The Impact of Laws and Regulations in Improving Physician Performance and Care Processes in Long-term Care

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Laws and regulations profoundly influence long-term care, including the performance and practices of individuals of various disciplines who provide the care. The purposes of this article are (1) to consider how and to what extent laws and regulations impact critical care processes and practices that could involve physicians who care for long-term care patients, and (2) to suggest how physicians might positively influence the care despite the limitations of, and problems related to, those laws and regulations.

OVERVIEW OF LAWS AND REGULATIONS

Laws reflect formal public policy. They represent general rules of conduct that are supposed to advance societal objectives by requiring private individuals and organizations to do things in certain ways, for example, to attain what society considers to be valid public goals.

Law could be constitutional, statutory, administrative, or common. All 4 of these categories are relevant to physicians and other healthcare practitioners who provide long-term care.

Constitutional law interprets basic governmental organizational and operational principles. For example, the right to privacy, which forms the basis for an individual’s right to refuse medical care, is derived from constitutional law.

Laws enacted by legislatures (statutory law) are termed statutes on the federal and state levels, and ordinances or codes on the local level. Congress, state legislatures, and other bodies enact statutes under the authority of a state or federal constitution. Laws are relatively permanent and can only be amended by the same legislative body. Judicial decisions that interpret the meaning of specific laws or parts of those laws become part of statutory law.

For example, the federal Omnibus Budget Reconciliation Act of 1987 (OBRA ‘87) enumerates the responsibilities of providers of nursing home care who receive federal funds. The so-called “OBRA ‘87” regulations are derived from these parts of the OBRA ‘87 statute.

Additionally, states and local governments have passed many laws that directly or indirectly affect nursing home care and practice. Examples include state laws about licensure requirements for nursing homes and healthcare practitioners, advance care planning and rights to refuse treatment, and infection control practices.

States, not the federal government, license individual nursing facilities. CMS contracts with state survey agencies to certify compliance with the OBRA ‘87 requirements and to enforce its provisions. Many states have adopted similar or additional requirements.

Administrative laws include rules, regulations, or orders enacted by the executive branch of government (the executive office or administrative agencies) based on instructions and powers granted them in specific laws. Regulations are the best known form of administrative law and are particularly important to those in the healthcare industry. They can be reviewed more regularly and can be rewritten more rapidly than can statutes.

The OBRA ‘87 regulations and related interpretive guidelines are the most substantial example of administrative law affecting long-term care. The Center for Medicare and Medicaid Services (CMS, formerly known as the Health Care Financing Administration) is responsible for creating and implementing OBRA ‘87-related regulations and surveyor guidance. Administrative law judges handle hearings related to nursing home compliance and appeals.

Interpretative rules are an agency’s interpretation of statutory requirements or of its own rules and regulations. The

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OBRA '87 Guidance to Surveyors interprets various sections of the regulations, for example, the meaning of the regulatory requirement that “The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident’s dignity and respect in full recognition of his or her individuality” (483.15[a] Quality of life: Dignity).

Procedural rules describe the processes by which the agency functions (eg, procedures for hearings, applying for grants or contracts, and handling of complaints). For example, the CMS has published rules about how to conduct the survey process and related hearings and appeals. All state agencies are expected to follow these procedures.

Finally, common law is made by judges or courts and is based on social custom, tradition, history, use, or legal or judicial precedent. For example, court cases regarding patients who acquire pressure ulcers are typically based on statutory requirements and related regulations as well as common law notions of duty and neglect.

PHYSICIANS AND REGULATIONS

Although they are routinely influenced by laws and regulations, physicians who practice in nursing homes are rarely concerned with the aforementioned distinctions. Typically, they want to know the “bottom line,” that is, what must or should they do in various situations. Often, they are told that they should do or order certain things because “the regulations require it” or because the “surveyors want to see it.” However, many such assertions do not reflect actual requirements, but are based on individual interpretations of the regulations by nurses, administrators, and others.

