Gruppo di ricerca geriatrica

27 Maggio 2011

Se dovessi ideare ex novo l'Assistenza Residenziale

Corrado Carabellese

PIO LUOGO CASA DI DIO

Nella molta lontana quaresima del 1577, la peste, che già da un hanno serpeggiava nelle campagne circostanti la nostra Brescia, si sviluppò anche in città, e vi infierì con tale violenza che, stando a quanto affermano gli scrittori del tempo, 20 mila furono le vittime. Ad essa seguirono ben presto, col languire di ogni attività e con la cessazione dei fiorenti commerci che la Repubblica veneta aveva saputo creare e incrementare, la carestia e la miseria più squallida, così che a gruppi si vedevano per le vie i mendicanti. Innanzi a sì triste spettacolo e alla gravità della situazione, il collegio di sanità e quello dei deputati pubblici, con « provvisioni » dell'8 settembre 1577, proposero *di drizzare una casa d' Iddio per li poveri vecchi mendichi et impotenti et anco provveder a' putti et putte senza governo, per cui mancamento divengono ministri d'ogni scelleraggine.*

Il consiglio generale accolse le proposte, e il 17 ottobre dello stesso anno incaricò tre consiglieri di trovare il locale da adibirsi a ricovero, autorizzandoli a *spendere denari della città.* Laboriose e difficili devono esser state le ricerche di questi tre consiglieri, perchè soltanto sei anni dopo, nel 1583, essi comunicarono d'aver rinvenuto il locale e diedero così modo al consiglio di effettuare l'impianto dell'istituto. Nell'ardua impresa gli amministratori

Legge n. 1 1986 della Regione Lombardia
Riordino dei servizi socio-sanitari

Specificità di cura:
Strutture protette **(contenitore)**
Prevenzione- Riabilitazione- Cura-

Responsabile di struttura **(contenuto)**
Medico **(contenuto)**
Fisioterapista **(contenuto)**
Infermiere **(contenuto)**
Animatore **(contenuto)**
Ausiliario Socio Assistenziale **(contenuto)**

La Regione ha finanziato ed autorizzato la trasformazione di “case albergo” in “struttura protetta” (FSR).

La Regione Lombardia ha provveduto ha istituire il “contributo sanitario” giornaliero per le strutture protette.

Il Progetto Obiettivo Anziani 1992 con legge Nazionale istituisce le **Residenze Sanitarie Assistenziali da inserire nella SSN.**

Strutture Residenziali accolgono Anziani disabili non gestibili al proprio domicilio.
(principio di appropriatezza: lega la RSA al domicilio).

La Regione Lombardia recepisce e trasforma tutte le Strutture Protette in Residenze Sanitarie Assistenziali.

L’integrazione socio-sanitaria nasce con il dl 502 del 1992.

Il dl del 14.2.2001 “atto di indirizzo e coordinamento in materia di prestazioni socio-sanitarie” definisce i criteri:

- **la natura del bisogno** (funzioni psicofisiche, attività del soggetto e limitazioni, partecipazione alla vita sociale, contesto ambientale e familiare),
- **la complessità** (è determinata dalla composizione di fattori produttivi: professionali e di altra natura),
- **l’intensità assistenziale** (fase intensiva, estensiva, lungoassistenza),
- **la durata** (fase intensiva breve e definita, estensiva medio o prolungato).

L’integrazione socio-sanitaria nasce con il dl 502 del 1992.

Prestazioni sanitarie a rilevanza sociale: la competenza è del SSN e di medio/lunga durata.

Prestazioni sociali a rilevanza sanitaria: la competenza è dei comuni e con partecipazione alla spesa di durata non limitata sono erogate nella fase estensiva ed lungoassistenza.

Prestazioni socio-sanitarie ad elevata integrazione sanitaria: caratterizzate da particolare rilevanza terapeutica e intensità della componente sanitaria. Le prestazioni sono a carico del SSN.

L’integrazione socio-sanitaria nasce con il dl 502 del 1992.

Condivide lo stretto rapporto tra prevenzione, cura e riabilitazione.

Privilegia la continuità assistenziale tra ospedale e territorio.

Il distretto è la struttura operativa che meglio consente di governare i processi fra le istituzioni, gestendo unitariamente le diverse fonti di risorse (SSN, Comuni, Solidarietà locale).

QUALE MEDICINA PER LE CASE DI RIPOSO

Renzo Rozzini, Angelo Bianchetti, Corrado Carabellese, Marco Trabucchi
Gruppo di Ricerca Geriatrica, Brescia

1 Introduzione

Le case di riposo (CDR) hanno ricevuto una larga attenzione culturale solo in tempi recenti. Nate con una connotazione sanitaria (anche se sempre isolate dal resto della vita medica) come tubercolosari, infermerie, istituti per ritardati mentali, ecc., si sono trovate impreparate di fronte ad una funzione per la quale non erano state concepite, cioè il ricovero di anziani non autosufficienti e la necessità di offrire risposte a seri bisogni di carattere somatico, psicologico, relazionale.

stenza domiciliare a fornire risposte adeguate alle necessità degli utenti anziani sia per mancanza di tipo organizzativo sia per le caratteristiche stesse dei fruitori.

Più in generale, il progressivo incremento della popolazione anziana, le modificazioni della composizione familiare (crescita, in particolare, degli anziani vedovi e che vivono soli, che rappresentano il 17% degli uomini e il 45% delle donne ultrasessantacinquenni, con una progressione notevole all'aumentare dell'età: rispettivamente il 13% e il 39% tra 65 e 74 anni, il 27% e il 56% fra 75 e 84 anni e il 27% e 54% oltre gli 85 anni)e del ruolo della famiglia stessa (con la conseguente impossibilità ad accogliere ed assistere un componente anziano), rendono in parte conto delle numerose

Metodologia della Medicina Low-tech

Physician Evaluation and Manegement of Nursing Home Residents.

(J. Ouslander and D. Osterweil Ann. Inter. Med. 1994)

"Physician evaluation of nursing home residents at admission and regularly thereafter is an important part of caring for this rapidly increasing segment of society."

"The diverse goals of nursing home care, the heterogeneity of nursing home residents, …….. care complex and challenging."

Metodologia della Medicina Low-tech

Physician Evaluation and Manegement of Nursing Home Residents.

(J. Ouslander and D. Osterweil Ann. Inter. Med. 1994)

"When evaluating and caring for home residents, physicians must address many issue besides treatment of multiple chronic diseases and **concenrs of family members**."

"The physician schould be integrated with an **interdisciplinary team** composed of nurses, reabilation therapists, social workers, and others."

Metodologia della Medicina Low-tech

Physician Evaluation and Manegement of Nursing Home Residents.

