POST-ACUTE AND LONG-TERM CARE MEDICAL ASSOCIATION
HOUSE OF DELEGATES
WHITE PAPER L02

SUBJECT:	**WHITE PAPER ON THE ROLE OF MEDICAL DIRECTOR IN THE SURVEY PROCESS**
INTRODUCED BY:	**WORK GROUP ON THE WHITE PAPER ON THE ROLE OF MEDICAL DIRECTOR IN THE SURVEY PROCESS**
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Introduction

Historically, medical directors have had an indistinct role in the survey process. The survey process includes both the actual survey itself, and the elements of care that influence survey results. There are few specific federal requirements or F-tags that directly pertain to the survey-related required roles and responsibilities of medical directors. Three areas of the State Operations Manual (SOM) explicitly address the role of the medical director: Drug Regimen Review, Medical Director Presence, and Quality Assurance.

Drug Regimen Review, F429, notes that facilities are encouraged to share the pharmacists' drug review with the medical director. Medical Director Presence, F501, states medical directors, retained by the facility, are responsible for implementing resident care policies and coordinating medical care in the facility. Quality Assurance, F520, notes that a medical director may be the physician designated by the facility to serve on the quality assurance committee.

Many clinically based *Interpretative Guidelines* associated with various F-tags imply the medical director's oversight and responsibility roles, but are not clearly delineated as to extent, methods or authority. Anti-psychotic drugs (F331), unnecessary drugs (F329), hydration (F327), nutrition (F324), naso-gastric tubes (F321-22), urinary incontinence (F315), pressure sores (F314), and restraints (F221-27) are prominent sections of concern, yet have no specified role for medical directors in the survey process.

Background

The Post-Acute and Long-Term Care Medical Association (PALTmed), which has encouraged the Centers for Medicare and Medicaid Services (CMS) Survey and Certification Group to include explicit language within the SOM to reflect a stronger leadership role for the medical director, has also long advocated that medical directors

should provide a leadership role in setting the standard of appropriate care practices within nursing facilities. Survey preparedness simply means being able to demonstrate good care for the resident at any time. Preparedness is achieved by ensuring that appropriate care processes and monitoring mechanism are in place. CMS would seem to endorse this role for medical directors. Surveyor guidance for medical director presence, F501 states:

> Resident care policies' include admissions, transfers and discharges; infection control; use of restraints; physician privileges and practices; and responsibilities of non-physician health care workers…. The medical director is also responsible for policies related to accidents and incidents; ancillary services such as laboratory, radiology, and pharmacy; use of medications; use and release of clinical information; and overall quality of care. The medical director is responsible for ensuring that these care policies are implemented.[1]

PALTmed's House of Delegates (HOD) has advocated that medical directors should play a key role in developing and implementing resident care policies as noted in HOD Resolution A91: Role and Responsibilities of the Medical Director in the Nursing Home. Collaborating with the nursing director, the administrator, and other health professionals, medical directors should assist in developing formal patient care policies that:

- Provide for the total medical and psychosocial needs of residents, including admissions, transfer, discharge planning, range of services available to residents, emergency procedures, and frequency of physician visits in accordance with residents needs;
- Help enhance residents' rights as identified in the federally mandated Patient Bill of Rights;
- Show that these patient care policies are carried out, as reflected and documented in the minutes of the drug regiment review and quality assurance committees; and
- Include written designation of specific facility personnel (with medical directors as advisory physicians) as responsible for the day-to-day execution of these policies.

Care coordination and implementation is also within the domain of medical directors. HOD Resolution A91 further states, with respect to resident care, medical directors should:

- Oversee the general clinical care of the residents, with final authority related to specific clinical practices;
- Act as liaison with and integrate the activities of other health professionals; and
- In an emergency, be prepared to assume the temporary responsibilities for the care of residents in the event that responsible physicians are not available.

