Roles and Responsibilities of Attending Physicians in Skilled Nursing Facilities

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There is an ongoing public debate on the perceived lack of quality care in many nursing facilities and the best means for improvement. Suggested solutions include improving reimbursement, mandating staffing levels, implementing practice guidelines and other care processes, reducing the regulatory burden, increasing the use of managed care, and much more.1,2 Little research has been done on the relationship between physician involvement and quality of care in nursing facilities. Recent literature suggests that quality of care in various settings, including nursing facilities, is related to physician involvement and physician staffing patterns.3–6 The Committee on Improving Quality in Long-Term Care of the Institute of Medicine believes that “nursing homes should . . . enable and require a more focused and dedicated medical staff” as part of the solution for improving quality.1 The American Medical Directors Association (AMDA) has always maintained that physician involvement in long-term care is essential to the delivery of quality care.7

Beginning with the shift in hospital reimbursement some two decades ago, there has been a shift in the type of population cared for in skilled nursing facilities.8,9 With the compression of morbidity, today’s older people have less disability,10 enabling them to take advantage of new options in community-based and assisted living programs. Today’s nursing facility residents are those for whom no other option exists: they need high acuity postacute or end-of-life care, are increasingly frail and medically complex, and more than half suffer from dementia.11 But paradigms of care have not shifted significantly in tandem with these changes. The current nursing-dominated process of care, combined with staffing shortage and competency issues, simply does not suffice, as evidenced by reports of inadequate care1 and the mounting liability crisis.12,13

Despite increasing medical complexity and acuity over time, physician involvement in nursing facilities has been inadequate.14–17 Physicians are reluctant to get involved for various reasons related to reimbursement, regulations, negative public perception, liability, and the unfamiliar nursing home culture and practice environment. Yet today’s nursing facility population requires much more medical attention than what is generally available. Given the acuity and medical complexity of today’s nursing facility residents, improvement in quality of care and resolution of the liability crisis can be achieved if attending physicians change the way they provide care to their nursing facility residents and treat them in the same manner they treat residents in the office or hospital. For example, physicians should be prepared to be available, personally or via adequate coverage arrangements, to see residents as often as medical conditions require, as well as proactively anticipating and arranging for follow-up visits.

The attending physician must also understand that nursing facility residents require an approach to care that combines chronic and acute elements. In addition to attention to apparent and to difficult-to-recognize acute or subacute problems (for example, delirium), attention must be directed to chronic problems, functional impairments and disabilities, palliative care, risks and preventive care, psychosocial and family issues, all in the context of resident choices, preferences or advanced directives and quality of life concerns.18–20 In addition, all this needs to be done within a difficult regulatory, institutional, and reimbursement environment requiring team work and specific documentation. It is the medical director’s responsibility to educate attending physicians about these issues as well as to provide them with tools and processes that help them practice quality care. Attending physicians should be educated in geriatric care principles, a process of care that includes recognition of multiple problems, cause assessment, care goals and planning, evidence-based intervention, geriatric prescribing, and care monitoring. They should be vigilant in attempting to obtain clinical information that is often minimal11 and provide adequate documentation rather than leaving it to others. They should have a working knowledge of available geriatric assessment tools22 the Resident Assessment Instrument (RAI), Minimum Data Set (MDS), and Resident Assessment Protocols (RAPs)23 as well as various state-specific assessment and transfer documents. Finally, they should understand and document the basis for billing level decisions as well as their supervision of midlevel practitioners.

Medical practice in nursing facilities is different than in other practice locations. Because of the special population served, physicians must work as members of the care team, and must understand regulatory and other requirements that are different than those in other practice settings.24–26 A previous review27 listed regulatory and accreditation requirements related to the role and responsibilities of attending physicians. The majority of recommendations in this review regarding physicians’ roles and responsibilities are driven by regulatory requirements. Few are based on evidence from the
models of medical care

Most long-term care facilities have an open medical staff, allowing any physician who wishes to admit and care for residents to do so. This allows for greater continuity in resident care, when the primary care physician is able to serve as the attending physician in the facility. Others have a relatively closed staff, allowing only a handful of physicians to provide care in the facility. An advantage to a closed staff model can be availability and involvement of the attending physicians in the care of the residents. A facility with a closed staff must still allow for resident choice of physicians as required by federal regulations, but can require physicians to meet certain requirements for medical staff membership. Some facilities require physicians to sign a written contract setting forth their obligations, and in others, there may exist an organized medical staff structure, with its own bylaws, rules, and regulations similar to the structure that exists in most hospitals. Physicians may practice individually or as members of a group practice. Some facilities have exclusive arrangements with medical groups to provide primary or specialty care or both. Such arrangements may be subject to legal scrutiny based on federal requirements for residents’ choice or state statutes. A small number of facilities choose a staff model where few primary care physicians, employed full-time or part-time by the facility or parent organization, provide all primary and/or specialty care. This correlates with the emerging concept of hospitalists. Proponents of this model point out to evidence of improved quality of care with this model. There are many permutations and variations of these basic arrangements. Regardless of the staff model, many facilities tend to assign physicians exclusively to certain geographic areas in the facility, such as nursing units or specialty units, the argument being that this improves teamwork and communications with the physician and increases presence on the unit.

physician involvement in committees and medical staff affairs

Where organized medical staffs exist, attending physicians need to participate in the affairs of the staff organization, including participation in committees and representation of the medical staff to the governing body. This function may be separate and apart from the medical director, who is an agent of the facility and may or may not be a member of the medical staff. Involvement may also mean participation on various facility committees such as quality improvement, ethics, pharmacology and therapeutics, or infection control. Physicians should also be a training resource to other professionals in the facility and participate in facility training programs.

ethics, professionalism, compliance and nondiscrimination

Ethical and professional conduct of attending physicians is governed by the principles of medical ethics, as described in codes adopted by major medical organizations such as the American Medical Association (AMA). Recently, several organizations adopted a new charter entitled “Medical Professionalism in the New Millennium: A Physician Charter” setting forth principles including the primacy of patient welfare, patient autonomy and social justice, and a set of professional responsibilities such as commitments to professional competence, honesty to patients, patient confidentiality, maintaining appropriate relationships with patients, improving quality of care and access to care, just distribution of finite resources, commitment to scientific knowledge and maintaining trust by managing conflicts of interest. Physician adherence to professional principles would go a long way towards improving patient care in the nursing home.

