CREATING A NURSING TRANSITION COORDINATOR ROLE FOR RESIDENTS MOVING THROUGH THE CONTINUUM

HOW TO CREATE AND UTILIZE THE GAIL SYSTEM: GERIATRIC AFTERCARE INTEGRATION LIAISON

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FOCUS FOR TODAY

- Understand how transitions of care impact a Life Plan campus
- Understand How High Acuity Assisted Living is being used at La Posada
  - Similarities / Differences from other Life Plan communities
- Discover where gaps in care coordination may exist on your campus
- Understand how to use your existing resources to help fill gaps

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LA POSADA BACKGROUND

- Started in 1986 as an off shoot of Tucson Medical Center
- Became a stand alone CCRC in 1996
- Located in Sahuarita/Green Valley AZ :125 acres
- 750 Independent Living
- 39 High Acuity Assisted Living
- 29 Memory Care Assisted Living
- 66 Personal Care Assisted Living
- Removed SNF 2013/converted to High Acuity Assisted Living
- La Posada Pusch Ridge Community: Opening 2025 Oro Valley AZ (no skilled nursing planned)

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ASSISTED LIVING: ONE LICENSE, THREE PROGRAMS

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- Licensed by the Arizona Department of Health
- Program is divided into three programs / buildings
  - La Joya
  - La Via Memory Care
  - La Hacienda High Acuity Care
- Each building serves a specific population
- All areas use Medication Technicians and Certified Caregivers and LPN Supervisors
- Nursing coverage varies per program

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LA JOYA APARTMENTS

- 66 Apartments
- Square footage range 315 Sq. ft. - 890 Sq. ft.
- Staffed with LPN supervisors M-F 7:00am -4:30pm. No weekend, evening, or overnight LPN supervisor nurse coverage (nurses are available at La Hacienda to assist with medical concerns at La Joya on weekends, evenings, and overnight.)
- There is an LPN Supervisor on-call after hours.
- Designed primarily for more independent (physically and mentally) residents.
- Offers 3 levels of care based on amount of care needs

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LA VIA MEMORY CARE APARTMENTS

- 29 Apartments
- Staffed with LPN supervisor M-F 7-4:30.
- No weekend, evening or overnight LPN supervisor
- There is an LPN Supervisor on-call after hours.
- Focus is on dementia and memory impairment.
- Secure area
- Offers 3 levels of care based on amount of care needs

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BACKGROUND: CONVERTING TO HIGH ACUITY AL

- 2013 Converted our 60 bed Skilled Nursing to High Acuity Assisted Living
- No Medicare Part A or Inpatient rehab
- Idea was to cut back on number of admissions/discharges
  - Started that way…not the situation now
- High Acuity location allows residents to use as temporary stay
  - La Posada offers up to 30 pre paid days that can be used in Assisted Living locations
  - Residents able to use these to stay in High Acuity on temporary basis
  - Most residents enjoy a brief stay in High Acuity after a hospital stay

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LA HACIENDA HIGH ACUITY APARTMENTS: HYBRID MODEL FOR POST ACUTE CARE

- 39 Apartments, all private rooms
- Staffed with LPN's 24/7 and LPN Supervisor M-F 7-4:30.
- There is an LPN Supervisor on-call after hours.
- Focus is on Advanced Care needs / Hybrid Post Acute Care model
- May offer temporary stay after hospital stay or surgery
  - Not a drop off center, still require medical orders/authorization
- Rates are by room type, no levels of care

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EVOLUTION OF HIGH ACUITY ASSISTED LIVING

- What we hoped for
  - Provide housing with services for our most frail/in need residents
  - Cut down on the number of admissions and discharges (stop/slow the "churn")
  - Allow for some short /temp stays on limited basis
  - Use more In home services in IL Apartments
- What happened
  - Number of long term residents has not changed.
  - Staffing challenges, increased since 2020
  - As much churn as in past
  - Our In Home services have increased

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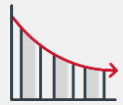
2020 TO PRESENT: NEW STAFFING CHALLENGES



Initial exodus

- Large number of post-acute staff, namely nurses, quit at the start of the pandemic—many leaving the healthcare industry completely
- Reasons for exodus include danger from infection and increased burnout from higher-than-normal ratios

Staff illness and absences

- Due to proximity to COVID-19 patients, frontline staff frequently fell ill; many staff have characteristics that put them at high risk for negative outcomes
- Closures of schools and daycares took many staff out of the workforce

Expensive solutions

- To stay competitive with workforce recruitment and retention, providers were forced to offer sign-on bonuses and implement large pay increases that many cannot afford long-term

Continual burnout

- Due to ongoing staffing shortages, remaining employees struggle to meet patients' needs and may experience moral distress

Provided by Advisory Board interviews and analysis.

