

# **ROLE OF THE ATTENDING PHYSICIAN IN THE NURSING HOME<sup>1</sup>**

## **Executive Summary**

Nationwide, nursing facility care is changing to include not only long-term care of frail residents but also complicated and resource-intensive post-hospital care. The population of people receiving care in nursing facilities is more medically complex as patients are discharged ‘sicker and quicker’ from the hospital to skilled nursing facilities and the hospitals focus on decreasing readmission rates. However, the majority of patients are still long term stay patients who themselves have increased in medical complexity and acuity. Both of these imperatives have resulted in an increased need for highly trained and committed health care practitioners willing to provide care on-site to nursing facility residents.

Physician involvement in nursing facilities is essential to the delivery of quality long-term care. Attending physicians should lead the clinical decision-making for patients under their care. They can provide a high level of knowledge, skill, and experience needed in caring for a medically complex population in a climate of high public expectations and stringent regulatory requirements.

The New York State Department of Health initiated and convened a workgroup of stakeholders in June of 2010 to address these issues with the goal of improving health outcomes and quality of life for nursing home residents by strengthening medical direction and medical care.

The charge to the workgroup was:

Improve health outcomes and quality of life for nursing home residents by strengthening medical direction and medical care through the provision of written guidance and model policies and procedures for:

- (1) Credentialing;
- (2) The role, responsibilities and accountabilities of medical directors; and
- (3) The role, responsibilities and accountabilities of attending physicians, nurse practitioners and physicians’ assistants.

Various stakeholders were called upon to help with this process. They included representation from the following organizations: New York Association of Homes and Services for the Aged (NYAHS), The New York State Health Facilities Association, Inc. (NYSHFA), Healthcare Association of New York State (HANY), Continuing Care Leadership Coalition (CCLC), Medical Society of the State of New York (MSSNY), the American Geriatrics Society (AGS), the American Medical Directors Association (AMDA), the New York Medical Directors Association and SUNY Albany School of Public Health, as well as physicians and nursing home administrators with rural (upstate) and urban (downstate) experience.

After consideration of the multiple issues and factors involved in the way medical care was currently being provided in nursing homes in New York State, consideration of the current research in the field, an exhaustive nationwide search of practices in other States, as well as holding it’s own medical culture change workshops and affinity exercises, the workgroup defined the new desired actions, beliefs and culture of medical care in the nursing home in order

to develop these model best practice guidelines for medical directors, attending physicians and physician extenders. The following is an outline of the guideline for the attending physician.

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## **ROLE OF THE ATTENDING PHYSICIAN IN THE NURSING HOME**

### **A. Introduction**

Nationwide, nursing facility care is changing to include not only long-term care of frail residents but also complicated and resource-intensive post-hospital care. The population of people receiving care in nursing facilities is more medically complex as patients are discharged ‘sicker and quicker’ from the hospital to skilled nursing facilities and the hospitals focus on decreasing readmission rates. However, the majority of patients are still long-term stay patients who themselves have increased in medical complexity and acuity. Both of these imperatives have resulted in an increased need for highly trained and committed health care practitioners willing to provide care on-site to nursing facility residents.

Physician involvement in nursing facilities is essential to the delivery of quality long-term care. Attending physicians should lead the clinical decision-making for patients under their care. They can provide a high level of knowledge, skill, and experience needed in caring for a medically complex population in a climate of high public expectations and stringent regulatory requirements.

The guidelines also endorse efforts to improve the training of all health care providers, including non-physician providers, in the principles and practice of geriatric medicine and other medical disciplines dealing with chronic care conditions in order to have all providers obtain a sufficient level of knowledge and skills so that care will be provided concomitant with patient’s complex needs.