In addition to ethical principles, physicians should participate in facility efforts to maintain regulatory compliance including assuring the medical necessity of their own services as well as services they order and appropriate documentation and billing. Physicians are also required, as any other entity, to accept and provide care to all residents regardless of age, sex, race, creed, color or national origin (and sexual preference in some states or locales). Facilities may establish additional requirements, such as acceptance without regard to payment source and participation in selected managed care plans.

credentialing, competence and performance

Most facilities require physicians to undergo an initial and periodic credentialing and privileging process. This may be required by state regulations, Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards in accredited facilities, or the facility’s own policies. Credentialing may ensure educational background and competence. Many facilities also perform a periodic evaluation of physicians’ specific administrative and clinical performance. Indicators may include availability, timeliness of care, effective communication, team participation, documentation accuracy, medication management, or clinical outcomes.

federal, state and joint commission regulations and standards

Medical practice in nursing facilities is regulated to a much larger extent than practice in any other setting. There are specific federal regulations for nursing facilities and state-specific additional regulations. A small number of facilities are voluntarily accredited by the JCAHO and need to abide by its standards. Nursing facilities, like all other healthcare facilities, are subject to regulatory oversight by many other agencies (such as the Occupational Health and Safety Adminis-
Physician Availability and Coverage

Admission. Federal regulations require that a physician personally approve each admission to a long-term care facility. This may be done by a physician outside the facility or by the admitting physician. The physician should visit the resident as soon after admission as the resident's medical condition requires and perform an admission history, physical examination, and assessment. Regulations do not prescribe a specific time frame for this visit and make an exception when an examination was performed within 5 days before admission with documentation in the record. Admission may be defined by facility policies to include any new admission, readmission, or return from bedhold. Because most residents are admitted to long-term care following an acute care stay and may not be medically stable, physicians are well advised to perform an admission visit as soon as possible. Many facilities have policies requiring an admission visit within 24 hours of admission. When a midlevel practitioner is available, such practitioner may see the resident upon admission. However, an admission visit cannot be done by a nurse practitioner. A nurse practitioner may visit the resident upon admission to the facility before the physician's admission visit, when such visit is medically necessary; however, such visit should be considered an interim visit, and the physician must complete the admission visit as required by facility policy.

Periodic visits. Primary care physicians should personally visit each resident in the facility (except when delegated to a midlevel practitioner) whenever the resident's condition warrants medical attention and regularly in accordance with the facility's established schedule but no less often than once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A scheduled physician visit must never occur more than 10 days after the visit is scheduled. Such slippage does not affect the next scheduled due date. This minimum schedule is required by federal regulation, but may not be sufficient for many residents whose level of medical complexity or acuity requires far more medical attention. The Medicare and Medicaid programs impose no limits on the number of billable visits, as long as the visits are medically necessary.

Acute change in condition, accidents and other emergencies. Primary care physicians should be notified and attend to any emergency or significant change in the resident's clinical status. They should make accident and emergency visits or upon significant change in condition upon notification or as soon as the resident's medical condition requires. The primary care physician, a midlevel practitioner or covering physician should come to the facility to see the resident in the event of an emergency or a significant change in the resident's medical condition within a reasonable time as determined by the nature of the emergency. In this situation, teamwork and familiarity with facility staff are invaluable, because the physician must rely on information conveyed verbally to make a decision on a medical condition. Thus, appropriate information must be conveyed. To improve the quality of this communications, facilities should have available protocols that outline what clinical situation merits a call to the physician and what specific information must be available and conveyed to the physician. AMDA has developed proposed protocols for common clinical conditions that can be used as the basis for developing facility-specific protocols.

Presence in the facility. Physicians should make an attempt to schedule routine visits in the facility as frequently as possible and warranted by the number of residents to whom they provide medical care, and ensure that staff is aware of their scheduled visits. This reduces unnecessary phone calls for routine matters that can be deferred until the physician is present in the facility, and reduces possible errors inherent in remote communications.

Coverage. The physician is responsible for the care of the resident at all times. This means that when a physician is not available, it is his or her responsibility to provide coverage by another physician to supervise the medical care of the residents. This may not always be practical or feasible, so physicians and facilities may rely on on-call and emergency coverage schedules. State regulations or facilities may require that covering physicians be credentialed to practice in the facility. Care by covering physicians who are less familiar with the residents they see or are called about is a potential weak link in the process of care and is prone to errors. Therefore physicians must ensure a robust system of communications between nursing staff and covering physicians and between attending physicians and their covering physicians or midlevel practitioners.

Availability by telephone. Physicians must be available to the staff for telephone consultations at all times except when an on-call coverage schedule is in effect. It is important to have a communication system established for such communications, such as facsimile or electronic transmission. In this situation, teamwork and familiarity with facility staff are invaluable, because the physician must rely on information conveyed verbally or electronically to make a decision on a medical condition. Again, protocols must be established for the purpose of communications as described above. To reduce transcription errors, physicians should, whenever possible, transmit orders via fax or electronically. It is a good risk management technique to keep a log of all conversations with facility staff as well as all verbal, electronic, and telephone orders. Physicians must document these conversations and orders in the medical record either by transmitting a progress note or documenting (with appropriate dating) when arriving next to the facility. More importantly, it is crucial that the physician, a covering physician or a midlevel practitioner follow the resident in a timely manner after providing a
telephone or verbal order as the clinical condition dictates. For example, if order is given for antibiotics because infection is suspected, a resident should be followed and examined as soon as clinically indicated. Other routine orders may not require an immediate follow-up. The facility should have a protocol for appropriate follow-up on telephone and electronic communications. State regulations may require physician signature on telephone orders within a certain amount of time. These regulations are intended to ensure appropriate follow-up rather than paper compliance.

