HRET HIIN
PFE SNAP
Patient and Family Engagement Safety Network To Accelerate Performance

Webinar #3
March 15, 2018
1:00 PM CT/2:00 PM ET
WEBINAR PLATFORM QUICK REFERENCE

- Mute computer audio
- Download slides/resources
- Chat with participants
- Today’s presentation
- Register for upcoming events
<table>
<thead>
<tr>
<th>Time</th>
<th>Objectives</th>
<th>Speakers</th>
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<tbody>
<tr>
<td>1:00-1:10 pm</td>
<td><strong>Welcome and Coaching Call Synopsis</strong>&lt;br&gt;- Review participants’ key learnings, barriers, strategies and goals from their coaching calls with the PFE SNAP coaches&lt;br&gt;- Review process for signing up for a coaching call and its significance to the project</td>
<td>Sue Collier, MSN, RN, FABC&lt;br&gt;Tom Workman, PhD&lt;br&gt;Martha Hayward&lt;br&gt;Tanya Lord, PhD</td>
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<tr>
<td>1:10-1:25 pm</td>
<td><strong>Readmissions Prevention through PFE</strong>&lt;br&gt;- Recognize approaches to implement PFE 1 (preadmission check-list)&lt;br&gt;- Discuss how patient and family inclusion on readmissions teams and at leadership level (e.g. Metric 4 &amp; 5) can be a lever to reduce readmissions</td>
<td>Pat Teske, RN, MHA</td>
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<td>1:25-1:40 pm</td>
<td><strong>Put It Into Action!</strong>&lt;br&gt;- Examine how patient/family engagement can be optimized to enhance readmission reduction efforts&lt;br&gt;- Prepare to test one or more ideas they heard in their own organization</td>
<td>Pat Teske, RN, MHA</td>
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<td>1:40-1:55 pm</td>
<td><strong>Open Forum</strong>&lt;br&gt;- Call and chat in with your thoughts, plans, questions and concerns – we want to hear from you!</td>
<td>All!</td>
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<tr>
<td>1:55-2:00 pm</td>
<td><strong>Bring it Home</strong></td>
<td>Mallory Bender, MA, LCSW</td>
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PFE SNAP: Purpose & Benefits

• Purpose: To provide targeted hospitals the opportunity to participate in a rapid cycle improvement team focusing on PFE, falls and readmissions

• Benefits of Participation:
  – Opportunity to work with peers to improve performance on PFE metrics
  – Access to PFE experts who will provide tailored, focused guidance
  – Additional coaching calls from PFE experts
  – No additional cost to participate in collaborative work group to enhance performance in falls, readmissions, and patient engagement
The Five PfP PFE 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)
Reducing Readmissions through Patient Family Engagement

Pat Teske, RN, MHA
Implementation Officer, Cynosure Health
Reduce all cause 30-day readmissions by 12 percent by September 27, 2018.
Results limited to hospitals with baseline data. HRET specified 2014 as the baseline timeframe for the measure.

*Based on CDS data as of 1/5/18

% reporting is calculated as: number of hospitals reporting pre-HIIN baseline data / number of hospitals expected to report (n=1631)

Results for months where data submission is below 50% should be interpreted with caution. Data are suppressed for months where submission is less than 30%.

### Progress towards 12% reduction goal (shown as relative reduction in the quarterly / aggregate rates since baseline)

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<tbody>
<tr>
<td>Rate</td>
<td>8.46</td>
<td>8.58</td>
<td>8.39</td>
<td>8.14</td>
</tr>
<tr>
<td>% reduction</td>
<td>-1.8%</td>
<td>-0.4%</td>
<td>-2.6%</td>
<td>-5.6%</td>
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<table>
<thead>
<tr>
<th></th>
<th>Oct 2016-Sep 2017</th>
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<tbody>
<tr>
<td>Rate</td>
<td>8.42</td>
</tr>
<tr>
<td>% reduction</td>
<td>-2.3%</td>
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</table>
Discharge Instructions

What did that mean?

