AHCA
AMERICAN HEALTH CARE ASSOCIATION
NCAL
NATIONAL CENTER FOR ASSISTED LIVING

IMPROVING LIVES by DELIVERING SOLUTIONS for QUALITY CARE

ACHIEVING EXCELLENCE IN LONG TERM CARE: TECHNICAL VS ADAPTIVE CHANGE

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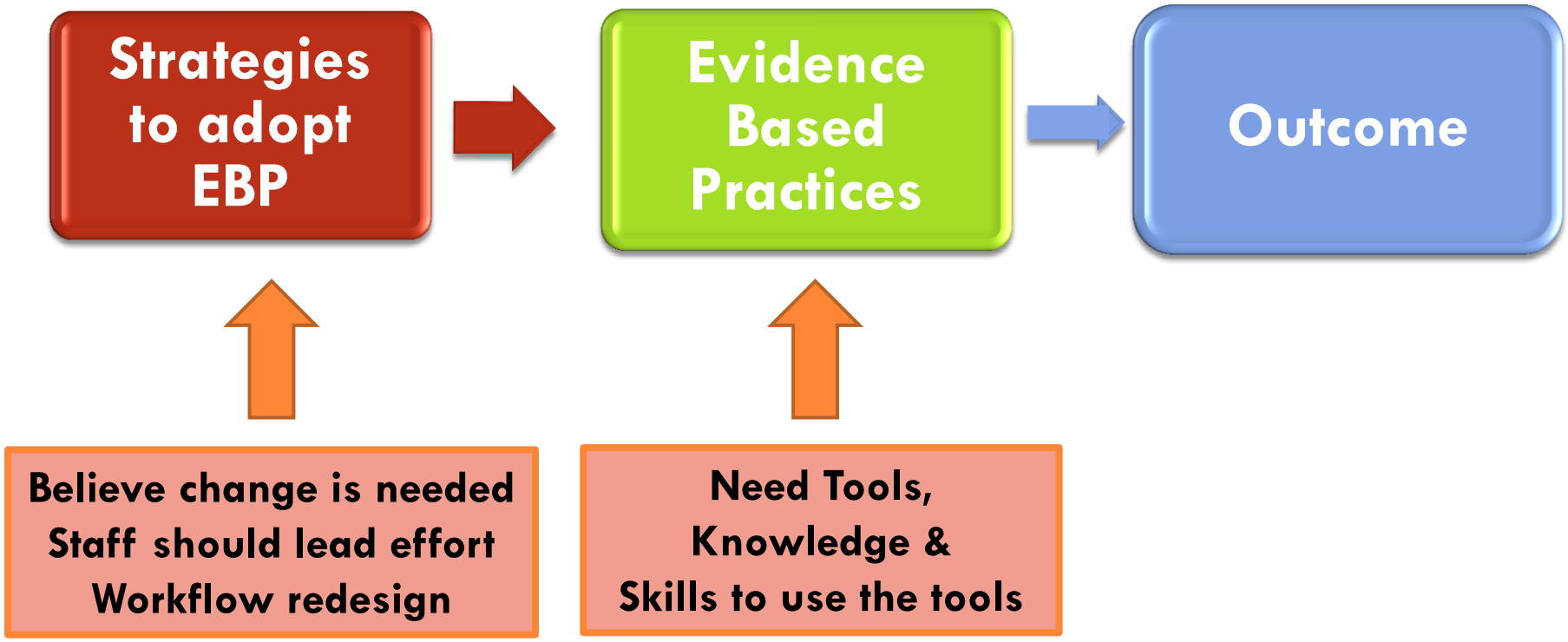
HCANJ

Atlantic City NJ Mar 19th, 2013

Adopting "Evidence Based Practices"



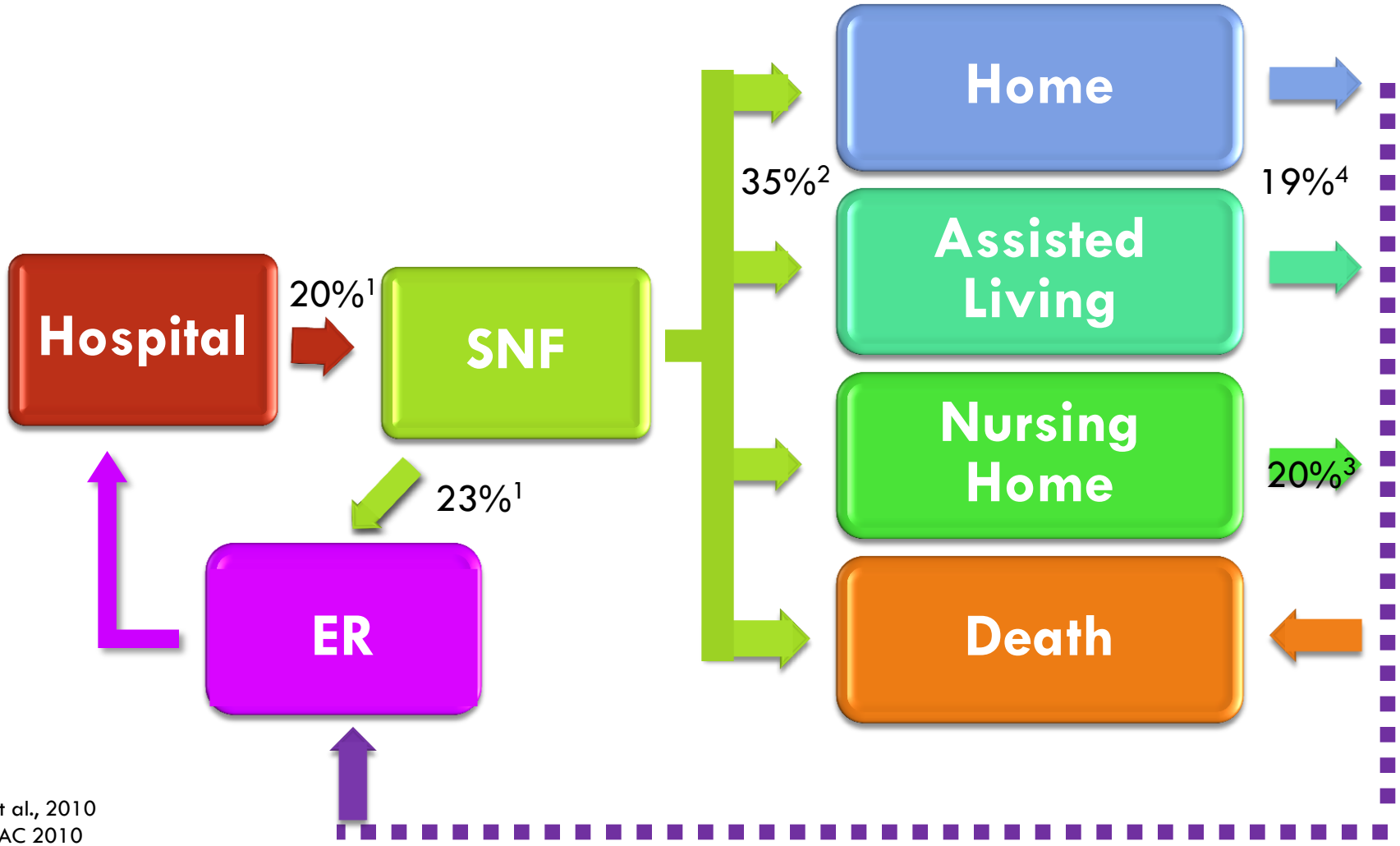
Technical vs Adaptive Change

- Balance technical vs adaptive changes
  - Technical changes often do not work because the adaptive changes needed to get staff to adopt and utilize the technical change have not been addressed.
  - New form vs workflow redesign to complete the new form

AHCA Quality Initiative Goals

- ***Reduce Hospital Readmissions***
  - By March 2, 2015 at 12:00 p.m., reduce the number of hospital readmissions within 30 days during a SNF stay by 15 percent
- ***Increase Staff Stability*:**
  - By March 2, 2015 at 12:00 p.m., reduce turnover among clinical staff (RN, LVN, CNA) by 15 percent
- ***Reduce the Off-Label Use of Antipsychotics*:**
  - By December 31, 2012 at 12:00 p.m., reduce the off-label use of antipsychotics by 15 percent
- ***Increase Resident Satisfaction*:**
  - By March 2, 2015 at 12:00 p.m., increase the number of customers who would recommend the facility to others up to 90%

Use of Long Term Care Services



1. Mor et al., 2010
2. MedPAC 2010
3. Commonwealth 2011
4. Jencks NEJM 2009

Why Hospitals care about you

- CMS has implemented a payment penalty to hospitals with high 30 d readmission rates for discharges with diagnosis of
  - CHF
  - Pneumonia
  - Myocardial infarction
- Partnering with LTC providers
  - Referring to low readmission providers
  - Admitting patients directly from ER

AHCA SNF 30 Day Rehospitalization

Numerator: # of individuals sent back to any hospital (excluding ER-only visits) from your facility within 30 days of admission as indicated on the MDS discharge assessment

Denominator: All residents admitted from an acute hospital to your facility who have an MDS admission assessment

