Roles, Responsibilities, Communication and Documentation of the Attending Physician, Nurse Practitioner/Physician Assistant, Medical Director and Administrator

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Table of Contents

I. “When You’ve Seen One Nursing Home, You’ve Seen One Nursing Home”—Background .....................5
   A. Nursing Home Characteristics ..............................................................................................................5
   C. The Nursing Home Care Team ..............................................................................................................6
II. Roles, Responsibilities and Regulations .......................................................................................................7
   A. Attending Physician, Nurse Practitioner (NP) and Physician Assistant (PA) .................................7
   B. Medical Director Roles, Responsibilities and Regulations .................................................................11
   C. Administrator—Roles, Responsibilities, and Regulations .................................................................16
III. Communication—The Foundation of Teamwork .....................................................................................23
IV. Documentation ............................................................................................................................................25
V. Conclusion ....................................................................................................................................................27
VI. References.....................................................................................................................................................28
Geriatric medicine, and in particular medical care of frail elders in the nursing home, is a team effort. The roles and responsibilities of various members of the clinical team may be indistinct, especially to individuals not practicing in the nursing home. As the nursing home population has become more medically complex, past roles, responsibilities, means of communication and documentation practices may need to change.

Further, the roles and responsibilities of health care providers, Medical Directors and Administrators vary in facilities with diverse characteristics: e.g., large vs. small facilities; rural vs. urban settings; stand-alone vs. corporate ownership vs. health-system ownership; employed physicians vs. community physicians; mid-level providers on-staff, or not; mid-level provider employed by the facility vs. employed by the physician; full-time (employed) Medical Director vs. part-time Medical Director.

To the extent possible, the Federal regulations regarding the roles, responsibilities, communication and documentation of these health care providers will be discussed. Recommendations of the New York State Department of Health Workgroup re: Attending Physicians and Medical Directors in the Nursing Home will be reviewed.

I. “When You’ve Seen One Nursing Home, You’ve Seen One Nursing Home”—Background

A. Nursing Home Characteristics

Contrary to the Silver Tsunami, generally, the number of nursing homes (15,634) has gradually declined over the past 10 years, but the decline essentially flattened out over the past five years. Over the past five years: 19 states have had an increase in the number of nursing homes and 7 states had no net change. The largest increases were in Alaska (20.0%), Nevada (8.2%) and Arizona (5.8%). The largest declines were in Vermont (7.5%), North Dakota (5.9%) and Maine (4.6%).

Nursing home occupancy has declined very gradually but steadily from 85.5% in 2005 to 82.4% in 2014.

There were decreases in the number nursing homes across all size categories, except those with 50-99 beds; these increased in number by 1.2% over the past five years. The largest nursing homes (those with 200 or more beds) declined the most (2.9%), though these constitute only 6.1% of the country’s nursing homes (and 15.2% of total beds).

Non-profit nursing homes have declined in number by 6.3% between 2010 and 2014, while for-profit nursing homes, which now constitute 69.8% of all nursing homes (and 72.2% of nursing home beds), increased by 1.6% over the same period. Government-owned nursing homes remain the smallest sector (6.2% of homes; 6.5% of beds) but have increased substantially in number since 2010 (8.5%).

From 2010 to 2014, dually participating nursing homes continued to become more prevalent, as the numbers of both Medicare-only and Medicaid-only nursing homes declined. In 2014, 92.2% of US nursing homes were dually certified. The number of Medicare-only nursing homes decreased by 1.4% to 764, while the number of Medicaid-only nursing homes saw the greatest decrease, dropping by 23.6% to 463, representing 3.0% of all homes and 2.1% of beds.
B. Nursing Home Patient / Resident Characteristics—A Diverse and Challenging Population

Just over 1.4 million residents were living in US nursing homes on December 31, 2014, corresponding to 2.6% of the over-65 population and 9.5% of the over-85 population.

While the average age of nursing home residents is 85 years, it is interesting to note that approximately fifteen percent (15.5%) of the nursing home population is under age 65, while 7.8% are over 95 years. Women constitute nearly two-thirds (65.6%) of the nursing home population. The majority are widowed. On average, the nursing home patient/resident has 3 to 5 chronic medical illnesses and is on multiple medications (6.7 routinely scheduled and 2.7 as needed). Nearly 4 of 5 nursing home residents (77.9%) are non-Hispanic Whites. Of course, there are variations among states in these demographic characteristics.

Both cognitive and functional impairment are common among nursing home residents. However, nearly 1 in 5 (19.8%) had no Activities of Daily Living (ADL) impairment and more than one-third (38.7%) had no more than mild cognitive impairment; further 11.1% had no ADL impairment and little or no cognitive impairment. The most impaired – those with 5 ADL impairments as well as severe cognitive impairment, represent 14.9% of the nursing home population.

A recent fall resulting in injury has been experienced by 5.3% of residents and an additional 11.0% of residents have had a non-injurious fall. Both injurious and non-injurious falls are more common among those with greater cognitive impairment.

Pressure ulcers of Stage 2 or greater were present in 5.1% of nursing home residents, a ten percent decline since 2011 (5.9%). Physical restraint use has become quite rare, with 1.0% of residents having any restraints in the past 7 days. Antipsychotic use, however, is quite common, with more than 1 out of 5 residents (21.7%) receiving an antipsychotic medication at least once in the past 7 days. These clinical measures vary according to age, state and cognitive status.

