ORIGINAL research

Rough Passages for Long-Term Care: The Churning Effect

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The growing numbers of frail elderly are the principal dual beneficiaries of both Medicare and Medicaid. In addition to home- and community-based alternatives, the frail elderly require both acute and long-term institutionally based services. From a payment perspective, both Medicare and Medicaid have the individual capacity to meet the different long-term or acute care needs of a dual beneficiary. However, an absence of programmatic integration between Medicare and Medicaid has consistently been missing. This, combined with a care continuum that is neither institutionally nor functionally integrated, creates negative consequences for both the costs of care and its quality.

At the base of the South American continent, the Atlantic Ocean meets the Pacific Ocean. The inevitable merging of these two oceans is not smooth; the churning water and its effect on ships and their crews attempting to navigate from one ocean to the other has been documented for centuries.

Unfortunately, our current system of transferring the frail elderly among an array of LTC and acute care services shares characteristics similar to those ocean-to-ocean passages. Furthermore, transferring the frail elderly within the health care system frequently amounts to double jeopardy, moving between health care institutions (LTC nursing facility vs. acute care hospital) and between payment systems (Medicare vs. Medicaid).

This article offers a snapshot of health care transfer patterns, through observations on a subgroup of patients in nursing facilities with a high frequency of nursing facility–to-hospital transfers over comparatively short periods of time. However, this picture, when added to an already extant body of knowledge concerning interinstitutional transfers, underscores the serious issues of cost and quality faced by patients in LTC facilities, especially dual beneficiaries of Medicare and Medicaid, their payers, and providers in accessing acute care services

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PATIENTS AND METHODS

During a 12-month period between July 1, 1996 and June 30, 1997, 21,674 individuals aged 65 years and older were precertified at least once for admission to one of Georgia's 356 licensed nursing facilities (Table I). These individuals served as the study base for an initiative focused on end-of-life care improvement for residents of nursing facilities. Continuity of care between nursing facilities and community hospitals was of special interest. (For the purposes of this article, continuity of care is defined as continuous management of a patient's care through a plan developed by a physician in cooperation with other health professionals and, as appropriate, the patient and family members. The operation and appropriate adjustment of the plan is under consistent and coordinated physician supervision, and continues throughout the patient's disability/illness period, moving with the patient and continuing in operation across health care institutions.)

For the precertified population, files from Medicare part A, Medicaid, and state precertification forms were searched and merged where appropriate. Within the population, a stratified, disproportionate random sample of 40 nursing facilities and 1,148 patients was drawn. To be included in the sample, the patient must have been admitted at least once to a nursing facility within the 12-month study period. (To control for variations in length of time in the study, database observations for each sampled patient were limited to the first six months of service.)

TABLE 1: DEMOGRAPHICS OF THE STUDY POPULATION

Variables		Age > 65 yr (N = 21,674)	Sample (N = 1,148)	Dual Eligibles (N = 568)	Medicaid (N = 86)	Medicare (N = 385)	Other Payer (N = 109)
Gender	Men (%)	30%	32%	31%	27%	36%	25%
	Women (%)	70%	68%	69%	73%	64%	75%
Age category	65–80 yr	42%	42%	43%	44%	41%	37%
	> 80 yr	58%	58%	57%	56%	59%	63%
Admitted from	Home	40%	43%	40%	58%	42%	52%
	Hospital	51%	52%	57%	33%	54%	39%
	Other	9%	5%	3%	9%	4%	8%
Assigned location of care	Skilled	67%	67%	67%	24%	78%	61%
	Intermediate	33%	33%	33%	74%	22%	39%
Dependent ADLs (N)	0	49%	51%	51%	50%	53%	46%
	1	9%	8%	7%	14%	9%	8%
	2	8%	8%	7%	12%	7%	6%
	3	7%	6%	6%	5%	7%	9%
	4	9%	8%	9%	8%	7%	9%
	5	11%	12%	13%	8%	10%	12%
	6	7%	7%	7%	4%	7%	9%
Overall condition	Improving	13%	12%	11%	4%	16%	10%
	Stable	48%	48%	48%	37%	49%	52%
	Fluctuating	17%	14%	15%	14%	14%	13%
	Deteriorating	20%	22%	23%	36%	17%	23%
	Critical	0%	0%	0%	1%	0%	0%
	Terminal	3%	7%	3%	8%	4%	2%
Restorative potential	Good	13%	12%	10%	4%	17%	8%
	Fair	45%	39%	38%	29%	41%	42%
	Questionable	9%	11%	12%	13%	8%	14%
	Poor	30%	35%	37%	42%	31%	32%
	None	3%	4%	3%	13%	3%	3%
Dementia		33%	37%	39%	61%	28%	37%
Payment source	Medicare only	34%	34%				
	Medicaid only	5%	8%				
	Dual eligible	52%	50%				
	Other	8%	10%				
Recertified		16%	14%				

