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Usefulness of the Nursing Home Quality Measures and Quality Indicators for Assessing Skilled Nursing Facility Rehabilitation Outcomes

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Abstract

Objective— To examine the usefulness of the nursing home quality indicators and nursing home quality measures for differentiating among providers from a rehabilitation outcomes perspective.

Design— Retrospective.

Setting— Skilled nursing facilities (SNFs) across the United States.

Participants— A total of 211 SNFs.

Interventions— Not applicable.

Main Outcome Measures— All quality indicators, all quality measures except for CWLS01 (residents who lose too much weight), and a set of rehabilitation outcomes including residualized FIM motor gain, the percentage of patients discharged to community, and the percentage of patients reporting “quite a lot” or “completely” prepared to manage their care at discharge from SNF-based rehabilitation.

Results— No quality measures correlated with any rehabilitation outcomes. Residualized FIM motor gain did not correlate with any quality indicators or quality measures. Only 1 quality indicator—prevalence of daily use of restraints (QI 22)—correlated with the rehabilitation indicator community discharge percentage. The third rehabilitation indicator, prepared to manage care at discharge, correlated (negatively) only with QI 18 incidence of decrease in range of motion. Among the rehabilitation outcomes, residualized FIM motor gain correlated significantly with both community discharge percentage and prepared to manage care at discharge.

Conclusions— Patients and referrers choosing SNF-based medical rehabilitation need tools that differentiate among prospective providers from a rehabilitation outcomes perspective. Data in this study indicate that nursing home quality indicators and quality measures are inadequate for this purpose.

Keywords

Quality indicators; health care; Quality of health care; Rehabilitation; Skilled nursing facilities

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Hospital lengths of stay (LOSs) for older patients with impairing and disabling conditions such as stroke, orthopedic fractures, joint replacements, and cardiac conditions have been decreasing steadily over the last 10 years.¹ Average LOS for patients 65 years and older (ie, Medicare beneficiaries) in 1983 was 6.9 days² compared with 5.8 days in 2002.³ In a similar period, the percentage of Medicare beneficiaries discharged to skilled nursing facilities (SNFs) increased from 37.4% in 1986 to 40.5% in 1993⁴ and to 46% in 1999.⁵ Furthermore, the survival rate of those 65 years and older and rates of nursing home admissions is projected to double by 2020.^{6,7} Although SNFs have delivered rehabilitation for Medicare-insured patients for decades, inpatient rehabilitation had been delivered primarily within acute hospitals and inpatient rehabilitation facilities (IRFs). The increasing number of Medicare beneficiaries receiving inpatient rehabilitation in SNFs, however, is likely to accelerate as they become more accepted as comparable and less expensive alternatives to IRFs for patients with certain rehabilitation diagnoses.^{8,9} As a result, the traditional SNF role as predominantly a provider of custodial, long-term care for the frail, chronically ill, and/or cognitively impaired elderly is shifting to that of a postacute rehabilitation provider, with a focus on functional recovery and return to community residence. This shift has been supported by the Medicare SNF benefit that provides for postacute rehabilitation to recover functional independence^{10,11} toward pre-morbid status. Postacute patients and their families now choosing an SNF-based rehabilitation facility must approach the decision as if they were choosing a rehabilitation center, not a nursing home. Consumers would be well advised to identify qualified, experienced, and successful rehabilitation teams that have the expertise necessary to maximize patients' recovery toward premorbid functional levels.

Another challenge postacute rehabilitation patients and their families face is that the Medicare benefit requires measurable, continuous progress toward premorbid functional levels, with a limit of 100 post hospital days per episode. Therefore, many Medicare-insured patients will return to a community living arrangement with residual impairments and/or disabilities that were absent before the event that led to hospitalization. SNFs that deliver inpatient rehabilitation, therefore, are responsible, not only to improve patients' functional independence but also to assure that patients and their families are prepared to manage their functional challenges and care needs after discharge to home.

