PATIENT ENGAGEMENT

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HRET
HEALTH RESEARCH & EDUCATIONAL TRUST

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
PARTNERSHIP FOR PATIENTS
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Let’s talk

- Please type into chat:
  - Names of everyone in the room
  - Your hospital name
  - Location

Welcome

This is the first of five cohort calls to support you in achieving the HIIN Metrics for PFE.

During these sessions we will focus one of each of the five metrics with case study presentations from hospitals in your states.

This time is for you to ask questions, solve problems, and get clarity in order to move ahead with action.

HRET HIIN Update

- What's Coming in PFE
  - Operational Metrics Release Oct 29, Due Nov 21
  - PFE Metrics Part of Milestone 10
  - PFE submission and 4 of 5 measures "Yes"

PFE Cohort Call #1

AGENDA

- 2:00 – 2:15pm The Metrics
- 2:15 – 2:25pm Sakakawea Medical Center
- 2:25 – 2:45pm Open Discussion
- 2:45 – 3:00pm Wrap up

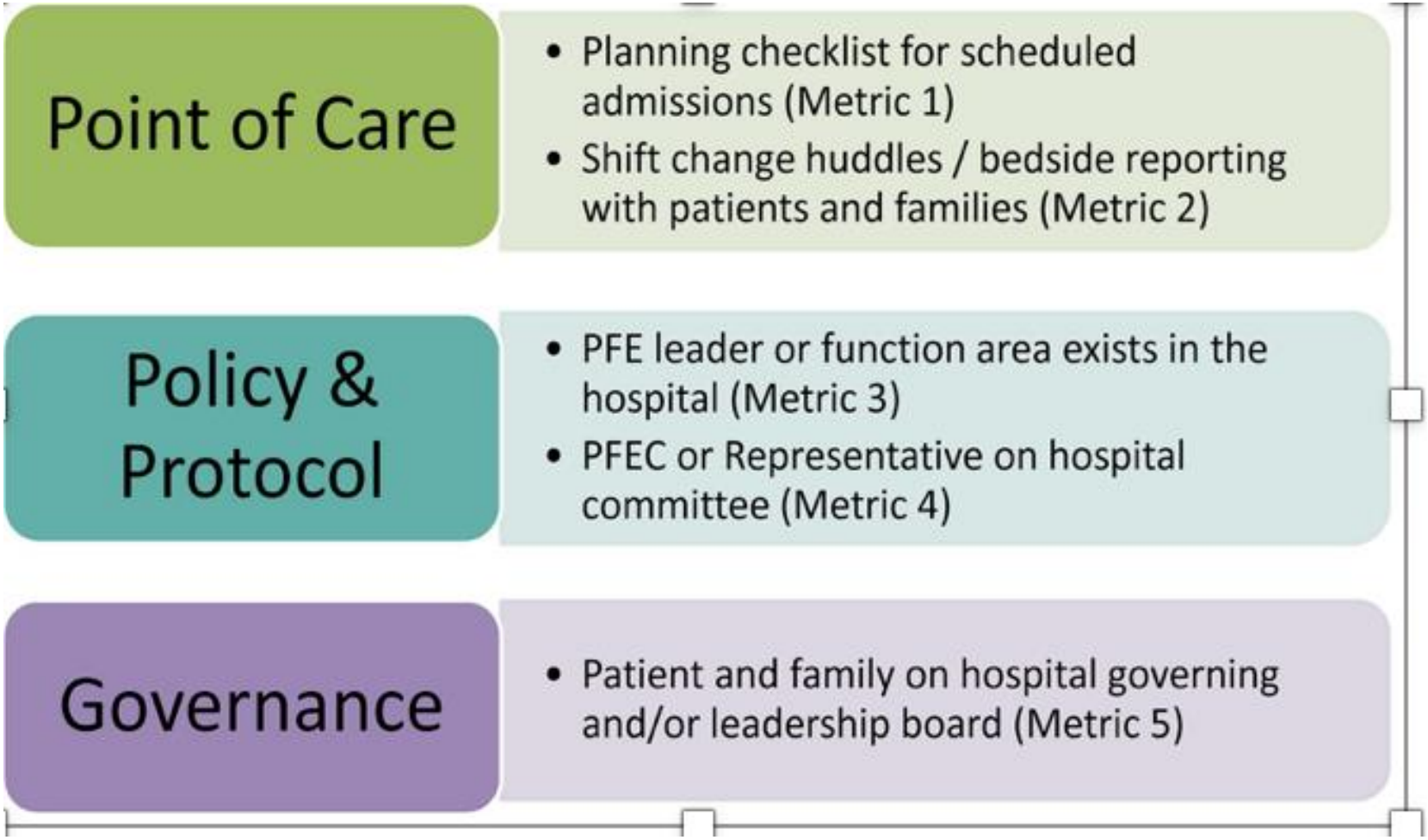
Get Noticed

- Please raise you hand if you are more of a dog person than a cat person

Get Noticed

- Now raise you hand if you are more than a cat person than a dog person.

The Metrics


Point of Care
• Planning checklist for scheduled admissions (Metric 1)
• Shift change huddles / bedside reporting with patients and families (Metric 2)
Policy & Protocol
• PFE leader or function area exists in the hospital (Metric 3)
• PFEC or Representative on hospital committee (Metric 4)
Governance
• Patient and family on hospital governing and/or leadership board (Metric 5)

Metric #1

- **PFE Metric 1 – Preadmision planning**
- "Prior to admission, hospital staff provide and discuss a discharge planning checklist with every patient who has a scheduled admission, allowing for questions or comments from the patient or family (e.g., a planning checklist that is similar to CMS's Discharge Planning Checklist)."

Do We Meet the Metric? YES, if:

- Hospital has a physical planning checklist for patients with scheduled admissions, AND
- At admission, hospital staff discuss the checklist with patient and family.

