A Nursing Home Rotation in a Family Practice Residency

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A nursing home rotation can be a complementary component of geriatrics education in a family practice residency curriculum. Using nursing homes in teaching geriatrics has been done for some time but has of late received more emphasis. This increasing emphasis has been brought about by the growing health care needs of an aging population and a concomitant focus on education in geriatrics. If implementation of a nursing home rotation is contemplated, both the positive and negative aspects of such action as it relates to the residents, the nursing home, and the nursing home patients should be explored. The rotation as incorporated into the geriatrics curriculum of the Family Practice Residency, Knoxville Unit, University of Tennessee College of Medicine, involves all second-year and third-year residents in the medical care for patients of a 222-bed long-term care facility. From an educational standpoint, overall evaluation of the rotation reflects satisfaction. The experience exemplifies personal and comprehensive continuity of patient care. Other educational benefits include desensitization to the nursing home environment, understanding the kinds of medical care that can be delivered in this setting, and appreciation for the cost not only to the patient and the family but also to the medical care system as well. **J FAM PRACT 1990; 30:594-598.**

The growing need for geriatric care associated with an increasingly aging population has led to a greater emphasis on geriatric education in family practice residency programs. In 1975 there were 22.4 million people in the 65-years or older age range. This population is expected to grow to 31.8 million in the year 2000 and to 55 million by 2030. Furthermore, it is estimated that there will be 13.3 million people over the age of 75 by the year 2000.[1]

Learning to provide longitudinal medical care for this geriatric population is a very important component of a family practice resident's training. Most longitudinal care can take place in the family practice center, an outpatient office setting. This setting is appropriate because over 90% of those over 65 years of age live at home and are ambulatory. Statistics indicate that another 5% of those over 65 years reside in long-term care facilities.[2] Advanced age is associated with increased risk for long-term care in an institution. About 1% of those aged 65 to 74 years, 6% of those aged 75 to 84 years, and 20% to 25% of those aged 85 years and older reside in long-term care institutions.[2,3] The physical and mental health of these nursing home residents is quite varied, ranging from bedridden, comatose patients to those who are quite independent but can no longer live at home as a result of a wide range of circumstances.

In the curriculum of the University of Tennessee, Knoxville Unit family practice residency program, the nursing home experience is an integral part of education in geriatrics. In 1984 the Knoxville program established a relationship with a local long-term care facility. The basis for this relationship with the nursing home, a description of residents' responsibilities, and the goals of this educational experience are addressed in this paper.

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THE NURSING HOME ROTATION

The concept of using nursing homes for teaching purposes has been around for over 20 years.[4] There is, however,

controversy concerning the use and the extent to which the nursing home should be used in the instruction of medical students and residents. Some educational benefits identified by proponents include improved knowledge of chronic disease, a more realistic perspective regarding the type of care available to the nursing home patient, development and refinement of skills needed to manage chronic disease, learning to set realistic management goals and to appropriately utilize support systems, reinforcement of a positive attitude concerning elderly patients and their care, and the nursing home's availability as a model environment for assessing and attending to the functional status of the patient.[3–5]

There are many authors who point out the disadvantages of using nursing homes for teaching purposes. They cite the generally negative image of nursing homes and the atypical characteristics of the nursing home patients relative to the elderly population as a whole.[4] A major concern is that the teaching of geriatrics is in danger of being relegated exclusively to the nursing home setting.[3] Additionally, there are indications that the medical student's or resident's nursing home experience may engender a negative attitude toward the elderly.[5]

There are positive and negative points also to using the nursing home for teaching purposes as far as the nursing home patient is concerned. From a positive standpoint, the patient will receive increased medical attention, and service will be upgraded. On the other hand, the patient may be exposed to more aggressive interventions and possibly to less appropriate care as a result of medical interference with established nursing home team approaches to patient care.[3,4,6]

Incorporating a nursing home experience into the curriculum of a family practice residency program is a challenging task. The design of this curricular element must meet the educational goals of the family practice department and its certifying board, the administrative responsibilities of the chronic care facility, and, last but not least, the health care needs of the patients. In planning and implementing the nursing home experience in the curriculum of the University of Tennessee Family Practice Residency at Knoxville, the foregoing concerns were addressed and continue to be monitored. The nursing home used for teaching by this program is a 222-bed facility that is composed of approximately one-fourth skilled care and three-fourths intermediate care beds. One author (J.B.M.) is the medical director of the nursing home, and another author (G.E.S.) chairs the appropriateness review committee.