(J. Ouslander and D. Osterweil Ann. Inter. Med. 1994)

The general goals of nursing care are:

1) to provide a safe and **supportive environment** for chronically ill and dependent person,

2) to **maximize individual autonomy, functional capabilities, and quality of life**,

3) to **stabilize** and delay, if possibile, the progression of chronic illnesses,

4) to **prevent subacute and acute illnesses** and recognize and **manage** them rapidly when they do occur.

Metodologia della Medicina Low-tech

Physician Evaluation and Manegement of Nursing Home Residents.

(J. Ouslander and D. Osterweil Ann. Inter. Med. 1994)

Valutazione multidimensionale all'ingresso Prima visita:

Revisione completa della documentazione clinica.

Inquadramento dei problemi clinici e funzionali pregressi ed attivi.

Rilevazione di eventuali problemi trattabili.

Valutazione severità e comorbilità delle malattie.

Rilevazione di rischi e/o problemi come: cadute, contenzioni, decubiti,disfagia, disidratazione, stato nutrizionale e cavo orale, incontinenza, problemi comportamentali, ecc.

Elettrocardiogramma

Indagini di laboratorio: esami ematici di routine (no, se recenti)

Valutazione di ulteriori indagini diagnostiche

Valutazione consulenza specialistiche

Patient Safety in Geriatrics: A Call for action.

D. Tsilimingras et al J Gerontology 2003

Central to geriatrics is the management of a variety of medical conditions “Geriatric syndromes”, which includes falls, delirium, pressure ulceres, and underfeeding.

These geriatric syndromes tend to developed when the compensatory ability of elederly people is compromised by accumulated effect of imapirments in multiple domains.

The geriatric syndromes are associated with increased mortality.

The literature has shown that these geriatric syndromes in many cases can be prevented from occurring.

Le cure continuative nelle RSA Lombarde

Responsabilità del Medico Inquadramento diagnostico-funzionale Classificazione fragilità ospite (SOSIA)	Percorsi Diagnostici-Terapeutici-Assistenziali	PAI
Responsabilità operatori sanitari Pianificazione/Esecuzione PAI Collaborazione alla definizione PAI Organiz. e Coord. Operatori di supporto	Percorsi Diagnostici-Terapeutici-Assistenziali	PAI
Responsabilità Operatori di Supporto Funzioni Assegnate art. 4 del 5428/01	Percorsi Diagnostici-Terapeutici-Assistenziali	PAI

Età media degli Ospiti della RSA “Casa di Dio” (240 pl.) e “A. Luzzago” (120 pl.) . Distribuzione per fasce d’età al 31.12.2002.

	“Casa di dio”	“A. Luzzago”
Maschi	81.2	79.9
Femmine	87.5	83.0
Totale	86.4	81.7
60-70	12 (10%)	9 (7.5%)
71-80	33 (16.3%)	27 (22.5%)
81-90	105 (44%)	60 (43.3%)
91-104	83 (34.7%)	24 (20%)

Ospiti ammessi nel 2002:

"Casa di Dio" 111 Ospiti con età media 83.6 (81 F = 84.9)

"A. Luzzago" 34 ospiti con età media 77.1 (22 F = 74.9)

Parametri Funzionali	"Casa di Dio"	"A. Luzzago"
MMSE > 24	23 (25.5%)	12 (48.0%)
MMSE < 24	67 (74.5%)	13 (52.0%)
Deambulazione Autonoma	26 (28.8%)	14 (56.0%)
Funzione Persa	64 (81.2%)	11 (44.0%)
Alimentazione Autonoma	47 (52.2%)	20 (80.0%)
Funzione Persa	43 (47.8%)	5 (20.0%)
Continenti	20 (22.2%)	11 (44.0%)
Incontinenza	70 (77.8%)	14 (56.0%)

Ospiti ammessi nel 2002:
"Casa di Dio" 111 Ospiti con età media 83.6 (81 F = 84.9)
"A. Luzzago" 34 ospiti con età media 77.1 (22 F = 74.9)

	"Casa di Dio"	"A. Luzzago"
Provenienza: Domicilio	31 (34.4%)	12 (48.0%)
RSA	11 (12.2%)	9 (36.0%)
Riabilitazione	30 (33.3%)	4 (16.0%)
Ospedale	18 (20.0%)	0
Lesioni da decubito	10 (11.1%)	2 (8.0%)
N. Medio Farmaci	3.9	3.6
Ospiti senza psicofarmaci	31 (37.4%)	8 (33.4%)
N. Medio psicofarmaci	1.7	1.9

Ospiti deceduti anno 2002
"Casa di Dio" 91 ospiti (Mortalità 37.9%)
"A. Luzzago" 23 ospiti (Mortalità 19.2%)

Permanenza Ospiti deceduti 2002	"Casa di Dio"	"A. Luzzago"
0-3 Mesi	27 (29.7%)	6 (26.1%)
4-6 Mesi	10 (11.0%)	1 (4.3%)
7-12 Mesi	7 (7.7%)	4 (17.4%)
13-24 Mesi	8 (8.7%)	3 (13.0%)
25-48 Mesi	12 (13.2%)	4 (17.4%)
> 49 Mesi	27 (29.7%)	5 (21.7%)

Presenza del medico e tassi di ospedalizzazione
A. Scotuzzi, M. Scarazzato, G. Guerini

Comunicazione SIGG 1992

8 Rsa con 993 pl, età media 80,6.

Ricoveri ospedalieri 293 di 241 ospiti per un totale di 2622 giornate di ospedale con 2,6 giornate per pl.

2 Rsa con 89 pl gestiti da medici di medicina generale con giornate di ospedalizzazione 4,9 pl. Nel 1986 il tasso di giornate di ospedalizzazione per la Regione lombardia e per anziani di > di 75 anni fu pari a 6,5.

CARATTERISTICHE E DIFFERENZE FRA ANZIANI ISTITUZIONALIZZATI, DECEDUTI E SOPPRAVISSUTI IN 48 MESI DI OSSERVAZIONE.

Comunicazione SIGG

S. Franzoni, G.B. Frisoni, P. R. Rozzini, M. Trabucchi.
PROLOGUS

Obiettivo: identificare i soggetti più idonei al ricovero (prologus).

Risultati: permanenza media dei soggetti deceduti pari a 19,6 mesi, maggiore età media (83,9) rispetto ai sopravissuti, maggior grado di malnutrizione; maggior livello di gravità delle cardiopatie. La presenza di lesione da decubito sono state riscontrante alla baseline solo nei pazienti deceduti.

Conclusioni:I soggetti più idonei al ricovero si caratterizzano alla baseline per una maggior fragilità biologica (età, malnutrizione, lesione da decubito) e malattie cardiovascolari.

