Susan M. Levy, MD, CMD: Disclosures

- President AMDA The Society for Post-Acute and Long-term Care Medicine
- Five Star Physician Services-contractor medical director
- CMO Linked Senior
- Legal case reviews
- Consultant
  - CMS Nursing Home division
  - IHI
  - HQI

VALUE OF MEDICAL DIRECTOR AND ATTENDING TRAINING

ACHCA 23rd Annual Winter Marketplace
Las Vegas, Nevada
December 10,2016
Susan M. Levy, MD, CMD
President AMDA The Society for Post-Acute and Long Tem Care Medicine

Learning Objectives

- Understand the value of a trained, competent medical director in post-acute care
- Appreciate the value of a trained, competent attending/NP/PA (practitioner) in post-acute care
- Evaluate training and competency fort he medical director and attending in post-acute care

Medical Director Role: History

- 1974 established requirement for medical director in nursing homes
- 1986 IOM report on Nursing Homes
- 1987 Nursing Home Reform Act (OBRA ‘87)
- 1991 AMDA approved Roles and Responsibilities of the Medical Director
- 2001 IOM report on Quality in Nursing Homes
- 2003 OIG report on Medical Director Survey
- 2005 CMS revised the F-tag 501 along with interpretive guidance
- 2016 New CMS ROPs- “THE MEGARULE”

2001 IOM REPORT: Medical Directors and Practitioners in Nursing Homes

- “The committee believes that nursing homes should develop structures and processes that enable and require a more focused and dedicated medical staff responsible for patient care.”
- “The committee believes that HCFA should make clear Medicare and Medicaid regulations for physician services in nursing homes and allow the number and type of services provided to be based on residents’ medical needs and the severity of their illness.”

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Nursing Home Medical Directors Survey

JANET REHNQUIST
INSPECTOR GENERAL

FEBRUARY 2003
OEI-06-99-00300

OIG Medical Director Survey 2003

- Survey of 119 medical directors in seven states
- Focused on Four Key Functions
  - Quality Improvement
  - Patient Services
  - Residents' Rights
  - Administration, includes training

Table 1: Quality Improvement Functions Most Frequently Identified by Medical Directors

Specific and Related Functions	Nursing Homes Expect of Medical Directors	Medical Directors Should Perform
Review and revise existing medical and clinical policies	90%	97%
Encourage quality of care, regardless of patient case mix	88%	92%
Review and analyze quality indicators for potential areas of concern	86%	91%
Quality improvement planning, implementing, and/or follow-up	84%	93%
Development of medical care policies and procedures	81%	92%
Confirm patient's problems identified by unit nurses are adequately addressed	73%	83%
Serve as patients' medical advocate	64%	81%

Source: OIG survey responses from nursing home medical directors

Table 2: Patient Services Functions Most Frequently Identified by Medical Directors

Specific and Related Functions	Nursing Homes Expect of Medical Directors	Medical Directors Should Perform
Intervene with attending physician when concerns are raised about his/her patient's care	92%	97%
Review consultant pharmacists' drug regimen reports	90%	93%
Interact with Nurses: Provide ongoing medical advice and guidance to nurses Meet routinely with nurses to discuss patient care issues	 86% 78%	 94% 88%
Perform attending physician duties	72%	83%
Participate in the planning of patient care by ensuring the appropriateness of services and treatments	69%	83%
Monitor for appropriate patient care by attending physicians	68%	85%

Source: OIG survey responses from nursing home medical directors

Table 3: Residents' Rights Functions Most Frequently Identified by Medical Directors		
Specific and Related Functions	Nursing Homes Expect of Medical Directors	Medical Directors Should Perform
Verify appropriateness of a patient's drug regimen, ensure that drugs are: -- appropriately prescribed -- necessary	 69% 69%	 80% 75%
Ensure patients' end of life decisions are honored	69%	80%
Verify appropriate medical response to drug regimen review concerns	68%	80%
Confirm appropriate restraint usage	65%	77%
Ensure cognitive patients' rights to refuse medications	60%	76%
Support patients' direct involvement in care planning, if mentally able	60%	70%
Source: OIG survey responses from nursing home medical directors		

Table 4: Administrative Functions Most Frequently Identified by Medical Directors		
Specific and Related Functions	Nursing Homes Expect of Medical Directors	Medical Directors Should Perform
Provide medical expertise for facility when necessary to respond to regulatory agency survey concerns	94%	96%
Serve as liaison between medical staff, nursing staff, and administration	84%	88%
Keep current with regulatory and medical treatment changes	83%	92%
Promote employee health	72%	78%
Source: OIG survey responses from nursing home medical directors		

F501
483.75(i) Medical Director (2005-revised)

- (1) The facility must designate a *physician* to serve as medical director
- (2) The medical Director is responsible for-
  - (i) Implementation of resident care policies; and
  - (ii) The coordination of medical care in the facility

F501: Intent

- The facility has a licensed physician who serves as the medical director to coordinate medical care in the facility and provide clinical guidance and oversight regarding the implementation of resident care policies;
- The medical director collaborates with the facility leadership, staff, and other practitioners and consultants to help develop, implement and evaluate resident care policies and procedures that reflect current standards of practice; and

F501: Intent

- • The medical director helps the facility identify, evaluate, and address/resolve medical and clinical concerns and issues that:
- o Affect resident care, medical care or quality of life; or
- o Are related to the provision of services by physicians and other licensed health care practitioners.

F501: Intent to Separate Roles of Attending and Medical Director

- While many medical directors also serve as attending physicians, the roles and functions of a medical director are separate from those of an attending physician. The medical director's role involves the coordination of facility-wide medical care while the attending physician's role involves primary responsibility for the medical care of individual residents.

F501: Medical Director Requirements

- Licensed in the state in which the facility he/she serves is(are) located
- Models for medical director include
  - Direct employment
  - Contractual arrangement
- Identify expectations
- Separate Corporate/regional work from individual facility

F501: Implementation of Resident Care Policies and Procedures

- The facility is responsible for obtaining the medical director's *ongoing guidance* in the development and implementation of resident care policies, including review and revision of existing policies.
- The medical director has a key role in helping the facility to incorporate *current standards of practice* into resident care policies and procedures/guidelines to help assure that they address the needs of the residents.
- Although regulations *do not require the medical director to sign the policies or procedures,* the facility should be able to show that its development, review, and approval of resident care policies included the medical director's input.

