Executive Summary

With a national spotlight on managing high-risk, high-cost populations, hospitals are in a unique position to partner with assisted living facilities (ALFs) to coordinate care and improve outcomes for the frail, functionally impaired elderly population. ALFs play a role in managing this population to prevent adverse health outcomes and decrease healthcare costs. Hospital partnerships with ALFs can reduce unnecessary emergency department (ED) visits, hospitalizations, and readmissions.

“The patient population is getting older so to not have a strategy to address that would be shortsighted. I definitely think both ALFs and acute care providers are on the hook. To not take that responsibility to some degree and work with partners is a big mistake.”

— Kendall Johnson, Senior Consultant, Strategic Partnerships and Business Development, Allina Health ACO
Hospitals can form effective partnerships with ALFs to manage this population by (1) assessing ALF capabilities and alignment with hospital goals, (2) establishing care coordination programs, and (3) measuring and maintaining the partnership. These stages build on each other, and create a solid foundation for achieving the triple aim of improving healthcare quality, elevating patient experience, and slowing spending growth.
The Problem: Managing Risk For High-Cost Populations

Hospitals face tremendous pressure to preserve margins despite increasing risk management responsibilities and declining reimbursement levels, especially for Medicare beneficiaries. The Medicare population is challenging to manage because of the high prevalence of high-cost care needs and fragmentation of Medicare coverage policies.

As healthcare spending climbs and quality gains prove elusive, payers are looking for new ways to align incentives across stakeholders. Many of these options shift accountability and risk for outcomes from public and private payers to providers.

As illustrated in Figure 1, several new Medicare policies increase risk for hospitals. While some present opportunities for hospitals to earn bonus payments, all of them will soon reduce payments for poor clinical and financial performance.
Providers wrestling with new accountable care models must pinpoint avoidable spending. One population ripe for such an exercise: Medicare beneficiaries in ALFs.

**High-Cost Care Needs**

Assisted living communities care for about 750,000 Medicare beneficiaries nationwide, according to the National Center for Assisted Living. The average ALF resident is older than 85, with dementia, sensory deficits, and functional impairments. On average, an assisted living resident has a deficiency in 1.6 activities of daily living (ADLs) and 4.5 instrumental activities of daily living (IADLs). Medicare spending for beneficiaries with one or more ADL limitations is considerably higher than for those with chronic conditions alone, suggesting that functional impairment is a key cost driver. Avalere research for the SCAN foundation found that 39 percent of beneficiaries with one or more chronic conditions and functional impairment had at least one inpatient hospital stay, compared to 15 percent of beneficiaries with one or more chronic conditions alone.

**Figure 1** Health Reform Further Encourages the Implementation of Accountable Care

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1 ADLs include bathing/showering, dressing, eating, getting in/out of bed/chairs, walking, and using toilet
2 IADLs include managing finances, driving, shopping, preparing meals, using the telephone and other communication devices, managing medications, housework and basic home maintenance
**Fragmented Medicare Policies**

Medicare covers acute care services and some post-acute care services, such as inpatient rehabilitation and limited skilled nursing facility stays, but does not cover the long-term services and supports (LTSS) that seniors with functional impairment often need to help manage their ADL and IADL deficiencies. Without coverage for LTSS, these seniors often rely on unpaid family caregivers and, to a more limited extent, on private long-term care insurance, out-of-pocket spending, or Medicaid to cover their LTSS needs. The result: seniors with chronic conditions and functional impairment face a highly fragmented system of health and supportive services, which can lead to coverage and care coordination gaps. Uncoordinated care can increase patients’ risk for adverse events and significantly increase Medicare and other healthcare spending.

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Source: American Association of Homes and Services for the Aging, American Seniors Housing Association, Assisted Living Federation of America, National Center for Assisted Living, and National Investment Center for the Seniors Housing & Care Industry. Overview of Assisted Living. 2009.
Medicare has implemented many care coordination demonstrations, with limited success. For the most part, these initiatives focused on clinical settings, largely overlooking Medicare patients’ residences and their daily lives. As providers take on more risk management responsibilities, this is a missed opportunity—and a costly one at that.

### Figure 3: Outcomes Related to Poor Transitions in Care

**Poor Care Transitions**

<table>
<thead>
<tr>
<th>Lack of communication between settings and multiple care providers</th>
<th>Poor understanding of information transfer needs</th>
<th>Discharge planning excludes specific patient circumstances</th>
</tr>
</thead>
</table>

- 1.5 million medication errors each year, costing 3.5 billion annually, with complex patients experiencing higher numbers of adverse events
- 19% to 23% rehospitalizations after discharge due to errors in medication continuity
- 19.6% of Medicare beneficiaries readmitted within 30 days, 34% within 90 days, accounting for $15 billion in Medicare spending
The Opportunity: Aligning With Assisted Living Facilities

Although partnerships between hospitals and ALFs are a recent phenomenon, the increasing acuity of ALF residents and proliferation of innovative care coordination strategies make ALFs a valuable potential partner for hospitals. This is especially true today with the growing emphasis on the triple aim of improving healthcare quality, elevating patient experience, and slowing spending growth.
ALFs can help hospitals, health systems, and accountable care organizations (ACO) manage the daily healthcare needs of their residents to reduce unnecessary adverse outcomes, hospitalizations, and emergency department visits. ALFs provide a more independent and less costly environment than skilled nursing facilities, with an added social management component often missing from care coordination strategies. ALFs incorporate social work, mental health, pre-acute care, and many clinical-social management techniques in their care coordination strategies.

Partnerships with ALFs not only present a care coordination opportunity for hospitals, but can also help reduce unnecessary readmissions. Each year, approximately two million Medicare beneficiaries return to a hospital after discharge within 30 days. Unplanned readmissions are costly: in 2005, the estimated cost of unplanned re-hospitalizations was $12 billion. This phenomenon was the impetus for the Medicare Hospital Readmission Reduction Program that began on October 1, 2012. In the first year of the readmission program, 2,217 hospitals will be subjected to a penalty.

