Nursing Home Readmissions Affinity Group Session 6: Engaging Patients and Care Partners

Danyce Seney, RN, BSN, IP, RAC-CTA, CPHQ
Amy Daly, MA, LNHA, CHES

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Danyce Seney, RN, BSN, IP, RAC-CTA, CPHQ

QUALITY IMPROVEMENT SPECIALIST

Danyce Seney is a quality improvement specialist and registered nurse with Lean, Infection Control Preventionist and Educator for Adult Learner certifications.

Danyce supports skilled nursing facilities in utilizing a quality improvement framework to implement evidence-based interventions and strategies to improve patient safety, immunization rates and reduce avoidable readmissions.

Email: DSeney@ipro.org

Amy Daly, MA, LNHA, CHES

SENIOR QUALITY IMPROVEMENT SPECIALIST

Amy Daly is a licensed nursing home administrator with over 20 years of leadership and long-term care management experience. In addition to her prior work as a vice president of long-term care and facility administrator, Amy has served on the boards of the Genesee Health Facilities Association (as treasurer and education committee member) and the Genesee Health Facilities Foundation. Amy serves as a New York State Department of Health Informal Dispute Resolution (IDR) panel member and has been an adjunct clinical instructor of dental hygiene at Monroe Community College. Amy has a master's degree in health promotion and a bachelor's degree in health sciences.

Email: adaly@ipro.org

Making Health Care Better *Together*

About Alliant Health Solutions

Where We Have Been

- ✓ Session 1: Facility Capabilities and Impact on Admissions, Re-Admissions, and ED Visits
- ✓ Session 2: Detecting and Communicating Change of Condition
- ✓ Session 3: Clinical Decision Support Tools and Advance Planning: Engaging the Patient and Care Partner
- ✓ Session 4: Managing Readmission Risk **Managing Readmission Risk**
- ✓ Session 5: Engaging the Interdisciplinary Team **AHS Virtual Events**

Learning Objectives

- Learn about tools that engage patient and care partners starting at admission for optimal discharge success.
- Identify strategies to engage the patient and care partner after discharge to mitigate readmission risks.
- Learn about online resources to support goals of care conversations.

It’s Brag Time!

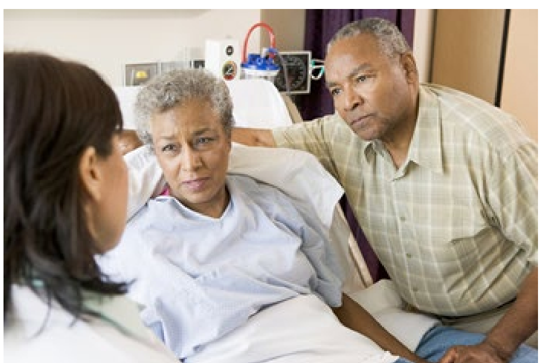
Jamboard

What is one thing your facility does well to engage family and care partners in discharge planning?

When to Begin?

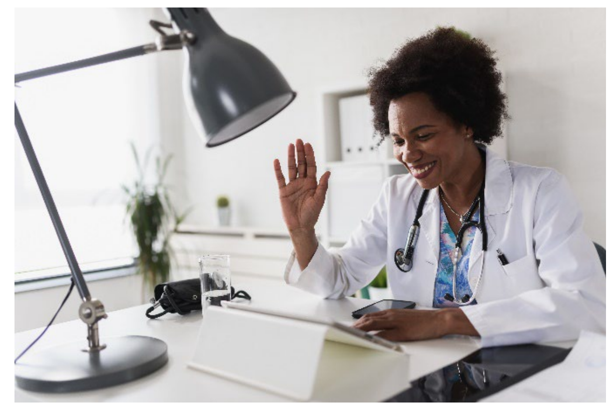
Begin at admission

Reinforce throughout the stay



Engage the interdisciplinary team

Follow-up at the next level of care



What Matters Most

- Printable Guide or Interactive Website
- Clinician training modules
- What Matters Most to the Resident/Patient?

MyHealthPriorities

Review and Print your Summary

NAVIGATION MENU

- Introduction
- 1. Identify What Matters Most to You
- 2. Set Your Health Goal
- 3. Review Your Health Symptoms and Problems
- 4. Review Your Health Care Tasks and Medications
- 5. Choose The One Thing to Focus On
- Talk With Your Health Care Team

Identifying My Health Priorities

Welcome to My Health Priorities!

Through this process we will help you identify what matters most to you- your **Health Priorities**.

Why are Your Health Priorities Important?

What matters most in life and health is different for everyone. Managing your health may be particularly difficult if you have multiple chronic conditions.

