Physician Involvement in Long-Term Care: Bridging the Medical and Social Models

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Long-term care is not easy to define. The boundaries between primary and acute and long-term care have become blurred.¹² It is not surprising, therefore, that there is no consensus on the extent to which physicians are, and should be, involved in long-term care delivery. The purpose of this article is to explore the current and potential role of physicians in long-term care and the challenges to their involvement, to identify models of successful physician engagement in long-term care settings, and to suggest strategies that should be explored to increase appropriate physician participation in the long-term care system to help adequately meet the demand for quality services in our aging society.

THE LONG-TERM CARE/MEDICAL CARE RELATIONSHIP

Long-term care is a variety of services and supports provided by unpaid (informal) and paid providers that concentrate on helping individuals to function as well as possible and to maintain their lifestyles in the face of disability. It frequently involves intense participation by family members, particularly wives and adult daughters, as providers and decision makers.² Long-term care encompasses a broad range of help with daily activities, over a long period of time, for chronically disabled people. These primarily low-tech services are designed to minimize, rehabilitate, or compensate for loss of independent physical or mental functioning. The services include assistance with basic activities of daily living (ADLs)—dressing, bathing, toileting, transferring, and eating. Services may also include help with instrumental activities of daily living (IADLs), including household chores like meal preparation and cleaning; life management such as shopping, money management, and medication management; and transportation. Services include hands-on and stand-by or supervisory human assistance, assistive devices such as canes and walkers, and technology such as computerized medication reminders and emergency alert systems that warn family members and others when an elder may be in trouble. Long-term care services also may include home modifications like building ramps, grab bars, and easy-to-use door handles.

The need for long-term care emerges from chronic and debilitating medical conditions that occur at birth, during various developmental stages, or from accidents. Examples are arthritis, diabetes, dementia, traumatic brain injury, and paraplegia. Often people who need long-term care also require primary and acute care when they are sick. In 2000, the personal health care expenditures for Medicare beneficiaries with no ADL limitations (excluding nursing home residents) averaged $5816; for beneficiaries with 3 or more ADL limitations, the expenditures averaged $16,425.³

Temporary, episodic services focus on curing illness or restoring an individual’s health to a previous state. In contrast, the predominant strategy in long-term care is to integrate treatment and living for elders with functional disabilities—not to undervalue health care for those getting long-term care, but to incorporate health care into the context of the functions of daily life.¹

One reason for the blurred boundaries between long-term care and various stages of medical care is the confounding of settings with services.² More and more acute care and high-tech rehabilitation formerly provided in hospitals are being provided in settings traditionally used for long-term care, such as skilled nursing facilities and private homes. It is, therefore, difficult to know where medically oriented care stops and long-term care begins. This lack of clarity also makes it difficult to understand how best to involve physicians in long-term care.

WHY DOES LONG-TERM CARE NEED PHYSICIANS?

For the past 3 decades, long-term care practitioners, policy makers, researchers, and consumers have debated the appropriate role of physicians in long-term care. Advocates of the social model have argued that physician involvement leads to an over-medicalization of long-term care with a primary focus...
on illness and goals that emphasize treatment of diseases and cure. Little attention is paid to the functional status of long-term care clients, the social and environmental aspects of their service needs, and their quality of life, as well as their clinical care. Supporters of the social model also argue that a physician-dominated system would be expensive and that long-term care can be provided much more cost effectively without medical intervention.

The social model advocates helped to promote this approach in the development of services across long-term care settings where individuals are not receiving postacute or subacute care. This includes nursing homes for long-stayers, assisted living and other residential care settings, and home and community-based services. Some might argue, however, that in their zeal to combat the medicalization of long-term care, they pushed the pendulum too far in the opposite direction.

There are many reasons why we need to encourage more physician involvement in long-term care. First, the acuity levels of individuals receiving long-term care services in nursing homes, assisted living, and their own homes have increased substantially over the past 10 years—the average care recipient is no longer just in need of custodial care.4 Most long-term care users have multiple chronic conditions and comorbidities that require acute and primary care intervention and monitoring. Many long-term care users are taking multiple medications without appropriate coordination and monitoring and without the knowledge or education to engage in good self-care. Reduced hospital stays have increased the demand for quick placement in long-term care settings that often occur without adequate care planning or follow-up to ensure smooth and safe transitions. Increasingly, people are dying in long-term care settings and there is a need for physicians to help ensure a quality of death as well as life.

