The Administrator-Medical Director Connection.

Sandeep Patel, MD, CMD

Associate Chief Medical Officer

A bit of history…

- 1974--in response to identified quality of care problems, Medicare regulations first required a physician to serve as medical director in skilled nursing facilities and ***to be responsible for the medical care provided in those facilities***.
- 1987--passage of the Nursing Home Reform Act.
- 1991--approved the role and responsibilities of the medical director in the nursing home.
- Nationwide, nursing facility care has been changing over the last 15 years from primarily long-term care of frail elders to complicated and resource-intensive post-hospital care.
- The population of people receiving care in nursing facilities is more medically complex as patients are discharged ‘sicker and quicker’ from the hospital to skilled nursing facilities.
- The majority of patients who are long-term stay patients have also had increased complexity and acuity.
- ***These changes have resulted in an increased need for highly trained, committed and available health care practitioners willing to provide care on-site to nursing facility residents and for competent medical directors to facilitate that level of care.***

CMS statute

§483.70(h) Medical director.

- §483.70(h)(1) The facility must designate a physician to serve as medical director.
- §483.70(h)(2) The medical director is responsible for—
  1. Implementation of resident care policies; and
  2. The coordination of medical care in the facility.

GUIDANCE §483.70(h)

- If the medical director does not hold a valid license to practice in the State where the nursing home is located refer to F839 - §483.70(f) Staff qualifications. The facility must designate a physician to serve as medical director.
- The facility must identify how the medical director will fulfill his/her responsibilities to effectively implement resident care policies and coordinate medical care for residents in the facility.
  - This may be included in the medical director's job description or through a separate facility policy.
  - Facilities and medical directors have flexibility on how all the duties will be performed.
  - However, the facility must ensure all responsibilities of the medical director are effectively performed, regardless of how the task is accomplished or the technology used, to ensure residents attain or maintain their highest practicable physical, mental, and psychosocial well-being.
- ***The medical director's responsibilities require that he/she be knowledgeable about current professional standards of practice in caring for long term care residents, and about how to coordinate and oversee other practitioners.***

Medical Director ≠ Attending Physician

Where do we fit in?

- It is relatively easier for the DON and administrator to have a firm working relationship.
- Medical directors are sometimes viewed as the “outsider” or “newcomer.”
- Is there a full understanding of what a competent medical director can offer beyond just satisfying the CMS requirement and signing critical paperwork?

More than a regulatory checkbox…

- No ones' role is more important that the others'
- Medical directorship should be a value-added proposition

NEWS | VOLUME 24, ISSUE 7, P1, OCTOBER 2023 Download Full Issue

Critical Shortage of Nursing Home Medical Directors: What Can Be Done to Solve the Staffing Crisis?

By Victoria Walker, MD, CMD

DOI: https://doi.org/10.1016/j.carage.2023.08.022

- Medical director roles typically require only a handful of hours each month, yet physicians who are willing and able to make the commitment are hard to find.
- Being a medical director is not high on the list of career goals for young physicians and It is not among the highest paying specialties.
- Nursing homes, especially those located in remote rural areas where there is extensive travel involved, do not always feel like the most attractive practice locations for new graduates.
- It takes time — sometimes many years of clinical practice — for physicians to realize how rewarding this type of work can be.
- Many medical directors do not take on the role until much later in their careers, which shortens their window of time to make a difference for nursing home residents.
- What can we do to encourage more physicians to support high-quality nursing home care earlier in their careers?

Some key questions to ask yourselves about your medical director…

- Do they have a firm understanding of the PALTC space?
  - ✓ Do they understand the needs of this specific patient population?
  - ✓ Do they keep up with the latest trends, news, updates in the industry?
  - ✓ Do they understand the dynamics of a SNF?
  - ✓ Are they a CMD? If not, are they working towards it?

- Are they knowledgeable with regards to the roles, functions, and tasks as outlined by PALTmed (Post-Acute and Long-Term Care Medical Association, formerly AMDA)?

- Can they work in a team dynamic?

- Can they truly devote the time needed to drive care quality?

- Do they understand the pressures YOU (as individuals and as facilities) are under?
  - ✓ Financial
  - ✓ QMs/Star ratings
  - ✓ Survey

- Are they able to actively participate in and help guide QAPI processes?

Framework of the 4 key roles…

- Role 1—Physician Leadership--The medical director serves as the physician responsible for the overall care and clinical practice carried out at the facility.
- Role 2—Patient Care-Clinical Leadership--The medical director applies clinical and administrative skills to guide the facility in providing care.
- Role 3—Quality of Care--The medical director helps the facility develop and manage both quality and safety initiatives, including risk management.
- Role 4—Education, Information, and Communication--The medical director provides information that helps others (including facility staff, practitioners, and those in the community) understand and provide care.

The functions…

- There are basic, universally relevant functions that are embedded in the overarching roles.
- The functions represent the foundation for developing the individual medical director's tasks. The relevance and nature of some tasks may vary.

