basic Training Course for New Practitioners and Those New to Long-Term Care.

This conference has earned a great reputation for its unique multidisciplinary approach to educating 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 will include national and regional authorities in the fields of medical direction, senior-care pharmacology, LTC and geriatric medicine, and LTC administration.

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.halloweenhorrornights.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 2012”** at *Disney’s* Magic Kingdom.

Let us know if you have any questions.

Yours truly,

Robert Kaplan, MD, FACP, CMD; Chair, CME/Education Committee; and Rhonda Randall, DO; Vice Chair, CME/Education Committee; and Program Director; Best Care Practices in the Geriatrics Continuum 2012

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2012 Poster Sessions Schedule*

Walt Disney World Dolphin Resort, Lake Buena Vista, Fla.

POSTER SET-UP

FRIDAY, Oct. 26, 11 a.m.–1 p.m.

POSTER VIEWING

FRIDAY, Oct. 26, 1-2:30 p.m., 5:15-7:15 p.m.

SATURDAY, Oct. 27

8-9 a.m.; 1:45 a.m.–12:30 p.m.,

Luncheon: Poster Recognition–12:45-2:15 p.m.

POSTER TEAR-DOWN

SATURDAY, Oct. 27, 2:15-4:15 p.m.

*Subject to change. Presenters are not required to be present during all viewing hours.

New Board Installed at FMDA's 20th Anniversary Conference

— Another Successful Annual Program

By Matthew Reese, Communications and Education Manager

FMDA hosted its 20th annual conference this past October, which gathered more than 400 long-term care (LTC) based practitioners and exhibitors at Disney's Grand Floridian Resort in Orlando. The conference was another huge success and capped another great year for the association.

American Medical Directors Association (AMDA) president Dr. Karyn Leible was on hand to install the new slate of officers – most notably, Dr. John Symeonides as president and Dr. John Potomski Jr. as chairman of the board. Drs. Symeonides and Potomski have had extensive roles in the shaping of FMDA and the organization will most certainly benefit from their continued leadership.

Dr. Symeonides, the co-chair of FMDA's education committee for the past year and program director for its annual conference, has put extensive time and effort in establishing FMDA as one of the leading organizations in LTC. As president, Dr. Symeonides will remain focused on issues that affect long-term care providers. "I look forward to continuing the fight for LTC and geriatrics in the state of Florida, and promoting our organization as an effective resource and sounding board for our members and other health care providers, so that they can provide the best possible medical care to our seniors," said Dr. Symeonides.

Dr. Potomski is a past-president of FMDA and a former chairman of the board, a role in which he is once again serving. He has worked diligently to establish FMDA as a national model and helped to catapult the association into one of the most respected LTC

membership societies in the state. As chairman of the board, Dr. Potomski looks to expand the organization even more and keep FMDA at the forefront of advancing geriatric care by encompassing the entire health care interdisciplinary team.

Other officers installed by Dr. Leible include Dr. Robert Kaplan as vice president; Dr. Leonard Hock as secretary/treasurer; and new directors Dr. Karl Dhana, Dr. Daniel Fortier, Dr. David LeVine, Dr. Naushira Pandya, Dr. Rhonda Randall, Dr. Diane Sanders-Cepeda, and Dr. Carl Suchar. In addition, Jan Cripanuk was elected to the FMDA board by its NP/PA members.

FMDA was honored to have the AMDA president officiate at the installation of the officers and directors. During the ceremony, Dr. Leible offered these words, "FMDA is at the forefront in LTC medicine and remains one of the most influential chapters of AMDA in the interest of best care practices and optimizing patient health in the geriatrics continuum."

During the Annual Awards Luncheon, FMDA announced the winner of the 2011

Poster Presentation Awards, Carol Motycka, PharmD, a pharmacist and assistant dean and clinical assistant professor at the University of Florida College of Pharmacy. Congratulations to Dr. Motycka!

Visit www.bestcarepractices.org for a complete photo display of the 2011 annual conference and updates for FMDA's 21st annual conference to be hosted at the Walt Disney World Dolphin Resort in Lake Buena Vista, October 25-28, 2012.



National leaders (from left) including AGS president Barbara Resnick, PhD; GAPNA President Elizabeth Galik, PhD; and AMDA President Dr. Karyn Leible with FMDA President and National Leadership Council moderator Dr. Hugh Thomas.



From left: Jan Cripanuk, MS, ARNP; Rhonda Randall, DO; Diane Sanders-Cepeda, DO; David LeVine, MD, CMD; Karl Dhana, MD, CMD; Naushira Pandya, MD, CMD; Daniel Fortier, MD, CMD; Leonard Hock, DO, CMD; and Robert Kaplan, MD, CMD
Not pictured: Carl Suchar, DO, CMD; John Symeonides, MD, CMD; John Potomski, DO, CMD; and Hugh Thomas, DO, CMD

Bylaws Revisions Approved at Annual Membership Meeting

FMDA's Bylaws Committee, chaired by Past-President and former Chairman of the Board Dr. Morris Kutner, has done a very thorough review of the Association's bylaws — which have not changed since 1999 — and identified a number of changes that will make governance of FMDA more appropriate, relevant, and meaningful. These changes were reviewed and endorsed by the board of directors, and approved during the annual meeting on Saturday, Oct. 22, 2011.

Overview of the main changes to FMDA's Bylaws

III. MEMBERSHIP

Section 1. FMDA has gone from three classes of membership to "multiple." Original classes included regular membership, honorary membership, and affiliate membership. The new classes include:

a. Retired – Including physicians who are fully retired; **b. Lifetime** – Including physicians who continue to work and are not retired; and **c. Students**.

Section 7. We were required to terminate any regular membership when a member no longer served as a medical director or attending physician of a LTC medical facility or organization in the state of Florida or neighboring states. This was rescinded. The fact that a member may not currently be a medical director or attending physician in a skilled nursing facility should in no way be an automatic reason for disqualification from FMDA membership.

IV. BOARD OF DIRECTORS

Section 2. The Board of Directors has consisted of the officers and five (5) directors. There can now be up to seven (7) directors. In addition, the office of the Chairman of the Board will automatically be held by the Immediate Past-President, instead of being elected by a majority vote of the Board of Directors.

Section 6. What had been a non-voting ex-officio board position was changed to a two-year voting board position for NPs and PAs. This individual will be elected by NP/PA members of FMDA every two years and will be either be an advanced registered nurse practitioner or physician assistant.

On behalf of the members, officers, and directors of FMDA, we salute Dr. Kutner for his commitment and diligence, and for his thoughtfully proposed revisions. They will define our association's governance for years to come, and for that we are very grateful.

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.

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Greetings from Across the Pond!

Please accept both my congratulations for this milestone 20th Anniversary Conference and best wishes for yet another successful meeting!



I regret not being able to be there — I was in London attending a medical school reunion and also celebrating my aunt's 90th birthday.

Several recollections come to mind concerning the annual conference — both professional and personal.

Professional:

1. Early on, we were so short of money that we had a protracted discussion as to whether or not we should register the internet domain name www.fmda.org for \$75!

2. In the late '90s, we had a significant misunderstanding with a pharmaceutical company that had the potential to be a significant setback. Instead, under Dr. John Potomski's leadership, the collective wisdom of FMDA leadership prevailed, and we created the first-ever AMDA state chapter industry advisory board. This was making a positive out of a potential negative.

