

# Talking Points for AMDA Priority Issues

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# Talking Points for AMDA Priority Issues

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## Introduction

AMDA physicians and staff are often asked to speak on clinical, public policy, and administrative topics to a variety of audiences, including the media. To help ensure consistent message delivery, the Communications Committee developed the following talking points to serve as a guide for those speaking on behalf of the association. The document is not intended to serve as a comprehensive analysis of each issue. Rather, the goal was to provide a short set of messages that are easy to communicate and easy for our audiences to understand.

If given the opportunity to speak to the media or another audience about the topics below, please incorporate the following key messages into your statement or presentation. Some of the messages may evolve over time, and the talking points will be updated accordingly. Please note that this document should be used as an internal document and should not be distributed to the media or other audiences in this format.

## Assisted Living

- Because of advances in technology and care-giving, many people are residing in assisted or independent living situations today with conditions that would have required them to reside in nursing homes 20 to 30 years ago. In states that permit individuals to “age in place” in assisted living, some assisted living and nursing home residents may have very similar medical issues, functional and cognitive impairments, and risk factors. The differences are a matter of degree, not absolute. As a result assisted living residents’ care needs may range widely from nutritional and psychosocial services to skilled nursing care. Many—if not most—Assisted Living residents are likely to have significant, often unpredictable, medical needs after they move in.
- Undoubtedly, physician care and oversight has had a positive impact on quality of care in nursing homes. Accordingly, public policy concerning assisted living resident care should recognize the importance of physician participation and oversight in improving quality in that setting.
- Especially as states recognize the importance of “aging in place,” or develop waiver programs under Medicaid that address chronic care needs in assisted living facilities, many individuals moving into assisted living are cognitively impaired and/or have multiple illnesses that require some type of medical oversight and care—a level of care that is not currently required by most states.
- A 2002 survey of AMDA members revealed that the primary impediment to delivering quality care to their patients in assisted living was that over time, they became too sick for the facility. In other words, the facility was not equipped to handle the complex nature of the residents’ illnesses and, was forced to discharge them to a setting that provided a more appropriate scope of care (e.g., a nursing home or skilled nursing facility).
- AMDA has a substantial amount of information about clinical and custodial care issues that affect Assisted Living residents, which can help residents and families identify reasonable expectations and help Assisted Living staff provide appropriate clinical services and care.

## Care Transitions

- Care Transitions is a crucial point in the medical care of patients, where benefits gained in prior interventions may be mitigated or lost. Crucial information may be lost or only partially transmitted. Sometimes failures are recognized and corrected at the receiving facility, such as when the accepting place of service recognizes and addresses issues such as delirium, polypharmacy, unrecognized infections and pressure ulcers.
- Care Transitions must be patient-centered; both addressing what a patient needs, and engaging patient and family in decision-making and even care as appropriate.
- Information adequate to allow quality care must travel with the patient rather than be isolated at the individual care sites
- Patients should never be “on their own” during their transitions; the sending entity must retain oversight and accountability of a patient until the receiving entity acknowledges and accepts medical care
- Advance Directive must be addressed at each change in site of care; a change in medical status may alter end of life and/or aggressiveness of care for an individual
- Typically the only common factor across sites of care is the patient themselves as providers and place of service is changing.
- Care Transitions are inherently risky. Medical history (recent and past), allergies, medication currently and previously used, pertinent family and social history, up to date examination findings, and current assessment and plans including advance directives are essential to provide quality care to the patient yet are often not addressed in the transfer.
- Every change of caregiver and site of care is a transition - even a change of caregivers within the same facility, or changes in level of care at the same site of care - and must be treated accordingly.
- Communication between sites of care, between caregivers and with the patient/family is the hallmark of good care transitions
- Care Transitions is a subset of care coordination. Care coordination is (Jackie insert the NTOCC definition of care coordination unless AMDA has one to use).
- A determination of the medical home/primary physician should be made at each transition; and, that entity should be regularly informed of patient status and follow up plans
- The patient/surrogate should always be kept informed of their diagnosis, medications, plan of care and caregivers responsible for subsequent care.

## Consumer Outreach

- The relationship between patients and physicians has always been an important one. It is especially key to the health and well-being of elderly patients, who generally have more chronic illnesses and co-morbidities and take more medications than their younger counterparts.
- According to the Census Bureau, as of July 1, 2005, the estimated number of baby boomers was 78.2 million. In 2006, the oldest of the baby boomers (born between 1946 and 1964) turned 60. Nearly 8,000 (7,918) people turned 60 every day that year.
- According to the Census Bureau, the elderly population will soar to 80 million by the year 2050. By that year, as many as 1 in 5 Americans could be elderly. Most of this growth will occur soon—between 2010 and 2030—when the “baby boom” generation entered their senior years. During this period, the number of elderly will grow by an average 2.8% annually.
- According to the U.S. Bureau of Labor Statistics, baby boomers should expect increased health care spending as they age; for instance, those ages 55 to 64 spent \$3,262 and those 65 and over spent \$3,899 in 2004 alone.

