RAMPING UP FOR HIGHER ACUITY

NURSING FACILITIES RESPOND TO THE NEED FOR REDUCING HOSPITALIZATIONS.

KATHLEEN LOURDE

Registered nurses (RNs) are taking center stage lately in some providers' efforts to combat avoidable hospitalizations. Genesis HealthCare is one example. The Kennett Square, Pa.-based company has had laudable success in this area by employing more RNs, as well as nurse practitioners and doctors, in its nursing facilities.

"We have really moved to an RN model of care," says Mark Reitz, chief operating officer. He describes the company's nursing centers as "med-surg units" where physicians and nurse practitioners are employed in "as many of our centers as possible. We still work under the mantle of long term care, but half of the people we're admitting today are discharged within 25 days," he says. "We need to staff with a much more medically intensive model."

Genesis' initiative, which began in 2004, has led to an 11 percent decline in unplanned hospitalizations.

Aiding in this effort is a requirement by the company that each facility must generate a performance scorecard that allows management to monitor, manage, and set expectations, says Reitz. And one of the clinical metrics on the scorecard is unplanned hospital readmissions. According to Genesis' calculations, about 25 percent of hospitalizations are avoidable.

Tracking The Variables

In an effort to reduce this figure, 60 percent of Genesis facilities now have a "transitional care unit," in which an RN-intensive staff team cares for residents who have been in the hospital within the past 25 days. In addition, these units are required to have a nurse practitioner or physician on staff every day.

All of the facilities' RNs are intravenous (IV)-certified, says Reitz, and the nurse practitioner's role is to provide not only direct care but to act as a clinical mentor for RNs to further develop their skills.

"We want all new admits seen by an RN at a maximum of two hours after admission," says Reitz. The physician or nurse practitioner is expected to see all new admissions within 12 hours of admission, if not sooner.

Having recently hospitalized residents all in one place—in the transitional care units—makes tracking what causes rehospitalizations much easier and gives facilities a better coordination of care, especially in the hand-off from facility to hospital, or vice versa. It becomes possible for Genesis to track a wide array of variables and identify patterns and potential triggers that may have caused an unplanned hospitalization, as well as what happens to residents at the hospital, including the number of days post-discharge that they're readmitted, what the diagnosis was, any inquiries from the hospital, and the name of the discharging physician at the hospital.

Discharge information is important because "those folks that are going back [to the hospital] within three days of

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admission…in all probability, there were issues related to the hand-off" that caused the rehospitalization, says Reitz. "Once it gets beyond three days, we generally feel the issues related to rehospitalization are controllable within our setting."

If something happened during the hand-off that may have caused the rehospitalization, Genesis staff discuss the situation with hospital staff. "The attention that we are now getting on this topic from acute care [facilities] has gone up exponentially in the last six months," says Reitz. That's because outlying hospitals will face reimbursement penalties for unnecessary rehospitalizations starting in 2012, says Reitz. "They're as interested as we are" in bringing avoidable rehospitalizations under control, he says.

Baylis

Krein

THERE ARE A VARIETY OF REASONS WHY SOME NURSING FACILITIES CHOOSE TO HOSPITALIZE RESIDENTS RATHER THAN MANAGE LOWER-ACUITY SITUATIONS IN-HOUSE.

Genesis isn't stopping there, however. The company is rolling out respiratory therapy as a way to "manage down" the pulmonary conditions that trigger many hospitalizations, says Reitz. That, he says, is producing results.

Why Hospitalize?

There are a variety of reasons why some nursing facilities choose to hospitalize residents rather than manage lower-acuity situations in-house.

To begin with, there is a "culture of hospitalization" not only on the part of nursing facilities but emanating from physicians and families as well. Health providers worry about being sued, and families become anxious and assume that the resident will be better served in a hospital.

According to one in a series of reports from the Henry J. Kaiser Family Foundation, residents are hospitalized so routinely that it tends to happen with little active decision making among facility staff. Nurses are especially likely to hospitalize a resident when the resident has fallen, has an infection, or is disruptive or violent. But other reasons simply involve the capabilities of the nursing facility. Its nurses may not be trained to care for sicker residents or in identifying changes of condition early, before they require a hospital. Or nurses may not think facility staff have time for all of the extra duties that may be required—collecting specimens and starting and monitoring IVs, for example.

