Incentivizing Nursing Home Quality and Physician Performance

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*Nursing homes (NHs) are under increasing pressure to accurately gauge and improve the quality of care they provide to their residents. Higher patient acuity, demand from consumers and policy-makers, and media reports of inadequate care are providing the impetus for change. In response to these pressures, researchers are devising more appropriate indicators of quality. States are creating innovative financial models to reward the delivery of higher quality care, and the American Medical Directors Association (AMDA) is developing strategies to better gauge the performance of NH physicians and medical directors. The interplay of these factors not only has provided new opportunities to impact approaches to quality measurement in the NH but also has rejuvenated interest in measuring the impact of physician performance on NH quality. In this article, we highlight the efforts of one state that is in process of implementing an incentivized model for high-quality care that includes physician certification in the model. We end by offering potential solutions to enhancing physician involvement in NH affairs and weaving physician performance into these evolving models.

Health care systems are complex adaptive systems that are resistant to change. It comes as no surprise then that the overall impact of pay for performance (P4P) systems on quality of care in various venues has, to date, been questionable. Under a P4P system, provider payments are determined, at least in part, by their performance on standardized measures of care quality. In theory, the idea is that providers will strive for high-quality care if better performance is rewarded with proportionately higher payments. Various barriers have been encountered in implementing P4P systems. It has been difficult finding accurate measures of performance, convincing providers to participate, structuring effective incentives, and changing provider behavior. Despite these barriers, as well as limited experience with P4P systems in NHs, the NH environment would seem to lend itself to potential P4P successes. Characteristics that are potentially aligned with P4P include care delivery in a single setting under controlled conditions, a relatively simple organizational structure, standardized data collection tools (e.g., the minimum data set) that provide abundant data on clinical quality, and state government positioned to lead quality improvement given Medicaid’s market power and regulatory responsibilities. Since 2002, at least 7 states (Iowa, Indiana, Georgia, Kansas, Minnesota, Ohio, and Oklahoma) have implemented P4P programs. These programs have had a short history with limited evaluation results.

Our experience in Indiana can shed light on issues of NH P4P. Indiana’s Nursing Home Value-based Purchasing system currently relies on a single performance measure, the Indiana Nursing Home Report Card, which scores facilities based on the scope and severity quality of care deficiencies cited through the regulatory process. It rewards facilities with incentive payments based on their Report Card scores. The NH industry and other stakeholders have called for a broader set of performance measures that give a more comprehensive picture of care quality. In January 2010, the Indiana Division on Aging assembled a clinical expert panel (CEP) to study and make recommendations for an expanded set of measures. The CEP brought a diverse group of stakeholders to the table including representatives of the state health department, a geriatrician representing the Indiana Medical Directors Association (author A.N.), an academic researcher experienced in NH P4P systems (author G.A.), leaders from for-profit and non-profit NH trade associations, NH administrators and directors of nursing, a state ombudsman, and representatives from advocacy organizations. The CEP studied several measures for inclusion in the scorecard such as nursing hours per resident day, nursing staff retention and turnover, administrator and director of nursing turnover, and surveys of resident quality of life, family satisfaction, and nursing facility staff satisfaction. The CEP collected data on the retention and turnover measures and found them to be significantly correlated with the Nursing Home Report Card score. Importantly, the panel also recognized the critical importance of physician performance in NH quality and considered that it should be represented as a scorecard domain if at all possible. Given the novelty and limited evidence-base for including physician performance as a scorecard measure, the panel recommended that for the time being the scorecard should focus on Medical Director Certifications using 2 measures: certification in geriatrics and certification in medical directorship through the AMDA CMD program. The measures would receive relatively little weight in the beginning; however, the CEP recommended further study of other measures to assess medical director engagement and performance. Also, the CEP thought that attending physicians were of utmost importance in the quality of NH care and that measures of their performance should be studied. The final CEP report has...
been made available for public and stakeholder comments. In order to lay the groundwork for new measures, the authors are partnering with the Indiana State Department of Health on a survey of NH administrators, medical directors, and attending physicians to describe their roles and relationships and to see how the state and the local AMDA chapter, with the help of AMDA, might assist them in becoming more effective.

This idea of incentivizing physician involvement and qualification appears rational and timely. Rising NH patient complexity is making it harder to omit physicians from the quality equation, and literature is finally emerging that is stressing the impact of physician factors on NH quality. Most notably, a recent study suggests that facilities with medical directors who are certified by the AMDA Certified Medical Director (CMD) program perform better. This comes as no surprise as the CMD curriculum teaches effective management, communication, and leadership skills that are crucial but for which physician leaders are not formally trained. Available research also points to better delivery of quality care for facilities that use the “closed” physician staffing models (only select, credentialed physicians can provide clinical care in the facility). In the same context, research has shown that higher performance on certifications in internal medicine (IM) and family practice (FP) specialties lead to better utilization and patient outcomes. This is relevant as IM and FP specialists most commonly serve as NH medical directors.

One may ask why physician performance has so far eluded NH scorecards. For example, in the National Quality Forum’s recently released set of recommended NH quality measures, there are no direct measures of medical director performance or attending physician care. Even in the regulatory process, surveys seem to be gun-shy when confronting facilities for the lack of medical director involvement. As an example, Indiana surveyors cited the survey F tag 501 (tag cited in conjunction with other care-related tags when medical director involvement is found lacking to resolve the care issue) only twice in 2009–2010. One explanation might be that regulators and the industry in general have been reluctant to implement or support systems that place physicians “on the spot” or scrutinize them. Facilities and states may be reluctant to challenge their medical directors because society generally holds physicians in high esteem and tends to give them the benefit of the doubt about their competence and credibility just by virtue of being a physician. Other possible reasons include lack of knowledge regarding the specific medical director roles, fear (true or unfounded) of losing the medical director, and lack of convincing evidence that physician incentives will actually impact quality of care. A recent review regarding the impact of P4P on health care points to the faulty design of the incentive programs for this lack of evidence. It suggests that for such incentives to work, they should not be unilateral, small-scale bonus arrangements, which precisely are the characteristics of most recent pay-for-performance programs in the U.S. health sector.