These guidelines support and encourage interdisciplinary, team-based care and are committed to promoting and celebrating the many unique and valuable contributions and perspectives of all disciplines to enhance the quality of care. In order to foster this interdisciplinary collaboration, in addition to delineating the role of the attending physician in the nursing home setting, these guidelines outline various responsibilities that the facility should entertain as well. The specifics are interspersed within the guideline. However, there are some overriding principles that are delineated here.

### **B. General Facility Responsibilities**

The administrator and staff will:

- collaborate with the medical director to create an environment conducive to the delivery of appropriate medical practice and health-related services;
- provide reference and guidance to regulatory guidelines for the attending physicians as needed; and
- provide attending physicians with supports needed to fulfill responsibilities, including ensuring that the personnel, resources, supplies, and ancillary services are available to allow the staff and practitioners to care for residents appropriately.

With regard to physician supervision; the facility shall ensure that:

- the medical care of each resident is supervised by a physician who assumes the principal obligation and responsibility to manage the resident's medical condition; and
- another physician supervises the medical care of residents when the resident's attending physician is unavailable.

### **C. Physician Training, Qualifications and Medical Director Oversight**

Physicians and others providing medical care to residents of nursing facilities and other long-term care facilities must possess a current and valid New York State license as a medical professional. This will be verified by the nursing facility as part of the process of granting privileges to the medical professionals.

Physicians and others providing medical care to residents of nursing facilities and other long-term care facilities must possess a unique set of knowledge and skills. This includes:

- understanding the principles and practice of geriatric medicine, and other pertinent medical disciplines dealing with chronic care conditions;
- understanding drug prescribing guidelines for older adults and other complex long term care patients;
- familiarity with pertinent regulations governing long-term care facilities;
- understanding systems of care delivery;
- the ability to work effectively as part of an interdisciplinary team; and
- flexibility to take on evolving competency-based physician education.

The medical director helps coordinate and evaluate the medical care within the facility by reviewing and evaluating aspects of physician care and practitioner services, and helping the facility identify, evaluate, and address health care issues related to the quality of care and quality of life of residents. A medical director should establish a framework for physician participation, and physicians should believe that they are accountable for their actions and their care.

### **D. Physician Supervision of Medical Care**

The facility shall ensure that the medical care of each resident is supervised by a physician who assumes the principal obligation and responsibility to manage the resident's medical condition and who agrees to visit the resident as often as necessary to address resident medical care needs. Each resident shall remain under the care of a physician and shall be provided care that meets prevailing standards of medical care and services. Another physician supervises the medical care of residents when the resident's attending physician is unavailable (see Coverage below).

#### **a. Regulatory Visits**

##### **i. Physician Responsibilities**

Comprehensive regulatory visits, in coordination with the facility's overall plan of care for a resident, establish and guide the total program of care for each resident. The intent of these visits is to have the physician take an active role in supervising the care of residents. This should not be a superficial visit, but should include an evaluation of the resident's condition and a review of and decision about the continued appropriateness of the resident's current medical regimen.

The attending physician should:

