

## Developing A Culture Change to Reduce Hospitalization



Loretta J. Kaes, BSN, RN, B-C, C-AL, CALA, LNHA  
Director, Clinical Services and Quality Improvement  
Health Care Association of New Jersey

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### Objectives

1. Develop a culture change of reducing potentially preventable hospitalizations safely.
2. Develop skilled and competent staff to manage the higher acuity of an aging population with chronic medical conditions.
3. Using evidence based data to implement processes that detect change in condition early.
4. Person-centered care and advanced care planning are key elements of successful outcomes.
5. Collecting, tracking and using data.

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Currently, Assisted Living/LTC is -

**Staff Directed** ➡

**Staff Centered**



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**Culture Change is defined as -**

**Honoring the voices and  
choices of residents and staff.**



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**Person Centered Care is -**

**Resident Centered →**

**Resident Directed**



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**Why is culture change  
needed now?**

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- Affordable Care Act
- Decreased emphasis on acute care
- Increased focus on managing chronic conditions
- Economically driven

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## HAZARDS OF HOSPITALIZATIONS



More hospitalizations  
= increased mortality

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## HAZARDS OF HOSPITALIZATION INCLUDE

Function



Cognitive Impairment



HAI – often leading to chronic severe debilitation and death, loss of self esteem and incidence of depression often severe.

Resident and Family Satisfaction



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### STARTLING STATISTICS

- Functional impairment key cost driver – not chronic disease
- Research found 39% of elderly with one or more chronic conditions and functional impairment had at least one inpatient hospital stay compared to 15% of elderly with one or more chronic conditions alone.

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### End of Life Care



- New Jersey leads the country in costs in last 2 years of life!
- In New Jersey, in the last 6 months of life these elders were seen by the most specialists and cost the most money.

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### 4 SIGNIFICANT CONFLICTS:

1. Confusion over the role of the licensed nurse
2. Conflict over the transformation of a traditional care model to a resident-centered care model
3. Reconciling individualized care with quality nursing care
4. Nurses fear perceived or real threats to nursing autonomy, regulatory-related issues and the professional nurse's scope of practice and accountability

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### How Did the ACA Change the Way We Deliver Care?

- Two Care Models
  - Acute and Chronic
- Emphasis on prevention and wellness
- Management of chronic medical diseases to include prevention of acute episodes
- Incentives for hospitals and providers to keep chronic illness out of the hospital

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### Reasons for Re-admission to Hospital

- Decline in Clinical Condition
  - Failure to recognize decline, prevent complication, or poor quality of care
  - Poor transitions of care/discharge planning
  - Lack of advance directive
  - Lack of ability to meet the needs of the patient/resident (perceived or real)

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### Bottom Line Goal



**Eliminate preventable  
re-hospitalizations by preventing  
the issues that cause them.**

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### How Does Reducing Hospitalizations Benefit Residents?

- **Residents stay** with familiar staff who know them and their needs
- **Residents remain** in a familiar environment with their personal possessions and maintain their routines as much as possible
- **Residents avoid** an uncomfortable, often traumatic, trip to the hospital and long waits in the ED

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### Benefits

- **Residents avoid** adverse events that can occur due to a change in medication.
- **Residents avoid** acquiring a hospital-related complication

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### What is INTERACT?

#### Interventions to Reduce Acute Care Transfers

- INTERACT is not just a set of tools, it's a quality improvement program with different components
- INTERACT improves the care of nursing home residents with acute changes in condition
- This program will help safely and effectively manage nursing home residents without hospital transfers
- Supports communication of patient condition to hospital provider when transfer is necessary

