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Strategies for Rehospitalization Reduction

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Medical Director Quality Insights

AGENDA

TOPICS TO BE COVERED

1. Why should we reduce hospitalizations?
2. Sepsis: Prevention and awareness
3. Advance care planning: Importance and education
4. Falls: Prevention opportunities
5. Medication Management: Red flags

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Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents

- CMS initiative to introduce clinical interventions and measure their impact
- Residents treated on-site were compared to residents treated in the hospital for one of six conditions.
- Residents treated initially in the hospital were about twice as likely to be subsequently treated in-hospital and more than twice as likely to die (17.0% vs 7.8%) compared to those initially treated in place.
- The results indicated a possible benefit to treating residents on-site.

Office of Inspector General (OIG) Top Diagnoses for Hospitalizations From Nursing Homes

- Sepsis
- Chronic obstructive pulmonary disease (COPD)/asthma
- Pneumonia
- Congestive heart failure (CHF)
- Urinary tract infection (UTI)
- Dehydration

LOW-HANGING FRUIT APPROACH TO HOSPITALIZATION REDUCTION

Let’s talk about some steps that we can implement to reduce preventable hospitalizations from the most common causes.

SEPSIS PREVENTION

FALLS PREVENTION

ADVANCE CARE PLANNING

MEDICATION MANAGEMENT

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SEPSIS PREVENTION

“Illness has a lot to teach wellness.”
– Matt Haig

What Is Sepsis?

- Centers for Disease Control and Prevention (CDC) defines sepsis as “the body’s extreme response to an infection.”
- The infection that causes sepsis starts prior to a patient going to the hospital 87% of the time.
- 1 in 3 people who die in the hospital had sepsis during that hospitalization.

https://www.cdc.gov/sepsis/what-is-sepsis.html

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Who Is at Risk?

- Age greater than 65
- Chronically ill
- Young children
- Immunosuppressed
- People who previously had sepsis
- People who had a recent severe illness or hospitalization

https://www.cdc.gov/sepsis/what-is-sepsis.html

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Sepsis in Long-Term Care

Nursing home residents:

- Are 7 times more likely to have severe sepsis
- Are more likely to be admitted to the ICU
- Have longer hospital lengths of stay associated with sepsis
- Have higher mortality rates associated with sepsis
- Are more susceptible to adverse affects of hospitalization (nosocomial infections, delirium, etc)

Ginde AA, Moss M, Shapiro NI, Schwartz RS. Impact of older age and nursing home residence on clinical outcomes of US emergency department visits for severe sepsis. J Crit Care. 2013 Oct;28(5):606-11. doi: 10.1016/j.jcrc.2013.03.018. Epub 2013 May 15. PMID: 23683561; PMCID: PMC3770757.

Can We Prevent Sepsis in the Nursing Home?

"Because symptoms and signs are nonspecific in older patients, especially those with multiple comorbidities and/or cognitive impairment, virtually any acute change in condition could represent possible sepsis due to an infection."

Reyes BJ, Chang J, Vaynberg L, Diaz S, Ouslander JG. Early Identification and Management of Sepsis in Nursing Facilities: Challenges and Opportunities. J Am Med Dir Assoc. 2018 Jun;19(6):465-471. doi: 10.1016/j.jamda.2018.04.004. PMID: 29793674.

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The Study

- 31 community nursing homes in North Carolina
- Mean bed size was 113 (mean occupancy was 87%)
- Licensed nurses and certified nursing assistants (CNAs) were staffed at an average rate of 1.5 and 2.2 hours, respectively, per resident; the mean quality rating on Nursing Home Compare was 3.3
- The nursing homes did not differ from nursing homes nationally

The Findings

- 59 sepsis and 177 nonsepsis cases
- All 4 vital signs (temperature, pulse, respiratory rate, and blood pressure) were documented during the 12 hours prior to hospitalization in 66% of the sepsis cases; for 13-72 hours prior to hospitalization, all 4 vital signs were documented in 73% of the sepsis cases.
- Documentation of a visit by a medical provider (physician, nurse practitioner, or physician assistant) in the 12 hours prior to hospital transfer was present in only 19% of the sepsis cases; during the 13-72 hours prior to transfer, that figure was also 19%.

Learning Points

- The sepsis tool that was shown to be the most sensitive was the 100-100-100 tool, as well as oral temperature > 99.0° Fahrenheit.
- It is essential to obtain and document vitals signs as well as changes in cognitive status.
- It is important to engage the physician or provider early to provide an in-person visit if possible.

100-100-100 Screening Tool

- Is their temperature above 100°F?
- Is their systolic blood pressure below 100?
- Is their pulse rate above 100?