DELEGATION TO MID-LEVEL PRACTITIONERS

Physicians may delegate every other scheduled visit to a nurse practitioner (NP) or physician assistant (PA) when such visits are within the NP or PA scope of practice in compliance with applicable state regulations. The physician may delegate to a NP or PA any other medical care related task when such task is within the NP or PA scope of practice in compliance with applicable state regulations. The physician may not delegate any task to a NP or PA when federal or state regulations require such task to be performed personally by a physician. Nurse practitioners provide care in collaboration with physicians under a written practice agreement and practice protocols, as defined by state regulations. Physician assistants usually work under direct physician supervision as defined by state regulations. Each facility needs to develop protocols defining the roles and responsibilities of NPs and PAs.

Admission visits cannot be done by a NP. A NP may visit the resident upon admission to the facility before the physician’s admission visit, when such visit is medically necessary; however, such visit may be considered an interim visit and the physician must complete the admission visit as required by the facility policy.

Physicians and midlevel practitioners should document their collaboration and the supervision of care by physicians. Failure to do so may result in legal liability. Physicians and midlevel practitioners should be familiar with Medicare billing requirements and with the specific regulatory requirements of their state.

Studies demonstrate that collaboration with midlevel practitioners, particularly in the context of long-term care, may reduce emergency department use and hospitalization of nursing facility residents and potentially improve primary care.

PHYSICIAN VISITS

Admission Visit

Admission documentation should start with the reason for admission to the long-term care facility. Accurate and complete medical, surgical and family/social history should be obtained. It is imperative to obtain recent results of pertinent diagnostic tests done at other institutions, as this may save unnecessary discomfort to the resident and expense to the facility. A list of current medications, including over-the-counter medications, vitamins and herbal preparations should be compiled. The complete physical examination should include an assessment of mental status and a functional assessment of impairments and disabilities. The physician or other staff as appropriate should administer bedside screening instruments, such as Geriatric Depression Scale or Folstein’s Mini-Mental State Exam (MMSE) and/or use respective MDS components such as recall score as part of the admission assessment. At a minimum, a functional assessment should address issues of mobility, nutrition, hydration, cognition, affect, anxiety and sleep, agitation and behavior problems, senses including hearing and vision, speech and communications, and presence of wounds, contractures, pain, constipation and urinary or fecal incontinence. A risk assessment should be documented including the risks for development of pressure ulcers, malnutrition and dehydration, aspiration, infection, falls and injuries, contractures and fecal impaction.

The assessment should also include determination of capacity to make healthcare decisions and obtaining the resident’s and/or family preferences and goals of care (cure, maintenance, or palliative care), advance directives, and preferences for cardiopulmonary resuscitation (CPR). A complete list of diagnoses/conditions/problems, functional impairments, disabilities and risks should be prepared.

At the time of admission, it may not be possible to complete all assessments and formulate care goals and plans, as that requires a comprehensive assessment by the care team. However, the first few days after admission are a time of increased risk of complications related to both the resident’s adjustment and lack of complete assessment in all domains. Some judgement about the potential for functional maintenance or improvement, rehabilitation and discharge planning may be feasible at that point. The physician must prepare at least a preliminary medical care plan and provide orders for further diagnostic tests and assessments, consultations, diet, interventions, treatments, medications, and monitoring that are necessary for the safety, health, or care of the resident. It is important to also document the possibility of unavoidable lack of improvement, deterioration, or development of complications.

First Visit After Admission

This visit should be performed as soon after admission as the resident’s medical condition requires, but no later than 30 days following admission. At this visit, the physician should review additional pertinent information that may have been obtained, such as copies of hospital records; review all consultation, laboratory data, diagnostic tests, and all assessments and evaluations performed by the facility staff and review the resident’s progress and adjustment to the facility with the staff. Based on all new data and evaluations, the physician should review and revise the medical care plan as necessary and revise the orders to reflect all necessary revisions.

Periodic Scheduled Visits

Periodic visits should be done according to the facility’s established schedule, but no less often than once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. A nurse practitioner may alternate visits with the physician. A visit is considered timely if it
occurs within 10 days of the scheduled date. Table 1 lists what the physician or nurse practitioner should include, at a minimum, at this visit.

**Interim Visits for Acute Change in Condition**

Interim visits in the facility should occur whenever the resident’s condition necessitates medical attention, including any acute or unusual medical or behavioral problem, medical emergency, or a change in the resident’s medical condition, accidents and incidents as appropriate. Table 2 lists the items that should be included, at a minimum, in the documentation of an interim visit.

**Accidents and Incidents**

The physician should visit and examine the resident as soon as necessitated by the resident’s condition following an accident. The physician should review the circumstances of the accident as documented in the nursing notes and the accident/incident report. Possible causes of the accident should also be reviewed. Particular reference should be made to mental status, cognitive deficits, sensory deficits, visual status, neurological- and muscular-related deficits including ambulatory status, cardiovascular status, and previous history of falls or other accidents. The medication regimen should be reviewed with particular reference to presence of antipsychotic, antianxiety, hypnotic, or antidepressant medications. Possible contribution of environmental factors should be considered. Items to be documented following an accident are listed in Table 3.

