Commentary: The Physician's Role in Nursing Home Quality of Care: Focus on Restraints

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ABSTRACT. The physician can play an important role in managing high-risk nursing home residents without restraints and working with interdisciplinary care teams in comprehensive fall evaluations. A reduction or elimination of physical restraints can be measured for a facility

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Journal of Aging & Social Policy, Vol. 20(3) 2008
Available online at http://jasp.haworthpress.com
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doi:10.1080/08959420802050868

over time, and it represents a relevant quality indicator of physician and facility interactions during the process of care. We discuss how the physician's role fits into this quality of care equation for nursing homes and its implications for new clinical, research, and policy directions for long-term care.

KEYWORDS. Nursing homes, physician, restraints, quality

INTRODUCTION

Some physicians justify the use of restraints in nursing homes as a means of reducing falls and ensuring resident safety. However, the current clinical evidence does not support the efficacy of restraints for resident safety or fall reduction (Evans & Strumpf, 1989; Capezuti, Evans, Strumpf, & Maislin, 1996). Physical restraints may cause an increase in agitation, and confused residents may actually have an increased number of falls when restraints are applied (Capezuti et al., 1996). Restraints can further limit mobility and place residents at increased risk for pressure ulcers or cause injury if the resident repeatedly pushes or pulls against the restraint. There is also a very real risk of death from strangulation with the use of physical restraints, and there are well-described case series in the literature of these events occurring (Miles & Irvine, 1992).

The nursing home physician can play an important role in managing high-risk residents without restraints and working with interdisciplinary care teams in comprehensive fall evaluations. When a physician medical director is engaged in the administrative efforts of a facility, there is the ability to create an institutional culture that can ultimately strive to be restraint-free. In this article, we propose that restraint use within the nursing home is a clinical quality indicator that can be measured and compared across nursing homes. Furthermore, the use of restraints implies a facility-specific process of care for managing residents at risk for fall-related injuries and behavioral disturbances secondary to dementia. An appropriate goal for medical care in the nursing home should be a reduction or elimination of restraint use. We will discuss how the physician's role fits into this quality of care equation for nursing homes, and in the process we suggest a number of new research and policy directions.

QUALITY OF CARE

The nursing home has become an increasingly regulated environment following enactment of the Nursing Home Reform Act as part of the Omnibus Budget Reconciliation Act (OBRA 1987), Public Law No. 100–203. This act provided for a Residents' Bill of Rights, which included the right to freedom from physical restraints. OBRA also played an important role in outlining the responsibilities of the attending physician in the nursing home and establishing the role of medical director as the physician leader responsible for medical staff oversight and quality of care.

The Nursing Home Reform Act appears to have had a significant impact on reducing the use of physical restraints nationwide (Castle, Fogel, & Mor, 1997). However, despite these reforms, national statistics continue to report considerable geographic variation in restraint use (Phillips et al., 1996; Castle & Mor, 1998).

THE NURSING HOME PHYSICIAN

At first glance, the relationship between physician care and overall nursing home quality would appear to be self-evident. Federal and state statutes clearly define the roles of both the nursing home medical director and attending physician. All medical treatments require physician approval, including orders on admission and discharge, and presumably the use of all physical restraints in a nursing home occurs under the medical provider's signature. How could there not be a relationship between this care delivery and nursing home resident outcomes like frequency of restraint use? Surprisingly, there is little empiric evidence illuminating this issue, despite expert consensus confirming the importance of the physician in nursing home care.

The medical model remains the dominant infrastructure for the delivery of care in the nursing home, adopted decades ago from the delivery of care in hospitals. This model places the physician at the center of diagnostic and therapeutic decision making. However, physicians have remained largely peripheral in the nursing home culture and hierarchy. There remains a negative perception, particularly among families, regarding the absence of physicians in nursing homes (Katz & Karuza, 2005). This may be due in part to a limited workforce presence or the episodic nature of direct physician interactions. There also remains a dearth of evidence defining physician "best practices" in the nursing home, and the linkage

between the medical director and attending physician remains poorly defined.

THE MEDICAL STAFF ORGANIZATION

The presence and dedication of the medical director, open vs. closed medical staff models, and the presence of full-time long-term care physicians all influence the types of working relationships and access to medical care in the nursing home. Despite the OBRA 1987 mandate of interdisciplinary care planning for nursing home residents, there is very little known about the physician role in interdisciplinary teams. The management of residents in a restraint-free environment requires the participation of all members of the nursing home care team, including administrators, physicians, and bedside caregivers.