### Sample Calculation of Hospital Readmission Reduction Program Penalty

**Hospital A (2013)**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Beds</td>
<td>500</td>
</tr>
<tr>
<td>Average Medicare Payment per Case</td>
<td>$10,000</td>
</tr>
<tr>
<td>Number of Medicare Discharges</td>
<td>30,000</td>
</tr>
<tr>
<td>Excess Readmissions Ratio</td>
<td>1.05</td>
</tr>
<tr>
<td>Average DRG Payment for Heart Failure</td>
<td>$5,000</td>
</tr>
<tr>
<td>Total Heart Failure Admissions</td>
<td>100</td>
</tr>
<tr>
<td>Aggregate Payments for All Discharges</td>
<td>$5 million</td>
</tr>
</tbody>
</table>

**Sample Calculation for Heart Failure Readmissions**

\[
\text{Aggregate Payments for Excess Readmissions} = 5,000 \times 100 \times (1.05 - 1) = 25,000
\]

\[
\text{Ratio of Excess Readmissions Payments} = 1 - \left( \frac{25,000}{5,000,000} \right) = 0.995
\]

\[
(30,000 \times 10,000) \times 0.995 = 1.5 \text{ million}
\]

The Hospital’s Medicare base DRG payment would be reduced by 0.5 percent in FY 2013.
The Solution: Effective Partnerships With Assisted Living Facilities

To take advantage of the evolution in the ALF industry, hospitals should look to ALFs as a key component in creating a continuous care network for patients—one that focuses on clinical issues and offers long-term services and support. We see three stages of activity for hospitals exploring partnerships with ALFs: (1) assess ALF capabilities and alignment with hospital goals, (2) establish care coordination programs with ALFs, and (3) measure and maintain the partnership. These approaches build on each other, and create a solid foundation for achieving the triple aim.
**Stage 1: Assess ALF Capabilities and Alignment with Hospital Goals**

Collaborating with ALFs to manage high cost, high-risk elderly patients is a proactive strategy for leveraging external resources and expertise. The first step in this process is gathering and evaluating information on local ALF offerings. Assessing ALF capabilities and alignment with hospital goals helps hospitals understand ALF service offerings and ensure smooth care transitions. Without clearly understanding ALF capabilities and aligning with hospital goals, communication breakdown and poor care coordination are inevitable, undermining hospital population health management strategies.

**Form an ALF Partnership Evaluation Committee**

Creating a committee to collect information on local ALF offerings provides a structured way for hospitals to better understand ALFs, identify potential partnerships, and align partnerships with hospital population health management goals. This cross-functional committee will be responsible for engaging with local ALFs to evaluate capabilities and help hospital associates understand how ALF partnerships can support broader goals related to the triple aim.

Table 1 shows how ALF capabilities can support a hospital’s financial, clinical, and patient engagement goals.

“We are evaluating how to work with ALFs in the future and want them to be on board to work closely with the Allina provider team. Our biggest concern is making sure we are bridging the gaps for folks in and out of the system. We make sure patients have good transitions and communicate with families and facilities to make sure patients do not feel lost after transitions.”

– Kendall Johnson, Senior Consultant, Strategic Partnerships and Business Development, Allina Health ACO

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**Table 1** Examples of Hospital Goals for Coordinating Care for ALF Residents

<table>
<thead>
<tr>
<th>TRIPLE AIM ELEMENT</th>
<th>EXAMPLE HOSPITAL GOAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce per capita healthcare costs</td>
<td>Contain costs for ALF residents by reducing the percent of unnecessary readmissions, admissions, and ED visits</td>
</tr>
<tr>
<td>Improve population health</td>
<td>Implement care coordination programs for high-risk, functionally impaired ALF residents</td>
</tr>
<tr>
<td>Improve patient experience of care (including quality and satisfaction)</td>
<td>Increase patient and family caregiver engagement by employing staff and allocating resources for effectively communicating and assigning responsibilities</td>
</tr>
</tbody>
</table>
The ALF partnership evaluation committee has several tasks:

- Solicit information from local ALFs in a standardized survey instrument
- Analyze survey responses to understand ALF capabilities and alignment with hospital goals
- Evaluate ALF partner performance to ensure continued alignment with hospital goals

The committee should include a well-rounded, relevant group of aligned internal stakeholders with clinical, strategic planning, patient relations, and provider relations responsibilities. Committee members should typically hold management level positions in areas such as:

- Health services management
- Strategic planning
- Quality improvement
- Provider relations
- Medical affairs, nursing, and discharge planning

**Identify Local ALF Capabilities**

Identifying and understanding local ALF service offerings is a prerequisite to establishing partnerships with ALFs and coordinating smooth care transitions between settings. Poor care transitions stemming from inappropriate and higher cost discharge destinations often result from not understanding available community resources.

**Arizona Connected Care: Identifying ALFs That Understand ACO Goals and Keep Residents Out of the Hospital**

Arizona Connected Care (ACC) Medicare Shared Savings Program (MSSP) ACO—which serves more than 7,500 Medicare beneficiaries through a collaboration of independent healthcare providers in southern Arizona, including more than 150 physicians, three Federally Qualified Health Centers and Tucson Medical Center—is identifying preferred post-acute providers, including local ALFs, to provide coordinated care to ACO patients. As a physician-led ACO, ACC evaluates ALFs based on data collection capabilities, quality metrics, established hospitalization management processes, and strong physician relationships. ACC considers partnerships with any organization that understands and actively engages in its goal to reduce hospitalizations. ACC values ALF initiatives that promote “aging in place.”