In order to accomplish effective care practice development, implementation, and monitoring, medical directors must be able to manage the attending physician staff. The

[1] Appendix P, Survey Protocol for Long Term Care Facilities, F-Tag 501, *State Operations Manual*, PP 193.

2001 Institute of Medicine report, *Improving the Quality of Long-Term Care* agrees stating:

> Although medical directors are accountable for the quality of care in nursing facilities, they generally have little authority within facilities (e.g., in terms of hiring and firing staff and in setting administrative policies) and little authority over attending physicians…. 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.[2]

PALTmed's HOD Resolution A91 mirrors this sentiment by stating that medical directors should:

- Monitor the activities of attending physicians and intervene as needed on behalf of patients or the administration of the facility.
- Actively help develop ongoing in-service education programs for attending physicians and professional staff within the institution, in cooperation with the director of nursing and the administrator.

Obstacles to Medical Directors Participating in the Survey Process

Employment status, geographic proximity, surveyor receptivity, and a lack of explicit statutory authority may present obstacles to medical directors participating in the survey process. Many medical directors work part-time for their facilities, and may not be readily available for personal involvement as the survey progresses. Some others, especially in rural areas, are geographically separated from the facility and not readily available. More importantly, many medical directors who make themselves available during surveys report that they are rebuffed or ignored by surveyors or their own facilities. Physicians and medical directors often are not consulted about patients' records or conditions before the facility is cited, missing a vital opportunity to clarify clinical situations for the surveyor.

The lack of a direct, required role for medical directors in the survey process remains problematic. The role, authority, and responsibility of attending physicians and medical directors must be clarified. The physicians' importance and autonomy in medical judgment and decision-making cannot be removed from surveyor consideration and must be included as part of the surveyor's examination of care processes. Facilities, in conjunction with medical directors, must establish expectations for physician performance and monitor physician practices.[3] Citing facilities for care problems related to physician practices without having the means to influence those practices cannot lead to better care. Physicians should provide adequate, clinically pertinent explanations regarding their care decisions so that facilities do not have to retroactively attempt to explain them on their behalf.

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[2] Institute of Medicine, Division of Health Care Services, Committee on Improving the Quality in Long-Term Care. *Improving the Quality of Long-Term Care*. (Washington, D.C.: National Academy Press, 2001), 139, 140.

[3] PALTmed has published a Toolkit for Physician Management that is designed to assist facilities, medical directors, and attending physicians with developing expectations for physician performance.

Adversarial relationships between surveyors and medical directors are all too common. Surveyors may antagonize physicians by failing to listen to or clarify information physicians try to present, or by failing to understand or refusing to accept the physicians' legitimate explanation for a medical decision. Physicians may antagonize surveyors by refusing to answer questions or challenging their right to ask them. More professional and collegial relationships would foster better survey processes and higher standards of care. In the article, *Regulating U.S. Nursing Homes: Are We Learning from Experience*, Kieran Walshe postulates three models of regulatory approaches that can be applied to survey processes. They are as follows:

- Deterrence regulatory model. In this model, regulators view the industry as amoral, willing to bend rules and hide problems if they can get away with it and profit. The use of frequent inspections, sanctions and penalties, coupled with rigorous and uniform regulation will deter unwanted behaviors. The approach tends to be formal, legalistic, punitive and sanction-oriented.
- Compliance regulatory model. In contrast, "compliance" regulators see the industry as basically well intended and likely to comply if able. They tend to view the current system as hostile, burdensome, and hindering quality improvement. A more informal, supportive, and developmental approach is advocated, with sanctions being a measure of last resort.
- Responsive or "smart" regulatory model. This model combines features of both previous models. The underlying principle is that regulatory approaches should be adapted in response to the behaviors of the individual organization. Collaborative approaches are directed towards facilities that have shown a history of effective performance and regulatory compliance. In contrast, poor performing facilities require a combination of sanctions and directed opportunities for improvement.[4]

The reliance on a deterrence model of regulation will not promote effective improvement of nursing home care and wastes the potential of medical directors. Instead, it promotes a defensive posture wherein facilities may try to deny responsibility, using medical directors to almost exclusively solve individual cited deficiencies. This therefore does not promote treating root causes in underlying system and care process problems.