Gerontologist. 2010 Aug;50(4):509-18. Epub 2010 May 12.

Associations of special care units and outcomes of residents with dementia: 2004 national nursing home survey.

Luo H, Fang X, Liao Y, Elliott A, Zhang X.

PURPOSE: We compared the rates of specialized care for residents with Alzheimer's disease or dementia in special care units (SCUs) and other nursing home (NH) units and examined the associations of SCU residence with process of care and resident outcomes.

DESIGN AND METHODS: Data came from the 2004 National Nursing Home Survey. The indicators of process of care included physical restraints, continence management, feeding tubes, and influenza and pneumococcal vaccinations. Resident outcomes included pressure ulcers, hospitalization, emergency room visits, weight loss, and falls. Analyses were conducted by using Stata SE version 10.

RESULTS: Multivariate logistic regression analyses show that SCU residents were more likely to have received specialized dementia care and specialized behavioral problem management. They were less likely to have bed rails (adjusted odds ratio [AOR] = 0.39, AOR = 0.35, ps < .01), use catheters (AOR = 0.33, AOR = 0.33, ps < .01), and yet more likely to have toilet plans/bladder training for incontinence control (AOR = 1.90, AOR = 1.62, ps < .01) than those in regular units and those in NHs without an SCU. Moreover, SCU residents were less likely to have pressure ulcers, hospitalization than those in regular units, and less likely to have experienced weight loss than those in NHs without an SCU. However, they were more likely to have falls (AOR = 1.32, AOR = 1.36, ps < .05) than those in regular units and those in NHs without an SCU.

IMPLICATIONS: Our study shows that SCU residents had, in general, better process of care than those in regular units and in NHs without an SCU. Further studies are needed to assess specific outcome changes among SCU residents and to evaluate the cost-effectiveness of having such units.

J Am Geriatr Soc. 2008 Feb;56(2):199-205. Epub 2007 Dec 27.

Is dementia special care really special? A new look at an old question.

Gruneir A, Lapane KL, Miller SC, Mor V.

OBJECTIVES: To quantify differences in care provided to nursing home (NH) residents with dementia living on and off dementia special care units (SCUs).

DESIGN: Cross-sectional study using propensity score adjustment for resident and NH characteristics.

SETTING: Free-standing NHs in nonrural U.S. counties that had an SCU in 2004 (N=1,896).

PARTICIPANTS: Long-stay (> or = 90 days) NH residents with a diagnosis of Alzheimer's disease or dementia and at least moderate cognitive impairment (N=69,131).

MEASUREMENTS: Resident-level NH care processes such as physical restraints, bed rails, feeding tubes, psychotropic medications, and incontinence care.

RESULTS: There was no difference in the use of physical restraints (adjusted odds ratio (AOR)=0.94, 95% confidence interval (CI)=0.79-1.11), but SCU residents were less likely to have had bed rails (AOR=0.55, 95% CI=0.46-0.64) and to have been tube fed (AOR=0.36, 95% CI=0.30-0.43). SCU residents were more likely to be on toileting plans (AOR=1.23, 95% CI=1.08-1.39) and less likely to use pads or briefs in the absence of a toileting plan (AOR=0.73, 95% CI=0.61-0.88). SCU residents were more likely to have received psychotropic medications (AOR=1.23, 95% CI=1.05-1.44), primarily antipsychotics (SCU=44.9% vs non-SCU=30.0%).

CONCLUSION:SCU residents received different care than comparable non-SCU residents. Most strikingly, SCU residents had greater use of antipsychotic medications

Trimestrale, n. 3 Settembre 2001

GERIATRIC NURSING NOTIZIE

Notiziario della
SEZIONE DI NURSING - GRUPPO DI RICERCA GERIATRICA

25122 BRESCIA - Via Romanino, 1 - Tel. 030.3757538 - Fax 030.48508 - E-mail: segreteria@grg-bs.it - Sito Web: www.grg-bs.it

Reg. Trib. di Brescia n. 7/1999 del 3/3/1999

EDITORIALE

Marco Trabucchi - GRG Brescia e Università Tor Vergata Roma

RSA: APPUNTI PER UNA STRATEGIA VERSO IL FUTURO

l'anziano fragile. Già da molti anni si parla dell'esigenza che le RSA si "aprano al territorio", con un'affermazione altrettanto retorica quanto scarsamente concretizzata. Qualche centro diurno integrato, un pezzo di servizio domiciliare, e poco altro. Ora si tratta di capire se le IPAB sono pronte ad assumere negli specifici territori il ruolo di "azienda per i servizi agli anziani": non sarà certamente un passaggio facile, perché il più delle volte nella stessa area sono presenti diverse realtà, con storia, interessi e aree di influenza difficilmente conciliabili; la strada però è tracciata e si deve fare ogni sforzo per poterla percorrere.

Trimestrale, n. 3 Settembre 2001

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ascoltata a livello locale. È quindi indispensabile che le nuove "aziende" rinforzino la propria struttura tecnica per predisporre piani adeguati ed articolati dopo un'analisi approfondita della domanda. Deve essere chiaro che si tratta di un impegno non facile. Nel piano di zona che l'azienda IPAB dovrà collaborare a realizzare assieme con gli altri attori interessati è importante tener conto quindi di tutti gli interventi possibili: l'assistenza domiciliare a vari livelli di intensità e di integrazione, i centri diurni, le residenze temporanee, le residenze stabili (con le specializzazioni che si rendono sempre più necessarie; l'Alzheimer ne è stato un esempio che ha precorso i tempi), la residenzialità con scopi riabilitativi, fino ad interventi complessivi rivolti alla qualità della vita nella città moderna delle persone non più giovani. In que-

Brescia 10.04.2001

SEMINARIO
"L'ORGANIZZAZIONE DELL'ASSISTENZA SANITARIA NELLE RESIDENZE SANITARIE ASSISTENZIALI"

LA QUALITA' NELL'ORGANIZZAZIONE DELLA RESIDENZA SANITARIA ASSISTENZIALE: RAPPRESENTAZIONE DELLE PROBLEMATICHE DEI FATTORI IN ENTRATA.

