Medical Direction and Medical Care in Nursing Homes
Education, Training, and Technical Assistance (ETTA)

Why Do We Need These Guidelines?

Nationwide, nursing facility care has changed to include not only long-term care of frail residents, but also complicated and resource-intensive post-hospital services. The population of people receiving care in nursing facilities is more medically complex as patients are discharged “sicker and quicker” from hospitals to skilled nursing facilities and the focus is on decreasing unnecessary readmissions and costs. Moreover, the majority of nursing home residents are there for a long-term stay and are characterized by increased medical complexity and acuity. These facts have resulted in an increased need for highly-trained and committed health care practitioners and facilities willing and able to provide more complex care to residents.

The 2001 Institute of Medicine report, *Improving the Quality of Long-Term Care*, urged nursing facilities to give medical directors greater authority and hold them more accountable for medical services, stating that nursing homes should develop structures and processes that enable and require a more focused and dedicated medical staff responsible for patient care.

Recent emerging federal and state health care finance and delivery reform initiatives and new models of care also demand collaboration, coordination, shared accountability for health outcomes, quality performance, and a process for the identification and implementation of measures to achieve quality improvement within nursing homes. There are
clear expectations that nursing home leadership teams—administrators, directors of nursing, and medical directors—are accountable for the organization’s performance and progress in these areas.

New models of care such as accountable care organizations (ACOs) and health homes require long-term care partners who provide assets and value in sharing the risks of providing high-quality, cost-effective care. This means they look for nursing homes that are actively implementing systems of care, creating environments that decrease unnecessary hospitalizations and readmissions, and improve health outcomes and quality of life for patients and residents.

New York State is transitioning the delivery of long-term care services to Medicaid recipients from fee-for-service to managed long-term care (MLTC) plans. This initiative is designed to provide care coordination for all Medicaid recipients of long-term care services and to achieve care efficiencies and risk-sharing.

The same themes (collaboration, coordination, and shared accountability for both health outcomes and organizational quality performance and improvements) are expressed in the Centers for Medicare and Medicaid Services’ (CMS) Quality Assurance Performance Improvement (QAPI) initiative, soon to be required for nursing homes.

QAPI requires every nursing home to submit to CMS a detailed written plan for a structured quality assurance and performance improvement process. The five elements of QAPI that all nursing homes must address in their plans are: design and scope; governance and leadership; feedback, data systems and monitoring; performance improvement projects, systematic analysis, and systemic action.

Complex care needs; demands for more coordinated systems of care resulting in better health and outcomes for nursing facility residents and patients; and a changing health care delivery system calling for collaboration, coordination, and shared accountability for quality and costs are all aspects addressed by implementing the nursing home medical director and attending physician guidelines.
How Were the Guidelines Developed?

The New York State Department of Health (DOH) partnered with the New York Medical Directors Association (NYMDA) to develop the guidelines. DOH and NYMDA convened a workgroup of stakeholders in June 2010 to address these issues with the goal of improving health outcomes and quality of life for nursing home residents by strengthening medical direction and medical care. The workgroup members included DOH and NYMDA staff and representatives from the Continuing Care Leadership Coalition, Healthcare Association of New York State (HANYS), New York State Health Facilities Association, Leading Age New York, New York Chapter of the American College of Health Care Administrators, American Medical Directors Association, Medical Society of the State of New York, American Geriatrics Society and State University of New York (SUNY) Albany School of Public Health, as well as a nurse practitioner, physicians, and nursing home administrators from both upstate (rural) and downstate facilities.

After considering the multiple issues and factors involved in the way medical care was being provided in nursing homes in New York State, and federal and state initiatives to change health care, the workgroup defined new desired actions, beliefs, and a culture of medical care in the nursing home.

The workgroup developed two sets of best practice performance guidelines: one for medical directors and one for attending physicians and physician extenders. Both sets of guidelines also address facility responsibilities to support medical directors and attending physicians and to facilitate an organizational environment focused on quality and accountability.

The guidelines reflect the following overarching principles:

■ creating a culture of accountability and shared responsibility;
■ integrating medical practitioners into care planning, delivery, and evaluation;
■ creating a culture of continuous quality improvement;
■ identifying physicians as teachers and educators; and
■ creating an environment of person-directed care.
What Is the Value of these Guidelines?

**Value to New Relationships with ACOs and Health Homes**

The principles, functions, and tasks outlined in the guidelines for the medical staff and the leadership team are intended to improve care coordination, resident outcomes, and quality of care. ACOs and health homes that aim to incorporate long-term care into the continuum of services that they provide are seeking nursing homes whose systems and culture of care produce the same outcomes.

**Value to Managed Long-Term Care Contracting**

The guidelines identify the facility responsibilities and actions that must be taken to support and facilitate the efforts of the medical director and staff. Nursing homes whose leadership teams implement these guidelines will improve collaboration and coordination and create shared accountability for health outcomes, quality performance, and organizational quality improvements. These nursing homes will be valued partners in the new models of care and will be in a preferred position for contracting with MLTC plans.

**Value to Quality Assurance Performance Improvement Compliance**

The guidelines offer nursing home organizations a model for addressing the five elements of QAPI: design and scope; governance and leadership; feedback, data systems, and monitoring; performance improvement projects; and systematic analysis and systemic action.

