39th Annual Meeting

Mastering Person-Centered Care
Through Improved Communication, Care Transitions, and Palliative Care

When Hospitalist Meets SNFologist Panel

Panelists

Nasim Afsarmanesh, MD

Joseph Bestic, NHA

Lisa Contreras, RN, BSN, MBA, NHA

James E. Lett II, MD, CMD

Disclosures

All panel participants have no relevant financial relationships with commercial interest to disclose.

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Learning Objectives

Participants will be better able to:

- Understand the roles and responsibilities of members of the Hospital and SNF interdisciplinary teams in their respective care settings.
- Realize how care transition tools can improve communications between the Hospital and SNF interdisciplinary teams.
- Learn of best practices employed by Hospital and SNF interdisciplinary teams for reducing avoidable hospital re-admissions.

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Case Study

Who is the most at fault for the bad outcome?"

- Hospitalist
- SNFologist
- DON
- Administrator
- No way to determine

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A Hospitalist Perspective

Nasim Afsar, MD SFHM
Associate Chief Medical Officer, UCLA Hospitals
Email: nafsarmanesh@mednet.ucla.edu

Concerns Identified

- Communication, communication, communication!
  - Immediate SNF evaluation upon transfer
  - Assessment by neurologist at SNF
  - Confusion about medications
  - Lack of follow-up with treatment
  - Respect in communication

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Potential Interventions

- Communication about plan of care
  - Hospitalist with SNFist
  - ED with SNFist
  - And yes, with the patient and family!
- Appropriate and timely follow-up
  - High risk patients
- Be part of the solution!

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QUESTIONS | CONTACT | SITE MAP

SEARCH GO

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  - QI Current Initiatives and Training Opportunities
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QUALITY INITIATIVES

BOOSTing Care Transitions *Resource Room*

Home | Project Team

Professional Development
Implementation Guide
Exchange Information

How to Use	First Steps	Best Practices	Analyze Care Delivery	Track Performance	The BOOST Intervention	Continue to Improve	Education Resources	Clinical Tools	QI Basics

Overview

The BOOSTing (Better Outcomes by Optimizing Safe Transitions) Care Transitions resource room provides a wealth of materials to help you optimize the discharge process at your institution. We developed this through support from the John A. Hartford Foundation (Read more about Project BOOST and the BOOST mentoring program) . We based the approach and tools on principles of quality improvement, evidence-based medicine as well as personal and institutional experiences. Of note, we are piloting the contents at multiple hospitals and will be constantly revising the resource room based on this invaluable experience.

PROJECT BOOST HOME PAGE

- Download the BOOST Fact Sheet
- Read more about BOOST and the BOOST Mentoring Program
- BOOST In The Media
- BOOST Case Studies:
  - Read about Piedmont Hospital, "BOOSTing a Team Approach to Patient Care
  - Read about SSM St. Mary's Medical Center, "Reducing Readmissions and So Much More"

This resource room will help you to:

- Analyze current workflow processes
- Select effective interventions
- Redesign work flow and implement interventions
- Educate your team on best practices
- Promote a team approach to safe and effective discharges
- Evaluate your progress and modify your interventions accordingly

www.hospitalmedicine.org/boost/

Essential First Steps in Quality Improvement

Garnering Institutional Support, Assembling a Team and Team Rules, and Understanding the Framework for Improvement

Essential elements for improving the discharge transition include:

1. **Institutional support** for and prioritization of this initiative, expressed as a meaningful investment in time, equipment, informatics, and personnel in the effort.
2. A **multidisciplinary team or steering committee** that is focused on improving the quality of care transitions in your institution.
3. **Engagement of patients and families** and recognition of the central role they play in executing the post–hospital care plan.
4. **Data collection and reliable metrics** that, at a minimum, reflect any relevant CMS core measures and the relevant PQRI measures. These data should be transformed into reports that inform the team and frontline workers of progress and problem areas to address.
5. **Specific aims, or goals,** that are time defined, measurable, and achievable.
6. **Standardized discharge pathways that** highlight key medications and any medication changes, important follow-up and self-management instructions, and any pending tests.
7. **Policies and Procedures** that are institution specific and that support the order sets and promote their safest and most effective use. These documents must be widely disseminated and used and when possible embedded in the order set. A high-reliability design should be used to enhance effective implementation. These policies and procedures should outline and guide the care team in:
   - Team communication
   - Content of the discharge summary
   - Patient education
   - Medication safety and polypharmacy
   - Symptom management
   - Discharge and follow-up care
8. **Comprehensive education programs** for health care providers and patients, re¬in¬forcing both general and institution-specific information about the discharge process and use of specific tools.

