DEAR DR. JEFF
Jeffrey Nichols, MD, CMD

Each One Teach One

Dear Dr. Jeff:
Our nursing home has been asked by a local hospital to be a teaching site for residents in their existing internal medicine training program and a newly formed family medicine residency. Although we would like to have a closer relationship with this major referral source, I am anxious about a wide range of concerns including the financial and risk burdens that might be involved, the time commitment for me or other nursing home staff, and regulatory concerns. I know that there are “teaching nursing homes” but we have never been one or are there any nearby colleagues to consult. What do you think?

Dr. Jeff responds:
The United States is facing a severe shortage of personnel in every field involved with the care of the elderly. The number of those certified with added qualifications in geriatrics has continued to decline as the original generation of those grandfathered into the field retires or dies. The number of new geriatrics fellows will only produce a small increase over the next decade. Approximately one-third of the 300 available fellowship positions go unfilled. According to the American Geriatrics Society, the totally inadequate number of certified geriatricians in Hawaii (currently 78) exceeds the combined total for Idaho, Wyoming, Alaska, Montana, Delaware, and Mississippi.

The American Association of Nurse Practitioners reports that the number of certified nurse practitioners (NPs) in the United States has approached 250,000, with 23,000 new NPs certified per year. But fewer than 10% of these NPs specialize in gerontology, and many do not receive exposure to nursing home care during their training. Only 55 to 60 psychiatrists per year choose to enter geropsychiatry fellowships, where funded positions often go unfilled. There are similar shortages of geriatric-trained specialists in social work, clinical psychology, rehabilitation medicine, and the rehabilitative therapies. As the population ages, these geriatric workforce issues will worsen.

Multiple national studies have detailed these occupational needs, but the major initiatives that would be necessary to address them and the massive funding that would be required to make those initiatives real is not forthcoming. The Hartford Foundation funded a Geriatric Workforce Education Project at 44 sites, but it will focus primarily on comparative evaluation of different strategies. The current federal administration’s proposed budget for 2018 would have eliminated federal Geriatric Workforce funding; the appropriation was only maintained at current levels by the intervention of an alliance of all the major organizations concerned with the health of the elderly. Within the overall need for health personnel trained in the care of seniors in general, and frail elderly or skilled nursing facility residents in particular, the obvious need exists to enhance the training of generalists in the special needs of our population. Many training opportunities exist for those already active within post-acute and long-term care. Among these are the NICHE program (Nurses Improving Care for Healthsystem Elders), which has expanded its programs and resources from acute care to PA/LTC. It provides an array of educational and support materials online or through resource centers and webinars. NICHE has also linked its materials to the Center for Advance Palliative Care (CAPC), affording its members access to excellent materials, both evidence-based when available and experienced-based when not.

Education Opportunities
AMDA – the Society for Post-Acute and Long-Term Care Medicine also offers a wide variety of educational opportunities, available at reduced price for members and generally available to all interested providers. These include the Core Curriculum and the Competencies for Attending Physicians Practicing in Post-Acute and Long-Term Care; live conferences, including selected streamed or recorded sessions, and educational meetings sponsored by state affiliates; clinical practice guidelines, podcasts (AMDA-On-The-Go), white papers on specific topics available on its website; and the Journal of Post-Acute and Long-Term Care Medicine (JAMDA) as well as Caring for the Ages (both published by Elsevier). The Gerontological Advanced Practice Nurses Association (GAPNA) and the American Geriatrics Society, along with their state affiliates, also provide educational materials and conference sessions for members related to PA/LTC, among their broader list of offerings.

Still, all these excellent educational and training opportunities are focused on those who are already working in the field. The AMDA Foundation Future Program does reach out to students and trainees who have a possible interest in long-term care, but only 50 to 60 available slots per year does not scratch the surface of the gaping shortfall. It is clearly our responsibility to reach out whenever possible to recruit and train new professionals for our field. This is not simply what corporate lingo calls “succession planning” — we must address the existing need. Virtually every other form of professional training at best makes nursing home care an optional exposure, and at worst totally ignores it. Most students graduate from medical or nursing school without ever entering a nursing home, except perhaps to visit a relative. Although internal medicine programs have a mandate from their residency review committees to provide geriatric training within their curriculum, to the extent that this mandate is honored the exposure typically consists of some didactic material and perhaps a brief exposure to geriatric inpatients or an ambulatory care clinic.