Regulations pertinent to nursing home attending physicians and medical directors include those regarding:

- reimbursement for facilities (for example, the prospective payment system for postacute patients);
- reimbursement for practitioners (for example, coding and billing requirements);
- public health and safety (for example, infection control);
- specific aspects of care (for example, advance directives);
- physician licensure and related requirements;
- medical director and attending physician responsibilities; and
- physician liability.

Thus, physicians should understand what laws and regulations do and do not tell them or make them do, and how these relate to good practice and proper patient care.

LAWS AND REGULATIONS RELATED TO LONG-TERM CARE

Nursing homes in the United States operate under federal, state, and local laws and regulations, which are meant to protect a vulnerable population, improve the care, and justify reimbursement. Federal nursing home reform legislation passed in 1987 as part of the “OBRA '87” law contains the primary federal requirements. Related components have evolved since the law’s passage.

Although facility staff and practitioners could refer to them all as regulations, many parts of the OBRA ‘87 package are interpretive and procedural rules, not regulations (Table 1). These components are intended to:

- identify topics and conditions of concern and interest such as pressure ulcers and decline in function;
- identify desired or expected outcomes such as “highest practicable outcome”;
- define compliance with government programs and requirements, for example, requirements for compliance with requirements regarding medication prescribing and utilization; and
- instruct reviewers in how to determine compliance and identify and interpret deficiencies.

Table 1. Key Components of the OBRA Survey Process

| Regulations: the basic statements of requirements and expectations, which carry the force of law
| Guidance to surveyors: information to help surveyors interpret the meaning of specific regulations and related performance expectations
| Survey procedures: instructions about how to conduct the survey and how to interpret the information collected during the survey to determine compliance and to specify noncompliance
| Investigative protocols: instructions about how to investigate compliance with specific requirements |
show surveyors how they have obtained the medical director’s input, review, and approval of policies and procedures; how the medical director has provided oversight for the quality of care, resident rights and quality of life, and overall implementation of the resident care policies; and how the medical director has exercised responsibility for the coordination of medical care. The facility should be able to demonstrate how they update and maintain current policies and procedures to reflect accepted standards of practice.

**SOURCES OF ATTENDING PHYSICIAN RESPONSIBILITIES**

Like with the medical director, most regulatory requirements for attending physicians are more implicit than explicit. Every state has some laws and regulations related to physician licensure and practice. However, only a few states have more detailed regulations regarding medical director and physician practice and performance in long-term care facilities.²

A primary source of attending physician requirements is found is Section 483.40 in the federal OBRA regulations, Tags F385 through F390.

**Service Provision**

One key aspect of legal and regulatory requirements concerns the availability of physicians and health-related services. A physician must oversee the care of each nursing home resident. Thus, facilities need attending physician support, for example, by giving admission orders that are consistent with a resident’s current mental and physical status (CFR483.40. Physician services). Therefore, a physician should be available, or have backup coverage, to give orders at the time of admission.

Subsequently, the physician must visit according to a prescribed schedule, review the individual’s total plan of care, write progress notes at each visit, sign and date orders, be available or arrange for coverage for emergencies, designate a backup physician, and supervise individuals such as nurse practitioners to whom tasks are designated.

The facility must be able to consult with a physician under specific circumstances, including (a) an accident involving the resident, which results in injury and has the potential for requiring physician intervention; (b) a significant change in the resident’s physical, mental, or psychosocial status (ie, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); and (c) a need to alter treatment significantly (CFR483.10 [b][11] Notification of changes). Therefore, the attending physician or backup coverage must respond appropriately to notification of a possible or actual clinically significant condition change.

**Patient Care**

Facilities must assess a resident’s needs in depth using a specified resident assessment instrument (RAI). The facility also must conduct a comprehensive assessment of a resident within 14 days after determining that there has been a significant change in the resident’s physical or mental condition (CFR483.20 [b][1] Resident assessment).