Website: <http://www.interact2.net/>

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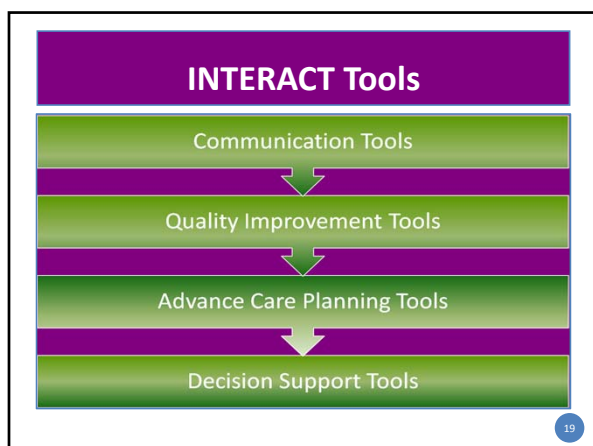
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### Benefits of INTERACT

- INTERACT can help your facility safely reduce admissions and readmissions by:
  - Preventing conditions from becoming severe
    - ✓ Early assessment
    - ✓ Early action
  - Managing conditions in the nursing home, without transfer, when safe and feasible
  - Improve advance care planning and use of palliative care plans as an alternative to hospitalization, when appropriate

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### INTERACT

- **INTERACT eCurriculum is comprised of 13 models**
- **Covers all aspects of the INTERACT quality improvement process for ALL disciplines**
- **Available on [www.INTERACT2.net](http://www.INTERACT2.net) and [www.MedlineUniversity.com](http://www.MedlineUniversity.com)**

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## INTERACT

- Start by implementing SBAR and Stop and Watch for AL
- Capabilities of AL
- Track hospitalizations & re-hospitalizations
- Use Care Path protocols for chronic diseases such as CHF, Fever, Symptoms of Lower Respiratory Infection, Acute Mental Status Change

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## ADVANCE DIRECTIVES

- More than just a YES/NO to CPR
- Know your state-specific requirements
  - Medical Orders for Life Sustaining Treatment (POLST)
  - Medical Orders for Scope of Treatment (MOST)
- Obtain upon admission if not before




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## Physician Order for Life Sustaining Treatment POLST

- Need to honor resident preferences for end-of-life care
- Far too many die in intensive care hooked-up to life support
- Discussion takes place when resident diagnosed and chronic medical condition explained by physician which should result in Advanced Care Plan

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### Care Path for CHF

- Resident is provided with a scale for daily weight completed each day upon wakening and after voiding
- Vital Signs
- Pulse Ox
- Intake and output
- Finger stick for Diabetics




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### Challenges

- ✓ Staff availability, staff training and lack of equipment
- ✓ Inadequate lab and x-ray services
- ✓ Reimbursement for third party billing
- ✓ Physician/Nurse Practitioner availability

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### Competency of Nursing Staff

- ✓ RN vs. LPN
  - Model for delivery of nursing care
  - Team/functional nursing vs. primary care
- ✓ Nursing skill/competency evaluation
  - Skills checklists, observation not self reported
  - Routine re-evaluation
- ✓ Staffing rotations
  - Avoid the Mon-Fri first string/weekend second string approach

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## Medication Management

- Medication reconciliation
  - ✓ Not just verification of orders with the physician
  - ✓ Review of home medications with resident or family member
  - ✓ Assess resident's medication knowledge
  - ✓ Identify new medications
  - ✓ If possible, determine which doctor ordered which medications

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## Help is on the way

- ACA will provide remote resident monitoring
- ALF is a lower cost and preferred community based option for many
- Bundled Care Payment will allow for cost of distant monitoring
- Hospital will provide monitoring service to avoid penalties of re-hospitalization

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## Market Forces - New Models of Care



**Walgreens WellTransitions<sup>sm</sup>**  
Provides discharge services to help hospitals and health systems reduce re-admissions.



**U.S. Department  
of Veterans Affairs**

"Care Coordination/Home  
Telehealth: The systematic

implementation of health informatics, home telehealth, and disease management to support the care of veteran patients with chronic conditions."