Relatore: Dr. Corrado Carabellese

ORGANIZZAZIONE PER NUCLEI ABITATIVI SECONDO IL CASE MIX, LA DURATA E LA SPECIALIZZAZIONE

PER SPECIALIZZAZIONE:

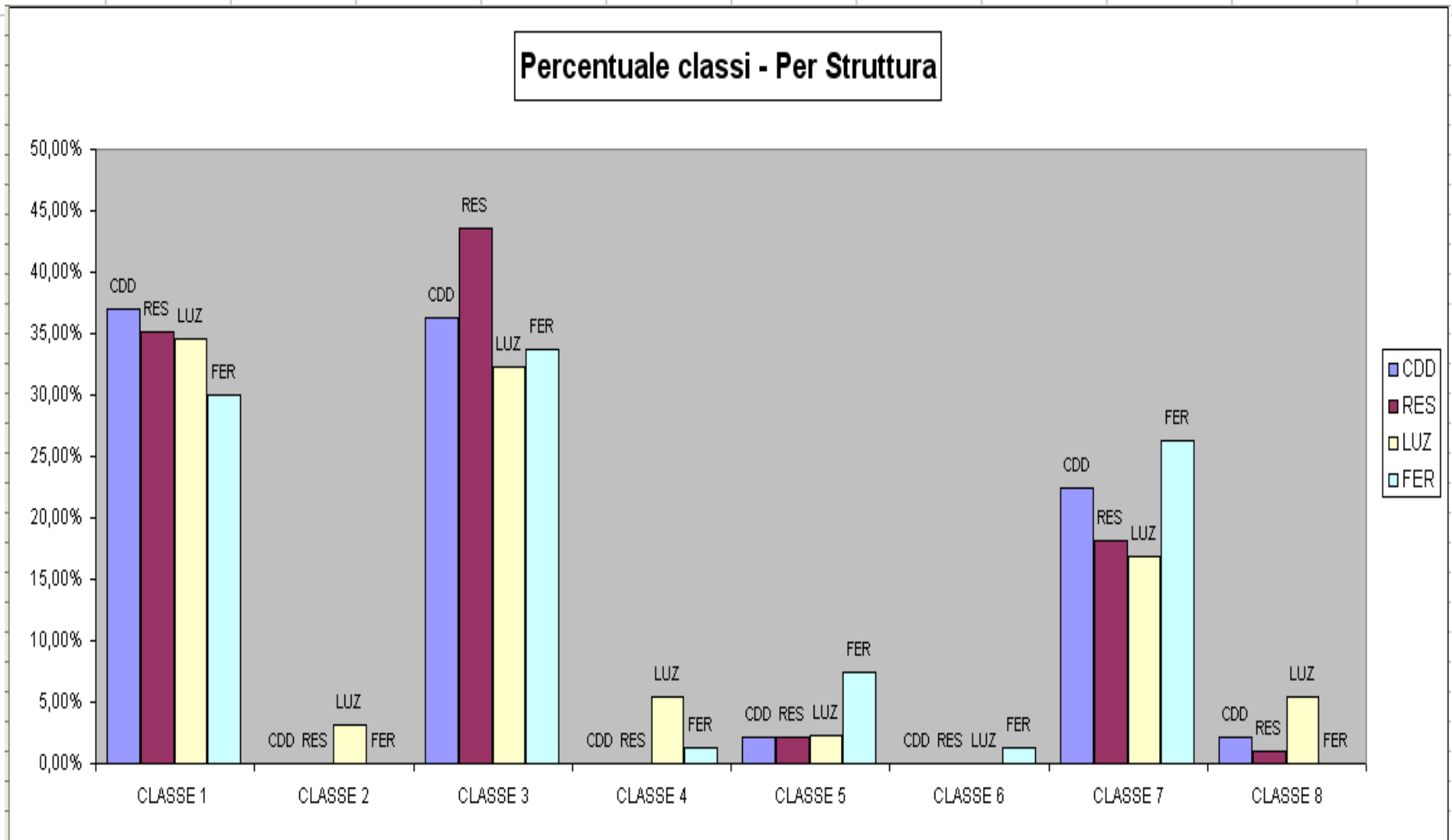
- **PROBLEMI COMPORTAMENTALI,**
- **TRATTAMENTI SANITARI PARTICOLARMENTE COMPLESSI (NUTRIZIONE PARENTERALE, OSSIGENOTERAPIA, CURE PALLIATIVE),**
- **PAZIENTI TERMINALI,**
- **PAZIENTI IN COMA.**

PER DURATA DELLA DEGENZA:

- BREVE DEGENZA: post-acuti, ospiti con necessità di intervento riabilitativo prolungato, ospiti con grado elevato di instabilità clinica, ospiti in condizioni terminali, ricoveri di sollievo.

- LUNGA DEGENZA: ospiti con grave perdita di autonomia, ospiti dementi.

R.S.A.	CLASSE 1	CLASSE 2	CLASSE 3	CLASSE 4	CLASSE 5	CLASSE 6	CLASSE 7	CLASSE 8	R.S.A.	ospiti
CDD	36,96%	0,00%	36,23%	0,00%	2,17%	0,00%	22,46%	2,17%	CDD	138
RES	35,11%	0,00%	43,62%	0,00%	2,13%	0,00%	18,09%	1,06%	RES	94
LUZ	34,62%	3,08%	32,31%	5,38%	2,31%	0,00%	16,92%	5,38%	LUZ	130
FER	30,00%	0,00%	33,75%	1,25%	7,50%	1,25%	26,25%	0,00%	FER	80



Alloggi Protetti e Comunità Alloggio Protette.

Negli ultimi anni si è dato grande enfasi a nuovi servizi residenziali senza un chiaro inquadramento in termini strutturali e gestionali dove vengono inseriti anziani con disabilità cognitiva e funzionale lieve (LOW-CARE).

Le attuali esperienze sono inserite in strutture che accolgono CDI, RSA o Autonome.

Non sono noti standard strutturali e gestionali se non indicazioni generiche come “garantire la tutela”.

La rete dei servizi per l'anziano fragile: appunti per un decalogo.

"l'epoca in cui si potevano avere risorse senza dover dimostrare il proprio livello di efficienza ed efficacia, sta rapidamente finendo. In questo le Rsa non fanno eccezione, ma anzi si collocano al centro di questo processo."

