Medical Director Finalists Share Their Secrets to Success

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-Friedman, 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/HbA1c 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 prevention).

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 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 standards...
Family Medicine Pioneer Reflects on LTC

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

BY MARY ELLEN SCHNEIDER

A s 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 physicians as we had known them over the previous half century didn’t do that – but it really became a necessity to do that.

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 new-borns 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 role in 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.

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