RESOLVE Forum
June 5, 2018

Improving Care Transition between Assisted Living Facilities and Hospitals

Working together to RESOLVE some common issues and concerns that exist throughout the assisted living provider community.

A partnership of these organizations:

• Bureau of Assisted Living
• Bureau of Adult Long Term Care Services
• LeadingAge Wisconsin
• Wisconsin Assisted Living Association
• Wisconsin Center for Assisted Living
• Disability Service Provider Network
• AND MOST IMPORTANT – YOU!
Department of Health Services

Agenda

9:30 a.m. Welcome/Announcements – Alfred Johnson
9:35 a.m. Introduction of the Assisted Living Facility and Hospital Interface guide – Alfred Johnson
   Assisted Living Facility Definitions – Jennylynde Packham
   Regulatory References – Alfred Johnson
   Roles and Responsibilities – Dyonne Wilhelm, Jennylynde Packham, Vaughn Brandt
   Provider Implementation – Dyonne Wilhelm, Jennylynde Packham, Pam Preston, Dan Drury
   Transition from/To Guidelines – Dyonne Wilhelm, Jennylynde Packham, Dan Drury, Jerry Riederer
11:00 a.m. WCCEAL-Quality Improvement – Kevin Coughlin
11:15 a.m. WCCEAL Provider Testimonial
11:30 a.m. Question and Answer – ALL
11:30 a.m. Adjourn

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**Background**

**Ineffective transitions of care:**

- Adverse health outcomes—medication errors, complications from procedures, falls
- Confusion about client’s condition, inappropriate care, duplicative tests, inconsistent client monitoring, delays in diagnosis, lack of follow through on referrals
- Burden the healthcare system with increasing costs—estimated that poorly coordinated care transitions from hospital to other settings cost $12 billion to $44 billion per year

(Kim & Flanders, 2013 & Hansen, et al., 2011)

**Needs Assessment**

Based on data obtained from the State of Wisconsin Department of Quality Assurance and Bureau of Assisted Living citations related to:

- Assisted living facility (ALF) staff not communicating with hospital staff at time of transfer
- Lack of communication during hospital stay
- Family/Power of attorney (POA) not being notified of client transfer to hospital

(Bureau of Assisted Living, 2017)
Literature Review

Barriers to effective transitions:

- Lack of communication
- Lack of collaboration
- Gaps in services across care settings

(Hirschman, et al., 2015 & Enderlin, et al., 2013)

What improves transitions:

- Structured models, frameworks and tools
- Direct staff educational interventions demonstrated that a training program in the ALF setting contributed to increasing caregiver self-efficacy throughout the course of the program’s implementation

(White & Cadiz, 2013)
Interface Document

Work group was developed in Wisconsin by the
- Department of Health Services (DHS)
- Division of Quality Assurance (DQA)
- Bureau of Assisted Living (BAL)

Work group created Assisted Living Facility and Hospital Interface
- published January 2018

Assisted Living Facility
- CBRF: Community Based Residential Facility
  - 5 to 100+ beds; serves specific client group; licensed base on size and class
- AFH: Adult Family Home
  - 4 beds or less
- RCAC: Residential Care Apartment Complex
  - Greatest variance in size, type, nature
- NO Regulatory requirement for RN/LPN/CNA on staff
Regulatory Considerations CBRF

**Reporting requirements**

- 83.12(4)(c) Report to the department within 3 working days of injury requiring Hospital Admission

- 83.12(5) **Immediately** notify resident’s legal rep. and physician when there is an injury, incident or significant change in the resident’s physical or mental condition.

**Resident Rights**

- 83.32(2)(h) Receive medications in the dosage and at intervals prescribed by the practitioner.

- 83.32(2)(i) Prompt and adequate treatment
Regulatory Considerations CBRF

Assessment and ISP update

- 83.35 (1)(a) and (3)(d) Change of condition

Regulatory Considerations AFH

Assessment and ISP update

- 88.06(3)(f) ISP updated when needs change
Regulatory Considerations
AFH

Resident Rights

- 88.10(3)(p) Prompt and Adequate Treatment
- 88.10(3)(q) Right to receive medications as prescribed.

Regulatory Considerations
AFH

Reporting

- 88.03(5)(e) Within 24 hours of an accident requiring hospitalization
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Regulatory Considerations

RCAC Services

- 89.23(4)(a)2 Delegated nursing services

Regulatory Considerations

RCAC

Comprehensive assessment

- 89.28(6) Updating risk agreement
Chapter 50

Rights of Residents

- 50.09(2)(l) Receive adequate and appropriate care within the capacity of the facility.