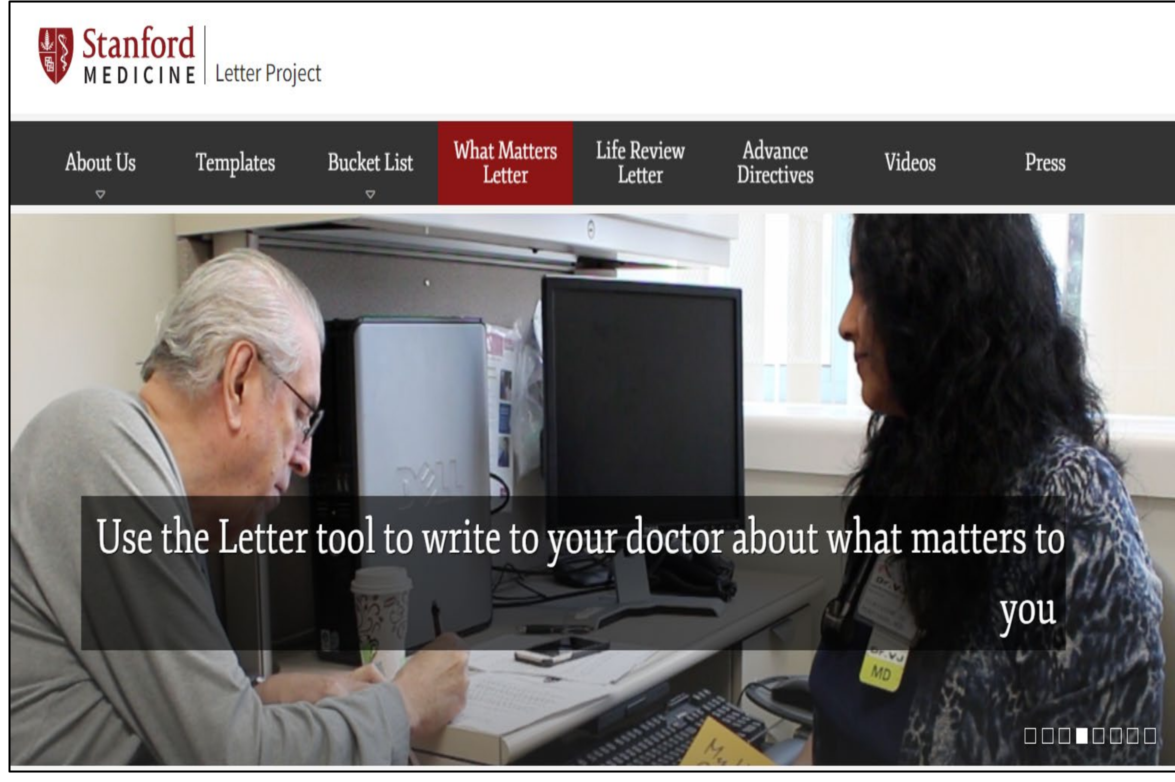
The more you and your health care team know about what matters most to you, the better you can work together to line up your health care decisions with your Health Priorities.

Note: use the "next" and "go back" buttons to move to the next page or previous page.