- As boomers age, they will have different needs and issues from their parents which will call for stronger relationships and better communication with their physicians. For example, they have fewer children to care for them, and more of their children are living farther away. They will have to maintain their health for longer periods of their life to stay functional and independent.
- The rising costs of health care also concern boomers and society; they will need to work closely with physicians to choose the best and most cost-effective treatments for their illnesses.
- Boomers—as adult children of aging parents and as seniors themselves—will likely want to be more involved in health care decisions. According to a Met Life survey, most boomers have had at least some college education, do not view themselves as old until they reach age 78, and are active in caring for children and parents simultaneously. In fact, 50% of all boomers are raising one or more young children and/or providing primary financial support to one or more adult children. At the same time, 71% of boomers have at least one living parent; although only 13% are providing financial support to a mother or father. These aging boomers need to guidance of their physicians to address their own health care issues, as well as issues relating to their elderly parents.
- According to a Pews Research survey of boomers, some 85% say they talk with their parents about their health. So, clearly, they are an important audience for information about geriatric health issues such as dementia and medication management.
- According to author Marc Freedman (*Prime Time: How Baby Boomers Will Revolutionize Retirement and Transform America*), retired baby boomers represent an enormous potential resource for addressing social issues such as health care costs, access, and insurance coverage. Physicians and other health care practitioners can help educate boomers about key issues and work with them as partners in advocacy.
- Helping boomers enjoy “quality” old age will be an important role for physicians. According to a Pews Research survey of boomers, only one-third says that their generation will enjoy old age.
- While many boomers expect to stay active and healthy during their later years, they will face a variety of health conditions that will require physician care.
- For most consumers, physician insights are key factors in their decision-making about long-term care. Physicians are viewed as a trusted source of information, and they are partners in patients’ care.
- AMDA is committed to promoting a strong and viable relationship between consumers and physicians. We have developed initiatives such as a tear-out consumer page in *Caring for the Ages* and a consumer section on our Web site to equip physicians to provide timely, relevant information to patients and families and to encourage patients and families to ask questions and seek the information they need to make informed decisions that consider their wishes and needs.
- AMDA urges consumers to use this information to become more informed about issues relating to long-term care and diseases of aging and partner with physicians to get the best possible care.

## **Culture Change**

- Culture change must involve the medical director. Improving resident quality of life cannot be complete without consideration for basic geriatric medical principles and sound care processes.
- The medical director F501 Tag specifically notes that the medical director should be involved in the facility processes which identifies, evaluates and addresses/resolves

concerns and issues that affect resident care, medical care, or quality of life, all integral for culture change.

- Surveys and regulations can be viewed as obstacles to innovative culture change steps. The medical director can play an integral role in determining what boundaries may exist and how compromises can be made.
- Autonomy and independence, foundations of culture change, can only be fully realized with well trained and involved physicians who can help balance resident choice and clinical functionality and practicality.

## **End of Life**

- Palliative care refers to those processes of care designed to prevent and treat physical, emotional and spiritual suffering in order to enhance quality of life for patients with chronic, progressive illnesses. Palliative care strives to improve the quality of life regardless of the stage of illness or types of treatment. Palliative care may be appropriate when a patient is receiving aggressive curative treatments or is in the final days and weeks of life.
- Hospice care refers to both a philosophy and a system of palliative care for patients who are considered terminal by virtue of an estimated life expectancy of six months or less. Hospice care addresses not only physical, emotional, and spiritual suffering, but provides support to families during the final months of life and in the bereavement period after death.
- Patients, families, physicians, and other health professionals should engage in end-of-life decision-making, document preferences, and re-evaluate decisions as needed.
- People should express their health care preferences and designate surrogates by way of legally valid documents such as a durable power of attorney for health care.
- Research into defining when residents are approaching end of life and about how to best reach consensus across cultures, family, staff and physician is needed.
- Palliative care is not merely an agreement to forgo attempts at resuscitation. It includes an organized interdisciplinary approach to addressing physical, emotional, social, and spiritual needs during the last stages of life.

## **Financing Long Term Care: Geriatric Assessment and Chronic Care Coordination Benefit**

- AMDA supported proposed legislation entitled the Geriatric Assessment and Chronic Care Coordination Act of 2007 (S. 1340) in the 110<sup>th</sup> and previous Congresses. Thirty two other organizations including American Geriatrics Society (AGS), American Academy of Family Physicians (AAFP), and American College of Physicians supported the bill.

### Components of the Bill

- The geriatric assessment includes a comprehensive history and physical examination as well as the individual's clinical and functional status, social and environmental functioning, and need for care giving.
- Requires the use of standardized clinical tools to measure cognition, environmental needs, and functional status. The geriatric assessment will only be conducted by a physician, a practitioner under the supervision of a physician or another provider that meets conditions by the Secretary of the Department of Health and Human Services (DHHS).
- Eligible individuals must have at least one chronic condition, multiple chronic conditions or dementia, or those with medical costs in the top 10% of Medicare beneficiaries. The bill excludes individuals who are receiving hospice care, residents in a skilled nursing facility, nursing facility, and patients with end stage renal diseases.

- The term chronic care coordination means services that are furnished to each eligible individual by a chronic care manager, who must be a physician, physician assistant, nurse practitioner, clinical nurse specialist, and/or a clinical social worker, chosen by the individual. If the care manager is someone other than a physician, they must work under the supervision of the physician. The manager will prescribe a plan of care to coordinate the chronic care needs of the individual.

#### Coding the Geriatric Assessment

- The code for the geriatric assessment is an S Code: HCPSCS S0250/Comprehensive geriatric assessment and treatment planning performed by assessment team. This is one of the temporary codes established by private payers. Medicare does not recognize these codes.

#### **Financing Long Term Care: Medical Home Model**

- AMDA signed onto the *Joint Principles of the Patient-Centered Medical Home*, proposed by the along with American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), American College of Physicians, and American Osteopathic Association (AOA).
- AMDA is a member of the Patient-Centered Primary Care Collaborative, which is a coalition of major employers, consumer groups, organizations representing primary care physicians, and other stakeholders who have joined to advance the patient centered medical home.
- AMDA supported proposed legislation in 2007 that would have expanded the ongoing Medicare three year demonstration project to the Medicaid program. The bill proposes setting the per-patient per-month care management fee to 2.50.