Prior to this section, consider reviewing the slide presentation on Quality Improvement Theory in the QI Basics section of the room.

A SNFologist Perspective

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Unrealistic Expectations Put Into Place

- SNFologist will be in the next day
- Lab & x-ray expected to be on site
- No neurologist attends at the SNF
- Opportunity: Have the SNFologist call the family upon the first visit

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Offhand Comments Can Be Devastating

- Whether it was said or not, “severe dehydration” was the perception the daughter took away.
- “This happens all the time in nursing homes.”
- “What do you expect when an 89 year old has major surgery”
- “Confidentially, it seems like a lot of our residents die after surgery there.”

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SNFologist Culpability

- Does your call coverage provide adequate coverage & what do they do when called
- Are you set up for failure by your call partners
- Communication with the NP
- Evaluation of weight loss appears sub-optimal

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The SNF-ED Interface

- INTERACT II
  - Stop and Watch
  - Algorithms for evaluation & reporting of dehydration
- Avoids dealing with the "UTI that never was" n
  - Unnecessary antibiotics
  - No criteria for UTI
- Averts the "dehydration" issue

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Poor Transition Handoffs

- The SNF did not send the lab with the resident when she went to the ED; the BUN was the same as it was when she was admitted to the SNF
- Unclear Vibramycin order
- No method of discovering discharge orders following change in nursing & hospitalist change in shift
- AMDA TOC CPG transition forms
- P&P on what information to send with transfers

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A DON Perspective

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Skilled Nursing

- Admission Assessment
  - Includes Family concerns, establish resident baseline
  - IDT discussion of resident/family concerns
- SBAR Communication
  - Improves Nurse to Physician Communication

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Emergency Room Visit

- Acute transfer sheet
  - Warm Handoff to ED staff
- Medication order clarification
  - 5 rights of medication administration

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Change in Condition Management

- Stop And Watch Tool
  - Provides focused assessment opportunity
- Assess resident and gather data
  - Decreased appetite, medication dose
  - Elevated BUN
  - Increasing lethargy
  - Daughter’s persistent concerns
- Refer to Interact II Care Path for dehydration

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A Nursing Home Administrator Perspective

Joe Bestic, NHA , BA
Director, Nursing Home
Health Services Advisory Group of California, Inc.
(HSAG-California)

Case Study NHA Concerns

- Hospitalist indicated that the SNF physician would see Sarah the next day. Lab work & x-ray would be done as needed.
- Hospitalist told the daughter Sarah could be evaluated by a neurologist at the nursing facility.
- DON statement to family member- “Hospitals have those DOG’s – or DRG’s or whatever they are – so people have to leave so the hospital does not lose money.”

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Case Study NHA Concerns

- The on-call doctor for the SNF physician, indicates he "does not like NH 's, resident should go to the ED."
- Vibramycin 50 mg po QID - Medication Rec. Issue.
- Sarah becomes nauseated & anorexic. Her weight drops 5 lbs. within a week; lethargic and is unable to participate well in therapy.
- Subsequent fall and fx.
- Surgery, decline, patient/resident expires.
- Daughter seeks legal counsel.

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Solutions from NHA Perspective

- Advancing Excellence Readmission Tracker
  http://www.nhqualitycampaign.org

- INTERACT III http://interact2.net/tools_v3.aspx
  - -NH Capabilities List
  - -Stop and Watch
  - -SBAR Communication Form
  - -Med. Rec. Worksheet (Post-Hospital Care)
  - -NH/Hospital Transfer Form

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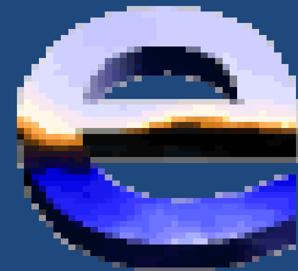
Questions?

Contact Information

Joe Bestic, NHA, BA

HSAG-California Director, Nursing Home

- jbestic@hsag.com
- Phone: 818.409.9229
- Fax: 818.409.0835



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References

- INTERACT II
  - http://interact2.net
- AMDA Transitions of Care in the Long Term Care Curriculum Clinical Practice Guidelines
  - http://www.amda.com/tools/clinical/toccpg.pdf

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