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

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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.

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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.

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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
- Session 5: Engaging the Interdisciplinary Team

Managing Readmission Risk
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
What Matters Most

Use the Letter tool to write to your doctor about what matters to 
you

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

Stanford Letter Project
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.
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

*ANCC Contact Hours & NAB Credits Awarded*

Join our Upcoming Live Educational Event!

Making Health Care Better Together

Featured Speakers:

Dr. Deirdre Mylod, PhD
Executive Director, Institute for Innovation, and Senior Vice President of Research & Analytics
Press Carey

Patty Webster, MPH
Community Engagement Leader
The Conversation Project
Institute for Healthcare Improvement

Thursday, March 23, 2023
12:30 p.m. ET/11:30 a.m. CT

Summary:
Few interactions are as satisfying as helping patients identify and then attain their goals. Join us as we learn about giving hope as a high-reliability function of health care. You’ll also learn how you can partner in this year’s National Healthcare Decisions Day campaign to promote advanced health care decision conversations.

In this Series, Attendees Will:
1. Learn how a new framework makes it possible to reliably create hope for patients even—and especially—as goals of care change over time.
2. Learn about NHDD and available resources, tools and tips to help you plan.
3. Walk away with concrete, simple ways to participate in NHDD.

Register Here:

Partnership for Community Health

In partnership with: Health Information Management Association, Quality Improvement Network, Community Action Management
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.
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:
  o Videos, tip sheets, checklists, Family meeting materials, calendar, and a section “all about me" for the patient
  o Tools for the patient as well as tools for the care partner/family
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
Follow-Up

- Provides a framework for follow-up discharge calls to patients identified as high risk for rehospitalization.
- Share the results 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
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
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
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.

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