Rehabilitation professionals have long recognized that a patient's rehabilitation team can be instrumental in producing a good treatment outcome. Considering the stakes involved now that SNFs provide a larger share of inpatient rehabilitation,^{12–15} the selection of the right SNF rehabilitation team has become increasingly important. Unfortunately, patients and their families, as well as physicians and referral sources such as hospital discharge planners, face a dearth of useful, objective tools to help differentiate among postacute SNF rehabilitation providers. As hospital discharge planners report, family decision makers often choose an SNF based on proximity (ie, convenient location) and physical plant amenities (eg, private room, preferred meal options, interior design preferences) combined with the absence of strong negatives including objectionable odor, apparent physical plant disarray or dirtiness, bad reputation, recent public reports of abuse, violations, and so on.¹⁶

Measurement and Benchmarking of SNF Quality

Concern for nursing home residents' rights and the quality of care provided by nursing homes led to the development of the Minimum Data Set (MDS) for resident assessment, the primary source of data-based resident evaluation and treatment planning. Data from the MDS have enabled significant advances in the assessment of nursing home quality over the past several years. The quality indicators were introduced in the late 1990s to help nursing home administrators and surveyors identify and rectify threats to quality of care. The Nursing Home Quality Initiative in November 2002 introduced the quality measures¹⁷ to help consumers

differentiate among nursing homes and, ostensibly, make better, more informed placement decisions.⁷ Three quality measures were designated specifically for short stay, postacute patients: delirium, pain, pressure ulcers. Subsequently, the push toward requiring SNFs to report nursing home quality data to Centers for Medicaid and Medicare Services (CMS) and state regulatory agencies and use external benchmarks to drive quality improvement efforts has accelerated.⁶ Tables 1 and 2 show the quality indicators and quality measures, which are referred to in this study as nursing home indicators (NHIs). These tables reveal the NHIs attempt to address consumers', legislators', and regulators' concerns about deficits in nursing home quality, the extent to which SNFs either: (1) avoid omissions, errors, or deficits in providing safe residential environments and necessary nursing/medical care; (2) prevent functional decline; and (3) house residents with various health or medical problems.

To give consumers direct access to SNF evaluation tools, governmental initiatives have disseminated state SNF surveys and the NHIs through publications and the Internet. Public dissemination of quality indicator data began through CMS's Nursing Home Compare initiative.¹⁸ (Individual nursing home results on a set of quality measures are posted on the Medicare website [<http://www.medicare.gov>] within the nursing home compare section.) Full-page advertisements paid for by CMS have listed individual SNF results in target regions on selected quality measures.

Although the validity of the NHIs has been debated in several studies,^{18–21} the initial validation work completed on the quality indicators found that as quality problems increase so do the scores on the quality indicators. Furthermore, the quality indicators were shown to have high levels of stability over 2 consecutive measurements, although stability varied with individual indicator characteristics.¹⁷ Although further research is needed to continue validation efforts,^{17,19} the NHIs are considered to be a significant advancement in nursing home quality assessment by CMS as well as state agencies.^{18,21}

As the NHIs reflect, preventing or slowing functional decline, managing incontinence and pain, and preventing skin breakdown represent public and professional expectations of SNFs as nursing homes. SNFs that provide postacute rehabilitation, however, must go beyond preventing decline, managing chronic illness and impairment, and avoiding quality of care lapses. Rehabilitation is improvement in function, improvement in adaptation. This point was made by the Medicare Payment Advisory Commission (MedPAC) who observed that failure to capture patient admission status and the absence of discharge measures for up to 45% of SNF patients limit measurement of change and preclude comparison of outcomes to other postacute settings.²² Given that the NHIs comprise SNF quality assessment today, how well do they address the emerging role of SNFs as postacute rehabilitation centers? The present study tests the usefulness of NHI data for differentiating among providers from a rehabilitation outcomes perspective, including the extent to which patients make functional gain, and return successfully to home or the community.²³

METHODS

Sample

Data for the present study came from quality indicator and quality measure reports from the second quarter of 2004 for 211 SNFs operated by a nationwide publicly held corporation. The rehabilitation outcomes were reported on Medicare beneficiaries from the second quarter of 2004 who received occupational therapy and physical therapy, stayed at least 3 days, and were discharged alive. Among all the 211 reporting facilities, 1203 patients were transferred to acute hospitals and not readmitted. These patients were excluded from the study. NHI data from the same facilities were reported to CMS during the same quarter. Overall, 7837 SNF patients (66.9% women) with an average age of 76.6 years were included.

