Identifying Challenges and Opportunities for the Long-Term Care Medical Practitioner

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I am a “SNFist” or a “SNFologist.” That is to say that I devote my full-time medical practice to taking care of residents and patients in long-term care (LTC) facilities. Firsthand knowledge and daily interactions with patients in various settings and different facilities has allowed me to gain insight into some of the challenges and opportunities of caring for residents in LTC facilities such as skilled nursing facilities (SNFs).

Currently, most of the residents I care for in skilled nursing facilities comprise two larger groups. The first is described as “post acute care.” As hospital stays have become shorter in recent years, the SNF has become an important and useful intermediary step in the transfer of residents from inpatient hospital care towards returning to their home setting. Common examples of this group include residents who suffered traumatic injuries, significant surgical interventions, elective orthopedic procedures, or debility and deconditioning, where patients are unable to safely perform their activities of daily living (ADLs) within the limitations or circumstances of their domiciliary arrangement. The second group of residents is what most people commonly associate with a nursing home resident. These are residents that reside long-term in a facility for daily assistance and management of their medical problems and ADLs. Returning home is not a practical or safe alternative for these patients. Circumstances that usually preclude a transition to a SNF include the availability of social support, frailty, and chronicity of medical problems.

One big challenge in meeting the needs of these two groups is the constraints of the physical facilities themselves; many were set up, designed, and built in the distant past. Residents and families in the post acute care setting, who are returning home, usually prefer to live in private rooms, which are not readily available. Some buildings have a specific area devoted to rehab patients; others do not. Sometimes patients in a facility for a short-term stay have to share space and areas with residents with entirely different needs. There is currently a national trend developing to convert and change the physical setup of some facilities to a ‘residential/community’ structure. In this arrangement, instead of all residents sharing a pool of interdisciplinary teams (e.g., patient care, nursing, dietary, laundry), residents reside in smaller subgroups within the facility, usually called neighborhoods, and are cared for by a smaller, more familiar core care team that share the duties of the interdisciplinary team with a smaller group of residents. The difficulties of retrofitting older facilities and building new facilities to accommodate this patient structure are major challenges in moving to this neighborhood concept.

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Transitions in care are a big issue within long-term care. Residents may initially come from their homes, an inpatient hospital setting, or from another facility. Obtaining accurate information on current medications, recent medication changes, indication for antibiotic treatments, duration of treatments, and dates for follow-up appointments with community providers can often be challenging. Residents can be sent to the emergency department and/or admitted to hospitals from the SNF for evaluation of new significant acute issues or decompensation of chronic medical problems. In the past, most patients were cared for by a primary care

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physician in the community who saw them in an outpatient setting and then in the hospital, and, if needed, in skilled nursing facilities. Some physicians even made home visits. Current changes in delivery of health care, driven by multiple constraints including time, expenses, and productivity have further fragmented the health care delivery system, and it is now more common to have a community primary care provider who does not follow patients in the hospital, where they are cared for by a hospitalist, and then transitioned back to the community or to a skilled nursing facility. In the case of transferring a patient to a skilled nursing facility, the patient is usually cared for by an attending who may or may not be in the primary care physicians’ group. Instead they may be another community attending not previously associated with the patient. We now have a group of providers that care for patients exclusively in some LTC facilities. These shifts in responsibility create challenges in coordination of care of residents, and in meeting expectations from patients, families, and other health care providers.

Many local communities struggle with finding physicians and providers to care for residents in their facilities. There is an increasing shortage and need of primary care physicians, especially in the field of geriatrics. Many facilities have medical directors and attendings that are no longer taking new patients in facilities or choosing not to continue to care for residents in LTC facilities. New medical students are choosing non-primary care medical specialties, and it has been hard to attract students to choose careers in primary care. Physician extenders (nurse practitioners and physicians assistants) help fill the void and are playing a larger role in caring for residents in LTC. New medical students are choosing non-primary care medical specialties, and it has been hard to attract students to choose careers in primary care. Physician extenders (nurse practitioners and physicians assistants) help fill the void and are playing a larger role in caring for residents in LTC. Physician extenders (nurse practitioners and physicians assistants) help fill the void and are playing a larger role in caring for residents in LTC. Physician extenders (nurse practitioners and physicians assistants) help fill the void and are playing a larger role in caring for residents in LTC. Physician extenders (nurse practitioners and physicians assistants) help fill the void and are playing a larger role in caring for residents in LTC. Physician extenders (nurse practitioners and physicians assistants) help fill the void and are playing a larger role in caring for residents in LTC. Physician extenders (nurse practitioners and physicians assistants) help fill the void and are playing a larger role in caring for residents in LTC.