Do you have any ?’s

“No”

Project ACHIEVE - This work was supported through a Patient-Centered Outcomes Research Institute (PCORI) award (Contract #TC-1403-14049).
There is still a long road ahead...
Why reduce readmissions?
Two reasons
In order to reach our AIM....

12% reduction by Sept. 2018

We need.....

• More
• Less
• Different

👍 Keep doing
👎 Stop
• Hospitals that took up any 3 or more strategies had significantly greater reductions in Risk Stratified Readmission Rates (RSRR) compared with hospitals that took up only 0-2 strategies.

• 93 different combinations of strategies were used.

• The only strategy used by itself that produced decreased RSRR was discharging patient with their f/u appointments.

• Four specific organizational approaches distinguished high performers:
  – Collaboration across departments/disciplines
  – Working with post-hospital providers
  – Learning and problem solving
  – Senior leadership support


No More

Non-Compliance
Questions to ask?

Why are your patients being readmitted?

What should you be doing differently?
Do you feel like this?
This is NOT the answer?
Leverage PFE

HRET HIIN Readmissions Change Package Driver Diagram

CP
Driver #1

• Use data and RCA to drive continuous improvement
30-Day Potentially Preventable Readmission (PPR) Rates by Race and Ethnicity

Major Respiratory Infections & Inflammations for New Jersey Hospitals, 2012

- Major Respiratory Infec & inflam combined: 13.3%
- White: 13.7%
- Black or African American: 13.4%
- Asian: 13.9%
- Other Race: 9.6%
- Hispanic White: 13.3%
- Hispanic Black: 50.0%
- Hispanic Other: 10.6%
Learning from small data as well

- Talk with patients and providers
- Help you understand where the gaps are in your current processes and program
- Helps you decide WHAT to prioritize from a PI perspective
51 year old male with 3 acute care admissions and 2 ED visits in the past 180 days.
When asked why he thought he was readmitted said...

“I RAN OUT OF LASIX”
Listen for themes

- Leaving the hospital unprepared, or inadequately informed, without specific instructions on what to do
- A lack of coordination - Challenges in accessing services: appointments, transportation, medications, equipment
- Changing circumstances after discharge
- PCP instructions to return to the ED
- Readmissions are O.K., expected, or very frustrating
Let’s chat

- How are/can PFAs contributing/contribute to your data collection and analysis?
- What have you learned from your readmitted patients?
What others are doing

- Having member(s) on their readmissions reduction team/committee (PFE 4)
- PFA on the Bd. to request the data (PFE 5)
- Focus groups
- Interviewing patients
- Responding to the data (PFE 4)
- Helping to set priorities (PFE 5)
Driver #2

- Improve standard hospital based care transitions practices for all
Identifying a family caregiver

- Who counts as family?

  - “Family” should be interpreted broadly.
  
  - Spouses and adult children are *most likely* to take on care, *but not always*. Often other relatives are involved.
  
  - Family members may or not be related by blood or marriage but are “fictive kin” or “families of choice,” such as neighbors, church members, and others.

- Ask patient, “Who helps you with your medications?”

- May be more than one family caregiver

https://www.nextstepincare.org/
Preparing before arrival (PFE 1)

A Guide to Bowel Surgery

This booklet is to help you understand and prepare for your surgery, how you can play an active part in your recovery and give you daily goals to achieve.

Please review it with the nurse and your family. Please bring it with you on the day of your surgery.
## The 8Ps:
Assessing Your Patient’s Risk For Adverse Events After Discharge

