

Go To The Hospital Or Stay Here:

The Use of Evidence-Based Guides to Reduce Readmissions

Welcome!

- All lines are muted, please ask your questions in Q&A
- For technical issues, chat to the 'Technical Support' Panelist
- Please actively participate in polling questions that will pop up on the lower righthand side of your screen

We will get
started shortly!



**Quality Improvement
Organizations**

Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES



The Quality Improvement Services Group of
ALLIANT HEALTH SOLUTIONS

Carolyn Kazdan, MHSA, NHA

AIM LEAD, CARE COORDINATION



Ms. Kazdan currently holds the position of Director, Health Care Quality Improvement for IPRO, the Medicare Quality Improvement Organization for New York State. Ms. Kazdan leads IPRO's work with Project ECHO® and serves as the Care Transitions Lead for Alliant Quality. Ms. Kazdan previously led the IPRO's work with the NYS Partnership for Patients and the Centers for Medicare & Medicaid Services (CMS) Special Innovation Project on Transforming End of Life Care in the Nassau and Suffolk County region of New York State. Prior to joining IPRO, Ms. Kazdan served as a Licensed Nursing Home Administrator and Interim Regional Director of Operations in skilled nursing facilities and Continuing Care Retirement Communities in New York, Pennsylvania, Ohio and Maryland. Ms. Kazdan has served as a senior examiner for the American Healthcare Association's National Quality Award Program, and currently serves on the MOLST Statewide Implementation team and Executive Committee. Ms. Kazdan was awarded a Master's Degree in Health Services Administration by The George Washington University.

Carolyn enjoys visiting her grandchildren, photography, crocheting, needlepoint, reading and being at the beach!

"I don't have to chase extraordinary moments to find happiness - it's right in front of me if I'm paying attention and practicing gratitude"

-Brene Brown

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Julie Clark B.S., LPTA

SENIOR QUALITY IMPROVEMENT ADVISOR

Julie is a Licensed Physical Therapist Assistant with more than 8 years experience in managing rehab departments while treating patients in long term care, hospital, outpatient, home health, and inpatient hospitals. She has served as a Quality Improvement Advisor in Tennessee since 2012 working with long term care, hospitals, community coalitions, families and beneficiaries as they work to improve the care provided in the health care system. Her areas of expertise include geriatric seating/positioning, QAPI, NHSN, MDS quality measure review, falls reductions, community coalition development and more.

As the Tennessee Senior Quality Improvement Advisor she can assist healthcare professionals in understanding and implementing quality improvement efforts in their organizations with training events, one on one root cause analysis, and process improvement plan development
Julie's current hobbies include hiking in the mountains of East Tennessee, supporting people interested in changing to a clean eating through social media, assisting my two sons on their journey through college at ETSU.

"Be the change that you wish to see in the world." ~ Mahatma Gandhi

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Ruth M. Tappen, EdD, RN, FAAN

**CHRISTINE E. LYNN EMINENT SCHOLAR AND PROFESSOR,
CHRISTINE E. LYNN COLLEGE OF NURSING**



Dr. Ruth Tappen, EdD, RN, FAAN is Professor and Christine E. Lynn Eminent Scholar at the College of Nursing. She is an experienced researcher and scholar who has conducted extensive research on issues related to care of individuals with Alzheimer's and related dementias and care transitions, particularly reduction of hospital readmissions of nursing home residents that are both costly and risky for the resident. Dr. Tappen recently completed a CMS supported project to help NHs reduce unnecessary hospital readmissions, traveling and meeting with long-term care providers across the Southeastern U.S

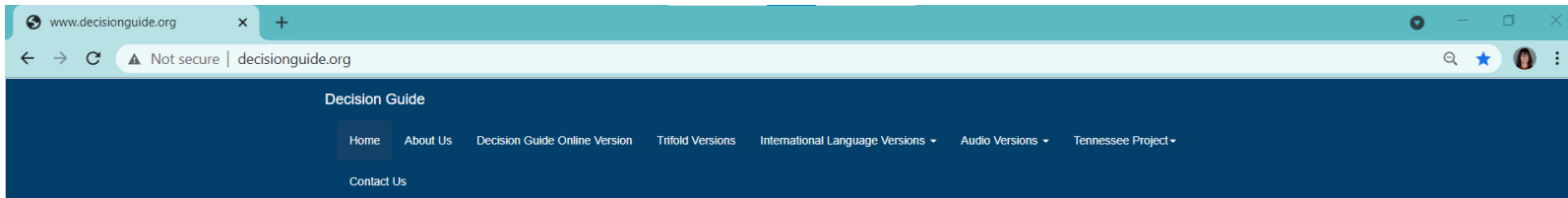
Polling Question

1. How confident are you that your staff feel empowered to have meaningful conversations with patients and families about the risks and benefits of hospitalization when changes of condition occur?
2. What is your current process for educating staff to prepare for these conversations?