- Maintain a schedule of visits appropriate to the resident's medical condition depending on the patient's medical stability, recent and previous medical history. The frequency of visits shall be no less often than once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.
- Review the resident's total program of care, including medications and treatments, at each regularly scheduled visit, including reasons for changing or maintaining current treatments or medications, and a plan to address relevant medical issues. Total program of care includes all care the facility provides residents to maintain or improve their highest practicable mental and physical functional status, as defined by the comprehensive assessment and plan of care. Care includes medical services and medication management, physical, occupational, and speech/language therapy, nursing care, nutritional interventions, social work and activity services that maintain or improve psychosocial functioning.
- Periodically review all medications and monitor both for continued need based on validated diagnosis or problems and for possible adverse drug reactions. The medication review should consider observations and concerns offered by nurses, consultant pharmacists and others regarding beneficial and possible adverse impacts of medications on the patient.
- Properly define and describe patient symptoms and problems, clarify and verify diagnoses, relate diagnoses to patient problems, and help establish a realistic prognosis and care goals.
- Participate as a member of the interdisciplinary care team in the development and review of the resident's comprehensive care plan with the understanding that the minimum level of physician participation in interdisciplinary development and review of the care plan shall be a person-to-person conference with the registered professional nurse who has principal responsibility for development and implementation of the resident's care plan.
- Determine progress of each patient's condition at the time of the regulatory visit by evaluating the patient, talking with staff as needed, talking with responsible parties and/or family as indicated, and reviewing relevant information, as needed.
- In consultation with the facility's staff, determine appropriate services and programs for a patient, consistent with diagnoses, conditions, prognosis, and patient and family goals and wishes, focusing on helping patients attain their highest practicable level of functioning in the least restrictive environment.
- Conduct or arrange for palliative care counseling and pain management interventions when the resident is determined to be terminally ill or has a life limiting condition that may benefit from these services.
- Prepare, authenticate and date progress notes at each visit.
- Maintain progress notes that cover pertinent aspects of the resident's condition and current status and goals.
- Provide documentation needed to explain medical conclusions and decisions; permit effective, timely resident care.
- Over time, documentation related to physician visits should address relevant information about significant ongoing, active, or potential problems and cover at least the following:
  1. Status of chronic medical conditions;
  2. Status of any recent or current symptoms or changes in condition;
  3. Pertinent physical findings;
  4. How the individual's acute and chronic conditions effect his/her functioning, quality

- of life, nutrition, hydration, cognition, mobility, prospects for improvement, and ability to socialize and participate in activities (for example, how a recent episode of pneumonia or exacerbation of COPD affected anticipated functional improvement);
5. Clinically important abnormal lab results;
  6. Rationale for substantial changes in medication and treatment orders, including identification and management of complications of existing medications and treatments, and ensure that each medication has an indication for continued usage;
  7. Identified special needs such as dental services or restorative care;
  8. Review of the pertinence of the overall plan of care; and
  9. Evaluation of any discharge potential.

## **ii. Facility Responsibilities**

The administrator and staff will collaborate with the medical director to create an environment conducive to the delivery of appropriate medical practice and health-related services, for example:

- ensuring that physician orders are carried out properly; and
- facilitating an organized and efficient medical record.

The facility will provide the physician with adequate staff support at the time of the regulatory visits in order to facilitate decision-making.

## **b. Acute Illness Visits**

### **i. Physician responsibilities**

Acute illness visits should be performed to meet the medical needs of the complex residents in the nursing home.

#### **1. Presence in the facility.**

Physicians should schedule their visits to the facility as frequently as possible and as warranted by the number and condition of residents to whom they provide medical care. This schedule should be made in advance and in consideration of facility resources in order to 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, reduces possible errors inherent in remote communications, and promotes direct physician-staff-resident interaction thereby improving care management and patient safety. Desirable physician practice should allow, as optimally as possible, for frequent visits to and significant presence in the nursing home.

The attending physician should:

- Respond promptly, in a manner determined jointly by the facility, administrator, medical director and medical staff, to notification of, and assess and manage adequately, reported acute and other significant clinical condition changes in patients. This includes visiting the resident whenever the resident's medical condition warrants medical attention;
- Make interim visits, as needed, for individuals with complex problems or unstable conditions that cannot be readily managed by phone;

- Properly define and describe patient symptoms and problems, clarify and verify diagnoses, relate diagnoses to patient problems, and help establish a realistic prognosis and care goals;
- Prepare, authenticate and date progress notes at each visit;
- Respond in an appropriate time frame (based on a joint physician-facility-developed protocol) to emergency notification;
- Note the presence of significant or previously unidentified medical conditions, or problems that cannot be handled readily by phone;
- Whenever safe and concordant with patient and family goals and wishes, the staff and practitioners will monitor, evaluate and treat problems in the nursing facility instead of transferring residents/patients to hospitals; and
- Communicate with family members/resident representatives as significant changes in medical condition occur.

