Improving End-of-Life Care by Reducing Avoidable Hospitalizations of NH Residents

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Gerri Lamb, PhD, RN — Emory University; Arizona State University
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Ruth Tappen, EdD, RN, FAAN — Florida Atlantic University

Improving End-of-Life Care by Reducing Avoidable Hospitalizations of NH Residents

- Why try to reduce hospitalizations?
- How many are avoidable?
- What are the incentives?
- What can we do to reduce avoidable hospitalizations, related morbidity, and unnecessary expenditures?

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Hospitalization of Nursing Home Residents

- Common
- Expensive
- Often traumatic to the resident and family
- Fraught with many complications of hospitalization
  (e.g. deconditioning, delirium, incontinence/catheter use, pressure ulcers, polypharmacy)

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Hospital Readmissions within 30 days from SNFs are Common

- Of ~1.8 million SNF admissions in the U.S. in 2006, **23.5% were re-admitted to an acute hospital within 30 days**
  - Cost of these readmissions = **$4.3 billion**

Mor et al. Health Affairs 29 (No. 1): 57-64, 2010

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Hospital Readmissions within 30 days from SNFs are Common

- Of 10,825 discharges of Medicare fee-for-service patients age 75+ discharged from a community hospital in south Florida, 3,301(30%) went to a SNF, and 597 **(18%) of these SNF admissions were readmitted to the hospital within 30 days.**
  - Of the 597readmitted to the acute hospital within 30 days, 201 **(34%) were readmitted within 7 days or less**
- Most common diagnoses:
  - **CHF**
  - **Pneumonia**
  - **Other infections**

Ouslander et al. J Amer Med Dir Assn, in press, 2010

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A Tale of Three Siblings

- Sara
- Sadie
- Sam

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Sara

92 years old

- Hospitalized for a lower respiratory infection
- Cardiology evaluation resulted in catheterization
- Fell and fractured her hip related to sedation from the procedure

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Sadie

96 years old

- Hospitalized for urinary infection and dehydration
- Re-hospitalized 7 days after discharge for recurrent urinary infection and dehydration

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Sam

101 years old

- Hospitalized for the 4th time in 2 months for aspiration pneumonia related to end-stage Alzheimer's disease
- Transferred to hospice on the day of admission

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How Many Hospitalizations are Avoidable?

- As many as 45% of admissions of nursing home residents to acute hospitals rated as inappropriate

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

- In 2004 in NY, Medicare spent close to $200 million on hospitalization of long-stay NH residents for "ambulatory care sensitive diagnoses"

  Grabowski et al, Health Affairs 26: 1753-1761, 2007

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CMS Special Study Awarded to the Georgia Medical Care Foundation

- **18 month project** (7/06 – 1/08)
- **Develop and pilot test tools and strategies to reduce potentially avoidable acute hospitalizations of nursing home residents**

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Mary Perloe APRN-BC, GNP - Project Coordinator,GMCF
JoVonn Hughley, MPH - Evaluation Specialist, GMCF
Tracy Rutland, MBA, MHA – Quality Improvement & Education Specialist
Linda Kluge RD, LD, CPHQ – Nursing Home Project Manager, GMCF
Gerri Lamb, PhD, RN – Professor, School of Nursing, Emory University
Adam Atherly, PhD – Associate Professor, School of Public Health, Emory University
Jeff Hibbert, PhD – Data Analyst/Statistician, GMCF

Expert Panel – 10 members

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CMS Special Study Results

Of 200 hospitalizations, an expert clinician panel rated *2/3 as potentially avoidable*

	Was the Hospitalization Avoidable?	
	Definitely/Probably YES	Definitely/Probably NO
Medicare A	69%	31%
Other	65%	35%
HIGH Hospitalization Rate Homes	75%	25%
LOW Hospitalization Rate Homes	59%	41%
TOTAL	**68%**	**32%**

