

# TOPICS

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## The Role of the Medical Director

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A middle aged nurse confided to me that she had left her previous job because she found it unchallenging. She decided to return to school and become a geriatric nurse practitioner. Her previous job? She ran one of the transplant units at a major university hospital. Her current job? She is thoroughly challenged in providing care to long term care residents. She loves it!

It is even more challenging to provide oversight of this incredibly complex environment called the skilled nursing facility. I hope you enjoy complexity and uncertainty because that is our workplace as medical directors. This article will provide some historical background to the role, highlight a recently released document, and give personal insights from 25 years (really, already?) of medical direction.

### A Little History

The history of medical direction dates back to 1970 when a Salmonella outbreak caused the deaths of 36 nursing home residents in a Baltimore nursing home. This led to increased federal scrutiny of substandard nursing homes. The AMA became involved and lobbied for the requirement for medical direction all LTC facilities. In 1974 the federal regulations included medical direction as a condition of participation in Medicare. A 1984 revision of the nursing home regulations threatened to leave out the medical direction requirement, but this time many other organizations (AMA, AGS, the new AMDA and others) weighed in and the position was subsequently retained. Dr. James Pattee and Dr. Thomas Altemeier, here in Minnesota, researched the role of the medical director, published a book, and began teaching a

nine day course for medical directors that became the impetus for the Certified Medical Director program through AMDA. I was privileged to take this life-changing course here in Minneapolis in the early 1990s. The IOM 2001 report, Improving the Quality of Long Term Care, recommended, “One approach to improving the quality of nursing home care would be for facilities to vest greater authority and responsibility in medical directors for medical care services and require attending physicians and nurse practitioners to follow facility medical policies and procedures.” In November 2005 CMS has updated the expectations of medical directors in the F501 portion of the “interpretative guidelines”. This document can be accessed by searching the AMDA website for F501 or at the CMS website. I strongly recommend it as bedtime reading. You will either have early onset of sleep or disturbing dreams, as you ponder all the unmet expectations of your medical director activities (review of all clinically relevant policies and procedures, oversight of all ancillary medical services, assuring timely provider visits, . . . I could go on and on.

It should be clear from the historical perspective that the medical director role is to assure quality of medical care in nursing homes. It should also be clear that the historical quality of care has been inadequate at times, even abusive and negligent. The medical director is therefore viewed as an essential component in preventing abuse, neglect, and substandard quality of care. How is this best accomplished?

## The Definitive Document

The task of writing to you about the medical director role became much easier on March 26, 2011. On that date the House of Delegates of the American Medical Directors' Association unanimously affirmed the document:

## THE NURSING HOME MEDICAL DIRECTOR: LEADER AND MANAGER

I suggest that you stop reading now and access this document at the following website: <http://www.amda.com/governance/whitepapers/A11.cfm>.

## Four Main Roles, Nine Essential Functions

The AMDA white paper identifies **Four Main Roles for the Medical Director:**

<b>Role 1-Physician Leadership</b>	The medical director serves as the physician responsible for the overall care and clinical practice carried out at the facility.
<b>Role 2- Patient Care-Clinical Leadership</b>	The medical director applies clinical and administrative skills to guide the facility in providing care.
<b>Role 3- Quality of Care</b>	The medical director helps the facility develop and manage both quality and safety initiatives, including risk management.
<b>Role 4- Education, Information, and Communication</b>	The medical director provides information that helps others (including facility staff, practitioners, and those in the community) understand and provide care.

