MDS Alert

Survey Compliance: Use The MDS To Red Flag Physician Care Shortfalls

That way you won't take a tumble under the revised F501 tag.

Are your attending physicians attending enough to residents' care needs? The MDS may provide the answer in time to make changes before surveyors start marching to the beat of a revamped F501 tag.

Beware the new survey reality: Under revised survey guidance for the medical director role (F501) now in effect, surveyors will be looking for deficiencies in the quality of physician care when they cite a quality of care tag. Surveyors could hand out an F501 tag in such cases if they find physicians aren't responding to residents timely or making appropriate clinical decisions--and the medical director hasn't addressed the issue, cautions attorney **John Lessner** with **Ober/Kaler** in Baltimore.

Match P7, P8 to Acuity

A resident's MDS can give you a heads up that a physician's visits and order changes don't fit a resident's condition. For example, frequent physician visits coupled with order changes at P7 and P8 signal a resident has high acuity or an unstable condition, says **Cheryl Field, MSN, RN**, a consultant with **LTCQ Inc**. in Lexington, MA. So review certain MDS acuity-related proxies to see if they jibe with coding at P7 (physician visits) and P8 (order changes).

Where to look: Start with problem conditions in Section J1. These include fever, respiratory distress, internal bleeding, fluid imbalance, etc., which would warrant physician attention and monitoring.

Make sure nursing doesn't drop the ball: "Physician visits and order changes should be a ... flag that a resident needs more monitoring of clinical signs than what's available on the MDS, such as assessment and monitoring of respiratory status, including lung sounds, fluid and electrolyte balance, etc.," says **Diane Brown**, CEO of **Brown LTC Consultants** in Boston.

Look at Stability of Conditions

J5a captures residents whose conditions are making their ADLs, cognitive status, mood or behavior unstable. J5b records a resident who has had a flare-up of an existing chronic condition.

For example, an exacerbation of congestive heart failure would be a red flag if it didn't correlate to physician visits or order changes, notes **Rita Roedel, RN**, director of clinical reimbursement with **Extendicare Health Services** in Milwaukee.

Diagnoses recorded in Section I can provide additional information about a resident's medical and nursing needs. For example, an active infection coded in I2 would necessitate physician intervention.

Check These Additional Items

Other assessment items that signal a resident should probably have received some physician visits and/or order changes include:

• Procedures recorded in P1aa-P1ar. Look for IV medications, for example, or oxygen therapy where the resident has O2 sat- urations all over the board, advises Roedel.

• Unstable laboratory findings (P9). These might include a diabetic with unstable blood glucose readings or someone on Coumadin with fluctuating INR levels, says Roedel.

• A change in overall care needs (Q2).

• Frequently moderate or episodes of excruciating pain coded at Section J2. You'd expect the nursing staff to be working with the physician to titrate medications and perhaps order diagnostic testing to look for the cause of new pain or a different type of pain.

• Delirium (B5) or a sudden change in mood or behavior.

Examine Emergency Room Usage (P6)

A pattern of emergency department visits not associated with falls or injuries may indicate that the nursing staff doesn't want to call a certain physician or the physician isn't responding, says **Nathan Lake, RN, MSHA**, in Seattle, who is director of clinical design for **American HealthTech Inc**. based in Jackson, MS. "Look at diagnoses before and after ED visits, such as UTI, pneumonia or dehydration."

Correlate New Meds (O2) to Resident's Condition

If the physician ordered a new medication (O2), look to see what the specific medication is and the resident's physician-documented diagnosis (reason for the medication). Then take a look at how the resident responded to the treatment, suggests Lake.

"For example, if someone had a UTI, received an antibiotic and then ended up hospitalized, you have to wonder if the physician selected the wrong antibiotic, dosage--or caught the infection too late to effectively treat it in the SNF," he says.

Another red flag: "A new antibiotic followed by pneumonia, fever, UTI and a hospitalization could be an indicator of inadequate treatment," says Lake.

Look at Significant Change in Status Assessments

To assess physicians' responsiveness to residents, facilities can also look at how many significant change assessments they have done and then tie those back to the timeliness of physician visits and order changes, suggests **Bet Ellis, RN**, a consultant with **LarsonAllen Health Care Group** in Charlotte, NC. "That way they don't have to audit every chart."

Tip: Take a look at SCSAs done for ADL decline in two or more areas. Figure out what preceded the ADL decline, suggests Lake.

"Did the resident have the flu or other infection--or a fall?" Lake asks. "Was the problem something that physician attention, order changes and care planning should have addressed to prevent the decline?"