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Long-Term Care Survey Alert

Survey Compliance: Have Foresight: Ward Off F Tags For Shortfalls In Medical Director Oversight

Comply with the new F501 tag before it goes into effect in November.

The handwriting is on the survey wall: Get your facility's medical director roles in line with the advance release of the new F501 slated to into effect in November - or be prepared to post a negative CMS 2567.

The main message to the revised F tag that is that medical directors must be involved in problem solving in the facility, according to **Charles Crecelius, MD, PhD, CMD**, chair of the **American Medical Directors Association's** House of Delegates.

Once the revisions go into effect, facilities can expect surveyors to target two key requirements. "These are also spelled out in F314 (pressure ulcer) and F315 (urinary incontinence/catheters)," says **Jacqueline Vance, RN**, director of clinical affairs for AMDA. These are:

1. The medical director must be involved in overseeing a facility's policies and procedures and care protocols. The F501 survey investigative protocol directs surveyors to interview directors of nursing and administrators to see "if and how" they involve the medical director in "developing, reviewing and implementing" polices and procedures for clinical care to ensure they are clinically valid and consistent with current standards of care.

Proactive strategy: To develop evidence-based care protocols, tap the wealth of available resources and references that address how to care for common conditions, advises **Steven Levenson, MD, CMD**, a multi-facility medical director in Baltimore, MD. "The new tags for pressure ulcers and incontinence reflect more of what's in the literature in that regard and include additional references that facilities and physicians can use," he adds.

2. The medical director should be involved in addressing attending physician noncompliance with OBRA requirements, accepted standards of care and the facility's own policies/procedures, etc.

Target These Key Clinical Issues

The revised F501 guidance specifically mentions the medical director's responsibility for helping to review and update standards of care for a hot list of survey issues:

1. pressure ulcers
2. incontinence
3. fall risk
4. delirium
5. weight loss
6. restraint reduction
7. hydration risks
8. quality of life.

But don't stop with the clinical issues cited by the revised F501. For example, developing best practices to address anticoagulation therapy can help keep your facility off the survey radar screen and court dockets. The medical literature includes a lot of information about how to manage people on such therapy, including lab monitoring and drug-drug interactions for patients taking Coumadin, says Levenson.

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Identify specific care issues that warrant the medical director's input and collaboration with nursing staff and attending physicians, such as behavioral issues, wanderers, unusual or complex clinical issues, psychoactive medications - and questionable admissions and discharges, advises attorney Joseph Bianculli in Arlington, VA. For example, surveyors hand out a lot of deficiencies related to residents who should have been discharged, he notes.

Proof Is in the Documentation

As far as surveyors are concerned, if you don't document it, they've gotcha. And you need two types of documentation to show medical director involvement and attending physician intervention:

9. Overall documentation about how and when the interdisciplinary team or administrators confers with the medical director about QA issues.
10. Medical record notations each time the staff confers with the medical director or attending physician about a resident's clinical condition. "The documentation should address the clinical issue (lab and X-ray results, clinical symptoms, etc.) and the plan of care and expected end point," advises Levenson. "The documentation helps support the decision making in situations where the resident has an unavoidable outcome."

Risk management tip: Physicians shouldn't just document significant changes in the resident's condition, stressed **Mark Heard, MD, CMD**, speaking at an AMDA conference in Nashville, TN. If the resident has a negative outcome, "you can't tell what a resident was like before" by reading blank pages.

Implement Care Management Systems

To ensure patient care issues don't fall through the cracks, develop systems to manage the care of complex residents and patients, including ancillary resources. For example, a facility in a more remote area can set up teleconferencing systems to consult with specialists, says Levenson.

Other care management systems include the following:

11. Protocols for when the staff should contact the attending physician or medical director about a clinical issue. "Facilities need a protocol for triaging symptoms and test results and for defining what it means for a physician to respond urgently or routinely," says Levenson. "Then you hold the physicians to those policies, procedures and protocols," he says.
12. Assessment formats that require nurses to collect designated information to communicate to physicians before contacting them about a resident's clinical issue. The use of such protocols promotes collegiality between nursing staff and attending physicians, observes **Clare Hendrick, ARNP**, a nurse practitioner and president of **ProTime Consulting Services** in San Clemente, CA.

"No physician likes to get a call from a facility staff person saying, Mrs. Smith doesn't feel well or Mrs. Smith has a fever," says Hendrick. "Then the doctor orders PRN Tylenol and the nursing staff gets annoyed because Mrs. Smith is also showing signs of delirium but no one communicated that to the physician."

Read the advance copy of the revised F501 tag at www.cms.hhs.gov/medicaid/survey-cert/sc0529.pdf.

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