Training Health Care Professionals in Long Term Care (LTC) Settings

Why LTC?

- Cost to society
  - 150 billion spent on LTC
  - Spending will double by 2025 and quadruple by 2050
  - Nursing homes (NH) represent almost 75% of total spending

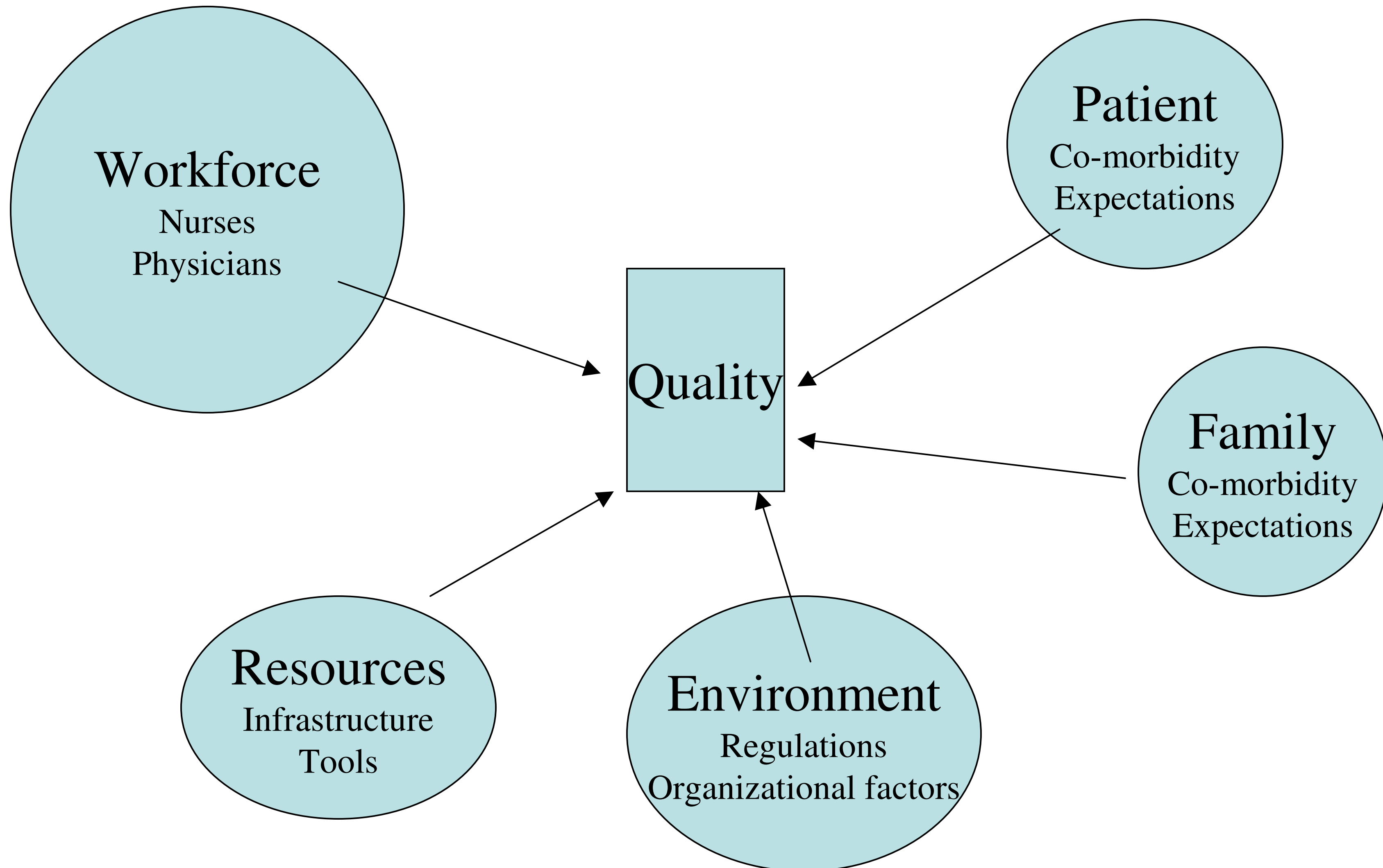
Why LTC?

- Personal risk
  - 14 million older adults will require LTC services by the year 2030
  - Number of older adults with two limitations in ADL's will grow by 1/3 over the next 25 years
  - 40% chance of nursing home admission after age 65
  - 16% of persons 85yrs and over reside in NHs

Why LTC?

- Critical component of the health care continuum
  - Accommodates the needs of the most frail (physical/psychologic)
  - Transition from acute care (e.g. subacute NH units)
  - Substitutes for diminishing social supports
  - Quality remains suboptimal

Determinants of Quality



Workforce: Links to Quality

- Underlying mechanisms:
  - Availability (supply)
  - Knowledge (training)
  - Competency (application of knowledge)
  - Acculturation (philosophy)
  - Organizational factors (relationships)

Physician Practice in LTC

- Physician care mandated but little information on staffing
- Only 20% of primary care providers see NH residents on a regular basis
- Most physicians in NH's spend 2 hours or less per week
- Home visits constitute very small percentage of primary care practice (1%)
- No information regarding Assisted Living

Perceptions of Physician Care in the Nursing Home

J Am Geriatr Soc 2005;53:1651-57

- Qualitative interviews on end of life care with 54 respondents who participated in national survey of 1,578 informants
- Physicians perceived as "missing in action" contributing to increased burdens on dying nursing home residents and their families

If There is a Physician Workforce Crisis in NHs…..

Will Increased Training Have the Desired Effect?

Does Physician Practice Make a Difference?

