Safe Transition Planning in the Assisted Living Setting

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Objectives:

- Define care transitions
- Understand why Assisted Living Facilities must begin to focus on care transitions
- Identify approaches/tools available to assist your organization in improving transitions

What is a Care Transition?

- The movement of patients from one health care setting to another as their care needs change
- Occurs at multiple levels
  - Between settings
  - Across settings


HOSPITAL

Meet Jack

- 85 year old male
- Living in your center for 6 months
- Mild memory issue
- Ambulatory
- Comorbidities:
  - Heart Failure
  - COPD
  - Diabetes controlled by diet

The Incident…

Transfer to the hospital

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

What's going to happen next?

This was a care transition

- Handed off Jack and his health information
- Vulnerable exchange point that can contribute to:
  - Unnecessary high rates of health services
  - Unnecessary spending
  - Exposing resident to health and safety risks

Danger Zone

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

(Brenny-Fitzpatrick, 2017)

What is the Resident thinking?

- Residents and their caregivers are unprepared for their roles in the next setting of care.
- They do not understand the steps
- Cannot contact appropriate practitioners for guidance
- Are frustrated because they have to do it.

(Lett II, 2014)

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 of Planning and Evaluation. Hospitalization of Nursing Home Residents Background and Options, June 2011, p. 1)

What would help?

- Have a plan
- Make coordination and continuity of the resident's healthcare a habit.
- Have current information about the resident's
  - Treatment goals
  - Preferences
  - Health or clinical status

Why does this matter?

- Increasing “medicalization” of ALFs
- Residents now residing in ALFs were the nursing home residents of 10-20 years ago
- Sicker, older, more frail, more medications
- No longer a real estate and hospitality business
- Acceptance of these residents with higher care need drives the expectation that the clinical expertise is available to care for them

(Lett II, 2014)

Why does this matter?

- Your community partners are watching.
- It will impact your bottom line
- The health and safety of your residents is at risk
- There is tremendous pressure from government and other payers to control health care costs

Hazards of Hospitalization

- Falls
- Infections
- Weight Loss
- Dehydration
- Pressure Injuries
- Functional Incontinence
- Worsening dementia/behaviors
- Delirium

(Brenny-Fitzpatrick, 2017)

Other Considerations: Baby Boomers

- Clinical Expectations
- As clinical expectations ramp up, so will regulatory oversight
- Liability considerations
- Family expectations

(Lett II, 2014)

Other Considerations: Environmental

- Pressure from government and market forces to join efforts to reduce hospitalizations and readmission
- Push for quality because hospitals want to know where they are sending their patients. It impacts hospital funding and ultimately your referral source.

(Lett II, 2014)

