How to Engage Patients and Families to Reduce Preventable Readmissions

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1. Person and family engagement (PFE) in Partnership for Patients
2. Communications competencies to promote and support PFE
3. IDEAL discharge planning
4. Discussion

Person and Family Engagement in PfP

Partnership for Patients 3.0 Goals

- By 2019
  - 20 percent reduction in overall patient harm (to 97 Hospital-Acquired Conditions [HACs] per 1,000 discharges)
  - 12 percent reduction in 30-day readmissions per 1,000 people

Partnership for Patients Definition of PFE

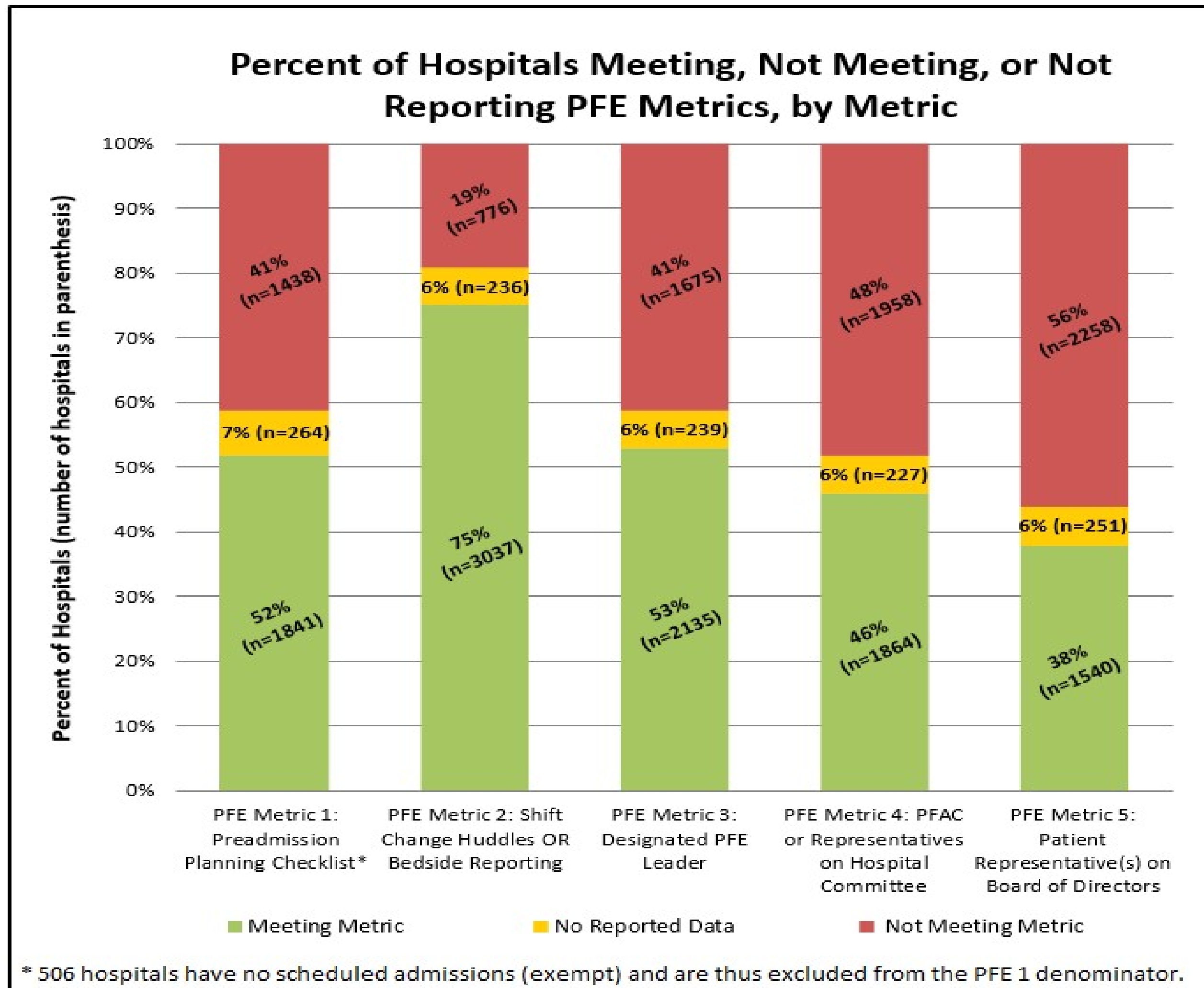
Persons, families, their representatives, and health professionals (clinicians, staff, and leaders) working in active partnership at various levels across the health care system and in collaboration with communities to improve health, heath care, and health equity.

