Medical Director Requirements for Nursing Facilities
Advance Issuance of Revised Survey Guidance

HIGHLIGHTS

On April 9, 2005 the Centers for Medicare and Medicaid Services (CMS) released revised interpretive guidelines for surveyors to use when determining nursing facilities’ compliance with 42 CFR 483.75(i) Medical Director at survey data tag F501. Through this guidance, CMS has defined a more detailed and clearer description than current guidance provides for medical directors’ roles and functions and facilities’ responsibilities in assuring that quality of care is delivered to residents. CMS has not changed the regulation. CMS has clarified and raised expectations of both the facility and the medical director and described the medical director functions and role as part of a facility system that supports its residents’ health care needs. The new guidance will be effective in November 2005, allowing time for dissemination of the guidance to surveyors, medical directors and facilities and provide education and training.

The American Health Care Association (AHCA) considers the medical director to be an essential link to the level of quality that facilities strive to achieve. To assist in this effort, CMS envisions development of partnerships among a facility’s medical director, administrator, director of nurses and other key personnel. These partnerships can become a powerful force in creating an environment conducive to facilities’ quality performance, and they are evidenced throughout the guidance. In addition, many of the items and suggestions in the guidance could help facilities to fulfill their responsibilities under F501 by encouraging medical directors to take an assertive and active leadership role.

This paper highlights key components and follows the sequence of the CMS document.

Expectations Underlying the Guidance
• Responsibility for compliance is placed on the facility and the medical director.
• The facility
  o Supports the role and functions of the medical director.
  o Involves the medical director in development, review and implementation of policies and procedures regarding clinical care.
  o Obtains medical director input in evaluating and coordinating the provision of medical care to residents.
  o Works with the medical director to assure that attending physicians are informed of expectations and facilities’ policies.
  o Communicates with the medical director regarding quality of resident care.
  o Disseminates information from the quality assurance committee to the medical director and the attending physicians.
• The medical director
  o Is involved in developing, reviewing and implementing policies and procedures regarding clinical care of residents to ensure clinical validity and consistency with current standard of care.
- Has input into the facility’s scope of services provided to residents, capacity to care for residents with complex or special care needs, appropriateness of care, processes for accurate assessment, care planning and treatment implementation and service monitoring, and review and updating of policies and procedures to reflect current standards of practice.
- Coordinates medical care, e.g., advises the facility when physicians’ or other practitioners’ performance is inadequate or their behavior is contrary to established facility rules and procedures.

- The surveyors
  - Are advised not to make automatic links between deficiencies at other F tags and F501. They must show an association between noncompliance at care tags and a failure to comply with one or more aspects of F501.
  - Determine severity of deficiencies at F501 according to the severity of noncompliance found at other F tag requirements.

**INTENT (501) 483.75(i) Medical Director**

The intent of the rule at F501 is twofold and reveals structural and process elements of the regulation that are the basis for the entire guidance for F501.

1. The facility must have a licensed physician designated to serve as a medical director.
2. The medical director must coordinate medical care and provide clinical guidance and oversight of the facility’s resident care policies.

**DEFINITIONS**

Definitions are provided for key terms used in the document. Notable are *current standards of practice* and *resident care policies and procedures* because CMS uses them repeatedly in describing the medical director’s roles and functions.

**OVERVIEW**

CMS’ intention to elevate the expectations and role of the medical director is evident in this section. This section establishes that the medical director:

- Has a leadership role in actively helping the facility provide quality care.
- Has two main responsibilities: implementation of resident care policies and coordination of medical care.
- Is expected to be knowledgeable about *current standards of practice* and coordination and oversight of related practitioners.
- Provides clinical leadership on resident care practices or treatments.
- Promotes optimal outcomes for residents.
- Provides input to surveyors on physician issues, resident’s clinical issues and facility clinical practices.

**MEDICAL DIRECTION**

The facility’s responsibility under F501 is far more than designating a medical director. Together with the medical director, the facility should clearly identify how the medical director will function and the expectations of his/her active involvement, including:

- Collaborating with the facility as it develops policies and protocols that guide *clinical decision making* by practitioners based in and out of the facility.
• Helping the facility incorporate current standards of practice into residents care policies and procedures/guidelines.
• Providing input into development, review and approval of resident care policies.
• Guiding, approving and helping to oversee implementation of resident care policies such as admission policies and care practices that address residents needs; availability, quantifications and clinical functions of staff necessary to meet residents’ care needs; and provision of physician services.

