OPTIMISTIC

An Approach to Increasing Quality of Life for Long Term Care Residents

Presented by
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Outline

- Overview of OPTIMISTIC project
- Discussion of various Interventions
- Acute care Transfers and Risk Factors
- Lessons learned
- Case Study
- Advance care planning
- Conclusions

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OBJECTIVES

- Describe the key components of the OPTIMISTIC Model of Care and its potential benefits
- Describe how the model of care for OPTIMISTIC enhances end of life planning

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- I am a Project NP for the OPTIMSITIC Program.
- I have no conflicts of interest or other financial interests to declare.

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Case Study

- 84 y.o. lady with history of COPD, UTI, sepsis, dementia.
- Has had a slow functional decline
- spikes a fever
- not eating
- lethargic
- refusing to get up.
- O2 sat is in the mid 80% on 2L O2 via N/C.
- She did not appear to be in any respiratory distress despite the low O2 sat.
- Denied pain.

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Optimizing Patient Transfers, Impacting Medical Quality, and Improving Symptoms: Transforming Institutional Care (OPTIMISTIC)

- CMS Demonstration:
  - Initiative to Reduce Avoidable Hospitalizations of Long Stay Nursing Home Residents
  - Seven projects nationally (NY, PA, AL, MO, NV, NE, IN)
  - Develop new models of care and achieve Medicare savings
- OPTIMISTIC
  - Nineteen Indianapolis area nursing facilities
  - Targets long-stay NH residents (> 100 day LOS or admissions with no plan for discharge)
  - Begun September 2012, implemented in all NHs in spring 2013, continues through 2016

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Role of front line staff

Nurse Practitioners

- Complement primary care providers
- Manage resident acute and chronic conditions

Project RNs

- Support nursing facility staff in management of acute conditions
- Advanced care planning discussions
- Quality improvement

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Interventions

- Care reviews of selected residents (CCRs)
- Transition support
  - Transition back visits (NP)
  - Transition Cue Card – hospital to facility handoff
- Advanced care planning
  - Conversations with residents and families
  - Indiana Physician Orders for Scope of Treatment (POST)
  - Respecting Choices
- Champions for implementing INTERACT II Tools
  - Acute transfer forms
  - Stop and Watch
  - SBAR communication tool
  - Clinical care pathways

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Evidence for Avoidable Hospitalizations

- 45% of hospitalizations among dual eligibles avoidable
- 314,000 potentially avoidable hospitalizations
- $2.6 billion in Medicare expenditures in 2005
- *Past interventions have proven effective:
  - Evercare reduced hospital admissions by 47% and emergency department use by 49%
  - Nursing facility-employed staff provider model in NY reduced Medicare costs by 16.3%
  - INTERACT II reduced hospital admissions by 17%.

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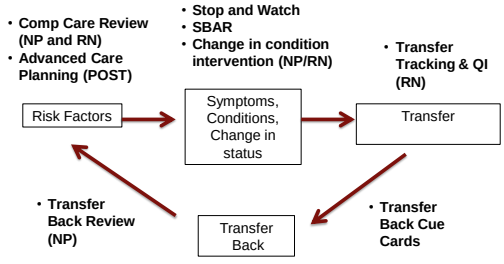
OPTIMISTIC Interventions

PRN = Project RN, PNP = Project NP



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Acute Care Transfers

- 1137 unplanned acute transfers
  - February 2013 – April 2014
  - Instruments
    - Circumstances of transfer
    - Quality improvement opportunities
    - Information on return to the facility
- 513 advanced care planning discussions
  - by project RNs
  - with residents and families

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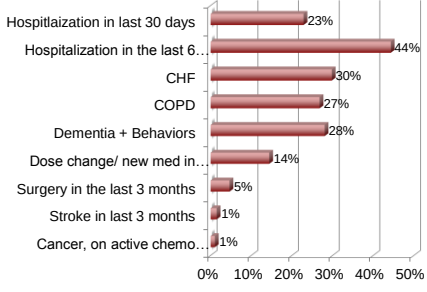
Risk factors contributing to the transfer (N=1137)



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Risk factors contributing to transfer

- Hospitalization in the past 6 months…….44%
- CHF……..30%
- Dementia with behaviors……28%
- COPD……27%
- Hospitalization in past 30 days……23%
- Dose change/new med……14%
- Stroke or surgery in past 3 mo……..6%
- Cancer, on active chemo……1%

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Who initiated transfer

- MD/PA/NP……..49%
- Facility staff……27%
- Family/Resident……16%
- Missing Data……7%

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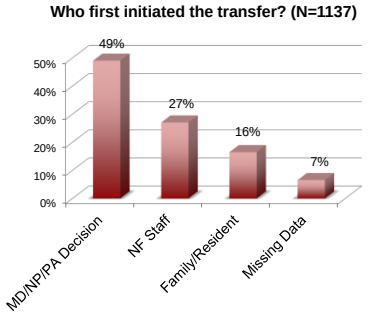