Source: PfP Strategic Vision Roadmap for PFE (PFEC)

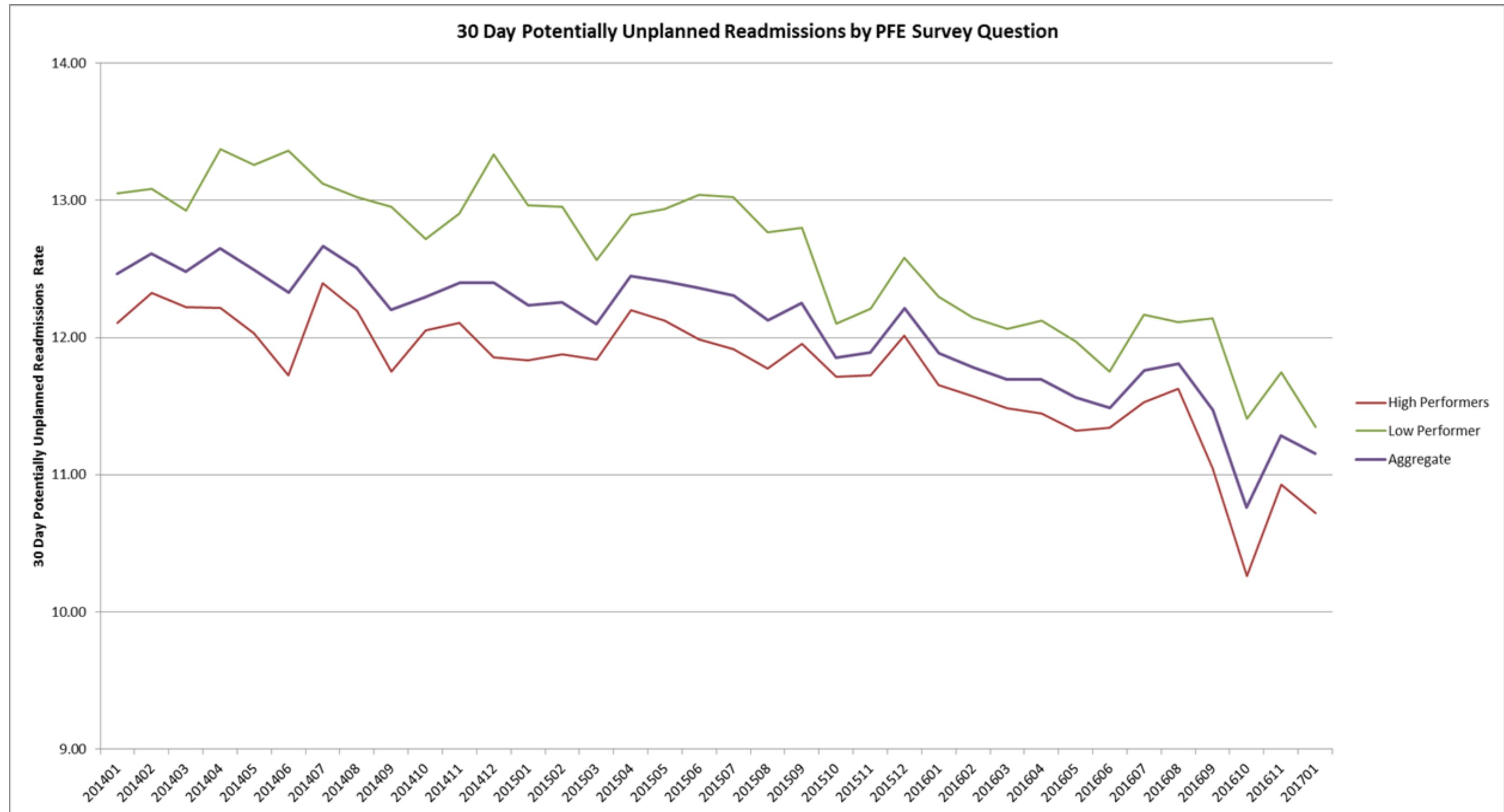
PfP PFE Metrics

Point of Care	• Preadmission Planning Checklist (PFE Metric 1) • Shift Change Huddles OR Bedside Reporting (PFE Metric 2)
Policy & Protocol	• Designated PFE Leader (PFE Metric 3) • PFAC or Representatives on Hospital Committee (PFE Metric 4)
Governance	• Patient Representative(s) on Board of Directors (PFE Metric 5)

HIIN Aggregate PFE Metric Implementation Data (October 2017)



The Case for PFE: Reductions in Readmissions



- **N = 140 Vizient HIIN hospitals**
- **High PFE performers = met 4 or 5 of the PFE metrics**
- **Low PFE performers = met 3 or less of the PFE metrics**

The Case for PFE: Improved Patient Experience

- **Improved patient experiences and higher HCAHPS scores**
  - The Valley Hospital (NJHA HIIN) uses the GetWellNetwork (GWN), an interactive patient/family tool developed and implemented in partnership with patient and family advisors, to provide education at the bedside through the television system
  - St. Alexius Medical Center (Great Lakes Partners for Patients HIIN) implemented a PFAC (PFE Metric 4) to address patients’ perceptions of care including pain management

The Case for PFE: Reduced Length of Stay

- **Improved patient outcomes and reduced length of hospital stay**
  - Hurley Medical Center's Joint Replacement Center (Great Lakes Partners for Patients HIIN) implemented a new curriculum designed to engage patients throughout the entire care continuum
  - Michigan Medicine (Vizient HIIN) created two pre-op guidebooks (PFE Metric 1) to share and discuss with patients prior to (hip and knee replacement surgery) that include simple "Checklists for Success" to help patients prepare for surgery

Communications Competencies to Promote and Support PFE

- Communication is the foundation of all interactions between clinicians and patients and families

