Experience of a Physician-Nurse Practitioner Team in Care of Patients in Skilled Nursing Facilities

Phillip M. Loeb, MD
Billie Joy Robison, RN, FNP
Fremont, California

The use of a physician-nurse practitioner team is advocated as an approach to delivering better health care to patients in skilled nursing facilities. The application of this approach in a young community with an inadequate supply of primary physicians and 596 extended care beds is discussed. Patients derive benefit from more comprehensive health care delivered with greater attention to individual needs. Staffs of skilled nursing facilities enjoy improved communication with the medical team and better compliance with legal requirements. The team physician is able to use his time more effectively and provide medical supervision for a greater number of patients by sharing responsibilities with a nurse practitioner.

Paper compliance, adherence to agency regulations, quality assurance, and payment are some of the problems encountered.

Fremont, California, a large suburban community in the San Francisco Bay area suffers, as do many similar communities, from a shortage of primary care physicians. Although the average age of Fremont's population is 25 years, the community has six skilled nursing facilities (SNFs) with 596 licensed beds, the majority of which are filled from outside the community. Most local physicians care only for SNF patients generated by their own practices. Many are too busy to accept new patients at all. This situation creates a problem for elderly patients who must have a physician of record before they can be admitted to a SNF. The result is that an administrator may call 15 or more doctors in attempting to find one who will accept a skilled nursing candidate as a patient.

Requests for reprints should be addressed to Dr. Phillip M. Loeb, Center Medical Group, 2190 Peralta Boulevard, Fremont, Calif 94536.

I found myself no less besieged by SNF patients than were my colleagues. I continued to accept SNF patients even though doing so caused a number of problems. To avoid office-hour conflict, rounds were made before hours and on days off. The time pressures produced "jet-propelled" rounds and family conflicts. I often was unable to respond promptly to urgent calls at a SNF because I was swamped by younger patients whose problems were less profound, but whose rehabilitation potential seemed much greater. Gradually, it became clear that I was practicing two grades of medicine. My geriatric patients who could not come into the office received less than adequate care, although it was on a par with that generally provided for the SNF patient population.

Considering the problem of geriatric medicine in the SNFs, I also felt uneasy that insufficient physician participation might provide a lever for more rapid socialization of the private practice of medicine. I began searching for a way to meet the needs of the SNF patients while maintaining a full range family practice and my sanity.

It seemed sensible that a physician-nurse practitioner team approach could provide comparable basic medical care with greater attention to patients' total health requirements without a greater investment of physician time. The combination of the curing skills taught in traditional medical education and the caring skills taught in traditional nursing education, when combined in a SNF setting where the latter are often more appropriate than the former, might provide better care than had ever before been possible. The team concept was discussed with the physician members of a SNF utilization review committee who thought SNFs an excellent location in which to utilize the skills of a physician extender.

This paper will report the experience over a one-year period of a physician-nurse practitioner team which was formed in July 1975.

Development of a Team Approach

On the date the family nurse practitioner (FNP) was to join me, I was providing a preceptorship for a Stanford physician's assistant (PA) student and had six weeks before completion of that commitment. The FNP used that time to familiarize herself with our convalescent hospital patients, key personnel, and the different hospital environments. She was able to do so

under less pressure by not having to spend half of her time in the office. During lunch hours, we reviewed her patient assessments and revised their form and content until they communicated what I needed to know about each patient. We also discussed patient problems during these sessions, which allowed me to assess the FNP's skills and progress in delivering patient care and investigating problems.

After the first six weeks, the FNP team member worked half time in the office seeing a full range of family practice patients. She assisted with complete histories and physical examinations and performed physical assessments for insurance, annual well checks, and sports, well-baby, and obstetric examinations. She also dealt with routine sick checks and made housecalls. My interaction with her in the office setting provided the opportunity to assess and augment her clinical knowledge, skills, and judgment. That assessment and interaction provided the basis for the mutual trust and communication essential to work as a team when she was in the SNF and I was in the office. She functioned well in the SNF to the limits of her ability, confident that I was always available for immediate consultation and support.