Effective geriatric practice requires proper problem definition, that is, clearly characterizing signs and symptoms and distinguishing incidental symptoms or abnormalities from those reflecting a problem requiring an intervention. Geriatric and chronically ill younger patients often present with nonspecific symptoms that could have several causes. A single condition, for example, chronic obstructive pulmonary disease, vasculitis, or stroke, could have many consequences and cause multiple symptoms involving several different organ systems; or a single symptom could have several coexisting causes.

Physicians are trained to analyze clinical information in depth and to distinguish diverse causes. Therefore, physicians should help the facility analyze information and draw appropriate conclusions about the significance of signs and symptoms, for example, help distinguish lethargy from weakness, apathy, or activity intolerance as the cause of functional decline, or help distinguish restless or anxiety from agitation resulting from psychiatric illness.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment (CFR483.20 [k] Resident assessment). Effective geriatric care requires thoughtful consideration of the relevance and risks of potential interventions. Physicians are trained to select appropriate combinations of symptomatic and cause-specific treatments, and to weigh the relative risks and benefits of medications and other treatments.

Nursing home residents have the right to participate in planning care and treatment, to refuse medical treatment, and to execute an advance directive for health care (CFR483.10 [b] Exercise of rights). A legally appointed representative could exercise the rights of someone who lacks the capacity to do so. Therefore, attending physicians should help facilities support these rights. They should help define decision-making capacity when needed, provide relevant information about a patient’s medical condition and prognosis, and advise the facility about the relevance of various interventions such as cardiopulmonary resuscitation (CPR), hospitalization, or tube feeding.

**LAWS, REGULATIONS, AND THE PATIENT CARE PROCESS**

The patient care process consists of some critical steps (Table 2). Both state and federal regulations and related guidance attempt to influence these various steps, often by establishing desired outcomes or by expecting specific actions. However, analysis of various state and federal laws and regulations shows that they are too general or incomplete to accomplish those objectives adequately.

**Topics of Concern and Interest**

Regulations typically allude to some important areas of concern such as functional decline and falling. However, they overlook other important areas (for example, gastrointestinal bleeding, fibromyalgia, vasculitis, or anemia) and they address...
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<th>Process</th>
<th>Objectives</th>
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<th>Examples of regulatory influences</th>
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| Assessment              | Collect information about the individual that enables proper definition of their needs and problems, including underlying causes | What about this individual must be evaluated to identify the causes and define consequences of their current condition, and identify their needs, strengths, risks, problems, and prospects? | OBRA requirement for comprehensive assessment (CFR 483.20[a] Resident assessment)  
Specified timeframes for doing the assessment (initial comprehensive assessment within 14 days of admission; subsequently, at least quarterly and with significant condition change (CFR 483.20[b][2] Resident assessment)  
Specified format for basic assessment (Minimum Data Set [MDS]) (CFR 483.20[b][2] Resident assessment) |
| Problem definition      | Correctly and completely define the individual's problems, risks, and needs so that appropriate measures can be developed | What are the manifestations or consequences of the individual's current situation?  
What are the significant risk factors for this individual?  
What about this individual presents a risk or problem that requires some action such as an intervention, monitoring, and so on? | OBRA requirements related to achieving "highest practicable" and demonstrating "medically unavoidable" outcomes (CMS State Operations Manual, Task 6: Information Analysis for Deficiency Determination)  
Resident Assessment Protocols (RAPs) and RAP guidelines (CMS State Operations Manual, Task 5C: Resident Review) |
| Identifying and         | Correctly relate the physical, functional, and psychosocial causes of problems to each other and to their consequences | What are the causes of the individual's current condition and situation?  
To what extent are those causes correctable?  
How would addressing those causes impact the consequences? | OBRA requirements related to demonstrating "medically unavoidable" outcomes (CMS State Operations Manual, Task 5: Information Gathering, General Procedures)  
Resident Assessment Protocols (RAPs) and RAP guidelines |
| evaluating causes       |                                                                                     |                                                                              |                                                                                                                                                                                                                                                                    |
| Identifying care goals  | Correctly and adequately define the purpose of giving care and the criteria that will be used to determine when the objectives have been met | What are the overall goals for this individual?  
How do we know when those goals will be met?  
How will specific treatments and services contribute to achieving those goals? | OBRA care planning requirements (CFR 483.20[k] Comprehensive care plans)  
Regulatory requirements for involving patients and families (CFR 483.10 Resident rights)  
Regulatory-based rights to refuse treatment (CFR 483.10[b][4] Resident rights)  
OBRA care planning requirements (CFR483.20[k] Comprehensive care plans) |
| and objectives          |                                                                                     |                                                                              |                                                                                                                                                                                                                                                                    |
| Care planning           | Create a plan to address the individual's problems, including the responsibilities of various individuals and disciplines, based on recognition of causes and consequences | How are current or proposed treatments and services expected to address the causes and consequences of this individual's current status?  
How are those treatments and services expected to help accomplish the overall objectives for that individual?  
How will we know when the individual has had enough of specific treatments and services? |                                                                                                                                                                                                                                                                     |
Table 2. Continued.