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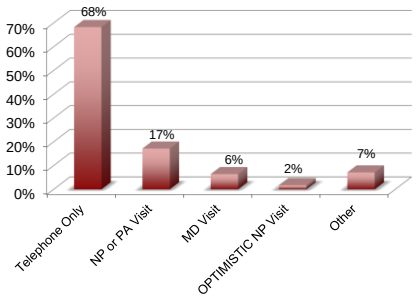
Medical evaluation prior to transfer (n=1137)



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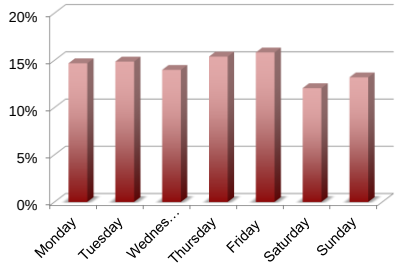
Transfer - day of week (N=1137)



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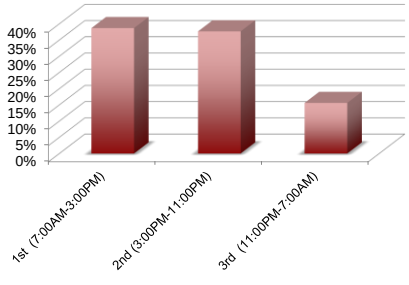
Transfer - shift and time of day (N=1137)



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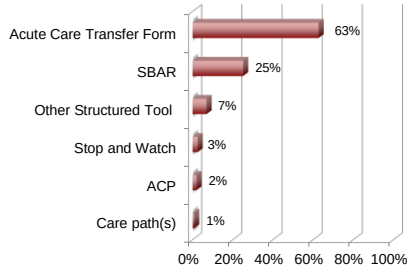
Intervention tool used prior to transfer (N=1137)



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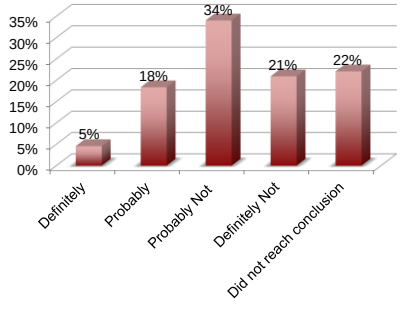
Was transfer avoidable? (N=1137)



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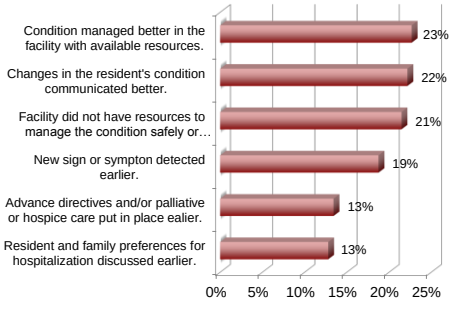
Opportunities for quality improvement (N=1137)



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Case Study

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Case study

- The nurse informed the OPTIMISTC NP and resident was assessed
- SBAR was completed and an event was started in the EMR
- STAT CXR, UA / C&S ordered.
- Orders were written for nebulizer treatments and orders to call as soon as test results came back.

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- CXR was negative
- UA came back with increased leukocytes, positive nitrites, positive for blood, bacteria level TNTC

- Started on broad spectrum antibiotics while waiting on Culture and Sensitivity results.

❖With OPTIMISTIC intervention:

Resident was kept in the facility and early intervention prevented a lengthy and serious course of illness.

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Advanced Care Planning (ACP) Discussions

- Carried out by project RNs with residents and families
- Respecting Choices model
- Indiana's Physicians Orders for Sustaining Treatment (POST) form
- 513 discussions from July 2013 – April 2014

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Conclusions

- Reasons for transfers are multifaceted
- Most initiated by medical providers over the phone
- SBAR and other INTERACT tools were used infrequently
- OPTIMISTIC staff concluded that 18% of transfers were judged avoidable
- Opportunities for improvement were identified in 63% of cases
- Advanced care planning discussions yielded changes in preferences and medical orders

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Questions?

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For further information

- Ouslander, MD, Joseph, et al. "Potentially Avoidable Hospitalizations of Nursing Home Residents: Frequency, Causes, and Costs." Journal of the American Geriatric Association. no. 58 (2010): 627-635. http://interact2.net/docs/publications/Ouslander et al Avoidable Hospitalizations of Nursing Home Patients JAGS 2010.pdf
- The impact of advance care planning on end of life care in elderly patients: randomised controlled trial BMJ 2010;340:c1345 doi:10.1136/bmj.c1345
- Indiana State Department of Health