Frail, generally elderly
Long-term residents and Short-term patients

C. The Nursing Home Care Team

The multiplicity of care required by the generally frail and elderly patients/residents requires the skills of every member of the interdisciplinary team. Each member of the team must offer input and the input must be communicated effectively to other members of the team. In an ideal world, all team members are available to meet, not only with each other, but with the patient/resident and their families/significant others. These face to face meetings would be both periodic and as needed, when significant decisions need to be made, or there is a change in the patient/resident's condition.

The reality, however, is that neither each member of the interdisciplinary team nor family members can be available at all times. Limited availability in the nursing home may be particularly true for physicians. Communication is often via telephone, with a nurse or family member. As the nursing home population has evolved to be more clinically complex, the clinical skills, availability, communication skills and documentation of all clinical members of the care team also must evolve.

While there are volumes of Federal and State regulations applicable to the skilled nursing facility (SNF, nursing home), it is difficult to legislate the topics of this paper. While their documentation may be more concrete, the roles, responsibilities and communication of the physicians, NPs, and PAs is very variable: more the culture of the facility. As the importance of administrative roles and responsibilities is being recog-
nized, there has been increasing regulation regarding both the Medical Director and Administrator in long
term care facilities.

II. Roles, Responsibilities and Regulations

A. Attending Physician, Nurse Practitioner (NP) and Physician Assistant (PA)

1. Medical Roles and Responsibilities
   Accurate and timely medical assessments;
   Careful definition and description of
   problems and diagnoses,
   prognosis and
   goals of care;
   Management of medical problems
   to optimize function and personal comfort,
   consistent with the individual’s goals, condition, and prognosis; and,
   Help the care team (including the resident and family) establish realistic care goals based on
   conditions & prognosis.

2. Nonmedical Roles and Responsibilities
   Provide reliable, understandable medical information to the patient/resident, family and staff;
   Consider the patient & family goals and expectations in medical decision-making;
   Support the patient/resident and family with decision-making; clarifying goals and expectations;
   Support the team with family members;
   Complete advance directives (DNR, POLST, MOLST);
   Participate in discussions of ethical issues; and,
   Support the facility in attaining and maintaining regulatory compliance and quality standards
   (measures).

3. Clinical Collaboration in the Nursing Home
   The use of advanced practice nurses (APRNs) and PAs is increasingly common in many practice
   settings, including post-acute and long-term care (PA/LTC). Changes in the business of NHs,
   such as the higher acuity of patients and the increased control exerted by managed care com-
   panies, have encouraged use of APRNs and PAs. Teamed with physicians, APRNs and PAs may
   enhance the nursing and medical care available to patients (post-acute) and residents (long-
   term) in the nursing home.

4. Federal Regulations
   §483.30 – Physician Services (F385through F390)
   §483.10(d), F163 – Choice of attending physician.
   §483.10(d)(3), F156
   §483.10 (g)(14), F157 - Notification of changes
   *Note: regulations noted in italics are recent changes/additions to the regulations.*
§483.30 Physician Services (F385)
A physician must personally approve in writing a recommendation that an individual be admitted to a facility.

Each resident must remain under the care of a physician.

*A physician, PA, NP or clinical nurse specialist (CNS) must provide orders for the resident's immediate care and needs*.

§483.30(a)

The facility must ensure that:

(1) The medical care of each resident is supervised by a physician; and,

(2) Another physician supervises the medical care of residents when their attending physician is unavailable.

§483.30(b) Physician Visits (F386)

The physician must:

(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph © of this section;

(2) Write, sign and date progress notes at each visit; and

(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines which may be administered per physician-approved facility policy after an assessment for contraindications.

§483.30(c) Frequency of Physician Visits (F387 and F 388)

F387

(1) The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter;

(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. (Some states more restrictive.)

F388

(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required visits must be made by the physician personally.

(4) At the option of the physician, required visits in SNFs after the initial visit, may alternate between personal visit by the physician and visits by a PA, NP or clinical nurse specialist, in accordance with paragraph (e) of this section.
§483.30(d) Availability of Physicians for Emergency Care (F389)
The facility must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.

§483.30(e) Physician Delegation of Tasks in SNFs. (F390)
§483.30(e)(1) Except as specified in paragraph (e)(4) of this section, a physician may delegate tasks to a PA, NP or CNS who –
(1) meets the applicable definition in §491.2 of this chapter or, in the case of a CNS, is licensed as such by the State;
(ii) is acting within the scope of practice as defined by State law; and
(iii) is under the supervision of the physician.
§483.30(e)(2) A resident’s attending physician may delegate the task of writing dietary orders consistent with 483.60, to a qualified dietitian or other clinically qualified nutrition professional who –
(ii) is acting within the scope of practice defined by State law; and
(ii) is under the supervision of the physician.
§483.30(e)(3)
A resident’s attending physician may delegate the task of writing therapy orders consistent with 483.65, to a qualified therapist who –
(ii) is acting within the scope of practice defined by State law; and
(ii) is under the supervision of the physician.
§483.30(e)(4)
A physician may not delegate a task when the regulations specify that the physician must perform it personally, or
when the delegation is prohibited under State law or by the facility’s own policies.
§483.30(f) Performance of Physician Tasks in NFs (F390)

At the option of the State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a NP, CNS or P who is not an employee of the facility but who is working in collaboration with a physician.