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<th>Objectives</th>
<th>Key questions</th>
<th>Examples of regulatory influences</th>
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<tr>
<td>Managing identified problems and risks</td>
<td>Identify and implement appropriate interventions to address the causes and consequences of an individual’s current status, problems, and risks</td>
<td>What measures should be taken to try to reduce risks? What specific treatments and services should be rendered? What changes to current treatments are needed? When should symptomatic or cause-specific interventions be used and why?</td>
<td>OBRA requirements related to demonstrating “medically unavoidable” outcomes</td>
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<td>Management of new situations, problems, and complications</td>
<td>Identify and manage situations and problems that arise as a result of existing conditions or that did not exist previously</td>
<td>What new needs, problems, risks, or conditions have arisen since admission? What are their causes? How, and how urgently, should they be managed?</td>
<td>Regulations and surveyor guidelines related to pressure ulcer treatment (CFR 483.25) and food intake (CFR 483.25[a][1][iv] Eating)</td>
</tr>
<tr>
<td>Monitoring progress</td>
<td>Review individual’s progress toward certain goals</td>
<td>How is the individual responding in general? What is the prognosis? Is discharge potential and to what degree?</td>
<td>OBRA care planning requirements</td>
</tr>
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<td>Adjust interventions accordingly</td>
<td>What new needs, problems, risks, or conditions have arisen since admission? What are their causes? How, and how urgently, should they be managed?</td>
<td>OBRA requirements related to demonstrating “medically unavoidable” outcomes</td>
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<td>Identify point at which care objectives have been achieved sufficiently to allow for change in overall plan or for transfer elsewhere</td>
<td>How is it to be identified when an individual has completed one phase of their care and is ready to begin another one?</td>
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<td>Arrange discharge and transfer when possible</td>
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Physicians are taught that effective care depends on collecting and interpreting enough pertinent information. They need detailed symptom descriptions and must analyze these descriptions to determine the appropriate treatments or conclusions about whether proper treatments or conclusions were rendered. Physicians must be careful not to be misled by regulatory frameworks or erroneous interpretations.
the information thoroughly to define problems correctly and differentiate the significance and causes of symptoms. A patient’s symptoms or test results could represent anything from normal variation to serious underlying illness.

For example, “agitation” could represent momentary anxiety in an otherwise calm person or, at the other end of the spectrum, acute psychosis or delirium; hyperventilation is not the same as dyspnea; tremor or loss of consciousness with shaking does not necessarily imply a seizure; apathy is not the same as depression; motor restlessness is not equivalent to agitation; and fatigue differs from weakness.

Patients in long-term care facilities rarely report their symptoms directly to a healthcare practitioner. If they can do so, they are most likely to report symptoms to a nursing assistant, family member, nurse, or other caregiver. Because they effectively become surrogate historians, facility staff must describe symptoms as accurately and completely as possible so that practitioners can determine their significance.