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**Table 1. Items to be Included in a Periodic Visit**

- Review the resident’s total program of care, including medications and treatments.
- Review all laboratory and diagnostic tests that were done since the preceding periodic visit with appropriate action regarding abnormal results.
- Review specialist’s consultations and evaluations by other members of the team.
- Review the medication regimen for continued efficiency and presence of side effects.
- Prepare and document an updated list of diagnoses and problems.
- Update the medical care plan for each of the active diagnoses/problems listed.
- Prepare, authenticate and date progress notes.
- Prepare, authenticate and date all orders; each order should have an explanation in the record.

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**Table 2. Items to be Included in Documentation of an Interim Visit**

- The medical necessity and reason for the visit
- Resident’s complaints or symptoms
- Findings of the physician’s physical examination
- Diagnostic impression (at least preliminary impression)
- Plan of care and further diagnostic work-up
- Appropriate orders

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**Table 3. Documentation Following an Accident**

- The circumstances of the accident
- Possible cause of the accident
- Pertinent findings of the physical examination with details of the injury, if any
- Plan of care for the injury, if any
- The need for intervention by physical or occupational therapy
- Plan of care for problems, which may have contributed to the accident (eg, change in medications)
- Recommendations for safety measures
- Recommendations for prevention of further accidents, as indicated
- Other changes to the care plan, such as medication changes, as appropriate

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**INTERACTING AND COMMUNICATING WITH CONSULTANTS**

Orders for initial consultations and follow-up visits by consultants must be written by the physician to specify specialty and/or consultant’s name, or specialty and time frame when appropriate. The medical necessity for each consultation must be documented by the physician at the time of the order. A protocol should be developed to define the practitioners who may independently order consultations. The protocol should define when follow-up visits by consultants require a new order by the attending physician and under what circumstances consultants may provide follow-up as needed without a new order or assume the clinical care of the resident in a specific area of specialty. The ordering practitioner must document the medical necessity for ordering each consult.

Medical necessity for consultations exists when a consultant possesses additional knowledge base or skills clearly beyond the scope of the attending physician; the service requested is appropriate for the specific individual; and the service would affect the resident’s assessment, diagnosis, or care planning and treatment.

Facility protocols should require consultants to provide services within a reasonable amount of time, which varies by clinical condition. Consultants should be required to communicate their findings and recommendations in a timely manner and provide signed, dated, and legible reports. Facilities and physicians should develop protocols to determine which consultants may write orders directly. Some facilities insist on all orders going through a primary care provider to keep control over the care, others allow all consultants to write orders. In the latter scenario, it is crucial to develop a protocol to ensure communication of these orders to the primary care provider.

Timely communication of findings and care recommendations between consultants and attending physicians is crucial to preventing medical error. Attending physicians should review and act on the reports, findings, and recommendations in a timely manner and document in their own progress notes, particularly if they choose not to follow a recommendation. Attending physicians are responsible for the appropriate follow-up on all consultants’ recommendations. There should be
a clear understanding between the attending physician and
the consultant when the consultant assumes the ongoing
clinical care of the resident, as is common with certain
specialties, such as psychiatry.47

Similar to attending physicians, consultants may delegate
to mid-level practitioners any medical care-related task when
such a task is within the practitioner’s scope of practice in
compliance with applicable state regulations. The consultant
may not delegate any task to a midlevel practitioner when
federal or state regulations require such task to be performed
personally by a physician.

LABORATORY AND DIAGNOSTIC TESTING

Diagnostic tests should be performed only upon order of a
physician, NP, or PA. The physician should document the
medical necessity and rationale for each test ordered in the
progress note. Diagnostic tests should be ordered when the
resident’s assessment, management, or care monitoring would
be affected, the test is appropriate to the care plan goals, and
the benefit exceeds the iatrogenic risk. Laboratory tests should
also be ordered to monitor drug therapy for efficacy and
adverse reactions. For residents on chronic medications, these
orders can be automated.48

Facilities must have a protocol to ensure that all diagnostic
tests ordered are performed, that nonperformance is communi-
cated to the ordering practitioner, and that all reports are
returned on a timely basis. There must be a means to com-
municate all results to the physician, as well as a protocol
defining parameters for common diagnostic and laboratory
tests that require immediate physician notification. The phy-
sician should consider quality of life issues when ordering
diagnostic tests. For example, while it may be medically prudent
to perform a blood sugar check four times daily, the pain
and discomfort associated with the procedure should be con-
sidered and discussed with the resident.

For CLIA-exempt laboratory tests that are performed in the
facility (blood glucose monitoring, urinalysis, occult blood in
stool, prothrombin time/international normalized ratio (PT/
INR)) there must be protocols to ensure accuracy as well as
documentation of results and physician notification.

Physicians are responsible to follow all abnormal diagnostic
test results, based upon patients’ need and the overall care
plan. All reports should be acknowledged by physician signa-
ture and date. All abnormal results should be documented in
the progress note with a plan for action including additional
or repeat tests and intervention as appropriate. Documentation
must occur even if there is no plan to act on an abnormal
result.

MEDICATION MANAGEMENT

The goal of medication management is to achieve cure,
improvement, maintenance, or palliation of a medical condi-
tion by using pharmacological agents. Using appropriate med-
ications means prescribing the right drug at the right dose for
the right period of time for each condition requiring treat-
ment and only for such conditions.49 The process of prescrib-
ing is complicated and does not end with providing the
medication, but is a continual process of monitoring response
and adverse effect.48 The prescribing process is described in
Table 4.

