Live Discussion with a Patient/Caregiver: Lessons Learned, Best Practices and Resources to Reduce Readmissions

Welcome!

- All lines are muted, so please ask your questions in Q&A.
- For technical issues, initiate a chat with the Technical Support panelist.
- Please actively participate in polling questions that will appear on the lower right-hand side of your screen.

We will get started shortly!

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CENTERS FOR MEDICARE & MEDICAID SERVICES
IQUALITY IMPROVEMENT & INNOVATION GROUP

Live Discussion with a Patient/Caregiver: Lessons Learned, Best Practices and Resources to Reduce Readmissions

Presented by:
Peg Hudock, DNP, RN, CCM, PCMH CCE

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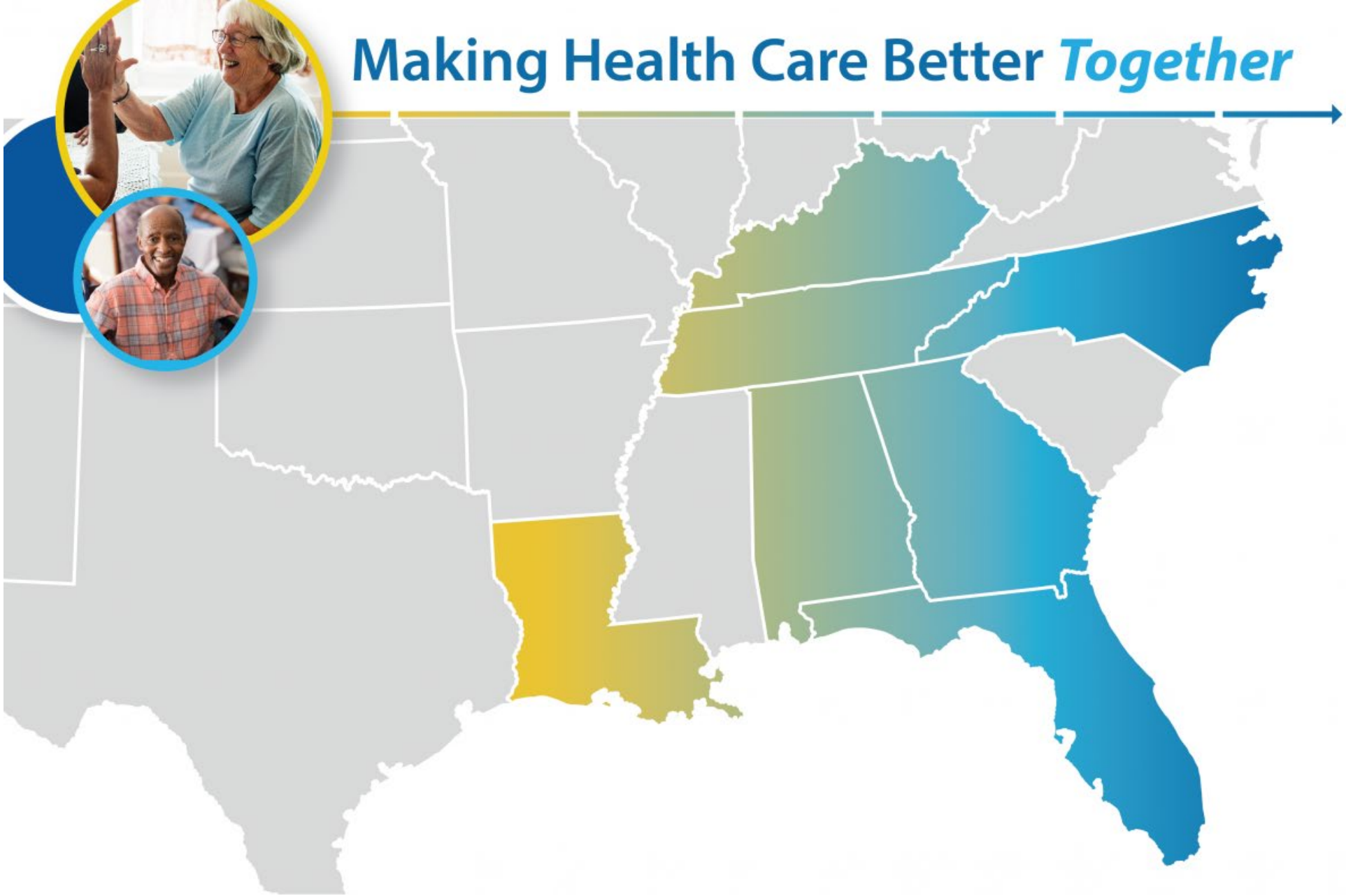

