



## Care Transitions in the Assisted Living Setting

James E. Lett, II, M.D., C.M.D.  
November 20, 2014

---

---

---

---

---

---

---



## Speaker Disclosures

Dr. Lett:

- Boehringer-Ingelheim Pharmaceuticals: Speakers Bureau for Care Transitions: Unbranded
- Sanofi Pharmaceuticals: Speakers Bureau for Diabetes Care in LTC

---

---

---

---

---

---

---



## Session Objectives

By the end of the session, participants will:

- Objective 1: Review the trends which have contributed to issues causing readmissions in the health care system.
- Objective 2: Understand programs currently in place to reduce readmissions in the long term care continuum.
- Objective 3: Learn to initiate actions to reduce hospital readmissions which will increase patient/resident satisfaction and augment patient-centered care.

---

---

---

---

---

---

---



---

---

---

---

---

---

---

---

Research indicates that transfers between health care facilities increase the risk of residents experiencing harm and other negative care outcomes and that resulting hospitalizations are costly to Medicare.

Asst Secretary for Planning and Evaluation (ASPE), Hospitalizations of Nursing Home Residents: Background and Options, June 2011, P. 1

The slide features a red arrow pointing right at the top left. Below the text is a small icon depicting various health care elements: a hospital building, an ambulance, a pharmacy, and a stethoscope.

---

---

---

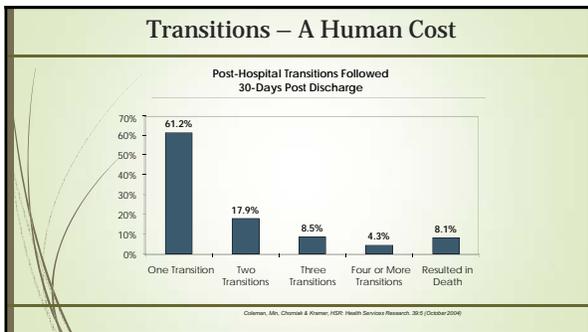
---

---

---

---

---



---

---

---

---

---

---

---

---



- Increasing "medicalization" of ALF's
  - Those in ALF now were the NH residents of 10-20 years ago
  - Sicker, older, more frail & more medications in the current population
  - No longer a real estate & hospitality business
  - Acceptance of more frail residents will carry the expectation that the clinical expertise is available at the ALF to care for them

---

---

---

---

---

---

---

---

### National Study of Long-Term Care Providers

- Conducted by the National Center for Health Statistics (CDC)
- Includes: Adult Day Centers, Nursing Homes, Residential Care Communities, Hospice, & Home Health Agencies
- Report available at: [cdc.gov/nchs/nsitcp.htm](http://cdc.gov/nchs/nsitcp.htm)
- "Residential care places are known by many different names. Just a few terms used to refer to these places are assisted living facilities; personal care and adult care homes, facilities, and communities; adult family and board and care homes; adult foster care; homes for the aged; and housing with service establishments. For NSLTCP, we refer to these places and others like them as residential care communities or RCCs."

---

---

---

---

---

---

---

---

### Long-term Care Users: By Age & Provider

Long-term Care Users: By Age & Provider



Provider Type	Under 65	65-74	75-84	85 and over
Adult day services center	38.6	19.4	37.2	16.9
Home health agency	17.6	26.6	32.2	25.5
Hospice	5.5	14.4	31.3	46.8
Nursing home	14.9	14.9	27.9	42.3
Residential care community	6.7	10.4	32.4	50.5

Harris-Kupatzi J., Sengupta M., Park-Lee E., Vidaverle R. Long-term care services in the United States: 2013 overview. Hyattsville, MD: National Center for Health Statistics, 2013.

From "A National Profile of Assisted Living & LTC" slide set by AHCA (American Health Care Assoc) & NCAI (National Center for Assisted Living)

