Dear Dr. Jeff:

The admissions director and the admissions director at our facility have asked me to do outreach and marketing to try to increase our post-acute admissions. Although we have a waiting list for potential long-term-stay residents, the central office says that without the highly reimbursed Medicare Part A stays the facility cannot survive financially. I don’t feel comfortable about doing this, have never done anything like it for other facilities where I have worked, and am not sure whether it is even ethical. I haven’t seen anything preparing for this role in medical director certification, and it is not described in my contract. We provide quality long-term care with four stars from the Centers for Medicare & Medicaid Services in a beautiful building and are trying to build a quality post-acute program as well. Several nearby facilities seem to have excellent programs. I worry that persuading patients to come to us instead of them might be doing those patients a disservice. What do you think?

Dr. Jeff responds:

There is certainly nothing improper or unethical about letting the community and potential acute care partners know what services you provide. Discharge planners may not know that you would accept short-term patients, particularly when a facility has the reputation of being very attractive. They may be reluctant to send you patients knowing of your waiting list (“Don’t bother to apply there — you won’t get in”) and believing that referred patients would simply languish in the hospital with prolonged lengths of stay, consequently failing to receive the post-acute services they require. If your facility has committed to having a certain number of beds devoted to short-term patients who might jump the waiting list, receive services, and ultimately return to the community, this is valuable information to share.

Even if your program is less experienced or less comprehensive than some competitors, your overall reputation for good care might be an attractive trade-off for some potential admissions. Sometimes experienced and compassionate nurses and nursing assistants, a sparkling clean environment, and good food may be equally important for recovery as fancy gym equipment and more physical therapy hours. This is a legitimate option, but only for those who know that it exists, particularly if those residents who do not recover sufficiently to return to the community are able to stay long term in their facility of choice.

The admissions director and administrator should provide this information to local hospitals and particularly to their social work, case management, and discharge planning staff, including details about availability, application procedures, forms, and criteria. Many facilities participate in electronic referral systems that allow rapid response to applications as well as facilitate communication before admission about the medications needed, insurance details, and hospital transfer times.

It is a good practice to arrange facility tours for the hospital discharge staffs, both to reinforce the facility’s new availability and because discharge planners feel more comfortable sending patients to facilities that they have actually seen. Facilities that market unevenly may schedule many such tours, sometimes sweetened with catered meals and evening events with cocktails or champagne, complete with taxi or limousine transportation. Welcome gifts and even frank bribery are not unknown in this competitive market.

Although it is illegal to pay for referrals, there is nothing improper about providing factual information about your services or distributing informational brochures or even ballpoint pens with the facility logo and telephone number to encourage calls.

Medical Director of Marketing

The largest contribution that a medical director can make toward marketing is through your work in designing and providing a high-quality post-acute program. The medical director should be involved with the director of nursing regarding issues of staff competencies and staffing levels needed for various clinical conditions. For example, can the facility safely manage residents requiring peritoneal dialysis, tracheostomy care, or drainage catheters? Are there sufficient licensed nurses every day on all shifts to administer nebulizer treatments, perform complex wound care, or supervise intravenous fluids and antibiotics? Is suitable medical coverage available to care for medically unstable residents or to address acute changes in condition? These are mandated medical director responsibilities under the categories of advising on medical care policies and coordinating care. Both capabilities and gaps should be identified before patients are admitted.

Many facilities group their “skilled” patients in designated units (in some states only certain beds may be Medicare certified), which also helps to identify clinical capabilities and staffing needs. The medical director should confirm that his or her contact information is available to the facility director of admissions and to the referral hospitals for consultation regarding the suitability of particular proposed admissions. Although this open line of communication is rarely needed, it protects patients and the facility against inappropriate transfers and medical errors.

Occasionally it may be helpful to discuss cases on a physician-to-physician or nurse-to-nurse basis to address the specifics of a patient’s needs. This should happen before the actual acceptance of an admission and the desired warm handoffs between the actual treating professionals.

Clues From Facility Assessment

Recent changes to the CMS Requirements of Participation for Medicare and Medicaid include a requirement to create and update at least annually an overall assessment of the facility’s resident population and the facility’s ability to meet their needs. If a significant change in the resident population is being planned, that process may be an excellent focus for strategic planning and for identifying potential care gaps. If your facility already has a significant problem with pressure ulcers, for example, should you be reaching out to hospitals for additional wound care patients? Alternatively, does this represent an opportunity to create an excellent skin care program that might benefit your current residents and be offered to potential short-term admissions? Facility performance on the existing CMS quality indicators for newly admitted residents may suggest possibilities for program improvement.

Two key indicators that should be reviewed initially and followed monthly are the 30-day readmission rates for those Medicare A patients (and other payer sources as well) who are being referred to you, and the overall percentage of post-acute patients who actually return to the community within 100 days. If these numbers are good, they should be shared with potential referral sources; if the numbers are less than ideal, the problems should be reviewed and addressed while new referrals are sought. Given the Medicare payment penalties for both hospitals and nursing homes that are addressed specifically to 30-day readmissions, most hospitals already track these data by discharge location, which often can be drilled down to the specific facility. You should be prepared to work collaboratively with referral hospitals to improve those numbers.

One part of the medical director’s analysis can and should be meeting with local hospitals to discuss quality initiatives, facility capabilities, and facility performance. Discussion about categories of patients who are not being referred may sound a little like marketing, but it is also quality improvement. If the hospital is developing new programs, it is sensible to discuss how your facility might help them with this through program linkages. For example, many SNF rehabilitation programs have collaborated with hospital bundled payment initiatives to shorten hospital lengths of stay and create linked clinical pathways to accelerate returns to the community.

A population health needs assessment should inform your facility’s strategic planning. This is another potential role for the medical director. Although many post-acute providers hold themselves out as suitable for any appropriately insured referral, many facilities are developing niche programs that provide genuinely superior care for selected diagnoses or care needs. The August issue of Caring featured an excellent lead article on this topic (2018;19:1,18–20). Informing the world that you have a better mousetrap is a form of public health education, even if the hope is that referrals will beat a path to your admissions office.

Squeamish About Marketing

Today, major hospital systems buy gigantic advertising spreads: the University of Pittsburgh Medical Center bought full-page ads in The New York Times, presumably to raise its national reputation rather than to lure New York patients to western Pennsylvania. Nursing homes purchase radio advertisements in major markets with celebrity endorsements (though they rarely place the name of their medical director on their website). Even physicians who would like to believe that their reputation is based on the respect of their colleagues and the gratitude of their patients are now no better than their last Yelp review.

Even if a facility succeeds in attracting some Medicare post-acute referrals, this may not achieve management’s long-term financial goals. Negative word of mouth in the community, high readmission rates, and family complaints to discharge planners may lead to referrals drying up. A poor reputation cannot be reversed by the ready smile of the medical director or a new round of free pens. But if you and your team create a quality medical program, there is no shame in letting others know that it is available. The work that you do to make this happen should be suitably appreciated and reimbursed by your facility.

Dr. Nichols is past president of the New York Medical Directors Association, and a member of the Caring for the Ages Editorial Advisory Board.