F501: Examples of Policies and Procedures that Should Have Medical Director Input

- Admission policies and procedures
- Transfers and discharge planning
- Use and availability of ancillary services
- Advance directives
- Provision of physician services (medical staff rules)
- Provision of other practitioner services
- Clinical guidance for physician/practitioner notification

F501: Coordination of Medical Care

- Ensure that residents have primary attending and backup physician coverage;
- Ensure that physician and health care practitioner services are available to help residents attain and maintain their highest practicable level of functioning, consistent with regulatory requirements;
- Develop a process to review basic physician and health care practitioner credentials (e.g., licensure and pertinent background);

F501: Coordination of Medical Care

- Address and resolve concerns and issues between the physicians, health care practitioners and facility staff; and
- Resolve issues related to continuity of care and transfer of medical information between the facility and other care settings.
- Other areas for input are identified in the guideline

F501 Investigative Protocol

- That the facility does not have a licensed physician serving as medical director; and/or
- That the facility has designated a licensed physician to serve as medical director; however, concerns or noncompliance identified indicate that:
- o The facility has failed to involve the medical director in his/her roles and functions related to coordination of medical care and/or the implementation of resident care policies; and/or
- o The medical director may not have performed his/her roles and functions related to coordination of medical care and/or the implementation of resident care policies.

F501: Criteria for Compliance

- They have designated a medical director who is a licensed physician;
- The physician is performing the functions of the position;
- The medical director provides input and helps the facility develop, review and implement resident care policies, based on current clinical standards; and
- The medical director assists the facility in the coordination of medical care and services in the facility.

F501: Noncompliance Facility Failure

- Designate a licensed physician to serve as medical director; or
- Obtain the medical director's input for timely and ongoing development, review
- and approval of resident care policies;

F501: Noncompliance Facility and Medical Director Failure

- Coordinate and evaluate the medical care within the facility, including the review and evaluation of aspects of physician care and practitioner services;
- Identify, evaluate, and address health care issues related to the quality of care and quality of life of residents;
- Assure that residents have primary attending and backup physician coverage;
- Assure that physician and health care practitioner services reflect current standards of care and are consistent with regulatory requirements;
- Address and resolve concerns and issues between the physicians, health care practitioners and facility staff;

F501: Noncompliance Facility and Medical Director Failure(cont.)

- Coordinate and evaluate the medical care within the facility, including the review
- and evaluation of aspects of physician care and practitioner services;
- Identify, evaluate, and address health care issues related to the quality of care and quality of life of residents;
- Assure that residents have primary attending and backup physician coverage;
- Assure that physician and health care practitioner services reflect current
- standards of care and are consistent with regulatory requirements;
- Address and resolve concerns and issues between the physicians, health care practitioners and facility staff;

ProPublica: Nursing Home Inspect F501 (September 2013-April 2016)

- 89 deficiencies in 53 facilities
- Reasons vary, multiple other tags
  - Failure to notify medical director
  - Not involved in policy and procedures
- Severity
  - 38 D-F
  - 10 G-I
  - 41 J-L

- *http://projects.propublica.org/nursing-homes/*

General Demographics

	2004	2006	2008	2010	2012
Total Surveys Started	670	551	648	1,155	496
Total Completed Surveys	670	551	606	1,045	417
% Completed	100%	100%	94%	91%	84%
Male/Female (496)	66% / 33%	68% / 32%	67% / 33%	56% / 44%	62% / 38%
Age Range (496)					
20-30	2%	<1%	<1%	1%	<1%
31-40	16%	11%	11%	10%	9%
41-50	33%	27%	22%	22%	22%
51-60	**38%**	**42%**	**44%**	**42%**	**40%**
61-70	7%	14%	16%	21%	25%
71 and Over	4%	6%	6%	4%	4%

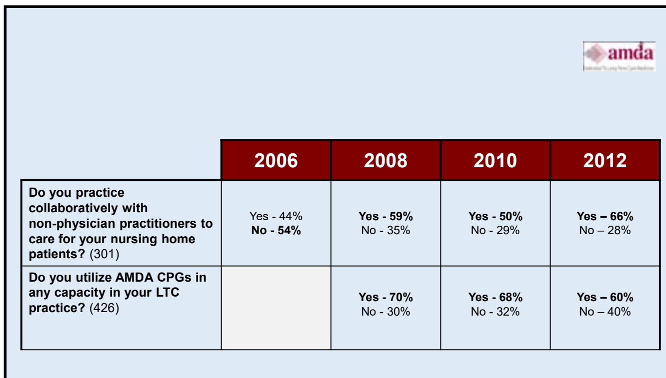
Profile of an AMDA Medical Director

	2004	2006	2008	2010	2012
Percentage of Medical Directors who work part time (280)	84%	85%	81%	79%	**79%**
Percentage who also serve as attending physicians (279)	87%	91%	89%	88%	**87%**
Age group largest set of respondents fit into (494)	51-60	51-60	51-60	51-60	**51-60**
Percentage of Medical Directors who are board certified (primarily in IM and FP) (494)	85%	80%	80%	79%	**81%**
Percentage of Medical Directors who have a CAQ in Geriatrics (494)	49%	42%	43%	35%	**39%**
Average number of years in LTC (494)	14	16.8	18	16.8	**19.1%**
Average number of years as Medical Director in LTC (285)	10.5	12.5	12.8	14.1	**16.7**
Average number of LTC facilities served (278)	1-2	1-2	1-2	1-2	**1-2**
Average facility size (beds/facility) (282)	159	100	100	100	**51-100**
Average number of hours spent as Medical Director per facility per month (278)	6-10	6-10	6-10	6-10	**6-10**
Average pay per hour for Medical Director Services (228)	$130	$140	$161	$151	**$153**
Percentage who are CMDs (282)	52%	50%	56%	55%	**61%**

	2006	2008	2010	2012
Do you practice collaboratively with non-physician practitioners to care for your nursing home patients? (301)	Yes - 44% **No - 54%**	**Yes - 59%** No - 35%	**Yes - 50%** No - 29%	**Yes – 66%** No – 28%
Do you utilize AMDA CPGs in any capacity in your LTC practice? (426)		**Yes - 70%** No - 30%	**Yes - 68%** No - 32%	**Yes – 60%** No – 40%

	SNF-Free Standing	SNF-Hospital	Assisted Living	Hospice	Home Care	CCRC	Sub/Post Acute	LTCH/ LTAC	PACE (or other community based program)
2004	96%	0%	54%	48%	40%	15%	54%	0%	0%
2006	85%	22%	47%	38%	33%	12%	33%	15%	0%
2008	78%	20%	50%	40%	36%	21%	32%	23%	3%
2010	80%	15%	49%	37%	27%	17%	35%	19%	4%
2012	**86%** 50%	12%	**51%**	**36%**	26%	18%	32%	9%	3%

