Balancing Productivity vs Quality
A Fools Errand?

Paul R Katz, MD, CMD

The Ideal Nursing Home

- High nurse staffing ratios; low turnover rates
- Nurses/CNAs highly competent regarding early assessment of change in condition and timely communication with medical provider
- 7 day a week therapy
- Fully resourced (diagnostic and therapeutic)
- Commitment to quality (5 stars plus)
- Fully coordinated admission process between hospital and NH

The Ideal Nursing Home

- On site physician/NP/PAs specializing in NH care who round daily and are an integral and engaged member of the team
- Seamless flow of clinical information
- Direct communication between hospitalists and medical providers

Objectives

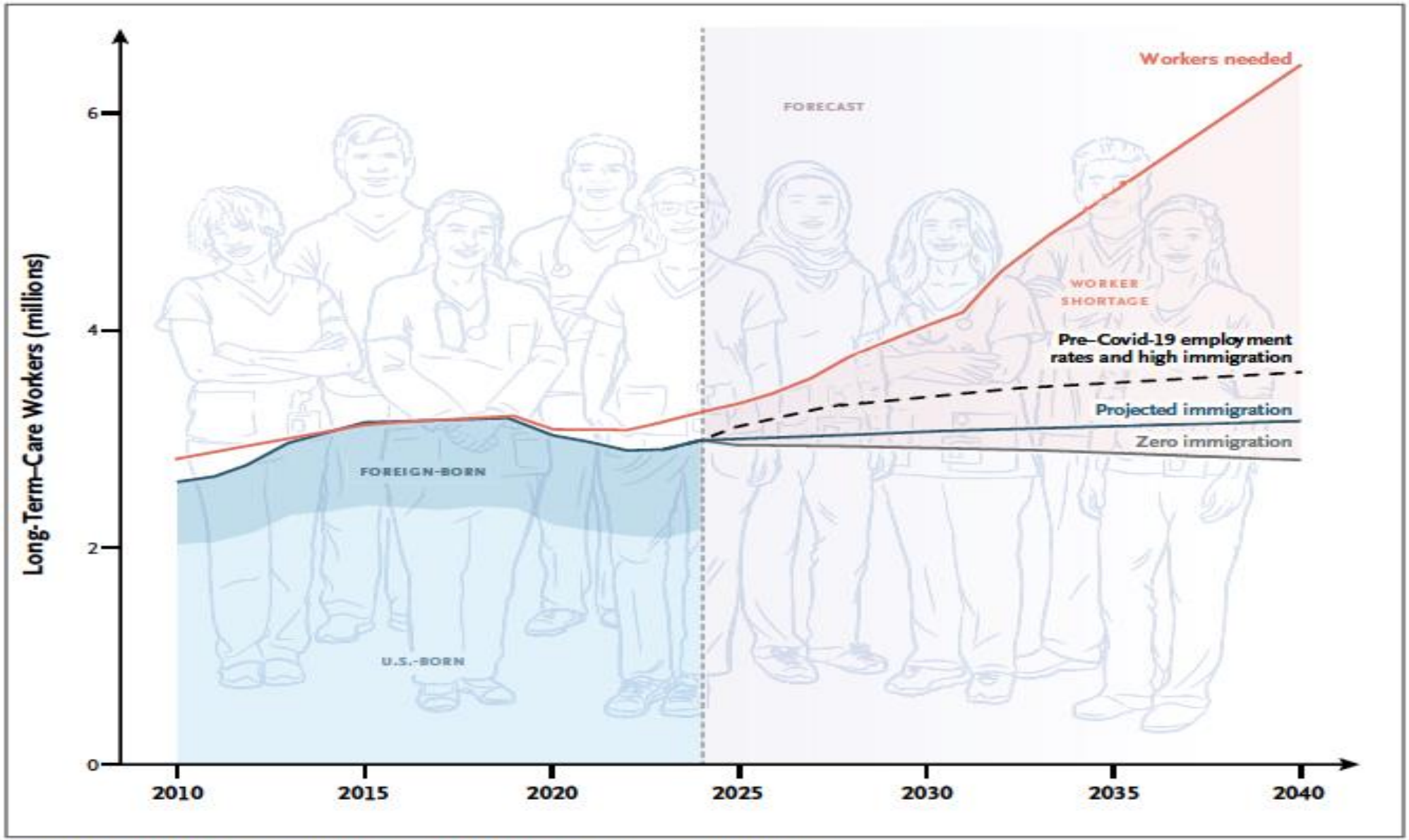
- Appreciate the gap between the current nursing home (NH) practice environment and the “ideal”
- Pros and cons of Value based payment systems
- Reconceptualizing the links between medical provider care and quality
- Less may be more when it comes to practice size/volume
- Establish a new paradigm of care in the NH

The Practice Environment

Caring for an Aging America-The Looming Crisis of the Long-Term Care Workforce

(Olenski A and Grabowski D. NEJM 395(2) 2026 107-110)

- The LTC workforce (nurses, nursing assistants and care aides) in both institutional and home-based settings numbers 3 million and is already insufficient to meet existing needs
- NHs are routinely understaffed with high turnover rates
- Home and community-based services are chronically oversubscribed with long waiting lists
- Medicaid cuts will translate into lower wages, fewer hires and accelerated attrition
- Reduced immigration severely restricts new workers



Estimated Demand for and Supply of Long-Term–Care Workers, 2010–2040.