Alternative: **Hospital has no scheduled admissions**

Hospitals are encouraged to consider and pursue options for achieving the intent of the metric. However, if a hospital does not conduct any scheduled admissions, PFE metric 1 does not apply. HIINs should calculate the percentage of hospitals implementing the metric based only on the hospitals in the HIIN that conduct scheduled admissions.

Intent of the Metric. For all scheduled admissions, hospital staff discuss a checklist of items to prepare patients and families for the hospital stay—and invite them to be active partners in their care. The metric focuses on the use of the checklist by admissions staff, an admitting nurse or physician, or other healthcare professional to guide a conversation with patients and families at the earliest point possible before or during their care. Ideally, patients and families also receive a physical copy of the checklist. While there is not a standard checklist that must be used by all hospitals, the checklist should facilitate conversation about topics such as: (1) what patients should expect during their stay (e.g., course of care, pain management); (2) patients' concerns and preferences for their care; (3) potential safety issues (e.g., preadmission medicines, history of infections); and (4) relevant home issues that may affect discharge, such as needs for additional support, transportation, and care coordination.

PFE Metrics Overall - Montana

PFE Metric	Response	Hospital Count (n=43)	Pct of Total
PFE 1: Preadmission Planning Checklist*	No Data Reported	10	29%
	Not Meeting Metric	12	35%
	Meeting Metric	12	35%
	No Scheduled Admissions	9	
PFE 2: Shift Change Huddles or Bedside Reporting	No Data Reported	10	23%
	Not Meeting Metric	15	35%
	Meeting Metric	18	42%
PFE 3: Designated PFE Leader	No Data Reported	10	23%
	Not Meeting Metric	12	28%
	Meeting Metric	21	49%
PFE 4: PFAC or Representative on Hospital Committee	No Data Reported	10	23%
	Not Meeting Metric	18	42%
	Meeting Metric	15	35%
PFE 5:Patient Representative(s) on Board of Directors	No Data Reported	10	23%
	Not Meeting Metric	19	44%
	Meeting Metric	14	33%