## The Nine Essential Functions Inherent in These Roles Are:

<b>Function 1- Administrative</b>	The medical director participates in administrative decision making and recommends and approves relevant policies and procedures.
<b>Function 2- Professional Services</b>	The medical director organizes and coordinates physician services and the services provided by other professionals as they relate to patient care.
<b>Function 3- Quality Assurance and Performance Improvement</b>	The medical director participates in the process to ensure the quality of medical care and medically related care, including whether it is effective, efficient, safe, timely, patient-centered, and equitable.
<b>Function 4- Education</b>	The medical director participates in developing and disseminating key information and education.
<b>Function 5- Employee Health</b>	The medical director participates in the surveillance and promotion of employee health, safety, and welfare.
<b>Function 6- Community</b>	The medical director helps articulate the long-term care facility's mission to the community.
<b>Function 7- Rights of Individuals</b>	The medical director participates in establishing policies and procedures for assuring that the rights of individuals (patients, staff, practitioners, and community) are respected.
<b>Function 8- Social, Regulatory, Political, and Economic Factors</b>	The medical director acquires and applies knowledge of social, regulatory, political, and economic factors that relate to patient care and related services.
<b>Function 9- Person-Directed Care</b>	The medical director supports and promotes person-directed care.

The article further lists tasks under each function, dividing them into essential and optional categories. This list can be overwhelming and discouraging. I can tell you at a practical level it is impossible to accomplish all these tasks, unless one is employed

full time. Few of us have that opportunity.

## At a Practical Level

It is important to consider each of the functions with every visit to the facility. How am I functioning as a physician leader, overseeing

physician services, providing quality review and education to the staff? Many of these functions can be combined into our routine visits, if we are mindful of these roles.

➤ **Become part of the leadership team:**

Visit with the administrator and DON at least monthly. Find out about strategic planning. Ask to be included in decision-making, especially clinical decisions such as radiology providers, dental services, new service lines. Discovering decisions after the fact means you are not considered part of the leadership team, and this severely limits your effectiveness.

➤ **Round on each nursing unit regularly:**

Dr. Robert Blomberg taught me this priceless tip early in my career. There is nothing more important than hearing from the front-line staff. Peters and Waterman described this as “Management by Walking Around” in their 1982 bestseller, *In Search of Excellence*. This MBWA activity can accomplish all 4 roles. You gain informal leadership by showing interest and solving problems for front-line staff. You hear about provider-nurse interactions, patterns of care, and concerns about medical care issues. Use your senses: smell, hearing, sight to discover quality care problems. Are there urine odors, too many pages/alarms/loud voices, poor quality interactions between staff and residents? Look for excellence and reward it with an immediate, “you’re doing a great job here!” When issues come up, use the time to educate staff. I recently took over two homes for a colleague, and heard the phrase from many nurses, “We hope you can be like Dr. Tom Pettus – he’s always teaching us new things.” Big boots to fill! These front-line inputs can then inform the need for data gathering for the QA process.

➤ **Quality Committee engagement**

The traditional role of eating donuts, drinking coffee and signing our name countless times to unread documents is gone. If QA meetings are boring, change them. They must be relevant to our goals as medical directors. I need an overview of how we compare to state and federal benchmarks. Then we need to identify quality deficiencies to process improvements. The new terminology “Quality Assurance/Process Improvement” (QAPI) emphasizes this pattern. Dr.

Robert Sonntag advises us to bring the latest articles and research to these meetings to stimulate quality improvement initiatives. I review late physician visits, INR values, infection control and antibiotic utilization, use of antipsychotics for “dementia behaviors” and other issues at various nursing homes. It is the time for my primary interaction with the consulting pharmacist. The QA meeting is vital to accomplishing all four roles of the medical director. Attend as many other committees as is practical to extend your influence into the nursing home quality process.

Always, **always be available for emergency back-up**. I draw a picture of the Titanic sinking and ask nurses who should be the last person off the ship. Far too often they respond, “The nurse.” Of course, it’s the captain. And the medical director is the captain (in regards to clinical care). The way the nurses get “off the sinking ship” is to access their chain of command – nurse supervisor, DON, and medical director. Long term care nursing can be lonely and isolating. It shouldn’t be without a life-line. I tell the nurses at orientation that they should never leave their shift with a bad feeling in the pit of their stomach. They should always call for assistance. It is a crucial role for the medical director in assisting with critical patient care decisions. It also stabilizes the work force. They must feel supported and protected. Of course these after hours phone calls can accomplish many of our other goals: quality monitoring, education, and physician services oversight. We are always doing more than one thing as a medical director. (If we can’t be available – establish a credible back-up plan.)