Bollettino S.I.G.G. Anno II, N 7 – Luglio 2005

Clinical review

Illness trajectories and palliative care

Scott A Murray, Marilyn Kendall, Kirsty Boyd, Aziz Sheikh

Summary points

Three typical illness trajectories have been described for patients with progressive chronic illness: cancer, organ failure, and the frail elderly or dementia trajectory

Physical, social, psychological, and spiritual needs of patients and their carers are likely to vary according to the trajectory they are following

Being aware of these trajectories may help clinicians plan care to meet their patient's multidimensional needs better, and help patients and carers cope with their situation

Different models of care may be necessary that reflect and tackle patients' different experiences and needs

Division of Community Health Sciences, General Practice Section, University of Edinburgh, Edinburgh EH8 9DX

Scott A Murray *clinical reader*

Aziz Sheikh *professor of primary care research and development*

Marilyn Kendall *research fellow*

Kirsty Boyd *honorary clinical senior lecturer*

Correspondence to: S Murray Scott.Murray@ed.ac.uk

BMJ 2005;330:1007–11

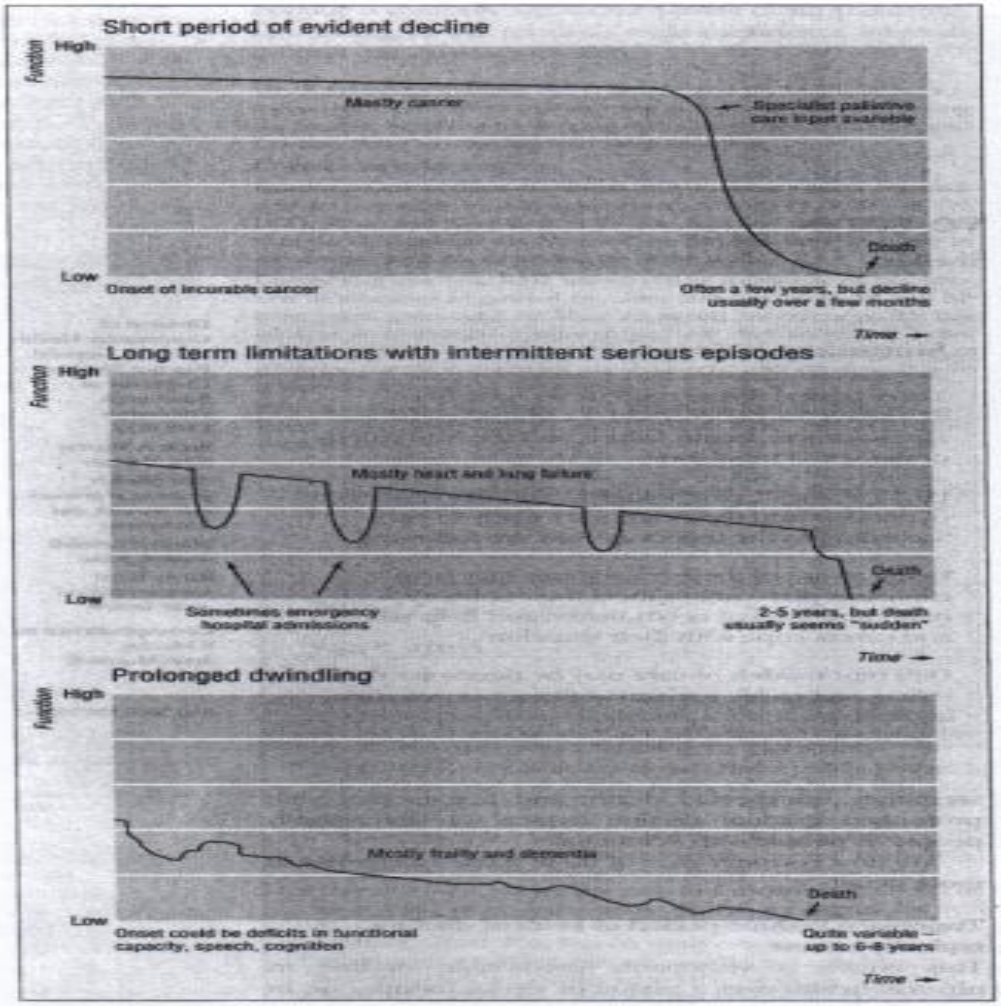


Fig 1 Typical illness trajectories for people with progressive chronic illness. Adapted from Lynn and Adamson, 2003.[7] With permission from RAND Corporation, Santa Monica, California, USA.

Change in Disability After Hospitalization or Restricted Activity in Older Persons

Thomas M. Gill, MD
Heather G. Allore, PhD
Evelyne A. Gahbauer, MD, MPH
Terrence E. Murphy, PhD

Context Disability among older persons is a complex and highly dynamic process, with high rates of recovery and frequent transitions between states of disability. The role of intervening illnesses and injuries (ie, events) on these transitions is uncertain.

Objectives To evaluate the relationship between intervening events and transitions among states of no disability, mild disability, severe disability, and death and to determine the association of physical frailty with these transitions.

Design, Setting, and Participants Prospective cohort study conducted in greater New Haven, Connecticut, from March 1998 to December 2008 of 754 community-living persons aged 70 years or older who were nondisabled at baseline in 4 essential activities of daily living: bathing, dressing, walking, and transferring. Telephone interviews were completed monthly for more than 10 years to assess disability and ascertain exposure to intervening events, which included illnesses and injuries leading to either hospitalization or restricted activity. Physical frailty (defined as gait speed >10 seconds on the rapid gait test) was assessed every 18 months through 108 months.

Main Outcome Measure Transitions between no disability, mild disability, and severe disability and 3 transitions from each of these states to death, evaluated each month.

Results Hospitalization was strongly associated with 8 of the 9 possible transitions, with increased multivariable hazard ratios (HRs) as high as 168 (95% confidence interval [CI], 118-239) for the transition from no disability to severe disability and decreased HRs as low as 0.41 (95% CI, 0.30-0.54) for the transition from mild disability to no disability. Restricted activity also increased the likelihood of transitioning from no disability to both mild and severe disability (HR, 2.59; 95% CI, 2.23-3.02; and HR, 8.03; 95% CI, 5.28-12.21), respectively, and from mild disability to severe disability (HR, 1.45; 95% CI, 1.14-1.84), but was not associated with recovery from mild or severe disability. For all 9 transitions, the presence of physical frailty accentuated the associations of the intervening events. For example, the absolute risk of transitioning from no disability to mild disability within 1 month after hospitalization for frail individuals was 34.9% (95% CI, 34.5%-35.3%) vs 4.9% (95% CI, 4.7%-5.1%) for nonfrail individuals. Among the possible reasons for hospitalization, fall-related injury conferred the highest likelihood of developing new or worsening disability.

Conclusions Among older persons, particularly those who were physically frail, intervening illnesses and injuries greatly increased the likelihood of developing new or worsening disability. Only the most potent events, ie, those leading to hospitalization, reduced the likelihood of recovery from disability.

JAMA. 2010;304(17):1919-1928 www.jama.com

AMONG OLDER PERSONS, DISability in essential activities of daily living, such as bathing, dressing, walking, and transferring, is common and associated with increased mortality, institutionalization, and greater use of formal and informal home services.[1] Active life expectancy, a metric that is often used by policy makers to forecast the functional health of older persons, is based on disability.[2,3]

According to several conceptual models,[4,5] disability is thought to arise when a vulnerable host is exposed to a new or worsening insult or intervening event. Supporting this theoretical framework, we have shown that intervening events, including illnesses and injuries leading to either hospitalization or restricted activity, are strongly associated with the development of disability in activities of daily living.[6] These results, however, were based solely on the initial onset of disability. We have subsequently demonstrated that disability is a complex and highly dynamic process, with high rates of recovery and frequent transitions between states of disability.[7,8] The role of inter-

Med Care. 1997 Aug;35(8):756-67.

