Responsibilities of Attending Physicians in Long-Term Care Facilities

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Physicians have been reluctant to attend to residents in skilled nursing facilities.[1–3] However, cooperation of primary care physicians,[4] and physician staffing patterns,[5] are key to providing quality care to residents in skilled nursing facilities as well as maintaining regulatory compliance[6] and Joint Commission for Accreditation of Healthcare Organizations accreditation status.[7] In 1974 federal regulations mandated the position of medical director in skilled nursing facilities, whose function was to coordinate the medical care in the facility.[8] Additional regulations in 1987 further defined the role of the medical director to include implementation of medical care policies in addition to medical care coordination.[6] The same regulations also define multiple responsibilities of the primary care physicians.[6] In order to fulfill their responsibilities, medical directors must secure availability and cooperation of attending physicians by providing physicians with an efficient practice environment and a clear set of expectations. In addition, medical directors must develop and implement general processes of care that assure appropriate care delivery,[4,9,10] assess physicians performance, and hold physicians accountable.[4,7] The delineation of physicians responsibilities described in this article provides medical directors with a minimum set of expectations that ought to be required of physicians practicing in any skilled nursing facility. The responsibilities enumerated in the document are based mostly on regulatory requirements[11,12] and the Joint Commission 1998 standards.[7] The applicable regulatory section (known as "F" tag), or the Joint Commission specific standard are referenced in the text. (The Joint Commission standards referenced in the text include Leadership - LD, Residents Rights and Organizational Ethics - RI, Continuum of Care - CC, Assessment of Residents - PE, and Care and Treatment of Residents - TX). In addition, Medicare and Medicaid documentation and medical necessity requirements[13,14] were considered in developing this document.

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ETHICAL AND LEGAL RESPONSIBILITIES

The physician should

- Abide by the principles of medical ethics as adopted and/or amended by the American Medical Association or other appropriate professional organizations (RI.4).
- Abide by the facility compliance policies, provide or order services only when medical necessity is established for such service, bill health care plans including Medicare and Medicaid only for medically necessary services.[13,14]
- Accept residents for care pursuant to residents right to choose a personal physician (F163, RI.2.18) without regard to age, sex, race, sexual preference, creed, color, or national origin.
- Provide continuous and adequate medical care to all residents (F309, CC.3).

GENERAL AND ADMINISTRATIVE RESPONSIBILITIES

The physician should

- Familiarize him/herself with federal and state regulations and facility policies.
- Abide by the facility-developed medical care policies and all applicable federal, state, and local rules and regulations.
- Serve on committees of the facility including quality assessment and assurance when designated by the medical director (F520).
- Provide residents and legal representatives with their name, specialty, office address, and telephone number (or other ways to contact the physician) and respond to calls from residents and their representatives to discuss the resident's medical care (F156).
- Be responsible for the care of the residents at all times except when other coverage is in effect (F385).
- Arrange for another physician who is credentialed as a member of the facility medical staff (F163, LD.2.8) to supervise the medical care of his/her residents even when he/she is unavailable (F385, F389, PE.1.4.1.1).
- Provide on-call and emergency coverage when arranged by the medical director or required by facility policy (F389).

- Make admission, periodic, accident, and emergency visits to residents as required by regulations and/or facility policies (F387, F389).
- Personally (F388) visit residents as soon after admission as the resident's medical condition requires, but no later than 72 hours (Joint Commission requirement; PE.1.4.1) after admission (except when an examination was performed within 5 days before admission and the results are fully documented in the medical record at the time of admission), to perform an admission history, physical examination, and assessment.
- Personally visit the resident at least once during the 30 days after admission (TX.1.4.1).
- Personally visit the resident in the facility (except when a mid-level professional substitutes consistent with applicable federal regulations and state law) whenever the resident's condition warrants medical attention and regularly in accordance with the facility's established schedule (PE.2, TX.3), 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, and such slippage should not affect the next scheduled due date (F387, F388).
- Visit residents in the event of an emergency or a significant change in the resident's medical condition upon notification or within a reasonable amount of time as determined by the nature of the emergency (F157, F389).
- Abide by facility policies, federal, state, and local regulations, and standards of care concerning infection control practices (F441–445).

DELEGATION TO MID-LEVEL PRACTITIONERS

Physician visits must be made by the physician personally, except that the physician 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 facility NP and PA policies as well as applicable state regulations (F388, F390).
- Delegate to a NP or PA any other medical care related visit or task when such task is within the NP or PA scope of practice in compliance with facility NP and PA policies as well as applicable state regulations (F390).
- Not delegate any task to a NP or PA when federal or state regulations require such task to be performed personally by a physician (F390).

PATIENT CARE

The physician should

- Personally approve each resident's admission to the facility (F385).
- Provide appropriate orders at the time of admission (CC.2.1), including dietary, drugs, and routine care until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan (F271).
- Supervise the medical care of each of his or her residents, including participating in the assessment and care planning, monitoring changes in the resident's medical status, and providing treatment (F272, F280, F385).
- Agree to be notified of and attend to any emergency or significant change in the resident's clinical status (F157, F389, TX.2.8).
- Review the resident's total program of care, including medications, treatments, rehabilitation therapy, nutritional interventions, nursing care, social work intervention, and therapeutic activities at each regularly scheduled visit (F386, PE.2, TX.3).
- Obtain consultations when necessary for resident care.
- Order laboratory and diagnostic tests as medically necessary for resident care, obtain results timely, and act on all results requiring action with appropriate documentation (F510, F511).
- Ensure appropriate prescribing and monitoring of all medications (F329, F330, F331, F429).
- Respond in writing to consultant pharmacist drug regimen review reports (F428–430).
- Provide orders for transfer and discharge (CC.4).