Scope of Practice Issues

Scopes of practice laws in each state define the parameters within which a given profession operates. Several licensed professions practice in the long term care setting including administrators, nurses, physicians, therapists of various types, nurse practitioners, physician assistants, registered dieticians, podiatrists, dentists, optometrists and ophthalmologists and others. States have various rules and regulations that determine the breadth of decision-making of these professionals and the types of practice they may conduct. PALTmed should work with CMS to refine the survey process toward recognizing the responsibilities of the various professions who practice in the long term

[4] Walshe, Kieran. "Regulating U.S. Nursing Homes: Are We Learning from Experience." *Health Affairs* 20, no. 6 (2001): 133-135.

care setting, as outlined in their respective scopes of practice. Surveyors should only cite facilities for decisions within their control, and wherever possible, citations should be based on measurable criteria to remove bias. A facility and its leadership—the administrator, the Director of Nursing, and the medical director—should be responsible for establishing and monitoring policies, procedures and programs. While the facility can monitor the actions of licensed professionals, they cannot be held accountable for the individual decisions that fall within the normal day-to-day scopes of practice of those practitioners.

Role of Medical Directors in the Survey Process

Medical directors should perform a number of roles during the survey process. These roles should not be limited to interactions only during the actual survey; they should be involved both pre- and post-survey.

Pre-survey

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. Michigan has recently passed legislation requiring newly hired surveyors to observe actual nursing home operation for at least ten days within a fourteen-day period. Consumer and Industry Services, the state agency that oversees the nursing home survey process, is required to provide joint training twice yearly to both surveyors and providers on at least one of the ten most frequently cited issues over the last year. Additionally, recently passed legislation in Michigan promotes the use of information in PALTmed's clinical practice guidelines to train both surveyors and providers and to help surveyors determine compliance in situations where the SOM's Surveyor Guidelines are insufficient.

In an effort to promote the medical director's role as a source of education, information, and guidance for state survey agencies (HOD Resolution A01), PALTmed's HOD has supported the formation of advisory boards for state survey agencies which could review policy implementation; monitor survey processes; provide training on medical issues; promote survey consistency; assist in technical training projects; and work cooperatively to improve nursing home care and the survey process.

Locally, medical directors can help reduce the number and severity of deficiencies by being allowed to oversee and evaluate specific care practices, and by educating physicians and staff in the importance of appropriate, documented care that meets regulatory needs. All direct care staff and physicians should understand the need to document the residents' condition at critical junctures. Direct care staff should also understand issues such as accommodation of resident preferences, relevance of medical interventions to quality of life, and risk-benefit considerations of medications. Examples of prior findings of deficiencies and plans of correction may help attending physicians understand surveyor observations and thinking. Medical directors should educate physicians about the general methods and intent of the survey process; for example, that surveyors have the right to question any aspect of the care process to help determine the basis for care decisions and the degree of regulatory compliance.

During the Survey

Medical directors can play an integral role throughout the survey process and should be notified by the facility when the survey starts. Medical directors should introduce themselves to the survey staff as soon as possible, by phone if not in person. They should ask to be contacted regarding clinical care or medical concerns of any resident in the facility.

Medical directors who are unable to attend on survey days should be available by phone with the administrator and/or director of nursing. They should review portions of charts in person or by fax as needed, and try to be at the facility at least part of one day of the survey. Administrators or directors of nursing should notify medical directors of all quality of care and medical issues noted during the survey. Medical directors should contact attending physicians of residents whose care is questioned by surveyors. If appropriate, medical directors may wish to help clarify issues directly with surveyors before consulting with attending physicians. Medical directors also can help explain, as appropriate, the judgment of other facility professionals.