State and federal regulations and surveyor guidelines cannot address the practical problems related to performing a proper professional assessment. Nursing facilities should have related protocols and guidelines to assist with these functions. For example, pain guidelines can identify key descriptions of symptoms (for example, onset, duration, intensity, location, and so on) and note important causes of pain such as fibromyalgia that might not be mentioned in regulatory guidance. Protocols could help to clarify important issues such as fluid and electrolyte imbalance, because even physicians often misdiagnose dehydration.65

Nursing facilities and physicians cannot rely just on regulations to assess or manage patients effectively. As noted in Table 3, physicians play an essential role in interpreting and applying information to define problems and identify causes of diverse conditions and symptoms. They must play, and be allowed to assert, their proper role in the care process.

Outcomes

Public oversight of long-term care tends to stress achieving certain outcomes. For example, public reporting about nursing home quality relies on indicators of outcomes (individuals with persistent pain, those with unplanned weight loss, and so on) to evaluate the success of the care and identify the need for improvement. However, it is not clear to what extent the emphasis on outcomes helps identify and address real care issues or demonstrates the effectiveness of care. Additionally, outcome measures rarely consider how treating one condition or symptoms could cause other problems that might not be measured.

Regulations have had a mixed influence on results in long-term care. For example, several practices appear to have improved, including a reduction in the use of physical restraints and indwelling urinary catheters, and increased presence of advanced directives, participation in activities, and use of toileting programs for residents with bowel incontinence. However, although psychoactive medication use declined initially,6 older psychoactive medications are being replaced by a new generation of medications and by expanded use of other medications such as antiepileptics. There is also little evidence of significant improvements in other areas such as the effective nonmedical management of problematic behavior7 or a reduction in pressure ulcer prevalence since implementation of OBRA ’87.7 Physicians should also consider the evidence of limited impact of other common practices that they are asked to authorize, for example, dietary restrictions,8 altered diet consistencies,9 and rehabilitation therapies in individuals with medical causes of impaired function.10,11

IMPLEMENTING A MORE EFFECTIVE PATIENT CARE PROCESS

With the facility medical director’s support, physicians can help implement the spirit of long-term care laws and regulations without being derailed by their shortcomings.

In the assessment stages, physicians can provide and clarify important patient history and perform a careful physical examination. Periodically, they can review the accuracy and relevance of information that other disciplines have documented and compare the information with their own assessments. They can distinguish between description and analysis of findings; for example, affect could be described as flat or sad, but should not be described prematurely as “depressed.”

In the problem definition stage, physicians can emphasize the importance of adequate detail in defining issues more accurately. Identifying the causes of symptoms requires details such as onset, duration, nature, frequency, and associated factors. For example, it is not enough just to describe someone as “having pain” or “having a behavior problem,” and it is imprudent to treat them based on such superficial information.

Physicians can challenge inadequate reporting and documentation of information and guide more detailed written and verbal reports of symptoms. Additionally, physicians can help correct the inappropriate use and interpretation of diagnostic testing; for example, pulse oximetry is often interpreted incorrectly and its limitations could be misunderstood.12

Physicians can play a vital role in the cause identification stage by appropriately reviewing available information, ordering relevant testing, explaining to staff the basis for various diagnostic conclusions, and discouraging facility staff from speculating inappropriately about causes. For example, nursing home staff could incorrectly attribute various symptoms such as agitated behaviors and decline in function to “urinary tract infections” in the presence of asymptomatic bacteriuria,13 and might not recognize other more relevant causes such as adverse drug reactions or fluid and electrolyte imbalance.

