OIG to CMS: Add hospitalization rates to nursing home quality ratings and surveys

by Alan C. Horowitz, RN, JD

One out of every four Medicare nursing home residents was hospitalized in FY 2011, according to a recent study by the Health and Human Services Office of the Inspector General (OIG).[1] According to OIG's study, more than 825,000, or 24.8 percent of Medicare residents were hospitalized during FY 2011, costing Medicare $14.3 billion. On average, Medicare spent $11,255 every time a nursing home resident was hospitalized. That amount is about 33 percent higher than the average cost of hospitalizations for all Medicare beneficiaries. As a result of the rate of hospitalizations and associated costs, providers can expect the Centers for Medicare and Medicaid Services (CMS) to scrutinize this aspect of long-term care even more closely.

In addition to examining the rate of hospitalizations and related costs, OIG also looked at the specific medical conditions triggering hospitalizations; the extent to which the hospitalization rates varied according to the type of nursing facility making the hospital transfer; and whether the hospitalization rates correlated to specific nursing home characteristics, such as a facility's rating on the CMS Five-Star Quality Rating System.

OIG found that among the hospitalizations, 15 primary diagnosis categories accounted for more than 60 percent of all resident hospitalizations. Topping the list of diagnoses are septicemia (13.4 percent), pneumonia (7 percent), congestive heart failure (5.8 percent) and urinary tract infections (5.3 percent). Those four categories alone accounted for more than 31 percent of the hospitalizations.

A nursing home's annual resident hospitalization rate varied according to four discrete factors: 1) the facility's location, 2) its size, 3) its CMS Five-Star rating, and 4) the category of ownership. While 1,059 nursing facilities experienced annual hospitalization rates greater than 40 percent, the average nursing home had an annual hospitalization rate of 25 percent, according to OIG. Arkansas, Louisiana, Mississippi and Oklahoma had the highest annual hospitalization rates, with Louisiana's rate of 38.3 percent being 14 percent higher than the national average.

CMS' Five-Star Quality Rating System rates facilities in four separate areas: 1) health inspections (i.e., surveys), 2) staffing, 3) quality, and 4) overall. OIG found that facilities that rated one through three stars in health inspections, staffing and overall experienced a higher annual hospitalization rate than those facilities rating four and five stars. The largest difference in hospitalization rates correlated with the staffing metric. Interestingly, OIG found that facilities rated one, two and three stars in the quality metric had the same hospitalization rate as those facilities rated four and five stars for quality.

OIG stated, "As a group, for-profit nursing homes had the highest annual hospitalization rate compared to the rate for government-owned and nonprofit nursing homes." However, OIG also notes that the average annual hospitalization rates for for-profit nursing homes, government-owned nursing homes and nonprofit nursing homes are 26.5 percent, 23.5 percent and 21.2 percent, respectively. Thus, for-profit and government-owned nursing homes are still within 1.5 percent of the national average. Without more meaningful data, it is difficult to draw a reasonable inference from the 1.5 percent variance, on either side. It might be conceivable that for-profit nursing homes do a better job of transferring residents to hospitals when the need arises. It would be interesting if OIG risk-adjusted for the number of residents who died because they were not transferred to a hospital.

Based on its findings, OIG has recommended that CMS develop a quality metric for hospitalization rates—and post the data on its Nursing Home Compare web site. OIG also suggests that CMS develop discrete measures to identify facilities whose residents are being hospitalized frequently for specific medical conditions, such as septicemia.

OIG also recommends that state survey agencies make an examination of resident hospitalization rates part of the survey and certification process. Presumably, by examining facilities' rates of hospitalization, surveyors could identify "areas of concern—such as infection control practices in homes with high hospitalizations for septicemia."

CMS Administrator Marilyn Tavenner noted that "CMS is actively developing a hospitalization measure for all nursing home residents and a re-hospitalization measure for Medicare SNF [skilled nursing facility] residents."

With the Hospital Readmissions Reduction Program now more than a year old, the tide may be turning. On December 6, 2013, CMS announced that the all-cause 30-day hospital readmission rate among Medicare beneficiaries began to fall in 2012, averaging less than 18 percent over the first eight months of 2013. CMS estimates that 130,000 fewer hospital readmissions occurred between January 2012 and August 2013. Those encouraging numbers reflect all hospital readmissions, not just those patients who were admitted from a nursing home.[2]

MORE THAN MEETS THE EYE?

