Medical Provider Guidelines

The purpose of these Medical Provider Guidelines (hereinafter, the “Guidelines”) is to outline the minimum standards for medical provider performance that are expected to promote a high level of quality healthcare within the skilled nursing facility.

The Guidelines define the relationships among the Organization and the Medical Providers, defined as: attending physicians, non-physician providers (physician assistants and nurse practitioners) and medical directors.

Organization:

The center has an open medical staff. This means any licensed medical provider who provides evidence of licensure and insurance coverage and has an established medical practice within the service area may care for residents at the center if they agree to adhere to minimum standards that are described in these Guidelines. All medical staff are expected to receive seasonal influenza vaccination.

Medical Providers will be given these Guidelines and asked to provide documentation specified in the Registration policy within two weeks of providing medical services to residents of the center.

Expectations of Attending Physicians:

Residents must have an attending physician assigned to them at the time of admission. Upon admission of a resident, the attending physician will ensure there is a history and physical in the chart within 72 hours (or less, if dictated by state regulations) that includes primary reason for admission, pertinent past medical and family history, current medications, allergies, recent diagnostic test results, pending tests and consultations, current diagnoses and goals of care.

Complete orders will be provided to give guidance to the center in meeting the resident’s needs, including:

- Specific order for admission to center and the skilled level of care (if admission is to a secure unit, the order must document a primary diagnosis of irreversible dementia)
- Advance directive wishes
- Allergies (food, medications, other)
- Diet
- Medical diagnoses
- Medication orders will include date, route, dosage, frequency, strength and medical reason/diagnosis for administration. Dosage range (i.e., 1-2 tablets) is not acceptable. PRN orders must include a medical reason for administration and indication for use.

- High risk medications:
    - PRN use of psychotropic medications is discouraged, and if used, should be re-evaluated within a short interval (14 days or less)
    - Care should be taken to order appropriate monitoring of anticoagulant medications and assure stop dates are appropriately assigned
    - Use of sliding scale insulin is discouraged
    - Opioids should be carefully evaluated, and written prescriptions should be provided
    - Antibiotics should be reviewed to assure that they are appropriate with culture results, and stop/reassessment dates should be assigned
- May use generic medications (yes or no)
- May use standing orders (yes or no)
- Treatments (i.e., wound care) should include the product to be used, when to change and when to reassess
- Rehabilitation potential
- Therapy orders when appropriate
- Two-step TB test unless contraindicated
- Pneumovax (both PCV13 and PPSV23), if not already current

Residents will receive visits as required by regulation. A nurse practitioner (and in some states, a physician assistant) may assist in the admission process, including writing the orders, but a physician still needs to do an “initial visit”. Regulations mandate that a new resident is seen by a physician within the first 30 days of admission, and subsequently every 30 days for the first 90 days of their stay. During this time, it is important to evaluate stability, ensure medications that were started in the hospital that were intended for short-term use are discontinued, and that all tests ordered in the hospital are followed up on. After this time period, a comprehensive review of the resident’s overall condition, medications and treatments is mandated every 60 days. The visits must be no later than 10 days after the due date.

Alternate visits may be provided by a nurse practitioner or physician’s assistant, as allowed by federal and state law. If either a nurse practitioner or physician’s assistant helps provide care, the center should be provided a copy of any supervisory agreement. When the attending physician is unavailable, the center should be notified of alternate on-call medical coverage for residents.

Attending physicians are expected to collaborate with other care providers on an appropriate plan of care. This includes, but is not necessarily limited to, collaborating with consulting physicians and responding to communication from the consulting pharmacist and interdisciplinary team in a collegial manner within two weeks of the recommendation.

Attending physicians are expected to participate in/support quality improvement efforts, as prioritized by the Quality Assurance Performance Improvement (QAPI) Committee.

Attending physicians are expected to respond to communication from center clinical staff about changes in condition in a time frame consistent with the urgency of the communication. They should reinforce nursing assessment and communication using the Situation, Background, Assessment, Request (SBAR) format and staff use of the INTERACT toolkit.

Attending physicians are encouraged to use the electronic health record. The health information manager (HIM) at the center will assist in getting a username, login and remote access.

If a transfer or discharge occurs, the attending physician is required to document in the medical record:

- The specific reason(s) that the resident's needs cannot be met in the center
- What the center has attempted in order to meet the needs
- How the receiving facility will be better able to meet these needs

Transfer or discharge notes (may be completed by the center staff) should include:

- Contact information for:
    - The practitioner responsible for the pre-transfer care of the resident
    - The resident's representative (i.e., family member)
- Advance directives
- Special instructions/precautions for ongoing care
- Comprehensive care plan goals

The attending physician is responsible for completing a discharge summary that includes:

- Review of diagnoses, course of treatments, pertinent lab/radiology and consultation results
- Medication reconciliation
- Post discharge plans (should include caregiver availability, capability and capacity), as well as follow-up care that is needed

Attending physicians must be licensed and in good standing in the state where they are providing services. Attending physicians should also have a Drug Enforcement Agency (DEA) number allowing them to prescribe controlled substances and evidence of professional liability insurance. The medical director of the center should be notified in writing if the status of any of these qualifications changes.