“[Hospitals] are anxious to keep people out of the ER. [We] use pro-active communication and chronic disease management processes, similar to INTERACT, in our assisted living communities and frequent “resident-at-risk” discussions, to keep residents out of the ER and the hospital. [We] call [the hospital] before we send someone over to have a dialogue before transfer agreements. In some of our skilled nursing communities, we use physician extenders to intervene and reduce readmissions. We are looking at implementing this in assisted living as well.”

— Kelly Gasior, VP of Housing and Strategy Operations, Trinity Senior Living Communities
A challenge to assessing local ALF capabilities is determining the type of information to collect and the method to collect it. One proven business method is a survey instrument, like a request for information (RFI). Hospitals can use the information collected to identify ALFs with limited resources and focus on working with ALFs offering the greatest potential to reach hospital population management goals. Figure 5 details ALF characteristics with high potential to meet hospital goals.

**Figure 5** Characteristics of ALFs with High Potential to Meet Hospital Goals

- Established method to identify high-risk residents and use of distinct care plans (e.g., staff, activities, monitoring, etc) for these patients
- Ability to collect and track resident hospitalizations and ED visits
- Use of standardized communication protocols such as Situation-Background-Assessment-Recommendation (SBAR)
- Clinical specialties, such as rehabilitation, physical/occupational/speech therapy, memory care, remote monitoring, medication management
- Specialized staff and staffing protocols, such care coordinators
- Ability to report health statistics on readmissions and admissions
- Use of standardized care pathways to reduce hospitalizations such as INTERACT quality improvement program
- Use of remote monitoring
- 24-7 nursing staff

The RFI also will help ALFs articulate their value in coordinating smooth care transitions. Committee members should use the RFI responses to identify ALFs with greatest potential within physical proximity. The sample RFI in Figure 6 illustrates how hospitals can solicit information from ALFs.

“We use the INTERACT quality improvement program created by Dr. Joseph Ouslander and colleagues to focus efforts on improving care transitions and communication. The INTERACT program’s Stop and Watch tool helps staff members identify changes in a resident’s condition and the SBAR tool enhances communication about transfers between acute and post-acute care providers.”

— Dr. Kevin O’Neil, Chief Medical Officer, Brookdale Senior Living
Request for Information to Support [Hospital Name] Care Coordination Efforts

[Hospital name] mission is to [hospital mission]. One of our main goals is to keep patients healthy inside as well as outside of the hospital. As such, we are looking to work with care providers beyond the hospital to coordinate care for high-risk patients. We appreciate you taking the time to complete this request for information to support our care coordination efforts. Please return this RFI to [hospital address].

Below, we provide questions that will help us better understand your facility and how we can work together to coordinate care for hospitalized patients requiring assisted living and for ALF residents entering the hospital.

1. What clinical-social management techniques does your facility use to improve care for residents, e.g., office hours by hospitalists that provide pre-acute care services?
2. How do you currently manage readmissions among your residents?
3. What care coordination strategies do you have in place to fulfill the following goals:
   • Goal 1:
   • Goal 2:
   • Goal 3:
4. What care transition protocols does your facility use to ensure smooth transitions to and from the hospital?
   a. How do you work with hospitals on coordinating care for residents to and from the hospital?
5. How do you track and monitor resident health status?
6. How do you measure quality improvement within your organization
7. What health information technology do you use to collect information, if at all?

Stage 2: Establish Care Coordination Programs with ALFs

Moving from one care setting to another is challenging for both the healthcare provider and the patient. Collaborating with ALFs on care coordination programs creates a common understanding of the cross-setting requirements for quality transitional care, provides a choice of local ALFs that best meet patient care needs, and helps keep patients in the system’s network. Lack of coordination between care settings often leads to myriad of problems including adverse clinical outcomes, misuse of healthcare resources, and patient leakage. Adverse events related to poor care transitions have resulted in higher hospital readmissions and spending. In 2005, hospital readmissions within 30 days accounted for $15 billion in Medicare spending.  

An effective care coordination program includes protocols for communication, care transitions, and staffing. Communication and care transition protocols ensure hospitals and ALFs set the ground rules for managing transitions, such as communicating essential health information. Staffing plans ensure the right healthcare professionals are involved at the right time in the care coordination process.
Sibley Memorial Hospital: Coordinating Care for ALF Residents Through Enhanced Communication

Noting a decline in referrals due to communication breakdown, Sibley Memorial Hospital—a 318-bed community hospital with skilled nursing, assisted living, and an Alzheimer’s facility serving the Washington, D.C. area—worked with their assisted living residence, Grand Oaks, to identify essential information for smooth care transitions from the hospital to the ALF. Information includes contact information for family, physicians, and emergency contacts, socioeconomic needs, and functional status. Sibley and Grand Oaks now experience smooth transfers between settings and have improved patient outcomes in medication management and follow up physician visits, and have reduced hospital visits.

Create a Communication Protocol

An effective communication protocol is central to a successful ALF care coordination partnership. Such a protocol addresses the content, frequency, mode, and technique for communicating critical information between settings. An effective communication protocol can help to prevent adverse events, such as medication errors, inappropriate care, and misuse of healthcare resources. Improving communication between care settings helps hospitals and ALFs avoid these errors and enables successful, smooth transitions of care.

One widely used communication technique for coordinating care across settings is the Situation-Background-Assessment-Recommendation or SBAR. This technique is a proven method for cross-setting communication and ensuring patient safety. It allows healthcare professionals to frame any conversation using a structured and comprehensive format.

Developed by Kaiser Permanente and endorsed by the Institute for Healthcare Improvement, SBAR uses four questions to prevent communication breakdown between healthcare professionals and enable efficient clinical decision-making for care transitions. SBAR Guidelines shown in Figure 7 provide steps for implementing the SBAR technique.