Impact of Effective Transitional Care

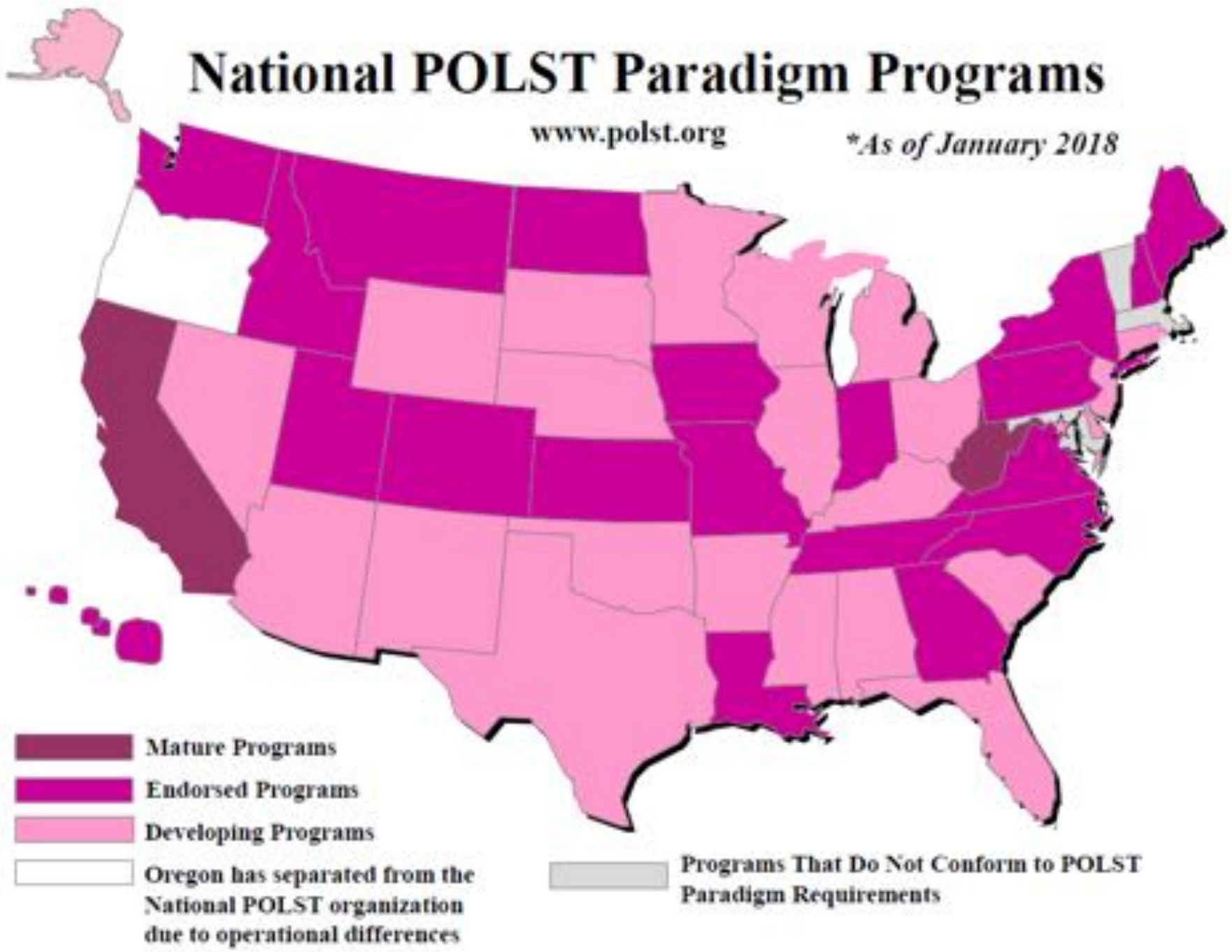
- Increased resident safety
- Increased resident/provider engagement
- Increase customer/provider satisfaction
- Decreased ER visits
- Decreased avoidable hospital readmissions

It’s Time…

What have you started to improve care transitions for the residents in your center?

Tools that can help you

- POLST
- INTERACT®
- LTC TRENDTRACKER


National POLST Paradigm Programs
www.polst.org
*As of January 2018
Mature Programs
Endorsed Programs
Developing Programs
Oregon has separated from the National POLST organization due to operational differences
Programs That Do Not Conform to POLST Paradigm Requirements

- **MOLST** (Medical Orders for Life-Sustaining Treatment)
- **MOST** (Medical Orders for Scope of Treatment)
- **POST** (Physician Orders for Scope of Treatment)
- **SMOST** (Summary of Physician Orders for Scope of Treatment)
- **TPOPP** (Transportable Physician Orders for Patient Preference)
- **COLST** (Clinician Order for Life Sustaining Treatment)
- **DMOST** (Delaware Medical Orders for Scope of Treatment)
- **IPOST** (Iowa Physician Orders for Scope of Treatment)
- **LaPOST** (Louisiana Physician Orders for Scope of Treatment)
- **MI-POST** (Michigan Physician Orders for Scope of Treatment)
- **OkPOLST** (Oklahoma Physician Orders for Life-Sustaining Treatment)
- **PAPOLST** (Pennsylvania Orders for Life-Sustaining Treatment)
- **WyoPOLST** (Wyoming Providers Orders for Life-Sustaining Treatment)
- **SAPO** (State Authorized Portable Orders)

What is Arkansas doing with the POLST?