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Carolyn Kazdan, MHSA, NHA

SENIOR DIRECTOR, HEALTH CARE QUALITY IMPROVEMENT

Ms. Kazdan is the senior director of health care quality improvement for IPRO, the Medicare Quality Improvement Organization for New York and 11 other states. Ms. Kazdan led IPRO's work with Project ECHO® and serves as the care transitions and nursing home lead for Alliant Health Solutions.

Ms. Kazdan previously led 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 Nassau and Suffolk counties of New York State. Before joining IPRO, Ms. Kazdan was a licensed nursing home administrator and the 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. She currently serves on the NY State MOLST Statewide Implementation Team and Executive Committee and PALTC's Education Subcommittee. Ms. Kazdan earned a master's degree in health services administration at The George Washington University.

"We live in a rapidly changing world, where we need to spend as much time rethinking as we do thinking" – Adam Grant

Contact: ckazdan@ipro.org

Peg Hudock, DNP, RN, CCM, PCMH CCE

AQ BFAC MEMBER

Peg began her nursing career as a diploma nurse in 1967, trained by the Sisters of St. Joseph in upstate New York.

Her first 25 years were spent in hospital nursing, including Med-Surg, five years of ICU at the UVA, office nursing, pediatrics and OB, from staff nurse to director. Her next 25 years were spent with health plans–Intracorp, CIGNA, Wellpoint, Optum/UHC, Coventry, and Florida Blue as an auditor, national account manager, certified case manager, national director of CM, VP of Medicare, retirement, and doing quality at an FQHC.

Over these 50-plus years, Peg returned to school—Mercer/GA Baptist for her RN to BSN, Emory for her MSN and GA College for her DNP. Peg believes in continuous learning.

Peg remains a licensed RN, a certified case manager (since 1992), credentialed by NCQA as a PCMH CCE (clinical content expert) since 2021, involved with Alliant BFAC and on an advisory council at NTOCC for care transitions.

Objectives

Learn Today:

- Following this session, participants will have a better sense of what works and what doesn't when it comes to the patient/caregiver perspective on discharges.

Use Tomorrow:

- Implement a better patient/caregiver perspective on discharge from the tools presented in this session.

Situations

Two situations:

1. Neighbor: 87-year-old discharged with PICC line and continuous antibiotics for six weeks; the 82-year-old wife is the caregiver

2. Me: (75 and a doctorate-prepared nurse): Discharged twice from the ER at a major teaching hospital after a hip replacement and home the same day; had two trips to the ER within a week

Key Take Aways

Probing conversation: Readmission is like a puzzle when one thinks everything was done. Look for the missing piece.

Review of discharge instructions is NOT done well: In the ER setting, it is RUSHED.

Avoid labeling your patient.

Be aware of Unconscious Bias.

What I Learned

- Care is very complex for older people at home, whether they are educated or not. Of course, health literacy is critical:
  - They need guidance and help from the community and ways to find it.
  - Discharge instructions should be recorded for patients or families to re-listen.
  - Unconscious Bias: Avoid labeling patients. They remember.

