



Avoiding Hospitalizations

Early identification and clinical best practices are key factors in averting hospitalization of nursing facility residents.

EVERYONE AGREES THAT HOSPITALIZING nursing facility residents can disrupt continuity of care, diminish quality of life, and consume a sizeable portion of Medicare spending.

Such hospitalizations rose dramatically between 1999 and 2004, according to a 2007 study from the Commonwealth Fund. Annual spending on nursing facility resident hospitalizations climbed 29 percent from 1999, to a staggering \$971.7 million in 2004, the study found.

Nearly 25 percent of these hospitalizations were for ambulatory care-sensitive conditions, including pneumonia, kidney/urinary tract infections, and congestive heart failure. An astounding one-third of them were later deemed potentially avoidable.

How were they avoidable? Nursing facility residents are generally hospitalized in response to a confluence of factors.

Some research suggests hospitalizations stem from treating a sicker population, nursing shortages, and the litigious nature of our society.

Other research points to health system factors, such as the availability of skilled nurses, access to diagnostic testing, and access to physicians or physician extenders, as contributing to a resident's hospitalization.

Data Shed Light

Therefore, the million-dollar question for nursing facilities is this: What can be done to affect positive change for at-risk residents? The ultimate cause for hospitalization always comes back to the resident's condition, however,

and that is precisely where the nursing facility needs to focus.

First and foremost, reducing hospitalizations requires early identification of at-risk residents, followed by preventive measures and a heightened awareness protocol whereby all clinicians are trained in identifying the early signs

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and symptoms of a declining condition. Only when these steps are in place and working effectively can a timely intervention be made and a hospitalization averted.

The first step—identification—is critical. Realizing this, many facilities perform thorough admission assessments and regular observations. Yet, few facilities are utilizing the predictive capabilities of the minimum data set (MDS) data, which can aid in correctly identifying residents at a higher risk of hospitalization. Developed by information-based health information technology providers, such tools can utilize various MDS items, such as diagnoses and unstable conditions, in a statistically validated model that predicts the risk probability of a resident's discharge to the hospital after admission or readmission to the nursing facility.

Resource utilization group (RUG)

data have also been used to identify at-risk nursing facility residents. In a recent evaluation of case-mix changes using RUG data, only one category of residents was at increased risk for hospitalizations—those that require extensive services. This is the only category of residents that have seen a rise in hospitalization rates.

Higher Acuity, Higher Risk

The study examined more than 520,000 discharge assessments sorted by the RUG-53 groups for the years 2004, 2005, and 2006. Within each RUG group, the residents were stratified into two categories: low and high risk for hospitalization. At this drilled down level, the researchers calculated RUG-specific hospitalization rates for both the low-risk group and the high-risk group.


By separating the RUG groups into these categories, researchers were able to confirm the notion that nursing facilities have in fact faced a steady increase in acuity and therefore a higher "risk" of hospitalization.

Interestingly, the actual rates of hospitalization in all but one RUG group revealed no significant increase. In fact, many RUG categories demonstrated a

STEVEN LITTLEHALE, MS, GCNS-BC, executive vice president of HealthCare and chief clinical officer, and SHEILA CAPITOSTI, RN-BC, MSN, MHSA, senior health care specialist, are with PointRight, a company that provides consulting services to providers, payers, regulators, suppliers, and consumers in the long term and post-acute care arena.

INTERACT Tool Enlists Nurse Assistants

Facilities have utilized the early warning tool by printing it on laminated pocket cards and giving them to all certified nurse assistant staff members. When a change was noted in a resident's condition, they were instructed to fill out the report and give it to the charge nurse, as follows:



INTERACT
Interventions to Reduce Acute Care Transfers

Early Warning Report

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

Resident Name: _____

<p>Seems like himself/herself Talking the same Overall function the same Participated in usual activities</p>	}	NO?
<p>Ate the same amount N Drank the same amount</p>	}	
<p>Weak Agitated or nervous Tired or drowsy Confused Help with dressing, toileting, transfers</p>	}	YES?

Staff: _____ Reported to: _____

Date: _____ Time: _____

Source: Adapted from Boockvar, Kenneth, et al., Journal of the American Geriatrics Society, 48: 1086-1091, 2000. Created by the Georgia Medical Care Foundation, the state's Medicare quality improvement organization, under contract with the Centers for Medicare & Medicaid Services.

statistically significant decline in hospitalization rates.