Community Hospitals in Texas: Managing Hospital Emergency Room Visits for Brookdale ALF Residents with SBAR

Community hospitals in Texas work with Brookdale ALFs to identify residents that require hospitalizations. Brookdale uses “Stop and Watch” and “SBAR” tools to determine whether situations are emergencies or if on-duty physicians and nurses can assess and treat the resident. The SBAR tool is used to report observations to the physician or emergency room staff in a methodical way. By implementing the INTERACT program in Brookdale ALFs, community hospitals are better prepared to handle care transitions and hospitalizations due to the structured communication and assessment protocols used for Brookdale’s residents on transfers to the hospital.

“Lack of communication is killer and an originator of problems. [We are] trying to work on best practices for this including INTERACT 2 and SBAR. ALFs need to communicate with physicians when weighing cost of hospitalizing a heart failure resident, for example, for just three days versus a much simpler intervention that could have been done for an eighth of the cost at the ALF. The resident returns in a much-deteriorated state with higher healthcare spending.”

– Loretta Kaes, RN, Director of Quality Improvement & Clinical Services, Health Care Association of New Jersey
Guidelines for Communicating with Physicians Using the SBAR Process

1. Use the following modalities according to physician preference, if known. Wait no longer than five minutes between attempts.
   1. Direct page (if known)
   2. Physician’s Call Service
   3. During weekdays, the physician’s office directly
   4. On weekends and after hours during the week, physician’s home phone
   5. Cell phone

Before assuming that the physician you are attempting to reach is not responding, utilize all modalities. For emergent situations, use appropriate resident service as needed to ensure safe patient care.

2. Prior to calling the physician, follow these steps:
   - Have I seen and assessed the patient myself before calling?
   - Has the situation been discussed with resource nurse or preceptor?
   - Review the chart for appropriate physician to call.
   - Know the admitting diagnosis and date of admission.
   - Have I read the most recent MD progress notes and notes from the nurse who worked the shift ahead of me?
   - Have available the following when speaking with the physician:
     - Patient’s chart
     - List of current medications, allergies, IV fluids, and labs
     - Most recent vital signs
     - Reporting lab results: provide the date and time test was done and results of previous tests for comparison
     - Code status

3. When calling the physician, follow the SBAR process:
   **(S)** Situation: What is the situation you are calling about?
   - Identify self, unit, patient, room number.
   - Briefly state the problem, what is it, when it happened or started, and how severe.

   **(B)** Background: Pertinent background information related to the situation could include the following:
   - The admitting diagnosis and date of admission
   - List of current medications, allergies, IV fluids, and labs
   - Most recent vital signs
   - Lab results: provide the date and time test was done and results of previous tests for comparison
   - Other clinical information
   - Code status

   **(A)** Assessment: What is the nurse’s assessment of the situation?

   **(R)** Recommendation: What is the nurse’s recommendation or what does he/she want?

   Examples:
   - Notification that patient has been admitted
   - Patient needs to be seen now
   - Order change

4. Document the change in the patient’s condition and physician notification
Hospitals can use other communication methods often seen embedded in care transition protocols, such as the Coleman, Naylor, Project BOOST and Project RED models (see the Appendix for program details).\textsuperscript{21,22} Embedded communication techniques typically follow a similar method as SBAR. However, SBAR is highlighted to emphasize its success and adaptability across many care providers.

Creating an ALF-specific communication protocol standardizes the process for determining whether an ALF resident should be transferred to the hospital and what information should be communicated between settings. Hospitals can create an ALF-to-hospital communication protocol in which ALFs conduct a resident assessment prior to sending the resident to the hospital. This assessment institutes a structured format that communicates vital information at the appropriate time to prevent unnecessary ED visits and hospitalizations. Communication protocol elements and examples are provided in Table 2.

<table>
<thead>
<tr>
<th>COMMUNICATION PROTOCOL ELEMENT</th>
<th>EXAMPLE</th>
</tr>
</thead>
</table>
| Communication modalities according to hospital preference and duration between attempts | • Direct page (if known), physician or hospital call service, cell phone, office, or home phone, or 9-1-1  
• Waiting 5 to 10 minutes between attempts |
| Situations when to use specific services | • For emergent situations, using appropriate ALF services, such as on-call nurses, or calling 9-1-1 for urgent safety situations |
| Resident assessment prior to calling the hospital | • Evaluation of the resident before contacting the hospital either using a nurse or other healthcare professional  
• Review of the resident’s chart information for primary care physician, diagnosis, and, recent health and functional status |
| Appropriate resident information on-hand prior to calling the hospital | • Patient’s health status  
• List of current medications, allergies, most recent vital signs, and functional status, if available in the chart  
• Primary care physician |
| Effective discussion points when speaking to the hospital | • Explanation of the situation in question, including what is it, when it happened or started, and how severe  
• Important background information on resident health status related to the situation, such as previous hospital admissions, recent injuries, etc. (see Communicating ALF-specific Information)  
• Recommended next steps, e.g., hospitalization or “watch-and-wait” |
[For ALF residents] don’t call 9-1-1, call the care advocate. The relationship [between the hospital and ALF] does not necessarily have to be hi-tech. Pick up the phone and let the ED know who you’re sending and why.

— Lorraine Glazar, Network Director/Director of Provider Relations, Arizona Connected Care ACO

Difficulties implementing a communication protocol with ALFs are likely to be operational and administrative. These challenges include training hospital and ALF staff on the new protocol, creating and disseminating materials, and regularly reviewing the document for updates.