#### Background

- The Patient-Centered Medical Home provides continuous access to a personal primary care physician who accepts responsibility for treating and managing care for the whole patient through an advanced medical home.
- Principles of the medical home include personal physician, physician directed medical practice, whole person orientation, coordinated/integrated care across all elements of the complex health care system and the patient's community.
- The model proposes
  - Physician accountability for continuous quality improvement, evidence-based medicine and clinical decision-support tools guide and active patient participation in decision making and patient feedback to ensure patient's expectations are being met.
  - Open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
  - Institution of a multi-component payment structure that facilitates more effective and care delivery for patients that would include a bundled and prospective payment component that would include all of the physician work associated with coordinating care that is not included in payments for face-to-face visits, such as arranging care with other health professionals and family-caregivers and following up with patients on self-management plans.
- The revised payment structure
  - reflects the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit,

- pays for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources,
  - supports adoption and use of health information technology for quality improvement; supports provision of enhanced communication access such as secure e-mail and telephone consultation,
  - recognizes the value of physician work associated with remote monitoring of clinical data using technology, and
  - allows for separate fee-for-service payments for face-to face visits; and recognizes case mix differences in the patient population being treated within the practice.
- Currently, the medical home model is a two tier model with increasing levels of capability.
    - Tier 1 or “typical” medical home must have 18 basic medical home capabilities such as:
      - Uses health assessment plan
      - Uses integrated care plan
      - Tracks tests and provider follow-up
      - Reviews all medications
      - Tracks referrals
    - Tier 2 or “enhanced” medical home must meet Tier 1 requirements plus 2 additional capabilities (electronic medical record and coordination of care including follow-up of inpatient and outpatient care), plus three of nine optional capabilities.
- The demonstration will focus on small practices (<3 full-time physicians) as well as academic settings and physicians in larger practices, particularly in rural and underserved areas.
  - Physician practices include family practice, internal medicine, geriatrics, general practice, specialty and sub-specialty practices (except where specifically excluded).
  - Excludes radiology, pathology, anesthesiology, dermatology, ophthalmology, emergency medicine, chiropractic, psychiatry, and surgery.

### **Financing Long Term Care: Pay for Performance**

- The Tax Relief and Health Care Act of 2006 (TRHCA), Section 101 under Title I authorized the establishment of a physician quality reporting system by CMS. CMS has titled the statutory program the Physician Quality Reporting Initiative (PQRI).
- The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 extended the PQRI program to 2009 and 2010 and increased the bonus payment to 2 percent. For 2007 and 2008 the bonus was 1.5 percent.
- PQRI establishes a financial incentive for eligible professionals to participate in a voluntary quality reporting program.
- Eligible professionals, who successfully report a designated set of quality measures on claims for dates of service from July 1 to December 31, 2007, and CY2008, may earn a bonus payment, subject to a cap, of 1.5% of total allowed charges for covered Medicare physician fee schedule services.
- AMDA is a member of the Physician’s Consortium for Performance Improvement (Consortium), the group that develops measures for the PQRI program.
- Dr. Eric Tangalos represents AMDA at the Consortium and serves as voting member of the PCPI. AMDA also has served on the Geriatrics and Stroke/Stroke Rehab work groups.

AMDA will likely nominate members to serve on the Transitions of Care Work Group of the Consortium that will be forming in the fall of 2008.

- CMS' reported that 16 percent of eligible professionals participated in 2007; however, only 52 percent of those received bonus payment. A survey of AMDA members indicated that 17.80 percent of respondents (416 total responses) participated in PQRI. Reasons for not participating included not interested in the programs, not enough resources to report measures, do not believe the program actually improves quality, and not enough compensation.
- The Nursing Home Value-Based Purchasing (NHVBP) Demonstration is part of the CMS initiative to improve the quality and efficiency of care furnished to Medicare beneficiaries. The demonstration will run in 5 states and will be open to both free-standing and hospital-based facilities and will include beneficiaries who are on a Part A stay as well as those with Part B coverage only.
- The demonstration will be budget neutral to Medicare. Funding will come from the savings incurred as a result of reduced hospitalizations.
- AMDA Past President Steven Levenson, MD, CMD met with CMS in 2005 to discuss Nursing Home Pay for Performance (P4P). In his meeting with CMS, Dr. Levenson shared AMDA's *Acute Change in Condition Clinical Practice Guideline* as a potentially useful tool for reducing hospitalization. Among the other topics discussed was how P4P might be applied to align incentives to help advance medical direction by improving the support of the nursing home industry for its medical directors more involved in overseeing facility practices that influence desired outcomes.

### **Interdisciplinary Team Outreach and Inclusion**

- Interdisciplinary teamwork is essential to quality care in long-term care facilities. The team approach provides optimal results by involving and valuing all caregivers. At the same time, families and patients often have better understanding of their care and more realistic expectations.
- The interdisciplinary team involves practitioners, caregivers, and others who are responsible in various ways for patient care in the long term care facility. This team includes, but is not necessarily limited to, the medical director, director of nursing, floor nurses, administrative leaders, attending physician, CNAs and pharmacist. Different individuals and areas-or disciplines-are involved for different activities, projects, or efforts. For example, a wound care team may involve a wound care nurse, attending physician, dietitian, and nursing assistants.
- As the facility's clinical leader, the medical director helps develop medical information and communication systems that promote teamwork, interaction and cooperation between and among staff, patients, families, and others.
- The medical director promotes teamwork via policies and procedures, processes, and formal and informal educational activities. He or she often takes the lead on enhancing educational and quality improvement projects—particularly those pertaining to issues such as pain management, Alzheimer's disease, quality of care , end-of-life care, quality of life and honoring patient choices..
- AMDA members agree that they can't do their jobs without having meaningful collaboration with all members of the interdisciplinary team. Physicians must be willing to step away from the traditional physician image to be members of a team—to mentor, educate, and collaborate so that patients receive the care they deserve.