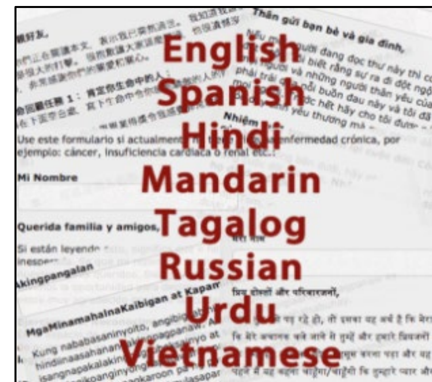
go back

next

What Matters Most



Stanford Letter Project



Dear Doctor,

My Doctor's name

RE: What matters most to me at the end of my life

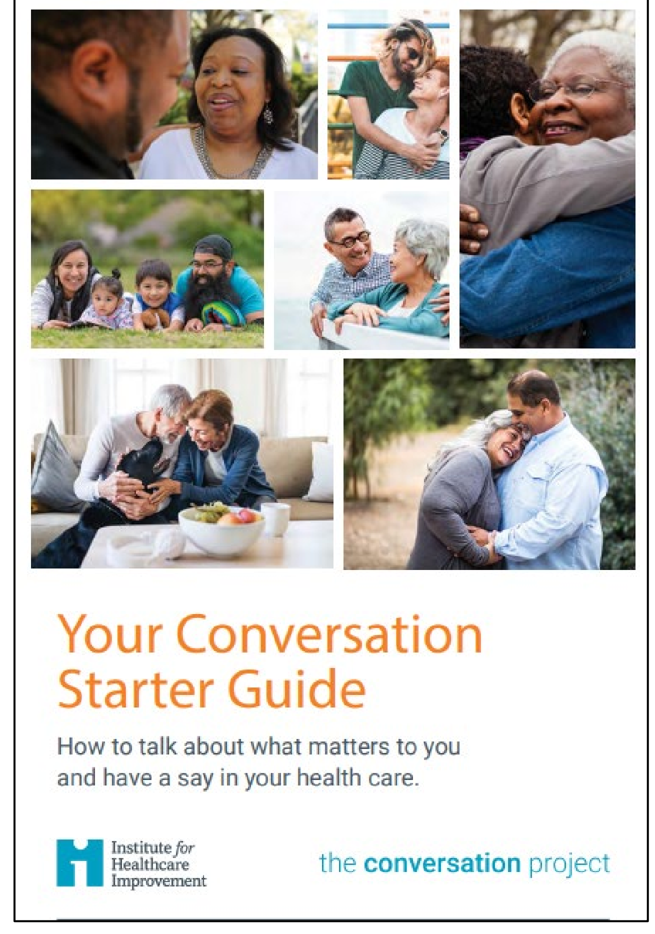
I have been reading and thinking about end-of-life issues lately. I realize how important it is that I communicate my wishes to you and my family. I know that you are very busy.
You may find it awkward to talk to me about my end-of-life wishes or you may feel that it is too early for me to have this conversation. So I am writing this letter to clarify what matters most to me.

My name

What Matters Most to Me
Examples: Being at home, doing gardening, going to church, playing with my grandchildren

My important future life milestones:
Examples: my 10th wedding anniversary, my grandson high school graduation, birth of my granddaughter

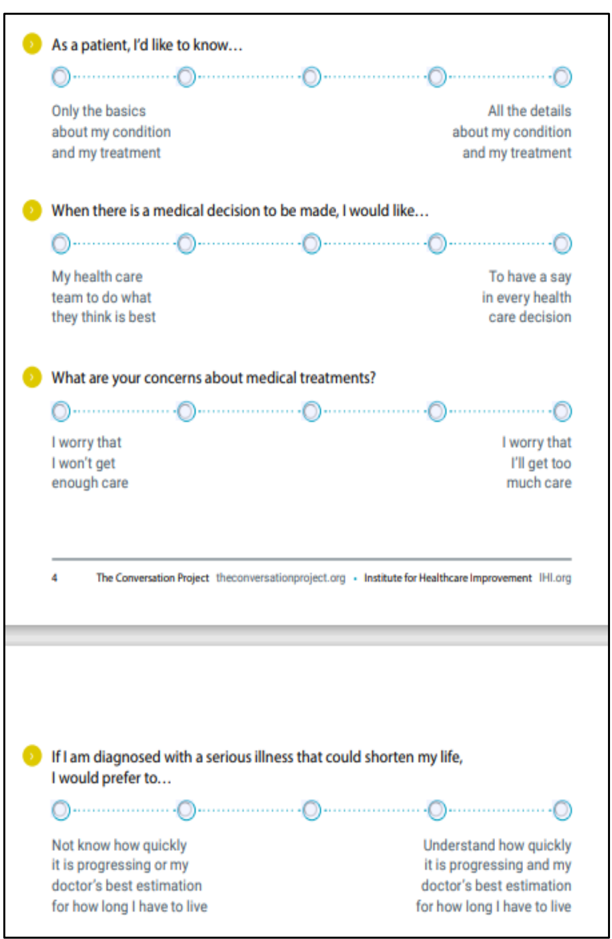
What Matters Most



Provides a guide for individuals to talk to the important people in their lives about what matters to them.

Quality of life wishes can help determine decisions regarding hospitalizations or other home care planning as needs change.

Lists of example topics to initiate discussions and topics to discuss are provided with areas to make notes as desired.