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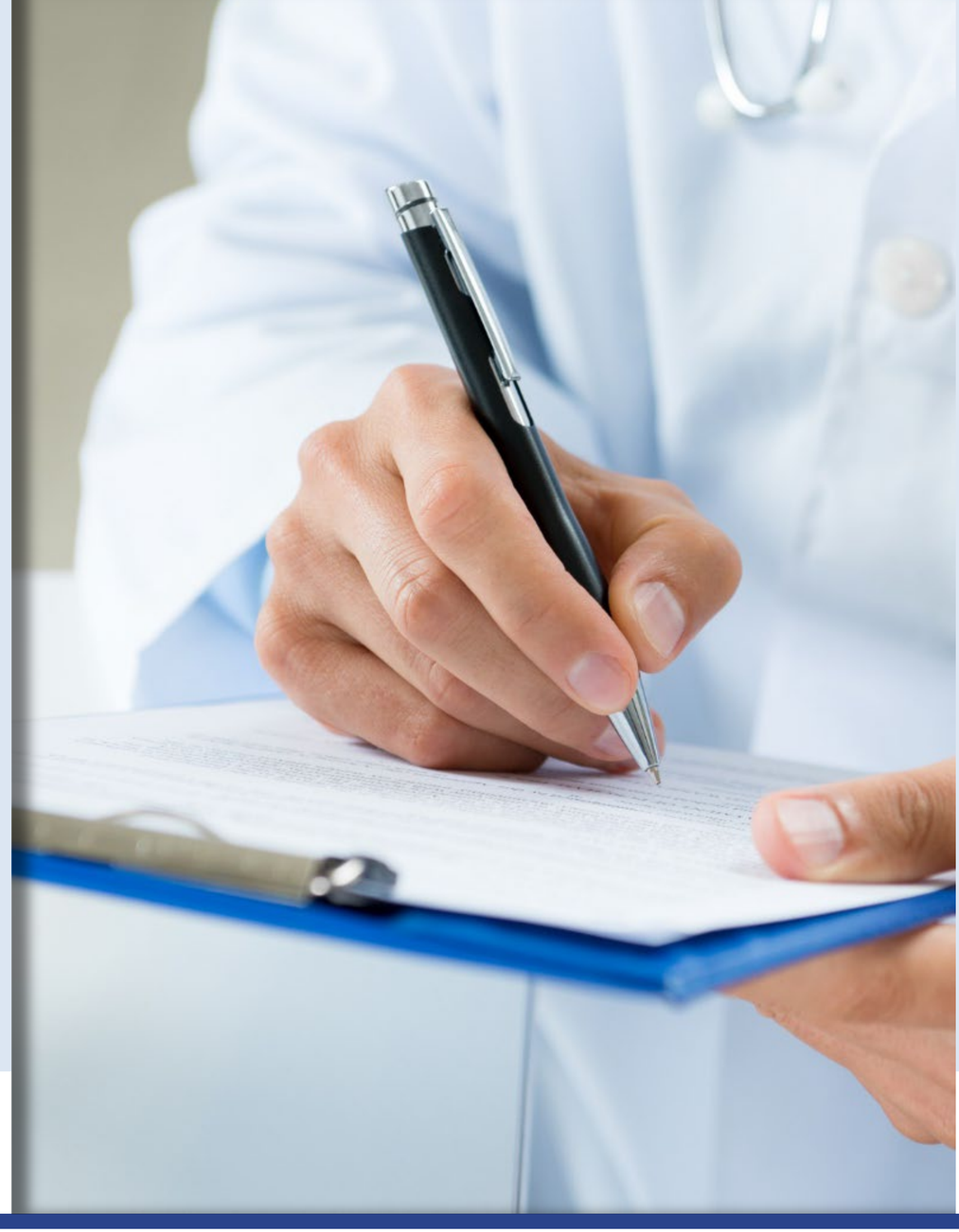
Stop and Watch: Early Warning Tool

INTERACT Assisted Living, Pathway Health

https://www.ohsu.edu/sites/default/files/2019-03/INTERACT-Stop-and-Watch.pdf



Management

- Educate staff to recognize and respond early.
  - Opportunity to empower staff to impact outcomes
  - CNA leadership opportunity
  - Possibility of both points positively influencing staffing stability
- Contact the provider early.
  - Holding the medical director or attending physician accountable
- Order lab studies early (white blood counts, lactate, procalcitonin).
  - Or at least the basics

Management Continued

- IV hydration is the cornerstone of sepsis management and should be started early.
- IV antibiotics should also be initiated early, preferably within 1 hour of sepsis recognition.
- Contact the provider early!

