

Nursing Home Physicians: Roles and Responsibilities

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In the United States, roughly 16,100 nursing homes house 1.5 million persons. Most (62%) of the homes are for-profit facilities; nearly 54% are part of regional or national chains; 31% are not-for-profit facilities; 7.7% are government-affiliated.¹ In the last 20 years, as nursing homes have assumed responsibility for more acutely ill residents, the jobs of the Administrator, Director of Nursing, Medical Director, attending physician and direct care staff have become more complex. In this article, we describe the roles and responsibilities of attending physicians and medical directors in the NH.

ROLE OF ATTENDING PHYSICIAN

Three concepts highlight the nature of NH medical care: competence in care of older and disabled persons; the interdisciplinary team approach; and government regulation.

NH physicians are expected to be familiar with geriatric care principles, including experience and knowledge about geriatrics syndromes and problems common in elderly residents. The ability to manage polypharmacy, delirium, dementia, falls, osteoporosis, malnutrition, pressure sores, incontinence and multiple interacting co-morbid conditions is essential. For example, older patients with pneumonia or urinary tract infection may present with a change in mental status or behavior rather than fever. The attending physician must assess behavioral changes, cognition, affect, gait, sphincter function, and overall physical function, as well as be familiar with interventions to maintain or improve functional outcomes.^{2,5}

Virtually all residents are debilitated, with multiple co-morbid chronic conditions. Residents require the services of nurses, rehabilitation personnel, dietitians, social workers, personal care attendants and others, with whom the attending physician should interact often - by phone, e-mail, fax or face-to-face. These ongoing interactions are necessary for the physician to receive information about the residents and to make better, often collaborative decisions.

The NH physician must work as a member of a team whose leader is a nurse. Attending physicians provide oversight and assume ultimate responsibility for the medi-

cal care of residents, and physicians write the orders that the other professionals carry out. Yet because physician presence in the facility is intermittent, nurses are the “eyes and ears” of the physician.

The nursing assessment is crucial, but nurses unfamiliar with a particular resident, as well as temporary pool nurses, may not give accurate assessments.

Physician responsiveness to nurse calls promotes better communication and provides attending physicians with the opportunity to teach and assist nursing staff in care and assessment. Concerns about nursing performance should be brought to the attention of the Director of Nursing or Medical Director. Interaction with residents’ families (and friends) is also important for exchange of information in both directions. Families need to know what to expect and the attending physician should ask families to participate in establishing the goals of care and expectations for frequency and medical follow-up.

Transitions are times of high resident vulnerability because the resident is new to the care team, and because the transfer of information between institutions (usually hospital and NH) often is incomplete or delayed. The high prevalence of dementia (>50%) among residents undermines reliability of medical histories. Interagency transfer forms filled out by the hospital staff at the time of discharge, or by the nursing home nurse at the time of transfer, often incompletely or inaccurately reflect allergies, medical diagnoses and medications. Ideally, nurses and physicians from both institutions should communicate directly; in practice, the multiple transitions, low priority accorded to paperwork, multiple providers and rush to move the patients act against such an ideal.

NHs are highly regulated. Providing medical care to NH residents differs from both the hospital setting and the outpatient setting. Hospitalized patients are acutely ill and seen daily. Ambulatory care patients receive episodic visits for chronic disease management, health maintenance or acute conditions. But such patients are generally independent, can carry out their physicians’ recommendations on their own or with minimal assistance, and can control the visit schedule. Nursing home residents are at risk of physician under-use,

resulting from regulations establishing a minimum frequency of physician visits. Skilled NH residents (short term rehabilitation) are seen at least 2-3 times in the first month, and once a month thereafter; long-stay residents are seen routinely at least once every two months. Medically necessary visits can be performed as frequently as necessary, but billed no more than once daily.