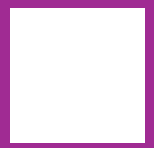
Colliding Forces-The Aging of the Baby Boom Generation and Contracting Nursing-Home Supply

Unruh M, Mor V, Jung H-Y. NEJM 2026. 395(2):105-107

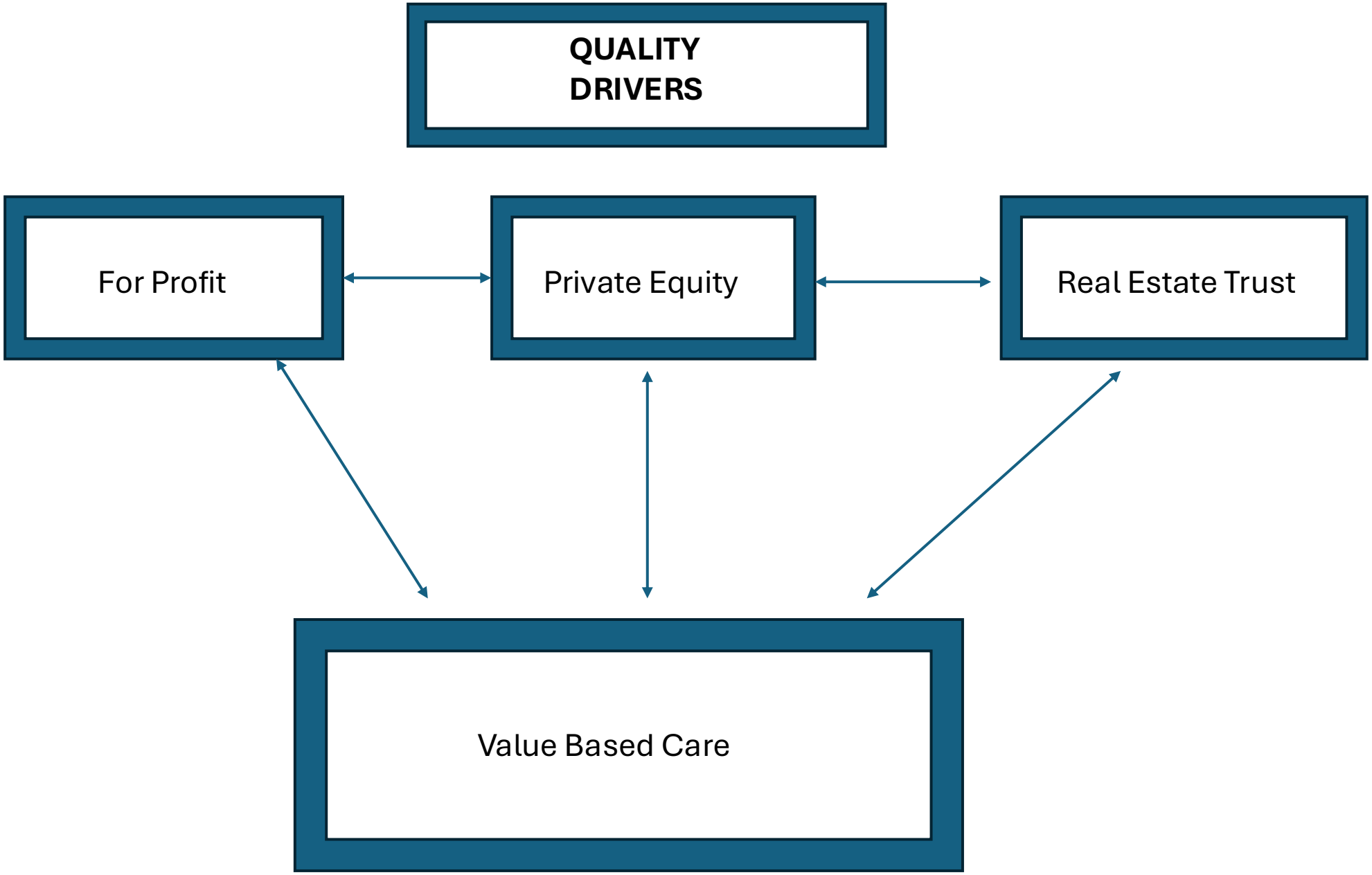
Many NHs have closed units or limited admission due to staffing constraints (10% of NHs closed between 2011-2021)

Medicaid cuts further threaten NHs as it is the primary payer for almost 2/3 of NH residents

Rural and low-income communities will be disproportionately impacted



Downstream impact on hospital discharges and burdens on unpaid caregivers


QUALITY
DRIVERS
For Profit
Private Equity
Real Estate Trust
Value Based Care

Optimizing Ethical Care, Quality and Safety in Long-Term Services and Supports: A Position Paper from the American College of Physicians (Ann Intern Med 2025; 178:839-846)

- 70% of US facilities and agencies providing LTSS have for-profit ownership; 24% non-profit and 6% government owned
- Many studies demonstrate lower quality with for-profit ownership
- Emergence of national chains and corporate investors such as private equity firms and real estate investment trusts

Optimizing Ethical Care, Quality and Safety in Long-Term Services and Supports: A Position Paper from the American College of Physicians (Ann Intern Med 2025; 178:839-846)

