The Future of LTC: The Continuing Evolution of the SNF
By Rebecca Elon, MD, MPH, CMD

The American nursing facility has been in continuous evolution since its inception in the early 19th century. The early “old age homes” were places to save “forever repeatedly respectable people from the indignities of the almshouse” (Elon et al., “Post-Acute and Institutional LTC for the elderly,” in Reischel Care of the Elderly, 7th ed., Cambridge University Press, 2016:659–670). In the late 19th century through the 20th century, nursing facilities were also places to convey lese from acute hospitalization. Initially known as “convalescent homes,” these facilities and programs evolved into what is now known as post-acute care. The late 19th century “homes for the incurable” — intended for those who could no longer benefit from hospitalization but lacked the family or resources to be cared for in their own homes — evolved into what we now call our institutional long-term care programs.

Today in the United States most nursing facilities have a dual role and function: (1) providing long-term, institutional residential and nursing care for individuals who require support in their activities of daily living and lack family or resources to be cared for in their own homes; and (2) providing short-term rehabilitative, nursing, and medical care to individuals who have had a qualifying hospital stay and whose needs exceed the capacity of their families or communities to provide that care in their homes. Over the coming 5 to 20 years, I believe short-term convalescence post-acute care will become more dominant in American skilled nursing facilities and the LTC component will continue to diminish.

Despite an increase in the aging population in the United States, along with an increase in the number of people who would qualify for nursing facility care, the number of people residing in American nursing homes has decreased over the past decade from approximately 1.5 million SNF residents to approximately 1.35 million. The reason for this change is thought to be due to two major factors: (1) the increase in the types and availability of in-home services for persons with disabilities of all ages and (2) the growth of assisted living options.

In addition, COVID-19 has had a huge and disproportionate impact on nursing facilities. Occupancy appears to have declined by 10% to 30%, at least on a short-term basis, due to the high death rates and lower admission rates. People have been choosing to return home after hospitalization, when in non-COVID times they would likely have been automatically discharged from hospital to a SNF.

Over the next 5 to 20 years, I believe there will continue to be a decrease in the LTC population in American nursing homes. Surveys repeatedly have shown that older people do not want to enter nursing facilities. Just as the old age homes of the 19th century "saved" older adults from the almshouse, home care and assisted living options will "save" older people from the nursing facilities that many still fear and revile. The future will provide an increasing array of options to allow care to be delivered in community-based settings rather than in nursing facilities.

**Industry Transformation**

The nursing facility industry in the United States is predominantly a for-profit venture. It has been estimated that on average the predominantly Medicaid-reimbursed LTC portion of the nursing home business model loses about 2% annually and must be subsidized from the post-acute business model that on average produces a 10% profit margin annually. Some nursing home operators in more affluent communities are already abandoning the nursing home LTC functions and are developing “post-acute only” facilities with private-payer assisted living communities next door for those who are unable to return home due to their activities-of-daily-living limitations. I believe over the next 5 to 20 years we will see more stand-alone post-acute facilities and fewer nursing facility beds devoted to LTC.

Many nursing facilities already provide medical care that could be labeled chronic hospital care. To decrease unplanned transfers back to the hospital over the coming years in the environment of growing case intensity, nursing facilities will need to upgrade their medical and nursing services to manage the increasing patient acuity. We are already seeing medical practices devoted exclusively to this type of care, and public policy will need to catch up to the evolving role of the nursing facility. Without pay equity for nurses and nursing assistants between hospitals and nursing facilities, and staffing levels commensurate with the expectations of higher acuity care, it will not be possible for nursing facilities to recruit and retain the quality and quantity of staffing required to provide top notch care. Without the appropriate policy responses, nursing homes could just become “second-rate geriatric hospitals.”

Perhaps the COVID-induced higher unemployment rates will encourage more people to consider working in nursing facilities, but reports are that this is not the case. The opposite seems to be true, likely due to the fear of contracting COVID-19 in this high-risk environment and the historically lower wages for entry level work in SNFs. Staffing remains a critical issue in many nursing homes.

**Post-COVID Models**

After COVID, I don’t think it will be possible to return to business as usual as it was in the pre-COVID times. More restrictive nursing home admission criteria may follow state Medicaid programs becoming increasingly strained financially, pushing more care back onto families. Also, community-based services for home care and assisted living options for both the private-pay and Medicaid populations will likely continue to expand. I also think there will be an expansion of the post-acute programming, with increasing pressure to care for higher medical acuity. Again, this cannot be achieved in a quality fashion without the resources for adequate staffing and infrastructure, but whether public policies will promote or hinder this evolution remains to be seen.

The present enforcement regulations are intended to change corporate behavior through civil monetary penalties large enough to make it unprofitable to deliver poor quality care. However, the evidence from studies of quality improvement teaches us that the best environment for performance improvement involves nonpunitive processes and settings. Nor has adequate attention been paid to the impact of the punitive regulatory process on the front-line staff. Policy makers must recognize that the enforcement regulations have not produced what they were intended to produce — and they have had an amazingly devastating effect on front-line staff (J. Legal Med. 2005;26:69–83).