Discharge destination and repeat hospitalizations.

Camberg LC, Smith NE, Beaudet M, Daley J, Cagan M, Thibault G.

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OBJECTIVES: Is discharge destination a determinant of readmission? Studies to date have been inconclusive. The primary purpose of this study was to identify the role of discharge destination in the occurrence of repeat hospitalizations for a national sample of patients discharged from Veterans Health Administration (VHA) hospitals.

METHODS: The authors studied a 20% random sample of individual patients, 65 years of age or older, with either chronic obstructive pulmonary disease, stroke, or dementia who were discharged from a Veterans Health Administration hospital in 1988. All data for the study were obtained from secondary administrative sources. Multiple sources were used to determine discharge destination. The authors focused on personal home versus nursing home discharge destination. Both VHA and Medicare discharge data were used to track hospital readmissions. Proportional hazards regression models were used to examine the independent association of discharge destination with time to readmission within 30 days, 6 months, 1 year, and 2 years of discharge, adjusting for severity, other clinical and demographic characteristics, and censoring deaths.

RESULTS: After adjustment and including out-of-system (Medicare) use, we found that patients with chronic obstructive pulmonary disease and patients with dementia who were discharged to nursing homes (community and Veterans Health Administration, respectively) were less likely to be readmitted within 30 days after discharge than patients discharged to personal homes.

CONCLUSIONS: These findings have important implications for adjusting hospital performance profiles based on discharge destination and for focussing efforts to reduce the frequency and associated costs of hospital readmissions.

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TABLE 1. Patients Discharged Live from any Department of Veterans Affairs Medical Center in 1988 by Discharge Destination[a]

Discharge Destination	COPD (n = 6,772) No. (%)	Stroke (n = 2,261) No. (%)	Dementia (n = 2,652) No. (%)
Home	6,039 (89.2)	1,775 (78.5)	1,613 (60.8)
VANH	164 (2.4)	163 (7.2)	265 (10.0)
CNH	392 (5.8)	282 (12.5)	712 (26.9)
AMA	85 (1.3)	20 (0.8)	17 (0.6)
Other	61 (0.9)	21 (0.5)	45 (1.6)

COPD, chronic obstructive pulmonary disease; VANH, Department of Veterans Affairs nursing home; CNH, community nursing home; AMA, against medical advice.

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TABLE 2. Patients Readmitted Within 30 days, 6 Months, 1 Year, and 2 Years of Index Discharge

Time to Readmission	COPD (*n* = 6,772) No. (%)	Stroke (*n* = 2,261) No. (%)	Dementia (*n* = 2,652) No. (%)
30 days	1,378 (20.4)	375 (16.6)	478 (18.0)
6 months	3,492 (51.6)	989 (43.8)	1,209 (45.6)
1 year	4,455 (65.8)	1,330 (58.8)	1,601 (60.4)
2 years	5,358 (79.1)	1,618 (71.6)	1,940 (73.2)

COPD, Chronic obstructive pulmonary disease.

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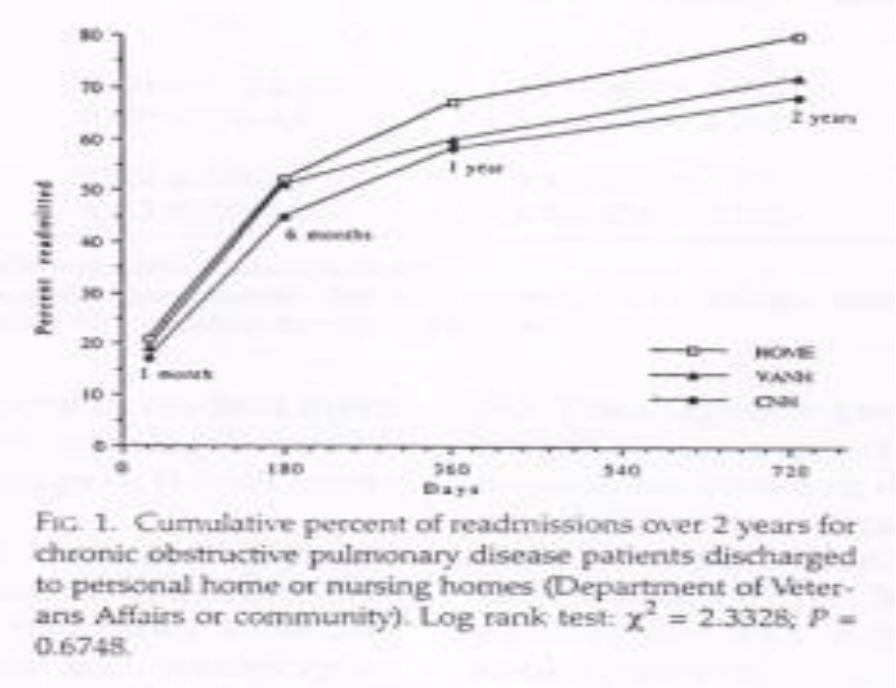

FIG. 1. Cumulative percent of readmissions over 2 years for chronic obstructive pulmonary disease patients discharged to personal home or nursing homes (Department of Veterans Affairs or community). Log rank test: $\chi^2 = 2.3328$; $P = 0.6748$.

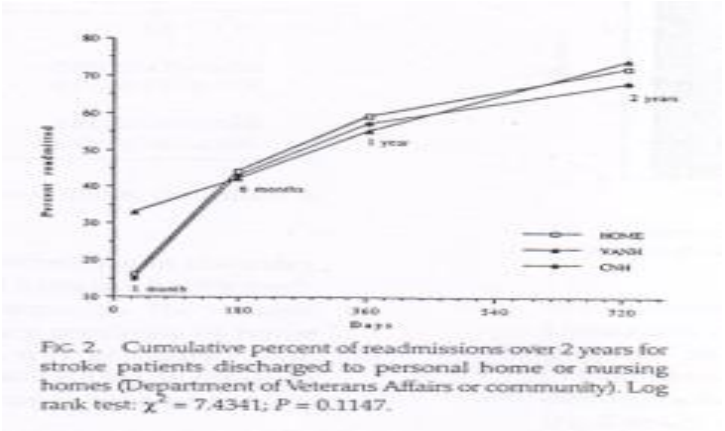

FIG. 2. Cumulative percent of readmissions over 2 years for stroke patients discharged to personal home or nursing homes (Department of Veterans Affairs or community). Log rank test: $\chi^2 = 7.4341$; $P = 0.1147$.