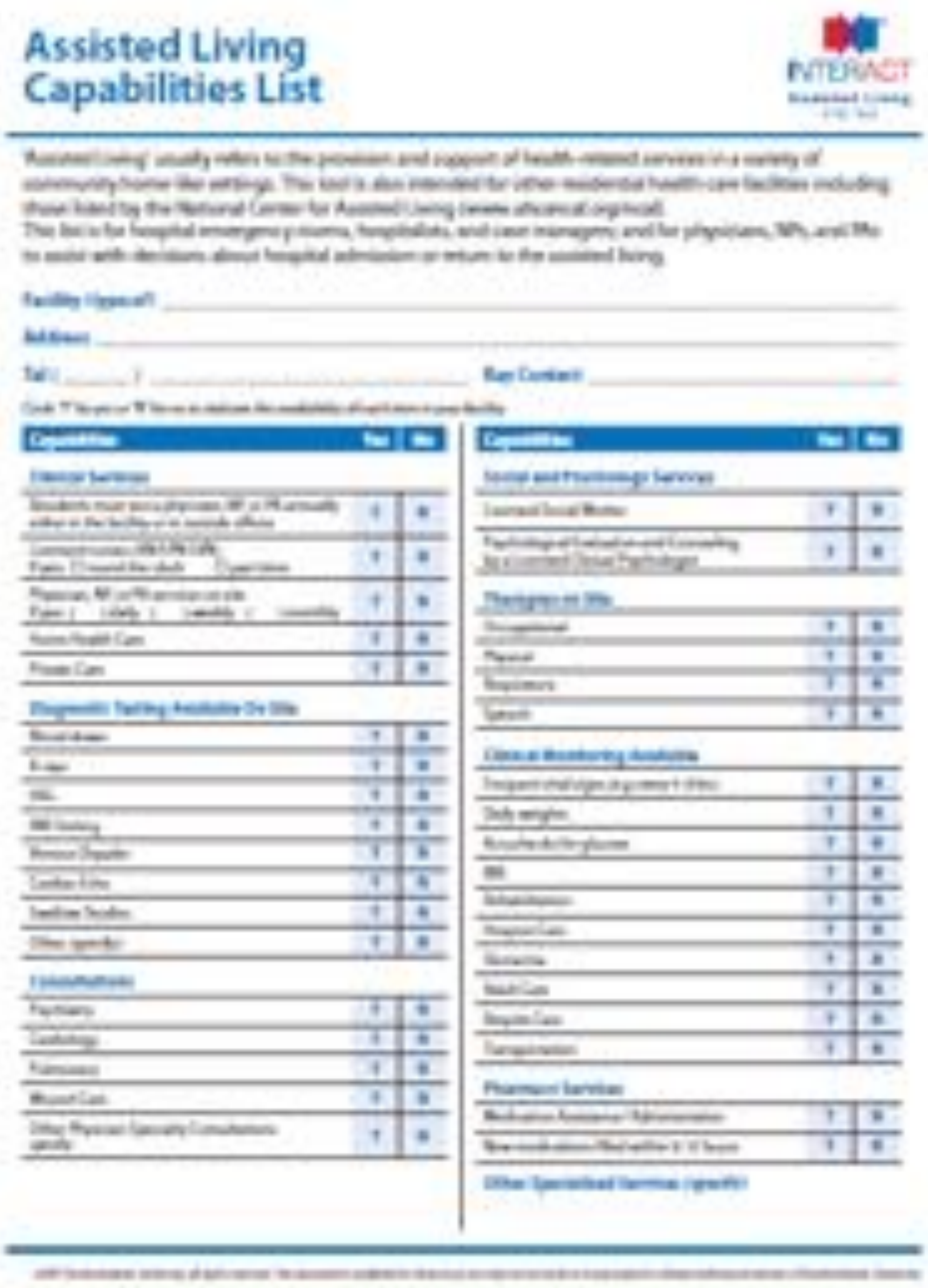
- 1 of 24 states that are Developing POLST Paradigm Programs:
- Submitted the Application for Developing Program Status
- Presented the state's POLST form and program to the Program Assistance Committee.
- Could be anywhere from the initial design of a POLST Form to active usage of the POLST Form.
- Working towards the goal of implementing the POLST Paradigm program statewide.

