

# The Role of the Medical Director in Long Term Care

Focus 2014:  
"Teach, Learn, Collaborate"

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During this talk I will try to illustrate...

1. Development of the role of LTC Medical Director
2. Requirements necessary to become an AMDA Certified Medical Director in long term care
3. Responsibilities and Roles of the Medical Director
4. How to use your Medical Director to provide feedback to your medical staff
5. Strategies to effectively utilize your Medical Director to improve quality

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## 1. Developing Role of Medical Director

1974-Medicare requires Medical Director for skilled Nursing Facility.

"The Medical Director should be responsible for the medical care of the residents of the facility."

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1987- Nursing Home Reform Act leading to activity that, in March 1991, AMDA House of Delegates approves "Roles and Responsibilities of the Medical Director in Nursing Homes."

That document sets AMDA's vision for nursing facility medical directors and lays framework for CMD credentialing and leads to the publication of AMDA's "Model Medical Director Agreement and Supplemental Materials: Medical Director of a Nursing Home."

2001 Institute of Medicine report-"Improving Quality of Long Term Care" urged facilities to give Medical Directors greater authority and accountability.

Also, NH should develop structure and policy to "enable and require" a more focused and dedicated staff through credentialing, peer review, and accountability to the Medical Director.

April 2002 AMDA convenes a panel and reviews and revises 1991 "Roles and Responsibilities..." document outlining the medical director's roles looking toward providing appropriate care to the increasingly complex, frail and medically challenging nursing home population.

- 2005 CMS revises F tag-501 incorporating 2001-02 revisions of that 1991 original AMDA document
- CMD Curriculum Faculty more formally recognizing the medical director’s dual Clinical and Management role and emphasized the leadership role to promote quality of care in 2009-10 and formally adopted by HOD in 2011.
- 2010-11 AMDA most recent update “Roles and Responsibilities....”

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## 2. Requirements for becoming a Medical Director

### Active License

but

The CMD credential “...offers an indicator for professional competence to long term care providers, government, quality assurance agencies, consumers, and the general public....”

AMDA White Paper A-11

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### CMD Certification

- By AMDACP
- Over 3000 CMDs currently
- 6 year certification
- Experiential model of certification
- Using existing mechanisms such as fellowships, board certification, CME, CMD approved and AMDA sponsored courses in medical direction
- No test or exam

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### Three Steps to CMD

- I. Eligibility
- II. Education and Clinical Experience
- III. Education and Experience in Medical Direction/Management

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### Step I Eligibility

- Must be a Medical Director in LTC
- Completed a US ACGME or American Osteopathic Association Post-graduate Training Program or Canadian Royal College of Physicians and Surgeons PGT program
- Unrestricted medical license
- Experience as Medical Director 5 years at least 8hrs/mo

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### Step 2 Education and Experience

#### Option 1

- Boarded in primary care field
- Completion of fellowship in geriatrics, pediatrics, psychiatry in last 5 yrs or ABMS certification of added qualification (CAQ)
- Two year clinical practice in specialty

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Step 2 Education and Experience  
Option 2

- ABMS Boarded in primary care
- 60 hr. AMA Cat I CME in last 3 yrs
- 3 yr clinical practice in LTC

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Step 2 Education and Experience  
Option 3

- Completion of ACGME or AOA PGY 1-3 years in primary care
- 75 hrs AMA Cat I CME in last 3yrs
- At least 4 yrs practice in LTC

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Step 3

Medical Direction/Medical Management

- Core Curriculum
- 2-5 yrs experience as Medical Director LTC
- Various amounts of additional training in medical direction depending on board specialty, fellowship, or experience.

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### AMDACP Core Curriculum

- 7 day course
- 46 hrs of instruction
- Equivalent hours additional for approved project completion
- Held twice per year June and Dec
- Course tuition \$2095 for members
- Dedicated Faculty

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### Core Curriculum Agenda

- Overview LTC
- Regulatory Environment
- Medical Information Systems
- Employee Health and Safety
- Resident Rights
- Financial Issues
- Medical Staff Oversight
- Ethics
- Quality Management
- Committees

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### AMDACP Mission Statement

“AMDACP mission is to recognize and advance physician leadership and excellence in medical direction throughout the Long Term Care continuum through certification thereby enhancing quality of care.”