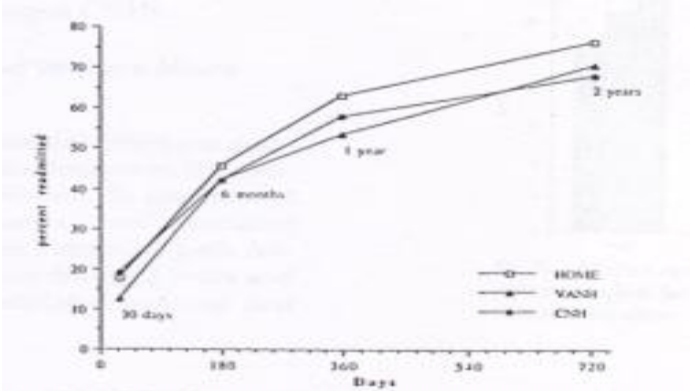

FIG. 3. Cumulative percent of readmissions over 2 years for dementia patients discharged to personal homes or nursing homes (Department of Veterans Affairs or community). Log rank test: $\chi^2 = 10.6933$; $P = 0.0302$.

Hospitalization of the Nursing Home Patient

Susan L. Charette, MD

JAMDA – March/April 2003

CONCLUSION

Nursing home patients represent a special segment of the geriatric population. Hospitalization is often necessary to manage and treat their acute medical conditions, yet, it may be a source of complications and functional decline for many patients. This article outlined some of the special considerations for physicians and other health care providers who care for these patients in the acute setting. To further address these issues, specialized in-hospital units and teams to care for geriatric patients are being developed across the country. Their multidisciplinary approach and dedicated environment and staff aim to reduce the complications of hospitalized older patient.[32] Ideally, improvements in nursing home care will parallel these advances in hospitalized services. The use of physician extenders such as physician assistants and nurse practitioners makes it easier—both financially and physically—to offer primary care and acute visits in the nursing home setting. Early diagnosis and treatment in the nursing home may reduce the need for hospitalization for many patients. The population is aging and these issues are going to become even more important in the future. Now is the time to become prepared.

Cochrane Database Syst Rev. 2007 Apr 18;(2):CD002214.

Effectiveness of intermediate care in nursing-led in-patient units.

Griffiths PD, Edwards MH, Forbes A, Harris RL, Ritchie G.

BACKGROUND: The Nursing led inpatient Unit (NLU) is one of a range of services that have been considered in order to manage more successfully the transition between hospital and home for patients with extended recovery times. This is an update of an earlier review published in The Cochrane Library in Issue 3, 2004.

OBJECTIVES: To determine whether nursing-led inpatient units are effective in preparing patients for discharge from hospital compared to usual inpatient care.

SELECTION CRITERIA: Controlled trials and interrupted time series designs that compared the NLU to usual inpatient care managed by doctors. Patients over 18 years of age following an acute hospital admission for a physical health condition.

MAIN RESULTS: Ten random or quasi-random controlled trials reported on a total of 1896 patients. There was no statistically significant effect on inpatient mortality (OR 1.10, 95% CI 0.56 to 2.16) or mortality to longest follow up (OR 0.92, 95% CI 0.65 to 1.29) but higher quality studies showed a larger non-significant increase in inpatient mortality (OR 1.52, 95% CI 0.86 to 2.68). Discharge to institutional care was reduced for the NLU (OR 0.44 95% CI 0.22 to 0.89) and functional status at discharge increased (SMD 0.37, 95% CI 0.20 to 0.54) but there was a near significant increase in inpatient stay (WMD 5.13 days 95% CI -0.5 days to 10.76 days). Early readmissions were reduced (OR 0.52 95% CI 0.34 to 0.80). One study compared a NLU for the chronically critically ill with ICU care. Mortality (OR 0.62 95% CI 0.35 to 1.10) and length of inpatient stay differ did not differ (WMD 2 days, 95% CI 10.96 to -6.96 days). Early readmissions were reduced (OR 0.33 95% CI 0.12 to 0.94). Costs of care on the NLU were higher for UK studies but lower for US based studies.

AUTHORS' CONCLUSIONS: There is some evidence that patients discharged from a NLU are better prepared for discharge but it is unclear if this is simply a product of an increased length of inpatient stay. No statistically significant adverse effects were noted but the possibility of increased early mortality cannot be discounted. More research is needed.

Gerontologist. 2007 Aug;47(4):535-47.

Determinants of remaining in the community after discharge: results from New Jersey's Nursing Home Transition Program.

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PURPOSE: To inform states with nursing home transition programs, we determine what risk factors are associated with participants' long-term readmission to nursing homes within 1 year after discharge.

DESIGN AND METHODS: We obtained administrative data for all 1,354 nursing home residents who were discharged, and we interviewed 628 transitioning through New Jersey's nursing home transition program in 2000. We used the Andersen behavioral model to select predictors of long-term nursing home readmission, and we used Cox proportional hazards regressions to examine the relative risk of experiencing such readmissions.

RESULTS: Overall, 72.6% of the 1,354 individuals remained in the community, with 8.6% readmitted to a nursing home for long stays (>90 days) and 18.8% dying during the study year. Cox proportional hazards regression analysis showed that being male, single, and dissatisfied with one's living situation; living with others; and falling within 8 to 10 weeks after discharge were significant predictors of long-term nursing home readmission during the first year after discharge.

IMPLICATIONS: Most of the factors predicting long-term readmission were predisposing, not need, factors. This fact points to the limits of formulaic approaches to assessing candidates for discharge and the importance of working with clients to understand and address their particular vulnerabilities. Consumers, state policy makers, nursing home transition staff, discharge planners, and caregivers can use these findings to understand and help clients understand their particular risks and options, and to identify those individuals needing the greatest attention during the transition period as well as risk-specific services such as fall-prevention programs that should be made available to them.

A Comparative Effectiveness Trial Between a Post-Acute Care Hospitalist Model and a Community-Based Physician Model of Nursing Home Care

F. Michael Gloth III, MD, and Mark J. Gloth, DO

Introduction: To evaluate whether a designated Post-Acute Care Hospitalist (PACH) (an individual physician charged with care of most residents in the nursing home and with set hours to be in the facility each week) could improve some measureable outcomes in the long-term care setting compared with a traditional cadre of community physicians, a comparative trial was designed to measure multiple cost and care variables.