FALLS PREVENTION

“Don’t mention the F-word.”

5 AREAS OF FALL RISKS

Medication

Antidepressants, antipsychotics, benzodiazepines, anticholinergics, others

Orthostatic Hypotension

Postural vital signs should be checked as appropriate

Vision

Observe resident during activities of daily living for signs of poor vision (tripping, difficulty finding objects, detecting changes in floor surfaces, etc.)

Mobility

Screen residents for safety issues gait, balance, and transfers

Unsafe Behavior

Screen residents for unsafe transfers and ambulation

https://www.ahrq.gov/sites/default/files/publications/files/fallspxmanual.pdf

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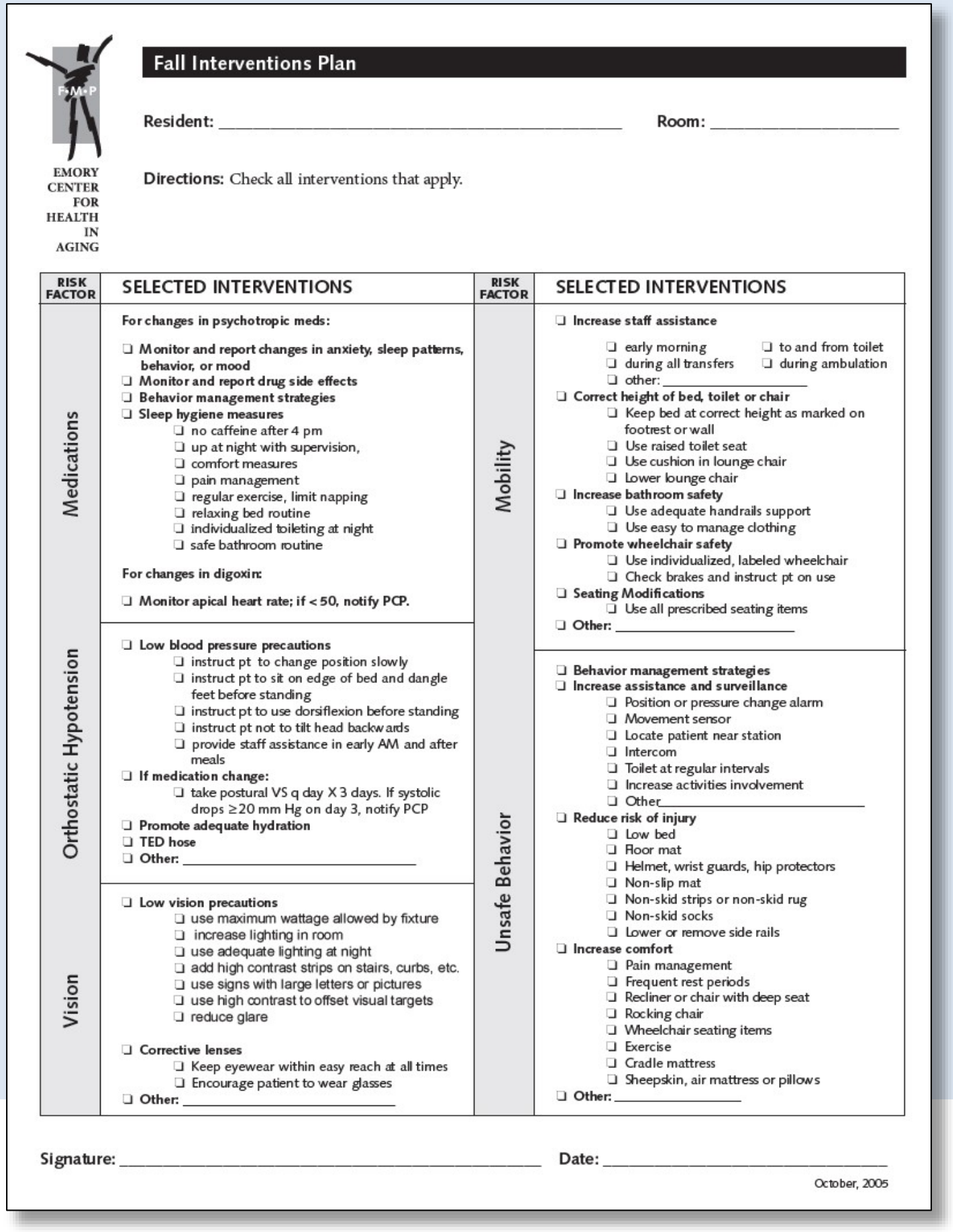
Interim Plan of Care

- Close observation and increased supervision
- Frequent orientation to room, bathroom, and facility
- Medication review
- Use of safe footwear
- Staff assistance to toilet or bedside commode
- Use of monitoring or sensor devices
- Use of pressure, position, or other alarms
- Use of protective clothing/devices



EMORY CENTER FOR HEALTH IN AGING

Fall Interventions Plan

Resident: _____ **Room:** _____

Directions: Check all interventions that apply.

