Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Nursing Home Medical Directors Survey

JANET REHNQUIST
INSPECTOR GENERAL

FEBRUARY 2003
OEI-06-99-00300

OFFICE OF INSPECTOR GENERAL

http://www.oig.hhs.gov/

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

Office of Evaluation and Inspections

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

Office of Investigations

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties. The OI also oversees State Medicaid fraud control units which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the Department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

EXECUTIVE SUMMARY

OBJECTIVE

To identify the functions reported by medical directors that are expected of them by nursing homes, their expenditure of time meeting these functions, and their self-reported credential status.

BACKGROUND

Medical directors are required by the Code of Federal Regulations, Title 42 §483.75(i)(2), to be responsible for *the implementation of resident care policies and coordination of medical care services in the facility.* Further, the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) and subsequent policies suggest, but do not clearly state, that medical directors should be utilized in the direct management and identification of potential quality improvement problems and plans, and should ensure implementation of existing law and regulations. The Centers for Medicare & Medicaid Services (CMS) has ultimate responsibility for ensuring implementation of OBRA 1987, but it is not always clear which individual(s) in the nursing home actually, and ultimately, must ensure that patients receive the necessary care – the medical director, the attending physician, the administrator, or the nursing staff. From the 191 sampled nursing homes, 119 responding medical directors identified many specific functions as expected or should be expected of them by the nursing home, in the four key areas of quality improvement, patient services, residents' rights, and administration.

SURVEY RESPONSE

Responding medical directors report many functions in four key areas they are frequently expected to perform

Quality Improvement – Medical directors report that quality improvement activities are important. These activities focus on the broader aspects of quality within the facility, including their review and revision of existing medical and clinical policies; encouragement of quality of care, regardless of patient case mix; and review and analysis of quality indicators for potential areas of concern. By comparison, quality improvement functions that are more centered on the individual patient are reported less often by medical directors as expected by the nursing homes. Committee involvement is one way that medical directors contribute to quality improvement in the nursing home. Eighty-seven percent of responding medical directors report participation on nursing home committees for improving patient care.

Patient Services – At 92 percent, intervening with attending physicians about patient care concerns is the most frequently mentioned patient service expected of responding medical directors by the sampled nursing homes. Other functions frequently reported by medical directors are their review of consultant pharmacists' drug regimen reports (90 percent), provision of ongoing medical advice and guidance to nurses (86 percent), and routine meeting with nurses to discuss patient care issues (78 percent). About half of the responding medical directors are not expected by the nursing homes to provide direct care to patients.

Residents' Rights – Ninety-six percent of responding medical directors report that the promotion of residents' rights is an expected leadership role for them. However, 60 to 69 percent of responding medical directors report that ensuring residents' rights is expected of them by the nursing homes. For example, they are expected to ensure: the appropriateness of a patient's drug regimen (69 percent), a patient's end-of-life decisions are honored (68 percent), and both patients' involvement in their own care planning and their right to refuse medication, when mentally competent to do so (60 percent).

Administration – Generally, medical directors report that their administrative functions involve advising on survey regulatory matters (94 percent), providing liaison with facility staff (84 percent), and keeping current on regulatory and medical treatment changes (83 percent). Few medical directors report participation in the training of nurses and nurse aides, as well as participation in the assurance of patients' safety in the physical environment. Few also report their participation in verifying that their facility's storage, preparation, and service of food are sanitary.

Medical directors report some functions they are not frequently expected to perform, nor do they often believe they should; for others, they indicate a more diverse opinion

Within patient services, residents' rights, and administration, medical directors report some functions that are infrequently expected of them by the nursing homes. For some of these functions, medical directors also seldom report that they should perform them. For other functions in these broad categories, the frequency at which they report that they should perform them is higher and indicates a diversity of opinion about what their duties should include.

Eighty-six percent of responding medical directors report spending 8 hours or less per week at the sampled facilities

Sixty-two percent of responding medical directors report visiting the facility one time per week or less often. Eighty-six percent of them spend 8 hours or less per week at the sampled facility. Seventy percent of medical directors report that 1 to 10 percent of their overall medical practice is devoted to their medical director role.

Responding medical directors report they are professionally trained

All responding medical directors report that they have professional medical training. Nearly all report specialization in either family practice (47 percent) or internal medicine (44 percent). Almost half of them report specialization in caring for elderly patients, either as geriatric physicians (21 percent) or by their obtaining a "certificate of added qualifications" in geriatrics (29 percent). Many medical directors also enhance their professional understanding of the elderly through additional training or participation in professional organizations. In fact, while regulations do not specify that medical directors should be licensed to practice, they are required to be physicians.

SUMMARY

This report identifies the functions for which 119 responding medical directors in 7 purposively-sampled states report as being expected of them by the nursing homes. The responding medical directors also identified those functions for which they report that they should have responsibility. Identified functions fall within four categories: quality improvement, patient services, residents' rights, and administration. These functions relate directly to their regulatory responsibility for implementation of resident-care policies and coordination of medical services in the facility. The reported functions clearly indicate a physician-related role for them. In fact, while regulations do not specify that medical directors should be licensed to practice, they are required to be physicians.

Beyond the few functions within each of the four categories, for which 80 to 94 percent of the responding medical directors report are expected by the sampled nursing homes (Appendix C), there are many more functions less frequently reported by medical directors. These are functions that medical directors report they are not expected to perform, nor do they report they should; for others, they indicate a diversity of opinion. Thus, much of what medical directors are expected to do by the nursing homes begins to vary markedly. Responding medical directors (86 percent) also report spending 8 hours or less per week performing the responsibilities expected of them.

The CMS routinely works directly with representatives of the nursing home industry, patient advocacy organizations, and physician-related associations. We believe that CMS will find the presented information useful as it continues to work with them in establishing, clarifying, and enhancing the medical director's role.

TABLE OF CONTENTS

PAGE

EXECUTIVE SUMMARY i

INTRODUCTION 1

SURVEY RESPONSE 6

Responding medical directors report many functions in four key areas they are frequently expected to perform 6

Quality Improvement 7
Patient Services 8
Residents' Rights 10
Administration 12

Medical directors report some functions they are not expected to perform, nor do they report they should; for others, they indicate a diversity of opinion 13

Eighty-six percent of responding medical directors report spending 8 hours or less per week at the sampled facilities 16

Responding medical directors report that they are professionally trained 18

SUMMARY 19

ENDNOTES 20

APPENDICES 23

A: Summary of Physician-Related Survey and Certification Nursing Home Regulations 23
B: Seven Sample States - Selected Information 25
C: Medical Directors' Self-reported Functions 26

ACKNOWLEDGMENTS 30

INTRODUCTION

OBJECTIVE

To identify the functions reported by medical directors that are expected of them by nursing homes, their expenditure of time meeting these functions, and their self-reported credential status.

BACKGROUND

The Omnibus Budget Reconciliation Act of 1987 (OBRA 1987)[1] requires all nursing homes, called "facilities," while participating in the Medicare and Medicaid programs to meet a common set of certification standards, to assess the needs of patients, and to help those patients maintain and achieve their highest practical level of physical, mental, and psychosocial well-being. The OBRA 1987 and subsequent policies require that all Medicare and Medicaid certified nursing homes retain a physician as medical director. These medical directors are required by the Code of Federal Regulations, Title 42 §483.75(i)(2), to be responsible for *the implementation of resident-care policies and coordination of medical care services in the facility.* This and other regulations (see Appendix A) suggest, but do not actually specify, that medical directors should be utilized in the direct management and identification of potential quality improvement problems and plans, and to ensure implementation of existing law and regulations.