PFE Metric 1 Montana

PFE Metric	Response	Hospital Count (n=43)	Pct of Total
PFE 1: Preadmission Planning Checklist*	No Data Reported	10	29%
	Not Meeting Metric	12	35%
	Meeting Metric	12	35%
	No Scheduled Admissions	9	

*Hospitals that have no scheduled admissions (exempt) and are thus excluded from the PFE 1 denominator

PFE Metric Overall – North Dakota

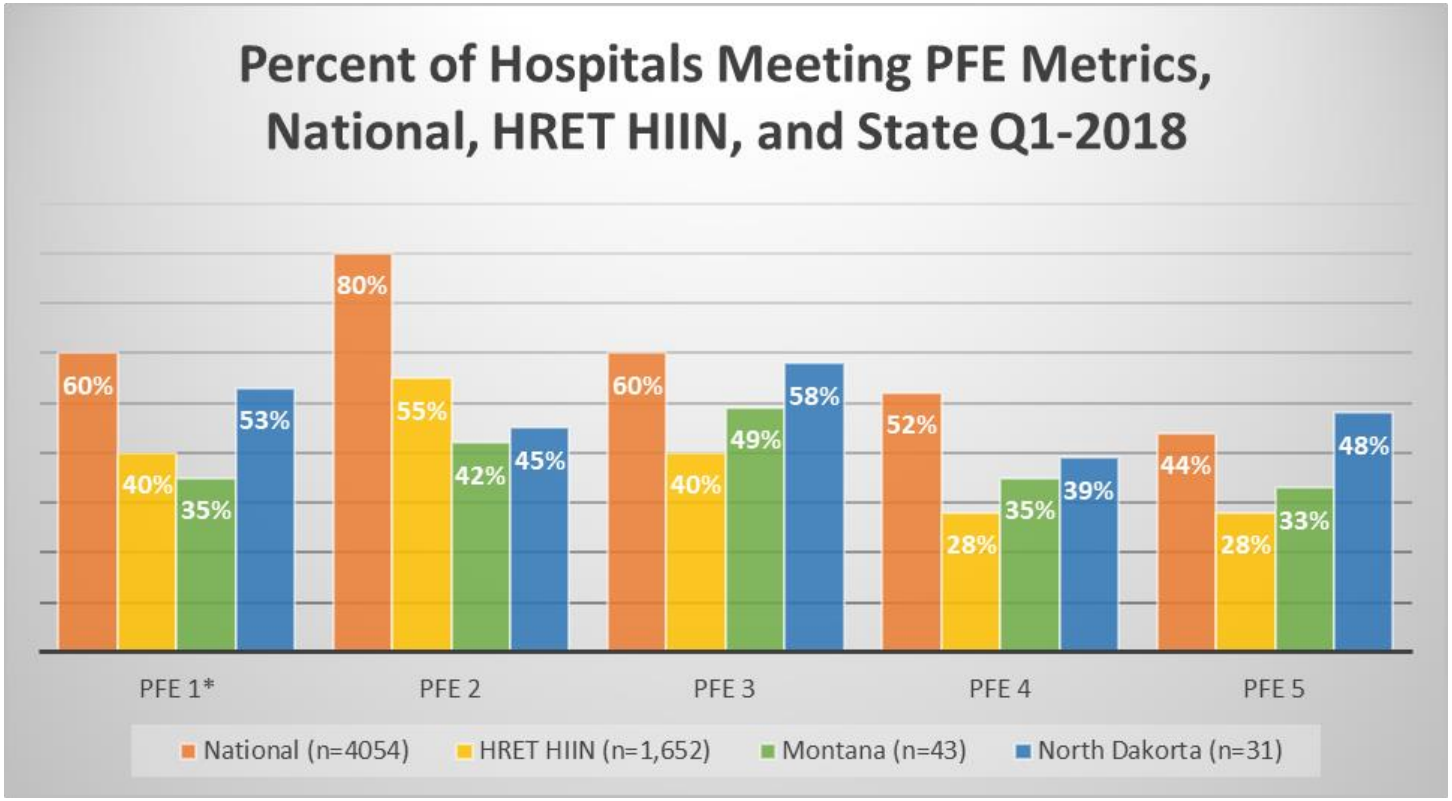
PFE Metric	Response	Hospital Count (n=31)	Pct of Total
PFE 1: Preadmission Planning Checklist*	Not Data Reported	1	7%
	Not Meeting	6	40%
	Meeting Metric	8	53%
	No scheduled admissions	16	52%
PFE 2: Shift Change Huddles or Bedside Reporting	No Data Reported	1	3%
	Not Meeting Metric	16	52%
	Meeting Metric	14	45%
PFE 3: Designated PFE Leader	No Data Reported	1	3%
	Not Meeting Metric	12	39%
	Meeting Metric	18	58%
PFE 4: PFAC or Representative on Hospital Committee	No Data Reported	1	3%
	Not Meeting Metric	18	58%
	Meeting Metric	12	39%
PFE 5: Patient Representative (s) on Board of Directions	No Data Reported	1	3%
	Not Meeting Metric	15	48%
	Meeting Metric	15	48%