The American Medical Directors Association (AMDA), the leading group of medical directors and attending physicians in LTC facilities, has a strong mentoring program for younger physicians who may be interested in a career in long-term care. AMDA also offers a curriculum for the certified medical director (CMD), and recently published results that a facility with a CMD demonstrated up to 15% improvement in quality measures.1

Caring for residents in skilled nursing facilities is often different than caring for residents in the community or outpatient setting. Discussion and review of goals of care between the patient and family and the interdisciplinary team are crucial. In order to provide person-centered care, one must understand the physical, medical, personal, and even spiritual needs and expectations of a patient. In contrast with a more interventional disease driven model, caring for a resident in a long-term care facility is frequently more about disease management and how these processes affect the resident’s quality of life. It is important to review and discuss expectations in order to facilitate and accommodate the patients and their families’ needs. In the state of North Carolina we are fortunate to have the Medical Orders Scope of Treatment (MOST) tool.2 This document is complementary to advanced directives, and expands upon the traditional “do-not-resuscitate” form. It differs in that it is a portable “medical order.” The form, in addition to addressing resuscitation orders, expands on issues such as the level of medical interventions, antibiotics, intravenous fluids, and nutritional support allowable. Local and coordinated community utilization of the MOST tool between facilities, emergency medical services, hospital, and emergency rooms is important in implementing this tool successfully. The admission process to a SNF is a good opportunity to discuss and review goals of care with a resident and their families when applicable.

The demographics of the Baby Boom generation predestine us to a significant growth in LTC services in all locations. Aging advocates have successfully lobbied Congress to fund a series of demonstration projects that focus on fostering a more patient-focused (and cost-effective) system of LTC care. This concept was incorporated into the Medicare Modernization Act (Section 646 of the Medicare Modernization Act, also known as the Medicare Health Care Quality Demonstration Program).

In North Carolina, the Division of Medical Assistance (Medicaid) saw the same problems as those recognized in Section 646. The Division, working with the 14 existing Community Care networks, established a new nonprofit—NC Community Care, Inc. This entity applied for and won a grant to implement a two-pronged program to improve “quality of care and services delivered to Medicare beneficiaries through system redesign that fosters best practices...”3 One arm focuses on community care, the other on LTC settings. In the demonstration, there will be 26 intervention counties in the state, with the target population being dual eligible (those eligible for both Medicaid and Medicare coverage) and Medicare-only patients.

Avoiding unnecessary transfers and the needs for pharmacotherapy management are two of the main issues in which LTC facilities may be affected by interventions. By coordinating patient care between facilities, attendings, and medical directors, the 646 Demonstration will treat patients in place, instead of, or prior to, sending them to the emergency room. Managing this population with multiple chronic illnesses may help in improving health care outcomes. With the utilization of pharmacy consultants, monitoring for drug interactions and pharmacotherapy optimization and medication reconciliation (the process of reviewing medications and changes) during the various transfer process of the residents may also result in improvement in health care outcomes.
Long-term care facilities are becoming a crucial component in the delivery of health care and management of chronic health problems. Challenges include recruiting health care providers to manage and care for residents to meet their personal care needs and coordinating the flow of information between inpatient services, community consultants, and specialists, as well as community providers. Opportunities exist to improve on systems to deliver health care to these residents that are consistent with their goals of care.

REFERENCES


The North Carolina Chapter of the American College of Physicians congratulates the winners of its 2010 Associate Poster Competition. The competition was held March 5, 2010 during the NC/ACP’s Annual Scientific Session at the Washington Duke Inn in Durham.

Best Overall: Laurel Kilpatrick, MD (Wake Forest University)
Best Clinical Vignette: Brittany Bohinc, MD (Southeast Area Health Education Center)
Second Place Clinical Vignette: Steven Heatherly, MD, PhD (Wake Forest University)
Third Place Clinical Vignette: Melanie McMinn, MD (Carolinas Medical Center)
Best Clinical Research: Laurel Kilpatrick, MD (Wake Forest University)
Best Basic Research: Surovi Hazarika, MD (Brody School of Medicine at East Carolina University)
Best Student (tie): Brian Petullo, MS (University of North Carolina at Chapel Hill) and Alex Warren, MS (Brody School of Medicine at East Carolina University)

Congratulations, winners!

The next meeting of the Chapter will be January 28-29, 2011. For more information, contact Nancy Lowe, CMP at (919) 833-3836 or nlowe (at) ncmedsoc.org.