N = Number; ADLs = activities of daily living.

For this sample group, clinical and administrative data were abstracted from medical records. This group is the subject of the findings described in this article.

Patient Characteristics, Health Status, and Payment Source. Based on precertification data at time of admission, this patient group could best be characterized as frail elderly. Fifty-eight percent of patients were over the age of 80 years. The overall condition of 22% of patients was evaluated as deteriorating, with an additional 4% evaluated as critical or terminal. Thirty-nine percent of patients were rated as having poor to no restorative potential, 38% were diagnosed with dementia, 27% had a urinary catheter, and about half had at least one activity of daily living (ADL) limitation (the majority of these patients had 3–6 ADL limitations).

Sources of health care payment for the study sample were: Medicare beneficiaries, 33%; Medicaid beneficiaries, 8%; Medicare and Medicaid patients with dual eligibility, 50%; and other sources—private pay or the Washington, DC–based Department of Veterans Affairs—9% (because of a lack of claims data, the "other sources" group could not be included in the subsequent analyses of interinstitutional transfers). Among the three Medicare and/or Medicaid beneficiary groups, observable differences were found in terms of selected demographics, health status, and ADL dependencies. Overall, persons within each group were very different from other groups, especially when their characteristics were used to describe potential care needs and skills (Table II).

RESULTS

Interinstitutional Transfers and Patient Deaths. One of the first areas of analysis concerned death and institutional

TABLE II: PATIENT CHARACTERISTICS BY PAYMENT SOURCE

Medicaid

- Predominantly women
- Most admissions from home
- Smallest number of dependent ADLs
- Largest proportion of patients with poor-to-no restorative potential
- Largest proportion of patients with dementia
- Largest proportion of patients assigned to intermediate LOC

Dual Eligible

- Highest proportion of dependent ADLs

Medicare

- Highest proportion of patients with good-to-fair restorative potential
- Highest proportion of patients assigned to skilled LOC
- Slightly oldest age group

ADLs = Activities of daily living; LOC = level of care.

location at time of death, because of the study's focus on end-of-life care. Within six months of admission, 31% of the patients in the analyzed sample (N = 1,039 patients) had died, although not necessarily in the nursing facility to which they were originally admitted.

An end-of-life care benchmark advocated by the Institute for Healthcare Improvement in Boston suggests, "Patients who are likely to die within 48 hours should not be interinstitutionally transferred."[1] However, there is widespread anecdotal opinion that many nursing facility patients in a terminal stage are being transferred routinely to acute care hospitals. As illustrated in Table III, almost one-third of patients who underwent nursing facility-to-hospital transfers died within 48 hours. This appears to be a sufficient proportion of deaths to warrant review.

Preventable Nursing Facility–to-Hospital Transfers. Apart from the issue of transfer appropriateness in the face of imminent death, over 85% of patients in nursing facilities who were transferred did survive, and were subsequently transferred again. Table IV illustrates the leading causes of the initial nursing facility-to-hospital transfer. A review of these causes indicates a potential for prevention or at least control within the nursing facility environment.

Saliba and colleagues[2] studied the appropriateness of decisions to transfer nursing facility patients to a hospital. They found that 40% of the transfers were determined to be inappropriate. When advance directives were considered, the proportion increased to 45%.