Medical directors or their appointed attending physicians should attend exit conferences if at all possible. By attending exit conferences, medical directors should be in a better position to understand possible deficiencies. They already should be aware of basic surveyor concerns, and discuss them as needed, well prepared with clinical facts and records. However, most detailed discussions should occur before the exit conference, as it is much more difficult and potentially awkward to vigorously debate in a group setting. Any unresolved issues should be probed so as to learn the factual basis for surveyor conclusions. This facilitates informed involvement in dispute resolution as well as in providing meaningful plans of correction that truly address root causes of clinical issues.

Post-Survey

Medical directors must understand deficiencies involving resident care and help in determining which should be challenged and which should be addressed as legitimate problems. Whether disputed or not, plans of corrections must involve the input of medical directors. HOD Resolution A91 states, “the physician medical director should assist management in its review and response to any official, medical review by federal, state or local surveys in the facility”. This is especially true of issues pertaining to quality of care, physician services, drug usage, and clinical issues such as pressure sores and infection control. Medical directors should assist in drafting, and not just reviewing, plans of corrections in these areas. They should ensure that these plans of correction are meaningful, thorough and will address care process problems and not superficial issues.

Relationship between Medical Directors and Surveyors

Promoting less adversarial, more cooperative relationships should start locally. Professional, non-confrontational, resident-oriented approaches towards the survey process are imperative for both surveyors and physicians, and should help medical directors gain a more authoritative role in the survey process. Establishing formal relations between local medical director associations and state survey agencies may assist

in mutually understanding survey policies and directions, and may demonstrate the value of involved medical directors to state survey agencies.

PALTmed should continue to work with CMS, in particular, regarding revisions in regulations, surveyor guidance, and the SOM. Medical directors should be included in discussions and revisions of all clinically relevant issues. PALTmed should collaborate with the Association of Health Facility Survey Agencies (AHFSA) to define survey concerns and directives and promote the utility of medical directors in the survey process.

Recommendations

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. They should be aware of survey problems as they arise, attend the exit conference, and be knowledgeable of potential deficiencies and their merits. They should be significantly involved in dispute resolutions and plans of correction, providing needed clinical expertise which is often lacking. The medical director's contract should include a general statement of expectation for their involvement in the survey process, especially with regard to plans of correction.[5] These steps would help promote the medical director's role in defining, establishing and monitoring care processes and policies. Given the wide range of involvement of medical directors, PALTmed could help establish a functional checklist of other desired or potential functions rather than mandate them.

Both individual medical directors and PALTmed need to engender a cooperative, professional survey climate that involves medical directors as useful and necessary resources for optimal resident care and facility performance. Promoting responsive or "smart" regulatory methods, providing education to and working on technical projects with surveyors, and working with CMS to improve survey methods are among many ways to assist these efforts. Ultimately, more explicit or even mandatory roles of medical directors in the survey process may be the most direct and impartial way to ensure more clinically consistent and fair assessment of resident care processes.

Implementing the suggestions outlined in this paper may necessitate a thorough examination of your existing contractual relationship with your nursing facility that includes (1) a greater specification of performance requirements; and a careful detailing of survey-related expectations, such as onsite time to review charts, meeting with surveyors, being available by phone, and attending exit conferences. As always, make sure that you have adequate liability insurance to cover your administrative/consultative

[5] PALTmed has published a model contract to assist medical directors in broaching these issues with nursing facilities.

functions as medical director and for any duties performed as an attending physician. Similarly, in the current litigious environment, medical directors also face exposure to civil liability associated with (1) failing to perform one's duties as a medical director; and (2) in the event that it becomes necessary to report-either to the facility or to a state surveyor-substandard care provided by a community-based attending physician.

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RESULTS: Passed. Work Group on the Role of the Medical Director in the Survey Process to develop strategic plan.