The Centers for Medicare & Medicaid Services (CMS) has ultimate responsibility for ensuring that OBRA 1987 requirements are implemented by states and nursing homes. The nursing home (facility) has the principal responsibility, assigned by most regulations, to implement or ensure implementation of those same reforms for the patients in their care. Yet, regulations provide no clear indication of which specific individual(s) in the nursing home will perform or ensure that patients receive the necessary care. Possible individuals include:

- *The medical director*, whose role is largely undefined by CMS, except in the broadest sense of resident care and clinical policies and coordination of medical care (see details on page 2). [2] Additionally, while the medical director is required to be a physician,[3] there is no regulation specifying that the physician should be licensed to practice;
- *The attending physician*, who certifies a patient's need for nursing home care and routinely provides the clinical response to a patient's needs and addresses patient concerns identified by nursing staff [4];
- *The nursing staff*, including the director of nursing, who have no direct regulatory requirements, except as their performance relates to their involvement in clinical care; and

- *The administrator*, hired by or is the owner of the facility, generally has little, if any medical background; expected to oversee all administrative and management activities associated with patient care and safety within the nursing home.

While the survey process requirements have many sections relating to functions, which appear to be specific to physicians' performance (see Appendix A), the CMS State Operations Manual (SOM), and the CMS *Interpretive Guidelines* (SOM, Appendix PP) explicitly address three areas for the role of the medical director:

1) Drug regimen review[5] "encourages facilities to share pharmacists' drug reviews with the medical director";
2) Medical director[6] states that medical directors, who are retained by the facility, must
   - *implement **resident care** policies regarding* admissions, transfers and discharges; attending physician privileges and practices; responsibilities of non-physician healthcare workers; 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[7];
   - *ensure establishment and implementation of all resident **clinical care** policies and assurance that the nursing home is providing required appropriate care* by monitoring and implementing policies for care, oversight, and supervision related to overseeing the overall adequacy of clinical care of patients; and
   - *coordinate **medical care** in the facility.*
3) Quality assessment and assurance[8] notes that the medical director may be designated by the nursing facility to serve as the required physician on the quality assurance committee.

No regulatory guidance exists on how medical directors are to accomplish these charges, nor is there any specific requirement for a medical director's direct, ongoing clinical interaction, or any related quality-specific activities, with patients or nursing home staff. The CMS and the General Accounting Office have each raised serious concerns for patients' care and well-being, principally resulting from their studies of nursing home responsibilities, processes, and patient care.[9]

METHODOLOGY

Scope

Given the lack of specificity in the law, regulations, and policy governing functions to be performed by medical directors, this study seeks to describe nursing homes' expectations. The range of possible functions and responsibilities of medical directors was based on the identification of potential roles that medical directors may have in a nursing home, according to the medical directors themselves, nursing home administrators, directors of

nursing, and attending physicians. Functions fell into the following categories: patient services, quality assurance and improvement, residents' rights, administration and management, training and education, and ensuring a safe physical environment.

Finally, because we used a purposive sample, we have not projected our findings to the nation.

Study and Survey Development

We consulted at length with several public and private organizations associated with nursing home care.[10] Each provided their professional perspectives on the inspection issues and methodologies, as well as advice on obtaining sample information about specific types of nursing home staff. In addition, the American Medical Directors Association (AMDA), during their annual training conference for medical director certification, provided our staff with basic training concerning the medical director's role. We also met with medical directors in nursing homes and research experts to gain their perspectives of both the many facets of the medical director's job and our planned methodology for this study.

Sample Selection

States Based on recommendations from knowledgeable parties[11] and research conducted during the study-development phase, we purposively selected California, Maine, New York, Ohio, South Dakota, Tennessee, and Texas as the sample states. Together, these states account for approximately 29 percent of certified nursing homes, 37 percent of Medicaid expenditures for institutional long-term care, and 30 percent of all certified beds (see Appendix B). Further, these seven states illustrate a variety of factors that may impact the role of a nursing home's medical director:

- High numbers of nursing home chains (California, Texas),
- Large nursing home patient populations (California, Ohio, New York, Texas),
- Less populous and more rural states with approximately 13 percent (+/-) Medicare and Medicaid enrollment as a percent of population (Maine, Tennessee),
- Low percentages of Medicare physicians in rural states (South Dakota), and
- States in which less than 75 percent of physicians and other practitioners participate in Medicare Part B (South Dakota).

Nursing Homes For each sample state, the number of nursing homes selected was based on the state's relative proportion of certified nursing home beds to the national number of certified nursing home beds. We believe that this is a more accurate indicator of each state's relative nursing home size than the use of overall state population (see Appendix B). We also limited the number of nursing homes in each sampled state to a maximum of 50 and a minimum of 5. We randomly selected the predetermined number of nursing

homes per state for a total of 205 certified nursing homes -- California (50), Maine (7), New York (45), Ohio (37), South Dakota (5), Tennessee (15), and Texas (46).

Of the 205 sampled nursing homes, we dropped 14 because their survey responses indicated that they had been incorrectly sampled, i.e., the CMS database identified the nursing home as free-standing, but the administrator or medical director reported the nursing home was hospital-based[12] or the facility had closed. As a result, our sample decreased to 191 nursing homes.

Individual Respondents We surveyed each of the sampled 191 nursing homes' medical directors. For about one-fourth of the 191 nursing homes (45 total across 7 States), we also surveyed nursing homes' administrators, directors of nursing, and attending physicians. These three individuals, in each of the sampled nursing homes, were chosen as those most likely to interact directly with the medical director at various points in the process of caring for patients.

Data Collection

Mail Survey and Response Rates Between the summer and winter of 2000, we collected data from respondents through a structured mail survey. Of the possible 326 respondents (191 medical directors and 45 each from administrators, directors of nursing, and attending physicians), a total of 205 respondents (63 percent) returned usable surveys.[13] By respondent type, this included 119 medical directors (62 percent), 31 administrators (69 percent), 33 directors of nursing (73 percent), and 22 attending physicians (49 percent).

We divided the functions performed by responding medical directors into four broad categories: quality improvement, residents' rights, patient services, and administration (which included training and education, as well as physical environment and employee health). Within each category were questions on specific functions that may be part of the medical director's role. For example, under the category "residents' rights" is the specific function "verify patients have a drug regimen free from unnecessary drugs."

For specific functions, we asked respondents for their perceptions about the medical director's role from three perspectives:

1) Expectation of the nursing home (e.g., required by the nursing home) that the function is the medical director's responsibility in that nursing home,[14]
2) Should the function be the responsibility of the medical director, and
3) Authority to the medical director from the nursing home to perform the function.

We also asked respondents about the importance of a medical director's leadership in several key areas and other questions intended to provide supplemental information about the medical director's role and activities.

Data Analysis

Using data from the completed surveys, we performed frequencies, cross-tabulations, and content analysis. Findings presented focus primarily on the responses from the medical directors. Data from the other respondent types, i.e., administrator, attending physician, and director of nursing, were used largely to discern marked differences between them and the responding medical directors and to provide supplemental information from another perspective. Occasionally, we reference possible functions that could be included in the medical director's job, but were chosen less frequently by respondents.

Non-Respondent Analysis

To detect non-respondent bias, we used our data to test for differences between responding and non-responding medical directors. We were limited to comparing characteristics that were available from our file of sampled nursing homes. Since the responses by medical directors were anonymous, we could not test for differences between responding and non-responding medical directors.[15] Factors for which we did test include state characteristics, the type of nursing facility (profit, non-profit, ownership), and the size of the facility (large, medium, small). No significant differences were found for any of these factors. In addition, we followed up with non-respondents by telephone, and the majority of them stated that the primary reason for not responding to the survey was lack of time.

