Improving the Discharge Process through Better Patient and Family Engagement

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Why Improve Discharges

Reduce Readmissions
Reduce length of stay
Improve coordination of services
Improve Transition home or to another facility
Reduce patient and family anxiety
Improve “compliance” with treatment plan
Improve medication errors post discharge
Improve patient and family satisfaction
Reduce chaos for everyone
Discharge Requirements

Successful transfer of information from clinicians to patients and families

◦ Patients and/or families understand
  ◦ Diagnosis
  ◦ Treatment plan
  ◦ Follow up
  ◦ What to do, who to call
  ◦ Clinicians know what families understand
  ◦ Additional support and information is made available

Patients and their families must be engaged for this to be successful
How have you been engaging patents and their families around discharge?

WHAT BARRIERS HAVE YOU FACED?
Engagement Tools

Assess Engagement Gaps
Discharge Check List
AHRQ IDEAL Discharge
Bedside Rounding, Shift Change
Shared Decision Making
Visitation Policy
Manage Expectations
Engage at the Organization Level
Engagement Tools

Assess Engagement Gaps
Assess Current Engagement

• Patient Family Engagement
• Gap Analysis of Best Practices/Strategies for Improvement
• Use sheet with patient advisors and staff
<table>
<thead>
<tr>
<th>Component</th>
<th>Best practice/Strategy</th>
<th>Present</th>
<th>Gap/Opportunity</th>
</tr>
</thead>
</table>
| Self Care          | • Conduct pre-discharge assessment of ability of patient/family to provide self-care (includes problem solving, decision making, early symptom recognition, and taking action, quality of life, depression other cognitive factors)  
• Provide pre-discharge condition specific education  
• Conduct post discharge telephone care management |         |                 |
| Care Planning      | • Work with patient/family for prepare for the post discharge visit planning (goals, questions, concerns)  
• Develop a comprehensive shared care plan using a shared decision making approach – consider patient values and preferences, social and medical needs  
• Use personal health records or patient portals so patients have access to necessary information (lab results, radiology results, request prescription refills, ability to email doctors, nurses, and staff with questions) |         |                 |
| Health literacy/   | • Embed health literacy principles into                                                 |         |                 |
Engagement Tools

Discharge Check List
Check List Inclusions

A physical checklist that encourage conversations with patients it can include:

- What patients should expect
- Patient concerns and preferences care
- Potential safety issues (pre-admission medicines, history of infections, etc.)
- Relevant home issues
  - Additional support
  - Transportation
  - Care coordination
Preparing For My Discharge
(Things I should make sure I know before I leave the hospital)

- I have been involved in decisions about what will take place after I leave the hospital.
- I understand where I am going after I leave the hospital and what will happen to me once I arrive.
- I have the name and phone number of a person I should contact if a problem should arise after my discharge from the hospital.
- I understand what my medications are and when to take them.
- I understand the potential side effects of my medications and whom I should call if I experience them.
- I understand what symptoms I need to watch out for and whom to call should I notice them.
- I understand how to keep my health problems from becoming worse.
- My doctor or nurse has answered my most important questions prior to leaving the hospital.
- My family or someone close to me knows that I am coming home and what I will need once I leave the hospital.
- I know how to make or have been scheduled a follow-up appointment with my doctor, and will have transportation to this appointment.

Questions I Have

[Blank lines for questions]
CMS Discharge Checklist

Your Discharge Planning Checklist:
For patients and their caregivers preparing to leave a hospital, nursing home, 

https://www.medicare.gov/Pubs/pdf/11376.pdf
Document the conversation

Patient preference, concerns, and expectations expressed by patients/family members

Share with the entire hospital care team for ongoing communication

Patients and families should retain a copy of the checklist
Engagement Tools

AHRQ IDEAL Discharge
TOOL: AHRQ Ideal discharge

Include the patient and family as full partners in the discharge planning process

Discuss with the patient and family five key areas to prevent problems at home:

- Describe what life at home will be like
- Review medications
- Highlight warning signs and problems
- Explain test results
- Make followup appointments
Ideal Discharge...cont

Educate the patient and family in plain language about the patient’s condition, the discharge process, and next steps at every opportunity throughout the hospital stay.

Assess how well doctors and nurses explain the diagnosis, condition, and next steps in the patient’s care to the patient and family and use teach back.

Listen to and honor the patient and family’s goals, preferences, observations, and concerns.
Engagement Tools
Bedside Rounding, Huddles, And Shift Change
Why Focus on Bedside Shift Report?

Transitions in care have potential for medical errors

Research shows bedside shift report can improve:

- Patient safety and quality
- Improved communication
- Decrease in hospital-acquired complications
- Patient experiences of care
- Time management and accountability between nurses
- Decrease in time needed for shift report
- Decrease in overshift time

Patients are able to supply missing information or correct erroneous information
Patients Included in Shift reports or physician rounds

Active participation as much as they desire
Part of the entire discussion not just selected parts of it
The patient and/or family member is able to
  ◦ hear
  ◦ question
  ◦ correct or confirm
  ◦ learn more about the next steps in their care
    ◦ Including discharges
Talk in front of a patient???