INTERACT®

- INTERACT® (Interventions to Reduce Acute Care Transfers) is a quality improvement program that focuses on the management of acute change in resident condition. It includes clinical and educational tools and strategies for use in every day practice in long-term care facilities.
- Not just for nursing homes

INTERACT® Tools

- AL capabilities list
- AL to hospital transfer form
- Stop and Watch tools
- Care Paths
- Advance Care Planning Tools for Assisted Living
- And many more…



Assisted Living Capabilities List

INTERACT

Assisted Living to Hospital Transfer Form

Assisted Living to Hospital
Transfer Form (additional information)

Stop and Watch
Early Warning Tool

INTERACT

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 grimaces (for residents with severe dementia); participated less in activities

a
- Ate less

n
- No bowel movement in 3 days; or diarrhea

d
- Drank less

W
- Weight change

A
- Agitated or nervous more than usual

T
- Tired, weak, confused, or drowsy

C
- Change in skin color or condition

H
- Help with walking, transferring, toileting more than usual

☐ Check here if no change noted while monitoring high risk resident

Name of Resident

Your Name

Observation Reported to Date and Time (circle one)

Nurse/Supervisor Response Date and Time (circle one)

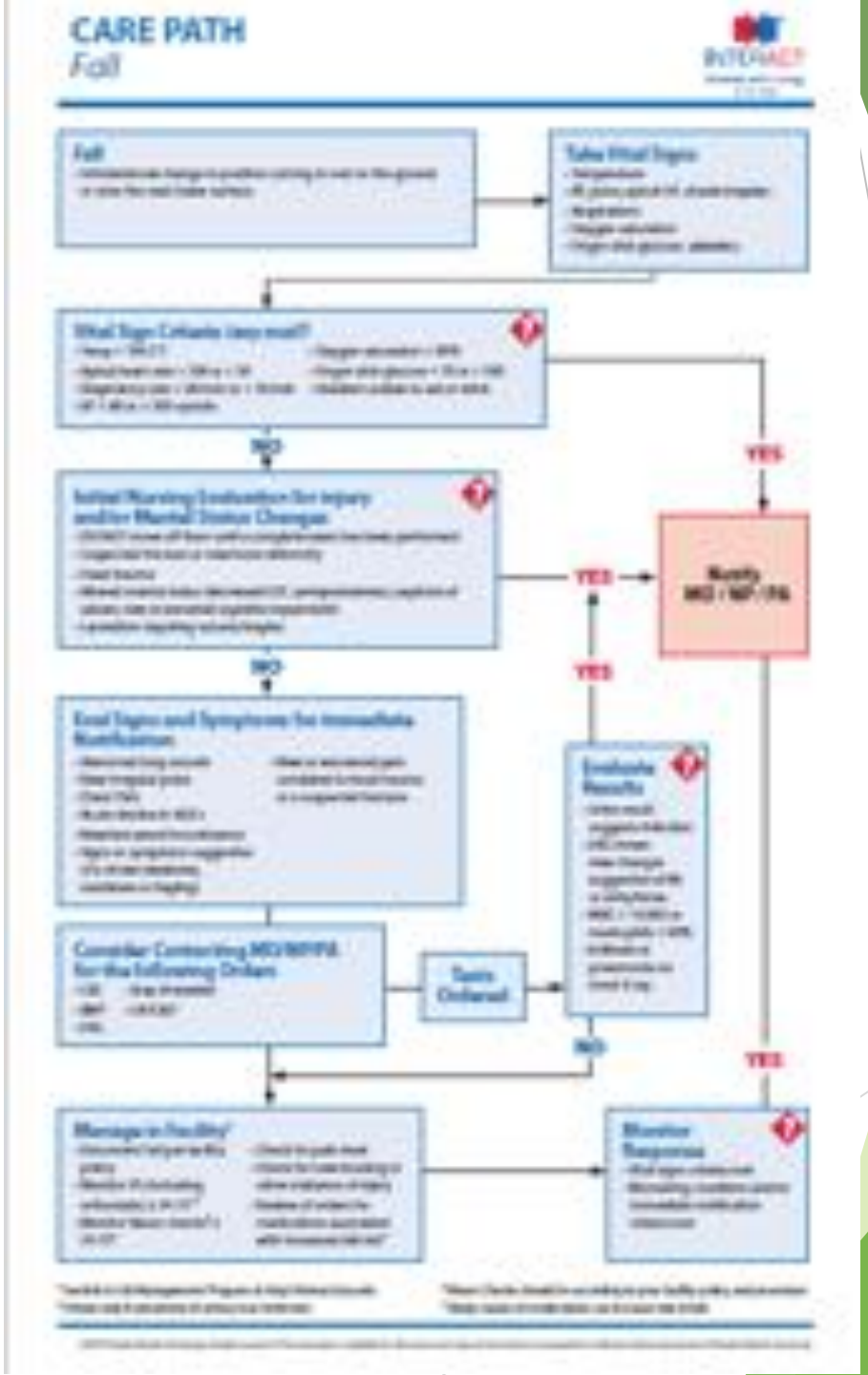
Nurse/Supervisor Name

This form is also intended for other residential/health care facilities including those listed by the National Center for Assisted Living (www.ahcancal.org/ncal).

Care Paths

- Acute Mental Status Change
- Change in Behavior
- Dehydration
- Fever
- GI Symptoms
- SOB
- CHF
- Symptoms of Lower Respiratory Infection
- Symptoms of UTI
- Fall

Let's Talk About Jack



Advance Care Planning Tools for the Assisted Living

- Advance Care Planning Tracking Form
- Advance Care Planning Communication Guide
- Identifying residents who may be appropriate for hospice or palliative/comfort care order
- Comfort Care intervention – examples
- Deciding about going to the hospital
- Education on CPR for Residents and Families
- Education on Tube Feeding for Residents and Families

Residents have rights during transitions of care

- To be treated fairly and with respect
- To have a care transition that fits the situation
- To know why the transition is needed
- To say what they want and need during the transition
- To take part in the planning

Rights (continued)

- To know the related costs