FMDA has been very important both to my family and me. Thank you for the opportunity to serve.

— Dr. Malcolm Fraser

Personal:

1. For many years, both of my daughters would attend the conferences. This contributed towards them both developing a passion for medicine and they are now both anesthesiology residents.

2. My daughters would share a connecting room and foolishly one night I threatened to sleep in the car if they did not stop disturbing me. Two hours later, Disney Security woke me up in my car and, after listening to my explanation and verifying that I had a room at the hotel, they explained that whenever there was an unusual event involving a group's guest, company policy required that they notify the leader of the group. However, since I was the leader of the group they were pleased to provide an additional free room immediately!

FMDA has been very important both to my family and me. Thank you for the opportunity to serve.

Please be assured of our continued interest in the success of FMDA.

Malcolm Fraser MD, CMD
Malcolm Fraser, MD, CMD
 President: 1993-1997

A Celebration of FMDA's Early Years as Witnessed by Some of its Past Presidents



Dr. Hanford Brace

Thank you so much for asking again about the early years of FMDA. Here are my thoughts.

I had become interested in long-term care after becoming medical director of one facility in 1980. It had just been built and during construction I was approached by our local hospital case planner who asked me if I would like to be medical director of this new facility. She had contacts everywhere and assured me the job was mine. I was told there was nothing to it and all I would have to do would be to attend a monthly meeting and take any "loose" patients as their attending physician.

I happened to arrive at the first lecture a few minutes late but just in time to see Dr. Eric Tangalos sitting in a chair on stage with full restraints on such as we used in those days to keep wandering residents in place.

— Dr. Hanford Brace

Sometime during my rounds, in our now three local LTC facilities, I came across a brochure describing a medical directors meeting in Tampa. I forget the description of the meeting but decided to attend. This was during the time period when Medicare started talking about restraints and drug management. Not liking anybody telling me what to do when I was caring for a patient, I went to that meeting with a chip on my shoulder.

The attendees of that meeting, 75 or so, came from the usual physicians from northern states wanting a sunny, warm, tax-deductible vacation, while only a handful were from Florida. We all were looking for CME. I happened to arrive at the first lecture a few minutes late but just in time to see Dr. Eric Tangalos sitting in a chair on stage with full restraints on such as we used in those days to keep wandering residents in place. During the whole lecture on restraints, including drugs in fashion at the time as well as physical restraints, Eric continued trying to get out of the chair and yelling out. He really was annoying and I thought it a bit rude of him to constantly be disrupting the meeting. However, as the lecture continued, we all understood his actions! He finally fell over "intentionally" and was taken out of the restraints and joined in the lecture. I made a comment when the audience was allowed, stating I now understood why Medicare and the small national group called AMDA were interested

in our long-term care patients' rights regarding physical restraints and drug restraints. I was also convinced at that meeting to start attending all AMDA yearly meetings. The statement I made at that meeting was used in a local newspaper.

Several years later, at another annual AMDA meeting in Orlando, now a bit larger with about 150 attendees, I found out that Florida did not have a state chapter. This was during the time that AMDA was a very small group nationally. I was attending a lecture by Roman Hendrickson on the benefits of being a medical director and state chapters' roles in the national group and the power we would have being united together. After we had some group discussion about the subject with him, I asked for those wanting a Florida medical directors association formed to stay and meet with me at the end of the lecture.

I think four doctors beside myself, stayed and the discussion began about the formation of a state chapter. I am sorry I do not remember all the doctors who stayed but I do remember Jim Lett being there. We made a resolution to form a state chapter and the others appointed me as president! They wanted me to get the state bylaws written for our now new state chapter. I also was given the task of calling our first annual meeting in October of 1991 and arrange the lectures and the speakers. We first met together during the annual AMDA meeting in early March of 1991 and FMDA was official in October 1991 with its first annual meeting. About 75 attended. We were off and FMDA has been thriving ever since! AMDA has worked very hard for all state groups, which I now know is every state in USA! I am proud to be a member of both AMDA and FMDA.

*Hanford Brace, MD
President: 1990-1991*

Dr. James Lett

I can still remember sitting in a room at Disney's *Contemporary Resort*, I believe, at an AMDA meeting when the AMDA staff said that we should start a Florida AMDA chapter. I recall thinking, "Why not?" Saying that got me appointed vice president of the new Florida chapter – FMDA.

Before really having time to determine just what that entity would do, Hanford Brace, the initial president, had an acute medical issue. Suddenly I was president after driving to Dr. Brace's home in Central Florida to pick up what papers and books existed for the chapter. Several years of letter writing and phone calls began to attempt to get some notice and more members.

The early supporters were everywhere: physicians, nurses, and nursing facilities were all helpful and all believed.

I was able to convince a pharmaceutical company to support the publication of a newsletter. Soon it was clear to me that we needed expertise in organization and promoting a more professional newsletter. I contacted Ian Cordes for help, and the rest is Florida long-term care history.

I always felt that Florida had the ideal setting for a physician long-term care organization: lots of elders needing good geriatric care, numerous nursing facilities, and a wide variety and number of providers. For example, my home county, Pinellas, had more

We Salute FMDA's Presidents



Hanford Brace, MD
1990-1991



James Lett, MD, CMD
1991-1993



James Honigman, MD
1993-1993 (6 mos.)



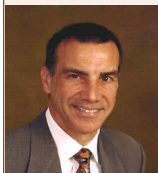
Malcolm Fraser, MD, CMD
1993-1997 (3 1/2 years)



John Potomski, DO, CMD
1997-1999



Morris Kutner, MD, CMD
1999-2001



Sherry King, MD
2001-2003



Victor Gambone, MD, CMD
2003-2005



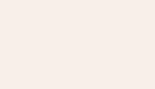
Carl Suchar, DO, CMD
2005-2007



John Potomski, DO, CMD
2007-2009



Hugh Thomas, DO, CMD
2009-2011



John Symeonides, MD, CMD
2011-2013

nursing facilities than many states. While there was never a doubt that FMDA was necessary, the efforts of numerous people have built an FMDA to a magnitude that those of us at the beginning could never have imagined.

While there was never a doubt that FMDA was necessary, the efforts of numerous people have built an FMDA to a magnitude that those of us at the beginning could never have imagined.

— Dr. Jim Lett

The First FMDA Meeting

The first FMDA meeting took place in Orlando, due to its central location, and better draw with its close proximity to Disney World. It was felt that the fledgling FMDA organization would not be able to grow without an annual meeting to showcase the importance of long-term care. Several people were instrumental in making the meeting happen. Pharmaceutical entities were generous in supplying speakers and donating sponsorships, and a meeting agenda was put together. Appropriately enough, that first FMDA occurred in Orlando. Some 40-50 people attended the single-day event.

James Lett
President: 1991-1993

Dr. Malcolm Fraser

Picking up from where Jim Lett left off . . .

I was invited to present at the first meeting, which was held at a Holiday Inn Express Hotel just east of Disney in 1991.

Under Jim's leadership, Bill Cosner and Marjorie Boyd provided a lot of the logistic support for the meeting, and the keynote presentation was made by Keith Rapp from Houston, TX.

At the end of the meeting, Jim kindly offered to walk me out to my car and told me that I had just been elected president, but I had the right to refuse since I had not been aware of being nominated!

I had already worked with Jim in a different capacity, had had dinner at his home, etc., and so my only condition was that he would be available for support, which he readily agreed to. Remember, this was before fax machines, cell phones, and e-mail!