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## Resources

- Private pay may be an option for many
- An increased care service level
- Negotiate with Home Care Agencies to meet the needs of the residents with chronic conditions
- Require your in-house therapy service to provide respiratory therapy to decrease symptoms
- All service should allow for one on one care for toileting during peak action of diuretic medication to avoid falls and use of catheter

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## Building Relationships

- Resident and Family
- Physician/Advanced Practice Nurse
- Hospital and Skilled Nursing Facility
- ACO/MCO

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## Consider a Retrospective Review

- Discharges to the hospital over the last 180 days
  - Reason for discharge and disposition
  - Primary diagnosis, comorbidities
  - Length of stay
  - Time/day of week discharge, discharging nurse
  - ER visits during stay
  - Contributions factors, i.e., family dynamics

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### Evaluation of Pre-admission Process

- Are you taking admissions that you have no business accepting?
- Are you receiving adequate information about potential residents' needs?
  - On-site assessment vs. telephone review
  - Confirm you can meet the patient's needs
  - Empower DON to control acuity
  - Manage expectations of the family/resident
  - Understand discharge goals prior to admission

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### Tracking Data

- Hospitalizations
- Infections
- Resident/ Family Satisfaction
- Staff satisfaction
- Quality Measures




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### Quality Nursing Assessment and Communication

- Head to toe assessment
- Full analysis of findings/observations
  - Goal is not to complete the task of assessment, but to use nursing knowledge and skill to evaluate the patient's response to illness.
  - determine nursing actions to promote healing and prevent complications
- Communicating with physician
  - Well prepared prior to call
  - Pertinent information

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### Building Relationships

- Present to your consumers your strengths
- Define weaknesses and work to correct
- Use consistent assignment to stabilize workforce
- All staff work to increase skill and competency
- Provide education and incentives
- Use the INTERACT Quality Improvement Process

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### Characteristics of ALFs with Potential to Meet Hospital Goals

- Establish method to identify high-risk residents and use of care path protocols
- Ability to track hospitalizations and ED visits
- Use of standardized communication protocols such as Situation-Background-Assessment-Recommendation (SBAR)
- Clinical specialties, such as rehabilitation, physical/occupational/speech therapy, memory care, remote monitoring, medication management

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### Relationship with Hospitals

- ✓ Ask the hospital what services they need
- ✓ Ask them what their discharge procedure is and how that works with your resident needs
- ✓ Ask for a warm hand off-nurse to nurse report
- ✓ Ask for a discharge medication reconciliation
- ✓ Ask that they provide a home visit based on the needs and acuity of the resident
- ✓ Be a solution not a problem

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### ALFs with Potential to Meet Hospital Goals

- Specialized staff and staffing protocols, such as care coordinators, NPs hired by the ALF
- Ability to report health statistics on readmissions and admissions
- Use of remote monitoring
- 24-7 nursing

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### In Conclusion, remember . . .

- Be true to what you are
- Be open to change-change is inevitable
- Educate and elevate your knowledge base-much more is expected of nurses
- Educate and train your staff-much more is expected of them
- Take every opportunity to educate the resident, their family and the stakeholders you depend on




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### Resources

- Centers for Medicare & Medicaid Services [www.cms.gov](http://www.cms.gov)
- INTERACT<sup>tm</sup> Tools: version 3 now available [www.interact2.net](http://www.interact2.net)
- American Medical Directors Association [www.amda.com](http://www.amda.com) (Protocols for AL, CHF, COPD, etc.)
- Advancing Excellence [www.nhqualitycampaign.org](http://www.nhqualitycampaign.org)
- American Health Care Association [www.ahca.org](http://www.ahca.org)
- HCANJ Best Practices [www.hcanj.org](http://www.hcanj.org)

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## Resources

- National Transitions of Care Coalition  
[www.ntocc.org/home.aspx](http://www.ntocc.org/home.aspx)
- BOOST (Better Outcomes for Older Adults through Safe Transitions) [www.hospitalmedicine.org](http://www.hospitalmedicine.org)
- Health Care Leader Action Guide to Reduce Re-admissions [www.hret.org](http://www.hret.org)
- American HealthTech [www.healthtech.net/15-ways-to-attack-readmissions](http://www.healthtech.net/15-ways-to-attack-readmissions)

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