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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

Background

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

  Saliba et al, J Amer Geriatr Soc 48:154-163, 2000

- 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 Nursing Home Residents

The Opportunity

- Reducing potentially avoidable hospitalizations of NH residents represents an opportunity to both:
  - Improve quality of care; and
  - Reduce overall Medicare expenditures on this population

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

Reducing Potentially Avoidable Hospitalizations of Nursing Home Residents

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

Reducing Potentially Avoidable Hospitalizations of Nursing Home Residents

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

Reducing Potentially Avoidable Hospitalizations of Nursing Home Residents

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

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

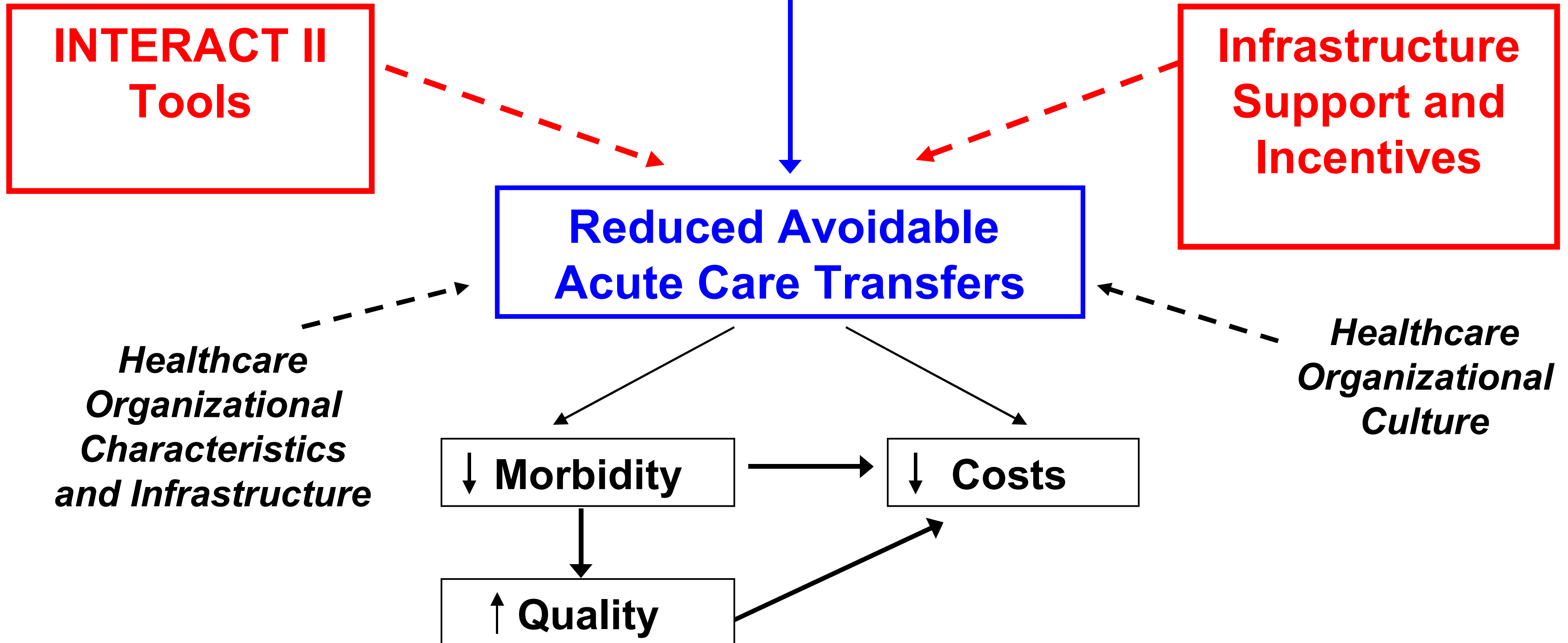
Developed based on interviews and ratings of avoidability, and Expert Panel ratings of importance and feasibility