Ouslander et al: J Amer Ger Soc 58: 627-635, 2010

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CMS Special Study Results

- The most common admitting diagnoses for hospitalizations rated as potentially avoidable were consistent with "Ambulatory Care Sensitive" Dxs

Hospital Admitting Diagnosis	Frequency (N = 105)
Cardiovascular (mainly CHF and chest pain)	22 (21%)
Respiratory (mainly pneumonia and bronchitis)	21 (20%)
Mental Status Change/Neurological	13 (12%)
Urinary Tract Infection	11 (11%)
Sepsis/Fever	8 (8%)
Skin (cellulitis, infected wound or pressure ulcer)	8 (8%)
Dehydration and/or metabolic disturbance	7 (7%)
Gastrointestinal (bleeding, diarrhea)	7 (7%)
Musculoskeletal pain and/or fall	3 (3%)
Psychiatric	1 (1%)
Other (adverse drug effect, surgical consult)	2 (2%)

Ouslander et al: J Amer Ger Soc 58: 627-635, 2010

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CMS Special Study Results

- Expert panel members rated improving quality of care for assessing acute changes, more involvement of primary care MDs and/or NPs/PAs, ability to do stat lab tests and IV fluids, improved advance care planning, and providing less futile care as important in reducing avoidable hospitalizations

Factors	Resources Needed
Better ***quality of care*** would have prevented or decreased severity of acute change	***Physician or physician extender*** present in nursing home at least 3 days per week
One ***physician visit*** could have avoided the transfer	Exam by ***physician or physician extender*** within 24 hours
Better **advance care planning** would have prevented the transfer	***Nurse practitioner*** involvement
The same ***benefits*** could have been achieved at a lower level of care	***Registered nurse*** (as opposed to LPN or CNA) providing care
The resident's overall condition limited his ability to ***benefit*** from the transfer	Availability of ***lab tests*** within 3 hours
	Capability for ***intravenous fluid*** therapy

Ouslander et al: J Amer Ger Soc 58: 627-635, 2010

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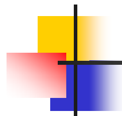

What are the incentives?

- Reducing hospitalizations from NHs will be challenging due to lack of infrastructure, on-site clinical support, and incentives to manage residents without transfer
  - **Current incentives all favor hospitalization**

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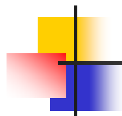
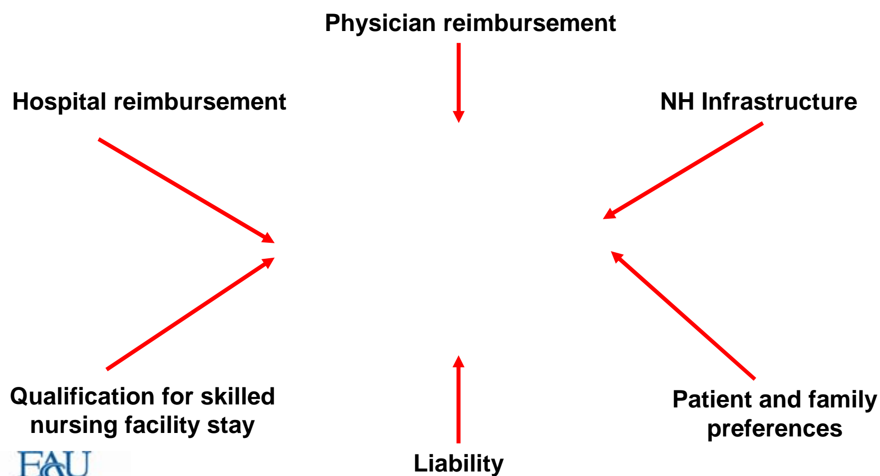


What are the Incentives for Providers?