The availability of on-site physicians may mean greater interaction with staff and interdisciplinary care teams and may result in more integration of the physician into the nursing home culture, with participation in committee work and involvement in quality improvement programs that may shift an entire facility's practice away from restraint use. The opportunity exists for staff education, role-modeling behavior, and improving documentation in the medical record. Greater physician availability can translate to increased access to care, which could result in more timely assessments of clinical problems, earlier identification of changes in condition or functional decline, and more appropriate interventions to handle behavioral disturbances without the use of restraints. However, there is no good current evidence regarding the details of these organizational models as they relate to the nursing home process of care. The only supporting evidence that could be extrapolated is from the literature describing the presence of non-physician providers (advanced practice nurses [APNs] and physician assistants [PAs]) and their influence on nursing home process and outcome measures (Caprio, 2006). Similar research initiatives will need to be undertaken regarding physician organizational models and time commitments to nursing home care.

There has been some discussion regarding the development of a skilled nursing home specialist ("SNFist") with specialized geriatrics training and enhanced presence within the nursing home. The notion of a link between this specialized physician training and organization may be observed in the literature regarding hospitalists, the specialist physicians focused on hospital-based delivery of care to patients. The variability in

medical practice between hospitalists and non-hospitalists appears to be linked to physician training, volume of practice, access to patients, length of visits, and case mix (Meltzer et al., 2002). Thus, it would make intuitive sense that some or all of these characteristics may apply to a specialized physician practice in nursing homes. This appears to be supported in the literature through operationalization of a nursing home–based physician specialist in the Netherlands (Hoek, Ribbe, Hertogh, & van der Vleuten, 2003).

THE PHYSICIAN WORKFORCE

All areas of primary care medical practice have continued to face the threat of a physician workforce shortage that likely will be exacerbated as more medical students elect to pursue careers in the higher-paid specialties of medicine. The current physician workforce practicing in nursing homes appears to be small, and these staffing patterns may be important determinants of quality (Karuza & Katz, 1994; Katz, Karuza, Kolassa, & Hutson, 1997). The only national survey of physician medical practice in the nursing home showed that the majority of physicians with a nursing home practice spent less than 2 hours per week on patient care in the facility (Katz et al., 1997). The current national data collected in the Online Survey Certification and Reporting (OSCAR) system lacks sufficient detail to capture the physician staffing of nursing homes (Feng, Katz, Intrator, Karuza, & Mor, 2005). Therefore, the current state of knowledge regarding physician staffing is not an adequate basis for policy decisions and contains areas that need to be targeted for further research.

The lack of a sufficient committed workforce with interest in long-term care is a significant hurdle in the path of advancing the practice of nursing home medical practice and reducing the use of physical restraints. The nursing home is a unique practice environment for physicians that is highly regulated, is composed of frail patients with multiple comorbidities, and has limited resources and staffing. It is a challenging educational environment with few role models and variable levels of exposure during residency training for physicians (Katz, Karuza, & Hall, 1992). The nursing home is often viewed as an undesirable place of practice by many physicians or one that is too costly in terms of time commitment and low reimbursement, especially if the physician is caring for a small number of residents within a facility. Many management decisions may be made over the telephone or by faxed physician orders to a facility. Therein lies

the potential for restraint use without a direct examination by the attending physician or careful follow-up with the staff to address behavioral disturbances and reduce subsequent use of restraints.

To meet some of the workforce needs of nursing homes and to improve access to medical care, attention has also focused on the collaboration between physicians and APNs or PAs. The evidence has long supported the utilization of these non-physician providers in improving the quality of nursing home medical care (Kane et al., 1989). There is the potential that collaborative relationships can be synergistic with physician practice and increase the medical attention to residents, reduce hospitalizations, reduce restraints, improve end-of-life care, and increase overall satisfaction with care (Caprio, 2006). The unique skills of each discipline have the potential to complement each other and improve quality; however, there continues to be limited evidence regarding this collaboration and these outcomes. No consensus exists regarding role definition and specific duties between physicians and APNs or PAs, despite state regulations defining the scope of practice and federal guidelines dictating the regulatory activities that may be delegated by physicians under Medicare and Medicaid. Future research efforts are needed better to understand collaborative models of care and establish the optimal methods to engage physicians, APNs, and PAs in nursing home medical practice.

MEASURING CLINICAL OUTCOMES

Reduction or elimination of physical restraint use is a relevant clinical outcome that can be measured for a particular facility over time. This outcome measure depends on the accuracy of reporting by staff, but restraint use should presumably occur only under the supervision of an attending physician. Therefore, one could argue that restraint use is a marker for physician and facility interaction in managing residents with behavioral disturbances or at high fall risk. The ultimate goal would be to develop a restraint-free facility and define this outcome as an appropriate standard of care.

