Long-Term Care Survey Alert

Quality Improvement: Cut Down on Unnecessary ED Visits and Hospitalizations

Implement these proven strategies in your facility.

Your facility can dramatically improve quality of care and prepare for impending changes in Medicare/Medicaid financing and regulations by implementing an evidence-based program to reduce unnecessary emergency department (ED) visits and hospitalizations.

About 45 percent of hospital admissions among individuals receiving either Medicare skilled nursing facility services or Medicaid nursing facility services could have been avoided, according to research conducted by the Centers for Medicare & Medicaid Services (CMS). This accounts for 314,000 potentially avoidable hospitalizations and $2.6 billion in Medicare expenditures in 2005.

Added risks: Nursing facility residents often experience potentially avoidable inpatient hospitalizations, which frequently are expensive, disruptive and disorienting, especially for frail elders and people with disabilities, CMS notes. "Nursing facility residents are especially vulnerable to the risks that accompany hospital stays and transitions between nursing facilities and hospitals, including medication errors and hospital-acquired infections," the agency stated in a recent press release.

As a result, CMS is implementing a new initiative to help nursing facilities reduce preventable inpatient hospitalizations by 20 percent by the end of 2012. As part of this initiative, the agency held a webinar on April 17, where industry experts discussed evidence-based interventions to reduce avoidable ED visits and hospitalizations. (Editor's note: The audio recording, slide presentations, and transcript of this webinar are available at: www.innovations.cms.gov/resources/rahnfr_evidence_based_interventions.html).

"Our goal is to present interventions that are supported by scientific evidence or extensive professional experience," the moderator of the webinar, **Lewis Lipsitz, MD**, professor of medicine at Harvard Medical School, explained. In particular, there are four areas -- care protocols and staff training (the INTERACT program), organizational changes (Advancing Excellence in Long-Term Care Collaborative), professional staff models (Evercare model), and medication and pharmacy interventions -- that the medical literature shows are particularly promising, he noted.

(**Editor's note**: The first two of these interventions, the INTERACT and the Advancing Excellence programs are described in this issue. The other strategies will be covered in upcoming issues of Long-Term Care Survey Alert.)

Identify the causes of your facility's acute care transfers

"There are many factors that go into the decision to hospitalize a particular long-term care patient," **Joseph Ouslander, MD**, professor and senior associate dean for geriatric programs at the Charles E. Schmidt College of Medicine noted. Some of the main factors include the availability in the facility of trained MDs, NPs, PAs and RNs, resident and family preferences, financial incentives, and concerns about legal liability and regulatory sanctions (see Figure 1: Factors and Incentives that Influence the Decision to Hospitalize LTC Patients).

Use these three INTERACT strategies to reduce acute care transfers

The INTERACT (Interventions to Reduce Acute Care Transfers) program, which has been proven to reduce hospital admissions by 17 percent, consists of three basic strategies, Ouslander explained.

1. Prevent conditions from becoming severe enough to require an ED visit or hospitalization by having staff identify and

assess changes in resident condition early on. "For example, if staff identifies that someone isn't eating or drinking over the course of a few days, you can prevent severe dehydration and the possible hospitalization related to that," he said.

2. Manage some conditions in the nursing facility without transfer to acute care when this is feasible and safe. "An example of this might be a lower respiratory infection which is not associated with unstable vital signs, hypoxia or delirium," Ouslander suggested.

3. Improve advance care planning and use palliative care plans, when appropriate, as an alternative to hospitalization for some residents. "Many times, nursing home residents go back and forth to the hospital for the same condition, and a comfort or palliative care program may be appropriate as an alternative to hospitalization for some of them," Ouslander noted.

However, he added, the goal of the INTERACT program is not to prevent all hospital transfers. "In fact, trying to prevent all hospital transfers might lead to unintended consequences," Ouslander emphasized, noting that the INTERACT protocols can actually help nursing home staff identify sooner those individuals who genuinely need to be transferred to acute care.

Check out these INTERACT-II tools

There are a number of tools available to help providers implement the INTERACT strategies. These include communication tools, decision support tools, advanced care planning tools and quality improvement tools (see Tools You Can Use to Reduce Your Acute Care Transfers on pg. 52). These tools, which are available at http://interact2.net, are meant to be used together on a daily basis in your nursing home to improve quality and reduce unnecessary acute care transfers, Ouslander noted.

The advanced care planning tools include:

- Guidance (pocket cards) on how to identify residents who may be appropriate for a palliative or comfort care plan, or hospice care
- Guidance (file cards) on how to communicate with residents and family members for those appropriate for a palliative or comfort care plan, or hospice care
- Guidance (file cards) on examples of orders that may be appropriate for residents on palliative or comfort care plans

"These tools are used when a resident is admitted or readmitted and can also be helpful when someone has an acute changing condition," Ouslander pointed out.

The early-warning "stop and watch tool" is used to guide frontline staff in the early identification of changes in a resident's condition. "Often the certified nursing assistants are the first ones to notice a change in the resident, and this tool helps to structure communication between the nursing assistant and the licensed staff. It can also be used by other front line staff such as rehabilitation therapists, dietary and housekeeping staff," Ouslander said.

The care paths include decision support tools for six common conditions (mental status change, fever, symptoms of lower respiratory infection, symptoms of CHF, symptoms of UTI and dehydration) that precipitate transfer. These care paths can be enlarged and printed as posters for the nursing station or med room, or printed and placed in a binder.

The acute change in condition file cards, which are based on the AMDA practice guideline on communicating changes in condition, provide very specific guidance about whether nursing staff should immediately notify the MD, NP, and/or PA of a resident's change in condition, Ouslander explained.

The SBAR (situation, background assessment, recommendation) form is a structured communication tool which also serves as an acute change in condition progress note. This is used by licensed nursing staff to evaluate and communicate and document acute changes to the MD, NP, and/or PA.

The acute transfer tool is a checklist that is completed if an acute care transfer is necessary. "There is a checklist of documents that should go to the hospital, which is put on the front of the envelope containing the documents,"

Ouslander explained.

The resident transfer form is a standardized form that can be reviewed by ED physicians and nurses to help them make a timely decision about whether a resident needs to be admitted or not, he added.

Bonus tools: And lastly, Ouslander noted, there are quality improvement tools, including a transfer log that helps facilities track their transfers over time, and a quality improvement review tool which is essentially a mini-root cause analysis to look back at the transfer and identify what happened, what the facility did, and what the facility learned from the experience to improve care.

"INTERACT is an overall quality improvement program, and if you're not tracking outcomes and doing root cause analyses, you're really not doing quality improvement," Ouslander emphasized.

In addition to these tools, a curriculum to train staff in implementing the INTERACT program is also available. Providers interested in the curriculum should contact Ouslander via e-mail at: jousland@fau.edu.