- Medical directors embrace collaborative opportunities with other practitioners to address ways to maximize quality care, plan for successful outcomes for each patient, and make sure that each patient is treated with the dignity and respect they deserve.
- Last year, AMDA adopted a new tagline, “Dedicated to Long Term Care Medicine” to reflect the organization’s commitment to promoting and encouraging teamwork and its growing constituency beyond medical directors to attending physicians and other practitioners, such as pharmacists and nurses. Interdisciplinary teamwork is an important part of everything the organization does. Various team players are involved on committees and workgroups to develop clinical practice guidelines for clinical conditions such as Alzheimer’s disease, diabetes, and pressure ulcers; and educational programs and publications include information of use to the team.
- While medical directors and attending physicians make up the majority of AMDA’s membership, twenty percent are non-physicians such as nurse practitioners, physician assistants, administrators, and pharmacists. Increasingly, non-physician practitioners—such as physician assistants and nurse practitioners—are key players on the interdisciplinary team.
- Interdisciplinary cooperation is important to make sure that facilities comply with federal rules and regulations. However, with the regulations provide a framework for care, they are not written with a clinical perspective. The medical director often works with practitioners and front-line staff to help them understand and meet regulatory requirements and provide consistent clinical care.

### **Long Term Care Quality and Modernization Act**

- The solution to the need for greater clinical oversight in skilled nursing facilities is not to shortchange patients by replacing physicians or delegating care to persons with less medical expertise, but rather for physicians, administrators and nurse practitioners to work together to address the root causes of the problems. AMDA is currently working on a task force with the American Health Care Association to do just that. The goal is for each discipline to work to its maximal level of licensure for efficient, cost effective and medically appropriate care.
- The American Medical Directors Association (AMDA) supports the role of non-physician practitioners in LTC.
  - Many AMDA physicians employ NPs and/or PAs to assist in their long term care work. 44% of AMDA members report using NPs to make nursing facility visits on their behalf.
  - AMDA supports NPs and/or PAs within a collaborative arrangement that includes a physician who takes responsibility for the health care provided.
  - AMDA supports NFs and SNFs having NPs to train and mentor nursing staff.
- AMDA also supports greater physician involvement in nursing facilities. Increased physician participation, often working collaboratively with nurse practitioners, can improve the quality of care and reduce unnecessary hospitalizations.
- However, the NP related provisions of this bill do not encourage greater physician involvement, rather they undermine it. Provisions of the bill would seek to replace physician supervision of very ill and frail, clinically complex patients with supervision by nurse practitioners, whose training and scope of practice is more limited than physicians.
- Physician supervision of nurse practitioners is essential not only to meet current statutory requirements, but also because ultimate responsibility and liability for clinical care resides with the physician.
- Patient safety is a major health care concern in all settings; collaborative practice models can optimize patient safety. The additional higher level training of physicians allows far

greater oversight and weighing of the potential risks and benefits of medications, treatments, and plans of care.

- The hospital setting is not always a usable model for the nursing facility and skilled nursing facility because the support systems and resources vary between the settings and within each facility.
- The patient population in nursing facilities is becoming frailer and much more complex, and requires significantly more complex clinical assessments, decision-making, and triage. The attending physician's role is to properly define and describe patient symptoms and problems, clarify and verify diagnoses, relate diagnoses to patient problems, and help establish a realistic prognosis and care goals.
- These decisions require a team approach, and we need to bring to bear all of the resources available to us, including the most experienced, most knowledgeable, and most broadly trained professionals to the bedside to assure that these patients receive the best care possible. Diluting the role of the physician in nursing facilities will not result in better patient care. Expecting more from a non-physician provider than training permits puts both the patient and practitioner at increased risk. AMDA urges opposition of these three provisions of the bill.

### **Specific Concerns**

- This bill would amend federal law in several ways. Those of concern to AMDA are:
  - Section 104 would eliminate the distinction between Medicare Skilled Nursing Facilities (SNFs) and Medicaid Nursing Facilities (NFs) regarding requirements that patient care be under the supervision of a physician. Current law requires care in a Medicare SNF to be under supervision of a physician (§1819(b)(6)(A) of the Social Security Act), while care in a Medicaid NF may be supervised by a physician or non-physician practitioners, so long as the non-physician practitioner is not employed by the facility (§1919(b)(6)(A) of the Social Security Act). The bill provides a state option for supervision of SNF care by a nurse practitioner, clinical nurse specialist or physician assistant who is working in collaboration with a physician. The proposal would also remove the Medicaid restriction (in nursing facilities) that non-physician practitioners who supervise patient care not be employed by the facility. (§1919(b)(6)(A) of the Social Security Act).
  - Supporters of the bill argue that this provision is necessary because there are no clinical distinctions between Medicare and Medicaid patients. Yet supporters have long supported increased payment for SNF services as a result of their recognition that patients requiring skilled care are more clinically complex.
- Due to distinction in law, AMDA believes there are significant distinctions between SNF and NF patients:
  - The average SNF patient is more clinically complex than the NF patient. Patients in SNFs often require sub-acute care provided by licensed professionals acting on the directives of a physician with the training to make complex care decisions.
  - Many clinical decisions regarding SNF patients are beyond the scope of practice of a nonphysician practitioner and require the higher level of training and decision-making expertise of a physician with years of additional training.
  - The statutory distinction at issue was enacted at a time when there was less clinical difference between SNF and NF patients than is now, thus the need for the distinction seems even greater.
  - AMDA believes it is unclear how the provision amending 1819 (b) (6) (a) to allow clinical nurse specialists, physician assistants, or nurse practitioners working in collaboration with a physician fits in with state laws, which vary widely across the country.