Role of the ALF

Transfer out of the Facility:

Contact:
- EMS
- Legal rep/ Family
- Hospital
- MCO
- Primary care physician
Role of the ALF

Transfer out of the Facility:

Transfer Documents/ Emergency Transfer Packet:

- Blue Envelope
- ALF Client Face Sheet
- Assisted Living Capability Form (& Interact Tool)

**Section IV Resources**
At the bottom, there is an area to check
“Documents to include”
Role of the ALF

Additional Info to include in the packet/with the transfer:
• Past 48 hour progress notes
• MAR
• Code Status
• Labeled assistive devices

Role of the ALF

Maintain frequent contact with hospital staff & review facility clinical capabilities

**During the stay:**
• Review meds
• Identify behaviors
• Discuss potential discharge date
• Conduct onsite assessment

**Prior to discharge:**
• Ensure prescriptions have been obtained
• Ensure DME is in place
• Coordinate transportation
• Update ISP
• Ensure staff are trained for any new treatments
• Inform Legal rep/family
Role of the ALF

Upon Return:

- Review discharge summary
- Review and process rehab and treatment needs
- Process post discharge appointments and ensure resident attends the follow up appts.
Tips

Blue Envelope:
• Envelopes: Order 9x12” clasp envelopes in color POOL (turquoise blue color) from www.envelopes.com. SKU # is 73821.
• Order the plain envelopes with no printing on them. Direct link: http://www.envelopes.com/business/clasp/9-x-12-clasp-envelopes-pool

½ Sheet Labels: Please order 4.25x11” vertical cut half sheet labels in color STANDARD WHITE MATTE. Product number is OL178WX.
• Direct link: http://www.onlinelabels.com/OL178.htm
Roles and Responsibilities: Adult Long Term Care

Medicaid-funded Long Term Care programs include:
- Family Care
- PACE
- Partnership
- IRIS

Other Medicaid Funded Services

- Medicaid Supplemental Security Income HMOs, may also be referred to as Managed Care, though these are a different benefit
- Non-institutional benefits for all Medicaid and BadgerCare Plus programs (including physician, dental, mental health, school-based services, therapies, family planning, transportation, home health, durable medical equipment, and disposable medical supplies), also called Fee for Service or Card Services
Managed Care Organizations (MCOs) in Long Term Care

- Serve a key role in providing and coordinating services
- Tailor services to individual needs, circumstances, and preferences
- Utilize an Interdisciplinary Team (IDT) composed of a nurse and a care manager

The IDT will coordinate and contract for medically necessary long term care and health care services in the Family Care benefit package, such as:

- Home health supplies
- Supportive home care
- Residential placements
- Mental health services
- Other services to promote community integration or community living
Communications

The IDT, Assisted Living Facility providers, and hospital staff should initiate communication:

• After a member’s admission to a medical facility
• With status updates regarding a person’s condition
• To coordinate discharge planning

For individuals living in a private home:

• The IDT works with hospital staff on a client’s discharge plan immediately after admission.
• The IDT provides hospital staff with all necessary background information.
• The IDT arranges for necessary services to provide continuity of care following the discharge.
For individuals transitioning to an ALF:

- The IDT coordinates planning with the person’s ALF provider to determine if the client can return, and to look at increased services or an interim plan of care to support the client, such as home health care or a stay in a rehabilitation facility.

If the client will require a new provider or services:

- The IDT will share their contracted provider list with the hospital staff to coordinate appropriate services after discharge.
- The MCO is the payer source for non-acute services; therefore, the IDT needs to arrange the services and authorizations identified in the discharge plan.
Behavioral Health

- Transitions in care and medical procedures often increase stress. Sharing information and proactive planning with the person and the team are essential to prevent or address complex or challenging behaviors.

Complex Behavioral Health Care Needs

- Elderly people with dementia
- Individuals with a serious and persistent mental illness
- Individuals with an intellectual or developmental disability
- Individuals with a substance use disorder
- Any combination of these conditions, or other emerging behaviors that involve risks
Person-centered Supports

- Person-centered practices focus on each person's abilities and strengths, including natural supports, so that he or she can maintain or work toward what is important to him or her.
- Remember: Any behavior may be a form of communication.

