Marginalization of physicians in the nursing home threatens the overall care of increasingly frail nursing home residents who have medically complex illnesses. The authors propose that creating a nursing home medicine specialty, which recognizes the nursing home as a unique practice site, would go a long way toward remedying existing problems with care in skilled nursing facilities and would best serve the needs of the 1.6 million nursing home residents in the United States. Reviewing what is known about physician practice in nursing homes and hospitals, and taking a lead from the hospitalist movement, the specialty would be characterized in 3 dimensions: the degree of physicians’ commitment, physicians’ practice competencies, and the structure of the medical staff organization in which they practice. Challenges to the adoption of a nursing home specialist model include mainstream medicine’s failure to recognize the nursing home as a legitimate medical practice, the need for the nursing home industry and policymakers to appreciate the links between physician practice and quality, and assurance of financial viability. Implications for quality of care, health policy, and research needs are discussed in this article.

For author affiliations, see end of text.
nursing facility and with individual residents. We think that nursing home specialists could practice under many different models, ranging from a full-time practitioner to a primary care physician in the community who devotes 1 day per week to nursing home residents. However, we propose that nursing home specialists devote at least 20% of their practice to nursing home care. Recognizing that physicians may visit multiple facilities, the time spent in any given nursing home should equate to at least 4 hours a week. Arguably, this is the minimum amount of time necessary to become facile with processes of care and the site-specific culture.

Competency in nursing home medicine would be defined by training or experience in handling complex medical care in a highly regulated, interdisciplinary care context that accommodates both postacute and long-term care. Training should be flexible enough to attract the broadest cross-section of primary care physicians, because limiting recognition initially to board-certified geriatricians or to certified medical directors would needlessly exclude other qualified practitioners. Future training might include an additional “mastery” year of residency training, flexible nursing home fellowships that would accommodate both early and midcareer candidates (22), or a certification process similar to that for medical directors. Examples of specific competency domains for training and certification include management of issues related to quality improvement, transitions of care, frailty, polypharmacy, and cognitive and behavioral disorders.

Nursing home medicine would also require a more structured, “closed” medical staff model, which restricts privileges to a limited number of providers. Support for a structured model can be found in the work of Roemer and Friedman (23) and others (24–26) who have shown an association between structured medical staff and quality of care. In our own work, which examines the impact of medical staff organization in nursing homes, physicians working within a closed staff model seemed to be more committed, knowledgeable about long-term care practice, and available (20). Existing policies, regulations, and care standards that define the role of the attending physician and medical director in the nursing home reinforce such a model (27, 28), as do programs for formal certification of medical directors (29).

**Challenges**

Change in the practice of nursing home medicine will occur only if organized medicine addresses several issues. Mainstream medicine must reinforce the nursing home as a legitimate medical practice site. Recruitment and retention of a competent, trained workforce will demand incentives (for example, loan forgiveness) and assurance of financial viability. In the Netherlands, nursing home physician specialists exist and are fully subsidized by the government (30). Health care reimbursement in the United States is clearly more complex than in the Netherlands, but options include increasing Medicare reimbursement for cognitive services, developing organizational efficiencies under the current reimbursement system, implementing new policies that reward providers for enhanced quality and cost savings (that is, decreased hospitalizations), and making pay-for-performance both equitable and feasible in nursing homes without electronic medical records. Market forces may eventually provide incentive to reward nursing home specialists for the value inherent in their practice specifically related to enhanced quality of care in the nursing home and during care transitions.

Such organizations as the American Medical Directors Association and the American Geriatrics Society are critical in defining the physician’s importance to the nursing home. Their efforts, however, must complement those of broader-based medical organizations, such as the American Medical Association, American College of Physicians, and American Academy of Family Physicians. These organizations, representing most primary care physicians in the United States, can enhance legitimacy of the nursing home specialist, help define career paths, establish curriculum, and craft relevant policy and regulations that preserve medicine's role in nursing home care. Nursing home practice accommodates a flexible rounding schedule and requires little overhead, in keeping with younger physicians’ demand for work–life balance (31). The specialty could be marketed as having these attractive features coupled with the opportunity to manage a diverse patient population with postacute and long-term care needs in an easily navigable environment. Many of these same characteristics helped attract practitioners to hospital practice and fueled the growth of hospital medicine as a specialty.

**Conclusion**

Literature reporting on increased patient satisfaction and lower hospitalization rates in nursing homes that employ nurse practitioners and physician assistants have not considered physician involvement as a moderating variable (32). Physician care positively influences residents’ hospitalization rates, functional status, and satisfaction (33–35). Marginal physician involvement impedes communication and integration of the physician into the nursing home culture, with detrimental patient outcomes (36–38). We contend that rather than accepting a diminished presence of physicians in nursing homes and finding alternative care models, it is time to fully consider, appropriately fund, and test the nursing home specialist model (39, 40). If nearly half of the baby boomers spend some time in a nursing home, the question “Is there a doctor in the house?” will take on new urgency and meaning.

From the University of Rochester School of Medicine and Dentistry, Rochester, and State University of New York at Buffalo, Buffalo, New York; and Brown University, Providence, Rhode Island.
Grant Support: Dr. Katz was supported by the National Institute on Aging (grant R21 AG025246).

Potential Financial Conflicts of Interest: Consultancies: P.R. Katz (Omicare Pharmacy and Therapeutics Committee board member).

Requests for Single Reprints: Paul R. Katz, MD, University of Rochester School of Medicine and Dentistry, 435 East Henrietta Road, Rochester, NY 14620; e-mail, Paul_Katz@urmc.rochester.edu.

Current author addresses are available at www.annals.org.

References


Current Author Addresses: Drs. Katz and Karuza: University of Rochester School of Medicine and Dentistry, 435 East Henrietta Road, Rochester, NY 14620.

Drs. Intrator and Mor: Brown University, 164 Angell Street, Providence, RI 02912.