The Changing Role of Physicians in LTCF

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CMS Changes to SNF Regs

- New rule makes extensive changes to SNF Requirements of Participation (RoP)
  - Last major update was in 1991
  - Basis for SNF State Operating Manual and F-tags
  - Redesigned how existing requirements are labeled

- Updates to RoP include:
  - Completely new language & new concepts
  - New requirements from ACA, IMPACT Act;
  - Existing requirements issued in S&C memos in the past several years;


RoP Sections with changes

- Resident rights (§483.10)
- Facility responsibilities (§483.11)
- Abuse & neglect (§483.12)
- Transitions of care (§483.15)
- Resident assessment (§483.20)
- Physician services (§483.30)
- Nursing services (§483.35)
- Pharmacy services (§483.45)
- Administration (§483.70)
- Infection control (§483.80)
- Physical environment (§483.90)
- Training requirements (§483.95)
- Compliance and ethics (§483.85)

RedTxt have implications to Physicians and/or Pharmacist.
Impact of RoPs on Physicians (overall themes)

- Increase physician involvement in all aspects of care from
  - Seeing patients
  - Goal setting for patient and care plan development
  - Discharge and transfer process
  - Communication with nursing and families
  - Notification of physicians for changes in patients and test results
- Minimize the overuse of medications (psychotropic & antibiotics)
- Increase documentation about the rationale for discharges, medications, treatments, and testing decisions
- Delegation of responsibilities to NPs, PAs, Therapists, Dieticians

Physician Visits & Notifications...

The physician must—
(1) Review the resident’s total program of care, including medications and treatments, at each required visit;
(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.
Physician frequency of visits (no changes)

Frequency of physician visits.

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.

3. Except as provided in paragraphs (c)(4) and (f) of this section, all required physician 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 visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist in accordance with paragraph (e) of this section.

§ 483.10 - (14) Notification of Physician

(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s), when there is—

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).

(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.

Physician Impacts

§ Impact for Physicians

- Greater use of SBAR
- Better communication of critical information from SNF staff
- Potentially better guidance to avoid unnecessary calls for non-urgent issues.
  - To avoid an increase in calls, physicians should develop protocols for SNF staff to call that is consistent with RoP language so scope creep of immediate calls for any little change does not happen.
Transfers & Discharges...

Transfers to hospital requires MD order

(i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and

§ 483.15 c) Transfer and discharge—

c) Transfer and discharge—

• (1) Facility requirements—

(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

(A) The transfer or discharge is necessary for the resident’s welfare and the resident’s needs cannot be met in the facility,
§ 483.15 Transfers & Discharges

- The documentation must be made by the resident’s physician when transfer or discharge is necessary.
- Documentation in the resident’s clinical record must include:
  (A) The basis for the transfer
  (B) the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).

IMPACT on Physicians

- Need to participate and increase details in the medical record on why patients are being transferred or discharged.

§ 483.15 c) Transfer and discharge—

- (iii) Information provided to the receiving provider must include a minimum of the following:
  • (A) Contact information of the practitioner responsible for the care of the resident
  • (B) Resident representative information including contact information.
  • (C) Advance Directive information.
  • (D) All special instructions or precautions for ongoing care, as appropriate.
  • (E) Comprehensive care plan goals.
  • (F) All other necessary information, including a copy of the resident's discharge summary, as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

Information Accompanying a Transfer

(iii) Information provided to the receiving provider must include a minimum of the following:
  (A) Contact information of the practitioner responsible for the care of the resident
  (B) Resident representative information including contact information.
  (C) Advance Directive information.
  (D) All special instructions or precautions for ongoing care, as appropriate.
  (E) Comprehensive care plan goals.
  (F) All other necessary information, including a copy of the resident's discharge summary, as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
Discharge Summary Requirements

- Discharge Summary: When the facility anticipates discharge a resident must have a discharge summary that includes, but is not limited to, the following:
  1. A recapitulation of the resident’s stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.
  2. A final summary of the resident’s status to include items in comprehensive assessment at the time of the discharge.
  3. Reconciliation of all pre-discharge medications with the resident’s post-discharge medications (both prescribed and over-the-counter).
  4. A post-discharge plan of care that is developed with the participation of the resident and, with the resident’s consent, his or her family, 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.