2012 AMDA Biennial Demographic Survey



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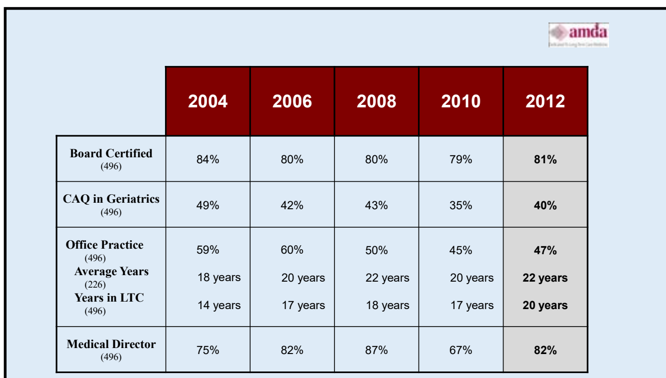
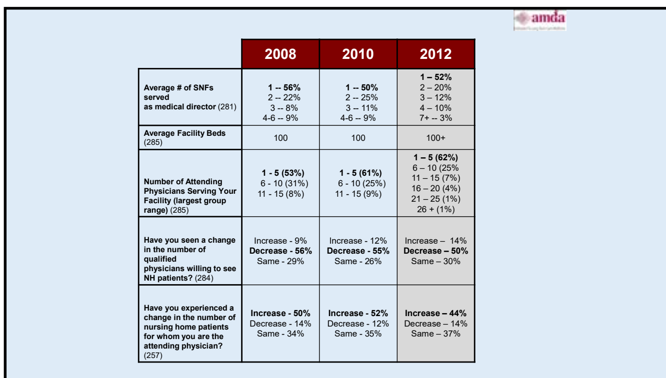


	2004	2006	2008	2010	2012
Board Certified (496)	84%	80%	80%	79%	**81%**
CAQ in Geriatrics (496)	49%	42%	43%	35%	**40%**
Office Practice (496)	59%	60%	50%	45%	**47%**
Average Years (226)	18 years	20 years	22 years	20 years	**22 years**
Years in LTC (496)	14 years	17 years	18 years	17 years	**20 years**
Medical Director (496)	75%	82%	87%	67%	**82%**



	2008	2010	2012
Average # of SNFs served as medical director (281)	**1 -- 56%** 2 -- 22% 3 -- 8% 4-6 -- 9%	**1 -- 50%** 2 -- 25% 3 -- 11% 4-6 -- 9%	**1 – 52%** 2 – 20% 3 – 12% 4 – 10% 7+ -- 3%
Average Facility Beds (285)	100	100	100+
Number of Attending Physicians Serving Your Facility (largest group range) (285)	**1 - 5 (53%)** 6 - 10 (31%) 11 - 15 (8%)	**1 - 5 (61%)** 6 - 10 (25%) 11 - 15 (9%)	**1 – 5 (62%)** 6 – 10 (25% 11 – 15 (7%) 16 – 20 (4%) 21 – 25 (1%) 26 + (1%)
Have you seen a change in the number of qualified physicians willing to see NH patients? (284)	Increase - 9% **Decrease - 56%** Same - 29%	Increase - 12% **Decrease - 55%** Same - 26%	Increase – 14% **Decrease – 50%** Same – 30%
Have you experienced a change in the number of nursing home patients for whom you are the attending physician? (257)	**Increase - 50%** Decrease - 14% Same - 34%	**Increase - 52%** Decrease - 12% Same - 35%	**Increase – 44%** Decrease – 14% Same – 37%

Medical Directors and the New ROPs

- They must now get copies of consultant pharmacist consults
- Presence at QAA
- Need to be involved in meeting the new requirements
  - Antibiotic stewardship
  - Scope of service and needs

Our Mission:

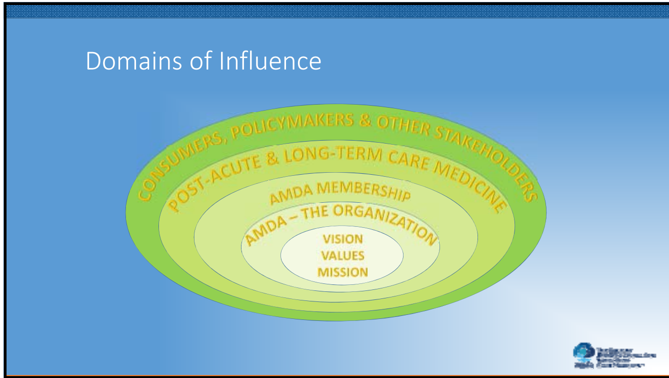
- We promote and enhance the development of competent, compassionate and committed medical practitioners and leaders to provide goal-centered care across all post-acute and long-term care settings.
- Dedicated to defining and improving quality, we advance o[...] through timely professional development, evidence-bas[...] guidance and tireless advocacy on behalf of members, [...] and staff.

Our Values:

- We are dedicated above all to quality in PA/LTC processes and outcomes.
- We affirm that a well-trained, collaborative, interprofessional team with physician guidance is best equipped to care for PA/LTC patients.
- We strive to deliver individualized, goal-directed ca[...] settings of care.
- We are tireless advocates in all venues.
- We are committed to being a credible information[...] PA/LTC.
- We are a community – connected to and supportive o[...]

Membership

NATIONAL	**5,531**
Physicians	3,982
NP/PA	327

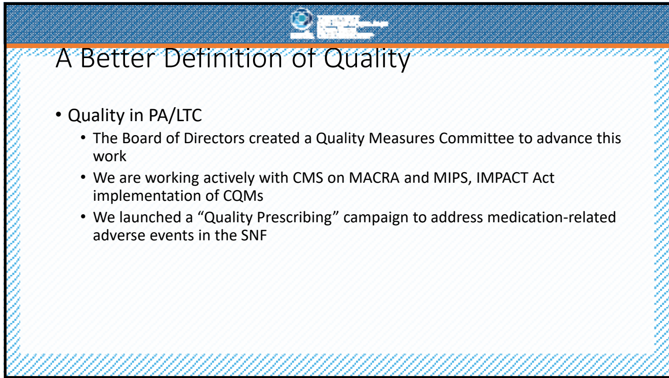


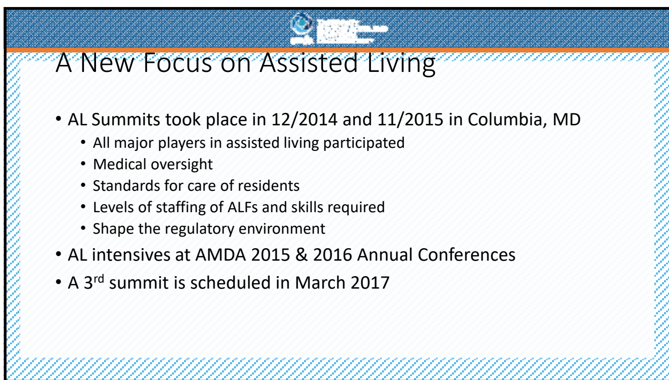
Advocacy: Concerns

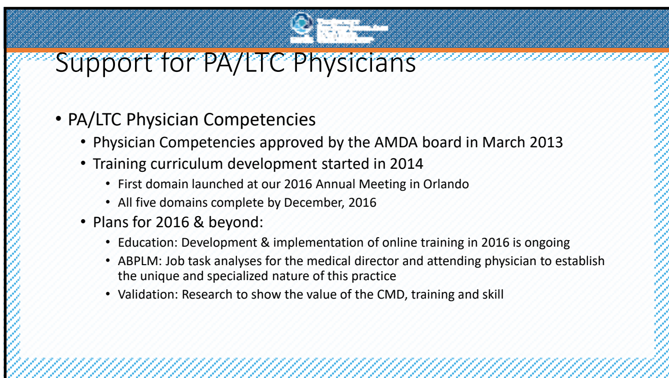
- Gradual, slow, subtle – but definite: Erosion of the indispensable role of the physician in the nursing home
  - Competent, compassionate and committed physicians are needed now more than ever
  - Reflected in our strategic planning survey: clinically complex, frail elders need more involvement from physicians now, not less
- MIPS/APMs are focusing our attention on appropriate quality measures
- … But providers and payers are focusing on risk (cost), not quality