Anyway, with a great board of directors and with no money we hired an outstanding executive director, Phil Runnels, and began to figure out a way to pay expenses.

Deanna McElenny blindly contacted us and suggested that we start a newsletter, *Progress Notes*, which she published for many years.

For a few years we had the annual meeting at the Holiday Inn or

Continued on the next page

FMDA's Early Years as Witnessed by Some of its Past Presidents *Continued from page 7*

Embassy Suites on Orlando's International Drive. I moved up to replace Jim as Board Chair. We began to form partnerships with other entities that had commonality of purpose and John Potomski as president took us to a whole new level.

Malcolm Fraser

President: 1993-1997

**Remember, this was
before fax machines,
cell phones, and e-mail!**

— Dr. Malcolm Fraser

Dr. Victor Gambone

In 2002, Dr. Sherry King was the FMDA president. As vice president I found myself suddenly engaged in more activities than I had ever imagined. It was an exciting time. The role and responsibilities of the medical director in long-term care was gaining much attention.

In 2003, the Office of the Inspector General concluded its investigation of the involvement of the medical director in long-term care. They found that, "...although every skilled nursing facility is required by law to have a medical director, few facilities are fully using this individual to improve care, improve survey results, or improve the bottom."

**FMDA members are a great group
of professionals who truly care
about the work they do. It was a
pleasure and an honor to serve as
their president and champion the
great work they do throughout the
state during this exciting time.**

— Dr. Victor Gambone

In March 2004, the Centers for Medicare and Medicaid Services released the final draft of the revised requirement for the medical director that is F-tag 501. This revision to the guidance to surveyors included 13 pages of expectations for the medical director.

We had a lot of work to do to get everyone up to speed. Our

award-winning newsletter, *Progress Report*, got the word out. We held town meetings around the state to engage local medical directors. FMDA membership grew and registration at the annual meeting doubled. The revised F-tag 501 guidelines were implemented in November 2005.

FMDA members are a great group of professionals who truly care about the work they do. It was a pleasure and an honor to serve as their president and champion the great work they do throughout the state during this exciting time.

Victor Gambone Jr., MD, FACP, CMD

Laguna Beach, California

President: 2003-2005

Executive Director's Turn

I will never forget the fateful phone call I received one day late in 1999 or early 2000. It was Dr. Malcolm Fraser from FMDA. He wanted to know if I knew anyone who could take over as the executive director of FMDA.

Dr. Fraser and I had worked together previously on behalf of FMDA and had created a new FMDA publication titled *FMDA Journal*. It had been completely funded by advertising and sponsorships and ran successfully for about two years.

As a former nursing home administrator already managing other long-term care associations in Florida, Dr. Fraser knew I would have an interest in working with FMDA again. So, he and I reached an agreement that was later approved by the board of directors. And so, I became FMDA's second executive director in March 2000.

I remember Dr. Morris Kutner coming to meet me at my old office in Lake Worth not long after I started. He was FMDA's president at the time and Dr. Fraser was Chairman of the Board. Dr. Sherry King, who was to become the next president, was editor of the *Progress Report*.

One event remains particularly clear in my mind. Sometime during our 2000 annual conference in Orlando at the Buena Vista Palace Hotel (then known as the Wyndham Palace), Dr. Fraser gathered Dr. Kutner and me, and we met with the leaders of the Florida Chapter of the American Society of Consultant Pharmacists to discuss how we could work together as organizations. Little did we know how much that meeting had laid the groundwork to allow us to forge a decade-long working relationship with the consultant pharmacists in long-term care and develop a new and exciting LTC conference paradigm.

Of course, I am referring to the experiment now better known as the nationally recognized conference, called the Best Care Practices in the Geriatrics Continuum.

As FMDA's executive director, I have had the pleasure and honor to work directly with every FMDA president except Dr. Brace, Dr. Honigman, and Dr. Lett. Each president brought his or her own focus, direction, energy, and greater passion to our association. I am always in awe of the commitment and dedication that all our board members, past and present, have provided in our continual effort to bring FMDA to higher and higher levels.

Thank you FMDA and Dr. Fraser, for giving me the opportunity to serve! It has been an honor and privilege.


Ian Cordes

Executive Director

Coding Corner

By Christopher P. Acevedo, CHC, CPC; Acevedo Consulting Incorporated



Welcome back to **Coding Corner**. In this and subsequent issues of *Progress Report*, we will present clinical long-term care cases and ask our expert coder, Chris Acevedo, how he would code that visit.



To recap the Medicare billing codes:

Initial nursing home: 99304, 99305, 99306

Subsequent nursing home: 99307, 99308, 99309, 99310

New assisted-living facility patient: 99324, 99325, 99326, 99327, 99328

Subsequent ALF patient: 99334, 99335, 99336, 99337

CASE 1. An 84-year-old man, a long-term care (LTC) resident of a nursing home, is re-admitted from a 4-day hospital stay on oral antibiotics. His past medical history is that of diastolic CHF, atrial fibrillation, hypertension, hyperlipidemia, mild COPD, mild to moderate dementia, anemia, and arthritis. The problem of today is follow-up of walking difficulties 2° functional decline, fatigue, and a foot infection. The documentation of the progress note is as follows: Hx: This is an 84-year-old African American male, still having problems with the right foot, an infection has him on antibiotics apparently. Today, he says he has had no fever or chills. His foot is better since his medications and dressings have been started. His appetite is okay. He has had no shortness of breath. On exam the patient seems fairly comfortable at rest at 30° in bed. Respiratory rate 20, BP 116/70, pulse 78, temperature 97. O2 sat 93% on 2 L. No JVD, lungs clear but diminished sounds, cardiac irregular, no murmur, no S1, S2, S3, trace edema, otherwise unremarkable. Your dx is same as above plus functional decline. Your treatment plan includes monitoring breathing, oxygen, BP. Starting physical and occupational therapy. Monitoring electrolytes, bun/cr and CBC. You expect the patient to stay for about 2-4 weeks if recovery to his baseline occurs at a steady pace.

Which code would you choose? 99304, 99305, 99306. Would the code be any different if this patient was an initial admission to the nursing facility and not a readmission. Why?

This type of patient represents a 99305 – Moderate complexity with the functional decline and monitoring of co-morbidities, however, the documentation above would only support a 99304. Both a 99305 and 99306 require a comprehensive history and exam. So in addition to the chief complaint, the history of present illness would need four (4) elements (location, duration, severity, etc.) a review of a minimum of 10 systems is required and the physical exam would have needed to include at least eight (8) organ systems (1995 E/M guidelines).

CASE 2. You are rounding in your assisted-living facility when a nurse asks you to evaluate the patient because of a painful knee. The patient is an 84-year-old female with arthritis, mild dementia, hypertension, hyperlipidemia, occasional behavioral problems. The documentation of the progress note is as follows. Hx: Patient with compliant of right knee pain 8/10 for the last 4 days. Exam of the right knee shows slight quadriceps wasting, slight puffiness of the knee which you believe is from bony overgrowth from arthritis. No erythema, no exudate, no induration, no limited motion seen. The foot and lower leg seem normal. Patient states the knee aches when she walks.

You order an X-ray and diagnose osteoarthritis, and start acetaminophen 650mg po 3x daily.