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## AMDA CMD Curriculum

The medical director provides input to policy, supervises medical staff, reviews and participates in QA, and provides oversight to safety and risk management.

Medical Director is responsible for all levels of resident care through oversight and guidance.

He is a leader who helps define a vision of quality improvement, and operations consultant to address organizational function, and a direct supervisor of the Medical practitioners who provide resident care.

A-11 White Paper AMDA

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## Curricular Emphasis

Roles-a set of expected and obligatory behaviors.

Functions-major domains of action within a Role,

Tasks-special activities undertaken to carry out those Functions.

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## JAMDA July 2009

- "Impact of Medical Director Certification in Nursing Home Quality of Care" Columbia University MD
- 547 LTCs with CMDs
- 15,230 LTCs without CMDs
- 27 F Tags identified that appear to reflect quality directly impacted by the medical director.
- # citations with "scope and severity" compared between the two sets for 3/08-3/09 (Data from CMS Online Survey Certification and Reporting OSCAR database)
- Raw scores standardized to account for the wide state-to-state variation in survey process

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## Study Concluded

“Having an AMDA certified CMD contributes positively to a nursing Home’s quality of care.”

The standardized quality score showed a 15% improvement in quality as measured by lower incidence of citation and lower severity of harm weighted scores

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## Wisconsin Association of Medical Directors- Society for Post-acute/LTC Medicine

- Wisconsin State Chapter of AMDA since 1988
- About 100 members-40 physicians plus DONs Administrators, APNPs, IPs
- Annual meeting with CME early October
- General membership sets WAMD policy
- Liaison to the Wisconsin State Medical Society
- Individual or Corporate membership
- Quarterly Board meeting
- Newsletter to members (6x/year)
- WAMD website

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## WAMD Oct 2014 Annual Meeting Education

- Regulatory Update
- Diabetes Management in LTC
- Falls Prevention update
- What’s new at AMDA
- Fellow Journal Club
- Behavior and Psych Symptom Management
- Improving Antibiotic Treatment Decisions
- Osteoporosis in LTC
- 5 Star Quality and How to Get There
- Wound Management
- CPR Update
- Happy Hour

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### 3. Responsibilities of the Medical Director

- Reviewed, Updated, and Outlined in AMDA White Paper A11
- Approved as AMDA policy House of Delegates March 2011
- Defines Roles, Functions, and Tasks

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#### Roles-the set of expected and obligatory actions

1. **Physician Leadership**-responsibility for overall care and clinical practice carried out by the facility.
2. **Patient Care/Clinical Leadership**-application of clinical and administrative skills to guide the facility in providing care.
3. **Quality of Care**-helping facility manage quality, safety, and risk management initiatives.
4. **Education**-providing information and experience to staff, providers and the community to understand and provide care.

A-11 White Paper AMDA

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#### Functions and Tasks of the Medical Director

**Functions** – are the major domains of action within a role and are embedded in the overarching roles of the medical director and represent foundations for developing tasks to carry out the roles of the medical director.

**Tasks** – are the special activities that are undertaken to carry out Functions

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## Two Types of Tasks

Tier 1 Tasks are essential tasks that all medical directors perform in any LTC facility and

Tier 2 Tasks vary depending on the situation or setting.

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## 9 Medical Director Functions

1. Administrative 6/2
2. Professional Services 7/9
3. Quality Assurance and Performance Improvement 6/6
4. Education 4/4
5. Employee Health 2/7
6. Community 1/6
7. Rights of Individuals 4/4
8. Social, Political, Economic Factors 2/4
9. Person Directed Care 3/3

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### Tier 1 Tasks for Function 2 Professional Services

- Task 1 Organizes, co-ordinates, and monitors activities of the medical staff and ensures that quality and service meets community standards.
- Task 2 Helps facility arrange for availability of qualified medical consultative staff and oversees their performance
- Task 3 Assures coverage
- Task 4 Collaborates with DON and other managers to assure the practitioners have good support to manage resident care

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### Tier 1 Tasks for Professional Services, cont.