- Section 105 would permit shared or split billing so that physicians and nurse practitioners could submit separate claims to Medicare for the services they provide to a resident, so long as the combined sum could not be greater than the amount that would be paid if services were billed together.
- This provision would establish a new payment methodology under Medicare.
  - Medicare billing for shared office or clinic visits are billed by either the physician or the nurse practitioner, depending on whether the NP services were provided “incident” to those of the physician. Medicare billing for shared hospital visits depends on whether there is face-to-face physician encounter with the patient. If there is no face-to-face encounter between the patient and the physician (e.g., if the physician participated in the service only by reviewing the patient’s medical record) the service is billed under the NP’s billing number. (Medicare Claims Processing Manual, Ch.12, §30.6.1.B)
  - In neither instance can both the physician and the nurse practitioner submit a bill for the same service. Billing is made by one or the other, depending on the circumstances of a shared visit.
  - There is no current payment methodology for dividing payment between physicians and nurse practitioners. Even if a method could be devised for splitting payment, it would mean creation of new claims processing methodologies to reduce the significant risk erroneous billing, as well as increasing Medicare administrative costs by requiring processing of two claims for the same service instead of one.
- Section 106 would amend Medicare law to permit SNF-Employed NPs to certify skilled care.
- Supporters of the legislation argue that SNF-employed physicians are not considered to have a disqualifying conflict of interest, so neither should a SNF-employed NP.
- AMDA is concerned that allowing NPs who are employed by a SNF to certify the need for skilled nursing facility services raise issues of conflict of interest and potential violations of anti-kickback laws. Typically, physicians are not employees of a skilled nursing facility, and separate statutory requirements with “safe harbors” govern potential physician conflict of interest (§1877(e)(2-3) of the Social Security Act and implementing regulations, 42 CFR §411.350 et. seq.).
- This provision does not reflect the current state of how NPs practice in these settings. Most nurse practitioners are not employed by the nursing facility or skilled nursing facility. Neither the profession nor companies like Evercare® have addressed any desire to change the current collaborative practice models.

## **Medicare Modernization Act / Medicare Part D**

- Medicare Part D, which began 1/1/06, is an important step towards ensuring access to medications by Medicare beneficiaries who need them, including nursing home residents.
- Nursing home residents should be able to obtain necessary medications in a timely fashion without undue obstacles.
- In a September AMDA 2006 survey, 64 percent of members reported continued problems with prior authorizations, 43 percent reported continued problems with requests for exceptions, and 74 percent reported problems obtaining certain drugs.
- Additional difficulties AMDA members have encountered include prompt access to medications; drug exclusions; quantity limits; step therapy requirements; diverse drug plan policies, procedures, and paperwork; and physician burden.
- The most common drugs that are sometimes difficult to obtain have been:
  - Dementia drugs

- Proton pump inhibitors
- Pain medications
- Erythropoetin
- AMDA has also received reports of problems obtaining medications to treat high blood pressure, high cholesterol and infections.
- AMDA had asked CMS to preclude drug plans from requiring prior authorizations for all dementia drugs, and in late summer, major drug plans ended that practice. As a result, drugs to treat dementia should be more readily available.
- Physician burden is still an important issue in the Medicare drug benefit, with 44 percent of AMDA members saying that they spent more than 4 hours a week on Part D issues.
- CMS should work with long-term care physicians to ensure that coverage decisions and medication management tools used, by drug plans consider the special needs of clinically fragile beneficiaries, and do not result in inappropriate drug utilization or inadequate access to drugs.
- Physicians should continue to report Part D problems to AMDA to aid in our advocacy efforts on behalf of members.
- AMDA will remain in close contact with stakeholders, including CMS, to try to help Medicare Part D succeed and evolve.

### **Omnibus Budget Reconciliation Act of 1987 (OBRA '87)**

- The federal Omnibus Budget Reconciliation Act of 1987 (OBRA '87) enumerates the responsibilities of providers of nursing home care who receive federal funds.
- The Center for Medicare and Medicaid Services contracts with state survey agencies to certify compliance with the OBRA '87 requirements and to enforce its provisions.
- The OBRA '87 Guidance to Surveyors interprets various sections of the regulations, for example, the meaning of the regulatory requirement that "The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality" (483.15[a] Quality of life: Dignity).
- The primary source of medical director responsibilities is Section 483.75(i) in the federal OBRA regulations (also designated as Tag F501 for survey reference). Each facility must designate a physician medical director who is responsible for implementing resident care policies and for coordinating medical care in the facility.
- One key aspect of legal and regulatory requirements concerns the availability of physicians and health-related services. A physician must oversee the care of each nursing home resident. Thus, facilities need attending physician support, for example, by giving admission orders that are consistent with a resident's current mental and physical status (CFR483.40. Physician services).
- Subsequently, the physician must visit according to a prescribed schedule, review the individual's total plan of care, write progress notes at each visit, sign and date orders, be available or arrange for coverage for emergencies, designate a backup physician, and supervise individuals such as nurse practitioners to whom tasks are designated.
- Concerns with OBRA
  - Regulations typically allude to some important areas of concern such as functional decline and falling. However, they overlook other important areas (for example, gastrointestinal bleeding, fibromyalgia, vasculitis, or anemia).
  - They do not necessarily establish realistic expectations for managing these conditions (symptoms often do not need interventions or could respond to simple non-medical approaches) or take into account current knowledge about the limitations and risks of treatments.