**Sunrise Hospital and Medical Center: Using a Structured Communication and Assessment Protocol with Emeritus ALFs to Reduce Unnecessary Readmissions and ED Visits**

Sunrise Hospital and Medical Center—a for-profit hospital located Las Vegas, NV with 730 beds, and services including inpatient, specialty surgical, and outpatient—works with Emeritus Senior Living ALFs to identify residents that require hospitalization using the Yes We Can Rapid Response program. Sunrise hospitals, in addition to other community and large hospitals across multiple states, receive Emeritus residents identified as “Yes” patients with non-emergent conditions that require some medical attention, such as dehydration, medication mismanagement, and changes in cognitive impairment. The agreement between the hospitals and Emeritus established specific 9-1-1 hospitals and identified specific protocols for non-life threatening medical events. Preliminary results show a decrease in unnecessary admissions and readmissions.

**Communicating ALF-specific Information.** For any communication protocol to be successful, the right information must be communicated. Studies have shown that information sharing between settings should consist of standard patient health information (diagnoses, abnormal physical findings, and important test results), medications, follow-up arrangements (including status of post-discharge appointments), and social work and counseling case notes if applicable. Failure to communicate the right information can lead to poor quality outcomes because of communication breakdown and related errors.

Due to the clinical and social complexities of patients transferring to or from the ALF, additional information is required for hospitals and ALFs to meet patients’ unique needs. This information should be communicated each time an ALF resident moves between the hospital and ALF. During each discharge planning process prior to transitioning a patient to the ALF, hospitals must provide the admission diagnosis for the ALF to assess the range of appropriate activities in which the resident can participate. Conversely, for the hospital to provide appropriate treatment each time an ALF resident is seen in the hospital, the ALF must provide the hospital with a recent history of medical notes if available, functional status (e.g., ADLs and functional impairment), updated medication list, and updated diagnoses.

**Swedish Medical Center (part of Providence Health & Services), Peace Health Hospitals, and Franciscan Health System: Improving Care Transitions to Avamere ALFs Using Specific ALF-Resident Information**

Swedish Medical Center; Peace Health, and Fran-
ciscan Health System hospitals—all large health systems in Washington and Oregon—work with Avamere ALF to coordinate discharges. The hospitals provide discharge information prior to sending patients to Avamere ALFs, including diagnoses, abnormal physical findings, test results, discharge medications, follow-up arrangements, status of post-discharge appointments, and social work and counseling case notes. Additional data elements for ALF residents include admission diagnoses, contact information for family, primary and specialist physician, and emergency contacts, functional status, and socio-economic needs. Since establishing this communication protocol, these hospitals and Avamere have experienced smoother transitions due to fewer breaks in communication.

**Align Care Transition Protocols**

Once hospitals create a communication protocol and identify necessary data elements to coordinate care with ALFs, hospitals can align existing care transition protocols as a foundation for implementing ALF care coordination programs. Aligning care transition protocols with ALFs standardizes and implements rules for discharging higher risk patients to the assisted living setting as well as for hospitalizing ALF residents. These standardized transition protocols give hospitals and ALFs the appropriate knowledge and guidance to reduce errors and improve outcomes by addressing the often overlooked, unmet social need in managing care transitions in ALF residents.

Care transition protocols typically consist of several key elements, such as a target population, discharge planning, communication of essential data elements, and designated care coordination staff. Numerous care transition models, such as the Care Transitions Program or Coleman Model, Transitional Care Model or Naylor Model, Project BOOST, and Project RED, use these elements, among other more detailed components and methods, to coordinate smooth transitions from the hospital to a less-intensive setting (see the Appendix for program details). As hospitals align care transition protocols with ALFs, they must continue to recognize and leverage existing ALF competencies. Difficulties encountered during this process are often related to resource management and leadership alignment.

**MaineHealth:**

**Using Care Coordination Programs to Manage ALF Residents in the Hospital**

MaineHealth—a large non-profit integrated delivery network and a MSSP ACO based in Portland, ME, covering 11 of the 16 counties in the state—uses the Coleman Model to coordinate care for high-risk patients. MaineHealth, in partnership with the MMC Physician-Hospital Organization, Southern Maine Agency on Aging, and Spectrum Generations, participate in the Centers for Medicare and Medicaid Innovation Community Based Care Transition Program and uses the Coleman model for transitioning hospitalized patients from the hospital to the SNF or home setting. MaineHealth uses hospital care coordinators to facilitate discharges for ALF residents and works with the Partnership for Healthy Aging to provide access to community-run evidence-based programs that promote self-management following an acute episode, such as falls prevention.

A central component to care transition protocols with ALFs is the discharge planning process. Hospitals can align discharging planning by adding specific ALF-related items to address the multifaceted and complex clinical and social needs of this population. For example, ALF-specific discharge items should ensure the patient understands the following:

- The hospital contacted the ALF to communicate the patient’s information and prepare for their arrival
- The ALF communicated with the hospital social worker and the patient’s family to ensure the
selected ALF is the most appropriate setting of care
- The period of time the patient is staying at the ALF in number of days/months/years
- The number of days before leaving the ALF that the ALF will coordinate the patient’s transition to either the patients’ home or another setting

For example, the Coleman Model uses a discharge preparation checklist (Figure 8) to cover critical activities designed to ensure the patient understands discharge instructions and the patient has a smooth transition from the hospital to the ALF. Hospitals can easily add ALF-specific items, as provided above, to this checklist.

![Figure 8](Care Transition Intervention™ Discharge Preparation Checklist)

**Discharge Preparation Checklist**

Before I leave the care facility, the following tasks should be completed:
- I have been involved in decisions about what will take place after I leave the facility.
- I understand where I am going after I leave this facility and what will happen to me once I arrive.
- I have the name and phone number of a person I should contact if a problem arises during my transfer.
- I understand what my medications are, how to obtain them and how to take them.
- I understand the potential side effects of my medications and whom I should call if I experience them.
- I understand what symptoms I need to watch out for and whom to call should I notice them.
- I understand how to keep my health problems from becoming worse.
- My doctor or nurse has answered my most important questions prior to leaving the facility.
- My family or someone close to me knows that I am coming home and what I will need once I leave the facility.
- If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.