Objectives

- Learn Today:
 - Describe the benefits of utilizing a standardized hospital decision guide
 - Identify strategies for implementing a hospital decision guide in post-acute care settings
- Use Tomorrow:
 - Add Hospital Decision Guide to your next community coalition meeting agenda

Decision Guide Resources



LOOK INSIDE



LOOK INSIDE

GO TO THE HOSPITAL OR STAY HERE?



A Decision Guide for Residents, Their Families, Friends and Caregivers



"The Decision Guide tools and resources have really helped us think differently on how we can prepare our Residents and Families for changes in condition and to let them know, WE take care of them in our Nursing Facility." NC SNF

Education & Resources

Use this section to access Training & Educational Videos, Case Studies and Webinar Presentations

Information for Residents & Families

[click here](#)

Information for Professionals

[click here](#)



Ordering information

To order printed, full-color guides with same-day shipping:

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Give feedback

[click here](#)

Funding for development of original Guide provided by Patient-Centered Outcomes Research Institute (PCORI). Funding for this updated Guide provided by the Eight States of CMS Region IV (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee) Copyright Florida Atlantic University





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2-3 / 16

EPAGE CREATOR



Did you know that almost half of transfers to the hospital may be avoidable? This Guide will help you understand why these transfers are made and how you can be involved in the decision.

CHANGE IN CONDITION

The question of sending you to the hospital or keeping you here may come up if your condition changes. This change could be a fever, shortness of breath, pain, an injury from a fall, or other change in your condition. If this happens, your medical provider has the responsibility to explain the change and the decisions that may need to be made to provide you the best possible treatment.

WHY THINK ABOUT THIS NOW?

This information is being provided to you so that you can make an informed decision if the question of going to the hospital arises.

It can be difficult to weigh the pros and cons of a transfer to the hospital when you become ill or to decide what treatment you prefer in the middle of a crisis.

IF IT IS NOT AN EMERGENCY


If this is not an emergency, the nurse will assess your condition:

- Ask you what happened, how you feel, where it hurts
- Listen to your heart and lungs
- Take your temperature, blood pressure, oxygen level
- Test your blood and urine

You can ask for the results and tell the nurse if you think your doctor, family, a friend or caregiver need to be called. If you have concerns about going to the hospital, this is the time to express them.

IN AN EMERGENCY

In a life threatening situation, the staff may call 911 to transport you to the hospital emergency department right away unless you have given them a Do Not Hospitalize request. They will also call your doctor or other medical provider (such as nurse practitioner or physician assistant) and a family member, friend or caregiver. You have the right to tell the staff ahead of time who you want called in an emergency.




"I want to be involved 100%."
(Patient)

"We do our best to keep them here. We do tests first, the proper assessment, diagnostic tests, whatever we can do here before we would transfer to the hospital."
(Nurse)

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[▶ CLICK HERE TO LISTEN](#)



Educational Resources for Staff

www.decisionguide.org/training x +

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Educational Materials for Staff


Best Practices [click here](#)

Powerpoint Presentation [click here](#)

Case Studies


- 1. Anxious Resident – Possible C. Difficile**
An 89-year-old post acute patient feels they should go back to the hospital. [click here](#)
- 2. Abdominal Tenderness**
A resident with CHF, hypertension and anxiety suffers abdominal tenderness. [click here](#)
- 3. Pneumonia**
Resident admitted after hip surgery – family feels she would be better in hospital. [click here](#)
- 4. Advance Directives**
Resident with pancreatic cancer has change in condition. [click here](#)
- 5. Advanced Dementia**
Resident's son insists his 99-year-old mother go to the hospital. [click here](#)

Videos




[The Usefulness of the Guide](#)

Dr Adrienne Mims shares her perspective as a gerontologist and the family member of a nursing home resident




[An Introduction from the Project Director](#)

Dr Ruth Tappen describes the development of the Decision Guide




[A Testimonial from a Nursing Home Resident](#)

Paul, a rehab center resident talks about how the Guide and better information could have helped avoid an unnecessary hospital transfer.




