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Role of Medical Director

Regulations – appears 134 times in the State Operations Manual ("SOM")

- Advise nursing home (F841)
  - Surveys
  - Care plans
  - Treatment plans
  - Transfers/discharges
  - Alternate attending physician
  - Quality Assurance
  - Emergency care
  - Pharmacy services (F755 and 756)
  - End of life – capacity and DNR

F841 – Medical Director

Medical Director is responsible for implementation of resident care policies and coordination of medical care in the facility.

- Medical director" means a physician who oversees the medical care and other designated care and services in a health care organization or facility.
- Under the regulations, the medical director is responsible for coordinating medical care and helping to implement and evaluate resident care policies that reflect current professional standards of practice.
- Facilities and medical directors have flexibility on how all the duties will be performed. However, the facility must ensure all responsibilities of the medical director are effectively performed, regardless of how the task is accomplished or the technology used, to ensure residents attain or maintain their highest practicable physical, mental, and psychosocial well-being

Medical Director

Responsibilities of Medical Director

- Recommending, developing and approving policies related to resident care
- Participate in the QA committee and address issues identified in QA process
- Organize and coordinate physician services provided by other professionals providing resident care
- Ensure quality care/performance of other practitioners
- Assist in development of educational programs
- Infection Control oversight
- Establishing policies related to resident rights
- End of life care

Medical Director

- What does your contract say?
- Keeping up with your functions as medical director (time allocation)
- Telehealth
- Signing orders
  - Medicaid audits

Attending physician

Choice of Attending physician

F555: A resident has the right to choose his or her attending physician (42 CFR 493.10(d))

- Attending physician: "the primary physician who is responsible for managing the resident's medical care. This does not include other physicians whom the resident may see periodically, such as specialists."
- If the physician chosen by the resident refuses to or does not meet requirements, the facility may seek alternate physician participation.
- "The right to choose a personal physician does not mean that a resident is required to do so. It also does not mean that the physician the resident chose is obligated to provide service to the resident."

Attending Physician/Alternate physician

If a resident or his or her representative declines to designate a personal physician or if a physician of the resident's choosing fails to fulfill their responsibilities, facility staff may choose another physician after informing the resident or the resident's representative.

Before consulting an alternate physician, the medical director must have a discussion with the attending physician. Only after a failed attempt to work with the attending physician or mediate differences may facility staff request an alternate physician.

Attending physician/Medical director

If the medical director is also an attending physician, there should be a process to ensure there are no concerns with the individual's performance as a physician (i.e., otherwise, the medical director is monitoring his/her own performance).

Attending physician

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Abuse – Strict Liability Standard

F600- The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

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Abuse – Strict Liability

"Abuse," is defined at §483.5 as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology."

"Neglect," as defined at §483.5, means "the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress."

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Abuse Strict Liability

"Willful," as defined at §483.5 and as used in the definition of "abuse," "means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm."

The word "willful" means that the individual's action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm. An example of a deliberate ("willful") action would be a cognitively impaired resident who strikes out at a resident within his/her reach, as opposed to a resident with a neurological disease who has involuntary movements (e.g., muscle spasms, twitching, jerking, writhing movements) and his/her body movements impact a resident who is nearby.

Abuse – Strict Liability

"Sexual abuse" is non-consensual sexual contact of any type with a resident…"

- Unwanted intimate touching of any kind especially of breasts or perineal area;
- All types of sexual assault or battery, such as rape, sodomy, and coerced nudity;
- Forced observation of masturbation and/or pornography; and
- Taking sexually explicit photographs and/or audio/video recordings of a resident(s) and maintaining and/or distributing them (e.g. posting on social media).

Capacity to consent – role as medical director in assisting facility in determining ability to consent to activity

Abuse – Strict Liability

Determination of Findings and Potential to Foresee Abuse

It has been reported that some facilities have identified that they are in compliance with F600- Free from Abuse and Neglect because that they could not foresee that abuse would occur and they have "done everything to prevent abuse," such as conducted screening of potential employees, assessed residents for behavioral symptoms, monitored visitors, provided training on abuse prevention, suspended or terminated employment of the perpetrator, developed and implemented policies and procedures to prohibit abuse, and met reporting requirements. However, this interpretation would not be consistent with the regulation, which states that "the resident has the right to be free from verbal, sexual, physical, and mental abuse…" Therefore, if the survey team has investigated and collected evidence that abuse has occurred, it is appropriate for the survey team to cite the current or past noncompliance at F600-Free from Abuse and Neglect.

Abuse – Strict Liability

F600 and F602

- Policy in developed and implemented
- Properly screened employee
- Training provided to employee
- Employee takes action in violation of policy
- Employee suspended/terminated
- Retraining occurs

STILL FINDING DEFICIENT PRACTICE

End of Life Care

DNR Orders – F678

Facilities should have procedures in place to document a resident's choices regarding issues like CPR. Physician orders to support these choices should be obtained as soon as possible after admission, or a change in resident preference or condition, to facilitate staff in honoring resident choices. Facility policy should also address how resident preferences and physician orders related to CPR and other advance directive issues are communicated throughout the facility so that staff know immediately what action to take or not take when an emergency arises. Resident wishes expressed through a resident representative, as defined at §483.5, must also be honored, although, again physician orders should be obtained as soon as possible.

Bio Slide

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Angie is a Partner in Burr & Forman's Health Care Practice Group where she devotes her practice to advising and defending health care providers in regulatory proceedings and medical malpractice and false claims litigation. She has successfully defended numerous clients in jury trials and arbitration and has been involved in successful appeals to the Alabama Supreme Court.

In addition to health care litigation and administrative proceedings, Angie also assists health care providers with navigating federal and state laws directly impacting the health care industry, including the federal Requirements of Participation, Health Insurance Portability and Accountability Act ("HIPAA"), the state of Alabama's certificate of need laws, and Medicare and Medicaid regulations. Her primary focus is on long term care providing regulatory guidance as outside counsel to several nursing home providers as well as the Alabama Nursing Home Association.

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