PFE Quickinar Series Session 5

Preparing the Patient and Care Partners for Discharge

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PFE= Patient and Family Engagement

CMS Definition of PFE

"Patients and families are partners in defining, designing, participating in, and assessing the care practices and systems that serve them to assure they are respectful of and responsive to individual patient preferences, needs, and values. This collaborative engagement allows patient values to guide all clinical decisions and drives genuine transformation in attitudes, behavior, and practice."

The Centers for Medicare & Medicaid Services (CMS). Person & Family Engagement Strategy. Available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/Person-and-Family-Engagement-Strategy-Summary.pdf.

OBJECTIVES

- Demonstrate methods of assessing patient social needs prior to discharge.
- Summarize the concept of discharge planning beginning at admission.
- Review how to use checklists to prepare patients for discharge.
- Review information on health literacy.

CMS PFE Metrics

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CMS Metrics for Person and Family Engagement (PFE)

PFE METRIC	INTENT	MUST BE IN PLACE TO MEET METRIC	Resources
1 Planning Checklist for Scheduled Admissions	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 care.	• Hospital has a planning checklist for patients with scheduled admissions. • Hospital staff discuss the checklist with the patient and family prior to or at admission.	https://www.mnhospitals.org/Portals/0/Documents/patientsafety/Patient%20Family%20Engagement/RoadmapMetric-1-508.pdf; Page 1–9
2 Discharge Planning Checklist	For all inpatient discharges, hospital staff utilize and discuss a checklist to ensure key elements of discharge planning and care transitions are covered to prepare patients and families for discharge and invite them to be active partners in care.	• Hospital has a planning checklist to proactively prepare for discharge. • Hospital staff discuss the checklist with the patient and family to ensure a successful transition of care.	https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy4/Strat4_Tool_1_IDEAL_chklst_508.pdf
3 Shift Change Huddles or Bedside Reporting	Include the patient and/or family caregiver in as many conversations about the patient's care as possible throughout the hospital stay.	• On at least one unit, nurse shift change huddles OR clinician reports/rounds occur at the bedside and involve the patient and/or family members in all feasible cases.	https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy3/Strat3_Tool_2_Nurse_Chklst_508.pdf
4 Designated PFE Leader	Hospital has a designated individual (or individuals) with leadership responsibility and accountability for PFE.	• There is a named hospital employee (or employees) responsible for PFE efforts. Such individual(s) can hold either a full-time position or a percentage of time within another position. • Appropriate hospital staff and clinicians can identify the person named as responsible for PFE.	https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/howtogetstarted/Best_Practices_Hosp_Leaders_508.pdf
5 PFAC or Patient/ Family Representative(s) on Hospital Committee	Ensure that a hospital has a formal relationship with patient and family advisors (PFAs) from the local community who provide input and guidance from the patient perspective on hospital operations, policies, procedures, and quality improvement efforts.	• Patient and/or family representatives from the community have been formally named as members of a PFAC or another hospital committee (at least one patient.). • Meetings of the PFAC or another committee with patient and family representatives have been scheduled and conducted.	https://www.ahrq.gov/patient-safety/patients-families/engagingfamilies/strategy1/index.html

CMS = Centers for Medicare & Medicaid Services; PFAC = Patient and family advisory council

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HSAG. CMS Metrics for Person and Family Engagement (PFE). Available at https://www.hsag.com/globalassets/hqic/pfemeasureschecklist_v1_508.pdf.

What Must Be in Place to Meet Metric 1

- Hospital has a physical discharge planning checklist for patients, preferably one that was designed or reviewed by patients and families.
- Prior to discharge, hospital staff discuss the checklist with patients and/or the family caregivers.

American Institutes for Research. PfP Strategic Vision Roadmap for Person and Family Engagement—Metric Digest. Available at https://www.mnhospitals.org/Portals/0/Documents/patientsafety/Patient%20Family%20Engagement/RoadmapMetric-1-508.pdf.

Benefits

- Invites patients and care partners to be active participants in the discharge process.
- Allows for identification of patients' social needs.
- Offers opportunities for patients to discuss and clarify any discharge instructions they may not understand.
- Decreases anxiety regarding the discharge process and improves patient satisfaction.
- Can be helpful in reducing readmissions.

Social Needs Screening

- Discharge planning offers an opportunity for identification of patient social needs.
  - Unmet social needs can impact patient compliance with discharge instructions.
  - Early identification and discussion with patients allows community resources and referrals to be set up for the patient.

Social Needs Screening Tools

- Multiple options for screening tools are available:
  - PRAPARE tool (https://prapare.org/)
  - CMS tool (https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf)
  - HSAG Social Work Assessment tool (https://www.hsag.com/globalassets/hqic/hqic_socialworkassessment.pdf)
  - Screening tool comparison (https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison)

Discharge Planning Begins at Admission

- Early discharge planning can decrease length of stay, readmissions, and mortality.
  - Discharge planning should begin as soon as possible.
- Discharge planning is complex and is not one-size-fits-all.
  - Care teams should communicate with patients and care partners to assess patient needs at discharge.
  - This communication should begin at admission history taken by bedside nurse.