PFE Metric 1 – ND Data

PFE Metric	Response	Hospital Count (n=31)	Pct. of Total
PFE 1: Preadmission Planning Checklist*	Not Data Reported	1	7%
	Not Meeting	6	40%
	Meeting Metric	8	53%
	No scheduled admissions	16	52%

*Hospitals that have no scheduled admissions (exempt) and are thus excluded from the PFE 1 denominator

Snapshot of Q1-2018



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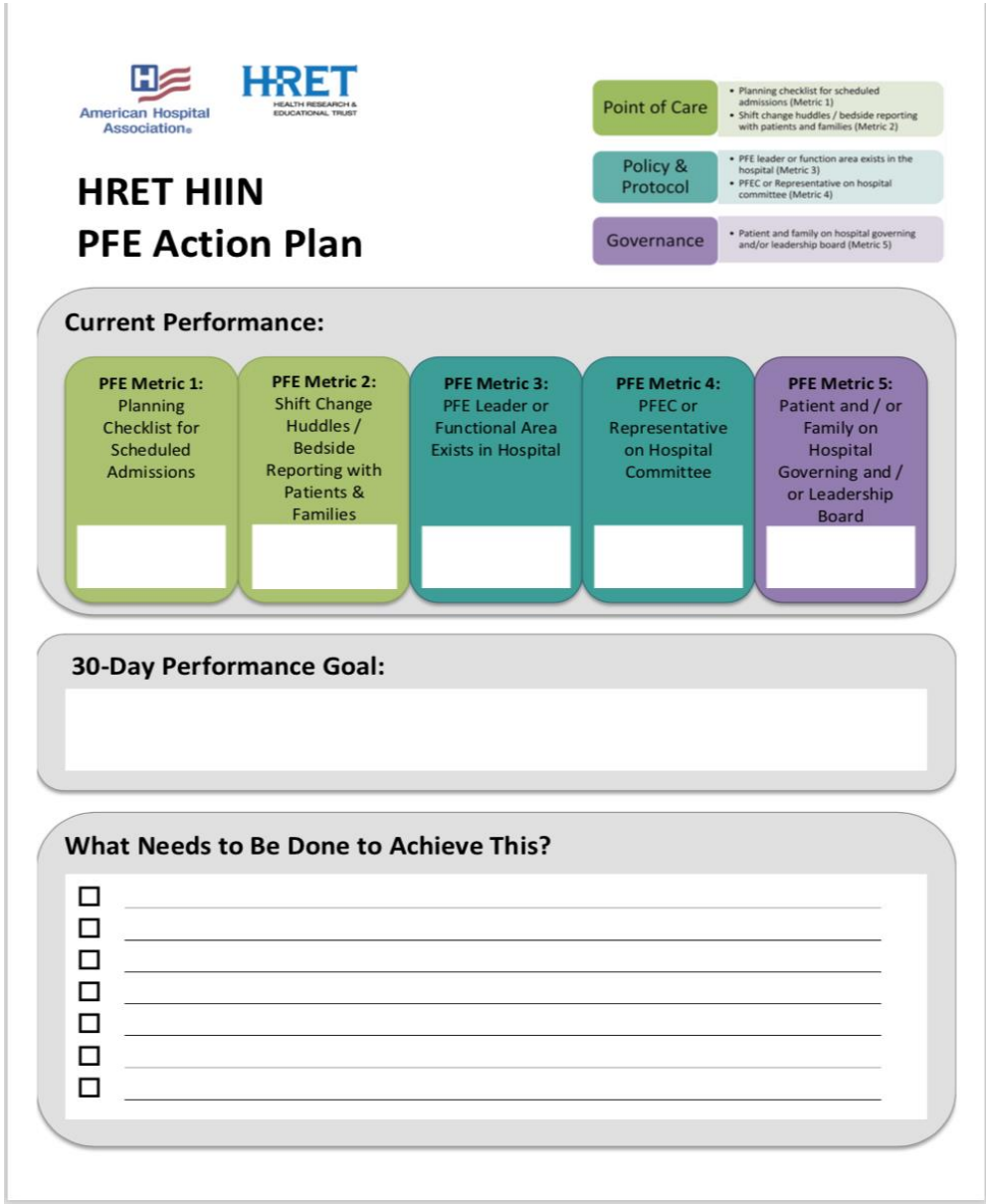
Action Planning