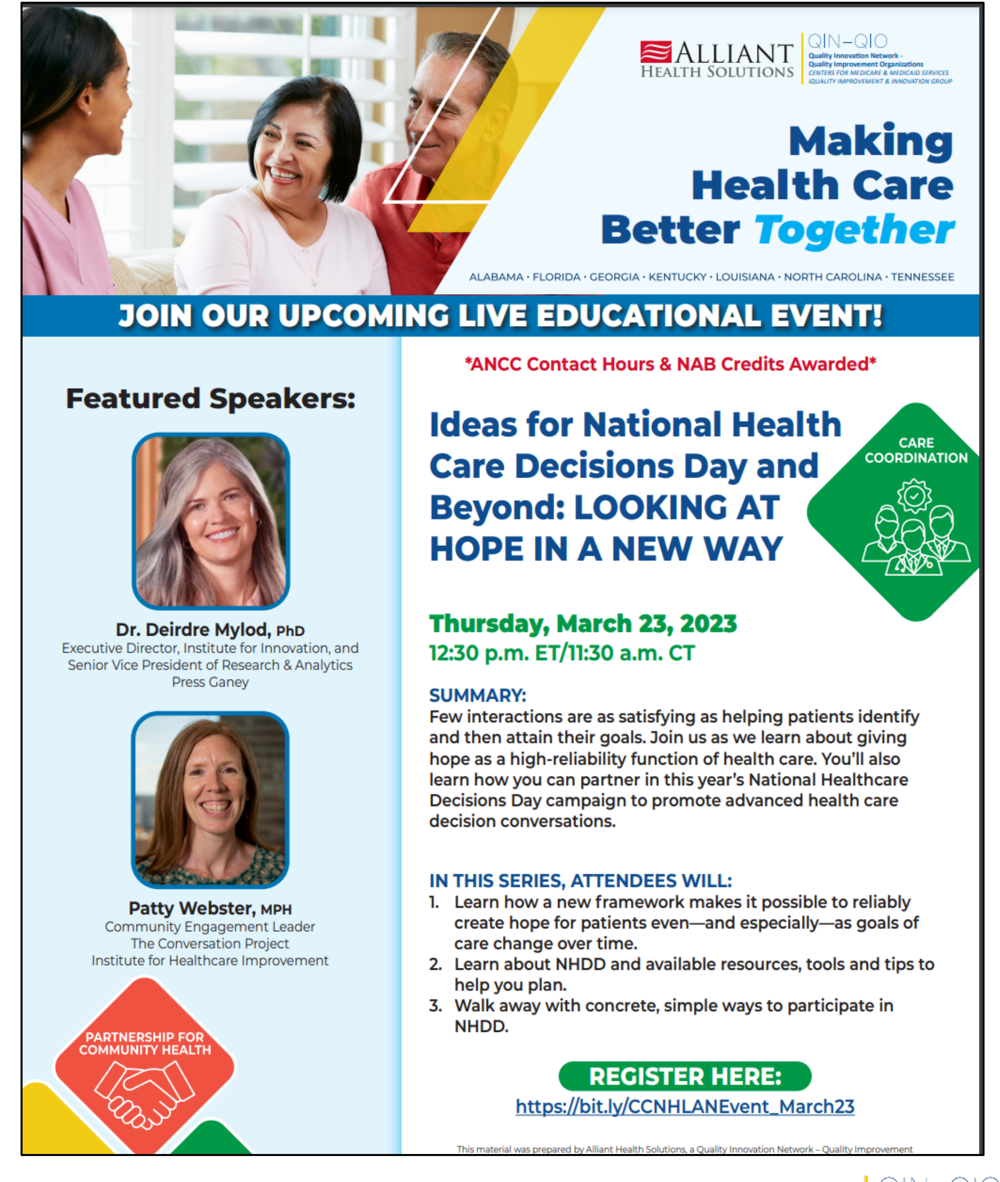
[The Conversation Project: Conversation Starter Guide]

Alliant Health Solutions March LAN Event

National Health Decisions Day

Attend the Alliant Health Solutions Learning Event
March 23, 2023

Speakers:
Dr. Deirdre Mylod PhD
Patty Webster, MPH



Ideas for NHDD and Beyond

Plan for Discharge at Admission

- Designed to help patients and families document and keep track of questions to ask before discharge from the hospital or skilled nursing/rehab.
- Helps providers proactively implement care plan interventions in areas that have the potential to raise the risk of readmission.
- Have a copy available as soon as possible before discharge.

MY CARE TRANSITION PLAN

Patients with caregivers and/or care partners are asked to complete this form, which lists their concerns on care needs at home. Hospital staff will work with you to address concerns on the list.

Name:

Care Partner:

Phone Number(s):

Follow-up Appointment

My Pharmacy:

Case Manager:

Care Partners are **SMART**[1] **and AWARE**

- **S** Signs and symptoms to look for & who to call
- **M** Medication changes or special instructions
- **A** Appointments
- **R** Results on which to follow up
- **T** Talk with me about my concerns

- **A** Available
- **W** Writing notes
- **A** Alert me about changes
- **R** Receive information
- **E** Educate me about my home care needs

CARE PARTNERS

Taking care of yourself can
especially when you are sic
help.

Care Partners can be family
neighbors, or paid help. Th
daily activities, such as dre
or cooking a meal.
Care Partners can also help
information—such as your
health history, or home car
doctor or nurse.