- Research shows patient-centered communication can improve:
  - Patient safety
    - More than 70% of adverse events are caused by breakdowns in communication
  - Patient outcomes
    - Including emotional health, functioning, and pain control
  - Patient experience
  - HCAHPS scores

PFE Metric 2: Shift Changes Huddles OR Bedside Reporting

Hospital conducts shift change huddles and bedside reporting with patients and family members in all feasible cases.

Intent

- Include the patient and/or family member in as many conversations about their care as possible throughout the hospital stay
- The patient and/or family member is able to hear, question, correct or confirm, and/or learn more about the next steps in their care as it is discussed between nurses changing shifts or clinicians making rounds

Why is this important?

- Enables the opportunity to correct errors and clarify care plans with the patient and family
- Encourages the patient and family to be an active partner in their care to the degree they desire
- Enables ongoing communication and interaction

Before entering the room…

- Read the patient’s chart

Entering the room…

- Make eye contact with the patient
- Smile, if appropriate
- Introduce yourself by name and your role in the patient’s care
- Introduce any new people in the room, their role, and what they will do
- Have conversations at the patient’s eye level

Source: Communication Competencies for Clinicians, Guide to Patient and Family Engagement in Hospital Quality and Safety (AHRQ)

Communication Behaviors for Clinicians (continued)

Assessing the patient…

- Ask how the patient prefers to be addressed (by first or last name)
- Let the patient identify family members who should be partners in care, and put their names on the white board
- Invite the patient and family to use the white board
- Invite the patient and family to ask questions and share any needs or concerns