- Function 1—Administrative
  The medical director participates in administrative decision making and recommends and approves relevant policies and procedures.
- Function 2—Professional Services
  The medical director organizes and coordinates physician services and the services provided by other professionals as they relate to patient care.
- Function 3—Quality Assurance and Performance Improvement
  The medical director participates in the process to ensure the quality of medical care and medically related care, including whether it is effective, efficient, safe, timely, patient-centered, and equitable.
- Function 4—Education
  The medical director participates in developing and disseminating key information and education.
- Function 5—Employee Health
  The medical director participates in the surveillance and promotion of employee health, safety, and welfare.
- Function 6—Community
  The medical director helps articulate the long-term care facility's mission to the community.
- Function 7—Rights of Individuals
  The medical director participates in establishing policies and procedures for assuring that the rights of individuals (patients, staff, practitioners, and community) are respected.
- Function 8—Social, Regulatory, Political, and Economic Factors
  The medical director acquires and applies knowledge of social, regulatory, political, and economic factors that relate to patient care and related services.
- Function 9—Person-Directed Care
  The medical director supports and promotes person-directed care.

The tasks…

- The tasks are listed as they relate to the nine functions and are divided into two tiers.
- ***Tier 1***—essential, universally applicable tasks
- ***Tier 2***—tasks that may vary with the individual's situation, availability, facility needs, and so on.

Medical director presence and time in U.S. nursing homes, 2017-2023

Conclusions: Though medical directors have a critical role in overseeing clinical care, some nursing homes report no medical director time and those that do report about 4 h per week. Together, these findings may indicate the need for improvement. More research is needed to understand these variations and the extent to which medical director regulations are being followed by nursing homes and enforced by regulators.

Goldwein EL, Mollot RJ, Dellefield ME, Wasserman MR, Harrington CA. Medical director presence and time in U.S. nursing homes, 2017-2023. J Am Geriatr Soc. 2024 Sep 2. doi: 10.1111/jgs.19161.

Impact of Medical Director Certification on Nursing Home Quality of Care

- Conclusions: The presence of certified medical directors (CMDs) is an independent predictor of quality in US nursing homes.

J Am Med Dir Assoc 2009; 10: 431–435

QAPI…the defining process that optimizes outcomes for all

QAPI

First announced in the 1980s

The ACA (2016) required all SNFs develop QAPI programs as part of the requirements of participation.

Definition

- QAPI is the merger of two approaches to quality management:
- Quality Assurance **(QA)** Performance Improvement **(PI)**
- Both concepts are data-driven: They seek and use information to improve health-care delivery
- **QA** = Process of meeting Quality standards and assuring that patient care reaches acceptable levels
- **PI** = Making "good" Quality even "better" by setting goals, measuring outcomes and improving systems, processes and efficiencies

Why is QAPI Important?

1. Solid QAPI processes impact facility star ratings.
2. Solid QAPI processes improve metrics (monthly CASPER/iQIES reports).
3. Improve Patient/Resident Outcomes.
4. Enhance Residents' Quality-of-Life.

QAPI Frustrations

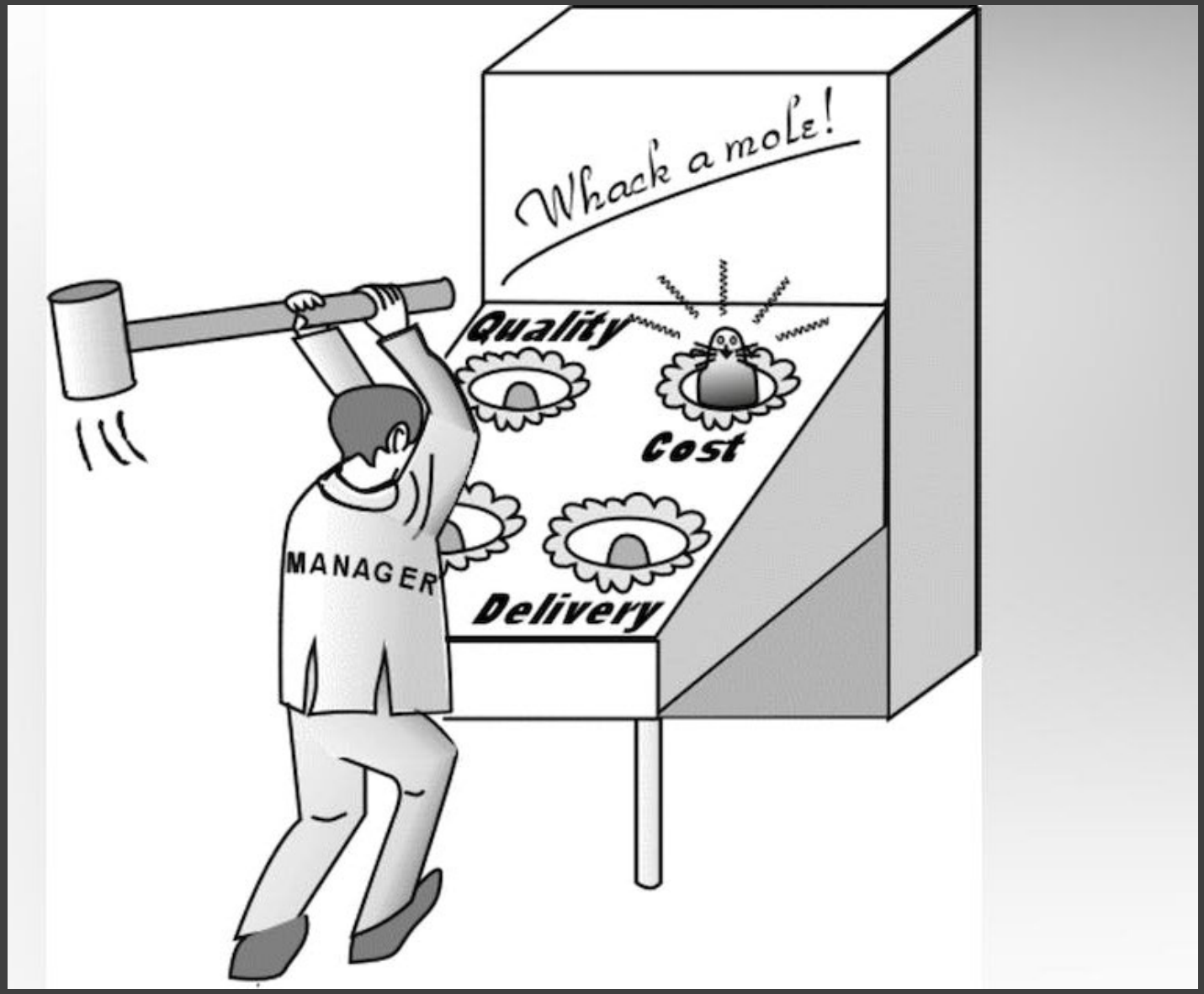
- Vomiting data for “corporate” purposes
- Reading off slides/”next slide”
- Lack of preparation
- “Education/in-service” as an answer for everything…
  - ➢ and repeating that same “education/in-service” over and over and over again yet the same problem persists month after month.