Quality Indicators and Quality Measures

All NHIs were included in the analysis with the exception of CWLS01 (residents who lose too much weight). This quality measure was not instituted until November 2004, after the time period of this study. The quality indicator for weight loss (QI 13), however, was included. The NHIs are expressed as the percentage of patients that meet the criteria specified by the quality indicator or quality measure. Examination of these variables reveals a seminal, common characteristic. They address the prevalence and incidence of clinical, treatment, or process deficits and threats. This focus is understandable considering (1) the traditional role of nursing homes as long-term custodians of chronically impaired, frail, and dependent residents and (2) the interests of federal and state agencies, lawmakers, and the public in ensuring acceptable nursing care and avoiding conditions that endanger or harm nursing home residents.

Rehabilitation Outcomes

The SNFs in this study are the first in a corporate-wide effort to collect rehabilitation outcome measures on patients receiving rehabilitation during Medicare Part A–covered stays. Data collection is integrated into therapist evaluation and reporting protocols. The data are used by the facilities (1) to drive rehabilitation quality improvement and (2) to provide evidence of rehabilitation outcomes to direct consumers, referrers, and insurers.

Functional status is assessed by using the FIM instrument. The FIM is the most widely used and studied rehabilitation status measure in the United States^{24–26} and has been mandated by CMS to be collected in all IRFs. The FIM contains 18 rating scale items addressing activities of daily living and mobility (the FIM motor scale) and communication and cognition (the FIM cognitive scale). Each item is rated at admission and again at discharge by a therapist or other clinician based on his/her observations of the patient's functioning. The scoring for each item is from 1 (total assistance) to 7 (total independence). Increasing levels of functional independence are represented by higher FIM levels. FIM cognitive scale and bowel and bladder items were excluded from this analysis because they are not typically rated in the SNFs studied.

Magnitude of rehabilitation progress is often characterized as the difference between discharge and admission FIM scores. This difference, however, is negatively related to admission status and fails to take admission status differences into account. To adjust for these differences and risk factors that may vary across facilities, residual change scores were used to characterize rehabilitation progress. To obtain these scores, discharge FIM motor scores were first predicted using admission scores, primary impairment, and whether the patient lived at home or in an SNF before hospitalization. The difference between the predicted and actual discharge FIM motor scores (the residual change score) was then computed and used in the analysis.

Percentage of patients discharged to the community is the percent of all Medicare patients whose discharge destination was either home or assisted living facility, as opposed to remaining in long-term care, expiring, or returning to an acute hospital. The analysis of community discharge percentage excluded patients who were long-term care residents before their rehabilitation programs.

Prepared to manage care is an outcome that describes the extent to which postacute SNF rehabilitation patients and their families have learned how to manage disabilities arising from the illness, injury, or procedure associated with their most recent hospitalization. It comprises the following question asked of patients or primary care givers at SNF admission and discharge: "If you had to be discharged today (or if your parent, spouse, etc. had to be discharged today), how prepared would you be to manage his care at home? Would you say 'not at all,' 'a little,' 'quite a lot,' or 'completely'?" The indicator used in the present analyses is the percentage of

respondents answering either “quite a lot” or “completely” at discharge to either home or assisted living.

Two sets of correlations were produced. Because the data are interval in nature, Pearson correlations were used to examine the relation between the NHIs and the 3 rehabilitation outcomes and among the rehabilitation outcomes. Significant correlations between the NHIs and the rehabilitation outcomes would indicate that the nursing home indicators differentiate among facilities from a rehabilitation outcomes perspective. Nonsignificant correlations between rehabilitation outcomes and NHIs, combined with significant correlations among the rehabilitation outcomes, would suggest a distinct rehabilitation outcomes construct, uncorrelated with NHIs. We adopted a conservative α level ($P < .01$) for the correlations between rehabilitation outcomes and NHIs, considering large number of tests and resulting inflated type I error risk.