5. Additional Federal Regulations Impacting/Involving the Attending Physician

a. §483.10(d), F163. The resident has the right to choose his or her attending physician.
   i. The physician must be licensed to practice, and
   ii. If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation as specified in paragraphs (d)(4) and (5) of this section to assure provision of appropriate and adequate care and treatment.
   iii. The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident’s preferences, if any, among options.
   iv. If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice.

b. §483.10(d)(3) F156 A facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.

c. §483.10(g)(14) F157 Immediately inform the resident; consult with the resident’s physician; and notify consistent with his or her authority, the resident’s representative(s) when there is
   i. An accident involving the resident which results in injury and has the potential for requiring physician intervention;
   ii. A significant change in the resident’s physical, mental or psychosocial status….;
   iii. A need to alter treatment significantly, that is ….; or
   iv. A decision to transfer or discharge the resident…..

6. NY State Regulations – 415.15, Medical Services

The federal regulations, plus:
The facility shall ensure that the responsible physician:
(2)(i) participates 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;
(2)(vi) provides residents and designated representatives with his or her name, office address and telephone number and responds to calls from residents to discuss the resident’s medical care;
(2)(vii) participates in facility training programs to familiarize him or herself with State regulations and facility policies.
(2)(viii) is informed of the results of all Department of Health surveys related to medical service deficiencies and is involved in resolving such problems.

7. Certainly, the availability of practitioners (physicians, NPs and PAs) will impact significantly their roles and responsibilities in the NH. In urban and suburban settings, due to greater numbers of practitioners in the community, a greater presence in NHs is likely. It would be expected that employed practitioners would be on-site more regularly than practitioners providing care on a fee-for service basis. The details of the employment (full-time, part-time) will be strong determinant of roles and responsibilities in the facility

B. Medical Director Roles, Responsibilities and Regulations

The ideal / goal: From the Society for Post-Acute and Long-Term Care Medicine (PALTC, formerly the American Medical Directors Association)

Position Statements regarding the roles and responsibilities of medical directors in long term care. (See references)

1. Medical Director Leadership and Management Roles
   a. Physician Leadership – The medical director serves as the physician responsible for the overall care and clinical practice carried out at the facility.
   b. Patient Care – Clinical Leadership - The medical director applies clinical and administrative skills to guide the facility in providing care
   c. Quality of Care – The medical director helps the facility develop both quality and safety initiatives, including risk management.
   d. Education, Information and Communication – The medical director provides information that helps others (including facility staff, practitioners and those in the community) understand and provide care.

2. Medical Director Functions – See References re: specific tasks
   a. Administrative – The medical director participates in administrative decision-making and recommends and approves relevant policies and procedures.
   b. Professional Services - The medical director organizes and coordinates physician services and the services provided by other professionals, as they relate to patient care.
   c. Quality Assurance and Performance Improvement (QA/PI) - The medical director participates in the process to ensure the quality of medical care and medically-relate care, including whether it is effective, efficient, safe, timely, patient-centered and equitable.
   d. Education - The medical director participates in developing and disseminating key information and education.
   e. Employee Health – The medical director participates in the surveillance and promotion of employee health, safety and welfare.
   f. Community - The medical director helps articulate the long-term care facility's mission to the community.
   g. Rights of Individuals – The medical director participates in establishing policies and procedures for assuring the the rights of individuals (patients, staff, practitioners and community) are respected.
h. Social, Regulatory, Political and Economic Factors – The medical director acquires and applies knowledge of social, regulatory political and economic factors that relate to patient care and related services.

i. Person-Directed Care - The medical director supports and promotes patient-centered care.

3. Federal Regulations - §483.70(h) Medical Director (F501)

   Note: regulations noted in italics are recent changes/additions to the regulations.

   a. Initial baseline - OBRA 1987 –

      §483.70(h)(1) The facility must designate a physician to serve as medical director.

      §483.70(h)(2) The medical director is responsible for –

   (i) Implementation of Resident Care Policies; And

   (ii) Coordination of Medical Care in The Facility.

   b. Institute of Medicine (IOM) Report - “Improving the Quality of Long Term Care”, 2001

      “Nursing homes should develop structures and processes that enable and require a more focused and dedicated medical staff responsible for patient care.”


      Given lack of specificity in the law re: role/responsibilities of medical directors,

      OIG surveyed facilities and medical directors re:

      credential status of medical directors;

      the amount of time spent in meeting the medical director functions;

      the nursing home's expectations of medical directors; and,

      the medical directors' perception of the expectations and their authority in the NH.

      Findings:

      29% with board-certification in Geriatrics;

      70% devote less than 10% of professional practice to their medical director role;

      81% maintain a private practice outside LTC responsibilities;

      54% serve as medical director for at least one other nursing home and 21% at facilities other than nursing homes;

      62% visit the facility less than once per week;

      86% spend 8 hours or less per week, while only 4% spend > 9 hours per week;

      72% spend < 4 hours per week; and

      Medical directors and facilities had very disparate expectations of each other.

   d. From IOM Report and OIG Survey to New Interpretive Guidelines -

      In November 2005, CMS replaced the interpretive guidelines for the existing regulation addressing medical directors in NHs. Expanded from one-third (1/3) page to 8 pages.