RISK FACTOR	SELECTED INTERVENTIONS
Medications	**For changes in psychotropic meds:** ❑ **Monitor and report changes in anxiety, sleep patterns, behavior, or mood** ❑ **Monitor and report drug side effects** ❑ **Behavior management strategies** ❑ **Sleep hygiene measures** ❑ no caffeine after 4 pm ❑ up at night with supervision, ❑ comfort measures ❑ pain management ❑ regular exercise, limit napping ❑ relaxing bed routine ❑ individualized toileting at night ❑ safe bathroom routine **For changes in digoxin:** ❑ **Monitor apical heart rate; if < 50, notify PCP.**
Orthostatic Hypotension	❑ **Low blood pressure precautions** ❑ instruct pt to change position slowly ❑ instruct pt to sit on edge of bed and dangle feet before standing ❑ instruct pt to use dorsiflexion before standing ❑ instruct pt not to tilt head backwards ❑ provide staff assistance in early AM and after meals ❑ **If medication change:** ❑ take postural VS q day X 3 days. If systolic drops ≥20 mm Hg on day 3, notify PCP ❑ **Promote adequate hydration** ❑ **TED hose** ❑ **Other:** _____
Vision	❑ **Low vision precautions** ❑ use maximum wattage allowed by fixture ❑ increase lighting in room ❑ use adequate lighting at night ❑ add high contrast strips on stairs, curbs, etc. ❑ use signs with large letters or pictures ❑ use high contrast to offset visual targets ❑ reduce glare ❑ **Corrective lenses** ❑ Keep eyewear within easy reach at all times ❑ Encourage patient to wear glasses ❑ **Other:** _____

RISK FACTOR	SELECTED INTERVENTIONS
Mobility	❑ **Increase staff assistance** ❑ early morning ❑ to and from toilet ❑ during all transfers ❑ during ambulation ❑ other: _____ ❑ **Correct height of bed, toilet or chair** ❑ Keep bed at correct height as marked on footrest or wall ❑ Use raised toilet seat ❑ Use cushion in lounge chair ❑ Lower lounge chair ❑ **Increase bathroom safety** ❑ Use adequate handrails support ❑ Use easy to manage clothing ❑ **Promote wheelchair safety** ❑ Use individualized, labeled wheelchair ❑ Check brakes and instruct pt on use ❑ **Seating Modifications** ❑ Use all prescribed seating items ❑ **Other:** _____
Unsafe Behavior	❑ **Behavior management strategies** ❑ **Increase assistance and surveillance** ❑ Position or pressure change alarm ❑ Movement sensor ❑ Locate patient near station ❑ Intercom ❑ Toilet at regular intervals ❑ Increase activities involvement ❑ Other_____ ❑ **Reduce risk of injury** ❑ Low bed ❑ Floor mat ❑ Helmet, wrist guards, hip protectors ❑ Non-slip mat ❑ Non-skid strips or non-skid rug ❑ Non-skid socks ❑ Lower or remove side rails ❑ **Increase comfort** ❑ Pain management ❑ Frequent rest periods ❑ Recliner or chair with deep seat ❑ Rocking chair ❑ Wheelchair seating items ❑ Exercise ❑ Cradle mattress ❑ Sheepskin, air mattress or pillows ❑ **Other:** _____

Signature: _____ **Date:** _____

October, 2005

Internet Citation: Appendix B11: Fall Interventions Plan. Content last reviewed February 2023. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/injuries/fallspx/manapb6.html

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ADVANCE CARE PLANNING

“The line between life and death is
not thicker than an eyelid.”
– Eiji Yoshikawa

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§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).

- (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
- (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
- (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
- (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
- (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf

Hospitalization at the End of Life

- 25.5% to 69.7% of nursing home residents at end of life are hospitalized.
- Advance care planning helps residents understand and communicate their wishes regarding end of life care.
- Advance care planning interventions have been shown to reduce hospitalizations of nursing home residents.
- ACP most effective when done:
  1. Within 7 days of admission/readmission
  2. When more information is needed (e.g. hospice)
  3. When there is a major health status change

Pimsen A, Kao CY, Hsu ST, Shu BC. The Effect of Advance Care Planning Intervention on Hospitalization Among Nursing Home Residents: A Systematic Review and Meta-Analysis. J Am Med Dir Assoc. 2022 Sep;23(9):1448-1460.e1. doi: 10.1016/j.jamda.2022.07.017. Epub 2022 Aug 11. PMID: 35964662.