These trends, coupled with the projected growth in the elderly population (particularly those aged 85 and older) over the next 30 years, suggests that physicians must become more involved in the long-term care decisions that their elderly clients and families make and the services that their patients access.

PHYSICIAN ROLES IN LONG-TERM CARE

Physicians can play a variety of roles in the long-term care system and in its relationship to the medical care system. One major role is serving as the medical director of a nursing home, an assisted-living facility, a home health agency, a hospice organization, or a continuing care retirement community. The physician's responsibilities here include providing direction and oversight for the clinical care, including medications, that is rendered to individuals, helping to develop and implement care protocols and ensuring patient/resident safety. Physicians also can provide primary care to long-term care users across the range of settings. To a great extent, many physicians are already assuming this role in that they provide medical care to individuals who may be receiving long-term care services in their own homes, an adult day care center, or an assisted-living facility. For the most part, however, the primary care provider has no formal relationship with the long-term care system.

Physicians also may serve as leaders of interdisciplinary care teams that manage the acute, primary, and long-term care needs of people with chronic illness and disabilities. As will be described in a later section of this article, physicians engaged in this type of activity apply a holistic approach to meeting the needs of the patient/client, provide overall direction to the team, but delegate much of the actual care and service delivery to other team members (eg, nurse practitioner, social worker, nutritionist, home health aide).

Physicians who are not directly providing care to long-term care users may offer consultant services to long-term care providers in the areas of clinical protocol development and continuous quality improvement. They may also actively engage in helping to coordinate care during an individual's transition from one setting to another, whether it is from the hospital to a nursing home, assisted-living facility, or private home or between long-term care settings. In this role, the physician's responsibility is to minimize the potential for an individual to "fall through the cracks" of the health and long-term care systems.

BARRIERS TO PHYSICIAN INVOLVEMENT

A variety of factors contribute to the current dearth of physicians in long-term care. One major impediment, introduced in a previous section, is the bifurcation of acute and long-term care, driven by the fear of medicalization, that has discouraged physicians and other medical care providers from getting actively involved in the development of the long-term care system. A second deterrent is the "sexiness of the acute care world" that attracts medical students and residents to hospitals and specialty practices. Long-term care typically is equated with the nursing home, a setting often viewed as a place of last resort where decrepit elderly people, most of whom have dementia, go to die and retired physicians go to supplement retirement income. The public image of the nursing home reinforces this view, deterring even those who might be interested in caring for the elderly to work within long-term care. Many aspiring physicians are not educated about the range of alternative settings where long-term care is provided and where their involvement might help improve the quality of care and life for chronically disabled elderly people. Most practicing physicians are not even aware of the long-term care services that their own elderly patients currently receive or should be receiving.

A third barrier to physician involvement in long-term care is the lack of a geriatric and gerontological focus in medical schools, residencies, and other in-service training programs. Because students are not required to take courses in these areas and to have clinical experiences in long-term care settings, most do not understand that caring for the elderly requires knowledge of and attention to the "whole person" including the functional and social needs as well as the medical care needs. Even individuals who are trained in geriatrics do not necessarily interact with the long-term care system. Many geriatricians, based in hospitals or a primary care practice, do not understand that long-term care is broader than the practice of geriatric medicine and that they must pay attention to the patient's quality of life, the ade-
quacy of the patient’s physical and social environment, the extent and nature of family involvement, and other aspects of the patient’s daily life. They often do not coordinate their medical care with the long-term care services being provided in either a residential setting or the patient’s family’s home.

A fourth barrier is the lack of financial incentives for individuals to practice in long-term care settings or to coordinate their patient care with the long-term care services provided in the long-term care setting. Facing staggering expenses at graduation from medical school, most medical students are not attracted to geriatrics in general and to long-term care in particular because their compensation is among the lowest of all physician practice areas. Medicare does not reimburse physicians for coordinating services or providing appropriate interdisciplinary care across the acute, primary, and long-term care sectors. With the exception of a few programs described later in this article, providers cannot pool funds from Medicare (which covers acute, primary, and subacute care) and Medicaid (which covers long-term care) to best meet the whole range of service needs of their patients. To the extent that physicians choose to provide care in alternative residential settings such as assisted living, they are discouraged from doing so because they are reimbursed at a lower rate than they would receive for a nursing home or home visit.