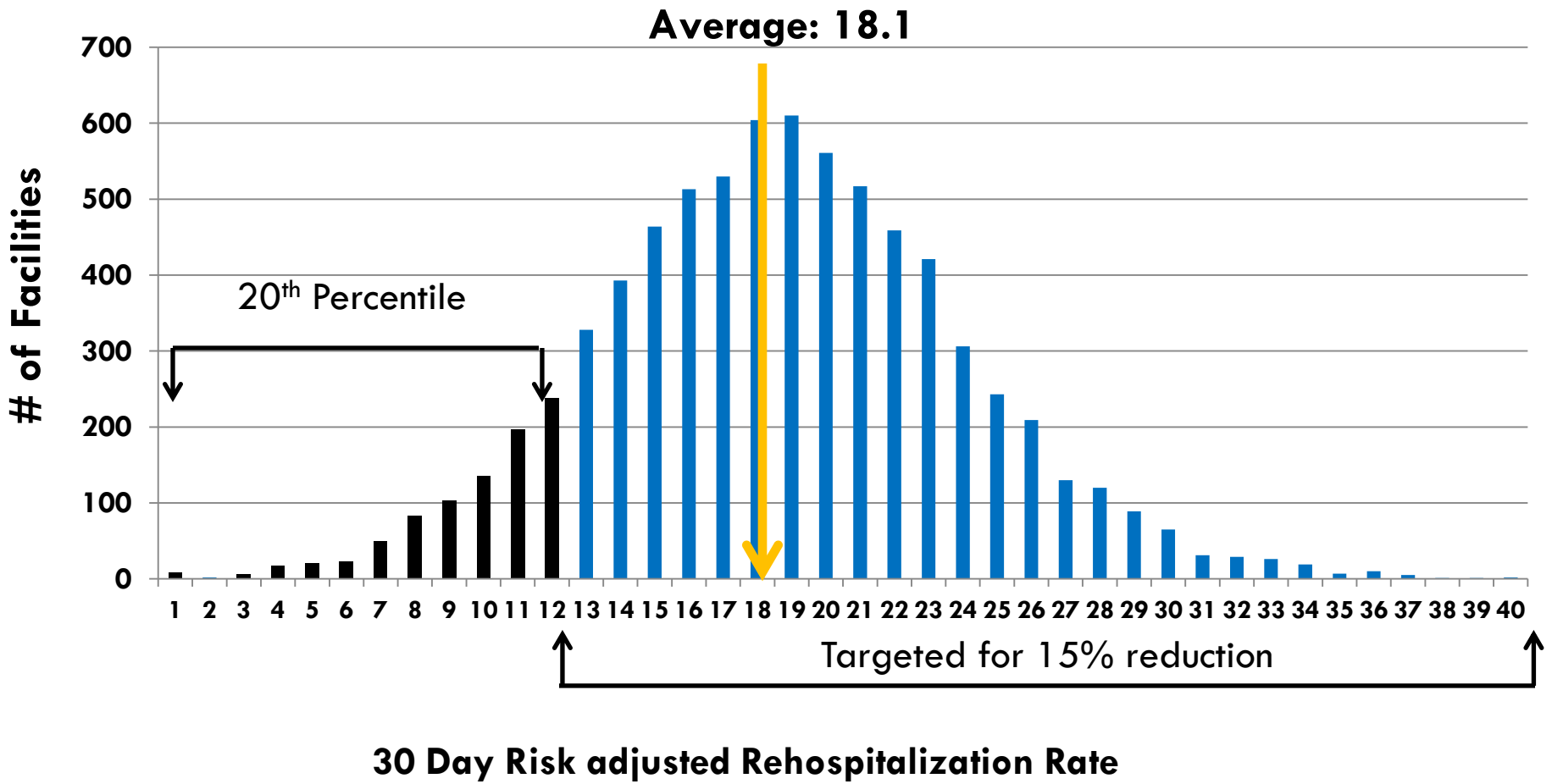
Risk adjustment: Logistic regression is used to risk adjusted for 33 different clinical variables (see next slide). Compares your observed rate to your expected rate

Data Source: MDS 3.0 admission assessments & MDS discharge assessments

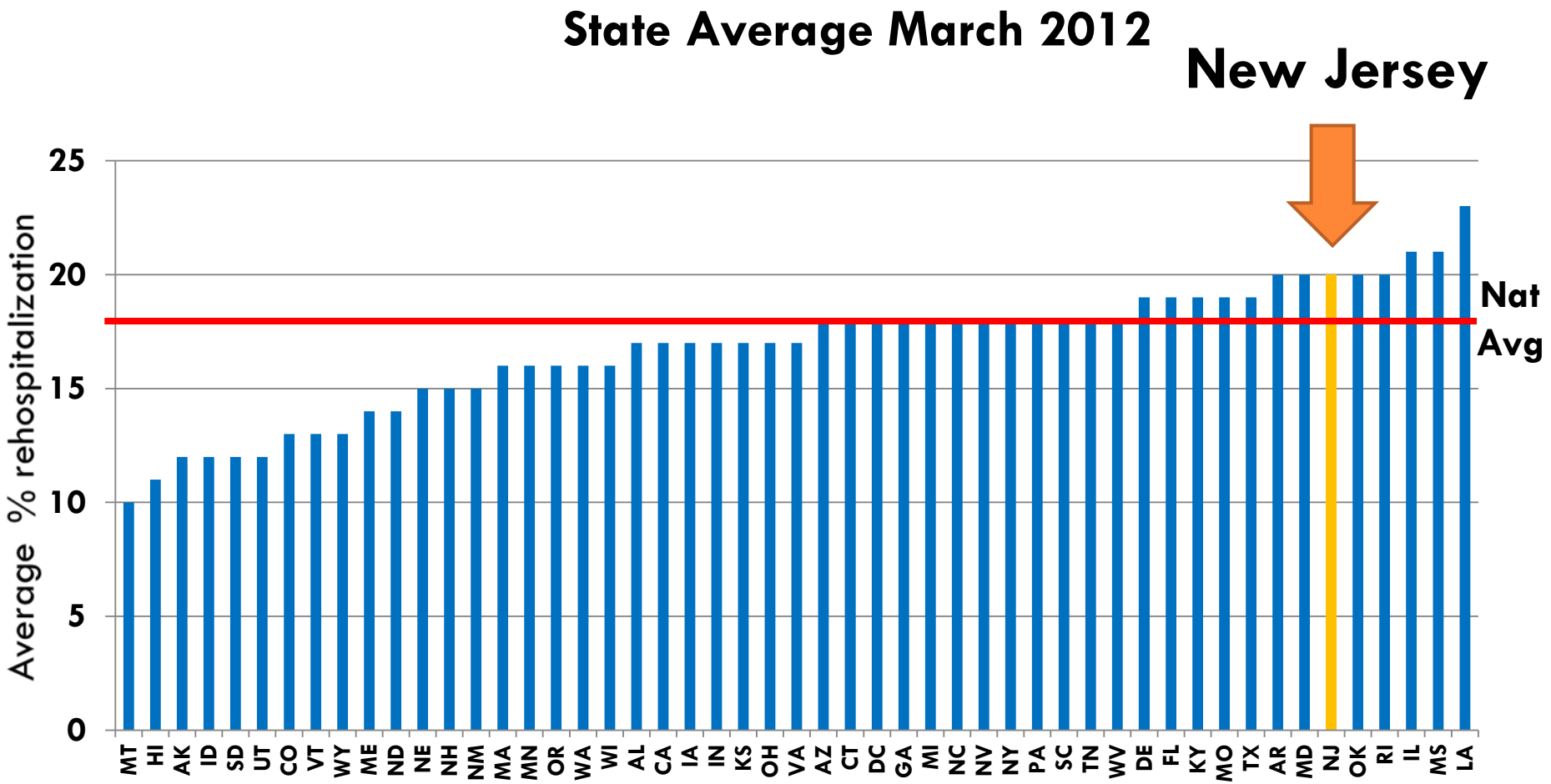
Risk Adjustment Variables Used

- Demographic
  - Age ≥65
  - Male
  - Medicare as Primary Payor
- Functional Status
  - Total Bowel Incontinence
  - Eating dependent
  - Needs 2 person assistance in ADLs
  - Cognitive Impairment (Dementia)
- Prognosis
  - End Stage prognosis poor
  - Recently rehospitalized
  - Hx of Respiratory Failure
  - Receiving Hospice Care
- Clinical Conditions
  - Daily pain
  - Pressure Ulcer Stage ≥2 (split into 4 variables)
  - Venous Arterial Ulcer
  - Diabetic Foot Ulcer
- Diagnoses
  - Anemia
  - Asthma
  - Diabetes Mellitus
  - Hx of Viral Hepatitis
  - Hx of Septicemia
  - Hx of Heart Failure
  - Hx of Internal bleeding
- Services & treatments
  - Dialysis
  - Insulin prescribed
  - Ostomy care
  - Cancer Chemotherapy
  - Receiving Radiation Therapy
  - Continue to receive IV Medication
  - Continue to receive oxygen
  - Continued tracheostomy care