Resident Notification of Transfer

- Before a facility transfers or discharges a resident, the facility must—
  1. Notify the resident and the resident’s representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
  2. Record the reasons for the transfer or discharge in the resident’s medical record in accordance with paragraph (c)(2) of this section; and
  3. Include in the notice the items described in b(5) of this section.

Physician Impact

- Discharge Summary will need more information on all transfers and discharges.
- Recommend developing a template for SNF to help complete
  - Look to adapt the INTERACT standard transfer and discharge form to meet this requirement
  - Look to dictation service or SNF EMR to help complete the discharge summary
- Will need to contact family members/representative to discuss reason for transfers or discharges and document discussion in medical record
- Need good medication list to reconcile with medications they will take upon discharge from SNF
Physician Can Delegate...

Delegation of Admission Approval

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, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident’s immediate care and needs. (underline and bold new)

Physician Impact

• Ability to delegate admission orders and certification for SNF stay to NP or PA.

Delegation to Dieticians

A physician may delegate the task of writing dietary orders, consistent with § 483.60, to a qualified dietitian or other clinically qualified nutrition professional who—

(i) is acting within the scope of practice as defined by State law; and

(ii) is under the supervision of the physician

Physician Impact

• Physicians no longer have to write or co-sign diet orders but can delegate to dieticians.
Delegation to Therapist

A physician may delegate the task of writing therapy orders, consistent with § 483.65, to a qualified therapist who—

(i) is acting within the scope of practice as defined by State law; and
(ii) is under the supervision of the physician

Physician Impact

‡ Physicians no longer have to write or co-sign therapy orders but can delegate to PT, OT or Speech therapists.

Delegation of Laboratory Services

‡ The facility must—

(i) Provide or obtain laboratory services only when ordered by a physician, physician assistant, nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws.

(ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician’s orders.

Physician Impact

‡ Need to document when you want to be notified or develop SNF policy on notification of abnormal lab results
‡ Allows delegation of ordering to NP or PA

Delegation of Radiology Services

The facility must—

(i) Provide or obtain radiology and other diagnostic services only when ordered by a physician, physician assistant, nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws.

(ii) Promptly notify the ordering physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician’s orders.

Physician Impact

‡ Need to document when you want to be notified or develop SNF policy on notification of abnormal lab results
‡ Allows delegation of ordering to NP or PA
Medication Prescribing...

Physician Response to Pharmacist Medication Regime Review

(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.

Pharmacists Drug Regime 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 at least every 6 months and:

(i) When the resident is new, that is the individual has not previously been a resident in that facility; or

(ii) When the resident returns or is transferred from a hospital or other facility; and

(iii) During each monthly drug regimen review when the resident has been prescribed or is taking a psychotropic drug, an antibiotic, or any drug the QAA Committee has requested be included in the pharmacist’s monthly drug review.
Pharmacy Drug Regime Review

(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.

Redefined Psychotropic Medications

485.43. 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;

Minimize usage of Psychotropic Medications

Psychotropic drugs. Based on a comprehensive assessment of a resident, the facility must ensure that—

(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;
(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;
(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and
(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in § 483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident’s medical record and indicate the duration for the PRN order.
(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
Unnecessary Medications

Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

1. In excessive dose (including duplicate drug therapy); or
2. For excessive duration; or
3. Without adequate monitoring; or
4. Without adequate indications for its use; or
5. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
6. Any combinations of the reasons stated in 1-5 above.

Physician Impact

- Need to increase documentation when using any antipsychotic medication (per new broad definition) and antibiotic
- Must respond in the medical record with rationale why pharmacy recommendations are not followed
- Assure adequate monitoring of medication effectiveness related to goal of treatment and for any side effects.

Infection Control...
Infection Control Program

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.

Physician Impact

- Follow protocols on the prescribing of antibiotics (e.g. SHAE criteria for UTI treatment)
- Respond to QA committee and Pharmacist review of antibiotic prescribing consistent with protocols

Infection Control Procedures

- Written standards, policies, and procedures for the program, which must include, but are not limited to:
  (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
  (ii) When and to whom possible incidents of communicable disease or infections should be reported;
  (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
  (iv) When isolation should be used for a resident;
  (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
  (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact
Approve admissions & attending physician oversight

- § 483.30 Physician services.
  - 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, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident’s immediate care and needs.