Physicians can also play a vital role in care planning and implementation. Although they might rarely attend care conferences and care plan meetings, they can discuss patient issues and respond to questions by telephone, review test results and staff documentation by fax, and explain medical factors that could impede functional improvement. They can also indicate which interventions are relevant to underlying causes, identify situations in which treatments could be causing complications, and discuss and guide the staff, patients, and families in end-of-life situations in which aggressive medical interventions might not be indicated.
### Table 3. How Laws and Regulations Relate to Physicians’ Clinical Responsibilities

<table>
<thead>
<tr>
<th>Physician roles</th>
<th>Specific physician functions</th>
<th>Impact of laws and regulations</th>
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<tbody>
<tr>
<td><strong>Physicians should help guide pertinent ethical decision-making and advance care planning</strong></td>
<td>Help guide patients, families, and staff in appropriate advance care planning</td>
<td>Constitutional law protects the rights of individuals to know about proposed treatments and their rights to refuse life-sustaining treatment</td>
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<td>Help identify the relevance of proposed treatments to patient wishes related to withholding or withdrawing treatments</td>
<td>Many laws and regulations require specific aspects of physician participation, for example, defining decision-making capacity, certifying terminal condition</td>
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<td>Help determine decision-making capacity in difficult situations, consistent with generally recognized approaches</td>
<td>Limited in helping patients, families, and staff identify relevant treatment options</td>
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<td></td>
<td>Review medical documentation and orders regarding advance care planning and treatment choices for consistency with patient/family wishes and applicable laws and regulations</td>
<td>Judicial system deals with competence; decision-making capacity is a separate but related issue</td>
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<td>Complete any ethics certifications correctly, in accordance with state law</td>
<td>Appropriate, timely documentation can minimize legal complications and allow for more relevant treatment to proceed</td>
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<td><strong>Physicians should help evaluate and manage behavior problems</strong></td>
<td>Assess patients for medical causes of problematic behavior</td>
<td>OBRA and other regulations emphasize appropriate medication use and provide lists of alternative causes of problematic behavior</td>
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<td>Help identify the nature and possible causes of changes in behavior or cognition before calling in a psychiatrist</td>
<td>Limited in helping identify nature and causes of a patient’s behavioral issues or whether or to what extent medications are indicated</td>
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<td>Seek and address medical causes of problematic behavior such as adverse drug reactions (ADRs) and fluid and electrolyte imbalance in individuals with changed or problematic behavior</td>
<td>Limited identification of nonpsychoactive medications that cause agitation, altered behavior, and other significant behavioral symptoms</td>
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<td>Prescribe or adjust psychoactive medications in accordance with generally acknowledged principles about their safe and effective use in the elderly</td>
<td>OBRA and other regulations recognize falling as a problem and provide lists of possible causes, but do not help identify specific causes in individual patients</td>
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<td>Recognize significant risks, side effects, and complications related to psychoactive medications, and to help staff address medication-related problems</td>
<td>Many medications that regulations do not identify as problematic are a significant cause of falling and increased fall risk</td>
</tr>
<tr>
<td><strong>Physicians should help evaluate and manage falls</strong></td>
<td>Assess medical causes of falling or fall risk in individuals who fall repeatedly or when staff cannot readily identify causes</td>
<td>OBRA and other regulations emphasize hydration issues, but do not help identify the nature, causes, or severity of fluid and electrolyte imbalance in specific cases</td>
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<td>If another plausible cause of falling is not readily identified, review and adjust medications that could be associated with falling or explain why it was not feasible to do so, despite the patient’s continued falling or fall risk</td>
<td>Regulations, like some practitioners, could use the term “dehydration” excessively and incorrectly; they do not adequately identify the various degrees, types, and causes of fluid and electrolyte imbalance</td>
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<tr>
<td><strong>Physicians should help evaluate and manage hydration risks and problems</strong></td>
<td>Assess and document significant hydration risks as a result of medical issues and medications</td>
<td>OBRA and other regulations discuss incontinence or the use of indwelling urinary catheters, but do not help identify causes, their potential reversibility, and appropriate interventions in specific patients</td>
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<td>Identify and help monitor individuals at risk for fluid and electrolyte imbalance and try to minimize such risks</td>
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<td>Advise the staff regarding monitoring of individuals with existing fluid and electrolyte imbalance</td>
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<td>Do not just defer to nurses and dietitians to address these issues that often have underlying medical causes</td>
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<tr>
<td>Physician roles</td>
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| Physicians should help evaluate and manage altered nutritional status and unplanned weight loss | - Assess and document significant nutrition risks as a result of medical issues and medications.  
- Assess and document medical conditions and medications that could be associated with nutritional risks (including lethargy, confusion, nausea, anorexia, and so on) or impaired nutritional status, including unplanned weight loss; unless situation is readily correctable, do not just order a dietitian consultation.  
- Help identify and document medically unavoidable weight losses situations.  