What's more, they may not have the skills to communicate a physical assessment and history to an off-site, on-call physician. Sometimes, of course, a resident is so sick that the hospital is necessary no matter how well prepared and equipped nursing staff are, depending on what the resident's advance directive says. Further, staff may not feel comfortable or competent to talk with families about on-site palliative care.

A study by Joseph Ouslander, MD, project director of INTERACT, a systematic program designed to reduce avoidable hospitalizations, looked at medical records of 20 Georgia nursing facilities. The results showed that hospitalizations occurred for the following reasons: not having an on-site primary care clinician, not being able to get lab tests quickly, and difficulties with identifying a change of condition. (*For an outline of the INTERACT program, see sidebar, page 24.*)

But licensing limitations won't allow some nursing facilities to do lab work on-site, and other diagnostic tools like X-rays and EKGs may not be readily accessible. Another reason for hospitalizations may be a lack of advance care planning, so that in the event of a critical illness, even in a terminal patient, what to do is open to question, and everyone prefers to err on the side of caution, providers say.

Medicare's Role In The Issue

Further, one of the Kaiser studies' authors found that Medicare contractors that adjudicate doctors' claims appear more likely to question daily visits to a long term care facility than those to a hospital.

What's ironic is that nursing facilities technically have further disincentives to reduce unplanned hospitalizations because patients who go to the hospital can requalify for Medicare if they're in the hospital for three days.

But long term care providers unanimously said that this didn't play into their strategizing. "We basically ignore that," says Genesis' Reitz. "We want to provide good care."

However, facilities will realize that if they get really good at preventing hospitalizations, their Medicare numbers may go down because fewer patients will get that qualifying three-day stay. One could say there's a financial disincentive to preventing rehospitalizations, according to several providers interviewed.

In addition, facilities good at preventing hospitalizations will have higher ancillary costs, some of which they won't be able to bill for, says Barbara Baylis, senior vice president, clinical and residential services, for Kindred Healthcare, Louisville, Ky. "But in

the long run, [preventing unplanned hospital visits] is the right thing to do," she says.

"Clearly, it's the right thing to do for the patient," says Keith Krein, MD, chief medical officer of Kindred's nursing center division.

But Reitz is convinced that decreasing unplanned hospitalizations in the emerging new world order of health care will result in more business. "It is good clinical care that drives market share," he says. "Our mission is to manage this metric [of unplanned hospitalizations] down as low as we possibly can, and as hospitals are seeing that we're having better clinical outcomes, that'll drive market share."

Charting Patient Wellness

Genesis RNs are specially trained to watch out for at-risk patients—those who come to the facility with a history of noncompliance, have severe depression, or experience an acute change of mental status. "Generically, those are three that are immediate flags even prior to doing the initial assessment," says Reitz.

Three common reasons for hospitalizing a resident are because of pneumonia, kidney or urinary tract infection, or congestive heart failure—these three categories make up nearly 25 percent of hospitalizations.

In the past, a change of condition would send a resident to the hospital, says Baylis. Today, treatment is initiated "sooner and more appropriately, and

INTERACT: THE PREVALENT UNDERLYING SYSTEM FOR REDUCING HOSPITALIZATIONS

Many of the companies interviewed for this article rely to one extent or another on the Interventions to Reduce Avoidable Hospitalizations of Nursing Home Residents (INTERACT II) program.

The program includes clinical and educational tools and strategies that long term care facilities can use every day to reduce unplanned hospitalizations. The initial INTERACT tools were developed by Joseph Ouslander, MD, and Mary Perloe, RN, GNP, with the Georgia Medical Care Foundation, the state's Medicare quality improvement organization, under contract with the Centers for Medicare & Medicaid Services.

The INTERACT II program, available for free at http://interact2.net, includes clinical and educational tools and strategies that long term care facilities can use every day to reduce unplanned hospitalizations. They were designed to be simple and feasible to incorporate into the everyday routine of long term care staff.