Coordination of Medical Care
The regulation mandates this coordination as a key function and responsibility of the medical director. It includes:
• Helping the facility obtain and maintain timely and appropriate medical care.
• Assuring that medical care supports residents’ health care needs, is consistent with current standards of practice, and helps the facility meet regulatory requirements.
• Reviewing and evaluating aspects of physician care and practitioners services.
• Helping the facility identify, evaluate, and address health care issues related to the quality of care and quality of life.
• Addressing issues related to coordination of medical care or other care issues that the facility’s quality assessment and assurance committee or quality assurance program identify as needing follow up. These include activities such as:
  o Ensuring primary attending and backup physician coverage.
  o Developing a process to review medical practitioner credentials.
  o Addressing and resolving concerns and issues between physicians, health care practitioners and facility staff.
  o Guiding physicians regarding specific expectations of their performance.
  o Reviewing individual resident cases as requested or indicated.

INVESTIGATIVE PROTOCOL – MEDICAL DIRECTOR
The objective of the protocol is for surveyors to determine:
1. Does the facility have a licensed physician designated as the medical director?
2. Does the medical director coordinate medical care and implementation of resident care policies in collaboration with the facility?

Surveyors are to use the protocol if they identify a facility failure and/or a medical director failure. That is:
1. The facility does not have a licensed physician serving as medical director and/or
2. The facility has a medical director as required but there is a failure in fulfilling the required role.
   a. The medical may not be performing the roles and functions as coordinator of medical care and/or the implementation of resident care policies.
   b. The facility has not involved the medical director in these roles.

Surveyors use investigative procedures of interview and review of pertinent policies and procedures. They may conduct additional reviews of resident care.

Provision of a Medical Director
In this portion of the protocol, surveyors interview facility leaders to determine:
• How they identify the roles and functions of the medical director.
• How they review roles and functions with the medical director.

Surveyors interview the medical director to determine:
• His/her understanding and performance of the roles
• Facility support of the medical director in performing the roles and functions.

If surveyors determine that the facility does not have a medical director, they ask the administrator the reason, the duration and facility action to retain a medical director.

Facility/Medical Director Responsibility for Resident Care Policies
After surveyors identify actual or potential noncompliance with requirements related to the provision of resident care or medical care they interview facility leaders to determine:
• How or if the facility involved the medical director in developing, reviewing and implementing policies and procedures regarding clinical care of residents.

Surveyors also interview the medical director about his/her input into a variety of clinical and medical aspects of the facility’s services such as:
• Scope and services that the facility chooses to provide.
• Capacity to care for residents with complex or special care needs.
• Appropriateness of care as it relates to clinical services.
• Processes for accurate assessment, care planning, treatment implementation and monitoring of care and services to meet resident needs.
• Review and update of policies and procedures to reflect current standards of practices for resident care such as pressure ulcer prevention.

Coordination of Medical Care/Physician Leadership
If surveyors identify issues or concerns related to the provision of medical care, they obtain information about the facility’s and the medical director’s actions.
• Interview facility staff, management and the medical director to find out what is done when a physician or other practitioner does not perform adequately or appropriately.
• Examine the facility’s process for obtaining the medical director’s input in evaluating and coordinating the provision of medical care in the facility.

Surveyors determine how information is exchanged between the quality assurance (QA) committee and the medical director and how relevant information is disseminated from the QA committee to the medical director and attending physicians.

Criteria for Compliance
Four elements constitute compliance with F501:
1. The facility has designated a licensed physician as its medical director.
2. The medical director performs the regulated functions of the position.
3. The medical director provides input and helps the facility develop, review and implement resident care policies, based on current clinical standards.
4. The medical director assists the facility in coordinating medical care and services.
Noncompliance for F501
The survey team must identify whether the noncompliance cited at other tags is related to the medical director’s role. In order to cite noncompliance at F501, the team must show an association between the identified deficiency and a failure of medical direction. A finding of noncompliance with requirements for delivery of care does not necessarily reflect on the medical director’s performance. Therefore, the team should not make automatic links between deficiencies at other F tags and F501.