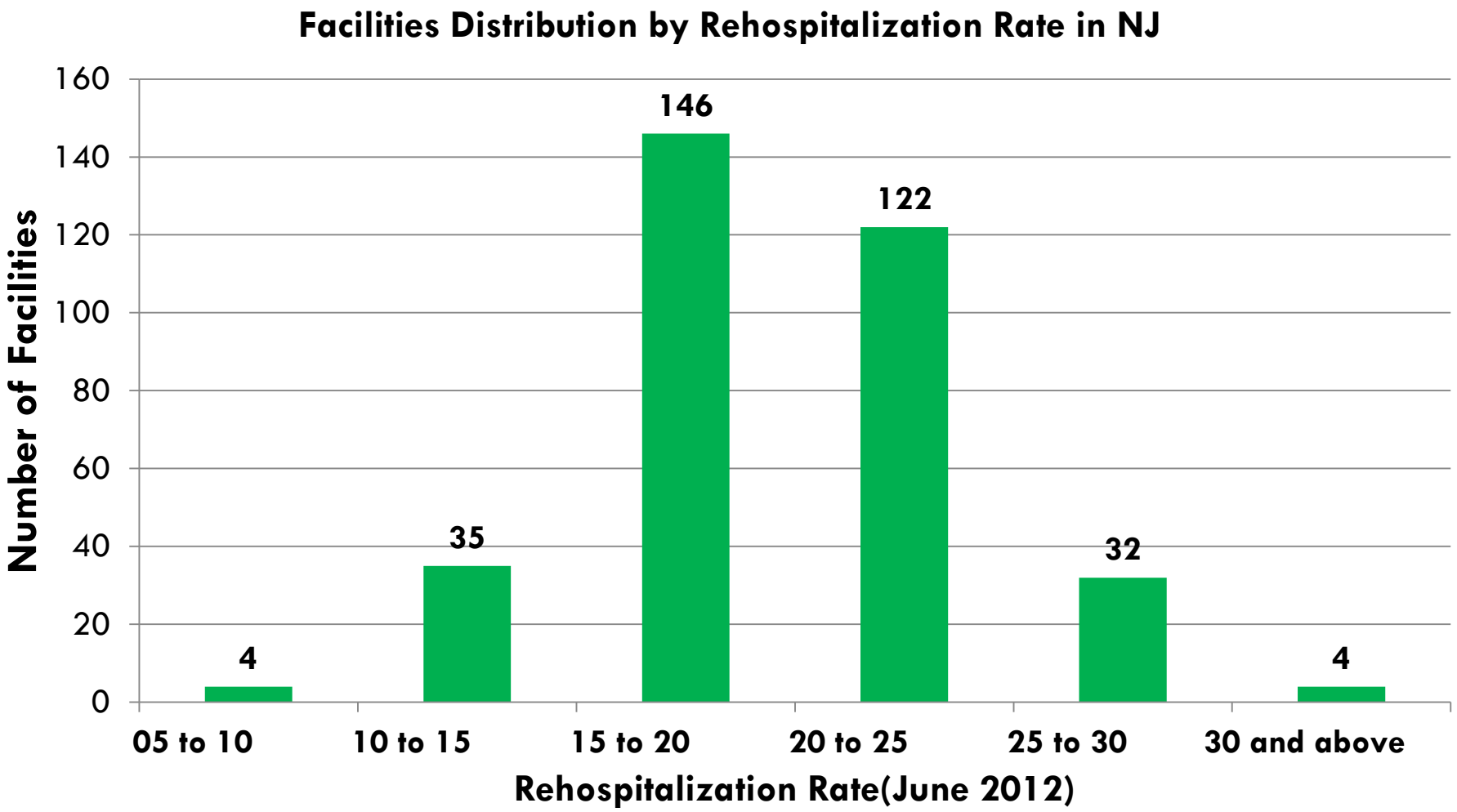
AHCA Members 30d Rehospitalization Rates (March 2012)



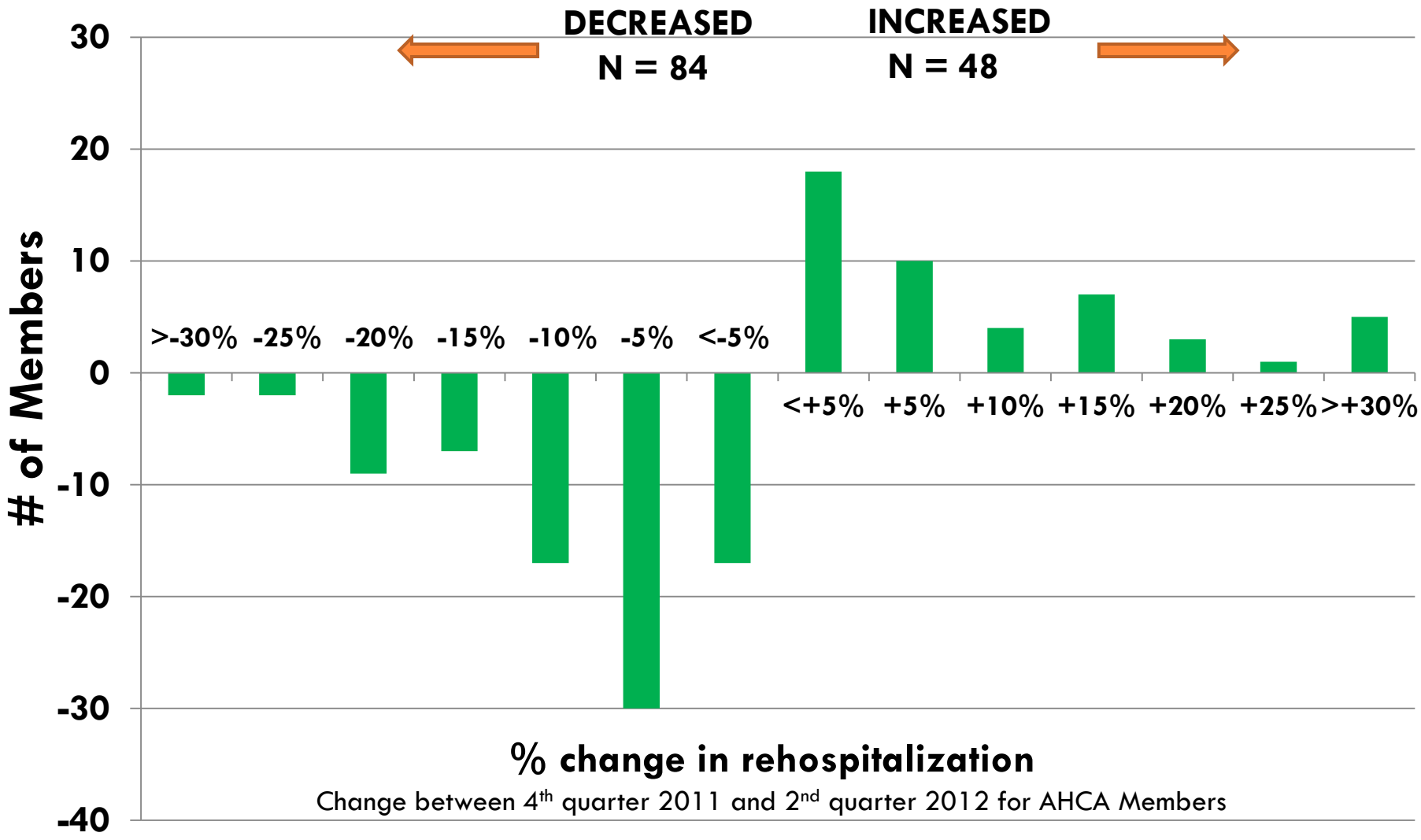
State Rankings 30d Rehospitalizations



Distribution of NJ Facilities' Rehospitalizations



NJ Members and their % Change in Rehospitalization



Where Can I Get Data on My Rates?

- AHCA – Long Term Care Trend Tracker
  - Free AHCA member benefit
  - www.ltctrendtracker.com
  - Now includes claims-based measure
  - By end of 2012, will have MDS-based, risk adjusted Point Right measure
- Many MDS vendors include in their systems
- Real-time internal data collection & analysis
  - Advancing Excellence free excel tracking tool
  - www.nhqualitycampaign.org/star_index.aspx?controls=HospitalizationsIdentifyBaseline