Patients admitted to the nursing home may be cared for by either their admitting physician or by the family practice resident or faculty member. The same provider options apply when and if hospitalization is necessary. In any event, wishes of the patient, family, and personal physician are always considered.

The educational objectives for a nursing home experience have been described in detail by Robbins et al[1] and have been listed more generally but with specificity by Walls et al.[7] The nursing home educational objectives developed by the Knoxville residency program have both a patient care and an educational focus. These objectives emphasize the following concepts:

1. Continuity of acute or short-term care
2. Continuity of long-term care
3. Interaction with patients and families and appreciation of family dynamics
4. Realistic goals of care
5. Desensitization to the nursing home environment
6. Familiarity with the rules and regulations of Medicaid and Medicare
7. Physiology and pathophysiology of aging
8. Reading of pertinent literature
9. Interaction with those who make up the nursing home team
10. Appreciation for the scope of care that can be provided in the nursing home
11. Cost of care in the nursing home to both the patient and family as well as to the medical system.

All second-year and third-year residents are involved in the nursing home experience. Each resident serves as the acute care physician on a rotating basis—about once every 12 to 16 months for a 1-month period. The resident is in the nursing home for 2 to 4 hours each day Monday through Friday during the assigned month. The resident attends all patients who are acutely ill, patients who have a more rapid deterioration in their chronic condition than would be expected, and skilled care patients who require certifications and recertifications.

Daily rounds allow the same resident to follow and treat the patients with acute illness and to become familiar with such early signs of deterioration in the elderly as a change in mental status or appetite. The resident must rely on the history and the physical examination, in particular, for a diagnosis and treatment plan, usually without the help of x-ray examinations, electrocardiograms, or other diagnostic procedures that would be readily available in a hospital or clinic setting. Providing acute care for a 1-month period offers sufficient time to (1) follow the treatment of an acute illness, (2) evaluate a more rapid than expected deterioration in the patient's chronic status, (3) appreciate the natural history of a disease, (4) observe the ability of aged patients to respond to therapy, and (5) manage the patient in transition from hospital discharge to skilled care.

At the start of the second year of residency, each resident is assigned a panel of 12 to 14 intermediate care

patients to follow in the nursing home for 2 years. Seeing the same patients consistently allows time for the resident to establish a relationship with the patient as well as gain a better understanding of the patient's condition and course.[4] Visits are made on a monthly basis for evaluation and recertification. New patients are assigned at the time of admission so that each resident's panel of patients will stay about the same size. The resident is asked to see and evaluate each patient monthly as well as perform a complete examination on one or two of these patients. Documentation to be completed at this time includes (1) an activities of daily living evaluation form,[8] (2) a mini-mental examination,[9] (3) a brief psychiatric questionnaire designed to assist in the identification of depression,[10] and (4) a chronic and temporary problem flowsheet. A progress note regarding the patient's physical, nutritional, and mental and emotional status is completed for each patient on a monthly basis.

Each month the residents also evaluate the medications that have been prescribed for their panel of patients, taking into consideration the appropriateness, dosage, frequency, and potential drug-drug or drug-nutrient interactions. As residents become comfortable with their panels of patients, the number and the amount of medications are usually reduced. This tendency to decrease medications has been documented in the literature.[6,11] Resuscitation status is determined for each patient by considering the wishes of the patient, if competent, or if not competent, then status is determined by family and physician discussion. The desire of the patient or family regarding hospitalization in the event of acute emergent illness is also discussed.

