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Cynosure HEALTH

PFCCpartners
Patient & Family Centered Care

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READY

The Admission encounter is a great opportunity to learn more about the patients and family caregivers receiving care. Enhancing existing Admission checklists to include items that relate to how a patient might manage their medication regime at home can provide critical insights for the clinical team managing care. Including a description of the people, the purpose and the opportunity for patients and their family caregivers to be active participants in bedside rounding, prepares patients to give information and receive education relevant to their care.

DOWNLOAD ADMISSION PLANNING ENHANCEMENT TOOL

ADMISSION PLANNING ENHANCEMENT

Consider the admission process as an opportunity to increase the quantity and quality of information the care team will have to treat the patient successfully during their hospitalization. The following items were suggested in focus groups with patient family partners, hospital staff and quality improvement advisors. Some of these elements may already be in your admission process, that's great! If you need to enhance the admission process, this list will give you some great ideas for deepening the knowledge the care team has to treat the patient effectively.

PROCESS ENHANCEMENTS

- Think of the admission encounter, not just as an administrative task but as an opportunity to set the expectation for engagement across the hospitalization.
- Provide information to prepare patients and family caregivers for bedside rounding and discharge planning on their way into the hospital.
- Capture information about the daily routines, including chronic care management, which will impact how the patient receives care and plans for discharge.
- Share patient reported information collected with the clinical team for integration in care planning
- Make these encounters available to everyone who is admitted, not just the planned admissions
- Make an effort to ensure alignment with what community practices may provide or acknowledge that their doctor may have provided additional and sometimes different information and identify discrepancies.
- Prep calls the night before admissions to avoid unnecessary scheduling/preparation direction complications
- Reframe the discussion of patient priorities and preferences as essential knowledge for the care team to have to provide safer, high quality care.
- Set realistic expectations by sharing hospital information as what is most likely to happen to least likely. Avoid "that never happens here" or "we always do that" which degrades trust
- If possible, be sure all authorization approvals are in place before contacting patient for admission planning
- Document outcomes of admission planning and share with the patient and with the clinical care team

MEDICATION MANAGEMENT

- Expand the discussion of current medications to include additional practices, supplements and help the patient make a plan for accessing those during hospitalization. Aromatherapy, music therapy, melatonin, CBD
- Enhance the discussion about drug allergies to include sensitivities – what antibiotics have been effective in the past and what medications come with intolerable side effects, include any potential interactions
- Discuss potential hurdles in managing medications in the hospital the same way the patients manage at home and develop work arounds for the patient to initiate if needed
- Discuss the changes in medications that will be necessary in the hospitalized environment and the anticipated return to home medications following discharge

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DOWNLOAD ADMISSION PLANNING ENHANCEMENT WORKSHEET

ADMISSIONS PLANNING ENHANCEMENT WORKSHEET

1. Who is currently responsible for admissions planning?

2. Does this individual have the capacity to own improvements to admissions planning?
   - ☐ Yes
   - ☐ No

3. Who needs to be engaged to improve the admissions process? Think broadly. Individuals may include pharmacy, marketing, admissions staff, etc.

4. Where is the patient's information from admissions planning currently captured?

5. How can the information be made available to the entire care team and the patient and family caregiver?

6. What 3 admission planning enhancements will we test with the team? How will we know we are successful?
   a. ______
   b. ______
   c. ______

7. How will we know we are successful?

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Hospitals have been implementing bedside rounds to help engage patients and their family caregivers into the clinical care received in hospitals. Family presence restrictions introduced during COVID 19 pandemic halted that engagement, to the detriment of care teams and patient outcomes Bedside rounding is an opportunity to ensure that the patient and family caregiver are informing care plans and management. To get set, hospitals can expand existing bedside rounding programs to include daily discussions of discharge, with a focus on medication changes, and anticipated home health needs and equipment to make sure the clinical team receives daily communication from the patient or family caregiver on the feasibility of the discharge plan in the context of the patients' life.

DOWNLOAD ENHANCING BEDSIDE ROUNDING TO IMPROVE DISCHARGE TOOL

ENHANCING BEDSIDE ROUNDING TO IMPROVE DISCHARGE

PREPARE FOR PARTNERSHIP WITH PATIENT & FAMILY

- Review information provided in the admission planning encounter about the patient
- Reiterate the purpose, schedule and structure of Bedside Rounds and invite the patient and family caregiver to participate
- Introduce team members and their specific roles as it relates to the patient's care (pharmacy may be involved as a new medication is tried, but will drop off when maintenance is achieved)
- Share the plan for communication between clinicians and sub specialists, include the patient in those communications
- Plan alternative for family caregivers who aren't present to inform bedside rounding
- Establish communication pathways between hospitalists and specialists that include the patient and provide opportunity for patient input directly into the communications
- Have a way of capturing patient insights and ideas about their care; ensure clinical staff listen actively, even when patient insights challenge medical knowledge
- Sign patients up on the patient portal while early in hospitalization to support communication and alignment

IMPLEMENT RECIPROCAL COMMUNICATION WITH PATIENT AND FAMILY CAREGIVERS

- Use Whiteboard for patients to list top 5 things staff need to know about to care for them, such as
  1. I am on a keto diet to manage my glycemic
  2. A lower than normal temp is normal for me
  3. I get red + sweat +get quiet when in pain
- Provide the opportunity for patients to update information during rounding
- Provide a pen and notepad for patients to write down questions and comments
- Include family caregiver in daily patient care instructions
- Ask patient for feedback on how medical interventions are going for them. Specifically, do they feel improvement? Are the side effects manageable? Is it sustainable for them to continue post discharge?