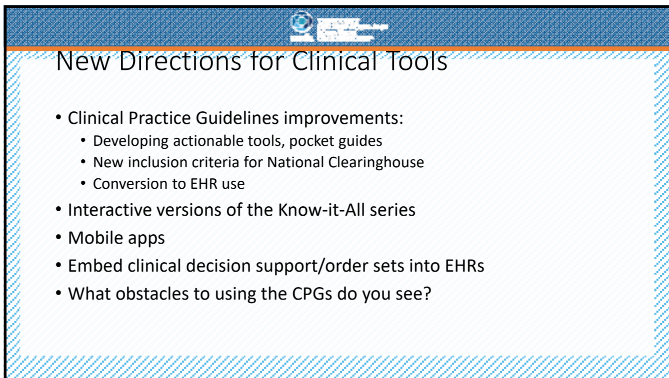
An Expanded Focus

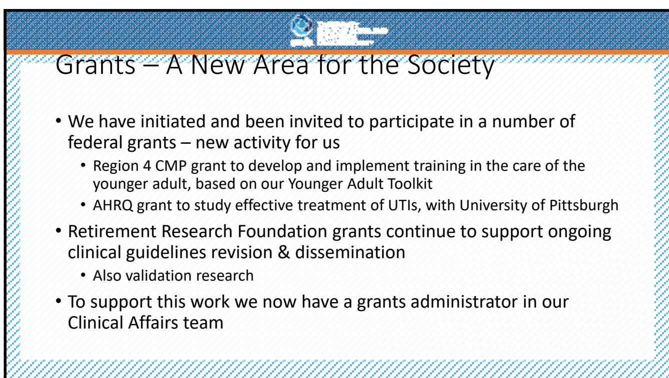
- Name change
  - AMDA – The Society for Post-Acute and Long-Term Care Medicine
- New website & domain, logo & branding
  - Consistent with the new, expanded direction for the Society
- Expanded membership
  - NPs and PAs are now “general members” with voting rights and may serve on the AMDA board
  - Help us to recruit attending physicians, NPs and PAs – some 50,000 practice in PA/LTC

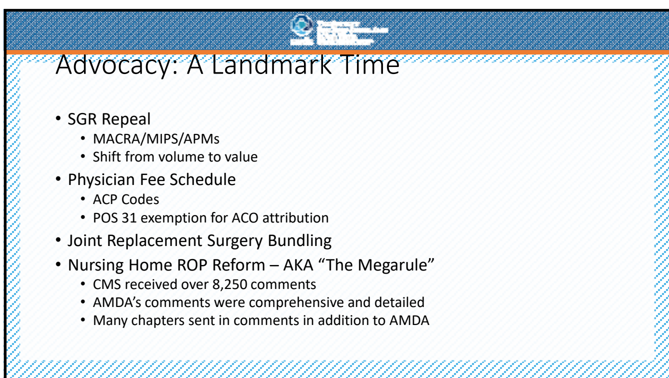

A Better Definition of Quality
• Quality in PA/LTC
• The Board of Directors created a Quality Measures Committee to advance this work
• We are working actively with CMS on MACRA and MIPS, IMPACT Act implementation of CQMs
• We launched a "Quality Prescribing" campaign to address medication-related adverse events in the SNF


A New Focus on Assisted Living
• AL Summits took place in 12/2014 and 11/2015 in Columbia, MD
• All major players in assisted living participated
• Medical oversight
• Standards for care of residents
• Levels of staffing of ALFs and skills required
• Shape the regulatory environment
• AL intensives at AMDA 2015 & 2016 Annual Conferences
• A 3rd summit is scheduled in March 2017


Support for PA/LTC Physicians
• PA/LTC Physician Competencies
• Physician Competencies approved by the AMDA board in March 2013
• Training curriculum development started in 2014
• First domain launched at our 2016 Annual Meeting in Orlando
• All five domains complete by December, 2016
• Plans for 2016 & beyond:
• Education: Development & implementation of online training in 2016 is ongoing
• ABPLM: Job task analyses for the medical director and attending physician to establish the unique and specialized nature of this practice
• Validation: Research to show the value of the CMD, training and skill


New Directions for Clinical Tools
• Clinical Practice Guidelines improvements:
• Developing actionable tools, pocket guides
• New inclusion criteria for National Clearinghouse
• Conversion to EHR use
• Interactive versions of the Know-it-All series
• Mobile apps
• Embed clinical decision support/order sets into EHRs
• What obstacles to using the CPGs do you see?


Grants – A New Area for the Society
• We have initiated and been invited to participate in a number of federal grants – new activity for us
• Region 4 CMP grant to develop and implement training in the care of the younger adult, based on our Younger Adult Toolkit
• AHRQ grant to study effective treatment of UTIs, with University of Pittsburgh
• Retirement Research Foundation grants continue to support ongoing clinical guidelines revision & dissemination
• Also validation research
• To support this work we now have a grants administrator in our Clinical Affairs team


Advocacy: A Landmark Time
• SGR Repeal
• MACRA/MIPS/APMs
• Shift from volume to value
• Physician Fee Schedule
• ACP Codes
• POS 31 exemption for ACO attribution
• Joint Replacement Surgery Bundling
• Nursing Home ROP Reform – AKA "The Megarule"
• CMS received over 8,250 comments
• AMDA's comments were comprehensive and detailed
• Many chapters sent in comments in addition to AMDA

WHITE PAPER ON THE NURSING HOME MEDICAL DIRECTOR: LEADER AND MANAGER

March 2011

Updates Resolution A06

Medical Director as Leader and Manager AMDA 2011

Roles, Functions, and Tasks

The position of the nursing home Medical Director can be identified in terms of the Role Functions, and Tasks hierarchy.

- Roles: the set of behaviors that an individual within an organization is expected to perform and feels obligated to perform.
- Functions: the major domains of activity within a role.
- Tasks: the specific activities that are undertaken to carry out those functions.

Medical Director Roles AMDA 2011

Role 1—Physician Leadership
The medical director serves as the physician responsible for the overall care and clinical practice carried out at the facility.

Role 2—Patient Care-Clinical Leadership
The medical director applies clinical and administrative skills to guide the facility

Role 3—Quality of Care
The medical director helps the facility develop and manage both quality and safety initiatives, including risk management.

Role 4—Education, Information, and Communication
The medical director provides information that helps others (including facility staff, practitioners, and those in the community) understand and provide care.

Medical director Functions AMDA 2011

Function 1—Administrative
The medical director participates in administrative decision making and recommends and approves relevant policies and procedures.