The monthly visits are scheduled far enough in advance so that family members can be at the nursing home to talk with the resident if they desire. This practice is strongly encouraged. At times, a joint meeting with family members, the resident, and the faculty physician is arranged. This meeting gives the resident firsthand experience in dealing with the family dynamics surrounding nursing home placement and continuing nursing home care. Meetings with family members help the resident to recognize guilt, fear, and anger expressed in various fashions. Dealing with misplaced anger can be difficult for the most experienced physician. Providing faculty support for the resident during such meetings can help structure the encounter to create a learning as well as a therapeutic experience.

The resident, just as any physician treating the nursing home patient, must learn to establish realistic goals and expectations. There is little chance for cure in the nursing home setting, so improvement in function or relief of pain may be all one can expect.[4,12] Preventive medicine, both primary and secondary, with an emphasis on improved nutrition is important.

It is noted that after several months of nursing home exposure, the residents do become much more flexible in their therapeutic expectations. Before the residents reach this stage, however, there may be varying degrees of depression associated with the care of nursing home patients. The depression can, in part, be related to the death and severe disability residents observe in the nursing home as well as the residents' realization that family members and ultimately they themselves may one day be in the condition of the nursing home patient.[4,12] Overcoming this depression as well as adjusting to the sights, sounds, and smells of the nursing home are major aspects of the process of desensitization of the resident to the nursing home. Unless the resident successfully goes through this desensitization, it is unlikely that in the future he or she will care for patients admitted to a nursing home, much less take the position of medical director.

Even though family physicians and internists make up about one half of community physicians, only 14% of them make nursing home visits. The care given is often characterized as substandard, superficial, or indifferent.[3] Their lack of enthusiasm is not surprising and, at least in part, can be attributed to little or no training in geriatrics and insufficient exposure to nursing homes.[13]

Caring for patients on an acute and chronic basis, as well as attending patient care planning meetings, gives the resident a working knowledge of Medicare and Medicaid rules and regulations. The rules and regulations are discussed by the faculty with the resident. The resident needs to have a working knowledge of methods of funding nursing home care, such as what constitutes skilled care vs intermediate care (federal definitions), what are sources of payment for prescription drugs, what constitutes rehabilitative physical therapy and who pays for it, what issues affect nursing home staffing, and what the regulations are regarding certification and recertification.

The nursing home rotation ensures that the resident has ample exposure to the physiology and pathophysiology of aging. The faculty and nursing home personnel reinforce these experiences. A reading list encompassing 24 topics has been developed (Table 1). One topic per month is assigned. The resident and a faculty physician discuss each topic during the time the resident is providing monthly chronic care at the nursing home. The topics are more interesting and easier to remember when they relate directly to a patient for whom the resident is currently responsible. Sharing the reading material with interested nursing home staff enhances staff job satisfaction by recognizing their role as a teaching team member. In fact, the nursing home staff does a great deal of teaching.

The resident attends rounds with the nursing director of the nursing home and at times with the head nurse on each wing. Rounds on patients with decubiti are made with the nurse in charge of quality assurance. There is direct inter-

TABLE 1. SUBJECTS USED FOR READING ASSIGNMENTS

1. Aging skin
2. Anemia
3. Assessment of the elderly patient
4. Benign prostatic hypertrophy
5. Decubitus care
6. Dementia
7. Deteriorating immune system with aging
8. Elder abuse
9. Eye changes in the elderly
10. Hearing loss
11. Hypertension in the elderly
12. Incontinence
13. Movement disorders
14. Nutrition of the elderly
15. Osteoarthritis
16. Osteoporosis
17. Physiology of aging
18. Pneumonia in the elderly
19. Preoperative evaluation of the elderly
20. Prescribing for the elderly patient
21. Sepsis in the elderly
22. Sleep disorders
23. Stroke
24. Urinary tract infection

action with the nursing staff on each wing. During the weekly patient care planning meeting, the resident sees the members of the nursing home health care team discussing, from their perspective, each newly admitted patient. This team includes the nursing home director, director of nurses, director of quality assurance (a nurse), pharmacist, dietitian, physical therapist, social worker, activities director, director of admissions, and the medical director. This experience gives the resident insight into the development of care plans and into the integrated function of the various departments of the nursing home.