The risk of being sued and the tremendous increase in liability insurance rates over the past decade, particularly for physicians practicing in nursing homes and assisted living, is another major impediment to physician participation in long-term care. Practicing physicians in these settings are leaving because of the financial and psychic stress placed on them by this trend, and newly minted physicians are deterred by the costs and stigma associated with medical malpractice.

MODELS OF PHYSICIAN INVOLVEMENT IN LONG-TERM CARE

Despite the barriers identified above, there are activities across the country where physicians have bridged the medical and long-term care worlds. Some have achieved this objective through participation in formal programs; others have coordinated and even integrated care through more informal approaches.

Formal Programs

Since nursing homes are required to have a physician as medical director, this setting has the most formal systematic physician involvement. The intensity of the medical director involvement in bridging the medical and more social aspects of care, however, varies greatly across facilities. The American Medical Directors Association (AMDA) has been working over the past several decades to strengthen the role of the medical director and help them to develop and disseminate tools that can be used to infuse a geriatric philosophy into nursing homes.

A number of initiatives at the federal, state, and provider levels seek to manage acute, primary, and long-term care by integrating services in various ways. Three federal demonstrations have been conducted to test the viability and efficacy of integrated service models. The Social Health Maintenance Organization (SHMO), which began as a federally funded demonstration in 1985 in 4 sites (2 HMOs and 2 community-based organizations), provides an extra payment to a Medicare HMO acute care plan to cover long-term care services, primarily community-based care with vigorous care management, and limited short-term nursing home care. The SHMOs enroll a broad cross-section of Medicare beneficiaries, most of whom do not need long-term care services, with the goal of redistributing service dollars to those with the greatest needs. Researchers evaluating the demonstration indicated that coordination between the physicians and other acute/primary care providers and the long-term care providers often did not occur for the highest risk enrollees. A second generation SHMO program with better risk adjustment and targeted geriatric care management for all high-risk clients is currently being implemented in one health system in Nevada.

The Program for All-Inclusive Care for the Elderly (PACE) began as a national demonstration funded jointly by the federal government and the Robert Wood Johnson Foundation to replicate an integrated model of care in San Francisco called OnLok. This program serves primarily low-income, chronically disabled elderly Medicare beneficiaries who are eligible for Medicaid and who are nursing home certifiable. Through an intensive care management approach conducted by interdisciplinary care teams that include physicians, nurses, social workers, aides, and others as necessary, PACE programs strive to keep individuals in community care and out of nursing homes. Providers receive a combined Medicare/Medicaid capitation payment per client and rely on the adult day care setting as the focal point for service coordination. Despite equivocal evaluation results, PACE organizations gained permanent Medicare provider status in 1997 with about 30 programs currently in various stages of operation.

Using Medicare and Medicaid waivers, the federal government is currently testing the EverCare model of integrated primary and long-term care in nursing homes. The program enrolls nursing home residents in a risk-based HMO, with the nursing home costs covered by Medicaid or private insurance. Teams of geriatric physicians and nurses provide intensive primary care services to the residents and coordinate this care with the long-term care services provided by the nurses and nurse assistants. Because EverCare pays for all medical services incurred by the resident, there is no incentive for the nursing home provider to shift costs to Medicare by hospitalizing a resident. A federally funded evaluation found that the program appears to save money by reducing preventable hospitalizations.

States have also experimented with the integration of services for their chronically disabled elderly populations. Arizona’s long-term care system is part of a mandatory Medicaid managed care program begun in the late 1980s. Medicaid acute, long-term, and behavioral health services are included in the package, but Medicare funding is not integrated. The program implicitly achieves a degree of integration at the contractor level, because Medicare services are usually delivered through the organization that provides the capitated long-term care services. This provides the opportunity for
participating physicians to work with the long-term care system to deliver good chronic care and to ensure continuity of care.