The issue of nursing home hospitalization rates may be more complex than appears at first blush. It is not just about numbers in a vacuum. Nursing facilities currently care for residents who have more medically complex and challenging conditions than in years past. Advances in medicine, pharmaceutical innovations and technology have made it possible for residents with serious medical conditions to live longer which might also be a factor in the hospitalization rates. According to the Centers for Disease

Control and Prevention ("CDC") the average life expectancy in the U.S. increased from age 70 in 1970 to age 78.7 in 2011.

Clearly, the longer someone lives with a serious medical condition, the more likely a hospitalization will occur. The fact that hospitalization rates have increased among nursing home residents needs to be viewed from a perspective that accounts for all variables and factors. To the extent hospitalizations can be appropriately avoided, that is a laudable and necessary goal. However, one should be mindful that many of those hospitalizations make the difference between life and death.

According to Daniel Haimowitz, MD, medical director at several nursing facilities and a member of AMDA—Dedicated to Long Term Care Medicine's *Caring for the Ages* editorial advisory board, "We live in a data-driven society. However, I think that there is a potential danger in looking only at numbers," Haimowitz observes. "Imagine two nursing facilities. Nursing Home A has a higher annual hospital admission rate than Nursing Home B. Does that mean the care at Nursing Home A is worse? Or could it be that the physicians and nurses at Nursing Home A are doing a better job of detecting clinical signs that a resident requires hospitalization? Taking a myopic view based solely on numbers without factoring in other variables may be problematic."[3]

RECOMMENDATIONS

Quality care requires avoiding preventable hospitalizations. Among the many resources available to help facilities achieve that goal are the quality improvement organizations (QIOs) in each state. According to Adrienne Mims, MD, MPH, vice president and chief medical officer of the Georgia QIO (Alliant GMCF) and president of the American Health Quality Association, "Providers should consider utilizing resources such as the QIO in their respective states to help reduce hospitalizations, where appropriate."[4]

Organizations such as the American Health Care Association suggest using resources such as INTERACT.[5] The goal of INTERACT is to improve the care residents receive and also reduce the frequency of potentially avoidable transfers to hospitals. As noted by Andrew Miller, chief medical officer, Integrating Care for Populations & Communities National Coordinating Center, "Resources such as INTERACT address the issue of hospitalizations in a number of ways. Currently, QIOs are working with over 400 communities throughout the country to improve transitions of care, so for many nursing homes, there may already be an organized effort in their community that they could join."[6]

Other initiatives and resources include the Advancing Excellence in Hospitalizations and AMDA—Dedicated to Long Term Care Medicine's practice guideline, *Transitions of Care in the Long Term Care Continuum*.[7] Given that many resources, including the INTERACT program are free, it may be a deal too good to refuse.

Although some facility personnel would have to expend time to utilize programs such as INTERACT, they could prove to be a very cost-effective programs in the long run. Utilizing valuable resources such as the QIOs and INTERACT can significantly promote quality care and avoid hospitalizations that are otherwise preventable. And, while the OIG study raises important questions, CMS still needs to take a holistic and rational approach to monitoring nursing home hospitalization rates.

[1] *Medicare Nursing Home Resident Hospitalization Rates Merit Additional Monitoring*, HHS Office of the Inspector General, OEI:-06-11-00040, November 2013.

[2] The CMS Blog, New Data Shows Affordable Care Act Reforms Are Leading to Lower Hospital Readmission Rates for Medicare Beneficiaries. Available at: http://blog.cms.gov/2013/12/06/new-data-shows-affordable-care-act-reforms-are-leading-to-lower-hospital-readmission-rates-for-medicare-beneficiaries/. Accessed on December 10, 2013.

[3] Email from Daniel Haimowitz, MD (medical director and member of the editorial advisory board for *Caring for the Ages*) to Alan C. Horowitz (December 10, 2013).

[4] Email from Adrienne Mims, MD, MPH, vice president and medical director, Alliant GMCF, to Alan C. Horowitz (December 11, 2013).

[5] INTERACT (Interventions to Reduce Acute Care Transfers) is a quality improvement program that focuses on the management of acute change in resident condition. It includes clinical and educational tools and strategies for use in every day practice in long-term care facilities. Available online at: http://interact2.net/index.aspx. Accessed on December 10, 2013.

[6] Email from Andrew Miller (chief medical officer, Integrating Care for Populations & Communities National Coordinating Center) to Alan C. Horowitz (December 11, 2013).

[7] Available online at: http://www.nhqualitycampaign.org/star_index.aspx?controls=hospitalizationsexploregoal, and,http://www.amda.com/tools/clinical/toccpg.pdf, respectively. Accessed on December 10, 2013.