LTC TrendTracker℠

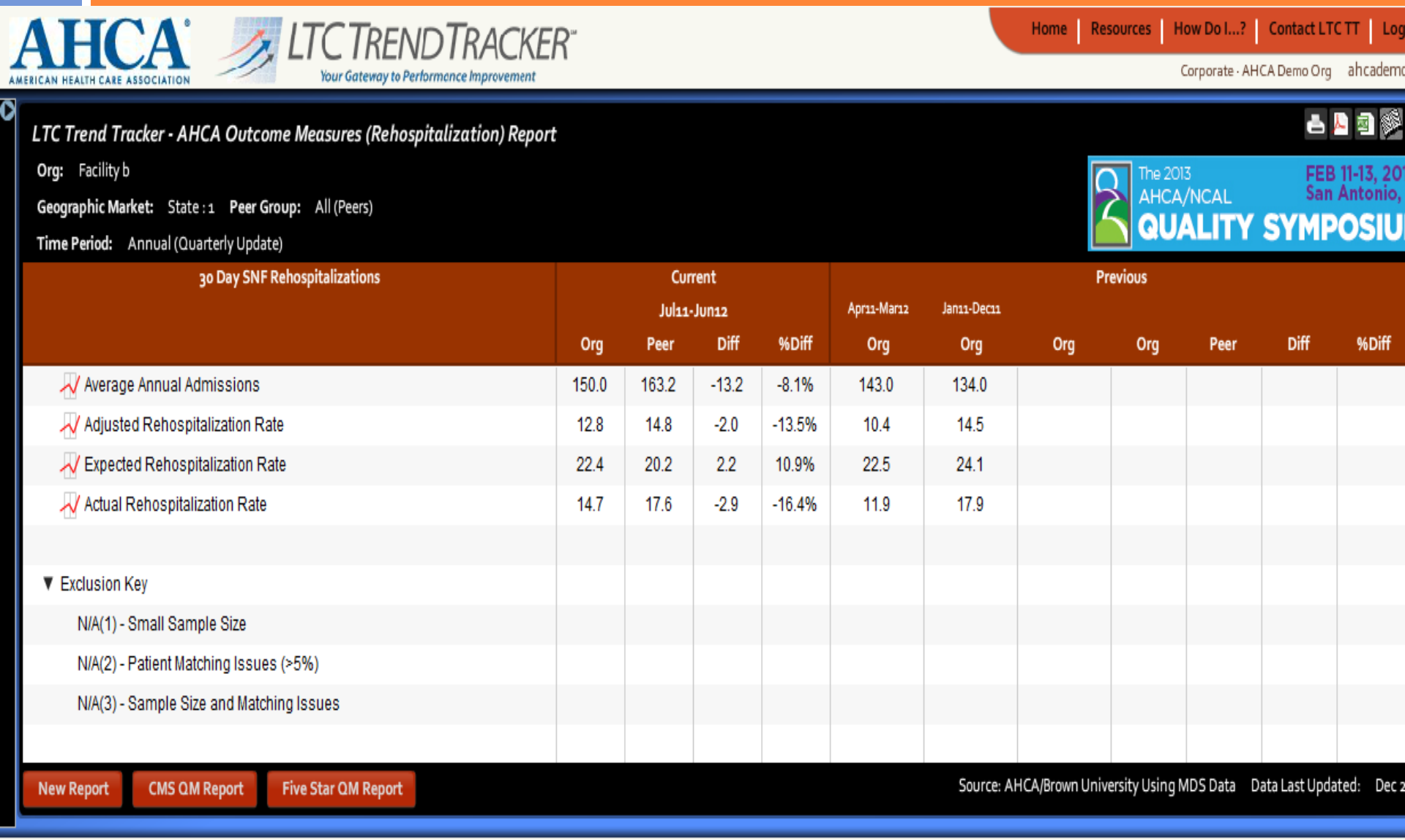
Your Gateway to Performance Improvement

Your Member Benefit

- Survey History
- Resident Characteristics
- Staffing Information & **Turnover**
- Cost Report and Medicare Utilization
- CMS Five Star Rating
- **Hospitalization & Antipsychotic rates**

www.ltctrendtracker.com

LTC TT Rehospitalization Report



30 Day SNF Rehospitalizations	Current Jul11-Jun12 Org	Current Jul11-Jun12 Peer	Current Jul11-Jun12 Diff	Current Jul11-Jun12 %Diff	Previous Apr11-Mar12 Org	Previous Jan11-Dec11 Org	Org	Org	Peer	Diff	%Diff
Average Annual Admissions	150.0	163.2	-13.2	-8.1%	143.0	134.0					
Adjusted Rehospitalization Rate	12.8	14.8	-2.0	-13.5%	10.4	14.5					
Expected Rehospitalization Rate	22.4	20.2	2.2	10.9%	22.5	24.1					
Actual Rehospitalization Rate	14.7	17.6	-2.9	-16.4%	11.9	17.9					
▼ Exclusion Key											
N/A(1) - Small Sample Size											
N/A(2) - Patient Matching Issues (>5%)											
N/A(3) - Sample Size and Matching Issues											

Factors Associated with low rehospitalizations

- 47 Nursing homes in NY (N=26,746 patients)
- Measured Clinical and non-clinical factors associated with rehospitalization rates
- Three strongest predictors

#1 Training provided to nursing staff on how to communicate effectively with physicians about a residents condition

#2 Physicians who practice in this nursing home treat residents within the nursing home whenever possible, saving hospitalization as a last resort

#3 Provided better information and support to nurses and aides surrounding end-of-life care

[1]Young Y et al. Clinical and Nonclinical Factors Associated with potentially preventable hospitalizations among nursing home residents in NYS. JAMDA 2011;12:364-371.

Strategies to Reduce Hospitalizations

- Track your rehospitalizations
- Improve Communication
  - Externally (e.g. with hospital/ER)
  - Internally (e.g. between nursing & physicians)
- Identify small changes in a resident's status early on
- Change Staffing
  - Consistent Assignment
  - Reduce staff turnover
  - Utilize nurse practitioners
- Advance Care Planning

INTERACT III

Is a comprehensive program that uses these strategies

INTERACT EFFECTIVENESS

Facilities	Mean Hospitalization Rate per 1000 resident days (SD)		Mean Change (SD)	p value	Relative Reduction
	Pre intervention	During Intervention			
All INTERACT facilities (N = 25)	3.99 (2.30)	3.32 (2.04)	- 0.69 (1.47)	0.02	**17%**
Engaged facilities (N = 17)	4.01 (2.56)	3.13 (2.27)	- 0.90 (1.28)	0.01	**24%**
Not engaged facilities (N = 8)	3.96 (1.79)	3.71 (1.53)	- 0.26 (1.83)	0.69	**6%**
Comparison facilities (N = 11)	2.69 (2.23)	2.61 (1.82)	- 0.08 (0.74)	0.72	**3%**

Ouslander et al, J Am Geriatr Soc 59:745–753, 2011

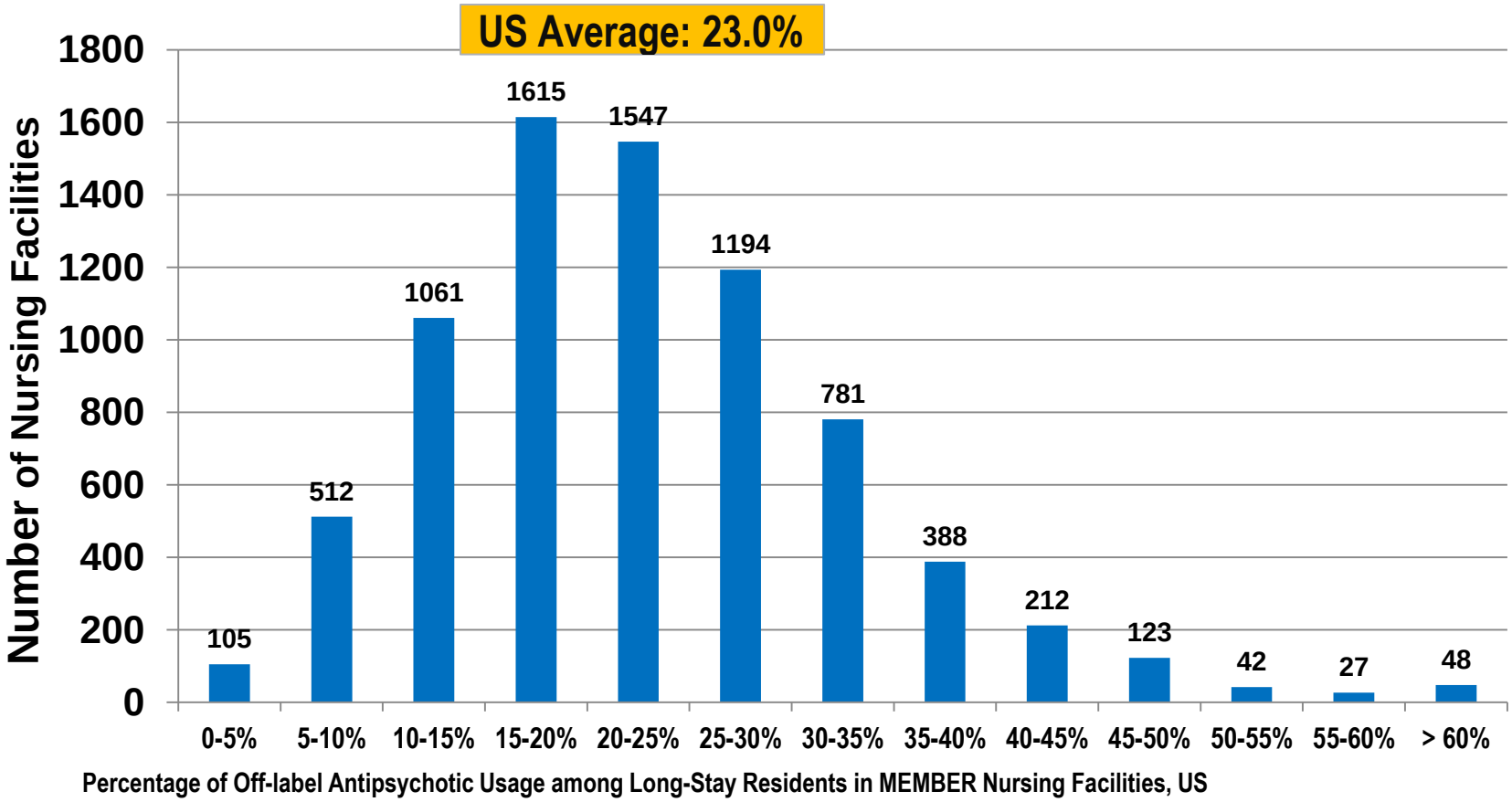
Successful Implementation Strategies

- Rely on staff to design & test implementation strategy
  - Top Down vs Bottom up implementation
- Pilot Test, Pilot Test, Pilot Test, Pilot Test
  - N of 1 trials (1 unit, 1 staff, 1 patient/resident, 1 day)
  - Rapid cycle PDSA
- Learn from Peers
  - Learning collaboratives
  - Visit other facilities
- Get at the adaptive change that is needed
  - Ask "what is the problem/issue we are trying to solve?"
  - How will what we/you propose help us solve the problem?