<table>
<thead>
<tr>
<th>Risk Assessment: 8P Screening Tool</th>
<th>Risk Specific Intervention</th>
<th>Signature of individual responsible for insuring intervention administered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problem medications</strong> (anticoagulants, insulin, oral hypoglycemic agents, aspirin &amp; clopidogrel dual therapy, digoxin, narcotics)</td>
<td>□ Medication specific education using Teach Back provided to patient and caregiver</td>
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<tr>
<td></td>
<td>□ Monitoring plan developed and communicated to patient and aftercare providers, where relevant (e.g. warfarin, digoxin and insulin)</td>
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<td></td>
<td>□ Specific strategies for managing adverse drug events reviewed with patient/caregiver</td>
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<td></td>
<td>□ Follow-up phone call at 72 hours to assess adherence and complications</td>
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<tr>
<td><strong>Psychological</strong> (depression screen positive or h/o depression diagnosis)</td>
<td>□ Assessment of need for psychiatric aftercare if not in place</td>
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<td></td>
<td>□ Communication with aftercare providers, highlighting this issue if new</td>
<td></td>
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<tr>
<td></td>
<td>□ Involvement/awareness of support network insured</td>
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<td><strong>Principal diagnosis</strong> (cancer, stroke, DM, COPD, heart failure)</td>
<td>□ Review of national discharge guidelines, where available</td>
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<td>□ Disease specific education using Teach Back with patient/caregiver</td>
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<td>□ Action plan reviewed with patient/caregivers regarding what to do and who to contact in the event of worsening or new symptoms</td>
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<td>□ Discuss goals of care and chronic illness model discussed with patient/caregiver</td>
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<tr>
<td><strong>Polypharmacy</strong> (≥ 5 more routine meds)</td>
<td>□ Elimination of unnecessary medications</td>
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<tr>
<td></td>
<td>□ Simplification of medication scheduling to improve adherence</td>
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</tr>
<tr>
<td></td>
<td>□ Follow-up phone call at 72 hours to assess adherence and complications</td>
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<tr>
<td><strong>Poor health literacy</strong> (inability to do Teach Back)</td>
<td>□ Committed caregiver involved in planning/administration of all general and risk specific interventions</td>
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<tr>
<td></td>
<td>□ Aftercare plan education using Teach Back provided to patient and caregiver</td>
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<td></td>
<td>□ Link to community resources for additional patient/caregiver support</td>
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<tr>
<td></td>
<td>□ Follow-up phone call at 72 hours to assess adherence and complications</td>
<td></td>
</tr>
<tr>
<td><strong>Patient support</strong> (absence of caregiver to assist with discharge and home care)</td>
<td>□ Follow-up phone call at 72 hours to assess condition, adherence and complications</td>
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<tr>
<td></td>
<td>□ Follow-up appointment with aftercare medical provider within 7 days</td>
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<tr>
<td></td>
<td>□ Involvement of home care providers of services with clear communications of discharge plan to those providers</td>
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<tr>
<td><strong>Prior hospitalization</strong> (non-elective; in last 6 months)</td>
<td>□ Review reasons for re-hospitalization in context of prior hospitalization</td>
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<tr>
<td></td>
<td>□ Follow-up phone call at 72 hours to assess condition, adherence and complications</td>
<td></td>
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<tr>
<td></td>
<td>□ Follow-up appointment with aftercare medical provider within 7 days</td>
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<tr>
<td><strong>Palliative care</strong> <em>(Would you be surprised if this patient died in the next year? Does this patient have an advanced or progressive serious illness?)</em> Yes to either:</td>
<td>□ Assess need for palliative care services</td>
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<td></td>
<td>□ Identify goals of care and therapeutic options</td>
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<td></td>
<td>□ Communicate prognosis with patient/family/caregiver</td>
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<td></td>
<td>□ Assess and address bothersome symptoms</td>
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<td></td>
<td>□ Identify services or benefits available to patients based on advanced disease status</td>
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<td></td>
<td>□ Discuss with patient/family/caregiver role of palliative care services and benefits and services available</td>
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HCAHPS SCORES

87%

GIVEN INFO. ABOUT WHAT TO DO DURING THEIR RECOVERY

52%

UNDERSTOOD THEIR CARE WHEN THEY LEFT THE HOSPITAL
What does this mean?

- There is a bear in a plain wrapper doing flip flops on 78 handing out green stamps.
What you can do

• Focus on “need-to-know” & “need-to-do”
• Use teach-back method
• Demonstrate/draw pictures
• Use clearly written education materials
• Simulate
<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Action</th>
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<tbody>
<tr>
<td>Breathing</td>
<td>RECORD WEIGHT</td>
</tr>
<tr>
<td>Swelling</td>
<td>CALL</td>
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<tr>
<td>Weight</td>
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**Caution**
- 1 day gain 2 lbs or 3 lbs in 1 week

**Danger**
- More than 3 lbs!!

**Records**
- 13th, 24th

To: Chinese Hospital 845 Jackson Street, San Francisco, CA 94133
• Signs
  – What they are
  – What to do
• Medications
• Appointments
• Results to track
• Talk to me about these three things

Call askAAMC at 443-481-4000 for urgent health questions after you leave the hospital.
“I’m going to talk to you about what you need to do every day at home to control your heart failure.