---

---

---

---

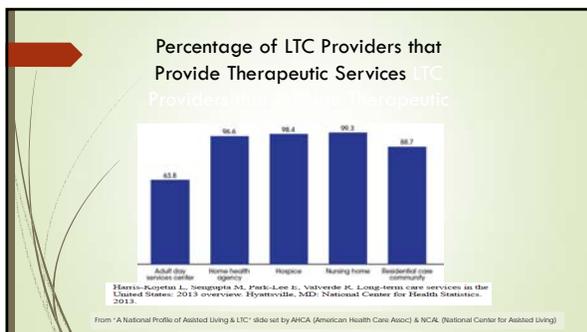
---

---

---

---





---

---

---

---

---

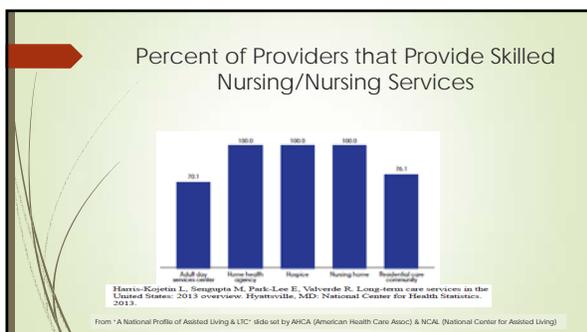
---

---

---

---

---



---

---

---

---

---

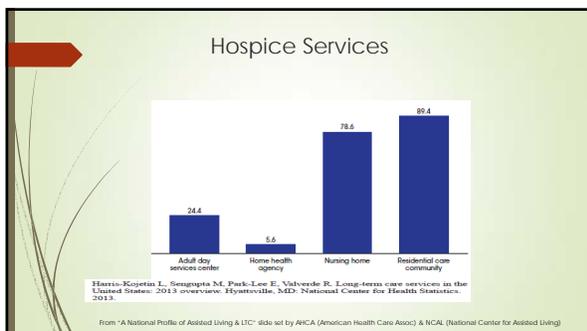
---

---

---

---

---



---

---

---

---

---

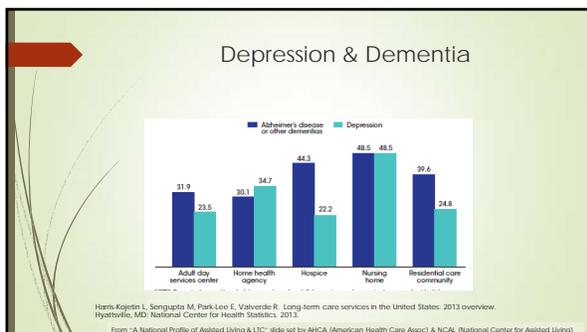
---

---

---

---

---




---

---

---

---

---

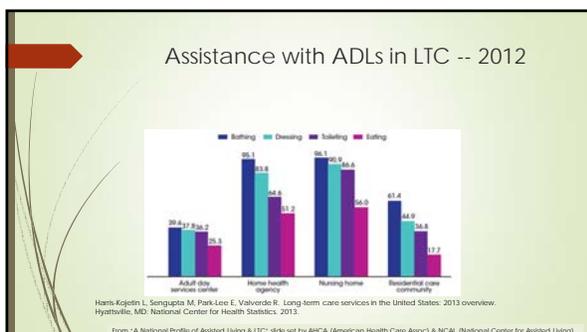
---

---

---

---

---




---

---

---

---

---

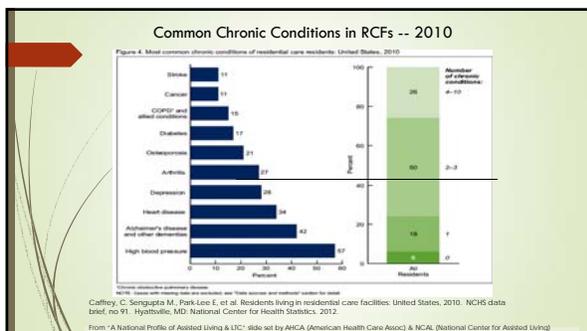
---

---

---

---

---




---

---

---

---

---

---

---

---

---

---

### National Survey of Residential Care Facilities: Residents' Cognitive Abilities – 2010

- 48.7% experience confusion
- 46% experienced difficulty with short term memory in the last 7 days
- 28% experienced difficulty with long term memory in the last 7 days
- 18% could not find apartment
- 21% could not recognize staff names & faces
- 15% don't know they are in a facility
- 22% don't know what season it is



Source: U.S. Dept. of HHS 2010 National Survey of Residential Care Facilities  
From "A National Profile of Assisted Living & LTC" slide set by AHCA (American Health Care Assoc) & NCAAL (National Center for Assisted Living)

---

---

---

---

---

---

---

---

### National Survey of Residential Care Facilities: Other Health-Related Characteristics -- 2010

- 19.9 % bowel incontinent in last 7 days
- 36.6% urinary incontinent in last 7 days
- 77.1% need help with medications
- 38% receive help with 3+ADLs
- 24% admitted to a hospital in last 12 months
- 35% treated in hospital ED in last 12 months
- 14% fell in last 12 months resulting in injuries other than hip fractures



From "A National Profile of Assisted Living & LTC" slide set by AHCA (American Health Care Assoc) & NCAAL (National Center for Assisted Living)

---

---

---

---

---

---

---

---

### Raising the Ante: Rise of the "Baby Boomers"

- Clinical expectations
- Survey expectations: as clinical expectations ramp up, so will regulatory oversight
- Liability considerations
- Family expectations



From "A National Profile of Assisted Living & LTC" slide set by AHCA (American Health Care Assoc) & NCAAL (National Center for Assisted Living)

---

---

---

---

---

---

---

---

### Raising the Ante: Environmental Considerations

- Increasingly, governmental & market forces will pressure the ALF as your residents become part of programs to reduce hospital admissions & readmissions
- Federal: The Affordable Care Act:
  - Accountable Care Organizations
  - Hospital Readmission Reduction Program
  - Bundled Payments
  - Community Based Care Transitions Program
- Market: Care Transition programs:
  - Care Transitions Initiative
  - Transition Care Model
  - Better Outcomes for Older Adults through Safer Transitions (BOOST)
  - Re-Engineered Discharge (Project RED)
  - Interventions to Reduce Acute Care Transfers (INTERACT)



---

---

---

---

---

---

---

---

### What is a "Transition of Care"

- The movement of patients** from one health care practitioner or setting to another as their condition and care needs change
- Occurs at multiple levels**
  - Within Settings**
    - Primary Care ↔ Specialty Care
    - ICU ↔ Ward
  - Between Settings**
    - Hospital ↔ Sub-acute facility
    - Ambulatory clinic ↔ Senior center
    - Hospital ↔ Skilled nursing ↔ ALF ↔ Home Health
  - Across Health States**
    - Curative care ↔ Palliative care/Hospice
    - Personal residence ↔ Assisted living



www.NTOCC.org  
Coleman E. <http://www.caretransitions.org/definitions.asp>

---

---

---

---

---

---

---

---

### Qualitative Studies Have Shown

- Patients and their caregivers are unprepared for their roles in the next setting of care.
- They:
  - Do not understand essential steps in management of their care
  - Cannot contact appropriate health practitioners for guidance
  - Are frustrated by being forced to perform tasks healthcare professionals left undone



---

---

---

---

---

---

---

---

### 30-day Hospital Readmissions – Medicare FFS

- Analysis of Medicare Claims data from 2003-2004
- 11,855,702 Medicare beneficiaries discharged from the hospital
  - 19.6% (nearly 1/5) were re-hospitalized within 30 days
  - 34% were re-hospitalized within 90 days
  - 50.2% of those re-hospitalized within 30 days after a medical discharge there was no bill for a visit to a physician office
  - \$17.4 B est. cost

Jencks SF, et al. N Engl J Med 2009;360:1418-28



---

---

---

---

---

---

---

---

### Re-hospitalizations Update:

- Medicare FFS hospital 30-day readmission rate based upon 2012 data has fallen to 18.4%

Gehardt G et al. Medicare readmission rates showed meaningful decline in 2012. Medicare and Medicaid Research Review. March 2, 2013.