Should you bill the lowest code 99334 because you only looked at the knee, or is this a more extensive evaluation, when he would bill 99335 or 99336?

This type of patient represents a 99336 – A new problem with prescription drug management, however, the documentation above would only support a 99334. A 99336 requires a detailed history and/or exam. So in addition to the chief complaint, the history of present illness would need four elements (location, duration, severity, etc.) a review of 2-9 systems is required and/or the physical exam would have needed to be detailed (a detailed examination of the affected body area/organ system and 2-7 additional body areas/organ systems). Even a 99335 requires an expanded problem-focused history and/or exam. So in addition to the chief complaint and history of present illness, at least a one symptom review of systems is required and/or the physical exam would have needed to be expanded problem-focused as well (a limited examination of the affected body area/organ system and 2-7 additional body areas/organ systems).

Submit your coding questions for future *Progress Reports* to **Chris Acevedo** at (561) 278-9328; Fax: (561) 278-2253; or www.acevedoconsultinginc.com.

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Sudden Appearance of Annular Skin Lesions in a Geriatric Male Patient

By Cheryl Atherley-Todd, MD, Assistant Professor of Family Medicine, Nova Southeastern University College of Medicine, Fort Lauderdale, Florida

Overview of generalized granuloma annulare (GA) — This condition was initially described by Fox in the *British Journal of Dermatology* in 1895. It is a non-infectious necrobiotic disease. This type of GA accounts for 15% of the cases and presents with several erythematous plaques and papules on the trunk and extremities. The exact prevalence is unknown. It is more common in women than men and adults over age 30 are more affected by this type of GA. The etiology of GA is uncertain. It has been speculated that GA is secondary to a delayed-type hypersensitivity reaction. Numerous factors have been associated with it such as trauma, insect bites, vaccinations, tuberculin skin testing, sun exposure, viral infections (such as hepatitis and HIV), and systemic diseases (such as thyroid disorders, diabetes mellitus, and malignancy).

Case Report

A 69-year-old Caucasian male first presented to his dermatologist with circular lesions on his forearms in 2005. These eruptions were not itchy or painful. They were not located anywhere else on his body. The patient had no history of trauma, insect bites, or recent vaccinations. He had no history of viral infections, diabetes, thyroid problems, or malignancy. His past medical history was significant for prostatic hypertrophy, hypertension, and hyperlipidemia. His medications were Flomax, aspirin, Lisinopril, and a statin. The dermatologist suspected GA and a punch biopsy confirmed the diagnosis.

Over the years the patient has developed more lesions, mainly on his forearms and one on the dorsum of his right foot. Sometimes the lesions feel warm and the peripheral papules are more erythematous and they sometimes fade, however they never go away completely.

Fig 1. Forearm of patient showing several granuloma annulare lesions.



Clinical Features

Generalized GA presents with widespread skin-colored to erythematous plaques and papules ranging in size from a few millimeters to centimeters in diameter. They are non-scaly, erythematous annular or arcuate plaques with peripheral papules and central clearing. GA affects mainly the trunk and extremities with head, neck, palms, soles, and mucous membranes unaffected. The involved areas may be pruritic or asymptomatic.

Diagnosis and evaluation

It is usually a clinical diagnosis, but a punch biopsy can be done to confirm the diagnosis.

Differential Diagnosis

Generalized GA maybe mistaken for other cutaneous lesions (see Table 1).

Condition Characteristics

Tinea Corporis Scaly border. Central clearing. Potassium hydroxide preparation or fungal culture confirm tinea infection.

Annular lichen planus violaceous, pruritic polygonal papules at periphery of annular lesions. Lesions commonly located on penis and scrotum.

Necrobiosis lipoidica violaceous patches. Advancing border red. Central area orange-yellow to brown.

This type of GA accounts for 15% of the cases and presents with several erythematous plaques and papules on the trunk and extremities.

Eruptive xanthomas associated with severe hypertriglyceridemia. Cutaneous sarcoidosis, widespread flesh-colored papules, and annular plaques.

Histopathology: naked granulomas.

Treatment

- Topical or intralesional steroids
- Systemic steroids for widespread lesions
- Topical calcineurin inhibitors
- Phototherapy
- Systemic treatments such as hydrochloroquine, isotretinoin, or dapsone

In our patient topical steroids were tried with no improvement. He remains asymptomatic and has tried no other modalities of treatment.

Prognosis

Generalized GA maybe self-limiting, persistent, or relapsing. In our patient the lesions are always present but sometimes they fade and sometimes they are more prominent. They are mainly on his forearms but one has recently erupted on his foot.

Continued on the next page

Sudden Appearance of Annular Skin Lesions . . .
Continued from the previous page

Summary

We presented a case of generalized GA in a 69-year-old male. It is a noninfectious necrobiotic granuloma. The etiopathogenesis is unknown. It presents as flesh- to red-colored papules on the trunk and/or extremities. Histologically it is recognized as interstitial or palisading granulomas with central degenerated collagen fibers and

mucin deposits surrounded by histiocytes and lymphocytes. Associated comorbidities are diabetes, thyroid disorders, HIV, or malignancies. Our patient had none of these. The treatment is steroids, calcineurin inhibitors, phototherapy, or systemic treatments such as hydrochloroquine, isotretinoin, or dapsone. Generalized GA can be cosmetically disfiguring but it is a benign condition that may resolve spontaneously.

Webinar Replay is available for download at <http://www.fha.org/video/2011Sept13ReadmissionInitiativeWebinar.wmv>.

Table 1: Differential Diagnosis

Condition	Characteristics
Tinea Corporis	<i>Scaly border. Central clearing. Potassium hydroxide preparation or fungal culture confirms tinea infection.</i>
Annular lichen planus	<i>Violaceous, pruritic polygonal papules at periphery of annular lesions. Lesions commonly located on penis and scrotum.</i>
Necrobiosis lipoidica	<i>Violaceous patches. Advancing border red. Central area orange-yellow to brown.</i>
Eruptive xanthomas	<i>Associated with severe hypertriglyceridemia.</i>
Cutaneous sarcoidosis	<i>Widespread flesh-colored papules and annular plaques. Histopathology: naked granulomas.</i>

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Jacksonville Clostridium difficile Prevention Collaborative is Seeking Participation by Area SNFs

By A.C. Burke, Florida Department of Health, and Dr. Walter Hellinger, Mayo Clinic, Jacksonville

The Florida Department of Health, the Northeast Florida Chapter of Professionals in Infection Control, and local physician champions are striving to implement a regional collaborative for the prevention of Clostridium difficile infection (CDI). Clostridium difficile is the most commonly recognized cause of infectious diarrhea in health care settings. The incidence of healthcare associated C. difficile infection has increased in northeast Florida as it has across the country and has become one of the greater challenges of local infection control programs. C. difficile infection may appear during care in hospitals or in long-term inpatient care facilities. Patients with CDI whose requirements for care require transfer between these settings bring their infection and its challenge to infection control with them.

We are inviting all acute care, long-term acute care hospitals, rehabilitation facilities, and nursing homes in Duval, Baker, Clay, Nassau, and St. Johns counties to participate in this initiative. We are seeking a high rate of participation by area hospitals and nursing homes, particularly those within Duval County. We currently have 13 of 15 hospitals on board. So far, only a few nursing homes have committed to participation.

Commitment of the participating facilities to success, therefore, beginning with the commitment of senior leadership, will be absolutely necessary.