PASSR Certification

(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section [e.g. PASSR] to the admission to a nursing facility of an individual—
  - (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
  - (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
  - (C) Whose attending physician has certified, before admission to the facility, that the individual is likely to require less than 30 days of nursing facility services.

Baseline Care Plan

(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must—
  (i) Be developed within 48 hours of a resident’s admission.
  (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to:
    (A) Initial goals based on admission orders.
    (B) Physician orders.
    (C) Dietary orders.
    (D) Therapy services.
    (E) Social services.
    (F) PASARR recommendation, if applicable.
Resident Care Plan

- The facility must develop a comprehensive person-centered care plan for each resident, consistent with § 483.10(b)(1) and § 483.11(b)(1), that includes measurable objectives and timetables to meet a resident’s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

IDT membership includes MD

(ii) Prepared by an interdisciplinary team, that includes but is not limited to—
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident’s representative(s). An explanation must be included in a resident’s medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident’s care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident’s needs or as requested by the resident.

Physician Impact

- Physicians will need to sign off on care plan and provide information about the resident’s—
  - Goals including what is the highest practicable level they can achieve
  - Timeline to achieve
  - Discharge potential and discharge plans
- Physicians may be asked to define what is the highest practicable outcomes a resident can achieve with care.
Resident Rights: Care Plan & Choice

- The right to be informed in advance of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.”
- The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.
- The right to be informed, in advance, of changes to the plan of care.
- The right to receive the services and/or items included in the plan of care.
- The right to self-administer medications if the interdisciplinary team has determined that this practice is clinically appropriate.

Physician Impact

- Need to make sure resident (or their representative) is aware of the risks and benefits of test, procedure or treatment prior to receiving the test.
- This is consistent with informed consent requirements in all settings. It does not require signed consent but does require (as in all settings) some documentation in MD note that risk and benefits were discussed with the patient and/or their representative.

Resident Representative

(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.
(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.
(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns in the manner required under State law.
Physician Impact

- Physicians need to focus on residents' ability to understand the consequences of their decision and consistent with prior expressed wishes.
- Need to involve residents in decision making to extent possible when they have dementia.
- Having dementia by itself does not negate the resident from being involved in decision making.

Attending Physician...

Selecting Physician #1

- Choice of attending physician. The resident has the right to choose his or her attending physician.
  - (1) The physician must be licensed to practice, and
  - (2) The physician must meet the professional credentialing requirements of the facility.
  - (3) 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.
- Impact for Physician:
  - SNFs may develop "admitting privileges" which MDs will need to meet.
  - SNFs may start to ask for documentation about active license.
Selecting Physician #2

(1) The 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.

(2) 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.

(3) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice.

d) Choice of attending physician.

The resident has the right to choose his or her attending physician.

- (1) The physician must be licensed to practice, and
- (2) 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.
- (3) The 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.
- (4) 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.
- (5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice.

How to Engage Physicians
5 Strategies to Engage Physicians

1. Understand actions performed by physicians
2. Provide information needed to make a decision
3. Enlist patient or family members
4. Provide feedback on their performance
5. Utilize Medical Director to communicate with physicians

#1 Actions Performed only by Physicians

Actions limited to physicians, NPs or PAs:

• Diagnose
• Prescott medications
• Prescott treatments (e.g. PT) or equipment
• Order tests
• Perform procedures

Physicians assume when a nurse calls, they expect one of these actions, since the nurse can do all others actions without a physician’s order.