- Annual cost of readmissions to Medicare is \$17.5 billion

Amour S. Hospital readmissions for U.S. medicare patients decline. Bloomberg. Feb 28, 2013.

- Appears to be no "right" 30-day readmission rate, but pressure to reduce the rate will continue



---

---

---

---

---

---

---

---

27

### Geographic Variation of Care

- Variation in Medicare beneficiary spending reveals no evidence that those in high spending areas have better health outcomes than in low spending areas.\*
- If there were no variation in post-acute care services (e.g., HHA, SNF, rehab facilities) Medicare spending would decline by an estimated 73%

\*CM March 2013. Interim Report Of The Committee On Geographic Variation In Health Care Spending And Promotion Of High Value Care: Preliminary Committee Observations  
[http://books.nap.edu/openbook.php?record\\_id=18308](http://books.nap.edu/openbook.php?record_id=18308)

Estimated Medicare per capita for cost for 2014 is \$11,328

CSO



---

---

---

---

---

---

---

---

### Hospital Discharge Concerns



- Upon hospital discharge 30% of patients have at least one medication discrepancy Wong JD, et al. Ann Pharmacother 2008;42:1373-9
- 14.3% with discrepancies readmitted within 30 days versus 6.1% in those with none Coleman EA, Smith JD, Raha D, Mir SJ. Posthospital medication discrepancies: prevalence and contributing factors. Arch Intern Med. 2005;165:1842-7
- Hospital to Nursing Home Adverse drug events (ADEs) attributable to medication changes occurred in 20% of bi-directional transfers
  - 50% of ADEs were caused by discontinuation of medications during hospital stay Boockvar K, et al. Arch Intern Med 2004;164:545-50

---

---

---

---

---

---

---

---

### The Discharge Disconnect

- 49% of patients experienced at least 1 medical error in the hospital to home transition
  - Those with a "work-up" error were 6 times more likely to be re-hospitalized within 3 months (Moore C, et al. J Gen Intern Med 2003;18:646-51)
- 41% of hospital discharged patients have test results returned after discharge. Up to 11% of patients were felt to have actionable abnormal test results - some requiring urgent action - that were *still pending* at discharge; however, PCPs were often unaware of the abnormal results. Roy, Poon et al. Patient safety concerns arising from test results that return after hospital discharge. Ann Intern Med. 2005; 143:121-128




---

---

---

---

---

---

---

---

### SNF Readmissions to Hospital



- In 2006 there were 1.70 million SNF episodes, of which 419,669 (23.5%) re-hospitalized within 30 days
- From 2000-2006 the re-hospitalization rate increased by 29% - from 18.2% to 23.5%
- Total Medicare reimbursements associated with these re-hospitalizations - \$4.34 billion Mix, Inntator, et al. Health Affairs. Jan 2010

---

---

---

---

---

---

---

---

### Observation Stays (OBS)

- Short term treatments provided to outpatients to determine whether beneficiaries require inpatient treatment or can be discharged. US Dept of HHS
- OBS vs. Inpatient Stays:
  - Three key differences in coverage:
    - Part B has a 20% co-pay
    - Part B does not cover the same services as Part A
    - OBS stay days do not contribute toward a Medicare covered SNF stay



Daughtridge, Archibald, Coway, JAMA, March 12, 2014

---

---

---

---

---

---

---

---

### The Affordable Care Act (ACA)

- Enacted in 2010 with evolving programs through 2020
- In its 906 pp a number of programs are influential in, & influenced by Care Transitions. Some prominent ones include:
  - Accountable Care Organizations (ACO)
  - Hospital Readmissions Reduction Program (HRRP)
  - Bundled Payments for Care Improvement (BPCI)
  - Community Based Care Transitions Program (CCTP)



---

---

---

---

---

---

---

---

### Accountable Care Organizations (ACOs)

- Voluntary program initiated in 2012.
- Entity headed by a hospital, physician group or "convener" which receives the CMS reimbursement & distributes payments to all providers.
- Must have an adequate panel of hospitals, clinicians & sites of care to provide quality clinical services.
- Agrees to serve at least 5,000 Medicare FFS recipients for at least 3 yrs.

---

---

---

---

---

---

---

---

**Accountable Care Organizations (ACOs)-cont.**

- Performance is based upon:
  - Prior financial benchmarks (what the cost of care was for patients prior to the ACO)
  - 33 quality measures
  - Recently proposed that one quality measure be 30-day readmission rates



---

---

---

---

---

---

---

---

**Hospital Readmission Reduction Program (HRRP)**

- Initiated October 2012 (FY 2013) for "excessive" 30 day hospital readmissions in AMI, CHF & Pneumonia
  - Penalty is for ALL Medicare diagnoses when initiated
  - 1% penalty affected >2000 hospitals & resulted in >\$280 million in penalties in FY 2013  
Kaiser Health News: Rau J  
<http://www.kaiserhealthnews.org/Stories/2012/August/13/medicare-hospitals-readmissions-penalties.aspx>
- Penalty 2% in FY 2014
  - Projected to affect 2,225 hospitals and result in \$227 million in penalties  
Kaiser Health News: Rau J  
<http://www.kaiserhealthnews.org/Stories/2013/August/02/readmission-penalties-medicare-hospitals-year-two.aspx>
- Increasing to 3% in FY 2015 (Oct 2014)