- Private equity firms acquiring LTSS facilities and agencies have pressure to generate high, short-term profits
- This business model has been associated with :
  - Lower quality of care
  - Higher rates of hospitalization and ED visits
  - Practices endangering residents such as increased use of antipsychotics

Optimizing Ethical Care, Quality and Safety in Long-Term Services and Supports:
A Position Paper from the American College of Physicians
(Ann Intern Med 2025; 178:839-846)

- Real estate investment trusts purchase the property of facilities providing LTSS
- Ideally, they provide an infusion of capital that could be used to make facility improvements, initiate QI programs or increase staffing
- However, lease payments may become unaffordable over time negatively impacting quality of care

From Patients to Consumers — The Corporatization of Ambulatory Care
N Engl J Med 2026;394:1-3
DOI: 10.1056/NEJMp2415483

The Antitrust Antidote to Hospital and Nursing Home Corporatization — Promises and Pitfalls
N Engl J Med 2025;393:1761-1764
DOI: 10.1056/NEJMp2505020

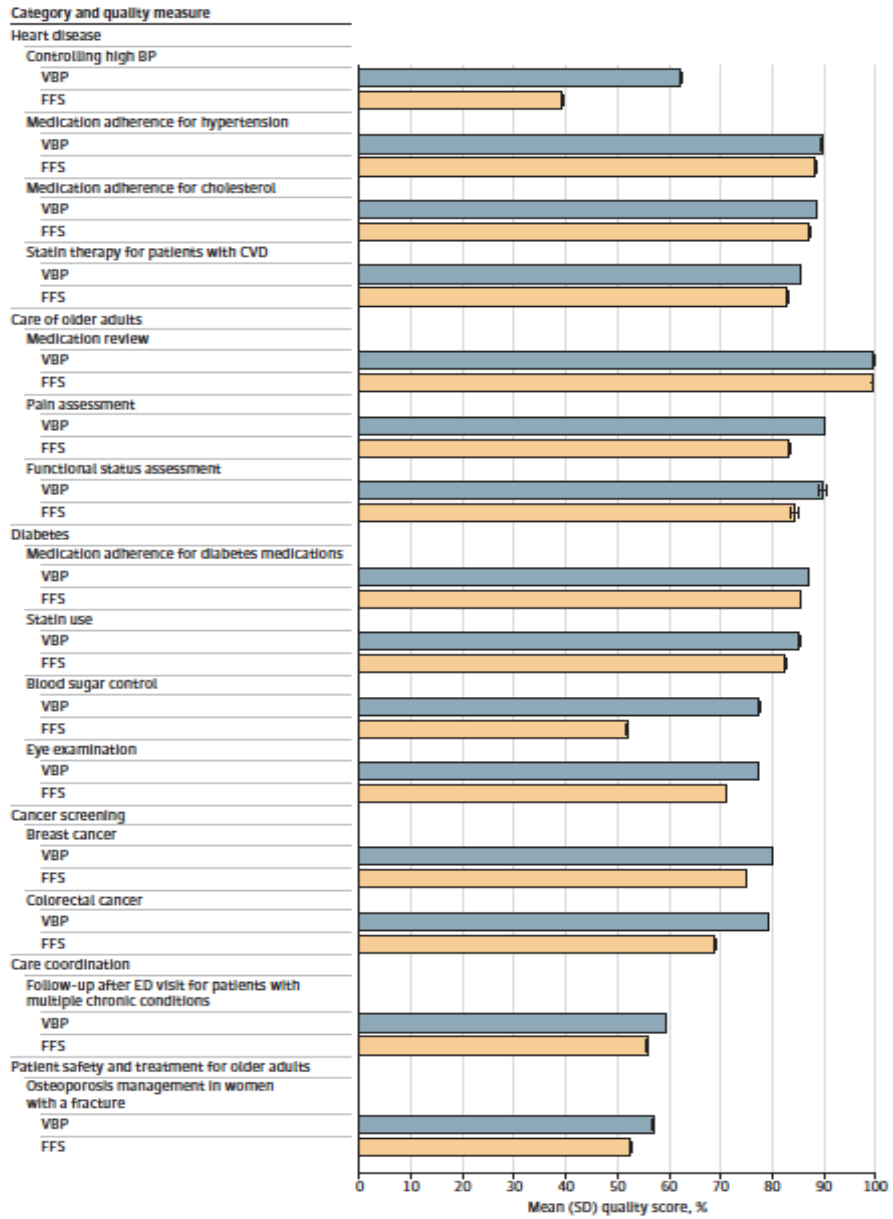
Perversity in Medicine — When Vocation and Corporatization Clash
N Engl J Med 2026;394:2079-2081
DOI: 10.1056/NEJMp2602962

Regulatory Framework for Private Equity and Corporatization in Health Care: A Position Paper
Annals of Internal Medicine
Volume 179, Number 7
https://doi.org/10.7326/ANNALS-25-03148

The Promise and Challenge of Value-Based Payment (JAMA Int Med 2024 184 (7); 716-17)

- Value Based Payment (VBP) links payment to quality and outcomes rather than volume
- Value Based Care is a component of all managed care plans
- Plans with managed care elements are now the dominant form of coverage in Medicaid and Medicare
- But…..Only modest improvements in quality outcomes; minimal cost savings in community settings

Figure 1. Comparison of Clinical Quality Performance Between Value-Based Payment (VBP) and Fee-for-Service (FFS) Arrangements



Mean and SD (denoted by error bars) scores plotted by quality measure. All comparisons are statistically significant at $P < .001$. BP indicates blood pressure; CVD, cardiovascular disease; and ED, emergency department.