Legal Status

Be sure to discuss if any legal matters have impact on the transition planning process:
- Supported Decision Making (Guardianship, Power of Attorney, etc.)
- Court Orders for Mental Health Treatment
- Protective Placement Orders
- Forensic programs or justice involvement
Does the person have (or need):

- A “pro re nata” (PRN) medication protocol?
- A Behavior Support Plan (BSP)?
- Some form of safety protocol?
- A Client Rights Limitation or Denial (CRLD)?
- A Crisis Plan (as defined by DHS 34)
- A Police Safety Plan to provide information and guide responses during contact with law enforcement?
Department of Health Services

Developing or updating a BSP

- A BSP should include positive behavior support strategies and personal experience outcomes for the individual. It is a plan to guide the caregivers’ responses to support an individual and requires the consent of the person or their guardian.
- A BSP may include protocols or addendums to direct providers in how they respond to specific need areas or situations.

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Department of Health Services

Releases of Information

- A written release of information should be specific to each record and specify exactly what part of the record is to be released to whom, and for what purpose.
- There are exceptions during emergency situations to convey essential information for health and safety. For exceptions, please see:
  http://docs.legis.wisconsin.gov/statutes/statutes/51/30/4/b

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MCOs as a liaison for teams:

- The MCOs IDT can attend or facilitate stakeholder meetings, provide assessments and other treatment records to health care and residential providers, and to arrange services to support successful transitions.

Transitions From/To Guidelines

Discuss clinical complexity before a resident is discharged from an inpatient or observation stay to determine the most appropriate post discharge plans and readmission capabilities.

Consider the following categories:
- Cardiac
- Respiratory
- Cognitive
- Ambulation
Transition From/To (cont.)

- Therapy
- Treatments
- Discharge meds
- Infections
- Continence
- ADL assistance
- Food and Nutrition
- Home Health Referral

Suggested Scripting for Assisted Living Facility Staff

1. What could ALF staff say when hospital staff calls with information they are not authorized to receive/don’t feel equipped to take the information?
   - **Suggested:** “I’m sorry but I am not able to take this information. Please call the [name of ALF”s preferred contact person] at [phone number]. May I have your name and phone number in case we need to reach you?”
Suggestions Cont.

It is suggested that ALF staff be instructed to notify a manager, or the ALF’s preferred contact person, per facility guidelines within no more than 15 minutes after the call from the hospital.

Suggestions Cont.

2. What could the ALF staff say when the ALF is unable to meet the client’s care needs or the ALF staff do not have the necessary skills to provide the required care?

The following should come from the ALF’s manager or preferred contact person:

- **Suggested:** “After hearing of the client’s change in [health/care] requirements following [his/her] recent hospitalization and conducting an assessment of the client’s needs, we will be informing the client and [his/her] responsible party that we cannot meet the client’s needs ad will be issuing a discharge notice. We will work with the [client/responsible party/managed care organization/hospital] to locate a suitable living arrangement.”
Regulatory Considerations

AFH

Medications

• 88.07(3)(d) Order to administer medications

Regulatory Considerations CBRF

Medication Orders

• 83.27(1)(a) Practitioner’s Order
Regulatory Considerations
RCAC
Tenant Rights

- 89.34(16) Receive medications as ordered

<table>
<thead>
<tr>
<th>Written Order Indicating Which Staff can Administer</th>
<th>CBRF</th>
<th>AFH</th>
<th>RCAC</th>
<th>ADC</th>
</tr>
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<tbody>
<tr>
<td>Silent</td>
<td>Yes</td>
<td>Silent</td>
<td>Silent</td>
<td>No Facility policy required</td>
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</table>

<table>
<thead>
<tr>
<th>Written order for each medication</th>
<th>CBRF</th>
<th>AFH</th>
<th>RCAC</th>
<th>ADC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes All prescription drugs required</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Written order for each medication when client self-administers</th>
<th>CBRF</th>
<th>AFH</th>
<th>RCAC</th>
<th>ADC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No All prescription drugs required</td>
<td>No All prescription drugs required</td>
<td>No All prescription drugs required</td>
<td></td>
</tr>
</tbody>
</table>
History and Critical Events

- Public/Private Collaboration
- Regulators, Public Funders, Advocates, Provider Associations
- Structure, process and outcome measures used to evaluate quality
WCCEAL

- Provider association sponsored
- Department approved
- Comprehensive quality assurance and quality improvement (QA and QI)
- Includes 9 guiding values

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Provider Associations

WCCEAL Approved Programs:

- LeadingAge - [LeadingAge Wisconsin Echelon](#)
- WALA - [Diamond Accreditation Program](#)
- WiCAL - [Performance Excellence in Assisted Living (PEAL) Program](#)
- DSPN - [STAR Accreditation](#)