Citations at F501 are related to facility failure or medical director failure, or both, e.g.
- Facility failed to designate a licensed physician to serve as medical director or failed to obtain the medical director’s input in the development, review and approval of resident care policies.
- Facility and medical director failed to perform expected functions and roles such as assuring that physician and practitioner services reflect current standards of care and are consistent with regulatory requirements or failed to assure that a system exists to monitor the performance and practices of health care practitioners.

V. DEFICIENCY CATEGORIZATION (Part V, Appendix P)
The survey team uses this section to apply severity ratings after they have completed their investigation, analyzed the data, reviewed the regulatory requirements and determined the existence of noncompliance. The team determines severity of each deficiency on the basis of its resultant effect or potential harm to the resident. Three key elements determine severity of noncompliance at F501.
1. Presence of harm/negative outcomes(s) or potential for negative outcomes because of lack of resident care policies and/or medical care.
   a. Example: Medical director is not involved in coordinating medical care regarding problems with physician coverage or availability.
2. Degree of harm (actual or potential) related to the noncompliance.
   a. Surveyors identify facility responsibility -- how its practices caused, resulted in, allowed or contributed to the harm.
3. The immediacy of correction required.
   a. Surveyors determine whether immediate correction is required in order to prevent serious injury, harm impairment, or death to one or more residents.

The survey team begins its severity evaluation starting with Severity Level 4, Immediate Jeopardy (IJ). If IJ is ruled out, the team proceeds to each subsequently lower level.

Severity Level 4 Considerations: Immediate Jeopardy to resident health or safety
In order to cite F501 at the IJ level, the team must have identified noncompliance at Level 4 at another regulatory tag, and it must be related to the failure of medical care and systems associated with the roles and responsibilities of the medical director.
- Citation at Level 4 (IJ) requires the presence of two elements:
  1. Noncompliance is cited at Level 4 at another regulatory tag and the findings at this tag that show evidence of process failures associated with the medical director’s responsibilities.
  2. The facility has no medical director, or
The facility failed to involve the medical director in resident care policies, resident care, or medical care as appropriate, or

The medical director failed to act as required when he/she knew about a problem with care or physician services or resident care policies and practices or failed to give guidance and/or oversight to the facility.

If the team rules out Level 4, they proceed to evaluate for Level 3.

Severity Level 3 Considerations: Actual Harm that is not Immediate Jeopardy
As with Level 4, in order to cite F501 at the Level 3, the team must have identified noncompliance at Level 3 at another regulatory tag, and it must be related to the failure of medical care and systems associated with the roles and responsibilities of the medical director.

- Citation at Level 3 requires the presence of the two elements required at Level 4 as they apply to Level 3.

If the team rules out Level 3, they proceed to evaluate for Level 2.

Severity Level 2 Considerations: No Actual Harm with potential for more than minimal harm that is not Immediate Jeopardy
As with Level 3, in order to cite F501 at the Level 2, the team must have identified noncompliance at Level 2 at another regulatory tag, and it must be related to the failure of medical care and systems associated with the roles and responsibilities of the medical director.

- Citation at Level 2 requires the presence of the two elements required at Level 3 as they apply to Level 2.

If the team rules out Level 2, they proceed to evaluate for Level 1.

Severity Level 1 Considerations: No actual harm with potential for minimal harm
As with Level 2, in order to cite F501 at the Level 1, the team must have identified noncompliance at Level 1 at another regulatory tag, and it must be related to the failure of medical care and systems associated with the roles and responsibilities of the medical director.

- Citations at Level 1 are based on two elements:
  1. The facility and/or medical director failed to coordinate medical care where there was a deficient facility care practice with no negative resident outcomes or failed to implement resident care policies with no resultant negative resident outcomes, or
  2. There is no medical director and no negative resident outcomes have occurred, required medical director related care and systems are in place, lack of director is of short duration and the facility is actively seeking a new director.


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