Our care of each SNF patient began with the FNP performing an initial assessment and developing a problem list and an investigational work-up or therapeutic plan which I promptly reviewed with her. She also made required monthly evaluations and updated annual physicals for the SNF patients. It is in the areas of initial assessment and routine visits that the largest savings of physician time have accrued.

Her recommendations were accepted as telephone orders from me. A telephone order form for the accepted orders was then dispatched to me for prompt signature and return. I countersigned each of her progress notes and signed orders monthly for each patient.

The FNP also made emergency calls on any patient who had an acute problem between the scheduled monthly visits and was constantly available for phone consultation. Additional important savings of physician time and improvement in promptness of response to patient needs were realized here. She also talked frequently and at length with the families of SNF patients. The FNP called for physician consultation for any patient who had complex or acute medical problems, or whose condition appeared terminal. She took first call for the SNF patients, I took second, and the physician on call for our group took third.

In addition to her patient care responsibilities, she became involved with administrative tasks such as in-service teaching, discharge planning, obtaining paraprofessional services for patients, record keeping, and attendance at utilization review meetings.

We feel that our patients benefit most by the greater amount of time the nurse practitioner is able to spend with them. Each patient is helped to feel important as a person and is given time to express symptoms, feelings, fears, and questions. The FNP takes time to discuss with patients the rationale for a suggested regimen. In short, reduction of time pressure allows a more humanistic approach to this patient group.

Patients also benefit from the absence of an "I-Thou" relationship which may unintentionally be generated when physician and patient are involved on a one-to-one basis. The FNP is greeted as often by a hug as by a handshake. She is an inveterate optimist whose conviction that each patient can improve is contagious.

A frustrating aspect of patient improvement is the re-classification of patients from skilled to intermediate levels of care, which sometimes results in their transfer to other facilities, often against their wishes. Even within the skilled nursing classification, however, patients are making improvement I was previously unable to obtain or recognize. By no means do all, or most, patients make the dramatic improvements of the examples we will cite, but an impressive number do. In attempting to determine what differences in care were responsible for the significant gains made by these patients, we submit that the team approach allows time for each component of patient health care to be identified, considered, and pursued by the FNP with her "care" oriented background and reviewed by the physician from his "cure" orientation.

Medications are not only reviewed on each visit, but also discussed with the patient and nursing staff to achieve maximal therapeutic response with the minimal number of medications. Overmedication is considered first as an explanation for untoward change in patient status. Nursing care plans are continually updated as improvement occurs or new patient problems develop. Restorative services are employed whenever possible and reconsidered as patient improvement permits. Personal contact with the restorative aide or physical therapist not only facilitates communication, but the "strokes" delivered in the exchange also involve the therapist more personally in the progress of the team's patient. These contacts allow intercourse regarding rehabilitation potential and specific attention to be drawn to each patient's strengths, weaknesses, and new developments that suggest progress that may be further pursued.

Dietary consultation by the FNP may include weight reduction to make walking a more realistic goal or to reduce the pain from arthritic, weight-bearing joints. The patient's dentition and neurologic status are considered and every possible consideration is given to patient food preferences and cultural background that might influence the adequacy of dietary intake. Each patient is started on multivitamins, as it has been our observation that failing appetite and limited food budget frequently result in a diet high in carbohydrates and inadequate in vitamins.

Psychosocial aspects are explored at the time of the initial assessment with particular attention given to how the patient views self and his desires, needs, and goals. For example, Mrs W had been bedfast for two years and required a Hoyer lift for transfer. Her major goal was to stand and walk. To make this possible, a reduction diet was started; physical therapy which the patient had previously refused was begun; and the nursing staff organized a step-by-step plan with a series of attainable goals. The patient learned to stand for five minutes using a walker for support and, though unable to walk, was able to transfer from bed with the assistance of aides. This improvement made it possible for her to go home for overnight visits with her family. Though she has since died, her family still expresses gratitude for the progress she was able to make.

Frequently the FNP encounters

grief, despair, and anger. Sometimes, the patient's stated goal is to die. The FNP encourages venting of negative feelings while supporting and reinforcing anything that can be used as a handle to start rebuilding the patient's self-esteem. Sometimes, the anger and hostility a patient vents can serve as such a handle. Mrs. L, though withdrawn and in the fetal position, was characterized by her sister as never having been a "quitter." The FNP, armed with this information while visiting the patient, demanded to know why she had suddenly become a quitter. A small voice responded, "I'm not a quitter!" Mrs. L climbed out of bed that night, has not resumed the fetal position, walks between parallel bars, and enjoys visiting with her family.