- Task 5 Develops and reviews policies that govern and reviews performance, and qualifications of non-physician providers
- Task 6 Guides administration in documenting credentials of facility practitioners
- Task 7 Collaborates with facility to hold practitioner accountable for their performance and practice including corrective action when needed

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### 9 Tier 2 Tasks for Professional Services

There are nine of them covering: develops provider by-laws, rules and regs, helps establish affiliation agreements with other health care organizations, helps support care-related activities of IDT, helps assure that MR system meets needs of patients and practitioners, helps ensure adequacy of documentation, advises on interaction with UR organizations, helps with policies for health care training programs, advises on admission screening and transfer, advises facility regarding family issues

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### So Many Tasks...

There are 35 Tier 1 tasks and 45 Tiers 2 tasks listed in the A-11 AMDA white paper to cover the nine Functions

1. Administrative 6/2
2. Professional Services 7/9
3. Quality Assurance and Performance Improvement 6/6
4. Education 4/4
5. Employee Health 2/7
6. Community 1/6
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### Medical Director's Role F-Tag 501

**"The Medical Director helps the facility identify, evaluate and address /resolve medical and clinical concerns and issues that affect resident care or quality of life related to provisions of services by physicians and other licensed health care providers. "**

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S&C 05-29 June 9, 2005

- Referenced AMDA 2002 R&R revisions
- Similar in intent to AMDA white paper A-11.
- Emphasis on Leadership to provide quality
- Requirement for a valid medical license
- Two roles of Medical Director:
  - implementation of resident care policies
  - co-ordination of medical care

"Revised Interpretive Guidelines for Tag F501,Medical Director"

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### The Medical Director...

Must be identified and must be licensed

and

leads, collaborates, identifies, provides, evaluates, guides, oversees, approves, addresses, reviews, helps, facilitates, discusses, and coordinates everything.

(These are things different than direct patient care)

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S&C 05-29

## Compliance with F-501

- There must be a Medical Director
- The survey team must identify whether noncompliance at other tags relates to the Medical Director Role.
- The team must show association between the identified deficiency and failure in medical direction.
- This does not presume that a facility's noncompliance...necessarily reflects on the performance of the Medical Director.

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## You and the Medical Director

- "The Medical Director is in a position...to provide input to surveyors on physician issues, individual resident clinical issues, and the facilities clinical practices." S&C 05-29
- "The Medical Director helps...with applicable social, regulatory, political and economic policies and expectation." AMDA white paper A-11, F-1 T-1.

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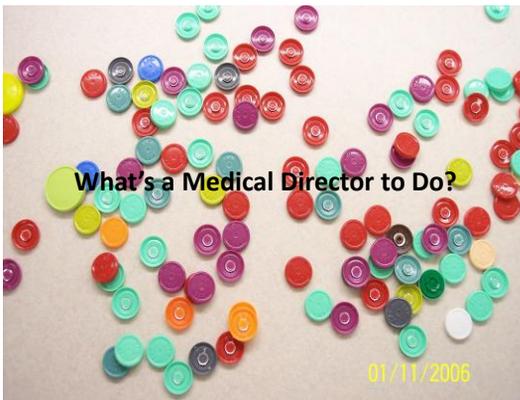
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### Wisconsin Healthcare Associated Infections in LTC Collaborative

- CMS initiative: National Action Plan to Prevent Healthcare Associated Infections: Roadmap to Elimination-2009.
- 3 phase approach over 5 years targeting specific provider types.
- LTC phase III, targeted for 2013.
- CMS DQA with CDC and Wisconsin DPH began discussion 2011
- March 2012 WI HAI in LTC Collaborative formed.
- WAMD became a member Nov 2012

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### Membership of 21

Four members from DHS including Vicky Griffin  
 One MetaStar quality consultant  
 One UW-Madison nurse research consultant  
 One Pharmacist  
 One Microbiologist  
 Three physicians  
 Ten infection preventionists from LTC centers throughout the state

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### Collaborative Projects to Date

- Toolkit for single patient use of Glucose meter.
- Long Term Care Baseline Infection Prevention Practices Assessment Tool for States Establishing HAI Prevention Collaborative Survey 10/12.
- "Infection Prevention & Control in LTC" An Emphasis on Surveillance, Antibiotic Stewardship & Outbreak Management. Sept 19-20, 2013. +/- 300 infection preventionists attended representing 70 % of WI LTC centers.
- Created WI-HAI website with IC information resource tab.
- Toolkit for UTI management in LTC (in development)

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## LTC Baseline Infection Control Practice Survey-Sept 2012

- 438 LTC Centers in Wisconsin surveyed
- 278 Respondents
- 45 questions about your facilities and their IC programs
- Average # beds = 94
- For Profit 43%
- Not for profit 44%
- Government/VA 13%

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### Question 39

- What external sources of information are used by your facility to address infection-control related questions (please check all that apply)?