This study was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

SURVEY RESPONSE

Survey responses from 119 nursing home medical directors found that they are expected by their nursing homes, and report they should be expected, to perform many specific functions in four key areas – quality improvement, patient services, residents' rights, and administration. Functions of quality improvement and patient services are most frequently reported by medical directors as expected of them and most strongly seen as important by the medical directors. Examples of quality improvement include reviewing and revising existing medical and clinical policies, and encouraging quality care. Examples of patient services are intervening with attending physicians, when necessary, reviewing consultant pharmacists' reports, and interacting with nurses. Functions associated with residents' rights and administration are reported less often as expected by nursing homes and less often perceived as important. Medical directors report that some functions pertaining to staffing, appropriate patient care, training, and residents' rights are infrequently expected of them by their nursing homes and may or may not be reported as functions which they should perform. Eighty-six percent of medical directors report spending 8 hours or less per week in the facility; 70 percent report spending less than 10 percent of their overall professional practice on their medical director responsibilities. Finally, regulations require medical directors to be physicians; 92 percent report they are currently licensed, and all say they are professionally trained.

Responding Medical Directors Report Many Functions In Four Key Areas They Are Frequently Expected To Perform

According to the responding medical directors, nursing homes expect them to perform many functions falling within four broad categories: 1) quality improvement, 2) patient services, 3) residents' rights, and 4) administration, which includes training. The CMS survey process requirements and their *Interpretive Guidelines* have many sections relating to functions which appear to be specific to physicians performing in these four areas (Appendix A). For this study, medical directors reported those activities that nursing homes most often expect of them and those which medical directors most often report should be their responsibility. In general, medical directors report that they have the authority from the nursing homes to perform many of the functions (see Appendix C).

Quality Improvement

Medical directors see quality improvement activities as important and focus on the broader aspects of quality care

Ninety-seven percent of responding medical directors report that their participation in the nursing home's quality improvement effort is important to their leadership role for establishing and maintaining quality patient care. Quality improvement in a nursing home can be as simple as ensuring conformance to state and federal requirements, or as complex as measuring the degree to which services meet professional standards. In this category, Table 1 shows the activities that medical directors report as expected by nursing homes, most of which the medical directors clearly agree should be their responsibility.

Table 1: Quality Improvement Functions Most Frequently Identified by Medical Directors

Specific and Related Functions	Nursing Homes Expect of Medical Directors	Medical Directors Should Perform
Review and revise existing medical and clinical policies	90%	97%
Encourage quality of care, regardless of patient case mix	88%	92%
Review and analyze quality indicators for potential areas of concern	86%	91%
Quality improvement planning, implementing, and/or follow-up	84%	93%
Development of medical care policies and procedures	81%	92%
Confirm patient's problems identified by unit nurses are adequately addressed	73%	83%
Serve as patients' medical advocate	64%	81%

Source: OIG survey responses from nursing home medical directors

Most specific to medical directors, as specified by both regulation and the CMS *Interpretive Guidelines*, is a charge to implement resident care policies and coordinate medical care in the facility. One of the functions specifically required of medical directors is *reviewing and revising existing medical and clinical policies*. At 90 percent, it is also the function in this category that most responding medical directors reported as expected by the nursing homes. Examples of such medical and clinical policies are procedures for how staff should handle patient accidents or when the use of restraints is appropriate. While not all medical directors report that their nursing homes expect them to review and revise existing medical and clinical policies, 97 percent report that it should be their responsibility. Additionally, 70 percent report that reviewing and revising existing care policies or developing them is important to their leadership role.

Encouraging quality of care, regardless of the patient case mix, is reported by 88 percent of medical directors as expected by the nursing home and by 92 percent as important to their role. This means that overall decisions related to patients' health-care needs should be determined fairly and equally, regardless of the severity of illness and the resultant services. This function is closely followed by others specifically related to general quality improvements. Examples of these other functions include medical directors conducting chart reviews on an ongoing basis, reviewing status reports from staff, conducting patient rounds, and attending quality assurance and improvement meetings monthly.

After the general quality improvement functions, responding medical directors report less often being expected by the nursing homes to perform quality functions that are more centered on the individual patient – *patient's problems identified by unit nurses are adequately addressed* (73 percent) and *serving as the patient's medical advocate* (64 percent). The latter refers to ensuring that the patient's medical care needs are adequately addressed, even if the facility has concerns about the potential cost of such care. However, a mean of 82 percent of medical directors report that these are functions which should be their responsibility.

Eighty-seven percent of medical directors report that they participate on nursing home committees for improving patient care

In addition to the specific quality improvement functions assigned to them, 87 percent of responding medical directors report that they fulfil the facility's expectation to have a physician on the facility's Quality Improvement Committee. These medical directors meet at least quarterly with the committee; 3 percent report never attending. Eighty-five percent of medical directors report their nursing homes have Quality Improvement Committees which generally meet quarterly or more often. Established for ongoing quality improvement, these committees are comprised of different disciplines, which may include the medical director. The committees identify patient care issues which should be addressed and those requiring preventive measures, and they identify possible medical- care policies needing development.

Patient Services

Professional interactions with attending physicians, nursing staff and consultant pharmacists on concerns with patient care are often expected of medical directors by the nursing homes and are viewed as important to patient services

For responding medical directors, patient services present many opportunities for leadership by directly influencing the provision of quality patient care. Given that they are charged by 42 CFR §483.75(i)(2)(ii) to coordinate medical care in the facility, responding medical directors report that application of geriatric principles (96 percent)

and patient care and consultation (92 percent) are important aspects of a medical director's leadership responsibility. In addition, 91 percent of responding medical directors indicate that they have a leadership responsibility to monitor attending physician performance.

In that vein, *intervening with attending physicians about patient care concerns*, at 92 percent, is the most frequently mentioned patient service expected of responding medical directors by the nursing homes; 97 percent of responding medical directors echo its importance by reporting that it should be their responsibility. Further, 68 percent report having nursing home responsibility to monitor for appropriate patient care by attending physicians, and 85 percent report that they should have this responsibility from their nursing homes. Although medical directors and nursing homes do not have direct regulatory responsibility for the performance of attending physicians, medical directors may influence an attending physician's delivery of medical care. Reflecting this potential opportunity, 69 percent of medical directors report they have at least moderate influence upon the quality of medical care provided by attending physicians in their nursing homes; 54 percent of responding attending physicians report that medical directors have at least minor influence on their performance.

Table 2: Patient Services Functions Most Frequently Identified by Medical Directors

Specific and Related Functions	Nursing Homes Expect of Medical Directors	Medical Directors Should Perform
Intervene with attending physician when concerns are raised about his/her patient's care	92%	97%
Review consultant pharmacists' drug regimen reports	90%	93%
Interact with Nurses:		
Provide ongoing medical advice and guidance to nurses	86%	94%
Meet routinely with nurses to discuss patient care issues	78%	88%
Perform attending physician duties	72%	83%
Participate in the planning of patient care by ensuring the appropriateness of services and treatments	69%	83%
Monitor for appropriate patient care by attending physicians	68%	85%

Source: OIG survey responses from nursing home medical directors

Ninety percent of responding medical directors are expected by their nursing homes to *review drug regimen reports*, in their role as medical director. This expectation is in keeping with the *Interpretative Guidelines*, Tag F429, which encourages facilities to share consultant pharmacists' drug reviews with their medical directors. These reviews identify concerns about medications ordered for a patients' diagnoses and possible problems, such as drug interactions or the need for dosage adjustments. Regulations require that drug reviews occur monthly for all patients, and for consultant pharmacists to report any irregularities to the attending physician and the director of nursing.