      §483.70(h), F 501

   (i) Intent of the requirement:

      The facility has a licensed physician who serves as the medical director to coordinate medical care in the facility and provide clinical guidance and oversight regarding the implementation of resident care policies;
The medical director collaborates with facility leadership, staff and other practitioners to develop, implement and evaluate resident care policies and procedures that reflect standards of practice; and,

The medical director helps the facility identify, evaluate and address/resolve medical and clinical issues that:

- affect resident care, medical care or quality of life; or
- are related to provision of services by physicians and other licensed health care practitioners.

(ii) Definitions and Overview

(iii) Medical Direction

Facility may provide for this service through any of several methods: direct employment, contractual agreement, or other type of agreement.

(iv) Implementation of Resident Care Policies and Procedures-

The medical director should Play a Key Role in Incorporating Current Standards of Practice into Resident Care Policies and Procedures (P & P).

The facility is responsible for obtaining the medical director's ongoing guidance in the development and implementation of resident care policies.

The medical director should collaborate With the Facility Regarding the Policies and Protocols That Guide Clinical Decision Making – e.g.

- Interpretation of clinical information,
- Treatment selection, and
- Monitoring of risks and benefits of interventions;

By any of the following:

Facility Staff;

- Licensed Physicians; NPs; PAs; CNSs;
- Licensed, Certified, Or Registered Health Professionals (e.g., Nurses, Therapists, Dietitians, Pharmacists, Social Workers, And Other Health Care Workers).

Resident Care Policies include:

- Admission Policies and Care Practices That Address the Types Of Residents That Are Admitted and Retained.
- The integrated delivery of care and services, such As Medical, Nursing, Pharmacy, Social, Rehabilitative, And Dietary services, which includes clinical assessments, Analysis of Assessment Findings, Care Planning, Care Plan Monitoring and Modification, Infection Control, Transfers to Other Settings, And Discharge Planning.
- Use and Availability Of ancillary services: Labs, X-ray, Etc.
- Availability, Qualifications, And Clinical Functions of Staff Necessary To Meet Resident Care Needs
- Advance Directives and End of Life Care.
- Provisions That Enhance Resident Decision Making, Including Choice Regarding Medical Care Options.
- Mechanisms for Communicating and Resolving Issues Related To Medical Care.
Conduct of Research, If Allowed, Within the Facility.

Provision of Physician Services

Scope of Practice of Other Health Care Providers.

Systems to Ensure That Other Licensed Practitioners Who May Perform Physician-delegated Tasks Act Within the Regulatory Requirements And Within the Scope of Practice as Defined by State Law

Procedures and General Clinical Guidance for Facility Staff Regarding When to Contact a Practitioner, Including Information That Should be Gathered Prior To Contacting the Practitioner Regarding a Clinical Issue/Question or Change in Condition.

(v) Coordination of Medical Care –

Help the facility obtain and maintain timely and appropriate medical care

that supports the healthcare needs of the residents,

that is consistent with current standards of practice, and helps the facility meet its regulatory requirements.

A medical director should establish a framework for physician participation, and physicians should believe that they are accountable for their actions and their care.

Help coordinate and evaluate the medical care by reviewing and evaluating aspects of physician care and practitioner services.

A response from a physician implies appropriate communication, review and resident management, but does not imply that the physician must necessarily order tests or treatments recommended or requested by the staff, unless the physician agrees that those are medically valid and indicated.

“Other activities” include, but is not limited to helping the facility:

Ensure that residents have primary attending and backup physician Coverage;

Ensure that physician and health care practitioner services are available to help residents attain and maintain their highest practicable level of functioning.

Develop a process to review basic physician and health care practitioner credentials.

“Other Areas for Medical Director Input to the Facility May Include”:

Facilitating feedback to physicians and other health care practitioners about their performance and practices.

Reviewing individual resident cases as requested or indicated.

Reviewing consultant recommendations.

Discussing and intervening (as appropriate) with a health care practitioner about medical care that is inconsistent with applicable current standards of care.

Assuring that a system exists to monitor the performance of health care Practitioners.

Guiding physicians regarding specific performance expectations.

Identifying facility or practitioner educational and informational needs.

Providing information to the facility practitioners from sources where current clinical information can be obtained.

Helping educate and provide information to staff, practitioners, residents, families, and others.
e. Created a new (11 page) investigative protocol to be used when there is potential that the facility is not in compliance with the regulation.

   (i) Objective, Use, Procedures
   (ii) Provision of a Medical Director
   (iii) Facility/Medical Director Responsibility for Resident Care Policies
   (iv) Coordination of Medical Care / Physician Leadership
   (v) Determination of Compliance
       a. Synopsis of Regulation (F501)
       b. Criteria for Compliance
       c. Noncompliance for F501
   (vi) Deficiency Categorization
       a. Severity Level 4 Considerations: Immediate Jeopardy to Resident Health or Safety
       b. Severity Level 3 Considerations: Actual Harm that is not Immediate Jeopardy to Resident Health or Safety
       c. Severity Level 2 Considerations: No Actual Harm with Potential for More than Minimal Harm that is not Immediate Jeopardy to Resident Health or Safety
       d. Severity Level 1 Considerations: No Actual Harm with Potential for Minimal Harm

5. N.Y. State Department of Health "Minimum Standards" (Part 415)

The (basic) Federal Requirements PLUS

(a) Coordinating the review, prior to granting or renewing professional privileges or association, of any physician, dentist or podiatrist as required by Public Health Law 2805-j.