AMDA leadership is also supportive of measuring and enhancing physician performance in NHs. Dr. Levenson in his recent 5-article treatise on reforming NH health argues that “improving overall care requires optimizing performance of those who provide care.” Others have proposed the creation of an NH “specialty” that would promote more training and knowledge by physicians in this field. Physician commitment, physician competencies, and structure of the medical staff organization have been proposed as a framework for such a specialty. It is argued that a specialty with specific competencies will bring credibility to the physicians already providing excellent care, help these physicians champion transitional care issues, and help with recruitment and retention of NH attending physicians. AMDA recently convened a task force to address competencies for NH physicians. These competencies will not only help define best practices for NH physician but will also act as a tool to assess their performance.

Including physicians on quality scorecards and addressing competencies are steps in the right direction, yet we need to approach this issue with careful planning and sensitivity. Physicians may consider performance assessment as too “paternalistic” as evidenced by the experience in Maryland, where in 2000, the Maryland State Legislature approved a package of legislation creating requirements for attending physicians and medical directors in Maryland NHs. Physicians perceived the effort as the “state dictating medical care of the residents.” Learning from this experience, it will be crucial that before physician accountability systems are mandated, states commit to supporting physician and medical director education. Our recent survey of NH providers and work with the CEP members have been informative. Medical directors and NH administrators appear oftentimes to be ambiguous about their roles and responsibilities. It is important to obtain the views of all key actors, including direct communication with medical directors and attending physicians. Unfortunately, the lack of an accurate and updated database of current NH providers and medical directors presented a huge barrier. Second, we have little information regarding the demographic profiles of this group of physicians and limited insight into their educational needs, preferred educational formats, and confidence in their roles or their expectations from the facility leadership and the state. Previous surveys provide limited insights; however, they may not be applicable to the individual states nor representative of physicians serving as medical directors, the majority of whom are not AMDA members. Efforts driven solely by AMDA may not be successful in reaching and impacting the majority of medical directors or attending physicians.

Innovative and locally sensitive solutions will be required to overcome these barriers, as NHs function as complex adaptive systems (CASs). As opposed to the traditional conceptual models that portray the health care system as a machine with replaceable parts and predictable behaviors that can be changed and reproduced based on past performance data, this theory asserts that health care organizations are composed of semiautonomous individuals who interact constantly in a nonlinear way. These individuals are constantly faced with and respond to external and internal stressors such as patients’ medical status, insurance requirements, regulations, new research findings, members’ turnover, and legal issues. Attempts to rigidly control these CASs often worsen the targeted problems and lead to unintended negative consequences. Recent research recommends the reflective adaptive process as a systematic process to induce a change in a CAS. This systematic process proposes that stakeholders (1) share a common mission and vision, (2) create time and space to meet regularly, (3) manage conflict and tensions in a controlled way, and (4) encourage different perspectives and that these efforts be supported by all area leaders. Various chronic care models have already shared their successes in implementing a sustainable change by following these steps.

We propose that states use the lens of the CAS and reflective adaptive process to introduce any changes seeking effective and enhanced physician involvement in their facilities. A reasonable approach would be for the state, facility, and physician leadership to come together and affirm a common mission and vision and then create opportunities to meet regularly. These meetings should provide opportunities to share perspectives in nonthreatening ways, resolve conflicts, and chalk out the next steps. The local AMDA chapters are well-suited to function as the facilitators. While the state would help by keeping an active database of the names and contacts of the NH physicians and directors, the group would construct a locally sensitive needs-assessment tool to sample the profiles of the physicians and their needs. Equipped with this
information and with guidance from AMDA leadership, the group would plan local educational seminars. These seminars would bring physicians and NH leadership to the same table and be modeled after the AMDA CMD program. The CMD program uses a fine combination of didactics, role-playing, and hands-on training sessions to impart crucial medical director skills to AMDA physician members. After the course concludes, participants are encouraged to engage in quality improvement initiatives in their own facilities and document and share their progress at regular intervals. Thus, these seminars will not only provide competency knowledge for NH physicians but also equip them with quality improvement skills and foster partnership and collaboration with the facility administration. Physician participation in such seminars and success in collaborative QI projects then would be tied to rewards for the facilities that these physicians staff as attendings and medical directors. It is only after the state has succeeded in connecting with and providing resources to the NH physicians that the physician pay-for-performance models be implemented.

Current literature provides limited insight into which outcomes might relate to individual physician performance and a detailed discussion about such measures is beyond the scope of this report. A recent study was able to link a measure of NH medical staff organization to some of the federally mandated NH quality indicators. These measures included restraint use, pneumococcal vaccination rates, and the prevalence of pain, pressure ulcers, and catheter use. Other potential indicators that possibly could help define individual NH physician performances include the appropriate use of antipsychotics, avoidable re-hospitalization rates, and patient-centered transitional care outcomes. Ongoing research and the work of the AMDA’s Competency Workgroup will be very helpful in further defining NH physician performance indicators.

The NH industry is moving toward more accurate and comprehensive measurement of its services so that valid strategies for rewarding higher quality can be implemented. The performance of NH physicians impacts quality but accurate measurement remains elusive. While researchers and AMDA leaders devise valid physician competencies and measures, and local governing bodies contemplate more regulations relating to these measures, it is crucial that locally sensitive solutions be sought to vitalize NH physician and facility collaboration and physician empowerment for higher quality care.

References