Identify And Communicate

The tools in INTERACT are essentially geared to help facilities more quickly identify changes of condition in residents—this being crucial to catching a developing condition quickly and intervening before hospitalization is necessary—and more effectively communicate those changes and other relevant clinical information up the clinical hierarchy, from nurse assistant to director of nursing to physician and, ultimately, to the hospital should a transfer become necessary.

The tools also assist staff in managing those difficult advance care planning discussions that are so necessary and help staff in their quality improvement efforts. SavaSeniorCare, Atlanta, has "embraced" the INTERACT II program, says Donna Hendrickson, Sava's senior vice president of clinical services.

Sava started a pilot with the program at the end of 2009, says Hendrickson, focusing on Michigan, Maryland, and the Gulf Coast of Texas. They worked with staff to give the program its best chance of success so that they could get a good idea of to what extent the program could reduce hospitalizations.

The INTERACT II program hasn't been implemented in all nursing facilities in Sava's portfolio. The company carefully reviewed each nursing facility to see if it was a good candidate for the program.

Communication Tools

■ Change-Of-Condition File Cards. Hendrickson especially likes INTERACT's "Stop and Watch" pocket card that all CNAs—called resident care specialists at Sava—carry in their pockets and that are available at a centrally located kiosk where any employee, such as a housekeeper or dietary staff, can pick one up if they notice something off about one of the resident's behavior or functioning.

The card walks CNAs or other staff through the things to keep in mind when being around a resident, starting with a general impression of the person's well-being and questions

as long as the patient is responding to the treatment they'll stay in the facility. When we've exhausted what we're able to do and the patient is not responding, then the decision is made to transfer the resident to the hospital."

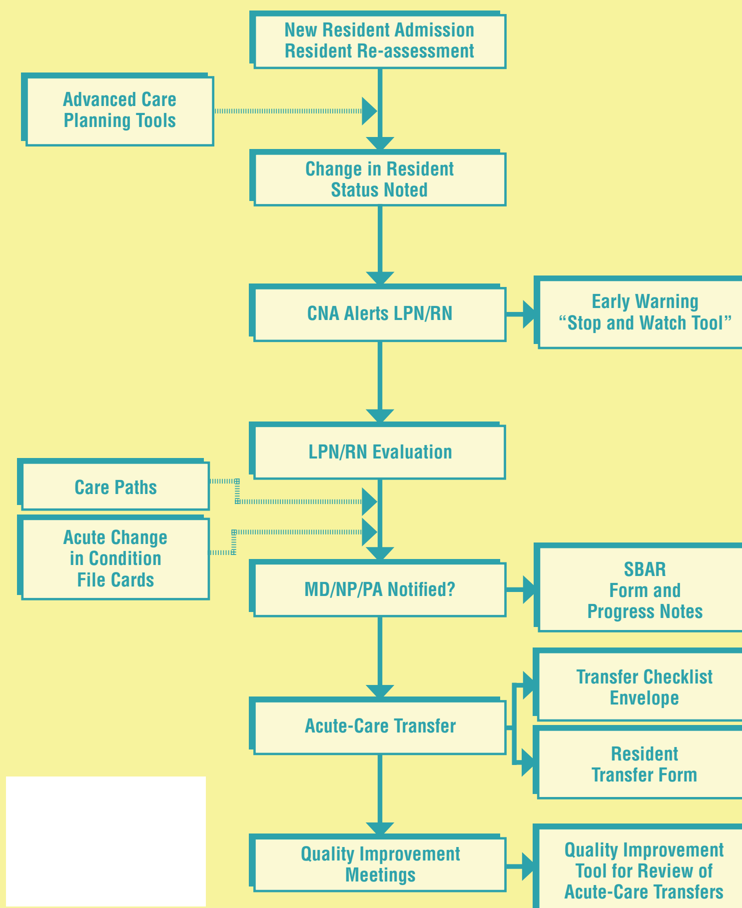
Baylis and Krein were involved in the development several years ago of the American Medical Directors Association's industry-recognized guidelines on identifying changes of condition and, thereby, avoiding unnecessary hospitalizations. "It has to be a collaborative effort of the entire interdisciplinary care team," says Krein, whether that's a certified nurse assistant (CNA), a therapist, or housekeeping or maintenance staff.

