Preventing Unnecessary Functional Loss When Elders Must Transition Care Settings

1

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2

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- Globally, the number of people 65 years and older is expected to double between 2019 and 2050 to 1.5 billion, resulting in a dramatic increase in the number of residents of long-term care facilities (LTCF). Residents of LTCFs (including nursing homes and residential aged care facilities) typically have multiple long-term conditions, have cognitive impairment, are twice as likely to experience unplanned hospital admissions compared with non-LTCF residents, and are more likely to be readmitted to the hospital.
- Of people 75 years and older in their last year of life, 81% have at least 1 hospitalization, and 96% have at least 1 emergency admission.

3

May 4, 2022 – Journal of American Medical Association

- Among residents of LTCFs, 67% of hospitalizations are potentially avoidable, and emergency department (ED) visits are associated with complications such as pressure ulcers, delirium, and infections.
- Reducing avoidable hospital readmissions has been the policy focus for residents of LTCFs before the COVID-19 pandemic, because US Medicare readmissions alone cost $24 billion annually and unplanned readmissions cost $17.4 billion

4

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- Improving the quality of care for older people in LTCDs who transition from one care setting or level to another (transitional care) is a major challenge for health care systems in most developed countries.

5

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- Quality transitional care has several dimensions, including communication between health care professionals around discharge assessment and care planning, preparation of the patient and caregiver for care transition, timely and complete exchange of information between all parties (staff in different settings, patients, family caregivers) staff training, and patient and caregiver education on self-management.

6

History of Transitions of Care

- Changes in medical care responsibility – Community to Acute Care
- Role of Attending Physician vs. Hospitalist
- Mobility of Elders has increased
- Incomplete Data when elders transition to Acute care from community or home care – Very common

7

Current Factors that Impact Transition to Acute Care

- More technology for elders – smart phones
- Physician records in electronic formats – My Chart
- Problem – Hospitals may not access electronic records – even if personal doctor is part of a network
- Incomplete data very common with trauma related admissions or self emergency department entrance

8

Development of Case Management Model

- Goals of Case Management are not clear at Hospital Admission
- Availability of family – or Significant other has changed
- Many elders live alone without support in the community – are not prepared for unexpected need for acute care of post acute care.

9

Acute Care Services Today

- Focused on primary reason for admission not the total medical picture of the elder.
- Many chronic conditions are frequently missed and if there are no family or significant others to provide information.
- The unique medical situation is often missed or symptoms are misunderstood
- Staffing levels are not adequate to gather individualized data
- Case Management is frequently aggressive and the elder and families are confused about services and time lines.

10

Transition from Acute Care to Post Acute or Home

Nursing Home | Home Health | Hospice | Assisted Living

Personal Care Living | Cost | Non Medical Support Servies

11

12

What influences the Quality of the Acute Care Transfer to the S.N.F.

- Unfortunately, the common practice is to discuss goals of care urgently in an acute care clinical context where patient-provider relationships are often underdeveloped. In this setting. Clinicians may not be perceived as knowledgeable about an individual's case, trustworthy, and persuasive, amplifying the existing ACP barriers.
- These situations may contribute to family disagreements and requests for treatments that the physician believes to be futile. Furthermore, 45-75% of terminally ill adults are incapacitated in the acute care setting, often leaving difficult decision to uninformed and unclearly identified proxies.

13

What influences the Quality of the Acute Care Transfer to the S.N.F.

- If a proxy decision-maker cannot be identified, the hospital ethics committee becomes involved and may even request the court to appoint a guardian.
- Not only is the guardian ship process slow, but public guardians are often unavailable. In these situations, decisions for the unrepresented patient fall to the medical provider Providers tend to err on the side of full restorative care to avoid legal implications for the alternative, resulting in prolonged and costly healthcare with unclear goals.

14

Optimal Transition-of-Care is Critical for High-Risk Elders

- When compared to their counterparts who go home from the hospital, patients discharged to S.N.F.s are often more medically complex with greater burden of disease.
- They are often frequent utilizers of acute care, require longer hospitalizations, and need considerable post-discharge medical care. Furthermore, they often have complicated psychosocial issues that make outpatient care coordination even more difficult.

15

Optimal Transition-of-Care is Critical for High-Risk Elders

- Hospitals and S.N.F.s are jointly responsible for the outcomes of the patients transitioning between them, and while clinicians in both care settings agree on the general principles of care transitions, their roles and responsibilities remain unclear. Variability in hospital transitional care processes, limited linkages between hospital and S.N.F. providers, and S.N.F. staffing and turnover levels contribute to adverse events within the first few weeks after hospital discharge.
- Indeed, 23% of patients discharged to S.N.F. are readmitted to the hospital within 30 days, a measure that is seen as a surrogate for suboptimal quality of care.

