Is There a Doctor in the House?

Physician Liability Fears and Quality of Care in Nursing Homes

California HealthCare Foundation

ISSUE BRIEF

September 2008

Introduction

Improvements in the nation's long term care system increasingly permit those in need of care to remain longer in home and community-based settings. On the positive side, this delays and abbreviates their need for nursing home care, and for many obviates it entirely. Another aspect of this change, however, is that the nursing home population has become older, sicker, and more disabled, with significant physical and/or mental problems, both chronic and acute, which require ongoing medical attention.

The physicians who provide medical care to nursing home residents do so in several roles. They may serve as facility medical director, a required staff position extensively regulated for all participating nursing homes by Medicare and Medicaid, as well as by individual state laws.[1] There are also attending physicians, either practicing privately or employed by the nursing home. Frequently, the medical director also serves as one of the attending physicians in the same facility he or she directs. Specialist consultants also treat patients in the nursing home setting, called in by either the medical director or the attending physician. (Other physicians also care for nursing home residents in other settings, such as a hospital or the physician's own office. The concerns of these physicians were not addressed in this study.)

In providing care, physicians in any of these roles are personally at risk of malpractice litigation and liability. This is in addition to the facilities' institutional risk regarding resident care. Moreover, physicians are to some extent legally responsible for resident care even during the substantial periods of time when the physicians are not physically present at the facility. During these times, physicians are dependent on the quality of the information they receive from staff, and on the care and competence with which staff carry out their treatment orders. In recent years, anecdotal complaints have indicated a widespread perception among nursing home physicians—in each of their roles—that this legal environment is becoming increasingly intimidating and constricting.

The California HealthCare Foundation is committed to improving the quality of end-of-life care in California. Since more than 20 percent of all deaths in California occur in nursing facilities, attention to end-of-life care—pain and symptom management, and involvement of residents and families in decisions about treatment alternatives—in that setting is crucial.

A major focus for The Commonwealth Fund is its Program on Quality of Care for Frail Elders. This program aims to transform the nation's long term care facilities into resident-centered organizations that are good places to live and good places to work, capable of providing the highest quality care.

In the context of their common concerns and engagement with these issues, in 2007 the California HealthCare Foundation partnered with The Commonwealth Fund to support Professor Marshall B. Kapp of Southern Illinois University in a study of physician anxiety about legal liability with regard to nursing home medical care. The project examined the extent to which

the psychological aura of legal risk among nursing home physicians affects the quality of medical care and quality of life for nursing home residents.

Nature of the Study

This study hypothesized that physicians' legal anxieties might produce both positive and negative consequences for nursing home residents. Positive consequences might include improvements in attention to resident safety, greater respect for residents' rights, and better documentation of resident care. Among detriments to residents might be physician unwillingness to serve either as nursing home medical director or as attending physician; premature or unnecessary resident transfers to acute care hospitals; excessively or insufficiently aggressive medical treatment; and infringement of resident autonomy.

The study included a review of relevant literature and laws relating to these issues, plus interviews with nursing home professionals (physicians, a nurse, attorneys, nursing home resident advocates, nursing home administrators, trade association executives, insurance industry representatives, and health services researchers) drawn from practice, private organizations, and academia. The interviews sought these professionals' experiences and opinions regarding:

- The origins and nature of the climate of apprehension among physicians;
- The extent to which the anxieties are justified by the actual risks confronted;
- The relationship between the liability insurance landscape and physicians' concerns; and
- The effects of these physician anxieties on the quality of care and quality of life of nursing home residents.

This issue brief examines the project's research findings and analysis, and seeks to distill from its recommendations those matters that the project researcher characterizes as actionable within the nursing home arena.

Summary of Findings

As more fully explored in this brief, the study found a pervasive atmosphere of anxiety about the potential for personal legal liability among nursing home physicians, both medical directors and attending physicians. This climate had a number of elements that were independent of the actual risk of litigation, including:

- The decreasing availability of nursing homes themselves as defendants in malpractice actions—resulting from state legislative efforts to limit nursing home liability plus the nursing homes' own structural and insurance-related efforts to shield themselves—which leaves physicians as primary targets of liability claims;
- Physicians' regular exposure to advertising and media, and direct contact with claimants' attorneys, regarding potential or existing litigation;
- Difficulty by physicians in obtaining affordable liability insurance for nursing home practice; and
- Nursing home staffing limits, which raise concerns that physicians are not receiving good quality information about patients and that their orders are not carried out fully or competently.

