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Nursing Home Physician Specialists: A Response to the Workforce Crisis in Long-Term Care

Paul R. Katz, MD, **Jurgis Karuza, PhD**, **Orna Intrator, PhD**, and **Vincent Mor, PhD**

University of Rochester School of Medicine and Dentistry, Rochester, and State University of New York at Buffalo, Buffalo, New York; and Brown University, Providence, Rhode Island

Abstract

Marginalization of physicians in the nursing home threatens the overall care of increasingly frail nursing home residents who have medically complex illnesses. The authors propose that creating a nursing home medicine specialty, which recognizes the nursing home as a unique practice site, would go a long way toward remedying existing problems with care in skilled nursing facilities and would best serve the needs of the 1.6 million nursing home residents in the United States. Reviewing what is known about physician practice in nursing homes and hospitals, and taking a lead from the hospitalist movement, the specialty would be characterized in 3 dimensions: the degree of physicians' commitment, physicians' practice competencies, and the structure of the medical staff organization in which they practice. Challenges to the adoption of a nursing home specialist model include mainstream medicine's failure to recognize the nursing home as a legitimate medical practice, the need for the nursing home industry and policymakers to appreciate the links between physician practice and quality, and assurance of financial viability. Implications for quality of care, health policy, and research needs are discussed in this article.

A recent Institute of Medicine report (1) highlights the disturbing trend of a net reduction in board-certified geriatricians and a reduction in the number of physicians entering geriatric fellowships. Clinical and leadership positions in nursing homes are often filled by geriatricians (2), and to address the shortage of geriatricians in nursing homes, the Institute of Medicine recommends expanding the role of midlevel providers, such as nurse practitioners. Rather than accepting that disengagement of physicians in nursing home practice is inevitable, we make the case here that quality of care in the nursing home is directly linked to physician practice, and that only by moving toward a nursing home specialist model will the needs of residents with complex postacute problems, who are burdened by multiple comorbid conditions, chronic illness, and functional limitations, be met.

Requests for Single Reprints: Paul R. Katz, MD, University of Rochester School of Medicine and Dentistry, 435 East Henrietta Road, Rochester, NY 14620; Paul_Katz@urmc.rochester.edu.

Current author addresses are available at www.annals.org.

Current Author Addresses: Drs. Katz and Karuza: University of Rochester School of Medicine and Dentistry, 435 East Henrietta Road, Rochester, NY 14620.

Drs. Intrator and Mor: Brown University, 164 Angell Street, Providence, RI 02912.

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The Problem

The nursing home population of the United States stands at 1.6 million and will double by the year 2030 (3). Even with declining disability rates and increases in housing options, the lifetime risk for nursing home admission remains high at 46% (4). Nursing homes have become an integral and unique component of the health care continuum in the United States, in part because they accommodate increasingly frail residents whose hospital stays have been dramatically shortened (5). This "sicker-but-quicker" trend has manifested as increasing functional dependence, comorbid conditions, and use of "high-tech" interventions in both short- and long-term nursing home residents (6). A large proportion of deaths overall occur in nursing homes (7), and expenditures currently exceed $120 billion per year—a figure projected to almost double by the year 2015—with Medicaid footing 44% of these costs (8, 9). Of all Medicare fee-for-service dollars, 7% are spent in nursing homes (10).

Despite these trends, the quality of care in nursing homes remains inconsistent and in many respects suboptimal (11). Nursing home practice is only 4% of work time among the 20% of physicians who practice in a nursing home, one third of whom are internists (12). Often rooted in reality, perceptions among nursing home physicians of excessive regulation, paperwork, professional liability, and lack of nursing support remain barriers to developing a widespread nursing home specialist culture (13). Perhaps more important, many physicians still find it difficult to overcome logistic challenges (for example, caring for a sufficient number of patients while traveling from one facility to another), even though reimbursement for nursing home visits has increased. Without salary derived from administrative duties associated with being a medical director, many practitioners find nursing home care untenable. Waning interest in primary care and geriatrics (14), coupled with few credible role models (15), further constrains physician involvement in nursing homes. In a survey of graduating residents, fewer than 15% felt "very prepared to provide nursing home care" (16). Finally, fear of cost increases and underappreciation of the link between physician care and quality may obviate support from the nursing home administration.