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Some Recommendations to Reduce Unwanted Transfers

- Discuss transfer to hospital wishes before a health crisis occurs as well as hospitalization impact on resident.
- Document preferences for hospital transfer in the setting of acute medical illness.
- Document preferences for hospital transfer in the setting of acute injury.
- Establish clear care plans for residents with complex medical issues or palliative care (as needed medication orders).
- Ensure all members of the care plan, the resident, and decision-makers understand the care plan prior to a health crisis.

Nemiroff L, Marshall EG, Jensen JL, Clarke B, Andrew MK. Adherence to "No Transfer to Hospital" Advance Directives Among Nursing Home Residents. J Am Med Dir Assoc. 2019 Nov;20(11):1373-1381. doi: 10.1016/j.jamda.2019.03.034. Epub 2019 May 27. PMID: 31147290.

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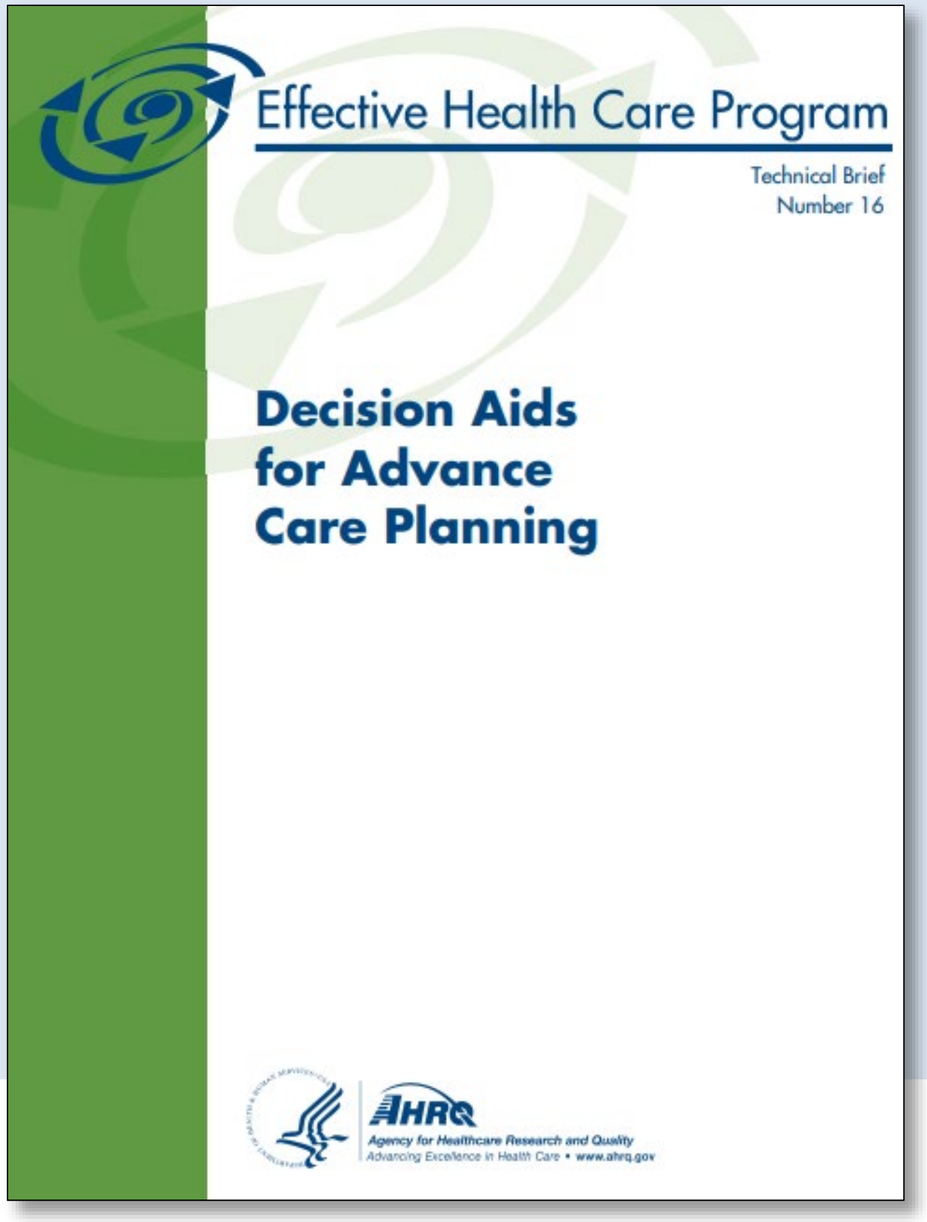

