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Client Advisory
Individualized Care Required for Nursing Facility Residents: The Role of the Medical Director

Nursing facilities are charged by federal survey standards (e.g., F309), and by courts applying those standards, with providing care that allows residents to achieve the highest practicable well being. The medical director's role is increasingly important in the nursing facility to assure any resident declines are unavoidable, to implement resident care policies, and to coordinate medical care to residents.

Nursing facility survey tag F309 was the most frequently cited deficiency in Virginia nursing facilities in 2004. To reverse this trend, each nursing facility needs to take steps now to avoid quality of care deficiencies. By working to coordinate medical care with attending physicians and staff, the nursing facility and its medical director can encourage the use of treatment orders and care that meets individual resident needs in an increasingly complex medical care environment.

The Centers for Medicare & Medicaid Services ("CMS") has recently produced new guidance documents for tag F501 that clarify the responsibilities of medical directors of nursing facilities. Nursing facility survey tag F501 requires a nursing facility to designate a medical director who is a licensed physician, who provides input and helps the facility develop, review and implement resident care policies based upon current clinical standards, and assists the facility in the coordination of medical care and services in the facility. To cite a F501 deficiency, the survey team must demonstrate an association between the identified deficiency and a failure of medical direction.

In order to comply with the implementation of resident care policies requirement, a nursing facility must be able to demonstrate that it has collaborated with its medical director during the development, review, and approval of the policies and protocols that guide clinical decision-making by all members of the facility's staff. The medical director incorporates current standards of practice into resident care policies and procedures to help assure that they address the needs of the residents.

Examples of resident care policies include, but are not limited to: admission and retention of residents, integrated delivery of care and services, use and availability of ancillary services, availability and qualifications of medical staff, formulation and implementation of advanced directives, provisions that enhance resident decision-making, mechanisms for communicating and resolving medical care issues, availability of emergency physician services 24 hrs/day, review of the resident's overall condition and program of care at each visit, documentation of progress notes, systems to ensure that

other licensed practitioners act within the regulatory requirements and within the scope of practice as defined by State law, and procedures for facility staff regarding when to contact a practitioner.

The coordination of medical care role of a medical director involves helping the facility obtain and maintain timely and appropriate medical care that supports the healthcare needs of the residents, is consistent with current standards of practice, and helps the nursing facility meet its regulatory requirements. The medical director coordinates and evaluates the medical care within the facility by reviewing and evaluating aspects of physician care and practitioner services, and helping the facility identify, evaluate, and address health care issues related to the quality of care and quality of life of residents.

Important components in a medical director's coordination role include ensuring that residents have primary attending and backup physician coverage, developing a process to review practitioner credentials, addressing and resolving concerns and issues between the physicians and other facility staff, and facilitating continuity of care and transfer of medical information between the facility and other care settings. Other areas for medical director input include reviewing individual resident cases as requested/indicated, discussing and intervening with a health care practitioner about medical care that is inconsistent with applicable current standards of care, assuring that a system exists to monitor the performance of the health care practitioners, identifying facility or practitioner educational and informational needs, and facilitating feedback to physicians and other health care practitioners about their performance.

Professional organizations, including the American Medical Directors Association and the American Health Information Management Association ("AHIMA"), have published position statements and practice guidelines for medical directors setting forth the current standards of care and documentation for attending physicians and, when available, their supplemental nurse practitioners or physician assistants. I recommend the attached guidelines to your attention and encourage their application in your nursing facilities.

For example, AHIMA practice guidelines specify that standing order policies should be used with discretion. In Virginia, standing orders are clearly disfavored in nursing facility settings. The Department of Medical Assistance Services Physician Manual notes that "orders must be specific for individual needs." As recently stated by a Virginia Department of Health official; "[Standing orders are] seriously frowned on—especially as LTC has moved toward 'individualized care'. In fact—beyond the standard annual flu immunization, I can't think of too many things that are encouraged as 'standing orders'."