Regulations do not require any direct involvement between medical directors and consultant pharmacists. However, 65 percent of medical directors report meeting with consultant pharmacists quarterly.

Interacting with nurses on patient care and providing on-going medical advice are also reported by responding medical directors as functions expected of them by the nursing homes. Ninety-seven percent of responding directors of nursing indicate that they routinely have conversations with their medical directors, typically about patient care issues (94 percent) and problem patients (91 percent). Such interactions may provide opportunities for medical directors to influence the quality of patient care throughout the nursing home, such as the need for a change in a patient's medications, or concern that a patient's symptoms are not typical of an identified diagnosis.

Residents' Rights

Sixty to sixty-nine percent of responding medical directors report that ensuring residents' rights, such as appropriate drug regimens, honoring end-of-life decisions, and ensuring treatment choices, is expected of them by the nursing homes

The OBRA 1987 created a bill of rights for nursing home residents,[16] which expands the individual rights they have outside nursing homes, e.g., privacy, religion, and speech, to include activities which may occur in the nursing home. These include such rights as having privacy, receiving appropriate medications, refusing treatment, and being consulted about their own care. Regulations for OBRA 1987 are intended to ensure that nursing home staff and physicians actively recognize the cognitive patient's autonomy and all patients' right to continued dignity.[17]

Ninety-six percent of responding medical directors report that the promotion of residents' rights is an expected leadership role for them. Yet, of the four broad categories of functions that medical directors cited, ensuring residents' rights are reported less often as expected by the nursing homes. Also, the percentage of medical directors concurring that ensuring residents' rights should be their responsibility is slightly higher compared to what is expected of them by the nursing homes (Table 3).

Table 3: Residents' Rights Functions Most Frequently Identified by Medical Directors		
Specific and Related Functions	**Nursing Homes Expect of Medical Directors**	**Medical Directors Should Perform**
Verify appropriateness of a patient's drug regimen, ensure that drugs are:		
-- appropriately prescribed	69%	80%
-- necessary	69%	75%
Ensure patients' end of life decisions are honored	69%	80%
Verify appropriate medical response to drug regimen review concerns	68%	80%
Confirm appropriate restraint usage	65%	77%
Ensure cognitive patients' rights to refuse medications	60%	76%
Support patients' direct involvement in care planning, if mentally able	60%	70%
Source: OIG survey responses from nursing home medical directors		

The right to an *appropriate drug regimen* has become more important over the past several years. Significant research continues to note concern for the numbers of nursing home patients having drug regimens, which included unnecessary and/or inappropriate drugs.[18] One major result has been the requirement that nursing home patients receive a drug regimen review at least once a month by a licensed pharmacist.[19] Through record reviews and interactions with staff, medical directors can confirm and correct *inappropriate restraint of patients* for discipline or convenience,[20] through the use of prescribed medications or physical restraints.

Consultant pharmacists are required by regulation to report concerns to the attending physician and the director of nursing.[21] However, there is no regulation or guidance indicating that the medical director or attending physician should be the one to respond to a consultant pharmacist's concerns or to verify that actions are taken to ensure recommended changes in a patient's drug regimen.[22] Yet, 68 percent of medical directors report that, in their role as medical directors, they are expected by their nursing homes to *verify appropriate medical response to drug regimen review concerns,* and 80 percent agree that they should have this responsibility. Additionally, 74 percent of responding medical directors report that they should have responsibility to develop indicators for physician quality assurance in drug prescribing; 51 percent of medical directors indicate that they currently have this responsibility.

Honoring patients' end of life decisions is as frequently a reported nursing home responsibility of the medical director as is their ensuring a patient's drug regimen. Few decisions are more personally important than when directing what treatments are or are not wanted. Eighty-nine percent of responding medical directors indicate that they

attempt to ensure that facilities have provided patients or their families with specific information about end-of-life issues, including the possibility of hospice care.

Another resident's right discussed directly in nursing home regulations[23] is *having direct involvement in care planning* for themselves and to make independent choices, while able.[24] This right is indirectly suggested by other federal laws established to ensure that patients are informed about this right.[25] Yet again, no regulation clearly indicates which "individual" is responsible. Sixty percent of responding medical directors report that it is expected of them by the nursing home, and 70 percent say that it should be their responsibility.

Administration

The responding medical directors report that their administrative functions include advising on regulatory matters, providing liaison with facility staffs, and promoting employee health

While the regulations are not explicit on the medical director's responsibilities in this category, many responding medical directors indicate three administrative functions as important to their leadership role: expanding knowledge of regulatory, legal, economic, and social factors affecting care (89 percent), participating in education or training for nurses (83 percent), and representing the facility in the community (78 percent).

Responding medical directors also report that they have a role in operational administration beyond their involvement in delivery of care and services to patients (Table 4).

Table 4: Administrative Functions Most Frequently Identified by Medical Directors

Specific and Related Functions	Nursing Homes Expect of Medical Directors	Medical Directors Should Perform
Provide medical expertise for facility when necessary to respond to regulatory agency survey concerns	94%	96%
Serve as liaison between medical staff, nursing staff, and administration	84%	88%
Keep current with regulatory and medical treatment changes	83%	92%
Promote employee health	72%	78%

Source: OIG survey responses from nursing home medical directors

By *providing medical expertise to survey concerns*, medical directors may have a role in helping the facility anticipate and resolve problems that later may be detected by

regulatory agency surveys.[26] Typically, about one-half to two-thirds of responding medical directors participate in specific aspects of the survey process. For example, 45 percent report attending exit interviews between the administrator and surveyors. Further, 47 percent assist in writing correction plans for identified survey deficiencies, while 64 percent report implementing those correction plans. Fifty-two percent of responding medical directors report conducting followup activities to ensure implementation of correction activities.

Acting as a liaison between medical staff, nursing staff, and administration allows medical directors to ensure assimilation of his/her quality care expectations and to ensure that other important quality care issues are addressed timely. *Staying current with regulatory and treatment changes* aids in the identification of new techniques and medications, techniques determined to be potentially detrimental, or improved treatments for certain diagnoses. For example, recent literature indicates that while side rails on patients' beds were once acceptable practices, they are now considered potentially dangerous for strangulation[27] and that thyroid testing may identify a reason for a patient's lack of mental clarity.[28]

Medical Directors Report Some Functions They Are Not Frequently Expected To Perform, Nor Do They Often Report They Should; For Others, They Indicate A More Diverse Opinion

Responses from medical directors showed specific functions within three of the four broad functional categories, i.e., patient services, residents' rights, and administration (includes training and physical environment), that are infrequently expected of them by the nursing homes. For some of these specific functions, medical directors also seldom reported they should perform them. For other functions in the broad categories, the frequency at which they report they should perform them is higher and indicates a diversity of opinion about what their duties should include.

In general, however, as mentioned earlier, the majority of medical directors have indicated they do have an important leadership role related to the general categories of patient services, residents' rights, and administration. Examples are :

- Patient Services – monitoring attending physician performance (91%) and staffing (79%),
- Residents' Rights – the promotion of residents' rights (96%), and
- Administration – participation in education or training for nurses (83%) and expanding knowledge of regulatory, legal, economic, and social factors affecting care (80%)

Infrequently Reported Functions

Table 5 shows some functions reported by medical directors that are both infrequently expected of them by the nursing homes, and infrequently mentioned as those that medical directors should perform. These functions fall predominantly into the broad category of patient services, with specific functions related to staffing and assuring appropriate care. Ensuring adequate lighting, which can protect patients from falls, and food safety under physical environment are also infrequently reported, as is the availability of appropriate admission records under residents' rights.