- Consider and document search for causes, or reasons why seeking causes was not indicated, before prescribing medications for appetite. | OBRA and other regulations could cause confusion by implying that specific disciplines should be involved in managing nutritional issues, which could be misinterpreted to mean that those disciplines should direct or primarily identify or manage underlying causes. Regulations, or misinterpretation of them, could be based on myths and misconceptions about nutrition and illness, exaggerate the benefits of nutrition in situations such as pressure ulcer management, and might not adequately recognize the limited benefits of nutrition in multisystem organ failure and advanced illnesses. |
| Physicians should be involved in the effective evaluation and management of pain | - Perform and document an adequate evaluation of pain, including causes, especially if the individual is not responding readily to simple interventions.  
- Help evaluate and document findings related to the patient with more complex or difficult to treat pain; do more than just order and adjust analgesics by telephone.  
- Manage pain in accordance with generally recognized principles about the indications, efficacy, potential risks and problems associated with analgesics, including considering causes and location of pain and relevance of different categories of analgesics.  
- Seek and address significant adverse drug reactions (ADRs) related to analgesics such as severe constipation, falling, lethargy, and anorexia. | Laws and regulations promote recognition and management of pain, but do not help to identify some issues that are critical to proper pain management such as proper treatment selection and minimizing adverse effects of analgesics in individual patients. |
| Physicians should be involved in prevention of skin breakdown and in the management of active pressure ulcers | - Help identify individuals at risk for skin breakdown and propose appropriate preventive measures as indicated.  
- Evaluate complex or nonhealing wounds and review for potentially improvable medical problems or medication side effects that could create risk factors such as altered level of consciousness, appetite, hydration status, or mobility that could directly or indirectly affect wound incidence or healing; do not just keep ordering wound treatment over the phone or request consultations.  
- After seeking to identify addressable causes and risk factors, help document why a wound is not expected to heal or has not healed as anticipated. | Laws and regulations identify pressure ulcers as an important issue, and promote prevention and treatment. Laws and regulations generally do not recognize known limitations of prevention and treatment measures, especially in individuals with serious underlying comorbidities. Laws and regulations are not applied uniformly to different settings where frail individuals are at risk for, and acquire, pressure ulcers such as hospitals. |
| Physicians should be involved appropriately in evaluating and managing anemia and other hematologic problems | - Attempt to identify cause, nature, and severity of anemia or other hematologic problems.  
- Prescribe treatments such as iron or erythropoietin consistent with generally recognized principles for their use and with adequate justification; do not just order and continue them indefinitely without clear justification. | Laws and regulations do not generally address numerous clinically important issues such as anemia. |
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<td>Physicians should try to prevent delirium, and to promptly identify and manage it when present</td>
<td>Help identify and manage delirium and try to minimize risks for its occurrence by addressing risk factors such as medications and predisposing medical conditions. Recognize and address delirium in new and existing patients, including identification of underlying medical and medication causes; do not just order a psychiatric consultation.</td>
<td>OBRA regulations identify delirium as an issue and require coding of possible symptoms in the MDS, but do not help identify its presence, severity, or causes in specific cases.</td>
</tr>
<tr>
<td>Physicians should use medications judiciously in the elderly, and should recognize and manage adverse drug reactions (ADRs) effectively when they occur</td>
<td>Consider relative risks and benefits of all medications used in the frail elderly and those with chronic illnesses and disabilities, because of significant potential for adverse drug reactions (ADRs) and because efficacy and indications could differ from those in healthier or younger patients. Recognize the importance of medications as a major source of preventable death and disability in the elderly. Prescribe medication doses or combinations that recognize the population’s high risk for ADRs. Refer to published precautions and warnings (e.g., the PDR) about significant risks of commonly prescribed medications. Be aware of common syndromes that often reflect adverse drug reactions, for example, recurrent falling, increasing confusion, worsening behavior, anorexia, or weight loss. Review for medication-related complications as a potential cause of acute condition changes and significant functional decline. Address ADRs by carefully considering the need to taper or stop problematic medications, or document reasons for continuing a medication or dose despite risks or probability of a current ADR; do not just treat symptoms related to ADRs by prescribing additional medications.</td>
<td>Regulations focus on the dangers of selected medications or medication categories while inadequately presenting or overlooking important risks posed by other medications or medication combinations. Laws and regulations could directly or indirectly promote excessive use of inappropriate medications by encouraging or expecting the medical treatment for individuals with specific conditions or by not acknowledging significant limitations and risks of medications. Laws and regulations rarely identify the significant risks of combinations of medications from various categories. Laws and regulations do not reflect the major physician role (including consultants and specialists) in the hospital and community in placing patients on high-risk medications or in causing or failing to identify or address ADRs.</td>
</tr>
<tr>
<td>Physicians should coordinate the input and recommendations of those of other disciplines and consultants</td>
<td>Help identify the relevance and risks of treatments requested or recommended by other staff and consultants, not just authorize orders or turn the problem completely over to others. Help integrate the input, recommendations, and patient management activities of other disciplines and consultants so that the patient has a consistent, coherent, and compatible treatment plan; do not just request and accept verbatim the comments and recommendations of individual consultants, because consultants often do not look at the entire patient.</td>
<td>Laws and regulations could overemphasize certain parts of the care process or could promote participation of specific disciplines possibly beyond the scope of their qualifications. Misinterpretation of laws and regulations could result in failing to recognize the important role of the primary care nurse and practitioner in coordinating and integrating the whole care picture, or in overusing specialists and consultants.</td>
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CONCLUSIONS