We have too many falls this month.

We're higher than the state average.

We're below the threshold.

These have no bearing on current processes



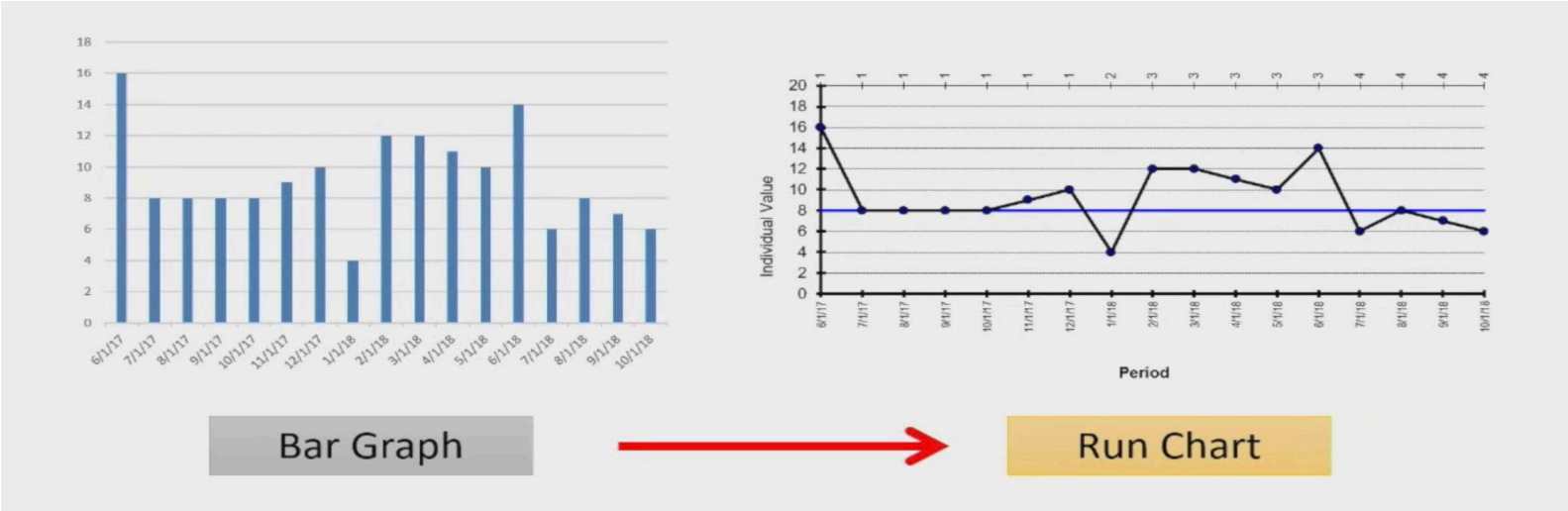
What is the goal/target?

Are we trying to reduce/increase the number of [metric]?

OR

Are we trying to improve the process that produced [metric] in the first place?

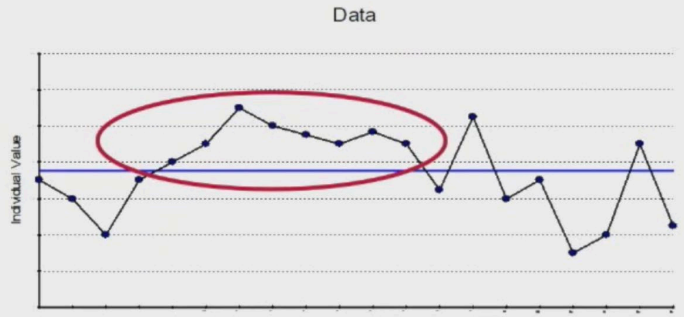
Let’s switch from an inappropriate graphical display to an appropriate display….



