INSIDE: A Wrap-Up of the 2011 Annual Meeting
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Caring Meeting Highlights

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Caring for the Ages

A Monthly Newspaper for Long-Term Care Practitioners

In This Issue

Medical Director Finalists Share Their Secrets to Success

Four CMDs recognized by peers urge addressing problems boldly.

BY JOANNE KALDY

TAMPA – Hurdling challenges and implementing change are hallmarks of the outstanding medical director, AMDA Medical Director of the Year nominees and winners showed in a panel discussion at Long Term Care Medicine – 2011. Sabine von Preyss-Freidman, MD, CMD, who won the 2011 award at the meeting, 2010 award winner Robert Schreiber, MD, CMD, and two award finalists discussed the impact that a medical director can have in efforts to change culture, improve processes, and maximize quality of care.

Diabetes Success in Seattle

Dr. von Preyss-Friedman, medical director to four skilled nursing facilities in the Seattle area, said she thought that the continuous quality improvement program she had developed was a complete success. Her facilities were making progress in reducing inappropriate medications, falls, and pressure ulcers, as well as managing infection control and the residents' nutrition and weights.

"I was doing what I was supposed to be doing and doing it well. We were getting positive results, and I felt good," she said. Then she discovered that fewer than half of her residents were getting annual vision examinations, and many of those not being examined were diabetic.

"It made me want to look at what else we were missing regarding diabetes." Dr. von Preyss-Friedman started by working with a continuous quality improvement subcommittee to review all diabetic patients' vision, foot health, frequency of chemsticks, glycemic control/HbA_{1c} levels, and consultant pharmacist collaboration.

"We found an abundance of sliding scales, frequent chemsticks, frequent hypoglycemia, chemsticks always done at the same time, and inconsistent glycemic control review, in addition to inconsistent vision checks," said Dr. von Preyss-Friedman.

She and her team devised an action plan that included setting goals for patients (including hypoglycemia preven-

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Courtesy Craig Huey Photography

Award finalist S. Liliana Oakes, MD, CMD, of Texas described turning around a high-deficiency facility.

ACOs, 3-Day Rule, Team Roles Are Top Issues

BY KATHLEEN M. WILSON, PHD

"Vigilance" could have been the official theme of the annual meeting presentation on AMDA's policy priorities, part of the Saturday general session of Long Term Care Medicine – 2011 in Tampa. AMDA is positive but remains on guard about new models of care, such as accountable care organizations (ACOs), as well as decades-old issues such as patient eligibility for skilled nursing care, said Public Policy Chair Eric Tangalos, MD, CMD.

On these and other fronts, he added, patients and caregivers were at the core of AMDA's 2010-2011 public policy achievements.

Dr. Tangalos explained that ACOs, as they are presently described in models, do not include the long-term care setting. In December, the association responded to a Centers for Medicare & Medicaid Services request for input on ACOs. AMDA recommended that ACOs establish relationships with LTC organizations, especially to ensure smooth and successful transfers of patients between LTC facilities and other care sites within the ACO framework. Related issues include easy access for LTC practitioners to the electronic medical records of patients in ACOs and efforts to provide cost-effective, high-quality, and person-centered care to LTC patients, whether or not they enter ACOs.

"ACOs are attempting to manage care in a fee-for-service universe," said Dr. Tangalos. "Our role is not to forget the nursing home patients."

AMDA's comments to the CMS served as a springboard for a resolution from AMDA's Public Policy Committee and the Missouri Association of Long-Term Care Medicine. The policy, passed by the House of Delegates on Saturday after the general session, directs AMDA to encourage investment by ACOs in infrastructure to improve processes and deliver high-quality and efficient care in all settings. It further recommends that ACO program stan-

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Family Medicine Pioneer Reflects on LTC

Past AMDA President Alva Baker, MD, CMD, was among first family medicine residents.

BY MARY ELLEN SCHNEIDER

As family medicine was being formally recognized as a medical specialty in 1971, the fledgling newspaper FAMILY PRACTICE NEWS sat down with three second-year family practice residents to find out what they thought of their newly recognized specialty and what their careers would hold.

One of those young family physicians was Alva S. "Buzz" Baker, MD, CMD, who would eventually become AMDA's 2007-2008 president. Now, 40 years after that interview, FAMILY PRACTICE NEWS (which is copublished with CARING FOR THE AGES) invited Dr. Baker to look back on how his expectations stacked up to the reality of clinical practice.

Dr. Baker was a second-year resident at the University of Maryland in 1971. He spent several years in general family practice before deciding that he wanted to concentrate on geriatric medicine. Much of the later part of his clinical career was spent in education and research on Alzheimer's disease and other forms of dementia. From 1994 until 2009, he served as executive director of the Copper Ridge Institute, where he helped develop best practices in caring for persons with cognitive impairment.

Today, Dr. Baker serves as director of the center for the study of aging at McDaniel College in Westminster, Md., and teaches in the gerontology program.

Dr. Baker has also worked to educate his colleagues in long-term care through AMDA. He was involved in shaping the AMDA Core Curriculum, a program for educating and training physicians to have leadership roles in nursing homes.

"A major emphasis of my life in the last several years has been on education of physicians and health professionals," he said.

FAMILY PRACTICE NEWS: In terms of your work in geriatrics, how do you feel your medical training prepared you for that – or did it?

Dr. Baker: It absolutely did not. Forty years ago, medical schools had very little emphasis on geriatric medicine. I have been involved in the care of people in nursing homes since 1972. As it was structured then, the training for geriatrics was really not sufficient in many residency training programs. I know that residencies now have more emphasis on geriatric medicine and taking care of older patients. The doctors who are coming out of residency now are going to live their lives in large part taking care of older persons.