16

Safe Transition from the Hospital to the S.N.F. is difficult

- The transition of care for medically complex patients to and from the SNF is unarguably critical; however, care providers in these settings have identified several significant challenges.
- Increasing complexity of patients with extensive psychosocial and specialized medical needs, requiring time-sensitive sharing of information and frank discussions with patients and caregivers.
- Difficulties in identifying the right discharge care setting(home versus S.N.F.), given variation in staffing, quality, and rehospitalization rates across S.N.F.s

17

Safe Transition from the Hospital to the S.N.F. is difficult

- Rising financial pressure leading to tension between hospital providers frustrated by nursing homes that decline their patients and nursing home providers complaining about premature discharges.
- Incomplete medical record transfers, often omitting important documents, together with other barriers to effective communication, such as frequent rotation of care teams, long wait times during the transfer process, and lack of knowledge of the resources available at the S.N.F.

18

Poor Information Sharing Compromises Quality of Care

- Medical information that is incomplete, delayed, or difficult to use results in high-risk disorganized care and avoidable readmissions.
- Although hospitals and S.N.F.s may both use electronic health records (EHRs), what is documented and shared is at their individual discretion, which may be impacted further by lack of standardization of the data fields in their EHRs.

19

Poor Information Sharing Compromises Quality of Care

- Additionally, the lack of standardized workflow across care facilities contributes to poor communication.
- Partnerships between hospitals and surrounding S.N.F.s are an effective approach to resolve communication barriers between levels of care. By prioritizing easy communication channels and facilitating warm handoffs, the quality of the care transition will improve.

20

Transition From Skilled Care – Discharge to Home or Other Services

- Half of all skilled nursing residents return home after a short stay. This transition presents a challenging time for residents due to frequent trouble understanding discharge instructions and medication regimens, inadequate follow-up and referrals, and lack of engagement on social needs.
- Gaps in care lead 1 in 5 of those discharged from an acute-care setting to be readmitted to a hospital within 30 days. And that's costing facilities. In 2019, the last year for which data is available, 73% of skilled nursing facilities received a penalty for their readmission rates.

21

Transition From Skilled Care – Discharge to Home or Other Services

- Facilities must consider
  - The top risks skilled nursing facilities face when residents leave
  - Types of support residents need to reduce rehospitalizations
  - Steps facilities can take to help affect care after residents leave
  - The impact of transitional care management on reimbursements and referrals

22

A.M.D.A. Study – Medication Management Skills in Older Skilled Nursing Facility Residents Transitioning Home

- These SNF residents are more likely to have polypharmacy, changes in health status, and longer periods of time without being responsible for medication administration, it is likely that this transition from SNF to home could often lead to drug-related problems.
- To the best of our knowledge, only one study has documented that over 90% of SNF-to-home discharges encounter drug-related problems (e.g., incorrect dosage, omitted therapy, therapeutic duplication, patient non-adherence, and contraindicated drug use).
- Medication management deficiencies are common in a high-risk group of elders making this important transition.

23

A.M.D.A. Study – Medication Management Skills in Older Skilled Nursing Facility Residents Transitioning Home

- S.N.F. –to-home transitions may be inherently riskier than other transitions of care because of a lack of care delivery staff in the home.
- There are important differences between the transition from S.N.F. to home and hospital to home. S.N.F. residents are the frailest older adults and take more medications than any other segment of the population; the S.N.F. setting lacks standard practices for medication reconciliation.
- The gaps in knowledge regarding drug-related problems after SNF discharge are common. We know little about the extent of the problem, the concerns of involved parties or the potentially unique needs of the population and settings. Future research is needed to determine the effectiveness of patient-tailored transition services that include medication-related oversight for these high-risk patients.

24

American Medical Directors Association. White paper C-09; Improving Transitions of Care from the Nursing Facility to a community – Based Setting

25

Navigating the Long Term Care Maze

- Discover and Assess the elder's current needs.
- Remember many elders and Families are reacting to a sudden health crisis.
- Listen to concerns and assess available options.
- Determine who can supply caregiving support and financial resources
- Do the elder and the family agree or understand realistic options.