A Possible Solution

Taking a lead from the adult and pediatric hospitalist movements (17, 18), we propose that creating a nursing home medicine specialty would remedy the problems with care in skilled nursing facilities. On the basis of existing literature (19–21), we propose that the specialty be characterized in 3 dimensions: the degree of physicians' commitment, physicians' practice competencies, and the structure of the medical staff organization in which they practice.

Commitment is conceptualized as the physicians' degree of involvement in nursing home care, recognizing the links between quality of care and the time spent in a given nursing facility and with individual residents. We think that nursing home specialists could practice under many different models, ranging from a full-time practitioner to a primary care physician in the community who devotes 1 day per week to nursing home residents. However, we propose that nursing home specialists devote at least 20% of their practice to nursing home care. Recognizing that physicians may visit multiple facilities, the time spent

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in any given nursing home should equate to at least 4 hours a week. Arguably, this is the minimum amount of time necessary to become facile with processes of care and the site-specific culture.

Competency in nursing home medicine would be defined by training or experience in handling complex medical care in a highly regulated, interdisciplinary care context that accommodates both postacute and long-term care. Training should be flexible enough to attract the broadest cross-section of primary care physicians, because limiting recognition initially to board-certified geriatricians or to certified medical directors would needlessly exclude other qualified practitioners. Future training might include an additional "mastery" year of residency training, flexible nursing home fellowships that would accommodate both early and midcareer candidates (22), or a certification process similar to that for medical directors. Examples of specific competency domains for training and certification include management of issues related to quality improvement, transitions of care, frailty, polypharmacy, and cognitive and behavioral disorders.

Nursing home medicine would also require a more structured, "closed" medical staff model, which restricts privileges to a limited number of providers. Support for a structured model can be found in the work of Roemer and Friedman (23) and others (24–26) who have shown an association between structured medical staff and quality of care. In our own work, which examines the impact of medical staff organization in nursing homes, physicians working within a closed staff model seemed to be more committed, knowledgeable about long-term care practice, and available (20). Existing policies, regulations, and care standards that define the role of the attending physician and medical director in the nursing home reinforce such a model (27, 28), as do programs for formal certification of medical directors (29).

Challenges

Change in the practice of nursing home medicine will occur only if organized medicine addresses several issues. Mainstream medicine must reinforce the nursing home as a legitimate medical practice site. Recruitment and retention of a competent, trained workforce will demand incentives (for example, loan forgiveness) and assurance of financial viability. In the Netherlands, nursing home physician specialists exist and are fully subsidized by the government (30). Health care reimbursement in the United States is clearly more complex than in the Netherlands, but options include increasing Medicare reimbursement for cognitive services, developing organizational efficiencies under the current reimbursement system, implementing new policies that reward providers for enhanced quality and cost savings (that is, decreased hospitalizations), and making pay-for-performance both equitable and feasible in nursing homes without electronic medical records. Market forces may eventually provide incentive to reward nursing home specialists for the value inherent in their practice specifically related to enhanced quality of care in the nursing home and during care transitions.

Such organizations as the American Medical Directors Association and the American Geriatrics Society are critical in defining the physician's importance to the nursing home. Their efforts, however, must complement those of broader-based medical organizations,

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such as the American Medical Association, American College of Physicians, and American Academy of Family Physicians. These organizations, representing most primary care physicians in the United States, can enhance legitimacy of the nursing home specialist, help define career paths, establish curriculum, and craft relevant policy and regulations that preserve medicine's role in nursing home care. Nursing home practice accommodates a flexible rounding schedule and requires little overhead, in keeping with younger physicians' demand for work–life balance (31). The specialty could be marketed as having these attractive features coupled with the opportunity to manage a diverse patient population with postacute and long-term care needs in an easily navigable environment. Many of these same characteristics helped attract practitioners to hospital practice and fueled the growth of hospital medicine as a specialty.

Conclusion

Literature reporting on increased patient satisfaction and lower hospitalization rates in nursing homes that employ nurse practitioners and physician assistants have not considered physician involvement as a moderating variable (32). Physician care positively influences residents' hospitalization rates, functional status, and satisfaction (33–35). Marginal physician involvement impedes communication and integration of the physician into the nursing home culture, with detrimental patient outcomes (36–38). We contend that rather than accepting a diminished presence of physicians in nursing homes and finding alternative care models, it is time to fully consider, appropriately fund, and test the nursing home specialist model (39, 40). If nearly half of the baby boomers spend some time in a nursing home, the question "Is there a doctor in the house?" will take on new urgency and meaning.

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