Minnesota was the first state to receive Medicare and Medicaid waivers to integrate acute and long-term care services for elders in 7 countries. The Minnesota Senior Health Options (MSHO) program offers a package of acute and long-term care services on a voluntary basis; plans pay for community-based care, case management for high-risk patients, up to 180 days of nursing home costs, and financial incentives to minimize nursing home use and to encourage early nursing home discharges. Other states (Massachusetts, Maine, Florida, Texas, Wisconsin) have established integrated initiatives combining Medicaid Home and Community-Based Waiver programs with fee-for-service Medicare through various coordination mechanisms.

Informal Activities

Despite the lack of financial incentives to integrate a continuum of care, some providers are attempting to create coordinated service systems that bridge the acute/primary and long-term care sector. Several continuing care retirement communities (CCRCs), which collocate independent housing, assisted-living, and skilled nursing facilities on a campus for a primarily high- to upper middle-income elderly population, have expanded the role of the physician beyond that of the medical director. The Erickson Communities, for example, headquartered in Baltimore, MD, has partnered with physician groups in close proximity to each of its CCRCs to offer intensive primary care as an option to their residents living in any part of the continuum.

A subgroup of physicians—primarily geriatricians, internists, and family practice physicians—have recognized the importance of reaching out into the community to serve chronically disabled elderly people who are “homebound” or have great difficulty getting to a doctor’s office. These physicians, many of whom are members of a national organization called the American Academy of Home Care Physicians, have developed housecall programs in which they provide chronic care management and help coordinate long-term care services in private homes and in congregate settings (eg, low-income housing properties, assisted-living facilities) where large numbers of elderly reside. Most employ interdisciplinary care teams—usually led by a geriatric nurse practitioner—to deliver services in the patient’s own living space where they have the opportunity to observe the physical and social environment as well as attend to clinical needs.

ENCOURAGING PHYSICIAN INVOLVEMENT

As noted in the introductory section, many believe that the bifurcation of the medical and social model of caring for the elderly has impeded the development of person-centered care that goes across the health and long-term care spectrum of services. The lack of physician involvement in long-term care is a symptom of a system that is fragmented and broken. A multidimensional strategy must be employed to encourage physicians to become a more active partner in the full repertoire of services, not just the hospital and ambulatory care.

First, we must work with policy makers, educational institutions, and provider organizations to develop curricula and experiential training that focuses on long-term care as well as hospital and ambulatory settings. Medical students and residents must have exposure to geriatrics and gerontology and learn how to become a major partner in interdisciplinary care teams that address the needs of patients/clients with the right set of providers at the right time in the right setting. Financial incentives such as loan forgiveness programs, stipends, and fellowships need to be available to interested individuals to encourage them to practice in settings that bridge the acute, primary, and long-term care sectors.

Medicare and Medicaid need to restructure their reimbursement to reward quality interdisciplinary care that is person-centered and follows the patient/client as they move through the repertoire of services. They also need to increase the reimbursement rate for domiciliary care visits so that physicians will be encouraged to provide care in a range of residential settings. The federal and state governments should partner with the private sector (including philanthropic foundations) to invest in new practice models that go beyond PACE and SHMO in the integration of services across systems and that test the effectiveness of physician involvement in long-term care. We also need to explore how public policy can best be used to expand technology such as electronic records and telemedicine equipment so that physicians practicing in long-term care settings can track the status of their patients and share information with other providers.

We also need to recognize that the liability issues in nursing homes and assisted living are a major deterrent for many physicians to get involved. As we try to get rid of the “bad apple” long-term care providers and ensure patient/resident safety, we must strike a balance between regulation/litigation and quality improvement efforts so that we can attract and retain physicians in these settings.

The aging of our society in the 21st century calls for a new cadre of physicians that is committed to the care of the elderly population wherever they live and need services and that are able to bridge the medical/social divide. We need continued advocacy on the part of organizations like the American Geriatrics Society and the American Medical Directors Association to raise awareness about the opportunities for physician involvement in long-term care and the barriers to increased participation. We also need to create stronger linkages between these professional organizations and long-term care provider associations. Finally, we need to develop, test, and provide an evidence base for models of physician involvement in long-term care including outcomes for patients and families and costs to the health and long-term care systems.

