

Successful Transitions for Assisted Living Residents

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Objectives

- Review precepts of transitional care best practices
- Understand why Assisted Living Facilities must begin to prioritize work with care transitions
- Discuss proven approaches to assist your organization to improve transitions: Including tools and processes being piloted in Madison

Introductions.....

- RN since 1980
- Dually certified as a Geriatric NP and a Family NP
- 2005 – co founded UW Acute Care for Elders (ACE) interdisciplinary consult team
- 2012- Accepted the Director of Transitional Care role for UW Health
- Doctorate of Nursing Practice
Candidate in Systems Leadership
December, 2015



What Do I Do?

- **Develop, coordinate and evaluate** transitional care initiatives across the UW Health system
- **Implement and evaluate** these initiatives across the healthcare continuum (including community partners)
- Make **recommendations for improvement** based upon evidence-based research and protocols

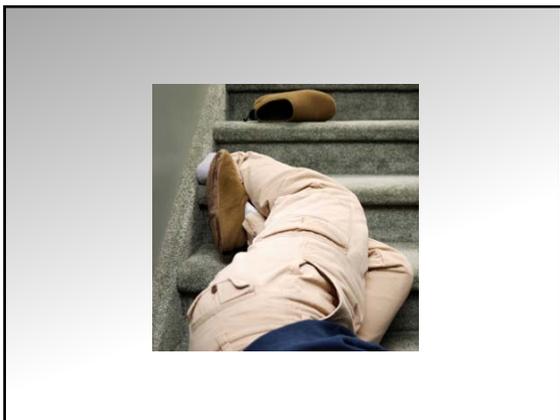
What Do You Do?



Meet Joe....



- 78 year old male
- Living in your facility x 6 months
- Ambulatory
- Mild memory issues
- Comorbidities
 - Heart Failure
 - Chronic Obstructive Pulmonary Disease
 - Diabetes controlled by diet



Transfer to Hospital

- Joe is conscious but flustered
- ALF staff calls 911
- Ambulance arrives and wants to leave
- Staff can't find any medical papers to send with ambulance to the ED
- Joe arrives at the ED

What's Going to Happen ?



Why Dangerous?

- Care is rushed at the time of transition/handoff
- Responsibility fragmented
- No designated accountability of sender-receiver
- Little (if any) standard communication (or tools) used across settings
- Low patient/family engagement in their own health care

What's Needed: Transitional Care

- **Set of actions** designed to ensure coordination and continuity of the resident's healthcare
- **Based on a comprehensive, well thought out care plan and the availability** of well-trained practitioners who have current information about the resident's:
 - treatment goals
 - preferences
 - health or clinical status

www.ntocc.org



Initial Call to Action
The Affordable Care Act of 2010

- Affordable Care Act (ACA) of 2010
 - established multiple initiatives related to safe transitions of care and avoidance of unnecessary hospital readmissions.
 - 2600 page bill
 - All initiatives focus on cost containment and care coordination between sites

Scrutiny....Shared

- **Skilled Nursing Facilities:** now under increased scrutiny for cost, care coordination and quality metrics
- **Assisted Living Facilities:** (when?)
 - One of the largest providers of care in U.S.
 - Third largest in terms of revenue \$33B
 - 90% of referrals to ALFs come from hospitals
 - Push for quality because....

Hospitals (and payers) want to know where they are sending their patients ...for multiple reasons.....

Leading Age 2014-2015 report

Patient Rights During Transitions of Care

- You have the right ..
 - to be treated fairly and with respect during care transitions.
 - to care transitions that fit your situation
 - to know why a care transition is needed
 - to say what you want and need during care transitions
 - to take part in planning care transitions for yourself or you loved one
 - to know your costs related to care transitions
 - to know the people and organization involved in your care transitions
 - to know the next steps during care transitions
 - to privacy and to your health care information during care transitions
 - to get help when care transitions don't go well

www.NTOCC.org

Pressure...

- There is tremendous pressure from government and payers to get a handle on health care costs...
- Insurers are beginning to refuse payment for unnecessary re-hospitalizations and health care

An illustration of a large, faceted diamond being weighed on a small scale. Two DNA double helix structures are positioned on either side of the diamond, suggesting a connection between genetics and healthcare costs.

Medicare: Cost Containment

- Cost of readmissions for Medicare patients: \$26 billion/annually
- More than \$17 billion for readmissions that need not happen

A photograph showing several stacks of US dollar bills and some coins scattered on a surface, symbolizing financial costs.

Most Importantly

A graphic of a purple-bordered sticker with the text "Do The Right Thing" in a stylized font. "Do The" is in a light blue script, "Right" is in large red letters, and "THING" is in blue block letters.

Question

- What work have you started to improve care transitions for your residents ?



Transitional Care

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**Transitional Care Models
Evidence Based**

<p>Care Transitions Intervention (CTI) Eric Coleman</p> 	<p>Gives patients with complex care needs and family caregiver's specific tools, and allows them to work with a Transitions Coach to learn transition specific management skills.</p>
<p>Transitional Care Model (TCM) Mary Naylor</p> 	<p>Establishes a multidisciplinary team, led by master's prepared transitional care nurses, to treat chronically ill high risk older patients before, during and after discharge from the hospital.</p>

**Transitional Care Models
Evidence Based**

<p>The Guided Care Model (Johns Hopkins)</p>	<p>Driven by highly skilled Guided Care Nurses who coordinate care for chronically ill patients.</p>
<p>Project RE-Engineered Discharge (RED) Dr. Brian Jack</p> 	<p>Project RED focuses on a standardized discharge process to ensure patients are prepared when leaving the hospital.</p>