Care Partners can listen to
others for you, and ensure
information you need and

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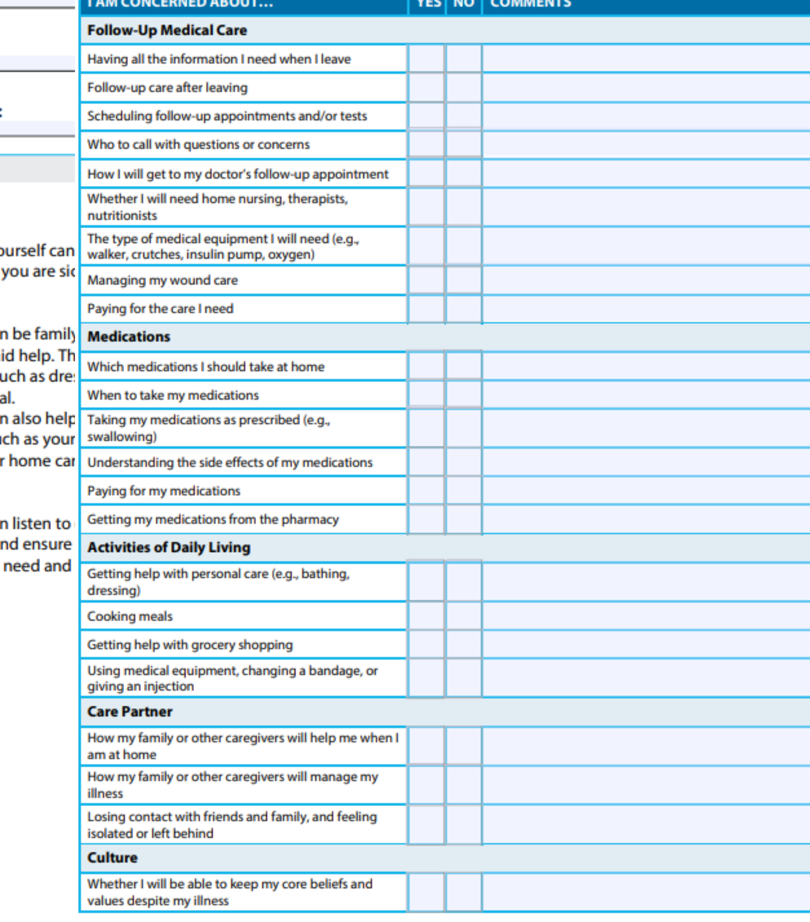
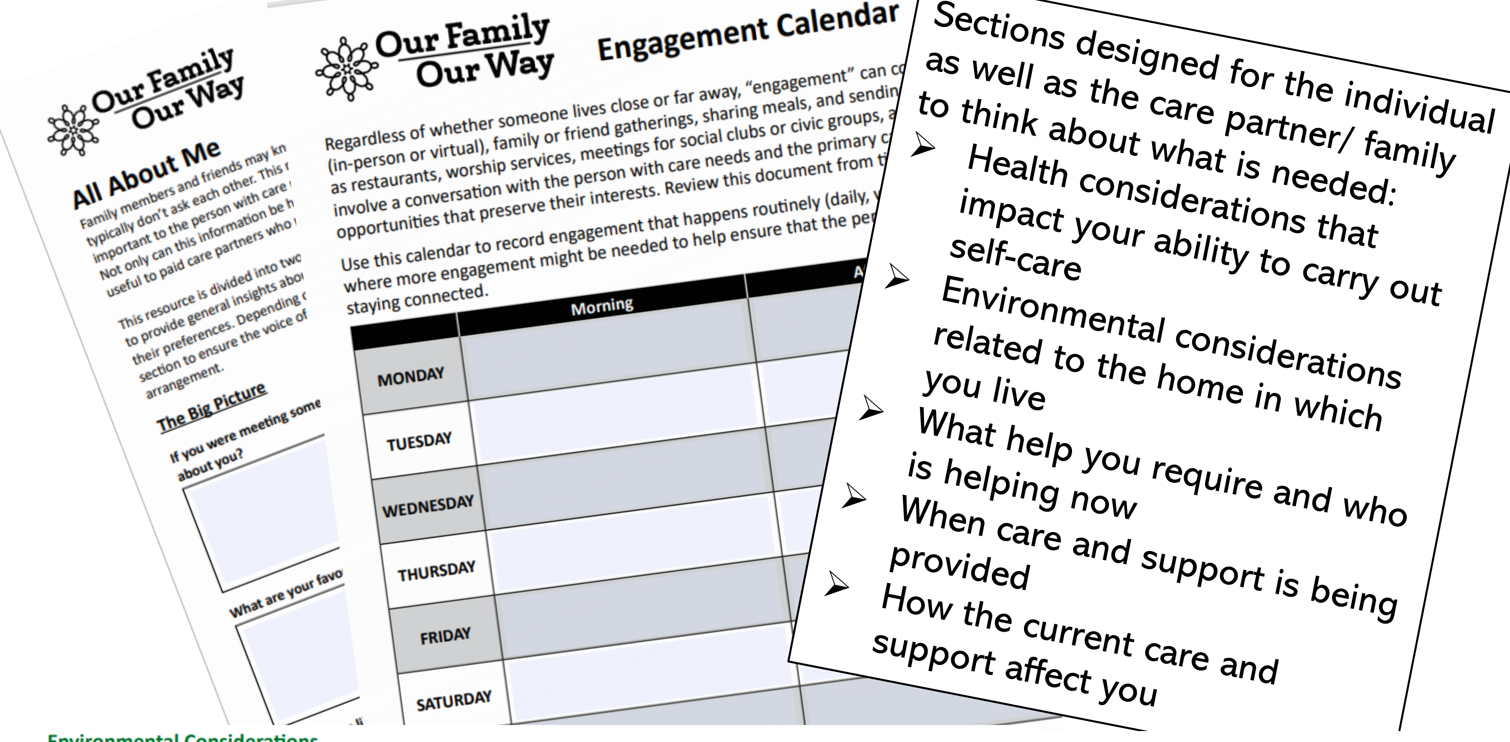


