Goal and Objectives
- To familiarize the audience with the roles and responsibilities of the Medical Director in the SNF in 2013. At the Conclusion of this lecture the audience should:
  - Be familiar with the Federal Regulations associated with medical direction (F tag 501 and others)
  - Be familiar with the scope of long-term care policies and procedures which cover the safety and health and well-being of residents and staff
  - Be able to help review critically current/develop and help implement policies and procedures associated with resident quality of life

History Lesson
- 1974: Medical director in SNF required and responsible for the medical care provided in those facilities.
- 1987: Nursing Home Reform Act in 1987
- 1991: AMDA House of Delegates approved the Role and Responsibilities of the Medical Director in the Nursing Home
  - Vision for nursing facility medical directors written by medical directors
  - Outlines the medical director’s roles in nursing facilities and is the foundation
AMDA's Vision Lead to:
- Medical Direction Core Curriculum and numerous educational products
- AMDA’s Certified Medical Director credentials
- AMDA’s Model Medical Director Agreement and Supplemental Materials
- Resolutions on medical direction in other long term care settings.

The Role of the IOM
- 2001: Institute of Medicine report Improving the Quality of Long Term Care
  - Urges facilities to give medical directors greater authority
  - Hold them more accountable for medical services.
  - Nursing homes should develop structures and processes that enable and require a more focused and dedicated medical staff responsible for patient care.

- 2002: AMDA convened a panel to review the document in the context of changes within long-term care.
- 2005: Centers for Medicare & Medicaid Services revised the Surveyor Guidance related to F-Tag 501 (Medical Director)
- 2012: New York DOH published in collaboration with NYMDA “Guidelines on Medical Direction and Medical Care in Nursing Homes”
Public Opinion of LTC:
- Rosaline Kane: Absence of bedsores, depression and malnutrition is hardly evidence of a good quality of life or of goals to inspire generations of care providers. A good quality of life should be elevated to a priority goal of LTC.
- Kaiser Family Foundation Health Poll Survey June 2005:
  - Percent who strongly or somewhat agree that NH provide safe & protected environment for frail & disabled unavailable at home: 69%
  - For most people moving into a NH:
    - Better off: 19%
    - Worse off: 41%
    - No difference: 23%
    - Don’t know: 17%

Kaiser Poll Continued:
- Staff concerned with resident well-being: 68%
- NH provide high quality services:
  - Agree: 46%
  - Disagree: 42%
- Who’s doing a good job:
  - Nurses: 84%
  - Doctors: 69%
  - Hospitals: 64%
  - Nursing Homes: 35%
  - Health Insurance Companies: 34%
  - HMOs: 30%

F501
- Three key aspects
  - Physician as Medical Director
  - Implementing resident care policies
  - Coordination of medical care
- The facility
  - Designates a physician
  - Collaborates with the Medical Director
- The medical director helps the facility identify, evaluate, and address/resolve medical and clinical concerns and issues that:
  - Are related to the provision of services by physicians and other licensed health care practitioners
  - Affect resident care, medical care, or quality of life
1) Development of Medical Care Policies and Procedures
- All resident medical care
  - Scope of services
  - Recruitment and credentialing/privileging of health care providers
  - On-going peer review
  - Capacity to provide adequate care
  - Dialysis patients
  - End-of-life
  - Acute/sub-acute care
  - Dementia care
  - Mental health care
  - Problem behaviors

2) Definition of Physician Responsibilities
- Resident medical care oversight
  - Assessments, diagnoses, treatment plan implementation, monitoring
  - Timely visits, medical orders
  - Documentation
  - Emergency coverage
  - Communication abilities with nursing and other staff
  - Communication with community agencies
- Medical Director Informs physicians of expectations
- Reviews and monitors medical care

3) Quality Initiatives
- Quality Assurance/Improvement
  - Regardless of whether the Medical Director is a member of the Quality Assurance or CQI Committee, is there input from the Medical Director?
  - How does the Medical Director communicate with the interdisciplinary team (particularly the physicians) medical care issues?
Medical Direction is about:
- Assuring the highest quality care
- Improving patient outcomes
- Improving family satisfaction
- Improving facility skill sets
- Improving facility survey results
  - Knowledge of regulations
  - Provision of resident-centered care
  - Empowering staff

Noncompliance with F501
- Facility and Medical Director fail to:
  - Have a physician identified in the role and is active in that role
  - Coordinate and evaluate medical care
  - Identify, evaluate, and address health care issues
  - Assure appropriate physician care/coverage
  - Resolve issues related to care continuity/transfer of medical information
  - Review, consider and/or act upon consultants' recommendations
  - Discuss/intervene with practitioners about medical care that is inconsistent with applicable current standards of care
  - Have system to monitor performance and practices of health care practitioners

How About Other Significant F Tags Involving Active Medical Direction ???
- 70 of the F Tags relate directly or indirectly to Quality of Life and could involve the leadership/guidance of the medical director and/or physician staff
  - F201-4: Transfer and Discharge
  - F208: Admission policies
  - F329: Unnecessary drugs
  - F428: Drug regimen review
  - F323-4: Accidents
  - F309: Assessment and management of pain
  - F 314: Assessment, care and prevention of pressure sores
5-STAR RATING

- The top 10 percent (lowest 10 percent in terms of health inspection deficiency score) in each State receive a five-star rating.
- The middle 70 percent of facilities receive a rating of two, three, or four stars, with an equal number (approximately 23.33 percent) in each rating category.
- The bottom 20 percent receive a one-star rating.