https://www.ncbi.nlm.nih.gov/books/NBK236845/pdf/Bookshelf_NBK236845.pdf

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MEDICATION MANAGEMENT

“Medicine sometimes snatches away health, sometimes gives it.”
– Ovid

Potentially Inappropriate Medications Shown to Lead to Hospitalizations

- Opioids
- Benzodizepines
- Diabetic medications (sliding scale insulin, sulfonylureas)
- Anticoagulants (warfarin, DOACs, asa)
- Anticholinergics (oxybutynin)
- Antipsychotics
- Diphenhydramine
- Hydroxyzine

Lau DT, Kasper JD, Potter DE, Lyles A, Bennett RG. Hospitalization and death associated with potentially inappropriate medication prescriptions among elderly nursing home residents. Arch Intern Med. 2005 Jan 10;165(1):68-74. doi: 10.1001/archinte.165.1.68. PMID: 15642877.

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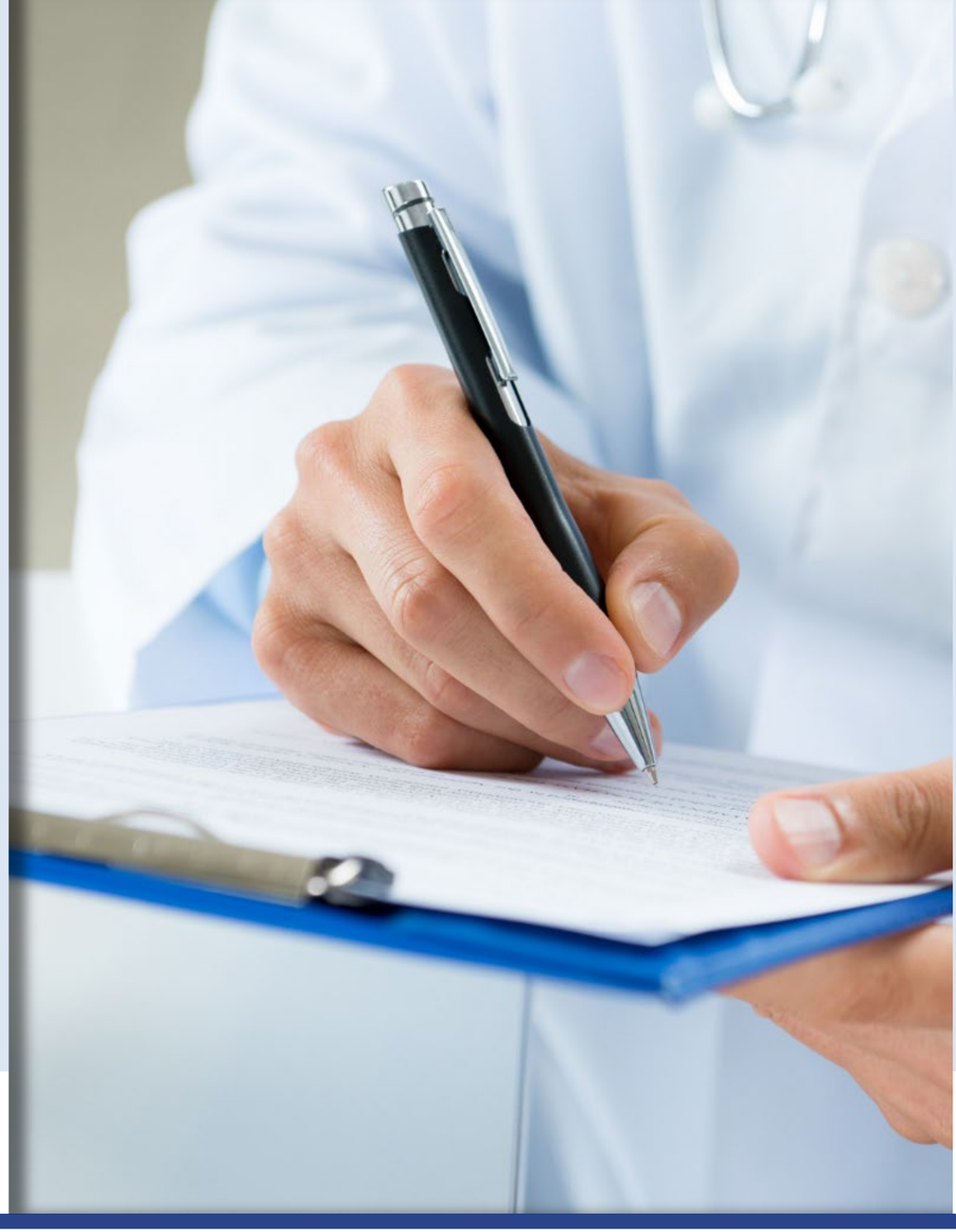
Resource

