

# The role of nursing homes in national health care reform:

## *From warehouse to medical home*

Author: Arthur Y. Webb\*

With the passage of the Patient Protection and Affordable Care Act ("PPACA," or, simply "ACA") in 2010, this country is moving towards a health care system that is more accessible, more patient-centered, more focused on efficiency and effectiveness, and perhaps more innovative. The nation's 15,000 skilled nursing facilities provide a unique combination of resources and capabilities that can contribute to these goals, and yet, they have so far been largely overlooked.

A review of the more than 30 references to skilled nursing facilities ("SNF"s) in ACA reveals that more than half are references to quality control features, such as state survey support, civil monetary penalties, special focus surveys, compliance requirements, and bolstering reporting via Medicare Compare<sup>1</sup>. This example gives you the flavor of the language targeted to nursing homes in ACA: "[skilled nursing facilities will] *have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care.*"<sup>2</sup>

Government policymakers' attention to nursing home quality control is understandable, given the tremendous vulnerability of the patients that typically make use of their services, and the scandals of the 1970s that still reverberate. But it's interesting to note that no other health provider has the same language or extent of quality monitoring references in ACA, despite significant accounts of fraud, neglect and abuse that have been uncovered in many other health care establishments.

Most of the other references to SNFs concern efforts to rebalance long-term care and otherwise avoid nursing home placement. In so many places throughout the country, nursing home alternatives are desperately needed, and far too many people are forced to reside there only because there is a dearth of appropriate home- and community-based care options. The architects of the ACA, as well as the advocates who are fighting for alternatives, should be applauded. Equally meritorious and worthwhile are the provisions aiming to improve health care for individuals with chronic conditions, frequently those who are eligible for both Medicare and Medicaid. It should be possible to delay or avoid self-care disability through better coordination, monitoring and prevention, and it is high time our health system adapt to chronic care needs.

On this latter point, I am especially passionate. I have been a practitioner in the field of long-term services and supports for over 30 years, and have done everything within my authority and role to reduce the dependence on institutions by building systems of care with clear alternatives to institutionalization and consumer choices. As Commissioner of the New York State Office of Mental Retardation and Developmental Disabilities (now the Office of People with Developmental Disabilities), I set in motion the closure of all the state institutions while building one of the most extensive community-based

1 Go to the National Senior Citizens Law Center for a complete list of provisions.

2 SEC. 6102. ACCOUNTABILITY REQUIREMENTS FOR SKILLED NURSING FACILITIES AND NURSING FACILITIES.

services in the U.S.; and as the CEO of a non-profit provider organization, I downsized its nursing home to replace those resources with community care options. I too have fought hard to build alternatives to nursing homes.

I am very disappointed, however, that all this attention to alternatives ignores the vital role that these facilities play in the health care of people with frailty, multiple co-morbidities and complex conditions. For example, where else can fragile individuals go after a hospital stay? They must leave the hospital setting once their care is not acute, and this is appropriate for both safety and cost-effectiveness. However, many people – especially older adults – cannot tolerate the rigors of rehabilitation hospitals, and require a 24/7 recovery option that consolidates multiple therapies and supports after a hospitalization. Only SNFs can fill this role.

Another vital role that cannot be filled elsewhere in the nation's healthcare system is the care of those who are especially frail or dealing with multiple disabilities and conditions. Patients on more than a dozen medications, with advanced dementia, ventilator-dependent, incontinent, or with other complex clinical conditions or disabilities often cannot be safely attended to in private homes or assisted living, and deserve good skilled nursing care to maximize their strengths and abilities.

Additionally, nursing homes often serve as a hub for an array of community services for the “nursing home-eligible” individual, including medical day care, various home health care programs and assisted living programs. With a physical facility serving as the point-of-contact for seniors and their caregivers/agents seeking services, effective community-based long-term care – those valuable alternatives that can delay or avoid institutionalization – become more accessible.