The collaborative objectives are to reduce the overall CDI rate in Jacksonville by 20% and the Jacksonville health area associated CDI rate by 30%. The measures that will be used to prevent CDI will include hand hygiene, environmental cleaning, barrier precautions, and antibiotic stewardship. The specific interventions to be deployed will be determined by the participants.

The facilitators of the collaborative will be the infection control directors of the participating facilities. Local facility-based, physician health care epidemiologists will provide guidance. The Florida Department of Health, which has already initiated a collaborative for CDI prevention across the state, has recognized the unique opportunities available to this collaborative and will be providing resources for secure, confidential data sharing and logistical support. Success, however, will require participation by everyone involved in direct patient care and in environmental cleaning. Commitment

of the participating facilities to success, therefore, beginning with the commitment of senior leadership, will be absolutely necessary.

In short we are asking facilities to do the following:

1. Take action to reduce the burden of C. diff infections by ensuring adherence to evidence-based prevention strategies such as hand hygiene practices, isolation precautions, and cleaning of high touch surfaces, and by optimizing the use of antibiotics;
2. Attend monthly meetings where you will receive additional education, tools to support implementation of best practices, and an opportunity to network with and collaborate with peers;
3. Track the number of positive lab cultures for CDI per the National Healthcare Safety Network Lab ID case definition at the level of the metropolitan area.

We are committed to keeping it inclusive, consensual, productive, cost-effective, and dedicated to the well-being of all of our patients and residents. We would especially welcome any recommendations that you can return to help us achieve our goal. We hope that you will be able to give the collaborative your full support by asking nursing leadership at your facility to contact us at HAI_Program@doh.state.fl.us to enroll!

Consultant Pharmacist Independence Proposal

You may have heard about a proposed new rule emanating from The Centers for Medicare and Medicaid Services (CMS) that is currently available on the Federal Register Inspections Desk called “Medicare Program; Proposed Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2013 and Other Proposed Changes; Considering Changes to the Conditions of Participation for Long Term Care Facilities.”

CMS is “considering requiring that LTC consultant pharmacists be independent of any affiliations with the LTC facilities’ LTC pharmacies, pharmaceutical manufacturers and distributors, or any affiliates of these entities... [These] changes would also prohibit nursing homes from contracting for the provision of consultant pharmacy services with entities (such as a subsidiary of an LTC pharmacy) that have been created for the purpose of providing reorganized consultant pharmacist services.”

You may read excerpts of critical sections of the rule that would affect consultant pharmacists at <http://www.ascp.com/ltrule>.

Even though this rule may not directly impact your medical practice, we are concerned about how this will affect our consultant pharmacist friends. Let us know what you think about this new rule. Please send your comments to **Matt Reese** at mattr@fmda.org.

F M D A M e m b e r s h i p A p p l i c a t i o n

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, Affiliates may be any individual or organization in the medical, regulatory, or political fields of long-term care and wishing to promote the affairs of FMDA. An Affiliate member shall have all FMDA privileges except shall not be eligible to vote or hold office. The two categories are: **B1. Professional Affiliate members.** This category is composed 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 **B2. Organizational Affiliate** members include 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 specialties 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:

Name: _____ Title: _____

The mailing address below is for _____ the facility, or _____ my office address. Referred by FMDA member: _____

Facility Name/Affiliation: _____

Organization's Name: _____

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Yes! I would like to join FMDA. Enclosed is a check for annual dues for the following category (check one):

A. Regular Membership for Physicians **B1. Professional Affiliate members** **C. Allied Health Professional Relations Committee.** Dues: **1-year (\$75);** or **2-year (\$125);** or **3-year (\$190);** or **Lifetime (\$750)**

B2. Organizational Affiliate members are \$325 per year.

Voluntary \$50 contribution to support FMDA's Careers in LTC, student scholarships, and AMDA's Futures Program. . . \$ 50

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Please make check payable to FMDA and mail to: 200 Butler Street, Suite 305 • West Palm Beach, FL 33407
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*Please share this information with a colleague who would benefit from membership in FMDA!
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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, 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.

Call for Oral and Poster Presentations Announced for Best Care Practices 2012

— 9th Annual Poster Presentations to be Featured

By Matthew Reese, Communications and Education Manager

Florida Medical Directors Association (FMDA) has begun accepting submissions for its 2nd Annual “Call for Speaker Presentations” for Best Care Practices in the Geriatrics Continuum 2012 this October in Orlando. Presenters who desire to lecture at the conference are encouraged to visit FMDA’s website at www.fmda.org to submit an online proposal. Submissions should be based on issues related to long-term care and geriatrics, or the health care field in general. The submission deadline for all applicants is May 10, 2012.

The submission process falls into FMDA’s mission of providing the highest quality education to health care practitioners in long-term care. High-profile, relevant educational programs have always been the pinnacle of the annual conference. Attendees expect clinical topics to be strong evidence-based lectures with cited references and administrative topics to be relevant to their setting and focused on current best care practices. It is the presentation review committee’s intent that the best presentations incorporate attendee networking, case-discussion (Q&A), small groups, and take-home tools such as handouts, key points, guides, or quick tips. These types of presentations are highly encouraged.

Dr. Naushira Pandya, chair of the Careers in Long-Term Care

High-profile, relevant educational programs have always been the pinnacle of the annual conference.

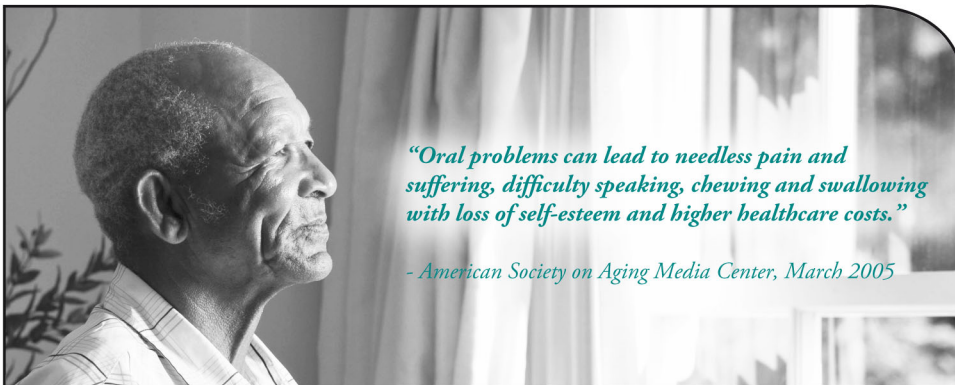
Awards & Poster Presentations Committee, has already started preparations for 2012’s poster presentation submissions. This marks FMDA’s 9th annual poster session, and as always, it will take place during the annual Best Care Practices in the Geriatric Continuum conference, October 25-28, 2012, in Orlando. 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. Each submission is a commitment by at least one author to be present at the designated times during the conference to discuss the information in the poster with conference participants and judges. The first 10 applicants who are accepted by the review committee will receive complimentary registration to the 2012 conference (only

one applicant per poster presentation will be considered). The deadline for this is Sept. 21, 2012.

FMDA President Dr. John Symeonides is very enthusiastic about the continued success of the call for presentations process. The 2011 Best Care Practices conference included many quality sessions identified through this system. He is also looking forward to the call for poster submissions, in which there is always a number of worthy presentations.