What About Nursing Homes?

- Managed Care Success Stories
  - Partial or full capitation models
    - I-SNP (Institutional Special Needs Plan)
    - PACE (Program of All-Inclusive Care of the Elderly)
      - Specific targeted population
      - Dedicated interdisciplinary team
      - Salaried on-site physician or NP
      - Compensation recognizes non-face to face tasks such as team meetings, home visits etc

What About Nursing Homes?

- Accountable Care Organizations (Medicare Shared Savings Program)
  - Expanding coverage over the past several years
  - Almost ½ of nursing homes participate in ACOs
    - Reduced hospitalizations and related cost savings

OUR PROGRAMS

Curana Health owns and operates multiple Medicare ACOs, providing flexibility to include the right patients in the right program.

	Medicare Shared Savings Program (MSSP) Enhanced Track Elite Patient Care ACO	**High Needs ACO REACH Program*** PCMA Cooperative
Eligibility	"Original Medicare" beneficiaries not in Medicare Advantage	Highest risk "Original Medicare" beneficiaries not in Medicare Advantage
Revenue Model	Curana holds all risk and **offers competitive shared savings** opportunity to participating partners	Curana holds all risk and **offers competitive shared savings** opportunity to participating partners
Community Type	• SNF, CCRC, and AL • Requires physicians as part of ACO for attribution	• SNF • Does not require physicians as part of ACO

Should Funding Always Inform Practice and How We Measure Quality?

- Consider other key parameters that ultimately inform what an ideal provider to nursing home resident ratio should be:
  - Defined roles/tasks for nursing home attending physicians/medical providers
  - Time necessary to fulfill tasks
  - Performance on provider specific quality measures linked to PALTmed competencies

Defining the Core Skills and Activities of the Attending Physician in Post-Acute and Long-Term Care (Morton L et al. JAMDA 22 (2021) 1778-1783)

ABPLM conducted 3-phase job analysis based on literature review, survey of attending physician and task force of subject matter experts

Table 1
Top 20 Attending Physician Task Statements in Rank Order of Mean Overall Rating by Domain (N=258-320)