Table 5: Functions Infrequently Identified by Medical Directors

Specific Functions	Nursing Homes Expect of Medical Directors	Medical Directors Should Perform
Patient Services - Staffing		
Ensure sufficient staffing required to meet all patients' needs	9%	27%
Ensure sufficient nursing coverage for all shifts	3%	13%
Ensure sufficient nurse aide coverage for all shifts	3%	11%
Patient Services - Appropriate Care		
Ensure sufficient, appropriate supplies for each patient's needs	17%	25%
Administration - Physical Environment	12%	22%
Verify facility's sanitary storage, preparation, and service of food		
Confirm facility's adequate and comfortable lighting levels for patients	11%	22%
Residents' Rights		
Ensure at admission availability of patients' prior medical records and advance directives	28%	39%

Source: OIG survey responses from nursing home medical directors

Reported Functions Showing Diversity of Opinion

Table 6 presents some functions reported by medical directors that may be infrequently expected of them by the nursing homes, but are viewed by 40 to 60 percent of them as functions that they should perform in their role as medical directors. Thus, these functions indicate some diversity among medical directors' responses as to which functions they should have responsibility. The functions fall predominantly into the broad categories of patient services, with specific functions related to direct patient care and appropriate care, and administration, with specific functions related to training and the environment.

Patient Services – Direct Patient Care Many responding medical directors are not required either by regulation or their nursing home to provide direct patient care. In fact, 51 percent or less of medical directors reported that nursing homes expected them to be responsible for patient services involving direct patient contact, such as conducting *patient rounds* (51 percent), managing *patients' acute illnesses* (50 percent), and participating in *patient assessments* to identify patients' needs (40 percent). However, for each of these functions, a higher percent of medical directors responded that they should perform these direct care functions.

Table 6: Medical Directors' Responses Indicating Diversity of Opinion

Specific Functions	Nursing Homes Expect of Medical Directors	Medical Directors Should Perform
Patient Services – Direct Care		
Perform patient rounds, which include direct contact with patients	51%	62%
Actively treat or supervise the treatment of patients' acute illnesses	50%	54%
Perform comprehensive patient assessments	40%	48%
Patient Services – Appropriate Care		
Monitor care performed by nurse aides	33%	46%
Develop performance indicators for attending physicians	31%	60%
Lead or chair the development of patient healthcare plans for all patients	27%	47%
Meet routinely with nurse aides to discuss patient care	24%	40%
Administration (Training)		
Teach attending physicians about state and federal regulations	38%	57%
Educate healthcare staff on new policies and procedures	37%	51%
Promote training related to all staffs' functional requirements	36%	45%
Administration (Environment)		
Promote a hazard-free environment	32%	46%

Source: OIG survey responses from nursing home medical directors

Even if medical directors are expected by the nursing home to be responsible for certain patient services, existing nursing home policies and procedures typically do not call for their direct involvement. For example, 98 percent of medical directors report the standard procedure for managing patients' acute illnesses is to directly notify the patient's attending physician first. It appears that typically the primary attending physician is notified and the medical director may be informed. However, if unable to reach the primary physician, the medical director is called for consultation. Also, if an emergency should occur, at the discretion of the nursing staff, the patient is transferred immediately to the emergency room for evaluation. Ninety-three percent of responding administrators report that it is not a facility policy for the nursing staff or

administration staff to consult with the medical director prior to patient transfers. According to 68 percent of the medical directors, the primary deciding factor is whether there are physician's orders for the transfer.

Patient Care - Appropriate Services Forty to 60 percent of responding medical directors report that they should perform functions to ensure appropriate patient care. At the same time, medical directors infrequently report a nursing home's expectation for ensuring appropriate care through monitoring or oversight of staff interacting directly with patients. Examples are developing performance indicators for attending physicians (31 percent), monitoring for appropriate care by nurse aides (33 percent) and meeting routinely with nurse aides to discuss patient care (24%).[29] Leading the development of patient health-care plans for all patients (27%) is also a function infrequently expected of medical directors by the nursing homes.

Administration - Training While 45 to 57 percent of medical directors indicate that they should provide training on various topics to attending physicians or nursing home staff, at 36 percent to 38 percent, they less often report that their nursing homes expect them to provide this training. However, 50 percent of them believe that their administrators encourage them to provide in-service training or education to nursing staff. At the time of our survey, 46 percent of the medical directors report that nurses receive little training beyond that related to negative medication reactions to observe and report. Fewer medical directors report training nurses in important care areas, such as abuse definitions and reporting requirements (20 percent), residents' rights (26 percent), rehabilitation principles and therapies (31 percent), restraints (38 percent), and providing care for patients at the end-of-life (40 percent).

Eighty-Six Percent Of Responding Medical Directors Report Spending 8 Hours Or Less Per Week At The Sampled Facilities

Facility Visits and Hours For each sampled facility, most responding medical directors report that, in their medical director capacity, they devote a portion of their professional time to the facility. Table 7 indicates how often medical directors report visiting the facility and the number of hours they report spending there weekly. For example, 62 percent of responding medical directors visit the facility 1 time per week or less often. Eighty-six percent spend 8 hours or less per week at the sampled facility. The amount of time spent on their nursing home role may allow them to complete work already scheduled and for which they are held directly accountable, such as certain paperwork related to patient care or participation in committees.

Other Professional Obligations Seventy percent of responding medical directors report that less than 10 percent of their overall medical practice is devoted to their medical director role. Many medical directors balance their professional time at the facility with their other medical practice obligations inside or outside the nursing home. For example,

54 percent of medical directors report serving as an attending physician in the same facility where they serve as medical director. As attending physicians, these

Table 7: Time Medical Directors Devote to their Nursing Home Functions	
Activity as Medical Director	**Percent Responding**
How often they visit the facility:	
daily	7%
2 to 3 times weekly	23%
1 time weekly	34%
1 time every 2 weeks	10%
1 time monthly	11%
1 time every 2 months	7%
variable schedule	9%
Number of hours per week they spend in the facility:	
less than 1 to 4 hours	72%
5 to 8 hours	14%
9 to more than 15 hours	14%
Part of their overall medical practice devoted to their medical director role:	
1 to 10 percent	70%
11 to 33 percent	23%
more than 33 percent	7%
Source: OIG survey responses from nursing home medical directors	

medical directors report having an average of 47 patients in the nursing homes where they also serve as medical directors. Eighty-one percent of responding medical directors also report that they maintain a private practice outside the nursing facility, 54 percent report serving as a medical director for another facility, and 53 percent report serving as attending physician at another nursing home. They may also serve as a medical director at facilities other than nursing homes (21 percent) or teach in a college or university (20 percent).

Although not frequently present in the nursing home, medical directors may communicate with nursing staff by telephone

Telephone calls may serve as a primary method of communication between medical directors and nursing staff. Sixty-two percent of responding medical directors, 57 percent of attending physicians, and 82 percent of directors of nursing report not working evenings or weekends. For those times they are not in the facility, policies exist requiring their notification or attempted notification prior to certain medical decisions concerning patients. As a result, the nursing staff and nurse aides must monitor the care of patients during such times, and the nurses are expected to telephone the medical directors, attending physicians, and directors of nursing to notify them regarding necessary medical care. Research supports that much of the medical care delivered in nursing homes occurs as a result of telephone calls, except for the regulatory need for 60-day certification of

medical necessity. These calls serve as a method for managing communication between the staff, the physicians, and the directors of nursing.[30]

Responding Medical Directors Report That They Are Professionally Trained

License To Practice While not required to be licensed, 92 percent of responding medical directors self-report that they are licensed as medical practitioners in their states. Regulations require medical directors to be physicians who will implement care policies and coordinate medical care in the facility.

