AMDA National Engagement in Care Transitions

To the Editor:

I was delighted to read your excellent editorial entitled “Transitions” in the November 2010 issue of the Journal of the American Medical Directors Association.1 The issue of safe movement for all patients, especially frail elders, has rightly assumed a seat at the table of national health care concerns. The projected annual cost of $17.4 billion in readmissions for 2003–2004 claims data on Medicare hospital readmissions nationally2 puts a financial price on the problem, but obscures the dreadful human toll inflicted.

I wish to respectfully bring to the attention of the editor and your wide readership that the American Medical Directors Association (AMDA) has not only identified the problem that unsafe transitions presents to our patients, but has been active in steps nationally to improve care as patients traverse the long-term care continuum. AMDA actions chronologically thus far include the following:

- Invited membership on the Pharmacy Quality Alliance, which was originated in 2006 with the mission to improve health care quality and safety through measuring pharmacy- and pharmacist-level performance.
- Participated in the Transitions of Care Consensus Conference, July 11–12, 2007, in Philadelphia, sponsored by the American College of Physicians, Society of General Internal Medicine, and the Society of Hospital Medicine. The goal was to develop consensus guidelines/standards for safe transitions of care using a multi-stakeholder process, and resulted in a white paper.
- Received membership on the National Advisory Board of the National Transitions of Care Coalition with 31 other associations and organizations to address gaps in care in moving patients from one site or level of care to another. Since the National Transitions of Care Coalition’s inception in 2006, AMDA has been a significant contributor to its white papers, clinician and consumer tools, and nationwide educational presence. The Web site with its array of valuable offerings can be accessed at www.ntocc.org.
- Presented, in June 2008, AMDA House of Delegates resolutions regarding care transitions to the American Medical Association House of Delegates in Chicago, IL, the first time this issue had been broached at the American Medical Association House of Delegates.
- Participated in a December 3–4, 2008, Technical Expert Panel in Baltimore, MD, on behalf of the Centers for Medicare and Medicaid Services, to seek modifications to the Continuity Assessment and Record Evaluation tool then currently being piloted. The purpose was to better adapt the Continuity Assessment and Record Evaluation tool so as to be able to use one assessment tool for transitioning Medicare patients and have standardized measures to evaluate performance.
- Was represented at the American Medical Association-Physician Consortium for Performance Improvement meeting, December 18, 2008, in Chicago, IL, with the goal of developing a comprehensive set of measures that could be used for accountability and that support the efficient delivery of high-quality health care in care transitions. Measurements are now in development.
- Produced the white paper, “Improving Care Transitions from the Nursing Facility to a Community-Based Setting,” which became policy in March 2009.
- Produced the white paper, “Improving Care Transitions between the Nursing Facility and the Acute-Care Hospital Settings,” which became policy in March 2010.
- Published the Clinical Practice Guideline Transitions of Care in the Long-Term Care Continuum, which contains 7 steps to safer transitions in the long-term care continuum for both planned and unplanned transitions. It contains 99 pages, 16 tables, and 14 appendices in addition to products, resources, references, and a bibliography, all related to improving care transitions. It is available free of charge at http://www.amda.com/tools/clinical/toccpg.pdf.
- Formed an ad hoc Transitions of Care Committee scheduled to meet initially at the March 2011 Annual Meeting. The committee has an aggressive agenda to develop tools and educational materials to the long-term care continuum community to improve care transitions.

AMDA will continue to drive the process of making transitions between sites of care safer, and is delighted that JAMDA advocates this course.

James E. Lett II, MD, CMD
Chair, AMDA Transitions of Care Committee,
Carmichael, CA

REFERENCES
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The Role of Physicians in Nursing Homes: A Comment

To the Editor:

We read with interest the article by Helton et al1 on the role of physicians in nursing homes (NHs).

We have studied these problems in the context of Italian NHs, and have published an article demonstrating the importance of having physicians on staff in NHs to provide timely and informed assistance to the very old and frail persons living in them.2

Unfortunately, in our country the trend is in the opposite direction at the moment, because the economic crisis induced many NHs to reduce the amount of time physicians spend in the NH. The gerontology community is trying to convince the health authority about the potential savings induced by reducing the number of patients transferred from NHs to hospitals. However, the Italian system is unable to calculate costs as a whole, because every sector (even the public sector) has its
own budget and is unable to consider that savings in hospitals may compensate for more costs in NHs. From a “political” perspective, the data regarding the development of a relationship with the families, which includes a discussion of care goals, are more impressive and probably more useful for the purpose of increasing physicians’ presence. In times culturally oriented toward the autonomy of patients, it is important to stress that physicians are the most appropriate interpreters of the will of their patients, protecting patients and families from the risks of a management that scarcely cares for the personal choices and the intimate wishes of old people.

We may conclude from the data of Helton et al1 that physicians are the most important protectors of old residents from the ageist culture prevailing in some NHs. Sometimes we are accused of medicalizing life in the NH; on the contrary, the reported data indicate that doctors, in particular those working in NHs as a personal choice, are respectful of freedom and dignity.

Dr Bellelli explains that the Italian health care system is not motivated to reduce costs in the system as a whole because every sector has its own budget, and there is no broad vision that recognizes that whereas physician presence would increase costs in the nursing home, those costs would be offset by the considerable overall savings of reduced hospitalization. Italy is certainly not alone in the inability to step back and see the big picture. In the United States, Medicare is the dominant payer of chronic nursing home services for the elderly, whereas Medicaid is the dominant payer of hospital services, and these systems have conflicting interests.2 Medicare might be motivated to save costs by reducing hospitalizations but Medicaid is unprepared to assume the increased cost of care in the nursing home. This silo approach is unsustainable, and it will take vision and political will to redo an outdated financing system. A failure to innovate in this area will be so expensive that health care will overwhelm every other societal need.

In the United States, outdated reimbursement policies still reward the hospitalization of patients. Unfortunately, at the same time, hospitals are the most expensive setting in which to provide medical care, and they are attendant with risks to the older patient including iatrogenic disease, infections, and delirium. In the United States, a promising new development is the Accountable Care Organization, which is a proposed system of care where physicians, hospitals, and health care organizations work more effectively together to both improve quality and slow spending growth.3 Nursing homes could be folded into Accountable Care Organizations so that the health care system, including the hospital, shares the goal of high-quality care delivered in a financially responsible manner. Because the savings would be shared, the system would have an incentive to reduce the hospitalization of nursing home patients, which is neither cost-effective nor necessarily better care. There is no better example of an area for improvement than in avoiding sending a nursing home patient to the hospital for a condition that could more appropriately be treated in the nursing home. These models can occur only with incentives in place to promote physician presence in nursing homes.

Margaret R. Helton, MD
Lauren W. Cohen, MA
Sheryl Zimmerman, PhD
University of North Carolina at Chapel Hill
Chapel Hill, North Carolina

Jenny T. van der Steen, PhD
VU University Medical Center
Amsterdam, the Netherlands

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