RESULTS

As shown in tables 1 and 2, no significant correlations were found between the quality measures (including the 3 quality measures identified as postacute) and the rehabilitation outcomes. The rehabilitation outcome, residual FIM motor gain score, did not correlate with any quality indicator or quality measure. Community discharge percentage correlated positively with QI 22 (prevalence of daily physical restraints) ($r=.251, P<.000$) but negatively with QI 2 (prevalence of falls) ($r=.165, P<.017$). This latter correlation came very close to our threshold of P less than .01. Prepared to manage care at discharge correlated negatively with incidence of decline in range of motion (QI 18) ($r=-.181, P<.009$). Among the rehabilitation outcomes, the residualized FIM motor gain score correlated with both community discharge ($r=.27, P<.000$) and prepared to manage care at discharge ($r=.215, P<.002$). Prepared to manage care at discharge was not correlated with community discharge.

DISCUSSION

The results indicate that nursing home indicators targeting prevalence of illness and disability, quality of care deficits, and incidence of decline are not related to rehabilitation outcomes as measured by functional gain and community discharge percentage. The positive correlation between community discharge percentage and “daily physical restraints” is counterintuitive and resists interpretation; indeed, we would have expected any significant correlation to be negative. The negative correlations between (1) incidence of decrease in range of motion (QI 18) and prepared to manage care at discharge and (2) incidence of falls (QI 2) and community discharge percentage may suggest that facilities serving residents at risk for falls or range of motion decline have more difficulties adequately preparing patients for discharge and their families to manage care needs postdischarge. This interpretation is not strongly supported, however, considering the absence of negative correlations between FIM gain or community discharge percentage and other functionally related NHIs (eg, incidence of decline in late lost activities of daily living [QI 17], incidence of need for help increase with daily activities [QM 1—CADL01], incidence of decrease in range of motion [QI 18]). The finding that no quality measure correlated with any of the rehabilitation measures further obscures interpretation of the significant correlations between quality indicators and rehabilitation outcomes and supports the conclusion that NHIs do not measure rehabilitation outcome.

Study Limitations

The present study has several limitations. Improvement in bladder and bowel functional independence and cognitive status are important rehabilitation objectives but were excluded because of a lack of data. Further research is required to increase sample size and include facilities operated by other companies, proprietary and not-for-profit. More controls for case

mix and covariates of rehabilitation outcome as well as a broader set of rehabilitation outcomes beyond the 3 available in the present study might reveal more interpretable and useful relations between NHIs and rehabilitation outcomes. Measures of quality of life, an important rehabilitation target, were not available in the present study.

CONCLUSIONS

Patients and their families referred to SNFs for rehabilitation after disabling illnesses, procedures, or injuries face an important, if not critical, decision. They must choose a rehabilitation team on which they will rely for a targeted, outcomes-oriented, suitably aggressive rehabilitation program. Unfortunately, they will likely confront this choice without tools for assessing the rehabilitation outcomes achieved by prospective providers. Furthermore, the common depiction of SNFs as “nursing homes” may convince a patient, family, or consumer that traditional “nursing home” criteria are adequate for guiding their decision. SNF patients whose primary need is effective postacute rehabilitation may rely on NHIs, which provide little insight regarding SNF rehabilitation track records.

No regulatory or licensing body requires SNFs to collect rehabilitation outcomes data. In response to this apparent deficit, MedPAC has recently advised the U.S. Congress and CMS to add admission and discharge activities of daily living measures and clinical process measures to the set of quality measures addressing short-stay SNF patients.²² The present study provides support for these recommendations. SNFs that offer postacute rehabilitation must accept the responsibility, as IRFs do, to measure rehabilitation results and use them to inform consumers and referrers and drive internal quality improvement. Comprehensive, ongoing cost-effectiveness comparisons between postacute rehabilitation settings will be impossible without SNF rehabilitation outcomes data.

The quality indicators and quality measures are important contributions toward objective nursing home quality measurement. Preventing harm, neglect, and decline, however, are necessary but insufficient criteria for SNFs that present themselves as rehabilitation providers. Consumers equipped with only the NHIs may conclude that, given a choice from among SNFs that are not identified as unsafe, neglectful, or lax in basic nursing care, they would be well advised to simply choose the most conveniently located and/or best appointed facility. Those experienced in facilitating patient discharge from acute hospital to SNF know this attitude is not uncommon.

