PREVENTING REHOSPITALIZATIONS

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1

The 5 Cs

1. Culture

2. Commitment of the providers.

3. Communication around goals of care.

4. Consistency in process and in team assignments.

5. Continuity with the discharge planning and goals.

2

1. CULTURE

Success in prevention of rehospitalization

begins with culture and philosopy.

3

Philosophy of Care

- Nazareth Home believes that each person is a unique individual having inherent worth and dignity. We believe that care should be delivered in a cost efficient, safe and therapeutically sound manner. This can be accomplished through a collaborative approach between the resident, their family, the interdisciplinary care team and providers.
- We believe that communication and comprehensive treatment planning will ensure person-oriented care that allows for a successful outcome for the resident.
- We believe that all patients, families and elders can thrive in our environment and we seek to recover and provide for them without transfer to an acute setting.

4

2. Commitment of Providers

Commitment to be available and willing to treat in place, joint planning with family and willingness for clinical conversations.

5

3. Communication around Goals of Care

6

Goals of Care/Crucial Conversations

- Develop a culture where there is shared vison with the Interdisciplinary Team of the need for and value of having a Goals of Care Discussion.
- This will identify what is important to the patient /family as you navigate caring for them.
- There will be a reduction in the need for specialist based on the goals identified.

7

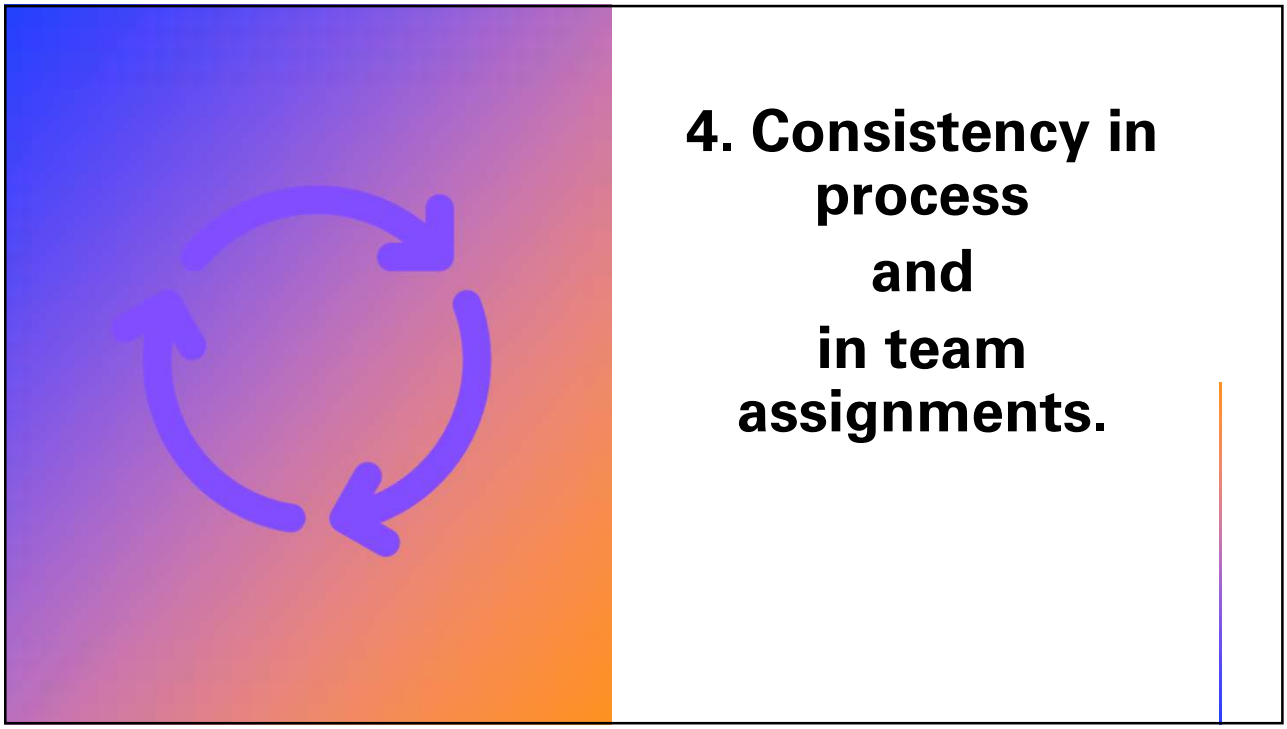
Medication/Pharmacy Intervention

Medication reconciliation is key. Be sure to review what medications the patient was on prior to their most recent hospitalization.

Partner with pharmacy that provides after hour deliveries. Develop a formulary for most frequent needed drugs for E-box.

Focus on deprescribing and polypharmacy.