REFERENCES

DISCUSSANT: THOMAS H. DENNISON, PHD, THE MAXWELL SCHOOL, SYRACUSE UNIVERSITY

Dr Stone elegantly paints a depressing picture of where we are with workforce issues in long-term care. Her realities include observations that there is a dearth of geriatrically trained clinicians (physicians, nurses, social workers, therapists) as well as a dearth of trained administrators and managers in this labor-intensive field. I would take it a step further and decry the shortage of nursing assistants who are enthusiastically embracing long-term care, rounding out this worrisome situation.

Her discussion of some of the barriers to effective and rewarding physician practice in long-term care is full of the realities. Financial inequities abound. And ageism plays a part. These barriers hold for all of the health care workforce in long-term care.

Dr Stone also lays out some of the strategies that can encourage physician involvement in long-term care. She identifies key actions that we must focus on to work toward a sufficient number of interested, educated, and motivated clinicians.

We have an underlying problem, however, that we also must address in a parallel track. That problem relates to the perspective of the general public on the quality of long-term care and, even more to the point, the quality of the people working in long-term care. The newspapers are full of horror story articles about the elderly being abused in nursing homes. Consumer Reports, a publication looked to many for advice, began an article in late 2003 entitled “Safety Alert: The Quality of Nursing Home Care” with a paragraph about how an 81-year-old woman was fatally beaten by 2 nursing home employees with brass knuckles. The article then went on to disclaim that “while this death may have been more gruesome than most among the nation’s 1.6 million nursing home residents, physical abuse and neglect at nursing facilities is not unheard of.” Is this the part of the health care system that you want to be identified with?

The government’s messages are no better. Reports issued by the General Accounting Office continue to emphasize quality problems. The state survey processes are viewed by many as punitive and negative.

I am afraid that regardless of how well we are able to adjust the financing system to reward long-term care practice, how well we develop models of care that integrate social and medical dimensions or how well we educate professionals in the technical aspects of delivery of long-term care, we are still going to have a problem in recruitment and retention of workers at all levels if we don’t work on the image of long-term care.

We need a broad agenda not only to rigorously police our own industry but also to advance a more positive and realistic message about who we are. Nursing homes are not bad places populated by an uncaring and criminal element. For many residents, they are truly a home providing support and caring at a vulnerable point in their lives. For workers at all levels, long-term care can be a rewarding practice venue.

We must work collaboratively to get a positive message out to the general public. Not until long-term care is “decriminalized” can we expect to see a turnaround in our ability to recruit and retain the kind of health care workers we need.

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Training of Physicians Who Care for Nursing Home Residents

Training in the care of nursing home (NH) residents is largely confined to geriatrics rotations in family practice residency or geriatric fellowship training. The current supply of physicians to care for persons admitted to NHs is less than one half the number needed (Wiener JM and Stevenson DG 1998), with only 8800 (1.2%) physicians possessing a Certificate of Added Qualification in Geriatrics. While 86% of family practice residency programs require geriatric medicine training, only 25% of internal medicine residency programs require any training in geriatric medicine. (Stone 2000). As a result, in the 1997–1998 National Study of Graduate Education, a third of respondents indicated that they were somewhat or very unprepared to care for NH residents near the completion of their training.

Academic geriatric faculty are necessary to train physicians in NH care, and yet, in a study conducted over a decade ago, researchers estimated that to develop the capacity to train academic geriatric leaders, the number of geriatric fellowship graduates would need to increase from 100 per year to 250 per year to meet conservative goal of 2100 academic geriatricians by the year 2000. This goal still has not been met in 2004. Methods to increase recruitment included establishing Centers of Excellence that have faculty and support personnel with strong research, clinical, and educational attributes; launching a national campaign to attract medical students, residents, fellows, and practicing physicians into geriatrics; and approaching public and private resources to support geriatric medicine training (Committee on Leadership for Academic Geriatric Medicine 1987). Unfortunately, faculty resources available to assist in recruitment are few in number and the income of academic and nonacademic geriatricians remains low compared to other specialties with fewer than
9000 certified geriatricians and only a small fraction in academic geriatrics (Warshaw, Bragg, & Shaull 2002; Reuben et al. 1993a; Thomas et al. 2003). While the capacity of physicians available to care for NH residents stalls, the medical complexity of patients discharged from hospitals to NHs steadily increases (Reuben, Schnelle, Buchanan, Kington, Zellman, Farley, Hirsch, & Ouslander 1999).