Antipsychotic Medications

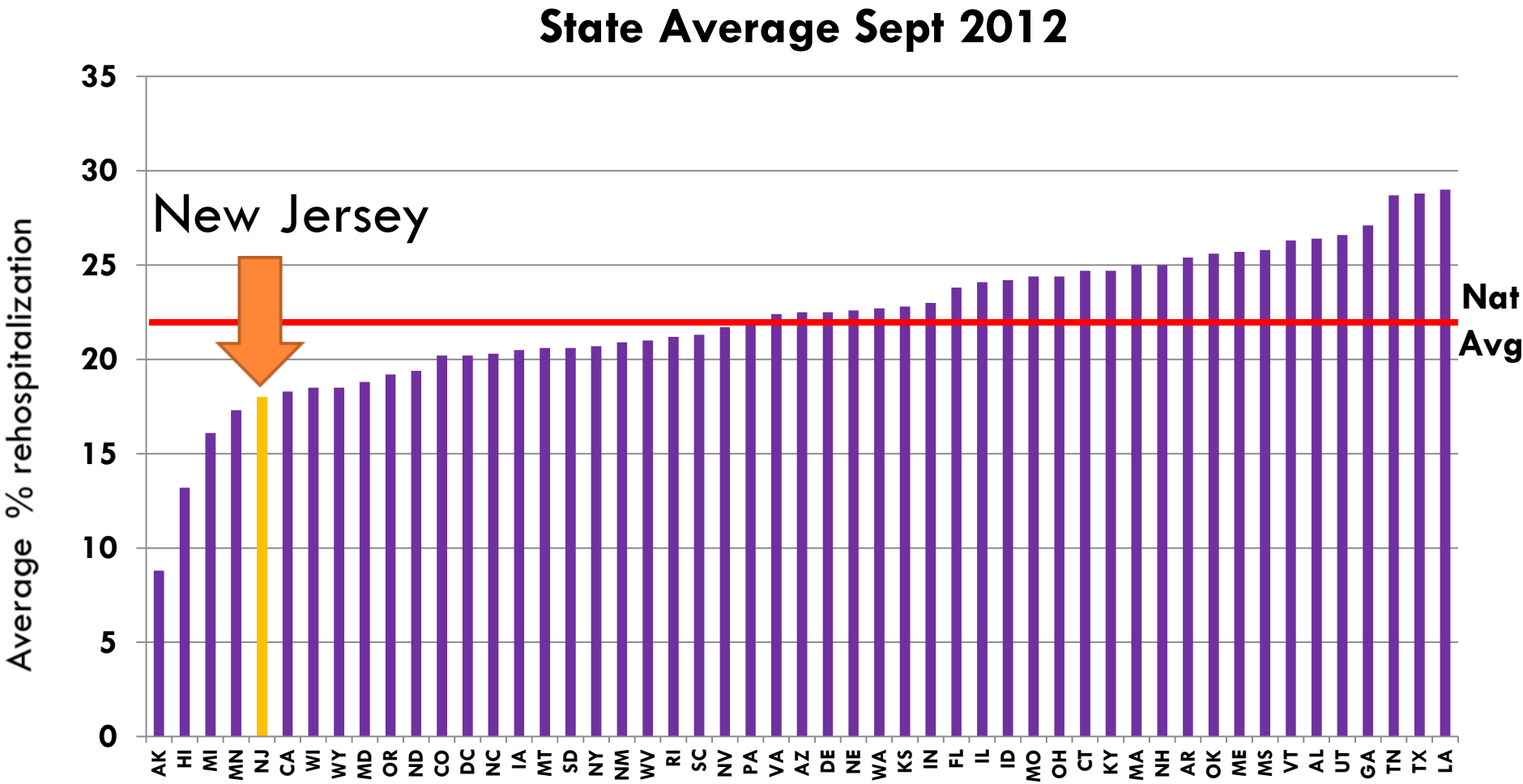
- Conventional
  - Compazine
  - Haldol
  - Loxitane
  - Mellaril
  - Moban
  - Navane
  - Orap
  - Prolixin
  - Stelazine
  - Thorazine
  - Trilafon
- Atypical
  - Aripiprazole (Abilify)
  - Asenapine
  - Clozapine
  - Iloperidon
  - Olanzapine (Zyprexa)
  - Paliperidone
  - Quetiapine (Seroquel)
  - Risperidone (Risperdal)
  - Ziprasidone

Distribution of AHCA members' Antipsychotic use Sept 2012

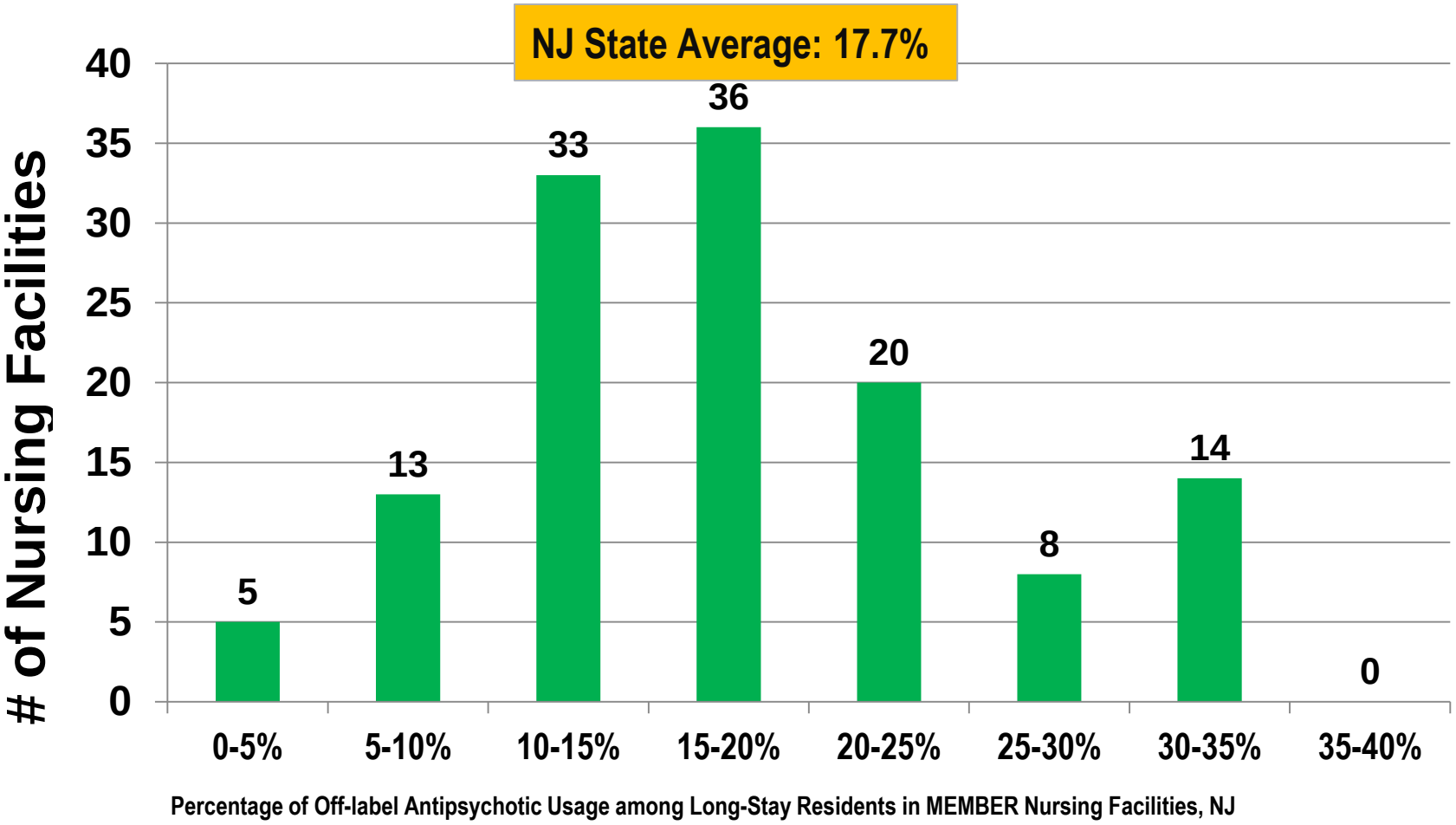


Source: CMS Nursing Home Compare Quality Measures, 2012.