Is there a trend to this data?

Clump of 8 (process shift)

A run of 8 consecutive points either all above or all below the median *(based in theory)*



QAPI…a focus on outcomes-centered healthcare

- ✓ View the medical director as a leader for the facility.
- ✓ Their involvement in the QAPI process is vital to achieve both:
  - ➢ Clinical patient outcomes … which lead to…
  - ➢ …Financial outcomes for the facility and for the healthcare system.
- ✓ Knowing the key metrics and analyzing root-cause of any deviations from goals is vital to ensure high-quality care.
- ✓ Hold the medical director and your own staff accountable to set targets/goals.
- ✓ *QAPI is a continuous PROCESS and NOT a discrete meeting.*

A brief word on QMs…the final output of solid QAPI processes.

Quality Measures (QM)

DEFINITION

Quality measures are **standards for measuring the performance of healthcare providers to care for patients and populations**.

Quality measures can identify important aspects of care like safety, effectiveness, timeliness, and fairness.

Purpose of Quality Measures

Nursing home quality measures have some intended purposes:

1. To give you information about the quality of care at nursing homes in order to help you choose a nursing home for yourself or others.
2. To give you information about the care at nursing homes where you or family members already live.
3. To give you information to facilitate your discussions with the nursing home staff regarding the quality of care.
4. To give data to the nursing home to help them in their quality improvement efforts.
5. *KNOW THE EXCLUSIONS AND CLINICALLY-APPROPRIATE INDICATIONS!*
6. *ALL members of the QAPI team are responsible towards the QM star rating!*


Some myths to
contemplate…

- Any physician can be a medical director.
- All physicians and APPs know how to care for patients in SNFs.
- Any physician with an outpatient practice can serve as medical director.
- Aligning with the local family doctor with an office practice will improve referrals.
- At a moment’s notice, a medical director is replaceable.
- Any adverse clinical outcome is solely on the medical team/medical director.

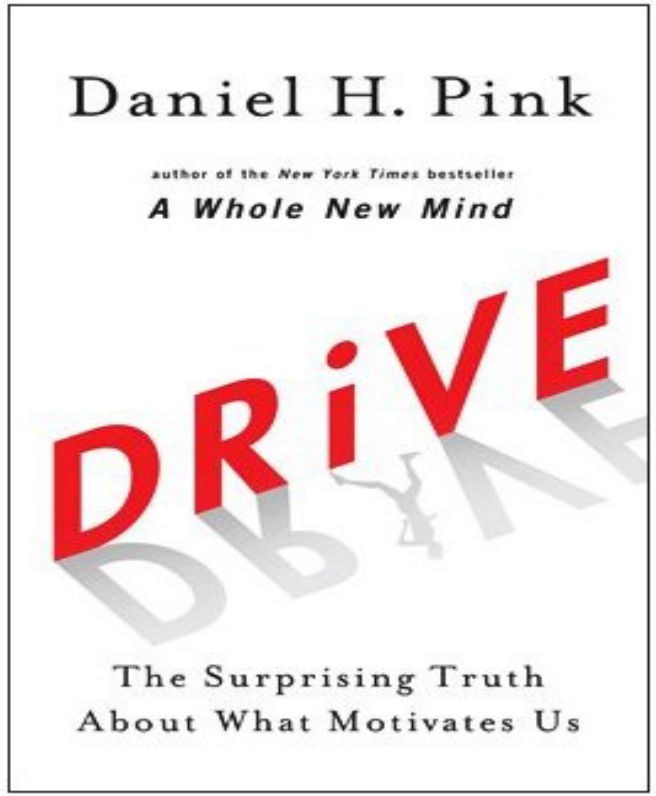
BUILD A CULTURE!

Promote intrinsic motivation…

Autonomy

Mastery

Purpose



Why is 2030 so important?