Medical Training and Experience All medical directors report that they have professional medical training. Consistent with other studies, medical directors report they typically come from a professional background of family practice (44 percent) or internal medicine (47 percent), both considered helpful for their role.[31] Of those who do not primarily specialize in either family practice or internal medicine, the majority of medical directors report receiving medical school residency training in internal medicine (30 percent) or family practice (24 percent). Few responding medical directors report specialization in caring for elderly patients, as such is not provided in most medical schools. However, 22 percent report that they specialized in geriatrics in medical school, 30 percent report having a "certificate of added qualifications" in geriatrics, and 4 percent report completing a geriatric fellowship.

Continuing Education Forty-eight percent of medical directors report that they complete continuing medical education credits yearly relating to geriatrics, gerontology, or long term care, but few indicate hours of clinical training in a long-term care setting or in geriatrics. However, 39 percent of medical directors report having membership in their state-affiliated American Medical Director Association (AMDA), and 25 percent indicate that they are currently certified or have been recertified through AMDA's medical director training program. Two percent of respondents indicate that they are currently working towards certification through AMDA, and 3 percent were formerly certified by AMDA, but report that their certification has lapsed.

SUMMARY

This report identifies the functions for which 119 responding medical directors in 7 purposively-sampled states report as being expected of them by the nursing homes. The responding medical directors also identified those functions for which they report they should have responsibility. Identified functions fall within four categories: quality improvement, patient services, residents' rights, and administration. These functions relate directly to their regulatory responsibility for implementation of resident care policies and coordination of medical services in the facility. The reported functions clearly indicate a physician-related role for them. In fact, while regulations do not specify that medical directors should be licensed to practice, they are required to be physicians.

Beyond the few functions within each of the four categories, for which 80 to 94 percent of the responding medical directors report are expected by the sampled nursing homes (Appendix C), there are many more functions less frequently reported by medical directors. These are functions medical directors report that they are not expected to perform, nor do they report that they should; for others, they indicate a diversity of opinion. Thus, much of what medical directors are expected to do by the nursing homes begins to vary markedly. Responding medical directors (86 percent) also report spending 8 hours or less per week performing the responsibilities expected of them.

The CMS routinely works directly with representatives of the nursing home industry, patient advocacy organizations, and physician-related associations. We believe that CMS will find the presented information useful as it continues to work with them in establishing, clarifying, and enhancing the medical director's role.

ENDNOTES

1. Public Law 100-203 passed by Congress on December 22, 1987.

2. *Interpretative Guidelines*, deficiency Tag F501, 42 CFR §483.75(i)-(ii).

3. 42 CFR §483.75(i)(1).

4. Attending physicians have no routine visit requirement, except as needed for continued certification for Medicare or Medicaid payment. The medical directors themselves appear to agree to some extent on the functions that they indicate are expected of them by the nursing homes and for which they also report believing that they should have responsibility. What constitutes a visit is largely undefined by any policy.

5. *Interpretative Guidelines*, deficiency Tag F429, 42 CFR §483.60, Pharmacy services, and by 42 CFR §483.75(i)(2)(ii) stating that the medical director has responsibility for coordination of medical care.

6. *Interpretative Guidelines*, deficiency Tag F501, 42 CFR §483.75(i)-(ii).

7. *Interpretative Guidelines*, deficiency Tag F501, 42 CFR §483.75(i) guidelines, PP-192.

8. *Interpretative Guidelines*, deficiency Tag F520, 42 CFR §483.75(o).

9. Reports on nursing home issues by GAO include:
   - *Nursing Homes - Many Shortcomings Exist in Efforts to Protect Residents from Abuse* (GAO-02-448T);
   - *Health and Human Services - Status of Achieving Key Outcomes and Addressing Major Management Challenges* (GAO-01-7489);
   - *Long Term Care - Implications of Supreme Court's Olmstead Decision are Still Unfolding* (GAO-01-1167T);
   - *Nursing Workforce - Recruitment and Retention of Nurses and Nurse Aides is a Growing Concern*(GAO-01-750T);
   - *Major Management Challenges and Program Risks* (GAO-01-247);
   - *Nursing Homes - Success of Quality Initiatives Requires Sustained Federal and State Commitment* (GAO/T/HEHS-00-209);
   - *Nursing Homes - Sustained Efforts are Essential to Realize Potential of the Quality Incentives* (GAO/HEHS-00-197);
   - *Nursing Homes - Enhanced HCFA Oversight of State Programs Would Better Ensure Quality Care* (GAO/T/HEHS-00-27);
   - *Nursing Home Care - Enhanced HCFA Oversight of State Programs Would Better Ensure Quality* (GAO/HEHS-00-06); and
   - *Nursing Homes - Proposal to Enhance Oversight of Poorly Performing Homes has Merit* (GAO/HEHS-99-157).

10. These organizations included:
    - the American Medical Directors Association (AMDA), the principal professional organization for medical directors,
    - the American Association of Homes and Services for the Aging (AAHSA) and the American Health Care Association (AHCA), the primary nursing home industry associations,
    - the American Society of Consultant Pharmacists,
    - the National Association of Directors of Nursing Administration in Long Term Care,
    - the National Citizens' Coalition for Nursing Home Reform (NCCNHR),
    - the Gerontological Society of America, and
    - the American Geriatrics Society.

11. Centers for Medicare & Medicaid Studies, AAHSA, AHCA, and NCCNHR each provided input for sample state selection.

12. Medical directors are positioned in many environments, nursing homes being but one. The environment is a specific determinant of how that individual may perform his or her responsibilities. For example, a hospital's medical director may be a physician working full-time for the hospital, allowing more ease of access to his/her services. The hospital-based nursing home may also have more ready access to physicians providing care to their patients in the hospital than the nursing homes may have in the availability of physicians willing to provide care to patients in nursing homes.

13. Initially, received surveys were reviewed to ensure that each was either completely answered or that specific questions were minimally completed (tables beginning each section and questions related to possible barriers). If neither was the case, the survey was considered a non-response.

14. In the survey instruments themselves, the phrase "required by the nursing home" is used to clarify expectations of medical directors. However, in reporting these findings, we will use the phrase "expected by the nursing home." This will more easily allow differentiation between those functions "expected by the nursing home" versus functions "required" by federal regulation.

15. We attempted to match non-responding medical directors with the unique physician identifier number (UPIN) database, which maintains selected information on registered physicians, including their specialties and graduate date from medical school. Our match rate based on the non-responding medical directors was too low for making any valid determinations.

16. 42 CFR §483.25.

17. Residents' rights queried in this inspection included appropriate restraint usage; honoring end-of-life decisions; patients' rights to refuse medications; patients' utilization of kitchen; patients' self-selection of attending physicians; patients' involvement in care planning; patients having drug regimens free from unnecessary and inappropriately prescribed drugs; and existing policy meeting drug withdrawal guidelines.

18. American Society of Consultant Pharmacists.

19. 42 CFR §483.60(c)(1) requires a licensed pharmacist to review each patient's drug regimen at least monthly with more frequent reviews, as necessitated by the patient's condition and drug regimen.

20. 42 CFR §483.25(1)(1), 42 CFR §483.13(a).

21. 42 CFR §483.60(c)(2).

22. *Interpretative Guidelines*, deficiency Tag F430.

23. 42 CFR §483.10(b)(4).

24. 42 CFR §483.10(d)(2)-(3).