The resident works with both highly skilled and relatively unskilled health care personnel and thereby becomes sensitive to the importance of this latter group to patient well-being.[4] The nursing home traditionally has been the purview of the nurse. Nursing care is central to the institution, and the teaching process must complement and undergird the nonphysician personnel.[14] The interaction of residents, faculty, and nursing home staff in the teaching program may have a beneficial effect on the nursing home staff, as demonstrated by less sick leave and less staff turnover.[11]

Exposure to the nursing home for 2 years, especially during the 2 months residents spend delivering acute care, gives them the experience and time to develop the concept of what types of medical care or therapy can and, perhaps more important, cannot be delivered in the nursing home. Of course, having a faculty physician available and having residents in the nursing home on a daily basis does permit nursing home care that might otherwise be available only through hospitalization.[15] The large amount of supervised time spent in the nursing home may be different from the "real world" but still broadens the residents' scope of practice. In reviewing orders that come with patients admitted to the nursing home, it is all too obvious that many physicians have minimal insight into the concept of realistic nursing home care.

Along with the concept of what can and cannot be provided in the nursing home, the resident must learn how the services are financed. For example, Medicaid varies from state to state but will pay for some medications, whereas Medicare will not. Physical therapy is covered by Medicare and Medicaid only if it fulfills the federal definition of "rehabilitative physical therapy" and if the patient demonstrates reasonable progress. If medications such as intravenous antibiotics are required, transferring the patient to a hospital will cost the health care system more than if the patient remains in the nursing home and the same antibiotic is administered. Administering the antibiotic in the nursing home, however, may mean a significant out-of-pocket expense to the patient or family. In such a case the patient and family should be informed before the medication is started.

There are many other examples that pit the patient or family against a third-party payer. If the resident physician understands the Medicaid and Medicare system, appropriate medical care can be provided with less financial burden for both the patient and the health care system.

DISCUSSION

Integrating a nursing home experience into a family practice residency can be a formidable task. From an organizational viewpoint, certain factors have been key elements in the success of the Knoxville Unit family practice residency program experience with a nursing home. These elements include the following:

1. Involvement of second-year and third-year residents
2. Assignment of a panel of 12 to 14 patients to each resident for chronic care to be evaluated monthly for 2 years
3. Provision of acute care Monday through Friday
4. Attendance by faculty physicians at the nursing home 4 days per week to help the resident providing acute care (answering questions, confirming physical findings, doing functional assessments, etc)
5. Treatment of patients who have decubitus ulcers or other skin injuries by residents in conjunction with faculty to enhance long-term continuity of care
6. Resident attendance at the weekly patient care team meeting

7. Assignment of reading material monthly and discussion between residents and faculty
8. Occasional attendance by residents at the appropriateness-of-care review committee meeting.

Based on evaluations from faculty and residents alike, the nursing home experience described here meets the educational objectives outlined and provides a great deal of service to the nursing home patients as well. Whether this increased service is advantageous to the nursing home, the patient, or patient's family cannot be known at this time, but there are some encouraging indications. Involvement of the resident education program does improve the morale of and enhances the education of nursing home employees, but it also increases their workload. Improved care may not significantly increase the patient's longevity but may increase patient comfort and quality of life. With some patients there will be a psychological uplift, but with others their dementia is such that they will not remember that the physician visited them. Psychological comfort is probably experienced by the patient's family. From a competence standpoint, the faculty has observed that as residents gain experience in the nursing home environment, they seem more at ease, which leads to more appropriate patient care. Experience with a more-at-ease feeling associated with nursing home encounters is probably true of the faculty as well.

In conclusion, it is important to keep in mind that the geriatric aspect of a family practice residency program curriculum is composed of many parts. One must not rely on any one component (ambulatory office patients, hospital inpatients, senior citizen centers, house calls, or nursing home patients) to the exclusion of others in implementation of a varied educational experience that will prepare today's resident physician for the challenges of tomorrow in this rapidly growing area in family practice.

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