## **ii. Facility responsibilities**

Facility responsibilities include:

- Supporting the attending physicians with the resources needed to fulfill their responsibilities at times when the physician is present in the facility for acute visits;
- Instituting appropriate notification protocols so proper assessments of a resident's status will be relayed to the physician in a timely and complete manner; and
- Ensuring that the personnel, resources, supplies and ancillary services are available to allow the staff and practitioners to care for residents' acute changes of condition at an appropriate level of complexity.

## **E. Initial Patient Care/Care Transitions**

### **a. Physician Responsibilities**

The attending physician should assess a new admission in a timely fashion, based on a joint physician-facility-developed protocol and, depending on the individual's medical stability, recent and previous medical history, presence of significant or previously unidentified medical conditions, or problems that cannot be handled readily by phone.

The attending physician should:

- seek, provide, and analyze needed information regarding a patient's current status, recent history, and medications and treatments, to enable safe, effective continuing care and appropriate regulatory compliance;
- provide appropriate information and documentation to support the facility in determining the level of care for a new admission;
- authorize admission orders in a timely manner, based on a joint physician-facility-developed protocol, to enable the nursing facility to provide safe, appropriate, and timely care; and
- for a patient who is to be transferred to the care of another health care practitioner, continue to provide all necessary medical care and services pending transfer until another physician has accepted responsibility for the patient.

## **b. Facility Responsibilities**

Facility responsibilities include:

- The admissions coordinator will identify that a qualified physician, who is licensed to practice in the state, has accepted responsibility as the attending physician.
- The staff will notify the attending physician of a resident/patient's admission.
- The nursing staff will obtain all orders needed at the time of admission from the attending physician or covering practitioner.
- Facilitate the procurement of appropriate medical records in a timely manner (for example, hospital records and prior physician office records) either at the time of admission or as soon thereafter as possible, in order to provide each resident with the medications, treatments and medical support needed to meet his/her immediate and longer term needs.

Essential transfer information for new admissions or readmissions should include the following:

- Discharge summary;
- Duration of orders;
- Authorization of level of care;
- Diet;
- Activity level;
- Laboratory and diagnostic tests (admission and follow-up);
- Frequency of monitoring (vital signs, finger sticks, weight, pacemaker checks, etc.);
- Medications and treatments, including indication for usage of medications;
- Medication and other allergies;
- Immunization status;
- Infection control related measures;
- Functional status;
- Precautions and contraindications (for example, limited weight-bearing or ambulation precautions);
- Consultations or follow-up evaluations; and
- Advanced directives.

For readmissions, the staff and physician should review the transfer information carefully to identify any item included above and:

- Any changes during hospitalization in medications and treatments that had been administered prior to the transfer;
- Any medications and treatments that were added during hospitalization, as some of those may need to be monitored closely or may not be appropriate for extended use in various individuals;
- Any medications that may not have been given while the individual was hospitalized, or may have been omitted from the transfer summary; and
- Any changes in advanced directives.

## **F. Discharges and Transfers**

### **a. Physician responsibilities**

Physician responsibilities include:

- Communicate with a physician or another health care practitioner at a receiving hospital as needed at the time of or after the transfer of an acutely ill or unstable patient;
- Provide appropriate documentation and other information that may be needed at the time of transfer to enable care continuity at a receiving facility and to allow the nursing facility to meet its legal, regulatory, and clinical responsibilities for a discharged individual; and
- Provide pertinent medical discharge information within 30 days of discharge or transfer of the patient.

### **b. Facility Responsibilities**

Facility responsibilities include determining, in a joint facility-medical staff-medical director protocol, the appropriate facility documentation that will accompany and or be sent in a timely manner to a receiving entity (i.e. hospital or local physician).

## **G. Physician Notification/Ongoing Coverage**

### **a. Physician Responsibilities**

#### **i. Coverage**

The attending 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. Covering physicians should 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.