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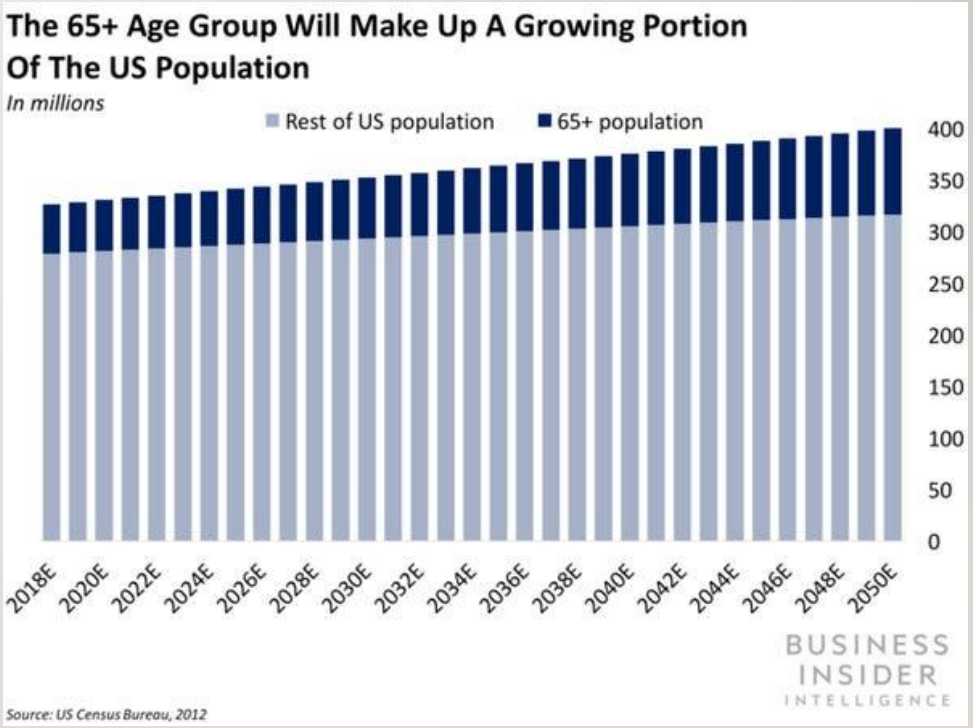
CHALLENGES

- By 2025, US providers will face a collective shortage of about 500,000 home health aides, 100,000 nursing assistants, and 29,000 nurse practitioners (Deloitte 2018)
- In 2010, **there were seven** potential caregivers for every person in the high-risk 80+ years, in 2050, estimated there will be only **three potential caregivers for every senior** in need of care.
- **The 80+ population is projected to increase by 79% by 2030**.
- The caregiver demographic (ages 45-64) will increase in the same period **by just 1%.**



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HIGH ACUITY AL/ HYBRID MODEL CHALLENGES

- High Acuity is a mix of Long Term residents and Post Acute needs in an Assisted Living setting
- Similar staffing challenges to a SNF post acute location
- Training AL caregivers to work in a Post Acute setting
- LPN staff doing more
- Transitions across continuum became increasingly difficult to manage effectively as staffing decreased (Catching medication issues, transfer issues, post acute care service alignment)
- Need for coordination in transfers of care was paramount to address gaps in care and services

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FOUR FOCUSED OUTCOMES

TRANSFER OF CARE GAPS

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TRANSITION OF CARE ISSUES

- A transfer of care happens when responsibility for a resident's care is passed from one professional, agency and/or location to another as their conditions and care requirements change.

Transition of Care Stats

- La Posada sees an average of 106 transfers a year from IL to AL
- Transfers from AL to hospital or rehab averages 97 yearly
- Transfers within AL (to memory care or enhanced AL from AL) averages 20 yearly
- Transfers from enhanced AL back to IL averages 40 yearly.
- Each transfer of care presents both challenges and opportunity
- Total yearly average of 263 transfers of care within our enhanced assisted living

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CREATING A G.A.I.L SYSTEM: FOUR FOCUSED OUTCOMES

- Outcome 1: Prevent adverse events during transfers of care.
- Outcome 2: Obtaining reconciled medication orders and prescriptions prior to discharge or transfers
- Outcome 3: Improved communication inter- and intra- healthcare team
- Outcome 4: Improved resident and staff satisfaction through transition of care

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OUTCOME 1: PREVENTION OF ADVERSE EVENTS DURING TRANSFERS OF CARE.