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CDC	94%
Health Department	86%
AMDA	74%
APIC	72%
Corporate	27%
Hospital IC	24%
Nat Ass Directors of Nursing	11%
Infection control consultant	7%
Other	3%
One of 278 nursing homes used the Medical Director	

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“You’re the Medical Director!  
You have to help us fix this!!!”



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Get Me the Data !

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START COUNTING STUFF

December 2006

helps the facility identify, evaluate,  
address and resolve medical and clinical concerns  
and issues that affect resident care

## Rainbow Spreadsheet

Spreadsheet with just about anything we could think of pertaining to antibiotic use in our facility.

Medical Director as Clinical Consultant

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## The Antibigram

- The total number of organisms by species isolated from your institution per year
- The frequency or percent each isolated bacteria is sensitive to antibiotics

Medical Director as Clinical Consultant

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Free Lunch Jan 2007

Rainbow Spreadsheet  
and  
Antibiogram

Medical Director Hosts Clinical Staff Meeting

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## The Dear Doctor Letter

- “ ‘Dear Doctor’ letters and other educational materials have targeted sliding-scale insulin, giving tips on reducing finger-stick blood sugar measurements, and coached judicious use of sulfonyleureas.”

Crececius, C. “Caring for the Ages”  
July 2014.

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## Letter to Physicians Dec 2006

- We have this program....
- Gentle scrutiny of your antibiotic usage
- >50% Empiric antibiotic use is a quinolone
- Note copy of our antibiogram sensitivity pattern
- You will be cued: change antibiotic if sensitivity pattern does not match your first choice
- You will be cued to stop unnecessary antibiotics
- Please read “Managing Urinary Tract Infection: Guide for Nursing Home Practitioners” Annals of Long Term Care 2005 Sept
- Consider local wound care to MRSA colonized wounds rather than IV Vanco
- Introduce Paula Kock RN as Certified Wound Care Nurse
- Invitation to participate in institutional infection control committee

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## Letter to Physicians June 2007

- Follow-up from Dec 2006-Thank you
- Significantly less use empiric quinolone except for one
- Most are responding to our nurse’s cues
- Most have been comfortable with not treating asymptomatic bacteriuria
- May be receiving requests for surveillance cultures on your residents or our staff who are your patients
- Please consider becoming a member of our infection control committee
- “...the responsibility for multi-drug resistant pathogens lies with those of us who prescribe within our community”

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"Dear Dr. Outlier,

You're the outlier in Antibiotic usage for UTI at PMNH....  
Your practice is the last holdout for use of antibiotics in  
Sterile pyuria and empiric quinolone therapy.... Please  
consider your approach.... I would be happy to speak  
with you directly or electronically....

Sincerely,  
Joe Boero MD  
[dr.boero.pfrmc@gmail.com](mailto:dr.boero.pfrmc@gmail.com)

CC: Regional Medical Director.

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Physician Follow-up Letter Sept 2008

- Floroquinolone usage is now rarely empiric choice for suspected UTI and you have been diligent about stopping or changing antibiotics based on culture results
- However..., in last six months, review of antibiotic usage in suspected resp infection, Quinolone is the most commonly chosen agent
- Please consider non-bacteriologic etiology of fever, cough, tachycardia, hypoxia in your patients before reflexive use of antibiotics
- Treatment of Bacteriuria in Older Adults: Still Room for Improvement JAMDA 2008. Crnich C. Drinka P.

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Follow-up letter Dec 2011

- Please see the enclosed antibiogram for our nursing home for 2011.
- Please note the increasing incidence of fluorquinolone resistance in our building.
- We have noticed that over 50 % of the time a fluorquinolone is chosen for empiric antibiotic therapy in suspected respiratory infections.
- Our nursing staff will continue to notify you for consideration of de-escalation of antibiotic therapy when cultures are negative or for change in therapy when sensitivities suggest alternate more appropriate therapy.