State Rankings Antipsychotic Use

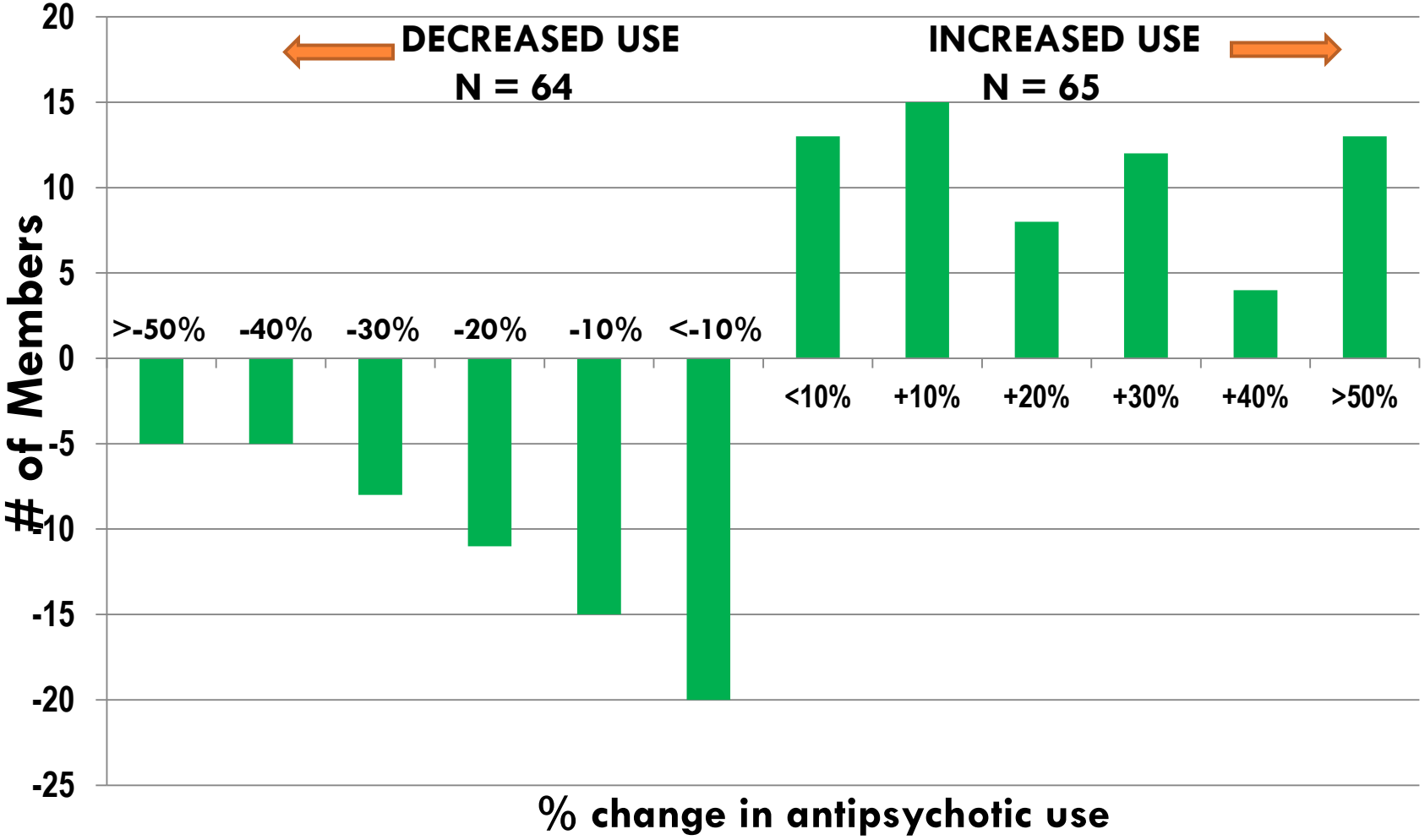


Distribution of Facilities Antipsychotic Use in NJ (Sept 2012)



Source: CMS Nursing Home Compare Quality Measures, 2012.

NJ Members and their % Change in Antipsychotic Use



Change between 4th quarter 2011 and 3rd quarter 2012 for AHCA Members using CMS's Quality Measure

#1 Challenge is changing attitude

- Most health care professionals and families believe
  - Behaviors in dementia are abnormal and need to be treated; and
  - these medications are effective to treat behaviors in dementia
- Thus, the adaptive change needed prior to any technical change to reduce antipsychotic medications requires addressing these attitudes & beliefs

What would you do if…?

- Make sense of the situation – what's going on here?
- How do you feel?
- What do you do?

Effectiveness of Antipsychotics in Dementia

- Antipsychotic effect takes 3-7 days to start working
  - Very sedating medication so acute effect is most likely due to sedating effect not the antipsychotic effect
- Randomized controlled trial (RCTs) is the gold standard method to evaluate the effectiveness of medications
  - RCTs randomized dementia patients to either receive an antipsychotic or a placebo and clinicians are blinded to who gets the meds when rating outcomes
- Meta-analysis is method that combines the results from multiple RCTs

Effectiveness in Dementia is weak Meta-Analysis (JAMA 2011)

- Aripiprazole, Olanzapine, and Risperidone had a small but statistically significant effect (12 – 20%) when compared to placebo
- Quetiapine did not have a statistically significant effect
- Antipsychotics led to an average change/difference on the NeuroPsychiatric Inventory (NPI) of
  - 35% from a patient's baseline
  - 3.41 point difference from placebo group

  (note: a 30% change and 4.0 difference is the minimum threshold needed for a clinically meaningful result)
- No conclusive evidence was found regarding the comparative effectiveness of different antipsychotics

Source: JAMA 306:1359-69 2011; Meta-analysis 38 RCTs in dementia

Dose for Antipsychotics Used in Dementia

Medication	Low Dose	Normal Dose
Aripiprazole (Abilify)	<2 mg/d	2-15 mg/d
Olanzapine (Zyprexa)	<5 mg/d	5-10 mg/d
Quetiapine (Seroquel)	<50 mg/d	50-100 mg/d
Risperidone (Risperdal)	<1 mg/d	1-2 mg/d

Effectiveness with Low Dose Meta-Analysis (Cochrane 2012)

- Low dose Risperidone <1 mg/d) - small positive effective but also increased risk of adverse events
- Low dose Olanzapine (5 mg/d) - no positive effect but does have increased risk of adverse events
- Low dose Aripiprazole and Quetiapine effectiveness unknown, but Quetiapine at normal dose is ineffective

Source: Cochrane Review 2012; Meta-analysis 16 RCTs in dementia

Associated with adverse outcomes

- Off-label use of antipsychotics in nursing facility residents are associated with an increase in:
  - Death (heart failure or pneumonia)
  - Hospitalization
  - Falls & fractures
  - Venothrombolic events (stroke)
- Conventional antipsychotics are worse than atypical antipsychotics

Odds of having an adverse event after receiving an Risperidone 1 mg/d compared to placebo

Adverse Event	Odd Ratio	95% Confidence Interval
Mortality	**1.25**	0.73 to 2.16
Somnolence	**2.40**	1.70 to 3.20
Falls	**0.84**	0.63 to 1.14
Extrapyramidal disorder	**1.78**	1.00 to 3.17
UTI	**1.40**	0.92 to 2.13
Edema	**2.75**	1.51 to 5.03
Abnormal Gait	**5.31**	2.24 to 12.62
Urinary Incontinence	**13.6**	1.81 to 101
CVA	**3.64**	1.72 to 7.69
Drop out (had to stop meds)	**1.43**	1.01 to 2.03

Source: Cochrane Review 2012; Meta-analysis 4 RCTs in dementia

FDA Black Box Warning

- Issued in 2005
- Warning: Increased Mortality in Elderly Patients with Dementia-Related Psychosis
  - Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. [Name of Antipsychotic] is not approved for the treatment of patients with dementia-related psychosis.

