The Medical Director in Integrated Clinical Care Models

Thomas F. Parker III* and George R. Aronoff†

Abstract
Integrated clinical care models, like Accountable Care Organizations and ESRD Seamless Care Organizations, present new opportunities for dialysis facility medical directors to affect changes in care that result in improved patient outcomes. Currently, there is little scholarly information on what role the medical director should play. In this opinion-based review, it is predicted that dialysis providers, the hospitals in which the medical director and staff physicians practice, and the payers with which they contract are going to insist that, as care becomes more integrated, dialysis facility medical directors participate in new ways to improve quality and decrease the costs of care. Six broad areas are proposed where dialysis unit medical directors can have the greatest effect on shifting the quality-care paradigm where integrated care models are used. The medical director will need to develop an awareness of the regional medical care delivery system, collect and analyze actionable data, determine patient outcomes to be targeted that are mutually agreed on by participating physicians and institutions, develop processes of care that result in improved patient outcomes, and lead and inform the medical staff. Three practical examples of patient-centered, quality-focused programs developed and implemented by dialysis unit medical directors and their practice partners that targeted dialysis access, modality choice, and fluid volume management are presented. Medical directors are encouraged to move beyond traditional roles and embrace responsibilities associated with integrated care.


Introduction
The penetration of integrated clinical care models into nephrology practice presents new opportunities to affect changes in care for individual patients undergoing dialysis: changes that result in improved patient outcomes. Unfortunately, there is sparse literature concerning dialysis facility medical directors and the application of associated responsibilities to integrated care models. What follows is an opinion-based commentary on the potential for them to expand their current role.

Two definitions are required before building a proposition for medical director involvement. One is to establish the perceived and real responsibilities of the medical director. Additionally, we need a common understanding of what is meant by integrated care. The first definition is easy: the regulatory responsibilities specified in the conditions for coverage for the medical director are precise (1). Especially noteworthy among the wide array of responsibilities articulated in this regulatory document is the absence of coordination of care within an integrated or any other coordinated care model. This is not a criticism but merely a statement of fact.

The second definition relates to what is meant by integrated care. There are numerous acronyms, but there are certain similarities: Accountable Care Organizations (ACOs) and Medicare Shared Savings Programs resulting from the Affordable Care Act, other shared savings models, integrated care systems, ESRD Seamless Care Organizations, Medicaid programs merged into managed care programs, and global capitated care processes. Likely, there are many more. However, the common features are an attempt at seamless care between physicians and providers of services, including dialysis facilities, hospitals, and payers, to achieve better outcomes at lower cost. Central to this approach is a coordination of care to achieve this savings while maintaining or achieving a high quality of care. Some models offer sharing in the savings, and others do not. All expect more value: enhanced quality at optimal costs.

The growth in the number of these programs is going to place pressure on providers of services to respond. This paper will use the term integrated care to indicate any of the aforementioned models.

Background
Integrated care models can initiate from the Centers for Medicaid and Medicare Services (CMS), payers, hospitals, or regional health systems. Each will have unique aspects, and this document will not address the variances. Likely, the models will require that the amalgamation of services, by whatever name, is responsible for a capitated, fully loaded life, a cost-plus, or a base payment with exceptional carve-outs. In addition, there may be outlier insurance. Regardless, for the most part, the entity and its constituents will manage every aspect of health care for that individual and that population.

In the United States, ACOs represent a well developed and widely distributed option for integrated care. According to a recent report from the accounting firm Oliver Wyman, on the basis of the announcement of CMS’s approvals for Medicare ACOs, more than two
thirds of the United States population live in localities served by at least one of an estimated 520 ACOs (2). The number of ACOs has doubled in 2013. They also estimated that about 5.3 million people or nearly 10% of all Medicare beneficiaries participate in ACOs (2).

To further put this issue into context, currently, a Medicare patient with ESRD has a fully loaded cost when receiving hemodialysis costing $87,000 or peritoneal dialysis costing $71,000 (3). Are these costs actionable? Can they be changed? Clearly, payers believe so. To meet this demand for change, the responsibilities, roles, and accountability of the medical director, in our opinion, must also change.