➤ **Policy and Procedure development, oversight and implementation**

The previous suggestions have involved developing informal leadership. Policy and procedures allow for formal authority to be exercised by the medical director. This includes many important medical care policies to be reviewed and revised. In addition, admission policies are increasingly critical. Will your facility admit chest tubes, nasogastric tubes, BIPAP for ventilatory insufficiency, or certain behavior challenges. This is a critical area for medical directors to assess the management skills of the facility and match them with the referrals for admission. It is part of our role to limit admissions

that our staff are not medically capable of managing.

➤ **Medical provider credentialing** falls under this authoritative leadership and should be considered as a means to establish leadership within the medical staff. At one home we have a one page attending physician agreement that establishes a basic code of conduct for practicing physicians in the facility. The medical care committee reviews deviations from this code of conduct and supports my role in overseeing provider care and conduct. Fortunately, it is rare that this becomes a problem.

➤ **Survey and compliance issues** need the presence of the medical director. I make every effort to stop and introduce myself to the survey team early during the annual survey. I specifically ask them to call me for any questions re: medical care issues. In the past, I have attempted to attend the exit sessions, but with the new QIS format it has become increasingly difficult. It seems that they conclude the survey and exit within 15-30 minutes. I always review the findings, help investigate questionable tags and attend any “informal dispute resolution” hearings. I frequently add a medical director note to charts when an adverse incident requires investigation and comment. These notes have been invaluable in explaining the steps taken by staff in providing good care, even when the outcome was negative.

➤ **Communication with Medical Staff**

This may be the hardest thing to do, if you only do it in response to misbehavior. So, I recommend proactive ways of meeting with the staff. At a couple larger homes we hold provider luncheons 2-4 times yearly. There is an educational component to these meetings, but they also help establish effective relationships. An occasional newsletter from the Medical Director to the staff helps with name recognition and policy and procedure implementation. Of course, face to face introductions are invaluable. I always (well most of the time) introduce myself to providers I have not met when doing rounds.

When an interventional phone call is necessary (late visit/unacceptable order/rude behavior) I strongly recommend hearing their side of the story first. I often repeat the proverb to myself just before dialing, "A kind word averts

anger, but a harsh word stirs up wrath." Our common goal should always be -- to enhance the quality of medical care for the resident. Be succinct, clinically relevant and helpful. I have made many "regulatory visits" on behalf of well-intentioned, but busy physicians. It builds good rapport with the medical staff.

**Dr. M's Pearls for the Medical Director**

- Four roles (leadership, care, quality, educate) every visit
- Make rounds (MBWA)
- Be a leader (visit the administrator)
- Educate - in every interaction
- Improve the quality of quality meetings
- "A kind word averts anger. . ."

**Ethics of Patient Care as a Medical Director**

Many, if not most, medical directors also provide primary care in their nursing homes. This poses a potential conflict of interest – the fox watching the hen house. It is good to acknowledge this to the nursing staff leadership and establish safeguards. The simplest safeguard is to appoint an associate medical director to attend QA meetings and to provide an avenue for nurses to review your patient care. At a minimum we should always have a back up MD available in the event of our incapacitation. The nursing staff should be informed when and how to reach this alternate provider.

**Unique Needs**

Each home has its own unique style and needs. Smaller homes deal with quality at the front desk. It seems that everyone knows all the patients, families and their medical care needs. The administrator likely answers the phone. The small home doesn't need a data gathering tool, but they do need a wide variety of expertise because they can't afford a full time infection control nurse, or wound specialist. So, in a small home the medical director needs to supplement the staff limitations. Larger homes have a broader range of staff, but it is harder to see where quality may be breaking down. A more robust quality data approach is needed. There

may be more need for provider staff monitoring and intervention/education.

Flexibility is a key attribute of medical direction. While the roles and functions remain stable, the tasks will change based on the need of the organization. It is a rapidly changing landscape. This article is not intended to be a comprehensive tome about medical direction, but rather give an overview of the scope of the task, with practical applications.