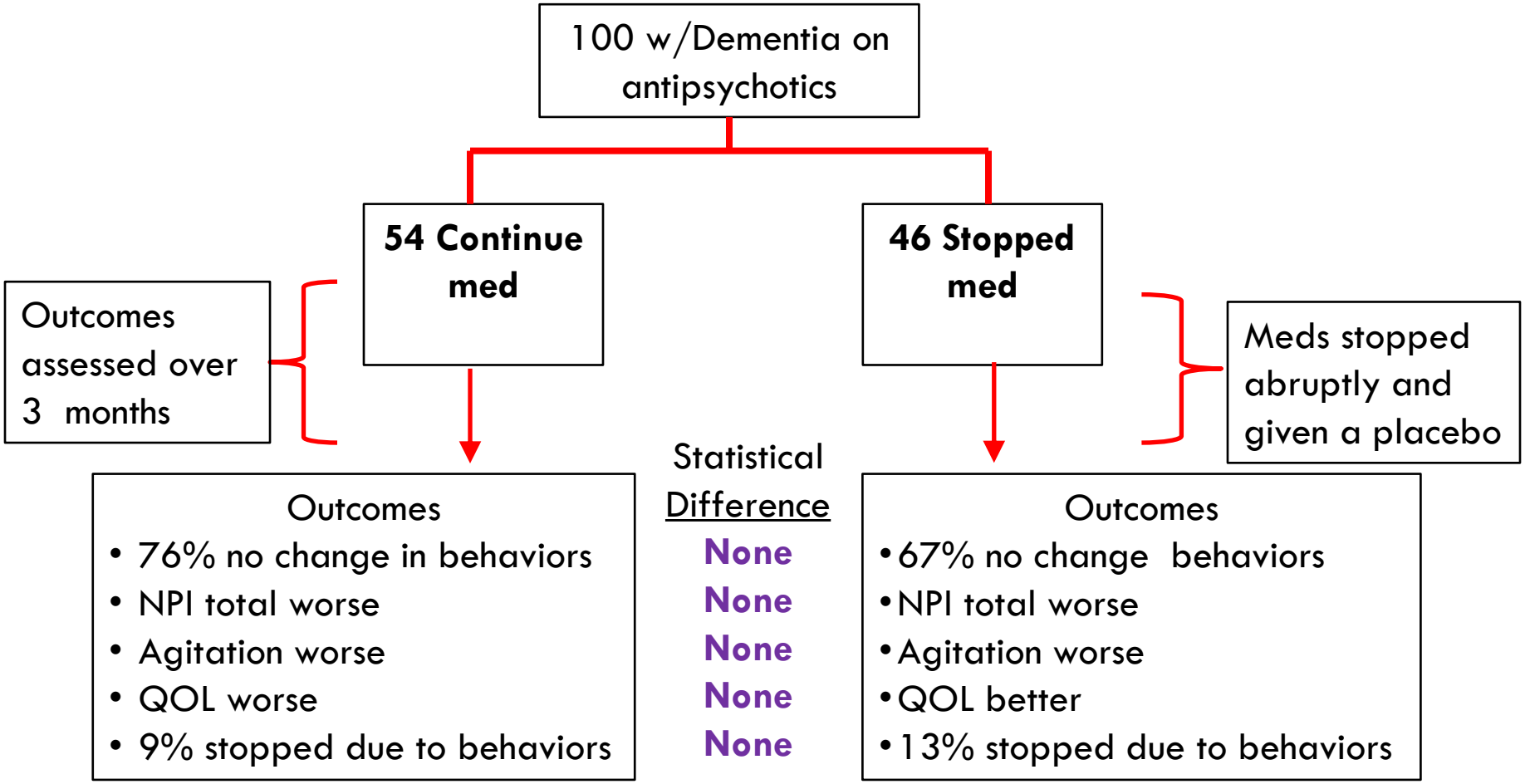
WARNING

Increased Mortality in Elderly Patients with Dementia-Related Psychosis — Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Analyses of seventeen placebo-controlled trials (modal duration of 10 weeks) in these patients revealed a risk of death in the drug-treated patients of between 1.6 to 1.7 times that seen in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. [this drug] is not approved for the treatment of patients with dementia-related psychosis.

Evidence Base for Discontinuing Meds at Lose Dose

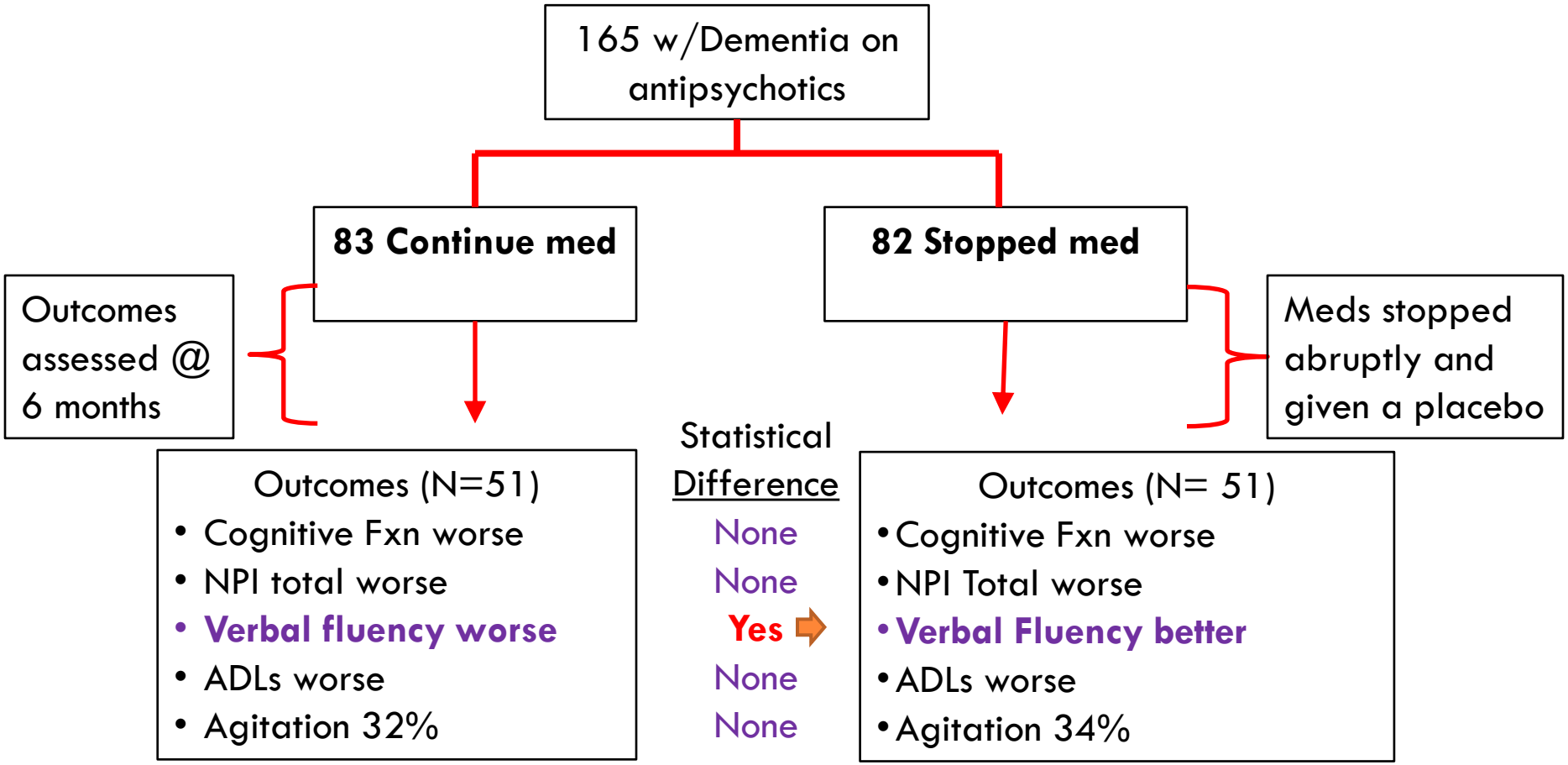
- RCTs comparing withdrawal of medication to continuing antipsychotics will show:
  - the medication to be effective, if more people randomized to stop the medication get worse than those randomized to continue on the medication
  - The medication to be ineffective, if the same percentage of people randomized to stop the medication as continue the medication get worse or do not change
  - The medication to be harmful, if more people randomized to stop the medication get better compared to those who continue the medication

RCT to withdraw antipsychotics[2]



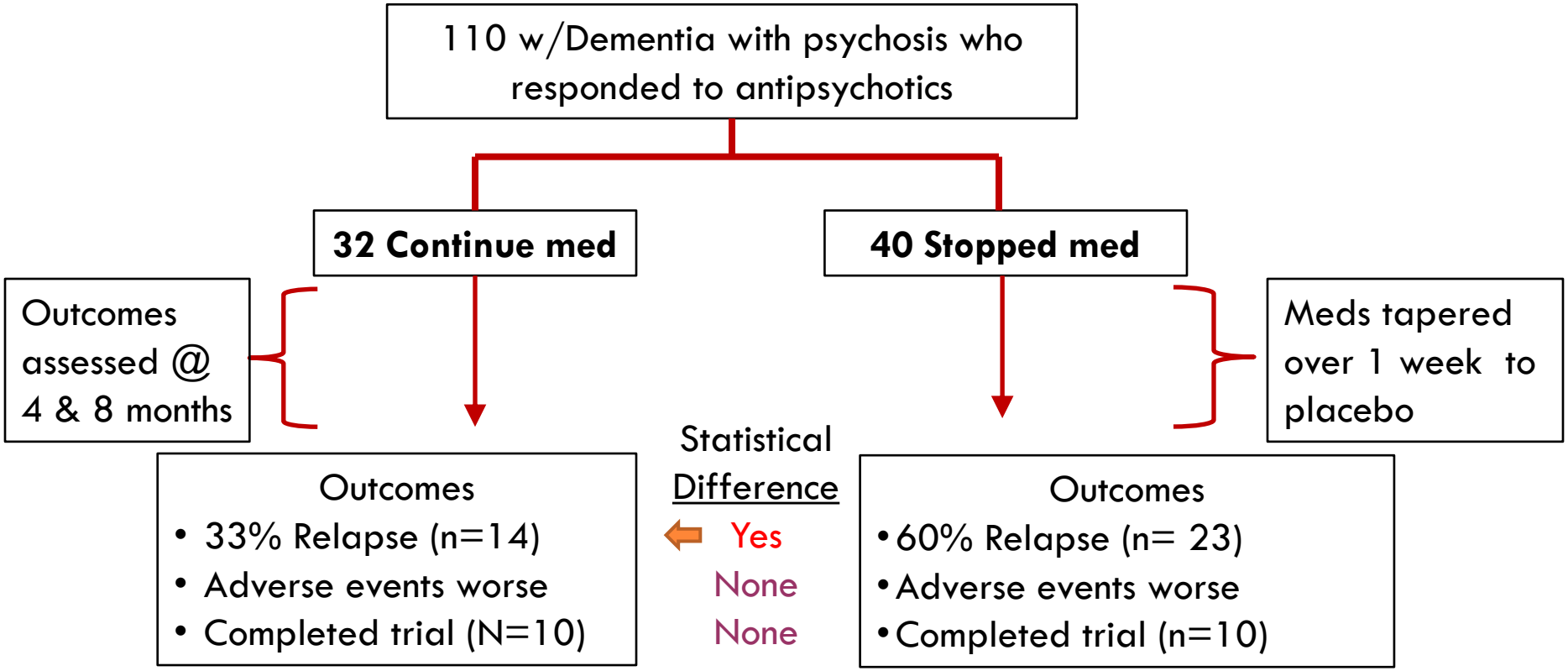
[2]*Ballard C et al J Clin Psychiatry 2004: 65:114-119*