“FMDA strives to be at the forefront of providing unsurpassed and unrivaled education to our health care practitioners working in long-term care and geriatrics. The unique process of accepting calls for presentations has bolstered the value of our annual conference and will undoubtedly continue to do so as our organization grows,” said Dr. Symeonides. “As always, FMDA is excited about this call for poster submissions, which will enhance an outstanding program.”

To learn more about FMDA’s Call for Presentations, Call for Posters, or to submit a proposal, go to www.bestcarepractices.org. Ian Cordes, the executive director for FMDA, can be reached by telephone at (561) 659-5581 or at ian.cordes@fmda.org.



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- American Society on Aging Media Center, March 2005

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FMDA Hosts 12th Annual IAB Meeting

By Matthew Reese, Communications and Education Manager

Steven Selznick, DO, CMD, chairman of the Industry Advisory Board (IAB), and co-chair Jaynie Christenson, Regional Account Manager for Abbott Laboratories, were thrilled with the level of discussion and quality of this year's invitation-only meeting. Many pertinent topics were discussed that directly affect the long-term care industry, such as the unintended consequences of the "Pill Mill Bill," the Sunshine Act and its effect on pharma, healthcare professionals, and health care organizations, new requirements for reimbursement for hospice and home care, and other challenges facing long-term care (LTC) organizations, pharmaceutical companies, and companies with ties to LTC. The 28 invitees (shown below) were able to share their experiences and give solid insight into each of these issues and how the IAB can overcome some of these challenges to benefit the health of Florida's most vulnerable population.

Probably the most pertinent topic that has unveiled itself through the passage of HB 7095 "The Pill Mill Bill," which requires physicians to follow a strict set of guidelines when prescribing controlled substances to their patients, is the unintended negative consequences of the bill that affect the physician and the patient. The extra rules placed on physicians unnecessarily delay the dispensing of pain meds for frail residents of SNFs. Some doctors are afraid to prescribe these medications in fear of harsh penalties that could be doled out to them, including heavy fines and even jail time. It is a known fact that skilled nursing facilities and hospice are some of the most highly controlled and regulated environments. There is a critical need for an amendment to the law that exempts skilled nursing and hospice physicians from the requirements of



Dr. Hugh Thomas (left), and IAB Chairman Dr. Steven Selznick, with Jaynie Christenson, IAB Co-Chair

this bill. The overwhelming consensus from the IAB was that something needs to be done, and that this law is creating unintended harm to our elderly patients. FMDA and other related organizations will continue to fight for the rights of physicians and their ability to properly care for their patients.

Another topic of discussion at this year's IAB was the Sunshine Act which requires health care manufacturers to track payments and transfers of value made to certain health care professionals (HCPs) and health care organizations (HCOs). The Sunshine Act, became federal law in 2010

as part of health care reform. The purpose of the Sunshine Act is to provide greater transparency into interactions between the health care industry and health care professionals. Physicians and teaching hospitals must report payments and transfers of value that are provided directly to them, and the companies that provide these payments must keep track of them. The law considers meals, consulting/speaker fees, travel, educational items such as textbooks, grants and charitable donations, clinical trial payments, research fees, and royalties and license payments, as expenditures that must be tracked and reported. Once the government releases final regulations of the law, tracking of these expenditures will begin, and they will be available to the public on a searchable, downloadable website. This will create the transparency that this law is intended to provide.

Lastly, there was discussion from each invited organization concerning issues or challenges that they are facing. Budget cuts and funding were touted as the biggest problem facing each

Continued on the next page



OIG Cautions Physicians When Reassigning Their Medicare Payments

Physicians who reassign their right to bill the Medicare program and receive Medicare payments by executing the CMS-855R application may be liable for false claims submitted by entities to which they reassigned their Medicare benefits.

The Office of the Inspector General (OIG) encourages physicians to use heightened scrutiny of entities prior to reassigning their Medicare payments. Physicians should carefully consider entities to which they choose to reassign their Medicare payments and ensure that the entities are legitimate providers or suppliers of health care items and services.

OIG recently reached settlements with eight physicians who violated the Civil Monetary Penalties Law by causing the submission of false claims to Medicare from physical medicine companies. Specifically, these physicians reassigned their Medicare payments to various physical medicine companies in exchange for medical directorship positions. While serving as medical directors, the physicians did not personally render or directly supervise any services. There was evidence that the services the physical medicine companies claimed the physicians performed were not actually performed or were not performed as billed.

The failure of the physicians to monitor the services billed using their reassigned provider numbers resulted in individuals with little to no medical background serving as physical therapy “technicians.” These unlicensed “technicians,” including retail cashiers and massage therapists, rendered unsupervised in-home physical therapy services to Medicare and Medicaid beneficiaries. The physical medicine companies falsely billed Medicare using the physicians’ reassigned provider numbers as if the physicians personally rendered the services or directly supervised a “technician” rendering the services. Many of the owners and operators of the physical medicine companies were criminally prosecuted. OIG determined that the physicians were an integral part of the scheme and pursued their liability under the Civil Monetary Penalties Law.

Note: A physician who reassigns his or her right to bill the Medicare program and receive Medicare payments has the right to access the billing information concerning the services the physician is alleged to have performed and for which the assignee billed Medicare. Physicians have unrestricted access to claims submitted by an entity for services that the entity billed using the physicians’ reassigned provider numbers to provide added assurances that the services for which the entity billed Medicare were, in fact, performed and were performed as billed.

OIG has developed a series of voluntary compliance program guidance documents directed at various segments of the health care industry, such as hospitals, nursing homes, third-party billers, and durable medical equipment suppliers, to encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements. These documents may be found on the “Compliance” page at <http://oig.hhs.gov/>.

Save the Date

FMDA's next Town Meeting will be held on Saturday, June 9, at the Renaissance Tampa International Plaza Hotel.

FMDA Hosts 12th Annual IAB Meeting Continued from page 15

organization. With the ever-changing landscape of long-term care and the health care industry, it is impossible to predict how these budget cuts will affect providers and their patients, but it is quite obvious that the impact will be a negative one. Health care organizations must constantly evolve and embrace change so that they can do what’s best for their providers and the patients they treat.

Chairman Dr. Steve Selznick was very pleased with the high-level of discussion and topical information presented at the meeting. “I consider this year’s IAB to be one of the best meetings in recent years due to the quality of discussion and the input that was given and received by all parties. Meetings such as this will undoubtedly bring us closer together in the fight for quality patient care.”

The IAB was established in 1999 as a way for the Florida Medical Directors Association and other interested organizations to enhance lines of communication and to work together to become part of the process to develop solutions for our common problems. Membership is on an annual basis and is limited to a select few pharma and non-pharma companies — by invitation only.

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

January 2012 Town Meeting in Palm Beach Gardens



Chairman of the Board Dr. John Potomski, with Town Meeting guest moderator Gilda Osborn, administrator of Whitehall Boca Raton and president of Florida Health Care Association’s District VII.



Dr. Carl Suchar (right), chairman of the Membership Committee and past president, welcomes guests and vendors to the Town Meeting while (from left) Dr. Leonard Hock, Dr. Gregory James, and Dr. John Symeonides look on.

