AMERICAN MEDICAL DIRECTORS ASSOCIATION
WHITE PAPER
RESOLUTION C-11

SUBJECT: WHITE PAPER ON THE ROLE OF THE MEDICAL DIRECTOR IN QUALITY ASSURANCE AND PROCESS IMPROVEMENT IN LONG-TERM CARE

INTRODUCED BY: BOARD OF DIRECTORS

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Medical directors of nursing facilities/skilled nursing facilities oversee both the implementation of resident care policies and overall coordination of medical care.[1,2] There are federal requirements or F-tags that directly pertain to the role of the medical director and their role in improving quality. These Tags are located in the *State Operations Manual* (SOM) in F-Tag 501, Medical Director and F-Tag 520, Quality Assessment and Assurance.

Medical Director, F-Tag 501, states medical directors are responsible for implementing resident care policies and coordinating medical care in the facility. While regulation requires only that a physician be part of the Quality Assessment and Assurance committee, F-Tag 520, notes that since the medical director is responsible for the implementation of resident care policies and coordination of medical care, the medical director's presence on the committee enhances its function.

Many clinically based *Interpretative Guidelines* associated with various F-tags imply the medical director's oversight and responsibility roles as they pertain to quality assurance and quality improvement, but are not clearly delineated as to extent, methods, or authority. The medical director's broad mandate impacts the quality of life of residents

[1] The federal regulation is 42 CFR §483.75(i), The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies and the coordination of medical care in the facility.

[2] The implementing regulation for 42 CFR §483.75(i) issued by the *Centers for Medicare and Medicaid Services, State Operations Manual* is F-Tag 501: " 'Resident care policies' include admissions, transfers, and discharges; infection control; use of restraints; physician privileges and practices; and responsibilities of nonphysician health care workers, (e.g., nursing, rehabilitation therapies, and dietary services in resident care, emergency care, and resident assessment and care planning). The medical director is also responsible for policies related to accidents and incidents; ancillary services such as laboratory, radiology, and pharmacy; use of medications; use and release of clinical information; and overall quality of care. The medical director is responsible for ensuring that these care policies are implemented. The medical director's "coordination role" means that the medical director is responsible for assuring that the facility is providing appropriate care as required. This involves monitoring and ensuring implementation of resident care policies and providing oversight and supervision of physician services and the medical care of residents. When the medical director identifies or receives a report of possible inadequate medical care, including drug irregularities, he or she is responsible for evaluating the situation and taking appropriate steps to try to correct the problem. This may include any necessary consultation with the resident and his or her physician concerning care and treatment. The medical director's coordination role also includes assuring the support of essential medical consultants as needed."

in all areas affected by medical care. Within this mandate, the provision of quality medical care in a resident-centered environment includes the optimizing of the most practicable level of resident functioning, addressing nutritional needs, and maintaining dignity of the residents. All resident care policies aimed at providing medical care fall into this purview consistent with federal regulations. The role of the medical director in promoting quality in the long-term care facility will be the focus of this white paper.

Background

The AMDA—Dedicated to Long Term Care Medicine (AMDA) which has encouraged the Centers for Medicare & Medicaid Services (CMS) Survey and Certification Group to include explicit language within the *SOM* to reflect a stronger leadership role for the medical director, also has long advocated that medical directors should provide a leadership role in setting the standard of appropriate care practices to improve the quality of care within nursing facilities.

Surveyor guidance on quality assessment and assurance states that a facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least three other members of the facility's staff. The medical director may be the designated physician who serves on this committee pursuant to 42 CFR 483.75(o)(l)(ii).

The quality assessment and assurance committee is to meet at least quarterly to identify issues with respect to quality assessment and assurance activities in the facility and is responsible for identifying issues that necessitate the action of the committee. In addition, the committee develops and implements plans of action to correct identified quality deficiencies.

