EXPERIENCES OF A FULL TIME IN HOUSE NURSING HOME PHYSICIAN

I. Introduction-Who am I?
   A. Graduated Indiana University School of Medicine in 1992, completed residency in family medicine at DH in 1995, board certified in FP 1995 and recerted 2001 and 2007.
   B. Worked 1995-2001 at Deaconess Primary Care West as a full service FP delivering babies, going to the hospital and nursing homes in addition to seeing office patients. During that time I served as Rehab Director for Parkview Care Center and their medical director and then opened private practice w Drs. Goodman and Hunter 2001-2010 at West Side Family Medicine. Worked as independent contractor in ER at Good Samaritan Hospital in Vincennes from Jan 2011 thru March 2012. Am certified in NALS, PALS, ACLS, ATLS, Difficult Airway, and enough other initials to choke a horse.
   C. Joined Life Care Physician Services in March 2012 as full time in house nursing home specialist at Life Care's building in Evansville, Parkview Care Center. To my knowledge am the only full time on site physician in that capacity in the state
   D. But wait! There's more!-on September 3rd I will be joining St. Mary's as their Director of Post Acute Care.
   E. So what does that mean besides the fact that I'm a colossal flibbertigibbet? Gives me a unique perspective of having been employed, having my own practice, working in a hospital, and an ER, and finally full time in a NH, that the demands and challenges placed on caregivers all along the path of care are extreme and severely frustrating.

II. What is the Scope of the Problem We are Facing?
   A. Growth of LTC in the 80s and now we are up to 1.6 million NH pt's in the US. Cost is about $120 billion (approx 7% of M'care budget) which could potentially double in the next two years. Currently 40% of all hospital DC go to NH
   B. Various studies say that by 2030-2050 the numbers in NH could double. Lifetime risk of being in a NH at some point is 46%
   C. Decrease length of stay in the hospitals (DRGs). Example would be that 10 years ago for CHF could stay in the hospital around eight days now is four w little change in the treatment regimen. More pressure on staff and less money for the hospital.
   D. NH face sicker patients on DC. By 2020 approx 40% of all deaths will be in NH. Statistically one third of all NH patients will die within one year of admission.
   E. Shortage of Primary Care Physicians esp geriatricians. Up until last few years med schools were graduating primary care in the single digits (very excited about the prospect of a four year med school here).
   F. Pressure, stress, staff burnout for people on the front lines.
   G. Poor communication/frequent transfer <u>despite</u> an information age. Which leads to...

III. Readmission!!! (In today's hospital corridors this is a four letter word)
   A. Approx 18% readmission rate in the US (studies vary from 15-25%) within 30 days and according to an oft quoted study, 76% of those are "preventable".
   B. Despite modern medicine, these rates have actually climbed about 10% over the last three decades.

IV. So WHY All this "sudden" Interest in Readmissions?
    A. Money, money, money! Cost of readmission approx $17.4 billion in 2004 study. Of course we stanchly hold out that people are actually concerned about quality of care as well .
    B. Starting this year and over the next two years, hospitals will incur payment reductions from M'care (1% this year, 2% 2014 and 3% by 2015) under the Hospital Readmission Reduction Program through the PP ACA. They are looking esp at AMI, CHF and pneumonia but will prob eventually be looking at GU, psychosis, COPD and GI issues as well. Six million people in the US suffer from CHF alone.
    C. Let's get ready to bundle! Integrating from now until 2018 this has been called one of the most far reaching changes in M'care payment in 30 years
V. So What Can We Do?
    A. Medical Homes
    B. Dedicated geriatricians which may include loan forgiveness
    C. Tort reform-the Australian experience
    D. Expansion of mid levels
    E. Technology-including telemedicine, med boxes, etc.
    F. Transitional Care Teams-some incredible experiences in Detroit, North Carolina
    G. Interact II
    H. Patient Safety Coalition
    I. In House Physician-The Life Care model.
        1. Dr. Katz call to arms in 2009 (he actually works for Life Care as well)
        2. Move to "site of care" medicine much like the rest of the current medical community.
        3. Similar to some European models. Dutch do a 2 yr fellowship. Their readmission rates are in the low single digits-they actually claim 1%!
        4. Study had shown hospital based LTC had less readmission due to availability of physicians, RNs, and ancillaries (Duh!)
        5. Initial data from Life Care showing readmission rates dropping from approx 40% to 13-15%. Several facilities have those down into the single digits.
VI. Results
    A. Decreased visits and time in the ER. Pts get seen and improved communication w staff, family and ER
    B. Decreased use of meds esp. neuroleptics (Dr. Evans viewpoint).
    C. Increased education and training for staff
    D. Able to deal w more ill pt's (it's not as simple as a weight for a CHF patient)
    E. Increased speed/pt and family satisfaction
    F. Wiser utilization of resources/better transition both in NH and hospital (interaction w managers/staff who understand costs, formularies, etc.)
    G. Decrease rehospitalization rates
        1. Cutting preventable readmits by 25% could save $25 billion/yr and that PAC centered care could cut readmits by at least a third.

VII. Pros and Cons

A. Always need a team. A physician is not enough.
B. Immediate care, greater pt and family satisfaction, able to spend time w patients and decreased overhead for docs. See also point VI
C. Some of the cons include autonomy-who is in charge? (Clinical or operations) "there is no mission without a margin" but.... Increased cost to facility both in taking on MDs and sicker patients. Interaction w other physicians. Loss of clinical distance. EMR still decreases time with patients.

VIII. Conclusion

Change is coming! What will you do to position yourself for the future?

Helpful web sites:
Agency for Healthcare Research and Quality (AHRQ)
Institute for Healthcare Improvement
Long Term Quality Alliance
Center for Post Acute Studies
Center for Medicare Services (CMS)
National Center for Quality Assurance (NCQA)

Questions?

SOURCES

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