Reducing Potentially Avoidable Hospitalizations of Nursing Home Residents

Joseph G. Ouslander, M.D.
Professor of Clinical Biomedical Science
Associate Dean for Geriatric Programs
Charles E. Schmidt College of Biomedical Science
Florida Atlantic University
Assistant Dean for Geriatric Education
University of Miami Miller School of Medicine (UMMSM) at Florida Atlantic University

Alice Bonner, PhD, RN
Executive Director
Massachusetts Senior Care Foundation
Assistant Professor
University of Massachusetts
Graduate School of Nursing
Worcester, MA
Reducing Potentially Avoidable Hospitalizations of Nursing Home Residents

Background

- Hospitalizations of NH residents are common, frequently result in morbid complications, and are expensive in terms of:
  - DRG payments to hospitals
  - Costs of complications
  - Medicare Part A Skilled Nursing Facility stays
- Previous research suggests many such hospitalizations are inappropriate and/or related to ambulatory care sensitive diagnoses
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Background

- 45% of admissions of 100 residents from 7 Los Angeles nursing homes to acute hospitals were rated as inappropriate
  

- Medicare spent close to $200 million on hospitalizations related to Ambulatory Care Sensitive Diagnoses among long-stay NH residents in New York state in 2004
  
  This figure does not include residents on the Part A skilled benefit, who get hospitalized frequently
  
  Grabowski et al, Health Affairs 26: 1753-1761, 2007
Reducing potentially avoidable hospitalizations of NH residents represents an opportunity to both:
- Improve quality of care; and
- Reduce overall Medicare expenditures on this population
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CMS Special Study Awarded to Georgia Medical Care Foundation
Objectives

July 2006 – January 2008

1. Identify NHs in Georgia with high and low hospitalization rates
2. Compare characteristics of these homes and their residents
3. Conduct interviews with NH and hospital staff
4. Rate potential avoidability of 200 hospitalizations
5. Develop intervention strategies and tools
6. Conduct a pilot test in 2-4 NHs with high hospitalization rates
7. Disseminate results and intervention strategies
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CMS NH Special Study Conclusions (1)

1. Rates of hospitalization of NH residents in Georgia varied considerably, and were related to several characteristics of the NHs and residents
2. 2/3 of 200 hospitalizations were rated as potentially avoidable by experts in NH care
3. Implementation of a toolkit addressing conditions commonly causing hospitalization, communication, and advance care planning was associated with:
   a. A 50% reduction of hospitalization in 3 NHs with high baseline rates
   b. A 36% reduction in hospitalizations rated as potentially avoidable
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**CMS NH Special Study Conclusions (2)**

1. Reducing potentially avoidable hospitalizations by 1/3 could save Medicare over $1 billion annually.

2. In order to safely reduce hospitalizations, NHs will need:
   a. Support for infrastructure: more trained RNs, on-site availability of primary care providers, better capabilities for lab tests and administration of IV or subcutaneous fluids
   b. Improved communication and adherence to evidence or consensus-based care paths
   c. More attention to advance care planning and avoidance of futile care
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Next Steps (1)

1. Evaluate the new INTERACT II tools and implementation strategies in a collaborative quality improvement project in 30 NHs in 3 states (FL, NY, MA)

1. Explore the incorporation of elements of the INTERACT II toolkit into Health Information Technology

1. Estimate the costs to NHs of using the tools

Supported by a grant from the Commonwealth Fund
MA Nursing Homes selected
Implementation 5/2009-1/2010
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Next Steps (2)

1. Further disseminate the INTERACT II tools via the Advancing Excellence Campaign, Emergency Nurse’s Association, AHCA and other organizations

Supported by a grant from the Commonwealth Fund 18 Month Study beginning 5/2009
A Toolkit to Improve Nursing Home Care by Reducing Avoidable Acute Care Transfers and Hospitalizations

Developed based on interviews and ratings of avoidability, and Expert Panel ratings of importance and feasibility

- Clinical Care Paths
- Communication Tools
- Advance Care Planning Tools
Institute of Medicine/CMS
STEEEP Goals for Quality Care
(Safe, Timely, Effective, Efficient, Equitable, Person-Centered)

