Transition from Acute Care for Elders (TACE) – Pilot Project

Marsha Vollbrecht, MS, CSW, NHA - Senior Services Director
Dr. Michael Malone, MD - Medical Director, Senior Services & Aurora VNA
Susan Garcia – Manager, Center for Senior Health & Longevity
Soryal Soryal, MD – Geriatrician, Project Medical Director
Kathleen Bobay, PhD – Research Scientist, Data
Aaron Malsch, GCNS-BC – Senior Services Program Coord.

Learning Objectives

• How we started
• How we trained the TACE GNP
• Interventions taken to prevent readmissions
• Outcomes
• Lessons Learned

How We Started

• Two urban hospitals experienced a high rate of re-admissions from SNF’s (18.6%, 15.4% respectively, 2010).
• Senior Service leaders reviewed literature for models of care that address re-admissions
• Developed and implemented an Advance Practice Nurse model of care to pilot at selected partner sites, as a QI (demonstration) project
Conceptual Model of the Vulnerable Senior During Transition to Post-Acute Care

Functional Older Person

Acute Illness
Hospital admission

• Transfer to skilled nursing facility
• Lack of standardized discharge summary
• Multi-complexity of the resident
• Poor communication between acute care and SNF
• Lack of communication with family re: goals
• Multiple providers and lots of orders
• Poor timeliness of response to change in condition
• Systems for physician evaluation of resident are hospital-based
• Poor physician knowledge of the patient

Worsening of trajectory of recovery
Change in condition
Re-hospitalisation

ACE

Post-Acute Care for Elders
Older Person from Community
Hospitalization
ACE Program
ACE consult assessment

TACE - Program Interventions:
- Access to discharge information
- Timely and regular assessments after hospitalization
- Post discharge—reaching out to the family
- Develop collaborative relationship with SNF provider

- Functional Older Person
- Decreased re-hospitalisations

Improved Mood
Positive Expectations
Reduced Impairment
Decreased iatrogenic Risk Factors

Project Goals

• Reduce avoidable hospital re-admissions of those 65 and older, from identified high volume referral skilled nursing facilities
• Reduce hospital re-admission rate at pilot sites to 10% or less
• Improve transition process
• Provide excellent evidence-based care for seniors
• Reduce cost related to re-admissions and avoid future cost penalties
Project Goals

• Part of the legal agreement with the skilled nursing facility sites is to provide geriatric education for the nursing staff.
  - This can be done through one on one contact as they work on direct care
  - Can be done through formal in-service or skills fair resources
  - The NP acts as a resource for SNF staff

Target Patients

• Age 65 and older
• Hospitalized at one of the pilot hospital sites (Hospital ‘A’, & ‘B’)
• Discharged to any one of the three identified partner SNF sites
• Have an Aurora aligned physician
• Any diagnosis (all cause)

Patients not Eligible for Model

• Patients under 65
• Patients discharged to other SNF’s (not identified partner sites)
• Patients with physicians not aligned or employed by Aurora
• Vent patients
• Hospice patients
• Patients already enrolled with another program followed by an APN (Optum) to avoid duplication
**Project Model**

- APN’s employed by Aurora, placed in partner skilled nursing facilities to assist in managing complex seniors and are independent practitioners
- Employed through the Aurora geriatric medical group/clinic for Administrative lead and geriatrics oversight
- Developed Memorandum of Understanding with partner SNF’s
- Practice collaboratively with attending physicians

**Project Design - Pilot**

- 2 Advance Practice Nurses (GNP or Adult NP or CNS with prescribing authority)
- Part time Medical Director (0.1 FTE)
- 3 participating SNFs, phased in, starting with one APN at one facility
- Target case load per NP – 20 - 25
- Set up Steering Committee with Leadership – to meet monthly
- Set up Operations Team – to huddle weekly and meet with SNF team as needed

**Program Operation**

- APN meets patient at SNF & offers project services
- Nursing visits are based on patient condition/acute, follows for 30 days
- Nurse does not bill for the service
- Does not take the place of physician, works collaboratively with attending
- Documents in clinical record, and keeps database of patient information for project
**APN Role Bridges the Transition**

- Critical review of hospital records including discharge summary
- Vitals signs at time of discharge and upon arrival to the Facility
- Medication reconciliation (different sources including asking patients and calling their pharmacy)

**APN Role Bridges the Transition**

- Evaluate Patients Systemically
  1. Cognitive assessment
  2. Behavioral health (depression, anxiety, delirium)
  3. Bowel and Bladder function
  4. Physical status and Falls risk
  5. Nutritional status and weight changes
  6. Sleep problems

**APN Role Bridges the Transition**

- Follow up on any orders
- Constant family communications: (updates, meetings, goals of care discussion)
- Advance Directives & End of Life Care
ANP Orientation/Training

- Orientation to the Aurora System
- Orientation to nursing facility systems
- Shadow the Medical Director for 2 weeks (inpatient, outpatient and nursing home rounds)
- Shadow palliative care physician on half day at an Aurora Hospital
- Attend primary palliative care course

Training Principles of Primary Palliative Care Course

- Small group learning environment (< 20)
- Time to discuss personal attitudes that impede communication; cognitive re-framing
- Time to practice different words using role playing
  - Focus on microskills
- Didactic information:
  - ethics and legal issues, advance directives, prognostication.

