DOWNLOAD PDF UTILIZATION PATTERNS AND FINANCIAL CHARACTERISTICS OF NURSING HOMES IN THE UNITED STATES

Chapter 1 : Products - Series Reports - Series 13

Data are presented that measure utilization, staffing patterns, cost of providing care, and profit- ability. National information on revenues are available for the first time from this survey. The NNHS covered all types of nursing homes in the coterminous United States.

Although older adults vary greatly in terms of health status, the majority of them have at least one chronic condition that requires care. Older adults also vary in their demographic characteristics, which leads to differences in their demand for and utilization of health services. Projections of the uti lization of health and long-term care services often suffer from important methodological limitations, but all projections indicate that the demand for services for older adults will rise substantially in the coming decades, which will put increasing pressure on Medicare and Medicaid budgets and on the capacity of the health care workforce to deliver those services. Over the coming decades, the total number of Americans ages 65 and older will increase sharply. As a result, an increasing number of older Americans will be living with illness and disability, and more care providers and resources will be required to meet their needs for health care services. In order to design effective models of care delivery and prepare a health care workforce to serve this future population, one needs to understand both the projected health status of this population and the demand for health services under the current system. Such an understanding will help identify what changes will need to be made in the health care workforce in terms of its size, distribution, and training to fulfill its looming charge. This chapter begins with an overview of the current health status and health services utilization patterns of older adults. Older adults today en counter a number of health challenges as they age and, on average, use a relatively large volume of health care services. However, the older adult population is quite heterogeneous, with individual members displaying an array of health statuses and needing a variety of services. Box presents some hypothetical examples to illustrate the diversity of the current older population by describing several typical older adult profiles. S is a year-old divorced woman who is retired from her job as an executive secretary and now lives in a retirement community where she plays golf three times a week. She lives without assistance more The chapter continues with a review of projections of the future health status and utilization patterns of older adults as well as a description of the assumptions and limitations of those projections. Although it is difficult to predict with accuracy the number and types of health services that will be demanded by older adults, it is clear that the total volume of health and long-term care services needed in the future will be much greater than the volume provided today. The chapter concludes with a brief discussion of the implications of these projections. Older adults today have greater longevity and less chronic disability than did those of previous generations Federal Interagency Forum on Aging Related Statistics, ; Manton et al. While these improvements appear to be related in part to declines in smoking rates and better control of blood pressure Cutler et al. Studies also show improvements in the reported physical functioning of older adults, such as the ability to lift, carry, walk, and stoop Freedman et al. The evidence for declines in limitations in activities of daily living ADLs , such as eating, bathing, dressing, using the toilet, transferring such as from bed to chair , and walking across the room is less strong Freedman et al. Despite these improvements, however, older adults still do have high rates of chronic disease and disability, particularly as compared to younger adults Table , and disease prevalence has risen as longevity has increased Crimmins, It is important to note that if one looks just at aggregate data, such as those on disease prevalence Table , it obscures important differences in the health status among subgroups of older adults. These healthier older adults tend to be community-dwelling individuals who require only preventive and episodic health services. On the other hand, a large majority of older adults approximately 82 percent have at least one chronic disease that requires ongoing care and management, with hypertension, arthritis, and heart disease being the most common Table In fact, Medicare beneficiaries with more than one chronic condition visit an average of eight physicians in a year Anderson, An analysis of Medicare expenditures shows that the 20 percent of Medicare beneficiaries