The consequences of these anxieties include physician avoidance of nursing home work, which results in a shortage of competent medical directors and in physicians seeing too many patients in too many locations. It also appears that fear of litigation is a factor, though not necessarily the determinative one, in premature or unnecessary transfers of nursing home residents to hospital emergency rooms. These anxieties also contribute to the practice of unnecessarily defense medicine—including both undertreatment and overtreatment—for nursing home residents.

The Sources and Elements of Physicians' Anxieties

Physicians' legal anxieties about providing nursing home care, either as medical directors or attending physicians, appear to vary widely by geography, ranging from a relatively relaxed attitude to serious concern bordering on paranoia. One major cause of their concern in some jurisdictions is recently enacted legislation reducing the exposure of nursing homes themselves as responsible parties in residents' litigation. The level of physicians' legal anxieties is also influenced by a variety of factors not necessarily related to the real risk of malpractice claims in that location or jurisdiction.

Reduced Nursing Facility Legal Exposure and Increased Physician Apprehension

In addition to the malpractice liability framework that forms the basis for their legal risk, physicians' legal anxieties have risen recently as nursing homes as institutions have become less available as primary defendants to be sued for a resident's injuries. This trend is traceable, in part, to legislation and/or judicial changes in a number of states discouraging resident injury litigation against nursing homes.

In a few jurisdictions, it appears that the number of malpractice claims and their outcomes have stabilized following legislation intended to produce that result, though changes in liability law are not the only factor

The Case of California: Heightened Legal Anxiety

In California, physician apprehension about potential litigation and legal liability is considerably higher than in most other states. This anxiety appears to be more well-grounded than in other jurisdictions, despite legislation that restricts medical malpractice damage awards. In 1975, the California Medical Injury Compensation Reform Act (MICRA) was enacted to curb medical malpractice lawsuits against physicians, hospitals, and nursing homes.[2] MICRA places a $250,000 limit on non-economic ("pain and suffering") damages; adds a collateral source offset rule that can reduce damages if a plaintiff receives funds from another source, such as health or disability insurance; and provides that damage awards may be paid over time.

The relative effects of MICRA on patients and physicians are still being debated, with the data somewhat mixed. It appears that the legislation has reduced large-loss claim payments, and has helped keep malpractice insurance costs low for physicians in California as compared to other states. On the other hand, it has not significantly decreased the number of medical malpractice lawsuits per capita filed in the state, nor the total number of claims filed against California physicians.[3]

Although shielded somewhat by MICRA, physicians who practice in California nursing homes have found themselves subject to additional liability claims through a different legal avenue. The California Elderly Abuse and Dependent Adult Civil Protection Act (EADACPA) of 1991 provides for non-economic damages and is not subject to the caps on damages established in MICRA.[4] In addition to general non-economic damages, awards under EADACPA may include attorneys' fees, punitive damages, and pre-mortem pain and suffering damages.[5] On the other hand, the standard for a finding of liability under EADACPA—recklessness, oppression, fraud, or malice in the commission of abuse—is more difficult to meet than in a malpractice action covered by MICRA limitations.

There are no reliable data on legal claims against nursing home physicians for violation of the EADACPA statute. Despite the unavailability of data and the high standard for a finding of liability, interviews conducted for this study indicate that California physicians widely believe that EADACPA places them at high legal risk in the nursing home context. Physicians know that malpractice liability insurance ordinarily does not provide financial indemnity or legal defense against elder abuse claims. This leaves the physician's personal assets exposed, and at a minimum forces an accused physician to obtain and pay for his or her own legal representation. Such personal exposure may also predispose accused physicians to settle EADACPA claims more often and more quickly than in a MICRA-covered malpractice action, rather than risk having their defense, no matter how meritorious they believe it to be, rejected by a jury or court.