No, no...
This isn’t gossip.
It’s the truth.
Invite patients to Engage

Patients and families won’t engage if they believe that you don’t want them to—it is simply too risky for them.

Your job is to make it safe for them to be involved, not just as patients but as partners in their care.
Are you doing bedside shift reports or rounding?

WHAT IMPROVEMENTS HAVE YOU OBSERVED?
Engagement Tools

Shared Decision Making
Shared Decision Making Essentials

Provides opportunities for better communication and understanding

Involves patients and health care providers partnering two way information sharing about:

◦ Diagnosis
◦ Available treatment options
◦ Pros and Cons of each option
  ◦ Including patient preferences, goals and values
◦ Treatment plan is developed together
Shared Decision Making
AHRQ’s SHARE

• **Step 1:** Seek your patient's participation.

• **Step 2:** Help your patient explore and compare treatment options.

• **Step 3:** Assess your patient's values and preferences.

• **Step 4:** Reach a decision with your patient.

• **Step 5:** Evaluate your patient's decision.
Hospital visitors, by the clock

In the first eight months of open visiting hours, Morristown Medical Center in Morristown, N.J., had more than 14,000 visitors between the hours of 8 p.m. and 5 a.m., with 53% of those visiting the med/surg floors. But that doesn’t mean a parade of strangers was traipsing through the hospital all night. Here’s the breakdown of visitors and when they came:

<table>
<thead>
<tr>
<th>Time</th>
<th>Visitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 p.m.-10 p.m.</td>
<td>12,125</td>
</tr>
<tr>
<td>10 p.m.-12 a.m.</td>
<td>1,834</td>
</tr>
<tr>
<td>12 a.m.-2 a.m.</td>
<td>313</td>
</tr>
<tr>
<td>2 a.m.-5 a.m.</td>
<td>172</td>
</tr>
</tbody>
</table>

Source: Journal for Healthcare Quality

VISITING HOURS

Any time of day. However, we recommend visiting between the hours of 11 a.m. and 8 p.m. to help patients achieve optimal rest during their healing process. Visitors after 9 p.m. must enter through the Emergency Department.
Engagement Tools

Manage Expectations
Manage expectations

7:00am “Good news Mr. Jones, it looks like you are going home today”

7:15am
Meanwhile... 7:15am

Good Job everyone! Mr Jones was discharged before 5:00pm!
Engagement Tools

Engage at the Organization Level
PFE Lead

Do you know the individual or Department that is:

- Responsible for PFE throughout the hospital
- Ensures that PFE activity occurs at all levels
- Able to assess and overcome barriers
- Evaluate improvement

The person responsible for PFE at the hospital does not need to have a special title or position or be 100% focused on PFE, but all hospital staff should be aware that this person manages the hospital’s PFE plans and activities.

The PFE leader should, at a minimum, identify, implement, monitor, and evaluate PFE activities, and is most likely coordinating the Patient and Family Advisory Council (PFAC).
Do you have a PFAC?

• What are they doing to help with discharges or readmissions?

• How are you engaging them to help you:
  • In the discharge process
  • Communicating with patients and families
  • Reviewing patient education material
  • Providing input into readmission rates
PFAC Members Reducing Readmissions

Choose Advisors that have the chronic conditions that are at high risk for multiple admissions and readmissions within the 30 day window.

Story Tellers: Have the advisor share their experiences in a variety of settings

Members of Improvement Teams: the advisor sits on the committees or work groups that are looking at methods to reduce readmissions.

Review all education materials: Anything that goes to patients

Provider and staff training

Advisor/Peer rounding: advisors round on patients with targeted objectives.

Advisors rounding with leadership or patient experience
What are your pfac members doing to help reduce readmissions?

HOW MIGHT THEY BE MORE HELPFUL?
Start Small

Plan, Do, Study, Act
Small tests of change
One Unit
One PFA
One committee meeting
Review with everyone
Adjust as necessary
Identify Next Steps

WHAT ARE YOU ALREADY DOING?
WHAT WOULD YOU LIKE TO ADD?
WHAT RESOURCES DO YOU NEED?
WHAT HELP DO YOU NEED?
References and Resources


• Shared Decision Making: http://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/workshop/module1/shareworkshop-mod1guide.html#seven
A Leadership Resource for Patient and Family Engagement Strategies: 

The Current State of Patient and Family Engagement Strategies in American Hospitals: 
http://link.videoplatform.limelight.com/media/?mediaId=c5214fa3c2b54842a3a14ef24bd2fc98&width=480&height=321&playerForm=Player


Partnering to Improve Quality and Safety: A Framework for Working with Patient and Family Advisors: 
http://www.hpoe.org/resources/hpoehretaha-guides/1828