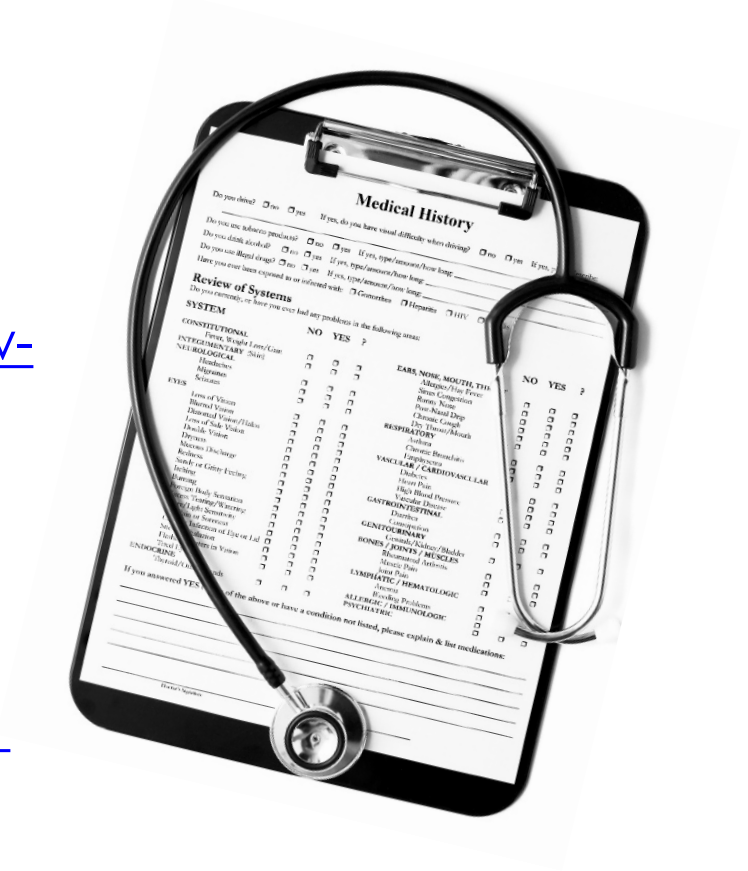
Health Literacy Video: https://www.youtube.com/watch?v=cGtTZ_vxjyA

Tools for Takeaway

1. https://quality.allianthealth.org/wp-content/uploads/2022/02/AHS-QIN-QIO-Post-Discharge-Follow-Up-Call-Script-V2-FINAL-508.pdf

2. https://quality.allianthealth.org/wp-content/uploads/2022/05/AHS-QIN-QIO-Readmissions-Patient-and-Care-Partner-Interview-Tool-FINAL_508-V2.pdf

3. https://quality.allianthealth.org/wp-content/uploads/2020/12/AQ_NYSPF-Brochure_FORM_508-1.pdf



Objectives Check-In

Learn Today:

- Following this session, participants will have a better sense of what works and what doesn't when it comes to the patient/caregiver perspective on discharges.

Use Tomorrow:

- Implement a better patient/caregiver perspective on discharge from the tools discussed in this session.

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 appeared in the lower right-hand side of your screen.
- Completion of this survey will help us ensure our topics cater to your needs.

Nursing Home and Partnership for Community Health:
CMS 12th SOW GOALS

OPIOID UTILIZATION AND MISUSE

Promote opioid best practices

•

Reduce opioid adverse drug events in all settings

PATIENT SAFETY

Reduce hospitalizations due to c. diff

•

Reduce adverse drug events

•

Reduce facility acquired infections

CHRONIC DISEASE SELF-MANAGEMENT

Increase instances of adequately diagnosed and controlled hypertension

•

Increase use of cardiac rehabilitation programs

•

Reduce instances of uncontrolled diabetes

•

Identify patients at high-risk for kidney disease and improve outcomes

CARE COORDINATION

Convene community coalitions

•

Reduce avoidable readmissions, admissions to hospitals and preventable emergency department visits

•

Identify and promote optimal care for super utilizers

COVID-19

Support nursing homes by establishing a safe visitor policy and cohort plan

•

Provide virtual events to support infection control and prevention

•

Support nursing homes and community coalitions with emergency preparedness plans

IMMUNIZATION

Increase influenza, pneumococcal, and COVID-19 vaccination rates

TRAINING

Encourage completion of infection control and prevention trainings by front line clinical and management staff