Clinical Care Paths

Communication Tools

Advance Care Planning Tools

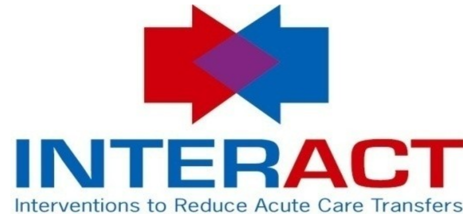
Interventions to Reduce Acute Care Transfers (INTERACT II)



Development of INTERACT Tools

- Evidence or consensus-based (and/or consistent with CPGs)
- Simple
- Feasible and efficient to use
- Acceptable to NH staff

Reducing Potentially Avoidable Hospitalizations of Nursing Home Residents

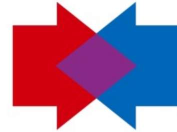


Current Versions of the Tools are available on the Quality Net website at:

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

Revised tools soon to be available on www.geriu.edu

Reducing Potentially Avoidable Hospitalizations of Nursing Home Residents



Communication Tools	
Early Warning Tool “Stop and Watch”	Pocket Cards and Report Forms
SBAR Communication (Nurse to Physician and/or ER)	Form and Progress Note
Acute Change in Condition Guidance for Communication	File Cards
Resident Transfer Form	Form completed on transfer
Nursing Home Capabilities	Pre- populated Checklist
Acute Care Transfer Documents	Envelope with Checklist

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

INTERACT II
Interventions to Reduce Acute Care Transfers

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 (circle one) worse/better/stayed the same 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: (Y/ N: confusion/agitation/lethargy) Temp__________ BP__________
Pulse rate/rhythm__________ Resp rate__________ Lung Sounds__________
Pulse Oximetry________ % On RA________ on O2 at________ 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)__________
Labs____________________
Medication changes or new orders in the last two weeks____________________
Advance Directives (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. cardiac, 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, xrays, 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)*

Unit: ____________

RESIDENT:
Last Name *First Name* *MI*

DOB: ____/____/____

Language: English Other: ____________

Resident is: SNF/rehab Long-term

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 HURSING 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____ pOx____ FS glucose____ Time Taken: ____:____ AM/PM

Allergies: ____________ Tetanus Booster *(date)*: ____/____/____

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:
- IV/PICC line
- Pacemaker
- Foley Catheter
- Internal Defibrillator
- TPN
- Other: ____________

AT RISK ALERTS:
- None
- Falls
- Pressure Ulcer
- Aspiration
- Wanderer
- Elopement
- Seizure
- Harm to: Self Others
- Restraints
- Limited/non-weight bearing: Left Right
- Other: ____________

ISOLATION / PRECAUTION:
- MRSA
- VRE
- C-Diff
- Other: ____________

Site: ____________

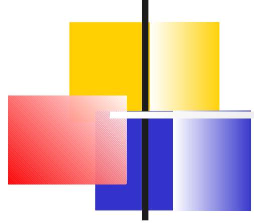
Comment: ____________

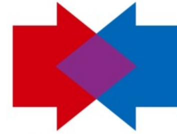
Form Completed By:
name *title* *signature*