There are many other roles – both currently and potentially – that skilled nursing facilities fill in our health care system, and they are here to stay. First, consider these facts:

- ▶ There are 15,000 nursing homes serving 1.7 million people in the U.S. annually
- ▶ More than 17% of Americans over the age of 85 live in nursing facilities.<sup>3</sup> As this age group is the fastest-growing cohort, the demand for good skilled nursing care will only increase.
- ▶ About half of all people turning 65 will enter a nursing home in their lifetime.<sup>4</sup>

Before I launch into the reform agenda, I want to lay out my assumptions:

### **WORKING ASSUMPTIONS FOR THIS DISCUSSION**

- ▶ Nursing homes are here to stay and with the aging of America, the use of nursing homes will grow.
- ▶ Nursing homes consume a considerable amount of public dollars.
- ▶ “Skilled nursing facilities” (the official terminology) and “nursing homes” are interchangeable terms.
- ▶ They are among the most heavily regulated care providers in our society.
- ▶ No value judgments are being made on whether nursing homes are good or bad places. Both types of places exist.

3 Long-Term Care: Facts on Care in the U.S., Brown University

4 Lifetime use of nursing home care, Kemper and Murtaugh, New England Journal of Medicine 1991

*\*Arthur Webb has been involved in health and human services since 1971, with over 20 years of experience as a provider of a wide range of health and human services and almost 18 years as public official in New York State government. His government experience includes responsibility for Medicaid budgets in the budget division; commissioner or director of four government agencies including Department of Social Services (the welfare, Medicaid and social services agency); Office of Mental Retardation and Developmental Disabilities; Office of Substance Abuse Services; and Health Planning Commission. As a provider, Mr. Webb was president & chief executive officer of Village Care of New York and, most recently, chief operating officer of St. Vincent's Catholic Medical Centers in New York.*

*The Arthur Webb Group provides advice and consultation to health care providers, health plans, disease and utilization management companies and government officials. The group specializes in offering innovative solutions in the post-acute world.*

- ▶ Nursing homes need to transform themselves into modern health care providers or re-invent themselves.
- ▶ All nursing homes need to be part of a larger system of care, an integrated network or an ACO. This includes information exchange and clinical networks.

### **WHY THEN, ARE NURSING HOMES LEFT OUT OF HEALTH CARE REFORM?**

First, I believe that advocates and policymakers are simply “stuck” in the watch-dog mindset. For the past 25 years, there have only been calls for more regulatory oversight, stiffer penalties, and closer monitoring of nursing homes, rather than postulating advances for the role SNFs play in meeting the growing demands. Of course, we do need to pay attention to our institutions lest they deteriorate, whether they are financial institutions, religious establishments or nursing homes. As a past regulator, I appreciate the voice of concern that is loudly spoken.

On the other hand, nursing homes have been demonized and admonished for far too long: they are branded as “warehouses” and disparaged in the public opinion. If we go a little deeper, we realize that nursing homes bear the blame for failed public policies to build adequate alternatives, to support family caregivers sufficiently, and to promote a comfortable end-of-life.

Another reason why nursing homes are left out of health care reform can be because they serve multiple purposes, making it difficult to fit them into the big picture. Bruce Vladeck wrote about nursing homes in 1989, saying that the role of nursing homes has never had a consensus. It is called upon to provide a number of different things, often contradictory: from post-acute stays, provision of rehabilitative care, providing homes for those in the last days of their life, for those with dementia and other behavioral conditions. He further noted that they have not been staffed, financed or organized to do all these things.<sup>5</sup> This is true today as it was over 20 years ago.

There is a third reason why nursing homes have so far been overlooked in national health reform discussions: the major policy centers and trade associations have not highlighted the unique value of skilled nursing facilities or defined an explicit role for them in national health reform. I cannot say that my search was exhaustive, but in looking at over 20 centers and trade groups, I did not find any specific opinions, references or research on nursing homes and how they could play a role.