The process of prescribing is prone to errors as well as the
occurrence of predictable and unpredictable adverse reac-
tions. Together they constitute what are termed adverse drug
events.48 Medication errors are the most prevalent cause of
medical errors in the healthcare system. In a nursing facility,
the process of medication management includes the prescrib-
ing, transcribing, administration, and monitoring. The largest
number of errors occurs in the prescribing and monitoring
steps.50 Common prescribing errors include: omission of a
required drug, wrong drug, too many drugs, wrong dose, form,
frequency or duration, failure to consider allergy, failure to
consider inability to follow instructions, failure to address
drug-drug or drug-disease interactions, and failure to request,
order, or perform precautions or clinical and laboratory moni-
toring. Transcribing errors stem from illegible handwriting,
use of abbreviations, and similar-sounding medication names.
Monitoring errors include failure to assess efficacy and failure
to recognize, assess, and treat adverse reactions.

Appropriate drug use is the responsibility of the attending
physician. Federal regulations address many issues related to
medication management, including unnecessary drugs, anti-
psychotic drugs, medication errors, and drug regimen re-
view.24,25,51 Medical directors and nursing facilities must have

<table>
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<th>Table 4. Steps in the Prescribing Process*</th>
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<td>● Recognition of a problem: disease, condition, symptom or impairment that may require intervention</td>
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<td>● An assessment including evaluation of the cause</td>
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<td>● A care plan for interventions when treatment is appropriate for the overall care goals and resident wishes with documentation of the objectives to be achieved</td>
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<td>● Evaluation and plan for nonpharmacological interventions (preceding or concomitant with pharmacological interventions)</td>
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<td>● Gathering information on prior and current drug response, adverse effects and allergies</td>
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<td>● Evaluation of available drugs, their efficacy and adverse effect profile, potential drug-drug and drug-disease interactions, physical or mental ability to follow instructions and precautions, and the overall risk/benefit for the intervention and for each drug under consideration</td>
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<td>● Ordering a specific drug with appropriate dose, route and frequency and duration</td>
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<td>● Ordering appropriate precautions, clinical and laboratory monitoring and predictable adverse events or side effects to be monitored</td>
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<td>● Assessment of drug efficacy and achievement of therapeutic goals during and after treatment or periodically for chronic administration</td>
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<td>● Continual assessment for predictable and unpredictable adverse events.</td>
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<td>● Prompt identification of adverse events.</td>
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<td>● Timely reevaluation of the care goals and care plan according to therapeutic response and adverse events as clinically appropriate.</td>
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*Adapted from reference 48.
Rehabilitation includes physical, occupational, or speech therapy to restore functional independence, reduce disability, and return to community. Rehabilitation includes physical, occupational, or speech therapy. Physicians must order specific evaluation and treatment by these professionals, renew the order periodically, and discontinue when no longer needed. Similar to other care processes, the physician evaluation of a resident for need of rehabilitation includes the steps shown in Table 5.

Following evaluation, the physician should provide an order for their treatment, treatment modality, frequency, duration. As all other interventions, efficacy and adverse effects need to be monitored and the need to continue evaluated periodically in conjunction with rehabilitation professionals.

**RELATIONSHIP WITH RESIDENTS AND FAMILIES**

Federal regulations require that nursing facilities provide residents and their legal representatives with their physician’s name, specialty, address, and telephone number. Physicians are required to respond to calls from residents and their representatives to discuss the resident’s medical care. It is important for physicians to contact families upon admission and approach families with sensitivity and compassion, particularly at the difficult time surrounding the first admission to a nursing facility.

**RESIDENT RIGHTS**

Residents have the right to choose a personal attending physician. However, facilities can require that physicians are appropriately credentialed and privileged to ensure a minimum standard of competency. Residents cannot choose a physician who is not so credentialed.

Residents have the right to be fully informed by the physician in language that they can understand of their total health status, including but not limited to their medical condition (“Total health status” includes functional status, medical care, nursing care, nutritional status, rehabilitation and restorative potential, activities potential, cognitive status, oral health status, psychosocial status, and sensory and physical impairments).

Residents have the right to be fully informed in advance about care and treatment options and participate in planning or changes in care and treatment. The facility has an obligation to assist residents and their representatives to participate in the care planning process including attending care planning conferences. Residents must be allowed to make choices, and their wishes and advanced directives must be respected. Residents have the right to refuse any treatment and participation in research. However, regulations do not create a right to demand interventions that the care team deems inappropriate.

Finally, physicians must ensure that residents are provided privacy and dignity during their examinations and other interactions with physicians.

**DOCUMENTATION**

The purpose of documentation is to communicate the physician’s findings and care plan to other members of the care team, serve as a reference for future visits, become a legal record, and support billing. Medicare, Medicaid, and many managed care and insurance carriers have requirements for documentation of medical necessity for physician visits and

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**Table 5. Steps in Physician Evaluation of a Resident for Need of Rehabilitation**

- Identification of conditions, impairments, disabilities and excess disabilities that may be amenable to rehabilitation therapy
- Assessment of the causes, scope, and severity of the conditions, impairments and disabilities
- Assessment of the potential to benefit from rehabilitation, in conjunction with therapy professionals
- Assessment of the appropriateness of rehabilitation therapy, in the context of the resident’s overall physical, mental and psychosocial condition, prognosis, quality of life and wishes
- Evaluation of the resident’s ability to tolerate the proposed therapy and the potential risks and complications

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**CLINICAL PRACTICE IN LONG-TERM CARE**

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the level or intensity of evaluation and management services. Thus, progress notes must convey the necessary information and comply with regulatory and reimbursement requirements. At a minimum, a progress note should document the complaint or the problem that prompted the visit (which generally also establishes the medical necessity for the visit), physical examination findings, diagnostic impression, additional diagnostic tests or consultations ordered, interventions ordered including medications, treatments, and others, and a plan for monitoring and follow-up. A SOAP format (i.e., subjective data, objective data, assessment, and plan) usually fulfills these requirements. Depending on the level of the service (admission, periodic evaluation, comprehensive evaluation, etc.), additional documentation should include medical and surgical history, allergies and vaccinations, family and social history, and available diagnostic and laboratory tests. Documentation also should include all diagnoses and conditions, complications, communications with family, family and psychosocial issues, and the interactions with the interdisciplinary care team. Progress notes should not include phrases like “status quo.”