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Action Planning

Who Needs to Support the Work?

By Providing Leadership:

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

By Implementing Action Steps:

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Who Will Ensure the Work Gets Done?

What Resources Will You Use?

Resources You Have:

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Resources You Need:

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

By Next Tuesday:

CARE COORDINATION: BRIDGING THE GAP

SAKAKAWEA MEDICAL CENTER/COAL COUNTRY COMMUNITY HEALTH CENTER

SAKAKAWEA MEDICAL CENTER

- 13 Beds
- Emergency Room
- Observation/Acute Care
- Swing Bed (SBS and SBI)
- Surgical Services
- Inpatient and outpatient lab, PT, OT and Respiratory Therapy
- Interventional Radiology
- Hospice Care
- Basic Care
- Community Care Coordination

“Insanity is doing the same thing over and over again and expecting different results.”

-Albert Einstein

NURSING CARE COORDINATOR

- Nursing Care Coordinator
  - Patient visits
  - Patient education
    - Teach-Back
  - Advance Care Planning discussions
  - Daily discharge planning
  - Medication reconciliation
  - Follow-up appointments/referrals
    - Chronic Care Management Services
    - Visiting Nurse, Hospice, Meals on Wheels, Diabetic Education, etc.
  - Warm hand-offs to primary care
  - Follow-up phone calls

CARE COORDINATION

- Monthly Care Coordination and Population Health Meetings
  - Sakakawea Medical Center
    - Director of Patient Care
    - Nursing Care Coordinator, ER Coordinator
    - Licensed Social Worker
  - CCCHC
    - Director of Patient Care & Innovation
    - Chronic Care Coordinators, Diabetic Educator
  - KRCC
  - Community Care Coordination
  - Visiting Nurse Services
  - County Health
  - Hospice
  - EMS
  - Mercer County Extension Bureau

TOOLS/RESOURCES

- Transitional Care Worksheet
  - LACE Index Scoring Tool
  - Table of Risk
- Follow-up phone call checklist
- Readmission Interview
- Binders
- Thank You cards
- Bedside Report
- Patient Whiteboards

UPCOMING PROJECTS

- Patient and Family Advisory Council
  - PFE Bootcamp in June
- Meds-To-Beds Project