So, for reasons of history, complication and a lack of advocacy, the skilled nursing facility has been considered in health care reform only as an entity to be carefully monitored or avoided. Yet, there is just too much potential in this large and uniquely qualified industry to let it go at that. Nursing homes – and the patients they care for – must not be relegated to the bin of leftovers.

The economic potential is also compelling. According to the Center for Health Care Strategies, the elderly and adults with disabilities – a good number of whom are treated or live in nursing homes – make-up only 25% of Medicaid beneficiaries but account for the majority of Medicaid spending. Within this population, fewer than 5% of the beneficiaries account for more than 50% of overall Medicaid costs.<sup>6</sup> Making systemic improvements in facilities caring for high-cost patients should reap significant savings.

Hospitalization – and its costs – are also disproportionately tied to skilled nursing facilities. Vincent Mor and his colleagues highlight this in their January 2010 Health Affairs article, “Revolving Door of Re-hospitalization from Skilled Nursing Facilities.” Not only do one in five Medicare patients discharged from a hospital return within a month, but the number is even higher for those referred to skilled nursing facilities – upwards of 25%. These re-hospitalizations cost Medicare over \$4.0 billion in 2006.

Of course, nursing homes admit the most complex and sick patients from hospitals, so that for many, re-hospitalization may be inevitable. But reform aimed at SNFs might have an impact on the re-hospitalization rate. For example, the Evercare Program of United Healthcare has shown that by enhancing some resources within the nursing home and emphasizing good end-of-life care, hospitalizations can be reduced, to the point of significant net savings.<sup>7</sup>

5 Bruce C. Vladeck, Ph.D., “Seminars in Health Care Delivery: Long-term Care for the Elderly,” United Hospital Fund of New York, 1989.

6 Long-Term Care: Facts on Care in the U.S., Brown University

7 The effect of Evercare on hospital use, Journal of the American Geriatrics Society, Kane et. al. 2003.

At the same time, skilled nursing facilities represent a “step-down” from acute care hospitals, enhancing the cost-effectiveness of the overall patient flow during an episode of care. A full 95% of SNF admissions in New York State come from hospital discharges<sup>8</sup>, which enables acute care length-of-stay to remain low, while at the same time, patients benefit from the more nurturing environment of a nursing home over a hospital.

It is important to note that nursing homes have also stepped into a role as step-down behavioral health providers. Often-times, a patient is hospitalized when their health deteriorates due to the inherent care barriers of mental illness, and once stabilized, require ongoing assistance to manage their clinical care. Without any official designation, SNFs have built up behavioral health capabilities that enable them to maintain good health for persons that would otherwise have no where to go and no wherewithal to care for their chronic conditions.

Nursing homes have evolved into institutional settings providing care at two ends of the residential long-term care spectrum. For one, they maintain a traditional role of providing long-stay services for frail individuals who often have no other care alternative. For these long-stay residents, nursing homes are providing, on average, 200 days of care. On the other end, there is a growing sub-acute care population found in nursing homes who are require only short stays before many move on back home. For these short-stay, post-hospital patients, nursing home care is, on average, some 20 days, and the movement in among many providers is to reduce that length of stay as much as possible.

This “bi-model” nature of nursing homes now complicates management and regulation.

With the vital role SNFs play in both post-acute health care and health care for high-need/high-cost individuals, it is clear they can play a tremendous role in both “bending the cost curve” and improving quality. We need to introduce a progressive notion of nursing homes as cost-effectiveness-enhancers.

Using Clayton Christensen's research on disruptive technologies, it is likely that nursing homes will be faced with pressure to change and compete with new models of alternative ways to meet the needs of the post-acute care and those with chronic care needs.

Here's the beginning of a national reform agenda that takes advantage of the skilled nursing homes' unique opportunities:

***Hospital-Physician Group-Skilled Nursing Facility Accountable Care Organization:*** While integrated delivery systems have been promoted before, CMS is now putting significant money and attention to the idea. In brief, the shared savings initiative for accountable care organizations (ACOs) assumes enrollment for Medicare beneficiaries that utilize a “cluster” of providers anyway.