---

---

---

---

---

---

---

---

**HRRP (cont.)**

- Expands to include diagnoses of COPD, hip & knee joint replacement surgery in FY 2015
- Proposed to add CABG to this list in 2017
- Structured so that about half of all hospitals will always be penalized
- Thus far, hospitals serving low income patients are far more likely to be penalized



---

---

---

---

---

---

---

---

**Bundled Payments** 

- Initiated 2013 with 4 distinct models
- Voluntary
- Sets payment for an "episode of care" based on historical costs & readmission rates
- If the entity can deliver *quality* care below the "bundle price," eligible to participate in the savings.
- Depending on which model chosen can select from 48 episodes of care, for 30-60-90 days as prospective or retrospective reimbursement.

---

---

---

---

---

---

---

---

**Community Based Care Transitions Program (CCTP)**

- 5-year demonstration created by Section 3026 of the ACA initiated in 2011. It provides funding to local community based organizations (CBOs) as the payee.
- CBOs are contracted to provide services across the continuum of care and must have formal agreements with a suitable array of partners, including hospitals.
- CBOs partner with acute care hospitals to test models of improved care transitions for high-risk Medicare patients. There must also be sufficient representation of multiple health care stakeholders, including consumers, on the board.
- Initial award is for 2 years, with annual renewal based upon performance. 102 sites are participating across the country providing care transition services to nearly 700,000 Medicare beneficiaries in 40 states.
- Initially, \$500 million was authorized to be distributed over 5 years to eligible CBOs. In March 2013, the Senate stripped \$200 million from the appropriation.

---

---

---

---

---

---

---

---

**THE CLINICAL ENVIRONMENT:  
Current Transition Models – A Sampling**



---

---

---

---

---

---

---

---



### Project RED

The Re-Engineered Discharge (RED) program was developed at Boston University Medical Center (BUMC) to improve hospital discharge planning.

**IMPLEMENTATION**  
A "discharge advocate," or specially trained nurse, educates patients about their diagnoses throughout the hospital stay, organizes post-discharge health-care services, verifies the medication plan, follows evidence-based guidelines, provides a written discharge plan and tests patient understanding of it, ensures the discharge summary gets to outpatient providers, and calls to reinforce the plan 2-3 days later. A toolkit and technical assistance is available to hospitals that use Project RED.

**IMPACT**  
Project RED significantly reduced hospital utilization and was especially effective for patients with higher rates of hospital utilization the previous six months.<sup>1</sup>

1. <http://www.lafayettegeneral.com/Images/Interior/pdf-documents/reengineered%20discharge%20plan.pdf>

---

---

---

---

---

---

---

---

---

---



### Project BOOST

The intervention was created by the Society of Hospital Medicine in Philadelphia. BOOST (Better Outcomes for Older adults through Safe Transitions) seeks to reduce 30-day readmission rates, with a focus on older adults; improve discharge patient satisfaction and HCAHPS scores; improve communication between hospital and outpatient physicians and providers; identify high-risk patients and target specific interventions to minimize adverse events; and improve patient and family discharge preparation.

**IMPLEMENTATION**  
The program, includes step-by-step project management tools such as a TeachBack training. It offers in-person training, followed by a year of mentoring and coaching. The mentoring program provides a train-the-trainer DVD and curriculum for nurses and case managers on using the process, and webinars targeting the educational needs of other team members including administrators, data analysts, physicians, and nurses. BOOST also has a listserve, community website, and quarterly webinars and teleconferences. The BOOST Data Center allows clients to store and benchmark data against others and generates reports.

**IMPACT**  
At six BOOST sites, 30-day readmission rates were reduced from 14.2 percent to 11.2 percent.<sup>1</sup>

1. <http://www.hospitalmedicine.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/HTMLDisplay.cfm&CONTENTID=27543>

---

---

---

---

---

---

---

---

---

---



### Transitional Care Model

The model, developed by Mary Naylor, RN, and colleagues at the University of Pennsylvania School of Nursing, provides pre- and post-discharge interventions by advanced practice nurses for high-risk, high-cost elderly patients with chronic conditions.

**IMPLEMENTATION**  
The nurses coach patients and their caregivers on managing their conditions, coordinate follow-up care, participate in home visits, and are available by phone for two months after discharge.

**IMPACT**  
At six Philadelphia hospitals, the model reduced readmissions by 36 percent and reduced costs by nearly \$5,000 per patient 12 months after discharge.<sup>1</sup>

1. <http://www.ncbi.nlm.nih.gov/pubmed/21471497>

---

---

---

---

---

---

---

---

---

---

**The CARE TRANSITIONS PROGRAM**

### Care Transitions Program

Pioneered by Denver geriatrician Eric Coleman, the program targets the social determinants of health, as well as a patient's medical and mental health needs. Transitions Coaches, primarily nurses and social workers, meet patients in the hospital and follow up with one home visit and phone calls over a four-week period.

**IMPLEMENTATION**  
 The essence of the Care Transitions Intervention (CTI) is skill transfer. This prepares patients for self-care and helping them achieve their goals. Transition Coaches work with patients on managing medications; scheduling and preparing for follow-up care; recognizing and responding to symptoms that could indicate a worsening condition; and taking ownership of their personal health by having patients become more active in their own care.

**IMPACT**  
 In a large integrated delivery system in Colorado, the Care Transitions program reduced 30-day hospital readmissions by 30 percent, reduced 180-day hospital readmissions by 17 percent, and cut average costs per patient by nearly 20 percent. The intervention has been adopted by 870 organizations in 43 states.