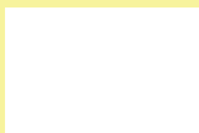
"The key is that if anyone notices something different about a resident that could be the early onset of a change in medical condition, it needs to be reported to the right personnel. It's a team effort."

"You would be surprised at the number of housekeeping staff and maintenance staff that will bring up things at the morning meeting," says Baylis.

Symptoms May Be Subtle

The reason why identifying changes of condition is so important, says Krein, is that "the geriatric population doesn't react in the same way that a normal, healthy person would react to, say, an infection. Early onset might manifest itself as simply a little bit of confusion, some slight mental status change that someone might not be as alert to as





about their mental status and physical functioning. The cards are given to the nurse or head nurse on each shift.

■ Care Paths. To help nurses identify whether a situation requires a call to a physician or can be managed within the facility are six care paths that cover conditions that commonly result in transfers to the hospital: dehydration, fever, mental status change, congestive heart failure, lower respiratory infection, and urinary tract infection.

The care paths walk staff through taking vital signs and further evaluation, clearly indicating via a flow chart at what points a physician should be called immediately and when it should be managed in-house.

■ Situational Background Assessment Recommendations (SBAR). When a physician does need to be notified, the nurse fills out an SBAR, a communication tool that helps nurses and doctors convey information in a way that everyone understands. The tool facilitates the evaluation of a resident's condition—as well as the communication of the information gleaned—to the primary care physician. It follows standardized criteria and provides clear guidelines. It also documents what was communicated.

they were before. Oftentimes, it's just subtle changes in the demeanor and mental status and such that need to be observed and reported so a more thorough assessment can be done by the nursing personnel."

Reitz agrees that early identification of changes in condition is crucial. "We believe the best solution to managing down hospital readmissions is for the RN to be very competent at physical assessment and change of condition," says Reitz. "We see when we don't do a good job of reacting to change of condition, that is a key factor" in patients being readmitted to a hospital.

Making an impact on rehospitalization rates means the skill-sets and competencies of nursing staff need to be enhanced, as does the follow-up and backup support by the physician, says Krein. In addition, equipment will likely need to be purchased and communication protocols will need to be overhauled.

Whether residents can receive IVs, how long it takes for staff to get lab results, whether the facility has a portable X-ray machine, and how long it takes for the pharmacy to deliver a new medication all must be assessed, says Krein.

Other things might not seem obvious at first blush. For example, it's not enough to have good communication in place with attending physicians, says Krein; you must have good communication with on-call physicians as well, so that when a resident's doctor is on

When a resident has a change of condition, before calling the doctor, the nurse checks with other staff members—CNAs, rehabilitation staff, social workers, activities staff—who have regular contact with the resident to get an accurate history and possibly a family member to clarify advance directives. The nurse then reviews the resident's chart for diagnoses, medications, and recent progress notes from the primary care clinician and nurses.

Then he or she fills out the SBAR and calls the primary care clinician, keeping the medical chart nearby for easy reference.

■ Acute-Care Transfer Package. When the resident is ready to go to the hospital, a packet of medical information goes with them.

On the front of this packet is a checklist to ensure that such things as a medication list; advance directive; the SBAR; summary of the most recent history and physical; any recent hospital discharge; recent primary care clinician's orders; relevant lab results or X-rays; whether the resident has glasses, a hearing aid, or a dental appliance sent with them; and a space for the ambulance staff taking the packet of documents to sign his or her name.

A copy of the checklist is kept for the facility's records.

This packet of valuable information will help emergency room staff do the most appropriate evaluation on the resident and ensure that the hand-off is done safely.

THE TOOLS ARE GEARED TO HELP FACILITIES QUICKLY IDENTIFY CHANGES OF CONDITION IN RESIDENTS BEFORE HOSPITALIZATION IS NECESSARY.

A phone call from the primary care clinician to the doctor at the emergency room is recommended, as is a phone call from the long term care nurse to the hospital nurse, so that all relevant information is communicated.

■ Advance Directives. INTERACT's advance care planning tools help nurses initiate the conversation from the very beginning about end-of-life care, advance directives, and palliative care and helps staff determine when a resident is in the dying phase of life. All staff should be familiar with end-of-life care so they can respond to families' questions.

