What is Expected of a Medical Director in the CMS Conditions for Coverage?

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CfC for ESRD Facilities

- Current dialysis CfC adopted in 2008
- First update of CfC since 1976
- Document is 116 pages long
- Provisions enforced by surveyors from state Dept. of Health acting as agents for Medicare
- ESRD Program Interpretive Guidance (304 pages) provides detail on the state survey process
- Many states have additional regulations that may exceed those of Medicare

Medical Director

- “The Medical Director has the responsibility of ensuring that all policies and procedures relative to patient care and safety are followed by all who treat the patients.”
- “The Medical Director is accountable to the governing body for the quality of medical care provided to patients.”
- The governing body is required to report the medical director to regulatory authorities if the medical director fails to perform his/her duties
Medical Director Responsibilities

- Leading quality improvement team
- Facility staff training and education
- Infection control
- Water quality
- Dialyzer reuse
- Ensuring patients’ rights
- Reviewing adverse events and outcomes
- Developing, reviewing and implementing patient care policies and procedures
- Reviewing and approving involuntary patient discharges
- Reviewing clinical performance measure data

The Interdisciplinary Team (IDT)

- Must consist of at least the patient or designee, RN, physician treating the patient, social worker and dietitian
- Must provide each patient with individualized and comprehensive assessment of his/her needs
- Develop patient’s treatment plan and expectations of care
- Medical director is responsible for assuring that treating physician complies with requirements to participate on IDT, see patient and review patient’s progress

Quality Assessment and Performance Improvement (QAPI)

- Every facility must develop, implement, maintain and evaluate an effective data-driven QAPI program with participation by the professional members of the IDT and led by the medical director
- QAPI is designed to achieve measurable improvements in health outcomes and reduction in medical errors by using measures that are tracked over time
- QAPI activities are prioritized based on the prevalence and severity of problems and their impact on clinical outcomes and patient safety
More QAPI

- The QAPI team is responsible for educating facility staff in QAPI objectives, communicating with the governing body, and evaluating the effectiveness of the QAPI program
- State surveyors focus on the data and records of QAPI activities, review improvements and interview staff
- The QAPI program will fail the state survey if the facility has failed to recognize and prioritize problems and/or has failed to develop and follow a written plan for correction

The Measures Assessment Tool (MAT)

- A matrix of clinical performance indicators that fall under the responsibility medical director and which are suitable for QAPI activities
- Specified in the ESRD Interpretive Guidance but not in the CfC
- The medical director is expected to prioritize the patient level indicators in the MAT and incorporate those with opportunities for improvement into QAPI activities

Patient-Level Indicators in the MAT

<table>
<thead>
<tr>
<th>HD adequacy</th>
<th>Vascular access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration (&gt;3hrs)</td>
<td>AVF (&gt;65%)</td>
</tr>
<tr>
<td>Kt/V (&gt;1.2)</td>
<td>Catheters (&lt;10% &gt;90 d)</td>
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<tr>
<td>Nutrition</td>
<td>Thrombosis</td>
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<tr>
<td>Albumin (&gt;4.0)</td>
<td>Infections</td>
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<tr>
<td>Body weight</td>
<td>Patency</td>
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<tr>
<td>Anemia</td>
<td>Reuse</td>
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<tr>
<td>Hgb (10-12 g/dL)</td>
<td>Patient QOL</td>
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<tr>
<td>Iron indices</td>
<td>KDQOL</td>
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<tr>
<td>Medical errors</td>
<td>CAFPS</td>
</tr>
<tr>
<td>Infection control</td>
<td>Grievances</td>
</tr>
<tr>
<td>Trends</td>
<td></td>
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<tr>
<td>Immunizations</td>
<td></td>
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</tbody>
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Water Quality

- Medical director is responsible
- Expected to be familiar with components of the water treatment system
- Should have basic knowledge of maintenance procedures and triggers for intervention
- Should review and sign-off on monthly testing of water system and dialysis machines
- QAPI activities as appropriate

Infection Control

- Medical director is chief infection control officer of the facility
- Must be familiar with infection control program
- Must review all infection control reports
- Must document action to address problems
- Ultimately responsible for reporting adverse event clusters to public health authorities

Infection Control Issues in the CfC

- Isolation of hepatitis B positive patients
- Contact precautions for skin wounds and fecal incontinence
- Strict hand hygiene
- Environmental cleaning and disinfection of dialysis stations
- One-way flow of supplies and medications
- Routine serologic testing of hepatitis B and C
- Immunization for hepatitis B, influenza and pneumococcus
- Infection control training of staff and patients
- Infection surveillance (e.g. catheter-related bacteremias)
### Other Responsibilities
- Approving the training program for patient care dialysis technicians
- Development, review and approval of patient care policies and procedures
- Signing off on all involuntary discharges and transfers
- Incorporating reports regarding quality metrics from external agencies into the QAPI

### Medical Director Compensation
- Deserves to be paid at fair market value
- Medicare estimates 25% time commitment
- 10 hours/wk @ $100/hour = $50,000/year
- Compensation in excess of this amount will be scrutinized by OIG as an inducement for patient referral (illegal and subject to criminal sanctions)
- Compensation does not include time spent providing direct patient care
- Compensation can include educational activities
- A log of time spent performing medical director activities is strongly recommended

### Implications of a Bundled Payment System for Medical Directors
- The bundling provisions of the PPS may place pressure on medical directors for cost containment
  - Medical Director is paid by the facility
  - Medical Director is accountable to patients and payers for high quality care
- The P4P provisions of the PPS were designed to attenuate the tendency to withhold services in a bundled environment but only affect 2% of payment
Bundling and Medical Directors (cont’d)

- The development of corporate policies and protocols in response to the PPS should be as inclusive as possible so that Medical Directors perceive ownership
- Since the PPS and P4P may encourage “cherry picking” the Medical Director must be objective in any patient deselection process
  - Discourage involuntary discharge for reasons other than threatening behavior
  - Participate in patient education to promote adherence

Bundling and Medical Directors (cont’d)

- The Medical Director should be the primary advocate for performance improvement activities to other members of the medical staff
  - Promote champions for various quality activities among the medical staff
  - Practice by example (“walk the walk”)
  - Reinforce quality implications on physician payment
- When practice dilemmas arise (cost vs. quality), use evidence-basis when possible (or lack thereof) to settle issue

Conclusions

- CfC make the Medical Director the “Captain of the Ship” for quality in the dialysis facility
- Responsibilities are far-reaching and time-consuming
- May require political and administrative skills that are not intuitive
- Medicare has acknowledged that the nephrologist is best suited for the job
- Rewards include the improvement of outcomes for all patients in the facility, not just the Medical Director’s own patients