Most importantly, any progress note should identify clear explanation for each medical decision embedded in the care planning and the ordering of any diagnostic test or therapeutic intervention, as well as in forgoing diagnostic tests or interventions. This explanation is helpful in conveying the information to other physicians, consultants, and the care team; risk management; and establishing the medical necessity for all orders. The physician should be aware that medical necessity needs to be established for any and all orders for diagnostic tests, consultations, ancillary services, rehabilitation, therapeutic interventions, equipment, and supplies.

All abnormal diagnostic and laboratory data should be noted along with explanation, plan of action, and required follow-up, even if no action is required. Disagreement between physicians should not be discussed in the medical record. However, discrepancies among physicians’ notes as well as among physicians and other members of the care team should be rectified. This means that physicians should be careful to review notes by other members of the care team and address any discrepancies appropriately.

Long-term care residents usually have multiple past and present medical problems, active and inactive, in addition to functional impairments, disabilities, and risks. It is important to have a location in the record that displays a comprehensive list of these problems in the form of a face sheet or otherwise.

**DOCUMENTATION OF TRANSFER, DISCHARGE, AND DEATH**

A discharge summary is a means of communicating with physicians who assume care in another setting when a resident is transferred or discharged. As such, they must be completed and available in a timely manner consistent with that purpose, and must contain elements that ensure appropriate continuity of care. At a minimum, a discharge summary should include: relevant medical history; allergies and sensitivities, particularly to medications; reason for original admission; significant physical findings; diagnostic and laboratory test results; course of events and treatment given at the facility; immunizations received; a list of diagnoses and problems; and a post-discharge medical plan of care with orders including medications, diet, and treatments.

In the event of a resident’s death in the facility, the physician should document in the progress note the time of death, the events leading to the death, and the probable cause of death. Pronouncement of death, notification to coroners, and completion of death certificates should be done in compliance with applicable state and local laws, rules, and regulations.

**DOCUMENTATION OF MEDICAL NECESSITY**

Medical necessity must be established for evaluation and management services, diagnostic tests and procedures, treatments, medical/surgical procedures, equipment or supplies necessary to assess, plan, manage and monitor the health care of a resident in the facility. Medical necessity relates to appropriateness of care. If care is appropriate, (which may depend on such subjective elements as an individual’s wishes), then medical necessity exists for services required to provide that care. Therefore, appropriateness of care must also be determined by the physician as part of the medical necessity decision making. Medical necessity does not always equate with covered or billable services by payers. Services may be deemed medically necessary by a physician or other provider but may not be either covered or regarded as medically necessary by a third-party payer.

Primary care services are those services provided personally by a primary care attending physician, a certified NP, and a dentist providing basic dental services. Certain physician visits are required by federal or state regulations, but regulatory requirements do not necessarily establish that any visit or service is reasonable and/or necessary. Medicare, however, does pay for “visits to comply with federal regulations” (42CFR 483.40). Necessity for a primary care provider visit is determined by the resident’s medical condition, as documented by the provider, the nursing staff, and the comprehensive assessment process. Notwithstanding other sources of documentation in the medical record, the primary care provider must document, via the appropriate progress note or forms, the medical necessity for each and every visit.

If a resident or family request a primary care provider to visit the resident, and it is determined that there is no medical necessity, the resident, family or legal representative should be informed and advised that the resident will have to assume the financial responsibility for the service. The primary care provider must document the extent and scope of services to support level of billing and coding.

The primary care attending physician (or an independent midlevel practitioner) determines the medical necessity of treatments, diagnostic services, equipment, and supplies requiring a physician order.

Payment for many Medicare items and services is conditioned on a certification signed by a physician attesting that the item or service is medically necessary. For example, physicians are routinely required to certify to the medical necessity for any service for which they submit bills to the Medicare program. Physicians also are involved in attesting to medical
necessity when ordering services or supplies that must be billed and provided by an independent supplier or provider. Medicare requires physicians to certify the medical necessity for many of these items and services through prescriptions, orders, or, in certain specific circumstances, Certificates of Medical Necessity (CMNs). These documentation requirements substantiate that the physician has reviewed the resident's condition and has determined that services or supplies are medically necessary. Medicare requires claims for payment for certain kinds of services and supplies to be accompanied by a CMN signed by a treating physician. When a CMN is required, the facility, provider, or supplier must keep the CMN containing the treating physician's original signature and date on file.

**MEDICAL RECORDS AND HEALTH INFORMATION PRIVACY**

The physician should complete medical records within reasonable time after discharge. Physicians should be aware of federal and state statutes related to privacy of medical records and health information. Since April 13, 2003, physicians and facilities must comply with HIPAA mandates. Many states already have similar privacy statutes. Essentially, HIPAA defines permissible uses of protected health information (PHI). PHI may only be used and disclosed for treatment, payment, and healthcare operations. A written authorization is required for any other use and disclosures, such as marketing, and any use or release of confidential HIV-related information, psychotherapy notes, or substance/alcohol abuse information. As all other individuals, long-term care residents have certain rights regarding their PHI, such as the right to access and amend the information, request additional restrictions, revoke any authorization, and receive an accounting of disclosures.