   Hospital-based nursing homes may utilize the hospital's medical staff membership review system to facilitate the review.

Such review shall be coordinated with the activities of the Quality Assessment and Assurance Committee and shall:

(i) provide for the maintenance and continuous collection of information concerning the facility's experience with negative health care outcomes and incidents injurious to residents, resident grievances, professional liability premiums, settlements, awards, costs incurred by the facility for resident injury prevention and safety improvement activities;

(ii) periodically reconsider the credentials, physical and mental capacity and competency in delivery or health care services of all physicians, dentists or podiatrists who are employed or associated with the facility;

(iii) gather information concerning individual physicians, dentists and podiatrists within the individual physician's, dentist's or podiatrist's personnel file maintained by the facility; and

(iv) prior to renewal of privileges of physicians, dentists or podiatrists, solicit and consider information provided by the Resident Council about each such practitioner; and

(b) assuring that each resident's responsible physician attends to the resident's medical needs, participates in care planning and follows the schedule of visits maintained in accordance with subdivision (b) of this section, and complies with facility policies.
6. New York State Guidelines

Dear Administrator Letter (DAL, January 20, 2012) announcing a “best practice”: Guidelines on Medical Direction and Medical Care in Nursing Homes Process guidelines.

Lay out roles, responsibilities and accountabilities of medical directors and attending medical practitioners in nursing facilities.

Voluntary, “strongly encouraged”

Incorporates: regulations (Federal and State), core elements of the American Medical Directors Association (AMDA, now PALTC) Position Statements re: Roles and Responsibilities of the Medical Director (described above)

Addresses:

Specific responsibilities for each role and specific tasks for each responsibility.

Medical Director Training.

Medical Director Certification (CMD).

Medical Director and QA/QI (now QAPI)

Survey Considerations.

Assistant Medical Director.

Facility Responsibilities re: supporting the attending physicians and medical director in accomplishing issues outlined in the Guidelines.

7. Similar to the attending physician, the availability of the medical director will have a significant impact on this/her roles and responsibilities. It can be expected that medical directors who also serve as attending physician for a panel of patients/residents may be present in the facility more frequently. A higher density of physicians in urban and suburban settings increases the likelihood of the medical director being more available in those settings. The amount of time supported monetarily is a significant determinant of the medical director's availability. In corporate or health-system owned facilities, additional medical direction resources may be available.

C. Administrator—Roles, Responsibilities, and Regulations

1. Background – Licensure Requirements – State-specific
   
   i. Minimum Age – 18, 19, 21, no requirement
   
   ii. Education – AA, BA, hours, no requirement
   
   iii. Administrator in Training (AIT)
      
      1. Board-approved Preceptor – Yes, No, no requirement
      
      2. Number of hours – Minimum 240 – 2080, no requirement
   
   iv. Exam – National and/or State, no requirement
   
   v. Continuing Education – 25 hours per year (50 Biennially) – no requirement

2. Ultimately responsible for all aspects of care and business operations.

   a. Leadership and Management
      
      i. Forecasting, Planning, Innovating
      
      ii. Organizing, Directing – all clinical and non-clinical departments and associated policies and procedures
iii. Marketing
iv. Daily Operations
v. Interface with State and Federal Agencies

b. Human Resources
   i. Organizational Pattern of the Facility and Staff
   ii. Staffing – Skill Mix, Staffing Levels, Job Descriptions
   iii. Recruiting, Hiring
   iv. Training
   v. Evaluating, Disciplining Staff
   vi. Retaining Staff
   vii. Managing Unions

c. Finance and Business
   i. Budget – Payroll, Supplies, Capital
   ii. Census
   iii. Contracted rates

d. Physical Environment, Equipment

e. Life Safety, Emergency Preparedness

f. Regulatory and Accrediting Body Compliance
   i. Requirements, Major Topics

§483.1  Basis and scope
§483.5  Definitions
§483.10  Resident rights
§483.12  Freedom from abuse, neglect, and exploitation
§483.15  Admission, transfer, and discharge rights
§483.20  Resident assessment
§483.21  Comprehensive person-centered care planning
§483.24  Quality of life
§483.25  Quality of care
§483.30  Physician services
§483.35  Nursing services
§483.40  Behavioral health services
§483.45  Pharmacy services
§483.50  Laboratory, radiology, and other diagnostic services
§483.55  Dental services
§483.60  Food and nutrition services
§483.65  Specialized rehabilitative services
§483.70  Administration
§483.75  Quality assurance and performance improvement
§483.80  Infection control
§483.85  Compliance and ethics program
§483.90  Physical environment
§483.95  Training requirements
ii. Americans with Disabilities Act

iii. OSHA

iv. HIPAA

v. Voluntary Accreditation
   1. Joint Commission
   2. Commission on Accreditation of Rehabilitation Facilities (CARF)

3. Federal Regulations: §483.70- Administration

   §483.85 – Compliance and Ethics Program
   §483.95 – Training Requirements

Note: regulations noted in italics are recent changes/additions to the regulations.