AHIMA practice guidelines address other sources of potential survey noncompliance and potential liability risks with physician oversight, such as timeliness of orders. In response to nursing facility survey tag F386, each nursing facility and its medical director should establish protocols, if not requirements, for progress notes (each

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recertification visit), the receipt time for dictated notes (7 days), the timeliness of orders, order renewals, and telephonic order validation. Survey tag 271 also requires specific admission orders, including dietary, drugs, and routine care to maintain or improve the individual resident's functional abilities as a part of comprehensive assessment and planning. Hence, both the adequacy of the physician's underlying orders and the nursing facility's close compliance with those orders are crucial to demonstrate successfully that any negative resident outcome was "unavoidable".

The physician's involvement and communication with staff are also critical to satisfying the federal certification standards. Demonstrating active medical oversight in resident management and appropriate communication have become important to demonstrating compliance with F385, F386, and F387 during nursing facility surveys.

Documenting that a physician receives and responds to changes in resident condition and laboratory findings, per F157, F505, F509, and F389, also allows the nursing facility and the physician to avoid lawsuits based upon poor outcomes and the failure to follow federal standards. In the absence of attending physician oversight, the medical director must step in when there is a decline in resident medical status.

The existence of appropriate and timely care orders (and the nursing facility's documentation of compliance with them) may make the difference at an IDR (or in an appeal to CMS) between a large civil monetary penalty and an unsanctioned correction of the problem under a time-limited plan of correction. Although the easy route for physicians is to establish a standing order for each possible resident event, an appropriate care order is not a standing order. Such orders have led to poor resident outcomes and do not provide protection to the nursing facility or the physician. This observation is best demonstrated in a 2002 decision of an administrative law judge at the Department of Health and Human Services on an appeal from "immediate jeopardy" findings against a nursing care facility facing significant civil monetary penalties. In *Beechwood Sanitarium v. CMS*, the nursing facility relied on a standing order as the basis for approval of treatments provided to a resident. The administrative law judge wrote:

> As to the issue of approval, Petitioner cites to the testimony of the resident's treating physician that the resident had a standing order for the administration of a glycerine suppository. [Brief reference omitted.] I find this evidence not to be persuasive. Generalized standing orders that are not individualized to deal with the specific needs of each resident are not an acceptable substitute for the requirement that a physician approve the administration of specific types of medication and care, including suppositories, oxygen, pain killers containing controlled substances, or the insertion of a rectal tube.
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> *Beechwood Sanitarium v. CMS*, CR966 (2002.10.28)
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> As a result of the problems with the timeliness of attending physician's response and the discouragement of standing orders, many nursing facilities have worked with their medical directors to develop decision matrices for care and physician

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contact. Even with such decision matrices, the facility staff should err on the side of attending physician and resident family contact to avoid regulatory citations under F157 and F385. "If in doubt, call" must be the rule. Facility quality assurance committees and in-services should weed out the inappropriate calls after the fact.

Nursing facilities should also be receptive to the use of nurse practitioners and physician assistants to assure coverage. The inclusion of nurse practitioners, especially with prescriptive authority, licensed jointly by the Board of Medicine and the Board of Nursing, has expanded nursing facility medical oversight available for routine problems, diagnoses, and treatments. An onsite nurse practitioner under an independent contractor medical director's supervision would reduce the administrative burden significantly, assure individualized care, provide more immediate resident assessment and orders, and virtually eliminate the perceived "need" of standing orders. Even the survey standards recognize and even encourage the use of nurse practitioners per F388 and F390.

Nurse practitioners are being engaged by physicians for resident coverage in nursing facilities. For rural settings, the General Assembly has encouraged the use of nurse practitioners in medically underserved areas by underwriting grants for nurse practitioner students who will commit to practice in medically underserved areas (Va. Code § 32.1-122.6:02), as well as a loan repayment program that, by regulation, maintains a similar obligation (Va. Code § 32.1-122.6:04; see generally Va. Code § 32.1-122.20). Recruitment of a nurse practitioner would be facilitated by those benefits.

I hope these observations and suggestions will be of some assistance to you in meeting regulatory criteria, and if you have additional questions, or if my firm can be of further assistance, please contact me.