in making the nursing home, as a corporate or other business entity, less of a litigation target in those jurisdictions. Other potentially contributing factors might include greater attention to quality of care and resident safety.[6,7]

California Nursing Homes Purposefully Dropping Insurance

One of the ways in which some California nursing homes have sought to remove themselves from meaningful exposure to legal liability for physical injuries to their residents is by dropping entirely their liability insurance coverage. By some estimates, about half the facilities in the state are either going without any liability insurance or are insured by companies that are not registered to do business in the state. The logic is that when attorneys representing injured residents learn that the facility has no readily accessible liability insurance, they will turn instead for legal redress to potentially responsible parties who do have substantial liability coverage. In the context of liability claims for injuries to residents based on improper or inadequate medical care, that means the medical director, attending physician, or both.[8]

On the other end of the spectrum, however, are a variety of financial and legal maneuvers by nursing home operators designed to limit their legal exposure: reducing the amount of their liability insurance coverage; employing corporate restructuring strategies to separate the lucrative real estate investment from the shoestring nursing home operations, thereby protecting financial assets from civil judgments; and going without liability insurance at all.[9] The ultimate result of these maneuvers is that physicians in those jurisdictions fear that they have now become the main target of liability claims and litigation. One researcher's findings bear out these physician fears: Following Florida's nursing home tort reform, which increased legal protection for nursing homes, the rate at which individuals—including physicians—were named as defendants in nursing home-related litigation almost doubled (from 13.5 percent to 26.5 percent) from pre-reform levels.[10]

The Broader Atmosphere of Apprehension

The psychological effect of the actual liability risk regarding resident injuries is exacerbated for many physicians by the way the litigation threat permeates the climate of medical practice in nursing homes. In the words of one physician interviewed for this study, "In shaping perception, one case opens the floodgates of anxiety and defensive reaction, and the word is out." Elements of this fearful climate include:

- Physicians' regular exposure to advertisements by personal injury law firms for potential nursing home plaintiffs (e.g., residents who have suffered from pressure ulcers);
- Direct contact with attorneys seeking a review of nursing home patient files in regard to legal claims against a different physician;
- Regular and sometimes sensational media coverage of untoward incidents in local nursing homes (especially those incidents that involve legal action); and
- The incidence of threatened lawsuits by residents' families, which fosters an atmosphere of unpredictability and emotional drain, even when the litigation does not materialize.

Personal Insurance Coverage Difficulties

Physicians who practice in nursing homes are also being influenced by worrying signals from the insurance industry about their own personal liability coverage. This adverse insurance situation has come as a particular shock because, until lately, coverage of physicians for their nursing home practice was more readily available and less expensive than in almost any other segment of the professional liability insurance market.

This study found that some physicians have experienced—and others have heard about it through the enormously influential physicians' grapevine—problems finding affordable coverage, and some have had difficulty finding any liability insurance, for the physician's role as

nursing home medical director or as attending physician. These encounters with insurance carriers often begin with inquiries, when applying for liability insurance policies, about the physician's nursing home involvement. Some physicians then find themselves rejected entirely, or forced to pay vastly inflated premiums with large deductibles. Numerous physicians report that they have curtailed or totally discontinued working in nursing homes in response to these liability insurance problems.[11]

Insurance carriers seem particularly reluctant to insure physicians regarding their administrative duties as nursing home medical director, even though interviewees uniformly report that malpractice actions naming a medical director personally for breach of administrative responsibilities are rare. These reports seem confirmed by the American Medical Directors Association (AMDA), the national professional organization comprised of nursing home medical directors (with 4,200 members in 2007). In 2005–2006, AMDA surveyed its membership about respondents' experiences during the preceding three years. AMDA found that 29 percent of the 670 respondents had experienced problems obtaining or renewing medical liability insurance, either based on their work in nursing homes (31 percent) or because the insurance carrier had withdrawn completely from the nursing home market in the respondent's state or area (26 percent).[12]

AMDA Fashions a Response to Its Members' Insurance Crisis

In response to the difficulties experienced by its members in obtaining liability insurance, AMDA entered into an arrangement with Roundstone Insurance to offer a new insurance product, MedDirect, beginning in 2007.[13] The basic MedDirect policy provides coverage up to $500,000/$1,000,000 limits for liability incurred during the course of administrative services in the physician's medical director capacity, and additional optional coverage for nursing home resident care as an attending physician.