26

Navigating the Long Term Care Maze

- What older adults in a crisis need most is a central place to go for help and someone who understand and supports their unique needs and preferences to foodie them there.
- Those who are discharged from the hospital might require rehabilitation at a post-acute care rehab facility or a skilled nursing home. Those who return home might need help with personal care, like bathing, eating and dressing, and household chores, like cooking and cleaning, and may need transportation.
- Other willer quire hospice or palliative care.
- Someone who recently lost a spouse might need a referral to a grief counselor or other supports.
- Those who are suffering from depression might require mental health services.

27

The Current Model

- Our whole system is based on an episodic model of care where we've got an issue that we must solve right now. It's not forward looking. There's no one saying to the family "Here's what's going to happen when we get past this situation." In the beginning when they are discharged to go home, there is a swarm of providers – home health and primary care physicians and physical therapists- and when the crisis is over, they're gone. They all check out. And then the client is left with no real plan, no idea what will happen until the next episode. We need to bridge those gaps because what happens in between episodes can decrease hospitalizations and keep costs down.

28

Educate the Elder and Family with Local Options

- Public programs
- Ranges of Private Services
- Payment Programs – Medicaid – Medicare – local agencies

29

Select and Connect

- Selection of Services – housing – care providers – screening for Medicaid eligibility
- Looking at providers – locations and services – lack of services in rural areas
- Visits with providers
- Realistic evaluation of cost and public programs

30

Re-evaluate

- Follow up is important
- Post S.N.F. discharge follow up is essential
- Regularly scheduled calls to elders and family members to offer support and document the quality of services
- Helping the elder to understand they can return to the S.N.F. if they are not able or strong enough to the care at home

31

Life Events That Can Trigger a Long-Term Care Crisis

- Health Emergency
- Death of a spouse
- Cognitive decline, dementia
- Frequent falls
- Depression
- Social Isolation
- Changes in financial status
- Losing weight, not eating
- Forgetting or refusing to take medication
- Any of these things might require a different approach to an older adult's care, whether it's a change in setting or in services.

32

MDS 3.0 Version 1.18.11 Effective 10-01-23

- New items to focus on re-hospitalizations and elder status at the time of admission
- Item A 1005 – Ethnicity
- Item A 1010 – Race
- Item A 1250 – Transportation
- Item A 2105 – Discharge Status
- Item A 2121 – Provision of Current Reconciled medication List to Subsequent Provider at Discharge
- Item A 2122 – Route of Current Medication List Transmission to Subsequent Provider
- Item A 2123 – Provision of Current Reconciled Medication List to Resident at Discharge
- Item A 2124 – Route of Current Reconciled Medication List Transmission to Resdient

33

MDS 3.0 Version 1.18.11 Effective 10-01-23

- Item B 1300 – Health literacy How often do you need to have someone help you when you need to have someone help you when you read instructions pamphlets or other written material from your doctor or pharmacy
- Item J 0510 – Pain Effect on Sleep
- Item J 0520 – Pain Interference with Therapy Activities
- Item N 0415 – High Risk Drug Classes (I – Anti platelet J – Hypoglycemic)

34

A1005. Ethnicity
Are you of Hispanic, Latino/a, or Spanish origin?

↓ **Check all that apply**

☐	**A.** No, not of Hispanic, Latino/a, or Spanish origin
☐	**B.** Yes, Mexican, Mexican American, Chicano/a
☐	**C.** Yes, Puerto Rican
☐	**D.** Yes, Cuban
☐	**E.** Yes, another Hispanic, Latino/a, or Spanish origin
☐	**X.** Resident unable to respond
☐	**Y.** Resident declines to respond

35

A1010. Race
What is your race?

↓ **Check all that apply**

☐	**A.** White
☐	**B.** Black or African American
☐	**C.** American Indian or Alaska Native
☐	**D.** Asian Indian
☐	**E.** Chinese
☐	**F.** Filipino
☐	**G.** Japanese
☐	**H.** Korean
☐	**I.** Vietnamese
☐	**J.** Other Asian
☐	**K.** Native Hawaiian
☐	**L.** Guamanian or Chamorro
☐	**M.** Samoan
☐	**N.** Other Pacific Islander
☐	**X.** Resident unable to respond
☐	**Y.** Resident declines to respond
☐	**Z.** None of the above

36

A1250. Transportation (from NACHC©)
Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?
Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

↓ Check all that apply	
☐	**A.** Yes, it has kept me from medical appointments or from getting my medications
☐	**B.** Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
☐	**C.** No
☐	**X.** Resident unable to respond
☐	**Y.** Resident declines to respond

37

A2105. Discharge Status
Complete only if A0310F = 10, 11, or 12

Enter Code

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
13. **Deceased**
99. **Not listed** → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge

38

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge
Complete only if A0310H = 1

Enter Code

At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider?

