Working Together to Reduce Hospitalizations During COVID-19

Webinar Transcript

Krista Davis: Good afternoon, and welcome to today's QIN-QIO, Regional Support and Sharing Call, Working Together to Reduce Hospitalizations During COVID-19. My name is Krista Davis and I'm a Communications Specialist at Quality Insights, and your host for today's presentation. We'll get started in just a few moments, but first, a few housekeeping items.

All participants entered today's webinar in a listen only mode. Should you have a question or comment during today's call, we ask that you please type it into either the chat or the Q&A box to the right of your screen. To activate your chat box, click on the word, Chat, with the speech bubble in the bottom, right corner of your screen.

At the end of today's program, you'll be directed to an evaluation and a post-test. Once completed, you will be presented with a certificate for you to fill out and print as proof of your course completion. Even if you do not need the CEs, we hope that you will still complete the evaluation as it helps tell us how we did and how we can shape future programming. To complete the course, you must watch the 30-minute webinar live or recorded and complete the post-test questions & evaluation with a score of 80% or better.

0.5 contact hours are approved for nursing, Quality Insights is accredited as a provider of nursing continuing professional development by the American Nurses Credentialing Centers Commission on Accreditation. There are no identify conflicts of interest.

After this course, we hope that the learner will be able to discuss the importance and development of specialized in-home programs, including the benefits to both patients and family, explain how hospital tracking can benefit your patients and describe two ideas to implement specialized programs during a pandemic.

We have a lot of excellent information to deliver today. So without further ado, I'd like to introduce our guest speaker, Jennifer Pisarchick-Drake, graduated from Bloomsburg University with a BA in Mass Communications with a concentration in advertising, marketing, public relations and strategic planning. She has been employed with nationally recognized health systems, such as St. Luke's University Health Network, Lancaster General Health, UPMC Health Susquehanna, and Guthrie Health System. Prior to being employed by United Disability Services Foundation. She was a member of the board of directors for

five years. She and her husband, Steve have a newborn daughter, Jocelyn. It's my great pleasure to turn the program over now to Jennifer Drake. Jennifer, the floor is yours.

Jennifer Drake: Thank you very much Krista, for that warm welcome. And I think everyone for joining us today, my hopes are that I can pass along some of the tactics that our organization, during this trying time has implemented to reduce hospitalizations for our consumers. Just a little bit about, United Disability Services Foundation, our backgrounds that our programs, we have been providing home and community based services for more than 56 years and participants in 60 counties in Pennsylvania. Our goal is to get to all 67 counties in Pennsylvania, and we've been reaching that slowly.

We have 12 internal programs such as adult enrichment, employment services, our transition school, our challenger football and cheerleading, our non-medical in-home personal care, independent living services, our accessible home modifications program, our mobility and rehab equipment, custom wheelchair seating, ever popular service dogs, our case management supports coordination division, our autism waiver care management and our resource center.

Well, our home and community-based services reducing hospitalization team has worked together to provide a transition of care or TOC, when a participant is moving from one setting to another. This puts the participant at a higher risk for hospital readmissions, medication errors and decreased health. A TOC requires accurate and timely communication between care providers for successful TOCs to take place. Within two days of a hospitalization and discharge, we are calling the participant to ensure health and safety and to make sure we are a part of the discharge planning process, to ensure a safe discharge to home can take place. Within five days of the discharge, we are going to the participant's home to follow up with them, ensuring they know all the information on our Ticket to Home, which outlines the four major risk factors people are readmitted to the hospital or nursing facility for. Reviewed Ticket to Home and use a teach back method to ensure they know what to do to stay home and when it is appropriate to call the PCP or the hospital.

With our MCOs, our managed care organizations we have been working with hospitalization is a trigger event, which means we will go into the nursing facility or hospital and reassess their needs for a change in services within 48 hours of the trigger event. This visit does not replace the quarterly visits that are already in place for our sports coordinators. And being in the facility allows us to connect with hospital or nursing facility staff, and be more involved in the discharge process. Now, let me make a little caveat, during COVID we have been doing a lot on this either remotely or by Zoom or video.