Staffing Limitations an Element of Concern

The project determined that another major source of anxiety for nursing home physicians is their sense that when they are physically away from the facility—which for the vast majority of medical directors and attending physicians is most of the time—they often receive unreliable information about residents' medical conditions.[14] The physicians are also apprehensive about how their treatment orders for residents are carried out by staff. The asserted reason for these concerns is that nursing facility staff members (nurses and nurse aides) are chronically deficient in both numbers and professional training.[15] These problems are exacerbated when the staff member works for a temporary agency and is not familiar with the facility and/or the particular resident. However, there was virtual unanimity among study participants that physicians are less apprehensive about their personal liability exposure when credentialed physician extenders (midlevel professionals), particularly Geriatric Nurse Practitioners (GNPs), are present.

Medical Director Concerns About Attending Physicians

Increasingly, medical directors are expressing anxiety regarding their own potential liability exposure for the negligence of attending physicians in the facilities for which the directors are responsible. These concerns have been heightened by federal Tag F501, effective November 18, 2005, which makes the medical director responsible for coordinating all medical care within a facility.[16] Medical directors are particularly concerned about physicians who fill in for regular attending physicians on nights and weekends. These physicians tend not to be familiar with either the residents or the staff, which can lead to unnecessary hospitalizations or to undertreatment in end-of-life situations.

Consequences of Physician Anxieties

Interviewees for this project, as well as other information sources, uniformly suggest that physicians' legal apprehensions are adding to an existing reluctance to practice in nursing homes, and are altering the way they

provide care there. Each of these consequences may be adversely affecting the quality of care and quality of life for nursing home residents.

Physician Avoidance of Nursing Homes

Physician legal anxieties add to the already difficult problem of decreasing physician willingness to work in nursing homes. This avoidance takes the form of physicians curtailing or ending their involvement with nursing homes; physicians refusing to continue caring for patients once they become nursing home residents; and fewer physicians entering the nursing home field at all.

There is no definitive data demonstrating a causal link between legal anxieties and physician curtailment of practice in nursing homes. But interviewees for this study indicated that legal anxieties were a contributing factor, and there is clear data that physicians are leaving the field: In its 2005–2006 survey concerning legal liability, AMDA found that in the previous three years 28 percent of respondents had stopped working as a medical director while 56 percent had reduced their medical director work.[17] The survey also found that 18 percent of respondents had reduced their attending physician hours, and 7 percent had stopped working as attending physicians in nursing homes.

One of the other elements of physician nursing home avoidance that negatively affects patient care is the refusal of a primary care physician to continue treating a patient who becomes a nursing home resident. A review of the literature conducted for the U.S. Department of Health and Human Services reports that once most patients are admitted to a nursing home, they are "unlikely to be followed by their physicians who had been treating them in office practices."[18]

The curtailment of nursing home practice by existing nursing home physicians, the refusal of primary care physicians to practice in nursing homes, and the small number of physicians entering nursing home practice, have combined to create widespread difficulty in attracting and retaining high quality medical directors and attending physicians. Interviewees in this study suggested that these recruiting and retention problems not infrequently had the following results:

- Inadequately trained or otherwise unfit medical directors are hired and retained.
- Medical directors take on the attending role for more residents than they can reasonably, let alone optimally, serve.
- Physicians work in too many facilities to effectively serve their residents in any one of them, as either medical director or attending physician.
- Physicians responsible for covering nursing homes distributed throughout a large geographic area are not sufficiently knowledgeable about local community resources relevant to patient care.

Some Positive Consequences

Much of what was reported by nursing home professionals in this study indicated that fears about legal liability had potentially significant negative effects on the quality of care and quality of life for nursing home residents. But not all the news was bad. A number of interviewees also identified some positive consequences that may result from the legal anxieties of nursing home physicians. These include: improved attention to resident safety; greater respect for residents' rights; and better documentation of resident care (which may contribute to higher quality care). One interviewee reported that medical directors are now "tougher" on attending physicians, while another cited better physician/nurse communication as part of greater attention to managing risks. Also, more nursing home physicians may be seeking second opinions and specialty consultations, which can improve the quality of resident care.