Several directors of geriatric education for medical students have told me that they do not wish to expose their students to nursing homes because they give the students the “wrong idea” that geriatrics is about patients with dementia or with multiple physical deficits near the end of life. How does this lay a foundation for the care provided in institutions for an average of 3 million seniors per year? Medical trainees typically treat nursing home residents in the hospital and discharge hospital patients back to our facilities without any idea of the nature of what we do or the resources available to our patients.

By contrast, family medicine residency programs and geriatric fellowships have mandatory training in nursing homes — including continuity training, in which the same patients are followed throughout training. Many of the best practitioners within the long-term care field discovered or confirmed their vocation during such rotations. NP training programs allow or expect their students to arrange their own “practicums” or supervised clinical training experiences, often in conjunction with formal coursework done primarily online. Many of these programs are also designed to allow students to continue their jobs while they pursue their graduate degree part-time. Their supervisors must be experienced NPs or qualified physicians. These practicums can occur in nursing home settings as well, with the supervision and education coming from the highly skilled professionals who already work in our space. Not only can this level of practical experience make the trainees more comfortable seeking employment in our setting, but it also can provide valuable experience for the facilities, group practices, or special needs plans who are recruiting these newly fledged NPs.

Physician assistant training programs require extended clinical placements, usually for several days per week during a 1-month rotation. Although most programs have established referral sites for these rotations, many programs are looking for new, different, or additional placement sites. Our facility receives referrals from two different programs, and between them we usually have at least one student every month. A single physician in our facility usually supervises these trainees and enjoys the opportunity to teach while the students help with significant aspects of the work.

For example, the physician-assistant students benefit from the experience of entering orders in the computer, thereby becoming familiar with typical doses and formulations, which the physician then reviews and authorizes. Also, all types of students are typically accustomed to the levels of laboratory, radiology, and consultation usage typical for a hospital setting. Learning appropriate utilization levels for nursing home care can prove a valuable part of their education.

Partnering With Schools
The practical details involved in developing and maintaining relationships with educational institutions — whether a hospital training program or a university — are relatively straightforward. There should be a memorandum of understanding (MOU) between the program and your institution: they accept responsibility for all necessary insurance, they arrange and provide copies of all needed health screening, and they warrant that the students have no known criminal histories or substance abuse issues that would make them unsuitable for a long-term care setting. Every program has models for these agreements, as all programs experience students going to other locations.

Most schools provide extensive training on the Health Insurance Portability and Accountability Act of 1996 (HIPAA) from the beginning of their program, and this might be included in the MOU as well. There is no HIPAA issue in sharing information with students who are participating in the care of the residents. You might wish to give a copy of your residents rights policy to the students on their first day as well; if you are especially concerned, you might want them to sign for receipt. And, in this era when everyone carries a smartphone and half your students photograph their meals to share with friends on social media, if you have policies in place against photographs of residents without their permission, it is important to spell them out from the beginning.

Do not expect that your referral institution will provide any form of faculty support. They may be collecting hefty tuition for the time the student spends with
CMS Finalizes Plans for Pay Hike, Less Regulation

Whitney McKnight

Regulatory changes impacting post-acute care facilities for fiscal year 2019 are expected to increase reimbursements while reducing bureaucratic burden, according to federal health officials.

The Centers for Medicare & Medicaid Services long-term care hospital prospective payment system (LTCH PPS) final rule for fiscal year 2019 will raise overall payments to acute care facilities by 3%, including monies for new technology add-ons and uncompensated care, according to the agency. The standard net payment rates will increase by 0.99% ($39 million). Skilled nursing facilities will see a 2.4% rise in reimbursements — about $820 million over fiscal year 2018.

The threat of the “25% rule” that would have reduced total reimbursements if more than a quarter of a long-term care hospital’s patients came from a single acute-care hospital has also been eliminated by the final rule. Because the changes are budget-neutral, CMS is imposing an annual decrease of about 0.9% to the standard payment rate for LTCHs through 2021. For site-neutral cases, the cut will impact only the standard rate portion of their combined payment.

A new “case-mix” model for skilled nursing home facilities will go into effect in October 2019, giving providers time to learn the new ICD-10-based payment system that is tied to what is clinically relevant, rather than to the volume of services provided. The new model also decreases patient assessments documentation requirements, a move that is expected to save facilities approximately $2 billion over 10 years.

Other changes include allowing post-admission physician evaluations to count as face-to-face physician visits. The rule takes effect October 1, 2018. For more information, go to https://bit.ly/2yfH8y

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