- The geriatric paradigm can significantly impact quality of care and cost when well targeted
- Variability of medical care in non-LTC sites has been linked to physician training, volume of practice, access to patients, length of visits and case mix (e.g.hospitalist vs nonhospitalists)
- Medical staff organization has been linked to quality measures in the acute care arena

Will increased training have the desired effect?

- Few studies have linked physician practice to outcomes in LTC
- Two recent analyses suggest a significant association between NH quality and:
  - Physician training
  - Medical staff organization

Does Physician Practice make a Difference?

- Nursing homes whose medical directors were certified (CMD) had a F-tag derived quality score that was 15% better than non-CMD homes (Rowland F., et. al AMDCP)
- Nursing home medical staff organization (NHMSO) dimensions were independent predictors of CMS quality measures (Katz P., et.al)

The Dangerfield Effect

- Unique physician skills necessary for host of clinical, ethical, legal, interdisciplinary issues but……
  - Primacy of medical model with acute focus
  - General lack of understanding of complexity of LTC practice
  - Under appreciation (among leaders in medicine) lowers expectations of physician care in LTC and impacts on perceived thresholds for physician involvement **(NO RESPECT)**

A Model for Nursing Home Physicians

Three critical dimensions…

- **Commitment** conceptualized as percentage of the physician's practice devoted to NH care and the amount of time, on average, spent per NH patient encounter.
- **Physician NH practice competency** defined by specialized training and experience necessary to handle the complex medical care in a highly regulated, interdisciplinary care context that is the contemporary NH.
- **Organizational structure** reflects the cohesive integration of the medical providers into the culture of the facility.

A Model for Nursing Home Physicians

- It is hypothesized that the quality of medical practice in NHs is optimized when physician geriatric competency and commitment are high within a closed staff model (few physicians responsible for all patients).
- Conversely, quality of care is lowest in an open staff model where physicians demonstrate low commitment and geriatric competency.

Improving medical care

The framework suggests quality of care can be improved by progressing along one or more of three paths--

- enhancing training and credentialing (competency)
- increasing reimbursement (commitment)
- developing new regulatory mandates and organizational models (closing medical staffs)

Goal: To Enhance the Training of Physicians Practicing in Nursing Homes

- Current training
- New Approaches

ACGME Training Requirements

- Internal Medicine
  - "Residents must have formal instruction and assigned clinical experience in geriatric medicine……these experiences may occur at 1 or more specifically designated geriatric inpatient units, geriatric consultation services, **long-term care facilities**, geriatric ambulatory clinics and/or in home care settings."

ACGME Training Requirements

- Family Medicine
  - “Programs should provide opportunity for residents to learn in multiple settings (e.g. hospital, ambulatory settings, emergency rooms, home and **long term care facilities**).”
  - “Residents must develop competency in assessing and meeting the healthcare needs of declining elders, episodic, illness related care, delivery of healthcare in the home, hospital and **long-term care facility**, and end of life care.”

ACGME Training Requirements

- Family Medicine
  - "Resident panels must include continuity patients requiring home care and care in long-term care facilities to provide each resident with continuity experience in those settings."
  - "Each residency must document that a patient population of adequate size, representing a broad spectrum of problems, with sufficient age and gender distribution, is cared for in the hospital,in the FMC, and in **institutions for long-term care** or rehabilitation as appropriate."

Resident Training in the Nursing Home

- **Internal Medicine**
  - Loose requirements;Significant inter-program variability;few offer longitudinal experiences
  - Account for 1/3 of practicing NH physicians
- **Family Medicine**
  - Specific requirements for nursing homes including longitudinal experiences. Curriculum and numbers of patients varies from program to program.
  - Account for 2/3 of practicing NH physicians

Adequacy of Training

- In a survey of graduating residents, fewer than 15% felt "very prepared to provide nursing home care"
  - (Blumenthal D, Gokhale M, Campbell EG, Weissman JS. Preparedness for clinical practice: reports of graduating residents at academic health centers. JAMA. 2001;286:1027-34)

Prerequisites for Optimal Training

- **Leadership** (deans/chairs/program heads) must accept the importance of LTC within the continuum
  - The "facts" only go so far
  - Need to advocate for quality metrics that recognize the linkage between acute/LTC (i.e. P4P)
  - Incentives must be aligned (i.e. hospitals held accountable for the adequacy of care transitions

Prerequisites for Optimal Training

- Nursing home culture that embraces "teaching"
  - Buy in from the NH leadership (administrator;DON) is critical
  - Association with University may enhance public relations (39% of AMDA members self identify as "faculty")
  - Systems must be in place to accommodate varying schedules of trainees (providers available to cover calls)

Prerequisites for Optimal Training

- Longitudinal experience with adequate patient volume
  - At least one year to appreciate the natural course of illness
  - Assures diversity
  - Exposure to myriad acute and chronic problems

Prerequisites for Optimal Training

- Mandated nursing home primer
  - Uniform knowledge base that assures consistent levels of competency
  - Focus on systems of care;regulatory environment;acute/LTC interface;principles of rehabilitation;quality measurement;capacity assessment;care planning

Prerequisites for Optimal Training

- Engaged and knowledgeable role models
  - Demonstrate the diversity and challenge of NH care
  - Demonstrate the skill necessary to practice effectively
  - Counter negative stereotypes
  - Establish credibility
  - Highlight career opportunities

Future Directions

- **Establish a "Nursing Home Specialty"**
  - The "Netherlands" paradigm
  - Enhanced credibility;reinforces NH practice as a legitimate practice
  - Pathways would need to embrace both early and mid-career providers
    - Focused recognition;certification akin to CMD
    - Mastery year of residency
    - NH fellowships

Summary

- Physicians play a vital and unique role in the care of long term care patients.
- A shortage of physicians in LTC currently exists and is likely to worsen in the future.
- Residency training must be broadened both in scope and content to assure a committed and competent physician workforce