Function 2—Professional Services
The medical director organizes and coordinates physician services and the services provided by other professionals as they relate to patient care.

Function 3—Quality Assurance and Performance Improvement
The medical director participates in the process to ensure the quality of medical care and medically related care, including whether it is effective, efficient, safe, timely, patient-centered, and equitable.

Medical Director Functions (cont.) AMDA 2011

Function 4—Education
The medical director participates in developing and disseminating key information and education.

Function 5—Employee Health
The medical director participates in the surveillance and promotion of employee health, safety, and welfare.

Function 6—Community
The medical director helps articulate the long-term care facility's mission to the community.

Medical Director Functions (cont.) AMDA 2011

Function 7—Rights of Individuals
The medical director participates in establishing policies and procedures for assuring that the rights of individuals (patients, staff, practitioners, and community) are respected.

Function 8—Social, Regulatory, Political, and Economic Factors
The medical director acquires and applies knowledge of social, regulatory, political, and economic factors that relate to patient care and related services.

Function 9—Person-Directed Care
The medical director supports and promotes person-directed care.

Medical Director Tasks AMDA 2011

The tasks are listed as they relate to the nine functions and are divided into two tiers.

- Tier 1—essential, universally applicable tasks
- Tier 2—tasks that may vary with the individual's situation, availability, facility needs, and so on.

Nursing Home Administrator Certification

- ACHCA certified administrators have demonstrated the knowledge, skills, and values consistent with the high standards of management necessary to provide quality care to residents, families, and communities.
- **CNHA: NURSING HOME ADMINISTRATOR CERTIFICATION**
- **CALA: ASSISTED LIVING ADMINISTRATOR CERTIFICATION**
- ***AMDA The Society for Post-Acute and Long Term Care Medicine like ACHCA values certification as necessary for quality care***

American Board of Post-Acute and Long-Term Care Medicine (ABPLM)

- The Certified Medical Director (CMD) credential is administered by the American Board of Post-Acute and Long-Term Care Medicine, Inc. (ABPLM)

ABPLM Mission Statement

- To recognize and advance physician leadership and excellence in medical direction and medical care throughout the Post-Acute and Long-Term Care continuum via certification, thereby enhancing quality of care.

Certified Medical Director, CMD Process

- Requires specific training in the roles and responsibilities of the Medical Director
- Recognizes that there are both clinical and administrative roles of the profession
- Requires recertification every six years
- Experience and Education Model where eligibility is documented via application
- Currently no test, but there may be a secure exam required within the next 2-5 years

Certification Elements

- ACGME residency/fellowship
- State medical license in good standing
- ABMS or AOA board certification in primary specialty (optional)
- ABMS or AOA Certificate of Added Qualification in relevant subspecialty (optional)
- Clinical education relevant to PA/LTC
- Management and leadership education relevant to PA/LTC
- Practice experience in PA/LTC facilities or programs

Time Frame for Certification

- Completion of the Core Curriculum on Medical Direction in Long-Term Care within the past 5 years
- Between 2-4 years of experience as a clinician in PA/LTC within the past 5 years
- Between 2-3 years of experience as a Medical Director in PA/LTC within the past 5 years

Core Curriculum on Medical Direction in Long-Term Care

- The required course for CMD certification
  - Online didactic portion - offered three times a year, participants will have at least 3-months to complete
  - Live synthesis weekend – offered twice a year over a 3-day weekend

Core Curriculum Content

- Overview of Long-Term Care
- Regulatory Environment
- Medical Information Management
- Employee Health & Safety
- Infection Control
- Residents Rights
- Financial Issues
- Essential Health Information Tools
- Governance
- Committees
- Influencing Employee Behaviors

Core Curriculum Content (cont.)

- Introduction to Medical Care Delivery Systems
- Transitions in Care
- Quality Management
- Medical Director's Contract
- Health Care Ethics Lecture
- Integration of Problem Solving and Systems Theory
- Risk Management
- Working with Families
- Hospice/ACOs
- Workshop on Action Plan
- Medical Staff Oversight
- Leadership in the Organization

Costs of Certification

- Application review fee
  - $475 Society members
  - $575 non-members
- Registration for Core Curriculum course (2016)
  - $2,240 Society members
  - $2,750 non-members
- Recertification application review fee
  - $350 Society members
  - $450 non-members
- Society Membership $342 (optional)

J Am Med Dir Assoc. 2009 Jul;10(6):431-5. doi: 10.1016/j.jamda.2009.05.012.
Impact of medical director certification on nursing home quality of care.
Rowland FN1, Cowles M, Dickstein C, Katz PR.

- 547 Certified Medical Directors compared to non certified medical directors in similar facilities showed 15% reduction in survey citations

LONG-TERM Living

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Medical directors: Key to quality care

April 2, 2014 by Alan C. Horowitz, RN, JD

| Reprints

Good Samaritan Society Support of Medical Directors

Case in Brief: Good Samaritan Society

- Good Samaritan Society is a not-for-profit provider of senior care and services operating over 250 locations nationally
- The organization administered an annual survey identifying that medical directors struggled to understand their role and needed support leading post-acute care staff and initiatives
- Good Samaritan Society leadership decided to support their medical directors by purchasing professional memberships
- Medical directors use their professional memberships to access resources for skill development and to network with other leaders in post-acute care

Tactic 3: Train on Post-Acute Specific Issues

Empowering Medical Directors through Financial Investment

Good Samaritan Society Supports their Medical Directors through Professional Membership

How Good Samaritan Society Obtains Value from Professional Memberships

Good Samaritan Society leadership committed to purchasing professional memberships for all their medical directors. They felt that the investment was justified due to the networking and skill development opportunities available to medical directors. Good Samaritan Society's medical directors gain an understanding of their role and confidence when leading post-acute staff training and quality improvement initiatives.

Medical Director Professional Membership

Financial Investments

Membership Fee
$244 year x
160 medical directors

Total Cost
$47,040

Networking Opportunity
- Provides opportunity to gain insight from other post-acute medical directors
- Demonstrates commitment to producing high-quality patient care when establishing partnerships with acute providers

Skill Development
- Supplies post-acute clinical practice guidelines
- Outlines standard post-acute physician competencies
- Provides physicians access to training modules in core skill competencies

Good Samaritan Society: Medical Director Support

Why Investing in Your Medical Director Pays Off

Medical directors are provided with resources and networking opportunities that empower their ability to make productive contributions to post-acute care provider staff and quality initiatives such as:

1. Medical directors have access to resources focused on preparing post-acute staff for the changing care needs of patients due to rising acuity.
2. Medical directors gain an understanding of changing post-acute care policies and can assist physicians transition from fee-for-service to value-based purchasing care delivery .