Brilinta: New Antiplatelet Drug Therapy

By Gaylon Fruit, BS, RPh; Geriatric Consultant Pharmacist, Managing Partner, Senior Care Consultant Group

A new oral antiplatelet agent, Ticagrelor (Brilinta), will provide an alternative to prescribers using clopidogrel (Plavix) and prasugrel (Effient) for secondary prevention of atherothrombotic events in patients with acute coronary syndrome (ACS). ACS includes a group of symptoms for any condition, such as unstable angina or heart attack that could result from reduced blood flow to the heart. Brilinta works by preventing the formation of new blood clots, thus maintaining blood flow in the body to help reduce the risk of another cardiovascular event.

Ticagrelor (Brilinta) reversibly inhibits the platelet P2Y₁₂ adenosine diphosphate receptor. Brilinta is indicated for prevention of cardiovascular events (stent thrombosis, cardiovascular death, heart attack) in adults with ACS. While Brilinta was studied for this indication in combination with aspirin, a Boxed Warning indicates that maintenance doses of aspirin over 100 mg daily reduce Brilinta's efficacy.

Brilinta's maintenance dose is 90 mg twice daily, with or without food, after the loading dose of 180 mg. It can be used with aspirin, using a loading dose of up to 325 mg then a maintenance dose of 75 to 100 mg daily.

Ticagrelor (Brilinta) increases bleeding risk. Risk factors include advanced age, invasive procedures, and use of medications that increase bleeding risk such as warfarin, fibrinolytics and NSAIDs, and moderate hepatic impairment. Brilinta should be stopped five days before surgery. Bleeding should be suspected in Brilinta patients who become hypotensive after recent surgery or invasive procedures. If bleeding occurs, the risk of cardiac events due to stopping Brilinta should be considered. If stopped, it should be restarted as soon as possible. The boxed warning also says that, like other blood-thinning agents, Brilinta increases the rate of bleeding and can cause significant, sometimes fatal, bleeding. The most common adverse reactions reported by people taking Brilinta in clinical trials were bleeding and difficulty breathing (dyspnea).

Dyspnea may develop or worsen in patients using Brilinta (up to 38% of users), however it is usually mild to moderate and resolves even with continued use. Other adverse effects were headache (6.5%), cough (4.9%), dizziness (4.5%), nausea (4.3%), noncardiac chest pain (3.7%), diarrhea (3.7%). Additionally, ticagrelor must be avoided or used cautiously in patients with bradycardia.

Brilinta (ticagrelor) is contraindicated in patients with a history of intracranial hemorrhage, active bleeding, or severe hepatic impairment.

Ticagrelor is metabolized to an active equipotent metabolite mainly by CYP3A4. Ticagrelor should be avoided with strong CYP3A inducers such as rifampin, dexamethasone, phenytoin, carbamazepine, and phenobarbital, or strong CYP3A inhibitors such as ketoconazole, clarithromycin, nefazodone, and ritonavir. Ticagrelor can increase simvastatin and lovastatin levels due to CYP3A4 inhibition. Patients should avoid using more than 40 mg of simvastatin or lovastatin daily while using ticagrelor. Levels of digoxin can be increased by ticagrelor. Digoxin levels require monitoring with initiation of Brilinta therapy or change in regimen.

Ticagrelor is Pregnancy Category C

In PLATO clinical trials, a randomized double-blind study comparing Brilinta (ticagrelor) to Plavix (clopidogrel), both given in combination with aspirin and other standard therapy, in patients with ACS, Brilinta reduced the risk of cardiovascular death, heart attack, or stroke in patients with ACS. Brilinta did not increase the risk of major bleeding overall, but did increase the risk of spontaneous bleeding. It is faster-acting than Plavix and reversible if the patient bleeds. Some patients respond to Brilinta who do not respond to Plavix, for genetic reasons.

Ticagrelor was not better than clopidogrel for preventing cardiovascular events in North American ACS patients. In addition, although ticagrelor does not increase the risk of major bleeding overall, it carries a higher risk than clopidogrel of spontaneous hemorrhagic events. Prescribers should continue to recommend clopidogrel first for most patients. Ticagrelor may best be suited for patients who may need urgent surgery. Like prasugrel, ticagrelor is an option for patients who have had a cardiac event while taking clopidogrel, and for patients with reduced CYP2C19 activity due to a genetic variation or interacting medication.

Brilinta, already approved in 38 other countries, was approved with a Risk Evaluation and Mitigation Strategy, a plan to help ensure that the drug's benefits outweigh its risks. As part of that plan, the company must conduct educational outreach to physicians to alert them about the risk of using higher doses of aspirin. In addition, Brilinta will be dispensed with a Medication Guide that informs patients of the most important information about the medication. The guide will be distributed each time a patient fills their prescription.

Brilinta is manufactured by Astra Zeneca in 90 mg tablets, available in 60- and 180-count bottles that should be kept in the original container. Unit dose for institutional use is also available.

References

1. www.astrazeneca-usa.com
2. The PLATO Study
3. www.brilintatouchpoints.com
4. www.fda.gov

Reserve Your Hotel Rooms NOW!

HOTEL RESERVATIONS: This year's annual conference will be held at the beautiful Walt Disney World Dolphin Resort, 1500 Epcot Resorts Blvd., Lake Buena Vista, FL 32830. FMDA has reserved a block of rooms at the group rate of **\$149** single/double occupancy, **50% parking discount** for any attendee staying on site, and a **\$10 daily resort fee** that includes complimentary bottled water replenished daily, high speed internet access, and unlimited admission to fitness centers.

To make a reservation, please call Walt Disney World Swan and Dolphin Group Reservations at **(800) 227-1500** or **(407) 934-4000**, 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 no later than Sept. 18, 2012**. 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.bestcarepractices.org/venue.html.

FMDA Year in Review

By Ian L. Cordes, Executive Director



ere is a brief recap of the major FMDA events that have occurred in the past year:

1) We hosted our first Town Meeting of 2011 on Feb. 5, in Gainesville. The dinner program sponsor was Boehringer Ingelheim and there were seven exhibitors and 50 guests in attendance. This was followed by a CME/Education Committee and Board meetings the next morning.

2) We celebrated our 11th Anniversary Industry Advisory Board meeting on Feb. 7 in Orlando, headed by new Chairman Dr. Steven Selznick.

3) On March 25, at AMDA's annual symposium in Tampa, we hosted a CME/Education Committee, followed by a board meeting. In addition to our chapter exhibiting, we held a Florida Chapter Reception, sponsored by Johnson & Johnson, and FMDA made a major donation to AMDA's Futures Program to representatives from AMDA's Foundation.

4) a. We held a 3.0 hour CME program titled, Long-Term Care Risk-Management Symposium on Falls, Accidents, & Wound Assessments which was joint-sponsored by FMDA and AMDA on July 9-10 in Jacksonville. b. This was followed by a Town Meeting and Dinner sponsored by Avanir where we had eight exhibitors and 30 dinner guests. c. The following morning, we hosted a CME/Education Committee and FMDA Board Meeting.

5) On July 24-25, our staff exhibited at the annual conference of the Florida Association of Homes & Services for the Aging in Orlando.

6) On August 15-17, our staff exhibited at the Annual Convention of the Florida Health Care Association in Orlando.