1. <http://www.mefiand.org/follow/763>  
 2. <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>  
 3. [http://healthaffairs.org/healthpolicybrief/brief\\_pdf/healthpolicybrief\\_76.pdf](http://healthaffairs.org/healthpolicybrief/brief_pdf/healthpolicybrief_76.pdf)

---

---

---

---

---

---

---

---

---

---

### ALF Transfers: Principles to Consider

- Better communication
  - Between caregivers & clinicians
  - During the transition process when necessary
- Medication reconciliation
- Clarifying advance directives

---

---

---

---

---

---

---

---

---

---

### Transitions of Care in the Long-Term Care Continuum (TOC CPG): AMDA

- <http://www.amda.com/tools/clinical/toccpg.pdf>
- Seven steps to safer transitions in the LTCC
- Both planned & unplanned transitions
- 99 pages, 16 tables & 14 appendices
- Products, Resources, References & Bibliography
- Access and use is free of charge




---

---

---

---

---

---

---

---

---

---

**Key Elements of the AMDA CPG in Safe Transitions**

1. IDT members communicate with each other
2. Communication with the receiving entity is performed.
3. End-of-life/Palliative care instead of unnecessary transfers is provided based upon resident wishes.
4. Verify the patient/resident has arrived at the receiving entity & appropriate information is received.
5. Accountability & responsibility is assigned for each step of a transition.
6. Monitor performance by specific measures with feedback & continuous quality improvement.




---

---

---

---

---

---

---

---

**TABLE 5: (p. 23)**  
**Essential Information That Should Accompany Every Transitioning Patient**

- Patient name
- Primary diagnosis for admission to sending facility
- Accurate medication list with prescription and non-prescription drugs, with doses and frequency
- Allergies and medication intolerances
- Vital signs
- Copies of advance directives including AND/DNR status
- Name and specific contact information for:
  - Sending facility (including phone number of facility/wing of facility and nurse name)
  - Responsible practitioner at sending and receiving sites of care
  - Responsible family member/decision-maker
- Barriers to communication
  - English comprehension is poor: provide primary language spoken by the patient
  - Vision: requires glasses to appropriately see, blind, etc.

AMDA 10C CPG

---

---

---

---

---

---

---

---

**TABLE 5 (cont.):**  
**Essential Information That Should Accompany Every Transitioning Patient**

- Hearing impairment
- Cognitive issues that impair decision-making; who should be contacted for decision-making
- Health literacy or cultural issues that may inhibit communication
- Reason for transfer (i.e., the acute change in condition or problem precipitating the transfer) along with any acute changes from baseline associated with this transfer (e.g., confusion, unable to walk, unresponsive)
- Medical devices, lines (e.g., central line, dialysis site, pacemaker) or wounds
- Patient's ability to feed self, special dietary needs (e.g., pureed foods, low-salt diet)
- Significant test results
- Tests with results pending, consults or procedures ordered but not yet performed
- Prognosis and goals of care

AMDA 10C CPG

---

---

---

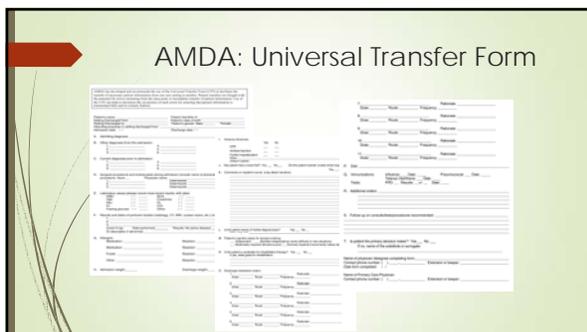
---

---

---

---

---




---

---

---

---

---

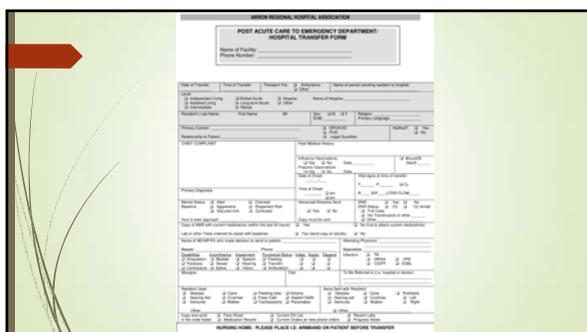
---

---

---

---

---




---

---

---

---

---

---

---

---

---

---



## INTERACT

The Interventions to Reduce Acute Care Transfers (INTERACT) program helps nursing home staff identify, assess and manage the severity of chronic conditions to avoid hospitalizations. The program also seeks to improve advance care and palliative care planning to keep patients out of the hospital at the end of life. The program was pioneered by Joseph Duslander, MD, and Mary Perloe.

**IMPLEMENTATION**  
 INTERACT uses tools to enable communication, care paths, and advance care planning.

**IMPACT**  
 INTERACT was evaluated at 25 nursing homes over a six-month period in 2009. The program reduced hospitalizations by 17 percent. The average intervention cost was \$7,700 and researchers estimate that Medicare could save about \$125,000 annually in a 100-bed nursing home.

