EDITORIAL

Paying for Performance in Nursing Homes: Don't Throw the Baby Out with the Bathwater

In previous centuries, before the advent of indoor plumbing, families bathed in the same tub of water. The order of bathing was determined according to age and stature within the family. The heads of the household bathed first, followed by the next generation, and so on. By the time the babies were bathed, the water was less than clear. Thus arose the saying "Don't throw the baby out with the bathwater."

In this issue of the *Journal of the American Geriatrics Society*, Briesacher et al.[1] have provided us with a thoughtful and thought-provoking analysis of pay-for-performance (P4P) in nursing homes. They raise numerous legitimate caveats about P4P in general and about the Centers for Medicare and Medicaid Services (CMS) plans for a P4P demonstration in nursing homes in particular.[2] They urge the nursing home industry to think carefully before participating in the CMS nursing home "Value-Based Purchasing" (i.e., P4P) demonstration. Indeed, there are myriad complex issues surrounding P4P in nursing homes—what one might refer to as "dirty bathwater." But there is a baby in there, and we should not be so quick to throw it out with the dirty bathwater. Like a baby, P4P is immature now, but realigning some incentives in Medicare funding based on better outcomes could evolve into a powerful tool in our efforts to improve the quality of care we provide in nursing homes, as well as for the geriatric population in other settings. Some have advocated this strategy for many years.[3,4]

P4P attempts to address some of the fundamental problems with the Medicare fee-for-service system. If you have read Stephen Levitt and Stephen Dubner's entertaining book *Freakonomics*,[5] you understand clearly that financial incentives drive much of human behavior in our modern society. As well intended as Medicare was when it was implemented in the 1960s, and despite its ongoing success in protecting older Americans from the potentially catastrophic costs of medical care, its fee-for-service system provides some perverse financial incentives that can drive healthcare professionals and institutions to do the wrong thing for older people. More care, and the use of expensive diagnostic and therapeutic procedures without careful thought to their risks and benefits as well as patient and family preferences, can result in potentially avoidable, costly complications that may in turn cause substantial morbidity and suffering. Many studies have, in fact, failed to show a correlation between Medicare spending and various outcomes of care, including patient satisfaction.[6] Admittedly, modern medicine can provide miracles when the right interventions are implemented in the right patients, and the costs in terms of quality of life in these cases may be viewed as inconsequential. My favorite female patient, who is going on 104, had thrombolysis after an acute stroke that caused hemiparesis and dysarthria when she was 98; she is now as affable and pleasant as ever, and the joy of her daughter's life. I myself felt the pain and disability of end-stage degenerative joint disease in my right hip, and after a hip replacement a few years ago, I am as healthy and active as ever. I could not imagine living the rest of my life with my presurgical function and quality of life. Thus, I am not suggesting that spending precious Medicare dollars on high-tech medicine is the wrong thing to do for all older patients. I am, however, suggesting that these interventions need to be carefully targeted and that financial incentives in the current Medicare fee-for-service system drive some inappropriate and ineffective care. Reducing such avoidable expenditures would improve care and produce savings that CMS could use for P4P or value-based purchasing initiatives.

One major sticking point in the proposed CMS demonstration on P4P in nursing homes is the requirement for Medicare savings to be achieved in order for facilities to receive financial incentives. As mentioned in Briesacher et al.'s article, several states have initiated P4P programs in nursing homes, but the performance measures they are using are unlikely to generate Medicare savings. One measure that might offer the opportunity to improve care quality and reduce Medicare expenditures at the same time is potentially avoidable hospitalizations of nursing home residents. Avoidable hospitalizations play a prominent role in the planned CMS P4P demonstration, accounting for 30 of 100 points that can be earned for incentive payments.[2]

For nursing homes to reduce potentially avoidable hospitalizations, they have to have the capacity to deliver appropriate and high-quality care for acute and subacute illnesses, as well as palliative care. Many if not most nursing homes currently do not have this capacity. Reducing avoidable hospitalizations from nursing homes will therefore cost before it saves. Unless adequate infrastructure is supported in these facilities, P4P initiatives that require savings without up-front investment will not be successful and may have unintended consequences. The incentives may encourage poorly prepared facilities to care for sicker patients than they can safely care

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for and delay hospital admission of those who should not be managed in a facility with inadequate resources.

There is room for improvement in the quality of care around transitions between nursing homes and hospitals. One study found 40% of 100 hospitalizations from eight Los Angeles nursing homes to be "inappropriate."[7] Preliminary data from a CMS Special Study presented at the May 2008 American Geriatrics Society meeting suggest that the rate of potentially avoidable hospitalizations in Georgia may be substantially higher than in some other areas of the country.[8] Recently published data from a Commonwealth Fund–supported project in New York state demonstrate that, in 2004, 23% of the $972 million spent on hospitalizations of long-stay nursing home residents was for "Ambulatory Care Sensitive Conditions" such as heart failure, urinary tract infection, and pneumonia—suggesting that they may have been avoidable.[9] Medicare reimbursement for these hospitalizations totaled close to $188 million. These figures underestimate the frequency and costs of such avoidable hospitalizations, because short-stay residents on the Medicare Part A skilled benefit, among whom hospitalization is more common than long-stay residents, were excluded. They also did not include the costs of managing complications of hospitalization or Medicare expenditures for postacute skilled nursing care.