Challenges during transfers of care that may result in adverse events for our residents include:

- Poor communication between (intra-and inter-healthcare team).
- Poor discharge planning and information sharing with the resident, families, outpatient providers, La Posada staff (pending results, home care needs, medication changes, follow-up appointments, referrals, etc.)
- Medication reconciliation
- Resident paternalistic model of care (residents don't speak up/advocate for themselves. Providers direct the care/resident is passive in role of care)

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OUTCOME 2: OBTAINING RECONCILED MEDICATION ORDERS IN TRANSFERS OF CARE

Challenges in obtaining orders and treatments at transfers of care from hospital, rehab, IL, nursing home include:

- Time constraints with overwhelmed hospitals and SNFs due to poor staffing and high patient volumes. No one has time to reconcile.
- Coordination of care is disjointed with many involved (discharge planners, IL staff, AL staff, resident, family, PCP, hospitalist, specialists, pharmacists, SNF staff, home health, hospice, and on and on)
- Varied expectations - misunderstanding of care available in AL such as no providers on site.
- Polypharmacy due to multiple specialists

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OUTCOME 3: IMPROVED COMMUNICATION INTER- AND INTRA- HEALTHCARE TEAM

Communication challenges with residents transferring within La Posada or outside entities to La Posada:

- Multiple La Posada IL staff and AL staff involved in transitions through continuum such as IL staff and AL staff, but also marketing, tech team, settling in team, service center, etc.
- Multiple staff within La Posada communicating with external-healthcare teams (hospital staff, SNFs, rehab staff, PCPs, specialists, home care, hospice, labs, pharmacies, etc.)
- Families/spouses

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OUTCOME 4: IMPROVED RESIDENT SATISFACTION THROUGH TRANSITION OF CARE.

Challenges in resident satisfaction at La Posada may include:

- Problematic transitions in care from outside entities to La Posada
- Problematic transitions in care within La Posada through the continuum of care
- Residents impressions of capabilities of La Posada (generating or initiating orders for meds or treatments, PT, OT, Skilled nursing)
- Residents and families or friends may perceive non-La Posada staff such as home care agencies, PCPs, hospice, hospitals, even moving companies as affiliated with La Posada with gaps in service and or care attributed to failures on La Posada.

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G.A.I.L: GERIATRIC AFTERCARE INTEGRATION LIAISON

A TRANSITION COORDINATOR NURSING ROLE FOR RESIDENTS MOVING THROUGH THE CONTINUUM OF CARE.

DESIGNED BY LA POSADA NURSING TEAM

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WHAT CAN A G.A.I.L DO?

- Decrease gaps in care or services with planned or unexpected transfers of care.
- Improve care with reconciled meds and orders during a transition of care.
- Improve communication between inter-and intra-healthcare teams and others involved in resident care with a central point of contact.
- Prudent hospital discharge planning.
- Improved resident satisfaction through transfer in care and through the continuum of care.
- Improved staff satisfaction.