This tool was developed by Dr. Eric Coleman, UCHSC, HCPR, with funding from the John A. Hartford Foundation and the Robert Wood Johnson Foundation.

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**Arizona Connected Care: Using a Hospital Care Coordinator to Manage Discharges to ALFs**

Arizona Connected Care (ACC) is a MSSP participant that works with several post-acute care and residential providers, including ALFs, on care coordination programs using the Coleman Model. ACC uses a care coordinator in the hospital to assess patient risk criteria and determine most appropriate discharge destination. For patients that are high risk for social decline, the care coordinator works with local ALFs on discharge planning. Once the hospital discharges the patient, an ACC care advocate and physician coordinate follow up care once transferred to the assisted living setting.

**Establish Staffing Plans**

Incorporating ALF care coordinators in the hospital...
and clinician office visits in the ALF is an effective way to implement successful care coordination programs with ALFs. These staffing plans put the appropriate staff in place to manage ALF residents by preventing unnecessary hospitalizations, ED visits, and negative health outcomes. In many care coordination models, a specific healthcare professional coordinates care, e.g., the Transition Coach in the Coleman Model, or Transitional Care Nurse in the Naylor Model. These models often require advance practice nurses to perform care coordination tasks. For ALF care coordination programs, hospitals and ALFs can rely on lower level staff and clinicians in the ALF to address patients’ clinical and social issues.

Offer Clinician “Office Hours” at ALF. Establishing office hours in the ALF for hospitalists, physicians, geriatricians, nurse practitioners, or physician assistants improves care management for the resident and helps prevent adverse outcomes, like unnecessary hospitalizations and ED visits. These clinicians offer regularly scheduled appointments for primary care services, such as immunizations and preventive care, consultations to discuss medications and medical care, and opportunities to address family questions related to functional status and condition management. In-ALF appointments offer a convenient way for residents to receive follow up care, avoid the risk of injury during transportation to external physician appointments, and facilitate effective communication between the ALF and hospital.

Allina Health ACO: Providing Clinician Office Hours to Reduce Unnecessary ED Visits and Hospitalizations

Allina Health ACO—a Pioneer and commercial ACO with 11 hospitals and more than 90 clinics and care centers—provides home visits in local ALFs consisting of a physician and nurse practitioner team. This physician-nurse team supplies “pre-acute” primary care services to residents that include physical exams, medication management, and functional assessments. Since implementing ALF home visits, Allina has seen a reduction in unnecessary ED visits and hospitalizations as well as an increase in ALF resident overall health and well-being.

Hospitals and ALFs can incorporate office-hours into discharge planning to ensure ALF staff coordinate office visits and resident awareness of the follow up care. On the hospital discharge checklist, hospitals should add items that require the ALF to coordinate with the hospital to schedule appropriate physician visits within a designated timeframe. For example, using the Coleman Model discharge checklist in Figure 7, hospitals should ensure patient understands the following:

- The name of the specific ALF they are being discharged to and that the ALF will schedule regular physician office hours at the facility
- The specific time and date of the first regular scheduled physician appointment in the ALF

"One of our main strategies is to be the provider team in the ALFs, as the link between their other services. Allina has home care, hospice, and other services to keep patients in our system."

— Kendall Johnson, Senior Consultant, Strategic Partnerships and Business Development, Allina Health ACO
Include ALF Care Coordinator in Hospital Discharge Process. As shown in numerous studies and almost all successful care transition models, e.g., Coleman and Naylor, care coordinators support efficient discharges, and help prevent adverse outcomes and untimely discharges. Due to the high-risk nature of ALF residents, an ALF care coordinator can address critical social facets of the patient’s daily life early in hospital discharge planning. This can include identifying and addressing ADLs or specific dietary needs, helping hospital staff evaluate patient acuity, communicating patient information to the ALF, and creating the preliminary ALF supervision and treatment plan. Further, the ALF care coordinator is immediately available for hospital staff, patient, and patient family questions related to post-discharge social and medical care at the ALF.

The ALF should identify appropriate ALF staff to help coordinate care in the hospital. The hospital will look to the ALF care coordinator to perform onsite evaluations and maintain communication with the hospital and other providers.

**Tucson Medical Center and Carondelet Hospital:**
**Coordinating Discharges to Devon Gables ALF Using Care Coordinators**

Tucson Medical Center (TMC) and Carondelet Hospital, two community hospitals that are part of Arizona Connected Care ACO, work with Devon Gables ALF staff to facilitate transitions. Two Devon Gables admissions coordinators conduct onsite hospital visits before discharge to ensure Devon Gables can meet the patient’s social needs. If the coordinators determine another long-term care setting to be more appropriate, Devon Gables assess and contacts other long-term care settings to match the patient’s needs with the facilities offerings. For complex cases, TMC and Carondelet work with Devon Gables nurses to evaluate the patient and determine appropriate post-acute care setting.

**Swedish Medical Center, Peace Health Hospitals, and Franciscan Health System:**
**Working with Avamere ALF Clinical Liaisons to Coordinate Discharges**

Swedish Medical Center, Peace Health Hospitals, and Franciscan Health System work with Avamere clinical liaisons once a patient is identified for assisted living. The clinical liaison helps the hospitals manage care transitions and facilitate communication between Avamere, the hospital, the patient, and the patient’s family. Hospitals also work with Avamere’s nurse clinical case manager to follow-up and help with transitions after discharge. The Avamere clinical case manager helps the patient comply with hospital discharge plans and helps coordinate transitions to other care settings, such as the home.

**Stage 3: Measure and Maintain ALF Partnerships**

Ongoing management of ALF partnerships is piv-
[We] manage quality of care using PointClickCare, a long-term care electronic health information tracking system, and WeCare, a computerized evaluation and measurement tool, to improve efficiency and quality of care. Through using these tools, we have lowered the readmission rate and enhanced communication.