- To know the people and organization involved
- To know the next steps
- To privacy and to health care information during the transition
- To get help when the care transition doesn’t go well

Measures to track

- 30 day readmission rates (% that were avoidable)
- Admission rates
- ER utilization rates

What can I do right away?

- Enhance Staff Education
  - Improve education on common disease processes and treatments
  - Partner with local hospitals, healthcare systems, and healthcare associations
  - Utilize tools such as INTERACT and POLST

(Brenny-Fitzpatrick, 2017)

What else?

- Be proactive in communication to healthcare providers with/for your residents
- Understand the capabilities of each setting and admission and discharge processes.
- Communicate with hospital discharge planners on day 1 of the hospitalization

(Brenny-Fitzpatrick, 2017)

Documentation

- Send complete documentation with the resident
  - INTERACT transfer form
  - Facility Capabilities form
  - Resident's Advance Directives papers
  - POLST form

(Brenny-Fitzpatrick, 2017)

When a Resident comes back to your center…

- Review paperwork ASAP
- Note post-discharge appointments time/date
- Note lab/diagnostic orders
- Review medication changes
- Review therapy and oxygen needs

(Brenny-Fitzpatrick, 2017)

Tips…

- Work within consistent standard operating procedures for any type of healthcare transition
- Use standardized tools for communications and handoff
- Do it the same for **EVERY** resident, **EVERY** time.

(Brenny-Fitzpatrick, 2017)

More Tips…

- Use data
- 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 them and keep a record which can be taken to medical appointments

(Brenny-Fitzpatrick, 2017)

Write this down…

- Pathway-interact.com
- Ltctrendtracker.com
- Polst.org

You're not alone…

- Community resources to help improve healthcare transitions
- Work together with
  - Other facilities
  - Resident/family advisors
  - Local health care systems, agencies
  - State and professional associations

(Brenny-Fitzpatrick, 2017)

Questions for you…

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

Questions for me…

References

- Brenny-Fitzpatrick, Maria, Director of Transitional Care, University of Wisconsin Hospitals and Clinics, *Successful Transitions for Assisted Living Residents*.
- Lett, James, MD., CMD. (2014) *Care transitions in the assisted living setting*
- Pathway Health, www.pathway-interact.com
- www.Polst.org