with five or more chronic conditions account for two-thirds of Medicare spending Partnership for Solutions National Program Office, Data from the Medical Expenditure Panel Survey show that almost all Medicare spending and 83 percent of Medicaid spending is for the provision of services to individuals with chronic conditions. In addition, many older adults experience one or more geriatric syndromes, clinical conditions common among older adults that often do not fit into discrete disease categories. Examples include delirium, depression, falls, sensory impairment, incontinence, malnutrition, and osteoporosis. The syndromes tend to be multifactorial and result from an interaction between identifiable patient-specific impairments and situation-specific stressors Flacker, ; Inouye et al. Estimates of incontinence, for example, range from 17 percent to 55 percent in older women and from 11 percent to 34 percent in older men. Almost half of older men and 34 percent of older women ages 65 and older report trouble hearing. Although estimates vary across surveys, data from the Health and Retirement Study indicate that 27 percent of community-dwelling adults ages 65 and older 8. Approximately 6 percent of older adults living in the community 2. This group of older adults requires more intensive care in the home, particularly personal-care services. The majority, approximately 1. Those over age 85 are much more likely to live in a long-term care setting than younger older adults. In fact, those over age 85 are four times as likely to live in a nursing home as those aged 75 to 84 Jones, On average, older adults living in nursing homes and residential care facilities tend to have more severe disabilities than older adults living in their own private homes, although more disabled older adults live in the community than in long-term care settings. Residents of long-term care facilities often have the additional need for symptom management and palliative care, that is, for noncurative care that is focused on alleviating physical symptoms and addressing psychological, social, and spiritual needs Moon and Coccuti, Approximately 80 percent of deaths in the United States occur among older adults Kung et al. Studies indicate that older adults follow different trajectories of dying IOM, Some have normal functioning but then die suddenly. Others die after a distinct terminal phase of illness, such as occurs with many types of cancer. Still others have a slower decline with periodic crises before dying from complications, as is the case with stroke or dementia. About half of Medicare patients who die from cancer use hospice services in the last year of life. Deciding whether to use palliative care or curative treatment for illness during these times is a very personal choice and depends on the individuals being affected Moon and Coccuti, Mental Health Conditions Vulnerability to mental health conditions tends to increase as older adults age and become more likely to encounter stressful events, including declines in health and the loss of loved ones. Approximately 20 percent of adults ages 55 and older have a mental health condition, the most common being anxiety disorders e. Cognitive impairment with no dementia CIND has been described as the intermediate state between normal cognitive function and dementia, a chronic illness characterized by a decline in memory and other cognitive functions. The prevalence of dementia increases with age, escalating from about 5 percent among individuals aged 71 to 79 to about 37 percent among those aged 90 and older Plassman et al. Additionally, suicide rates for men 65 and older are higher than any other age group and are more than twice the national rate for all persons NCHS, In approximately 31 percent of persons with disabilities and 45 percent of severely disabled persons reported depressive symptoms, and 15 percent of older adults with disabilities and 25 percent of severely disabled older adults had cognitive impairments Johnson and Wiener, The prevalence of mental health conditions is even higher among nursing home residents. In nearly half of nursing home residents had dementia, and 20 percent had other psychological diagnoses Houser et al. One reason for these trends may be that mental and physical health are interrelated New Freedom Commission on Mental Health, While the direction of causality between the two remains unclear, the correlation between them has been well documented. Persons with dementia and CIND have more serious comorbidity than those without cognitive impairment Lyketsos et al. Physically disabled adults report higher rates of mental health conditions. People with depressive symptoms often experience higher rates of physical illness, health care utilization, disability, and an increased need for long-term care services Federal Interagency Forum on Aging Related Statistics, ; Ormel et al. In addition, depression in later life is associated with poor health habits and diminished adherence