In the present study, patients experienced potentially unnecessary interinstitutional transfers immediately before death. Thirty-nine percent of the 1,039 patients were transferred and alive at the study's end. In addition, there appeared to be transfers for conditions that could have been prevented or controlled within a nursing facility. Controlling or preventing hospital transfers assumes that intervention programs, sufficient staff capacity, financial resources, and incentives (e.g., appropriate reimbursement) exist to maintain such programs within nursing facilities. If such programs are not present, transfers may become necessary.

Intervention programs hold potential for both quality and cost benefits. Thus, opportunities exist for quality interventions in disease prevention and control. The essential question regarding the future of prevention and control is: Can there be a development and/or reallocation of resources to nursing facilities to control frequent patient transfers between hospitals and nursing facilities?

Posthospitalization Transfer Patterns. It was anticipated that individuals who survived the first hospitalization would return to a nursing facility. However, this was not the case for almost half the surviving individuals (Table V). Many patients left the hospital and continued to move among health care institutions. Whereas almost half of the patients did not move from a nursing facility during the observational period, nearly 25% moved from three to 13 times over the six-month period (Figure 1). This group of patients was identified as the "churned population." In the total sample, 80 distinct transfer patterns were identified. The simplest pattern was nursing facility admission with no further transfer; the most complex involved some 13 changes within the observational period.

As previously indicated, over 30% of patients in the sample died within the six-month observation period. Those deaths occurred randomly over that period and within the full range of institutions. When mortality status after transfer was added to the other patterns, the number of identified transfer patterns increased from 80 to 120.

The scope of interinstitutional transfers was not only limited to movement between nursing facilities and hospitals. Whereas such transfers were the most common, they did not always involve the same nursing facility or hospital for a particular patient. In addition, some patients left institutional care to return home and remain, but others later returned to some component of the health care system.

DISCUSSION

Limitations. Studies by Shaughnessy and colleagues[3,4] found substantial case-mix differences between the Medicare and

TABLE III: OCCURRENCES OF DEATH BY TIME AND PLACE OF FINAL ADMISSION

	Location of Death		
Time of Death	Hospital (N = 87)	Nursing Facility (N = 188)	Home (N = 47)
≤ 48 hr postadmission	32%	4%	NA
> 48 hr postadmission	68%	96%	NA

N = Number; NA = not applicable.

TABLE IV: PRINCIPAL DIAGNOSES LEADING TO FIRST HOSPITAL TRANSFER (N = 467)

Rank	Diagnosis	Proportion of Study Group (%)
1	Community-acquired pneumonia	8%
2	Aspiration pneumonia	6%
3	Congestive heart failure	6%
4	Urinary tract infection	4%
5	Dehydration	3%

N = Number.

TABLE V: DISPOSITION STATUS AND DESIGNATED CARE SITE POSTHOSPITALIZATION

Status, Site	Proportion of Study Group (%)
Deceased	14%
Alive, other hospital	2%
Alive, other care site	5%
Alive, nursing facility	46%
Alive, intermediate care facility	5%
Alive, home, self-care	23%
Alive, home care	5%
All dispositions (N = 476)	100%

N = Number.

Medicaid beneficiary populations that tend to support the differences observed in the present study. Medicare beneficiaries were perceived to be more rehabilitative; those not receiving Medicare benefits (including Medicaid recipients) were regarded as more custodial.

The differences in eligibility between Medicare and Medicaid affected the completeness and accuracy of reporting, especially in patient-related administrative and demographic areas. In general, Medicare files tend to be more complete than Medicaid files. Of particular concern is whether a beneficiary is alive or dead. Experience indicates that Medicare beneficiaries who die, even when not receiving Medicare program services, tend to be identified in database files. In the case of Medicaid, on the other hand, completeness of such reporting remains in doubt unless the beneficiary was receiving program services at the time of death. Observed mortality differences between Medicare and Medicaid should be interpreted with caution.

Confounding factors in analyzing patterns of interinstitutional movement as described in the literature are two issues related to administrative and reimbursement policies. The first issue is that, in the literature, it is not always clear whether the terms "discharge" and "transfer" are being used interchangeably, although they can represent two very different actions, especially as influenced by mode of reimbursement. In the case of a discharge, the patient is formally dismissed from a nursing facility to another location (e.g., home or hospital). In the case of a transfer, the patient is informally dismissed, but a bed remains in the individual's name and the facility receives at least partial reimbursement for the vacant reserved bed. There is no such reimbursement to the nursing facility for a discharged patient. A greater financial incentive exists for the nursing facility to transfer rather than discharge.