The proper care of the frail elderly and others with complex chronic illnesses and disabilities depends heavily on an effective patient care process and on appropriate physician performance and practice. Many key medical director functions relate to overseeing effective facility and physician performance in these critical areas.

Laws and regulations play a major role in all aspects of long-term care. They reflect public expectations and identify some key aspects of care. They allude to care processes but they do not provide enough detail about valid processes and practices. To some extent, they identify key medical director and attending physician roles and responsibilities, but not enough to guide effective physician practice or medical director performance.

Researchers continue to study various aspects of long-term care and to identify many allegedly inadequate practices; others propose that results could and should be better. Various recommended solutions include more regulations, stronger enforcement, more research, and more evidence-based interventions. However, perhaps much of this misses the mark.

It could be time to get back to the basics: (1) study and identify how the basic patient care process has been shortchanged; (2) realign incentives and instructions to promote it properly; and (3) identify and promote the proper role of key participants, including physicians, in that process.

Medical directors and physicians should vigorously promote good practice and proper care process, as identified in key professional protocols and guidelines. After all, the OBRA ‘87 regulations assign the medical director to oversee and implement all clinical policies, not just medical ones. Laws and regulations cannot replace the basic care process or substitute for effective physician participation in key care process steps, especially problem definition, cause identification, decisions about whether and which interventions are warranted, determinations of patient progress, and identification of reasons for failure to improve or stabilize.

Nursing facilities should recognize the limitations of laws and regulations, and the critical value of physicians, in achieving an effective patient care process. They should identify medical director responsibilities and encourage and allow the medical director to ensure that staff and physicians follow that process and provide effective care based on the vast geriatric and medical literature.

REFERENCES