25. The Patient Self Determination Act of 1990 requires all institutions receiving either Medicare or Medicaid funding to inform patients of their right to accept or refuse medical treatment through an advance directive. Further, the Balanced Budget Act of 1997 requires that such advance directives be placed in a prominent place within the individual's medical record.

26. Nursing facility performance is monitored through regulatory state and federal surveys, as well as *ad hoc* investigations addressing specific patient concerns, which may occur over time.

27. Food and Drug Administration, Center for Devices and Radiological Health, "FDA Safety Alert: Entrapment Hazards with Hospital Bed Side Rails," August 1995. Available on internet at http://www.fda.gov/cdrh/bedrails.html. Parker, K, Miles SO, "Deaths Caused by Bed rails," *Journal of the American Geriatric Society*, 1997; 45:797-802.

28. Myers, Wayne A., M.D., New Techniques in the Psychotherapy of Older Patients, 1991, and American Psychiatric Association, "Mental Health of the Elderly," Public Information Internet site, Revision June 1992.

29. Nine percent of directors of nursing report that medical directors meet with nurse aides and that such meetings occur quarterly. Fully 70 percent of medical directors and 91 percent of directors of nursing report no meetings between medical directors and nurse aides, except as necessary.

30. W. Fowkes, D. Christenson, D. McKay, "An analysis of the use of the telephone in the management of patients in skilled nursing facilities," *Journal of American Geriatric Society* 1997; 45 (1):67-70. The result of this research is a recommendation that voice mail is a primary tool for managing the communication between nursing staff and physicians.

31. Levinson, Monte J., MD, CMD and Jonathan Musher, MD, CMD, "Current role of the medical director in community-based nursing facilities," *Clinics in Geriatric Medicine* 1995 Aug; 11 (3):343-358.

SUMMARY OF PHYSICIAN-RELATED SURVEY AND CERTIFICATION NURSING HOME REGULATIONS [1]

General Purpose of Regulation[2] Physicians should Ensure for Patients and Facility	Code of Federal Regulations (42 CFR Citation)	Centers for Medicare & Medicaid Services Deficiency Tags	Intent of Regulation for Physicians (Attending or Medical Director)
Resident Rights			Lays the foundation for resident's rights requirements and ensures promotion of the exercise of these rights by patients'.
Right to a Dignified Existence	483.10	150	
Right to be Informed (understandability related to the patient's needs)		154	
Right to Refuse Treatment		155	
Right to be Informed concerning costs, legal rights, and name, speciality, and way of contacting the physician responsible for his/her care		156	
Right to Choose attending physician		163	
Participate in Planning Care and Treatment (and changes)	483.13	280	
Right to Self-Administer Drugs		176	
Right to be Free from Restraints		221, 222	
Right to be Free from Abuse		223	
Staff Treatment of Residents		224	
Resident Assessment and Comprehensive Care Plans, including Review and Frequency	483.20(b)(1)-483.20(b)(2)(i-xiii), 483.20(b)(4)	272-280, 285	Monitor physician participation in assessment and care planning, particularly as related to the state-specified Resident Assessment Instrument, including both the Minimum Data Set and the utilization guidelines with Resident Assessment Protocols. This includes ensuring that the assessment is accurate and reflects the patient's current status, to ensure each assessment is prepared by those qualified to assess care based on knowledge about the patient's status and needs.
Quality of Care	483.25	309-331	Monitor and ensure that patients receive, from the facility, the necessary care and services to attain or maintain their highest practical physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This includes ensuring each patient's activities for daily living do not deteriorate, unless such deterioration was unavoidable. These treatments and services are any provided by employees, contractors, or volunteers, particularly those services related to pain control, use of special communication systems, vision and hearing, pressure sores, urinary incontinence, range of motion, mental and psychosocial functioning, special eating requirements, accidents, nutrition, hydration, any special needs, and unnecessary drugs.

General Purpose of Regulation[2] Physicians should Ensure for Patients and Facility	Code of Federal Regulations (42 CFR Citation)	Centers for Medicare & Medicaid Services Deficiency Tags	Intent of Regulation for Physicians (Attending or Medical Director)
Drug Regimen Review	483.6	428	Ensure that each patient has a review at least monthly by a licenced pharmacist with the understanding that the review may have to occur more frequently, depending on the patient's condition and drugs prescribed.
Infection Control	483.65	441	Ensure that a facility infection-control program effectively investigates, controls, and prevents infections.
Medical Director	Relates to 483.60 483.75 483.75(i) 483.75(i)(2)(i) 483.75(o)	4.29502e+11	Encourages the facility to share pharmacists' drug regimen review reports with the medical director. Implement resident care policies regarding admissions, transfers and discharges, physician privileges and practices, and responsibilities of non-physician health-care workers. Implement resident care policies regarding 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. Ensure establishment and implementation of all resident care policies, and ensure that the nursing home is providing appropriate care as required by monitoring and implementing policies for care, and oversight, supervision as related to overseeing the overall clinical care of patients to ensure adequacy of patient care services. The medical director may be the designated physician serving on this committee.
Clinical Records	483.75(l)	514	Ensure accurate, complete, and organized clinical information concerning each patient and ready access to such information. To ensure safety and confidentiality of patient records.
Quality Assessment and Assurance	483.75(o)	520	Ensure the establishment of quality assurance committees to identify and address quality issues and to implement quality improvement/corrective action plans as necessary.

(1) These regulations, interpretive deficiency tags, and intent of the regulations are excerpted and interpreted for this study as being services for medical directors and attending physicians. Source: CMS' State Operations Manual.

(2) Federally certified nursing homes, including skilled, are required to be in compliance with the requirements set at Title 42, Code of Federal Regulations (CFR) Part 483, Subpart B, to receive payment under the Medicare and Medicaid programs. This certification requires a minimum of a life safety code survey and a standard survey conducted onsite at the facilities by federal or state survey teams.

SEVEN SAMPLE STATES - SELECTED INFORMATION[1, 2]

States	1999 Certified NFs[3] as % of Total Certified NFs	1999 Nursing Home Beds as % of Total State Medicare/ Medicaid Recipients[4]	Certified Beds as % of Total Certified Beds	Av Beds per Nursing Home	Medicare/ Medicaid Recipients in NFs	Medicaid Expenditures Institutional LTC[1]	Medicaid Medical Vendor Expenditures in NFs[1]
CA	1,390 (8.1)	132,962 (59.5)	7.4	96	79,099	$2,530,105,425	$2,097,872,885
ME	125 (0.7)	8,393 (73.7)	0.5	67	6,182	$263,089,445	$181,220,851
NY	659 (3.9)	118,656[5] (81.0)	6.6	180	96,114	$7,377,851,374	$4,906,873,789
OH	1,007 (5.9)	104,817 (59.2)	5.8	104	62,048	$2,065,785,756	$1,569,723,823
SD	114 (0.7)	7,938 (60.1)	0.4	70	4,767	$126,339,319	$97,951,839
TN	352 (2.1)	39,275 (74.9)	2.2	112	29,418	$829,152,516	$619,886,256
TX	1,254 (7.3)	125,904 (56.4)	7.0	100	71,064	$1,852,938,381	$1,270,530,921
State Total	4,901	537,945	29.9	104	348,692	$15,045,262,216	$10,744,060,364
U.S. Total	17,083	1,807,285		106	1,140,996	$40,799,455,374	$29,629,741,643
% U.S. Total	28.70%	29.77%		98%	30.56%	36.88%	36.26%

(1) *Health Care Financing Review, Medicare and Medicaid Statistical Supplement, 1998,* Pub. No. 03409, December 1998.