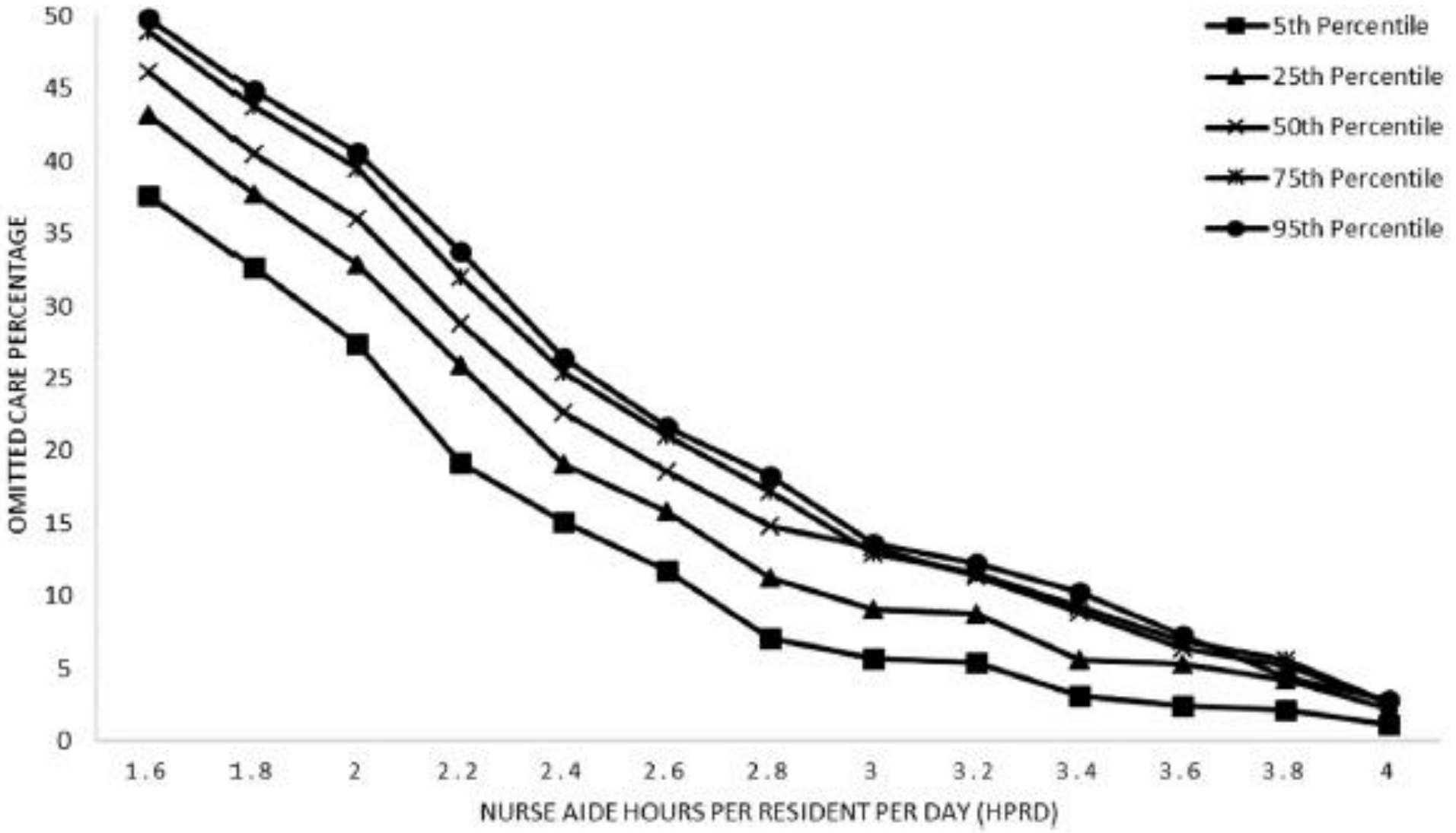
Overall Rank	Task Description	Mean Importance	Mean Frequency	Mean Overall Rating
Domain 1: Foundation (9 statements)				
2	Exhibit professional, respectful, and culturally sensitive behaviors	3.72	3.60	91.52
15	Adhere to principles of ethical conduct and decision making (eg, beneficence, autonomy, justice, fidelity, nonmalfeasance)	3.65	3.37	87.80
18	Utilize principles of shared decision making in routine medical care to achieve a patient- and resident-centered approach to care	3.57	3.41	87.26
20	Utilize elements of effective communication (eg, verbal, nonverbal, cultural considerations, open-ended)	3.55	3.42	87.10
Domain 2: Medical care delivery (57 statements)				
1	Problem recognition, assessment, management, and monitoring in the management of patients and residents	3.73	3.65	92.22
3	Respond promptly to notification concerning the patient's or resident's health status	3.72	3.60	91.48
5	Perform a patient or resident history and physical examination in a timely fashion based on status or acuity, including regulatory requirements	3.66	3.56	90.24
7	Provide timely and appropriate patient and resident visits, phone calls, and documentation	3.65	3.56	90.14
10	Evaluate the patient's and resident's health status in a timely manner on changes in health status based on medical necessity	3.67	3.44	88.93
11	Perform medication reconciliation at the time of admission, discharge, and all care transitions	3.65	3.47	88.90
13	Arrange for continuous coverage by a medical practitioner when unavailable (ie, 24-h coverage 7 d/wk)	3.67	3.37	89.74
17	Provide care that minimizes discomfort and disruption to the lives of patients and residents	3.59	3.39	87.26
Domain 3: Systems (18 statements)				
6	Adhere to federal and state regulations	2.64	3.57	90.15
12	Ensure that medical documentation is appropriately completed, signed, and shared with the facility or program in a timely manner	3.55	3.52	88.40
Domain 4: Medical knowledge (27 statements)				
4	Identify, evaluate, and address symptoms based on knowledge of diagnoses in individuals with multiple comorbidities and risk factors	3.68	3.62	91.19
8	Identify geriatric syndromes and use an individual and holistic approach to their evaluation, diagnosis, and treatment	3.67	3.47	89.20
9	Construct a preliminary differential diagnosis based on the information collected that offers additional data collection decisions and plans for evaluation, treatment, and re-evaluation	3.59	3.54	89.13
14	Routinely review medications for indication, duration, dosage, interactions, and presence of adverse consequences	3.58	3.45	87.86
16	Deprescribe unnecessary medications whenever possible	3.64	3.34	87.31
19	Develop a pertinent and adequate differential diagnosis for all medical signs and symptoms	3.52	3.46	87.23

Note: Importance scores ranged from 1 (no importance) to 5 (very important). Frequency scores ranged from 0 (never) to 4 (very often). No statements from the Personal Professional Development domain were among the top 20.

Time to Complete Tasks Limits Number of NH Residents Served

Determining Nurse Aide Staffing Requirements to Provide Care Based on Resident Workload: A Discrete Event Simulation Model (Schnelle et al. JAMDA 2016 (17):970-977)

- Purpose:
  - To describe the relationship between ADL workload and the level of nurse aide staffing reported by NHs
  - MDS data related to level of dependency on staff for ADL care for residents in 13,500 NHs
  - A discrete event simulation model determined the relationship between ADL workload and nurse aide staffing necessary for consistent, timely ADL care


5th Percentile
25th Percentile
50th Percentile
75th Percentile
95th Percentile
OMITTED CARE PERCENTAGE
0
5
10
15
20
25
30
35
40
45
50
1.6
1.8
2
2.2
2.4
2.6
2.8
3
3.2
3.4
3.6
3.8
4
NURSE AIDE HOURS PER RESIDENT PER DAY (HPRD)

Determining the Optimum Physician-to-Resident Ratio in the Nursing Home (Katz, P et al JAMDA 18 (2017): 1087-88)

- Based on estimated time to fulfill necessary tasks
- 1 FTE physician can effectively care for 10 SNF beds plus 100 NF beds
- Alternatively, 30 SNF beds equates to 3420 minutes per week (57 hrs)
- 25 SNF beds equates to 2850 minutes per week (47.5 hrs)

JAMDA 18 (2017): 1087-1088

Table 1
Average Time Per Encounter

Encounter	Clinical Time, min*	Administrative Time, min†
New admit	60	60
30/60 day‡	30	15
Acute visit	20	10
Discharge‡	30	30

*Includes face-to-face time with patient and family, review with nursing, counseling.