Hint: Value-based care

Understanding Value Based Care/Outcomes Centered Care

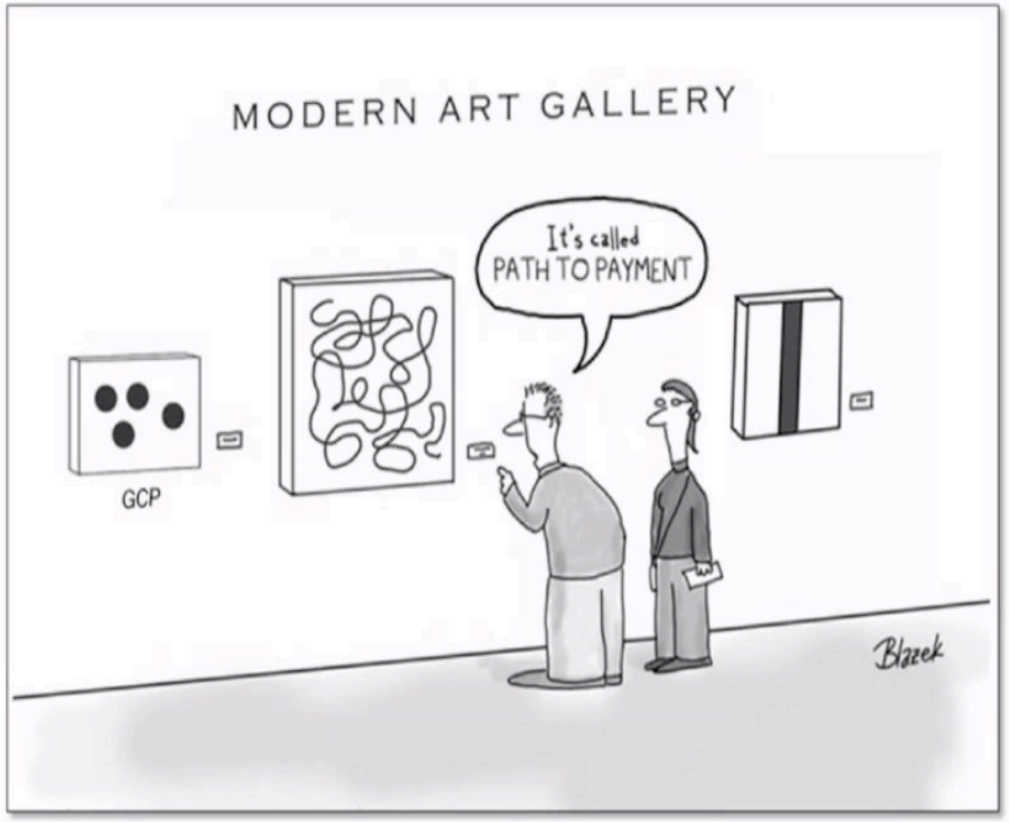
Cathy Parker, NP

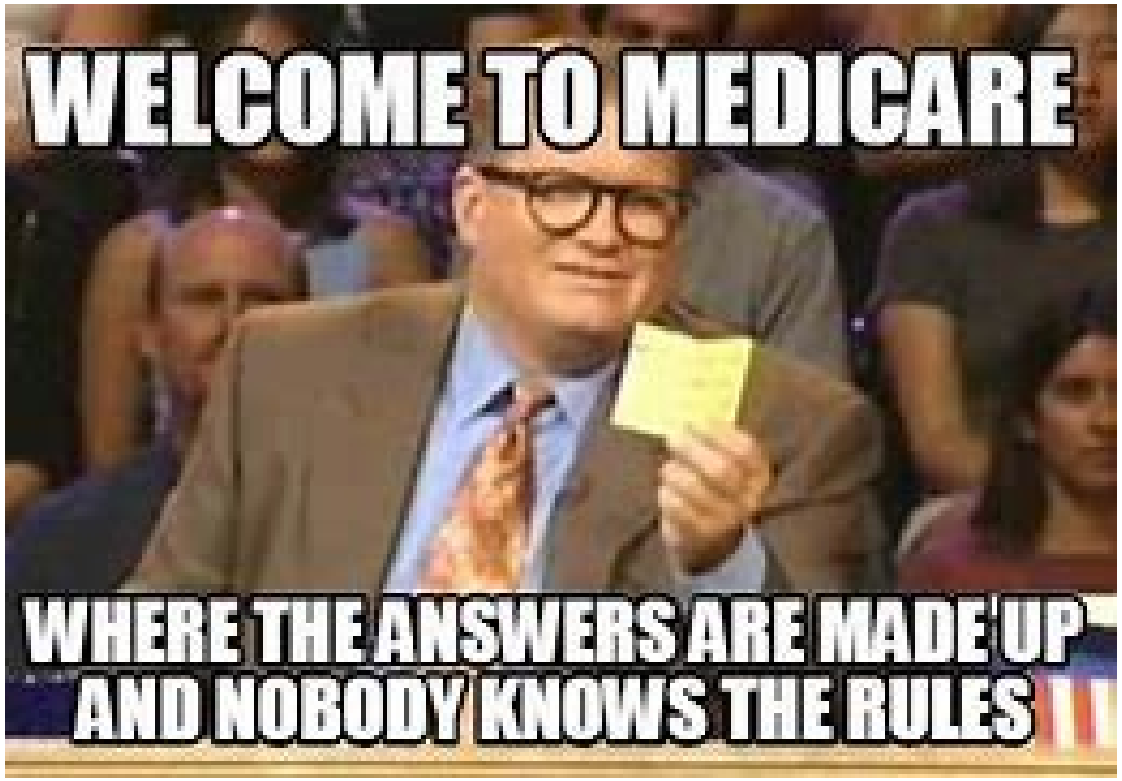
VP of OCH Success

Learning Objectives

By the end of the presentation, participants will be able to:

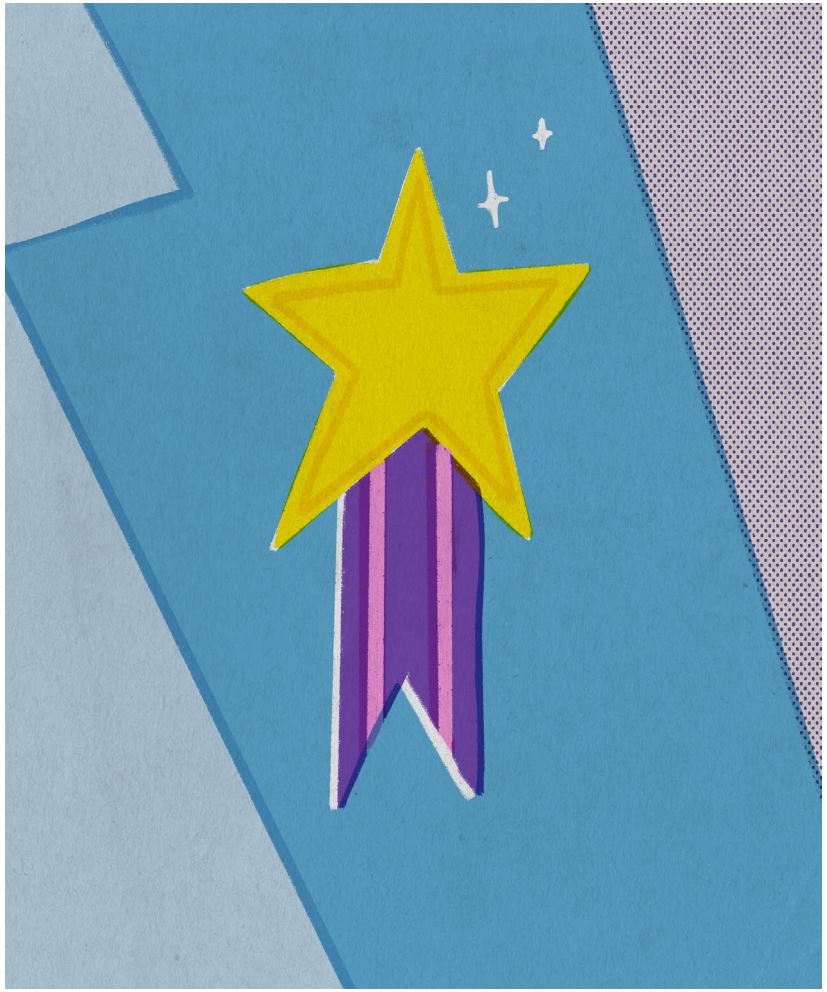
- Define value-based care and its specific relevance in LTC settings
- Describe the impact of value-based care on a PALTC practice
- Identify unique actions YOU can take to optimize patient outcomes and reduce cost to the healthcare system.


MODERN ART GALLERY
It's called
PATH TO PAYMENT
GCP
Blazek


WELCOME TO MEDICARE
WHERE THE ANSWERS ARE MADE UP
AND NOBODY KNOWS THE RULES

The Why Behind Value Based Care

- Health care costs have skyrocketed. Prior payment model was fee for service: reimbursement for services provided- this includes provider visits, diagnostics, hospitalization
- This fee for service model incentivizes use of services, and has driven our health care costs out of control
- CMS determined the best way to curb these costs is to create a new model of care as a strategy to reform how health care is delivered and funded
- Value Based Programs reward health care providers with incentive payments for the quality of care they give to people with Medicare



Outcomes Centered Healthcare vs. Value Based Care

- CMS uses the term “Value Based Care” to identify specific programs it offers designed to reward providers who focus on quality and cost of care rather than volume of care.
- Eventus has always been aligned with this mission and has consistently focused on the outcomes of care as an indicator of our success. To this end, we choose to use the term “Outcomes Centered Healthcare” as a reminder of our commitment to our patients.

Key Takeaway Points About VBC/OCH

- Fee for service pays for quantity of visits

- Value based care incentivizes quality of care

- By 2030 all Medicare beneficiaries have to be aligned to some kind of VBC platform

Abbreviations

- VBC – Value Based Care
- ACO – Accountable Care Organization
- MSSP – Medicare Shared Savings Program, a permanent program
- ACO REACH - An ACO demonstration project by CMMI with a greater focus on equity and community healthy initiatives and more advanced payment models (expires 12/31/2026)
- ISNP – Institutional Special Needs Plan and type of Medicare Advantage plan for long term care and long term care equivalents
- MLR – Medical Loss Ratio – financial metric that measures how much of an insurance premium is spent on medical claims and quality improvement
- PMPM or PBPM – Per Member Per Month or Per Beneficiary Per Month – Dollar Amount allotted per patient
- SS – Shared Savings – payment strategy that offers providers a percentage of net savings when healthcare spending is reduced and quality requirements are satisfied
- Attribution/Alignment/Assignment – Terms used interchangeably to describe CMS's process to identify Medicare beneficiaries who have received the bulk of their primary care from an ACO participating practitioner during a specific year
- Benchmark – CMS's total cost of care target that measures an ACO's financial performance

Definitions

ACO : accountable care organization- groups of doctors hospitals and other HC providers who come together voluntarily to give coordinated high quality care to the Medicare patients they serve.