A. §483.70 Administration (F490).

**See the regulation for full details of §483.70 Administration

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

(a) Licensure. A facility must be licensed under applicable State and local law.
(b) Compliance with Federal, State, and local laws and professional standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.
(c) Relationship to other HHS regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph.
(d) Governing body.
(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and
(2) The governing body appoints the administrator who is -
   (i) Licensed by the State, where licensing is required;
   (ii) Responsible for management of the facility; and
   (iii) Reports to and is accountable to the governing body.
(3) The governing body is responsible and accountable for the QAPI program, in accordance with §483.75(f).
(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:

1. The facility's resident population, including, but not limited to,
   (i) Both the number of residents and the facility's resident capacity;
   (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
   (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
   (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
   (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

2. The facility's resources, including but not limited to,
   (i) All buildings and/or other physical structures and vehicles;
   (ii) Equipment (medical and non-medical);
   (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
   (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
   (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
   (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

(f) Staff qualifications. …

1. The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.

2. Professional staff must be licensed, certified, or registered in accordance with applicable State laws. ...

(g) Use of outside resources. …

1. If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must…

(h) Medical director. (Details above)

(i) Clinical records. …

(j) Transfer agreement….
Disclosure of ownership. …

Facility Closure-Administrator. …

Facility closure…. 

Binding arbitration agreements. …

Hospice services…..

Social worker. Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is:

(1) An individual with a minimum of a bachelor’s degree in social work or a bachelor’s degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and

(2) One year of supervised social work experience in a health care setting working directly with individuals.

Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.

(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long-term care facility (for example, housekeeping).

(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:

(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);

(ii) Resident census data; and

(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS.

(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.

B. §483.85 Compliance and ethics program. (F490)- Effective 11/28/2017

(a)Definitions. For purposes of this section, the following definitions apply:

Compliance and ethics program means, with respect to a facility, a program of the operating organization that -
(1) Has been reasonably designed, implemented, and enforced so that it is likely to be effective in preventing and detecting criminal, civil, and administrative violations under the Act and in promoting quality of care; and

(2) Includes, at a minimum, the required components specified in paragraph (c) of this section.

High-level personnel mean individual(s) who have substantial control over the operating organization or who have a substantial role in the making of policy within the operating organization.

Operating organization means the individual(s) or entity that operates a facility.

(b) General rule. Beginning on November 28, 2017, the operating organization for each facility must have in operation a compliance and ethics program (as defined in paragraph (a) of this section) that meets the requirements of this section.

(c) Required components for all facilities. The operating organization for each facility must develop, implement, and maintain an effective compliance and ethics program that contains, at a minimum, the following components:

(1) Established written compliance and ethics standards, policies, and procedures to follow that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under the Act and promote quality of care, which include, but are not limited to, the designation of an appropriate compliance and ethics program contact to which individuals may report suspected violations, as well as an alternate method of reporting suspected violations anonymously without fear of retribution; and disciplinary standards that set out the consequences for committing violations for the operating organization’s entire staff; individuals providing services under a contractual arrangement; and volunteers, consistent with the volunteers’ expected roles.

(2) Assignment of specific individuals within the high-level personnel of the operating organization with the overall responsibility to oversee compliance with the operating organization’s compliance and ethics program’s standards, policies, and procedures, such as, but not limited to, the chief executive officer (CEO), members of the board of directors, or directors of major divisions in the operating organization.

(3) Sufficient resources and authority to the specific individuals designated in paragraph (c)(2) of this section to reasonably assure compliance with such standards, policies, and procedures.

(4) Due care not to delegate substantial discretionary authority to individuals who the operating organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under the Social Security Act.

(5) The facility takes steps to effectively communicate the standards, policies, and procedures in the operating organization’s compliance and ethics program to the operating organization’s entire staff; individuals providing services under a contractual arrangement; and volunteers, consistent with the volunteers’ expected roles. Requirements include, but are not limited to, mandatory participation in training as set forth at §483.95(f) or orientation programs, or disseminating information that explains in a practical manner what is required under the program.

(6) The facility takes reasonable steps to achieve compliance with the program’s standards, policies, and procedures. Such steps include, but are not limited to, utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under the Act by any of the operating organization’s staff, individuals providing services under a contractual arrangement, or volunteers, having in place and publicizing a reporting system whereby any of these individuals could report violations by others anonymously within the operating organization without fear of retribution, and having a process for ensuring the integrity of any reported data.
(7) Consistent enforcement of the operating organization's standards, policies, and procedures through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect and report a violation to the compliance and ethics program contact identified in the operating organization's compliance and ethics program.

(8) After a violation is detected, the operating organization must ensure that all reasonable steps identified in its program are taken to respond appropriately to the violation and to prevent further similar violations, including any necessary modification to the operating organization's program to prevent and detect criminal, civil, and administrative violations under the Act.

(d) Additional required components for operating organizations with five or more facilities. In addition to all of the other requirements in paragraphs (a), (b), (c), and (e) of this section, operating organizations that operate five or more facilities must also include, at a minimum, the following components in their compliance and ethics program:

(1) A mandatory annual training program on the operating organization's compliance and ethics program that meets the requirements set forth in §483.95(f).

(2) A designated compliance officer for whom the operating organization's compliance and ethics program is a major responsibility. This individual must report directly to the operating organization's governing body and not be subordinate to the general counsel, chief financial officer or chief operating officer.

(3) Designated compliance liaisons located at each of the operating organization's facilities.