†Includes record review, calls to other caregivers, documentation and development of care plan.

‡Factors in team and family meetings.

Determining the Optimum Physician-to-Resident Ratio in the Nursing Home (Crecilius, C. JAMDA 18 (2017): 1088-89)

- Model is based off productivity with quality metrics affecting final payment (examined billing patterns for all codes (initial-subsequent-discharge-annual)
- A typical practitioner patient panel = 23 SNF patients and 82 NF patients
- Model is based on current time spent per code billed
- Avg time per visit = 41 min; At 14.9 visits per day, the avg practitioner will spend 10.17 hrs/day

From Task Completion to Quality Measurement: The Measurement Conundrum

- Productivity is not an ideal key performance measure nor are outcomes such as rehospitalization rates
- Administrative data misses the qualitative dimensions of physician/provider practice
- Ideally, quality measures should reflect a provider's competency
- We measure what is measurable rather than what matters (D. Dash)

Quality Indicators Specific to Primary Care Providers in NHs

- Identify Quality Indicators demonstrating value of primary care providers in nursing homes
- International research team, technical expert panel (TEP)
- Adapted existing QI to PALTmed competency framework
- IF, THEN statements
- RAND modified Delphi process
  - Valid
  - Feasible

Mays AM, Saliba D, Feldman S, Smalbrugge M, Hertogh CMPM, Booker TL, Fulbright KA, Hendriks SA, Katz PR.
J Am Med Dir Assoc. 2018 Oct;19(10):824-832. doi: 10.1016/j.jamda.2018.08.001.
PMID: 30268288

Quality Measures

99 quality measures narrowed down to 37 by the Technical Expert Panel

Based on following criteria:

Prevalence/ Incidence = The QI addresses an event that occurs with moderate or high frequency.	**Impact** = Health care described in the QI makes a substantial difference in an outcome that is of major importance to health status and quality of life.	**Performance gap** = A significant proportion of residents with this condition receive suboptimal care.	**Provider Relevant** = The PCP's role in influencing the care process is substantial.	**Measurement Feasibility** = The necessary information should be present in the typical medical record or the absence of documentation is, in itself, a marker of poor care.

Competency	Example Item:
Communication and Coordination of Care	IF a Nursing Home Resident (NHR) is admitted with the intention of a long stay, THEN the primary care provider (PCP) should see the NHR to initiate a comprehensive assessment within 1 day before or 3 days after transfer.
Cognition, Affect, Behavior	IF a NHR has a suspected or definite diagnosis of delirium, acute confusional state, or reduced level of consciousness, THEN there should be a documented attempt to identify a potential etiology.
Urinary	IF a NHR has bacteriuria, THEN antimicrobials should be prescribed only when symptom of UTI are present.
Goals of Care & Palliative	IF a NHR has an advance directive on admission, THEN the PCP is responsible for documentation in the medical chart upon admission.
Falls, Mobility, & Pressure Ulcers	All NHRs or their proxy should be asked about the occurrence of falls on admission and quarterly.
Medications	IF a NHR is prescribed a new chronic medication, THEN the subsequent PCP note should document response to therapy and continued need.
Pain Management	IF a NHR is treated with opiates for pain, THEN there should be documentation of a bowel regimen and a plan to document bowel patterns.

Mays AM, Saliba D, Feldman S, Smalbrugge M, Hertogh CMPM, Booker TL, Fulbright KA, Hendriks SA, Katz PR.
J Am Med Dir Assoc. 2018 Oct;19(10):824-832. doi: 10.1016/j.jamda.2018.08.001.
PMID: 30268288

How to Capture Process Measures Efficiently?

Building a Learning Health System for Long-Term Care

- Costa A et al. Healthcare Management Forum 2026 39(2); 178-184
  - Use machine learning to capture process-based QMs from the EMR
    - Ontario Supporting Partnerships to Advance Care and Knowledge (OnSPARK)
    - First Learning Health System Data platform for LTC
    - Integration of de-identified resident assessments (InterRAI), EMR records(Point Click Care) and staffing data (payroll) from 200 homes in Ontario
    - Designed to strengthen decision making, workforce planning and policy design at multiple levels of the system

EHR Data

interRAI

ASSESSMENTS
Infection surveillance

DEMOGRAPHICS
Gender, DOB, marital...

PROGRESS NOTES
Physicians note (medical care.. NP), allied health, head injury, falls, fall assessment, nutrition notes, dietician, skin, observation, palliative care, foot care notes.

PointClickCare
Care confidently.

FACILITITES

CENSUS

***LABS**

ORDERS
meds, dosage, frequency

DIAGNOSES

VITALS

IMMUNIZATIONS

Corporate Data

- HHR Systems
- Pharmacy (MAR)
- Falls
- BSO Observations
- QoL Surveys
- Visitor Logs

What's Missing?