to treatment for co-existing medical disorders. Among older adults, the combination of heavy alcohol or substance use with depressive symptoms has been shown to be associated with high risk for suicidal ideation and poor physical well-being Bartels et al. Although they represent about 12 percent of the U. Utilization data for several acute-care services are displayed in Table In the most common reasons for older adults to make office visits were all related to chronic conditions: Older adults frequently made visits to internal and family-medicine physicians, but more than half of their visits were to specialists NCHS, Older adults also tend to visit multiple physicians. In half of Medicare patients visited between two and five different physicians, 21 percent visited six to nine physicians, and 12 percent visited ten or more different physicians MedPAC, Although there are many specialists for which older adults constitute a large percentage of visits e. The stigma associated with seeking mental health services presumably contributes in part to this low utilization, but limited coverage by Medicare for psychiatric services is also a reason Manderscheid, Medicare requires a 50 percent copayment for outpatient mental health services as compared with only 20 percent for most other outpatient services. Older adults also receive a considerable amount of ambulatory care at hospital outpatient departments. Older adults accounted for more than 13 million visits to hospital outpatient departments in , not including visits to emergency departments EDs ; the reasons for these visits were similar to those for visits to office-based physicians Middleton and Hing, Older adults account for a disproportionate share of emergency services. In fact, the rate of use of emergency medical services EMS by older adults is more than four times that of younger patients, and older adults account for 38 percent of all EMS responses Shah et al. Between and ED visits by patients between the ages of 65 and 74 in creased by 34 percent, and adults over age 65 had the greatest increase in visit rate of all age groups Roberts et al. In older adults made More than one-third of older adult ED patients arrived by ambulance, using ambulance transport at more than double the rate of ED patients as a whole McCaig and Nawar, These EDs do not have the expertise, equipment, or policies to provide optimal care for older patients. Once they have been treated, older adults are more likely to have an overnight hospital stay and also more likely to have multiple overnight hospitalizations. In older adults accounted for more than 13 million inpatient discharges. The most common inpatient diagnoses included coronary atherosclerosis hardening of the heart arteries and other heart disease , congestive heart failure, and pneumonia Merrill and Elixhauser, Forty-two percent of older adults receive some post-acute care services after discharge from the hospital. Approximately 27 percent of older adults are discharged to another institution, such as a skilled nursing facility SNF or rehabilitation center; another 15 percent receive home health care AHRQ, Medicare covers up to days 20 days of full coverage and 80 days of partial coverage in a SNF after a hospitalization of at least three consecutive days MedPAC, b. Overall, almost 3 million Medicare beneficiaries received home health services in , including skilled nursing, physical therapy, speech-language pathology services, aide service, and medical social work MedPAC, a. Medicare provides home health care to homebound beneficiaries needing part-time fewer than 8 hours per day or intermittent temporary but not indefinite skilled care to treat their illness or injury. Personal care and other non-skilled needs are not covered by Medicare. Older adults are especially vulnerable as they transition between types of care. A lack of coordination among providers in different settings can lead to fragmentation of care, placing older adults at risk for absence or duplication of needed services, conflicting treatments, and increased stress Parry et al. For example, medication changes, which are a common cause of adverse drug events, are not unusual in the transition from hospital to long-term care settings such as nursing homes and private home settings Boockvar et al. Incomplete procedures during hospital discharge may also be linked to unnecessary rehospitalizations Halasyamani et al. Coordination of care and the use of interdisciplinary teams, is discussed in more detail later in this report. Long-term care services include health and personal services provided to chronically disabled persons over an extended period of time. Estimating the total amount of long-term care services received by older adults is difficult because utilization data are not often collected in a consistent manner across settings or care providers. Just over 60 percent of disabled older adults living in the community obtain some long-term care services, most commonly basic personal-care services and help with household chores, averaging about

hours per month Johnson and Wiener, Informal caregivers provide the vast majority of these services. Only about 18 percent of long-term care services provided to disabled older adults in their homes are delivered by formal paid sources. Medicaid accounts for about 41 percent of total long-term care expenditures including non-elderly persons , while Medicare and out-of-pocket costs each account for 22 percent of expenditures Kaiser Commission on Medicaid Facts,

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Utilization patterns and financial characteristics of nursing homes in the United States: National Nursing Home Survey.