I AM CONCERNED ABOUT...	YES	NO	COMMENTS
Follow-Up Medical Care			
Having all the information I need when I leave			
Follow-up care after leaving			
Scheduling follow-up appointments and/or tests			
Who to call with questions or concerns			
How I will get to my doctor's follow-up appointment			
Whether I will need home nursing, therapists, nutritionists			
The type of medical equipment I will need (e.g., walker, crutches, insulin pump, oxygen)			
Managing my wound care			
Paying for the care I need			
Medications			
Which medications I should take at home			
When to take my medications			
Taking my medications as prescribed (e.g., swallowing)			
Understanding the side effects of my medications			
Paying for my medications			
Getting my medications from the pharmacy			
Activities of Daily Living			
Getting help with personal care (e.g., bathing, dressing)			
Cooking meals			
Getting help with grocery shopping			
Using medical equipment, changing a bandage, or giving an injection			
Care Partner			
How my family or other caregivers will help me when I am at home			
How my family or other caregivers will manage my illness			
Losing contact with friends and family, and feeling isolated or left behind			
Culture			
Whether I will be able to keep my core beliefs and values despite my illness			

What Do We Need?

- Our Family, Our Way is a communication and care coordination process
- Some families need help deciding who will do what, where and when it will happen, and how it will be accomplished
- Includes:
  - Videos, tip sheets, checklists, Family meeting materials, calendar, and a section "all about me" for the patient
  - Tools for the patient as well as tools for the care partner/ family



Environmental Considerations

This tool helps you and your family think about your current living column. If you generally disagree with the category, check the "Nc category is not applicable (for example, there are no stairs), check

The neighborhood...
is safe.
is convenient.
is near family and/or friends.
Other. Please describe.

The home...
has rooms and hallways clear of clutter.
has non-skid rugs.
has safe stairways (clutter free, handrails, clearly marked, well lit)
has easy to use furniture.

Environmental Considerations

This tool helps you and your family think about your PWCN's current living environment. If you generally agree with the category, check the "Yes" column. If you generally disagree with the category, check the "No" column. If you're not sure, check the "I'm not sure" column. If the category is not applicable (for example, there are no stairs), check the "N/A" column.

The neighborhood...	N/A	I'm not sure	Yes	No	Notes
is safe.					
is convenient.					
is near family and/or friends.					
Other. Please describe.					

The home...	N/A	I'm not sure	Yes	No	Notes
has rooms and hallways clear of clutter.					
has non-skid rugs.					

[Our Family Our Way Recording]

Communication and Education on Medications

"Patients are most at risk to return to the hospital immediately following discharge. Often new medication routines or lifestyle changes after being sent home can increase the chance of returning to the hospital. Access to community resources and family support can impact the chances that a patient returns to the hospital." Hospital Readmissions | Patient Safety & Quality at Johns Hopkins Medicine

Reducing Medication Confusion

- Admissions, transfers, and discharges often result in medication changes that are confusing for patients, care partners and families.

- Medications have brand names, generic names and over-the-counter names.

- Explaining to your patients and their care partners or families, in plain language, that they should bring all their medications to their next appointment is one way to enable the patient and care partner to manage their health and wellness.

[AHS Medication Review Tip Sheet]

[Order Medication Bags]

MEDICINE REVIEW: TIPS FOR YOU

Alliant Health Solutions is Working with YOU to Make Health Care Better

EVERY MEDICINE, EVERY TIME

Keeping track of your medications will help keep you safe and healthy.

Bring to Doctor

Reviewing your medications at doctor visits is the best way to make sure your doctor knows all of the medicines that you take. Your doctor also wants to make sure that you take the correct medicine in the correct amount at the correct time.