- Competency, medical staff organizational structure and commitment have been proposed as links to quality in the NH (Ann Intern Med 2009; 150:411-413)
- While time spent on fulfilling necessary tasks is an element of commitment, it doesn't tell the whole story

Commitment

- A multi-faceted concept that goes beyond
  - Proportion of medical practice dedicated to LTC (e.g. SNFists)
  - Number of LTC residents for whom they provide care

Defining and Evaluating the Impact of Physician Commitment to NH Practice: A Population-Level Cross Sectional Study (JAGS 2025 73(7): 2057-2069)

- Retrospective cross-sectional study of practice patterns of physicians caring for NH residents in Ontario
- 3 measures of commitment
  - Proportion of NH practice based on residents
  - Years in NH practice
  - Number of NHs a physician worked in
- Higher commitment associated with reduced ED visits but inconsistent association with outcomes such as use of antipsychotics, antibiotics and hospital admissions

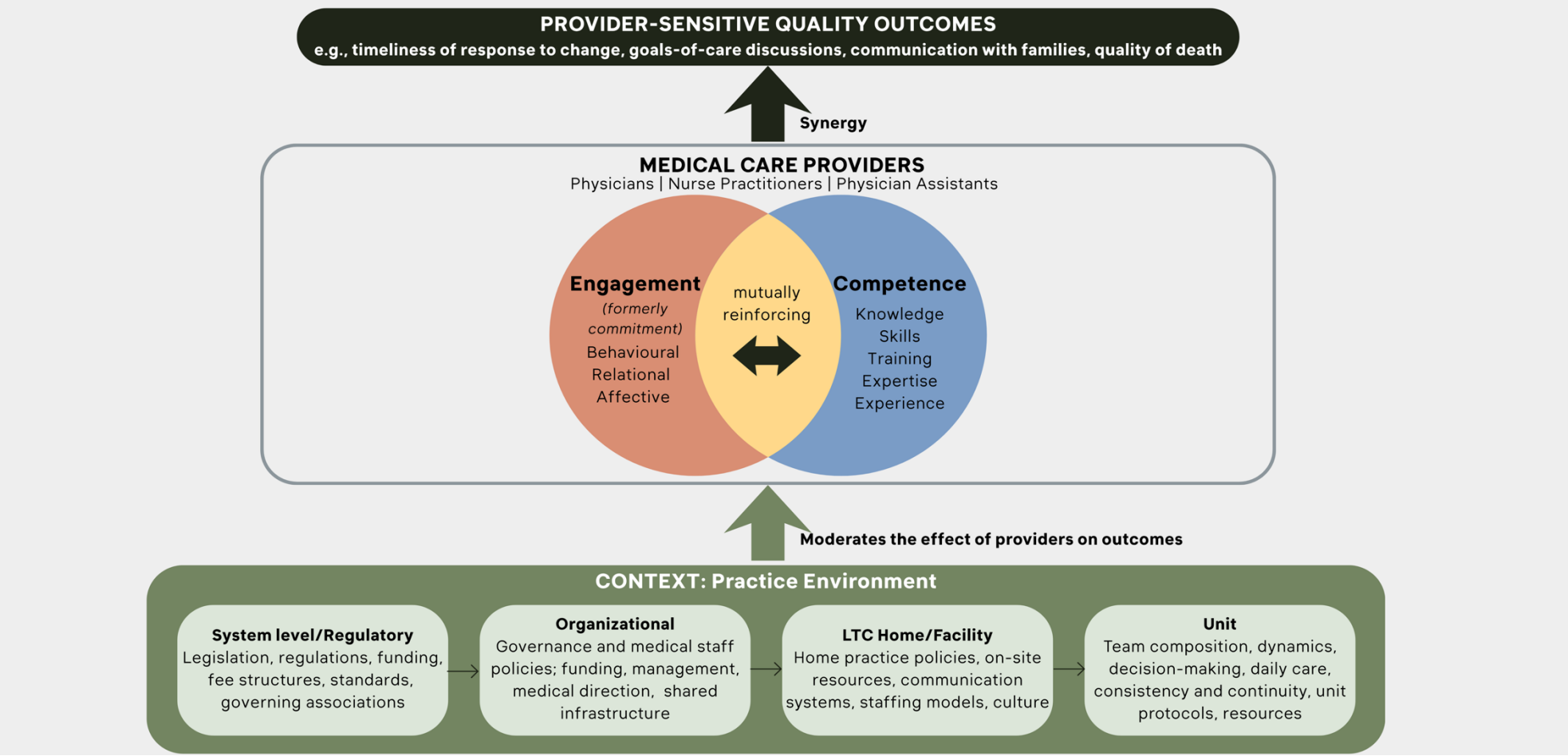
A Framework for Expectations of Physician Commitment in LTC Homes: A Consensus Statement (JAMDA 2026 27(1); 106001)

- A 2- round modified e-Delphi study engaging 27 Canadian LTC primary care physician
- 21 consensus statements endorsed covering time allocation, resident volume, in-person and remote visits, interdisciplinary collaboration, staff accessibility, medication management, palliative care and continuous competency development
- Excluded metrics tied strictly to practice proportions, billing structures, number of homes covered, extra certifications or leadership/research roles

A Framework for Expectations of Physician Commitment in LTC Homes: A Consensus Statement (JAMDA 2026 27(1); 106001)

- Future research should establish how to operationalize the framework using specific data sources beyond the traditional administrative data to:
  - Create validated instruments to assess the multidimensional aspects of commitment and
  - Consider variations in practice environments.