Consider some hypothetical calculations. Suppose that approximately one-third of 1.5 million elderly nursing home residents are hospitalized in a year, resulting in 450,000 hospitalizations; that the average Medicare reimbursement for each hospitalization is $6,500; and that one-third of these hospitalizations result in discharge to a Medicare skilled bed in a nursing home for an average of 30 days. That adds up to $4.5 billion. If you assume that one-third of these hospitalizations could have been avoided, that would result in $1.5 billion in Medicare expenditures that could be avoided. Theoretically, these potential savings could be invested in the infrastructure that is needed to manage sicker people in the nursing home and to improve the overall quality of nursing home care. Indeed, managed care programs, in which the financial incentives in the fee-for-service system are reversed, such as Evercare,[10] Program of All-Inclusive Care for the Elderly,[11] and others[12] have demonstrated that hospitalization rates and related costs for nursing home residents can be reduced by 30% to 80%.[13] Two decades ago, a demonstration program in Monroe County, New York, in which a Medicare "sudden decline benefit" provided reimbursement to the nursing home and the physician to manage residents with signs of acute illness without hospital transfer, was successful in reducing hospitalizations without increasing mortality rates.[14,15] Evercare uses a similar strategy to provide financial support to nursing homes to care for sicker residents without transferring them for acute care.

In addition to the need for up-front investment in the infrastructure needed to care for sicker people in nursing homes, there are numerous daunting challenges to using avoidable hospitalizations as a quality measure for P4P. In many respects, these challenges parallel those expressed about P4P in other settings.[16–21] First, a key challenge is defining the quality measures upon which incentives will be based. What is an "avoidable" hospitalization of a nursing home resident? In the study conducted in Los Angeles and the CMS study in Georgia cited earlier, experts used a structured implicit review tool to rate hospitalizations as potentially avoidable.[7,8] Although this tool has good face validity and reasonable interrater reliability, it would not be possible to use it in a large-scale P4P program, because it would require large numbers of professionals with expertise in nursing home care and copies of nursing home and hospital records and takes 20 to 30 minutes per case to complete. The measure used in the above-cited study in New York[9] and the one recommended for use in the CMS nursing home P4P demonstration is "Ambulatory Care Sensitive" diagnoses. Although these diagnoses include the most common reasons for potentially avoidable hospitalizations in nursing home residents (such as pneumonia, urinary tract infection, and heart failure), severity of illness in relation to the nursing home's clinical care capacity, along with several other factors, play an important role in the decision to hospitalize. CMS has developed methodology for risk adjustment for these diagnoses for the P4P demonstration as well as its Ninth Scope of Work for Quality Improvement Organizations. The accuracy of this methodology will be critical to the fairness and success of P4P based on rates of avoidable hospitalizations.

A second major challenge, alluded to above, is the capacity of nursing homes to manage sicker residents. Some facilities do not have access to rapid turnaround for laboratory, X-ray, and other critical clinical services, resulting in sending residents to local emergency departments, where hospital admission is likely. Many nursing homes struggle to find enough adequately trained long-term care nurses, and such nurses may not be prepared to handle subacute and acute conditions. A critical example is the capability to start, maintain, and monitor fluid administration intravenously or subcutaneously. Although the involvement of nurse practitioners in nursing home care has been shown repeatedly to reduce hospitalization rates, there are currently not enough trained nurse practitioners to cover all nursing homes. Nor are there enough physicians with special interest or expertise in geriatrics in long-term care. This poses a substantial barrier to one of the most common reasons hospitalizations have been rated as avoidable—on-site evaluation by a physician or nurse practitioner within approximately 24 hours of the onset of new symptoms or signs could prevent many hospitalizations.[8] To some extent, well-trained staff using care protocols and communication tools can mitigate some of the lack of on-site medical evaluations, but without financial support for the staff and other infrastructure necessary to manage sicker residents in the nursing home, P4P initiatives using avoidable hospitalizations as a quality measure are likely to be unsuccessful.

A third challenge is determining who is accountable for avoidable hospitalizations and who should reap the benefits of P4P incentives. This is a difficult issue in our complex and fragmented healthcare system. In CMS's Ninth Scope of Work for Quality Improvement Organizations, selected sites will work on "transitions in care" by defining a local community and working with a variety of healthcare providers. One logical way to approach this is by defining a local group of physicians, nursing homes, and hospitals who can be aligned together in some way to receive the benefits of reducing avoidable hospitalizations. Another approach would be to use the evolving "medical home,"[22]

in collaboration with local nursing homes, as the entity with accountability and the potential to benefit from P4P based on rates of avoidable hospitalizations. In any scenario, a mechanism will need to be in place to ensure that the incentive payments are being used to increase the nursing homes' capacities to care for residents who might otherwise be sent to the hospital.

