IN THIS ISSUE

The Honest Truth: CNAs Speak Out About Workforce Issues
Certified nursing assistants share their experiences in post-acute and long-term care facilities. 7

Key Insights Into Schizophrenia Misdiagnosis and the Use of Antipsychotics
Experts offer insights amidst concerns of overdiagnosis. 11

Remote Support for Families and Caregivers During Transitions
The pandemic restrictions have helped skilled nursing facilities improve remote support for families. 14

Quality Healthcare in Nursing Homes: Falls, and the Trap of Benchmarks
Focusing too much on metrics may actually take away from true quality care. 18

Updates in Sepsis Management Show Thoughtful Approach
By Christine Kilgore

The strengthening of protocols for close monitoring, active surveillance, and goals of care (GOC) discussions during the pandemic have likely positioned more nursing facilities to confidently recognize and initiate early management for residents with sepsis or suspected sepsis.

“The positive of COVID is that facilities that might have questioned their ability to create such a standard of care and manage sick patients in accordance with their wishes have realized they’re capable of doing it,” said Swati Gaur, MD, MBA, CMD, chair of AMDA – The Society for Post-Acute and Long-Term Care Medicine’s Infection Advisory Committee and medical director of New Horizons Nursing Facilities with the Northeast Georgia Health System. “The protocols and frameworks that facilities put in place to manage COVID were not one-off functions,” she said. “We can use the competencies we had to develop for COVID to do well in other areas of patient care.”

Dr. Gaur has advocated at the Society’s conferences for PALTС providers to embrace feasible elements of the “hour-1 bundle” introduced by the Society of Critical Care’s Surviving Sepsis Campaign (SSC) in 2018, such as obtaining blood samples to send for culture, administering crystalloid fluids in residents who are hypotensive, and administering broad-spectrum antibiotics when indicated.

In a 2018 JAMDA editorial, Robin L.P. Jump, MD, PhD; Susan M. Levy, MD, CMD; and Wayne S. Saltzman, MD, PhD, CMD, urged nursing homes to serve as first responders by developing a sepsis protocol tailored to its institution and by stocking an “S-Kit” with pertinent supplies (J Am Med Dir Assoc 2019;20:275–278).

Now, updated international guidelines from the SSC will further shape early management in long-term care (Intensive Care Med 2021;47:1181–1247; Crit Care Med 2021;49:e1063–e1143). Issued in October 2021 as an update to 2016 recommendations, the new guidance draws a distinction between sepsis and septic shock in addressing treatment and management of sepsis in long-term care.

California Requires All Skilled Nursing Facility Medical Directors Be Certified
By Karl Steinberg, MD, CMD, HMDc, and Michael Wasserman, MD, CMD

On October 6, 2021, Governor Gavin Newsom signed California’s AB 749 into law after it sailed through the state’s Assembly and Senate with minimal opposition. The bill requires almost all nursing facility medical directors to be certified through the American Board of Post-Acute and Long-Term Care Medicine (APBLM) by 2027. The California Association of Long Term Care Medicine (CALTCM), which is the state affiliate of AMDA – The Society for Post-Acute and Long-Term Care Medicine, was the sponsoring organization for this bill.

In 1974, in response to identified quality of care problems, the federal government began to require that all skilled nursing facilities have a physician serve as medical director and be responsible for the medical care provided. One year later, a group of concerned medical directors formed the California Medical Directors Association (now called CALTCM) and immediately began...
to promote education for physicians practicing in long-term care. Since this organization’s inception it has emphasized the concept of effective, informed, engaged medical direction in its educational offerings.

Medical director certification has been around since 1991, when the Society formed the American Medical Directors Association Direct Certification Program (AMDCP), now called the ABPLM. Many CALTCM leaders have pursued the certification and recertification. Yet there are only a little over 100 active certified medical directors (CMD) in California, which has over 1,200 skilled nursing facilities.

In 2001, the Maryland Office of Health Care Quality implemented detailed requirements for nursing home medical directors that were supposed to encourage Maryland medical directors to become certified. Unfortunately, these requirements have not been fully enforced or monitored, so there has not been an opportunity to assess the effectiveness of mandatory certification.