Keeping an accurate list helps avoid problems that could hurt you, such as:

- Drug Interactions
- Food Interactions
- Missing Medications
- Duplicate Medications
- Incorrect Dose
- Incorrect Time or Frequency

All Meds

Bring all of your medications to doctor visits, including:

- All prescriptions you take
- Any prescriptions you no longer take
- Over-the-Counter (OTC) medicines such as Aspirin or Benadryl
- Vitamins & Herbs
- Eye drops, creams, patches and inhalers
- Testing or self-monitoring supplies

Ask for Updated List

After your doctor has reviewed all of your medicines, ask for a printout of the updated medicine list and share it with your other doctors and pharmacy.

Talk to your doctor or pharmacist about ANY medicine question or concern, especially if you cannot read the name of a medicine or understand the directions. NEVER stop taking medicine without telling your doctor.

Follow-Up

- Provides a framework for follow-up discharge calls to patients identified as high risk for rehospitalization.
- Share the results from this with primary care physicians and other providers as part of care transition communication.
- This tool addresses topics such as food insecurity, medication orders, equipment, transportation and understanding of discharge instructions.

[AHS Discharge Follow UP Call Script]

Post Discharge Follow-Up Call Script

Tips for Using This Tool:

- The tool is one element of a transitional care services program and provid follow-up discharge calls to patients identified as high risk for rehospitaliz discharges from multiple levels of care, including hospital to home, skillec or hospital to hospice.
- The tool can be modified for specific high-risk conditions or align with you up protocol.
- The tool can be modified to include your institution's logo.
- It is recommended that this tool (or a summary of information and readm post-discharge calls) be shared with primary care physicians and other pr post-discharge care as part of care transitions communication.
- Establish a process to review unanticipated call findings or trends with Qu leadership for ongoing process improvement. Trends could be by topic (fc equipment) by discharging unit or provider.
- In communities where ED alert systems are in place for multi-visit patient information gleaned from follow-up calls.

Pre-Call Checklist

Patient Name: ______________ Date of birth: ________ Ph

Individual that the patient has asked to be called on their behalf:

Name: ______________ Phone Number: ______________

Language Interpreter needed? ☐ No ☐ Yes: ______________ (l

Review the following to gather pertinent background inform

- Discharge summary
- Case management or social services notes (pay particular attention to rea health literacy and references to other social determinants of health)
- Patient discharge instructions
- Zone tools: circle zone tools given to patient on discharge: (i.e., CHF, C UTI, Anticoagulation, other)
- Current vaccination status: ☐ Flu ☐ Pneumococcal ☐ Shingles ☐ COVID #1____ #2______ Booster______
- Referral to Home Health made: ☐ Yes ________ (Name of Agency) ☐ No (declined or did not meet criteria) – (
- Current or newly added high-risk medications:

High-Risk Medication	Medication Name	Dose/Frequency	Upcoming and Due D
Antibiotic			
Anticoagulants			
Antipsychotics			
Diabetic Medications			
Opioids			
Other (patient-specific)			

Readmission Risk Categories	Notes/Follow-Up Guidance
Medications	
What medications and supplements are you currently taking?	Compare to discharge instructions
Have you called in and picked up the new prescription(s) given to you at discharge? • Are you taking all of the new prescriptions given to you? • What is your plan for getting refills?	
Do you have medication(s) you were taking before hospitalization that you have been instructed to continue taking? • Do you have a supply of these medications, or do you need refills?	
Interviewer Guidance: If the patient is unable to answer questions about medications or does not have a plan for obtaining refills	• Contact the patient's pharmacy to determine delivery options, medication reconciliation assistance or patient education. • Ask the patient for permission to involve care partner or family in coming up with a plan to obtain medications • Contact the home care provider to engage in care planning and medication reconciliation.
Equipment, Services and Personal Care	
Has the home care provider seen you since you returned from the hospital (or SNF)? • Is the home care provider using your zone tool with you during each visit, or do you tell them which color zone you are in?	Consider follow-up with the home care provider if the zone tool is not being used during each visit or call.
Has a physical, occupational and/or speech therapist been to your home? • Have they made any suggestions about furniture, rugs, etc.? • Have you been able to do what they suggest?	Consider contacting the home health care social worker or community agency if the patient needs assistance with implementing recommendations.
Are you able to do personal care and bathing without assistance?	
How are you getting food? • Who is preparing your meals? • What did you eat yesterday?	
Have you received all of the equipment and supplies ordered for you? ☐ medical equipment ☐ oxygen / nebulizer treatment/CPAP ☐ IV or feeding tubing/supplies ☐ wound or incisional care supplies (dressings, tape, packing) ☐ ostomy supplies ☐ other: ______________	
Has your primary care provider been contacted to schedule a follow-up appointment? • When is your appointment?	

Bridge the Gap

- Text messaging is another method for staying connected with patients and care partners after discharge to ensure questions and concerns are addressed.
- Consider creating text messages to send at regular intervals to follow up on discharges with prompts for responses.