## Conclusion

Medical Direction was introduced to counter trends of poor quality, neglect and abuse in certain nursing homes. It has expanded to be a true leadership role in these increasingly complex facilities. Being mindful of the four main roles (leadership, patient care, quality management, and education) of medical direction keeps us on track. We begin to realize that we fulfill these four roles each time we enter the building, and frequently on the phone. Each medical director's own style and personality should mesh with the needs of the nursing home to create a unique relationship, improving patient outcomes and quality of life. I hope you enjoy this as much as I do!

## About the Author

Dr. Mielke is President of the Minnesota Medical Directors Association.

## F-329: Unnecessary Drugs – Antihypertensives

**Rich Januszewski, M.S., Pharm.**

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Based upon contemporary standards, about two-thirds of the elderly have hypertension (HTN). And it is believed that 90% of normotensive individuals 55 years of age or older will develop HTN later in life.

Thus, it is no surprise that there are Federal long-term care facility (LTCF) interpretive guidelines for HTN therapy. Table I in the State Operations Manual devotes 8 of the 65 sections to medications commonly used to treat HTN. Although citations involving HTN therapy are not common, they do occur.

Most recent reasons for citations involved the following situations:

1. Elevated blood pressure (BP) levels were not communicated to the physician as ordered.
2. Medications were not held when vital signs were below physician stated parameters.
3. Vital sign monitoring was not done with the frequency ordered.
4. Ordered vitals were not checked before giving the medication.
5. Lab. work was not performed as ordered (e.g. electrolytes).
6. The prescriber failed to order a repeat K+ check for a Hospice resident on diuretic therapy when the last recorded level was 2.8.
7. A prescriber failed to specify a desired BP range for a resident with “frequent” SBP levels above 170 and failed to document the clinical rationale for the “ineffective” drug therapy.
8. Medications were held by LTCF staff without written parameters directing when to do so.
9. A low K+ level of 3.1 was acknowledged by the NP but no instructions were given to LTCF staff on how to deal with the result.
10. A resident was receiving four medications for HTN and the prescriber lacked documentation justifying the polypharmacy.
11. A resident on three BP lowering medications had BP levels that were “too low” and the prescriber was not informed.

The first nine examples may be hard to defend against. But, the last two situations should have been challenged by the facilities. Although example 10 involved a resident receiving 4 antihypertensives, that is true only so far as what the medication administration record (MAR) states. In reality the medications were being given for more than just HTN. They were also being given to treat coronary artery disease and diabetes. The subsequent provision of this fact to the MDH

surveyors did not dissuade them from issuing the citation. MARs commonly list incorrect indications for use which compounds the problem of compliance. To avoid this type of situation it is important that LCTF staff as well as prescribers assure that the MAR's listed indications for use are complete and accurate.

Example 11 involved a resident with atrial fibrillation, coronary artery disease, essential tremor, and an abdominal aortic aneurysm. This citation was issued because the surveyors felt the BP levels were too low in spite of the fact that the resident lacked adverse drug effects and the surveyors ignored current standards of practice stating aortic aneurysms requires very intense BP control to the lowest tolerated level.

Some of the above citations may have been avoided if the residents were not on HTN therapy to begin with. Over a dozen studies have shown that between 20% to 85% of antihypertensives can be discontinued in the elderly while remaining normotensive and not requiring reinstatement of therapy. With newly published clinical guidelines involving HTN treatment in the elderly it can only be expected that a lot of antihypertensives will soon be discontinued. Belief in the J-curve phenomena for HTN therapy has been around for dozens of years. This belief is that you can only go so low with BP control before you start to see an increase in morbidity and mortality with further BP reductions. Although this phenomenon has never been proven, empiric evidence supports its existence.

Now, new clinical guidelines supported by ten national organizations, raise the question of whether HTN in the elderly is being over treated. To understand this it helps to realize that the traditional goals of HTN therapy are not based upon results from randomized controlled trials (RCT). The new HTN treatment guidelines state that for residents > 80 years of age the goal of therapy should be a SBP of 140-145 mm Hg if tolerated. Furthermore, SBP <130 mm Hg and DBP <65 mm Hg should be avoided.

Frail older residents are particularly vulnerable to adverse effects of over treatment of HTN. A number of studies have identified increased mortality and morbidity with lowering BP in the elderly.