Interviewees for this project observed that many nursing homes retain their medical directors by imposing only minimal demands on them, and prefer medical directors who do not raise too many questions or make too many demands about the facility's quality of care. Some nursing homes, it was reported, reward such low-impact medical directors by assigning to them a large number of fee-generating residents within the facility. All of this may result in nursing homes doing a mediocre job of educating their medical directors about their administrative responsibilities, and in medical directors going along uncritically with a status quo that may not always be in their residents' best interest.

Contributing Effect of Legal Anxieties Should Not Be Overstated

Nursing homes are having significant problems attracting and retaining both medical directors and attending physicians. However, there is a clear consensus among those interviewed for this study that while physician legal anxieties may be significant, they are not necessarily determinative in discouraging physicians from nursing home practice. Rather, these anxieties add to the many other powerful financial, organizational, and professional disincentives that make caring medically for nursing home residents an uninviting proposition. As one geriatrician put it:

"There are a thousand reasons besides malpractice worries keeping physicians out of nursing homes. It's the lowest prestige thing you can do in medicine. There is a stigma that you cannot be a very good physician if you are spending a lot of time in nursing homes. Someone is always looking over your shoulder. There is bad publicity when there are bad outcomes, and bad outcomes are inevitable in this setting even when care is conscientious. For medical directors, there is the additional administrative burden (paperwork, phone calls every time a resident's condition changes), with minimal compensation."

Unnecessary Hospital Transfers

Another negative consequence of physician legal apprehensions appears to be their role in premature and unnecessary transfers of nursing home residents to hospital emergency departments.[19] As reported recently in *Health Affairs,* these transfers are proliferating: Spending on nursing home hospitalizations increased 29 percent between 1999 and 2004.[20] These transfers frequently are antitherapeutic for the resident, who is taken from a familiar, supportive environment to a strange, technologically aggressive setting where the resident and family have little control, and iatrogenic and nosocomial risks abound. Yet for approximately 40 percent of these transfers, the resident could have been cared for safely at a lower level of care.[21] As with other aspects of physician decision-making with regard to nursing home practice, however, it should be noted that while legal anxieties may play some role in the hospitalization of a nursing home resident, the decision is usually complicated and involves numerous factors.[22]

Defensive On-Site Medicine

Another negative consequence of physicians' legal anxieties may be an increase in so-called defensive care. This may take the form of overtreatment of residents, particularly at the end of life, including:

- The use of life-prolonging medical treatments for residents whose families have unreasonable expectations about the survival and recovery of their loved ones;[23]
- Invasive diagnostic tests, even when the results would not influence the treatment plan; and
- The use of clinically inappropriate drugs, often prescribed to placate families, which may place the patient at risk for adverse polypharmacy reactions.

Undertreatment, too, may result from physician defensiveness. This seems especially likely in the treatment of residents' pain, because of physicians' worry about sanctions for overprescribing narcotics. And general

overprotectiveness of residents may also be a function of defensive practice: Physicians and facilities may unnecessarily impose restrictions—electronic tracking, for example, or food prohibitions—on resident behavior, which can infringe resident autonomy and thereby lessen their quality of life.

Issues for Consideration

The study identified an array of challenges regarding physician involvement in the medical care of nursing home residents. The study also concluded that the sources of the nursing home system's shortcomings in this regard are manifold, and strategies for addressing them must come from various directions.

Targeted Attention to Specific Participants

Several approaches pertain to increased training, education, and use of specific groups engaged in and affected by the physician-nursing home relationship.

Development of Skilled Nursing Facility Specialization

The problem of too few qualified physicians in nursing homes is part of the larger problem of too few qualified physicians willing to specialize in geriatric medicine. One avenue to explore is increasing the number of skilled nursing facility specialists (SNFists)—physicians with specific geriatric expertise who dedicate their clinical practices exclusively to the care of nursing home residents. There are still relatively few of these specialists, however, and interviewees for this project were uncertain about their effect on nursing home care. On one hand, their particular expertise and focus on the nursing home context might bring a higher level of appropriate attention to residents' medical care. On the other hand, some interviewees expressed concern that an SNFist on a facility staff might be more reluctant than a community physician to pressure facility administrators regarding care deficiencies, or to bring those deficiencies to the attention of regulators.