1. <http://online.library.wiley.com/doi/10.1111/j.1532-5415.2011.03333.x/abstract>

---

---

---

---

---

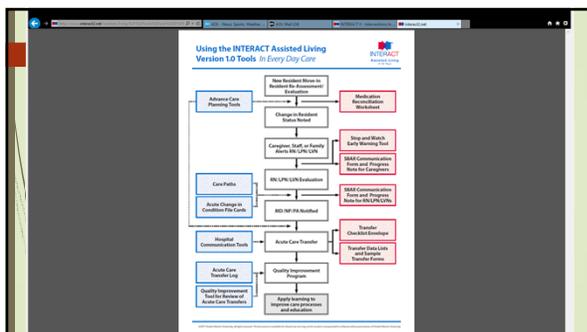
---

---

---

---

---




---

---

---

---

---

---

---

---

---

---

**INTERACT** Interventions to Reduce Acute Care Transfers

Home | About INTERACT | INTERACT Tools | Educational Resources | Links to Other Resources | Project Team | Contact Us

**Assisted Living Tools New!**

**Overview of the INTERACT Quality Improvement Program for Assisted Living**

- INTERACT Assisted Living Version 1.0 Tools Table
- Using the INTERACT Assisted Living Version 1.0 Tools in Every Day Care - Overview Figure
- Assisted Living V.1.0 Tool Implementation Guide 2014

**Quality Improvement Tools for Assisted Living**

**Tracking Hospitalization Rates**

- Acute Care Transfer Log

**Quality Improvement Reviews - Root Cause Analyses**

- Quality Improvement Tool for Review of Acute Care Transfers
- Quality Improvement Summary

**Program Implementation**

- Implementation Checklist

[www.interact2.net](http://www.interact2.net)

---

---

---

---

---

---

---

---

---

---

**Acute Care Transfer Log**

You can use this tool as a worksheet for recording all acute care transfers during a month. Print more pages as needed. Instructions for calculating hospitalization rates are available on the INTERACT website (<http://interact2.net>).

Assisted Living Name: \_\_\_\_\_ Month/Year: \_\_\_\_\_

Resident ID	Resident Name	Resident Address	Resident Phone	Resident Email	Date of Birth	Date of Transfer	Reason for Transfer	Transfer to	Transfer by
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									

1) Range - column one through 18 - column 10 - column 10  
 2) IP - identified as an inpatient, OHS - identified as observation status, ER - emergency room and only with return to the facility (includes residents who die in the ambulance or ED)  
 3) Examples of reasons for the above subsequent Transfer from: Wandering, Confusion, Chast Pun, CPE/CODE, Dehydration, Electrolyte Imbalance, Fall/G-rolling, Abusive events, Pneumonia, Respiratory infections, Seizure, Sepsis, Shortness of Breath, UTI, Other

---

---

---

---

---

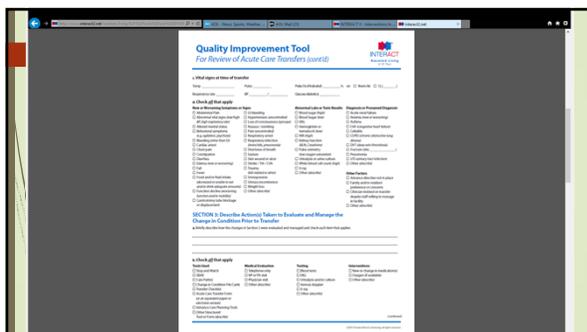
---

---

---

---

---



---

---

---

---

---

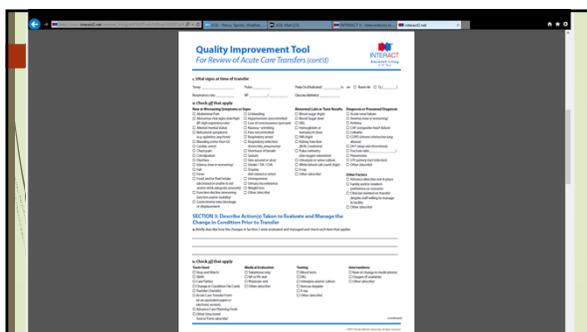
---

---

---

---

---



---

---

---

---

---

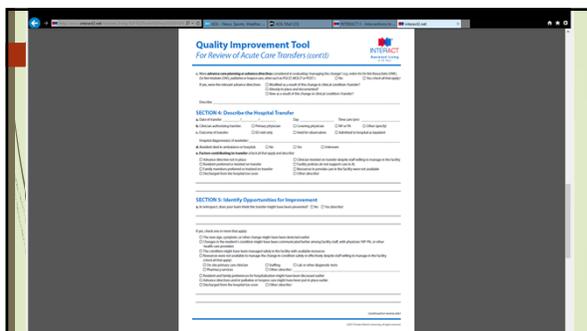
---

---

---

---

---



---

---

---

---

---

---

---

---

---

---



---

---

---

---

---

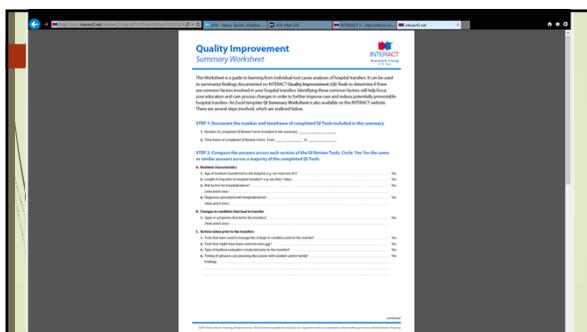
---

---

---

---

---



---

---

---

---

---

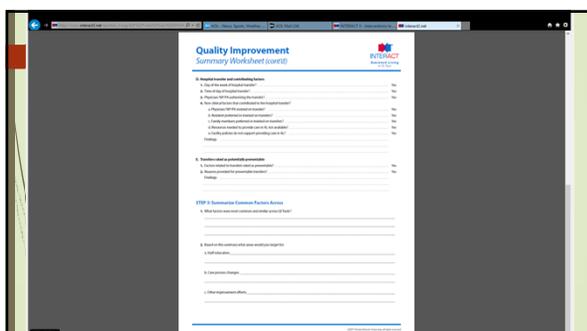
---

---

---

---

---



---

---

---

---

---

---

---

---

---

---

**Decision Support Tools: Change in Condition File Cards and Care Paths for Assisted Living**

**Acute Change in Condition File Cards**

- [Acute Change in Condition File Cards](#)