Reconceptualizing Provider Links to Quality: Redefining the NH Specialist Framework



Optimum Medical Provider to Resident Ratio

- Time to fulfill roles/tasks

+

- Engagement/Competence

+

- Performance using quality measures that are provider sensitive in addition to system level outcomes

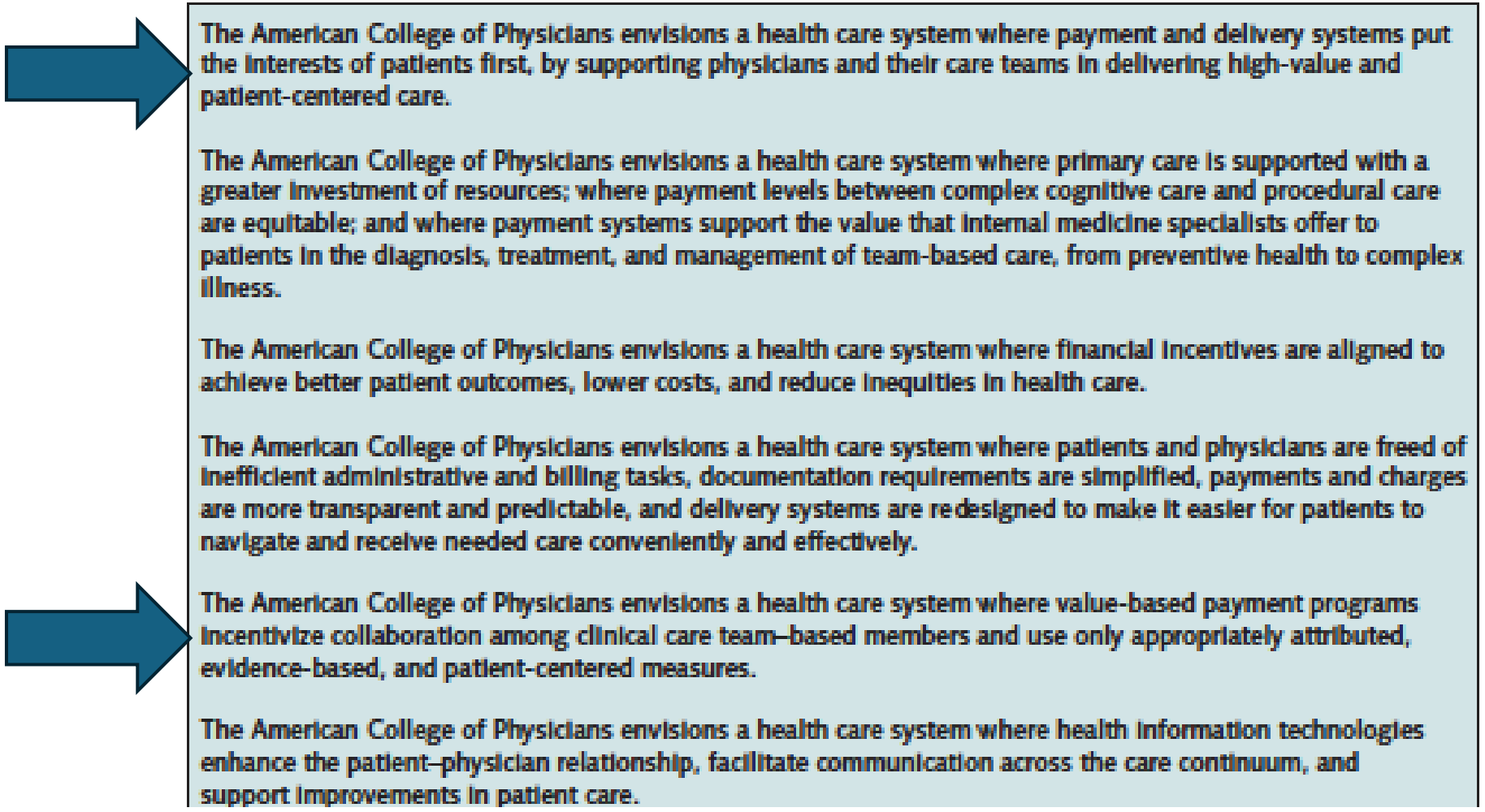
Moving Forward

- Set PALTmed standards for attending physicians in NHs regarding volume and roles/tasks; Same for NP/PAs in addition to specifying nature of collaboration
  - ? Specialty status as a framework
  - Research critical to demonstrate proof of concept regarding the engagement model

Moving Forward

- Less fee for service and more capitation/salary support
- Measure what matters rather than what's available/accessible
- Advocate for health system and regulatory reform (i.e. equity; access; transparency)

Figure. American College of Physicians vision statements related to health care delivery and payment reform.



Moving Towards the Ideal Nursing Home

- On site physician/NP/PAs specializing in NH care who round daily and are an integral and engaged member of the team
- Quality is based on both process and outcome measures that are provider specific
- Practice size based on empiric evidence demonstrating enhanced patient centered care
- Funding models that eliminate fee for service-based incentives
- A nursing home specialty