Role of the Nursing Home: Medical Director 
Attending Physician

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ONE OF THESE 3 IS DIFFERENT

- ADMINISTRATOR
- DIRECTOR OF NURSES
- MEDICAL DIRECTOR
DIFFERENCES

- Medical Directors are usually not full time
- Medical Directors often have no contract and usually no written job description
- Medical Directors may be at more than one facility or have an outside practice
- Medical Directors often are not employees and may not receive standard benefits
- Medical Directors typically have significant responsibilities outside the nursing home
- Attending physicians may not report to the Medical Director
- The Medical Director may also be an Attending Physician
Implications

- Medical Directors may not be available for meetings which are not set around their schedule.
- Medical Directors may have special issues fitting into a leadership “team.”
- Families and outside institutions may believe Medical Directors have more control of their facilities than they have.
- Medical Directors may have difficulty separating their Attending Physician role from the Medical Director role.
Many facilities have expectations of the Medical Director which exceed those in the Guidelines, and are not based on code requirements.

These may include control of the use of expensive medications and tests, creation and revision of the formulary, employee safety, representing the facility to the community, guidance on medical ethics decisions and committees, review of ancillary services and contracts such as laboratory and x-ray, and review of potential admissions.
Hospital physician leaders have set expectations from The Joint Commission. The Joint Commission is rarely present in long term care. Medical Directors may not see themselves as “physician leaders.”

Nursing homes typically do little to “credential” medical staff leaving Medical Directors with limited controls over their staffs.
Physicians are usually not employees. They may behave as vendors, working for themselves. They are torn between the demands of this work, the realities of fee-for-service billing, and other outside obligations.

Physicians and non-physician practitioners are not trained to be part of a team, but if anything to lead a team.

Even long-serving physicians typically bring to the facility their expectations about physician roles, behaviors, and status from the hospital or their office.
Implications

- Attending physicians are frequently conflicted over degree of authority. Picture, for example, the first time an attending doing an admission is asked by a concerned family to order siderails.

- Attending physicians are frequently confused about the mysterious “code” that seems to dictate how they practice.

- Attending physicians frequently don’t understand the dual nature of the nursing homes medical facility and patient home. “Why are they never in bed when I come to see them?”
Circumstances beyond your control for the next 2,650 miles.
Medical Directors & Federal Regulations

- For thirty years, Medicare regulations have required medical directors in SNFs
- OBRA ’87: extended requirement to nursing facilities
- Federal regulations specify two duties
  - Implementation of resident care policies
  - Coordination of medical care
Medical Directors & Interpretive Guidance

- Interpretive Guidance
  - Clarify meaning and implications of basic federal regulations
  - Subject to periodic revisions
  - Stakeholders can provide input

- Original CMS Interpretive Guidelines define seven functions for medical director
Medical Director Functions: Original OBRA

- Assure that facility is providing appropriate care as required
- Monitor and ensure implementation of resident care policies
- Provide oversight and supervision of physician services and the medical care of residents
Medical Director Functions: Original OBRA

- Play significant role in overseeing overall clinical care of residents to ensure to extent possible that care is adequate

- If possibly inadequate medical care – including drug irregularities – identified or reported, evaluate and try to correct situation
Medical Director Functions: Original OBRA

- If necessary, consult resident and his/her physician concerning care and treatment
- Assure support of essential medical consultants as needed
Purpose & Goals

- Better define medical director’s importance
- Standardize expectations for providers
- Meet needs of contemporary long-term care population
Importance of Medical Director
AMDA Position Statements

- Medical director & attending physician
  - 1991 original
  - 2002 updates
- Interpretive Guidelines are consistent with these position statements
Importance of Medical Director

- “An Insider’s View: The Role of the Nursing Home Medical Director” (OIG Report, Feb 2003)
  - Medical directors very committed
  - Medical directors value role more than administrators do
  - Inadequately defined regulatory role results in underutilization
Importance of Medical Director

- Improving the Quality of Long-Term Care
  (Institute of Medicine report, 2001)
  - Medical directors accountable for quality of care in LTC, but have little authority within facilities and over attending physicians
  - One approach to improve care
    - Vest greater authority & responsibility in medical directors for medical services and require attending physicians and nurse practitioners to follow facility medical policies and procedures
Medical Director
Current Status

- Medical director role varies widely
  - Distant advisor or active participant
- Some nursing homes value competent attending physician practice and medical director oversight
- Many providers uninformed
  - Complain and don’t explore or learn
  - Avoid, don’t solve, physician issues
Concerns

- Many nursing homes and physicians still skeptical and resistant about medical director responsibilities

- Offer common arguments and concerns
Facilities

- Impossible to control physicians
- We’re not health care practitioners
  - Don’t know enough about patient care to dictate clinical practice
- Impossible to give guidelines that apply to everyone
Facilities