INTERACT's advice is that before ever having the first conversation about advance care planning, make sure the resident's conditions and prognosis are clear, then find a private environment where the resident and staff member can have the discussion. Start by encouraging them to talk and recognize resident and family concerns. Identify loss, legitimize and explore feelings, and offer support. Ask what everyone understands about advance care planning and about the resident's condition and prognosis.

Ask what their goals for care are. Ask about their advance care planning wishes, including cardiopulmonary resuscitation, artificial hydration and nutrition, and palliative care. Communicate the need to hope for the best while preparing for the worst. Focus on the positive, be humble, and don't force decisions.

■ Quality Improvement (QI). Hendrickson says INTERACT's QI tools are another key component of the program so Sava can find out "what can we learn from this so we can work with our staff" on ways to improve care. The QI tools include an acute-care transfer log and a quality improvement tool for the review of transfers.

Get a list of all emergency room transfers twice a month, and complete the QI review tool for two to three transfers per week. This helps staff identify what triggered the hospitalization and whether it could have been avoided and how.

Source: INTERACT II, Florida Atlantic University, Boca Raton, Fla.

vacation that on-call physician doesn't just order the resident to the hospital as a knee-jerk reaction.

Kindred's Story

Not all facilities may be geared to handling higher-acuity patients. Figuring out what facilities were best suited to provide transitional care with reduced hospitalizations was a process of years, says Baylis. The first step was recognizing that rehospitalizations were a problem. Then they collected retrospective data on those hospitalizations to figure out who was returning to the hospital and what factors were involved in making the hospitalization necessary, identifying what equipment would have helped and what kinds of assessments would have helped, and what to measure to determine the effectiveness of interventions.

Kindred started working on preventing unplanned hospitalizations several years ago by piloting INTERACT tools, and it continues to refine its approach.

Fifty percent of Kindred's patients go home within 33 days, 90 percent go home within 90 days, and the company has started hiring respiratory therapists to help staff manage bronchitis, pneumonia, and congestive heart failure.

But not all nursing facilities have the capabilities to adequately care for residents with more acute conditions.

"The crux of this is what kind of nursing facility it is," says Krein. "This notion that if you've seen one nursing home you've seen all nursing homes, that might have been true maybe even a decade ago, but what has happened in the last decade is we have a tremendous variety of skill-sets across the spectrum" of long term care, he says.

He compares two facilities in Kindred's own portfolio: One cares solely for residents who have dementia but are otherwise medically stable and may live at the facility for years. That facility is, therefore, appropriately staffed with a lot of nurse assistants and restorative aides, but not a lot of therapists or RNs. Another facility of the same size has high resident turnover, admitting 160 patients a month and sending 100 home. It is heavily staffed with RNs and has a host of diagnostic capabilities and two full-time physicians making rounds in the center each day.

UNDER A CLAUSE IN THE HEALTH CARE REFORM ACT, IN 2012 HOSPITALS WILL FACE FINANCIAL CONSEQUENCES FOR CERTAIN READMISSIONS.

The two facilities represent "very different situations," says Krein, and very different capabilities when it comes to being able to prevent unplanned hospitalizations.

Hospitals Act As Gatekeepers

"Hospitals are under great scrutiny of inappropriately admitting folks," says Reitz. It's getting harder to admit someone to the hospital, which means residents transferred to the hospital may spend hours on a gurney in the emergency room and then are sent right back to the facility.

"Many hospitals are…certainly gatekeeping at the emergency department more than ever before," says Krein. "You're not just going to show up at the ER and say you want to be hospitalized. If [a resident's] condition is such that they don't need to get into the hospital, they may get all kinds of tests done in the ER and lie on a stretcher for eight hours and get stuck several times by the lab, and the end result may be that they're going to be sent back to the nursing center."

Letting people leave the hospital "quicker and sicker" has been a hospital trend for many years, observer says. "The sooner they can get them out of the hospital, the more profitable the hospital is," says Krein. Reimbursement is based on diagnosis, with an expected length of stay. So, if the hospital can get the patient out of the hospital sooner than expected, it makes money; if the patient stays longer, the hospital loses money. Under a clause in the health care reform act, in 2012 hospitals will face financial consequences for certain readmissions that have yet to be determined.