FPN: When you look back to when you were a resident, are you surprised by the path your career has taken?

Dr. Baker: Absolutely. I grew up on a farm in a rural area. I went to college and to medical school with the goal of becoming a small-town physician, as my family physician had been when I was growing up. I was very comfortable with that into residency, because the folks who were faculty in the residency program and served as teaching mentors were basically physicians who were in small towns or had been in small towns.

When I went into practice in 1976, it was in what was then a relatively small town of 10,000 people. That town is now home to about 30,000 people, part of a bedroom community of Baltimore. So, my goal to be the "country doctor" was never fully realized.

Even in that small-town environment, the writing was on the wall that family doctors as we had known them over the previous half century needed to evolve into a different kind of physician, one who was much more science based, one who was constantly interacting with other aspects of the medical community. Not that the country doctors over the previous half century didn't do that – but it really became a necessity to do that.

COURTESY DR. ALVA BAKER

Dr. Alva S. Baker never became the "country doctor" he envisioned but found satisfaction in caring for frail elderly.

FPN: With that in mind, and especially in light of some of the teaching activities that you still do, where do you see the specialty going as you talk to young physicians and as you look at how family medicine has changed over the past several decades?

Dr. Baker: Family medicine is still family medicine. So, the physician who is going to practice broad-based family medicine still needs training in all the specialty disciplines in order to do that and to do that confidently. If somebody is going to take care of children and newborns and adolescents and young adults and middle-aged adults, as well as older persons, the different aspects of caring for certain age groups are constantly evolving and changing.

I think it is a lot harder, actually, than when I was in residency for somebody to be able to put together and achieve a sufficient level of education and skill level in the 3 years that the residency comprises.

FPN: Do you have any advice for today's residents – especially if they have an interest in geriatrics – about how to approach that and have a meaningful career?

Dr. Baker: If they are interested in geriatrics, they need to get a better understanding of what practicing geriatric medicine is all about. My advice to them would be to try to find a true geriatrician who is just doing geriatrics, try to spend time with that person, and learn what his or her life as a geriatrician is all about. The second thing that they could do is to get involved with a nursing home.

FPN: Looking back, what are some of the more rewarding things that have happened over the years in your career?

Dr. Baker: Overwhelmingly, number one is the satisfaction of working with humans at whatever age, assisting them in their health care, and helping them to learn about themselves and their health issues and how to manage them. The second thing would be the period of practicing geriatrics for the frail elderly. I think the third significant concept of my practice life has been the joy of being a lifelong learner.

Mary Ellen Schneider is with the New York bureau of Elsevier Global Medical News.

AMDA Vigilance

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dards allow for the generally lesser technologic capabilities of small practices and those involved with long-term care.

Three-Day Stay

Dr. Tangalos also reviewed new developments concerning the longstanding Medicare policy on patient eligibility for care in skilled nursing facilities. He recalled that as far back as 1991, AMDA, within the framework of the American Medical Association, was raising the problem of the requirement for a 3-day inpatient hospital stay for skilled nursing care. "Twenty years later, we are still having the same problem," said Dr. Tangalos.

Furthermore, some hospital patients today are being held for extended periods in observation status, which doesn't count toward Medicare eligibility for skilled nursing care. A patient may be in observation status for many reasons, said Dr. Tangalos, including not being well enough to be discharged but still not fulfilling criteria for inpatient status. Or, the hospital simply might not have an inpatient bed available. "The care furnished in these other settings within the hospital is often indistinguishable from the inpatient care that follows the formal admission," Dr. Tangalos said in an interview.

AMDA's Connecticut chapter worked with Rep. Joe Courtney (D-Conn.) when he authored the Improving Access to Medicare Coverage Act of 2010, which he introduced last year. The legislation would force Medicare to count observation in a hospital exceeding 24 hours toward satisfying the 3-day-inpatient eligibility requirement.

Although the legislation died at the end of last year's Congress, Rep. Courtney has pledged that it will be reintroduced this year, and AMDA will support the bill.

AMDA also testified on the issue at an August 2010 CMS Listening Session. Testimony pointed out that AMDA members directly observe the placement of patients in skilled nursing facilities and have long opposed efforts that interfere with the timely admission of individuals who require that level of care versus acute care hospitalization.

Team Approach to Care

Last fall, the Institute of Medicine issued a report calling for a maximum level of performance for nurse practitioners. "The Future of Nursing: Leading Change, Advancing Health" suggested that nurse practitioners should be allowed to perform nursing home–admission assessments as well as certifications for hospice and home-health care services. "If there are indeed shortages, simply throwing more [nurse practitioners] at it won't fix the situation," said policy-session copresenter and incoming Public Policy Committee chair Charles Crecelius, MD, PhD, CMD.

Even before the report, AMDA had authored a paper on the roles of attending physicians and advanced practice nurses in long-term care. AMDA's position is that the policy makers should focus on building the most effective care team, said Dr. Crecelius. "We shouldn't promote one profession over another. … The regulatory definition [of supervision and collaboration] is brief and may not cover every circumstance in long-term care," and it is hard to extrapolate definitions from other fields of medicine.

AMDA created its paper by convening a work group that included representation from the Gerontological Advanced Practice Nurses Association, the American Academy of Family Physicians, and the American College of Physicians, explained Dr. Crecelius. "If you collaborate, read this paper," he advised the audience. The report was published in the January 2011 issue of the Journal of the American Medical Directors Association (J. AMDA 2011;112:12-18).

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