ADMISSION VISITS

At the time of admission, the physician should obtain a complete medical history, perform a physical examination, and document the following (PE.1.1):

- Complete medical history, including history of any allergies, particularly to medications and vaccinations.
- Physical examination findings.
- List of available laboratory data and diagnostic test results from transfer forms.
- Complete list of diagnoses/conditions/problems, functional impairments and disabilities, and risks.
- Rehabilitation potential in all functional areas.
- Resident or designated representative awareness of the diagnosis/condition and participation in care planning.
- Medical care plan.
- Orders, including medications, diet and supplements, ambulation, consultations, further diagnostic and laboratory work (F510, F511, PE.1.2), monitoring, limitations and precautions, pass privileges if granted, and any other orders necessary for the safety, health, or care of the resident.
- Discharge potential/plan (PE.1.3).

SCHEDULED VISITS

At each scheduled visit the physician (or mid-level practitioner) should see and examine the resident and (PE.4, TX.3)

- Review the resident's total program of care, including medications and treatments (F386).
- Prepare, sign, and date progress notes (F386).
- Review all laboratory and diagnostic tests with appropriate action and documentation regarding abnormal results (F510, F511).

- Resident's condition at the time of discharge.
- Pertinent postdischarge medical plan of care with orders, particularly medications, diet, and treatments.

DOCUMENTATION

The physicians (or mid-level practitioner) should (IM.7.2, IM.7.3)

- Prepare, sign, and date admission, progress, and discharge notes in accordance with legal and regulatory requirements and facility policies.
- Document the medical necessity of each service provided in the progress notes.
- Prepare, sign, and date all orders.
- Ensure that each order has a documented medical necessity and a corresponding progress note.
- Sign and date telephone or verbal orders within time limits as required by regulations or facility policy.
- Sign and retain an original of all faxed orders (faxed copy does not need to be re-signed) (F386).
- Sign and date laboratory and diagnostic test reports timely.
- Document reason for all interventions or lack thereof.
- Document the reason negative outcomes are unavoidable (resident's condition or wishes).
- Complete medical records on a timely basis (F514-516, IM.7.5.1).

RESIDENTS' RIGHTS

The physician and mid-level practitioner should

- Ensure that the resident is afforded privacy and dignity in his/her interaction with the physician and during interview and physical examination (F164, F241, RI.2.1.1).
- Inform the resident (or legal representative) in language that he or she can understand of the diagnosis, medical condition, and total health status, whenever possible, unless medically contraindicated ("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) (F154).
- Discuss care planning with the resident and/or family as appropriate (RI.2.21), who should be offered alternatives and afforded the opportunity to participate fully in decisions regarding medical care (F280. RI.1.1 - RI.1.4).
- Consider and respect the resident's wishes or prior wishes/advanced directives (RI.2.22) regarding medical care, including refusal of care (RI.2.17), in preparing the medical care plan. (However, the resident or surrogate do not have the right to request inappropriate or contraindicated treatments or interventions; F155, 280.)
- Ensure that the resident provides informed consent where appropriate (RI.2.20).
- Respect the resident's right to select medical and dental providers (F163, RI.2.18).
- Ensure the privacy of the resident's medical information (F164, IM.2.1).

DISCUSSION

This document has evolved for many years. The initial document was developed in 1978 as a facility medical staff policy and was based, in part, on the American Medical Association's Dr. H.W. Gruber's[15] work on medical direction as well as applicable federal regulations in effect at that time. In 1983 the document was further developed in another facility as a part of a set of medical staff bylaws addressing the responsibilities of attending physicians practicing in the facility, as well as a part of a comprehensive set of policies and procedures governing physicians' practices, and was instrumental in establishing quality medical care in that facility.[16] These policies and procedures were further revised 1990 to include OBRA '87 requirements[17] and later to conform with Joint Commission standards and with other regulatory developments.[14,18] The development and evolution of this document was always a collaborative effort of the medical director and the medical staff in the facility.[16]

The OBRA '87 regulations and subsequent revisions have increased the regulatory scrutiny of medical practice in long-term care.[19] Physicians practicing in long-term care must comply with these regulations. But the regulations in and by themselves cannot assure the provision of quality care. There must be structural and process elements embedded in the way physicians practice in the facility. Joint Commission standards define performance expectations, structures, or processes that must be substantially in place in an organization to allow quality care to proceed.[7] Therefore, even though only a small fraction of long-term care facilities are accredited by the Joint Commission,[20] it is suggested that medical directors use these standards as elements in developing policies and procedures for physician services in their facilities. Therefore, the performance expectations in the above document were developed based on both regulatory requirements and Joint Commission standards. In addition, there are many processes and performance expectations of physicians practicing in long-term care that emanate from prevailing community standards of care and the practice of evidence-based medicine that are not spelled out in this document.[21,22] Developing and implementing such standards is left to the discretion of physicians and medical directors but are important to truly be able to provide quality care.

Medical directors and physicians can utilize this document to help in developing medical staff bylaws, medical care policies and procedures, physician job descriptions, or physician performance expectations and evaluations. The document may also be helpful as an educational tool to assist physicians understand basic expectations required of them in the long-term care practice setting. Again, although this set of expectations is based on regulations and Joint Commission standards, it reflects what physicians need to do in order to provide quality care to frail people in an institutional environment while maintaining regulatory compliance, respecting residents rights and choices, working as part of an interdisciplinary team, practicing within a process of care that includes assessment, cause finding, care planning and care monitoring,

and adherence to principles of geriatric care emphasizing function and prevention of disability.[23,24]

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