Risk Management in Medical Education

Risk management training for physicians, especially concerning the care of nursing home residents, might be a valuable addition to medical education. Nursing homes with visible, proactive risk management programs use it as a recruitment tool to attract physicians. Such programs can also be useful in putting physicians' legal risks into a realistic perspective, thereby mitigating anxiety.

Expanded Use of Midlevel Professionals

Physicians interviewed for this study expressed much higher levels of confidence in resident care information, and in the likelihood their orders would be implemented competently, when qualified midlevel professionals were physically present in the facility. Moreover, the general clinical benefits of midlevel professionals—as supplements to, rather than substitutes for, physician involvement—in nursing homes is well understood and should be expanded.

Wider Public Education

Study participants called for more public education about the capabilities and limitations of nursing homes, and about the natural course of frailty and the progression of disease at life's end. This could help families understand more realistically what they should reasonably expect, and demand, from nursing homes and their physicians.

Regulatory and Structural Reform

Changes in legal, regulatory, and insurance structures pertaining to nursing home physicians are seen as an important component to improvement in their work atmosphere, and therefore in quality of care for their patients.

Legal Reform

The study concluded that legal reform is only a small part of addressing difficulties in providing high quality medical care for nursing home residents. Nonetheless, attention must be paid to the dual nature of physicians' complaints: that the civil justice system misses too many

meritorious cases at the same time it includes too many false accusations. Changes in the civil justice system should address the anxieties of both medical directors and attending physicians by reforming the substantive rules and procedural mechanisms for resolving their personal exposure.

Regulation of Medical Director Position

Reformers must think creatively about the regulatory structure governing medical directors in nursing homes. Much attention has been devoted to the regulation of nursing homes as institutions, but the regulation of individuals serving as medical directors has received much less scrutiny. Additionally, federal and state regulations assign responsibility for quality of care to the medical director, who has limited ability to impact certain factors that contribute to quality of care, such as staff turnover or staffing levels.

Liability Insurance Changes

Successful reform must address the availability and affordability of liability insurance for physicians working in nursing homes, as medical directors or as attending physicians, in order to remove a powerful disincentive to practice in the nursing home setting. Because of the complexity of these issues, it is recommended that a group of expert stakeholders convene to consider changes in the following elements of the nursing home physician insurance landscape.

Expanded group coverage. Expanded group liability coverage—either through nursing homes themselves or through attending physicians' medical practice groups—for physicians' clinical and administrative nursing home roles could address problems of both availability and cost. This might be facilitated through adjustment of facility and physician payment, or through other financial incentives.

Added regulation of insurance practices. Direct insurance industry regulation should be considered. For instance, insurers could be prohibited from selling or pricing their professional liability products based on a physician's practice setting. Or, they might be required to underwrite their products on an individual, rather than a community, basis.

Physician access to claims data. Insurance industry data regarding malpractice claims against nursing home physicians can educate physicians about risk management, including improved practice behavior. States could require that insurers make such data publicly accessible. [California has enacted such a requirement, but the data remains difficult to obtain; this study was unsuccessful in efforts to obtain data under the California law.] States could also require more transparency from insurers regarding how risk is calculated and what claims are actually paid, not just filed.

Mandatory facility insurance minimums. States could require nursing homes to carry a minimum level of liability insurance coverage. This would address physicians' concerns that they personally become the primary liability target if a nursing facility is underinsured or uninsured.

New insurance products and approaches. Nonregulatory approaches could include development of new insurance products, such as AMDA's venture with MedDirect. Also, more insurers might require physicians, as a condition of their liability coverage, to participate in periodic risk management education. State legislation could enforce this practice.

Changes in Reimbursement Structures

The study found significant support for altering the structures and mechanisms by which Medicare, Medicaid, and private insurance reimburse physicians in the nursing home setting, as well as suggestions for increased public funding for facility staff.