INCLUDE DAILY DISCUSSIONS TO FACILITATE DISCHARGE

- Prioritize discharge teaching daily
- Frame home care in terms of nice to haves and must haves
- Find out what is covered by insurance early so patient has time to work around barriers
- Include family caregivers to brainstorm on how to overcome hurdles to care
- Identify distance patient has to travel home to create a safe discharge with appropriate medication timing days before anticipated discharge
- Review medications with patient every day, ask about effectiveness, especially when new meds are added.
- Share medication details – what is the purpose and anticipated outcomes for each medication daily Confirm insurance coverage for anticipated medication and equipment needs
- Confirm availability of prescribed medications at local pharmacy
- Confirm a DME provider that services the community the patient lives in, create a workaround plan with the patient/family caregiver if needed

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Hospitals across the country are spending time, energy and resources to reduce readmissions rates. Patients and family caregivers are aligned on the goal of staying healthy and staying home following a hospitalization. Enhancing the Discharge Planning checklist to include more details related to medication management after discharge and integrating discharge planning in daily rounds provides more time for the clinical team and the patient to plan for a successful discharge.

DOWNLOAD ENHANCED DISCHARGE PLANNING TOOL

ENHANCED DISCHARGE PLANNING

SET EXPECTATIONS

- Discharge is a day, not an event
- Patients engaged in D/C planning increasing investments. Assures care plan is financially viable for patient/family
- Which doctor will finalize D/C decision order? Identify a coordinator for discharge
- Expectations for timing realistic hours, transportation
- No surprises on discharge equates to a successful discharge

PREPARATION ENHANCEMENTS

- Provide Family caregiver a room to allow 30 minutes with D/C coordinator to ask questions to ensure patient has family caregiver that can manage care at home
- Send patients home, not to the pharmacy
- Make follow up appointments with patients before discharge
- Contact info for medication prescribers while in hospital
- Use teach back to confirm understanding
- D/C instructions include drawings, metaphors to increase understanding
- Too much information from too many sources creates confusion, help prioritize information for patient
- Ensure information included is specific to the patient, alter templated handouts to be specific
- Share costs of post discharge care to align with patients' ability to pay
- Confirm insurance coverage
- Involve patient and family caregivers in D/C care and instructions

ENHANCE PATIENT RESOURCES POST DISCHARGE

- Patients need contact info on where to get questions answered after you leave the hospital from a source that has access to the medical record
- Large packets are not helpful when provided at D/C event. Provide specific information for the patient and provide ample time for patient and family caregiver to review before asking if they have any questions
- Provide peer connection portal. Patients discuss their recovery and give advice, provide important perspectives
- Include mental health resources and tools to address post D/C depression "Re-entry" into daily life
- Provide 1:1 patient liaison with full access to all information

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IMPLEMENTATION GUIDE

Are you ready to get started connecting these three activities to improve patient outcomes and avoid readmissions? The following suggestions are given to provide guidance on implementing the tool in your hospital.

1. **Move information not people.** Admission checklists are so helpful in gathering critical insights from patients and family caregivers, not only about preferences and priorities, but also about critical self management of chronic conditions that will be impacted during hospitalizations. Be sure this information moves forward to the clinical care team. Consider identifying a Patient Information Steward who is responsible for ensuring information follows the patient journey from admissions through bedside rounding to inform discharge.

2. **Expand current information sharing pathways.** Patients have important information about how they manage their health or healthcare when not in the hospital. Expand current communication tools to provide an opportunity for reciprocal communication and have a place to document and share patient reported care. If changes to the EMR are not immediately feasible, consider low tech solutions such as white boards, bedside iPad or notebooks. A consistent place where patient and family caregiver insights are captured and shared with members of the clinical team.

3. **Define Roles.** Who is responsible for the admission checklist? See if that person can own the process where that checklist becomes a reciprocal information sharing event. Where is the information documented and how does the information move to the clinical team? It might be helpful to develop a team of staff members across these activities to test how they can best share information with hospital staff and the patient and family caregiver.

4. **Talk to your patients.** Journey map recent hospitalization with a patient and family caregiver. If your hospital has a Patient Family Advisory program, engage them in this activity. If you don't have a Patient Family Advisory program, invite a few recently discharged patients to inform your improvement efforts. Let them know what your hospital is trying to achieve and bring them on as a team member. No one is more invested in staying healthy at home then your patients! The additional perspective helps identify unseen barriers

DOWNLOAD MAPPING A PATIENT'S JOURNEY TOOL

ACKNOWLEDGMENTS

The Ready. Set. Go! Tool was developed through an iterative process informed by a diverse group of patient family partners, Cynosure Improvement Advisors, State Hospital Association partners and hospital staff for the Cynosure HQIC. Thank you for all those who shared their personal and professional wisdom to help hospitals move forward with engaging patients and families it the effort to reduce readmissions.

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