In 2009, Frederick Rowland, MD, PhD, CMD, published a seminal study in *JAMDA* demonstrating that facilities with certified medical directors had at least a 15% improvement in quality measures, and the study methodology actually lent itself to undervaluing the impact of certified medical directors (J Am Med Dir Assoc 2009;10:431-435). To date, this has been the only study of its kind. A number of other published papers and an Office of Inspector General report have discussed the value and importance of competent and engaged medical directors—which seems intuitively obvious, but it would be desirable to devise and implement additional research providing evidence. The Society and ABPLM will be working on this actively as AB 749 rolls out.

The pandemic had a devastating impact on nursing homes across the country, and when the governor of California proposed that nursing homes accept COVID-19 patients from hospitals, similar to the mandate from Governor Andrew Cuomo of New York, CALTCM’s Board immediately took action. The Board passed several resolutions in a very short period of time, one of which strongly stated that nursing homes should not be required to accept COVID-19 patients. Another resolution advocated that every nursing home in California be required to have a full-time infection preventionist. CALTCM members soon found themselves quoted in news articles and interviewed on television regarding the pandemic. This definitely had the effect of raising the profiles of CALTCM and the Society.

During the summer of 2020, a political affairs consultant contacted CALTCM with the idea of working with the organization to influence regulatory and legislative initiatives in California. The CALTCM Board engaged some members of its dormant Public Policy Committee and began developing ideas for legislation. This ultimately led to a proposed “Nursing Home Safety Act” with five proposals:

- **Required 24/7 on-site registered nurse (RN) coverage.** It is essential that an RN be available at all times to adequately assess the residents with multiple medical conditions and a high degree of frailty. Although licensed vocational nurses can monitor patients’ health, they lack the educational preparation and regulatory authority to perform comprehensive nursing assessments.
- **A minimum of 0.75 RN hours per resident day.** COVID-19 has demonstrated that sufficient nursing staff must be available to handle clinical situations as they arise.
- **Medical director certification.** As the clinical leader of a nursing home, the medical director needs the skills and tools to be an integral part of the leadership team. Certified medical directors receive additional education and training related to the complexities of nursing home operations and regulations as well as the principles of geriatric medicine and bioethics that are essential to providing appropriate care to an aging population.
- **Full related-party transparency.** Corporations who operate nursing facilities can siphon off funds by using third-party vendors that they themselves own; these related-party vendor charges may be above fair market value or their services may be neither appropriate nor necessary (Health Affairs Blog, Feb. 11, 2021: [https://bit.ly/3rmMLbJ]). The scarce financial resources of nursing homes must be effectively and appropriately utilized, so full transparency for these related-party transactions is needed to effectively determine the true amount of resources necessary to ensure the adequate funding of operations.
- **Administrative costs ceiling.** The bill would place a ceiling on the combined administrative costs and profits of each nursing home and its related parties, including parent companies, at 15% of net revenues per year. Nursing homes cannot be operated and financed like an apartment complex; they provide for the health care needs of a complex and vulnerable population, so there must be a balance among profit, quality of care, and safety.

In the fall of 2021, discussions with the legislative staff for Assemblymember Adrin Nazarian, chair of the Committee on Aging and Long-Term Care, led to the development of AB 749. There was surprise and dismay among many legislators when they learned that despite the acuity level of skilled nursing facility residents, there was no requirement beyond a medical license to be a medical director — and that beyond the medical director, nursing facilities do not have a mandatory mechanism to evaluate the performance of other attending practitioners.

This bill, by virtue of being part of a package of nursing home quality improvement bills, quickly garnered support from AARP, the Service Employees International Union (SEIU), and California Advocates for Nursing Home Reform. CALTCM developed a trusting and collaborative relationship with Mr. Nazarian’s staff and let them shepherd the bill through the legislative process. As part of the process, some minor amendments were made, including waiving the requirement for hospital-based nursing facilities and — happily — incorporating a request from the California Department of Public Health to add language authorizing them to collect data on all nursing home medical directors, including their certification status and/or the progress of their path to certification. AB 749 sunsets in 10 years, so it will be important to demonstrate the tangible benefits of mandatory certification. The Society is working on methods to collect data that will provide ongoing support for this requirement, and we hope that in the meantime other states can use AB 749 as a springboard to mobilize similar legislative efforts. The Society’s state-based policy and advocacy workgroup, led by Carl (Christian) Bergman, MD, CMD, is working with CALTCM and the Society’s Board and Public Policy Committee to create templates and mentoring. It will be most important to find a champion in state legislative bodies to promote the cause of requiring minimal standards for nursing home medical direction.

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