(e) Annual review. The operating organization for each facility must review its compliance and ethics program annually and revise its program as needed to reflect changes in all applicable laws or regulations and within the operating organization and its facilities to improve its performance in deterring, reducing, and detecting violations under the Act and in promoting quality of care.

C. §483.95 Training requirements.

A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at §483.70(e).

Training topics must include but are not limited to –

(a) Communication. A facility must include effective communications as mandatory training for direct care staff.

(b) Resident's rights and facility responsibilities. A facility must ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at §483.10, respectively.

(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in §483.12, facilities must also provide training to their staff that at a minimum educates staff on –

(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at §483.12.

(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property.

(3) Dementia management and resident abuse prevention.
(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility’s QAPI program as set forth at §483.75.

(e) Infection control. A facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program as described at §483.80(a)(2).

(f) Compliance and ethics. The operating organization for each facility must include as part of its compliance and ethics program, as set forth at §483.85 -

(1) An effective way to communicate that program’s standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program.

(2) Annual training if the operating organization operates five or more facilities.

(g) Required in-service training for nurse aides. In-service training must -

(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.

(2) Include dementia management training and resident abuse prevention training.

(3) Address areas of weakness as determined in nurse aides’ performance reviews and facility assessment at §483.70(e) and may address the special needs of residents as determined by the facility staff.

(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.

(h) Required training of feeding assistants. A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in §483.160.

(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.70(e).

4. While the scope of responsibilities of the administrator are vast, much of the daily function and the majority of tasks are delegated to departmental directors. The Director of Nursing has a significant role in daily patient care and facility operations. Larger facilities likely have Associate or Assistant Directors of Nursing. Corporately- or health-system owned facilities provide administrative resources, structure and other supports not available to administrators of “stand-alone” NHs. As the administrator may have no clinical training, the medical director and director of nursing are important allies in assuring quality clinical care.

III. Communication—The Foundation of Teamwork

Care of older adults generally requires multiple interventions by various members of the health care team. Staff must intervene in multiple risk factors and multiple medical conditions, and this requires a great deal of communication and coordination among a variety of staff and disciplines.

A. Patient-Specific

   a. Face to Face, at the facility
   b. Telephone, by the nurse
   c. Physician Communication Book transitioning to
   d. Electronic Health Record - Timeliness
i. Telephone Orders
ii. “Recommendations”
iii. Documents
iv. Messages
e. Fax, E-mail and Text
   i. Cybersecurity (HIPAA)
   ii. Timeliness
   iii. Certainty / documentation that message was sent/received.
f. Alternative Communication Strategies
   i. INTERACT® (Interventions to Reduce Acute Care Transfers) is a quality improvement program that focuses on the management of acute change in resident condition. It includes clinical and educational tools and strategies focusing on patient/resident assessment and effective communication of the findings with the practitioner.
   ii. CONNECT - An intervention to enrich connections, communication, and problem-solving. CONNECT helps staff better understand residents' issues by identifying communication gaps. It is designed to teach staff the importance of sharing information across disciplines. CONNECT is taught using story-telling, role play, relationship mapping, mentoring, self-monitoring, and feedback.

B. Interdisciplinary Team
   a. Care Plan Meetings
      i. Practitioner, Medical Director and Administrator not typically present
      ii. Infrequent
      iii. Attendance of resident and/or family varies
         1. Conference calls can be effective
   b. Family Meetings
      i. Ad hoc Care Plan meeting, when there is an issue
      ii. Attendance of Practitioner and/or Medical Director more likely
      iii. Attendance of Administrator is usual
   c. Interdisciplinary Walk/Unit Rounds
      i. Uncommon in the nursing home

C. Leadership Operations (Morning Report)
   a. Daily
   b. Department Directors/Mangers
   c. Nurse Managers, Each Floor/Unit
   d. Administrator (or Director of Nursing) leads the meeting
   e. Medical Director, variably present

D. Committees
   a. QA/PI – more stringent requirements effective November 2017
   b. Infection Control,
Roles, Responsibilities, Communication and Documentation...

i. soon to include Antibiotic Stewardship

c. Patient Safety / Occurrence
d. Pharmacy
E. Resident Council
F. Family Council
G. Long-term Care Ombudsman
H. Anonymous (Hotline) Complaints

IV. Documentation

A. Clinical Issues relevant to practitioner and/or Medical Director Documentation

1. Medical Necessity
   Medications –
   Each Medication is Necessary (per regulatory definition)
   In Particular, Psychotropic Medications
   Restraints –
   There must be a physician's order reflecting the presence of a medical symptom” justifying the need for a restraint.

   Feeding tubes –
   Inability to swallow without choking or aspiration;
   Lack of sufficient alertness for oral nutrition;
   Malnutrition not attributable to a single cause or causes that can be isolated or reversed.

   Urinary (Foley) catheters
   A resident who enters the facility without an indwelling catheter is not catheterized unless medically necessary.
   Appropriate indications for continuing catheter use beyond 14 days may include:
   Urinary retention (PVR>200ml, intermittent cath not possible) (neurogenic bladder, obstructive uropathy)
   Contamination of Stage III or IV pressure ulcers which has impeded healing
   Terminal illness or severe impairment which makes positioning or clothing changes uncomfortable, or which is associated with intractable pain.