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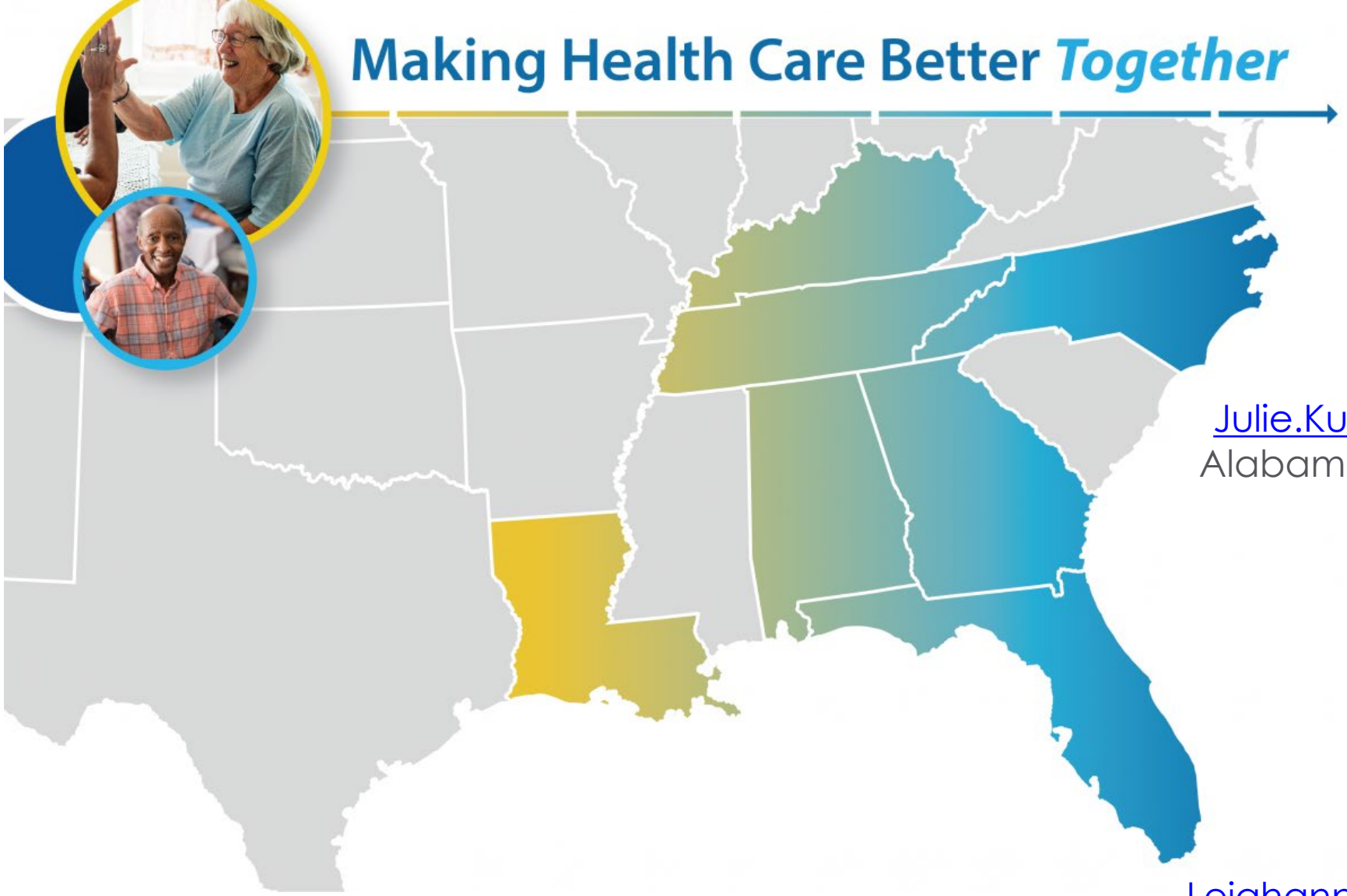

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