AMDA's House of Delegates (HOD) has advocated that medical directors should play a key role in developing and implementing resident care policies, as noted in the 2006 HOD Resolution A06: Role and Responsibilities of the Medical Director in the Nursing Home. Collaborating with the director of nursing, the administrator, and other health professionals, medical directors should assist in developing formal patient care policies on quality of care that:

- Helps the facility establish systems and methods that review and provide appropriate feedback on the quality of clinical care and other health-related services;
- Participates in the facility's quality improvement process; and
- Helps the facility provide a safe and caring environment.

In order to accomplish the development, implementation, and monitoring of effective care practices, medical directors must engage the cooperation of the attending physicians

and midlevel practitioners. The 2001 Institute of Medicine report, *Improving the Quality of Long-Term Care*, agrees stating:

"Although medical directors are accountable for the quality of care in nursing facilities, they generally have little authority within facilities (e.g., in terms of hiring and firing staff and in setting administrative policies) and little authority over attending physicians…. One approach to improving the quality of nursing home care would be for facilities to vest greater authority and responsibility in medical directors for medical care services and require attending physicians and nurse practitioners to follow facility medical policies and procedures."[3]

AMDA's HOD Resolution A06 mirrors this sentiment by stating that medical directors should:

- Ensure that patients have appropriate physician coverage and access to physician and other health care practitioner services;
- Help the facility to develop a credentialing process for physicians and other health care practitioners;
- Provide guidance as to specific expectations for performance of physicians and other health care practitioners;
- Help the facility ensure that a system is in place for monitoring the performance of health care practitioners; and
- Facilitate feedback to all practitioners on performance and practices.

Aside from federal regulations and AMDA policy, the Patient Protection and Affordable Care Act of 2010 (PPACA) has a continued focus on quality assurance and process improvement. Section 6102 of the law calls for the establishment of standards relating to quality assurance and process improvement in nursing and skilled nursing facilities. The Act calls for the provision of technical assistance and best practices to assist facilities in meeting the standards. In 2010, a CMS Technical Expert Panel invited AMDA to assist with the development of the technical assistance and best practices. AMDA hopes that our work on the panel, as well as this paper will contribute to medical directors' involvement in the quality improvement process.

Coordination of Care

Overall coordination of medical care requires the involvement of the medical director in both formal and informal activities in the long-term care setting. While the federal guidelines only require that a physician serve on required committees, the medical director should fill this role. Formal activities for quality evaluations include committee participation.

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

Specifically, the medical director should be a part of the Quality Assurance, Infection Control, and Pharmacy Committees. AMDA's *Synopsis of Federal Regulations in the Nursing Facility: Implications for the Attending Physician and Medical Director*[4] recommends that the medical director establish a relevant medical quality assurance program and help the facility implement an appropriate facility-wide quality assurance program that covers clinical and operational issues. It further recommends that the medical director identify appropriate areas for review and data for collection; review and analyze this information; help develop useful care quality indicators; guide the facility's development and implementation of resident care policies and coordination of medical care; make recommendations to the administrator and director of nursing to help improve care and operational issues; and participate in problem-solving efforts.

Additionally, to promote medical staff cooperation with assuring quality care in the long-term care facility, the medical director should provide feedback to physicians on their performance. The medical director should give the practitioners pertinent information that includes information from evidence-based literature in medicine, geriatrics and long-term care medicine.

The role of the medical director may be further expanded through informal activities. For example, the medical director may review incident reports related to patient care and/or may focus on specific areas such as nutrition and hydration, functional decline, and falls, by establishing separate committee meetings to review these specific issues. The medical director also may participate in the education of families, attending physicians, and facility staff.

The medical director should maintain regular communication with attending physicians through written or verbal communications. Regular meetings with facility administration may further improve communications among those responsible for overall quality in a long-term care facility.

Oversight and Review

AMDA's position B07 on Performance Review[5] states that medical directors should provide guidance in the development and implementation of policies on oversight and review of attending physician services, including those situations when the medical director is the attending physician. Such performance reviews would be conducted under the auspices of the quality assessment and assurance process. These performance reviews may include physician behaviors in the facility, such as evaluation of visitation practices assuring not only timeliness, but physician responsiveness to changes in resident conditions. This requires open communications with facility staff.