**PHYSICIAN COMPENSATION**

The model of care is related to the way physicians are paid for their services. In the majority of cases, physicians operate in the fee for service environment, with or without capitation agreements for residents who have managed care or Medicare Plus Choice. In some cases, capitation is paid to the facility as a component of its daily rate, and physicians are contracted with the facility to be paid on a fee for service or capitation basis for their services. Depending on the payer mix in a specific facility, physicians may be required to participate in specific managed care plans in addition to participation in the Medicare and Medicaid programs. Most physicians are free agents and bill the residents or insurance for their services. Medicare and Medicaid billing requires using specific codes and adhering to billing regulations. Medicare billing requires the use of Current Procedural Terminology (CPT) codes for reporting physician services. There are specific CPT codes for various levels of physician services in nursing facilities and additional requirements for the reporting of place of service. In addition, Medicare payments are predicated on the services being reasonable and necessary. The Evaluation and Management coding system with its attendant documentation requirements are currently under revision by the AMA.

**QUALITY ASSURANCE AND IMPROVEMENT, RESIDENT SAFETY, RISK MANAGEMENT, AND MEDICAL ERRORS**

The quality assurance and improvement process includes steps to ensure that facility processes are designed to deliver care according to current standards (quality planning), that the processes in fact deliver the care as planned (quality control), and that over time the processes are changed to deliver better outcomes (quality improvement). When the process goes errant, the result is medical errors, which may compromise resident safety and cause legal and regulatory risk. Therefore, the facility must constantly measure and monitor processes and outcomes to ensure that care is delivered as intended and that problems with the delivery of care are dealt with and corrected or improved promptly. This process is not something that some manager somewhere does at a remote location. To be successful, it requires active participation by all members of the care team who provide the care within the process, including the physician. Every physician should be familiar with, and actively participate, in developing and maintaining this process. When problems with the process or outcome of care occur, they must be promptly detected and reported so correction can follow. When physicians detect systemic problems, they should work with the medical director to correct or improve them.

In the process of delivering care, physicians apply specific medical knowledge in a systematic manner to provide a solution to a healthcare problem. Each time care is provided, the physician should follow a process of care that includes the following: recognition of the problem; assessment; evaluation of the problem's root cause; development of a care plan for intervention; delivering the intervention; and monitoring the outcome for efficacy, complications, and adverse reaction with appropriate and timely adjustments to the care plan. If the process is applied appropriately, it will generally result in expected outcomes. Within a healthcare facility, many such processes occur at any given time. Policies and procedures set forth the facility care goals and the processes needed to achieve them. The process of care is the organizational foundation to performing all the complex steps and interactions required to provide care to multiple residents by a diverse group of professionals. Policies and procedures should be designed to provide consistent care in an effective and efficient manner, while complying with various regulatory requirements. The process of care is the foundation for providing quality, managing risk, and preventing errors. Physicians must be familiar with pertinent policies and procedures, participate in their development and implementation, and help in the organizational efforts to constantly improve them.

In today's litigious climate, physicians need to protect themselves as well as the facility with appropriate risk management effort. The most common risk areas are pressure ulcers, nutrition and hydration, and falls and injuries. To manage this risk, physicians need to develop knowledge and expertise pertinent to the special needs of nursing facility residents, understand geriatric principles of care, learn to work...
as members of a multidisciplinary team, effectively supervise midlevel practitioners and other caregivers, and spend the time needed to document the care and supervision. Physicians should become an integral part of the care team. The care and prevention of pressure ulcers, malnutrition, dehydration and falls should not be left solely to other members of the interdisciplinary team such as wound care nurses or dietitians. Physicians must be active participants in the assessment and care planning for prevention and treatment, and provide appropriate documentation of these efforts and involvement. Similarly, physicians should participate in the facility systemic effort to prevent and detect physical abuse and neglect. Much resident-resident abuse is related to failure to address behavior problems related to dementia. In addition, mental illness is common in nursing facilities and may also contribute to the problem. Physicians must be familiar with the principles of pharmacological and nonpharmacological treatment and care of behavior problems related to dementia and the use of mental health professionals as appropriate. Likewise, physicians must be familiar with common care problems in the nursing facility, such as weight loss and malnutrition, dehydration, pressure ulcers, fever and infections, incontinence and catheter management, fall prevention, and pain management. Facilities can manage the risk of medical errors, negative outcomes, and legal liability by developing systems and programs to address prevalent or high-risk problems. Such programs have been shown to improve care and reduce negative outcomes. Clinical practice guidelines can be helpful in developing such systems and programs.

THE PHYSICIAN AS A MEMBER OF THE INTERDISCIPLINARY CARE TEAM AND PHYSICIAN PARTICIPATION IN CASE MANAGEMENT

The complexity of the care process in nursing facilities, as well as geriatric care principles, require that physicians work as members of an interdisciplinary team. Although much of the process in provided by other members of the team, physician involvement and leadership is vital to the process. Thus physicians must be prepared to provide leadership and participate in a timely manner in all aspects of assessment, care planning and care monitoring.

Certified nursing assistants (CNAs) provide the majority of hands-on care in nursing facilities. Often they are in the best position to recognize changes in residents’ condition. Physicians should recognize the importance of CNAs and encourage them to participate in recognition of medical problems. The process of assessment in nursing facilities revolves around completion of the Minimum Data Set (MDS-2.0) by various care team members. The MDS is intended to be the basis for development of the comprehensive care plan and is not without pitfalls, but it provides the physician with a wealth of information about the resident’s functional status, which can be helpful for the medical assessment and care planning. Conversely, the physician’s medical assessment, diagnoses, and care plan are needed by other members of the team to complete the MDS. Furthermore, the care team must use the Resident Assessment Protocols (RAPs) to further evaluate the cause of conditions and functional impairments, a step that must include medical input and orders from the physician. Unfortunately, few physicians use the MDS to facilitate medical decision making.

Physicians are also required by regulations to participate in the team’s comprehensive care planning process. Care planning is usually accomplished at team meetings that physicians rarely attend, but physicians must provide input into the process. The facility should have a protocol to facilitate physician input. Although interventions prescribed and ordered by physicians are usually provided by other team members, physicians remain responsible to ensure that the care is provided as ordered and monitored. The physician must also rely on team members to routinely monitor care for efficacy, complications, and adverse events.

