A Call to Action

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Dr Levenson’s 5-article treatise on improving and reforming healthcare care is a call to action for all health care professionals committed to nursing home (NH) practice. Dr Levenson has laid bare many of our current administrative, regulatory, and clinical practices and processes, calling for approaches that are truly evidence based and person centered. Dr Levenson admonishes us to eschew fragmented care and to reward those holistic approaches that are evidenced by “flexibility, comprehensiveness, and sensitivity.”1p600 In addition, we are encouraged to critically evaluate extant quality metrics upon which we are currently judged. Overemphasizing outcomes at the expense of processes of care may not be the optimum approach to improving quality of care.

Dr Levenson argues that “improving care overall requires optimizing performance of those who provide care”2p520 … “more effective clinicians know more, know how to understand and decipher information about specific situations, and know how to apply their knowledge effectively”2p521 (ie, phronesis). Dr Levenson further notes that “NH reform requires as much respect for competent clinical problem solving and decision making activities as there is for competent surgical technique”1p601 … and that “capable facilities recognize that the route to regulatory compliance always lies in effective clinical problem solving and decision making.”1p603

How then do we ensure that attending physicians in the NH possess those skills in order to optimize practice? The American Medical Directors Association (AMDA), as the organization representing long-term care practitioners, must lead the way in defining these critical physician competencies. Once defined, these competencies may then be used to guide the development of a curriculum embodying the knowledge base and skill set necessary to “handle the complex medical care in (the) highly regulated, interdisciplinary care context that accommodates post-acute and long-term care.”3

Recent calls for the establishment of a “nursing home specialty” recognize the existence of these unique physician competencies in the NH that link directly to quality. It is argued that the creation of such a specialty will ultimately enhance the credibility of NH practice, expand the physician workforce, optimize quality of care, and eventually lead to greater reimbursement based on perceived value.3

Defining and promulgating physician competencies is a necessary first step but will not be sufficient in and of itself to address the critical shortage of well-trained and committed NH physicians. The success of the hospitalist movement may serve as a guidepost for NH medicine. Seemingly overnight, hospitalists have been recognized as de facto experts in providing “venue-specific care.” The Society of Hospital Medicine now boasts more than 9000 members and is poised to achieve the status of focused recognition from the American Board of Internal Medicine (ABIM). According to the ABIM, “certification with a focused practice in hospital medicine recognizes the specific knowledge, skills and attitudes of general internists who focus their practice in the care of hospitalized patients.”4

If NH specialty status is eventually to be sought, it will clearly need to apply equally to internists and family physicians, the latter representing nearly two thirds of NH practitioners. A “focused practice model” will not require additional formal training such as a fellowship, but rather will provide a unique designation predicated on both experience and a test of knowledge. This practice model will not demand anywhere near full-time NH practice and should be amenable to a variety of lifestyles. It will clearly embrace the majority of physicians already practicing in and committed to NH practice.

Creating a NH specialty in no way connotes that medical providers currently are underperforming. On the contrary, the call for a specialty recognizes the excellent care already being delivered by those physicians who can translate their special knowledge and experience to improved outcomes at the bedside. Proclaiming these individuals eventually as “specialists” recognizes their unique contributions and adds much-needed credibility to their chosen profession.

Will specialization add yet another “silo” to medical care and contribute further to discontinuity? On the contrary, NH specialists will play a key role in ensuring continuity during transitions of care and will provide primary, longitudinal care to the long-stay resident population. Indeed, NH specialists embrace all of the tenets of the “patient-centered medical home” and are positioned to play a key role in future health care reform. As Dr Levenson discusses in his series, competent physicians play a vital role in helping nursing homes understand and apply the care-delivery process correctly, completely, and consistently. This is critical for effective care of both short-stay postacute patients and long-term nursing home residents. Not surprisingly, obtaining the basic knowledge on quality improvement by becoming a certified medical director (CMD) has been shown to improve quality of care in the nursing home.5,6

Is a specialty focus on the nursing home too narrow, ignoring other venues of long-term care such as home care and assisted living? Although much of the same rationale for specialty status may apply equally throughout the long-term care continuum, the NH clearly is unique with regard to the evidence pertaining to care standards and the regulatory and administrative framework under which care is delivered.
This, in essence, defines the unique skill set and knowledge base that undergirds specialty designation. Whether or not a broader-based “long-term care specialty” may be justified in the future, NH practice already meets the necessary criteria.

Specialty status will go a long way toward the recruitment and retention of a competent NH physician workforce. Financial viability must be assured, however, if such a workforce is sustainable. Such viability may emerge from health care reforms that realign incentives so that quality of care (ie, reduced avoidable hospitalizations) is rewarded. “Pay for performance” may be a powerful tool to change practice but first must be made both equitable and feasible in the nursing home. Market forces may eventually provide incentives to reward NH specialists for the value inherent in their practice specifically related to enhanced quality of care in the NH and during care transitions. Finally, in order to eliminate both real and perceived disincentives to practice, meaningful liability reform in the NH that guarantees coverage for nursing home–based physicians must parallel future health care reform.

As Dr Levenson acknowledges, “for genuine improvement and reform to occur, everyone involved in overseeing, influencing, and managing NHs needs to review, if not rethink, their current roles and input.” This will require consensus from organizations representing the professions (ie, American College of Physicians [ACP], American Academy of Family Physicians [AAFP], American Geriatrics Society [AGS], American Association of Homes and Services for the Aging [AAHSA], American Health Care Association [AHCA]), regulatory bodies (ie, Centers for Medicare and Medicaid Services [CMS]), and advocacy groups (eg, National Citizens Coalition for Nursing Home Reform [NCCNHR]). Finally, we will need a much greater emphasis on outcomes research that is relevant to the nursing home and that ultimately measures the effectiveness of physician care and different staffing models. NHs are, and will remain, a critical part of the health care continuum. Steve Levenson’s recommendations for reform should be required reading for all those professing to change a system that clearly requires improvement.

REFERENCES