Every day:

– Weigh yourself in the morning before breakfast and write it down
– Take your medication the way you should
– Check for swelling in your feet, ankles, legs and stomach
– Eat low-salt food
– Balance activity and rest periods”
Teach-back

Not teach-back

• List four things for me that you are going to do everyday?

Teach-back

• I teach people about this every day, and sometimes I go over it quickly or may not make myself clear. I want to make sure you know what you need to do. So, can you tell me some things you will do each day?

• We just discussed a lot of things for you to do every day. You might be doing some of these already. Have you already been doing any of these things? What do you think will be the hardest one for you to do at home?”
Let’s chat

- How are/can PFAs help you to improve standard hospital based care transitions practices for all?
- How specifically are you meeting/planning to meet PFE 1?
What others are doing

• Inviting patients to have an active voice in planning (PFE 1)
• Co-developing discharge plans (PFE 1)
• Whole person assessment
• Setting up appointments
• Making calls
• Producing educational materials
Driver #3

• Deliver enhanced services based on needs
Enhanced services

- Enhanced services generally mean $
- Choose enhanced services based on need
- Prioritize
  - What will benefit my readmission reduction efforts the most?
## Enhanced Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Change Idea</th>
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<tbody>
<tr>
<td>PALLIATIVE CARE</td>
<td></td>
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<tr>
<td>CONDITION SPECIFIC PROGRAMS</td>
<td></td>
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<tr>
<td>PHARMACY INTERVENTION</td>
<td></td>
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<tr>
<td>COMPLEX CARE MANAGEMENT</td>
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<tr>
<td>ED PAUSE</td>
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</table>
Sepsis

1. Increase awareness of long term consequences
2. Carefully plan discharge, esp. medications
3. Timely F/U with PCP and knowing who to call
4. Work to get stronger and increase activity
5. Seek medical attention for signs and symptoms of infection
Let’s chat

• How are/can PFAs help with enhanced services?
What others are doing

- PFA on the board to advocate for enhanced services (PFE 5)
- Help to prioritize enhanced services (PFE 4)
- Help design enhanced services (PFE 4)
Driver #4

- Collaborate with providers and agencies across the continuum
High utilizers

- Identify highest utilizers
- Learn what drives their utilization
- Meet the needs
Congregational health network
Walk a mile in my shoes

- Shadow program
- ED & SNF
- Experience a day in the life
- Stronger understanding and empathy
Let’s chat

• How are/can PFAs help with community collaboration?
What others are doing

- Help to identify and provide linkages to community resources, esp. non-clinical resources (PFE 4)
- Identify needs (PFE 4,5)
“THERE IS NO COMPARISON BETWEEN THAT WHICH IS LOST BY NOT SUCCEEDING AND THAT WHICH IS LOST BY NOT TRYING”

Sir Francis Bacon (1561 – 1626)

Are you ALL IN?
Commitments

- What ideas did you like?
- What idea will you test in your organization?
  - Who?
  - By when?
Thank you!!
PFE SNAP: Next Steps

- **Sign up**/prepare for personalized coaching calls
  - Decide which metric you’d like to discuss
  - Identify team who will participate in calls
  - Identify day/time to talk with HRET faculty
  - Review the PfP Roadmap content for PFE Metric 1, 4, and 5
  - Update performance score as needed for each PFE Metric

Put next PFE SNAP webinar on calendar and invite team members to participate

- April 5, 2018 @ 1-2 CT
RESOURCES

• PfP Strategic Vision Roadmap for PFE* (PFEC)

*Available at the PfP Resource Center:
https://www.healthcarecommunities.org/ResourceCenter/PartnershipforPatientsLibrary.aspx
THANK YOU!