A fourth issue, also unique to this proposed quality measure and the nursing home, is complexities surrounding advance care planning. All clinicians who work in nursing homes recognize that, for many of the severely impaired residents under their care, hospitalization is a futile intervention. It commonly results in complications, discomfort, and discontinuity in care, whereas palliative management in the nursing home would result in much-better-quality end-of-life care, but for a variety of reasons, many severely impaired and terminally ill nursing home residents do not have advance directives. One recent study showed that the rate of "do not hospitalize" orders in nursing homes is approximately 7%.[23] A myriad of complex issues may affect the ability to obtain care-limiting advance directives, ranging from ethnic and religious beliefs; to family members with unrealistic expectations, fear, and guilt; to the practicality of obtaining advance directives in residents admitted without the capacity to execute them. Tools that enhance nursing home staff's capabilities to conduct advance care planning and more aggressive documentation of advance directives before admission to the nursing home should be instituted not only to avoid hospitalizations, but also to reduce the futile and expensive care that many nursing home residents receive at the end of life.

Last but not least is the issue of the structure, timing, and adequacy of the financial incentives in a P4P program for nursing homes. In this regard, I very much agree with the concerns raised by Briesacher et al.[1] A difficult challenge with respect to reducing acute care hospitalizations of nursing home residents as a strategy to save money is the conflicting priorities in the Medicare and Medicaid programs—reducing hospitalizations will result in savings for Medicare but not for Medicaid. Because a majority of long-stay nursing home residents are supported by Medicaid, these competing priorities are problematic in efforts to provide incentives to reduce hospitalization.[24] Medicaid bed-hold policies, in which many states pay the nursing home the Medicaid rate for a period of time (usually 7 days) while dually eligible residents are in the acute hospital, are associated with higher hospitalization rates for nursing home residents.[25] Although managed care programs such as Evercare may provide nursing homes with financial support to manage sicker residents, savings on managed care Medicare patients are excluded from the calculations of Medicare savings in the proposed P4P demonstration. This places nursing homes in the untenable position of trying to manage sicker patients with inadequate infrastructure and financial resources to do so in order to reduce avoidable hospitalizations—which is why some upfront support for such infrastructure is essential for a P4P initiative to be successful in the nursing home setting. Moreover, financial incentives for reducing avoidable hospitalizations must be adequate to cover the ongoing costs of staff education and retention efforts and for providing the essential infrastructure that will be necessary to provide quality care for residents with acute changes in condition.

There is clearly a lot of "dirty bathwater" that surrounds P4P initiatives in nursing homes. Much more research and deliberation is needed on the definition of quality measures, who to hold accountable and reward, the timing and amount of the financial incentives, and the clinical practice tools that nursing home staff will need to manage sicker residents in the nursing home. Unless upfront support for infrastructure is provided, only a select few nursing homes with stable, high-quality nursing staff; good medical coverage; and ready access to ancillary services will have an interest in participating in the proposed P4P demonstration. Nevertheless, such facilities should be encouraged to do so, so that the ability to improve care quality and save costs by reducing avoidable hospitalizations can be demonstrated.

In the long run, P4P may not be the best strategy to improve care quality and reduce avoidable costs in typical nursing home settings, or any other setting for that matter. Arnold Epstein from the Harvard School of Public Health has written that "CMS may have much to gain from recognizing that P4P is fundamentally a social experiment likely to have only modest incremental value,"[20] and Karen Davis, President of the Commonwealth Fund, has written that "P4P is unlikely to fundamentally alter the incentives in the fee-for-service payment system. Ideally, it would serve as an interim program in the transition to fundamental payment reform,"[21] but fundamental healthcare payment reform may be years, if not decades, away.

Despite all the dirty bathwater, I still think that there is a baby in there—the basic strategy underlying P4P. The Medicare fee-for-service system too often provides incentives to do the wrong thing for older patients. Attempting to align some financial incentives with improving care quality, although potentially generating some savings that can be invested in the infrastructure needed for high-quality geriatric care, makes a lot of sense. It is one approach to the complex challenges of health financing reform that should continue to be given careful consideration—we should not be so quick to "throw the baby out with the bathwater."

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Joseph G. Ouslander, MD
Boca Institute for Quality Aging
Boca Raton Community Hospital

Division of Gerontology and Geriatric Medicine
Department of Medicine
University of Miami Miller School of Medicine

Christine E. Lynn College of Nursing
Florida Atlantic University
Boca Raton, FL

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