**Care Paths** Updated Care Paths will be available soon

- [Acute Mental Status Change](#)
- [Change in Behavior: Evaluation of Medical Causes of New or Worsening Behavioral Symptoms](#)
- [Dehydration \(potential for\)](#)
- [Fever](#)
- [Gastrointestinal \(GI\) Symptoms](#)
- [Shortness of Breath \(SOB\)](#)
- [Symptoms of Congestive Heart Failure \(CHF\)](#)
- [Symptoms of Lower Respiratory Infection](#)
- [Symptoms of Urinary Tract Infection \(UTI\)](#)

---

---

---

---

---

---

---

---

**Change in Condition: When to report to the MD/NP/PA**

**Immediate Notification**

Any symptom, sign or apparent discomfort that is:

- **Acute or Sudden** in onset, and:
- **A Marked Change** (i.e. more severe) in relation to usual symptoms and signs, and
- **Unrelieved** by measures already prescribed

**Non-Immediate Notification**

- New or worsening symptoms that do not meet above criteria

This guidance is adapted from: AMDA Clinical Practice Guideline – Acute Changes in Condition in the Long-Term Care Setting 2003; and Ostendorp, J, Osterwald, D, Morley, J. Medical Care in the Nursing Home. McGraw Hill, 1996.

---

---

---

---

---

---

---

---

**CARE PATH**  
Acute Mental Status Change

```
graph TD
    Start[New Mental Status Change Suspected] --> Mild[Mild]
    Start --> Severe[Severe]
    Mild --> Eval[Further Nursing Evaluation]
    Eval --> MonitorM[Monitor Status and Signs]
    Severe --> MonitorS[Monitor Status and Signs]
    MonitorM --> Report[Report to MD/PA]
    MonitorS --> Report
    MonitorB[Monitor Breaths] --> Report
```

---

---

---

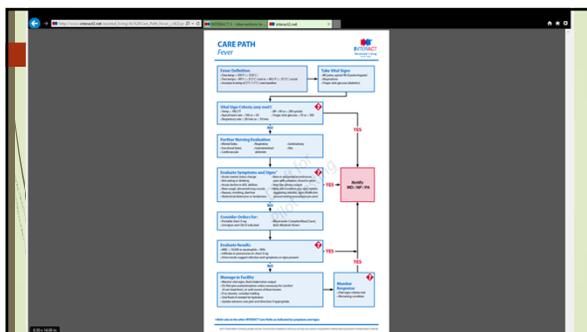
---

---

---

---

---



---

---

---

---

---

---

---

---

- ### Advance Care Planning Tools for Assisted Living
- [Advance Care Planning Tracking Form](#)
  - [Advance Care Planning Communication Guide](#)
  - [Identifying Residents Who May be Appropriate for Hospice or Palliative/Comfort Care Orders](#)
  - [Comfort Care Interventions - Examples](#)
  - [Deciding About Going to the Hospital](#)
  - [Education on CPR For Residents and Families](#)
  - [Education on Tube Feeding For Residents and Families](#)

---

---

---

---

---

---

---

---

- ### Communication Tools for Assisted Living
- For Communication Within the Assisted Living Facility
- [Stop and Watch Early Warning Tool](#)
  - [Stop and Watch Early Warning Tool - in Spanish](#)
  - [SBAR Communication Form and Progress Note for RN/LPN/LVNS](#)
  - [SBAR Communication Form and Progress Note For Caregiver \(other than nurses\)](#)
- For Communication Between the Assisted Living and Hospital
- [Assisted Living Capabilities List](#)
  - [Assisted Living to Hospital Transfer Form](#)
  - [Assisted Living To Hospital Transfer Data List](#)
  - [Acute Care Transfer Document Checklist](#)
  - [Hospital to Assisted Living Transfer Form](#)
  - [Hospital to Assisted Living Transfer Data List](#)
  - [Medication Reconciliation Worksheet](#)

---

---

---

---

---

---

---

---

**Stop and Watch Early Warning Tool**

If you have identified an important change while caring for or visiting a resident, please circle the change and notify a nurse or supervisor.

**S** Seems different than usual  
**T** Talks or communicates less  
**O** Overall needs more help  
**P** Pain - new or worsening; Moans or grumbles (for residents with severe dementia); participated less in activities  
**A** Ate less  
**R** No bowel movement in 3 days; or diarrhea  
**d** Drank less  
**W** Weight change  
**A** Agitated or nervous more than usual  
**T** Tired, smoky, confused, or drowsy  
**C** Change in skin color or condition  
**H** Help with walking, transferring, toileting more than usual

Name of Resident \_\_\_\_\_  
Your Name \_\_\_\_\_  
Observation Reported to \_\_\_\_\_ Date and Time (approx) \_\_\_\_\_  
Name/Supervisor Response \_\_\_\_\_ Date and Time (approx) \_\_\_\_\_

Note: Supervisor Name  
This form is not intended for use as a substitute for other resident health care or for other services including those listed by the Resident Center for Resident Living with Dementia (see below)

---

---

---

---

---

---

---

---

---

---

**SBAR Communication Form and Progress Note for RN/LPN/CNA in Assisted Living**

Before Calling the Physician (NPI/PN) or Other Health Care Professional  
Resident Name: \_\_\_\_\_ Room Number: \_\_\_\_\_ Date/Time: \_\_\_\_\_  
Subjective: \_\_\_\_\_  
Objective: \_\_\_\_\_  
Assessment: \_\_\_\_\_  
Plan: \_\_\_\_\_