Report Called In By:
name *title*

Report Called To:
name *title*

Reducing Potentially Avoidable Hospitalizations of Nursing Home Residents



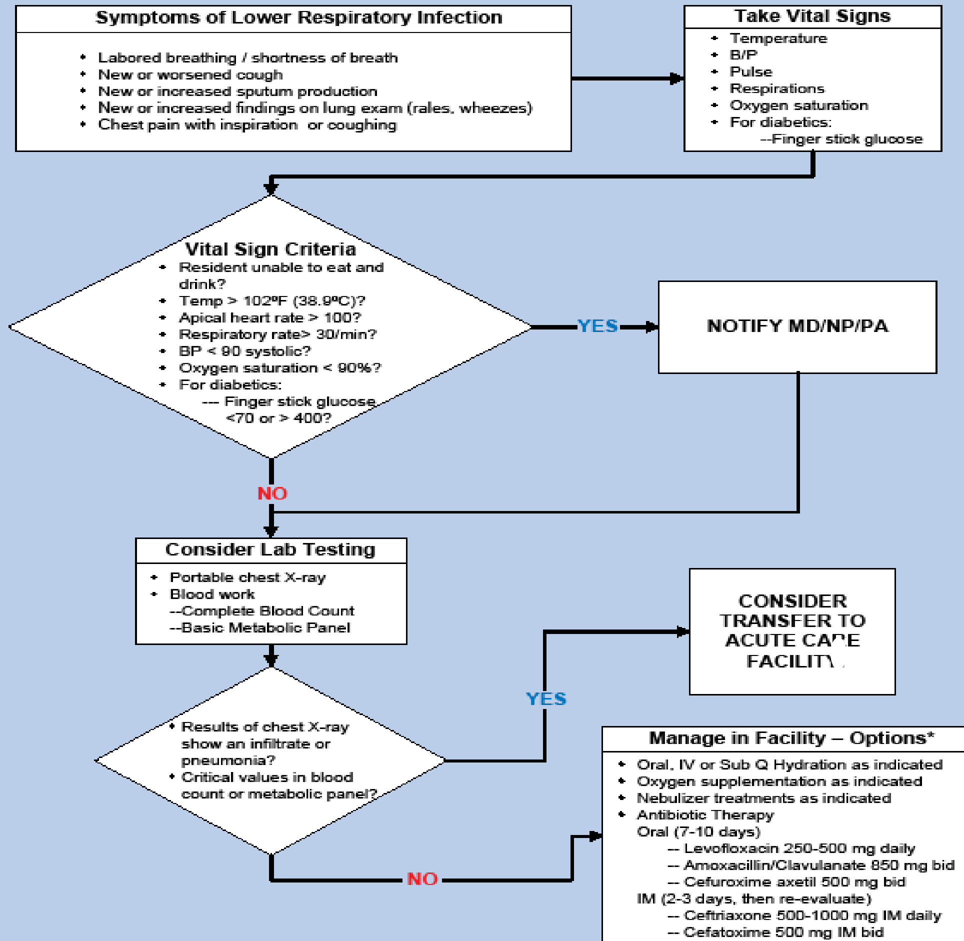


INTERACT II

Interventions to Reduce Acute Care Transfers

Care Paths	
Fever Acute mental status change Symptoms of Lower Respiratory Illness Symptoms of CHF Symptoms of UTI Dehydration	Posters

Lower Respiratory Infection Care Path



* Other options may be appropriate for individual residents

Sources:

Loeb M, Carusone SC, Goeree R, et al: Effect of a Clinical Pathway to Reduce Hospitalizations in Nursing Home Residents with Pneumonia – A Randomized Controlled Trial. JAMA 295: 2503-2510, 2006

Mylotte JM: Pneumonia and Bronchitis from Yoshikawa, Thomas T, Ouslander JG: Infection Management for Geriatrics in Long-Term Care Facilities. New York, Informa Healthcare, 2nd Edition, Chapter 14, 223.

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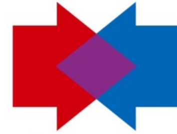
Reducing Potentially Avoidable Hospitalizations of Nursing Home Residents



INTERACT II

Interventions to Reduce Acute Care Transfers

Advance Care Planning Tools	
Identifying Residents to Consider for Palliative Care and Hospice	Pocket Card
Advance Care Planning Communication Guide	File Cards
Comfort Care Order Set	File Cards
Educational Information for Families	Reprints

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

Last Name	*First Name*	*MI*	*Age*	*Room #*	*Unit*

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: ☐ LTC ☐ 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) ________________________________

- 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

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

Reducing Potentially Avoidable Hospitalizations of Nursing Home Residents

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