Discharge Planning Begins at Admission (cont.)

- Early identification of patient needs allows for successful coordination of post-discharge care.
  - Assists in identifying the best setting to discharge to and getting this coordinated.
  - Allows time for facilitating community resources for patients with social needs.
  - Addresses gaps in care during hospitalization that can increase patient confidence in their discharge plan.
- Early engagement also allows opportunities for patient education throughout the hospital stay.
  - Medication reconciliation or meds-to-beds programs
  - Teach-back with patient
  - Discussion of Zone tools or other patient education

HSAG PFAC Hospital Admission Instructions Flyer

First Things First

- ☐ Tell the nurse* or doctor what you would want to be done if you should stop breathing or your heart should stop (if you have Do Not Resuscitate wishes).
- ☐ Give the nurse a copy of your Advance Directives/Living Will for your chart.
  - If you do not have one, information can be provided.
- ☐ Tell the nurse if you have a specific person who can get information about you during your hospital stay.
- ☐ Tell the nurse if you have a Power of Attorney for your healthcare and who that person is.
- ☐ Make sure all hospital staff are washing their hands when entering and leaving your room.
- ☐ Talk to your doctor and nurse about your plan of care.
  - Discuss what you may need when you are released from the hospital.
- ☐ Ask hospital staff to explain anything that you may not understand.

Medications

- ☐ Give the nurse an updated list of medications you are taking right now.
- ☐ Tell the nurse if you have any allergies.
- ☐ Tell the nurse if you have trouble getting your medications.
- ☐ If you are given a new medication(s), ask:
  - What it is for.
  - How it will help you.
  - How often you take it.
  - What the side effects are.

Nutrition

A heathy diet is necessary to heal wounds, control illnesses, and build or maintain strength.

Tell or ask the nurse:

- ☐ How you have been eating and drinking at home.
- ☐ If you need help with your meals.
- ☐ If you have trouble swallowing food or liquids.
- ☐ What kind of foods you like.
- ☐ How you can order your meals.
- ☐ How you get your meals at home.

Mobility

Even though you may not be feeling well, getting you moving as soon as possible will help decrease the chance of your muscles getting weak and you developing blood clots or bed sores.

Tell or ask the nurse:

- ☐ How you have been getting around at home.
- ☐ If you use anything to help you walk.
- ☐ If you can get out of bed and go to the bathroom on your own, or if you should call for help first.
- ☐ If you can get out of bed to eat your meals.
- ☐ To show you how you can prevent getting blood clots by doing exercises, such as ankle pumps.

To prevent bed sores, tell or ask the nurse:

- ☐ If you have trouble holding your urine or stool.
- ☐ To look at your skin.
- ☐ Where skin injury can happen to you.
- ☐ If you see any changes on your skin.
- ☐ How you or your caregiver can safely change your position in bed.
- ☐ To tell you about rubbing or friction on the skin and ways to prevent it.

Mental State

Sometimes being in the hospital can cause confusion because of

Tell or ask the nurse:

- ☐ How your thinking can be affected during your hospital stay
- ☐ If you have trouble sleeping.

For family members, tell or ask the nurse:

- ☐ If your loved one is acting different.
- ☐ If anything causes confusion for your love
- ☐ If your loved one gets confused during

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Discharge planning checklist

- Hospital discharge planning checklist should include questions assessing multiple areas
  - Patient safety at home and daily routines
  - Potential patient needs (food, transportation, medical equipment, household assistance)
  - Patient medications
  - Follow-up care or home health referral