The focus may be on the site of care, the timing or duration of care, or the need for a specific procedure or other service. The first point of assessment, often called preadmission review, may occur before an elective hospital admission. This is what Greta Harrison and her physician experienced in one of the vignettes that opened this chapter. In this case, the review did not challenge the need for the procedure itself or the need for hospital care, but it did challenge the proposed admission 2 days before surgery. The terms preservice review and preprocedure review are sometimes used to indicate that the focus of review is the need for a procedure, regardless of whether it is to be performed on an inpatient or an outpatient basis. For emergency or urgent admissions to the hospital when prior review is not reasonable or feasible, admission review may be required within 24 to 72 hours after hospitalization to check the appropriateness of the admission as early as possible. The vignette describing Mr. Travers involved this technique as well as continued-stay review or concurrent review, which assesses the length of stay for both urgent and nonurgent admissions. Reviewers may press for timely discharge planning by hospital staff and, in some instances, assist in identifying and arranging appropriate alternatives to inpatient care. Increasingly, preadmission review or preservice review is used to screen patients so that referrals for second opinions are focused on patients for whom the clinical indications for a service are dubious. To encourage patients covered by a health plan to cooperate in the 2 Medical necessity is another term that is used differently by different people in different contexts. Some use it generally to cover assessments of the site and duration of care as well as the clinical need for a particular procedure, whereas others use it only in the latter sense. Those who use the term more restrictively tend to apply the term appropriateness to the former assessments. For a discussion of legal interpretations of medical necessity, see the paper by William A. Helvestine in Appendix A of this report. Page 19 Share Cite Suggested Citation: Controlling Costs and Changing Patient Care?: The Role of Utilization Management. The National Academies Press. Chapter 3 provides more details about the mechanisms of prior review. Although terms like prior review, predetermination, precertification, and prior authorization of benefits are often used interchangeably, the approval of benefits in advance of service provision may be contingent rather than final. For example, if a retrospective claims review suggests that the information on which the predetermination was based was seriously flawed, payment of a claim may be denied upon further investigation. Or if a utilization management firm does not have access to the details of the benefit plan for a group, it might authorize services not covered by the contract. A review of claims prior to payment might then result in denial of benefits. Retrospective denials of claims following prior certification appear to be rare, as are refusals to preauthorize services. For the United States as a whole in , 1 percent of the population accounted for 29 percent of total health care spending Berk et al. It differs in its targets, those very expensive cases for which specialized attention may encourage appropriate but less costly alternative forms of treatment. In contrast to prior review programs, high-cost case management programs are usually voluntary, with no penalties for patient failure to become involved in the process or comply with its recommendations. Finally, exceptions to limitations in benefit contracts may be authorized in advance if this will permit appropriate but less expensive care. For instance, additional home nursing benefits may be arranged so that an individual can avoid further Page 20 Share Cite Suggested Citation: Retrospective Utilization Review Utilization management techniques, particularly prior review methods, attempt to overcome the disadvantages and unhappiness associated with retrospective review and denial of claims after services have already been provided. Retrospective utilization review methods have a longer history of general application than do prospective methods Blum et al. Its strengths and weaknesses have been scrutinized in a number of studies before this one and are not explicitly considered in this report. However, constraints on retrospective review have been a key stimulus for the development of prior review methods. Many of the concerns raised by the committee about the clinical