If significant others are involved with the patient, they are enlisted as allies in helping the patient reach a therapeutic goal. All patients are coerced to participate in any activity consistent with physical limitations that will provide stimulation and social interaction. We feel that sensory deprivation may be a commonly missed explanation for confusion in reclusive old people. Orientation to time and place may be an inadequate tool for evaluation of one whose friends are all dead; whose scope of life has narrowed to a room, a mailbox, and a grocery store; and whose failing health has resulted in transport to a hospital and later to a SNF where passage of time becomes meaningless.

Every patient is evaluated for potential discharge. Re-evaluation for discharge when it becomes more feasible is an ongoing process that is pursued when the FNP makes her monthly visits. When discharge is a possibility, community resource persons are recruited to help prepare the patient for transition from the hospital to the community and to provide the services needed to maintain the patient within the community.

The involvement in all of these aspects of patient care often takes less time to accomplish than to describe. The FNP may be discussing a patient with the director of nursing when they are approached by a restorative aide. The resulting conversation, lasting no more than five minutes, could result in changes in several patients' care plans for restorative services. The key to these miniconferences is the availability, accessibility, and flexibility of the FNP and her contact with the physician member of the team.

Benefits of Team Approach

The following cases are illustrative of the kinds of improvement we have been able to obtain within our patient group using the principles outlined, applied by a "care-cure" team. Mrs. C became our patient on transfer from an acute-care hospital. She arrived with the diagnoses of atrial fibrillation, insulin-dependent diabetes, and post-cerebrovascular accident with left hemiparesis. She was somnolent and the transferring physician considered her restorative potential to be poor. Observation of minimal responses suggested some restorative potential to the FNP and physical therapy was started. The patient had supportive family members who were included in her care plan. Under the physician's supervision, medications were adjusted and the atrial fibrillation stopped while the diabetes was brought under control. The patient continued to make progress in physical therapy and can now walk with the aid of a tripod cane. She is completely oriented and recently told the FNP team member an amusing story dealing appropriately with current events.

Another patient, Mr. M, came to the SNF totally confused, bedfast, and incontinent. He now reads, is alert, walks, and has been reclassified. A third patient, Mrs. D, was confined to a wheelchair and bed and had incessant complaints. Her complaints were reduced to her neuralgia, and she again walked without assistance. Before her death, her emotional tone was optimistic and she felt pride in her progress.

Our greatest therapeutic triumphs are the patients who improve enough to go home. Mrs. J, for example, was admitted from the acute-care hospital bedfast, psychotic, and incontinent. Six months later, she was discharged walking, oriented, and able to perform daily activities with minimal assistance. She now attends a weekly YMCA exercise group and helps with the household chores.

Mr. R had liver decompensation from cirrhosis and was totally confused, non-ambulatory, and incontinent. He was diagnosed as an insulin-dependent diabetic. He now enjoys reading, gives himself his own insulin, has abstained from alcohol while released on several visits home, and with the help of a medical social worker is being reintegrated into the community.

The patients profit from several technical aspects of our team approach. Patients' needs are more quickly met because of the FNP's mobility. Their problems are considered from two points of view and two backgrounds. The FNP team member, from her nursing experience, considers nursing roles in patient care more carefully than I was able to do, and her consideration results in improved communication with nursing staffs in the facilities.

We serve the families of the SNF patients by discussing care and treatment of their elders. We try to help them work through their feelings of guilt and grief, and accept the mortality of their relatives. Our support and reassurance sometimes make more acceptable the painful decision to place a loved one in a long-term care facility when home care is no longer possible.

Benefits to the SNF are more tangible than those to the patient or family. SNF administrators are reprimanded by inspectors if patients are not visited at prescribed intervals and if annual updates of physical assessments are not done in a timely fashion. We are able to relieve the SNF administrators of that problem with our patients. The accessibility of the FNP improves communications, so SNF personnel feel more secure than when working with a physician whose availability is uncertain. Also, employees of SNFs are required by law to have an annual physical examination, a function we perform for all six facilities. Finally, teaching services are provided in each facility by the FNP.

