CMS Issues New Guidance on Medical Director's Role

The following article from the Centers for Medicare and Medicaid Services addresses tag F501 and the medical director.

The Centers for Medicare and Medicaid Services (CMS) on Nov. 18, 2005, implemented revised surveyor guidance on the role of the medical director in long-term facilities. This guidance provides surveyors and providers with a clearer interpretation of the medical director regulation found in 42 C.F.R. §483.75 (i).

The ultimate goal of developing revised guidance (located at tag F501 in the surveyor's guidelines) is to educate surveyors and facilities as to the important role of medical directors in the effective administration of long-term care facilities.

In 2001, a report from the Institute of Medicine recommended that facilities give medical directors greater authority over attending physicians and hold them more accountable for medical care. A subsequent 2003 study from the Office of Inspector General (OIG) indicated many medical directors were not clear as to who ultimately was responsible for ensuring that residents receive necessary care.

In response to those concerns, CMS convened a panel of experts that included medical directors, a nursing home administrator, several stakeholder groups, and surveyors from the state and CMS regional levels to provide current information about the role of the medical director. This information contributed to the development of this new guidance and the accompanying investigative protocol. CMS also developed guidance for tag F501, which explains when surveyors are to select various levels of severity for deficiencies.

CMS is committed to promoting consistent interpretations of F501 guidance among surveyors of long-term care facilities. Thus, a national training program was developed and distributed to all surveyors of long-term care facilities. That program also was made available in a Nov. 14, 2005 Survey and Certification letter, available at http://new.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp. (Scroll to Revised Nursing Home Medical Director Tag and Accompanying Training Materials, dated 11/14/2005.)

CMS believes the medical director has an important leadership role as promulgated by regulation 42 C.F.R. §483.75 (i).

That regulation states that the facility must designate a physician to serve as medical director. It also specifies that the medical director is responsible for implementation of resident care policies, as well as the coordination of medical care in the facility.

The CMS guidance on the role of the medical director reflects the roles and responsibilities of a medical director as prescribed in the regulation. While CMS requires that the medical director have input and guide the development and implementation of resident care policies, medical directors are not required to single-handedly put the policies into practice or monitor implementation.

However, it is the responsibility of the facility to be able to provide evidence of the medical director's input in the review of policies and procedures, and to ensure that policies and procedures reflect the current standard of practice (e.g., geriatrics approaches applicable to caring for the elderly resident).

The other critical role of the medical director is the coordination of medical care. Coordinating medical care includes organizing, directing, and managing care from appropriate health care providers to meet the health care and psychosocial needs of residents. The medical director is an important liaison among the facility, attending physicians and other providers, and promotes a common understanding of the "big picture" for individual residents.

CMS recognizes that resident outcomes may not be optimal despite appropriate medical director interventions and facility practices. It also understands that while some medical directors may fulfill their roles appropriately, some facilities may not involve the medical director as appropriate and/or that some medical directors may not be fulfilling their roles.

During the survey process, surveyors may interview the medical director regarding the care of specific residents, the coordination of various aspects of their medical care and about facility policies related to standards of practice. The medical director may also choose to attend the exit conference at the conclusion of the survey.

CMS considers AMDA and its state chapters a key resource to help facilities strengthen the medical director's role, optimize physician performance and facility practices, and assure the highest practicable well-being of the long term care resident. Medical directors and AMDA state chapters should refer their questions regarding this important guidance to the AMDA national office.

AMDA Responds

The CMS statement clarifies the role of the medical director, and it does not confer additional tasks or liabilities.

BY LORRAINE TARNOVE

AMDA members certainly validate the opinion that it is hard to get physicians to agree about anything. Almost every issue, policy or otherwise, has inspired a dichotomous response from the AMDA membership. The revision of the tag F501 is no exception.

More than 20 years ago, at my first AMDA state meeting in New York, the opening presenter spoke passionately about the dilemma of the medical director's position—responsibility without authority. I understood little that day, but the role of the medical director and the need for authority came across strongly and resonated with the audience.

At subsequent AMDA meetings and in my work with volunteers and CMS (then HCFA), through the changes spurred by the Nursing Home Reform Act contained in OBRA '87 and the ensuing reports from the Government Accountability Office and the Office of the Inspector General, the essential issue of the long-term care medical director's misunderstood role and lack of authority endured and prevented full recognition and acceptance of the entire profession.

Over the past 2 decades, AMDA leaders have discussed this basic rate-limiting issue in every policy venue with every possible stakeholder.

Finally, the clarion call for a clear definition and appropriate authority has been answered. Medical direction has come so far as a result of AMDA's definition of the role and responsibilities of the medical director, education through its core curriculum, and certification with the establishment of the American Medical Directors Certification Program (AMDCP).

Yet, as the revised guidance began to take shape, AMDA members had two very different reactions. Some embraced the long-awaited completion of the work to define medical direction. Others feared more would be expected and that more risk would come with these expectations. One member chided me that AMDA should be careful what we wished for and described a fearful scenario with increased legal activity and friction with the facility administration.

During my tenure, I have written continuously on the need to define medical direction as have AMDA members Dr. Steven A. Levenson and Dr. Charles A. Crecelius. We have emphasized that the revision does not expand the medical director's role and does not confer any additional responsibility or liability. The revision does confer the long-awaited authority but clarifies that responsibility ultimately rests with the nursing facility.

Physicians react to change in two ways: Either they turn to AMDA, educating themselves and redoubling their efforts and commitment, or they overreact, ... based on old information.
—Ms. Tarnove

To quote the above article provided by CMS, "medical directors are not required to single-handedly put policies in practice or to monitor their implementation."

The history of physician involvement in long-term care has been characterized by its own enduring dichotomy. As a result, a small cadre of dedicated physicians takes care of the majority of nursing facility patients, providing 40% of nursing facility visits.

Every time change threatens or occurs, physicians react in one of two ways: Either they turn to AMDA, educating themselves and redoubling their efforts and commitment, or they overreact, jumping to conclusions based on old information, and do a minimal job in their nursing facility practice or leave long-term care.

Medical directors who continue to abdicate their role in nursing facilities leave the care of the most frail and complex to physician extenders or to other physicians who are not fully engaged.

AMDA's commitment to counteract this behavior parallels my own presence as executive director. So I can witness that staff and leadership interact daily with government and other long-term care and medical groups assuring them that primary care physicians and geriatricians are ready and able to provide—no, to improve—care in this setting, to take a leadership role with physicians and other staff, and to guide patients and families.

This is my mission, my belief, my mantra. I try not to let myself get discouraged when physicians have that all too familiar retro reaction and fall back into the spiral of negativity.

The article from CMS that appears at the top of this page resolves long-standing issues. It clarifies the role of the medical director but does not confer additional tasks or liabilities. The article does answer the question of authority, and it emphasizes the need for medical directors to hold the attending staff accountable.

Physicians need to respond with a positive approach. As I have written before, educate yourself about the revision. Meet with your administrator, and review your contract using AMDA tools. Show your value to the nursing facility: Submit quarterly medical director reports and attend the survey exit interview.

This truly is an opportunity for physicians who work in nursing facilities, and we all know more and more primary care physicians will be doing so as the population ages.

Solutions to core issues of professional liability problems, access to insurance, and fair compensation will not be found in fearful reactions.

Resist becoming a "nattering nabob of negativity." Here comes the year of the medical director. Be a part of it.

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