- They rarely provide reviewers or surveyors with enough detail to clarify what is important to the care of a specific individual.
- Some positive progress has been noted. The use of antipsychotic drugs and restraints in nursing homes has declined. (Psychiatr. Serv. 1998;49:229-33)

## **Pain Management**

- Pain is common in LTC residents. While cure of underlying causes may not be possible, control or reduction of pain can usually be achieved.
- Treating pain by using established guidelines, via a multidisciplinary team and a quality improvement model, can yield improved results.
- It is important that prescribing practitioners acquire familiarity with the different pain control options, both pharmaceutical and non-pharmaceutical options that are appropriate for elderly persons.
- Goals for pain control should take into account quality of life and function, e.g., having pain controlled enough to participate in activities and socialization.
- A variety of medications may be needed to adequately treat pain. Practitioners should be able to prescribe appropriate analgesics for their patients without undue fear of consequences for doing so.
- Treatment of pain at end of life is especially important, and in selected cases pain management may benefit from hospice involvement.

## **Professional Liability Issues**

- Problems with access to affordable medical liability coverage adversely impact AMDA members, and may limit access to long term care physicians and medical directors.
- In a 2006 survey, one-quarter of AMDA members reported problems obtaining or renewing professional liability insurance coverage.
- Over 5 percent were refused coverage because they worked in nursing facilities.
- For 7 percent of members, carriers imposed conditions on policies for long term care work, such as requiring physicians to restrict their practices to current patients, ceasing nursing facility work or ceasing medical director work.
- Medical directors' administrative activities are usually not covered by their individual malpractice insurance policies, and adequate liability coverage for this work is increasingly difficult to obtain.
- Liability concerns influenced 17 percent of AMDA members to modify their medical practices in the past year. Over 4 percent of respondents stopped working as medical director in one or more facilities, while 8 percent limited their work as medical directors.
- While 73 percent report having liability coverage for their office practices, only 59 percent have coverage for their administrative duties as medical director. When medical directors were covered, nursing facilities paid for the coverage nearly two-thirds of the time.
- Increased cost, access, and liability claims against nursing facilities have caused some facilities to "go bare", without liability insurance. In such instances, medical directors who had been covered under the facility policy would no longer be covered for their administrative work.
- While medical liability remains a concern to long term care physicians, only 0.5 percent indicated that they had claims against them in their capacities as medical directors.
- A number of factors affect liability risks in health care, including (among other things) insurance carriers, physician performance, laws and regulations, facility issues, actions of management and staff, and the legal and judicial system. Increasingly, nursing facilities and

physicians are also subject to claims of fraud and abuse for delivery of substandard care in long term care, thus increasing their liability exposure.

- Access to and affordability of medical liability coverage is limiting medical practice among long term care physicians and medical directors. AMDA is concerned that this trend may continue, which could jeopardize patient access to quality health care, especially for the frailest and most vulnerable individuals in the long term care continuum.
- Throughout the U.S., access to qualified physicians is a growing problem, as physicians retire prematurely, stop providing long term care, or relocate their practices because of skyrocketing insurance premiums.
- AMDA supports legislation that would place caps on malpractice awards as one step towards an overall revision of the liability crisis
- Other reforms, such as the establishment of specialized medical tribunals to assess merit and assign damages in medical negligence cases, or using arbitration rather than jury trials to decide these cases, should also be supported.
- Another important reform would ensure that only appropriately trained, credentialed, and experienced individuals should be utilized as expert witnesses.
- An AMDA White Paper on Expert Testimony in Long Term Care is available, in the event that members are called to serve as expert witnesses.

### **Quality Improvement in LTC**

- Improving quality of long-term care is the responsibility of all stakeholders, including physicians, facility staff, administrators, government agencies and consumers.
- Although much is already known about effective and prudent practices for frail older individuals, additional research could help in some aspects of nursing home medicine. Much of the current clinical care in nursing homes is based on studies and experiences of younger or less frail elderly patients and may not apply to older frail patients.
- AMDA recognizes the importance of informing the public about nursing home quality and supports CMS' efforts to do so.
- Nursing home residents and their families should have ready access to understandable information about nursing home care to help make decisions about their long term care needs and to evaluate the quality of care in long term care facilities.
- CMS developed the nursing home quality initiative to give consumers more information about the quality of care in nursing homes. However, the data that are used provide a very limited basis for reaching relevant conclusions about the care. Consumers should not draw conclusions about the quality of care at a nursing home based on these measures alone. Instead, they should use the information as a starting point for asking questions of the professionals at the facility. If consumers have concerns about quality of care, the medical director, attending physician, administrator, or director of nursing at the nursing home can be excellent information resources.
- The AMDA Web site ([www.amda.com](http://www.amda.com)) includes information for consumers about the CMS quality measures and how they can be used to ask meaningful questions at a facility. It also explains how sometimes, even with the best effort, nursing home residents may experience decline in some of the measured outcomes.

## **Research in Long Term Care**

- Much of our current medical knowledge and practices related to care of the elderly is based on research in younger persons. Some of this may have limited applicability in LTC.
- While future research is likely to yield very significant discoveries, effective application of existing knowledge based on previous research is also important and may be applied to the long-term care setting.
- More research involving LTC residents should be encouraged.
- Research involving long-term care residents involves significant ethical issues. These issues should be addressed appropriately whenever research is conducted in a long-term care setting.
- Community physicians should participate in LTC research as their abilities allow.
- LTC professional organizations should support and cooperate to promote research benefiting residents in the LTC continuum, including efforts to effectively use the abundant existing knowledge about geriatrics.
- As our society ages, the need for additional research and training in LTC will markedly increase if we are to provide humane, medically appropriate and fiscally sound care.