Teaching models that include NH care may improve physician competency in the care of NH residents and inspire graduating physicians to treat NH residents. Evidence exists that internal medicine residents who provide primary care to NH residents have improved attitudes toward seniors and improved skills in the assessment of geriatric syndromes (Katz, Karuza, & Counsell 1995). For example, family practice residents with NH experience during training tend to continue to provide NH care after graduation. Similarly, graduates of family practice residencies who rate their training in geriatrics favorably are significantly more likely to make NH visits after graduation.

The paucity of physicians involved in NH care prompted the Residency Review Committee of Family Practice and Internal Medicine to recommend NH rotations and the Institute of Medicine to recommend 9 months of geriatric experience for medical residents (Katz, Karuza, Kolassa, & Huston 1997). In 1996, NH rotations were offered in 86.5% of family practice and 32.2% of internal medicine residencies; while only 6% of internal medicine residents and 1% of family practice residents had formal geriatric training (Katz, Karuza, J, & Hall 1992).

Part B Reimbursement Issues Related to Practice Patterns

Reimbursement affects both a physician’s choice to practice in a NH and decisions regarding the medical care of NH residents. One issue is denial of claims. While federal requirements dictate the minimum number of physician visits to NH residents, any visit that occurs outside of the 30- or 60-day window must be deemed medically necessary by the physician’s carrier. A carrier is the insurance company contracted by Medicare to determine payment. Skilled nursing facility residents have more frequent visit schedules, with a presumption of medically necessary visits more frequently than every 30 to 60 days. Carriers commonly disallow visits between the required 30-day or 60-day intervals as “routine” (Stone & Reublinger V 1995). Claims submitted in excess of the required monthly visits must contain documentation to support the medical necessity of both the service and the frequency of visits or they will be identified as “routine” rather than medically necessary.

While CMS has been making a concerted effort to lower the claims error rates, significant processing errors exist. No data was found on the denial rates for NH visits, however, some information was uncovered for processing errors. The “services processed error rates” include both claims that were overpaid as well as those that were underpaid upon medical record review and vary among provider types and carriers. Family practice and internal medicine have more than double the error rates (13.1% and 15.3%, respectively) of ophthalmology or diagnostic radiology (6.2% and 5.8%). The error rates for individual carriers ranged from 6.9% to 35.8% (Center for Medicare and Medicaid Services 2003).

Physicians may feel more comfortable with their billing practices for office visit CPTs and be unwilling to risk claim denial by seeing NH residents. The lack of guaranteed payment is one reason physicians may refuse to see acutely ill residents (Kayser-Jones 1995). Physicians also cite claim denial in the decision to hospitalize residents for acute episodes rather than treat them in the NH (Kayser-Jones J.S., Wiener, & Barbaccia 1989). NH visit claims may be denied under the message “consecutive daily or courtesy visit not reasonable and necessary.” Subsequent hospital visits are presumed necessary on a daily basis, and so are much less likely to be denied.

Nonreimbursable Activities

Another concern is the time spent on nonreimbursable activities. A time and motion demonstration project in New York State determined that 64% of a physician’s time practicing in a NH was spent on nonreimbursable activities (Moore & Martelle 1996). No reimbursement is provided for telephone calls, family meetings, coordination of care with other physician and nonphysician health care providers such as therapists, depression screening, or for evaluating cognitive function. While all physician specialties face a range of nonreimbursable activities, NH care and other types of care for frail elder patients (eg, home health care) require more of these activities than other types of practice.

The extent of nonreimbursable time necessary for the care of geriatric patients contributes to physicians’ attitudes toward caring for these residents and the high rate of specialist referral for geriatric residents that could be competently treated by a general internist (Thomas, Leipzig, Smith, Dunn, Sullivan, & Callahan 2003). Four common nonreimbursable activities for physicians in NHs were found to be telephone evaluation, care planning meetings, staff communication about the resident, and meeting with family members (Moore & Martelle 1996). The activity most likely to deter physicians from seeing NH residents is expectation of a large number of phone calls from the NH. NHs are required to report any change in a resident’s condition to the resident’s attending physician, often resulting in phone calls for problems that could be dealt with by NH staff (Warshaw, Bragg, & Shaull 2002).