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## Letter of notice for inappropriate antibiotic use 2013

- Greetings from yours truly,
- Your patient Mrs. Tuulkala was treated for uti with ciprofloxin. Please note...,
- There was no dysuria, fever, leukocytosis, incontinence. Hematria,.... If you have further clinical information...?
- Urine culture 1000 cfu Gram neg rod,
- Nurse prompted to de-escalate therapy,
- You chose to continue and said "...because I'm the Doctor!"
- Although....., I feel this represents inappropriate Abx use...
- Please read "Treatment of Bacteriuria in Older Adults Still Room for Improvement" Crnich, Drinka JAMDA Oct. 2008.
- Please consider participating in our IC Committee.

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## Doctor Letter Jan 2014

- We have new nursing policy on UTI management
- Nurses will have more discretion on requesting urine testing
- As a result, hopefully, we will not need to bother you as much
- Also, we have incorporated McGeers Criteria for Respiratory Infection in assessing and reporting to you about wheezes, sneezes, and coughs....

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## Comprehensive Intervention for MD

MD	Date	Sympt	Spec	UA	Cx	CC	Abx	F/U
	1/16/11	Ment. chg	St cath	Leu(-), nit(-)	Strep wind	>100,000	pcn	Yes
F/U	1/25/11		St cath		No growth			
	2/23/11	Ment.chg, temp	ccmsu	Leu(tr), nit(-)	Strep B	15,000	macrobid	Yes
F/U	3/7/11		ccmsu	Leu(-), nit(-)	No growth		Macrobid cont	
	5/12/11	Visual hallucin	St cath	Leu(tr),nit(+)	Kleb pn gr (+) lac	>100,000 00,8000	macrobid	yes
F/U	5/27/11		St cath	Leu(-) nit(+)	Klebsiella pneu	>100,000	cipro	no
	7/23/141	Cont. hallucin	ccmsu	Leu(sm) Nit(+)	E.Coli Strep B	>100,000	Cipro & dancyc	No
	8/18/11	Cont. dipsoia	St cath	Leu(tr) Nit(+)	E.Coli gram+lc	>100,000/7 000	macrobid	no
	10/18/11	Somatic c/o	St cath	Leu(tr) nit(+)	E.Coli	>100,000	macrobid	No
	12/15/11	Somatic c/o	ccmsu	Leu(mod) nit(+)	Proteus mirabilis	>100,000	Rocephin to bactri	no

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### Strategies to Improve Quality of Service

- Medical Director as consultant accessing his/her knowledge, experience, and investigative resource skill
- Medical Staff gathering
- Dear Doctor Letters
- Personal Intervention
- Personal audit and feedback with peer profiling

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Annual Antibiotic Utilization PMNH

Year	Antibiotic	Abx/Kdays	Abx/patient
2006	503	11.75	2.57
2007	400	10.68	2.23
2008	343	9.68	1.63
2009	360	9.72	1.81
2010	351	9.93	1.87
2011	295	8.14	1.52
2012	315	8.13	1.23
2013	352	9.41	1.39

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### 5. Strategies to effectively utilize your Medical Director to improve quality

**Just ask**  
but follow through

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## ENGAGE YOUR MEDICAL DIRECTOR

- Define QA projects with input of the Medical Director
- Tell EVERYBODY what you're doing
- Ghost write letters to Medical Staff and ask him to read and sign them
- Invite the Medical Director to attend Survey exit conference
- Give the Medical Director policy book for review
- Notify the Medical Director of critical incidents

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## ENGAGE...

- Ask Medical Director to deliver in-service ed.
- Do walk around to meet the CNAs, Kitchen staff, Maintenance dept.
- Support membership in AMDA/WAMD and go to the meetings together
- Encourage CMD certification
- Be tuned to young physician staff and mentor them toward the next generation of Medical Directors
- If the fit is not satisfactory, fire your Medical Director or get an assistant Medical Director

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- "Effects of an Out Patient Antimicrobial Stewardship Intervention on Broad Spectrum Antibiotic Prescribing by Primary Care Peditricians: A Randomized Trial" JAMA 309(2345-2352) June 12, 2013

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