I benefit from working with a nurse practitioner because I feel comfortable about the quality of care our patients receive. Combining our abilities in

caring and curing seems especially useful when caring services may be the lion's share of what we can offer many patients. Without a physician extender, I was stressed to care for 50 SNF patients; as a team, we provide better care for 250. Interruption of my days off is rare, and I am almost never called by the SNFs at night. Though early in our relationship the FNP and I spent a great deal of time together working out policies, protocols, and procedures, we now share only two lunch hours a week discussing new patient work-ups and patient problems. To be sure, there are frequent hallway consultations and occasionally some by telephone, but my own expenditure of time is considerably less than that required to care for 50 SNF patients by myself. One of the greatest conveniences is being able to send the FNP team member to a SNF for assessment of an urgent problem while I stay behind to care for patients waiting in the office. Finally, more time can be spent with each patient and better communication with patient, family, and SNF staffs provides a broader data base for problem identification and treatment.

Some Problems

I have emphasized the positive aspects of a team approach to elder care. There are also some problems. If a patient, who has not been visited by a physician within 20 days dies, the death is automatically a coroner's case, even though the patient's passing may have been anticipated. To reduce the incidence of this problem, I make a special effort to see any patient who is failing, even though the visit may add little to his overall medical care.

Because of the use of telephone order forms to assure prompt countersigning of orders initiated by the FNP, a constant stream of paper flows between my office and each SNF. The stream is larger now than before I worked with a nurse practitioner because of increasing the number of patients we supervise by 500 percent. Each month, I make a special trip to each SNF to sign the monthly order review and countersign each of the FNP's progress notes.

A minor, but annoying problem, is that of limited office space. The addition of another working person to a space already fully occupied requires understanding and good humor on both sides. This problem is diminished by a record-keeping system that is portable and concise and that allows me to keep current on patients and the FNP to work anywhere that she can find a phone.

Other Issues

Quality assurance for the services provided by the team is a subject that lies at the crux of evaluation of the quality of team care in the SNF. The team concept involves not only the physician and nurse practitioner, but also other members of the health-care community and provides a built-in system of checks and balances for attaining the goal of effective patient care. The physician member of the team is presently medical director of all SNFs in Fremont. In that role I am in continuous contact with the administrator and nursing staff of each facility. Any problems arising in patient care are freely and frequently discussed. Monthly chart review requiring cosignature of physical assessments, progress notes, and therapeutic recommendations offers additional opportunity for monitoring quality of care. Frequent medication reviews by the facility pharmacist serve as another check on appropriateness of therapy.

The problem of compensation is one that deserves consideration. The FNP team member started work at a salary lower than that usually paid nurse practitioners, and lower than she had been offered elsewhere. She was started at $1,200 monthly plus 25 percent of the net proceeds from her productivity. In the year we have worked together, our patient load has increased from 50 to 250, but she has received neither bonus nor raise in salary. Our family practice group has underwritten the expense of hiring a FNP. At this point, cash received approximately equals expenses, but we have accounts receivable from Medicare and Medi-Cal which, if collected at the rate prevailing so far, should yield $10,000 to $12,000. Clearly this form of health-care delivery is not a moneymaker in the beginning, but we are confident of a reasonable profit in time.

The chief problem is one of which the reader is probably well aware. Our office has collected only 37 percent of our total gross billing for team services in the SNFs because of the delay of the agencies in payment. Of the accounts for which we have been paid, we have collected 65 percent and must write off 35 percent. It is apparent that the lower overhead associated with a nurse practitioner is of benefit when trying to make financial sense of skilled nursing patient care.

Comment

In short, there exist a host of reasons that make physicians reluctant to care for SNF patients on the traditional fee-for-service basis. The drawbacks of a team approach are far outweighed by the advantages of this form of health-care delivery. The patients receive far more attention and time, the physician's time is spent much more efficiently, and the SNFs are aided by better compliance with regulations and better communication between the nursing staff and the nurse practitioner. We feel the team approach to care for skilled nursing patients is a most workable and effective solution to a prevalent problem.