Patients discharged from hospitals who need medical rehabilitation—and the physicians, discharge planners, and case managers who assist them—should have access to information that differentiates SNF providers from the standpoint of improving functional independence and preparing patients and families for successful transitions to home or community. Data in this study indicate that the nursing home quality indicators and quality measures are inadequate for this purpose.

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Table 1
Pearson Correlations Between Nursing Home Quality Indicators and Rehabilitation Outcomes

Quality Indicators	Descriptor	FIM Motor [*]	Home Care Prepared [†]	Community Discharge [‡]
QI 1	Incidence of new fractures	-.003	-.035	.022
QI 2	Prevalence of falls	.010	-.041	-.165
QI 3	Prevalence of behavior symptoms affecting others (all residents)	-.119	.020	.077
QI 4	Prevalence of symptoms of depression	-.021	-.035	-.004
QI 5	Prevalence of symptoms of depression without antidepressant therapy	.030	-.016	-.008
QI 6	Use of 9 or more different medications	-.048	.004	.056
QI 7	Incidence of cognitive impairment	.094	.003	.103
QI 8	Prevalence of bladder or bowel incontinence	.075	-.044	.088
QI 9	Prevalence of occasional or frequent bladder or bowel incontinence without a toileting plan	-.079	-.015	-.074
QI 10	Prevalence of indwelling catheter	-.066	-.032	-.060
QI 11	Prevalence of fecal impaction	-.081	.049	.049
QI 12	Prevalence of urinary tract infections	-.014	.067	-.024
QI 13	Prevalence of weight loss	-.031	.038	.082
QI 14	Prevalence of tube feeding	-.072	-.030	.059
QI 15	Prevalence of dehydration	-.027	.065	.038
QI 16	Prevalence of bedfast residents	-.052	.031	-.084
QI 17	Incidence of decline in late loss activities of daily living	-.009	.100	-.048
QI 18	Incidence of decline in range of motion	.012	-.181 [§]	-.050
QI 19	Prevalence of antipsychotic use in absence of psychotic or related	-.069	-.080	-.114
QI 20	Prevalence of anti-anxiety/hypnotic use	.139	.029	.138
QI 21	Prevalence of hypnotic use more than two times in last week	.088	.011	.083
QI 22	Prevalence of daily physical restraints	.057	.014	.251 [§]
QI 23	Prevalence of little or no activity	-.036	.052	-.020
QI 24	Prevalence of stage 1–4 pressure ulcers	-.027	-.040	.106

* Residual change score for FIM motor scale.

[†] Percentage prepared to manage care at discharge.

[‡] Percentage discharged to community.

[§] Significant at $P < .01$.

Table 2
Pearson Correlations Between Nursing Home Quality Measures and Rehabilitation Outcomes

Quality Measures	Descriptor	FIM Motor [*]	Home Care Prepared [†]	Community Discharge [‡]
Chronic care residents				
CADL01	Residents whose need for help with daily activities has increased	.059	-.018	-.154
CBFT01	Residents who spend most of their time in bed or in a chair	-.103	-.029	-.028
CCAT02	Residents who have/had a catheter inserted and left in their bladder	.039	.077	.090
CCNT04	Low risk residents who lose control of their bowels or bladder	.008	.061	-.077
CCNT06	Residents with a urinary tract infection	-.095	-.043	-.012
CMOB01	Residents whose ability to move about in and around their room got worse	-.004	.036	-.079
CMOD03	Residents who are more depressed or anxious	.052	.010	-.152
CPAI0X	Residents who have moderate to severe pain	-.039	-.095	-.044
CPRU02	High risk residents who have pressure ulcers	.066	-.041	.053
CPRU03	Low risk residents who have pressure ulcers	.051	.054	.053
CRES01	Residents who were physically restrained	-.104	-.014	.047
CWLS01	Residents who lose too much weight			
Postacute residents				
PAC-DELOX	Short-stay residents with delirium	.098	.058	-.085
PAC-PAI0X	Short-stay residents who had moderate to severe pain	.035	-.005	.116
PAC-PRUO	Short-stay residents with pressure ulcers	.047	-.003	.129

NOTE. No correlations were significant at $P < .01$.

^{*} Residual change score for FIM motor scale.

[†] Percentage prepared to manage care at discharge.

[‡] Percentage discharged to community.