Other nonreimbursable time is the travel time to the NH. With low reimbursement rates for routine visits, it may only be cost-effective for a physician to follow NH residents in NHs where he or she treats multiple residents. This, in combination with differences in reimbursement between settings, creates incentives for physicians to request that NH residents are to be sent to the hospital or emergency room rather than to make an unscheduled visit to the NH. The level of reimbursement and the inconvenience of seeing residents outside of the office are both speculated to influence physician decisions to decline to treat NH residents (Hazzard W 1991).

Travel time is not the only overhead a physician incurs when treating NH residents. While physicians do not have the obvious practice overhead associated with office visits, an AMDA survey found practice staff to be performing a signif-
Among residents of NH visits, more than half of all physician practices report staff time involvement in the following 7 tasks for each billed NH visit: scheduling, reviewing clinical reports, coordinating home/outpatient care, coordinating therapy, phone calls, coordinating ancillary services, monitoring/notifying physician of change in condition, and responding to pharmacist or nutritionist (Lett 2003). The overhead costs of NH residents includes a high burden of paperwork for visits. For example, whereas an ophthalmologist completes one set of billing forms to earn over $1000 for cataract surgery, the NH practitioner would need to see 45 to 50 NH residents and complete 45 to 50 separate billing forms to earn the same amount (Kane 1993).

Reimbursement may affect the decision to specialize in the care of NH residents. While NH specialization may be a more cost-efficient way to see NH residents, it may be financially imprudent to have a practice that is predominately composed of Medicare patients. In many geographic areas, private insurance payment rates are significantly higher than Medicare payment rates (Warshaw, Bragg, & Shaull 2002), making specializing in NH care financially unattractive to many physicians because they will make more by treating younger patients with private insurance.

Financial Risk From Treating Nursing Home Residents

Malpractice is one of the biggest issues in physician practice today and NH care exposes physicians to the additional financial risk associated with a lawsuit. In lawsuits directed against a NH for poor care, the physician is named directly around 10% of the time. Recently, insurance companies who have settled lawsuits against the NH where the physician was not named have then sued the physician after the settlement (Fraser 2004). Physicians who feel they are accepting legal responsibility for the care delivered by the NH staff may be reluctant to see any NH residents, or to be more selective in declining residents from specific NHs. As NHs face increasing premiums, many are choosing to go “bare,” or without coverage, making the physician’s personal malpractice insurance a more attractive target for litigation.

The inability to get coverage for NH care or the cost of such coverage may deter physicians. Physicians report difficulty obtaining coverage for their NH work and note policy renewal premium increases of up to 300 times previous premiums (Wilson 2003). A recent AMDA survey found that 27% of respondents claimed they had reduced patient care hours, no longer provided certain services, or referred complex cases as a result of malpractice concerns. Of respondents, 5.6% were unable to get liability coverage because they worked in NHs. One in 20 medical director respondents indicated they had stopped working because of lack of liability coverage (OIG Report 2004). Many people expect a surcharge to be added to malpractice premiums of all physicians who see NH residents as they are currently added for physicians who assist in surgeries (Fraser 2004). Malpractice concerns have also been noted as a reason why physicians will hospitalize a NH resident rather than seeking to treat the resident in the NH setting (Zimmer, Eggert, Treat, & Brodows 1988).

Nurse Staffing

Although not well studied, one potential barrier to recruitment of physicians in NHs is a belief that well-qualified nurses do not choose to work in NHs and without the aid of well-qualified nurses, the provision of good care is difficult. Physicians cite higher quality nursing care in a hospital as a reason for a preference to transfer residents to the hospital for care rather than to provide care in the NH (Kayser-Jones 1995). In addition, evidence exists that low salary, difficult working conditions, and lack of prestige influence the decision of nurses to work in NHs. Whether or not this translates to decreased competence among NH nurses and results in difficulty recruiting physicians into NHs is not known.

● Recommendations:
  ○ Expand geriatric curriculum with focus on long-term care and the interdisciplinary model of geriatric medicine
  ○ Develop and test models of care delivery to determine best practices
  ○ Reduce burden of liability