Preventing MDs from giving an order

• Physician’s respond to nurse’s requests
  • Most calls are for requests for an order
  • “If you do not respond, nurses will keep calling you”
• When calling to ask a physician for an opinion or to “make physician aware” say so, otherwise the physician will assume the nurse wants an order
  • When physician gives an order you don’t want or need, its ok to tell them you don’t think the order is necessary
Preventing MDs from giving an order

- Nurses often ask for the vary things we are trying to prevent (e.g. antipsychotics)
- Your Medical Director & DON need to support physicians when they say “no” to nurse’s requests for:
  - Antipsychotics for “behaviors”
  - Chair alarms
  - Antibiotics for bacteria in urine
  - Feeding tube for end stage dementia

#2 Provide Information Needed to Make Decision

- Provide information needed to make a decision
  - Vital signs (BP, Pulse, Resp & Temp as well as pulse ox)
  - Duration of symptoms and change from baseline
  - Medications and recent administration times
  - Recent labs (e.g. last CBC was on <date> and showed <insert values>)
  - Other medical diagnoses (e.g. Diabetes, CHF, etc)
- Not having key information available during the call makes the caller sound stupid

How You Communicate is Important

Introductory sentence is key

- Do NOT apologize for calling/interrupting them
  - Apologies are for when you have done something wrong. MDs often interpret apology as: “I'm not sure I needed to call you.”
  - You are calling about a patient that needs his/her attention. No apology is necessary.
- First sentence: “I am calling you about <name> because of <XXX> to ask you if we should <yyy>
- Then provide information needed to make a decision
Factors Associated with low rehospitalizations

- 47 Nursing homes in NY (N=26,746 patients)
- Measured Clinical and non-clinical factors associated with rehospitalization rates
- Three strongest predictors
  1. Training provided to nursing staff on how to communicate effectively with physicians about a resident's condition
  2. Physicians who practice in this nursing home treat residents within the nursing home whenever possible, saving hospitalization as a last resort
  3. Provided better information and support to nurses and aides surrounding end-of-life care

SBAR: A Communication Tool

- Structured format to assemble key information physicians need to make a decision
- Complete prior to calling MD

4-6 months to successfully roll out SBAR

#3 Enlist Patients or Families

- Physicians usually respond to patient/family requests
  - Have relationship prior to nursing home admission
  - Many of the treatments at admission were started after family-physician discussion
    - Physician is concerned that the family will be upset if orders are changed
  - Get families to make the request for changes to treatments
    - Let physician know that families are ok with requested to change orders
#4 Compare Performance to Peers

- Physicians respond to data comparing them to peers
  - Compare to respected peers or “top performers”
  - List all MD names & performance (e.g. prescribing rates)
  - List all the physician’s residents who are triggering the performance measure
  - Acknowledge
    - Residents who have a reason for being on the list;
    - small sample size.

Example Physician Report about Antipsychotic Use

Provide rate compared to other physicians:

<table>
<thead>
<tr>
<th>Physician</th>
<th># patients</th>
<th># on antipsychotic</th>
<th>% on antipsychotic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Ralston</td>
<td>10</td>
<td>5</td>
<td>50%</td>
</tr>
<tr>
<td>Dr Snow</td>
<td>2</td>
<td>1</td>
<td>50%</td>
</tr>
</tbody>
</table>

List his/her patients with info about prescribing:

<table>
<thead>
<tr>
<th>Patient</th>
<th>Antipsychotic</th>
<th>Dose &amp; Freq</th>
<th>Dementia</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sallie Smith</td>
<td>Risperdal</td>
<td>5 mg 2x day</td>
<td>Alzheimer’s</td>
<td>Family Request</td>
</tr>
<tr>
<td>John Davis</td>
<td>None</td>
<td>None</td>
<td>dementia</td>
<td></td>
</tr>
<tr>
<td>Mary Myers</td>
<td>Seroquel</td>
<td>10 mg QHS</td>
<td>dementia</td>
<td>Started for agitation</td>
</tr>
</tbody>
</table>

#5 Utilize Medical Director

- Meet with medical director to determine:
  - Attitude and knowledge about antipsychotic medication for individuals with dementia
  - Willingness to send letter to attending physicians
  - Willingness to call attending physicians about:
    - Their practices (e.g. antipsychotic prescribing)
    - Their response to pharmacist’s recommendations for GDR
    - Their methods of interacting with nursing (e.g. SBAR)
Medical Director Contacts other MDs

- Announce new policies, new protocols, by
  - Letter from med director to attending physicians
  - Phone calls from medical director
- Need to provide feedback on attending and coverage physician behavior and practices
  - Medical director needs to follow up on these issues

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