Care Transitions in the Assisted Living Setting
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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.

Coleman, Min, Chomiak & Kramer, HSR: Health Services Research. 39:5 (October 2004)

<table>
<thead>
<tr>
<th>One Transition</th>
<th>Two Transitions</th>
<th>Three Transitions</th>
<th>Four or More Transitions</th>
<th>Resulted in Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>61.2%</td>
<td>13.9%</td>
<td>8.8%</td>
<td>4.3%</td>
<td>8.1%</td>
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Transitions – A Human Cost
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/nsltcp.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

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Depression & Dementia

Assistance with ADLs in LTC -- 2012

Common Chronic Conditions in RCFs -- 2010
National Survey of Residential Care Facilities: Residents’ Cognitive Abilities – 2010

- 48.7% experience confusion
- 48% 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 National Survey of Residential Care Facilities

From “A National Profile of Assisted Living & LTC” slide set by AHCA (American Health Care Assoc) & NCAL (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
- 58% 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

Source: “A National Profile of Assisted Living & LTC” slide set by AHCA (American Health Care Assoc) & NCAL (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
Raising the Ante: Environmental Considerations

- Increasingly, governmental and market forces will pressure the ALF as your residents become part of programs to reduce hospital admissions and 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 conditions and care needs change.
- Occurs at multiple levels:
  - Within settings:
    - Primary Care
    - Specialty Care
    - ICU
    - Ward
  - Between settings:
    - Hospital
    - Sub-acute facility
    - Skilled nursing
    - Ambulatory clinic
    - Senior center
    - Home Health
  - Across health states:
    - Curative care
    - Palliative care/Hospice
    - Personal residence
    - Assisted living

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 health care 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 Billion cost


Re-hospitalizations Update:

- Medicare FFS hospital 30-day readmission rate based upon 2012 data has fallen to 18.4%
- Annual cost of readmissions to Medicare is $17.5 billion
- Appears to be no “right” 30-day readmission rate, but pressure to reduce the rate will continue


- Annual cost of readmissions to Medicare is $17.5 billion


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%.


Estimated Medicare per capita for cost for 2014 is $11,306.
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, Min 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.

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. Mor, Intrator, 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:
    1. Part B has a 20% co-pay
    2. Part B does not cover the same services as Part A
    3. 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 (ACOs)
  - 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 for all Medicare diagnoses involved
- Originally affected 200 hospitals; expanded to additional hospitals in FY 2013
- Kaiser Health News; Rau J

- Penalty 1% in FY 2013 for all Medicare diagnoses in hospitals in FY 2013
- Resulted in >$280 million in penalties

- Penalty 2% in FY 2014
- Proposed to affect 12,000 hospitals & result in $227 million in penalties
- Kaiser Health News; Rau J

- Increasing to 3% in FY 2015 (Oct 2014)

HRRP (cont.)

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

IMPLEMENTATION

A “discharge educator,” or specially trained nurse, educates patients about their diagnoses throughout the hospital stay, provides pre-discharge and education, verifies the medication plan, follows up, ensures discharge summary gets to outpatient providers, and calls to confirm the plan 2–4 days later.

IMPACT

Project RED significantly reduced hospital utilization and was especially effective for patients with higher rates of hospital utilization the previous six months.


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; implement 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 Toolbook training. It offers in-person training, followed by a year of mentoring and coaching. The mentoring program provides a care manager and monitor and is available for nurses and case managers of age at all the participating hospitals. It involves a run-on care management team, care managers, clinicians, and patients. BOOST also has a leadership, community outreach, and quality improvement teams. The BOOST Data Center allows clients to store data benchmark data against others and generate reports.

IMPACT

At six BOOST sites, 30-day readmission rates were reduced from 16.2 percent to 11.2 percent.


Transitional Care Model

The Transitional Care Model (TCM), developed by Mary Rogers, 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 teach 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 $1,000 per patient 12 months after discharge.

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.


