NH COMPARE'S HEALTH DEFICIENCY 5-STAR RATING: DO WE LEARN DIFFERENT THINGS FROM SURVEY AND COMPLAINT DEFICIENCIES?

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The Centers for Medicare and Medicaid Services (CMS) publishes a 5-star rating system for nursing homes (NH). Currently, the 5-star rating for health deficiencies weights deficiencies from annual recertification surveys and complaints equally. Complaint deficiencies may contain different information than survey deficiencies because complaint deficiencies originate with consumers and complaint inspections are less predictable than surveys. The objective of this study is to construct separate 5-star ratings for survey and complaint deficiencies, and to compare them to CMS' 5-star rating for health deficiencies. Using CASPER and ASPEN Complaints/Incident Tracking System for all NHs in 2017 (N=15,373), we calculated the 5-star rating for health deficiencies as reported by CMS, and then decompose CMS' rating into separate 5-star ratings for survey and complaint deficiencies. The overall distributions of the CMS' deficiency rating and survey deficiency rating are similar. The distribution of the complaint deficiency rating is different from CMS' deficiency rating. Using complaint deficiencies, more NHs have 5-stars (26.5% vs. 10.5%) and fewer facilities have 4-stars (11.2% vs. 23.3%). Comparing the ratings for each facility relative to CMS' rating, 35.3% of NHs have a different survey deficiency rating while 54.4% have a different complaint deficiency rating. A 5-star rating based on survey and complaint deficiencies results in different ratings for NHs, indicating that complaint deficiency ratings contain different information from survey deficiency ratings. CMS should publish separate ratings based on survey and complaint deficiencies to provide different information.

PROFILING NURSING HOME CARE SPECIALIZATION GROUPS

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The nursing home (NH) industry has experienced a shift toward care specialization. This study used NH-level panel data from 2011 to 2017 to describe unique care specialization groups in urban areas using latent profile analysis (LPA) (N= 64695, with 12,143 unique NHs). We focused on urban NHs because NHs specialize in care due to competition and memetic pressure, more likely to be the case for urban NHs. To identify care specialization profiles, LPA was applied using different types of specialist staffing levels (physical therapist, occupational therapist, physicians, and dietitians) and the share of special care units aimed at chronic conditions like Alzheimer's Disease and AIDs. Model diagnostics and information criterion guided selection of the best fitting model. Model stability over time, interpretability of results, and parsimony were also taken into consideration. The final results indicated a 4-profile model fit the underlying data best and the patterns remained comparatively stable over seven years. The 4-classes are uniquely identified as: high use of specialists of all types (3%), moderate use of specialists of all types (7%), mixed use of specialists and special care units (26%), and low specialization use (64%). From 2011 to 2017, the size of the 'low specialization' group became smaller, whereas the high and moderate groups grew larger. In addition to describing a clear trend towards increased care specialization, our findings indicated great heterogeneity in NHs' care specialization patterns in urban areas. Future studies should examine market and organizational characteristics, as well as performance outcomes for different specialization groups.

WHAT'S DRIVING SNF READMISSION RATES? EXPLORING DIFFERENCES IN PROCESSES BETWEEN HIGH AND LOW PERFORMING HOSPITALS

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Despite the increasing national focus on improving post-acute care outcomes, best practices for reducing readmissions from skilled nursing facilities (SNFs) are unclear. The objective of this rapid ethnographic study was to observe processes used to prepare older patients for post-acute care in SNFs, and to explore differences between hospital-SNF pairs with high or low thirty-day readmission rates. We stratified hospitals according to readmission rates from SNF and used convenience sampling to identify two high and two low performing sites and associated SNFs (n=5). We conducted intensive multi-day observations (n=148 hours) and key informant interviews (n=30 clinicians) to describe hospital processes for discharging patients to SNF. We used thematic analysis of interviews and fieldnotes to identify differences in transitional care processes of hospitals discharging patients to SNFs. Hospitals used five major processes prior to SNF discharge that could affect care transitions for older adults: recognizing the need for post-acute care, deciding level of care, selecting SNF facility, negotiating patient fit, and coordinating care with SNF. During each stage, high-performing sites differed from low-performing sites by focusing on: 1) earlier, ongoing, systematic identification of high-risk patients; 2) discussing the decision to go to a SNF as an iterative team-based process; and 3) anticipating barriers with knowledge of transitional and SNF care processes. Identifying variations in processes used to prepare patients for SNF provides critical insight into the best-practices for transitioning patients to SNFs and areas to target for improving care of older adults.

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ARE THE SELF-EMPLOYED MENTALLY HEALTHIER THAN SALARIED WORKERS? EVIDENCE FROM KOREA, MEXICO, AND THE UNITED STATES

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Self-employed workers are often reported to have better health than salaried workers. Whether this is because