F-tag 501 Medical Director: Where Are We Now?

Charles Crecelius, MD, PhD, FACP, CMD

It has been almost 4 years since the revised F-tag 501 medical director was released by the Centers for Medicare and Medicaid Services (CMS). There was much consternation at that time regarding the impact it would have on the future of long-term care and medical director–facility relationship. Much has been written on what the medical director should be doing given the new regulations. The question remains, is it being done, and does anybody know if it is?

The mandatory presence of a medical director in nursing facilities came about in the 1980s, after the congressional-commissioned Institute of Medicine report detailed the need for widespread reform of nursing home regulations. Most of these were incorporated into the Omnibus Budget Reconciliation Act of 1987 (OBRA-87), including Tag F501, Medical Director. The regulation itself, CFR 483.75(i), notes the medical director was responsible only for the implementation of medical care policies and the coordination of medical care in the facility, without much further elaboration under the original guidance to surveyors or investigative protocols. Words in such documents such as “appropriate care,” “significant role,” and “appropriate steps” were relatively broad and vague. Before 2005, there were no investigative protocols and no formal methods for surveyors to determine true compliance.

Pragmatic changes were necessary to allow the medical director to perform basic functions with authority. Interdisciplinary cooperation must occur for the medical director to achieve his or her goals, as quality assurance cannot occur with the effort of a single individual. The medical director must determine the educational needs of the staff, establish protocols for medication and practitioner monitoring, and promote accountability, teamwork, and quality of care. The medical director in brief should be a troubleshooter, patient advocate, and technical advisor.

The revised interpretive guidance now has clearly spelled out expectations of medical directors in much more detail. Perhaps the key aspect was that citation for F501 can be cited only with the context of other federal tags. That is, there must be a deficiency in a quality-of-care issue, such as pressure ulcers, medications, or hydration for the medical director to be found deficient in his or her practice. Interestingly, there are 2 ways this F-tag can be cited. First, if the home did not or should have involved the medical director, and the medical director had no knowledge of the care deficit, the F501 citation is only against the nursing facility. If the medical director could have or should have known of the care deficiency, then the F-tag is cited against both the nursing home and the physician. What has not been entirely clear is how the latter situation in particular could affect the liability and credentialing of the medical director. Theoretically, a citation against the nursing home and medical director could substantially increase litigation risk and affect credentialing processes, although this appears not to have been reported. An F501 citation against just the home should not raise these same problems for the medical director alone. However, it may drive a wedge between the nursing home and the medical director if litigation were to occur. If a serious care deficiency involving F501 and another tag arose, the plaintiff’s attorney could call upon the medical director to testify against the nursing home, given the implied neglect of the home to involve the medical director in the deficient practice.

It is imperative that the medical director be involved in the survey process to minimize the risk of an F-tag 501 citation. He or she must introduce themselves to the survey team and be promptly available to discuss any quality-of-care concerns with the survey team, especially as this relates to his or her role of responsibility. Coordination of medical care, physician leadership, and quality assurance are key areas the surveyor should look for. Surveyor investigator areas regarding the medical director include basic credentialing of practitioners, 24-hour physician services including ongoing emergency coverage, timely visits and orders, physician expenders including their scope of practice, medical director response to care problems, attending physician liaisons, education monitoring, feedback, and interventioning. Severity criteria for the F501 tag depends on the deficiency at the clinical care tag and whether the medical director (or nursing home via not notifying the medical director) failed to intervene with the attending physician to facilitate and/or coordinate care, whether they failed to provide guidance in a rule for resident care policies, and whether they showed evidence of process failures with respect to their responsibilities.

There are many activities medical directors can undertake to address potential problems and improve quality to demonstrate their involvement with overall quality of care. Physician responsibilities must be defined, including but not limited to, making periodic pertinent visits, providing adequate coverage, and making appropriate timely visits, including documentation supporting resident/patient transfers. Medical
directors should disseminate written expectations that clarify the expectations of all practitioners, which may include the signing of an agreement. Medical directors should define policies and scope of care. They can help develop and disseminate policy and procedures relating to effective patient care and regulatory compliance, and help identify clinical conditions and risks pertinent to the patient population. Medical directors must demonstrate activities relative to both physician and nonphysician practitioners in the facility. They should assess and compare practitioner performance to expectations and give appropriate feedback. They should advise the facility of clinical risk management concerns, and help evaluate the care of individual patients. They should help identify quality indicator trends, pattern causes, and help the QA team understand underlying causes of clinical problems and deficiencies. It is imperative that the medical director meet with the administrator and regularly discuss routine and emergent clinical issues, survey data, infection control issues, and any other quality-of-care issues.

So, back to the original question, has F501 had an impact on the medical director’s role in long-term care? Recent surveys of medical directors provide some interesting insights.3,4 In 2008, 21% of medical directors felt tag F501 had helped them be more effective medical directors, compared with 16% in the previous year. In 2007, 16% felt that F501 caused conflict between the medical director and attending physician, but in 2008, this number was down to only 5%. Concern for increased liability and chance of lawsuit involving medical directors has decreased with 36% reporting concern in 2007, but only 28% in 2008. From 2007 to 2008, there was little change in the percentage of medical directors who felt F-tag 501 required more of their time (37% to 38%) or had no impact (16% to 18%). There was a slight increase in the number of those who felt that F501 increased the likelihood of facilities compliance with CMS surveys from 2007 to 2008 (20% to 24%). Overall, these data seem to indicate that medical directors are seeing a positive impact on F501.

Regulatory compliance is undoubtedly affected by many factors, including inadequate reimbursement, lack of physician training in medical direction, and inadequate support by the nursing home industry.5 The value of the Certified Medical Director (CMD) in promoting quality at the nursing home is still yet to be proven, although it is anticipated in the next year data will be released that will demonstrate a positive correlation between a CMD and improved clinical measures.

Are surveyors citing F501 more? The answer is yes. Data through the first half of 2008 has shown a significant increase in F501 citations since it was released in 2005 (Center for Medicaid State Operations, Survey and Certification Group, Division of Nursing Homes, personal written communication, September 4, 2008). Before the release of the revised medical director F-tag, there were 67 citations involving 0.4% of nursing homes nationally. There has been a steady increase in citations, such that in 2007, the last year of complete data, there were 302 citations involving 1.7% of nursing facilities. Preliminary data for 2008 continue to show increases above 2007 data. Whether this trend will continue is uncertain, but the nearly 5-fold increase in citation rate postrevised F-tag 501 is testimony to an increased awareness of the need for reasonable medical direction.

So, should we be quaking in our boots about the prospect of being cited for an F501 tag deficiency? The simple answer is no, but it is highly dependent upon following the principles promulgated by the American Medical Directors Association (AMDA). AMDA had a key role in assisting the development and promulgating the essentials of the F501 survey tag. Theoretically, following the principles we espoused should make us relatively immune to any F501 citation as a medical director. Whether the nursing homes will arise to the point where they involve the medical director appropriately to protect themselves from an F501 deficiency may be another matter. Unfortunately, key data regarding whether the current citation involves both the home and/or the medical director are not currently available. Such data might help demonstrate whether medical directors are indeed rising to the occasion or whether the homes have not involved medical directors as they should. This saga will certainly continue.

REFERENCES