Actions organizations can take to enhance the role of their Medical Director

- Develop a clear job description of what you expect from your Medical Director
- Encourage the Medical Director to join AMDA – The Society for Post-Acute and Long-Term Care Medicine and the local state chapter
- Consider funding attendance of the AMDA annual meeting
- Require the Certified Medical Director Course
- **Encourage your Medical Director to become a Certified Medical Director**

F385: Physician Services

- **§483.40 Physician Services**
- **A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.**
- **The facility must ensure that--**
  (1) The medical care of each resident is supervised by a physician; and
- **(2) Another physician supervises the medical care of residents when their attending physician is unavailable.**

F385 Physician Services: Intent

- The intent of this regulation is to ensure the medical supervision of the care of nursing home residents by a personal physician.

F385 Interpretive Guidelines

- A physician's "personal approval" of an admission recommendation must be in written form. The physician's admission orders for the resident's immediate care as required in §483.20(a) will be accepted as "personal approval" of the admission.
- "**Supervising the medical care of residents**" means participating in the resident's assessment and care planning, monitoring changes in resident's medical status, and providing consultation or treatment when called by the facility. It also includes, but is not limited to, prescribing new therapy, ordering a resident's transfer to the hospital, conducting required routine visits or delegating and supervising follow-up visits to nurse practitioners or physician assistants.

F385 Interpretive Guidelines

- Resident is allowed to designate a personal physician
- Facility assists resident in obtaining physician
- Facility should share MDS and other relevant assessments with the physician

F386: Physician Visits

- **(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;**
- **(2) Write, sign, and date progress notes at each visit; and**
- **(3) Sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.**

F386: Intent

- The intent of this regulation is to have the physician take an active role in supervising the care of residents. This should not be a superficial visit, but should include an evaluation of the resident's condition and a review of and decision about the continued appropriateness of the resident's current medical regime.

F387: Frequency of Physician Visits

- **(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.**
- **(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.**

F387: Frequency of Physician Visits

- **§483.40(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.**
- **§483.40(c) (4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section.**

F388: Interpretive Guidelines

- The timing of physician visits is based on the admission date of the resident. In a SNF, the first physician visit (this includes the initial comprehensive visit) must be conducted within the first 30 days, and then at 30 day intervals up until 90 days after the admission date. After the first 90 days, visits must be conducted at least once every 60 days thereafter.
- Permitting up to 10 days slippage of a due date will not affect the next due date. However, do not specifically look at the timetables for physician visits unless there is indication of inadequate medical care.

F388: Authority of NPP to Perform Visits and Sign Orders when Permitted by the State

	Initial Comprehensive Visit/Orders	Other Required Visits	Other Medically Necessary Visits &Orders
SNF's			
PA, NP & CNS employed by the facility	May not perform/ May not sign	May perform alternate visits	May perform and sign*
PA, NP & CNS not a facility employee	May not perform/ May not sign	May perform alternate visits	May perform and sign*
NF's			
PA, NP, & CNS employed by the facility	May not perform/ May not sign	May not perform	May perform and sign
PA, NP, & CNS not a facility employee	May perform/ May sign	May perform	May perform and sign

Nursing Home Physicians/Practitioners in North America: What do We Know?

- In the U.S. only one in five primary care physicians engages in the care of nursing home residents (JAGS 45: 911, 1997)
- The majority spend 2 hours or less per week in NH care
- In Ontario (2005), 1190 physicians engage in NH care out of 10,317 (12%); of these 628 (53%) cared for 90% of all residents.
- Around 50,000 practitioners bill nursing home visit codes in US from Medicare data
  - 30% Nurse practitioners
  - 70% Physicians (more choosing as their site of practice-SNFists)
    - Increasing consultants (psychiatrists, rehab medicine)

Credibility Gap

J Am Med Dir Assoc 14(2):83-84, 2013

- Physicians practicing in NHs have low credibility/respect compared to their peers
- Skill set not recognized or appreciated
- Acute care is the center of the health care universe reflecting predominance of the medical model
  - Disease focused
  - Cure at all costs
  - Technology

Is this Assumption True?

- Optimal physician practice in any setting translates into desirable outcomes:
  - Clinical quality/Quality of Life
  - Efficiency/cost effectiveness
  - Patient and family satisfaction

  - ***THE TRIPLE AIM FOR HEALTH CARE***

A Model for Nursing Home Physicians: Linking Practice to Quality
Ann Intern Med 2009; 150:411-413

Three critical dimensions…
Commitment conceptualized as percentage of the physician's practice devoted to NH care and the amount of time, on average, spent per NH patient encounter.

Physician NH practice competency defined by specialized training and experience necessary to handle the complex medical care in a highly regulated, interdisciplinary care context that is the contemporary NH.

Organizational structure reflects the cohesive integration of the medical providers into the culture of the facility.

BRIEF REPORTS

Association Between Proportion of Provider Clinical Effort in Nursing Homes and Potentially Avoidable Hospitalizations and Medical Costs of Nursing Home Residents

Yong-Fang Kuo, PhD, Mukaila A. Raji, MD, and James S. Goodwin, MD

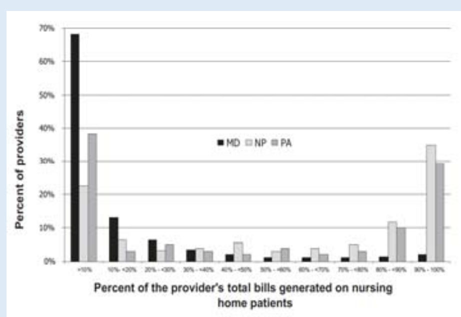

Table 2. Potentially Avoidable Hospitalization and Yearly Medicare Cost for Nursing Home (NH) Residents Cared for by Primary Care Providers (PCPs) According to Level of Provider NH Effort

Nursing Home Medical Staff Organization: Correlates With Quality Indicators

Paul R. Katz, MD, Jurgis Karuza, PhD, Julie Lima, PhD, and Orna Intrator, PhD

Objectives: Little is known about the relationship between how medical care is organized and delivered in nursing homes. Taking a lead from the acute care arena, we hypothesize that nursing home medical staff organization (NHMSO) is an important predictor of clinical outcomes in the nursing home.

Methods: A total of 202 usable surveys from a 2-wave survey process using the Dillman Method were returned from medical directors who were randomly selected from the AMDA membership and were asked to fill out a survey on the structure of medical organization in their primary nursing home practice. Quality measures that are likely to be affected by physician practice patterns were culled from NH Compare and OSCAR data sets and matched to the physician surveys, ie, long stay residents' prevalence of pain, restraint use, catheter use, pressure ulcers, pneumococcal vaccination, influenza vaccination, presence of advanced directives, prescription of antibiotics, and prevalence of depression.

Results: Using a series of hierarchical multiple regressions, significant R^2 changes were found when the medical staff organization dimensions were added in the regressions after controlling for nursing home structural characteristics for the following outcomes: pneumococcal vaccination and restraint use. Near significant findings were noted for pain prevalence among long-stay residents, catheter use, and prevalence of pressure ulcers.