The second issue has to do with those patients who are moved from a nursing facility to a hospital emergency room or department (ER). It is not always clear whether the care received postmovement was actually in the ER or whether the patient was admitted to an inpatient unit through the ER. In fact, nursing facility residents have a high utilization of the hospital ER—the exact proportion of those passing through the department within an administrative procedure versus those actually receiving care is unknown. In the study by Saliba and colleagues,[2] 88% of transferred patients initially went to the ER, whereas 80% were subsequently admitted to an inpatient unit.

Frequent Transits: Not New, but Increasing in Frequency?

One of the first major studies of the relationship between nursing facilities and hospitals was initiated more than 20 years ago, when Lewis and colleagues[5] began to develop a natural history of patients in nursing homes. The researchers mapped frequent and complex patient movements between nursing facilities and hospitals. The study reported movement among multiple health care sites and high numbers of transfers similar to the observations discussed in this article, albeit among smaller groups of surviving patients.

Patients in the present study appeared to transfer more frequently than those in the study by Lewis and associates[5]—taking place more quickly and occurring within a six-month period for individual patients. Lewis' group made their observations over a two-year period. Taking into consideration the differences in time of performance (1980 vs. 1996), geography (Southern California vs. Georgia) and methodology used, a remarkable similarity can been observed in the patient mobility patterns observed in both studies. Little in the patterns appears to have changed between 1980 and 1996, except that the patient population has increased numerically, the speed of transfer may have increased, and the negative cost and quality consequences may have increased proportionately.

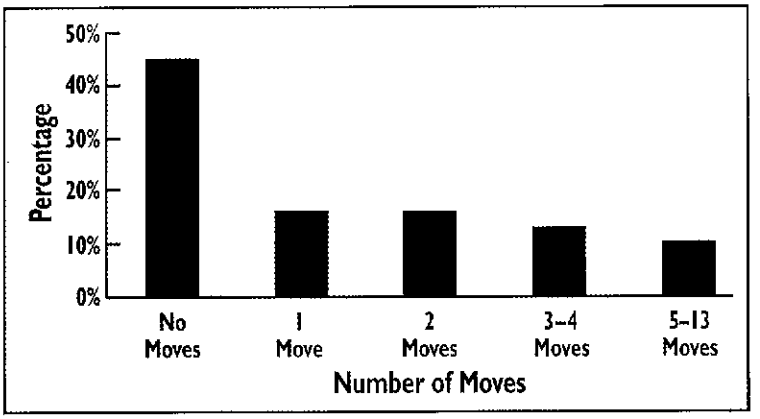

Figure 1. Proportion of interinstitutional transfers (N = 1,039). No moves = Patients remaining at the nursing facility of original admission at the time of death or at the end of the six-month observational period.

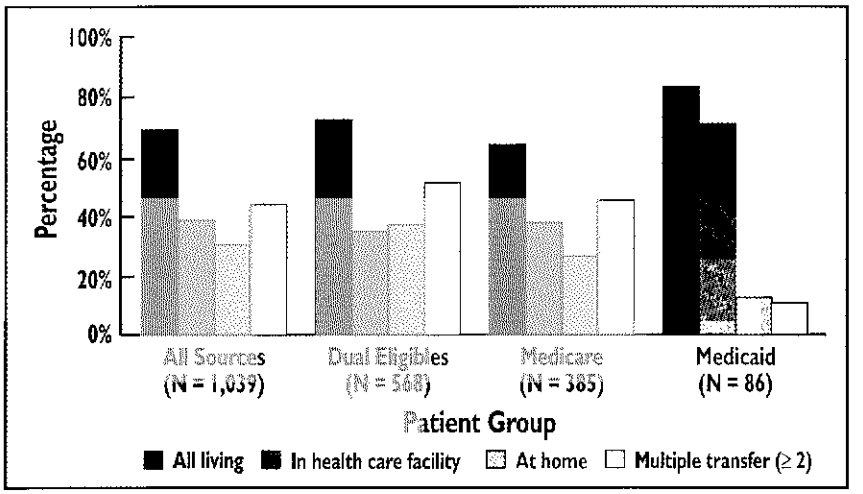

Figure 2. Patient status at the end of the observation period. N = Number.