Many state and federal regulations are intended to promote better care. By accepting responsibility for the medical care of NH residents, the attending physician implicitly agrees to comply with those rules and regulations, including the regulatory visitation schedule, provision of 24/7 coverage, responsiveness to report change in resident condition and other concerns or questions from nurses, care documentation and medications and treatment orders and reviews.

Unfortunately, many physicians choose not to practice in NHs. One barrier is the public image of NHs as a place of last resort where older persons go to die. Second, the “magnetism of the acute care world” attracts medical students, residents and attending physicians to hospitals and specialty practices. Third, the paucity of training in geriatric medicine during medical school and residency, and worsening shortage of geriatricians, discourages physicians from entering geriatrics. Fourth, the lack of specialists willing to visit NH residents often requires NH attending physicians to extend their scope of practice beyond their ordinary hospital or office practice. There are no regulatory limitations on consultations, but few specialists visit NH residents, who must be transported to consultants’ offices. Fifth is a financial disincentive: Medicare does not reimburse physicians for coordinating services or providing interdisciplinary care across settings. NH physicians spend time traveling between facilities, practicing telephone medicine and managing paper flow without reimbursement. Finally, high liability risk is generated by the fact that most long-term care NH residents die in the NH, with the potential for “wrongful death” claims. And the problem of persistent under-funding of NH care can limit services. The practical difficulty to comply and document compliance with over 100,000 pages of rules and regulations, and the resulting sub-

stantial increase in malpractice insurance rates for physicians practicing in NHs create another major impediment.⁶

Medical care of NH residents is potentially rewarding. Optimal NH care is interdisciplinary, preventative, curative and palliative, and the physician may be able to improve residents' lives beyond purely clinical interventions by taking on administrative roles collaboratively with or as the medical director. Listed below are the responsibilities of the physician practicing in the NH setting.⁷ These responsibilities reflect appropriate care, as well as specific regulations. The regulations encompass several domains, each of which corresponds to a regulatory code known as a Federal tag (F-tag) number. Also listed below are suggested time management guidelines for efficient NH practice.

Physician Responsibilities in the NH (examples)

1. Physically attend to each resident in a timely manner consistent with state and federal guidelines (visit every 30 days for the first 90 days following admission, and at least every 60 days thereafter) while assuring that the appropriate diagnostic tests are performed (Tag F 387, F 500-512).
2. Respond in a timely fashion to a resident's change in function or condition (F 157).
3. Assess each patient comprehensively, assist in care plan development, periodically review it and assure that the goals for each care plan are rational and relevant (Tag 272, 279, F 250, F 309).
4. Implement treatments and services consistent with good geriatric practice to enhance or maintain physical and psychological function and to avoid accidents (TAG F 502-512, F 310, F 311, F 323 and F 324).
5. Assure that residents are free from unnecessary drugs by periodic review of drug regimens and consultant pharmacist recommendations (Tag F 329-F331, F 428 and F 429).
6. Inform residents of their health status and enable residents to exercise self-determination including advance directives (Tag F 151, 152 and 154).

Time Management Advice

- Establish regular days for rounding in a particular NH
- Cluster routine visits, avoid single

resident visits unless urgent

- Limit practice to only a few facilities
- Use protocols or established clinical practice guidelines for common problems
- Employ a nurse practitioner or physician assistant who can manage routine and acute care, and serve as liaison among you, nursing staff and families
- Address care plan, expectations, and advance directives with resident and family soon after admission
- Establish strong relationships with NH nursing and administrative staff
- Conduct rounds with the floor nurse to ensure acquisition of key information and to make sure care plans are being carried out.
- Collaborate with the medical director to train staff to limit after-hours calls to urgent medical problems, and establish a system for conveying routine information (e.g., regularly scheduled calls)

ROLE OF MEDICAL DIRECTOR

A medical director oversees certain aspects of medical care and services for an organization or a health-care system. Hospitals have department chairs, chiefs of staff, division directors or vice-presidents for medical affairs. The Omnibus Reconciliation Act of 1987 (OBRA '87) requires that all long-term care facilities designate a medical director who is a licensed physician to practice in that state. Interpretive guidelines describe the following duties:⁸