Conclusions: This study is the first to demonstrate a relationship between medical staff organizational dimensions and clinical outcomes in the nursing home setting and as such represents an initial "proof of concept." NHMSO should be considered as a potentially important mediating or moderating variable in the quality of care equation for nursing homes. **(J Am Med Dir Assoc 2011; 12: 655–659)**

Keywords: Nursing home; medical staff organization; physician practice; quality outcomes

Nursing homes (NHs) have evolved significantly over the past 2 decades. They have come to accommodate an increasingly frail population with an array of both acute and chronic care needs.[1] Understandably, the quality of care delivered in US NHs remains a high priority among all the relevant stakeholders, including NH residents and their families, state and federal regulators, policy makers, and the full array of professional caregivers employed in NHs.[2,3]

Although quality of care has improved over the past few years, in large part as a result of reforms emanating from a series of critical Institute of Medicine and Government Accountability Office reports, much remains to be done.[4,5] Indeed, quality of care in the NH has been linked to a number of structural and process variables.[6] Although some of these variables are mutable (eg, nurse staffing ratios), others, such as NH size and proprietary status, are relatively fixed. Surprisingly, little is known about the relationship between how medical care is organized and delivered in NHs and outcomes, despite governmental and professional organizations' public recognition of the critical role played by physicians in NHs and explicit regulatory mandates specific to physicians.[7]

Taking a lead from the acute care arena, we hypothesize that NH medical staff organization (NHMSO) is an important predictor of clinical outcomes in the NH. The relationship between medical staff organization and quality in acute care hospitals was first described more than 30 years ago. In their classic article, Roemer and Friedman[8] defined 7 dimensions that could describe medical organization in hospitals: staff composition, appointment process, job commitment of physicians, reporting and coordination systems, number of control committees, documentation, and informal interpersonal relationships. Hospitals' performance, as measured by national accreditation, was related to the aspects of the physician's job commitment and the more tightly structured hospital staff organization. Results from Shortell and his colleagues[9] and Flood and Scott[10] further suggest that structured medical staffs

University of Rochester School of Medicine, Rochester, NY (P.R.K., J.K.); Brown University Center for Gerontology and Health Care Research, Providence, RI (J.L., O.I.).

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Address correspondence to Paul R. Katz, MD, University of Rochester School of Medicine, 435 East Henrietta Road, Rochester, NY 14620. E-mail: paul_katz@urmc.rochester.edu

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Original Study

Nursing Home Medical Staff Organization and 30-Day Rehospitalizations

Julie C. Lima PhD, Orna Intrator PhD, Jurgis Karuza PhD, Terrie Wetle PhD, Vincent Mor PhD, Paul Katz MD

Nursing Home Medical Staff Organization

- Clinical and Nonclinical Factors Associated with Potentially Preventable Hospitalizations Among Nursing Home Residents in New York State (JAMDA 12: 364-371, 2011)
  - 147 randomly selected NHs
  - Outcomes derived from DON survey, MDS and SPARCS (patient level data related to hospitalizations) 2007-8

Nursing Home Medical Staff Organization

- Results
  - Four factors significantly associated with reduction in ambulatory care sensitive (ACS) conditions
    - Nursing staff trained to effectively communicate with physicians regarding a resident's condition
    - Physicians treat residents within the nursing home and admit to hospital as a last resort
    - NHs that provide better information and support to nurses and aides surrounding end-of-life care
    - Easy access to stat lab results in <4hrs on weekends

Treatment of Pain in European Nursing Homes: Results from the SHELTER Study

JAMDA online: www.jamda.com/article/S1525-8610(13)00250-8/fulltext

- Cross sectional study of pharmacological and non-pharmacological pain management involving 4156 residents
  - Assessed with interRAI instrument for LTCF
  - 7 countries involved: Czech Republic, England, Finland, France, Germany, Italy, Netherlands and Israel
- High turnover of regular staff and low to moderate physician availability were negatively associated with pharmacological pain management

Organizational Factors Associated with Inappropriate Neuroleptic Drug Prescribing In Nursing Homes (J Am Med Dir Assoc 2015;16:590-597)

- 6275 residents of 175 nursing homes included as part of larger IQUARE study in southwestern France
- The number of GPs working at each home varied from 1 to 42 with mean of 13.8
- Residents in NHs with 20 GPs or more/100 beds had more inappropriate prescribing than in NHs with less than10 GPs/100 beds (OR 1.8)

Organizational Determinants of Transfers from Residential Aged Care Facilities

- Unplanned transfer to emergency departments for frail elderly residents of aged care facilities: A review of patient and organizational factors (J Am Med Direc Assoc 2015;16:551-562):
  - Literature review of observational studies (N=78)
  - Meta-analysis not possible given heterogeneity of studies
  - 36% of studies included some prospective data
  - 54% from US;12% Australia;10% Canada

Organizational Determinants of Transfers from Residential Aged Care Facilities

- Lower rates of hospitalizations if:
  - Greater involvement of medical staff through full time appointments
  - Greater availability of facility medical director
  - Greater availability of primary care physicians
  - Increased physician hours per resident
  - More formal structured appointment process for physician

If Physician practice relates to quality then……

- What metrics do we use to measure physician performance??

RAI based Measures (MDS) as a Gauge of Physician Performance

- RAI measures often rely on the interdisciplinary team and only indirectly relate to physician practice
  - Same issue for QOL and satisfaction
- Most RAI measures are outcome based and ignore process
- Frail NH residents often decline and have “poor” outcomes despite optimum care

The Physician Value Proposition

- Should physician worth be predicated on financially based measures?
  - Number of patients seen per unit time-productivity
  - Malpractice suits/license complaints
  - Billing compliance

  - ***SHIFT FROM VOLUME AND FEE FOR SERVICE TO VALUE IN ADVANCED PAYMENT MODELS***

The Physician Value Proposition

- Should physician worth be based on measures that exemplify a special skill set and how it's applied at the bedside?
  - Accuracy of medication reconciliations
  - Use of antibiotics based on established guidelines
  - Number of hospitalizations avoided
  - Time spent with staff teaching at the bedside
  - Documentation and comprehensiveness of advance care planning discussions

Rationale for Establishing Competencies for Physicians Practicing in the NH

- Nursing Home practice demands a unique skill set
- Competencies linked to relevant clinical outcomes/quality
- Credibility of physicians predicated, in large part, on specialization
- Impetus to set the bar independently or allow government to determine performance metrics
- Helps inform new curriculum development

Physicians/Nurse Practitioners/Physicians Assistants in PALTC

- All residents need an attending physician
- How do you know they (MD/DO, NP, PA) can provide good care in PALTC settings
  - Basic credentialing and privileging
  - Competency assessment (site specific)
  - Re-credentialing (ongoing performance assessment)

PERSPECTIVES

EXAMINING THE RATIONALE AND PROCESSES BEHIND THE DEVELOPMENT OF AMDA'S COMPETENCIES FOR POST-ACUTE AND LONG-TERM CARE

ALTC

November 7, 2014

Authors: Paul R. Katz, MD, CMD [1] • Matthew Wayne, MD, CMD [2] • Jonathan Evans, MD, CMD [3] • Leonard Gelman, MD, CMD [4] • Sheena L. Majette, BS [5]