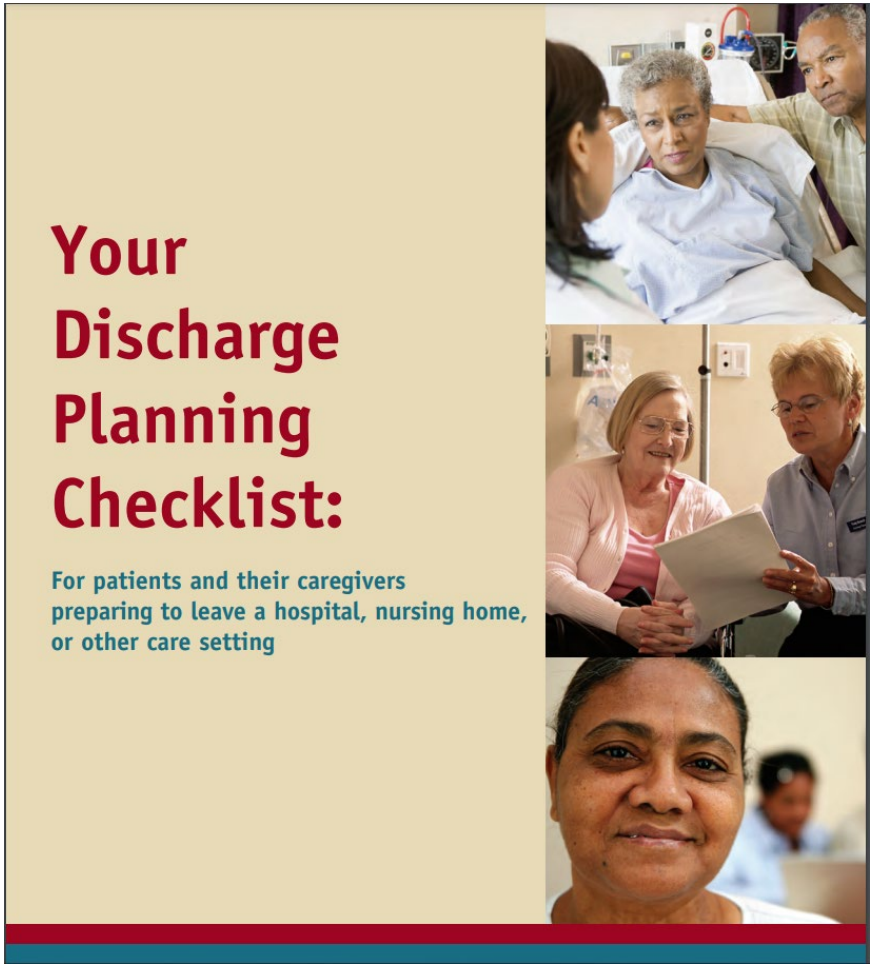
Discharge Planning Checklist Examples

- Examples of discharge planning checklists include
  - AHRQ Ideal Discharge Planning Checklist
  - CMS Discharge Planning Checklist
  - Robert Wood Johnson Discharge Planning Checklist

AHRQ = Agency for Health Care Research and Quality

CMS Discharge Planning Checklist

- Designed for patients and caregivers
- Contains multiple action item lists that can be filled out with assistance from the care team.



Health Literacy and Discharge Planning

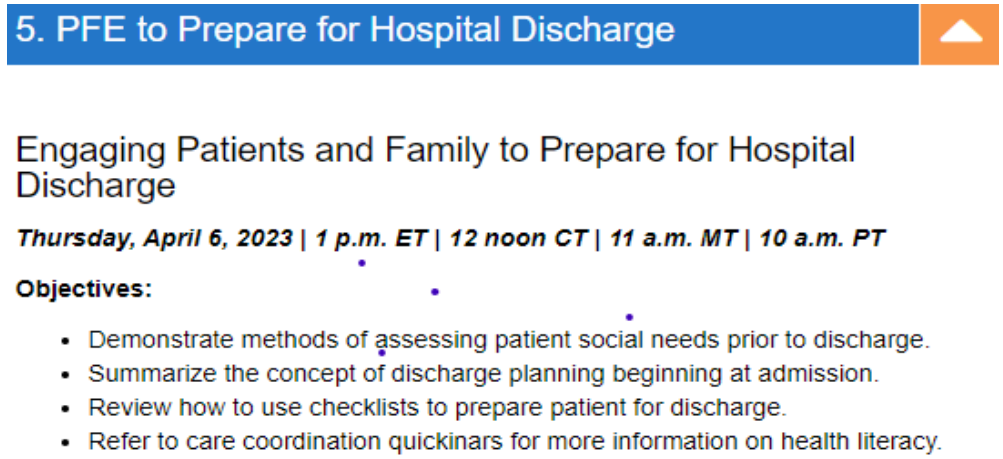
- Health literacy is an important factor to consider in discharge planning.
  - Patients with low-health literacy can have difficulty understanding and following discharge planning.
  - Low-health literacy can impact patient trust and the level of communication with providers.
- For more information, please visit HSAG's Care Coordination Quickinar on health literacy at https://www.hsag.com/en/medicare-providers/care-coordination-quickinar-series/#_The_Impact_of_Health_Literacy.
- HSAG will be hosting a second Care Coordination Quickinar on the impact of health literacy on May 2, 2023.
  - Register at https://www.hsag.com/en/medicare-providers/care-coordination-quickinar-series/#_Health_Literacy_Part_Two

Key Concepts

- Hospitals should actively engage patients and care partners in preparing for discharge as soon as possible.
- Social needs screening and case management are important parts of discharge planning.
- Hospitals should have a discharge planning checklist in place that assesses key elements of patient preparedness for discharge.
- Health literacy is important factor to consider in preparing patients for discharge.

Join Us for the Entire Series

Recordings, slides, and resource links will be posted for on-demand access after every session.



1. Intro to PFE
2. Achieving Patient/Family Centered Care
3. Preparing for PFE Programs
4. PFE to Prepare for Hospital Admission
5. PFE to Prepare for Hospital Discharge
6. Role of PFE in Readmission Prevention
7. Bedside Hand Off to Improve Patient Outcomes
8. Adverse Event Transparency
9. Role of the PFE Advisor
10. Selecting/Training/Engaging Advisors
11. PFE in Critical Access & Small Rural Hospitals
12. PFE in Acute Care Hospitals

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QUESTIONS?

Thank you!

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