LEADING DEFICIENCIES

United States

<table>
<thead>
<tr>
<th>Deficiency</th>
<th>Percent</th>
<th>0% - 100%</th>
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<tbody>
<tr>
<td>Infection Control</td>
<td>43%</td>
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<tr>
<td>Accident Environment</td>
<td>43%</td>
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<tr>
<td>Food Sanitation</td>
<td>38%</td>
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<tr>
<td>Quality of Care</td>
<td>34%</td>
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<tr>
<td>Professional Standards</td>
<td>30%</td>
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<tr>
<td>Comprehensive Care Plan</td>
<td>28%</td>
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<tr>
<td>Unnecessary Drugs</td>
<td>23%</td>
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<tr>
<td>Clinical Records</td>
<td>21%</td>
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<tr>
<td>Dignity</td>
<td>20%</td>
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<tr>
<td>Housekeeping</td>
<td>20%</td>
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Michigan

<table>
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<tr>
<th>Deficiency</th>
<th>Percent</th>
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<td>Unnecessary Drugs</td>
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<td>Clinical Records</td>
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<td>Dignity</td>
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<tr>
<td>Housekeeping</td>
<td>32%</td>
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</tbody>
</table>
Information Gathering with QIS
- MDS - 24%
- Resident interviews - 21%
- Resident chart reviews - 18%
- Resident observations - 16%
- Family interviews - 12%
- Staff interviews - 9%

Medical Director Initiatives
- Accident Assessment and Prevention
  - Safety Committee
  - Falls subcommittee
  - Developing investigational skills
  - Tracking patterns
    - Units
    - Shifts
    - Specific times
    - Locations
- Fecal Impaction
  - Prevalence of Fecal Impaction (Most Recent MDS) MDS > 1.0%
- Infection Control & Immunizations
  - Infection Control - Program
- Hospitalization or Death
  - Death (Chart/ Most Recent MDS) Random Admission >1.0%
  - Hospitalization Within 30 Days
Pressure Sore Initiative
"War on the Sore"
- Interdisciplinary team approach
  - Wound Rounds
  - Medicine, Nursing, Therapies, Nutritional Services, Pharmacy
  - Communication with primary care
  - Hands-on caregivers
  - Physicians
  - Expectations of caregivers/families

Unnecessary Drugs
- When are medications considered unnecessary ????
  - What is magical about 9 or more meds?
  - Can we “treat” everything
  - Expectations of medicine
    - Dementia management
    - Mental health
    - Palliative care
    - Preventative care
    - Symptomatic care
  - Increasing the role of the pharmacy services

Pain Recognition and Management
- Everyone on the same assessment page
  - Continuing education
    - Acute vs. chronic pain assessment
    - CNAs
    - Nursing
    - Physicians
    - Residents
    - Family members
  - Active involvement of pharmacy services
Safely Admitting/Transferring

- Developing more than a simple “transfer” agreement with receiving institutions
- Sharing of cultures
- Using the “HIPAA Excuse Barrier”
- How to make information readable/useable/accessible??
- Case Examples:
  - The resident after a fall
  - The injured resident
  - The confused identity resident

Resources, Where to Go, What to Get?

- www.amda.com
  - This Webpage of the American Medical Directors Association provides a wealth of information to the professional as well as the consumer:
    - General Long-Term Care Information, Toolkits, Guidelines, Position Papers, Associated Web Links
  - DO FACILITIES KNOW OF THESE RESOURCES FOR THEIR MEDICAL DIRECTOR AND PHYSICIANS MEMBERS ????????
  - Contact AMDA at:
    11000 Broken Land Parkway, Suite 400
    Columbia, MD 21044
    Phone: 800-876-2632/410-740-9743
    FAX: 410-740-4572 or
    email: webmaster@amda.com

UPCOMING EDUCATIONAL EVENTS:

April 30th, 2013
AMDA Live Webinar: Medication Management: Antipsychotics
Presenter: Matthew Wayne, MD, CMD

July 27th - August 2nd, 2013
Core Curriculum on Medical Direction in Long Term Care
Baltimore, MD

October 4th - 6th, 2013
Advanced Curriculum on Medical Direction in Long Term Care
Atlanta, GA

March 21st - 24th, 2013
AMDA Long Term Care Medicine - 2013
Washington, DC

September 21st, 2013 - Registration now open!
Navigating Mood and Behavior Challenges in Long Term Care: Strategies for Optimal Outcomes
New Orleans, LA

November 2nd - 8th, 2013
Core Curriculum on Medical Direction in Long Term Care
Orlando, FL