Reimbursement Policy and Transit Patterns. Over the last 2 decades, federal reimbursement policy has been cited as a causal factor in frequent patient transfers between hospitals and nursing facilities. Lewis and associates[5] speculated in 1985 that the pace of transfer would quicken with the coming of the PPS. In 1986, Goodwin[6] wrote that anecdotal data from a Congressional study ". . . suggest that Medicare beneficiaries are being discharged from hospitals earlier, sicker, and with more complex skilled nursing requirements than before the implementation [of PPS]." Tresch and co-workers[7] observed sicker patients' having a greater potential for interinstitutional movement. Ouslander and associates[8] indicated economic incentives as a factor related to interinstitutional transfers. In 1987, Sager and associates,[9] in a study of the effect of PPS on Wisconsin's hospitals, nursing homes, and elderly Medicaid beneficiaries, established factual bases for speculations prior to the present study on the admission of sicker patients into nursing facilities.

The PPS does appear to promote more frequent use of the hospital for nursing facility patients. However, those patients who survive and return to the nursing facility are usually sicker than those who do not move. Consequently, questions have arisen about the aggressiveness of these patients' treatments while in the hospital. This "sicker" status dynamic between the nursing facility and the hospital appears reimbursement-related and could be the trigger for the observed patterns of patient churning. Vladeck[10] predicted an expanding transfer relationship between facility and hospital fueled by PPS. In an overview of the status and prognosis of LTC for the elderly, he observed, "Many [patients] may experience the 'revolving door' between hospital and nursing home."[10]

Transfer Rates and Governmental Sources of Payment. Figure 2 illustrates the health care location of all living patients among governmental reimbursement sources at the end of the six-month observational period. Overall, half of the surviving individuals were in a nursing facility, although not necessarily the one to which they were originally admitted. The study criteria were admission between July 1, 1996 and June 30, 1997. Over 75% of surviving patients experienced at least two site-of-care changes (up to a maximum of 13) before becoming residents in their final locus of care at the end of the observation period.

Movement frequency and survival rates differed by source of governmental payment from the overall pattern. The population with dual eligibility experienced the highest proportion of frequent interinstitutional transfers, the highest proportion of survivors living at home, and the lowest proportion still in residence at a nursing facility. Medicaid beneficiaries had the lowest proportion of interinstitutional transfers; indeed, the stability of this population was especially striking when compared with the other reimbursement groups. Medicaid beneficiaries also appeared to have the lowest mortality rate, although there was some concern about the completeness of data on deaths in the Medicaid system. Medicare beneficiaries had the highest mortality; on all other points, they tended to mirror patients with dual eligibility, but at smaller rates.

The mobility patterns illustrated in this study probably underrepresent actual interinstitutional mobility for a number of reasons. First, 50% of the original admissions came to the nursing facility from a hospital. Such preobservation transfers were not counted, as the study was attempting to create a one-time snapshot taken of a constantly moving picture of health system use. Second, Medicare and Medicaid ER claims records were not available to the study; however, nursing facility patients were frequently transferred to ER units both with and without subsequent admission to an inpatient unit (evidence of ER transfer was abstracted from patient records).

Mortality and Governmental Payment Source. Figure 3 illustrates the frequency of patient movement and mortality Patients with dual eligibility had a greater proportion of deaths at the higher transfer levels (2–4 moves) than Medicare