Goals of Care Micro-Skills in Course

- Asking what the patient/family knows
- Provides a succinct medical review
- Silence/Attends to patient emotion
- Discusses prognosis
- Presents two major care options
- Manages conflict—makes an empathic statement
- Asks about prior expressed wishes/values
- Explores patient-centered goals
- Makes a recommendation
- Summarizes a plan
Palliative Care Training Agenda

<table>
<thead>
<tr>
<th>Giving Bad News</th>
<th>Role Play</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prognostication: cancer and non-cancer factors</td>
<td>Readings/Gro</td>
</tr>
<tr>
<td>up discussion</td>
<td></td>
</tr>
<tr>
<td>Decision Making Capacity</td>
<td></td>
</tr>
<tr>
<td>Advance Directives: clinical responsibilities/protections</td>
<td></td>
</tr>
<tr>
<td>Informed consent: emergency exception</td>
<td></td>
</tr>
<tr>
<td>Hospital policies</td>
<td></td>
</tr>
<tr>
<td>Family Goal Setting meeting Part 1</td>
<td>Group Discussion</td>
</tr>
<tr>
<td>Family Goal Setting meeting Part 2</td>
<td>Role Play</td>
</tr>
<tr>
<td>Conflict management</td>
<td>Role Play</td>
</tr>
<tr>
<td>DNR/CPR</td>
<td>Role Play</td>
</tr>
</tbody>
</table>

ANP Educational Opportunities

- Attend Monthly Most Difficult Case Conferences and Geriatric Psychiatry Colloquium.
- Attend Acute Care for the Elderly National conference yearly.
- Attend Grand Rounds that discuss geriatric care issues.

Interventions Taken to Prevent Readmissions

- Create spread sheet for Coumadin patients to monitor their dosing and lab values.
- Establish a CHF pathway for heart failure patients.
- Establish infection pathways (pneumonia and UTI) and get familiar with McGeer Criteria
Interventions Taken to Prevent Readmissions

- Medication review and reconciliation
- Monitor BM closely and formulate a bowel regimen
- Educate families, physicians and staff on what can be done at the facility (IVF, IV Antibiotics, Echo, US, PICC line, availability of a respiratory therapist, consultants...)
- Have continuous open communication with the physicians and families

Interventions Taken to Prevent Readmissions

- Utilize comfort care order set
- Utilize POLST form if present
- Establish a monthly meeting to discuss readmit cases and further intervention to prevent similar cases
- Communicate, Communicate, Communicate!

Scope of Program

- Based in the Nursing Home
- Has access to PCP and Medical Director, works collaboratively for timely orders
- Has access to hospital electronic health record, transfer documents from hospital, and MDS/Medical Record at Nursing Home, labs, etc.
- Works with Patient’s Family, Physician and N.H. staff
- Provides education for N.H. staff
Outcomes – Early at Full Program

TACE Program Volumes and Readmissions

<table>
<thead>
<tr>
<th>TACE Program Volumes and Re-Admissions November 2011 - June 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Admitted to the TACE Program - 453</td>
</tr>
<tr>
<td>Hospital A 245</td>
</tr>
<tr>
<td>Hospital B 208</td>
</tr>
<tr>
<td>Total Hospital Re-Admit Rate - 16%</td>
</tr>
<tr>
<td>Hospital A 17.80%</td>
</tr>
<tr>
<td>Hospital B 13.30%</td>
</tr>
<tr>
<td>Total TACE Program Re-Admit Rate - 9.6%</td>
</tr>
<tr>
<td>Hospital A 9.90%</td>
</tr>
<tr>
<td>Hospital B 9.40%</td>
</tr>
<tr>
<td>Total Cost Avoidance - $227,567.56</td>
</tr>
<tr>
<td>Hospital A $216,475.36</td>
</tr>
<tr>
<td>Hospital B $11,092.00</td>
</tr>
</tbody>
</table>

Re-admission Rate, Baseline and Current

- Hospital A – baseline 18.6%, current 17.8%
- Hospital B – baseline 15.4%, current 13.3%
- Overall average – 9.6%
  - Goal 10% or less
Lessons Learned

• Volume of pilot too small to greatly reduce a large hospital’s re-admit rate
• Difficult to change physician (admitting & ED) behavior, especially if on-call physician
• Since inception, seeing more complex/acute ill patients, that potentially could have increased re-admit rate
• Increased need for end of life and palliative care

More Lessons Learned

• Medication reconciliation and end of life care planning take much time
• APN takes time to consult with SNF staff on residents who are not part of the project (makes suggestions), and educating staff – difficult to measure
• Interventions that prevent hospitalization are often subtle and difficult to quantify – including staff education
• Have likely understated the cost avoidance factor

Future Goals

• Develop plan to ‘scale up’ for wider dissemination
• Explore more targeted approach to highest risk – Disease-focused, facility-specific
• Explore ability to expand project to include residents with non-aurora physicians
• Explore cost-sharing model with SNF partners