Ten Medications Older Adults Should Avoid or Use with Caution

HealthinAging.org

https://www.healthinaging.org/tools-and-tips/learn-more-ten-medications-older-adults-should-avoid-or-use-caution



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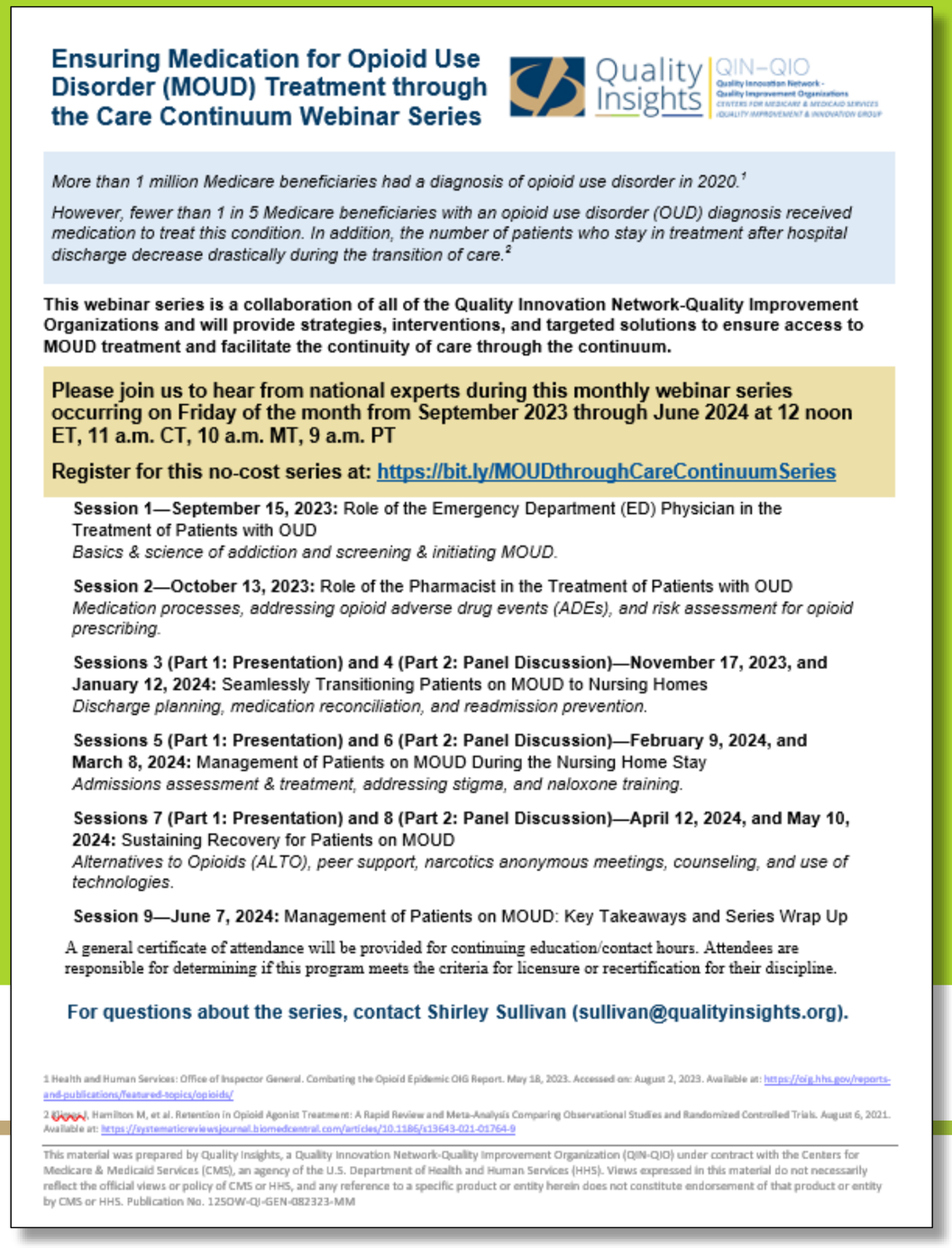

Ensuring Medication for Opioid Use Disorder (MOUD) Treatment through the Care Continuum Webinar Series

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More than 1 million Medicare beneficiaries had a diagnosis of opioid use disorder in 2020.[1]

However, fewer than 1 in 5 Medicare beneficiaries with an opioid use disorder (OUD) diagnosis received medication to treat this condition. In addition, the number of patients who stay in treatment after hospital discharge decrease drastically during the transition of care.[2]

This webinar series is a collaboration of all of the Quality Innovation Network-Quality Improvement Organizations and will provide strategies, interventions, and targeted solutions to ensure access to MOUD treatment and facilitate the continuity of care through the continuum.