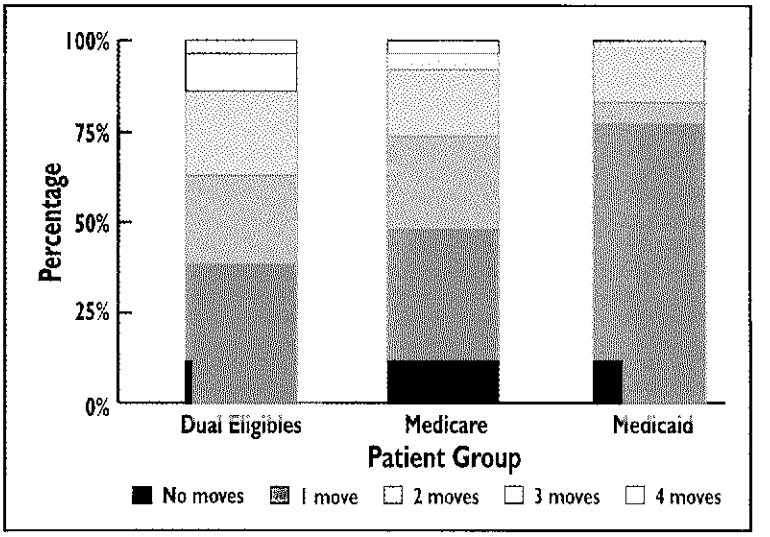

Figure 3. Nursing facility patient deaths by number of interinstitutional moves.

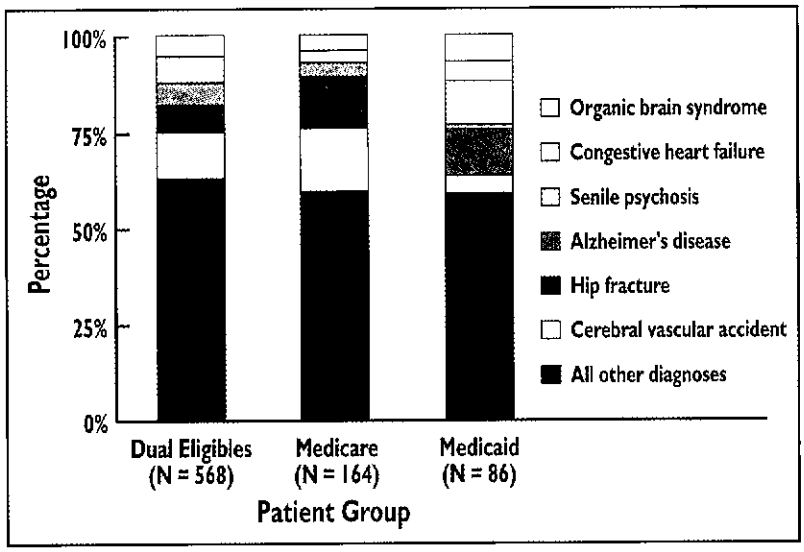

Figure 4. Principal diagnoses necessitating nursing facility admission by sources of payment. N = Number.

beneficiaries. Medicaid beneficiaries, because they moved less frequently, experienced the largest proportion of deaths in the nursing facility of admission. Among all three, it appears that as the number of transfers increased, the proportion of deaths within each move decreased.

Governmental Payment Source and Transfer Diagnoses. As illustrated in Figure 4, the patients among the three governmental reimbursement groups had different reasons for being admitted to nursing facilities. Although the groups share three out of the five leading diagnoses (Alzheimer's disease, cerebrovascular accident, and congestive heart failure), the proportions vary between diagnostic groups. Clustering the leading diagnoses by physical and behavioral health groups (Table VI) produces evidence of a strong tendency for Medicaid beneficiaries to have behavioral health problems, Medicare beneficiaries to have physical health problems, and patients with dual eligibility to fall between the two extremes.

Figure 5 breaks down the leading principal diagnoses that necessitated nursing facility admission by governmental sources of payment. The five leading diagnoses precipitating the first transfer to a hospital from a nursing facility varied according to payment source; the factors underlying these differences were unclear. Only five nursing facility residents receiving Medicaid only required transfer to a community hospital.

TABLE VI: LEADING DIAGNOSTIC CLUSTERS BY GOVERNMENTAL PAYMENT SOURCE

	Patient Group		
Diagnosis Group	Dual Eligibles (N = 209)	Medicare (N = 159)	Medicaid (N = 35)
Physical health*	65%	81%	23%
Behavioral health†	35%	19%	77%

*Congestive heart failure, hip fracture, and cerebrovascular disease.
†Organic brain syndrome, senile psychosis, and Alzheimer's disease.
N= Number.