Facilities Doing A Good Job

Based on these data, it is evident that many nursing facilities are actually performing an outstanding job managing an increasingly complex base of residents.

What's more, within the top nine new RUG groups, the rate of hospitalization either dropped or remained unchanged. For example, when examining those residents who left the nursing facility shortly after admission, excluding those who passed away, the proportion of those that went to the hospital for the RUG group RVX—rehab very

high plus extensive services—shows a statistically significant improvement, from 68.7 percent in 2004 to 64 percent in 2005, and down to 60 percent in 2006. Surprisingly, the majority of RUG groups followed a similar trend of either improvement or no change.

The one exception was for the category for extensive services (SE3). For a resident to qualify for RUG-SE3 classification, the resident must have an activities of daily living index greater than seven and one or more of the following: intravenous feeding or medications, suctioning, tracheotomy care, or ventilator/respirator care.

These are very frail, very sick residents unable to tolerate extensive therapy. Not surprisingly, these are the residents whose hospitalization rates are increasing. Again, when examining only those residents who were discharged from SE3, in 2004, 2005, and 2006, the rates of those who went to the hospital increased from 76.3 percent to 77.1 percent, to 81.2 percent, respectively. Here is where an opportunity lies for nursing facilities to affect further positive change in hospitalization rates.

New Tools

The predictive ability of MDS analytic tools, coupled with an effective clinical protocol to manage this frail population of residents, enables nursing facilities to further reduce hospitalizations. A new program known as the INTERACT framework, or Interventions to Reduce Avoidable Hospitalizations of Nursing Home Residents, was created for this purpose.

Developed through a Centers for Medicare & Medicaid Services special study to assist nursing facilities nationally in their efforts to reduce potentially avoidable acute-care transfers, INTERACT includes a tool kit that is available to any nursing facility through MedQIC, a Web site that serves as an online resource of quality improvement information for Medicare quality improvement organizations.

An expert panel assisted in the development of the INTERACT intervention framework and tools, which were designed from evidenced-based resources and focus on communication, disease-specific care paths, and advanced care planning. The INTERACT tool kit includes clinical care pathways, communication aids, early warning cards, acute change in condition cards, and acute-care transfer forms.

The SBAR—Situation Background Assessment Recommendations—is a tool that guides facility staff in assessing a resident's situation and making a recommendation regarding the likelihood of hospitalization.

The Disease-Specific Care Paths are care protocols that assist facility clinicians in the treatment of residents with

specific conditions, such as hydration, congestive heart failure, fever, and urinary tract infections.

Implementation Strategies

Also available through INTERACT are detailed improvement strategies and key interventions to guide nursing facilities in the use of the tools.

These strategies are broken down into four instructional steps for facilities that are ready to implement the framework:

1. *Organizational commitments.* Develop an organizational goal for quality improvement efforts that focuses on reducing avoidable acute-care transfers.

Appoint a team responsible for overseeing implementation of the program and monitoring its progress. Involve the medical director and all attending

physicians in the process. Educate facility staff, family members, and residents regarding the initiative.

2. *Communications strategies.* Enhance communication practices relating to a change in resident condition: Establish communication protocols between nurse assistants and licensed nurses at every change in shift, between attending physician and staff, and between nursing facility staff and the acute-care hospital. An important component of this includes the evaluation and revision of transfer forms, including a checklist for all documents that should accompany a resident upon transfer.

3. *Care paths.* Implement basic care paths for common causes that result in acute-care transfers. Residents with common acute conditions—acute change in mental status, fever, dehydra-

Health Status Linked To Quality Of Life

Nursing facility residents' physical health affects their self-reported quality of life, researchers found after comparing resident health data with information gained from interviews.

As health problems or depression increased, residents reported declines in certain elements of quality of life. The study found different health issues associated with different declines in quality-of-life areas, according to an article in the October 2008 issue of *The Gerontologist*, published by the Gerontological Society of America.

"As interest in using [quality of life] to evaluate nursing home performance grows, understanding the link between health status and subjective [quality of life] will become more important," wrote authors Howard Degenholtz, Jules Rosen, Nicholas Castle, Vikas Mittal, and Darren Liu in their study, entitled, "The Association Between Changes in Health Status

and Nursing Home Resident Quality of Life."