INTERACT II Tools

Reduced Avoidable Acute Care Transfers

Morbidity
↓ Costs
↓ Quality

Infrastructure Support and Incentives
Healthcare Organizational Characteristics and Infrastructure
Healthcare Organizational Culture
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Development of INTERACT Tools

- Evidence or consensus-based (and/or consistent with CPGs)
- Simple
- Feasible and efficient to use
- Acceptable to NH staff
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Current Versions of the Tools are available on the Quality Net website at:

http://www.qualitynet.org/dcs/ContentServer?cid=1211554364427&pagename=Medqic/MQTools/ToolTemplate&c=MQTools

Revised tools soon to be available on

www.geriu.edu
### Communication Tools

<table>
<thead>
<tr>
<th>Tool</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Warning Tool “Stop and Watch”</td>
<td>Pocket Cards and Report Forms</td>
</tr>
<tr>
<td>SBAR Communication (Nurse to Physician and/or ER)</td>
<td>Form and Progress Note</td>
</tr>
<tr>
<td>Acute Change in Condition Guidance for Communication</td>
<td>File Cards</td>
</tr>
<tr>
<td>Resident Transfer Form</td>
<td>Form completed on transfer</td>
</tr>
<tr>
<td>Nursing Home Capabilities</td>
<td>Pre- populated Checklist</td>
</tr>
<tr>
<td>Acute Care Transfer Documents</td>
<td>Envelope with Checklist</td>
</tr>
</tbody>
</table>
EARLY WARNING TOOL
“Stop and Watch”

If you have identified an important change while caring for a resident today, please circle the change and discuss it with the charge nurse before the end of your shift.

Name of Resident ________________________________

S eems different than usual
T alks or communicates less than usual
O verall needs more help than usual
P articipated in activities less than usual

A te less than usual (Not because of dislike of food)
N
D rank less than usual

W eight change
A gitated or nervous more than usual
T ired, weak, confused, or drowsy
C hange in skin color or condition
H elp with walking, transferring, toileting more than usual

Staff __________________________________________

Reported to ______________________________________

Date _____ / _____ / ________    Time ________________
SBAR
Physician/NP/PA Communication and Progress Note

Before Calling MD/NP/PA:
☐ Evaluate the resident, complete the SBAR form (use "N/A" for not applicable)
☐ Check VS: BP, pulse, respiratory rate, temperature, pulse ox., and/or finger stick glucose if indicated
☐ Review chart (most recent progress notes and nurse’s notes from previous shift, any recent labs)
☐ Review an INTERACT II Care Path or Acute Change in Status File Card if indicated
☐ Have relevant information available when reporting (i.e. resident chart, vital signs, advanced directives such as DNR and other care limiting orders, allergies, medication list)

S
SITUATION
This is ______________________ (nurse) I am calling about ______________________ (Resident’s name)
The problem/symptom I am calling about is ______________________
The problem/symptom started ______________________
The problem/symptom has gotten (worse or better) ______________________ since it started
Things that make the problem/symptom worse are ______________________
Things that make the problem/symptom better are ______________________
Other things that have occurred with this problem/symptom are ______________________

B
BACKGROUND
Primary diagnosis and/or reason resident is at the nursing home ______________________
Pertinent medical history/include recent falls, fever, decreased intake/fluids, CP, SOB, other ______________________
Mental Status or Neuro changes: (V: N: confusion/agitation/lethargy) Temp __________ BP __________
Pulse rate/rhythm __________ Resp rate __________ Lung Sounds ______________________
Pulse Oximetry __________ % On RA, on O2 or __________, L/min via __________ (NC, mask)
GI/GU changes (nausea/vomiting/diarrhea/impaction/distension/decreased urinary output) ______________________
Pain level/location/status ______________________
Change in function/intake/hydration ______________________
Change in Skin Color ______________________ Wound Status (if applicable) ______________________
Lab ______________________
Medication changes or new orders in the last two weeks ______________________
Advance Direcives (Full code, DNR, DNI, DNH, other, not documented) ______________________
Allergies ______________________ Any other data ______________________