- Ensure that the facility provides appropriate medical care
- Monitor and ensure implementation of resident care policies
- Provide oversight of physician services
- Play a role in overseeing the overall clinical care of the residents to ensure to the extent possible that care is adequate
- Evaluate potential inadequate medical care and take appropriate steps to try to correct the situation
- Consult with residents and their attending physicians concerning care and treatment when needed and requested

General Statement

Services provided to nursing home residents can be broken into 3 categories:

(a) *Domains of care that fall under physician expertise* include physician and other practitioner services, including timeliness of visits, appropriateness of medical care,

credentialing of physician/practitioners; infection control; formulating advance directives; employee health; and medical records (e.g., admission notes, progress notes, discharge summaries). The medical director should be actively involved, in collaboration with the facility's leadership (administrator and director of nursing) in oversight of the above domains, and shares responsibility for satisfactory performance of the NH in those areas. If problems are discovered during inspections or quality assurance activities, the medical director should provide assistance and recommendations pertaining to corrective action plans. The medical director may need to intervene directly with attending physicians and practitioners who are not performing according to expectation.

(b) *Domains of care that are primary responsibility of other health professionals (e.g. nursing, physical therapy, dietary, social work), but require some degree of medical director input.* The medical director should be aware of those departments' policies and procedures, and how they are fulfilling their function. If problems are identified internally (e.g., as a result of a mishap or during the quality assurance process) or by an external party (state inspectors), the medical director should be informed and may be involved in helping the NH to formulate plans to correct the problem(s). The medical director should not be held responsible for actual implementation of corrective actions, given that the medical director has no authority over any NH employees and has no access to NH financial resources.

(c) *Domains of services to NH residents that should not be under medical director oversight or responsibility include cleaning, laundry services, food services, plumbing, fire, safety et al.* Physicians have no training or expertise in these areas. Accordingly, if problems are identified (e.g., a "deficiency" during an inspection), the medical director can be informed of those problems (as may be required by the regulatory process), but there should be no expectation that the medical director has responsibility in the plan of correction.

AREAS OF RESPONSIBILITY:⁹

1. General
 - a) Overall coordination, and monitoring of physician/practitioner activities
 - b) Monitoring the outcomes of the health care services; i.e., quality assurance/improvement (QA/QI).

2. Physician/practitioner oversight
 - a) Establish a procedure to review physician/practitioner credentials and grant privileges to attend
 - b) Establish rules that govern the performance of physicians/practitioners
 - c) Establish a formal procedure to oversee physician/practitioner performance (QA)
 - d) Define the scope of practice for non-physician practitioners (would usually use state/federal regulations).

3. Ensure physician performance in the following activities:
 - a) Accepting responsibility for the care of residents assigned to them
 - b) Performing timely admissions, including review of medical records
 - c) Making scheduled and as-needed visits
 - d) Providing adequate ongoing 24/7 medical coverage
 - e) Providing appropriate medical care
 - f) Documenting care and doing so legibly
 - g) Formulating and approving advance directives/end-of-life orders
 - h) Others (may be physician, resident, or facility specific)

4. Cover for the attending physician when the latter is unavailable or not performing appropriately.

5. Policies and procedures: the medical director is responsible for the content and implementation of those policies and procedures that fall under the physician's domain (see above), and monitoring of their execution. The medical director should review policies and procedures that pertain to other types of health care professionals (e.g., nursing) but not be held responsible for their execution.

6. Quality Improvement (QI): The medical director (or designee) must attend the quality assurance meetings and be an active participant in the QI process, including areas that are not in the medical domain; a physician is often the most knowledgeable and able member of the QI committee in the management and interpretation of statistical data.

7. The medical director is involved with policies that cover employee health.

8. Infection Control: The medical director advises and consults with designated nursing staff regarding communicable diseases, infection control and outbreaks.