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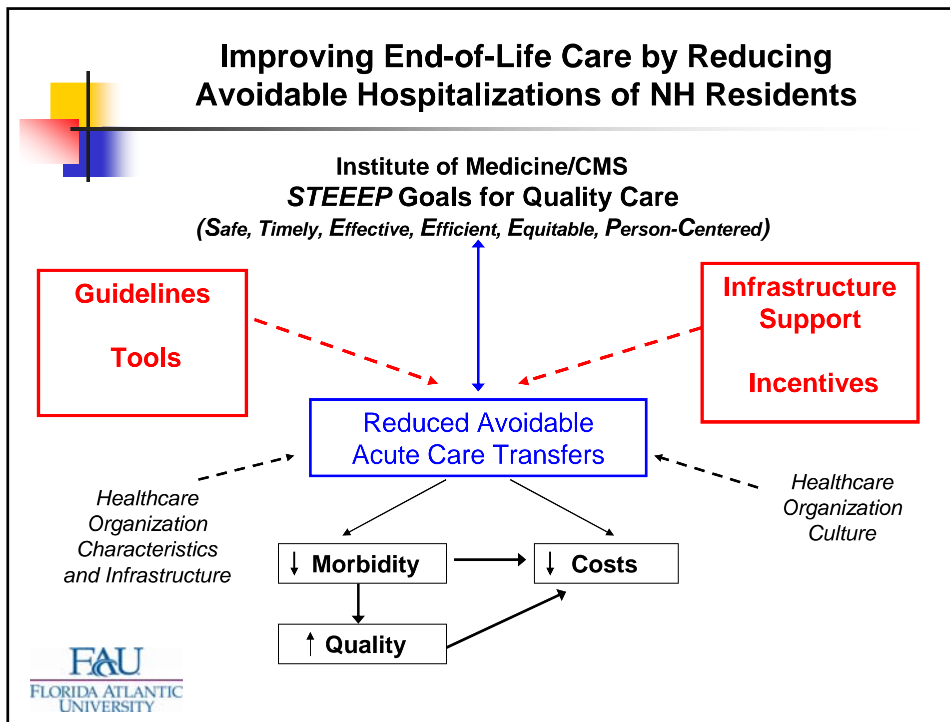

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What Can We Do?

- Financial incentives
  - Bundling
  - P4P
- Regulatory incentives
  - Address assessment of acute change in condition and advance directives in the survey process
- Limit liability
- Educate patients and families about realistic expectations and advance care planning
- Improve NH infrastructure
  - Workforce
  - Ancillary services
- Guidelines and tools for every day clinical practice

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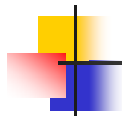

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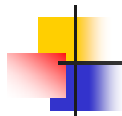
INTERACT II

Interventions to Reduce Acute Care Transfers

- Care Paths
- Communication Tools
- Advance Care Planning Tools

http://interact.geriu.org

Revised tools based on CMS pilot study
Supported by a grant from the Commonwealth Fund



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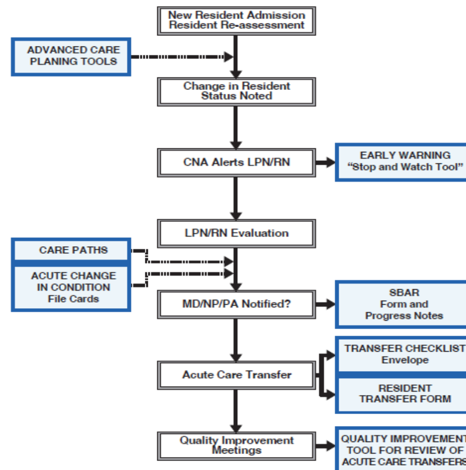

INTERACT II

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 _______________

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- Lower respiratory infection could have been managed in the NH, avoiding the cardiac cath and hip fracture

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Sam

101 years old

- Advance care planning should have led to a palliative or comfort care plan, or hospice before recurrent hospitalizations occurred

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