– Kellie Murray, VP Hospital Relations and Transitional Care Environment, Emeritus Senior Living

“[We are] following the discharges and making sure they are not going back to the acute-care setting. We use Hospital Compare to look at current rehospitalization rates to understand local and current problems. [We try to] help [hospitals] stop rehospitalizations [often due to being] discharged too quickly.”

– Tim Bush, VP of Operations, and Chris Krebsbach, Director of Operations, Tealwood Care Centers

otal to achieving hospital goals based on the triple aim. Measuring specific aspects of the partnership and care coordination programs helps determine their success and ensures smooth care transitions for ALF residents. Hospitals can determine ALF partnership success by measuring care coordination across the triple aim and maintaining ongoing communication that provides a collaborative environment for improving care coordination efforts.

**Measure ALF Care Coordination Programs**

Jointly establishing measures and reporting methods to evaluate the relationship is central to effective evaluation and success of care coordination efforts. Hospitals and ALFs must define specific performance measures founded on hospital goals and establish a method of reporting performance to improve elements of the program.

**Define Measures.** Measures should focus on the three areas of the triple aim: improve quality of care, improve care experience, and reduce per capita costs. Hospitals should ensure measures are attainable and measurable. In addition, hospitals should establish a baseline for measuring change from the baseline to the performance period. Table 3 provides examples of measures for evaluating performance of care coordination programs against hospital goals and the goals of the triple aim.

**Track Data and Report Measure Performance.** Hospitals and ALFs should track clinical, financial, and utilization data to measure how well the partnership meets hospital and ALF goals. Hospitals can instruct ALFs to monitor and track utilization data between settings such as, admission and readmission rates, number of ED visits, number of discharges to the ALF, and patient satisfaction. Hospitals can use existing reporting functions to track and report on financial data, such as reduction in spending related to unnecessary ED visits and hospitalizations. Hospitals can discuss ALF partnership performance metrics and determine
<table>
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<tr>
<th>TRIPLE AIM ELEMENT</th>
<th>HOSPITAL CARE COORDINATION GOAL</th>
<th>EXAMPLE MEASURES</th>
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<tbody>
<tr>
<td>Improve Quality of Care</td>
<td>Implement care coordination programs for high-risk, functionally impaired ALF residents</td>
<td>• Compliance with communication and care transition protocols&lt;br&gt;• Percent of residents identified for “pre-acute” preventive health services through immunizations, screenings, cognitive assessments, and chronic disease management for diabetes, heart disease, mental disease, and others reflective of local population&lt;br&gt;• Reduction in medication reconciliation errors&lt;br&gt;• Percent of residents identified for fall risk through periodic screenings&lt;br&gt;• Reduction in falls after discharge</td>
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<tr>
<td>Improve Care Experience</td>
<td>Increase patient and family caregiver engagement by employing staff and allocating resources for effectively communicating and assigning responsibilities</td>
<td>• Percent of residents that receive in-ALF clinician appointments&lt;br&gt;• Percent of patient and patient family members that receive ALF-specific discharge instructions prior to transferring to the ALF&lt;br&gt;• Increase in resident satisfaction of care transitions to and from the hospital&lt;br&gt;• Number of self-management training events for residents and resident families&lt;br&gt;• Increase in resident and resident family involvement in the decision making process&lt;br&gt;• Percent of residents that have updated chart information at hospital admission/discharge and at ALF admission&lt;br&gt;• Changes in patient volume&lt;br&gt;• Improved patient flow</td>
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<td>Reduce per Capita Costs</td>
<td>Contain costs for ALF residents by reducing the percent of unnecessary readmissions, admissions, and ED visits</td>
<td>• Reduction in spending related to ED visits, and unnecessary admissions and readmissions&lt;br&gt;• Reduction in spending on ALF residents compared to prior year before care coordination program implementation</td>
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areas in need of improvement at regularly scheduled meetings. ALFs can compile reports for the first performance measurement meeting (i.e., after six months of implementing the care coordination program) and at quarterly meetings thereafter. Once hospitals and ALFs measure the first year of care coordination program performance, hospitals can use their established quality improvement methodologies to strengthen the program. To ensure quality improvement, hospitals and ALFs should analyze past utilization data and discuss new capabilities and services to determine new targets for the upcoming year.

**Tucson Medical Center:**
*Conducting Ongoing Collaboration to Better Coordinate Care for ALF Residents*

Tucson Medical Center, part of the Arizona Collaborative Care (ACC) ACO, meets monthly with post-acute care and residential care providers, including ALFs, to share lessons learned in coordinating care for high-risk populations. During meetings, care coordinators address ALF-resident transfers to and from the hospital and reinforce existing care coordination protocols. In addition, ACC provides ALFs with information on the number of residents admitted, readmitted, and who came into the ED over the last month and year-to-date. ACC and the ALFs discuss lessons learned and areas of care transition protocols that can help decrease areas of high volume.

**Identify Partnership Manager**

Based on initial partnership-building meetings with ALFs, hospitals can assign an ALF liaison from each ALF to be responsible for maintaining the relationship. This person can be a care coordinator, nurse, or administrative representative at the ALF. Assigning an ALF liaison gives structure to the relationship and supports care coordination goals. It also helps prevent communication breakdown and misalignment.

The ALF liaison will help manage recurring meetings and other team communication, which includes setting up ad hoc meetings to discuss updates to care transition protocols and encouraging ongoing attendance of meeting members. Regular meetings or teleconferences offer a venue to review performance and propose improvements to the care coordination program. In addition, regular meetings between hospital and ALF executives, managed by ALF liaisons, address challenges and potential modifications to goals and operating models as the partnership matures.