The hope for quality and cost improvement under ACOs is based on the successes of entities such as the Mayo Clinic, the Cleveland Clinic or Kaiser Permanente. It is not envisioned as an initiative specific to high-cost/high-need chronically-ill Medicare beneficiaries, and yet the concept applies even better to this population, but only when skilled nursing facilities are included.

In a recent Urban Institute paper on ACOs by Kelly Devers and Robert Berenson, the authors point to three essential characteristics of ACOs:

1. The ability to provide, and manage with patients, the continuum of care across different settings;
2. The capability of prospectively planning budgets and resource needs; and
3. Sufficient size to support comprehensive, valid, and reliable performance measurement.

---

8 New York Association of Homes and Services for the Aging (NYAHSa)

For older adults with multiple chronic conditions, the cluster of providers typically includes not only a physician group and a hospital, but also a skilled nursing facility, at the very least for short-term post-acute care. In fact, in many geographic areas, the physicians with privileges at the nursing home are the same ones caring for a preponderance of frail older adults in their private practices, and the same ones who attend on the geriatric units of the hospital. In the greater New York City Metropolitan area, some high-profile triple-linked entities include:

- ▶ Mount Sinai, Martha Stewart Center for Living and Jewish Home and Hospital
- ▶ North Shore-LIJ, Geriatric Medical Group, and Parker Jewish Geriatric Institute
- ▶ Maimonides Medical Center, Geriatrics Ambulatory Care, and Metropolitan Jewish Geriatric Center

If the ACO is really to be effective among the high-cost/high-need Medicare beneficiaries, incentives must be put in place to include skilled nursing facilities in the organization. In fact, if nursing homes were included in ACOs, additional quality improvements, efficiencies and cost savings can result. For example, care transitions, which drive so much cost and morbidity in the Medicare program, would get the necessary attention and resources under a triple-entity ACO. Skilled nursing facilities could also support direct admissions, bypassing unnecessary emergency room visits and hospitalizations. Health information technology across multiple settings will be advanced.

It would be easy enough to mandate that a defined proportion of the total ACOs authorized include at least one skilled nursing facility. Such a mandate would also provide invaluable information to continue to improve our health care system for older adults.

### **PATIENT-CENTERED MEDICAL HOME FACILITY**

The most important reform initiative and one that will be most disruptive is to get nursing homes organized into behaving as if they are medical homes. Medical homes are seen as the latest version of a continuous and comprehensive primary care model. Likewise these principles should guide nursing home medical care. For example, some research shows that if patients are seen within 24-hours of discharge from hospitals, their rates of re-hospitalizations go down. With such a high rate of re-hospitalization from nursing homes, using a medical home model, nursing homes can be effective in reducing these high rates.

Using the PPACA language as a framework for understanding the scope of the medical home model, a nursing home also would incorporate much of the following: assignment of personal and specialist physicians; whole person orientation; coordinated and integrated care; safe and high-quality care through evidence-informed medicine, appropriate use of health information technology and continuous quality improvements; and expanded access to care. Nursing homes should be in collaboration with local care providers with a combined focus on those conditions amenable to prevention.

With a medical home model, nursing homes would play an important function in the following health reform initiatives under PPACA, for example:

- ▶ Preventable hospitalizations
- ▶ Reduction of preventable conditions
- ▶ Participation in ACO initiatives (see above)
- ▶ Participation in payment reforms such as "bundling"
- ▶ Participation in the health homes for chronic conditions (Sec. 2703 of PPACA)
- ▶ Model the continuing care hospital demonstration under Sec. 10308 of PPACA

Bending the cost curve is certainly a major goal of health reform. Nursing homes can lead the way with several initiatives under a reform agenda:

- ▶ Value-based purchasing: This could become a central driving force to reform nursing homes and incentivize them to participate in the larger reform agenda.
- ▶ Dual Eligible Demonstration: For example, a managed care risk model for nursing home patients along the lines of an Evercare model will work to improve care and reduce hospitalizations
- ▶ Doing more intensive reviews of medications to reduce Part D costs in nursing homes.
- ▶ Improving use on institutional hospice care: Incentivize nursing homes by being paid at Medicare hospice rates to direct patients who need institutional hospice instead of hospital admissions.