(2) *Across the States 2000, Profiles of Long Term Care Systems,* Policy Institute, American Association of Retired Persons, Fourth Edition.

(3) Starting in fiscal year 1991, the distinction between intermediate and skilled nursing homes was eliminated; conditions of participation for both were unified with the services being renamed nursing facility (NF) services (e.g., nursing facilities now include both intermediate and skilled nursing homes).

(4) Percentage indicated followed in parentheses by state population in thousands.

(5) New York has no Medicare-only certified nursing homes.

Medical Directors' Self-reported Functions			
FUNCTIONS	**Nursing Home EXPECTS OR REQUIRES of Medical Director**	**Medical Director SHOULD PERFORM**	**Medical Director has AUTHORITY TO PERFORM**
	Percent of medical directors indicating "Yes"		
QUALITY ASSURANCE AND QUALITY IMPROVEMENT			
Review and revise existing medical and clinical policies	90	97	95
Encourage quality of care irrespective of the case mix	88	92	90
Review and analyze quality indicators for potential areas of concern	86	91	90
Quality improvement planning, implementing, and/or follow-up	84	93	88
Development of medical care policies and procedures	81	92	89
Confirm that patient problems identified by unit nurses are adequately addressed	73	83	83
Serve as patients' medical advocate	64	81	78
Monitor for adequate documentation of health care by any provider	60	77	75
Develop indicators for physician quality assurance in drug prescribing	51	74	66
Write and implement patient health maintenance policies	51	70	67
Monitor for appropriate patient care by nurses (RNs, LVNs, LPNs, PNs)	50	68	65
Monitor for appropriate patient care by nurse aides	33	46	47
Balance a patient's needs with financial and administrative constraints of the facility	33	41	42
Develop performance indicators for attending physicians	31	60	57
INDIVIDUAL RESIDENT'S RIGHTS			
Ensure that patients' end-of-life decisions are honored	69	80	79
Verify patients have a drug regimen free from inappropriately prescribed drugs	69	80	75
Verify patients have a drug regimen free from unnecessary drugs	69	75	74
Verify appropriate medical response to drug regimen review concerns	68	80	75
Confirm appropriate restraint usage	65	77	79
Verify existing policy meeting COBRA drug withdrawal guidelines	65	76	74
Ensure cognitive patients' rights to refuse medications	60	76	74
Support patients' direct involvement in care planning, if mentally able	60	70	70

FUNCTIONS	Nursing Home EXPECTS OR REQUIRES of Medical Director	Medical Director SHOULD PERFORM	Medical Director has AUTHORITY TO PERFORM
	Percent of medical directors indicating "Yes"		
Secure opportunity for patients' self-selection of attending physicians	60	64	65
Provide opportunity for patients to utilize the kitchen during evening hours, if able	10	9	12
PATIENT SERVICES			
Intervene with an attending physician when concerns are raised about that physician's patient care	92	97	93
Review reports of consultant pharmacist's drug regimen reviews	90	93	94
Provide ongoing medical advice and guidance to nurses (RNs, LVNs, LPNs, PNs)	86	94	89
Meet routinely with nurses to discuss patient care issues	78	88	84
Perform attending physician duties	72	83	91
Mediate differences or inappropriate conduct between providers	72	86	80
Monitor the availability of attending physician services	72	85	84
Participate in the planning of patient care by ensuring the appropriateness of services and treatments	69	83	78
Monitor for appropriate patient care by attending physicians	68	85	79
Monitor for appropriate consultant pharmacist performance	66	84	74
Monitor the availability of any consultant services	64	74	72
Serve as member of interdisciplinary team and participate in most or all meetings	61	66	78
Interact directly with attending physicians concerning patient care provided by nurse practitioners and physician assistants	61	78	76
Verify qualifications of attending physicians	54	74	62
Ensure appropriate care of patients by nurse practitioners and physician assistants	54	73	65
Perform patient rounds, which include direct contact with patients	51	62	73
Actively treat or supervise treatment of patients' acute illnesses	50	54	74
Monitor patient charts for appropriate attending physician documentation	49	70	63
Interact directly with patients' families concerning patients' care needs	48	55	69
Monitor patient care provided by nurse practitioners and physician assistants	50	67	65
Verify qualifications of any consultants	43	68	54
Perform comprehensive patient assessments	40	48	63
Refer patients for nursing home admission	31	42	57
Ensure that, upon admission, patient's prior medical records and advance directives are available	28	39	46

FUNCTIONS	Nursing Home EXPECTS OR REQUIRES of Medical Director	Medical Director SHOULD PERFORM	Medical Director has AUTHORITY TO PERFORM
	Percent of medical directors indicating "Yes"		
Lead or chair the development of medical interdisciplinary health-care plans for all patients	27	47	47
Meet routinely with nurse aides to discuss patient care issues	24	40	48
Ensure sufficient and appropriate supplies per patient needs	17	25	21
Ensure sufficient staffing as required to meet patients' needs	9	27	10
Ensure sufficient nurse coverage (RNs, LVNs, LPNs, and PNs) per shift	3	13	3
Ensure sufficient nurse aide coverage per shift	3	11	4
ADMINISTRATION AND MANAGEMENT			
Provide medical expertise for facility when necessary to respond to regulatory agency survey concerns	94	96	96
Liaison between medical staff, nursing staff, and administration	84	88	89
Keep current with regulatory and medical treatment changes	83	92	86
Promote employee health	72	78	75
Liaison between patients/their families and the medical staff, nursing staff, and administration	49	62	68
Develop and strengthen community relations	46	52	54
Recruit attending physicians	27	40	42
Participation in facility budget process	7	18	12
TRAINING AND EDUCATION			
Train or coordinate training for nursing staff to provide physicians appropriate and necessary patient medical information	54	68	70
Teach nursing staff, including aides, that certain drugs are inappropriate for elderly patients	53	71	70
Teach attending physicians about state and federal regulations	38	57	56
Educate health-care staff on new policies and procedures	37	51	55
Promote on-going training of medical and non-medical staff related to their functional requirements	36	45	46
Provide training on health-care ethics	34	50	59
Teach nursing staff, including aides, about state and federal regulations	28	38	42
Teach the aging process to direct care staff, other than nursing staff (e.g., social worker, dietitian, etc.)	25	42	51
Provide training to community regarding nursing home services, possible care choices, and patient's rights	22	35	44
ENSURING A SAFE PHYSICAL ENVIRONMENT			
Promote a hazard-free resident environment	32	46	40
Ensure occurrence of emergency evacuation and safety drills	21	26	29
Promote noise control	18	33	28

FUNCTIONS	Nursing Home EXPECTS OR REQUIRES of Medical Director	Medical Director SHOULD PERFORM	Medical Director has AUTHORITY TO PERFORM
	Percent of medical directors indicating "Yes"		
Verify facility's sanitary storage, preparation, and service of food	12	22	26
Confirm facility's adequate and comfortable lighting levels for patients	11	22	25

ACKNOWLEDGMENTS

The OEI Region VI office prepared this report under the direction of Judith V. Tyler, Regional Inspector General. Principal OEI staff included:

Dallas

Leah K. Bostick, *Project Leader*
Marnette Dhooghe, *Program Analyst*
Clark Thomas, *Program Analyst*
Scott Whitaker, *Program Analyst*
Nancy Watts, *Administrative Officer*
Lisa White, *Administrative Officer*

Headquarters

Sandy Khoury, *Program Analyst*

For information or copies of this report, please contact
the Office of Inspector General's
Public Affairs office at (202)619-1343

Reports are also available on the World Wide Web at our home page address:

http://oig.hhs.gov/