For our in-home personal care, reducing hospitalizations, we have a staff member known as a safety mentor. The safety mentor, monitors safe and unsafe visits daily for all of our consumers. We schedule home visits to monitor

participant safety. We have been doing this during the pandemic with all the CDC guidelines in place. We have an LPN that is doing a six month participant check-in of all our visits. Hospitalization tracking and ED trends for our individual participants. What we mean by that is we are looking to see what our participants, our consumers are being admitted to the hospital for. And we are looking to see how we can create specialized education programs for them to reduce further hospitalization. Our independent living services care team and hospital care management team work closely together for safe discharge and implementation of patient home care plans. Each home care plan is specifically designed for that participant is not cookie cutter, as we know that each individual has different needs. We work with the different waivers programs our HealthChoices and private pay consumers.

One of the programs that we have put into place is our fall prevention program. Our UDS safety mentor and home modification professionals assess participant environment and current transfer status. We work collaboratively with discharge planners, insurance carriers and participants. What they do then when they are safety mentor at our home modification professionals. So they go into the homes, they assess for things such as handrails on stairways, adequate lighting, pathways free of clutter, throw rugs, mounted grab bars in tub, shower, and commode areas, is the commode the proper height for function of the participant? Is it too high? Is it too low? Would there be a possible fall risk there? Movement up a participant up and down the stairs for a stair lift if applicable, can work with both homeowners and landlords. And again, we work with the waivers, HealthChoices and private pay consumers.

I wanted to put together a little slide of our fall prevention outcomes. Our latest one was our home modifications of 2018. We do survey all of our home modifications participants, and these are the critical outcomes that we have for the data for our program. Where are participants one to two years after receiving our services for home modification? 91% responded, they are still in the same residence. 7.5% had said they were in other residents such as assisted living or a personal care home or living with a family member or loved one. And 1.5% are now residing in a nursing facility.

Another question that we asked to kind of weigh the benefits of this program is has modification improved participant's health and safety. 92% said, yes. 8% said, no. And that 8%, please let me make the disclaimer that those might have been who digressed because of their disease or diagnosis. Our falls and injuries since modification. This was a very important statistic for us, for myself. 21% said there were a fall or injuries since modification. For my caregiver, 0%. That is something that we often forget about is that caregivers are succumbed to falls and injuries while transferring or assisting patients.

Some other specialized programs that we've created during this pandemic to help better educate our families are the diabetes program. What we do with our diabetes program is patient and family education. We know that a patient can

be educated, but oftentimes family are the support for that patient. Family are providing care, family are providing meals, providing medication. So we feel it's important to be a centered care plan for both patient and family.

Nutrition and diet monitoring. This is very important with our diabetic program, because we all know those diabetic patients who are noncompliant, that will be seeking snacks, that are not eating properly. They might not know how to eat properly. Their family members might not know how to care for them.

We are working with other care providers to make this program a success such as the discharge planners. We work with hospital nutritionist. We work with nursing care. We work with skilled nursing care because all the other care providers, it takes a village sometimes. And that is what we, we utilize with our diabetes program.

With our wound care program. But we also again provide patient and family education. Family members might not be sure what they're looking for. They might not understand the importance of transitioning a patient, why they need to be rolled, how do you reduce bedsores? We try to teach them how to look for that.

What to look for while they're dressing. If you're seeing something that does not look normal, we're educating them along with the skilled nursing providers to be advocates for their health, to call when they need something with their dressing, that something isn't right.

And again, we work closely with other care providers. This is a truly a team effort. This is the skilled nursing team. This is the nonmedical in-home team. This is the service coordination team. This is the hospital discharge planning team, everyone. We want to reduce people coming back into the hospitals because we want to educate them.

But please keep in mind. Both programs are always successful with participant compliance, if you have, and we all know we do have the non-compliant participants, the program is not going to be successful. It doesn't mean that we don't try, or we don't attempt to do it again, but we're only going to have success when they understand they can't be having the snacks underneath their chairs for watching television. When they can't leave dressings on for a week, that look like they needed to be changed immediately.

Increasing awareness during COVID-19. We all know we're enduring this pandemic. And hopefully with the vaccines being available for everyone, it's going to be making a world of difference. But right now we still need to be vigilant. We still need for both our caregivers and our participants to be safe. And again, what are we doing? We're providing in-home care during a pandemic, we're following all CDC recommendations and guidelines. We're

hand washing and sanitizing. We know though, Dr. Levine says sing happy birthday twice. I think we've all been singing happy birthday to ourselves a lot longer, but we need to keep doing that. Wearing a mask or cloth covering, social distance when applicable. We need to keep in mind that a lot of times we are providing direct patient care or direct consumer care, that's not possible, but if there's family members that stopped by, or if there's other providers, let's be respectful of that six feet distancing. Continuously disinfected environment. These are all things we've been practicing, but we're adding to our daily routines.

