Public Policy

Adverse Events in SNFs: The Ugly, the Bad, and the Good

A little over a month ago, the Office of the Inspector General (OIG) released its report on the frequency of adverse events among Medicare beneficiaries in skilled nursing facilities (SNFs). More importantly, the report determined, through a rigorous review process, how often such events are avoidable.

A similar report on hospitals, released 2 years ago, resulted in significant efforts to reduce medical harm in that setting. The question now is how postacute and long-term care (PA/LTC) medicine will respond to its report.

The Ugly

It will be easy for PA/LTC to be defensive about these findings. Finger-pointing could undoubtedly follow. Of course, adverse events are going to occur. We work with the sickest patients, who have the worst life expectancy and the least amount of resources. In fact, the report does not claim that events won’t occur. The rub is in the OIG’s assessment of how often medical harm is avoidable.

Can we be sure the report is accurate in this area? The answer appears to be yes. This was not the OIG’s first foray into determining whether such events are avoidable, and the reviewers were well-seasoned clinicians, including a past AMDA president. The ugly fact is that the report concludes that one-third of all skilled nursing facility (SNF) residents experienced adverse events or some temporary harm, that 59% of such events were clearly or probably preventable, and that half of the events caused hospitalizations. Thus, Medicare spends up to $1.6 billion on hospitalizations that result from avoidable harm in SNFs, and about 1.5% of all Medicare beneficiaries in SNFs die because of an adverse event in a facility (although the reviewers noted the difficulty in determining that an event is avoidable).

The Bad

PA/LTC operates under many restrictions that would seem to militate against preventive measures and safety improvements for our residents. Many nursing home leaders feel that their staff and resources are maxed out, and they find it hard to imagine reallocating time and monies to improvement efforts that could be central to coping with the OIG results. PA/LTC facilities have experienced declines in reimbursement that make any new effort difficult, and more cuts are on the way.

Some of the adverse events that the report describes are well-known quality issues in PA/LTC that should be easily addressed, such as catheter-associated urinary tract infections and Clostridium difficile colitis (each accounting for 3% of adverse events, according to the report). Some were relatively surprising in presence and frequency, such as excessive bleeding due to medication (5%). Some were not surprising, but sobering, such as medication-induced delirium (12%).

Most of the problems cited are familiar PA/LTC themes that facilities and practitioners have been struggling with for years — medication-induced delirium, fluid and electrolyte disturbances, respiratory infections, and injuries from falls — and together these account for nearly half of all adverse events. Many initiatives have sought to address these problems one by one, but almost none has attempted to create an overall culture of safety through systematic preventive approaches. While some potential harms in SNFs may be addressed by the Minimum Data Set and individual facility quality measures, most do not have to be monitored and tracked under current regulations.

Certainly, well-trained physicians, nurse practitioners, physician assistants, and medical directors can have a positive impact on the incidence of adverse events. But the fact is that many clinicians still do not have the competencies to adequately assess and treat geriatric conditions. Some do not understand how to work with an interdisciplinary team, how facilities function, or how procedures can be optimized for resident care. The lack of integrated electronic records among the practitioner, SNF, and pharmacy is a serious detriment to avoiding adverse events and improving resident care and safety.

The current misalignment of physician and facility quality metrics furthers the problem of achieving a truly integrated approach to reducing adverse events. The Medicare quality-assurance system operates only to penalize the SNF that allows certain events to occur. It offers no or only indirect rewards to PA/LTC providers that take proactive steps to prevent adverse events.

Traditional fee-for-service medicine offers few performance metrics for the practitioner. The only real threat to the practitioner for causing harm is malpractice liability. Reimbursements reward practitioners mainly for addressing acute problems, which may or may not be a plus toward preventing adverse events. Fee-for-service medicine does not provide incentives for spending time in person or on the phone with an interdisciplinary team to prevent an adverse event. It actually encourages hospitalizations by offering more reimbursement for acute care as opposed to early, preventive treatment in the SNF.

The Good

Recent quality improvement initiatives may be reducing adverse events in nursing homes. The National Partnership to Improve Dementia Care in Nursing Homes, which includes AMDA, is having a positive impact on the inappropriate prescribing of antipsychotics, and so it should reduce harm to residents.

The Center for Medicare & Medicaid Innovation, with the Medicare and Medicaid Coordination Office, is running a multisite project to reduce hospitalizations from nursing homes, and this may directly and indirectly reduce adverse events. AMDA has several PA/LTC tools that can improve consistency of care and communication: two issues that were the root causes of many problems described by the OIG report.

The Centers for Medicare & Medicaid Services’ Quality Assurance and Performance Improvement (QAPI) program will offer facilities and practitioners tools and education to improve resident care. Process improvement is to address and avoid the root causes of adverse events. The OIG report is a roadmap to understanding what needs to change to improve resident care the most. It can help each SNF understand its unique system operates only to penalize the practitioner. The only real threat to the practitioner for causing harm is malpractice liability. Reimbursements reward practitioners mainly for addressing acute problems, which may or may not be a plus toward preventing adverse events. Fee-for-service medicine does not provide incentives for spending time in person or on the phone with an interdisciplinary team to prevent an adverse event. It actually encourages hospitalizations by offering more reimbursement for acute care as opposed to early, preventive treatment in the SNF.

The accountable care organizations may partner only with those nursing facilities that have demonstrated track records of controlling cost and maintaining high quality. SNFs with poor adverse events records may find themselves with no postacute patients. Similar considerations will apply to any bundled payment or alternative models that spread financial risks among providers.

Overall

So, the ugly news is that more people are being harmed in skilled nursing facilities than we had thought — we cannot afford to stick our heads in the sand anymore. The bad news is that this will be difficult, but not impossible, to surmount. Perhaps the good news is that we now know where we need to put our effort and how we need to work with each other to solve the problem of medical harm to the people who have entrusted their care to us. AMDA should be at the forefront of physician-led efforts to improve these statistics and better care for the people we serve.

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