

## **Best Practices in Hospital Discharge to Reduce Preventable Readmissions**

PATRICIA DONOVAN: This is Patricia Donovan for the Healthcare Intelligence Network. Today I am speaking with Nora Baratto, Manager of the Case Management Department at St. Peter's Hospital's CHOICES program in Albany, New York. Nora is presenting at HIN's audio conference on "Best Practices in Hospital Discharge to Reduce Preventable Readmissions." Thanks for joining me today Nora.

NORA BARATTO: Thank you.

PATRICIA DONOVAN: To begin with how does the CHOICES program assess its customer satisfaction and service deliver?

NORA BARATTO: Basically, what we do is we have the client patient family survey that is just personal feedback on how the client is doing with the services that are being provided. And that's done on a regular visit basis after they complete the assessment then once they provide the care plan and then they also follow up with once the plan is implemented and in place. So those are the three key times that they are constantly talking to the client and family regarding how they're satisfied and did we meet their expectations in terms of the services that we're providing.

PATRICIA DONOVAN: Thank you Nora. I read that the CHOICES program screens the elderly for depression and honestly I was surprised to learn that suicide attempts are the third leading cause of injury in the over 65 population. How is the discharge

or care plan affected if an elderly patient shows signs of depression at that point?

NORA BARATTO: Well we do the screening regularly in our assessment process and we reassess. If the client, and I keep switching back and forth between the patient and the client but in the hospital setting they're the patient. And then many of the patients are offered the CHOICES program as an option and those that choose of course will become our clients. In terms of depression at discharge, what we do is we work with the inpatient staff, we have an inpatient behavioral health team and if we feel that they're depressed we will address that through meeting with the psychiatrist and the patient and the liaison. We also have an outpatient team that we still utilize and do the assessment there and follow up with them on the recommendations.

PATRICIA DONOVAN: Is there any assessment done in the patient or the client's home after they're released?

NORA BARATTO: Yes. That's an ongoing assessment. If they're deemed that they're safe and that then they go home and they do the follow-up visits and if we feel that they need regular counseling. And we arrange for that to happen in the home if they're homebound and if they're not we arrange for them to seek out the counseling portion.

PATRICIA DONOVAN: I see, thank you Nora. And finally what kind of community partnerships have you been able to establish and how important are these partnerships to your program?

NORA BARATTO: I think the partnerships are critical. We have macro level—we're reaching out. I'm giving a presentation to

Albany Law School on their Senior Day on the later part of this month to get the word out about how important it is to be proactive. Older adults identifying and having an emergency health plan. We often see that older adults do a very good job of planning for retirement, planning for their death, making funeral arrangements and taking care of their cars. And that, yet when it comes to looking at what are they going to do in the middle of a health emergency there's really no plan. So we really believe in being very proactive in the community through senior citizen centers, through local parish liaison groups and going out and getting the word out. So we work very closely with Catholic Charities and community agencies and the local seniors. We also work very closely with physician offices and also with elder law attorneys to reach those adults. Also with the health care community we're involved with them on a regular basis, the certified home health agencies licensed home care agencies, Albany County Department of Social Services and Adult Protective, and the local police at times. So we all work hand-in-hand, because often one older person's needs can't be met exclusively by all parties. You have to reach out and work side by side with these partners. That's been very helpful to us because it's met an unmet need, and we have found that those relationships have become very solid and cemented in the hospital practices and routines in terms of discharge planning.

PATRICIA DONOVAN: I see, thank you Nora. Well those are all the questions I have today. I want to thank you for being with us and we're looking forward to hearing more from you during the audio conference.

NORA BARATTO: Well thank you.