While even the highly referenced Hypertension in the Very Elderly (HYVET) study provided evidence of HTN treatment benefits in the

elderly, it must also be noted that this study had a number of limitations which reduce the applicability of the benefits to the elderly we see in LTCFs. Pooling the small number of octogenarians from various published trials reveals a reduction in both stroke and CV morbidity, but a trend toward increased all-cause mortality.

Therefore, the overall benefits of treating the old-old LTCF residents still remains questionable. Also, it is suggested that treatment may be withheld in more frail or medically compromised patients and there is less evidence of benefit in residents approaching or above 90 years of age. There is limited data as to whether residents with initial SBP between 150 and 159 mm Hg would benefit from treatment.

Before starting or continuing HTN therapy it helps to keep in mind that the diagnosis may be inaccurate due to a number of factors. These include:

- Ø Inaccurate and inappropriately measured blood pressures
- Ø Pseudohypertension (occurs in 2%-70% of elderly)
- Ø White coat hypertension (prevalence of about 15%-25%)

This column was devoted to the treatment of HTN in the elderly LTCF resident and due to space limitations I cannot delve into the treatment of HTN with comorbid conditions. But, even for diabetics the stated goal of less than 130/80 is not supported by RCT. New clinical guidelines for the treatment of diabetes state that the BP goal of <130/80 is not from conclusive evidence-based data and has a less than weak intuitive level to support it. Studies have found that a treatment goal of reducing SBP < 120 has no additional benefit than <140. In fact, there may be an increased mortality when SBP is <115 mm Hg or DBP is <65 mm Hg. Suffice it to say that there is no evidence involving older residents to support the use of lower BP targets when diabetes mellitus, CKD, or CAD are present.

Whether you choose to believe HTN is being over treated or not, the rules of the game are about to change, especially for LTCF residents. When reviewing HTN therapy in the LTCF resident there is the additional regulatory requirement that residents have the right to be free from unnecessary drugs. If a HTN medication is not clinically needed then it has risks that exceed its benefits and its use

violates the resident's right to be free from unnecessary drugs. Based upon a number of studies HTN medications can be withdrawn and discontinued with minimal to no risks to the resident when done properly. With the new HTN guidelines, regulatory compliance may now begin to involve reductions or discontinuations of antihypertensives unless there is a documented clinical contraindication to doing so.

Rich is the President of Health Care Consultants of Minnesota and has been a consultant pharmacist for over 30 years. He is nationally certified as a geriatric pharmacist and provides consulting services to 40 long-term care facilities throughout the mid-west.

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### President's Column

**By John Mielke, MD**

The results of our strategic planning session included a strong commitment to increase the engagement of our members and other physicians who are medical directors or attending MDs in the long term care setting. We intend to continue to provide a high caliber fall conference, regular Topics publications and improved internet based information exchange. We will be nominating new board members and board officers over the next few weeks, so please contact us if you have an interest in serving your colleagues or would like to nominate someone for the board.

The revised Mission statement of MMDA is as follows:

### **MMDA Mission Statement**

The Minnesota Medical Directors Association is a professional association representing physicians who provide medical direction, chronic care and geriatrics services.

### **Values**

MMDA is committed to medical care that is: Competent, comprehensive, compassionate and ethical.

### **Core Objectives**

1. educate clinicians on geriatrics and chronic care as well as administrative medical direction;
2. support the development of information exchange;
3. create and maintaining liaisons with organizations with similar goals;
4. engage with other State and Federal organizations that impact regulation and legislation;



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<b>MMDA Fall Conference:</b>	
<b>October 27-28, 2011</b>	
<b>Marriott Minnetonka Hotel, Minnetonka</b>	

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Manuscripts should be emailed to [rlobeck@mnmeddir.org](mailto:rlobeck@mnmeddir.org) and [cdwighttownes@hotmail.com](mailto:cdwighttownes@hotmail.com). The first page should include the title and a 50 to 60 word abstract. Manuscripts should range around 1800 to 3000 words.

Review Policy: Manuscripts will be reviewed by at least two members of the review board whose evaluations will provide a basis for the publication decision. We are committed to a rapid review process.

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