Source: Communication Competencies for Clinicians, Guide to Patient and Family Engagement in Hospital Quality and Safety (AHRQ)

Communication Behaviors for Clinicians (continued)

During the stay…

Invitation Behaviors

- Welcome the patient and family as part of the health care team
- Use open-ended questions
- Give complete information about the patient's condition
- Use "teach back"
- Find out how much the patient and family members want to know

Source: Communication Competencies for Clinicians, Guide to Patient and Family Engagement in Hospital Quality and Safety (AHRQ)

Communication Behaviors for Clinicians (continued)

During the stay…

Supportive Behaviors

- React positively when people engage
- Listen to and respect observations and values of the patient and family
- Help patients and family members articulate their concerns as needed
- Use plain language
- Invite the patient and family members to take notes
- Identify others to answer questions, if needed

Source: Communication Competencies for Clinicians, Guide to Patient and Family Engagement in Hospital Quality and Safety (AHRQ)

What is Teach Back?

- An opportunity to assess how well clinicians explained a concept and, if necessary, reteach the information
- Ask the patient and family to repeat back in **their own words** what they need to know or do to be sure you **explained things well**
- Tips for teach back…
  - Start slowly
  - Do not ask “yes or no” questions
  - Chunk information when explaining more than one concept and use teach back after each concept

Source: Health Literacy Universal Precautions Toolkit (AHRQ)

Tips to Help Patients and Families Be Partners

1. Give us information about your health
2. Make sure you understand what your doctors and nurses tell you
   - Repeat what doctors and nurses say in your own words
   - Take notes
3. Ask questions until you understand the answers
   - Speak up if something is unclear or confusing
   - Ask questions about your medicines
4. Tell us who your family members or friends are and how you want them to be involved

Source: Tips for Being a Partner in Your Care, Guide to Patient and Family Engagement in Hospital Quality and Safety (AHRQ)

Prepare Patients and Families to Partner

Give three tools to the patient and family before or at admission

1. Be a Partner in Your Care
2. Tips for Being a Partner in Your Care
3. Get to Know Your Health Care Team

Source: Strategy 2, Communicating to Improve Quality, Guide to Patient and Family Engagement in Hospital Quality and Safety (AHRQ)

IDEAL Discharge Planning

Why Focus on Discharge Planning?

- Nearly 20% of patients experience an adverse event within 1 month of discharge— ¾ of events could be prevented
- Common complications are adverse drug events, hospital-acquired infections, and procedural complications
- Many complications can be attributed to problems with discharge planning
  - Changes in medicines before and after discharge
  - Inadequate preparation for patients and families
  - Disconnect between information giving and patient understanding
  - Discontinuity between inpatient and outpatient providers

What is IDEAL Discharge Planning?

I nclude the patient and family as full partners

D iscuss with the patient and family 5 key areas to prevent problems at home

E ducate the patient and family throughout the hospital stay

A ssess how well doctors and nurses explain the diagnosis, condition, and next steps in their patient's care and use teach back

L isten to and honor the patient and family's goals, preferences, observations, and concerns

Source: [IDEAL Discharge Planning Overview, Process, and Checklist](), Guide to Patient and Family Engagement in Hospital Quality and Safety (AHRQ)

What is IDEAL Discharge Planning? (cont.)

At initial nursing assessment…

- Identify who will be at home with the patient
- Tell the patient and family that they can use the white board in the room to write questions or concerns
- Elicit the patient and family goals for the hospital stay
- Inform the patient and family about steps toward discharge

What is IDEAL Discharge Planning? (cont.)

Daily…

- Educate the patient and family about the patient’s condition at every opportunity
- Explain medicines to the patient and family
- Discuss progress toward goals
- Involve the patient and family in care practices

What is IDEAL Discharge Planning? (cont.)

Before the discharge planning meeting….