**Situation**  
Resident Name: \_\_\_\_\_ Room Number: \_\_\_\_\_ Date/Time: \_\_\_\_\_  
What is the problem or situation or what you observed?  
How long has the problem/situation been going on?  
How long has the problem/situation been going on?  
Resident's response to your intervention:  No  Yes  
Resident's current condition:

**Background**  
Resident History: \_\_\_\_\_  
Current Medications: \_\_\_\_\_  
Recent Events: \_\_\_\_\_

**Assessment**  
Subjective: \_\_\_\_\_  
Objective: \_\_\_\_\_  
Assessment: \_\_\_\_\_  
Plan: \_\_\_\_\_

---

---

---

---

---

---

---

---

---

---

**SBAR Communication Form and Progress Note for RN/LPN/CNA in Assisted Living**

Before Calling the Physician (NPI/PN) or Other Health Care Professional  
Resident Name: \_\_\_\_\_ Room Number: \_\_\_\_\_ Date/Time: \_\_\_\_\_  
Subjective: \_\_\_\_\_  
Objective: \_\_\_\_\_  
Assessment: \_\_\_\_\_  
Plan: \_\_\_\_\_

**Assessment**  
Subjective: \_\_\_\_\_  
Objective: \_\_\_\_\_  
Assessment: \_\_\_\_\_  
Plan: \_\_\_\_\_

---

---

---

---

---

---

---

---

---

---



The image shows a screenshot of a web-based form titled "Assisted Living to Hospital Transfer Form (additional information)". The form is divided into several sections with blue headers: "Patient Information", "Medical History", "Assisted Living Information", "Hospital Information", and "Transfer Information". Each section contains various text input fields, checkboxes, and dropdown menus. The form is presented in a browser window with a dark background.

---

---

---

---

---

---

---

---

### Mediation Perils Leading to Hospital Admissions

- ▶ Hospital to Nursing Home Adverse drug events (ADEs) attributable to medication changes occurred in 20% of bi-directional transfers
- ▶ 50% of ADEs were caused by discontinuation of medications during hospital stay Boockvar E, et al. Arch Intern Med 2004;164:545-50
- ▶ 10-30% of hospital admits in elders are drug-related. Cot et al., 1990; HORN et al., 2001; Pincus et al., 2005; Cypriotti et al., 2004
- ▶ 20% of readmissions to the hospital in a geriatric population of 706 were drug related and 75% could have been prevented with proper med use. Bero et al.
- ▶ Nearly two-thirds of NH residents had ADRs over a 4-year period, with one in seven resulting in hospitalizations. Casper JW 1999

---

---

---

---

---

---

---

---

### Medication Discrepancies

- ▶ "Medication Reconciliation in Continuum of Care Transitions: A Moving Target"
- ▶ Results: We reviewed 1696 medications in the 132 transition records of 44 patients, identifying 1002 discrepancies. Average age was 71.4 years and 68% were female.
- ▶ Conclusion: This study is the first to follow medication changes throughout 3 transition care points in a large health care system and to demonstrate the widespread prevalence of medication discrepancies at all points. Our findings are consistent with previously published results, which all focused on single site transitions. Outcomes of the current reconciliation process need to be revisited to insure safe delivery of care to the complex geriatric patient as they transition through health care systems.

---

---

---

---

---

---

---

---

**Medication Reconciliation Worksheet for Post-Hospital Care**

Part 1: Hospital Recommended Medications/Needing Clarification

Medication Name (Include Strength, Dosage, Frequency, Route)	Dosage/Route	Clarification/Action

Part 2: Medications Prior to Hospitalization/Needing Clarification

Medication Name (Include Strength, Dosage, Frequency, Route)	Dosage/Route	Clarification/Action

Resident Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

---

---

---

---

---

---

---

---

### Create a Relationship with a Consultant Pharmacist

- Medication evaluation with new arrivals & post-hospital
- Periodic review of resident medication
  - Beer's list
  - Duplications of drugs
  - Drug interactions
  - OTC medications
- Respond to medication questions by residents and/or families
- Immunizations



---

---

---

---

---

---

---

---

### End-of-Life/Palliative Care



---

---

---

---

---

---

---

---

### End-of-Life & ED Utilization

- In the last month of life, 41% of NH residents visited the Emergency Department
- In the last month of life, 3% of hospice enrollees & 56% of seniors not enrolled in hospice care (including both community & NH seniors) visited an ED



Alexander K. Smith, M.D. & Researchers in the Division of Geriatrics at UCSF

---

---

---

---

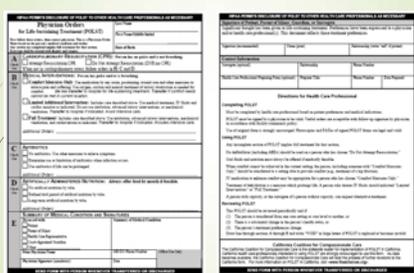
---

---

---

---

### POLST




---

---

---

---

---

---

---

---

### Not a "Yes-No" Scenario

- Clarify Advance Directives, not "DNR: Yes/No" upon admission & each readmission... & document it
- Does the patient want:
  - Chest compression/intubation
  - IV antibiotics
  - Tube feeding
  - Re-hospitalization, etc...
- Facility policy to designate a site in the chart where the Advance Directives are located




---

---

---

---

---

---

---

---

**Create a Relationship with a Physician**

- On-site appointments & round in rooms
- Respond when unable to reach regular physician
- Interaction with the hospital/ED when problems arise
- On-site educational sessions for staff, residents & families
- Assistance with Advance Directives/POLST
- Immunizations
- Policies for transitions



---

---

---

---

---

---

---

---

**QA**  
**QUESTIONS**

Contact Information James E.  
Leit, II, MD, CMD  
[jlett2md@aol.com](mailto:jlett2md@aol.com)

---

---

---

---

---

---

---

---