Many clinical outcomes reflect the input of several different disciplines and of care processes often out of the physician's purview. Thus, a negative outcome (such as the development of a decubitus ulcer in a low-risk patient) may reflect any of the following: failure to recognize risk (physician/nursing); failure to order (physician) or apply (nursing) preventive measures such as frequent turning, adequate pressure support, incontinence

care, or nutritional support (dietician); or resident noncompliance with the recommended care plan. The pressure ulcer may also be a consequence of the inappropriate use of restraints that limit a resident's mobility and may represent a treatment failure on the parts of both the facility and medical providers. Sorting out how each of these contributes to the "quality equation," although important for a given facility under a quality improvement framework, is rarely captured in nationally representative administrative data.

To prove the link between physician care and quality, physician-centered care outcomes must be defined. Many of the measures of the Assessing Care for Vulnerable Elders (ACOVE) project that are specific to nursing homes (Wenger & Shekelle, 2001; Saliba et al., 2005) are derived from available evidence and expert consensus but generally describe a mix of processes of care and discrete outcomes. The presence or absence of a given condition is often less important than the strategy employed to achieve a specific goal. For example, the alternative measures implemented to redirect agitated or combative residents in a nursing home are probably more important to understand than simply the decision not to use physical restraints.

Care guidelines, often referred to as best practices, have also been offered as quality markers. The American Medical Directors Association (2006) has created a number of guidelines specific to the physician role in the delivery of appropriate care in the nursing home. These guidelines are based on the existing evidence base and expert consensus and may serve as a useful starting point for quality improvement. Although guidelines have been accepted as defining the standard of care by some regulatory agencies, there is limited evidence linking guideline adherence to accepted outcomes.

CONCLUSIONS

To achieve effective physician integration to the nursing home, reduce restraint use, and influence the quality of care, there will need to be a number of initiatives undertaken from both the research and policy perspectives. There needs to be development of an evidence base for nursing home practice that can be used to identify and disseminate best practice guidelines for a variety of quality indicators. This research evidence for nursing homes must be clear, concise, and user-friendly. New metrics will need to be developed to reflect practice expectations (such as a reduction

of restraint use). Furthermore, a consensus regarding relevant quality and outcome measures will need to be developed, including a uniform standard for restraint-free nursing homes nationally. These efforts will likely necessitate the creation and dissemination of tool kits for medical directors to operationalize key findings and consensus recommendations.

If one accepts the reality of a nursing home physician workforce shortage, quick action on a number of fronts will be necessary to reverse current trends. Recruitment and retention of a dedicated workforce of nursing home physicians will need to be a top priority. Some potential responses to workforce shortages include enhanced geriatric content infused into discipline-specific curricula, certification examinations, and continuing education. There can also be creation of centers of excellence (teaching nursing homes) to test and disseminate best practices and innovative curriculum for reducing falls or addressing behavioral disturbances in residents with dementia. Other innovative strategies may include loan forgiveness programs, more opportunities for specialized training with graduate medical education programs, establishment of a long-term care health services corps, and even the development of a new nursing home specialty (the SNFist) analogous to the hospitalist movement for acute care.

Increased research funding needs to be directed toward defining the link between workforce characteristics, environment, processes of care, and outcomes as components of quality. Existing data sets, including OSCAR, will need to be refined to reflect staffing characteristics of all disciplines. Individual provider training, experience, and credentials can also be utilized as new quality measures. Fundamentally, the method of oversight for nursing home practice should change from the current punitive process to one of empowerment for facilities. We must ask ourselves the question, how can we provide incentives to nursing homes that avoid restraints in managing even the most difficult of resident behaviors? Physicians, APNs, and PAs are critical components of the nursing home medical staff who can have powerful influences on restraint use and resident outcomes, and they should remain actively engaged in these discussions regarding future research and policy directions.

Although there are ever-present funding constraints and a lack of cohesion among the various long-term care stakeholders, it is important to keep the previously-discussed issues at the forefront due to their significant implications for quality of care. While policy changes are intended to be evidence-based, the personal experience of decision makers and widespread publicity may substitute for evidence and provide a powerful impetus for change. Nursing home medical providers need to be aware of

these issues and capitalize on the public's efforts to improve the quality of care, ensure resident autonomy, and protect the right to freedom from restraints.

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RECEIVED: 02/06
REVISED: 04/06
ACCEPTED: 05/06