#### **ii. 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 require physician signature on telephone orders within 48 hours. These regulations are intended to ensure appropriate follow-up rather than paper compliance.

The attending physician should:

- Respond to notification of laboratory and other diagnostic test results in a timely manner, based on a protocol developed jointly by the physicians and the facility, considering the patient's condition and the clinical significance of the results;
- Analyze the significance of abnormal test results that may reflect important changes in the patient's status and explain the medical rationale for subsequent interventions or decisions not to intervene based on those results when the basis for such decisions is not otherwise readily apparent;
- Designate an alternate physician or appropriately supervised midlevel practitioner who will respond in an appropriate, timely manner in case the attending physician is unavailable;
- Respond to issues requiring a physician's expertise, including the patient's current condition, the status of any acute episodes of illness since the last visit, test results, other actual or high risk potential medical problems that are affecting the individual's functional, physical, or cognitive status, and staff, patient, or family questions regarding the individual's care and treatments;
- At the next visit after an acute change in condition, review the status of the condition change and document his/her evaluation, including the significance of the acute situation; for example, anticipated residual effects on the individual's function, psychosocial status, or prognosis;
- Make an interim visit, if needed, to assess the situation (especially if the individual is not stable or is not improving as anticipated);
- Respond in an appropriate time frame (based on a joint physician-facility-developed protocol) to routine notification;
- Update the facility about his or her current office address, phone, fax, and pager numbers to enable appropriate, timely communications, as well as the current office address, phone, fax and pager numbers of designated alternate physicians or an appropriately supervised midlevel practitioner;
- Help ensure that alternate covering practitioners provide adequate, timely support while covering and intervene with them when informed of problems regarding such coverage;
- Adequately notify the facility of extended periods of being unavailable and of coverage arranged during such periods; and
- Adequately inform alternate covering practitioners about patients with active acute conditions or potential problems that may need medical follow-up during their on-call time.

#### **b. Facility Responsibilities**

The facility shall ensure that:

- The medical care of each resident is supervised by a physician who assumes the principal

obligation and responsibility to manage the resident's medical condition and who agrees to visit the resident as often as necessary to address resident medical care needs;

- Another physician supervises the medical care of the resident when the resident's attending physician is unavailable;
- Attending physicians receive the support needed to fulfill responsibilities at times when they are not present in the facility;
- Appropriate notification protocols are instituted whereby proper assessments of a resident's status are relayed to the physician in a timely and complete manner;
- Before contacting a physician about someone with an acute change of condition, the nursing staff makes pertinent observations and collects appropriate information to report to the physician; and
- Nursing staff assess acute changes of condition comprehensively and communicate with the attending or covering physician.

Nursing staff will continually re-evaluate the condition of anyone who received an order for new or additional medications and treatments during the previous evening or overnight shifts. Physicians or their coverage should be notified with updates as appropriate in this situation. The charge nurse or supervisor should contact the attending physician at any time if he/she feels a clinical situation requires immediate discussion and management. When contacting the practitioner, especially at night and on weekends (when physicians not familiar with the residents may be on call), the nurse should have at least the following information available:

- Detailed description of current issue or problem, including vital signs, symptoms and results of physical assessment;
- Active medical problems (problem list);
- Pertinent information from any recent hospitalizations (hospital discharge summary or admission history and physical form);
- Current medications (orders);
- Allergies to medications, food, etc.;
- Resuscitation ("Code") status/any limitations on intubation/hospitalization status; and
- Family/contact person.

## **H. Appropriate Care for Residents**

The attending physician should:

- In consultation with facility staff, ensure that treatments, including rehabilitative efforts, are medically necessary and appropriate in accordance with relevant medical principles and regulatory requirements;
- In consultation with the facility staff, manage and document ethics issues consistent with relevant laws and regulations and with patients' wishes, including advising patients and families about formulating advance directives or other care instructions and helping identify individuals for whom aggressive medical interventions may not be indicated; and
- Provide orders that ensure individuals have appropriate comfort and supportive care measures as needed, for example, when experiencing significant pain or in palliative or end-of-life situations.