Transitional Care Worksheet

Patient: Patient Name Here ***DOB:*** DOB Here ***Provider:*** Examining Provider Here ***Visit#:*** Visit # Here ***MR#:*** MR # Here
Doc #: Doc # Here Version #: Version Here Saved By: Initials Here Saved On: DateTime Here
Sakakawea Medical Center (510 8th Ave NE, Hazen, ND 58545)

Transitional Care Management Worksheet

Date: 2/1/2017 Name: *Patient Name* Admit Date: Select a date
DOB: DOB Age: Age Sex: Gender Discharge Date: Select a date

Attending Provider: Primary Provider:

Admitting Diagnosis:

Hospital Course

Status:

Family and/or caretaker present at time of discharge:

Medication Changes/Adjustments:

Immunizations Received:

Diagnostic tests reviewed/disposition:

Home health/community services discussion/referrals:

Transitional Care Worksheet

Patient: Patient Name Here ***DOB:*** DOB Here ***Provider:*** Examining Provider Here ***Visit#:*** Visit # Here ***MR#:*** MR # Here
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Sakakawea Medical Center (510 8th Ave NE, Hazen, ND 58545)

Transitional Care Management Worksheet

Establishment or re-establishment of referral orders for community resources:

Discussion with other health care providers:

Rehab/RT Services:

Appointments coordinated with:

Disease/Illness education:

Education for self-management, independent living, and activities of daily living:

Advanced Directive?:

Is this a 30 day readmission? ☐ Yes ☐ No

Level of Risk:

Transitional Care Worksheet

Patient: Patient Name Here ***DOB:*** DOB Here ***Provider:*** Examining Provider Here ***Visit#:*** Visit # Here ***MR#:*** MR # Here
Doc #: Doc # Here Version #: Version Here Saved By: Initials Here Saved On: DateTime Here

Sakakawea Medical Center (510 8th Ave NE, Hazen, ND 58545)

LACE Index Scoring Tool

Step 1: Length of stay (including day of admission and discharge): _____ days

Length of stay (days)	Score (check as appropriate)
1	☐ 1
2	☐ 2
3	☐ 3
4-6	☐ 4
7-13	☐ 5
14 or more	☐ 7

Length of stay score: _____

Step 2: Acuity Of Admission

Was the patient admitted to hopsital via the emergency department?
If yes, enter "3" in Box A, otherwise enter "0" in Box A

Box A: _____

Step 3: Comorbidities

Condition:	
Previous myocardial infarction	☐ +1
Cerebrovascular disease	☐ +1
Peripheral vascular disease	☐ +1
Diabetes without complications	☐ +1
Congestive heart failure	☐ +2
Diabetes with end organ damage	☐ +2
Chronic pulmonary disease	☐ +2
Mild liver or renal disease	☐ +2
Any tumor (including lymphoma or leukemia)	☐ +2
Dementia	☐ +3
Connective tissue disease	☐ +3
AIDS	☐ +4
Moderate or severe liver or renal disease	☐ +4
Metastatic solid tumor	☐ +6

If the TOTAL score is between 0 and 3 enter the score into BOX C. If the score is 4 or higher, enter 5 into Box C.

Box C: _____

Step 4: Emergency department visits

How many times has the patient visited an emergency department in the six months prior to admission (not including the emergency department visit immediately preceding the current admission)?
Enter this number or 4 (whichever is smaller) In Box E

Box E: _____

Total for the LACE score

Add numbers in Box L, Box A, Box C, and Box E to generate a LACE score and enter into box below. If the patient has a LACE score that is greater than or equal to 10 the patient can be referred.