Because there is concern that hospitals are discharging people to nursing facilities before they're fully stabilized, the government "has been proposing bundling—one payment for the hospital stay as well as the first 30 days after the hospital stay," says Krein.

It will force hospitals and nursing facilities to work collaboratively to both ensure the resident isn't discharged too soon and that the nursing facility receives more complete information "so the receiving facilities can be more prepared with equipment and such to care for the patient," Krein says.

Implementing Solutions

A study by Ouslander and others, published in the *Journal of the American Medical Directors Association*, took stock of the INTERACT program.

The six-month study of three volunteer facilities with high rates of hospitalization was conducted by the Georgia Medical Care Foundation, the Medicare quality improvement organization for Georgia. Participating nursing facilities received, in addition to the INTERACT materials, on-site and telephonic support from an advance practice nurse.

The study found that none of the facilities fully implemented the INTERACT tools and that the degree to which the materials had been adopted varied among the facilities. Despite the degree to which the program was not implemented, participating facilities saw, on average, a 50 per-

cent reduction in the overall hospitalization rate. The percentage of hospitalizations later deemed to have been potentially avoidable also dropped by 30 percent.

A study participant, SavaSeniorCare, Atlanta, found that those facilities that really took to the program and made it a part of their culture did see noticeable reductions in their hospitalization rates.

Most nursing facilities need "more infrastructure and resources in order to make a big dent in avoidable hospitalizations," says Ouslander. It's not enough to just up the number of nursing staff, says Ouslander; their training needs to be enhanced as well. And more primary care clinicians—doctors, nurse practitioners, physician assistants—need to be more available to long term care facilities.

On top of that, facilities need the capability to "administer intravenous fluid and have rapid access to diagnostic tests and pharmacy services," he says.

"However, there are some things that most nursing homes have the capability to do that aren't being done now as well as they could be," he says. The first and, arguably, most important of these things is to become more skilled at identifying changes in condition early and intervening so they don't become so severe as to require hospitalization.

Nursing facilities need to become better at identifying certain conditions that can be managed without transferring the resident to a hospital, such as a "lower respiratory infection, where the resident is not critically ill, or a urinary tract infection or an exacerbation of congestive heart failure," says Ouslander. "Lots of nursing home residents get sick with those conditions and need to go to the hospital, but some are only mildly ill, and the risks of complications in the hospital outweigh the benefits" of transferring them.

"The INTERACT tool addresses both of these" areas in which most nursing facilities could impact their rehospitalization rates without a dramatic change in their infrastructure, he says.

THE RISKS OF HOSPITALIZATION

Going to the hospital brings with it a number of iatrogenic risks for geriatric patients, says Ouslander, who is also professor and associate dean for geriatric programs at Boca Raton, Fla.-based Florida Atlantic University's medical college. These include disorientation, acute confusion, or delirium; hospital-acquired infections such as methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile*, which causes diarrhea and other intestinal disease; complications from catheter placement; falls; skin breakdown; disruption of care; adverse effects of drugs; and the consequences of being immobilized in bed, including pressure ulcers and deep vein thrombosis.

Further, residents suffer from what's known as "transfer trauma"—which often causes psychological harm and mental and physical deterioration and can even result in death, according to studies.

"It's at best a very disorienting experience" for nursing facility residents, says Reitz. "I speak to that first hand, having had a mother who had to go back to the hospital. I was with her and watched the process, and it's not that providers in acute care are bad, but they've got a lot of stuff going on." Because the resident has had the benefit of facility clinical staff being as on top of the situation as possible, "folks coming back from our setting are lower in the queue," he says.

A recent study showed that treating residents with pneumonia or lower respiratory tract infections using a clinical pathway in the nursing facility can benefit residents both in terms of the outcome and the transfer trauma avoided.

However, the study also found that nursing facilities would need to receive supplemental funding that could be used to hire a nurse practitioner.

Set Facility Goals

INTERACT recommends that facilities begin implementation by identifying a hospitalization reduction goal to strive for and measure progress with a quality improvement tool. The program promotes the enlistment of key personnel to act as an implementation team. These people would oversee and monitor the progress, involve the attending physicians and the medical director, and educate everybody—residents, families, and staff—on what the facility is working toward.