Quality Of Life Critical

The authors say that there is a high priority on measuring quality of care at nursing facilities but that "with isolated

■ Residents with pressure ulcers reported declines in autonomy, security, and spiritual well-being.

exceptions, the quality measures used in nursing home quality public report cards do not address [quality of life]."

"It is vitally important, therefore, to establish whether improvement in the underlying health of nursing home

residents—which is the fundamental goal of quality-of-care improvement—and in nursing home environments can have a beneficial effect (or no effect) on aspects of [quality of life]," according to the article.

Using a multidimensional resident self-report instrument developed by Kane and colleagues in 2003, the researchers had residents rank their feelings on quality-of-life issues. The tool measures 11 dimensions of quality of life: comfort, functional competence, privacy, dignity, autonomy, meaningful activities, relationships, food enjoyment, spiritual well-being, security, and individuality.

Residents rank their feelings on a scale or answer "generally yes" or "generally no," as explained in the report.

Residents with pressure ulcers for two consecutive six-month periods reported declines in autonomy, security, and spiritual well-being, while residents with declines in physical disability re-

tion, urinary tract infection, pneumonia, chronic heart failure—should be managed in place whenever possible.

Incorporate targeted American Medical Directors Association clinical practice guidelines and protocols for acute changes in condition into tools for daily practice, such as communication templates, laminated cards by the phone, or quick reference pocket guides.

Train all staff on early warning signs, especially nurse assistants who see residents regularly.

4. *Advance care planning.* Enhance

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advance care planning by focusing on resident and family education about advance directives, palliative care, and the

benefits of hospice. Also, involve physicians in identifying residents at end of life and communicating with the family members.

Without advance directives, family involvement, and physician communication regarding

end-of-life signs, this group is often transferred to the hospital.

Through the utilization of newly developed tools, such as MDS-based predictors of at-risk residents, combined with clinical protocols like those

detailed in the INTERACT study, nursing facilities can continue the progress under way to reduce avoidable hospitalizations.

However, real improvement will only come from the implementation of best practices and an organizational commitment to incorporate the reduction of unnecessary hospitalizations into facility quality improvement plans and processes. ■

For More Information

■ Go to www.MedQIC.org, click on Care Transitions on the left side of the page, then click on Collaboratives, Change Packages, and Frameworks near the bottom of the page, then click on INTERACT-Reducing Avoidable Hospitalizations in Nursing Home Residents.

ported declines in dignity. Increases in depressive symptoms led to decreases in comfort, meaningful activities, and food enjoyment quality-of-life areas, and residents with increases in pain reported decreases in functional competence and dignity.

The study included residents at two nonprofit nursing facilities in western Pennsylvania. The researchers linked clinical data for residents from the minimum data set to self-report interviews using the quality-of-life instrument.

They conducted five waves of interviews at six-month intervals. The facilities already were participating in a four-year study on quality improvement processes, but during this study nothing was put in place that had the specific goal of changing or improving residents' quality of life.

Physical Trait Pointers

Interviewers approached 208, 205, 200, 188, and 194 residents in each inter-

view wave, including some who were present in more than one wave. The researchers obtained about 62 percent of the resident populations at the two facilities, or 624 surveys for 307 unique residents, according to the article.

“We found that increases in physical

■ Other studies have looked specifically at changes in physical function, pain, and risk factors.

disability and pain, the incidence of depressive symptoms, and the prevalence of pressure ulcers were related to drops in several domains” of quality of life, according to the article.

Pressure ulcers and depressive symp-

toms had the strongest evidence, with each associated with changes in more than three quality-of-life areas.

The authors say the study makes “an important contribution to the literature on the dynamics of health status among nursing home residents.” Other studies have looked specifically at changes in physical function, pain, and risk factors for decline in health and function, but there has been little done looking at changes on quality-of-life factors in nursing facilities.

The authors also point out that many regulatory and legislative reforms have focused on quality of care at nursing facilities. “With isolated exceptions, the quality measures used in nursing home quality public report cards do not address [quality of life].”

The authors suggest that not every quality-of-life dimension showed the same pattern so more research is needed.

—Suzanne Struglinski