## **I. Appropriate, Timely Medical Orders and Documentation**

The attending physician should:

- Provide timely medical orders based on an appropriate patient assessment, review of relevant pre- and post-admission information, and age-related and other pertinent risks of various medications and treatments;
- Provide sufficiently clear, legible written medication orders to avoid misinterpretation and potential medication errors, such orders to include pertinent information such as the medication strength and formulation (if alternate forms available), route of administration, frequency and, if applicable, timing of administration, and the reason for which the medication is being given;
- Verify the accuracy of verbal orders at the time they are given and authenticate, sign and date them in a timely fashion, no later than the next visit to the patient;
- Provide documentation required to explain medical decisions that promotes effective care and allows a nursing facility to comply with relevant legal and regulatory requirements; and
- Complete death certificates in a timely fashion, including all information required of a physician.

## **J. Relationship With Residents and Families**

Physicians should understand:

- Federal regulations require that nursing facilities provide residents and their legal representative with their physician's name, specialty, office 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 at critical times during a nursing facility stay, such as upon admission or at end of life, and approach families with sensitivity and compassion, particularly at these difficult times; and
- Communicate with family members/resident representatives as significant changes in medical condition occur.

## **K. Professional Conduct**

Professional conduct includes the following:

- Abide by pertinent facility and medical policies and procedures;
- Maintain a courteous and professional level of interaction with facility staff, patients, family/significant others, facility employees, and management ;
- Work with the medical director to help the facility provide high quality care;
- Keep the well-being of patients/residents as the principal consideration in all activities and interactions; and

- Be alert to, and report to the medical director -- and other appropriate individuals as named through facility protocol -- any observed or suspected violations of resident rights, including abuse or neglect, in accordance with facility policies and procedures.

## **L. General**

General responsibilities for attending physicians include:

- Participation in facility training programs to familiarize him or herself with State regulations and facility policies;
- Being informed of and reviewing the results of all Department of Health surveys related to medical service deficiencies; involvement in resolving problems;
- Designate prognosis and the potential for functional improvement, if possible. The components of a statement of prognosis should include the physician's best professional judgment about the resident's expectations for medical and functional stability, the time frame for stability or not, and the potential for complications.

## **M. Non-physician Providers**

The presence of nurse practitioners and other non-physician practitioners who work collaboratively with attending physicians and medical directors will maximize the value of all members of the interdisciplinary care team. 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. Physicians should commit to fostering and strengthening this collaboration. Physicians and midlevel practitioners should document their collaboration and the supervision of care by physicians.

Physicians and midlevel practitioners should be familiar with Medicare billing requirements and with the specific regulatory requirements of New York State.

These guidelines support and encourage interdisciplinary, team-based care and are committed to promoting and celebrating the many unique and valuable contributions and perspectives of all disciplines to enhance the quality of care. The guidelines also endorse efforts to improve the training of all health care providers, including non-physician providers, in the principles and practice of geriatric medicine in order to have all providers obtain a sufficient level of knowledge and skills so that care will be provided concomitant with patient's complex needs.

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<sup>1</sup> These guidelines were developed by The Medical Direction and Medical Care Work Group, a group of non-government stakeholders convened by the NYS Department of Health. The Work Group developed the guidelines over the course of a year from June, 2010 to May, 2011, relying heavily on (and in some cases quoting directly from) resources and publications of the American Medical Directors Association (AMDA), including those listed below. The Executive Directors of both AMDA and its New York affiliate, New York Medical Directors Association (NYMDA), were members of the Work Group. Dr. Jacob Dimant was a member of and Dr. Steven Levenson was a special advisor to the Work Group.

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