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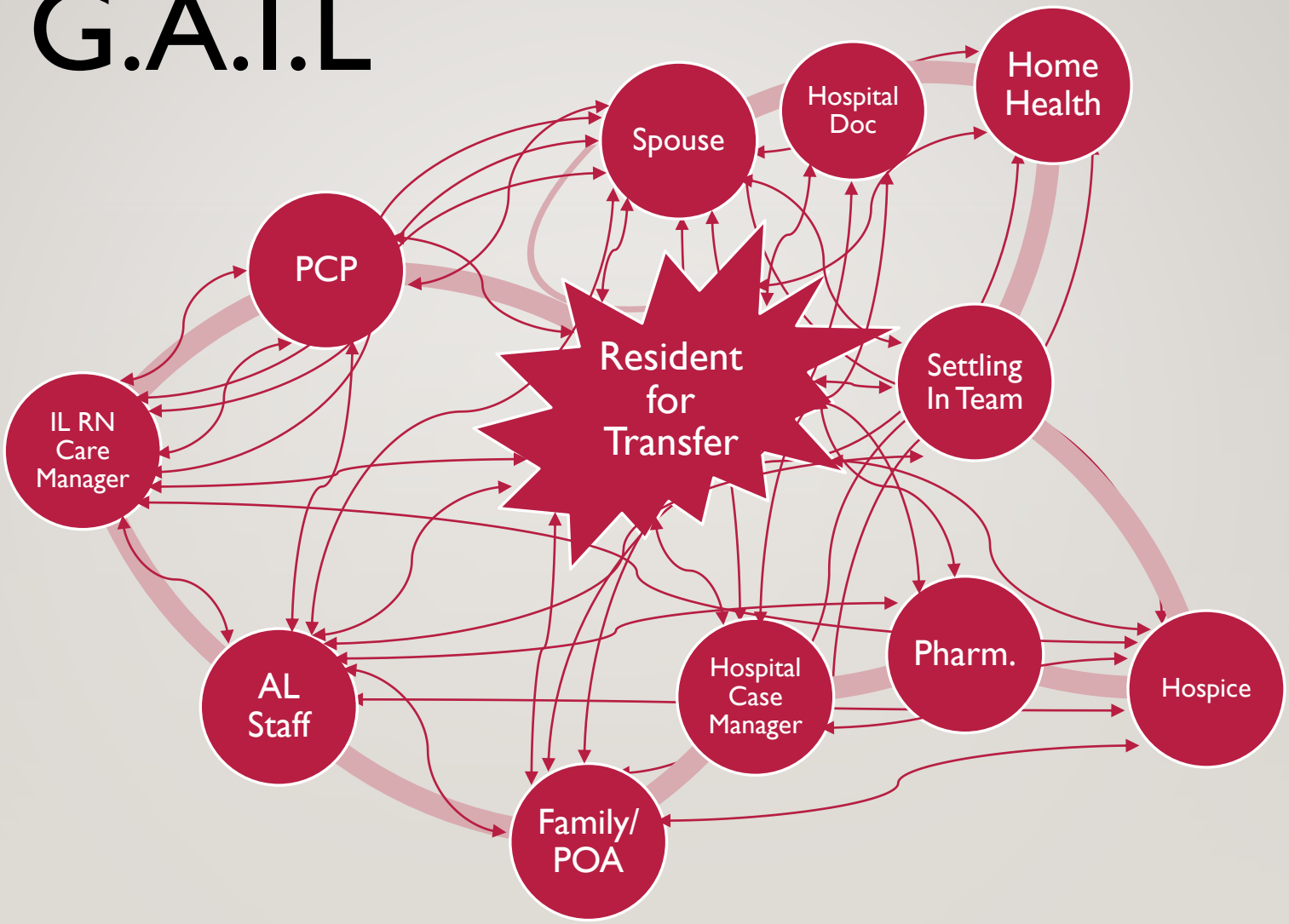
BEFORE G.A.I.L



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BEFORE GAIL

IL resident in hospital to AL	An IL staff (any one of the 6 nurses) will communicate with hospital	Resident needs AL and orders must be obtained	Any one of 6 nurses will communicate with hospital staff for admit	Resident comes to AL with multiple issues (home health not ordered, missing DME, referrals not completed)	Resident care affected and poor satisfaction
IL resident transfer to AL	An IL staff (any one of the 6 nurses) will communicate need to any one of 5 AL nurses	An AL staff member visits resident in IL	Resident gets appt. with PCP for move-in orders	Orders do not have current meds, treatments, or other info	Resident care affected and poor satisfaction