The Dialysis Facility Medical Director

Historically, medical directors took an active role in designing, maintaining, and managing their dialysis facilities. Previously, when most facilities were owned by the medical director and his/her practice partners, every aspect of the dialysis operation was the responsibility of the medical director. In parallel, the primary care of the patient on dialysis fell to the nephrologist. With the shift of dialysis facility ownership toward large, medium, and small dialysis organizations, many of the previous tasks of the medical director are now perceived to be corporate responsibilities. As an employee of the dialysis company, through the medical director contract or agreement, the job description of the medical director is now mostly perceived as limited to assuring compliance with the CMS Conditions for Coverage for ESRD Facilities.

Furthermore, coordination of care has become vastly more complex. Presently, the primary care of patients on dialysis occurs outside the dialysis unit and is largely provided by non-nephrologists. There are many more venues for care other than the dialysis facility and a nearby hospital. Transportation to more remote tertiary care centers is common, procedures are often performed in independent outpatient specialty facilities, short stays at extended care or rehabilitation facilities occur regularly, and nursing home placement frequently follows hospitalization. Complicating care coordination further is the proliferation of multiple electronic health records that do not communicate among facilities. Clearly, there are many opportunities for the dialysis facility medical director to improve patient outcomes by supervising care processes that improve outcomes.

We know, as nephrologists, that there are certain comorbid conditions and factors that lead to the high costs of care for these patients: patients who would have been best managed with conservative care, patients with catheters or volume overload, patients returning from the hospital, care within the first 120 days to name the ones most responsible. Rather than managing myriad extrinsic issues, the medical director, in its simplest approach, can merely offer programs that change outcomes for the involved parties.

New Responsibilities

The dialysis provider, the hospitals in which the medical director and staff physicians practice, and the payers with which they contract are going to insist that, as care becomes more integrated, dialysis facility medical directors take on new responsibilities. These responsibilities, at the very least, will include the following tasks:

Awareness of high-cost patients who require extraordinary services. This information will become available from the payer or entity responsible for the capitated life (likely a hospital consortium).

Analysis of those patients with ESRD within the context of comorbid conditions who have frequent hospitalizations and overall higher costs.

A lessening from an average of 1.8 hospitalizations per year per patient (4).

A lessening from an average of 11.7 days in the hospital per year per patient (4).

A significant reduction in the 33% of patients returning to the hospital within 30 days (4).

The most extensive review of traditional responsibilities of medical directors has been outlined by Maddux and Nissenson (5) in this series on medical directors. Although Maddux and Nissenson (5) do not specifically address the medical director’s responsibility in integrated care, they do make the following comment:

An effective Medical Director is asked to be more capable of influencing effective operations, culture, staff development, education, and sustainability of the facility. Medical Directors should seek and obtain background in basic business principles so that they can understand how to influence good decisions about equipment, standardized processes and hiring. This knowledge supports the need for developing a sustainable, healthy dialysis facility. Although specifics regarding business competency are not a regulatory requirement of the CFC, such expertise enhances effectiveness of the Medical Director. When a Medical Director does not participate in the business and operational decisions regarding the promotion of safe, effective and efficient care the facility will suffer sustainability risk (5).

Clearly, involvement in developing ongoing care models is associated. Furthermore, the Renal Physicians Association has provided a compendium on meeting the requirements of the medical director (6).

Elements of Integrated Care for the Medical Director

However, it is noteworthy that none of these sources addresses the medical director’s role in the setting of integrated care. Integrated care was simply not part of a vocabulary at the time. The following represents our view of this new responsibility, which extends beyond the usual activities previously noted. We present this vision in a stepwise manner as a sort of template for adaptation.

Awareness of Regional Medical Care Delivery Systems

No one is in a better position than the medical director to understand what the regional hospitals and their respective payers are doing to develop integrated care models. Whether they are in a stage of purchasing practices, are developing unique payment plans with payers, are evaluating data to establish cost and care issues, or have moved beyond all of this must be known. The medical director should be in contact with the chief medical officer, the chief financial officer, or other appropriate decision makers within the care
system to understand the immediate and long-range plans within the region. If the dialysis provider that the medical director represents is going to be integrated into the process and a preferred provider, then the conversations cannot begin early enough. Likely, attention will have been given to cardiovascular disease, oncology, orthopedics, and others, but the emphasis on patients with ESRD will not be at the forefront. However, there will be an awareness of the complicated care required, the cost of that care, and the need to be responsive. Our experience is that hospital administrators are overwhelmed with the complexity of taking care of patients with ESRD and their comorbidities. This is an opportunity for the medical director to simplify the understanding and process.