## **Resident Safety Related to Medications**

- Physicians or other licensed health care practitioners prescribe all medications that elderly patients receive.
- A practitioner trained in geriatric pharmacology is needed to determine the appropriate pharmacologic therapy for the individual resident.
- Since frail elderly patients in LTC are often on multiple medications, the medical director and attending physician should collaborate with the nursing staff and consulting pharmacist to achieve safe, effective medication regimens for each resident.
- Regular reassessment of medication risk and benefit by the physician and nursing staff in conjunction with the consulting pharmacist are vital to maximize efficacy and minimize adverse drug consequences.

## **Role of the Attending Physician**

- Attending physicians lead the clinical decision-making for patients under their care. They provide a high level of knowledge, skill, and experience needed in caring for a medically complex population in a climate of high public expectations and stringent regulatory requirements.
- The attending physician coordinates and helps provide medical care for the patient, including initial comprehensive assessment, ongoing evaluation, and discharge planning.
- The attending physician applies his/her knowledge of geriatric syndromes and pharmacology to provide appropriate care to residents of nursing and skilled nursing facilities.
- The attending physician works cooperatively with other members of the care team, using his/her expertise to guide the process of providing appropriate care to facility residents.
- Physician communication with residents and families is vital, including presentation of information about a resident's status and prognosis to facilitate decisions regarding care.

## **Role of the Medical Director / Tag F501 Medical Director**

- The revised surveyor guidance for Tag F501, Medical Director, recognizes the utilization of physician leadership to help improve quality of care.
- The medical director should be viewed as a primary source of clinically current information that serves as the basis for excellence in care practices and processes.
- The medical director should play an important role in reviewing and guiding clinical policies in the nursing home (i.e., whether they conform to current standards of practice in geriatrics and related areas).
- The medical director should help the facility provide comprehensive medical care and the facility should seek the medical director's advice if there is a clinical problem.
- The medical director's roles and responsibilities in the nursing home can be divided into four areas: physician leadership, patient care/clinical leadership, quality of care, and education.
- The medical director is a patient/resident advocate, whose ultimate goal is to help the facility provide quality care to residents of the facility.
- The medical director is an integral part of a facility's quality improvement efforts.
- Inadequate involvement or exclusion of the medical director in clinical issues may adversely affect a facility's ability to reduce adverse resident events and avoid serious survey deficiencies.

## **Survey Issues**

- The quality of surveying—like the quality of long-term care—varies widely throughout the U.S.
- There are some legitimate concerns about inadequate surveyor investigations and unwarranted conclusions. However, the survey process should not be faulted for finding true instances of inadequate or inappropriate care that result in deficiencies.
- Surveyors should seek input from the medical director and others at the nursing home with experience in providing long-term care. They can be a valuable resource in the survey process.
- The survey should consider both the processes of care and outcomes as important measures. Because patients in long term care are already frail and have significant medical conditions, it is not realistic or appropriate to judge outcomes without considering related care processes and realistic clinical expectations.
- State survey agencies should provide surveyors with enough ongoing standardized training, resources, and references to enable them to survey effectively.
- The survey team should have the input and guidance of a physician with experience in long term care and knowledge of geriatrics principles and practices, to help improve the accuracy and consistency of surveys.
- Nationwide, facilities should be surveyed following established surveyor guidelines and be less subject to inconsistent approach by surveyors.
- AMDA is committed to help with surveyor training, in part by providing educational material adapted from AMDA resources and by offering appropriate individuals to help with training.
- A fair, standardized informal dispute resolution process should be available in all states. It should be moderated by non-surveyor staff and should use appropriate expert opinion to judge compliance and appropriateness of care.
- Regionally, medical directors should function as key sources of education, information, and guidance for state survey agencies, providing clinical information and medical interpretations for issues within nursing facilities.
- Medical directors should be involved in the survey process by both understanding the survey itself and the elements of care that influence survey results.

- Full-time medical directors may certainly be better able to allocate time daily during the survey itself, but even part-time directors should participate.
- Medical Directors should be made aware of survey problems as they arise, attend the exit conference, and be knowledgeable of potential deficiencies and their merits.
- Medical Directors should be significantly involved in dispute resolutions and plans of correction, providing needed clinical expertise.

### **Unnecessary Drugs/F329**

- Implemented on December 18th 2006, the Centers for Medicare and Medicaid Services expanded and revised the interpretive guidelines for the regulatory requirements at 42 CFR §483.25(l) Unnecessary Drugs (designated as F329).
- F329 now includes the guidance for regulations related to antipsychotic drugs that used to be under F330 and F331.
- The revised guidance directs surveyors on factors related to the implementation, use, and monitoring of medications, including antipsychotic drugs.
- Psychotherapeutic medications of any type, and not just antipsychotics, are now reviewed under this guidance.
- It also includes an Investigative Protocol for both Unnecessary Medications and Medication Regimen Review and a guide for determining severity levels of related deficiencies.
- Deficiencies that would have been cited under F330 and F331 are now being combined under F329.
- The guidance continues to expand beyond the Beer's list of medications.
- The American Medical Directors Association is identified in the F tag as one of several recognized clinical resources "available for understanding the overall treatment and management of medical problems, symptoms and medication consequences and precautions".
- Implementation of F329 includes developing pertinent systems and policies and fostering effective interactions among the administration, staff, consulting pharmacists and attending physicians within a facility.
- The medical director should play a role in developing, reviewing and guiding a facility's clinical policies and procedures to help his or her facility use, monitor, and adjust medications appropriately.
- If deficiencies are noted in a survey with regards to F329, the guidance instructs surveyors to investigate other F-tags for possible noncompliance, including F501 (Medical Director). Specifically, surveyors are instructed to determine, "whether the medical director collaborated with the facility to help develop, implement and evaluate policies and procedures for the safe and effective use of medications in the care of residents."