8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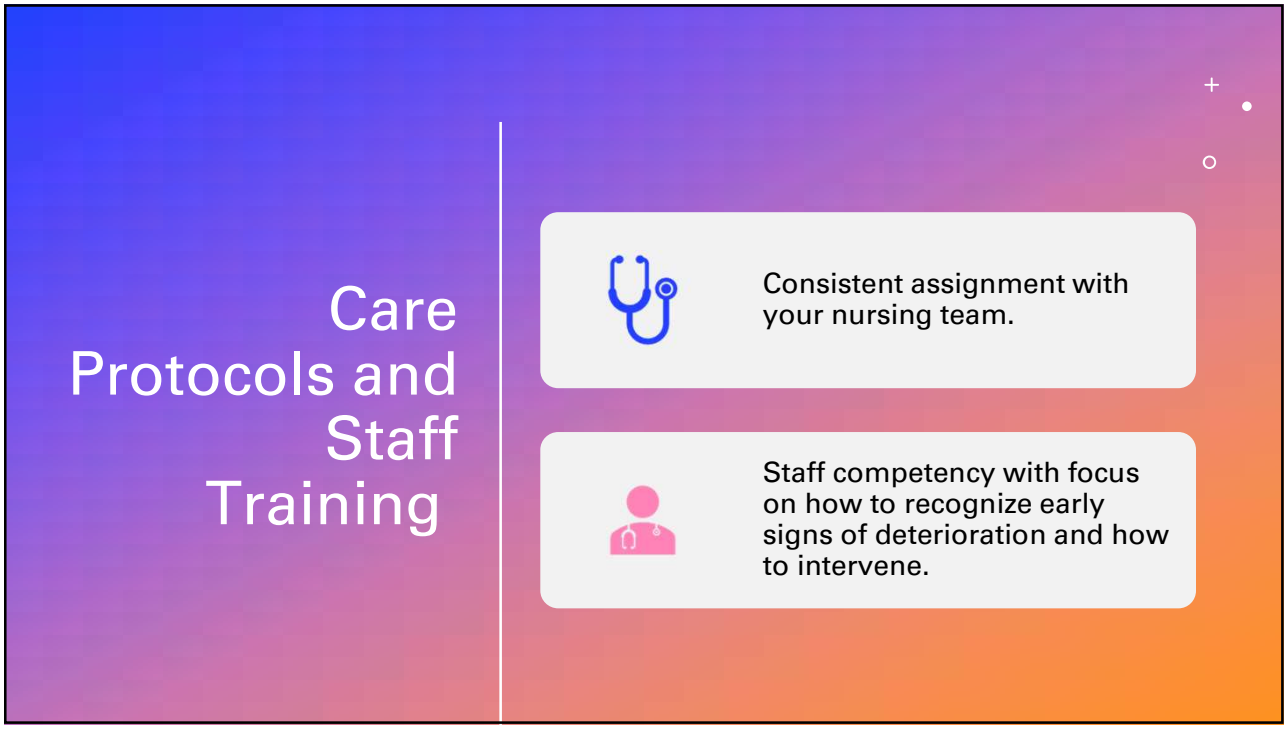
9


Care Protocols and Staff Training
Consistent assignment with your nursing team.
Staff competency with focus on how to recognize early signs of deterioration and how to intervene.

10

Care Protocols and Staff Training

Implement use of the INTERACT II "Interventions to Reduce Acute Care Transfers".

The purpose of the INTERACT Quality Program is to reduce frequency of transfers to the hospitals.

There are 4 types of INTERACT tools available.

- Quality Improvement tools
- Communication tools
- Decision tools
- Advance Care planning tools

11

Medical Model

Foster	Foster collaboration between physicians and nurse practitioners.
Offer	Offer consistent physician/nurse practitioner services Monday thru Friday.
Provide	Provide physician as Clinical Director of short stay rehab.

12

5. Continuity with the discharge planning and goals

- Development of Utilization Review Team that is collaborative and interdisciplinary.
- Review resident prior level of function in comparison to current.
- Develop realistic goals.
- Begin discharge planning on day one of admission.
- Involve resident and families in care plan meetings.

13

Organizational Opportunities

- Utilization of the INTERACT Acute Care Transfer worksheet https://pathway-interact.com/wp-content/uploads/2021/08/5-INTERACT-Acute-Care-Transfer-Log-Worksheet-2021.pdf
- Utilization of INTERACT Root Cause Analysis tool and summary https://pathway-interact.com/wp-content/uploads/2021/08/10-INTERACT-Quality-Improvement-Tool-for-Review-Acute-Care-Transfers-2021_082021.pdf
- https://pathway-interact.com/wp-content/uploads/2021/08/11-INTERACT-Quality-Improvement-Summany-Worksheet-2021.pdf
- The Goals-of-Care Conversation: A Best- Practice, Step-By-Step Approach (acpdecisions.org)

14

Organizational Opportunities

Develop QAPI committee to focus on Best Practices in prevention of rehospitalization

Partner with intiatives like AHCA

15

Resources

- https://pathway-interact.com
- https://www.acpdecisions.org

16