Many Medicaid beneficiaries, as previously stated, do not appear to transfer to a hospital even once; the preponderance of behavioral health diagnoses among this group might explain this lack of interinstitutional movement. These conditions can be managed effectively within the nursing facility with existing resources, whereas management of physical health diagnoses may require the more complex resources of a hospital. Medicaid policy could also have some influence, as there are cost consequences for the facility in transferring patients to a hospital that is not operable by policy in either Medicare-only or dual-eligible groups.

Dual-eligible beneficiaries appeared to have a larger array of "all other" diagnoses, although they share the same leading five diagnoses (dehydration, urinary tract infection, congestive heart failure, and two types of pneumonia) with Medicare in smaller proportions In this situation, the principal diagnosis offers little insight into variations in underlying causes of the first interinstitutional transfer, let alone subsequent movement. However, source of payment appears to have influenced transfer patterns.

CONCLUSION

The high proportion of interinstitutional transfers of patients just before they died indicates an opportunity for quality interventions within nursing facilities that could control the volume of such transfers and improve end-of-life care. High proportions of interinstitutional transfers for preventable or controllable diseases also indicate opportunities for quality improvement programs designed to improve management of such diseases within nursing facilities.

Each of the three payment groups has clinical and sociodemographic differences, which might account for the differing patterns of facility use and patient survival. Clinical and social characteristics alone do not explain the observed differences in service use and patient survival patterns. This indicates that the individual reimbursement policies of the governmental payment sources contribute an equal, causative role for pattern differences. As such, the reimbursement policies have the same weights as other factors within the same group.

Analyses to date suggest evidence of a churning effect among nursing facility patients and institutions providing that service. This presents potential problems for quality and continuity of care as well as negative consequences for the cost of care. Even at this early stage of analysis, however, it is evident that patient management–oriented quality interventions and interinstitutional continuity of care planning could result in improved quality of and cost control over such care.

The growing numbers of frail elderly are the principal dual beneficiaries of Medicare and Medicaid. With increasing frequency, these

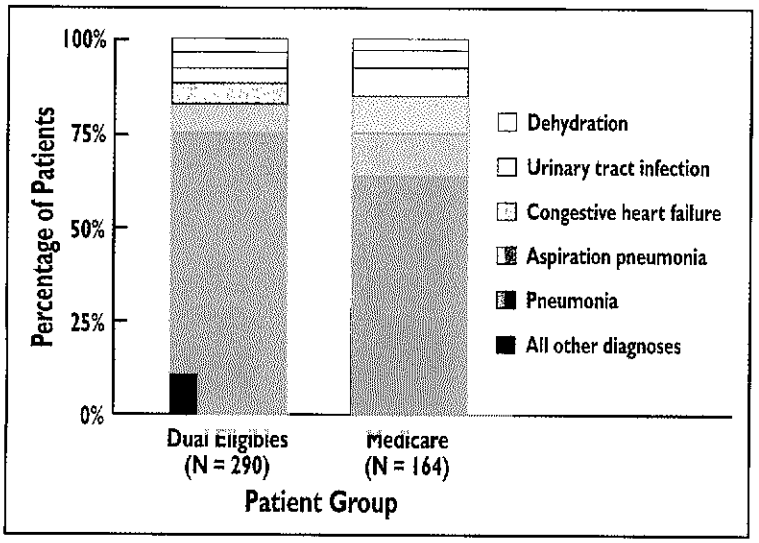

Figure 5. Principal diagnoses necessitating first transfer from the nursing facility to the community hospital. For Medicaid patients, there was no common diagnosis among the five patients who were transferred from the nursing facility to a community hospital. N = Number.

individuals require both LTC and acute institutionally based services in addition to home- and community-based alternatives. From a payment perspective, both Medicare and Medicaid have the individual capacity to meet the different LTC and/or acute care needs of an individual dual beneficiary. However, from the beginnings of Medicare and Medicaid almost two generations ago, there has been a consistent absence of program-based integration. This fact, coupled with a care continuum that is neither institutionally nor functionally integrated, creates negative consequences for both the costs of care and its quality

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