## Workforce

### AMDA Positions

- AMDA agrees with National Commission for Quality Long-Term Care when they reported that “long term care providers could make better use of the expertise that medical directors have to offer.”<sup>1</sup>
- AMDA has worked to improve medical director knowledge by outlining the medical director’s role and responsibilities<sup>2</sup> and providing physicians with the knowledge to manage their clinical and administrative responsibilities through AMDA’s certified medical direction program.
- AMDA recommends that government policy should be developed to endorse and promote geriatric and long-term care education for all health care providers. A large number of current practicing physicians and health care professionals have not had long-term care training.
- AMDA supports requirements for greater long-term care experience, as well as experience working with interdisciplinary teams. Given the complexity of medical care for long-term care patients, it is critical to maintain a strong physician role on the care team. Medical directors of nursing facilities are responsible for implementation of resident care policies and coordination of medical care in the facilities.
- AMDA —through the Alliance for Aging Research— supports Congressional legislation to maintain or increase funding for geriatric training. The Alliance for Aging Research is a coalition of more than 85 non-partisan disease groups, patient advocates, and foundations.
- The retention and recruitment of medical directors may require changes in hierarchal structures to support them in their role as the clinical leader in long-term care facilities. This may include structures where the attending physician is accountable to the medical director.
- AMDA supports proposed legislation by Senator Barbara Boxer entitled the Caring for an Aging America Act of 2008. The act would establish a Geriatric and Gerontology Loan Repayment Program to enter into contracts with physicians, physician assistants, nurse practitioners, clinical nurse specialists, psychologists, and social workers trained in geriatrics or gerontology to pay educational loans in exchange for providing full-time clinical practice and service to older adults; and establishes the National Advisory Council on the Geriatric and Gerontology Loan Repayment Program.
- AMDA plans to develop practice models to make the practice of long term care medicine more attractive to physicians. These practice models would assist the physician in fitting LTC into their current practice; reach physicians earlier in their careers by developing LTC modules for internal medicine, family practice, and geriatric education programs; develop staffing models and policy on open versus closed staff; and revise the primer for attending physicians and new medical directors.

### Background

- The Congressional Budget Office has projected that by 2010, some 9.2 million people age 65 and over will need long term care, rising to 12.1 million in 2040.
- The U.S. will not be able to meet the future demand for geriatric health care and long-term care services and supports, without a workforce prepared for the job.
- Unless the supply of the workforce is increased, the severe shortages of personnel with the specialized skills and particular knowledge needed to care for the complex needs of older adults could reach crisis proportions in the next 25 years.

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<sup>1</sup> National Commission for Quality Long-Term Care. 2007. *From Isolation to Integration: Recommendations to Improve Quality in Long Term Care*. Available at [www.qualitylongtermcarecommission.org/reports.html](http://www.qualitylongtermcarecommission.org/reports.html)

<sup>2</sup> See AMDA position statement *Roles and Responsibilities of the Medical Director in the Nursing Home*. Available at [www.amda.com/governance/resolutions/a06.cfm](http://www.amda.com/governance/resolutions/a06.cfm)

- According to the ADGAP study, 25 percent of medical students reported in 2005 that their geriatric training was “inadequate”.<sup>3</sup> While more than 90 percent of all internal medicine residency programs include some geriatric curriculum, only 40 percent exceeded 25 half days, and one third of the programs required less than 12 half days.

### **Concerns**

- Caring for older adults with chronic conditions requires special skills and training. Inadequate training in geriatrics and gerontology often results in misdiagnoses, inappropriate services and a lack of care coordination that are harmful to older patients and costly to our health and long-term care system.
- Choosing a career focused on the care of older adults remains financially unattractive for young physicians and other health care professionals with increasingly large educational debt. Few financial or other incentives are available to encourage training or the pursuit of careers in the care of older adults.
- In order to finance geriatric training, student loan forgiveness programs through the Public Health Service and National Institutes of Health (NIH) could be provided for individuals who complete specialty training in geriatric medicine. In addition, we encourage Congress to increase the number of Graduate Medical Education slots for geriatric trainees. Congress also should support continued funding for Title VII of the Public Health Service Act, which provides funding for geriatric academic development awards, geriatric education centers, and awards to geriatric training programs.
- Nurses and social workers play a central role in care coordination for older adults, yet nurses and social workers are in short supply in the U.S., and those with specialized training and skills in geriatrics and gerontology are relatively few.
- Recruitment and retention of direct care workers<sup>4</sup> (90% of whom are women) in home-based care, assisted living and nursing homes also is a looming crisis due to low wages and benefits, lack of work status, lack of career advancement, potential for injury, and inadequate training and supervision.

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<sup>3</sup> David Ruben, MD, Chief of Division of Geriatrics, David Geffen School of Medicine, UCLA, speaking at 1st meeting of IOM Committee on Future Health Care Workforce for Older Americans, March 27, 2007

<sup>4</sup> According to the Bureau of Labor Statistics, direct care workers include home health aides, certified nursing assistants, nurses aides, personal care and home care aides, and personal care attendants.