[January 2023 LAN: Leveraging Technology to Support Safer Transitions of Care]

Post-Discharge Text Messaging WORKS!

Text messaging is a convenient, familiar and effective transition management tool when implemented as part of an overall readmissions improvement strategy by hospitals, skilled nursing facilities, physician practices, home health agencies and more.

For example, home health agencies can use text messaging to remind beneficiaries to contact them if challenges arise between scheduled doctor visits.

Read on for valuable tips on implementing a post-discharge text messaging program.

Additional information and example consent forms and processes, logic diagrams and vendor information can be found in the Texting Better Care Toolkit: https://www.careinnovations.org/resources/texting-better-care-toolkit/

Health Insurance Portability and Accountability Act (HIPAA), Consent and Compliance Considerations

Involve the facility or health system compliance officer to review the pilot or rollout to ensure compliance with HIPAA, the Telephone Consumer Protection Act (TCPA) and other pertinent federal, state or local regulations.

Considerations include:

- Process for obtaining and documenting consent
- Process for opt-out at any time, honored immediately and communicated during each message
- Controls that ensure no marketing is perceived
- Time of day restrictions
- Controls to ensure that messages go only to numbers authorized to receive these specific messages
- Restrict health information to extent possible
- Record retention

Message Development Considerations

- Keep messages clear and concise
- Clearly state your opt-out process
- Ensure messages are culturally appropriate
- Consider the health literacy of enrolled recipients
- Establish and publish anticipated response times to replies
- Create messages for enrollment, appointment check-in/follow-up and closing message
- Utilize patient advisors to obtain feedback on proposed message content, delivery schedules/times and message frequency

Operational Considerations:

- Texting schedule
- Response time frames
- Care Partner engagement
- Text monitoring, response and backup processes
- Downtime processes
- Inclusion of process in facility or health system emergency preparedness plan

Vendor Selection Considerations

- Security
- Convenience
- Text message fees/cost
- Ability to integrate with existing systems
- Level of internal IT support and external support needed
- Degree of customization available/needed (e.g., utilizing group texting when patients consent to inclusion of a care

Additional resources:

1. **Texting Better Care Toolkit:** https://www.careinnovations.org/resources/texting-better-care-toolkit/ This toolkit was developed in part through the UCSF Center for Vulnerable Populations (CVP) and Public Healthcare Evidence Network and Innovation eXchange (PHoENIX), supported by the Agency for Healthcare Research and Quality (AHRQ) grant number R24HS022047.
2. Bressman E, Long JA, Honig K, Zee J, McGlaughlin N, Jointer C, Asch DA, Burke RE, Morgan AU. Evaluation of an Automated Text Message-Based Program to Reduce Use of Acute Health Care Resources After Hospital Discharge. JAMA Netw Open. 2022 Oct 3;5(10):e2238293. doi: 10.1001/jamanetworkopen.2022.38293. PMID: 36287564; PMCID: PMC9606844
3. **JAMA Study:** https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2797716.

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Keys to Success

- Use Plain Language
- Check For Understanding
- Incorporate Patient/Care Giver Feedback
- Use Technology

Use Tomorrow

- Have your team select one tool from today's presentation to review.
- Discuss how and where in your discharge planning process you can implement a small test of change with this tool at your facility.

Questions?

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

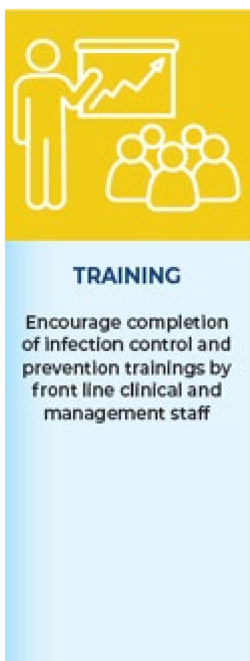
TRAINING

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

Scan the QR codes or Click the Links to Complete the Assessments!

CMS requested Alliant Health Solutions, your QIN-QIO, to work with select nursing homes to understand emerging healthcare needs in nursing homes. Alliant Health Solutions is engaging nursing home leadership in this key area to ensure plans are in place to achieve and maintain health quality and equity!

Please scan the QR code below and complete the assessment.



Nursing Home Infection Prevention (NHIP) Initiative Training Assessment

https://bit.ly/NHIPAssessment

Making Health Care Better *Together*

Program Directors

Julie Kueker
Julie.Kueker@AlliantHealth.org
Alabama, Florida and Louisiana

Leighann Sauls
Leighann.Sauls@AlliantHealth.org
Georgia, Kentucky, North Carolina and Tennessee

Making Health Care Better *Together*

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Alliant Health Solutions

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