The guidelines describe four roles for the medical director: physician leadership; patient care and clinical leadership; quality of care; and education, information, and communication. The guidelines provide detailed functions and tasks designed to help the medical director fulfill these roles. Two of these functions are: administrative and quality assurance, and performance improvement. The tasks or activities described for these two functions address the medical director’s participation in quality assurance committees and quality assurance/performance improvements. They include the analysis of data to identify issues and update and improve policies, procedures and practices, as well as ensure the quality of medical care and medically-related care.
**Value to Changing Public Views about Nursing Homes**

Guidelines implementation will enhance a facility’s reputation as a trusted, compassionate, and state-of-the-art health care provider. Facilities implementing the guidelines will demonstrate that their organizational commitment and focus is in an environment that supports person-directed care, continuity of care coordination, and timely, comprehensive communication among all members of the care team.

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**Guidelines Education Plan**

The workgroup that developed the guidelines understood that nursing homes will not be uniformly prepared to implement them, and will benefit from two different intensity levels of ETTA:

- General education about the guidelines with tools and resources for implementation throughout the three-year project; and
- An ETTA Facility program provided over an extended period to facilities that are committed to substantially implementing the guidelines.

Nursing homes may participate in either or both levels of ETTA.

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The workgroup developed a statewide education plan to inform and educate nursing home leadership teams about the guidelines and their value, and how to implement them. CMS approved DOH’s request to use approximately $1 million from New York’s civil monetary penalty fund to provide education, training, and technical assistance (ETTA) on the guidelines over a three-year period, beginning January 1, 2014. ETTA will provide nursing home leadership teams with the tools, skills, and strategies to implement the guidelines.
General ETTA

Some nursing homes will have all or most of the internal resources necessary to successfully integrate the guidelines into their organizations. These nursing homes will need relatively little ETTA. The general level of ETTA is structured to provide an overview of the guidelines and identify the tools necessary to effectively implement them. Nursing facilities in this group will likely be able to implement the guidelines largely independent of the ETTA offered to other facilities.

Throughout the three-year project, free, statewide education will be delivered in regional meetings and Webinars to all facilities about the guidelines and their implementation. The Webinars will be archived and freely available for viewing during the entire project.

General educational program content includes all aspects of the guidelines, the use of implementation tools and strategies, and related education for the leadership team. This education will be both role-specific and team-related. ETTA tools will include a self-assessment tool to identify current gaps in the organization with regard to guidelines implementation, and an organizational action plan to help leadership teams develop a quality improvement plan to address those gaps.

ETTA Facility Program

Other facilities will benefit from a more focused and intense ETTA Facility program tailored to their unique circumstances and needs. The ETTA Facility level provides a more structured and intense level of facility participation and commitment that, if followed and applied effectively, will better position the organization for successful implementation of the guidelines.

The two goals for the facilities that participate in this level of ETTA are:

- obtain critical ETTA knowledge and skills; and
- develop and execute a guidelines implementation action plan such that the guidelines are substantially implemented by the end of the three-year project.

The ETTA Facility program offers 50 nursing homes the general education experience followed by focused attention to facility-specific needs and issues such as moving from an open to a closed physician model, team
building and teamwork, and compensation for the medical director and physicians. As an ETTA Facility, providers will have more opportunities for education sessions, Webinars, and conference calls with ETTA faculty, reinforcement of the guidelines, use of tools, and several hours of facilitation for addressing facility-specific issues.

Facilities that wish to participate in the program will submit a simple application for evaluation by the program’s steering committee. The committee will make a recommendation to the ETTA administrator, HANYS’ Healthcare Educational and Research Fund (HERF), regarding the facility’s participation in the project.

The ETTA Facility application requests a primary facility contact, the names of the leadership team, and the name of a governance representative. It asks for a one-page statement of intent signed by the entire leadership team and the governance representative. The statement of intent provides the leadership team’s case for participating in the project as “an ETTA Facility,” the goal(s) they hope to achieve for their organization, and the added value it will create.

If a facility is invited to participate in the ETTA Facility program, there will be a participation agreement between the ETTA program administrator, HERF, and the facility’s governance representative and administrator of record. The participation agreement outlines expectations for both ETTA and the facility’s participation and performance. A nominal, one-time fee ($500) will be paid by the facility to offset the costs of added education and support provided in the ETTA Facility experience. The facility will commit its leadership team—at minimum, the administrator of record, the director of nursing services and the medical director—to the ETTA project.

ETTA Facilities will have unlimited access to the general educational programs and Webinars offered in the three-year ETTA project. In addition, they will have added access to ETTA consultants who will provide facility-specific assistance and guidance on the guidelines, use of project tools, and guidelines implementation.

Facility-specific guidance will be based on the results and analysis of the self-assessment tools and the improvement action plan developed by each facility’s leadership team. Consultants will
then assist the ETTA Facility’s leadership team to address the gaps identified, and assist the leadership team with executing the action plan, including advising on additional available resources that are topic-specific. Consultants will be available to assist their assigned ETTA Facility through a pre-determined number of hours of conference calls and attendance at additional regional education sessions.

**ETTA Project Eligibility**

Any nursing home in New York licensed under Article 28 of the Public Health Law may participate in either or both levels of the project regardless of auspice (non-profit, proprietary or public); bed-size; location; affiliation or network agreements; participation in Medicaid MLTC plans; or proportion of residents enrolled in Medicare and/or Medicaid managed care plans.

**QUESTIONS?**

Questions about the nursing home medical director and attending physician guidelines and the ETTA Project may be directed to any ETTA Project Advisory Group member listed below.

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