**Transitional Care Models
Evidence Based**

<p>Better Outcomes by Optimizing Safe Transitions (BOOST) Society of Hospital Medicine</p>	<p>Provides hospitals with project management tools and expert mentoring. Universal Discharge List 8P's Risk for Readmission Tool</p>
<p>Interventions to Reduce Acute Care Transfers (INTERACT)</p>	<p>Toolkit for SNF personnel to reduce avoidable hospital admissions focusing on: Communication Clinical care paths Advance care planning.</p>

**Transitional Model
Evidence Based**

<p>The Coordinated-Transitional Care (C-TraC) Dr. Amy Kind Madison VA Hospital</p> 	<p>Telephonic program Patients work with specially trained RN's on care and health issues, including medication reconciliation, before and after hospital discharge. All contacts are made by phone once the patient is home. Patients who received the C-TraC protocol experienced 1/3 fewer rehospitalizations than those in a baseline comparison group, producing an estimate savings of \$1,225 per patient new of programmatic costs. UW Hospital has had significant outcomes</p>
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Kind A, Jensen L, Barczi S. (2012)

Commonalities of the Models

- **Current programs share the following interventions:**
 - **Medication management**
 - **Transition planning** with a clearly identified practitioner
 - Patient and family **engagement and education**
 - **Information transfer using transitions tools** and information that is **expedited** ahead of the traditional discharge summary
 - **Follow-up care:** phone calls, visits
 - **Healthcare provider engagement:** responsible and accountable for the patient at each site
 - Shared **accountability across** providers and organizations

Cheung-Lai-Wei, K. (2012).

Outcomes of Effective Transitional Care

- Increased patient safety
- Increased patient/provider engagement
- Increased customer and provider satisfaction
- Enhanced service efficiency
- Timely and complete information transfer at discharge
- Follow-up care and accountability established at transfer (tracked)
- Decreased unnecessary emergency room visits
- Decreased hospital avoidable readmissions

ALF: Outcome Considerations

- **Patient and family experience and satisfaction** with care received
- **Providers experience and satisfaction** with the quality of the interaction and collaboration among providers involved in the transition
- **Health care utilization and costs**
- **Health outcomes** and whether they are consistent with the residents' wishes

Question

- What have you found to be the most challenging part of trying to coordinate your residents health care?
- Do you have any best practices that you'd like to share?



Utilization Measures to Track

- 30 day readmission rates
- Admission rates (date, reason)
- Emergency department utilization rates
- ALF : INTERACT
 - Hospital readmission rates for your resident
 - % of re-hospitalizations from your agency that were avoidable

Why the Focus on Hospitalization and Readmissions?

- Hospitals provide extremely important services to all they serve
- They save millions of lives each year!
- But there are some hazards involved with being in the hospital

Hazards of Hospitalization

- Normal changes in aging:
 - Reduced muscle strength
 - Balance receptors not as sensitive
 - Decreased bone density
 - Reduced breathing capacity
 - Altered vision, taste, smell
 - Fragile skin
 - Tendency to urinary incontinence
- Hospitalization hazards mostly due to inactivity
 - Falls
 - Infections
 - Weight loss and dehydration
 - Pressure sores
 - Functional incontinence
 - Worsening of dementia symptoms/behaviors
 - Delirium

INTERACT Tools on the web

- **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](#)

Hospitalization Stories



ALF-UW Hospital Coalition



Alfred Johnson: Wisconsin Division of Quality Assurance



#1: Staff Education

- Residents are increasingly more complex in healthcare needs
- Current education standards for direct caregivers is minimal and proving to be inadequate
- Education does not have to be expensive
- Improved education on common disease processes and their treatments is imperative
- Partner with local hospitals, healthcare systems and health associations
- Past rationale of why staff isn't trained well isn't going to hold much longer...especially with increasingly educated public/families

Proven Approaches from the UW Coalition

- Be proactive in your communication to healthcare providers with/for your residents
- Understand the capabilities of each setting and admission and discharge processes
 - Send in a facility capabilities form each time
 - **Talk with hospital discharge planners on Day 1 of the hospitalization**
 - Call them and establish a relationship with easily accessible communication lines

Documentation

- Send in complete documentation with the resident
 - Have a transfer packet started for each resident(especially if not feeling well)
 - INTERACT transfer form sample
 - ALF-UW Coalition paperwork (pilot release Winter)
 - Facility Capabilities form (INTERACT example)
 - Resident's Advance Directives Papers

Resident Return to Facility

- Review paperwork ASAP so if questions you can catch the discharging provider
- Note post-discharge appointments time/date
- Note lab/diagnostic orders
- Meticulous review of medication changes
- Meticulous review of therapy and oxygen needs

Word of Advice

- Work within consistent standard operating procedures for any type of healthcare transition/appointment/admissions
- Use standardized tools for communications and handoff
- Every resident, every time

Data: Very Important to Drive Actions and Interventions

- Know how many of your residents have the common diseases (Diabetes, Heart Failure, COPD)
- Know what clinical metrics are important for you to track for each disease
- Track these for each resident and keep a longitudinal record which can be taken to medical appointments

Doing it alone?

- Depending where you live there are tremendous community resources to help you improve the health care and transitions of your residents
 - Be sure to know about them and partner with them
 - Join Community/Health Care Coalitions to learn about them (Dane County Coalition)

Work Together

- Other facilities
- Resident/family advisors
- Partner with local health care systems
- State and professional conferences
- Online references (with great caution)
- Community partnerships with ADRC's, Senior Focal Points, pharmacies

Questions and Discussion



Contact

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