Please join us to hear from national experts during this monthly webinar series occurring on Friday of the month from September 2023 through June 2024 at 12 noon ET, 11 a.m. CT, 10 a.m. MT, 9 a.m. PT

Register for this no-cost series at: https://bit.ly/MOUDthroughCareContinuumSeries

Session 1—September 15, 2023: Role of the Emergency Department (ED) Physician in the Treatment of Patients with OUD
Basics & science of addiction and screening & initiating MOUD.

Session 2—October 13, 2023: Role of the Pharmacist in the Treatment of Patients with OUD
Medication processes, addressing opioid adverse drug events (ADEs), and risk assessment for opioid prescribing.

Sessions 3 (Part 1: Presentation) and 4 (Part 2: Panel Discussion)—November 17, 2023, and January 12, 2024: Seamlessly Transitioning Patients on MOUD to Nursing Homes
Discharge planning, medication reconciliation, and readmission prevention.

Sessions 5 (Part 1: Presentation) and 6 (Part 2: Panel Discussion)—February 9, 2024, and March 8, 2024: Management of Patients on MOUD During the Nursing Home Stay
Admissions assessment & treatment, addressing stigma, and naloxone training.

Sessions 7 (Part 1: Presentation) and 8 (Part 2: Panel Discussion)—April 12, 2024, and May 10, 2024: Sustaining Recovery for Patients on MOUD
Alternatives to Opioids (ALTO), peer support, narcotics anonymous meetings, counseling, and use of technologies.

Session 9—June 7, 2024: Management of Patients on MOUD: Key Takeaways and Series Wrap Up

A general certificate of attendance will be provided for continuing education/contact hours. Attendees are responsible for determining if this program meets the criteria for licensure or recertification for their discipline.

For questions about the series, contact Shirley Sullivan (sullivan@qualityinsights.org).

1 Health and Human Services: Office of Inspector General. Combating the Opioid Epidemic OIG Report. May 18, 2023. Accessed on: August 2, 2023. Available at: https://oig.hhs.gov/reports-and-publications/featured-topics/opioids/

2 [redacted], Hamilton M, et al. Retention in Opioid Agonist Treatment: A Rapid Review and Meta-Analysis Comparing Observational Studies and Randomized Controlled Trials. August 6, 2021. Available at: https://systematicreviewsjournal.biomedcentral.com/articles/10.1186/s13643-021-01764-9

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New Webinar Series

Ensuring Medication for Opioid Use Disorder (MOUD) Treatment through the Care Continuum

Session 1 – Friday, Sept. 15, 2023, 12 p.m. ET

Role of the Emergency Department (ED) Physician in the Treatment of Patients with OUD

Basics & science of addiction and screening & initiating MOUD

https://8095482.fs1.hubspotusercontent-na1.net/hubfs/8095482/QIN%20Resources/QINQIOMOUDseriesFINAL%20Quality%20Insights.pdf

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Ensuring MOUD Through the Care Continuum Series

More than 1 million of Medicare beneficiaries had a diagnosis of opioid use disorder in 2020.
However, fewer than 1 in 5 Medicare beneficiaries with an opioid use disorder diagnosis received medication to treat this condition. In addition, the number of patients who stay in treatment after hospital discharge decrease drastically during the transition of care.
This series of webinars will provide strategies, interventions, and targeted solutions to ensure access to treatment and facilitate the continuity of care after hospital discharge.

Choose one or more webinars to attend:

- [ ] Select all upcoming webinars

- [ ] **Session 1: Role of the ED Physician in the Treatment of Patients with OUD**
  12:00 PM - 1:00 PM | Sep 15, 2023 (UTC-04:00) HEATHER FISHER

- [ ] **Session 2: Role of the Pharmacist in the Treatment of Patients with OUD**
  12:00 PM - 1:00 PM | Oct 13, 2023 (UTC-04:00) HEATHER FISHER

*Facility Type

*Full Facility/Company Name (Actual Name of Company/Facility-No Acronyms or Nicknames)

If you are a facility in Pennsylvania, please include your County.

*Zip Code

*I agree to have my information shared with my respective Quality Improvement Organization for my state (ex. Arizona and California attendee information will be shared with HSAG)

- [x] Yes
- [ ] No

Register

PLEASE SELECT 'YES'

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QUESTIONS?

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