Ultimately, it is my hope that the overly punitive regulatory environment will yield to more meaningful root cause analyses of why our SNFs are as they are and that an evidence-based quality improvement environment can emerge.

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Finding the Ideal Medical Director for Your Nursing Home
By Rebecca Elon, MD, MPH, CMD

When asked to describe the ideal medical director, nursing home administrator Mike Moranz’s face beamed with a broad smile. “Well, to understand today’s ideal, you must understand how far we have come over the past 20 years.” Mike Moranz, MPH, started his health care career as a respiratory therapist 50 years ago and ventured into nursing home administration in Maryland 20 years ago. “My first nursing home medical director was an internist with a busy office and hospital practice. He did not have the time or knowledge to really help the nursing home staff in any sort of leadership role. We were pretty much on our own.”

The demands of the position also have evolved, as Mr. Moranz explained: “Twenty years ago, we were doing some post-acute care, but nothing like the volume and acuity we see today. Today we really need nursing home medical directors who are engaged and knowledgeable about our regulatory and risk management concerns, quality improvement initiatives, infection control requirements, and upgrading clinical services to decrease rates of hospital readmission. In addition to having administrative knowledge, we need medical directors who are expert clinicians and can guide residents, families, and staff when tough clinical issues arise, especially about goals of care and end of life decision-making.”

Engagement is key for medical directors, Mr. Moranz said. “Clinical and administrative expertise are necessary but insufficient without both the time and interest on the part of the medical director to be involved in the life of the nursing home. I have worked with numerous medical directors over the past two decades. Some were like my first medical director. A few were truly ideal.”

Mr. Moranz led a 200-bed, high-acuity, urban nursing facility through the COVID-19 pandemic. “Having an ideal nursing home medical director during the time of COVID has been essential,” he said. Early on the availability of and recommendations about personal protective equipment, testing, and isolation were rapidly evolving. “Our medical director was in frequent communication...
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with the corporate chief medical officer and helped us keep the medical staff updated. Our medical director was able to educate the clinicians about how to accurately code diagnoses on COVID-related death certificates and helped keep the medical staff in compliance. He meets weekly with the nursing staff, and we have seen a real improvement in their clinical knowledge and acumen. I am not sure how we would have made it through the time of COVID without such expert medical direction.

Twenty years ago, Maryland became the first state in the United States to require that all nursing home medical directors complete education regarding their clinical and administrative role. The Maryland regulations specify that nursing home medical directors complete AMDA – The Society for Post-Acute and Long-Term Care Medicine’s Core Curriculum on Medical Direction in PALTIC or a similar course of study approved by the state licensing agency. This ensures that nursing home medical directors in Maryland have an understanding of their roles and responsibilities, which is the first step to becoming an ideal medical director.

Roles and Responsibilities

The Society’s Core Curriculum is divided into two parts: an online course and a synthesis weekend, which was held live before the time of COVID and is currently offered as a virtual symposium. The course provides comprehensive instruction on management and leadership within PALTIC settings—the knowledge base necessary to become an ideal medical director. The course outlines the four basic roles of the medical director: physician leadership; patient care–clinical leadership; quality of care; and education, information, and communication. These roles are further refined as the nine main functions of the medical director, which in turn are further delineated into the various tasks performed by the medical director to carry out the roles and functions. (Visit https://apex.paltc.org/page/core-curriculum-on-medical-direction for more information.)

Physicians who have completed the Core Curriculum have invested time into obtaining the knowledge to perform their duties. Physicians who have been awarded the Certified Medical Director (CMD) credential by the American Board of Post-Acute and Long-Term Care Medicine (ABPLM) have demonstrated they have the knowledge, experience, and professional standing to assume a medical leadership role in PALTIC settings.

Most nursing homes in the United States rely on part-time medical directors, who may be present in the home to perform administrative duties anywhere from 2 to 20 hours per week, depending on the home’s size and medical acuity. The part-time medical director will need to select from the comprehensive list of medical director roles and responsibilities which activities should be prioritized to monitor and improve care. The administrator and director of nursing should meet with the medical director to communicate their perceptions of the home’s areas of greatest need.

An engaged medical director can act as an advocate for both patients and families, often helping the nursing home resolve difficult situations. A knowledgeable medical director can help create a stable and engaged staff who feel valued, are continuously learning, and can work together as a highly functioning team. A committed medical director can facilitate strong relationships with hospitals, helping ensure that the nursing home is seen as a preferred provider in this era of narrow networks.

The priorities will likely change over time, so the medical director will need to be able to adapt. This was conclusively demonstrated with the advent of the COVID pandemic. As Dr. Moranz said, “Having an ideal medical director is the difference of night and day for the success of the nursing home.”

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