Excuse me. Sorry. My slide got held up. I do apologize, little technical difficulty. Report symptoms, quarantine, get tested. If participants have symptoms, we need to report that, we need to report consumer symptoms. We need to report staff symptoms. We need to quarantine the 10 to 14 days, and we need to get tested. We're doing electronic and mail in enrollment. We're doing Zoom family questions and answer sessions. We're making sure all caregivers are supplied with proper PPE to provide the very best care to their participants. And what we're doing with supplying PPEs, is we are supplying the N-95 masks. We are supplying masks that were so generously donated by Hershey. We're supplying gloves, we're supplying hand sanitizer and sanitizing cleaner.

Continuous communication with discharge planners and other care providers in the home. We are constantly working with and keeping them up to date on what is going on and what is happening in the home for COVID-19.

Continuous communication and education to participants on all CDC safety reminders. Now, we know our consumers hear this, our participants hear this, but certainly we need to educate them. What does that mean? What does that mean to wear proper PPE? What does that mean to wear your mask? What does that mean? How do you wear a mask properly? We all know we've seen this, people wearing their masks on their chins. If it doesn't cover your nose, how's it going to help? We need to do that. COVID-19 has really taken us by storm and we really adjusted well as healthcare providers. And Krista, I'm having a little difficulty with advancing my last slide.

Krista Davis: Okay. I got you. No problem.

Jennifer Drake: You got me? Okay. Again, I apologize. Does anybody have any questions?

Krista Davis: Thank you, Jennifer. And we are going to be entering the Q&A portion of today's program in just a moment. But before we do that, while you all are thinking of your questions and typing them into the chat box and the Q&A box, we are going to launch a poll. We here at Quality Insights would like to know what is your preferred length of time for an educational webinar or activity that includes nursing contact hours? This is for our future reference, so that we can continue to provide you with the best educational opportunities that best fit

your schedule. So we'll leave this open for a few moments. The poll is on the right side of your screen, so draw your attention there.

And we do have a few questions. So we will go ahead and get started with asking those. Jennifer, our first question is how are all of these services paid for?

Jennifer Drake: No, it is a great question. As I mentioned, that we work closely with waiver programs, we work closely with the MCOs, the managed care organizations and community HealthChoices. And we also work with private pay consumers. It all depends if they qualify for the waiver or the MCO program, that might be covered under there, in-home care might be covered, inaccessible home modification might be covered. That is why our support coordination division and our resource center, which certainly, I'll be happy to provide the number. Again, we have people that will help your participants or your referrals see if they are eligible for any program for that service.

Krista Davis: Thank you. And our next question is what are the four major risk factors for readmission that are listed on the Ticket to Home?

Jennifer Drake: They are hospital readmissions, medication errors, decrease health and fall risks. I'm sorry.

Krista Davis: Thank you. Our next question is who can refer patients to your program?

Jennifer Drake: Anyone, that's a great question. It could be a family member or friend. It could be a support coordinator. It could be a hospital case manager. It could be a physician, it could be a nurse in a practitioner's office. It could be someone at the senior center. Anyone can refer for our programs.

Krista Davis: Thank you. And our next question is what are the criteria for a referral?

Jennifer Drake: The criteria for a referral, that would all depend on what you're being referred for. So for a nonmedical in-home care, for instance, they need to have help with an ADL to be covered by the waiver or managed care organization or options program. For private pay, really we do companion services, companion services are not covered by the MCOs or the waiver program, but certainly we would look at that to see if they would be eligible for any other ADL's.

Home modifications again, we would assist to see what they need help with. Is it getting from point A to point B? We would do all of that assessment for the referrals.

Krista Davis: Thank you. And our next question is, do you get many refusal for your services?