7) a. FMDA celebrated its 20th Anniversary during Best Care Practices in the Geriatrics Continuum 2011, which was held at the beautiful Disney's Grand Floridian Resort; there were 289 attendees.

b. For the first time, FMDA offered CPEs for pharmacists through the University of Florida College of Pharmacy, for the 30 pharmacists in attendance.

c. For only the second year, we hosted the "Ambassador" program that connected FMDA members with first-time attendees.

d. The conference was a huge success, the venue was excellent, and the course evaluations were exceptional.

e. We issued our very first "Call for Presentations" in 2011 with an online submission process. It allowed us to offer four concurrent sessions and some very interesting and diverse educational programming.

f. ACCME Accreditation: FMDA is working toward becoming ACCME-accredited through FMA to provide physician CMEs or continuing medical education contact hours. AMDA would still provide CMD contact hours for certified medical directors.

g. NADONA and the Florida Chapters of GAPNA joined the Best Care Practices conference as its newest collaborating organizations.

h. New bylaws were approved by the membership at its annual meeting. Bylaws had not been revised since 1999. As a result, we have new membership categories such as lifetime, retired, student memberships, etc. In addition, what used to be an ex-officio board position reserved for NPs and PAs is now a full voting member of the board.

8) Our first Town Meeting & Dinner of 2012 was held in Palm Beach Gardens on Jan. 14 and it was sponsored by Lundbeck. Our guest facilitator, Gilda Osborn, a former DON, and now a SNF administrator, did a great job discussing how her facility is coping with reimbursement cuts. The Town Meeting was followed by the CME/Education Committee and Board meetings the next morning.

9) We are planning our second Town Meeting & Dinner in June, probably in Tampa.

10) Plans for Best Care Practices in the Geriatrics Continuum 2012 are under way and our call for presentations has already produced two impressive proposals.

The Walt Disney World Dolphin Resort is a deluxe

hotel designed by award-winning architect Michael Graves. Inspired by Florida itself, the resort features distinctive architectural silhouettes, punctuated by elaborate fountains and towering palm trees, on grass expanses and white sand-shored Crescent Lake. As a nod to



Italian Renaissance design, a pair of stylized, 56-foot dolphin statues grace the rooftop. Across Crescent Lake sits the Dolphin's sister hotel, the Graves-designed Walt Disney World Swan Resort.

Luxurious guest rooms and suites have been redesigned with sophisticated décor and the ultimate in comfort, the popular Heavenly Bed®. Each room is equipped with a 32-inch flat-panel television, wireless high-speed internet access, and MP3 connection. Disability-accessible guest rooms are also available.

Resort guests can choose from 17 different restaurants and lounges, each offering unrivaled cuisine. Experience fine dining and exceptional wines amid richly-appointed settings at Shula's Steak House, Todd English's bluezoo, Il Mulino New York Trattoria, and Kimonos. Choices for casual dining include a 24-hour self-service buffet and poolside café.

Walt Disney World Resort guest benefits include complimentary transportation to Walt Disney World theme parks, Extra Magic Hours benefit, advance tee times on nearby championship Disney golf courses, and on-site Disney ticket desks.

Find plenty of room to relax with 5 swimming pools, the Balinese-themed Mandara Spa, whirlpools, and saunas. Guests also enjoy a wide range of recreation facilities including 2 health clubs, 4 tennis courts, jogging trails, a white sand beach, Swan paddle boat rentals, and seasonal poolside activities.

Walt Disney World Swan and Dolphin Resort is located in the heart of the Walt Disney World Resort, near Epcot theme park, Disney's Hollywood Studios theme park, and a short walk to Disney's BoardWalk Area.

Exemption from Pill Mill Bill Sought by FMDA

— View FMDA's Letter of Support, Press Release, Position Statement, and Proposed Amendment Language to Exempt Hospices and Skilled Nursing Facilities from the requirements of the Pill Mill Bill at <http://fmda.org/advocacy.html>.



Dedicated To Florida Long Term Care Medicine

January 30, 2012

To Whom it May Concern:

Florida Medical Directors Association

Serving medical directors in Florida's postacute, subacute, skilled care and assisted living facilities.

www.fmda.org

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The Florida Medical Directors Association (FMDA) and the organizations listed below applaud the passage of the Pill Mill Bill in 2011 and its efforts to reduce and prevent Pill Mill proliferation, the elimination and prevention of prescription controlled drug trafficking, and its provisions for the treatment and prevention of addiction to prescription pain medications.

The results of a recent FMDA survey of physicians practicing in skilled nursing facilities, contained in the attached press release, indicated that 88 percent reported that the chances are very high that patients will suffer with untreated pain, have poor outcomes, or be unnecessarily transferred to an acute care facility because of this new law. This is a troublesome finding.

As a result, FMDA, with the assistance of the Florida Osteopathic Medical Association, propose an amendment to the Pill Mill Bill exempting skilled nursing facilities and hospices. We believe it is possible to maintain respect for the spirit of the law and further its goals because there are more than adequate regulations already in place to prevent drug diversion and drug addiction issues while avoiding any unnecessary hardship and risk of harm to Florida's frail elderly and hospice populace.

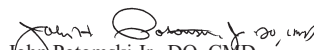
As described in detail in the attached position paper, The Impact of the Pill Mill Bill Controlled Substance Prescribing Requirements on the Hospice and Nursing Home Populace, an exemption is imperative for the following reasons:

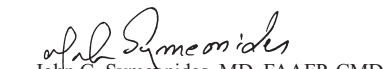
- (1) The elderly and other patients on hospice or residing in skilled nursing facilities are not the populace or source of the problem that was intended to be addressed by the Pill Mill Bill.
- (2) There are already more than adequate regulations in place at skilled nursing facilities to address the issues of pill mill proliferation, prescription medicine diversion and prescription drug trafficking in Florida, and problems with prescription medicine addiction.
- (3) The Pill Mill requirements pose a risk of hardship, and needless pain and suffering, to the elderly and other inpatient residents by delays they may experience in pain management treatment that may arise (and are arising) in the SNF setting due to the regulations.

Accordingly, the Florida Medical Directors Association and the organizations represented below, support the following proposed exemption be passed by the Florida Legislature to clarify the language of the definition of chronic nonmalignant pain to expressly exclude the rendering of hospice care from the controlled substance prescribing requirements of s. 456.44, F.S.; adding the definition of outpatient treatment to expressly exclude inpatient care rendered at hospitals, licensed skilled nursing facilities, and licensed psychiatric facilities from the controlled substance prescribing requirements of s. 456.44, F.S.

We appreciate this opportunity to share our concerns on behalf of the nearly 80,000 nursing home residents and thousands of hospice patients in Florida. In conclusion, FMDA and its supporters urge the Florida Legislature to exempt from the Pill Mill Bill provisions of Section 456.44 (Ch. 2011-141, § 3, Laws of Fla.) for controlled substance prescribing in order to prevent needless pain and suffering patients may experience as unintended consequences of implementing the new requirements.

Sincerely,


John Potomski Jr., DO, CMD
Chairman of the Board


John G. Symeonides, MD, FAAFP, CMD
President

Supporting Organizations:

- Brevard County Commissions on Aging
- Florida Association Directors of Nursing Administration/Long-Term Care
- Florida Chapter of the American College of Health Care Administrators
- Florida Chapter of the American Society of Consultant Pharmacists
- Florida - Gerontological Advanced Practice Nurses Association
- Florida Health Care Association
- Florida Nurses Association
- Florida Osteopathic Medical Association
- Home Care Association of Florida
- LeadingAge Florida (formerly Florida Association of Homes & Services for the Aging)
- Omnicare

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See you at “Best Care Practices in the Geriatrics Continuum 2012”

FMDA’s Progress Report

March 2012

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