**Allina Health ACO:**
*Engaging Local ALFs to Prepare for and Manage the Aging Population*

Allina Health ACO is conducting meetings with local ALFs as part of their strategies to develop effective programs to meet the needs of their growing elderly patient population. These meetings cover compliance with care coordination protocols. Although this relationship is new, Allina has seen an increase in communication between hospital and ALF staff.

Hospitals may experience several challenges to managing partnerships with ALFs. This includes staff alignment, reporting structures, and quality improvement methods. In addition, hospitals currently making infrastructure changes may deem maintaining and managing relationships with ALFs less of a priority. As such, hospitals should ensure ALFs assume greater responsibility for managing the partnership.

**Fairview Health System:**
*Conducting Regular Meetings with Senior Services to Manage ALF Resident Health*

Fairview Health System—a non-profit academic healthcare system with seven hospitals, 40+ primary care clinics, a wide range of specialty services, home care and senior services—meets
regularly with Fairview Senior Services to discuss and develop resident health management strategies. The Fairview Health System and Senior Services teams meet to plan and modify population management activities, such as updating care coordination protocols, and implementing new care models that support the triple aim. As part of discussions addressing Fairview Health System ACO population management strategies, Fairview Senior Services is monitoring readmission and admission rates among assisted living residents and is working with the ACO to develop methods to measure trends in these areas.
New partnerships, particularly with nontraditional providers like ALFs, are part of a long-term strategy to manage population health. Given the shift of more clinical and financial risk to providers, hospitals have great opportunities in ALF partnerships to manage this risk.
To understand the partnership opportunity with ALFs in helping acute facilities manage healthcare utilization by the frail, functionally impaired elderly patients, Avalere Health reviewed federal and state regulations and literature from over 100 publicly available scientific publications, research studies, and news articles. Resources included Kaiser Family Foundation, PubMed, HealthAffairs, Assisted Living Federation of America (ALFA), the SCAN Foundation, and Journal of the American Medical Association, among others.

Avalere limited the literature search from 2000 until the present, and covered a range of search terms, such as high readmission rates, fragmented care in post-acute and long-term care settings, care coordination strategies, care transitions, ALF residents, ALF industry trends, healthcare spending drivers, and population trends.

Additionally, Avalere identified and interviewed more than 20 leaders from 15 ALFs, hospitals, and ACOs across the nation to learn how they are already working together. These interviews helped Avalere identify successful care coordination strategies between the stakeholders. The interviewees ranged from assisted living and senior care Vice Presidents to c-suite ACO leaders.

To conduct the interviews, Avalere developed and used structured interview guides tailored for each stakeholder group. The interviews explored a number of topics:

- Current and future care coordination efforts, and the influence of healthcare reform on these initiatives
- Current and future partnership agreements between acute care facilities and ALFs to coordinate care and reduce readmissions
- Communication processes and protocols developed to facilitate coordination and management of patients between acute and assisted living facilities
- Collaboration challenges between ALFs, hospitals, and ACOs
- Technology endeavors with acute care facilities and ALFs, including interoperability efforts between the settings

The information gathered from the literature review and interviews informed the recommendations discussed in this report.
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Darunee “Da” Smith, Director of Nursing, Devon Gables Health Care Center
## Appendix / Care Transition Models

### CARE TRANSITION MODEL

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<th>Model</th>
<th>DESCRIPTION GOAL</th>
<th>COMPONENTS</th>
<th>Staff</th>
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| The Care Transitions Intervention (Coleman Model) | • Hospital to home  
  • Founded on 4 Pillars:  
    - Medication self-management  
    - Personal health record  
    - Timely physician follow-up  
    - Patient warning-sign education for “red flags” and how to respond  
  • Ask and repeat with patient and physician to ensure patient understanding of discharge instructions and next steps | 30-day intervention with:  
  - One hospital visit  
  - One home visit  
  - Three follow-up phone calls  
  - Patient/family self-management | Care transitions coach  
  (advanced practice nurse [apn], registered nurse [rn],  
  or other healthcare worker) |
| Transitional Care Model (Naylor Model)      | • Hospital to home  
  • Transitional Care Nurse (TCN)-led team conducts in-hospital assessment and discharge planning  
  • TCN coordinates care to prevent unnecessary hospitalizations, medical complications, and health decline  
  Communicate and coordinate with medical professionals to increase collaboration  
  • On-call TCN | 30 to 90 day intervention with:  
  - Hospital visits/interdisciplinary planning  
  - Physician office visit with TCN  
  - Tapering home visits transitioning to phone calls  
  - Use of risk assessment and other tools | Transitional care nurse |
| Project BOOST (Better Outcomes by Optimizing Safe Transitions) | • Hospital to home  
  • Identifies high-risk patients on admission  
  • Focused on reducing 30-day readmission rates and length of stay  
  • Improves communication between settings, data transfer, and facility/patient satisfaction | Risk evaluation and standardized discharge planning including:  
  - Teach-Back  
  - Transition record  
  - Risk assessment  
  - Medication reconciliation  
  - Follow-up visit or 72-hour follow-up call for very high-risk patients | Hospitalist; multidisciplinary team; quality improvement (qi) staff |
| Project RED (Re-Engineered Discharge)       | • Hospital to home  
  • Focuses on educating patient for self-management  
  • Post-discharge planning and appointments for medication continuity and next steps  
  • Written instructions and phone call follow-up | Discharge planning including follow-up telephone calls, medication reconciliation, cause/effect diagram, and process maps | Discharge advocate; pharmacist; multidisciplinary team |

2 Avalere Health LLC analysis of the 2010 National Survey of Residential Care Facilities and the 2010 Medicare Current Beneficiary Survey.  N = 656,091 residential care residents age 65 and older.  N = 33,030,236 community residents age 65 and older.  Low-income individuals are those dually eligible for Medicare and Medicaid.


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