As the medical acuity and complexity of nursing facility residents continues to increase and medical technology advances, interventions are becoming numerous and complex. A variety of payers including managed care organizations are involved, and many residents are discharged to the community or to lower levels of care. This requires intensive case management with coordination of the medical care with payers and other agencies to an extent not seen before in nursing facilities. Such coordination requires a high level of medical expertise, and thus physicians are increasingly called upon to assist and participate in the case management process.

INTERDISCIPLINARY COMMUNICATIONS

Effective communication between physicians and members of the interdisciplinary care team, particularly nursing staff, is critical for provision of adequate care, assuring resident safety, and preventing medical errors. Yet, this is one of the weakest processes in many facilities. Barriers to effective communication abound. Failure of communications on multiple levels was identified as a significant barrier to timely care of acute infections in nursing facilities. Barriers included failure of communication medium, difficulty in contacting on-call physicians, clinical decision makers who interact through intermediaries, communicating inappropriate or incorrect information and inadequate information transfer at shift changes. Attitude issues (physicians’ perception of nurses’ lack of competence and nurses perception of physicians’ unpleasantness or disrespect during telephone conversations) were also identified as significant barriers. Extensive use of telephone communication is a significant communications barrier. A 1997 study concluded that there is a significant burden of telephone calls associated with care of residents in skilled nursing facilities, and much of the medical care delivered occurs as a result of these calls. Remote decision making may be risky. In a 1991 study, 96% of physician callbacks and actions were judged to be timely, but only 87% of the actions were judged to be appropriate, and the percentage of actions judged to be inappropriate was higher for certain clinical problems including infections, cardiovascular accidents (CVAs) and diabetic control. While providing admission orders by telephone, physicians made adjustments to medications and orders in a majority of newly admitted residents.
The medical director should develop a professional and educated group of physicians who are dedicated to the care of residents in the facility and understand their roles and responsibilities, the environment of long-term care, and the needs of the special population they serve.93 The medical director’s functions should include those listed in Table 6.

Medical directors can play a crucial role in helping attend-

ing physicians fulfill their roles and responsibilities. They can assist in providing attending physicians with administrative and clinical leadership, arrange or provide education to physicians (and other team members) and help facilities develop administrative and clinical practices and processes that promote physician practice and resident care.93–95 In 1974, a federal requirement for physician medical directors in skilled nursing facilities was enacted.96 The Omnibus Budget and Reconciliation Act of 1987 (OBRA ’87) and later revisions imposed additional responsibilities on medical directors and attending physicians.24,25 The imposition of OBRA ’87 regulations brought increased involvement of medical directors in nursing facilities not only because of direct responsibilities it imposed on them, but also because it raised the quality bar for nursing facilities and achieving the higher standard clearly required more physician and medical director involvement.26,97 The increased responsibility and accountability required physicians and medical directors to have additional education and information resources. In the years following OBRA ’87 introduction, the American Medical Directors Association responded with development of specific long-term care education, information, and certification, and this was a factor in the association’s explosive growth in the 1990s. In 2001, the state of Maryland recognized the contribution of physicians and medical directors to quality care in nursing facilities and revised its regulations to increase physicians’ and medical directors’ responsibilities and accountability.98,99

The medical director has a role as a manager of the physician staff as well.99 Important managerial roles include identifying and defining clinical and administrative performance expectations, ensuring that expectations are met (ie, evaluating performance), providing feedback and holding physicians accountable. An important test of the medical director as manager is the ability to maintain the medical care program over time, which requires defining process and outcome measurements and performing quality assurance functions.

**REFERENCES**


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**Table 6. Leadership Functions of the Medical Director**

- Recruit and develop the medical staff
- Develop a system and criteria for physician credentialing and periodic competence and performance evaluations
- Develop medical care systems, policies and procedures (including communication, documentation, forms and flow sheets, information systems, supervision of mid-level practitioners and other professionals, assessments, monitoring and ancillary services) that help physicians change established practice patterns and enable them to provide quality care efficiently and effectively, comply with government regulations and mandates, and minimize medical errors
- Educate physicians in the principle of clinical care for the population they serve and the environment of long term care including teamwork, multidisciplinary care, regulations, documentation, impact of practice patterns on facility reimbursement, billing and compliance
- Help physicians change and improve clinical and administrative practice patterns

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unexpected outcomes, however, occurred more commonly in residents who had no change to their orders.92

Telephone communication is a step fraught with risk of failure. Physicians and facilities must develop strategies to reduce reliance on telephone calls. Many facilities have midlevel practitioners on site to provide care. Reduced reliance on telephone communications requires physicians to increase presence in facilities or work with midlevel practitioners. When there are no alternatives, physicians must be required to respond to calls in a timely fashion. Since this is not always feasible, medical directors and physicians should provide for an on-call or emergency coverage system as appropriate for each location. Protocols should be developed to ensure effective communication during or instead of telephone calls, such as use of facsimile or electronic transmissions. In addition, facilities should have protocols to identify the appropriate information that must be conveyed by staff to physicians during a call.40

Communications between physicians and members of the interdisciplinary team or consultants is another area requiring development of protocols to ensure that physicians are aware of assessment, care plans, and recommendations made by others. Detailed protocols defining when laboratory and diagnostic test results should be communicated to physicians on an urgent basis should also be developed.

**THE MEDICAL DIRECTOR: A LEADER AND MANAGER OF THE MEDICAL STAFF**

The medical director’s most important role in the facility is as a leader of the medical staff. In that role, the medical director should develop a professional and educated group of physicians who are dedicated to the care of residents in the facility and understand their roles and responsibilities, the environment of long-term care, and the needs of the special population they serve.93 The medical director’s functions should include those listed in Table 6.
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