2. Medically Unavoidable
   Decline in functional status - Highest practicable level of function is maintained and, or when possible, improve functional ability
   Decline in range of motion (contractures);
   Pressure ulcers
   High vs. Low risk patient
   Decline in nutritional status – weight loss, protein levels
3. Behavioral Symptoms:
   Remediable causes for behaviors were Ruled Out (pain, hunger, thirst, boredom, etc.);
   Attributable to a specified medical condition;
   Identified; and
   Quantified.
4. Psychotropic Medications: antipsychotics, anti-anxiety,
   Antidepressants and hypnotics –
   Dose Does Not Exceed Certain Maximums
   Therapy is Effective in Reducing or Eliminating the Behavior (Distress)
   Therapy is Without Side-effects
   Therapy is Time-limited
   Specified Time Frames
   Specified percentage for gradual dose reduction
B. Physician documentation for “special circumstances” re: transfer or discharge:
   necessary for resident's welfare and the resident's needs cannot be met at the facility;
   appropriate because the resident's health has improved sufficiently so the resident no lon-
   ger needs the services provided by the facility;
   when the health of individuals in the facility would otherwise be endangered
C. At the time each resident is admitted, the facility must have physician orders for the resident's
   immediate care. (§483.20(a), F271)
D. The physician must participate as part of the interdisciplinary team in preparing a comprehen-
   sive care plan. (§483.20(k)(2), F 283)
E. §483.21(c)(2) - Discharge Summary
   When the facility anticipates discharge, a resident must have a discharge summary that includes,
   but is not limited to the following:
   (i) a recapitulation of a resident's stay that includes, but is not limited to, diagnoses, course of ill-
   ness/treatment or therapy, and pertinent lab, radiology and consultation;
   (ii) a final summary of the resident's status to include items in paragraph (b)(1) of 483.20,
   at the time of discharge that is available for release to authorized persons and agencies, with
   the consent of the resident or resident's representative;
   (iii) reconciliation of all pre-discharge medications with the resident's post-discharge medications
   (both prescribed and over-the-counter).
   (iv) A post-discharge plan of care that is developed with participation of the resident and, with
   the resident's consent, the resident representative(s), which will assist the resident to adjust to
   his or her new living environment.
The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident’s follow up care and any post-discharge medical and non-medical services.

F. §483.45(c), F428 - Drug regimen review.

(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

(2) This review must include a review of the resident’s medical chart. (Effective 11/28/2017)

(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:

   (i) Anti-psychotic;
   (ii) Anti-depressant;
   (iii) Anti-anxiety; and
   (iv) Hypnotic.

(4) The pharmacist must report any irregularities to the attending physician and the facility’s medical director and director of nursing, and these reports must be acted upon.

   (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.

   (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility’s medical director and director of nursing and lists, at a minimum, the resident’s name, the relevant drug, and the irregularity the pharmacist identified.

   (iii) The attending physician must document in the resident’s medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident’s medical record.

(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.

V. Conclusion

Nursing facility care is changing from long-term, custodial care of frail elders to medically complex and resource-intense care for medically stable, but acutely ill long-term residents and for post-hospital care for short-stay, subacute patients. The population of people receiving care in nursing facilities is more medically complex as nursing homes strive to “treat in place” their long-term residents and to avoid re-hospitalization of sub-acute patients that are discharged ‘sicker and quicker’ from the hospital. This has resulted in an increased need for highly trained, committed and accessible health care practitioners willing to provide care on-site, at the nursing home.

The Nursing Home Reform Act (OBRA ’87) codified the requirement for physician medical directors in nursing facilities and ascribed specific responsibilities to them. It also set minimum requirements for physician visits to facility residents. As long-term care has evolved and as expectations for quality post-acute care...
have risen, the importance of physicians and other health care practitioners, medical directors and administrators in long-term care settings has received more attention. Along with this attention, regulations are evolving and multiplying.

A shortage of qualified practitioners who are available and willing to care for nursing facility residents has been recognized (e.g., IOM report “Retooling for an Aging America: Building the Health Care Workforce.”) Physicians and nursing facility operators have been hiring nurse practitioners and other non-physician practitioners to supplement or perhaps even replace scarce physicians in long-term care settings. Nurse practitioners and other non-physician practitioners must work collaboratively with the care team, attending physicians, medical directors and administrators to maximize the value of all members of the interdisciplinary care team. Physicians, medical directors and administrators must commit to fostering and strengthening this collaboration.

Interdisciplinary, team-based care is the only effective way to meet the diverse health and psychosocial needs of the frail NH population. The contributions and perspectives of all disciplines are unique and valuable. Long-term care facilities, administrators, owners and operators must support the practitioners and medical director in carrying out their various professional roles and responsibilities, including providing support, encouragement, and opportunities for education.

VI. References

Role of the Attending Physician in the Nursing Home
AMDA White Paper, March 1, 2003

The Nursing Home Medical Director: Leader & Manager
AMDA White Paper, Update to Resolution A06, March 2011.

The Role of the Medical Director in Quality Assurance & Process Improvement in Long-Term Care

The Role of the Medical Director in Person-Directed Care

New York State Department of Health Work Group
Role of the Attending Physician in the Nursing Home, November 2011
Available at www.health.ny.gov/professionals/nursing_home_administrator/docs/11-13_att_phys_role.pdf

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