Expectations of Non-Physician Medical Providers (NPP):

NPPs are expected to collaborate with other care providers on an appropriate plan of care. This includes, but is not necessarily limited to, responding to communication from the consulting pharmacist and interdisciplinary team in a collegial manner within two weeks of the recommendation.

A nurse practitioner (and in some states, a physician assistant) may assist in the admission process, including writing the orders, but a physician still needs to do an "initial visit".

During the first 30 days of admission, it is particularly important to evaluate resident stability, ensure medications that were started in the hospital are still appropriate, and that all tests ordered in the hospital are followed up on.

Alternate visits may be provided by a nurse practitioner or physician's assistant, as allowed by federal and state law. If either a nurse practitioner or physician's assistant helps provide care, the center should be provided a copy of any supervisory agreement. When the attending physician is unavailable, the center should be notified of alternate on-call medical coverage for residents.

NPPs are expected to participate in/support quality improvement efforts, as prioritized by the Quality Assurance Performance Improvement (QAPI) Committee.

High risk medications:

- PRN use of psychotropic medications is discouraged, and if used, should be re-evaluated within 14 days or less
- Care should be taken to order appropriate monitoring of anticoagulant medications and assure stop dates are appropriately assigned
- Use of sliding scale insulin is discouraged
- Opioids should be carefully evaluated, and written prescriptions should be provided
- Antibiotics should be reviewed to assure that they are appropriate with culture results, and stop/reassessment dates should be assigned

NPPs are expected to respond to communication from center clinical staff about changes in condition in a time frame consistent with the urgency of the communication. They should reinforce nursing assessment and communication using the Situation, Background, Assessment, Request (SBAR) format, and staff use of the INTERACT toolkit.

NPPs are encouraged to use the electronic health record. The health information manager (HIM) at the center will assist in getting a username, login and remote access.

If a NPP makes a decision to urgently transfer a resident to a higher level of care, they should follow the same standards of documentation as the attending physicians, outlined above.

Physician assistants and nurse practitioners must hold a state license in the state where they are providing services. They should also hold a Drug Enforcement Agency (DEA) number that allows them to prescribe controlled substances, and provide evidence of professional liability insurance. Physician supervisory agreements, as appropriate in the state where they are providing services, should be provided to the location.

Expectations of the Medical Director:

The medical director has contractual obligations; they generally function in a manner similar to the chief of staff for a hospital. The Medical Director Agreement entered into by and between the medical director (or his/her employer) and the center shall remain the controlling document of the relationship.

In summary, the medical director is responsible for the overall coordination of the medical care in the center, for ensuring adequacy and appropriateness of the medical services provided to the residents and oversight of patient care policies.

If the medical director also serves as an attending physician and is expected to model excellent professional behavior in both roles.

The medical director is expected to actively participate in Quality Assurance Performance Improvement (QAPI) meetings, and to support performance improvement efforts. This should include supporting antibiotic stewardship, resident safety and the use of the INTERACT tools to reduce inappropriate re-hospitalization.

The medical director will contact medical staff for periodic meetings to discuss various issues related to care, center operation and medical staff functions.

The medical staff may also expect that the medical director has authority to provide feedback to medical staff if there are concerns about the quality of care or unprofessional behavior.

The medical director is encouraged to review performance of all medical providers on an annual basis, more frequently if concerns are noted.

The medical director is encouraged to utilize the electronic health record personally, and to encourage use by the medical staff.

If an attending physician or NPP is not meeting the guidelines to provide the H&P, regulatory visits and transfer/discharge documentation, the medical director may be asked to complete the required visit and documentation. The medical director will then assist the administrator in addressing this issue with the attending physician.

Discipline:

Violations of state or federal regulations, practice of medicine that does not facilitate resident wishes or follow evidence-based practices, or display of unprofessional conduct may result in the resident being asked to choose a different medical provider. The medical director may be asked to consult in the case prior to this step. If the medical director is the provider of concern, or if there is dispute of the local decision, this may be appealed to the chief medical and quality officer of The Evangelical Lutheran Good Samaritan Society.

Acknowledgement:

I have received a copy of the Medical Provider Guidelines.

Signed _____

Date _____

References: State Operations Manual; 483.12; 483.60; 483.40 F Tags 385, 386, 387, 388, 389, 390; 483.60; 483.12