Jennifer Drake: Great question. Yes, we do. Unfortunately we all know that we can't make someone do what they don't want to do. We know we're there to help better

their lives and give them a longer life at home, everyone wants to stay at home. But if they refuse care with our waiver program, currently, if there are three, we make three attempts for services. Then we will contact the supports coordinator that is in charge of that participant's case. Let them know that they are noncompliant with their waiver process. I would say if I was estimating a percentage right now, we probably get about 25% of after we signed them up for services and everything's a go and everything is great. When we do the knock on the door for the first day service, it's like, "Ah, I don't want this anymore." So we do have some refusal. And as long as they are able to make decisions on their own, they certainly are not obligated to receive services.

Krista Davis: Thank you. And our next question is, do you go into the hospital to see patients that are referred and also what always is involved in the hospital tracking?

Jennifer Drake: Yes, actually, that's one of my roles personally. I do go to all 60 counties in Pennsylvania if I'm needed to, but my concentration is certainly the Schuylkill County, Carbon County, Berks County, Lancaster County, I have a colleague. But we do go to the hospitals when it's applicable. And if we do need to go in to see, we work with the case manager right now during the pandemic to make sure we're complying with their guidelines. We will go in and we will talk to the family, talk to the patient. We will assess them to see what their needs are, see what they want. We want them to be a buy-in for these services, because if they're not on board, it's like bringing a horse to water, you can't make them drink. And then that goes to answer the question before about refusal of services.

How we track the hospitalizations are for our nonmedical in-home care and our supports coordination division. We don't want a participant in hospitalized. We know what they are hospitalized for. So what we will do is we will track when they're going to be discharged to reinstate services. But then that is where we incorporate the education program. Our goal is to develop additional education programs from this hospitalization. Right now, the two major are diabetes and wound care. I'm sure heart disease will be coming up. I'm sure stroke care will be coming up. We are working on an Alzheimer's program, a dementia program. Our goal is to educate, so they are not readmitted for any symptoms or any causes due to that same diagnosis.

Krista Davis: Thank you. And there are not currently any further questions in the queue. While we wait to see if there are any last minute questions that are submitted, I just wanted to draw everyone's attention to the screen. To obtain your 0.5 contact hours, the survey monkey link is on the screen there, you will also automatically be put to this page as soon as you close out of the webinar. So if you didn't take it down, no worries, you'll be taken there as soon as the webinar is concluded. And there are no further questions.

Jennifer Drake: Can add one thing?

Krista Davis: Sure. Absolutely.

Jennifer Drake: What I want to do, and I apologize. I did want the audience to know that we are here to be your partners. So we're here to help your participants and help you through this process. If you have questions or you have [inaudible 00:23:52], we do question and answer sessions. This is our job. Everything is free of charge, there is no billing to anyone to answer questions, to get set up for programs. So if you're not sure, we work very closely with, I'm going to say some of the larger health systems, with the social workers that say, "Hey ha I have a person that needs help with ADL's and might need some home mods. Can you take care of them?" And I will talk to the family. I will talk to the patient to get their needs. And I compile that and take that back to our team. And then we work from there.

We're not leaving you out on your own to try and gather all this information. You can certainly call our resource center, and the number is given there. Let me go over that real quick, that is (888) 837-4235. Or you can call me directly. My number is (570) 900-1421. I'm happy to do Q&A's. I'm happy to do team education. If you would like education on one of our specific programs, whether it be home and community based services and the patient-centered care, whether it be our home modifications, I've been doing those virtually or by Zoom. I'm happy to do that. But my point I'd like to stress is we're here to help you. And that's why we exist is to help you with your participants.

Krista Davis: Thank you. And while you were speaking, Jennifer, we did have one other question come in. And that question is whether there's any age limits for the program?

Jennifer Drake: Age limit for program, for waivers and managed care organizations, it is 18 and over. But we do also work with the autism waiver. So that is the exception right now, but currently right now it is 18 and over.

Krista Davis: Thank you. And there are [crosstalk 00:25:46] no further questions in the queue now. So I think we're good. So on behalf of Quality Insights and everyone who was able to join us, Jennifer, I thank you so much for joining us and sharing your knowledge with us.

Jennifer Drake: Sure. Thank you for having me. I hope you all found it beneficial.

Krista Davis: Thank you. And to those of you who attended, we thank you for joining us today. We hope you all found this useful, and we look forward to seeing you on future programs. We hope you have a great afternoon. Thank you.

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