- We need physicians to admit patients
  - If we challenge them too much, they will take their patients elsewhere
- We cannot afford to pay medical directors more money
- Physicians are too busy to accept more responsibility as medical directors
Physicians

- Busy practitioners, don’t have time
- Not paid much to care for patients
- Facilities don’t want to pay for medical direction
- We can’t control some of the physicians
- Physicians have a right to practice as they see fit
  - All patients must be treated as individuals
Physicians

- We don’t have control of the other staff or the organization
- Facilities may discourage us from holding physicians accountable
- Facilities often let those of other disciplines dictate care practices or override physician input
Bottom Line

- Physicians are critical part of adequate long-term care
- Unparalleled training to see “big picture”
  - Sort out multiple simultaneous causes
  - Diagnose complex conditions
  - Evaluate risks and benefits of treatments
Bottom Line

- Most long-term care attending physicians and medical directors are part-time
  - Challenged by busy primary care practices, low reimbursement, demands of long-term care system, complex patients
- Despite obstacles, some physicians have done a stellar job as medical directors and attending physicians
  - Others, not so good
- Challenges are formidable but not insurmountable
Nothing New

- Revised CMS surveyor guidance (F501) does not impose additional responsibilities
  - Clarifies meaning of original requirements
  - More details of essential functions and tasks
  - Lists various options for fulfilling roles
  - Consistent with core roles / functions identified by medical directors themselves
Core Areas

- Ensure adequate, appropriate physician services
- Review credentials; oversee physicians and those who perform physician-delegated tasks
- Review physician performance and provide feedback
Core Areas

- Oversee and help develop care-related policies and practices
- Participate in efforts to improve quality of care and services
- Serve as liaison between physicians and facility staff and management
Additional Areas

- Liaison with community
- Source of education, training, and information
Can This Really Be Done?

- Medical director regulations (first in SNFs, then in all nursing facilities) have existed for several decades
- Physician’s role as a manager has been amply described and discussed in the literature over the years
  - Considerable support and training exist
Can This Really Be Done?

- Little regulatory enforcement and inconsistent implementation, nationwide
- Potential benefits of effective physician leadership have barely been realized
- Challenges in obtaining effective medical direction are unmistakable, but not insurmountable
Maryland Experience

- Experience in detailing responsibilities and requiring accountability of both attending physicians and medical directors has been documented.
- Overall, dire predictions about efforts at accountability didn’t materialize.
- Overall results at least somewhat positive.
Maryland Experience


Current Threats

- Liability, insurance, and reimbursement issues threaten to further disrupt physician involvement in long-term care.
- Some suggest that these issues represent a reason to minimize expectations of physicians and restrain medical director authority.
Current Threats

- Some physicians assert: holding physicians accountable, admitting to problems, and trying to change physician behavior simply invites more lawsuits.

- But accountability is vital, not a handicap.

- “Bad apples” spoil the whole barrel and raise everyone’s risks.
Alignment of Forces

Fig. 122.—An unmagnetized bar. The individual molecular magnets are disarranged.

Fig. 123.—A magnetized bar. The individual molecular magnets are arranged uniformly.

NS REPRESENTS A MOLECULAR MAGNET
So What Happens During the Survey Regarding F501?

- F501 generally cited with quality of care deficiencies
- Investigative protocol for F501 added
- Surveyors directed to communicate with medical director about various concerns
- Surveyors will correlate quality of care issues with medical director involvement
- F501 citation is against the facility
Surveyor Communication with Medical Director

- Admission of residents whose care needs cannot be readily met by the facility
- Access to or provision of physician or consultant services
- Identification, assessment, or provision of services to meet resident needs
- Facility’s success in honoring resident rights and enhancing personal dignity
- Implementing and maintaining current standards of practice for resident care and quality of life
- Effectiveness of the various committees responsible for overseeing resident care and quality of life
What will be investigated?

- Presence of a functioning medical director
- If concerns for resident care
  - Facility / medical director responsibility for resident care policies
  - Coordination of medical care / physician leadership – quality assurance
Investigative Areas

Facility – Medical Director

- Basic credentialing (background, training)
- 24 hour physician services, ongoing and emergency coverage
- Timely visits & orders
- Physician extenders including scope of practice
- Medical director response to care problems
- Attending physician liaison, education, monitoring, feedback, intervention
- QA activities
Severity Determination
F501 Deficiency

- **Severity Level 4** Immediate Jeopardy
- **Severity Level 3** Actual Harm, not IJ
- **Severity Level 2** No actual harm with potential for more than minimal harm
- **Severity Level 1** No actual harm with potential for minimal harm
General Severity Criteria – F501

- Failed to intervene with attending physicians in order to facilitate and/or coordinate medical care
- Has failed to provide guidance and/or approval for resident care policies
- Show evidence of process failures with respect to the medical director’s responsibilities