RCT to withdraw antipsychotics[3]



[3]*Ballard C et al Plos Medicine 2008; 5:e76: 587-599*

RCT to withdraw antipsychotics[4]



[4]*Devandand DP et al NEJM 2012; 367:1497-1507*

Third group not shown here: continued med for 4 moths then discontinued meds

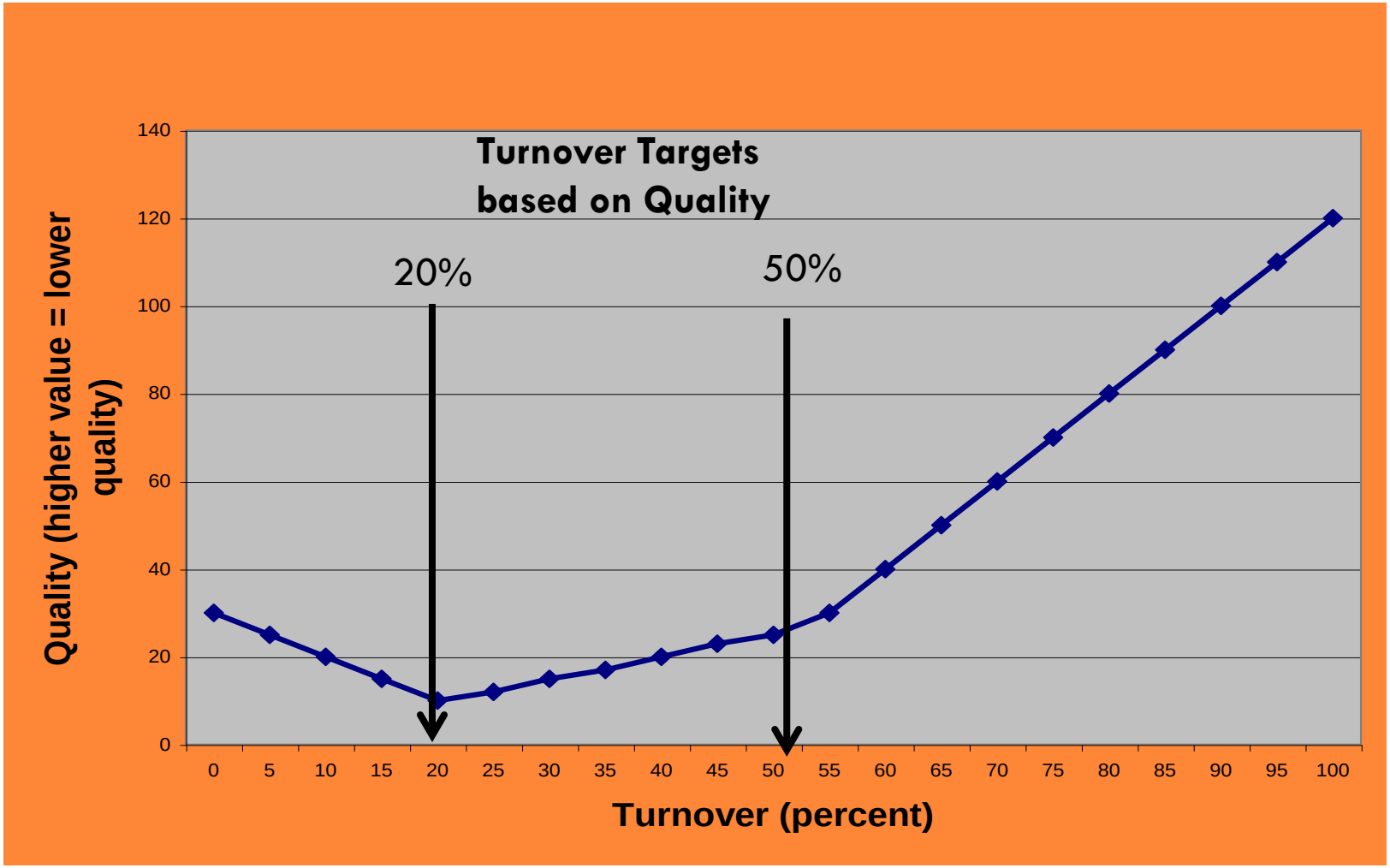
Initial steps to reduce

- Discontinue PRN only orders for antipsychotics
- Look at discontinue or gradual dose reduction for residents on medications for greater than 12 weeks (3 months), particularly those on very low doses
- Evaluate need for antipsychotics started on residents during the evening/night shift or over the weekend
- Evaluate the need for continuing antipsychotics at admission

Questions to ask before Rxing

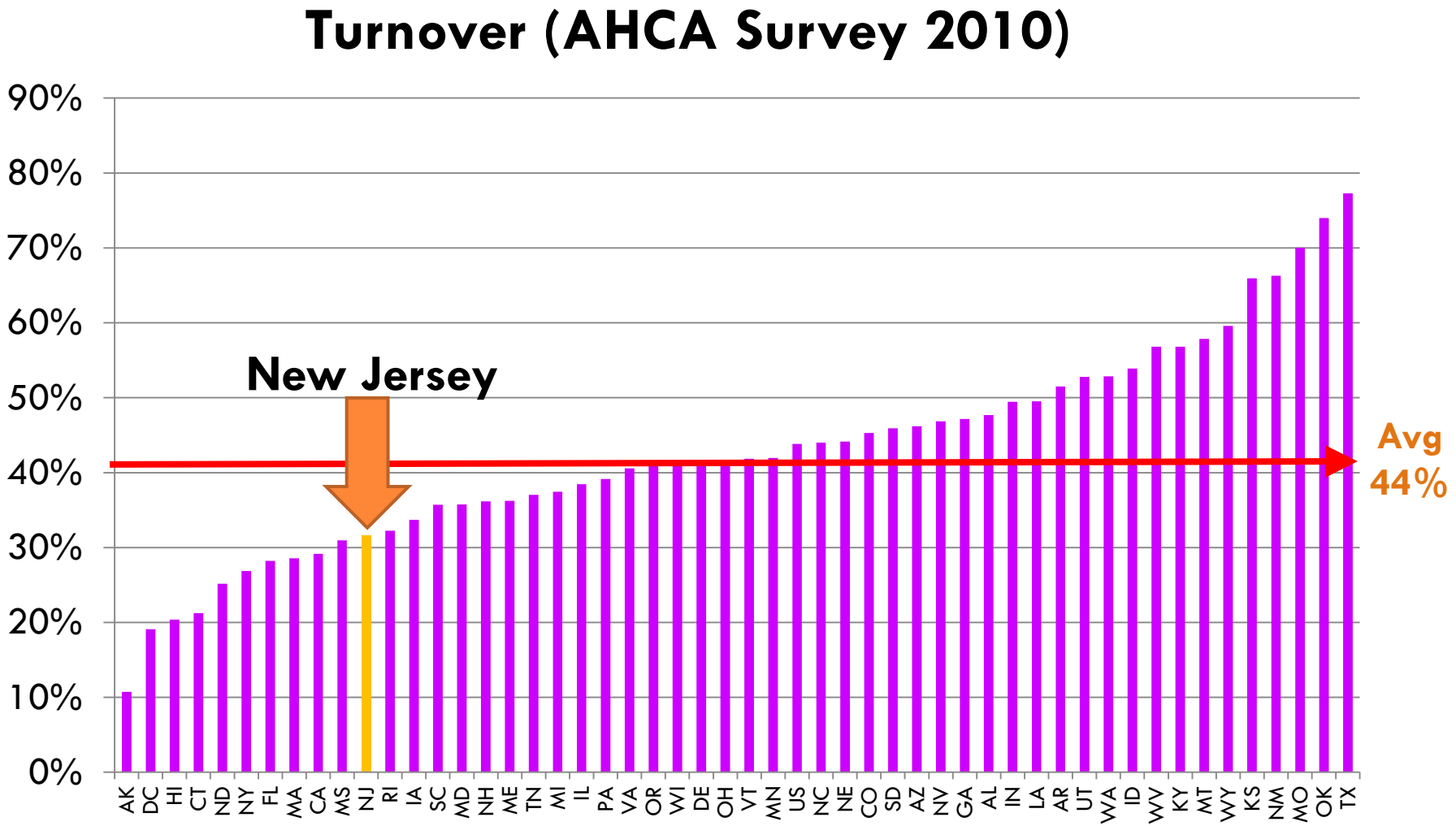
- What did you do to try and figure out why the resident was doing <fill in the blank>?
- What is resident trying to communicate to us about their <fill in blank>?
- What is reason for resident doing <fill in blank>?
  - Unacceptable answer (Dementia or sun-downing)
- What did you try before requesting medications?

All STAFF TURNOVER vs QUALITY



Castle 2011

Turnover Clinical Staff by State



What Matters Most to Employees?

- Management cares about employees
- Management listens to employees
- Help with stress and burnout
- Workplace is safe
- Supervisor cares about you as a person
- Supervisor shows appreciation

- MyInnerView, Inc. 2005

Initial Step to Take

- Walk rounds
  - Once a week during walk rounds ask 1 staff person how it is going
    - Ask “what frustrates them about their job?”
    - Ask “what they need to make their job easier?”
    - Conduct off hours or weekends at least 1x week

Contact Information

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