Much needs to be done in the following areas that would promote the integration of nursing homes:

- ▶ What would be the shared risk model if they participate?
- ▶ What standards of quality would apply?
- ▶ How would they get paid or incentivized?
- ▶ What clinical structure and relationships would have to be in place to upgrade the clinical practice and management of nursing homes?
- ▶ How would transition planning be implemented?

The CMS Innovation Center should authorize a demonstration to develop a certification program akin to the NCQA Patient-Centered Medical Home, tailored to residential health care facilities. SNFs may then similarly receive Level I to Level III certification – which in turn can entitle them to payment enhancements through some State Medicaid programs – by ensuring such features as:

- ▶ Assignment of a personal physician and active physician oversight of care
- ▶ Comprehensive clinical and ancillary information maintained and accessible
- ▶ Proactive sub-population management
- ▶ Adherence to evidence-based protocols for most common clinical conditions in the facility
- ▶ Rigorous performance improvement infrastructure
- ▶ Enhanced patient and family education and decision-making support

As an alternative, skilled nursing facilities can be certified for the rigor and quality of their **Transitional Care** capabilities, including full information collection and immediate physician visits. In addition, pharmacist-delivered medication management and reconciliation, utilization of evidence-based pain management and palliative care standards, assessment and treatment of depression, and other requirements for high-quality care must be specified.

**Dual-Eligible Innovation Expansion:** Currently, States seeking to innovate programs and benefits for dual-eligibles face tremendous complications and bureaucracy in doing so. Moreover, the incentive to promote programs for people eligible for both Medicare and Medicaid is weakened because typically savings are achieved through reducing unnecessary hospitalizations, the financial benefit of which accrues almost exclusively to Medicare and the federal government. However, with the CMS Innovation Center implemented, new opportunities emerge.

Perhaps the most promising opportunity is an ***Institutional Shared Savings Plan***, combining the idea of an institutional special needs plan – pioneered and most often found in United Healthcare's Evercare program – with some of the features of an ACO.

As discussed, skilled nursing facilities today are well-equipped to provide complex clinical care, given the morbidity of long-stay residents and the intensity of short-stay sub-acute patients. With the right incentives, these capabilities and resources could be re-organized to provide “step-up care” within the facility, rather than sending a resident/patient to the hospital. At the same time, if incentives were in place to focus resources on improving palliative and end-of-life care within a skilled nursing facility, many more hospitalizations can be avoided as well.

This opportunity can also be developed through capitation models, as Evercare and some other programs have developed it. With state-wide initiatives, the state can facilitate the management of risk, through state-wide pools or re-insurance mechanisms. In fact, state governments may also be called upon to utilize the resultant savings to promote acute care downsizing and shifts to ambulatory care capacity.

These are just a few of the more powerful opportunities that skilled nursing facilities represent, as the nation marches forward with health system quality and efficiency improvements. Nursing homes might also meaningfully contribute in efforts at value-based purchasing, hospice expansion, and pharmaceutical expense reductions.

In closing, I believe that nursing homes are here to stay, and that's because they play a vitally important role in the care of our nation's frail and clinically-complex individuals – a role no other industry seems willing or able to play. As a result, skilled nursing facilities can contribute uniquely to health reform and cost-efficiency. The ideas in this paper seem especially promising, but so much more is possible. With the nursing home industry filling its share of the health reform puzzle, we can achieve the kind of health care system that our country and its older citizens deserve.