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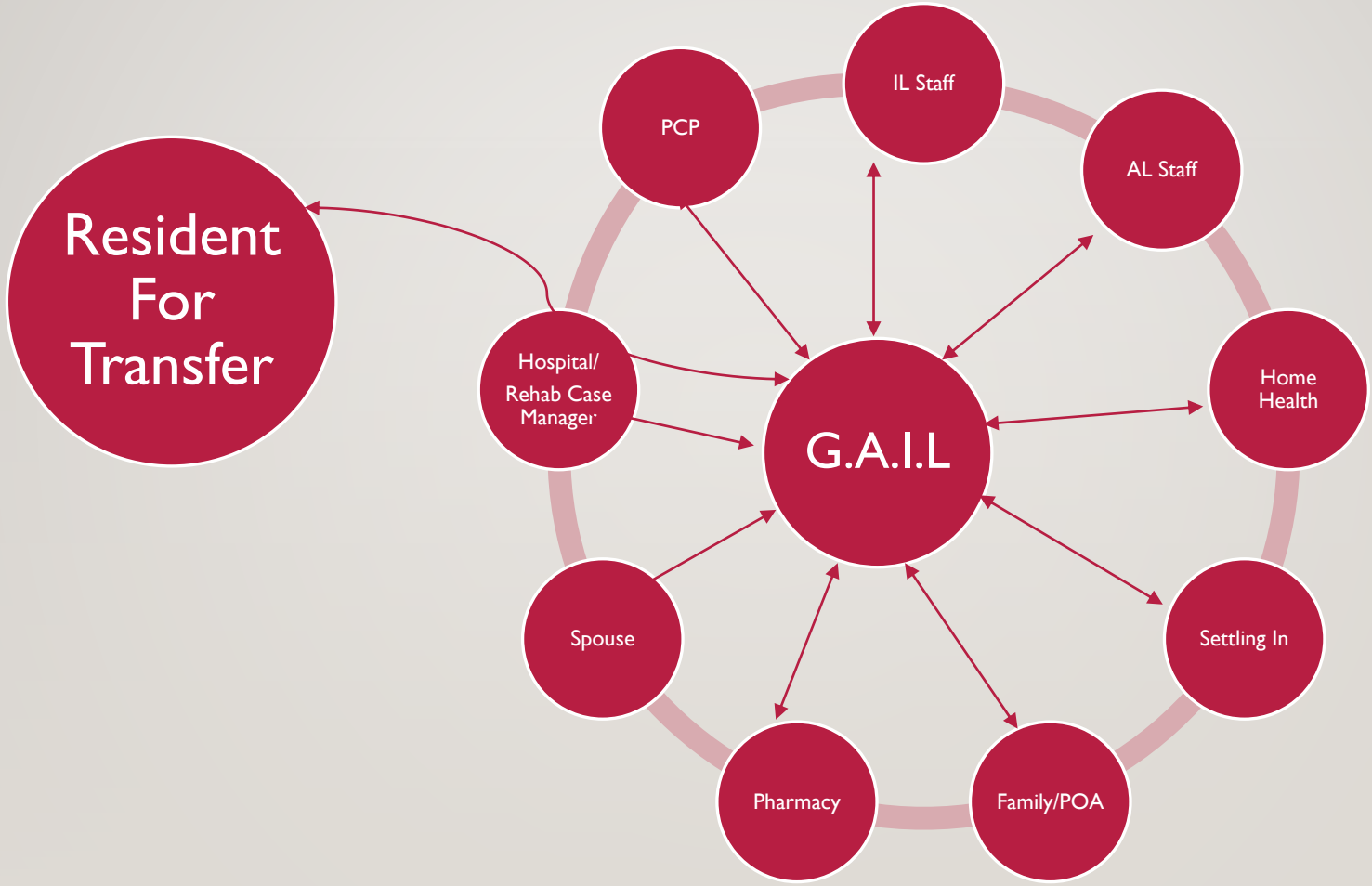
AFTER G.A.I.L.



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AFTER GAIL

IL resident in hospital to AL	Gail communicates with hospital to determine placement and aftercare needs	Gail visits residents home and reconciles home meds with current meds	Gail sends AL move in orders to hospital/rehab for signature then verifies accuracy	Gail confirms meds called into pharmacy and any homecare ordered is set before transportation	Gail sets up transportation and inputs orders into EMR
IL resident transfer to AL	IL staff/resident/family contact Gail for a tour of AL	Gail sets up tour and meets with resident/family	Gail communicates intent to transfer with LP staff using Resident Transfer email	Gail visits IL home to obtain current meds, works with PCP and other providers to get accurate med list and AL move in orders and assess for placement	Gail puts in orders and follows up with AL staff

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ALSO AFTER G.A.I.L.

Improved processes for emergency room send-outs to address gaps in transfers

- Red envelopes
- Resident Transfer: Assisted Living Facility Capability Form

Improved processes for safe hospital discharge

- Verify pharmacy receipt of prescriptions ordered prior to transport set-up
- Verify established home care or hospice referrals made prior to transport set-up
- Verify DME delivery prior to transport set-up
- Eyes on resident as needed prior to hospital discharge.

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SATISFACTION AFTER CREATION OF G.A.I.L

- Resident satisfaction

  Residents still have complaints – most not at a level of adverse event concern

  Residents overall satisfaction of transfer or care through planned or urgent transfer improved

- Staff satisfaction

  Staff still have complaints – most not at a level of adverse event concern

  Staff overall satisfaction with their job increased with decreased frustration and increased productivity.

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CONCLUSION

- The Use of High Acuity Assisted Living at La Posada
  - Similarities / Differences from other Life Plan communities
- Challenging transitions of care impact a campus by affecting residents, families, staff
- Talk with staff where gaps in care coordination may exist on your campus and develop your own version of a G.A.I.L.
- Existing resources can help fill gaps and improve overall resident and staff satisfaction while improving resident safety

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