- Identify who will give the “Be Prepared to Go Home” checklist and booklet to the patient and family
- Identify who will schedule the discharge planning meeting with the patient and the patient’s choice of family member or close friend
  - *When* depends on the patient’s condition—at least 1 to 2 days before discharge or earlier if needed

Source: Be Prepared to Go Home Checklist and Booklet, Guide to Patient and Family Engagement in Hospital Quality and Safety (AHRQ)

What is IDEAL Discharge Planning? (cont.)

At the discharge planning meeting…

- Identify who will take part in the meeting
- Use the “Be Prepared to Go Home” checklist and booklet as a starting point for discussing the patient and family’s questions and concerns about going home
  - Review the checklist verbally if needed
  - Use teach back to check the patient’s understanding of the information
  - Follow up on any questions you cannot address during the meeting
- Offer to schedule follow-up appointments with all providers (primary care, specialists, or therapy) as needed

Day of discharge…

- Identify who will review the reconciled medication list with the patient and family
  - Hand the patient the list of medicines that he or she needs to take at home
  - Review the medication list with the patient and family
  - Ask them to repeat back the name of each medicine, its purpose, and when and how to take it

- Identify who will write down follow-up appointments and give the name and contact information of someone to call if problems arise

Everyone Plays a Role in Discharge

- **Patient:** Heal; ask questions in preparation for leaving/going home; take responsibility for care at home
- **Family:** Ask questions and prepare to help at home
- **Doctor:** Give order for discharge; communicate clearly with other team members—including nurses, patient, and family—about discharge plans and next steps
- **Nurses**
- **Case manager**
- **Discharge planner**
- **Interpreter**

For Clinicians

- Improves information about the patient’s condition and discharge situation
- Reduces risk and liability
- Improves quality of care

For Patients

- Demonstrates that hospital staff view the patient’s perspective as important
- Shows teamwork among hospital staff
- Ensures patient and family have a good care experience (with less anxiety)
- Prevents post-discharge complications and avoidable readmissions

Potential Challenges

- May take more time at first, but should be incorporated into the everyday process
- Difficult to identify family members who will be caregivers
  - Patient has no family or other support
  - Family caregiver has not been at the hospital
- Discharge plans change immediately before discharge
- Patient unable to read, write, or articulate questions or concerns

Hospitals in New Jersey must comply with the CARE Act that requires hospitals to: (1) record the name of the family caregiver on the medical record of the patient; (2) inform the family caregiver when the patient is to be discharged; and (3) provide the family caregiver with education and live instruction of the medical tasks he or she will need to perform for the patient at home.

PFE in Action: Kennedy Hospital

- Sepsis is the #1 cause of hospital readmissions
- Recommends that sepsis initiatives include representation from the infection control team
- Initiatives related to sepsis include…
  - Signage
  - Sepsis patient education handout
  - Discharge antibiotic counseling including a patient information sheet to reduce readmissions due to infections including sepsis

Discussion

Next Steps

- Train clinicians on communication competencies, including teach back
  - Partner with patient and family advisors (PFAs)

- Ask leadership, clinicians, and PFAs to commit to helping patients and families be partners in their care
  - Share data—including a patient story—about the benefits of PFE on patient safety, readmissions, and patient experience
  - Invite patients and families to use the white board
  - Customize and distribute materials (e.g., “Tips for Being a Partner in Your Care,” “Be Prepared to Go Home” checklist and booklet)

- Review/refine roles for discharge planning

Resources

- Guide to Patient & Family Engagement in Hospital Quality and Safety, AHRQ (https://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/index.html)
- Better Together Campaign, IPFCC (http://www.ipfcc.org/bestpractices/better-together-partnering.html)
- PfP Strategic Vision Roadmap for PFE, PFEC*
- How PFE Can Help Hospitals Achieve Equity in Health Care Quality and Safety, PFEC*

**Available in the PfP Resource Library at: www.healthcarecommunities.org/ResourceCenter/PartnershipforPatientsLibrary.aspx*

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