A
ASSESSMENT (RN) or APPEARANCE (LPN)
(For RNs): What do you think is going on with the resident? (e.g. cardio, infection, respiratory, urinary, dehydration, mental status change?) I think that the problem may be ______________________ — OR
I am not sure of what the problem is, but there had been an acute change in condition.
(For LPNs): The patient appears ______________________ (e.g. SOB, in pain, more confused)

R
REQUEST
I suggest or request:
☐ Provider visit (MD/NP/PA)
☐ Monitor vital signs (Frequency ______________________) and observe
☐ Lab work, x-rays, EKG, other tests ______________________
☐ Medication changes ______________________
☐ New orders ______________________
☐ IV or SC fluids ______________________

Staff name ______________________ RN/LPN

Reported to: Name ______________________ (MD/NP/PA) Date __/__/_____ Time _______ am/pm
If to MD/NP/PA, communicated by: ☐ Phone ☐ Fax (attach confirmation) ☐ In person

(Please see Progress Note on back of this Form)
# RESIDENT TRANSFER FORM

## SENT TO:
(Name of Hospital)

## SENT FROM:
(Name of Nursing Home)

### RESIDENT:
- Last Name
- First Name
- Mi
- DOB: ___/___/____
- Language: English  Other: ___
- Resident is:  SNF/rehab  Long-term
- Unit: ___

### CONTACT PERSON:
(Relative, guardian or DPOA/Relationship)  name

- Is this the health care proxy?  Yes  No
- Telephone: ( )-____-____
- Notified of transfer:  Yes  No
- Aware of diagnosis:  Yes  No

### CODE STATUS:
- DNR  DNH  DNI

### MD/NP/PA IN NURSING HOME:
- MD  NP  PA  name
- Telephone: ( )-____-____  Pager: ___

### WHO TO CALL TO GET QUESTIONS ANSWERED ABOUT THE RESIDENT?
- name
- title
- Telephone: ( )-____-____

### REASON FOR TRANSFER (i.e., What Happened?)

List of Diagnoses:

**VS:** BP  HR  RR  T  pO2  FS  glucose  Time Taken:  ____ AM/PM

Allergies: ___

**Usual Mental Status:**
- Alert, oriented, follows instructions
- Alert, disoriented, but can follow simple instructions
- Alert, disoriented, but cannot follow simple instructions
- Not alert

**Usual Functional Status:**
- Ambulates independently
- Ambulates with assistance
- Ambulates with assistive device
- Not ambulatory

Please see SBAR form for additional information

### DEVICES / SPECIAL TREATMENTS:

<table>
<thead>
<tr>
<th>Device</th>
<th>Special Treatment</th>
<th>Alert</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV/PICC line</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Pacemaker</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Foley Catheter</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Internal Defibrillator</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>TPN</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Other: ___</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

### AT RISK ALERTS:

<table>
<thead>
<tr>
<th>Alert</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls</td>
<td>None</td>
</tr>
<tr>
<td>Pressure</td>
<td>None</td>
</tr>
<tr>
<td>Ulcer</td>
<td>None</td>
</tr>
<tr>
<td>Aspiration</td>
<td>Others</td>
</tr>
<tr>
<td>Wanderer</td>
<td>Others</td>
</tr>
</tbody>
</table>

### ISOLATION / PRECAUTION:

<table>
<thead>
<tr>
<th>Isolation</th>
<th>Precaution</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA</td>
<td>VRE</td>
</tr>
<tr>
<td>C-Diff</td>
<td>Others</td>
</tr>
<tr>
<td>Other: ___</td>
<td>Site: ___</td>
</tr>
</tbody>
</table>

### Form Completed By:
- name
- title
- signature

### Report Called In By:
- name
- title

### Report Called To:
- name
- title
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**Care Paths**

<table>
<thead>
<tr>
<th>Fever</th>
<th>Posters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute mental status change</td>
<td></td>
</tr>
<tr>
<td>Symptoms of Lower Respiratory Illness</td>
<td></td>
</tr>
<tr>
<td>Symptoms of CHF</td>
<td></td>
</tr>
<tr>
<td>Symptoms of UTI</td>
<td></td>
</tr>
<tr>
<td>Dehydration</td>
<td></td>
</tr>
</tbody>
</table>
## Advance Care Planning Tools