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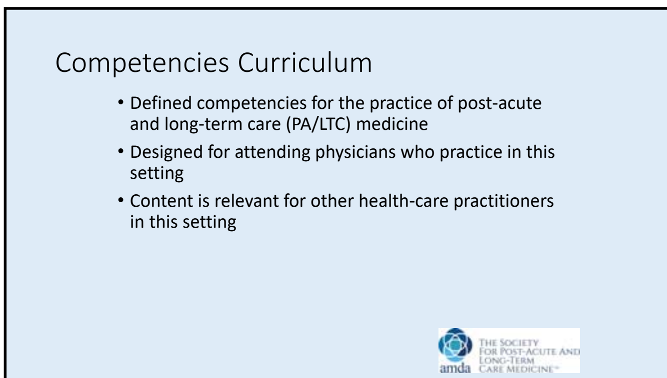


Target Audience

- Attending Physicians
- Medical Directors
- Geriatric Fellows
- Nurse Practitioners
- Clinical Nurse Specialists
- Physician Assistants

Competencies Curriculum

I. Foundation (Ethics, Professionalism and Communication)

II. Medical Care Delivery Process

III. Systems

IV. Medical Knowledge

V. Personal Professional Development in Post-Acute and Long-Term Care

Domain I: Foundation (Ethics, Professionalism and Communication)

- Module 1.1 Application of Ethical Principles in Clinical Decision-Making
- Module 1.2 Clinical Implications of Legal and Regulatory Requirements
- Module 1.3 Recognizing and Adapting to Patient Limitations and Impairments
- Module 1.4 Optimizing Communication with Patients and Families
- Module 1.5 Culturally Sensitive Interactions with Patients, Families and Staff
- Module 1.6 Elements of Appropriate and Timely Practitioner Performance

Domain II: Medical Care Delivery Process

- Module 2.1 Applying the Care Delivery Process to Patient Care
- Module 2.2 Developing a Person-Centered Evidence-Based Medical Care Plan
- Module 2.3 Identifying and Incorporating Prognosis into Care Decisions
- Module 2.4 Principles of Palliative and End-of-Life Care
- Module 2.5 Developing Effective Palliative and End-of-Life Care Plans

Domain III: Systems

- Module 3.1 Providing Prudent and Minimally Disruptive Care
- Module 3.2 Using Patient Databases in Clinical Practice
- Module 3.3 Determining Appropriate Levels of Care
- Module 3.4 Optimal Management of Care Transitions
- Module 3.5 Working Effectively with the Interdisciplinary Care Team
- Module 3.6 Understanding and Explaining the Impact of Finances on Care Decisions

Domain IV: Medical Knowledge

- Module 4.1 Identifying and Managing Changes in Condition
- Module 4.2 Formulating a Pertinent and Adequate Differential Diagnosis
- Module 4.3 Identifying and Developing a Person-centered Medical Plan
- Module 4.4 Minimizing Risk and Optimizing Patient Safety
- Module 4.5 Managing Pain Safely and Effectively
- Module 4.6 Prescribing Medications Prudently and Effectively

Domain V: Personal Professional Development in Post-Acute and Long-Term Care

- Module 5.1 Developing a Personal Professional Development Plan
- Module 5.2 Utilizing Quality-Related Information to Improve Care
- Module 5.3 Using Patient Outcomes to Improve Practice

Competencies Curriculum Online Course

- Web-based
- Asynchronous
- Case studies
- Pre and post-test questions
- Evaluations
- Certificates

Continuing Education Credit

- Physician *AMA PRA Category I Credit*™
- CMD Credit
- Nursing CEUs

Purchase

- Domain I
  - Available Now
  - $149 for Society Members
  - $199 for Non-members
  - Approved for a maximum of 2.25 *AMA PRA Category 1 Credits™*
  - *2.25 CMD Management Credits*
- Domain II – available for sale in September
- Domain III – available sale in October
- Domain IV – available for sale in November
- Domain V – available for sale in December

Competency Based Performance

- Challenges
  - How to operationalize a specific competency statement into something that is easily measurable
  - Subjective vs objective measures (attitudes vs performance)
  - Time necessary for chart review or provider interviews

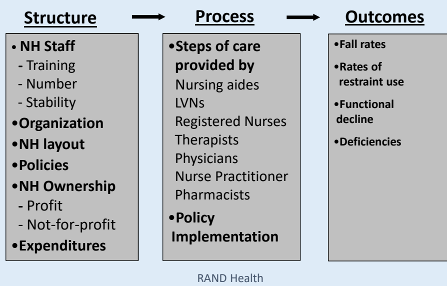
Potential Performance Standards Based on Competencies

- Utilizes the principles of ethical decision making to resolve clinical care conflicts
- Works with the interdisciplinary team to effect safe transitions of care
- Constructs a differential diagnosis for common medical signs and symptoms, recognizing atypical presentation of disease in residents in the NH
- Utilizes reported data (e.g. QI indicators, MDS, patient satisfaction) to improve resident care in the NH

Linking Competencies and Performance

- If NH practice demands a unique skill set and knowledge base (competencies) then…….
  - It is logical to assume that providers who possess certain competencies will deliver care that is of higher quality when compared to those without the requisite competencies

Provision of Care in the Nursing Home



RAND Health

Preferred Provider Networks

- Readmissions
- LOS
- Quality Measures
- Facility Staff
- Medical Staff
  - Practitioner presence and competency
  - Medical director CMD status

Pay for Performance (P4P)/Value Based Purchasing

Achieving Quality through Incentives: Focus on LTC

JAMDA

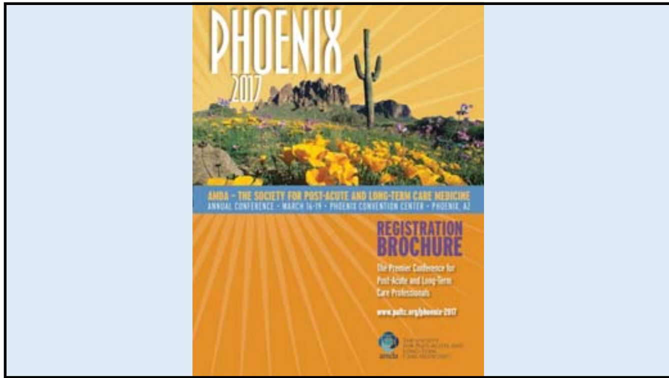
Editorial

Physician Practice in Post-Acute and Long-Term Care: Determining the "Value Proposition"

Paul R. Katz MD, CMD, Jurgis Karuza PhD

Summary

- Physicians and Medical Directors are a critical piece in providing value in SNF
- Medical Director and practitioner site specific training and competency is increasingly important if we are to optimize the value of SNF services
- Measuring the impact of physician performance on care is understudied in the NH setting but will be important as you select practitioners and medical directors
- Physicians and medical directors are key to helping you with many of the current initiatives impacting care in nursing homes
- We all need to work together for better cost-effective care.



Questions

Susan M. Levy, MD, CMD
susan@susanlevymd.com