AND

- Deficiency at another tag
Example

- Pneumonia not treated due to poor attending-nursing home communication
- Sepsis, hospitalization, complications, permanent change in status
- Medical director aware of issue
Example

- History of difficulty getting timely responses to INR results
- Bleeding complication in several residents handled at nursing home
- No anticoagulation policies, not addressed in QA
Activities to Fulfill Roles and Promote Compliance

What should the facility and medical director do to ensure compliance?
Choose Medical Director and Clarify Functions

- Facility chooses a physician as medical director
  - Based on availability, interest, and identification of responsibilities required by law and regulations and recommended by pertinent professional associations
Clarify Functions

- Administrator and medical director create job description, based on review of
  - Facility's needs
  - Necessary and desired medical director functions and tasks
Clarify Functions

With administrator, jointly develop plan to guide medical director’s activities, with at least these components:

- Clarify relationships between the facility and its medical director and physicians
- Identify how medical director will define physician responsibilities
- Identify medical director quality assurance activities relative to the practitioners
- Identify medical director quality assurance activities relative to the facility
Clarify Relationships

- With facility management, define lines of accountability between administration, governing body or owner, and the physicians.

- With administrator, review and clarify implications for facility physicians of applicable federal and state regulations.

- With administrator, clarify medical director’s role in helping develop, approve, implement, review, and revise facility clinical policies and practices.
Define Physician Responsibilities

- Accepting responsibility for each resident/patient’s care
- Supporting resident/patient discharges and transfers
- Making periodic, pertinent visits in the facility
Define Physician Responsibilities

- Providing appropriate care, including managing medical problems and conditions
- Providing adequate coverage
- Providing appropriate, timely medical orders
- Providing appropriate, timely, and pertinent documentation
Disseminate Written Expectations

- Develop and disseminate written information to clarify expectations of attending physicians
  - For example, medical rules and regulations, practice agreements, policies and procedures, and related documents
  - Each physician required to acknowledge and sign agreement
Policies and Scope of Care

- Help develop and disseminate policies and procedures related to effective patient care and regulatory compliance
  - For example, timely patient visits, have significant condition changes, backup coverage
- Help identify clinical conditions and risks pertinent to the facility's population
  - ADRs, acute changes in condition, fall risks, etc
Policy Adherence

- Help facility incorporate medical and geriatrics information into clinical policies and procedures
- Advise physicians to follow clinical procedures and protocols that the facility, medical director, and/or medical staff agree are needed, or provide a valid medical rationale for deviating from them.
Medical Director as Resource

- Guide nursing and other staff and management about when to contact the medical director
  - For example, complicated cases, unsatisfactory physician responses
QA Activities Relative to Practitioners

- Help develop and implement program to evaluate care and performance of physicians and other licensed health care practitioners (for example, nurse practitioners) whom the medical director oversees
- Assess and compare practitioner performance to expectations
- Give appropriate feedback
QA Activities Relative to Practitioners

- Take corrective actions, as needed
  - Define corrective actions that may be taken, and the mechanisms for taking such actions
QA Activities Relative to Practitioners

- Intervene as appropriate in care of other physicians' patients
  - See patient if another physician's actions or inactions jeopardize individual's life, health, or safety, or prevent facility from meeting key legal and regulatory requirements
- Summarize physician-related issues and actions for the facility's QA Committee
QA Activities Relative to the Facility

- Provide clinical guidance and oversight regarding standards of practice for quality of resident / patient care and for quality of life
- Review consistency of facility's clinical policies and protocols with applicable standards of medical and geriatrics practice
QA Activities Relative to the Facility

- Help the facility review and tailor its approaches to managing various clinical conditions and problems
  - For example, diabetes, heart failure, falling, and delirium
  - Consistent with pertinent protocols, studies, and guidelines
QA Activities Relative to the Facility

- Help staff and management evaluate care of individual residents / patients and act on quality of care concerns
- Advise facility about clinical risk management concerns
  - Adverse drug reactions, medication errors, falls, etc
QA Activities Relative to the Facility

- Help review accidents and incidents
  - Help identify and address trends, patterns, and causes
- Help identify and address underlying causes of clinical problems and deficiencies on licensure survey, including those involving physician practice and compliance
QA Activities Relative to the Facility

- Help facility identify objective quality indicators to evaluate and improve the care and assess problems

- Review and discuss quality data and clinical topics presented at QA meeting
  - Falls, unplanned weight loss, etc
  - Help identify trends, causes, interventions
  - Review impact of physician practices on desired results
Other Activities

- Periodically, meet with DON and administrator to discuss issues of mutual interest and concern
- Be available during facility surveys (state, federal, accreditation, etc.)
  - Consult with facility, help respond to surveyor questions about medical care, etc.
- Advise facility on employee health and infection control issues and practices