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[4] American Medical Directors Association. 2010. AMDA's *Synopsis of Federal Regulations in the Nursing Facility: Implications for the Attending Physician and Medical Director.* Columbia, MD.

[5] American Medical Directors Association. 2007. Position B07: Performance Review. Available at http://www.amda.com/governance/resolutions/b07.cfm. Last accessed December 8, 2010.

Quality Assurance Committee

A facility is required by the Omnibus Reconciliation Act (OBRA) of 1987's nursing home reform provisions to have at least a quarterly meeting to address the facility's quality assurance activities.[6] When possible, the medical director should take the leadership role on this committee in order to enhance his/her awareness of issues of quality and general trends in resident care within the facility. Quality assurance activities and team participation vary from facility to facility. Some programs are structured and proactive; others have less structure and may function only reactively to facility issues.

The role of the medical director on the Quality Assurance Committee begins with awareness of the current quality assurance program within the facility. Issues to consider include: (1) the structure and process of the facility's program, (2) the role of interdisciplinary team participants, and (3) how issues are identified, addressed, and monitored. Medical directors can act as technical experts or as leaders of the quality assurance process, and as such should participate in the development of appropriate monitoring systems to detect potential problems and address the findings.

The development of monitoring systems can utilize available tools through AMDA, local Quality Improvement Organizations and those developed internally by the facility or its corporate entity. Common methods for addressing quality assessment include the use of "dashboards". Dashboards provide an overview of where the facility is performing at a given point in time. These may be clinical issues such as falls and incidence of acquired pressure ulcers or may be administrative such as nurse turnover or occupancy. Other tools that are available assist the facility with identifying potential quality of care issues and potential interventions. In this case, a root cause analysis may be needed with subsequent use of the PDSA (plan-do-study-act) methodology to develop an intervention to improve the process and then remeasure. The medical director active in the quality assurance and process improvement process assists the facility to analyze data and interpret results.

The Minimum Data Set as a Tool for Assessing Quality

Since the first published Institute of Medicine (IOM) study in 1986, quality of care in nursing homes has had a federal regulatory focus. The 1986 IOM study entitled *Improving the Quality of Care in Nursing Homes*[7] spawned Omnibus Budget Reconciliation Act (OBRA) '87, which reformed nursing home regulations. In July 1995, the OBRA enforcement regulations became effective and with this changes to the long-term care industry all with a focus on improving quality of life and care. Included in these regulations were provisions for oversight of clinical care by a designated physician, appointed to serve as the facility medical director. Other provisions included definitions of residents' rights including the right to be free from chemical and physical restraints and the requirement for a standardized assessment tool for monitoring outcomes of care processes in the nursing home. Subsequent studies have shown that these regulations

[6] See 42 CFR 483.75(o), F-Tag 520.

[7] Institute of Medicine, *Improving the Quality of Care in Nursing Homes*. (Washington, D.C.: National Academy Press, 1986. Available at http://www.iom.edu/Reports/1986/Improving-the-Quality-of-Care-in-Nursing-Homes.aspx. Last accessed December 7, 2010.

have been effective in making improvements in care, but issues relating to quality remain.

The OBRA regulations called for a standardized assessment tool for monitoring residents in nursing facilities. The purpose was to follow outcomes and to provide guidance to providers for resident assessment and early intervention to improve individual outcomes. As of October 1, 2010, the resident assessment instrument is in three parts: the Minimum Data Set (MDS), the Care Area Assessments (CAA), and the care plan.

The MDS has evolved to become a valuable collecting tool for data. Information gathered from the MDS is now used for Medicare and Medicaid reimbursement, as indicators for quality and for research on the elderly and long-term care.

Knowledge regarding the MDS is important for the medical director of each facility as data driving facility quality measures and indicators are derived from this tool. A medical director should be familiar with the facility process of gathering MDS data and reviewing the quality indicators/quality measures at least quarterly as a part of ongoing quality assurance activities.