Methods: Data were collected in a historical prospective study design for 6 months before the institution of a PACH model in a nursing home in the Baltimore area. Similar data were collected in a similar setting in the same region during the same time frame. During the same 6 months in the following year (ending June 30, 2008) after initiating the PACH program, the same outcome measures, which included demographic information, admissions per census, number of medications per resident, laboratory services and fees per resident day, fallers and falls per resident day, unplanned discharges per resident day, and average pharmacy costs per patient, were collected.

Results: Demographic information was similar in all groups. PACH and non-PACH models per resident day were significantly different for laboratory tests (intrafacility pre-PACH \$1.93, post-PACH \$2.97; $P < .005$ and interfacility post-PACH \$2.97, non-PACH \$0.97), fallers (intrafacility pre-PACH 0.006, post-PACH 0.008; $P = .01$ and interfacility post-PACH 0.008, non-PACH 0.006; $P < .005$), and falls (intrafacility pre-PACH 0.007, post-PACH 0.01; $P < .05$ and interfacility post-PACH 0.01, non-PACH 0.008; $P < .05$). Medication errors after PACH was instituted were 1/6 of pre-PACH rate and 1/60 of the non-PACH facility. Post-PACH pharmacy costs were also better than the non-PACH facility pharmacy costs per resident day by \$7.74, but differences for medication errors and pharmacy costs were not statistically significant.

Conclusion: Institution of a PACH in a nursing home was associated with a significant increase in laboratory costs and no improvement in fall rates. There was a nonsignificant reduction in medication errors and pharmacy costs. These data support the hypothesis that a PACH model may lead to greater clinician involvement, which may be associated with an increase in clinical testing and a decrease in pharmacy costs and medication errors. If true, the latter would likely far offset any costs associated with additional laboratory testing. These findings warrant further investigation of larger magnitude. **(J Am Med Dir Assoc 2010; ■: ■–■)**

Conversion Diversion: Participation in a Social HMO Reduces the Likelihood of Converting From Short-Stay to Long-Stay Nursing Facility Placement

Kathryn E. Thomas, PhD, Zachary D. Gassoumis, and Kathleen H. Wilber, PhD

Objectives: To determine the effect of a Social Health Maintenance Organization (S/HMO) on diverting older adults admitted into a nursing facility from converting to long-stay placement.

Design: Members of the SCAN S/HMO and those in Medicare Fee-For-Service were compared on successful discharge to the community after being admitted to nursing facilities between January 1, 2001, and December 31, 2003.

Setting: Skilled nursing facilities in 4 counties in Southern California (Los Angeles, Orange, San Bernardino, Riverside).

Participants: Data (N = 4635) were extracted from Minimum Data Set (MDS) 2.0 records for nursing facility residents in the S/HMO or the Medicare Fee-for-Service 5% sample who were aged 65 and older with an episode of care greater than 14 days.

Measurements: Predisposing, enabling, and need measures were used to predict successful discharge to the community within 90 days.

Results: After controlling for selected sociodemographics, comorbidities, behavioral issues, mental health conditions, and other risk factors, being enrolled in the S/HMO increased the likelihood of successful discharge by 26%.

Conclusion: With systemic increases in short-stay patients, research on diversion must look past the avoidance of unnecessary entry to nursing facilities, to the successful transition of short-stay residents to the community. As described in this study, the S/HMO model is an important but largely unaddressed method of avoiding the conversion to long-stay. **(J Am Med Dir Assoc 2010; 11: 333–337)**

Keywords: Nursing facility transition; conversion; diversion; community discharge; S/HMO

An International Perspective on Long Term Care: Focus on Nursing Homes

Paul R. Katz, MD, CMD

The world is facing an unprecedented growth of older adults, a sizable number of whom will require nursing home services. Although community-based care delivery systems strive to keep most of those in need at home, nursing homes are increasingly accommodating a more frail population that is straining available resources. This article focuses on common themes evident around the world regarding long-term care of the elderly. Issues related to service delivery, financing, and quality are highlighted. **(J Am Med Dir Assoc 2011; ■: ■–■)**

Keywords: Nursing home; international; quality; financing; demographics

Table 1. *Differences in Nursing Home Use in Selected Postindustrialized Countries*

Country	% 65 y and older in Nursing Homes
Australia	5.3
Austria	3.6
Canada	3.7
Germany	3.9
Ireland	4.6
Japan	3.2
Korea	0.2
Luxembourg	4.0
Netherlands	2.4
New Zealand	5.9
Norway	6.0
Sweden	7.9
Switzerland	7.0
United Kingdom	5.1
United States	4.3

Table 2. *Dementia Diagnosis and Place of Death, %*

Country	Cause of Death	Home	Hospital	Nursing Home	Hospice
Belgium	Dementia	16.4	22.8	60.6	0.1
	Cancer	26.4	60.3	13.2	0.1
	Other	22.3	50.5	26.9	0.1
Netherlands	Dementia	4.7	3.0	90.7	0.7
	Cancer	40.3	29.7	25.3	3.5
	Other	21.9	40.0	36.1	0.9
England	Dementia	4.9	39.1	55.4	0.2
	Cancer	20.5	50.8	12.6	14.8
	Other	16.6	65.8	15.9	0.9
Wales	Dementia	3.3	52.8	43.8	0.0
	Cancer	20.5	60.9	9.8	6.7
	Other	15.2	71.7	12.5	0.2
Scotland	Dementia	7.3	37.6	54.9	0.3
	Cancer	21.9	58.3	19.7	0.0
	Other	17.1	67.6	15.2	0.1

These data, in part, likely reflect differences in how services are funded between countries as well as the case mix characteristics of specific populations. For example, in the "Aged in Home Care Project," southern European countries (Italy, France) appeared to have home care populations that were significantly more disabled (functionally and cognitively) than their northern European neighbors (Table 4).[38] This, in part, reflects cultural norms that emphasize the care of frail elderly at home rather than in an institutional setting.[39]

FUTURE DIRECTIONS

Regardless of existing funding mechanisms, the need to more fully integrate systems of care has become a priority for countries facing the "geriatric tsunami." Cost and quality are better served when an individual's needs are specifically targeted in a timely manner and preferably in a location that is easily accessible. Examples of care integration are

Table 6. *Future Directions*

- Person-centered care
- Redefinition of caregiver roles
- Deinstitutionalization (eg, Greenhouses)
- Integration of families into care (shared responsibilities)
- Quality of care definitions broadened to embrace quality of life
- Change in regulatory framework to promote use of best practices without fear of punishment
- Prevention/delay in disability
- Optimizing care through technology

Association of Gerontology and Geriatrics is a clarion call to action.[45] A global focus on leadership competency, evidence-based quality of care indicators, practitioner education, and research within the nursing home setting holds the key to success for the coming years. We can only hope that Robert Browning's inspiring quote is our future… "grow old along with me, the best is yet to be."