Total LACE score: _____

Signature _____ Date: Select a date Time: _____

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Follow-Up Phone Calls

- **Assessment of Health Status**
  - How are you feeling?
  - Are you having any unusual symptoms or problems?
- **Discharge Instructions**
  - Were your discharge instructions clear and understandable?
- **Medication Check**
  - Have you filled your new prescriptions yet?
  - Do you have any questions about your medications?
- **Follow-Up Appointments**
  - Reminder of follow-up appointment *OR*
  - Were you able to make a follow-up appointment with your PCP?
  - If no, can we help you make your follow-up appointment?
- **Coordination of Post-Discharge Home Services**
  - Review the services that were set up for patient post-discharge.
- **Review of Red Flags for Disease Process**
  - Review steps to take in an emergency.
- **Advance Care Planning**
  - If patient doesn't have an advance directive and would like more information or would like to make changes to a current advance directive, set up a time to meet with them to go over the ACP process.
- **Satisfaction**
  - Is there anything we could have done to make your stay better?
  - Is there anyone you want to recognize for doing an outstanding job?
- **Phone Survey**
  - Reminder that the patient may receive a telephone survey regarding their hospital stay.

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Readmission Interview

- **Why were you hospitalized earlier this month?**
  - Prompt the patient/caregiver for understanding of the reason for hospitalization.
- **When you left the hospital:**
  - How did you feel?
  - Where did you go?
  - Did you have any questions or concerns? If so, what were they?
  - Were you able to get your medications?
  - Did you need help taking care of yourself?
  - If you needed help, did you have help? If so, who?
- **Tell me about the time between the day you left the hospital and the day you returned:**
  - When did you start not feeling well?
  - Did you call anyone (doctor, nurse, other)?
  - Did you try to see or did you see a doctor or nurse or other provider before you came?
  - Did you try to manage symptoms yourself?
  - Prompt for patient/caregiver self-management techniques used.
- **In our efforts to provide the best possible care to you and others like you, can you think of anything that we—or anyone—could have done to help you after you left the hospital the first time so that you might not have needed to return so soon?**

LESSONS LEARNED

- You cannot do it alone.
- Healthcare is no longer delivered in silos.
- Collaboration is key.
- Start with one small project and expand as you learn. Tackle one area at a time.
- Keep the patient at the forefront.

CONTACT INFORMATION

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Discussion

- What are you doing?
- Successes?
- Challenges?
- What do you need to move forward?

Resources

Recommended Resources for PFE Metric 1

Your Discharge Planning Checklist from the Centers for Medicare and Medicaid Services: https://www.medicare.gov/Pubs/pdf/11376.pdf

Care About Your Care Discharge Checklist & Care Transition Plan from the Robert Wood Johnson Foundation: http://www.rwjf.org/en/library/research/2013/01/care-about-your-care-discharge-checklist---care-transition-plan.html

Strategy 4: Care Transitions From Hospital to Home: IDEAL Discharge Planning, Guide to Patient and Family Engagement in Hospital Quality and Safety from the Agency for Healthcare Research and Quality: http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/strategy4/index.html

Next Call – Metric #2 – Shift Change

PFE 2 Shift Change Huddles OR Bedside Reporting (point of care)

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

Do We Meet the Metric? YES, if:

- In as many units as possible, but in a minimum of at least one unit, nurse shift change huddles **OR** clinician reports/rounds occur at the bedside and involve the patient and/or care partners.

Alternative: **None**

This activity should be possible in all hospital types and structures. However, a hospital may offer alternatives to accommodate patient and care partner participation (e.g., adjust time of shift changes, offer options for care partners to participate via phone or Skype).

Intent. The intent of this metric is to include patients and care partners as active participants in as many conversations about their care as possible throughout the hospital stay. They should have the opportunity to question, correct or confirm, and learn more about the next steps in their care as it is discussed between nurses changing shifts and/or clinicians making rounds. Patients and care partners should be encouraged and prompted by clinical staff to be active participants in these meetings to whatever degree they desire and to add to the information being shared between nurses or other clinicians.

PFE Cohort Call #2

- Date: October 9th
- Time: 2:00pm – 3:00pm MST
- Call In: (800)832-0736, Room# 4920194

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Call – email – text – carrier pigeon

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