[Introduction for a new Resident and Family Member](#)

A new resident and a family member are introduced to the Guide



[Teaming with Resident to Prevent Hospitalization](#)

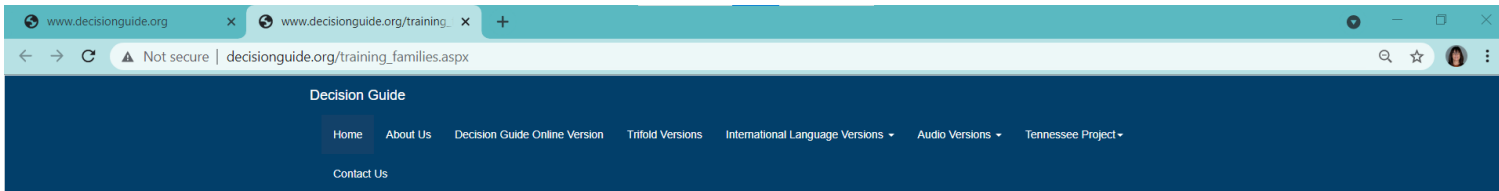
A resident's change in condition that can be managed in the nursing home. (Pneumonia)



[Engaging the Resident and Family in the Plan of Care](#)

Resident and family learn how following the recommended diet can prevent another hospitalization. (Salty Fish)

Educational Materials for Residents and Families



Home / Educational Materials for Residents & Families

Educational Materials for Residents & Families

Videos



The Usefulness of the Guide

Dr Adrienne Mims shares her perspective as a gerontologist and the family member of a nursing home resident



A Testimonial from a Nursing Home Resident

Paul, a rehab center resident talks about how the Guide and better information could have helped avoid an unnecessary hospital transfer.



Introduction for a new Resident and Family Member

A new resident and a family member are introduced to the Guide



Decision Guide for Resident in Palliative Care

Offering Options: Speaking to a resident on palliative care about the Guide



The Decision Guide in Tablet Form

A Social Worker gives the Guide to a short-term rehab resident in tablet form



DECISION GUIDE LIVE

A full presentation of the content of the Guide

Funding for development of original Guide provided by Patient-Centered Outcomes Research Institute (PCORI). Funding for this updated Guide provided by the Eight States of CMS Region IV (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee) Copyright Florida Atlantic University



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Objectives Check In!



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How will this change what you do? Please tell us in the poll...



Closing Survey

Help Us Help You!



- Please turn your attention to the poll that has popped up in your lower right-hand side of your screen
- Completion of this survey will help us steer our topics to better cater to your needs

CMS 12th SOW Goals



Behavioral Health Outcomes & Opioid Misuse

- ✓ Promote opioid best practices
- ✓ Decrease high dose opioid prescribing and opioid adverse events in all settings
- ✓ Increase access to behavioral health services



Patient Safety

- ✓ Reduce risky medication combinations
- ✓ Reduce adverse drug events
- ✓ Reduce C. diff in all settings



Chronic Disease Self-Management

- ✓ Increase performance on ABCS clinical quality measures (i.e., aspirin use, blood pressure control, cholesterol management, cardiac rehab)
- ✓ Identify patients at high-risk for developing kidney disease & improve outcomes
- ✓ Identify patients at high risk for diabetes-related complications & improve outcomes



Quality of Care Transitions

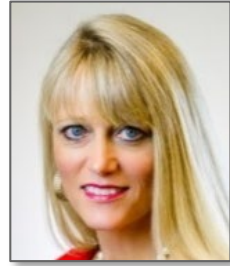
- ✓ Convene community coalitions
- ✓ Identify and promote optical care for super utilizers
- ✓ Reduce community-based adverse drug events



Nursing Home Quality

- ✓ Improve the mean total quality score
- ✓ Develop national baselines for healthcare related infections in nursing homes
- ✓ Reduce emergency department visits and readmissions of short stay residents

Making Health Care Better *Together*



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Program Directors



Upcoming Events



Learning and Action Webinars

Nursing Homes

Tuesdays, 2pm ET/1pm CT

Community Coalitions

Thursdays, 12:30 pm ET/11:30am CT

July 20, 2021: Understanding F-758: A Practical Approach to Gradual Dose Reductions (GDR) with a Definite Purpose	July 22, 2021: Optimizing Transitional Care for Older Adults with Diabetes
August 17, 2021: Immunizations Let's get back to basic immunization practices: Assessment Recommendation Administration Documentation	August 26, 2021: TBD

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