Dear Dr. Jeff:

As a nursing home administrator, I find it nearly impossible to manage our medical staff, whose actions have produced multiple survey deficiencies for other departments. Our rates of psychotropic drug use and other quality measures compare poorly with nearby competitors, as does our length of stay for post-acute residents. The medical staff mostly ignores scheduled meetings. Can you help?

Dr. Jeff responds: Yours is not an uncommon complaint, frequently followed by clichés about herding cats or rolling boulders uphill. But after all, why should anyone think that highly trained professionals could be herded like sheep, particularly when they aren’t your employees and you’re not paying them?

Typical employee management systems effective for other departments, including tables of organization, mandatory procedures, and ‘ladders of discipline’ are rarely effective for doctors (or other allied health professionals) whose status within your facility does not fit those models. Very few nursing homes actually employ physicians. Staffing models vary. “Closed” staffing models that limit the number of attending physicians to those with an established relationship to the facility and a panel of residents may produce better outcomes.

Nurse practitioners—who might work for themselves, for one or more of the attending physicians, or for Medicare Special Needs Plans such as Evercare—now provide an increasing share of patient care. Moreover, for many practitioners, the time spent in long-term care is a tiny portion of their practice and an even smaller fraction of their income.

Demographic studies of physicians practicing in long-term care show that they are more likely to also have hospital practices, see more outpatients in their offices, and work longer hours than those who do not provide nursing home care. Indeed, practitioners from busy individual or group practices are often competitively recruited by multiple homes. They are potential referral sources, particularly when they can bring with them valuable residency eligible for Part A Medicare coverage. For all these reasons, members of the medical staff cannot be “managed” through traditional employee management techniques or equated with vendors competing for your business. Indeed, they more closely resemble clients with their own needs and demands.

Multiple studies, including a 2003 report from the usually negative Office of Inspector General have concluded that medical directors are highly committed to improving care and value their role more highly than do administrators (Office of Inspector General. An Insider’s View: The Role of the Nursing Home Medical Director. Washington, DC: OIG; Feb. 2003). In 2001, the Institute of Medicine followed up its landmark 1986 study of nursing homes—later enshrined in the Omnibus Budget Reconciliation Act (OBRA) ’87 regulations—and found that medical directors lacked the authority to implement quality improvements within institutions or over the medical staff (Institute of Medicine. Improving the Quality of Long-Term Care. Washington, DC: National Academy of Sciences; 2001).

Manual Labor

In accordance with federal regulations, the medical director should be consulted regarding all resident care policies, a requirement that is rarely followed except during crises. Most facilities have extensive policy and procedure manuals that cover most or all aspects of resident care. These policy manuals tend to live in drawers deep in the administration and nursing administration offices, brought to light when they are updated or modified, or when the survey team asks for them. The existence and content of these policies may very well be a complete mystery to the medical practitioners in the building, who are often equally uninformed regarding the work or functions of others in the same building.

I once had the sad experience of listening to one of “my” attending physicians explain to a family member that the reason her loved one’s pressure ulcer was not healing was that “she is incontinent and there is no one here at night to change her diaper or reposition her.” He had followed a panel of patients in the building for 30 years and was unaware of the existence of the night shift! The night nursing supervisor was the only staff person who ever called him and he assumed she provided the sole night coverage in the building.

In his defense, no one ever described to him anything about the facility or how it ran. Every facility provides some training to new employees specific to their jobs and to the institution as a whole. However, the average housekeeper sweeping the floor knows more about the facility, fire safety procedures, policies and procedures regarding resident abuse and neglect, and the names and roles of senior staff than do many attending physicians. For some facilities, the instruction manual for a new medical staff member is only the unit where their patients are housed and the name of the charge nurse. Although administrators tend to focus on physician complaints regarding inadequate reimbursement, surveys of physicians regarding barriers to nursing home practice list communication issues with the facility and the nursing staff as the greatest obstacle.

Up to Code

Practitioners generally come to long-term care with no background in nursing home medicine. Medical school curricula fail to address it. Even schools with mandatory geriatrics rotations omit any exposure to nursing homes or nursing home residents, as this is believed to be too depressing and thus discouraging to an interest in geriatrics. Although most family practice residencies include rotations in nursing homes, which, at times, include following a few residents sequentially throughout their training, internal medicine residencies do not. Thus, the typical physician entering an LTC facility for the first time brings essentially no knowledge base regarding this setting. Unsurprisingly, practitioners follow familiar patterns, most commonly the hospital model, where communicating with floor nurses means flagging a chart. Often they are confronted on the units with staff assertions that some mysterious “code” (which neither they nor the staff have ever seen) forbid various actions that are standard in the hospital setting. Moreover, survey deficiencies, including medical services or direction, are cited to the facility, not the individuals involved, leaving medical practitioners marginally aware and little concerned regarding state survey outcomes.

For many years, the use of bedrails was a focus of struggle among family members, physicians, and LTC facilities. What was universal practice in acute care was unacceptable in long-term care (until the Joint Commission responded to the evidence that bedrails simply worsen the severity of injuries). Confronted by family expectations, facility staff simply informed physicians that the rails were “forbidden by code.” Although not strictly true, this communication mystified both practitioners and families. The same discordance of practice now exists for the use of antipsychotic medications for agitation or dementia patients. Again, what is standard practice in the community and common in hospitals is not acceptable in nursing facilities. Without adequate explanation of the evidence, and discussion of the evaluation process that should be done before their initiation, why would anyone expect practitioners to limit the use of FDA-approved medications to specific indications or avoid “as needed” regimens? Certainly the repeated assertion that they are forbidden by the code is neither true nor effective, particularly for the physicians who have been trained to prescribe for his or her particular patient’s needs, not national usage percentages.

Physicians need to be educated about best practices in nursing home care. Clear written expectations should be provided to all attending physicians, nurse practitioners, physicians assistants, and consultants active within the facility. Evidence-based literature and expert best practice reviews do change practitioner performance, particularly when they provide the rationale for desired practices. These are often most effectively introduced by the medical director, whose administrative position, experience, and knowledge should encourage acceptance. Practitioners tend to respond to suggestions from other medical professionals. Physicians have been trained to follow the community standard of practice and respond to guidelines. Clinical practice guidelines, such as those produced and updated by AMDA, can be an effective tool to reshape behaviors.

Guidelines for Care

Several years ago, the New York State Department of Health spearheaded the development of guidelines for attending physicians and medical directors by convening an expert panel including nursing home administrators, medical directors, and representatives of provider organizations. These guidelines, intended to elaborate and explain the statutory requirements, do not add any requirements beyond actual federal regulations. They were distributed in a “Dear Administrator” letter, available on the Department of Health website and, perhaps, more easily accessible at Healthcare Association of New York State (HANYS) at www.hanys.org/etta/. HANYS is now coordinating a statewide initiative in which the guidelines are being actively implemented in 22 nursing homes throughout the state, along with a significant amount of facility training and the assistance of facilitators and instructional materials.

To begin, rethink the stated intention of “managing” physicians. If the goal is to improve care, as measured by outcomes data and resident satisfaction, then that objective can only be achieved through collaboration with the medical director and the medical practitioners. By working together, clarifying expectations, and improving care systems, you will find the road to progress.

Dr. Nichols is president of the New York Medical Directors Association and a member of the Caring for the Ages Editorial Advisory Board.