Then, communicating these conversations to the dialysis facility physician staff, where appropriate, and the dialysis provider would be a next logical step. Facilitating communication between the hospital and the dialysis provider becomes the domain of the medical director. Unless the provider has an acute dialysis contract, it is unlikely that the entities have even met. Determining how to proceed to the next step is essential. Call it facilitating, brokering, being a catalyst, or being a leader. Communication at this point is the dominant element.

It must be fully understood that some patients may be undergoing dialysis in a specific facility and may not be part of an integrated hospital system (may not go to those hospitals and providers). There is no official integrated care responsibility for the medical director in that setting. However, the medical director may, indeed, find himself/herself negotiating and involved with several integrated systems. This is all very new, and sensitivity to this will be hugely complicated. Thus, there is a need for a leader who understands the full process.

Developing Actionable Data

Hospitals generally have an overabundance of data about patients and physician providers. Assisting in gaining an understanding of what data are significant is an area where the medical director can be of enormous assistance. What is the cost of an incident or prevalent patient with ESRD within that system? What can be done to change those costs? It is known that almost 50% of hospitalizations and the associated costs for patients on dialysis are caused by three entities: cardiovascular disease, infection, and access (the latter two are codependent on catheter rates). What can be done to change the aforementioned rehospitalization rate?

Accurate and timely data are essential. Information by patient, physician, location of care, and provider will be required. Who are the high-cost patients and why? What are the quality of care issues and why? Are there differences in caretakers? Where does the care take place? Who is responsible?

Determine Mutual Outcomes

For the first time, perhaps, the alliance between patients, hospitals, and other providers, including the dialysis providers, can align outcomes. Clearly, there is agreement that all want high quality. However, there likely have not been significant conversations related to concurrence of just what is entailed in high quality. Is this just hitting the numbers of regulatory agencies? Is it patient satisfaction and quality of life? Is it patient safety? Is it measured by hospitalizations, durations of stay, and rehospitalization rates? Is it achieving goals that have never been set by any of the represented parties (goals that extend quality beyond what has been discussed separately or collectively)? This is an opportunity for the medical director to inform the various providers as to what really determines outcomes in patients undergoing dialysis.

Developing a Process

There is no one better to take the lead in developing a process for managing patients with ESRD than the nephrologist, and there is no one better to coordinate care among the various providers of care than the medical director of the dialysis facility. Systems for the major comorbid conditions that affect outcomes must be developed. Foremost are those conditions that cause the greatest numbers of hospitalizations and rehospitalizations (i.e., fluid volume-related hospitalizations, catheter-related infections, wounds, pneumonia, and the results of missed treatments). What is the dialysis provider doing to avoid hospitalizations associated with these factors? How can the provider assure the integrated care system that these conditions are being optimally managed?

Developing effective methods for transitions of care is essential. The smooth movement of patients and records from one care location and provider to another is critical. The handoff of records and plans of care, discharge planning, appointments, and points of contact are elements that must be rigorously maintained.

Optimizing the care of patients while in the hospital, maintaining anemia control and volume control, medication reconciliation, and awareness of the prevalence of depression in patients with ESRD are just a few needs that are vital. How are these ongoing needs communicated to the caring medical team, especially if care is led by a hospitalist rather than a nephrologist? The dialysis unit medical director should be empowered to develop processes that reflect understanding of the acuity of the issue for patients returning from the hospital, especially during the vulnerable 30 days after discharge.

This approach requires systems of care. The medical director needs to lead the team to assure that these systems are in place and being audited and enforced. A typical dialysis provider thinks about how to provide dialytic care. The paradigm must shift to caring for the patient who happens to be on dialysis.

If we start with the notion that improved quality of care results in lower costs, then the dialysis facility medical director has an enormous opportunity to increase value for the managing care organization by simultaneously improving quality and decreasing costs. To accomplish this goal, however, the medical director must develop and enforce systems of care that improve meaningful outcomes. Participation in an integrated care model makes such efforts both possible and mandatory. Nissenson (7) recently proposed that the traditional focus on biochemical quality surrogates be replaced by patient-centered care, which results in improved longevity, decreased hospitalizations, better experience of care, and improved quality of life for patients on dialysis. To illustrate the concept, Nissenson (7)
proposed a patient-focused quality hierarchy, now widely referred to as the quality pyramid. With a nearly 20% annual mortality rate, an almost 40% mortality rate for patients starting dialysis, an average of about two hospitalizations each year, and a very high rehospitalization rate, even a modest improvement in quality outcomes would enhance thousands of lives and decrease costs. Also, according to Nissenson (7), this is not likely to occur if we continue to simply use biochemical measures. We must move up the pyramid.

