Can Avoidable Hospitalizations Among Nursing Home Residents Be Significantly Reduced?

By Mark Bobek, MD

The short answer is a resounding "YES!" There is widespread evidence that hospitalizations among nursing home residents can be avoided. According to data presented in April by CMS's Medicare-Medicaid Coordination Office and the Center for Medicare & Medicaid Innovation, studies have estimated that from 30% to as many as 67% of hospitalizations among this population could be prevented with well-targeted interventions (Jacobson, et. al, 2010). Medicare-Medicaid enrollees make up a significant percentage of this population. In fact, CMS's data shows that reducing potentially avoidable hospitalizations by 1/3 could save Medicare over $1 billion annually.

Dr. Joseph Ouslander, one of the country's most committed advocates for furthering geriatric care, recognizes this issue as being essential to improving the quality of care for frail elderly and reducing costs. Ouslander is the creator of Interventions to Reduce Acute Care Transfers (INTERACT), a tool designed to help nurses and nurses' aides working in nursing homes identify clinical problems and manage them more effectively, to reduce the rate of unnecessary hospitalizations. Ouslander has published over 200 original articles and book chapters and is a co-author of Essentials of Clinical Geriatrics and Medical Care in the Nursing Home, and an editor of Hazzard's Geriatric Medicine and Gerontology. He served as an Associate Editor of the Journal of the American Geriatrics Society for ten years. ***"Reducing potentially avoidable hospitalizations of nursing home residents represents an opportunity to both improve quality of care and reduce overall Medicare expenditures on this population. These savings can then be shared with providers and reinvested in the infrastructure of facilities to provide high quality care,"*** said Ouslander.

What we do know for sure is that past interventions throughout the country have proven effective. For example, according to CMS, several interventions for nursing home residents stand out:

- Evercare reduced hospital admissions by 47% and emergency department use by 49% (Kane, et. Al, 2004).
- A nursing facility-employed staff provider model in New York reduced Medicare costs by 16.3% (Moore & Martelle, 1996).
- INTERACT II reduced hospital admissions by 17% (Ouslander, et. al, 2011).

WHAT CAN WE DO TO BRING SIMILAR RESULTS TO OUR COMMUNITY?

Over the past few months key players from across the health care continuum, including health systems, providers and payers have been engaging in a dialogue about the role each of us plays in both the problem and the many possible solutions. Effective and consistent communication is the missing ingredient. In fact what all the interventions noted above have in common is improved communication among the many professionals participating in the patient's care.

Indeed, the necessity to improve communication is not new. In 2009 the American College of Physicians, Society of General Internal Medicine, Society of Hospital Medicine, American Geriatric Society, American College of Emergency Physicians and Society for Academic Emergency Medicine jointly issued a Consensus Policy Statement describing ten principles for care transitions, many of which revolve around communication. Of particular importance to the skilled nursing environment is Principle # 5: ***The sending provider maintains responsibility for the care of the patient until the receiving provider confirms that the transfer is complete. The sending provider should be available to clarify issues of care, and the patient should be able to identify the responsible provider.***

"We realize that care transitions (i.e. when a patient transitions from hospital to skilled nursing or visa-versa) are critical times in the patient care continuum and can often be fraught with gaps in communication. At our facilities, we pay particular attention during these times of transition to ensure that we support communication among providers to avoid service duplication, patient safety issues and the sometimes inappropriate and avoidable use of the emergency room and acute hospital," said Cary Smith, Vice President of Regional Operations at Adventist Care Centers, a not-for-profit, long term care organization.

As the largest hospitalist group in the region, practicing at multiple Hospitals and Skilled Nursing Facilities throughout Central Florida and discharging over 40,000 patients per year, Central Florida Inpatient Medicine (CFIM) also committed itself to exploring its own role in advancing communication among the "sending and receiving providers" in the community.

To that end, CFIM partnered with Adventist Health Systems

and other community players to come up with new ideas for providing enhanced care and coordination to long term nursing home residents with the ultimate goal of reducing avoidable hospitalizations for this population. Among the concepts emerging from the group are:

- Improving communication and formalizing handoff between Hospital and Nursing Home physicians
- Enhancing technology tools and staff training to support the implementation of INTERACT
- Educating nursing home staff to implement non-pharmacological behavioral interventions
- Coordinating and communicating Advanced Care Planning
- Working hand in hand with other professionals, such as Pharmacists and Mental Health providers

CFIM, along with other community players, have applied for CMS funding in support of a program to further their proposed interventions for nursing facility residents. If successful, the proposal will test a new model of enhanced care and coordination for long term nursing home residents, including service delivery and payment methodologies. As the number of new Americans living to advanced age increases, any seeds we can sow to prepare our communities to deliver better geriatric care, will bear the fruits of improved quality of life, better outcomes and reduced costs for all of us.

Dr. Mark Bobek is the Medical Director for CFIM's Skilled Nursing Division, which attends 23 Skilled Nursing Facilities in the Central Florida region. He attended medical school at The University of Miami and completed his residency in Family Practice at St. Vincent's Medical Center in Jacksonville, Florida. As CFIM's SNF Medical Director his responsibilities include collaborating on clinical consultations alongside practice physicians, addressing complex patient and family concerns and writing and implementing compliance program initiatives. One of his most important tasks is detecting patterns of infection within facilities and developing protocols to rid the infection spread area. His communication between the SNFs' administration and staff is also vital to our mutual success. ■