Altered Medicare and Medicaid Physician Reimbursement Structures

For almost all physicians, inadequate payment under Medicare and Medicaid is one of the most important factors discouraging their involvement in nursing homes. Restructuring physician payment in the nursing home setting, therefore, is essential. Amending Medicare's physician payment mechanism could encourage physicians to spend more time talking with residents and families about realistic care goals and expectations. Such increased communication would improve residents' quality of life. It would also tend to lessen legal risk by reducing the confusion and dismay that many families experience in response to care that is not sufficiently explained.

Additional Medicare and Medicaid Support for Direct Care Staff

Many interviewees in the study urged higher Medicare and Medicaid payment to nursing homes for the hiring and training of additional nursing and other direct care staff (and regulatory measures to ensure that such support is used for its intended purpose).

Capitated Insurance Payments

The financial incentives found in capitated payment models may provide a route to increased and improved physician involvement in nursing home practice. Many interviewees indicated that by changing financial incentives, insurance plans could encourage the involvement of good physicians in the care of nursing home residents enrolled in those plans. Residents are visited by their own physicians more often under capitated models than under fee-for-service models, resulting in reductions in resident hospitalizations, emergency department visits, and anti-therapeutically aggressive medical interventions. Another benefit for residents under this model is that the plans require participating physicians to collaborate and consult with residents' families and with the plan's midlevel practitioners.

In some geographic areas, capitated Medicare Advantage (Part C) managed care plans are available; expansion of these plans should be encouraged. Some states are taking a second look at risk-based Medicaid managed long term care (MMLTC).

Conclusion

Neither a legal system overhaul nor any other single-pronged initiative, by itself, can solve the problem of inadequate medical care for nursing home residents. Nonetheless, legal reforms could play a part by instilling confidence among physicians in the basic fairness of the civil justice system, which in turn could inspire clinical behavior likely to enhance quality of care and quality of life for residents. The wider strategy for improvement in care must be comprehensive in order to address current limitations. Its design and implementation would require active participation not only by legislators and the courts, but also by physicians, medical educators, nursing home owners and administrators, the casualty insurance industry, government and private long term care payers, consumer advocates, regulators, and families.

About the Author

Marshall B. Kapp, J.D., M.P.H., is Garwin Distinguished Professor of Law and Medicine at Southern Illinois University School of Law and School of Medicine. Professor Kapp is the founding editor of the *Ethics, Law, and Aging Review* and editor of the *Journal of Legal Medicine,* the official scholarly publication of the American College of Legal Medicine.

About the Commonwealth Fund

The Commonwealth Fund is a private foundation that aims to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults. For more information, visit www.commonwealthfund.org.

About the Foundation

The California HealthCare Foundation is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information on CHCF, visit us online at www.chcf.org.

Endnotes

1. 42 C.F.R. § 483.5; U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, Center for Medicaid and State Ops/Survey and Cert. Group, *Revised Nursing Home Medical Director Tag and Accompanying Training Materials,* S&C-06-05, Nov. 14, 2005.

2. Ch. 1, § 1, 1975 Cal. Stats. 2d Ex. Sess. 3949, codified in various sections of *California Civil Code.*

3. Hamm, William G., C. P. Wazzan, and H.E. Frech III. "MICRA and Access to Healthcare," February 2005, (www.hcla.org/studies/2005MICRA&AccessToHC.pdf).

4. SB 679, Ch. 774, Statutes of 1991, codified at *California Welfare and Institutions Code* §§ 15600 – 15657.3.

5. *California Welfare and Institutions Code* § 15657.

6. AON Global Risk Consulting. "Long Term Care: 2006 General Liability and Professional Liability Actuarial Analysis 17," 2007 (www.aon.com/about/publications/issues/2006_ltc_study.jsp).

7. Kapp, Marshall B. 2005. "Making Patient Safety and a 'Homelike' Environment Compatible: A Challenge for Long Term Care Regulations," XII *Widener Law Review* 227.