MSSP: Medicare Shared Savings program -groups of health care providers who come together to give coordinated high quality care to Medicare patients , focusing on delivering the right care at the right time while avoiding unnecessary services and medical errors. When the ACO succeeds in both delivering high quality care and spending health care dollars wisely, they may be eligible to share in the savings it achieves for the Medicare Program.

SNP plans: a Medicare advantage coordinated care plan specifically designed to provide targeted care and limit enrollment to special needs individuals . Special needs could be any of the following:

- Institutionalized individual
- Dual eligible
- Individual with a severe or disabling chronic condition as specified by CMS
- And I SNP is an institutional SNP

ACO REACH: Accountable care organization Realizing Equity, Access, and community health model. Purpose is to encourage health care providers to coordinate care to improve the care offered to people with Medicare, especially those from underserved communities.

MSSP ACO overview

ACO is an **A**ccountable **C**are **O**rganization

MSSPs contract with Medicare to help care for eligible residents in long-term care.

- Only patients in AL and SNF

Eventus has entered a contract with the LTC ACO (an MSSP) since 2021

- ❑ An ACO is a type of Value-Based Care (VBC) platform
- ❑ Goal of the ACO is to provide fiscally responsible quality care
- ❑ All Medicare beneficiaries will be aligned to some type of VBC platform by 2030.

How Does This Actually Work

- CMS establishes a “benchmark” or target amount of Medicare spend per member per month (PMPM)
- Benchmark for LTC ACO is approximately $2477- includes breast cancer screening, diagnostics, labs, therapy, hospice care and provider visits
- CMS established quality metrics for ACO: BP control, DM control and depression screening
- Shared savings are generated if quality measures are met and cost of care is under the benchmark

How are patients assigned to an MSSP ACO?

- Patients are eligible based on their insurance payor- if they have traditional Medicare
- Patients are assigned based on primary care provider participation
- Patients are “attributed” or “eligibility is turned on” when an ACO credentialed physician sees the patient for the first time in the calendar year
- Whoever bills Medicare the most in the calendar year gets “plurality” of the patient; if we are outbilled, the ACO patient does not count

How Are Patients Enrolled in an ISNP?

- Patients/POA must sign resident up-Reassign Medicare to the alternative ISNP insurance plan
- Optum- outside representative markets to residents
- Facilities with ISNPs will be marketing to their residents/families to enroll patients
- May or may not involve a provider change

- Provider groups, facilities or corporations can create their own ISNP or partner with a managing ISNP organization (Longevity, PPHP)
- ISNPs are an insurance plan and requires a network of providers that agree to be "in the network"
- Requires up front capital
- Has risk associated with participation, however could yield a bigger return in the end

ACO REACH / Voluntary Alignment

Press release

CMS Redesigns Accountable Care Organization Model to Provide Better Care for People with Traditional Medicare

Feb 24, 2022 | Innovation models, Medicare Parts A & B

Share

Building on the Biden-Harris Administration's priorities for a better health care system, today the Centers for Medicare & Medicaid Services (CMS) announced a redesigned Accountable Care Organization (ACO) model that better reflects the agency's vision of creating a health system that achieves equitable outcomes through high quality, affordable, person-centered care. The ACO Realizing Equity, Access, and Community Health (REACH) Model, a redesign of the Global and Professional Direct Contracting (GPDC) Model, addresses stakeholder feedback, participant experience, and Administration priorities, including CMS' commitment to advancing health equity.

Related Releases

Medicare Shared Savings Program Saves Medicare More Than $1.6 Billion in 2021 and Continues to Deliver High-quality Care
Aug 30, 2022

Biden Administration Announces New Model to Improve Cancer Care for Medicare Patients
Jun 27, 2022

Enhancing Oncology Model
Jun 27, 2022

Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH)

WHAT IT MEANS FOR
Medicare Medicaid Recipients

- This is about traditional Medicare/Medicaid. It is not a Medicare Advantage Plan

- CMS wants improvements in the quality of care and expanded access to high quality care.

- For a resident/patient to participate they need to make a commitment to a provider who is enrolled in the CMS program

- Unlike Medicare Advantage Plans, nothing changes for the patient in terms of things common to Medicare advantage plans such as “capitation” on various benefits.

Quality Measures

REDUCE COST

Hospital Admissions/re-admissions and ER visits

- 80% of hospital admissions come through the ER
- 33% of all ER visits result in an admission (medicare national average)
- A reduction of as few as 50 hospital admissions can reduce healthcare costs by $1.2 million

SITUATION OVERVIEW

- **IMPROVE QUALITY**
- Care coordination
- Provider Integration
- Home Health/Hospice Utilization
- Advanced Care Planning
- Therapy Services
- Specialist Referrals
- Closing “Gaps”
- Enhanced provider oversight