<table>
<thead>
<tr>
<th>Identifying Residents to Consider for Palliative Care and Hospice</th>
<th>Pocket Card</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance Care Planning Communication Guide</td>
<td>File Cards</td>
</tr>
<tr>
<td>Comfort Care Order Set</td>
<td>File Cards</td>
</tr>
<tr>
<td>Educational Information for Families</td>
<td>Reprints</td>
</tr>
</tbody>
</table>
QUALITY IMPROVEMENT TOOL
For Review of Acute Care Transfers

Use this tool to review all transfers of residents to an emergency department or for direct admission to the hospital. The goal is to understand the reasons for the transfer and identify potential opportunities to prevent avoidable acute care transfers.

Date of QI Review: ______/_____/_______

1. RESIDENT BACKGROUND INFORMATION

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Age</th>
<th>Room #</th>
<th>Unit</th>
</tr>
</thead>
</table>

Date of most recent admission to nursing home: ______/_____/_______
Resident hospitalized in the past year?  Yes  No
If yes, list dates and reasons:

Resident status at time of transfer:  [ ] LTG  [ ] SNF
Payer was:  [ ] Medicaid  [ ] Medicare  [ ] Evercare  [ ] Other managed care

2. TRANSFER INFORMATION

Date of transfer ______/_____/_______ Day of week ______  Time of transfer ______:____ AM/PM
Sent by 911?  Yes  No
Nurse (RN/LPN) involved in transfer
MD/NP authorizing transfer
Provider was:  [ ] Resident’s Primary  [ ] Covering Provider

What happened?
(describe clinical scenario ON THE DAY of the transfer, including presenting symptom(s))

Were there any other factors that led up to the transfer? If so, describe what was going on with the resident in the days BEFORE the transfer (i.e. do a "root cause analysis")

3. EFFORTS TO HANDLE SITUATION WITHOUT TRANSFER

What was done to try to assess and treat in the facility?

- [ ] Stop & Watch tool completed by nursing assistant
- [ ] SBAR completed (MD or NP: ______ Called  ______ Not Called)
- [ ] Care Path used (Which one?)
- [ ] Physician onsite evaluation/Nurse Practitioner onsite evaluation
- [ ] Practitioner telephone discussion  [ ] Discussion with family member
- [ ] Intravenous or subcutaneous fluids initiated
- [ ] Lab tests done  [ ] Xrays  [ ] EKG/rhythm strip  [ ] Other tests (describe)_______
- [ ] Medications given (describe)_______
- [ ] Other (specify)_______
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- It’s not about the tools
- It’s about the process
- It’s about the conversations and the relationships among providers and institutions
Reducing Potentially Avoidable Hospitalizations of Nursing Home Residents

Commonwealth Fund Grant

Principal Investigator: Joseph G. Ouslander, M.D.

Co-Principal Investigator: Gerri Lamb, PhD, RN
Independence Foundation and Wesley Woods Chair
Associate Professor of Nursing, Emory University

Collaborators: Laurie Herndon, MSN, GNP/ANP
Senior Project Manager
Alice Bonner, PhD, RN
Co-Investigator
Massachusetts Senior Care Foundation

Multidisciplinary teams from FL, NY, and MA

Support: ~ $390,000 over 2 years
Reducing Potentially Avoidable Hospitalizations of Nursing Home Residents

Commonwealth Fund Grant

Methods

1. Obtain input from national thought leaders in innovative models of long-term and transitional care and NH health care professionals from a nationally representative sample of NHs on the design, content, and implementation strategies for the toolkit

1. Refine the toolkit based on this input

1. Implement and evaluate the refined toolkit in a representative sample of NHs using a quality improvement project incorporating principles of an Institute for Healthcare Improvement (IHI) Collaborative

30 NHs will be involved: 10 in FL, 10 in NY, and 10 in MA
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Methods

1. Collect data during the Collaborative that will be used to:
   • Understand factors and strategies that are important for successful implementation and sustained use of the toolkit
   • Estimate the costs of implementing the toolkit to inform P4P initiatives
2. Explore incorporating key elements of the toolkit into health information technology (HIT) using web-based formats and/or an electronic health record