8. Petersen, Andrea. "Nursing Homes' Liability Crisis Eased Up Somewhat Last Year," *The Wall Street Journal*, Apr. 27, 2005, at D5; Darmiento, Laurence. "Nursing Facilities Drop Insurance as Prices Ratchet Up," *Los Angeles Business Journal,* May 17, 2004 (2004 WLNR 14370548) (describing the California situation); Robertson, Kathy. "Malpractice Cancellations Worry Nursing-Home Docs," *Sacramento Business Journal,* Oct. 11, 2002 (http://sacramento.bizjournals.com/sacramento/stories/2002/10/14/focus2.html).

9. Casson, Joseph E., and J. McMillen. "Protecting Nursing Home Companies: Limiting Liability through Corporate Restructuring," 36 *J. Health L.* 577, 2003.

10. Hedgecock, Deborah K.. "The Preliminary Impact of 2001 Florida Tort Reform on Nursing Facility Litigation in One County 65," (Mar. 30, 2007) (unpublished Ph.D. dissertation, University of South Florida, on file with study author), at 97.

11. See, e.g., Brooks, Robert G. et al. "Availability of Physician Services in Florida, Revisited: The Effect of the Professional Liability Insurance Market on Access to Health Care," 165 *Archives of Internal Medicine* 2136, 2005 (reporting that 42.1 percent of Florida physicians surveyed in 2004 had eliminated nursing home activity in response to the liability insurance situation there).

12. American Medical Directors Association. "Medical Liability and the AMDA Physician," member survey (www.amda.com/about/liabilityfacts.cfm).

13. American Medical Directors Association. Jan. 12, 2007. Press Release: "MedDirect Professional Liability Insurance is First to Provide Comprehensive Coverage for Medical Directors." (www.amda.com/news/releases/2007/011207.cfm; www.meddirectcoverage.com/products/index.htm).

14. Institute of Medicine. *Improving the Quality of Long-Term Care* 199 (G. S. Wunderlich and P. O. Kohler, eds., 2001); Katz, P. R. and J. Karuza. "Physician Practice in the Nursing Home: Missing in Action or Misunderstood," 53 *Journal of the American Geriatrics Society* 1826 (2005); Levy, C. et al. *Literature Review and Synthesis of Physician Practices in Nursing Homes* 13, U.S. Dept. of Health and Human Serv., Off. Ass't Sec Planning and Eval., Off. Disability, Aging and Long-Term Care Pol'y, Contract #HHS-100-03-0028, note 7, at 7 (Oct. 17, 2005); Dep't of Health and Human Serv., Off. Inspector Gen. *Nursing Home Medical Directors Survey,* OEI-06-99-00300, at 16 (2003) (reporting that 86 percent of surveyed nursing home medical directors spend eight hours or less per week at the nursing home for which they serve as medical director).

15. Parmelee, Patricia A. "Quality Improvement in Nursing Homes: The Elephants in the Room," 52 *Journal of the American Geriatrics Society* 2138, 2004; see also, Castle, N. G. et al. "Nursing Home Staff Turnover: Impact on Nursing Home Compare Quality Measures," 47 *Gerontologist* 650, 2007.

16. 42 C.F.R. § 483.5; U.S. Dept. of Health & Human Serv., Cent. for Medicare & Medicaid Serv., Cent. for Medicaid and State Ops/Survey and Cert. Group. *Revised Nursing Home Medical Director Tag and Accompanying Training Materials,* S&C-06-05, Nov. 14, 2005.

17. American Medical Directors Association, *supra,* note 12.

18. Levy, et al., *supra,* note 14.

19. Levy, et al., *supra,* note 14, at 25.

20. Grabowski, David C. et al., 2007. "The Costs and Potential Savings Associated with Nursing Home Hospitalizations," *Health Affairs,* 26, No. 6: 1753-1761.

21. Saliba, D. et al., 2000. "Appropriateness of the Decision to Transfer Nursing Facility Residents to the Hospital," *Journal of the American Geriatrics Society* 48, No. 2; 154-163.

22. See, Cohen-Mansfield, Jiska and S. Lipson. 2006. "To Hospitalize or Not to Hospitalize? That is the Question: An Analysis of Decision Making in the Nursing Home," 32 *Journal of Behavioral Medicine* 64.

23. Kapp, Marshall B. 2003. "Legal Anxieties and End-of-Life Care in Nursing Homes," 19 *Issues in L. & Med.* 111.