How to Drive Outcomes

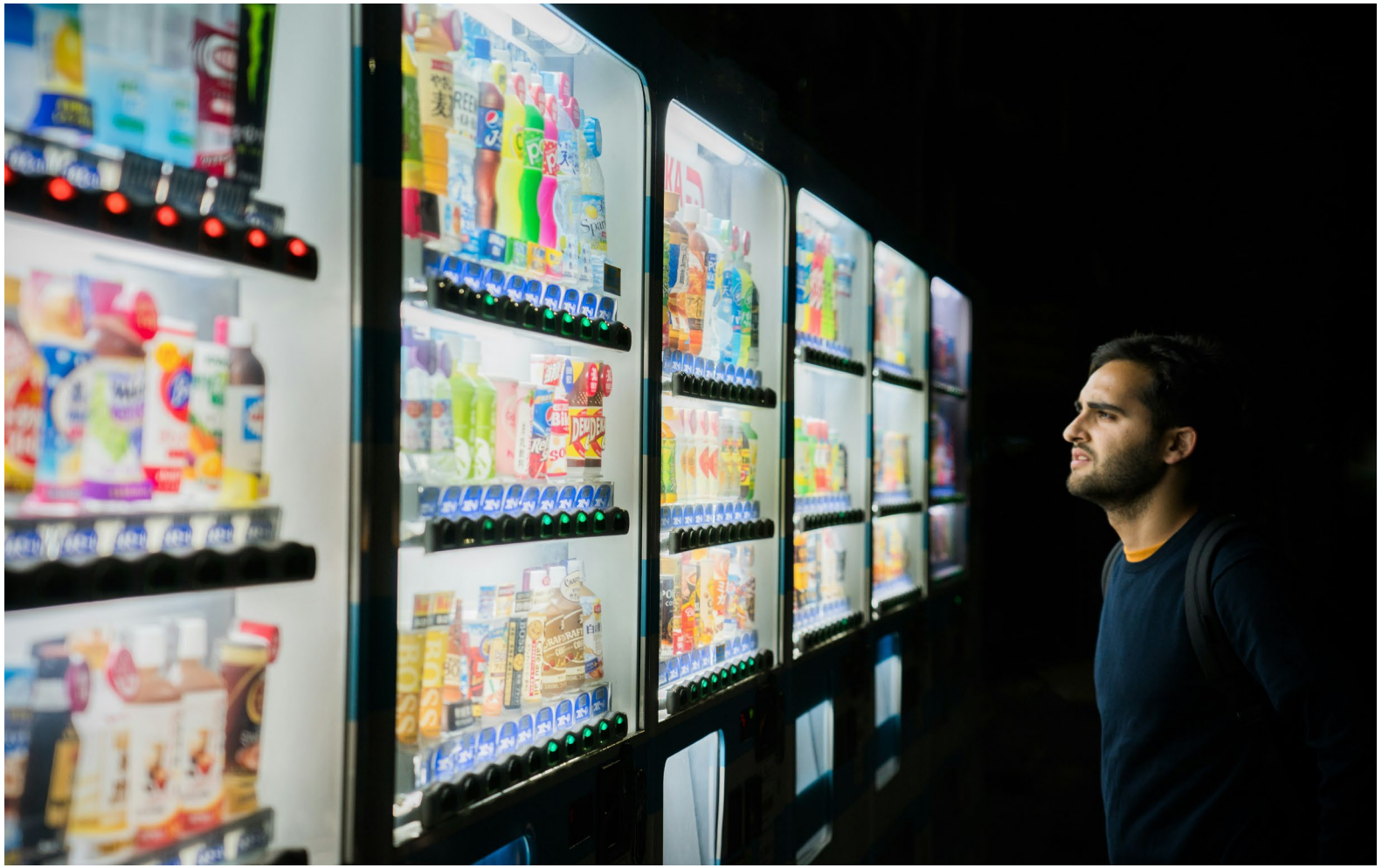
- ACO Physician visits completed by end of April
- Ensuring plurality- not switching to another insurance or provider, meeting physician visit/seeing resident for QM before discharging or passing away, integrated services
- Integrated Services-data shows 11-15% more shared savings when we have PCP and MH
- Proactive model of care-catching things early to minimize send outs
- Minimizing duplication of procedures, labs, diagnostics, visits
- Complete Annual Wellness Visit and list all historical and active diagnoses to capture complexity of patient
- Complete Advanced Care Planning discussion annually
- Refer to Palliative care vs Hospice when appropriate and have collaborative discussion prior to hospice consult
- Be Proactive with changes in condition to minimize ER transfers
- Timely follow up after stat orders, IV Fluids, abnormal labs and changes in condition, or ER transfers and hospitalizations
- Look at root cause of ER transfers and admissions
- Refer to specialists and therapy when truly necessary
- Monthly review of ACO data
- A way to track quality measures
- Openness to adjustment along the way
- Teamwork – between providers and facilities to minimize hospital send outs

Psychology around perception of “hospital” for patients

- ❑It is the safest place to be when they are sick.
- ❑The ER knows more than the primary care team.
- ❑The family feels that the hospital staff knows how to manage acute issues better than the facility team.
- ❑They feel they are not getting what they want, when they want it.
- ❑Mistrust of facility staff.

- ***Potentially avoidable hospital transfers among dual-eligibles in LTC cost Medicare upward***s of $3 bil

Facilities Should be Broad Not Exclusive



- Because facilities can be partnered with a number of provider groups who participate in multiple VBC programs, it is important to understand various offerings, such as:
- MSSP (ACO)
- ACO REACH – specific to high-needs populations
- ISNP – Institutional Special Needs Plans
- Medicare Advantage Plans

Q&A Period