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

- Seven steps to safer transitions in the LTC
- 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)

<table>
<thead>
<tr>
<th>Essential Information That Should Accompany Every Transitioning Patient</th>
</tr>
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<tbody>
<tr>
<td>Patient name</td>
</tr>
<tr>
<td>Primary diagnosis for admission to sending facility</td>
</tr>
<tr>
<td>Accurate medication list with prescription and non-prescription drugs, with doses and frequencies</td>
</tr>
<tr>
<td>Allergies and medication intolerances</td>
</tr>
<tr>
<td>Vital signs</td>
</tr>
<tr>
<td>Copies of advance directives including AND/RNR status</td>
</tr>
<tr>
<td>Name and specific contact information for:</td>
</tr>
<tr>
<td>Sending facility (including phone number of facility/wing of facility and name)</td>
</tr>
<tr>
<td>Responsible practitioner at sending and receiving sites of care</td>
</tr>
<tr>
<td>Responsible family member/decision-maker</td>
</tr>
<tr>
<td>Barriers to communication</td>
</tr>
<tr>
<td>English comprehension is poor: provide primary language spoken by the patient</td>
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</tbody>
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TABLE 5 (cont.): (p. 23)

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<th>Essential Information That Should Accompany Every Transitioning Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing impairment</td>
</tr>
<tr>
<td>Cognitive issues that impair decision-making; who should be contacted for decision-making</td>
</tr>
<tr>
<td>Health literacy or cultural issues that may inhibit communication</td>
</tr>
<tr>
<td>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)</td>
</tr>
<tr>
<td>Medical devices, lines (i.e., central line, dialysis line, pacemaker) or wounds</td>
</tr>
<tr>
<td>Patient’s ability to feed self; special dietary needs (i.e., pureed foods, low-salt diet)</td>
</tr>
<tr>
<td>Significant test results</td>
</tr>
<tr>
<td>Tests with results pending, consultation procedures ordered but not yet performed</td>
</tr>
<tr>
<td>Prognosis and goals of care</td>
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</tbody>
</table>
The Interactions 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 Ouslander, 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.

Advance Care Planning Tools for Assisted Living

- Advance Care Planning Timeline Form
- Advance Care Planning Communication Guide
- Identifying Residents Who May Be Appropriate for Hospice or Palliative Care Orders
- Comfort Care Interventions - Examples
- Opening Road Maps to the Hospital
- Education on CPRs for Residents and Families
- Education on Title XIX for Residents and Families

Communication Tools for Assisted Living

For Communication Within the Assisted Living Facility:
- Shop and Visit Guests - Telephone Tool
- Shop and Visit Guests - Telephone Tool - in Spanish
- OHSU Communication Form and Process Notes for PHN/PACU
- OB/GYN Communication Form and Process Notes for Gonorrhea (other than major)

For Communication Between the Assisted Living and Hospital:
- Assistant Living Capabilities List
- Assistant Living to Hospital Transfer Form
- Assistant Living to Hospital Transfer Data List
- Add a Care Transient Document Completed
- Hospital to Assistant Living Transfer Form
- Hospital to Assistant Living Transfer Data List
- Medication Reconciliation Worksheet
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, et al. Arch Intern Med 2004;164:545-50)
* 10-30% of hospital admissions are drug-related. (Col, et al., 1990; Hohl, et al., 2001; Passarelli, et al., 2005; Grymonpre, et al., 2004)
* Nearly two-thirds of NH residents had ADRs over a 4-year period, with one in seven resulting in hospitalizations. (Cooper, 1999)

Medication Discrepancies

* "Medication Reconciliation in Continuum of Care Transitions: A Moving Target"
* Results: We reviewed 1096 medications in the 132 transition records of 44 patients, identifying 1000 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 ensure safe delivery of care to the complex geriatric patient as they transition through health care systems.
Create a Relationship with a Consultant Pharmacist

- Medication evaluation with new arrivals & post-hospital
- Periodic review of resident medication
- Beers’ 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

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