In the INTERACT study, implementation teams were composed of the director or assistant director of nursing, a member of the social worker staff, and a licensed nurse. One member was designated as the project champion, acting as the key contact and promoting the use of the tools. Every two to three weeks, the champion met with the project coordinator to systematically review hospital transfers.

A critical component of

successfully implementing a program to reduce unplanned hospitalizations is "working with [the] entire staff to understand that this is a No. 1 priority for the facility, and for the care of the resident and success of the business," says Reitz. "The No. 1 thing that an administrator needs to do is help the entire staff embrace the program and understand it."

"I would begin with as few beds as possible" when starting the effort to reduce unplanned hospitalizations, says Reitz. "We chose to do it on a unit basis."

Second, well-trained staff are key. "Clearly you have to staff those units very differently than traditional units," he says. Intensify the involvement of RNs in the admission process, he says, so that residents are thoroughly assessed upon admission and any change in condition can be identified. "To the extent that you can employ nurse practitioners on those units, all the better," he says.

Limit the number of physicians seeing patients in the facility, Reitz recommends. While it might not be feasible for a smaller, independent nursing facility to have a physician on staff, "clearly, limiting the number of physicians who are attending at your center will help" make managing the incidence of rehospitalizations more doable, says Reitz.

In the past, a nursing facility might see 30 different physicians coming into the facility to care for various patients.

"You can't do that in this environment," he says. Staff need to build good communication with each attending physician so that in the event of a change of condition, the physician and nursing facility staff can communicate quickly and clearly about the resident's situation, and the physician can have confidence in the nursing facility staff's ability to handle it.

Finally, consider hiring a respiratory therapist to limit the number of discharges due to pulmonary problems. This, says Reitz, "is going to be absolutely essential for the long term care provider to manage down the readmits."

THE NO. 1 THING THAT AN ADMINISTRATOR NEEDS TO DO IS HELP THE ENTIRE STAFF EMBRACE THE PROGRAM AND UNDERSTAND IT.

Change Is Coming

Medicare is planning to use pay for performance, bundled payments, and other strategies to provide financial incentives to reduce avoidable hospitalizations.

"The world is beginning to change in terms of this whole effort of looking at rehospitalization rates," says Krein. He believes that the "perverse incentives" to send long term care residents back to the hospital repeatedly will be eliminated.

In the new world, hospitals will "keep the patients in the hospital as long as they need to be there" and then expect long term care providers to do an adequate job of "meeting the needs of the patient and not sending them back to the hospital," he says.

"What health care reform is looking at is coordination and integration, and we know health care reform is putting us in a position" where improved coordination with hospitals and physicians will be a must, says Donna Hendrickson, senior vice president, clinical services, for Sava.

"Sava is trying to be very progressive and look ahead," says Hendrickson. "First, it's important that we're providing the highest quality of care," including being able to prevent avoidable hospitalizations. This is a focus for our health care industry as well as for the regulators, focusing on, 'Are the individuals paying for health care getting what they deserve and are paying for?'" says Hendrickson.

Paradoxical Results

"There may be diminishing returns" with a hospital reduction program, says Krein. "If these trends continue" with hospitals increasingly sending their more complex patients to a facility that's proven to do a good job with medically intensive patients, "it may be harder and harder to lower [hospitalization] rates."

Krein tells a story about a Tufts teaching nursing facility where the prevalence of pressure ulcers was way too high at 15 percent. Tufts worked hard to improve its wound care, and three years later, after the involvement of wound care experts and surgeons, its prevalence rate was 40 percent—because it had become known as being an outstanding provider of care for people with pressure ulcers, so all the hospitals sent their patients with complex pressure ulcers to Tufts.

"What we really need is a more robust risk adjustment strategy," says Krein. "My concern is if, for example, the government starts comparing [rehospitalization] rates without doing adequate risk adjustments" to allow for the acuity level of a facility's patients.

"Like everything else, this rehospitalization rate is going to need to be put in some type of context," he says.

"We know we have to impact this outcome, first and foremost, for those residents that we care for," says Hendrickson. ■

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NOTE: A sidebar covering extra research figures on the rise in hospitalizations will be posted with the Web version of this month's cover story at ProviderMagazine.com.