Quality Indicator Survey: Using Data to Assess Quality

The Quality Indicator Survey process became another powerful tool for enforcement of standards and improvements in long-term care quality. The survey process is not perfect, but changes in the system are ongoing. In the fall of 2005, Quality Indicator Survey process was started in an effort to standardize how the survey process measures nursing facility compliance with federal standards. CMS describes the QIS as a process that "uses an automated process that guides surveyors through a structured investigation intended to allow surveyors to systematically and objectively review all regulatory areas and subsequently focus on selected areas for further review."[8]

This revised survey process is more data driven then the traditional survey process. The data is derived from the facility residents' MDS. There are internal quality indicators that are calculated by the QIS program that evaluate quality of life and quality of care. The QIS survey process is being introduced to 3-to-4 states each year.

Quality Indicators

The traditional survey process still is being used in many states. This process is dependent on the SOM. In July 1999, CMS revised the SOM to include a new format for the evaluation of long-term care performance. The revisions included utilization of a set of 24 indicators developed by the Center for Health Services Research in Wisconsin (CHSR). The indicators are derived from the MDS and are specific for each nursing facility. These indicators allow the survey team and individual facilities to review facility

[8] See Centers for Medicare & Medicaid Services, *Evaluation of the Quality Indicator Survey (QIS) Contract #500-00-0032, TO#7, Final Report (December 2007).* Available at https://www.cms.gov/CertificationandComplianc/Downloads/QISExecSummary.pdf. Last accessed December 7, 2010.

data and performance on these indicators and then compare an individual facility's performance with other facilities in the state.

Soon after the indicators were in place, CMS launched the Nursing Home Quality Initiative (NHQI). As part of the initiative, 11 quality measures were introduced for public reporting. These measures are derived from facility MDS data. The purpose behind the NHQI is to drive quality upwards by introducing consumer awareness and competition for consumer dollars among facilities.

CMS' NHQI data is available for both the survey process and to consumers of long-term care services through CMS' Five-Star Rating System. The quality measures are weighted along with nursing staffing patterns and facility health department surveys over the past five years. A facility is then assigned a star rating with five stars considered excellent; four stars above average; and three stars average. Facilities involved in the rating are compared with facilities within the individual states.

Concluding Remarks

AMDA has risen to be the voice of the medical director of long-term care services. Through a standardized educational curriculum and certification process for long-term care medical directors, AMDA has sought to improve long-term care quality. AMDA devotes significant time within its core curriculum training toward education regarding formal quality assurance activities. AMDA also continues to develop tools, guidelines, and position papers to assist its membership with improving and maintaining quality in long-term care facilities.

Medical directors have an essential role in promoting quality and performance improvement within a long-term care facility. As the technical expert or leader in the formal program of quality assurance a facility medical director has the opportunity to emphasize the importance of the overall process. Independent of the regulatory requirement staff education and buy in for quality assurance is fundamental towards improving and maintaining quality of care in the long-term care facility. A committed medical director can have a significant positive impact on facility culture and sense of staff professionalism, which in turn directly influences the quality of all services provided to the residents and families.

Positions and Recommendations

1. AMDA policy on the *Role and Responsibilities of the Medical Director in the Nursing Home* states that the medical directors should assist in developing formal patient care policies on quality of care that:

    - Help the facility establish systems and methods for reviewing the quality and appropriateness of clinical care and other health-related services and provide appropriate feedback;

- Participate in the facility's quality improvement process; and
- Help the facility provide a safe and caring environment.

Reaffirms Policy A06.

2. AMDA policy on Performance Review supports performance review conducted under the auspices of the Quality Assessment & Assurance process for all attending physicians caring for residents in long-term care facilities, including performance review of the medical director when the medical director is also serving as attending physician.
   Reaffirms Policy B07.

3. AMDA policy on Performance Review states that medical directors should provide guidance in the development and implementation of policies on oversight and review of attending physician services, including those situations when the medical director is the attending physician.
   Reaffirms Policy B07.

4. AMDA recommends that the medical director should be a part of the Quality Assurance, Infection Control, and Pharmacy Committees.
   New Policy.

5. AMDA recommends that medical directors be familiar with the facility process of gathering MDS (minimum data set) data and reviewing the quality indicators/quality measures at least quarterly as a part of ongoing quality assurance activities.
   New Policy.