0. **No** - Current reconciled medication list not provided to the subsequent provider → Skip to A2200, Previous Assessment Reference Date for Significant Correction
1. **Yes** - Current reconciled medication list provided to the subsequent provider

39

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider
Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.
Complete only if A2121 = 1

Check all that apply ↓	Route of Transmission
☐	**A. Electronic Health Record**
☐	**B. Health Information Exchange**
☐	**C. Verbal** (e.g., in-person, telephone, video conferencing)
☐	**D. Paper-based** (e.g., fax, copies, printouts)
☐	**E. Other methods** (e.g., texting, email, CDs)

40

A2123. Provision of Current Reconciled Medication List to Resident at Discharge
Complete only if A0310H = 1

Enter Code	
☐	At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver? 0. **No** - Current reconciled medication list not provided to the resident, family and/or caregiver → Skip to A2200, Previous Assessment Reference Date for Significant Correction 1. **Yes** - Current reconciled medication list provided to the resident, family and/or caregiver

41

A2124. Route of Current Reconciled Medication List Transmission to Resident
Indicate the route(s) of transmission of the current reconciled medication list to the resident/family/caregiver.
Complete only if A2123 = 1

Check all that apply ↓	Route of Transmission
☐	**A. Electronic Health Record** (e.g., electronic access to patient portal)
☐	**B. Health Information Exchange**
☐	**C. Verbal** (e.g., in-person, telephone, video conferencing)
☐	**D. Paper-based** (e.g., fax, copies, printouts)
☐	**E. Other methods** (e.g., texting, email, CDs)

42

B1300. Health Literacy
Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

Enter Code

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

0. **Never**
1. **Rarely**
2. **Sometimes**
3. **Often**
4. **Always**
7. **Resident declines to respond**
8. **Resident unable to respond**

43

J0510. Pain Effect on Sleep

Enter Code

Ask resident: *"Over the past 5 days,* ***how much of the time has pain made it hard for you to sleep at night?"***

1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

44

J0520. Pain Interference with Therapy Activities

Enter Code

Ask resident: *"Over the past 5 days,* ***how often have you limited your participation in rehabilitation therapy sessions due to pain?"***

0. **Does not apply - I have not received rehabilitation therapy in the past 5 days**
1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

45

N0415. High-Risk Drug Classes: Use and Indication

1. Is taking
Check if the resident is taking any medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days
2. Indication noted
If Column 1 is checked, check if there is an indication noted for all medications in the drug class

	1. Is taking	2. Indication noted
	↓ Check all that apply ↓	
A. Antipsychotic	☐	☐
B. Antianxiety	☐	☐
C. Antidepressant	☐	☐
D. Hypnotic	☐	☐
E. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin)	☐	☐
F. Antibiotic	☐	☐
G. Diuretic	☐	☐
H. Opioid	☐	☐
I. Antiplatelet	☐	☐
J. Hypoglycemic (including insulin)	☐	☐
Z. None of the above	☐	

46

Operational Approaches to Improving Rehospitalization Rates

- Review current rehospitalization rates
- Identify incomplete elder specific information from the acute stay – at the time of S.N.F. Admission
- Did the elder or family have time to discuss the choice of the S.N.F. As appropriate for care
- Is this a short or intermediate stay – comorbidities
- Foster relationships with post discharge providers that are reliable and deliver quality services

47

Existing Models for Post Discharge Services

- Administration on Aging – is federal works through state programs – does not directly place elders
- Eldercare Locator is port of the Administration on Aging – Can refer families to services in most populated areas.
- Area Agency on Aging – acts to co-ordinate home bound services – mostly public funded services. Most programs are not available equally throughout the country.
- Geriatric Care Managers – paid by families – usually licensed nurses or social workers

48

Current Research Models

- Application of High Intensity Functional Resistance Training in a Skilled Nursing Facility – Physical Therapy – Volume 100 Number 10 PP. 1746-1758
- Journal of American medical Association – Transitional Care Interventions for Older Residents of Long Term Care Facilities – May 4, 2022 JAMANETWORKOPEN.2022.10192
- The Avoidable Transfer Scale: A New Tool for Identifying Potentially Avoidable Hospital Transfers of Nursing Home Residents Innovation in Aging, 2022 Vol. 6 No 4 1-9- Gerontological Society of America

49