WCCEAL Membership criteria:

- The assisted living community is a member of an association in good standing (Wisconsin Assisted Living Association [WALA], LeadingAge Wisconsin, Wisconsin Center for Assisted Living [WiCAL], Disability Services Provider Network [DSPN]).
- The community is licensed as an assisted living community (CBRF, RCAC, AFH).
- The community has implemented a provider association and department-approved quality improvement program.
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One of the Major Guiding Values
Continuous Quality Improvement

• Quality benchmarks
• Data collection
• Performance analysis
• Continuous efforts

QA and QI

• Facility information
• Resident information
• Quality measures:
  • QI structure and process
  • Resident satisfaction
  • QI clinical outcomes
Firewall

WCCEAL individual assisted living communities:
* Satisfaction results
* Indicators
* Other reported information

Department of Health Services, Division of Quality Assurance, Division of Medicaid Services, advocates, and public

Wisconsin Partnership Grant

- 2015 Wisconsin Partnership Program Community Impact Grant. DHS and CHSRA awarded a $1,000,000, 5 year grant to expand the statewide impact of WCCEAL.

- March 2016 – 2021
Wisconsin Partnership Grant

Grant Aims:
1. Ensure that residents of Wisconsin ALCs have access to quality care by expanding the reach of the collaborative to engage more ALCs
2. Improve ALCs’ ability to report and compare their progress and quality improvement by updating the WCCEAL data infrastructure
3. Address health disparities in ALCs by assessing and targeting underserved communities and resident groups
4. Reach more publicly-funded and underserved residents through integrating WCCEAL into the Family Care Quality Strategy
5. Improve specific quality targets for ALCs by developing processes for ALCs to work together with their peers
6. Produce and disseminate evidence to sustain positive systems change through this collaborative

Assisted Living Quality Collaborative Model with External Partners

- Assisted Living Communities
- Provider Associations
- Researchers
- Advocates
- Quality Improvement Supports
- Information Dissemination

__Regulatory Entities__
__Managed Care Organizations__
__Public Funding Agencies__

Assisted Living Community Certification
Outcome Measure

- Hospitalizations
- Re-Hospitalizations

### WCESAL Hospitalization-Re-hospitalization

<table>
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<tr>
<th></th>
<th>Q2 2017</th>
<th>Q3 2017</th>
<th>Q4 2017</th>
<th>Q1 2018</th>
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</thead>
<tbody>
<tr>
<td># of ALCs Submitting Data in the Quarter</td>
<td>376</td>
<td>376</td>
<td>368</td>
<td>365</td>
</tr>
<tr>
<td># of ALCs Sharing Hospitalizations</td>
<td>325</td>
<td>335</td>
<td>326</td>
<td>329</td>
</tr>
<tr>
<td>% of ALCs Sharing Hospitalizations</td>
<td>86.44%</td>
<td>89.10%</td>
<td>89.07%</td>
<td>90.14%</td>
</tr>
<tr>
<td>Total Hospitalizations (Shared)</td>
<td>998</td>
<td>855</td>
<td>865</td>
<td>1033</td>
</tr>
<tr>
<td>Total Re-hospitalizations (Shared)</td>
<td>130</td>
<td>115</td>
<td>110</td>
<td>147</td>
</tr>
<tr>
<td>% of Re-Hospitalizations (Shared)</td>
<td>13.03%</td>
<td>13.45%</td>
<td>11.56%</td>
<td>14.23%</td>
</tr>
<tr>
<td>Avg Re-Hospitalization Rate (Shared)</td>
<td>15.14%</td>
<td>12.98%</td>
<td>12.77%</td>
<td>12.95%</td>
</tr>
</tbody>
</table>
Demo - Visitor Login Process

- [https://wcceal.chsra.wisc.edu/](https://wcceal.chsra.wisc.edu/)
- Username: wccealvisitor
- Password is: blue123

National Recognition

2015 – Harvard Innovations in American Government Award Program, Bright Idea Award

2016 - Association for Health Facility Survey Agencies, Promising Practice Award
[http://www.ahfsa.org/annual-conference/promising-practices](http://www.ahfsa.org/annual-conference/promising-practices)

2017 – Pioneer Institute, Better Government Competition, Special Recognition Awardee

2017 – Approval to claim Federal Matching funds
CEU

If you would like a certificate of attendance, please contact Darien Woods at

- Darien.Woods@dhs.wisconsin.gov
- When sending an email include the following:
  - Facility name
  - Attendee(s) (First and Last name)
  - Email address