Renal Ventures Management, LLC (RVM), a small dialysis organization with 36 facilities (T.F.P. is the Chief Medical Officer of RVM, and G.R.A. is the Assistant Chief Medical Officer of RVM), implemented a system-wide, quality-focused program for patients with stages 4 and 5 CKD. Dialysis unit medical directors and their practice partners developed and implemented protocols that decreased emergent dialysis starts, maintained better volume control, and improved nutritional status, while focusing on hemodialysis access placement and dialysis options decisions (T.F. Parker, G.R. Aronoff, unpublished data). Although these results have not appeared in reviewed journals, the results of this initiative were clear. Almost 90% of the patients enrolled in the program started dialysis with a noncatheter permanent dialysis access; >30% chose a home dialysis modality. We, too, were startled at the outcomes.

RVM also implemented an initiative to identify our most vulnerable patients on dialysis (patients in the first 120 days after initiation of dialysis). Within 120 days, <5% of patients were dialyzing with a catheter only. Peritoneal dialysis prevalence rates increased from 7% to 15% within 2 years. This program, by giving extraordinary attention to the sickest of patients, changes those outcomes that are of interest to integrated care administrators (8).

In an effort to improve volume management and decrease hospitalizations and rehospitalizations for fluid volume overload, we are also testing the universal monitoring of intravascular volume. In a previous quality collaboration on intradialytic volume management with large dialysis organizations, we showed a dramatic decrease in volume-related hospitalizations. Our additional internal studies have confirmed this finding (T.F. Parker, G.R. Aronoff, unpublished data).

These initiatives and others show at the facility level that, while concentrating on the usual markers to which we are held accountable, if we are truly going to make a difference in quality for emerging models of care, we must move up the pyramid.

Leading and Informing Medical Staff

Within each dialysis facility, attending physicians from single or varied practices may have patients for whom they care. They must be on board with an understanding of the importance of the integrated care model, the data, the systems, and the auditing process. The medical director’s responsibility is to instruct them, gain their understanding, and then, hold them accountable. This task is easy to describe, but difficult to accomplish. However, these tasks are necessary. It is not the responsibility of the medical director to oversee the care of each individual patient or coordinate that care with each provider. Rather, it is the responsibility of the medical director to fully inform the attending physicians of the issues, processes, and systems in place and oversee their compliance. Future credentialing by payers and health systems will likely include such participation.

Discussion and Summary

The medical director is in a complicated and diverse situation. On the one hand, she or he is a nephrologist practitioner and must represent the clinical practice entity, whether it is owned privately, corporately, or by a hospital consortium. On the other hand, she or he is expected to represent the entity paying the privately negotiated but federally regulated medical director agreement fee. For the dialysis provider (the company managing the dialysis facilities), this commitment takes priority over the other possibly conflicting relationships.

Of course, there is the issue of compensation for these aforementioned activities. The relationship between the medical director and the dialysis provider is a contractual one, usually a robust legal relationship. The activities described in this paper are clearly in addition to those that have traditionally been performed. The CMS suggests that a medical director should be spending 25% of their time performing medical director responsibilities. If these activities go beyond that time, then the medical director will need to change the contractual relationship for compensation. It clearly translates to an advantage to the provider to have the medical director involved in these activities. The benefits of fewer hospitalizations and rehospitalizations and therefore, fewer missed treatments and the possibility that better integrated care leads to lessened morbidity and even mortality accrue benefit to the dialysis provider. Additionally, the CMS is considering the inclusion of standardized rehospitalization rates, a measure that integrated care should minimize, as a component of the Quality Improvement Program, which has direct financial implications. Because both the dialysis provider and the integrated health care system stand to benefit financially through medical directors’ additional activities, additional payment will need to come from either or both to compensate for the medical directors’ added duties.

Dialysis unit medical directors may have been comfortable managing those responsibilities associated with the CMS conditions for coverage. Now, we are encouraging them to move beyond the traditional and the comfort to the frontier of medical care by taking a leadership role in the development of systems and processes of care that result in improved patient outcomes.

Disclosures

T.F.P is a salaried employee of Renal Ventures Management, LLC. G.R.A. is a salaried employee of Renal Ventures Management, LLC, and the University of Louisville School of Medicine.

References


Published online ahead of print. Publication date available at www.cjasn.org.