9. Review the reports of formal inspections by the state department of health. When deficiencies are identified, the medical director should be involved in the plan of correction of problems that are in the medical domain.

Sources of Medical Director Responsibilities, Accountability and Caveats

The federal and state regulations define a broad outline of NH medical director responsibilities. Pursuant to the Federal NH Reform Act of 1987, and specifically, 42 C.F.R. 483.75(i) (also designated as Tag F501 for survey reference), each NH covered by the Act must designate an individual to serve as a medical director.¹⁰ The regulations further state that each medical director is responsible for

- the implementation of resident care policies; and
- the coordination of medical care in the facility.

While these may appear simple and straightforward, the variety of responsibilities included within each function calls for interpretation. Indeed, taken literally, the job description implied by the regulatory language goes far beyond the role of a hospital chief of staff or department chair. The vague regulations preclude a direct translation into a functional and realistic job description. Additionally, the breadth of the regulatory scope of responsibilities of the medical director job is unreasonable; it could be interpreted to include domains in which physicians have no expertise. Finally, the authority bestowed upon medical directors is limited by the part-time nature of the position and its advisory status, without authority over the NH employees and budget.

During 2006, CMS introduced new surveyor guidance to clarify the federal requirements for Tag F 501. The medical director is now viewed as a medical leader who should actively help facilities provide effective medical care. The updated surveyor guidance expects the medical director to:

- Coordinate medical care in the facility;
- Collaborate with the facility leadership and provide clinical guidance to help develop, implement and evaluate resident care policies and procedures that reflect current standards of practice;
- Help the facility identify, evaluate, and address/resolve clinical concerns and issues that affect resident care, medical care or quality of life, and are related to the provision of services by physicians and other licensed health care practitioners.

The revitalized F-501 tag addresses medical direction concerns raised during state inspections, and specifically whether the medical director, in collaboration with the facility, coordinates medical care and is involved in the implementation of resident care policies. Two types of medical direction failures can be identified:

1. The facility has failed to involve the medical director in his/her role.
2. The medical director has not performed his/her role.

The survey team must first identify whether noncompliance cited at other tags relates to the medical director's roles and responsibilities. In order to cite at F501 when noncompliance has been identified at another tag, the team must link the identified deficiency to a failure of medical direction.

NHs are subjected to considerable oversight by government agencies and other parties (e.g., ombudsperson, families of residents). The frail nature of NH residents and their multiple co-morbidities can lead to medication errors, injuries, pressure ulcers or malnutrition, and even death; accordingly, complaints about NHs, their medical directors and their physicians are not uncommon. The state's department of health and the state's board of licensure and discipline may be asked to adjudicate those complaints. Despite the breadth of responsibility imposed upon the medical director, that responsibility is not matched by the medical director's regulated authority over the NH operations. The 2001 Institute of Medicine report "Improving the Quality of Long Term Care" urged facilities to give Medical directors greater authority for medical services and care. Furthermore,

most medical director contracts only require that the director work at the facility for a brief period, often 2-4 hours weekly. In combination with the regulations, such arrangements make the medical director an easy target for liability, investigation by state licensing boards, and even criminal prosecution, but do not provide an obvious mechanism whereby the directors can implement sound policies and practices consistently in facilities. A carefully worded employment contract may offer some protection. Medical directors should also maintain a written record of their activities; for example, in the form of a quarterly report to the QA committee.

Despite its pitfalls, NH medical direction and patient care can be a rewarding experience. Physicians can enhance the well being of medically complex frail patients admitted for short-term rehabilitation, as well as for long-term residents in the final phase of their lives. Medical directors and attending physicians are encouraged to become the members of American Medical Directors Association (AMDA), attend AMDA's annual symposium, and learn more about these positions. [<http://www.amda.com>]

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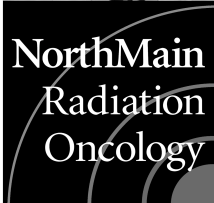
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