soundness of review criteria, the fairness of procedures, and other matters described apply to both prospective and retrospective reviews. Other Cost-Containment Methods The techniques of prior review and high-cost case management are but a subset of the cost-containment methods that can influence decisions about patient care. Other methods, some of which are discussed in Chapter 2 and Appendix B, include the following: The different strategies for influencing decisions about patient care, however, vary in their emphasis or reliance on different models of control such as professional self-regulation, informed consumerism, or prudent purchasing , their techniques of influence such as education, financial incentives, peer pressure, or external oversight , and the parties involved that is, patients, primary care practitioners, or specialists. As will be described in Chapter 2, different strategies for cost containment have been tried, abandoned, and revived as third-party financing of health care has expanded. This history reflects both the difficulties of the task and an appreciation that there is no single solution to problems of health care costs, quality, or access. Many strategies have a place, each of which has different strengths and weaknesses and each of which needs monitoring and adjustment as circumstances change and people adapt to various attempts to shape their behavior. Two Notes of Caution Obstacles To Evaluation This report laments the limited evidence on utilization management and calls repeatedly for more and better assessments. Nonetheless, the committee is well aware that sound evaluation of utilization management programs faces several obstacles. Some are intrinsic to the research problem, some reflect common organizational behaviors, and some involve particular pressures faced by market-driven organizations. Rigorous evaluation also tends to be quite expensive. In Appendix B of this report, the commissioned paper by Joan B. Trauner notes that evidence about the impact of physician financial incentives on patient care decisions and quality of care is also quite limited. Intrinsic Conceptual and Methodological Problems A number of problems in evaluating utilization management and other cost-containment programs are predictable difficulties faced, to one degree Page 22 Share Cite Suggested Citation: One such problem is that there are no uniformly accepted and applied rules for measuring health care utilization or adjusting data for differences in the characteristics of groups being compared. Other methodological difficulties involve 1 data quality and availability; 2 definitions and measurements of program characteristics, group characteristics, outcomes, and other variables; 3 projections of what would have happened without the interventions; and 4 generalizations to other programs and settings. Common Behavioral Biases Against Evaluation Under this heading come obstacles to systematic evaluation that are typical of organizations whether they be public or private, for-profit or not-for-profit, big or small Eddy and Billings, ; Hatry et al. In addition, faced with limited resources, managers are frequently reluctant to allocate funds for evaluation instead of wages and benefits, shareholder dividends, or other activities. The committee has no information about what utilization management firms spend on evaluation for internal use or for clients or how much different employers invest in systematically assessing the impact of prior review or other cost-containment strategies. The Health Care Financing Administration does have performance standards for PROs, but they tend to emphasize process rather than outcome and tend to involve measures of impact that are more appropriate for ongoing monitoring rather than systematic evaluation of the review techniques. Page 23 Share Cite Suggested Citation: Certainly, competition can be a powerful stimulus for internal evaluation of how well a product is working and what makes it work better. Also, clients of utilization management organizations have a strong interest in obtaining reports on results and in shifting their business to other firms if they cannot get such reports. Balanced against these forces are several threats posed by evaluation. Further, evaluations of utilization management programs may provide competitors with statistical norms or even provider-specific information that would not be readily available to them otherwise. Likewise, if firms that invest in relatively sophisticated research and development reveal their work, they may give a free ride for competitors to copy or build on the resulting review criteria, analytic methodologies, or other products. In a new and rapidly evolving industry, this can seem a significant issue for more experienced organizations. Forces Behind Rising Health Care Costs The Committee on Utilization Management by Third Parties also recognizes that the forces behind rising health care costs are exceptionally strong and difficult to constrain through moderate means. Many believe that, for the foreseeable

future, health care costs will continue to increase faster than costs in the rest of the economy. For example, women who underwent mastectomy for breast cancer and had no evidence that the cancer had spread were until recently not expected to benefit from chemotherapy, but some new analyses suggest such treatment does increase survival rates. Recent guidelines for the use of mammography screening could greatly expand the amount of such screening but some professional sources question whether the guidelines are clinically warranted McIlrath, Page 24 Share Cite Suggested Citation: Advances in screening techniques may catch individuals much earlier in the course of disease and reduce the numbers who will receive later expensive treatments. The question is, will the costs of screening and early treatment offset the savings? Will real survival rates increase? Researchers involved with cancer point to methods under development to screen for very early traces of dozens of different kinds of cancer, not all of which are more successfully treated if they are detected earlier. Department of Health and Human Services, Whether this will bring a surplus of physicians is a matter for debate Ginsburg, ; Schwartz et al. What are the short-term costs and for whom of increasing access? What long-term costs and benefits can be expected? Society may not be willing to make such changes, particularly in the short run Curran, It may continue the search, described in the next chapter, for more moderate strategies to control health care expenditures. Utilization management is one such strategy. It is an unfortunate reality, however, that most cost-containment strategies eventually disappoint their supporters and evaluators to some degree. Even when these strategies seem to reduce costs initially, trend projections do not appear to show an appreciably lower increase in total costs over the longer term Prospective Payment Assessment Commission, Unwarranted or excessive negativism can, in turn, be counterproductive and lead to premature abandonment of modest but still helpful strategies. Cognizant of these hazards, the Committee on Utilization Management by Third Parties has tried to approach its initial evaluation of utilization management with reasonable expectations. To this end, the committee has reviewed the development of third-party financing of health care in the United States and the ways in which various strategies to manage costs have evolved. The next chapter summarizes this review. Aspen Systems Corporation, Health Administration Press, Page 26 Share Cite Suggested Citation: