



## Medical Direction and Medical Care in the Nursing Home

January 18, 2012

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## Workgroup Charge

To improve health outcomes and quality of life for nursing home residents by strengthening medical direction and medical care through the provision of written guidance and model policies and procedures for:

- (1) credentialing;
- (2) the qualifications, role, responsibilities and accountabilities of medical directors; and
- (3) the role, responsibilities and accountabilities of attending physicians, nurse practitioners and physicians' assistants.

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## What is the value of these guidelines?

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- Health and quality of life outcomes for residents;
- Resident and family satisfaction;
- Staff satisfaction, pride and morale;
- Community reputation;
- Team-based care;
- Person-centered planning;
- Fewer emergency room visits and hospitalizations;
- Stakeholder expectations and demands;
- Payers' performance expectations;
- Managed, coordinated and integrated care environment; and
- Litigation.

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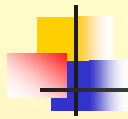


## Institute of Medicine 2001 Improving the Quality of Long Term Care

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- “Nursing homes should develop structures and processes that enable and require a more focused and dedicated medical staff responsible for patient care
  - Credentialing
  - Peer review
  - Accountability to the medical director”

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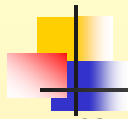
## Institute of Medicine 2001

### Improving the Quality of Long Term Care

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- “Physicians, nurse practitioners, and other primary care providers in long term care need to have expertise relevant to the populations they are serving.”
- “Geriatric training is especially important.”

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## Physician Staffing

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- Katz and Karuza 1997
- National Physician Study
  - For those with NH practice
    - Median time –2 hours / week

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## 1. Delineating the current status of medical care, what works

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- Care planning meetings
- Nurse practitioners (NP) and physicians' assistants (PA)
- Peer review and monitoring
- Communication:
  - person-centered care management,
  - care planning, resident needs, expectations, and advance directives
  - comprehensive medical records-electronic health records
- Physicians who have a full-time presence
- Frequent, regular visits to residents and physician supervision of non-physician staff.
- Teamwork

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## 1. Delineating the current status of medical care, what works

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- Regulatory requirements
  - Changes in CMS guidance and regulations have strengthened the role of medical directors
- Education:
  - medical practitioners who have expertise
  - access to guidelines and standards
- Use of transitions coordinator between settings.

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## 1. Delineating the current status of medical care, what doesn't

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- Medical and nursing personnel do not communicate
- Peer review and monitoring
- The physician believes in his/her own autonomy
- Medical practitioner availability is limited due to rural isolation or regional shortage of medical staff.
- Disjointed care planning
- Documentation
- Regulatory requirements tend to be overly burdensome
- Credentialing is inadequate. However, few practitioners would meet meaningful credentialing criteria.

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## 1. Delineating the current status of medical care, what doesn't

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- Too much care: residents are over-medicated and unnecessary tests and treatments are ordered
- There are no incentives to promote more efficient care, reduce medical errors, and engage physicians in clinical care, survey reviews and QA meetings
- Inadequate use of available data.
- Differences across nursing homes
- A medical team or group practice approach for nursing home residents does not promote "knowing the resident."
- Lab test results are not available on a timely basis.
- Nursing home administrators are insufficiently involved with medical practitioners regarding coordination of care.

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## 1. Delineating the current status of medical care, what doesn't

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- Physician attitudes toward and communication with nursing staff needs to be improved.
- Physicians are not acting as educators.
- Resident population is changing rapidly, particularly with regard to acuity and complexity of morbidity.
- Fewer physicians have background in gerontology, geriatrics or long-term care management.
- Physician presence in the nursing home is minimal.
- Interventions for chronic diseases are isolated and episodic
- Little is done to acquire prior resident medical records from hospitals, primary care physicians, or other facilities.

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## 2. Defining the beliefs of the old (current) culture

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- Defensive medicine is justifiable.
- Dominance: physicians and hospitals hold a high and isolating level of power in regard to medical long term care. Physicians had the final say in resident care.
- Long term care settings are not a good place to practice medicine.
- Long term care is a part-time, short-term practice with low pay.
- Long term care is unskilled and therefore offers little incentive to improve quality.
- Nursing home care is minimal and a last stop, temporary stay with little hope of improved care or comfort to residents. A nursing home stay is a death sentence.
- There are few regulatory requirements governing medical care.
- Nursing homes are a low stress environment for medical practitioners

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## 2. Defining the beliefs of the old (current) culture

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- There are minimal incentives to improve quality of medical care
- Physicians have little to no responsibility for a resident's life outside of nursing home.
- Nursing homes focus on care, not cure.
- The sole purpose of quality assurance committees is to meet minimal survey requirements. The committees do not need to try to improve quality or inquire with medical staff, which are often encouraged to avoid attending meetings.
- Physicians, administration and nursing staff do not work as a team.
- Interdisciplinary teams are not really necessary.
- Physicians diagnose and delineate care. They are responsible only for the resident's medical condition. Any further engagement with facility or resident is unnecessary.

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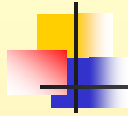


## 2. Defining the beliefs of the old (current) culture

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- Physicians do not have time
- Medical directors have minimal involvement in policy development for procedures both medical and facility related.
- Physicians and medical directors think that 30 – 60 minutes per week meets the needs of the nursing home resident population.
- Physician's roles are to sign-off on orders and policies, which requires minimal interaction with facility.

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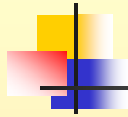


## Physician Staffing

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- Katz and Karuza JAMDA 2006  
The Nursing Home Physician Workforce
  - Potential Linkages Between Physician Practice and Outcomes
  - **Physician Availability on Site**
    - Appropriate use of ancillary services
    - Timely assessment of clinical problems
    - Treatment of acute issues
    - Interaction with care team/medical director
    - Role model for staff
    - Staff educator
    - Medical record completion
    - Integration into nursing home culture
    - Active participation in facility committee work
    - Active in quality improvement program

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## CULTURE OF ACCOUNTABILITY

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“People being accountable to think and act in the manner necessary for their organization to achieve results.”

“Journey to the Emerald City” Roger Connors,  
Tom Smith

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## **CULTURE OF ACCOUNTABILITY**

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“A Culture of Accountability is a place where everyone continually asks, “What else can I do to achieve results, attain objectives, and accomplish goals?”

“Journey to the Emerald City” Roger Connors,  
Tom Smith

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## **MEDICAL CULTURE CHANGE**

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### Four Steps to Accountability

1. See It
2. Own It
3. Solve It
4. Do It

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# MEDICAL CULTURE CHANGE



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1. Delineated the current status of medical care, what works, what doesn't
2. Defined the beliefs of the old culture
3. Defined the results expected
4. Defined the actions/behaviors that we expect
5. Defined the beliefs that the new culture will have

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## 3. Defining the results expected



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- More complete and timely communication among interdisciplinary staff, residents and families.
- Physicians held responsible for sharing information with facility regarding resident care and overall greater physician involvement, including staff education.
- Physicians will create an environment of shared responsibility (across all staff) for resident quality of care and quality of life.
- Systems thinking, benchmarking and outcomes management.
- More accurate and timely assessment
- The number of hospitalizations and readmissions to hospitals is reduced
- Fewer crises.

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### 3. Defining the results expected

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- Better continuity of care.
- Fewer instances of missing/inaccurate information; fewer surprises for clinicians.
- Physicians being an integral part of the interdisciplinary care planning team
- High turnover is reduced and job satisfaction among all staff increases.
- Increased presence of medical staff with gerontology/LTC experience and interest.
- Use of measurable clinical outcomes supported by standards (not cumbersome guidelines) that improve practice.
- Introduce statistical evaluation of care and their processes beyond the scope of traditional quality assessment and MDS reporting.

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### 4. Defining the actions/behaviors that we expect

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- **Improved skills for administrators:**
  - an understanding of the need for clearly defined expectations for medical directors and attending physicians
  - administrators will ensure that these expectations are in writing, that all staff are familiar with them, and that physicians and medical directors honor them
  - strong communication skills and an understanding of and commitment to the importance of communication among all staff
  - administrators will be role models who demonstrate effective and timely communication every day and will ensure that their department heads follow suit with their staff

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## 4. Defining the actions/behaviors that we expect

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### **Improved skills for physicians**

- Strong communication skills and an understanding of and commitment to the importance of communication among all staff
- The ability to distinguish uncertainty and wrongful diagnosis
- The ability to generate an environment in which the resident, family and staff are comfortable with diagnostic uncertainty
- Better medication prescribing skills (leading to a reduction in polypharmacy)
- Greater influence on the philosophy of the facility through education and time spent in facility
- Use of empirical methods to seek, interpret, and act upon evidence
- Responsive to acute conditions that often go unchecked by clinical staff

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## 4. Defining the actions/behaviors that we expect

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### **Improved skills for medical directors:**

- Heightened leadership skills that promote shared responsibility and support among all staff
- Strong communication skills and an understanding of and commitment to the importance of communication among all staff
- Greater influence on the philosophy of the facility through education and time spent in facility

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#### 4. Defining the actions/behaviors that we expect

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- Greater nursing home use of information technology including electronic medical records for quicker access to medical charts and labs
- Improved palliative care (pain reduction and management) and improved partnerships with local hospice organizations
- Stronger focus on appropriately addressing the specific medical needs of the resident rather than just meeting minimal survey standards
- Improved coordinated care between nursing homes and hospitals
- Guidelines for how to manage acute illnesses of unknown origin

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#### 5. Defining the beliefs that the new culture will have

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- New role models: physicians are leaders, educators, policy makers and communicators. Their presence is welcomed in nursing homes as an asset.
- Long term care and geriatrics are prestigious medical practices. Physicians are proud to identify themselves as long term care specialists and geriatricians caring for nursing home residents.
- Teams at all levels of the organization and teamwork are acknowledged as integral to effective long term care in nursing homes.

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## 5. Defining the beliefs that the new culture will have

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- Every nursing home must have a leadership team comprised of at least the medical director, the director of nursing services and the administrator. This team meets on a regular basis to plan, implement and evaluate the needs of the nursing home. It is responsible for developing a strategic plan based on core values and the mission.
- A systems approach to care is critical. Statistical analysis of care and clinical processes is helpful to defining organization systems with the greatest health outcomes.

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## 5. Defining the beliefs that the new culture will have

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- A high quality nursing home fosters learning among and across staff, residents and families.
- Residents deserve the best care possible and the best outcomes possible.
- Strong relationships between hospitals, hospices, community-based physicians and specialists and nursing facilities is critical.
- Leaders in the nursing home are committed to creating an environment in which all staff embrace the implementation of new information technology

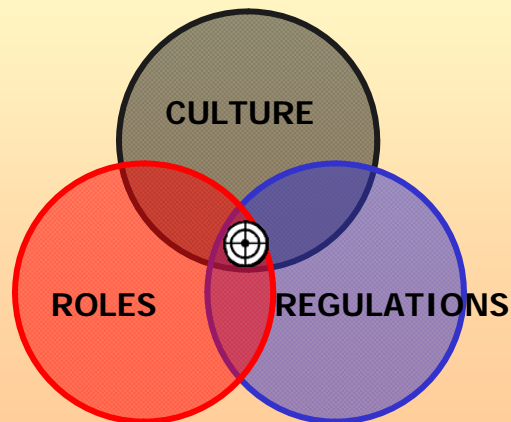
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## 5. Defining the beliefs that the new culture will have


- Nursing homes and medical practitioners recognize the value of evidence-based and cost-effective interventions.
- Medical care in nursing homes is viewed with the same respect and regard as medical care delivered in any other setting.
- Value of the individual: ensure the right to each resident and proxy's role in care planning.
- Value the potential for more homelike and less institutional environment and care practices for residents.

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## THE GUIDELINES

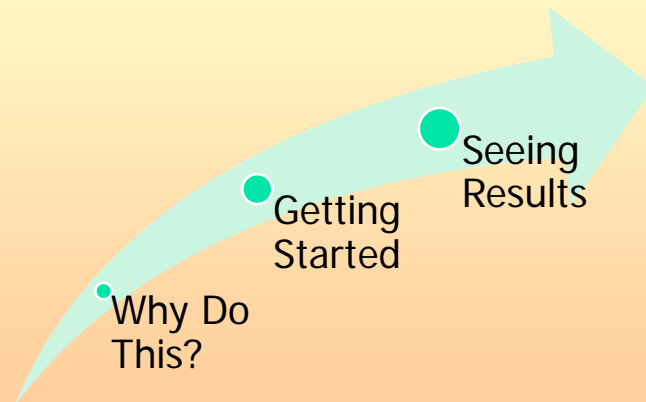


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## Putting Guidelines Into Practice

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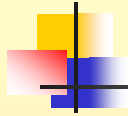


## Take The Test

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- What are your written qualifications for the position of Medical Director?
- How invested is the M.D. in facility performance; outcome measures; quality of life?
- When was the last meaningful conversation you had with the M.D. related to facility practices? Physician services?
- Do you know the M.D. schedule for administrative duties?

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## First Step – Take the Test

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- What is the original date on the current M.D. contract? Has it yellowed with time?
- How many retrospective or concurrent chart reviews have been conducted by the M.D. in the past 6 months? How many resulted in process change recommendation or other QI initiative?

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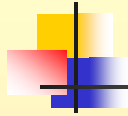
If you're not satisfied with any of your responses...perhaps the Guidelines are the place to start...

after all...

Insanity is doing the same thing over and over again and expecting different results.

*Albert Einstein*

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## More Reasons to Act

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- Medical Director (and attending MDs) have broad responsibility in many F-tags
- There is regulatory authority and responsibility to oversee, direct and coordinate the medical care provided, including areas of QOL
- Essential role in the quality improvement process
- Medical Care Plays primary role in reducing unnecessary hospitalizations – bed hold days
- Quality Measures Matter!

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## Where To Start?

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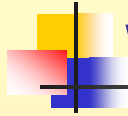
### 1. Understand the Guidelines

Organized into functional categories with regulatory references

Provide measurable outcomes

Establishes a *collaborative* model

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## Where To Start? ...Continued

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### 2. Identify where you are currently

Conducting an honest appraisal of your process, structure and outcome will establish a common ground from which to build. Include M.D., DON, Administrator, or other key clinical staff

Include assessment of facility practices that impede optimal performance (lack of structure, expectations, resources, etc.)

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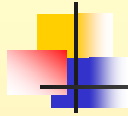
## Where To Start? ...Continued

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### 3. Establish performance objectives in collaborative fashion with M.D. based on guidelines

Establishing mutually agreeable objectives that are consistent with the resources invested and the abilities of the M.D. will increase potential for success.

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## *Collaborative is a 2-way street*

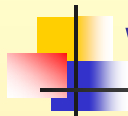
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Is there too little resource invested compared to the expected outcome?

Are you spending too much for what you're getting?

Is your investment equal to your result?

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## *Where To Start?* ...Continued

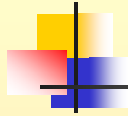
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### 4. Dust off the M.D. Contract

View it as any other service contract: be sure that facility responsibilities and M.D. responsibilities are clear, measurable, achievable and consistent with expectations. It's a business relationship.

Consider incorporating guidelines into agreement (appending)

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## Key Areas of Focus

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- *Overall medical care* – survey history, satisfaction scores, etc.
- *Physician Oversight* – peer review, visit compliance, physician performance
- *Credentialing* – consistent, critical, compliant
- *Quality Improvement* – present and accounted for

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## Seeing Results

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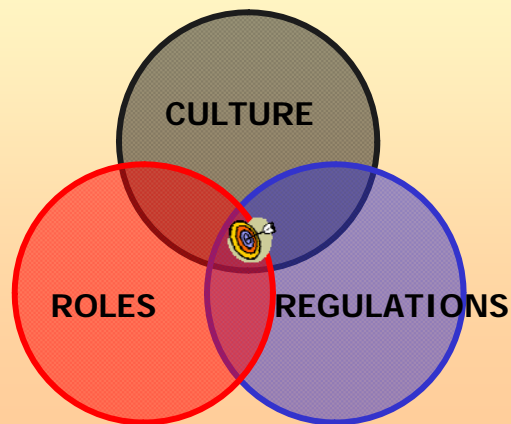
- Physician Engagement – Satisfaction
- Improved Communication
- Shared Accountability
- Resident Care – Quality Outcomes
- Attending Physician Compliance through Expectations

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# THE GUIDELINES

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For additional information or questions,  
please contact any of the Empire Quality  
Partnership lead staff:

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